London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 01 AUGUST 2017 AT 09:00-12:00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	REF.	SUBJECT	PURPOSE	LEAD
09.00	**1.**	**TB/17/45** Oral	**Welcome and apologies for absence** To welcome attendees and note any apologies received.		HL
09.05	**2.**	**TB/17/46** Oral	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda.		HL
	3.	**TB/17/47** Attachment	**Minutes of the meeting held in public on 27 June 2017** To approve the minutes of the meeting held on 27 June 2017.	Approval	HL
	4.	**TB/17/48** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	Information	HL
09.15	**5.**	**TB/17/49** To follow	**Report from the Chair** To receive a report from the Chair.	Information	HL
09.20	**6.**	**TB/17/50** Attachment	**Report from Chief Executive Officer (CEO)** To receive a report from the CEO.	Information	GE
PERFORMANCE AND ASSURANCE					
09.25	**7.**	**TB/17/51** To follow	**Performance Report – June 2017** To receive the integrated performance report:	Discussion	LB
09.55	**8.**	**TB/17/52** To follow	**Board Assurance Framework and Risk Management** To receive the Board Assurance Framework and risk register.	Discussion	PH
10.05	**9.**	**TB/17/53** Attachment	**Quality Governance Committee Assurance Report** To receive the report of the Quality Governance Committee meeting on 11 July 2017	Assurance	RMc, TB

10.15	**10.**	**TB/17/54** To be tabled	**People and Organisational Development Committee Assurance Report** To receive the report for the People and Organisational Development Committee meeting on 24 July 2017	Assurance	JM, PG
10.25	**11.**	**TB/17/55** To be tabled	**Finance, Investment and Performance Committee Assurance Report** To receive the report from the Finance, Investment and Performance Committee meeting on 27 July 2017.	Assurance	FC, LB
10.35	**12.**	**TB/17/56** Attachment	**Serious Incident Management** To note declared and closed Serious Incidents.	Discussion	TB
STRATEGY & PLANNING					
10.45	**13.**	**TB/17/57** Attachment	**Ambulance Response Programme** To provide the Board with a briefing on the Ambulance Response Programme.	Information	PW
11.05	**14.**	**TB/17/58** Attachment	**North Central Dispatch Group Trial: the Tethering Principal** To provide the Board with a briefing on the trial of a number of changes to our EOC operating model in North Central around a realigned dispatch group, a Solo Responders desk and tethering of DCA resources.	Information	PW
GOVERNANCE					
11.30	**15.**	**TB/17/59** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	Information	PH
11.35	**16.**	**TB/17/60** Oral	**Questions from members of the public**		HL
11.45	**17.**	**TB/17/61** Oral	**Any other business**		HL
11.50	**18.**	**TB/17/62** Oral	**Review of the meeting** To consider: - Behaviours at the meeting - Standard of papers submitted for Board consideration - Standard of debate		HL
12.00	**19.**		**Meeting close** The meeting of the Trust Board in public closes.		HL

			Date of next meeting The date of the next Trust Board meeting in public is on Tuesday 03 October 2017 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD. The London Ambulance Service NHS Trust's Annual General Meeting takes place on Tuesday 26 September 2017.		HL

Additional reports, circulated for information only:

TB/17/63: Quality Report

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Thursday 27 June 2017 at 10:00

DRAFT Minutes of the Public meeting of the Board held 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	Interim Director of Finance
Fergus Cass	FC	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		
Karen Broughton	KB	Director of Transformation and Strategy
Ross Fullerton	RF	Interim Chief Information Officer
Patricia Grealish	PG	Director of People and Organisational Development
Philippa Harding	PH	Governance Improvement Director
Apologies		
Jessica Cecil	JC	Associate Non-Executive Director
Sheila Doyle	SD	Non-Executive Director

1. TB/17/30 – Welcome and apologies

- The Chair welcomed all to the meeting and noted the apologies that had been received.
- One member of the public was in attendance.

2. TB/17/31 – Declarations of Interest

- There were no declarations of interest in matters on the agenda.

3. TB/17/32 – Minutes of and matters arising from the previous meeting held on 25 May 2017

- The minutes of the Trust Board meeting held on 25 May 2017 were approved as a true and fair record, subject to the following amendments:

    - (TB/17/18) to reflect the fact that Mark Hirst had acted as the Trust's Interim Director of Workforce, not its Interim HR Director;
    - (TB/17/20) to reflect the fact that, the Workforce and OD Committee had reviewed recruitment plans, rather than receiving assurance that staffing numbers were appropriate;
    - (TB/17/20) to remove reference to there being a strong pipeline for both EACs and paramedics; and
    - (TB/17/26) to refer to the Ambulance Response Programme, rather than the Ambulance Radio Programme.

4. TB/17/33 – Matters arising

- The Board reviewed the action log and noted the following:

    - Action reference 8 – the Executive Leadership Team (ELT) had yet to discuss the Estates Strategy. In light this and the fact that the work was to be incorporated into broader strategy work, a more detailed update would be provided to a future meeting of the Trust Board.
    - Action reference 35.2 – the ELT was due to consider an action plan for ensuring appropriate compliance with mandatory and statutory training requirements at its meeting on 28 June 2017.

5. TB/17/34 – Computer Aided Dispatch (CAD) / Information Management & Technology (IM&T) Resilience

- The CEO presented the report, which summarised the findings of a number of separate reviews into the causes of the computer outage that affected the handling of 999 calls on New Year's Day 2017. As a result of this outage, the London Ambulance Service (LAS) had been required to use its manual back up system for recording 999 calls and sending ambulance responses. In addition to the causes of the outage itself, the reviews summarised by the report had considered its impact on patient care, the adequacy of LAS' back-up systems and the overall resilience of its IT function. The report also included a number of recommendations that had been made in response to the findings of these reviews, and an update on the Trust's progress in responding to these. Board members were informed that the ELT would be reviewing this regularly and that updates would be brought to each Board meeting. Detailed discussions would also take place at meetings of the Logistics and Infrastructure Committee.

- Non-Executive Directors requested further information about the clinical investigation that had taken place and the assurances available with regard to the Trust's provision of a safe service during the CAD outage. It was noted that the investigation had found that, due to the high volume of calls and the fact that they were being handled manually, ambulance staff were delayed in reaching one patient who had sadly died. Other patients, particularly those with non-life threatening conditions, had

waited longer for a response. However, clinicians in the LAS control room had been able to identify patients whose condition started to deteriorate and upgrade those calls so they received a faster response.

- Board members noted the number of actions to be undertaken by the LAS in response to the recommendations that had been made as a result of the separate reviews. Consideration was given to the question of whether the Trust's IT team had the capacity to ensure that the actions were carried out appropriately. Technically, the fault that had occurred on New Year's Day had been fixed and the computer system used by the LAS to respond to 999 calls was considered to be fit for purpose. It was reported that, whilst some interim members of staff were being used to ensure that short terms actions were taken, a comprehensive longer term recruitment plan was also being developed. The level of possible recruitment required was significant, however, and would take time to complete.

- JJ undertook to ensure that the Audit Committee added the specific risks associated with the completion of the action plan to its detailed consideration of risks faced by the Trust and the actions taken to mitigate these. It was also proposed that the Committee focus on cyber risk more generally.

- The Board confirmed that it was content with the report and the proposed action plan, noting that updates on progress against this would be received regularly at future meetings. Board members expressed their thanks to all who had been involved in the reviews to provide the necessary assurance that the computer system was fit for purpose and identify the actions required to ensure that any shortcomings in the LAS' IT processes and governance were addressed.

6. TB/17/35 – Staff story

- Justin Wand (Deputy Director of Fleet & Logistics) and Achanda Neale (Team Leader Paramedic) joined the meeting to provide the Board with information about the "Make Ready" Programme. The programme focussed upon quality assured vehicle and equipment preparation in order to minimise cross infection and maximise patient safety. Board members were provided with information about the aims of the programme and the manner in which paramedic crews were responding to it.

7. TB/17/36 – Report from the Chair

- In addition to the information set out in her report, the Chair highlighted an increased focus on mental health issues, both amongst patients and amongst staff members. This had been particularly noticeable in speeches given by the Secretary of State for Health and the Chief Executive of NHS England at the recent NHS Confederation Conference.

8. TB/17/37 – Report from Chief Executive Officer

- The Chief Executive reflected upon the number of serious incidents that the LAS had been called upon to respond to in recent weeks. The impact of these incidents on the health and wellbeing of staff members was being given due consideration and additional support was being made available to staff across the organisation. As there was also an administrative impact associated with these incidents, for example in relation to the Trust's participation in related Inquests and Public Inquiries,

consideration was being given to the possibility of requesting mutual aid from other ambulance trusts.

- Board members emphasised the importance of finding ways to recognise the exemplary manner in which LAS staff members had responded to the incidents on an individual and cumulative basis. They also emphasised the importance of ensuring that the Trust's response to every incident was reviewed, in order to identify any possible learning points. It was noted that "hot debriefs" occurred at the conclusion of each incident, and that these had already led to some operational changes. Time was also being taken to review the Trust's response as a whole in greater depth. Additionally, the National Ambulance Resilience Unit (NARU) would be undertaking a confidential lessons learned exercise in due course.

- Consideration was given to the serious concerns that the LAS and Imperial College Healthcare NHS Trust had with regard to the "Paddington Cube" scheme. These related to the ability of St Mary's Hospital to operate a busy emergency department and one of London's four major trauma centres in light of the anticipated impact of revised access arrangements associated with the development. Meetings on this had been held with the Mayor of London, the Greater London Authority and Transport for London and these would continue with a view to reaching an appropriate solution.

9. TB/17/38 – Performance Report – May 2017

- 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.

- Non-Executive Directors requested an update on the Trust's contractual arrangements. It was proposed that a more detailed update should be provided to the Finance and Investment Committee, which continued to scrutinise the Trust's financial position and progress in the implementation of Cost Improvement Programmes (CIPs).

  ACTION: LB/KB to provide an update on the Trust's contracts to the Finance and Investment Committee.

- The importance of linking the performance report to the Trust's objectives, as set out in its Business Plan was noted. Board members were informed of the actions being instigated to ensure that the Trust operated a holistic performance framework. These included an appropriate framework for executive scrutiny of performance against a number of metrics. The ELT would be ensuring that it set aside dedicated time for focussed performance discussions on a regular basis. These would also be linked to the business of the Board's assurance committees.

- In response to a request for a further information about the Trust's position with regard to recruitment and filing of vacancies, the Board was informed that further work was being undertaken with regard to the development of a comprehensive People and Organisational Development Strategy. This would be considered by the People and Organisational Development Committee at its meeting in July.

- The Board noted the reported and welcomed the continued work that was ongoing to improve the Trust's performance.

10. TB/17/39 – Board Assurance Framework (BAF) and Risk Management

- The Board reviewed the report, noting that the BAF was in the process of being refreshed and that it would, in the future, align the Trust's risks with its Business Plan objectives.

- In considering the top five risks that had been identified according to their net ratings in the BAF, Non-Executive Directors referred to the need to reflect recruitment as one of the top risks facing the Trust. It was also considered appropriate that the risks associated with cyber security should be reflects in the BAF. It was emphasised that the risk process had to be sufficiently dynamic to reflect the pace of change within the organisation. Ongoing consideration of the Board's risk appetite was also very important. In order to achieve this, a greater level of engagement from the organisation's senior executive would be required. It was proposed that the amended form of reporting should be in place by no later than the Board meeting on 3 October 2017. Board members confirmed that they would be content to attend a seminar in order to facilitate the implementation of a new approach.

  ACTION: PH to ensure a new BAF approach is implemented for consideration at the meeting of the Board on 3 October 2017.

- A number of more detailed comments were provided on the BAF, including the need to ensure that stated deadlines were appropriate and up to date.

- With regard the risk that patients could suffer avoidable harm across shift change periods due to deterioration in response times as a result of reduced resource availability (risk 7), Non-Executive Directors considered the assurance that had been provided in relation to the implementation of an updated Rest Break Policy. This was currently being discussed with unions and staff representatives and it was on track to be implemented by the end of July. In light of this it was expected that the risk scoring would be reduced by the time of the report to the next meeting.

11. TB/17/40 – Logistics and Infrastructure Committee Assurance Report Assurance Report

- TdP provided the Board with an overview of the meeting of the Logistics and Infrastructure Committee on 19 June 2017.

- It was noted that the Logistics and Infrastructure Committee had considered 2017/18 capital expenditure and cost improvement programme budgets relating to IM&T, Fleet and Estates as well as the progress of strategy implementation in each area. With regard to the IM&T team, as previously noted by the Board, a key action would be to recruit the additional technical skills required in order to ensure long term resilience and improved project delivery.

12. TB/17/41 – Trust Board Forward Planner

- Board members reviewed the content of the meeting forward planner. It was noted that an alternative approach was being proposed to the Annual General Meeting, in order to improve engagement with the Trust's key stakeholders.

- Following the Chair's discussions with Non-Executive Directors about changes to the membership of the Board's assurance committees, it was confirmed that this would be circulated to the Board for approval ahead of its next meeting.

- In order to facilitate planning for 2018/19, proposed dates for Board and Committee meetings in 2018 would be submitted for consideration by the Board at its next meeting.

13. TB/17/42 – Questions from members of the public

- The Patients' Forum (represented by Malcolm Alexander) asked the following questions:

    - Does the Board intend to publish a short and medium term Action Plan for delivery of its Clinical Strategy?
    - In the (excellent) Chief Executive's report:
        - Why does the CEO refer to achievement of 60% A8 response, instead of the national target of 75%
        - Is the LAS funded to deliver the 75% A8 target?
        - With reference to staff wellbeing – should the Board consider the provision of spiritual support for staff affected by major disasters?
        - When will the £0.5m provided by the HEE to the LAS start to have an impact on front line staff diversity?

- It was confirmed that the LAS was committed to the delivery of a pan-London target of 75% A8 response. Effort was being put into the achievement of a more even distribution of performance across each of the London sectors and the approach that was being taken in 2017/18 was to ensure that traditionally poorer performing sectors improved, whilst the LAS maintained its aggregate performance against national targets. It was noted that, excluding those NHS Trusts participating in the Ambulance Response Programme, the LAS was currently the top performing NHS Trust in the country and that it had improved its performance in comparison to the same point in time in 2016/17.

- On the question of racial diversity within the LAS workforce, it was reported that work was being undertaken with a number of different communities to improve the diversity of the LAS workforce. Consideration was also being given to the most appropriate drivers of this.

- With regard to the remaining questions, the CEO undertook to ensure that a detailed response was provided outside the meeting.

14. TB/17/43 – Any other business

- No other business was raised.

15. Date of next meeting

- The date of the next Trust Board meeting in public is on 01 August 2017 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.

TRUST BOARD - Public Meeting: ACTION LOG

Commenced w.e.f. 25 may 2017

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late	Comments / updates *(i.e. why action is not resolved / completed)*
8	Estates Strategy: - Finalise the strategy document - Strategic Outline Case to Trust Board	Andrew Grimshaw	28/02/17 17/03/17	28/03/17 25/05/17	**1 month late**	To be incorporated into broader strategy work.
35.2	Quality Governance Committee Report – Bank Staff: ELT to receive further update re bank staff mandatory training.	Patricia Grealish ~~Karen Broughton~~	28/03/17	25/05/17	**1 month late**	19/06/17 - update from Nikki Fountain: P&OD undertaking a full compliance review of Statutory and mandatory training with bank staff. To be reported ELT and People and OD Committee on 24/07/17. Matters arising 25 May 2017 The action is being progressed by the Executive leadership Team.
TB/17/21	Garrett Emmerson / Philippa Harding to review and secure agreement of the Trust's top five risks and other risk ratings within the BAF.	Garrett Emmerson / Philippa Harding	25/05/17	07/06/17	**CLOSED**	The BAF report included information about the Trust's top five risks.
TB/17/26	Karen Broughton to provide the Board with a summary of the Trust's strategies, their critical dependencies and plans to deliver them.	Karen Broughton	25/05/17	01/08/17	**1 month late**	
TB/17/27	Philippa Harding to ensure that the Trust Board forward planner reflects new meeting plans.	Philippa Harding	25/05/17	01/08/17	**CLOSED**	See item on agenda
TB/17/38	Provide an update on the Trust's contracts to the Finance and Investment Committee.	Lorraine Bewes Karen Broughton	27/06/17	01/08/17	**CLOSED**	An update was provided to the Finance and Investment Committee meeting on 27 June 2017
TB/17/39	PH to ensure a new BAF approach is implemented for consideration at the meeting of the Board on 3 October 2017.	Philippa Harding	27/06/17	03/10/17	**On track**	

London Ambulance Service NHS Trust

Report of the Chair – 01 August 2017

1. Care Quality Commission (CQC) Quality Summit

The Quality Summit took place on 29th June 2017 as planned and following the release of the report setting out our progress since the initial report in 2015. The report findings were:-

Care	- Outstanding
Responsive	- Good
Effective	- Good
Safety	- Requires Improvement
Well led	- Requires Improvement

This represents significant progress; however we have more to do before exiting Special Measures. It is understood that there will be a 'light touch' review of 'Well led' in a few months' time at a date to be agreed. The aim of this review will be for the CQC to be able to recommend to NHS Improvement that the Service exits Special Measures. The executive team is in the process of completing an action plan and this will be discussed at the next Board meeting.

Once the Service is out of Special Measures and the Board is confident that it is on track to meet key targets (i.e. financial, performance and quality) I intend to review the monthly Board meetings with the aim of reducing these possibly to alternate months from no later than the beginning of next financial year.

2. Committee membership

Philippa Harding, Governance Improvement Director has circulated a paper for consideration on the proposed membership of the Board committees which form an integral role in the Governance of the Service.

We have tried to ensure that there is representation from key committees to ensure cross referencing and at the same time to ensure that I am not asking NEDs to attend too many regular meetings.

The final version will be circulated in due course.

3. Non-executive Directors (NEDs) appraisals and Objective setting

I have now completed the NED appraisals and objective setting for 2017/18. The overarching objective for the Board is:

- **To achieve collective accountability for the strategic development and performance of the Trust.**

4. **Review of Board Meetings**
   As an element of the 'Well led' aspect of Governance I have asked for an agenda item to be added that allows us to reflect on the meeting and discuss things we have done as a Unitary Board in carrying out our functions.

   Questions we might ask ourselves include:-

   Did we spend the right amount of time on Performance, Governance sand Strategy?

