London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 28 NOVEMBER 2017 AT 09:00-15:00 LONDON AMBULANCE SERVICE NHS TRUST HEADQUARTERS, 220 WATERLOO ROAD LONDON SE1 8SD

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.00	**1.**	**TB/17/118** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
09.05	**2.**	**TB/17/119** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	3.	**TB/17/120** Attachment	**Minutes of the meeting held in public on 31 October 2017** To approve the minutes of the meeting held on 31 October 2017.	HL	Decision
	4.	**TB/17/121** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
09.15	**5.**	**TB/17/122** Oral	**Patient Story** To hear about the Merton Sickle Cell Disorder group, the experiences the members report in relation to their contacts with the London Ambulance Service NHS Trust and the work being undertaken jointly to explore these themes, share experiences and develop mechanisms to address them.	TB	Information
09.45	**6.**	**TB/17/123** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
10.00	**7.**	**TB/17/124** Attachment	**Report from Chief Executive Officer (CEO)** To receive a report from the CEO.	GE	Information

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
10.15	**8.**	**TB/17/125** Attachment	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Discussion
10.45	**9.**	**TB/17/126** Attachment	**Audit Committee Assurance Report** To receive the report for the Audit Committee meeting on 6 November 2017.	JJ	Assurance
11.00	**10.**	**TB/17/127** Attachment	**Quality Assurance Committee Assurance Report** To receive the report for the Quality Assurance Committee meeting on 14 November 2017.	RM	Assurance
11.15	**11.**	**TB/17/128** Attachment	**People & Organisational Development Committee Assurance Report** To receive the report for the People & Organisational Development Committee meeting on 20 November 2017.	JM	Assurance
11.30	**12.**	**TB/17/129** To follow	**Finance & Investment Committee Assurance Report** To receive the report for the Finance & Investment Committee meeting on 23 November 2017.	FC	Assurance
11.45	**13.**	**TB/17/130** Attachment	**Board Assurance Framework** To receive the Board Assurance Framework.	PH	Discussion
12.00	**14.**	**TB/17/131** Attachment	**Serious Incidents Update** To note declared and closed Serious Incidents.	TB, FW	Discussion
STRATEGY & PLANNING					
12.30	**15.**	**TB/17/132** Attachment	**LAS Strategy update** To receive an update on progress towards the new strategy.	AF	Information
12.45	**16.**	**TB/17/133** Attachment	**Quality and Improvement and Learning Framework** To approve the framework and agree to the developments being taken forward.	TB	Decision
GOVERNANCE					
1.15	**17.**	**TB/17/134** Attachment	**Draft Health and Safety Strategy and action plan update** To review the draft Health and Safety Strategy and progress against the Health and Safety action plan	TB	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
1.30	**18.**	**TB/17/135** Attachment	**Quality Improvement Plan and CQC Preparation** To receive an update on the progress of the Quality Improvement Plan	TB	Discussion
1.45	**19.**	**TB/17/136** Oral item	**CQC Briefing** To receive a briefing from the Care Quality Commission on its new processes	TB	Information
2.15	**20.**	**TB/17/137** Attachment	**Unaudited Charitable Funds Annual Report & Financial Statements for 2016/17, independently examined by Ernst & Young LLP** To approve the annual report and financial statements of the LAS Charity.	LB	Decision
2.20	**21.**	**TB/17/138** Oral	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
2.25	**22.**	**TB/17/139** Oral	**Questions from members of the public**	HL	Information
2.40	**23.**	**TB/17/140** Oral	**Any other business**	HL	Information
2.45	**24.**	**TB/17/141** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
3.00	**25.**		**Meeting close** The meeting of the Trust Board in public closes.	HL	
	Date and time of next meeting: The date of the next Trust Board meeting in public is on Tuesday 31 January 2018 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.				

Additional reports, circulated for information only:

TB/17/142: Quality Report (October 2017)

TB/17/143: Workforce Race Equality Standard (WRES) Action Plan

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 31 October 2017

DRAFT Minutes of the public meeting of the Board held at 9am in the Conference room – Headquarters, 220 Waterloo Road London SE1 8SD

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Director of Finance and Performance
Fergus Cass	FC	Non-Executive Director
Jessica Cecil	JC	Associate Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
Angela Flaherty	AF	Director of Strategy (Acting)
Ross Fullerton	RF	Chief Information Officer
Patricia Grealish	PG	Director of People and Organisational Design
Philippa Harding	PH	Governance Improvement Director
Maeve Stevenson	MS	Administrator

1. Welcome and apologies (TB/17/89)

1.1. The Chair welcomed all to the meeting. No apologies had been received.

2. Declarations of interest (TB/17/90)

2.1. There were no declarations of interest.

3. Minutes of the meeting held in public on 03 October 2017 (TB/17/91)

3.1. The minutes of the Trust Board meeting held in public on 03 October 2017 were approved as a true and fair record of that meeting, subject to the following amendment:

3.1.1. Minutes reference TB/17/72 should reflect the fact that the Board approved the recommended amendments to the Audit Committee's Terms of Reference.

4. Matters arising (TB/17/92)

4.1. The actions arising from the previous meeting were noted. There were no further matters arising.

5. Staff Story – Emergency Operations Centre (TB/17/93)

Jules Lockett (Practice Learning Manager, EOC Management) joined the meeting for this item.

5.1. Jules Lockett provided the Board with a presentation on working in the Emergency Operations Centre (EOC), being an Emergency Medical Dispatcher (EMD) and the support that was provided for those undertaking this work.

5.2. Board members noted the importance of the work that was carried out by EMDs and considered the challenges faced in recruiting and retaining people to do this work. Consideration was given to the question of whether these individuals were remunerated appropriately for the work that they did. The flexibility of the working arrangements required of EMDs was also discussed.

5.3. The resilience of those working within the EOC was considered. The importance of working to build this was emphasised, as many of those who worked as EMDs did not have a significant amount of experience upon which to draw. However, it was also noted that those who worked as EMDs could provide valuable insight and drive with regard to innovations that would make the Trust more efficient, effective and economic, particularly with regard to the use of technology. Board members emphasised the importance of working with these members of staff in these areas.

5.4. Board members emphasised the importance of those working as EMDs and expressed their appreciation for the role that these individuals played with regard to patient care.

6. Report from the Chair (TB/17/94)

6.1. In addition to the information set out in her report, the Chair provided a further oral update on the Women of Achievement Award for the Women of the Emergency Services that she had collected together with Danny Cotton (Commissioner, London Fire Brigade) and Lucy D'Orsi (Deputy Assistant Commissioner, Metropolitan Police Service). An afternoon tea was being arranged for women across the London Ambulance Service NHS Trust (LAS) in recognition of this award.

6.2. Consideration was given to the Q-volunteering Programme (a high profile national programme of work overseen by the Centre for Social Action, Office for Civil Society and Department for Digital Culture, Media and Sport). It was noted that the Chair was working to facilitate the implementation of this programme within the LAS.

6.3. Board members noted the fact that the LAS would be participating in the NExT Director (Non-Executive Director scheme) being run by NHS Improvement. The Chair announced that Amit Khutti would be placed with the LAS through this scheme and that it was hoped that he would be able to join the next meeting of the Board.

7. Report from the Chief Executive Officer (TB/17/95)

7.1. The CEO reported that work was being undertaken with a view to increasing the ability of the LAS to deliver Advanced Paramedic Practitioner (APP) Urgent Care. It was noted that this would improve the Trust's ability to deliver advanced care to its sickest patients at the scene. The importance of working with Strategic Transformation Partnerships on such advances was emphasised. It was proposed that further information on the work of the APPs should be presented as part of the next staff story to the Board.

ACTION: next staff story to the Board to focus on the APP (Urgent Care) role.

7.2. Board members were informed that, following further negotiations with the Trades Unions, an in principle agreement had been reached with regard to the introduction of rest breaks at flexible locations, rather than requiring these be taken at base station. The new policy had been recommended to staff by the Trades Unions and was expected to be in force from 4 December 2017. The impact of implementing the new policy would be kept under review in order to ensure that it achieved the Trust's patient safety and staff welfare objectives. Board members welcomed this outcome.

ACTION: a full report on the impact of the new rest break policy to be brought to the Board at its meeting in July 2018, with an interim report to be brought to the Board in March 2018.

7.3. Consideration was given to the Trust's longer term aims with respect to improving the numbers of breaks being taken by staff on 12 hour shifts. It was noted that this also linked to staffing levels, annual leave, rosters, job cycle times and the implementation of the Ambulance Response Programme (ARP). Further assurance would be required on this work in due course.

7.4. Board members were provided with an oral update on Quality Improvement Programme activities, noting that a full update had been circulated with the Board papers. This assurance was noted.

7.5. The independent report by Lord Harris into what could be done to improve London's resources and readiness to respond to a major terrorist incident was noted. Board members requested an update on the progress being made by the LAS in its recruitment activities in this regard.

ACTION: provide the Board with an update on recruitment to the Hazardous Area Response Team and other recruitment activities in line with bolstering the LAS' ability to respond to major terrorist incidents.

8. Integrated Performance Report (TB/17/96)

8.1. LB provided an overview of the report, which provided an executive summary of the Trust's performance in relation to quality, operations, workforce and finance. Individual Executive Directors also provided further oral updates and clarifications with regard to their areas of responsibility and the Chairs of the Board's Assurance Committees provided additional input with regard to pertinent issues discussed at recent meetings.

8.2. It was noted that year to date Cost Improvement Plans (CIPs) were £1.9m behind plan, although they were currently being offset by fortuitous non recurrent underspends on pay budgets. Board members emphasised the importance of clarity with regard to how many of these CIPS would be delivered and it was reported that a detailed update with assurance was due to be provided to the next meeting of the Finance and Investment Committee. Board members requested that the Committee pay particular attention to the split between recurrent and non-recurrent savings that were anticipated in the current financial year, whilst considering the implications for the next. It was noted that benchmarking productivity data available from NHS Improvement would be key to identifying additional opportunities with regard to efficiencies.

8.3. With regard to the Trust's performance, it was noted that A8 performance for September 2017 was at 66.6%, which was 3% below trajectory (whilst being 4% higher than at the same time in the previous year). Board members considered the implications of the ARP for the Trust's future performance, noting the importance of improving job cycle times in order to continue improving efficiency.

8.4. On the issues considered by the Logistics and Infrastructure Committee at its most recent meeting the Board was asked to consider the risks associated with the replacement of the uninterruptable power supply (UPS) at the Bow site. There was a potentially very significant risk associated with this work and the Executive Leadership team (ELT) was asked to consider this in detail in order to provide the necessary assurance.

8.5. Consideration was given to the Trust's performance with regard to compliance with mandatory and statutory training requirements. It was noted that improved reporting on this made this compliance more visible across the organisation.

8.6. Board members welcomed the face that the LAS had been able to increase its recruitment offers and pipeline in September, but expressed concern that it was currently behind plan for paramedic, T/EA and EMD recruitment. Particular attention was paid to the Trust's ability to recruit individuals from BAME backgrounds. It was proposed that further work was required in order to understand what prevented people from successfully navigating LAS recruitment processes.

8.7. With regard to medicines management, Board members noted the additional information that had been provided with the Board papers on the use of medicines by ambulance personnel.

8.8. Consideration was given to the progress of the Trust's Health and Safety Action Plan and the detailed content of the Quality Report, both of which had been circulated to Board members alongside the papers for the meeting.

8.9. The progress that was being made with regard to Quality Assurance visits was noted. Two Non-Executive Directors who had participated in these visits provided oral feedback on their observations. It was noted that a briefing would be provided by the Care Quality Commission at the next Board meeting, in advance of the Trust's re-inspection at the end of 2017/18.

9. Logistics and Infrastructure Committee Assurance Report (TB/17/97)

9.1. The report was noted; TdP had provided an overview of the meeting of the Logistics and Infrastructure Committee on 2 October 2017 during the Board's consideration of the performance report.

10. Board Assurance Framework (TB/17/98)

10.1. Board members noted the Board Assurance Framework (BAF), which was tabled at the meeting. The content of the BAF had not changed significantly from its last presentation to the Board and it was expected to be re-presented in a new format at the Board meeting on 28 November 2017. Board members asked for early sight of the new format.

ACTION: circulate the new format BAF in advance of the papers for the meeting of the Board on 28 November 2017.

11. Serious Incidents Update (TB/17/99)

11.1. TB presented the report which provided an update on the current status of Serious Incident (SI) investigation compliance across the Trust and updated the Board on the current projects and improvements that were being made within the Quality, Governance and Assurance Team.

11.2. Consideration was given to the manner in which appropriate learning from SIs was achieved. It was noted that improvements of systems and processes continued; however the team's focus over the next few months would be on guidance and support for staff when things went wrong and ensuring that patients were involved at the beginning of all investigations (when they felt able to do so).

12. Complaints Charter (TB/17/100)

12.1. Board members considered the report which contained information about the development of a complaints charter, outlining the principles of this charter and the commitments requested of the LAS by the Patients' Forum. It was noted that the Patients' Forum had undertaken a similar exercise with other London healthcare providers.

12.2. The Board focussed upon the following issues within the Charter:

12.2.1. Consideration would be given to the question of whether patients who had complained and suffered financial loss as a result of the Trust's actions;

12.2.2. Further information was required in relation to the steps that could be taken locally if someone had complained and was not satisfied with the Trust's response;
12.2.3. Whilst consideration would be given to service improvement as a result of a complaint, this would not always be appropriate; and
12.2.4. How best to ensure that the charter was accessible to those whose first language was not English.

RESOLVED:

12.3. The Board resolved to agree that the Complaints Charter should be approved in principle and that final authority to resolve the issues raised at the Board should be delegated to the ELT.

13. Annual Reports for STEMI, Cardiac Arrest, Stroke and Major Trauma (TB/17/101)

Rachel Forthergill (Head of Clinical Audit & Research, Nursing & Quality Management) joined the meeting for this item.

13.1. The Board was provided with a presentation on the work of the Clinical Audit and Research Unit, with a particular focus on the annual reports regarding the clinical care and outcomes of STEMI, Cardiac Arrest, Stroke and Major trauma patients attended by the LAS during 2016/17.

13.2. Board members noted the presentation and the information provided within the reports. The Board emphasised the importance of ensuring that there was a good understanding of why almost one fifth of patients who reported pain did not receive any analgesia.

14. Our Strategic Intent (TB/17/103)

14.1. AF presented the Board with a draft document setting out the LAS "strategic intent", which, once approved, would be used as the foundation of a series of engagement events with staff, patients and external stakeholders. These engagement events would then be used to inform the Trust's strategy.

14.2. Board members discussed the challenges associated with drafting a document that was intended for use with a number of different audiences, all of whom would have different areas of focus. It was proposed that further work could be undertaken to more explicitly set out the challenges facing the LAS, not only externally but also internally. The importance of including more about the impact of technology was emphasised. It was also suggested that could be done to summarise the urgent and emergency care opportunities that the LAS was likely to experience. The value of a more detailed analysis of the strengths, weaknesses, opportunities and threats which the strategy was intended to address was also noted.

14.3. Subject to these comments, Board members confirmed that they were content for the document to be used as an engagement tool for the development of the Trust's strategy.

15. Freedom to Speak Up (TB/17/106)

Margaret Luce (Freedom to Speak Up Guardian / Head of Patient and Public Involvement and Public Education) joined the meeting for this item.

15.1. PH presented the report which provided the Board with information about the Freedom to Speak Up activities that had taken place nationally and within the LAS over the course of the last year and set out the proposed next steps to be taken with regard to the role of Freedom to Speak Up Guardian.

15.2. Board members noted that, over the last quarter, no issues had been raised with the Freedom to Speak Up Guardian and only one issue had been raised via the Non-Executive Director with Freedom to Speak Up responsibilities (Fergus Cass). Non-Executive Directors would receive a report on this issue in private at the next meeting of the Board

15.3. The Chair offered her thanks to those who had been exercising the Trust's responsibilities with regard to Freedom to Speak Up. The importance of ensuring that this work continued and was built upon was noted and Board members confirmed that they were supportive of the approach proposed within the report.

16. Winter Plan (TB/17/102)

16.1. PW provided the Board with an oral update on the progress being made with the implementation of the ARP and its anticipated impact over the winter period.

16.2. Board members emphasised the need to provide assurance with regard to the Trust's plans to address any resource gaps and the safety thresholds that would need to be met. An update to the paper that had been presented to the previous meeting of the Board (ref: TB/17/81) was requested, for consideration by the Board in correspondence ahead of its next meeting.

ACTION: provide the Board (in correspondence ahead of the next Board meeting) with additional assurances in relation to the Trust's plans to mitigate the risks that it will be facing over the winter period.

17. Risk Management Framework (TB/17/104)

17.1. PH tabled the paper which proposed a draft Risk Management Framework to replace the Trust's current Risk Management Policy. It was proposed that authority be delegated to the Audit Committee to approve the Framework at its meeting on 6 November 2017.

RESOLVED:

17.2. The Board resolved to approve that authority be delegated to the Audit Committee to approve the Risk Management Framework at its meeting on 6 November 2017, subject to any comments provided by Board members on the detail of the proposed Framework in correspondence ahead of this meeting.

18. Review of 2017/18 Business Plan (TB/17/105)

18.1. LB presented the report which provided an update for the Board on progress at the half year with delivery of the Business Plan deliverables that were agreed in May 2017. Consideration of the report had been deferred from the Board meeting on 3 October and ELT members had refreshed their updates where there had been further progress.

19. Trust Board Forward Planner (TB/17/107)

19.1. Board members noted the revised Trust Board forward planner. It was also noted that a forward plan of all Board and Committee meetings until the end of 2018/19 had been circulated. The timing of Committee meetings within the month had been reviewed with a view to ensuring that they were able to provide appropriate assurance to the Board. Final amendments were being made to ensure that all Board members' availability was taken into account and the final plan would be presented to the next meeting of the Board.

20. Questions from members of the public (TB/17/108)

20.1. The Patients' Forum had raised the following questions in advance of the meeting:

ARP:

20.1.1. Will the Board confirm that patients suffering a sickle cell crisis will receive a Category 2 response (18 minutes mean response time)?

20.1.2. Will the Board confirm the response times for patients in a mental health crisis and ensure that the parity of esteem will be implemented for patients in mental health crisis?

20.1.3. Will the Board take steps to communicate with national charities like the Sickle Cell Society and Mind to explain the impact of ARP and to get their views?

LAS Strategy:

20.1.4. Will the Board explain the objectives of the engagement exercise on new Strategy? Is it to share the Board's vision, or to consult with community groups and other stakeholders on the Board vision?

Bariatric Care:

20.1.5. Can you Board confirm that there is am implementation plan for enhanced bariatric care?

20.1.6. Can the Chief Executive please explain what is meant by a "System wide case review for mental health patients" and how patients will be involved in this process?

20.2. It did not prove possible to provide the answers to these questions at the meeting, however the following answers were provided following the meeting:

20.2.1. All patients meeting the internationally agreed criteria where the primary complaint is sickle cell crisis will receive category 2 response within 18 minutes mean response time. Patients with known sickle cell may present with other complaints and these will be triaged accordingly. The LAS

continually reviews this to make sure the care they receive is timely and appropriate.

20.2.2. The categorisation of patients has been nationally led, based on evidence. Within LAS mental health patients will continue to be monitored by the CHUB. Engagement with patient groups has been led by NHSE.

20.2.3. The LAS is engaging widely on the strategy and the Patients' Forum has been instrumental in providing the perspective of patients.

20.2.4. Bariatric care was discussed at the Health and Safety Committee recently. The manual handling and bariatric group has been re-established into one and will be discussing the two key elements that will improve the current situation: tagging patients on the system once bariatric care has been provided so we are aware that they may need specific equipment if they call again and also re-activating the review of equipment.

20.2.5. The system wide case review relates to the current meeting of various groups across the health system that discuss mental health patients (including frequent callers). Case reviews are conducted by social services rather than LAS.

21. Any other business (TB/17/109)

21.1. No other business was raised.

22. Review of the meeting (TB/17/110)

22.1. The Chair noted that, whilst papers were being circulated to the Board in a more timely manner, further work was required to ensure that they were appropriately succinct and demonstrated that consideration was being given to ensuring that the Trust was effective, efficient and economic. In order to facilitate the circulation of Board and Committee papers, Board members were supportive of the use of an electronic distribution system.

22.2. It was considered that further work was required to ensure the smooth running of the Board's conversations around performance and assurance. The Chair undertook to work on this.

Meeting close

The meeting closed at 1.15pm. The next Trust Board meeting in public will take place at 9am on Tuesday 28 November 2017.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/68	Paper to be presented to the November Board meeting setting out the arrangements in place for senior engagement with STPs and how feedback from this activity will be presented to the Board in the future	Philippa Harding, Angela Flaherty	03/10/17	28/11/17	**1 month late**	Paper pushed back in order to enable the new Director of Strategy and Communication to shape this work.
TB/17/70	Bring a paper on Trust-wide activity and planning in relation to training to the Board in the near future	Patricia Grealish	03/10/17	30/01/18	**On track**	Initial paper presented to the private Board meeting 31/10/17
TB/17/71	Cyber risk action plan to be considered by the Audit Committee at its next meeting	Ross Fullerton, Philippa harding	03/10/17	06/11/17	**CLOSED**	This was considered by the Audit Committee at its meeting on 6 November 2017
TB/17/79	Re-submit an updated report reviewing progress against the 2017/18 Business Plan to the Board meeting on 31 October 2017	Lorraine Bewes, Philippa Harding	03/10/17	31/10/17	**CLOSED**	This was presented to the last meeting of the Board
TB/17/81	Board members to provided further comments on the Winter Plan 2017/18 to the CEO in correspondence	Board members	03/10/17	31/10/17	**CLOSED**	Comments were provided in correspondence.
TB/17/80	Arrange Board seminar on the evolving staffing issues expected to be faced by the LAS in the future	Patricia Grealish, Philippa Harding	03/10/17	30/01/18	**On track**	Scheduled for Board meeting on 30/01/18
TB/17/95 para 7.1	Next staff story to the Board to focus on the APP (Urgent Care) role	Fenella Wrigley, Philippa Harding	31/10/17	30/01/18	**On track**	As there will be no Board meeting in December, the next staff story will be brought to the Board in January
TB/17/95 para 7.2	A full report on the impact of the new rest break policy to be brought to the Board at its meeting in July 2018, with an interim report to be brought to the Board in March 2018	Paul Woodrow	31/10/17	31/07/18	**On track**	Scheduled for Board meetings on 27/03/18 and 21/07/18
TB/17/95 para 7.5	Provide the Board with an update on recruitment to the Hazardous Area Response Team and other recruitment activities in line with bolstering the LAS' ability to respond to major terrorist incidents	Paul Woodrow, Patricia Grealish	31/10/17		**On track**	Oral update to be provided at the Board meeting.
TB/17/98	Circulate the new format BAF in advance of the papers for the meeting of the Board on 28 November 2017	Philippa Harding	31/10/17	17/11/17	**CLOSED**	The new format BAF was presented to Committee meetings throughout November.

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/102	Provide the Board (in correspondence ahead of the next Board meeting) with additional assurances in relation to the Trust's plans to mitigate the risks that it will be facing over the winter period	Paul Woodrow	31/10/17	17/11/17	**CLOSED**	This was circulated to the Board on 20/11/17

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Report from the Chair			
Agenda item:	06			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information

Background / Purpose:

The report from the Chair provides an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Chair – 28 November 2017

Ambulance Response Programme (ARP) Implementation

1. The Chief Executive Officer (CEO) will cover this important topic but I wanted to acknowledge the excellent and smooth implementation of the new national performance standards overnight on 31 October 2017. Like all complex projects this involved excellent leadership from the Executive Leadership Team, particularly Paul Woodrow, Director of Operations; Ross Fullerton, Chief Information Officer (CIO); Director of Performance, Jill Patterson and Fenella Wrigley, Medical Director; their teams and the staff in the Emergency Operations Centre (EOC) for whom the impact was quite considerable. The reputation of the Service has been enhanced by this smooth implementation.

Visit by Baroness Dido Harding – Chair, NHS Improvement

2. Baroness Harding was appointed as Chairman of NHS Improvement (NHSI) with effect from 30 October 2017, prior to this she was Chief Executive of TalkTalk Telecom Group PLC.

3. We were delighted to welcome her to the Service in her first week in the role on Friday 03 November 2017. Dido visited the EOC and listened in to some calls and spent time with Garrett Emmerson, CEO; Philippa Harding, Director of Corporate Governance; Ross Fullerton, CIO; and myself.

4. Separately, I have been invited to join the NHSI and Care Quality Commission's (CQC) Chairs' Advisory Board to expand the representation from Ambulance services.

NHS Providers Annual conference for Chairman and CEOs

5. I attended this conference where the Rt Hon Jeremy Hunt MP, Secretary for State for Health and Simon Stevens, CEO of NHS England presented. The main issues discussed were winter pressures, finance and workforce set against a context of the achievements of the NHS in terms of clinical outcomes when compared with international comparisons.

6. As always with conferences the main benefit comes from networking and I attended a private breakfast meeting for Chairman hosted by Dame Gill Morgan, Chairman of NHS Providers specifically to share issues with Baroness Harding.

Special Measures for Quality Leadership Conference

7. Tricia Bain, Chief Quality Officer and I attended this conference for Trusts in Special Measures with the aim of learning from those Trusts who have successfully come out of Special Measures. Professor Ted Baker, Chief Inspector for Hospitals gave the key note address. The event was also attended by the Rt Hon Jeremy Hunt MP and was hosted by Dr Kathy McLean, Medical Director of NHSI and Philip Dunne, MP Minister for Health.

8. Key messages were about the importance of the Board visibly setting the culture and values of the organisation in a clear accountable governance framework; demonstrating leadership at all levels in the organisation, staff engagement and tackling operational performance. It was also emphasised that Trusts who exit special measures have adopted one improvement methodology across the whole organisation. All of this needs to occur in the context of the broader health economy.

9. This last point demonstrates the importance of the Service engaging with the Sustainability Transformation Partnerships (STPs) at Board level as well as consulting with a wide audience on our proposed strategy.

LAS Quality Assurance Review 16/11

10. I took part in the assurance review visit at Fulham, North Kensington and Chiswick Ambulance stations, this was followed by a visit to meet crews at Chelsea and Westminster Hospital. The staff carrying out the assurance review were excellent and were both inspecting and learning.

11. Staff we spoke to were friendly and open in their responses; however we know we have more to do to ensure that corporate messages are more widely spread and that we as a Board are more visible to staff. The culture was positive with a recognition that there is always more to do.

12. Fulham Ambulance station is a Make Ready site and crews were able to confirm that the ambulances were clean and ready for use. However consideration could be given to ensure that the Make Ready teams feel part of the wider team and not outsiders.

13. Medicines management was effective and the staff we spoke to had received an appraisal and knew the corporate values. Answers to Health and Safety questions were good as were those relating to learning from events.

Meeting with Care Quality Commission – Professor Ted Baker and Stella Franklin

14. The CEO and I had a useful meeting with Professor Baker and Stella Franklin, Inspection Manager. The purpose of the meeting was to seek some clarity as to when the Well-led inspection will occur and what it will cover. We understand that the CQC will consider our submission and present to an internal committee to discuss what the intended inspection will consist of. The visits are now of an unannounced nature and in addition to the Well-led domain they will also inspect one or more other aspects.

NExT Director Scheme

15. I can confirm that Amit Khutti has been accepted on the NExT Director scheme and will join the Service as an Associate Non-Executive Director. https://improvement.nhs.uk/resources/non-executive-director-scheme/

Deputy Chair and committee membership

16. I can confirm that Theo de Pencier has agreed to take on the important role of Deputy Chair. In my absence, he will have authority to act as Chair. Unless I am incapacitated for some reason, confirmation of when he may exercise this authority will be provided in writing. This appointment is effective immediately for a period of 12 months, after which the manner in which he has carried out this role will be reviewed.

17. John Jones has agreed to take on the role of Senior Independent Director (SID) for a period of 12 months. As you will be aware, the SID supports the Chair by :

    - acting as an intermediary for other Non-Executive Directors when necessary;
    - acting as a conduit to the Board for stakeholders to communicate their concerns if contact through the normal channels of the Chair, Chief Executive or other Directors has failed to resolve, or for which such contact is inappropriate;
    - leading the Non-Executive Directors in the oversight of the Chair; and
    - ensuring that there is a clear division of responsibility between the Chair and Chief Executive.

18. If the Board agrees, Jessica Cecil will continue in her membership of the Quality Assurance Committee.

19. I've included a list of all Board members' roles and responsibilities as an appendix to this report, for ease of reference.

Heather Lawrence OBE
Chair

Name	Role - eg Job Title	Specific responsibilities/lead areas
Heather Lawrence	Chair	Nominations & Remuneration Committee Chair Quality Assurance Committee member Finance & Investment Committee attendee
Fergus Cass	Non-Executive Director	Finance & Investment Committee Chair Charitable Funds Committee Chair Audit Committee member Quality Assurance Committee member Logistics & Infrastructure Committee member Nominations & Remuneration Committee member Freedom to Speak Up Lead Bullying & Harrassment Lead
Jessica Cecil	Associate Non-Executive Director	Quality Assurance Committee member People & Organisational Development Committee member Nominations & Remuneration Committee member
Sheila Doyle	Non-Executive Director	Logisitics & Infrastructure Committee member Nominations & Remuneration Committee member Invited to comment on Audit Committee papers Technology Lead
John Jones	Non-Executive Director	Audit Committee Chair Finance & Investment Committee member Nominations & Remuneration Committee member Charitable Funds Committee member Quality Assurance Committee attendee Senior Independent Director

Name	Role - eg Job Title	Specific responsibilities/lead areas
Jayne Mee	Non-Executive Director	People & Organisational Development Committee Chair Finance & Investment Committee member Nominations & Remuneration Committee member Invited to comment on Quality Assurance Committee papers EPRR Assurance Lead
Robert McFarland	Non-Executive Director	Quality Assurance Committee Chair People & Organisational Development Committee member Nominations & Remuneration Committee member Audit Committee attendee Safeguarding Lead
Theo de Pencier	Non-Executive Director	Logistics & Infrastructure Committee Chair Audit Committee member Finance & Investment Committee member Nominations & Remuneration Committee member Deputy Chair Health & Safety Lead
Garrett Emmerson	Chief Executive	Finance & Investment Committee member Audit Committee attendee
Dr Trisha Bain	Chief Quality Officer	Quality Assurance Committee member People & OD Committee member
Lorraine Bewes	Director of Finance and Performance	Finance & Investment Committee member Logistics & Infrastructure Committee member Charitable Funds Committee member Audit Committee attendee
Dr Fenella Wrigley	Medical Director	Quality Assurance Committee member
Paul Woodrow	Operations Director	People & Organisational Development Committee member

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Report from the Chief Executive			
Agenda item:	07			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information

Background / Purpose:

The report from the Chief Executive gives an overview of progress and key events within the Service since the last time the Board convened.

The report is structured in sections, covering key areas of focus of the Trust and Board.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒

Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Chief Executive – 28 November 2017

1. This report provides the Trust Board with an update regarding key issues, events and activities.

Operational Performance

2. The Trust successfully transitioned overnight on the 31 October 2017 to the new Ambulance Response Programme (ARP) model and the associated new time standards and measures following a well-planned and well enacted elective Computer Aided Dispatch (CAD) system take down. As part of this implementation process a 24/7 multi-disciplinary oversight cell was in place from 0700 on the 1 November 2017. The objectives of the cell were to monitor in real time the operational performance against the new standards paying particular attention to the impact on Category 1 response times. The cell were key in supporting both EOC and frontline staff as they adjusted to the new way of working as well as monitoring and resolving any teething issues in the first stages of implementation.

3. Performance to date has been encouraging with the trust substantially achieving all of the main ARP performance standards in the first full week of operation (the week beginning 6 November 2017).

4. I would ask the Trust Board to acknowledge the high level of commitment the whole organisation has displayed in preparation for the introduction of ARP. The team fully engaged with a number of key directorates over a number of months to provide the required assurance ahead of the go live date.

5. For the month of October operating under the old Category A/Category C regime, the trust achieved 68.9% A8 performance an improvement of +1.3% delivered on October 2016. Red 1 performance was achieved 73.5% +5.4% above October 2016. A19 performance 95.0%, compliant with the national standard.

6. Overall demand was 96,549 incidents, 2.5% above trajectory but remaining within the 3% collar and cap contract threshold. Total activity rose 6.7% compared to September 2017. Capacity (in terms of patient facing vehicle hours) was marginally above plan at 0.2%. The average Job Cycle Time (JCT) for October was 82.2 minutes, an increase of 0.4 minutes on September, but a reduction of 2.6 minutes from October 2016. Hospital handover delays are still a prominent feature in this metric and the Director of Operations and the Medical Director are working very closely with the rest of the healthcare system across London to try to resolve these.

7. Over the next few weeks, we will continue to develop the new suite of reporting and forecasting tools for ARP. As more information and data is collected, we will begin evaluating the changes in behaviour resulting from the new operating model, and look at quantifying new relationships and trends as they materialise within operations.

8. As we head into winter, the Performance directorate will continue to drive planning by iteratively reviewing the position as new intelligence arises to help

support decision making with evidence-based recommendations. Winter and Christmas preparations now are specifically focused on translating demand into resourcing requirements under ARP.

Finance

9. As reported in detail elsewhere on the agenda the overall financial position for the Trust is £4.7m ahead of the internal plan at Month 7, largely due to on-going vacancies in front-line staff groups, clinical education tutor establishment and training placements. This is despite incident activity continuing to run at 2.5% above contract baseline for the year to date. Executive focus remains on acceleration of recruitment to address resilience and catch up with the pipeline required to deliver the requirements introduced recently through ARP.

10. The latest forecast is that the Trust will achieve the £2.4m deficit control total and could deliver further improvement on this, subject to a number of risks as the Trust heads into winter, such as incentive payments and the impact of ARP. The CIP savings programme remains behind trajectory and additional support has been put in place to build in a more strategic programme approach to savings and efficiency delivery, to ensure that we identify recurrent efficiency savings for 18/19 onwards to replace some element of fortuitous savings to date. CIP delivery continues to be managed through the bilateral executive performance reviews.

11. Capital spend is £7.2m against a Capital plan of £12.3m, £5.1m behind plan, however the current forecast is to spend £21.9m vs the plan of £24.3m. The Capital Programme Group has been established and will ensure capital is regularly monitored and deployed effectively to meet the strategic needs of the service.

IM&T

12. To support the transition to the ARP introduction the IM&T team undertook a great deal on planning and testing to allow the Trust to ‘go live’ on the 31 October 2017. A number of significant changes across our IT systems including mobile data terminals in ambulances, control room PCs and a dozen other systems were successfully delivered.

13. During the month of October there were a total of 6 critical IT incidents which is the highest reported number this year. A number of these related to underlying issues within the file storage function. However, the telephony stability within the 111 system has substantially improved and there will be further enhancements going forwards.

14. Following the increased awareness of the risks associated with cyber security a number of projects have been initiated which will reduce the exposure of the trust to associated risks. A new managed service is now in place to address cyber security operations.

Strategy

15. During October we have undertaken a number of activities associated with the strategic intent and direction of the Trust. These have included the publication of 'Our Strategic Intent' on both internal and external websites, the development of surveys for staff and external stakeholders, held a workshop with Strategic Transformation Partnership (STP) programme leaders to introduce the strategic intent document and obtain initial feedback.

16. Following the publication of 'Our strategic intent' we are working on development and appraisal options as to how each of our service propositions could be delivered. This work is being facilitated by the strategy team with support provided by clinical colleagues. Finance and performance colleagues will be assisting with the options appraisals for each service proposition. These options appraisals will also feed into the reference case model to demonstrate the extent to which they close the identified performance gap.

17. In terms of staff engagement meetings have been held with union representatives to agree an approach. We have also met with representatives of the Patients Forum to co-design our patient and public engagement sessions.

Quality Improvement

18. The preparations for the Care Quality Commission (CQC) inspection in early 2018 are underway. The Trust is now in receipt of a formal request for Pre-inspection Information which arrived on 10 November 2017. Some aspects of the pre inspection information has already been collated (Well Led Domain) and the Programme Management Office (PMO) team are cross referencing these documents against those requested. At this moment we anticipate a visit will take place in February 2018.

19. The date for the mock review has been arranged for 29 and 30 November 2017. Many of our stakeholders have agreed to participate and feedback will be given to the executive team on the day of the visits. Any further actions will be put into the 'burn-down' chart and actioned via the agile techniques currently being used.

20. The Quality and Learning Framework is being presented to the Board this month. It sets out further developments of our infrastructure and people to build a culture of continuous quality improvements and learning. The full implementation of the framework will be complete in Q1 2018. Consultation on our 2018-19 quality priorities will begin in December with Patients Forum, staff and stakeholders.

21. A range of new sector risks and incident reports have been developed for the senior managers to highlight incidents and risks to ensure they are reviewed and actioned in a timely manner. Incident management e-learning tools have now been approved and are ready for January 2018 implementation. Reviews of NHS 111 and EOC Datix systems have now commenced and included in the programme plan to re-configure these systems by April 2018.

22. There is on-going progress with the Health and Safety action plan (see Board update report). A series of meetings are planned for the Health and Safety Executive to meet the Executive Leadership Team to discuss further ways of assessing ambulance trusts as well as discussing the progress we have made against the improvement notice the trust received. The Trust has been working

closely with our occupational health providers to ensure a collaborative approach to work related injuries/illness and invited their regular attendance at the Health and Safety Committee.

Medical Directorate

23. The Medical directorate has supported the development of quarterly education days to be held at Fulham Education Centre. These sessions will focus on aspects of care requiring an improvement, highlighted through learning from incidents. To further bolster operational clinical support, a Clinical Team Leader conference has been developed and will be held on 27 and 29 November 2017. We have also worked to strengthen our relationships with higher education partners to provide an insight into the paramedic career for students entering into the programme. A number of lectures have also been delivered to the new cohort of Advanced Paramedic Practitioners who will soon begin a period of operational mentorship.

24. Pop up CPR has now visited 10 hospitals with 155 staff attending (whilst awaiting a call) and enabled them to test their skills ventilating a patient using the JAWs technique and cardiopulmonary resuscitation.

25. At the Pan London Clinical Network Annual Conference of Maternal Deaths attended by our Consultant Midwife, the London Ambulance Service was cited for maintaining high standards of care related to co-ordination and quality of resuscitation, communication and transfer to hospital. In addition, a joint Maternity training session between the LAS and the whole of the Community Midwifery Team from Hillingdon Hospital (30 midwives) has resulted in an ongoing programme of education collaboration.

26. The Clinical Audit Annual Report (2016-17) was published this month summarising: published projects; continuous clinical audit activity; national clinical audit; staff engagement, and patient and public involvement in clinical audit. In October CARU also published their clinical audit report of the care provided to patients with a genuine illness treated at the “No Duff Medical Centre” during Exercise Unified Response in 2016.

27. Recruitment of patients to the Pararmedic2 trial has now finished with the last patient of the trial being recruited by the trust. This trial is to evaluate the benefits of adrenaline for patients in cardiac arrest. Since the beginning of the study 2102 patients have been recruited by the LAS out of a total of 8100 across participating ambulance trusts.

People and Organisational Development

28. The launch of My ESR has been a great success with over 50% of Trust staff (2,642) now having accessed the system. We have the 2nd highest number of users using the new ESR Portal in London. In October we launched the ESR Workforce Dashboard which will improve the ability for all Trust managers from Team Leader to Director to access workforce data about their teams. A programme of engagement sessions has started for Sector and Corporate teams and feedback has been very positive.

29. An integral part of the Statutory and Mandatory training is CSR 2017.2 for clinical staff. This is an e-learning CSR that went live on 31 October 2017. Staff will be able to complete this via the new ESR Portal and will be given until March 2018 to complete the 8 modules which includes Health and Safety. There has been comprehensive and sustained communications to all staff to raise awareness, provide support and to encourage staff to complete their e-learning.

30. The current compliance level for the Trust is 70% at the end of October 2017. I have asked the Executive Leadership Team to actively monitor their directorate teams and actively engage with them to encourage completion of all modules. Approval has been given by the executive team to include a fixed objective within the PDR Appraisal process for individuals to be compliant with all relevant statutory and mandatory training.

31. Statutory and Mandatory training compliancy of Bank workers has been a significant concern for the Trust.

32. A new Bank contract has been finalised and will be in operation from week commencing 20 November 2017. Bank workers who have not completed any CSR training modules will be removed from the register leaving only approximately 170 Bank workers on the register (approximately 140 of these are ex-LAS employees). The new Terms of Engagement stipulate that all Bank workers must meet London Ambulance Service NHS Trust requirements for Statutory and Mandatory training, before they can work any shifts. A review of Bank workers and their training has been undertaken and the following actions will be implemented by the end of November.

33. An Interim Head of Learning and Development, Jane Hubble, has been appointed who joined the Trust on 13 November 2017. A Learning and Development Facilitator also joined on the 6 November and an E-Learning Co-ordinator on 23 October 2017.

34. A number of individual meetings with members of the Executive Leadership Team and the Board have/are being held to discuss Culture and Behaviours with Caroline Dove and Jim Timpson from NHS Elect. This will be followed by a wash up and review meeting with NHS Elect to design and develop finalised versions of the London Ambulance Service NHS Trust Target Culture and it's supporting our Behaviour Model, supported by a Communications and Engagement plan. The Behaviour Model is currently being rationalised from 9 behaviours to 4 to better promote and market clear expectations going forward which will be underpinned by people's professional registrations and codes of conduct

35. Design continues on developing the Visible Leader element of the Leadership Development Pathway with NHS Elect. An options paper will be provided to directors in terms of its delivery schedule and target audience. Other elements of the pathway, already underway include HR Master Classes, Health and Safety for Managers (both Management Essentials), and Supportive Leadership and Management Behaviours continue to run. New elements of Management Essentials due to launch soon include PDR Appraisal Skills to support delivery of Appraisals.

36. A new Clinical Team Leader Programme will be running throughout November 2017 which combines Clinical and Management skills development and is supported by a residential 2 day course with Cranfield University.

Diversity

37. We continue to focus on recruitment with a very successful Diversity Skills Fair attended at the Emirates Stadium on 10 November 2017. The Communications team has produced a number of short 'job review' videos with our employees talking about the work they do. These are being used as a back drop to our stand at employment events. Specific activities with local partnerships (Newham is one example) are underway to provide support, to those that need it, in developing their skills to make an application to join the trust and undergo our assessment process.

38. The Workforce Race Equality Standard (WRES) report highlighted a number of other activities being planned to positively affect the experience of BME employees at the London Ambulance Service NHS Trust. In addition to a number of focus groups in December, we will also be starting a series of "lunch and learn" sessions to build understanding of equality and the challenge faced by London Ambulance to address the balance in our workforce. The first session will focus on "who we are" with a presentation of the analysis of our workforce – including where our employees live in relation to where they work, the demographics of our operating area and examples of best practice from other health system organisations to address their own diversity challenges.

39. The Equality Committee has now been re-established and met in October with a further meeting planned for 6 December 2017. This group, including representation from the Patients Forum and Trade Unions, will consider both employee and patient perspectives. The Committee will meet 6 times a year and will further extend inclusion of different groups in developing and delivering different work strands in this area. The meeting in December will hear a Staff Story from an employee who uses a wheelchair.

40. The Executive Leadership Team considered a report of bullying and harassment specialist Cathe Gaskell where recommendations have been made which will support embedding a positive resolution of conflict into the way we work.

41. The report recognised that there is not an independent route to resolving conflict informally and this is an important process to support staff engagement and maintain effective working relationships. Work is well underway to refresh the training and build the capability of 60+ round table facilitators and has started to identify and develop skills in dealing with bullying and harassment. The ongoing management of this work will be built into the restructure of the People and Organisational Development function to ensure that it is sustainable and becomes part of the way we work.

Communications

42. A number of staff, who responded to the terror attacks in London and the Grenfell Tower fire, were honoured at a reception at 10 Downing Street in October. Twenty five members of London Ambulance Service NHS Trust staff including representatives from operational teams and the control room attended the emergency services reception which was hosted by the Prime Minister.

43. James Brokenshire, MP for Old Bexley and Sidcup, visited in October, meeting myself and Assistant Director of Operations for South East, Darren Farmer, before spending time in Waterloo control room and ambulance station.

44. We have been working with TfL on their kindness campaign which encourages commuters to be kinder to each other during their travels across the underground network. Paramedic Anwara Lewis features in a social media film advising passengers to help others off the train if they fall ill so they can be seen quicker by staff.

45. The Ambulance Response Programme understandably attracted a level of media attention and the Evening Standard published a page lead article about the introduction of the new national ambulance response standards following an interview with Consultant Paramedic Paul Gates who took the opportunity to encourage Londoners to learn to use defibrillators.

46. On 8 November 2017, Metropolitan Police Commissioner Cressida Dick, London Fire Commissioner Dany Cotton and I hosted a demonstration day showing how London's emergency services work together. Our Service, London Fire Brigade and the Metropolitan Police Service ran through a series of scenarios including a river rescue, responding to a firearms terrorist attack and the release of an unknown hazardous gas.

47. I very proudly joined staff in representing the Service at remembrance events in November. I laid a wreath at City Hall alongside the Mayor and other emergency service colleagues. I was also privileged to attend the service at Westminster Abbey. I would like to thank the members of the ceremonial unit who attended the Royal British Legion Festival of Remembrance event hosted by the BBC at the Royal Albert Hall and took part in the march past the Cenotaph on Remembrance Sunday.

48. One year on from the Croydon tram crash, members of staff joined the Croydon community at a local memorial event to remember the seven people who died and over 50 who were injured. A number of media interviews were done at the event with Assistant Director of Operations Liam Lehane and Croydon Team Leader Terry Healy.

49. Twenty-five members of staff and retirees joined other agencies to mark the 30th anniversary of the King's Cross fire on 18 November 2017. Assistant Director of Operations Peter Rhodes laid a wreath at King's Cross station before staff attended a service at St Pancras church, followed by a reception at Euston Fire Station.

50. The communications team managed national media interest following an incident where two members of staff were assaulted by a member of the public after they blocked the road to treat a seriously-ill elderly patient. The assault was covered by the Evening Standard, The Sun, Mirror Online and Mail Online, as well as ITV News who interviewed Deputy of Director of Operations Kevin Bate.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report Title:	Integrated Quality and Performance Report			
Agenda Item:	08			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Executive Leadership Team members and Board Assurance Committee Chairs			
History:	Executive Leadership Team			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This high level Integrated Performance Report serves to provide an Executive Summary for Trust Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendation(s) to Trust Board:

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

Links to Board Assurance Framework (BAF) and key risks:

This report contains an overview of Trust risks directly linked to the BAF but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUST BOARD EXECUTIVE SUMMARY

November 2017

* All available data is correct as of the 15th of every month.
* Please note that this report relates to performance throughout October 2017 unless otherwise stated.

Delivery of care continues to be safe, but the rising demand pressures on the system continues to remain challenging.
A8 Performance for October 2017 was 68.9%, this is 6.7% below trajectory, whereas category A demand was 4.5% above trajectory.
Year to date the position is £3.2m ahead of plan and £4.7m ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.
Trust vacancy rates have improved from 7.2% to 6.1%. Statutory and Mandatory training rates have remained at 70%.

OUR PATIENTS

- There has been a further reduction in the number of Controlled Drug being lost this month.
- The number of serious incidents occurring during shift changeover has continued to decrease since August 2017. In October there were no incidents declared at this time. This indicates that shift changeover has not had a negative effect on patient safety.
- Level 2 Safeguarding training has been included in CSR 2017.2 and is now live. As this module has only recently commenced it will take time for the Trust to see an improvement in completion rates.
- Following implementation there have been 3 incident reports relating to ARP recorded on the Trust incident reporting system (Datix). All of these incidents have been rated as 'No Harm'.
- 6 weekly deep cleaning continues to demonstrate good levels of compliance - performance achieved 93% against a target of 90% this month.

OUR PERFORMANCE

- A8 Performance for October 2017 was 68.9%, this is 6.7% below trajectory however is 1.4% above October 2016. Red 1 was 2.7% above trajectory at 73.5% and Red 2 was 7% below trajectory at 68.7%.
- There were 48,780 Cat A incidents in October, 4.5% above trajectory. Cat C demand was above trajectory by 0.9%. Overall demand was at 96,549 incidents, 2.7% above plan.
- Job Cycle Time for October was above trajectory at 82.2 by 3.7 minutes. However this is lower than October 2016 by 2.6 minutes.
- Capacity in October was 0.2% above plan for patient facing vehicle hours.
- The multiple attendance ratio was successfully below target at 1.26 for October, the target is 1.29.

OUR MONEY

- Plan / Target – Year to date the position is ahead of plan.
- YTD demand is currently running at 2.5% ahead of contract baseline. This is below the budgeted level of activity included in the Trust's plan, and as such main contract variable income is £0.7m below budget.
- Year to date CIPs are £1.2m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Programme planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.
- Capital spend is £7.2m against a Capital plan of £12.3m, £5.1m behind plan. The forecast is to spend £21.9m vs the plan of £24.3m.
- Cash is £31.9m, £6.3m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £6.6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.8m lower than planned, DH have not approved £5.5m central capital funding in the plan and there are higher than planned creditor payments of £4.6m. These are being offset by under payments of £8.3m on capital, provision of £0.6m and £9.7m on pay. NEL CCGs are querying their contribution to the costs of re-banding the paramedics along side the funding received from NHS England. They are currently withholding £0.7m of overdue debt which we have assumed we will receive in the forecast.

OUR PEOPLE

- Vacancy rates have improved from 7.2% to 6.1%. Frontline vacancies have reduced from 5.1% to 4.5% and Paramedic vacancies from 6.2% to 5.8%.
- Overall turnover has increased from 9.9%. to 10.0%
- The monthly sickness position for October is 5.2%, an increase from 5.1% in September.

111 service delivery remains safe with no Serious Incidents declared during October.
October saw a drop in the number of PTS journeys with a total of 2,197 journeys being delivered. This was result of two PTS contracts finishing during the month.

LAS 111 (SOUTH EAST LONDON)

- 111 failed to achieve 95% or more of calls answered in 60 seconds on 23 days.
- Call demand was higher than predicted in October, by up to 16.2% on weekdays and 13.3% at weekends which has presented a challenge to achieving the target for calls answered in 60 seconds(>95%).
- Referrals to 999 remain consistently low.
- NHS Pathways V14 training has been a focus in October.

LAS IMPROVEMENT

Single Oversight Framework

The purpose of the Single Oversight Framework (SOF) is to identify where providers may benefit from, or require, improvement support across a range of areas. The five themes are: Quality of care, Finance and use of resources, Operational performance, Strategic change, and Leadership and improvement capability.

NHSI segment the provider according to the scale of issues faced.
It does not give a performance assessment in its own right.

1 - Providers with maximum autonomy
2 - Providers offered targeted support
3 - Providers receiving mandated support for significant concerns
4 - Special measures

LAS Current Status	
LAS Shadow Segmentation	4
LAS Breach Status	Breach & Special measures

CQC Overall Rating	Caring	Effective	Responsive	Safe	Well-led
Requires improvement	Outstanding	Good	Good	Requires improvement	Requires improvement

PATIENT TRANSPORT SERVICE

- October saw a drop in the number of PTS journeys with a total of 2,197 journeys being delivered as compared to the September total of 4,136 journeys.
- The drop in journeys was the result of us finishing one contract mid-month. A further two will finish in October one at the start of the month and the second on the 20th of October.
- This now leaves PTS with two contracts operating St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March 2018.

↑	Increasing concern	↓	Decreasing concern
↑	Increasing negatively	↓	Decreasing negatively
↑	Increasing positively	↓	Decreasing positively
↔	Remains steady / Information only		

Key Performance Indicator Report Summary

	Key Performance Indicator	Oct-17	Sep-17	Aug-17	Chart
QUALITY	Adverse Incidents (Patient)	↓	↓	↑	
	Adverse Incidents (Staff)	↑	↓	↓	
	Potential Serious Incidents referred to SI Group	↓	↓	↑	
	Serious Incidents (LAS Declared)	↓	↔	↑	
	Serious Incidents (LAS Declared) Overdue	↔	↓	↑	
	Regular Reporting of Incidents - Shared Learning	↔	↔	↔	
	Total Complaints	↑	↓	↑	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↓	↑	↑	
	Controlled Drug Incidents - Not reportable to LIN	↑	↓	↑	
	All LIN Reportable Incidents	↑	↔	↔	
	Overall Medication Errors	↓	↑	↓	
	Missing Equipment Incidents	↑	↑	↓	
	Failure of Device/Equipment/Vehicle Incidents	↑	↓	↓	
	CPI - Completion Rate*		↓	↑	

	Key Performance Indicator	Oct-17	Sep-17	Aug-17	Chart
111	Calls answered within 60s	↓	↓	↑	
	Calls abandoned after 30s	↓	↑	↓	
	Percentage of calls referred to 999	↓	↑	↑	

	Key Performance Indicator	Oct-17	Sep-17	Aug-17	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↑	↓	
	Vacancy Rate (Frontline)	↓	↓	↓	
	Vacancy Rate (Trust)	↓	↔	↓	
	Turnover Rate (Frontline Paramedic)	↔	↔	↓	
	Turnover Rate (Frontline)	↓	↔	↓	
	Turnover Rate (Trust)	↑	↓	↑	
	Sickness (Trust)*	↑	↓	↓	
	Sickness (Frontline)*	↑	↓	↔	

* These KPIs are reported one month in arrears

	Key Performance Indicator	Oct-17	Sep-17	Aug-17	Chart
PERFORMANCE	A8 Performance	↑	↓	↑	
	A19	↑	↓	↑	
	R1	↑	↓	↑	
	R2	↑	↓	↑	
	Calls	↑	↓	↓	
	Incidents	↑	↓	↓	
	Cat A Incidents	↑	↓	↓	
	Cat C Incidents	↑	↓	↑	
	Patient Facing Vehicle Hours (PFVH)	↑	↓	↓	
	Full Job Cycle Time	↓	↑	↓	
	Job Cycle Time (JCT)	↑	↑	↓	
	Multiple Attendance Ratio (MAR)	↓	↓	↔	
	EOC - Call Answering Rate	↑	↓	↓	
	EOC - FRU Cat C Share	↓	↑	↓	

	Key Performance Indicator	Q1	Q2	Q3
FINANCE	Financial Stability Risk Rating (FSRR)	↔		
	Capital Service Capacity	↔		
	Liquidity Days	↔		

	Key Performance Indicator	Oct-17	Sep-17	Aug-17
	Cash Balance - Monthly Profile - £000s	↓	↓	↓
	Income and Expenditure Deficit by Month - £000s	↑	↓	↓
	Income and Expenditure Deficit Cumulative - £000s	↑	↓	↓
	Income Variance from re-phased budget - £000s	↑	↓	↓
	CIP Delivery Against Plan - £000s	↑	↑	↑
	CIP Forecast Against Plan - £000s	↑	↓	↓
	Forecast Capital Spend Against the CRL - £000s	↑	↑	↑
	Debtor Days	↑	↓	↓
	Creditor Days	↔	↔	↑
	Agency spend against plan - £000s	↑	↑	↑

The RAG status is calculated against targets/trajectories/thresholds where available. The Chart column shows the trend over the previous 3 months | The arrows indicate the direction of KPI compared to previous month

Executive Summary: Exception Report (Positive)

Safety

- No reported incidents relating to adrenaline 1:1000 administration
- Reduction in retention of morphine by staff off duty
- No reports of PGD breaches
- The number of controlled drugs lost has reduced to one this month, from 5 in September.
- A thematic review which included 79 serious incident investigation has been conducted (Jan to Sep17)
- There have been no serious incidents at the shift changeover period. In addition, there are no overdue serious incidents.
- Deep dives into the top three categories will take place over the next month
- Hand hygiene is increasing, and vehicle deep cleans are maintaining their targets

Actions & Assurance

- Ongoing monitoring via Datix incident reporting system.
- Continue robust management of staff retaining morphine off duty
- Thematic review revealed the top three categories to be:
    - Dispatched and call
    - Clinical Assessment
    - Clinical Treatment

Effectiveness

- A further nine dates have been set for November to provide updated Datix training

Actions & Assurance

Caring

- LAS Staff acknowledged for good practice around the resuscitation of pregnant women in regards to resuscitation, communication and care on transfer to hospital.

Actions & Assurance

Executive Summary: Exception Report (Improvement Required)

Safety

- Unaccounted for loss of two ampoules of morphine
- Breakages of morphine ampoules
- There is a decrease in the number of patient incidents being reported, however November is on track to have this number stabilise
- There are issues with the incident category type, which may result in patient safety incidents being categorised as Trust (and vice versa). The categories and sub-categories are undergoing a review in conjunction with the National Reporting and Learning System improvements have been made to the Datix system, however these improvements will take time to embed. Staff will be receiving feedback on a regular basis from November for incidents reported in October
- Level 2 safeguarding training has been included in CSR2017.2
- The rate of patient related adverse incidents is decreasing, however it is expected to increase with a better reporting culture
- Infection Prevention Control – splashes to the face remains an issue
- Only 50% of the total number of personal protective packs ordered were delivered and this has had an impact on roll out of the packs

Actions & Assurance

- Continue to work closely with Metropolitan Police controlled drugs liaison officers
- Progress roll out of secure drug rooms on stations to enhance security and traceability
- Procure drugs ampoule holders and investigate alternative morphine supply with different packaging.
- All patient safety incidents are being quality checked prior to being uploaded to the National Reporting and Learning System for accuracy

- As this module has only just commenced it may take time to see an increase in the number of staff having undertaken level 2 safeguarding training. Completion rates will be monitored during the training window.

Effectiveness

- The staff survey and friends and family survey has reported that staff receiving feedback from incidents is low
- ROSC at hospital has declined for October by 21% and is 13% below target, this is thought to be a natural variation given the sample size is circa 300 patients per month. Similar variations have been observed previously.

Actions & Assurance

- The Quality Governance and Assurance Team will monitor the response to the surveys over the coming months. It is excepted that the feedback figures will increase due to the automated email system being activated within Datix
- The Clinical Audit and Research Unit will review this variation as part of the annual report where the sample size will be larger and therefore provide a clearer representation of ROSC performance.

Caring

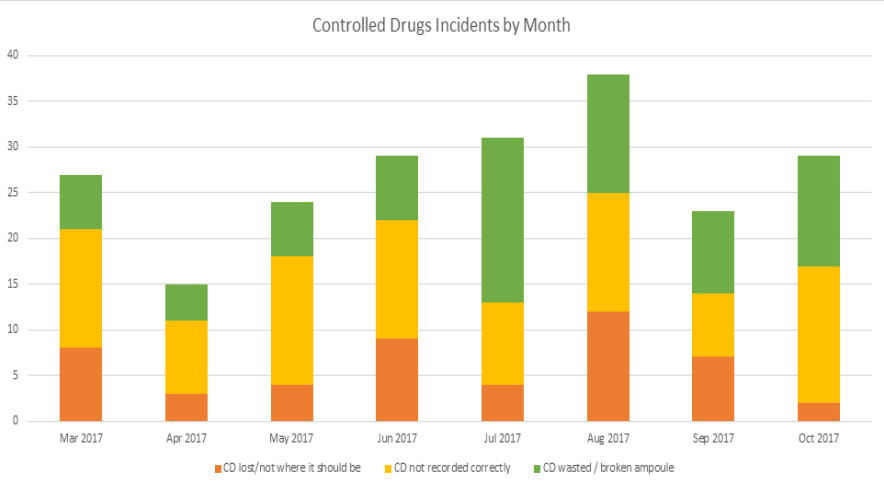
- There has been an increase in the number of complaints relating to patient treatment. The reasons for this is being explored further.

Actions & Assurance

- Patient Experience Department are monitoring this increase and will attempt to identify any potential patterns.

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



Summary

- One unaccounted for loss involving two ampoules of morphine.
- Other controlled drugs incidents as follows
  - Morphine retained by staff off duty (n=2)
  - Documentation errors (n=11)
  - CD register full or damaged (n=2)
  - Ampoules of morphine (n=11) and midazolam (n=1) broken.
- Total of 49 non-controlled drugs issues including the following
  - Discrepancies in drug stocks with KitPrep app (n=15)
  - Medicines found in wrong location and/or out of date (n=20)
  - Access codes written on walls (n=3)
  - Damaged or incomplete drugs packs (n=4)
  - Issues with drug storage facilities (n=4)
  - Errors or omissions in drugs usage documentation (n=3)

Actions

- Increase in controlled drugs breakages may have resulted from new style morphine packaging therefore ampoule tray holders are being procured from supplying the pharmacy.
- Medicines management e-learning programme now live as part of Core Skills Refresher
- Planned trial of medical gases tracking system via Logistics Support Unit
- Stepwise personal issue of Abloy electronic keys to staff to facilitate traceable access at stations where secure drugs rooms are being installed.
- Delivery of further medicines management training to new Clinical Team Leaders during November 2017

Assurance

- No incidents of inappropriate administration of adrenaline 1:1000
- Pre CQC Mock Inspections ongoing to identify medicines management issues
- Roll out of secure drugs rooms on station project predicted to reduce unaccounted for controlled drugs losses and breakages due to enhanced security and purpose designed facilities.

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Jul-17	Aug-17	Sep-17	Oct-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	31%	34%	31%		↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	56%	51%	63%	42%		↓			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	G	70%	70%	66%	74%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	65%	R	67%	63%	65%	64%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	97%	96%		↓			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:34		↓					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:42	00:41		↑					
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	88%	94%			↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	1.72%	3.61%			↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98%	97%		↓		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	91%	91%	91%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	96%	96%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		95%			↓		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%		97%		↔			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	79%	89%	90%	89%	↓			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)	85%										LQ11	✓	

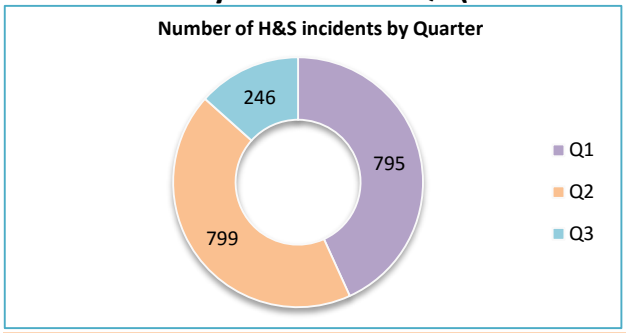
Actions

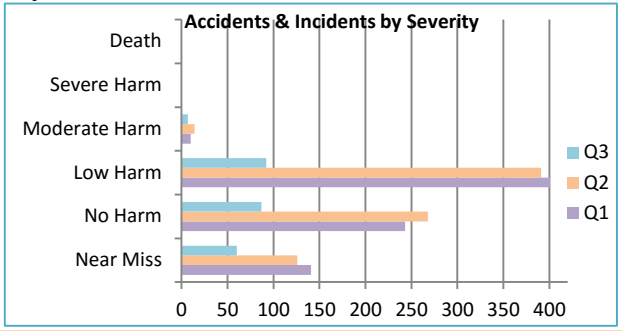
- 17 members of staff attended this quarter's Evidence for Practice session which focused on a retrospective study led by CARU on Double Sequential Defibrillation in cardiac arrest and recently published in *Resuscitation*. Evidence for Practice provides an opportunity for attendees to discuss research papers and their relevance to the Service in a relaxed and friendly environment.

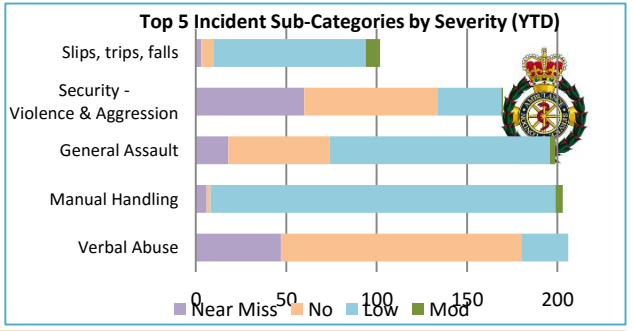
Assurance

- In September we saw the first reduction in CPI completion since May, however the highest proportion of PRFs so far this year were audited by Team Leaders. CARU continue to facilitate additional CPI training with 26 mentors, 10 prospective Team Leaders and 5 members of staff on restricted duties all receiving training on how to undertake CPI audits in October.

Health & Safety Scorecard – Q3 (October 2017)



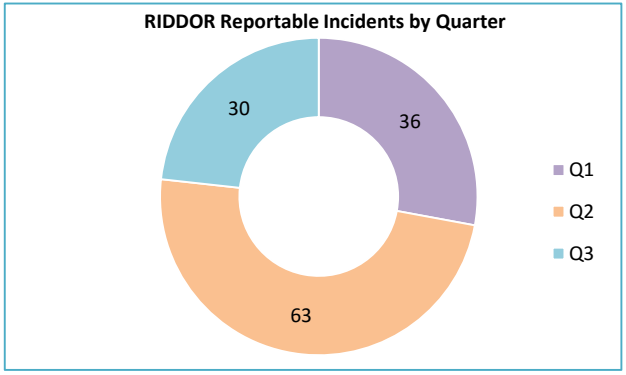


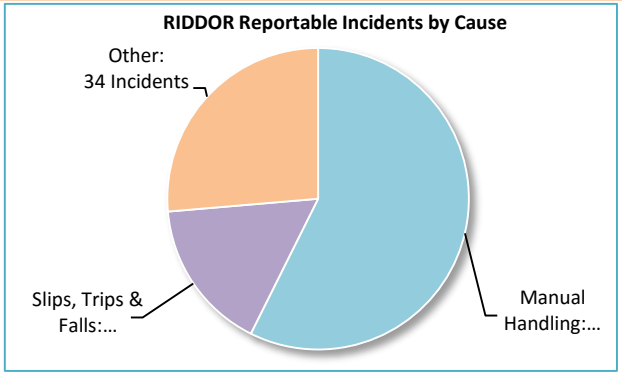


1840 health and safety related incidents were reported during 2017/18 up to October 2017. These incidents account for 38% of the total incidents reported during the year.

915 (49.7%) of the H&S related incidents reported during 2017/18 resulted in harm. 925 (50.2%) of the incidents were reported as 'No Harm/Near misses'.

Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported In Q3 (up to October 2017).

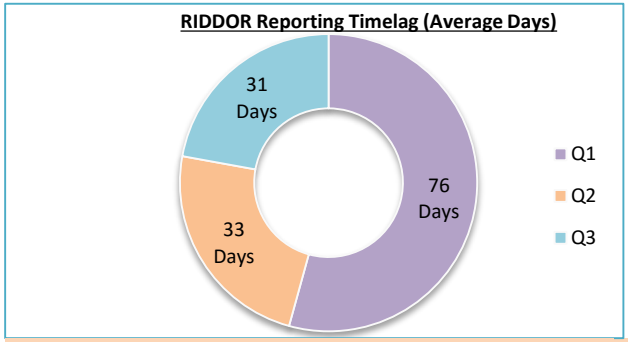


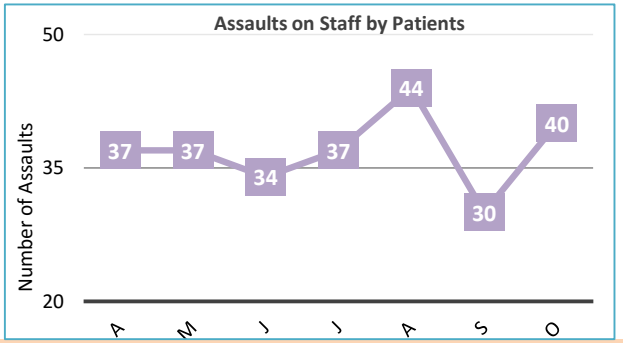


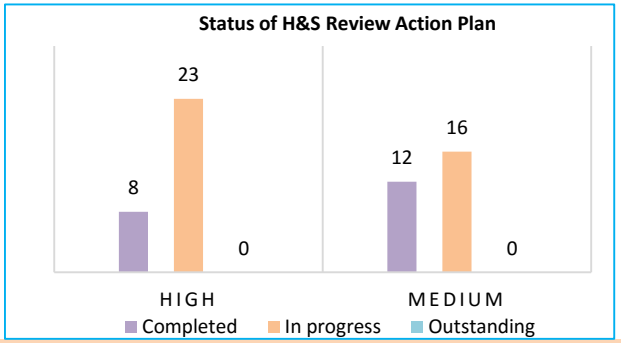
There was a reduction in 'Exposure to Bodily Fluid Incidents' reported in October 2017. YTD, a total of 97 'Exposure to Bodily Fluid Incidents' have been reported compared to 102 'Slip, Trips and Fall' Incidents.

Assurance:

1. Key training in practical MH to be undertaken in December 2017 by Clinical Tutors. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
2. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
3. No trends identified with the increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
4. Prototypes of the proposed integrated Vehicle based first response bags to go on trial at the end of November 2017.
5. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of MAST training during CSR 2 – 2017.



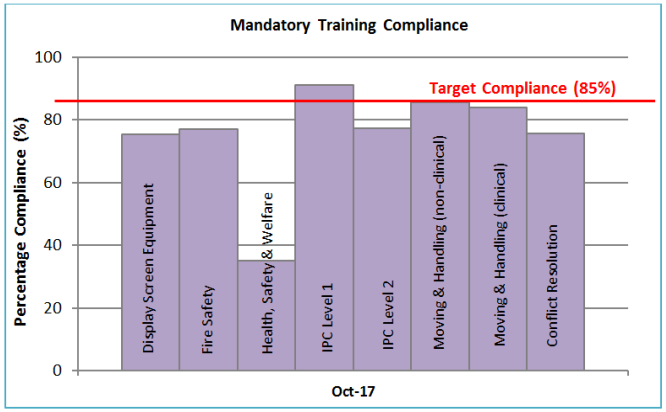




6. The current Trust-wide average of 31 days for reporting RIDDOR incidents currently exceeds the statutory requirement for reporting most RIDDOR incidents which is 15 days.

7. Assaults on staff by patients make up 32% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required. Lone worker policy has been developed and circulated to key stakeholders for review.

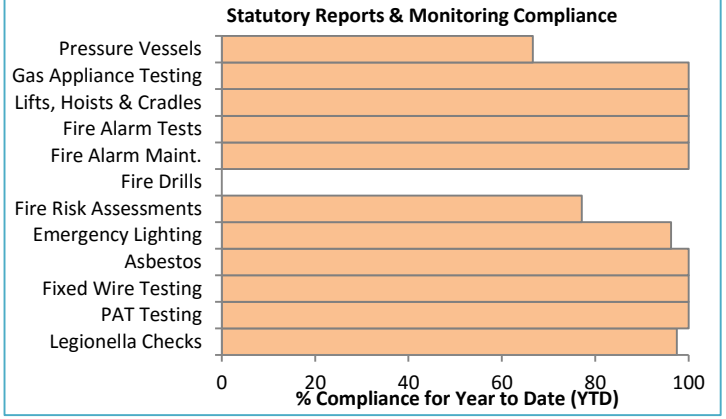
8. 20 of the 59 actions recommended have been completed, 39 actions are in progress and currently underway. A monthly update report is provided to the ELT/Board to highlight progress of actions as well as barriers.



Trust-wide compliance in October 2017 for 6 out of the 8 mandatory health and safety training courses are below 85%.

IPC 1 and Moving and Handling (non-clinical) are at or above 85%.

A new training package for Health, Safety and Welfare Training was launched in September 2017. Trust-wide compliance is currently at 35.14.



Compliance with the statutory fire drills across the Trust is currently at 0.

This is largely because fire drills are not currently completed across a lot of the LAS sites, and where these are completed, they are not recorded. The H&S Dept. is reviewing fire arrangements across the Trust with the aim of improving Trust-wide compliance.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q2 Jul	Current Risk Rating Q2 Aug	Current Risk Rating Q2 Sep	Current Risk Rating Q3 Oct	Target Risk Rating	Key changes/updates since last review
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	9	Key training in practical MH to be undertaken by Clinical Tutors in December 2017. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – developed and circulated for comments.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	3	Withdrawal of paper forms implemented on 01/10/2017. Proactive monitoring of RIDDOR incidents undertaken daily by H&S Team through Datix and GRS. Current reporting time lag is 31 days.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	3	Risk register reviewed, awaiting sign-off by RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q3, 2017.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management. These will be implemented in Q3, 2017.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.
118	IPC	There is a risk of infection due to a sharps injury.	Eng-Choo Hitchcock	Briony Sloper	6	6	6	6	6	3	Risk to be reviewed with Infection Prevention and Control Team.

