LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD

Tuesday 25th July 2006 at 10am

Conference Room, 220 Waterloo Road, SE1

A G E N D A

1.	Declarations of Further Interest.		
2.	Opportunity for Members of the Public to ask Questions.		
3.	Minutes of the Meeting held on 23rd May 2006	Part 1 and II	Enclosure 1& 2
4.	Matters arising		
5.	Chairman's remarks		Oral
6.	Report of the Chief Executive		Enclosure 3
7.	Audited accounts for 2005/06 for approval		Enclosure 4
8.	Month 3 2006/07 Financial Report.		Enclosure 5
9.	Report of the Medical Director		Enclosure 6
10.	Receive update regarding strategic outline case CAD 2010		Enclosure 7
11.	Update on the implementation of the Governance Review and approve terms of reference for the Audit Committee and Clinical Governance Committee.		Enclosure 8
12.	Review & re-approve Freedom of Information policy		Enclosure 9
13.	Note the LAS' response to the commissioning arrangements for London		Enclosure 10
14.	Report from Trust Secretary on tenders opened since last Board meeting & the use of the Trust Seal.		Enclosure 11
15.	Draft minutes of the Audit Committee, 3rd July 2006		Enclosure 12
16.	Draft minutes of the Service Development Committee, 27th June 2006		Enclosure 13
17.	Draft minutes of the Charitable Funds Committee, 27th June 2006		Enclosure 14
18.	Draft minutes of the Clinical Governance Committee, 15th May 2006		Enclosure 15
19.	Any Other Business.		
20.	Opportunity for Members of the Public to ask Questions.		
21.	Date and Venue of the Next Trust Board Meeting. 26th September 2006, 10.00am at 220 Waterloo Road, London SE1		

Enclosure 1

LONDON AMBULANCE SERVICE

TRUST BOARD

Tuesday 23rd May 2006

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

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Non Executive Directors	
	Barry MacDonald	Non Executive Director
	Sarah Waller	Non Executive Director
	Beryl Magrath	Non Executive Director
	Ingrid Prescod	Non Executive Director
	Roy Griffins	Non Executive Director
	Executive Directors	
	Mike Dinan	Director of Finance
	Fionna Moore	Medical Director
	Caron Hitchen	Director of Human Resources & Organisation Development
Apologies:		
	Caroline Silver	Non Executive Director
	Martin Flaherty	Director of Operations
In Attendance:		
	David Jervis	Director of Communications
	Peter Suter	Director of Management Information & Technology
	Kathy Jones	Director of Service Development
	Russell Smith	Deputy Director of Operations
	John Wilkins	Head of Governance
	Ian Todd	Assistant Director of Operations, Urgent Care
	Martin Brand	Head of Planning & Programme Management
	Christine McMahon	Trust Secretary (Minutes)

The Chairman welcomed Russell Smith, Deputy Director of Operations to the meeting.

41/06 Declarations of Interest

Although he was confident that there would be no conflict of interest Barry McDonald wished to declare that he was no longer employed by the HFEA and is now working for The International Institute of Communications and Irving International Ltd.

42/06 Opportunity for Members of the Public to ask Questions

There were no questions.

43/06 **Minutes of the Meeting held on 28th March 2006**

Agreed: The minutes of the meeting held on 28th March 2006 as a correct record of that meeting.

44/06 **Matters Arising**

Minute 26.06 (page 2) the HR Director will present the findings of the 2005 staff survey to the Service Development Committee in June 2005. **ACTION: HR Director**

Minute 28.06 (page 7) the Deputy Director of Operations suggested that the reference to 'a stockpile of vaccine' should read 'a stockpile of antiviral' in preparation for an outbreak of a pandemic influenza

Minute 30.06 (page 8) the HR Director undertook to provide Beryl Magrath with a reconciliation of the 2 tables (the workforce plan and the February workforce figures) **ACTION: HR Director**

45/06 **Report of the Chairman**

The Chairman reported that the appointment of the senior team of the National Health Service has been confirmed. Sir Ian Carruthers' appointment as Acting Chief Executive of the NHS has been extended to December 2006 and the Chairman welcomed the period of stability this would bring as the search continued for a successor to Sir Nigel Crisp. Duncan Selbie has been appointed Director of Commissioning. Andrew Cash has been appointed as Director of Provider Development and he is expected to focus initially on Acute Trusts.

In respect of the new Strategic Health Authority (SHA) for London Dr George Greener has been appointed Chairman with David Nicholson appointed Chief Executive. Dr Greener has been invited to visit the LAS on 19th June which will provide an opportunity to discuss ideas about the future delivery of emergency care in London.

The national reconfiguration of Primary Care Trusts (PCTs) has taken place, with the number of Trusts decreasing from 302 to 152/153 which is a fairly dramatic change. In London, the PCTs will continue to number 31 but are expected to change the way they operate i.e. develop local pathways to respond to local needs. It is expected that service commissioning will be increasingly driven by the SHA, with the prospect of a commissioning directorate having genuine negotiating power.

The Ambulance Services in England have also undergone reconfiguration, with the number of ambulance services decreasing from 31 to 12; Staffordshire has won a reprieve and will not be amalgamated with neighbouring services for the time being. It has also been recognised that the Isle of Wight is a special case and it will not be part of the reconfiguration.

The Deputy Director of Operations enquired about the future of Patients' Forums. The Director of Communications reported that a review is expected shortly regarding that future of Patient Public Involvement and is expected to recommend the Forums be based around PCTs.

46/06 **Report of the Chief Executive**

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

The Trust achieved two key performance targets in 2005/06, Category A8 and A14 minutes. Performance in 2006-07 for Category A8 was 76.2% for April and in May, to date, it was 74% - the year to date figure was 75%.

Training in the new Resuscitation Guidelines is being delivered; with staff being taken off the road for 3 hour training sessions which is having a knock on effect on performance. The cessation of double time being paid for overtime worked at the weekend has had a detrimental effect on the number of staff available. This has been partly offset by new recruits working rotas that include a lot of weekend shifts. Efforts are being made to ensure that Team Leaders undertake their office rotation which will enable them to complete the Clinical Performance Indicator checks.

The Board's attention was drawn to Category A8 which in April 2006 dropped from 40% to 37% of the total proportion of calls. The target is for Category A8 to drop to 30% by 1 April 2007 and work is being undertaken by Clinical Audit & Research to support the case to the Department of Health.

PTS won the Bromley contract (£2m per annum). The Chief Executive and the Director of Finance are currently holding consultation meetings with PTS staff. Overall, staff expressed confidence with the progress of integration of PTS with A&E, though concerns were voiced regarding communications and job security.

Talks are being held with the Department of Health at a national level to delay the new clock start for a further year. A two year plan is being drafted on how the LAS will achieve the new clock start which will be shared with the Service Development Committee in June 2006. **ACTION: Director of Operations**

In April 2006 the measurement for Doctors' Urgents changed – with time arrived at the patient being measured and not, as previously, the hospital. The measurement of Category B changed from a 14 to a 19 minute response time.

The Chief Executive was confident that all 4 targets – Category A8 and A14, Doctors Urgents and Category B 19 will achieved by then end of 2006/07.

Agenda for Change (AfC): 98% of staff have been assimilated with the control room staff being the only staff group not assimilated.

Work is being undertaken to ensure the Trust can go live with Electronic Staff Records (ESR) in July but this will not happen unless the Project Board is confident that it is ready.

Staff absenteeism has been an issue, though there has been an improvement month on month since December 2005.

An options paper regarding rest breaks will be presented to the next Service Development Committee for discussion in June. **ACTION: HR Director**

Paramedics: 450 applicants recently applied for the 100 paramedic training places. Following assessments, it is possible that not all of the places will be filled, which is a concern. A debrief is taking place for those staff and further training offered where appropriate.

Communications: MORI has been appointed to undertake a survey of Londoners' views about the LAS; its findings will be shared with the Trust Board in due course.

Preparations are in hand to respond to the expected increase in demand as a result of the forthcoming World Cup.

It is expected that the Greater London Authority's inquiry into the emergency services response to the July 2005 bombings will be critical of the lack of routine communication available to the LAS. A response to the report has been prepared by the Director of Communications.

Travel: retrospective permission was sought for the Awards Manager who visited Norway on 10th-12th May 2006 in connection with the exchange programme between the LAS and the Ulleval University Hospital. The trip was funded by the LAS.

Permission was also sought for the Assistant Director of Operations, Mike Boyne to travel to the USA to speak at a conference on Response to Terrorism 5-7 June 2006. The trip will be funded by the conference organisers.

Roy Griffins queried whether the approval of foreign travel needed to be part of Trust Board business. The Chairman pointed out that this complied with the Trust's existing Standing Orders. The issue would be considered as part of the bi-annual review of the Standing Orders.

The Board wished to record its thanks to both staff and managers for achieving the Category A8 and A14 performance targets in 2005/06.

In response to a question from Sarah Waller the HR Director confirmed that the Trust had made good progress with the development of KSF outlines (Knowledge & Skills Framework) with approximately 80% of posts completed. The HR Director confirmed that the AfC appeal process has only 2 stages with no further stage beyond the decision of the joint panel. The panel is comprised of both staff and management representatives.

Barry McDonald suggested that the graph illustrating PTS performance could be amended to state 'patient collected within allocated time'. The Director of Finance, who has responsibility for PTS, undertook to implement the suggestion. **ACTION: Director of Finance.**

Barry McDonald queried graph 7 'hours staff per day which was split between total ambulance and FRU and ambulance only' and wondered which calls were answered by ambulance and which by single responder. The Director of Finance commented that the presentation of the balanced scorecard should address this issue. A draft balanced scorecard will be presented for consideration by the SDC in June 2006. **ACTION: Director of Finance.**

Beryl Magrath asked whether the Emergency Operations Centre staff were receiving additional support in light of their increased workload – answering 23,000 calls per week. The Chief Executive stated that 18 extra staff had been recruited to assist with the increased volume in call taking and that EOC was expected to reach full establishment very shortly. The ADO EOC has undertaken extensive work with EOC and is in the process of re-organising the roles and responsibilities of managers, which will prove quite a challenge.

It was explained that the survey of Londoners being undertaken by MORI will include gathering the views of a sample of London's Black & Minority Ethnic populations. The work being undertaken will be of a qualitative nature and will involve the use of focus groups. The Director of Communications commented that this is one of the biggest pieces of work to be undertaken by the Trust and will enable the Trust to understand the views and perceptions held by Londoners about the role of the LAS.

In response to a question from Barry McDonald concerning the Gold Suite's reported relocation to EOC, it was suggested that a report regarding the use of the Gold Suite in recent months to improve performance, be prepared for the Trust Board. **ACTION: Director of Operations.**

The HR Director reported that the parallel testing undertaken with ESR has given some concern. She gave an undertaking that unless there is full confidence in ESR's feasibility, it will not go live in July.

Roy Griffins referred to the achievement of performance targets despite the Trust experiencing a serious resource pressure. The Chief Executive responded by saying

that there are a number of challenges facing the Trust in 2006/07: achieving full establishment; achieving all the performance targets; implementing rest breaks and reducing job cycle time.

The Chairman commented that currently there are, on average, 1.3 responses sent to each incident the Trust responds to which may not be the most efficient use of resources. Work is being undertaken to address this issue whilst at the same time, ensuring there is good clinical governance in place and appropriate staff safety measures.

The Director of Finance suggested that Roy Griffins might wish to read the staff modelling report produced by ORH which underpins the Trust's operational regime.

In reply to a question from Beryl Magrath concerning the proposed new clock start the Chief Executive confirmed that the Trust would need to achieve a performance target of 95% for Category A8. There are currently significant fluctuations in performance on a weekly basis with rapid call answering being identified as a key issue.

Agreed: **1. To grant retrospective permission to the Awards Manager who visited Norway 10th-12th May 2006.**

2. That ADO Mike Boyne could visit the USA, 5th-7th June, to speak at a conference on Response to Terrorism.

Noted: **3. That copies of 'Talkback' (referred to in the CEO's report) were circulated at the meeting by the Director of Communications for information.**

47/06 **Month 12 2005/06 Finance Report**

The Director of Finance presented Month 12 finance report for 2005/06 and reported that the Auditors were currently undertaking the annual audit. There was an underspend of 0.6% of the annual budget which was due to unforeseen additional income being received. The Trust generated £3m savings from both operational and non-operational directorates. In 2005/06 PTS incurred a loss of £160k due largely to the use of third party.

Of the 4 financial targets set by the Department of Health the Trust achieved two significant ones which are balancing Income and Expenditure and External Financing Limit. The two financial targets not achieved related to capital (Capital & Resourcing Limit and Capital Cost Absorption Rate) as there was an underspend on capital in 2005/06. Historically, the Trust has experienced difficulties spending its entire capital budget.

Barry McDonald recognised the progress that has been made with PTS.

Barry McDonald asked if the year to date variance on CBRN[1] funding (£4.6m) related to the additional funding for the terrorist incidents of 7th July 2005. This was confirmed by the Director of Finance.

Beryl Magrath asked about the £500,000 overspend on legal expenses against budget; the Director of Finance explained that this was due to a budgeting error where the NHS Pensions cost of early retirement had been under-budgeted compared to previous years.

In response to a question concerning gas cylinders, the Director of Finance reported that the Logistics department are reviewing the arrangements with British Oxygen Company.

[1] CBRN: chemical, bombing, radiological and nuclear

The Director of Finance confirmed that the Croydon Emergency Care Practitioner (ECP) programme is being continued as the Trust is getting some benefit from the programme; discussions are ongoing with Croydon PCT regarding funding for the programme.

Sarah Waller referred to the reported £66,000 A&E operational costs incurred by the CAD[2] project in 2005/06. The Director of Finance assured her that all costs connected with the CAD 2010 are being tracked; the capital expenditure to date is £400,000. Of the budgeted £2,012,000 only £145,000 was spent in 2005/06. The Director of IM&T pointed out that the cost of the operational staff is not part of the CAD 2010 costs.

Noted: The Month 12 2005/06 finance report

48/06 Month 1 – 2006/07 Finance Report

The Director of Finance presented the Month 1 finance report for 2006/07 to the Trust Board. He apologised that the format remained unchanged and undertook to present a revised format at the next board meeting which would include a traffic light style of reporting and information concerning trends. **ACTION:Director of Finance**

Month 1 has been a very positive month; PTS made a surplus of £500,000. As the Trust received funding late in the 2005/06 financial year it missed the deadline for brokering funds, consequently the Trust's cash balance is quite high at £10m. In accordance with national guidelines the Trust's tangible assets have been revalued and increased by approximately £6m to £112,436,000.

The Trust Board was informed that the Trust had been asked by the London Strategic Health Authority (SHA) Transition team to make a surplus of 1% on revenue as part of the financial recovery plan for London; this is in addition to the £4.6m savings that the Trust is required to achieve in 2006/07. An undertaking has been given that the 1% brokered would be returned in 2007/08. The budget for 2006/07 had been approved by the Trust Board in March 2006 and was completed, largely on zero-based basis. The Director of Finance has not forecast a surplus over and above that already approved. The additional savings required would be in the order of £2m and would materially impact on both performance and resilience. The Director of Finance has proposed to the SHA that the £1.2m surplus for 2005/06, which would be brokered into 2006/07, be used as a surplus for 2006/07. This would equate to 0.6% of revenue. This may not be acceptable to the SHA but the Director of Finance would not agree any change without Trust Board approval and would keep the Board updated accordingly.

Beryl Magrath was informed that the £11,000 incurred as part of the Bromley contract was due to start up costs and will be recovered during the financial year.

Barry McDonald asked about the Workforce Confederation Income; the Director of Finance reported that less funding has been received than expected with £400,000 being queried.

Noted: The Month 1 2006/07 finance report

49/06 Report of the Medical Director

The Medical Director presented her regular report to the Trust Board and explained that the format of the report reflected the seven domains of the Standards for Better Health. She highlighted the following from her report:

[2] CAD: Computer Aided Despatch

- The Chief Medical Officer has issued a warning concerning an anti-depressant which is of some significance for the LAS, work has been undertaken to make staff aware.
- Information regarding the Safety Alert Bulletins that the Trust receives was included with the Medical Director's report (Appendix 1). The Medical Director commented that only a small percentage of SABs were relevant to the Ambulance Service in general.
- Andrew Lingen-Stallard, Consultant Midwife has been recruited on a part time basis to advise the Trust on maternity and obstetric issues. There are concerns in London about the pressures on maternity units which often puts LAS staff under pressure e.g. closing delivery wards without informing the LAS or their neighbouring hospitals.
- Dr Daryl Mohammed has been appointed Assistant Medical Director (Primary Care) on a part time basis; his role will be to continue to offer support to the ECP programme and take forward the delivery of Urgent Care.
- The Medical Director reported on the results of the ongoing drug usage audit undertaken by the Management Information department for December 2004-December 2005 (Appendix 2). The audit highlighted the increased use of morphine as an analgesic since its introduction in October 2005; 800 doses per month of injectable analgesia have been used. Prior to the introduction of morphine the Trust previously used two other analgesics: nalbuphine and tramadol. Although tramadol is being used less since the introduction of morphine it is likely to be retained in case there are any problems concerning the management of morphine i.e. missing ampoules.
- The LAS Reperfusion Strategy was implemented from 3rd April 2006 with patients experiencing ST Elevation being taken to the nine cardiac centres in London. The London Chest Hospital reported that it received 67 patients in a 4 week period in April 2006. For a variety of reasons a small number of crews have continued to take patients with ST elevation to the nearest A&E hospitals. The Medical Director felt that the implementation of training for front line staff regarding the revised Resuscitation Guidelines will be a 'fantastic' opportunity to deliver practical training and to talk through the reasons behind the changes.
- It has become apparent from research undertaken separately by the Director of Service Development and the LAS Patients' Forum that there is some confusion as to the provision of care for patients who suffer a stroke. Further work will be undertaken with PCTs to highlight the issue.
- A pilot study is being undertaken with the London Hospital and Barts in the use of a new assessment tool – ROSIER[3] which, if successful, may augment the current FAST[4] system used by crews to identify when a patient has had a stroke.
- In terms of staff development the Trust has introduced an electronic learning tool on capnography[5] that enables individuals to learn at their own pace and can be accessed either from LAS or home computers. A certificate is issued on completion of the course; to encourage participation those staff issued with a certificate are entered into a monthly prize draw with the opportunity to win an iPOD.

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[3] ROSIER – Recognition of stroke in the emergency room
[4] FAST – Face Arm Speech Test
[5] Capnography –the display of the C02 content of expired breath in a wave form.
[6] CPR – cardio pulmonary resuscitation

- A pilot is being undertaken in North East London using software that has been fitted to existing shock boxes (FR2+). The machine will advise on whether CPR[6] should be delivered prior to a shock or whether a shock should be delivered. This work is being undertaken with the New York State Ambulance Service. The Medical Director commented that she had a useful meeting with the New York State Ambulance Service's Medical Director at the recent Stravgar Conference.

The Medical Director reported that the failure of many staff to return their drug packs at the end of their shift continues to be a concern; in addition there has recently been an issue with the supply of mini-jets of morphine. The necessity of crews using ampoules instead of mini-jets has led to an increase in the risk of needle stick injuries. Work will shortly be undertaken with suppliers to ensure the availability of mini jets.

Serious Untoward Incident: the Board was informed that a Serious Untoward Incident had been declared following the death in police custody of a man in his early 40s. An investigation is being undertaken involving the attending LAS crew.

In response to a query from Sarah Waller the Medical Director confirmed that work has been undertaken to encourage the return of drug packs. The issue was highlighted during the Chief Executive's consultation meetings plus there was an amnesty declared which resulted in a number of packs being returned. The matter was raised again at the recent Team Leaders' conference. The Director of Finance reported that the Logistics Manager is investigating the introduction of a tracking system by which the issuing of drugs could be better managed. It is also possible that the Make Ready contractors will be able to undertake an audit of drug packs. It was recognised that in addition to the risk of out of date drugs being used due to staff retaining their drug packs, there is also the financial cost to the Service as additional packs are required.

The Medical Director confirmed for Beryl Magrath that in the early days following the introduction of morphine, there had been 3-4 occasions when the issue of the drug had to be halted due to missing ampoules. There have been no reports recently of any problems being experienced with the issuing of morphine. All but one of the complexes are issuing morphine. It was confirmed that the morphine ampoules are issued separately; they are kept secure whilst staff are on duty and any unused ampoules are returned at the end of the shift.

The Medical Director confirmed she had only received one call from a London hospital following the introduction of the Reperfusion Strategy; the opening of the 9 cardiac centres offering angioplasty will mean less patients being taken to A&E departments. Approximately 20% of patients with STEMI[7] self-present at A&E departments; arrangements are in place so that when a patient is diagnosed as having a STEMI s/he can be transported as a critical transfer from that A&E department to a centre offering angioplasty.

Ingrid Prescod asked how significant the issues are surrounding obstetric patients; the Medical Director estimated that the Trust receives 6,000 to 9,000 calls a year which would involve transporting a patient in normal early labour. Although there is anecdotal evidence from crews about being summoned to transport women in labour whilst their husbands followed behind in a car, there is a small percentage that represent a medical emergency. In order to be able to respond to those latter calls AMPDS 11.2[8] has been modified so that the call taker can give assistance until the ambulance crew arrive on scene. It is anticipated that with the appointment of the

[7] STEMI – ST elevated myocardial infarction
[8] AMPDS – Advanced Medical Priority Despatch System

Consultant Midwife, further modifications will be suggested to the AMPDS User Group. With a good clinical audit facility in place, there is the possibility of influencing the next version of AMPDS.

Noted: The Medical Director's report

50/06 **Approve new Governance and risk management arrangements**

The Finance Director presented the report to the Trust Board. Dr Beryl Magrath, who led the Review, outlined the process undertaken and what the anticipated benefits will be for the Trust with the implementation of the recommendations contained in the report. She felt it was important that governance involved and was owned by all staff in the Trust.

The recommendations included the amalgamation of some committees (e.g. Risk Management Group and Risk Management Committee being replaced by the Risk Assurance & Compliance Group) to streamline the work undertaken regarding corporate and clinical governance and risk management. The Senior Management Group would have an enhanced role in risk management as will the Audit Committee. The Governance Development Unit will become the LAS Compliance Unit and play a key role in supporting the Audit Committee and Risk Assurance and Compliance Group to oversee the continuous improvement of the trust's governance and risk management arrangements. With the amalgamation of some committees a review will be undertaken to ensure appropriate time-tabling of meetings, their terms of reference and their membership. t was also anticipated that there would be better use of the Trust's web site with regard to agendas and minutes of meetings; this should decrease number of FOI enquiries dealt with by the Trust. The Complaints Panel will play a significant part in ensuring that the Trust managescomplaints effectively in compliance with the core and developmental standards of the Annual Health Check and implements lessons learnt from incidents.

The Board had previously considered the recommendations of the Governance Review at the Service Development Committee's away day in April 2006. The Chairman, on behalf of the Board, expressed his thanks to Beryl Magrath, the Finance Director and the Governance Development Unit for their efforts in undertaking the review.

Agreed: That the recommendations of the Governance Review be implemented; one of which is that an annual review of the governance arrangements be undertaken.

51/06 **Urgent Care workforce plan for 2006/07**

The HR Director presented the Urgent Care Workforce plan for 2006/07; it was explained that this is a follow up to the Workforce plan previously presented in March 2006. The plan is by its very nature complicated, containing as it does disparate elements that make up Urgent Care (ECPs, Doctors' Urgents, EBS, PTS, CTA, EMT1s and Whitework). It is envisaged that all but the most seriously ill patients will eventually receive a response from the Urgent Care service.

A pilot will be undertaken with the Bromley PTS staff to confirm whether PTS staff, with additional training, can support the Urgent Care Service. The proposed trial is in response to the difficulties experienced in recruiting and retaining EMT1s due to the closeness of the skills required of EMT1s and EMT2s. The HR Director confirmed that staff side representatives were in agreement with the proposed pilot. The additional training includes the use of defibrillators and Emergency First Aid treatment.

If the pilot is successful it will be rolled out to Barnet and Chase Farm PTS crews. If the Bromley pilot is not a success, the EMT1 role will be reviewed to address some of the difficulties with recruitment and retention.

In response to a question from the Chairman, it was said that the criteria by which to judge the Bromley pilot a success would depend on the level of staff utilisation, the details of which had yet to be agreed. Following further discussion by the Senior Management Group, this will be shared with the SDC in June. **ACTION: Finance Director**

The Assistant Director of Operations, Urgent Centre (ADO UC) assured Sarah Waller that to date there had been no difficulty recruiting to Clinical Telephone Advice (CTA) posts; a number of the posts are full time posts while some are on a secondment basis. He anticipated that the Urgent Operations Centre (UOC) will be able to handle 50% as opposed to the current 32% of calls. The process by which calls are deemed suitable for UOC was explained. When 999 calls are received, triage is undertaken using the AMPDS 11.2 version; calls identified as not requiring an immediate response are forwarded to the UOC where the call is assessed as being suitable to receive CTA. There are occasions when CTA is not appropriate e.g. if the patient is in a public place and in those circumstances, a response would be sent immediately.

There was a discussion about the risks involved in using staff with lower levels of training; the Chairman expressed concern that what was being proposed would compartmentalise the workforce. The ADO UC explained that it was intended that Urgent Care will revert to being part of EOC once the processes and procedures were bedded down; probably within the next two years. The aim of the UC workforce plan is to be able to respond appropriately to patients without necessarily despatching a double crewed ambulance. The Chief Executive assured Trust Board Members that what was being proposed was as set out in the strategic plan previously approved by the Board. The ongoing challenge will be to ensure that the Service responds in a clinically safe way with high levels of utilisation of all staff.

Sarah Waller requested that information be presented regarding skills sets for particular types of the staff group. The HR Director explained that work was currently being undertaken in finalising the long term Workforce Plan. With the ADO UOC and the Medical Director she is looking at the skills set the Trust will require in 7 years time. Sarah Waller felt that it would be useful to have a paper that set out the overlap between the existing grades and would provide the HR Director with the specifics of her request. **ACTION: HR Director**.

Sarah Waller enquired whether three months would be sufficient for a trial and whether planning to implement the new arrangements at Chase Farm in September might not be premature. The Director of Finance responded by saying that although it might be ambitious, there will be 28 staff in post from PTS Central Services who are based at Chase Farm which will make it easier to implement.

In response to a question from Barry McDonald regarding EMT4 and ECPs, it was clarified that within the proposed ORH model, a single responder car would be sent to calls unless an ambulance was deemed necessary.

The Board was assured by the ADO UC that the normal audit trail will be in place and risks assessed using the Trust's risk matrix. The Chief Executive commented that in order to achieve the new Clock Start time, it will be necessary for 80% of green calls to be handled by Urgent Care. This will mean UOC's workload

increasing from 5,000 calls to 12,000 calls with the accompanying clinical risks needing to be managed by having the appropriate clinical governance arrangements in place.

Noted: The report outlining the Urgent Care Workforce Plan for 2006/07.

52/06 Clinical Education & Development Programme for 2006/07

The HR Director presented the Clinical Education and Development Programme for 2006/07. She drew the Board's attention to the final page which summarised the training proposed for 2006/07. The plan includes 400 extra days to provide EMT4 training and to meet the shortfall in training originally scheduled for 2005/06 due to operational pressures. The progress of the education and development programme will be monitored by the Training Services Group. A future training plan will be produced to support the long term Workforce Plan.

Sarah Waller suggested that the programme should also show courses attended by staff which are provided by external bodies such as the University of Hertfordshire as this would give the Board an indication of total training days being invested by A&E Directorate. **ACTION: HR Director undertook to circulate the revised figures to the Board by the next meeting.**

Beryl Magrath suggested that team leaders receive refresher training on the revised Clinical Performance Indicators web based process given the time that has elapsed. She was assured that this was being facilitated where necessary.

Noted: The Clinical Education and Development Programme for 2006/07 report

53/06 Professional Standards Unit

The Chief Executive presented the findings of the recent review of the Professional Standards Unit to the Board. The review, undertaken by Ralph Morris, had been extensive and took into account stakeholders' views such as the LAS Patients' Forum, the Governance Development Unit and the requirements of the NHS Litigation Authority. A full copy of the report was available if any of the Trust Board members wished to view it. Further discussions are being held regarding the final agreement of job descriptions and role names. The Chief Executive commented that a key recommendation in the report was the suggestion that the central office be sited in Bow to facilitate close working relations with the Governance Development Unit and PALS.

It is hoped that the implementation of the recommendations will result in a separation of the disciplinary procedure from the complaints procedure; that the Trust will be in a position to learn from complaints and implement that learning. The Unit is to be renamed Patient Services Department and will be based in the three operational areas with a central administrative centre situated at Bow, co-ordinating investigations of complaints. The implementation plan will take 6-9 months and regular progress reports will be provided to the Complaints Panel.

Beryl Magrath welcomed the report and recognised the significant amount of work expended; she was pleased that there was to be a separation of the complaints and disciplinary procedures. She noted that recommendation 10 referred to reviewing the complaints procedure.

Sarah Waller commented that she hoped there would be training concerning the Trust's Capability and Disciplinary procedures following lessons learnt from recent appeals.

Noted:
1. **The findings of the Professional Standards review.**
2. **That an update on progress with the implementation of the recommendations will be presented in November. ACTION: Chief Executive.**

54/06 **Service Improvement programme out-turn**

The Director of Service Development reported that three reports are being prepared following the end of the five year Service Improvement Programme. A 'popular' report setting out the achievements of the SIP; a review, which will be presented to the SDC in June on lessons learnt from the implementation of the SIP and finally, today's report, which is an out-turn report on what was achieved, what was not achieved and what will be carried over to the Seven Year Plan.

The Head of Planning and Programme Management presented the out-turn report. All but 30 of the 283 initiatives were successfully achieved. Details of the 30 that were not achieved were outlined in the report. Of those that were successfully implemented, there were clear measurable out-turns showing improvement in a number of areas: *performance* (Category A8 minute: performance was 40% in 2000, 75% in 2006); *people* (there was a substantial shift in staff attitude and morale e.g. 60% of respondents in the Autumn 2005 felt positive about working for the LAS compared to 42% in 2000) and *patients* (cardiac arrest survival rates improved from 4% in 2000 to 8.6% in 2005). A final SIP bulletin will be issued to staff reporting on the success and the work that is still on going.

The Chief Executive expressed his thanks to the Head of Planning and Programme Management, who joined the LAS 2 years ago, for the support he has given to the implementation of the SIP. He reported that representatives of the Office for Governance Commerce recently visited the Trust and were very complimentary about the SIP. The Chief Executive expressed his thanks to colleagues for the support they have given to the SIP and he expressly wished to thank the Chairman for the support he has given to the SIP.

The Chairman stated that the success of the SIP had exceeded the expectations and hopes he had in 2000 and that it had been one of the most successful turnaround programmes he had witnessed. Other members of the Board also expressed their pride in the achievement of the SIP.

Noted: **The update regarding the Service Improvement Programme.**

55/06 **Report from the Trust Board Secretary – tenders opened since the previous board meeting and the use of the Trust seal.**

07/06	Extension and refurbishment of Hillingdon AS	Logan Construction SE Russell Crawberry Ltd Mitie Property Services Bryers & Langley Coniston Construction
08/06	Extension to the Communications Room	Russell Crawberry Verry FM Crispin & Borst
09/06	Extension & reconfiguration of Frien Barnet	Coniston Ltd Russell Crawberry Axis Europe Plc P&J Services Neilcott Special Works

10/06	Public Opinion Research	Mori BMRB TNS ICM Research GFK NOP

The Trust Seal has been used on three occasions since the last Trust Board meeting: reference 94-96. The entries related to:

No. 94: lease of ground floor and basement of 122 Albany Road, London SE5 8UJ between Ashley John Herring and the LAS

No.95: lease of two parking spaces (12 & 13) at Doctors' Practice/Pharmacy, 949 London Road, Thornton Heath, Croydon, Surrey between Bencroft Holding Corporation and the LAS.

No. 96: Retrospective licence for alterations relating to ground and first floor offices, 8-20 Pocock Street, London SE1 between Shaftsbury HA, PHE 1 Limited and PHE (Pocock No. 2) Limited and PHE (Pocock No 1) Limited and the LAS.

Noted: The reports concerning the tender openings and the use of the Trust Seal.

56/06 Draft Minutes of the SDC Away Day – 25th April 2006

Noted:
1. **The draft minutes of the SDC Away Day – 25th April 2006**
2. **That the presentations given by the Senior Management Group concerning the Seven Year Plan and CAD 2010 have been circulated for information to the Non-Excutives.**

57/06 Draft Minutes of the Audit Committee – 20th March 2006

The Chairman of the Audit Committee, Barry McDonald, highlighted the following from the minutes of the Audit Committee held on 20th March 2006: the intention that implementation of the Auditor's recommendations will be added to Area Operation Manager's Key Performance Indicators as part of their annual performance measurement. There were three waivers of Standing Orders reported, one of which was an unwitting contravention of the OJEC Tendering Rules. Details of the waivers were contained in the minutes.

Noted: The draft minutes of the Audit Committee – 20th March 2006

58/06 Draft Minutes of the Risk Management Committee – 20th March 2006

The Chairman of the Risk Management Committee, Barry McDonald referred the Board to the summary of the Risk Management Committee minutes as he had nothing further to add.

Noted: The draft minutes of the Risk Management Committee – 20th March 2006

59/06 Draft Minutes of the SDC – 28th February 2006

Noted: The draft minutes of the SDC – 28th February 2006

60/65 **Opportunity for Members of the Public to ask Questions**

There were no members of the public present.

61/06 **Date and Venue of the next Trust Board Meeting**

Tuesday, 25th July 2006 in the Conference Room, LAS Headquarters, 220 Waterloo Road, London, commencing at 10.00 am.

Noted : Apologies were received from Barry McDonald and Sarah Waller as they will be unable to attend the next Trust Board meeting.

The meeting concluded at 1.00 pm

Enclosure 2

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD
Part II

Summary of discussions held on 23rd May 2006

Held in the Jack Disney Room, Union Jack Club, Sandell Street, 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 23rd May 2006 in Part II the Trust Board briefly discussed:

- the forthcoming publication of the GLA's enquiry into the bombings inflicted on London in July 2005. It was anticipated that the Trust would be criticised in ht report with regard to the failings of the radio communications;
- the Trust's plan to commemorate the London bombings which would be a corporate recognition of the combined efforts of staff. This event would be held on 3rd July. The Director of Communications would ensure that Members of the Board would receive a formal invitation;
- the progress to date of the CAD 2010 Strategic Outline Case; it is the Director of Information Management & Technology which will be presented for the Board's approval in July 2006;
- the Serious Untoward Incident involving a death a police custody which was reported by the Medical Director in Part I. The Board was provided with details that were of a confidential nature at this state of the enquiry.

The Board was informed that a member of staff would be appearing in Court charged with downloading child porn on his home computer. The Board was assured that measures are in place to ensure that staff do not access such sites from LAS computers.

Enclosure 3

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 25 JULY 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.

New standards with effect from 1 April 2006

	CAT A 8	CAT A 19	CAT B 19	Urgent, at patient within 15 mins
Standard	75%	95%	95%	95%
YTD*	73.4%	97%	81.8%	74.6%

*As of 12th July 2006

Key highlights

i. The new financial year began well with A8 performance for April finishing on 76.6% and May on 74.8%. Further work has still to be completed on quality assuring these response times and these figures are set to improve slightly once that work is completed at the end of July.

ii. June and the early part of July have proved to be much more difficult for a variety of reasons, outlined below and June finished at a disappointing 71%. Once again there may be some improvement on this figure once all the quality assurance checks have been completed.

iii. The year-to date position was holding above target during April and May despite re-instating considerable volumes of developmental training for front line staff. It has however deteriorated during June and early July to 73.4% at time of writing. Once again the figure will rise to circa 74% once all final data has been inputted.

iv. Overall demand has been flat across April and May is in fact slightly down for June when compared to the same three months last year. The first quarter activity is down 0.4% when compared to the same period last year.

v. We have however seen a great deal of volatility in demand associated with particularly hot weather and some of the World Cup games together with a peak in the number of Central London Events. This has resulted in some very busy days including 18 days in June when overall responses exceeded

2500. These high volume days have generally resulted in poor performance which has pulled the month down as a whole.

vi. Resourcing remains our single greatest challenge due to a combination of vacancies (138 in May) and poor overtime uptake at weekends. This situation will ease as in post figures improve across the summer and as more staff are posted to the new weekend rosters.

vii. The new Operational Command Unit is now in place and is carrying out the functions which were previously part of the Gold Suite.

viii. We have virtually completed resuscitation guidelines training for 2500 staff and have embarked on an ambitious programme of staff development through Continuous Professional Development (CPD) training; and personal development reviews. In addition we have returned Team Leaders to their normal duties and re-instigated the completion of Clinical Performance Indicators.

Actions to recover performance

- Recruitment courses are full and the programme is on track to deliver full establishment by end November.

- All new staff are being allocated to the new weekend relief roster . The numbers working on this will rise from 89 currently to 250 by December which will significantly improve the weekend situation

- We have raised the REAP level to level 3 'Severe Pressure' from Level 2 'Concern' and we are working through the actions detailed in the plan.

- With the resuscitation training almost complete all management teams are being re-focussed on improving the overall staffing situation through rigid management of all absence and abstractions from front line work.

- We continue to focus on maximising the performance of our Fast Response Units.

- We are actively working to reduce the total volume of calls we attempt to reach in 8 minutes (Red Calls) and hope to be able to make some reductions in the next few weeks. This work obviously has to be done carefully in order to remain clinically acceptable.

- We are working hard to contribute to the evidence base on call categorisation to help influence a national meeting in the autumn. We are hopeful that this work will allow DH to significantly reduce the volumes of calls falling into Category A.

- We are increasing the numbers of CTA staff by a further 15 to increase the numbers of Cat C calls receiving telephone advice. The current establishment is dealing with circa 1000 Cat C calls per week and not sending a resource on 500. We believe that by increasing the establishment still further we can improve significantly on these figures.

- We will be working hard in coming weeks to drive down overall job cycle times and improve overall availability.
- We will be looking at ways to mitigate against the performance fall at shift changeover times. This is particularly acute during the evening and we will be introducing some new initiatives including rostering additional vehicles across this time period to mitigate against this fall.
- We will be trialling off duty crews taking home fast response units and being tasked from home to Category A calls when there are no on-duty resources available. It is anticipated that we will be able to commence this trial in August. If successful it may become part of our ongoing operating regime in the future.
- We continue to plan for the introduction of the new operational response regime which will progressively increase the numbers of FRUs in line with recent modelling work over the coming 21 months. This work coupled with the introduction of a range of other 'High Impact Changes' will significantly improve our ability to sustain performance and meet the challenges of the new clock start targets which will now come into force in April 08.

1.2 Resourcing

There were still 138 A&E vacancies in May however the recruitment programme is on track and the Trust will now be fully established by December.

Conducting training on resuscitation guidelines for front line staff and commencing this years comprehensive development programme including the introduction of PDR against this background of high vacancies has impacted on resourcing. Average FRU hours produced per day has been steady across the first quarter and there is a slight improvement in ambulance hours produced. This average however does hide days of poor ambulance resourcing in particular and these days when coupled with high workload have impacted on performance.

Resourcing has been particularly volatile due to the impact of good weather and World Cup football. These factors undoubtedly contribute to our staff deciding whether or not to work overtime and have prevented us from resourcing up to the levels required to maintain performance on our busiest days in June and early July.

There continues to be a more general reluctance of staff to work overtime, both on ambulances and in EOC. New Agenda for Change salaries including enhanced overtime across the whole week are the main causes. However, weekends have become particularly difficult to staff as there is no additional weekend enhancement under Agenda for Change. Since April the uptake of overtime at weekends has almost halved.

We continue to post new recruits to our new weekend relief roster and there are currently 89 staff on the new system. This will rise to circa 250 by December and at these levels will considerably enhance our ability to resource weekends without significant reliance on overtime.

Sickness in A&E has fallen for the fourth month in a row, but remains too high at 6.9%. Local managers and HR advisers are carrying out regular audits to ensure attendance is being managed.

We are now reviewing all unfunded secondments with a view to reducing the overall numbers involved.

1.3 Emergency Operations Centre (EOC)

We continue to implement Agenda for Change within EOC and this has been a difficult period for all the staff involved. It is clear that the inevitable anxiety caused by this period of change has had some impact on the smooth running of the control room.

The high call rates associated with hot weather, the world cup and central London events have been particularly challenging and have resulted in a rise in incoming emergency 999 calls of circa 200 calls per day during June. These averages once again mask some particularly high figures in excess of 4000 on individual days.

Resourcing has been a particular challenge and hours produced in EOC have fallen across the first quarter with a sharp drop in June when hours staffed per day fell to 1216 compared to 1269 in May and 1294 in April. The same issues seem to be at play as with front line crew staffing in that it has proved increasingly difficult to staff weekends and this has been coupled with a general overall reluctance to work overtime.

Call taking performance has been disappointing with a consistent fall across the first quarter. This is in part explained by high call volumes coupled with the resourcing issues described above. It is imperative that this situation improves steadily over coming months and the management team are focussed on the difficult task of ensuring that both call taking performance and dispatch performance receive equal focus in the future.

1.4 Urgent Operations Centre

Activity within the Urgent Operations Centre has now levelled off at c.33% of the potential workload. This represents an increase of around 300% since the co-location of services and the introduction of revised clinical decision support software in November 2005.

The main obstacle to increasing volume continues to be the limited number of operational staff in post and it has now been agreed to supplement the Bromley PTS trial with internal and direct entry recruitment. To this end 20 posts at the revised EMT1 grade will be advertised imminently.

Additional technical functionality will come on line in late July which will allow Urgent Care to fully utilise vehicle Mobile Data Terminal (MDT) information in the same way as the EOC. Although difficult to quantify these changes should realise measurable benefits in utilisation.

Process redesign is now underway, aligned to a restructuring across Control Services and some significant management changes due within the Emergency Bed Service.

Recruitment is underway for two new ECP schemes in Greenwich and City and Hackney, due to commence in September.

1.5 The Operational Benefits of 'Gold Suite'

Background

Last year, the Trust Board approved the revised LAS Capacity Plan, which lists various actions to protect patient care and recover performance, should the need arise.

During the last few months of 2005/06, the Capacity Plan was triggered at Level 3, due to poor LAS performance.

The first action at Level 3 is to "Establish a Gold Command team to manage recovery". This was carried out and the team brought about a considerable performance improvement.

The Gold Group met at least twice a day to scrutinise all the constituent parts of performance. The group became known as 'Gold Suite', after the room from which they were operating.

It is always difficult to precisely quantify the performance uplift that is achieved by different actions, but it is widely accepted that the Gold-level scrutiny brought about a step-change in performance.

Once performance had recovered, we were keen not to lose the operational benefits that had been achieved through the use of the Gold Suite. Unfortunately the Conference Room was no longer available and it was therefore decided to put the Gold function into the control room. This was difficult due to the lack of space available, and a cut-down version had to be used, which was less effective than the original Gold Suite had been.

Operational Benefits

The Gold Suite brought together representatives from the Resource Centres, the Control room, Duty Station Officers and AOMs, with operations led by the relevant Gold for that week.

This is the first time that all the aspects affecting performance have been brought together in one place, giving Gold an excellent overview.

This degree of scrutiny has allowed Gold to make *'real time'* decisions to bring about performance improvement. This is a new method of working.