   Where the papers timely and did they give us sufficient information to inform debate and decision making?

   Were we suitably challenging whilst also being supportive and respectful and inclusive?

   Did we act as a Unitary Board?

5. **Interim Chairman of NHS Improvement (NHSI)**
   Richard Douglas has been appointed as the interim Chairman of NHSI effective from 21 July 2017, whilst the recruitment of a new chairman is completed. Richard is a Non- Executive Director at NHSI and former Director General of Finance at the Department of Health.

6. **Association of Ambulance Chairs and CEO meeting 18-19 July 2017**
   On 18 July I attended the Chairman's meeting which can best be described as a networking occasion as it appears that there is no formal Governance arrangement in place.

   Garrett and I then attended the following two events:-
   A dinner attended by CEOs and Chairmen at which Dr Jonathan Benger was the after dinner speaker. His topic was Ambulance Response Programme (ARP) and its implementation.

   The work of our Medical Director, Dr Fenella Wrigley in interpreting the many codes was publicly acknowledged. There are key lessons to be learnt from the pilot sites and these include:-

   - Risk around perception of the Public re 8 minute target
   - Rostering revised
   - Technical alterations to the Computer Aided Dispatch (CAD) system
   - Fleet impact on first responders

   On 19 July I attended the CEO and Chairmen's meeting; this was a helpful meeting particularly in relation to:

- The Welsh Ambulance Trust Clinical Response Model - relevant to our strategy development at LAS.

- Q Volunteering - Garrett will arrange a briefing session for the Board on this important initiative that could be linked to both our opportunity to recruit young people to volunteer and the WRES targets. The Trust has submitted a bid for additional funding and there is the potential for considerably more to be made available.

- Workforce Race Equality Standards (WRES) - this remains an area of particular focus not just for us but across the wider NHS. Simon Stevens has asked Yvonne Coghill, the National Lead Director to focus on LAS. Melissa Berry presented the work that we have done on this over the last year which was well received; however we have a considerable way to go to be both an organisation of choice for employment by people of a Black and Minority Ethnic (BME) background and in meeting the national targets.

- Manchester Arena terrorist attack (North West Ambulance Service) We saw a video of the event as it unfolded and received a presentation on what went well and lessons to be learnt. They have been in contact with LAS to share learning and experiences.

7. Victoria Health Association visit

A number of CEOs and Directors from the Victoria Healthcare Association visited the Service as part of their educational visit to Healthcare providers in the UK. Our staff provided an excellent overview of how the NHS is regulated in the UK and about the Service. We also discussed recruitment in Australia and the opportunities we provide to their Paramedics.

8. Staff meetings

Garrett and I supported a workshop set up by Melissa Berry to develop the WRES plan for this year. Attendees included Directors, Unions and staff of different backgrounds from across the Service.

9. Meeting staff members

I met with Ginika Nwafor-Iwundu, Safeguarding Specialist Children to discuss the complexities of her role in LAS and to offer my support. I also met wiht Tina Ivanov, Deputy Director of Clinical Education and Standards to talk about training and new roles that are emerging. Both members of staff were highly professional and excellent ambassadors for the Service.

10. Patients' forum

I attended the Patients forum on 10 July 2017 with Trisha Bain, Chief Quality Officer who gave an excellent presentation on the CQC findings.

Heather Lawrence OBE
Chair

From Quality Assurance Committee Date: 11/07/2017

Summary Report to:	**Board**	**Date of meeting:**	**11/07/2017**
Presented by:	**Non-Executive Director**	**Prepared by:**	**Non-Executive Dir. Robert McFarland**

1

Matters for escalation	Although we are re-assured that the issue re unclosed actions in relation to Sis has been identified, we have asked that a report be provided to September meeting with evidence of actions we cannot provide assurance to the Board that these have been acted upon. Training in some areas e.g. MAST, Manual handling, Infection control, Safeguarding is not consistent and up to date for all staff (Including bank staff and where relevant non-clinical staff), not consistently included in CSR and not recorded for individual staff. The issue is being taken forward by the Director Of People and Organisational Development and this will be reviewed at September QAC. There is an urgent need to act on the poor estate in NE sector.
Other matters considered from the weekly review:	Serious incidents – The committee felt it was helpful to see details of the SI and was pleased that incident reporting had improved. There was a substantial number of SI for which the resultant action had not been completed. Trisha Bain reported regular review of all SI was underway at QOG and progress on ensuring lessons are learned would be reported to next meeting. Delay is still a significant theme - There is concern that when there are significant delays there must be a risk to safety as well as patient experience even if there is no evidence of actual harm in an individual case. There is a need for more frequent Clinical safety reviews because Surge Purple/Blue is no longer an exceptional event. Recent inspections have demonstrated Infection Prevention and Control (particularly hand washing and waste management) remain below standard and these will be addressed through the 2017/2018 work plan and progress monitored in the Quality report. Other issues escalated by QOG involved reporting and delivery of training (MAST and Manual handling), levels of incident reporting compared to other ambulance services, mental health assessment recording on PRF and on scene times for STEMI and Stroke had increased. Progress will be monitored in the monthly Quality report. The committee remains concerned that the BAF and risk register are not providing assurance that risks are being mitigated and progressed in a timely fashion. Another review of the risk process is underway by Philippa Harding but there is concern that this should translate into a focus on actions and outcomes. Trisha Bain assured us all Quality risks were to be regularly reviewed by QOG and failure to progress would be escalated. We are assured in relation to other quality domains in the Quality report

	that we are aware of and addressing issues and that progress is also being made in many areas.
Key decisions made/ actions identified:	ToR for QAC were reviewed and recommendations made regarding membership and quorum levels. Four 2016/2017 Annual reports can be recommended to the Board for approval. • The 2016/2017 Clinical Audit report was presented and Rachel Fothergill commended for the substantial quality work done by her team. The positive comments in the CQC report were noted. The 2017/2018 objectives will be regularly reviewed by QOG. • The 2016/2017 Infection Prevention and Control report was presented and approved. Substantial progress has been made and now the team is adequately resourced it should be possible to raise standards (including addressing CQC concerns) by a "back to basics" programme. • The 2016/2017 Annual Safeguarding report was presented by Alan Taylor and there has been substantial progress this year while the workload increases. The report highlighted issues around training (especially bank staff) which are due to be addressed in 2017/2019. • The 2016/2017 Mental Health report was reviewed. Satisfactory progress has been made. A key area of concern was the recruitment and retention of adequate numbers of Mental Health nurses. The Mental Health CPI remains red due to the safeguarding assessment not being recorded if no referral required – we were told that a record of safeguarding should be part of every patient assessment and a prompt would be included in a revised PRF. There is a plan to include a prompt in a revised paper PRF being introduced prior to the introduction of a new e-PRF – however this committee will not be assured until there is a confirmed timeline for these changes. Progress of 2017/2018 objectives in these areas will be regularly reviewed by QOG and any issues escalated to QAC. The committee approved the programme of reports and deep dives for the year (to April 2018) and these were seen to include reports on the main Quality risks on the BAF. **DEEP DIVES** <u>Handover delays at Northwick Park Hospital.</u> Emily Grist presented and was commended for her work to reduce the time lost by ambulances "stacking" outside the A/E department. A protocol for cohorting several waiting patients under one paramedic allowed other teams to get back on the road – but also, by developing relationships with the hospital staff, she had made them understand the consequential delay in reaching patients who needed an ambulance. Use of the NEWS (early warning system) records any deterioration (or improvement) while

	waiting and data being collected will improve decision making. Lessons learnt from this will be applied across London. However helpful in the short term the real solution to this problem does not lie within the ambulance service. Review of North East Sector Natasha Wills (ADO) presented the North-east Sector situation. Poor estate (many small and inadequate stations), high activity in a deprived area and inadequate numbers of staff are compounded by historically inflexible working practices and rosters and inappropriate staff habits which were in some cases unacceptable breaches of working practice. The committee was pleased to hear of the support senior executives were giving to Natasha and that improvements were being made. The committee was concerned to hear of staff working from small portacabins with ambulances parked in nearby streets. Urgent action on the estate in NE sector is required within or without the overall review of estates.
Risks:	No new risks were identified at this meeting The committee were informed several new risks had been identified for inclusion in the risk register. In brief: • PDAs for NETS and PTS staff are obsolete and no longer working. • The Clinical Hub may be unable to retain and thence maintain staff levels • Delivery of patient care and therefore performance may be reduced at weekends due to historical staff rostering agreements. • We may be in breach of our contract for not updating our MPDS system due to delays in updating the IT infrastructure.. Details of mitigation and the action plans to resolve these risks was provided within the risk registers, however further action plans were requested.
Assurance:	There are a two areas for which we will only have satisfactory assurance when we receive the reports requested at September QAC for manual handling training and SI closed actions.

London Ambulance Service NHS Trust

Serious Incidents Monthly Report

July 2017

Presented to: Trust Board, CQRG, Quality Oversight Group

Introduction

- The purpose of this report is to give a high level overview of the London Ambulance Service's position and progress.
- This report will cover activity in the previous month otherwise stated, in this case June 2017 although the analysis itself may take into account activity prior to these dates.

Serious Incidents - Activity

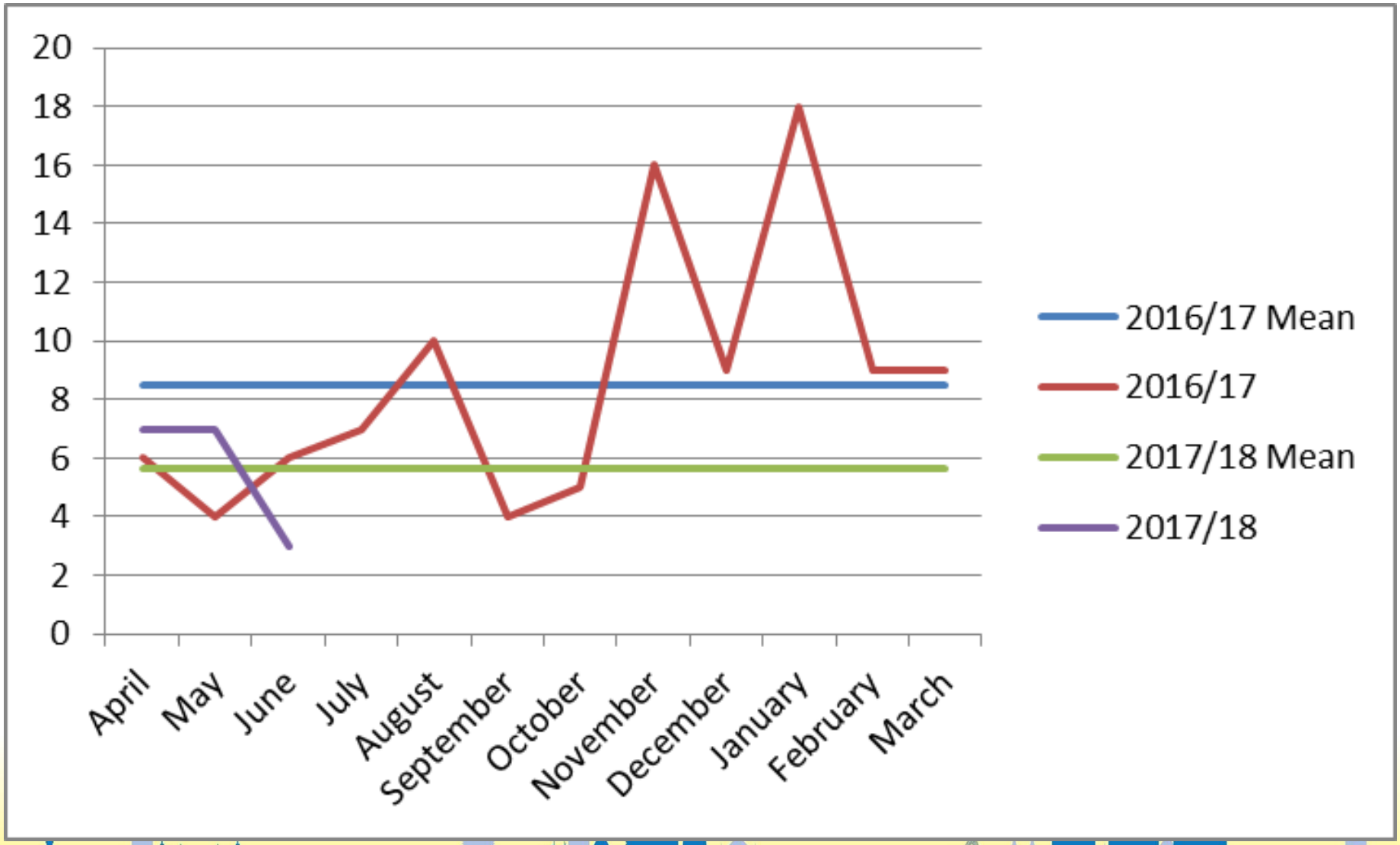
- In June there were 25 incidents raised to SIG, with 3 declared. The number raised was lower than the previous month, and the number declared is currently at a lower level compared to the previous financial year.
- For 2016-17 on average 45 incidents were reviewed and 9 SIs were declared each month.
- Of the 3 SIs declared in May 2017 these include 2 incidents where there were delays to treatment and 1 maternity incident.
- As of 07/06/2017 there are currently 18 SIs under investigation, a reduction of 12 the previous month, with 4 overdue, a decrease of 6 on the previous month and slightly higher than the trajectory. The 4 overdue reports are very close to completion.
- 12 reports were submitted in June, an increase of 3 on the previous month and in line with the projected figure.

Serious Incident Group Activity

	Number of Incidents raised to SIG	Number of incidents declared as SIs	Number of SIs declared within 2 working days of reporting	Number of SIs declared within 5 working days of reporting	Number of SIs declared after over 5 working days of reporting	% of SIs declared within 2 days of reporting	Number of SIs entered onto STEIS within 48 hours	% of incidents put on STEIS within 48 hours	Number of SIs requested for de-escalation from this reporting month
Jul-16	39	7	3	2	2	43%	7	100%	0
Aug-16	59	10	7	0	3	70%	10	100%	2
Sep-16	40	4	1	2	1	25%	4	100%	1
Oct-16	33	5	1	1	3	20%	5	100%	1
Nov-16	50	16	10	5	1	63%	16	100%	2
Dec-16	48	9	2	3	4	22%	9	100%	3
Jan-17	48	18	5	4	9	27%	18	100%	2
Feb-17	55	9	4	2	3	44%	9	100%	0
Mar-17	55	9	2	6	1	22%	9	100%	2
Apr-17	28	7	4	6	1	57%	7	100%	1
May-17	47	7	5	1	1	71%	7	100%	0
Jun-17	25	3	2	1	0	66%	3	100%	0

Overview into Open SIs as of 07/07/2017								
Number of Open SIs on STEIS	Number within 30 days	Number between 30 and 60 Days	Number overdue	Number on Stop the Clock	Number Submitted awaiting feedback or closure	Number requesting further information – outstanding	Number of De-escalation requests submitted in May	Number of De-escalation requests submitted in June
30	4	8	4	2	11	1	4	1

Serious Incidents Activity



Declared SIs – The detail

Incident date	Date reported to STEIS	STEIS Ref:	Category	CCG	Due Date
05/06/2017	08/06/2017	2017/14619	Treatment delay meeting SI criteria	Haringey	01/09/2017
15/06/2017	19/06/2017	2017/15481	Maternity/Obstetric incident meeting SI criteria: baby only	Haringey	12/09/2017
18/06/2017	22/06/2017	2017/15866	Treatment delay meeting SI criteria	Hillingdon	15/09/2017

Duty of Candour compliance

The Trust reported 3 Serious Incidents onto STEIS that met the threshold for Duty of Candour in June (including one declared on 30/05/2017 but not on STEIS until the following day).

Of these 4 incidents –
2 patients/ Next of Kin(s) have been contacted, apologised to and been followed up in writing
1 patient's duty of candour work is being led by the Acute Trust as they are leading the SI investigation. This has been agreed by the LAS consultant Midwife
1 patient's NOK has been contacted and apologised to and will be followed up in writing

Final reports from investigations will be shared with the patients/ NOK where they are happy to receive them.

The Trust reported 2 incidents where moderate harm was caused.
1 patient has been contacted and followed up with a letter of apology.
1 is currently under investigation by the QGAM to confirm level of harm. The patient/NOK will be contacted, apologised to and will be followed up in writing

Overdue Serious Incident Investigations as of 07/07/2017

ELT	SMT	STEIS ref	Datix ref	No of days overdue	Due Date	Update
DDO - Sector	GM – EOC	2017/4509	6324	35	16/05/2017	6/7/17 – Draft has been sent back to LI to confirm changes prior to ELT review
Deputy Director of Clinical Education	ADO – Central Ops	2017/5457	6536	30	24/05/2017	28/6/17 – LI is completing report for ELT sign off
Deputy Director of Nursing	AMD	2017/4505	6196	35	16/05/2017	28/6/17 – further changes required by LI before ELT sign off
Dir of Transformation & Strategy	ADO - NE	2017/6891	6613	20	08/06/2017	29/6/17 – Report is with ELT lead for sign off

Serious Incident Action Compliance as of 07/07/2017

Since the inception of Datixweb in May 2016 142 Actions have been completed and closed out of 241 actions due by the end of May 2017 (59% compliance, 3% increase on the previous month). The majority of the outstanding actions require individual feedback to members of staff and actions around recruitment have been grouped.

There is a thematic action plan to address the major causes of the Trust's Serious Incidents covering;

- Equipment and Documentation
- Delays and Rest Breaks
- Clinical Assessment
- Call Handling

The Governance and Assurance team will be commencing a review into action compliance with a sampling methodology applied to evidence review and a thematic action plan applied.