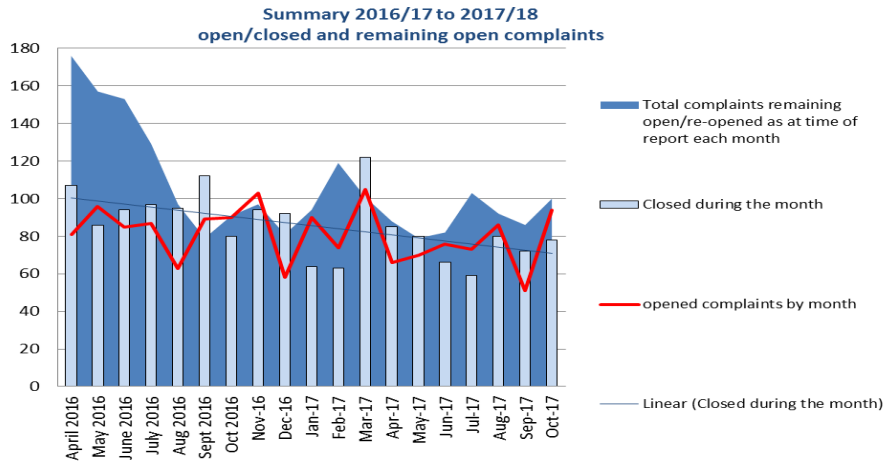
Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 key complaints themes November 2016 to September 2017

Complaints by subject 2015/17	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Total
Delay	37	19	36	16	27	21	17	16	14	26	9	22	260
Conduct	22	15	26	27	36	16	19	24	19	19	16	17	256
Road handling	8	8	7	9	16	12	11	13	14	10	7	14	129
Treatment	6	1	3	3	5	1	2	5	1	7	5	16	55
Non-conveyance	1	1	1	3	4	3	0	4	12	0	1	6	36
Total these subjects	74	44	73	58	88	53	49	62	60	62	38	75	736
Overall totals	103	58	90	74	105	66	70	76	73	86	51	94	946

Complaint summary April 2016 to September 2017



Actions

- During October we received 94 complaints which included 5 from other Health Care Professionals on behalf of the patient
- This represents a 46% increase over September but reflects the historic increase in complaints at this time of year.
- You will see from the above table that there was a marked increase in October (30%) in complaints where treatment was the key aspect. The current annual average is 5 per month.
- From November 2017, the recording of overdue complaints (35 days) will be changed from 100% to 75% this takes into account delays in obtaining supporting information and throughput at Executive Office level.
- One feedback leaflet was received during October – the complainant advised that the response completely addressed their concerns. We are aiming to add the feedback leaflet on the new website in November
- We have set up a monitoring process to review re-opened cases within Datix with individual case officers

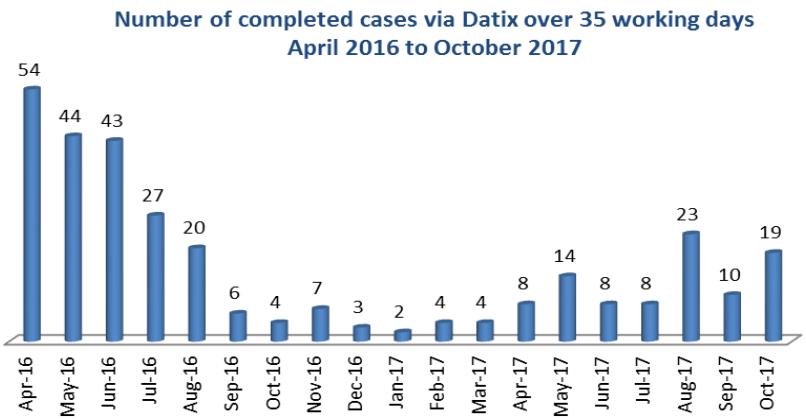
Assurance and learning

- As at 08 November there are 98 open complaints. Of these 2 are overdue based on the target provided during case management and 3 have been re-opened .
- Of the 94 October complaints, 27 have been closed. Of these, 6 have been upheld, 10 were not upheld, 2 were partially upheld and 9 were referred elsewhere.
- One upheld complaint related to reimbursement to a complainant whose mobile phone was accidentally knocked to the floor by LAS staff. The complainant was very abusive to staff in PED supporting the need to record duty calls in the future.
- We are also negotiating the funding of the cleaning of a complainants driveway after an ambulance had a hydraulic spillage. This has highlighted the lack of a budget at local complexes to manage such incidents.
- Overtime complaint numbers increased slightly during October due to staff shortages in August & September and the increase in complaints this month

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

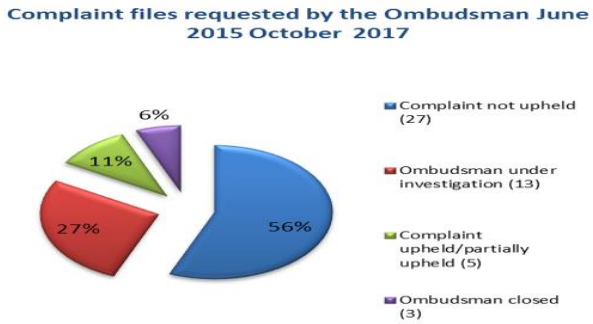
Performance against 35 day response target



Assurance and learning

- Accumulatively the YTD figure of overtime complaints is 17% (against 516 complaints)
- One case was returned by the Ombudsman citing that the LAS acted in line with established good practice and that it was reasonable that the patient was not transported to hospital. As no failings were identified the Ombudsman has not upheld this complaint.
- We were beset by a number of IT issues during October outwith our control.
- The new call log has now 'gone live' and we continue to work with IM&T when we identify any issues with that.
- 6 complaints received and closed during October were upheld. These included a range of subject issues : 2 x delay, 1 x non-conveyance, 1 x damage to property , I relating to an LAR entry and 1 x road handling.
- 2 complaints in this criteria were partially upheld.

Overview of Ombudsman cases 2015-2017



Assurance and learning

- Case examples from October complaints:

Example one:
Complaint from patient's father who was upset that despite her symptoms, his daughter was declined an ambulance.
The Quality Assurance evaluation identified that the call handler gave the incorrect referral information to the caller. The patient should have been referred to the CHUB as opposed to NHS111.

Example two:
Complaint from patient to LAS111 regarding the length of time awaited for a clinical call back.
The 111 QA review identified that the call was managed and assessed properly with a correct determinant of a call back within 6 hours being achieved. This was not communicated to the patient who was advised that she would receive a call within 2 hours.

Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Learning from Incidents

- An article was produced in the RIB on the use of personally procured medical devices following a SI investigation. The information reminded crews that the use of personal medical equipment (pulse oximeters, sphygmomanometers etc) is not permitted.
- A recall notice was sent out regarding the incorrect delivery of suture maternity packs which had been highlighted to the Medical Directorate. The root cause of the error is currently being investigated and no patient safety incidents have been reported.
- An article has been drafted on clinical decision making and the importance of adequate safety netting to be included in the next clinical update. Examples taken from SI investigation and Inquests have been included.

Incidents

SI update	Incidents reviewed In October	SIs declared In October	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	23	4	20	6	14	0	4
Trend on previous week	↓	↓	↑	↔	↑	↔	↑

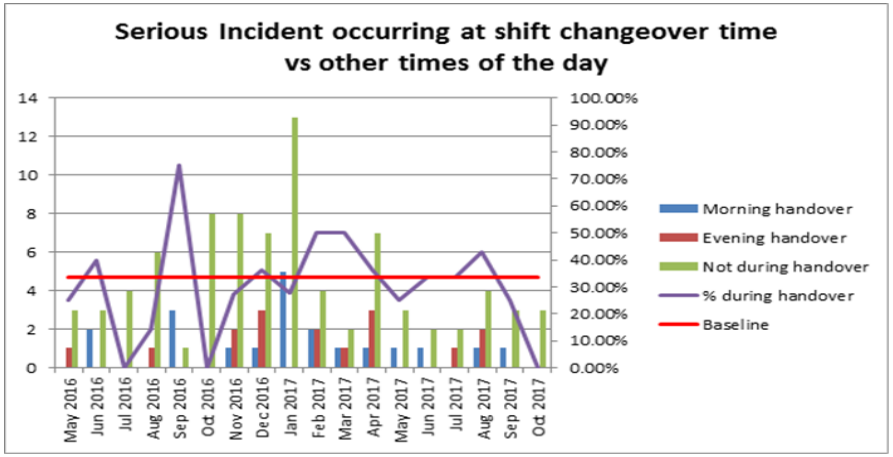
Serious Incidents & Incidents

- The third Lead Investigator training session has been arranged for the 17th November. Currently 15 managers have confirmed their attendance.
- Following on from last months report; of the 344 incidents that had not been assigned a responsible manager, 93% of the incidents have now been allocated
- Benchmarking figures have now been set for the LAS in relation to no harm, and low to moderate harm incidents based on the national average of ambulance Trusts in the UK
- A thematic review which included 79 SI reports completed between Jan to Sep 17 has shown the main categories which have resulted in SI' to be:
  - Call and Dispatch
  - Clinical Assessment
  - Clinical Treatment
- Deep dives will be conducted into each category to form a further thematic review and action plan

Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Overdue Serious Incidents Investigations

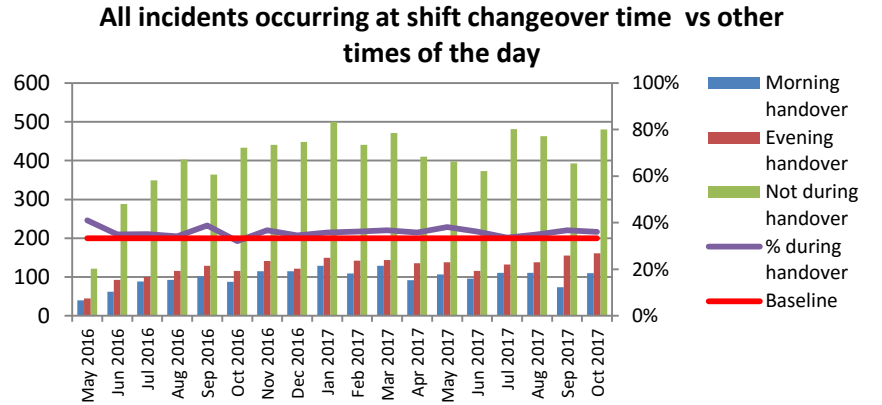


Actions relating to Serious Incident Investigations

SI action plan update (relating to closed overdue SI investigations)

- 36 actions are currently overdue (reduction of 39 from last month)
- Weekly reminder emails continue to be sent to those accountable and responsible for the actions in addition to those generated by Datix
- The reporting Dashboards relating to actions by Sector/Directorate are now live for the use of the Senior Management Team
- Any overdue action where the team have received no communication from the accountable and/or responsible manager have been escalated to the Executive Director for the Directorate

All Incidents occurring during shift changeover



Actions and assurance regarding incidents during shift changeover

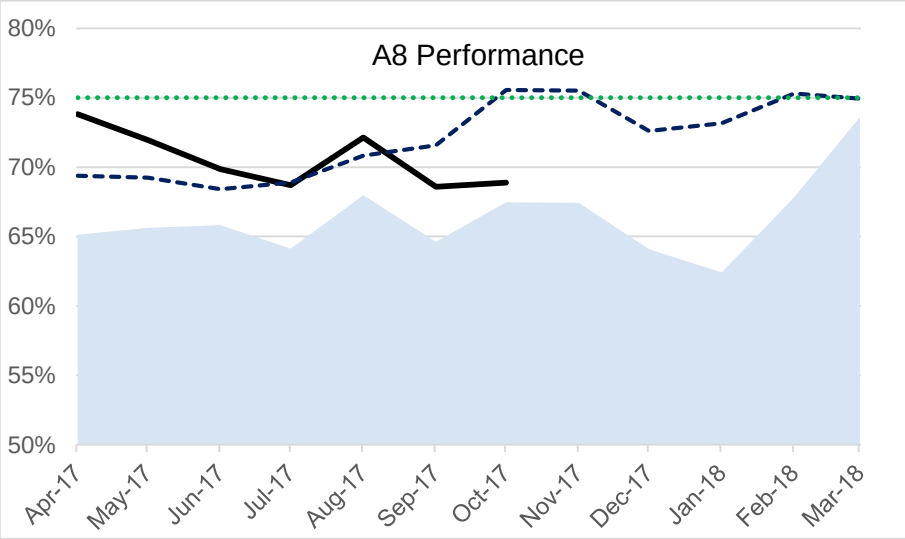
The number of serious incidents occurring during shift changeover has dropped since August 2017, which seems to indicate that the shift changeover has no longer had a negative effect on patient safety.

The chart to the left shows that just over a third of all incidents reported occurred during shift changeover, which is only slightly higher than expected (assuming an even spread of incidents throughout the day), and this figure has remained fairly level since DatixWeb was introduced.

Our Performance

Section	Key Headlines	Oct	Sep	Aug
A8 Performance	A8 Performance for October 2017 was 68.9%, this is 6.7% below trajectory however is 1.4% above October 2016.			
Other Performance	A19 performance was at 94.9% in October. This is 1.8% below trajectory however, this is 1.1% higher than October 2016. C1 to C4 performance saw increases in October when compared to September.			
Demand	There were 48,780 Cat A incidents in October, 4.5% above trajectory. This represents 2,106 incidents. Cat C demand was above trajectory by 0.9%. Overall demand was at 96,549 incidents, 2.7% above plan. October 2017 ranked 3rd for highest monthly Cat A demand to be recorded and was also ranked 4th for highest monthly total demand to be recorded.			
Capacity	The patient facing vehicle hours (PFVH) deployed during October was 0.2% above plan, an increase from the previous month by 8.9%.			
Efficiency	Job Cycle Time (JCT) for October 2017 was 82.2 minutes. This is above trajectory by 3.7 minutes but is 2.6 minutes lower that October 2016. The multiple attendance ratio (MAR) was 1.26 which is successfully below the target of 1.29.			
EOC – Call Answering	The 5 Second Call Answering for October was at 78.8%.			
EOC – FRU Cat C Share	FRU share of Cat C for October was 8.10%.			
Resource Escalation Action Plan (REAP)	In line with the National Ambulance Resilience Unit recommendations, our REAP identifies the level of pressure the Service is under at any given time, and gives a range of options to deal with the situation. Four levels of escalation are used, which aim to help ambulance services integrate into the wider NHS surge or escalation framework. These levels are used to determine what actions are necessary to protect service delivery and supply the best possible level of service to patients with the resources available. The REAP score is currently at level 2.			

A8 Performance

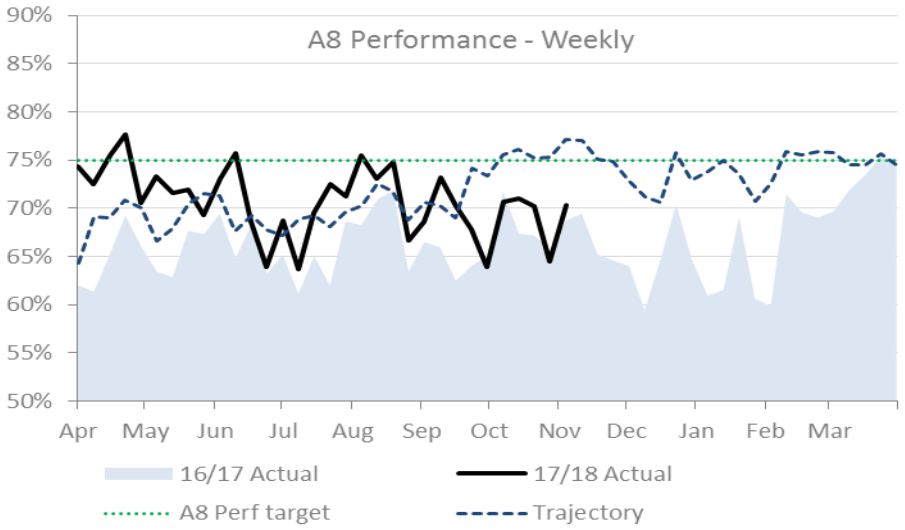


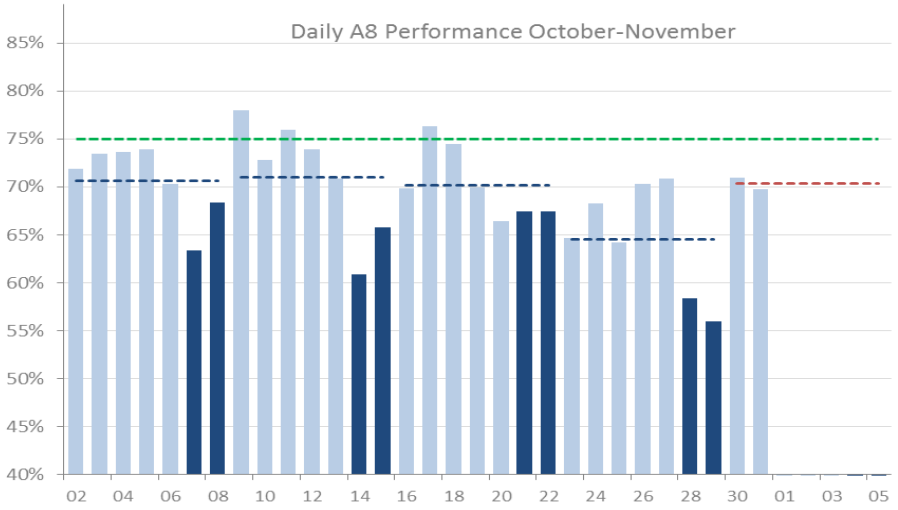
A8 Performance for October 2017 was 68.9%, this is 6.7% below trajectory. For additional context, A8 Performance for October 2016 was 67.5%.

The following factors have contributed to October's Cat A performance:

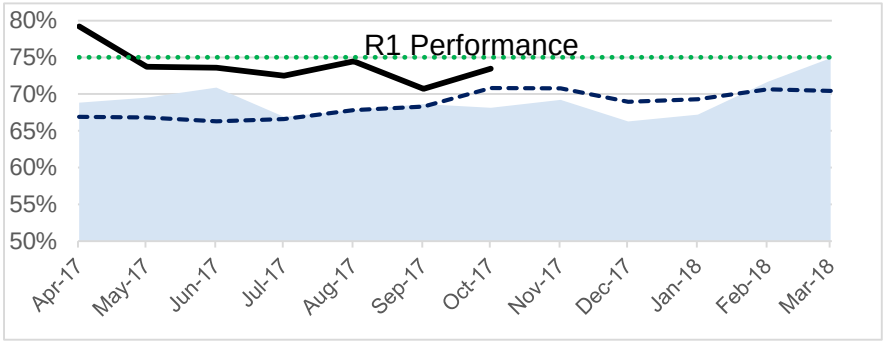
- **Demand** – Overall the number of incidents were 2.7% above plan. Cat A was 4.5% above trajectory, this represents 2,106 incidents in the month. Cat C was 0.9% above plan.
- **Capacity** – Overall patient facing vehicle hours was 0.2% above plan, a 8.9% increase from previous month.
- **Efficiency** - Average job cycle time in October was 82.2 whilst trajectory was 78.5. An increase of 0.4 minutes from last month. Full JCT was 103.7 whilst trajectory was 99.3 and MAR was successfully at 1.26 against a trajectory of 1.29.

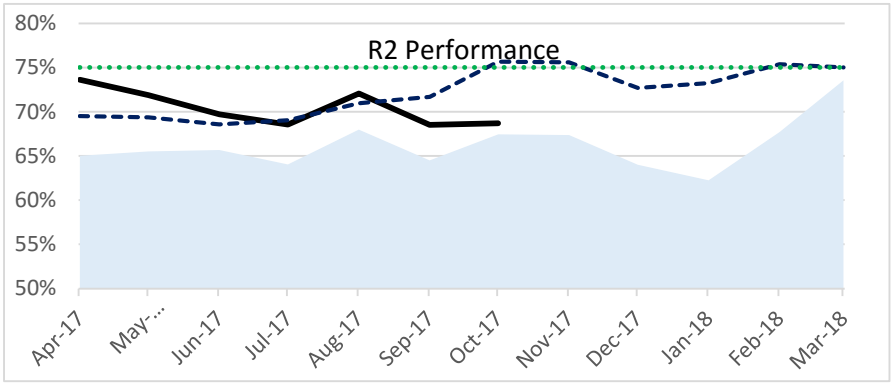
16/17 actual data
17/18 actual data
Trajectory
National target

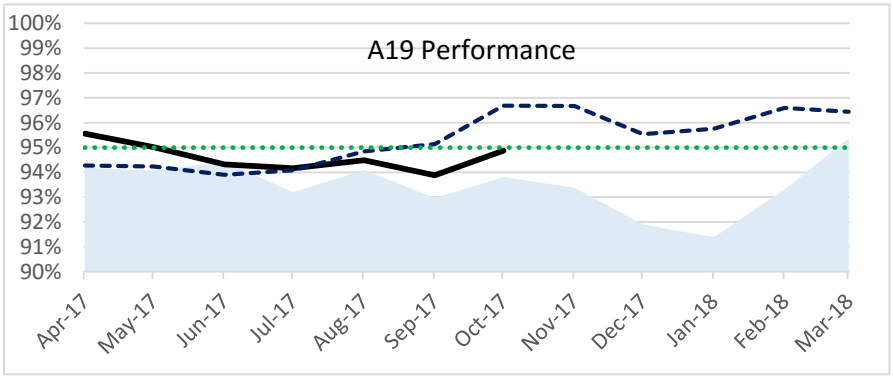




Other Performance







A19 performance was at 94.9% in October. This is 1.1% higher than October 2016. The national standard is 95%.

- Red 1 was 73.5% -2.7% above trajectory and 5.4% above October 2016
- Red 2 was 68.7% - 7% below trajectory but is 1.3% above October 2016

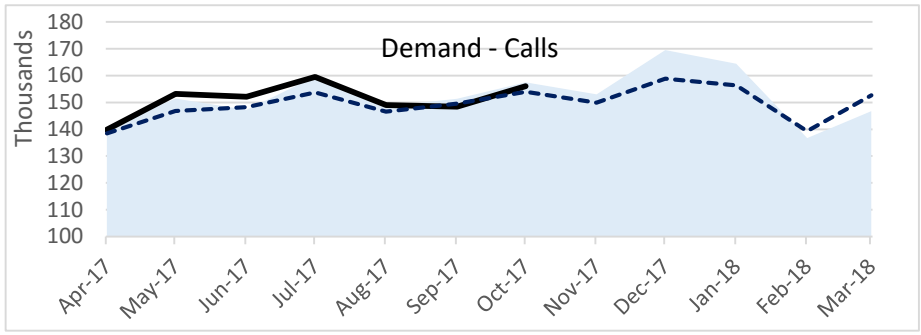
C1 to C4 performance saw increases in October when compared to September.

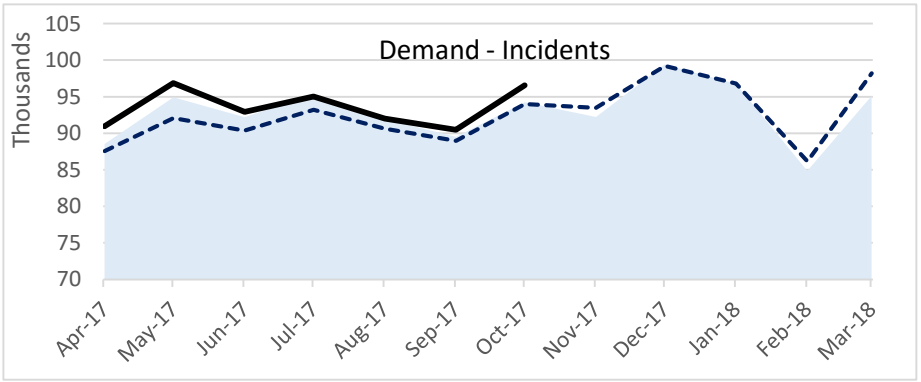
Please note – weekending 5th November only has data for the 30th and 31st October.

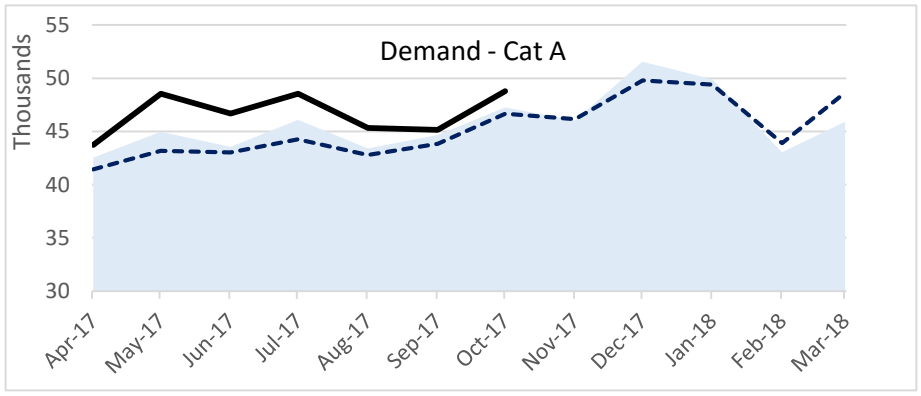
16/17 actual data
17/18 actual data
Trajectory
National target

Week ending	A8	A19	R1	R2	C1	C2	C3	C4
08-Oct	70.6	95.1	74.5	70.5	79.8	81.8	80.9	59.8
15-Oct	71.0	95.1	71.2	71.0	79.7	81.3	82.2	61.1
22-Oct	70.2	95.0	73.4	70.0	77.1	79.7	82.2	58.4
29-Oct	64.5	94.3	74.7	64.1	79.7	79.5	80.1	60.6
05-Nov	70.4	96.1	80.8	69.9	87.7	86.4	85.3	66.3
Aug-17	72.1	94.5	74.5	72.1	79.0	80.8	81.5	60.1
Sep-17	68.6	93.9	70.7	68.5	74.7	78.4	78.8	57.6
Oct-17	68.9	94.9	73.5	68.7	79.4	80.8	81.5	60.3

Demand







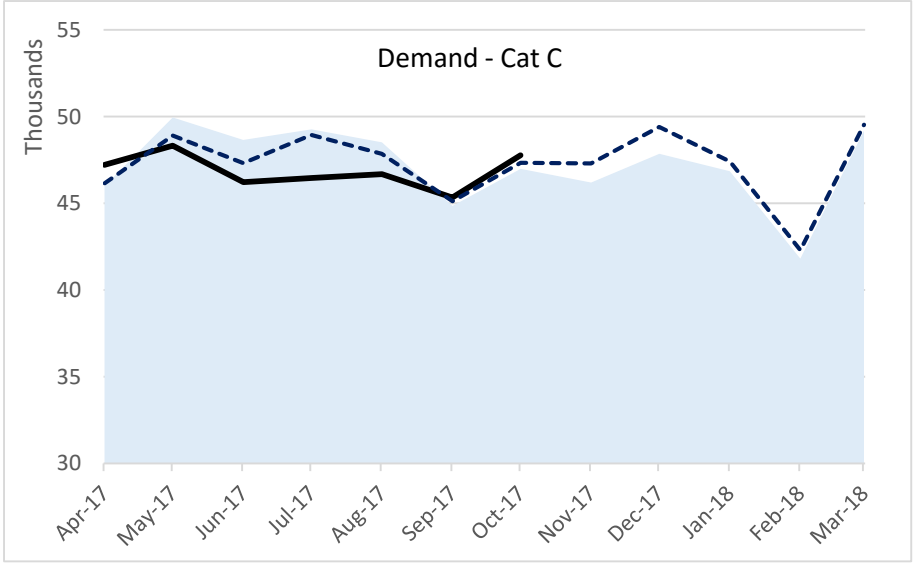
Overall demand for October 2017 was at 96,549 incidents, this is 2.7% above plan but there was a 6.7% increase from last month. October 2016 was at 94,240 incidents.

Cat A demand was 4.5% above trajectory but saw a 8.0% increase from last month.

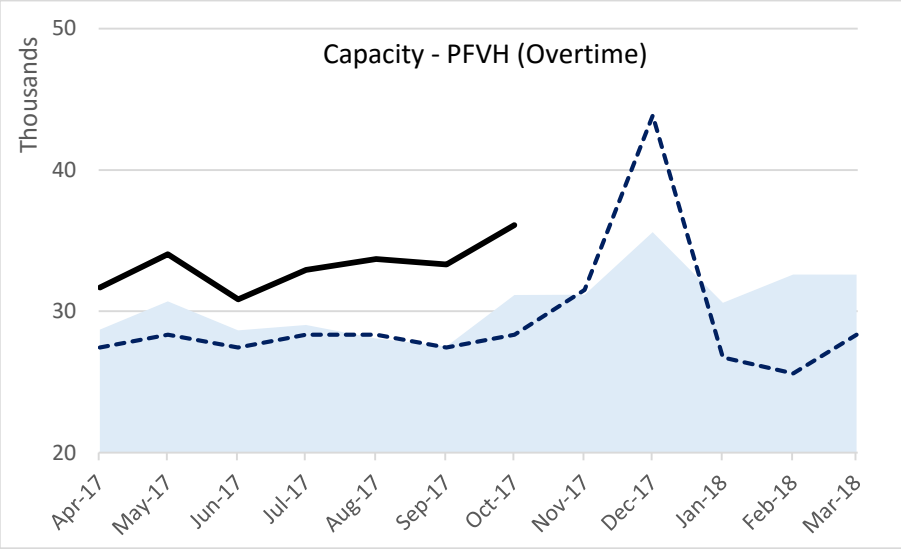
October's Category C incidents 0.9% above plan. There was an increase of 5.4% from the previous month and was 1.7% higher than October 2016's incidents.

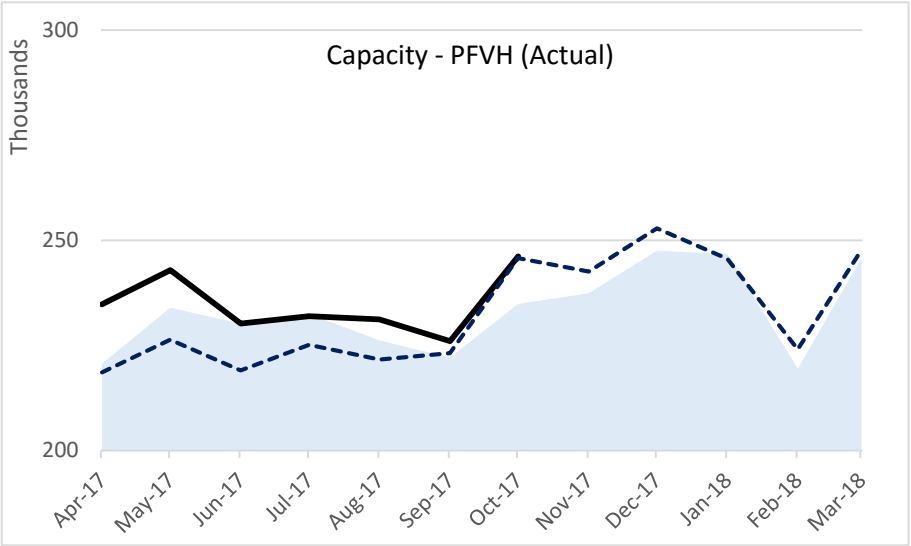
Call volumes were 1.3% above trajectory and 5.2% higher than the previous month.

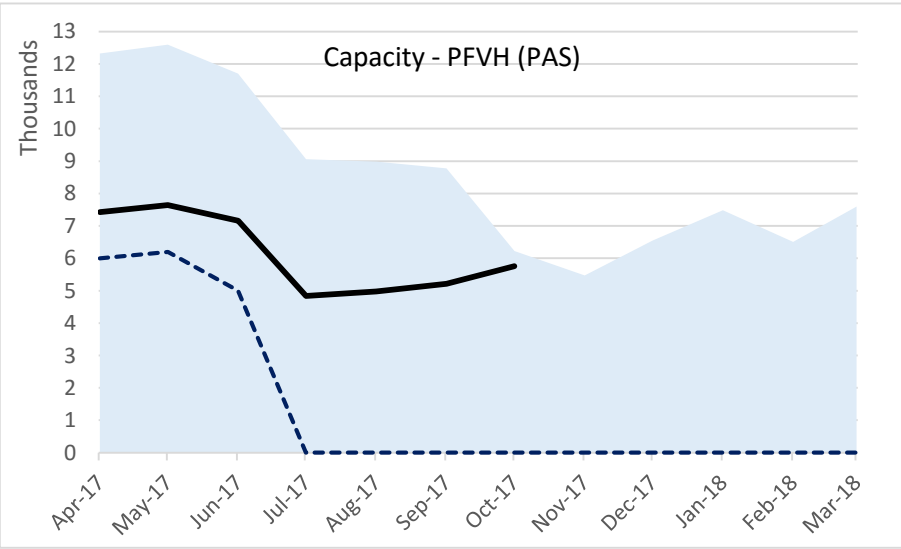
16/17 actual data
17/18 actual data
Trajectory



Capacity





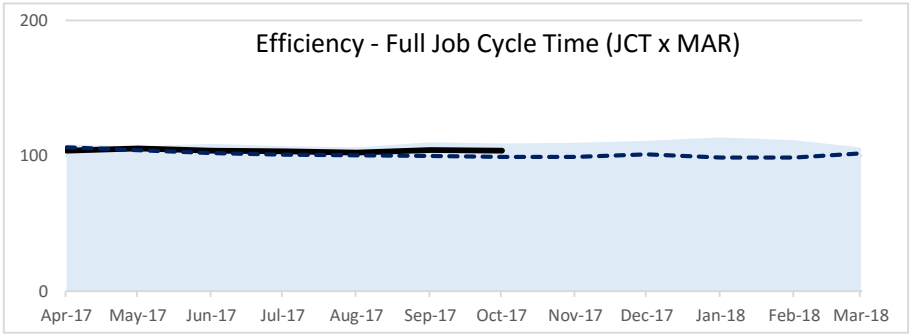


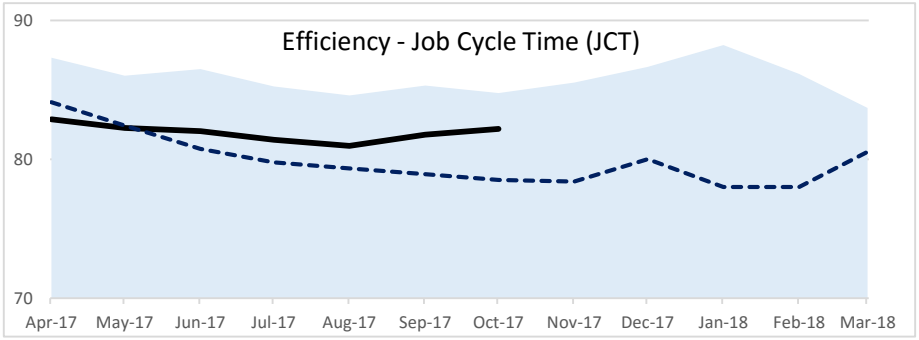
The Patient Facing Vehicle hours deployed in October were 246,164. This was 0.2% above plan and 4.8% above October 2016.

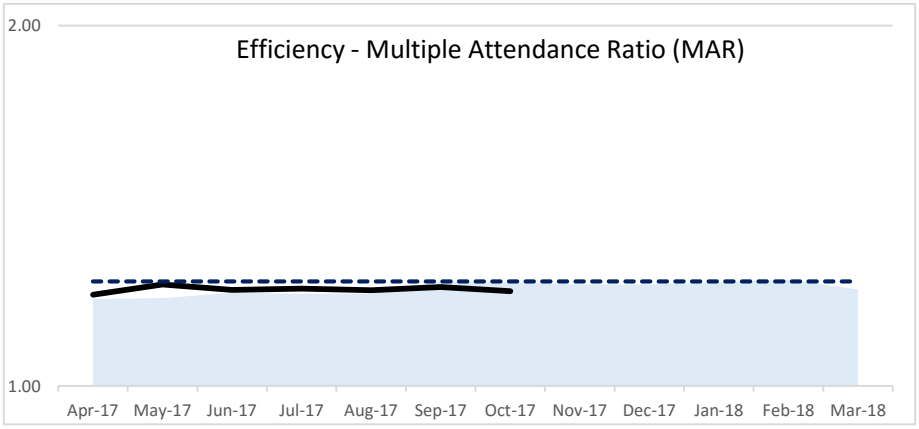
PAS/VAS hours for October 2017 increased by 10.5% from the previous month and was 7.4% below October 2016.

16/17 actual data
17/18 actual data
Trajectory

Efficiency







There is a requirement to reduce JCT from 85 minutes to 78 minutes in 2017/18.

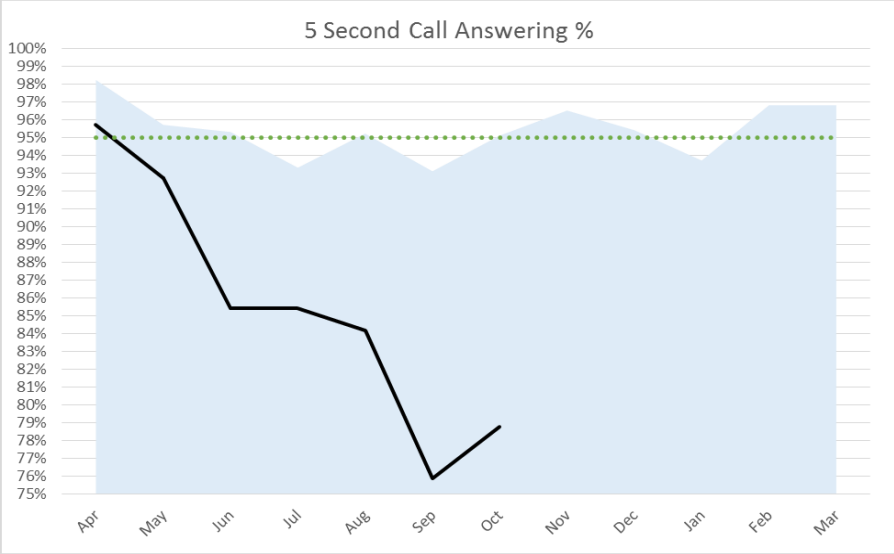
Job Cycle Time for October was 82.2 whilst the trajectory was 78.5. This was an increase of 0.4 minutes from the previous month, however it was 2.6 minutes lower than October 2016 last year.

Full Job Cycle (JCT x MAR) was 103.7 minutes against a trajectory of 99.3. This is also better than October last year by 5.4 minutes.

The Multiple Attendance Ratio (MAR) was successfully below target for October at 1.26.

16/17 actual data
17/18 actual data
Trajectory

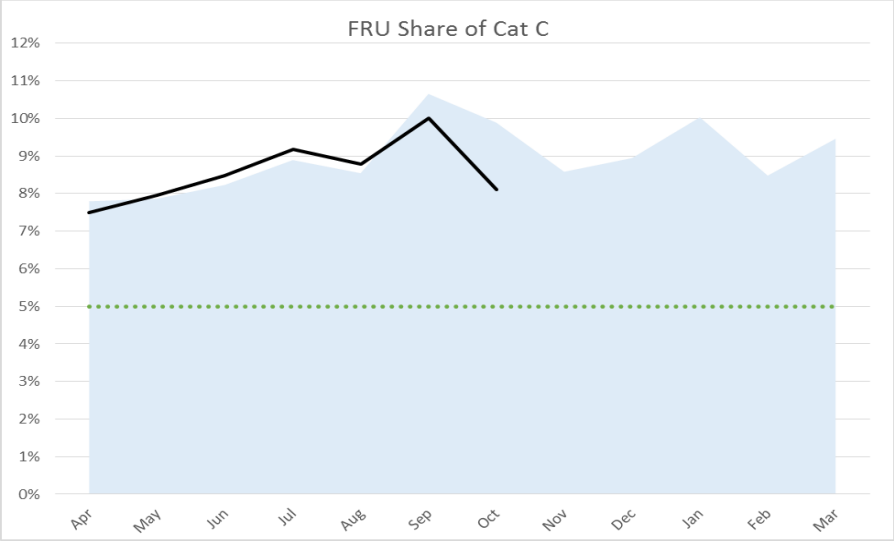
Emergency Operations Centre (EOC)



5 Second Call Answering for October 2017 was at 78.8%, the target is 95%.

FRU share of Cat C for October 2017 was 8.1% which is 3.1% above the 5% target.

16/17 actual data
17/18 actual data
Target



Month	5 Second Call Answering %	
	2016-17	2017-18
Apr	98.21%	95.70%
May	95.70%	92.70%
Jun	95.30%	85.40%
Jul	93.30%	85.40%
Aug	95.21%	84.20%
Sep	93.10%	75.90%
Oct	95.10%	78.80%
Nov	96.50%	
Dec	95.40%	
Jan	93.70%	
Feb	96.80%	
Mar	96.80%	

Month	FRU Share of Cat C	
	2016-17	2017-18
Apr	7.80%	7.49%
May	7.87%	7.95%
Jun	8.23%	8.48%
Jul	8.89%	9.18%
Aug	8.54%	8.78%
Sep	10.65%	10.00%
Oct	9.89%	8.10%
Nov	8.58%	
Dec	8.95%	
Jan	10.03%	
Feb	8.48%	
Mar	9.46%	

Ambulance Quality Indicators (AQI) Update – September 2017

The AQIs for September 2017 were published on 9th November 2017. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

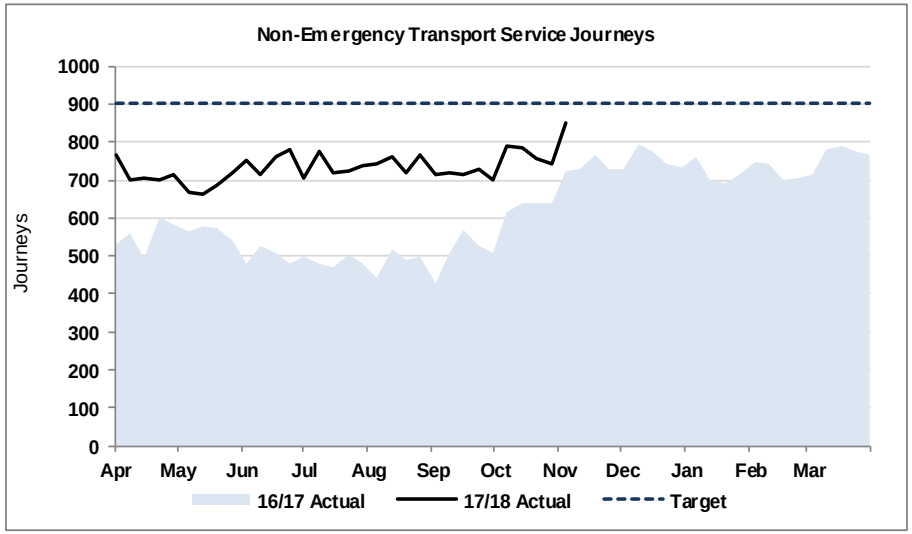
The table below details 7 of these indicators with the description and LAS performance.

Please Note: Due to the Ambulance Response Programme for Category A measures the Yorkshire, West Midlands and South Western Ambulance Trusts are only included in the first two measures in the table below (Ranking Position).

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**			
AQI Indicator Description SYSTEM INDICATORS	**Units**	**Target**	SEP	AUG	JUL	Ranked out of (for Sep)	SEP	AUG	JUL
The time taken to answer 95% of 999 calls in the emergency control room	(secs)	5 secs	94	66	52	9	6	7	8
The percentage of callers who have hung up before their call was answered in the emergency control room	%		3.10%	2.60%	1.10%	9	6	8	5
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	70.70%	74.50%	72.40%	7	2	1	3
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	68.50%	72.00%	68.50%	7	2	1	2
The time taken to reach 95% of Category A (Red 1) calls	(mins)		13.8	13.4	13.1	7	2	5	1
The percentage of Category A calls reached within 19 minutes	%	95%	93.90%	94.30%	94.10%	7	1	1	2
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	(mins)		19	17.8	18.7	7	2	4	2

Latest Publication : 9th November 2017 (Sep-17 data)
Date of next publication : 14th December 2017

Non Emergency Transport Service



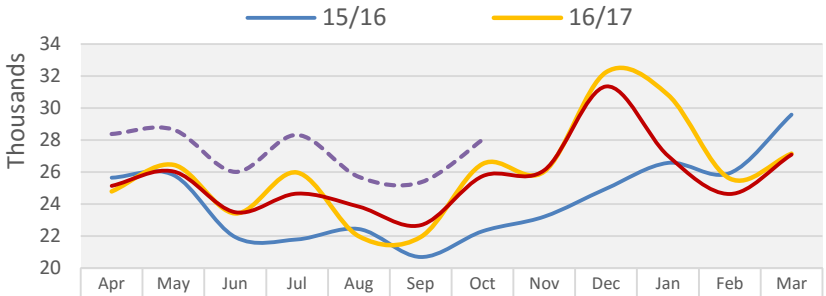
Non-Emergency Transport Update

- NETs saw an increase in the month and delivered an average of 761 journeys per week for the month.
- During October we saw the NETs overall weekly performance fluctuate in line with the impact of resources and activity levels. The team maintained its continued focus in ensuring the quality and number of calls to the NETS dispatch group was maintained. The average number of calls passed to NETS also increased from last months 940 per week to 985 calls per week for the month.
- Performance was also challenged due to increasingly lengthy handover times at hospitals with specific issues with North West London hospitals.
- From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETs and completed.

Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
04/09/2017	869	4	148	721
11/09/2017	967	5	251	716
18/09/2017	928	9	193	735
25/09/2017	999	4	295	704
02/10/2017	991	7	210	774
09/10/2017	1007	10	213	784
16/10/2017	1007	9	246	752
23/10/2017	937	15	187	735
30/10/2017	1052	16	192	844

LAS 111 (South East London) - Demand and Capacity – October 2017

QR02 - Calls Answered



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	25,648	25,812	21,939	21,794	22,442	20,697	22,305	23,219	24,963	26,573	25,935	29,586
16/17	24,791	26,451	23,419	25,971	21,988	21,947	26,505	26,037	32,237	30,826	25,596	27,151
14/15	25,137	26,036	23,492	24,654	23,842	22,685	25,743	26,118	31,346	27,019	24,631	27,091
17/18	28,381	28,656	26,015	28,321	25,703	25,361	28,026					

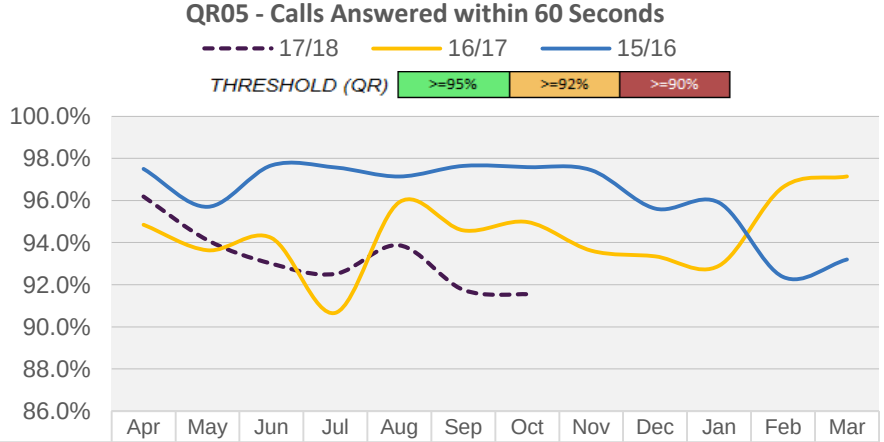
Demand: Call volumes was higher than October 2016 and 17.2% higher than in October 15/16.

Capacity: Induction commenced on 16 October to maintain robust Call Handler capacity and increase Clinical Advisor establishment fill.

Efficiency: The percentage of calls answered in 60 seconds was 91.6% in October with the target achieved on only 8 days. The operational focus has been on balancing access to the service and minimizing time to clinical call back and saw an increase in call backs achieved within 10 minutes.

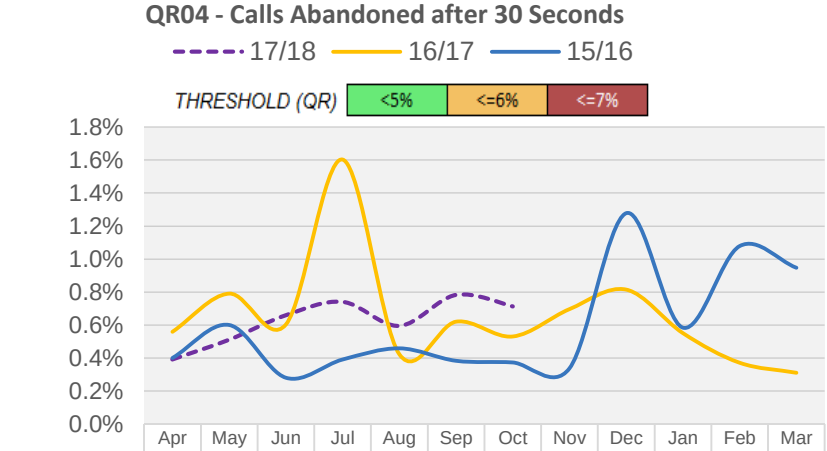
Service Projects: The service focus throughout October has been on SEL 111/IUC Evolution Action Plan and the development of pilots in a range of areas.

QR05 - Calls Answered within 60 Seconds



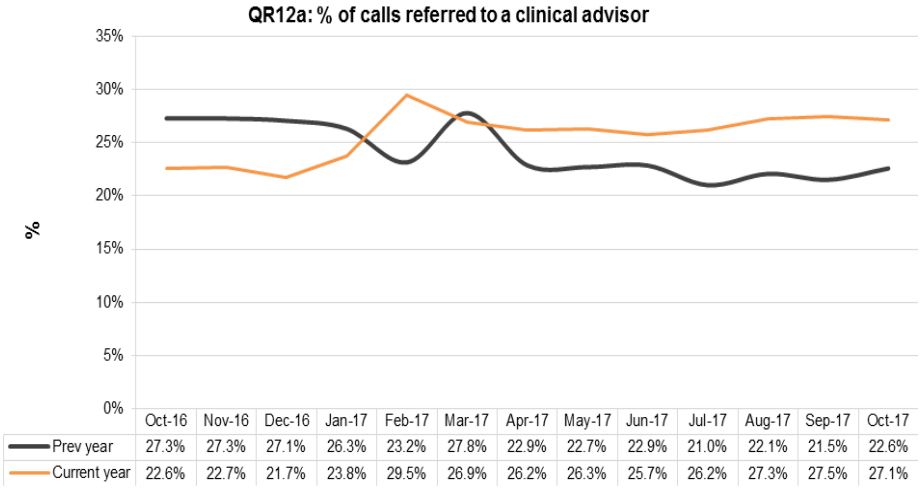
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	96.2%	94.1%	93.0%	92.5%	93.9%	91.8%	91.6%					
16/17	94.8%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%
15/16	97.5%	95.7%	97.7%	97.6%	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%	93.2%

QR04 - Calls Abandoned after 30 Seconds



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.4%	0.5%	0.7%	0.7%	0.6%	0.8%	0.7%					
16/17	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%
15/16	0.4%	0.6%	0.3%	0.4%	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%	0.9%

LAS 111 (South East London): Call Destinations – October 2017

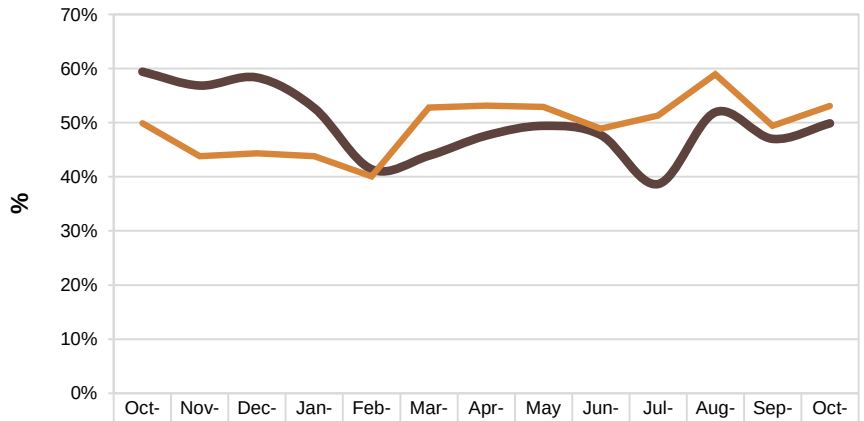


	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Prev year	27.3%	27.3%	27.1%	26.3%	23.2%	27.8%	22.9%	22.7%	22.9%	21.0%	22.1%	21.5%	22.6%
Current year	22.6%	22.7%	21.7%	23.8%	29.5%	26.9%	26.2%	26.3%	25.7%	26.2%	27.3%	27.5%	27.1%

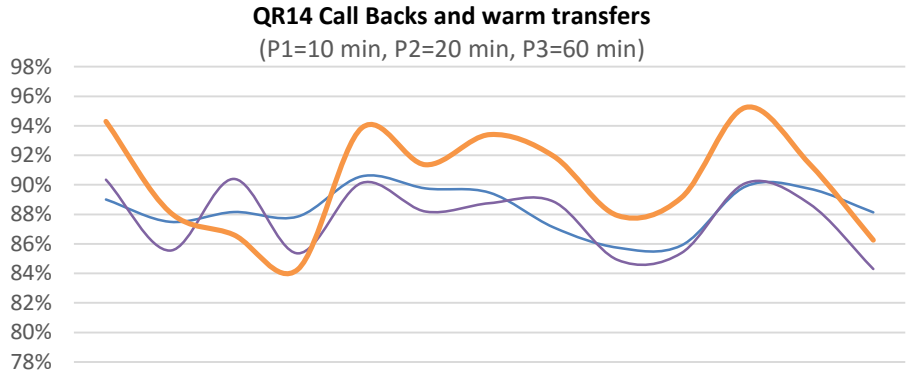
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green ambulance outcomes and availability of Clinical Advisors to accept a warm transfer. A prioritisation system is in place to inform those decisions.

Safety: There were 117 Incidents in Datix with completed investigations in March. Of these 6.8% (n=8) related to authorised breaches in confidentiality including safeguarding referrals made with our patient consent, 31.6% (n=37) to failure to follow procedure, 56.4% (n=66) to delay in care and the remaining 5.1% (n=6) to other issues. Incidents are under investigation and feedback given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received ten complaints, one compliment and feedback from two HCPs. The reason for the increase in complaints is being investigated.



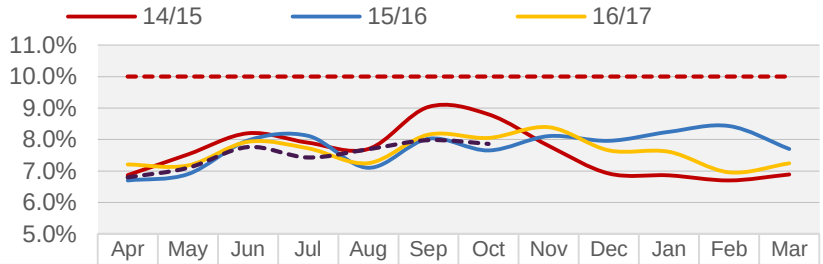
	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May -17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Prev year	59.4%	56.9%	58.3%	52.7%	41.4%	43.9%	47.6%	49.4%	47.7%	38.7%	51.9%	47.0%	49.9%
Current year	49.9%	43.8%	44.4%	43.8%	40.1%	52.8%	53.2%	52.9%	48.9%	51.3%	59.0%	49.4%	53.1%



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
P1 <10m)	89%	87%	88%	88%	91%	90%	89%	87%	86%	86%	90%	90%	88%
P2 <20m)	90%	86%	90%	85%	90%	88%	89%	89%	85%	85%	90%	89%	84%
P3 <60m)	94%	88%	87%	84%	94%	91%	93%	92%	88%	89%	95%	91%	86%

LAS 111 (South East London): Triage destinations – October 2017

QR10 - Percentage of answered calls transferred to 999



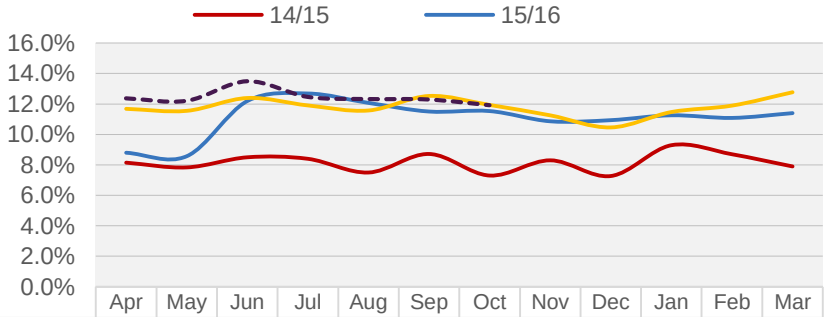
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14/15	6.9%	7.5%	8.2%	7.9%	7.7%	9.0%	8.8%	7.8%	6.9%	6.9%	6.7%	6.9%
15/16	6.7%	6.9%	8.0%	8.1%	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%	7.7%
16/17	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%
17/18	6.8%	7.1%	7.8%	7.4%	7.7%	8.0%	7.9%					
Target (QR)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for Green ambulance outcomes.

Referrals to Emergency Departments are higher than for other providers, this figure includes Urgent Care Centres and Walk-in Centres.

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 refers the lowest number of calls overall.

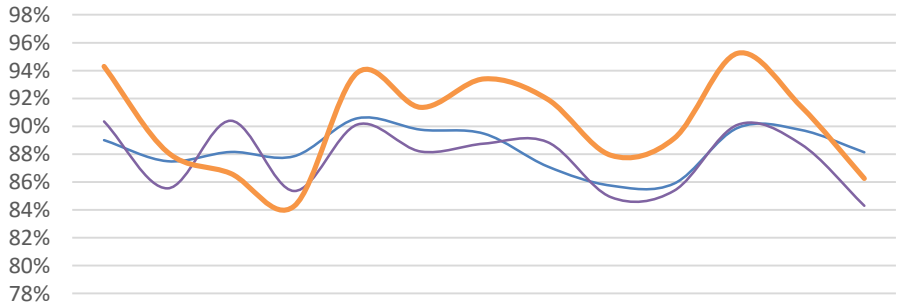
QR11 - Percentage of patients advised to attend Emergency Treatment Centre



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14/15	8.1%	7.8%	8.5%	8.4%	7.5%	8.7%	7.3%	8.3%	7.3%	9.3%	8.7%	7.9%
15/16	8.8%	8.6%	12.2%	12.7%	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%	11.4%
16/17	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%
17/18	12.4%	12.2%	13.5%	12.5%	12.3%	12.3%	11.9%					

QR14 Call Backs and warm transfers

(P1=10 min, P2=20 min, P3=60 min)



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
P1 <10m)	89%	87%	88%	88%	91%	90%	89%	87%	86%	86%	90%	90%	88%
P2 <20m)	90%	86%	90%	85%	90%	88%	89%	89%	85%	85%	90%	89%	84%
P3 <60m)	94%	88%	87%	84%	94%	91%	93%	92%	88%	89%	95%	91%	86%

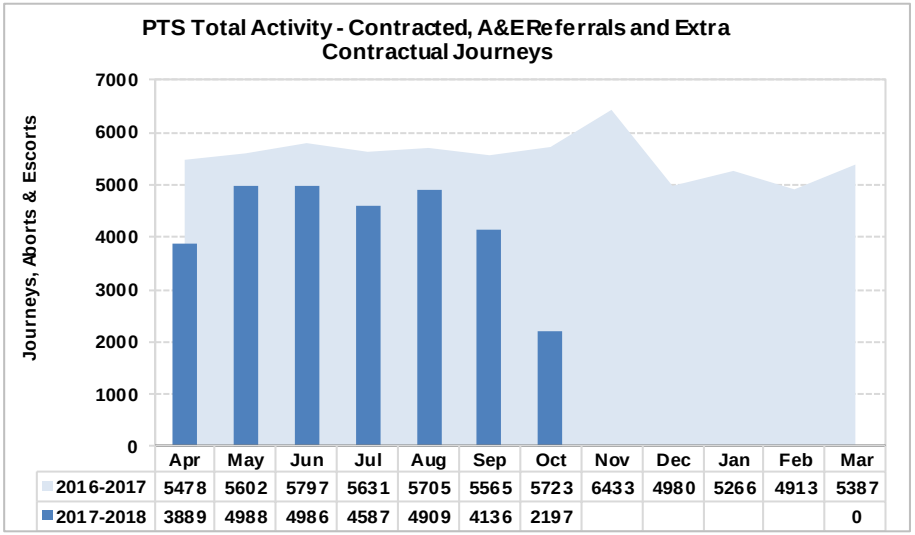
LAS 111 (South East London): London & National Comparison – October 2017

The table below shows LAS' performance on key Quality Requirements (QRs) agreed in Schedule 12 contract of the SEL CCGs contract for providing 111 services. It shows a comparison to that of the other three London providers and the regional and national totals. ***Our ranking is out of five London providers***.
Data is taken from the weekly NHS England 111 Situation Report, and is collated for October 2017.

October 2017									
Description	**Target**	**LAS**	**Care UK**	**LCW**	**PELC**	**Vocare**	**London**	**LAS ranking (pan-London)**	**England**
Total calls answered	N/A	28,139	23,994	31,703	35,935	26,448	156,655		1,161,088
% of Calls answered within 60 seconds	95%	91.36%	90.59%	82.21%	96.69%	85.52%	89.50%	2	87.06%
% of Calls abandoned after 30 seconds	5%	0.70%	1.38%	3.05%	1.49%	2.26%	1.78%	1	2.24%
% of Calls transferred to, or answered by a clinical advisor	N/A	28.07%	24.19%	32.15%	24.57%	24.82%	26.87%		23.96%
Of calls transferred, percentage transferred warm	N/A	55.28%	30.31%	74.90%	71.39%	43.63%	58.35%		43.84%
Of call backs, percentage within 10 minutes	100%	59.95%	48.18%	51.92%	70.55%	51.12%	55.42%	2	40.62%
% of Calls referred to 999	10%	7.77%	11.02%	12.08%	9.13%	10.00%	9.98%	1	11.75%
% of Calls referred to Emergency Department	N/A	11.95%	9.69%	10.17%	14.21%	11.02%	11.47%	4	8.87%

*Modified clinical call back model agreed with commissioners. Contract QR target does not reflect this
*Ranking is from 1-5 with 1 representing the best performance in that area.

Patient Transport Service – Activity and Profitability Update



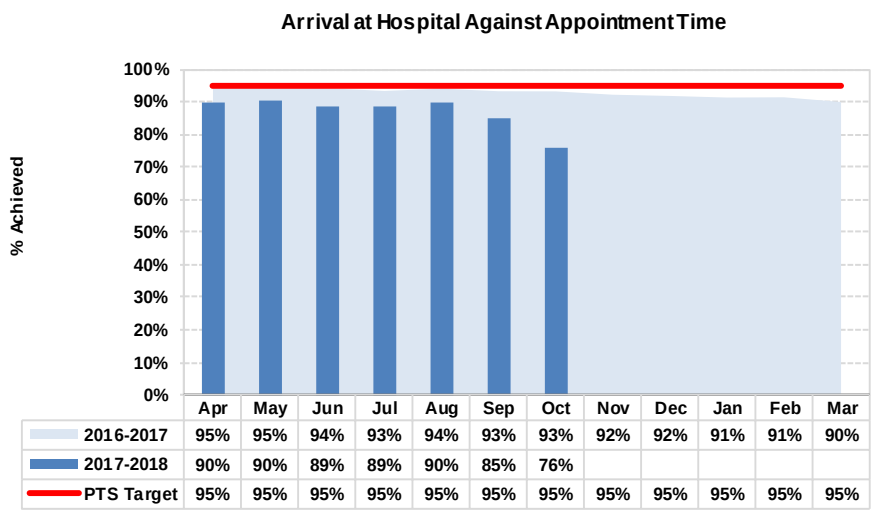
October saw a drop in the number of journeys with a total of 2,197 journeys being delivered as compared to the September total of 4,136 journeys.

The drop in journeys was the result of us finishing two contracts during the month. The first finished at the start of the month and the second on the 20th of October.

This now leaves PTS with two contracts operating St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March 2018.

Month	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Apr	15044	13227	8495	5478	3889
May	15987	13164	7943	5602	4988
Jun	14852	10129	8967	5797	4986
Jul	16481	10508	8923	5631	4587
Aug	14401	9028	5457	5705	4909
Sep	15002	9602	6097	5565	4136
Oct	16739	10957	5841	5723	2197
Nov	15981	10063	5989	6433	
Dec	13986	9250	4943	4980	
Jan	16409	9753	5103	5266	
Feb	15232	9787	5306	4913	
Mar	13978	10520	5264	5387	
Total	184092	125988	78328	66480	29692

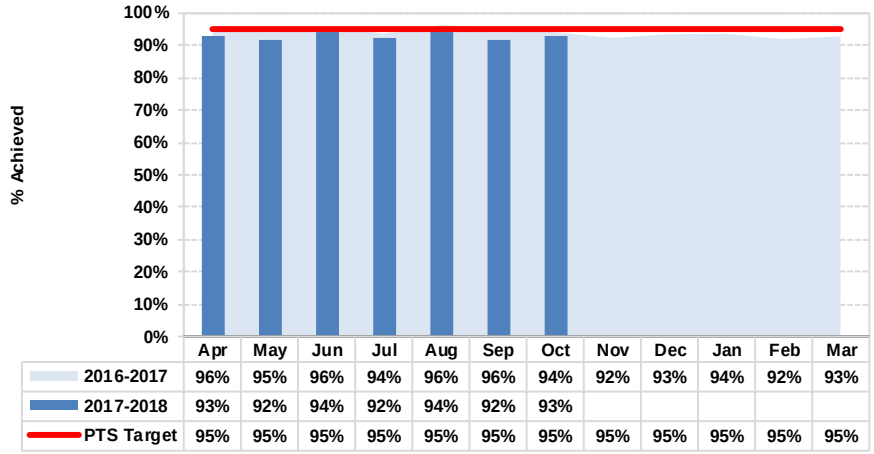
Patient Transport Service – KPI Update



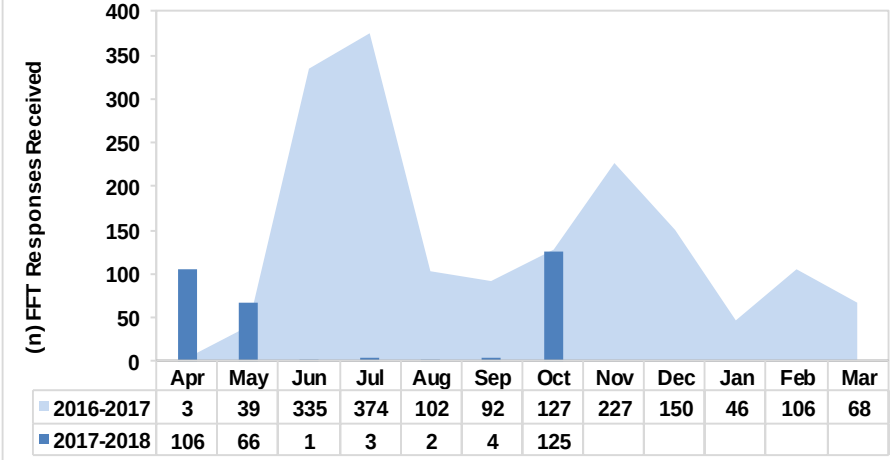
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	95%	95%	94%	93%	94%	93%	93%	92%	92%	91%	91%	90%
2017-2018	90%	90%	89%	89%	90%	85%	76%					
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The arrival at hospital against the appointment time decreased by 9% to 76% in October even with the drop in overall activity for the month, but was well below the 95% target. Part of the fall was linked to the disruption caused by number of staff consultation meetings (both individually and in groups) re TUPE on two of our contracts which finished in the month and where we used third party providers to cover.

Departure against patient ready time saw an increase from the 92% we had in September back to 93% for October against the background of decreased activity. This is below the target of 95%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	96%	95%	96%	94%	96%	96%	94%	92%	93%	94%	92%	93%
2017-2018	93%	92%	94%	92%	94%	92%	93%					
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

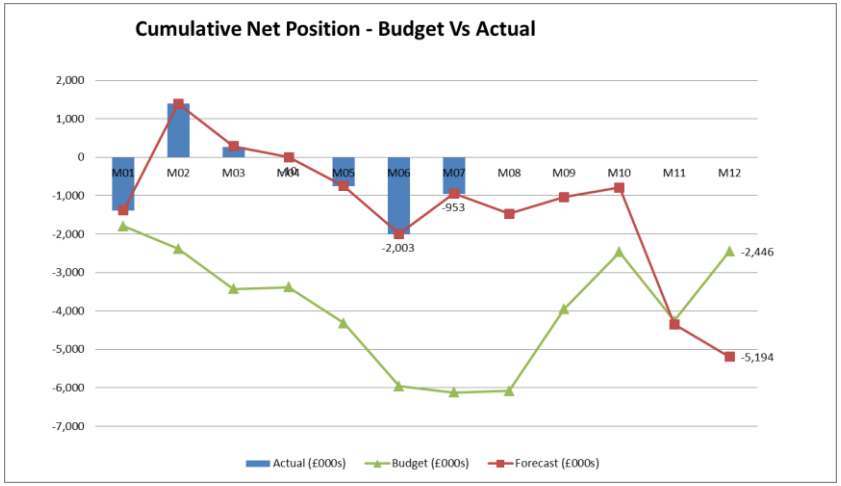


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-2017	3	39	335	374	102	92	127	227	150	46	106	68
2017-2018	106	66	1	3	2	4	125					

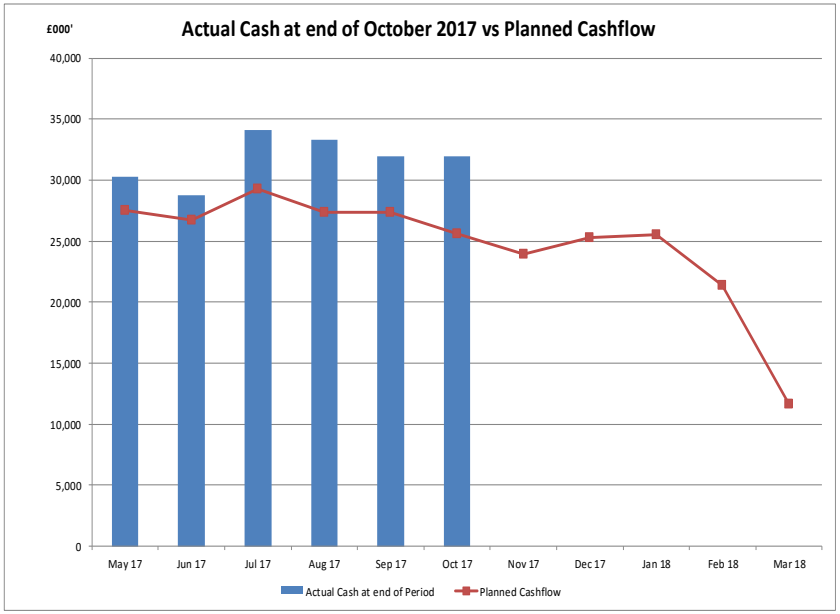
Our Money

Financial Indicator	Key Headlines	Forecast Outturn	Current Month	Previous month
Surplus/Deficit (Year to date and Forecast)	Year to date the position is £3.2m ahead of plan and £4.7 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. Whilst the month 7 forecast is to achieve plan, there is a risk that the Trust could end the year with a worst case £7.8m deficit if CIP and CQUIN risks materialise and are not mitigated further. Key issues in the position are: • Income is £0.6m adverse compared to re-phased budget due to the budget including over activity at 3% and only 2.5% being achieved YTD. • On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand			
Income	Income is £0.1m favourable in month, and £0.6m adverse year to date compared to re-phased budget due to: • PTS £0.3m favourable variance in month as contract was initially budgeted to have ended in July. • Main contract activity for M7 YTD is 2.5% higher than the contract baseline, and the variable income in relation to this (£3.3m) has been recognised in the Trust accounts. • There is a risk around band 6 funding as additional criteria has been issued by NHS England that must be met before funding is released.			
Expenditure (incl. Financial Charges)	In month expenditure is £1m favourable to re-phased budget in month, and £5m favourable YTD. The key drivers for this are: • On-going vacancies in operational pay (incl. EOC) (£1.9m favourable in month, £13m favourable YTD) • PAS overspends to compensate for vacancies (£0.4m unfavourable in month, £3m unfavourable YTD) are offset by various underspends in budgeted services spend			
CIPs	Year to date CIPs are £2.2m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is now in to ensure the Trust achieves the full year plan of £17.8m.			
Balance Sheet	Capital spend is £7.2m against a revised internal Capital plan of £7.2m and the NHSI submitted plan of £12.3m, £5.1m behind plan. The risk around the uncertainty of the availability of last year's carry forward (£6.9m) has been removed as it has been allocated this month. The Trust has only been allocated £0.998m of the £5.5m centrally funded initiatives assumed in the initial plan.			
Cashflow	Cash is £31.9m, £6.3m above plan. The Trust has overdue debts of £6.6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.8m lower than planned, DH have not approved the £5.5m the central capital funding and there are higher than planned creditor payments of £4.6m are being offset by under payments of £8.3m on capital, provision of £0.6m and £9.7m on pay. NEL CCGs are querying their contribution to the costs of re-banding the paramedics along side the funding received from NHS England.			
BPPC	Non-NHS 86%, NHS 90% performance (volume) for this month, performance is still below 95% target.			