Gold is supported in doing this by significant management information available about the items listed below. Typically, Gold would be considering:

- whether cars and ambulances were evenly spread out and in the right place for receiving calls (standby),
- whether ambulances were building up at hospitals, causing delays in their availability,
- whether extra resources were required (St John/Red Cross/ private ambulances/PTS)
- whether resourcing for the next shift/day/weekend was adequate

- whether Team Leaders and Trainers were being well used
- whether the control room was functioning efficiently
- whether too many cars or ambulances were unavailable due to faults
- other tactical or strategic interventions required

The Future

The Gold Suite has now been renamed the 'Operational Command Unit (OCU)' and has been moved to a permanent office overlooking the control room. The main constituent parts of the successful original model detailed above are being reintroduced.

The function of the Operational Command Unit has brought us two main benefits:

- The opportunity to see how each aspect of the operation is working, from a single location;
- The opportunity to adjust aspects of the operation on a minute by minute basis, to reflect demands.

There is still some debate to be had about where overall responsibility should rest for this type of real time performance management. The various options have been have been considered by the Assistant Director of Operations group, which has concluded that these functions should be incorporated into the future operation of the Emergency Operations Centre (EOC).

It is our intention to re-structure the management arrangements within the control services during this financial year and the requirement to incorporate the running of the Operational Command Unit will be built into the new senior roles which are currently being developed.

The OCU continues to be managed at present by the on-duty AOM, with overview and or active on-duty involvement of the on call GOLD for the week.

1.6 Analysis of increased workload in February 2006.

The Board will recall that it asked for some analysis to be done on the reasons behind increased demand in February 2006

The background is as follows:

Average total responses per day February 06 rose to 2430 which was a 9% increase on February 05.

Category A demand averaged 917 per day in February 06 compared to 881 in January 06 and 909 in December 05. Direct comparisons with the previous year are not possible due to AMPDS code changes made in April 05.

This meant that February 06 was busier than the previous December which would traditionally have been the busiest month of the financial year. The first three weeks of the month is when we experienced the highest workload whilst perversely the last week was the coldest with five days of snow.

We are currently looking at the individual illness codes which make up this increase and correlating that against the weather patterns during the month and also the incidence of influenza and general respiratory illnesses which peaked later in the year than normal.

It has not been possible to finalise this work prior to the preparation of the Board papers and the intention is to table a short paper on the day of the meeting to provide a summary of the analysis.

2. PATIENT TRANSPORT SERVICE

2.1 Commercial

The Chelsea and Westminster contract, which the LAS currently holds, is out to tender. Our bid has now been put together and will be submitted before the closing date of 21 July 200.

Other forthcoming tenders include Northwick Park, Mayday and Tower Hamlets.

We have been notified that we were unsuccessful in our bid for the Royal Marsden. Like the bids for Lewisham and St Georges we failed to pass the initial sift stage where the prime consideration is price. We are pursing these hospitals to obtain greater clarity over their selection criteria and to push the message of the benefits of our quality service.

The Bromley contract commenced as agreed on 1 April 2006. A review of the first 3 months of operation has now been conducted with the hospital management team, who have confirmed that they are delighted with the service they are receiving. They have been advised of the proposal to trial combining Urgent Care and PTS operations using the AP resource and are happy for it to proceed. Final operational changes are now being put in place and the trial should commence in the near future.

2.2 Operations

Quality statistics for PTS are as follows:

	February 2006	June 2006	Target
Hospital Arrival Time	83%	86.1%	90%
Hospital Departure Time	88%	88.5%	90%
Patient Time on Vehicle	93%	93%	90%

Arrival time continues to improve although have still to reach the target of 90%. Departure time did reach the target of 90% in May, though it fell back in June. 'Time on vehicle' remains on target. There are resourcing issues on 3 contracts in particular which are affecting results and are now being resolved through recruitment.

PTS has provided resources to help A&E during the World Cup and with the various alternative response vehicles. This coupled with the resource issues has led to a drop in the number of calls dealt with by Central Services on referral from A&E. Work is underway to consider the transfer of Central Services from PTS to UOC to rectify this.

3. HUMAN RESOURCES

3.1 Electronic Staff Record (ESR)

In recognition of the unique position of the LAS and the identified risks of introducing a new Payroll/HR system on the anticipated July go-live date, it has been agreed with the national ESR project leads to extend the period of implementation. The revised go-live date is now scheduled for October 2006 giving the project more time to conduct further testing and provide additional training. This is welcomed as a very positive agreement between all parties concerned and the LAS project team is maintaining momentum with support from the DH and McKesson (system provider) teams.

3.2 Agenda for Change

Full assimilation is almost complete with only 5 posts awaiting final banding.

Appeals (request for banding reviews) have been received for 55 posts to date. A small number of these reviews have been conducted. It is hoped that the majority of these will be concluded by the end of the summer with monthly panels meeting thereafter for consideration of new/revised jobs.

3.2.1 KSF /PDR update

The position as at the end of June is that 80% of staff have an agreed Knowledge and Skills Framework (KSF) outline.

There is currently a lot of activity regarding the remaining KSF outlines, and in particular PDR, within the Trust with A&E operations now fully engaged in the process. It is therefore anticipated that we will be reporting a significant increase in numbers of staff completing the PDR process and possessing PDPs by next quarter. PDPs are currently reported manually and to date records show only 4% completion. Reminders have been sent (and will be repeated) for manager to confirm when PDPs are completed.

3.2.2 Rest Break Agreement

Work on the introduction of a new rest break agreement continues, with an options paper with an associated impact assessment currently under discussion with the SMG. In addition, a presentation has been made to staff side and a joint working group is to be established to consider the preferred option which, in principal, has been accepted as the way forward. It is intended that project management support will be provided to ensure project principles are followed and progress is maintained.

3.2.3 Organisation Development support to A & E Operations

Bill O'Neill has been seconded to the post of Assistant Director of Organisation Development to provide dedicated support to A & E Operations for a period of up to twelve months. The aim is to maximise the benefits from the Sector Operations Model, particularly in relation to management capacity and capability.

3.2.4 Pay Award

In spite of the considerable workload currently being experienced by the Payroll Department, the national pay award of 2.5% was paid to all staff on AfC rates in their June salaries.

3.2.5 Visit by the Review Body for Nursing and Other Health Professions (NOHPRB)

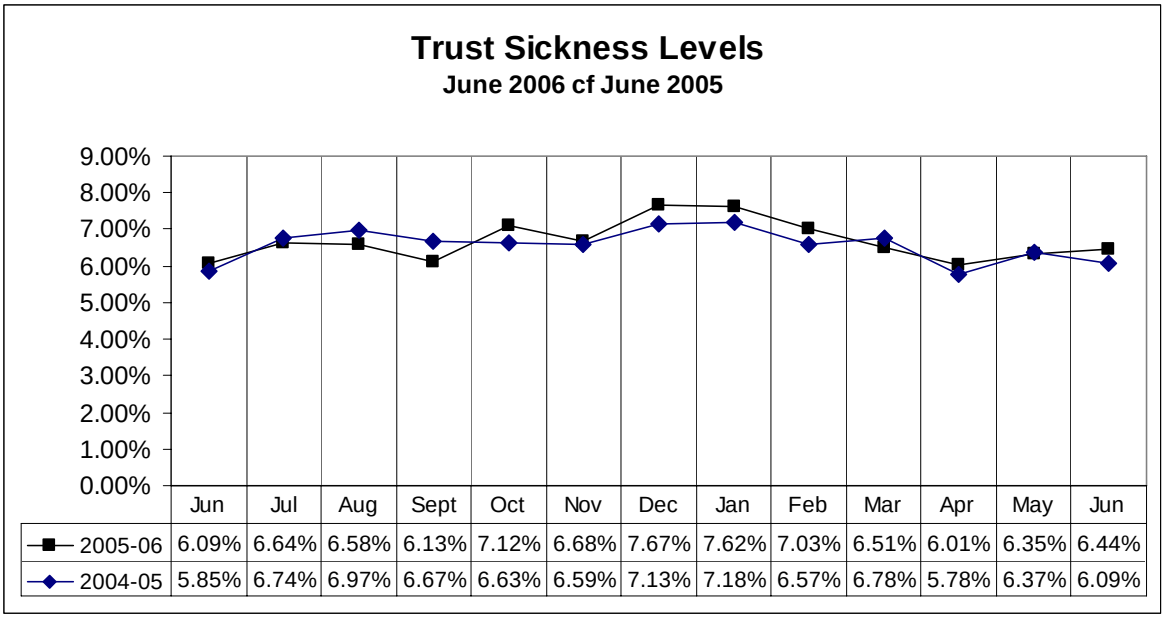
As part of their national programme of visits in preparation for the 2007 pay round, the Pay Review Body (Professor Gillian Morris, Wilma MacPherson CBE, and Ian Mackay) visited the LAS on the 7th July. The group met with Caron Hitchen and Martyn Salter followed by discussions with local staff and staff representatives to hear what they had to say about pay and related issues, and to gain a better understanding of the pressures facing staff. Members expressed the view that their visit to the LAS was one of the best of such visits they had made. The members also joined staff in observing the 7/7 two minutes' silence at HQ.

3.3 Longterm Workforce Planning

Further modeling is taking place on workforce requirements for the next seven years, and informal discussions with union colleagues have been initiated. Indicative long term staffing plans should be ready to share at the Strategic Steering Group (SSG) meeting in August. While work is already going forward to develop the detail of the seven year programme, it cannot be fully costed until the workforce plans have been finalised. Given that time is required for both informal and formal consultation with staff representatives on the future workforce model, we expect to be in a position to ask the Board for formal sign-off of the seven year plan in November 2006.

3.4 Attendance Management

The sickness levels for the year up to June, and compared with the same period for the previous year, are shown on the table below. This shows a slight improvement on the same period last year but has increased slightly from the previous month. This remains an area of specific management focus.



June 06 Absence	
Staff Group	**%**
A & E	7.36%
EOC (Watch Staff)	7.96%
PTS	5.95%
A & C	2.52%
SMP	2.94%
Fleet	5.15%
Total (Trust)	**6.44%**

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

Table 1 shows progress against the trajectory for staff in-post to be on track as at June 2006.

(ii) EOC and UOC Staff Numbers – Progress against Trajectory for 2005/2006 by Month

Tables 2 and 3 shows progress against the trajectory for staff in-post against agreed establishment.

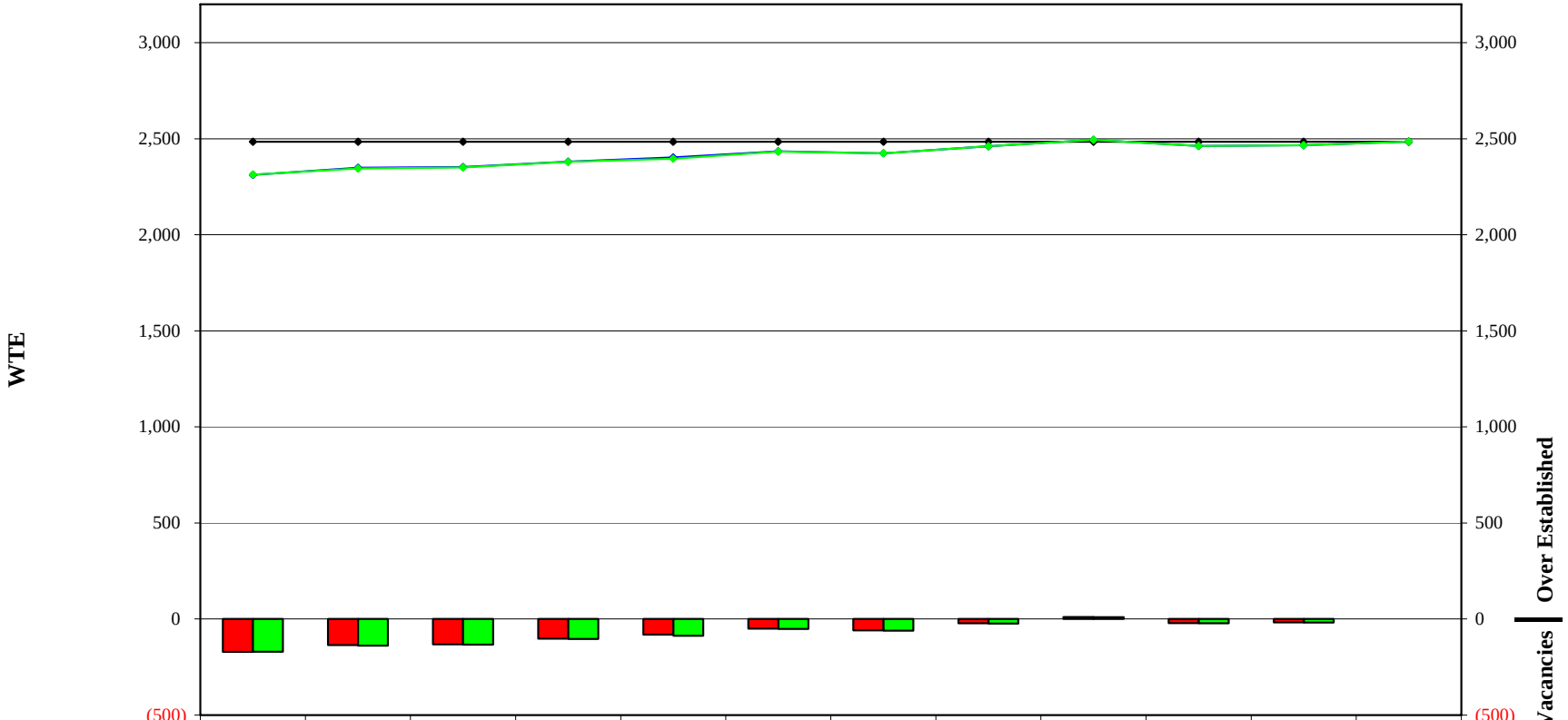
The figures reported differ from those previously reported to the Trust Board following a full reconciliation of actual staff in post. This has resulted in the reporting of an increased vacancy factor to that previously shown for April and May. The majority of these vacancies are attributed to the Sector Controller role (13 out of 19) to which we are currently not recruiting. (This discrepancy reflects the historic difficulty in providing accurate data from a variety of sources – IPS, payroll, promis, general ledger). Amendments to the recruitment plan have been made to increase the numbers on existing training programmes.

3.5 Suspensions

Table 4 indicates numbers of staff suspended as at 30 June 2006.

Table 1

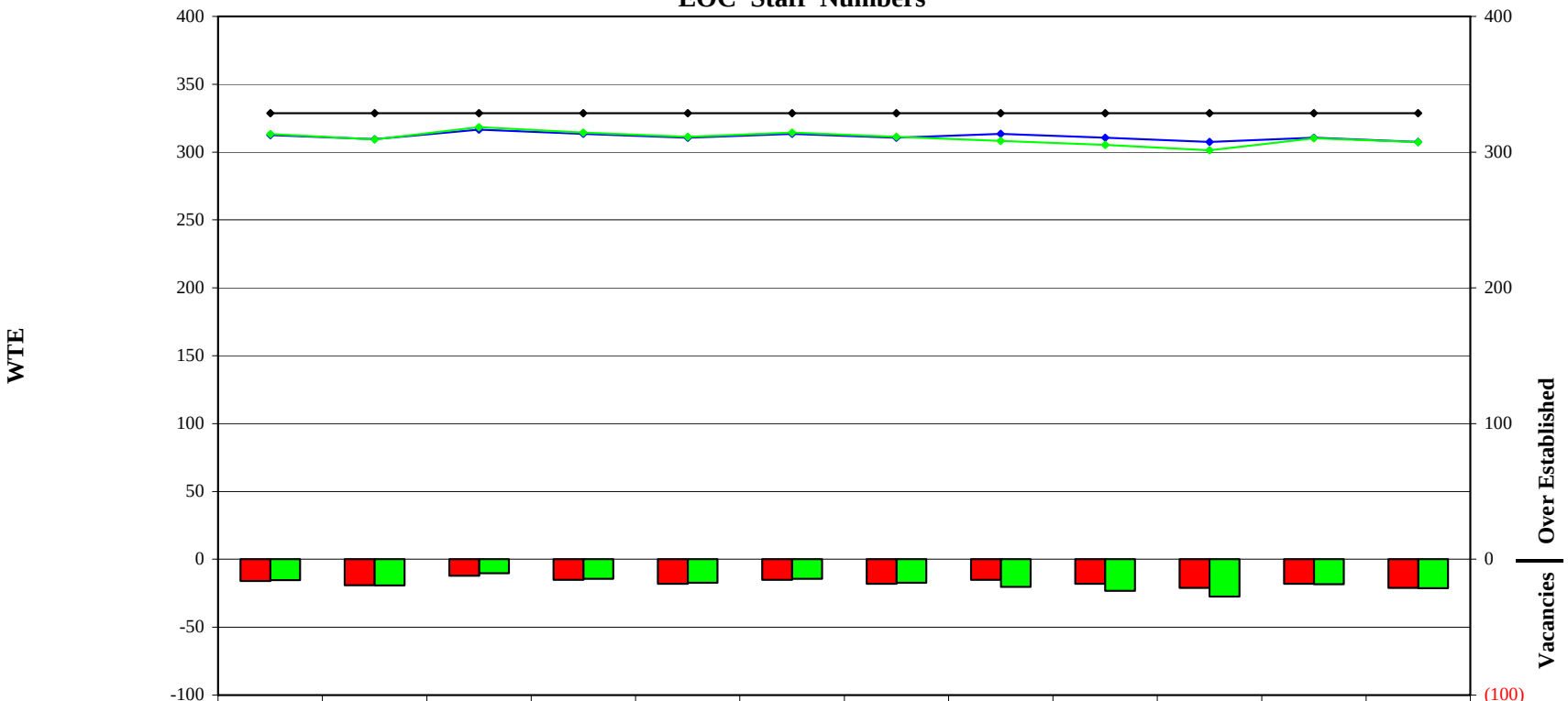
2006/07 A&E Crew Staff Numbers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(171)	(135)	(132)	(103)	(81)	(50)	(59)	(22)	11	(22)	(18)	1
Actual Vacancies	(170)	(138)	(133)									
Forecast In Post	2,313	2,349	2,352	2,381	2,403	2,434	2,425	2,462	2,495	2,462	2,466	2,485
Establishment	2,484	2,484	2,484	2,484	2,484	2,484	2,484	2,484	2,484	2,484	2,484	2,484
Actual In Post	2,314	2,346	2,351									

Table 2

2006/07
EOC Staff Numbers

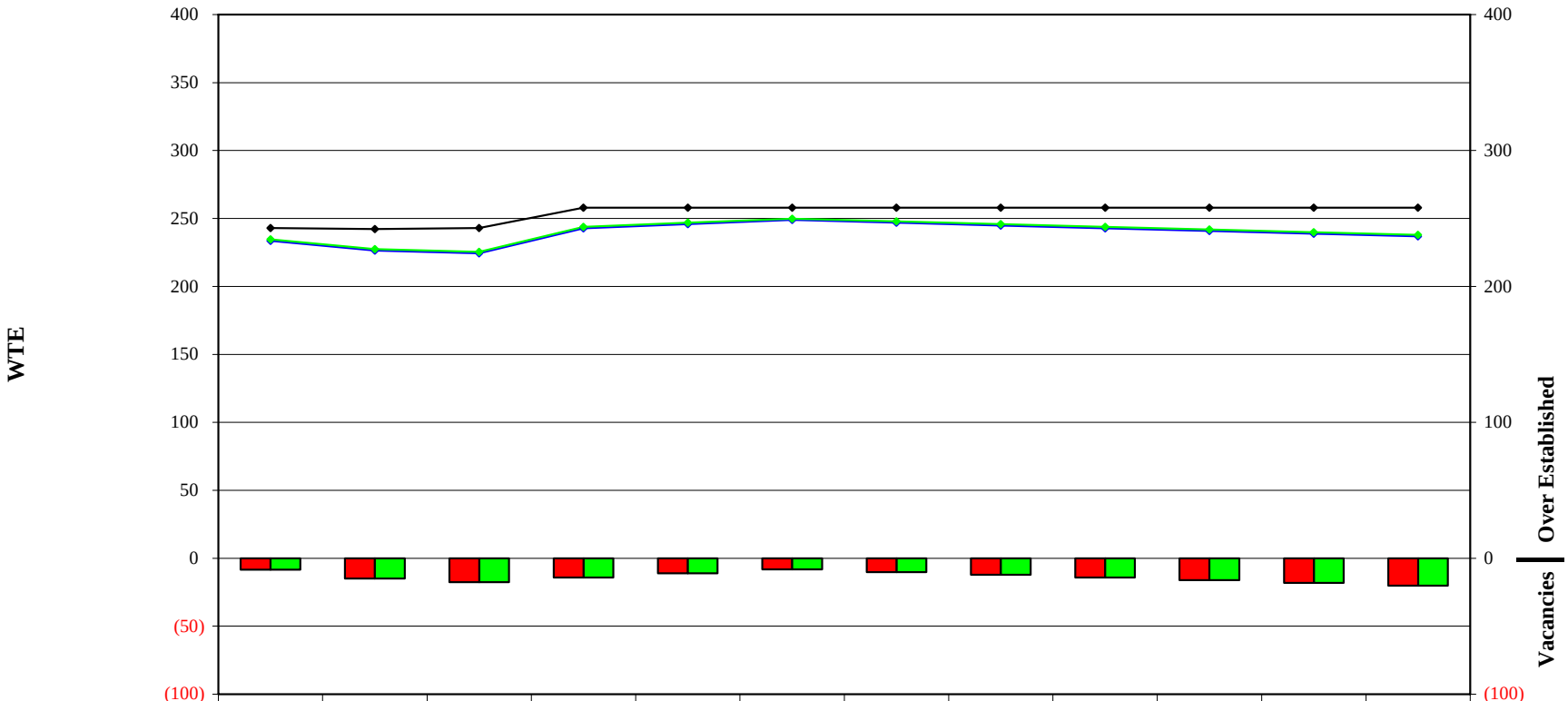


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(16)	(19)	(12)	(15)	(18)	(15)	(18)	(15)	(18)	(21)	(18)	(21)
Actual Vacancies	(15)	(19)	(10)									
Forecast In Post	313	310	317	314	311	314	311	314	311	308	311	308
Establishment	329	329	329									
Actual In Post	313	309	318	314	311	314	311	308	305	301	310	307

At Month End

Table 3

2006/07 UOC Staff Numbers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast Vacancies	(8)	(15)	(18)	(14)	(11)	(8)	(10)	(12)	(14)	(16)	(18)	(20)
Actual Vacancies	(8)	(15)	(18)									
Forecast In Post	234	226	224	243	246	249	247	245	243	241	239	237
Establishment	243	242	243	258	258	258	258	258	258	258	258	258
Actual In Post	235	227	225									

At Month End

Table 4

SUSPENSIONS AS AT 30 JUNE 2006

		Date of Suspension	Reason for Suspension	Stage in Investigation	Investigating Officer	Hearing Date
East	0					
South	0					
West	1	27.06.06	Interviewed under caution for handling NHS equipment.	Police investigation underway. No internal investigation started yet.	Not appointed.	
EOC	2	16.06.06	Harassment of a caller	Currently arranging an investigation interview	John Wilkins	
HQ/Fleet/ Others	1	05.06.06	Falsely presenting as a Paramedic	Investigation complete. Report in progress	Wendy Chalk	
	1	19.06.06	Handling of petty cash	Investigation in progress	Tony Crabtree	

4. COMMUNICATIONS

4.1 London bombings

In the last couple of months, the Communications Directorate has focused on a number of issues relating to the bombings last July.

4.1.2 London bombings anniversary

One year on, the Service joined the people of London in remembering the events of 7 July last year. The Communications department coordinated the Service's representation at a number of events during the day.

On the morning, staff represented the Service as they laid flowers at Aldgate, Russell Square, Tavistock Square, Edgware Road and King's Cross, bearing the message 'Remembering the innocent people who lost their lives, and those who were injured'.

At midday, staff participated in the two-minute silence at each of the sites, and over 100 staff gathered outside Waterloo HQ to join the rest of the nation in reflecting on the events of last July. BBC News 24 broadcast live from HQ and images of staff featured in their coverage of people across the country marking the two-minute silence.

In the afternoon, Assistant Chief Ambulance Officer John Pooley, accompanied by Emergency Medical Dispatcher Lisa Andrew and Waterloo Emergency Medical Technician Andrea Ray, visited Regent's Park to join members of the public in adding a flower to the floral tribute that was later completed by survivors and the families and friends of those who died.

Media interviews with members of staff were broadcast through the day. Director of Operations Martin Flaherty was interviewed by Sky News, BBC London Radio and BBC Asian Network. Team Leader Bill Kilminster spoke with Radio 5 Live; Performance Improvement Manager Paul Woodrow and Duty Station Officer Martin McTigue had a live interview with BBC Breakfast at Tavistock Square; Graeme Baker was also featured on BBC Breakfast with survivor Danny Biddle; and John Pooley gave an interview to Sky News from Regent's Park. A special ITV programme hosted by Trevor McDonald and broadcast on Sunday 9 July included interviews with Paramedic Adam Desmond and Emergency Medical Technician Sam Sinclair.

An article about Paramedic Craig Cassidy was published in The Guardian; the Evening Standard and Radio 1 Newsbeat featured interviews with Paramedic Liam Whittaker; and First magazine ran a feature involving Emergency Medical Dispatcher Lisa Andrew and Team Leader Bill Kilminster. Bloomsbury Team Leader Ken Murphy was interviewed on BBC Breakfast earlier in the week.

Reporters did ask about the findings of the London Assembly in some of the broadcast interviews, but the Service's message remained that thoughts of staff were with the families and friends who lost loved ones, and those who were injured on the day.

4.1.3 Internal commemorative event on 3 July

Members of the Communications Directorate coordinated a special Service event, held on Monday 3 July, to commemorate the response of staff to the London bombings and to remember all those who were killed and injured.

Over 200 nominated members of staff from all areas of the Service attended the event at Savoy Place to hear from survivor, Gill Hicks, who was seriously injured at Russell Square. Gill presented certificates signed by the Prime Minister to members of staff representing the bomb sites at King's Cross, Edgware Road, Aldgate and Tavistock Square, as well as representatives from the control room and support services.

In a recorded video message, the Prime Minister thanked staff for their work and messages of thanks and support from Londoners were also broadcast.

A certificate will displayed in every Service building and station in the near future to remember the work of staff that day.

4.1.4 Publication of the London Assembly's 7 July review

On 5 June 2006, the London Assembly published its review of the response to the London bombings. Whilst the Committee praised the actions of ambulance staff and other emergency service personnel, its criticisms of the London Ambulance Service generated negative media coverage for the organisation.

The Service was proactive in issuing a response to the review and a number of interviews were given by the Chief Executive Peter Bradley and Deputy Director of Operations Russell Smith (with London Tonight, BBC London, BBC Six O'clock and BBC Ten O'clock news, BBC Radio 4 and LBC radio).

Evaluation of media coverage indicates that there were 13 stories carried in national newspapers which referred to the London Ambulance Service's response on 7 July. London's regional papers (Evening Standard and Metro) also covered the issue; Sky, BBC News 24, London Tonight, BBC London, and the BBC's Six O'clock and Ten O'clock ran the story with reference to the Service, as did BBC Radio 4 and LBC radio.

In terms of exposure of the Service's messages, just under a third of the stories carried the messages that the events of 7 July were unprecedented and the courageous actions of staff saved lives; difficulties with communications did not prevent the Service treating and transporting over 400 patients within three hours; and pagers have now been issued to managers. A number of stories also stated that the difficulties had minimal impact on the care of patients.

Critical issues focused on the failure/breakdown of communication experienced by the Service; the Service's over-reliance on mobile phones; the shortage of ambulances at some sites; and a shortage of medical equipment.

The most critical reports were the BBC Ten O'clock news (five million viewers), the Evening Standard (¾ million readers), The Guardian (one million readers) and the Daily Mail (5.5 million readers). All these stories reported that the Service came in for most criticism within the Assembly report.

The findings of the review were carried in a number of regional papers across the country – nine key regionals carried Peter Bradley's quote: 'We have

acknowledged we faced difficulties with communications that day, but this did not prevent us treating and transporting more than 400 patients to hospital from all the sites within three hours.'

It should be noted, however, that public opinion research carried out on behalf of the Service since publication of the review, shows that 67% of Londoners felt the organisation responded 'very well' to the events of 7 July, with a further 21% saying 'fairly well'.

4.2 Media Issues

4.2.1 The World Cup and hot weather

As the World Cup tournament placed additional pressure on the Service during June, messages were conveyed via the media to warn people that abusing the 999 service could risk lives.

The mobile treatment centres set up across the capital, including in Croydon and near Trafalgar Square, generated widespread media coverage. An extended news item featuring ambulance staff treating drunk football fans at Leicester Square on the Sunday England beat Ecuador was broadcast on ITV's national lunchtime news and on ITV1's London Tonight programme. Media also reported on the high call levels experienced by the Service during the England games, with coverage in international, national and regional papers including the Daily Telegraph, Evening Standard and Metro.

The hot weather compounded the situation further, and an increase in calls to heat-related incidents attracted media attention in early July. National media interest was also triggered earlier in June when more than 800 people had to be evacuated after a train got stuck in a tunnel at Bank underground station. Twelve people were treated after suffering the effects of heat exhaustion and dehydration.

4.2.2 Other issues

The Communications team managed local and national media interest following the tragic death of two-year-old child after an incident involving an ambulance on a school visit in Ealing in June, and a lightning strike on a teenage boy in Croydon at the beginning of July generated coverage. The Service received media calls when former DJ Bruno Brookes was treated by staff after suffering a heart attack; he later praised the Waterloo crew when he appeared on BBC1's City Hospital with Paramedic Brian Hayes who treated him. The Service's use of St John and other voluntary ambulance services to respond to some 999 calls came under the media spotlight at the end of May; Deputy Director of Operations Russell Smith spoke to London Tonight about the case of a pensioner who was attended by St John staff last December.

4.3 Patient and Public Involvement

Recent Patient & Public Involvement (PPI) events from across the Service include visits to community organisations in Harrow and Lambeth, attendance at careers events in Camden and Tower Hamlets, and plans for a health awareness day in Waltham Forest. The Events and Schools team have been involved in a number of initiatives, including Junior Citizens' Schemes in Newham, Haringey and Harrow, and Crime and Safety Days with the police, fire and prison services. They are also involved in "Safe Drive, Stay Alive", a

high profile project aimed at young people, which is being piloted in Havering.

A number of staff with two vehicles took part in the Euro Pride parade on 1st July. Special boards were made for the sides of the vehicles, containing health promotion messages and the telephone number for Heartstart training. The event was extremely successful and the LAS Co-ordinator for the event (Andi Scott from the Emergency Operations Centre (EOC) was interviewed for a new TV channel, *Pride TV*.

The Patient Advice and Liaison Service (PALS) team has received 1152 enquiries since April. Recruitment is underway for a new PALS Officer, who will concentrate primarily on the Frequent Callers programme.

Senior LAS managers continue to attend the monthly Patients' Forum meetings. In June the Senior Operations Manager (Planning & Risk) gave a presentation on the Baby Emergency Transfer Service and the Director of Service Development attended the July meeting to talk about the Older People's Strategy.

In June the PPI Committee discussed community liaison and linking with services in other countries, the public education strategy, plans for a number of patient surveys and the forthcoming trial of Medical Visual Translator cards with the Cycle Response Unit and members of the deaf community. The Committee now plans to review its Terms of Reference and membership, clarifying its role and links with other development work across the Service.

As a result of enquiries made to other emergency services about how they facilitate access for deaf people, the PPI Manager was invited to a meeting with the Metropolitan Police. They are in the process of replacing their control room technology and are considering access for deaf people as part of this work. A number of emergency services are already using SMS messaging systems for deaf people to use in an emergency, but they all have different numbers and work in a different way. At the meeting it was agreed that the emergency services should work together to influence the Department for Communities and Local Government (previously the Office of the Deputy Prime Minister) and the mobile telephone networks to develop a national SMS number for deaf people and the technology to support it.

The PPI Manager is developing closer links with the voluntary sector. She recently took part in a workshop to develop a strategy for the national umbrella group for the voluntary sector, *The Patients Forum.* At this event Harry Cayton, the National Director for Patients and the Public, talked about the forthcoming recommendations of the National PPI Expert Review. These are likely to include increased capacity for patients to engage with the NHS at a local level, at a commissioning level, at provider level and involvement of patients and the public in regulation.

These new PPI arrangements are likely to be local authority based, via the Overview and Scrutiny Committees. Stronger links between the LAS and local authorities will therefore be essential. To this end, the PPI Manager has undergone local authority training in facilitation of community groups, and has made a commitment to co-facilitate at least two events a year for the Westminster Open Forum. She plans to develop this approach in other

boroughs by involving local LAS management teams. She has also recently met the new Scrutiny Manager at the GLA.

A national resource centre for PPI has recently been established. It aims to provide information and advice, build capacity and share good practice. The centre's directors have asked for examples of PPI that could be shared with other organisations, and the PPI Manager has written to them, proposing some joint work on public education, the *Cardiac Arrest* DVD and the work on access for deaf people.

5. OVERSEAS TRAVEL

As part of a proposed exchange programme, four members of staff visited Boston earlier in July. Exchanging views and approaches to specialist responses i.e. Motorcycle, HEMS, CBRN, Stadia events, the staff report a very successful visit. As the visit occurred between Trust Board meetings Chairman's Action was requested. To ensure more robust management of travel on behalf of the Trust, revised paperwork and processes are being introduced by SMG.

Approval is also sought for a group of staff to visit Norway in October 2006

The following members of Staff have been selected and approved by their managers to represent the Service in Norway between 7 and 14 October, subject to Board approval.

Katherine Smith	Paramedic	Streatham Station
Ian Rhymer	Paramedic	Wimbledon Station
Matthew Fisher	Team Leader /Paramedic	Wimbledon Station
Sara Sandven	Paramedic	City & Hackney Station
James Rouse	Technician	City & Hackney station
John Donaghy	Training Officer	City & Hackney Station
Daniel Stretch	Paramedic	Tottenham Station
Daniel Barnwall	Paramedic	Barnhurst Station
Lee Emmett	Technician	Romford Station

Trevor Vaughan Awards Manager will be travelling to Norway as part of the staff exchange scheme 11 October to 14 October.

Total cost of this visit is not expected to exceed £12,000 which has been pre-budgeted for the year in the Ceremonial Budget.

Finally, Fionna Moore and Mark Whitbread have been invited to visit the New York Ambulance Service, with whom the LAS are collaborating on the 'Smart CPR' research project (details of which were given in the May report). Laerdal have kindly agreed to fund the flights and possibly the cost of the hotels etc. This visit will provide the opportunity to visit the New York Ambulance Service control centre, teaching centres and to ride out, as well as talking directly with colleagues and clinicians involved in this important multi-centre project.

6. RECOMMENDATION

The Board is asked to note my report and approve the travel requested under section 5

Peter Bradley CBE
CHIEF EXECUTIVE OFFICER

18th July 2006

Enclosure 4

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board Meeting – 27 July 2006

Report on behalf of the Executive Trust Director Finance

Audited Annual Accounts for the year ending 31 March 2006

1. **Annual Accounts**

   The Audited Annual Accounts for the year ending 31 March 2006 are attached.

2. **Audit Committee**

   The audit committee approved the accounts on the 3rd July 2006.

3. Audit Commission

   The Audit Commission our external auditors gave the accounts a clean opinion.

4. **Statutory Duties (Note 23, pages 35 & 36)**

   Performance against the four statutory duties was as follows:

   - **Breakeven performance – achieved**

     The retained surplus for the year was £1,258k.

     This differed from the forecast of £1,272k surplus reported at Month 12 (25th May).

   - **Capital Cost Absorption Rate – not achieved**

     The Trust is required to make a 3.5% financial return on average relevant net assets. The actual rate of return in 2005/06 was 4.1%, 0.1% above the permitted range of 3.0% to 4.0%.

   - **External Financing Limit – (£9,640k) – achieved**

     The Trust achieved its EFL target of (£9,640k) for the year.

- **Capital Resource Limit – achieved**

  The Trust is given a Capital Resource Limit which it is not permitted to overspend. The CRL was underspent by £1,250k against the limit agreed with the Strategic Health Authority of £6,695k.

5. **Accounts Completion**

   The Annual Accounts were completed by the 8th May target date and submitted to the NHSE and the Audit Commission.

6. **Public Sector Payment Policy (PSPP) (Note7.1, page 22)**

   The PSPP performance was 79% (in numbers of invoices), the target set by the Strategic Health Authority was 95%.

7. Provisions

   The Trust has included a provision of £9.7m for amounts payable to staff under agenda for change.

8. **Other Matters**

   A verbal commentary on the annual accounts will be provided at the meeting.

9. **Recommendation**

   THAT the Trust Board approve the audited annual accounts for the year ended 31st March 2006.

Michael Dinan
Director of Finance
27th July 2006

Definition of Statutory Duties

External Financing Limit (EFL)

The External Financing Limit (EFL) is the means by which the Treasury via the NHSE controls public expenditure in NHS Trusts.

The EFL can broadly be defined as "a form of cash limit on net external financing". External financing can broadly be defined as the difference between agreed expenditure on capital and internally generated resources.

Each year, each individual NHS Trust is allocated an EFL as part of the national public expenditure planning process. The Trust has a statutory duty to maintain net external financing within its approved EFL.

For 2005/06 the Trust achieved its EFL.

Capital Resourcing Limit (CRL)

The introduction of Resource Accounting and Budgeting in the NHS required the introduction of a capital control – the capital resource limit (CRL), which controls capital expenditure in full accruals terms. All NHS bodies have a capital resource limits. The CRL is accruals based as opposed to the cash-based EFL in NHS Trusts.

Underspends against the CRL can be carried forward (but should not exceed 5% of the CRL). Overspends against the CRL are not permitted.

A capital resource limit controls the amounts of capital expenditure that a NHS body may incur in the financial year.

For 2005/06 the Trust did not achieve its CRL due to slippage in the capital programme.

Capital Cost Absorption Rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £3,733,000, bears to the average relevant net assets of £90,901k that is 4.1%.

This was 0.1% higher than the permitted range of 3.0% to 4.0%. The variance from 3.5% is due to slippage in the capital programme.

Break-even duty

The Trust is required to break-even each year. For 2005/06 the Trust exceeded this requirement and generated a surplus of £1,258k. (See board report for details).

Enclosure 6

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board July 2006

REPORT OF THE MEDICAL DIRECTOR

Standards for Better Health

1. First Domain – Safety

The Trust will not be assessed during this financial year by the NHSLA. There is a new standard for assessment of risk management in ambulance trusts being developed. The Trust is participating in the piloting of the new scheme in 2007. The assessment will be based on five standards, governance, competent and capable workforce, safe environment, clinical care and learning from experience. Each standard contains 10 criteria. This new scheme represents a change in approach for the NHSLA and the Trust will be undertaking a self-assessment in line with good practice during the next six months, as the criteria will enhance our compliance with the core and developmental standards of the Annual Health Check. A checklist to be used in the self assessment will be considered at the next meeting of the Risk Compliance and Assurance Group. The NHSLA is a member of the Concordat with the Healthcare Commission and the Department of Health.

The annual trust wide risk assessment has been developed with three workshops in held in the three respective areas and a further risk assessment workshop being held at the recent senior managers' conference.

The Risk Register is also being revised to reflect advances in controls and changes in the governance committees and groups.

Safety Alert Broadcasting System:

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

Four alerts have been received during the period of 04th May – 04th July 2006. In total the trust has four alerts outstanding as follows:

- **NPSA/2005/8: Protecting patients with allergy associated with latex**

The final policy was forwarded to Bob Whittington on 04th July 2006.

- **NPSA/2005/10: Being open when patients are harmed**

This SAB alert remains on-going and has been forwarded to Ralph Morris for further action by the PSU department. Currently awaiting feedback on progress.

- **MDA/2005/069: Blood pressure monitors and sphygmomanometers**

This SAB alert remains on-going and continues to be actioned by the Corporate Logistic Manager. The possibility of in-house calibration checks continues to be considered, as well as replacing relevant sphygmomanometers annually.

- **MDA/2006/036: Electrically powered indoor wheelchairs (EPICS)**

This alert was received on 26.06.2006 and relates to the use of electrically powered indoor wheelchairs. The alert outlines the potential for injury when chairs are used outdoors. PTS are currently drafting a notice to be circulated which incorporates the recommended action by the MHRA.

2. Second domain – Clinical and Cost Effectiveness

Update on Stroke Management

This month has seen some very encouraging results from the effects of fast tracking patients to a dedicated stroke care unit. In particular the Medical Directorate would like to highlight the cases below which were treated at the St. Thomas Stroke Unit. One of the main clinical triggers for a referral to the Stroke Unit is the completion of the FAST test. FAST looks at **F**acial movements, **A**rm movements, **S**peech ability with all three elements **T**ested – if one or more element is abnormal then a stroke is suspected.

July 06

- FAST completed and called ahead
- Arrived with face, speech, arm and leg signs
- Thrombolysed within 20 mins with complete recovery
- Patient was discharged – living independently

July 06

- 98 year old man - FAST test completed
- Randomised to thrombolysis trial
- Making good progress with arm and leg weakness

June 06

- Patient at Guy's Hospital developed signs of stroke
- LAS called
- FAST test completed - patient deteriorated in transit
- Thrombolysed and now making good recover
- Beginning to walk although still has left sided weakness

June 06

- Patient collapsed at Eurostar arrivals
- FAST test completed and phoned ahead
- Thrombolysed within 1 hour of onset of stroke
- Making progress and beginning to walk with phsyios

The following comment was also received with the above reports from St. Thomas Hospital:- "I hope this helps and reinforces the fantastic service we get from LAS in dealing with stroke as an emergency."

The Medical Directorate is continuing to explore ways to increase the education of staff in the importance of stroke. Educational posters regarding stroke are being distributed to all stations. Information regarding an e-learning resource on stroke hosted by the University of Lancaster, is also being promulgated via RIB.

A summary of a clinical audit currently being undertaken by the Clinical Audit & Research Unit is attached at appendix 1.

3. Third Domain – Governance

The Governance review is reported elsewhere on the agenda. Workshops are planned to advance the main issues raised in the review using the skills of a cross section of corporate and operational managers across the trust. Amongst the Core tasks to be included in the action plan with time scales include an enhanced risk reporting system and a managers' network to develop ownership of governance at every level in the organisation.

4. Fourth Domain – Patient Focus, and Fifth Domain – Accessible and Responsive Care

Sickle Cell

David Whitmore represented the LAS at the launch of the Lambeth PCT Patient Held Sickle Cell Record Booklet on 4th July 2006. David has been assisting Lambeth PCT in its contents & design. It is intended to be held by the patient and to give all healthcare professionals vital information about the patient and their preferred treatment regimen etc… Although currently only being used in SE London, the LAS has indicated to Lambeth PCT and again at the launch that the LAS would be very keen to see this booklet rolled out across London in particular, as well as supporting its adoption nationally.

5. Sixth Domain – Care environment and Amenities

Infection Control

The LAS is soon to introduce a range of new equipment aimed at further reducing the risks of infection for both patients and staff. The new equipment primarily consists of single use (disposable) laryngoscope blades and Bag-Valve-Mask (resuscitator) units,

which will replace the current reusable versions. In addition, we are introducing the Braun Vasofix Safety Cannula for use in establishing intravenous access, which has been specifically designed to reduce the risks associated with needle-stick injuries. Further supplementary items include bacterial filters for use with Entonox and the Microvent resuscitator units, together with disposable face masks which will also be utilised with this equipment.

6. Seventh Domain – Public Health

Nothing to report

Recommendation

THAT the Board notes the report.

