MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 26th JULY AT 10.00am – 1.00pm
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
10.00	1.	**Welcome and apologies for absence** Apologies received from:			
	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		HL	
	3.	**Minutes of the meeting held in public on 31st May 2016** To approve the minutes of the meeting held on 31st May 2016	Approval	HL	TAB 1
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	HL	TAB 2
10.10	5.	**Report from the Chair** To receive a report from the Chair	Information	HL	TAB 3
10.20	6.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	FM	TAB 4
PERFORMANCE AND ASSURANCE					
10.30	7.	**Integrated Board Performance Report – June 2016** 7.1 To receive the integrated board performance report (including Operational Performance) 7.2 Quality report – June 2016	Information	JP FW/B	TAB 5
10.50	8.	**Quality Improvement Programme** To receive assurance on progress with the Quality Improvement Programme	Assurance	KB	TAB 6
11.00	9.	**Quality Governance Committee Assurance Report** 9.1 To receive the Quality Governance Committee Assurance Report – 12th July 2016. 9.2 To approve the following annual reports for 2015/16: • Infection Prevention and Control • Safeguarding • Patient Experiences • Patient and Public Involvement and Public Education	Assurance Approval	BMc	TAB 7 TAB 8
11.15	10.	**Finance Report – Month 3** 10.1 To receive the Finance report for Month 3 10.2 2016/17 Control Total 10.3 Report from Finance and Investment Committee on 21st July 2016	 Information Approval Assurance	 AG AG NM	 TAB 9 TAB 10
11.30	11.	**Workforce Committee Assurance Report** To receive the Workforce Committee Assurance Report – 18th July 2016	Assurance	FC	TAB 11
11.40	12.	**Board Assurance Framework and Risk Management** To receive the Board Assurance Framework and risk register – July 2016	 Information	SA	TAB 12
BREAK 11.40 – 11.50					
GOVERNANCE					

11.50	13.	**Staff Survey** To receive a presentation on staff survey.	Information	KB	TAB 13
12.10	14	**Patient Engagement Strategy** To approve the Patient Engagement Strategy	Approval	BS	TAB 14
12.25	15.	**Equality and Inclusion** To receive a progress report on the Workforce Race Equality Scheme	Assurance	MH	TAB 15
12.45	16.	**Report from Trust Secretary** No activity recorded for tenders or Use of the Seal since the last Trust Board meeting	Information	SA	
	17.	**Trust Board Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 16
	18.	**Questions from members of the public**		HL	
	19.	**Register of Interest** To note the register of interests	Information	SA	TAB 17
	20.	**Any other business**		HL	
	21.	**Meeting Closed** The meeting of the Trust Board in public closes		HL	
13.00	22.	**Date of next meeting** The date of the next Trust Board meeting in public is on Tuesday 4th October 2016 at 9.00am Annual General Meeting: 27th September 2016		HL	

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING IN PUBLIC

Minutes of the meeting held on Tuesday 31st May 2016 at 12.00p.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Heather Lawrence	Chair
Fergus Cass	Non-Executive Director
Jessica Cecil	Non-Executive Director (joined the meeting at 9:30)
Theo de Pencier	Non-Executive Director
John Jones	Non- Executive Director
Nick Martin	Non-Executive Director
Bob McFarland	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
Paul Woodrow	Acting Director of Operations
Fenella Wrigley	Medical Director

By telephone:	
Fionna Moore	Chief Executive (joined for items 15-17)

In Attendance:	
Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation, Strategy and Workforce
Mark Hirst	Interim Director of Human Resources
Jill Patterson	Interim Director of Performance
Andrew Watson	Chief Information Officer
Mercy Kusotera	Committee Secretary (minutes)

Members of the Public:	
Malcolm Alexander	London Ambulance Service Patients' Forum
Ross Lydall	Evening Standard
Darryl Smith	Ferno UK Ltd
Isobel Gowan	Project Director, G E Finnamore
Dr Amrit Sachar	Consultant Liaison Psychiatrist, West London Mental Health Trust
Jan Norman	Director of Quality and Safety, Brent Clinical Commissioning Group
Lesley Cave	Associate Director of Quality and Safety, Brent Clinical Commissioning Group
Michael Earnshaw	Senior Consultant, Harvey Nash (Recruitment)

Members of Staff:	
Christina Clynes	Communications Officer
David Fletcher	Darzi Fellow

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49. Welcome and Apologies

49.1 The Chair welcomed all to the meeting. A particular welcome was extended to Mark Hirst, who was attending his first Trust Board meeting since his appointment as Interim Director of Human Resources. Apologies were received from Fionna Moore and Charlotte Gawne. Fionna would be joining the meeting by telephone for the Annual Accounts and Annual Report items.

50. Declarations of Interest

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

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51. Patient Story

51.1 Due to unforeseen circumstances the patient story had to be deferred.

52. Minutes of the Board meeting held on 29th March 2016

52.1 The minutes of the meeting held on 29th March 2016 were approved as a true record of the meeting subject to:

- 30.11 should be reworded.
- A minor amendment to minute 31.3.

Action: Sandra Adams
Date: 26th July 2016

53. Matters Arising

53.1 The Trust Board reviewed the action log and noted the following:
29.2 and 35.1 – It was noted that a paper on staffing and the Emergency Operations Centre had been scheduled for a private meeting of the Board due to contract and resource issues.

53. 2 Karen Broughton confirmed that a paper would be taken to the Workforce and Organisational Development Committee once the plan of action was agreed.

53.3 29.6 and 125.10 – Paul Woodrow confirmed that a report on the findings of the operations structure review would be presented to a private meeting of the Board in June. The deadline for feedback from managers was 27th May. The action remains outstanding.
Action: Karen Broughton/Paul Woodrow
Date: 28th June 2016

53.4 40.1 – Karen Broughton confirmed that Staff Survey update had been rescheduled for the July Trust Board.

53.5 127.3 – Andrew Grimshaw reported that the Business Case was subject to the provisions of the contract; there were ongoing contracts discussions with the CCGs.

53.6 122.2 - Fenella Wrigley reported that the information on cardiac arrest would be incorporated in the 2015/16 Cardiac Arrest Annual Report. The report would be available in July/August.

54. Report from the Chairman

54.1 The following points were noted from the report:

- The Chair had met all Board members individually as part of her induction; spent time in EOC and out with a crew to experience first-hand service delivery.
- Attended the Patients Forum meeting.
- On 24th May, the Chair had attended a session at the Reform Group where the Rt Honorable Therese May announced her plans for the Fire and Rescue service that would be embedded in legislation.
- Spent much of her time engaging with partner organisations.
- Had a meeting arranged with Dr Ted Baker, Deputy Chief Inspector of Hospitals at the Care Quality Commission (CQC).
- The Chief Executive and the Chair had met Dr Kathy McClean, Medical Director of NHSI to update her with the progress we have made on the Quality and Improvement Plan.
- In terms of management structure, the Remuneration Committee had approved the Executive Structure. Two Board posts needed to be substantively appointed to; the Director of Operations and a new post Chief of Quality.

- Theo de Pencier would take the Non-Executive Director lead and together with Andrew Grimshaw would progress our estates strategy.
- The Chair had engaged Adrienne Fresko from GE Healthcare Finnamore to undertake a Board skills review.
- The Trust vision and strategy needed a refresh and to that end Dr Penny Dash would work with us at our Strategy and Planning session on 28th June.

54.2 Trust Board noted the Chairman's report.

55. Report from the Chief Executive Officer

55.1 In the absence of Fionna Moore, the report from the Chief Executive was presented by Karen Broughton. She reported on the following key areas:

- Sustainability and Transformation Plans (STPs) – five sector STPs had been set up in London setting out how local services would deliver improved health and wellbeing over the next five years. The Chairman added that this was an ideal time for directors to be involved and influencing whilst the STPs were sorting out their governance structures. The 5-year plans were to be submitted by the end of June.
- Operating Plan – the final version of the Trust's operating plan had been submitted to NHS Improvement on 11th April 2016.
- 'Making the LAS Great' – four managers' briefing sessions had been held in May talking to managers about progress and the focus going forward with our Quality Improvement Plan. An internal campaign to encourage conversations and discussions between managers and staff around Trust vision, values and what people's involvement is in the improvement programme would be launched on 7th June. A new appraisal system was also being launched.
- Quality Account 2015/16 – this was on the Trust Board agenda. It was confirmed that the Medical Director had completed an internal review of safety across the service.
- Control Services Award - in April 2016 Control Services received the Cabinet Office Customer Service Excellence Award for the sixth year running. The Chairman asked that a letter be sent from the Board recognising this achievement.
  Action: Sandra Adams
  Date: 26th July 2016

- Quality Improvement Plan (QIP) – progress on QIP remained strong. More details to be provided later on the agenda. The Chairman and Chief Executive had met with NHS Improvement on 24th May to provide assurance on progress. This had been a positive meeting.
- Key Performance Indicators (KPI) – it was confirmed that the new KPI report had been produced.
- The NHS Trust Development Authority (now NHS Improvement) reviewed our progress against QIP in March 2016. The outcome of the review was positive however we still have work to do. A Clinical Review was planned for June.
- Performance – the Medical Director, acting Director of Operations and the Chief Executive met with NHS England in May to discuss the context of our increased demand, drivers of demand and ways in which the service could work with external stakeholders to mitigate demand. A strong improvement was noticed in performance in April.
- Re-contact rate following discharge by telephone 2015/16 was 2.9% (second lowest in England). Call abandonment rate 2015/16 was 0.2% (the lowest in England).
- Finance – there were ongoing discussions with commissioners regarding additional funding to support the QIP for 2016/17.
- Mental Health Awareness – the Trust took part in Mental Health Awareness

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- week. Managers and staff across the Trust spoke out about their experience of mental health.
- Dignity at work – over 350 staff had completed bullying and harassment awareness training. Training sessions in both mediation and investigation skills had been commissioned to ensure better staff support.
- The VIP annual awards ceremony took place in April.
- London Marathon – a number of LAS staff had run in the London Marathon raising £10,000. The service assisted St John Ambulance in providing medical cover for the event.

55.2 Theo de Pencier asked whether the new appraisal system had started and this was confirmed. Targets were in place for corporate staff appraisals to be completed in July and trajectories had been set for front line/operational staff appraisals.

55.3 The Trust Board noted the Chief Executive's report.

56. **Integrated Performance – April 2016**

56.1 Jill Patterson presented the High Level Integrated Performance Report providing organisational oversight of all key areas across the Trust. The report related to performance throughout April 2016. Jill Patterson stated that the Key Performance Indicator (KPI) Assurance Report underpins the High Level Integrated Performance Report and provides a monthly status position of teach KPI from all the key areas as well as identifying the data source and accountable officer. The KPI Assurance Report had been circulated to Board members as a reference document and assurance on data quality.

56.2 Theo de Pencier asked how the report could be used and Andrew Grimshaw responded that the Executive Leadership Team (ELT) had had a similar conversation. The Board pack provided high level information and was supported by more detailed information that was available electronically for local areas. The Board committees could be used to focus on specific areas.

56.3 Bob McFarland noted that there was duplication between the Integrated Performance Report and the Quality report and he asked whether these could be brought together.

56.4 There was potential risk of missing a key issue by not challenging or looking at the green rated indicators. It was noted that it would be helpful to see both trends and some narrative, for example, the Friends and Family Test was rated green however the data indicated red and a narrative report would provide a clearer picture.

56.5 Jessica Cecil joined the meeting.

56.6 The Trust Board noted the report.

57. **Quality Report**

57.1 Fenella Wrigley presented the report reviewing April 2016 data. The following key headlines were noted:

- 6 serious incidents were declared.
- The Trust went live with the implementation of the DatixWeb on 9th May 2016.
- 103 staff related incidents were reported in April; most of these related to manual handling.
- 88 patient related incidents were reported in April; main themes were missing or faulty equipment and issues with patient treatment.
- Significant progress in medicines management compliance.
- 81 complaints were received in April and the number outstanding beyond 35 days was reducing.

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- Cardiac arrest figures showed a 4% increase in Return of Spontaneous Circulation (ROSC).
- CPI face to face feedback remained low; however recruitment of team leaders is expected to improve this.
- The number of frequent caller incidents and patients had fallen in April partly due to enhanced collaborative approach and the implementation of the new frequent caller strategy.
- On scene time for some critical patients were too long but were improving and feedback to staff was supporting this.
- Friends and Family Test – numbers are still low. A proposal had been submitted, with the support of NHS England for a strategy to engage complex patients. The Trust would work with the Sickle Cell Society this year.

57.2 Jessica Cecil recognised that on scene times had remained challenging and she asked how this could be addressed. Paul Woodrow responded that work was underway to review response profiles for certain call determinants and taking into account the specialist roles such as HEMs and Advanced paramedic Practitioners. An update would be provided in September.
Action: Paul Woodrow
Date: 4th October 2016

57.3 Bob McFarland noted that in terms of serious incidents, it was possible to view the increase in reporting as positive with improvements in the reporting system. This would need to be monitored to get the balance right.

57.4 Nick Martin asked how Friends and Family Test numbers could be improved. Fenella Wrigley responded that the Trust had asked NHS England to expand the group to include complex and non-emergency patients. It was anticipated that including these patients would improve the numbers.

57.5 The de Pencier asked whether incidents relating to manual handling were related to lack of training or the kit being used. Fenella Wrigley responded that it varied and she gave the example of the new carry chair introduced as a mitigation for manual handling incidents. On implementation and training it was identified that shorter staff found the chair more difficult and there was a risk of injury. As a result the training was being changed and a lesson had been learnt in terms of engaging a wider group of staff in these types of trials in future.

57.6 John Jones commended the Hillingdon Group Station for achieving 95% face-to-face CPI feedback sessions. He sought clarification on why this could not be achieved in other stations. Paul Woodrow noted that there were still some variables across stations and additional team leaders had been appointed in some areas. He reported that the Hillingdon Group Station manager had been asked to share with other stations how the group had managed to achieve that level of compliance.

57.7 Regarding the Benger report, Fenella Wrigley reported that NHS England had commissioned an external safety review of the LAS (Benger Report) in December 2014. NHSE had passed the responsibility for monitoring the actions to the commissioners' Clinical Quality Review Group. Fenella Wrigley confirmed that a lot of the work from the Benger Report had been completed; most of the actions would be delivered as part of the QIP and would be monitored accordingly. The Trust would continue working with Commissioners to complete the actions which could not be delivered as part of QIP; for example actions relating to Primary care commissioning support and calls from residential homes.

57.8 Regarding operational performance, Paul Woodrow noted the following key headlines:

- Performance for Red 1, Red 2 and A19 were all above the trajectory for April. There was a significant increase for Cat C performance compared with last

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month.

- Activity (Quarter 1) had been lower than anticipated. It had been agreed with Commissioners to do a standardised activity. A formal review of that activity would be done at the end of Quarter 1.
- Overall demand was 0.4% above plan.
- Patient facing vehicle hours deployed during April were above trajectory by 4.9%.
- Level of supervision for new staff – some staff needed extended supervision.
- Job cycle time remained challenging and was affected by a number of factors, for example handover. Ongoing work with provider organisations.
- Multiple attendance ratio had improved to 1.25.

57.9 In response to a question regarding patient facing vehicle hours, Paul Woodrow reported that there had been some underlying issues relating to conversion courses for trainee emergency ambulance crew (TEAC) in 2015/16 and this was now being addressed through additional courses which was in turn placing pressure on resource capacity. Tina Ivanov, Deputy Director of Clinical Education and Standards was reviewing operational supervision.

57.10 Paul Woodrow reported that he had agreed to reduce the usage of private ambulance services (PAS) in the 2nd quarter but had asked for more in the 1st quarter whilst the Trust moves towards more substantive staff becoming operational. The level of spend on PAS would reduce during the year and this would be monitored at Board level.

57.11 In response to a question relating to demand and the Trust trajectory, Andrew Grimshaw noted that demand was complex; the Trust was working with the system to understand demand better. There was a focus on productivity and how to improve job cycle time. A balance of all three (demand, productivity and activity) was needed. High utilisation meant that if one factor changed then it had an impact on the others.

57.12 In terms of money, Andrew Grimshaw noted ongoing contract negotiations with Commissioners. Andrew Grimshaw drew the attention of the Trust Board to the following:

(i) Cost Improvement Plans (CIPs) - following previous discussions at the Finance and Investment Committee on 26th May 2016, CIPs would change from green to amber.

(ii) Balance sheet: Capital – there was a delay in the approval of the Dual Crewed Ambulance business case pending finalising the 2016/17 contract.

Theo de Pencier asked if this would delay have the vehicles kitted out and Andrew Grimshaw said that the team was working hard to avoid any delay.

57.13 Karen Broughton provided an update on workforce. She noted the following key headlines:

- Overall establishment had increased by 64 (wte) and this had increased our vacancy rate to 6.0%. Frontline vacancy rate stood at 4.9% and we would recruit to 400 vacancies this year.
- Turnover continued to improve; Trust turnover decreased from 12.0% to 11.5%. Out of 11 ambulance services, the Trust has the 5th best turnover rate nationally and is below the national average of 13.4%.
- Strong recruitment pipeline – the 4th recruitment trip to Australia in April was a success.
- Leavers continued to show a downward trend; there had been an average of 28 frontline leavers per month since April 2015.
- Retention strategy is being refreshed.
- Sickness levels remained unchanged at 5.1%. The Trust had the second best sickness rate when compared to all 11 ambulance trusts.
- It was noted that a national CQUIN had been set for health and wellbeing and by

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July 2016 the Trust would identify three health and wellbeing objectives as part of the CQUIN.

- Friends and Family Test (staff response) – there had been a significant improvement compared to last year. However this still need to improve.

57.14 The 2015 staff survey would be presented to the July Trust Board meeting. The survey had confirmed the LAS was in a better workforce position however the Chairman wanted to see the response rate increase to >50%.

57.18 Fergus Cass raised concern around Friends and Family Test (staff responses). The Chair commented that this must be RED rated as 40% of those who had responded had said they would not recommend the service. The Chair then gave feedback from the meeting with Dr Kathy McClean on the importance of staff survey throughout the year and not waiting for annual survey. She noted that Dr Kathy McClean had advised where another Trust in special measures had an excellent method of communication with staff; it was suggested that we should adopt that trust is doing.

57.19 The Trust Board noted the report.

58. **Quality Improvement Plan (QIP)**

Quality Improvement Programme Board report

58.1 Karen Broughton reported that the focus area for the programme during April was to recover the delivery of activities reported in March as being delayed or at risk. The following activities were reported as at risk:

(i) Agreement with commissioners for additional funding relating to the Quality Improvement Programme in the 2016/17 contract.
(ii) Activities to be delivered by the Equality and Inclusion Team which had been affected by unexpected staff absences.

58.2 It was noted that there had been good and sustainable progress in April; for example (i). 319 staff had attended bullying and harassment workshops (ii). 100% compliance with drug locker code changes was achieved (iii) 82% staff completed Duty of Candour training to date (iv). Positive feedback had been received from the Make Ready pilot in North East London.

58.3 Karen Broughton highlighted the following:

- Achieving required appraisal targets (100% corporate appraisals by mid-July).
- Implementation of DatixWeb which was launched in May 2016 for incident reporting.
- Addressing the rest break arrangements.

58.4 There would be an external clinical review at the end of June and a series of deep dive reviews had been agreed with the Improvement Director.

Quality Improvement Progress Report

58.5 It was noted that significant progress had been made on a number of workstreams including bullying and harassment. A discussion took place around Fleet/vehicle ‘Make Ready’ pilot and the assessment of this before full implementation to ensure the right model was working. The Chairman asked that full implementation takes place by early November.

58.9 The Trust Board noted progress on the delivery of the Quality Improvement Programme.

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59. **Quality Governance Committee Assurance Report**

59.1 Bob McFarland presented the assurance report on the meeting of the Quality Governance Committee meeting held on 17th May 2016. He reported that the Committee was pleased to receive the outcome of the Clinical Safety Review of the Service. The review was carried out by the Medical Director. The Quality Governance Committee was assured that although the quality of our response is not always ideal, current measures do mitigate the safety risk of delay and prevent the risk materialising into actual harm when the service is under pressure.

59.2 Bob McFarland reported that the Quality Governance Committee had approved a statement concerning the CQC warning notice for some specific controlled drugs. This had been included in Trust Board pack for recommendation to the Trust Board. The Quality Governance Committee had recommended that the Trust Board approve the Quality Account for 2015/16. It was noted that the Committee was not able to recommend the Annual Safeguarding report to the Board at this stage.

59.3 The Trust Board:

- Noted the Quality Governance Committee report.
- Approved the statement regarding CQC Warning Notice for some specific controlled drugs.

60. **Clinical Safety Review Report**

60.1 Fenella Wrigley reported that she had undertaken a Clinical Safety review of the service using the same methodology used in 2014. She noted that the outcome of the review had been shared with the Clinical Safety and Standards Committee, the Executive Leadership Team and the Quality Governance Committee.

60.2 A five day period (Friday 30th October 2015 to Tuesday 3rd November 2015) was chosen for the review. The period included a weekend and a four and half hours at Surge Purple. 238 patient records were reviewed (fewer than last year) and were categorised as high risk (6), medium risk (46) low risk (92) and no risk (94) of harm. There was evidence that patients were waiting less time for a vehicle response. Risk information had been triangulated and it was noted that no patients went into cardio-pulmonary arrest whilst waiting for an ambulance. There were no serious incidents declared during this period. It was noted that no patient had demonstrable deterioration in their condition whilst waiting for an ambulance.

60.3 Fenella Wrigley gave assurance that the Trust continued to provide a safe service and she proposed to repeat the review annually. The outcome of the review would be communicated to front line staff via a clinical update article.

60.4 The Trust Board thanked Fenella Wrigley for the review. It was noted that clinical safety had been maintained despite some delays in attendance to some patients.

61. **Finance Report Month 1**

61.1 The Trust Board noted the Finance report taking into account the earlier discussion under the Integrated Performance Report.

62. **Assurance from Finance and Investment Committee**

62.1 Nick Martin provided an update from the meeting of the Finance and Investment Committee (FIC) meeting held on 26th May 2016 with reference to the agenda included in the Board pack. He noted the following headlines:

- Composition of the Committee.

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- Performance management strategy.
- Finance Risk Register and the Board Assurance Framework.
- Fleet Delivery Board.

62.2 The Committee would undertake deep dives in the coming year on job cycle time and performance modelling. Theo de Pencier would be taking a lead role in Estate and Fleet. Bob McFarland asked if it was unusual not to have the finances resolved at this stage in the year and the Chairman responded that the activity and baseline plan had been agreed, with QIP investment the outstanding issue. The year ahead would be challenging.

62.3 It was noted that CIPs remained challenged.

62.4 The Trust Board noted the report.

63. Assurance from the Workforce and Organisational Development Committee

63.1 Fergus Cass reported that the Committee had held its first meeting on 16th May 2016. It was noted that the Committee would meet 6 times a year; the terms of reference had been included in Trust Board pack for approval. Fergus Cass stated that it had been agreed to clarify the Committee relationship to other workforce-related committees.

63.2 The Committee had been encouraged by positive trends in Human Resources indicators, for example continued progress with recruitment, a significant reduction in sickness rates and further improvement in turnover. It was noted that staff survey results were poor; however current plans in particular those in the QIP were addressing the main issues. It was anticipated that this would improve the results. Staff Friends and Family Test results showed some improvements.

63.3 Fergus Cass reported that the Equality and Inclusion workstream of the QIP was at risk due to unexpected absences; a full briefing about staff aspects of Equality and Inclusion would be provided at the next Workforce and Organisational Development Committee meeting. This would be reported to the Trust Board and if necessary, recommending any required changes in the Trust's existing strategy in this area.
Action: Fergus Cass
Date: 26th July 2016

63.4 The Committee had received an overview of 'Workforce Planning' covering the overall approach, for example significant priorities and key assumptions for the next three years, forecast of turnover and availability of qualified recruits. The Committee would map a programme of deep dives for the year ahead.

63.5 The Trust had recently received the report on Workforce Race Equality Scheme performance and it was agreed that Karen Broughton would share the report with the Committee. It was noted that there is a QIP action to address that. The Trust Board had approved the Equality and Inclusion Strategy last year and that the focus would be on the patient. The Equality and Inclusion resource had been split and this might need to be re-thought. The Chairman assured Malcolm Alexander, having responded to his questions, that the focus would remain on this area.
Action: Karen Broughton
Date: 26th July 2016

63.6 Malcolm Alexander commented that there was need for the Trust to improve recruiting locally. Karen Broughton recalled previous discussions around emergency ambulance crew recruitment and she noted that some changes had been made but there is still a long way to go.

63.7 The Trust Board noted the Workforce report and thanked Fergus for the update.

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Workforce Terms of reference

63.8 Sandra Adams commented that oversight of paramedic education governance needed to be clarified. Karen Broughton and Fenella Wrigley would clarify this for the next meeting.
Action: Karen Broughton/Fenella Wrigley
Date: 26th July 2016

63.9 The Trust Board noted the terms of reference of the Committee.

64. **Assurance from Audit Committee**

64.1 John Jones provided an update from the meeting of the Audit Committee meeting held on 19th May 2016. He reported that the Committee had received the draft annual report from the Internal Auditors and had noted that 8 reviews had been delivered in 2015/16 in line with the annual plan and that 39 recommendations had been raised, of which 4 were categorised as high priority.

64.2 John Jones reported that the Audit Committee had approved its Annual Report; this was recommended to the Trust Board for approval.

64.3 It was noted that the draft Head of Internal Audit Opinion for 2015/16 stated that 'The Head of Internal Audit Opinion is one of 'significant assurance with minor improvements required' and had confirmed that there was generally a sound system of internal control designed to meet the Trust's objectives.

64.4 It was noted that the Committee had received feedback from the Internal Auditor about the timeliness of management responses and actions taken to address recommendations. It was confirmed that Internal Auditors meet with Executive leads to discuss the recommendations; however the process needed to be tightened. The Committee had noted that the Executive Leadership Team had urged the Executive leads to maintain the focus on the recommendations and ensure that actions were progressed. It had been agreed that where actions were not being delivered, an explanation should be provided by the Executive lead.

64.5 John Jones reported that the Audit Committee had considered and approved the revised Board Assurance Framework format and had agreed that this should remain in place without further detailed review of the format. However the Committee remained concerned about the length of time risks remain on the BAF and the focus on actions to mitigate the level of risks accordingly.

64.6 It was noted that the Auditor Panel had met on 19th May and had discussed the re-appointment of the Trust's External Auditors. This would be further discussed at the next meeting in September.

64.7 The Trust Board noted that the Audit Committee had met in the morning (31st May 2016) and had approved for recommendation to the Trust Board:

- the Annual Accounts 2015/16,
- The Annual Report 2015/16, and
- The Annual Governance Statement 2015/16.

64.8 The Trust Board:

- Noted the Audit Committee assurance report.
- Approved the Audit Committee 2015/16 Annual Report.

65 **Board Assurance Framework (BAF) and Corporate Risk Register**

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65.1 Sandra Adams presented the latest version of the BAF and she noted that the revised format had been agreed by the Risk Compliance and Assurance Group on 12th May 2016 and by the Audit Committee on 19th May. The revised format included additional text boxes indicating the progress of risks and also groups the risk in relation to the key business objectives as described in the quality improvement plan.

65.2 Sandra Adams reported that from 21st June 2016 risk owners would be expected to use the risk module on Datix to add and update local and Trust risks. It was anticipated that this would enable the flow of information through the Trust Committees with responsibility for monitoring progress with risk mitigation and ensure timely escalation where required.

65.3 Sandra Adams confirmed that two BAF risks had been removed from the BAF; the risk relating to NHS 111 contracts (BAF risk 20) and the risk relating to quality assurance dispatch (BAF risk 28).

65.4 In regards to the risk relating to service performance (BAF risk 4), Sandra Adams reminded the Board that it was previously agreed to tolerate the risk at its current level for the foreseeable future pending the outcome of the 2016/17 contract negotiations. The ELT had reviewed the risk description and suggested that it was too all-encompassing and needed to be better articulated to reflect the current position and work would continue on this.

65.5 Sandra Adams recalled previous discussions around the Trust risk appetite statement and she noted ongoing work around that. It was noted that this would form part of the Board strategy review discussion in June
Action: Sandra Adams
Date: 28th June 2016.

65.6 The Trust Board were pleased with the revised format of the BAF.

66. <u>Business Plan 2015/16 End of Year Review</u>

66.1 Fionna Moore joined the meeting over the phone.

66.2 Karen Broughton noted that the Trust had a challenged performance position during 2015/16. Following the CQC inspection of the Service in June 2015, the Trust developed a quality improvement plan to address the actions required however this meant that some of the elements of the 2015/16 Business plan were deferred or not completed.

66.3 A number of projects were undertaken to improve performance and there had been a significant achievement in a number of areas for example, launching our Non-Emergency Transport Service (NETS) to improve the quality of care for our less acutely ill patients, recruiting a significant number of frontline staff and reducing sickness rates.

66.4 It was noted that the Trust reported a deficit of £4.4m following agreement with the TDA in quarter 4. The Trust continued to invest in new equipment, spending in excess of £9.2m on new vehicles, Information Management and Technology system renewal and improvement and additional clinical equipment. The Trust had met a number of NHS Trust financial duties apart from missing the 95% Department of Health target of paying all NHS trade invoices within 30 days.

66.5 The Trust worked closely with Health Education England to address the national shortage of paramedics to ensure that paramedics were added to the national shortage occupation list.

66.7 It was noted that the Trust performance against national ambulance targets was

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challenging. High demand for our services, in particular in Quarter 4 resulted in the Trust falling to meet the national A8 Ambulance target of 75%.

66.8

Fionna Moore added that during the year the Trust worked closely with Commissioners, the TDA and NHSE to discuss initiatives to improve performance. She noted that the Trust would continue to review the trajectory.

66.9

Fergus Cass acknowledged that the Trust had a challenging year and he noted that there were areas where the Trust was also found short. He asked whether there were any lessons learnt and if there was a process in place to address things which went wrong. Karen Broughton confirmed that the Trust had agreed a single plan going forward. A review of the project plans had been undertaken; progress against the plan would be provided regularly during the year. It was anticipated that the KPIs should help.

66.10

In response to a question on how the 2015/16 Business Plan was developed, Fionna Moore reported that there had been discussion and involvement with the full Trust Board.

66.11

The Chair sought clarification from the Chief Executive on what the Trust could do differently to deliver. Fionna Moore responded that there was need for the Trust to be realistic on what could be delivered; this involved setting realistic timelines and outcomes. She felt that the current trajectory was deliverable.

66.12

Nick Martin commented that external recognition of the trajectory was helpful. Andrew Grimshaw noted that there was need to risk assess all the objectives and seek to understand the drivers of some of the issues as well as recognising that the model for example would evolve.

6.13

The Chair recommended moving towards a three year business plan instead of a one year plan and Andrew Grimshaw acknowledged the importance of having the right focus at the right time.

67.

<u>Annual Report and Accounts</u>

67.1

<u>2015/16 Annual Report</u>

Sandra Adams presented the 2015/16 Annual Report which had been reviewed and approved by the Audit Committee that morning along with the Annual Governance Statement. Both the Annual Report and the Annual Governance Statement were being recommended to the Trust Board for approval.

67.2

It was noted that as an NHS organisation, the Trust has a duty to share the report with NHS Improvement (NHSI) and the Department of Health, as well as being available to the public and stakeholders.

67.3

The Trust Board <u>approved</u> the 2015/16 Annual Report.

67.4

<u>2015/16 Annual Governance Statement</u>

It was noted that the 2015/16 Annual Governance Statement would be incorporated into the Annual Report but would be submitted to the auditors and the Department of Health as a standalone document.

67.5

The Trust Board <u>approved</u> the Annual Governance Statement for 2015/16.

67.6

<u>2015/16 Annual Accounts</u>

67.7

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67.8 Andrew Grimshaw tabled the 2015/16 Annual Accounts.

67.9 The Audit Committee had reviewed the Annual Accounts in detail on three occasions and had endorsed it with the ISA 260 statement from the Auditors at its last meeting and was recommending to the Trust Board for adoption and submission to the Department of Health on 2nd June 2016. The Trust had achieved all core financial duties, with no significant issues highlighted.

67.8 The Trust Board thanked Andrew Grimshaw and the team for the accounts.

The Trust Board approved the 2015/16 Annual Accounts.

Fionna Moore confirmed that she was content to sign off the 2015/16 Annual Report, Annual Governance Statement and Annual Accounts.

68. **2015/16 Quality Account**

68.1 Bob McFarland reported that the Quality Governance Committee had reviewed the report twice and was happy to recommend the report to the Trust Board for approval.

68.2 Fenella Wrigley confirmed that the Annual Account had been shared externally; feedback had been received and incorporated into the report and the final version would be submitted later in June. The external Clinical Quality and Risk Group was reviewing the report later today.

68.3 The Trust Board approved the 2015/16 Quality Account.

69. **2016/17 Business Plan**

69.1 Andrew Grimshaw provided a summary of 2016/17 Business Plan. Risk areas were highlighted.

69.2 The following were noted:

- The core contract had been agreed with the CCGs but we had not been able to finalise the position regarding investment as yet. Once finalised this would form a contract variation.
- The Trust had been offered strategy and transformation funding by NHSI to improve the bottom line. The NHSI had asked the Trust to respond by 1st June 2016 however we had advised that we would be unable to confirm this until a satisfactory conclusion was reached regarding the additional investment from commissioners.

69.3 There was a discussion around the plan and associated risks. Andrew Grimshaw said that the Executive Leadership Team had been discussing what could be achieved in the QIP at risk. Some non-executive directors were concerned about the potential impact on the bottom line if we were to proceed at risk. Fionna Moore commented that the investment position could put the delivery of the QIP at significant risk.

69.4 Andrew Grimshaw reported that the maximum reportable deficit would be £3-5m. The Chair asked that we communicate with staff so they knew what we were doing.

69.5 The 2016/17 Business Plan was agreed subject to contract variation.

69.6 Fionna Moore, Jan Norman and Lesley Cave left the meeting.

70. **Report from Trust Secretary**

70.1

70.2

The Trust Board noted the report from the Trust Secretary.

71. The amendment to Section 10, paragraph 10.3, Appendix VII of the Standing Orders regarding the acceptable level for gifts and hospitality was agreed.

71.1

Forward Planner

The following were proposed:

- To add the Workforce and Organisational Development Committee to the calendar
- Workforce Report to be scheduled for July.

Action: MK
Date: 26th July 2016

71.2

The Trust Board noted the forward planner.

72. **Questions from Members of the public**

72.1 The following questions from Malcolm Alexander were:

- *Preventing Future Deaths - what progress had been made to improve communications between the LAS and London's 111 services and improve emergency care for diabetes patients:* It was noted that a flagging system had been implemented for 111.

- *Equality and Inclusion:* This was covered in earlier discussions.

- *NETS development resources:* It was intended to roll out as Pan London for Mental Health patients.

73. **Any Other Business**

73.1 There was none.

74. **Date of next meeting**

74.1 The next meeting of the Trust Board would be on Tuesday 26th July 2016 at 09.30am in the Conference Room, Waterloo.

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ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
Date of schedule: 31st May 2016

Meeting Date	Minute No.	Action Details	Responsibility	Progress and outcome
31/05/16	52.1	Sandra to amend the minutes	SA	Completed.
31/05/16	53.3 29.6 125.10	**Operations structure** To present the findings of the operations structure review to the Trust Board Paul Woodrow and Karen Broughton to review the operations structure and to confirm the timescale	PW/KB	Matters Arising 26th July 2016
31/05/16	55.1	**Chief Executive Report** Sandra Adams to send a letter from the Board recognising Control Services Award.	SA	
31/05/16	57.2	**Quality Report** Paul Woodrow to provide an update scene times.	PW	Matters arising 26th July 2016
31/05/16	63.3 63.5	**Workforce and Organisational Development Report** Fergus Cass to report about staff aspects of Equality and Inclusion. Karen to discuss with Malcolm those issues relating to Patient Experience across the organisation.	FC KB/MA	
31/05/16	63.8	**Workforce Committee Terms of Reference** To clarify paramedic education governance.	KB/FW	
31/05/16	65.5 39.12	**Board Assurance Framework and Corporate Risk Register** Risk appetite statement – ongoing work and would be discussed at the Board strategy review in June.	SA	This is being formalised for the Board Strategy Review in September.
31/05/16	71.1	**Forward Planner** To update the forward planner.	MK	Completed.
Actions from previous meetings				
29/03/16	40.1	Karen Broughton to reschedule the staff survey presentation for the June Board seminar.	KB	Agenda 26th July 2016.
24/11/15	127.3	The Chairman to email non-executive directors once he had reviewed the Full Business Case.	Chairman/AG	Matters arising 26th July 2016

24/11/15	**127.5**	The Chairman to authorise inclusion of maintenance following review with Andrew Grimshaw and Nick Martin.	**Chairman/AG**	Matters arising 26th July 2016.
		COMPLETED ACTIONS		
29/03/16	**29.2** **29.3** **35.1**	**Control services staffing review:** Discuss within the context of 2016/17 Business Planning Karen Broughton to present an EOC report to the Workforce Committee in April 2016. Paul/Karen to develop an action for EOC issues	**PW** **KB**	Completed
29/09/15	**99.11**	Karen Broughton to revisit the original construct of the turnover metric in order to understand how the target figure had been set.	**KB**	Completed
29/03/16	**44.4**	Andrew to present the Business Plan to the Trust Board in April	**AG**	Completed
29/03/16	**29.1**	Jill Patterson to review all the indicators on turnover metrics.	**JP**	Completed
29/03/16	**28.1**	Sandra Adams to amend the minutes.	**SA**	Completed
02/02/16	**05.9**	Sandra Adams to extend the Chief Executive report time.	**SA**	Completed.
02/02/16	**17.2**	Sandra to check with TDA re Board Declarations – self certification, compliance and board statements.	**SA**	Completed
02/02/16	**14.2**	Sandra to identify dates for ELT and Trust Board risk management training.	**SA**	Completed
24/11/15	**119.2**	Sandra Adams to confirm that the EOC capacity review would be presented to EMT and would be scheduled for the next Trust Board meeting.	**SA**	Completed

Report of the Chair – 26 July 2016

1. Ministerial team update

As Board members will be aware, Theresa May has implemented a substantial restructure of the Department of Health (DH) ministerial team as part of her wide-ranging reshuffle. The Rt. Hon. Jeremy Hunt has been confirmed as Secretary for State for Health and Lord Prior retains his role as Under-secretary of State.

Philip Dunne has been appointed as Minister of State for Health, the second ranked position behind Mr Hunt, having previously been Minister of State for Defence Procurement at the Ministry of Defence.

Nicola Blackwood and David Mowat, Parliamentary Private Secretary to Greg Clark, have been appointed Parliamentary Under-secretaries of State at the DH. Ms Blackwood was previously Chair of the Science and Technology committee, a role she held since June 2015.

The incoming trio follow the departure of junior health ministers Jane Ellison and Ben Gummer, who were moved to Financial Secretary to the Treasury and Minister for the Cabinet Office respectively.

Minister for Community and Social Care Alistair Burt has also left the DH, after announcing his resignation from government earlier this month.

Life sciences minister George Freeman has left the DH to chair the Prime Minister's policy board. Mr Freeman's portfolio included the cancer drugs fund, the NHS digital drive, genomics, life sciences industrial strategy and driving the uptake of new drugs and medical technology.

2. LAS Strategy – taking the Service forward

I have forwarded the slides from our away day together with a proposal from McKinsey as to how we might take the work forward. Given the heavy workload in relation to the Quality Improvement Programme (QIP) and our delivery I am discussing with NHS England and McKinsey, if we can deliver a programme of development for Directors alongside the development of the strategy, and I will update the Board at the meeting.

As you are aware the development of a strategy engaging our staff and stakeholders in its development is essential to achieving the cultural change we need to make and for shaping the estates, fleet, IT and workforce strategies that will enable our staff to deliver our service to Londoners and to achieve our target performance for our Commissioners. It is an essential part of the well led review. For these reasons we need a very clear programme of action to ensure we deliver on this.

3. Update on 360° appraisals

Firstly, I would like to thank everyone for engaging with this process which is also part of our 'well led' programme of work and enables us to identify skills shortages, areas for development – individual and as a Board.

Fionna and I have met with the team from - Foresight Partnership - to discuss how best to take this forward. They have agreed to produce a short report to focus our minds for the half day that is planned for 02 September – 09:00-13:00; at this meeting we will aim to agree a plan of action to improve our collective performance and governance.

We also have an additional Board meeting on 06 September where we need to agree the Board risk appetite.

4. Clinical review – June 2016

The QIP report covers the progress made and feedback we received.

Whilst we are moving in the right direction it is essential that we now make progress on the key issues highlighted in the report, namely improving the development and utilisation of increased staffing levels; and reducing variability of crew's experience of vehicle maintenance, equipment availability, and extending to medicines management.

We must concentrate on appropriate action and challenge with granular plans in these areas and the Board must be assured as to actions to deliver improvements.

A key issue will be deciding where best to invest our additional funding to maximum benefit. I am concerned that with our existing staffing plan we will not achieve the desired trajectories in our contract which needs discussion and agreement.

5. Workforce Race Equality Standard (WRES)

Fionna and I have met with the Equality and Diversity lead for the Trust. The analysis of our position and the work ahead of us to change both the experience of BME staff and the culture in the organisation is significant. It is a deeply distressing report; the findings of which I think each of you will feel as embarrassed about as I do.

The Workforce committee will be able to update us on the work programme and provide assurance to us on our plans and actions.

As a Board we need to schedule in Equality and Diversity training and show leadership by seeking to reflect diversity on our Board.

6. NARU Board awareness and assurance of interoperable capabilities

Keith Prior, Director at the National Ambulance Resilience Unit (NARU), wrote to all Ambulance Trusts earlier this month to remind us of our responsibilities relating to our HART (hazardous area response team), MTFA (marauding terrorist firearms attack) and CBRN (chemical, biological, radiological and nuclear defence) service lines. Mr Prior's letter states:

"As you are aware, Ambulance Boards are required to provide annual assurance to NHS England that the obligations under SC30 of the Standard NHS Contract (maintaining the EPRR Core Standards) are being maintained.

Following a number of recent high profile events including flooding, terrorist attacks in Paris and the outbreak of Ebola, attention has remained focused on the specialist interoperable capabilities maintained by English Ambulance Trusts. Over recent months, NARU has received a number of requests for additional information regarding these specialist and complex service lines.

As part of a wider programme of communications, NARU has produced an awareness film aimed at Executive and Non-Executive Directors of Ambulance Services. This film provides an overview of Board responsibilities in relation to the following high risk service lines and has been recommended for circulation to you by Tony Yeaman, West Midlands Non-Executive Director".

Given the progress which our EPRR (Emergency Preparedness, Resilience and Response) team has made over the last ten months to improve the Trust's resilience (and commended by NHS Improvement in its Clinical Review findings), it is timely for the Board to have a dedicated development session with the Trust's resilience leads so that we can be assured that our HART, MTFA and CBRN services meet the standards of training, equipment, leadership and interoperability that are required. This will ensure that the Board can satisfy itself that the Trust has the appropriate capabilities and resources to deliver in practice. This session is currently being organised and will be held within the next few months.

7. Feedback on meeting with, Chair of South London Mental Health Trust

Peter Molyneux was interested to hear about the work that LAS has done in this area and is keen for us to link with their Director of Nursing to see if we can take this work further.

Separately, Peter has developed a site rationalisation plan with a housing association that fits with the Carter Review, upgrades the accommodation for clients and provides opportunities for staff to part-buy property, whilst

retaining the stock of accommodation to the NHS. Peter has agreed to make an introduction to the company.

I have also met the interim Chairman of South East Coast Ambulance Service – Sir Peter Dixon.

8. Association of Ambulance Chief Executives (AACE)

I am attending the CEO and Chairman of AACE conference and will update the Board at the meeting.

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Chief Executive's report to the Board
Report Author(s):	Daryl Belsey
Presented by:	Fionna Moore
Contact Details:	Fionna.moore@lond-amb.nhs.uk
History:	*n/a*
Status:	*For information*

Background/Purpose

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

The report is structured in five sections, covering the primary areas of focus of the Trust and the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement
- Emerging issues

Action required

The Board are asked to take note of the contents of this report as the Trust progresses with its strategic objectives.

Assurance

N/A

Key implications and risks arising from this paper	
Clinical and Quality	**X**

Performance	**X**
Financial	**X**
Governance and Legal	**X**
Equality and Diversity	**X**
Reputation	**X**
Other	
This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	**X**
To make LAS a great place to work	**X**
To improve the organisation and infrastructure	**X**
To develop leadership and management capabilities	This paper provides key information to the Board, informing them of the progress to date of the Trust against key objectives and ensures that the Chair, Executive Leadership Team and Non Executives Directors are fully briefed on the Trust's achievements.

CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 26th July 2016

The Chief Executive's report gives an overview of progress and events since the last time the Board convened. The report is presented in five sections, covering the primary areas of focus of the Trust and the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement
- Emerging issues

Strategy

Sustainability and Transformation Plans (STP)

Across London, the health and care system - Clinical Commissioning Groups, providers and local authorities are working together to develop their strategy, which will set out how local health and care services implement their plan over the next five years, building and strengthening local relationships and ultimately delivering their vision for the Five Year Forward View. London has been divided into five geographical areas known as footprints with each area having now submitted their STP.

The common vision of the five STP's is:

- To measure and improve health and wellbeing outcomes to ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all; focused on prevention and out of hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.
- Closer integration of key health services and departments

Quality

Executive Leadership Team appointments

The Executive Leadership Team is pleased to announce the appointment of Paul Woodrow as Director of Operations following a full recruitment process. We are also delighted to announce that Briony Sloper has taken up the post of interim Chief Quality Officer, pending a substantive appointment.

Clinical Review

The scheduled Clinical Review visit led by NHS Improvement was completed during June to assess how the Trust is progressing against the Quality Improvement Plans to address the CQC concerns across the five quality domains. In comparison to the Warning Notice Review carried out in March which solely focussed on the urgent and immediate actions to be carried out by the Trust, the review carried out in June was more extensive and included: the submission of documentary evidence, selected focus group sessions, site visits to stations and A&E Departments, and observational ride outs with frontline staff on shift. The areas of focus were Emergency Operations Centre (EOC), Patient Transport services (PTS), Resilience and Urgent and Emergency care.

Preliminary outcomes following the review has shown encouraging progress, however there continue to be areas that need greater focus and attention, in particular quality consistency in the delivery of

improvement. A full briefing of the Clinical Review outcomes will be provided separately to the Trust Board.

Clinical update
As a result of our work with the Patients' Forum and feedback from patient groups we have agreed a CQUIN this year which focuses on the care we provide patients with Sickle Cell Disease. The Medical Director held a meeting with the Sickle Cell Society and Patients' Forum to hear the concerns of this patient group and also share with them how calls are triaged and assessed. Over the next year we will be undertaking an audit of the care we provide, providing refresher training for all frontline staff and working with hospitals to get care plans developed where needed for individual patients

Quality Improvement Programme
During June 2016, there were high numbers of activities to be delivered 88% of scheduled activities were completed. Although July and August reflects relatively quieter months, project teams will utilise the next two months to recover any activities that are reporting as delayed and to progress activities due at the end of September. A deep dive review of the Patient Transport Service and improvements to the care of Mental Health patients was presented in June to the Clinical Quality and Review Group who provide external assurance of delivery, and a similar review of fleet and logistics will be presented to the group in July.

The greatest area of risk still remains the outstanding decision from Commissioners relating to the funding of the Quality Improvement Programme. Discussions and negotiations continue and it is anticipated this will be resolved during July 2016.

A detailed report of QIP performance to date will be provided separately to the Trust Board

Delivery – performance, money and workforce

Performance
July 2016

- July's A8 performance month-to-date (1st-17th) is 62.82% against the trajectory of 63.15%, at present if the rest of month follows our forecast we will finish at 62.44%. This forecast encompasses the increased demand expected in this week from the hot weather. We are reviewing all of our efficiency and capacity measures to maximise performance and achieve the trajectory for July 2016 but the position is tight.
- Cat A demand is currently 9% up against last July, last week Cat A demand exceeded the trajectory by 3.5% and again if the rest of the month follows the forecast, we would exceed the July's Cat A demand trajectory by 5.4%.
- We were above the A8 performance trajectory in each of the three months in Q1 2016-17, despite actual Cat A demand exceeding the combined Cat A demand trajectory by 3.4%.

August 2016 and beyond

- In August the Cat A trajectory rises substantially to 67.08%, albeit against an expected fall in Cat A demand next month. However from then on the Cat A performance trajectory continues to rise until December as does the expected level of Cat A demand with Q3 expected to be the busiest in the year.

- Currently the production of patient facing vehicle hours has been regularly above the trajectory level by 2000+ hours per week, although this is reliant on overtime being taken up and the use of PAS/VAS vehicles (although this has been reduced by 20% since July 1st), but there remains significant difficulty in staffing to meet demand across all hours of the day (post 1900) and days of the week, particularly the weekends and indeed, across all of the LAS sectors, most notably the North-West sector.
- Annual leave abstractions are expected to increase significantly from this month in to August, which will make it challenging to maintain the level of patient facing vehicle hours produced that we may need to meet the A8 performance trajectory of 67.08% if Cat A demand continues to be above the trajectory level.
- Improving performance efficiency in terms of reducing job-cycle time to provide greater operational resource capacity continues to present a big challenge with the majority of LAS sectors.
- In recent weeks though, we have seen a significant reduction, by several minutes, in the time from arrival at ED hospital to patient handover which has reduced the average time our vehicles spend at hospital.
- In May, the Business Information (BI) team began producing the LAS Operational Performance Report for the service overall and all of the sectors which allows for a comprehensive view of all the main aspects of operational performance, demand, capacity and efficiency. This has recently been expanded for even greater transparency by breaking down these elements to group station level. This report is distributed with a summary to each sector every week and is then analysed and discussed at the weekly Service Delivery Group (SDG) meeting so that the main areas that are impacting on operational performance delivery can be easily and quickly identified and acted upon in order to deliver the performance recovery required for the rest of 2016-17

111 Transition
The 111 transition from Beckenham to our new premises in Croydon was successfully completed on the planned date with the satisfaction of Commissioners.

Workforce
At the end of July the Trust will be submitting our Workforce Race Equality Action Plan to NHS England and publishing it on the website.

We know we have a long way to go to ensure our workforce is broadly representative of the communities we serve but our new and robust WRES Action Plan confirms our commitment to address the ‘gap’. This ‘gap’ represent a missed business opportunity in the sense that it suggests we are potentially overlooking important recruitment ‘pools’ but it is also an issue for patient care given the research shows that diverse teams and leaderships are better for innovation and increase organisation effectiveness.

One of the ways we aspire to close the gap over time is by developing links with BME community groups and schools and colleges to promote the role of the paramedic as a career that is second to none and the LAS as a great place to work. This approach also encompasses local recruitment plans.

Culture and Engagement

Making the LAS Great – internal campaign
We launched “Making the LAS Great” to start hundreds of conversations locally about what everyone can do to help support our quality improvement plan for the benefit of patients, and how the plan relates to our vision and values. 180 “conversation packs” were distributed to all sites across the Service, with local and senior managers talking with staff in their workplaces, or outside emergency departments between

responding to emergency calls. There was a great deal of activity and positivity from staff across the Service on our internal social media channel.
The next phase of the campaign will focus on:

1) Support our vision and values
2) Book your appraisal
3) Medicines management – Shut it, Lock it, Prove it, Return it
4) Speak up – risk, incidents, behaviour, duty of candour
5) Protect vulnerable people
6) Look after your equipment
7) Keep information safe
8) Represent the Service with pride

LAS News
The latest edition of LAS News, our quarterly staff magazine, was published in June and distributed to all sites across the Service. Further editions this year will be published in September and December.

Pride
We ran a live social media event for #Pride2016. This involved sharing information as it happened via words, pictures and films to our followers on Twitter and Facebook. As a result we had over 211,000 impressions (people who saw our content on Twitter) on Saturday and a further 100,000 on Sunday. This compares to a normal daily average of 43,000 impressions.
In addition to this, over 11,000 people watched the film we created on the day and shared via Facebook and secured some media coverage in the Evening Standard and EMS News.
We also tweeted about our medical response, warning those at Pride about the risk of taking drugs and asking them to look after their friends if they were drinking.

BBC Documentary
We are continuing to work with Dragonfly on the BBC documentary series planned for broadcast in the autumn. The team have been focussing on getting specialist shots of vehicles and even hired a helicopter for an aerial shoot of ambulances driving around the capital. Dragonfly is also interviewing staff who have been followed during the series and we expect to review a near to final edit of all three episodes in early September.

Social media growth
Our use of social media continues to grow. For example, we can attract around 1,000 extra followers a month to our Twitter account and now have an audience of over 60,000. Our Youtube channel has had over 100,000 views of the films we have hosted there in the first six months of 2016. This is over 50 per cent more views than the same period last year.

Local bulletins to our stakeholders
Eight stakeholder bulletins were issued covering a range of topics, including an update on the Quality Improvement Plan, VIP awards and working with hospitals to manage delays. The sector bulletins also included an introduction to the sector management teams. The bulletins are sent to MPs, London Assembly members, CCG's, other trusts, Healthwatch, the Patients Forum, local authorities and other interested parties.