Executive Summary - Key Financial Metrics



	2017/18 - Month 7			Year to Date			FY 2017/18
	Re-phased Budget	Act	Var	Re-phased Budget	Act	Var	Plan
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Surplus / (Deficits)	(157)	1,051	1,209	(6,118)	(942)	5,177	(2,438)
EFL				(1,363)	(12,648)	11,285	12,538
CRL				12,267	7,299	4,968	28,806
Suppliers paid within 30 days - NHS	95%	90%	(5.0%)	95%	77%	(18.3%)	95%
Suppliers paid within 30 days - Non NHS	95%	86%	(9.1%)	95%	86%	(8.8%)	95%
Monitor							
EBITDA %	4.6%	8.1%	3.5%	2.3%	4.4%	2.2%	5.0%
EBITDA on plan	1,400	2,466	1,066	4,614	9,051	4,437	18,185
Net Surplus	(157)	1,051	1,209	(6,118)	(942)	5,177	(2,438)
NRAF (net return after financing)				(1.67%)	1.09%	2.8%	1.2%
Liquidity Days				(0.13)	4.31	4.44	(9.90)
Use of Resources Rating				3.0	1.0	2.0	2.0



- Year to date the position is £3.2m ahead of plan and £4.7 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit.
- Income is £0.1m favourable in mth due to PTS contract planned to be completed and adjustments made to the phasing of contract income and cquin.
- On-going vacancies in core frontline staff groups offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand.
- Demand is currently running above 2017-18 contracted baseline activity (2016-17 contract activity plus 6%) by circa 2.5% YTD, lower than the level included in the budget of 3%. This figure differs from the figures quoted in the weekly performance packs as the weekly performance data includes activity for dates outside the reporting period (i.e. week 1 includes 2016/17 activity and the YTD activity in the weekly performance packs will not align exactly to the end of each month).
- CRL position – the capital plan is £5.0m behind target.
- Cash is £31.9m, £6.3m above plan. The Trust has overdue debts of £6.6m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.8m lower than planned, DH have not approved the £5.5m the central capital funding and there are higher than planned creditor payments of £4.6m being offset by under payments of £8.3m on capital, provision of £0.6m and £9.7m on pay. NEL CCGs are querying their contribution to the costs of re-banding the paramedics along side the funding received from NHS England.
- Non-NHS 86%, NHS 90% performance (volume) for this month, performance is still below 95% target.

Forecast and CIP Outturn (I&E)

Divisional Budget Summary 2017/18	Income and Expenditure						Cost Improvement Plan					
	YTD			Full Year			YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Division	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Central Corporate	13,468	11,250	2,218	25,949	22,072	3,878	(1,413)	(1,323)	(90)	(2,899)	(1,980)	(919)
Central Income	(196,255)	(194,700)	(1,555)	(346,561)	(345,889)	(672)	(1,100)	0	(1,100)	(2,225)	(1,125)	(1,100)
Chairman & Non-Executives	65	64	1	111	106	5	0	0	0	0	0	0
Chief Executive	1,985	1,819	166	3,150	3,036	114	(147)	(493)	346	(250)	(596)	346
Corporate Services	2,656	2,492	164	4,553	4,330	222	0	0	0	0	0	0
Estates	6,092	6,122	(30)	10,400	10,559	(160)	(147)	(117)	(30)	(250)	(90)	(160)
Finance	1,865	1,353	512	3,282	2,680	601	0	0	0	0	0	0
Fleet & Logistics	15,974	18,877	(2,902)	27,016	33,098	(6,083)	(684)	0	(684)	(1,257)	0	(1,257)
IM&T	7,302	6,966	336	14,478	14,159	318	0	0	0	0	0	0
Clinical Education & Standards	8,218	5,466	2,752	13,336	11,285	2,051	0	0	0	(250)	(250)	0
Medical	2,915	2,290	625	4,975	4,569	406	0	0	0	0	0	0
111 Service	34	(99)	133	(94)	(221)	127	0	0	0	0	0	0
Central Operations	13,159	12,689	469	22,510	22,416	94	(280)	(749)	469	(500)	(594)	94
Control Services	13,699	14,032	(333)	23,826	24,020	(195)	(1,367)	(1,092)	(275)	(2,000)	(1,929)	(71)
Core Frontline Central	13,462	23,682	(10,220)	21,026	41,795	(20,770)	(2,519)	(1,514)	(1,005)	(6,550)	(1,514)	(5,036)
South East Sector	20,460	18,317	2,143	35,064	31,491	3,574	0	0	0	0	0	0
South West Sector	13,185	12,564	621	22,591	21,505	1,086	0	0	0	0	0	0
North West Sector	22,051	19,139	2,913	37,791	33,219	4,571	0	0	0	0	0	0
North Central Sector	14,867	12,628	2,239	25,477	21,762	3,715	0	0	0	0	0	0
North East Sector	19,684	16,428	3,256	33,723	28,486	5,237	0	0	0	0	0	0
Non Emergency Transport	4,069	3,656	413	6,937	6,486	450	(444)	(857)	413	(1,000)	(1,450)	450
Patient Transport Service	(331)	(341)	9	(331)	(303)	(28)	0	0	0	0	0	0
Performance	701	655	46	1,201	933	268	0	0	0	0	0	0
Quality & Assurance	1,655	1,469	185	3,037	2,698	339	0	0	0	0	0	0
Special Measures	0	0	0	0	(3)	3	0	0	0	0	0	0
Strategic Communications	602	560	42	1,032	1,057	(25)	0	0	0	0	0	0
Support Services Senior Mngmnt	61	(0)	62	105	(0)	106	0	0	0	0	0	0
Transformation & Strategy	661	348	313	1,691	804	887	0	0	0	0	0	0
People & Organisational Development	3,814	3,218	597	6,174	5,898	276	(336)	(127)	(208)	(600)	(359)	(241)
Total	**6,118**	**945**	**5,173**	**2,446**	**2,049**	**397**	**(8,437)**	**(6,272)**	**(2,165)**	**(17,781)**	**(9,888)**	**(7,893)**

Year to date CIPs are £1.2m behind plan and are currently offset by fortuitous non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.
NB: Forecast above is before month 7 performance review updates.

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Statement of Comprehensive Income

2017/18 - Month 7				Description	Year to Date					FY 2017/18	
Plan	Re-phased Bud	Act	Re-phased Bud Var		Plan	Re-phased Bud	Act	Plan Var	Re-phased Bud Var	Plan / Re-phased Bud	Fcast
£000	£000	£000	£000 fav/(adv)		£000	£000	£000	£000	£000 fav/(adv)	£000	£000
				Income							
29,625	30,143	29,930	(213)	Income from Activities	208,165	202,624	201,005	(7,160)	(1,619)	357,210	357,081
255	255	567	312	Other Operating Income	1,300	2,273	3,249	1,949	976	3,645	4,968
29,880	**30,398**	**30,497**	**99**	**Subtotal**	**209,465**	**204,897**	**204,255**	**(5,210)**	**(642)**	**360,855**	**362,049**
				Operating Expense							
22,421	22,796	21,366	1,430	Pay	158,819	156,499	147,820	10,999	8,680	269,735	259,055
5,964	6,202	6,665	(463)	Non Pay	43,577	43,784	47,388	(3,811)	(3,604)	74,833	86,334
28,385	**28,998**	**28,031**	**966**	**Subtotal**	**202,396**	**200,283**	**195,208**	**7,188**	**5,075**	**344,568**	**345,389**
1,495	**1,400**	**2,466**	**1,066**	**EBITDA**	**7,069**	**4,614**	**9,047**	**1,978**	**4,433**	**16,287**	**16,660**
5.0%	4.6%	8.1%	3.1%	**EBITDA margin**	3.4%	2.3%	4.4%	-38.0%	2.2 %	4.5%	
				Depreciation & Financing							
1,386	1,204	1,069	135	Depreciation	9,124	8,255	7,585	1,539	670	14,487	14,567
350	350	350	0	PDC Dividend	2,450	2,452	2,450	0	2	4,204	4,200
(8)	(8)	(5)	(3)	Finance Income	21	(55)	(47)	68	(8)	(95)	(64)
11	11	2	9	Finance Costs	0	80	16	(16)	64	137	27
0	0	(1)	1	P&L on Disposal of Fixed Assets	0	0	(12)	12	12	0	(11)
1,739	**1,558**	**1,414**	**143**	**Subtotal**	**11,595**	**10,732**	**9,992**	**1,603**	**740**	**18,733**	**18,719**
(244)	**(157)**	**1,051**	**1,209**	**Net Surplus/(Deficit)**	**(4,526)**	**(6,118)**	**(945)**	**3,581**	**5,173**	**(2,446)**	**(2,059)**
				NHSI Adjustments to Fin Perf							
3	3	3	0	Remove Depr on Donated assets	21	22	22	1	0	38	38
0	0	0	0	Remove STP funding 2016/17	0	0	(419)	(419)	(419)		(419)
(241)	**(154)**	**1,055**	**1,209**	**Adjusted Financial Performance**	**(4,505)**	**(6,096)**	**(1,342)**	**3,163**	**4,754**	**(2,408)**	**(2,440)**

Income

- Commissioners have retained 40% of the Trust's CQUIN income in a Service Development and Improvement Plan (SDIP) which means that it cannot be recognised until its requirements are achieved. CQUIN income is on plan YTD due to CQUIN phasing, however this will slip in future months due to SDIP phasing.
- Main contract activity for M7 YTD is 2.5% higher than the contract baseline, and the income relating to this (£3.3m) has been recognised in the Trust accounts.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £8.7m under re-phased budget, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure (£3m YTD) in non-pay. This underspend is expected to reduce with targeted recruitment.
- Private Ambulance expenditure is overspent by £3m (this is offset by vacancies as noted) and rent, leases costs and training and recruitment related expenditure are underspent due to differences in the phasing of the budget vs actual expenditure.

Depreciation and Financing

- Overall Financial Charges are £0.7m favourable YTD due to lower than budgeted depreciation.

Risks

- The Trust's main A&E contract incorporates variable income for the first time and as such variations in activity may result in either the Trust receiving additional income or being required to pass back income to Commissioners. This fluid budget structure will need to be carefully managed to ensure resourcing expenditure aligns with income and is managed sustainably.
- If the criteria for STP funding is not met (e.g. Agency restrictions) then £1.9m would be withheld which would put the Trust's control total at risk.

Main Contract Variable Income

Month:	Oct-17	2017-18 Monthly Contract Base (2016-17 Plan plus 6%)			2017-18 Actual Activity			2017-18 Actual Activity Increase / (Decrease) vs Contract Base			Total Incidents Difference to Contract Base (%)	CCG Split Based on Incident Difference - cap at 2.49%
Area	CCG Names	Cat A	Cat C (incl Other)	Total Incidents	Cat A	Cat C (incl Other)	Total Incidents	Cat A	Cat C (incl Other)	Total Incidents		
NEL	NHS City and Hackney CCG	10,333	11,039	21,372	10,688	11,153	21,841	355	114	469	2.19%	£ 98,959.00
NEL	NHS Newham CCG	12,312	12,402	24,714	12,125	12,024	24,149	-187	-378	-565	-2.29%	-£ 119,215.00
NEL	NHS Tower Hamlets CCG	10,369	9,792	20,161	10,398	9,976	20,374	29	184	213	1.06%	£ 44,943.00
NEL	NHS Waltham Forest CCG	9,509	9,409	18,918	8,674	9,328	18,002	-835	-81	-916	-4.84%	-£ 193,276.00
NEL	NHS Barking and Dagenham CCG	8,319	9,011	17,330	8,040	8,833	16,873	-279	-178	-457	-2.64%	-£ 96,427.00
NEL	NHS Havering CCG	9,409	10,686	20,095	9,117	10,913	20,030	-292	227	-65	-0.32%	-£ 13,715.00
NEL	NHS Redbridge CCG	10,076	10,121	20,197	9,716	10,638	20,354	-360	517	157	0.78%	£ 33,127.00
NEL	**NEL Total**	**70,327**	**72,460**	**142,787**	**68,758**	**72,865**	**141,623**	**-1,569**	**405**	**-1,164**	**-0.82%**	**-£ 245,604.00**
NCL	NHS Barnet CCG	12,386	13,152	25,538	12,027	13,573	25,600	-359	421	62	0.24%	£ 13,082.00
NCL	NHS Camden CCG	10,330	10,408	20,738	10,442	11,074	21,516	112	666	778	3.75%	£ 164,158.00
NCL	NHS Enfield CCG	12,270	11,009	23,279	11,485	11,583	23,068	-785	574	-211	-0.91%	-£ 44,521.00
NCL	NHS Haringey CCG	9,501	9,478	18,979	9,322	10,061	19,383	-179	583	404	2.13%	£ 85,244.00
NCL	NHS Islington CCG	8,688	9,596	18,284	9,051	9,521	18,572	363	-75	288	1.58%	£ 60,768.00
NCL	**NCL Total**	**53,175**	**53,643**	**106,818**	**52,327**	**55,812**	**108,139**	**-848**	**2,169**	**1,321**	**1.24%**	**£ 278,731.00**
NWL	NHS Brent CCG	12,187	11,914	24,101	12,067	12,905	24,972	-120	991	871	3.61%	£ 183,781.00
NWL	NHS Harrow CCG	7,063	7,496	14,559	7,153	8,349	15,502	90	853	943	6.48%	£ 198,973.00
NWL	NHS Hillingdon CCG	11,615	14,099	25,714	12,315	14,776	27,091	700	677	1,377	5.36%	£ 290,547.00
NWL	NHS Central London (Westminster) CCG	10,728	10,247	20,975	11,565	11,686	23,251	837	1,439	2,276	10.85%	£ 480,236.00
NWL	NHS Ealing CCG	11,926	12,045	23,971	12,421	13,507	25,928	495	1,462	1,957	8.16%	£ 412,927.00
NWL	NHS Hammersmith and Fulham CCG	6,650	6,598	13,248	6,862	8,018	14,880	212	1,420	1,632	12.32%	£ 344,352.00
NWL	NHS Hounslow CCG	9,802	10,059	19,861	9,464	10,348	19,812	-338	289	-49	-0.25%	-£ 10,339.00
NWL	NHS West London CCG	8,127	8,416	16,543	8,741	9,563	18,304	614	1,147	1,761	10.64%	£ 371,571.00
NWL	**NWL Total**	**78,098**	**80,874**	**158,972**	**80,588**	**89,152**	**169,740**	**2,490**	**8,278**	**10,768**	**6.77%**	**£ 2,272,048.00**
SEL	NHS Bexley CCG	7,923	9,336	17,259	8,001	9,800	17,801	78	464	542	3.14%	£ 114,362.00
SEL	NHS Bromley CCG	9,886	12,073	21,959	9,410	12,832	22,242	-476	759	283	1.29%	£ 59,713.00
SEL	NHS Greenwich CCG	9,530	10,445	19,975	9,251	10,898	20,149	-279	453	174	0.87%	£ 36,714.00
SEL	NHS Lambeth CCG	11,820	14,097	25,917	11,951	13,789	25,740	131	-308	-177	-0.68%	-£ 37,347.00
SEL	NHS Lewisham CCG	9,673	10,724	20,397	9,741	11,570	21,311	68	846	914	4.48%	£ 192,854.00
SEL	NHS Southwark CCG	11,417	13,820	25,237	11,416	14,087	25,503	-1	267	266	1.05%	£ 56,126.00
SEL	**SEL Total**	**60,249**	**70,495**	**130,744**	**59,770**	**72,976**	**132,746**	**-479**	**2,481**	**2,002**	**1.53%**	**£ 422,422.00**
SWL	NHS Croydon CCG	13,276	15,381	28,656	13,381	16,521	29,902	105	1,140	1,246	4.35%	£ 262,842.70
SWL	NHS Kingston CCG	4,767	6,201	10,968	4,941	6,319	11,260	174	118	292	2.66%	£ 61,612.00
SWL	NHS Merton CCG	5,681	7,568	13,249	5,757	7,753	13,510	76	185	261	1.97%	£ 55,071.00
SWL	NHS Richmond CCG	4,786	6,429	11,215	4,907	6,539	11,446	121	110	231	2.06%	£ 48,741.00
SWL	NHS Sutton CCG	5,985	8,004	13,989	6,343	8,163	14,506	358	159	517	3.70%	£ 109,087.00
SWL	NHS Wandsworth CCG	8,855	10,546	19,401	8,791	11,003	19,794	-64	457	393	2.03%	£ 82,923.00
SWL	**SWL Total**	**43,350**	**54,129**	**97,478**	**44,120**	**56,298**	**100,418**	**770**	**2,169**	**2,940**	**3.02%**	**£ 620,276.70**
London Total		**305,199**	**331,601**	**636,799**	**305,563**	**347,103**	**652,666**	**364**	**15,503**	**15,867**	**2.49%**	**£ 3,347,873.70**

Initial reported activity at M7 YTD was 2.5% above the contract baseline. This is 0.5% lower than the planned level of activity in the Budget (3%).

On that basis the LAS would be able to invoice £3.347m of additional variable income. This has been recognised in the accounts at month 7.

The YTD activity is based on April, May, Jun, Jul & Aug freeze and Sep & Oct flex figures.

Cash flow Statement YTD

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	YTD Move	YTD Plan	Var
	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	21,829	30,268	28,740	34,142	33,342	31,985	**18,637**	**18,700**	**-63**
Operating Surplus	4,215	332	1,146	669	181	2,467	9,063	7,070	1,993
(Increase)/decrease in current assets	9,094	(5,832)	8,535	965	5,815	(1,826)	14,846	15,214	(368)
Increase/(decrease) in current liabilities	(2,149)	4,864	(2,588)	(1,850)	(3,355)	233	1,522	(724)	2,246
Increase/(decrease) in provisions	591	(449)	(175)	87	(630)	(120)	(562)	(270)	(292)
Net cash inflow/(outflow) from operating activities	11,751	(1,085)	6,918	(129)	2,011	754	24,869	21,290	3,579
Cashflow inflow/outflow from operating activities	**11,751**	**(1,085)**	**6,918**	**(129)**	**2,011**	**754**	**24,869**	**21,290**	**3,579**
Returns on investments and servicing finance	6	6	4	6	5	5	34	56	(22)
Capital Expenditure	(3,318)	(449)	(1,520)	(677)	(1,324)	(828)	(9,575)	(17,883)	8,308
Dividend paid	0	0	0	0	(2,049)	0	(2,049)	(2,100)	51
Financing obtained	0	0	0	0	0	0	0	5,520	(5,520)
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(3,312)**	**(443)**	**(1,516)**	**(671)**	**(3,368)**	**(823)**	**(11,590)**	**(14,407)**	**2,817**
Movement	8,439	(1,528)	5,402	(800)	(1,357)	(69)	13,279	6,883	6,396
Closing Cash Balance	**30,268**	**28,740**	**34,142**	**33,342**	**31,985**	**31,916**	**31,916**	**25,583**	**6,333**

There has been a net inflow of cash to the Trust of £13.3m.

Cash funds at 31 October stand at £31.9m.

Operating Surplus

- The operating surplus at £9.1m is higher than planned.

Current Assets

- The YTD movement on current assets is £14.8m, (£0.4m) lower than planned movement.
- Current assets movement was lower than planned due to receivables (£0.4m), accrued income (£0.1m) and prepayments £0.1m.

Current Liabilities

- The YTD movement on current liabilities is £1.5m, a £2.2m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£4.0m), accruals £2.4m and deferred income £3.8m.

Provisions

- The YTD movement on provisions is (£0.6m), is a £0.3m decrease on plan.

Capital Expenditure

- Capital cash outflow is £8.3m behind the initial NHSI plan for the year. This is due to capital slippage and a high level of work-in-progress.

Financing obtained

- DH have only approved £1.0m of the £5.5m central capital funding requested by the Trust. The £1.0m funding is expected later in the year.

CQUINs

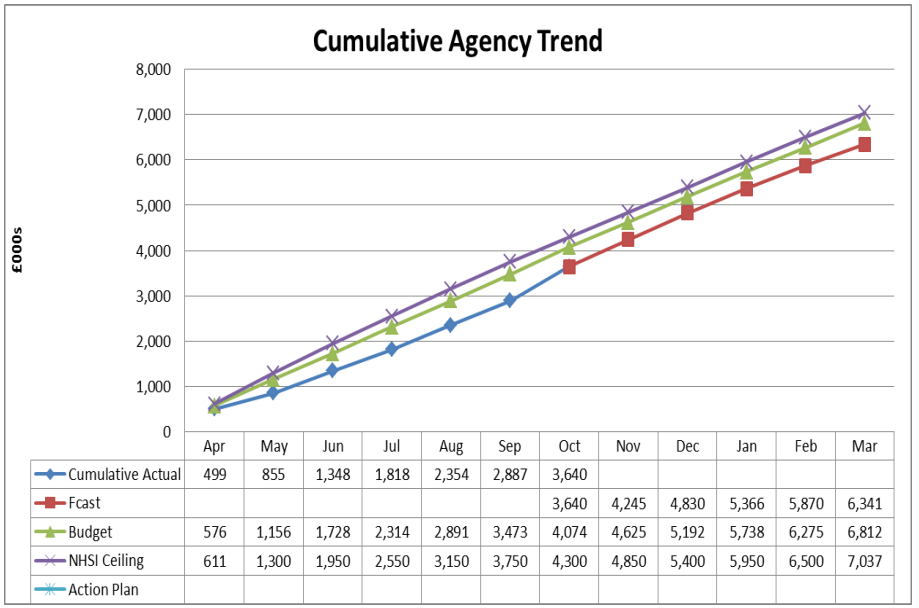
FIC - LAS 2017/18 ES & UC Contract – Commissioning for Quality & Innovation (CQUIN) SCHEDULE & UPDATE – as at 3rd November 2017

#	CQUIN Indicator title	ELT lead	Local lead	Final indicator period	Annual value	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Risk/ Issue/Notes
	Note all CQUINs follow a two year contract period and so apply across 2017/18 – 2018/19. The below outlines commitments and funding related to 2017/18 financial year only.									
1a	**National CQUIN 1a:** Improvement of health and wellbeing of NHS staff	Patricia Grealish	Jessica Bochenek	Final Period – Q4 17-18	**£263,701**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £263,701	Q2 report submitted to commissioners on the 23/10/2017.
1b	**National CQUIN 1b: Healthy food** for NHS staff, visitors and patients	Lorraine Bewes	Martin Nelhams	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Q2 report submitted to commissioners on the 23/10/2017.
1c	**National CQUIN 1c:** Improving the uptake of **flu vaccinations** for front line staff within Providers	Fenella Wrigley	Neil Thomson Julia Hilger-Ellis	Final Period – Q4 17-18	**£260,562**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £260,562	Q2 report submitted to commissioners on the 23/10/2017. Clarification of cohort following updated guidance
12	**National CQUIN 12: Ambulance Conveyance**	Paul Woodrow	Craig Harman	Final Period – Q4 17-18	**£784,825**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 0% £0	Q4 = 100% £784,825	Q2 Report submitted to commissioners 23/10/2017.
STP 1	**National CQUIN: STP Engagement**	Angela Flaherty	TBC	Final Period – Q4 17-18	**£1,569,650**	Q1 = 0% £0	Q2 = 0% £0	Q3 = 50% £784,825	Q4 = 50% £784,825	Q2 Report submitted to commissioners 23/10/2017. CQUIN documentation agreed with financial weighting split between Q3 & Q4.
STP 2	**National CQUIN: STF Delivery (Control Total)**	Lorraine Bewes	James Corrigan	Final Period – Q4 17-18	**£1,569,650**	Q1 = 0% £0	Q2 = 100% £1,569,650	Q3 = 0% £0	Q4 = 0% £0	Achieved, based on 16/17 control total. LAS provided written confirmation to commissioners that the funding will be held in reserve until further notice.
L1	**Mobile Devices**	Ross Fullerton	Ian Golding	Final Period – Q4 17-18	**£3,139,299**	N/A	N/A	Q3 – 50%* £1,569,650	Q4 – 50%* £1,569,650	Contract variation awaiting signature, then will formally vary into contract.
	Total Value (2.5% of contract value)				£7,878,248	£0.00	£1,569,650	£2,354,475	£3,924,125	
	Total Value Achieved				-	-	£1,569,650	-		

Key - RAG status	
INTERNAL RAG (for ELT / monitoring)	
	Red denotes: CQUIN not achieved
	Amber denotes: partial achievement
	Green denotes: CQUIN confirmed as achieved in full

Agency Analysis

	In Month				YTD			Full Year	Run Rate
	Budget £000s	Actual £000s	Variance £000s	Actual WTE	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Fcast £000s
Clinical									
Ambulance Staff	0	0	0	0.00	0	0	0	0	0
Nurses	95	89	5	10.92	613	643	-30	1,123	1,103
Medical Staff	0	0	0	0.00	0	0	0	0	0
Other	0	0	0	0.00	0	0	0	0	0
Subtotal	**95**	**89**	**5**	**10.92**	**613**	**643**	**-30**	**1,123**	**1,103**
Non Clinical									
Managers & Executives	257	516	-259	0.02	1,747	1,534	213	2,995	2,629
Admin & Clerical	227	87	140	0.04	1,554	1,043	512	2,421	1,787
Maintenance & Works	23	58	-35	0.02	160	394	-234	274	676
Other	0	2	-2	7.14	0	28	-28	0	47
Subtotal	**506**	**663**	**-157**	**7.22**	**3,461**	**2,998**	**463**	**5,690**	**5,139**
Total	**601**	**752**	**-151**	**18.14**	**4,074**	**3,641**	**433**	**6,812**	**6,242**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Actual	499	855	1,348	1,818	2,354	2,887	3,640					
Fcast							3,640	4,245	4,830	5,366	5,870	6,341
Budget	576	1,156	1,728	2,314	2,891	3,473	4,074	4,625	5,192	5,738	6,275	6,812
NHSI Ceiling	611	1,300	1,950	2,550	3,150	3,750	4,300	4,850	5,400	5,950	6,500	7,037
Action Plan												

Agency Compliance

Rule	Measurement	Description	Target	Achieved	Variance
Framework	% Agencies used on Framework	Are all agencies used on an approved framework?	100%	91.20%	8.8%
Agency Ceiling	£000s	Is the Trust on Track to deliver on or below its agreed agency ceiling?	7,037	6,242	795

- If the Trust does not stay within the notified agency cap of £7m, the £1.9m STF funding will be at risk.
- From 1st October NHSI require additional Agency analysis (Top 20 high cost staff, Top 30 longest serving, Trend spend by Cost Centre).
- On the 30th November the Trust submitted an agency assurance questionnaire which was signed by the CEO and the Chair.
- YTD The Trust has spent £3.6m on agency which is £0.4m favourable to plan.
- In Month spend is £752k.
- Based on the full year average the Trust would spend £6.2m which is £0.8m below the Trust's maximum agency ceiling of £7.0m.
- Agency reduction actions are on-going with Divisional leads and ELT members. Reductions are being achieved across Q3 and the Trust expects to meets its agency cap target.

2017/18 Capital Plan/Spend YTD – Month 7 Summary

Capital Programme	Exec Lead	Operational Lead	Month 6 Revised Plan £'000	Actual £'000	Variance £'000	Forecast Outturn £'000
Expenditure Plan:						
Estates - Maintenance	L Bewes	M Nelhams	661	661	0	1,605
Secure Drugs	L Bewes	M Nelhams	169	169	0	880
General Capital	L Bewes	L Bewes	84	84	0	1,476 *
Fleet & Logistics Programme	L Bewes	J Wand	5,154	5,154	(0)	11,889
Other Fleet (Stretchers)	L Bewes	J Wand	403	403	0	807
Fleet Replacement	L Bewes	J Wand	287	287	0	1,229
IM&T General	R Fullerton	R Clifford/J Downard	396	396	0	4,020
IM&T Digital Maturity Investment (Exterr	R Fullerton	R Fullerton	0	0	0	2,378 **
Capital Expenditure Plan			**7,153**	**7,153**	**0**	**24,284**
Capex Surplus/(Deficit)			**0**	**0**	**0**	**0**

- The latest capital plan shows £24.3m of Capex. The plan has been profiled in month 7 to reflect forecast profile spend as agreed with operational leads.
- £24.3m has been confirmed as the Trusts capital resource limit for 17/18.
- Since month 5 the Trust has had confirmation of the £6.9m carry forward from 2016/17.
- The initial capital plan assumed £5.5m Central Programme funding. The Trust has received confirmation that it will receive only £0.998m in 2017/18. The shortfall in funding created by this has been met from the General Capital allocation.

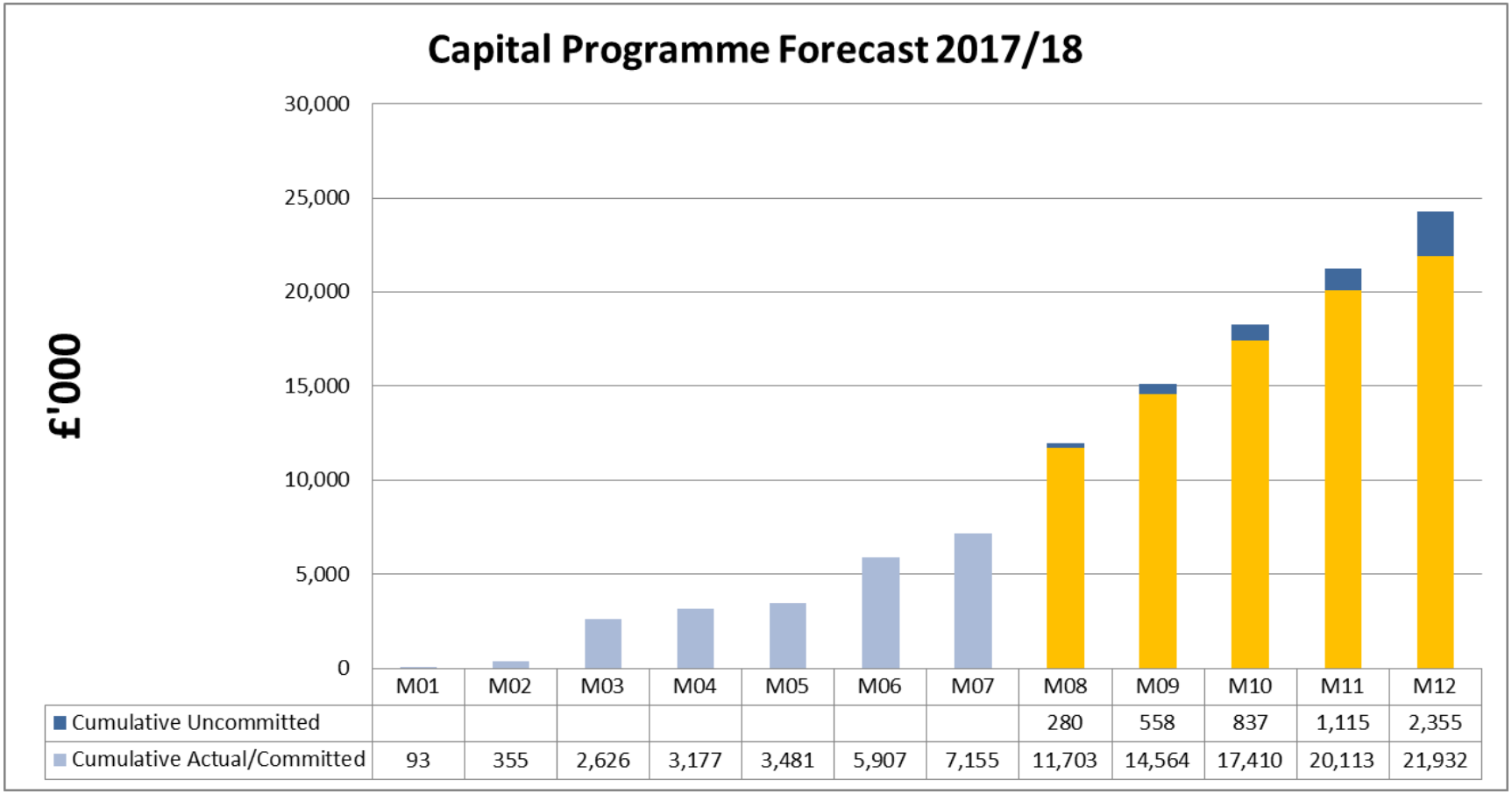
Assumptions:

* Use unallocated 'general' capital to fund shortfall in IM&T Digital Maturity Investment

** Revised capital expenditure based on current proposal for Mobility Business Case. Funded as follows:

	£
Cental Programme Bid	998
Use of 'General' Capital Allocation	1380
Total Mobility Business Case	**2378**

2017/18 Capital Plan/Spend YTD – Month 7 Summary



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cumulative Uncommitted								280	558	837	1,115	2,355
Cumulative Actual/Committed	93	355	2,626	3,177	3,481	5,907	7,155	11,703	14,564	17,410	20,113	21,932

Statement of Financial Position: YTD – Month 7 Summary

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Sep-17		
	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Non Current Assets										
Property, Plant & Equip	142,368	141,832	141,216	142,568	142,218	141,629	143,200	146,519	(3,319)	-2.27%
Intangible Assets	6,577	6,116	5,901	5,687	5,505	5,322	5,101	4,806	295	6.14%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	
Subtotal	148,945	147,948	147,117	148,255	147,723	146,951	148,301	151,325	(3,024)	-2.00%
Current Assets										
Inventories	3,115	3,124	3,124	3,122	3,134	3,130	3,136	3,005	131	4.36%
Trade & Other Receivables	35,467	37,359	28,265	34,099	25,552	24,591	18,770	16,192	2,578	15.92%
Cash & cash equivalents	18,637	21,829	30,268	28,740	34,142	33,342	31,985	27,337	4,648	17.00%
Non-Current Assets Held for Sale	44	44	44	44	44	44	44	44	0	
Total Current Assets	57,263	62,356	61,701	66,005	62,872	61,107	53,935	46,578	7,357	15.80%
Total Assets	206,208	210,304	208,818	214,260	210,595	208,058	202,236	197,903	4,333	2.19%
Current Liabilities										
Trade and Other Payables	(41,463)	(46,813)	(41,952)	(48,953)	(45,746)	(43,872)	(39,919)	(38,401)	(1,518)	3.95%
Provisions	(8,064)	(8,174)	(8,639)	(7,601)	(7,543)	(7,661)	(7,559)	(3,873)	(3,686)	95.17%
Borrowings	0	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	0	
Net Current Liabilities)	(49,527)	(54,987)	(50,591)	(56,554)	(53,289)	(51,533)	(47,478)	(42,274)	(5,204)	12.31%
Non Current Assets plus/less net current assets/Liabilities	156,681	155,317	158,227	157,706	157,306	156,525	154,758	155,629	(871)	-0.56%
Non Current Liabilities										
Trade and Other Payables	0	0	0	0	0	0	0	0	0	
Provisions	(10,548)	(10,574)	(10,702)	(11,293)	(11,178)	(11,149)	(10,623)	(10,491)	(132)	1.26%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	0	
Total Non Current Liabilities	(10,655)	(10,681)	(10,809)	(11,400)	(11,285)	(11,256)	(10,730)	(10,598)	(132)	1.25%
Total Assets Employed	146,026	144,636	147,418	146,306	146,021	145,269	144,028	145,031	(1,003)	-0.69%
Financed by Taxpayers Equity										
Public Dividend Capital	58,016	58,016	58,016	58,016	58,016	58,016	58,016	63,536	(5,520)	-8.69%
Retained Earnings	36,212	34,822	37,604	36,492	36,207	35,455	34,214	29,327	4,887	16.66%
Revaluation Reserve	52,217	52,217	52,217	52,217	52,217	52,217	52,217	52,587	(370)	-0.70%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	146,026	144,636	147,418	146,306	146,021	145,269	144,028	145,031	(1,003)	-0.69%

Non Current Assets

- Non current assets stand at £148.3m, (£3.0m) below plan. This is due to capital slippage.

Current Assets

- Current assets stand at £53.9m, £7.4m above plan.
- Cash position as at September is £32.0m, £4.7m above plan.
- Within Trade & Other Receivables, Receivables (debtors) at £18.8m are £2.6m above plan, accrued income at £7.4m is £1.9m above plan and prepayments at £3.8m are £1.5m below plan. The increase in receivables relates to 2016/17 CQUIN, QIP investment, additional funding for over activity and 2017/18 under payments on the contract being overdue for payment.

Current Liabilities

- Current liabilities stand at £47.5m, £5.2m above plan.
- Payables and accruals at £37.0m are £1.2m below plan.
- The Trust has a high volume of unapproved trade payables at £5.4m.
- Current provisions at £7.6m are £3.7m higher than plan. This is due to new provisions not included in the plan and lower than expected payments being made to international recruits.
- Deferred Income at £2.9m is £2.7m above plan. The Trust received full payment of £5.3m MTFA funding for the year in May 2017.

Non Current Liabilities

- Non current provisions at £10.6m are £0.1m above plan. Borrowings are on plan.

Taxpayers Equity

- The Trust received late STF funding last year not included in the plan and this is contributing to the higher than planned movement on Taxpayers Equity and Retained Earnings.
- Public Dividend Capital stands at £58.0m, £5.5m lower than planned. DH have only approved £1.0m of the £5.5m central capital funding requested by the Trust. The £1.0m PDC is expected later in the year.
- Retained Earnings stands at £34.2m, £4.9m higher than plan.
- Taxpayers Equity stands at £144.0m, £1.0m lower than plan.

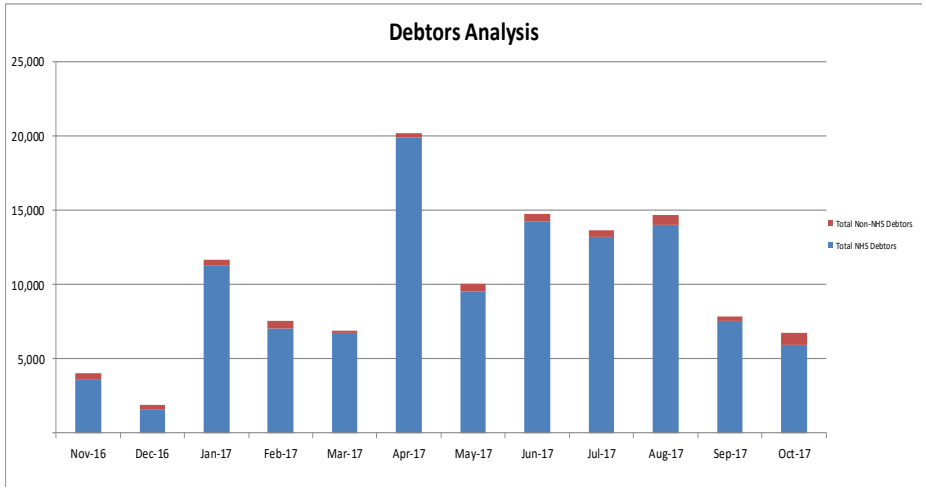
Debtors Analysis

Debtors:

Aged debtors Summary 31st October 2017

NHS Debtors	Note	Total	Current	1 - 30	31 - 60	61 - 90	91 - 180	181 - 365	> 365
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Nhs Havering Ccg	1	650	1	106	2	72	63	406	-
Nhs Barnet Ccg	1	601	-	169	85	114	156	78	-
Nhs Bromley Ccg	1	574	1	573	-	-	-	-	-
Nhs City And Hackney Ccg	1	516	-	135	66	64	185	68	-
Nhs Camden Ccg	1	501	2	129	61	64	181	64	-
Health Education England	1	495	495	-	-	-	-	-	-
<£495,000	1	3,712	129	1,720	-	-	276	1,428	160
Total Debtors		**7,051**	**627**	**2,831**	**213**	**315**	**861**	**2,044**	**160**
Southwark CCG (Income in advance)	2	-1,120	-1,120	-	-	-	-	-	-
Total NHS Ledger Balance		**5,931**	**-493**	**2,831**	**213**	**315**	**861**	**2,044**	**160**
Non-NHS Debtors									
Heathrow Airport Ltd	3	220	220	-	-	-	-	-	-
London Stadium 185	4	208	208	-	-	-	-	-	-
Sodexo Healthcare	5	41	36	-	-	5	-	-	-
Arsenal Football Club	6	25	25	-	-	-	-	-	-
Kennington Oval Ltd	7	24	24	-	-	-	-	-	-
<£24,000	8	295	138	39	5	10	17	16	71
Total		**814**	**651**	**39**	**5**	**15**	**17**	**16**	**71**
TOTAL DEBTORS 31st October 2017		**6,745**	**158**	**2,870**	**218**	**330**	**877**	**2,060**	**230**

Source: Debtors Ledger 31st October 2017



Total outstanding NHS and Non-NHS debtors as at 31st October 2017 amounted to £7.9 million.

The NHS over 60 day's figure of £3.4m includes amounts due from both CCGs £3.2m and NHS Trusts £0.2m.

1. CCGs

- 2016/17 CQUIN Funding - £148k (top 3 aged debtors - Enfield CCG £60k, Haringey CCG £46k and Richmond CCG) The CSUs are working with CCGs to get the invoices to be approved and paid in November. Richmond CCG has confirmed payment on the 15th of November for £42k.
- 2016/17 Additional Activity Funding - £0.9m; £0.1m was paid on the 1st of November. Top 3 aged debtors - Barking & Dagenham CCG £0.2m, Havering CCG £0.3m and Redbridge £0.3m have approved the invoices and they will be paid on the 15th of November.
- 2016/17 QIP Investment Funding - £0.5m (top 3 aged debtors – Enfield CCG £91k, Haringey CCG £82k and Richmond CCG £54k) £132k was paid on the 1st of November. The CSUs are working with CCGs to get the invoices to be approved and £95k will be paid in November.
- 2017/18 Main SLA April – October - £1.9m (top 3 aged debtors - Barnet CCG £0.4m, Camden CCG £0.3m and City & Hackney CCG £0.3m) The LAS and NEL CSU are working with CCGs to get the invoices to be approved and paid in November.
- 2017/18 50% CQUIN July & October - £38k (top 2 aged debtors – Brent CCG £17k and Harrow CCG £11k). Hillingdon CCG paid £10k on the 9th of November. The remaining £28k will be paid by the 15th of November.
- 2017/18 Paramedic Re-banding M1-M4 - £1.3m (top 3 aged debtors – Croydon CCG £94k, Barnet CCG £82k and Newham CCG £78k). £280k has been approved and will be paid on the 15th of November.

The trust is actively pursuing the outstanding debts.

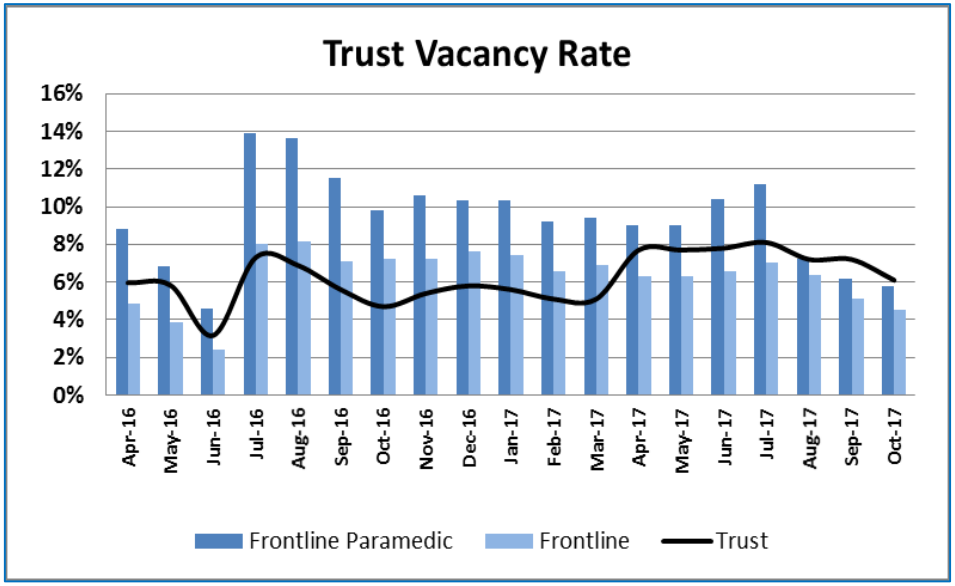
2. Southwark CCG - £1.1m November SLA & CQUIN paid in advance.
3. Heathrow Airport Ltd - £220k, 2 invoices for October and November. Both invoices have been approved and will be paid in November.
4. London Stadium 185 - £208k (6 invoices), 3 invoices £18k has been paid on the 8th of November. 1 invoice £7k will be paid on the 10th of November. 2 invoices £183k have been disputed as London Stadium believe they have been overcharged. We are dealing with the query and if necessary credit notes will be raised.
5. Sodexo Healthcare - £41k (3 invoices) The invoices have been approved and will be paid in November.
6. Arsenal Football Club - £25k (1 invoice) – Invoice has been approved and will be paid on the 30th of November.
7. Kennington Oval Ltd - £24k (12 invoices) – 11 invoices £23k has been paid on the 7th of November, 1 invoice £1k is awaiting approval.
8. Non-NHS Debtors - £295k consists of; £106k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £84k of stadia events, the stadiums are been chased for payment on a regular basis. The remaining £105k is due from local Government bodies and other miscellaneous organisations.

The graph to the left shows the debtors trend for the last 12 months.

Our People

Section	Key Headlines	Oct	Sep	Aug
Vacancy and Recruitment	• The overall vacancy rate has reduced to 6.1% against a 5% target. • We have identified additional posts to deliver the 17/18 increased demand. Work is in progress with colleagues in Operations to determine how these posts should be allocated across the Sectors. Please note that the vacancy rates for both paramedics and the total frontline will increase as a result of these additional posts. • A recent paper to the Executive Leadership Team ('Emergency Operations Centre Capacity Review' - 4th October 2017) identified an additional 73 posts for Emergency Operations Centre which will increase the current vacancy rates.			
Turnover	• Total Trust turnover has increased from 9.9% to 10% against a threshold of 10%. • Frontline turnover has reduced at 8.2%. Please note this does not include Control Room or NHS 111 leavers. • Frontline paramedic turnover has remained at 9.2%			
Sickness	• Monthly sickness for October is 5.2% against a target of 5%. • Frontline sickness (non-corporate areas) is 5.5%.			

Vacancy – Trust wide



Paramedic recruitment

- We have now filled all of our Q4 training places with 146 iParas and 4 UK Graduate Paramedics.
- The current international recruitment trip to Australia has resulted in 166 conditional offers. We are currently working with the individuals themselves and Education to co-ordinate visas and start dates to maximise use of training places.
- We have recruited 93 UK Graduate and Qualified Paramedics against our target of 90, 89 of whom have started.
- We have 11 Paramedics who have been appointed and are awaiting course dates. We have another assessment on 1st December which is fully booked.
- In July and August we had 76 Apprentice Paramedics who graduated, taking up Newly Qualified Paramedic positions. In December, there are 10 Advanced Paramedics graduating, with a further 13 in May 18 and 30 in July 18.

Source of data: ESR

The establishment figures represent current budgeted position and may be subject to change following completion of current forecasting activities	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	5,322.33	4,998.92	323.41	6.1%
Total Frontline (Sector)	3,113.00	2,973.77	139.23	4.5%
Frontline (Sector) Paramedics	1,821.24	1,714.89	106.35	5.8%
Frontline (Sector) Non-Paras	1,291.76	1,258.88	32.88	2.5%
EOC	429.00	419.47	9.53	2.2%
Other staff (including Corporate)	1,780.33	1,605.68	174.65	9.8%

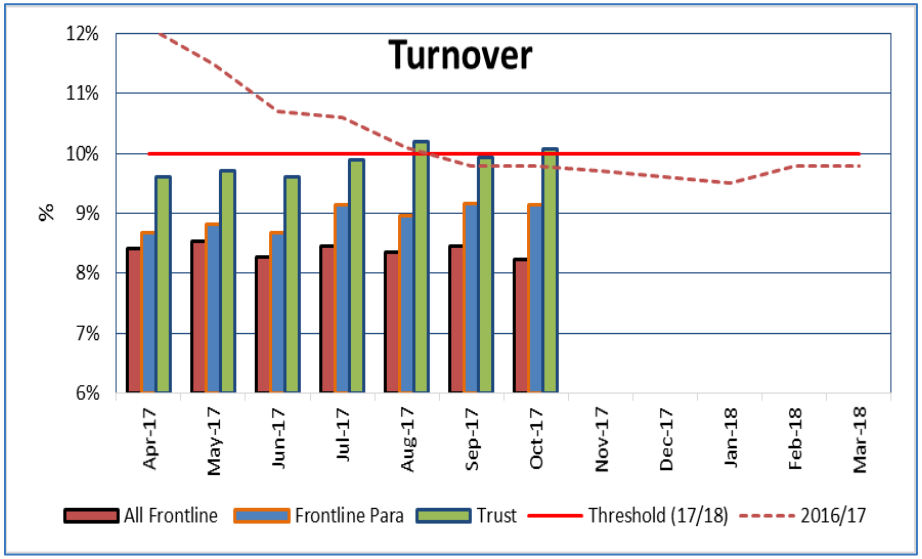
Trainee Emergency Ambulance Crew recruitment

- Against our 17/18 plan of 375, we have filled 257 Training Emergency Ambulance Crew (TEAC) training places to date. A further 81 are either awaiting their C1 driving licenses or a training start date. In order to to unblock our pipeline, we have agreed to fund C1 licence costs for our TEAC recruits (approximately £1,200 per person), starting Feb to May 2018 at an estimated cost of £100,000. This will be paid as an RRP and will have a 2 year post employment start claw back.

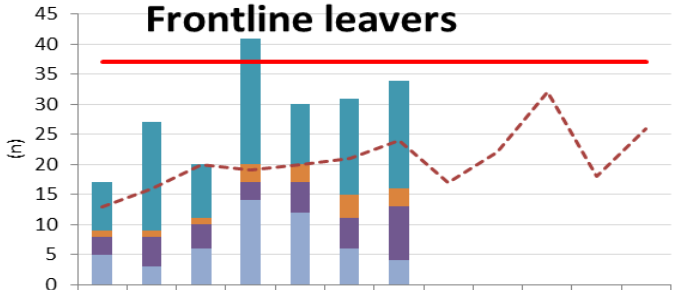
EOC recruitment (Emergency Medical Dispatchers)

- Against our recruitment plan of 186 for 17/18 we have to date recruited 85 EMDs. Whilst applicant numbers remain high, conversion rates from shortlisting to appointment still remain a challenge. We are preparing to 'overfill' training place to allow for drop outs. Recent Met Police recruitment activities in Bow and Lambeth (200 vacancies) may have an impact, and this being monitored.

Turnover/Leavers – Trust wide



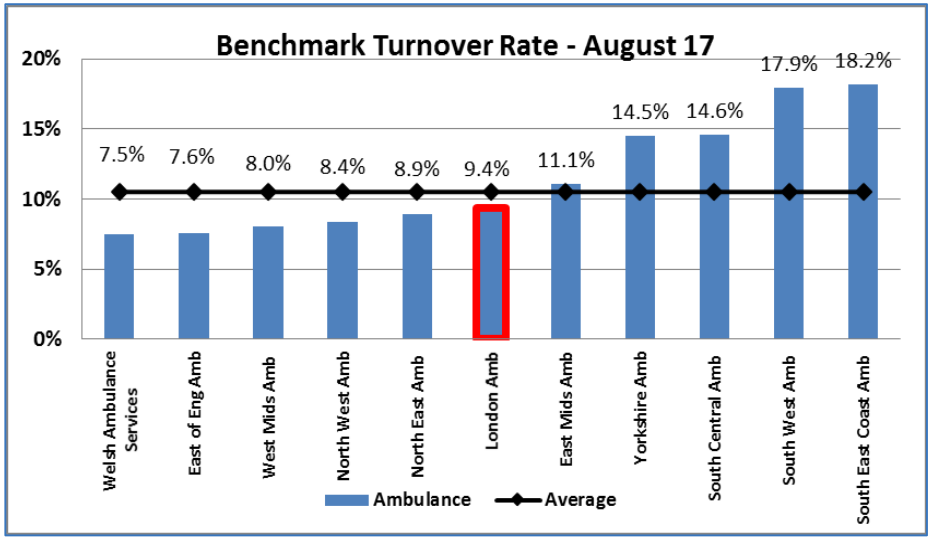
- The total Trust turnover has increased from 9.9% to 10.0% (12 month rolling figure).
- Frontline turnover (Sector Ops) has reduced from 8.5% to 8.2%.
- Frontline paramedic turnover has remained at 9.2%.
- Control Services turnover is 16%.
- NHS 111 turnover is 18.5%.
- Corporate Directorates turnover is 15.7%.
- Plans are in place to address these turnover rates.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paramedics	8	18	9	21	10	16	18					
EMT	1	1	1	3	3	4	3					
T/EAC	3	5	4	3	5	5	9					
EMD	5	3	6	14	12	6	4					
Total	17	27	20	41	30	31	34	0	0	0	0	0
Threshold (17/18)	37	37	37	37	37	37	37	37	37	37	37	37
2016/17	13	16	20	19	20	21	24	17	22	32	18	26

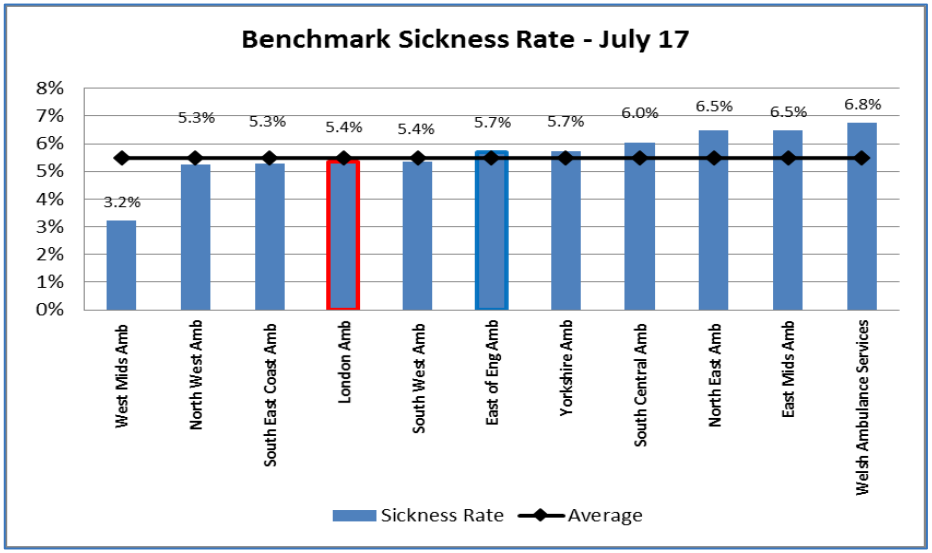
- There were 34 frontline leavers in October (see table opposite).
- 74% of the frontline leavers (25 staff) were resignations i.e. unplanned.
- 56% (10) of paramedics left for reasons of relocation, 17% for work life balance and 17% for retirement.
- Year to date there have been 98 paramedic and 38 Emergency Ambulance Crew leavers (136 total). This is a total of 53 Full Time Equivalents less than we had built into the planning model for 17/18.
- We are looking at further analysis of this data.

Benchmarking Turnover/Sickness – Trust wide



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has remained in 6th place.
- The LAS is below the national average of 10.5%.

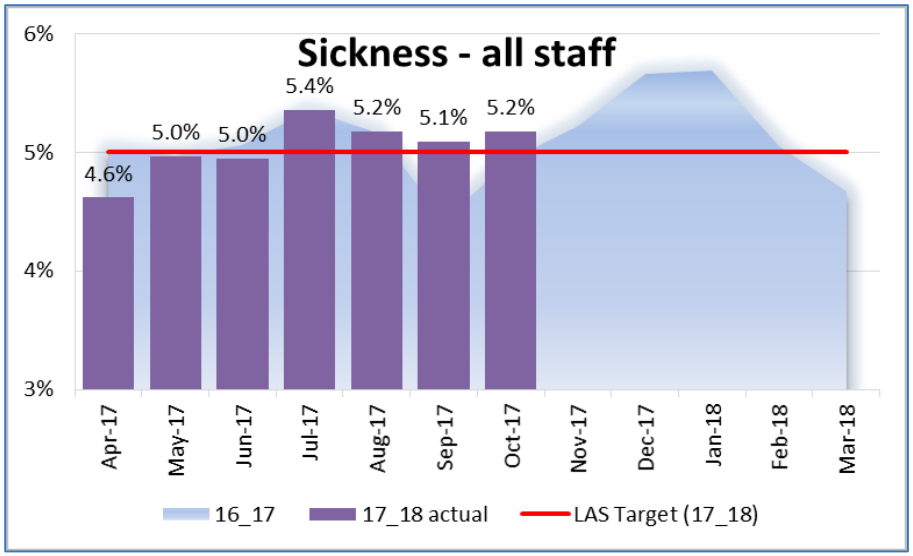
Source of data: NHS Health and Social Care Information Centre – data as at 31st August 2017. Data is available two months in arrears.



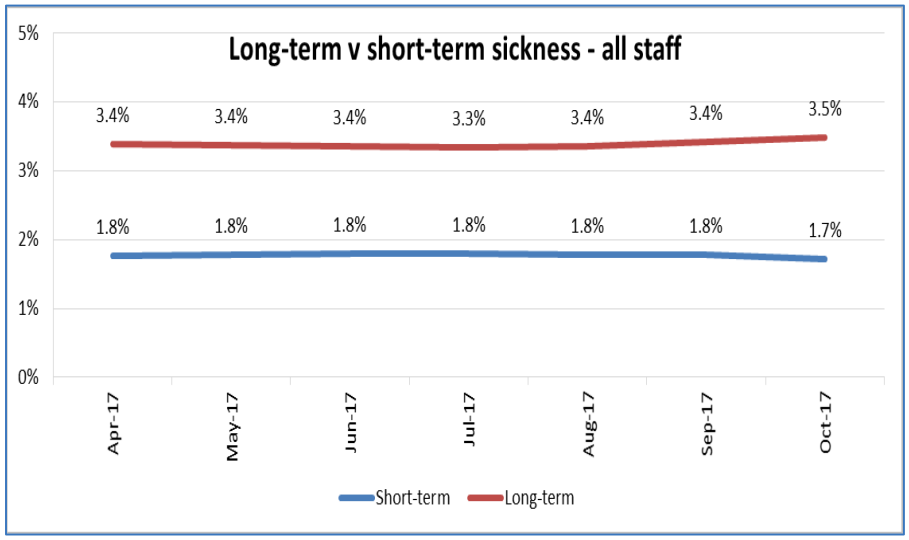
- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has moved from 3rd to 4th place.
- The LAS is below the national average of 5.5%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st July 2017. Data is available three months in arrears.

Sickness Absence – Trust/Sector level



- Trust wide sickness for October was 5.2% (851 episodes, 7,578 days).
- This is equal to 98,988 days lost or an average of 19 days for each of our staff for the 12 month period.
- Frontline sickness (non-corporate) is 5.5%
- Corporate sickness is at 2.8%.



- This graph shows the sickness rate for all staff split by short-term and long-term sickness.
- The LAS 17/18 target for sickness is 5% (2% short-term, 3% long-term), a reduction of 0.5% from 16/17.
- In October there were 598 episodes of short-term sickness (2,673 days sickness). The average length of each episode was 4.5 days.
- Long-term sickness is any continuous episode of sickness lasting for 28 days or longer. In October there were 253 episodes of long-term sickness (5,962 days). Long-term sickness accounts for 67% of all sickness.

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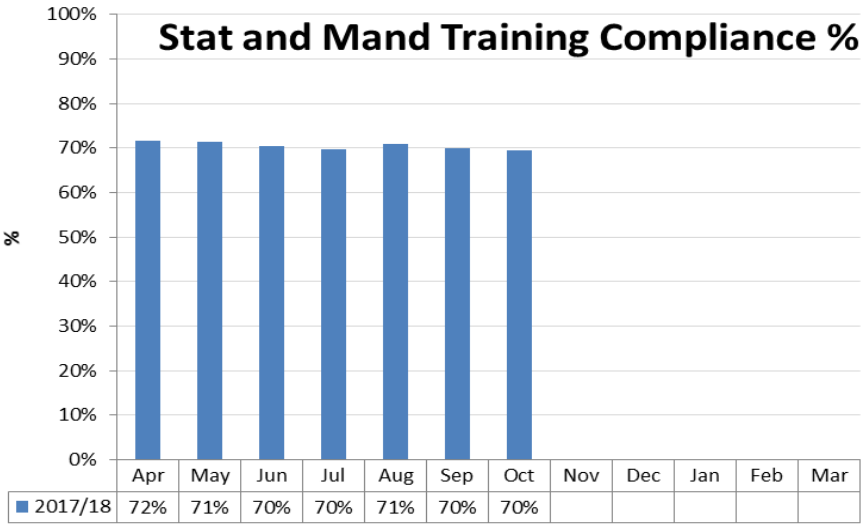
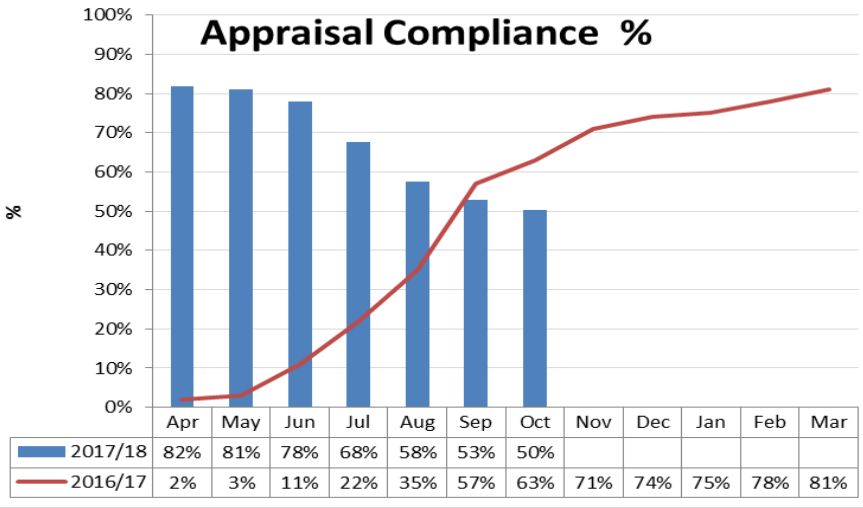
Statutory and Mandatory Training Compliance/Appraisal



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	72%	71%	70%	70%	71%	70%	70%					

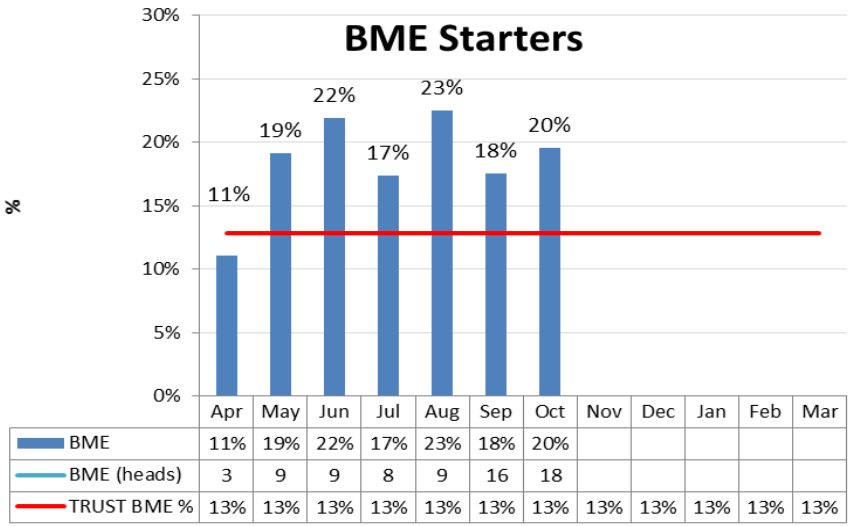
- The Trust has a target of 85% compliance by end of Mar-18 and current compliance is 70% at the end of October-17. Corporate compliance is 76%.
- Current compliance for Operations is 72% at the end of October-17. Discussions are ongoing to look at the ability to roster staff to achieve 85% Operational compliance by the end of Feb-18.
- Core Skills Rrefesher 2017.2 was launched on 31st October. An extra one hour module for Health, Safety and Welfare has been included. One statutory training module, Equality, Diversity & Human Rights has not been included in the CSR 2017/18 programme and current discussions are looking at adding this to CSR in 2018.
- A new Bank contract has been finalised. A review of bank workers and their training has been undertaken. 167 Bank Workers have not completed a CSR course in the last rolling year and from November these bank workers will be moved into a 'do not use' status.
- This will leave us with 171 on the register until others either a) complete one of the current CSR courses and evidence on-going training from another Trust or b) complete both CSR courses if they have no evidence of on-going training from another Trust.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	82%	81%	78%	68%	58%	53%	50%					
2016/17	2%	3%	11%	22%	35%	57%	63%	71%	74%	75%	78%	81%

- The appraisal rate has reduced from 53% in August to 50% in October.
- From 1st November to 31st October 2017 there have been 2,357 appraisals completed out of 4,695 eligible staff (we exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS).
- These rates are being discussed at the monthly performance review meetings to ensure management awareness and that all PDRs are completed as required.

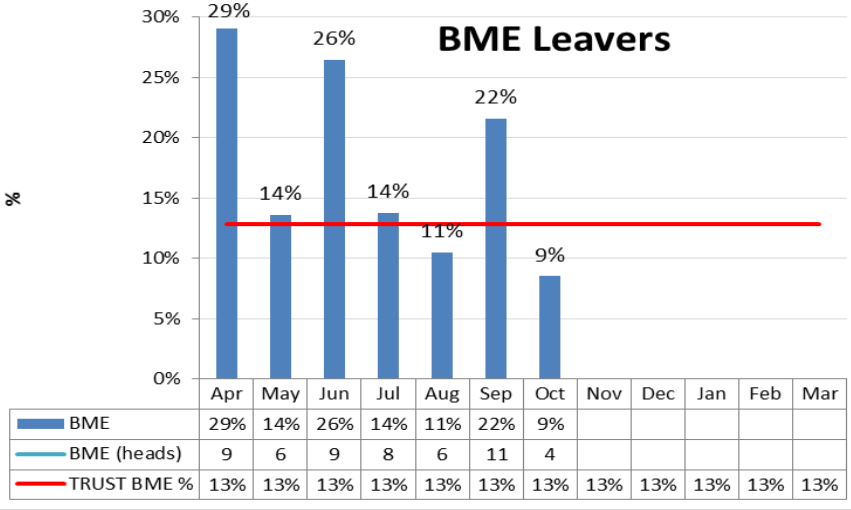
Workforce Race Equality Standard (WRES)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BME	11%	19%	22%	17%	23%	18%	20%					
BME (heads)	3	9	9	8	9	16	18					
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

On-going activities

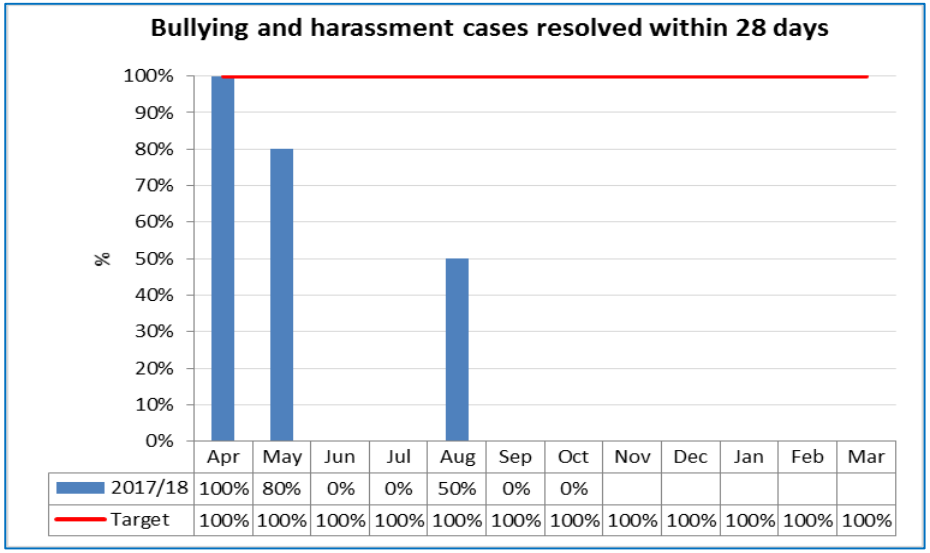
- WRES action plan – we have developed a new action plan which will be reviewed by the Trust Board in December.
- As part of the WRES action plan and the People & OD Strategy we are required to report on our monthly starters and leavers and quarterly on our recruitment and disciplinary data. The first of these are featured in the table opposite. These show the numbers of BME starters and leavers from April to October 2017 compared to the current Trust BME profile.
- In October we had 18 BME starters and 15 were in frontline roles.
- In October we had 4 BME leavers, all of whom were in frontline roles.
- Year to date we have 72 BME starters and 53 BME leavers.
- We are looking at further analysis of this data.



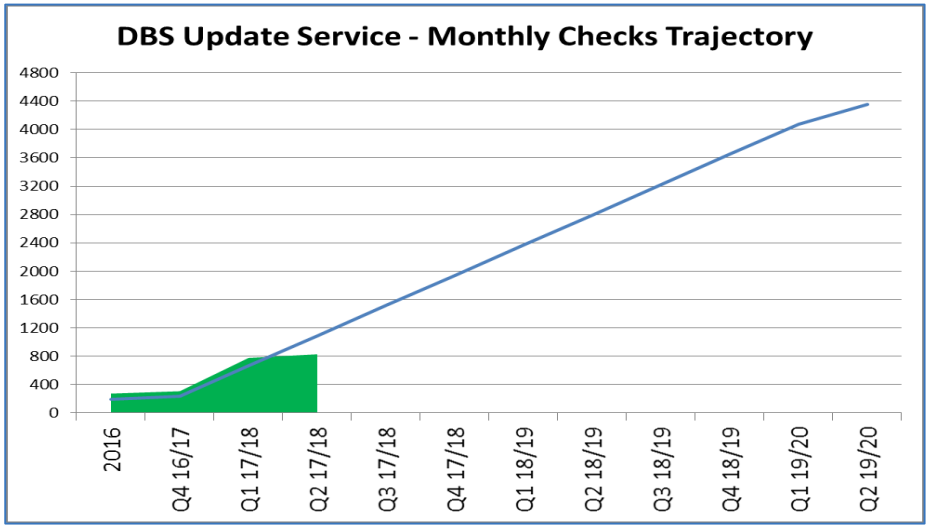
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BME	29%	14%	26%	14%	11%	22%	9%					
BME (heads)	9	6	9	8	6	11	4					
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

- We have secured £500,000 from Health Education England to fund:
  - Outreach into schools to raise profile of LAS as an employer and paramedic science as a potential career with BME students (and others)
  - Coaching & mentoring for our BME talent
  - Supporting and building the BME Staff Network to give staff a forum for raising issues and the Trust a BME 'focus group'.
- Positive action advertising to encourage applicants from BME and other under-represented communities.
- We have had a number of recruitment events during October for EMD and TEAC roles. We had a positive response and a high number of local BME applicants.

Bullying & Harassment/DBS



- In October, there was one open formal bullying and harassment case and this had breached the 28 day target.
- Since mid-July B & H Specialist Cathe Gaskell has continued with the Phase 4 activities of the Trust's Bullying and Harassment Plan. This has included diagnostic work, training round table champions and supporting informal resolution of B&H cases.
- To date, 29 staff have contacted her for advice on managing bullying behaviours in the workplace or to report being bullied at work.
- We are now collating more information on round tables and have a list of 18 requests that we are monitoring for progress.
- Jessica Bochenek is now the Round Table Co-coordinator and staff can request these directly with her. We anticipate requests increasing as this is advertised.