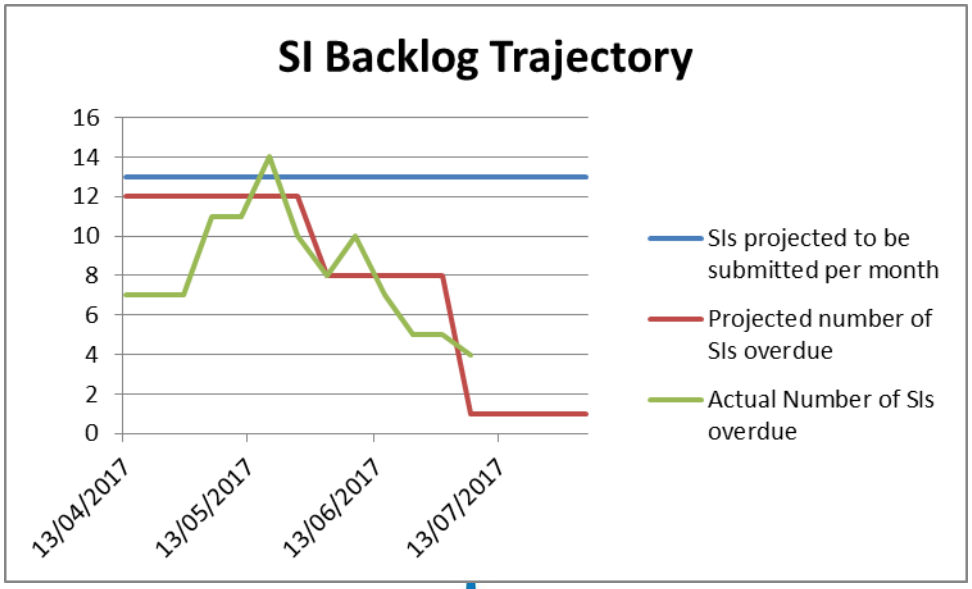
Activity analysis as of 07/07/17

- There are currently 4 reports overdue with a further 4 due by the end of July, 5 due in August and 3 due in September so far. Therefore over the next two months 13 reports will need to be completed and submitted in order to ensure a minimal number of SIs are overdue and that the Trust continues to work on SIs that are in date.
- On average 7 SI reports will have to be signed off per month over the next two months, with capacity for at least 10 reports per month signed off following this period.
- Throughput has recently increased with an average of approximately 13 reports submitted per month over the last 4 months.
- As a result of the backlog, an action plan was put in place which is being monitored weekly by the Chief Quality Officer with updates into ELT. Key actions include;
  - Review of capacity in the department
  - Rewriting of SI process and policy
  - Training of 15 preferred Lead Investigators, including human factors and use of datix
  - Reduction of ELT escalation threshold from 40 days to 30 days

This action plan is subject to additions once the SI process is signed off.

SI Trajectory graph

This trajectory is based upon 9 SIs being declared per month and 13 reports submitted per month, which is the capacity of the current resource in place.



SI Backlog Action plan

Action No.	Action Required	Lead	Time Frames	Status
1	Identification of 15 preferred investigators plus 15 reserve	PN	10/04/2017	Complete
2	More overt escalation at ELT of SIs stuck in train – held at SMT/ELT and those where a 1st draft has not yet been received post 30 days. Context of potential contract notice made explicitly clear	PN/TB	12/04/2017	Complete
3	Reduction of the escalation threshold from 40 days to 30 days to ELT	PN	12/04/2017	Complete
4	Communication of the 30 day timeframe in first comms with investigation team	JM/EL	13/04/2017	Complete
5	Single running of tracker on datix, then extracted to excel as opposed to double running	NC/EL	18/04/2017	Complete
6	Review and sign off of SI policy and process	TB/PN/LS	23/04/2017	Complete with comms place for launch
7	Submit new SI policy and process to ELT	TB	26/04/2017	Not required
8	Begin implementation of revised SI process to speed the process up – starting with move from ELT lead to ELT group asap	All	30/04/2017	On Track, process has begun to be implemented, keep action open until process is fully in place
9	Training sessions for those 15+15 to cover human factors, investigations solely through datix and timeframes	TB/PN	31/07/2017	Complete
10	Write up business case for Business Partner Model		31/05/2017	Funding agreed
11	Recruitment on a secondment basis of band 4 admin support to the team	PN	June	Complete and due to start by the end of July

London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**
Date of meeting:	**01 August 2017**
Document Title:	**Ambulance Response Programme**
Report Author(s):	**Dan Gore**
Presented by:	**Paul Woodrow / Dan Gore**
Contact Details:	dan.gore@aace.org.uk
History:	**NHS England National programme released 13 July 2017**
Status:	

Background / Purpose:

Introduction

The purpose of this paper is to provide a high-level briefing to the Trust board following the announcement by NHS England on the 13 July of the intention to roll out the Ambulance Response Programme across England.

Background

A new way of working for ambulance services is to be implemented across the country to ensure patients get the right response, first time.

These changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time. They are designed to change the rules on targets so they are met by doing the right thing for the patient.

Under the current standards the Trust often sends more than one vehicle to have the best chance of meeting the current target. This frustrates staff and is often inefficient the changes will free up more vehicles and staff to respond to all patients.

Under the new system early recognition of life-threatening conditions, particularly cardiac arrest, would also increase. A new set of pre-triage questions identifies those patients in need of the fastest response earlier in the call cycle.

This redesigned system for ambulance services in England focusses on ensuring patients get rapid life-saving, life-changing treatment and is strongly endorsed by expert organisations such as the Royal College of Emergency Medicine, the Stroke Association, and the College of Paramedics.

Principles

Since February 2015 Ambulance services in England have been engaged in an NHS England led trial of a new operating model. The Ambulance Response Programme (ARP) is the most comprehensive study about ambulance services completed anywhere in the world. It has been independently evaluated on a continual basis by Sheffield University's School of Health and Related Research (ScHARR). The ARP focussed on four main areas:

- Identifying the most seriously ill patients as early as possible through processes known as

Pre-Triage Sieve (PTS) and Nature of Call (NOC).

- Giving control room staff more time (up to 240 seconds) to assess incidents through a process known as Dispatch on Disposition (DOD).
- Developing new clinical code sets and response categories using the best available clinical evidence.
- Developing new targets, indicators and measures.

PTS and NOC involves asking callers a series of four brief questions before entering the triage tool (MPDS). Ambulance Services within the trial are capturing as many as 75% of Category 1 patients through this process saving up to 50 seconds when dispatching a resource. This process offers assurance that a high proportion of the most seriously ill patients are being identified and responded to at the earliest opportunity.

These high capture rates offer assurance about the safety of allowing staff more time to assess other patients through the DOD process. DOD allows control room staff up to 240 seconds from the point that the call is connected to the switchboard to assess the patient's needs. This has dramatically reduced the dispatch of multiple resources to patients whose condition doesn't warrant that response. It preserves fast response resources for those in greatest need and preserves conveying resources for those who require transportation.

The review of clinical code sets was led by the National Ambulance Services Medical Directors group (NASMeD) under the governance of ARP. The code set was reviewed and approved by the Emergency Call Prioritisation Advisory Group (ECPAG) which comprises a broad range of regulators, stakeholders and clinical experts. The code set has been continually developed through the ARP trials arriving finally at four categories:

- Category 1 – Life threatening event.
- Category 2 – Emergency - potentially serious incidents.
- Category 3 – Urgent problem.
- Category 4 – Less urgent problem.

The code set has dramatically reduced the over triage of patients and the proportion categorised for an 8-minute response has dropped from circa 50% to circa 7% of incidents. This has released significant levels of resource to enable ambulance services to address the lengthy delays that lower acuity patients were experiencing under the previous model. It has also reduced the tail delays for higher acuity patients.

LAS readiness

LAS along with all English Ambulance Trusts have been involved with the ARP development and delivery groups. In addition to this the LAS Medical Director has been heavily involved in the national programme.

The Control Services team are working through adopting some of the principles of ARP in terms of the early recognition and dispatch of life threatened Red 1 patients. This workstream has been constructed to allow for its expansion for the new Category 1 patient group.

The Trust has been preparing for the potential changes ARP will bring and has undertaken some initial modelling as well as implemented a programme board, project team and steering group. A project plan has been developed by the Operations Service Improvement Team, with input from across the wider Trust.

East Midlands Ambulance Service NHS Trust (EMAS) who went live on ARP on the 19th July have conducted a peer review of our planning and readiness for ARP. In addition, EMAS have kindly offered to provide ongoing partner support as the Trust prepares for going live in the context of their

experiences and learning. In addition to this the Trust is receiving ongoing support from the Association of Ambulance Chief Executives (AACE). At this stage LAS are working towards an Autumn 2017 go live for ARP and is keen to be able to leverage off the improvements that ARP will provide both staff and patients. A more detailed briefing will be provided later in the year to the Trust board.
Action required:
Presentation for information only.
Links to Board Assurance Framework (BAF) and key risks:
Key implications and risks in line with the risk appetite statement where applicable:

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
NHS Trust

Ambulance Response Programme

Briefing to the Trust Board

1st August 2017

National ARP Programme.

- Led by NHS England
  - Professor Jonathan Benger (National Dir Urgent Care)
- Significant Ambulance Sector / AACE involvement
- Programme has been running since February 2015
- Four main areas
  - Dispatch on Disposition (coding) max window 240s (allows call handlers more time to establish what is happening for most appropriate resources to be sent to meet patient needs)
  - Pre-triage Sieve / Nature of call (allows sickest patients to be identified much earlier in the call cycle)
  - New Categories and Clinical Code sets
  - Development of new Ambulance measures, standards and indicators

National ARP Programme

Three Objectives overall

- Prioritising the sickest patients quickly to ensure they receive the fastest response
- Driving clinically and operationally efficient behaviours so patients get the right response in a clinically appropriate timeframe
- Putting an end to unacceptability long waits especially for many lower acuity patients

National ARP Programme

Trialled by 3 ambulance services

- South West Ambulance Service NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- West Midlands Ambulance Service NHS Foundation Trust

14 million 999 calls

- no patient safety or adverse incidents attributed to the programme

National ARP Programme

Three Components

- A detailed data driven analysis of the trial results from Sheffield University's School of Health and related Research (ScHARR)
- An Impact Assessment
- Recommendations for future measures , indicators and standards.

National ARP Programme

Timescales for completion

- New standards announced for ambulance services 13th July 2017
- Trial sites to continue working to new ARP model
- All other Trusts to implement new model and standards over coming months and preferably in time for winter

New Patient Categories

Category 1 – Life Threatening

Category 2 – Emergencies

Category 3 – Urgent

Category 4 – Less urgent

New Standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Patient / LAS benefits

- National response targets to apply to every single 999 patient for the first time
- More equitable response for patients across the call categories
- Faster treatment for those needing it set to save 250 lives a year nationally
- An end to “hidden waits” for millions of patients
- New standards to drive improved care for stroke and heart attack (right resource first time, patient to definitive point of care)
- World’s largest clinical ambulance trial to update decades-old system

LAS progress

- Program of work since January 2017 specifically focusing on response to life threatened patients
- Staff engagement particularly within EOC to begin awareness and partial delivery of key elements of ARP
- LAS Medical Director has been heavily involved in ARP at a national level
- LAS ARP Program board commenced February 2017
- Modelling underway for implications for LAS response model
  - Initial high level modelling suggests a mode equitable response for patients
- Project plan constructed with input from across the organisation

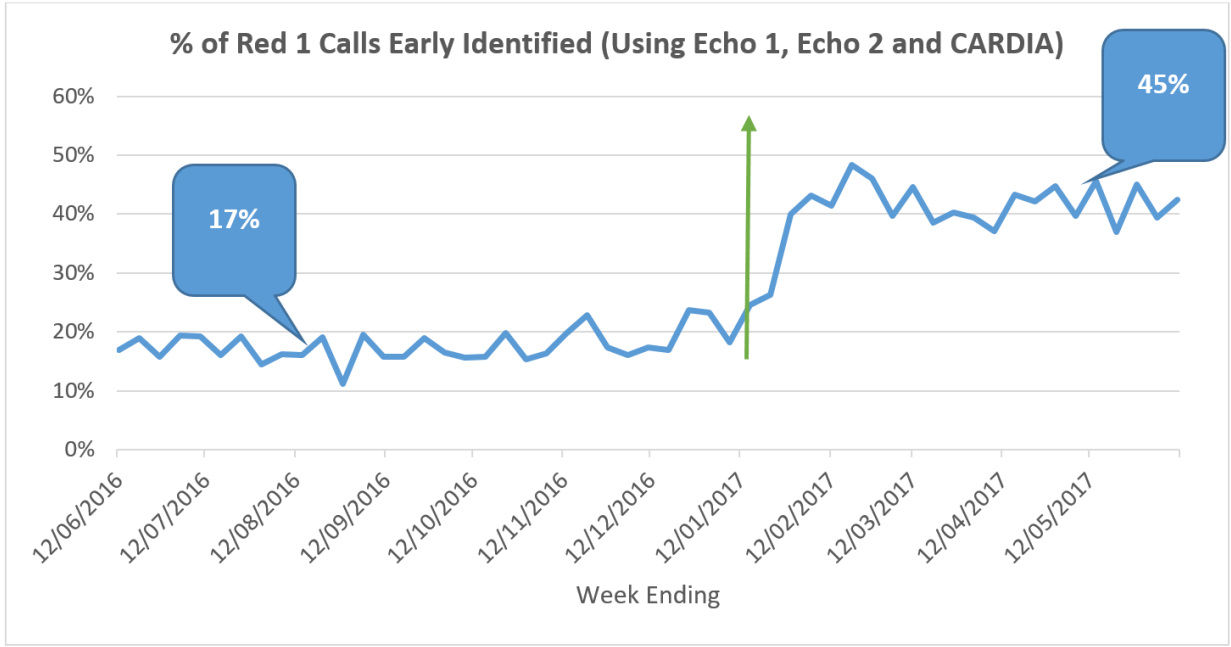
LAS next steps

- Continue project planning
- Further and more detailed modeling following clarification of categories and measures
- Engagement with patients, public and commissioners
- Review of contract
- Agree go live date (aiming for Autumn 2017)

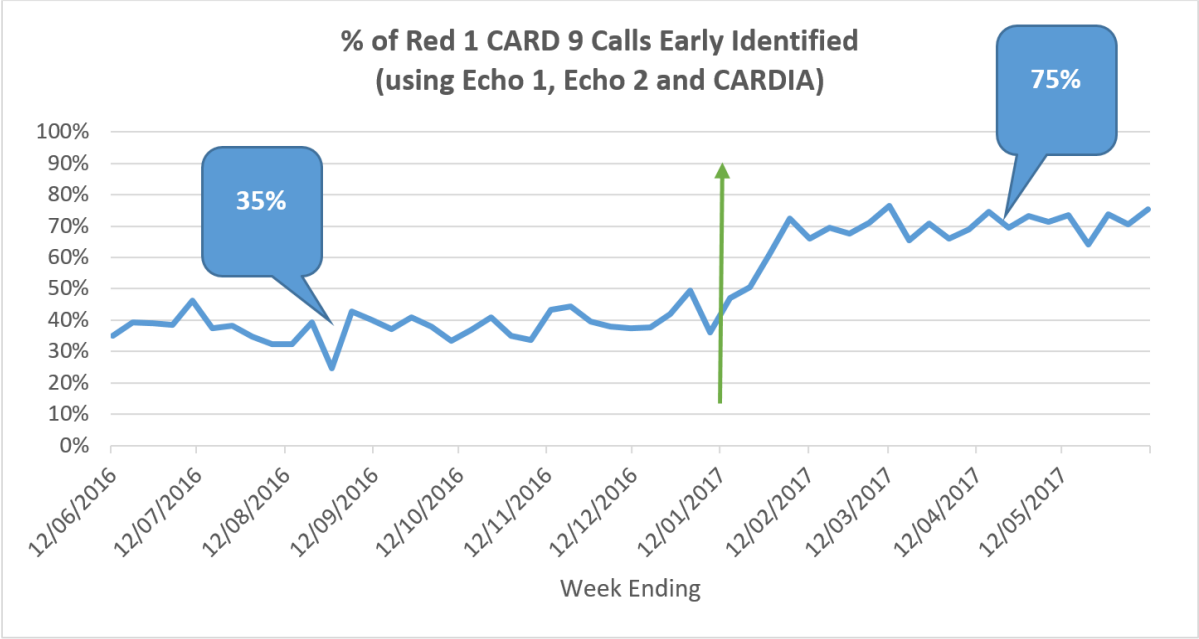
The following slides set out progress LAS has made so far in terms of implementation of some of the principles of ARP

This data was used by the national team and forms part of the ScHARR report for the Ambulance Response Programme

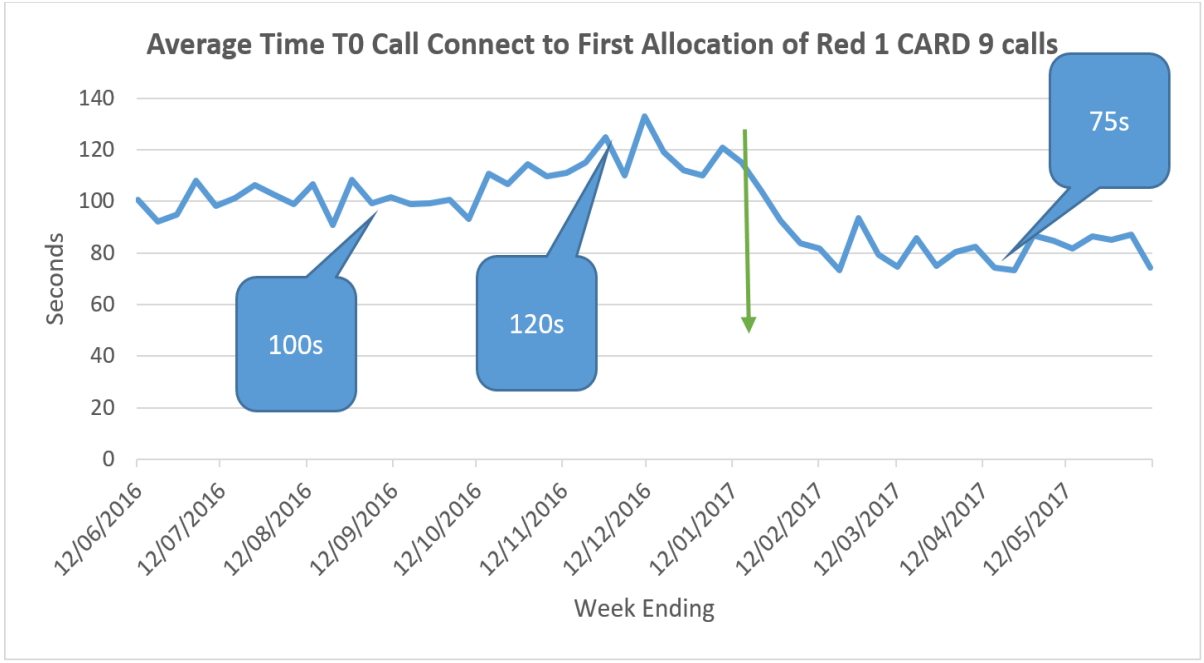
% patients with life threatening condition identified early