New London Assembly/ Mayor

Following the London Assembly elections we wrote to all new assembly members with introduction about the Service and offering a meeting. Florence Eshalomi AM visited the Service in July, meeting with Graham Norton, Assistant Director of Operations South East London and Fiona Claridge, Stakeholder Engagement Manager. She also visited the Emergency Operations Centre

Since the new Mayor has been in post we have been asked to provide information to brief him in relation to questions from Assembly members about the Service. We have provided information for seven mayor's questions about recruitment and retention, housing, resilience, blue light collaboration, end of life care, siren usage and our relationship with the GLA/ NHS. In his responses the Mayor has been broadly supportive of the Service, praising the work our staff undertake. He has highlighted that he would like to discuss having greater strategic control of the Service and will be meeting with the chair and CEO

Chief Executive Officer engagement

9th June - Hosted the Australian Governor General
24th June - Clinical shift on the Physician Response Unit (PRU)
25th June - Pride London LGBT event
29th June - Speaker session at Goldman Sachs alongside a table top exercise focusing on leadership within the NHS
30th June - Launch of the mediation workshop
30th June –launch of the London Chamber of Commerce and Industry (LCCI) report 'Living on the Edge: Housing London's Blue Light Emergency Services.'
7th July - Wreath laying ceremony in remembrance of the victims of the 7th July terrorist attacks
11th July - Impact Factor day – Joint Emergency Service prevention and information session aimed at local schools with high emergency service utilisation or contact.
12th July - London Fire Brigade, cadet passing out parade in Tower Hamlets
13th July - Brent ambulance station Continuing Professional Development (CPD) event
21st July - Clinical shift on the Physician Response Unit (PRU)
31st July - Ride London event, staff and public engagement.

Emerging Issues

E20 mapping issue

This issue is currently being addressed with a comprehensive set of actions culminating in the new Mobile Data Terminal (MDT) and Satellite Navigation roll out starting in January. We have introduced new inserts for our existing map books and new map updates have been created for our Computer Aided Dispatch system (CAD). A process has been agreed with the Queen Elizabeth Park security team to assist 'lost' crews. New park specific map books are currently in draft form and will be manufactured and distributed in August.

Dr Fionna Moore
Chief Executive

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Integrated Performance Report – Trust Board Executive Summary. Key Performance Indicator - Assurance Document.
Report Author(s):	Jill Patterson
Presented by:	Jill Patterson
Contact Details:	
History:	Executive Leadership Team – 20/07/2016
Status:	Information Assurance and Discussion.

Background/Purpose

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

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

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

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

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

Action required

For Trust Board to note the Integrated Performance Report and receive it for information, assurance and discussion.

Assurance

- To assure the provision of high quality data and intelligence to support the Trust's decision making processes.
- To provide an integrated and comprehensive picture of the Trust's overall performance.
- To ensure that the Trust Board receives early oversight of trends and issues.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Governance and Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**YES**
Achieving Good Governance	**YES**
Improving Patient Experience	**YES**
Improving Environment and Resources	**YES**
Taking Pride and Responsibility	**YES**

London Ambulance Service NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

JULY 2016

* All available data is correct as of the 15th of every month.

* Please note that this report relates to performance throughout June 2016 unless otherwise stated.

Delivery of care continues to be safe, but quality remains challenged at times. Some patients experience longer waits due to capacity constraints. In June, the position is £0.4m adverse to plan and the year end position of £6.7m deficit is seen as challenging but achievable. A8 performance ended at 65.4%. This is above the LAS trajectory of 63.4%. Looking forward to July and August this trajectory is challenging. Trust Turnover is now at 10.8% against a threshold of 13%, down from 10.9% in May.

OUR PATIENTS

- ⇔ 12% of cardiac arrests had defibrillator downloads, an increase of 4% on April's data.
- ⇔ 6 serious incidents declared of 41 incidents reviewed, with 10 overdue incidents which have been escalated to ELT leads.
- ↑ 338 Friends and Family Tests were received in June owing to a one-off mailshot. Over 97% of the responses received said they were likely to recommend our service.
- ↓ 153 complaints remain open, with 43 (28%) exceeding the 35 working day completion target.

OUR PERFORMANCE

- ↑ A8 Performance was 65.4% for the month of June. This is higher than the trajectory figure of 63.4%.This is the third month in succession that we have achieved above our contractual trajectory.
- ↑ There were 43,110 category A incidents in June (3.2% above trajectory). Category C demand was 4.5% above trajectory. Overall demand was at 91,588 incidents, 3.9% above plan.
- ↑ Job Cycle Time has remained above the trajectory at 86.5 minutes. This is 1.6 minutes above the expected trajectory for June (84.9 minutes).
- ↑ Capacity was above trajectory with patient facing vehicle hours at 8.2% above plan.
- ↓ The multiple attendance ratio has remained below plan at 1.27 in June. This has resulted in three consecutive months being positively below plan.

OUR MONEY

- ⇔ Plan / Target – The Trust has a planned deficit target of £6.7m. The revised Control Total and associated changes in income and expenditure have been accepted by the Board.
- ⇔ YTD the Trust reports £0.4m adverse variance from the original plan of £2.2m deficit.
- ⇔ YTD CIPs are on plan. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.
- ⇔ Capital spend is £0.3m against a revised Capital plan of £0.5m. DCA replacement have been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14m of the £19m Capital Resource Limit requested.
- ⇔ Cash is £17.6m, £1.5m adverse to plan. The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year.

OUR PEOPLE

- ↓ The vacancy rate for frontline staff has improved from 3.9% to 2.4%. This remains below the Trust target of 5%.
- ↓ Turnover has further improved from 10.9% in May to 10.8% in June. This remains below the Trust target of 13%.
- ↓ The sickness percentage has reduced from to 5% to 4.9%. This is below the 5.5% target.

Achieving the calls answered in 60 seconds target has been a challenge for the 111 service due to fluctuating call demand and staffing shortfalls. The Patient Transport Service remains constant in patient waiting times.

LAS 111 (SOUTH EAST LONDON)

- ⇔ The LAS 111 service achieved an overall figure of 94.2% in June for the calls answered within 60 seconds KPI.
- ⇔ Calls offered were 7.2% higher than in June 2015. This reflects the increasing demand for 111 services experienced over recent months.
- ⇔ The LAS 111 service remains safe with no Serious Incidents declared during June.

PATIENT TRANSPORT SERVICE

- ↑ 5,797 journeys were completed in June 2016, an increase from the previous month's total of 5,602 journeys.
- ↑ The patient departure KPI exceeded it's 95% target for June with 96%.
- ↑ The Friends and Family Test (FFT) responses have increased again this month as a result of sending a daily mailshot to all patients.

Our Patients

Section	Key Headlines From Each Sub-Section	Apr	May	Jun
SAFETY	➢ 6 SI's declared in June out of 41 incidents reviewed, with 10 reports overdue. Overdue SI's have been escalated internally to the Executive Lead for completion compliance. ➢ 81% completion rate for CSR2016.1 to date. June saw 859 attendees of 953 bookings made. ➢ 14 medicines management issues were reported during June with main themes being incorrect drug / dose of drug and shortages of available drugs packs for crew usage. ➢ There are 153 open complaints with 43 over 35 working days. ➢ 72% of patient safety incidents were logged onto DatixWeb within 4 days of the incident occurring.			
EFFECTIVE	➢ 27 patients with ROSC presented with a STEMI following their cardiac arrest and were all conveyed to Heart Attack Centres (HAC) appropriately. ➢ 12% of cardiac arrests had defibrillator downloads, an increase of 4% from April 2016. ➢ Call to hospital times for STEMI patients have decreased by 1 minute to 72 minutes. ➢ 5 FAST positive patients (0.5%) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback to crews for learning.			
CARING	➢ The Severe Sepsis CPI compliance is consistent at 95% since it's introduction in March 2016. ➢ In May, 89% of PRFs were audited a reduction of 4% on the previous month and remains below the agreed KPI target of 95%. ➢ 338 Friends and Family Test's were received during June, a significant increase on previous months following a marked effort by PTS and internal communications with staff. ➢ 35 public events were attended by the Patient and Public Involvement team.			
RESPONSIVE	➢ The Trust is currently at Pressure Level 2 – Moderate. ➢ The Trust remains at Surge Red, with one period of 3.5 hours noted in June at Surge Purple Enhanced. ➢ A number of hospital breaches were noted during June, with 1001 of these breaches exceeding 1 hour.			
WELL LED	➢ NHSI inspections took place across the Trust supported by a number of staff from different departments Trust wide. ➢ The Trust has delivered it's first Mediation awareness session led by the Bullying and Harassment Specialist.	**N / A**	**N / A**	**N / A**

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Serious & Adverse Incidents (SI)

Patient safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	72%	13%	

%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	11%	32%	25%	20%	30%	40%	26%	13%	20%	23%	25%
2016/17	21%	46%	72%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The average number of days in June (up to 24/06/16) between incident date and the date reported was 3.88 days. 72% of all patient safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting.

Staff safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	60%	25%	

%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13%	10%	23%	17%	20%	17%	22%	23%	10%	22%	19%	21%
2016/17	20%	17%	60%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The average number of days in June (up to 24/06/16) between incident date and the date reported was 5.4 days. 60% of all staff safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting.

Adverse Incidents

The Trust is currently moving from two methods of data capture to using DatixWeb only.

It is estimated that more than 90% of incidents in June 2016 have been received. A total of 314 adverse incidents have been recorded; The staff and patient categories make up 93% of these, which are detailed below.

Staff Incidents: 149 (-21%)

Manual Handling incidents: 27 (+33%)

Assault and Abuse: 45 (-49%)

Patient Incidents: 143 (+14%)

Failure of equipment: 18 (-10%)

Missing Equipment: 8 (-58%)

Medication Incidents: 14 (+8%)

Adverse Incidents due to items of equipment which failed or missing

Failed in use

Lifepak 15: ECG Cables	6
EZIO: Battery	3
Entonox: Mouthpiece	2
Tail Lift	1

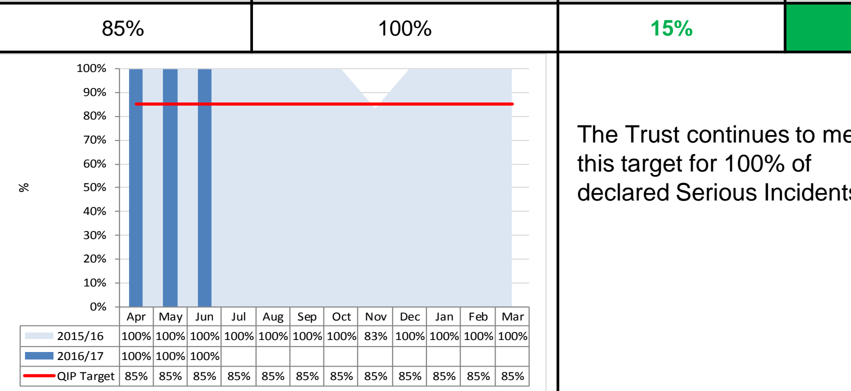
Missing Items

EZIO (hand-held drill to deliver fluids to the bone)	3
Paramedic Drug Pack	2
Laerdal Suction: Battery	1
Lifepak 15: ECG Cables	1

Serious Incidents / Governance

Percentage of Serious Incidents (Sis) reported on STEIS within 48 hours of being declared

Target 2016/17	Actual	Variance	RAG
85%	100%	15%	



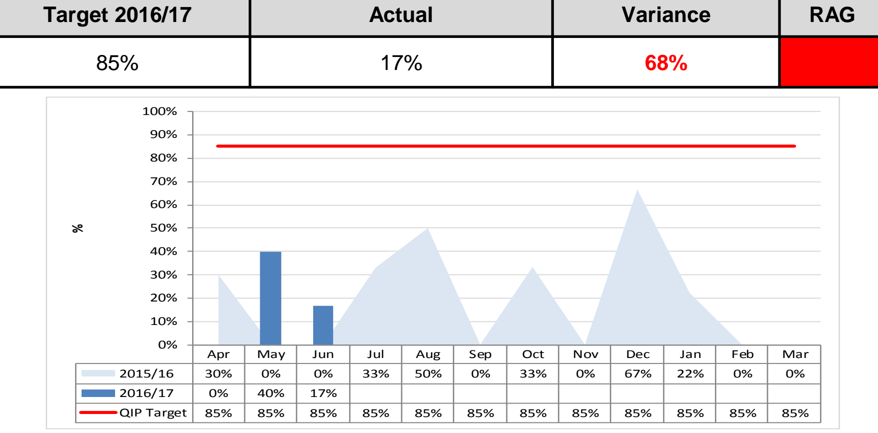
The Trust continues to meet this target for 100% of declared Serious Incidents.

Serious Incidents (SI's)

- 6 SI's were declared in June 2016 out of 41 incidents reviewed, with 10 reports overdue as of 5th July 2016.
- Overdue SI's have been escalated internally to the Executive Lead for completion compliance. Projected completion dates have been requested from Executive Leadership Team members.
- Recent SI themes identified in the first 3 months of 2016-17 include:-
  - Issues with identification and management of patients in early cardiac arrest.
  - Information governance / security issues
  - Ambulance delays.

Completed investigations and reports within 60 working days of a serious incident being declared

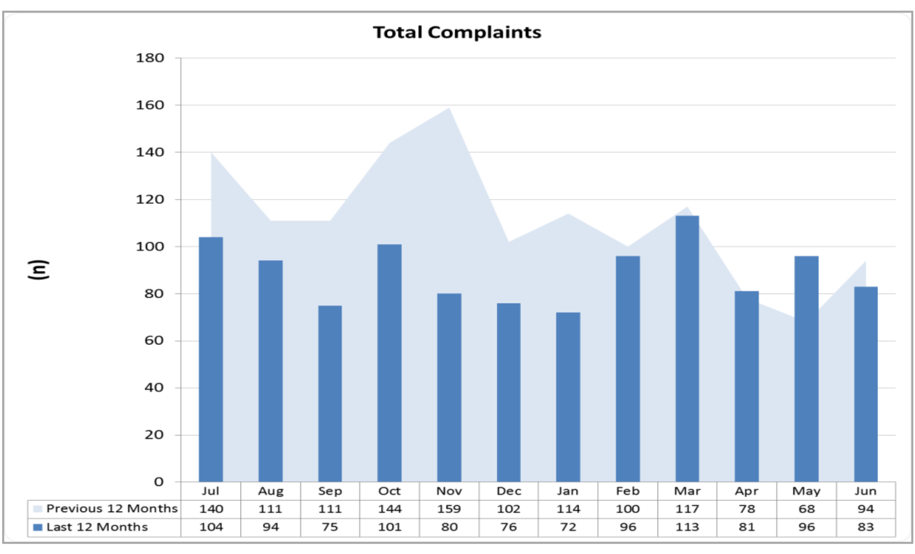
Target 2016/17	Actual	Variance	RAG
85%	17%	68%	



In Q1 16/17 the LAS submitted 18 SI reports with the average time for completion of 107 days. 3 were completed within 60 days. July is the first month where 60 working days will have elapsed from 1 April.

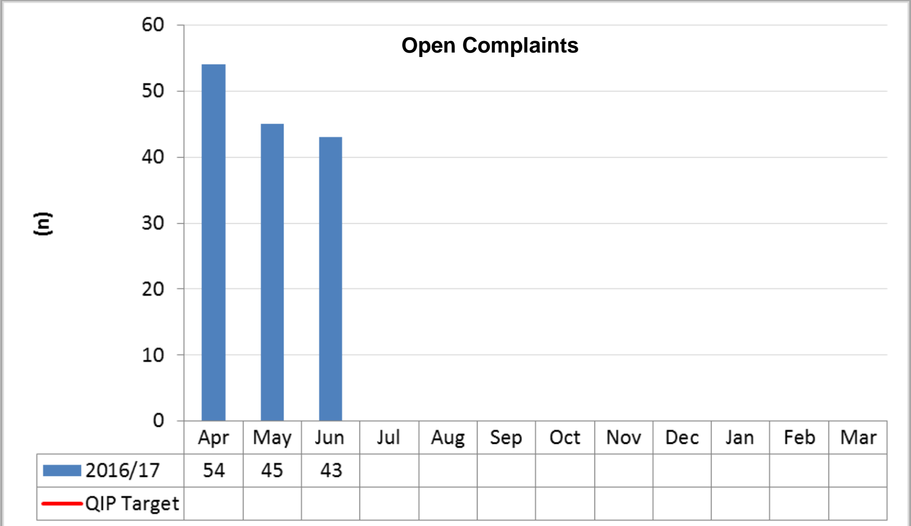
There is a risk in that there is a small backlog of cases which requires an investigator and ELT/ Governance team resources. There has been significant work undertaken to clear the backlog of SI reports and to alert the ELT of overdue investigations. Further training is being provided to investigators across the Trust.

Complaints – Volume & Response time



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Previous 12 Months	140	111	111	144	159	102	114	100	117	78	68	94
Last 12 Months	104	94	75	101	80	76	72	96	113	81	96	83

- 83 complaints were received in June 2016, lower for the month of June than in the previous two years.
- This includes 5 from Health or Social Care providers which were treated as having been made on behalf of the patient. This adheres to best practice guidelines (and as approved by HSC) and the Duty Of Candour obligations.



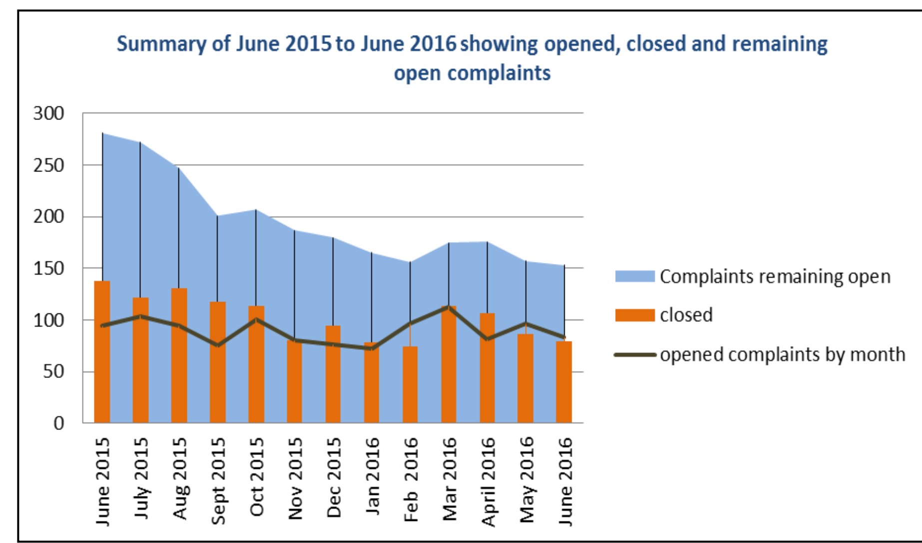
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43									
QIP Target												

- The chart opposite shows the number of complaints over 35 working days that remain open.
- There are 153 open complaints with 43 over 35 working days (this includes 8 cases awaiting further Quality Assurance reports).
- The oldest complaint is from March 2016 – awaiting a clinical review following identification that further information was required before the case could be closed. This is being addressed with the clinical reviewer.

Complaints – Volume & Response time

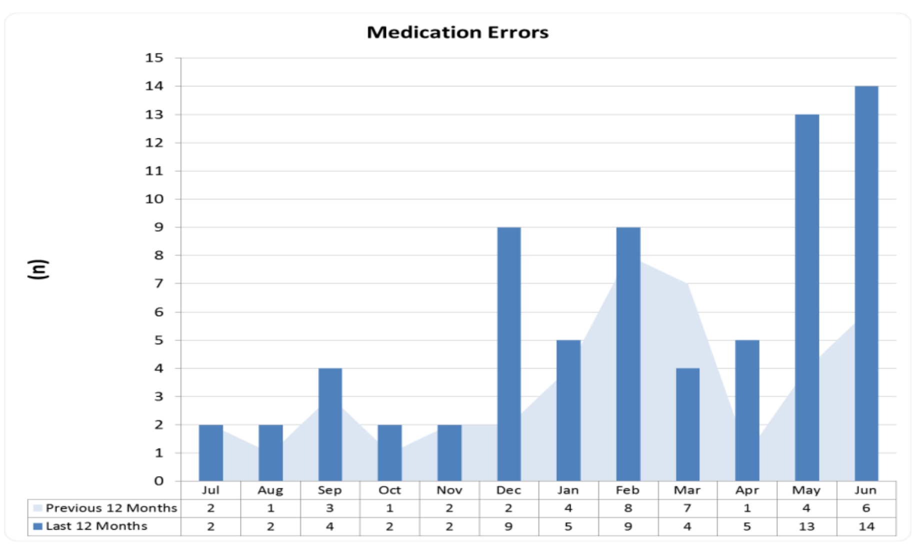
	2012/13	2013/14	2014/15	2015/16	2016/17
June Complaints	76	73	130	94	83
Average per annum	81	88	117	88	87

- Overall complaint numbers are lower than for 2015/16.
- Complaints about delay have increased in June (31) in comparison to 20 received in May.
- Complaints about conduct and behaviour have declined in June (25) compared to 38 in May.
- A recurrent theme remains the failure to adopt a care plan approach in relation to Locality Alert Register entries. A review is taking place with the Medical Directorate to evaluate current policy and procedural guidance.



- DatixWeb was implemented in the department on 10th May 2016 and previous case management systems are now archived. The introduction of a new system has identified some technical amendments required, which are being addressed internally.
- Data for reporting complaints by area and Local Authorities / CCG's will commence in August following completion of further training on DatixWeb for the Patients Experience Department.
- The number of complaints closed during June 2016 was 79.

Medicines Management



Controlled Drugs

There has been one reportable controlled drugs incident in June. A motorcycle response unit paramedic returned to station and noticed that their morphine belt pouch was missing. Despite retracing steps and conducting area searches the morphine could not be located and the matter has been reported to the MPS and Home Office.

Although not a reportable incident, two break-ins have occurred at Ruislip Ambulance Station where controlled drugs are stored. The MPS CD team have inspected the premises following the first break-in. The second occurrence has been reported to the MPS CD team and their response is awaited.

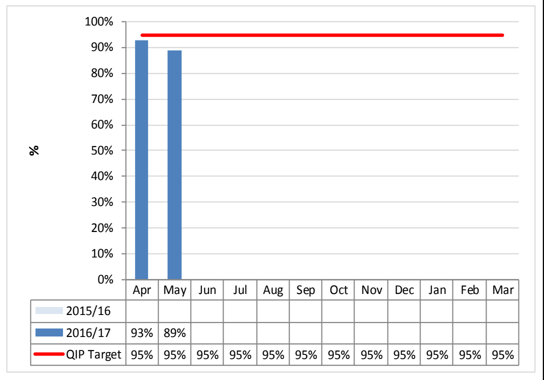
Other medicines management issues

- A total of nine further medicines management issues have been reported during June 2016.
- These include wrong dose and/or wrong drug in five cases. The remaining cases relate to lack of availability of drugs due to shortages at station level or missing drugs form sealed drugs packs.
- Efforts to recruit a Darzi fellow pharmacist continue as part of the recruitment plan. Four candidates have been shortlisted and are due to be interviewed in July 2016.
- The quarterly Trust Medicines Management Group meeting took place on 1/6/16. During this meeting it was reported that the issues relating to ambulance service use of oral morphine and rectal diazepam are on-going at a national level.
- Nerve Agent Antidote Kits (NAAKs) have been delivered. There is a requirement for these to be stored on every Trust frontline vehicle and the Medicines Management Group in conjunction with the Director of the Central Operations Division are currently determining the most appropriate methods for achieving this.
- Incident Response Officer (IRO) medicines spot checks are on-going and demonstrate an improvement in compliance over time.

CPI Completion, Feedback Sessions and Compliance (May 2016 data)

Number of eligible Patient Report Forms (PRFs) audited per month

Target 2016/17	Actual	Variance	RAG
95%	May: 89%	6%	



This KPI is reported 1 month retrospectively. Three Team Leaders are expected to start this month and this will improve completion rates overall. CARU recommends that if possible stations who have capacity (such as additional support from restricted duties staff) provide assistance to station groups.

CPI Compliance

- The care provided to patients with a diagnosed psychiatric problem was maintained in both April and May 2016 at 91%. Consistent documentation by all sectors for safeguarding concerns and appearance will increase compliance considerably.
- For the 8th month, a consistently high level of care (>95%) was provided to patients discharged at scene. However, documentation of final observations continues to require improvement as it is at 91% compliance.
- General documentation of patient care remains high (>95%), with drug pack codes recorded on 98% of relevant PRFs.
- Patient care provided to those experiencing a glycaemic emergency is at a consistently high level. Recording final observations would further improve this as this currently at 92% compliance.
- The Severe Sepsis CPI is in its 2nd month and achieving 95% compliance. Improvements have been made in the documentation of oxygen, IV fluids, and the site of infection; however, further improvements are required for these aspects of care. A business case has been submitted to add the severe sepsis CPI as a hot topic on the next round of Core Skill Refresher courses.

CPI Completion

- In May, at 89%, we saw the number of PRFs audited return to levels seen before April 2016.
- Twelve group stations and teams have audited every PRF available so far this financial year: Bromley, Croydon, Edmonton, Friern Barnet, Hanwell, Hillingdon, Newham, and New Malden Group Stations, as well as the Clinical Hub, HART, MRU and Tactical Response Unit. The newly formed Wimbledon Group Station did not audit any PRFs for the second month due to staff availability; however, three Team Leaders will be joining Wimbledon in June 2016.
- The overall proportion of CPI audits of PRFs undertaken by Team Leaders fell slightly this month. However, all audits were completed by Team Leaders at Bromley, New Malden, Romford, plus the Clinical Hub and HART.

CPI Feedback

- The method of calculating monthly feedback targets changed in April with targets now based on a monthly ratio to reflect expected operational pressures and Team Leader office time.
- Service wide, fewer than half of the staff received the expected number of face-to-face feedback sessions in May. Hillingdon Group Station is commended for exceeding the level of feedback required at this point in the year, as are Romford and the Tactical Response Unit who delivered over 75% of expected sessions.
- Low numbers of feedback sessions were delivered at the Clinical Hub, MRU and to Volunteer Responders. Hear and Treat Peer to Peer review has continued on the Clinical Hub.
- CARU will continue to monitor the progress of the feedback provided to members of staff across the LAS and specifically focus on the areas where feedback sessions are considerably lower than expected.

CARU Reports (Cardiac Care) - May 2016

CARDIAC ARREST

- Resuscitation efforts were commenced on **40%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **8 minutes**, thus meeting the target. **Twelve** station groups had an average 999 call to scene time of 8 minutes or less.
- **29%** of cardiac arrest patients that had resuscitation commenced gained and sustained Return of Spontaneous Circulation (ROSC) until arrival at hospital. This is a **3%** decrease from April, although it is in line with the average from 2015/16. **St. Helier** station group had the highest ROSC rate with 50% of their patients maintaining ROSC to hospital.
- **27** patients with ROSC presented with a STEMI following their cardiac arrest, all of which were conveyed to HACs in line with the pathway.
- An advanced airway management device was placed successfully in **86%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **Three** patient had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout and these have been shared with Sector management teams for further investigation.
- Approximately **12%** of cases had defibrillator downloads submitted, which was a **4%** increase from April. All the downloads were submitted by Advanced Paramedic Practitioners on-scene.

STEMI

- **99%** of patients were conveyed to an appropriate destination, with **three** patients not being transported according to the HAC pathway. These cases have been shared with Sector management teams for feedback.
- The average time from the 999 call to arrival on scene decreased by **2** minutes to **9** minutes in May.
- Average overall on scene time has increased by **1** minute and remains high at **45** minutes. **Brent** and **Fulham** station groups achieved a notably lower than average overall on scene time this month. However, on-scene times continue to require monitoring and review to identify themes.
- Call to hospital times have decreased by **1** minute to **72** minutes.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) has increased by **4%** to **75%**, with **Croydon** station group supplying the full care bundle to 100% of patients attended this month. Analgesia administration continues to be the element where least compliance is seen, with **82%** of patients receiving pain relief.

CARU Reports (Stroke and Major Trauma) – May 2016

STROKE

- **97%** of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF.
- Almost all FAST positive patients (**99.6%**) had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- Almost all FAST positive patients (**99.5%**) were conveyed to the most appropriate destination for their condition. However, **5** FAST positive patients (**0.5%**) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback as necessary.
- The average response time for 999 call to arrive on scene was **12** minutes.
- The average time on scene is **35** minutes, which remains longer than the recommended 30 minutes. Just over half of LAS crew (**51%**) attending stroke patients who were potentially eligible for thrombolysis spent 30 minutes or less on scene.
- The percentage of patients, who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes, remains at 65%.

MAJOR TRAUMA

Major trauma data is produced quarterly.

Q1 data will be available in August’s report.

Our Performance

Sub-Section	Comment	June	May	Apr
A8 Performance	A8 Performance was 65.4% for the month of June. This is higher than the trajectory figure of 63.4%. The Trust have successfully achieved above trajectory for 3 consecutive months.			
Other Performance	Performance for Red 1, Red 2 and A19 were all above the trajectory for June. All four cat C performance measures are higher than the same period last year therefore providing improved patient care and better clinical outcomes.			
Demand	There were 43,110 category A incidents in June (3.2% above trajectory). Category C demand was 4.5% above trajectory. Overall demand was at 91,588 incidents, 3.9% above plan.			
Capacity	The patient facing vehicle hours (PFVH) deployed during June were above trajectory by 8.2%. This was primarily due to the number of patient facing overtime vehicle hours which was 8.1% above plan and the continued use of PAS/VAS.			
Efficiency	Job Cycle Time has remained above the trajectory at 86.5 minutes. This is 1.6 minutes above the expected trajectory for June (84.9 minutes). MAR was 1.27, this is below the plan of 1.29.			
EOC – Call Answering	5 Second Call Answering for June was at 95.3%, this was 0.3% above the target of 95%.			
EOC – FRU Cat C Share	FRU share of Cat C for June was 8.4%, this was 3.4% above the target of 5% but 1.5% below June 2015.			

Ambulance Quality Indicators (AQI) Update – May 2016

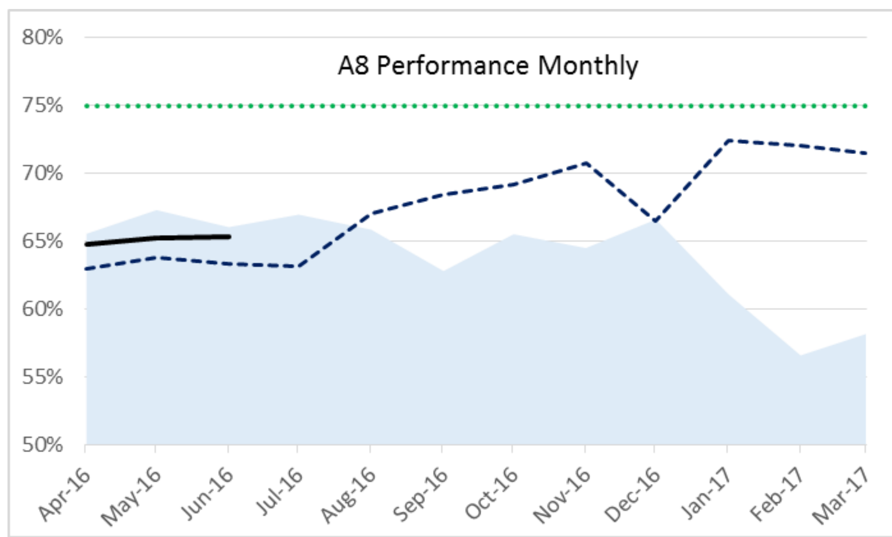
The AQIs for May 2016 were published on 14th July 2016. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.
The table below details 7 of these indicators. It shows the indicator description, the LAS performance and it's position in relation to the other 11 ambulance trusts.

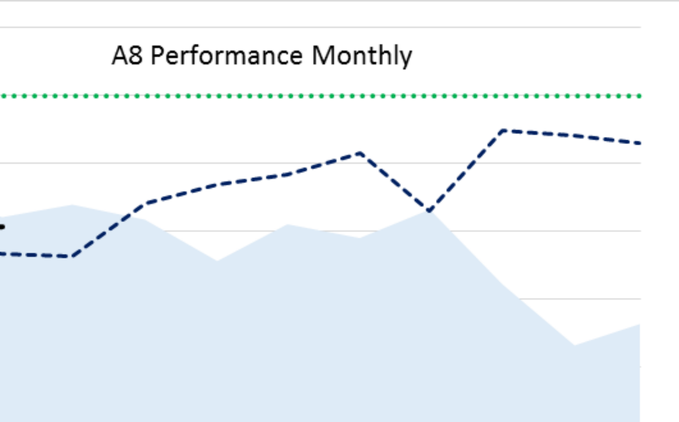
The System Indicators will show complete data for the previous month.

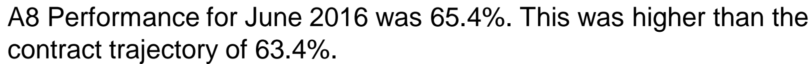
Source: NHS ENGLAND			**Last 3 months**			**Ranking Position**		
AQI Indicator Description SYSTEM INDICATORS	**Units**	**Target**	MAY	APR	MAR	MAY	APR	MAR
The time taken to answer 95% of 999 calls in the emergency control room	(secs)	5 secs	2	2	4	2	2	2
The percentage of callers who have hung up before their call was answered in the emergency control room	%		0.2%	0.0%	0.3%	1	1	1
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	70.3%	70.0%	65.6%	4	6	6
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	65.1%	64.6%	57.9%	6	7	7
The time taken to reach 95% of Category A (Red 1) calls	(mins)		13	13.8	14.2	4	4	3
The percentage of Category A calls reached within 19 minutes	%	95%	94.1%	94.2%	91.1%	4	4	5
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	(mins)		18.3	18.2	21.9	5	4	5

Latest Publication : 14th July 2016 (May-16 data)
Date of next publication : 11th August 2016

A8 Performance





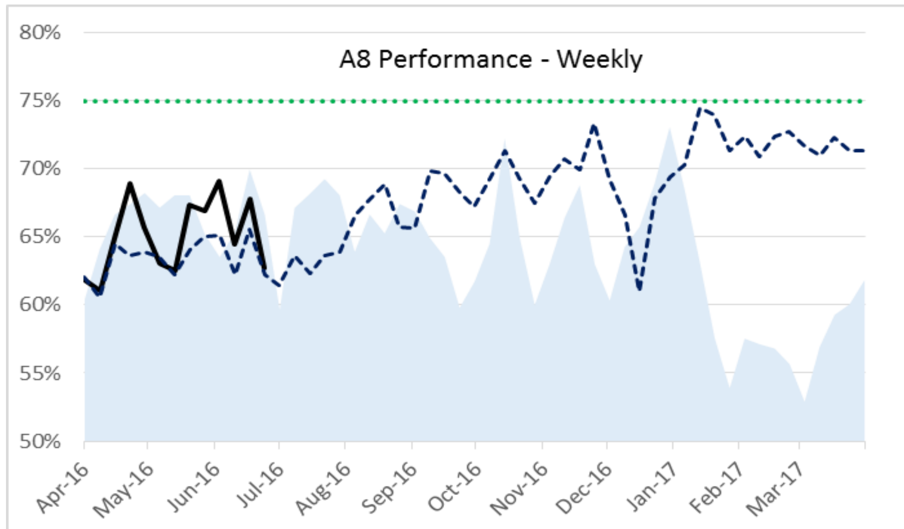


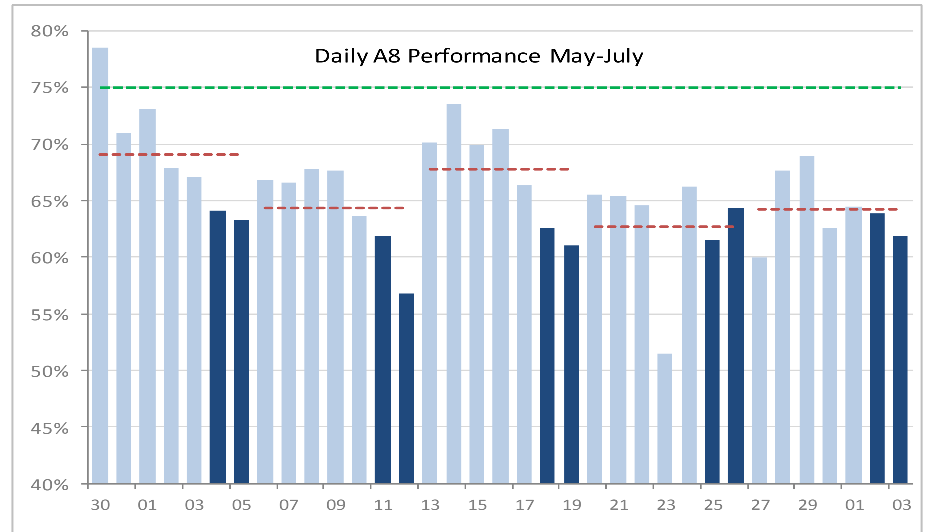
A8 Performance for June 2016 was 65.4%. This was higher than the contract trajectory of 63.4%.

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

- **Demand** – Overall the number of incidents was 3.9% above plan. Cat A was 3.2% above trajectory, Cat C was 4.5% above trajectory.
- **Capacity** – Overall patient facing hours was 8.2% above plan with overtime vehicle hours 8.1% above trajectory for June.
- **Efficiency** - Average job cycle time was 1.6 minutes above trajectory however MAR was 1.27 better than the plan of 1.29.

A8 performance has consistently achieved above trajectory for the 3 months in Q1.





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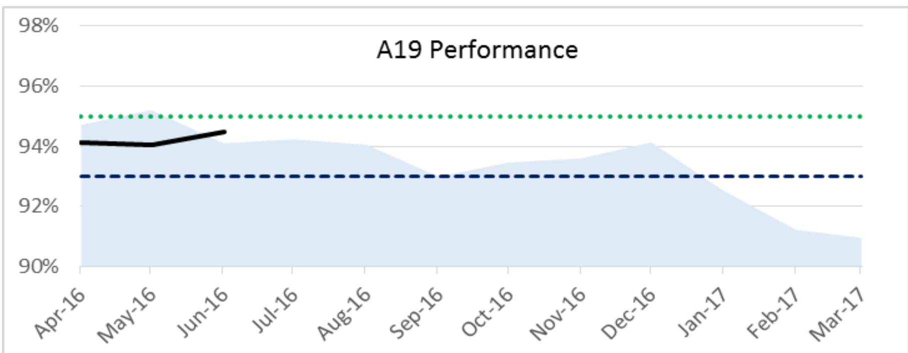
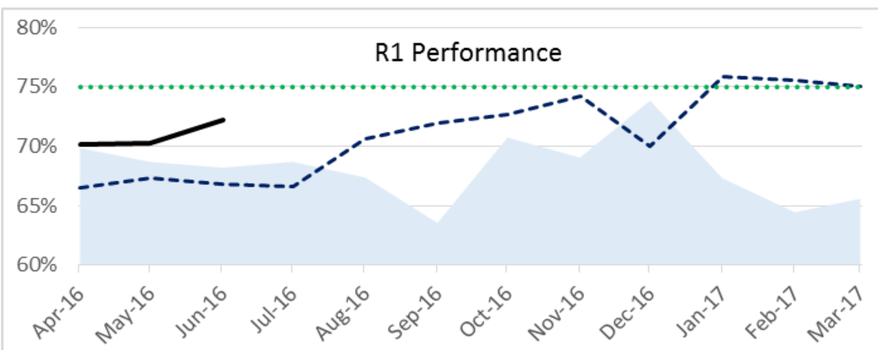
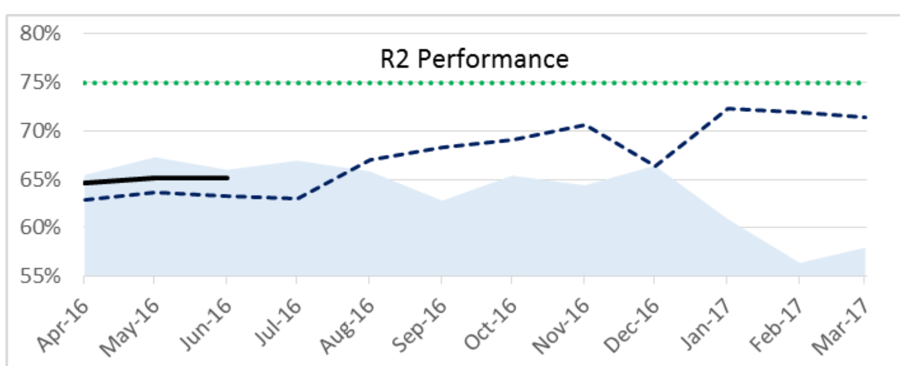
Other Performance





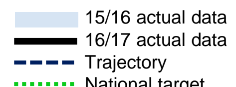


Performance in June 2016 improved for the A8, A19, Red 1 and Red 2 measures when compared with May 2016. This improvement has been sustained despite the 3.9% rise in demand. Red 1, Red 2 & A19 performance finished above trajectory for June 2016.

- Red 1 was 72.2%, above plan by 5.3%.
- Red 2 was 65.2%, above plan by 1.9%
- A19 was 94.5%, above plan by 1.5%

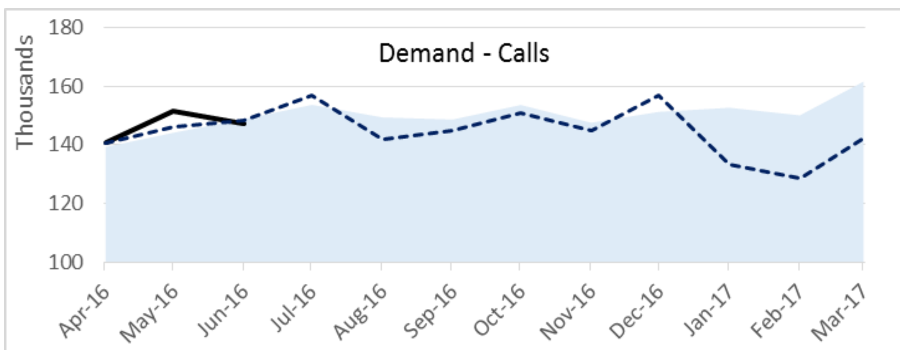
The contracted target for Cat C performance has changed for 2016-17. The new measures are:

- C1 performance - 50% within 45 minutes
- C2, C3 and C4 performance – 50% within 60 minutes



Week Ending	A8	A19	R1	R2	C1	C2	C3	C4
05-Jun	69.1%	96.0%	69.7%	69.1%	86.7%	89.0%	87.8%	72.0%
12-Jun	64.4%	93.5%	70.9%	64.2%	82.1%	83.0%	80.0%	63.2%
19-Jun	67.8%	95.1%	74.9%	67.6%	87.1%	88.1%	85.0%	69.5%
26-Jun	62.7%	94.0%	74.8%	62.4%	82.4%	84.0%	83.3%	61.7%
03-Jul	64.6%	94.2%	70.5%	64.5%	82.4%	86.3%	84.0%	63.9%
Apr-16	64.8%	94.1%	70.1%	64.6%	83.1%	84.9%	84.9%	65.4%
May-16	65.3%	94.0%	70.3%	65.1%	83.8%	85.4%	84.6%	65.9%
Jun-16	65.4%	94.5%	72.2%	65.2%	83.6%	85.9%	83.7%	65.7%

Demand

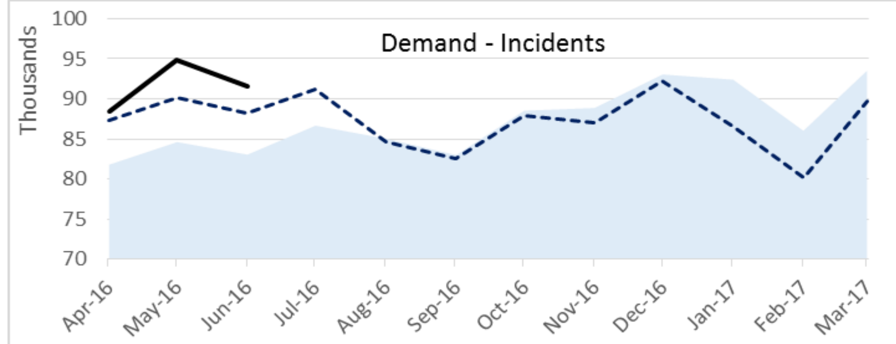


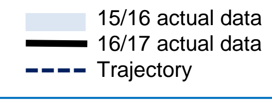
Overall demand was 3.9% above trajectory in June and 10.3% higher than June last year.

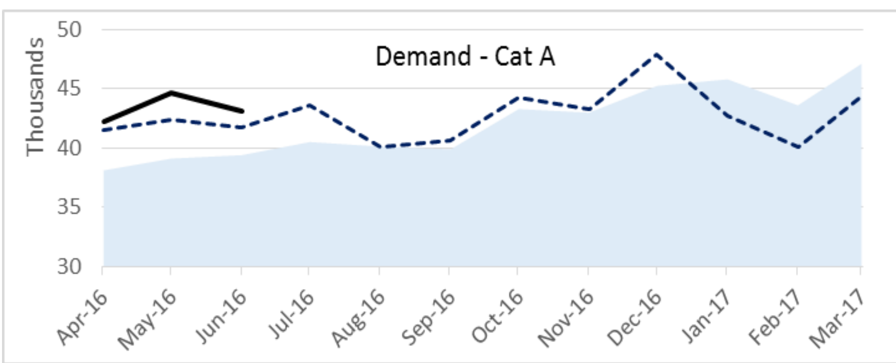
Cat A demand was 3.2% above plan and 9.4% higher than May last year.

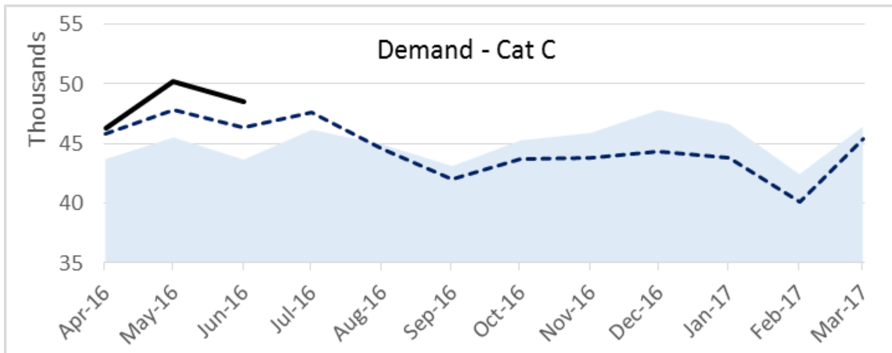
Category C incidents were above trajectory by 4.5% and higher than last year by 11%.

Call volumes were 0.7% below contract level for June 2016 and 1.1% below June last year.

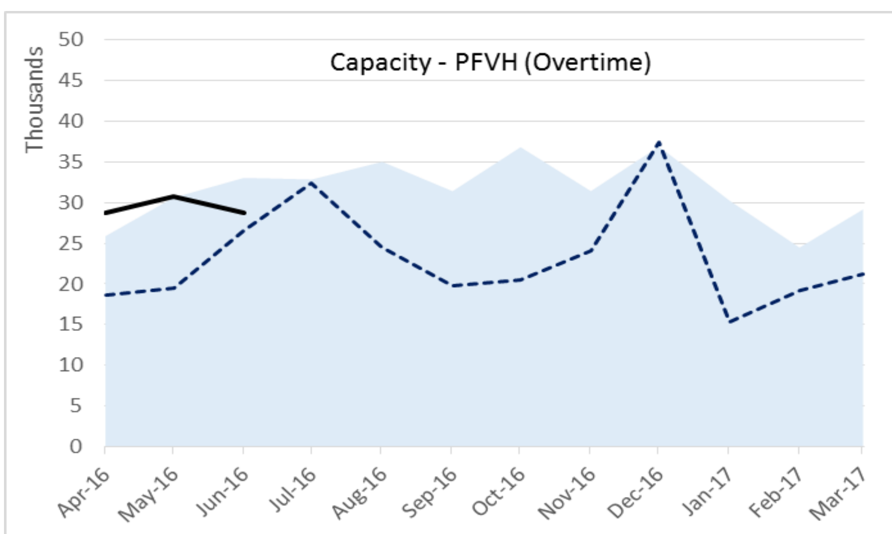


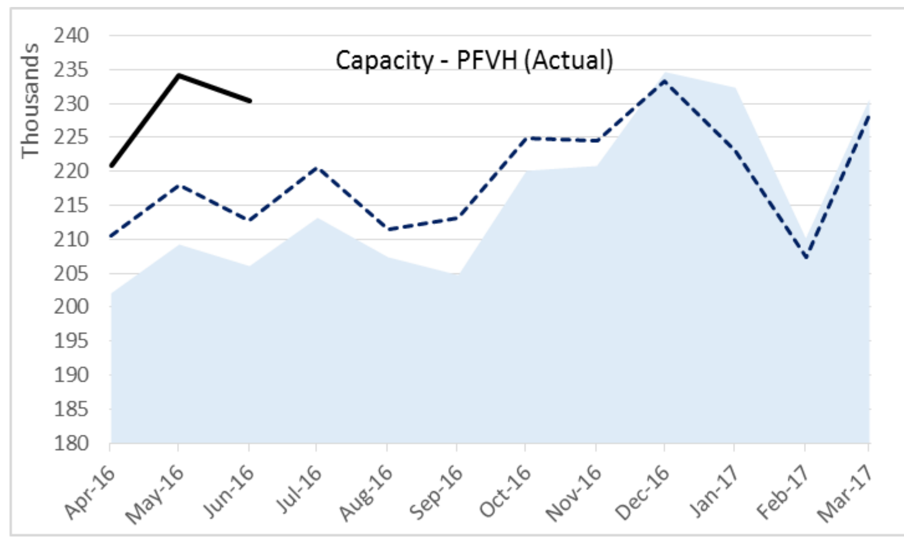


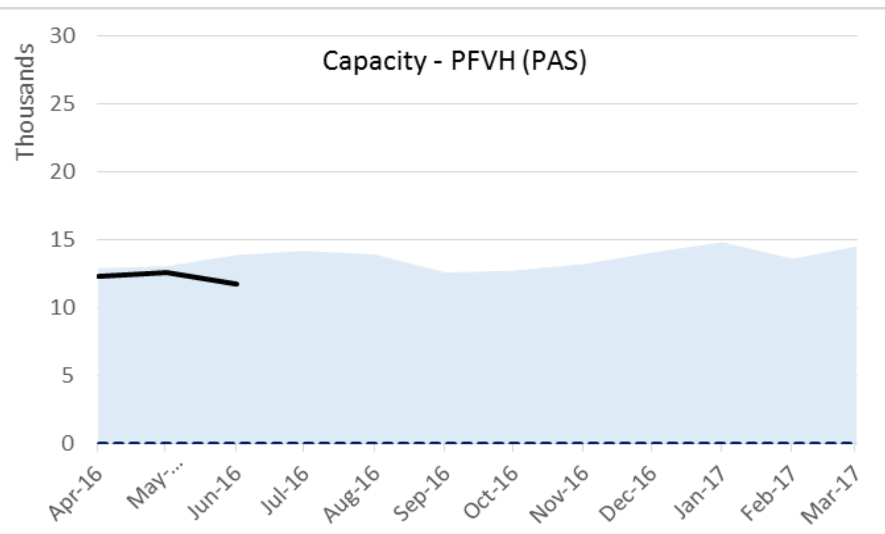




Capacity





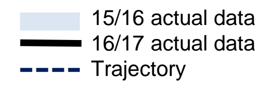


Total patient facing hours are above the trajectory for June. The actual hours are 230,358 against a plan of 212,819 hours – a difference of 8.2%.

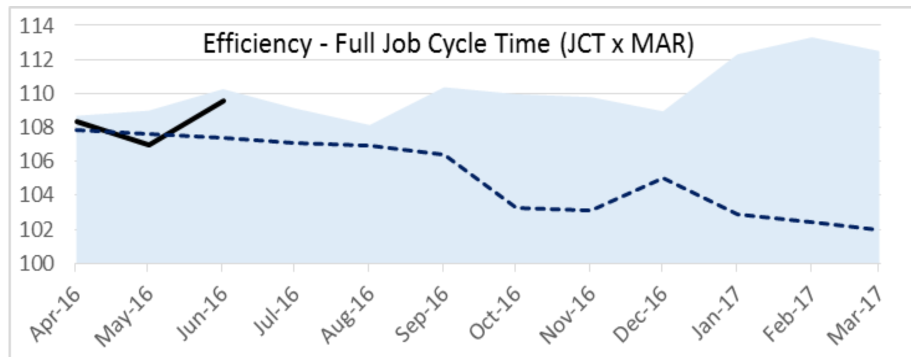
This is an increase in capacity on last month, May 2016, by an average of 127 (hrs) per day.