- DBS rechecking - we are slightly behind plan for Q2. The plan remains to complete the 4,500 checks by September 2019 (three years). To meet this target we need to ensure that 142 applications are in progress with the DBS each month.
- HR teams continue to work with their local management teams to identify staff availability and escalate any resourcing or compliance issues.
- DBS Update Service - all starters from 1st April 2017 have a contractual term which requires them to sign up to the DBS Update Service. All recruitment adverts also highlight this requirement.

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description
A19	Category A incidents requiring an 19 minute response
A8	Category A incidents requiring an 8 minute response
ADO	Assistant Directors of Operations
APP	Advanced Paramedic Practitioners
AQI	Ambulance Quality Indicator
BME	Black and Minority Ethnic
CARU	Clinical Audit and Research Unit
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDLO	Controlled Drugs Liaison Officers
CISO	Clinical Information & Support Overview
CPI	Clinical Performance Indicator
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRU	Cycle Response Unit
CSR	Core Skills Refresher (Training)
DBS	Disclosure & Barring Scheme
DOC	Duty of Candour
EAC	Emergency Ambulance Crew
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Dispatcher
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ESR	Employee Service Record
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)
FFT	Friends and Family Test
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale
FRU	Fast Response Unit
GCS	Glasgow Coma Scale

Acronym	Meaning / Description
GTN	Glyceryl Trinitrate
HAC	Heart Attack Centres
HART	Hazardous Area Response Teams
HASU	Hyper Acute Stroke Unit
HCP	Health Care Professional
iPara	International Paramedic
JCT	Job Cycle Time
KPI	Key Performance Indicator
LIN	Local Intelligence Network
LINC	Listening Informal Non-Judgemental Confidential
MAR	Multiple Attendance Ratio
MRU	Motorcycle Response Unit
MTC	Major Trauma Centre
NETs	Non-Emergency Transport
NRLS	National Reporting and Learning System
OOH	Out Of Hours
OWR	Operation Workplace Review
PAS / VAS	Private / Voluntary Ambulance Services
PED	Patient Experiences Department
PGD	Patient Group Directions
PFVH	Patient Facing Vehicle Hours
PRF	Patient Record Form
PTS	Patient Transport Service
QGAM	Quality, Governance and Assurance Manager
QR	Quality Requirement
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
SI	Serious Incident
SIG	Serious Incident Group
STEMI	ST-Segment Elevation Myocardial Infarction
TEAC	Trainee Emergency Ambulance Crew
TRU	Tactical Response Unit
YTD	Year to Date
WTE	Whole Time Equivalent

LAS 111 (South East London): Glossary October 2017

QR	Measure	Target	Description
	Total calls answered		Number of calls made to 111 and answered by an LAS call handler.
05	Calls answered within 60 seconds	95%	Of the total answered calls, how many were answered within 60 seconds of being queued for an advisor?
04	Calls abandoned after 30 seconds	1%	Of the total calls offered and reaching 30 seconds following being queued for an advisor, how many did the caller hang up before they were answered?
	Calls transferred to or answered by a clinical advisor		Of the total answered calls, what percentage were directly triaged by a clinician during their 111 episode?
	Of calls transferred, percentage transferred warm		Of the total answered calls that were transferred to a trained 111 clinical advisor, how many were transferred while the caller was on hold?
13	Of call backs, percentage within 10 minutes	100%	Of the total calls where person was offered a call back by a 111 clinician, for how many was the person actually called back within 10 minutes of the end of their first call?
10	Calls referred to 999	10%	Of the total number of calls answered, what were the number of final dispositions that result in an ambulance being dispatched?
11	Calls referred to Emergency Department	5%	Of the total calls received and triaged by a 111 call handler or clinician, how many were referred to a type 1 or 2 A&E department?

London providers – areas covered:

London Ambulance Service (LAS): 1. South East London
Care UK: 1. Hillingdon,, 2. North West London
Partnership of East London Co-operatives (PELC): 1. East London & City
London Central & West: 1. Inner North West London, 2. North Central London
Vocare : 1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond

London Ambulance Service NHS Trust

Assurance report:	**Audit Committee**	**Date:**	**06/11/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/11/2017**
Presented by:	**John Jones, Non-Executive Director, Audit Committee Chair**	**Prepared by:**	**John Jones, Non-Executive Director, Audit Committee Chair**

Matters for escalation:

Risk Management Framework (RMF)

The draft Risk Management Framework (which replaces the current Risk Management Policy) was delegated for approval to the Committee from the Trust Board meeting of 31 October 2017. A number of amendments were made and the Framework has now been approved. A copy is attached at Appendix A. Actions for implementation include a review of the Boards risk appetite, dissemination and training, and identification of risk leads, risk owners and action owners.

Proposed new format of the Board Assurance Framework (BAF)

The revised format was presented to the Committee and following comments will now be used to present the BAF to the Trust Board.

The highest risk score on the BAF (BAF risk 45) -risk of cyber- attack - was discussed in some detail and a progress report presented by the Chief Information Officer. There is a delay in addressing this issue due to the difficulty in recruiting expert resource and alternative sources have now been identified.(see Risks section)

Charitable Funds annual report and financial statements 2016/17.

Following perusal by the Charitable Funds Committee the annual report and financial statements for 2016/17 were approved by the Audit Committee with a recommendation to the Trust Board for their approval and signing of the letter of representation by the Trust Chair

Other matters considered:

The Committee reviewed:

Use of single tender waivers to September 2017;

The approach to assessing the effectiveness of the internal audit and counter fraud service;

2017/18 annual accounts timetable;

	Progress report on the work of internal audit and the counter fraud service - fifteen audit recommendations are now overdue and the Committee requested urgent action on this and an update report before its next meeting; Progress on the internal audit and counter fraud tender; The Committee's forward plan.
Key decisions made / actions identified:	Adoption of the new Risk Management Framework Confirm the revised BAF format. Recommend approval to the Trust Board of the Charitable Funds annual report and financial statements for 2016/17. Monitor progress on outstanding audit recommendations.
Risks:	Risks are now well presented in the revised BAF with all risks identified to scrutinising board sub committees. The highest risk (BAF 45) was subject to further scrutiny by the Audit Committee. A bid for funding from the Department of Health has resulted in an extra £341k being allocated. Work is now in progress to address the most pressing issues and further monitoring will be required to ensure adequate progress. An update report to the Trust Board on 12th December is planned.
Assurance:	No internal audit reports were due for completion at the November meeting but work on five studies has commenced for report back to the February Audit Committee.

London Ambulance Service NHS Trust

Assurance report:	Quality Assurance Committee	Date:	14/11/2017

Summary report to:	**Trust Board**	**Date of meeting:**	**28/11/2017**
Presented by:	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**	**Prepared by:**	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**

Matters for escalation:

There is continued concern about Emergency Operations Centre (EOC) staffing and performance and a deep dive is planned for the January meeting.

Other matters considered:

Trisha Bain presented the Quality Improvement and Learning Framework for discussion. The Committee felt this was a valuable new and systematic framework bringing together all the various work programmes underway with a single methodology, linked to our quality goals. It was felt that this main purpose could be made clearly and positively before getting into the detail.

The Quality Report for October had been circulated. We were told that the areas of concern (Mental Health Safeguarding, STEMI pain relief and Mandatory & Statutory Training) were improved and this would be demonstrated in the November Quality report). We agreed that 111 issues should be given more consideration.

Trish Bain outlined the current Quality Improvement Board status pending CQC reinspection. This weekly update had a number of overdue objectives but the position is improving as the weeks progress.

The four BAF risks assigned to Quality were reviewed

- BAF Risk 37 *The agreed A8 trajectory …..adversely affected by sustained overactivity…*This risk needs to be rewritten and reevaluated following the introduction of the ARP.
- BAF Risk 36 *Delays to defibrillation where fine VF is not recognized* Following an education drive to all staff the incidence of these SI has reduced, and this risk is now expected to be downgraded.(The related but separate issue of the number of downloads from defibrillators recorded is being addressed with IT).

	• BAF Risk 7 *Performance fall at staff changeover time* This issue is complex and since 2006 has become linked to other issues. There are actions scheduled for completion in July 17 not completed. This risk needs review/reevaluation. • BAF Risk 29 *Lack of ringbacks on delayed response in EOC….* This risk is no longer describing the important issue. Ringbacks were a response to the long delays for category C patients in 2014/2015. The Committee discussed problems in EOC staffing and deployment as evidenced by the recruitment and retention figures (Turnover around 18%). A deep dive on EOC decision making is also being carried out in response to the findings of a thematic review of SIs (this will be considered by the Committee at its next meeting). The Risk Compliance and Assurance Group (RCAG) is to consider a proposal for a new risk around EOC staffing (see separate report to the Board on the BAF). The Director of Operations was not represented at the meeting. Serious Incidents - We were pleased to see continued improvement in the management process although there are still actions overdue. The main issues are still clinical treatment and patient assessment, and 999 call management. These are being analysed by the Quality Governance team and the results will be presented next month. It was recommended that the length of time an action is outstanding be documented so that new actions are reported separately.
Key decisions made / actions identified:	The Deep Dive plan for 2018 was felt to need review as it no longer reflected priorities. Philippa Harding and RJM agreed to consult with Trisha Bain and bring a new plan to the next meeting.
Risks:	No new risks were identified. Training Resource -we were told the risk that not all training required will be delivered within the present resource is to be evaluated by RCAG. Tina Ivanov is undertaking a gap analysis of training requirements, due to complete in February, and will bring her findings to QAC in March.
Assurance:	• ARP - We were assured that ARP is being monitored daily and weekly and that there have been no untoward events. There is a national assessment expected at three months and we will be auditing our own processes then. These results, with important implications for planning. will be presented to the Board.

- Bank staff training - We were assured the staff on the bank had been reviewed. The many who were on the system but largely inactive have been taken off – there are 140 who are having training actively reviewed.

London Ambulance Service NHS Trust

Assurance report:	**People & Organisational Development Committee**	**Date:**	**20/11/2017**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/11/2017**
Presented by:	**Jayne Mee, Non-Executive Director, People & Organisational Development Committee Chair, Patricia Grealish, Director of People & Organisational Development**	**Prepared by:**	**Jayne Mee, Non-Executive Director, People & Organisational Development Committee Chair**

* The meeting was not quorate, but went ahead as an informal meeting, with any recommendations requiring ratification by the full Committee being circulated in correspondence or presented to the next meeting of the Committee.

Matters for escalation:

- EMD recruitment - it was noted that there was risk associated with the Trust's ability to fulfil its establishment requirements (see Risks). There is no pipeline of candidates for these roles although the majority of candidates we attract are interested in these roles. Consideration was given to the challenges associated with the conversion of applications to appointments in these roles. The Chair of the Committee asked about whether work was being undertaken to establish whether the bar for successful recruitment had been raised and, if so, what was the rationale for this. Some work had been undertaken with the EOC and recruitment teams and it was noted that recruitment standards for these roles were very vigorous with currently little flexibility; The Chair of the Committee requested that urgent work be undertaken with representatives of the Operations directorate and Emergency Operations Centre (EOC) on possible alternative recruitment approaches with a view to increasing the conversion rate of application to appointment in EMD roles.

Other matters considered:

- Operations Restructure - PW provided the meeting with an oral update on the progress of the restructure of the Operations directorate. It was noted that, further to the report, which had been submitted to the Board meeting on 31 October 2017 (ref: PTB/17/37), work was progressing on the evaluation and banding of certain roles within the directorate.
- Education Calendar - In light of the relationship between the LAS' training capacity and its ability to employ individuals within key frontline positions,

	the value of having a “reserve” list for people able to join training courses at short notice was stressed. • Core Front Line Establishment - The question of the size of the establishment to which the LAS was recruiting for core front line roles and EOC was discussed. It was noted that, for planning purposes, an establishment had been posited. However, this was to be confirmed, particularly in light of the implementation of the Ambulance Response Programme (ARP) and possible changes to the skills mix required by the LAS to carry out its key activities. In light of this it was proposed that this figure should not be used for reporting purposes, other than forecasting at this point. • Succession Impact Matrix - PG set out a proposed approach to supporting management discussions around “key roles and experiences” in the organisation. It was envisaged that this work would form part of the broader succession planning and talent management activities identified within the People and Organisational Development Strategy. The proposed approach was welcomed and the Chair of the Committee noted the importance of undertaking this work. It was proposed that the outcome of this work would require consideration by the Nominations and Remuneration Committee in due course.
Key decisions made / actions identified:	• Recruitment report - Future iterations of the recruitment report to provide information on progress made since the last report. • International recruitment - More information with regard to conversion rates of conditional offers made to international candidates for key frontline positions into employment so that level of ‘drop out’ can be assessed • StatMand Training/Bank workers - The meeting was informed that the number of bank workers had been reduced in order to ensure compliance with mandatory and statutory training requirements. The Chair of the Committee noted the importance of ensuring that there were sufficient bank staff to be called upon when required in particular during the winter period. • P & OD Strategy KPI’s - The Committee would receive a dashboard in future demonstrating performance against P&OD Strategy KPI targets
Risks:	• Risk & Audit Report - On the risk relating to maintaining service levels due to insufficient staff in the EOC, the meeting proposed that consideration be given to increasing the rating of this risk from 12 to 16 and including it on the BAF, for presentation to the Board at its meeting on 28 November 2017.
Assurance:	• Recruitment Campaign - The meeting was provided with a presentation of the creative concept for a London Ambulance Service NHS Trust (LAS)

recruitment campaign. There is a little more work to do but it will provide a clear strategy for attraction.

- P & OD Plan - As many of the activities were heavily dependent on cross functional planning and decision-making, the meeting noted the importance of ensuring that the proposed refresh of the Business Plan that had been discussed at the Board meeting on 31 October 2017 took account of this. The report was considered to be an accurate reflection of the achievements that had been possible and those that required review in light of the challenges faced by the People and Organisational Development directorate.
- Statutory & Mandatory Training – The Trust is still on track to meet its overall target of 85% compliance by March 2018.
- TEAC Recruitment - The meeting was informed that the TEAC role was one of the most challenging to recruit to, as it was often misunderstood, required the ability to drive and required a significant amount of training. However, progress was being made with regard to recruitment to these roles and 64 individuals were in the training pipeline.

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report Title:	Board Assurance Framework			
Agenda Item:	13			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Executive Leadership Team			
Status:	☒	Assurance	☒	Discussion
	☒	Decision	☒	Information

Background / Purpose:
This paper provides the Trust Board with an updated Board Assurance Framework (BAF)
Recommendation:
The Board is asked to consider the BAF.
Links to Board Assurance Framework (BAF) and key risks:
This paper sets out the content of the BAF

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒

Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Board Assurance Framework (BAF)

Current BAF Risks

1. There are currently 10 risks on the BAF which have a net rating of 15 and above:

Risks owned by the Director of Finance:

BAF risk 42
The Trust may not receive the full £7.8 million attached to the contractual CQUINs.

BAF risk 49
The preferred LAS strategy may not be deliverable within the Trust's identified strategic timeframe due to the scale of investment required.

Risks owned by the Director of Operations:

BAF risk 7
Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.

BAF risk 41
The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.

BAF risk 48
The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability.

Risks owned by the Director of People & Organisational Development:

BAF risk 40
The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.

BAF risk 43
The management of bank workers may not meet current standards relating to training, governance and management.

BAF risk 47
The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

Risk owned by the Chief Information Officer:

BAF risk 45
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

Risk owned by the Chief Quality Officer:

BAF Risk 46
Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.

Risks added to the BAF since the last Board meeting

2. The following risks are new to the BAF since the last Trust Board meeting:

BAF Risk 46 - Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.

BAF risk 47 - The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

BAF risk 48 - The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability.

BAF risk 49 - The preferred LAS strategy may not be deliverable within the Trust's identified strategic timeframe due to the scale of investment required.

Risks removed from the BAF since the last Board meeting

3. The following risks have been removed from the BAF since the last Trust Board meeting:

BAF risk 37 – Owned by the Director of Operations
There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.

4. This risk was approved for closure by the Operations Risk Group with the rationale that since the implementation of the Ambulance Response Programme (ARP) the A8 response target no longer exists and therefore the risk is no longer applicable. Compliance with the ARP categories will be monitored and a new risk defined where appropriate in the next month.

BAF risk 29 – Owned by the Director of Operations
There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.

5. This risk was reviewed the Control Services Quality and Business Group with a proposal for closure which was endorsed by the Quality Assurance Committee and the Risk Compliance and Assurance Group. This was based on the rationale that, following recruitment to operational establishment and the implementation of the ARP, the Trust is seeing fewer calls being held waiting for an ambulance response.

BAF risk 36 – Owned by the Medical Director
There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised.

6. This risk was reviewed by the Quality Assurance Committee and by the Risk Compliance and Assurance Group and approved for de-escalation from the BAF, from a net rating of 15 to a net rating of 10. This was based on the rationale that, following a thematic review of cases where defibrillation may have been delayed, all teaching materials were quality assured to verify they reflect current teaching ahead of CSR 2017.1. SI action reference 5276. The CSR 2017.03 curriculum has been agreed and will see clinical staff of all grades undertaking a 4hr session on ALS/BLS with an emphasis on early defibrillation. The "Train the Trainer" sessions for Clinical Tutors are completed and this module is due to go live in early 2018. All clinical staff will undergo an annual refresher.

BAF risk 44 – Owned by the Director of Finance
There is a risk to achievement of the LAS control total for 2017/18 and a risk to achieving the LAS strategy in the long term if it does not have a sustainable financial plan due to a number of work streams not being fully implemented.

7. This risk is being replaced by two new risks BAF risk 44 as set out above and Corporate Risk Register risk ID 714 - There is a risk that the Trust will be subject to regulatory intervention as a result of not achieving its 20178/18 control total which has a net rating of 10.

Risk discussions in November and December

8. The following risks have been discussed by Board Assurance Committees in the last month:

BAF risk 47 - The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

9. This risk was added to the BAF in November following consideration by the People & Organisational Development Committee, the Quality and Assurance Committee and the Audit Committee at their meetings in November. It has a net rating of 16.

BAF risk 42 - The Trust may not receive the full £7.8 million attached to the contractual CQUINs.

10. This risk, which is currently included in the BAF, will be considered in detail by the Finance and Investment Committee at its meeting on 23 November 2017.

BAF risk 41 – The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.

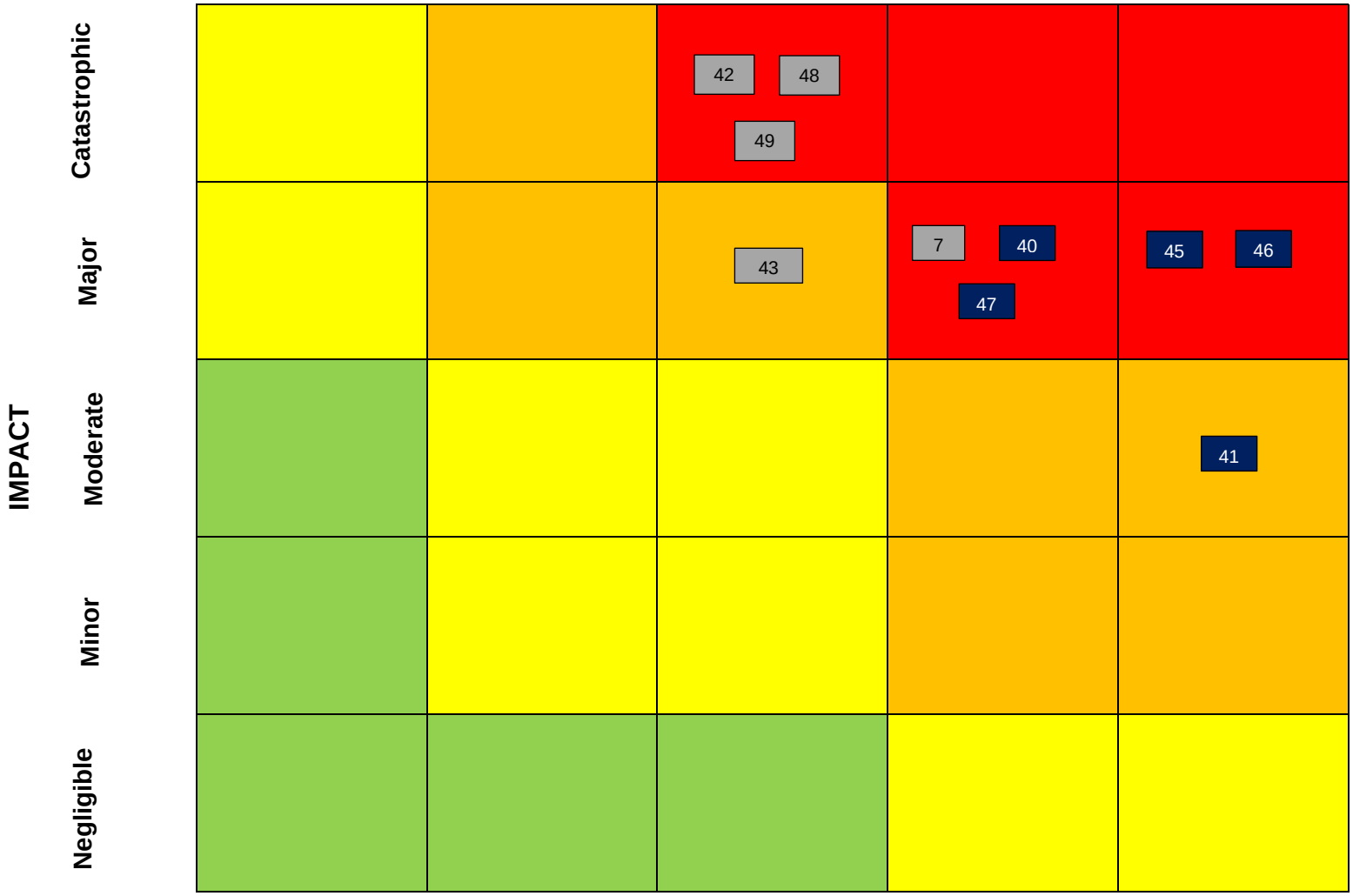
11. It is anticipated that this risk will be brought to the Risk Compliance and Assurance Group in December with a proposal for closure with the rationale that new mobile devices have now been delivered to operational sites and being rolled out to staff.

    CRR ID 712 - There is a risk that the Trust remains subject to Special Measures as a result of not having made sufficient sustained improvement in its CQC ratings.

12. This risk was considered the Risk Compliance and Assurance Group on 17 November 2017 and approved with a net rating of 12. It has not been included in the BAF due to it being considered to be adequately managed within the Quality Improvement Programme.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – November 2017



BAF Risk 42
The Trust may not receive the full £7.8 million attached to the contractual CQUINS.

BAF Risk 7
Performance falls at staff changeover time.

BAF Risk 40
The Trust may not be able to recruit sufficient Paramedics to meet workforce profile requirements in 2017/18.

BAF Risk 43
The management of bank workers is not meeting current standards relating to training, governance and management.

BAF Risk 41
Obsolete Personal digital Assistance in use by PTS and NETS staff.

BAF Risk 45
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

BAF Risk 46
Lack of compliance with statutory health and safety requirements.

BAF Risk 47
Unable to maintain service levels due to insufficient staff in the EOC.

BAF Risk 48
Capability of the Trust to effectively manage major and significant incidents.

BAF Risk 49
The preferred LAS strategy is not deliverable within the Trust's timeframe due to the scale of investment

Key

Net risk rating

Gross risk rating = net risk rating

Risk Severity

High Risk (15-25)

Significant Risk (8-12)

Moderate Risk (4-6)

Low Risk (1-3)

GOAL 1	Patients Receive Safe, Timely & Effective Care

OBJECTIVES	1. To drive high quality and safe patient care 2. To improve clinical outcomes and enhance clinical excellence 3. To achieve agreed performance, ambulance and regulatory standards

Links to Objectives	BAF Risk	Further mitigation required
1, 2, 3	7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	• Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements
1, 2, 3	45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
1, 3	43 The management of bank workers may not meet current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts
1, 2, 3	40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.	• Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1, 2	41 The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.	• Roll out on NETS Devices to NET Operational Devices
1	42 The Trust may not receive the full £7.8 million attached to the contractual CQUINs.	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies
1, 2, 3	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	• Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) . • Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements
1, 2 3	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service.

		• Continuation of the support offered to recruitment for shortlisting, assessment space and interviews.
1, 2, 3	48 The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability	• 1. Finance department or KPMG external auditors to undertake individual tax liability reviews to assess the additional costs • 2. Trust to increase on-call allowances to compensate for increased tax liability • 3. Trust to accept redemption fees for lease car returns • 4. Trust to provide a dedicated car for use by the individual on-call which is shared by the cohort • 5.Amend the on-call roster to factor on duty staff only • 6. Provide accommodation in London for the individual who is on-call during their on-call period • 7. Provide marked cars for the use of on-call staff

GOAL 2 Staff are Valued, Respected & Engaged	OBJECTIVES	1. To ensure our workforce model meets future patient needs 2. To support the health and wellbeing of our staff 3. To develop our culture and improve our diversity 4. To support and equip our managers to lead well, from 'Board to Station' 5. To make things easier for our staff to do their jobs

Links to Objectives	BAF Risk	Further mitigation required
1	40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18.	• Explore strategies/benefits to encourage UK graduates to see LAS as 'employer of choice'. • Continue to identify additional partner Universities • Review mentoring capacity • Review skill mix in line with clinical strategy • Review skill mix in line with ARP • Apprentice paramedic pipeline including EAC progression • Further development of LAS Academy pathway • Improved workforce planning and reporting
1	43 The management of bank workers may not meet current standards relating to training, governance and management.	• Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts
4	41 The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed.	• Roll out on NETS Devices to NET Operational Devices
2, 4	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	• Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) • Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements
1	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service. • Continuation of the support offered to recruitment for shortlisting, assessment space and
5	48 The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability	• 1. Finance department or KPMG external auditors to undertake individual tax liability reviews to assess the additional costs • 2. Trust to increase on-call allowances to compensate for increased tax liability • 3. Trust to accept redemption fees for lease car returns • 4. Trust to provide a dedicated car for use by the individual on-call which is shared by the cohort • 5.Amend the on-call roster to factor on duty staff only • 6. Provide accommodation in London for the individual who is on-call during their on-call period • 7. Provide marked cars for the use of on-call staff

GOAL 3	**Partners are Supported to Deliver Change in London**

OBJECTIVES	1. To proactively work with London's five STPs to support delivery of the Five Year Forward View 2. To expand our reach into the London Integrated Urgent & Emergency Care System 3. To use data and system intelligence to improve patient care 4. To work with partners to improve patient care and value for money

Links to Objectives	BAF Risk	**Further mitigation required**
4	42 The Trust may not receive the full £7.8 million attached to the contractual CQUINs	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies

GOAL 4 Efficiency & Sustainability Will Drive us	OBJECTIVES	1. To achieve financial targets and deliver a £17.8m Cost Improvement Programme 2. To deliver a transformation programme to continue our improvement journey 3. To have stable and reliable IT platforms to enable 21st century working 4. To deliver the LAS 5 year strategy and strategic plans for essential infrastructure

Links to Objectives	BAF Risk	Further mitigation required
1	42 The Trust may not receive the full £7.8 million attached to the contractual CQUINs.	• Fortnightly meetings between contract and commissioning team internally and external LAS contracting team • Improving relationships with the external commissioning team • Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies
4	7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability	• Implement new rest break policy • Commence operational roster review • Enact end of shift protection arrangements
3	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
1, 2, 4	49 The preferred LAS strategy may not be deliverable within the Trust's identified strategic timeframe due to the scale of investment required.	• Review Finance structure and prepare case to Trust Board to enable business partnering support • Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme

BAF Risk no. 42 The Trust may not receive the full £7.8 million attached to the contractual CQUINs

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance and Investment Committee
Date risk opened: 22/06/2017	**Date risk expected to be removed from the BAF:** 31/03/2018	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
Failure to deliver CQUINs in methodology agreed with Commissioners and CQUIN owners. Some national CQUINs are outside of the sphere of influence of the Trust and may be unrealistic to achieve. Other priorities in place across the Trust, resulting in a lack of engagement and ownership of CQUINs.	**20**	**15**	**10**

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. A full review of all reports prior to submission undertaken to ensure achieving as specification 2. CQUIN briefing papers distributed to all Directors and CQUIN leads 3. Contracting and Commissioning Team hold monthly catch up calls with all CQUIN owners 4. Quarterly, face to face, meetings held with the relevant Executive Leadership Team member, in conjunction with the Contracting and Commissioning Team 5. Monthly CQUIN working group established in partnership with the commissioners to recover a particular CQUIN 6. Monthly meetings now amended to fall in sequence with submission dates and external CQUIN meetings 7. All CQUINs assigned to a lead Executive Leadership Team member, explaining the importance of following the exact wording 8. A finance and reporting tracker created and reviewed at monthly performance meetings **Gaps in Controls** No gaps identified	1. Reports to be submitted to ELT updating progress against all key milestones 2. Update reports to FIC and Trust Board where required **Gaps in Assurance** No gaps identified	1 Fortnightly meetings between contract and commissioning team internally and external LAS contracting team 2. Improving relationships with the external commissioning team 3. Early escalation routes being created, both internally and externally, to ensure all parties aware of any discrepancies	Ongoing since May 2017 Ongoing since June 2017 evidenced by successful conclusion of negotiation of 1718 outstanding CQUIN issues in Sept 17.

Signed: Lorraine Bewes
Comment: Risk to be reviewed by the Finance & Investment Committee on 23/11/2017

BAF Risk no. 7 Patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.

Risk Classification: Operational	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Quality Assurance Committee
Date risk opened: 08/12/2006	**Date risk expected to be removed from the BAF:** 31/03/2018	

Underlying Cause/Source of Risk: Roster configuration, Rest break arrangements, Increased OOS, High demand, Response model, staff wanting to finish their shifts on time and avoid late finishes

Gross Rating	Current/Net Rating	Target Rating
20	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 5 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Robust implementation of the existing rest break policy 6. On-going rigorous management of out of service. 7. Implementation of the Ambulance Response Programme (ARP) will see fewer cancellations and more efficiency in dispatch which will produce more capacity and resource availability over the shift changeover period **Gaps in Controls** 1. Culture and behaviour of staff being driven by perverse incentives within the current rest break agreement 2. The desire of staff to end their shift on time and avoid late finishes 3. Sufficient management capacity within EOC 4. Management of non-compliance with rest break allocations	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the Operations Board on progress and compliance 5. Sector GSM will spend time on DDS desk in EOC to challenge non-compliance issues in real time 6. Instigation of New Dispatch Model Trial in North Area to include tethering to Sectors which will make rest break implementation easier. Extension of critical cover at end of shift for NC Sector FRUs **Gaps in Assurance** There appears to be a relationship between the number of rest breaks allocated per day and out of service (OOS) rates at shift end. The more rest breaks that are given the higher the end of shift OOS and this is being looked into	Implement new Rest Break Policy as agreed with Trades Unions Enact end of shift protection arrangements	04/12/2017 31/03/2018

Signed: McKenna, Peter

BAF Risk no. 40 The Trust may not be able to recruit sufficient core front line staff to meet workforce profile requirements in 2017/18

Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 06/03/2017	**Date risk expected to be removed from the BAF:** 31/03/2018	

Underlying Cause/Source of Risk: Increase in paramedic numbers over and above planned 2016 levels in order to meet agreed 2017/18 contract; existing and known shortfall in supply of UK graduate paramedics, exacerbated by "fallow year" in 2017 due to degree programme extending from 3 to 4 years.

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Recruitment Plan for 2017/18 developed against initial requirement for paramedics (prior to agreed projected increase in demand) 2. Based on anticipated graduate numbers (90) and apprentice paramedics (76), an additional requirement for c.400 has now been confirmed, 300 of which we have already planned to source internationally. 3. Clinical Education capacity identified **Gaps in Controls** 1. Skill mix profile as yet undefined/unconfirmed. 2. Identify source of supply of c. 100 additional paramedics **Gaps in Assurance**	1. Initial recruitment Plan for 2017/18 developed and is evolving 2. Weekly meetings in place, chaired by the Deputy Director of Operations to review recruitment activities, education capacity and outcomes and numbers released to operations (A&E Resourcing) 3. Weekly recruitment tracker and slide pack in place focusing on performance against plan, attrition and internal staff movements 4. Monthly reporting to ELT on front line recruitment 5. Progress against recruitment plan a standing item at People & OD Committee 6. Number of Paramedics required identified 7. International Recruitment campaigns in Australia (April and October) - we have recruited over 350 paramedics with start dates betwn Jan & Jun 2018. 8. Monthly contact with iPara cohorts to confirm starting arrangements 9. Improved UK Graduate numbers for 2018/19 – estimated to recruit 244 FTE 10. Healthy TEAC recruitment pipeline – we have recruited 244 this year with over 80 in the pipeline 11. Working with partner universities to encourage graduates to London 12. Working with non-partner universities to increase graduate numbers to London 13. Implementation of Band 6 - will reduce migration to other Trusts 14. Development of an improved workforce planning report 15. Closer working relationships with HEE 16. Potential conversion of other HCPS 17. Encourage UK graduates to see LAS as 'employer of choice' through direct engage at universities	1. Further improved workforce planning and reporting to include supervision 2. Continue to identify additional partner Universities 3. Review mentoring capacity to ensure ability to process numbers of employees in training 4. Review skill mix in line with clinical strategy 5. Review skill mix in line with ARP 6. Apprentice paramedic pipeline including EAC progression 7. Further development of LAS Academy pathway 8. Confirm 2017/18 core frontline funded establishment	31/12/2017 31/3/2018 31/12/2017 31/12/2017 31/12/2017 31/12/2017 31/12/2017 31/12/2017

Signed: Patricia Grealish

BAF Risk no. 43 The management of bank workers may not meet current standards relating to training, governance and management

Risk Classification: HR / Workforce	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 04/07/2017	**Date risk expected to be removed from the BAF:** 30/11/2017	

Underlying Cause/Source of Risk: No manager identified for Bank Workers and no one responsible for ensuring compliance with Trust requirements. There is a need to ensure bank workers have a current DBS and that current driving licences are provided. Bank Workers are expected to attend CSR but are not paid for attending this training. We have historically not had robust and readily available training completion data.

Gross Rating	Current/Net Rating	Target Rating
16	12	4

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. HR to prioritise DBS checks for all bank workers and volunteers; All external Bank workers go through full recruitment process (as per substantive employees); External bank workers (i.e. not-ex LAS) are Paramedics required to uphold their professional registration. Core skills must be maintained to successfully re-register. 2. There is now a co-ordinator in post to manage Bank Workers. For performance management it is proposed to allocate Bank Workers to a sector, central control will be held by Resourcing who will ensure compliance with necessary checks (driving licences, DBS and training). **Gaps in Controls** No gaps identified	1. Ongoing reports have been made via Statutory Mandatory training reports to ELT and CEO performance reviews. 2. Discussions at ELT have included paying Bank Workers to undertake CSR training. This route was not pursued 3. Bank Worker contracts for paramedics have been reviewed by Beachcroft and are being finalised for issue w/c 13 November 2017. 4. Only 'active' Bank Workers – who have worked a shift within the last 12 months will be on the active register. We will require them to evidence their training as part of the registration. This numbers 171 individuals – 43 of whom are ex-LAS employees. **Gaps in Assurance** No gaps identified	Ensure all Bank workers have completed Statutory and Mandatory training before being assigned to shifts.	30/11/2017

Signed: Patricia Grealish

Comment: Good progress has been made with the appointment of a Bank Co-Ordinator. A refresh of the Register is underway to ensure that only Bank Workers that are working shifts and have the right checks and training are included. This will also significantly reduce the size of the Register to approximately 171 individuals.

Regular meetings will be scheduled with Resourcing (who hold responsibility for managing the Bank Worker Register and allocating to rotas) to check progress. In relation to training, once the Refresh is complete the Bank Workers will be included as a group on the Trust's Stat Man training reports. Currently training records for this group are held by the Resourcing Team.

BAF Risk no. 41 The current Personal Digital Assistants (PDAs) in use by PTS and NETs staff for the electronic dispatch of jobs to crews and subsequent data collection are obsolete and can no longer be fixed

Risk Classification: Operational	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 12/05/2017	**Date risk expected to be removed from the BAF:** 30/11/2017	

Underlying Cause/Source of Risk: Issues raised by control and crew staff.	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	15	**15**	**6**

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
Hand held airwave radios. Crews personal mobile phones. Data collection currently verbally relayed to control. Crews advised to contact control every 20 minutes where delays occur. **Gaps in Controls** No device supplied by the LAS for consistent collection of data and means of communication	Manually collected data is recorded in Meridian and Command Point. Telephone conversations with crews are recorded within EOC. **Gaps in Assurance** No automatic flagging of delays by system, should crews not make contact verbally.	Roll out on NETS Devices to NET Operational Devices	30/11/2017

Signed: Nic Daw on behalf of Paul Woodrow

BAF Risk no. 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period

Risk Classification: IM&T	**Risk Owner:** Ross Fullerton	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 01/06/2017	**Date risk expected to be removed from the BAF:** ongoing	

Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats has accelerated rapidly in the last 5 years; cyber-attacks are regularly successful at disrupting many organisations in ways that weren't considered possible only a short time ago. This is compounded by an under-investment in IT security at LAS over the same time frame. As a consequence there is a deficiency in the overall awareness of cyber risk inside and outside of IM&T and we lack the skillsets, processes, governance and tools to mitigate the evolving threat profile effectively.

Gross Rating	Current/Net Rating	Target Rating
20	20	12

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Existing defences have mitigated threats to-date; these include various technical and procedural elements 2. Independent review by PA Consulting has identified necessary mitigations for CAD system **Gaps in Controls** The existing controls do not meet good practice requirements as defined by HMG's National Cyber Security Centre.	1. Reports to Information Governance Group of cyber-related incidents each quarter – Reporting will be tied to Key Performance Indicators and services. 2. Reports from IGG to RCAG – All work carried out as part of the Cyber Security Improvement Programme will be reported to the IGG and RCAG. 3. To align with the NCSC guidance we will look to comply with Cyber Essentials by the end of February 2018. **Gaps in Assurance** The gaps are being investigated by the Cyber Security Improvement team and pragmatic/practical recommendations and an action roadmap will be drawn up.	Initial Bid to NHSD for Cyber funding Capital (Bid 1) NHS Digital led review of LAS cyber security (November 2017). Implementation of HMG good practice in cyber controls (Cyber Essentials) Potential second bid to NHSD for Cyber funding Capital (Bid 2) Implementation of recommendations from PA Consulting report. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS	30 Nov 2017 Successfully Completed Jan 2018 Feb 2018 Feb 2018 April 2018 Apr 2018

Signed: Ross Fullerton

BAF Risk no. 46 **Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust**				
Risk Classification: Health and Safety	**Risk Owner:** Trisha Bain	**Scrutinising Committee:** Corporate Health and Safety Committee		
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF:**			
Underlying Cause/Source of Risk: The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance.		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		20	**20**	**4**
Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
1. Corporate Health and Safety Committee in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in place through Datix. 7. ELT/Board oversight for H&S compliance through the Trust's committee reporting structure. 8. Regular update reports are provided for Trust-wide committees. 9. Responsible Director for Health and Safety in place for the Trust. 10. Regular reporting of H&S action updates through the monthly Quality Report, Quarterly Health and Safety Committee and the Quality Oversight Group. 11. Senior Management Level H&S Training completed by ELT/Board Members.	1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. **Gaps in Controls** 1. Lack of capacity within the Health and Safety Department to support the Trust, and to ensure Trust-wide H&S compliance. 2. A large number of the Trust-wide H&S policies require updating as they refer to out dated processes, legislation or to staff who have left the Trust. 3. The health and safety training provided is limited with gaps in areas such as manual handling refresher training, general health and safety refresher training for Managers. 5. Lack of robust arrangements for monitoring/checking the effectiveness of the training provided to staff as well as staff competency.	1. Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed seperately) . 2. Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements.		31/03/2018 31/03/2018
Signed: **Trisha Bain**				

BAF Risk no. 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre

Risk Classification: People & OD	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF:**	

Underlying Cause/Source of Risk:
Recruitment: Remuneration level for new entrants is not competitive with other similar roles within the immediate vicinity of both control rooms (HQ and Bow). The current standards set within the recruitment assessment process are such that conversion rates are low from expression of interest to numbers starting

Retention: The working environment in control rooms is frequently pressurised and staff turnover is high compared to other roles in the trust

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. They have discuss and reviewed the existing recruitment process to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment function to ensure specialist knowledge in the recruitment team to allow good decisions on passing candidates through the shortlisting process. 7. A number of external advertising opportunities to be funded and actioned. 8. EMDs have been released to support job fairs to promote the role. 9. EMDs support EOC Training team delivering Open Evenings for potential candidates interested in joining. **Gaps in Controls**	1. Monthly recruitment project meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support form PLM, Control Services	1. Role will be included as part of planned recruitment campaign. 2. Continuation of the project meetings to maintain the level of scrutiny required by the service. 3. Continuation of the support offered to recruitment for shortlisting, assessment space and interviews	

Signed: Patricia Grealish

BAF Risk no. 48	**The capability of the Trust to effectively manage major and significant incidents will be impacted as a result of insufficient operational mangers having out of hour's access to blue light equipped vehicles, as a result of changes to how HMRC calculate benefit in kind liabilities have resulted in increased personal cost to managers for having access to vehicles with emergency response capability.**		
Risk Classification: Operational	**Risk Owner:** Paul Woodrow	**Scrutinising Committee:** Quality Assurance Committee	
Date risk opened: 17/011/2017	**Date risk expected to be removed from the BAF:**		
Underlying Cause/Source of Risk: This results in some staff having a higher tax liability over and above that of a normal company car and poses a risk that these managers will have the emergency response capability (lights and sirens) removed.		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		20	**15**	**5**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**	**Due Date**
Strategic and Tactical Commanders can attend out of hours incidents by driving under normal road conditions when on-call **Gaps in Controls**	None identified	1. Finance department or KPMG external auditors to undertake individual tax liability reviews to assess the additional costs 2. Trust to increase on-call allowances to compensate for increased tax liability 3. Trust to accept redemption fees for lease car returns 4. Trust to provide a dedicated car for use by the individual on-call which is shared by the cohort 5.Amend the on-call roster to factor on duty staff only 6. Provide accommodation in London for the individual who is on-call during their on-call period 7. Provide marked cars for the use of on-call staff	

Signed: Paul Woodrow

BAF Risk no. 49 **The preferred LAS strategy may not be deliverable within the Trust's identified strategic timeframe due to the scale of investment required.**				
Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee		
Date risk opened: 17/011/2017	**Date risk expected to be removed from the BAF:**			
Underlying Cause/Source of Risk: 1. Unknown Target Operating Model 2. Level of recurrent CIPs required - need to be driven by appropriate benchmarking metrics in order to achieve full efficiency opportunity 3. The capital budget is insufficient to support the LAS strategy 4.Need for appropriate programme approach/resource 5.The LAS has a deficit plan of £2.4m which needs to improve to achieve a sustainable surplus to achieve its strategic objectives. (links to Control 6 and Actions 1 and 5) 6. Up until 2017/18, the LAS operated within a block contract and fixed income financial envelope and has been in special measures over the last year, with the result that priority could not be given to developing financial and commercial awareness of budget holders to develop a devolved service level management model in line with the norm in other NHS organisations. (links to Control 3 and Action 2 and 4) 7. Instead, budget control has largely been achieved through central management and contingency accounting. (links to Control 3 and Action 2 and 4) 8. From 2017/18 the LAS contract income has and will become more variable with performance, the LAS strategy is to become the integrated emergency & urgent care provider and a significant transformation of service delivery is required. (links to Action 2, 4 and 5.)		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		25	**15**	**10**
Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process.	None identified	Review Finance structure and prepare case to Trust Board to enable business partnering support Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme		
Signed: Lorraine Bewes				

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Serious Incidents Update			
Agenda item:	14			
Report Author(s):	Kirstie Smith, Interim Head of Quality Governance and Assurance			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	Executive Leadership team			
Status:	☒	Assurance	☐	Discussion
	☐	Decision	☐	Information

Background / Purpose:

An outline of the current status in relation to serious incidents (SIs) and to provide assurance to the Board that actions from closed incidents are complete and/or on track. Additionally the report provide deep dive into findings from the Thematic review reported last month.

Recommendation(s):

Findings of the deep dive are shared with the relevant directorates to address any systemic issues identified.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☒
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Serious Incidents Update
Trust Board: November 2017

1. Introduction and Background

1.1. An outline of the current status in relation to serious incidents (SIs) and to provide assurance to the Board that actions from closed incidents are complete and/or on track.

1.2. This paper also provides the executive summaries from all in-month serious incident reports that have been sent to our commissioners for closure to meet the 60 day contractual obligations (Appendix 1).

2. Investigation Update

2.1 To recap on in-month activity and individual SI reports:

StEIS Number	Incident type	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales
2017/17636	Operations – Clinical decision making	Review existing training materials to ascertain gap analysis	30.11.2017	05.10.2017	Submitted before deadline
		Review existing process of notifications; If none exist consideration for new process	30.11.2017		
		Engagement with senior midwives at maternity units to reiterate agreement as per the LAS Maternity Care Policy OP035	31.12.2017		
2017/18240	Delayed response	EMD D to meet with their manager to discuss the importance of documentation.	November 2017	13.10.2017	Submitted before deadline
		EMD D to meet with their manager to discuss the requirement stated in (OP 60) to attempt to make 3rd party calls into 1st or 2nd party calls with someone at the incident.	November 2017		
		EOC QA manager to feedback QA report to EMD A	Completed		
		Sharing of the SI amongst the EOC team Line manager to meet with area controller to provide feedback and area controller to reflect on learning form this incident.	December 2017		
		Develop a process for staff to	November		

		pass information to EOC when encountering a running call. This should be led by Operations with support from the EOC GM for Performance & Process.	2017		
2017/19503	Treatment delay	Detail and obtain relevant information to make an informed clinical decision on a patient's condition.	Completed	27.10.2017	Submitted on deadline
		An article to be included in the LAS Clinical Bulletin.	31.12.2017		
		To ensure call taker follows LAS call handling protocols	Competed		
		Options to be discussed accounting for how this is communicated within Operational Policy (OP023: Procedure for the dispatch of Resources by the Emergency Operations Centre) and alongside primacy of care responsibilities as outlined in Trust Policy (TP003: Statement of Duties to Patients).	31.01.2018 (Policy agreed and live)		

2.2 Since the completion of the report, the total number of actions (n=12) completed for the above reports is three. The remaining actions are currently on track for completion within the assigned timeframe. One action has been completed but awaiting the publication of the Clinical Update scheduled for December 2017.

2.3 Reports currently with commissioners for closure, including those identified in Table 1, currently stands at four (the above three and one submitted in November). It is accepted that a decrease in the time taken to receive sign off by the CCG will be reflected over the next few months. The Quality Governance and Assurance Team will be monitoring this compliance.

3. Thematic review

3.1 Analysis of the reports this month showed the three root causes of the incidents to be:

- Clinical decision making in complex maternity calls
- Delays in attendance due to communication issues between operations and EOC
- Delay in treatment due to communication issues between EOC and operations. Additional concerns raised regarding a paramedic responsibilities under the Duty of Care

Deep Dive Thematic Review

3.2 Following on from discussions at the Quality Assurance Committee and Trust Board it was agreed to conduct a deep dive into the three main themes that were produced from the thematic review which was reported last month.

The three main themes included:

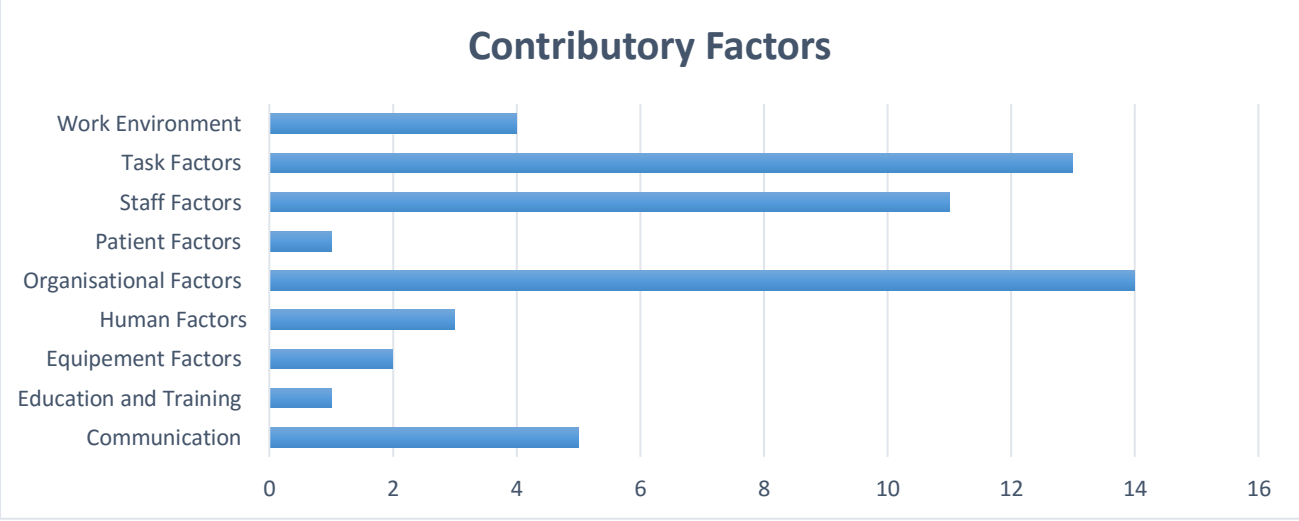
- Dispatch and Call issues (n=21)
- Clinical Treatment issues (n=18)
- Clinical Assessment issues (n=15)

3.3 From the collated information further analysis of the contributory factors that influenced the above incidents was undertaken. Further analysis of the individual points of error was incorporated into this review.

Analysis

Dispatch and Call Issues (n=21)

3.4 Of the 21 SI investigation undertaken, a review of the contributory factors showed that issues relating to task, staff and organisational factors were considered to have contributed to the root cause of the incidents. These matched the overall thematic review finding from last month's analysis.



Tasks Factors

3.5 Issues relating to task factors typically included:

- Operational policies were identified to be unfit for purpose or in need of review (OP/023, OP/060 and OP/066)
- Operational polices had not been adhered to (OP/023 and OP/060)

Staff Factors

3.6 Issues relating to staff factors typically include:

- Call handling error (incorrect protocols selected, mismanagement of 999 call)
- Emergency vehicle allocation errors

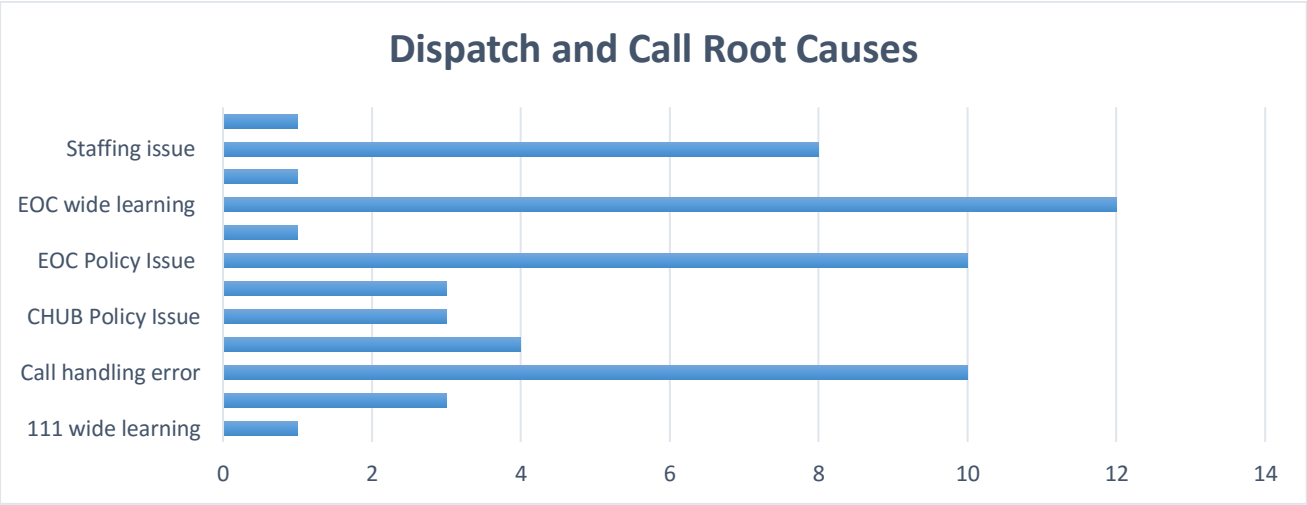
Organisational Factors

3.7 Issues relating to organisational factors typically include:

- Gazetteer issues (system not recognising location of 999 call)
- Dispatch system issues (CommandPoint issues identified)
- Staffing issues

Dispatch and Call Root Causes

3.8 Further analysis into the individual points of error (root causes) identified that EOC wide learning was required, EOC policy issues and Call Handling errors contributed to the majority of the incidents investigated.



EOC Wide Learning (n=12)

3.9 Directorate wide learning included the dissemination of official bulletins, incorporation of updates into Core Skills Refresher Training or additional training (this included the Clinical Hub).

EOC Policy Issues (n=10)

3.10 Investigation revealed the three policies that required amendment, updating or further review included:

- OP/023 – Procedure for Dispatch of Resources by EOC
- OP/060 – Control Services Call Taking Procedure

- OP/066 – Operational Procedure for the use of Paper Operations within Control

3.11 Additionally there was one action which related to the revision of the Clinical Hub procedures relating to assessment attempts that were not answered on ring back.

3.12 The assigned actions regarding the above EOC policies appear to suggest that specific sections within each policy are unfit for purpose and require reviewing by relevant senior manages.

Call Handling Errors (n=10)

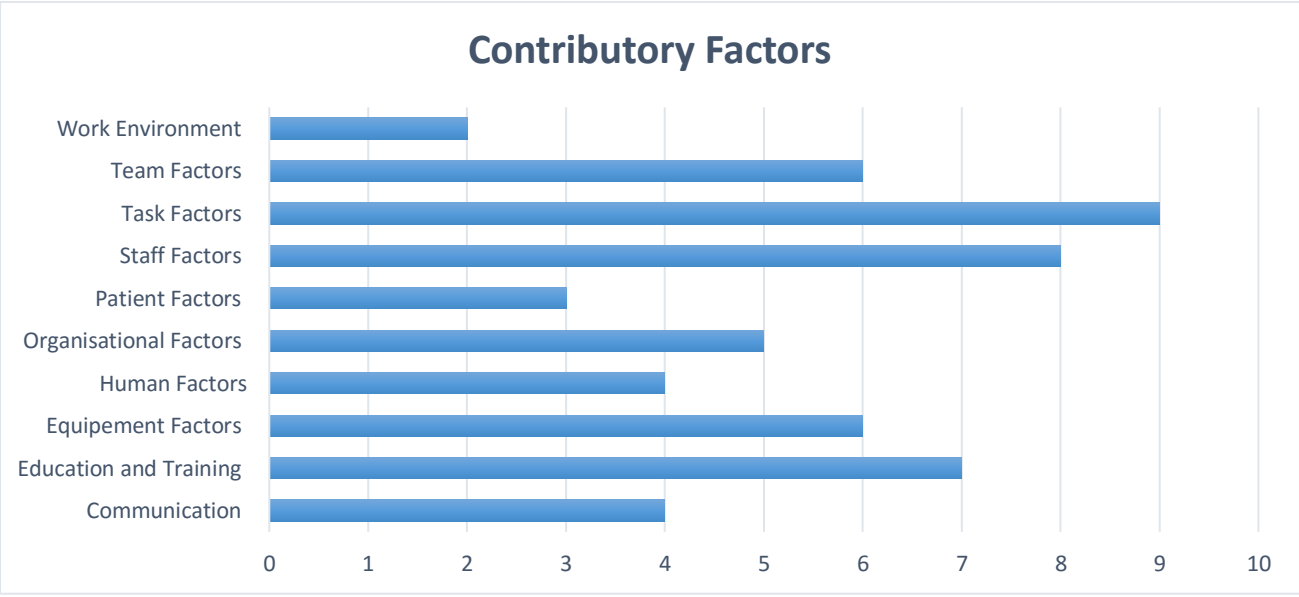
3.13 Investigations revealed the main errors made during the call handing process were associated to complex 999 calls. The main errors were around the Emergency Medical Dispatcher selecting the incorrect protocol required to triage the call which produced the incorrect priority (usually a lower priority response) which then contributed to a delayed response.

3.14 Additionally, minor errors regarding the provision of the correct pre-dispatch or arrival instructions were identified but not consider causative during the investigations.

3.15 There does not appear to be an isolated issue regarding one particular Medical Priority Dispatch System (MPDS) protocol.

Clinical Treatment Issues (n=18)

3.16 Of the 18 SI investigation undertaken, a review of the contributory factors showed that issues relating to task, staff and education and training factors were considered to have contributed to the root cause of the incidents.



Tasks Factors

3.17 Issues relating to task factors typically included:

- Clinical guidance not being adhered to

Staff Factors

3.18 Issues relating to staff factors typically include:

- Distraction
- Social/domestic issues

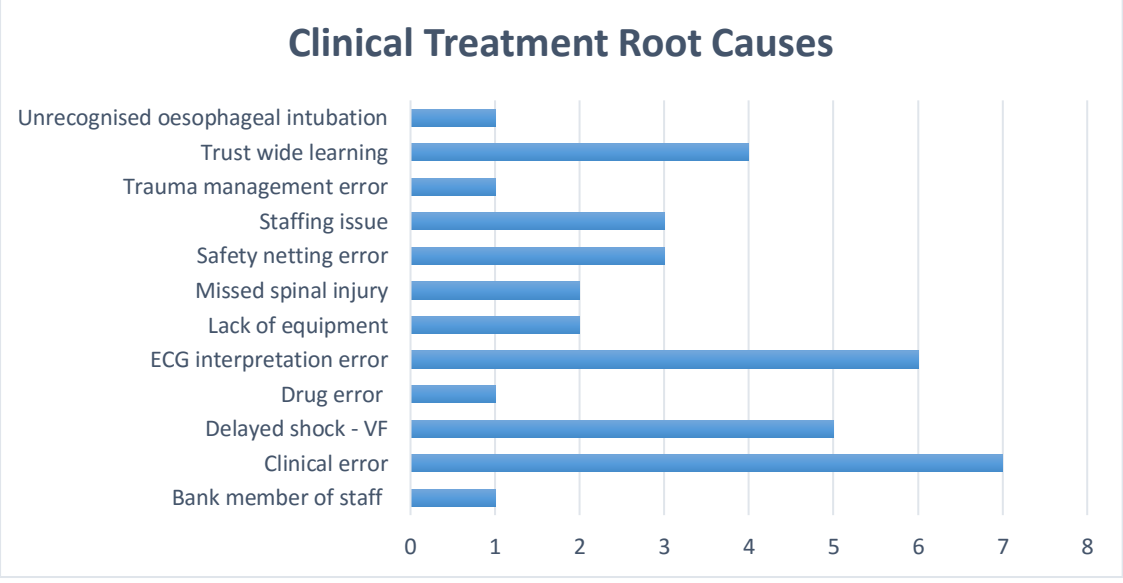
Education and Training Factors

3.19 Issues relating to education and training factors typically include:

- Inadequate clinical assessments
- Inadequate application of guidelines or supportive assessment tools
- Electrocardiogram (ECG) interpretation errors (subtle but significant changes on the ECG being missed)
- Inappropriate safety netting when discharging care to another health care provider (referral not matching the clinical presentation)
- Inappropriate non-conveyance decisions

Clinical Treatment Root Causes

3.20 Further analysis into the individual points of error (root causes) identified that clinical errors, ECG interpretation and the management of a shockable rhythm during a cardiac arrest contributed to the majority of the incidents investigated.



Clinical Error (n=7)

3.21 The majority of clinical errors made related to complex clinical presentations where either the assessment conducted by the attending crews was adequate but the clinical findings were not interpreted correctly, or the clinical assessment was not to a standard expected by the Trust which resulted in key clinical findings being missed.

3.22 It is worth noting that the second finding was generally linked to an inappropriate non-conveyance decision or inadequate safety netting.

ECG interpretation (n=6)

3.23 The review revealed that in a number of cases where the attending crews had misinterpreted the findings on the ECG which had then lead to either an inappropriate conveyance decision or inappropriate non-conveyance decision.

3.24 It is appreciated that ECG interpretation can be challenging and it should be noted that, in the majority of cases (n=6), the ECG abnormalities were subtle and generally in patient's under the age of 50. It is thought that this may be a root cause for the misinterpretation however further analysis would be need to confirm this.

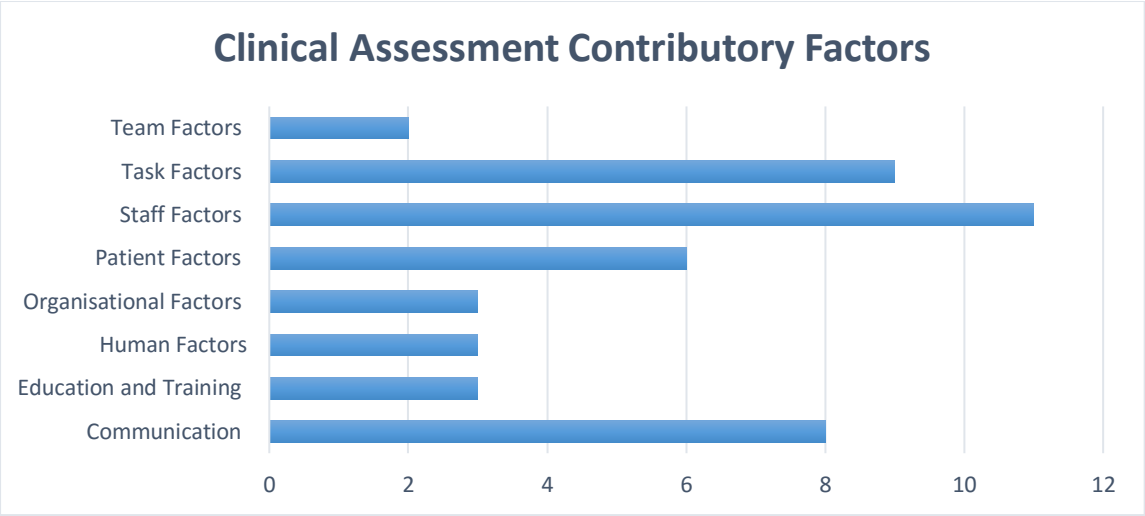
Delayed shock in cardiac arrest (n=5)

3.25 This issue has been extensively investigation by the Trust and a thematic review has been produced. Several changes have been implemented across the Trust to reduce this including a change in practice, core skills refresher training etc.

3.26 The Trust has also received a Preventing Future Death submission and has fully complied with the requirements.

Clinical Assessment Issues (n=18)

3.27 Of the 18 SI investigation undertaken, a review of the contributory factors showed that issues relating to task, staff and communication factors were considered to have contributed to the root cause of the incidents.



Tasks Factors

3.28 Issues relating to task factors typically included:

- Clinical guidance not being adhered to
- Clinical assessment tools not being referred to or appropriately applied

Staff Factors

3.29 Issues relating to staff factors typically include:

- Distraction
- Social/domestic issues

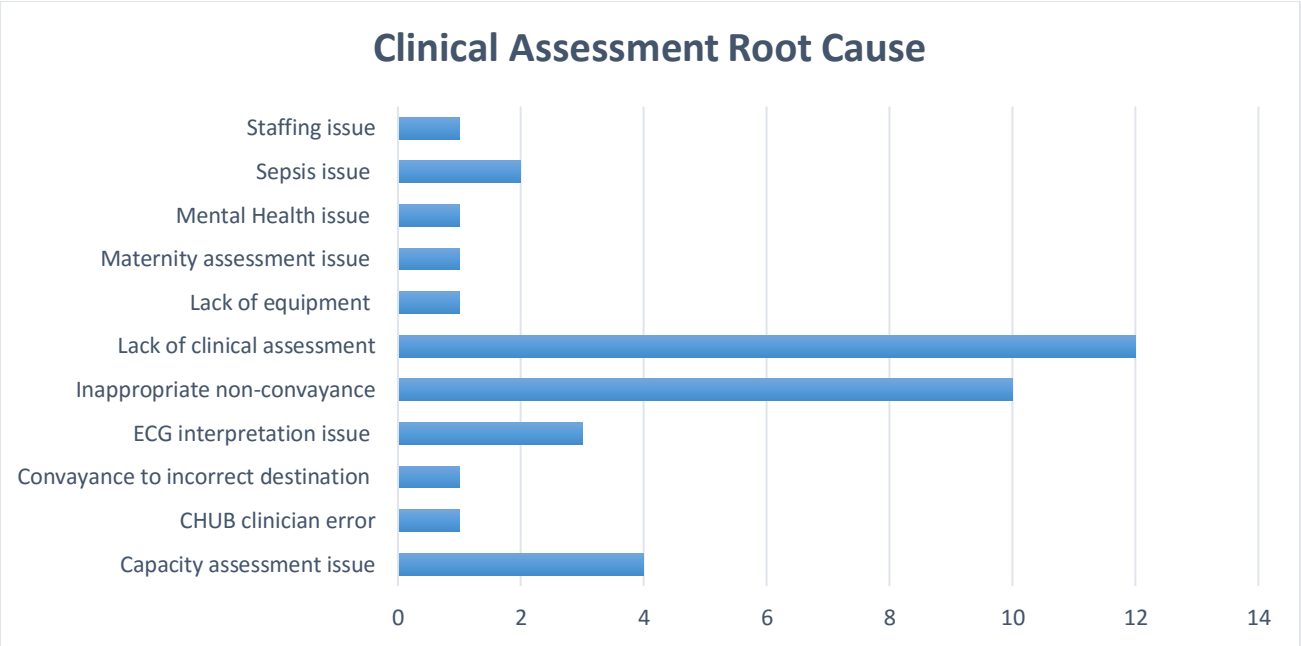
Communication Factors

3.30 Issues relating to communication factors typically include:

- Clinical and patient communication
- Updated information communication
- Operations and EOC

Clinical Assessment Root Causes

3.31 Further analysis into the individual points of error (root causes) identified that a lack of clinical assessments, inappropriate non-conveyance decisions and capacity assessment issues contributed to the majority of the incidents investigated.



Lack of clinical assessment (n=12)

3.32 The majority of the clinical assessment errors were a result of the assessment carried out by the attending crews being below the standard expected by the Trust. This root cause appears to be closely linked to the clinical treatment concerns highlighted above.

3.33 Generally it was shown that the significance of clinical red flags that were highlighted during the assessment were not recognised by the attending crews and therefore not acted upon.

3.34 It was evident that this area of concern was closely linked to inappropriate non-conveyance decisions that resulted in the patients re-presenting to the Trust and being conveyed to hospital under emergency conditions.

Inappropriate non-conveyance decision (n=10)

3.35 These cases were initially identified by the on-going re-contact audit being undertaken by CARU.

3.36 As stated above the majority of these cases were linked to inappropriate or inadequate clinical assessment or by the attending crews failing to recognise the significance of clinical red flags.

3.37 These patient were not conveyed to hospital despite their clinical presentations indicating that conveyance was required.

3.38 An article had been produced by a Consultant Paramedic for the Trust for inclusion in the next clinical update. The Quality Governance and Assurance Team has provided input into this article including examples from Serious Incident investigations that are linked to this area.

Capacity assessment decision (n=4)

3.39 It is acknowledged that the assessment of mental capacity can be challenging. The Trust provides a number of documents to assist clinicians assess a patient's capacity.

3.40 It is worth noting that the cases that have been identified (n=4) were associated with a lack of adherence to the guidance provided by the Trust or a capacity assessment not being undertaken.

Recommendations

3.41 The majority of the actions that had been assigned to address the root causes of the serious incident investigations concerned individual feedback to the Emergency Medical Dispatcher, Allocator or Clinician involved in the incident. Whilst it is appreciated that individual feedback is important, it is apparent that there may be a more systemic issue that requires addressing.

3.42 It is therefore recommended that the details of this report are shared with relevant departments and Trust wide actions plans are signed off. It is suggested that the themes of action plans/discussions includes:

- Policy review of OP/023, 60 and 66 including the learning from the 10 serious incident investigations
- Review of the content of the bulletins and updates in EOC relating to the 12 serious incident investigations to identify any trends and ensure all required updates are reflected in Trust policy where required
- Conduct deep dive into call handling errors and root cause for these (human error, staff facts, environmental factors etc)
- Review the serious incidents that reference clinical error, lack of assessment and inappropriate non-conveyance for trends and themes in line with the identified contributory factors (task, staff and education and training). Possibly link this review to the ongoing re-contact audit being undertaken by CARU
- Review serious incident investigations which included errors in ECG interpretation. It is worth noting that the numbers of investigations that were associated with incorrect ECG interpretation was relatively low (n=6)

4. In-month Quality Assurance System and Process Developments

4.1 The quality assurance directorate have continued their improvement plans and this month have completed:

Datix Project Updates

4.2 Feedback from the first round of the Datix improvement project has been positive. When reviewing the staff survey and friends and family survey it is concerning that the percentage of staff that receive feedback from submitting incidents is lower than expected. It is thought that this will greatly improve following the implementation of the feedback email system however it is appreciated that this will take time to embed before the benefits are seen Trust wide.

4.3 The second Quality Governance and Assurance bulletin was circulated and included a 'You said, we did' section to highlight to staff what changes have been implemented as a result of their comments and feedback. Staff have been offered the opportunity to become actively involved in the improvement work.

4.4 Training dates set in October were reasonably well attended however the numbers could be improved. A further nine dates have been set for November across all sectors and were communicated in the last Quality Governance and Assurance bulletin and the RIB. The team have attempted to maximise attendance by ensuring the training dates are located across the sectors and on days where other sector meetings are being held to capture as many members of staff as possible. Further work is required to increase attendance to these training sessions. Offering incentives to attend, mandatory training, inclusion in core training courses (CTL etc), operational stand down etc should be explored.

4.5 System wide coding is currently being worked through across the Governance and Patient Experiences directorates. This project is significantly time consuming and engagement is needed, together with support and validation from NHS Improvement. This is currently being mitigated by manual data collection and uploads by each department.

4.6 E-learning New Content request form has been approved and due for delivery January 2018. Two new e-learning packages will be designed in relation to patient safety and non-clinical incident management.

4.7 The two e-learning packages will be available on My ESR (Electronic Staff Records) for staff to complete.

Health Assure Project

4.8 The project has commenced with the Health Assure PID being signed off.

4.9 Training and roll out will be in January 2018.

4.10 Site visits have been conducted with East of England Ambulance Service NHS Trust and Manchester University NHS FT.

4.11 Process mapping of the 'as is' and 'to be' process have commenced to support the design and workflow for the system.

Safety and Risk

4.12 A new Risk Management Framework was approved by the Audit Committee in November.

4.13 A weekly report of overdue risks and incidents is to commence on 13th November which will see a number of reports being circulated to the Assistant Directors of Operations and Quality, Governance & Assurance Managers.

4.14 Training in incident investigation delivered on 6th October was well attended. The next training date is scheduled for 17th November. A total of 15 managers have confirmed their attendance. Other dates have been provisionally booked and staff are contacting the Quality Governance and Assurance Team requesting availability for the training.

5. Conclusion

5.1 We are maintaining our contractual targets in relation to SI investigations and action compliance is continually being monitored.

5.2 The results from the deep dive reviews revealed that Trust wide areas that require further action include:

- EOC policies
  - Recommendation for senior managers to review these polices in conjunction with the learning from the related serious incident investigations
  - Ensure that all bulletins and updates that have been shared as learning from individual serious incidents have been included into Trust policy where relevant

- Call Handling procedures
  - Recommendation to review the errors made for themes and root causes

- ECG interpretation
  - The number of errors identified relating to ECG interpretation is relatively low. The Trust already provides a significant amount of formal training in ECG interpretation both during core training courses, Core Skills Refresher Training and at a local level. The training is provided (or produced) by the Trusts cardiac specialists. It is therefore recommended that the serious incident investigations are shared with the relevant clinicians for inclusion in further training courses as learning from incidents

- Application of clinical guidance and assessment tools
  - The Trust is moving to hand held mobile devices which will have the ability to store the clinical assessment tools and guidelines for staff to refer to in real

time. The Trust App is already accessible however it is accepted that not all members of staff will have this downloaded.

- Delayed defibrillation
    - The Trust has undertaken a significant amount of work in this area of clinical practice over the previous months including a response to a Preventing Future Deaths report. There has been a decrease in the number of delayed defibrillation cases identified since the change of practice guidance was introduced.