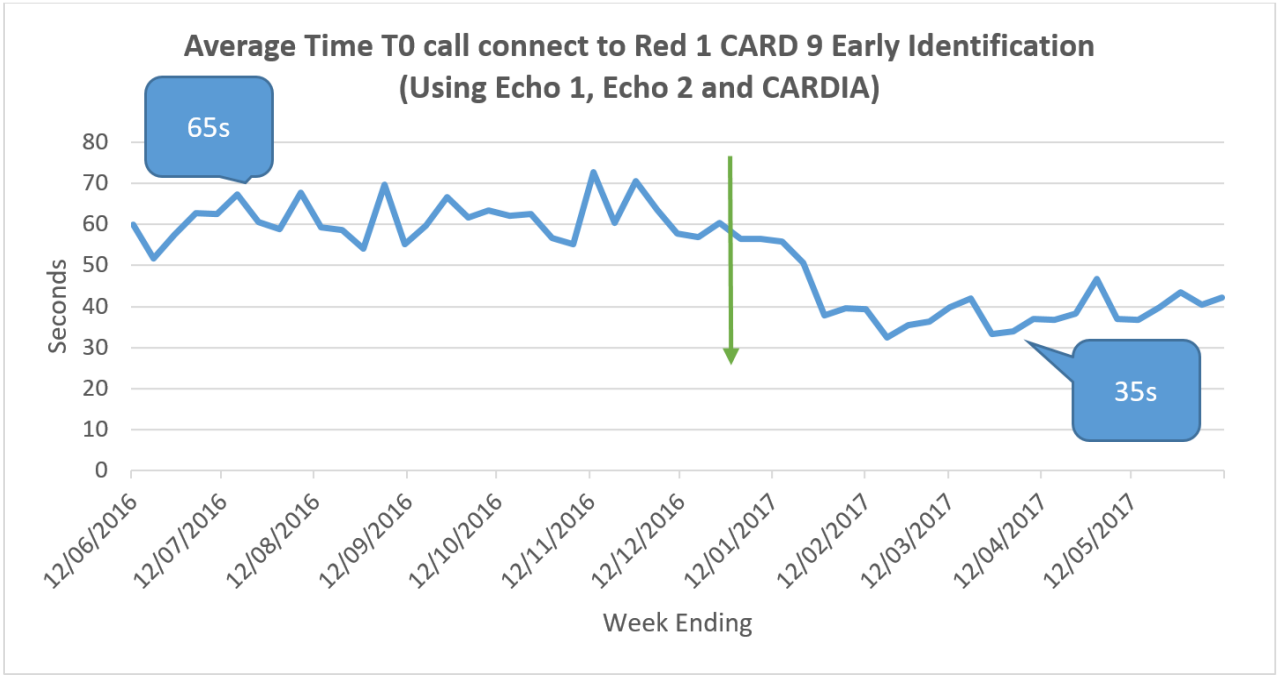
75% of Cardiac Arrest patients now identifed early in call cycle



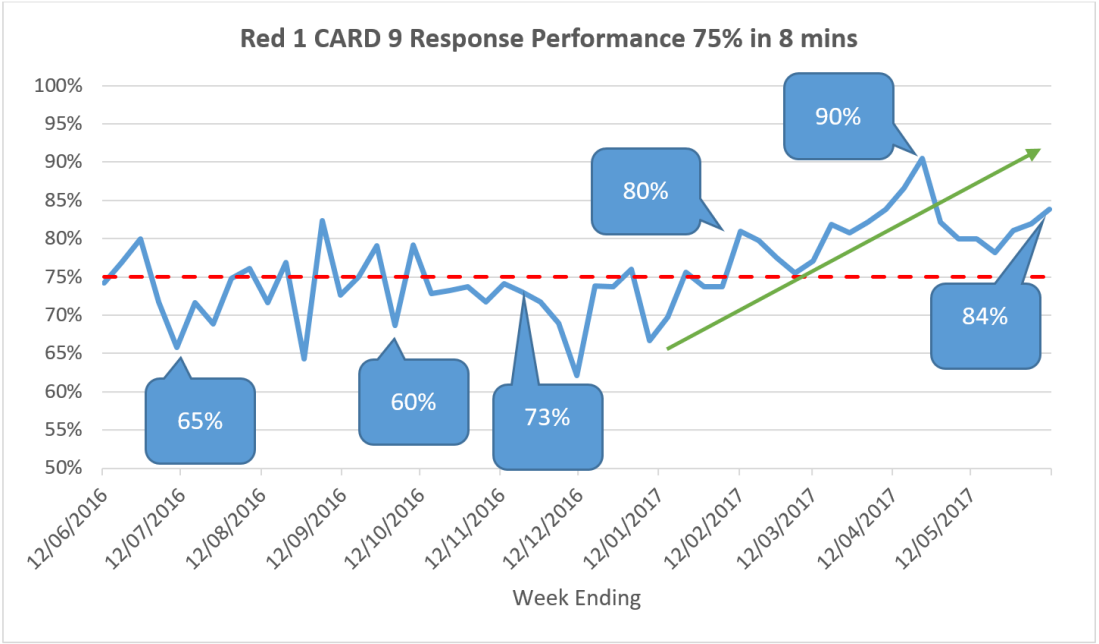
LAS now allocating up to 45s faster to Cardiac Arrest patients



From the point of accessing LAS for care, early recognition of life threatened patients is faster than ever before



The number of cardiac arrest patients receving a fast response has increased



London Ambulance Service NHS Trust

Report to:	**TRUST BOARD**
Date of meeting:	**01 August 2017**
Document Title:	**North London Dispatch Group Trial**
Report Author(s):	**Craig Harman**
Presented by:	**Paul Woodrow / Alex Ewing**
Contact Details:	**Craig.Harman@lond-amb.nhs.uk**
History:	**Presented to ELT**
Status:	

Background / Purpose:

The North Central Dispatch Group (NCDG) will be created to test a new dispatch operating model over 10 weeks. Once an analysis has taken place a formal recommendation will be made about the future dispatch model for EOC. The trial will see all dispatch elements for North Central London brought under the leadership of one person. Whilst exploring the EOC model, which will include managing solo resources differently. The trial will also investigate the 'tethering' of ambulance resource in all three north sectors and will support the expansion of the FRU rest break and end of shift trial.

Action required:

Presentation / paper is for information only.

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

Key implications and risks in line with the risk appetite statement where applicable:

Clinical and Quality	**Yes**
Performance	**Yes**
Financial	
Workforce	**Yes**
Governance and Well-led	**Yes**
Reputation	
Other	**Yes – Business Plan 2017/18**

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	

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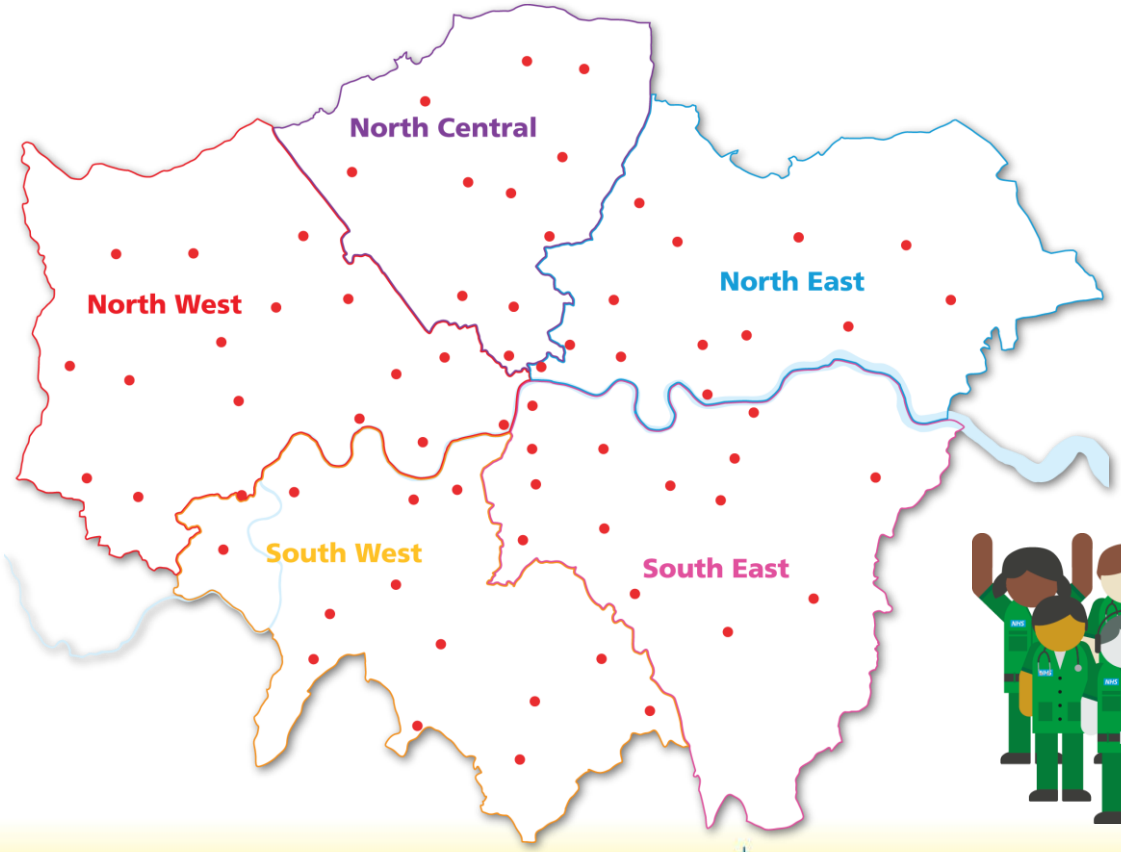
The Tethering Principal

Craig Harman
General Manager
Alex Ewings
Quality, Governance and Assurance Manager

North Central in context…



Edmonton
Chase Farm
Ponders End
Tottenham
Bounds Green

Camden
Bloomsbury
Islington

Friern Barnet
Barnet
Mill Hill

A note about CCG performance…
(April 2017)

Barnet
A8 64.97%

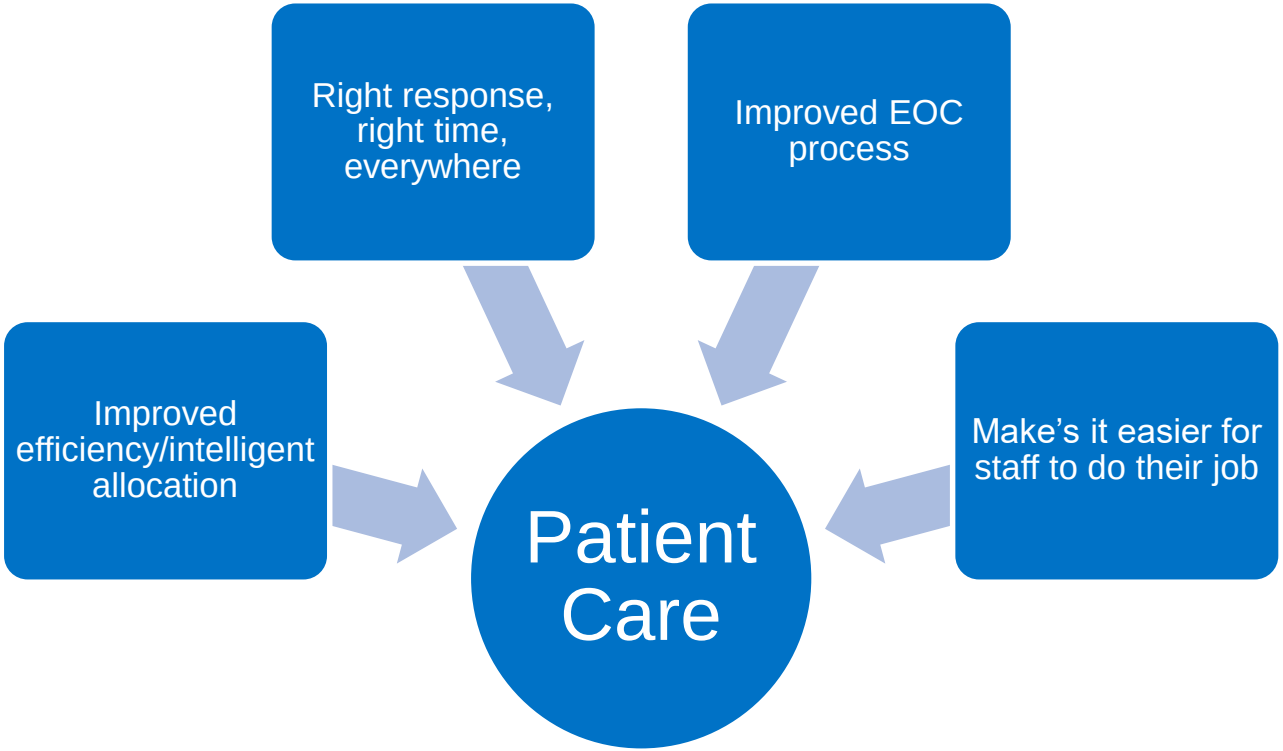
Enfield
A8 61.97%

Haringey
A8 63.57%

Camden
A8 82.43%

Islington
A8 74.38%

Why do we need tethering?

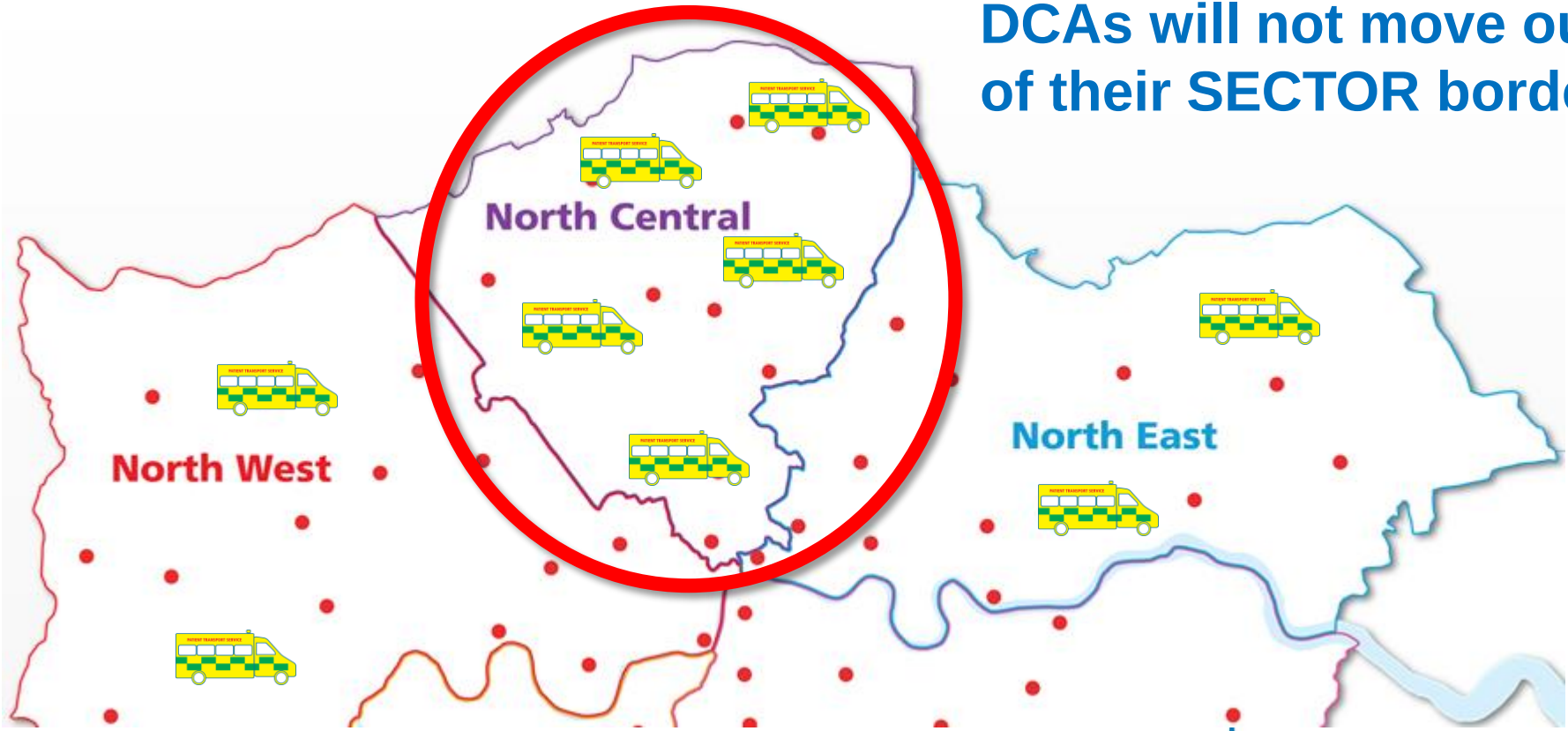


Demand is increasing

Improving our response

What is tethering?

DCAs will not move out of their SECTOR border



What are the safeguards?

DCAs can move if…

For patient safety…

Solos will not be tethered

…protects the 60% patient safety threshold

Red 1

Hot 1

Hot 2

Resp 1

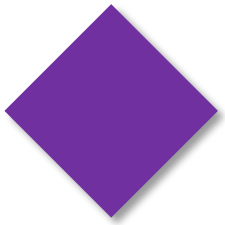
Resp 2

Safe for patients and staff…

Risks have been formally evaluated

Turned off for Significant or Major incidents

Dynamic decisions by hour if required



Linked to SURGE

Questions…

London Ambulance Service NHS Trust

North Central Dispatch Group Plan on a Page

Craig Harman, General Manager
8 June 2017

WHY?

- The EOC dispatch model no longer reflects the Trust operating model
- Welfare ring backs and rest break allocation need to be brought under the leadership of one person with sole accountability to see improvements in both areas
- STP 72% A8 requirement by Q4 and 60% A8 patient safety threshold in each CCG
- Build on the work undertaken last year to redesign to EOC dispatch model
- Realise Dispatch on Disposition benefits

PURPOSE

The North Central Dispatch Group (NCDG) will be created to test a new dispatch operating model over 10 weeks. Once an analysis has taken place a formal recommendation will be made about the future dispatch model for EOC. The trial will see all dispatch elements for North Central London brought under the leadership of one person. Whilst exploring the EOC model, which will include managing solo resources differently. The trial will also investigate the 'tethering' of ambulance resource in all three north sectors and will support the expansion of the FRU rest break and end of shift trial.