Fionna Moore
Medical Director
18th July 2006

Appendix 1

Clinical Audits of Call Categorisation: Progress Update

Authors: Gurkamal Virdi & Dr. Rachael Donohoe, Clinical Audit and Research Unit, Medical Directorate

The London Ambulance Service NHS Trust (LAS) uses the Advanced Medical Priority Dispatch System (AMPDS) to triage its 999 calls. Using AMPDS, Emergency Medical Dispatchers (EMDs) elicit information about the patient's condition and assign the call a determinant code that describes the chief medical complaint and the level of response needed. In line with Department of Health (DH) definitions, each determinant code is allocated one of the following three response categories: Category A responses are assigned to patients who have a life threatening condition and require an immediate response; Category B responses are provided where an immediate response is needed but the patient's condition is not life threatening, and a Category C response is assigned to calls where the patient's condition is not life threatening and does not require an immediate response. Currently, Category A calls account for approximately 40 percent of the LAS emergency workload.

The DH's Emergency Call Prioritisation Advisory Group (ECPAG) meets regularly to review the current response categories allocated to each AMPDS determinant code. Following the national review of Ambulance Services, *'Taking Healthcare to the Patient'*, ECPAG released a call for Ambulance Services to undertake fourteen clinical audits examining the appropriateness of the response categories allocated to a range of determinant codes relating to assaults, road traffic accidents (RTA's), falls, stroke, pregnancy and general sick persons (see Table 1). Four Ambulance Services, including the LAS, are currently undertaking this work. The aim is to spread the workload amongst the Trusts, however, the LAS intends to undertake all fourteen clinical audits. The audits compare the determinant code and categorisation of the call against outcome factors as documented on the Patient Report Form by the responding ambulance crew(s). These factors include the condition of the patient on arrival of the crew, the number of interventions undertaken and patient survival.

To date, the LAS Clinical Audit and Research Unit has collected data for ten clinical audits examining determinant codes listed in the table below. We plan to collect data for the remaining four audits in the next couple of months. Data analysis will begin

shortly and reports will be available for internal discussion by September 2006. The evidence from these audits will be used by ECPAG at their meeting in November 2006 to inform whether it is clinically safe to re-categorise the responses allocated to the determinant codes. It is predicted that downgrading determinant codes set as Category A to Category B will lead to a ten percent reduction in Category A workload.

Table 1: LAS Progress for ECPAG audits

Chief Complaint	Determinant code	Description of determinant	Data collected
Assault	4D2*	Not alert	✓
	4D3	Abnormal breathing	✓
	4D4*	Dangerous injuries	✓
RTA's	29D2b	vs motor bike	✓
	29D2c**	vs pedestrian	✓
	29D2d*	Ejected	✓
Falls	17D2	Fall over 6 foot	✓
Stroke	28C1	Not alert	Planned
	28C2**	Abnormal breathing	Planned
Pregnancy	24D3	Imminent delivery	Planned
	24D4*	Third trimester haemorrhage	✓
	24D6	Baby born	Planned
Sick Person	26A1	Specific diagnosis (no priority symptoms)	✓
	26C1	Altered level of consciousness	✓

* DH Category A determinants
** DH Category B determinants upgraded by LAS as Red Calls
No asterisk = DH Category B

Enclosure 7

London Ambulance Service NHS TRUST

TRUST BOARD DATE 25 July 2006

CAD REPLACEMENT

1. Sponsoring Director: Peter Bradley

2. Purpose: For noting

3. Summary

On 22 February 2005 the Service Development Committee approved a paper entitled "CAD – The Way Forward". Stage 1 of this project was described as "Procurement Preparation" with the intention to:

> "define the user requirement, conduct market research (including looking at the existing Ambulance CAD products) and produce a business options report recommending how the new environment should best be provided".

The business options report was presented to, and approved by, the Trust Board in November 2005. It identified that the best way forward was by a commercial procurement, seeking to engage suppliers to work with the LAS to adapt (potentially with some development) and integrate existing products. It was agreed that the project should proceed on the assumption that the project would require approval by the SHA, who require completion of the following three stage business case process:

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

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

Work on the Strategic Outline Case has now been completed and it is ready to be presented to the SHA for approval. Given that the details within the SOC are commercially sensitive, it is being presented to the Trust Board in part 2 of the meeting in order to seek agreement to forward it to the SHA.

4. Recommendation

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

Enclosure 8

London Ambulance Service NHS TRUST

TRUST BOARD 25th July 2006

UPDATE ON THE IMPLEMENTATION OF THE GOVERNANCE REVIEW

1. Sponsoring Executive Director: Mike Dinan

2. Purpose:

   To note progress with the implementation of the main issues and recommendations from the Governance Review

3. Summary

   The main issues and recommendations from the Governance Review are now being addressed. The first step taken has been to re-design the terms of reference for the Audit Committee, the Clinical Governance Committee and the Risk Compliance and Assurance Group

   The terms of reference for the Audit Committee and the Clinical Governance Committee have been drafted with input from the chairmen and members of those committees. Details of the terms of reference for the Risk Compliance and Assurance Group are being discussed with the NHSLA in the light of changes being made to the NHSLA Risk Management Standard for Pre-Hospital Care. These terms of reference are appended to this paper

4. Recommendation

   THAT the Board:

   1. Notes the progress to date in implementing the recommendations of the Governance Review

   2. Agree terms of reference for the Audit and the Clinical Governance committees

   3. Notes the terms of reference for the Risk Compliance and Assurance Group are currently under review with the NHSLA

Enclosure 9

London Ambulance Service NHS TRUST

TRUST BOARD DATE 25th July 2006

FREEDOM OF INFORMATION POLICY

1. Sponsoring Director: Peter Bradley

2. Purpose: For approval

3. Summary

The original Freedom of Information policy was approved by the Trust Board in February 2005. Given the unknown impact of the act on Trust business, it was further reviewed at six months. As a result of this review, the following changes were approved by the Trust Board in July 2005:

i The next review date was set for 12 months – July 2006

ii At section 1.1, clarification added in relation to patient confidentiality

iii The section originally numbered 2.3 & 2.4 that related to departments providing information manuals was removed. Experience has shown that these have added little value to the process of seeking information.

iv Section 6 was re-written (with a new section 7) to clarify the process's of appeals and complaints.

v There were minor grammatical changes to improve the overall readability of the document.

Over the past 12months the policy has been used to guide all FOI requests (including detailed research questions as a result of 7/7). Based on this experience, in terms of policy it is considered fit for purpose without further amendment.

4. Recommendation

THAT the Trust Board re-approves the policy for a further period of 3 years. The Director of IM&T will review the policy during this period should either further experience or a change in legislation require it.

Enclosure 11

LONDON AMBULANCE SERVICE NHS TRUST BOARD

TRUST BOARD 25th July 2006

Report of the Trust Secretary
Tenders Received & the Register of Sealings

1. Purpose of Report

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

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

2. Tenders Received

Register no.	Details of tender:	Tenders Received From
11/06	Refurbishment of Fielden House	Crispin Russell Crawberry W T Cuffe Coniston
12/06	Driver Testing Vehicle	McNellie Wilker UK

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. Register of Sealings

There have been 2 entries, reference 97 and 98 since the last Trust Board meeting. The entries related to:

No. 97 Contract for works at Barnehurst AS, 164 Erith Road, Bexleyheath, Kent DA7 6BZ

No. 98 Lease, first floor, Fielden House, 28-42 London Bridge Street, London, SE1.

4. Recommendations

THAT the Board note this report regarding tenders received and the use of the Trust's seal.

Christine McMahon
Trust Secretary

Enclosure 12

DRAFT

AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE

Monday 3rd July 2006

Present:	Barry McDonald	Non-Executive Director (Chair)
	Sarah Waller	Non-Executive Director
In Attendance:	Peter Bradley	Chief Executive (until 4.20pm)
	Mike Dinan	Director of Finance
	Caron Hitchen	Director of HR and Organisation Development (until 3pm)
	John Wilkins	Head of Governance
	Michael John	Financial Controller
	Tim Merritt	Bentley Jennison
	Chris Rising	Bentley Jennison
	Sue Exton	Audit Commission, District Auditor
	Terry Blackman	Audit Commission
	Keeley Saunders	Audit Commission (until 3.00pm)
	James Larkin	Bentley Jennison, Local Counter Fraud Specialist
	John Downard	Head of Software Development & Support (until 3pm)
	Christine McMahon	Trust Secretary (Minutes)
Apologies:	Peter Suter	Director of Information Management & Technology.
	Beryl Magrath	Non Executive Director
	Robert Brooker	Bentley Jennison, Local Counter Fraud Specialist

Prior to the start of the meeting the Audit Committee met privately with the Internal and External Auditors.

During the meeting the Chairman referred to an email he received from Beryl Magrath which contained her comments regarding reports to the Committee.

13/06 Minutes of the last Audit Committee meeting 20th March 2006

Agreed: The minutes of the last audit committee meeting held on 20th March 2006 with the amendment that the tender exercise for internal audit will commence July 2006 and will take about 3 months including OJEU advertising. The specification for internal audit will be circulated in due course to the Audit Committee for comment. ACTION: Finance Director

14/06 Matters Arising

- Minute 28 & 29: The following internal audit reports (Drug control; CTA, Urgent Care, Complaints and PTS) were not finalised in time for presentation to the Audit Committee; the Head of Governance undertook to circulate them within a couple of weeks. **ACTION: Head of Governance**
- Minute 30: *ESR* – the HR Director informed the Committee that the implementation of ESR has been extended by 3 months and it would not be going live in July 2006. The extension had been agreed with McKesson (Consultants) and the Department of Health. Though a lot of work has taken place preparing for the implementation of ESR the Project Board was not confident that all staff would be paid correctly if the system

is implemented in July. The Committee was informed that more testing on data cleansing is required.

- Minute 05/06: That the NHSLA along with 14 other health care inspectorates has signed up to the Health Care Concordat.
- Minute 08/06: The procedural gap around travel permission has been addressed.

15/06 Annual Accounts 2005/06

The Financial Controller presented the annual accounts for 2005/06 to the Committee. The report on page 19 will be changed to show pension benefits in bandings rather than lump sums. **ACTION: Financial Controller**

The Committee suggested that the Statement of Internal Control be amended as the level of detail included in the report was thought to be unnecessary. The same information is accessible in other Trust documents. The District Officer suggested that strategic issues should be highlighted within that section of the report. The Director of Finance undertook to liaise with the Director of Communication on the form of wording to be used. **ACTION: Director of Finance.**

Agreed: 1. The 2005/06 annual accounts that will be signed by the Chief Executive and the Finance Director.

Noted: 2. That the annual accounts will be presented to the Trust Board in July 2006.

3. That the actual result (£1,258) and the forecast result (£1,272) were very similar.

16/06 Internal Audit

Progress Report 2005/06

The Internal Auditor's report to the Committee contained one final report (PPI) with 12 reports still in draft. 7 of the 12 reports had been finalised since the circulation of the Audit Committee's agenda and these will be circulated by the Head of Governance. **ACTION: The Head of Governance.**

The Committee was assured that a process has recently been in place to expedite the turnaround of reports which will include a debrief by the internal auditor with the relevant manager so that the new timeline for finalising reports should be three weeks from this debrief and performance indicators will be published. Sarah Waller requested that an aged report be included as an appendix to the Auditor's report. **ACTION: Internal Auditors.**

The internal audit report concerning PPI was very positive, with adequate assurance being given with regard to the processes in place. There were no significant recommendations. The recommendations that have been made by auditors were accepted and implemented by management.

Sarah Waller expressed surprise that the Trust did not have a way for users to give feedback on the service they have received or leaflets in different languages. The Finance Director undertook to pursue this matter outside the meeting. **ACTION: Finance Director.**

Noted: That a reconciliation will be undertaken regarding the actual and billed internal audit days and the appropriate adjustment made.

Annual Internal Audit plan

Tim Merritt, Bentley Jennsion, presented the annual internal audit plan; he drew the Committee's attention to 2.2, the basis of opinion which relied on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

an assessment of the range of individual opinions arising from risk based audit assessments; an assessment of the process by which the organisation has arrived at its declaration in respect of the Standards for Better Health and any reliance that is being placed upon third parties such as RPST.

Bentley Jennison were satisfied that they could give significant assurance with no caveat as no material weaknesses had been identified.

The Committee considered the benchmarking information presented as part of the report. It was explained that although the LAS had less substantial assurance in comparison to Bentley Jennison's other NHS clients and in comparison to the previous year; this was probably due to more focus being placed on areas were there were suspected weaknesses, consequently their audits resulted in recommendations for improvement. It was recognised that although it is not necessarily a bad thing when areas for improvement have been identified following an initial audit, it is a serious matter when the same issues are highlighted during a second audit. The audits conducted in 2005/06 where limited assurance was given would be re-audited in 2006/07. The Finance Director also suggested that ESR be audited in 2006/07.

Noted: That the Internal Auditors felt 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'.

Client Briefings: Corporate Manslaughter and Infection Control. The Committee's attention was drawn to the two client briefings prepared by Bentley Jennison. The Finance Director suggested that corporate manslaughter would be a suitable item to include in board development training session. The Chief Executive said that staff do not currently receive any training or information concerning corporate manslaughter. Corporate manslaughter will be raised with staff as part of general management training/professional development e.g. as part of health and safety training disseminated at departmental meetings.

Noted: The contents of the two client briefings regarding corporate manslaughter and infection control.

17/06 Audit Commission

Terry Blackman, Audit Commission, presented the progress report for 2005/06. He reported that the review of the new CAD system has been rescheduled and will take place in 2006/07.

Three of the five sections of the Auditor's Local Evaluation (ALE) report have been completed. The assigned scores for the three completed sections were Financial management (3); Internal Control (2) and Value for Money (3) which Terry Blackman suggested reflected very well on the Trust.

The two outstanding assessments are Financial Reporting and Financial Standing. Following completion the ALE will be submitted to the Healthcare Commission as part of the annual health check; the deadline is 12 October 2006. The Audit Commission will share the final report with the Trust prior to its submission to the Healthcare Commission.

The Finance Director disagreed with the score of 2 for internal control; Sarah Waller commented that the 'improvement opportunities' concerning internal control appeared to be focused on the provision of training to staff. The Finance Director undertook that further work would be undertaken to raise awareness regarding counter fraud. Terry Blackman pointed out that the score in part reflects compliance with the Trust's standing orders and financial regulations at complex level. He also said that not many scores of 3 were being awarded.

The Finance Director expressed the hope that the ALE will remain unchanged as it has the potential to be a useful tool for benchmarking NHS Trusts. The District Auditor said that although the key lines of enquiry were likely to remain unchanged in 2006/07, the financial targets may be amended to reflect changes in the financial regime.

2006/07 audit plan:

The District Auditor presented the plan, which had been agreed by the Chief Executive and the Finance Director, to the Committee for its approval. The audit plan for 2006/07 will include work around identifying risks which will include considering the benefits realised arising from the 2005/06 workforce contract changes (AfC); ALE and value for money conclusion.

It was noted there may not be many benefits to show from Agenda for Change due to the limited opportunities for LAS to negotiate changes in working practices in exchange for the pay rises agreed centrally. However the resolution of the rest break would deliver a material benefit for the Trust as would the introduction of the EMT 4 grade.

The Committee considered the increase in the Audit Commission's fees (2006/07: £125,500 compared to £117,850 in 2005/06). The District Auditor pointed out that the fee increase reflected the additional work expected of the Audit Commission. As part of the Audit Commission's report (page 15) there were recommendations as to what actions the Trust could take to reduce its audit fees.

Annual Governance report

The annual governance report highlights any issues that may have arisen during the audit concerning governance. The District Auditor introduced Keeley Saunders who had conducted the 2005/06 audit. She informed the Committee that the audit commenced 12th May, that the auditors had received full co-operation from staff and there was nothing she needed to highlight.

The District Auditor confirmed that there will be an unqualified audit opinion and that the Audit Commission was satisfied that the proper arrangements were in place to achieve the 3 'e's (effectiveness, efficiency and economy). There were no material misstatements to report.

The Finance Director undertook that in 2007 the 2006/07 Audit Commission would see the final statement before they have to give their opinion on the annual accounts for 2006/07. It was commented that Foundation Trusts are required to lay their annual reports and annual accounts before Parliament prior to the summer recess (July).

Noted:

1. **That the Audit Commission's Audit Letter will be presented to the Audit Committee in December 2006.**
2. **That the work on the Trust's financial statements is now substantially complete and subject to the satisfactory conclusion of the work outstanding the Audit Commission expect to issue an unqualified opinion by 10th July 2006.**
3. **That the report concerning the Trust's use of resources (to secure economy, efficiency and effectiveness) has been completed and an unqualified value for money conclusion will be issued by the Audit Commission by 10th July 2006.**
4. **That the Audit Committee wished to record its thanks to staff for their efforts with the annual audit.**

18/06 Report of the Local Counter Fraud Specialist and plan for 2006/07

James Larkin attended the Committee meeting in Robert Brooker's absence. He reported that there are two investigations ongoing. In addition the following have been reported which will require investigation: excess mileage claim (PTS); inappropriate use of fuel card; misuse of petty cash and potentially stolen goods (Isleworth).

Plan for 2006/07

The Committee was informed that an annual survey of 100 staff was recently undertaken which had a good response rate of 33%. Disappointingly few of the respondents were aware of who their local counter fraud officer was. During 2006/07 the counter fraud team will dedicate 6 days to giving presentations to staff and managers highlighting the work they undertake. The posters advertising the contact details of the counter fraud officers will be reviewed. The positive outcomes of investigations will be publicised in the LA News.

The Committee was informed that a national audit of payroll is being undertaken by the NHS.

Agreed: 1. That the Director of Communications would be involved in publicising internally the counter fraud work. ACTION: Finance Director/Director of Communications.

Noted: 2. The report.

3. The workplan for 2006/07.

19/06 Risk Register Update

The Committee was informed that the annual trust wide risk assessment (TWRA) had not yet been completed. Following completion of the TWRA the Risk Register will be updated to ensure it reflects the Trust's current risks. The revised Risk register and Risk Management Framework will be presented to the Trust Board in September 2006.

A report regarding the implementation of the Governance review will be presented to the Trust Board in July 2006; the report will include the revised terms of reference for the Clinical Governance Committee, the Risk Assurance and Compliance Group and the Audit Committee.

The Committee considered the risks from the Register it is responsible for. The Chief Executive observed that the top three risks are unlikely to change when the risk register is reviewed following completion of the TWRA.

It was commented that some of the commentary included in the report is 'dated' with reference being made to actions in 2005; e.g. risk 70, *risk of not learning and changing practice, as appropriate, as a result of complaints* had a comment referring to the proposed review of PSU. The Chief Executive said that a report on the findings of the PSU review was presented to the Trust Board in March 2006. The commentary included in the risk register will also be reviewed post the TWRA. **ACTION: Head of Governance**

Risk 10 *(failure to undertake comprehensive clinical assessments which may result in the inappropriate non-conveyance or treatment of patients)* - the five day continuing professional development course is being rolled out and will conclude in 2007.

Risk 8 *(failure to fully complete the Patient Report Form with details of drugs given*) Sarah Waller was assured that every effort is being made to ensure CPI checks are undertaken.

Risk 121 *(lack of comprehensive fully integrated contingency plan)* Sarah Waller was informed that the inclusion of this item on the Risk Register predates the Trust's business continuity plan.

Noted:
1. **The report concerning the Risk Register**
2. **That the Risk register and Risk Management framework will be presented to the Trust Board on 26th September 2006.**
3. **That a report outlining the implementation of the Governance Review will be presented to the Trust Board on 25th July 2006.**

20/06 Standing Committee Items

Noted:
1. **That there had been no declarations of hospitality since the previous Audit Committee meeting held in March 2006.**
2. **That retrospective permission will be sought from the Trust Board with regard to a member of staff who travelled outside the EU without prior approval from the Board.**
3. **That the Standing Orders will be reviewed and will be presented to the Trust Board in September. ACTION: Trust Secretary**

21/06 Update re. NHSLA

The Committee was informed that there has been some progress made with the NHSLA with regard to the criteria by which Ambulance Trusts are assessed. To date the NHSLA has used 291 criteria to assess Ambulance Trusts which were more suited to acute hospitals. The NHSLA recently proposed a set of standards, with 5 domains, containing 50 criteria by which Ambulance Services would be assessed which will have scope to recognise local initiatives. The Trust is not required by the NHSLA to be assessed against the current criteria in this financial year. The Head of Governance will be attending a consultative event being held by the NHSLA in September 2006, to formulate the criteria with in the five new standards

As a consequence the objective of attaining level 3 pre hospital care standard needs to be reassessed in light of the changes being proposed by the NHSLA. The Head of Governance undertook to circulate to the Committee information in advance of the NHSLA's consultative event in September. **ACTION: Head of Governance.**

An action plan will be presented to Audit Committee in December. **ACTION: Head of Governance.**

Noted: The progress achieved with the NHSLA and the work that is being undertaken to agree new criteria for the assessment of ambulance services.

22/06 Audit Recommendations

The Chairman was assured that the Auditor's recommendations from the 2005/06 internal audit had been included in the report presented to the Committee.

The Management response to the Auditor's recommendation concerning the Payroll audit was highlighted; the management response appeared to suggest that what was recommended was not possible. The Director of Finance pointed out that a lot of 'data cleaning' has been undertaken due to the requirements of the ESR project. When ESR is implemented it will no longer be necessary to use the IPS system. The Management Comment will be updated. **ACTION: Finance Director.**

Inventory – Make Ready has been rolled out to all complexes; the Trust is still using paper returns to manage its inventory. Plans are in place to introduce more sophisticated process i.e. electronic bar codes. A stock audit was recently undertaken as part of the annual audit and it was surprisingly clean. The Finance Director said that £2m stock too high.

The Committee was informed that PTS is not currently included in the Make Ready scheme but it will be.

It was observed that some of the auditor's recommendations (recommendations being implemented) included the comment 'awaiting response'. The Finance Director said that as part of the Assistant Director of Operations performance management they are expected to take ownership of the implementation of the auditors' recommendations.

Noted:
1. **The progress being made to implement the auditor's recommendations.**
2. **The areas where management response was still awaited (e.g. CTA, Payroll, and ECP).**

23/06 Draft minutes of the Clinical Governance Committee (15/5/06) and draft terms of reference for the Risk Assurance and Compliance Group.

Draft Clinical Governance Minutes, 15th May 2006. Minute 28: the Committee disagreed with the suggestion that the Clinical Governance Committee receive reports on the progress of the action plans on an exceptional basis. The Committee recommended that the Clinical Governance Committee receive a full report on the progress of the action plan with a front sheet that highlights any changes to the plan and any concerns regarding progress. **ACTION: Head of Governance.**

Risk Assurance & Compliance Group (RA&CG): the Head of Governance reported that the terms of reference had been shared with the NHSLA as requested at the last meeting of the Risk Management Group. The NHSLA were satisfied with the proposed terms of reference but recommended that the Group be a Board Committee in its own right rather than reporting to the Board via the Audit Committee. The Audit Committee will receive the minutes of the RA&CG.

Noted:
1. **The draft minutes of the Clinical Governance Committee**
2. **The draft terms of reference for the Risk Assurance & Compliance Group.**

23/06 Work plan and timetable for meetings 2005/06

Noted:
1. **That the workplan will need to be reviewed in the light of the review of the Committee's terms of reference.**
2. **That the Audit Committee is scheduled to meet at 2.30pm on Monday, 4th December 2006.**

Any other Business

Sarah Waller wondered how the governance review was going to be implemented throughout the organisation. The Finance Director outlined the work that has been undertaken regarding the balanced scorecard; which is intended to measure progress of both clinical and non clinical objectives, including the undertaking of CPI checks.

Noted: **That work is being undertaken to implement the governance review with an initial progress report being presented to the Trust Board in July 2006 with timeline for implementation including revised terms of reference for all committees. A further progress report will be presented to the Audit Committee in December 2006.**

Meeting finished at 4.45pm

LONDON AMBULANCE SERVICE NHS TRUST

SERVICE DEVELOPMENT COMMITTEE

Tuesday, 27th June 2006 at 10:00 a.m.

Held in the Conference Room, LAS HQ

Present:	Sigurd Reinton	Chairman
	Peter Bradley	Chief Executive
	Barry MacDonald	Non Executive
	Sarah Waller	Non Executive
	Beryl Magrath	Non Executive
	Ingrid Prescod	Non Executive
	Caroline Silver	Non Executive
	Roy Griffins	Non Executive
In attendance:	Caron Hitchen	Director of Human Resources & Organisation Development
	Fionna Moore	Medical Director
	Mike Dinan	Director of Finance
	Martin Flaherty	Director of Operations
	David Jervis	Director of Communications
	Kathy Jones	Director of Service Development (until 10.40)
	Ian Pentland	CAD2101 Project Manager
	Chizoba Okoli	Senior Management Accountant
	Christine McMahon	Trust Secretary (minutes)
Apologies:	Peter Suter	Director of Information Management & Technology

The Chairman congratulated Fionna Moore, the Medical Director, who recently gained her Fellowship in Immediate Medical Care.

The Chairman asked the Director of Service Development to convey the Committee's condolences to the family of Lisa Taylor. Lisa, a member of the Project Support Office, died recently, and her funeral was being held that morning.

21/06 Minutes of the last two meetings of the Service Development Committee, held on 28th February and 25th April 2006.

The Chairman **signed** the Minutes as a correct record of the meeting held on 28th February 2006.

Minute 3.6: the HR Director wished to clarify that although there is only one stage of appeal for Agenda for Change, staff can use their Trust's Grievance Policy if they feel that the Agenda for Change process has been misapplied. The Trust has not received any grievances of that nature.

Minute 5.6: the Chief Executive apologised that the analysis of demand in February has not been completed and he undertook to include it in his report to the July Trust Board. **ACTION: Chief Executive**

The Chairman **signed** the Minutes as a correct record of the meeting held on 25th April with the proviso that the minutes be amended to reflect the presentations given at the Awayday, in particular the presentation delivered by the Director of Operations. **ACTION: Trust Secretary**

22/06 Chairman's Update

Following the recent publication of the Greater London Authority's (GLA) review of the response of the emergency services to the 7th July bombings, the Chairman and the Chief Executive met with the GLA Committee's Chairman (Richard Barnes) and Vice Chairman (Sally Hamwee) to discuss the findings of the review and how it was presented to the media. The meeting had been helpful and Richard Barnes had recognised that consideration should be given as to how the media will treat the contents of reports such as those undertaken by his committee. Though the majority of the meeting was concerned with the response to the 7th July and the implementation of the lessons learnt, there was also discussion about the routine work undertaken by the Service responding to urgent and emergency calls in London. There will be a follow up report to the GLA in November when the emergency services will report on the implementation of lessons learnt from the bombings.

Dr George Greener, the new London SHA Chairman, visited the Trust on 19th June; it was a very positive meeting. He wrote recently to the Chairman expressing the positive impression he received of the Trust's senior management team.

The Chief Executive recently met with David Nicholson, the new Chief Executive of the London Strategic Health Authority. The Chief Executive and Julie Dent have been asked to give a presentation on emergency preparedness to the SHA's first Trust Board meeting on 10th July 2006.

The Chairman recently chaired the Appointments Commission's panel for the South East Ambulance Service's non executive directors. There were some very good candidates and if the same calibre of appointments is repeated across the country then the LAS will have some very strong colleagues to work with.

The Chairman, the Chief Executive and the Director of Finance recently attended the NHS Confederation's annual conference; the Chairman said that the atmosphere was noticeably more positive than last year as the uncertainty regarding reconfiguration had been resolved.

23/06 Performance update

The Chief Executive reported that although Category A 8 minute performance had started well in 2006/07 (77% achieved in April and 75% in May) June has been a difficult month. In comparison to June 2005 demand has not increased, however there has been real difficulty attracting staff to work at weekends now that double time has ceased. There is now a clinical risk for the Trust (as opposed to purely a performance risk) as a result of poor weekend staffing levels. Managers are reviewing the level of abstractions from front line duties. Work is also being undertaken in EOC to ensure consistent attention is being paid to the current performance difficulties.

The Director of Operations reported that during the forthcoming weekend (1st July 2006) the following events will be held in London: Euro Pride march, the World Cup (England vs. Portugal) and Wimbledon. The Director of Operations said that there have been 'difficult days' experienced at weekends with 55-60% Category A 8 minute response. The Gold Suite's function has been re-established in the control room and a report will be presented to the Trust Board in July. **ACTION: Director of Operations.**

The Chief Executive reported that Hayden Newton (Department of Health) is undertaking a review of all the English ambulance services to ensure ambulance services are reporting performance correctly.

Noted: The report regarding performance in June 2006.

24/06 Finance report – Month 2

The Finance Director reported that for Month 2 the Trust had a modest surplus of £400,000. He highlighted the following areas from his report:

A&E is overspent by £130,000 to date. This is mostly due to overtime. The resuscitation training recently delivered was costly as people were taken off the road for 3 hours training on the new resuscitation guidelines and this had not been properly budgeted for.

The 2006/07 budget for overtime is £6m for the first six months and £3.5m for the remaining 6 months. Senior staff will be meeting on a weekly basis to review overtime, its cost and the success of high impact changes. The Trust is recruiting to fill 140 vacancies, reaching full establishment in November 2006. It may be necessary at some point to restrict overtime during the week so as to improve staffing at the weekend; discussions will be held with Staff Side. UOC was also overspent on overtime due to the extra cover required as changes were introduced in the room.

The Committee was informed that although the Trust had won a significant arbitration case no money has been received. The Director of Finance was confident, once the new SHA's financial team is firmly established, the money will be received.

In response to a question from Barry McDonald, the Director of Finance confirmed that discussions are still ongoing regarding the SHA's request for an additional £1m surplus. He also confirmed that the Trust would be reluctant to broker any monies whilst a substantial sum of money was owed by another London NHS Trust.

The Director of Finance explained to Sarah Waller the apparent discrepancy in the Committee's papers regarding the level of CBRN funding received. The Trust has received £7.5m CBRN funding; the remaining £0.5m is in dispute. However, as the Trust has a written guarantee of recurrent funding of £8m CBRN funding, the Director of Finance was confident the remaining funds will be received.

Funding from the Workforce Development Confederation (WDC) is currently in dispute. The funding to London has been top sliced due to the London health sector's financial deficit, and the discretionary pot from which the LAS would draw funding has been ring fenced for PCT Commissioners. The Trust will continue to argue that it should receive £300,000 funding from the WDC.

The Director of Operations confirmed that body armour identical to that worn by the Metropolitan Police, has been purchased. The body armour will be stored in Duty Station Officer (DSO) vehicles and be available to staff responding to armed response incidents.

Barry McDonald asked about Emergency Care Practitioner (ECP) funding and was informed that, despite signing Service Level Agreements with the LAS, Havering PCT are arguing that the ECP funding is a discretionary item and are threatening to withdraw funding. As part of the recent discussions with Dr Greener it was proposed that there should be a central procurement of services such as the ECPs.

Noted: The finance report for Month 2 and that the format will be changed for presentation to the Trust Board in July, including larger font.

25/06 Implications of the new London Strategic Leadership

The Chief Executive reported on his meeting with David Nicholson, the recently appointed Chief Executive for NHS London (the name of the new pan London

Strategic Health Authority). Prior to the meeting David Nicholson had written informing of the interim arrangements being put in place whilst consideration is given to the long term objectives for the healthcare sector in London. He is keen that the LAS play a key role in the emergency preparedness and said that he had been impressed with the Trust's performance. The Chief Executive said it had been a very helpful meeting. Mr Nicholson undertook to visit the LAS in September/October 2006 once his new team are in place.

Noted: 1. The Chief Executive's report on his meeting with the recently appointed Chief Executive for NHS London.
2. The briefing note prepared by the Director of Service Development and the Chief Executive.

26/06 Discussion re. the CAD 2010 strategic outline case.

The Director of Service Development presented a summary of the Strategic Outline Case (SOC) for CAD 2010 to the Committee in the absence of the Director of Information Management and Technology.

The summary outlined the rationale, the process undertaken in drafting the SOC and the three options the Trust may wish to pursue (do nothing, develop in-house and commercial procurement).

Following the useful Gateway Review recently undertaken by the Office of Government Commerce, the paper submitted to the Committee will be slightly amended prior to its presentation to the Trust Board in July 2006. The Gateway Review team suggested that a fourth option be included i.e. buying a commercial product off the shelf. It also suggested that the debate about functionality of CAD 2010 needed to be grounded in the Trust's business objectives.

It was recognised that the cost of CAD 2010 is inflated due to the requirement to build in an 'optimism bias'. At each subsequent stage of the process the optimism bias applied will be lower. Another major cost is the requirement for a fully functional test regime including, potentially, third control room – unless one is required and budgeted for anyway. At this stage it was necessary to include the cost of commissioning and decommissioning a third control room as a project cost even if it turns out later that the third control room needs to be created anyway.

The Finance Director has pointed out to the Gateway Review team that, should additional external funding not be secured for this project, the required cost savings required internally would equate to 60 WED on an annual basis. The Committee discussed the need for a plan B should the funding for CAD 2010 not materialise.

In response to a question from Sarah Waller, the Director of Service Development said that CAD 2010 needed to be in place at least 18 months prior to the Olympics in 2012. This reinforced the need to press on with the process and so the Trust Board in July will be asked to give its approval for the SOC to be submitted to the SHA. The time required for the procurement process is likely to be lengthy; the Director of Information Management & Technology was keen to commence the process.

There was a discussion about the inclusion of the 4th option i.e. the possibility of buying a commercial product off the shelf. This would be the cheapest option but might involve a number of compromises in the requirements specified by users. Informal discussions have been held with a number of suppliers and the Director of Service Development was pleased to report that they were keen to work with the LAS to develop the necessary technology. Procurement will be a challenge, given that there are relatively few suppliers in the market place.

The Chief Executive pointed out that the recent reconfiguration of ambulance services has meant that London will no longer be able claim to be unique simply because of its size. He mentioned that the Department of Health has engaged a firm of consultants to undertake a review of control rooms around England. The consultants are expected to report their findings in October 2006.

The Chairman asked that the Committee be kept closely informed as this progresses; in particular, it will be important to be very clear about the trade offs that might have to be made between the functionality desired by staff and what can be obtained in the market place. He underlined that the Committee needed to understand and be comfortable with these trade offs.

Noted: That a revised version of the Strategic Outline Case will be submitted to the Trust Board for approval in July 2006.

27/06 SIP – review of the lessons learnt

The Chief Executive presented a review of the lessons learnt from undertaking the recent Service Improvement Programme. The Head of Programme Management had spoken to a number of colleagues, obtaining views as to what had worked well, what had not worked so well and what lessons could be learnt for managing the next service improvement programme.

A similar report will be given to the Office of Governance Commerce (OGC). Roy Griffins suggested that the report for the OGC could be differently presented in that an extract from each of the 8 areas could be made into one check list. This checklist could in turn be incorporated into the next service improvement programme. **ACTION: Head of Programme Management**

Beryl Magrath commended the summary; she felt the consultation undertaken by the Head of Programme Management reinforced the need for those on the 'shop floor' to contribute to the continued improvement of the Service.

Noted: The findings of the review and the lessons learnt from the Service Improvement Programme.

28/06 Update on PTS.

The Director of Finance presented an update on PTS which included the following:

- In 2005/06 PTS lost the Hammersmith contract and some painful but valuable lessons were learnt by the PTS managers as approximately £200k of unrecoverable cost was incurred during the exit phase.
- Work is being undertaken with Central Services to improve its flexibility and responsiveness to the outlying contracts.
- Approximately 80% of PTS' business is based around 13 contracts.
- Generally contracts with PCT are more profitable than those with Acute hospitals.

Tighter controls and more proactive contract management are needed. He was optimistic that although the PTS lost some contracts in 2005/06 there is scope out there to win other contracts. It was undeniable that, compared to its private competitors, LAS' PTS service is expensive; what it has offers is higher quality clinical care.

PTS' performance as measured by arrival times at hospital, pick up times following appointments and length of journey time has generally been good. The

Finance Director said this needed to be seen in the context of PTS currently having virtually no access to technology, but nevertheless managing to effectively use the data it does have access to. It is planned that in 2006/07 PTS will receive better technological tools to further improve performance and productivity.

He expected that in the next few years there will be a consolidation in the PTS sector. LAS' share of the London PTS market is currently 30%.

In response to a question from Beryl Magrath, the Director of Finance did think there was merit in retaining PTS; it is paying its way and, by getting closer to A&E, it will be able to respond to green calls and support A&E accordingly. He pointed out that on 7th July 2005 approximately 200 PTS vehicles were available to the Gold Commander as part of his operating resource.

Bromley PTS is presenting some challenges which have not been helped by the fact that it is physically some distance from Bromley Ambulance Station. Work is ongoing to ensure closer links between PTS and UOC in respect of proving transport for non-urgent patients.

For the benefit of new members of the Committee the Chairman explained that a few years ago the Trust had unsuccessfully tried to divest itself of PTS but received little interest from commercial operators. It had therefore been decided to keep the PTS operations but to insist on proper patient care standards even if this meant losing some contracts where the terms on offer were too tight.

The Director of Finance suggested that by better marketing, working more closely with A&E, introducing technology to assist improved productivity, there is no reason why PTS will not be successful.

The Chief Executive commented that work being undertaken by the Department of Health regarding the licensing of patient transport service may raise the quality threshold for services to patients and possibly level the playing field. A separate (but possibly related) problem is that some private contractors are not paying Agenda for Change rates when they should be.

The Director of Finance commented that at the recent PTS consultations undertaken by the Chief Executive staff had not complained about Agenda for Change and the majority of their questions had been around patient care.

Noted: The contents of the presentation concerning PTS.

29/06 **Presentation: Update on progress with the 7 Year Plan .**

The HR Director presented a progress report on aspects of the Seven Year Plan, notably the work undertaken on the long term workforce plan which in turn will inform the work on what funding will be needed to realise the Seven Year Plan. Work is also being undertaken with regard to the balanced scorecard.

The HR Director circulated information illustrating the process that has been undertaken to identify the Trust's long term workforce requirements in terms of the interventions and associated skills required of staff in response to the anticipated range of possible calls. It was clear that green calls, many of which are often quite complex (since patients in this category often have multiple underlying illnesses) will require highly skilled practitioners e.g. ECPs. A number of scenarios are being considered in terms of different levels of demand etc. Subsequent work will include an assessment of the impact on other areas such as support services and training.

The Medical Director confirmed that she was confident that up to 90% of red calls may be suitable for suitably qualified solo responders. She assured Sarah Waller that work is being undertaken to align red calls and Category A calls more closely.

Reviewing the questions used by AMPDS 11.2 will ensure better triaging and result in a reduction in the number of inappropriate category A calls.

The HR Director assured the Board that existing recruitment activity for the year 2006/07 will not compromise the Trust's staffing needs being identified in the long term plan.

It was recognised that CTA will have an important contribution to make as every call dealt with by telephone clinical advice means less ambulances/staffing resources being required.

Noted:
1. **That a further update report including possible costings will be presented to the July Trust Board**
2. **That the Seven Year Plan will be presented to the Trust Board for final approval in the September 2006.**
3. **That the Seven Year Plan will be launched at the Patient Care Conference on 24th July 2006**.

30/06 2005/06 staff survey

The HR Director presented the findings of the 2005/06 staff survey. This is an annual NHS survey undertaken by the Picker Institute on behalf of the LAS. Compared to the 2004 survey, results were noticeably less positive some key areas – reflecting the problematic implementation of Agenda for Change and the attendant need to pile on pressure to meet response time targets. The responses showed no significant change in 22 out of 28 areas and were more positive in two areas.

The 2005/06 staff survey included bar codes which enabled the Picker Institute to identify members of staff who had not returned their questionnaire, thereby potentially raising questions about the anonymity of the questionnaire. Given the use of the barcode, Caroline Silver thought it more accurate to describe the survey as confidential rather than anonymous. The HR Director explained that the survey is anonysmised as the LAS does not receive information concerning individual responses; the breakdown it receives is per department. Methods of improving trust and response rates need to be considered prior to the 2006 survey. **ACTION: the HR Director.**

The survey highlighted that stress is an issue for staff. A pilot project is being undertaken with the Health & Safety Executive to fully understand the implications of this for the Trust. It was thought that the less positive response about working for the LAS (60% compared to 76% in 2005) was due, in part, to the survey coinciding with the implementation of AfC,

The HR Director drew the Committee's attention to assaults on staff, which has decreased from 371 in 2005 to 341 in 2006. This is due in part to the training delivered regarding personal safety.

Noted: The findings of the 2005/06 staff survey

31/06 Operational rest breaks

The HR Director presented an overview of the arrangements for operating rest breaks. The driving force for change is legislation (European Working Time Directive) and national terms and conditions (AfC). In addition there are financial

considerations as the Trust is currently paying 1.5 hours overtime per week per front line staff together with claims for subsistence payments to staff not receiving official meal breaks.

The Senior Management Group is considering an options paper concerning the implementation of rest breaks; the recommended option is that uninterrupted breaks are offered to staff. The Chairman pointed out that any agreement regarding where rest breaks are taken needs to be as flexible as possible i.e. that staff are not required to go back to their Ambulance Station to have a break.

The Trust will need to ensure that when rest breaks are introduced the process is simple and auditable so as to clearly record when staff receive a break. Discussions are taking place to identify the potential for technological support in EOC. However, it may be that a manual process is required rather than an IT fix, as the target implementation date is October 2006.

Sarah Waller commented that the Inland Revenue expressed interest regarding subsistence payments and there is still a possibility that these payments will become taxable. It is in the Trust's interest to ensure that the issue is resolved quickly.

There was a discussion concerning the probable reaction of Staff Side and staff regarding the introduction of rest breaks. Staff side are advocating waiting for a national agreement for rest breaks; the HR Director did not think that such an agreement is imminent. The Chief Executive had raised the issue at his consultation meetings and found staff evenly split as to whether they wanted to receive rest breaks or continue to receive overtime and subsistence payments.

Noted:
1. **The progress to date with introducing rest breaks for operational staff**
2. **That an update will be presented to the Trust Board in July 2006.**

32/06 <u>Date of future meetings:</u>

The next meeting of the Trust Board is the 25th July 2006, conference room, LAS HQ.

The next meeting of the Service Development Committee will be 31st October 2006, Conference room, LAS HQ.

The meeting concluded at 13.10pm

LONDON AMBULANCE SERVICE NHS TRUST

CHARITABLE FUNDS COMMITTEE

Tuesday 27th June 2006

Present:	Barry McDonald (Chair)	
In Attendance:	Caron Hitchen	Director of HR & Organisation Development
	Tony Crabtree	Head of Employee Services
	Michael John	Financial Controller
	Eddie Brand	Staff side representative
	Nicholas Row	Investec
	Christine McMahon	Trust Secretary (minutes)
Apologies:	Eric Roberts	Staff side representative

Circulated at the meeting: 2005/06 investment performance report from Investec

01/06 The Minutes of the last Charitable Funds Committee 4th July 2005

Agreed: The minutes of the previous charitable funds committee meeting held on 4th July 2005

02/06 Annual Accounts for 2005/06

The Committee reviewed the annual accounts for 2005/06. The Financial Controller presented the annual report which this year was drafted in the format prescribed by the Charity Commission accompanied by the annual accounts. The accounts have not yet been audited; this is expected to take place in July 2006. The Chairman approved of the new format as it made the report easier to read.

In 2005/06 the Charitable Funds received £5,000 donations (£3,000 of which was ring-fenced funding from Transco in favour of the Cycle Response Unit). The Fund received £12,000 investment income which has been a standard figure for the last few years. With a total income of £17,000 and expenditure of £45,000 the Fund had a deficit of £28,000 in 2005/06.

The Fund's stock market investments performed well – at the start of the financial year the investments were valued at £394,357 and in March 2006 they were valued at £410,899.