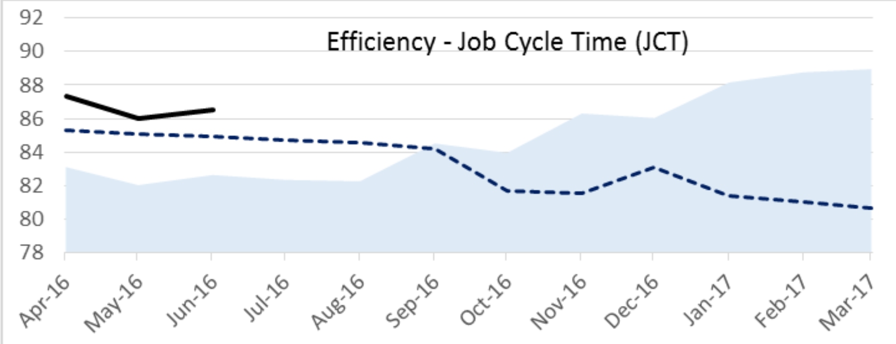
Overtime hours were 8.1% above trajectory

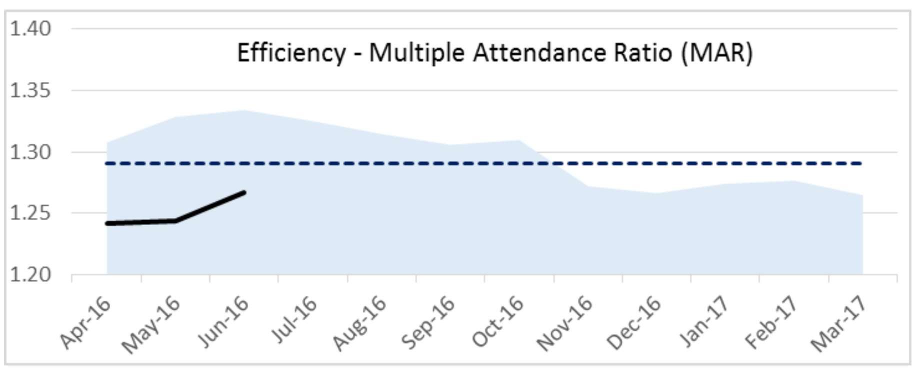
PAS/VAS hours for June 2016 are 15.6% below the level of June 2015.



Efficiency



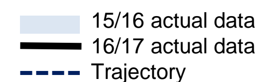




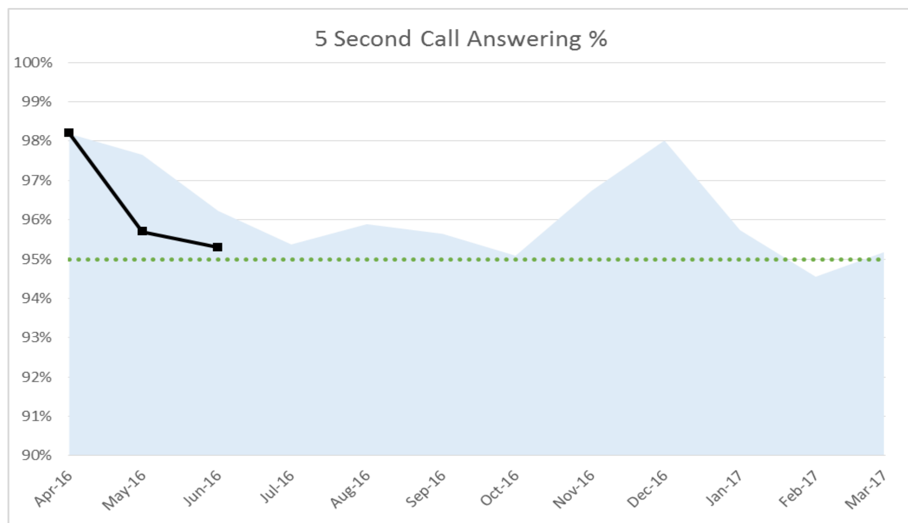
Job Cycle Time for June 2016 was 86.5 minutes, above the trajectory of 84.9 by 1.6 minutes.

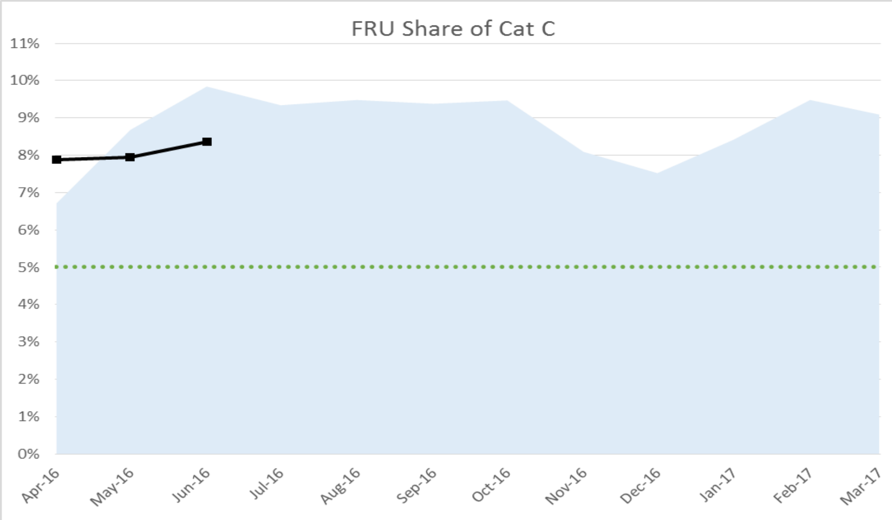
Full Job Cycle (JCT x MAR) was 109.6 minutes, also above the June trajectory of 107.4.

The Multiple Attendance Ratio (MAR) was better than trajectory for June at 1.27. The trajectory for every month this year is 1.29.



Emergency Operations Centre (EOC)





5 Second Call Answering for June was at 95.3%, this was 0.3% above the target of 95%.

When compared to Ambulance Services across England, the London Ambulance Service rank second in answering 95% of all 999 calls within 5 seconds.

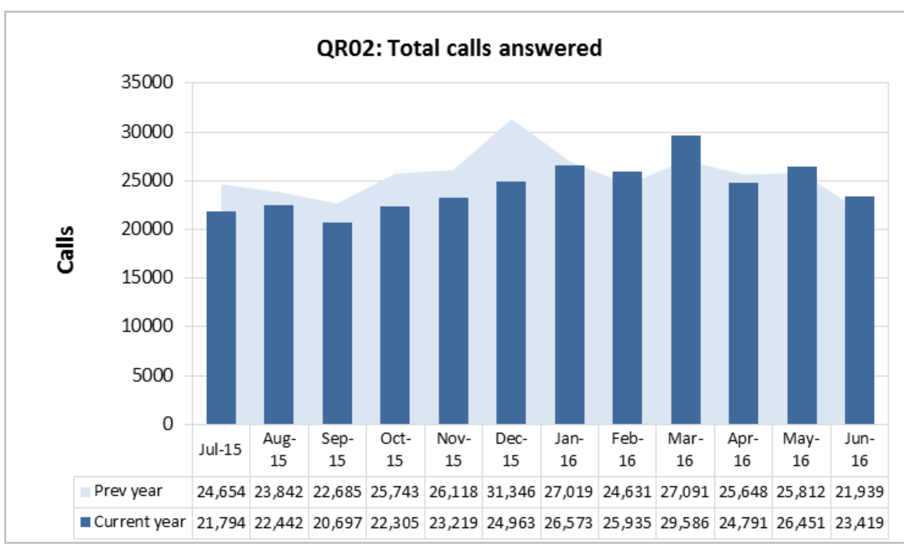
FRU share of Cat C for June was 8.4%, this was 3.4% above the target of 5%.

15/16 actual data
16/17 actual data
Target

5 Second Call Answering %		
Month	2015-16	2016-17
Apr	98.19%	98.21%
May	97.65%	95.70%
Jun	96.23%	95.30%
Jul	95.37%	
Aug	95.89%	
Sep	95.64%	
Oct	95.09%	
Nov	96.73%	
Dec	98.02%	
Jan	95.73%	
Feb	94.55%	
Mar	95.18%	

FRU Share of Cat C		
Month	2015-16	2016-17
Apr	6.71%	7.88%
May	8.68%	7.85%
Jun	9.84%	9.35%
Jul	9.34%	
Aug	9.48%	
Sep	9.38%	
Oct	9.47%	
Nov	8.09%	
Dec	7.52%	
Jan	8.42%	
Feb	9.48%	
Mar	9.09%	

LAS 111 (South East London): Demand and Capacity



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	24,654	23,842	22,685	25,743	26,118	31,346	27,019	24,631	27,091	25,648	25,812	21,939
Current year	21,794	22,442	20,697	22,305	23,219	24,963	26,573	25,935	29,586	24,791	26,451	23,419

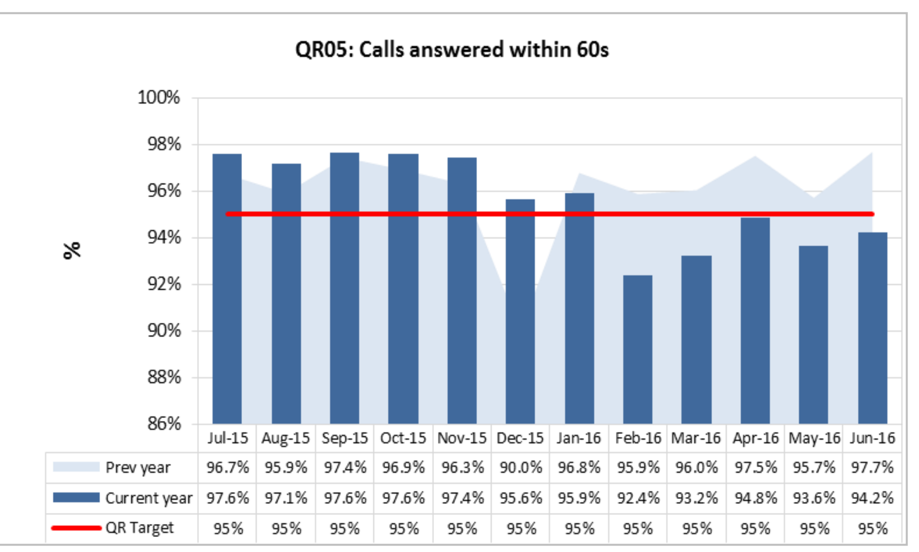
Demand: Call volumes exceeded original forecast on all weekdays except three and remained within forecast on each weekend day.

Capacity: Call Handler induction commenced on 27th June and will provide 4.8 WTE from 1st August with recruitment underway for September 2016.

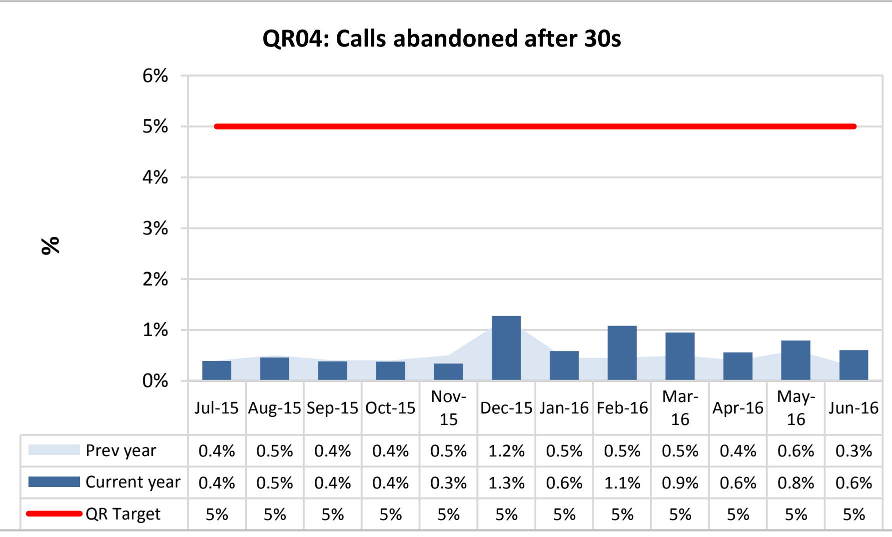
15.5 WTE Clinical Advisor vacancies remain due to challenges recruiting Nurses and Paramedics in London. A combination of overtime and agency are in place to backfill roster gaps.

Efficiency: The percentage of calls answered in 60 seconds was 90% or more on 29 days and achieved KPI on 16 days, achieving an overall figure of 94.2% for June. The operational focus has been on balancing access to the service and minimizing time to clinical call back. There continues to be challenges with consistent access to real time performance data which has been raised as an issue to be resolved.

Service Projects: Planning for the move of the service and staff to Southern House is a key operational focus. Staff visits are in place and a 111 based project team are working together to ensure a smooth transition.

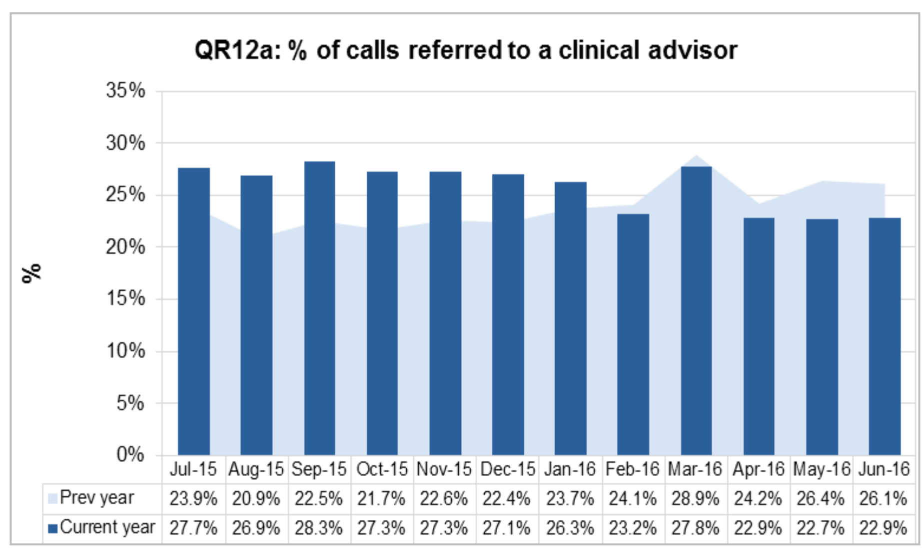


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	96.7%	95.9%	97.4%	96.9%	96.3%	90.0%	96.8%	95.9%	96.0%	97.5%	95.7%	97.7%
Current year	97.6%	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%	93.2%	94.8%	93.6%	94.2%
QR Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	0.4%	0.5%	0.4%	0.4%	0.5%	1.2%	0.5%	0.5%	0.5%	0.4%	0.6%	0.3%
Current year	0.4%	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%	0.9%	0.6%	0.8%	0.6%
QR Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

LAS 111 (South East London): Call Destinations

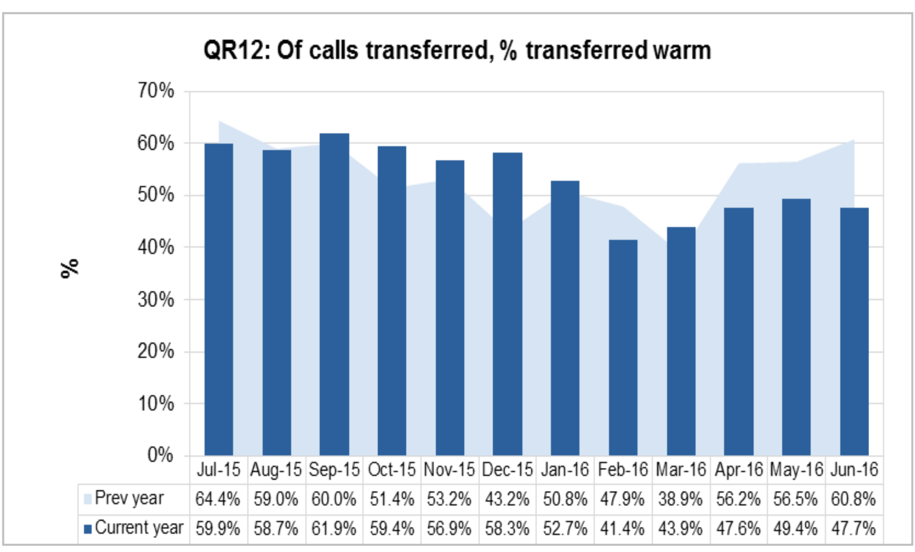


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	23.9%	20.9%	22.5%	21.7%	22.6%	22.4%	23.7%	24.1%	28.9%	24.2%	26.4%	26.1%
Current year	27.7%	26.9%	28.3%	27.3%	27.3%	27.1%	26.3%	23.2%	27.8%	22.9%	22.7%	22.9%

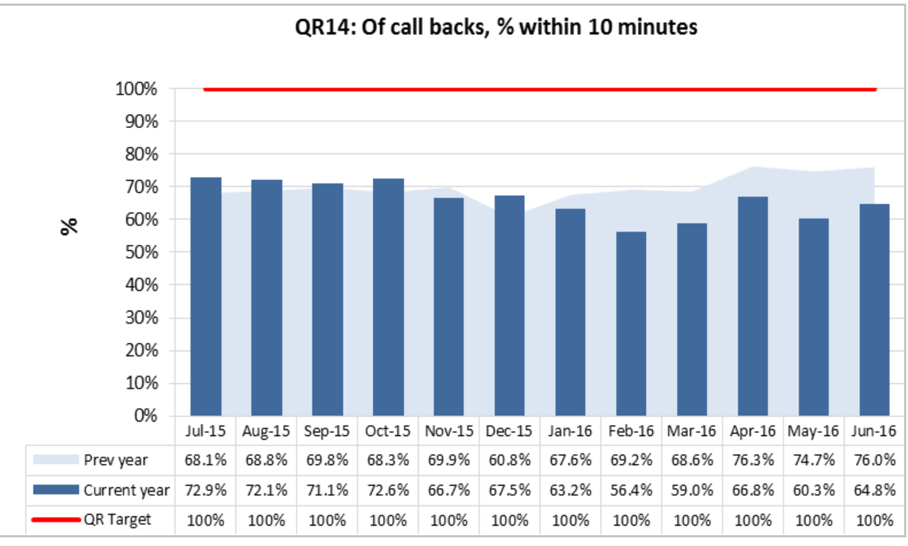
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green ambulance outcomes and availability of Clinical Advisors to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

Safety: There were 45 Incidents reported in Datix by the LAS 111 Team. Of these, 31.5% related to calls referred to an incorrect OOH Provider, 55.3% breaches of procedure and the remaining 13.2% to other issues. Incidents are under investigation and feedback was given to staff where appropriate.

No Serious Incidents (SIs) were identified during June. The service received three complaints, two compliments and feedback from 2 HCPs.

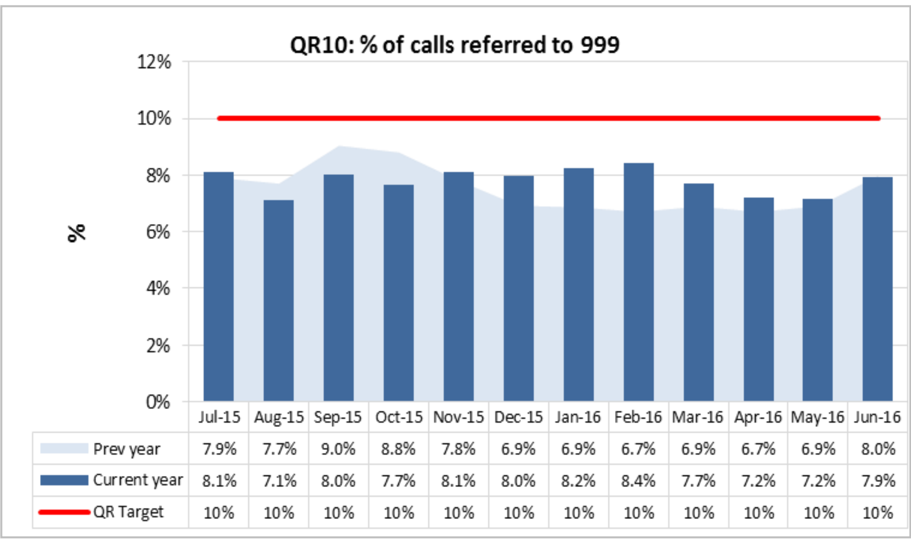


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	64.4%	59.0%	60.0%	51.4%	53.2%	43.2%	50.8%	47.9%	38.9%	56.2%	56.5%	60.8%
Current year	59.9%	58.7%	61.9%	59.4%	56.9%	58.3%	52.7%	41.4%	43.9%	47.6%	49.4%	47.7%

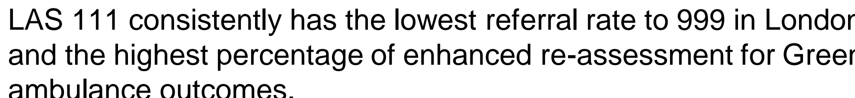


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	68.1%	68.8%	69.8%	68.3%	69.9%	60.8%	67.6%	69.2%	68.6%	76.3%	74.7%	76.0%
Current year	72.9%	72.1%	71.1%	72.6%	66.7%	67.5%	63.2%	56.4%	59.0%	66.8%	60.3%	64.8%
QR Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

LAS 111 (South East London): Triage destinations



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	7.9%	7.7%	9.0%	8.8%	7.8%	6.9%	6.9%	6.7%	6.9%	6.7%	6.9%	8.0%
Current year	8.1%	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%	7.7%	7.2%	7.2%	7.9%
QR Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

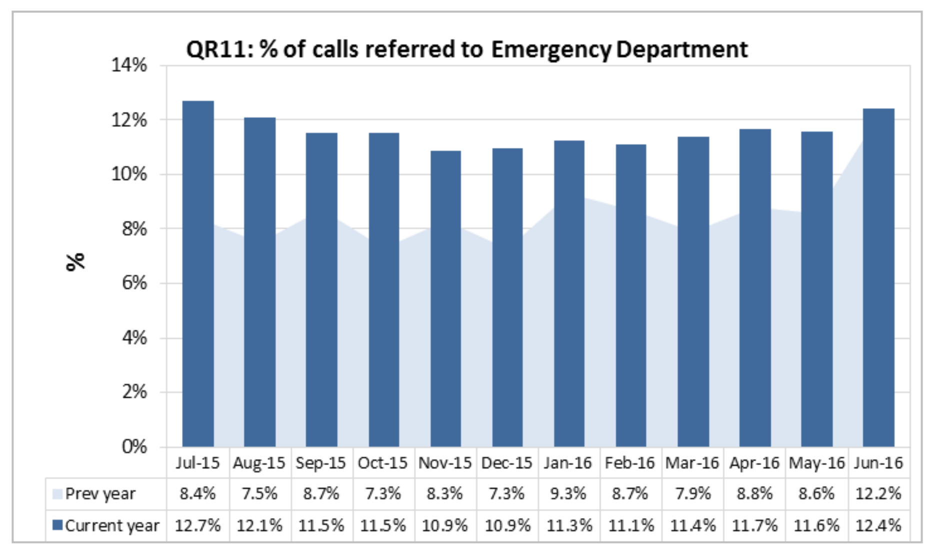


LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for Green ambulance outcomes.

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

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 is consistent with other London Providers.

LAS 111 maintains a higher than average number of clinical call-backs within 10 minutes.



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Prev year	8.4%	7.5%	8.7%	7.3%	8.3%	7.3%	9.3%	8.7%	7.9%	8.8%	8.6%	12.2%
Current year	12.7%	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%	11.4%	11.7%	11.6%	12.4%

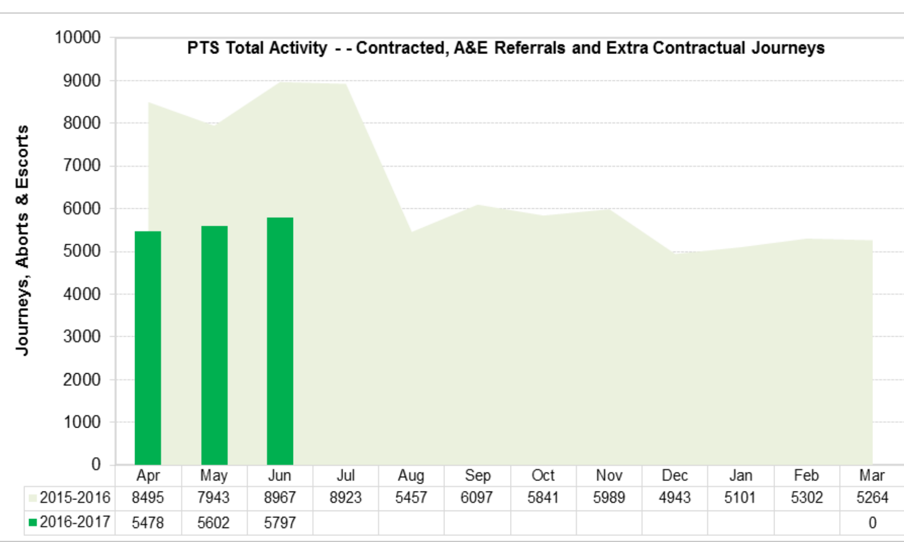
LAS 111 (South East London): Glossary

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

London providers – areas covered:

London Ambulance Service (LAS): 1. South East London
Care UK: 1. Hillingdon, 2. Croydon, 3. Wandsworth, 4. Sutton & Merton, 5. Kingston & Richmond, 6. North West London
Partnership of East London Co-operatives (PELC): 1. East London & City. 2. Outer North East London
London Central & West (LCW): 1. Inner North West London, 2. North Central London

Patient Transport Service – Activity and Profitability Update



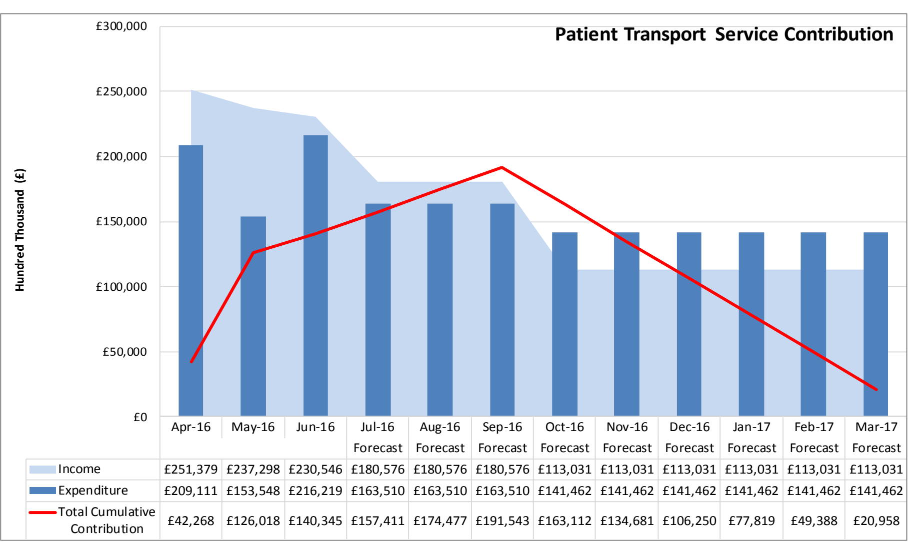
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	8495	7943	8967	8923	5457	6097	5841	5989	4943	5101	5302	5264
2016-2017	5478	5602	5797									0

5,797 journeys were completed in June 2016, an increase from the previous month's total of 5,602 journeys.

Income for the month has again been supported by additional numbers of Extra Contractual Journeys completed in the month.

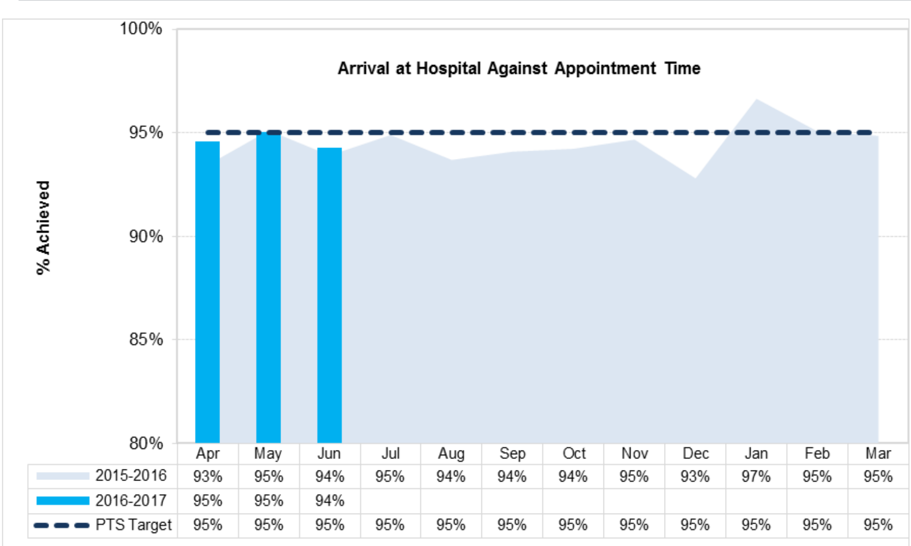
The graph below shows income and expenditure for each month with a total cumulative contribution back to the Trust.

Month	2013-2014	2014-2015	2015-2016	2016-2017
Apr	15044	13227	8495	5478
May	15987	13164	7943	5602
Jun	14852	10129	8967	5797
Jul	16481	10508	8923	
Aug	14401	9028	5457	
Sep	15002	9602	6097	
Oct	16739	10957	5841	
Nov	15981	10063	5989	
Dec	13986	9250	4943	
Jan	16409	9753	5101	
Feb	15232	9787	5302	
Mar	13978	10520	5264	
Total	**184092**	**125988**	**78322**	**16877**



	Apr-16	May-16	Jun-16	Jul-16 Forecast	Aug-16 Forecast	Sep-16 Forecast	Oct-16 Forecast	Nov-16 Forecast	Dec-16 Forecast	Jan-17 Forecast	Feb-17 Forecast	Mar-17 Forecast
Income	£251,379	£237,298	£230,546	£180,576	£180,576	£180,576	£113,031	£113,031	£113,031	£113,031	£113,031	£113,031
Expenditure	£209,111	£153,548	£216,219	£163,510	£163,510	£163,510	£141,462	£141,462	£141,462	£141,462	£141,462	£141,462
Total Cumulative Contribution	£42,268	£126,018	£140,345	£157,411	£174,477	£191,543	£163,112	£134,681	£106,250	£77,819	£49,388	£20,958

Patient Transport Service – KPI Update

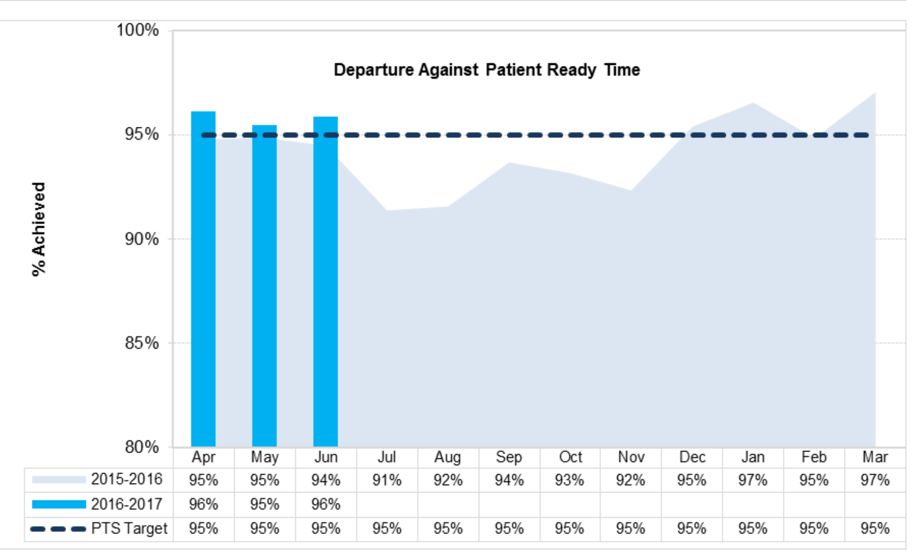


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	93%	95%	94%	95%	94%	94%	94%	95%	93%	97%	95%	95%
2016-2017	95%	95%	94%									
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

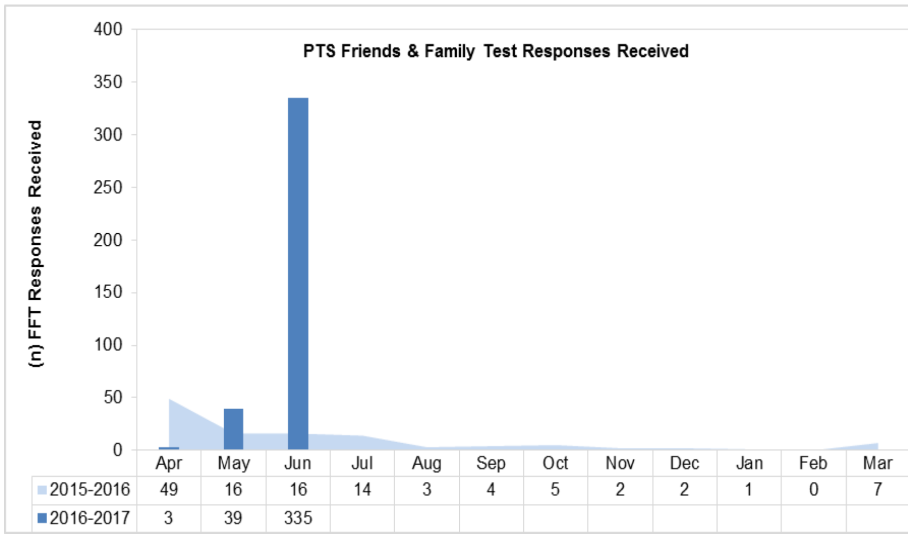
Performance against KPI's for June are shown in these graphs. June saw a slight drop in the arrival KPI down to 94% from 95% in May. A slight rise in the patient departure KPI to 96% from 95% in May. The departure KPI for the YTD is above target at 96%.

There has been continued improvement in the departure time KPI this month as a result of the work undertaken and identified in our QIP plan.

The Friends and Family Test (FFT) responses have significantly increased this month due to a daily mailshot sent to all patients travelling with PTS. This is as part of the above QIP Plan. We have received a number of calls from patients who travel frequently with us regarding the number of FFT's they are now receiving from us.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	97%
2016-2017	96%	95%	96%									
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

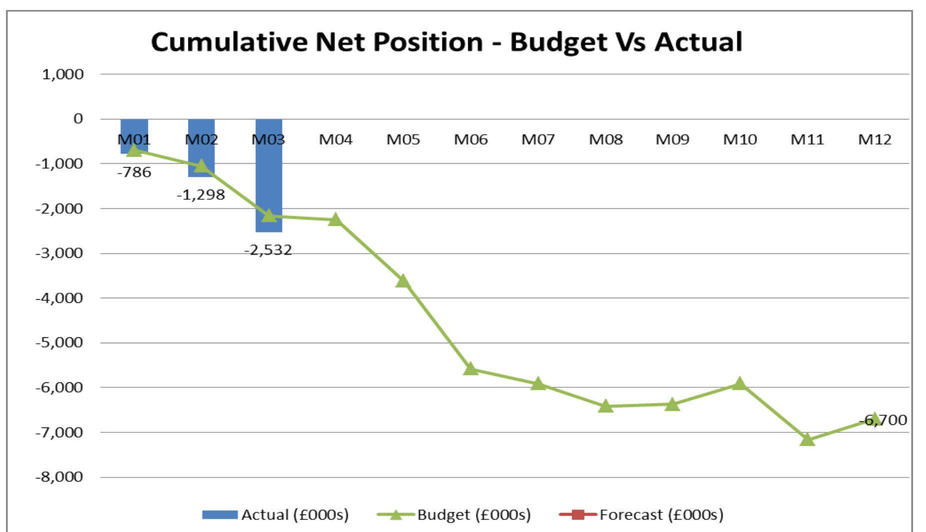


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	49	16	16	14	3	4	5	2	2	1	0	7
2016-2017	3	39	335									

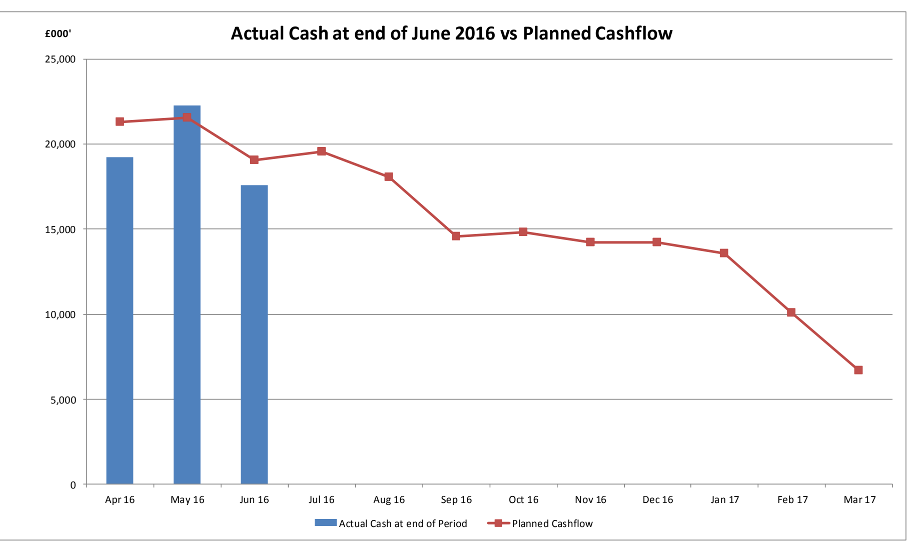
Our Money

Financial Indicator	Summary Performance	June	May	Apr
Surplus (Year to date)	Year to date the position is £0.4m adverse to plan, The year end position of £6.7m deficit is seen as challenging but achievable. As requested the Trust has submitted a revised plan to NHSI in June. This reflected a revised control total (£6.7m deficit) and adjusted income and expenditure to reflect the £10m of QIP expected from CCGs. The adverse position is driven by: • Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1. Demand is currently running at 3+% above contracted activity growth (4%). • This overspend is partly offset by underspends in other areas.			
Income	Income is on plan in month and £0.4m adverse YTD. • Education & Training Income is currently below the expected plan YTD by £0.2m. This could recover throughout the year if bids area successful. • PTS Income is £0.2m adverse due to reducing PTS contracts and activity. This is largely offset against reduced cost.			
Expenditure (incl. Financial Charges)	In month expenditure is £0.1m adverse to plan, YTD the position is £0.4m adverse to plan. The key drivers for this position are: • £1.6m Favourable in Frontline substantive pay due to on-going vacancies. • £0.7m Favourable in Operational Management due to vacancies in Training and Team Leader roles. • £0.2m Favourable in Non Operational Pay. • £2.8m Adverse in Private ambulance usage used to offset frontline pay vacancies and support additional demand pressures. • £0.4m Favourable in other non pay areas.			
CIPs	Year to date CIPs are on plan. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.			
Balance Sheet	Capital spend is £0.3m against a revised Capital plan of £0.5m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14m of the £19m Capital Resource Limit (CRL) requested.			
Cashflow	Cash is £17.6m, £1.5m adverse to plan. The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year.			

Executive Summary - Key Financial Metrics



	2016/17 - Month 3			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(1,114)	(1,234)	(119)	(2,166)	(2,530)	(365)	(9,025)
EFL				1,137	2,622	(1,485)	8,648
CRL				507	219	288	20,664
Suppliers paid within 30 days - NHS	95%	71%	(24.0%)	95%	81%	(14.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	85%	(10.0%)	95%	85%	(10.0%)	95%
Monitor							
EBITDA %	1.6%	1.1%	(0.4%)	2.9%	2.5%	(0.4%)	6.3%
EBITDA on plan	421	304	(117)	2,441	2,064	(377)	12,217
Net Surplus	(1,114)	(1,234)	(119)	(2,166)	(2,530)	(365)	(9,025)
NRAF (net return after financing)				(0.3%)	(1.3%)	(1.0%)	-6.90%
Liquidity Days				(4.92)	(2.76)	2.2	(10.86)
FSRR (Financial Sustainability Risk Rating)				2.0	2.0	0.0	2.0



- In Month the position is £0.1m adverse to plan . YTD the Position is £0.4m adverse to plan
- The adverse position is driven by:
  - Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1. Demand is currently running at 3+% above contracted activity growth (4%).
  - This overspend is partly offset by underspends in other areas.
- Cash is £17.6m, £1.5m below plan. The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year.
- CRL position – The capital plan is £0.3m behind target.
- Financial Sustainability Risk Rating is on target.
- In Month the Trust only paid 71% of its NHS suppliers within 30 days. This is significantly below the national KPI but is not seen as material. The Trust paid invoices to the value of £6.4m in Month 3 of which only £0.2m related to NHS suppliers. As such the total Value of invoices paid outside of the 30 day limit was 15 invoices totalling a value of £59k.

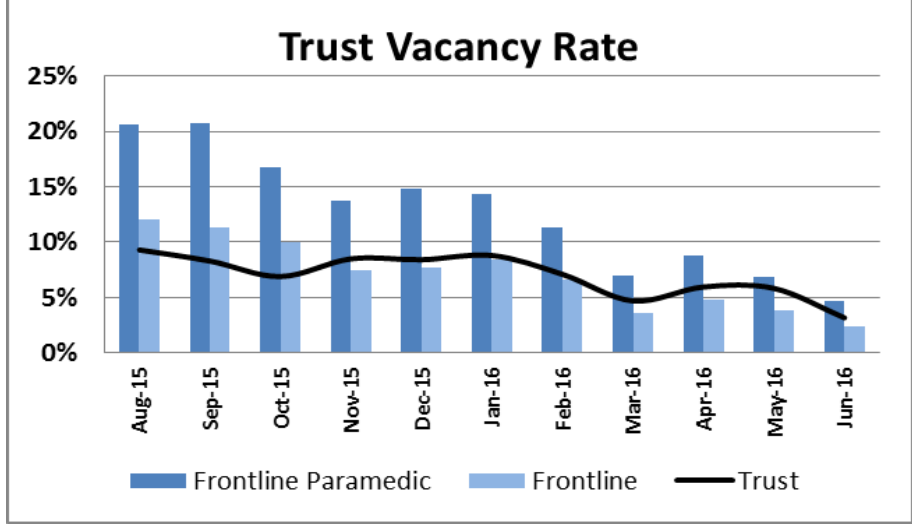
Our People

Section	Key Headlines From Each Section.	June	May	April
Vacancy and Recruitment	• The overall vacancy rate has improved from 5.8% to 3.2%. • The vacancy rate for frontline staff has improved from 3.9% to 2.4% against a target of 5%.			
Turnover	• Trust turnover has further improved from 10.9% to 10.8%. • Frontline turnover has improved from 10.1% to 9.9%. • Frontline paramedic turnover has improved from 9.5% to 9.1%.			
Sickness	• Overall trust sickness has reduced to 4.9% against a target/threshold of 5.5%. • Frontline sickness has reduced from 5.6% to 5.5%.			

Vacancy – Trust wide

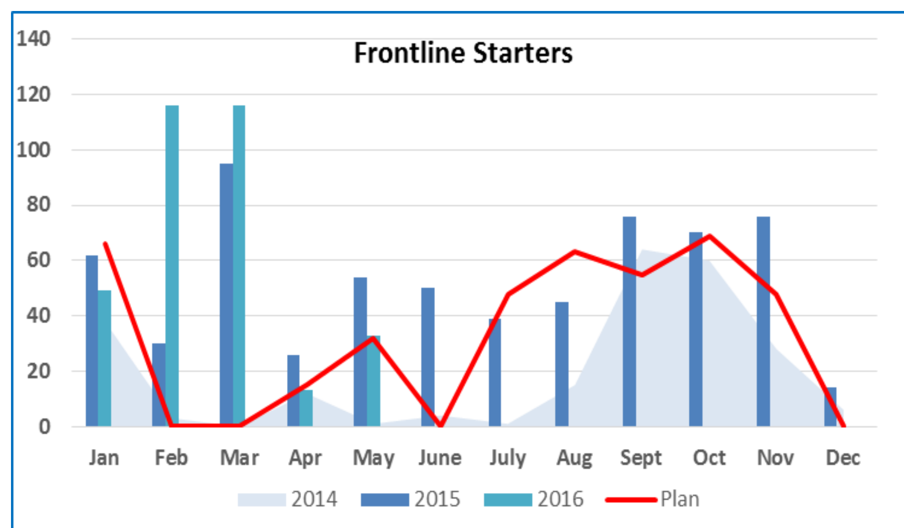
	Target	In post	Vacancy (wte)	Vacancy %
1. Paramedic	1931.74	1842.4	89.34	4.62%
2. Apprentice Paramedics	85	124.33	-39.33	-46.27%
3. Frontline EAC / TEAC	773.19	768.98	4.21	0.54%
4. Frontline EMT & support tec	425.97	403.66	22.31	5.24%
Subtotal	**3215.9**	**3139.4**	**76.53**	**2.38%**
5. Non frontline Paramedics	285.02	241.22	43.8	15.37%
6. EOC staff on watches	378	389.54	-11.54	-3.05%
7. All other staff	1152.06	1101.18	50.88	4.42%
Total	**5030.98**	**4871.3**	**159.67**	**3.17%**
Total Paramedic	2216.76	2083.62	133.14	6.01%
Total Non FL Staff	1815.08	1731.94	83.14	4.58%

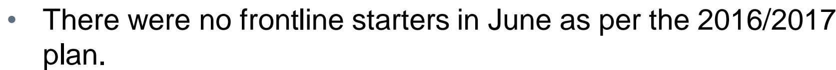
- The vacancy rate for total frontline paramedics has improved from 6.8% to 4.6%.
- The total number of paramedics in-post has improved from 1,813 wte to 1,842 wte (including 40 wte on bank). The new cohort of staff will undergo a period of training and supervision prior to becoming fully operational on the frontline.
- The frontline vacancy rate has successfully decreased from 3.9% to 2.4% against a target of 5%.
- The overall vacancy rate has also positively decreased from 5.8% to 3.2%.



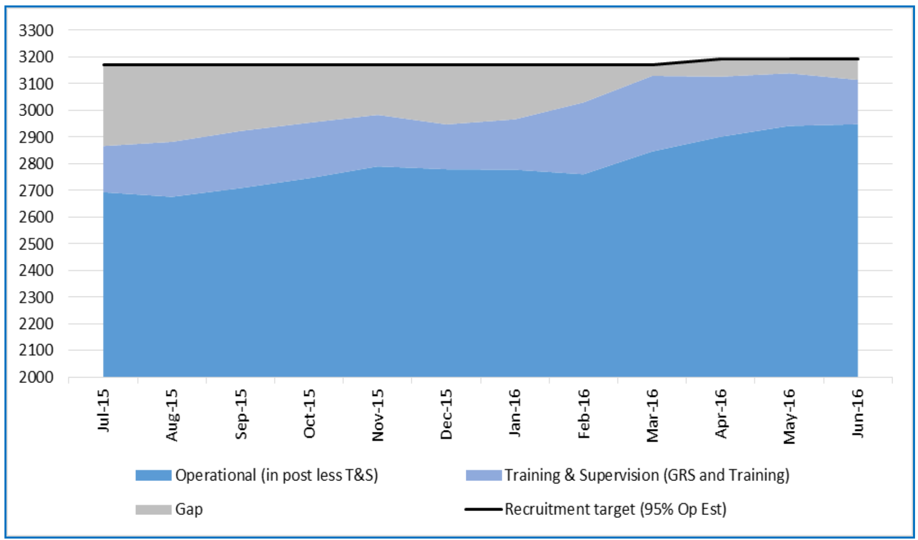
- Operations and Recruitment have attended a recruitment job fair, where the roles we currently have to offer were showcased.
- Operations and Recruitment held a careers fair on the 13th July for schools in and round London, to highlight careers within the Trust.

Recruitment





- There were no frontline starters in June as per the 2016/2017 plan.
- Recruitment are currently working alongside the local Job Centre Plus in several locations across London to help recruit staff for a number of roles including Trainee Emergency Ambulance Crews. (TEACs)
- Over 300 candidates responded to our recent TEAC advert.
- Recruitment and Operations have been attending “keeping in touch sessions” with the offered graduates from our partnership universities.

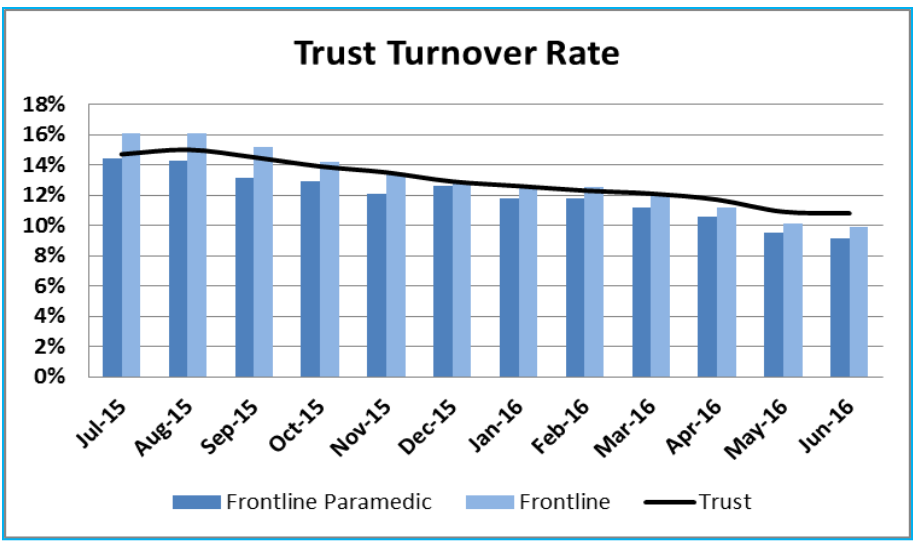


- This graph shows our operational staff in post by month, including those in training and supervision.
- Our full establishment is 3,361 and we have a recruitment target of 3,193.
- This represents 95% of the establishment as we account for a 5% vacancy factor.

Turnover – Trust wide

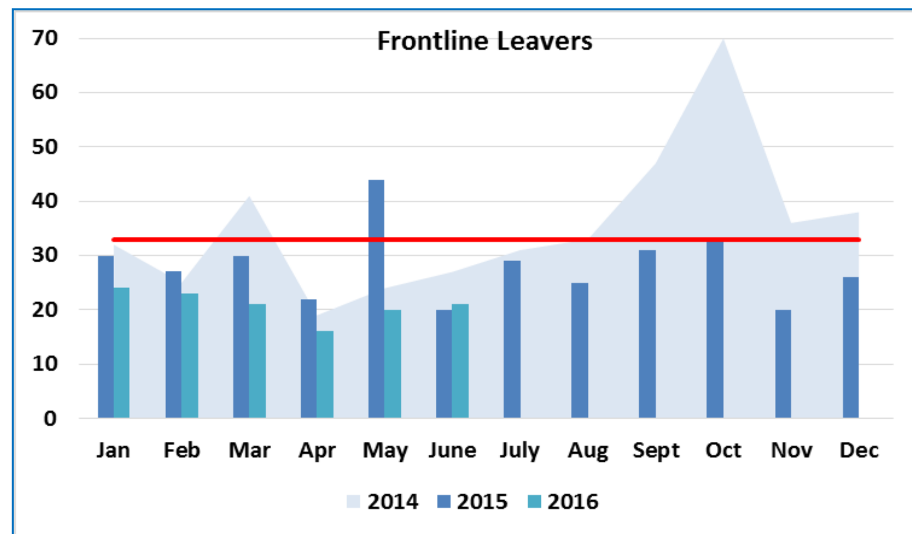
12 Month Rolling Turnover	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Frontline Paramedics	14.4%	14.3%	13.1%	12.9%	12.1%	12.6%	11.8%	11.8%	11.2%	10.6%	9.5%	9.1%
Apprentice Paramedics	11.4%	10.8%	10.2%	7.3%	8.1%	6.2%	5.4%	3.1%	3.1%	2.4%	2.4%	1.6%
Frontline Technicians	18.3%	18.2%	18.0%	15.8%	14.9%	13.3%	13.5%	13.5%	13.2%	11.8%	10.9%	10.8%
Non-Frontline Paramedics	5.5%	6.5%	6.1%	6.3%	6.4%	5.6%	5.8%	5.3%	5.5%	6.2%	4.9%	4.6%
PTS & Ambulance Persons	19.6%	21.2%	22.6%	21.3%	21.2%	19.0%	19.0%	19.5%	18.6%	16.5%	15.3%	15.9%
EOC Staff on Watches	19.9%	21.1%	21.5%	22.1%	22.7%	21.8%	20.7%	18.0%	18.9%	19.4%	18.2%	18.6%
All Other Staff	11.4%	12.0%	11.9%	12.0%	12.0%	11.6%	11.5%	11.9%	11.9%	12.6%	12.5%	12.7%
Trust Total	**14.7%**	**15.0%**	**14.5%**	**13.9%**	**13.5%**	**12.9%**	**12.6%**	**12.3%**	**12.1%**	**11.7%**	**10.9%**	**10.8%**
(All Frontline Staff)	16.1%	16.1%	15.2%	14.2%	13.4%	12.9%	12.6%	12.5%	12.1%	11.2%	10.1%	9.9%

- The turnover figure for frontline paramedics has improved from 9.5% to 9.1% against a target of no more than 15%.
- The turnover for all frontline staff has continued to improve for the twelfth month in a row, currently at 9.9% (threshold 15%).
- The total Trust turnover fell slightly this month from 10.9% to 10.8% (12 month rolling figure). The monthly target is 13%.
- Trust turnover has improved month on month for the past ten months.