SUPPORTING THE 2017/18 BUSINESS PLAN

NCDG supports the following goals:

- Patients receive safe, timely & effective care
  - *To achieve agreed performance ambulance and regulatory standards*
- Staff are valued, respected & engaged
  - *To make it easier for our staff to do their job*
  - *To support and equip our managers to lead well*
- Efficiency & sustainability will drive us
  - *To deliver a transformation programme to continue our improvement journey*

THE STORY SO FAR

Comprised of three station groups and encompassing five CCGs the North Central Sector is currently achieving a year to date Cat A8 performance rating of 69.23% and A19 of 94.41% (as of 30/05/17). Placing it fourth of five in terms of Cat A sector performance across the Service. In addition North Central sees some of the longest delays in response to our lower acuity patients. Furthermore a disparity in performance exists across CCGs within the sector. Camden and Islington are consistently meeting A8 targets whilst the other three CCGs underperform. Notably CCG performance in Barnet and Haringey vary from that in neighbouring Camden by c.16-17%.

Building upon a number of different work streams a multidisciplinary short life working group was established in partnership with our staff side colleagues to trial new ways of operating. This will include separating the dispatch of solo and DCA resources, tethering ambulance resources and working closely with the sector leadership team to improve service provision in North Central London.

We aim to deliver benefits to our patients in the form of an improved and more equitable service across North Central London. There will be improvements for our staff as well. In EOC we will operate a model that staff have helped shape and gives them the environment to do their jobs well. For vehicle crew staff the increased allocation of rest breaks with more intelligent allocation decisions will improve the likelihood of late finishes and will change behaviour which in turn will increase patient facing time.

WHAT DOES SUCCESS LOOK LIKE?

RED1, RED2, Cat A
- Increased % within 8 minutes, decreased response times
- Improved deployment from strategic deployment points

C1, C2 and C3
- Increased % within agreed times, decreased response times
- Improved welfare ring backs when delays occur

JCT
- Decreased running times, scene times, FRU pre and post DCA arrival, OOS

End of shift
- Increased rest break allocated %

London Ambulance Service NHS Trust

TRUST BOARD FORWARD PLANNER 2017

Tuesday 3rd October 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Staff story Report from the Trust Chair Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M5** **EPRR assurance from the Audit Committee**	STPs	Report from Trust Secretary Trust Board Forward Planner	Audit Committee – 4th September 2017 Quality Governance Committee – 19th September 2017 Finance Investment and Performance Committee – 21st September 2017 Annual General Meeting – 26th September 2017 People and Organisational Development Committee – 18th September 2017	

Tuesday 31st October 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Patient story Report from the Trust Chair Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register**		Report from Trust Secretary Trust Board Forward Planner	Logistics and Infrastructure Committee – 9th October 2017	

Tuesday 28th November 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Staff story Report from the Trust Chair Report from Chief Executive	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M7** **EPRR assurance from the Audit Committee**	Review of Business Plan STPs	Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement HES report	Audit Committee – 6th November 2017 Workforce and Organisational Development – 13th November 2017 Quality Governance Committee – 14th November 2017 Finance Investment and Performance Committee – 23th November 2017	

Tuesday 12th December 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Patient story Report from the Trust Chair Report from Chief Executive	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register**		Report from Trust Secretary Trust Board Forward Planner		

London Ambulance Service NHS Trust

Quality Report

July 2017

All data pertains to May 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

- A process for validating and quality checking all reported Health & Safety related incidents across the Trust has been put in place by the Health, Safety & Security Team. The ongoing exercise is to ensure that incidents are reported appropriately using the relevant Datix categories, as well as to improve future reporting and analysis of incident trends/issues.

Actions & Assurance

- Following the review, any proposed changes will be tabled at the July Health and Safety Committee meeting for approval.
- Current Datix incident categories are also being reviewed to simplify some of the descriptors and to better align them to the incidents being reported.

Effectiveness

- Outstanding areas of practice were commented on by the CQC around equipping staff with maternity training and the maternity screening and action tool.

Actions & Assurance

Caring

- Introducing braille stickers for staff ID badges, to make it easier for blind and partially-sighted people to recognise and trust us.
- Working with three patient groups (personality disorder, respiratory disease and sickle cell disorder) to improve their experience.
- Our Easy Read' Leaflet '*How to make a complaint about the Ambulance Service'* will shortly be published on the website.

Actions & Assurance

Executive Summary: Exception Report (Improvement Required)

Safety

- Increase in RIDDOR incidents from 7 incidents reported in May to 32 incidents in June due to retrospective reporting of incidents. This was highlighted following the implementation of a revised process for flagging or highlighting incidents through the Datix system.

Actions & Assurance

- Pro-active monitoring and reporting of incidents now completed by the Health, Safety and Security Department immediately RIDDOR incidents are picked up through Datix.

Effectiveness

Actions & Assurance

Caring

- CQC were pleased that the complaints process was robust but requested more evidence of learning. This will be managed with improved use of the Action Plan section of Datix.

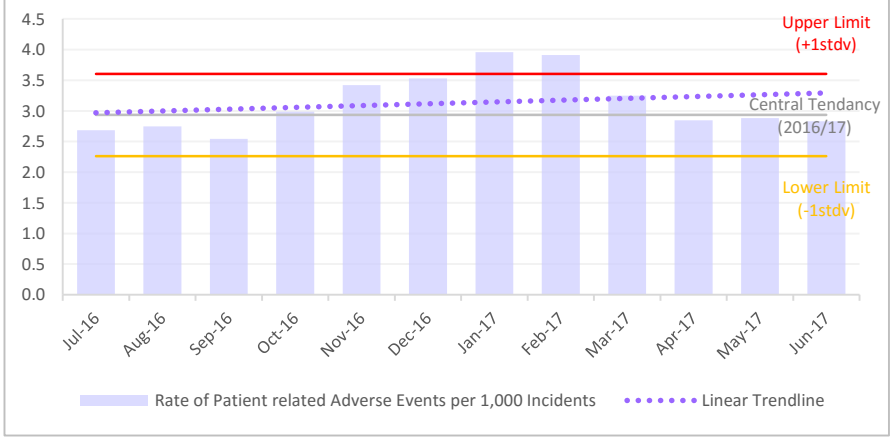
Actions & Assurance

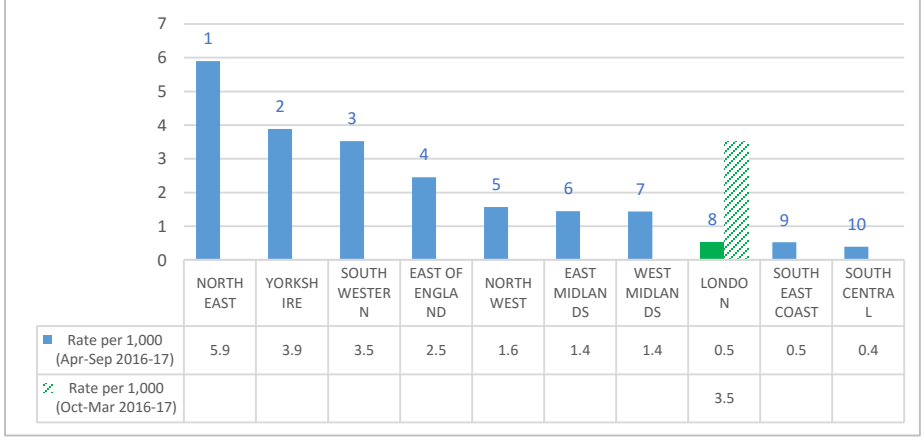
Patient Safety

Measures	Target / Range	RAG	Movement	Apr-17	May-17	Jun-17	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	↓	69.8%	84.8%	76.2%			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	2.3 - 3.6	G	↓	2.8	2.9	2.8					
Rate of Staff related Adverse Events per 1,000 Incidents	2.7 - 3.5	R	↓	3.6	2.7	2.6					
Controlled Drugs - Non LIN Reportable Incidents	0	R	↑	16	24	28					
Controlled Drugs - LIN Reportable Incidents	0	G	↔	0	0	0					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	↓	91%	97%	90%					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	↔	100%	100%	100%			LQ20		
Potential Serious Incidents referred to SI Group			↓	29	46	24					
Serious Incidents declared in-month			↓	7	7	3					
Serious Incidents breaching 60 days	0	R	↓	7	9	5					
Serious Incidents breaching 40 days	0	R	↔	11	5	5					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	↔	100%	100%	100%					
Medication Errors as % of Patient Adverse Events	0%	R	↑	2%	6%	6%					
Needle Stick Injuries as % of Staff Adverse Events	0%	R	↑	1%	0%	2%					
Never Events	0	G	↔	0	0	0					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	↑	0%	0%	0%					
Total Prevent Future Deaths In-Month	0	G	↓	1	1	0			LQ25	✓	
Safeguarding Referrals as % of total LAS attended incidents				2.1%	2.0%	↓					
Safeguarding Training (Level One)	90%	R		75.7%	87.8%	↑					
Safeguarding Training (Level Two)	90%	R		74.7%	75.6%	↑					
Safeguarding Training (Specific - Trust Board)	90%	R		13.6%	23.1%	↑					
Safeguarding Training (Specific - Bank)	90%					↔					
Safeguarding Training (Specific - Operational)	90%	R		78.3%	90.3%	↑					
Total Inquests where LAS asked to give evidence - In-Month			↓	4	6	4					
Total Inquests where LAS asked to give evidence - Year to Date			↑	4	10	14					
Missing Equipment Incidents as % of all reported incidents			↓	3%	3%	3%					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			↑	10%	12%	16%					
Number of NRLS uploads In-Month	1	G	↑	1	2	3			LQ21		

Patient Safety

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





Actions and Assurance

The Governance Team are currently reviewing a new process to centrally review all incidents submitted across the Trust with the outcome of no harm, low harm and moderate harm to ensure that any incident meeting the SI criteria is captured and referred to the Serious Incident Group.

The Serious Incident Group will be implementing 72 hour reporting this month following the identification of an SI in order to ensure that mitigating actions are put in place pending the final SI report with relevant recommendations.

A review of the outstanding actions relating to closed SI's is underway with the view to implement a formal action plan to ensure completion of all outstanding actions that sit outside the thematic review.

National Reporting and Benchmarking

- Looking at our position nationally for 2016 (most recent data available) which is publicly available, we are shown to be in the lower quartile for incident reporting.
- Having reviewed the Datix system and discussions with other ambulance services there is a clear lack of standardisation relating to reportable incidents – type and categorisation. For example it is voluntary for organisations as to whether they report all incidents or just those identified as moderate harm or above.
- LAS have since reviewed the way we report via NRLS and since April reported all patient safety incidents onto the system. We expect this to take the Trust into the highest quartile for ambulance services..
- The national quality forum for ambulance services have identified and raised this issue, there is a programme to review and understand the variance.

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Hand Hygiene Compliance April – June 2017 (Trust Compliance target: 90%)

	Apr		May		Jun		YTD	
Compliance/ submission	**%**	**Sub**	**%**	**Sub**	**%**	**Sub**	**%**	**Sub**
TRUST Overall	**69.8**	**61**	**84.8**	**120**	**76.2**	**101**	**77**	**282**
North East	97.4	13	90.6	35	60.9	27	83	75
North Central	100*	0*	100*	14*	48.9	8	83	22
North West	56	19	73.8	39	92	17	74	75
South East	33.3	14	95.8	21	95.8	27	75	62
South West	62.5	15	62.5	26	83.6	22	71	63
Others	-	-	-	-				-
TPAPs	-	-	-	-				-

- Based on 282 OWRs submitted this quarter (LAS employed staff)
- Variation of compliance in the Sectors with the overall Trust compliance at 77%, which falls short of the Trust target of 90%
- North Central has the lowest OWR submissions, with one station still using the obsolete methodology (reassuringly July submissions are via OWR)

Actions

- Hand hygiene compliance will continue to be monitored by the IPC team, through IPC meetings, supported by local IPC Champions.
- IPC Work Plan 2017-2018 actions builds on previous year's improvements and is focused on 'getting the basics right'.
- OWR implementation continues, with greater focus and monitoring from QGAMs, and IPC; Audit Schedule re-iterated
- Hand gel use has been re-iterated; exploring alternative design with more robust belt holders
- Re-introduce hand hygiene practical in IPC sessions being discussed - refreshers and induction, using UV lights and disclosing cream; review appropriateness e-learning methodology for IPC sessions
- Funding required for UV lights/disclosing cream for IPC Champions to support Hand Hygiene at stations
- Increase IPC team observational audits of practice when recruited.
- Engagement continues with influencers such as mentors, CTLs and, Education.
- Data to include NETS, VAS/PAS, and CFRs/ERs in future.

Assurance

- Summary IPC Work Plan 2017-2018 agreed at IPCC June 2017.
- Monthly reporting through OWRs undertaken by CTLs .
- Monthly Quality Reporting.
- Quarterly monitoring and scrutiny by IPCC and new Infection Control and Decontamination Group (ICDG).
- Quarterly Commissioner Report.

- Training data capture has been improving since December and monitored monthly by IPC and quarterly at IPC meetings.
    - Trust-wide IPC training compliance:
        - Level 1 IPC Training: 88% (4471/5093)
        - Level 2 IPC Training: 86% (3288/3872)

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Actions

- **Vehicle Deep Clean**
- Logistics manager met with the Contractor to address shortfalls 6/7/17; extra resources was implemented immediately to address North Central low compliance.
- IPC met with Contractor to ensure training provided to contractor staff met standards.
- Monitoring continues via Logistics manager supported by IPC team.

Assurance

- **Vehicle deep Clean**
- Shortfalls were addressed immediately.
- KPI meetings are held weekly with contractors, and sub-optimal compliance is challenged.
- Hub roll out meetings held weekly and areas of concerns are addressed.
- 6 weekly deep clean data is submitted by the Logistics Contract manager and is challenged by IPC; e.g. this month North Central figures.
- Monitored monthly by IPC team; Quarterly IPC meetings.
- Quarterly reporting.
- Quality of clean using ATP swabs commenced May 2017; data from Q2.
- **Premises Cleaning**
- To note that performance consistently exceeds 90% target.

Sector Analysis	6 weekly VP Deep Clean A&E Vehicles			Premises Cleaning Audits			Flu Vaccine Uptake				A&Es Observe Practice			IPC Station audit
Target	95%			90%			75%				No Set			85%
Frequency	Monthly			Monthly			Cumulative (seasonal)				Monthly			Quarterly
	Apr-17	May-17	Jun-17	April-17	May-17	Jun-17	Up to March 22				Feb-17	Mar-17	Apr-17	Q4 2017/178
TRUST	**97%**	**97%**	**94.8%**	**96%**	**96.4%**	**96.7%**	**63%**				**No Data Available Yet.** Previous data demonstrated the compliance was low and the average per sector as less than 50%			incomplete
North East	95%	95%	97.8%	92%	93%	95%	63%							incomplete
North Central	99%	99%	82.5%	99%	99%	96%	68%							incomplete
North West	99%	99%	98%	96%	95.4%	97%	72%							incomplete
South East	99%	98%	98.3%	97%	97%	97%	61%							incomplete
South West	97%	97%	94%	96%	98.5%	98.5%	58%							94.5%
Others	93%	93%	98.3%	--	-	-	57%							incomplete

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Exposure to blood and bodily fluids and sharps injuries

Sharps & Splash Incidents	Q1'17	Q2'17	Q3'17	Q4'17	Total
Exposure to bodily fluids	44				44
Incident involving broken ampoule or vial	11				11
Lancets injury (clean)	1				1
Lancets injury (contaminated)	3				3
Needle stick injury - Cannula (clean)	0				0
Needle stick injury - Cannula (contaminated)	10				10
Needle stick injury - IM (clean)	0				0
Needle stick injury - IM (contaminated)	3				3
Needle stick injury - sub-cutaneous (clean)	0				0
Needle stick injury - sub-cutaneous (contaminated)	2				2
Razor injury (clean)	6				6
Razor injury (contaminated)	1				1
Bit by a person	3				3
YTD Total:	84	0	0	0	84

- 84 - total incidents reported YTD
- 44/84 Bodily fluid exposure - incidents range from patient spitting at staff, being vomited on, to direct splash/contamination from procedures.
- 19/84 were contaminated sharps injuries (with additional 3 being bitten by a person).