During subsequent discussions regarding the funding received from Transco it was suggested that the accounts be amended to show the funding as a restricted fund. **ACTION: Financial Controller**

It was suggested that staff be reminded that if donations are received locally they should be forwarded to the Charitable Funds rather than the Benevolent Fund. There is some confusion about the purpose of the two bodies. The Benevolent Fund is a separate 'members only' body which is subscribed to by staff (Payroll collect subscriptions from staff salaries). The Charitable Funds is for all staff. The Financial Controller undertook to re-issue guidance to ensure that donations are correctly given to the Charitable Funds. **ACTION: Financial Controller**

Management Accounts: The Committee reviewed the internal management accounts for 2005/06. The Financial Controller outlined the actual income and expenditure against the budgeted income and expenditure. Investment income was slightly higher than budgeted for; expenditure (£45,581) was £3,239 lower than budgeted for. This

was due to a miscalculation of staffing numbers as the Financial Controller had used the staffing figures for March 2005 rather than November 2005 which meant there was less spent at from the Christmas amenity budget than expected. In addition there were a number of staff who retired and did not wish to have a retirement party.

Noted: 1. The report
2. That there had been no changes to the accounting policies

03/06 Draft Budget for 2006/07

The Committee considered the proposed budget for 2006/07. The Financial Controller forecast the same level of income, £17,000, with expenditure budgeted at £45,000, resulting in a budgeted deficit of £36,000. The deficit is in line with previous years' projected deficit figures and the policy of permitting a gradual running down of the Fund over the next decade or so.

It was proposed that the rate of contribution per person for Christmas amenities be increased from £7.50 to £8.00; it has been a number of years since the amount was last reviewed.

Agreed: 1. The budget for 2006/07
2. That the money paid per head from the amenities fund be increased from £7.50 to £8.00.

04/06 Annual Investment Report.

Nicholas Rowe, Investec, circulated his annual report to the Committee. The report outlined the performance of shares and bonds generally in the stock market for the last three years, which has generally been quite good for shares, and reported on the performance of the funds invested by the Charitable Trust.

He explained that the investment approach adopted by the Fund Manager is a 'contrarian' one; which means that he will be looking for investments that buck the current investment trend and seek to invest in companies that are currently undervalued. It is essentially a long term investment strategy. The return for 2005/06 has been 20% which is acceptable. To allow comparison, information was included concerning the performance of All Share FTSE, this showed an average return of 28%. The current under-performance reflects the long term approach being adopted.

The current mix of shares/bonds is 75:25 and he advised that this continue with the provision that if he felt it necessary he would adjust the mix in line with the discretionary agreement that is in place.

Noted: The annual report from Investec regarding the performance of the investment portfolio.

05/06 Report from the sub-group

The Committee reviewed the disbursements agreed by the Fund's sub-group; it was clear that funds are being disbursed pan London and range across goods such as fish tanks, televisions and cricket equipment.

It was reported that prior to the sub-group's quarterly meeting a reminder is placed in the Routine Information Bulletin (RIB) inviting applications for funding. The sub-group rarely agree 100% funding as staff are expected to make a contribution of approximately 25% to the cost of an item. Occasionally requests that have health and safety issues are rejected e.g. gas barbeque.

Noted: The report

The meeting concluded at 2.25pm

Enclosure 15a

London Ambulance Service NHS TRUST

Trust Board – 25th July 2006

SUMMARY OF THE MINUTES
CLINICAL GOVERNANCE COMMITTEE - 15th MAY 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. ❑ **Noted:**

- That the Trust's statement of compliance with the Standards for Better Health was submitted to the Healthcare Commission.
- That an action plan has been put in place to ensure the Trust attains NHSLA level 3 in January 2007.
- The Draft Annual Clinical Governance report and the Clinical Governance out-turn report
- The governance arrangements which have been introduced for the Urgent Operations Centre as outlined by the ADO UOC.
- That the Clinical Governance Strategy is no longer considered relevant given the introduction of Standards for Better Health and the Trust's Seven Year Plan.
- The findings of the Annual Clinical Audit of PRF documentation; only 1% of PRF documentation has been checked.
- The findings of the ASA review of BME recruitment and retention and its recommendations for improving the number of BME staff recruited by the Trust.
- The risks on the Risk Register that are the responsibility of the Clinical Governance Committee; that a progress report on the action plan for mitigating those risks identified as high.
- The measures put in place to train front line staff about the changes to the RESUS Guidelines which were implemented across the London NHS Trusts in April 2006.
- That a trust wide risk assessment will be undertaken in June and July 2006 with the findings presented to the Trust Board in September 2006.
- The training and development plan which included information on the audit trail in place to record attendance at training.
- That a working group has been formed to consider how the Trust could have a central point for policies and procedures.

❑ **Standing items**: reports from the PPI and PALS managers on work being undertaken in their respective areas.

❑ **Presentation** by the Chairman of the findings of the recently undertaken Governance Review.

❑ **Minutes Received:** Training Services Committee – 28th April 06
Clinical Risk Group – 21st March 06

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

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Governance Committee
15th May 2006, Committee Room, LAS HQ

Present:	
Beryl Magrath (Chair)	Non-Executive Director
Fionna Moore	Medical Director
David Jervis	Director of Communications
Kathy Jones	Director of Service Development
John Wilkins	Head of Governance
Tony Crabtree	Head of Employee Services
Julian Redhead	Consultant in Emergency Medicine, St Mary's, Paddington
Stephen Moore	Head of Records Management
Paul Carswell	Diversity Manager
Ian Todd	ADO – Urgent Care
Malcolm Alexander	Patients' Forum Chairman
In attendance	
Christine McMahon	Trust Secretary (minutes)
Margaret Vander	PPI Manager
Gary Bassett	PALS Manager
Laverne Harris	Governance Manager
Angela Bennett	Clinical Governance Co-Coordinator
Pat Billups	Clinical Standards Manager (deputising for BON)
Apologies	
Barry McDonald	Non-Executive Director
Sarah Waller	Non-Executive Director
Martin Flaherty	Director of Operations
Bill O Neill	Head of Education & Development

19 Minutes of the meeting held on Monday 16th January 2006

Agreed: The minutes of the Clinical Governance Committee meeting held on 16th January 2006

20 Matters Arising

Minute 2 (41) – A meeting has been arranged between the Chairman of the Clinical Governance Committee, the Medical Director and the Senior Clinical Adviser to the Medical Director to discuss how the work on Advance Directives can be progressed.

Minute 5 – the Head of Governance informed the Committee that the Trust provided evidence of compliance with five of the Healthcare Standards to the Healthcare Commission Inspectors when they visited the Trust in February 2006. The Trust has submitted its Final Declaration declaring full compliance with all twenty four core Healthcare Standards. 13 developmental standards are included in the annual health check for 2006-7 in addition to the core standards. It will be necessary to include this workstream in the new Service Plan.

NHSLA Level 3 – an action plan has been agreed to ensure that the Trust attains Level 3 when it is reassessed in January 2007. The action plan includes requirements to be met for complaints handling and trust wide risk assessment.

It was noted that the Risk Management Framework and Risk Register will be presented to the Trust Board in July 2006.

Minute 13 – a report regarding an audit trail for attendance at training was presented as part of the Education and Development Report (minute 31).

21 Governance Review

The Chairman of the Committee presented a summary of the findings of the Governance Review she had recently undertaken at the request of the Trust Board Chairman. The Review will be presented to the Trust Board on 23rd May for approval. She was confident that the proposed revision of the Trust's governance systems and processes will ensure there is less duplication of information reported, and there is a streamlining of reporting and information channels up to the Board and back down from it. The Review recommends that SMG takes on a central role in delivering good governance within the Trust. The Risk Compliance and Assurance Group, amalgamating the Risk Management Group and the Risk Management Committee, will become the key group for risk management in the trust. Another key recommendation of the Review will be the change of role and function for the Governance Development Unit which will become the LAS Compliance Unit and will be responsible for holding the Compliance and Risk Registers.

Subject to approval by the Trust Board; further work will then be required to implement the recommendations from the Review. Actions derived from the main recommendations of the Review are included as an appendix to the report.

The Chairman commented that change is often painful but she was confident that the proposed changes will make for a more efficient and effective system that will deliver good governance. Good governance enables NHS organisations to deliver better patient care.

Noted: The report.

22 Draft Annual Clinical Governance report

The Committee considered the initial draft of the Annual Clinical Governance report; examples of clinical governance undertaken during the year are to be included e.g. PPI work undertaken in 2006/07, the attendance by staff at CPD course, the introduction of ethnic monitoring etc. The Medical Director asked that her regular reports to the Trust Board be used as a primary source for examples of improvements in clinical governance introduced during the year.

The Medical Director commented on the high level of duplication between the draft annual clinical governance report and the clinical governance outturn report. The Head of Governance responded that there was inevitably some duplication as the out turn report was required to reflect the implementation of the Clinical Governance Development Plan and the Clinical Governance Annual Report was required to report the principal achievement of clinical governance during the period covered by the out turn report. Both documents were required by the Strategic Health Authority and to meet the criteria for NHS trusts set out in Health Service Circular HSC/065/1999.

The Head of Records Management reported that he is liaising with IM&T colleagues regarding the development of a network fileplan that could better serve the needs of the Trust with electronic documents being stored in networked drives and available to all with the necessary access permissions. It could, for example, be used to provide evidence as/when required by different external assessors. There is no definite timeframe as yet but it is likely that the work will be rolled out gradually, initially within the Finance Directorate and the IM&T department and then the rest of the Trust. It was recognised that a mapping exercise will need to be undertaken and this has been included in the Records Management Strategy.

Noted: The report

23 Clinical Governance out-turn report

The Committee considered the quarterly out turn report – May 2006. The Clinical Governance Co-ordinator explained that the quarterly reports feed into the annual report and the annual out-turn report. The Medical Director suggested that in future the progress reports be amalgamated, with the Clinical Governance report being referenced to the out-turn report. This would satisfy

the requirements of the external agencies but the information would be in one place and duplication avoided.

Noted: The report

24 Update on governance arrangements/progress with the Urgent Care Operations Room

The ADO Urgent Care outlined the governance arrangements that have been in put in place for the Urgent Operations Room. ECPs, PTS, EBS, CTA and the Urgent Operations desk were re-located so as to be sited in one room; once staff have settled down work will begin on further integrating the different elements.

Dr Daryl Mohammed has been appointed Assistant Medical Director for Primary Care and provides medical advice to the ECPs and to other staff with regard to any primary care issues that arise. One example of good practice that has been introduced is a peer review process; ECP Clinical Leads plan to undertake two ride outs a year with another ECP assessing his/her practice.

It was reported that a number of papers on the methodology and evaluation of the ECP role are being written for submission to peer review journals e.g. the Emergency Medicine Journal (EMJ).

Clinical Telephone Advice (CTA): the change in support software has resulted in a significant change in productivity with 300% increase in call handling with savings realised in ambulances not being despatched to calls. Work is being undertaken with regard to quality assurance of CTA which, with minor modifications, has been adopted by the pan UK Users' Group and is being implemented nationally. It was recognised that with the increased volume of calls the 1:1 feedback is proving to be a challenge for the 2 quality assurance staff. Another challenges is ensuring that CTA staff maintain their clinical experience, however some of the CTA staff are off the road for medical reasons, and this is being kept under review.

Emergency Medical Technicians 1 (EMT1): problem with recruitment and retention as EMT 1 very close in skills set to EMT2 and EMT3. A trial is taking place with the Bromley PTS contract. PTS staff will be given additional training so that in their downtime they can be despatched to respond to low priority planned Category C calls which in turn will ensure better utilisation of those staff.

The funded establishment for EMT1s is 74; there are currently 33 in post. On joining the Service as EMT1s there is a clear expectation that they will be EMT1s for a minimum of 18 months. Due to the EMT1 role being very close to that of EMT2 it has been difficult to recruit and retain staff as EMT1s. This is being actively reviewed and steps have been taken to manage the situation e.g. the use of PTS staff who have received additional training.

The ADO UC undertook to provide the minutes of the only constituted governance group for UOC to the Clinical Governance Committee. **ACTION: ADO UOC**

The Head of Governance asked if the audits and peer reviews undertaken were available as evidence of good governance practices. It would be useful to use as evidence the results from the audits and improvements put in place. He was assured that they were.

The Medical Director commented that overall the report was exceptionally positive given that the room had only been opened 7 months ago. She reported that the trial period for the general telephone advice for ECPs and CTA staff from Consultants at Guys is coming to an end and a meeting has been arranged to discuss the possibility of a joint bid for funding to ensure staff available to give advice re. drug overdoses. Although there has been good feedback from staff regarding the facility it may be difficult to justify funding as there has only been 1-2 calls a day.

It was recognised that with regard to auditing, the 2% undertaken for CTA is acceptable given that an audit of 1% is undertaken for AMPDS. It was felt there might be an issue in terms of the EOC's quality assurance team having sufficient capacity to support the UOC. **ACTION: ADO UOC to liaise with Senior Operations Officer for Planning & Risk.**

In reply to the Patients' Forum representative query about the Emergency Bed Service the ADO Urgent Care stated that at the moment that unit is being allowed to settle in to their new accommodation before any further work is done regarding integration. With further integration in the Urgent Operations Room there will more joint processes.

The ADO Urgent Care further stated that the management team for EOC and Urgent Care is being reviewed with the view that a number of staff will progress to new roles across function across the two rooms.

Noted: The report

25 Clinical Governance Strategy

The Medical Director reported that previously members of the Directorate team had undertaken an annual review of progress made against a number of the Trust's strategic goals. These goals were set out in a table contained in the LAS Clinical Governance Strategy. The review was undertaken on a subjective basis i.e. evidence free zone. Both the Medical Director and the Director of Service Development were in agreement that the goals currently included in the Trust's Clinical Governance Strategy had been superseded by the Standards for Better Health. In addition a number of the same strategic goals had been included in the Trust's Seven Year Plan (2006-2013).

Agreed **That the Clinical Governance Strategy is no longer considered to be relevant given the introduction of Standards for Better Health and the Trust's Seven Year plan.**

Post meeting note: the Clinical Governance Strategy will need to be revised so that it reflects the strategic direction for clinical governance identified within the Seven year Plan and will need to be officially withdrawn for the reasons given above.

26 Annual clinical audit of PRF documentation

The Medical Director presented the findings of the annual clinical audit of Patient Report Form documentation produced by the Clinical Audit and Research Department. Team Leaders are expected to review 1:20 PRFs to assess the standard of documentation; the findings of the audit are that though there are very good examples of completion there is considerable variability in the standard. The Clinical Audit Co-ordinator will share the findings of the audit with AOMs in May and specific findings will be taken forward.

It was recognised that the actual number of CPI checks undertaken (1%) represents a very small number of PRF documentation and steps have been taken to improve the degree of CPI checks undertaken e.g. making the process web based. The CPI checks are a very important element in the Trust's clinical governance.

The Patients' Forum representative asked about electronic devices being used to capture the PRF data. Though hand held data recorders have not been included in the scope of the Electronic Patients Record (EPR) Project the IM&T department have it as part of their long term projects. A further advantage of linking into the EPR project will be the availability of outcome data which at the moment is lacking for the majority of LAS patients.

The Head of PALS commented that the PALS team had not noticed deterioration in the quality of the PRF documentation produced in recent months when there had been significant

operational pressures. The Diversity Manager commented that the ethnic box on the PRF form has not been filled in for 94.5% of the PRF documentation audited.

Noted: The report and the efforts being made to improve the rate of CPI checks.

27 ASA Review of BME recruitment and selection

The Diversity Manager presented the findings of the ASA review of BME recruitment and selection by the LAS. The report's conclusions were in agreement with the findings of previous research into BME communities' attitude towards the LAS. The findings of the review will be considered by the Race Equality Strategic Group in May 2006.

The Diversity Manager commented that at the moment that Group does not report anywhere; the Chairman undertook to include it in the proposed governance structure. **ACTION: The Chairman**

The Director of Service Development confirmed that the recommendations contained within the report regarding recruitment have been incorporated into the Seven Year Plan.

In response to a query from the Chairman it was confirmed that although the BME Media is currently used to advertise vacancies there is no evidence that has a significant impact on recruitment; mainstream media is used by all communities when seeking work. One of the recommendations for actively recruiting BME staff is that events be held at BME community centres or religious centres. The Director of Communications pointed out that recruitment activity can be included in PPI work being undertaken.

Noted: The report

28 Risks on the risk register that are the responsibility of the CGC

The Governance Manager presented the report, outlining progress that has been made in managing risks on the Risk Register which are the responsibility of the Clinical Governance Committee. The Chairman commended the format of the report. It was confirmed that action plans are in place to manage those risks identified as high (red). It was suggested that It would be useful for future Clinical Governance Committees to receive a report on the progress of the action plans on an exceptions basis. **ACTION: Governance Manager**

With the amalgamation of the Clinical Risk Group and the Clinical Governance Committee it was felt that it is essential to preserve the Risk Information Report which combined significant information on clinical incidents, claims, risks and complaints. This report enables the Trust to meet core criteria of the NHSLA assessment currently underway.

The Medical Director reported that the recent Clinical Risk Group had reviewed clinical risks on the Risk Register. Where there had been changes to the level of risk regradings these had been presented to the Risk Management Group for approval e.g. Risk 8 was regraded from 1 to 15 to reflect the poor completion of PRFs.

Noted: The report.

29 RESUS Guidelines

The Medical Director reported that the Resuscitation Guidelines adopted by the Trust Board in March 2006 have had significant implications for the Trust in terms of delivering training and recalibrating equipment. All London NHS Trusts had implemented the revised Resuscitation Guidelines in April 2006.

Initially a paper based system of updates was issued to front line crews e.g. rate of compression and sequence of shocks to be administered to a patient suffering a heart attack. A series of 3

hour training sessions are being rolled out to team leaders and station trainers with regard to the changes in the Resuscitation Guidelines; to date 50% of operational staff have received training.

Julian Redhead commented that there was good co-ordination between the London A&E departments in implementing the new guidelines. As yet there were no figures demonstrating improvements in the survival rate. The Medical Director reported that the evidence of improved survival rates as presented at the Stavanger conference she recently attended, was very impressive

Noted: The report

30 Trust Wide Risk Assessment

The Head of Governance outlined the work that is being undertaken in preparation for the Trust Wide Risk Assessment. He is liaising with the Assistant Directors of Operations to hold half day workshops in each service area where members of staff will be asked to define and submit new risks for addition to the Risk Register as part of the annual Trust wide risk assessment. The work should be completed by the end of July and available in October as one of the submissions to the NHSLA, subject to Board approval in September. The attendees will be given information regarding the current Risk Register so as to avoid duplication and a briefing pack will be prepared on how to use the Risk Matrix etc.

Noted: The report

31 Training and Development Plan

Pat Billups presented the training and development plan on behalf of the Head of Education and Development.

The report included the audit trail for attendance at training; the procedure showed the process whereby attendance is logged, non-attendance is followed up by the Training Department with the Resource Centre and AOMs.

The Chairman commented that although the report described the process of training she was still left wondering about the outcomes of the training – what quantifiable evidence is there for the training's impact on crews' clinical practice and behaviour.

The Committee also considered the training and development courses being planned for existing staff in 2006/07; the CPD courses, the Paramedic Recertification courses. It was highlighted that this year the Trust received 400 applicants for the 100 paramedic training course places. A procedure for deciding which of the 100/400 staff will be successful has been circulated to staff and management; the procedure has a number of elements i.e. assessment, seniority of staff, sickness and attendance record as well geographical location of the member of staff. Those members of staff who are unsuccessful at the assessment stage will be followed up by team leaders and any shortfalls addressed.

Noted: The report

32 Policy and procedures update

The Head of Records Management reported on the progress achieved since the Committee's meeting in January 2006. Following liaison with colleagues eight of the previously reported policies and procedures were considered to be no longer required with three being issued. The Chairman commented that those that were not of a clinical nature needed to be considered by another more appropriate committee e.g. SMG. **ACTION: Head of Records Management**

The Head of Employee Services queried the decision that some of the policies and procedures under development were considered to be no longer required; this would be followed up in the subsequent report to SMG.

The Head of Governance pointed out that there was an issue of timeliness to be considered with regard to some of the reported policies and procedures. He suggested that there needed to be a central place for authorising strategies required by the Trust. Following a report presented by the Head of Records Management to the Information Governance Panel on 22nd March 2006 a small working group with representatives from stakeholder departments has been formed. It will consider how the recommendations in the report could be implemented. It should be possible to have documents in one place on the intranet and also on a database whereby the process can be appropriately managed. The Director of Communications suggested that the deliberations of the working group should be presented to the SMG in due course when approval is required. He suggested that the working group's terms of reference be presented to this Committee when it next met. **ACTION Head of Records Management**

Noted: The report

33 PPI update

The PPI Manager outlined the work she has been doing in terms of patient, public involvement; she attended Southall and SE London Cardiac network at Queen Elizabeth in Woolwich. At both these events she met people who were keen to tell her about their experiences of using the Ambulance Service.

The Patients' Forum recently had a couple of good meetings; the PPI Manager and the Director of Finance reported on the Trust's response to the GLA scrutiny in 2004. Councillor Dr Horatio Cheng, a panel member of the GLA's Scrutiny Panel , who was at the meeting stated how impressed he was with the progress in particular around the areas of diversity and improving social care, PTS and career development for staff.

Work has been undertaken with the Royal National Institute for the Deaf on how access to the Service can be improved for deaf people. The work has been included in the Trust's Seven Year Plan but there is no quick fix in terms of technological access. In the meantime 2 pilot schemes are being run trialling the use of visual translation cards. If these prove unsuccessful then work will be undertaken with the RNID on developing own version of the visual translation cards.

A workshop was recently held for staff who are engaged in educating the public; it was clear there were a number of approaches being adopted, with some presentations being very structured while others were less so. A review has been undertaken following that workshop emphasising the commonality between the different groups which will in turn lead to a standardised responding process – increasing the profile of the LAS amongst other NHS Trusts and other organisations.

An internal audit recently undertaken of the PALS service was very positive; the two minor recommendations which have been implemented.

In response to the Diversity Manager's comments that PPI should be seen by operational managers as part of their day job rather than something that is done in their 'spare time' the Director of Communications pointed out that Operational Managers objectives include specific measurable PPI work. Although there is commitment and willingness there is also the competing pressures of meeting performance targets. The continuing challenge will be getting the balance right so that PPI work becomes part of the mainstream activities.

It was also commented that it was difficult to understand why the LAS is unable to provide technological access for deaf people given that other Ambulance Services and the Police are able to provide the facility. The Director of Service Development pointed out that the work has been identified as part of the CTAK project.

The PALS manager reported that a number of people who have made complaints have been invited to the attend the Patient Care conference so that hopefully there will be a balance of views voiced at the conference

Noted: The report.

34 PALS update

The PALS manager presented his report which was in 3 sections: the quarterly report for January –March 06; the Network Rail incident and the Freedom of Information inaugural annual report – 2005/06.

The Chairman queried whether it would be possible to know the length of time taken per PALS inquiry; this is not possible at the moment but she was informed that all but one of the Freedom of Information enquires were dealt with within the required timeline.

There was a brief discussion concerning DATIX; the PALS team have experienced some technological difficulties recently with the upgrading of DATIX resulting in the system being out of commission for half a day.

Noted: The report

35 Reports from Groups/Committees

1 *Training Services Committee – 28th April 2006*

The Medical Director reported that the Training Services Committee met in April and considered the training plan for 2006/07 and the ongoing delivery of training.

Noted: The report

2 *Clinical Risk Group – 21st March 2006*

The Medical Director reported that this had been a very useful meeting; that the risk information report which is a joint commentary co-ordinated by the Head of Legal Affairs provides evidence of risk management. She expressed the hope that this report will continue to be produced.

The Group reviewed the clinical risk register. The Medical Director commented that there had not been a representative from PSU in attendance at the last two meetings of the CRG.

The Head of Governance assured the Medical Director that the review of terms and reference membership and core functions recommended in the Governance Review would afford an opportunity to ensure key members, reports and functions are clearly defined.

Noted: The report.

Noted: That of the other reporting groups, the Clinical Audit and Research Steering Group has not met since 9th December 2005; the Clinical Steering Committee has not met since 9th January 2006 and the Complaints Panel has not met since 7th December 2005.

36 Any Other Business

Complaints Panel: in response to a question from the Patients' Forum representative it was stated that there no date has yet been set for a meeting of the Complaints Panel. A review has been undertaken of the Professional Standards Unit, the findings of which will be presented to the May Trust Board.

Briefing paper re. Child protection and vulnerable adult statement on LAS Patient Report Form. The Committee considered the proposal that the current PRF form be amended (by the addition of a sticky label) highlighting for staff whether they had considered issues around

abuse of children for vulnerable adults. The Committee considered the proposal to be a sensible one and agreed that a pilot to assess the practicality be undertaken by ECPs over a 3 month period.

Noted: The report

37 Dates of next meeting:

Monday, 2nd October 2006 at 9.30 in the Conference Room, HQ.

Meeting concluded at 12.25

London Ambulance Service
NHS Trust

Information Pack for Trust Board

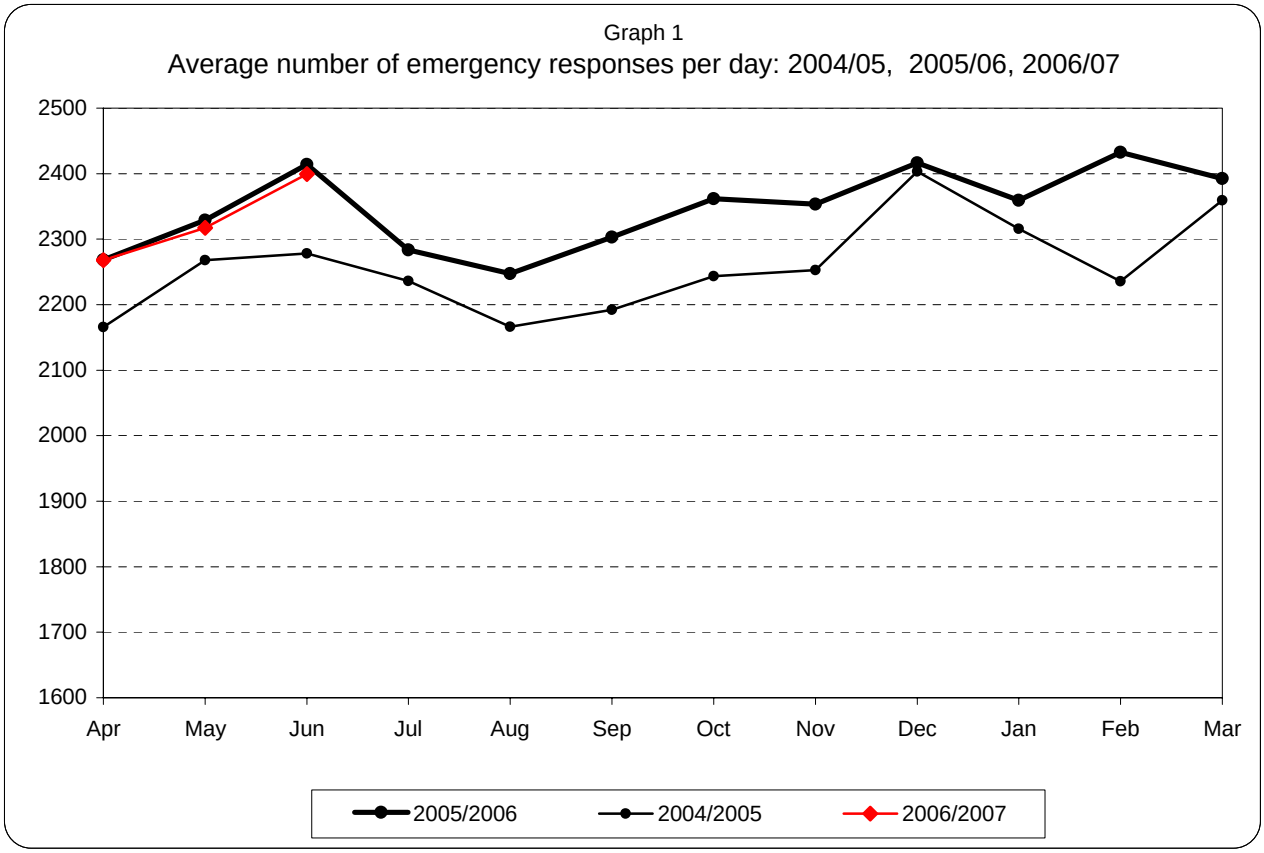
June 2006

Please note:

PRF data entry is up to the 25th June 06

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

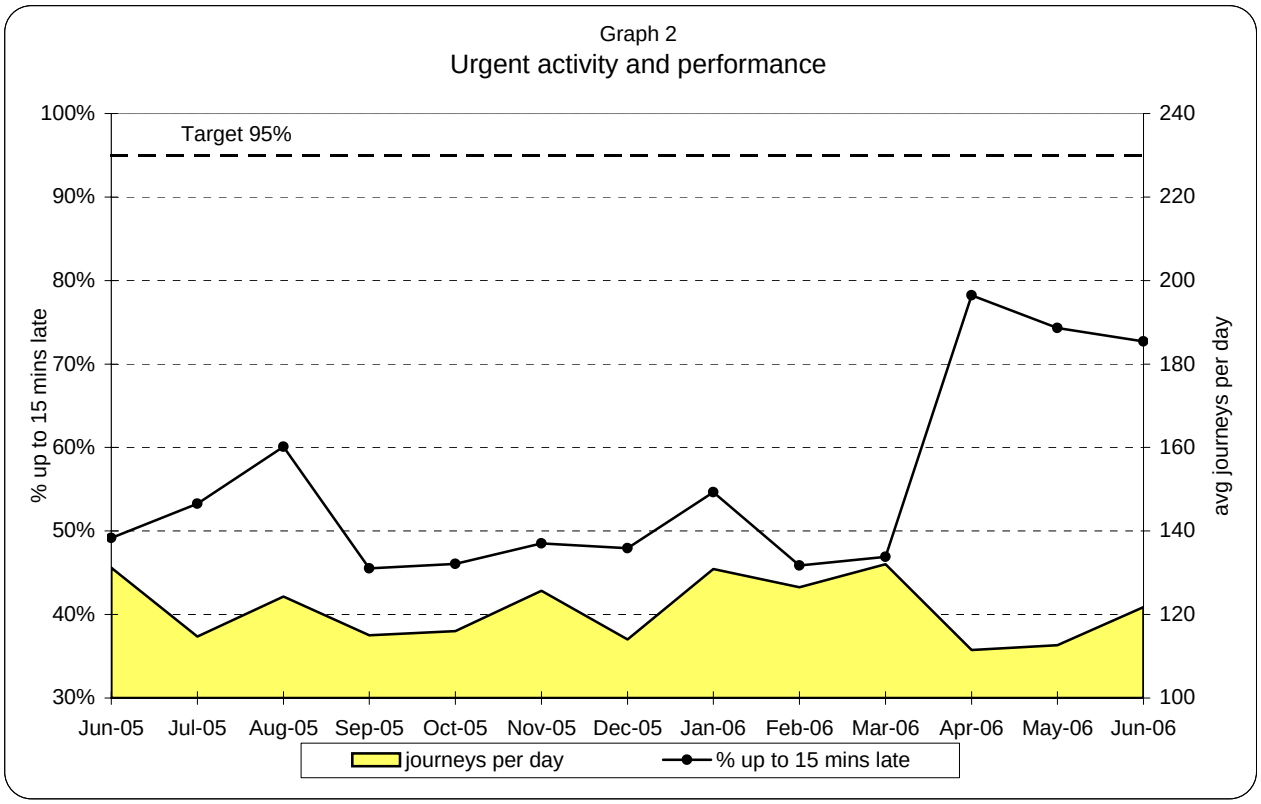
Graph 1



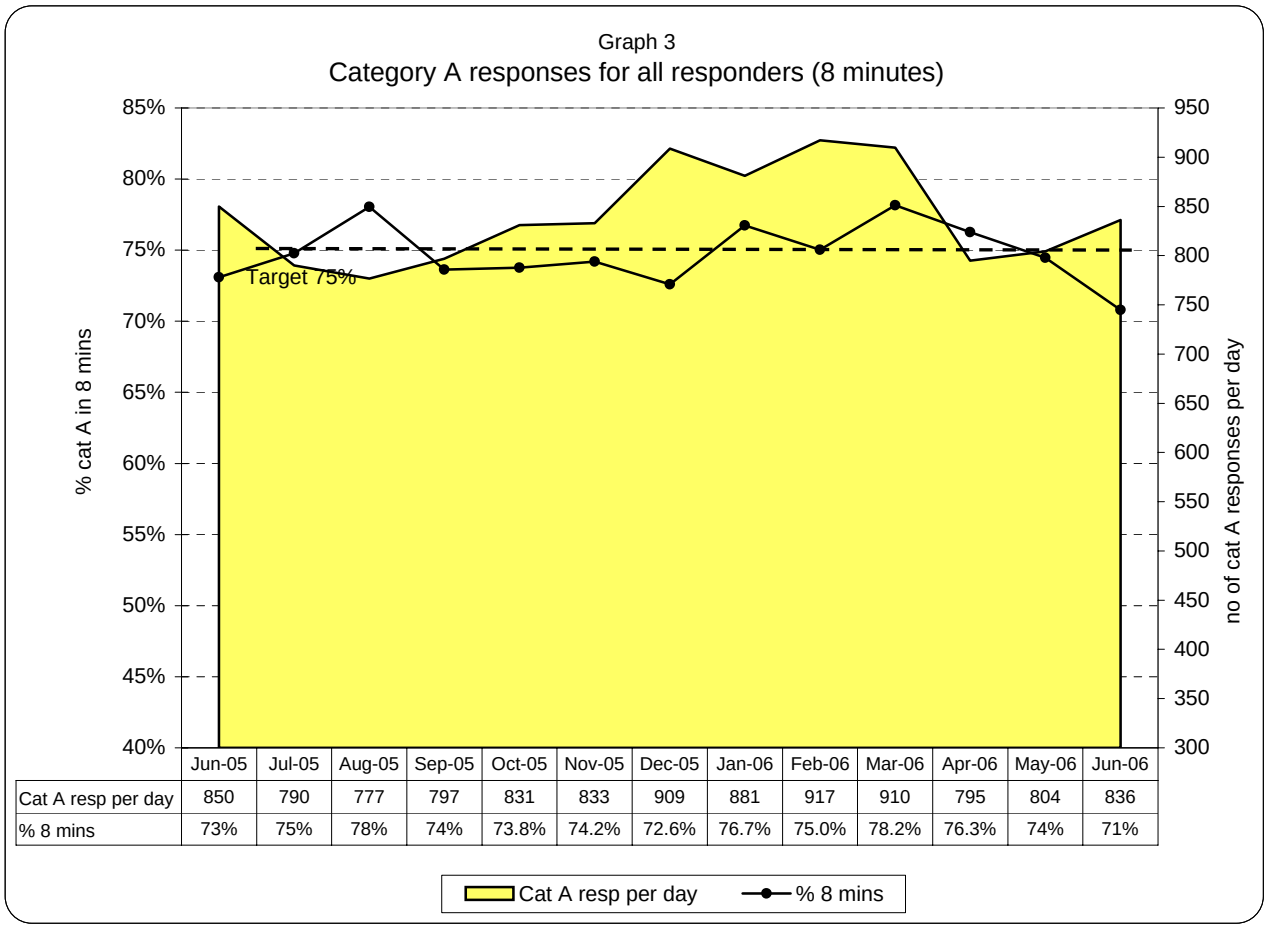
Emergency responses: monthly and year to date comparison

June 06 v June 05	Apr 06-Jun 06 v Apr 05-Jun 05
-0.6%	-0.4%

Graph 2



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



	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06
Cat A resp per day	850	790	777	797	831	833	909	881	917	910	795	804	836
% 8 mins	73%	75%	78%	74%	73.8%	74.2%	72.6%	76.7%	75.0%	78.2%	76.3%	74%	71%

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-06	78%	80%	73%	76%	76%	**76%**
May-06	76%	77%	71%	74%	75%	**74%**
Jun-06	71%	74%	68%	71%	71%	**71%**
Jul-06						
Aug-06						
Sep-06						
Oct-06						
Nov-06						
Dec-06						
Jan-07						
Feb-07						
Mar-07						
YTD	**75%**	**77%**	**71%**	**74%**	**74%**	**74%**

London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency responses: 19 minute response activity and performance (cat A)

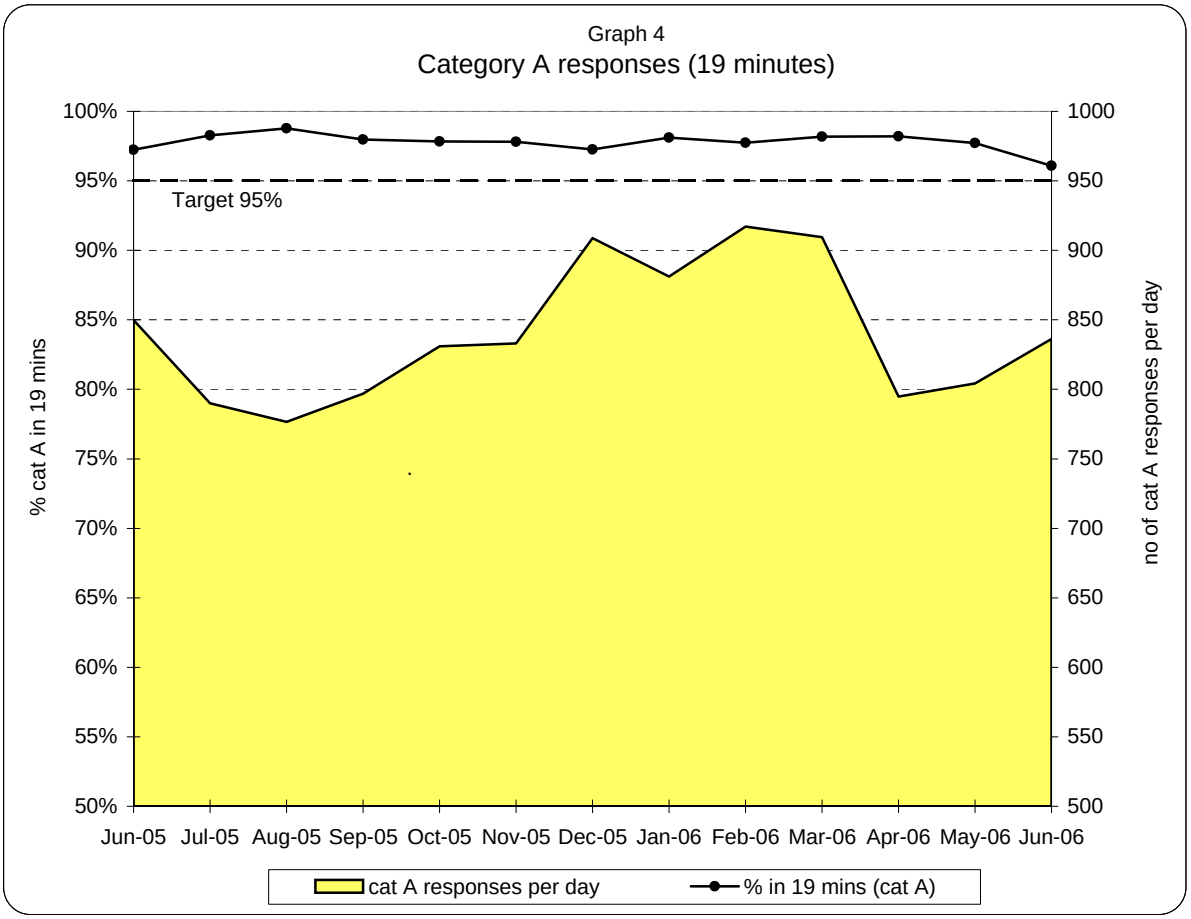
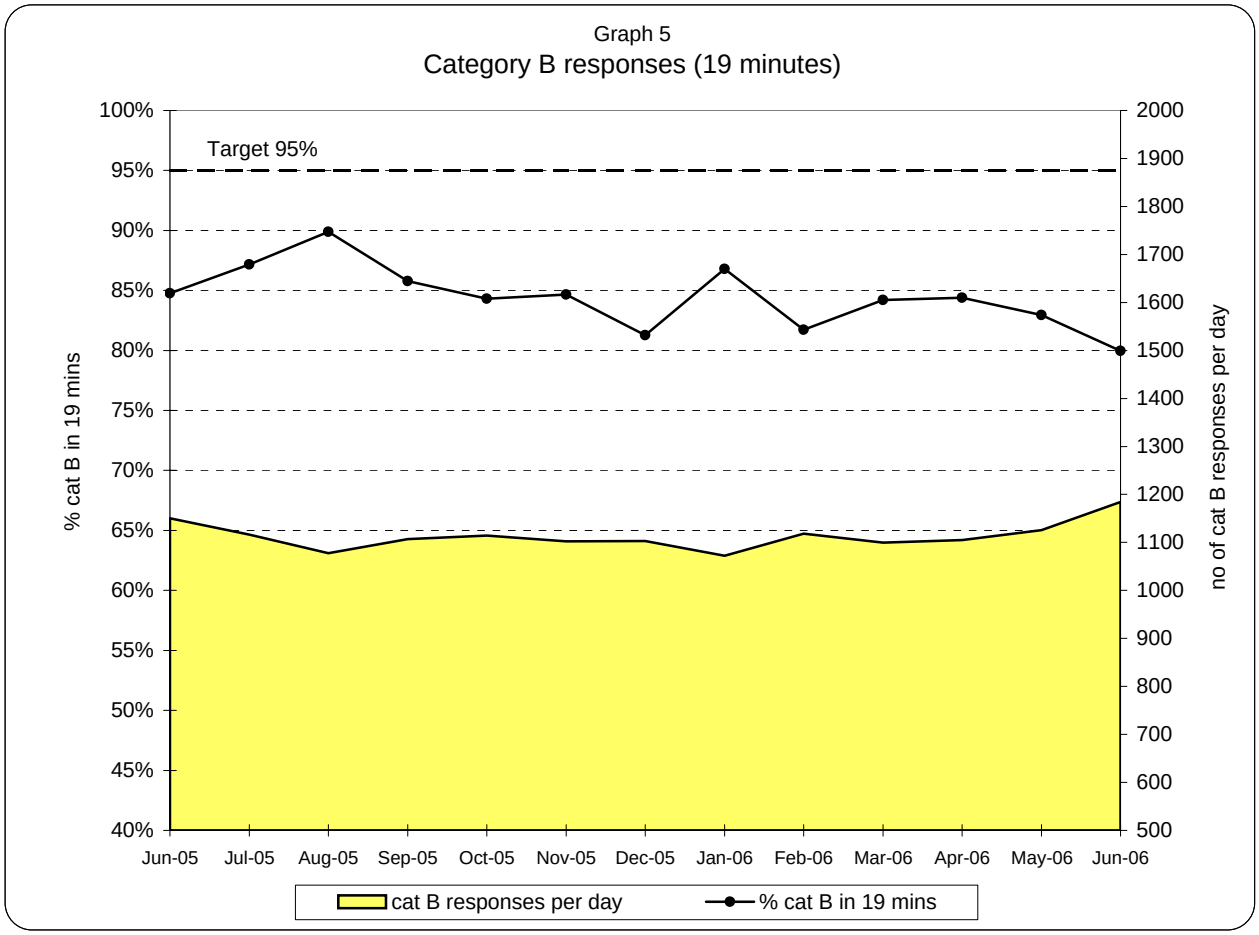