- Inappropriate non-conveyance decision making
    - The Trust is currently conducting an audit into non-conveyance decisions and patient outcomes. Of the cases referred to the serious incident group, the majority of cases identified a lack of awareness of clinical red flags or an inappropriate clinical assessment which resulted to the decision not to convey the patient. It is recommended that the serious incidents that referenced clinical error, lack of assessment and inappropriate non-conveyance are reviewed for trends and themes in line with the identified contributory factors (task, staff and education and training).

- Awareness of capacity assessment requirements
    - The number of incidents that were related to an inappropriate capacity assessment was low (n=4). The Trust currently provides a significant amount of information and support tools on the assessment of capacity. It should be noted that the four cases in question were associated with a capacity assessment not being undertaken or a lack of adherence to guidance.
    - The Trust currently provides:
        - Mental Health Nurses in the Clinical Hub who can provide real time advice and support to operational crews
        - OP/031 Policy for consent to examination and treatment
        - Clinical update articles
        - Core skills refresher; specifically 2014.2, 2015.3, 2016.1
    - Aide memoires
        - Mental Capacity Act information circular 001
        - Mental Capacity Act information circular 002
        - Lasting Power of Attorney information
        - LA66 – guidance on best interests assessments
        - LA67 – guidance on advanced decisions
        - LA68 – guidance on lasting power of attorney
    - Clinical audits
        - CARU conducted an audit assessing the documentation of mental capacity assessment which was published in April 2017. Several recommendations were made and are being worked through. It is therefore recommended that the recommendations from this report are concluded and compliance reviewed over the next quarter.

APPENDIX 1- Executive summaries of closed Serious Incident reports

London Ambulance Service NHS Trust

SERIOUS INCIDENT

EXECUTIVE SUMMARY

STEIS NO:	**2017/17636**	**Date report:**	**22/09/2017**
Date of Incident:	**12/07/2017**	**Datix Reference:**	**9946**

Incident description:

The London Ambulance Service NHS Trust (LAS) received a call, from a third party caller who was not with the patient, to attend a female, who was over 20 weeks pregnant suffering abdominal cramping and vaginal bleeding. The call was received at 15:19.

The call received a 24 D3 -Imminent Delivery (over 5 Months/20 Weeks) C1 category. This call should have received a 24D5 -Maternity - High Risk Complications Red 2 category.

There were difficulties encountered by the call handler to confirm the exact location of the patient. The first crew staffed by two Emergency Ambulance Crew (EAC) were on scene at 15:33, 14 minutes after the first call and arriving with the patient at 15:38, 19 minutes after the original call was made to LAS.

On assessment of the patient it was established that the she had started to deliver the baby which was in breech presentation. A second crew led by a paramedic arrived on scene at 15:59 and continued to attempt delivery of the baby.

The baby was delivered and required neonatal resuscitation and a blue light transfer to hospital where it was sadly pronounced life extinct. Mother was in a stable condition throughout, was conveyed to Kingston Maternity Unit and subsequently discharged.

They delay was unlikely to have changed the outcome, given the prematurity of the baby, and the breach position.

Immediate risk mitigation:	An immediate Hot debrief was undertaken at the hospital with support from a Clinical Team Leader (CTL). A subsequent 'cold' debrief took place on 26th July 2017 with the Trust Consultant Midwife. Feedback was given to the Emergency Medical Dispatchers (EMD's) in relation to call triage
Findings of investigation:	• The actions taken by the two attending ambulance crews were appropriate for an obstetric emergency. • The crews utilised appropriate guidance tools and assistance from the Clinical Hub (CHUB). • There were some communication issues highlighted. • Poor information given to the midwife at the Hospital led to no midwife attending the scene and confusion over catchment areas. • There was a lack of communication between Emergency Operations Centre (EOC) / CHUB and the on scene crews when it was identified that a midwife / specialist resource would not be attending. • The guidance provided to the attending paramedic by the CHUB was incorrect relating to fetal positioning.
Recommendations:	a. A review of how communication can be improved between EOC and attending crews when specialist resources have been requested, in particular if the resource will not be attending scene. b. A review of teaching materials for specific obstetric emergencies i.e. Breech presentation with consideration of a new reference card / process. c. Engagement with the maternity units to identify issues where attendance to scene has been refused and ascertain catchment areas to update records held in EOC. d. Feedback to the EMD's regarding handling calls from third party callers and identifying red flags. This took place as part of the investigation.

Current Risk Score:	A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
	4 (major)	2 (unlikely)	8

Action plan/owner:	
	A review of existing training materials provided on obstetric emergencies, specifically Breech presentation. **Owner:** Consultant Midwife. A process for providing updates to attending crews from EOC if a specialist resource e.g. midwife is unavailable. **Owner:** Deputy Director of Operations – Control Services. Discussion with maternity units to identify parameters to request midwife support to scene and identify catchment areas in line with the LAS maternity policy. **Owner:** Consultant Midwife.

London Ambulance Service NHS Trust

SERIOUS INCIDENT
EXECUTIVE SUMMARY

STEIS NO:	**2017/18240**	**Date report:**	**12/10/2017**
Date of Incident:	**14/07/2017**	**Datix Reference:**	**9996**

Incident description:	In July 2017 the LAS received three 999 calls to attend a Road Traffic Collision (RTC) which was triaged as a red 2 priority call. The calls were timed at 17:24, 17:27, and 17:28. The exact location of the incident was not clear from any of the calls. This led to confusion over whether the incident was in the jurisdiction of the London Ambulance Service (LAS) or the South East Coast Ambulance Service (SECAMB). A number of callers stated there was an ambulance on scene, which turned out to be a Patient Transport Service (PTS) vehicle. This information led the LAS to believe that SECAMB was responding and a number of LAS resources were cancelled. Due to the confusion over location and confirming the jurisdiction of the call, the first LAS crew did not arrive with the patient for 27 minutes form the initial call being received. The patient received treated in hospital for injuries to his arms, and was discharged after 2 days.
Immediate risk mitigation:	• The lead investigator listened to the call recording to confirm there was not an instruction from the scene to cancel LAS resources. • Feedback was given to the Emergency Medical Dispatcher (EMD) involved as part of the QA process.
Findings of investigation:	• The initial call was triaged correctly as a red 2 but the correct location was not confirmed.

	• SECAMB gave a mobile number to the LAS of a person on scene who could have confirmed the location. This person was not contacted by LAS to confirm the location. • The area controller cancelled LAS resources dispatched to the incident believing that SECAMB were attending the incident.
Recommendations:	a. EMD D to be advised of the importance of information being entered into the log i.e. no NHS ambulance Trust resource on scene. b. EMD D to be reminded of the importance of establishing a correct location and where possible obtaining this information from someone at the incident. c. EMD A to receive feedback following the QA of the call identifying their failure to confirm the location d. The area controller to receive feedback to confirm the attendance of another service prior to cancelling resources.

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
3 (moderate)	2 (unlikely)	6

Action plan/owner:

- EMD D to meet with their manager to discuss the importance of documentation
  Owner - EOC manager
- EMD D to meet with their manager to discuss the requirement stated in (OP 60) to attempt to make 3rd party calls into 1st or 2nd party calls with someone at the incident.
  Owner - EOC manager
- EOC QA manager to feedback QA report to EMD A.
  Owner QA Manager (Completed)
- Sharing the SI amongst the EOC team.
  Owner - EOC manager
- Line manager to meet with area controller to provide feedback and area controller to reflect on learning form this incident.
  Owner EOC manager

London Ambulance Service NHS Trust

SERIOUS INCIDENT
EXECUTIVE SUMMARY

STEIS NO:	**2017/19503**	**Date report:**	**21/07/2017**
Date of Incident:	**20/07/2017**	**Datix Reference:**	**10186**

Incident description:

At 23:32, a 999 call (Call A) was received by the Emergency Operations Centre (EOC). The call was triaged by an Emergency Medical Dispatcher (EMD) and related to a 40 year old female who had fallen, hit her head and was still on the ground. The call was initially categorised as a C2, requiring a response time within 60 minutes.

Whilst the emergency call (Call A) was still in progress, FRU (Fast Response Unit) staffed by Paramedic A was en-route to another call (Call B). This call (Call B) had been categorised as a Red 2 call which was a higher priority than Call A.

Due to the location of Call B, they drove past the location of Call A and was flagged down by bystanders with the patient. Paramedic A stopped their vehicle at the location of Call A as requested by the bystanders.

The bystanders confirmed with Paramedic A that EOC were aware of the 999 call and informed Paramedic A that the patient had been witnessed to stumble and fall.

A brief visual assessment of the patient was undertaken by Paramedic A who was on scene for under two minutes followed by conversation between Paramedic A and EMD B which resulted in Paramedic A leaving the scene to continue responding to Call B.

EMD A re-contacted the bystanders for Call A and additional information was provided indicating that the patient had fallen again and deteriorated, which resulted in the call being upgrade to a Red 2 response. Emergency vehicles were dispatched however a further 999 call was received prior to the crews arriving on scene indicating that the patient was in cardiac arrest.

A resuscitation attempt achieved a return of spontaneous circulation. The patient was conveyed to Hospital but subsequently died.

Immediate risk mitigation:	Paramedic A was provided education and refresher training relating to their responsibilities regarding the primacy of care and their obligation to conduct a thorough patient assessment specifically focussing on the risk factors associated with intoxicated patient presenting with a head injury. The training also included the Trust Policy on completing clinical documentation regarding all interaction with patients.
Findings of investigation:	• A Quality Assurance (QA) Report regarding the management of the 999 call highlighted areas for improvement and feedback to EMD A. • Paramedic A has undertaken a reflective account of the incident with a Clinical Team Leader. • Paramedic A has subsequently undertaken a training package detailing the importance of acknowledging primacy of care of the attending clinician and of conducting a thorough patient assessment specifically relating to the risks associated with alcohol and head injuries and the need for accurate documentation in relation to patient contact.
Recommendations:	a. EMD A to receive feedback to ensure lessons are learned and LAS protocols followed in the future. b. Paramedic A received training on the assessment of a head injury with special consideration to alcohol as a significant history. c. Paramedic A received education on the importance of thorough history taking and documentation for every patient encounter. d. The next issue of the LAS Clinical Bulletin (target audience service wide) to include an article highlighting the importance of attending clinicians to understand they have primacy of care of any patient until discharged or handed over to another Health care professional. The next issue is due in November 2017. e. Consideration should be given to formalising the process for the management of running calls, when already responding to an emergency call. This needs to differentiate between the responsibilities of EOC and frontline operational staff. Options will need to be discussed accounting for how this is communicated within Operational Policy (OP023: Procedure for the dispatch of Resources

	by the Emergency Operations Centre) and alongside primacy of care responsibilities as outlined in Trust Policy (TP003: Statement of Duties to Patients).

Current Risk Score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
5 (catastrophic)	2 (unlikely)	10

Action plan/owner:

To discuss with Paramedic A the need to detail and obtain relevant information to make an informed clinical decision on a patient's condition

Owner: Nominated Clinical Team Leader

An article to be included in the LAS Clinical Bulletin highlighting primacy of care in relation to running calls.

Owner: Consultant Paramedic

To ensure that EMD A follows LAS call handling protocols

Owner: EOC Quality Assurance Manager

In regard to a running call; EOC allocation and Paramedic decision making to reflect the revised policy.

Owner: Assistant Director of Operations; Assistant Director of Operations, EOC

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**28 November 2017**			
Report title:	**LAS Strategy update**			
Agenda item:	**15**			
Report Author(s):	**Angela Flaherty, Director of Strategy (Acting)**			
Presented by:	**Angela Flaherty, Director of Strategy (Acting)**			
History:	**Trust Board Reports on 'Our Strategic Intent' and strategy development have been presented at the following Trust meetings:** • **31 October 2017 (ref: TB/17/103)** • **3 October 2017 (ref: TB/17/78)**			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Trust Board approved the launch of 'Our Strategic Intent' on 31 October 2017 as the basis for a 6 week engagement period with staff, public & patients and stakeholders.

A number of engagement sessions have already taken place with staff and stakeholders with further sessions planned throughout November and December. Feedback from those who we have spoken to so far has been largely positive about the vision and proposals outlined in the document, as well as the extent to which we are engaging on it. We are also working with the Patients Forum to co-design our engagement with the public and patients.

In parallel with the engagement work, we are also continuing to develop the detail of our strategy including how each of the differentiated service propositions could be delivered. This will involve detailed financial and activity modelling and forecasting and will allow us to develop a Target Operating Model.

Recommendation(s):

The Board is asked to note the presentation and the progress made on the engagement with staff, patients and stakeholders.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Ambulance Service NHS Trust

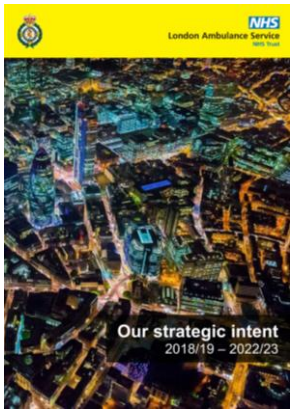
‘Our strategic intent’

Developing our strategy

28th November 2017

Progress Summary: November 2017

‘Our strategic intent’ has now been published internally on the ‘Pulse’ and on our corporate website.



Over the last month we have undertaken the following activities:

- Developed surveys for both staff and external stakeholders
- Held a workshop with STP programme and clinical leaders to introduce the themes of ‘Our strategic intent’ and gain their initial feedback. There was great engagement and the session was very positive. People are interested to know more, particular how the four ‘pioneer’ differentiated services (maternity, falls, mental health and end of life care) could work in practice.
- We have met with Unison representatives to agree an approach to staff engagement
- We have met again with the Patients Forum to co-design our patient and public engagement sessions
- Throughout November and December we are conducting internal and external engagement sessions

Next steps: developing our strategy

- Following the publication of 'Our strategic intent' we are working on the spectrum of optionality for how each of our service propositions could be delivered.

- This work is being facilitated by the strategy team with SME support provided by clinical and operational colleagues. Finance and performance colleagues will be assisting with the options appraisals for each service proposition.

- These options appraisals will feed into the reference case model to demonstrate the extent to which they close the identified gap and will allow us to develop a Target Operating Model and make recommendations about what should be delivered in 2018/19 (year 1) and future years.

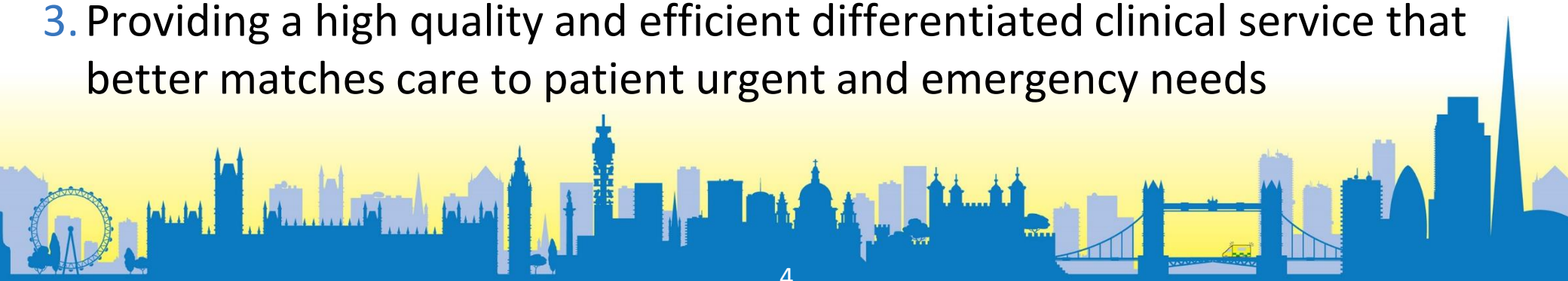
- We will provide monthly updates to the Trust Board until the strategy is published in early 2018.

Summary of ‘Our strategic intent’

Our ambition is: “To be a world class ambulance service for a world class city’.

We will provide the right care at the right time, enabling rapid access to the most appropriate patient care by:

1. Using our influence and working with partners to ensure a consistent approach to urgent and emergency care
2. Acting as a multi-channel single point of access and triage to the urgent and emergency care system across London
3. Providing a high quality and efficient differentiated clinical service that better matches care to patient urgent and emergency needs



How we will deliver our strategy

Our strategy is underpinned by six key enablers

- Improved clinical quality and clinical decision-making
- Flexible workforce with right education to better match demand and capacity
- Robust IT and mobile technology to improve operational performance
- Match fleet, infrastructure and footprint to patients' needs
- Improved organisational health and culture for better care
- Analytics to drive improvement and integration

Initial feedback on ‘Our strategic intent’

Feedback from CEO Briefings and Roadshows

- Overall feeling was “yes” to the ambition. It is the right ambition, but do we have the capacity?
- We need to invest in training and skill mix.
- Development of IUC means secondment opportunities for our staff.
- Staff must understand and be on board for this to be successful.
- There are concerns about **how** we deliver this vision. We need to be clear as to what the system looks like and what part we play.
- Turning our EOC into a part of a larger system is pivotal.
- We need to sit at the right tables and influence the right people.

Feedback from staff members on ‘Our Strategic Intent’

- “Our document absolutely hits the mark now and for the future. There are so many parallels across many external partners I work with now, therefore some real opportunity for us.”
- “One of the best strategic documents out there at the moment.”
- “Great opportunities to build and develop our business model while still remaining true to our core principles.”

Initial feedback on ‘Our strategic intent’

Feedback from Chair of Patients’ Forum

- Keen to see the how.
- They have been involved in strategy engagement work previously and are keen to see that their feedback has been taken on board and really does contribute to the final strategy. Not just a tick box exercise!
- Keen to get involved (co-production) and use toolkits so forum members can discuss LAS strategy development plans with others.

Feedback from STP Workshop

- A very positive first meeting with a lot of enthusiasm in the room and willingness to work with us.
- Need to engage local areas to get understanding and expertise; will help STPs to bring consistency.
- Need to work together to manage the flow of patients through U&E services; appreciation that it makes sense to integrate 111 and 999.
- “This is the first time in 30 years that LAS have invited me to engage on strategy.”
- “The critical bit is how we start doing things together.”
- “Flexibility of people is ‘the future’: people need to be able to move around.”
- “It would be good to understand the current gap between what [pathway] was used and what could have been used.”

Planned internal and external face to face engagement activities

Date	Event title	Venue
14/11/2017	Patient Care Conference	ETC Venues Avonmouth House
17/11/2017	Open engagement session	HQ Ground Floor (by stairs)
22/11/2017	EOC Away Day	ETC Venues Avonmouth House
23/11/2017	Clinical Team Leader course	Fulham
24/11/2017	Strategy Session, Unison – Senior Sector Reps	LAS HQ
29/11/2017	EOC Away Day	ETC Venues Avonmouth House
04/12/2017	Management Group Meeting	TBC
07/12/2017	LAS Strategy – Public & Patient Conference	Coin Street
07/12/2017	LAS Strategy – Stakeholder Conference	Coin Street
07/12/2017	LAS Strategy – Staff Conference	Coin Street
TBC	Open engagement session	Bow

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Quality Improvement and Learning Framework			
Agenda item:	16			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer Jo Cutting, Interim Deputy Quality Director			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	Quality Assurance Committee 14 November 2017			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☐	Information

Background / Purpose:

The purpose of the framework is to set out the development of supporting infrastructure, methods, and principles to build capacity and capability in relation to quality improvement, a learning culture and strong assurance mechanisms in relation to the quality and safety priorities.

Included in the document is the improvement methodology for the organisation which reflects the Institute of Healthcare Improvement (IHI 2017) model. In addition, the document sets out an implementation plan with Key Performance Indicators (KPIs) to provide a monitoring framework over the next 6 months.

In December the Trust will review its quality priorities as part of the consultation for the Quality Account 2018-19. The priorities will aim to move the Trust good/outstanding across all Care Quality Commission (CQC) domains. The framework reflects the “Learning from Special Measures” Department of Health document November 2017. Funding is being sought via NHS Improvement for the Quality Improvement training programme outlined in the document. No other costs are identified.

Recommendation(s):

The Board is asked to approve the framework and agree to the development being taken forward.

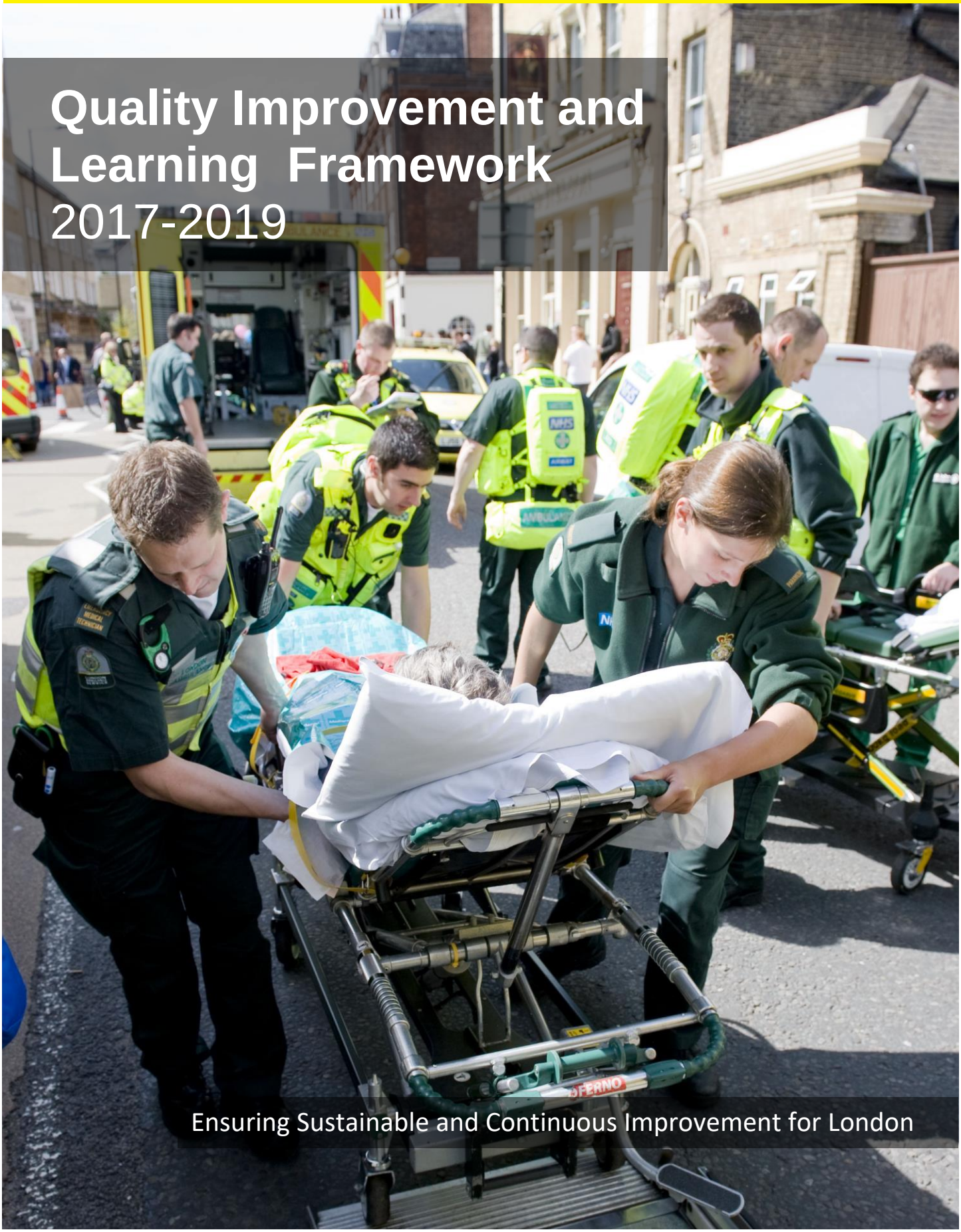
Links to Board Assurance Framework (BAF) and key risks:

The framework aligns to the risk that the Trust might not being removed from the Special Measures regime.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Ambulance Service
NHS Trust

Quality Improvement and Learning Framework 2017-2019



Ensuring Sustainable and Continuous Improvement for London

CONTENTS

APPENDICES

1. SUMMARY

The London Ambulance Service is the only pan London Trust and is the busiest ambulance service in the country responding year on year to increasing demands. Despite this, external assessment confirms what we know, that our services have improved over the last two years. However we also know there is further improvement to make to achieve our vision of providing a world class service. Our Quality Improvement and Learning Framework aims to build on the Clinical Strategy and other enabling strategies i.e. Data Quality, IM&T, People and Organisational Development, to ensure sustainable, continuous and consistent learning and improvement across the Trust. Our ultimate aim is ensuring our service users receive high quality, safe and effective care and have good experience of the services we provide.

The framework and the implementation plan (Appendix B) sets out how we will build capacity and capability, develop our supporting infrastructure and strengthen and improve our current assurance reporting mechanisms to support this aim.

1.1 What is different about this framework?

Various plans have been presented that identify various elements of the quality improvement , none have described an overarching framework for learning and improvement specifically relating to the quality agenda. As an organisation we do not have an agreed improvement methodology- the document sets out the methodology for the Trust. This methodology will be incorporated into all improvement programmes, not just quality related i.e. efficiency programmes aligned to the Carter review. The current development of a programme management office will further support the consistent delivery of improvement across all portfolios.

Capacity and capability in quality improvement methodology is currently very limited, the implementation plan sets out a process for ensuring we increase this capacity and how it will support the development of a continuous learning and improvement culture.

In addition, LAS have not aligned their quality systems and processes to the regulatory framework as set out by the Care Quality Commission (CQC 2017) new frameworks. This is particular important as the new inspection regimes will involve on-going monitoring throughout the year, not just a 'one-off' inspection. Building systems and processes that allow the assessment against these standards to become 'business as usual' is therefore imperative.

The assurance processes described will ensure that all tools, governance systems and processes link to this framework. Quality Assurance sector reviews, a new reporting system (Health Assure) will be introduced, alongside the re-structuring of the Datix system, to support this and provide the whole organisation with regular self-assessment reports both at sector and corporate levels to enable constant identification of risk and improvement opportunities. This will be further strengthened by the review of corporate governance and risk management frameworks.

1.2 Benefits for our patients and staff

The overall aim of this implementing this framework is to provide high quality care to all of **our patients and to develop a culture where our staff feel valued and engaged in improving that care.**

The direct benefits of the strategy and improvement programme for our patient are:

- Patients will work more closely with the trust in identifying where improvements need to be made
- Increased engagement in contributing to improvements activities
- Consistent themes that create risks to patients should be eliminated
- Improvements that affect them will be more rapid
- Variation in the care provided will be reduced
- Providing consistent and trust wide information to show the extent of improvements that the LAS make will give them more confidence in the service.

The direct benefits of the strategy and improvement programme for our staff are:

- Providing a place of work for LAS staff in terms of feeling valued, engaged
- Staff will feel supported when things go wrong
- Staff will have input into making improvements that they identify on a day to day basis
- Improvements can be made in a more timely way
- Integrating quality and safety better into existing meetings and teams, reducing the variation in care provision and best practice
- Reducing the likelihood of incidents and reducing potential for prosecution or other legal interventions
- Empowering staff through targeted training and competence activities

2. Our current quality priorities 2017-18

2.1 Our current priorities are set out in our annual Quality Account (2017-18). During the year and following our Care Quality Commission (CQC) inspection report (June 2017) we have aligned the identified and additional quality priorities and produced a detailed action plan to ensure delivery by February 2018. These actions are aligned to the business plan and the current clinical strategy.

2.2 In addition, we have undertaken an analysis of the activities that the trust needs to deliver to move from our current status to good across well-led and safe CQC domains. A quality improvement action plan was developed and the activities in the plan have now been delivered. Work to ensure these are embedded and sustained is on-going.

2.3 We will therefore review our quality priorities in December 2017 as part of our consultation process for the 2018-19 Quality Account. The quality improvement plan will revised accordingly and included in the programme of activities for the Trust to move to outstanding overall as assessed by the CQC by 2019-2020.

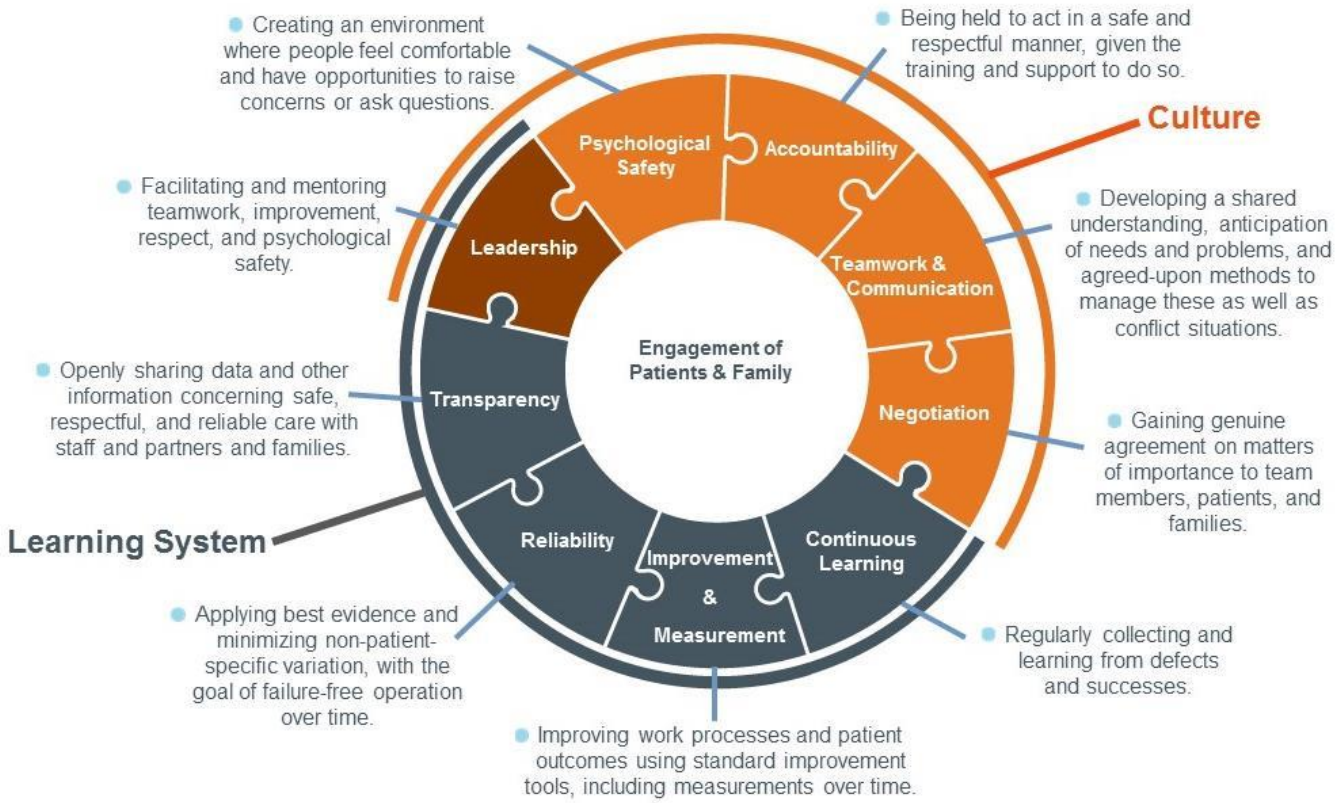
2.3 The system improvements, quality improvement methodology and capacity and capability developments, set out in the framework, will support the delivery of our current priorities and to successfully deliver and sustain continuous improvement.

3. Framework for learning and continuous improvement

3.1 The are two essential and underpinning domains within the framework outlined in this document: culture and learning systems. Culture is the product of group values, attitudes, competencies and behaviours to build a learning system. Learning systems identify defects and act on them, by applying improvement science, building the capacity and capability the organisation can meet its aims of delivering sustained continuous improvement. At the core of the framework is engagement of patients and their families to ensure the best outcomes for our patients.

3.2 The framework (Fig 1)is based on the Institute for Healthcare Improvement (IHI) model for providing safe, reliable healthcare (IHI, Safe Reliable care 2017). Our organisation needs to have a good culture to achieve learning, however we also need to do learning to change the culture. We have gone some way towards this and the improvement plan acknowledges current progress and what is and isn't working and therefore what requires action or revising. The implementation plan (Appendix B) therefore identifies areas of focus and where our efforts need to be directed.

Fig . 1 Learning and continuous improvement framework



4. Creating the culture: key components

4.1 Leadership

The primary function of leaders at all level of the organisation is to influence and develop behaviours, processes and technologies that result in outstanding and continuous improvement. The framework similar expectations of leaders at all levels, regardless of leadership title, with four main responsibilities:

- Fully supporting transparency, understanding improvement science and continuous learning and inspire this work
- Making sure that everyone can raise concerns without fear of retribution and they will be heard and ideas acted on
- Creating trust in an environment of respect, opinions are valued and negative and abusive behaviour is dealt with
- Be open and honest when mistakes have been made
- Aligning of these values to every decision made.

The organisation needs to ensure these responsibilities are consistently delivered to create a culture that underpins continuous improvement. The People and Organisational Development Strategy sets out the key activities available for key staff at all levels of the organisation to support the framework aligned to our vision and values.

4. 2 Accountability for quality improvement

Leadership, with clear accountability for all aspects of the quality agenda and clear roles and responsibilities throughout the organisation, Table 1 below sets out the responsibilities for the quality improvement agenda more generally.

Table 1.

Role	Responsibility
Executive Leadership Team	• Ownership of framework • Ensure review of progress against plans and Trust performance • Ensure adequate allocation of resources • Alignment to strategies and business plans • Develop culture and lead by example • Ensure effective communication of learning and improvement
Quality Oversight Group/Quality Assurance Committee Members	• Represent ELT/ Board on quality issues • Make recommendations to ELT/Board • Monitor compliance and progress • Decision making body for issues raised.

Role	Responsibility
Chief Quality Officer/Medical Director	• Ensure provision of adequate resource • Provide leadership on quality improvement and, working with the non-executive director for quality • Lead Corporate Quality Oversight Committee • Align PMO activities to ensure monitoring of quality projects
Quality & Assurance Directorate	• Prepare progress reports against plans • Provide competent advice and support to departments • Provide competent knowledge to relevant corporate committees • Manage and maintain policies and management systems • Provide monitoring and audit function.
Sector Quality Governance and Assurance Managers	• Implement actions defined in the plan • Provide appropriate membership to corporate and sector groups • Ensure their own teams/sectors are informed of requirements • Monitor compliance within own teams
ALL staff	• Support and engage with the plans • Ensure understand quality improvement methods • Report incidents, monitor risks • Share learning

4.3. Teamwork and Communication

Key component of effective teamwork include working together, communicate clearly and manage risk. High functioning organisations have structured communication and feedback mechanisms in which they share critical information and infrastructures that support this philosophy. The infrastructure developments (see section 6) will also support more effective team-working and communication. The Director of Strategy and Communications will lead on the development of both internal and external communications, working closely with leadership teams at all levels to ensure effective sharing of learning and improvement progress.

5. Creating a learning system : key components

5.1 Quality Improvement Methodology

The improvement methodology the trust will adopt is the Institute of Healthcare Improvement (IHI) methodology: Model for Improvement (Fig 2) . The methodology is nationally and internationally accepted as best practice across NHS organisations. The model combines three questions (Fig 2) and a Plan Do Study Act (PDSA) cycle for testing change to assess whether or not they lead to improvement:

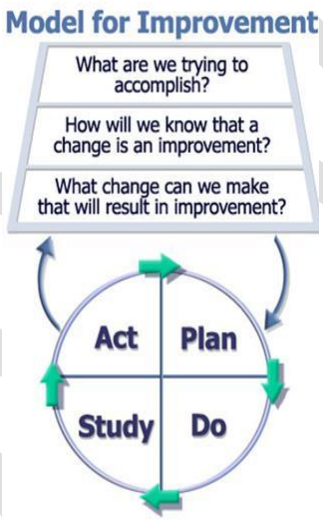
Plan: plan the test or observation, including a plan for collecting data

Do: try out the test of change (using various improvement methods)

Study: analyse the data and study the results

Act: refine the change, based on the learning from the test

Fig 2: Model for Improvement



In order to apply this model , staff need to be trained in various techniques and have the additional the capabilities to drive this system of wide improvement, they include:

- An understanding of Human Factors
- Concept of safety systems
- Driver diagram development
- Change management principles and techniques
- Measurement skills and knowledge
- Flow and service re-design management (using Lean principles, creative thinking etc)

We will **engage the support** of the People and Organisational Development teams to develop the programmes. Evidence internationally (IHI) suggest for an organisation the size of LAS that a commitment to training 1% of the workforce in improvement methods is required for continuous improvement. A programme to identify and prioritize the appropriate staff at all levels and utilisation of 'train the trainer' techniques will build the capacity required. A business case for training financial support via NHSI is currently being developed.

5.2 Continuous learning through engagement with patients and staff

We will encourage staff to identify, improve and implement a system or improvement for ease of use and access through the organisation and engage staff an patients to ensure an improvement project or programme delivers the right change to the people that matter the most by:.

- Implement a 'light bulb moment' system for staff with ideas of areas for improvement, implement change and expand the change to other areas.
- Ensure a system for feedback is in place for staff and patients
- Involve service users in service improvement
- Implement a rewards system for the highlight and involvement in service improvement
- Make quality improvement recognisable in the organisation with an easily identifiable 'brand' and use the 'brand' in all projects and programmes of work
- We will act on reviews and share good practice utilising 'web quality community' portals
- We will celebrate success by presenting at regular events both internal and external and through a clear communication strategy

Integral to all programmes must be the aim of robust **patient engagement** so they support the definition of what represents a high quality and efficient service. It is important that we continue to explore further ways of getting feedback from patient and carers and community groups, in addition to our continued engagement with the Patients Forum. The Patient Involvement teams will review their improvement plans in 2017-18 to ensure these aims and the successes they have already achieved are embedded into 2018-19 plans.

The importance of ensuring that we take every opportunity to **engage with partners** in the redesign of services and pathways in order to secure the right outcomes is articulated in our organisational and clinical strategies

5.3 Being Transparent

On the whole, operational transparency exists when leaders, staff, patients and their families, organizations, and the community are able to visibly see the activities involved in the learning process. In transparent organizations, it is clear how the entities make decisions and track performance, and they have the courage to display their work openly.

- **Transparency among clinicians** exists when there is no fear of giving suggestions, pointing out problems, or providing feedback.
- **Transparency with patients**, specifically after an adverse event, involves clearly describing what happened and what is being done to prevent it from happening again.
- **Transparency among organizations** includes sharing good practices and applying lessons learned.
- **Transparency with the community** requires robust information sharing so that patients can make informed decisions and easily access the care they need.

The Duty of Candour policy sets out clear requirements for staff to be open with patients and provide support when things go wrong. Learning from incidents is part of the current processes and lessons shared through training programmes and Insight quarterly feedback and is integral to the clinical stratgey. The development of the infrastructure and business partner model (section 6) will increase the opportunities to share and learn across and within sectors.

Posters are now being distributed to all group stations to ensure that all performance and key quality metrics are clearly visible to staff and visitors to promote operational transparency . The Trust regularly share all performance data and information with commissioners and key stakeholders.

5.4 Building reliability

To achieve high levels of reliability across processes and systems, the organizations must apply best evidence and minimize non-patient-specific variation, with the goal of failure-free operation over time. This is the science of reliability. There are three foundational principles for making systems and processes more reliable:

- **Standardize:** This involves designing processes so that people do the same thing the same way every time. Standardization makes it easier to train people on the processes, and it becomes more apparent if the processes fail and where they fail, enabling the organization to better target improvements.
- **Simplify:** The more complex something is, the less likely it is to be successful because there are more opportunities for mistakes, and staff may avoid following processes that are too difficult or time consuming. Simplified processes, however, make it easy for people to do the right thing.
- **Reduce autonomy:** Health care professionals have historically been autonomous, making decisions based on personal preference or an individualized belief in their perspective. However, this can result in care variation and less consistent outcomes. To achieve greater reliability, the organizations must set the expectation that care delivery follows evidence-based best practices, unless contraindicated for specific patients.

Currently we monitor nationally agreed clinical standards via the clinical audit department and through performance reviews. The further development of care pathways pan-London (rather than individual commissioning teams) is part of future improvement plans. This and the development of the Programme Management Office will further support the review of the current services and implement service change that is consistent, simplified and standardised.

6. Building the delivery infrastructure

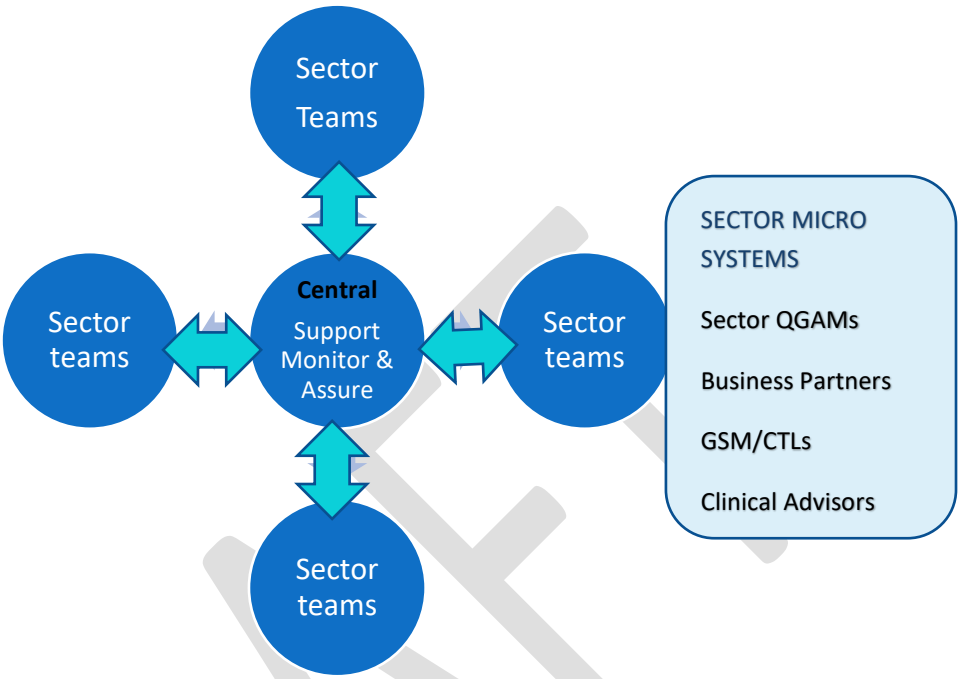
During 2017 the executive leadership team reviewed portfolios to ensure that functions relating to quality where re-aligned. The development of the Quality and Assurance (QA) Directorate is now complete and in parallel the review of the operational structures. The quality and assurance directorate includes a 'business partner' model that aligns to the five sector teams e.g. safety and risk business partners to support the investigation of incidents and risk management within each sector.

The Quality Governance and Assurance Managers (QGAMs) who are aligned to each sector will be supported by and work with the QA teams to ensure a consistent and standardised approach to quality improvement. Key staff in each sector will be identified in each sector to work closely with the teams to share learning and increase capacity and capability and embed change through agreed sector quality improvement plans.

The five sector teams (Fig 3) will work a 'micro support systems' that will involve supporting teams to lead and manage their improvement work. Teams will be supported in identifying and addressing areas for improvement through a framework of data collection and tools and

techniques described in Section 4. The focus of the team (Fig 3) is to ensure the smallest practicable unit i.e. group station, is performing optimally. The key local staff will be trained in quality improvement methodology and also lead and support delivery.

Figure 3: Sector team collaboration and central support



6.4 The business partner model will be expanded to include all corporate support functions e.g. human resources, finance as part of the strategic objectives. A key link to the quality agenda will be the Carter efficiency programmes, led by Director of Finance. The Director of Finance and Chef Quality Officer will work closely to ensure that the two programmes are linked.

6.5 Currently, executive team are developing a central Programme Management Office (PMO), this model is yet to be determined. However it will play a co-ordinating role across all improvement programmes i.e. link to efficiency programmes, capital programmes all of which will align to the strategic goals of the organisation and business planning development.

The benefits of this model are:

- Improve and accelerate decisions making
- Implement solutions rapidly
- Deliver programmes with predictable consistency
- Provide transparent status reporting
- Improved accountability and responsibility

6.6 The **support required** for each project/programme will vary depending on the size and complexity of the change. At the start of any project we will clarify the conditions for change to ensure there is recognition of the costs both emotional/personal and financial to the staff and organisation. This assessment will provide a view of what is required to support the improvement to ensure success i.e. local team support or trust wide central PMO support.

7. Strengthening Governance and Assurance: Supporting continuous learning

Continuous learning entails the proactive and real-time identification and prevention of defects and harm resulting from medical errors and adverse events. Increasingly, more time and focus are being placed on proactive rather than reactive learning. Learning organizations search for ever better ways of working toward and achieving results that improve the lives of patients, families, and staff.

An enormous amount of data and information is continuously generated at every level of the organisation and fed into reports that meet legal and regulatory requirements, but are often underutilized to effect real change and improvement at the point of care. Continuous learning requires feedback loops to provide data back into the various reporting systems to share information and generate insights to prompt action and learning.

Measurement and information are therefore crucial aspects of improvement, if we do not measure or use information effectively via our governance, assurance and performance monitoring systems then we will not know what impact our actions are having and also where other risks may be emerging.

The implementation of the **Health Assure System** began in October 2017. The system is a sophisticated document and information repository that provides status reports for every level (operational stations, sectors, corporate, trust wide) in relation to compliance with:

- CQC Key Lines of Enquiry for every quality domain
- Clinical Audit
- NICE Guidance
- Safety Alerts

Health Assure will be fully implemented by early 2018 and all evidence and information will be collated into the system to provide 'real-time' reports for all areas. These reports will be scrutinised via corporate oversight, operational and sector oversight and feed into the governance structures using a consistent approach across all sectors.

The **Datix system** will be developed to align to the approved risk management framework by December 2017 accompanied by e-learning programmes in relation to risk management, The BAF will also have been re-designed to clearly articulate the key risks to the organisation with a more robust, dynamic assessment process in place.

Over the last few months the Chief Quality Officer (CQO) and Governance Improvement Director and various Trust staff have been further developing the Trusts' **governance and quality assurance frameworks**. In May of this year the Board agreed the revised clinical governance arrangements that underpin and support this framework. In addition the review of risk management systems and processes has taken place, with the revised Risk Management framework agreed.

The Chief Executive has also revised and developed the **Performance Management Framework** in the organisation to ensure that all sector team and corporate teams provide updates on their performance against key quality, safety, financial, workforce and training, operational performance indicators. This will continue to be developed and supported by the Data Quality strategy to ensure that the information used is of high quality.

Sector Quality assurance reviews (appendix A) will take the form of quarterly reviews against each domain of the KLOEs. The sector reviews involves observations, discussions with staff and evidence collation, with a rolling programme of review against each of the KLOE domains. These will utilise peer review methodology. Reports from these visits, will be directly uploaded to Health Assure and available to all staff at all levels. Support for these visits will be given by the Quality Assurance Directorate generally and the Quality Compliance Manager specifically.

Deep Dive Programmes have been developed over 2017-18 and will continue on an annual basis to identify areas in which more in-depth review is required based on the risks to the organisation. The Deep Dives will either be included within the improvement programmes undertaken by wither corporate teams, PMO or internal auditors, proportionate to the investigation required.

We will also use the annual staff and patient surveys to assess impact. All information/outcomes from the various systems will be available and will be reported at sector quality governance meetings, key issues and progress reports will be provided to the Quality Oversight Group via the Quality Governance and Assurance managers (QGAMS) regular report to the committee. Any escalations will then be provided to Quality Assurance Committee (QAC) and onto the Board via the quality report and also via the performance management framework through the Integrated Performance Report.

The main response to the outcomes from these various reporting mechanisms will be:

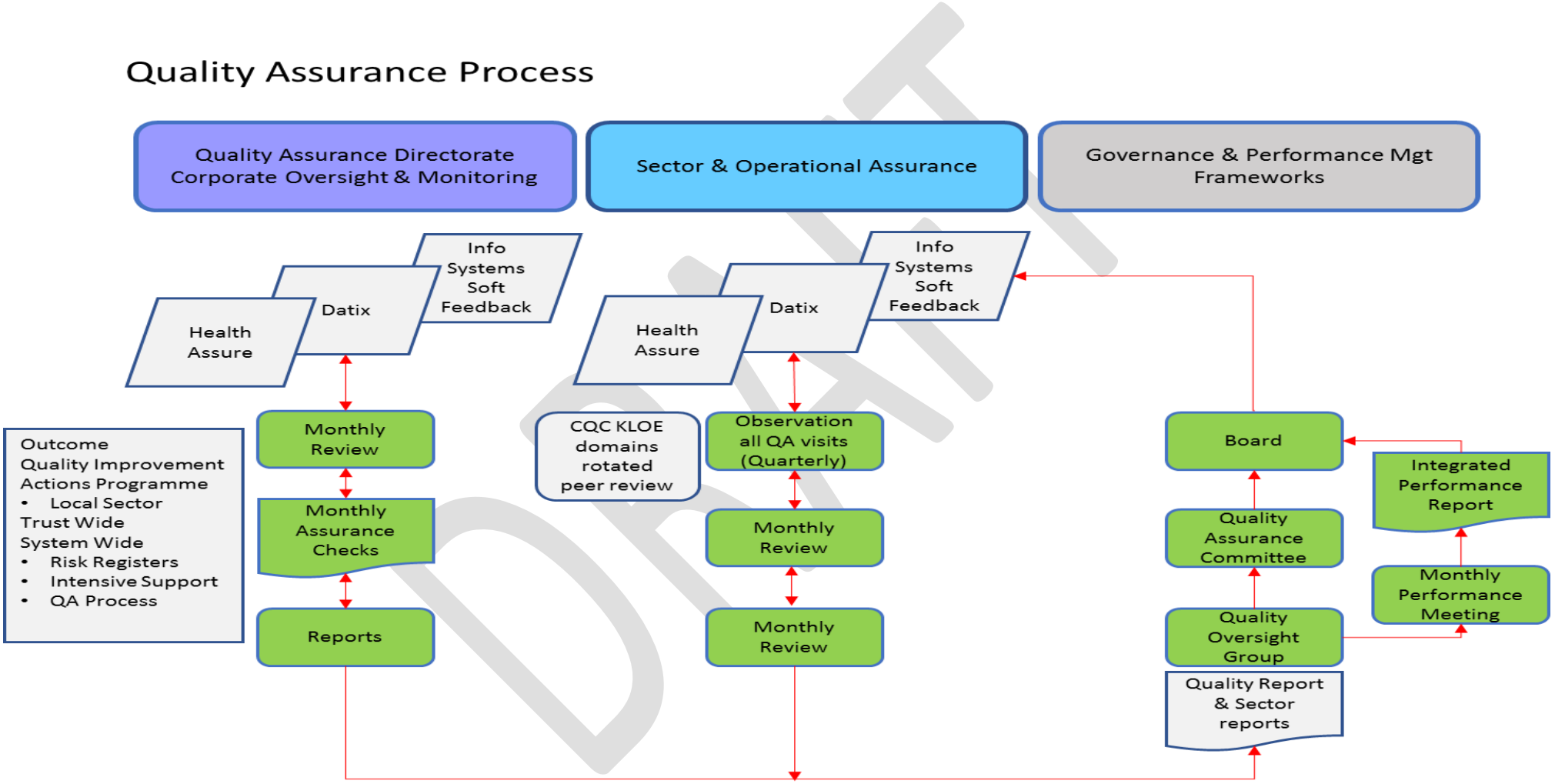
- Immediate risk mitigation if necessary) and review/update of risk registers
- Identification of a quality improvement activity: station, sector and trust wide using an agreed criteria and methodology
- Feed into clinical skills refresher training programmes
- Consideration of developing a Deep Dive review
- Consideration of 'intensive support programme' in areas that are not consistently meeting standards – using the approach that is currently in place for the North East sector.

7.10 The streamlining of governance and **'floor to Board' assurance structures** will support the delivery of high quality and efficient care with early identification of risks, monitoring performance issues quickly to ensure we are meeting our legally required standards. The further development and embedding of these frameworks will continue through to 2017-2018. Further and on-going development of IT systems (e-PRF, hand held devices) will allow more timely data to be uploaded into the systems.

We will monitor implementation of this framework via the key performance indicators as set out in Appendix B

APPENDICES

APPENDIX A


Quality Assurance Process
Quality Assurance Directorate Corporate Oversight & Monitoring
Sector & Operational Assurance
Governance & Performance Mgt Frameworks
Health Assure
Datix
Info Systems Soft Feedback
Health Assure
Datix
Info Systems Soft Feedback
Outcome
Quality Improvement Actions Programme
• Local Sector
Trust Wide
System Wide
• Risk Registers
• Intensive Support
• QA Process
Monthly Review
Monthly Assurance Checks
Reports
CQC KLOE domains rotated peer review
Observation all QA visits (Quarterly)
Monthly Review
Monthly Review
Board
Quality Assurance Committee
Quality Oversight Group
Quality Report & Sector reports
Integrated Performance Report
Monthly Performance Meeting

APPENDIX B
Key Tasks and Performance Indicators : Phase 1(Q3&4 2017-18) Phase 2 (Q1 & 2 2018-19)

Quality Improvement and Infrastructure development				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Development of business case for QI training	Identify number of staff required corporately and sector wide	Number and name of staff idetified	CQO	1
Management systems	Develop and approve business plan	Business case developed and approved by ELT	DDN	1
	Identify external training team	1. External team identified and proposal agreed	CQO	1
	Develop and implement Trust-wide training programme in line with best practice (IHI)	1. Implemented training System delivered and embedded within the Trust. 2. Suite of tools and methodologies agreed. 3. Implement audit programme to measure the effectiveness of implemented training	QA Directorate	1 & 2
Infrastructure development	Quality Business partners for each sector agreed Roles, responsibilities, alignment QGAMs agreed Web quality community portal developed	1. Directorate structure reflects BP model 2. Team meetings and minutes 3. Web portal 'hits'	QA directorate/QGAMs ADOs Comms	1&2

Quality Improvement and Infrastructure development				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Staff and Patient engagement	Develop engagement plan Introduce 'light bulb moment' process for staff input Communication strategy to ensure feedback to staff Datix feedback loops to include reports Quality and Safety annual award	1. Patient engagement plan developed 2. Evidence of staff ideas in improvement programmes 3. Datix feedback to inc reports (complete)	DDN DS&C Head of Quality Governance	1 & 2

Governance and Assurance Systems				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Development of corporate governance structures	Review and development of governance framework	Achievement against plan reviewed	Head of H&S	1 & 2
	Agree and approval of implementation plan	Implementation plan ELT Agenda and minutes	Governance Improvement Director (GID)	2
	Improve visible leadership of governance across the Trust	Directors/ managers to undertake related visits /communication strategy	ELT	1 & 2
Implement Governance system	Monitoring plan in place	1. Frequency and consistency of Committee /group meetings 2. Quality of attendance at the Committee/group meetings.	GID	2
		The development of a policy with clearly defined roles and responsibilities.	GID	2
		Established and defined process for escalating issues from committee to the Board.	GID	2
Implement Health Assure and re-configure Datix system	Project plans (agreed)	Identification and regular reporting of leading and lagging indicators	Head of Quality Intelligence	1

Governance and Assurance Systems				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
		Regular review of actions taken to address and mitigate any identified risks	Head of Quality Intelligence	1
		Reporting and escalation through the Quality Oversight Group incidents and risks	Head of Quality Intelligence	1
Improvement programmes	Process for prioritising improvement programmes based on risk/incidents	Evidence of learning via insight and improvement programmes	Head of Quality Intelligence	1
Implement a process for audit and review following implementation of usage	Develop Programme of Quality Assurance visits	Audit reports completed with actions tracked to completion from QA visits across all sectors	Head of Quality Intelligence	1 –on-going
	Periodic review of Trust-wide Performance	Systematic scrutiny of system to assess the degree of compliance with organisational procedures and achievement of specific objectives.	CQO	2
Standardised framework for assessing quality	Develop assessment tools, agendas, assurance visits that align to CQC KLOEs	1. Minutes and agendas from governance meetings 2. Assessment tools aligned to KLOEs	QGAMs	1&2

Risk management				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Assess, control and minimise quality and safety risks	Define process for managing risks across the Trust.	1. Development of Risk Management Framework 2. Corporate risk register reflective of key H&S risks	GID/CQO	1
	Establish process for identifying, reporting and escalating risks from site (local) to Corporate level.	1. Implement site specific risk assessments – which are reviewed annually. 2. Implement process of periodic inspections via quality assurance visits	CQO	1

Risk management				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
		3. Closure of actions identified		
	Ensure that quality and safety risks are assessed prior to the commencement of new projects or implementation of change across the Trust. QIA process agreed	Q&S issues associated with changes assessed and mitigations established – QIA evident for change programmes	Chief Quality Officer/MD	1
	Undertake and implement e-learning programmes and group training session in risk management	1. Compliance with e-learning. 2. Training programme uptake	Head of Quality Governance	2
Deep Dive programmes	Identify on an annual rolling programme of deep dives	1. Deep Dives 2018-19 agreed	CQO	2

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**28 November 2017**			
Report title:	**Draft Health and Safety Strategy and action plan update**			
Agenda item:	**17**			
Report Author(s):	**Ayodeji Adeyemi, Head of Health, Safety & Security**			
Presented by:	**Dr Patricia Bain, Chief Quality Officer**			
History:	**Executive Leadership Team**			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The Health and Safety Strategy has been developed to define the aims and objectives of the London Ambulance Service NHS Trust (LAS) for Health and Safety over a five-year period.

Recommendation(s):

The Board is asked to review, comment and feedback on the direction, aim and vision of the strategy.

Links to Board Assurance Framework (BAF) and key risks:

Links to Datix risk 676 – relating to the lack of Trust-wide compliance with statutory health and safety requirements. Risk Rating: 20

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☒

London Ambulance Service
NHS Trust

Health & Safety Strategy

2017 - 2023

Ayodeji Adeyemi

November 2017

Contents

1. Introduction

The effective management of health and safety is integral to the success of every organisation. All organisations have a legal duty to manage and safeguard the health, safety and welfare of their employees, and that of others who might be affected by their activities.

The London Ambulance Service NHS Trust (LAS) has statutory responsibilities for staff, patients, visitors and others as defined in the Health and Safety at Work etc. Act, 1974 and the Management of Health and Safety at Work Regulations 1999.

The Trust recognises the importance of having a healthy and well-motivated workforce to deliver high quality services to patients in/around London. The effective management of health, safety and well-being is key to this, and the Trust is committed to implementing robust and effective occupational health and safety arrangements that will enable it adequately undertake its legislative, statutory and moral duties.

The effective safeguarding of health and safety can only be achieved when health and safety management systems are well integrated into the core function and culture of the organisation. In an organisation like the LAS, versatile and well embedded Health and safety management systems governed by the core principles of effective risk control, reasonable practicability and proportionality as set out in the framework of Health and Safety legislation are required to address/mitigate the risks that staff are faced with in the rapidly changing, time critical and complex environments and situations they are exposed to. The Trust's health and safety management systems will need to focus not **only** on the prevention of accidents, injuries and ill health, or with the management of workplace risks (e.g. fire, exposure to hazardous substances and manual handling); it will also need to cover and account for the psychosocial hazards (e.g. stress) and risks that employees face.

This Strategy has been developed to define the aims and objectives of the London Ambulance Service NHS Trust (LAS) for Health and Safety over a five-year period from 2017 to 2023, and commits the Trust to continually improve the health, safety and welfare of its staff and patients.

The aim of this strategy is to set the performance indicators and framework for:

- Achieving Trust-wide Compliance with Health and Safety legislative requirements.
- Establishing good governance that ensures the Executive Leadership Team (ELT) is well informed regarding Health and Safety performance.
- Promoting a positive and open safety culture at all levels of the organisation.
- Improving visibility of Health and Safety activities to demonstrate that this does matter to Senior Management, and to empower all managers and staff to proactively contribute to good H&S performance
- Providing a safe and healthy environment for all employees, and others affected by LAS activities.

This health and safety strategy supports the purpose and function of the Trust to care for people in London: save lives; provide qualitative care; and ensure that patients get the help they need. It also provides a similar focus on LAS staff ensuring they are cared for and are able to provide a strong service to the population who rely on LAS.

2. Background

This strategy follows through on the themes identified following the Trust-wide occupational health and safety review completed in July 2017. This review was completed at the request of the Chief Quality Officer with the primary aim of determining whether LAS arrangements for occupational health and safety management were legally compliant, and to assess the effectiveness and robustness of the trust's health and safety governance arrangements.

The review assessed the Trust's health and safety performance against the recommendations of the joint IOD-HSE Leading Health & Safety at work guidance which recognises the management of health and safety as a corporate governance function which needs to be integrated into the every organisation's main governance structures.

The review conducted in July 2017 identified a number of weaknesses in the Trust's health and safety arrangements. It concluded that legislation was currently not being fully complied with and that health and safety governance arrangements needed to be strengthened. The review report was submitted to the Executive Leadership Team in August 2017 with recommendations endorsed. These have been translated into an action plan that is being managed by the Health and Safety Department and monitored by the ELT.

It is recognised that there is an opportunity to improve on the Health and Safety Management systems implemented at the LAS, and the Executive Leadership Team are committed to the delivery of effective change across the Trust. The ELT are committed to addressing the gaps identified by the review and ensuring that a way forward is developed collaboratively with all staff, primarily through consultation with the established trade union structures.

3. Developing Key Priorities
(A New Framework for Health and Safety)

The challenge of this strategy centres on how a robust health and safety management system will be embedded into the operations of a large, complex, changing and multi-sited organisation like the LAS. In order to achieve success in this area, it is important that health and safety is integrated into the management structure of the Trust and that key priorities are identified and implemented methodically.

In order to establish a new framework for health and safety across the LAS, and to effectively deliver on the health and safety strategy, the following priorities have been defined based on the findings from the Trust-wide Health and safety Review conducted in July 2017.

The initial focus of the health and safety strategy is to support the Trust with achieving compliance with its legislative and statutory duties during 2018, with aspirational elements defined for subsequent years. The key priorities are summarised below:

Objective	Period	Year
- Achieving Trust-wide Health & Safety compliance	Year 1	2017/18
- Embedding, monitoring, reviewing and (where necessary) improving on Trust-wide Health and Safety Performance. - Achieving recognised accreditation – e.g. ISO 45001	Year 2 – 5	2018/19 – 2023/24

4. Strategic Health & Safety Objectives

The strategic health and safety objectives have been defined by and aligned to the priorities highlighted in section 3 above. The identified themes and objectives which this strategy aims to achieve are categorised into the below headings:

a. Legal Compliance
b. Good Governance
c. Risk Management
d. Competence
e. Health and Wellbeing

4.1 Legal Compliance

The primary aim of the Health and Safety Strategy is to support the Trust with achieving legal compliance with its statutory health and safety responsibilities. The review undertaken in July 2017 highlighted significant gaps in compliance with legislation. These included:

- Lack of arrangements to manage risks
- Failure to address recommendations made in Improvement Notice issued in 2010 regarding manual handling
- Poor and uncontrolled implementation of fleet controls.

The activities/key performance indicators necessary to promote the achievement of this objective include:

- Implementation of actions/recommendations identified in July 2017 Health and Safety Review Report.
- Implementation of any outstanding actions from the 2010 improvement notice issued by the HSE.
- Implementation of a system of regular audits, monitoring and reviewing arrangements for all health and safety systems within the Trust.
- Development and implementation of Health and Safety Policy
- Development of legislation register used to map and demonstrate health and safety compliance.
- Certification to ISO 45001 to demonstrate good systems and provide external verification.

The programme at Appendix A contains more detail against specific actions recommended.

4.2 Good Governance

Good Governance ensures that Health and Safety Management is embedded and runs across the organisation, and is visible to Staff and the ELT. The follow table breaks down the number of key themes that are necessary for achieving Good Governance:

- Improvement of Director level awareness of H&S leadership and legal framework
- Establishing an effective downward communication system and clear management structures.
- Review and delivery of effective governance arrangements that facilitates a positive culture of learning
- Appointment of non-executive H&S Director
- Regular monitoring, reporting and feedback arrangements to the ELT/Board
- Use of data to drive improvements
- Establishment of Effective audit and review processes
- Provision of training, instruction and supervision to all staff at induction and regularly.

4.3 Risk Management

Effective and proportionate risk management should ensure both legal compliance and the safety of LAS employees. There were a number of areas where there was no clear risk management, as required by legislation.

The activities/key performance indicators necessary to promote this theme are:

- Implement systems to proactively identify hazards and ensure Key H&S risks can be assessed and managed through the Trust's corporate risk management process.
- Define the process requirements and competence required for undertaking risk assessments.
- Ensuring risk assessments are completed and implemented for human factors including manual handling, lone working, alcohol, fatigue, violence
- Ensure that health and safety is always an integral part of the planning and review processes at the Trust.

4.4 Competence

Health and safety competence has not been well defined historically, and the delivery of key/required training to staff has been ad hoc and not always ineffective. This is a key area where improvement is required as LAS staff work in a wide range of environments where their skills in identifying and managing risks are an essential control. Some key areas were identified including manual handling and completion of dynamic risk assessments.

- Define Minimum H&S competence requirements for all key roles.
- Use of competent staff to ensure policies and procedures are developed, kept up to date and reflect best practice.
- Ensure the delivery of training for high risks such as manual handling, lone working and dynamic risk assessment
- Minimum manager and director awareness requirements defined and delivered

4.5 Health and Wellbeing

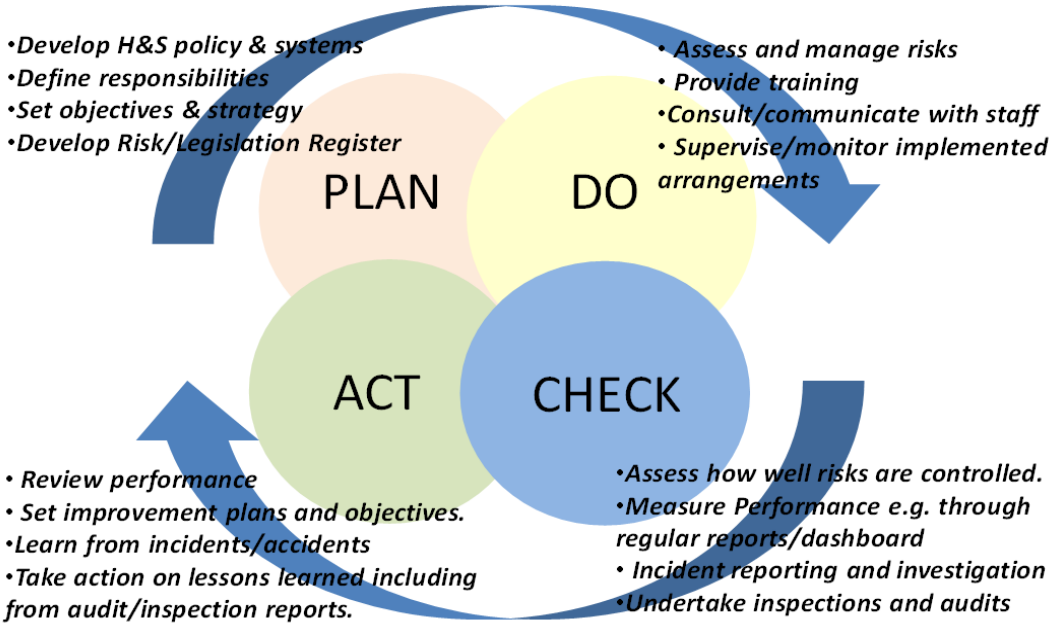
Staff well-being is an increasingly relevant and necessary consideration in the modern workplace. From an organisational management perspective, wellbeing is a major factor in quality, performance, productivity and therefore business effectiveness.

The activities/key performance indicators necessary to promote this theme are:

- Promote, encourage participation and support initiatives that enhance occupational health and wellbeing for staff.
- Adopting a preventative approach to reducing sickness absence and proactively managing cases of ill health in order to keep staff at work/ facilitate a more timely return to work.
- Equipping staff with the right training and skills to enable them undertake their work safely and competently.
- Ensuring that staff understand and are accountable for their responsibilities with regards to the health, safety and wellbeing of themselves and others.

5. Implementation and Responsibilities

The review undertaken in July 2017 was structured around the plan-do-check-act model defined in the joint IOD-HSE Guidance 'Leading health and safety at work'. In broad terms this strategy aims to deliver good practice against this model through the approach summarised below:



A detailed implementation plan is attached as an appendix to this report. It is broadly structured in 2 phases:

- Phase 1: Achieve legal compliance and robust management of key risks, by the end of 2017/18.
- Phase 2: Aspirational H&S activities planned for 2019-2023

In order to achieve this strategy key roles and responsibilities are defined below:

Role	Responsibility
ELT	• Ownership of H&S strategy • Ensure periodic (to be defined) review of progress against H&S plans and Trust performance • Direct Corporate H&S Committee as appropriate • Ensure adequate allocation of resources
Corporate H&S Committee Members	• Represent ELT/ Board on H&S issues • Make recommendations to ELT/Board • Monitor legal compliance • Decision making body for issues raised.