Actions

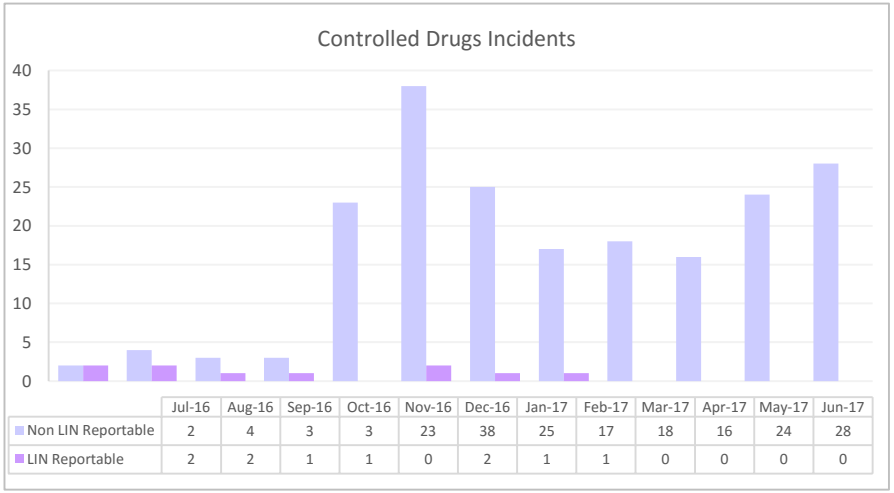
- Exposure to bodily fluids – integrated masks and face shield are in the IPC vehicle pack; the lack of use are due to culture, behaviour and attitude and this is being taken forward in 2017/2018 work plan.
- Increase engagement when team capacity increases with other influencers e.g. up-skilling mentors, clinical team leaders, as well as using IPC Champions, tutors and buddies to reinforce standards, mutually support and enhance each other's knowledge & competency, embedding IPC procedures like a golden thread into all patient interactions and procedures during practical training and to challenge poor practice
- Reviewed for lessons in *NHS Resolution: Did you know? Preventing needle-stick injuries (2017)* and actions being aligned with work plan actions
- Continue to ensure safer needles are appropriately used
- North West Operational Lead was informed to monitor clinical practice relating to the high numbers of sharps injuries
- Closer working with Health and safety and Occupational Health

Assurance

- Summary IPC Work Plan 2017-2018 agreed at IPCC June 2017 – actions addressing basic IPC practice in the plan
- Regular reporting by staff and IPC/H&S reviews of Datix incidents, lessons shared with crew via IPC meetings, bulletins, IPC Champions, training content, intranet
- Monthly IPC oversight, Quarterly monitoring and scrutiny by IPCC and new Infection Control and Decontamination Group (ICDG)
- Quarterly Commissioner Report
- Policies and procedures; training includes measures to reduce risk
- Occupational Health Information and service provision
- Bulletins: Safe disposal of sharps, best practice to avoid splash back to facial mucosa from administering medication via port in IV cannula; video clips for safer ampoule breaking
- Safer Razors provided;
- PPE – integrated face mask and eye shield in Vehicle packs

Medicines Management

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



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Non LIN Reportable	2	4	3	3	23	38	25	17	18	16	24	28
LIN Reportable	2	2	1	1	0	2	1	1	0	0	0	0

Summary

- Quarterly Medicines Management Group meeting held in June 2017
- One LIN reportable CD incident in June 2017 compared with none in the preceding month.
- Total of 12 reported non-CD medicines incidents in June 2017
- One incident relating to administration of 1:1,000 adrenaline in the wrong dose or via the wrong route.
- Secure drugs on stations project in consultation phase – planned roll out to selected stations later this year.
- New process for movement of controlled drugs between stations completed
- New process for ordering station based drugs via email as opposed to fax drafted
- Survey of estates to assess suitability of premises for storage of drugs completed.

Actions

- New security seals to be attached to oral morphine bottles which will provide immediate visual confirmation relating to tampering
- Secure drugs room project on-going to provide secure storage and CCTV monitoring of all drugs alongside swipe-card access.
- Re-issue of promotional posters relating to correct dose and route of administration for adrenaline 1:1,000
- Ongoing input including professional pharmacy advice in relation to secure drugs on station and vehicle based drugs projects.
- Expansion of data fields on medman system to capture full range of drugs used.

Assurance

- Medicines Management Group Meeting confirms no impending supply chain issues with Frimley Park pharmacy.
- Datix reports demonstrate reduction in incidents specifically relating to adrenaline 1:1,000
- Workforce Control Panel approval for temporary augmentation of data entry capacity within MI to ensure drug usage data records are maintained.
- Medman compliance with requirement to complete drugs usage form demonstrates 7.3% error rate (n=9).
- CARU audit on use of adrenaline has been published.

Effectiveness (Clinical Measures)

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

Measures	Target	RAG	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	R	31%	27%	34%	36%	28%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	48%	60%	59%	64%	59%		↑			LQ1b		
STEMI to PPCI w ithin 150 minutes (AQI)	91%	G	80%	93%					↔			LQ2b		
STEMI care bundle (AQI)	74%	G	73%	75%	71%	70%	74%		↑			LQ2c		
Stroke to HASU w ithin 60 minutes (AQI)	65%	G	57%	60%	67%	70%	67%		↑			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	98%	97%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R	00:37	00:35	00:34	00:34	00:35		↓					
Survival to Discharge (AQI)			7%						↔					
Survival to Discharge UTSTEIN (AQI)			15%						↔					
STEMI- On scene duration (CARU continual audit)			00:45	00:43	00:42	00:41	00:43		↑					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	91%	89%	87%	83%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving Feedback YTD							0%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	97%	98%	98%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	91%	90%	91%	92%	92%		↑		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%		↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G		95%		96%			↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		98%		↑			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training			29%	55%	89%	100%	26%		↓			LQ11	✓	

Actions

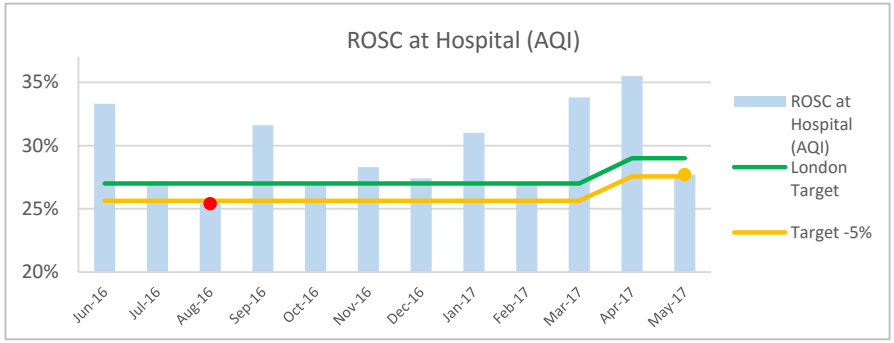
- Following the successful trial of a new function within the CPI database whereby the auditor states, for every PRF, whether they have any clinical concerns about care overall. This will be rolled out across the Service in Q2.
- CARU have received final sign-off to review how the safeguarding is measured via the CPIs (auditors will now be asked to judge whether there was a safeguarding concern, and if so, state whether a referral was carried out). We will trial this at one station, before rolling out across the Trust.

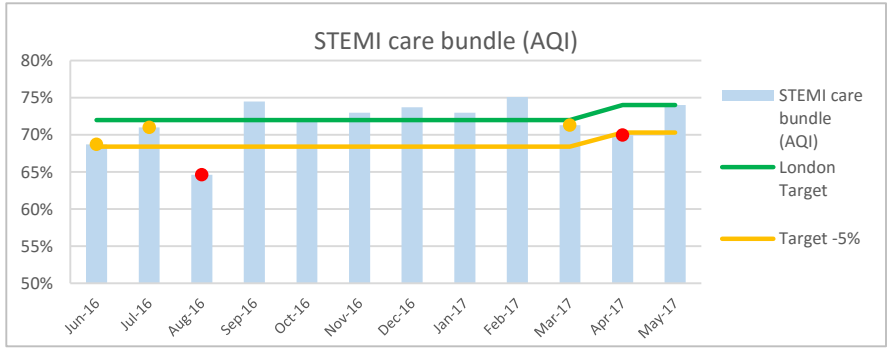
Assurance

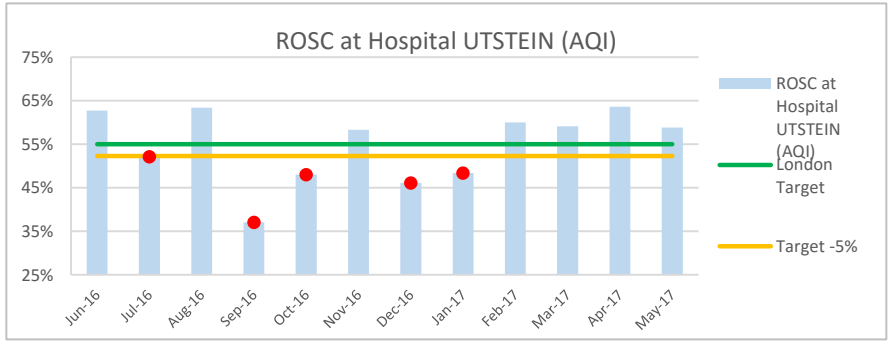
- Lower completion in May was largely due to a reduction in the number of staff on alternative duties. However over the past month, there has been increased demand for CPI training for this group of staff and a result, CARU have organised extra training sessions in July.
- All the above measures have been communicated widely across the Trust and to Complexes via our monthly reports for discussion at the appropriate local forums.

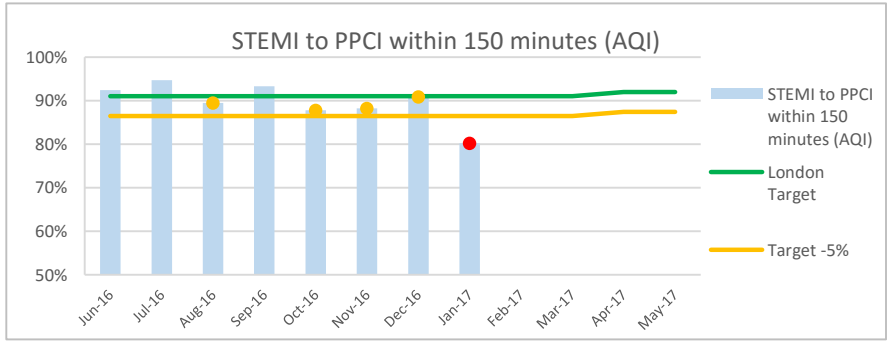
Effectiveness (Clinical AQIs)

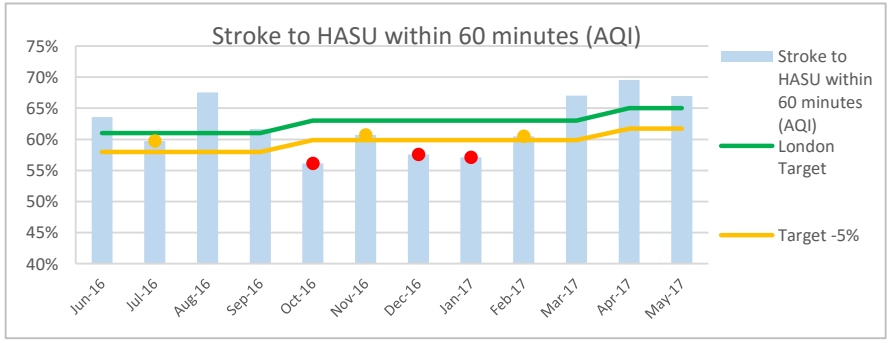
Owner: Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

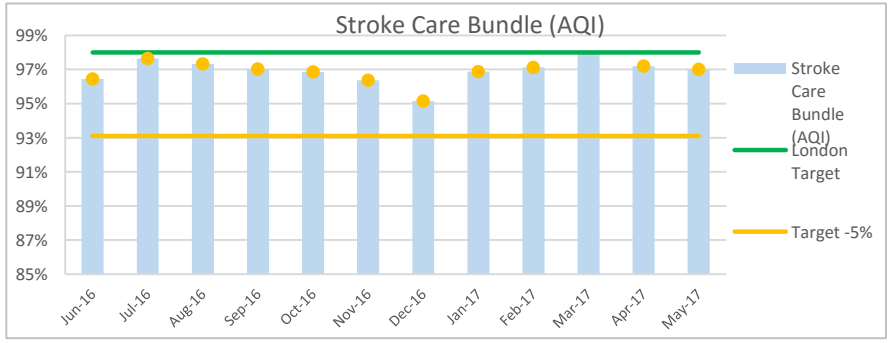








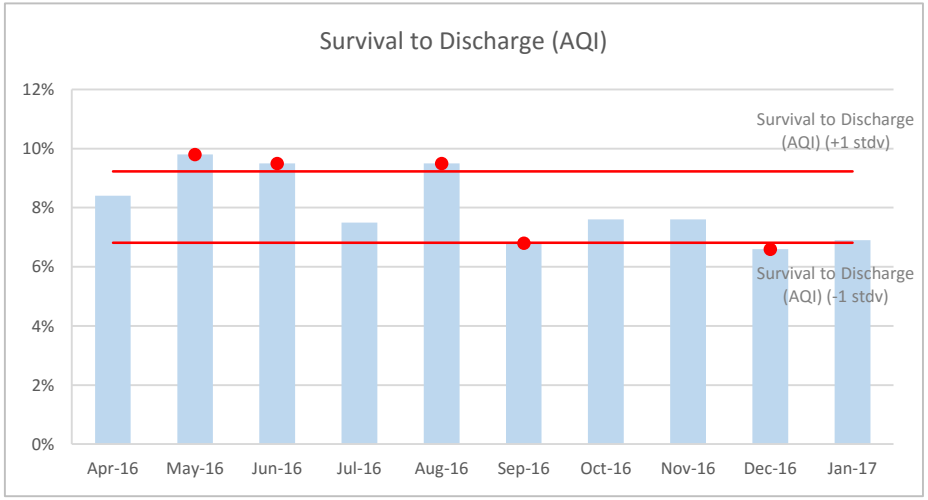


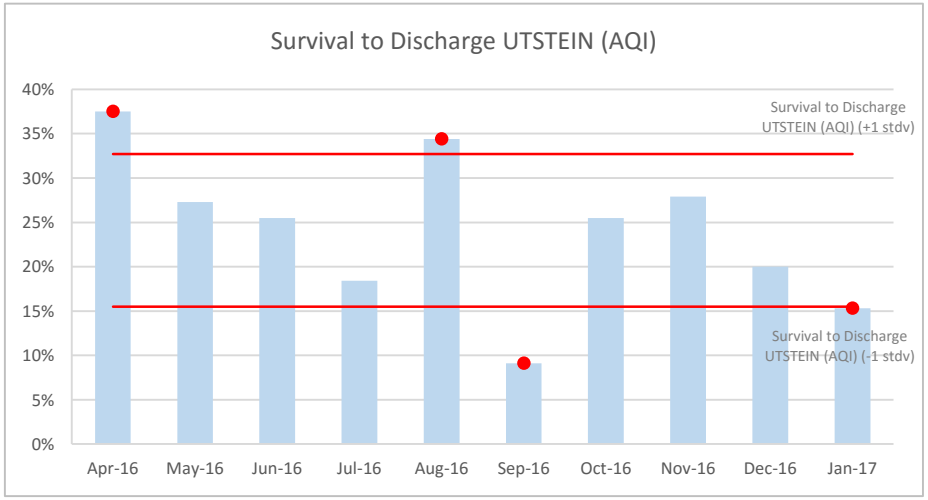


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

Effectiveness (Clinical AQIs)

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





AQI: Actions

- The downward trend in survival must be treated with caution: these data are provisional as we're awaiting hospital survival data. Figures are likely to change and will not be finalised until August 2017. We are continuously updating our figures as hospital data becomes available.
- We expect variation in the number of patients for whom we achieve ROSC to hospital. For example, the reduction may be explained by attending more patients this month who had a lower chance of survival, as indicated by only a small reduction in ROSC in the Utstein group.
- Poor compliance to the STEMI care bundle may be due to both a lack of documentation and failure to provide adequate pain relief. The Trust needs to consider how to improve analgesia administration.
- Although clinicians are recognising stroke, compliance to the Care Bundle is less than the target because clinicians are not documenting all three elements of the FAST test.

AQI: Assurance

- To improve compliance to the STEMI care bundle, a reminder to consider analgesia for all patients was included as an infographic within the STEMI care pack, that was circulated widely across the Trust. The infographic is available for Team Leaders to print and display on station.
- The infographic also highlighted the importance of reducing the time spent on scene with STEMI patients.
- The importance of documenting a full FAST has been highlighted in the infographic that went to all complexes.

* 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: Progress

- Good progress is being made against the clinical audit work programme for 2017/18.
- Five recommendations from the Section 136 Clinical Audit are outstanding and related to the Memorandum of Understanding between the LAS and MPS. The latest update received is that the MOU is still awaiting final sign-off by the MPS.
- Two draft clinical audits will be sent to the Clinical Audit & Research Steering Group (CARSG) for their review w/c 10th July 2017: an Adrenaline (1,1:000) re-audit and a clinical audit on the use of analgesia in adults.
- The final draft of the 'Undiagnosed Psychiatric Problem' clinical audit is with the project's clinical advisor before being sent to CARSG for their review.
- A non-traumatic cardiac arrest CPI for the APPs is going live on the 15h July 2017. Two further APP CPIs are also in development.

Research Actions & Outcomes

- **Paramedic-2**: 91 patients were recruited in June; 1,809 since the beginning of the study (contractual target =1600).
- **RIGHT-2**: 9 patients were recruited in June; 46 since the beginning of the study (contractual target =180). This is below the expected recruitment figures at that point of the study (n =90) and an average of 62% eligible stroke patients are missed each month.
- **ARREST:** the research contract has been signed and we are in early set up stages of the study.
- **MPDS-Birth:** the final research protocol is being developed with a team of experts (Midwife, Quality Assurance Manager in EOC, Paramedic).
- **Take Home Naloxone**: The Head of Clinical Audit & Research has collaborated with Prof John Strang (Institute of Psychiatry) and put in a bid for research funding from the NIHR HTA.

Actions

- Our draft newsletter sharing the findings of our Sickle Cell Re-audit and useful information for patients has been very well received by the Sickle Cell Society. It will be published on the Society's website and in their next newsletter.
- An article raising awareness of the tools available for assessing pain in paediatric patients (Wong-Baker faces and FLACC scale) has been submitted for the Clinical Update and will be published in the next issue.
- We will feed back missed patients in the RIGHT-2 trial to Team Leaders so they can debrief the trial-trained Paramedics and hopefully increase recruitment rates.

Assurance

- The high standard of our clinical audit programme was recognised by the Care Quality Commission (CQC) in their re-inspection. The importance of our work and it's contribution to improving patient care was highlighted throughout their report.
- Continuous Re-contact Clinical Audit:31 members of staff received feedback as a result of the audit in June 2017 (19 constructive and 12 positive).
- Through the Continuous Re-contact audit, we identified 3 potential serious incidents that were uploaded to Datix; two were reviewed by SIG and not declared-SIs, and one is awaiting review.
- RIGHT2: We have trained more paramedics and extended the trial area to increase the recruitment of patients in order to meet the targets.
- New research projects are in development to ensure sufficient research activity and funding once Paramedic-2 and RIGHT-2 are completed.

Caring

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Measures	Target	RAG	Apr-17	May-17	Jun-17	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	G	90%	96%	100%	↑			LQ27	
Friends and Family Test Response Rate			4.2	2.6	0.1	↓			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	4	5	8	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.7	0.7	0.8	↑			LQ29c	
Positive Feedback Compliments			98	91	84	↓			LQ29e	
Mental Health related calls as percentage of all calls			8.5%	8.2%	9.9%	↑				
Mental Health related MPS calls as percentage of all calls			2.3%	2.2%	2.1%	↓				
Mental Health related Incidents as percentage of all calls			6.1%	5.7%	5.7%	↓				
Mental Health related HCP Incidents as percentage of all calls			0.5%	0.4%	0.4%	↑				
Rate of Frequent Callers per 1,000 Calls			3.5	2.6	2.8	↑				
CMC records viewed			4	7		↑			LQ30	

Actions

Assurance

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

Safeguarding Risks

There are currently 4 safeguarding risks which are reviewed at the Safeguarding Committee bi-monthly. (Safeguarding Assurance Group quarterly from October)
It is expected that 2 and 4 will be closed and risk 3 reduced following safeguarding committee review.