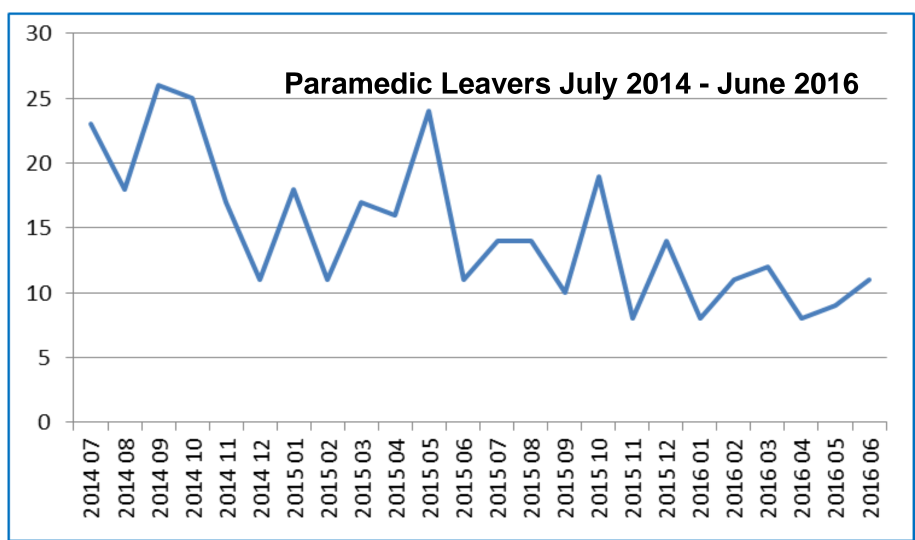


- There were a total of 47 leavers in June, 21 of whom were frontline staff.
- 89% (42) of all leavers were unplanned i.e. resignations
- As part of the Quality Improvement Plan we are refreshing the retention strategy.

Turnover – Trust wide



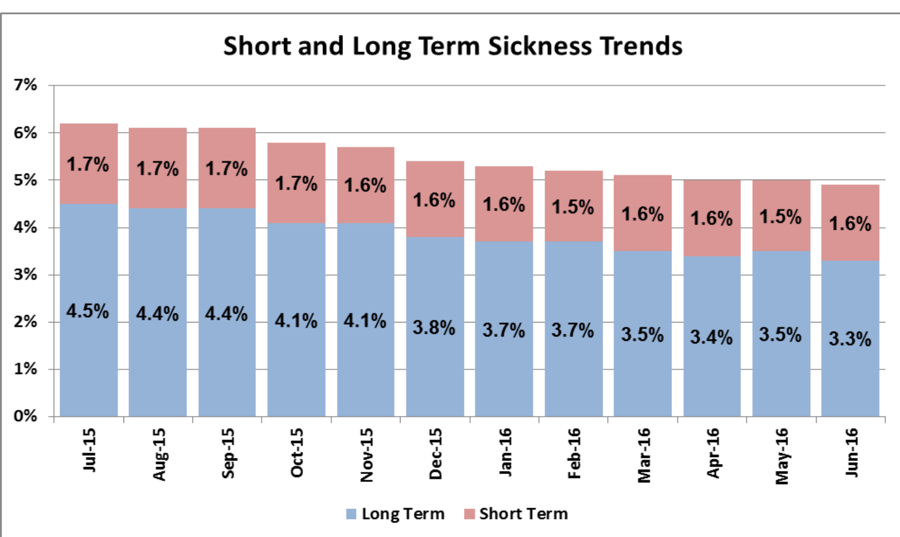
- This graph shows the number of frontline leavers per month since January 2014.
- Frontline leavers rose from 20 to 21 in June. 3 were retirements and 18 were unplanned resignations. Of these resignations 6 were for reasons of relocation and 4 for promotion.
- The LAS staff leaver's form is being redesigned to improve the quality of data including the reason for leaving and the destination on leaving.
- Leavers have significantly reduced from a peak in October 2014 of 71 frontline staff.



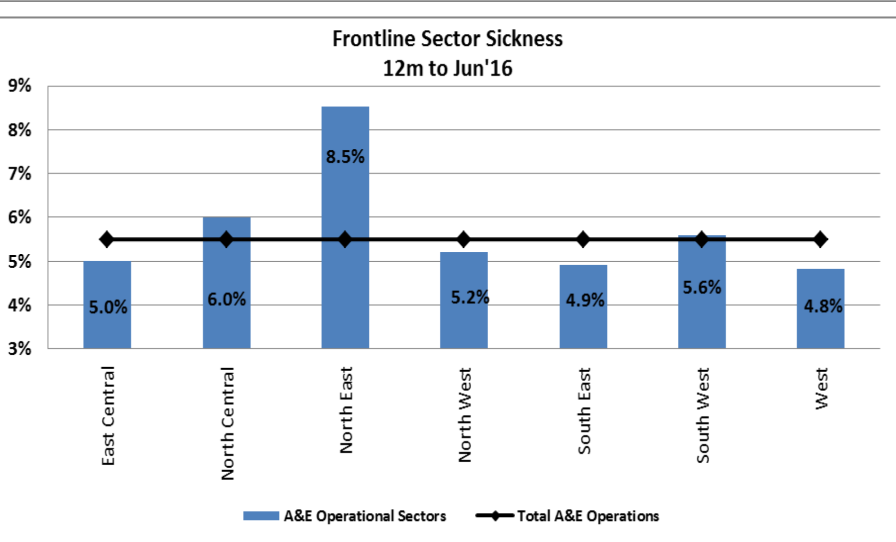
Frontline paramedic leavers

- The average number of monthly paramedic leavers has reduced from **21** per month (July to December 2014) to **11** per month for the most recent six monthly period (January 2016 to June 2016).
- 88% of paramedic leavers during this two year period were unplanned i.e. resigned.
- The top three reasons for leaving for resignations were relocation (46%), not known (18%) and promotion (17%).

Sickness Absence – Trust level



- The current trust 12 month sickness level has reduced to 4.9% against a target/threshold of 5.5%.
- The Trust 12 month sickness level has reduced by 1.6% since its peak of 6.6% in March 2015.
- The 'Supporting Your Health and Well-Being' objective under the Trust's retention strategy is under review as part of Theme 1: Making the London Ambulance Service (LAS) a great place to work.
- A national CQUIN has been set for health and wellbeing and by July 2016 the Trust will identify three health and wellbeing objectives as part of this CQUIN.



- The 12 month rolling frontline sickness has improved from 5.6% to 5.5%.
- HR are working closely with their management teams to support an on-going improvement in absence levels.
- Key to this are the weekly dial-in absence conferences, led by the Assistant Director of Operations. This is where managers outline actions being taken to resolve any outstanding absence cases as well as providing support to those who are ill.
- In addition to this, the 'Supporting Your Health and Well-Being' objective under the Trust's retention strategy is under review as part of the Trust's Quality Improvement Plan.

London Ambulance Service NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Quality Report – July 2016
Report Author(s):	Dr Fenella Wrigley
Presented by:	Dr Fenella Wrigley, Medical Director
Contact Details:	Fenella.wrigley@lond-amb.nhs.uk
History:	Executive Leadership Team
Status:	For assurance

Background/Purpose

The monthly quality report is produced to give organisational assurance that quality and safety standards are being met. The July 2016 report, reviewing June 2016 data, is attached for noting. The report is structured against the 5 Care Quality Commission domains: safe, effective, caring, responsive and well-led.

Key messages from all areas are escalated on the front summary page and, in more detail, at the beginning of each section.

Action required

To take assurance from the report.

Key implications

LAS continues to provide a safe service to patients in London. Quality remains consistent with previous months. Some patients experience longer waits due to capacity constraints however this number is reducing.

Key implications and risks arising from this paper	
Clinical and Quality	**Safe, effective, caring: LAS continues to provide a safe service**
Performance	**Responsive: mitigating actions such as the Surge Plan reduce the level of risk to patient care at times of performance pressure**
Financial	
Workforce	
Governance and Well-led	**Well-led: governance structures are in place and report through to the executive team and the Trust Board.**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	**Yes**

London Ambulance Service NHS Trust

Quality Report

July 2016

Please note that the report relates to data throughout June 2016 unless otherwise stated

Our Patients

Section	Key Headlines From Each Sub-Section.
SAFETY	➢ 6 SI's declared in June out of 41 incidents reviewed, with 10 reports overdue. Overdue SI's have been escalated internally to the Executive Lead for completion compliance. ➢ 81% completion rate for CSR2016.1 to date. June saw 859 attendees of 953 bookings made. ➢ 14 medicines management issues were reported during June with main themes being incorrect drug / dose of drug and shortages of available drugs packs for crew usage. ➢ 72% of patient safety incidents were logged on DATIX within 4 days of the incident occuring ➢ There are 153 open complaints with 43 over 35 working days.
EFFECTIVE	➢ 27 patients with ROSC presented with a STEMI following their cardiac arrest and were all conveyed to Heart Attack Centres (HAC) appropriately. ➢ 12% of cardiac arrests had defibrillator downloads, an increase of 4% from April 2016. ➢ Call to hospital times for STEMI patients have decreased by 1 minute to 72 minutes. ➢ 5 FAST positive patients (0.5%) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback to crews for learning.
CARING	➢ The Severe Sepsis CPI compliance is consistent at 95% since it's introduction in March 2016. ➢ In May, 89% of PRFs were audited a reduction of 4% on the previous month and remains below the agreed KPI target of 95%. ➢ 338 Friends and Family Test's were received during June, a significant increase on previous months following a marked effort by PTS and internal communications with staff. ➢ 35 public events were attended by the Patient and Public Involvement team.
RESPONSIVE	➢ The Trust is currently at Pressure Level 2 – Moderate. ➢ The Trust remains at Surge Red, with one period of 3.5 hours noted in June at Surge Purple Enhanced. ➢ A number of hospital breaches were noted during June, with 1001 exceeding 1 hour.
WELL LED	➢ NHSI inspections took place across the Trust supported by a number of staff from different departments Trust wide. ➢ The Trust has delivered it's first Mediation awareness session led by the Bullying and Harassment Specialist.

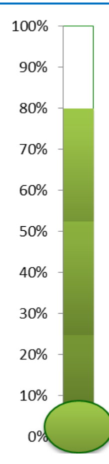
SAFETY

Sub-Section	Key Headlines From Each Sub-Section.
Training & CSR	➢ 81% completion rate for CSR2016.1 to date. June saw 859 attendees of 953 bookings made. Non-attendee information is passed to the Resource Centres to cascade to Group Station Management Teams for further action. ➢ 14 students completed the EAC Programme and 19 students completed the International Paramedic course during June.
Adverse Incidents	➢ An overall decrease in reported incidents were noted in June: there were 149 Staff related incidents and 143 patient related incidents. The main themes were missing or faulty equipment and manual handling incidents. ➢ Missing items reported for June were EZIO and Drug Packs. This is being addressed through Logistics and Clinical Safety and Standards Committee.
Medicines Management	➢ There was one reportable controlled drug incident which was reported to the relevant authorities for investigation. ➢ 14 medicines management issues were reported during June with main themes being incorrect drug / dose of drug and shortages of available drugs packs for crew usage. ➢ Recruitment for a Darzi Fellow Pharmacist is ongoing with four candidates shortlisted for interviews to take place in July 2016. .
Safeguarding	➢ A clinical advisor has been appointed to focus on Dementia, learning disabilities and End of Life Care vulnerable patients. ➢ NHSE have provided funding for Safeguarding supervision which is currently an area of focus across the Trust.

SAFETY

Sub-Section	Key Headlines From Each Sub-Section.
Serious Incidents	➢ 6 SI's declared in June out of 41 incidents reviewed, with 10 reports overdue. Overdue SI's have been escalated internally to the Executive Lead for completion compliance. ➢ SI themes from the first 3 months of 2016-17 are being relate to identification / management of peri-arrest patients, information governance and security issues and delay in ambulance response.
Total Complaints	➢ 83 complaints were received in June, including five from Health and Social Care providers on behalf of the patient. ➢ There are 153 open complaints with 43 over 35 working days. ➢ June saw an increase in complaints relating to delay but a decline in complaints related to conduct and behaviour.
NHS CAS Alerts	➢ 5 Medical device alerts were received, of which none were relevant to the Trust. ➢ 1 general information bulletin was received regarding electrical socket inserts. This was circulated to relevant parties.
Prevention of Future Deaths and Legal Claims	➢ There were no PFD's received in June 2016.

Training and CSRs



Core Skill Refresher (CSR)

CSR 2016.1 has continued with positive attendance rates – a 81% completion rate to date. For the period April, May and June a total of 3069 places were made available, 60 of these were cancelled due to insufficient booking numbers in April, no places were cancelled in May or June. 953 bookings made for June, with 859 learners attending. To date the attendance figure is 2554.

There were a total of 94 staff recorded as Did Not Complete for May. Line Managers are responsible for reviewing non-attendance and following up with individuals. Reasons for non-attendance and recorded as 'Did Not Complete (DNC)' include:

** 60 DNCs no reason provided*
** 7 DNCs non attendance (re-schedul*
** 11 DNCs non attendance (sickness)*
** 4 DNCs non attendance (no show)*
** 1 DNCs Training Refused - Manager*
** 3 DNCs non attendance (transport problems)*
** 1 DNCs non attendance (annual leave)*
** 1 DNCs non attendance (arrived late)*
** 1 DNCs non attendance (child care)*
** 2 DNCs non attendance (on other course)*
** 1 DNCs non attendance (overbooked schedule)*
** 1 DNCs personal reasons*
** 1 DNCs other special leave*

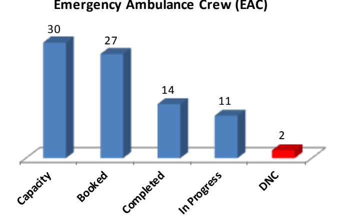
Due to the need to manually enter attendees on receipt of achievement records, the dashboard data lags behind the Clinical Education and Standards Department data records. The total number of clinicians required to attend for this month is 3135.

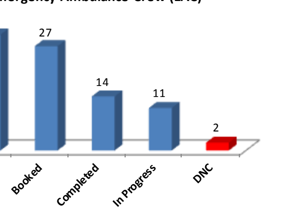
New Entrant Course Numbers

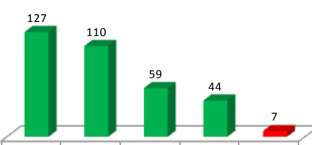
In June a total of 25 learners commenced their programmes; 3 EAC Conversion courses started with 25 learners.

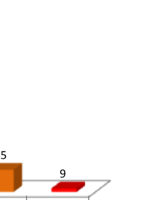
A total of 14 learners completed the EAC programme and 19 learners completed the International Programme.

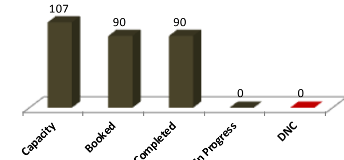
The PED (Placement Educator) throughput for June was of 18 trained PED 1's, 13 trained PED 2's. 2 courses with a capacity of 40 places were planned for the 29th June but due to the early submission of this months report not all the data has been received.





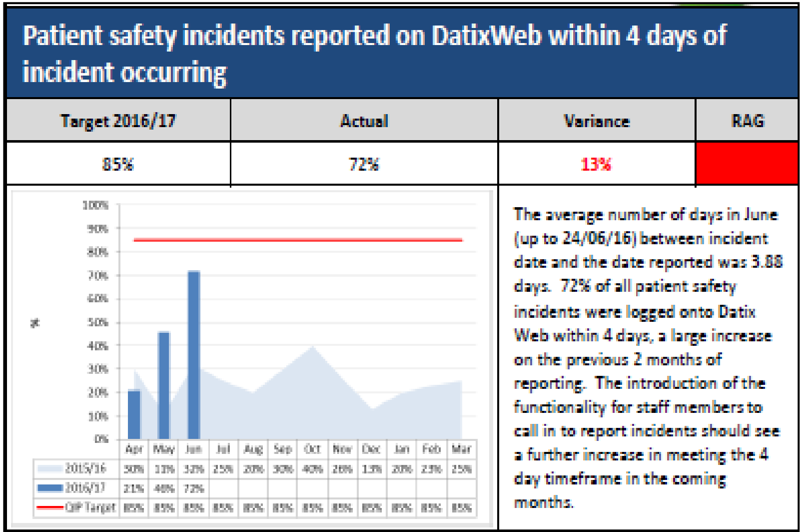






*DNC = Did Not Complete

Adverse Incidents



Patient safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	72%	13%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	13%	32%	25%	20%	30%	40%	26%	13%	20%	23%	25%
2016/17	21%	46%	72%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The average number of days in June (up to 24/06/16) between incident date and the date reported was 3.88 days. 72% of all patient safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting. The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

Adverse Incidents

There are some annomilies for June 2016 data as some incidents are entered directly (via Datix), and some are sent via paper LA52, but it is estimated that >90% of incidents in June 2016 have been received. A total of 314 adverse incidents have been recorded, with staff and patient incidents break down below.

Staff Incidents: 149 (-21%)
Manual Handling incidents: 27 (+33%)
Assault and Abuse: 45 (-49%)

Patient Incidents: 143 (+14%)
Failure of equipment: 18 (-10%)
Missing Equipment: 8 (-58%)
Medication Incidents: 14 (+8%)

Staff safety incidents reported on DatixWeb within 4 days of incident occurring

Target 2016/17	Actual	Variance	RAG
85%	60%	25%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13%	10%	23%	17%	20%	17%	22%	23%	10%	22%	19%	21%
2016/17	20%	17%	60%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The average number of days in June (up to 24/06/16) between incident date and the date reported was 5.4 days. 60% of all staff safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting. The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

Adverse Incidents due to items which failed or missing

Failed in use

Lifepak 15: ECG Cables	6
EZIO: Battery	3
Entonox: Mouthpiece	2
Tail Lift	1

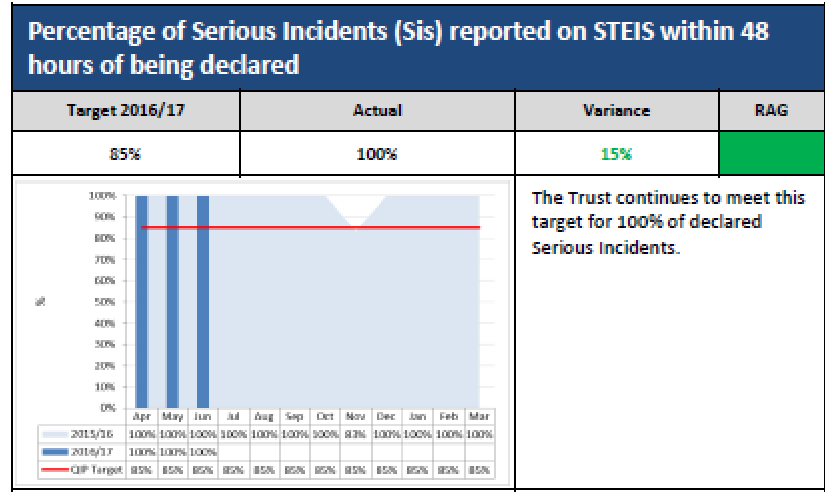
Missing Items

EZIO	3
Paramedic Drug Pack	2
Laerdal Suction: Battery	1
Lifepak 15: ECG Cables	1

Serious Incidents (SI) / Governance

Percentage of Serious Incidents (Sis) reported on STEIS within 48 hours of being declared

Target 2016/17	Actual	Variance	RAG
85%	100%	15%	



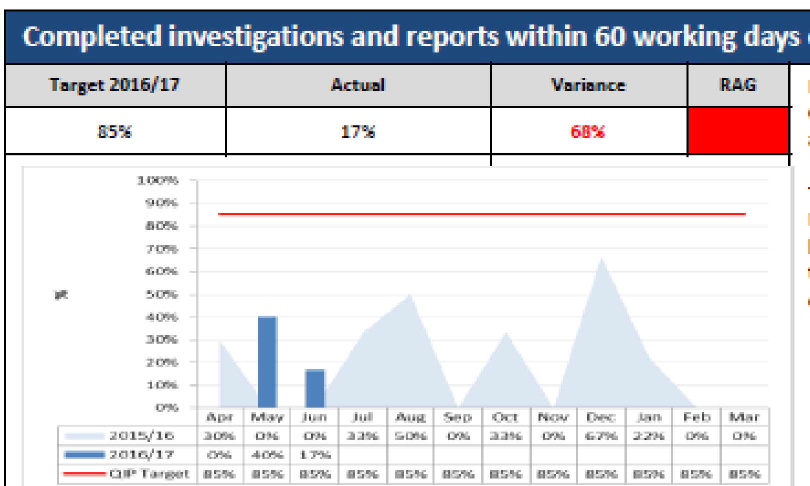
The Trust continues to meet this target for 100% of declared Serious Incidents.

Serious Incidents

- 6 SI's were declared in May 2016 out of 41incidents reviewed, with 10 reports overdue as of 5th July 2016.
- Overdue SI's have been escalated internally to the Executive Lead for completion compliance and projected completion dates have been asked of ELT leads.
- Recent SI themes identified in the first 3 months of 2016-17 include:-
  - Issues with identification and management of patients in early cardiac arrest
  - Information governance / security issues
  - Ambulance delays

Completed investigations and reports within 60 working days of a serious incident being declared

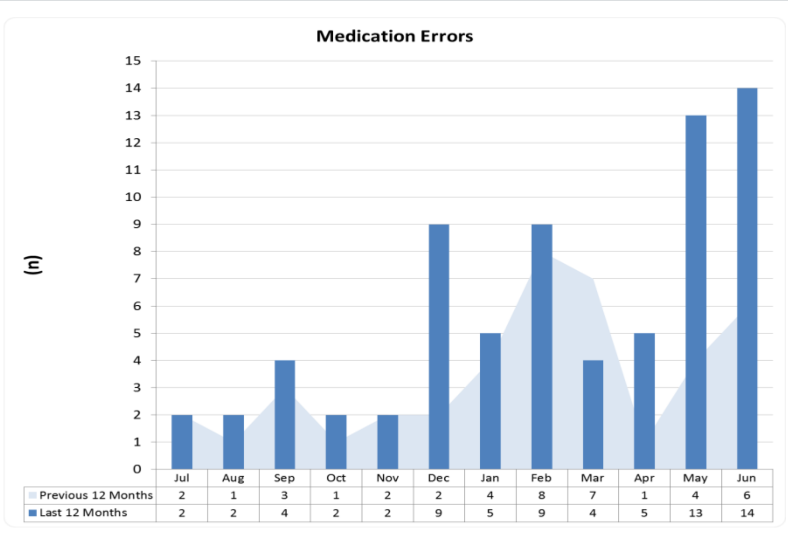
Target 2016/17	Actual	Variance	RAG
85%	17%	68%	



In Q1 16/17 the LAS submitted 18 SI reports with the average time for completion of 107 days. 3 were completed within 60 days. July is the first month where 60 working days will have elapsed from 1 April and we would therefore expect to see this impact upon next month's data.

There is a risk in that there is a small backlog of cases which requires an investigator and Executive Leadership Team / Governance team resources. There has been significant work undertaken to clear the backlog of SI reports and to raise the profile to ELT of overdue investigations. Further training is also taking place to increase the skillset of investigators and on investigation report writing for SMT & ELT, all of which should help reduce time to completion

Medicines Management



Controlled Drugs

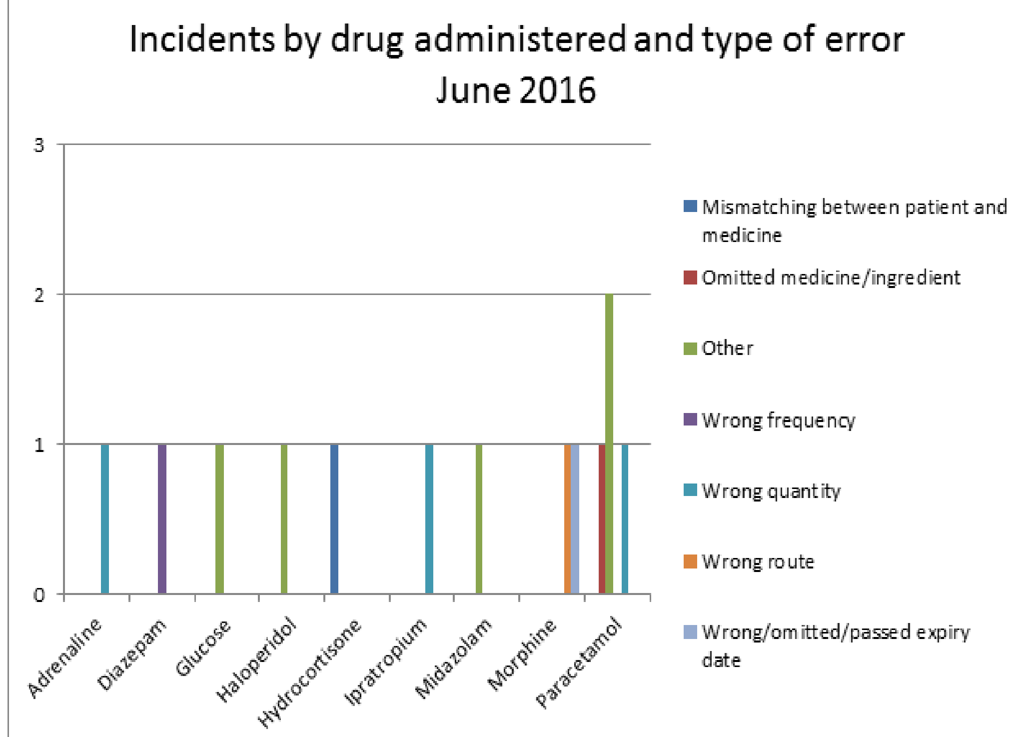
There has been one reportable controlled drugs incident in June. A motorcycle response unit paramedic returned to station and noticed that their morphine belt pouch was missing. Despite retracing steps and conducting area searches the morphine could not be located and the matter has been reported to the MPS and Home Office.

Although not a reportable incident, two break-ins have occurred at Ruislip Ambulance Station where controlled drugs are stored. The MPS CD team have inspected the premises following the first break-in. The second occurrence has been reported to the MPS CD team and their response is awaited.

Other medicines management issues

- A total of nine further medicines management issues have been reported during June 2016
- These include wrong dose and/or wrong drug in five cases. The remaining cases relate to lack of availability of drugs due to shortages at station level or missing drugs form sealed drugs packs.
- Efforts to recruit a Darzi fellow pharmacist continue as part of the recruitment plan. Four candidates have been shortlisted and are due to be interviewed in July 2016.
- The quarterly Trust Medicines Management Group meeting took place on 1/6/16. During this meeting it was reported that the issues relating to ambulance service use of oral morphine and rectal diazepam are on-going at a national level.
- Nerve Agent Antidote Kits (NAAKs) have been delivered. There is a requirement for these to be stored on every Trust frontline vehicle and the Medicines Management Group in conjunction with the Director of the Central Operations Division are currently determining the most appropriate methods for achieving this.
- Incident Response Officer (IRO) medicines spot checks are on-going and demonstrate an improvement in compliance over time.

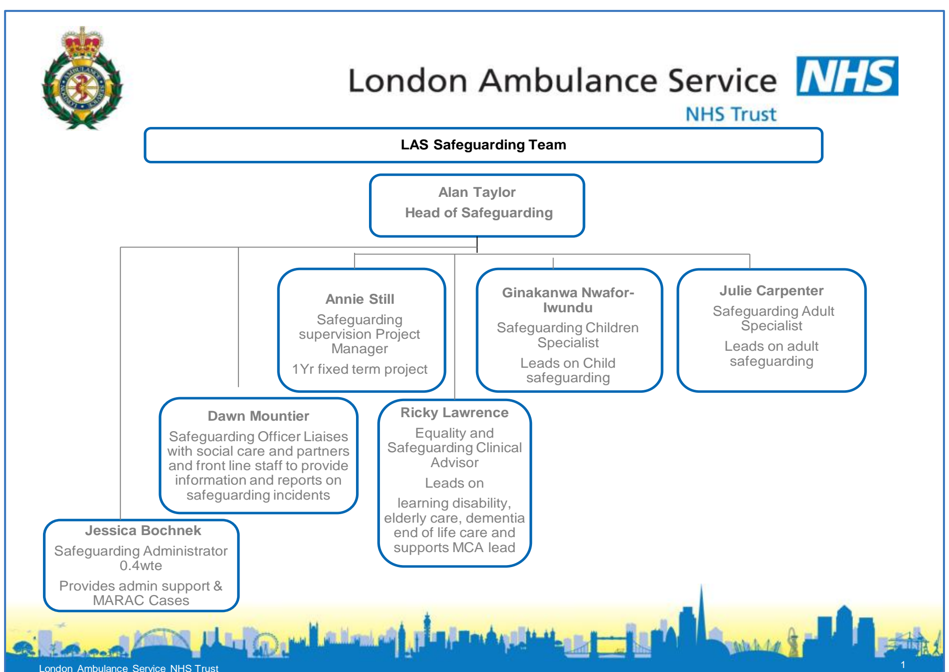
Medicines Management - KPI



Medicines Management – KPI data

- There have been **no** LIN reportable incidents this month.
- There have been **three** CD incidents that are not LIN reportable. In one case an ampoule was smashed whilst drugs were being returned to the safe. In another case an ampoule was returned but not signed back in. In the final case a member of staff took morphine home in error – this was quickly identified and the drugs returned promptly.
- 'Other' drug incident causes include:
  - Extravasation from an IV cannula when glucose infusion started – stopped and patient managed with glucagon
  - Refusal of conveyance by patient after administration of midazolam/haloperidol
  - Standard notification of use of chemical restraint/sedation
  - No spoon for oral paracetamol suspension administration
  - Single unintended overdose of paracetamol – pt said had taken none and then actually had one hour before call
  - No Sodium Chloride 0.9% 500ml bottles available on station

Safeguarding



Safeguarding Training

2014
Consent
FGM- recording
Staff Safeguarding action plan
Multiple referrals
NHS Prevent
Learning disabilities
Human Trafficking
Pressure Ulcers

2015
Care Act
Safeguarding V welfare
Referral update
Domestic Abuse
Child Sexual Exploitation
Self Neglect
Full Prevent training

2016- proposed
Children and Gangs
Looked after children
Hoarding
Domestic abuse update
DoLS

MCA and Fluctuating capacity has also been delivered on CSR in last two years

The Trust has invested in additional safeguarding resources and with effect from July 2016 the whole team will be in post. This will enable a greater focus on safeguarding child and adults at risk as well as providing safeguarding support to staff and improving feedback on referrals.

In addition we have a clinical advisor post that will focus on learning disabilities and dementia and end of life care.

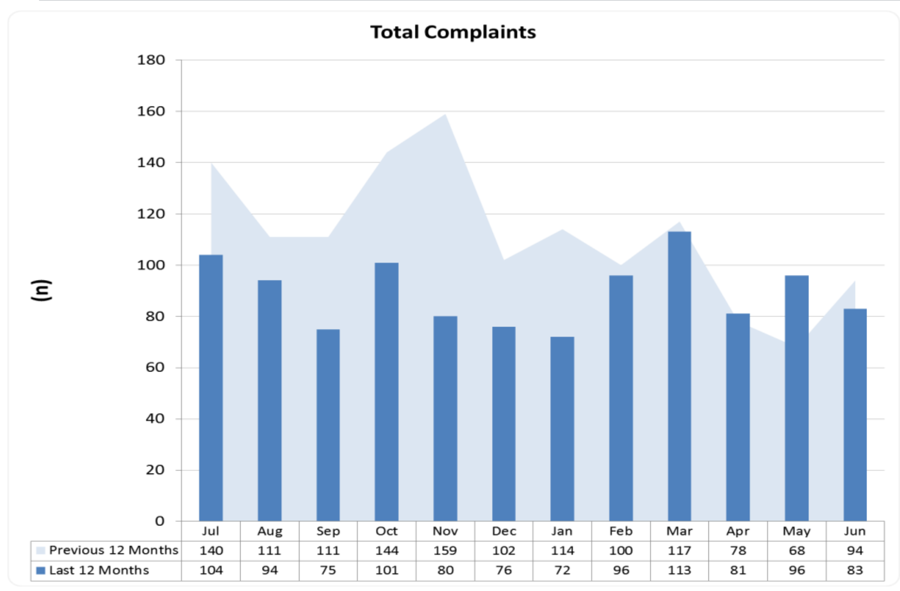
NHSE has also funded a 1 yr fixed term post to look at safeguarding supervision within the ambulance service as currently we do not provide any structured supervision. This post will look at various options and consider who should receive supervision within the Trust and supporting processes required.

The Trust delivers the statutory training on induction and provides level one e learning for non clinical staff. All frontline clinical staff have received face to face level two update training annually on the range of subjects listed above.

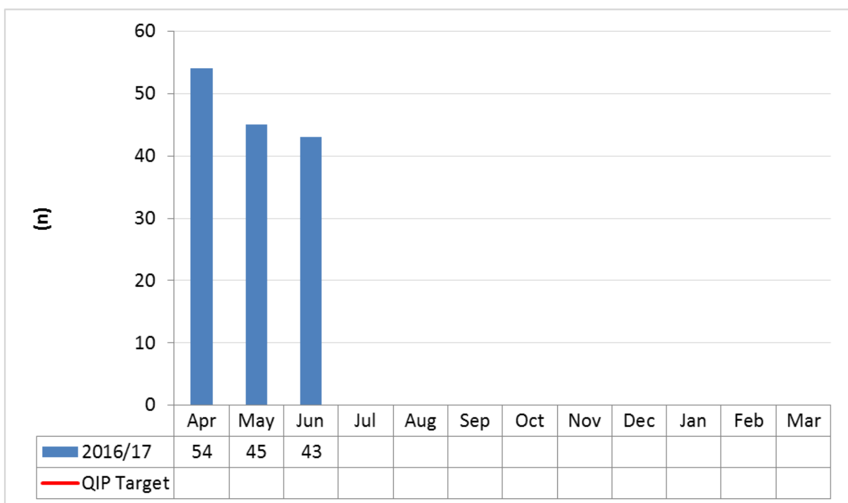
Last year 93% of clinical staff undertook the safeguarding update training.

This years update is planned for quarter 4 delivery and sessions are currently being developed but will include topics listed above.

Complaints – Volume & Response time



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Previous 12 Months	140	111	111	144	159	102	114	100	117	78	68	94
Last 12 Months	104	94	75	101	80	76	72	96	113	81	96	83



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43									
QIP Target												

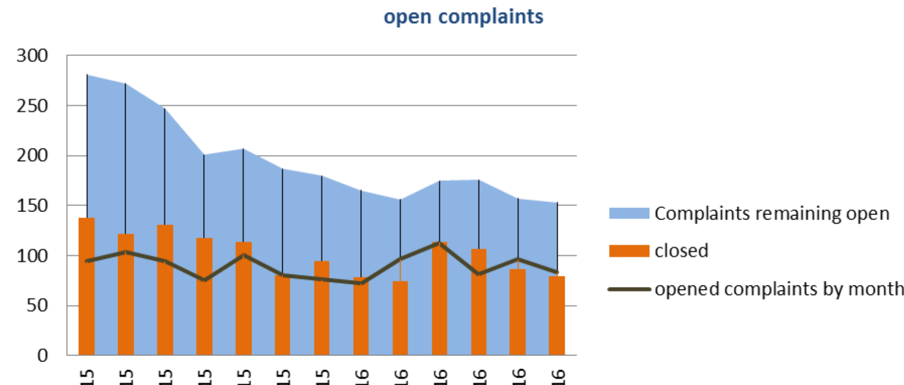
- 83 complaints were received in June 2016, lower for the month of June than in the previous two years.
- This includes 5 from health or social care providers which were treated as having been made on behalf of the patient, illustrating how the best practice is applied (and as approved by HSC) and beyond the DOC obligations. .

KPI Report – complaints responses over 35 days

- The QIP KPI data reflects the number of complaints over 35 working days that remain open.
- There are 153 open complaints with 43 over 35 working days (this includes 8 cases awaiting further QA reports).
- The oldest complaint is from March – awaiting a clinical review following identification that further information was required before the case could be closed. This is being addressed with the clinical reviewer.

Complaints – Volume & Response time

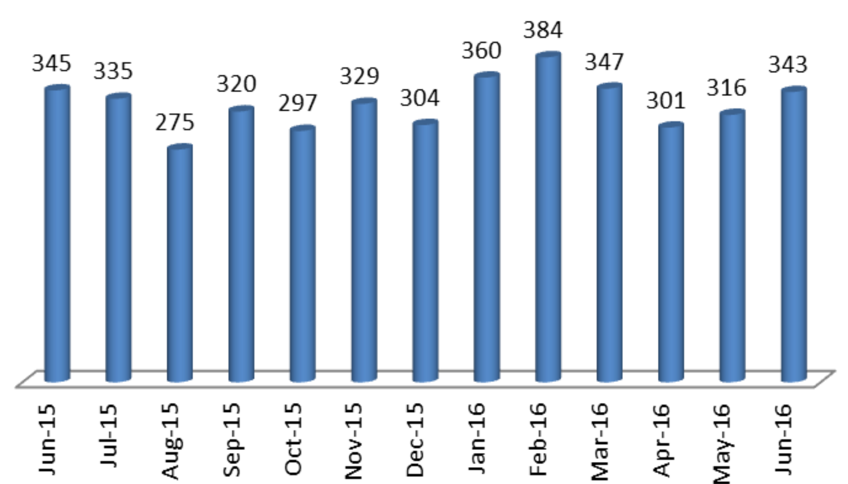
	2012/13	2013/14	2014/15	2015/16	2016/17
June complaints	76	73	130	94	83
Average per annum	81	88	117	88	87



- Overall complaint numbers are lower than for 2015/16
- Complaints about delay have increased in June (31) in comparison to 20 received in May.
- Complaints about conduct and behaviour have declined in June (25 compared to 38 in May).
- A recurrent theme remains the failure to adopt a care plan approach in relation to Locality Alert Register entries. A review is taking place with the Medical Directorate to evaluate current policy and procedural guidance.

- Datixweb was implemented in the department on 10 May 2016 and previous case management systems are now archived. The new system has required time for the complaints team to adjust to and has identified some technical amendments required which is being addressed with the Governance and IM&T departments.
- Data for reporting complaints by area and local authorities / CCG's will commence in August on completion of further training on Datix for the PED team.
- The number of complaints closed during June 2016 was 79.

PALS



PALS specific enquiries June 2016 = 343

- Average monthly PALS for 2013/14 = 287
- Average monthly for 2014/15 = 298
- Average monthly for 2015/16 = 322
- Average monthly for 2016/17 = 320

There was an increase in PALS enquiries from 327 during May to 343 during June. Entering these onto the web system is more time consuming as this now involves additional administration by the PALS team.

Month	2011/12	2012/13	2013/14	2014/15	2015/16
November	109	124	141	96	86
December	66	87	83	88	102
January	94	125	104	101	89
February	104	120	128	92	104
March	109	116	96	126	111
April	118	122	110	101	98
May	121	100	103	91	113
June	96	109	100	108	104
Totals	**817**	**903**	**865**	**803**	**705**

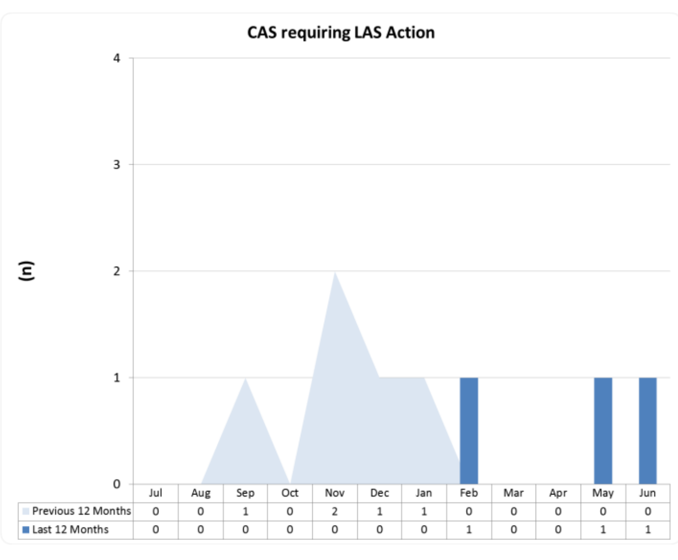
Themes are consistent with previous months regarding information and enquiries:-

- Patient destination
- Signposting to other departments
- Policy and procedure requests
- Families seeking clarification of events

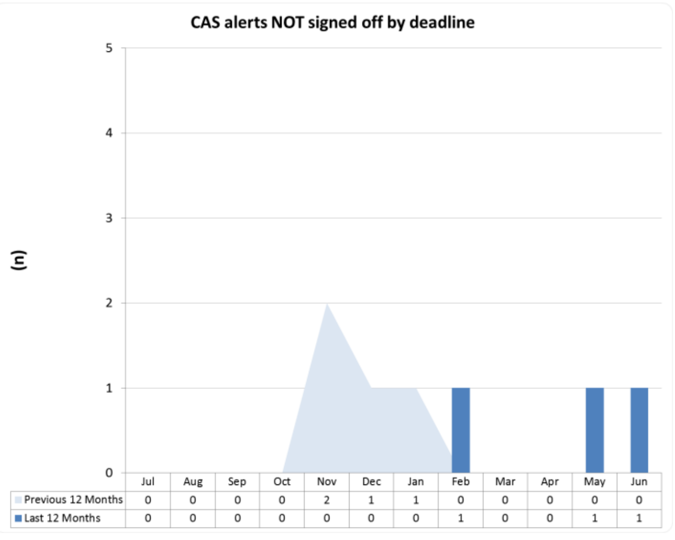
Full cover is provided on the ‘duty’ phone and each officer undertakes a duty session.

Currently PALS, complaints, concerns and compliments are now recorded in the web version, with Communications recording ‘compliments’ data.

NHS CAS Alerts & Preventing Future Death (PFD) Notifications



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Previous 12 Months	0	0	1	0	2	1	1	0	0	0	0	0
Last 12 Months	0	0	0	0	0	0	0	1	0	0	1	1



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Previous 12 Months	0	0	0	0	2	1	1	0	0	0	0	0
Last 12 Months	0	0	0	0	0	0	0	1	0	0	1	1

May 2016:

- 13 High Voltage alerts and 8 Low Voltage alerts were received, none of which were relevant.
- 5 Medical device alerts were received, of which none were relevant to the Trust.
- 1 general information bulletin was received regarding electrical socket inserts. This was circulated to relevant parties.

All notifications were acknowledged and no action was required to be taken by the Trust. The Safety and Risk department continues to respond within the notification window, on behalf of the Service, for modifiable alerts

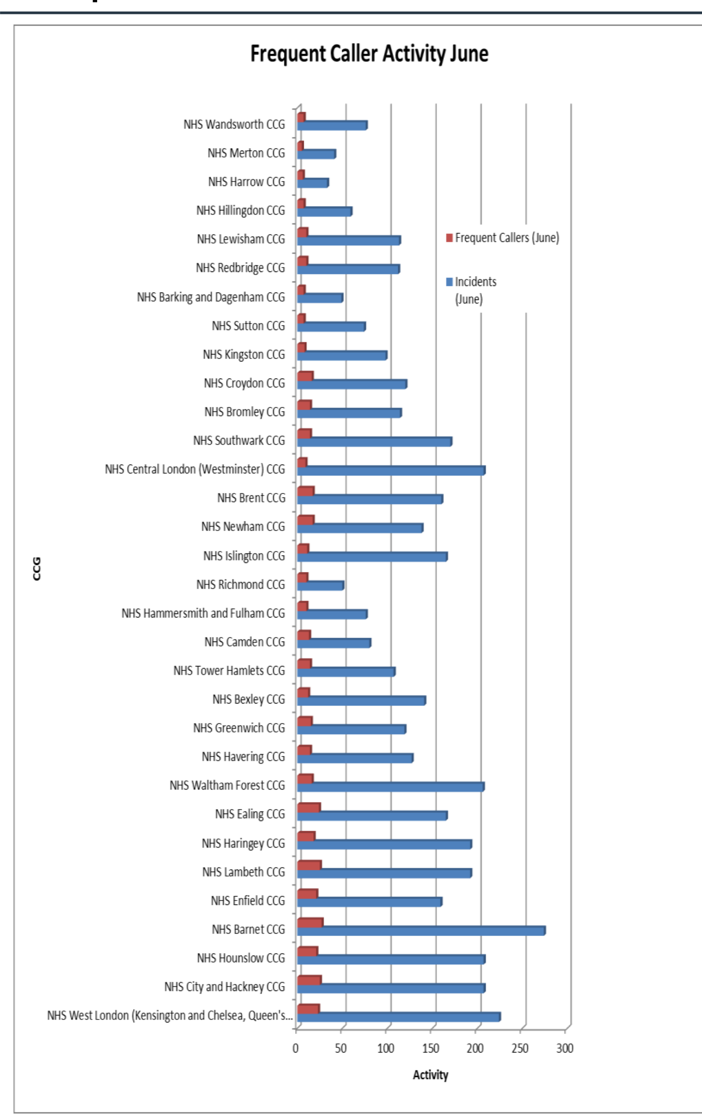
Preventing Future Deaths Reports:

- There were no PFD's received in June 2016.

EFFECTIVENESS

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides
Frequent Callers	➢ The number of overall Frequent Caller incidents have decreased in June. ➢ Phase one of the organisational Frequent Caller education programme has concluded, which will promote robust reporting, data sharing, case management and care planning best practice methodologies.
CARU Report Cardiac Arrest Care	➢ The average time from 999 call to LAS on scene was 8 minutes, thus meeting the target. Twelve Group Stations achieved the 8 minute or less target. ➢ 27 patients with ROSC presented with a STEMI following their cardiac arrest and were all conveyed to Heart Attack Centres (HAC) appropriately. ➢ 99% of patients has an advanced airway placed with ETC02 recorded, with three patients not having any ETC02 recorded. This has been fed to Clinical Team Leaders for follow up with crew members. ➢ 12% of cardiac arrests had defibrillator downloads, an increase of 4% from April 2016.
CARU Report STEMI Care	➢ The average time from the 999 call to arrival on scene decreased by 2 minutes to 9 minutes in May, exceeding the category A target by 1 minute. This is being addressed through CISO and Clinical Team Leader feedback. ➢ Call to hospital times have decreased by 1 minute to 72 minutes. ➢ Analgesia administration continues to be the element where least compliance is seen, although has improved by 4% in May, with Croydon Group Station delivering full care bundle to 100% of STEMI patients.
CARU Report Stroke Care	➢ 99.5% of FAST positive patients were conveyed to the most appropriate destination for their condition. ➢ 5 FAST positive patients (0.5%) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback to crews for learning. ➢ Patients eligible for thrombolysis arriving at a HASU within 60 minutes remains at 65%.

Frequent Callers



The number of Frequent Caller incidents has marginally reduced in June however the number of identified patients has increased.

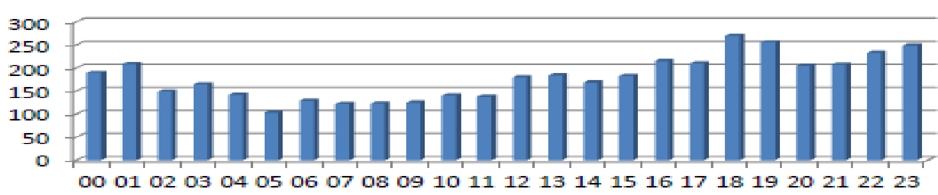
Phase one of the organisational Frequent Caller education programme has concluded, which has equipped stakeholder engagement managers, community involvement officers and a select of local champions in reporting, data sharing, case management and care planning best practice methodologies. E–Learning modules are being developed for external clinicians and stakeholders.

Meetings with Southwark, Kingston and Richmond CCG's have contributed toward the generation of further frequent caller management schemes through enhancing collaboration between health and local authority services. Opportunities to explore public health support to investigate health and wellbeing outcomes of Frequent Callers are being actively pursued with Bromley CCG.

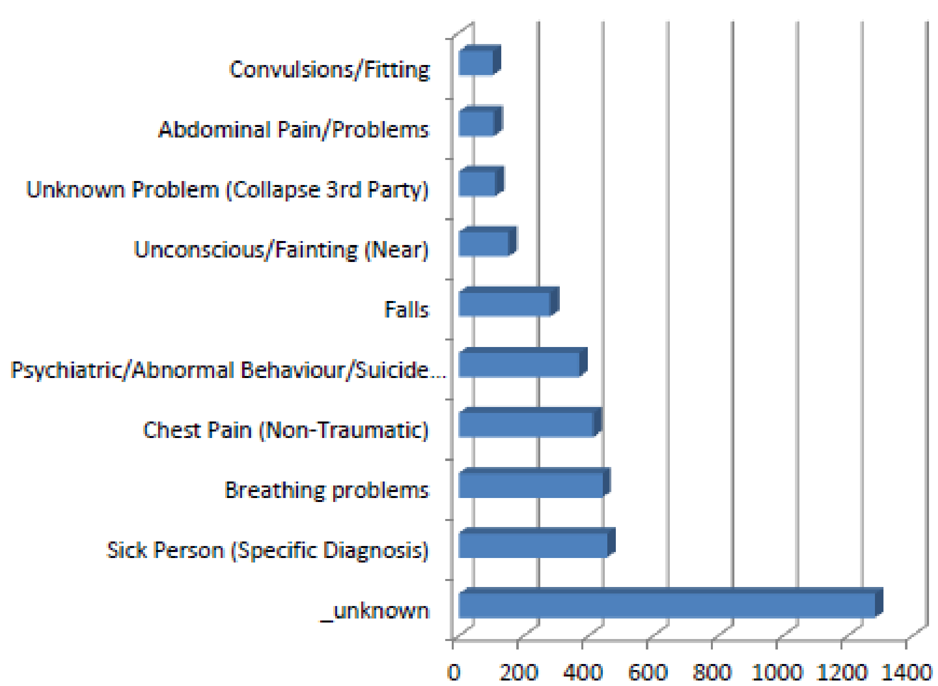
Feedback from the demand management workshop hosted by NHS England is being collated which will underpin a Pan London multidisciplinary frequent caller strategy. Meetings with NHS England have shared the LAS vision, focussing on collaboration and enhancing the value of networks.

The co-productive expert patient draft project plan has been shared with NHSE for comment. It is hoped project activities will commence within the next month which will enhance Frequent Caller quality and experience.

The graph to the left demonstrates the number of patients per CCG in orange and the number of incidents they generated in blue. CCG's are ranked following calculation of the number of frequent callers relative to CCG population. Better performing areas are located at the top of the graph.



Frequent Callers



Row Labels	HRG Cost	Cumulative resource time (mins)
NHS Barking and Dagenham CCG	£3,909.70	1872
NHS Barnet CCG	£23,347.76	13738
NHS Bexley CCG	£22,030.44	12948
NHS Brent CCG	£14,251.64	6272
NHS Bromley CCG	£13,679.16	7310
NHS Camden CCG	£10,712.46	5328
NHS Central London (Westminster) CCG	£14,623.92	7490
NHS City and Hackney CCG	£21,691.58	11544
NHS Croydon CCG	£13,686.12	6730
NHS Ealing CCG	£20,063.10	9815
NHS Enfield CCG	£13,401.28	7450
NHS Greenwich CCG	£15,218.04	7825
NHS Hammersmith and Fulham CCG	£12,660.22	6061
NHS Haringey CCG	£13,700.62	6958
NHS Harrow CCG	£4,750.40	2462
NHS Havering CCG	£14,169.68	7337
NHS Hillingdon CCG	£9,880.74	5290
NHS Hounslow CCG	£16,278.08	8946
NHS Islington CCG	£22,146.26	10892
NHS Kingston CCG	£5,811.64	2317
NHS Lambeth CCG	£23,053.86	11394
NHS Lewisham CCG	£11,779.18	6330
NHS Merton CCG	£5,719.70	3027
NHS Newham CCG	£16,090.38	7874
NHS Redbridge CCG	£11,757.56	6548
NHS Richmond CCG	£6,483.58	3598
NHS Southwark CCG	£10,870.38	4586
NHS Sutton CCG	£12,970.46	7007
NHS Tower Hamlets CCG	£11,808.64	5278
NHS Waltham Forest CCG	£16,223.16	7743
NHS Wandsworth CCG	£7,279.98	3494
NHS West London CCG	£21,987.24	10987
Grand Total	**£442,036.96**	**226451**

- The table to the right indicates cumulative HRG cost and resource time for frequent user activity throughout February.
- The table above demonstrates the top ten chief complaints presented by the frequent caller cohort.