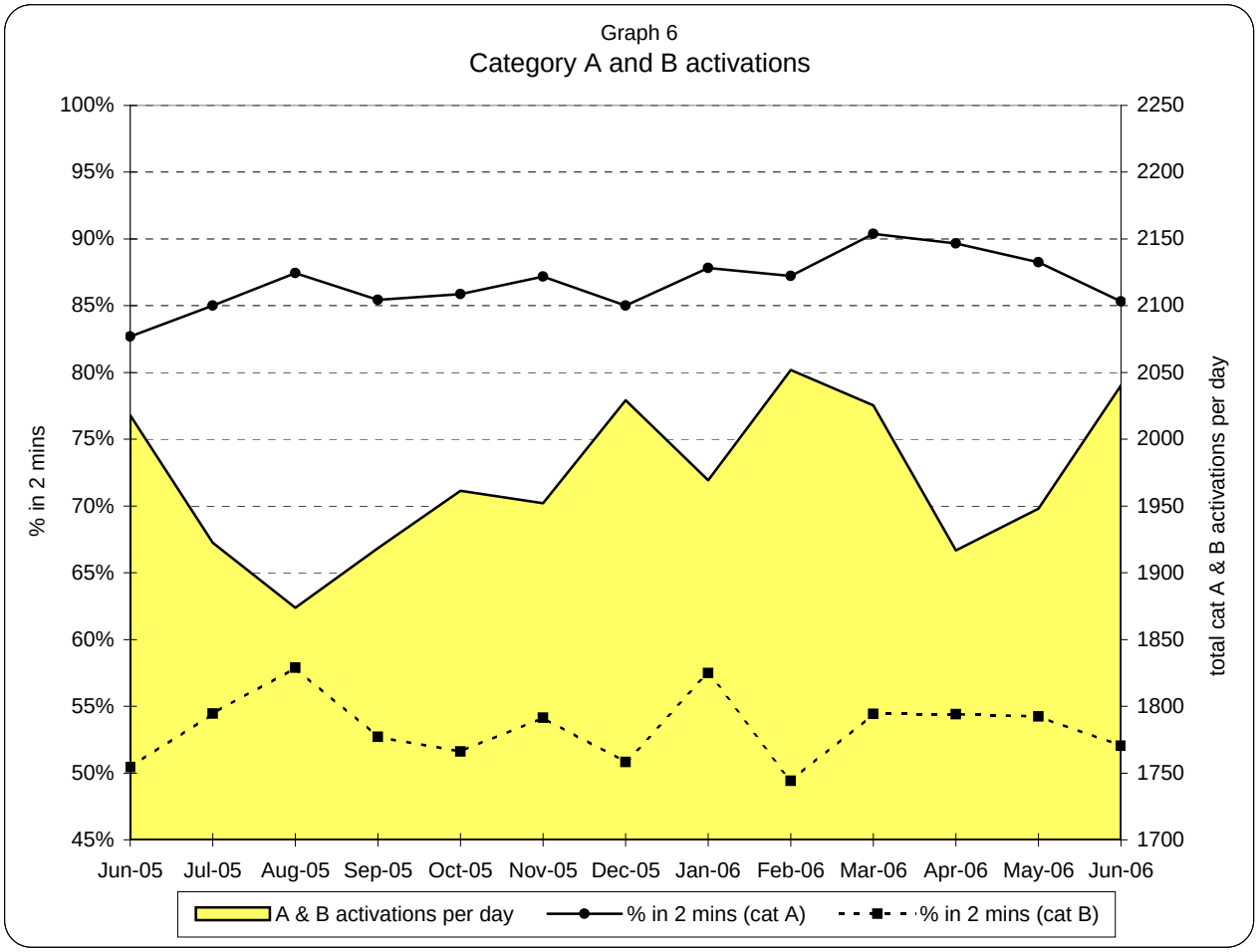
Table 2
19 minute response by Strategic Health Authority (category A)

	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-06	99%	99%	97%	98%	99%	98%
May-06	98%	98%	97%	98%	99%	98%
Jun-06	97%	97%	95%	96%	96%	96%
Jul-06						
Aug-06						
Sep-06						
Oct-06						
Nov-06						
Dec-06						
Jan-07						
Feb-07						
Mar-07						
YTD	**98%**	**98%**	**96%**	**97%**	**98%**	**97%**

London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency responses: 19 minute response activity and performance (cat B)

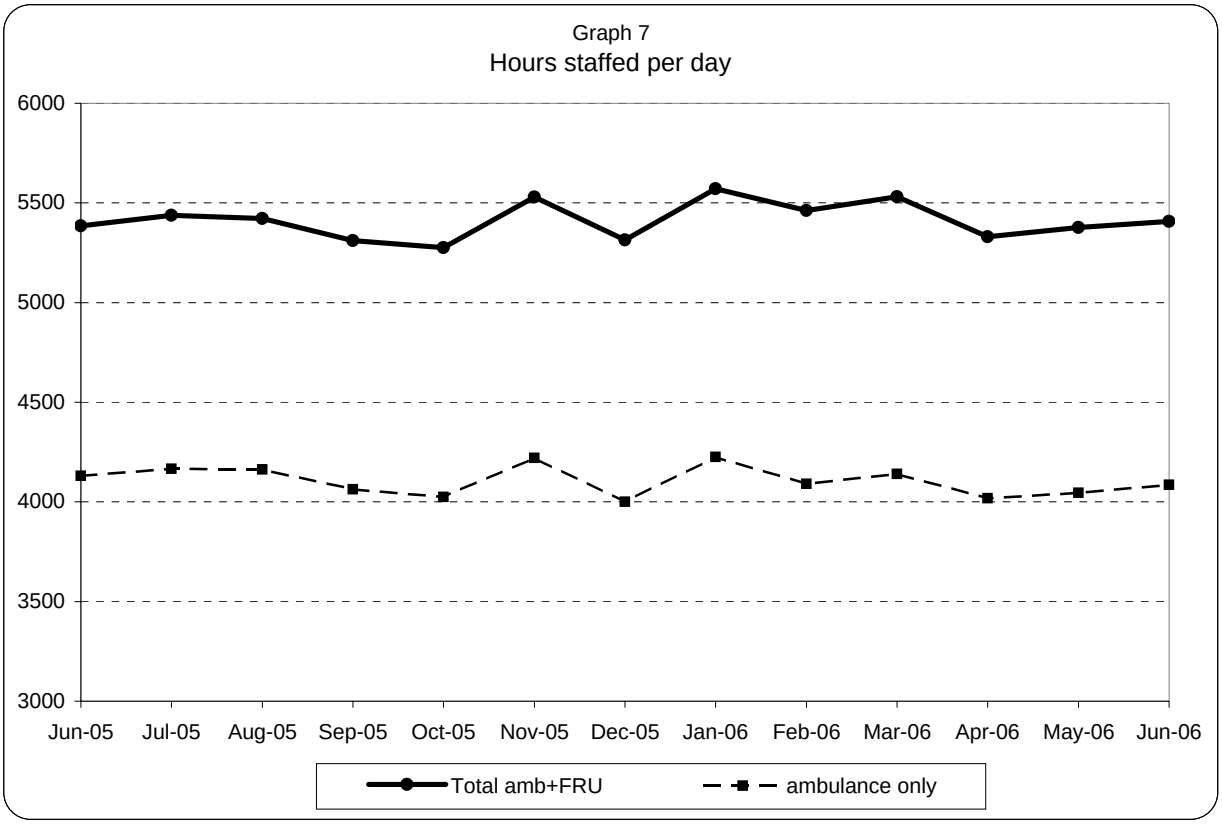


London Ambulance Service NHS Trust
Accident and Emergency Service
Emergency activations: activity and performance

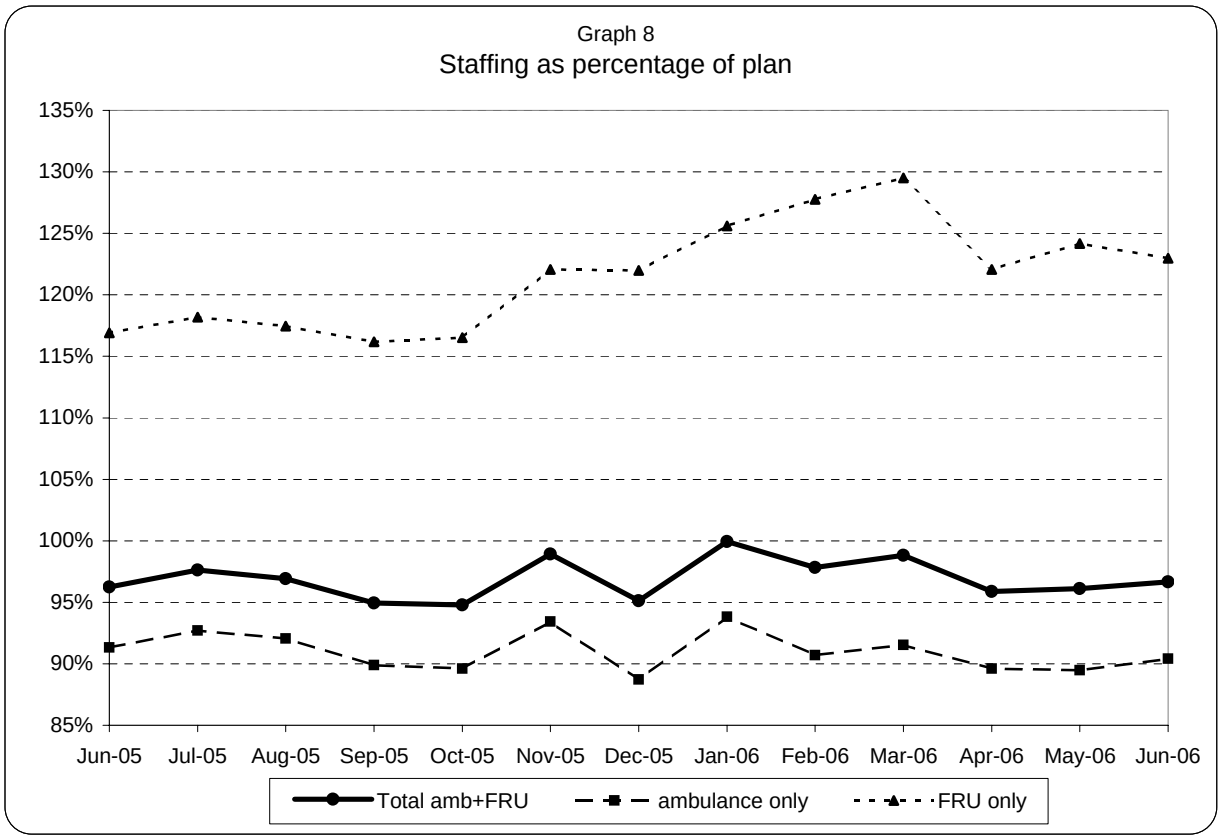


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance and FRU staffing

Graph 7

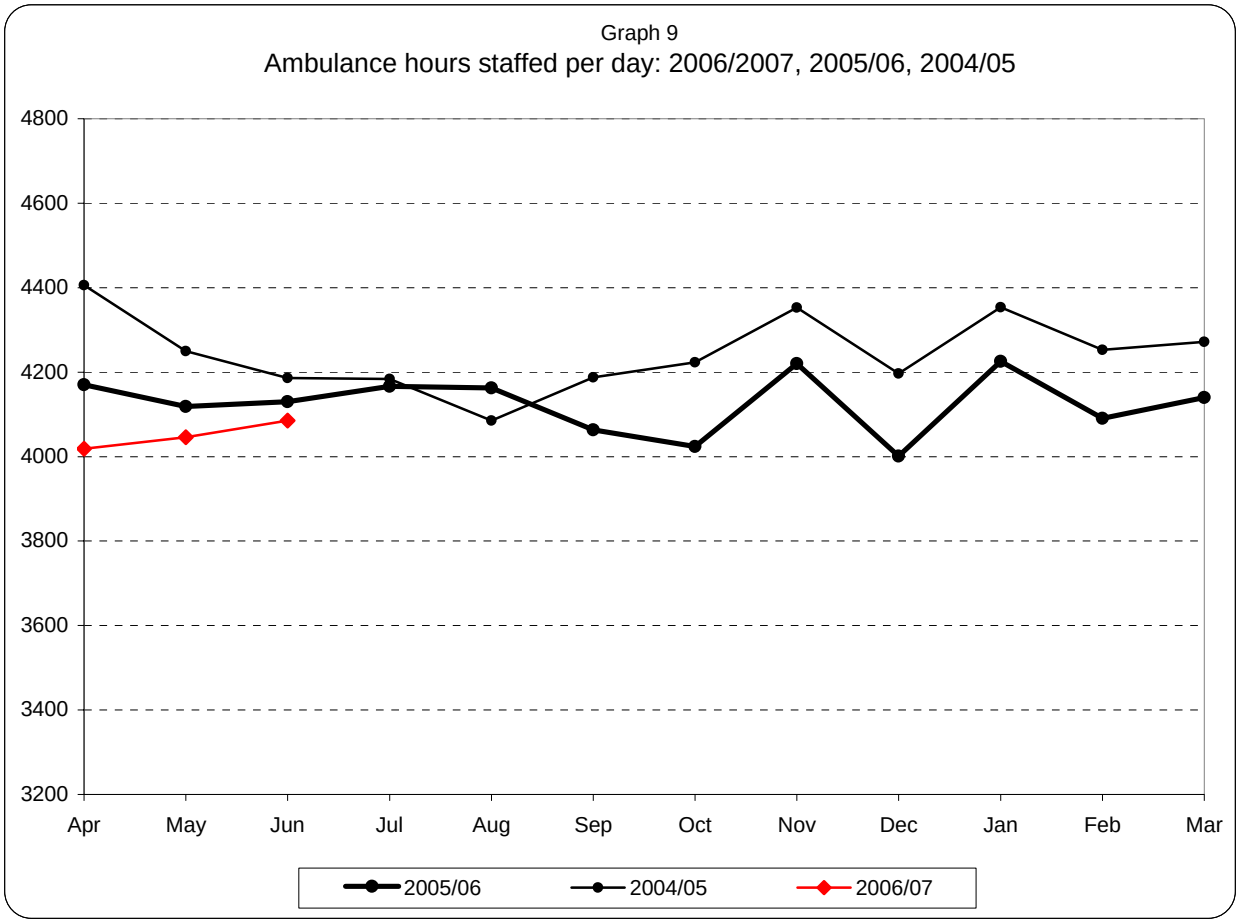


Graph 8



Note:
1) staffed = plan + additional - unmanned - single

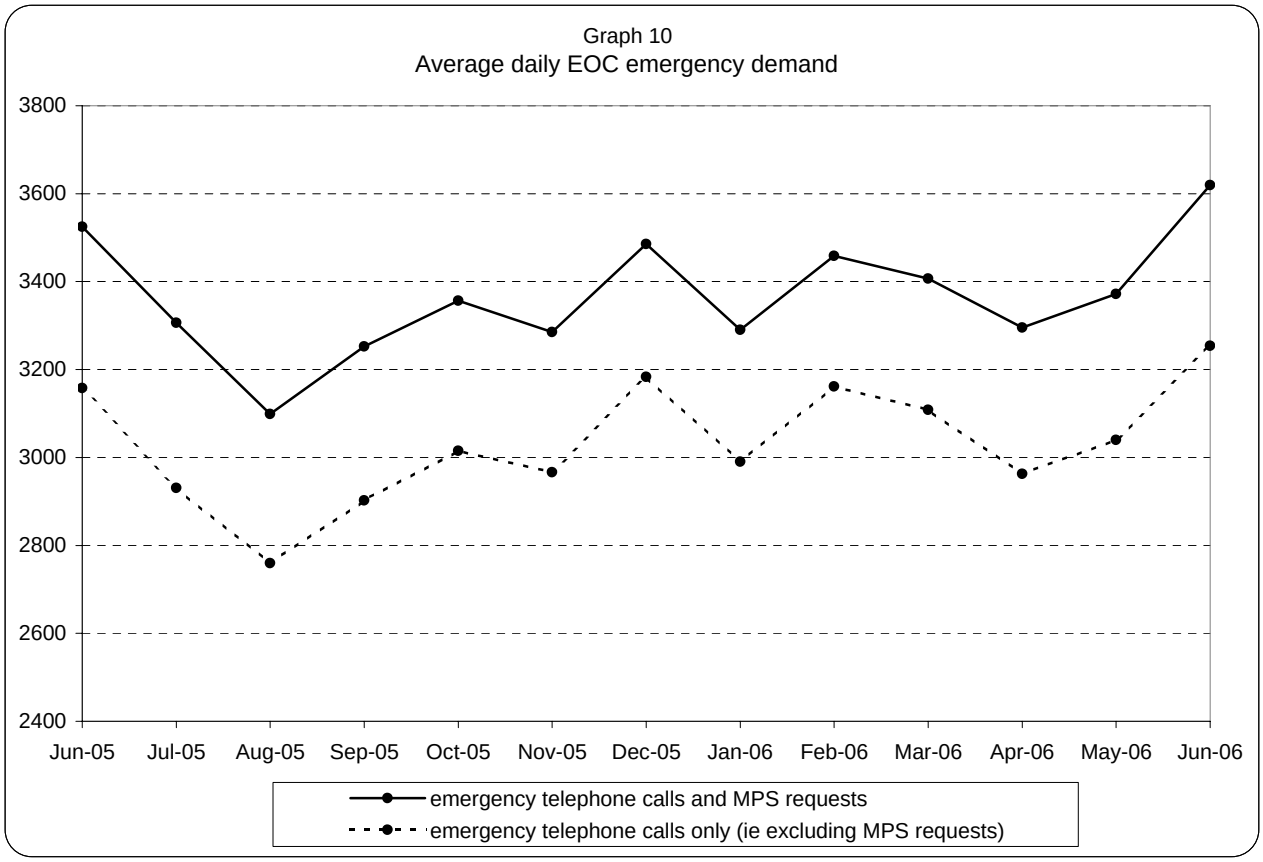
London Ambulance Service NHS Trust
Accident and Emergency Service
Yearly comparison of ambulance staffing



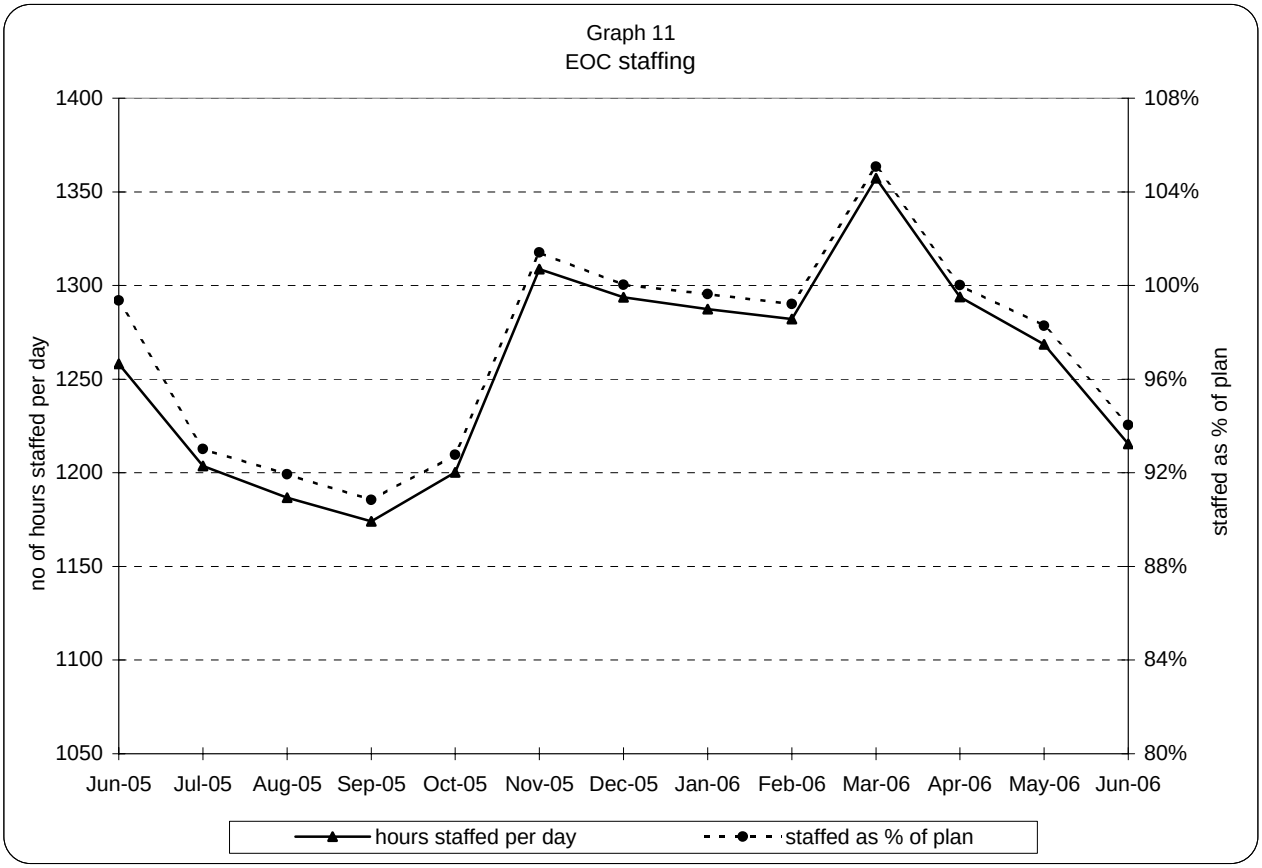
Note:staffed = plan + additional - unmanned - single

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

Graph 10
Average daily EOC emergency demand



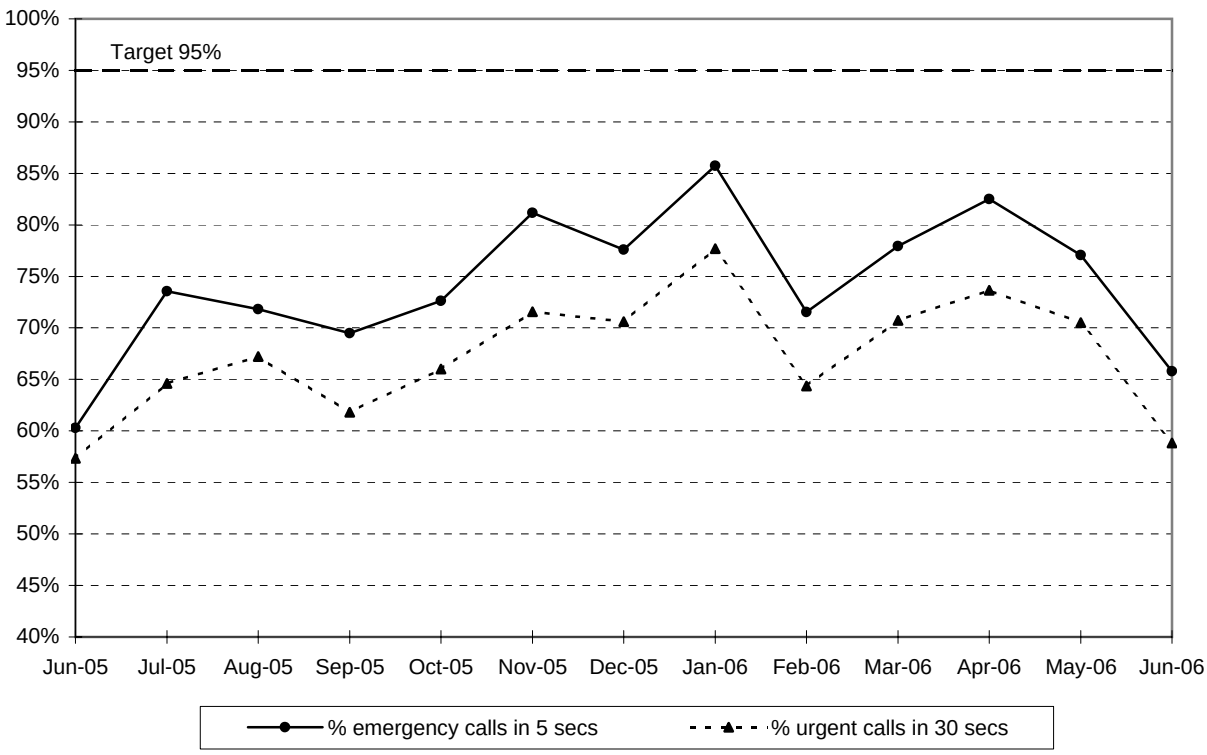
Graph 11
EOC staffing



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

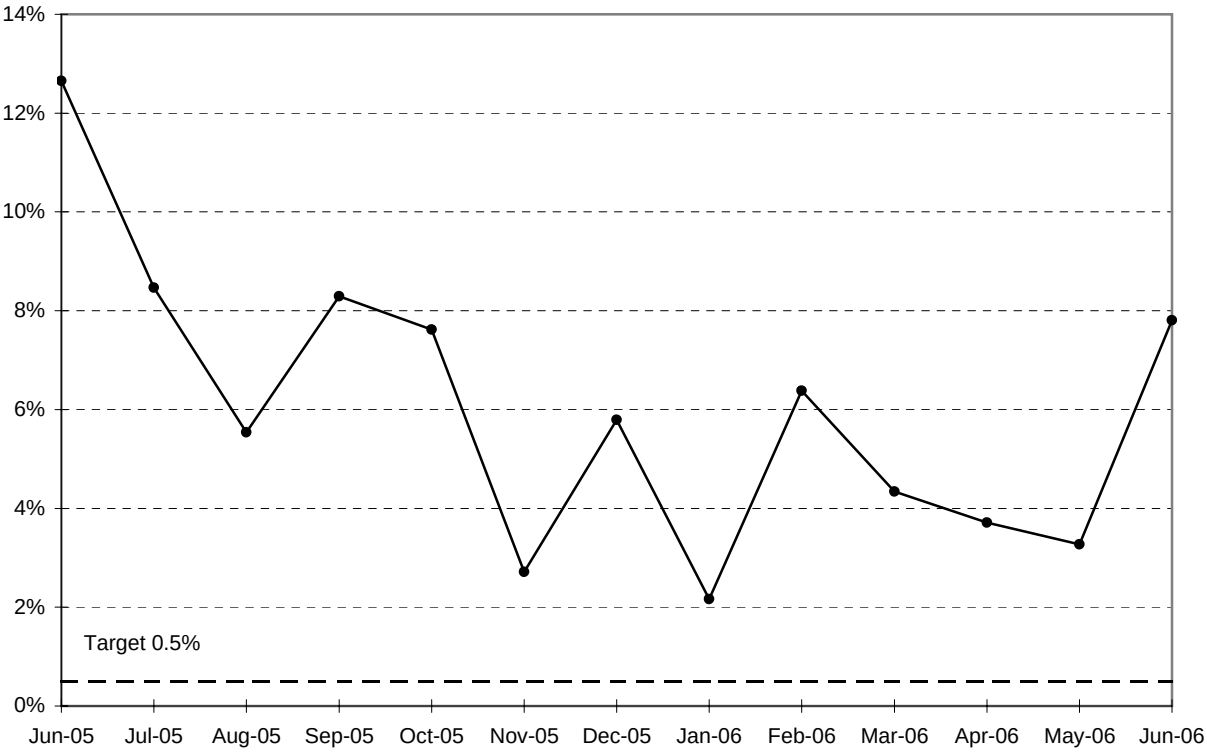
Graph 12

EOC call answering for Emergency and Urgent calls



Graph 13

Percentage of emergency calls answered after 120 seconds



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

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

Table 3

		Apr-06			May-06			Jun-06		
		Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins	Cat A resp	Cat A in 8	% cat A resp in 8 mins
5K5	Brent PCT	814	616	76%	916	644	70%	988	673	68%
5HX	Ealing PCT	953	724	76%	1,047	756	72%	1,037	678	65%
5H1	Hammersmith & Fulham PCT	557	443	80%	583	454	78%	618	493	80%
5K6	Harrow PCT	561	452	81%	601	483	80%	600	465	78%
5AT	Hillingdon PCT	927	683	74%	861	645	75%	937	674	72%
5HY	Hounslow PCT	690	537	78%	737	556	75%	747	517	69%
5LA	Kensington & Chelsea PCT	394	306	78%	471	368	78%	499	354	71%
5LC	Westminster PCT	1,041	842	81%	1,101	887	81%	1,164	827	71%
North West London Strategic HA		**5,937**	**4,603**	**78%**	**6,317**	**4,793**	**76%**	**6,590**	**4,681**	**71%**
5A9	Barnet PCT	911	631	69%	932	655	70%	866	600	69%
5K7	Camden PCT	798	700	88%	853	721	85%	874	714	82%
5C1	Enfield PCT	877	714	81%	865	679	78%	907	644	71%
5C9	Haringey PCT	849	672	79%	820	599	73%	868	608	70%
5K8	Islington PCT	737	618	84%	761	622	82%	786	625	80%
North Central London Strategic HA		**4,172**	**3,335**	**80%**	**4,231**	**3,276**	**77%**	**4,301**	**3,191**	**74%**
5C2	Barking & Dagenham PCT	664	493	74%	636	462	73%	657	466	71%
5C3	City & Hackney PCT	908	669	74%	998	710	71%	943	688	73%
5A4	Havering PCT	665	474	71%	593	398	67%	617	414	67%
5C5	Newham PCT	879	588	67%	1,007	711	71%	1,043	699	67%
5NA	Redbridge PCT	649	493	76%	704	502	71%	763	508	67%
5C4	Tower Hamlets PCT	811	594	73%	821	551	67%	828	545	66%
5NC	Waltham Forest PCT	782	606	77%	766	567	74%	755	502	66%
North East London Strategic HA		**5,358**	**3,917**	**73%**	**5,525**	**3,901**	**71%**	**5,606**	**3,822**	**68%**
5AX	Bexley PCT	588	450	77%	583	455	78%	576	444	77%
5A7	Bromley PCT	755	543	72%	808	596	74%	778	532	68%
5A8	Greenwich PCT	817	630	77%	828	610	74%	810	600	74%
5LD	Lambeth PCT	943	741	79%	1,099	820	75%	1,069	742	69%
5LF	Lewisham PCT	801	594	74%	854	610	71%	818	529	65%
5LE	Southwark PCT	1,083	831	77%	1,101	819	74%	1,063	760	71%
South East London Strategic HA		**4,987**	**3,789**	**76%**	**5,273**	**3,910**	**74%**	**5,114**	**3,607**	**71%**
5K9	Croydon PCT	943	711	75%	1,032	762	74%	998	731	73%
5A5	Kingston PCT	386	295	76%	392	286	73%	356	258	72%
5M6	Richmond & Twickenham PCT	379	273	72%	425	309	73%	377	230	61%
5M7	Sutton & Merton PCT	930	719	77%	936	729	78%	916	662	72%
5LG	Wandsworth PCT	702	526	75%	752	568	76%	776	563	73%
South West London Strategic HA		**3,340**	**2,524**	**76%**	**3,537**	**2,654**	**75%**	**3,423**	**2,444**	**71%**
	Lowest (excl out of London)			67%			67%			61%
	Highest (excl out of London)			88%			85%			82%
	Range			21%			17%			21%

Data entered below will be used throughout the workbook:

Trust name:	London Ambulance Service NHS Trust
This year	2005/06
Last year	2004/05
This year ended	31 March 2006
Last year ended	31 March 2005
This year beginning	1 April 2005

DIRECTORS' STATEMENT

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers' Memorandum issued by the Department of Health.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

……..Date……Chief Executive

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Services Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state affairs of the trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury

- make judgements and estimates which are reasonable and prudent

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirement outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

……Date…….Chief Executive

……Date…….Finance Director

INDEPENDENT AUDITORS' REPORT TO THE DIRECTORS OF THE BOARD OF LONDON AMBULANCE SERVICE NHS TRUST

I have audited the financial statements on page 1 to 44 which have been prepared in accordance with the accounting policies relevant to the National Health Service as set out on pages 7 to 13.

This report is made solely to the Board of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose as set out in paragraph 54 of the Statement of Responsibilities of Auditors and Audited Bodies prepared by the Audit Commission.

Respective Responsibilities of Directors and Auditors

As described in the statement of directors' responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements in accordance with directions issued by the Secre of State. Our responsibilities, as independent auditors, are established by statute, the code of Audit Practice issued by the Audit Commission and our profession's ethical guidance.

I report to you my opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

I review whether the directors' statement of internal control reflects compliance with the Department of Health's guidance 'The Statement on Internal Control 2003/04' issued on 15 September 2003 and further guidance issued on 5 April 2005. I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' statement on internal control covers all risks and controls. I am also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. My review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation

of information in the financial statements.

Opinion

In my opinion the financial statements give a true and fair view of the state of affairs of London Ambulance Service NHS Trust as at 31 March 2006 and its income and expenditure for the year ended in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

Certificate

I certify that we have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Signature……. Date…….

Susan M Exton
District Auditor

Audit Commission
London Region
First Floor
Millbank Tower
Millbank
London SW1P 4HQ

STATEMENT ON INTERNAL CONTROL 2005/06

LONDON AMBULANCE SERVICE NHS TRUST

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The accountability arrangements that surround this role are supported by the management structure, process and monitoring arrangements set out in the Risk Management Framework. The Framework defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks. The Chief Executive has overall responsibil for risk management in the London Ambulance Service. A summary of the Risk Management Framework c be found on our website. In addition to this, stakeholder involvement as part of our seven year strategic planning process has been used to define both our strategic objectives and associated risks.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to :

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ended 31st March 2006 and up to the date of the approval of the annual report and accounts.

3. Capacity to handle risk

The leadership of risk within the LAS is delegated by the Trust Board through the Chief Executive who attends the Audit Committee and is chair of the Risk Compliance and Assurance Group.
Risk is divided into corporate, financial, clinical and health and safety; with the Director of Finance having overall responsibility for financial risk and any other corporate risks not covered by other directors. He attends the Audit Committee and chairs the Standards for Better Health Group, overseeing part of the Annual Health Check that includes the healthcare standards. Individual executive directors are responsible for, and manage, the corporate risks within their particular areas of responsibility.

Risks, as identified using the risk assessment tool in the Risk Management Framework, are approved at Risk Compliance and Assurance Group and allocated to an appropriate specialist risk management group

for management. The tool has recently been amended to use a numerical scoring system when grading risk Those of a high priority are monitored by one of the sub-committees of the Board. All significant risks are recorded on the Risk Register which is used to help prioritise and make decisions on spending allocation for service development.

The LAS has recently reviewed its governance arrangements and other infrastructure requirements that are statutory, mandatory or desirable for the organisation. The review considered the strengths and weaknesses of current governance practice within the LAS.

4. The risk and control framework

The Risk Management Framework defines the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. In addition to this an assessment was undertaken against the Risk Management Standard for the Provision of Pre Hospital Care in the Ambulance Service by the NHSLA which involved a cross section of staff from all areas and levels of the organisation.

The Risk Management Framework describes responsibilities for embedding risk management in the organisation. On a local level staff report clinical and non-clinical incidents as indicated in the Incident Reporting procedure. All incidents are assessed using the LAS Risk Scoring Matrix and according to grade investigated so that actions can be implemented to prevent a re-occurrence. In addition the Infection Control Steering Group has implemented an infection control audit programme delivered to all complexes which has been undertaken by trained frontline staff and produced an Annual Infection Control Report to th Board which provided assurance regarding the implementation of the Make Ready Scheme.

In addition to the Risk Management Framework and the Risk Register, the Assurance Framework enables us to examine how we are managing risks that are threatening the achievement of our strategic objectives and key targets in the Healthcare Commission's Annual Health Check. This has been achieved by mapping risks from the Risk Register against the standards contained within the Health Check, identifying the key controls in place that are managing these risks and listing assurances (positive or negati that we have received assuring the effectiveness of these controls. The Assurance Framework has been scrutinised this year by the SHA on behalf of the Department of Health.

The development of the Assurance Framework is an ongoing process and will be amended with further objectives as they are reviewed and developed in strategic plans. As the Framework covers all of our organisation's main activities, it is a key tool in examining the system of internal control that is in place to manage our risks. The Assurance Framework provides the Board with assurance of full compliance with the core standards of the Annual Health Check and was also presented as evidence of compliance by the Overview and Scrutiny Committees of the boroughs of London. It helps contribute evidence in support of the Statement of Internal Control.

The Assurance Framework has highlighted some gaps in control and assurance to the Board. This is part of an ongoing process where the Board uses the Assurance Framework as a decision making tool. Building on the gaps from last year's Statement of Internal Control developments in controls and assurance have taken place in the following areas;

Human Resource and Organisation Development

> An internal audit reviewed our system for Criminal Records Bureau and Protection of Children Amendment (POCA) checks. The audit has reassured us that we are compliant with the national guidance to check staff who have direct patient contact. We have developed and implemented protection and training guidance for children and vulnerable adults using existing staff to strengthen controls with the management of child protection.

> We have taken action to introduce ethnicity monitoring in order to meet our responsibilities under the Race Relation Act. The LAS has now received assurances on the effectiveness of its controls under the Race Relation Act from the recent audit conducted by the South West London Strategic Health Authority. Further controls were also achieved with the award made to the LAS of Practice Plus status under the aegis of Improving Working Lives.

Operational Support

> An example is indicated below.

> A Fleet and Transport Management audit highlighted the need for having records of vehicles when they are out of service. Fleet Status Reporting options are being explored starting with a manual reporting system.

Clinical

> With the development of clinical performance indicators and electronic recording facilities, the Clin Audit and Research Group will oversee enhanced audit reports from all operational staff. A 3 year to reach 100% compliance with Clinical Performance Indicator audits on PRF's has been put in place

Central Ambulance Control

> Immediate dispatch of calls when there is only one hour to scheduled time of arrival is to be impleme a triaging system has been introduced and a blue-light response given to one hour urgent calls.

Information Management and Technology

> Controls to ensure records management have been enhanced now with the appointment of Head of Records Management. Subsequently, the development of the Trust's Records Management Policy, Records Management strategy has set down systems and processes for the standardisation of records management processes across the Trust. The progress made by the Information Governar Panel has enabled the requirements of the Freedom of Information Act to be managed effectively.

Business Continuity

> A fully integrated business continuity operational plan has been developed and is held under perman review by the Business Continuity Steering Group.

A&E Operations

> National Category B targets have been highlighted by internal performance monitoring mechanisms as being high risk for non-achievement. The senior A&E management team will be introducing a range of high-impact changes in 2006/07 together with linked performance improvement trajectories designed to address this issue.

Finally with respect to the risk and control framework, complaints are routinely used to help identify risks to the service and determine appropriate action to reduce risk and limit the possibility

of reoccurrence in the future. Developments of the Mental Health Strategy has involved contribution from patients and plans have been agreed to appoint a Head of Policy and Evaluation to oversee implementation this strategy. The Patient Advice and Liaison Service has had a significant impact on managing risks, with a comprehensive understanding of interagency working producing a higher quality of patient care trust wide.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed. My review is also informed by bodies such as external auditors, the Healthcare Commission, the HSE and the validation team of Improving Working Lives.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee and Risk Compliance Assurance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board is informed of the effectiveness of the system of internal control through its sub-committees. The Audit Committee advises the Board about how well the Trust is operating the Risk Management System. To carry out this responsibility it receives reports from the Chief Executive and from both internal and external audit when they look at risk management systems and processes.

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care in the LAS. This is achieved through monitoring and making appropriate recommendations on performance in the areas of clinical governance reviewed by the Healthcare Commission.
The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of a risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by Trust systems and processes. Another full trust-wide risk assessment was undertaken this year and generated a further four high priority risks to the Trust's risk profile.

The structure is supported by the Executive Managers of the LAS including the Director of Finance who has overall responsibility for financial risk, and for any corporate risks not covered by other directors. The Medical Director has overall responsibility for clinical risk and clinical governance, and is a member of the Clinical Governance Committee and Standards for Better Health Group . The Director of IM&T is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems and he also chairs the Information Governance Panel The Director of Communications is chair of the PPI Committee.

To supplement this mechanism information is provided to the Board through minutes and annual reports on risk management, infection control, PALS and clinical governance in order for the Board to be confident that sufficient progress has been made.

To conclude, procedures are in place to ensure a robust system of internal control which is reflected in the risk and assurance frameworks.

Signed……Chief Executive Date……
(on behalf of the Board)

FOREWORD TO THE ACCOUNTS

LONDON AMBULANCE SERVICE NHS TRUST

These accounts for the year ended 31 March 2006 have been prepared by the London Ambulance Service NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2006

	NOTE	2005/06 £000	2004/05 £000
Income from activities	3	**212,984**	189,357
Other operating income	4	**2,963**	3,231
Operating expenses	5-7	**(210,497)**	(189,240)
OPERATING SURPLUS (DEFICIT)		**5,450**	3,348
Cost of fundamental reorganisation/restructuring*		**0**	0
Profit (loss) on disposal of fixed assets	8	**22**	4
SURPLUS (DEFICIT) BEFORE INTEREST		**5,472**	3,352
Interest receivable		**391**	508
Interest payable	9	**0**	0
Other finance costs - unwinding of discount	16	**(129)**	(165)
Other finance costs - change in discount rate on provisions	16	**(743)**	0
SURPLUS (DEFICIT) FOR THE FINANCIAL YEAR		**4,991**	3,695
Public Dividend Capital dividends payable		**(3,733)**	(3,363)
RETAINED SURPLUS (DEFICIT) FOR THE YEAR		**1,258**	332

The notes on pages 6 to 44 form part of these accounts.
All income and expenditure is derived from continuing operations.

NOTE TO THE INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2006

	31 March 2006 £000	31 March 2005 £000
Retained surplus/(deficit) for the year	**1,258**	332
Financial support included in retained surplus/(deficit) for the year - NHS Bank	**0**	0
Financial support included in retained surplus/(deficit) for the year - Internally Generated	**0**	0
Retained surplus/(deficit) for the year excluding financial support	**1,258**	332

BALANCE SHEET AS AT 31 March 2006

	NOTE	31 March 2006 £000	31 March 2005 £000
FIXED ASSETS			
Intangible assets	10	**447**	415
Tangible assets	11	**106,257**	105,085
Investments	14.1	**0**	0
		106,704	105,500
CURRENT ASSETS			
Stocks and work in progress	12	**1,916**	1,938
Debtors	13	**22,980**	16,822
Investments	14.2	**0**	0
Cash at bank and in hand	18.3	**667**	665
		25,563	19,425
CREDITORS: Amounts falling due within one year	15	**(9,193)**	(14,177)
NET CURRENT ASSETS (LIABILITIES)		**16,370**	5,248
TOTAL ASSETS LESS CURRENT LIABILITIES		**123,074**	110,748
CREDITORS: Amounts falling due after more than one year	15	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	16	**(24,539)**	(25,017)
TOTAL ASSETS EMPLOYED		**98,535**	85,731
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	22	**49,617**	39,977
Revaluation reserve	17	**41,261**	40,284
Donated asset reserve	17	**508**	698
Government grant reserve	17	**0**	0
Other reserves*	17	**(419)**	10
Income and expenditure reserve	17	**7,568**	4,762
TOTAL TAXPAYERS EQUITY		**98,535**	85,731

Signed: ……(Chief Executive) Date: ……

The financial statements on pages [a to b] were approved by the Board on [date] and signed by:

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2006

	2005/06 £000	2004/05 £000
Surplus (deficit) for the financial year before dividend payments	**4,991**	3,695
Fixed asset impairment losses	**0**	0
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	**2,540**	13,328
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**17**	0
Additions/(reductions) in "other reserves"	**(429)**	0
Total recognised gains and losses for the financial year	**7,119**	17,023
Prior period adjustment	**0**	0
Total gains and losses recognised in the financial year	**7,119**	**17,023**

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2006

	NOTE	2005/06 £000	2004/05 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	18.1	**(558)**	21,930
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**391**	502
Interest paid		**0**	0
Interest element of finance leases		**0**	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		**391**	502
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(5,589)**	(5,976)
Receipts from sale of tangible fixed assets		**35**	73
(Payments) to acquire intangible assets		**(186)**	(63)
Receipts from sale of intangible assets		**0**	0
(Payments to acquire)/receipts from sale of fixed asset investments		**0**	0
Net cash inflow/(outflow) from capital expenditure		**(5,740)**	(5,966)
DIVIDENDS PAID		**(3,733)**	(3,363)
Net cash inflow/(outflow) before management of liquid resources and financing		**(9,640)**	13,103
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of current asset investments		**0**	0
Sale of current asset investments		**0**	0
Net cash inflow/(outflow) from management of liquid resources		**0**	0
Net cash inflow/(outflow) before financing		**(9,640)**	13,103
FINANCING			
Public dividend capital received		**9,640**	0
Public dividend capital repaid (not previously accrued)		**0**	(12,861)
Public dividend capital repaid (accrued in prior period)		**0**	0
Loans received		**0**	0
Loans repaid		**0**	0
Other capital receipts		**0**	0
Capital element of finance lease rental payments		**0**	0
Cash transferred (to)/from other NHS bodies*		**0**	0
Net cash inflow/(outflow) from financing		**9,640**	(12,861)
Increase/(decrease) in cash		**0**	242

* This line is only used by NHS Trusts that are dissolved mid-year.