1. "There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to manage the increased workload, notably Marac requests for information. This may impact on the care of vulnerable adults and children.

2. "There is a risk that due to our inability to link safeguarding referrals and identify previous referrals made to Social Services, this will impact on our ability to escalate any continued safeguarding concerns identified, which will impact on patient care.

3. "There is a risk that the Trust is unable to provide assurance that it is compliant with safeguarding training requirements for clinical and non-clinical staff.

4. Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made and appropriate help and support may not be provided

Safeguarding allegations against staff								
Number in last month	Total Children	Total Adults	multiple	Borough	Number Open	Number Closed	Outcome	Total number this financial year
0	4	5	1	Croydon x2 Merton Hackney Camden Essex Windsor	7	3	Support offered No case to answer	10

Safeguarding Supervision Actions

- The LAS has a Safeguarding Supervision Project ongoing which is funded by NHSE to assist with introducing supervision into the LAS.
- A project manager has been appointed for the year and is finalising the matrix of who will receive supervision, frequency and type.
- A policy is currently in draft form.
- Pilot supervision sessions have been undertaken and supervisors have been trained. Moving forward this report will update on progress of the project and number who have received safeguarding supervision.

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Dr Trisha Bain

Patient & Public Engagement

Events on database	Events attended	Interested staff
66	39	1146

Kingsley Road Preschool
"The visit was fantastic. The kids all loved it and staff were all very complimentary of Miriam! She was amazing and we would definitely request her next time!"
Chase Lane Primary School Fete
"The ambulance visit went very well! The children loved it and Ashley and Jill were amazing. The fact that the children could go into the ambulance was fantastic. I can't thank you and Ashley and Jill enough for supporting us."
King George's Hostel talk
"Samad and Zafar gave a sterling performance and both residents and staff learnt a lot about the history of your service and how to save lives."

Key Updates

- In a survey of blind and partially-sighted people, carried out on our behalf by RNIB, we asked what factors affected their feelings of trust and confidence in people attending to help them. As a result of their feedback, we are introducing braille stickers to be issued to staff. These will be attached to their ID cards and will include a telephone number they can call, to confirm LAS identification details.

- As a result of a series of focus groups held with three patient groups with specific conditions (sickle cell disorder, respiratory disease and personality disorder), we are taking action to improve their experience. Developments include supporting patients to create crisis plans, involving them in staff training, and working with individual patients to test the improvements we make.

Staff Awards

The LAS Safeguarding Team who were shortlisted in the Education and Training Category at the Patient Safety Awards this week. The team were shortlisted for their "Dementia Care matters in the Ambulance Service" project, for which they produced four films on dementia.

Volunteers, partner organisations and trained members of the public who respond to emergencies alongside our front-line crews were celebrated at the third Saving Lives Awards on Friday 23rd June. Recipients in eight categories were recognised at the event, which was attended by Chief Executive Garrett Emmerson and more than 200 guests.

Staff Recognition

Colleagues from the North West Ambulance Service and Lancashire Fire and Rescue visited the Service on Sunday to offer their support and thanks. It followed the visit to Great Manchester EOC by some of our staff who also ran the Great Manchester Run, in support of colleagues who experienced the terrorist attack in Manchester.

The Service has received cards and handwritten letters from a primary school near Grenfell Tower thanking everyone who responded to the fire for their work and bravery. The class teacher from St Charles' RC Primary School wanted to let us know that thanking our brave emergency services reminded the children of the good stories that have come out of the tragic incident.

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Patient Story
July 2017

A maternity patient will be discussing her experience of care for the first cohort of paramedics on the Paramedic Programme in Fulham.
The clinical education team will provide feedback from Staff on the impact.

The maternity patient will be working with the LAS to create a video for the core skills refresher with emphasis on “Caring – conveying a sense of urgency” and “Safety – Recognising “red flags”.

Care Quality Commission (CQC) 2017 and Maternity

- CQC acknowledge the outstanding practice within maternity care and the LAS
  - LAS first UK ambulance trust to “Spotlight on Maternity”
  - Provision of joint training with midwives
  - LAS provides a maternity education programme
  - Staff reported that the pre hospital maternity screening & action tool was helpful in their practice

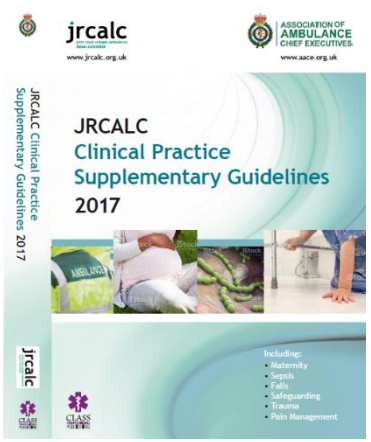

Outstanding practice and areas for improvement

Outstanding practice

- Frontline staff were caring, compassionate, and kind. Patient care was at the centre of their role.
- Staff were understanding of patient needs and treated them with dignity and respect.
- Patients told us staff went out of their way to ensure they were well looked after and always involved them in their treatment of care.
- We saw staff spending time with patients to allay their fears and anxieties. They found a common ground with all their patients to make them feel comfortable and reassured.
- Staff treated patients equally regardless of their circumstances and were non-judgmental. They treated patients in difficult environments in a calm professional manner.
- The London Ambulance Service was the first ambulance service to "spotlight on maternity" and had taken the following actions. They currently have joint maternity education in progress with midwives across the capital. They have established a maternity risk summit, which meets every six weeks and has a focus on maternity safety, which identified the following themes: recognising deterioration in pregnancy, management of preterm delivery and managing temperature in newborns.

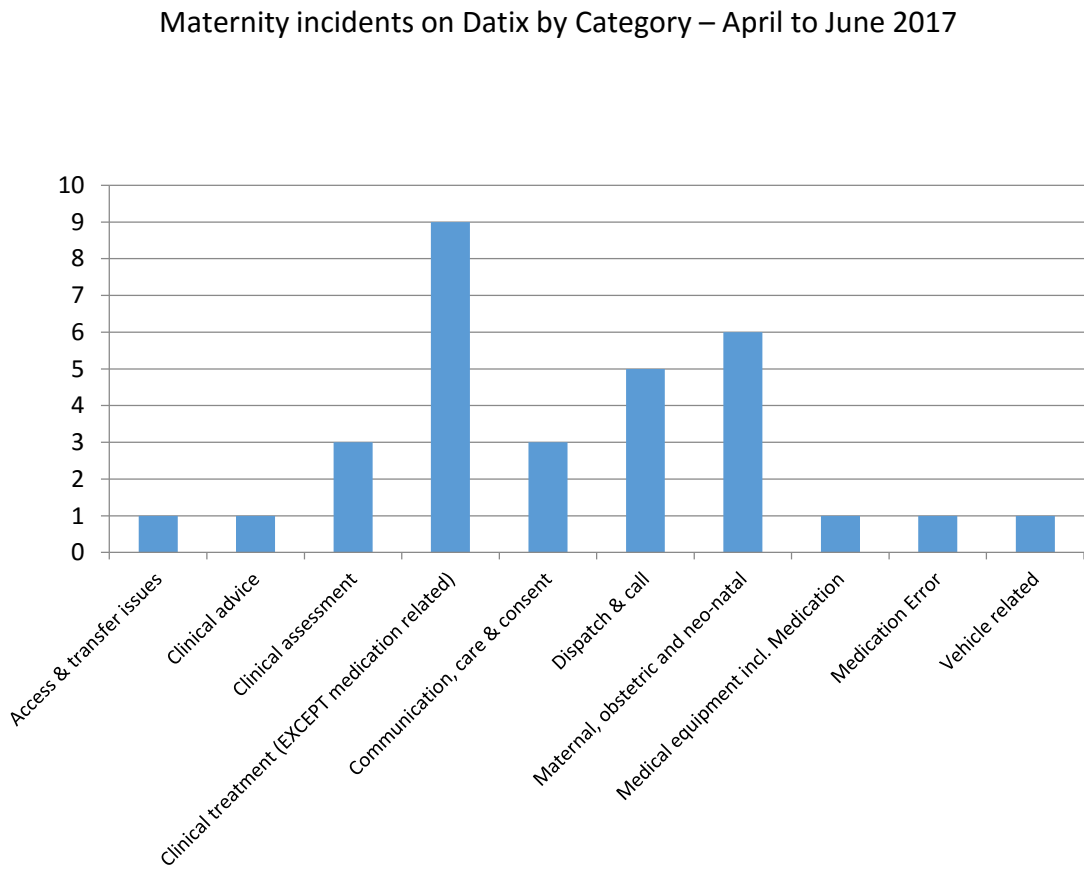
Collaboration

- LAS Clinical Education Team worked with Class Publications to produce new maternity images/photographs to accompany the September publication of the Maternity supplement of the Clinical Practice Supplementary Guidelines 2017.
- LAS Consultant Midwife will launch the Maternity guidance at National Launch September 2017.
- LAS Scoping the development of Midwives employed within the Control Room environment. Initial scoping meeting engaged:
  - Commissioner from North East London Local Maternity System
  - Visit to Southampton Labour Line – August 2017
  - Steering group to be initiated by September 2017.



Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley



Maternity Incidents

- New maternity reporting will incorporate the % of incidents reported to total maternity calls received
- Incident reporting to be communicated to staff by the Clinical Update/Routine Information Bulletin (RIB) to raise awareness
- New incident report inclusions focus upon:
  - Themes within clinical care
  - Themes within access and handover to definitive care.
- 9 themes focus around clinical treatment and accessing midwifery care in a timely way.

Maternity Complaints

- Current on going complaint focusses around not recognising the red flags associated with placental abruption and not conveying a sense of urgency and critical decision making. – LAS has met with the Patient to engage her in the investigation process and defining the terms of reference for the Root Cause Analysis.

Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Maternity Pre Hospital Quality Dashboard

National Maternity Indicators:
Developed set looking at the measures available in the emergency maternity setting that can be used to look at quality.

Mortliaty and Morbidity (relevent to pre hospital setting)
- Proportion of births, >24 weeks, attended – Apgar < 7 at 5 mins of age
- Proportion of births with severe post partum haemorrhage greater than or equal to 1500ml

Clinical Care and health promotion
- Vaginal births attended each month
- Proportion of births between 23 weeks +0 days and 27 weeks +6 days

Actions

Clinical communication to all staff about new Maternity Datix incident reporting
- BBA (born before arrival of the LAS)
- Ante-partum bleeding - less than 20 weeks with maternal compromise
- Ante-partum bleeding - more than 20 weeks with maternal compromise
- Post-partum haemorrhage - more than 500mls in first 24 hours or with maternal compromise
- Secondary post-partum haemorrhage - after 24 hours and up to 12 weeks more than 500 mls or maternal compromise
- New-born resuscitation - where cardiac compressions were required
- If the patient was conveyed, did you come across any difficulties with the maternity unit accepting the patient?
- Maternity unit declining to accept unbooked patient
- Maternity unit challenging decision to accept patient
- Delay in arrival of midwife >30 minutes
- Delay in accessing maternity unit (lifts/signage)

Current Risk

- Trust Risk 286 – Failure to recognise serious maternity issues or fail to apply correct guidelines leading to adverse maternal and neonatal outcomes – Link to assurance 1.
- RCA on going – Failure to recognise “red flags” – Link to assurance 2,3.
- Staff reporting difficulty recording newborn temperatures

Actions

1. Next Core Skills Refresher (CSR) 2018 to include a maternity component regarding the maternity tool – Conveying urgency, pre term labour.
2. Maternity Education Lead to incorporate training critical decision making skills into CSR for 2018
3. Progress the maternity risk summit to ensure ongoing learning and themes are captured.

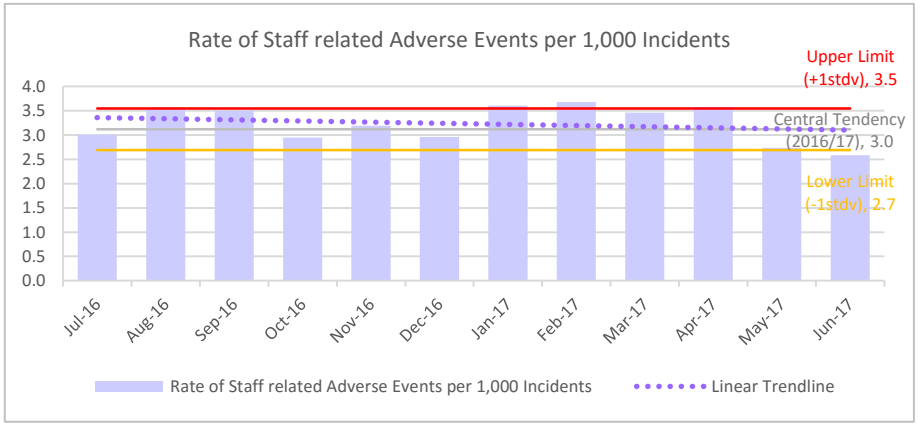
Assurance

1. Risk 286 – Review annual due 05/18
2. Clinical Update Bulletin to provide staff familiarisation with Maternity Policy OP35 and new maternity Datix incident reporting categories to be circulated by the Medical Directorate August 2017
3. Continue the LAS Maternity Risk Summit and agree feed into the Quality & Safety Groups.
4. Procurement review of newborn thermometers and roll out – September 2017

Safety (Health and Safety)

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Trust H&S incidents	Apr-17	May-17	June-17
Incidents affecting Patient(s)	0	1	1
Incidents affecting LAS Staff	274	217	207
Incidents affecting Visitors, contractors or the public	5	10	9
Incidents affecting the Trust	14	14	12
Total:	764		



H&S Incidents by Result in Q1	Near Miss	No Harm	Harm
Incidents affecting Patient(s)	0	0	2
Incidents affecting LAS Staff	125	189	384
Incidents affecting Visitors, contractors or the public	4	16	4
Incidents affecting the Trust	16	22	2

Harm Incidents by Severity	Q1'17
Low - Minimal harm - required minor treatment or observation	386
Moderate - Non-permanent harm - requiring admission, surgery or prolonged episode of care	6
Severe - Permanent or Long-Term Harm	0
Death - Caused by the incident	0

Top 5 H&S Incidents in Q1 by Sub-category	Q1' 17
Manual handling injury - lifting patient	79
Security - violence, aggression and abuse - Other	72
General assault	62
Verbal abuse	54
Exposure to bodily fluids	45

Key Updates:

- Changes have been made to the Datix System to align the RIDDOR reporting categories to the incident categories specified under RIDDOR Regulations 2013.
- Daily review of all incidents reported across the Trust undertaken by the Health, Safety and Security Team in order to validate the quality of the information submitted as well as to facilitate the prompt investigation and where required, external reporting of incidents.
- Daily horizon scanning undertaken by the Health, Safety and Security Team to identify alerts issued through the CAS System/MHRA relating to medical equipment.

Safety (Health and Safety)

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

RIDDOR Incidents	Apr-17	May-17	June-17
RIDDOR reportable incidents	10	4	18

RIDDOR

32 incidents were reported as RIDDORs in Q1 – 2017. A breakdown of the incidents is provided below:

- Over 7-day injuries – 27
- Major Injury – 2 (Fractures)
- Non-fatal accident affecting non-employee – 3

Management of CAS Alerts	Apr-17	May-17	June-17
Total alerts received	6	11	15
Total alerts relevant to LAS	0	1	0
Total under assessment	0	0	0
Total relevant alerts outstanding	0	0	0
Alerts acknowledged within 2 days	5	8	14

Management of MHRA Alerts	2017
Total alerts received	7
Total alerts assessed as relevant to LAS	0
Total (relevant) alerts closed	0
Total outstanding (relevant) alerts	0
Total assessed 'not relevant'	0
Total under assessment	0

Actions:

Security:

Security related incidents accounted for 25% of all incidents reported in Q1. Actions taken to address these incidents includes:

- Regular monitoring by Corporate H&S Team of all incidents to ensure appropriate follow up, investigation and sharing of lessons.
- Lone working arrangements under review to enable the implementation of robust measures to mitigate risks.
- Review of Datix security incident categories /descriptors ongoing – to enable better analysis of incidents reported.

Manual handling:

- 16% of incidents reported in Q1 related to 'Manual handling injury - lifting patient'.
- Contributory factors identified include: lifting of bariatric patients, carry/track chair faults, lifting patients in difficult/tight environments and unexpected patient movements.

Actions:

- Review of manual handling training underway – to ensure refresher training sessions can be provided to all frontline staff on a regular basis.
- Review of Ferno Track chairs undertaken through independent ergonomist. Recommendations and actions submitted to Manual Handling Implementation group. Full report to be tabled at 27/07/2017 Corporate H&S Committee Meeting.
- Current practical training provided to staff does not cover the moving/lifting of bariatric patients. Gap to be addressed during review of practical training currently underway.

Infection Control:

- 45 incidents relating to 'Exposure to bodily fluids' were reported in Q1. Contributory factors include: Non adherence to IPC Practices & wearing of appropriate PPE supplied to staff.

Assurances:

- Quarterly reports to and monitoring by Corporate Health, Safety & Security Committee.
- Monitoring of incidents by Corporate Infection Control and Prevention Committee.
- Independent Report following review into the use of Ferno Track Chairs.