CARU Reports - Cardiac care (May data)

CARDIAC ARREST

- Resuscitation efforts were commenced on **40%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **8 minutes**, thus meeting the target. **Twelve** station groups had an average 999 call to scene time of 8 minutes or less.
- **29%** of cardiac arrest patients that had resuscitation commenced gained and sustained Return of Spontaneous Circulation (ROSC) until arrival at hospital. This is a **3%** decrease from April, although it is in line with the average from 2015/16. **St. Helier** station group had the highest ROSC rate with 50% of their patients maintaining ROSC to hospital.
- **27** patients with ROSC presented with a STEMI following their cardiac arrest, all of which were conveyed to HACs in line with the pathway.
- An advanced airway management device was placed successfully in **86%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **Three** patient had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout and these have been shared with Sector management teams for further investigation.
- Approximately **12%** of cases had defibrillator downloads submitted, which was a **4%** increase from April. All the downloads were submitted by Advanced Paramedic Practitioners on-scene.

STEMI

- **99%** of patients were conveyed to an appropriate destination, with **three** patients not being transported according to the HAC pathway. These cases have been shared with Sector management teams for feedback.
- The average time from the 999 call to arrival on scene decreased by **2** minutes to **9** minutes in May.
- Average overall on scene time has increased by **1** minute and remains high at **45** minutes. **Brent** and **Fulham** station groups achieved a notably lower than average overall on scene time this month. However, on-scene times continue to require monitoring and review to identify themes.
- Call to hospital times have decreased by **1** minute to **72** minutes.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) has increased by **4%** to **75%**, with **Croydon** station group supplying the full care bundle to 100% of patients attended this month. Analgesia administration continues to be the element where least compliance is seen, with **82%** of patients receiving pain relief.

CARU Reports – (Stroke / Major Trauma) May data

STROKE

- **97%** of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF.
- Almost all FAST positive patients (**99.6%**) had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- Almost all FAST positive patients (**99.5%**) were conveyed to the most appropriate destination for their condition. However, **5** FAST positive patients (**0.5%**) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback as necessary.
- The average response time for 999 call to arrive on scene was **12** minutes.
- The average time on scene is **35** minutes, which remains longer than the recommended 30 minutes. Just over half of LAS crew (**51%**) attending stroke patients who were potentially eligible for thrombolysis spent 30 minutes or less on scene.
- The percentage of patients, who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes, remains at 65%.

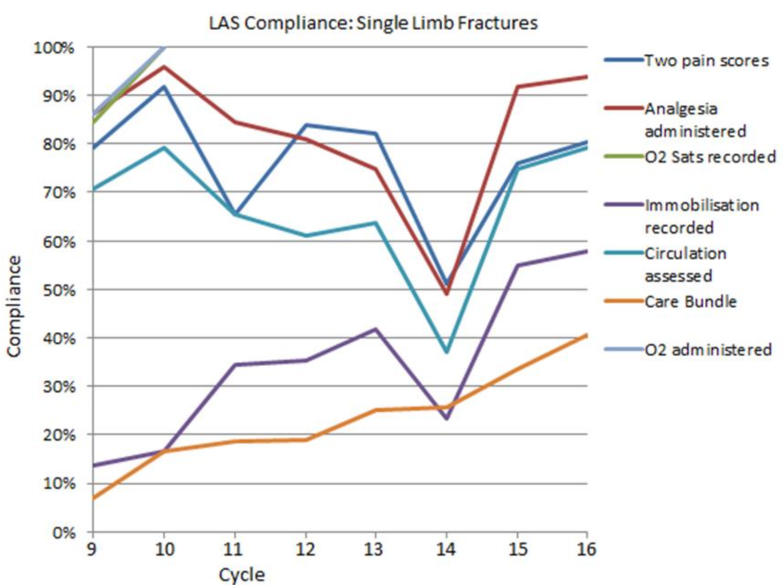
MAJOR TRAUMA

Major trauma data is produced quarterly. Q1 data will be available in August's report.

CARU Reports – National CPI compliance; lower limb trauma

	CYCLE 15 (Data sample: July 2015)			CYCLE 16 (Data sample: January 2016)		
	LAS Performance in C15	National Average	Rank in cycle 15	LAS Performance in C16	National Average	Rank in cycle 16
Two pain scores	76.00%	76.20%	**7th**	80.30%	73.30%	**3rd**
Analgesia administered	91.70%	90.20%	**6th**	93.70%	93.30%	**7th**
Immobilisation recorded	55.00%	64.60%	**7th**	58.00%	63.90%	**8th**
Circulation assessed	74.70%	80.10%	**8th**	79.30%	86.50%	**9th**
Care Bundle	33.70%	46.20%	**9th**	40.70%	49.10%	**9th**

***All aspects of care are included in the care bundle*



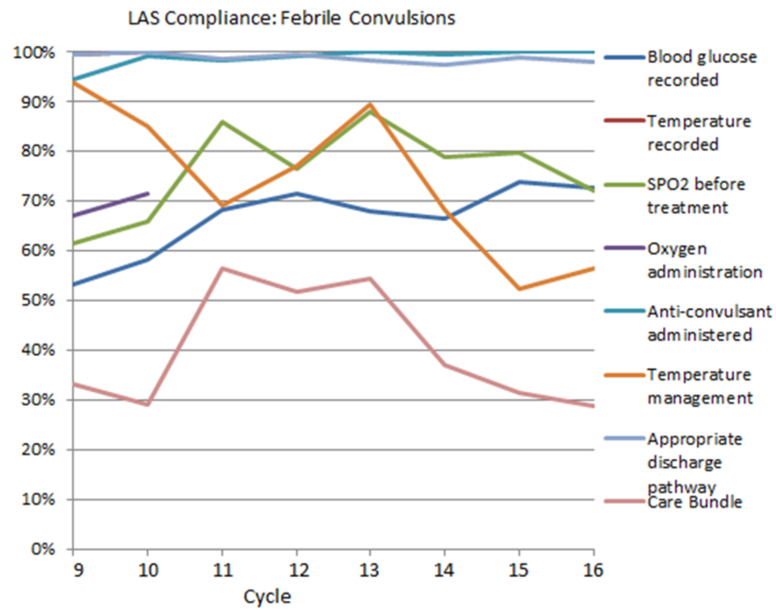
- The data shows improved compliance in pain score recording, with little change in compliance for immobilisation, circulation and overall care bundle.
- The Trust remains above the national average for administration of analgesia and has improved significantly when recording pain scores.

CARU Reports – National CPI compliance; Febrile Convulsions

	CYCLE 15 (Data sample: August 2015)			CYCLE 16 (Data sample: February 2016)		
	LAS Performance in C15	National Average	Rank in cycle 15	LAS Performance in C16	National Average	Rank in cycle 16
Blood glucose recorded	73.90%	86.00%	**10th**	72.70%	88.10%	**11th**
SpO2 before treatment	79.70%	90.20%	**11th**	72.00%	93.30%	**11th**
Anti-convulsant administered	100.00%	98.90%	**Joint 1st#**	100.00%	98.70%	**Joint 1st/**
Temperature management	52.30%	87.20%	**11th**	56.30%	90.20%	**11th**
Appropriate discharge pathway	98.70%	97.80%	**5th$**	98.00%	96.30%	**7th$**
Care Bundle	31.40%	72.10%	**11th**	28.70%	75.90%	**11th**

KEY
- # 6 services = 100%
- $ 4 services = 100%
- / 7 services - 100%

The care bundle is comprised of BM, SpO2 and Temperature management

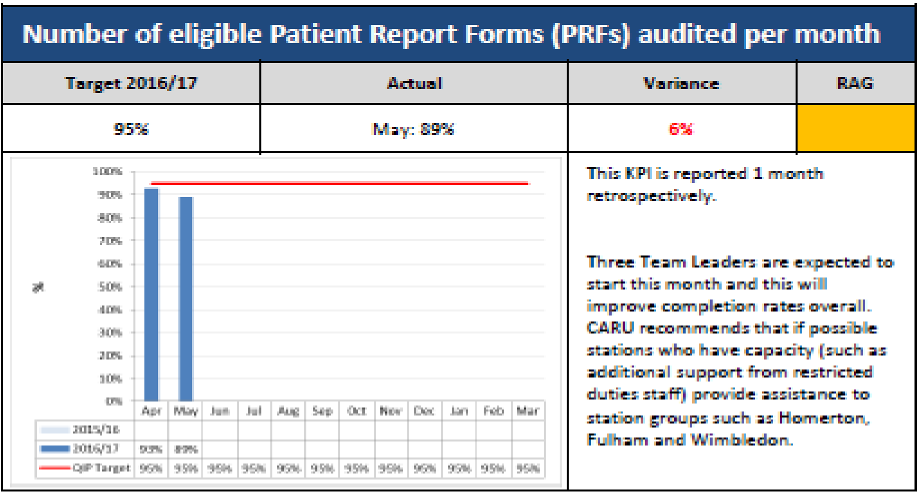


- The data shows the Trust is joint 1st of 7 services to administer anti-convulsant medication.
- Other aspects of care remain consistent with previous 6 month data. Great focus is required to improve overall care bundle for the aspects of care detailed above, specifically temperature management.

CARING

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides
CPI Compliance	➢ Final observations documented would see an improvement in compliance for Discharge at Scene and Glycaemic Emergencies, which these both currently lack. ➢ The Severe Sepsis CPI is showing a 95% compliance in the first two months of auditing. Improvements are required for the appropriate administration of oxygen and fluids and a business case has been submitted for a Sepsis update to be included in a CSR.
CPI completion	➢ May saw a decrease in the number of CPI's completed from 93% in April to 89% in May. ➢ Twelve group stations and teams audited every PRF available. Wimbledon Group Station did not audit any PRFs for the second month due to staff availability; however, three Team Leaders will be joining Wimbledon in June 2016.
CPI Feedback	➢ Fewer than half of staff received face to face feedback sessions which is being monitored by CARU. ➢ Hillingdon is congratulated for delivering the expected number of feedback sessions this month ➢ Exceptionally low numbers of feedback were delivered by MRU and Clinical Hub which has been fed back to the Group Stations.
Friends & Family Test	➢ 338 FFT responses were received June, a huge increase on previous month (39 in May). This can be contributed to a marked effort by PTS who are sending leaflets direct to patients for feedback and recent engagement with the Communications department to promote internally the FFT to all staff.
Patient & Public Education	➢ 35 events were attended out of 55 events entered on the database. This included 4 People who Help Us events, 7 Careers events and 3 Junior Citizen Schemes.

CPI - Completion, Feedback Sessions and Compliance (May 2016)



Number of eligible Patient Report Forms (PRFs) audited per month			
Target 2016/17	Actual	Variance	RAG
95%	May: 89%	6%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	93%	89%										
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

This KPI is reported 1 month retrospectively.

Three Team Leaders are expected to start this month and this will improve completion rates overall. CARU recommends that if possible stations who have capacity (such as additional support from restricted duties staff) provide assistance to station groups such as Homerton, Fulham and Wimbledon.

CPI Completion

- In May, at 89%, we saw the number of PRFs audited return to levels seen before April 2016.
- Twelve group stations and teams have audited every PRF available so far this financial year: Bromley, Croydon, Edmonton, Friern Barnet, Hanwell, Hillingdon, Newham, and New Malden Group Stations, as well as the Clinical Hub, HART, MRU and Tactical Response Unit. The newly formed Wimbledon Group Station did not audit any PRFs for the second month due to staff availability; however, three Team Leaders will be joining Wimbledon in June 2016.
- The overall proportion of CPI audits of PRFs undertaken by Team Leaders fell slightly this month. However, all audits were completed by Team Leaders at Bromley, New Malden, Romford, plus the Clinical Hub and HART.

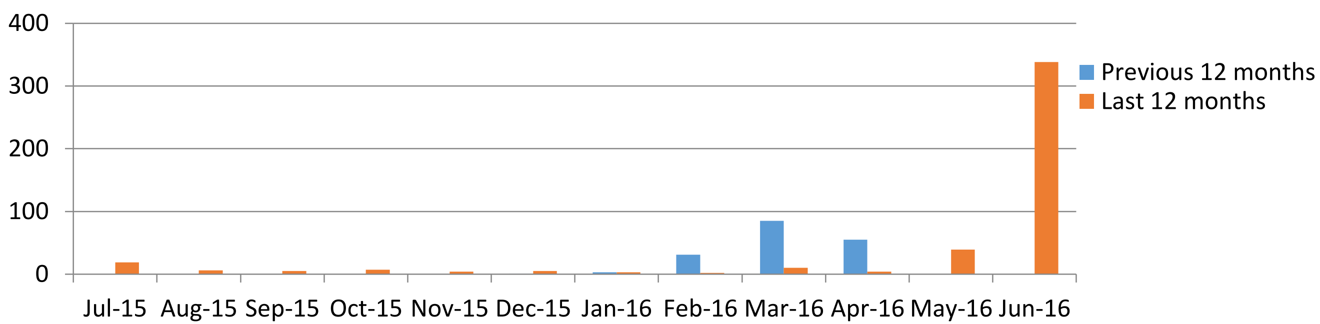
CPI Compliance

- The care provided to patients with a diagnosed psychiatric problem was maintained in both April and May 2016 at 91%. Consistent documentation by all sectors for safeguarding concerns and appearance will increase compliance considerably.
- For the eighth month, a consistently high level of care (>95%) was provided to patients discharged at scene. However, documentation of final observations continues to require improvement as it is at 91% compliance.
- General documentation of patient care remains high (>95%), with drug pack codes recorded on 98% of relevant PRFs.
- Patient care provided to those experiencing a glycaemic emergency is at a consistently high level. Recording final observations would further improve this as this currently at 92% compliance.
- The Severe Sepsis CPI is in its second month and achieving 95% compliance. Improvements have been made in the documentation of oxygen, IV fluids, and the site of infection; however, further improvements are required for these aspects of care. A business case has been submitted to add the severe sepsis CPI as a hot topic on the next round of Core Skill Refresher courses.

CPI Feedback

- The method of calculating monthly feedback targets changed in April with targets now based on a monthly ratio to reflect expected operational pressures and Team Leader office time.
- Service wide, fewer than half of the staff received the expected number of face-to-face feedback sessions in May. Hillingdon Group Station is commended for exceeding the level of feedback required at this point in the year, as are Romford and the TRU who delivered over 75% of expected sessions.
- Low numbers of feedback sessions were delivered at the Clinical Hub, MRU and to Volunteer Responders. Hear and Treat Peer to Peer review has continued on the Clinical Hub.
- CARU will continue to monitor the progress of the feedback provided to members of staff across the LAS and specifically focus on the areas where feedback sessions are considerably lower than expected.

Friends and Family



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Previous 12 months	0	0	0	0	0	1	3	31	85	55	0	0
Last 12 months	19	6	5	7	4	5	3	2	10	4	39	338

Friends and Family Test figures for **June 2016**

•Total number of FFT responses received = 338

Extremely likely = 272	Likely = 57
Neither Likely or unlikely = 2	Unlikely = 1
Extremely unlikely = 2	Blank = 4

- PTS responses = 335
- Number of PTS journeys = 4,330
- See & treat responses = 3
- Number of see & treat patients = 26,136 (this figure will change by 17th May)

PTS numbers are higher as they are now sending leaflets directly to patients

Patient & Public Engagement

June 2016

Events on database = 55

Events attended = 35

- x7 Careers events
- x4 People who help us (4-5yr olds)
- x2 First aid badges (Brownies etc)
- x3 School visits (5-11yrs)
- x1 PPI
- x3 Junior Citizen Schemes
- x2 London Fire Brigade events
- x13 Other

Public engagement feedback

We have had some great feedback from the pupils at Holy Trinity School, Sidcup after a visit we did back in May.

Thank you for giving up your time to teach us some useful skills, we could save some peoples life and be a hero.

We are so grateful that you kindly gave up your work time to visit our school. It was really good to learn about the life threatening job you do.

Thank you for giving up your time to teach us some of your skills so if we see someone on the floor we can help them. We learnt DRABC, D = Danger R = Response A = Airway B = Breathing and C = Call 999.

Patient and Public Involvement (PPI)

We have had to make some changes to our risk assessment form (LA168), due to changes with booking vehicles. A new version will be up on the Pulse soon.

Our procedure for managing public events (TP036) is currently in the final editing stages, to bring it up to date.

We have now taken over the management of Foundation Trust Membership, we are waiting for an update from Communications to inform the members about the recent changes.

The Patient Forum is attended on a monthly basis by appropriate Senior Managers and feedback from the Patient Forum has helped to inform the 2016/2017 CQUINS.

RESPONSIVENESS

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides
EOC Surge Plans	➢ The Trust has remained at Surge Red as agreed by ELT. A review of the criteria to continue at this level confirms we are still operating under significant operational pressure and that Surge Red continues to enable LAS to respond to the sickest and most seriously injured patients quickly. ➢ There was on episode of Surge Purple Enhanced on 23rd June 2016 which lasted for 3 ½ hours. During this time there were unprecedented spikes in call demand and 89 hospital delays, exceeding 45 minutes. ➢ Surge Purple Enhanced is designed to ensure that ensure that resources are directed to the most critically ill and injured patients to maintain patient safety.
Hospital Delays	➢ Hospital handover breaches are being closely monitored and work is on-going with NHSE and a number of Acute Trusts to address this. ➢ During June, there were 2343 hospital breaches of greater than 45 minutes, of which 1001 were greater than 1 hour. Of particular note there were a number of breaches at Queen Elizabeth – Woolwich, Barnet, Princess Royal – Farnborough and Lewisham.
Revised REAP Levels	➢ The Trust is operating at Pressure Level = Moderate (2) ➢ Current year to date performance as of 10th July is Cat A 8 minutes 64.87%, Cat A 19 minutes is 94.09%.

WELL LED

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides
CQC & QIP Update	➢ The scheduled Clinical Review visit led by NHS Improvement was completed during June. The review was extensive and included the submission of documentary evidence, selected focus group session, site visits to stations and ED Departments, and observational ride outs with frontline staff on shift. ➢ A deep dive review was presented to the Clinical Quality and Review Group in June which focussed on progress on the Patient Transport Service and improvements to the care of Mental Health patients. ➢ There were high numbers of activities to be delivered in June, and programme performance for the month resulted in 88% of scheduled activities being delivered. ➢ A draft audit tool to assure the compliance and quality of OWRs (Operational Workplace Reviews) has been designed by the Consultant Paramedics in collaboration with the Operations Directorate. The process will involve three auditors who will who independently review and assess completed OWRs, and the outcome of the audit will be reported and shared appropriately with managers. ➢ An initiative identified by Greenwich station to improve the management of station based drugs is due to commence, and this will be trialled for four weeks followed by an evaluation to determine the effectiveness and feasibility of implementing changes widely across the Trust.
Making the LAS Great	➢ An introduction to mediation workshop was held in June, and 60 staff widely across the Service attended. Mediation training will promote a new way of working, including courageous conversations which is a skills based course to help staff learn how to facilitate difficult messages in a positive way and will empower staff to resolve issues as soon as they arise. ➢ The agreed target to provide 400 staff with bullying and harassment awareness training across the Trust has been achieved, and exceeded at the end of June.

WELL LED

Sub-Section	Key Headlines From Each Sub-Section. Should be supported by following slides
Clinical Review / NHS Improvement visits	➢ Following on from the CQC inspection, the NHSI undertook a mid-term clinical review in the Trust. ➢ Trust welcomed the review as a learning and developmental opportunity and invited staff form all areas / grades to participate in focus groups and site visits ➢ Preliminary feedback has been provided, and ELT are reviewing the feedback and are formulating an action plan to focus on areas identified as still requiring progress to be made

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Quality Improvement Programme Update
Report Author(s):	Donna Fong PMO Manager, Quality Improvement Programme
Presented by:	Karen Broughton Programme Director, Quality Improvement Programme
Contact Details:	
History:	Update on the Quality Improvement Programme
Status:	For assurance and information
Background/Purpose	
The purpose of this paper is to provide the Trust Board a status report on the delivery of the Quality Improvement Programme.	
Action required	
The Trust Board are asked to note: • the QIP update report • the QIP progress report (June performance) • the QIP KPI report (June performance)	
Assurance	
The Quality Improvement Programme Board have reviewed activities delivered up to the end of June, and the main concern on programme delivery relates to the outstanding decision to fund delivery of the Quality Improvement Programme which currently sits with Commissioners. The update provides detail of the outcome of the recent Clinical Review carried out by NHS Improvement in June, and immediate actions to be taken following this review.	

Key implications and risks arising from this paper	
Clinical and Quality	The QIP details activities to mitigate against identified clinical risks including deliverables relating to medicines management, improving patient outcomes for bariatric and mental health patient groups, and how the organisation learns from reportable

	incidents, risks and complaints. Additionally, the development of a Trust Quality and Clinical strategy will set the direction and organisational approach to managing clinical and quality risks.
Performance	There may be risk to Trust performance if activities within the QIP are not delivered to time, or they do not have the anticipated impact on operational functions to improve performance. This needs to be continually reviewed and understood to maintain sustainability.
Financial	Delivery of the QIP will require dedicated funding. These requirements will be included in the 2016/17 contract negotiations with Commissioners, which are still under negotiation.
Governance and Legal	The QIP Board is a sub committee of the Trust Board which meets monthly. It will provide a report to formal Trust Board meetings on progress
Equality and Diversity	There are no specific equality and diversity risks identified in this paper.
Reputation	There may be a reputational risk if the Trust does not deliver against the QIP in making effective changes that result in meeting the standards required by the CQC and other stakeholders.
Other	

This paper supports the achievement of the following 2015/16 objectives	
Improve the quality and delivery of urgent and emergency response	Activities within the QIP will lead in due course to achievement of this objective.
To make LAS a great place to work	Activities within the QIP will lead in due course to achievement of this objective.
To improve the organisation and infrastructure	Activities within the QIP will lead in due course to achievement of this objective.
To develop leadership and management capabilities	Activities within the QIP will support achievement of this objective, over time.

2016/17 QUALITY IMPROVEMENT PROGRAMME

Trust Board: QIP progress update

26 July 2016

QIP: Programme Summary

The Quality Improvement Programme has been operating for over six months, following the formal launch on 16 January 2016.

Since October 2015 when the CQC report was published and the Warning Notice issued, the Trust has made significant progress in addressing concerns and issues raised, and has achieved to date completion of 133 activities.

The internal Quality Improvement Group regularly meet on a monthly basis to review the delivery of programme activities to time, scope, and quality. In addition, the QIP Board continue to challenge and seek assurance that the activities delivered are having the right impact on the organisation and changes are sustainable.

External assurance is provided to the Regional Oversight Group and the Clinical Quality Review Group, where joint assurance arrangements are in place and detailed reviews are undertaken during scheduled deep dive sessions.

Three external assurance reviews have been carried out to date to assess The Trust's progression in addressing CQC concerns:

- March 2016 Warning Notice Review
- May 2016 NHSI Stocktake Review
- June 2016 NHSI Clinical Review

QIP: External Support

There have been a number of support mechanisms put in place to aid delivery of continued organisational improvements, including:

- Appointment of Lesley Stephen as the Improvement Director in January 2016.
- Mentoring and support provided by the Association of Ambulance Chief Executives for the interim Director of Operations.
- The buddying relationship with Defence Medical Services in providing leadership training to managers within the service and to improve organisational culture.
- An independent review carried out on our governance functions.
- We have had expertise and additional specialist support for the programme in the following areas:
  - Trust Board on strategy development
  - Trust Board skills review
  - Organisational Development specialist
  - Bullying and Harassment specialist
  - Programme Management Office
  - Governance subject matter expert
  - Pharmacist support and funding for a Darzi fellow

We have welcomed the advice, guidance, and specialist knowledge of our external experts to ensure that our organisational workplan is robust, and contributes to ongoing development of the organisation.

QIP: External Assurance Outcomes

March 2016: Review of progress against the Warning Notice

- Some good progress made across all areas
- Acknowledgement by staff of progress made – particularly for recruitment of staff (both in the frontline and HART) and medicines management
- Systems and processes need further review
- Cultural issues in terms of willingness to accept introspection, review and challenge
- ‘Crew to Board’ was not evident from the data review or visits, and an absence of verification of how the Board is provided with assurance against these areas
- Ongoing need for an evidence store for the elements within the CQC warning notice / Pre Inspection Request
- Limited evidence of the Trust using data where it is available, and triangulating with other evidence sources to understand the impact that actions are having across the Trust
- Having a good suite of KPIs, that can drill down to the relevant level (sector, sub-KPI) will provide assurance to key stakeholders and the Board

May 2016: Stocktake Review

- encouraged by what has been achieved but LAS acknowledged that a great deal remains to be done if the trust is to exit special measures in Quarter 4 2016-17.
- There is good evidence of progress against the three warning notices
- Recommended to consider how staff can be encouraged to identify and articulate improvements in patient care and how internal communications could be strengthened to share best practice and areas of success.
- Encouraged to note that the external support package helpful and effective to date.

QIP: External Assurance Outcomes

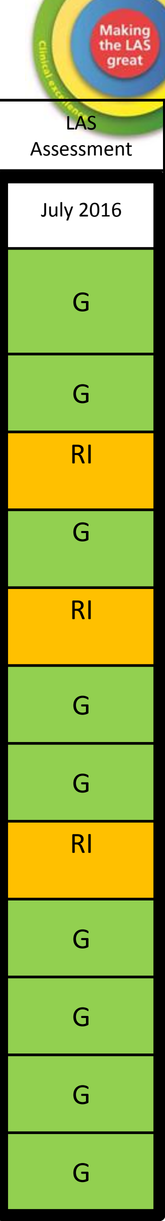
June 2016: Clinical Review

- The scale and speed of the recruitment programme is commended.
- The impact of the substantial increase in staffing is however not having the anticipated positive impact on response times or staff morale.
- There are two elements of resourcing which the Trust must address at pace: distribution of staff across stations, and pathways to autonomous operational practice.
- Feedback from crews and observations confirmed that vehicle preparation (VP) pilots in the Trust are improving the physical environment of care delivery by reducing missing equipment and improving vehicle cleanliness. The positive impact on staff morale resulting from these improvements was also evident.
- The Trust needs to push forward on the evaluation and roll-out of successful VP pilots.
- Medicines management at stations has improved significantly from the CQC visits and the Warning Notice Review in mid-March.
- The Trust needs to consider the end to end process from drug packing to destruction
- Areas that were not explored as thoroughly in the warning notice review due to its limited scope, but which featured consistently during the clinical review were:
    - a desire for clarity of strategy – which could be characterised as a dilemma as whether to embrace urgent care or retrench to emergency care;
    - a wealth of information from the centre outwards (top-down) but limited channels to engage ie share a dialogue; and
    - a paucity of information technology resources inhibiting service development.

QIP: Expected Trajectory for Improvement

CQC Rating		Objective within the improvement plan	TDA expectations by quarter							LAS Assessment
			BASELINE CQC report	WN findings March 16	Forecast 6 mths	CR Findings - June 16	Forecast 9 mths - Sept 16	Forecast 12 mths - Nov 16	Forecast 15 mths - Jan 17	July 2016
SAFE	Inadequate	Incident reporting, investigation, feedback and learning	I	I	RI	RI	RI	RI	RI	RI
		Mandatory training completion and compliance	I	RI	RI	RI	G	G	G	G
		Safeguarding training, understanding and awareness	RI	G	G	G	G	G	G	G
		Cleanliness, infection control and hygiene across all areas of the Trust	I	RI	RI	RI	G	G	G	RI
		Environment and equipment - provision of equipment, vehicle maintenance and work environment for EOC staff	I	RI	RI	RI	RI	RI	RI	RI
		Medicines management - systems, checks and audits, use of PGDs, executive oversight	I	RI	RI	RI	RI	RI	RI	RI
		Records security, audit and process (paper based system)	I	I	RI	RI	RI	RI	RI	RI
		Assessing and responding to patient risk processes framework	G	G	G	G	G	G	G	G
		Staffing - frontline numbers and retention	I	RI	RI	RI	RI	RI	RI	RI
		Staffing - HART and resilience functions	I	G	G	G	G	G	G	G
		Major incident awareness and training - protocols and awareness	I	G	G	G	G	G	G	G

QIP: Expected Trajectory for Improvement



CQC Rating		Objective within the improvement plan	TDA expectations by quarter							LAS Assessment
			BASELINE CQC report	WN findings March 16	Forecast - 6 mths	CR Finding - June 16	Forecast 9 mths - Sept 16	Forecast 12 mths - Nov 16	Forecast 15 mths - Jan 17	July 2016
EFFECTIVE	Requires Improvement	Evidence based care and treatment - training, communications and agreements with other organisations	G	G	G	G	G	G	G	G
		Assessment and planning of care - medical protocols, SLAs and call grading	G	G	G	G	G	G	G	G
		Response times - frontline and EOC	I	RI	RI	RI	RI	RI	RI	RI
		Patient outcomes - ROSC, cardiac patients, stroke, telephone advice and recontact rates	G	G	G	G	G	G	G	G
		Competent staff - appraisals, clinical supervision, MCA, HART competencies	RI	RI	G	G	G	G	G	RI
		Coordination with other providers - e.g. Met, 111, health and social care	G	G	G	G	G	G	G	G
		Multidisciplinary working with other providers	G	G	G	G	G	G	G	G
		Access to information via the intranet, dispatch system and in vehicles	G	G	G	RI	G	G	G	RI
		Consent, MCA and deprivation of liberty safeguards - training and capability	RI	G	G	G	G	G	G	G
CARING	Good	Compassionate care - communication with patients and maintaining dignity	G	G	G	G	G	G	G	G
		Understanding and involvement of patients and those close to them	G	G	G	G	G	G	G	G
		Emotional support to patients and carers	G	G	G	G	G	G	G	G

QIP: Expected Trajectory for Improvement

CQC Rating		Objective within the improvement plan	TDA expectations by quarter							LAS Assessment
			BASELINE CQC report	WN findings March 16	Forecast - mths	CR Findings - June 16	Forecast 9 mths - Sept 16	Forecast 12 mths - Nov 16	Forecast 15 mths - Jan 17	July 2016
RESPONSIVE	Requires Improvement	Service planning and delivery to meet the needs of local people - including surge management and triage of calls	G	G	G	G	G	G	G	G
		Meeting people's individual needs through the use of appropriate care pathways	RI	G	G	G	G	G	G	G
		Access and flow including call abandonment and deployment	I	I	I	I	RI	RI	RI	RI
		Learning from complaints and concerns	I	I	I	I	RI	RI	RI	RI
WELL-LED	Inadequate	Vision and strategy - communication to staff	I	RI	G	RI	G	G	G	G
		Governance, risk management and quality management, including risk register management, call audits and HR support for poor performance	I	RI	G	G	G	G	G	G
		Leadership - executive and local	RI	G	G	G	G	G	G	RI
		Culture within the service	I	I	RI	RI	RI	RI	RI	RI
		Public and staff engagement	G	G	G	RI	G	G	G	G
		Innovation, improvement and sustainability	G	G	G	G	G	G	G	G

QIP: Expected Trajectory for Improvement

Summary ratings	TDA expectations by quarter							LAS Assessment
	BASELINE CQC report	WN findings March 16	Forecast - 6 mths	CR findings June 16	Forecast 9 mths - Sept 16	Forecast 12 mths - Nov 16	Forecast 15 mths - Jan 17	July 2016
Safe	I	I	I	I	RI	RI	RI	RI
Effective	RI	RI	G	G	G	G	G	G
Caring	G	G	G	G	G	G	G	G
Responsive	RI	RI	RI	RI	RI	RI	RI	RI
Well led	I	I	RI	RI	RI	RI	RI	RI
OVERALL	**I**	**I**	**I**	**I**	**RI**	**RI**	**RI**	RI

QIP: Trust Board Assurance

The Board should be seeking assurance not just of the completion of actions in the improvement plan but also of the positive impact of the actions, which needs to be sustained.

In order to ensure the Trust Board are fully informed of progress, at formal meetings the following information as assurance of progress against the Quality Improvement Programme:

- monthly programme progress report
- monthly programme KPI report
- update on specific programme activity, for example: the outcome of external assurance reviews
- a RAG-rated report of progress against trajectory for each of the cells in the CQC 'grid',
- A regular report of internal assurance activities and outcomes (following the establishment of a dedicated QIP internal assurance team in July 2016)

In addition to existing assurance documentation provided, the Trust Board can request:

- An independent report or presentation from those providing external support on their findings / assessment
- Deep dive presentations on any project within the QIP
- Any other information that would be useful in obtaining assurance

QIP: Next Steps

In order to maintain the pace, focus and delivery of the Quality Improvement Programme there are a number of actions that will be taken:

- A formal review of the Programme Management Office function to ensure the resource and support remains fit for purpose
- Introduction of a dedicated QIP internal assurance team to strengthen internal assurance activities
- To begin organisational preparations for CQC reinspection
- A bi monthly review of progress against the concerns raised in the Warning Notice
- Development of a detailed action plan following the outcome of each external assurance review, to be monitored regularly by the internal governance groups
- To trial a change to the internal governance framework, by combining the monthly Quality Improvement Group and QIP Board meeting in August so that
- To deliver phase 2 of the 'Making the LAS Great' campaign, to increase communication and engagement activities with staff
- To seek feedback from the Trust Board on additional assurance measures to be implemented
- Continued engagement with staff to deliver the QIP, and monitoring of staff morale through the friends & family test, review of communications and feedback from Facebook, and other staff surveys.
- To progress top five priorities for the Trust:
    1. Leadership and Organisational Culture
    2. Medicines Management
    3. Developing as a Learning Organisation
    4. Implementation of the Make Ready pilot across the Trust
    5. Addressing workforce utilisation issues: rest breaks, job cycle time etc.

2016/17 QUALITY IMPROVEMENT PROGRAMME

Progress Report: June 2016

July 2016

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Definitions

Colour	***Project Delivery***	Colour	***Project Performance***
Blue	*All scheduled activities have been completed*		
Green	*The scheduled activities are on track for completion by the due date*	Green	*Performance has been met or is over 95% towards the agreed trajectory / target*
Amber	*The scheduled activities have been delayed and are no more than 4 weeks*	Amber	*Performance is between 85-95% towards the agreed trajectory / target*
Red	*The scheduled activities are at risk and have delays over 4 weeks*	Red	*Performance is below 85% of the agreed trajectory / target*

EXECUTIVE SUMMARY
June 2016

Progress this month

- There were high numbers of activities to be delivered in June, and programme performance for the month resulted in 88% of scheduled activities being delivered.
- The finalisation of the funding to deliver the Quality Improvement Programme remains outstanding, however discussions continue to take place with Commissioners to mutually agree a position.
- The scheduled Clinical Review visit led by NHS Improvement was completed during June, and this assurance exercise was to assess how the Trust are progressing against actions to address areas identified as requiring improvement by the CQC. The review was extensive and included the submission of documentary evidence, selected focus group sessions, site visits to stations and A&E Departments, and observational ride outs with frontline staff on shift.
- The Making the LAS Great campaign was launched across the organisation to promote the Trust vision and values and to engage staff to contribute to improvement works. The campaign also supported the recent launch of the revised appraisal process.
- A deep dive review was presented to the Clinical Quality and Review Group in June which focussed on progress on the Patient Transport Service and improvements to the care of Mental Health patients.

Theme	Executive Director	# Complete	% Complete	RAG
Making LAS a great place to work	Karen Broughton	9/10	90%	Red
Achieving good governance	Sandra Adams	16/19	84%	Amber
Improving patient experience	Briony Sloper	3/3	100%	Blue
Improving environment and resources	Andrew Grimshaw	4/5	80%	Amber
Taking pride and responsibility	Fenella Wrigley	5/5	100%	Blue

PROGRAMME SUMMARY
Forecast View

Programme:

- There are fewer activities to be delivered during July and August compared to June, however there are a high number of activities to be delivered in September. Project teams will utilise the next two months to recover any activities that are reporting as delayed and to progress activities due at the end of quarter 2.
- Following the outcome of the Clinical Review, areas noted as requiring further improvement will be reviewed and an action plan will be in place to address these issues. This will be regularly monitored by Executive Director Leads and the Quality Improvement Group
- A formal review will be undertaken in July of the Programme Management Team to ensure that the structure in place remains fit for purpose to deliver the remainder of the Quality Improvement Programme and is equipped to help the organisation prepare for a CQC reinspection.
- A deep dive review on Fleet and Logistics will be presented to the Clinical Quality and Review Group in July, with specific focus on progress made with blankets, infection control, and the outcome of the make ready pilot for vehicles in North East London.

		July 2016				August 2016			
Theme	**Executive Director**	**Complete**	**On Track**	**Delayed**	**At Risk**	**Complete**	**On Track**	**Delayed**	**At Risk**
Making LAS a great place to work	Karen Broughton		4				1		
Achieving good governance	Sandra Adams		2				2		
Improving patient experience	Briony Sloper		3						
Improving environment and resources	Andrew Grimshaw		2						
Taking pride and responsibility	Fenella Wrigley		3						
	Total		14				3		

WORKSTREAM PROGRESS REPORTS

1| MAKING THE LAS A GREAT PLACE TO WORK

Executive Lead: Karen Broughton

HIGHLIGHTS THIS MONTH

Recruitment

- To ensure the LAS is promoted as a prospective employer to graduate paramedics, and to build a future pipeline of recruits, the clinical tutors based at the four partnership universities have been taking forward key messages as part of the 'keep in touch sessions' to build relationships with trainee paramedics

Bullying and Harassment

- The agreed target to provide 400 staff with bullying and harassment awareness training across the Trust has been achieved, and was exceeded at the end of June.
- An introduction to mediation workshop was held in June, and 60 staff from across the service the Service attended. Mediation training will promote a new way of working, including courageous conversations which is a skills based course to help staff learn how to facilitate difficult messages in a positive way and will empower staff to resolve issues as soon as they arise.
- In addition, there will be practical mediation skills training workshop made available to staff over the coming months.
- 38 staff have completed the Investigations Training conversations workshops

Training

- The new corporate induction programme has been completed and all new inductions will be conducted using the new format from July onwards. A dedicated Induction Administrator has been appointed who will be the main point of contact for the induction process across the Trust. The new format includes an element of eLearning, however once OLM is in place this will be replaced with some further elements around the vision and values of the Trust. All presentations are now in a standard format aligned with the corporate branding and hand outs new recruits require are accessible via the Trust intranet.

1| MAKING THE LAS A GREAT PLACE TO WORK

Executive Lead: Karen Broughton

HIGHLIGHTS THIS MONTH

Equality and Inclusion

- A new interim Equality and Inclusion Manager has been appointed, who will be working for the Trust on a part time basis. The focus of this role is address the Equality and Inclusion concerns raised in the CQC report, specifically to undertake a baseline assessment of the Trust position, to review current recruitment and promotion practices to ensure best practice and compliance with legislative requirements. It is anticipated that there will be short term delays in delivering these activities with the recent introduction of the Equality and Inclusion Manager, therefore they will form an initial view on the Trust position and QIP activities may be developed accordingly.
- A review of the Workforce Race Equality Standard is currently being completed and will be submitted in July 2016 in alignment with the national deadlines.
- Equality and Inclusion training was included as part of the statutory and mandatory training matrix launched in May. This is an online elearning module, and reporting completion of this training will be included in the QIP KPI report following implementation of the new system to capture and record staff training in September 2016

Staff Recognition and Engagement Plan

- The 2016/17 staff recognition and engagement plan has been approved by both the Director of Transformation and Strategy and Director of Communications . This will be made available to staff from the Trust intranet site.

1| MAKING THE LAS A GREAT PLACE TO WORK
Progress – June 2016

Deliverable	Lead	June 2016 Complete	June 2016 Delayed	June 2016 At Risk
Advert to Action (Recruitment)	Julie Cook	1		
Bullying and Harassment	Karen Broughton	3		
Training	Karen Broughton	1		
Equality and Inclusion	Andrew Buchannan	1		
Vision and Strategy	Karen Broughton			
Supporting Staff	Karen Broughton	2		
Retention	Greg Masters			1
Workforce and Organisational Development	Karen Broughton			

Outstanding actions
At Risk • *Negotiate the funding for 'The London Package' as part of contracting round 2016/17* Discussion and negotiations continue with Commissioners and it is anticipated that the contract will be agreed as soon as possible.

1| MAKING THE LAS A GREAT PLACE TO WORK
Forecast View

Focus for next month	Key risks and challenges
• A two-day complex investigation training session has been created, and has been designed to assist all staff in the facilitation of robust investigations across the Trust • Continued work to reaffirm the Trust vision and values across the organisation and to drive the completion of 100% of personal development reviews for all corporate services by the end of July	• Operational pressures mean that some staff who wish to attend the workshops are currently unable to, however the B&H Specialist is working with the Assistant Directors or Operations for each of the sector groups to address this

Deliverable	Lead	July 2016				August 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Advert to Action (Recruitment)	Julie Cook						1		
Bullying and Harassment	Karen Broughton								
Training	Karen Broughton								
Equality and Inclusion	Andrew Buchannan		2						
Vision and Strategy	Karen Broughton		2						
Supporting Staff	Karen Broughton								
Retention	Greg Masters								
Workforce and Organisational Development	Karen Broughton								

2| ACHIEVING GOOD GOVERNANCE

Executive Lead: Sandra Adams

HIGHLIGHTS THIS MONTH

Risk Management

- The latest audit identified that 87% of risk registers were RAG rated as green, which demonstrated that high quality registers were recently updated and have been maintained, appropriate mitigating actions identified and consistent scoring applied. Work is being undertaken with the risk owners of the 13% which were not green and this is also highlighted through Risk, Compliance and Assurance Group (RCAG) and the Executive Leadership Team (ELT).

Capacity and Capability of Health, Safety & Risk Function

- As reported last month, the backlog of incident reports was cleared a month ahead of schedule and the team continue to process incident reports as and when they are received to prevent a backlog building up again.
- The Health & Safety consultation was not launched in June, however job descriptions are being written and will be submitted for banding. It is the intention the consultation will be launched in July and brought back on schedule for implementation by the end of September.

Improving Incident Reporting

- The Health and Safety Team produced and published a newsletter on 16/06/2016. This newsletter included information on fire safety, manual handling, display screen equipment at work and how to access further Health and Safety training on e-learning
- LA52 availability inspections were undertaken by QGAMs in each area with pads available on all stations and vehicles that were inspected except two vehicles which were addressed at the time.
- The single point of access for incident reporting was launched on 27 June. It has been launched on an 8am-8pm basis for 4 weeks whilst the team embeds the new processes and will then roll out further to become a 24 hour service. The service will have quarterly reviews to assess call volume, team capacity and what impact this service is having on incident reporting.
- Datixweb training has now been delivered to 240 staff out of 350 who require the training. Further sessions are being offered throughout July at different sites across LAS. The training delivery will be reviewed at the end of July to identify any gaps and what else can be done to address those gaps.
- Communications on the Trust's new incident management processes has been included in the RIB every week and a case study is being developed to be published in July.

Duty of Candour

- Information on Duty of Candour has been in the RIB and on the LIA facebook page. Work is now proceeding to design a leaflet which will be attached to all payslips during Q2

2| ACHIEVING GOOD GOVERNANCE

Executive Lead: Sandra Adams

HIGHLIGHTS THIS MONTH

Operational Planning

- A formal review of the Out of Service Policy has been undertaken by a cross-organisational working group. This policy revision has identified a minimum equipment list for vehicles, refined the definition of the Out of Service codes to provide greater clarity which will allow us to more accurately assess what is most commonly leading to vehicles going out of service.
- The review of the rest break policy is being reviewed by the Executive Leadership Team and recommendations will be agreed to be taken forward

Listening to Patients

- We now report on activity, throughput performance and emerging themes in relation to complaint feedback to the Improving Patient Experience Committee. We triangulate a variety of qualitative measures including reporting on changes that have been achieved arising from complaints, with case examples, and the outcome of cases that have been referred to HSC. We are also now starting to report in more detail about where cases are upheld or partially upheld.
- Discussions have been held with local operational management teams to ensue that complaint feedback is always provided to staff, particularly where wider learning has been identified. We are also devising a systematic approach to improve the reporting of actions taken by local teams as part of the Trust's move towards better evidencing of outcomes across all feedback mechanisms. This will be further supported by Datix going forward.

Preparing for the next CQC inspection

- A Clinical review was undertaken by NHS Improvement, and in preparation for this a range of communications had been arranged and a series of unannounced inspections were carried out. The majority of these unannounced inspections were positive and any concerns were escalated to relevant managers

Internal Audit

- Internal Audit recommendations were reported to the Executive Leadership Team in June and for the first time all outstanding and overdue actions were completed.

Policy & Guidance Review

- The terms of reference for the new Policy group have been written and the group met for the first time on 5th July. The group will manage the process for updating out of date policies and will ensure they are reviewed in a timely manner going forward. The group will also give a steer to policy owners about how extensive a review they expect.

2| ACHIEVING GOOD GOVERNANCE
Progress – June 2016

Deliverable	Lead	June 2016 Complete	June 2016 Delayed	June 2016 At Risk
Risk Management	Sandra Adams	2	2	
Capability and capacity of Health, Safety and Risk function	Sandra Adams	1	1	
Improving incident reporting	Sandra Adams	5		
Duty of Candour	Sandra Adams	1		
Operational planning	Paul Woodrow	1		
Listening to patients	Fenella Wrigley	2		
Blue light collaboration	Karen Broughton			
CQC reinspection	Fionna Moore	1		
Business intelligence systems	Jill Patterson			
Internal audit	Sandra Adams	1		
Policy and guidance review	Sandra Adams	1		

Outstanding actions

Delayed

- ***Complete a strategic risk review of the Trust risk register***
  This was set to be discussed and completed at a Trust Board meeting at the end of June however had to be delayed due to other organisational priorities. A meeting will be rearranged to complete this action.

- ***Risk management training for NEDs and Executive Directors***
  A skills audit for the Trust Board is underway, therefore it is proposed that requirements for risk management training is aligned with this and deliver of this activity moved to September. A change request has been prepared.

- ***Commence staff consultation on proposed changes to Health and Safety function***
  The launch of the consultation with the Health and Safety team was not completed in June, however is due to be launched in July.

2| ACHIEVING GOOD GOVERNANCE

Forecast View

Focus for next month	Key risks and challenges
• Ensure that all delayed actions from June are recovered and brought back on track to ensure no further delays • To progress activities that are scheduled for delivery in September actions to prevent any delays	• No specific risks to July and August delivery

Deliverable	Lead	July 2016				August 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Risk Management	Sandra Adams								
Capability and capacity of Health, Safety and Risk function	Sandra Adams								
Improving incident reporting	Sandra Adams		1				1		
Duty of Candour	Sandra Adams								
Operational planning	Paul Woodrow								
Listening to patients	Fenella Wrigley								
Blue light collaboration	Karen Broughton								
CQC reinspection	Fionna Moore								
Business intelligence systems	Jill Patterson								
Internal audit	Sandra Adams								
Policy and guidance review	Sandra Adams		1				1		

3| IMPROVING PATIENT EXPERIENCE
Executive Lead: Briony Sloper

HIGHLIGHTS THIS MONTH

Meeting People's needs – Bariatric Patients

- The multidisciplinary bariatric working group, which includes a patient representative, has continued to meet. The group has been analysing serious incidents reported and the Trust Health and Safety data to understand any issues that have been raised for both patients and staff in the respect of caring for bariatric patients and manual handling.
- The group has been working with the Business Intelligence team to develop a baseline of Trust data to understand the number of bariatric patients currently accessing the service and plan accordingly. There is also work to forecast the potential number of patients for the next 3-5years using data from NHS England and Public Health England. The Business Intelligence team are looking into an alternative model to determine levels of activity, by focusing geographically on the prevalence of obesity in the London population as opposed to LAS activity alone .
- Based on available data, it is estimated that the LAS receives an average of approximately 1.5 calls from bariatric patients per day. The group has identified the current inadequacy of data and the need for a more robust process for collecting data in relation to this patient group is required. Any change of data collection process at call taking may impact on call taking performance and may require changes to the CAD system. Consideration will also be given to changing the current PRF so that additional data about this patient group can be collected and analysed retrospectively.
- Updated clinical guidance has been prepared by the LAS Senior Clinical Advisor, and the implication of implementing the policy in relation to airway management, staff training requirements, and procurement of equipment is under review by the bariatric working group. The guidance provides a definition for bariatric patient to LAS staff when considering the needs of the patient.
- A clinical aide memoire for inclusion in the LAS mobile app is also in development. This aid memoire will support staff with advice on how to manage the patient until transport arrives (if required).
- In view of the current estimated patient numbers and the new guidance, consideration will be given to optimising the Trust's existing resources whilst more reliable and accurate data becomes available on current patient volumes. The group has commenced the review of specialist equipment currently available, and this will inform our need to provide training, or to procure any addition equipment or vehicles .

3| IMPROVING PATIENT EXPERIENCE
Executive Lead: Briony Sloper

HIGHLIGHTS THIS MONTH

Patient Transport Service

- The engagement with the stakeholders is complete. St Joseph's Hospice in E8 has been confirmed as the pilot site for pre booking palliative care patients
- The commencement of the pilot has been slightly delayed whilst final arrangements were confirmed with the Hospice, and the pilot is expected to start at the beginning of July. The pilot will operate for two weeks to identify any modifications required to the booking process, prior to a pan London roll-out planned by the end of July (as per milestone).
- The Non Emergency Transport Service is already delivering a number of palliative care journeys captured through the Healthcare Professional line in the Clinical Hub.

Response times

- Following the hospital hand over workshop at the end of February hosted by representatives from Commissioning Groups, the Director of Operations and the Head of Delivery and Development, North West London are meeting on a monthly basis and have developed an action plan to address ongoing issues. Updates on progress against the plan are provided the Regional Oversight Group.

Patient engagement strategy

- This updated document in on track for presentation at the Executive Leadership Team meeting, and relevant sub committees of the Trust Board. In addition, the strategy will be shared with Trust board members for initial comment to ensure that the strategy is reviews and approved at the public board meeting in July .

3| IMPROVING PATIENT EXPERIENCE
Progress – June 2016

Deliverable	Lead	June 2016 Complete	June 2016 Delayed	June 2016 At Risk	Outstanding actions
Patient Transport Service	Paul Woodrow	1			
Meeting peoples needs	Briony Sloper/ Paul Woodrow	1			
Response Times	Paul Woodrow	1			
Learning from experiences	Briony Sloper				

3| IMPROVING PATIENT EXPERIENCE
Forecast View

Focus for next month	Key risks and challenges
• The roll out of the pan- London process for pre-booking palliative care patients • Work with fleet, operations and clinical education has already started to scope any implementation plans and require training in respect of new processes or vehicles. • The patient engagement strategy is due to go to Trust Board at the end of July	• Lack of participation of providers using the pre-booking option for palliative patients • Summer holiday annual leave impacts on communication with providers on the roll out for the palliative care pilot. • Additional recruitment required to back fill for those NETS crews taking a development option and moving to a TEAC role. • Lack of robust data on number of patients means that there could be an over or under estimation of the requirements for bariatric patients

Deliverable	Lead	July 2016				August 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Patient Transport Service	Paul Woodrow		1			No milestones for Theme 3 in August 2016			
Meeting peoples needs	Briony Sloper / Paul Woodrow		1						
Response Times	Paul Woodrow								
Learning from experiences	Briony Sloper		1						

4| IMPROVE ENVIRONMENT AND RESOURCES
Executive Lead: Andrew Grimshaw

HIGHLIGHTS THIS MONTH

Fleet/Vehicle Preparation: Workshops
- The zero tolerance maintenance work continues to be carried out with over 600 jobs completed in the period November 2015 to May 2016. The number of zero tolerance jobs has steadily declined from 136 jobs in November 2015 to 78 jobs in May 2016 with processes now embedded and working.

Infection Prevention and Control
- Review of the protective clothing pack contents is now complete with recommendations from Infection Prevention and Control team included. 750 packs have been ordered with deliveries commencing in early July for implementation. It is anticipated the roll out will be completed by the end of September 2016.

Facilities and Estates
- Approval has been granted for contractor services to proceed with the cleaning of garages. The roll out of the extended cleaning services has commenced with 67% of sites now compliant, and an expectation that the roll out will be completed by the end of August 2016.
- Internal audits against the new cleaning specification have commenced and results will be available from mid July.

Information Management and Technology
- An additional electronic review of current provisions of IMT on station has been completed.
- Review of options to improve access to hot desk areas and assessment of personal issues electronic devices will now be completed and presented to the Executive Leadership Team in July.

Operations Management
- The Operations Management review was completed, and presentation pack has been developed outlining the impact of the new management structure which was presented to the Executive Leadership Team on 29 June. The next steps is to develop a project plan and the Executive Leadership Team will be provided with monthly updates on progress.

Fleet/Vehicle Prep: Vehicle Make Ready
- An evaluation report of the North East Pilot is complete, and the Business Case is now under development to support roll out of the Hub model to remaining sites. Project planning continuing with governance structures established.