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trust Manual for Accounts which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2005/06 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.5 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or

- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost

Expenditure on digital hearing aids in the year ended 31 March 2004 (but not in earlier years) was treated as capital expenditure, in accordance with the amendment to the Capital Accounting Manual issued in July 2003, giving rise to an increase in fixed assets regardless of the cost of the individual hearing aids. Subsequent purchases of digital hearing aids are capitalised only when the total value is greater than £5,000. Where small numbers of appliances are purchased the costs are expensed as incurred.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on the 31 March 2005.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets once they have been taken out of operational use and subsequently disposed of.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Total Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost using the indexes as for land and buildings, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets as 'assets under construction and payments on account' where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	Years
Medical equipment and engineering plans and equipment	5 to 15
Furniture	10
Mainframe information technology installations	8
Soft Furnishings	7
Office equipment	5
Information Technology Equipment	3
Set-up costs in new buildings	10

Ambulances are depreciated over their estimated lives; other vehicles are depreciated over 7 years.

Impairment losses resulting from short-term changes in price that are considered to be recoverable in the longer term are taken in full to the revaluation reserve. These include impairments resulting from the revaluation of fixed assets from their cost to their value in existing use when they become operational. This may lead to a negative revaluation reserve in certain instances.

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income may be paid by the Trust's main commissioner using funding provided by the NHS Bank.

1.6 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.7 Government Grants

Government grants are grants from government bodies other than funds from NHS bodies or funds awarded by Parliamentary Vote. The government grants reserve is maintained at a level equal to the net book value of the assets which it has financed. Gains and losses on revaluations are also taken to the Government Grant Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Government Grant Reserve to the Income and Expenditure account. Similarly, any impairment on grant funded assets charged to the Income and Expenditure Account is matched by a transfer from the Reserve.

1.8 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of the Application Note F to FRS 5 and the guidance 'Land and Buildings in PFI schemes Version 2'.

PFI schemes are schemes under which the PFI operator receives an annual payment from the Trust for the services provided by the PFI operator.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI obligations are recorded as an operating expense. Where the trust has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Income and Expenditure Account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.9 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.10 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Trusts are unable to disclose the total amount of research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms. This is a change from the rate of 3.5% in 2004/05 and earlier. The effect of the change is to increase the carrying value of the provision and this is shown in the Income and Expenditure Account and at Note 16.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2004/05 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.12 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full valuation for FRS 17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers contribution rates, this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14% of pensionable pay from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

NHS bodies are directed by the Secretary of State to charge employer's pension cost contributions to operating expenses as and when they become due.

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final years pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years pensionable pay less their retirement lump sum for those who die after retirement is payable.

Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Income and Expenditure account at the time the NHS Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

1.13 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.16 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure account.

1.16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 28 to the accounts.

1.17 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.18 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calulated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the income and expenditure account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 30 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.20 Other Reserve

This reserve was created when the London Ambulance Service became an NHS Trust. The negative reserve balance was caused by the legal title of a property not being correctly transferred from NHS Estates when the Trust was created. Once the error had been identified the London Ambulance Service NHS Trust purchased the property from the NHS estates and thereby creating a negative reserve.

2 SEGMENTAL ANALYSIS

The Trust does not have more than one business segment as defined in Statement of Standard Accounting Practice 25 and therefore there is no requirement for segmental reporting.

3. Income from Activities

	2005/06	2004/05
	£000	£000
Strategic Health Authorities	**97**	0
NHS Trusts	**9,712**	11,898
Primary Care Trusts*	**200,644**	175,576
Foundation Trusts	**1,124**	1,001
Local Authorities	**0**	0
Department of Health	**151**	90
NHS Other	**0**	0
Non NHS:		
- Private Patients	**0**	0
- Overseas patients (non-reciprocal)	**0**	0
- Road Traffic Act	**0**	0
- Other	**1,256**	792
	212,984	189,357

4. Other Operating Income

	2005/06	2004/05
	£000	£000
Patient transport services	**0**	0
Education, training and research	**922**	816
Charitable and other contributions to expenditure	**0**	0
Transfers from donated asset reserve	**222**	215
Transfers from government grant reserve	**0**	0
Non-patient care services to other bodies	**0**	0
Income Generation	**0**	0
Other income	**1,819**	2,200
	2,963	3,231

Other income includes £905,655 back-to-back income, £444,966 as recovery of cost for staff on secondment and £164,000 for the national defibration programme.

5. Operating Expenses

5.1 Operating expenses comprise:

	2005/06	2004/05
	£000	£000
Services from other NHS Trusts	**853**	1,185
Services from other NHS bodies	**1,390**	617
Services from Foundation Trusts	**1**	20
Purchase of healthcare from non NHS bodies	**0**	0
Directors' costs	**621**	740
Staff costs	**156,115**	141,701
Supplies and services - clinical	**4,162**	3,052
Supplies and services - general	**1,285**	1,328
Establishment	**7,618**	7,188
Transport	**16,433**	15,131
Premises	**8,859**	6,917
Bad debts	**0**	3
Depreciation and amortisation	**6,368**	6,567
Fixed asset impairments and reversals	**0**	0
External contracts	**1,756**	1,588
Legal & Professional fees	**331**	841
Non-motor insurance	**14**	21
Audit fees	**139**	131
Other auditor's remuneration	**0**	0
Clinical negligence	**0**	0
Other Training	**1,482**	896
Other	**3,070**	1,314
	210,497	189,240

5.2 Operating leases

5.2/1 Operating expenses include:

	2005/06	2004/05
	£000	£000
Hire of plant and machinery	**0**	0
Other operating lease rentals	**5,291**	4,345
	5,291	4,345

5.2/2 Annual commitments under non - cancellable operating leases are:

	Land and buildings		**Other leases**	
	2005/06	2004/05	**2005/06**	2004/05
	£000	£000	**£000**	£000
Operating leases which expire:				
Within 1 year	**32**	32	**26**	1,696
Between 1 and 5 years	**90**	22	**742**	907
After 5 years	**474**	484	**3,442**	2,197
	596	538	**4,210**	4,800

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2005-06			2004-05		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Sigurd Reinton, Chairman	£20,001-£25,000	£0-£5,000		£20,001-£25,000	£0-£5,000	
Colin Douglas, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
**Toby Harris, Non-Executive Director	£0-£5,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Barry MacDonald, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
Sarah Waller, Non-Executive Director	£5,001-£10,000	£0-£5,000		£5,001-£10,000	£0-£5,000	
**Roy Griffins, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
**Ingrid Prescod, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
**Caroline Silver, Associate Non-Executive Director	£0-£5,000	£0-£5,000		£0-£5,000	£0-£5,000	
Peter Bradley, Chief Executive	£150,001-£155,000	£0-£5,000	£5,000	£135,001-£140,000	£0-£5,000	£4,000
Michael Dinan, Director of Finance	£90,001-£95,000	£0-£5,000		£30,001-£35,000	£0-£5,000	
Martin Flaherty, Director of Operations	£90,001-£95,000	£0-£5,000	£3,000	£0-£5,000	£0-£5,000	£3,000
**Wendy Foers, Director of Human Resources	£20,001-£25,000	£0-£5,000		£90,001-£95,000	£40,001-£45,000	
**Caron Hitchen, Director of Human Resources	£75,001-£80,000	£0-£5,000		£0-£5,000	£0-£5,000	
Fionna Moore, Medical Director	£60,001-£65,000	£0-£5,000		£60,001-£65,000	£0-£5,000	

* Other Remuneration - Consent to disclosure withheld.

** Directors who were in post for part of the financial year. Roy Griffins, Ingrid Prescod and Caroline Silver were appointed Associate Non-Executive Directors on 1st March 2006. Toby Harris resign from the post of Non-Executive Director on 30 November 2005. Wendy Foers resigned from the post of Director of Human Resources on 21 July 2005. Caron Hitchen was appointed Director of Human Resources on 30 May 2005. Martin Flaherty was appointed Director of Operations on 1st April 2005.

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.

5.3 Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2006 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2006 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2006	Cash Equivalent Transfer Value at 31 March 2005	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Colin Douglas, Non-Executive Director	**	**	**	**	**	**	**	
Toby Harris, Non-Executive Director	**	**	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Associate Non-Executive Director	**	**	**	**	**	**	**	
Ingrid Prescod, Associate Non-Executive Director	**	**	**	**	**	**	**	
Caroline Silver, Associate Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£5,001-£10,000	£25,001-£30,000	£132,437	£114,042	£10,881	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£0-£5,000	£0-£5,000	£19,087	£4,874	£9,864	
Martin Flaherty, Director of Operations	£2,501-£5,000	£10,001-£12,500	£25,001-£30,000	£85,001-£90,000	£416,909	£347,229	£42,700	
Wendy Foers, Director of Human Resources	£0-£2,500	£0-£2,500	£25,001-£30,000	£85,001-£90,000	£449,057	£427,178	£2,406	
Caron Hitchen, Director of Human Resources	£0-£2,500	£5,001-£7,500	£15,001-£20,000	£50,001-£55,000	£233,307	£197,417	£18,106	
Fionna Moore, Medical Director	£2,501-£5,000	£7,501-£10,000	£30,001-£35,000	£100,001-£105,000	£584,154	£500,229	£49,993	

** As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when th member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

6. Staff costs and numbers

6.1 Staff costs

	2005/06 Total	**Permanently Employed**	**Other**	2004/05
	£000	**£000**	**£000**	£000
Salaries and wages	**130,669**	128,481	2,188	120,549
Social Security Costs	**10,972**	10,972	0	8,209
Employer contributions to NHSPA	**15,051**	15,051	0	12,848
Other pension costs	**(8)**	(8)	0	637
	156,684	**154,496**	**2,188**	142,243

6.2 Average number of persons employed

	2005/06 Total	**Permanently Employed**	**Other**	2004/05
	Number	**Number**	**Number**	Number
Medical and dental	**0**	0	0	0
Ambulance staff	**3,229**	3,175	54	3,110
Administration and estates	**585**	541	44	616
Healthcare assistants and other support staff	**0**	0	0	0
Nursing, midwifery and health visiting staff	**0**	0	0	0
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**0**	0	0	0
Social care staff	**0**	0	0	0
Other	**93**	64	29	121
Total	**3,907**	**3,780**	**127**	**3,847**

6.3 Employee benefits

There were no employee benefits in the year and there were none in 2004/05.

6.4 Management costs

	2005/06	2004/05
	£000	£000
Management costs	**12,226**	11,079
Income	**215,645**	192,256

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en.

6.5 Retirements due to ill-health

During 2005/06 (prior year 2004/05) there were 8 (11) early retirements from the trust agreed on the grounds. of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £778,048 (£490,570). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2005/06 Number	2005/06 £000
Total Non-NHS trade invoices paid in the year	**58,453**	**52,112**
Total Non NHS trade invoices paid within target	**46,215**	**43,999**
Percentage of Non-NHS trade invoices paid within target	**79%**	**84%**
Total NHS trade invoices paid in the year	**548**	**2,367**
Total NHS trade invoices paid within target	**389**	**1,928**
Percentage of NHS trade invoices paid within target	**71%**	**81%**

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2005/06 £000	2004/05 £000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

8. Profit/(Loss) on Disposal of Fixed Assets

Profit/loss on the disposal of fixed assets is made up as follows:

	2005/06 £000	2004/05 £000
Profit on disposal of fixed asset investments	**0**	0
Loss on disposal of fixed asset investments	**0**	0
Profit on disposal of intangible fixed assets	**0**	0
Loss on disposal of intangible fixed assets	**0**	0
Profit on disposal of land and buildings	**0**	0
Loss on disposal of land and buildings	**0**	0
Profits on disposal of plant and equipment	**22**	4
Loss on disposal of plant and equipment	**0**	0
	22	4

9. Interest Payable

	2005/06 £000	2004/05 £000
Finance leases	**0**	0
Other	**0**	0
	0	0

10. Intangible Fixed Assets

	Software Licences £000	Licenses and trademarks £000	Patents £000	Development Expenditure £000	Total £000
Gross cost at 1 April 2005	1,377	0	0	65	1,442
Indexation				0	0
Impairments	0	0	0	0	0
Reclassifications	101	0	0	(58)	43
Other revaluation	0	0	0	0	0
Additions purchased	132	0	0	95	227
Additions donated	0	0	0	0	0
Additions government granted	0	0	0	0	0
Disposals	0	0	0	0	0
Gross cost at 31 March 2006	**1,610**	**0**	**0**	**102**	**1,712**
Amortisation at 1 April 2005	1,027	0	0	0	1,027
Indexation				0	0
Impairments	0	0	0	0	0
Reversal of impairments	0	0	0	0	0
Reclassifications	9	0	0	0	9
Other revaluation	0	0	0	0	0
Charged during the year	229	0	0	0	229
Disposals	0	0	0	0	0
Amortisation at 31 March 2006	**1,265**	**0**	**0**	**0**	**1,265**
Net book value					
- Purchased at 1 April 2005	350	0	0	65	415
- Donated at 1 April 2005	0	0	0	0	0
- Government Granted at 1 April 2005	0	0	0	0	0
- Total at 1 April 2005	**350**	**0**	**0**	**65**	**415**
- Purchased at 31 March 2006	345	0	0	102	447
- Donated at 31 March 2006	0	0	0	0	0
- Government Granted at 31 March 2006	0	0	0	0	0
- Total at 31 March 2006	**345**	**0**	**0**	**102**	**447**

11. Tangible Fixed Assets

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account*	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2005	43,850	45,649	0	3,425	7,312	25,045	8,209	0	133,490
Additions purchased	200	2,374	0	1,241	199	850	367	0	5,231
Additions donated	0	0	0	0	0	17	0	0	17
Additions government granted	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,255	0	(2,401)	494	352	257	0	(43)
Indexation	2,192	840	0	(21)	154	529		0	3,694
Other in year revaluation	31	(663)	0	0	0	0	0	0	(632)
Disposals	(210)	(242)	0	0	0	(6,339)	0	0	(6,791)
Cost or Valuation at 31 March 2006	**46,063**	**49,213**	**0**	**2,244**	**8,159**	**20,454**	**8,833**	**0**	**134,966**
Depreciation at 1 April 2005					3,614	21,133	3,658	0	28,405
Charged during the year	0	1,850	0		1,269	1,547	1,473	0	6,139
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0		0	0	(9)	0	(9)
Indexation	0	0	0		76	446		0	522
Other in year revaluation					0	0	0	0	0
Disposals	0	(22)	0		0	(6,326)	0	0	(6,348)
Depreciation at 31 March 2006	**0**	**1,828**	**0**	**0**	**4,959**	**16,800**	**5,122**	**0**	**28,709**
Net book value									
- Purchased at 1 April 2005	43,850	45,649	0	3,425	3,000	3,912	4,551	0	104,387
- Donated at 1 April 2005	0	0	0	0	698	0	0	0	698
- Government Granted at 1 April 2005	0	0	0	0	0	0	0	0	0
- Total at 1 April 2005	**43,850**	**45,649**	**0**	**3,425**	**3,698**	**3,912**	**4,551**	**0**	**105,085**
- Purchased at 31 March 2006	46,063	47,385	0	2,244	2,707	3,639	3,711	0	105,749
- Donated at 31 March 2006	0	0	0	0	493	15	0	0	508
- Government Granted at 31 March 2006	0	0	0	0	0	0	0	0	0
- Total at 31 March 2006	**46,063**	**47,385**	**0**	**2,244**	**3,200**	**3,654**	**3,711**	**0**	**106,257**

* Residual interests of off balance sheet PFI schemes should be recorded here. If the amount is material a disclosure should be made stating what the figure represents.

11.1 Tangible Fixed Assets (contd)

Of the totals at 31 March 2006, £Nil related to land valued at open market value and £Nil related to buildings valued at open market value and £Nil related to dwellings valued at open market value.

The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date are as follows:

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2006	0	0	0	0	0	0	0	0	**0**
At 31 March 2005	0	0	0	0	0	0	0	0	**0**

The total amount of depreciation charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Depreciation 31 March 2006	0	0	0	0	0	0	0	0	**0**
Depreciation 31 March 2005	0	0	0	0	0	0	0	0	**0**

11.2 The net book value of land, buildings and dwellings at 31 March 2006 comprises:

	31 March 2006	31 March 2005
	£000	£000
Freehold	**92,341**	87,588
Long leasehold	**758**	1,892
Short leasehold	**349**	19
TOTAL	**93,448**	89,499

12. Stocks and Work in Progress

	31 March 2006	31 March 2005
	£000	£000
Raw materials and consumables	**1,916**	1,938
Work-in-progress	**0**	0
Finished goods	**0**	0
TOTAL	**1,916**	1,938

13. Debtors

	31 March 2006	31 March 2005
	£000	£000
Amounts falling due within one year:		
NHS debtors	**9,262**	4,868
Provision for irrecoverable debts	**(21)**	(20)
Other prepayments and accrued income	**2,309**	2,071
Other debtors	**1,887**	827
Sub Total	**13,437**	7,746
Amounts falling due after more than one year:		
NHS debtors	**9,543**	9,076
Provision for irrecoverable debts	**0**	0
Other prepayments and accrued income	**0**	0
Other debtors	**0**	0
Sub Total	**9,543**	9,076
TOTAL	**22,980**	16,822

Other Debtors include £Nil prepaid pension contributions at 31 March 2006 (£Nil at 31 March 2005)

14. Investments

14.1 Fixed Asset Investments

	Description* £000	Description* £000	Other £000	**Total £000**
Balance at 1 April 2005	0	0	0	**0**
Additions	0	0	0	**0**
Disposals	0	0	0	**0**
Revaluations	0	0	0	**0**
Balance at 31 March 2006	**0**	**0**	**0**	**0**

* NHS Trusts shoud insert a title/heading to describe the type of fixed asset investment held.
Please note: Any NHS Trust that holds a fixed asset investment should include the accounting policy on the fixed asset investment in Note 1 - Accounting Policies, i.e. details should be given of valuation policies etc

14.2 Current Asset Investments

	Description* £000	Description* £000	Other £000	**Total £000**
Balance at 1 April 2005	0	0	0	**0**
Additions	0	0	0	**0**
Disposals	0	0	0	**0**
Revaluations	0	0	0	**0**
Balance at 31 March 2006	**0**	**0**	**0**	**0**

15. Creditors

15.1 Creditors at the balance sheet date are made up of:

	31 March 2006	31 March 2005
	£000	£000
Amounts falling due within one year:		
Bank overdrafts	**104**	101
Current instalments due on loans	**0**	0
Interest payable	**0**	0
Payments received on account	**0**	0
NHS creditors	**191**	280
Non - NHS trade creditors - revenue - other	**4,667**	4,690
Non - NHS trade creditors - capital	**378**	694
Tax and social security costs	**341**	3,589
Obligations under finance leases and hire purchase contracts	**0**	0
Other creditors	**2,775**	3,206
Accruals and deferred income	**737**	1,617
Sub Total	**9,193**	14,177
Amounts falling due after more than one year:		
Long - term loans	**0**	0
Obligations under finance leases and hire purchase contracts	**0**	0
NHS creditors	**0**	0
Other	**0**	0
Sub Total	**0**	0
TOTAL	**9,193**	14,177

Other creditors include;

- £Nil for payments due in future years under arrangements to buy out the liability for Nil early retirements over 5 years; and

- £1,886,605 outstanding pensions contributions at 31 March 2006 (31 March 2005 £1,870,977).

15.2 Loans [and other long-term financial liabilities]

The Trust had not entered in to any loan arrangements at 31 March 2006 or 31 March 2005.

15.3 Finance lease obligations

	31 March 2006 £000	31 March 2005 £000
Payable:		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
	0	0
Less finance charges allocated to future periods	**0**	0
	0	0

15.4 Finance Lease Commitments

London Ambulance Service NHS Trust has not entered into any new finance lease arrangements during the year.

16. Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restructurings	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2005	0	2,723	744	0	21,550	**25,017**
Change in discount rate	0	521	0	0	222	**743**
Arising during the year	0	1,126	43	0	4,206	**5,375**
Utilised during the year	0	(308)	(175)	0	(6,172)	**(6,655)**
Reversed unused	0	0	0	0	(70)	**(70)**
Unwinding of discount	0	71	0	0	58	**129**
At 31 March 2006	**0**	**4,133**	**612**	**0**	**19,794**	**24,539**

Expected timing of cashflows:

Within one year	0	319	612	0	18,078	19,009
Between one and five years	0	1,277	0	0	569	1,846
After five years	0	2,537	0	0	1,147	3,684

Pensions relating to other staff - payments relating to this provision will be made quarterly over the life of each member of staff and have been discounted using a rate of 3.5%. Every year the provision is adjusted for inflation.

Other legal claims - claims brought against the Trust provided for the above vary between probabilities of success of 10% to 94%. The amounts provided are based upon estimates of costs and settlements provided by the NHS Litigation Authority.

Other - £6.5 million (2004/05 £6.5million) of the balance relates to an estimate for our tax liability on subsistence payments made to staff. Both the exact amount and the expected timing of the payout are currently uncertain. £1,854,780 (2004/05 £1,779,131) is an estimate for pension payments due to employees made redundant prior to 1995 as a result of restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees. £9,680,493 (2004/05 £11,793,331) of the balance relates to amounts payable to staff as a result of a change to their salary entitlement under Agenda for Change. This will be paid out in 2005/06. A balance of £1,008,034 also exists in Other Provisions relating to estimated amounts payable in 2005/06 as a result of motor accidents that occurred during the year.

£1,173,726 is included in the provisions of the NHS Litigation Authority at 31 March 2006 in respect of clinical negligence liabilities of the trust (31 March 2005 £653,460).

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Government Grant Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	**Total £000**
At 1 April 2005 as previously stated	40,284	698	0	10	4,762	**45,754**
Prior Period Adjustments	0	0	0	0	0	**0**
At 1 April 2005 as restated	40,284	698	0	10	4,762	**45,754**
Transfer from the income and expenditure account					1,258	**1,258**
Fixed asset impairments	0	0	0			**0**
Surplus on other revaluations/indexation of fixed assets	2,525	15	0			**2,540**
Transfer of realised profits (losses) to the Income and Expenditure	(575)	0	0		575	**0**
Receipt of donated/government granted assets		17	0			**17**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/government granted assets		(222)	0			**(222)**
Other transfers between reserves	(973)	0	0	0	973	**0**
Other movements on reserves [see note 1.20]				(429)		**(429)**
Reserves eliminated on dissolution	0	0	0	0	0	**0**
At 31 March 2006	**41,261**	**508**	**0**	**(419)**	**7,568**	**48,918**

18. Notes to the cash flow Statement

18. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2005/06 £000	2004/05 £000
Total operating surplus (deficit)	**5,450**	3,348
Depreciation and amortisation charge	**6,368**	6,567
Fixed asset impairments and reversals	**0**	0
Transfer from donated asset reserve	**(222)**	(215)
Transfer from the government grant reserve	**0**	0
(Increase)/decrease in stocks	**22**	(328)
(Increase)/decrease in debtors	**(6,158)**	(231)
Increase/(decrease) in creditors	**(4,668)**	157
Increase/(decrease) in provisions	**(1,350)**	12,632
Net cash inflow/(outflow) from operating activities before restructuring costs	**(558)**	21,930
Payments in respect of fundamental reorganisation/restructuring	**0**	0
Net cash inflow from operating activities	**(558)**	21,930

18.2 Reconciliation of net cash flow to movement in net debt

	2005/06 £000	2004/05 £000
Increase/(decrease) in cash in the period	**0**	242
Cash inflow from new debt	**0**	0
Cash outflow from debt repaid and finance lease capital payments	**0**	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	**0**	0
Change in net debt resulting from cashflows	**0**	242
Non - cash changes in debt	**0**	0
Net debt at 1 April 2005	**563**	321
Net debt at 31 March 2005	**563**	563

18.3 Analysis of changes in net debt

	At 1 April 2005	Cash Transferred (to)/from other NHS bodies	Other cash changes in year	Non-cash changes in year	**At 31 March 2006**
	£000	£000	£000	£000	**£000**
OPG cash at bank	631	0	26		**657**
Commercial cash at bank and in hand	34	0	(24)		**10**
Bank overdraft	(102)	0	(2)		**(104)**
Debt due within one year	0	0	0	0	**0**
Debt due after one year	0	0	0	0	**0**
Finance leases	0	0	0	0	**0**
Current asset investments	0	0	0		**0**
	563	**0**	**0**	**0**	**563**

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2006 were £2,018,455 (31 March 2005 £1,94

	£000
Fielden House Refurbishment	294
Bow Site Improvements	333
ARRP Accommodation	433
Other Estate Projects	120
Windows CTAK	200
CAD2010	499
Other Information Technology Projects	139

20. Post Balance Sheet Events

Post balance sheet events having a material effect on the accounts are nil.

21. Contingencies

	2005/06	2004/05
	£000	£000
Contingent liabilities (gross value)*	**(395)**	(233)
Amounts recoverable against contingent liabilities	**25**	104
Net value of contingent liabiliies	**(370)**	(129)
Contingent Assets*	**0**	0

There are no contingencies for clinical negligence since all clinical negligence claims are handled by NHSLA as from 1st April 2002.

22. Movement in Public Dividend Capital

	2005/06	2004/05
	£000	£000
Public Dividend Capital as at 1 April 2005	**39,977**	52,838
New Public Dividend Capital received (including transfers from dissolved NHS Trusts)	**9,640**	0
Public Dividend Capital repaid in year	**0**	(12,861)
Public Dividend Capital repayable (creditor)	**0**	0
Public Dividend Capital written off	**0**	0
Public Dividend Capital transferred to Foundation Trust	**0**	0
Other movements in Public Dividend Capital in year	**0**	0
Public Dividend Capital as at 31 March 2006	**49,617**	**39,977**

23. Financial Performance Targets

23.1 Breakeven Performance

The trust's breakeven performance for 2005/06 is as follows:

	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Turnover	105,814	107,964	116,759	123,578	135,775	160,750	168,508	192,588	215,947
Retained surplus/(deficit) for the year	(163)	485	(1,073)	101	46	94	89	332	1,258
Adjustment for:									
- Timing/non-cash impacting distortions									
- Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	0	0
- 1999/2000 Prior Period Adjustment (relating to 1997/98 and 1998/99)	0	0							
- 2000/01 Prior Period Adjustment (relating to 1997/98 to 1999/2000)	0	0	164						
- 2001/02 Prior Period Adjustment (relating to 1997/98 to 2000/01)	0	0	0	0					
- 2002/03 Prior Period adjustment (relating to 1997/98 to 2001/02)	0	0	0	0	0				
- 2003/04 Prior Period Adjustment (relating to 1997/98 to 2002/03)	0	0	0	0	0	0			
- 2004/05 Prior Period Adjustment (relating to 1997/98 to 2003/04)	0	0	0	0	0	0	0		
- 2005/06 Prior Period Adjustment (relating to 1997/98 to 2004/05)	0	0	0	0	0	0	0	0	
Break-even in-year position	(163)	485	(909)	101	46	94	89	332	1,258
Break-even cumulative position	(163)	322	(587)	(486)	(440)	(346)	(257)	75	1,333
The Trust's recovery plan, approved by the SHA aims to achieve break-even in 20XX/XX. This should be the date of the financial year end e.g. 2006.									0
If anticipated financial year of recovery is more than two years state the period agreed with SHA									0
Materiality test (I.e. is it equal to or less than 0.5%):									
- Break-even in-year position as a percentage of turnover	(0.15%)	0.45%	(0.78%)	0.08%	0.03%	0.06%	0.05%	0.17%	0.58%
- Break-even cumulative position as a percentage of turnover	(0.15%)	0.30%	(0.50%)	(0.39%)	(0.32%)	(0.22%)	(0.15%)	0.04%	0.62%

*delete as appropriate

23.2 Capital cost absorption rate

The trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £3,733,000, bears to the average relevant net assets* of £90,901,000, that is 4.1%.

The variance from 3.5% is due to slippage in the capital programme relating to a number of estate projects.

23.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	£000	**2005/06 £000**	2004/05 £000
External financing limit		**9,640**	(13,103)
Cash flow financing	9,640		0
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**9,640**	(13,103)
Undershoot (overshoot)*		**0**	0

23.4 Capital Resource Limit

The Trust is given a Capital Resource Limit which it is not permitted to overspend

	2005/06 £000	2004/05 £000
Gross capital expenditure	**5,475**	6,581
Less: book value of assets disposed of	**(13)**	(69)
Plus: loss on disposal of donated assets	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of fixed assets	**(17)**	0
Charge against the CRL	**5,445**	6,512
Capital resource limit	**6,695**	6,601
(Over)/Underspend* against the CRL	**1,250**	89

24. Related Party Transactions

London Ambulance Service NHS Trust is a body corporate established by order of the Secretary of State for Health.

Chairman Sigurd Reinton is also a member of the Ambulance Service Association (ASA). During the year details of related party transcations undertaken by the Trust with the Ambulance Service Association.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Ambulance Service Association	46,899	564,222	840	16,241

The Department of Health is regarded as a related party. During the year London Ambulance Service NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Richmond & Twickenham PCT
the NHS Supplies Authority;
the NHS Litigation Authority;
the NHS Pensions Agency
Other Primary Care Trusts

The Trust received an adminstration fee of £2,500 (2004/05 £2,500) from the London Ambulance Service charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

25. Private Finance Transactions

25.1 PFI schemes deemed to be off-balance sheet

The Trust has not entered into any PFI schemes deemed to be off-balance sheet.

25.2 'Service' element of PFI schemes deemed to be on-balance sheet

The Trust has not entered into any PFI schemes deemed to be on-balance sheet.

26 London Ambulance Service NHS Trust Pooled Budget

The Trust did not participate in any Pooled Budget Projects.

27 Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions should be shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. London Ambulance Service NHS Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of nterest. London Ambulance Service NHS Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

27.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2006							
Sterling	10,212	659	9,545	8	2.20%	8	0
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**10,212**	**659**	**9,545**	**8**			
At 31 March 2005 (prior year)							
Sterling	9,741	657	9,076	8	3.50%	8	1
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**9,741**	**657**	**9,076**	**8**			

27.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2006							
Sterling	74,156	0	1,855	72,301	2.20%	21	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**74,156**	**0**	**1,855**	**72,301**			
At 31 March 2005 (prior year) 0							
Sterling	52,458	0	5,128	47,330	3.50%	21	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**52,458**	**0**	**5,128**	**47,330**			

Note: The public dividend capital is of unlimited term.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

27.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2006.

	Book Value	Fair Value	Basis of fair valuation
	£000	£000	
Financial assets			
Cash	667	667	
Debtors over 1 year:			
- Agreements with commissioners to cover creditors and provisions	9,545	9,545	Note a
Investments	0	0	
Total	10,212	10,212	
Financial liabilities			
Overdraft	(104)	(104)	
Creditors over 1 year:			
- Early retirements	0	0	Note b
- Finance leases	0	0	Note c
Provisions under contract	(24,539)	(24,539)	Note d
Loans	0	0	
Public dividend capital*	(49,617)	(49,617)	Note e
Total	(74,260)	(74,260)	

Notes

a These debtors reflect agreements with commissioners to cover creditors over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with notes c and e, below, fair value is not significantly different from book value.

b Fair value is not significantly different from book value since interest at 9% is paid on early retirement creditors.

c To obtain fair value, cash flows have been discounted at prevailing market interest rates for finance leases for a similar term.

d Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 3.5% in real terms.

e The figure here should be the full value of PDC in the balance sheet and 'book value' should equal 'fair value'.

* This figure includes £Nil which relates to short-term repayable (within a set period) PDC held by the Trust.

28 Third Party Assets

The Trust held £Nil cash at bank and in hand at 31 March 2006 (£Nil - at 31 March 2005) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	645	0	341	0
Balances with Local Authorities	4	0	0	0
Balances with NHS Trusts and Foundation Trusts	9,262	9,543	2,143	0
Balances with Public Corporations and Trading Funds	31	0	0	0
Balances with bodies external to government	3,495	0	6,709	0
At 31 March 2006	13,437	9,543	9,193	0
Balances with other Central Government Bodies	3,593	9,076	5,531	0
Balances with Local Authorities	3	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,777	0	192	0
Balances with Public Corporations and Trading Funds	0	0	11	0
Balances with bodies external to government	2,373	0	8,443	0
At 31 March 2005 (prior year)	7,746	9,076	14,177	0

30 Losses and Special Payments

There were 1,476 cases of losses and special payments (2004/05: 1,355 cases) totalling £1,385,608 (2004/05: £1,163,240) paid during 2005/06.

There were nil clinical negligence cases where the net payment exceeded £100,000 (prior year:nil cases).

There were nil fraud cases where the net payment exceeded £100,000 (prior year nil cases).

There were nil personal injury cases where the net paymebnt exceeded £100,000 (prior year nil cases).

There were nil compensation under legal obligation cases where the net payment exceeded £100,000 (prior year nil cases

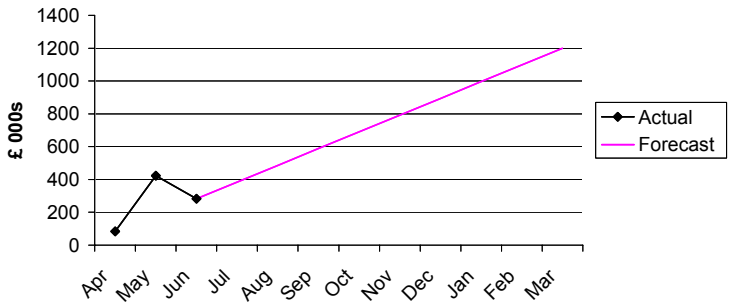
There were nil fruitless payment cases where the net payment exceeded £100,000 (prior year nil cases).

London Ambulance Service NHS Trust

Summary of Financial Performance for the month ending June 30th 2006 (Month 3)

Income and Expenditure

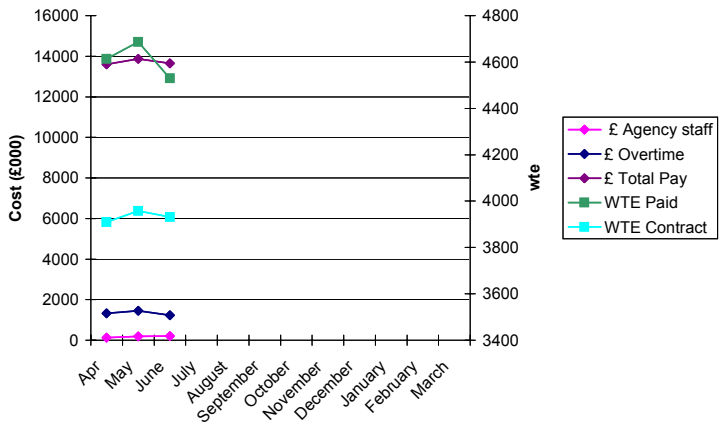
Cumulative Net Financial Position



Year to Date net surplus	£282k

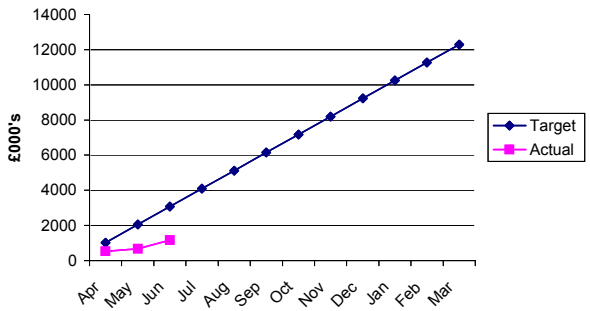
Workforce

Agency, Overtime and Total Pay, Paid and Contract WTE

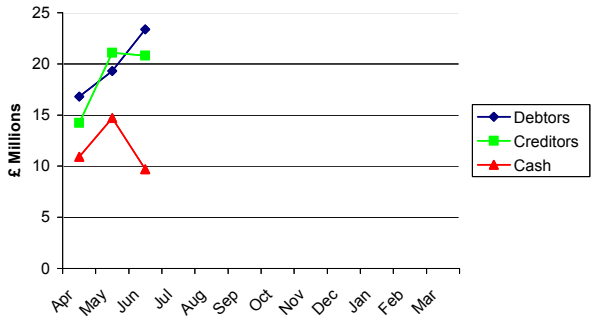


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	Apr	May	June	Risk rating
Asset turnover ratio	1.93	1.92	1.92	
Debtors % > 90 days	13%	8%	6%	
A&E Debtor days	8	6	13	
PTS Debtor days	50	55	43	
PSPP NHS	80%	63%	89%	
PSPP Non NHS	88%	90%	87%	

Key Financial Drivers

	April	May	June	Risk
A&E Overtime expenditure	£1,302k	£1,449k	£1,229k	
A&E Overtime (% of paybill)	9.71%	10.45%	9.01%	
A&E Overtime Variance against plan £	-10	-181	-233	

note: + is underspent, - is overspent

Subsistence expenditure	£195k	196k	£242k	
Subsistence per head £	£66	£66	£84	
Subsistence variance against plan %	-£7k	-£14k	-£95k	

Accident Damage expenditure	£85k	£177k	£341k	
Accident damage variance against plan (£)	+£43k	+£134k	+£126k	

Third party transport expenditure	£197k	£234k	£415k	
Third party transport variance against plan (£)	-£110k	-£54k	-£134k	

A&E Cost per incident	£246	£240	£238	
A&E Abstractions				
PTS Profitability	2.90%	3.91%	4%	

Financial Risks

Overall risk rating	MED	

1	Savings target of 2% is not met	MED	
2	£700k recurrent CBRN funding is at risk	HIGH	
3	Unable to manage crew overtime within budget	MED	
4	Fuel prices are higher than expected	MED	
5	Income levels within PTS Central Services may not be achieved	MED	
6	Subsistence budget will materially overspend due to a possible delay in the introduction of meal breaks	MED	

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report

For the Month Ending 30 June 2006 (Month 03) **£000s**

	IN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	%Variance	Budget	Forecast	Year end Variance
Total Income	(17,918)	(17,974)	(56)	(53,920)	(54,108)	(188)	(0.3)U	(216,311)	(217,511)	1,200
Total Expenditure	18,185	18,100	(85)	54,087	54,557	470	0.9F	216,311	216,311	0
Trust Result	268	126	(141)	167	449	282	62.9F	0	(1,200)	1,200

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report

For the Month Ending June 30th 2006 (Month 03)

1. **Month**

1.1. The position in June is an overspend of £141k.

1.2. Income reported an unfavourable variance of £56k. This is due to ECP income being lower than plan. In addition, there are shortfalls on CBRN and Workforce Development Confederation income.

1.3. Expenditure reported an unfavourable variance of £85k, due to a combination of A&E Overtime being higher than plan and a reprofile to the Estates Maintenance budget, which was moved to later months in the year when most of the planned maintenance work will occur.

2. **Year to date**

2.1 The year to date position is £282k underspent.

2.2 Trust income is £188k less than expected. This is as a result of there being lower levels of CBRN and Workforce Development Confederation income than had been estimated in budgets.

2.3 Trust expenditure is £470k less than budget. This is mainly due to non pay, there are some projects and items budgeted where expenditure has not yet commenced or is expected to increase later on in the year. However the budget is profiled in equal twelfths throughout the year, hence an underspend. This underspend is not expected to continue for the rest of the year.

3. **Annual**

3.1 The forecast at month 3 is an underspend of £1.2million. This is the underspend from 2005/06, which will be brokered into this financial year. We have proposed to South West London SHA that we will plan to underspend by this amount in 2006/07.

3.2 SWL SHA has requested that the LAS make a surplus of 1% on revenue for 2006/07 as part of the NHS recovery plan for London which equates to £2.2million. Discussions with the SWL SHA continue.

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LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 30 June 2006 (Month 03)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*
	Actual	Budget	Variance	Actual	Budget	Variance	%Variance	Budget
Income	16,914	17,013	(99)U	50,972	51,225	(253)U	0.5U	205,311
A&E Operations Cost								
Sector	11,298	11,220	(78)U	32,990	32,754	(237)U	0.7U	128,505
Control Services	1,150	1,174	23F	3,335	3,375	39F	1.2F	13,347
A&E Operational Support	926	939	13F	2,715	2,768	53F	1.9F	10,984
Urgent Care	365	367	2F	1,941	2,108	167F	7.9F	8,423
Total Operations Cost	13,739	13,699	(40)U	40,982	41,005	22 F	0.1F	161,258
A&E gross surplus/(deficit)	3,175	3,314	(139)U	9,990	10,221	(231)U	2.3 U	44,052
A&E Gross Margin	18.9%	19.6%	(1.0)%U	19.7%	20.1%	(0.4)U	1.8%U	21.6%
Corporate Support								
Medical Director	52	54	1F	132	152	19F	12.8F	606
Service Development	67	58	(9)U	147	145	(2)U	1.3U	603
Communications	108	127	20F	363	384	20F	5.3F	1,562
Human Resources	1,155	1,219	64F	3,327	3,708	381F	10.3F	13,873
IM&T	561	623	62F	1,787	1,848	61F	3.3F	7,347
Finance	1,444	1,338	(105)U	4,156	4,286	130F	3.0F	18,692
Chief Executive	93	91	(2)U	362	357	(5)U	1.5U	1,424
Total Corporate	3,480	3,511	31F	10,274	10,880	605 F	5.6F	44,108
A&E net surplus/(deficit)	305	197	(108)U	285	659	374F	56.8U	(55)
A&E net margin	-1.8%	-1.2%	(0.6)%U	-0.6%	-1.3%	0.7U	56.6%U	0.0%
PTS								
Income	1,004	961	43F	2,948	2,883	65F	2.3F	11,001
Expenditure	967	890	(76)U	2,830	2,673	(158)U	5.9U	10,945
Surplus/(Deficit)	37	70	(33)U	118	210	(92)U	43.8U	55
Margin	3.7%	7.3%	(3.6)U	4.0%	7.3%	(3.3)U	45.1U	0.5%
Trust Result	268	126	(141)U	167	449	282F	62.9F	0

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 30th June 2006 (Month 3)

Notes

Variances commented upon are those higher than £25k in month and year to date:

1. **Income**
   - The monthly and year to date adverse position stems from CBRN income and Workforce Development Confederation income. Both these income streams are less than had been previously notified.