Sector Heat Map: Quality Data

CQC		Key Performance Indicator	NW	NC	NE	SW	SE	Other	LAS Target	LAS Ranges	SPC RANGES Lower Limit	SPC RANGES Lower Limit +5%	SPC RANGES Upper Limit -5%	SPC RANGES Upper Limit
SAFETY		Hand Hygiene OWR compliance	92%	49%	61%	84%	96%		90%					
		Rate of Patient related Adverse Events per 1,000 Incidents	2.2	2.1	3.4	2.4	3.0				1.3	1.3	3.3	3.5
		Rate of Staff related Adverse Events per 1,000 Incidents	2.2	1.9	3.1	2.8	2.3				1.6	1.6	3.9	4.1
		Controlled Drugs - LIN Reportable Incidents	0	0	0	0	0		0					
		Percentage of Incidents reported within 4 days of incident occurring	92%	89%	99%	93%	99%		85%					
		Potential Serious Incidents referred to SI Group	3	2	1	2	3				1.2	2.2	3.2	4.2
		Serious Incidents declared in-month	0	1	0	0	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	4.3%	7.4%	3.4%	10.0%	12.7%							
		Needle Stick Injuries as % of Staff Adverse Events	4%	0%	0%	3%	0%				0%	1%	3%	3%
		Missing Equipment Incidents as % of all reported incidents	1%	2%	2%	4%	5%				1%	1%	10%	10%
		Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	10%	11%	6%	4%	8%				8%	8%	19%	20%
	*	Safeguarding Training (Level One) YTD	92%	95%	91%	94%	95%		90%					
	*	Safeguarding Training (Level Two) YTD	85%	82%	77%	84%	88%		90%					
EFFECTIVENESS	*	ROSC at Hospital (AQI)	21.8%	31.9%	33.8%	21.7%	30.1%				28%	28%	29%	
	*	STEMI care bundle (AQI)	76.7%	85.4%	81.8%	54.3%	77.8%				62%	64%	65%	
	*	Stroke to HASU within 60 minutes (AQI)	69.0%	51.6%	66.9%	76.9%	70.9%		65%					
	*	Stroke Care Bundle (AQI)	98.0%	98.1%	98.2%	97.8%	95.3%		98%					
	**	Survival to Discharge (AQI)	-	-	-	-	-							
	*	CPI - Completion Rate (% of CPI audits undertaken)	62%	93%	99%	100%	71%				75%	94%	95%	
	*	CPI - Percentage of Staff receiving Feedback YTD	0.1%	0.2%	0.6%	0.2%	0.0%							
	*	Documented Care - Cardiac Arrest Compliance (CPI audit)	98%	98%	98%	97%	98%				75%	94%	95%	
	*	Documented Care - Discharged at Scene Compliance (CPI audit)	97%	97%	97%	98%	97%				75%	94%	95%	
	*	Documented Care - Mental Health Compliance (CPI audit)	92%	90%	90%	91%	97%				75%	94%	95%	
	*	Documented Care - Severe Sepsis Compliance (CPI audit)	97%	97%	97%	97%	97%				75%	94%	95%	
	*	Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-				75%	94%	95%	
	*	Documented Care - Glycaemic Emergencies Compliance (CPI audit)	97%	98%	97%	98%	98%				75%	94%	95%	
CARING		Rate of Complaints per 1,000 Incidents	0.8	0.6	0.3	0.4	0.9							
		Mental Health Related Incidents	9%	10%	8%	9%	11%							
		Mental Health Related HCP Incidents	1%	1%	0%	1%	1%							
		Rate of Frequent Callers per 1,000 Calls	4.9	5.9	5.5	5.3	3.6							

* data shown refers to May-17

** data shown refers to Mar-17

Learning from Incidents

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

Learning from Incidents

Following a significant increase in incidents relating to the recording and handling of morphine sulphate injection across the Trust a bulletin was issued to all staff highlighting areas of concern and the correct procedure when handling controlled drugs. Examples of incidents include incomplete controlled drug (CD) register entries, staff signing in but not placing ampoules back into CD cabinet and missing ampoules.

Following a Serious Incident investigation involving the care provided to a patient who was pregnant, the trust Consultant Midwife and a Stakeholder Engagement Manager have been tasked to work with the maternity unit in question to improve communication and joint working that ensures the patient journey is safe, streamlined and efficient.

A comprehensive debrief event was held following the two most recent major incidents at London Bridge and Grenfell Tower. These debriefs were held by external facilitators with staff welfare support on site. Staff were encouraged to attend in order to provide feedback on the LAS response, to identify any lessons we can learn from and to contribute towards improving the future LAS major incident response. These sessions were well attended with representation from across the service. Feedback is currently being collated and a full report with recommendations will be submitted to ELT in the coming months.

Incidents

SI update	Incidents reviewed In June	SIs declared In June	SIs with outstanding report	SIs 0-30 days	SIs 30-60 days	Overdue SIs	SIs with further comments from CCG requiring response
Number	25	3	18	4	8	4	1
Trend on previous week	↓	↓	↓	↓	↓	↓	↓

Serious Incidents & Incidents

Recent themes identified include:

- Serious Incidents where there was a delay in shocking VF. A thematic report has been completed and submitted to commissioners that covers 20 incidents.
- Delays and performance issues during shift changeover. There is an action plan in train to improve performance at shift changeover including review of the rest break policy. This theme is incorporated into the Trust's thematic action plan

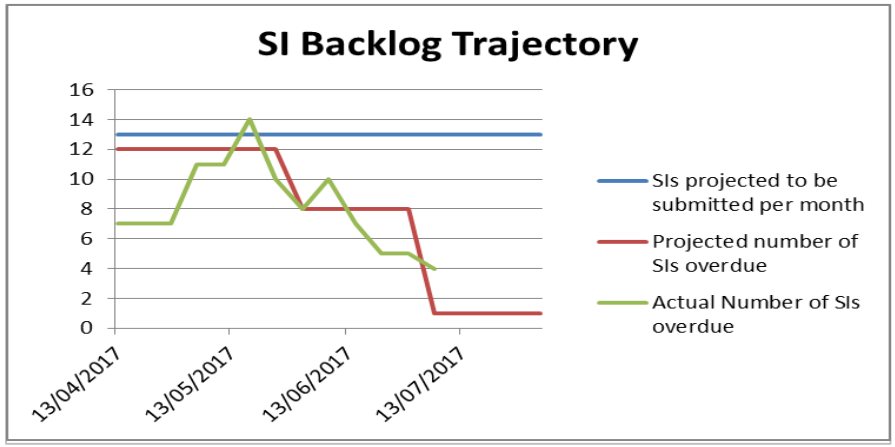
Learning from Incidents

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

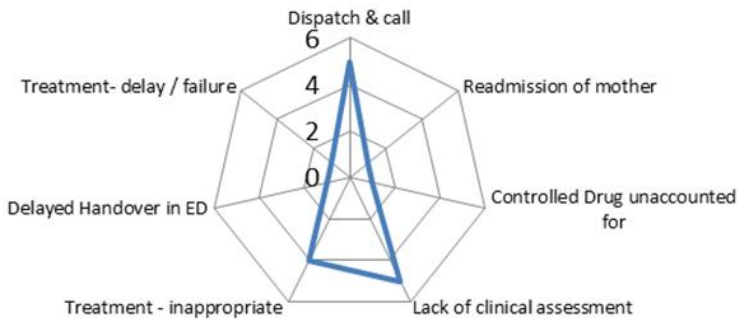
Overdue Serious Incidents Investigations

ELT	STEIS ref	No of days overdue	Due Date	Update
DDO - Sector	2017/4509	35	16/05/2017	6/7/17 – Draft has been sent back to LI to confirm changes prior to ELT review
Deputy Director of Clinical Education	2017/5457	30	24/05/2017	6/7/17 – Report is with SMT and ELT for sign off
Deputy Director of Nursing	2017/4505	35	16/05/2017	6/7/17 – further changes required by LI before ELT sign off
Dir of Transformation & Strategy	2017/6891	20	08/06/2017	6/7/17 – Report is with ELT lead for sign off

SI Trajectory



SIs under investigation as of 7/7/17



Actions

Key Actions emerging from SI investigations cover;

- Equipment and Documentation
- Delays and Rest Breaks
- Clinical Assessment
- Call Handling

In addition the SI process is being refined to;

- Improve the standard of reports and investigations
- Speed up drafting and signing off of investigations to a 40 days timeline
- Increase the number of investigators trained in the new process to standardise investigations
- Introduce a new template to better capture the requirements of the NHSI Closure Checklist and reflect the focus on human factors

Learning From Deaths, Inquests and Claims

Owner: Nicola Foad Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

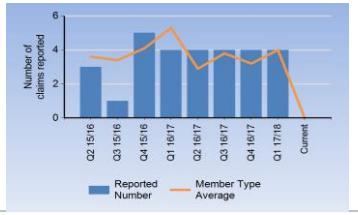
Inquests – figures and learning

- In June LAS staff were requested to attend Inquests on 4 occasions to give oral evidence. No Prevention of Future Death (PFD) Reports were received.
- A response is being prepared to the PFD received in May for submission to the Coroner by 14 July 2017 (see June Quality report)
- Risk Management recommendation from Panel solicitors following an Inquest held in May: Panel solicitors indicated that there may be a lacuna in the safe hold training as the evidence crews gave that they frequently have to restrain patients, in circumstances falling short of requiring police involvement, though are not trained in any form of restraint. Therefore it was advised that LAS ensure all crews are trained in this regard and refreshed on a regular and on-going basis.

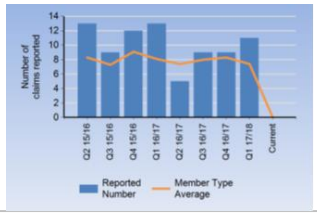
Claims - figures

- As at the end of Quarter 1 2017/2018 NHS Resolution had 40 claims against LAS open under their Clinical Negligence Scheme for Trusts and 75 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- Claims received by Quarter compared to other Ambulance Trusts:

CNST- 5/8 quarters LAS was at or above member average



LTPS - 7/8 quarters LAS was at or above member average



Claims – learning

- During the investigation of a recent claim, LAS' solicitors identified that LAS may wish to consider providing enhanced training to its junior paramedics on recognising and acting upon signs of neurological deficit as well as further training and/or guidance for ambulance crew members that if insufficient space is available on the PRFs then continuation sheets should be used.
- Spotlight on needle-stick injuries- met with Infection control to discuss NHS Resolution's guidance on 'preventing needle-stick injuries'. Of the 5 red flags identified by NHS Resolution 2 are key issues for LAS in terms of infection control: non-compliance with standard infection control precautions and inadequate disposal of clinical waste. However, the use of PPE, use of safer sharps and overfull sharps bins are not key issues for LAS in terms of infection control

Actions

Completed:

- Neurological deficit – LAS took these actions: Trauma update in CSR 2016.3 and CSR 2017.1; Clinical Update article 'Necks Backs and Spines: Learning from litigation' July 2016 and poster on 'learning from experience poster: the elderly and neck injuries'.

Ongoing:

- **PFD** - to respond to the PFD dated 12 May 2017 by Coroner's deadline of 14 July 2017 and to report on learning identified in Quality Report and to the Quality Oversight Group
- **Safe hold training** – The Medical Directorate are discussing our safe hold training with NASMeD in light of the recommendation.
- **PRF continuation sheets** – Legal Services are following up with the Training team as to the most recent training in this regard.

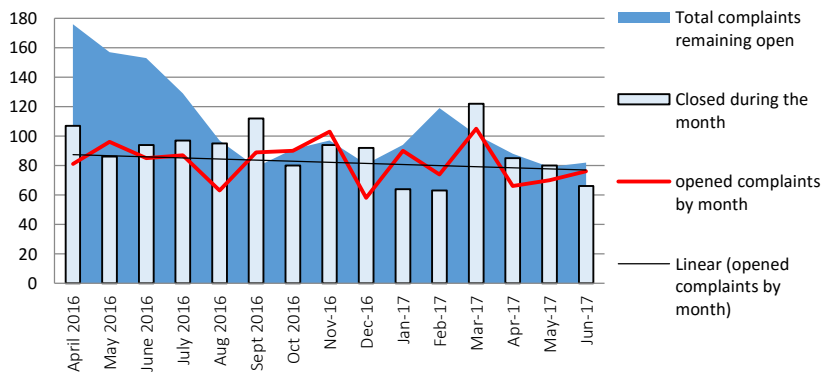
Learning from Complaints

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

Top 5 Key complaint themes June 2016 to June 2017

Complaints by subject 2015/17	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Total
Delay	31	45	20	35	29	37	19	36	16	27	21	17	16	349
Conduct	25	15	18	16	25	22	15	26	27	36	16	19	24	284
Road handling	8	9	3	14	11	8	8	7	9	16	12	11	13	129
Treatment	2	7	3	8	14	6	1	3	3	5	1	2	5	60
Non-conveyance	7	1	3	0	4	1	1	1	3	4	3	0	4	32
Total these subjects	73	77	47	73	83	74	44	73	58	88	53	49	62	854
Overall totals	83	87	63	89	90	103	58	90	74	105	66	70	76	1054

Complaint summary April 2016 to June 2017



Actions

- 76 complaints were received in June. The key component of complaints over 5 of the previous 6 months related to conduct and behaviour. However, complaints regarding delay in attending remains the top subject.
- Calls attended were lower than in May 2017 (despite the very hot weather).
- The percentage of complaints to calls attended was 0.08% (slightly below the monthly average of 0.09%)
- During May/June we achieved 100% compliance with the 3 day acknowledgement target
- As at 06 July there are 87 open complaints, this includes one that has been re-opened and 8 that have exceeded the 35 working day target.
- One case has been requested by the Ombudsman this month. A total of eight cases currently remain under investigation with the Ombudsman
- 353 PALS enquiries included a significant number of appreciations (31) including a number related to recent tragic events

Assurance and learning

- The new Health Service Ombudsman will visit London Ambulance Service as a Trust performing well with regards to complaints management
- We are working with QGAM's to utilise the Action Chain section of Datix to evidence outcomes and learning.

1. Challenges to patients entered on the Locality Alert Register

Complaints from patients have driven a review of Trust policy to improve practice in arranging a care plan approach where a patient's behaviour may be linked to their condition

2. Destination hospital in cardiac care cases

The patient was not taken to the correct treatment centre. We identified that the crew should have contacted the Clinical Hub for advice about optimum destination and that the clinical information relevant to this case is contained within three separate cardiac care circulars, all of which contain different information. The Medical Directorate are therefore combining this guidance into a single document .

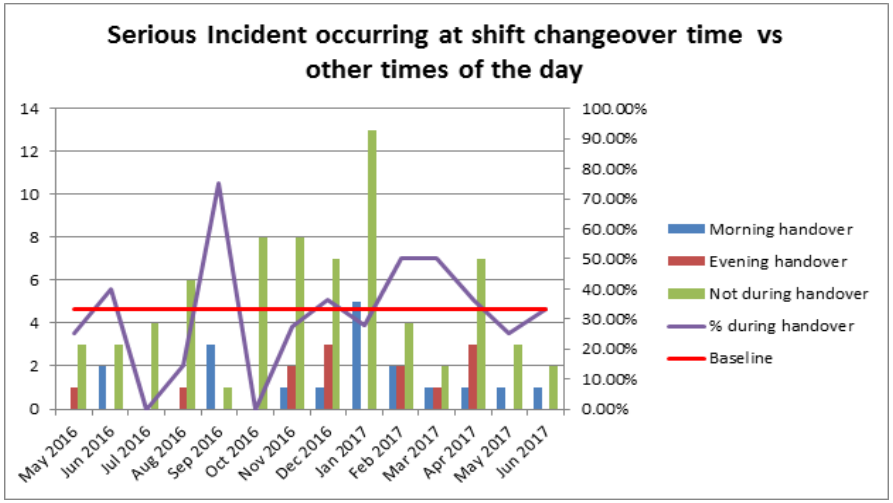
Rest Breaks & Serious Incidents

Owner: Brian Jordan | Exec Lead: Paul Woodrow

Thematic Review

The handover period looked at is 05:00-08:59 and 17:00-20:59, 8 hours out of a 24 hour day. With perfect distribution, a third of incidents would occur during the handover period (Baseline). The average for the year is 30.39%, slightly less than this. Additionally, the percentage of incidents has fluctuated slightly above/below this baseline since November 2016.

- Capacity / activity imbalance at shift changeover is one of the Trust's top 3 organisational risks because of the safety and welfare issues which have been identified through serious incidents
- To address the risk we are doing three things:
- Introducing a new rest break policy
- Taking action to improve compliance with the existing rest break arrangements
- Taking action to address late finishes which are a major driver for rest break avoidance.



Actions

- Negotiations with the Trade Unions about the new policy are drawing to conclusion. Progress stalled over the last two months due to the rise of the threat level to CRITICAL post Manchester; and following the London Bridge and Grenfell incidents. Negotiations did however resume on 7 and 12 July

- Current targets for rest breaks are 50 ambulances per shift, 75 FRUs and 90% of HART, MRU and CRU shifts
- Control and sector operational managers are dealing with non-compliance in real time
- End of shift pilot in South West London was live between 22 February and early May.

Assurance

- The Operations Board is holding control and sector operations to account for current rest break KPIs
- A live dashboard which control and operational managers can access to determine the number of rest breaks given, and the levels of non-compliance, was launched at Operations Board in June and is being further refined
- Performance in the 05:00 – 06:00 and 17:00 – 18:00 hours has risen significantly since March when the number of rest breaks increased
- The end of shift pilot analysis was presented to the Chief Executive, Director of Operations and the Deputy Directors of Operations in June. The full report will be published by the end of July.

Quality Risk Register

All Quality/Clinical Risks by Sector/Department	Serious Risk					Total
	12	15	16	20	25	
Emergency Operations Centre	1		1			**2**
Fleet and Logistics	5		2			**7**
Information Management & Technology (IM&T)	1	1				**2**
Medical Directorate	2	2				**4**
Office of the Director of Operations	1		1			**2**
Quality	1			1		**2**
Safeguarding	2					**2**
Total	**13**	**3**	**4**	**1**	**0**	**21**

Actions

- Improved process within operational risk review and escalation has seen an increase in movement of risks being escalated and de-escalated to the Trust Risk Register, increasing the visibility of risks with a high score being visible across the Trust.
- Improved risk review process across the Trust as a result of recommendations for improvement across Sectors and Departments following a detailed audit in March 2017, resulting in improved quality of information within the risk reporting system.
- Increased scrutiny of compliance with the risk management process in committees reporting to the Trust Board has resulted in more timely reviews of risks across the Trust.

Assurance / Progress

- There are currently six risks on the Trust Risk Register that are included on the BAF which have a clinical and quality impact. These are reviewed monthly at RCAG and where issues are identified these are then escalated to ELT.
- A quarterly Risk Register Audit takes place with feedback provided to risk owners on areas of non compliance with the risk management process.
- Risk Owners are asked to complete a quarterly compliance statement.
- Emerging risks scored at 10 and above are flagged to RCAG with strict timelines for submission stated.
- Over 300 managers across the organisation are trained on how to identify, articulate, escalate and manage risk.
- Quality Assurance Committee has oversight of all quality risks rated greater than 10.