4| IMPROVE ENVIRONMENT AND RESOURCES
Progress – June 2016

Deliverable	Lead
Fleet / Vehicle Preparation	Andrew Grimshaw
Information Management and Technology	Andrew Grimshaw
Infection prevention and control	Fenella Wrigley
Facilities and Estates	Sandra Adams
Resilience functions	Paul Woodrow
Operations Management	Paul Woodrow
Improving operational productivity	Paul Woodrow
Cost improvement programme	Andrew Grimshaw
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw

June 2016		
Complete	Delayed	At Risk
1		
	1	
1		
1		
1		

Outstanding actions

Delayed

- ***Scope options to improve access including the assessment of personal issue of electronic device which will allow staff to access information remotely***

  This milestone will not be achieved due to other priorities within the IM&T team. The options paper will be completed and presented to the Executive Leadership Team in July. A change request will be submitted to the QIP Board to realign subsequent activities in light of this delay.

4| IMPROVE ENVIRONMENT AND RESOURCES
Forecast View

Focus for next month	Key risks and challenges
Fleet/Vehicle Prep: Make Ready: Continue project planning activities relating to the Vehicle Preparation, and development of the Vehicle Preparation Business Case. **Vehicle Procurement:** Continue to work with FRU supplier to deliver vehicles in accordance with the revised production plan. Approval being sought for the DCA business case. **Information Management &Technology:** Ensure the scope of options is completed and presented to the Executive Leadership Team, and to prepare business case to agree preferred option. **Infection Control and Prevention:** Begin roll out of agreed protective clothing packs	• **Information Management & Technology:** A risk that other priorities within IM&T team causing delay the completion of options paper and business case. • **Procurement of Fast Response Units –** This remains a challenge due to deadline and on-going issues with supplier. A revised production plan in place, with an agreed timeline for delivery extended to September 16. • **Double Crew Ambulance –** Final approval of business case has not been received from NHSI. Until approval received, a final date of delivering of 140 vehicles has not yet been confirmed

Deliverable	Lead	July 2016				August 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw		1			No milestones for Theme 4 in August 2016			
Information Management and Technology	Andrew Grimshaw			1					
Infection prevention and control	Fenella Wrigley								
Facilities and Estates	Sandra Adams								
Resilience functions	Paul Woodrow								
Operations Management	Paul Woodrow								
Improving operational productivity	Paul Woodrow								
Cost improvement programme	Andrew Grimshaw								
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw								

5| TAKING PRIDE AND RESPONSIBILITY
Executive Lead: Fenella Wrigley

HIGHLIGHTS THIS MONTH

Clinical supervision

- A draft audit tool to assure the compliance and quality of OWRs (Operational Workplace Reviews) has been designed by the Consultant Paramedics in collaboration with the Operations Directorate. The process will involve three auditors who will who independently review and assess completed OWRs, and the outcome of the audit will be reported and shared appropriately with managers.
- The Deputy Director for Clinical Education and Standards has made a recommendation to reintroduce tutors to complexes, and these team members could help support the Clinical Team Leaders in completing OWRs.
- Operations continue to monitor numbers of completed OWRs (149 OWRs completed in June)

Medicine Management

- A review of eLearning materials is now underway to assess the quality and ongoing suitability.
- Further communication on Medicine Management was included in the latest edition of LAS news and the Routine Information Bulletin (RIB) which included operationally led articles highlighting the progress being made in improving medicines management and changes to the revised medicines management policy.
- A visual field guide or "card" has been developed and has been added to the LAS mobile app and the LAS Facebook pages.
- The Incident Response Officers (IROs) are undertaking regular unannounced station visit to review medicines management compliance , and the outcome of each visit are shared with sector Assistant Directors of Operation (ADOs) and Quality Governance Assurance Managers (QGAMs) to take action as necessary. The number of stations reporting full compliance with medicines management compliance is increasing, and there is focussed action to address stations where there is a shortfall to achieving full compliance.
- An initiative identified by Greenwich station to improve the management of station based drugs is due to commence, and this will be trialled for four weeks followed by an evaluation to determine the effectiveness and feasibility of implementing changes widely across the Trust.

Safeguarding:

- EOC Safeguarding Training is already underway as content is included in the current EOC CSR1.2016.
- CSR safeguarding training is planned for the last CSR (3.2016) this year.
- Delivery of annual safeguarding training to staff within Patient Transport Service and Non-Emergency Transport service is also already under way in the current CSR.
- Between April and June 74 staff attended CSR and 31 new staff were trained.
- Following the delivery of safeguarding training, a self assessment tool has been developed to enable the safeguarding team to determine staff knowledge and understanding of handling safeguarding issues.
- On-going attendance at local safeguarding boards, social services and key stakeholders in conjunction with quality governance assurance managers and stakeholder engagement managers is taking place and progress reported to Quality committee and commissioners monthly.
- The recruitment for additional safeguarding supervision staff continues to progress, however there is a reported delay due to the unavailability of the candidate until the end of July.

5| TAKING PRIDE AND RESPONSIBILITY
Progress – June 2016

Deliverable	Lead	June 2016 Complete	June 2016 Delayed	June 2016 At Risk
Clinical supervision	Fenella Wrigley			
Consent MCA	Fenella Wrigley			
Medicine Management	Fenella Wrigley			
Safeguarding	Fenella Wrigley	5		
Quality and clinical strategy	Fenella Wrigley			
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton			
Developing the 111 Service	Paul Woodrow / Karen Broughton			

Outstanding actions

- There are no outstanding actions

5| TAKING PRIDE AND RESPONSIBILITY
Forecast View

Focus for next month	Key risks and challenges
• To scope and review the current process for carrying out of routine checks of drug locker security. • The completion of the quality and clinical strategy for ratification by the Executive Leadership Team and the Trust Board.	• There is a current delay to the implementation of the safeguarding supervision model, due to the unavailability of the recently appointed individual who is responsible for developing the scope of how the model will be delivered. A commencement date of 18/06/2016 has been confirmed and a change request will be presented to the QIP Board to agree the delayed delivery of the supervision model.

Deliverable	Lead	July 2016				August 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Clinical supervision	Fenella Wrigley					No milestones for Theme 5 in August 2016			
Consent MCA	Fenella Wrigley								
Medicine Management	Fenella Wrigley		1						
Safeguarding	Fenella Wrigley			**1**					
Quality and clinical strategy	Fenella Wrigley		1						
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton								
Developing the 111 Service	Paul Woodrow / Karen Broughton								

RISKS AND ISSUES

Risk ID	Risk Description	Gross	Existing Controls (Already In Place)	Risk Owner	Net	Further Actions Required	Action Owner	Date Action to be Completed	Assurance Measures	Target Rating
00-01	The programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support	15	• * In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17 • * A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders • * A PMO has been established that will central monitor and review programme progress	Karen Broughton	12	* Executive Leads to regularly review upcoming activities, and to give an early indication of any potential risk to delivering project outcomes and to take steps to mitigate the risk or to escalate the matter to the QIG to seek assistance to resolve * Programme KPIs have been set and should be regularly monitored by Executive Leads * In April, Executive Leads have been asked to consider bringing forward activity which may have a positive impact on staff	QIP Exec Leads	ongoing - monthly review	• All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time	6
00-02	The programme fails to engage stakeholders on the organisational changes taking place	12	• * In January 2016, the QIP narrative and milestone plan was published externally / internally and key stakeholders will have visibility of activities to be delivered as part of the QIP. • * Stakeholders should be engaged early on in the process through the Quality Summit and LAS should seek to agree commitments • * A communication and stakeholder engagement plan has been drafted to support the work of the QIP to ensure regular updates are provided to our stakeholder groups.	Karen Broughton	8	• Executive Leads to regularly review upcoming activities, and to give an early indication to stakeholders of their input required and to ensure there are mechanisms in place to communicate and consult on required changes.	QIP Exec Leads	ongoing - monthly review	• All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time	4

RISKS AND ISSUES

Risk ID	Risk Description	Gross	Existing Controls (Already In Place)	Risk Owner	Net	Further Actions Required	Action Owner	Date Action to be Completed	Assurance Measures	Target Rating
00-03	Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable.	16	• Indicative costs have been identified by each of the project workstreams, and will form the basis of contract discussions with Commissioners which is currently underway. However these costs may be subject to change as projects progress delivery of activities, and the outcome following option appraisals may require funding that was not known at the outset	Andrew Grimshaw	12	• * Executive Leads to consider other means of funding initiatives through existing budget or cost savings. If this is not possible, then a robust justification to be provided to ELT for further consideration • * Ongoing discussions and refinement of the funding bid with Commissioners • * As a result of this ELT review and commissioner conversations, any potentially unfunded activities that cannot be delivered will be raised urgently with ELT and the QIP Board	QIP Exec Leads	30 June 2016	• ELT have considered all requests for funding, and prioritised these into a funding bid to Commissioners. • Exec discussions with lead Commissioner and SRG leads are ongoing. • Programme finances will be a regular agenda item to be reviewed by ELT and QIP Board	9
00-04	Activities delivered as part of the QIP does not result in the impact anticipated or meet performance targets	12	• * In developing detailed project plans, Executive Leads should consider any dependencies that would negatively impact on the delivery or performance of their projects and to address any issues at an early stage • * The TDA Improvement Director is in post and has regular meetings with the CEO and Programme Director on QIP performance 11/05/2016 Each sector within the organisation are required to develop a local action plan to deliver the QIP and progress will be reviewed on a monthly basis	Executive Leads	8	• * Executive Leads to ensure full compliance of project deliverables to ensure maximum benefits are realised • * Executive Leads to regularly monitor KPIs and the outcome of audits, and to take action if data indicates unfavourable performance • * NHSI Clinical Review planned in June 2016 to seek assurance of the Trust's progress in addressing concerns raised by the CQC • * Monthly assurance visits planned with Commissioners from June 2016, and scheduled CQRG deep dive reviews on each of the QIP themes	QIP Exec Leads	ongoing - monthly review	• Internal and external assurance groups within the governance of the QIP in place to provide challenge to Executive Leads to ensure that tangible outcomes are achieved to time • The QIP KPI report has been developed to provide assurance and performance against delivery of QIP activities • The QIP internal assurance programme agreed with CQRG will ensure a programme of specialist inspections across the Trust • NHS Improvement (TDA) completed a review of progress against the CQC Warning Notice in March 2016. Feedback from the review has been considered and included in ongoing delivery of the QIP	6

RISKS AND ISSUES

Risk ID	Risk Description	Gross	Existing Controls (Already In Place)	Risk Owner	Net	Further Actions Required	Action Owner	Date Action to be Completed	Assurance Measures	Target Rating
00-05	Imposition of nationally driven directives could divert focus and resources from delivering the QIP	12	* ELT are apprised of intended changes to national standards for A8 performance and resourcing for HART	Executive Leadership Team	9	* Proactive planning to prepare the organisation for likely changes should be initiated as soon as possible, including identification of key stakeholders and resources likely to deliver the change * Regular discussions to take place with NHSE / Commissioners / AACE / NARU of the possible implications on the QIP to deliver national directives	ELT	ongoing - monthly review	Once national requirements are known, ELT should assign an Executive Lead to take action and progress should be monitored regularly to ensure organisational obligations are met	6
00-06	The programme fails to provide external stakeholders relevant levels of assurance in relation to the delivery of the QIP	9	* a review of the CQC Warning Notice is being undertaken in preparation for the TDA audit on 16/03/2016 * The TDA Improvement Director is in post and has regular meetings with the CEO and Programme Director on QIP performance 11/05/2016 * a NHSI-led review of the CQC Warning Notice was completed on 16/03/2016 and a further clinical review to be completed in June 2016	Karen Broughton	6	* regular assurance reporting is provided to the ROG and CQRG * A schedule of QIP audit is in the process of development which will provide assurance of compliance and demonstrate the impact activities are having on operational areas	Karen Broughton	ongoing - monthly review	All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time	6

RISKS AND ISSUES

Risk ID	Risk Description	Gross	Existing Controls (Already In Place)	Risk Owner	Net	Further Actions Required	Action Owner	Date Action to be Completed	Assurance Measures	Target Rating
00-07	The Trust is not prepared for the CQC reinspection or other external assurance audit.	9	* In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17 * A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders * A PMO has been established that will central monitor and review programme progress	Fionna Moore	6	* Executive Leads to regularly review upcoming activities, and to give an early indication of any potential risk to delivering project outcomes and to take steps to mitigate the risk or to escalate the matter to the Quality Improvement Group (ELT) to seek assistance to resolve * A schedule of QIP audit is in the process of development which will provide assurance of compliance and demonstrate the impact activities are having on operational areas * ELT to take priority action following the outcome of any audits or mock inspections	ELT	ongoing - monthly review	All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time	6
00-08	There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead	16	LAS are aware of discussions to date and further information will be available as to whether the industrial action will eventuate following a ballot on 31/05/2016	ELT	16	Trade unions are required to provide 6 weeks notice from when a decision has been made, which will trigger activation of Trust protocols and plans will be developed	ELT	30/09/16	An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Board	9

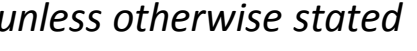
2016/17 QUALITY IMPROVEMENT PROGRAMME

KPI Report: June 2016 Performance

July 2016

Definitions

Green	*Performance has been met or is over 95% towards the agreed trajectory / target*
Amber	*Performance is between 85-95% towards the agreed trajectory / target*
Red	*Performance is below 85% of the agreed trajectory / target*

Note: *Information presented is up to 25th of the month. (unless otherwise stated) and is subjected to validation.*
Previous months position is updated to reflect the entire month.
Please note that this report relates to performance throughout  *June 2016 unless otherwise stated*

Executive Summary

Areas where we achieved good performance:

- Performance relating to workforce continues to achieve set trajectories and targets, and the number of frontline leavers is considerably lower than planned over the last three months.
- Staff sickness rates continues to remain below the target of 5.5% since December 2015. It is anticipated that additional actions in the Quality Improvement Programme and CQUINs will contribute to a continued decrease in sickness rates.
- The number of staff that attended Bullying and harassment workshops has exceeded the target to provide training to 400 participants. Specialist training provided to bullying and harassment investigators also exceeded the QIP target. A total of 39 staff have been trained to date with further sessions planned.
- Attendance at the current Core Skills Refresher course to date has shown 81% of frontline staff has attended, which is on track to meet the target of 85% by the end of July.
- Members of the Executive Leadership Team have continued to maintain regular visits to their allocated area during June, particularly during the campaign launch of Making the LAS Great across the organisation in June.
- 100% of Serious Incidents (SIs) have been consistently reported on STEIS within 48 hours of declaration over the last three months
- A total of 92% of frontline staff have received training in relation to Duty of Candour training. With the introduction of the statutory and mandatory training matrix in June, data will soon be reported on the number of support staff who are completing Duty of Candour training through the online module.
- There were two Emergency Operations Centre (EOC) management surgeries held in June, and these sessions are made available to staff to speak to EOC senior management team.
- The target for the Patient Transport Team to ensure patients do not wait longer that the 60min contracted timeframe is consistently achieved, and the friends and family test results have shown that 100% of patients would recommend the service.
- Disregarding exceptional weather experienced in in June, the Make Ready vehicle preparation team in North East London continue to maintain high compliance with vehicles entering the clean and equip process and having all essential kit available.
- The fleet and logistics team have met, and in most cases exceeded, their required targets to achieve vehicle deep cleans and maintenance works.
- Since the introduction of recording drug bag numbers onto PRFs in April 2016, the Trust has continued to consistently achieve favourably over target.

Executive Summary

Additional focus is still required in the following areas:

- Results of the Friends and Family Test for the first quarter of 2016/17 are not yet available, however should be reported from next month. Results to date indicate that only a quarter of those who provided feedback would recommend LAS as a place of work. Priorities for the Quality Improvement Programme is to deliver activities that will have the most positive impact on staff, however we will continue to seek feedback from staff to identify how this rating can be improved.
- The number of appraisals completed to date still remains below trajectory, however there was an 8% increase completed in June compared to May which is encouraging. Support staff have been provided a timeframe to complete their appraisal by the end of July 2016, therefore a considerable increase in performance is anticipated in next month's report.
- Although there has been focussed effort to ensure timely investigations and reports following a serious incident being declared, this has been heavily impacted by a backlog of cases and the capacity of both investigators and Executive Directors to complete the reviews. This issue is regularly raised at Executive Leadership Team meetings ensure there is a clear timetable to resolve overdue investigations.
- As the DatixWeb system continues to be embedded within the organisation, there is clear increase of both patient and staff incidents being reported onto the system in June compared to the previous two months. This will continued to be monitored to ensure the agreed target of 85% is met on a routine basis.
- Complaints responded to over the 35 day target, have steadily decreased since April. We are still noticeably underperforming against this KPI
- There has been no change reported in the performance of handover to green times, and over the last 10 weeks the Trust has lost a total of 1,110 hours at hospital handover. The Director of Operations is working closely with NHS Improvement to address hospital handover issues and progress is reported regularly to the Regional Oversight Group. In addition, an external review of job cycle time has been completed and recommendations of this review are being considered in relation to next steps.
- During June, 93.5% of HART shifts had been filled however the contingency plans the Trust has in place did not have to be enacted as the two HART teams maintained a minimum of ten officers on duty.
- There is still a reported shortfall of eligible Patient Report Forms (PRFs) that are audited monthly. Overall completion has decreased slightly on last month, but remains very high at the vast majority of Group Stations.
- To encourage improved completion rates of Operational Workplace Reviews, focussed attention will be applied by local managers to ensure the completion rate improves as per agreed trajectories.

Performance Dashboard

Theme	Key performance indicator	RAG	Page
Making the LAS a great place to work	Frontline recruitment	Green	8
	Staff recommending LAS as a place to work on Family & Friends test	Red	
	Frontline starters	Green	
	Frontline leavers	Green	
	Paramedics starters	Green	9
	Trainee Emergency Ambulance Crew (TEACs) starters	Green	
	Staff(all) turnover	Green	
	Staff Sickness	Green	
	Bullying and harassment workshops	Green	10
	Bullying and harassment cases resolved within 28 days	Jul 2016	
	Staff trained in bullying and harassment investigations	Green	
	Clinical staff will have completed their Core Skills Refresher (CSR training)	Green	
	Staff with all training recorded on an online system	Oct 2016	11
	Appraisal Rates from April 2016	Red	
	Planned Director visits take place	Green	

Performance Dashboard

Theme	Key performance indicator	RAG	Page
Achieving good governance	Updated local risk registers		12
	Managers trained in risk management		
	Completed investigations and reports within 60 working days of a serious incident being declared		
	Percentage of Serious Incidents (Sis) reported on STrategic Executive Information System (STEIS) within 48 hours of being declared		13
	Patient safety incidents reported on DatixWeb within 4 days of incident occurring		
	Staff safety incidents reported on DatixWeb within 4 days of incident occurring		
	Frontline Staff trained on Duty of Candour		
	Complaints response (Over 35 days)		14
	Emergency Operations Centre (EOC) management surgeries held		
	Staff taking a rest break during shift	Q2 2016	
Improving patient experiences	Patient Transport Service patients will not wait longer than the 60 minute contracted departure window		15
	Handover to Green takes place within 15 minutes		
	Number of hours lost for arrival to Handovers Over 15 minutes – LAS		
Improving environment and resources	Available vehicles that enter the clean and equip process in the North East area pilot		16
	Available vehicles that are made ready with essential kit in the North East area pilot		
	Available vehicles that enter the clean and equip process across the Trust	Q2 2016	
	Available vehicles that are made ready with essential kit across the Trust	Q2 2016	

Performance Dashboard

Theme	Key performance indicator	RAG	Page
IMPROVING ENVIRONMENT AND RESOURCES	Vehicle deep clean completed as a rolling average every 6 weeks		17
	12 week cycle planned maintenance / servicing to be completed against schedule		
	Planned maintenance of vehicles to be completed within 48 hour target		
	Unplanned jobs (defects) to be completed within 48 hours		
	Minimum of 4 blankets available at start of shift	Q2 2016	18
	Number of double crewed ambulances available against peak vehicle requirements		
	Number of station premises cleaning compliance audits are passed	Q2 2016	
	Hazardous Area Response Team (HART) shifts fully staffed with 6 officers per team 24/7		19
TAKING PRIDE AND RESPONSIBILITY	Number of eligible Patient Report Forms (PRFs) audited per month		20
	Percentage of staff trained to the appropriate safeguarding level by year end		
	Frontline staff having two Operational Workplace Reviews (OWRs) completed per year		
	Compliance with completion of drug pack forms	Q2 2016	21
	Audited Patient Report Forms (PRFs) with drug bag numbers recorded if applicable		
	Percentage compliance of drug code changes		

1| MAKING THE LAS A GREAT PLACE TO WORK

Frontline recruitment

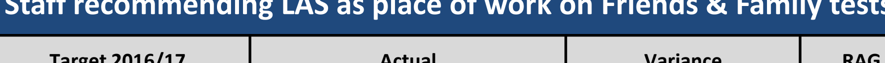
Target 2016/17	Actual	Variance	RAG
3193 wte	3114	79	

Operational (in post less T&S) | Training & Supervision (GRS and Training) | Gap | Recruitment target (95% Op Est)

This graph shows our operational staff in post by month, including those in training and supervision. Our full establishment is 3,361 and we have a recruitment target of 3,193. This represents 95% of the establishment as we account for a 5% vacancy factor.

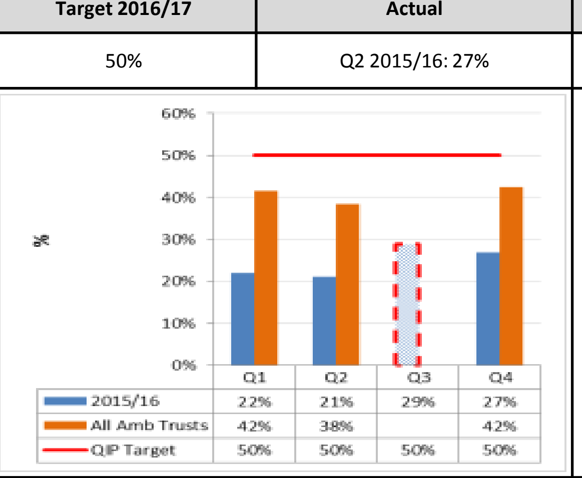
Ops and Recruitment will be attending a recruitment job fair on the 6th July where we will be able to showcase the roles we currently have to offer.

Recruitment and Ops are working with local schools in and around London to highlight careers within the Trust and we have a "careers fair" on the 13th July.



Staff recommending LAS as place of work on Friends & Family tests

Target 2016/17	Actual	Variance	RAG
50%	Q2 2015/16: 27%	23%	



	Q1	Q2	Q3	Q4
2015/16	22%	21%	29%	27%
All Amb Trusts	42%	38%		42%
QIP Target	50%	50%	50%	50%

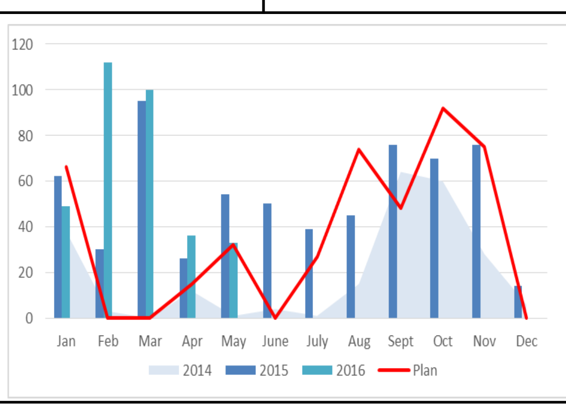
Data showing here is for 2015/16 as a baseline for the 2016/17 reporting period.

The deadline for staff to complete the Q1 survey is 28th June 2016. Results should be available in the next report.

Note: this survey is not completed during Q3 as this coincides with the National Staff Survey.

Frontline starters

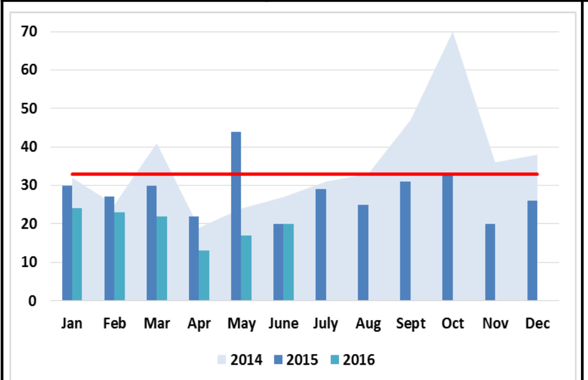
Planned – June 2016	Actual	Variance	RAG
0 wte	0 wte	0 wte	



There were no frontline starters in June as per the 2016/2017 plan.

Frontline leavers

Target 2016/17	Actual	Variance	RAG
33 wte (12% turnover)	20	13	



There were 20 wte frontline leavers in June.

16 were resignations (unplanned), 6 of which were for reason of relocation and 4 for reason of promotion.

The LAS staff leaver's form is being redesigned to improve the quality of data, including the reason for leaving and the destination on leaving.

1| MAKING THE LAS A GREAT PLACE TO WORK

Paramedic starters

Planned – June 2016	Actual	Variance	RAG
0 wte	0 wte	**0 wte**	

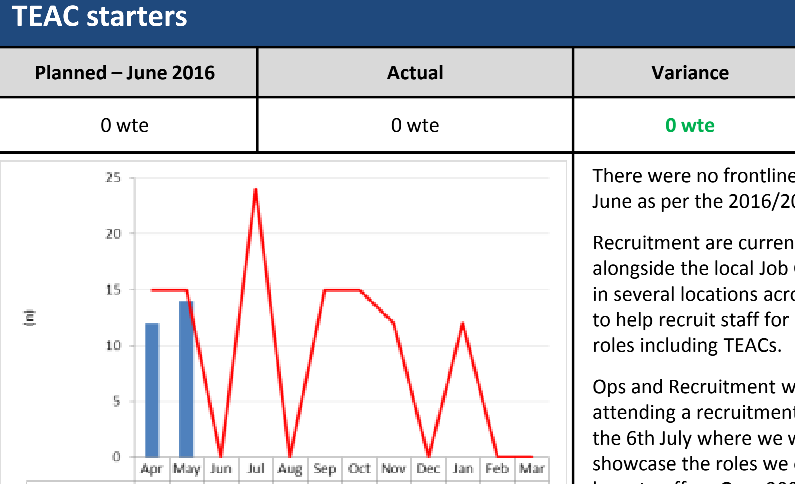
(n)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	2	19	0									
QIP Target	0	17	0	24	63	40	54	36	0	36	76	60

There were no frontline starters in June as per the 2016/2017 plan.

Recruitment and Ops have been attending "keeping in touch sessions" with the offered graduates from our partnership universities.

TEAC starters

Planned – June 2016	Actual	Variance	RAG
0 wte	0 wte	**0 wte**	



(n)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	12	14	0									
QIP Target	15	15	0	24	0	15	15	12	0	12	0	0

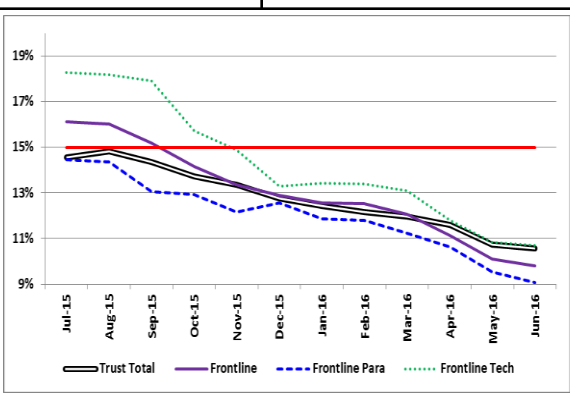
There were no frontline starters in June as per the 2016/2017 plan.

Recruitment are currently working alongside the local Job Centre Plus in several locations across London to help recruit staff for a number of roles including TEACs.

Ops and Recruitment will be attending a recruitment job fair on the 6th July where we will be able to showcase the roles we currently have to offer. Over 300 candidates responded to our recent TEAC advert.

Staff (all) turnover to remain below 15%

Target 2016/17	Actual	Variance	RAG
Below: 15%	10.6%	**4.4%**	

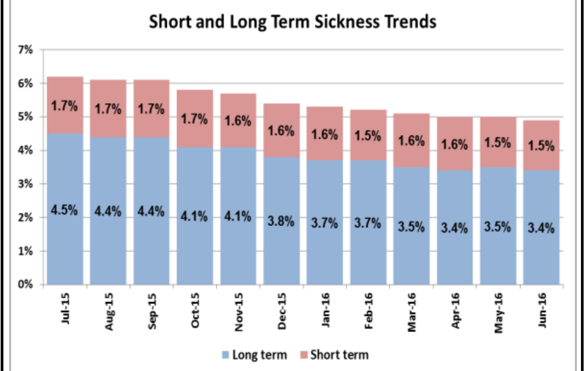


There was a slight reduction in Trust turnover to 10.6%. We continue to see improvements in turnover rates for frontline paramedics and all frontline staff.

As part of the Quality Improvement Plan we are refreshing the retention strategy.

Staff sickness to remain below 5.5%

Target 2016/17	Actual	Variance	RAG
Below: 5.5%	4.9%	**0.6%**	



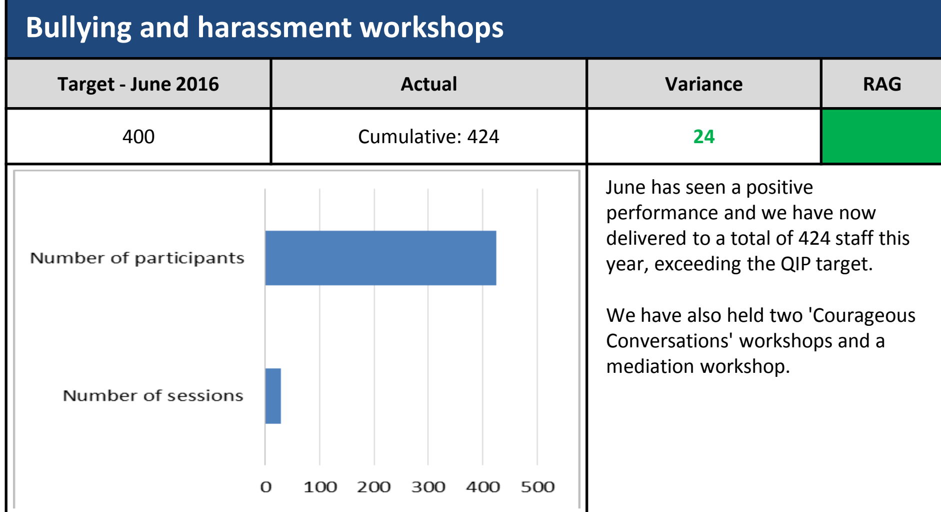
The sickness rate has improved to 4.9% for June. Please note that this is accurate as at 26th June. This has reduced by 1.7% since its peak of 6.6% in March 2015.

The 'Supporting Your Health and Well-Being' objective under the Trust's retention strategy is under review as part of Theme 1: Making the London Ambulance Service (LAS) a great place to work.

A national CQUIN has been set for health and wellbeing and by July 2016 the Trust will identify three health and wellbeing objectives as part of this CQUIN.

Bullying and harassment workshops

Target - June 2016	Actual	Variance	RAG
400	Cumulative: 424	24	

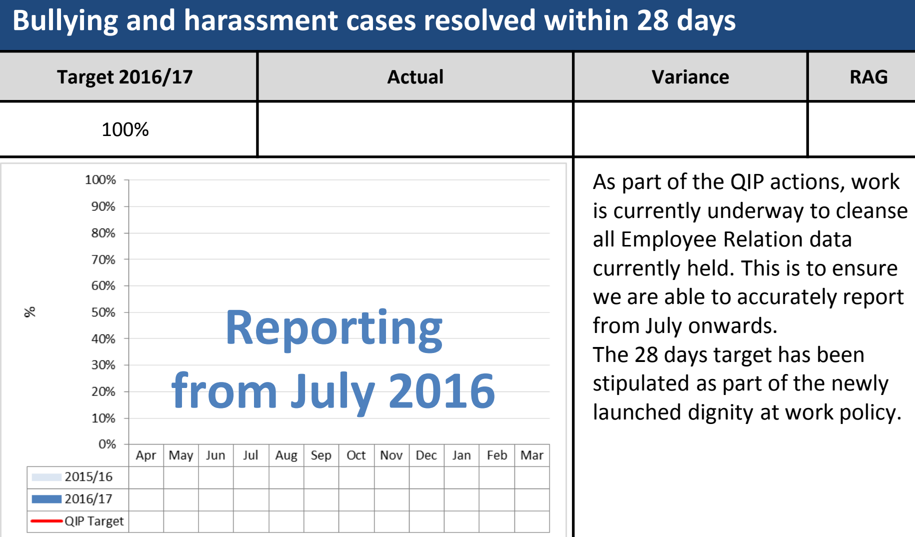


June has seen a positive performance and we have now delivered to a total of 424 staff this year, exceeding the QIP target.

We have also held two 'Courageous Conversations' workshops and a mediation workshop.

Bullying and harassment cases resolved within 28 days

Target 2016/17	Actual	Variance	RAG
100%			



As part of the QIP actions, work is currently underway to cleanse all Employee Relation data currently held. This is to ensure we are able to accurately report from July onwards.
The 28 days target has been stipulated as part of the newly launched dignity at work policy.

Staff trained in bullying and harassment investigations

Target - June 2016	Actual	Variance	RAG
24	Cumulative: 39	15	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17		18	39									
QIP Total target	8	16	24	24	24	24	24	24	24	24	24	24

June has seen a positive performance and we have now delivered to a total of 39 staff this year, exceeding the QIP target.

The Trust held sessions for 21 staff during June and it is expected that a further 16 will attend the session on 5th July.

Clinical staff completing their Core Skills Refresher (CSR) training

Target April – June 16	Actual	Variance	RAG
64%	81%	17%	

Topics included within 2016.1:

- Mental Capacity Act
- Managing a difficult airway
- Medicines Management
- Abbreviated Mental Test and Dementia

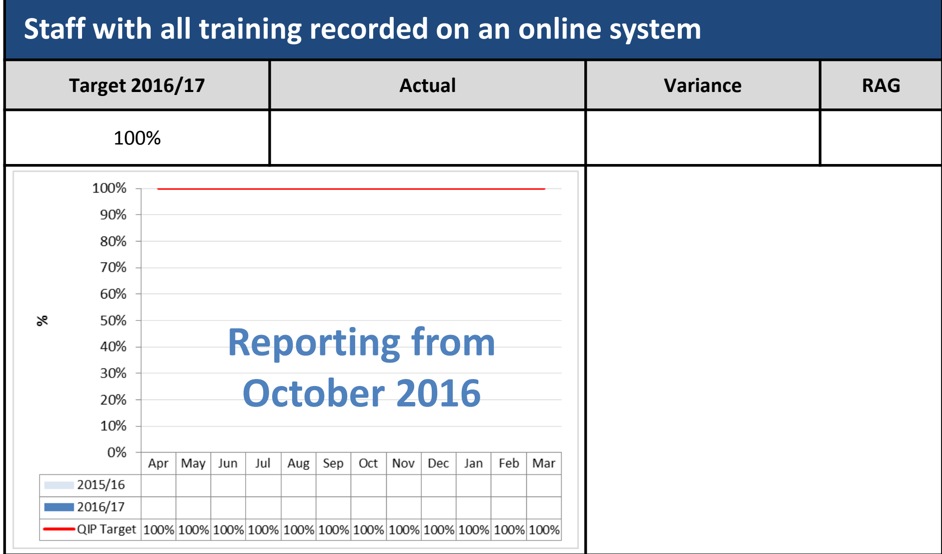
The completion rate for 2016.1 currently stands at 81% against a target of 64% with 2,554 frontline staff trained. Please note that this includes data up to and including 23rd June.

85% is the target for the four month duration of the particular CSR programme and we are on track to achieve this.

1| MAKING THE LAS A GREAT PLACE TO WORK

Staff with all training recorded on an online system

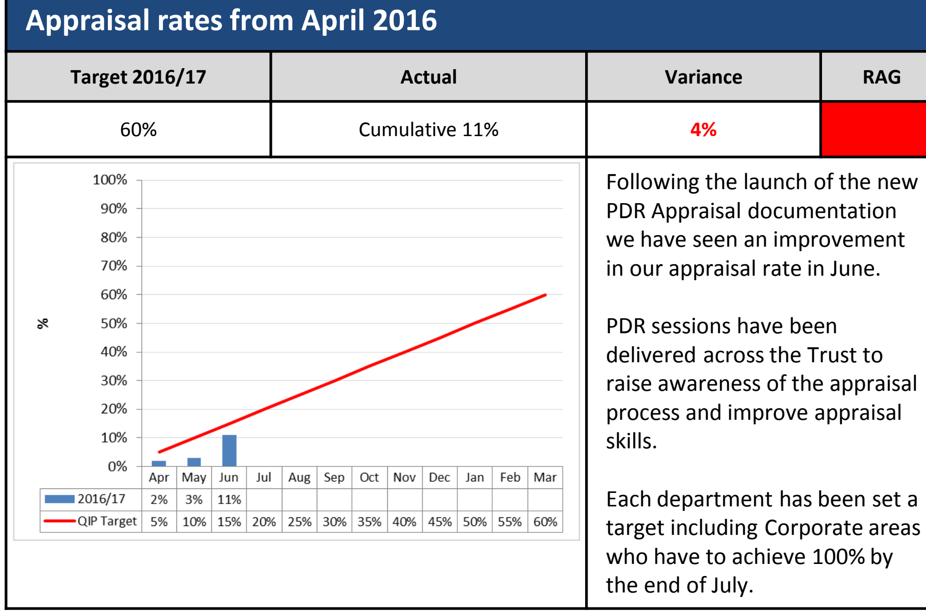
Target 2016/17	Actual	Variance	RAG
100%			



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17												
QIP Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appraisal rates from April 2016

Target 2016/17	Actual	Variance	RAG
60%	Cumulative 11%	4%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	2%	3%	11%									
QIP Target	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%

Following the launch of the new PDR Appraisal documentation we have seen an improvement in our appraisal rate in June.

PDR sessions have been delivered across the Trust to raise awareness of the appraisal process and improve appraisal skills.

Each department has been set a target including Corporate areas who have to achieve 100% by the end of July.

Planned Director visits take place

Target 2016/17	Actual	Variance	RAG
80%	100%	20%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	100%	75%	100%									
QIP Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

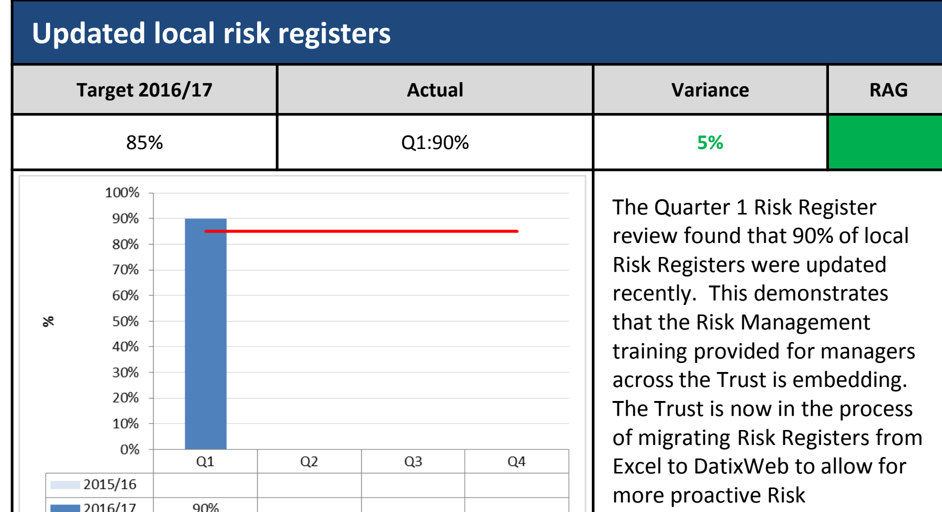
Members of the Executive Leadership Team continue to undertake monthly visits to their allocated areas.

During the month of June, the number of visits exceeded the required target.

2| ACHIEVING GOOD GOVERNANCE

Updated local risk registers

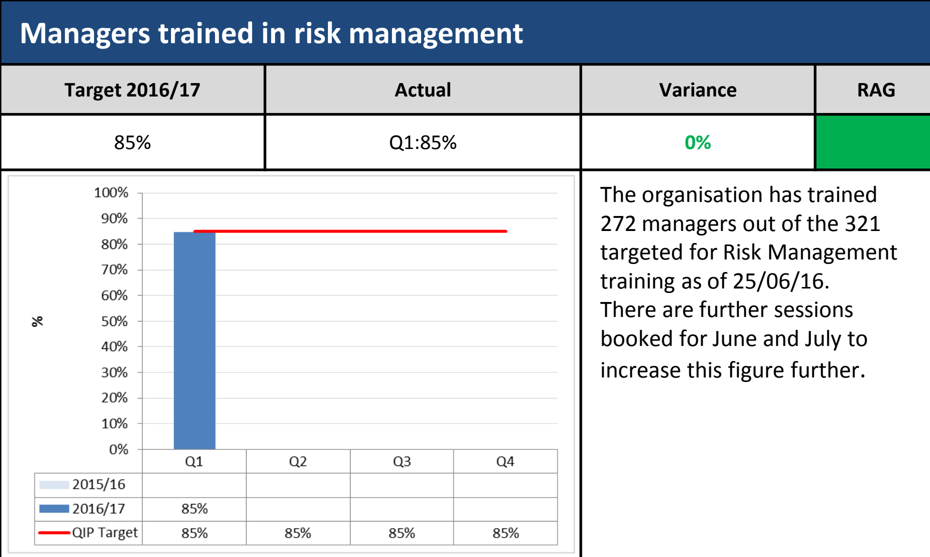
Target 2016/17	Actual	Variance	RAG
85%	Q1:90%	5%	



The Quarter 1 Risk Register review found that 90% of local Risk Registers were updated recently. This demonstrates that the Risk Management training provided for managers across the Trust is embedding. The Trust is now in the process of migrating Risk Registers from Excel to DatixWeb to allow for more proactive Risk Management.

Managers trained in risk management

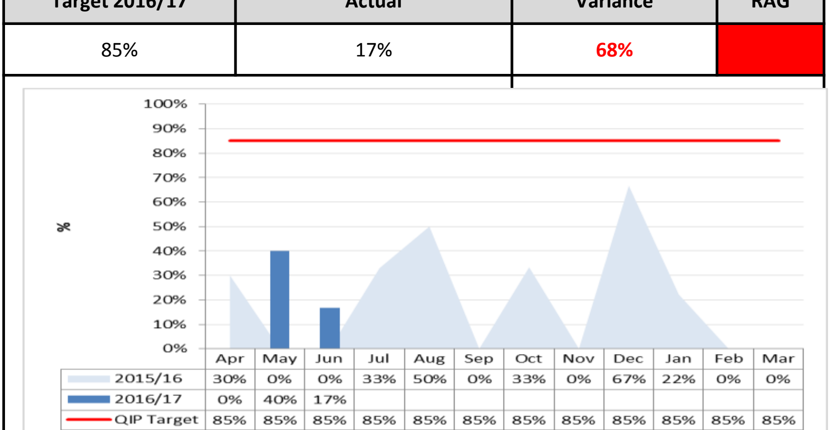
Target 2016/17	Actual	Variance	RAG
85%	Q1:85%	0%	



The organisation has trained 272 managers out of the 321 targeted for Risk Management training as of 25/06/16. There are further sessions booked for June and July to increase this figure further.

Completed investigations and reports within 60 working days of a serious incident being declared

Target 2016/17	Actual	Variance	RAG
85%	17%	68%	



In Q1 16/17 the LAS submitted 18 SI reports with the average time for completion of 107 days. 3 were completed within 60 days. July is the first month where 60 working days will have elapsed from 1 April and we would therefore expect to see this impact upon next month's data.

There is a risk in that there is a small backlog of cases which requires an investigator and Executive Leadership Team / Governance team resources. There has been significant work undertaken to clear the backlog of SI reports and to raise the profile to ELT of overdue investigations. Further training is also taking place to increase the skillset of investigators and on investigation report writing for SMT & ELT, all of which should help reduce time to completion

2| ACHIEVING GOOD GOVERNANCE

Percentage of Serious Incidents (Sis) reported on STEIS within 48 hours of being declared

Target 2016/17	Actual	Variance	RAG
85%	100%	15%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%
2016/17	100%	100%	100%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The Trust continues to meet this target for 100% of declared Serious Incidents.

Patient safety incidents reported on DatixWeb within 4 days of incident occurring

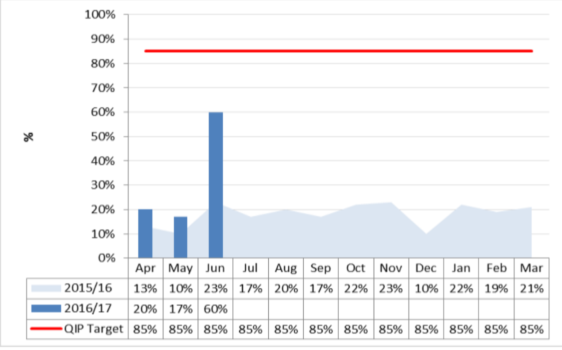
Target 2016/17	Actual	Variance	RAG
85%	72%	13%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	30%	11%	32%	25%	20%	30%	40%	26%	13%	20%	23%	25%
2016/17	21%	46%	72%									
QIP Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

The average number of days in June (up to 24/06/16) between incident date and the date reported was 3.88 days. 72% of all patient safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting. The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

Staff safety incidents reported on DatixWeb within 4 days of incident occurring

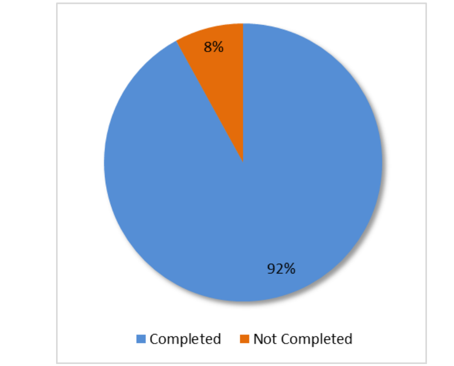
Target 2016/17	Actual	Variance	RAG
85%	60%	25%	



The average number of days in June (up to 24/06/16) between incident date and the date reported was 5.4 days. 60% of all staff safety incidents were logged onto Datix Web within 4 days, a large increase on the previous 2 months of reporting. The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

Frontline staff trained in Duty of Candour

Target 2016/17	Actual	Variance	RAG
85%	92%	7%	



Following the delivery of Duty of Candour (DoC) training in the Core Skills Refresher (CSR) programme 2015.3, 92% of staff have up to date DoC training.

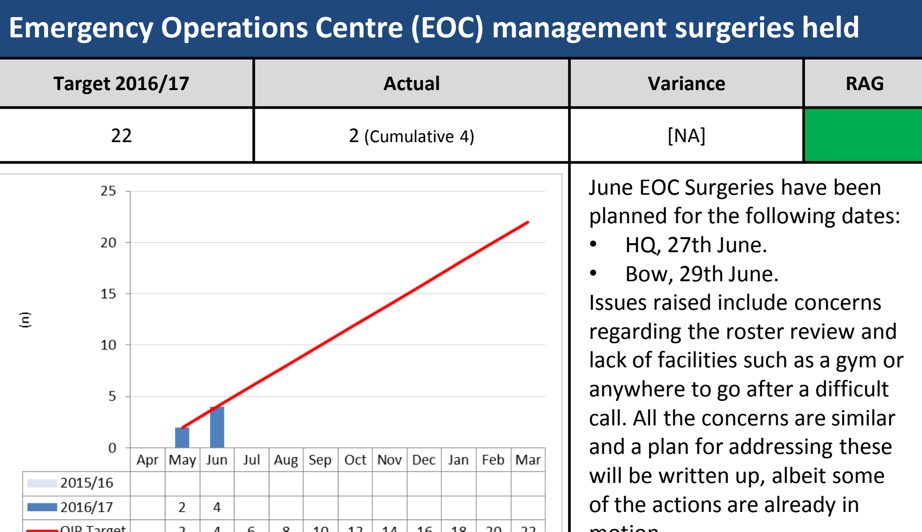
The total number of staff who received this training was 2,799 out of a total number of 3,048 staff in post.

Complaints Response (Over 35 days)

Target 2016/17	Actual	Variance	RAG
0	43	[NA]	

(n)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	54	45	43									
QIP Target	0	0	0	0	0	0	0	0	0	0	0	0

Currently there are 56 records awaiting response in the Rich Client version of Datix, once closed this version will be used as our Archive. During May the department closed 92 complaints and concerns.
We anticipate that closure rates will slow whilst staff familiarise themselves with Datix Web and we continue to cope with staff shortages.
The current number of open complaints is 151, the oldest of which is from March 2016.



Emergency Operations Centre (EOC) management surgeries held

Target 2016/17	Actual	Variance	RAG
22	2 (Cumulative 4)	[NA]	

(n)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17		2	4									
QIP Target		2	4	6	8	10	12	14	16	18	20	22

June EOC Surgeries have been planned for the following dates:

- HQ, 27th June.
- Bow, 29th June.

Issues raised include concerns regarding the roster review and lack of facilities such as a gym or anywhere to go after a difficult call. All the concerns are similar and a plan for addressing these will be written up, albeit some of the actions are already in motion.

Staff taking a rest break during shift

Target 2016/17	Actual	Variance	RAG
[TBC]	8%	[NA]	[NA]

%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	11%	8%	9%	9%	8%	6%	8%	9%	10%	8%	5%	6%
2016/17	10%	10%	8%									
QIP Target												

The number of staff taking a rest break during their shift has dropped slightly this month. The work to determine the requirements with rest breaks is being aligned with the activity to deliver the recruitment and retention strategy and further detail will be available next month.

3| IMPROVING PATIENT EXPERIENCES

Patient Transport Service patients will not wait longer than the 60 min contracted departure window

Target 2016/17	Actual	Variance	RAG
95%	96%	1%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	97%
2016/17	96%	95%	96%									
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Performance increased by 1% in June to 96% above the 95% target.

Actions continue to review and improve areas where the departure window has been missed.

The friends and family test shows that, of the 107 forms analysed, so far, 100% of patients stated that they would recommend the service.

Handover to green (ambulance conveyances/non blue calls) take place within 15 minutes

Target 2016/17	Actual	Variance	RAG
90%	60%	30%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	63%	63%	59%	60%	62%	61%	63%	63%	64%	62%	61%	62%
2016/17	61%	60%	60%									
QIP Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

In June 2016 we achieved 60% of handovers to green within 15 minutes.
An action plan has been developed to address and improve this position and continues to be implemented in operations. This action plan will be aligned with the outcome of the external review of the Trust's job cycle time.

Number of hours lost for arrival to Handovers Over 15 minutes - LAS

Target 2016/17	Actual	Variance	RAG

Hours (0–1400); weeks: 24/04/2016, 01/05/2016, 08/05/2016, 15/05/2016, 22/05/2016, 29/05/2016, 05/06/2016, 12/06/2016, 19/06/2016, 26/06/2016

Total Hours lost

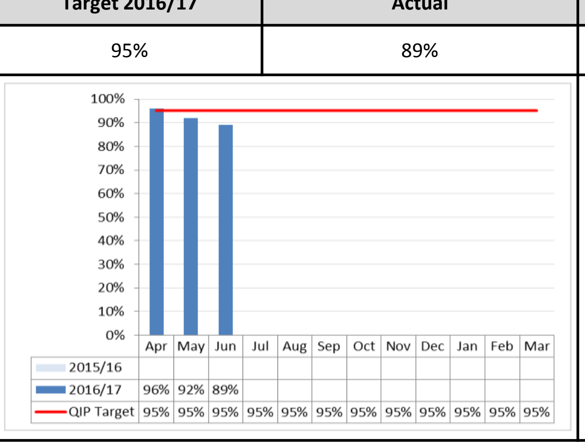
Over the last 10 weeks 27% (2,773 hours) of the total time lost for the LAS (10,110 hours) for handovers over 15 minutes originated entirely from

- Kings College,
- North Middlesex
- Princess Royal (Farnborough) and
- Royal Free.

4| IMPROVING ENVIRONMENT AND RESOURCES

Available vehicles that enter the clean and equip process in the North East area pilot

Target 2016/17	Actual	Variance	RAG
95%	89%	6%	



The storms and floods of w/c 19th June impacted on the ability of the Vehicle Preparation team to collect and deliver available vehicles.

Additionally there was a 50% increase in unplanned workshop jobs resulting in a reduction in available vehicles to swap out for 24 hour DCA's.

Available vehicles that are made ready with essential kit in the North East area Pilot

Target 2016/17	Actual	Variance	RAG
100%	100%	0%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	100%	96%	100%									
QIP Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Improved supply chain support from the Logistics Support Unit has resulted in the timely availability of key equipment items for the Vehicle Preparation Teams.

Available vehicles that enter the clean and equip process across the Trust

Target 2016/17	Actual	Variance	RAG

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17												
QIP Target												

Reporting from Q2

The process for data collection is currently being developed.

We expect the data to start being collected by Q2.