Role	Responsibility
Chief Quality Officer	• Ensure provision of adequate H&S resource • Provide leadership on H&S, working with the non-executive director for H&S • Lead Corporate H&S Committee
Head of H&S team	• Prepare progress reports against plans • Provide competent advice and support to departments • Provide competent knowledge to relevant corporate committees • Manage and maintain policies and management systems • Provide monitoring and audit function.
Heads of Departments	• Implement actions defined in the H&S plan • Provide appropriate membership to corporate committees • Ensure their own teams are informed of requirements • Monitor compliance within own teams

6. Key Tasks and Performance Indicators

Legal compliance				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Development of legislation register	Develop procedure to manage legal updates and track compliance	Legal register in place with regular planned updates. Progress reports to H&S Committee	Head of H&S	1
Policies and management systems	Develop and approve H&S policy in line with good practice models including responsibilities	Policy developed and approved by ELT	Head of H&S	1
	Communicate H&S Policy	1. Policy displayed on intranet, RIB and notice boards 2. Directors and managers aware of responsibilities 3. Staff awareness of policies	Head of H&S	1
	Develop and implement Trust-wide health and Safety management system in line with best practice and legislative guidelines.	1. Implemented H&S Management System delivered and embedded within the Trust. 2. Suite of H&S Policies and procedures developed and approved. 3. Implement inspection and audit programme to measure the effectiveness of implemented H&S Management Systems.	Head of H&S	1 & 2
	Achieve external accreditation to ISO 45001 management systems.	UKAS certifying body appointed Successful certification.	Head of H&S	2
	Produce annual report outlining Health & Safety performance and areas of future need.	Published annual report approved by the ELT/Board.	Head of H&S	1 & 2

Legal compliance				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
	External certification to FORS	Programme in place to achieve FORS Successful achievement of FORS Bronze accreditation	Head of Fleet	2
Good governance				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Improvement in Director/Senior Management Health and Safety awareness	Arrange for annual health and safety update training to be delivered to the ELT/Board	Sessions planned and attended Achievement against plan reviewed	Head of H&S	1 & 2
	Ensure H&S is added as a regular item on ELT agenda	ELT Agenda and minutes – highlighting review of H&S performance	Chief Quality Officer	1
	Improve visible leadership of H&S across the Trust	Directors/ managers to undertake safety related visits to sites.	ELT	1 & 2
Approval and monitoring of performance against H&S Strategy	Delivery of action plan associated with June 2017 review	All actions closed.	Head of H&S	1
	Approval of finalised Health and Safety Strategy	Strategy approved and communicated to all staff and key stakeholders.	Chief Quality Officer	1
Implement a system of Effective Health and Safety Governance	Develop arrangements for planning, doing and checking Trust-wide health and safety compliance.	1. Frequency and consistency of H&S Committee meetings 2. Quality of attendance at the Committee meetings.	Chief Quality Officer	1
		Appointment of non-executive H&S Director to provide the required scrutiny on the Trust's H&S performance.	Chief Quality Officer	1

Good governance				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
		The development of a H&S policy with clearly defined roles and responsibilities.	Chief Quality Officer	1
		Established and defined process for escalating issues from committee to the Board.	Chief Quality Officer	1
Implement an effective process for performance reporting	Develop 'Active and Reactive' monitoring H&S dashboard to report against key risks and highlight performance.	Identification and regular reporting of leading and lagging indicators	Head of H&S	1
		Regular review of actions taken to address and mitigate any identified risks	Head of H&S	1
		Reporting and escalation through the Corporate H&S Committee.	Head of H&S	1
Implement a process for audit and review	Programme of audits defined and implemented	Audit reports completed with actions tracked to completion	Head of H&S	1 & 2
	Periodic review of Trust-wide H&S Performance	Systematic scrutiny of health and safety management system to assess the degree of compliance with organisational procedures and achievement of specific objectives.	Non-Exec Director	2
	Annual review of H&S performance	Report from independent audit to review Trust-wide H&S performance and to highlight progress and opportunities to improve.	Head of H&S	2
	Improved understanding of staff H&S awareness and culture across the Trust.	Annual staff survey	Chief Quality Officer	2

Risk management				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Assess, control and minimise health and safety risks	Define process for managing risks across the Trust.	1. Development of Risk Management Framework 2. Corporate risk register reflective of key H&S risks	Chief Quality Officer	1
	Establish process for identifying, reporting and escalating health and safety risks from site (local) to Corporate level.	1. Implement site specific risk assessments – which are reviewed annually. 2. Implement process of periodic H&S inspections 3. Closure of actions identified in June 2017 review	Head of H&S	1
	Ensure that health and safety risks are assessed prior to the commencement of new projects or implementation of change across the Trust.	H&S issues associated with changes assessed and mitigations established	Chief Quality Officer	1
	Review legislation and develop process for assessing and managing key risks	Robust risk assessment process in place compliant with legislation.	Head of H&S	1
	Ensure manual handling risk assessments are in place and reflective of the activities undertaken by frontline staff.	1. Manual handling risks controlled and HSE improvement actions addressed. 2. Reduction in manual handling incidents	Head of H&S	1
	Undertake and implement lone working and security risk assessments.	1. Lone working and security risks controlled. 2. Implement strategies to support the reduction in assaults and incidents	Head of H&S	2
Fleet risks identified and managed	Define key pre-use checks and process for managing	All required peruse checks of fleet completed in line with procedure.	HR Manager	1
	Risk assessments associated with human factors	Drugs and alcohol policy in place with appropriate testing regime.	Head of Fleet	1

Risk management				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
	Define frequency of driver competence training	Reduction in RTIs Reduction in insurance claims associated with RTIs	Head of Fleet	2

Competence				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Definition of minimum H&S competence requirements for managers	Update job specifications to identify minimum H&S requirements for Managers.	1. All job specifications include relevant and specific H&S element 2. Training requirements included in POD software and tracked	Director or People & Organisational Development Head of H&S	1
	Organise dedicated H&S training to familiarise Managers with their health and safety responsibilities.	1. Delivery and attendance at Managing Safety Course. 2. H&S training incorporated into the Trust's MAST training requirement. 3. Targets for training satisfied 4. Training validated	Director or People & Organisational Development Head of H&S	1
Implement arrangements for monitoring the effectiveness of training provided to staff as well as staff competency (e.g. Manual Handling)	Implement process for assessing staff training competency, and for evaluating the effectiveness of training provided to staff.	1. Competency assessment records. 2. Training evaluation records	Deputy Director of Operations – Sector Operations Deputy Director Clinical Education and Standards	

Competence				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Delivery of key H&S training	Ensure the delivery of practical manual handling training to all frontline/operational staff on an annual basis.	1. Manual handling training delivered and validated for all operational staff. 2. Manual handling training records. 3. Reduction in manual handling incidents	Director or People & Organisational Development Head of H&S	1
	Develop and deliver dynamic risk assessment training to key staff.	1. Dynamic risk assessment course designed and delivered to all operational staff 2. Reduction in incidents	Director or People & Organisational Development Head of H&S	1
	Ensure the regular provision of assault avoidance and lone working training to staff.	Training designed and delivered	Director or People & Organisational Development Head of H&S	1

Health and Wellbeing				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Promote, encourage participation and support initiatives that enhance occupational health and wellbeing for staff.	Ensure collaborative working with the People and Organisational Development Directorate to facilitate the promotion of wellbeing initiatives across the Trust.	1. Promotion of Wellbeing campaigns across the Trust. 2. Monitoring of occupational health incidents through the Corporate H&S Committee 3. Reduction in sickness/incident numbers.	Head of H&S	1&2

Health and Wellbeing				
Action	**Task**	**Key performance indicators**	**Owner**	**Phase**
Adopting a preventative approach to reducing sickness absence and proactively managing cases of ill health in order to keep staff at work/ facilitate a more timely return to work.	Improve the collection and understanding of ill-health and sickness absence data	1. Standardised reporting, recording and monitoring system introduced.	Head of H&S	1&2
Equipping staff with the right training and skills to enable them undertake their work safely and competently	Review health and safety training provision – ensure it is robust, reflects best and legislative practice and is delivered by competent tutors.	1. Staff health and safety training records. 2. Reduction in work related incidents/accidents	Head of H&S	1&2

7. Benefits of this Strategy

This strategy has been developed as a direct result of the review undertaken in July 2017 that aimed to determine the status of LAS with respect to legal compliance and good governance. It has also referenced the overall purpose and organisational goals of LAS as it is important that good health and safety is seen as an integral part of leadership and management.

The initial review focused on the guidance from the IOD and HSE where it lays out what good health and safety leadership looks like.

The overall aim of this strategy is to ensure legal compliance and to ensure that proactive arrangements are in place to identify and address risks/gaps, and prevent harm to staff and others.

The table at Appendix 1 summarises the actions recommended in this guidance, the status of LAS as at July 2017 and where actions can be found in this strategy that seek to address gaps identified.

The direct benefits of the strategy and improvement programme are:

- Providing a safe place of work for LAS staff in terms of physical and mental health
- Understanding as an organisation where there are gaps through effective use of information and a clear governance structure
- Integrating health and safety better into existing meetings and teams
- Reducing the likelihood of accidents and reducing potential for prosecution or other legal interventions
- Empowering staff through targeted training and competence activities

Appendix 1:
MAP against IOD/HSE Guidance Leading Health and Safety at Work

This appendix sets out the recommended actions in the IOD/HE guidance Leading Health and Safety at work, and comments on LAS status and key theme where actions to address findings are located.

PLAN – SET THE DIRECTION.

Recommended actions	LAS Status	H&S Strategy Key theme
• Set and agree policy based on risk. • Own and understand key issues involved. • Maintain policy as organisation evolves. • H&S to regularly appear on agenda for board meetings. • Named H&S champion. • Non-executive to act as independent scrutiny.	• The H&S policy and organisation document has been documented and updated at reasonable frequencies. There are also a number of policies and procedures but no clear safety management system, and no clarity over difference between policies and procedures. Each document appears to be updated by several different authors/ owners. • There is a corporate risk register that is reviewed by senior management. • Corporate H&S Committee recently re-established. This will inform the Board • The Chief Quality Officer is named. Champion, supported by the Head of Health, Safety & Security. • There was no evidence provided of non-executive or independent scrutiny with respect to health and safety.	• Legal compliance • Risk management • Good governance • Good governance

DO – EFFECTIVE MANAGEMENT SYSTEMS

Recommended actions	LAS Status	H&S Strategy Key theme
• Ensure H&S arrangements adequately resourced. • Obtain competent H&S advice. • Ensure risk assessments are carried out. • Involve employees in decisions that affect their H&S. • Directors visible in operational areas asking about H&S. • Consider H&S in senior management appointments. • Procurement standards that prevent introduction of new H&S hazards. • Assess H&S arrangements of partners. • Set up separate H&S committee. • Provide H&S training to board members • Support worker involvement in H&S.	• There is evidence of inadequate H&S resource in terms of numbers, competence and location with respect to sectors and core functions. • Newly appointed Head of HS&S. • There is a risk register, but there was limited evidence of risk assessments being completed for all activities. • It was reported that there is good Trade Union involvement. • Senior managers and directors do not undertake safety tours, or other activities that visibly demonstrate their commitment to H&S. • A corporate H&S Committee has been re-established. • Senior Managers and Directors interviewed reported they had not received H&S training relevant to their position and responsibilities.	• This is already being addressed through re-organisation and recruitment • Risk Management • Good governance • Good governance & competence

CHECK – MONITORING & REPORTING

Recommended actions	LAS Status	
• Appropriate preventative information should be used as well as incident data. • Periodic audits of the effectiveness of management structures and risk controls. • Assess impact of changes, such as new procedures. • Procedures to implement new and changed legal requirements. • Benchmark against other organisations. • Appraisals to include H&S performance.	• There is good evidence of distribution of information, but almost no validation that people have understood or acted upon safety messages. There is also inconsistent understanding regarding use of Datix, what to report and how to investigate. The information potentially available through this resource is not being fully utilised. • There have been no audits • No evidence was provided regarding impact of change on H&S performance • There are no procedures or clear process regarding dealing with new or changed legislation • There was no evidence provided regarding benchmarking against other organisations	• Competence • Good governance • Risk Management • Legal compliance • Good governance

ACT – FORMAL REVIEW/ FEEDBACK

Recommended actions	LAS Status	
• Examine whether H&S policy reflects current priorities, plans and targets. • Examine whether risk management and other health and safety systems have been effectively reported to the board. • Decide actions to address weaknesses and monitor implementation. • Record H&S performance in annual reports. • Reward good H&S performance.	• The focus at Board level is on the risk register, and does not examine wider risk management or effectiveness of other health and safety systems and performance. • There was no evidence of monitoring (beyond physical conditions checks), partly due to poorly defined management system and lack of defined responsibilities. • Currently the only performance data collected is reactive regarding incidents. • There was no evidence seen of rewarding good H&S performance.	• Legal compliance • Good governance • Risk management • Good governance • Good governance

Health and Safety Update

1. Introduction & Background

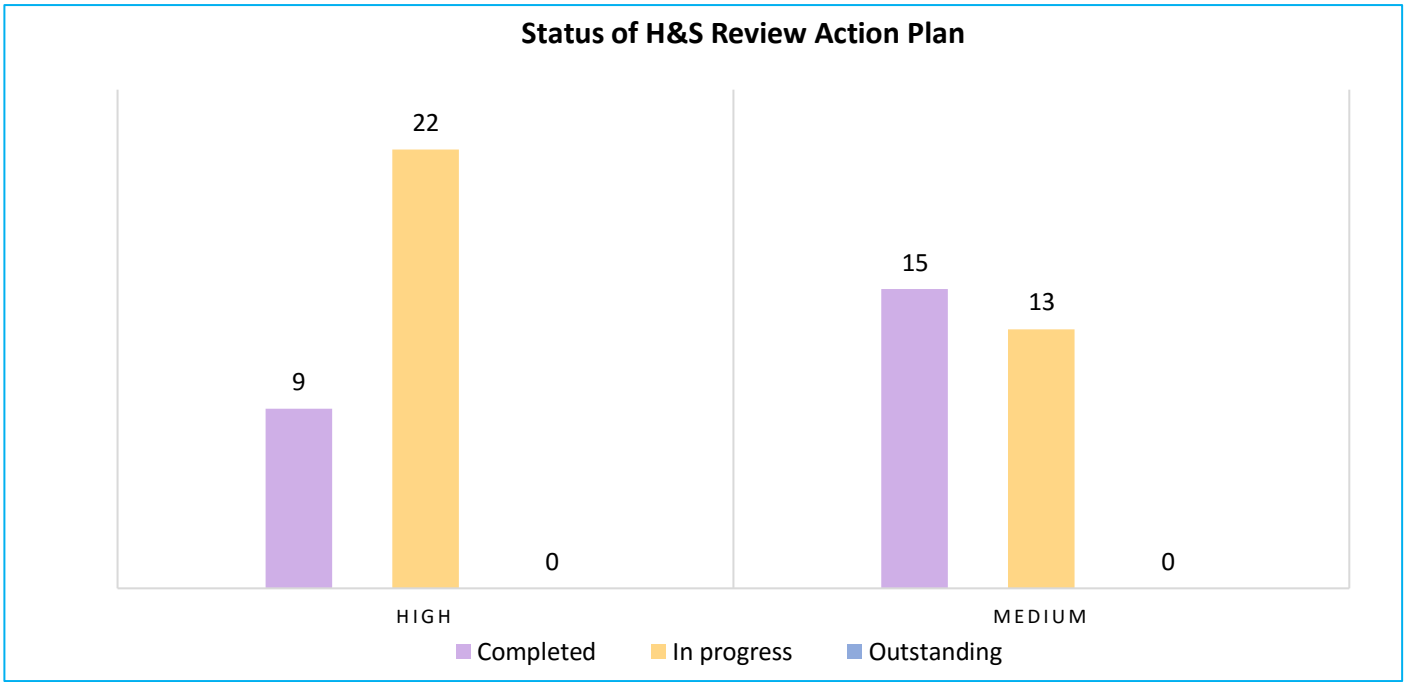
1.1 An independent review of the Trust's arrangements for health and safety was undertaken in June 2017 with the objective of assessing the level of the Trust's compliance with health and safety legislation/statutory requirements. The report from the review highlighted key risks and areas of non-compliance across the Trust, and recommended key actions that need to be completed to improve compliance. The review report and action plan was received by the ELT in August 2017.

1.2 This report aims to provide an update on the current status of actions recommended in the Health and Safety Independent Review Report, and to provide assurance/highlight issues that might impact the successful implementation of the recommended actions.

2. Highlight of actions recommended

2.1 A total of 59 actions (categorised as high/medium priority) were recommended following the independent review. A total of 24 actions have been completed, 35 actions are in progress and currently underway, no actions are outstanding.

2.2 A breakdown of the current status of the actions is provided below:



Key:
Completed: Actions completed and can be evidenced
In progress: Actions currently underway – on track.
Outstanding: Actions are yet to be commenced.

3. Key updates on the H&S Review Action Plan

Manual Handling:

3.1 The reviewed Manual Handling Policy has been approved by the Corporate Health and Safety Committee. Policy to be forwarded to PMAG for final approval and publishing to the Pulse.

3.2 Risk assessments for specific high-risk manual handling activities have been completed, discussed and approved at the Manual Handling Steering Group meeting of 22/09/2017. Risk assessments to be uploaded to the Health and Safety page on the Pulse so that they can be easily accessed by staff.

3.3 Key training in practical manual handling will be delivered to Clinical Tutors in December 2017. This will enable the delivery of practical manual handling refresher training to all frontline operational staff from CSR 1 – April 2018. Key components of the training to be provided will include – Principles for undertaking Dynamic Risk Assessments as well as the basics of moving and handling bariatric/plus size patients.

Management of Health and Safety Risks:

3.4 Trust-wide Health and Safety Strategy is currently being developed. Draft document to be completed by 15/11/2017 and presented to the ELT and Board in November 2017 for approval.

3.5 The Corporate Health and Safety Committee met on 30th October 2017 to review Trust-wide Health and Safety Performance.

3.6 Sector specific health and safety reports have been developed to highlight health and safety performance. Reports have been circulated to DDO/ADOs, QGAMs, GSMs and Union Health and Safety Representatives.

3.7 The Trust's Lone Working Policy has been reviewed and circulated to Union Representatives as well as Managers for comments. The finalised policy to be forwarded to PMAG for approval by 30th November 2017.

3.8 Trust-wide Display Screen Equipment arrangements have been reviewed. The Health and Safety Department are liaising with the Occupational Health Providers (PAM) to agree robust arrangements to support staff where problems are highlighted. The policy with revised arrangements to be completed in November 2017.

3.9 Meeting held with representatives of PAM (Occupational Health Providers) on 9th November 2017 to discuss improved ways of working with the H&S Department. Commitment received that the OH providers will actively engage and support the department with implementing measures to improve the health, safety and wellbeing of staff.

3.10 Regular monitoring of Health & Safety trends/issues through the monthly Quality Report.

3.11 Meeting organised with the HM Principal Inspector of Health & Safety at the HSE on 16th November 2017 to discuss progress that has been made against actions in the Improvement Notice that was issued to the Trust in 2010.

3.12 A further meeting has been requested by the HSE with the CQO and the ELT to discuss how the Trust manages health and safety issues especially manual handling related incidents. Meeting to be arranged in January 2018.

Training:

3.13 Dynamic Risk Assessment training package has been developed with the Clinical Education Department and launched with CSR 2 -2017. The DRA training will also be emphasised during the Conflict Resolution Training and Practical Manual Handling Training that will be provided to staff during CSR 1, 2018.

3.14 Senior Management Health and Safety Training was delivered to the ELT/Board on 31st October 2017.

3.15 The compliance rate for the mandatory Health, Safety and Welfare training in October 2017 was 35.14%. A new E-Learning training package was launched in September 2017.

3.16 The Managing Health and Safety Course for Managers will be re-launched in December 2017.

Health & Safety Department:

3.17 Approval has been received for the recruitment of additional resources to the Health and Safety Department. Revised department structure agreed. Consultation on the new structure was completed on 31st October 2017.

4. Barriers/Issues

4.1 Reduced capacity of the Health and Safety team due to long-term staff sickness/absence.

Action: Additional support provided to team by external Health & Safety Consultant.

4.2 Concerns have been highlighted about the implementation of action 2.5 and how random drugs and alcohol sampling of staff will be implemented fairly across the Trust. Clarification and agreement is sought from the ELT about the process for effectively implementing this process across the Trust.

Action: HR Manager (Action Lead) is putting together a paper for the ELT highlighting key requirements and concerns.

5. Conclusion

5.1 All Directorates and Action Leads have been actively engaged with progressing and implementing their respective actions, and a lot of work is being done to ensure that these actions can be completed and embedded to improve the Trust's compliance. The focus of the

Health and Safety Department is to support all leads with completing any actions that are currently underway. Updates on the progress of actions will be collated and provided to the ELT on a monthly basis

5.2 An overview of the Trust's health and safety performance from Q1 to Q3 (October 2017) is provided in the Health and Safety Scorecard (Appendix 2).

APPENDIX 1- Health and Safety Review Action Plan

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
1.4	Engage employees and representatives in completion of risk assessments.	High	Ayodeji Adeyemi	Trisha Bain	Trust-wide Governance arrangements have been reviewed to facilitate the engagement of staff and Union Representatives when risk assessments are completed. Consultation relating to H&S matters will be through the Corporate Health & Safety Committee and sub-groups.	31/12/2017	Completed			Corporate H&S Committee meeting minutes.
1.5	Complete and implement assessments for manual handling activities	High	Ayodeji Adeyemi	Trisha Bain	Manual Handling risk assessments have been completed, discussed and approved at the Manual Handling Steering Group meeting of 22/09/17. Risk Assessments to be uploaded to the Pulse so that they can be accessed by all staff.	31/09/2017	Completed			Completed Manual Handling Risk Assessments to be uploaded to the H&S Page on the Pulse.
4.4	Develop and implement a risk based monitoring programme that itself is subject to review	High	Ayodeji Adeyemi	Trisha Bain	A framework for identifying, monitoring and reviewing risks is in place across the Trust. All trust-wide Health and Safety risks will be aligned to the implemented framework. All H&S risks will be subject to regular review and scrutiny by the QOG and the Risk, Compliance and Assurance Group.	31/12/2017	Completed			Minutes of H&S Committee, QoG Trust Risk Register H&S Committee Report
7	Recruit additional resources to support/take forward the programme of works highlighted via the review of Trust-wide H&S Compliance.	High	Ayodeji Adeyemi	Trisha Bain	Discussions have been had with Julie Parham – Matura Health & Safety to provide consultancy support to the Trust for about 6 days per month over a 3 month period. The daily cost to enable this is estimated at: £560 (per day).	30/09/2017	Completed		£10,080	External Consultant in post to support the H&S Team with the delivery of actions.
3.3	Ensure systems are implemented to monitor staff competence after training and to ensure that training requirements are achieved and maintained.	High	Peter McKenna	Paul Woodrow	Combined action for Operations and Clinical Education Department. Action recently reassigned to Operations: Process for monitoring staff competence currently being reviewed with suggestion to incorporate this into the OWR process for frontline staff.	31/12/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
					Clinical Education Department - working with H&S Department to ensure that training requirements are achieved and maintained.					
3.4	Develop and deliver dynamic risk assessment training to all relevant staff, with appropriate refresher periods mandated.	High	Tina Ivanov	Fenella Wrigley	Dynamic risk assessment training package completed and e-learning package developed and incorporate this into the mandatory CSR sessions for all Frontline staff. Commencing CSR 2 - 2017. DRA training will also be incorporated into the Practical MH training as well as emphasized during CRT training provided at CSR 1 - 2018.	31/03/2018	Completed			
3.6	Develop system for and maintain clear records associated with training in use of equipment	High	Tina Ivanov	Fenella Wrigley	A system has been implemented for reporting on MAST training however, system for recording equipment training and competency assessments is being developed/incorporated into work being done by Clinical Edu. Department.	31/12/2017	In progress			
3.15	Implement monitoring regime to verify effectiveness of training provided to staff.	High	Peter McKenna	Paul Woodrow	Action recently reassigned to Operations: Process for monitoring staff competence currently being reviewed with suggestion to incorporate this into the OWR process for frontline staff.Feedback from staff following training sessions is currently being collected and reviewed by the P&OD Department. System for ensuring regular review of all training programmes delivered to staff to be developed.	31/12/2017	In progress			
1.8	Complete and implement assessments for activities undertaken by Estates e.g. working at height/in confined spaces.	High	Martin Nelhams	Lorraine Bewes	Estates department staff do not undertake any duties that include working at heights etc, only contractors do this. Contractors are responsible for carrying out their own risk assessments and where necessary providing method statements. All contractors used for	31/12/2017	Completed			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
					LAS work are on an approved list which is updated every 3 years. Contractors Health & safely policies are reviewed during the 3 yearly review - during this period, they all provide Method statements on generic risks. RAMS are requested where specific works are to be undertaken. Departmental/divisional health and safety risk assessments will be undertaken for the Estates Department as part of the site/Department specific H&S risk assessments to be implemented in Q3, 2017.					
1.11	Complete and implement risk assessments for activities undertaken in Fleet Workshops.	High	Justin Wand	Lorraine Bewes	Process and templates for completing site specific risk assessments to being developed. Workshop specific risk assessments to be undertaken by external consultants and will commence in November 2017.	31/03/2018	In progress			
4.7	Review Daily Vehicle Check LA(1) form to confirm all checks required, and ensure appropriate facilities are provided to allow staff to achieve the checks in time.	High	Justin Wand	Lorraine Bewes	LA1 forms as well as process for completing these are currently under review.	31/12/2017	In progress			
2.5	Review alcohol and drugs policy and consider more detailed advice on limits and need for testing regime where appropriate.	High	Andrew Buchanan	Patricia Grealish	Action under review: process can be developed to randomly sample staff however, clarification and agreement is required from the ELT regarding the process for effectively implementing this process across the Trust. Action Lead to develop paper highlighting key requirements and concerns to the ELT.	30/11/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
1.7	Complete and implement assessments for driving	High	Mark Crouch	Paul Woodrow	The Driving Standards Policy and Procedure has been re-written, approved and published. Policy will establish requirement for all relevant staff driver checks and assessment to be undertaken when staff join the Trust and before driving Trust Vehicles. RIB bulletin to be sent out to inform all staff. Blue light course in place for all staff who drive Trust vehicles. Training records held by Clinical Education. For non-blue light drivers, a Check Drive (driving competency and license check) is completed before staff are allowed to drive Trust Vehicles. Medical Declaration signed by staff during the 6-monthly license checks where staff are required to declare that they have no medical conditions that prevent them from driving. Where staff are involved in repeated/multiple incidents, these are managed local management with support from the Head of Driving Standards.	30/11/2017	Completed			
1.9	Complete and implement assessments for HART activities (This was not assessed as part of the review).	High	Marc Rainey	Paul Woodrow	H&S Department currently reviewing risk assessments for HART Activities. Visit to HART facilities to be undertaken in December 2017 - following HART NARU Audits.	30/11/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
1.13	Ensure appropriate risk assessments are completed under COSHH and DSEAR for hazardous and flammable substances used across the Trust including in workshops and by HART	High	Justin Wand / Marc Rainey	Paul Woodrow	Trust-wide COSHH and DSEAR risk assessments process under review. Implementation of COSHH/DSEAR risk assessments to commence in Q3 2017 and will completed across the Trust by March 2018.	01/03/2018	In progress			
3.7	Confirm refresher period requirements for driver training.	High	Mark Crouch	Paul Woodrow	Driver Training is currently being developed and will be a requirement for staff who drive. The refresher period will be 5 yearly.An options paper is currently in draft to be presented to the ELT for consideration.	31/12/2017	In progress			
3.8	Ensure all staff that drive vehicles for work (not just ambulances and emergency response vehicles) provide details of their driving licenses to be checked at 6 monthly intervals.	High	Mark Crouch	Paul Woodrow	6 monthly checks is currently completed by local Managers. Current Ops-wide compliance status is up from 52% to 95% however, issues have been highlighted with regards to how compliance is currently monitored, recorded and how non-compliance is managed. A new electronic system is currently being scoped (circa £20k annual fee), but ESR are looking to build a module nationally. Head of Driving Standards is actively pursuing updates to establish timeline.	31/12/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
4.11	Audit procedures in place in HART and bring into line with wider LAS HS&S systems.	High	Marc Rainey	Paul Woodrow	Meeting held with Head of CBRN & HART to review arrangements in place within the HART & Special Operations Unit. Visit to HART facilities to be undertaken in December 2017 - following HART NARU Audits. Audits will be incorporated into the H&S Work plan with HART.	31/01/2018	In progress			
1.1	Review process for identifying, assessing and managing health and safety risks in line with legislation and statutory requirements.	High	Ayodeji Adeyemi	Trisha Bain	Process under review – implementation of arrangements to commence in Q3, 2017 following the restructure of H&S Department.	31/12/2017	In progress			
1.2	Ensure human factors including fatigue, alcohol, drugs, night-working and stress are considered in the risk assessment process	High	Ayodeji Adeyemi	Trisha Bain	Risk assessments relating to Human factors will be incorporated into the site specific risk assessments which will look at how specific staff groups work as well as the risks they are exposed to. Implementation of site assessment process to commence in Q3, 2017.	31/12/2017	In progress			
1.3	Ensure staff completing health and safety risk assessments are competent	High	Ayodeji Adeyemi	Trisha Bain	Managers and staff who are required to complete H&S risk assessments are encouraged to attend the Managing Health and Safety Course. This course is currently being reviewed with the view of making it mandatory for managers/leads responsible for completing risk assessments. Aim is to re-launch training in November 2017.	31/12/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
1.6	Complete and implement assessments for lone working and security risks	High	Ayodeji Adeyemi	Trisha Bain	Lone working policy and risk assessments have been completed and circulated to key stakeholders for comments. Once feedback is received, the appropriate amendments will be made and policy will be sent to PMAG for approval.	30/11/2017	In progress			
1.10	Complete and implement assessments for facilities i.e. site specific risk assessments. This should consider traffic flows and location of equipment such as pressure gauges.	High	Ayodeji Adeyemi	Trisha Bain	Process and templates for completing site specific risk assessments developed. Site specific risk assessments to be completed for 83 sites across LAS. The department's aim is to complete 20 site risk assessments per month from Q3, 2017.	31/03/2018	In progress			
2.1	Update Health & Safety Policy document in line with good practice and clearly define responsibilities for Directors, HS&S team, Heads of departments and managers.	High	Ayodeji Adeyemi	Trisha Bain	Trust-wide Health and Safety Strategy is currently being developed. The finalised strategy will inform the review of the Trust's H&S Policy. Aim is to submit to ELT and Board for approval by 30 November 2017.	30/11/2017	In progress			
2.2	Review policy for lone workers and ensure it considers process for monitoring lone workers, emergency procedures and any restrictions.	High	Ayodeji Adeyemi	Trisha Bain	The Lone Working policy has been reviewed and circulated to key stakeholders. Draft policy to be forwarded to PMAG for approval.	31/12/2017	In progress			
2.9	Reorganise HS&S resources in line with this report to address systemic weaknesses across the Trust.	High	Trisha Bain	Trisha Bain	Funding and request to recruit additional resources approved by ELT on 23/08/2017. Consultation on department restructure completed in October 2017. Job descriptions have been completed and sent to HR for banding so that recruitment process can be commenced.	30/11/2017	Completed	£138,237.17	£7,000.00	

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
3.5	Ensure there are sufficient resources to deliver manual handling training, with appropriate refresher dates set and met.	High	Kerry Fowler	Trisha Bain	Trust wide Manual Handling Policy has been reviewed and approved by the Corporate Health & Safety Committee. Policy to be forwarded to PMAG for approval.	31/12/2017	Completed	N/A	£17,450	Updated Manual Handling Policy
3.12	Ensure HS&S training identified in Core Training Policy is implemented. This includes risk awareness training for senior managers, manual handling, investigation of incidents, slips trips falls.	High	Ayodeji Adeyemi	Trisha Bain	Provision of Health and Safety Training across the Trust is currently under review with the P & OD Team. The proposal is to re-launch the training in November 2017 as well as make this mandatory for managers with responsibility for teams/completing risk assessments.	30/11/2017	In progress			
3.14	Define and communicate requirements for PPE maintenance and replacement. This should include head protection, fall protection and stab vests.	High	Ayodeji Adeyemi	Trisha Bain	Trust-wide PPE policy is currently under review - to be completed by 31/12/2017.	31/12/2017	In progress			
8	Undertake review of bariatric provision across the Trust – with aim of reducing manual handling risks to staff.	High	Kevin Bate	Paul Woodrow	Organisational review of bariatric and private ambulance contracts is currently underway and led by the Deputy Director - Central Operations.	31/11/2017	In progress			
9	Produce Health and Safety Strategy Document for the Trust.	High	Ayodeji Adeyemi	Trisha Bain	Strategy development process underway - to be completed and submitted to ELT by 15th November 2017/	30/11/2017	In progress			
1.14	Review process surrounding HS&S in corporate risk register to ensure this reflects legislation and provides meaningful assurance. Ensure staff completing and	Med	Ayodeji Adeyemi	Trisha Bain	Health and Safety risks have been incorporated into the management framework of the organisation (uploaded to Datix) and will be subject to review and scrutiny through the Directorate Review	30/09/2017	Completed			Trust Risk Register.

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
	managing this are competent to do so.				Process as well as by the Trust's high-level committees.					
2.10	All incidents to be reported using Datix rather than paper forms for consistency	Med	Nathan Colman	Trisha Bain	Process agreed. All incidents to be reported through the Datix system from 01/10/2017.	01/10/2017	Completed			Trust - Datix System.
3.2	Work with Medical and POD to ensure that HS&S training for managing significant risks is integrated into wider competence and training programme.	Med	Ayodeji Adeyemi	Trisha Bain	Health, Safety and Welfare Mandatory Training launched for all staff in September 2017.	30/11/2017	Completed			ESR Training records.
3.11	Provide training on incident investigation and root cause analysis	Med	Kirstie Smith	Trisha Bain	Trust-wide programme in place for managing Sis. The management of all incidents will be aligned to this process to ensure consistent and robust investigation across the Trust.	30/11/2017	Completed			SIG Panel meeting reports and minutes.
4.1	Develop HS&S dashboard based on leading and lagging indicators to provide assurance to the Board. This should include statutory checks and legal compliance status.	Med	Ayodeji Adeyemi	Trisha Bain	H&S Dashboard has been developed. To be presented to the ELT in October 2017.	31/10/2017	Completed			Health and Safety Scorecard
4.6	Report safety related inspections through HS&S to the HS&S Committee to ensure high risk items are identified and managed.	Med	Ayodeji Adeyemi	Trisha Bain	Statutory inspections dashboard developed for monitoring H&S and Estates inspections. This will be presented on a regular basis to the Corporate H&S Committee.	30/11/2017	Completed			Minutes of Corporate H&S Committee Meetings.
4.9	Initiate programme of safety tours for senior managers and directors	Med	Trisha Bain	Trisha Bain	Programme of safety tours will form part of the review of CQC KLOEs.	31/10/2017	Completed			ELT Meeting Minutes

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
4.12	Complete combined analysis of proactive and reactive data to identify underlying trends.	Med	Ayodeji Adeyemi	Trisha Bain	This is currently ongoing. Regular reporting of health and safety data is undertaken for the Trust's monthly Quality Report as well as for other High level committees e.g. Corporate H&S, QOG e.t.c.	31/10/2017	Completed			Corporate H&S Committee Report, Monthly Quality Report, H&S Score Card, QoG Reports.
4.2	H&S to regularly appear on agenda for board meetings	Med	Trisha Bain	Trisha Bain	Reflected on Board Agenda. Monthly assurance reports to be provided to the ELT and Board with updates on H&S action plan.	31/10/2017	Completed			Board Agenda
6	Update the CQC on Trust-wide progress with Health and Safety Compliance.	Med	Trisha Bain	Trisha Bain	The CQO met with and briefed the CQC on the Trust's current level of compliance as well as actions being taken to address gaps on 13th September 2017.	31/10/2017	Completed			
1.15	Ensure that impact of any organisational changes on Health, Safety & Security is assessed and managed.	Med	Trisha Bain	Garrett Emmerson	Health and Safety will be incorporated into the change management framework of the organisation so that consideration and assessment of health and safety risks can be undertaken prior to the implementation of changes. Current support to be reviewed to enable the provision of PMO approach for service re-design and change.	31/12/2017	In progress			
4.3	Non-executive to act as independent scrutiny	Med	Trisha Bain	Garrett Emmerson	To be discussed at the November 2017 Board.	31/10/2017	In progress			

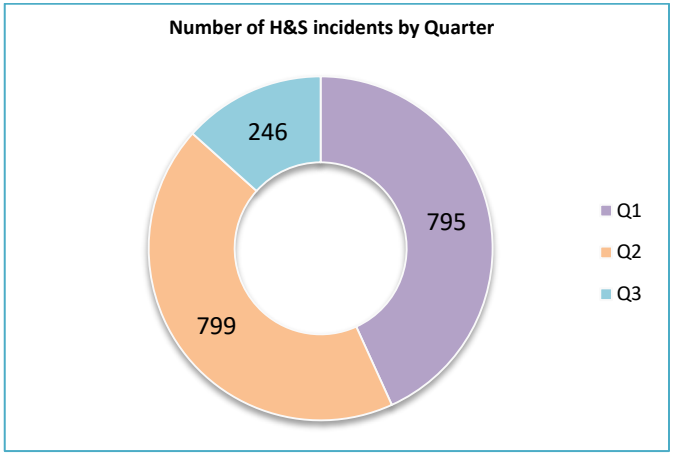
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
2.7	Define process for managing legionella risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Martin Nelhams	Lorraine Bewes	Action log completed where risk assessments are completed - this is Managed via Estates. Updates provided to monthly performance review meetings. Action log with updates to be provided to Corporate H&S Committee.	30/11/2017	Completed			
2.8	Define process for managing fire risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Martin Nelhams	Lorraine Bewes	Action log completed where risk assessments are completed - this is Managed via Estates. Updates provided to monthly performance review meetings. Action log with updates to be provided to Corporate H&S Committee.	30/11/2017	Completed			
4.5	Enforce use of HEAT portal for reporting defects and tracking completion. Consider addition of a sign off facility for local managers to confirm work completed.	Med	Martin Nelhams	Lorraine Bewes	Estates department to send out RIB guidance to all staff regarding the use of the HEAT system. Information to be communicated through the Corporate H&S Committee and through the Unions.	31/10/2017	In progress			
4.8	Ensure that local station managers have access to statutory checks regarding facilities. These are the people who are directing staff to work in the premises and must be assured they are in good condition and are aware of their responsibilities.	Med	Martin Nelhams	Lorraine Bewes	Information on site specific statutory checks/inspections can be accessed by all Managers via the RED Boxes that are kept and updated at each site by Estates or through the Shared X drive.	31/10/2017	Completed			
10	Put a system in place to ensure that staff cannot leave ambulance stations without radios on the vehicles	Med	Peter McKenna	Paul Woodrow	Action reviewed by Fleet & Logistics with recommendation to re-assign to Ops. The rational is: Vehicle Preparation will check for availability of hand portable radios. If not present, they advise local GSM who then	31/12/2017	In progress			

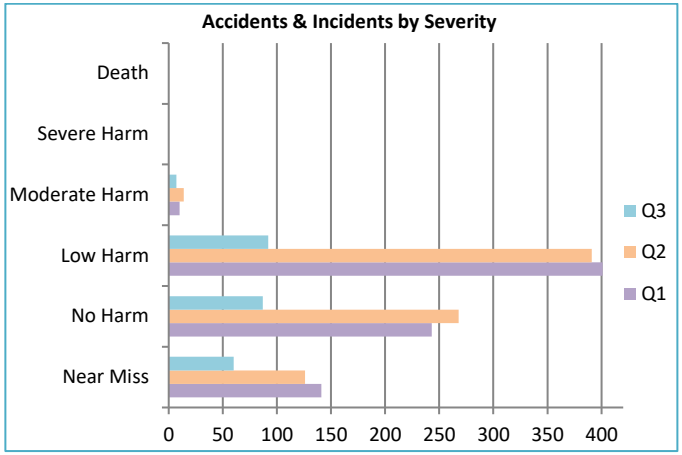
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
					takes on responsibility for resolving shortages.					
1.12	Complete and implement health and safety assessments of office activities including DSE	Med	Ayodeji Adeyemi	Trisha Bain	The Trust's DSE risk assessment process has been reviewed - to be circulated to all key managers and stakeholders. In addition to the policy updates, a local process map has been completed and agreed with PAM for OH involvement. The register of Trust DSE assessors has also been compiled.	30/11/2017	In progress			
2.4	Clarify and document responsibilities of committees where HS&S is discussed, and of boundaries between HS&S, QGAM, Estates, People & Organisational Development and Fleet. This should consider what is appropriate for the HS&S Committee and what meetings HS&S should attend. (Suggested guidance is included at Appendix 15)	Med	Ayodeji Adeyemi	Trisha Bain	Trust Governance and Committee meeting structure agreed and implemented. Review is currently underway - changes will be reflected in the updated Health and Safety Policy	30/11/2017	In progress			
2.6	Develop robust process for tracking legislation, standards and enforcement notices.	Med	Ayodeji Adeyemi	Trisha Bain	Action to be implemented following recruitment and re-organisation of Health and Safety Department. Additional resource also agreed to manage compliance with Medical Equipment as well as implement the Health Assure system. This will help to ensure robust coverage and oversight across the Trust.	30/11/2017	In progress			

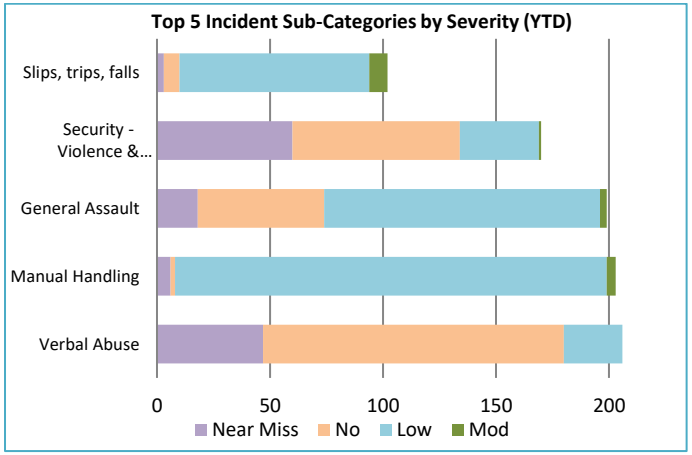
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
3.1	Appropriate training on health and safety leadership should be organised for Executive Directors and Non-Executive Board members	Med	Ayodeji Adeyemi	Trisha Bain	ELT/Board Level Training completed on 31st October 2017. Recommendation is that this is becomes a 3 yearly training programme that the Board/ELT undertake.	31/10/2017	Completed	N/A	£1,000	Training records and documents.
3.9	Provide guidance and training to staff on how to effectively use Datix	Med	Nathan Colman	Trisha Bain	E-learning package has been developed for all staff and will form part of the Mandatory training requirement. The package will be launched in Q4 2017.	31/03/2018	In progress			
3.10	Include guidance and training on Datix in induction sessions for new staff.	Med	Nathan Colman	Trisha Bain	E-learning package has been developed for all staff and will form part of the Mandatory training requirement. The package will be launched in Q4 2017.	31/03/2018	In progress			
3.12	Develop communication strategy to work alongside the HS&S Strategy to support effective implementation.	Med	Ayodeji Adeyemi	Trisha Bain	This will be incorporated into the Health and Safety Strategy being developed.	30/11/2017	In progress			
3.13	Develop standard for HS&S Notice boards in all locations.	Med	Ayodeji Adeyemi	Trisha Bain	To be completed during review of site specific risk assessments - to commence in November 2017.	30/11/2017	In progress			

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Estimated Timescale	Action Status	Revenue Cost	Capital Costs	Evidence of completion and Assurance
4.10	Implement system of internal audits	Med	Ayodeji Adeyemi	Trisha Bain	Programme of internal audits to be implemented from March 2018.	31/03/2018	In progress			
4.14	Implement independent assurance regime to verify robustness of systems in place.	Med	Trisha Bain	Trisha Bain	This will provide independent assurance to the ELT and Board regarding the effectiveness of the Health & Safety Department in implementing and maintaining appropriate arrangements to ensure compliance with Health & Safety requirements.Independent audits of Trust-wide compliance to commence in 2018/19.	31/03/2018	In progress	N/A	£2,875	
5	Provide progress updates to the HSE regarding progress with the Improvement Notice issued in 2010	Med	Trisha Bain	Trisha Bain	Meeting with the HSE planned for 16/11/2017	30/11/2017	Completed			

Health & Safety Scorecard – Q3 (October 2017)







1840 health and safety related incidents were reported during 2017/18 up to October 2017. These incidents account for 38% of the total incidents reported during the year.

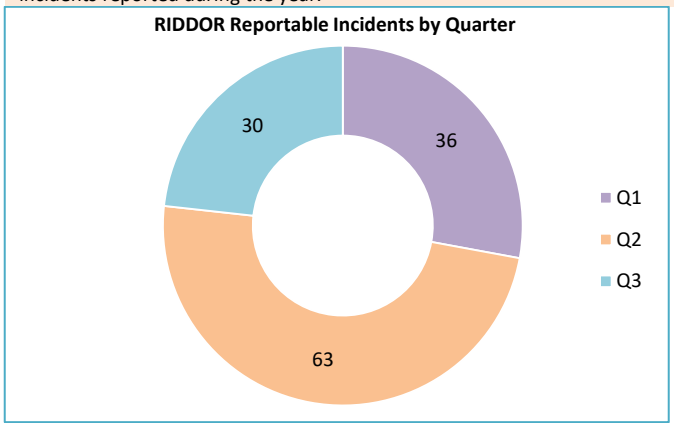
915 (49.7%) of the H&S related incidents reported during 2017/18 resulted in harm. 925 (50.2%) of the incidents were reported as 'No Harm/Near misses'.

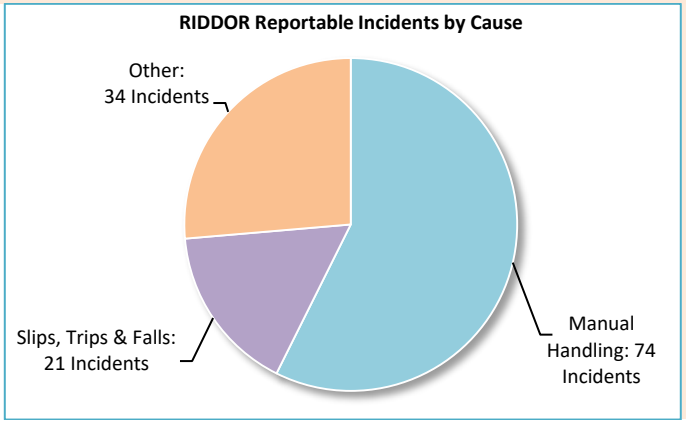
Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported In Q3 (up to October 2017).

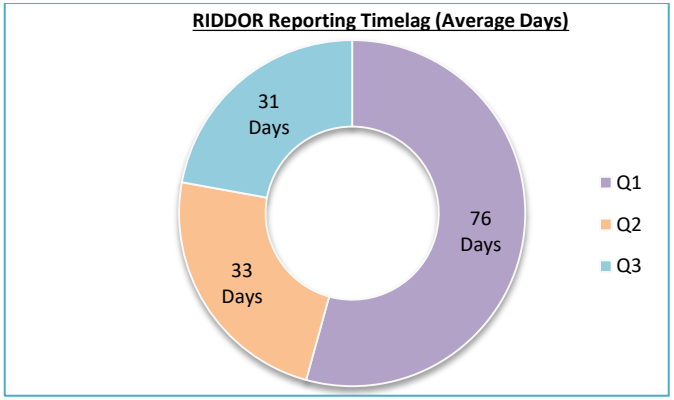
There was a reduction in 'Exposure to Bodily Fluid Incidents' reported in October 2017. YTD, a total of 97 'Exposure to Bodily Fluid Incidents' have been reported compared to 102 'Slip, Trips and Fall' Incidents.

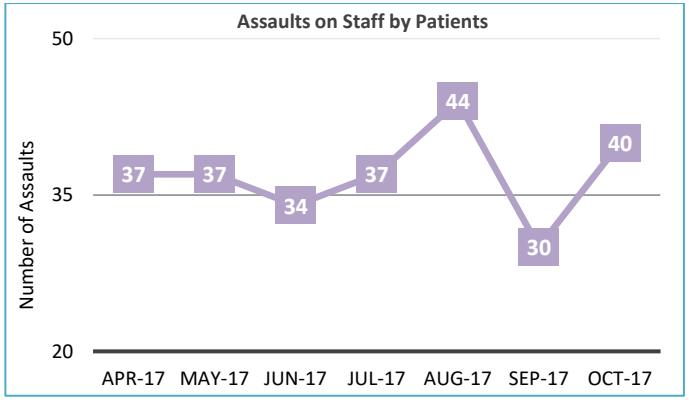
Assurance:

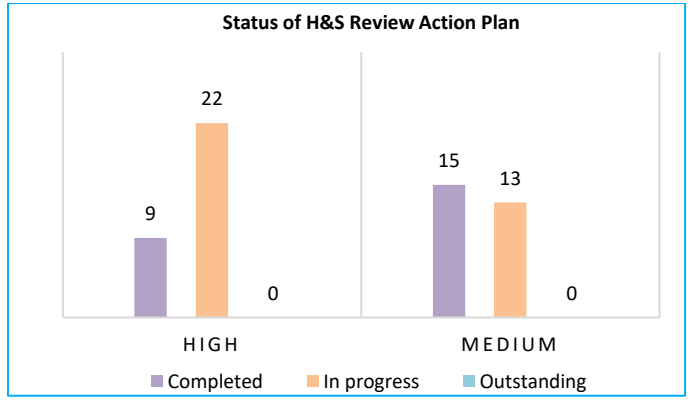
1. Key training in practical MH to be undertaken in December 2017 by Clinical Tutors. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
2. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
3. No trends identified with the increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
4. Prototypes of the proposed integrated Vehicle based first response bags to go on trial at the end of November 2017.
5. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of MAST training during CSR 2 - 2017.







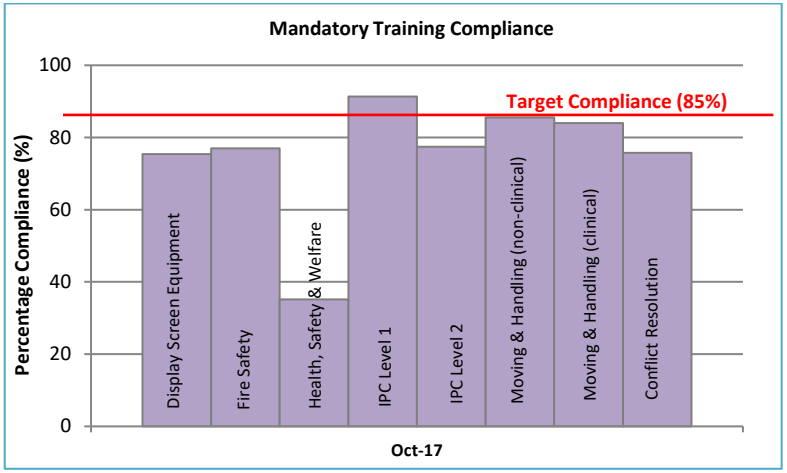




6. The current Trust-wide average of 31 days for reporting RIDDOR incidents currently exceeds the statutory requirement for reporting most RIDDOR incidents which is 15 days.

7. Assaults on staff by patients make up 32% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required. Lone worker policy has been developed and circulated to key stakeholders for review.

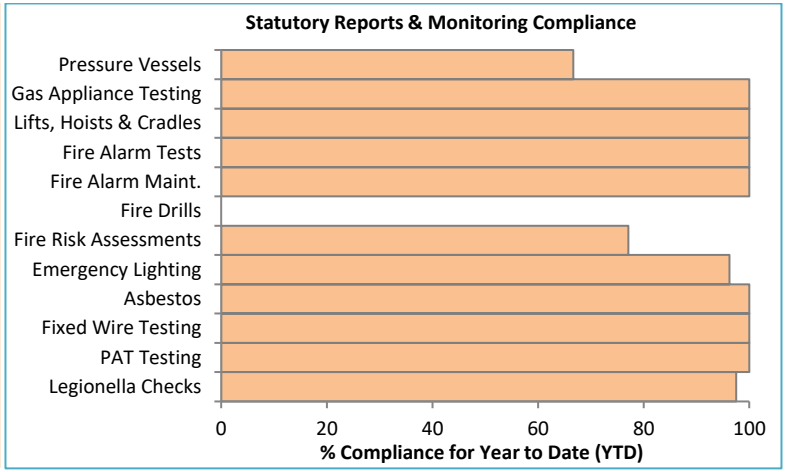
8. 24 of the 59 actions recommended have been completed, 35 actions are in progress and currently underway. A monthly update report is provided to the ELT/Board to highlight progress of actions as well as barriers.



Trust-wide compliance in October 2017 for 6 out of the 8 mandatory health and safety training courses are below 85%.

IPC 1 and Moving and Handling (non-clinical) are at or above 85%.

A new training package for Health, Safety and Welfare Training was launched in September 2017. Trust-wide compliance is currently at 35.14.



Compliance with the statutory fire drills across the Trust is currently at 0.

This is largely because fire drills are not currently completed across a lot of the LAS sites, and where these are completed, they are not recorded. The H&S Dept. is reviewing fire arrangements across the Trust with the aim of improving Trust-wide compliance.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Target Risk Rating	Key changes/updates since last review
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	9	Key training in practical MH to be undertaken by Clinical Tutors in December 2017. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – developed and circulated for comments.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	3	Withdrawal of paper forms implemented on 01/10/2017. Proactive monitoring of RIDDOR incidents undertaken daily by H&S Team through Datix and GRS. Current reporting time lag is 31 days.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	3	Risk register reviewed, awaiting sign-off by RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q3, 2017.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management. These will be implemented in Q3, 2017.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.
118	IPC	There is a risk of infection due to a sharps injury.	Eng-Choo Hitchcock	Briony Sloper	6	6	6	6	6	3	Risk to be reviewed with Infection Prevention and Control Team.

London Ambulance Service NHS
NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**28 November 2017**			
Report title:	**Quality Improvement Plan and CQC Preparation**			
Agenda item:	**18**			
Report Author(s):	**Dr Patricia Bain, Chief Quality Officer**			
Presented by:	**Dr Patricia Bain, Chief Quality Officer**			
History:	**QIP Programme Board**			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The purpose of this document is to provide an update on the current actions in Quality Improvement Plan (QIP) and Care Quality Commission (CQC) Preparation Plan for the next Well-Led CQC inspection.

Recommendation(s):

The Board is asked to review and comment. The QIP plan includes CQC Must Do/Should Do actions.

Links to Board Assurance Framework (BAF) and key risks:

Links to risk in relation to the Trust's special measures status.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☒

Quality Improvement Plan Update

1 Summary of Progress

1.1 The Routine Provider Information Request (RPIR) has been received from the CQC and needs to be completed and returned by 30 November 2017. The Station quality assurance reviews have continued with the majority complete and the remaining stations due to be completed by the end of November. A comprehensive staff communication plan has been developed and approved by the QIP Programme Board with products being developed ready for roll-out. The burndown scrum process has continued with 3 of the 7 weeks completed and 79 of the 133 actions closed. Work has started on the Mock Inspection which are scheduled to be carried out late November.

2 Routine Provider Information Request (RPIR)

2.1 The Routine Provider Information Request (RPIR) has been received from CQC, this request will be sent once annually and needs to be completed and returned by 30 November 2017. Some data collection preparation, has been completed for the Well Led domain, however the request requires information across all five domains. This is now being worked on and will be submitted to the CQC for our deadline of 27 November 2017.

3 Quality Assurance Visits

3.1 The purpose of the quality assurance review is to measure each of our stations against the Key Lines of Enquiry (KLOE) (focusing on Well Led for this review) as part of the re-introduction of ongoing quarterly visits. Following the Pilot review of two stations last month, the majority of all the stations have been visited, with all stations planned to be completed by the end of November.

3.2 Generally, there is a marked improvement on last year's observations. Any issues identified are being raised with the GSM and logged in Datix for urgent resolution, with common themes across Stations being considered for further investigation and wider learning. These related to clinical waste management, unlocked PRF boxes and sharps disposal, however these issues related to 5 stations.

4 Quality Improvement Plan (2017-18)

4.1 The Quality Improvement Plan is the consolidated actions from the original CQC Plan and Well Led gap analysis which is aligned to the Business Plan objectives.

4.2 The agile approach outlined last month to complete and close these actions by the end of the year has been running for 3 weeks with 79 out of 133 actions now completed. (10/11/17). The Daily Scrum meetings will continue for a further 4 weeks until Friday 8 December 2017, with the aim of closing all the actions with evidence to demonstrate successful completion.

4.3 Progress on the QIP plan including the Burndown Chart activities is reported at the QIP Programme Board every two weeks, with any blockers/barriers identified and actions agreed to resolve. In addition, a Management Dashboard is updated every week and displayed in the Management Corridor.

4.4 A comprehensive staff communication plan has been developed with the following objectives:

- Focus on Senior Managers, putting the onus on them as drivers of change and the delivery of the Trust's strategy and QIP;
- Ensure that all staff know who is responsible for managing their areas and have regular opportunities of meeting with them;
- Enable responsive two-way communications through which staff at all levels can feel genuinely connected with the leadership and engaged in the Trust's change agenda;
- Recognise, celebrate and share achievement in an engaging manner that enables all staff to feel valued and part of the bigger picture.

4.5 Various products are being developed and will be rolled out over the next few months.

4.6 The Mock Inspections are part of a range of activities aimed at ensuring the Trust is well prepared for the upcoming CQC Inspection and will cover the Well Led domain and Warning Notice. Ideally, they will be carried out to be as close to the real thing as possible, so will be unannounced. A critical dependency is external resource to support the inspection as well as London Ambulance Service NHS Trust (LAS) chaperones for the inspection team.

Why?	To test preparation and readiness for the upcoming inspection and ensure corrective actions are being embedded.
What?	Focussed on the Well Led domain and Warning Notice but would also look for obvious safety issues. Includes key Executive/Non-executive interviews.
Whot?	A team of externally drawn 'inspectors' pre-briefed on key issues/findings from previous reports (as currently defined in the QIP plan)
How?	A series of inspection visits and interviews
When?	2 days duration on the following dates: • 28 November – 30 November Dependent on agreeing the approach and resource availability if the above dates cannot be achieved the plan would move a single day duration with a reduced scope
Where?	Headquarters including the EOC, Stations, 111 and some Corporate functions such as People, Quality and I&MT. As much coverage as possible with the resource available. If limited resources minimal sub-set of key functions two sectors only, EOC and 111, all time limited to fit within the day.

5 LAS Countdown Plan

5.1 A LAS Countdown plan identifying the all the activities that need to be completed prior, during and after the CQC inspections has been developed. At present the dates in the plan are only indicative as CQC have yet to confirm the actual date of the Inspection.

5.2 Activities in the plan have continued to ensure the Trust is ready for the Inspection regardless of when the date falls.

5.3 The plan will be updated with the revised communications plan which was approved at the QIP Programme Board 8 November.

5.4 The latest version of the LAS Countdown plan is attached in the appendix.

6 Statutory and Mandatory Training: Action Plan status on Requirements Notice

6.1 The improvement in the Trust's position has continued with Trust wide compliance now 69% (3/11/17) against the target of 85% compliance by end of Nov-17. Current compliance against all Statutory and Mandatory training is highlighted in Appendix A.

6.2 Corporate compliance is 75% (3/11/17) against a target of >90% compliance by end of Nov-17. The trajectory will be actively managed over the next 3 weeks utilising the information from the newly launched Workforce dashboard.

6.3 Operations compliance is 68% (3/11/17) against a target of 85% by the end of Nov 2017. Initial modelling of the trajectory of compliance around the delivery structure of the Core Skills Refresher programme indicated that the Trust would fall short of target compliance, which would apply to the Trust target equally. Potential solutions are being discussed.

6.4 The full extent of bank workers and their use at LAS has been investigated and a report presented to the Executive Leadership Team (ELT) to discuss next steps. This has now been resolved with numbers being agreed and a revised policy implementation.

6.5 A communication plan has been designed and implemented to embed the process, responsibilities and accountabilities for compliance across all management groups.

6.6 Compliance targets and dates have been agreed for clinical staff to recognise the Block training nature of their core skills refresher programme.

6.7 A review to agree consequences of non-compliance with MAST requirements and to investigate options to require new employees to complete training period between offer and starting work with LAS has been completed.

7 Progress against CQC /Should Dos (aligned to Business Plan objectives)

7.1 The latest Impact KPIs against the various domains have been updated and are presented in the Appendix.

7.2 Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by December 2017.

Staff are Valued, Respected, and Engaged (Should Do)

7.3 Focus on Statutory and Mandatory training has continued to ensure that staff complete all required training. (see previous section for more information)

7.4 A draft implementation plan to launch the People and Organisational Development Strategy has been completed.

7.5 Work in relation to Bullying and Harassment is on-going including diagnostic work, training round table champions and supporting informal resolution of Bullying and Harassment cases.

7.6 Work continues on the implementation of the new Rest Break policy due to start from 4 December 2017.

7.7 Following a comprehensive review of health and safety compliance, a robust action plan is in place and continues to be monitored via ELT and the Board.

Description	Deliverable Status (Number is brackets is previous month)
Deliverable is complete	**20 (10)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by December 2017.	**2 (3)**
Deliverable is at risk of missing due date, but deemed recoverable	**1 (3)**
Deliverable is on target to meet due date	**6 (13)**
Assurance Status (Evidence from Burndown w/c 23rd Oct)	**20**

Patients Receive Safe, Timely and Effective Care (Should Do)

7.8 The Quality Improvement and Learning framework is being presented to this Board. A key aspect of the Quality Improvement work going forward is the development of Quality Improvement at group station/sector level. These staff will be the key link to the QGAMS to drive forward quality improvement and ensure that learning is shared in a more timely and meaningful way from Board to frontline.

7.9 Funding to train a core group of staff in each station on QI methodology is currently being sought from external funding mechanisms. Although key staff will be trained in Level 1 and 2 QI approaches it is envisaged that the majority of staff should participate in improvement programmes within and across sectors as part of an annual cycle of improvement programmes.

7.10 The roll-out of hand held devices, continues on track for completion in December. The review of sites to agree solutions to ensure safe storage of drugs continues as part of the second phase of the medicines management programme. LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target.

7.11 The revised Risk Management Framework was presented to the Board on 31 October and approved under delegated authority by the Audit Committee at its meeting on 6 November 2017. Development of the Datix system continues and implementation of Health Assure is under way for completion in early 2018

Description	Deliverable Status (Number is brackets is previous month)
Deliverable is complete	**16 (11)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by December 2017.	**1 (0)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (0)**
Deliverable is on target to meet due date	**3(9)**
Assurance Status (Evidence from Burndown w/c 23rd Oct)	**16**

Efficiency and Sustainability Will Drive Us (Should Do)

7.12 The implementation of the Ambulance Response Programme (APR) was successfully achieved on 1 November 2017

7.13 The Head of Procurement is leading a rapid review investigating shortage of equipment starting at the end of November and to complete no later than end of January.

Description	Deliverable Status (Number is brackets is previous month)
Deliverable is complete	**5 (0)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by December 2017.	**0 (0)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (2)**
Deliverable is on target to meet due date	**2 (4)**
Assurance Status (Evidence from Burndown w/c 23rd Oct)	**5**

8 Progress against Well Led domain (Should dos)

8.1 **Leadership**: Executive interviews for the two new Director posts (Director of Strategy & Communication and Director of Asset Management) have been held, with an appointment being made for the Director of Strategy & Communication role being appointed and due to start late November. An executive away day was scheduled to take place on 15 November 201 to develop the leadership programme going forward; however this was cancelled as a result of the RPIR being received and needing to take priority. The away day will be re-arranged.

8.2 **Strategy and Engagement**: The stakeholder mapping exercise continues to ensure that all key stakeholders are engaged with the strategy and that all relevant meetings are attended by appropriate level of representation from LAS.

8.3 The operational re-structure was presented to the Board on 31 October 2017 and is being taken forward with operational teams to implement.

Description	Deliverable Status (Number is brackets is previous month)
Deliverable is complete	**27 (2)**
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by December 2017.	**11 (0)**
Deliverable is at risk of missing due date, but deemed recoverable	**0 (0)**
Deliverable is on target to meet due date	**9 (19)**
Deliverable date to be confirmed	**6 (31)**
Assurance Status (Evidence from Burndown w/c 23rd Oct)	**27**

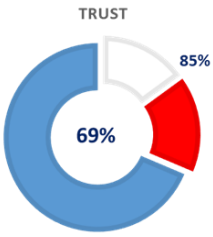
9 Issues

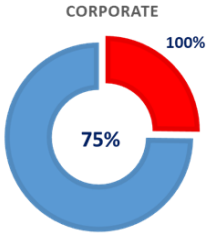
9.1 A number of issues have been identified with owners and mitigating actions.

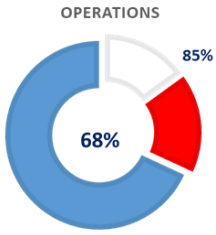
Programme	Issue	Comment
PIR	The Routine Provider Information Request (RPIR) has been received from CQC and needs to be completed and returned by 30th November.	Whilst some preparation has been down on the Well-Led domain, the request for information across all the domains
Burndown	The number of items burnt down at end of week 2 is **80%** of target, due to lack of evidence to confirm completion of action or a plan to deliver action	The actions are from the original CQC and Well-Led action Plans and should be completed prior to Inspection. Implementation plans for actions must demonstrate how the action will be sustainable and how this will be measured/monitored.
Mock Inspections	There is a shortage of external resources to support the inspection, with currently only c15 confirmed 'Inspectors'. Target is to get 25-30.	Other sources of external Inspectors are being identified and contacted. Fall-back position is scope of 'Mock Inspections' is reduced.

Appendix A: Impact KPI's Scorecard *(Statutory and Mandatory Training)*

Statutory and Mandatory Compliance – 3rd November







Appendix B: Impact KPI's Scorecard *(Must Do/Should Do and Well-Led Domain)*

Sep-17 Impact KPI's Scorecard - *sorted by RAG / Monthly Trend*

Domain	Measure	RAG	Trend
	Statutory & Mandatory Training: Trust compliance	●	▼
	Statutory & Mandatory Training: Corporate	●	▼
	Statutory & Mandatory Training: Operations	●	▼
	BME% Starters	●	▼
	BME% Leavers	●	▲
	Job Cycle Time (mins)	●	▼
	Avg. Hospital arrived to Patient Handover (mins)	●	▲
	Avg. Patient Handover to Green (mins)	●	▲
	Controlled Drugs: Non LIN reportable incidents	●	▼
	Missing equipment incidents as % of all reported incidents	●	▲
	Sickness/Absence - Frontline Staff	●	◀▶
	Incident Reporting - Low Harm *(Reported incidents to NRLS - 12 month rolling)*	●	▲
	Incident Reporting - No Harm *(Reported incidents to NRLS - 12 month rolling)*	●	▲
	Sickness/Absence - All Staff	●	▼
	Sickness/Absence - Long-term	●	▼
	Failure of device/equipment/vehicle as % of all missing incidents	●	▼
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean	●	▼
	Sickness/Absence - Short-term	●	▲
	Infection, Prevention & Control: Hand Hygiene compliance	●	▲
	Infection, Prevention & Control: Monthly Premises Cleaning	●	▲
	Serious Incidents breaching 60 days	●	▼
	Controlled Drugs: LIN reportable	●	◀▶
	Bullying & Harrasment cases resolved within 28 days	●	◀▶
	Statutory & Mandatory Training: Bank MAST compliance		▶▶
	Rest Breaks		▶▶

Legend					
●	Target is not being met. Position has deteriorated since last month.	●	Target is not being met / No Target Set Position improved / static since last month.	●	Target is being met.
Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement				▶▶	Fast forward. Trend not available

STAFF ARE VALUED, RESPECTED & ENGAGED

PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

EFFICIENCY & SUSTAINABILITY WILL DRIVE US

Sep-17 Impact KPI's Scorecard

Domain	Measure	Baseline 2015/16	Baseline 2016/17	Benchmark	Target	Actual / Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	RAG	Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
STAFF ARE VALUED, RESPECTED & ENGAGED	Statutory & Mandatory Training: Trust compliance				85%	Actual	67%	67%	66%	65%	66%	66%	●	▼						
						Trajectory									67%	69%	75%	80%	85%	87%
	Corporate				100%	Actual	58%	57%	58%	59%	66%	65%	●	▼						
	Operations				85%	Actual	68%	68%	67%	66%	66%	66%	●	▼						
	Bank MAST compliance				100%	Actual						tbc		▶▶						
	Sickness/Absence - All Staff			4.3%	5.0%	Actual	4.6%	5.0%	5.0%	5.4%	5.2%	5.1%	●	▼						
	Long-term		3.3%		3.0%	Actual	3.0%	3.3%	3.4%	3.5%	3.6%	3.3%	●	▼						
	Short-term		1.8%		2.0%	Actual	1.6%	1.7%	1.6%	1.9%	1.6%	1.8%	●	▲						
	Frontline Staff	5.6%			5.0%	Actual	5.1%	5.5%	5.5%	5.5%	5.6%	5.6%	●	◀▶						
	KF17. % of staff feeling unwell due to work related stress in the last 12 months	55%	51%	48%	Improve	Actual								▶▶						
	KF19. Organisation & management interest in & action on health & wellbeing	2.84	3.24	3.21	Improve	Actual								▶▶						
	BME% of workforce		13%	*BME% of London Population 45%*										▶▶						
	BME% Starters		22%	-	24%	Actual	11%	19%	22%	17%	23%	18%	●	▼						
	BME% Leavers		16%	-	14%	Actual	29%	14%	26%	14%	11%	22%	●	▲						
	BME Conversion rate shortlisting to appointment					Actual	tbc	tbc	tbc	tbc	tbc	tbc		▶▶						
	Staff Survey: BME response rate		12%	14%	13%	Actual								▶▶						
	KF20 % experiencing discrimination at work in last 12 months	30%	21%	Avg. 20%	26%	Actual								▶▶						
	KF21. % believing the org provides equal opportunities for career progression/promotion	60%	78%	Avg. 70%	73%	Actual								▶▶						
	Bullying & Harrasment cases resolved within 28 days					Actual	100%	80%	-	-	50%	-	●	◀▶						
	KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	38%	33%	Avg. 28%	27%	Actual								▶▶						
PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE	Serious Incidents breaching 60 days			0		Actual	7	9	5	0	1	0	●	▼						
	Incident Reporting - Low Harm *(Reported incidents to NRLS - 12 month rolling)*			1200		Actual						922	●	▲						
	Incident Reporting - No Harm *(Reported incidents to NRLS - 12 month rolling)*			500		Actual						370	●	▲						
	Q13a % saying if they were concerned about unsafe clinical practice they would know how to report it	86%	90%	94%	Improve	Actual								▶▶						
	Q13b "I would feel secure raising concerns about unsafe clinical practice"	50%	59%	63%	Improve	Actual								▶▶						
	Q13c "I am confident that the organisation would address my concern"	34%	49%	50%	Improve	Actual								▶▶						
	Infection, Prevention & Control: Hand Hygiene compliance				90%	Actual	70%	85%	76%	87%	90%	93%	●	▲						
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean				90%	Actual	97%	97%	95%	94%	97%	96%	●	▼						
	Infection, Prevention & Control: Monthly Premises Cleaning				90%	Actual	96%	96%	97%	98%	79%	94%	●	▲						
	Controlled Drugs: Non LIN reportable incidents				<15	Actual	16	24	38	31	35	22	●	▼						
	Controlled Drugs: LIN reportable				0	Actual	0	0	0	0	0	0	●	◀▶						
	Missing equipment incidents as % of all reported incidents					Actual	3%	3%	3%	2%	2%	3%	●	▲						
	Failure of device/equipment/vehicle as % of all missing incidents					Actual	10%	12%	16%	9%	9%	8%	●	▼						
	Q4f "I have adequate materials, supplies and equipment to do my work"	32%	40%	52%	Improve	Actual								▶▶						
	Ambulance Response Programme: Cat 1	7 mins (mean) (15 mins 90th centile response time)				Actual								▶▶						
	Ambulance Response Programme: Cat 2	18 mins (mean) (40 mins 90th centile response time)				Actual								▶▶						
	Ambulance Response Programme: Cat 3	120 mins 90th centile response time				Actual								▶▶						
	Ambulance Response Programme: Cat 4	180 mins 90th centile response time				Actual								▶▶						
	Rest Breaks		13%			Actual						22%		▶▶						
	Job Cycle Time (mins)	88			78	Actual	82	82	81	81	80	81	●	▼						
	Avg. Hospital arrived to Patient Handover (mins)		19		15	Actual	20	20	19	19	19	19	●	▲						
	% Arrive at Hospital To Patient Handover Over 15 Mins					Actual	60%	60%	57%	57%	57%	58%								
	Arrive at Hospital to Patient Handover - Total Hours Lost > 15 Mins					Actual	5018	5422	4638	4757	4751	5166								
	Avg. Patient Handover to Green (mins)		17		14	Actual	18	18	18	18	18	18	●	▲						
	% Patient Handover To Green Over 14 Mins					Actual	58%	57%	57%	57%	57%	57%								
	Patient Handover to Green - Total Hours Lost > 14 Mins					Actual	4878	4965	4851	4906	4805	4751								
WELL LED	Exec / Non exec visits					Actual								▶▶						
	Q8a "I know who the senior managers are here"	65%	72%	73%	Improve	Actual								▶▶						
	Q5b "The support I get from my immediate manager"	49%	63%	57%	Improve	Actual								▶▶						
	Staff survery response rate	35%	42%	41%	Improve	Actual								▶▶						
	Overall Staff Engagement *(the higher the score the better)*	3.13	3.40	3.41	Improve	Actual								▶▶						
	KF4. Staff motivation at work *(the higher the score the better)*	3.33	3.52	3.67	Improve	Actual								▶▶						
	KF7. Staff ability to contribute towards improvements at work %	37%	46%	48%	Improve	Actual								▶▶						
	KF1. Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.03	3.43	3.46	Improve	Actual								▶▶						

Legend

●	Target is not being met. Position has deteriorated since last month.	●	Target is not being met / No Target Set Position improved / static since last month.	●	Target is being met.

Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement

▶▶ Fast forward. Trend not available

London Ambulance Service NHS
NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**28 November 2017**			
Report title:	**Unaudited Charitable Funds Annual Report & Financial Statements for 2016/17 independently examined by Ernst & Young LLP**			
Agenda item:	**20**			
Report Author(s):	**Michael John, Head of Financial Services**			
Presented by:	**Lorraine Bewes, Director of Finance and Performance**			
History:	**The unaudited Charitable Funds Annual Report & Financial Statements for 2016/17 that have been independently were reviewed by the Charitable Funds Committee on 5 October 2017 and reviewed by the Audit Committee on 6 November 2017 and now require approval from the Trust Board.**			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

As the corporate trustees of the London Ambulance Service charity, we face a statutory requirement to publish an annual report and financial statements to include the annual report; the primary financial statements and notes; a statement on the trustee's responsibilities; and an independent examination report.

- The minimum content for the annual report is set out in the Charities SORP (FRS 102).
- The financial statements are in accordance with the Charities Act 2011.
- The Trust is required to submit the charity's annual report and financial statements to the Charity Commission on or before 31 January 2018.
- The cash balance as at 31 March 2017 was £184k.
- Total income was £32k; this was £160k lower than last year.
- Total expenditure was £164k; this was £162k higher than last year.
- The net movement in funds was (£132k); last year it was £190k.

Independent examiner's statement (page 8)

"In connection with my examination, no matter has come to my attention:

a.) which gives me reasonable cause to believe that in any material respect the requirements:
- to keep accounting records in accordance with section 130 of the 2011 Act; and

- to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

b.) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Recommendation(s):

The Audit Committee has reviewed and endorsed the Unaudited Annual Report and Financial Statements that have been independently examined by Ernst & Young LLP for approval by the Trust Board.