2. **A&E Sectors**
   - The directorate overspend stems mainly from pay, which is overspent by £193K of which £237K relates to operational overtime, a revised budget profile is being investigated. The overtime is offset by vacancies in support departments.
   - Non-pay is overspent year to date by £72K. Fuel is overspent by £126K and this is both price and volume driven. The budget was set at 92.8p/litre and the current cost is 96.7p/litre. Subsistence is £76K overspent in the month despite the budget being profiled towards the early part of the year. These are partially off-set by underspends on Fleet costs (£138k).

3. **A&E Operational Support**
   - The year to date favourable variance stems from Fleet where there is an underspend on vehicle maintenance and RAC, this is in part due to the employment of a Fleet Co-ordinator in EOC which has seen the number of RAC callouts reduce. This underspend is partially compensated by an overspend in Logistics on oxygen usage; analysis is currently been undertaken to determine whether this is a price and/or volume variance.

4. **Urgent Care**
   - Pay is underspent by £127K due to vacancies across several staff groups. Non pay is underspent on 3rd party (£40k) and IT but overspent on subsistence (£19k).

5. **HR**
   - The underspend within this directorate stems mainly from the Education and Development Department. Non pay is underspent by £295k year to date, on training and course fees, uniforms and Fleet costs. The training and uniform expenditure should happen later in the year when more courses are planned. Within pay, training officers are overspent by £126K in part due to a provision of £60K for a potential payment of a R&R premium. This is offset by under spends elsewhere.
   - Elsewhere within HR, the Organisational Development department reports an underspend as plans for the Trust OD strategy are have not yet been finalised. Recruitment also reports an underspend on advertising as there have been no A&E recruitment campaigns to date.

6. **IM&T**
   - The favourable variance stems from vacancies (primarily within Management Information) and on office and station expenses. The favourable swing in the month stems from a correction to a previous months entry on telephone rental.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis by Function

For the Month Ending 30th June 2006 (Month 3)

7. Finance

- The adverse movement in the month is due to the Estates Department on building and engineering maintenance. This is due to a combination of an increase in expenditure and the budget being reprofiled to fit in with the Estates planned maintenance program. Expenditure will be analysed to determine whether some relates to capital projects.
- Interest received is higher than planned for the first three months of the year which causes an underspend in the Finance Department. Within the Legal Services Department the level of 3rd party claims is less than anticipated for the first quarter of the year, hence reporting an underspend.

8. PTS

- The operating position on PTS contracts for month 3 is £46k unfavourable: Central Services (£22k), UCLH (£16k), Queen Elizabeth Hospital (£12k), Kingston Hospital (£10k) and UCLH (£8k). These are partially offset by a one-off credit in the month on RNO Stanmore Contract, giving a favourable variance of £16k.

LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type

For the Month Ending 30 June 2006 (Month 03) **£000s**

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*
	Actual	Budget	Variance	Actual	Budget	Variance	%Variance	Budget
Payroll Expenditure								
A&E Operational Staff	7,917	7,912	(5)U	23,605	23,527	(78)U	0.3U	96,077
A&E Overtime	1,146	1,039	(108)U	3,667	3,430	(237)U	6.9U	9,086
A&E Management	789	887	98F	2,532	2,604	73F	2.8F	10,580
EOC Staff	854	856	1F	2,433	2,487	54F	2.2F	10,462
PTS Operational Staff	631	662	31F	1,916	1,982	66F	3.4F	7,549
PTS Management	98	104	5F	285	311	26F	8.5F	1,189
Corporate Support	2,207	2,152	(54)U	6,677	6,706	30F	0.4F	26,231
	13,643	13,611	(32)U	41,113	41,048	(66)U	0.2U	161,175
Non Pay Expenditure								
Staff Related	459	419	(39)U	1,324	1,301	(24)U	1.8U	4,266
Training	114	166	51F	233	467	234F	50.1F	1,888
Medical Consumables and Equipment	335	346	10F	914	1,027	113F	11.0F	4,230
Fuel & Oil	287	298	11F	952	875	(78)U	8.9U	3,622
Third Party Transport	181	101	(80)U	415	281	(135)U	47.9U	1,216
Vehicle Costs	748	796	48F	2,110	2,427	317F	13.1F	9,709
Accomodations and Estates	731	527	(204)U	2,015	1,853	(162)U	8.7U	8,720
Telecommunications	410	442	32F	1,290	1,266	(25)U	1.9U	5,122
Depreciation	560	612	52F	1,667	1,662	(5)U	0.3U	6,739
Other expenses	407	416	9F	1,083	1,253	170F	13.6F	5,234
	4,233	4,123	(110)U	12,005	12,412	407 F	3.3F	50,745
Financial Expenditure	310	366	56 F	969	1,098	129 F	11.7F	4,391
Total Trust Expenditure	18,185	18,100	(85)U	54,087	54,557	470F	0.9 F	216,311

1. **A&E Overtime**
   - Operations overtime expenditure reflects the higher than planned use of overtime in the first part of the year.
2. **PTS Operational Staff**
   - The £3k favourable position against budget in the month relates to vacancies across contracts.
3. **Corporate Support Staff**
   - Management and Admin staff are underspent throughout the Trust due to vacancies. The largest area of underspend is within Admin and clerical staff in the resource centres and ambulance stations.
4. **Staff Related**
   - Operations and Urgent care subsistence is overspent. This is attributed to requests for increased manning and therefore additional shifts are being put on.
5. **Training**
   - Training is underspent as the majority of courses are due to commence later in the year, whereas the budget is profiled in equal twelfths throughout the year.
6. **Medical Consumables & Equipment**
   - The year to date underspend is caused by the Oxylitre equipment maintenance and blanket purchase. This underspend is not expected to continue at this rate and budgets will be re-profiled in future months so that they fit expected expenditure patterns.
7. **Fuel and Oil**
   - Fuel is overspent to date and is due to price and volume variations compared to budgeted levels.
8. **Third Party Transport**
   - PTS third party transport continues to be used across contracts, with a slight increase to cover vacant posts; the unfavourable variance relates to missed savings targets for PTS Central Services usage.
9. **Vehicle Costs**
   - This item of expenditure is usually underspent in the first quarter of they year. The rate of expenditure increases as the year progresses, therefore the underspend is not expected to continue at the current rate.
   - The big area of underspend is on the cost of repairing vehicles that have been in accidents. Expenditure is less than plan for the first quarter of the year. In addition The RAC vehicle recovery contract is also underspent. The employment of a Fleet Coordinator working in EOC has reduced the number of recovery call outs compared to last year.
10. **Accommodation & Estates**
    - The underspend stems mostly from the utilities budgets (electricity, gas and water) where expenditure is expected to be lower in the summer months. The budget is profiled in twelfths currently but will be reprofiled to reflect expected expenditure throughout the rest of the year.
11. **Telephones**
    - The favourable movement in the month is due to a correction of a previous month's entry on telephone rental where too much expenditure had been included in the first two months of the year. This correction now rectifies the year to date position on telephone expenditure.
12. **Other Expenses**
    - The underspend is spread across the all directorates. The areas with the biggest overspend are: Logistics and IM&T. This is due to an underspend on PRF printing within Logistics and underspend on microfilm and scanning within the Management Information Department.

LONDON AMBULANCE SERVICE NHS TRUST

Analysis of Income

For the Month Ending 30th June 2006 (Month 03) **(£000s)**

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Budget
A&E Income								
A&E Services Contract	15,713	15,713	0F	47,138	47,138	0F	0.0F	188,552
CBRN Income	651	777	(126)U	2,108	2,331	(223)U	9.6U	9,323
ECP Revenue	33	59	(26)U	307	366	(59)U	16.2U	1,464
BETS & SCBU Income	33	48	(16)U	132	145	(13)U	8.9U	580
A & E Long Distance Journey	100	40	61F	202	119	83F	(69.8)F	475
Stadia Attendance	70	70	0	149	149	0U	0.0U	598
Heathrow BAA Contract	35	34	1F	104	101	3F	(2.7)F	405
Resus Training Fees NHS	26	15	11F	31	21	10F	(45.5)F	270
Resus Training Fees Non NHS	1	10	(11)U	6	12	(6)U	46.9U	270
ELECTIVE BETS	30	0	30F	30	0	30F	100.0F	0
HEMS Funding	2	2	0	7	7	0F	0.0F	29
A&E Income	**16,692**	**16,768**	**(76)U**	**50,214**	**50,389**	**(176)U**	**0.3 U**	**201,967**
PTS Income	**994**	**961**	**33 F**	**2,929**	**2,883**	**47 F**	**1.6 F**	**11,001**
Other Income	**232**	**245**	**(14)U**	**777**	**836**	**(59)U**	**7.0 U**	**3,344**
Total Income	**17,918**	**17,974**	**(56)U**	**53,920**	**54,108**	**(188)U**	**0.3 U**	**216,311**

Notes

1. CBRN Income

- The £126k adverse variance on CBRN Income is the result of the year to date accrual being adjusted to reflect an expected shortfall in CBRN funding of £892k. This shortfall is due to a proposed top-slice by South West London SHA which is currently under discussion.

2. ECP Revenue

- The unfavourable variances on ECP revenue of £26k in the month and £59k year to date reflect shortfalls in income for Sutton, Greenwich and Newham PCTs.

3. PTS Income

- The favourable variance of £33k on PTS income year to date is due to additional contract income on RNO Stanmore (for a shuttle bus service provided) and excess activity on Queen Victoria, South West London and St Georges and St Andrews.

4. Other Income

- The £59k year to date adverse variance on Other Income is mainly due to an accrued shortfall in WDC funding (£87.5k year to date), partially offset by higher levels of chargeable secondments to non-NHS bodies than budgeted.

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Staff Numbers

For the Month Ending 30 June 2006 (Month 03)

	Last Month Actual Paid WTE	This Month Actual Paid WTE	Variance
A&E Operations			
Sector	3,096.91	3,054.89	(42.02)
Emerg Control Services	380.46	349.28	(31.18)
A&E Operational Support	117.78	102.79	(14.99)
Urgent Care	244.30	185.69	(58.61)
	3,839.45	3,692.65	(146.80)
Corporate Support			
Medical Director	10.41	9.53	(0.88)
Service Development	5.80	4.84	(0.96)
Communications	21.58	20.91	(0.67)
Human Resources	331.52	332.88	1.36
IM&T	54.54	56.91	2.37
Finance	59.38	59.20	(0.18)
Chief Executive	20.19	20.37	0.18
Total Corporate	503.42	504.64	1.22
PTS	344.09	332.59	(11.50)
Trust Total	4,686.96	4,529.88	(157.08)

1. **A&E Sectors**
   - The major reason for the decrease is the omission of the additional meal break wtes.

2. **Emergency Control Services**
   - The decrease in paid WTE reflects the reduction in overtime and a reduction in enhanced rates for overtime and bank holiday working.

3. **A&E Operational Support**
   - There are a large number of staff in this directorate who are paid on a weekly basis. The decrease stems from there being a 5 week month in May and a four week month in June.

4. **Urgent Care**
   - The movement in WTE reflects the move of 47 white work staff back to A&E operations to Urgent Care.

5. **IM&T**
   - The increase stems from the recoding of a couple of months worth of Project Management staff to the LARP project in May.

6. **PTS**
   - An decrease of 11.50 wte reflects a marked decrease in overtime and payments at time and a half to cover vacancies.

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 30 June 2006 (Month 03)

Cost Centre	Cost centre description	Total Project Budget	CURRENT YEAR				Goods Ordered/ Not Received	TOTAL PROJECT	
			Annual Budget	YEAR TO DATE					
				Budget	Spend	Variance		Spend	Variance
S92	**Total Equipment Projects**								
S93	**Total Estates Projects**								
80179	Bow Office Changes	1,142,160	333,000	254,797	254,797	0 U	16,081	850,089	292,071 F
80222	New Brixton Ambulance Stat	925,000	425,000	0	0	0	0	0	925,000 F
80246	Station Fire Alarms	300,000	150,000	47,472	47,472	0 F	0	109,701	190,299 F
80256	ARRP Accomodation	948,678	465,639	95,665	95,665	0 U	0	168,237	780,441 F
80267	Shoreditch A/S Extension	310,000	155,000	0	0	0	0	0	310,000 F
80278	Edmonton extensio	150,493	150,493	34,150	34,150	0 F	0	34,150	116,343 F
80279	Hillingdon A/S refurb SPPP 14	417,125	417,125	0	0	0	0	0	417,125 F
80280	Fielden Hse Refurb SPPP 071	323,750	323,750	0	0	0	0	0	323,750 F
80283	Fr Barnet ext & alt SPPP151	175,620	175,620	0	0	0	0	0	175,620 F
80286	Bromley Fixed Satelliite Point	30,000	30,000	0	0	0	0	0	30,000 F
80287	HQ and digital CCTV upgrade	35,000	35,000	0	0	0	0	0	35,000 F
S932	Minor Estates Projects	1,017,839	431,941	37,903	37,903	0 U	3,299	407,851	609,988 F
	Total Estates Projects	**5,775,665**	**3,092,568**	**469,987**	**469,988**	**(1)U**	**19,380**	**1,570,027**	**4,205,638 F**
S94	**Total IM&T Projects**								
80232	CAD 2010 Capital	711,736	499,000	41,210	41,210	0 U	1,627	188,720	523,016 F
80252	CTAK enhance capital	329,350	200,000	40,562	40,562	0 U	16,834	85,203	244,147 F
80266	Replacement PC programme 05	302,952	19,300	15,140	15,141	(1)U	61,644	264,117	38,835 F
80281	LARP project (Capital) SPPP 0	154,550	154,550	17,778	17,778	0 F	0	17,778	136,772 F
80285	Server replacements SPPP 032	152,000	152,000	0	0	0	37,598	37,598	114,402 F
S934	Minor Technology Projects	213,000	75,000	7,690	7,690	0 U	329,121	399,202	(186,202)U
	Total IM&T Projects	**1,863,588**	**1,099,850**	**122,380**	**122,381**	**(1)U**	**446,824**	**992,618**	**870,970 F**
S97	**Approved SPPPs not Committ**								
80045	Buckhurst Hill - Disposal	5,192	0	0	0	0	0	26,111	(20,919)U
80176	Poplar Ambulance Station Rep	0	0	0	0	0	0	0	0 F
80204	Relocation Of Isleworth Ambul	200,000	0	0	0	0	0	0	200,000 F
89998	Approved ISONs not Committe	10,909,275	8,571,982	0	0	0	0	0	10,909,275 F

LONDON AMBULANCE SERVICE NHS TRUST

Capital Expenditure Report

For the Month Ending 30 June 2006 (Month 03)

Cost Centre	Cost centre description	Total Project Budget	CURRENT YEAR				Goods Ordered/ Not Received	TOTAL PROJECT	
			Annual Budget	YEAR TO DATE					
				Budget	Spend	Variance		Spend	Variance
	Approved SPPPs not Committed	**11,114,467**	**8,571,982**	**0**	**0**	**0**	**0**	**26,111**	**11,088,356 F**
S98	**Total Old Projects**								
	Total Old Projects	**11,760,149**	**0**	**0**	**81,566**	**(81,566)U**	**38,535,758**	**73,212,911**	**(61,452,762)U**
S99	**Un Allocated Capital Funds**								
S99	Un Allocated Capital Funds	(188,469)	(469,400)	0	0	0	0	0	(188,469)U
	Un Allocated Capital Funds	**(188,469)**	**(469,400)**	**0**	**0**	**0**	**0**	**0**	**(188,469)U**
	Total Programme	**30,325,400**	**12,295,000**	**592,367**	**673,935**	**(81,568)U**	**39,001,962**	**75,801,666**	**(45,476,266)U**

LONDON AMBULANCE SERVICE NHS Trust

Balance Sheet

For the Month Ending 30 June 2006 (Month 3)

	Mar-06	Apr-06	May-06	Jun-06	
	£'000s	£'000s	£'000s	£'000s	
Fixed Assets					
Intangible assets	447	431	417	399	
Tangible assets	106,271	112,451	112,054	111,984	
	106,718	112,882	112,471	112,383	
Current Assets					
Stocks & WIP	1,916	1,908	1,914	1,919	
Debtors A&E	8,114	1,996	5,662	10,252	£403k > 60 days (4.21%), May - £147k > 60 days (11.49%)
Debtors PTS	959	1,957	1,545	1,370	£899k > 60 days (61.65%), May - £555k > 60 days (33.58%)
Prepayments, Vat Recoverable, Other Debtors	4,384	3,343	2,561	2,212	
Back to Backed Debtors - PCTs	9,545	9,545	9,545	9,545	
Investments - Short Term Deposits	0	10,000	10,200	9,500	
Cash at Bank and in Hand	667	908	4,512	226	
Total Current Assets	25,585	29,657	35,939	35,024	
Creditors: Amounts falling due within one year					
Bank Overdraft	104	53	14	25	
Creditors - NHS	2,077	1,991	2,051	2,047	PSPP - This month (89%), May (63%), Ytd (75%)
Creditors - Other	7,019	11,840	18,347	17,713	PSPP - This month (87%), May (90%), Ytd (89%)
Dividend Provision	0	345	689	1,034	
Total Current Liabilities	9,200	14,229	21,101	20,819	
Net Current Assets	16,385	15,428	14,838	14,205	
Total Assets less current liabilities	123,103	128,310	127,309	126,588	
Creditors: Amounts falling due after more than one year					
Provisions for Liabilities & Charges	24,539	22,630	22,034	21,607	
Total Net Assets	98,564	105,680	105,275	104,981	
Capital & Reserves					
Donated Assets	508	502	483	455	
Income & Expenditure account	7,592	8,064	7,678	7,481	
Other Reserves	-419	-419	-419	-419	
Public Dividend Capital	49,617	49,617	49,617	49,617	
Revaluation Reserve	41,266	47,916	47,916	47,847	
Total Capital & Reserves	98,564	105,680	105,275	104,981	

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement

For the Month Ending 30 June 2006 (Month 3)

	Apr-06	May-06	Jun-06
	£'000s	£'000s	£'000s
Opening Cash Balance	563	10,855	14,698
Operating Activities			
Trust I&E	495	-394	-276
Depreciation	553	554	554
Transfer from Donated Asset Reserves	-20	-20	-20
(Increase)/Decrease in Stocks	8	-4	-5
(Increase)/Decrease in Debtors	6,161	-2,472	-4,066
Increase/(Decrease) in Creditors	5,080	6,872	-306
Other	-1,909	-596	-427
Net Cashflow from operating activities	10,368	3,940	-4,546
Financial Activities			
Interest received	33	54	72
Interest paid	0	0	0
Other	0	0	0
Net Cashflow from financial activities	33	54	72
Capital Expenditure			
Tangible fixed assets acquired	-109	-151	-523
Tangible fixed assets disposed	0	0	0
Other	0	0	0
Net Cashflow from capital expenditure	-109	-151	-523
PDC Dividends paid	0	0	0
Financing - PDC Capital	0	0	0
Closing cash balance	10,855	14,698	9,701

Finance Risk Register Items - 2006/07 Risks

	Risk	Priority *(High, Medium or Low)*	Lead Person *(SMG Member)*	Action Plan	Timescale
1	The trust has a savings target of 2% to be achieved in 2006/07, which may not be realised.	H	SMG	Work up realistic plans.	During 2006/07
2	There is £700k recurrent CBRN funding at risk. £8.2 was budgeted for but £7.5m has been agreed with the DOH.	H	SMG	Pursue DOH	During 2005/07
3	Trust may not manage crew overtime within budget.	H	MF	Monitor closely and manage in year	During 2006/07
4	Fuel prices in excess of the sums held in budgets, and Centrally Held Funds.	M			
5	Failing to manage and control third party expenditure.	H	MF/MD	Monitor closely and manage in year	During 2006/07
6	PTS: The demanding income levels within the central services budget may not be achieved.	M	MD	Monitor closely and manage in year	During 2006/07
7	Until more details of some capital projects are known, the levels of VAT and its recovery cannot be forecast accurately.	L			
8	Some capital projects agreed as part of the 2006/07 Capital Programme may have revenue cost implications.	L	MD	Monitor expenditure in year and identify possible revenue costs.	During 2006/07
9	Until tenders for each project are received, there is the possibility that costs will increase.	M	MD	Hold some capital back for this uncertainty	During 2006/07
10	Subsistence budget will materially overspend due to the non-introduction of meal breaks from 1st Oct 2006	H	MD		During 2006/07

Enclosure 10

London Ambulance Service NHS TRUST

TRUST BOARD 25th July, 2006

PROPOSALS FOR COMMISSIONING ARRANGEMENTS IN LONDON AND LAS RESPONSE

1. Sponsoring Executive Director: Mike Dinan

2. Purpose: For noting

3. Summary

Attached are two papers: the London PCTs' proposals *"London: Commissioning for Health"* and the LAS response to the paper

Although the proposals include greater co-ordination of commissioning and better business support to the process, they are a little disappointing from the LAS point of view as they suggest that commissioning of the LAS is likely to continue in much the same way as now.

This means that the opportunity may be lost to make radical changes to the provision of urgent and emergency care in London.

The LAS response makes this point and sets out the arguments for more central, strategic commissioning of urgent care services.

4. Recommendation

THAT the Trust Board note the attached papers

NHS
Londonwide PCTs

London: Commissioning for Health

Developing world-class commissioning to improve the health of Londoners

June 2006

London: Commissioning for Health

Contents

1 Executive Summary

London PCTs have agreed to strengthen their commissioning functions to improve the health of Londoners and reduce health inequalities in the capital. We will do so by developing key elements of the commissioning process, as outlined below. Taken together, they constitute a newly developed **London Commissioning Model.**

- **Effective local partnership arrangements between PCTs and London Boroughs,** developed through Local Area Agreements and focused on improving the health and wellbeing of local people

- **Enhanced strategic commissioning roles of PCT Boards and Professional Executive Committees,** with the voice of patients and the public increasingly influencing strategic commissioning plans, and PCTs fulfilling their responsibilities as the local NHS body accountable to their populations for improvements in health and service delivery

- **Strong primary care and practice based commissioning arrangements**, to raise standards of primary care services across the capital, with front line clinicians driving improvements in services to meet local needs and ensuring appropriate use of NHS resources to maximise health improvement

- **A first class commissioning business process** to provide a high quality, consistent approach to commissioning in London

- **More effective pan PCT and lead commissioning arrangements, underpinned by a newly developed Duty of Partnership**, with a London wide Commissioning Group and 5 Local Commissioning Groups established to bring PCTs together where appropriate to plan and commission services collaboratively. Lead commissioning arrangements will be further developed to streamline the relationships between the 31 London PCTs and service providers. It is proposed that Local Commissioning Groups align with existing 'Turnberg' sectors, based on current acute and tertiary care patient flows[1]. The Local Commissioning Groups will also work across sector boundaries when required.

- **A highly performing Commissioning Business Service** developed across London to provide PCTs with a range of expertise and skills to support them in their commissioning functions

  This paper outlines proposals for the development of this London Commissioning Model to deliver a world class commissioning process across London.

[1] We have carried out a brief analysis to confirm that this is sensible, and details are available from the project group.

1 London PCTs recognise the need to strengthen commissioning to drive improvements in health and service delivery in line with *Commissioning a Patient led NHS*, the White Paper*, Our Health, Our Care, Our Say,* and the need to address the current critical financial and capacity challenges in London. The retention of borough- based PCTs with their local knowledge and local relationships, combined with strengthened and more effective collaborative commissioning arrangements provides a unique opportunity to achieve significant improvements in the range and quality of health services in London. PCTs need to make a step change in their commissioning capacity and capability to secure greater leverage with service providers, and to ensure their Fitness for Purpose as effective commissioners.

2 The model we propose will be cost-neutral or better across London, but individual PCTs will need to make commitments to invest if necessary, given the differing levels of current investment. We will prepare a business case for the development of the Commissioning Business Service (CBS) early in the implementation programme, and ask PCT Boards to approve it. Within the business case there will be a baseline assessment of current costs and outcomes, which will include all costs associated with commissioning, including network support. The business case will seek to achieve significant reductions in transaction costs across London, as well as supporting the development of stronger and more effective commissioning of all services.

3 The approach to the development of the Commissioning Business Service will be iterative, and there will be opportunities for discussion between PCTs and Practice-based Commissioners, Local Authorities and the SHA about the range of services that the CBS will provide.

4 The establishment of the London and Local Commissioning Groups, together with the Commissioning Business Service will support PCTs to deliver more effective commissioning by achieving collective impact where it is required. Commissioners in the new model will be expected to apply consistent quality and efficiency standards in commissioning at all levels, from London wide specialised services to the commissioning of primary care and joint commissioning with Local Authorities, in all cases recognising the fundamental importance of the patient care pathway.

5 Our key principles are:

- **Addressing Health Inequalities and improving Londoners' Health**
  London's communities are highly diverse and the commissioning model must be able to respond to that. It will support wider work to tackle health inequalities and social exclusion

- **Focusing on Patient Pathways, Quality and Choice**
  We should ensure that our commissioning is innovative, based on best practice and led by patient needs and expectations.
- **Spending Londoners' money well, and reducing bureaucracy by doing it once**
  Londoners should expect PCTs to commission services which are responsive to their individual and collective needs, are effective, deliver value for money and are affordable
- **Commissioning on integrated basis with Local Authorities**
  Local partnerships and services built up since the introduction of PCTs should be strengthened and supported, not replaced, by collaborative arrangements in local sectors and across London
- **Developing new markets**
  New primary care contracts and the impact of the White Paper make it imperative that PCTs work together to manage the market and develop new providers from both traditional and new sectors. Working together will give the scale and leverage required to work effectively both in these new markets and with existing providers, including Foundation Trusts.
- **Focusing on specific challenges – for example mental health, TB, prison health**
  The new model will be introduced with an agreed prospective programme of work where London has specific challenges to address

6 We have developed this model on the approach agreed in January 2006. The proposals build on:

- The London wide collaborative commissioning arrangements developed for 2006/07, including publication of pan London commissioning intentions and the implementation of lead commissioning arrangements;
- A review of commissioning business process models carried out by Matrix[2];
- Publication of the White Paper *Our Health, Our Care, Our Say;*
- The Department of Health confirmation of PCT functions issued in early May;
- The recommendations of the Warner review of specialised services commissioning, which has recently been published;
- The PCT Fitness for Purpose programme, which sets out key assessment criteria for effective commissioning.
- Our understanding of the requirements of the DH 'Commissioning Framework' due to be issued in July

7 Section 2 describes the **specific aims** of London PCTs in commissioning services to improve health, reduce health inequalities and improve the experience of patients.

[2] The matrix document (*a Unified Commissioning Model for London / a strategic overview)* is available from the project group.

8 Sections 3 to 6 ('Developing Our Commissioning Capability') set out the **key elements** of the proposed London Commissioning Model, consistent with the PCT **Fitness for Purpose Assessment Framework**. The model delivers effective commissioning across strategic planning, care pathway management, provider management, monitoring and remediation activities. The Matrix review of international commissioning models (undertaken as part of this commissioning workstream) indicates that these proposals will be consistent with best practice in the international context.

9 Section 7 sets out proposals for a **Duty of Partnership** between London PCTs to ensure that our collaborative commissioning arrangements are effective. The Duty of Partnership is not a complex set of rules or mechanisms – it supports and enables PCTs to commission collaboratively to maximise their position in the health market and achieve their organisational objectives. Also included are the proposed Terms of Reference for the Local and the London Commissioning Groups. The proposed timetable for implementation of these proposals is as follows:

- PCT Boards' approval of these proposals by August
- Discussions with stakeholders and partners during July to September to ensure wide involvement in the development of the model;
- Establishment of the London and Local Commissioning Groups by October 2006 to lead the 2007/08 commissioning business process
- Development of a costed Commissioning Business Service (CBS) specification and proposed implementation plan by the end of October 2006;
- A review of commissioning skills by October 2006;
- Review and evaluation of proposals in place by March 2007 to ensure that the introduction of the new model is properly tested against our objectives.

2 Our Commissioning Aims

10 Our commissioning challenge is to make the best use for our communities of the £10 billion that the NHS invests each year in London, to achieve significant improvements in the health of Londoners and to improve the quality of the patient experience. Our new London Commissioning model will need to ensure delivery of these key aims and to do so, it will need to respond to the following challenges.

11 **Meeting the needs of our Population**

London's current resident population of 7.4 million is highly mobile, **with 20-40% p.a**. **turnover on GP lists**. London is ethnically diverse – almost **40% of people are from an ethnic minority**, with over 90 different ethnic groups and 300 different languages spoken. **Three hundred thousand Londoners** arrived here from overseas in the last 5 years, and the population is increasing more rapidly than in any other city – by 2016 we anticipate over 800,000 more London residents, the equivalent of a city the size of Leeds. We are also responsible for commissioning services for the estimated **1 million daily commuters** to London and the **13.1 million tourists coming every year.**

12 London is **relatively young -** 27% of people are aged between 20 and 34 years compared with 20% in England as a whole. Many are living in poor housing - 60% of England's homeless households in temporary accommodation are in London. Many are living in poverty - **41% of children in London live in households below the poverty line.** There are profound inequalities within and between boroughs: Tower Hamlets, Hackney and Islington are in the **10 most deprived local authorities** in England, whereas others are amongst the best off.

13 Improving Health and Reducing Health Inequalities

Average life expectancy in London is similar to the national figure, but the average masks significant differences across London. Kensington and Chelsea has the highest life expectancy in England, but as you travel by Underground on the Jubilee line from Westminster to Canning Town, **each of the 8 stops represents nearly a year's drop in life expectancy**. Similarly, the infant mortality rate varies considerably across London despite London having a similar rate to England (5.4 and 5.2 per 1000 live births respectively). The rate in Southwark (8.1) is 2 and half times that in nearby Wandsworth (3.2).

14 Premature deaths from circulatory diseases are higher in London (103 as against 97 per 100,000 in England), with a **2.5 times difference between the London boroughs with the lowest and highest rates** (Bromley 66, Tower Hamlets 161). Perhaps more worryingly, mortality

is falling more slowly than in England in some of the areas with the highest rates, implying that inequalities may well widen.

15 Whilst *on average* health in London does not compare too badly with the UK, some health problems are particularly profound. For example **incidence of TB is over two and a half times the national average and up to seven times higher** in some boroughs**; nearly half of new cases of HIV** are resident in London; rates of other sexually transmitted disease are substantially higher than elsewhere, as is the prevalence of drug use; one in four adult drug users live in London. The prevalence of mental illness is higher than elsewhere, particularly psychotic disorders**: the rate of compulsory admissions is twice that of any of any other region**.

16 To deliver improved health and reduced health inequalities, we need to emphasise preventing ill health, ensuring early intervention, and managing chronic diseases. The White Paper '*Our Health, Our care, Our say*: *a new direction for community services*' emphasises the need over time for growth in health spending to be directed more towards preventative, primary, community and social care. In addition it underlines the importance of stronger joint local commissioning between PCTs and local government, and improved joint working between the NHS, local government and the voluntary sector; with the need for the patient's voice to be central to commissioning decisions.

17 Local borough-based PCTs, working with Local Authorities, have the central role in strategic planning to meet health needs. The approach should be population-based, taking as its starting points the determinants of health, health status and the current performance of health promoting and health service interventions to improve health and reduce inequalities.

18 A commissioning strategy on this model needs to assess where investment will have most **impact** in terms of health improvement and reducing health inequalities. We propose an approach to commissioning which does this, and which makes those aims the key drivers for investment decisions.

19 **Restoring financial stability and review strategic configuration** - PCTs' responsibilities for strategic commissioning mean that they must ensure that their commissioning plans meet the needs of their local communities, and are also consistent with the health resources available. Overcapacity and duplication exist in some parts of the system. Restoring financial balance in London will require hard choices and imaginative proposals about whether the current service configuration can be sustained. PCTs will need to take the lead in this process through the commissioning decisions that they make.

20 **Reducing variations in performance and cost across all services -** Reviews of performance and cost across London providers consistently

reveal significant differences. PCTs will need to contest these variations from best practice and financial prudence, to ensure that equity in standards and cost are achieved. We must also recognise that there is significant variation in the present capacity and capability of PCTs as commissioners, and recognise the value of collaborative working in achieving the full benefit of scarce skills and abilities across London.

21 **Stimulating the market and developing choice.** We must ensure the greater involvement of primary care professionals, the public and of patients in redesigning care pathways. The Practice Based Commissioning and Choice initiatives will lead to exciting and innovative ways of working in which PCTs will have the critical role, working closely with health providers, both existing and new to the market, to create, manage and modify services in response to these fundamental initiatives. Key to this will be the further expansion of plurality in NHS provision, with the role of the voluntary and independent sector market developing further to meet specific needs in London.

3 London PCTs – Developing Our Commissioning Capability

22 This section outlines the roles of PCTs, their local partners and clinicians in developing more effective commissioning arrangements as outlined in the first 3 elements of the proposed London Commissioning Model (see Executive Summary). These are as follows:

- Effective local partnership arrangements between London PCTs and the London Boroughs, focused on improving the health and wellbeing of local populations
- Enhanced strategic commissioning roles of PCT Boards and Professional Executive Committees (PECs)
- Strong primary care and practice-based commissioning arrangements

For each of the elements we look at how they will fit within the proposed London commissioning model, and the nature of agreements required between partners.

Effective local partnership arrangements

Partnership Arrangements with Local Authorities

23 PCTs are the leaders of the local NHS, and work in partnership with Local Authorities to improve the health and healthcare of the communities they serve. PCTs discharge this responsibility in a variety of ways, but remain the accountable body for health improvement and healthcare services in their area. The specific benefits of the decision to retain borough based PCTs need to be embodied in our models of **joint commissioning**, and the commissioning and providing relationships between PCTs and their Borough partners will be enhanced and developed through this model.

24 In line with the *White Paper* and the *Every Child Matters* agenda, there must be a joint process between PCTs and Local Authorities to agree appropriate commissioning arrangements for the following services in order to deliver agreed strategic health outcomes for their population

- Mental health
- Learning disabilities
- Physical disabilities
- Drugs and alcohol
- Older people
- Children and young people
- HIV/AIDS

25 The relationship between the proposed new Londonwide structures, the PCTs and their partners will need to be developed with Local

Authority colleagues early in the development process. We will ensure that the work of the Commissioning Business Service helps to add consistency and value not only to NHS commissioning but also to the wider range of services commissioned by and with Local Authority partners, including third sector providers.

26 This, and the present direction of travel towards joint appointment of Public Health professionals, will improve the ability of PCTs and their local partners to work together in tackling social exclusion and improving health. This will require integrated approaches at local level, focused within boroughs, reflected in Local Area Agreements and in integrated approaches to commissioning and providing local services across traditional organisational boundaries.

27 This whole system approach is crucial to meeting the strategic commissioning aims outlined in section 2, supports care pathway management in commissioning and extends the care which be provided outside the hospital setting, enabling commissioners to rebalance the health and social care system.

Enhanced Commissioning Roles of PCT Boards and Professional Executive Committees

28 **Individual PCTs are the local centre of accountability for NHS Services** – ensuring that their commissioning plans meet the needs of their local communities, achieve improvements in health and service provision and are delivered within available financial resources. *Commissioning a Patient-led NHS* places patients and the public at the centre of the commissioning process; and the development of Practice-based Commissioning will strengthen local clinical engagement.

29 PCTs will find new ways to involve patients and the public in these enhanced commissioning structures, and the implementation programme for the new commissioning model will ensure that there is a Londonwide as well as local process for ensuring real engagement with Londoners.

30 Many PCTs in London are currently reviewing their corporate structures to ensure that they will meet their requirements both in terms of financial balance and Fitness for Purpose. This means that there will be:

- A clearer division between commissioning and providing roles at all levels within PCTs;
- Strengthened PEC structures to enhance the role of the PEC as the clinical commissioning arm of the PCT, and to ensure that the PCT priorities and strategic commissioning framework have broad clinical support;

- A clearer role for PCT Boards in ensuring that commissioning is effective and outcome focused.

Primary care and Practice-based Commissioning

The commissioning of Primary Care

31 PCTs have been facing major changes in their commissioning and provider roles as a result of *Commissioning a Patient-led NHS,* and although there is no longer an obligation on PCTs to divest themselves of all provider functions, there must now be a clear, formal separation within the PCT between commissioning and service management functions[3]. This of course will have a specific impact on the *commissioning* of primary care, where traditionally the knowledge and skills in PCTs have been found in service development and provision, rather than in commissioning. It will be absolutely critical to the development of services in primary and community care, in line with the White Paper, that the commissioning of these services embraces the same standards of quality, effectiveness and value for money as it does for Acute, Mental Health and Foundation Trusts.

32 The London PCTs are working together to define excellence in the commissioning of primary care and what changes PCTs need to make to improve the quality of primary care consistently across London The responsibility for commissioning Primary Medical Services, of course, has not been devolved to practices and is fully retained at PCT level.

33 Given that the performance management of contracts in primary and community care must be as robust as it is elsewhere, this is an area where a collective approach will be particularly helpful in ensuring that local performance management structures, whilst recognising particular local issues, are consistent with objective quality standards.

34 The workstream will deliver a commissioning framework, a skill set, and the options for the level at which the commissioning of primary care can be carried out. This framework will be consistent with the structures described here, whilst recognising the different issues in the commissioning of primary care contractors.

35 The framework will pick up how we tackle issues such as entry to and exit from the market, the PCT role in supporting practices, the statutory requirements of contracts, service specifications and the approach to pricing. We will define the significant levers for change, and set out an approach to performance management (including the recommended indicators) consistently across London.

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[3] *Our Health our Care Our Say, January 2006, para 7.90*

36 Some significant issues that have emerged so far include:

- Contestability
- How to address the question of the optimum size of primary care providers;
- The involvement of patients at this critical level;
- The balance between commissioning and managing a national contract;
- The commissioning of self-care.

37 All of these issues must be considered across the whole range of primary care providers – the commissioning of primary care must not be seen as just being about GPs, and is about all the Family Health Service (FHS) practitioners - GPs, dentists, pharmacists, and optometrists. The different contract arrangements across the range of FHS services will need to be effectively managed, but throughout all of this we need to be really explicit about commissioning for improved outcomes and care pathway management. Quality and access need to improve and there need to be more consistently high quality services available for Londoners.

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38 This approach will also apply to directly provided (community) services, and we will need to use the new collaborative commissioning structures to make sure that there is a wide spectrum of provision based on patient needs and the building of capacity, rather than on purely historic models of care. This will develop more integrated services across the NHS and social care, build capacity in the voluntary and third sector providers and develop interfaces between primary care and hospital care, using practice-based commissioning to build (and manage) new care pathways that are patient rather than provider focused.

Strong practice based commissioning arrangements

39 Practices that participate in Practice-based Commissioning are allocated an indicative budget and are given the opportunity to redesign services to better meet the needs of their patients. However, responsibility for contracting for services is retained by PCTs.

The aim of **practice-based commissioning** is to improve the health of local people and improve health services, and Practice-based Commissioning will work only if it is directly driven by clinicians. The new commissioning model must avoid the risks of:

- Setting up collaborative structures that do not have the flexibility and capacity to respond to local clinical issues – the ‘lowest common denominator’ error,
- Allowing the new structures to lead rather than follow the intentions and requirements of the PCTs’ service change strategies.

40 Similarly, PCTs will have to ensure that their own PBC groups are linked into these service change strategies, and that the relationships between the PBC groups, the PCT and the collaborative structures are absolutely clear.

41 Practice based commissioning may also become the **key driver of change towards a preventive commissioning strategy**, and this must be recognised in how the new model is shaped – particularly in the delivery of accurate, timely and systematic data analysis and commissioning information.

42 We must recognise that Practice-based Commissioning is a **key element of the system reform programme** currently being implemented across the NHS. It is a key mechanism for delivering more care outside of hospital. Elements of the framework for this form of commissioning will need to be consistent across PCTs, and one aim of the pan-PCT commissioning proposals is to ensure that there are mechanisms in place to deliver this consistency where required.

43 Implementing PBC successfully is a major challenge for PCTs. We have to ensure that practice based commissioners operate within a coherent service framework and support delivery of national priorities. However, practices must also have the power and ability to make local changes to improve services. Practice-based Commissioning has the potential to unlock innovation in primary care if the commissioners are given the support and freedom to act. The challenge for PCTs is to develop a strategic framework within which practice based commissioners can be given flexibility to develop local service solutions.

44 PCTs in London have encouraged GP practices to work together in commissioning clusters, and the majority of practices have now agreed to work together with neighbouring practices in local groups. However, while many services will appropriately be shaped at this type of 'cluster' level, the individual practice remains the building block for Practice-based Commissioning. Where possible, individual practices will be given the opportunity to use PBC to improve services for their patients.

45 Practice-based commissioning will therefore be supported and not led by the three new structures proposed here, and practice commissioners must be closely involved in the early stages of establishing the Local Commissioning Groups and setting out the detailed functions of the Commissioning Business service. **The relationship between the CBS and local PBC groups will be a key indicator of the ability of the model to deliver true patient-led NHS care**.

4 A first class Commissioning Business Process

46 We want to ensure that we have a consistent and clear definition of commissioning activities carried out by PCTs and practice based commissioners, working collaboratively with each other and with Local Authorities We therefore propose that London PCTs adopt the Commissioning Business Model set out in the *Fitness for Purpose* review. This will help us to be clear that 'commissioning' covers a wide range of activities undertaken at various levels – from practice, or Borough to pan- London and even national levels for highly specialised services.

47 This Commissioning Business Model is outlined below – illustrating the cycle of commissioning activities required. We will develop this model further over the coming months to produce a consistent annual commissioning cycle to align these various activities appropriately, so that London PCTs are best placed to maximise their commissioning leverage and meet the challenges outlined earlier. This will be complemented by the Fitness for Purpose review process, which will help PCTs to identify and plan for their development needs to perform an enhanced commissioning role.

48 The proposed Commissioning Business Service (CBS) will support the range of commissioning activities and levels of commissioning within the London Commissioning model. The proposed functions of the Commissioning Business Service are set out in section 6 of this paper.

49 The Commissioning Business Process incorporates the following key components:

- Strategic planning
- Care pathway management
- Provider management
- Monitoring

Each of these components is outlined below.

Strategic Planning

50 The strategic planning role of PCTs is critical to ensuring that PCT commissioning plans meet the needs of their local communities, achieve improvements in health and service provision and are delivered within available financial resources. Strategic planning activities include assessing the needs of the population by review of a range of health indicators and service metrics and securing the views of service users and local people to inform future priorities. PCTs will

work closely with Local Authorities to align their commissioning plans and resources, where appropriate.

The PCT's strategic planning role will also involve clinicians – including PbC commissioners – to ensure that there is a unified 'commissioner' strategic approach in place. PECs will also play a key role in providing PCT Boards with strategic clinical commissioning input.

51 PCT strategic plans will need to articulate the health and service outcomes to be achieved for the benefit of local populations over a medium to long term basis, recognising that measures to reduce health inequalities will require a focused and sustained strategic approach. Strategic plans will be developed jointly with Local Authority partners, based on agreed outcomes to be achieved in improving the health and wellbeing of local people.

52 PCTs will implement their strategic commissioning intentions by developing 'operational' plans, which will detail the PCT's key commissioning plans and priorities over the following 1 – 3 year business cycle. These operational plans will be known as the PCT's Commissioning Prospectuses, and will be produced and widely consulted on by PCTs on an annual basis. These prospectuses (informed by systematic feedback from patients, carers, and GPs) will provide a powerful vehicle for the voice of patients and local communities.

53 London wide priorities will be agreed by the London PCTs and the SHA, and will be incorporated into all PCT prospectuses; they will feed into the annual London wide commissioning intentions.