Available vehicles that are made ready with essential kit across the Trust

Target 2016/17	Actual	Variance	RAG

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17												
QIP Target												

Reporting from Q2

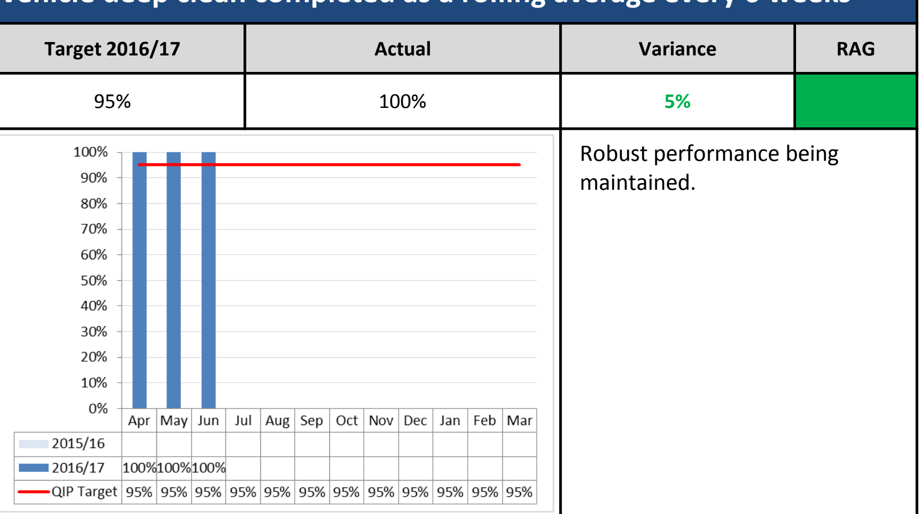
The process for data collection is currently being developed.

We expect the data to start being collected by Q2.

4| IMPROVING ENVIRONMENT AND RESOURCES

Vehicle deep clean completed as a rolling average every 6 weeks

Target 2016/17	Actual	Variance	RAG
95%	100%	5%	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	100%	100%	100%									
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Robust performance being maintained.

12 week cycle planned maintenance/servicing to be completed against schedule

Target 2016/17	Actual	Variance	RAG
95%	95%	0%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	90%	87%	95%									
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

10% reduction in scheduled work assisted achievement of target.

Planned maintenance of vehicles to be completed within 48 hour target

Target 2016/17	Actual	Variance	RAG
95%	97%	2%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	98%	98%	97%									
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Target being consistently maintained.

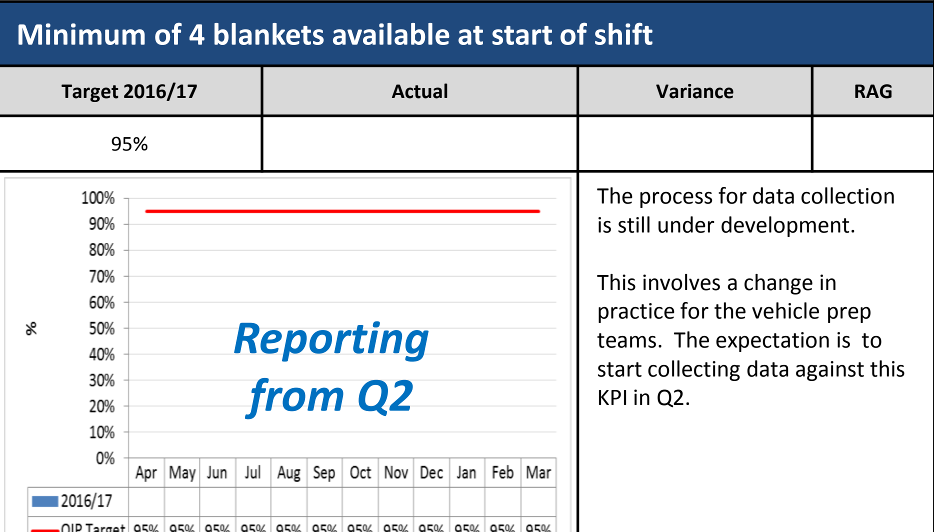
Unplanned jobs (defects) to be completed within 48 hours

Target 2016/17	Actual	Variance	RAG
90%	96%	6%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	98%	97%	96%									
QIP Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Consistent performance being maintained against target.

4| IMPROVING ENVIRONMENT AND RESOURCES

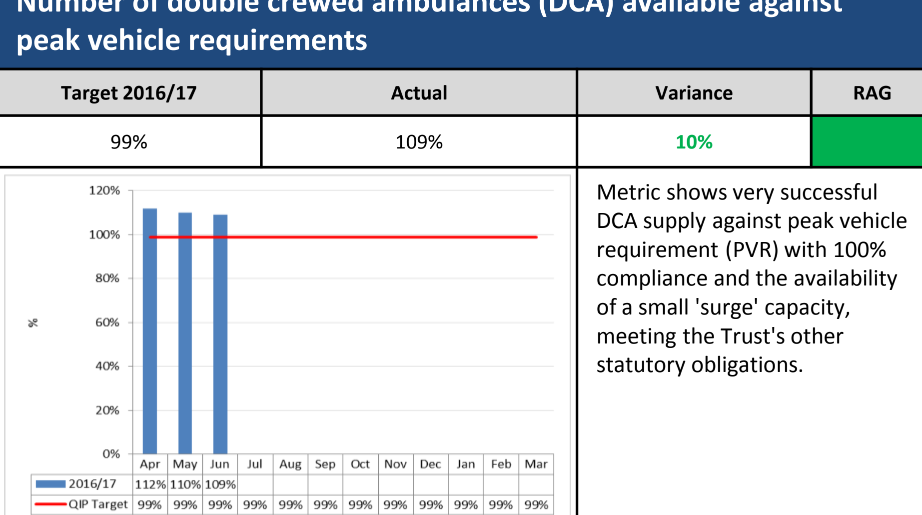


Minimum of 4 blankets available at start of shift

Target 2016/17	Actual	Variance	RAG
95%			

The process for data collection is still under development.

This involves a change in practice for the vehicle prep teams. The expectation is to start collecting data against this KPI in Q2.



Number of double crewed ambulances (DCA) available against peak vehicle requirements

Target 2016/17	Actual	Variance	RAG
99%	109%	10%	

Metric shows very successful DCA supply against peak vehicle requirement (PVR) with 100% compliance and the availability of a small 'surge' capacity, meeting the Trust's other statutory obligations.

Number of station premises cleaning compliance audits are passed

Target 2016/17	Actual	Variance	RAG

Reporting from Q2

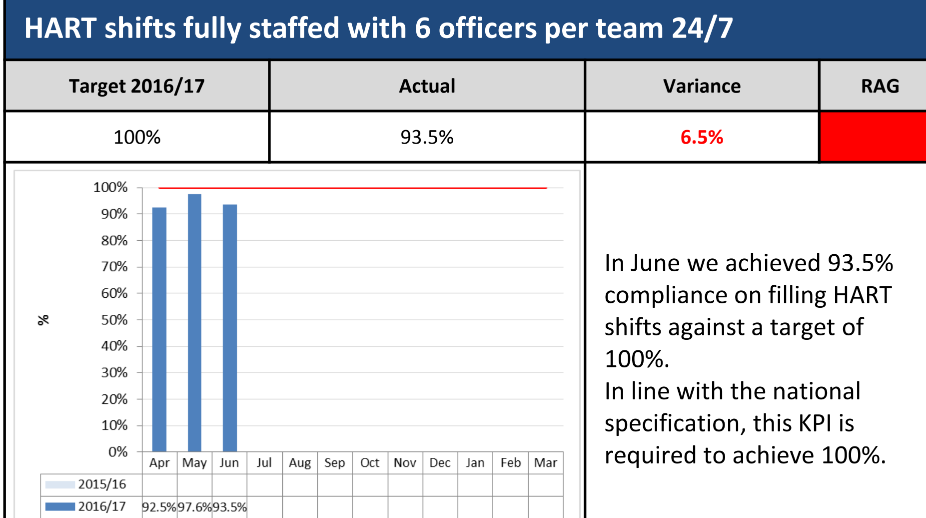
%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17												
QIP Target												

Station premises cleaning schedules are being established with the contractor with audits to commence once new arrangements are fully embedded in Q2.

4| IMPROVING ENVIRONMENT AND RESOURCES

HART shifts fully staffed with 6 officers per team 24/7

Target 2016/17	Actual	Variance	RAG
100%	93.5%	6.5%	

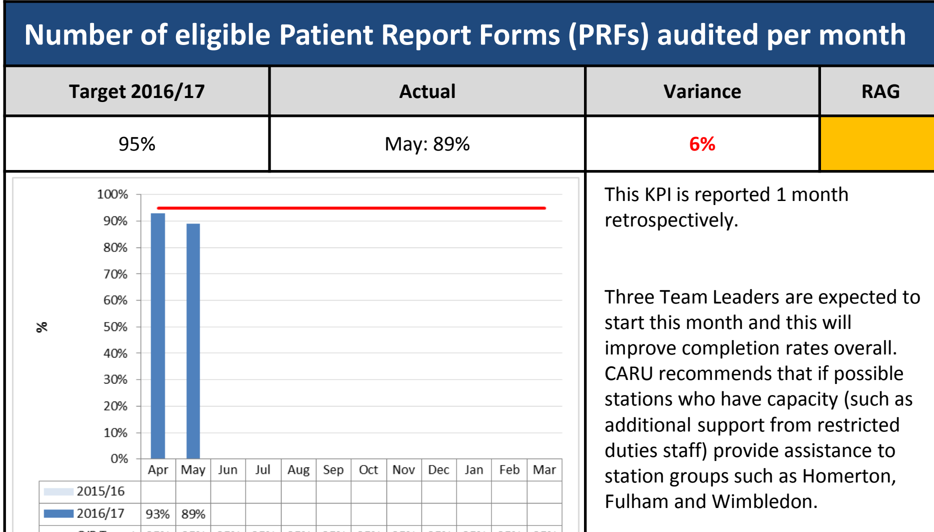


In June we achieved 93.5% compliance on filling HART shifts against a target of 100%.
In line with the national specification, this KPI is required to achieve 100%.

HART rosters are reviewed on a daily basis to maximise capacity as far as possible and overtime incentives are offered to fill gaps in the rosters. The gaps experienced in June are due to staff being unavailable because of annual leave and training. At this present time, we are working with NHSI ,Commissioners and NHSE to determine the number of HART officers required. We are also currently recruiting to fill the current vacancy in HART.

In those instances when two full HART teams are not available, we comply with the notification protocols required by the National Ambulance Resilience Unit (NARU) and we have systems in place to notify the London Fire Brigade and the Metropolitan Police Service. Our formal agreement with South East Coast Ambulance Service (SECAMB) to provide coverage at Heathrow at times when LAS HART staffing is incomplete was signed in December 2015 and is still active. While 6.5% of our HART shifts were incomplete in June, it should be noted that (as per our agreement with SECAMB) they did not have to move their HART assets on any of these occasions because our two HART teams always had more than ten officers on duty.

5| TAKING PRIDE AND RESPONSIBILITY



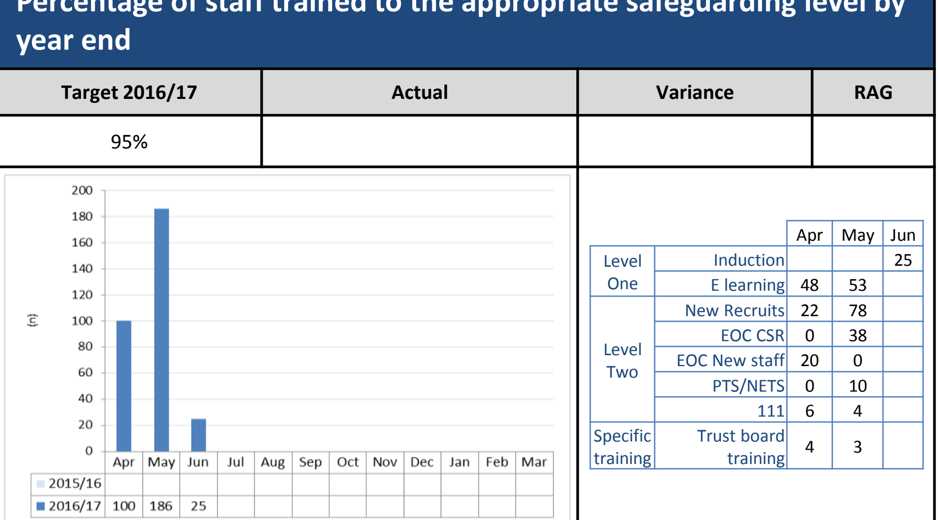
Number of eligible Patient Report Forms (PRFs) audited per month

Target 2016/17	Actual	Variance	RAG
95%	May: 89%	6%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	93%	89%										
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

This KPI is reported 1 month retrospectively.

Three Team Leaders are expected to start this month and this will improve completion rates overall. CARU recommends that if possible stations who have capacity (such as additional support from restricted duties staff) provide assistance to station groups such as Homerton, Fulham and Wimbledon.



Percentage of staff trained to the appropriate safeguarding level by year end

Target 2016/17	Actual	Variance	RAG
95%			

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	100	186	25									

		Apr	May	Jun
Level One	Induction			25
	E learning	48	53	
Level Two	New Recruits	22	78	
	EOC CSR	0	38	
	EOC New staff	20	0	
	PTS/NETS	0	10	
	111	6	4	
Specific training	Trust board training	4	3	

Frontline staff completing one operational workplace review annually

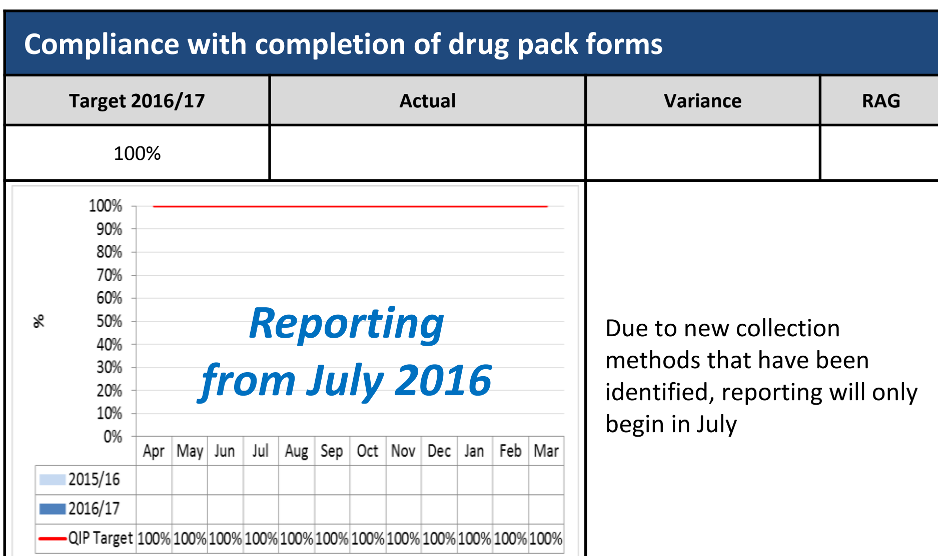
Target 2016/17	Actual	Variance	RAG
85%	Cumulative: 15%	13%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
(2015/16)	0%	1%	2%	4%	6%	12%	16%	23%	27%	33%	34%	39%
(2016/17)	5%	12%	15%									
(Target)	8%	17%	28%	37%	42%	54%	57%	62%	65%	70%	75%	85%

Although significantly ahead of 15/16, local focus will be required in order to meet the QIP target of 85% by year end. June's data is partial and numbers are expected to increase once all OWRs have been inputted by Clinical Team Leaders (CTL).

The following actions have been taken:

1. The Sector Services business plan has been distributed to Assistance Director of Operations (ADO), Service Delivery Manager (SDM), Group Station Manager and CTL detailing their responsibility for objective 20 (to ensure 1 OWR is conducted per staff member per year).
2. OWR guidance issued in 2014 has been reissued advising CTLs they should also conduct OWRs whilst working one-to-one with a staff member as opposed to only whilst supernumerary.
3. ADOs have been asked to focus on OWR and PDR completion rates, developing local recovery plans where necessary.
4. A trajectory has been agreed; the lead ADO for CTLs and Deputy Director of Operations will closely monitor progress against this.

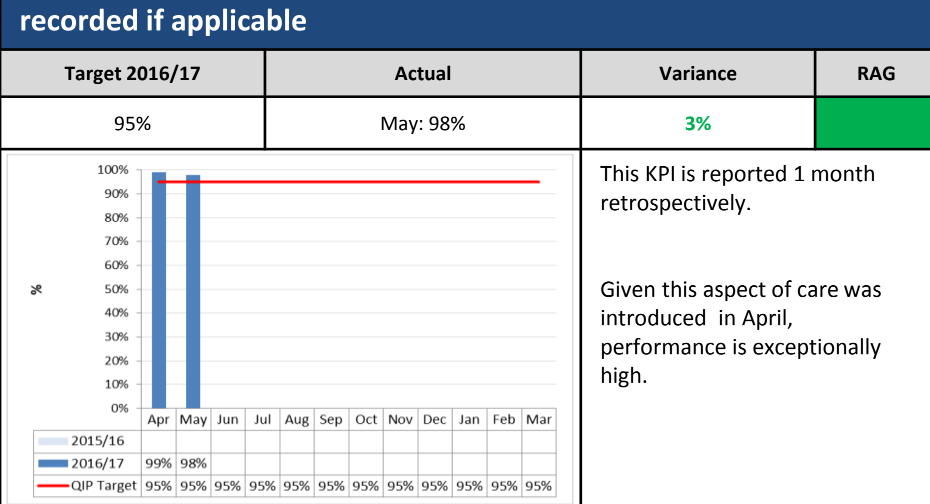


Compliance with completion of drug pack forms

Target 2016/17	Actual	Variance	RAG
100%			

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17												
QIP Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Due to new collection methods that have been identified, reporting will only begin in July



Audited Patient Report Forms (PRFs) with drug bag numbers recorded if applicable

Target 2016/17	Actual	Variance	RAG
95%	May: 98%	3%	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16												
2016/17	99%	98%										
QIP Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

This KPI is reported 1 month retrospectively.

Given this aspect of care was introduced in April, performance is exceptionally high.

Percentage compliance of drug code changes

Target 2016/17	Actual	Variance	RAG
100%	Q1: 100%	0%	

Percentage compliance of drug code changes

	Q1	Q2	Q3	Q4
2016/17 North	100%			
2016/17 South	100%			
QIP Target	100%	100%	100%	100%

This KPI is measured on a quarterly basis. The drug locker codes changes in Quarter 1 2016 were fully compliant.

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board
Date of meeting:	26th July 2016
Document Title:	Assurance report from the Quality Governance Committee
Report Author(s):	Bob McFarland, Non-executive director and Chair of the committee
Presented by:	Bob McFarland
Contact Details:	
History:	N/A
Status:	Assurance report from the meeting held on 12th July 2016 and approval of annual reports

Background/Purpose

The Quality Governance Committee is a Board committee with oversight of quality and safety. The committee meets bi-monthly and this is the assurance report from the meeting held on 12th July 2016. The Committee is also recommending the following annual reports to the Trust Board for approval:

Infection Prevention and Control
Safeguarding
Patient Experience
Patient and Public Involvement and Public Education.

Action required

To receive assurance from the committee and to note any areas of concern.
To approve the 2016/17 annual reports listed above.

Key implications

The Trust Board takes its assurance from Board committees and needs to consider any areas of concern raised and take assurance that these are being addressed.

Key implications and risks arising from this paper	
Clinical and Quality	The committee has oversight of clinical governance and will bring to the attention of the Board areas of good practice and areas of concern and any potential risks.
Performance	The committee considers the impact/implications of performance issues on the quality and safety of services for patients.
Financial	The committee seeks assurance during the year on the quality impact of cost improvement programmes.
Workforce	The committee considers workforce issues in relation to the provision of safety and quality of services to patients.
Governance and Well-led	Providing assurance on quality governance.
Reputation	
Other	

This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	Yes
Achieving Good Governance	Yes
Improving Patient Experience	Yes
Improving Environment and Resources	Yes
Taking Pride and Responsibility	Yes

Report from the Quality Governance Committee on 12th July 2016

The committee has been concerned about the risk to Category C patients when resources do not match demand and so was pleased to hear that there is a significant improvement in this area.

The Board is asked to note that although we were able to approve the Safeguarding and Infection Prevention and Control Annual Reports as an accurate reflection of the considerable work undertaken by these departments we were concerned that when reviewing the action plans for 2015/2016 there were many actions not completed within that year.

INTERNAL ASSURANCE

Clinical Governance

For some time the committee has been concerned that there has not been an action plan following the EOC review. We were therefore pleased to be told that recruitment is underway for QA (Quality Assurance) staff to enable them to fulfil both their regular audit function in EOC and their role in informing reports on Serious Incident and Complaints. We were also told the pressure on the *welfare* ringback system has been reduced as our performance has improved and the staffing of this function and the Clinical Hub is under review.

There is still uncertainty concerning the reporting system for the Quality Governance structure and the Chief Quality Officer post is vacant, with Briony Sloper currently acting into the role.

We received a report from the Improving Patient Experience Committee. The Oracle Learning Management system (OLM) will be in place by September which will enable us at last to have immediate figures on training levels of staff in all areas. Work continues on frequent callers and there is now a full time social worker post being recruited as well as a training programme by the Darzi fellow underway.

The work undertaken to develop the role of mental health nurses in the clinical hub was shortlisted for a National Patient Safety Award and we were pleased to congratulate the team and look forward to this activity being further developed.

There was an update on Clinical Education by Tina Ivanov. The Clinical Education Delivery group is functioning but discussion is ongoing about the reporting structure for education and training which bridges both workforce and clinical/professional standards. The committee emphasised the importance of a clear personal responsibility and secure governance pathway for education and training as emphasised in the report on paramedic examination practice.

There is some evidence to suggest that a delay in response has an impact on the outcome for patients in cardiac arrest. The detailed review of cardiac outcomes is underway and should be included in the annual Cardiac report, available by September. We noted that our current figures for timely response to cardiac patients show considerable improvement.

There are still a number of Serious Incident reports overdue and action needs to be taken to address the bottlenecks in the process. Complaint responses are still expected to achieve

100% within the prescribed time this year though the target date has been put back to end of September.

The Quality Report, Board Assurance Framework and Risk register were noted with the agenda for the recent Risk Compliance and Assurance Group.

BUSINESS ITEMS

Patient Engagement Strategy

The committee were pleased to approve the plan for this year and noted the considerable work underway in this area. Also we noted the substantial voluntary work undertaken by committed staff in their own time. A discussion followed around how we could better use the large number of people signed up to the foundation trust membership for example and the patient representative group, within the Trust's governance arrangements such as patient representation on the quality governance committee and reporting groups, and also how they could be more visible to the Board as currently the Patient Forum was the only body with which we had regular contact. Similarly we felt the Board could be more visible to these groups. It was also felt that we could better use this network of activities for intelligence about staff and patients attitudes and concerns and for promoting the Equality and Diversity agenda. There is an opportunity to use social media to raise performance levels for patients with most urgent needs, and the Committee asked for a report on how the GoodSam app has been used since it was introduced.

Safeguarding

The Annual Safeguarding Report was re-presented. It had been sent back for review in May because 26/38 actions planned for 2015/2016 had not been completed in year. This included actions around the Saville and Lampard reports. There is now a new column in the actions table "as of May 2016" which reflects the work done since to close most of the actions. The most significant remaining item is the need to institute a system of regular DBS checks on staff and we were told this is in hand.

EXTERNAL ASSURANCE

Fenella Wrigley summarised the findings of the recent **Clinical Review**. We were pleased to hear of encouraging progress and the good rating of the HART and resilience function in particular. We noted that although there has been considerable improvement in many areas (e.g. medicines management) there is considerable variation by site (see also Infection Prevention and Control report below) from very good to poor.

ANNUAL REPORTS

Infection Prevention and Control Annual Report.

Eng –Choo Hitchcock, Head of Infection Prevention and Control, presented the 2015/2016 Annual Report. We were pleased to note the considerable work done in this area over the year although there were a number of areas which were identified as below standard in the CQC report following the June 2015 inspection.

The report is an accurate reflection of the work done during the year and as such we can recommend its acceptance by the Board. However the committee was concerned to note

another report in which a proportion of the actions for 2015/2016 had not been completed in year (eight out of twenty four). It is not clear in the report how some of these actions translate into this year's priorities and Briony Sloper is going to look into this. There were challenges last year due to sick leave of the single post holder and withdrawal of the IPC support post for much of the year. Even so we were told that in this area there was a variable commitment to raise standards in different sites; in the year of the CQC visit the IPC team had not managed to get some localities on side.

The **Mental Health Annual report for 2015/2016** and action plan for 2016/2017 was not ready for approval until September. We will be half way through the year by then and we are concerned at the delay in presenting reports and action plans in a number of areas.

Date of next meeting

The next meeting of the Quality Governance Committee is on Tuesday 13th September 2016.

NOTE THE MEETING WILL BEGIN AT 1300 in order that several members can still attend the full meeting which we will aim to finish by 1600.

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Director of Infection Prevention and Control Annual Report 2015-2016
Report Author(s):	Eng-Choo Hitchcock
Presented by:	Eng-Choo Hitchcock
Contact Details:	Eng-choo.hitchcock@lond-amb.nhs.uk
History:	Infection Prevention and Control Committee June 2016
Status:	For Assurance

Background/Purpose

1. Executive Summary

The Annual Report of the Director of Infection Prevention and Control (DIPC) provides information on the progress and achievements of the infection prevention and control objectives for 2015/16 and outlines objectives for 2016/17.

1.1. Background

The Infection Prevention and Control (IPC) overall delivery Trust-wide, for year ending March 2016, concentrated on preparation for Care Quality Commission (CQC) inspection and post-inspection improvement work streams. The IPC team worked collaboratively with all services. The work continued amid challenges associated with organisation structure changes in Q1 and Q2, a lack of resource within the Infection Prevention and Control Team and inadequate data capture system to provide the required assurance.

The LAS was inspected by the Care Quality Commission (CQC) in June 2015. The CQC found that LAS was inadequate and placed Trust into special measures in November 2015.

The areas identified for improvement associated with infection control, related to vehicle and station cleanliness, equipment cleanliness, 'bare-below-the-elbow' adherence, and management of blankets. From Q3, the LAS Quality Improvement Plan (QIP) was established to address shortfalls identified in the report, and drove the priority actions (including IPC related issues) from December 2015.

1.2. Summary of progress made in practice and governance 2015-2016

- Improved IPC Governance with new structure and membership of monthly IPCT and quarterly IPCC and terms of reference, which took place as scheduled over the past year, with appropriate escalation and management of issues when they arise
- Training reviewed - developed new course for APP, enhanced CSR IPC training content and delivery to ensure acquisition of practical basic principles skills and knowledge; Level 1 e-learning course aligned to Core Skills Framework

- Audit compliance:
- Premises cleaning standard exceeded 90% having been stretched from 85%;
- CSR IPC refresher training achieved 90% against a target of 80% (stretched from 60% set previous year);
- Hand hygiene averaged 93% against a target of 95%;
- Vehicle 6-weekly deep clean compliance achieved 94% against a target of 95% (stretched from 90% set previous year);
- Audit data capture system (Docworks) being initiated trust-wide by Transformation Team, for full implementation in 2016/17
- Policy and information development:
- Policies approved – IPC, Waste management, Workforce Immunisation, Legionella
- Developed and waiting for approval – IPC Workbook, Medical Device management (including decontamination)
- Supported the review of the Uniform, Management of Sharps Policy, Body Armour procurement
- Developed a range of IPC posters and information for the Pulse
- Seasonal Flu vaccine uptake frontline staff achieved 47% compared to 44% last year; for total staff 47% against 33% last year.
- Personal protective equipment - enhanced IPC PPE (excludes FFP3 reusable mask) for general crew agreed for procurement; for roll out early 2016/2017
- Provided advice and support to Logistic Team to procure external Decontamination Service (initiated Q1), solution for blankets/linen, medical device management and the North East Pilot Project
- Provided advice and support to Estates Team to reduce IPC risks in refurbishment and re-configuration of stations/services to include renovation of hand hygiene facilities, and enhancement of cleaning specification
- Established a local risk register

1.3. Key risks to note

- Lack of robust data monitoring capture system to provide required assurance – for example training, audit, FFP3 reusable masks implementation.
- Management of Medical Devices, including contaminated equipment collected from A&Es.
- Bare-below-the-elbows monitoring of adherence to policy.
- Robust process for management of crew exposure to infectious diseases.

1.4. IPC priorities for 2016-2017

- Fully resource the IPC team with a fulltime IPC qualified support to deliver the Annual IPC Work Plan, Quality Improvement Plan (QIP) and IPC risks identified
- Provide IPC support and advice across directorate to achieve the Trust-wide Quality Improvement Plan
- Cleanliness of stations, Stations and Equipment
- Bare-below–the-elbow implementation and oversight
- Supporting Logistics with procurement of services and addressing management of blankets and North East Sector project
- Supporting Estates with procurement of services and the Hand Hygiene refurbishment in stations
- Devise blended training content to meet the Skills for Health Core Skills Framework
- Delivering on the outstanding areas identified in the IPC Work Plan 2015-2016
- Continuation of policy and information development, undertake a programme of validation audits, training for educators, PPE video/poster development and implementation
- Support the resurrection of IPC Champions in Group Stations to provide local means of IPC delivery
- Support the Workforce Team to find a solution for management of crew exposure to infectious diseases
- Participating in the QGARD Vehicle Cleaning Research project
- Participating the IPS Glove research project

Conclusion
The IPC will continue to drive forward the improvements made to date and ensure that gaps remaining in 2015-2016 IPC Work Plan and the development areas identified by the CQC inspection team, in QIP, continues to be addressed for 2016-2017 to meet national standards.

Action required

The Trust Board is asked to note:

- the continuing lack of a fully resourced IPC team to deliver the Annual IPC and QIP work streams
- the key risks in the report that will require a collaborative multi-directorate approach to mitigate risks

Key implications

- Partial compliance with the Hygiene Code and recommendations from CQC Report.
- Legal, financial, reputational impact on the organisation

Key implications and risks arising from this paper	
Clinical and Quality	✓
Performance	✓
Financial	✓
Workforce	✓
Governance and Well-led	✓
Reputation	✓
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	✓
Achieving Good Governance	✓
Improving Patient Experience	
Improving Environment and Resources	✓
Taking Pride and Responsibility	✓

Annual Report of the Director of Infection Prevention and Control

Reporting on the period April 2015 to March 2016

Report Author:

Eng-Choo Hitchcock, Head of Infection Prevention and Control

Director:

Zoë Packman, Director of Infection Prevention and Control

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FINAL

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The LAS was inspected by the Care Quality Commission (CQC) in June 2015. The CQC found that LAS was inadequate and placed Trust into special measures in November 2015.

The areas identified for improvement associated with infection control, related to vehicle and station cleanliness, equipment cleanliness, 'bare-below-the-elbow' adherence, and management of blankets. From Q3, the LAS Quality Improvement Plan (QIP) was established to address shortfalls identified in the report, and drove the priority actions (including IPC related issues) from December 2015.

1.2. Summary of progress made in practice and governance made in 2015-2016

- Improved IPC Governance with new structure and membership of monthly IPCT and quarterly IPCC and terms of reference, which took place as scheduled over the past year, with appropriate escalation and management of issues when they arise
- Training reviewed - developed new course for APP, enhanced CSR IPC training content and delivery to ensure acquisition of practical basic principles skills and knowledge; Level 1 e-learning course aligned to Core Skills Framework
- Audit compliance:
    - Premises cleaning standard exceeded 90% having been stretched from 85%;
    - CSR IPC refresher training achieved 90% against a target of 80% (stretched from 60% set previous year);
    - Hand hygiene averaged 93% against a target of 95%;
    - Vehicle 6-weekly deep clean compliance achieved 94% against a target of 95% (stretched from 90% set previous year);
- Audit data capture system (Docworks) being initiated trust-wide by Transformation Team, for full implementation in 2016/17
- Policy and information development:
    - Policies approved – IPC, Waste management, Workforce Immunisation, Legionella
    - Developed and waiting for approval – IPC Workbook, Medical Device management (including decontamination)
    - Supported the review of the Uniform, Management of Sharps Policy, Body Armour procurement
    - Developed a range of IPC posters and information for the Pulse
- Seasonal Flu frontline staff uptake achieved 47% compared to 44% last year; for total staff 47% against 33% last year.
- Personal protective equipment - enhanced IPC PPE (excludes FFP3 reusable mask) for general crew agreed for procurement; for roll out early 2016/2017

- Provided advice and support to Logistic Team to procure external Decontamination Service (initiated Q1), solution for blankets/linen, medical device management and the North East Pilot Project
- Provided advice and support to Estates Team to reduce IPC risks in refurbishment and re-configuration of stations/services to include renovation of hand hygiene facilities, and enhancement of cleaning specification
- Established a local risk register

1.3. Key risks to note

- Lack of robust data monitoring capture system to provide required assurance – for example training, audit, FFP3 reusable masks implementation.
- Management of Medical Devices, including contaminated equipment collected from A&Es.
- Bare below the elbows monitoring.
- Robust process for management of crew exposure to infectious diseases.

1.4. IPC priorities for 2016-2017

- Fully resource the IPC team with a fulltime IPC qualified support to deliver the Annual IPC Work Plan, Quality Improvement Plan (QIP) and IPC risks identified
- Provide IPC support and advice across directorate to achieve the Trust-wide Quality Improvement Plan
  - Cleanliness of stations, Stations and Equipment
  - Bare-below–the-elbow implementation and oversight
  - Supporting Logistics with procurement of services and addressing management of blankets and North East Sector project
  - Supporting Estates with procurement of services and the Hand Hygiene refurbishment in stations
  - Devise blended training content to meet the Skills for Health Core Skills Framework
- Delivering on the outstanding areas identified in the IPC Work Plan 2015-2016
  - Continuation of policy and information development, undertake a programme of validation audits, training for educators, PPE video/poster development and implementation
  - Support the resurrection of IPC Champions in Group Stations to provide local means of delivery IPC
- Support the Workforce Team to find a solution for management of crew exposure to infectious diseases
- Participating in the QGARD Vehicle Cleaning Research project
- Participating the IPS Glove research project

The DIPC and Head of IPC will continue to drive forward the improvements made to date and ensure that gaps remaining in 2015-2016 IPC Work Plan and the development areas identified by the CQC inspection team, in QIP, continues to be addressed for 2016-2017 to meet national standards.

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2. Introduction

This annual report from the DIPC at London Ambulance Service (LAS) NHS Trust is to inform the Board of the progress made against the Care Quality Commission (CQC) Essential Standards, and the Health and Social Care Act 2008 (revised 2015): Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department of Health), commonly known as the 'Hygiene Code', for the period April 2015 to March 2016.

The Annual report demonstrates the on-going commitment of the Trust to address and embed IPC principles and practices throughout the service and provides a report on the performance for 2015-2016. It further identifies the gaps and risks to the organisation and mitigating actions required going forward.

3. Infection Prevention and Control Arrangements

The NHS Operating Framework recognises that there is still scope to drive Healthcare Associated Infections (HCAIs) down further to safeguard patients through a zero tolerance approach to all avoidable HCAIs including Multi-Drug Resistant Organisms (MDROs). Healthcare providers have to have a delivery plan to reduce HCAIs in line with the national objectives and contractual agreement. This organisation continues to drive performance towards harm free care through its assurance structure and the delivery of the IPC Annual Work Plan.

Infection Prevention and Control Team (IPCT)

The Head of Infection Prevention and Control (HIPC) has continued to lead on the implementation of the infection control programme and policies and to provide advice about the prevention and control of infection despite a continuing lack of an additional fulltime IPC permanent support and long-term sickness absence of the HIPC in Q3. Table 1 lists the Infection Prevention and Control Team establishment including changes that have taken place during the year.

Table 1. The Infection Prevention and Control Team

Post	Post Holder	WTE	Comment
Interim Director of Infection Prevention and Control	Zoë Packman	0.1	Also Interim Director of Nursing and Quality
Head of Infection Prevention and Control	Eng-Choo Hitchcock	1.0	Substantive post

There were challenges associated with the delivery of the IPC service between July 2015 and January 2016 due to the termination of the temporary Band 4 support and the long term sickness absence of the substantive post holder. Temporary IPC support was partially re-instated in January – March 2016 with 0.5 WTE temporary post-holder. It is planned that a permanent Band 5 administrator 0.4 WTE be recruited for 2016-2017.

Infection Prevention and Control Reporting Arrangements

Infection Prevention and Control Committee (IPCC)

The quarterly IPCC is a strategic and assurance committee (Terms of Reference, Appendix 2), with the operational scrutiny undertaken by the monthly IPC Taskforce (Terms of Reference, Appendix 3; Governance Chart, Appendix 4).

The strategic IPCC met four times in the year 2015/16. The DIPC chaired the meetings and the committee membership comprised of representatives of key support services,

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management, staff and patient representation. Reports were regularly presented to the Trust Board via the Quality Governance Committee (QGC).

The IPCC committee provided scrutiny of IPC delivery and assurance to the Trust Board that all services were provided in a clean and safe environment through the effective performance monitoring of key performance indicators.

Clinical Safety and Standards Committee (CSSC)
The CSSC evolved from the Safety Development and Effectiveness Committee (SDEC) in 2015 following organisational changes. CSSC received assurance reports on the progress of the Infection Prevention and Control delivery plan, including escalation issues, relevant IPC and decontamination issues and onwards to the QGC and onwards to the Trust Board. In addition, there were regular monthly reporting to the Senior Management and Executive Leadership Team (previously Executive Management Team).

Infection Prevention and Control Taskforce (IPCT)
The monthly Operational IPCT, performance managed the implementation of IPC Annual Work Plan for the Trust. Its pivotal role provided a robust mechanism for scrutinizing, challenging poor practice, risk mitigation, performance monitoring and managing, and oversight of appropriate policy implementation. The IPCT regularly escalated relevant issues and risks to the quarterly IPCC.

The IPCT provided a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust. It monitored IPC compliance with the Hygiene Code through the monthly updates from complexes, relating to the IPC audits for vehicles, premises and observed practice, deep clean status of vehicles, training attendance and reported infectious and sharps incidents, as well as annual flu uptakes.

The IPCT promoted best practice in all areas of IPC and decontamination and lessons were shared through its membership. The IPCT ensured that current and future legislation, national policies, guidelines, and initiatives were applied and developed.

The IPCT regularly received recommendations from other key groups, and through the HIPC, worked collaboratively with external partners such as the National Ambulance Infection Prevention and Control Group (NASIPCG) and Public Health England Health Protection Units.

The IPCT continued to be chaired by the Deputy Director of Nursing. The membership comprised of operational and support staff; clearly identified in the IPCT Terms of Reference (Appendix 3) and the Governance Chart, Appendix 4). The TOR was reviewed in March 2016.

Director of Infection Prevention and Control (DIPC): role summary
The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national standards and ensures continuous CQC registration as healthcare provider. The responsibility for the Trust is delegated to the DIPC/Director of Nursing and Quality.

The DIPC:

- Reports directly to the Chief Executive Officer, CSSC, Executive Leadership Team (ELT), and the Trust Board to ensure that any changes in legislation or national guidance are made known to the organisation.
- Ensures that the Trust provides adequate resources to secure effective prevention and control of healthcare acquired infections.
- Ensures that appropriate actions relating to the prevention and control of infection

are taken following recommendations from the ELT or Trust Board.
- Ensures that the Trust Board receives regular reports (including key performance indicator reports).
- Is responsible for the Infection Prevention and Control Team within the Trust.

Head of Infection Prevention and Control (HIPC): role summary
The HIPC has delegated responsibility from the DIPC to provide strategic leadership, challenge and improve practice, seek assurance of compliance, and provide infection prevention and control expert advice to all disciplines within the Ambulance Trust on a day to day basis.
Duties of the HIPC:

- Produce the IPC Annual Work Plan.
- Advise line managers within the Trust on the implementation of agreed policies in their areas.
- Have oversight of IPC performance within the Trust; ensure that standards are being met.
- Produce written reports on compliance status with the Health & Social Care Act 2008 Hygiene Code, and the Care Quality Commission Essential Quality Standards to ensure continuous registration and ensure that accurate records are kept.
- Report to the IPCT, IPCC and other appropriate committees within the Trust's governance structure as necessary.
- Use evidence based practice and to ensure clinical effectiveness when transforming and planning future services, addressing any training needs and mitigate risk.
- Produce and maintain a local risk register.
- Horizon scans for emerging issues and provides a mitigation plan, undertake research to contribute to and enhance clinical practice in the ambulance service.

4. Budget Allocation for Infection Control Activities

Staff resource: See Table 1 for IPC Team
The HIPC role was in Q1-2 temporarily supported by a fulltime Band 4 audit and support agency worker. The HIPC role is operational during office hours, with no-call responsibility.

The gap in resilience for out-of-hours and out-of-office cover arrangements for IPC advice was temporarily addressed in December 2014, via EPRR Lead. The lack of progress to ensure a fully resourced team with appropriate skillset continued to impact on the delivery on the 2015-2016 IPC Annual Work Plan.

There was no locally devolved IPC budget.

Budget holder: Zoë Packman

5. Progress of the Infection Prevention and Control Annual Work Plan and LAS CQC Quality Improvement Plan (QIP)

The objectives of the IPC Annual Work Plan, was to ensure a healthy workforce and safe care to patients by preventing transmission of healthcare associated infections (HCAIs) and contribute to the national antimicrobial resistance strategy, where appropriate. This is achieved by embedding effective IPC practice in all staff groups through a comprehensive IPC programme.

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During 2015-2016, an inspection was undertaken by the CQC in June followed by a report with recommendations in November 2015. A trust-wide QIP and actions were prioritised for implementation. Progress continued to be made in identified areas in the QIP work streams. The HIPC will continue to support various departments to make improvements in 2016-2017 (Appendix 1, 6), and delivery of the IPC Annual Work Plan, subject to the constraints within IPC team complement.

5.1. Audit Programme

Significant work was undertaken in in the previous year to develop a suite of e-audit tools, by merging the IPC with the Health and Safety premises audit tool to ensure effective use of the station auditors' time; however the work stream ceased due to a lack of foreseeable funding stream to purchase the web-based system in 2015-2016. The Transformation and Engagement team lead has since taken this forward in Q4 under the QIP work stream to improve the trust-wide audit system and process.

An integrated audit programme (DocWorks) using a centralised web-based system will be launched in 2016-2017. The initial roll out plan will focus on medicines management compliance audits along with the premises inspection. Once these have been implemented further audits regarding bare-below-the-elbows, vehicle cleanliness and decontamination of equipment will be brought on line. The Transformation team has been working with the supplier to develop a Windows-based application which will form part of the trust's IM&T suite of applications.

In the meantime, monthly audit data continued to be provided via a localised paper based, manually aggregated and analysed system, which was time-consuming, not timely and lacked robustness, with an inability to be easily benchmarked.

The audit schedule was operated on a monthly basis; each station group self-reported their compliance, within a strict timeframe and populated on the data x-drive, by their delegated local leads.

It was noted Group Station Manager (GSM) Top 10 audit data continued to be uploaded by Group Station staff with varying compliance and submission rates, due to the organisational structure and role changes during the reporting period. Submission rates were observed to have dropped from end of August to end of Q4. Quality Governance and Assurance Managers (QGAMs) were tasked with addressing the challenges locally.

Group stations continue to use the paper-based 5 audit tools and data is manually uploaded.

- Monthly Observed Practice (Hand hygiene compliance)
- 6 weekly vehicle deep clean compliance
- Monthly Premises Cleanliness – submission rates low since August.
- Quarterly IPC Audit

GREEN	≥ 85%	Compliant
AMBER	75.1 – 84.9%	Partially Compliant, action required
RED	≤ 75%	Minimal Compliance, Urgent action required

The IPC performance data was presented via a monthly IPC Balance Scorecard to the IPCT and shared with Quality Governance and Assurance Managers (QGAMs), to provide assurance to the Trust via various Committees to demonstrate compliance with the Health and Social Care Act 2008: Code of Practice for the Prevention and Control of infections and related guidance ('the Hygiene Code', amended 2015). The data collated on the IPC Balance Scorecard informed a Quality Report to commissioners.

A planned programme of validation audits at stations by the IPC team was not undertaken in 2015-2016, due to inconsistency of capacity in the IPC team and lack of appropriate skillset in temporary staff recruited from Restricted Duty staff members. This approach is not adequate and did not allow forward planning. In addition the long-term sickness absence in the substantive post-holder impacted on the delivery of the work plan.

5.2. Compliance with Hand Hygiene and Aseptic Protocols

Compliance with hand hygiene

- **Hand Hygiene audits**

Self-audits continued to show high compliance averaging 93% over the whole year (Table 2). In 2015-2016, the new target was set at 90%. When sporadic third party hand hygiene audit scores were provided, figures were much lower. IPC performance data capture for Patient Transport Service (PTS), Community Responders, specialist teams and VAS/PAS services were established by April 2015 but the reporting was not regularly submitted, despite reminders. This was discussed at the IPCT meetings.

Table 2. Hand Hygiene Compliance

Monthly Scorecard 2015 -2016													
MONTHS	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET
Hand Hygiene	95.2%	92.1%	95.0%	91.3%	91.7%	88.8%	90.5%	87.3%	91.7%	100%	99.1%	85%	90%
Submission %	91.7%	79.2%	87.5%	87.5%	70.6%	70.6%	64.7%	70.6%	70.6%	64.7%	64.7%	41.2%	

The 2015-2016 self-audit compliance scores continued to show good hand hygiene behaviour by operational staff during patient contact. The consistent reports of high scores have been challenged for the last 3 years at IPCT/IPCC meetings. Going forward, it is expected hand hygiene audits will be undertaken as part of the Operational Workforce Review (OWR), to ensure an objective observational audit, decreasing the Hawthorn effect.

- **Hand Hygiene facilities at stations (QIP Theme 4)**

A number of stations did not have dedicated, appropriate hand wash facilities due to estates constraints. This was a core part of the IPC action plan for 2015-2016. The LAS has since commenced a programme to install hand wash basins in the majority of its sluice areas. Since October 2015 five have already been installed and another 16 are due for completion by April 2016. The rest are planned for completion for year 2016-2017. Where it is not possible to install a hand wash basin due to space restrictions or cost, a risk assessment will be undertaken. In addition, hand gel will be available for use.

Application of aseptic non-touch technique (ANTT) - clinical protocols

Aseptic Non-touch technique continued to be taught in IPC sessions at Clinical Induction and Clinical refreshers. Adherence to ANTT was self-reported in patient hand-over documents; however this is currently not audited. A review will be required on how best to embed this possibly within OWR suite of tools in future.

Operational Workforce Review (OWR) provides an opportunity to observe and audit clinical practice, and this process is expected to be re-instated in Q1 in 2016/2017. The process is currently being enhanced and should support the monitoring of IPC standards and competency in Hand hygiene, Bare-Below-the-elbows, and ANTT. Observational audit standards are planned to be incorporated into OWR from Q1 2016-17.

5.3. Prevention and Control of Infection risks relating to Estates

Waste management

The waste management policy was enhanced to ensure that all elements of waste segregation and appropriate disposal are captured. This included management of Category A infectious healthcare waste, responsibilities clearly identified, with audit and reporting arrangements to the quarterly IPCC for oversight. The Waste Management Policy was ratified in Q1 2015.

Water quality

The management of water quality has improved since Q2 2013. The LAS undertakes bi-annual risk assessments of its water systems to ensure they are safe for use. Any risks identified are logged and tracked with relevant action taken recorded. This risk log is presented to the IPC committee. The LAS also undertakes monthly non-compliance checks in line with its approved policy and the named person responsible monitors and checks compliance and take relevant action when required. Non compliances vary from month, ranging from 0 to 25. These are monitored or corrected as necessary. A new Legionella policy was ratified in Q1 2015.

Cleaning services (QIP Theme 4)

The Trust recognised that cleanliness in the patient and frontline staff environment is paramount for patient safety and can reduce the likelihood of Healthcare Associated Infections (HCAIs) and microbial resistance.

Following the CQC report, the LAS reviewed its cleaning programme to include the cleaning of garage areas which was not undertaken, increasing the frequency of cleaning and carrying out more regular deep cleans. Funding was declined and a way forward will need to be identified for 2016-2017.

A planned programme of sluice improvement programme with dedicated hand washing facilities was being implemented (refer to 5.2, page 8).

Cleaning audits

Cleaning audits are currently being triangulated from 3 sources, and work continued to ensure that data received reflected standards observe locally. Improvement to the Trust – wide e-audit system and process being taken forward by the Transformation and Engagement Team Lead as a Trust-wide project should improve matters in 2016-2017.

Lakethorne (provider) premises cleaning

The LAS have in place a cleaning contract for domestics cleaning for all premises it occupies. Quarterly contract meetings are held where the contract reports on performance, complaints and other issues. The cleaning contract is audited by local staff, the contractor and the Estates department and given a score rating.

Premises cleaning compliance target for 2015/2016 was stretched to 90% from 85% in 2014-2015, and continue to exceed the target of 90%. See Table 4 below.

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Table 4. Premises Cleaning Standards

Monthly Scorecard 2015 -2016													
MONTHS	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET
Premises cleaning	94.1%	94.2%	92.9%	92.1%	93.9%	95.4%	97.3%	93.5%	96.2%	95.8%	98.3%	92.6%	90%
Submission %	87.0%	91.7%	87.5%	87.0%	64.7%	70.6%	76.5%	64.7%	58.8%	76.5%	64.7%	41.2%	

Reactive IPC visits to stations were undertaken in Q1 as part of the CQC preparatory work. There were discrepancies in the compliance data submitted and the standards of cleanliness observed varied markedly. To facilitate high standards of cleaning and to reduce cross contamination, IPC recommended clear demarcation for clean and dirty areas in the stations, alongside a de-clutter programme and regular monitoring as part of the preparation for CQC inspection.

Local management and operational staff were advised to take ownership and to assist with maintaining high standards of cleanliness in stations. The exemplar ‘productive stations’ was initiated in 2015/16, but was not implemented to due capacity issues and the absence of the HIPC.

5.4. Prevention and Control of Infection risks relating to Logistics

- ***Vehicle Cleanliness (QIP Theme 4)***

Vehicle Preparation – 6-weekly deep cleaning compliance

Vehicle Preparation (VP) deep 6 weekly cleaning compliance standards for front line vehicles has continued to improve, with an average of 94% compliance at the year-end, (Table 3), against a target of 95% for 2015-2016. The 95% target was stretched from 90% in 2014-2015.

Table 3. Vehicle Prep 6 weekly Deep Clean of A&E vehicles

Monthly Scorecard 2015-2016													
MONTHS	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET
VP 6/52 Deep Clean	92.6%	97.7%	96.7%	95.4%	95.9%	94.0%	96.2%	94.0%	92.4%	90.9%	95.5%	94.7%	95%

Interquartile results demonstrated that 46.2% complexes either met or exceeded the new higher target of **95%,** compared to 53.8% that achieved the previous target of **90%** last year. For interquartile results broken by complex see Appendix 5.

Quality of vehicle cleaning (and vehicle stock management)

In order to shape the processes for quality of vehicle cleaning in 2015-2016, the North East Pilot Project was commenced in February 2016 to find an integrated solution to continuing cleanliness and stock control problems experienced by crews. A North East Pilot Project reviewed and implemented a local, suitable and comprehensive solution to managing stock, provision of a clean and well equipped frontline vehicle for crews to aid operational delivery of the service.

The trial of microfibre cleaning materials, cleaning solutions, restocking supported by a 24/7 vehicle preparation service, overseen daily by a local ‘quartermaster’, seemed to be going well and positively received by crews. It should be noted that the quality of vehicle cleaning audits is expected be initiated during 2016-2017.

The HIPC supported this workstream with advice, development of the ATP swabbing protocol for the project and enhanced the daily vehicle inspection tool to include equipment cleanliness. In addition, cleaning products for vehicle interiors were reviewed and

standardized in Q4. New information leaflets to guide operational and cleaning staff were made available on the *Pulse*, to aid timely access to current cleaning advice to staff members.

- **Medical devices management and patient equipment decontamination (QIP Theme 4) and Trust Risk 411 & 326**

The Medical Devices and Decontamination executive lead was delegated to the Director of Finance, who led the improvements in this area, supported by the Logistics manager.

A comprehensive Medical Device Management Policy, aligned to the national MHRA Medical Device Management Guidance (2014), was drafted in Q4 2015-2016 for wider consultation at the IPCT and the Clinical Equipment Working Group (CEWG). It is expected to be ratified in 2016-2017. The Medical Devices and Decontamination Lead, IPCT, CEWG, will ensure all policies and procedures relating to medical device management and decontamination, are up-to-date and being adhered to.

An externally provided disinfection service for A&E contaminated equipment was commenced in April 2015. The risk associated with contaminated equipment continues to be monitored through the Trust Risk Register and at IPCT meetings. Contaminated A&E equipment collection and implementation of clear signage regarding identification of clean and contaminated equipment is being overseen by the Logistics Manager.

The incorporation of the equipment decontamination into the Daily Vehicle Inspection is currently being considered. Decontamination related issues have been monitored by the IPCT for the last 2 quarters following the cessation of CEWG meetings in September 2015, whilst structural changes were taking place. There is an expectation that the CEWG will commence in Q1 2016-2017.

- **Blanket supplies (QIP Theme 4) and Trust Risk 381**

Blanket use was identified as not meeting the IPC standard required, and significant work has been undertaken by the Blanket Group which met fortnightly to ensure continuous improvement. This group was chaired by the Director of Finance.