The Trust Board is asked to approve:

1. The unaudited annual report and financial statement of the London Ambulance Service Charitable Fund for 2016/17 that have been independently examined by Ernst & Young LLP; and
2. The Letter of Representation

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Charitable Funds Unaudited Annual Report and Financial Statements for 2016/17 independently examined by Ernst & Young LLP.

1. Purpose

1.1 To present the London Ambulance Service NHS Trust Charitable Funds Annual Report and Financial Statements for 2016/17 for approval that have been independently examined by Ernst & Young LLP.

2. Background

2.1 As the corporate trustees of the LAS Charity, we have a statutory requirement to produce and publish an Annual Report and Financial Statements comprising the Annual Report, the primary financial statements and notes; a statement on the Trustee's responsibilities for the Trust's charitable funds and independent examination report.

2.2 The Annual Report is in accordance with the Charities SORP (FRS 102). The financial statements are in accordance with the Charities Act 2011. The Trust is required to submit these by 31 January 2018.

3. Financial Performance of Charity

3.1 The Charity had a deficit of (£132k) for the year; the deficit was funded from surpluses from previous periods. The deficit was due to a timing difference relating to the Charity receiving a donation of £159k for the purchase of vehicles in 2015/16 and the vehicles being delivered in 2016/17.

3.2 The cash balance as at 31 March 2017 was £184k.

3.3 The income for the year was £32k; this was £160k lower than last year's income of £192k. Last year's income included a donation of £159k to purchase vehicles for the voluntary responder group (VRG).

3.4 The expenditure for the year was £164k; this was £162k higher than last year's expenditure of £2k. This year's expenditure included £159k for cost of purchasing vehicles for the voluntary responder group (VRG).

3.5 The Charity has restricted funds of £54k and general funds of £27k as at 31 March 2017.

3.6 The Charitable Funds Committee and Audit Committee have reviewed the Unaudited Annual Report and Financial Statements for 2016/17 that have been

independently examined by Ernst & Young LLP and confirm that there are no issues that should be brought to the attention of the Trust Board.

4. Independent examiner's statement (page 8)

4.1 In connection with my examination, no matter has come to my attention:

a. which gives me reasonable cause to believe that in any material respect the requirements:

- to keep accounting records in accordance with section 130 of the 2011 Act; and
- to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

b. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

5. Recommendations

5.1 The Trust Board is asked to approve:

- the Charitable Funds Unaudited Annual Report and Financial Statements for 2016/17 that have been independently examined by Ernst & Young LLP; and
- the Letter of Representation.

LONDON AMBULANCE SERVICE CHARITABLE FUND

DRAFT UNAUDITED ANNUAL REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2017

LONDON AMBULANCE SERVICE CHARITABLE FUND

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2017

Foreword

The Charity's annual report and accounts for the year ended 31 March 2017 have been prepared by the Corporate Trustee in accordance with the Statement of Recommended Practice by Charities (SORP FRS 102) as it applies from 1 January 2015, applicable UK Accounting Standards and the Charities Act 2011.

The Charity has a Corporate Trustee, the London Ambulance Service NHS Trust. The members of the Trust Board who served during the financial year were as follows:

Board Member	Designation within the Trust
Heather Lawrence	Chairman
Fionna Moore	Chief Executive (Resigned 31st December 2016)
Andrew Grimshaw	Acting Chief Executive (Appointed 1st January 2017) Director of Finance (up to 31st December 2016)
Jessica Cecil	Non-Executive Director
Nicholas Martin	Non-Executive Director (Resigned 28th February 2017)
John Jones	Non-Executive Director
Robert McFarland	Non-Executive Director
Fergus Cass	Non-Executive Director
Theo De Pencier	Non-Executive Director
Jayne Mee	Non-Executive Director (Appointed 9th January 2017)
Sheila Doyle	Non-Executive Director (Appointed 6th February 2017)
Andrew Bell	Acting Director of Finance (Appointed 1st January 2017)
Paul Woodrow	Director of Operations
Fenella Wrigley	Medical Director
Zoe Packman	Director of Nursing & Quality (Resigned 25th May 2016)
Briony Sloper	Acting Director of Nursing (Appointed 6th June 2016, Resigned 31st December 2016)
Patricia Bain	Chief Quality Officer (Appointed 3rd January 2017)

REFERENCE AND ADMINISTRATIVE DETAILS

The London Ambulance Service Charitable Fund (No 1061191) was entered on the Central Register of Charities on 7 March 1997. It is an NHS Special Purpose Charity.

Charitable funds received by the Charity are accepted, held and administered as funds for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

Trustee

The London Ambulance Service NHS Trust is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and also the law applicable to Charities which is governed by the Charities Act 2011.

The Board has devolved responsibility for the on-going management of the funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

This committee was formed on 7 March 1997 and the names of the people who served during the year as agent for the Corporate Trustee as permitted under regulation 16 of the NHS Trust (Membership and Procedures) Regulations 1990 and reports to the Board Members were as follows:

Heather Lawrence (Chairman)
Andrew Bell (Acting Director of Finance)

Michael John (Head of Financial Services)
Eric Roberts (UNISON representative)
Eddie Brand (UNISON representative)
Mercy Kusotera (Committee Secretary)

The Charitable Funds Committee normally meets once a year and the minutes of the meeting are received by the Trust Board in the public agenda. In addition a sub group of the Charitable Funds Committee meets on a regular basis to review grant applications and financial performance of the fund.

Principle Charitable Fund Adviser to the Board

Andrew Bell, Acting Director of Finance, is the budget holder, who under a scheme of delegated authority approved by the Corporate Trustee, has day-to-day responsibility for the management of the Charitable Fund, and must personally approve, on behalf of the Corporate Trustee, all expenditure over £1,000 with an upper limit of £5,000 using his delegated authority.

Michael John, Head of Financial Services, acts as the principal officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

Principal Office

The principal office, which is also the registered office, for the charity is:

Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London SE1 8SD

Principal Professional Advisers

Bankers

Lloyds Bank plc.
City Office
Bailey Drive
Gillingham Business Park
Gillingham
Kent
ME8 0LS

Independent Examiner

Janet Dawson
Ernst & Young LLP
1 More London Place
London
SE1 2AF

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2017

STRUCTURE, GOVERNANCE AND MANAGEMENT

The charity has two funds, the Voluntary Responders restricted fund and the General Fund. The General Fund was established in 1996 using the model declaration of trust and all the funds held on trust as at the date of registration were part of this fund. The Voluntary Responders Fund was launched in March 2012. This fund supports the work of volunteer lifesavers in the capital.

Members of the Trust Board and the Charitable Funds Committee are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. Non-Executive members of the Trust Board are appointed by the NHS Appointments Commission and Executive members of the Board are subject to recruitment by the NHS Trust Board. The NHS Trust as corporate trustee appoints the Charitable Funds Committee to manage the charitable funds under delegated authority.

Newly appointed members of the Trustees Board and the Charitable Funds Committee receive copies of the standing orders which include the terms of reference for the Charitable Funds Committee.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources;
- Manage and monitor the receipt of income and support/guide any fundraising activities;
- Ensure that best practice is followed in the conduct of its affairs fulfilling all of its legal responsibilities;
- Ensure that the Investment Policy approved by the NHS Trust Board as Corporate Trustee is adhered to and performance is continually reviewed whilst being aware of ethical considerations; and
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The financial record and day to day administration of the funds are dealt with by the Finance Department of the London Ambulance Service NHS Trust whose address is given above.

Trustees' Responsibilities in the Preparation of Financial Statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England & Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing those financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles in the Charities SORP;
- Make judgements and accounting estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2017

The trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the governing document. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Risk Management

The major risks to which the charity is exposed have been identified and considered. They have been reviewed and systems established to mitigate those risks.

ACHIEVEMENTS AND PERFORMANCE

Partnership Working and Networks

London Ambulance Service NHS Trust and its staff are the main beneficiaries of the charity and is a related party by virtue of it being the Corporate Trustee of the charity. By working in partnership with the Trust, the charitable funds are used to best effect and so when deciding on the most beneficial way to use charitable funds; the Corporate Trustee has regard to the main activities and plans of the Trust. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of the fund.

OBJECTIVES AND ACTIVITIES

The Charity has the following objective:

Voluntary Responders Group

To apply the income, and at its discretion, so far as may be permissible, the capital to advance health, save lives and to promote the efficiency of ambulance services, and in particular, but without limitation by the promotion of volunteering within London Ambulance Services' geographical area of responsibility and in relation to its services.

General Fund

To apply the income, at its discretion, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the London Ambulance Service NHS Trust.

The Charitable Funds Committee have agreed that the main purpose of the general fund is to fund projects for the benefit of all employees of the London Ambulance Service NHS Trust.

The London Ambulance Service Charitable Fund is defined as a Public Benefit Entity. The Trustees confirm that they have given due consideration to the Charity Commission's published guidance on the Public Benefit requirements under the Charities Act 2011.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2017

ANNUAL REVIEW

Donations received by the Voluntary Responders Fund are applied to advance health, save lives and to promote the efficiency of ambulance services, particularly, but not limited to, the promotion of volunteering within the geographical area served by the London Ambulance Service.

Donations received by the General Fund in the past and currently are specifically given to thank ambulance staff. Hence, the main charitable activities undertaken by the fund are those which will benefit staff by providing goods and services that the NHS is unable to provide. Typical examples are grants towards improved facilities for staff at ambulance stations.

Grant Making Policy

Each year applications are invited from any member of the London Ambulance Service. Based on their knowledge of the service, the Charitable Funds Committee agrees funding priorities and reviews the applications for quality and value for money.

FINANCIAL REVIEW

Reserves are needed to provide funds, which can be designated to specific projects to enable those projects to be undertaken at short notice.

The level of reserves are monitored and reviewed by the Corporate Trustee, on an annual basis (free reserves at 31 March 2017 were £27,000).

The net assets of the charity as at 31 March 2017 were £81,000 (31 March 2016: £213,000). Overall net assets decreased by £132,000 due to net expenditure of £132,000.

The main source of income of the charity is donations. Total incoming resources for the year were £32,000 (2015/2016: £192,000).

Expenditure totalled £164,000 during the year.

The charity has no employees so relies on the London Ambulance Service NHS Trust staff to review the appropriateness of grant applications. Each year the Charitable Funds Committee sets a budget and reviews income and expenditure against this budget twice a year.

Reserves Policy

The Trustee recognises its obligation to ensure that funds received by the charity should be spent effectively in accordance with the funds objectives. The charity's reserves comprise those funds freely available for its general purposes. The reserves are held at a level that will enable the charitable fund to operate for a year. The charities hold reserves of £3,000 for this purpose.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2017

OUR FUTURE PLANS

The future plans for the London Ambulance Service Charitable Fund is to expand the Volunteer Emergency and Community First Responders schemes in order that more patients can benefit and also to continue to fund projects for the benefit of staff education and welfare.

The Responders Fund has been set-up to support the groups of volunteers that operate under the management of the London Ambulance Services First Responder department. These include community first responders, emergency responders, staff at public access defibrillator sites and members of the public that have received resuscitation training.

The Charity plans to maintain and more actively use their Just Giving website and hold a number of funding raising events over the coming year to procure additional and replacement vehicles to support resuscitation training in the community.

Signed: ……

…… on behalf of the Corporate Trustee

Date: ……

STATEMENT OF TRUSTEES' RESPONSIBILITIES IN RESPECT OF THE TRUSTEES' ANNUAL REPORT AND ACCOUNTS

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the income and expenditure for that period.

In preparing these financial statements, generally accepted practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at the time, and to enable the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the Corporate Trustee:

Date: ……

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF THE LONDON AMBULANCE SERVICE CHARITABLE FUND

I report on the accounts of the London Ambulance Service Charitable Fund for the year ended 31 March 2017**,** which are set out on pages 9 to 21.

This report is made solely to the Charity's trustee, as a body, in accordance with section 149 of the Charities Act 2011 and regulations made under section 149 of that Act. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustee, as a body, for this examination, for this report, or for the statements made.

Respective responsibilities of trustee and independent examiner

The charity's trustee is responsible for the preparation of the accounts. The trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

„ examine the accounts under section 145 of the 2011 Act;

„ to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and

„ to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in any material respect the requirements:

„ to keep accounting records in accordance with section 130 of the 2011 Act; and

„ to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act

have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Janet Dawson
For and on behalf of Ernst & Young LLP
Chartered Accountants
London

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2017

	Note	2016-17 Unrestricted Funds £000	2016-17 Restricted Funds £000	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Income from:					
Donations and Legacies	3	12	20	**32**	22
Charitable activities	4	-	-	-	170
Total income		**12**	**20**	**32**	192
Expenditure on:					
Charitable activities	5	4	160	**164**	2
Total expenditure		**4**	**160**	**164**	2
Net income/ (expenditure)		**8**	**(140)**	**(132)**	190
Net movement in funds		**8**	**(140)**	**(132)**	190
Reconciliation of Funds					
Total funds brought forward		19	194	**213**	23
Total funds carried forward		**27**	**54**	**81**	213

The net movement in funds for the year arises from the charity's continuing operation. No separate statement of total recognised gains and losses has been presented as all such gains and losses have been dealt with in the statement of financial activities.

The notes at pages 12 to 21 form part of these accounts.

BALANCE SHEET AS AT 31 MARCH 2017

	Note	2016-17 Unrestricted Funds £000	2016-17 Restricted Funds £000	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Current Assets					
Stock	6	-	-	-	159
Debtors	7	-	1	1	-
Cash at bank and in hand	8	131	53	**184**	215
Total current assets		**131**	**54**	**185**	374
Creditors: Amounts falling due within one year	9	104	-	**104**	161
Net current assets/ (liabilities)		**27**	**54**	**81**	213
Total assets less current liabilities		**27**	**54**	**81**	213
Total net assets		**27**	**54**	**81**	213
Funds for the charity					
Income Funds:	12				
Restricted fund		-	54	**54**	194
Unrestricted fund		27	-	**27**	19
Total charity funds		**27**	**54**	**81**	213

The accounts set out on pages 9 to 21 were approved by the Corporate Trustee on ……2017, and signed on its behalf by

Signed: ……

…….on behalf of the Corporate Trustee

Date: ……

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017

	Note	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Cash Flows from operating activities:			
Net Cash provided by (used in) operating activities	9	**(31)**	189
Change in cash and cash equivalents in the reporting period		**(31)**	189
Cash and cash equivalents at the beginning of the reporting period	7	**215**	26
Cash and cash equivalents at the end of the reporting period	7	**184**	215

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2017

1. Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared, in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The financial statements have been prepared to give a 'true and fair' and have departed from the charities Accounts and Reports Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The trustees consider that there are no material uncertainties about the London Ambulance Service Charitable fund ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the London Ambulance Service Charitable Fund is a fall in income from donations but the trustees have arrangements in place to mitigate those risks.

Donations and Legacies

Donations and Legacies have been grouped together on the Statement of financial activities.

1.2 Funds Structure

Where the donor has provided for the donation to be sent in furtherance of a specified charitable purpose and has therefore created a legal restriction on use of the funds the income is allocated to a restricted income fund.

The remaining funds held by the charity are classified as unrestricted income funds. The expenditure of these funds is wholly at the trustee's unfettered discretion.

The major funds held under these categories are disclosed at note 11.

1.3 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three conditions can be met:

- entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- probable – it is more likely than not that economic benefits associated with the transaction or gift will flow to the charity; and
- measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms and conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before income is recognised as the entitlement condition will not be satisfied until this point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

Confirmation has been received from the representative of the estate that the payment of the legacy will be made or properly transferred and once all the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimated amount receivable.

1.5 Resource expended and irrecoverable VAT

Liabilities are recognised as resources are expended as soon as there is a legal constructive obligation committing the charity to the expenditure. A liability is recognised where the charity is under a constructive obligation to make a transfer of value to a third party as a result of past transactions or events. All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category.

a. Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity.

b. Charitable activities

Costs of charitable activities comprise all costs identified as wholly or mainly incurred in the pursuit of the charitable objectives.

Grants payable which are payments, made to third parties (including NHS bodies) in the furtherance of the charity's charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. Provisions are made where approval has been given by the trustee due to the approval representing a firm intention which is communicated to the recipient.

c. Allocation of support costs

Support costs are those costs that do not relate directly to a single activity. The support costs have been allocated against charitable activities.

d. Irrecoverable VAT

Irrecoverable VAT is charged as a cost against the activity for which the expenditure was incurred.

1.6 Stock

Stock is stated at the lower of cost and net realisable value.

1.7 Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

1.8 Cash at bank and in hand

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

1.9 Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to pay to settle the debt.

2. Prior Year Comparatives by type of fund

2a. Restricted funds – Statement of Financial Activity for the year ended 31 March 2017

	2016-17 £000	2015-16 £000
Income from:		
Donations and Legacies	**20**	11
Charitable activities	**-**	170
Total income	**20**	181
Expenditure on:		
Charitable activities	**160**	-
Total expenditure	**160**	-
Net income/ (expenditure)	**(140)**	181
Net movement in funds	**(140)**	181
Reconciliation of Funds		
Total fund brought forward	194	13
Total fund carried forward	**54**	194

Restricted funds – Balance sheet for the year ended 31 March 2017

	2016-17 Total £000	2015-16 Total £000
Current Assets		
Stock	**-**	159
Debtors	**1**	-
Cash at bank and in hand	**53**	194
Total current assets	**54**	353
Creditors: Amounts falling due within one year	**-**	159
Net current assets/(liabilities)	**54**	194
Total assets less current liabilities	**54**	194
Total net assets	**54**	194
Funds for the charity		
Restricted fund	**54**	194
Total charity funds	**54**	194

2b. Unrestricted funds – Statement of Financial Activity for the year ended 31 March 2017

	2016-17 £000	2015-16 £000
Income from:		
Donations and Legacies	**12**	11
Total income	**12**	11
Expenditure on:		
Charitable activities	**4**	2
Total expenditure	**4**	2
Net income/ (expenditure)	**8**	9
Net movement in funds	**8**	9
Reconciliation of Funds		
Total funds brought forward	**19**	10
Total funds carried forward	**27**	19

Unrestricted funds – Balance sheet for the year ended 31 March 2017

	2016-17 Total £000	2015-16 Total £000
Current Assets		
Cash at bank and in hand	131	21
Total current assets	**131**	21
Creditors: Amounts falling due within one year	**104**	2
Net current assets/(liabilities)	**27**	19
Total assets less current liabilities	**27**	19
Total net assets	**27**	19
Funds for the charity		
Unrestricted income fund	**27**	19
Total charity funds	**27**	19

3. Income from donations and legacies

	2016-17 Unrestricted Funds £000	2016-17 Restricted Funds £000	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Donations from individuals	8	6	**14**	5
Corporate donations	1	4	**5**	11
Legacies	3	10	**13**	6
	12	**20**	**32**	22

There was two legacies of £13,000 received during the year (2015/2016: £5,594).

4. Income from Charitable Activities

	2016-17 Unrestricted Funds £000	2016-17 Restricted Funds £000	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Donation and Legacies	-	-	-	150
Grants	-	-	-	20
	-	**-**	**-**	170

5. Analysis of charitable expenditure

	Support costs £000	**2016-17 Total Funds £000**	2015-16 Total Funds £000
Goods Donated to Beneficiaries	159	159	0
Staff welfare	5	5	2
	164	**164**	**2**

All grant applications are considered and approved by a sub group of the Charity Funds Committee on behalf of the Corporate Trustee.

The independent examiners remuneration of £2,026 (2015/2016: £2,054) related solely to the independent examination with no other work undertaken (2015/2016: £nil).
The charity has no employees.

6. Stock

	2016-17 Total Funds £000	2015-16 Total Funds £000
Stock	-	159
Total Stock	-	159

7. Debtors

	2016-17 Total Funds £000	2015-16 Total Funds £000
Amounts falling due within one year:		
Other debtors	1	-
Total Debtors	1	-

8. Analysis of cash and cash equivalents

	2016-17 Total Funds £000	2015-16 Total Funds £000
Cash in hand	184	215
Total cash and cash equivalents	184	215

9. Analysis of Liabilities

	2017 Total £000	2016 Total £000
Amounts falling due within one year:		
Trade Creditors	100	159
Accruals	4	2
Total creditors	104	161

10. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2016-17 Total Funds £000	2015-16 Total Funds £000
Net income/ (expenditure) for the reporting period as per the statement of financial activities	(132)	190
	(132)	190
Adjustment for:		
(Increase)/decrease in stock	159	(159)
(Increase) decrease in debtors	(1)	-
Increase/(decrease) in creditors	(57)	158
Net cash provided by (used in) operating activities	(31)	189

11. Allocation of Support Costs and Overhead

Governance costs are those costs which relate to the day to day management of the charity. The governance costs are wholly charged against charitable activities.

12. Analysis of Charitable income funds

a. Restricted funds

	Balance 1 April 2016 £000	Resources expended £000	Incoming resources £000	Balance 31March 2017 £000
Voluntary Responders Fund	194	(160)	10	**44**
	194	**(160)**	**10**	**44**

Name of Fund	**Description, nature and purpose of the fund**
Voluntary Responders Fund	The objects of the restricted fund are to advance health, save lives and to promote the efficiency of ambulance services.

b. Restricted funds

	Balance 1 April 2016 £000	Resources expended £000	Incoming resources £000	Balance 31March 2017 £000
Harrow Staff Fund	-	-	10	10
	-	**-**	**10**	**10**

Name of Fund	**Description, nature and purpose of the fund**
Harrow Staff Fund	The restricted fund is for the benefit of staff operating out of the Harrow area.

c. Unrestricted income funds

	Balance 1 April 2016 £000	Resources expended £000	Incoming resources £000	Balance 31March 2017 £000
General Fund	19	(4)	12	27
	19	**(4)**	**12**	**27**

Name of Fund	**Description, nature and purpose of the fund**
London Ambulance Service General Fund	The objects of the unrestricted fund are that it is available for any charitable purposes relating to the NHS at the absolute discretion of the trustees.

The general fund includes all donations for which the donor has not expressed any preference as to how the funds shall be spent.

13. Related party transactions

The London Ambulance NHS Trust is the corporate trustee of the charity.

During the year, none of the members of the Trust Board, senior NHS Trust staff or parties related to them were beneficiaries of the charity. Neither the corporate trustee nor any member of the NHS Board has received honoraria, emoluments or expenses in the year and the Trustee has not purchased trustee indemnity insurance.

The London Ambulance Service NHS Trust waived the annual administration fee of £2,500 in both the current and previous year.

14. Trustees' remuneration, benefits and expenses

The charity's trustees give their time freely and receive no remuneration for the work that they undertake as trustees.

15. Role of Volunteers

Volunteer Emergency Responders and Community First Responders, are activated alongside LAS employees to provide an additional response to life-threatened or seriously ill or injured patients. If they arrive before the LAS response they are able to provide emergency life support to the patient. For incidents when the volunteer arrives after an LAS solo responder, they have a vital role in providing trained support to the LAS responders, adding significant benefit to patient outcomes.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

Ernst & Young LLP
1 More London Place
London
SE1 2AF

Tel: + 44 20 7951 2000
Fax: + 44 20 7951 1345
ey.com

Independent examiner's report to the trustees of the London Ambulance Service Charitable Fund

I report on the accounts of the London Ambulance Service Charitable Fund for the year ended 31 March 2017**,** which are set out on pages 9 to 21.

This report is made solely to the Charity's trustee, as a body, in accordance with section 149 of the Charities Act 2011 and regulations made under section 149 of that Act. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustee, as a body, for this examination, for this report, or for the statements made.

Respective responsibilities of trustee and independent examiner

The charity's trustee is responsible for the preparation of the accounts. The trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in any material respect the requirements:
   - to keep accounting records in accordance with section 130 of the 2011 Act; and
   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act

   have not been met; or
2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Janet Dawson
For and on behalf of Ernst & Young LLP
Chartered Accountants
London

London Ambulance Service NHS
NHS Trust

28 November 2017

Janet Dawson
Partner
Ernst & Young LLP
1 More Place
London
SE1 2AF

Dear Janet

This representation letter is provided in connection with your examination of the financial statements of the London Ambulance Service Charitable Fund ("the Charity") for the year ended 31 March 2017. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention:

a. which gives you reasonable cause to believe that in any material respect the requirements:

   - to keep accounting records in accordance with section 130 of the 2011 Act;

   and

   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

b. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as Trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

    - Additional information that you have requested from us for the purpose of the examination and

- Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: 28 November 2017.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal advisers.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Grants and Donations

1. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions during the period in the application of such income.

G. Transactions with Trustees

1. The trustees during the period have received no emoluments, pensions, benefits, or compensation for loss of office.

H. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

Yours Faithfully

Signed on behalf of the Trustees

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**			
Date of meeting:	**28 November 2017**			
Report title:	**Trust Board Forward Planner**			
Agenda item:	**21**			
Report Author(s):	**Philippa Harding, Director of Corporate Governance**			
Presented by:	**Philippa Harding, Director of Corporate Governance**			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an updated forward plan for Board meetings until the end of the 2018/19 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas.

This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.

Recommendation(s):

The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2018/19 financial year.

This report relates to the following Board Assurance Framework (BAF) or other risk:

Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒

Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	2017/2018 January - Tuesday 30 January 2018
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Patient Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	
	RM	Quality Assurance Committee Assurance Report
	JM	People & OD Committee Assurance Report
	FC	Finance & Investment Committee Assurance Report
	TdP	
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
Annual Reporting	LB, PH	CQC Inspection readiness
	PH	
	JJ	
	TB	
Strategy & Planning	GE	
	LB	Business and financial planning process
	PG	
Governance	TB	Quality Improvement Plan Update
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	
	PH	
	PH	
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	February - Tuesday 27 February 2018
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Staff Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	Audit Committee Assurance Report
	RM	
	JM	
	FC	
	TdP	Logisitics & Infrastructure Cttee Assurance Report
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	
	LB	
	PG	
Governance	TB	Quality Improvement Plan Update
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	
	PH	
	PH	FTSUP Quarterly Report
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	March - Tuesday 27 March 2018
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Patient Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	
	RM	Quality Assurance Committee Assurance Report
	JM	People & OD Committee Assurance Report
	FC	Finance & Investment Committee Assurance Report
	TdP	
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	Quarterly Streategy Update
	LB	Business and Financial Plan
	PG	Staff Survey Results and Actions
Governance	TB	Quality Improvement Plan Update
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	Approval of Information Goveranance Toolkit
	PH	Annual Corporate Governance Review
	PH	
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

Trust Board forward planner: 2017/18 + 2018/19

		2018/2019	
Area	**Lead**	**April**	**May - Tuesday 29 May 2018**
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		Annual Report and Accounts (incl AGS)
	PH		Self Certification of Compliance with Provdier Licence
	JJ		Audit Committee Annual Report
	TB		Health & Safety Annual Report
Strategy & Planning	GE		
	LB		Business and Financial Plan
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		
			Infection Prevention and Control Annual Report
			Safeguarding Annual Report
			Mental Health Annual Report

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	June	July - Tuesday 31 July 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		
			Patitent Experience Annual Report
			Patient and Public Involvement Annual Report
			Public Education Annual Report

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	August	September - Tuesday 25 September 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	October	November - Tuesday 27 November 2018
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		Audit Committee Assurance Report
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		Logisitics & Infrastructure Cttee Assurance Report
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		
	LB		Business Plan progress review
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	December	January - Tuesday 24 January 2019
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Patient Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		FTSUP Quarterly Report
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	February	March - Tuesday 26 March 2019
Standing items	HL		Welcome and apologies
	All		Declarations of Interest
	HL		Minutes of previous meeting
	HL		Matters arising & action log
	TB		Staff Story
	HL		Report from the Chair
	GE		Report from the CEO
	All		STP Engagement Update
Quality, Performance &	LB		Integrated Quality & Performance Report
	JJ		
	RM		Quality Assurance Committee Assurance Report
	JM		People & OD Committee Assurance Report
	FC		Finance & Investment Committee Assurance Report
	TdP		
	PH		BAF & Corporate Risk Register
	TB		Serious Incident Management
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		Quarterly Streategy Update
	LB		
	PG		
Governance	TB		
	PH		Report from the Trust Secretary
	PH		Trust Board forward planner
	PH		
	PH		
	PH		
Concluding matters	HL		Questions from members of the public
	HL		Any other business
	All		Review of the meeting
Additional reports	TB		Quality Report
	TB		
	RF		
	PG		

London Ambulance Service NHS Trust: Trust Board and Committee meetings schedule 2017/18 + 2018/19

	2017/18										2018/19																					
	November		December		January		February		March		April		May		June		July		August		September		October		November		December		January		February		March	
Monday					1	BH											2						1											
Tuesday					2								1				3						2						1	BH				
Wednesday	1	ELT (f)			3	ELT (f)							2	ELT (i)			4	ELT (i)	1	ELT (f)			3	ELT (i)					2	ELT (f)				
Thursday	2				4		1		1				3				5		2				4		1				3					
Friday	3		1		5		2		2				4		1		6		3				5		2				4		1		1	
Saturday	4		2		6		3		3				5		2		7		4		1		6		3		1		5		2		2	
Sunday	5		3		7		4		4		1		6		3		8		5		2		7		4		2		6		3		3	
Monday	6	Audit	4		8		5		5		2	BH	7	BH	4		9		6		3	Audit*	8		5	Audit	3		7		4		4	
Tuesday	7		5		9	QAC	6	L&IC	6		3		8		5	L&IC	10		7		4		9	L&IC	6		4		8		5	L&IC	5	
Wednesday	8	ELT (i)	6	ELT (i)	10	ELT (i)	7	ELT (i)	7	ELT (i)	4	ELT (i)	9	ELT (i)	6	ELT (i)	11	ELT (f)	8	ELT (i)	5	ELT (i)	10	ELT (i)	7	ELT (i)	5	ELT (f)	9	ELT (i)	6	ELT (i)	6	ELT (i)
Thursday	9		7		11		8	P&OD	8		5		10		7		12	P&OD	9		6	P&OD	11		8	P&OD	6		10	P&OD	7		7	P&OD
Friday	10		8		12		9		9		6		11		8		13		10		7		12		9		7		11		8		8	
Saturday	11		9		13		10		10		7		12		9		14		11		8		13		10		8		12		9		9	
Sunday	12		10		14		11		11		8		13		10		15		12		9		14		11		9		13		10		10	
Monday	13		11		15		12	Audit*	12	P&OD	9		14	P&OD	11		16		13		10		15		12		10		14		11	Audit	11	
Tuesday	14	QAC	12	TB	16	FIC	13		13	FIC	10		15	FIC	12		17		14		11	FIC	16		13	FIC	11		15	FIC	12		12	FIC
Wednesday	15	ELT (f)	13	ELT (f)	17	ELT (f)	14	ELT (f)	14	ELT (f)	11	ELT (f)	16	ELT (f)	13	ELT (f)	18	ELT (i)	15	ELT (f)	12	ELT (f)	17	ELT (f)	14	ELT (f)	12	ELT (i)	16	ELT (f)	13	ELT (f)	13	ELT (f)
Thursday	16		14		18		15		15		12		17	Audit	14		19		16		13		18		15		13		17		14		14	
Friday	17		15		19		16		16		13		18		15		20		17		14		19		16		14		18		15		15	
Saturday	18		16		20		17		17		14		19		16		21		18		15		20		17		15		19		16		16	
Sunday	19		17		21		18		18		15		20		17		22		19		16		21		18		16		20		17		17	
Monday	20	P&OD	18		22		19		19		16	Audit	21		18		23	FIC	20		17		22		19		17		21		18		18	
Tuesday	21		19		23		20		20	QAC	17		22	QAC	19		24	QAC	21		18	QAC	23		20	QAC	18	TB	22	QAC	19		19	QAC
Wednesday	22	ELT (i)	20	ELT (i)	24	ELT (i)	21	ELT (i)	21	ELT (i)	18	ELT (i)	23	ELT (i)	20	ELT (i)	25	ELT (f)	22	ELT (i)	19	ELT (i)	24	ELT (i)	21	ELT (i)	19	ELT (f)	23	ELT (i)	20	ELT (i)	20	ELT (i)
Thursday	23	FIC	21		25		22		22		19		24	Audit/TB*	21		26		23		20		25		22		20		24		21		21	
Friday	24		22		26		23		23		20		25		22		27		24		21		26		23		21		25		22		22	
Saturday	25		23		27		24		24		21		26		23		28		25		22		27		24		22		26		23		23	
Sunday	26		24		28		25		25		22		27		24		29		26		23		28		25		23		27		24		24	
Monday	27		25	BH	29		26		26		23		28	BH	25		30		27	BH	24		29		26		24		28		25		25	
Tuesday	28	TB	26	BH	30	TB	27	TB	27	TB	24	TB	29		26	TB	31	TB	28	TB	25	TB*	30	TB	27	TB	25	BH	29	TB	26	TB	26	TB
Wednesday	29	ELT (f)	27	ELT (f)	31	ELT (f)	28	ELT (f)	28	ELT (f)	25	ELT (f)	30	ELT (f)	27	ELT (f)			29	ELT (f)	26	ELT (f)	31	ELT (f)	28	ELT (f)	26	BH	30	ELT (f)	27	ELT (f)	27	ELT (f)
Thursday	30		28						29		26		31		28				30		27				29		27		31		28		28	
Friday			29						30	BH	27				29				31		28				30		28						29	
Saturday			30						31		28				30						29						29						30	
Sunday			31								29										30						30						31	
Monday											30																31							
Tuesday																																		

(09.00-16.00)		TRUST BOARD
(14.00-17.00)		Audit Committee
(14.00-17.00)		Finance & Investment Committee
(14.00-17.00)		Logistics & Infrastructure Committee
(14.00-17.00)		People & Organisational Development committee
(14.00-17.00)		Quality Assurance Committee
ad hoc		Nominations & Remunerations Committee
(13.00-14.00)		Charitable Funds Committee
		Bank holiday /weekend
(09.00-12.00)		Executive leadership team (f = formal) (i = informal)

N.B 25/09/17 - AGM to be held in the evening

N.B 24/05/18 - Audit Cttee meeting in the morning ahead of TB meeting

N.B 12/02/18 & 03/09/18 - Charitable Funds Cttee meeting ahead of Audit Committee meeting

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Quality Report – November 2017			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Various			
Presented by:	Dr Patricia Bain, Chief Quality Officer Dr Fenella Wrigley, Medical Director			
History:	Quality Assurance Committee			
Status:	☒	Assurance	☐	Discussion
	☐	Decision	☐	Information

Background / Purpose:

The purpose of this paper is to provide assurance to Board of the standards of care provided by the London Ambulance Service during the month of October for which the data in this report relates (unless otherwise stated). For those instances where aspects of care are identified as having fallen below acceptable standards the actions and assurances required to prompt an improvement are clearly detailed. The report also highlights areas of good practice and areas where progress has been made.

Recommendation(s):

The Board is asked to note the report (information from which has been incorporated into the integrated Quality and Performance Report).

Links to Board Assurance Framework (BAF) and key risks:

BAF Risk 7 - Performance falls at staff changeover time - this report evidences a decrease in the number of declared Serious Incidents at the shift changeover time

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service
NHS Trust

Quality Report

November 2017

All data pertains to October 2017 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

Legend
- Above Target
- Within 5% of Target
- Over 5% from Target

Executive Summary: Exception Report (Positive)

Safety

- No reported incidents relating to adrenaline 1:1000 administration
- Reduction in retention of morphine by staff off duty
- No reports of PGD breaches
- The number of controlled drugs lost has reduced to one this month, from 5 in September.
- A thematic review which included 79 serious incident investigation has been conducted (Jan to Sep17)
- There have been no serious incidents at the shift changeover period. In addition, there are no overdue serious incidents.
- Deep dives into the top three categories will take place over the next month
- Hand hygiene is increasing, and vehicle deep cleans are maintaining their targets

Actions & Assurance

- Ongoing monitoring via Datix incident reporting system.
- Continue robust management of staff retaining morphine off duty
- Thematic review revealed the top three categories to be:
    - Dispatched and call
    - Clinical Assessment
    - Clinical Treatment

Effectiveness

- A further nine dates have been set for November to provide updated Datix training

Actions & Assurance

Caring

- LAS Staff acknowledged for good practice around the resuscitation of pregnant women in regards to resuscitation, communication and care on transfer to hospital.

Actions & Assurance

Executive Summary: Exception Report (Improvement Required)

Safety

- Unaccounted for loss of two ampoules of morphine
- Breakages of morphine ampoules
- There is a decrease in the number of patient incidents being reported, however November is on track to have this number stabilise
- There are issues with the incident category type, which may result in patient safety incidents being categorised as Trust (and vice versa). The categories and sub-categories are undergoing a review in conjunction with the NRLS
- Improvements have been made to the Datix system, however these improvements will take time to embed as staff will be receiving feedback on a regular basis from November for incidents reported in October
- Level 2 safeguarding training has been included in CSR2017.2
- The rate of patient related adverse incidents is decreasing, however it is expected to increase with a better reporting culture
- IPC – splashes to the face remains an issue
- Only 50% of the total number of personal protective packs ordered were delivered and this has had an impact on roll out of the packs

Actions & Assurance

- Continue to work closely with Metropolitan Police controlled drugs liaison officers
- Progress roll out of secure drugs rooms on stations to enhanced security and traceability
- Procure drugs ampoule holders and investigate alternative morphine supply with different packaging.
- All patient safety incidents are being quality checked prior to being uploaded to the NRLS for accuracy

- As this module has only just commenced it may take time to see an increase in the number of staff having undertaken level 2 safeguarding training. Completion rates will be monitored during the training window.

Effectiveness

- The staff survey and friends and family survey has reported that staff receiving feedback from incidents is low
- ROSC at hospital has declined for October by 21% and is 13% below target, this is thought to be a natural variation given the sample size is circa 300 patients per month. Similar variations have been observed previously.

Actions & Assurance

- The Quality Governance and Assurance Team will monitor the response to the surveys over the coming months. It is excepted that the feedback figures will increase due to the automated email system being activated within Datix
- The Clinical Audit and Research Unit will review this variation as part of the annual report where the sample size will be larger and therefore provide a clearer representation of ROSC performance.

Caring

- There has been an increase in the number of complaints relating to patient treatment. The reason for this is unknown but is believed to be a natural variation.

Actions & Assurance

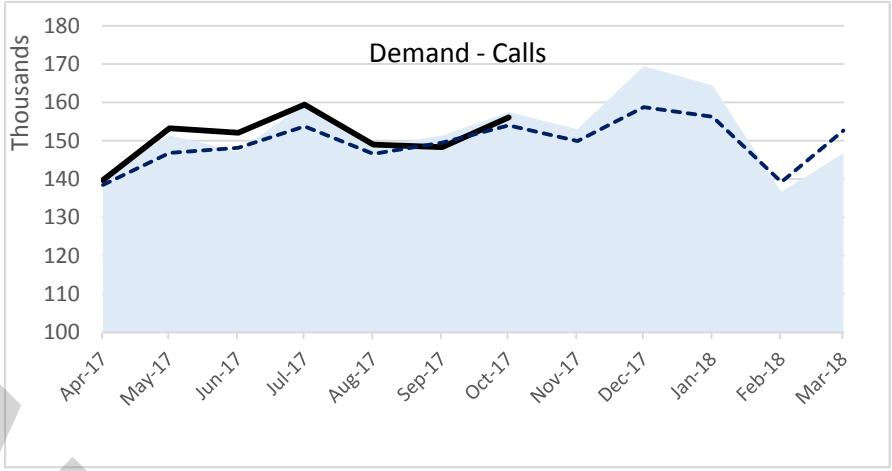
- Patient Experience Department are monitoring this increase and will attempt to identify any potential patterns.

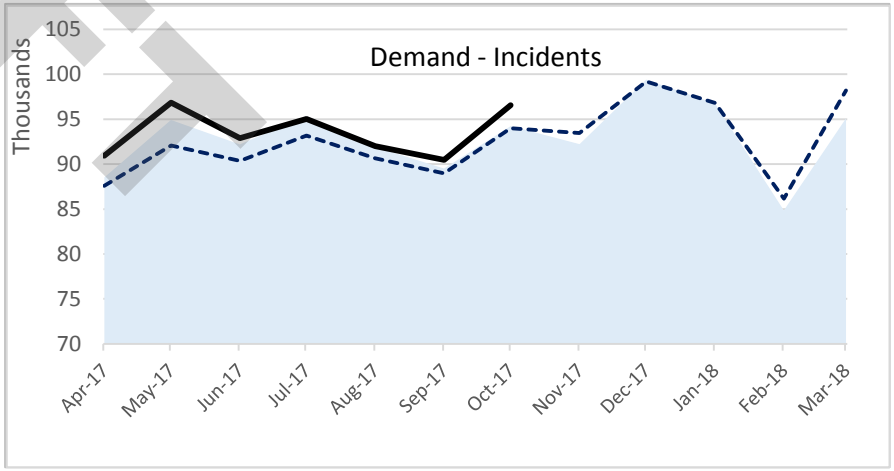
Organisational Pressure

Pressures

- In November the Trust was heavily engaged in the introduction of the national Ambulance Response Program (ARP). This required a significant level of involvement from staff across many directorates to ensure the Trust and its staff were well prepared for its implementation on the night of 1st November.
- Following implementation there have been 3 incident reports relating to ARP recorded on the Trust incident reporting system (Datix). All of these incidents have been rated as 'No Harm'.
- Feedback from staff has highlighted a review of the response provided to patients presenting with bleeding is required. This was originally planned as part of the national post implementation review in May 2018 however it has been requested this be undertaken sooner given there have been similar experiences nationally.

Performance





Ambulance Response Program

Following one of the largest clinical ambulance trials in the world led by NHS England, the London Ambulance Service successfully implemented the nationally approved Ambulance Response Program on the night of 31st October.

The changes focus on making sure the best, high quality and most appropriate response is provided for every patient.

Prior to implementation, ambulance services were allowed up to 60 seconds from receiving a call to sending a vehicle. However given the short timeframe, this didn't allow enough time to ensure the correct response for the patients condition was always dispatched. So from now on call handlers are given more time to assess 999 calls that are not immediately life-threatening. This will enable them to identify patients' needs better in order to send the most appropriate response.

There are now 4 categories of call;

Category 1 – Calls from people with life-threatening illnesses/injuries (i.e. Cardiac Arrest, Choking, Unconscious, fitting)

Category 2 – Emergency Calls from people with a potentially serious condition (i.e. Stroke, chest pain, burns)

Category 3 – Urgent Calls (i.e. Falls, diabetic problems, isolated limb injuries, abdominal pain)

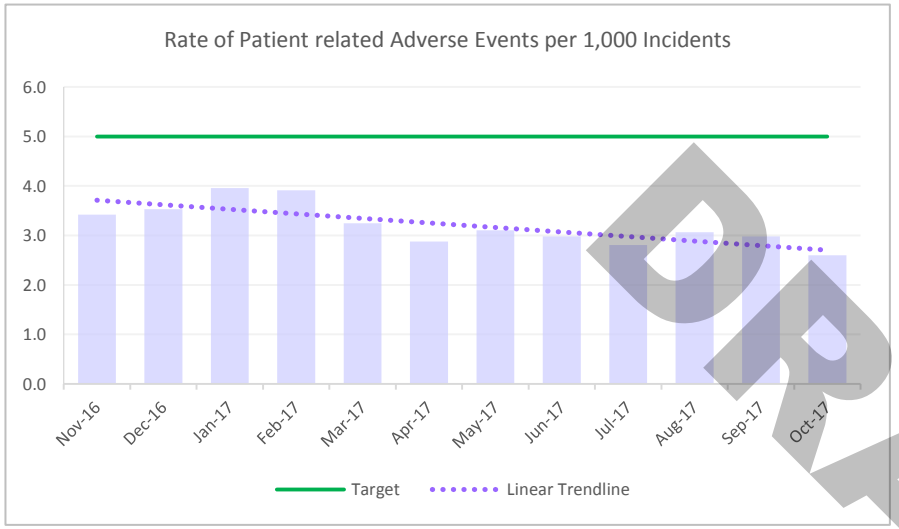
Category 4 – Less Urgent (i.e. Diarrhoea, Vomiting, non-traumatic back pain, calls from healthcare professionals)

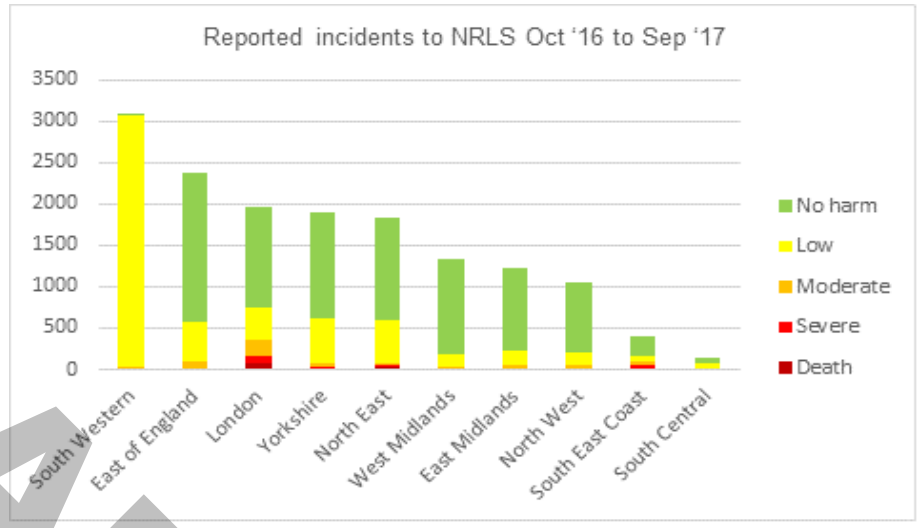
Under the new system early recognition of life-threatening conditions, particularly those patients in cardiac arrest or who are unconscious, will increase. A new set of pre-triage questions identifies those patients in need of the fastest response.

The new targets will also free up more vehicles and staff to respond to emergencies for example; for a stroke patient this means that the ambulance service will be able to send an ambulance to convey them to hospital, when previously a motorbike or rapid response vehicle would arrive and 'stop the clock' but was not able to transport them to hospital.

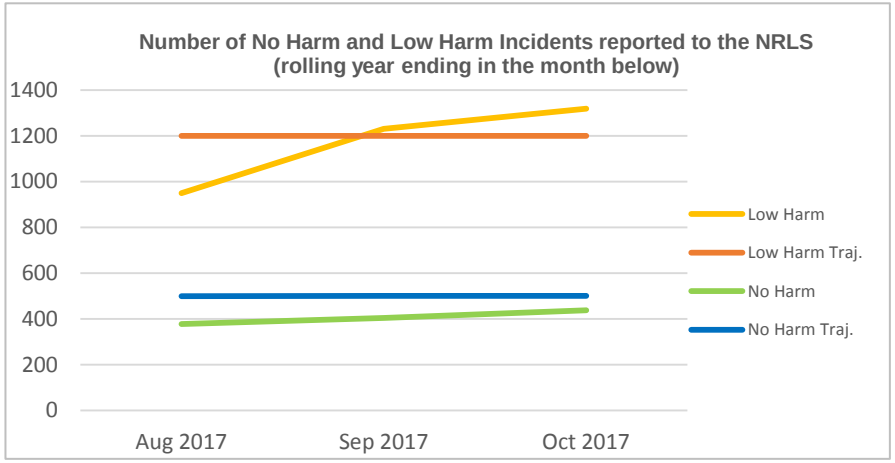
Patient Safety

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain





Actions and Assurance



National Reporting and Benchmarking

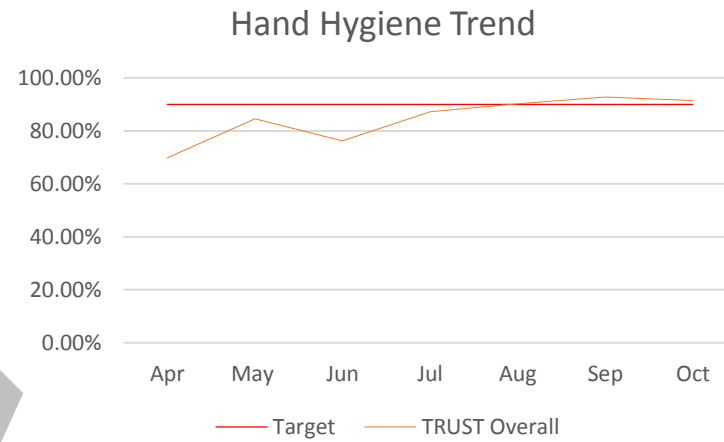
- Data is provided by the NRLS on the 18th of each month for a rolling year ending the month prior
- The LAS has reported a significantly higher number of deaths than other Ambulance Trusts due to the severity of incidents not being changed upon review.
- A quality check process has been put in place from October 2017, which includes a review of the reported severity. As the data includes incidents investigated prior to this quality check, this number will take time to decrease.
- The number of no harm incidents has been above trajectory since the rolling year ending September 2017, and is continuing to increase (see left)
- The number of low harm incidents is currently under the trajectory but increasing and at the current rate is due to match trajectory in the rolling year ending December 2017
- Please note as at 14th November there are 71 patient safety incidents within Quality Check that need to be reported to the NRLS, which will increase the numbers

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Hand Hygiene Compliance 2017 – 2018 (Trust Compliance target: 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	
TRUST Overall	69.84%	84.54%	76.24%	87.20%	90.22%	92.78%	91.44%	84.61%
North East	97.40%	90.60%	60.90%	57.00%	95.30%	100.00%	67.00%	81.17%
North Central	100.00%	100.00%	48.90%	89.00%	100.00%	100.00%	96.70%	90.66%
North West	56.00%	73.80%	92.00%	95.00%	100.00%	76.40%	97.50%	84.39%
South East	33.30%	95.80%	95.80%	95.00%	62.00%	100.00%	96.00%	82.56%
South West	62.50%	62.50%	83.60%	100.00%	93.80%	87.50%	100.00%	84.27%



Performance

- All stations except one in North East submitted their hand Hygiene OWR data this month.
- All stations except North East met the 90% target
- Overall Trust compliance for the month of September was 91.44%.
- The trend over the last 2 quarters is demonstrating an improvement in compliance

Actions

- Continue to monitor locally by QGAMs and by the IPC team
- Closer liaison and communication between Sector Quality and IPC Team
- E-audit tool via Perfect Ward system is being explored to ensure consistency of data, reduce transcription errors, and just-in-time performance data accessibility for monitoring and management
- Implement Hand Hygiene Training session at Trust Induction as soon as possible – not possible to consider inclusion until Q4 at the earliest
- Support IPC Champions with training equipment (UV light and disclosing cream) to ensure long-term consistent practice

Assurance

- Last 2 quarters performance is showing an upward trend – improvement is demonstrated
- Monitoring at Sector, by IPC Team monthly, and at quarterly ICDG, IPCC

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly IPC Training Compliance 2017 -2018 (Trust Compliance target: 90%)

TRUST Overall	Apr	May	Jun	Jul	Aug	Sep	Oct
Level 1 *	87.80%	88.18%	87.96%	88.50%	91.56%	91.88%	91.31%
Level 2 *	87%	84.92%	82.30%	78.28%	78.15%	79.73%	77.41%
Level 1 (No: trained)	4471/5093	4491/5093	4493/5108	4510/5096	4634/5061	4707/5123	4719/5168
Level 2 (No: trained)	3383/3887	3288/3872	3200/3888	3039/3882	3018/3862	3128/3923	3081/3980

Performance

- Robust data continues to be provided via the monthly training dashboard for LAS employees
- Overall compliance for LAS employees are as follow, for October:
  - Level 1 continues to be compliant against target of 90% for the second month, 91.31% achieved
  - Level 2 achieved this month 77.41%, fractionally lower than September

Actions

- To ensure that IPC is well embedded in the Trust, all new staff should have access to face-face training in hand hygiene and an understanding of their roles in the prevention and control of infections – IPC session to be Corporate Trust Inductions; unable to consider inclusion of IPC session until Q4.
- Front line staff are able to access e-learning Level 2 IPC Training
- Data capture for other groups e.g Bank staff is being progressed
- Assurance data from TPAP, CRs/ERs to be streamlined and routinely submitted; delegates to be identified for data submission during absence
- Work with system leads to ensure that all courses undertaken (external) equivalent to or higher than Level 2 are appropriately recorded in the LAS system

Assurance

- Data capture system implemented, is providing robust monthly data for Level 1 and 2 IPC training
- E-learning packages Level 1 & 2 are accessible to staff – this should facilitate access and increase uptake of training
- Support from the DIPC to ensure IPC is in the new Induction
- Oversight by the IPC team monthly and quarterly at ICDG

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

6-Weekly Vehicle Deep Clean 2017-2018 (Trust target: 90%)								
	Apr	May	Jun	Jul	Aug*	Sep	Oct	YTD
TRUST Overall	97%	97%	94.80%	94.30%	96.80%	95.72%	93%	96%
North East	95%	95%	97.80%	96.20%	96%	97.00%	98%	96%
North Central	99%	99%	82.50%	91.20%	97%	97%	97%	95%
North West	99%	99%	98%	98%	98%	96.00%	96%	98%
South East	99%	98%	98.30%	95.50%	97%	98.00%	98%	98%
South West	97%	97%	94%	94%	96%	98.00%	99%	96%
Others							95%	
HART							65%	
NETS	93%	93%	98.30%	91%	-	88.33%	96%	93%

Performance

- 6 weekly deep cleaning continues to demonstrate good levels of compliance - performance achieved 93% against a target of 90% this month;
- Trust overall compliance have over the last 6 months consistently exceeded the 90% target set
- ATP swabbing to provide evidence of the quality of cleaning is continuing (3/5 sectors completed so far)
- All 14 Vehicle Preparation Hubs are now in full operation since July, and Phase 2 Vehicle Preparation project is now underway, aimed at embedding the improvements achieved under Phase 1 and developing new areas to enhance support for Operations.

Actions

- Analyse and report results of ATP swabs and triangulate with the results provided by the contractor to provide assurance re quality of the cleaning for Q3
- Continue to monitor monthly by IPC team, quarterly at ICDG and IPCC

Assurance

- Monitoring continues by IPC team, ICDG, IPCC
- Robust monitoring of the Hub contract as above by Logistics
- Evidence of completion of Phase 1 of the VP project in July and initiation of Phase 2

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Premises Cleaning data from Stations October 2017 (Trust target: 90%)								
	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
TRUST Overall	96%	96.40%	96.70%	98.20%	78.65%	92.00%	98.15%	94.00%
North East	92%	93%	95%	96%	97.30%	64.30%	96.60%	91.00%
North Central	99%	99%	96%	100%	66.70%	66.70%	100%	90.00%
North West	96%	95.40%	97%	98%	98%	94%	98%	97.00%
South East	97%	97%	97%	98%	33%	98%	97.66%	88.23%
South West	96%	98.50%	98.50%	99%	98.25%	98.25%	98.50%	98%
HART							97.56%	

Performance and actions if require:

- October data is showing overall the premises cleaning standards is demonstrating compliance 98.15% against a target of 90%

- Compliance in South East Sector dipped in October. IPC team is working with the stations to improve standards
- IPC audit of the remaining 30 stations have been completed and a report has been produced for submission to ICDG in November. All 70 stations action plans are being followed up and areas of concerns will be addressed with local management with support from Champions

- **Actions**: Continue local monitoring by sectors; complete analysis of sector data received by IPC team; IPC to work with all stations to ensure completion of actions identified in the audits

Assurance

- Monitoring at ICDG and IPCC meetings, and by the IPC team
- Dedicated team member to provide support and advise to assist in the closure of the audit loop
- Report completed

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

H&S Incidents by Sub-category	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Total	CAT
Exposure to bodily fluids	43	45	6		94	IPC
Incident involving broken ampoule or vial	11	11	5		27	IPC
Needle stick injury - Cannula (contaminated)	11	10	3		24	IPC
Razor injury (clean)	7	4			11	IPC
Bit by a person	4	3	1		8	IPC/Sec
Needle stick injury - IM (contaminated)	3	1	3		7	IPC
Needle stick injury - IM (clean)	0	3	1		4	IPC
Lancets injury (contaminated)	3				3	IPC
Needle stick injury - Cannula (clean)	0	1	2		3	IPC
Lancets injury (clean)	2				2	IPC
Needle stick injury - sub-cutaneous (contaminated)	2				2	IPC
Contact with sharps (includes needle stick)	0	1	1		2	IPC
Razor injury (contaminated)	1				1	IPC
Needle stick injury - sub-cutaneous (clean)	0				0	IPC

Performance

YTD performance data was extracted from Datix by the H&S team.

- 188 Incidents have been reported to date. Of these 94 (50%) relates to Body Fluid Exposure (BFE), with most not using facial protection. However in some instances, staff was not in a position to utilize PPE as BFE was not predicted
- Clean sharps injury 20 to date; contaminated sharps injury 37 to date. October data was analysed for contaminated incidents - it was found an incident was wrongly categorized; another was due to erratic patient behavior who was under the influence of substances; 3 near misses where used canulae were found but did not cause injuries; and 5 actual incidents due to poor practice
- Personal protective equipment are available for use in the IPC Vehicle packs; personal pack of integrated facemask and eyeshield has arrived, however inadequate numbers were supplied; affecting full rollout

Actions

- Ensure personal PPE pack is implemented by Q3
- Re-iterate safe practice and enhance practice through local sectors, IPC Champions
- Continuing monitoring and challenging of poor practice when observed
- Continue to engage with specific groups/influencers and forge alliances to enhance practice
- Closer working with PAM OHS to understand the issues and the outcomes/impact on staff affected. Agreed November: IPC team will attend PAM Contract meetings and they will attend future IPCC meetings to provide progress updates

Assurance

- Datix incident monitoring continues by the IPC team, and trends at ICDG, IPCC
- PAM OHS provides management and oversight through OHS contract

Safety Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

All reported incidents and their trends reported 30th September 2016 to 30th September 2017

	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Total
Dispatch & call	1	70	75	80	86	80	75	58	41	49	55	73	65	808
Failure of device / equipment	5	40	46	39	43	40	50	38	54	25	41	48	43	512
Manual handling injury - lifting patient	3	41	34	46	47	27	15	25	29	30	42	32	32	403
Lack / unavailability of device / equipment	2	60	69	43	30	36	27	20	23	19	19	15	18	381
Vehicle defect	0	14	22	22	40	22	38	42	33	39	42	30	22	366
Non-medical equipment	7	45	33	44	54	57	32	13	17	16	11	13	10	352
General assault	1	31	29	23	28	28	34	21	26	25	50	32	21	349
Verbal abuse	3	20	17	21	18	13	18	26	22	22	39	38	36	293
Other violence or abuse	0	18	15	21	23	20	23	28	24	11	28	24	26	261
Medication	3	22	36	42	21	19	14	17	21	17	22	9	16	259
Total	25	361	376	381	390	342	326	288	290	253	349	314	289	3984

The most frequent incident types reported across the Trust are highlighted in the table above. This table illustrates a significant increase in incident reporting from October 2016 and this corresponds with the introduction of DatixWeb within the organisation.

Medicines Management & Drug availability

Following concerns related to drug pack availability by clinical staff, 800 new drug packs were purchased and released into the system. This resulted in a significant decrease in the number of incident reports where a drug was not available to be administered to a patient.

H&S (Assault & Manual Handling)

The trust have committed to including manual handling into the Core Skills Refresher curriculum on a rolling basis. In addition all frontline vehicles have been equipped with 'Spit Kits' which contain swabs that can be used as evidence in criminal proceedings.

Non-medical equipment and availability

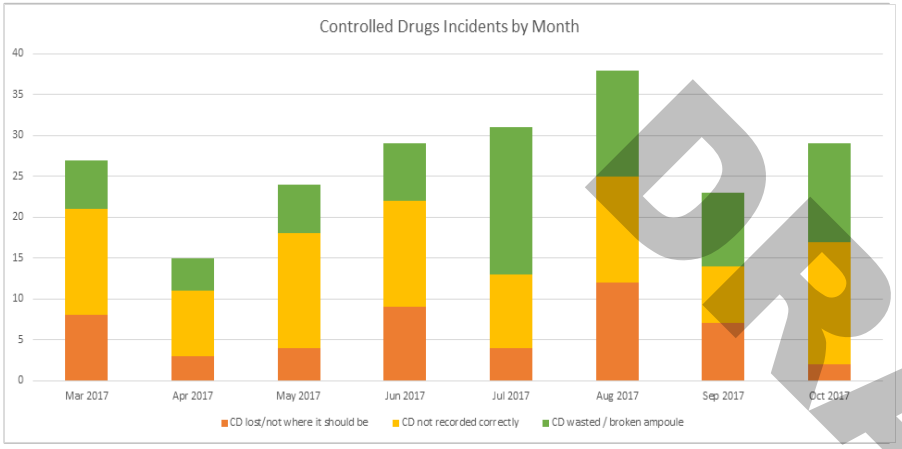
Staff told us the didn't always have the equipment they needed to do their jobs. As a result the Trust have introduced 24hr Vehicle Preparation Hubs where teams of dedicated staff are tasked with ensuring vehicles meet IPC standards and are fully equipped. This has resulted in a significant decrease in the number of incident reports.

Dispatch & Call

20% of all reported incidents have related to the triage of emergency calls and the dispatch of resources. A thematic review has been undertaken by the Governance team and a report has been produced which will be presented at Trust board.

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- One unaccounted for loss involving two ampoules of morphine.
- Other controlled drugs incidents as follows
    - Morphine retained by staff off duty (n=2)
    - Documentation errors (n=11)
    - CD register full or damaged (n=2)
    - Ampoules of morphine (n=11) and midazolam (n=1) broken.
- Total of 49 non-controlled drugs issues including the following
    - Discrepancies in drug stocks with KitPrep app (n=15)
    - Medicines found in wrong location and/or out of date (n=20)
    - Access codes written on walls (n=3)
    - Damaged or incomplete drugs packs (n=4)
    - Issues with drug storage facilities (n=4)
    - Errors or omissions in drugs usage documentation (n=3)

Actions

- Increase in controlled drugs breakages may have resulted from new style morphine packaging therefore ampoule tray holders being procured from supplying pharmacy.
- Medicines management e-learning programme now live as part of Core Skills Refresher
- Planned trial of medical gases tracking system via Logistics Support Unit
- Stepwise personal issue of Abloy electronic keys to staff to facilitate traceable access at stations where secure drugs rooms are being installed.
- Delivery of further medicines management training to new Clinical Team Leaders during November 2017

Assurance

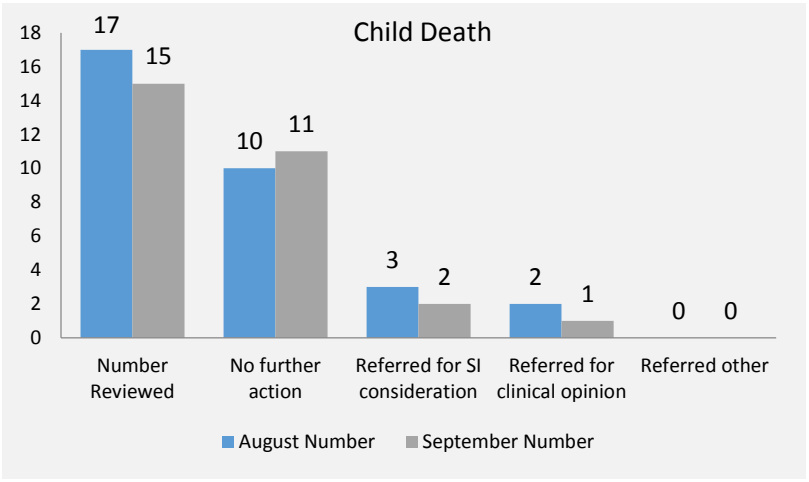
- No incidents of inappropriate administration of adrenaline 1:1000
- Pre CQC Mock Inspections ongoing to identify medicines management issues
- Roll out of secure drugs rooms on station project predicted to reduce unaccounted for controlled drugs losses and breakages due to enhanced security and purpose designed facilities.

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

Referrals and Concerns Raised with Local Authority					
	Adults Safeguarding	Adults Welfare	Children	Total Referrals	% of Incidents
Jan-17	387	852	442	1681	1.70%
Feb-17	316	652	553	1521	1.80%
Mar-17	430	657	748	1835	1.90%
Apr-17	406	595	715	1716	1.90%
May-17	366	680	753	1799	1.90%
Jun-17	385	708	787	1880	2.00%
Jul-17	379	656	735	1770	1.90%
Aug-17	366	666	622	1654	1.80%
Sep-17	369	623	667	1659	1.80%

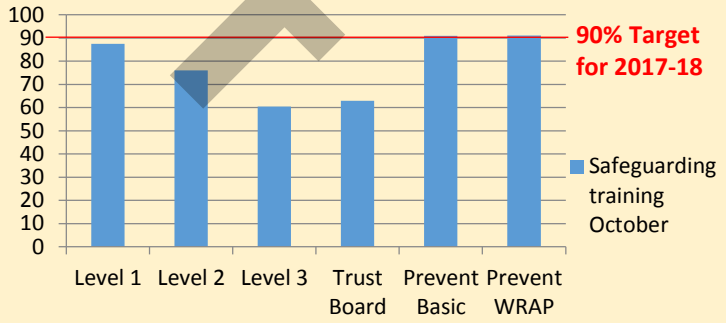
Referrals remain static at around 1.80%



Local Partnership Working Attendance at Rapid Response Meetings(RRM)

The Trust continues to engage with statutory RRM and are currently on target in 4 of the 6 areas.

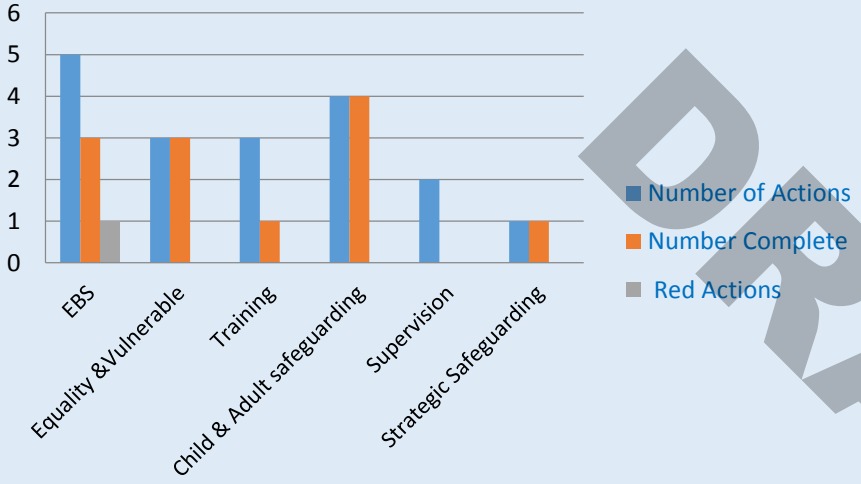
Safeguarding Training October

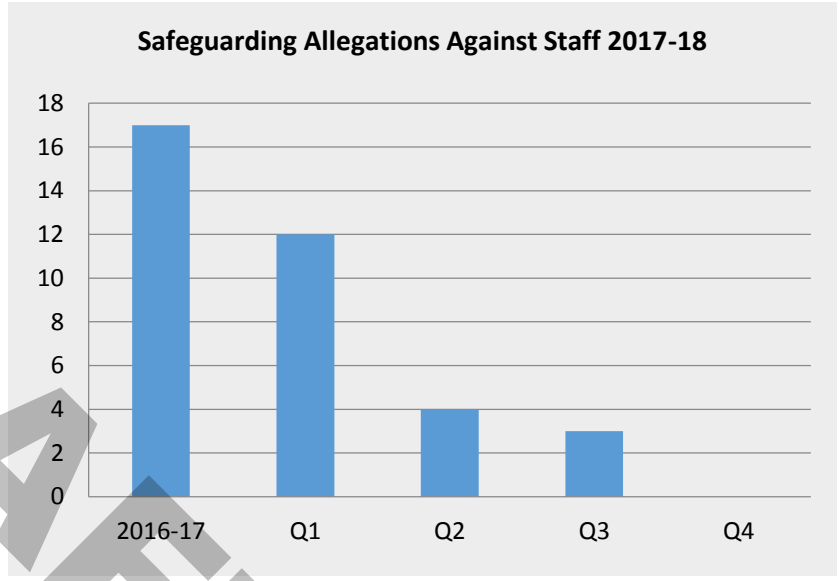


Training for level 2 commenced in CSR2017.2 this week. Level 3 training in ongoing and Trust Board training is booked for January

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain





Work plan progressing well apart from ongoing blockage of additional staff for EBS to move fully to 24/7 telephone referrals. This has been outstanding for over 2 years.

Allegations are continuing to be reported, most are unfounded on investigation. No serious cases to note at present.

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Jul-17	Aug-17	Sep-17	Oct-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	31%	34%	31%		↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	56%	51%	63%	42%		↓			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	92%	G	93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	G	70%	70%	66%	74%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	65%	R	67%	63%	65%	64%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	97%	96%		↓			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:34	00:35	00:34		↓					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:42	00:41		↑					
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	88%	94%			↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	1.72%	3.61%			↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98%	97%		↓		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	91%	91%	91%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	96%	96%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		95%			↓		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%		97%		↔			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	79%	89%	90%	89%	↓			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)	85%										LQ11	✓	

Actions

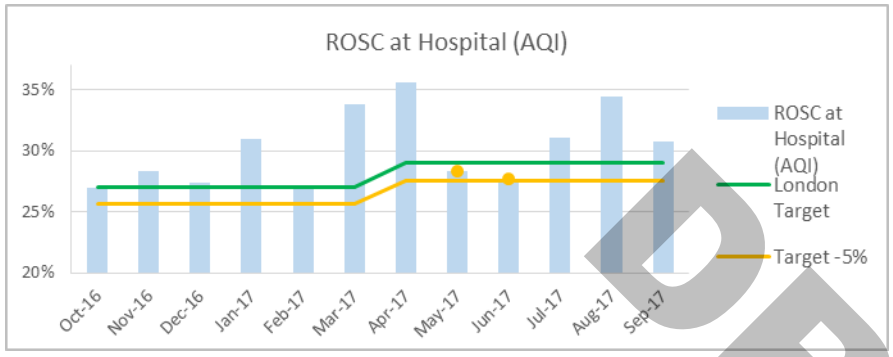
- 17 members of staff attended this quarter's Evidence for Practice session which focused on a retrospective study led by CARU on Double Sequential Defibrillation in cardiac arrest and recently published in *Resuscitation*. Evidence for Practice provides an opportunity for attendees to discuss research papers and their relevance to the Service in a relaxed and friendly environment.

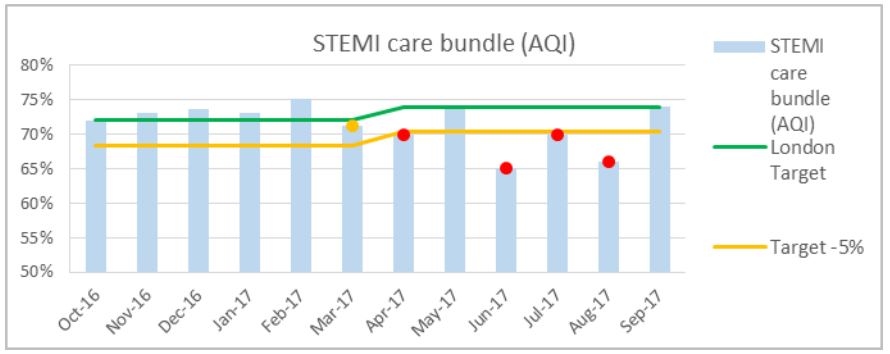
Assurance

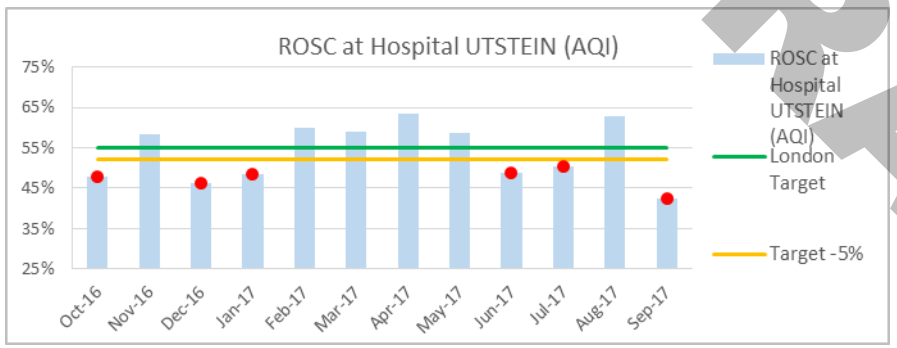
- In September we saw the first reduction in CPI completion since May, however the highest proportion of PRFs so far this year were audited by Team Leaders. CARU continue to facilitate additional CPI training with 26 mentors, 10 prospective Team Leaders and 5 members of staff on restricted duties all receiving training on how to undertake CPI audits in October.