Care Pathway Management

54 Over the next 2-3 years, the NHS commissioning process will develop further, underpinned by the effective implementation of Practice based Commissioning, the roll out of Payment by Results across all services (with the potential unbundling of some tariffs for 2007/08), the Choice agenda and Foundation Trusts.

55 Practice-based commissioners will increasingly take the lead for the development of new care pathways, which will deliver improvements in the quality of the patient experience, improved health outcomes and more cost effective use of NHS resources. These new care pathways will be consistent with the direction of travel in the White Paper and jointly planned and commissioned with social care -developing more services close to where people live, and ensuring high quality specialised services to support these local arrangements.

56 We will need to ensure that care pathway management across London is consistent, so that commissioners and providers can ensure the following:

- Delivery of the 18 week waiting time target by 2008, including the key role that diagnostics will play in reducing waits within current patient pathways;
- Effective referral management from primary care to hospital services – to ensure the management of appropriate referrals and thereby the effective utilisation of hospital resources
- Effective care for people with long term health conditions – to significantly reduce the level of unplanned admissions to hospital
- An integrated urgent care system which is responsible to the needs of individuals and communities at a local level.

57 New care pathways will articulate the patient 'journey' across primary, secondary and tertiary care – they will place patients at the centre of the commissioning process to ensure that these key requirements can be met.

Provider Management

58 PCTs will bring together their annual plans (as detailed in the Commissioning Prospectus and PbC care pathway plans) into service and activity requirements, which in turn will feed into the contracts to be negotiated with NHS and Foundation Trusts.

59 The Commissioning Business Service (when fully developed) will provide PCTs with a range of information on the performance of providers which will inform priorities for commissioning, for example, services that are poorly performing or not meeting population needs are likely to be subject to a service review/ development of a service specification and procurement process. The CBS will support PCTs to work with providers to assure the quality of services and improve standards.

60 The CBS will provide expertise in contract development and negotiation, supporting the lead commissioner arrangements which will be further developed to provide a single commissioner/ provider relationship for Acute Hospital Trusts in London. These lead commissioner relationships will also be developed for Mental Health NHS Trusts for 2007/08. Lead commissioning arrangements for mental health services will reflect the context of joint commissioning relationships and section 31 arrangements in place between PCTs and Local Authorities Further discussions will be held with Local Authority colleagues and Mental Health Trusts to agree the model of lead commissioning .

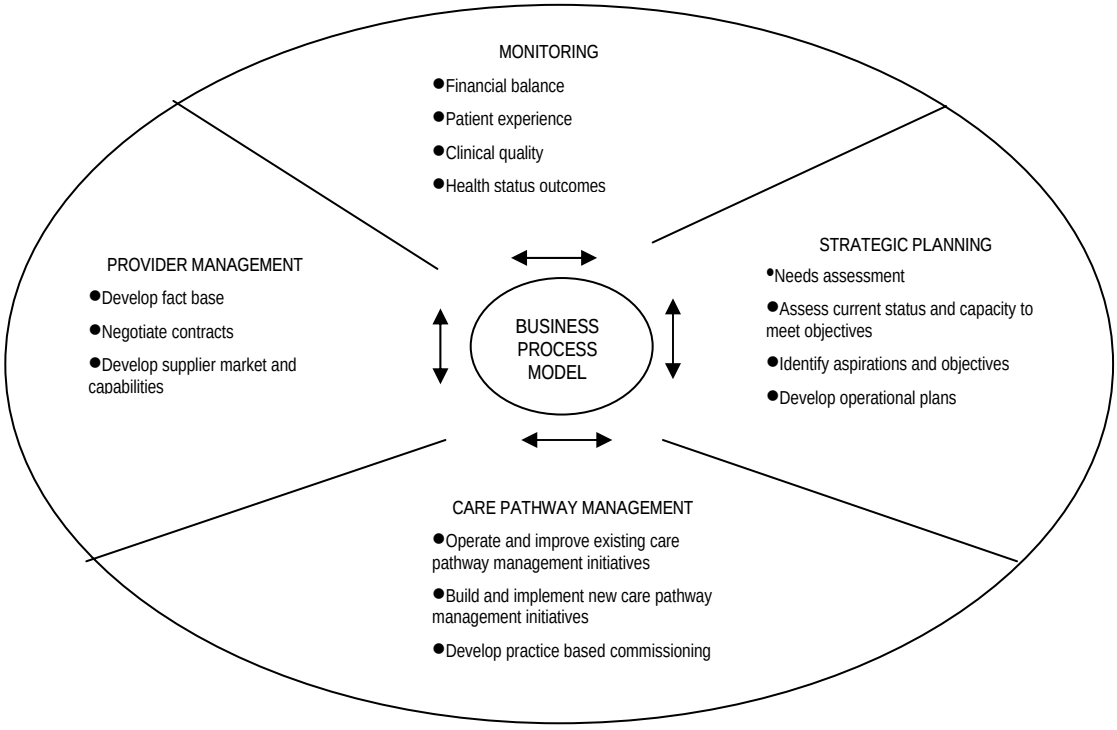
61 The CBS will also provide a role in supporting PCTs, Practice- based commissioners and Local Authorities to develop new markets to meet local needs.

Monitoring

62 PCTs will strengthen their monitoring of providers to ensure that agreed contracts deliver the outcomes prescribed in service specifications. This will include activity and financial monitoring, taking remedial measures where needed to ensure that contracts are fulfilled according to agreed plans.

63 In addition, the quality of services, patient experience and health outcomes will increasingly be monitored on a regular and systematic basis by the lead commissioner, supported by information and expertise secured from the Commissioning Business Service. The contract agreed between commissioners and providers will identify remedial measures to be taken, should the contract underperform on quality and performance indicators.

64 These monitoring indicators will be reviewed with providers as part of the ongoing contract review process and will feed into the future commissioning plans of PCTs.



Diagrammatic representation of the four main commissioning functions

5 Pan- PCT and lead commissioning arrangements

65 This section sets out our basic organisational proposals (the 'building blocks') for Londonwide commissioning arrangements, as follows:

- The role of the London Commissioning Group and the SHA;
- The role of the Local Commissioning Groups
- Lead Commissioning arrangements
- Performance management, scrutiny and overview, fitness for purpose and financial stewardship.

The London Commissioning Group

66 The London PCTs have agreed that they will be more effective in discharging their key responsibilities by establishing more effective collaborative commissioning arrangements. However, a variety of different approaches to collaborative commissioning currently exists across London. Different approaches are also in place for clinical networks and the degree to which they are co-ordinated on a sector and London basis**.**

67 We therefore propose that a Londonwide Commissioning Group be established, with the following terms of Reference:

- Oversee the London wide commissioning process, and ensure that there is "fit " between local plans;
- Undertake an annual 'horizon scanning' process to identify prospective commissioning priorities, with input from all London PCTs to form the basis of annual London wide Commissioning Intentions;
- Market manage on a London wide basis, where appropriate, and ensure that a comprehensive range of patient services exists within reasonable access of all Londoners;
- Stimulate the market on a London wide basis where necessary to align capacity and resources.
- Take the lead for specialised commissioning activities on a London wide basis, as set out in the recommendations of the Warner Review.

68 The London Commissioning Group will also help support the relationship of commissioners with the London SHA, but this will not

intervene in the normal relationship between PCTs and the SHA, and its role will be limited to the commissioning agenda.

69 Membership of the London Commissioning Group will be representative of the Local Commissioning Groups (see next section, paragraph 69 onwards), and the SHA. The London Commissioning Group will co-opt members (from, for example, the Commissioning Business Service and the Specialised Commissioning Group) or invite external attendance on specific issues.

Local Commissioning Groups

70 PCTs are the **strategic planners** and leaders of the local NHS, as well as relationship managers**,** meeting the health needs of their populations through their commissioning and contractual arrangements and within the context of Foundation Trusts, Payment by Results, Independent Sector providers, joint commissioning arrangements, practice based commissioning and primary care commissioning. Our proposals recognise these responsibilities, and will strengthen support for PCTs in meeting their responsibilities rather than attempting to dilute them.

71 It is proposed to strengthen lead and collaborative commissioning arrangements by establishing **Local Commissioning Groups.** These groups will comprise at least the Chief Executives of a group of PCTs, under an explicit duty of partnership, to agree on shared commissioning arrangements for their populations. The presence of Chief Executives will give the Group the appropriate level of representation, but the Local Commissioning Groups will clearly need to have appropriate input from clinicians and others. Discussions will be held with Local Authority colleagues to agree appropriate pan-borough partnership arrangements. The terms of reference of these Groups and the Duty of Partnership itself are set out in section 7, and there is a descriptive list of the Local Commissioning Groups' range of responsibilities at the end of this section.

72 A key indicator of the success of the commissioning model will be its ability to sustain successful performance across **all levels and elements** of the system. This will mean applying the model not just to the acute, mental health and joint commissioning areas, but also to Practice-based Commissioning and to primary care commissioning, where the issues of collaboration between PCTs are somewhat different. With the milestones set out in the recent White Paper giving a new focus on care outside hospital these are increasingly critical areas, and we have referred already to the need for London's approach to include strong and effective **primary care and Practice-based Commissioning arrangements**

73 For acute services, analysis of patient flows[4] shows that in the main patients seek their care from a relatively limited group of service providers, and initially this will form the basis for the London commissioning sub structure arrangement. At present the data indicates that acute flows still reflect the five 'Turnberg' sectors, and it is therefore sensible to propose that there be five cluster commissioning groups, but it is equally important to recognise that flexibility will be required as the system is established, to reflect new pathways that commissioners will create.

74 The Local Commissioning Groups will ensure that there will be a consistent model for joint working arrangements in each sector, rather than a multitude of different models, and these joint working arrangements will build on the best features of the structure currently in place for specialised commissioning – i.e. a structure that operates at both sector and London wide levels.

An example of how the new London model could operate, drawn from Cardiology Services.

A multi-PCT Local Commissioning Group, following a debate initiated by local clinicians, requests and receives information from the Commissioning Business Service highlighting capacity, performance and cost variation across cardiology services in the 6 acute trusts in the area.

The Local Commissioning Group agrees the need for a service review and draws up a specification agreed with the PECs and Boards stipulating the involvement of the CHD network and PbC commissioners in the review which is commissioned from the Business Service.

The outcome is a proposed service rationalisation across the 6 hospital sites, an agreed care pathway and the development of a Network Heart Attack Centre.

The proposal is discussed by the Local Commissioning Group and remitted to PCT Boards for decision.

75 Specialised commissioning itself will be integrated within these new arrangements and not function separately, either at Local or London Commissioning group levels**.** Each sector currently has a Local Specialised Commissioning Group and there is a London wide Specialised Commissioning Group, which brings together the lead PCT Chief Executives and Directors of Specialised Commissioning in each sector with representatives from the SHAs and NHS Trusts to manage the specialised commissioning agenda on a London wide basis. There

[4] A summary analysis of 2004/05 patient flows is available from the project group

are also a number of pan London and wider specialised services commissioning consortia currently in place which are based on pooled commissioning resources, agreed risk sharing arrangements and collective service agreement/ contractual agreements with Foundation and NHS Trusts. This model is consistent with the findings of Lord Warner's review, and will align with the proposed Local and London Commissioning Groups.

76 **Networks** have developed considerable commissioning expertise essential to establishing the PCT collaborative commissioning arrangements. However, arrangements vary between networks and the staff working for these networks is spread between commissioning and providing organisations. We will need to scope the networks, map out their services and staff, and identify their current funding, and then agree a process and timetable for transition. They will be accountable to the PCT, but it is noted in the descriptions following that 'provider' networks will also have a role, and that role needs to be clarified and defined; it will become a matter for providers rather than commissioners to support these organisations.

77 The overall responsibilities of the Local Commissioning Groups are summarised in the boxes below;

Local Commissioning group responsibilities

Strengthening Lead Commissioning - given the changes and constraints which influenced the 2005/06 commissioning round the Lead Commissioning arrangements proposed and adopted by the London Directors of Commissioning were an important advance and the proposals contained in this document aim to build upon and strengthen this.

Provider Management – ensuring that the range and quality of acute hospital services provided meet population needs (but ensuring local contestability) / reviewing strategic cases for service investment and reconfiguration – market management can take place at a number of levels;

Network management – commissioning clinical networks to deliver on agreed objectives, with clinical networks being accountable to the Commissioning Group – this approach would ensure that there is a clear commissioning rather than provider development role for clinical networks; and the provider network role itself will need to be clarified, with providers themselves taking this responsibility.

Specialised Commissioning – collaborative commissioning for those specialised services needing a planning population of 1 million or less will be undertaken by the Local Commissioning Groups. The Local Commissioning Group will also lead the collaborative commissioning of specialised services, through commissioning consortia or other arrangements, for services needing a planning population of more than 1 million. These commissioning consortia may be London wide, or larger.

Care Pathway management – ensuring consistency and 'fit' in the building and implementation of new care pathway initiatives at PBC, PCT and sector level.

Practice-based Commissioning – agreeing common ground rules where appropriate.

Contract planning – agreeing the aggregated activity, financial and performance requirements to be included in contracts (which might be negotiated by or with the extended support of the Londonwide commissioning business service). This would entail PCTs agreeing the level of financial resources available to feed into the contract planning and negotiating processes/ parameters for variances from resource plans and risk share arrangements

Risk share arrangements and risk management – these will be developed separately, and will emerge appropriately as lead commissioning arrangements are developed.

Contract compliance – receiving regular reports on contract compliance to assess performance against plans and agree action plans where required.

Workforce and skills development – ensuring co-ordinated development and building on the expertise available at PCT Director level across London.

Lead Commissioning

78 In January 2006, PCTs across London (through the Londonwide Directors of Commissioning Group) agreed collaborative arrangements for commissioning in the current round - 2006/07. The PCTs agreed to abide by a set of common rules and business processes, set out in:

- 2006/07 London planning guidelines (issued by SHAs)
- London wide commissioning - Primary Care Trust commissioning intentions 2006-07
- London PCTs Lead Commissioner arrangements.

Lead commissioning in this context means '*the delegation of a PCT's contract negotiation responsibilities with an Acute Trust to a team led by the Trust's host PCT*', with the leading PCT team responsible for developing a clear and specific set of objectives and priorities from those contributed by all PCT commissioners and those contained within London wide commissioning intentions. Once negotiated, all PCTs abide by the final SLA agreed by the host-led team.

79 The 2006/07 planning guidelines included requirements for sector-wide PCT management and co-ordination arrangements to oversee:

- Consolidation of strategic commissioning plans by provider;
- Review of standard documentation;
- Consistency of approach to lead commissioning and practice-based commissioning

80 PCTs reflected these requirements in their Commissioning Intentions, a document developed for the Londonwide PCT directors of Commissioning, and sponsored by PCT Chief Executives from each sector, which set out the strategic context for commissioning, and some underpinning principles. The latter included commitments, for example, that all Service Level Agreements and Contracts should:

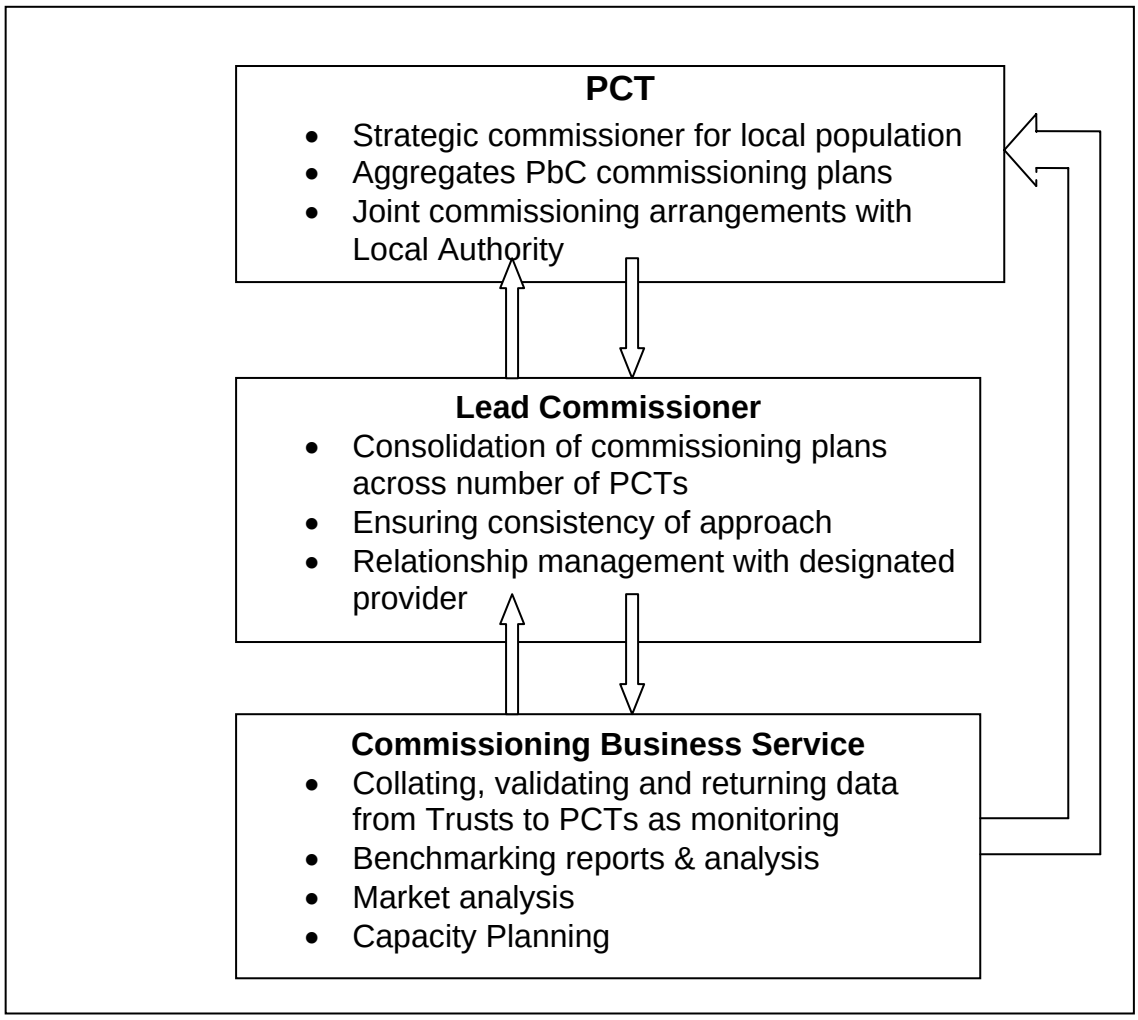
- Reflect the principles of key policy initiatives including Payment by Results (PbR), PbC, Choice, Plurality, the roll out of Foundation Trust (FT) status and the development of Integrated Service Improvement Programmes;
- Manage imperfections in the health market and individual policy areas in a fair and practical manner, in order to ensure organisations are able to fulfil their statutory responsibilities, including the achievement of key performance targets, financial balance and long term sustainability.
- Support the development of more effective strategic commissioning for services best planned for larger populations and the managed introduction of new technologies.
- Support the development of high quality services that are convenient for people to use, making use of best practice models of care and cost effective design and delivery.
- Support improved public involvement in the design, development delivery and performance management of health and healthcare services to local populations.
- Recognise the responsibility of the Trusts to provide evidence that activity has taken place which is payable by the PCT; and the need for PCTs to manage demand for services with the support of service providers

81 The Commissioning Intentions also set out key priorities for acute commissioning, and were a first stage of commitment by PCTs to the development of lead commissioning arrangements across London. They were accompanied by management arrangements, and

agreements on the respective responsibilities of lead and supporting commissioner PCTs.

82 The proposal in this document is that we adopt and improve on these arrangements through the Local Commissioning Groups and the London Commissioning Group, but strengthen their supporting infrastructure through the Commissioning Business Service. We also propose that lead commissioning arrangements are extended to (for example) Mental Health Trusts, and have set out below how these relationships would look under the new arrangements.

Flowchart of Relationships between PCT, Lead Commissioner & CBS



83 The current lead commissioner arrangements as established for the 2006/07 commissioning round are listed in Appendix A

.**Performance management, scrutiny and overview**

84 **Performance Management.** It is important to be clear that the proposed London Commissioning Group will not substitute for the

London SHA's Performance Management function, although it may be a forum for discussion on performance. We assume that the SHA will continue to work directly with PCTs, as the 'local headquarters of the NHS', The SHA would have an arbitration role in disputes resolution between members of Local Commissioning Groups.

85 **Overview and Scrutiny.** PCTs will maintain their existing relationships with Borough Overview and Scrutiny Committees. In the event that collective arrangements for scrutiny across a number of Local Authorities are needed in relation to service changes affecting populations greater than that of one single borough, discussion will be held with the Local Authorities involved to agree appropriate arrangements.

86 **Financial Stewardship.** There is no proposal in either the collaborative arrangements described here or in the Duty of Partnership for any change in the PCTs' accountability for their own financial balance, or for their effective local use of resources. In the immediate development of the Duty of Partnership and the creation of Local Commissioning Groups and the Commissioning Business Service, we will take careful note of the McKinsey standards for Governance Assessment, and ensure that the model is in line with the standards for financial governance

6 A highly performing commissioning business service

87 A London wide commissioning business service will be established to bring together expertise and knowledge better to support PCTs in their commissioning role. This proposed model of functions draws from similar arrangements being developed in Manchester and Birmingham.

88 The key functions of the proposed London Commissioning Business Support Service (CBS) must support the four main commissioning tasks:

Strategic Planning	A local activity supported by the Commissioning Business Service and then potentially aggregated to a sector or London level;
Monitoring:	The CBS has a supporting role in combining local intelligence to provide Londonwide coverage and analysis;
Care Pathway Management	Developed on a local basis and then shared or rolled out more widely
Provider Management	Using local intelligence aligned with wide information – for example benchmarking data.

89 **The Commissioning Business Service will be accountable directly to PCTs,** and will not form a separate 'commissioning' organisation. PCTs will performance manage the CBS, possibly through the London Commissioning Group.

90 PCTs will need to resource the CBS, and we will produce a business case by October 2006, setting out how its functions will be linked to and integrated with –

- Information 'hubs' across London, including new PCT/PBC information systems;
- Londonwide Public Health functions;
- Development of clinical efficiency benchmarks through other strands of the Londonwide work programme

91 Our outline implementation programme recognises that there will need to be a comprehensive review of existing support arrangements, before the service specification can be tested with commissioners and stakeholders, and this is therefore a preliminary set of functions. We are clear however that the correct specification will bring improvements in quality and reductions in transaction costs

92 The development of the CBS will necessarily be iterative, and by listing out commissioning support functions here, we do not imply that all of

them will be carried out by the CBS in the first phase of its development. The Public Health workstream will be working in parallel to develop the panLondon and PCT Public Health functions, and we will need to co-ordinate how these and the CBS will work together most effectively. We will concentrate in the initial implementation programme on aggregating where possible those functions that can bring early gains to the lead commissioning process, and there will be a process of agreement and amendment as the service specification is drawn up

93 Public health and service intelligence, strategic analysis and market management support

- Public health intelligence to support value added commissioning approach, clinical engagement; including 'horizon scanning' systems and policy/clinical development reporting and updating; workshops/seminars and commissioner guidance publications
- Public health led needs assessment, critical appraisal of effectiveness and cost effectiveness, health economics, independent clinical advice, best practice in care pathway management;
- Information - to include data cleaning, analysis and handling, health determinants, health needs, health service activity, quality and outcomes data, statistics
- Effectiveness and quality analysis, utilisation analysis;
- Capacity analysis, modelling of future demand and patient flows including analytical systems for population risk stratification
- Performance reporting
- Provider and market intelligence/analysis, including input and response to major capital investment appraisal on appropriate aggregation scales

94 Service specifications, standards of clinical effectiveness, quality assurance The role of the CBS here is to support and provide expertise to PCTs, not to take from the PCT the authority or responsibility for the management of care pathways. The supporting role as far as Practice-based Commissioning is concerned will centre on the development and dissemination of the evidence base and of best practice; and the CBS role in the development of community services will be similarly based. The CBS will clearly have a role in the operational delivery of Healthcare Commission standards and policy.

- Utilisation management
- Network accreditation and liaison
- Standards specification
- Expertise in specialised/tertiary services
- Benchmarking
- Key quality assurance processes inc primary care support
- Support for service analysis/pathways

- Expertise to support local development of evidence based services at PCT, Borough, practice and PBC levels
- Development of service specifications in contracts reflecting agreed protocols and care pathways, including Practice-based Commissioning service plans
- Specification of quality standards in contracts together with legally robust incentives/penalties structures
- Contract negotiation and competitive tendering support
- Hold and develop PbR understanding and expertise including in relation to tariff unbundling and fitting PbR to service redesign

95 **Contracting support and management** There will not be a 'big-bang' approach to the Londonwide development of data and information resources, but the CBS will rapidly develop central analysis functions where they do not exist or are in short supply locally, and will procure and provide advice and technical support where it makes sense to 'do it once' across London. Support to local services where these remain the best option will be generic (training, validation, etc)

- Utilisation/capacity planning;
- Contracting;
- Back-office information systems and data-processing;
- Audit and analyse PBR claims and ensure robust application of Assurance System locally;
- Clearing house for data dispute resolution;
- Production of contract monitoring reports;
- Local negotiation support services;
- Support for Practice-based Commissioning consortia;
- PbR audit ;
- Obtain/provide legal advice;
- Receipt, validation and triggering payment of provider bills in line with contract terms (in conjunction with national system), including SUS deadlines;
- Maintenance of Directory of Services.

96 The **central delivery** of these functions will:

- Develop and deliver a high quality analytical specification that can be used as a basis for prioritisation by all commissioning bodies (i.e. identify the scope for improvement for different market segments);
- Accelerate innovation in commissioning capability;
- Reduce duplication and costs; and
- Free commissioning time to focus upon tackling strategic challenges.

97 The Commissioning Business Service will support the development of the commissioning Prospectus, which will be a key driver at three specific levels – practice based commissioning, PCT and London-wide, and will be a signal to the market about how commissioners intend to

shape services during the next 1-3 years. The combination of Londonwide and more local sector-based activity offers us flexibility for the future, and can evolve over time as commissioners' needs develop.

98 As part of the development of the business case for the CBS, we will undertake an appraisal to confirm which of the functions outlined above should be delivered **once** across London, and which might be best delivered more locally in support of PCT cluster arrangements. Criteria for this appraisal will include:

- Scope of intelligence/ analysis needed – i.e. local or London wide
- Best use of scarce resources
- Ensuring close client relationships with the London PCTs

99 Information systems across London will be the key enabler of the CBS, and the Matrix review[5] (section on *Strategic commissioning information requirements*) contains an analysis of the type and levels of information that need to be generated by the commissioning business service. The business case will also need to indicate how diverse information standards and mechanisms across Trusts, PCTs and the SHAs will be integrated, and give an appropriate timescale is for this integration. It will also review the feasibility of bringing NHS information and analysis more closely aligned with that of Local Authorities, in line with the recommendations of the White Paper.

100 Proposals on the **size, skill mix, organisation and cost** of the commissioning support service will be set out in the business case. This will also include an analysis of funding currently available to PCTs eg current clinical networks, specialised commissioning and modernisation resources, which could be redesigned to support its costs. The Commissioning Business Service will require staff with very specific skills, and there will need to be an analysis (and stocktake) of where these skills can be found in the existing system.

[5] Available from the project group.

7 The Duty of Partnership

"It is the duty of Strategic Health Authorities, Special Health Authorities, Primary Care, NHS and Foundation Trusts to cooperate with each other in exercising their functions." Section 26 Health Act 1999

101 PCTs in London have strongly articulated that the retention of borough-based PCTs is essential to maintain and strengthen local commissioning partnerships, improve health and reduce health inequalities. But London PCTs also recognise that they need to work collaboratively to strengthen Londonwide commissioning arrangements.

102 PCT Governance as defined by the Audit Commission - *Governing the NHS,* DH 2003 - sets out the system and processes by which health bodies lead, direct, and control their functions in order to achieve organisational objectives. An organisational duty placed upon PCTs is to commission effectively within an increasingly difficult and diverse market. The Duty of Partnership means that where this is appropriate, PCTs should commission collaboratively to maximise their position in the health and social care market and therefore achieve their organisational objectives.

103 Each PCT Board is asked to approve formally the remit of the Local and London Commissioning Groups and confirm its intent to act in partnership. The Commissioning Groups will consist of PCT Chief Executives as a minimum, with SHA representation on the London Commissioning Group. In addition to PCT CEO involvement, the London and the Local Commissioning Groups will secure appropriate clinical, expert Director and partner engagement. A dispute resolution procedure is therefore included with the Terms of Reference set out below, which will ultimately be performance managed by the London SHA. This section and the following sections will be issued with this paper as a formal recommendation for adoption by PCT Boards in June/July 2006.

Terms of Reference for London and Local Commissioning Groups

London Commissioning Group

104 We propose that a Londonwide Commissioning Group be established, with the following terms of Reference:

- Oversee the London wide commissioning process, and ensure that there is "fit " between local plans;
- Undertake an annual 'horizon scanning' process to identify prospective commissioning priorities, with input from all London PCTs to form the basis of annual London wide Commissioning Intentions;
- Market manage on a London wide basis, where appropriate, and ensure that a comprehensive range of patient services exists within reasonable access of all Londoners;
- Stimulate the market on a London wide basis where necessary to align capacity and resources.
- Take the lead for specialised commissioning activities on a London wide basis, as set out in the recommendations of the Warner Review.

105 Membership

- Each Local Commissioning Group will nominate a Chief Executive representative onto the London Commissioning Group
- To ensure that the strategic development of services in London and London wide commissioning plans are aligned and consistent the SHA will nominate its representative
- The Group will elect a Chair
- The Group will co-opt members or invite external attendance on specific issues
- The Group will secure public health, finance and information support

Local Commissioning Groups

106 We propose that Local Commissioning Groups be established, with the following terms of reference:

- Manage the lead commissioning of the 2007/08 Commissioning round, supported by the Business Service, with acute services as a priority, but with commissioning progressively rolled out to

all other services including mental health, specialised and primary care commissioning.

- Implement and monitor the progress of negotiations across its geographical area and undertake joint action where appropriate

- Through representation on the London Commissioning Group, performance manage the Commissioning Business Service.

- Oversee the role and performance of commissioning clinical networks , and liaise with provider networks

- **'**Market manage' through planning and provider stimulation to meet the needs of the local population, where gaps in service provision or market failures are identified. In this respect the Local Commissioning Groups will work with Practice Based Commissioning Consortia in addressing the provider management of new or revised Patient Pathways.

107 Membership

- Each constituent PCT Chief Executive will be a member. Each Group will also determine appropriate clinical and technical membership.
- The Group will elect its Chair
- The Group will co-opt members or invite external attendance on specific issues

108 **Meetings**

- The Local Commissioning Groups will meet monthly
- The London Commissioning Group will meet monthly

109 **Administrative Arrangements**

- The London CBS will provide administrative support to both London and Local Groups

110 **Accountability**

London Commissioning Group

- The Group will be accountable to the London PCTs within the performance management framework of the London SHA.

Local Commissioning Group

- The Group will be accountable to its constituent PCTs. Copies of the minutes of all meetings will be supplied to each PCT, and the Group shall produce an annual report of its activities for submission to each PCT Board.

111 **Dispute Resolution Procedure**

- These procedures are designed to provide a clear and easily understood set of rules for dispute resolution and reaching agreement amongst the PCT members of the Local and London Commissioning Groups.

- PCTs by agreeing to the "Duty of Partnership" and the establishment of the Commissioning Groups agree to adhere to these procedures and the collaborative approach which underpins it.

- Disputes and issues requiring agreement will be categorised under three headings: **collective procurement**, **service development** (e.g. the cardiology example referred to in section 5 above); and **major service reconfiguration** as defined by the policy to be agreed by the London Commissioning Group and PCTs.

- Disputes involving issues about **collective procurement** will normally be resolved by a 75% majority. Procurement consortia will need to determine the detailed implementation of this arrangement as it applies to the scope and size of the consortia portfolios. These majority agreements already operate within the specialised services consortia that have been in place across London PCTs for some time. Any new procurement consortium will agree its financial and decision making arrangements at inception, consistent with arrangements already in place.

112 **Pan PCT Agreements**

- Groups will decide in advance of considering a specific piece of joint work around **service development** or **service reconfiguration** a process for decision making and how they intend to deal with a failure to agree. This will involve agreement to the prospective service review and sign off at the end of the process by the sponsoring PCT Boards.

- Disagreements will be subject to mediation within the Group, conducted by the Chair, but if at the end of the review PCTs cannot agree on their recommendations, then the SHA would be asked to facilitate reaching a decision.

- The SHA's performance management responsibility remains and complements these arrangements.

LONDON: COMMISSIONING FOR HEALTH

Appendix A Lead Commissioners for London Trusts, 2006/07

Lead PCT	Acute Trust
Barnet PCT	Royal Free Hampstead NHS Trust
Barnet PCT	Royal National Orthopaedic Hospital NHS Trust
Bexley Care Trust	Queen Mary's Sidcup NHS Trust
Brent PCT	North West London Hospitals NHS Trust
Bromley PCT	Bromley Hospitals NHS Trust (Princess Royal University Hospital)
Camden PCT	University College London Hospitals NHS Trust
City & Hackney PCT	Homerton University Hospital NHS Trust
Croydon PCT	Mayday Healthcare NHS Trust
Ealing PCT	Ealing Hospital NHS Trust
Enfield PCT	Barnet and Chase Farm Hospitals NHS Trust
Greenwich PCT	Queen Elizabeth Hospitals NHS Trust
Hammersmith & Fulham PCT	Hammersmith Hospitals NHS Trust (including Ravenscourt Park Hospital)
Haringey PCT	North Middlesex University Hospitals NHS Trst
Havering PCT	Barking, Havering & Redbridge Hospitals NHS Trust
Hillingdon PCT	HEMS
Hillingdon PCT	Hillingdon Hospital NHS Trust
Islington PCT	Moorfields Eye Hospital NHS Trust
Islington PCT	The Whittington Hospital NHS Trust
Kensington & Chelsea PCT	Royal Brompton and Harefield NHS Trust

Lead PCT	Acute Trust
Kensingon & Chelsea PCT	Chelsea & Westminster Healthcare NHS Trust
Kingston PCT	Kingston Hospital NHS Trust
Lambeth PCT	Guys and St Thomas NHS Trust
Lewisham PCT	Lewisham Hospital NHS Trust
Newham PCT	Newham University Hospitals NHS Trust
Richmond & Twickenham PCT	London Ambulance Service NHS Trust
Southwark PCT	Kings College Hospital NHS Trust
Specialist Commissioning Haringey PCT	Great Ormon Street Hospital for Children NHS Trust
Sutton & Merton PCT	Epsom & St Helier University Hospitals NHS Trust
Sutton & Merton PCT	Royal Marsden NHS Trust
Tower Hamlets PCT	Barts and The London NHS Trust
Waltham Forest PCT	Whipps Cross University Hospital NHS Trust
Wandsworth PCT	St Georges Healthcare NHS Trust
Westminster PCT	St Marys Hospital NHS Trust

LONDON AMBULANCE SERVICE NHS TRUST

Response to 'London – Commissioning for Health – Developing World-Class Commissioning to Improve the Health of Londoners'

The London Ambulance Service (LAS) has been asked by the Primary Care Trust (PCT) Chief Executives for comments and opinions on their proposals for London-wide commissioning. Our response is set out below.

The Strategic Agenda for the LAS

The LAS' new 7-year strategic plan will make the Service of 2013 radically different from the one of today and will create an organisation capable of delivering significant benefits for the whole health care system in London. Benefits expected to be delivered include:

- A reduction of around 200,000 in the number of patients referred to A&E
- More "treat and discharge"
- Provision of appropriate care in a more cost-effective way than in the current system
- Increased use of alternative care pathways both for urgent and emergency patients
- A cohort of flexible emergency/unscheduled care professionals able to work in a variety of care settings including Minor Injuries Units (MIUs), Walk In Centres (WICs) and out of hours primary care.

Current Commissioning Arrangements

The LAS is the only pan-London NHS Trust.

In this context it is extremely disappointing that no specific attention is paid to the commissioning arrangements for the LAS. In fact the only mention of the LAS is in the Appendix to the document!

The current commissioning arrangements consist of a group formed of one representative from each of the 5 old Strategic Health Authority (SHA) areas, one Lead Commissioner from Richmond and Twickenham PCT and one representative from the Trust's previous lead SHA, South West London.

Sub-group commissioning meetings are held for one afternoon each month with Chief Executive level meetings held twice a year. The commissioning meeting usually comprises a performance review, an update on clinical developments and, towards the end of the year, an increased focus on the following year's funding.

The Key Proposals Impacting the LAS

Structure

The proposals include the formation of a ‘London Commissioning Group’ with 5 ‘Local Commissioning Groups’.

The London Commissioning Group would take a strategic role overseeing the London-wide commissioning process and this would include taking the lead on specialised commissioning activities. This does not include the LAS which does not fit into the ‘high cost, low volume’ definition of ‘specialised services’.

The 5 Local Commissioning Groups would be formed (in alignment with the old SHA sectors) for the purpose of strengthening lead and collaborative commissioning arrangements. Their role would include monitoring performance against plans, commissioning clinical networks, ensuring consistency and ‘fit’ of new care pathway initiatives and agreeing activity levels across the sector.

The Commissioning Business Service

The proposals advocate the establishment of a London-wide Commissioning Business Service (CBS) to provide PCTs with a range of expertise and skills to support them in their commissioning functions.

This Service, accountable to PCTs, would be a provider of information, data and analysis across the London health economy, including quality and outcomes data, effectiveness and quality analysis, capacity analysis, provider and market intelligence, benchmarking information, dissemination of best practice information and advice on service and standards specifications, support on contract negotiation and competitive tendering and audit and analysis of Payment by Results (PbR) claims.

Our response to these proposals

Structure

The Ambulance Service is not referred to in the proposals but our understanding from the paper is that a similar commissioning arrangement is being recommended as currently exists for the LAS with representatives from each sector (from each Local Commissioning Group under the new arrangements) forming a consortium with a lead commissioner.

Although PCTs have been positive about LAS local developments, they are not of a size to influence successfully broader, more strategic change of the sort being undertaken by the LAS as proposed under the 7 year plan. Our management structure has 3 Assistant Directors of Operations responsible for performance and for working with local PCT commissioning groups. This enables local issues to be addressed at a local level. What is required for the LAS is a commissioning arrangement which focuses on strategic London-wide

issues and which is able to influence London-wide change to realise benefits the LAS can provide.

For each PCT, the LAS represents a very small element of its annual investment. Those currently charged with commissioning LAS services on behalf of other PCTs in their SHA area, whilst supportive of change, are not able to give this element of their work the attention it requires.

For a Service undergoing significant change, the speed of decision-making is crucial. A sector-based lead-commissioning group, required to consult individual PCTs on significant changes, does not support the speed of change required for the LAS to deliver the benefits of its strategic plan.

With our commissioning arrangements being sector-based and without dedicated commissioning resource, our most forward-thinking developments have been provider-led. We are now bypassing emergency departments to take patients with myocardial infarction directly to one of nine units in London that we know are best suited to provide primary coronary interventions such as angioplasty. We hope to do the same for stroke patients in due course.

Developments such as these have a direct impact on demand and income in other parts of the health economy. We have discussed with our commissioners how we can ensure our developments in patient care link-in with overall commissioning intentions and have asked for their assistance in influencing further such developments but the lack of London-wide influence restricts the effectiveness of this process.

Some of the commissioners who attend from PCTs have an acute sector focus. Some PCTs have sent individuals who have a brief for older people's care or long term conditions. This has provided a refreshing range of perspectives, but does not seem to have led to a coherent, whole systems approach to commissioning ambulance services as part of urgent care generally. The CEO meetings have been presented with and welcomed this perspective, but it not clear that this has led to any strategic focus on commissioning ambulance care as part of broader imperatives and objectives in healthcare development.

Indeed, it is probable that single-organisation commissioning can never bring about systemic change, since what is required is a shift in resources between organisations that simply cannot be achieved by incremental and silo-based commissioning.

Further, the cost savings the LAS expects to deliver to the London health economy are dependent on costs being extracted from elsewhere in the system and innovative, local PbR-type funding arrangements being developed through the commissioning process. This requires in-depth understanding of the LAS, strong financial skills and a significant time investment in working jointly to develop such arrangements.

Even with the creation of the CBS, designed to free commissioning time to focus on strategic challenges, we do not feel these challenges can be met without dedicated commissioning arrangements.

The most innovative and progressive developments in Ambulance Services recently have occurred where there is one commissioning lead. The PCTs commissioning East Anglian Ambulance Service (now part of East of England Ambulance Trust) appointed one full-time commissioner for the Service, empowered to make decisions on their behalf and with the time to invest in understanding and analysing the Service. As result, the Service has already developed Out of Hours (OOH) services, Community Responders and Community Paramedics. Essex Ambulance Service (also now part of East of England) was commissioned by only one PCT and has been able to develop an innovative PbR-based funding arrangement. This has resulted in a quicker process of agreeing funding as well as better alignment of purchaser and provider incentives.

Our 7 year plan will details for our future workforce requirements. The LAS always has and will continue to train the majority of its own frontline staff both in terms of initial training and continuing training and development. Funding for this comprehensive training school provision is currently within the baseline funding for the Trust and therefore needs to be considered when commissioning agreements are made. This internal requirement will continue and indeed increase as we expand and change the workforce skill mix to meet future requirements. Unlike other NHS Trusts, central funding provision for operational staff training such as NMET does not apply to the LAS and previous allocations of NPET funding is now minimal.

The commissioning proposals seem to be silent on the topic of how links will be made between workforce plans and commissioning. But this is as important as the need to take a whole systems approach to urgent care development as a whole.

<u>The Commissioning Business Service</u>

We welcome the development of this new Service, particularly the opportunities for more joined up procurement and the overall savings in the health economy it should help identify.

It is important that the CBS consults the LAS on its reviews of capacity and cost-savings in the London health economy. Cost-savings are often assessed without reference to the impact on the LAS. For example, the closure of an A&E department or the opportunity for us to have parking bays and facilities at a new Walk In Centre have a significant impact on our cost-base and on our performance in that area.

It is also important to the LAS that the CBS supports the development of ‘themes’ in line with the vision of the new London SHA, for example, reviewing Unscheduled Care as a whole, rather than simply benchmarking acute trusts

against other acute trusts and looking for capacity and opportunities within the same tier of providers.

We also welcome the CBS' role in advising on service and standard specifications and would particularly welcome this being extended to cover the specifications for the purchase of Patient Transport Services (PTS) by PCTs and acute providers. We understand that the task of London PCTs commissioning PTS has to date been considered too large to tackle with existing PCT capacity. However, in the current market, there is no consistency of provision and little quality assurance. Where contracts are awarded to commercial providers, there is no standard specification and 'overspill' costs (e.g. of services not covered by a commercial provider or work 'upgraded' to urgent) will be incurred by the purchaser and the LAS.

Our recommendations

1. A full-time commissioning post be created, dedicated to the LAS. This would alleviate some of the issues outlined above and enable the LAS to prepare for more significant change in the future. This post would need to control some of the PCT A&E capacity related funding to effectively lead and drive system change.

2. The CBS consults the LAS on the impact of proposed changes in London and focuses on a 'theme' basis (e.g. Unscheduled Care) as well as on tiers of individual providers.

3. That commissioning is not organisation-focussed but focuses instead on areas of care such as urgent/unscheduled care in acute and primary care as well as ambulance services and that the appropriate integration is gained with workforce planning and workforce development funding.

4. The CBS includes PTS in its work regarding contract specifications to ensure that the perceived benefits of lower-cost provision are realised.

Vicky Clarke
Finance Manager

4th July 2006