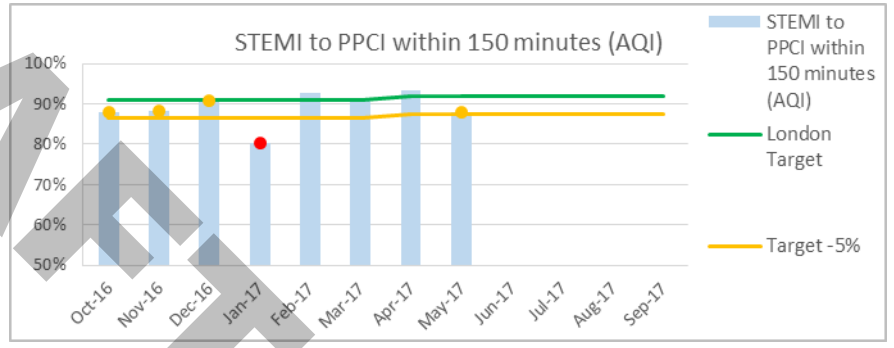
Effectiveness (Clinical AQIs)

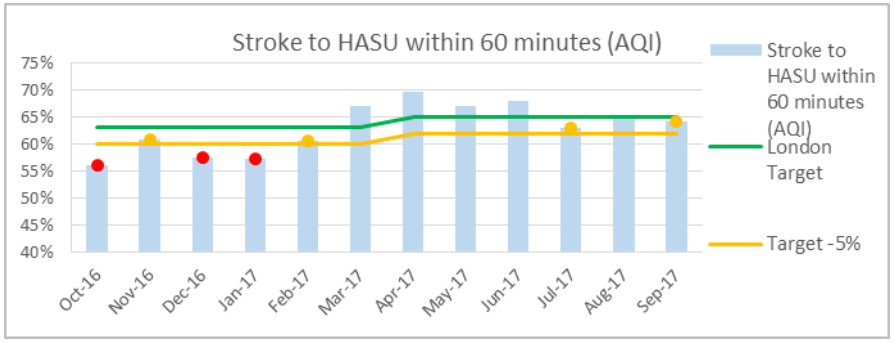
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

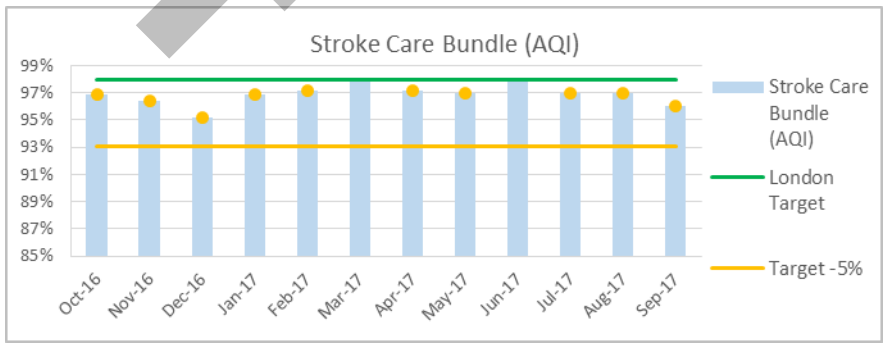








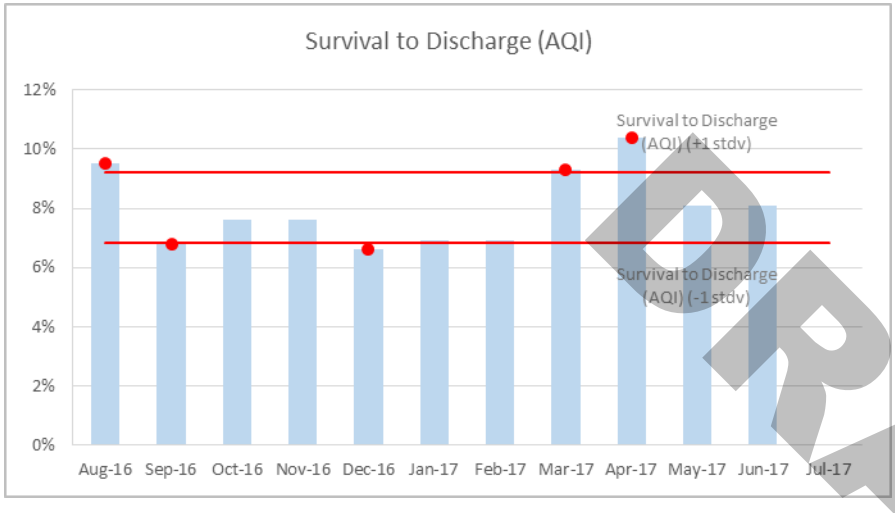


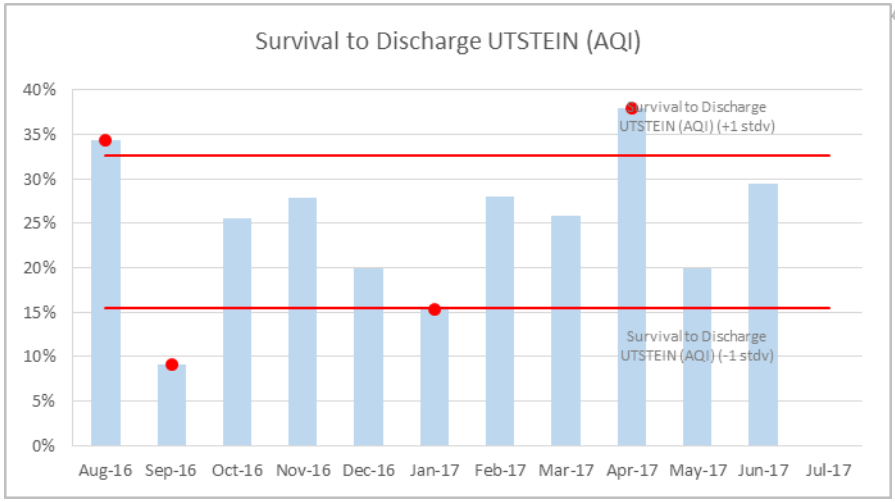


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Effectiveness (Clinical AQIs)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





AQI: Narrative

- We continued to see fluctuations in ROSC for the overall group in September. For the Utstein group, ROSC was the lowest it has been this financial year.
- Survival to discharge for the Overall Group remained consistent in June. However, for the Utstein Group we saw an increase compared to May*.
- In September compliance to the STEMI care bundle returned to the highest level we have seen this financial year, 74%. The percentage of patients who received PPCI within 150 minutes also reached a high of 95% in June*.
- We saw a slight decrease in compliance to the Stroke care bundle in September and the percentage of patients who arrived at a HASU within 60 minutes continues to fluctuate.

*Please note there is a three month time lag to receive hospital outcomes.

AQI: Action

- Nine crews received feedback as the clinical care recorded on the PRF was not in line with guidelines. All nine patients were in cardiac arrest.

AQI: Assurance

- CARU continue to send messages to staff regarding the importance of providing the full care bundle in the monthly care packs for STEMI and Stroke patients.

* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Clinical Audit: Latest project summary

In October CARU published their clinical audit report of the care provided to patients with a genuine illness treated at the "No Duff Medical Centre" during the Exercise Unified Response 2016. The results showed:

- 76% of patients had full set of initial observations; only 57% had a final set
- History of the event and drugs given were well recorded (both 96%)
- Only 63% of patients were left with a responsible adult and 76% given appropriate advice prior to discharge

Recommended actions to improve documentation of care at future events:

- To explore the feasibility of including event call signs into the CPIs
- To put further support mechanisms in place for clinicians who are not normally deployed on frontline duties

Research Actions & Outcomes

Paramedic-2: The recruitment phase of the study has now finished with the last patient of the trial recruited by the LAS. Since the beginning of the study 2102 patients have been recruited by the LAS; 8100 in total across the participating Ambulances Services. Follow up of survivors is on going.

RIGHT-2: 108 patients have been recruited since the beginning of the study (contractual target =180). Study is to be extended until the end of May 2018.

ARREST: The training video is currently being filmed.

MATTS (Major trauma Triage Tool Study): This study is being developed in partnership with the University of Sheffield. The project has been submitted for the 2nd round of bidding to NIHR HTA for £825,000.

Clinical Audit: Progress

Good progress continues to be made against the clinical audit work plan:

- Two clinical audit reports are due to be released in November:
  - the recognition, assessment and treatment of patients in hypovolaemic shock
  - the management of patients who have taken an intentional overdose
- We are working on a further eight projects and facilitating three members of staff to undertake their own clinical audit projects. Five projects are yet to commence

Actions & Assurance

The Clinical Audit Annual Report (2016-17) was published summarising: published projects; continuous clinical audit activity; national clinical audit; staff engagement, and patient and public involvement in clinical audit.

Five clinical audit actions were completed in October:

- The adrenaline infographic was posted on LiA and hard copies sent to ambulance stations
- The EUR 2016 No Duff report was also shared with the EPRR; Medical Directorate; CRU and CFRs
- Medicine Management Group reviewed paediatric analgesic options
- A Sickle Cell article was published in Governance in Action

There are five actions all related to amending the Memorandum of Understanding with the MPS that have exceeded their due date – these will be escalated to CESG.

As a result of our continuous re-contact clinical audit, in October:

- 28 crews were recommended for feedback (14 positive & 14 constructive)
- One patient was flagged to the LAS Frequent Caller department – who have since confirmed they were aware of this patient
- One call has been escalated and we await a decision as to whether an incident report needs to be created

Caring

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 17/18	Aug-17	Sep-17	Oct-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	93%	100%	93%	96%	↑			LQ27	
Friends and Family Test Response Rate			1.8	0.1	0.2	0.0	↓			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	77	23	10	19	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.79	0.9	0.6	1.0	↑			LQ29c	
Positive Feedback Compliments			668	63	117	91	↓			LQ29e	
Mental Health related calls as percentage of all calls			8%	7.9%	7.8%	8.0%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.2%	2.2%	2.2%	↓				
Mental Health related Incidents as percentage of all calls			6%	5.3%	5.9%	5.4%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.4%	0.4%	↓				
Rate of Frequent Callers per 1,000 Calls			3.02	3.0	3.3	3.3	↑				
CMC records viewed			776	228	246	291	↑			LQ30	

Actions

- Mental Health activity has been consistent and actions are underway to ensure this is sustainable
- A Mental Health car pilot is scheduled to commence in early December 2017 in West and South West London. This will link in with a similar pilot by South London and the Maudsley Mental Health nurses in with the LAS and Metropolitan Police collaborate.
- Adverts to recruit additional mental health nurses will be posted in the new year. As part of the recruitment process a skills assessment centre is being planned.
- Complaint figures show a steady pattern. This will be reviewed post ARP.

Assurance

- The Mental Health dashboard is shared monthly with Mental Health Trusts and includes detailed activity including the use of Non-Emergency Transport Service use.
- The Trust continues to work with other organisations to ensure an interoperable approach to learning is achieved. This also strengthens our links with external partners.

Frequent Callers

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Frequent Caller Team (FCaT) updates:

- The national definition of a frequent caller: Any one aged 18 or over who:
  - calls 5 or more times in 1 month from a private dwelling, or
  - calls 12 or more times over a 3 month period from a private dwelling.
- New Frequent Caller Management Database (FCMD) is working well, allows earlier identification of Frequent Callers (FC's) & therefore early intervention. Gradual evolution of design and contents.
- Last month the FCMD identified 528 new & existing frequent callers meeting the national definition. 99% of these patients are now matched with a NHS number. Where possible, patients are matched with a GP.
- Strengthening links with Metropolitan Police Service (MPS) and London Fire Brigade (LFB). Sharing call information from tri-services has assisted in Health & Social Care responding more quickly & effectively to complex FC's.
- Receiving increasing numbers of A&E Mental Health Care Plans from A&E Frequent Attender meetings, relating to NHS England CQUIN for reducing A&E attendances. These require an agreed process for storage & access.
- Positive engagement with Stakeholder Engagement Managers (SEMs) and Community Involvement Officers (CIOs).

FCaT challenges:

- Increasing numbers of A&E Care Plans being shared with FCaT that require storage and ease of access.
- Developing robust 'No Send' call management plans for FC's.

Case study:

Typical Frequent Caller with complex care needs -

77 year old female living alone in sheltered accommodation; regular homecare visits. Anxiety, loneliness, bed-bound, frail, possible early stages dementia. Calls spiked from Feb 2017. During March 2017 alone, patient made 362 calls to 999. Calls with 'unknown reasons', hungry, complaints about carers, breathing problems, threatening suicide. Call Category: mainly C2-C4, with occasional R2. Patient demands crew carry out domestic/personal care tasks when on scene.

Has capacity to make decisions around care & accommodation. Refused nursing home placement. Denied calling 999 when presented with evidence. Abusive to home carers. No family in UK & refuses consent to liaise with family overseas. Mental Health services declined to review patient's mental health & capacity. No consistent GP input due to locums covering practice. Metropolitan Police Service (MPS) felt prosecution for misuse of 999 not viable.

Joint home visits with LAS, Health & Social Care colleagues, & MPS, plus regular professionals meetings, helped build up positive working relationships with partner agencies, & urgent multi-agency plans made.

After months of ongoing liaison, patient was persuaded to move to nursing home for short respite stay, as part of a hospital discharge plan. Some initial calls to 999 persisted from patient's mobile whilst residing at nursing home. However, due to an Individual Dispatch Protocol flag being in place to pre-empt this behaviour, nursing staff were made aware each time patient called 999 & no units were dispatched.

Patient now agreeing to remain at nursing home longer term, though her decisions around accommodation fluctuate regularly. Not yet willing to give up permanent tenancy. May still choose to return home against advice of professionals. No calls to 999 for 3 months. FCaT continue to monitor & liaise with local services.

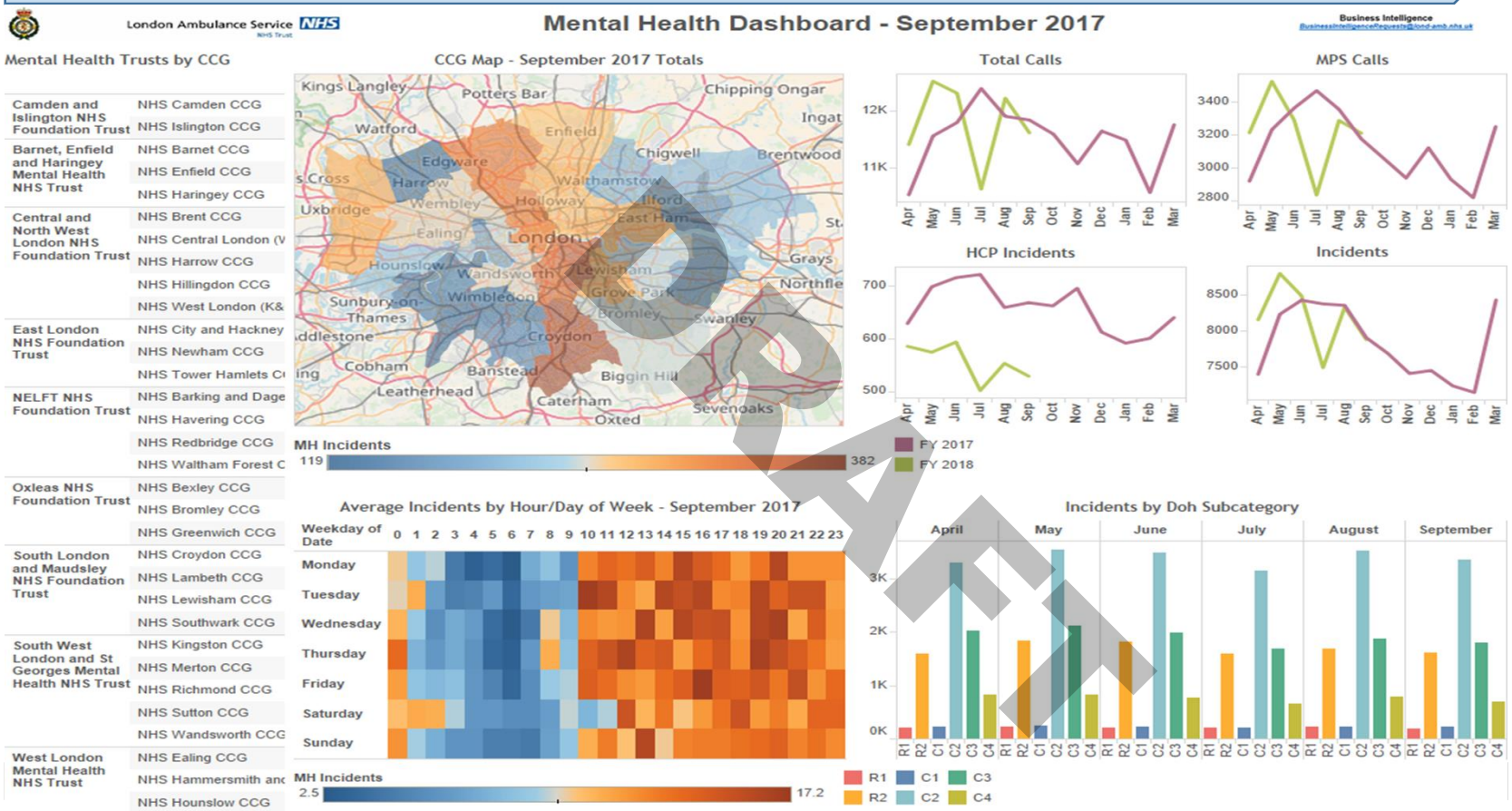
Frequent Callers

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Cluster	CCG	Patients	Calls last month	Calls last quarter	Calls last 12 months	% of patients with NHS no.
NC	BARNET CCG	25	554	1458	5428	100
NE	CITY AND HACKNEY CCG	25	332	811	2375	100
SE	SOUTHWARK CCG	21	250	809	2577	95
NW	EALING CCG	24	330	881	2889	100
NC	HARINGEY CCG	27	280	779	2831	93
SE	GREENWICH CCG	14	131	400	1307	100
NC	ISLINGTON CCG	22	296	733	1860	100
SE	BEXLEY CCG	16	118	452	1333	100
NW	WEST LONDON CCG	24	275	833	1573	96
SW	CROYDON CCG	28	163	558	1663	100
SE	LAMBETH CCG	14	117	389	1251	100
NE	HAVERING CCG	13	222	689	1868	100
NW	HAMMERSMITH AND FULHAM CCG	13	129	457	1272	100
NC	CAMDEN CCG	20	243	548	1416	100
NW	HILLINGDON CCG	16	117	492	1687	100
NW	HOUNSLOW CCG	16	175	913	2316	100
NW	BRENT CCG	20	153	497	1388	100
SW	MERTON CCG	11	74	245	906	100
NE	WALTHAM FOREST CCG	13	228	844	1827	100
NE	TOWER HAMLETS CCG	15	97	327	988	100
NE	NEWHAM CCG	18	142	446	979	100
NW	CENTRAL LONDON (WESTMINSTER) CCG	14	162	431	1233	100
NE	REDBRIDGE CCG	17	190	404	1203	94
SE	LEWISHAM CCG	12	195	533	1190	100
NC	ENFIELD CCG	18	220	516	1297	94
SW	WANDSWORTH CCG	17	86	353	845	100
NE	BARKING AND DAGENHAM CCG	11	85	238	782	100
SE	BROMLEY CCG	12	109	274	778	100
SW	RICHMOND CCG	10	127	325	870	100
NW	HARROW CCG	11	84	489	1310	100
SW	SUTTON CCG	10	49	208	589	100
SW	KINGSTON CCG	5	28	103	242	100
	Top 5					
NC	BARNET CCG	M	334	859	3594	Unwell & assisted
NC	ISLINGTON CCG	M	149	256	554	Falls & unknown illness
NE	WALTHAM FOREST CCG	M	144	566	907	Anxiety
NE	HAVERING CCG	F	70	149	371	Unknown illness
SW	RICHMOND CCG	F	63	135	279	Psychiatric

Mental Health

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain



Croydon has the highest Mental Health demand for September at 382 incidents, with Southwark not far behind with 359 incidents. Kingston had the least (n=119)
Between 12-18 hrs Monday to Friday are the peak hours for Mental Health Demand as well Tuesday to Friday between 18-24 hrs.
Total Calls and Incidents declined in September.
C1 incidents increased slightly by 10 incidents, the rest of the sub categories decreased in September.

Clinical Hub MH Nurses Activity for October: **621** compared to **515** in September

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Patient & Public Engagement

Events on database	Events attended	Interested staff
40	35	1,214

The Ladies' Guild Talk – 3 October 2017
"John gave a fantastic talk to the Ladies Guild last night. It was presented well, very interesting and the ladies thoroughly enjoyed it."

St Joseph's School – 17 October 2017
"It was fantastic and well received. Chris was so informative and raised so many important issues. All the staff were very positive about Chris and we would love to have him back next year or at any time again."

Southfield Park Primary – 19 October 2017
"Steve was very engaging, and handled the Scouts very well. He is arranging to come back another night after half term to cover more of the badge work."

Key Updates

- Following a survey of blind and partially-sighted people, we are issuing braille stickers to operational staff, to attach to their ID badges. This is to offer reassurance to patients that staff are genuinely from the ambulance service. A telephone number is provided for them to contact EOC if they have any concerns.
- One of the Public Education Officers, Katy Crichton, is doing a training course on dementia at UCLH. As part of this course, she is undertaking a service development project within the LAS. The project will focus on improving communication with people with dementia, and putting them at their ease in potentially stressful situations.

Awards

- The Facebook Listening into Action page has won a national award for helping to improve communications across the Service. It took the 'best use of internal social media' category at the Institute of Internal Communications Awards on Friday 29th October)
- In October the Trust Consultant Midwife took on her first ever Ironman Challenge in Barcelona to raise money to support charity MAMA Academy that work to prevent stillbirths
- Service staff were the worthy winners of The Royal College of Emergency Medicine 50th anniversary CPR challenge. The challenge, which took place at St Mary's and Charing Cross Hospitals, saw nurses, doctors, ambulance crews and emergency department staff go head to head in the Service pop up CPR trucks to test their resuscitation skills.

Staff Recognition

- Four members of staff were presented with their long service certificates on today with their total length of service reaching an amazing 145 years

- In October the Service was honoured in the Evening Standard 'Progress 1000' list attended by the London Mayor. The event saw London's emergency service workers being celebrated to be named London's most influential people of 2017. The service was represented at the event by one of our paramedics and the Head of Resilience and Special Operations

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Performance January – October 2017

0	23	26	36	22	27	35	26	25	27	24	271
1	19	28	32	26	29	36	32	35	29	13	279
2	24	33	38	29	37	23	29	31	34	28	306
3	36	40	26	29	44	21	33	39	26	17	311
4	29	32	38	31	23	24	19	34	30	19	279
5	29	26	36	25	17	27	31	23	25	14	253
6	28	30	31	27	37	15	31	12	27	20	258
7	33	32	24	34	35	36	36	26	29	26	311
8	33	26	24	32	44	37	32	36	38	25	327
9	30	35	36	24	30	25	35	24	32	29	300
10	25	22	34	22	22	26	20	29	31	25	256
11	29	23	26	22	32	24	27	28	20	19	250
12	18	25	27	23	26	32	28	37	28	16	260
13	27	22	11	33	34	23	27	16	25	24	242
14	25	21	30	22	35	25	26	35	22	9	250
15	27	14	24	24	28	16	25	29	33	25	245
16	31	23	33	18	32	36	29	28	29	17	276
17	29	26	29	28	38	31	25	21	29	12	268
18	24	29	33	16	29	34	19	13	32	10	239
19	23	28	23	23	24	39	27	33	28	17	265
20	27	39	32	39	30	24	30	34	37	13	305
21	18	13	31	32	26	24	24	29	36	20	253
22	37	42	30	25	32	30	37	30	23	12	298
23	34	19	40	35	31	33	28	42	23	29	314
Grand Total	**658**	**654**	**724**	**641**	**742**	**676**	**676**	**689**	**693**	**463**	**6616**

Actions

- Pan London Maternity Divert Policy to be ratified in December and shared with LMS Maternity Leads
- Recruitment to the Practice Development Lead Midwife to take place prior to December 2017
- Business case to be presented to Executive Team for December 2017 – Midwives within the London Ambulance Service.

Pan London Activity

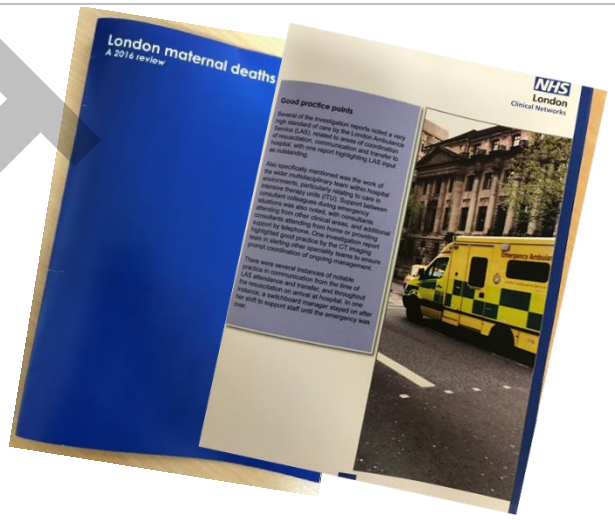
- 10% Non conveyance rate
- 5903 Conveyances
- 1622 Birth Imminent Calls
  - 27% Calls
- NE - 445
- SE – 408
- NW - 321

Maternity Emergencies

- 27 Breech Births
- 1973 Antepartum haemorrhage
- 34 Baby's born with complications
- 123 Baby's born without complications
- 92 labour (contractions more than 2 minutes)

Success

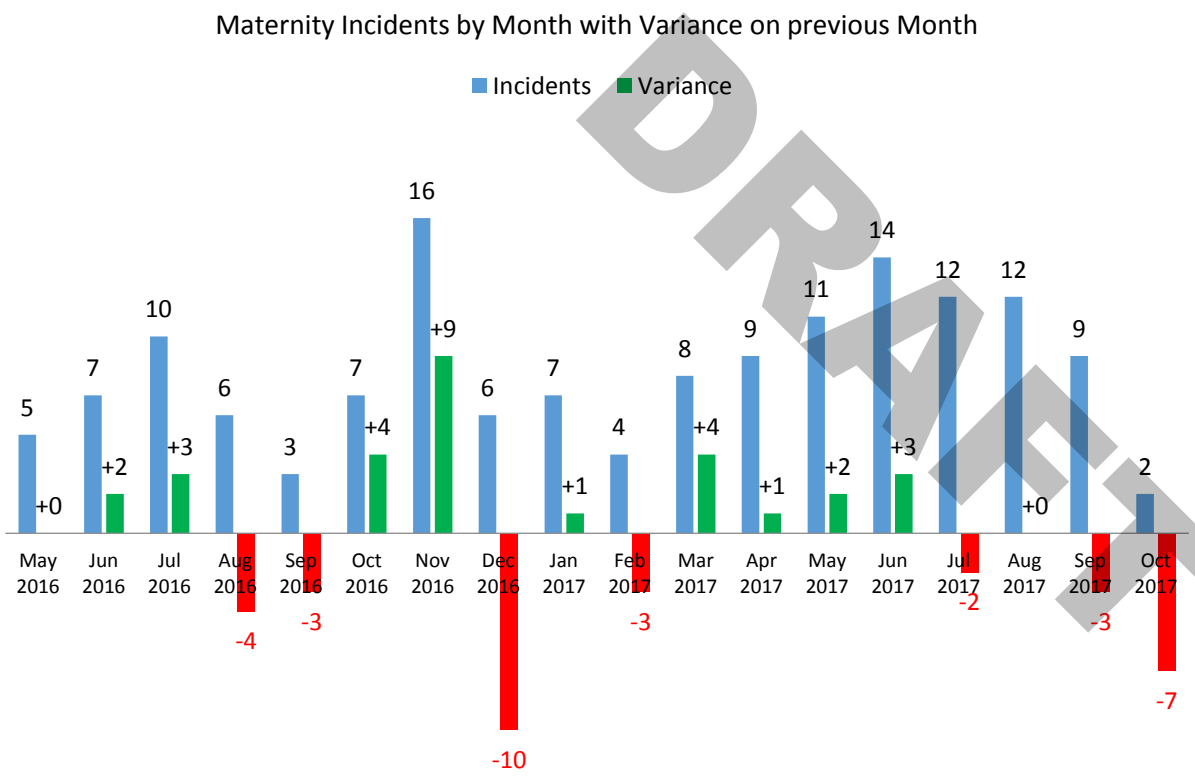
- Pan London Clinical Network Maternal Deaths report (2016) acknowledged aspects of good practice in regards to communication, management of resuscitation, and transfer to hospital
- Joint Maternity Training with Hillingdon Hospital community midwifery team
- Maternity "Deep Dive" presentation to the Clinical Commissioning Group
- Visit planned for NHS England Director of Patient Experience



Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Maternity Risk 2017 to date



Maternity Incidents October 2017

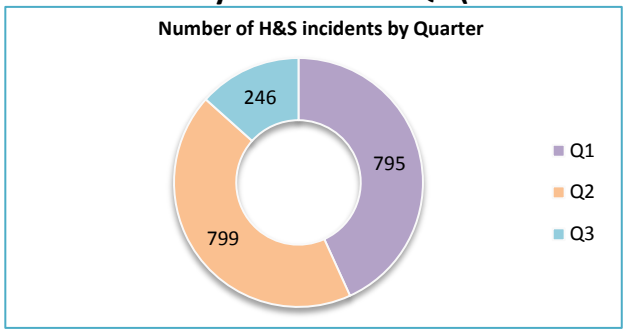
2 Cases reviewed:

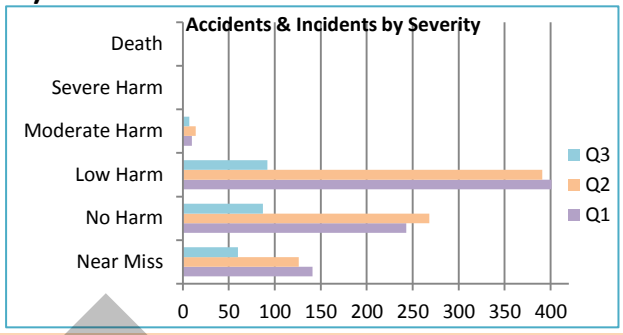
- 1. Maternity Unit Access difficulties – Joint Discussions with Maternity Unit commenced and to be raised at Trust Governance Meeting
- 2. Management of Maternity Emergency at a Homebirth with midwives in attendance. LAS and Midwives worked well together and Mother and Baby doing well and discharged home. Feedback provided to LAS Team.

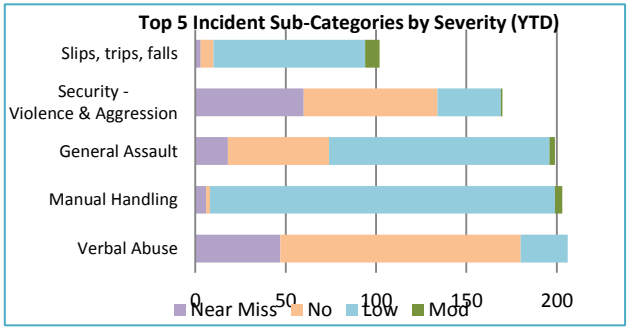
Maternity Complaints

- Total Complaints to date = 12
- One complaint October – Gp complaint in regards to referral to NHS 111, woman made her own way to hospital, no known subsequent poor outcome.

Health & Safety Scorecard – Q3 (October 2017)



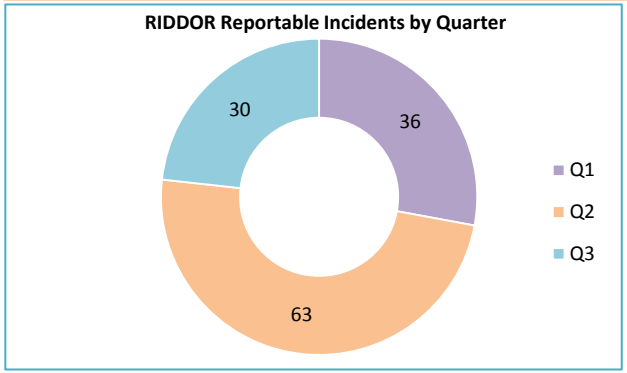


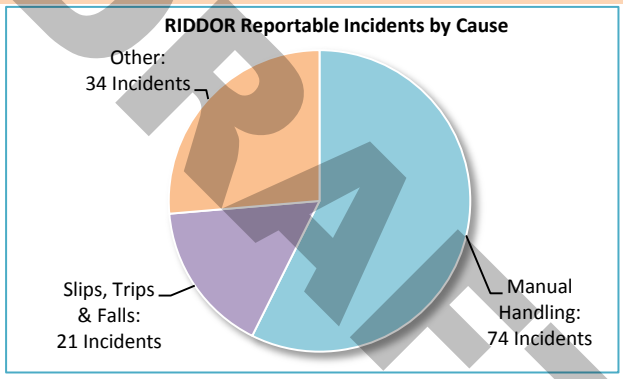


1840 health and safety related incidents were reported during 2017/18 up to October 2017. These incidents account for 38% of the total incidents reported during the year.

915 (49.7%) of the H&S related incidents reported during 2017/18 resulted in harm. 925 (50.2%) of the incidents were reported as 'No Harm/Near misses'.

Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported In Q3 (up to October 2017).

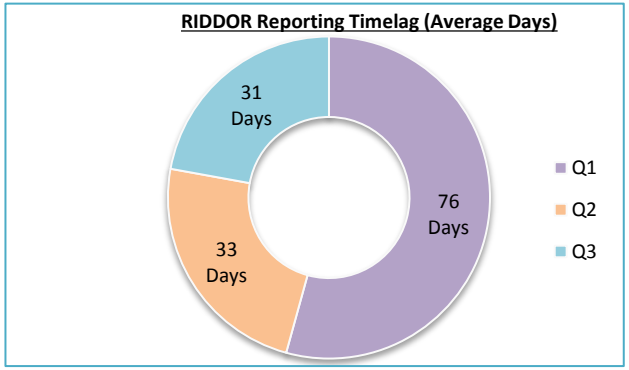


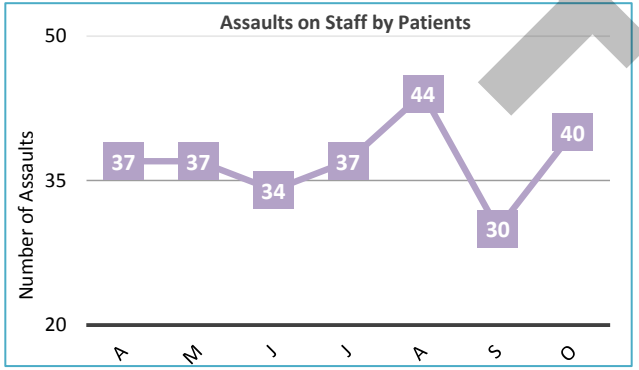


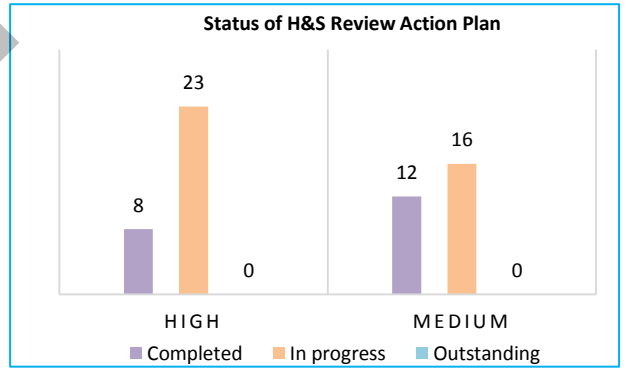
There was a reduction in 'Exposure to Bodily Fluid Incidents' reported in October 2017. YTD, a total of 97 'Exposure to Bodily Fluid Incidents' have been reported compared to 102 'Slip, Trips and Fall' Incidents.

Assurance:

1. Key training in practical MH to be undertaken in December 2017 by Clinical Tutors. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
2. MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Review currently underway to identify root cause of tail lift, track chair and Manger Elk equipment failures.
3. No trends identified with the increase in Slip, Trip and Fall incidents. A large number of incidents reported were due to human error.
4. Prototypes of the proposed integrated Vehicle based first response bags to go on trial at the end of November 2017.
5. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of MAST training during CSR 2 – 2017.



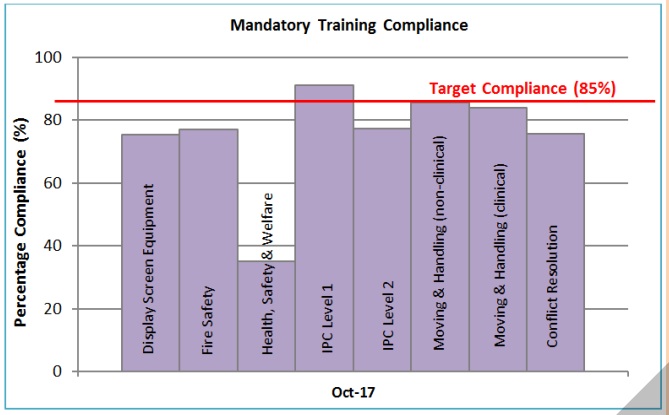




6. The current Trust-wide average of 31 days for reporting RIDDOR incidents currently exceeds the statutory requirement for reporting most RIDDOR incidents which is 15 days.

7. Assaults on staff by patients make up 32% of the violence, abuse and assault incidents reported in 2017/18. Incidents are followed up by Managers, H&S Department and reported to the Met Police where required. Lone worker policy has been developed and circulated to key stakeholders for review.

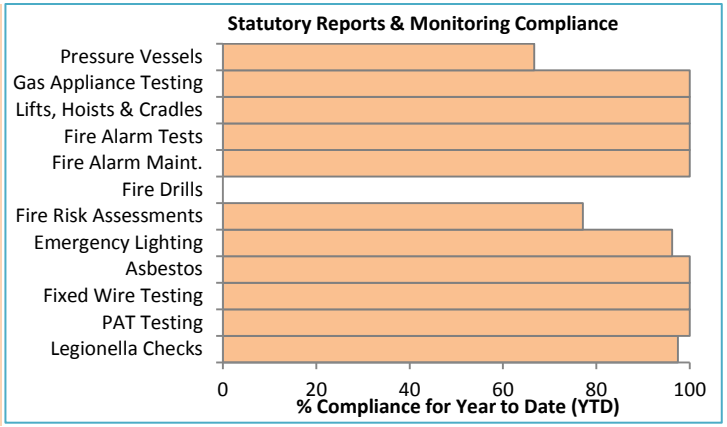
8. 20 of the 59 actions recommended have been completed, 39 actions are in progress and currently underway. A monthly update report is provided to the ELT/Board to highlight progress of actions as well as barriers.



Trust-wide compliance in October 2017 for 6 out of the 8 mandatory health and safety training courses are below 85%.

IPC 1 and Moving and Handling (non-clinical) are at or above 85%.

A new training package for Health, Safety and Welfare Training was launched in September 2017. Trust-wide compliance is currently at 35.14.



Compliance with the statutory fire drills across the Trust is currently at 0.

This is largely because fire drills are not currently completed across a lot of the LAS sites, and where these are completed, they are not recorded. The H&S Dept. is reviewing fire arrangements across the Trust with the aim of improving Trust-wide compliance.

Health and Safety Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q2			Q3		
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Jul	Aug	Sep	Oct		
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Trust Board/ELT training undertaken in October 2017. H&S procedures to improve compliance are being implemented and monitored through the Trust's governance and committee reporting process.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	9	Key training in practical MH to be undertaken by Clinical Tutors in December 2017. Practical MH refresher training to be provided for all frontline operational staff from CSR 1 – April 2018.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments – developed and circulated for comments.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	3	Withdrawal of paper forms implemented on 01/10/2017. Proactive monitoring of RIDDOR incidents undertaken daily by H&S Team through Datix and GRS. Current reporting time lag is 31 days.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	3	Risk register reviewed, awaiting sign-off by RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q3, 2017.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management. These will be implemented in Q3, 2017.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	9	9	6	6	3	Additional resources approved to enable the Team adequately support the Trust. New team structure approved – consultation to restructure completed in October 2017. Recruitment to commence.
118	IPC	There is a risk of infection due to a sharps injury.	Eng-Choo Hitchcock	Briony Sloper	6	6	6	6	6	3	Risk to be reviewed with Infection Prevention and Control Team.

Sector Heat Map: Quality Data

CQC		Key Performance Indicator	NW	NC	NE	SW	SE	Other	LAS Target	LAS Ranges
SAFETY		Hand Hygiene OWR compliance	-	-	-	-	-		90%	
		Rate of Patient related Adverse Events per 1,000 Incidents	2.5	1.9	3.6	2.1	1.9		5	
		Rate of Staff related Adverse Events per 1,000 Incidents	3.3	2.4	4.9	2.6	3.3		3	
		Controlled Drugs - LIN Reportable Incidents	0	0	0	1	0		0	
		Percentage of Incidents reported within 4 days of incident occurring	96%	93%	98%	98%	98%		85%	
		Potential Serious Incidents referred to SI Group	4	3	4	1	2			
		Serious Incidents declared in-month	1	1	0	1	0		0	
		Serious Incidents breaching 60 days YTD	0	0	0	0	0		0	
		Serious Incidents breaching 40 days YTD	0	0	0	0	0		0	
		Medication Errors as % of Patient Adverse Events	3.6%	3.8%	1.5%	7.4%	2.9%		0%	
		Needle Stick Injuries as % of Staff Adverse Events	3%	3%	4%	0%	0%		0%	
		Missing Equipment Incidents as % of all reported incidents	4%	5%	3%	6%	7%			
		Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	9%	14%	11%	16%	12%			
		Safeguarding Adults & Children Level 1	91%	93%	91%	95%	94%		90%	
		Safeguarding Adults & Children Level 2 - Clinical	84%	80%	76%	84%	86%		90%	
		Percentage of staff completing Core Skills Refresher 2017.1 (cumulative)	90%	92%	86%	86%	93%		85%	
EFFECTIVENESS	*	ROSC at Hospital (AQI)	36.4%	20.7%	30.5%	19.5%	35.9%			
	*	STEMI care bundle (AQI)	81.9%	64.8%	71.4%	72.5%	78.8%			
	*	Stroke to HASU within 60 minutes (AQI)	65.4%	38.4%	62.8%	82.2%	63.6%		65%	
	*	Stroke Care Bundle (AQI)	94.7%	96.1%	96.1%	96.4%	97.3%		98%	
	**	Survival to Discharge (AQI)	6%	5%	11%	13%	7%			
	*	CPI - Completion Rate (% of CPI audits undertaken)	85%	93%	100%	87%	99%			
	*	CPI - Percentage of Staff receiving ONE Feedback Session YTD	43.5%	45.2%	40.0%	47.2%	39.2%			
	*	Documented Care - Cardiac Arrest Compliance (CPI audit)	98%	99%	97%	98%	96%		95%	
	*	Documented Care - Discharged at Scene Compliance (CPI audit)	97%	98%	97%	98%	97%		95%	
	*	Documented Care - Mental Health Compliance (CPI audit)	90%	93%	89%	93%	93%		95%	
	*	Documented Care - Severe Sepsis Compliance (CPI audit)	95%	96%	96%	97%	96%		95%	
	*	Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-		95%	
	*	Documented Care - Glycaemic Emergencies Compliance (CPI audit)	97%	98%	97%	97%	96%		95%	
CARING		Rate of Complaints per 1,000 Incidents	0.5	0.6	0.5	0.6	0.7			
		Mental Health Related Incidents	8%	10%	8%	8%	10%			
		Mental Health Related HCP Incidents	1%	1%	0%	1%	0%			
		Rate of Frequent Callers per 1,000 Calls	6.3	8.4	6.6	6.1	4.8			

* data shown refers to Sep-17

* data shown refers to Jun-17

Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Learning from Incidents

- An article was produced in the RIB on the use of personally procured medical devices following a SI investigation. The information reminded crews that the use of personal medical equipment (pulse oximeters, sphygmomanometers etc) is not permitted
- A recall notice was sent out regarding the incorrect delivery of suture maternity packs which had been highlighted to the Medical Directorate. The root cause of the error is currently being investigated and no patient safety incidents have been reported

- An article has been drafted on clinical decision making and the importance of adequate safety netting to be included in the next clinical update. Examples taken from SI investigation and Inquests have been included

Incidents

SI update	Incidents reviewed In October	SIs declared In October	SIs open	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	23	4	20	6	14	0	4
Trend on previous week	↓	↓	↑	↔	↑	↔	↑

- 100% of serious incidents in October 2017 were reported on STEIS within 48 hours of being declared
- Duty of Candour (DoC) was undertaken for all serious incidents declared in October 2017
- Following a review and reconfigure of the Trust incident reporting system (Datix) we will be reporting DoC compliance for all 'moderate harm' cases from December 2017

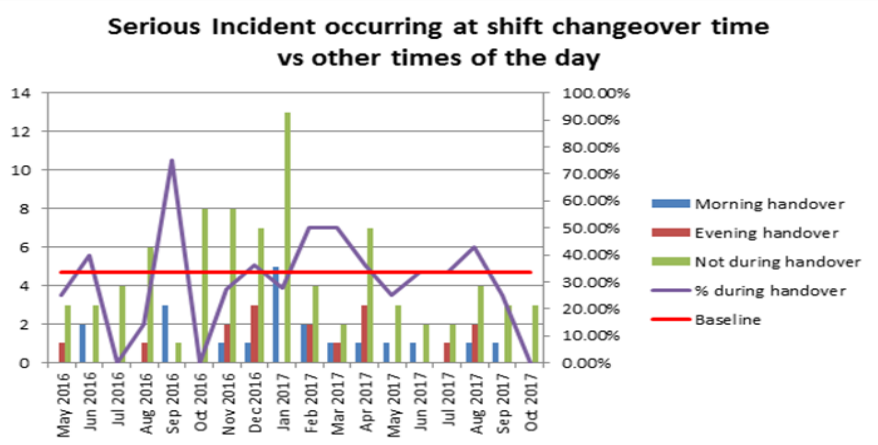
Serious Incidents & Incidents

- The third Lead Investigator training session has been arranged for the 17th November. Currently 15 managers have confirmed their attendance.
- Following on from last months report; of the 344 incidents that had not been assigned a responsible manager, 93% of the incidents have now been allocated
- Benchmarking figures have now been set for the LAS in relation to no harm, and low to moderate harm incidents based on the national average of ambulance Trusts in the UK
- A thematic review which included 79 SI reports completed between Jan to Sep 17 has shown the main categories which have resulted in SI' to be:
  - Call and Dispatch
  - Clinical Assessment
  - Clinical Treatment
- Deep dives will be conducted into each category to form a further thematic review and action plan

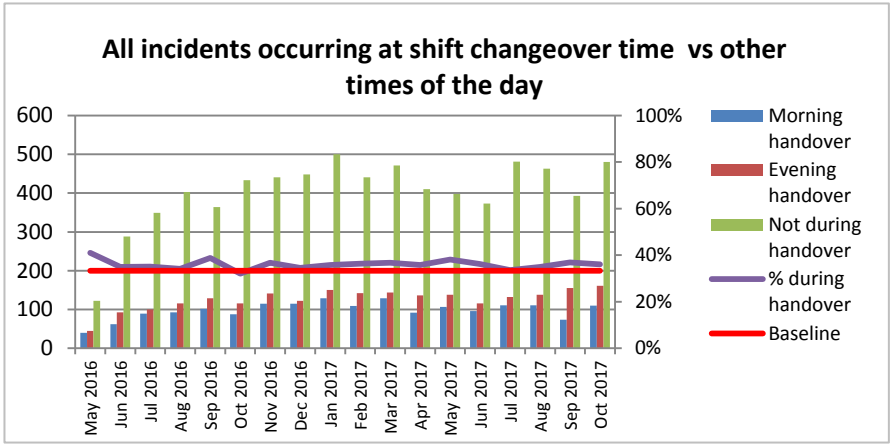
Learning from Incidents

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

Serious Incidents occurring during shift changeover



All Incidents occurring during shift changeover



Actions relating to Serious Incident Investigations

SI action plan update (relating to closed overdue SI investigations)

- 36 actions are currently overdue (reduction of 39 from last month)
- Weekly reminder emails continue to be sent to those accountable and responsible for the actions in addition to those generated by Datix
- The reporting Dashboards relating to actions by Sector/Directorate are now live for the use of the Senior Management Team
- Any overdue action where the team have received no communication from the accountable and/or responsible manager have been escalated to the Executive Director for the Directorate

Actions and assurance regarding incidents during shift changeover

The number of serious incidents occurring during shift changeover has dropped since August 2017, which seems to indicate that the shift changeover has no longer had a negative effect on patient safety.

The chart to the left shows that just over a third of all incidents reported occurred during shift changeover, which is only slightly higher than expected (assuming an even spread of incidents throughout the day), and this figure has remained fairly level since DatixWeb was introduced.

Learning From Deaths, Inquests and Claims

Owner: Nicola Foad | Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

Inquests – figures and learning

- In October LAS staff were requested to attend Inquests to give oral evidence on 4 occasions, 2 less than last month.
- No Prevention of Future Death (PFD) were received in October.
- The Response to HM Coroner to the Report received in September and sent to 9 organisations / individuals is due by 21st November 2017.

Actions

Ongoing

Response to PFD dated 12th May 2017 – to be shared with Quality Oversight Group on 14th December 2017.
NHS Resolution Scorecard – analysis received but further identification of learning and trends to be undertaken through discussion with the Head of Non-Clinical Claims for NHS Resolution.
Risk Management Recommendations – LAS reliance on the Intranet for the circulation of policies as reported in September – action pending discussion between the Chief Quality Officer and Director of Corporate Governance.
The two recommendations received in October are being discussed with the Head of Health, Safety and Security and the Deputy Director of Fleet and Logistics respectively.

Claims – figures and learning

- In October two Risk Management Recommendations were made by Panel Solicitors in relation to employer liability claims:-

No1. The Trust are aware that the tracks used for carry chairs become stiff as disinfectant is regularly sprayed on them. We suggest:-

- carrying out regular inspections of the track to ensure that they are working efficiently.
- enquiring if there is an alternative disinfectant which can be used on the track which would not cause this problem.
- ensuring that any maintenance and inspection records are kept for carry chairs /tracks so that the Trust can show regular checks are carried out.

No2. The Trust have in place a procedure for the scheduled maintenance and exchange of ambulance equipment with staff acting as equipment exchange personnel. This is a reasonable system but staff may not have checked

Claims – figures and learning cont'd

equipment stocked on their vehicle at the start of a shift. We suggest:-

- Procedures for checking equipment, dealing with broken equipment and requesting replacement missing equipment are reiterated to all staff.
- if possible, confirmation should be obtained (electronic or manual signature) that staff have read and understood the procedures.

- As at the end of Q2 2017/18 NHS Resolution had 47 claims open against LAS under the Clinical Negligence Scheme for Trusts, up from 40 at the end of Q1, having received 7 claims in Q2.
- Q2 saw 11 claims reported under the Liabilities for Third Parties Scheme (employer/public liability claims), bringing the total claims open to 69, down from 75 in Q1.

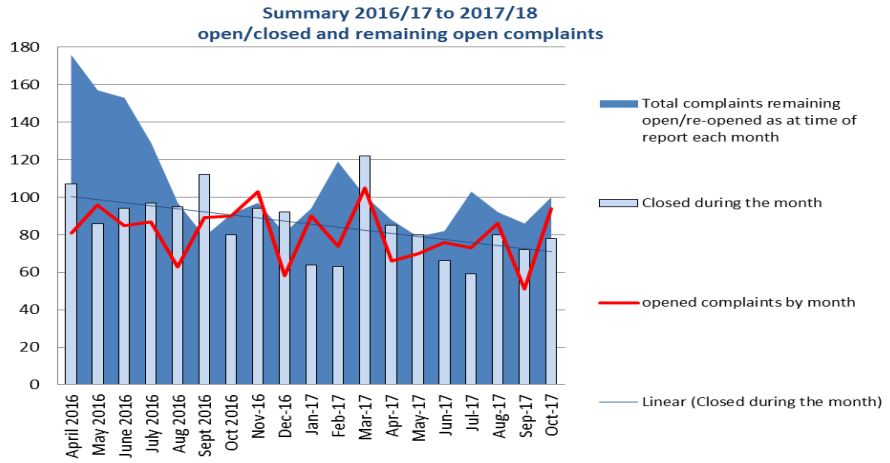
Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 key complaints themes November 2016 to September 2017

Complaints by subject 2015/17	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Total
Delay	37	19	36	16	27	21	17	16	14	26	9	22	260
Conduct	22	15	26	27	36	16	19	24	19	19	16	17	256
Road handling	8	8	7	9	16	12	11	13	14	10	7	14	129
Treatment	6	1	3	3	5	1	2	5	1	7	5	16	55
Non-conveyance	1	1	1	3	4	3	0	4	12	0	1	6	36
Total these subjects	74	44	73	58	88	53	49	62	60	62	38	75	736
Overall totals	103	58	90	74	105	66	70	76	73	86	51	94	946

Complaint summary April 2016 to September 2017



Actions

- During October we received 94 complaints which included 5 from other Health Care Professionals on behalf of the patient
- This represents a 46% increase over September but reflects the historic increase in complaints at this time of year.
- You will see from the above table that there was a marked increase in October (30%) in complaints where treatment was the key aspect. The current annual average is 5 per month.
- From November 2017, the recording of overdue complaints (35 days) will be changed from 100% to 75% this takes into account delays in obtaining supporting information and throughput at Executive Office level.
- One feedback leaflet was received during October – the complainant advised that the response completely addressed their concerns. We are aiming to add the feedback leaflet on the new website in November
- We have set up a monitoring process to review re-opened cases within Datix with individual case officers

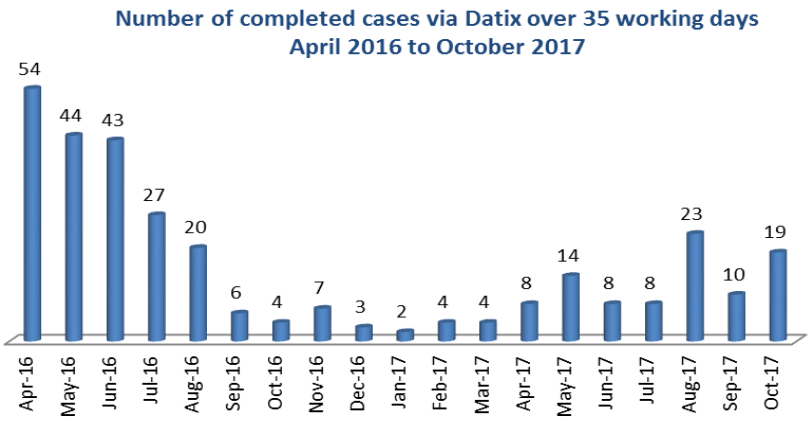
Assurance and learning

- As at 08 November there are 98 open complaints. Of these 2 are overdue based on the target provided during case management and 3 have been re-opened .
- Of the 94 October complaints, 27 have been closed. Of these, 6 have been upheld, 10 were not upheld, 2 were partially upheld and 9 were referred elsewhere.
- One upheld complaint related to reimbursement to a complainant whose mobile phone was accidentally knocked to the floor by LAS staff. The complainant was very abusive to staff in PED supporting the need to record duty calls in the future.
- We are also negotiating the funding of the cleaning of a complainants driveway after an ambulance had a hydraulic spillage. This has highlighted the lack of a budget at local complexes to manage such incidents.
- Overtime complaint numbers increased slightly during October due to staff shortages in August & September and the increase in complaints this month

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

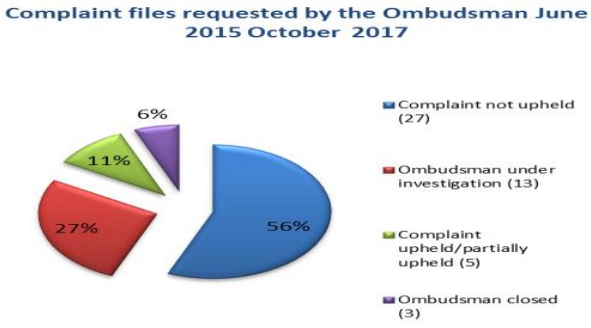
Performance against 35 day response target



Assurance and learning

- Accumulatively the YTD figure of overtime complaints is 17% (against 516 complaints)
- One case was returned by the Ombudsman citing that the LAS acted in line with established good practice and that it was reasonable that the patient was not transported to hospital. As no failings were identified the Ombudsman has not upheld this complaint.
- We were beset by a number of IT issues during October outwith our control.
- The new call log has now 'gone live' and we continue to work with IM&T when we identify any issues with that.
- 6 complaints received and closed during October were upheld. These included a range of subject issues : 2 x delay, 1 x non-conveyance, 1 x damage to property , I relating to an LAR entry and 1 x road handling.
- 2 complaints in this criteria were partially upheld.

Overview of Ombudsman cases 2015-2017



Assurance and learning

- Case examples from October complaints:

Example one:
Complaint from patient's father who was upset that despite her symptoms, his daughter was declined an ambulance.
The Quality Assurance evaluation identified that the call handler gave the incorrect referral information to the caller. The patient should have been referred to the CHUB as opposed to NHS111.

Example two:
Complaint from patient to LAS111 regarding the length of time awaited for a clinical call back.
The 111 QA review identified that the call was managed and assessed properly with a correct determinant of a call back within 6 hours being achieved. This was not communicated to the patient who was advised that she would receive a call within 2 hours.

Quality Risk Register

- There are currently 6 open risks on the Quality Directorate register. All have a net rating of 12 and have clearly documented mitigating actions

- At the recent Risk Compliance & Assurance Group (RCAG) meeting a further Quality Directorate risk was discussed and approved. This relates to a potential risk that the Trust may not come out of special measures at the next inspection. This risk details the Quality Improvement Plan as the mitigating action

- 3 risks relate to Safeguarding which continue to be regularly monitored (Datix ID 63,65 and 495). Additional staff have been recruited into the team with an administrator due to commence in January 2018. Along with implementation of the Escalation policy we should see improvements in the processing of request from MARAC which will enable all 3 risks to be closed.

- 1 risk relates to CMC records being flagged in a timely manner (Datix ID 291). The LAS now receives detailed monthly access data which indicates a steady increase in the number of CMC records being accessed. Identified incidents and issues are investigated timely in collaboration with CMC. The EOLC group monitors activity their monthly meetings

- 2 risks relate to SI investigations and Learning from Incidents (Datix ID 18 and 21). It is anticipated that these risks will reduce in view of the new processes put in place and the ongoing training on SIs as supported by the Datix and HealthAssure projects

- All Directorate risks are currently being reviewed

Actions

A Risk Register deep dive and reconfiguration of Datix system activity is planned for November and December ready for Q4 implementation.

Assurance / Progress

Weekly overdue incidents and unapproved risk tracker reports are being circulated to ADOs, QGAMs and Sector Leads to improve the timeframe for reviewing unapproved risks.

A Risk Management Framework was signed of at the November Clinical Audit Committee.

Emerging risks scored at 10 and above are being flagged to RCAG monthly with strict timelines for submission stated.

Quality Assurance Committee has oversight of all quality risks rated greater than 10

London Ambulance Service NHS Trust

Report to:	TRUST BOARD			
Date of meeting:	28 November 2017			
Report title:	Workforce Race Equality Standard (WRES) Action Plan			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Melissa Berry, Interim Equality & Inclusion Manager			
Presented by:	Patricia Grealish, Director of People and Organisational Development			
History:	This is the second action plan LAS has produced for the WRES			
Status:	☒	Assurance	☐	Discussion
	☐	Decision	☒	Information

Background / Purpose:

The main purpose of the WRES is to help local and national NHS organisations review their data against the nine WRES indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff and to improve BME representation at the Board level of the organisation.

Recommendation(s):

The Board is asked to note the report

Links to Board Assurance Framework (BAF) and key risks:

To strengthen the work we have done over the past 12 months to improve the BME staff experience.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒ Research demonstrates a direct link between staff morale and engagement and patient care
Performance	☒ The business benefits of diversity and inclusion include improved innovation and effectiveness
Financial	☒
Workforce	☒ Improved morale and staff engagement should promote improved recruitment and retention and reduced absence
Governance and Well-led	☒ The WRES is part of the "well-led" domain in the CQC inspection programme
Reputation	☒ It is important that the Trust's workforce is broadly representative of the communities the Trust serves

Other	☒ Implementation of the WRES action plan will ensure the Trust is complying with its legislative and statutory duties

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒ Research demonstrates a direct link between staff morale and engagement and patient care
Efficiency and sustainability will drive us	☒

1. Introduction

1.1 This report specifically reports activities against the WRES indicators set at a national level.

1.2 It has been the experience of the majority of Trusts that Indicator 4 has not be able to be reported on and work is underway to review this in the 18/19 re-iteration of the standard.

1.3 Both the CEO and Director of People and OD have set personal objectives to support driving this agenda forward.

2. Workforce Race Equality Standard (WRES) 2017 reporting template

2.1 The WRES reporting template for 2017 has been improved to make the template user friendly

1. Name of organisation London Ambulance Service NHS Trust	**2. Date of report** Month: October Year: 2017
3. Name and title of Board lead for the Workforce Race Equality Standard Patricia Grealish– Executive Director People & Organisational development	**4. Name and contact details of lead manager compiling this report** Melissa Berry – Diversity consultant
6. Name and contact details of coordinating commissioner this report has been sent to LAS commissioning Team/Brent CCG	**6. Name and contact details of coordinating commissioner this report has been sent to** LAS commissioning Team/Brent CCG
7. Unique URL link on which this Report and associated Action Plan will be found n/a	**8. This report has been signed off by on behalf of the board on** Date: 25 October 2017 Name: Patricia Grealish– Executive Director People & Organisational development

3. Background narrative (reported against the paragraph numbers in the standard WRES Action Plan)

Any issues of completeness of data

3.1 This year LAS has reported on 8 of the 9 WRES indicators, this is an improvement from 2016/2017 data submission where 7 of the key indicators were reported on.

Any matters relating to reliability of comparisons with previous years

3.2 The data is extracted from the NHS Workforce Profile Dashboard in ESR Business Intelligence (BI), which has been input into the Unify2 upload template. The BI report is designed to provide organisations with the information required to complete requirements 1-4 and 9 of the Workforce Race Equality Standard (WRES) return. Once completed the

Unify2 system calculates the WRES Indicator outcomes automatically, and these values are then submitted in the Trust WRES template.

- The data for Indicator 1 includes staff on local pay scales mapped into the matching AFC scale
- For indicator 1, as per the technical guidance, this measure does not include non-Executive board members as they are not employees
- For indicator 9, as per the technical guidance, membership of the Board includes all members of the Board irrespective of whether they are executive or non-executive members
- For indicators 5-8, the data is drawn directly from the Staff Survey results

Total number of staff employed within this organisation at the date of the report

3.3 5212

Proportion of BME staff employed within this organisation at the date of the report?

3.4 13%

Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

3.5 Ethnicity is entered by the recruitment team on start date. HR, and now payroll have access to update the ethnic origin field in ESR. The recruitment team have had training in the past six months to improve the data inputted into the TRAC system. Staff currently cannot do this themselves via My ESR or previously via Employee Self Service.

Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?

3.6 As part of our ESR communication work plan there is a plan to encourage staff to review their ethnic origin (they can see what appears against their record) and then contact the ESR team to update their record.

4. Workforce Data

What period does the organisation's workforce data refer to?

4.1 April 2015 to March 2016 and April 2016 to March 2017

Workforce Race Equality Indicators

For each of these workforce indicators, compare the data for White and BME staff.

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
WORKFORCE INDICATOR. Workforce Representation						
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 2	Please see appendix 1	BME Staff at LAS are proportionately over-represented in Bands 2 and 3 by 20% and under-represented in bands 5 upwards including VSM. There has been a small improvement over the last 12months	Supportive leadership training, BME applications band 6 and above should be encouraged to participate in this programme	Julia Smyth, Consultant, People and Organisational Excellence	Ongoing
				With Health Education England funding, BME paramedic Science (BSc) being offered for up to 12 suitable qualified BME candidates. Course provider St Georges University of London that can lead to HCPC Paramedic Registration.	Melissa Berry, Diversity Consultant Tina Ivanov, Deputy Director Clinical Education & Standards, Clinical Development	September 2017, February 2018

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
WORKFORCE INDICATOR. Recruitment						
2. Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff Relative likelihood of White staff being appointed from interview compared to BME staff	1.7 x	No data for previous year	In 2015/2016 there was no data Due to the implementation of the TRAC system there is data for 2016/17 A person from a BME background is 1.7 times less likely to be appointed than someone from a white background	Recruitment events – attendance at recruitment events across London to promote LAS as an employer. Diversity careers fair, Emirates Stadium Skills Fair London, Excel Anticipated total footfall – 41,810	Averil Lynch, Head of Recruitment, Melissa Berry, Diversity Consultant	September 2017-January 2018
				Job Centre Plus partnership – working alongside various job centres across south London, Job Centre Plus offer pre-screening of candidates and application support for LAS EMD roles (they have to be JCP clients)	Averil Lynch, Head of Recruitment	Ongoing
				Recruitment campaign – 'Be There' campaign to be developed and used to target BME candidates. Targeting areas Newham, Redbridge, Tower Hamlets, Enfield, Barnet, Haringey, Harrow, Brent, Ealing Developing catalogue of images that are reflective of BME staff	Averil Lynch, Head of Recruitment, Melissa Berry, Diversity Consultant Patricia Grealish Director of People & Organisational Development	December 2017

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
				Partnership - working with Newham Workplace (employment support organisation funded by Newham Council) who offer pre-screening, application and interview support to Newham residents for LAS EMD roles	Averil Lynch, Head of Recruitment	October 2017- July 2018
				Require agencies to source candidates in a way which encourages applications from as diverse a pool of talent as possible and which demonstrates the Trust's commitment to diversity and inclusion. Establish targets for shortlist that ensure a diverse talent pool is considered for all post at LAS.	Patricia Grealish Director of People & Organisational Development	Ongoing
				All shortlisting and interview panels should only be chaired by staff who have attended LAS Recruitment and Selection Training (or NHS equivalent) in the last 3 years.	Julia Smyth, Consultant, People and Organisational Excellence	Ongoing

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
WORKFORCE INDICATOR. Disciplinary Action and Performance Management						
3. Relative likelihood of White staff entering the formal disciplinary process, compared to that of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	BME 16-17 18%	BME 15-16 28%	Total Disciplinary cases **2015/2016 = 60 of which 11 (18%)** were BME staff Total Disciplinary cases **2015/2016 = 95 of which 27 (28%)** were BME staff	Undertake an annual in-depth analysis of the qualitative and quantitative data from the disciplinary process to identify any issues and trends by department or sector, by profession and pay banding.	Tracey Watts, Acting Deputy Director of People and OD Chris Randall, Workforce Intelligence & Planning Manager	January 2018
				Encourage managers undertaking disciplinary investigations, hearings and appeals to undertake Courageous Conversations Training.	Melissa Berry, Diversity Consultant Tracey Watts, Acting Deputy Director of People and OD	Ongoing

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
WORKFORCE INDICATOR. Access to Training						
4. Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	No Data	No Data	This data is not currently collected centrally and we are exploring options for recording this data for 17/18, ESR being the most likely option	A plan of action needs to be formulated to ensure that this indicator is reported on for the next WRES data submission.	Melissa Berry, Diversity Consultant Julia Consultant, People and Organisational Excellence Chris Randall, Workforce Intelligence & Planning Manager	Ongoing
NATIONAL NHS STAFF SURVEY INDICATOR						
5. KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 56% BME: 34%	White: 56% BME: 35%		Review of datix security incident categories/descriptors to be completed by November 2017 to enable better analysis of security incidents reported	Ayo Adeyemi Head of Health, Safety & Security	November 2017
				A booklet to support staff and managers with the post assault process is currently being developed in the NE sector.	Ayo Adeyemi Head of Health, Safety & Security	Ongoing

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
				Regular bulletins - issued to remind staff to be aware of security including: ensuring buildings and vehicles are secure when not in use (Procedure on Station Duties and Security Management Policy); awareness of their own safety, adhering to Uniform and Work Wear Policy.	Ayo Adeyemi Head of Health, Safety & Security	Ongoing
6. KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White: 32% BME: 32%	White 38% BME 40%	White staff decrease of 6% BME staff decrease 8%	Implementing a programme of Lunch and Learns to support positive debate around all aspects of diversity	Patricia Grealish Director of People & Organisational Development, Melissa Berry, Diversity Consultant	February 2018
				Develop a calendar of events that support diverse LAS. Help staff to become more culturally competent and reflecting on behaviours	Patricia Grealish Director of People & Organisational Development Melissa Berry, Diversity Consultant	February 2018

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
7. KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White: 74% BME: 57%	White: 63% BME: 42%	White staff reported an increase of 11% BME Staff reported an increase of 15%which is a significant improvement in 12 months	With Health Education England funding, BME paramedic Science (BSc) being offered for up to 12 suitable qualified BME candidates. Course provider St Georges University of London that can lead to HCPC Paramedic Registration.	Melissa Berry, Diversity Consultant Tina Ivanov, Deputy Director Clinical Education & Standards, Clinical Development	September 2017, February 20187
				Development of a programme of coaching, mentoring and master class opportunities for BME staff as part of the BME staff networking meetings.	Melissa Berry, Diversity Consultant Agatha Nortley-Meshe, Assistant Medical Director	March 2018
8. In the last 12 months have you personally experienced discrimination at	White: 9% BME: 18%	White: 13% BME: 25%	White staff percentage decreased by 4% And BME Staff decreased by 7%	Review of the Dignity at Work strategy Refreshing the roundtable training, with 60 people retraining in October and November 2017	Melissa Berry, Diversity Consultant Cathe Gaskell Bullying & Harassment specialist	Ongoing

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
work from any of the following? Manager/team leader				Developing guidance on the difference in Bullying and harassment and firm management	Cathe Gaskell Bullying & Harassment specialist Melissa Berry, Diversity Consultant	March 2018
BOARD REPRESENTATION INDICATOR						
9. Percentage difference between the organisations' Board voting membership and its overall workforce	White: 100% BME: 0%	White: 100% BME: 0%		The Next Director Scheme provides support to senior people who are currently under-represented on boards and helps them gain the skills needed to get In to the board room. The scheme will enable a potential BME NED to join the LAS board for 6 months.	Heather Lawrence, Chair	February 2018
				Reverse Mentoring Programme - set up with Board members and senior team to mentor LAS BME staff. The benefit of this mutual mentorships is to empower emerging and established leadership to mutually mentor one another	Melissa Berry, Diversity Consultant	March 2018

Appendix 1: Pay Band by Ethnicity 2015/2016

Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)

Staff in post by band				
Band	**BME**	**Not Known/ specified**	**White**	**Heads**
Band 2	32%	13%	55%	31
Band 3	32%	3%	65%	512
Band 4	12%	10%	77%	1065
Band 5	8%	2%	89%	2484
Band 6	9%	1%	91%	509
Band 7	10%	1%	89%	294
Band 8a	11%	3%	86%	70
Band 8B	6%	4%	90%	51
Band 8C	0%	5%	95%	22
Band 8D	0%	0%	100%	10
Band 9	0%	0%	100%	1
N/A	13%	13%	73%	15
VSM	0%	0%	100%	9
Other	33%	0%	67%	3
Grand Total	12%	4%	84%	5,076

Appendix 2: Pay Band by Ethnicity 2016/2017

Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)

Band	**BME %**	**Not Known/ specified**	**White %**	**Heads**
Band 2	21%	28%	52%	29
Band 3	33%	2%	65%	525
Band 4	14%	8%	78%	1141
Band 5	12%	1%	87%	897
Band 6	8%	2%	91%	2123
Band 7	13%	2%	86%	318
Band 8A	12%	3%	85%	66
Band 8B	9%	2%	89%	56
Band 8C	9%	5%	86%	22
Band 8D	0%	0%	100%	12
Band 9	0%	0%	100%	1
Medical	25%	0%	75%	4
VSM	0%	0%	100%	8
WQ00	10%	0%	90%	10
Grand Total	13%	3%	84%	5212