Since Q4 2014-2015, significant progress has been made in the retrieval of reusable used blankets from hospital and laundry systems. Current supply of blankets was increased, including the use of disposable blankets. To ensure continuous supply, 10,000 reusable blankets were procured in Q4 of 2015-2016. Another 25,000 single-use blankets are expected in Q1 of 2016-2017. Work is progressing well towards full compliance.

5.5. Compliance with IPC training

A robust data capture system trust-wide is being progressed by the Transformation team.

IPC refreshers for existing patient-facing staff were included in CSR 2015.3 which began in December 2015. Training compliance achieved 90% (2745/3048) for patient facing staff at year-end, against a target of 80%, stretched from 65% from last year. See Table 5 below. This target is being further stretched to 90% for 2016-2017. A new approach to facilitating CSR attendance through Individual Learning Accounts (ILA) was implemented this year which led to the increase in attendance (90%) compared to the 48% achievement last year.

Table 5. CSR 2015.3 Training Compliance

Monthly Scorecard 2014 -2015													
MONTHS	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET
CSR 2015.3 (cumulative %)	15.1	15.1	15.1	15.1	15.2	15.2	15.2	15.2	294/3048 9.6%	949/3048 31.1%	1751/3048 47.4%	2745/3048 90.1%	80%

Infection Prevention and Control training for non-patient facing staff is available through an e-learning package from March 2015. From April 2015 - March 2016, 595 certificates have been issued. An additional course for 3 yearly refresher training is being developed to meet the requirements of Core Skills Framework in 2016-2017.

In May 2015 a specific training course was developed for Advance Paramedic Practitioners (APP) to refresh and enhance their IPC knowledge to meet their expert roles.

The Fast Responder Department has responsibility for volunteer responders to Category A and emergency calls. Community Fast Responders (CFRs) currently have access to IPC training. Recently mandatory IPC training was extended to Emergency Responders (ERs) in 2015/16 to align with the provision for CFRs. In 2015-2016, 41 existing ERs were trained; 14 new ERs in Q4; an additional 16 received refresher IPC training.

VAS and PAS providers, training compliance data was monitored through the contracts manager from 2015. No compliance data was submitted to IPC; likewise, in HART and PTS.

In 2015-2016 standard IPC training packages were enhanced by the HIPC and the Educational Lead to include lessons from incidents and a greater focus placed on developing practical skills in IPC good practices. Alternative delivery methodologies were explored in 2015-2016 and an e-learning package (Level 1) was developed for use for non-patient facing staff. Video of practical demonstration of PPE removal was not developed due to the delay in procurement of the enhanced PPE. This will be taken forward in 2016-2017.

5.6. Policies, procedures and guidelines

The IPC Workbook (February 2013) was reviewed in Q4 and finalised in Q1 2016-2017, and currently awaiting sponsorship funding. Hard copies supplies were exhausted by Q4, however it is accessible on the ‘Pulse’ in the IPC dedicated section. In Q1 the following policies were updated and approved: IPC Policy, Waste Management; and new policies ratified: Workforce Immunisation, Legionella.

Review and development of other policies and the IPC manual remains delayed due to lack of appropriately skilled capacity in the IPC team, and other QIP priority work streams. The lack of capacity was recorded as a risk in the IPC Local Risk Register.

In response to the threat of viral haemorrhagic fever (VHF) cases in London, local LAS HART VHF transfer guidance was enhanced with the addition of Category A waste management. Regular internal bulletins were issued to staff as required, with guidance from PHE.

6. Healthcare Associated Infection (HCAI) statistics and incidents

Ambulance services are not required to provide HCAI data for *MRSA bacteraemia* or *Clostridium difficle.*

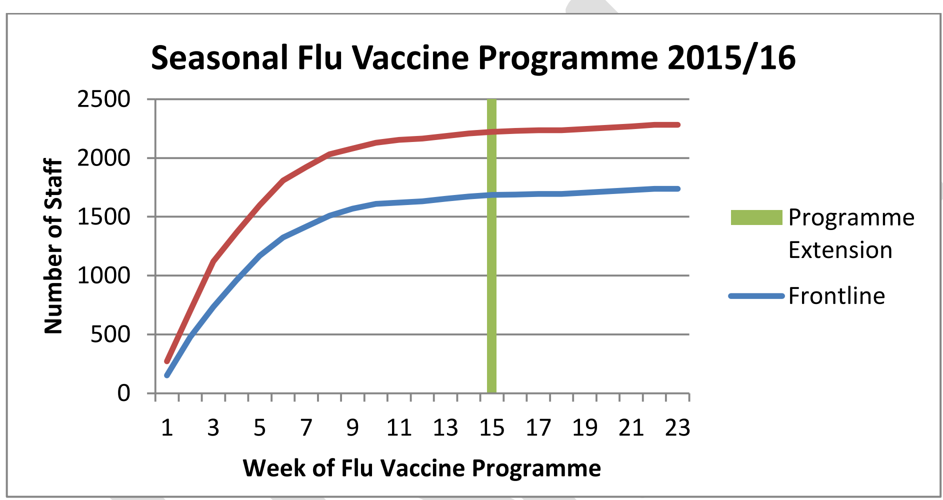
6.1. Annual Seasonal influenza Programme

In 2015/16, the Seasonal Flu Lead reported that overall 47% of total staff received the influenza vaccination compared with 33% last year, 47% of the frontline staff received the influenza vacation compared with 44% last years.

	2015/16	2014/15	2013/14
Frontline	47%	44%	48%
Total	47%	33%	45%

The Flu Vaccine Programme for 2015/16 led by EPRR, commenced mid-October whereby staff were offered and vaccinated with the annual Flu vaccine. Originally the programme was to last 15 weeks until the end of January but was extended through the end of March.

Flu uptake data was regularly submitted to the IPC Scorecard from Q3 2015 to Q4 2016.



6.2. Enhanced Personal Protective Equipment – IPC kit (QIP Theme 4)

As a consequence of the VHF work stream (2014-2015), Personal Protective Equipment (PPE) for Standard IPC kit for general crews was enhanced, and approved for use at CEWG in March 2015. Procurement was agreed at Q4 at the CSSC. PPE kit for vehicles and individual crew bags will be implemented in 2016-2017 led by Logistics manager. Additional training to use the enhanced equipment will be supported by a planned video when new supplies are received. There will be oversight of implementation by CEWG and monthly IPCT. PPE implementation was registered in the IPC Local Risk Register with the risk owned by Logistics.

FFP3 reusable face masks supplied to crews requires individual fit testing and personal supply. **Fit testing data** was regularly submitted to the IPC Scorecard by the Flu Lead (EPRR) until August 2015. Since then there were significant gaps in reporting as well as discrepancies in figures from various sources due to staff and organisational changes. It was not possible to quote figures provided that could robustly assure our trust re compliance. This is being monitored at the monthly IPCT and in the interim period QGAMs were tasked with ensuring accuracy of data collected locally. Robust data capture is an improvement area in 2016-2017, and with the implementation of GRS in 2016, it is expected that assurance will be more robust in future.

6.3. Untoward incidents including outbreaks and staff exposure to communicable disease

No outbreak was reported this year.

Thirteen (13) staff exposure incidents to communicable incidents were reported to IPC team in the 4 month period (April 2015 to August 2015). No data was captured from September 2015 to February 2016.

Table 6 highlighted the number and type of staff exposure to communicable disease incidents in 2015-2016.

Table 6. Crew exposure to communicable disease/incident

Communicable disease	Apr-15	May-15	Jul-15	Aug-15	Mar-16	Total
? MERS			1			1
Chicken pox	1					1
IGAS				1		1
Measles		1			1	2
Meningitis	3		1	1	1	6
Scarlet fever				1		1
Shigella					1	1
Total	**4**	**1**	**2**	**3**	**3**	**13**

There was a lack of clarity in the internal management of staff exposure to communicable disease and the management of associated risks.

All staff exposure incidents were previously managed by the HIPC until July 2015, and included internal contact tracing; liaison with external partners such acute hospitals, microbiologists, Occupational Health Service (OHS) and the PHE London HPTs.

Contact tracing after this period was undertaken by the DIPC and her deputy. The lack of evidence of a safe system with robust and clear processes between August 2015 and March 2016, impacted on the level of assurance for Criterion 10 of the Hygiene Code.

The LAS identified the risk to staff in a formal risk assessment and actions continued to be taken to finalise and implement new policies. The process for managing and capturing staff exposure incidents was being developed by Workforce Development in Q4, to ensure that staff exposed, had support and received the follow-up they required to ensure their health needs are properly met. Implementation of the new process would also provide evidence and assurance of the LAS meeting Criterion 10 of the Hygiene Code.

The Trust recognised the importance of providing a safe working environment under the Health and Safety at Work Act (1974), hence the progress of actions, continued to be monitored at the monthly IPCT (Local Risk Register), with appropriate escalation when required,

6.4. Sharps Injuries (Trust Risk 46)

Overall, there were 180 sharps injuries for all categories in 2015 -2016 (See Table 7).

Safer needle system was introduced in the Trust in July 2014. An increase in clean needle injuries was observed in 2015-2016, which was due to an equipment packaging fault. The packaging design was corrected by the manufacturer.

FINAL

In 2015/16, 39/180 used sharps injuries (derived from a dirty/used needle and the highest risk) was reported; this has reduced by 11.4% compared to the year before. The majority of incidents could be avoided by adhering to good practice. Good practice was re-iterated through CSR training.

Table 7. Sharps injuries 2010-2016

Count of records	2010/11	2011/12	2012/13	2013/14	*2014/15	2015/16
Clean Needles	10	18	7	36	51	66
Dirty/Used Needle	48	67	48	51	44	39
na	64	45	48	35	61	46
Razor		4	58	20	24	29
Grand Total	**122**	**134**	**161**	**142**	**180**	**180**

Note:
NA=Incident involving broken ampoule or vial, Incident involving broken glass, Needle stick – lancet
* Safer sharps implementation was completed in Q2 of 2014/15.

To address the increase in razor injuries, a trial of storage containers to store clean razors was undertaken in Q4 by staff side to further reduce this type of injuries. Acquisition of these containers was awaiting approval at IPCT in Q1 2016-2017.

7. Occupational Health Provision

A new occupational health service (Health Management Ltd) was phased in from April 2015. It became fully operational in July 2015, with the Blood and Body Fluid Exposure (BFE) incidents sub-contracted to Guys and St Thomas Occupational Health Service.

8. Mitigating IPC Risks

The Trust and local risks identified were scrutinised and monitored by the monthly IPCT and assurance provided to the quarterly IPCC, and onwards to Quality Governance Committee, with regular oversight from the Governance team.

The Trust risks related to IPC included medical device management and decontamination (RR 411, 326), reuse of linen (RR 381, see section 5.4, page 11) and sharps injury (RR46, see section 6.4, page 14). Mitigating actions have been taken and continued to be progressed and monitored.

A number of local risks were reported and escalated to quarterly IPCC. Key ones included the lack of clarity of internal process for contact tracing and follow-up of staff exposure to communicable disease, delay in provision of enhanced PPE, and the continuing impact on the IPC workplan due to lack of a fully resourced IPC team. Actions were being taken to address these issues.

9. Infection Prevention and Control Objectives 2015/2016

Achievements in practice and governance made in 2015-2016:

- Provided advice and support Logistics - solution for blankets/linen; vehicle and equipment design and procurement of equipment; support medical

device management and knowledge in decontamination; and the North East Pilot Project
- Provide IPC advice and support to Estates to reduce IPC risks in refurbishment and re-configuration of stations/services to include hand hygiene facilities, and cleaning specification
- Established local risk register, monitored monthly at IPCT
- Developed new course for APP, reviewed and enhanced CSR IPC training content and delivery to ensure acquisition of practical basic principles skills and knowledge
- Ensured IPC session was included trust mandatory training (IPC session was removed from Corporate Induction in 2015/16 without IPCT agreement)
- Reviewed delivery methodology to meet the needs of a mobile workforce to increase uptake – Level 1 Course 1 e-learning package completed Q1
- Supported the setting of measureable IPC KPIs for contracted services
- Supported the monthly IPCT and quarterly IPCC
- Completed new structures for IPCC and IPCT membership and terms of reference
- Enhanced the standard IPC kit and personal kit for crews
- Developed a range of IPC posters and information for the Pulse.
- Completed the update of the IPC workbook
- Supported the review of the Uniform, Management of Sharps Policy, Body Armour and cleaning specification
- Initiated the introduction of an IPC manual of procedures

Partial or Not achieved:

- Review recently developed policies to ensure accountabilities are correctly described when new structures are finalized
- Develop manual of procedures to align with Hygiene Code
  - Video development for standard PPE kit delayed due to availability of supplies
- Support the establishment of exemplar ‘productive stations’ in South sectors as pilots – initiated, unable to complete due to absence of HIPC
- Partially resolve IPC performance data capture to inform Balanced Scorecard with robust data
- Ensure IPC and aseptic competencies through Operational Workplace Review (OWR)
- Address discrepancies in self-reported and observed audit data by:
  - Establish a planned programme of validation audits by IPC team
  - Peer or mystery shopper audits
  - Procurement and implementation of E-Audit tool system
  - Participate in IPS regional hand hygiene research project
- Resurrection IPC Champions in complexes to provide local support
- Fully resourced IPC Team with fulltime permanent member of staff was not fulfilled from July 2015. This gap impacted on the delivery of the IPC service until January 2015, when temporary support WTE 0.5 was provided

Conclusion

During 2015-2016, the IPC team focused on supporting the trust in the preparation for CQC inspection in June 2015. In November 2015, the CQC report recommendations helped drive forward the IPC work streams, with prioritisation being focused to supporting the delivery of QIP actions to ensure we meet recommendations from the CQC.

There were achievements made in 2015-2016 despite the challenges, identified in this annual report. The outstanding actions from the IPC Annual Action Plan were due in part to the lack of clear trust-wide system and process, organisational change, the lack of resources and long-term sickness absence of service lead, which are being addressed.

The Infection Control Objectives for 2016-2017 will continue to be prioritised to support the delivery of QIP work streams.

Report Author:
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Head of Infection Prevention and Control
London Ambulance Service NHS Trust

Formatting: Jessica Bochenek

26 April 2016
Updated 12/5/16, 19/5/16 (Transformation additions), 24/5/16, 26/7/16 (OHS, Risk and Safety, Estates additions)
Executive Summary 4 July 2016.

FINAL

Appendices

Appendix 1- Hygiene Code Criteria and Care Quality Commission Essential Standards

Hygiene Code Criterion	Hygiene Code Requirement	Compliance Status		
		Apr-14	Apr-15	Apr-16
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users are and any risks that their environment and other users may pose to them.	Partial	Partial	Partial
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Partial	Partial	Partial
Criterion 3	Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Compliant	Compliant	N/A Criterion changed 2015
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant	Compliant	Compliant
Criterion 5	Ensure prompt identification of people who have or are at risk to developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Partial	Partial	Partial
Criterion 6	Systems to ensure that all care workers (including contactors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Partial	Compliant	Compliant
Criterion 7	Provide or secure adequate isolation facilities.	N/A	N/A	N/A
Criterion 8	Secure adequate access to laboratory support as appropriate.	N/A	N/A	N/A
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Partial	Partial	Partial
Criterion 10	Providers have a system in place to manage the occupational health need and obligations of staff in relation to infection.	Partial	Compliant	Partial (lacks robust managem ent of Crew exposure)

Key	
(green)	Compliant
(orange)	Partial – actions initiated
(light orange)	Partial – actions progressing

Appendix 2- IPC Committee Terms of Reference

LAS Infection Control Committee Quarterly Assurance

Terms of Reference

Purpose
The Infection Prevention and Control Committee (IPCC) is part of the LAS Governance Framework. The IPCC is a multi-disciplinary committee that serves as an advisory body to the Trust on the provision of an Infection Prevention and Control Service for patients, staff, contractors and visitors to the London Ambulance NHS Trust.

The IPCC will provide assurance to the Trust Board that the Infection Prevention and Control measures taken within the LAS are sufficient to achieve compliance with regulatory requirements, legislation and national directives and best practice.

In addition, the committee provides the Trust with timely advice and recommendations on current and emerging infection prevention and control issues in LAS services as well as in contracted and voluntary services.

The main outcome of its activities is to minimise infection throughout London Ambulance Services NHS Trust and ensure a safe healthcare environment for patients, staff, contractors; protecting them from avoidable harm.

Objectives

- To horizon scan for and monitor the implementation of new legislation, national directives, evidence based practice and other relevant guidance
- To review and agree relevant Trust Policies relating to infection prevention and control (IPC) issues, prior to submission for approval by Senior Management Team
- To agree and monitor the annual infection prevention and control work programme
- Evaluate reports/minutes received:
    - Incident reports and investigations relating to IPC
    - IPC Risk mitigation
    - Audits undertaken and action plan progress
    - Decontamination
    - Equipment and Environmental hygiene
    - Vehicle cleanliness
    - Building/Estates development, including water quality
    - Occupational Health quarterly activity reports relating to IPC risk management
    - Public Health by London Health Protection Teams' Lead
    - Minutes from IPC Taskforce and escalation points, Clinical Equipment Group, Vehicle Working Group

Accountability and Reporting Arrangements
- The Infection Prevention and Control Committee is directly accountable to the Chief Executive who is represented on the committee by the Director of Infection Prevention and Control (DIPC).
- Once approved by the IPCC, all IPCC meeting minutes, reports, policies and guidelines will be forwarded to the Quality and Governance Committee (previously Safety, Development and Effectiveness Committee) and Trust Board as part of the governance process.

Membership

Chair
The chairperson will be the Director of Infection Prevention and Control. The chairperson will be responsible for:
- Developing IPCC meeting agenda, aided by the PA to the DIPC

- Assess and provide recommendations on issues related to membership and terms of reference
- Identifying IPCC priorities

Vice Chair
The vice chairperson will be Deputy Director of Operations and will assist the chair to fulfil his/her duties.

Members
Members will have:
- Expertise and be actively involved in the area they represent
- Knowledge in the field of infection prevention and control
- A practical understanding of problems faced in the delivery of healthcare
- Effective communication and team working skills
- The ability to critically appraise scientific literature.

Members will include:

- DIPC, representing the Chief Executive and Trust Board (currently Interim Director of Nursing)
- Director or Deputy Directors of Operations
- Director Paramedic Education
- Medical Director/Deputy Medical Director
- Clinician – Medical Directorate (TBA)
- Head of Infection Prevention and Control (HIPC)
- Head of Governance
- CCG Infection Prevention and Control Representative
- Representative from London Health Protection Teams – Lead SELHPT
- Occupational Health representation (TBA)
- Head of Estates
- Assistant Director Fleet and Logistics
- Decontamination Lead
- Representative from Patient Forum

Ad-Hoc members (Non-voting)
- Attendance by co-opted members will be as when necessary/invited by the Chair

Quorum
- Members are expected to attend at least three out of four meetings each year, and send a representative who can make decision on their behalf when they are unable to attend in person.
- Quorum of 75% of the IPCC members, should include the Chair (DIPC or Deputy Chair), HIPC, a clinician and an associate director.

Frequency of meetings
- Meetings will be held a minimum of four times per year.
- In the event of an outbreak the IPC Team and key members of the IPCC will meet and manage the situation and provide verbal and written reports to the Chief Executive, Trust Board and Safety, Development and Effectiveness Committee and written reports to the Infection Prevention and Control Committee.

Authority
- IPCC is authorised by the Trust to monitor and assist in compliance with the Code of Practice for the prevention and control of Healthcare Associated Infections. The committee has been authorised to produce, review and approve infection prevention and control related Trust guidelines and policies, investigate activities within its remit, create sub-groups, and co-opt members.

Monitoring Effectiveness

FINAL

IPCC produces an annual report for Trust Board and sends a monthly report to the Executive Management Team meeting and to the quarterly Quality and Governance Committee (previously Safety, Development and Effectiveness Committee).

Key indicators

- Commissioner KPIs
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and Regulation 15
- Health and Social Care Act 2008: Code of Practice for the Prevention and Control of infections and related guidance
- Care Quality Commission Fundamental Standards of Care 2014
- NHS Outcomes Framework 2015/16 – Domain 5
- NICE Quality Standards in infection prevention and control (QS61) April 2014
- NHS Constitution 2013

Key Tasks

- To review and approve the Director of Infection Prevention and Control Annual Report, annual delivery plan, to manage infection prevention and control throughout the Trust.
- To review and ratify all Infection Prevention and Control related Policies, Procedures and Guidelines in a timely manner using evidence-based literature, best practices, and expert opinion.
- To monitor and audit the Infection Prevention and Control delivery plan and lessons are shared and implemented.
- To discuss and advise on Infection Prevention and Control related issues brought to the Committee.
- To support the implementation of approved infection prevention and control measures throughout the Trust.
- To support interdepartmental co-ordination and education in the prevention and control of infection for all members of the Trust.
- To advise and ensure the programme of mandatory surveillance is carried out, as appropriate, the findings are widely distributed and recommended changes in practice are implemented.
- To monitor decontamination and water quality.
- To ensure adequate IPC capacity within the team to deliver the annual work programme.

Review of Terms of Reference

The Terms of Reference (TOR) shall be reviewed annually by the infection prevention and control team. Changes will be discussed at the IPCC meetings. Approved changes will then be sent to the Quality and Governance Committee (previously Safety, Development and Effectiveness Committee) for ratification.

Sub Committee

- The Infection Prevention and Control Taskforce reports to the IPCC meeting quarterly. Action log of the meeting will be presented at the IPCC meeting

- The Vehicle Equipment Group and the Clinical Equipment Group report to the Infection Prevention and Control Committee quarterly. Minutes of the meeting will be presented at the IPCC meeting.

Uploading to the Intranet

The terms of reference and meeting papers will be on the shared drive and published on the intranet.

Ratified Date: 14 May 2015

07/05/15 Infection Prevention and Control Committee- Amendments recommended

FINAL

14/05/15 Amended TOR- approved by Chair

03/06/15 Corrected member title from Assistant Director Facilities to Assistant Director of Fleet and Logistics.

Appendix 3- IPC Taskforce Terms of Reference

Infection Prevention and Control Taskforce
(Monthly Operational)
Terms of Reference

Purpose:

The purpose of the Infection Prevention and Control Taskforce (IPC Taskforce) is to ensure the implementation of the trust's Infection Prevention and Control Programme, including the annual healthcare associated infection (HCAI) Delivery Plan. It seeks to proactively address any infection prevention and control issues that emerge.

Objectives: As above

Accountability and Reporting Arrangements:

- The Taskforce is accountable to the Infection Prevention and Control Committee, (IPCC) which commissioned the group and reports verbally to the IPCC at their quarterly meetings.
- The annual HCAI delivery plan is tabled at every IPC Taskforce meeting for information.
- Action log and areas of escalation from Taskforce meetings will go to the quarterly IPCC with a cover sheet.
- Relevant information is cascaded to appropriate IPC Taskforce members by the Head of Infection Prevention and Control.
- The Taskforce meets monthly and the report is usually verbal unless a report needs to be shared.

Membership:

- Interim Deputy Director of Nursing, Chair
- Head of Infection Prevention and Control
- PIMs from South, East and West replaced by 2 X QAMs from North and South Sectors June 2015 onwards
- CHUB and EOC
- HART and Central Ops
- PTS
- ER/CR
- VAS/PAS Contract Manager
- Medical Devices and Decontamination Lead
- Logistics
- Estates
- Education IPC Lead
- Risk, Health and Safety Advisor
- Governance and Compliance
- EPRR and CBRN
- Staff Group Rep (Optional)

Co-Opted Members as required

- Flu Lead
- Legionella Head
- Occupational Health

- Infection Prevention and Control Support Officer (minutes) (non-voting member)

Members will nominate and send deputies as appropriate.

Quorum:

The following 6 members must be present to make a decision/action:

- DIPC
- Head of Infection Prevention and Control
- EPRR
- Estates
- One PIM (or QAM from June 2015)
- Logistics

Two additional people should be present to the core to facilitate probity and challenge. This includes:

- Medical Devices and Decontamination Lead
- Risk, Health and Safety Advisor

Taskforce members are required to attend i.e. at least four of eight meetings per year or send a nominated deputy of equal standing who can make decisions on their behalf.

- There will be times when due to the issue to be discussed *adhoc* members will be invited to attend

Frequency of meetings

- Monthly, except when the month includes and Infection Prevention and Control Committee meeting

Authority

- The Taskforce is authorised to drive forward initiatives and activities that are required for successful achievement of the Infection Prevention and Control Programme.

Monitoring Effectiveness

- The effectiveness of the Taskforce will be evidenced through the Director of Infection Prevention and Control's Annual Report, which reports on achievement of the annual infection prevention and control objectives.

Key indicators:

- The Health & Social Care Act 2008, Code of Practice for health and adult social care on the prevention and control of infections
- NHSLA Risk Management Standard 2, Criterion 8 Hand Hygiene Training.
- NHS Constitution, Section 2a Quality of care and environment, page 28-31, The handbook of the NHS Constitution, updated 2012 for England
- NICE Quality Standard QS 61 (April 2014)

Key Tasks

Review progress with the annual healthcare associated Infection Prevention and Control (IPC) delivery plan.

An action focused meeting, therefore the responsibility of those attending is to feedback each time on their progress with particular actions.

Feedback and lessons learned from infectious incidents in staff and patients.

To invite members of trust staff to discuss specific issues as required.

Review of Terms of Reference

FINAL

The terms of reference will be reviewed annually and sent to the Infection Prevention and Control Committee for ratification.

Sub Committee

There are no sub-committees reporting to the committee, although sub groups may be set up on an *adhoc* basis to focus on particular issues.

Developed 12/2/15

Approved Date: 19/03/2015

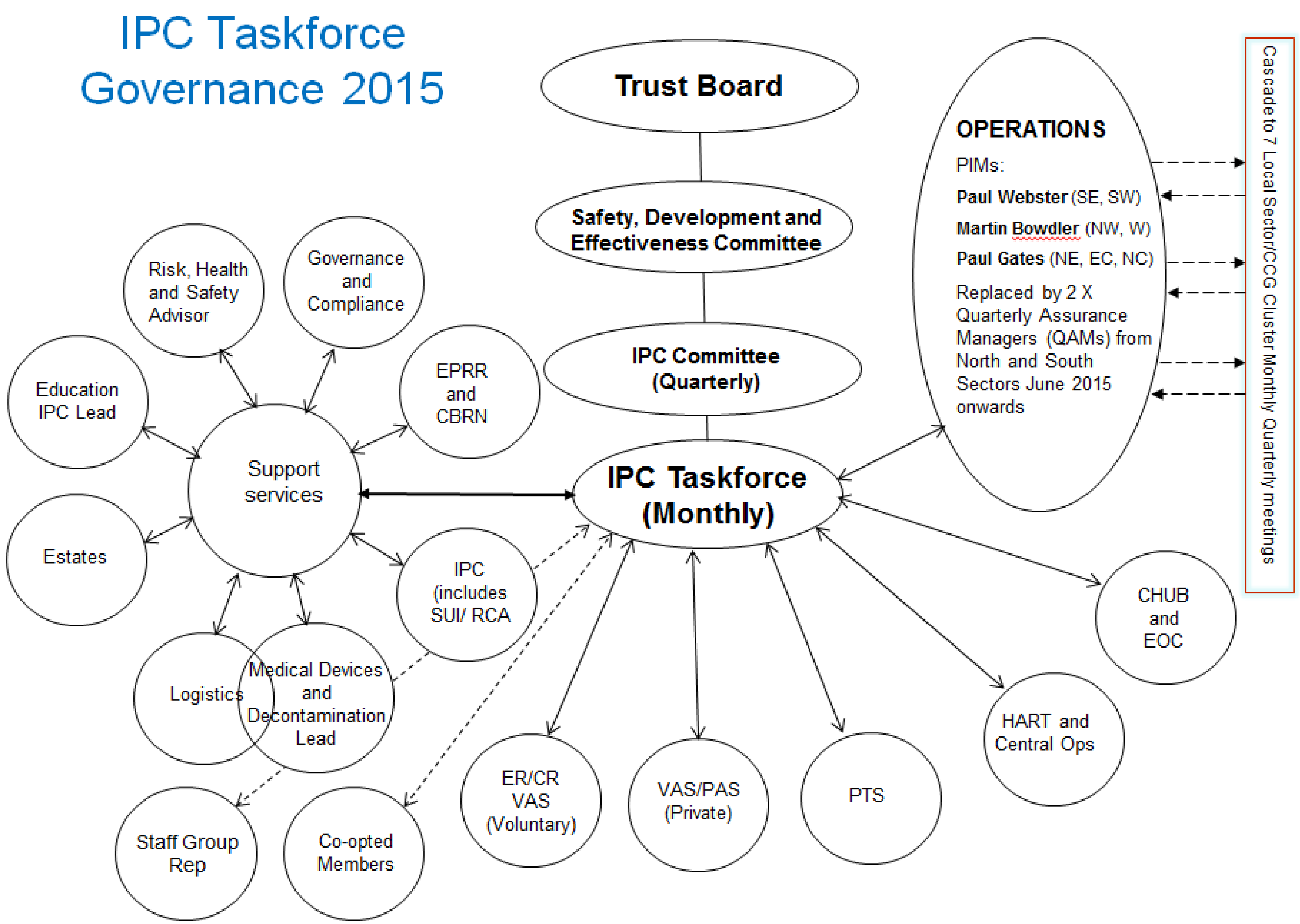
By: Infection Prevention and Control Taskforce

Review Date: 18/03/2016

Version FINAL

FINAL

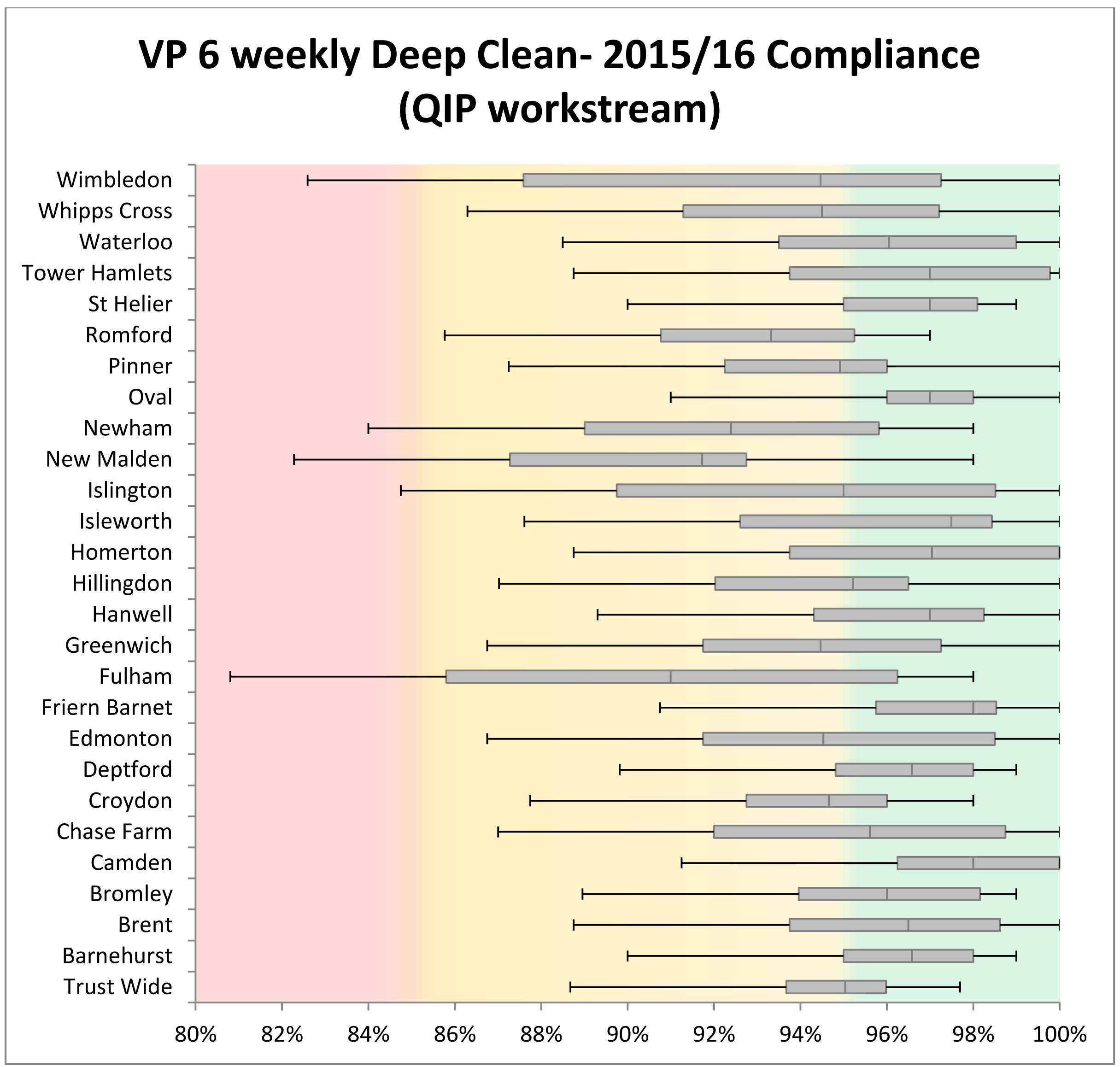
Appendix 4- IPC Taskforce Governance 2015



Appendix 5- VP Deep Clean 2015/16 Compliance by Complex (old structure)

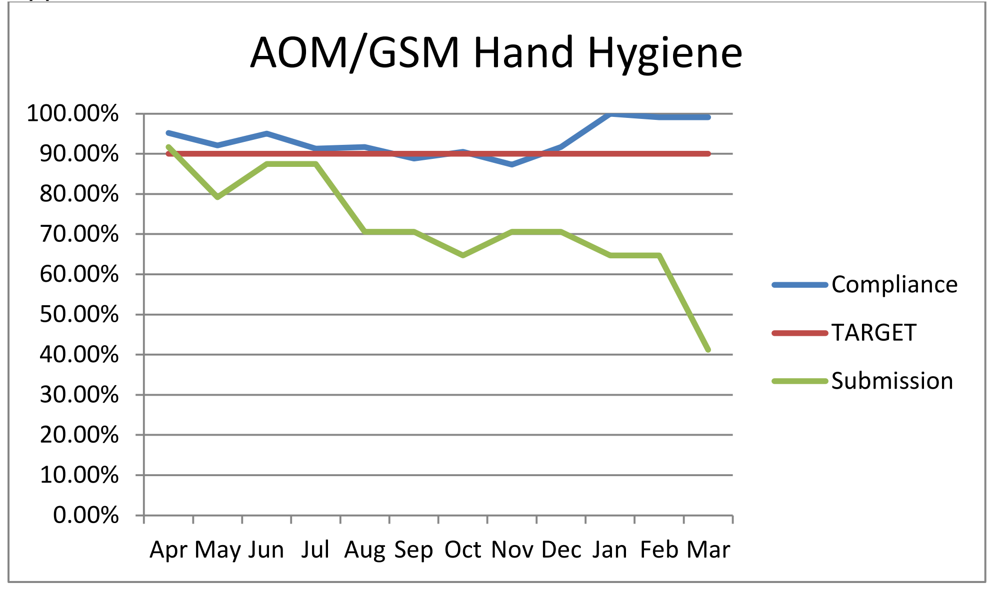
Overall achievement for 2015/16 for deep clean of A&E vehicle is demonstrated in the Table 3 and box whisker plot below. The grey box, inter-quartile, represents the middle 50% of results for each complex with the dark grey line showing the median result. The error bars, whiskers, represent the lowest and highest quartile results over the year.

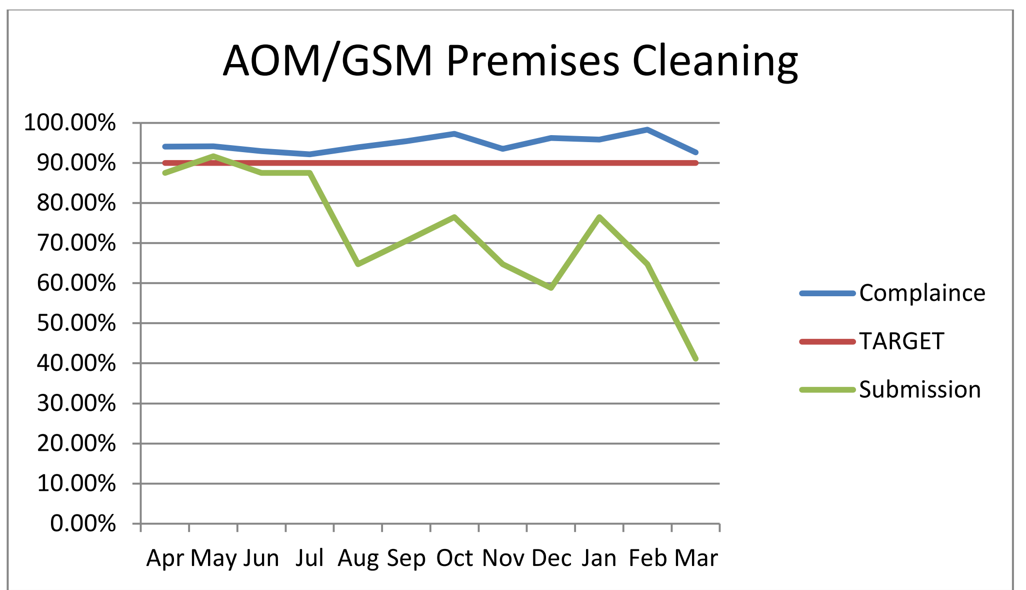
The plot demonstrates that the median for 46.2% (12 out of 26) complex exceeds the target of 95%, this is comparable to last year, where only 53.8% achieved the previous target of 90%. Furthermore, 30.7% (8 out of 26) complexes exceeded the target for at least 8 months out of the year.

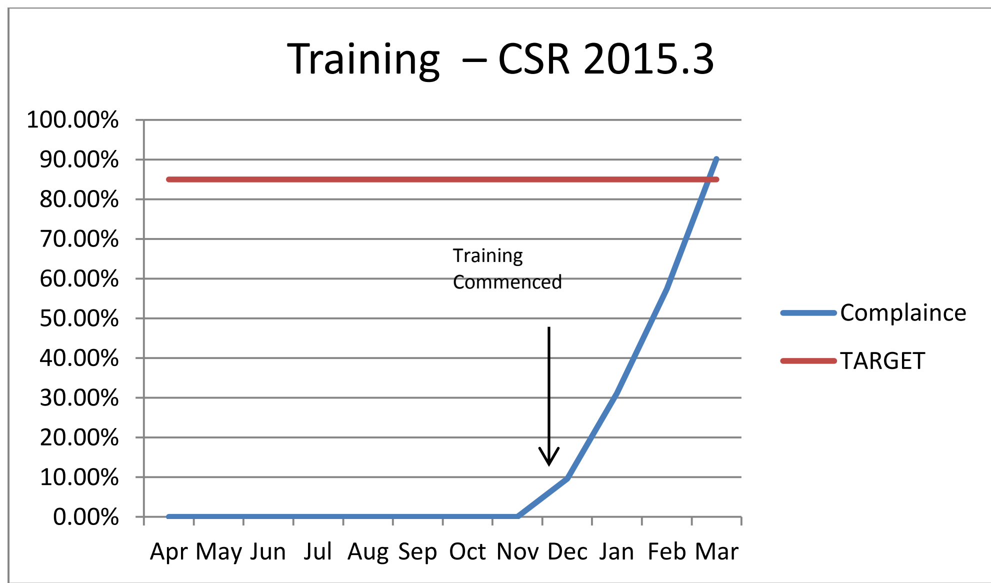


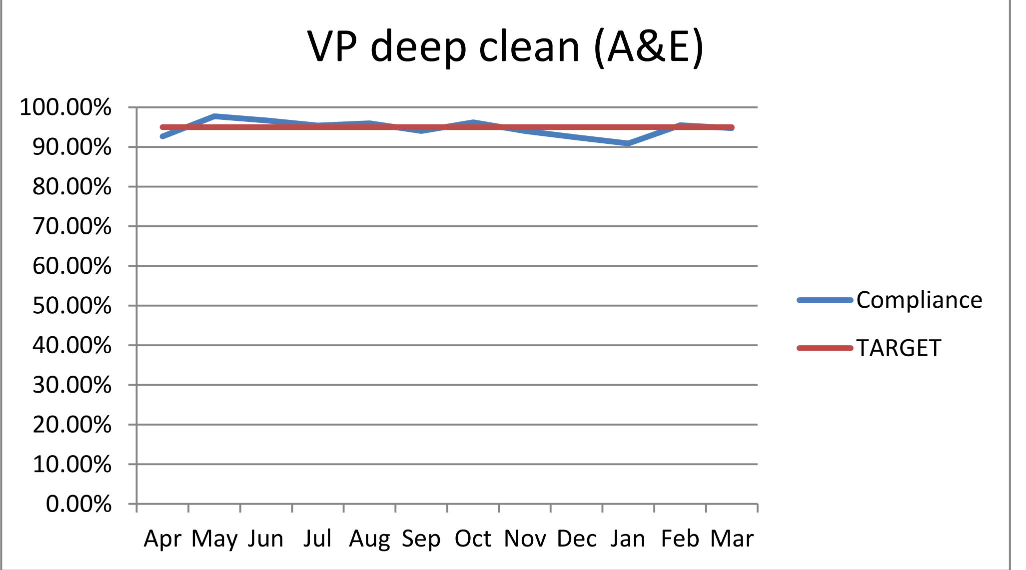
To note- current data capture based on old station complex format and in future will be aligned with new structure.

Appendix 6- IPC Performance to date: 2015/2016









Appendix 7- IPC Risk Register

March 2016 Trust
IPC Risk Register.xls

Appendix 8- List of Abbreviations

A&E	Accident and Emergency
ANTT	Aseptic Non-Touch Technique
APP	Advance Paramedic Practitioners
BFE	Body Fluid Exposure
CBRN	Chemical Biological Radiological and Nuclear
CEWG	Clinical Equipment Working Group
CFR	Community First Responders
CHUB	Clinical Hub
CQC	Care Quality Commission
CSR	Clinical Skills Refresher
EOC	Emergency Operations Centre
EPRR	Emergency Preparedness, Resilience and Response
ER	Emergency Responders
GRS	Global Rostering System
GSM	Group Station Manager
HART	Hazardous Area Response Team
HCAI	Healthcare Associated Infections
HPT	Health Protection Team
IGAS	Invasive Group A Streptococcus
ILA	Individual Learning Account
IM&T	Information Management and Technology
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Taskforce
IPS	Infection Prevention Society
KPI	Key Performance Indicators
MDRO	Multi-Drug Resistant Organisms
MHRA	Medicines and Healthcare products Regulatory Agency
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
OHS	Occupational Health Service
OWR	Operational Workforce Review
PA	Personal Assistant
PAS	Private Ambulance Service
PHE	Public Health England
PIM	Performance Improvement Manager
PPE	Personal Protective Equipment
QGAM	Quality Governance Assurance Manager
QGARD	Quality, Governance and Risk Directors
QIP	Quality Improvement Plan
RR	Risk Register
SELHPT	South East London Health Protection Team
TOR	Terms of Reference
VAS	Voluntary Ambulance Service
VHF	Viral Haemorrhagic Fever
VP	Vehicle Preparation
WTE	Whole Time Equivalent

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Safeguarding Annual Report
Report Author(s):	Alan Taylor
Presented by:	Briony Sloper
Contact Details:	
History:	Approved by the Safeguarding Committee on 30th June 2016 and the Quality Governance Committee (after update on action plan) on 12th July 2016
Status:	*For approval*

Background/Purpose

This is the annual report detailing the Trust Safeguarding activities for the year 2015-16 with amended action plan to 20/05/16.

This report is provides assurance on safeguarding activities and that the Trust is meeting its safeguarding responsibilities.
The Quality Governance Committee were concerned that the original report had a large number of actions on the plan still outstanding and requested an update on progress over the two months since the report was compiled. This showed an improved position in relation to outstanding actions on the plan, however there is still further improvements required in relation to DBS checks and safer recruitment that will be carried over to the 2016-17 work plan along with the other items still to be completed.

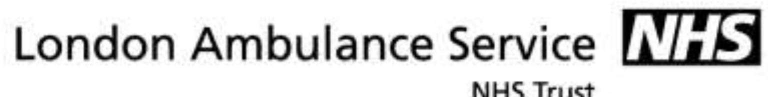
Action required

The Trust Board is asked to approve the annual report.

Key implications

- This report is published on our website and shared with commissioners and Safeguarding Board partners.

Key implications and risks arising from this paper	
Clinical and Quality	**X**
Performance	**X**
Financial	
Workforce	
Governance and Well-led	**X**
Reputation	**X**
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**X**
Improving Patient Experience	**X**
Improving Environment and Resources	
Taking Pride and Responsibility	**X**



Safeguarding Annual Report

2015-16

Care | Clinical Excellence | Commitment

1.0 Introduction and background

1.1 The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

1.2 This report provides evidence of LAS commitment to effective safeguarding measures, which is evident by the work and progress made in the LAS during 2015-2016.

1.3 It is a statutory requirement to present an Annual Report to the Trust Board showing how the Trust has met their safeguarding responsibilities in line with Working Together to Safeguard Children (H.M. Government 2015).

1.4 The report will include the current position regarding the work being undertaken and will detail the organisational responses to changes in safeguarding matters.

1.5 The Trust has a commitment and a duty to safeguard adults at risk as stipulated in Outcome 7 of the Care Quality Commission Regulations. To achieve this goal the organisation has to ensure robust systems and policies are in place and are followed consistently, to provide training and supervision to enable staff to recognise and report incidents of adult abuse, to provide expert advice and to reduce the risks to vulnerable adults at risk of being abused.

1.6 The Care Act 2014 safeguarding element commenced in April 2015 provides a statutory requirement for health providers to protect adults with care and support needs from abuse and neglect. The Care Act places adult safeguarding on a statutory footing and puts new legal duties on agencies to work more closely together and share information. “There must be sufficient support, specialist expertise, independent advocacy and access to criminal justice within each area”.

1.7 The NHS England document Safeguarding Vulnerable People in the NHS-Accountability and Assurance Framework published in July 2015 provides details of the governance and assurance requirements and also recommends levels for resources and responsibilities for safeguarding.

1.8 The Counter Terrorism and Security Bill received Royal Assent on Thursday 12th February 2015. The Channel duty, placing Channel on a legislative footing as part of the Act, came into force on 12th April 2016. It ensures all health Trusts “have due regard, in the exercise of its functions, to prevent people from being drawn into terrorism”, i.e. strengthening the existing NHS Contract Prevent agenda to a statutory duty.

1.9 High media focus ensures that health trusts must constantly strive to adhere to recent enquiry recommendations such as Savile, Rotherham, as well as new themed focuses, such as Child Sexual Exploitation, Female Genital Mutilation and Managing Allegations against Staff.

2.0 Multi agency working

2.1 The Trust is committed to partnership working in relation to safeguarding.

2.2 The Trust introduced a new operational model from September 2015 which has resulted in clear roles and responsibilities for safeguarding at a sector level, increasing representation at Local Authority Safeguarding Board meetings.

2.3 The Trust continues to endeavour to attend short notice meetings but LAS will continue to keep the number of meetings not attended to a minimum.

London Ambulance Service NHS
NHS Trust

2.4 The chart below shows the level of engagement at a local level

Year to date LAS Local Complex partnership engagement 2015-16

Areas and Safeguarding boards	safeguarding children board	safeguarding Adult board	Sub group meetings	Multi agency safeguarding hub (MASH) Multi agency risk assessment conference (MARAC)	Rapid response meetings	Domestic homicide reviews	Serious case reviews	other safeguarding meetings	Attended-Totals	Not Attended Totals
West										
Three boroughs (West,Ham & Ful , Ken &Ch)	3	1	0	0	4	0	0	7	15	3
Ealing	1	0	0	0	1	0	0	2	4	4
Hounslow	0	0	0	0	1	0	0	2	3	4
Totals	**4**	**1**	**0**	**0**	**6**	**0**	**0**	**11**	**22**	**11**
North West										
Brent	0	3	0	0	7	0	0	1	11	4
Hillingdon	1	0	0	0	1	4	0	1	7	4
Harrow	0	2	0	1	4	1	3	12	23	7
Totals	**1**	**5**	**0**	**1**	**12**	**5**	**3**	**14**	**41**	**15**
North Central										
Camden	0	0	0	0	0	0	2	0	2	1
Enfield	2	3	0	0	7	0	0	9	21	4
Haringey	3	0	0	0	8	0	0	4	15	6
Barnet	4	3	5	3	3	0	0	1	19	1
Islington	0	0	0	0	2	0	0	1	3	1
Totals	**9**	**6**	**5**	**3**	**20**	**0**	**2**	**15**	**60**	**13**
East Central										
Hackney	1	1	0	0	3	0	6	2	13	7
Newham	1	1	0	0	3	0	0	4	9	2
Tower Hamlets	0	3	0	0	0	0	0	1	4	1
Waltham Forest	0	1	0	0	1	0	0	2	4	0
Totals	**2**	**6**	**0**	**0**	**7**	**0**	**6**	**9**	**30**	**10**
North East										
Barking & Dagenham	2	0	0	0	3	0	1	1	7	1
Havering	0	0	0	0	1	0	1	0	2	4
Redbridge	0	0	2	0	2	0	0	3	7	10
Totals	**2**	**0**	**2**	**0**	**6**	**0**	**2**	**4**	**16**	**15**
South East										
Bexley	0	0	2	4	3	0	0	6	15	5
Bromley	0	4	1	0	1	0	0	2	8	3
Lambeth	0	3	0	0	1	0	0	5	9	6
Lewisham	0	0	0	0	8	0	0	1	9	4
Southwark	0	0	0	0	0	0	1	1	2	2
Greenwich	0	2	0	2	2	0	0	2	8	3
Totals	**0**	**9**	**3**	**6**	**15**	**0**	**1**	**17**	**51**	**23**
South West										
Croydon	3	3	2	0	5	0	3	22	38	4
Kingston	6	4	3	0	2	0	0	4	19	1
Richmond	4	1	0	0	2	0	0	5	12	2
Merton	1	1	0	0	1	0	0	1	4	1
Sutton	0	2	0	0	5	0	0	5	12	2
Wandsworth	1	0	0	0	0	0	0	2	3	1
Totals	**15**	**11**	**5**	**0**	**15**	**0**	**3**	**39**	**88**	**11**
LAS Totals	**33**	**38**	**15**	**10**	**81**	**5**	**17**	**109**	**308**	**98**

Multi-Agency Risk Assessment Conferences (MARAC) and Multi Agency Safeguarding Hub (MASH)

2.5 MARACs are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a risk focused MARAC, a coordinated safety plan can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year.

2.6 The Trust has had limited representation at MARACs this year (due to manager availability and boroughs not engaging), the Trust provides documentation for six boroughs. The Trust is obligated to share the information it holds in a similar way to undertaking an Independent Management Review.

2.7 MASHs bring together agencies (and their information) in order to identify risks to children and adults at the earliest possible point and respond with the most effective interventions. This will in turn ensure timely and necessary interventions, improving the outcomes for vulnerable children and adults. We provide information to MASHs across London when requested.

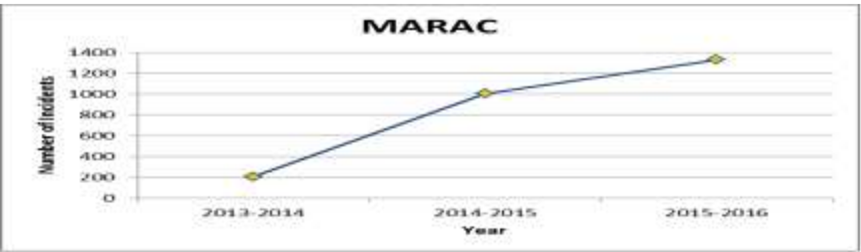
2.8 The number of MASH information requests for 2015-16 was 69.

Multi Agency Risk Assessment Conference (MARAC)

2.9 The information provided to the MARAC from the LAS is often key because we gain access to homes where other agencies are often unable to. Individual MARAC cases for this year were 1332 (see chart below for comparison).

2.10 Due to the heavy administrative burden the Trust has only been able to support these MARAC's by assistance of sector level staff on restricted duty.

2.11 Below shows the number of incidents the LAS have provided information on to the 6 boroughs.



3.0 Governance arrangements

3.1 The Director of Nursing and Quality is the accountable Executive Director for safeguarding within the Trust.

3.2 The Head of Safeguarding provides a safeguarding report to the Clinical Safety and Standards Committee (CSSC) meeting, detailing progress against Serious Case Review (SCR) action plans, legislation and Trust safeguarding activity.

3.3 The CSSC is the Trust Board assurance group of the Safeguarding Service.

3.4 The Trust has a Safeguarding Committee that meets every 6 weeks and is authorised by CSSC to ensure effective and high quality safeguarding practice within the Trust.

3.5 The Trust has a safeguarding action plan which is reviewed by the Safeguarding Committee (See appendix one).

3.6 The Trust completed the Safeguarding Adult Risk Audit Tool (SARAT) in Jan 2016 and identified actions which are included in the Adult Action Plan.

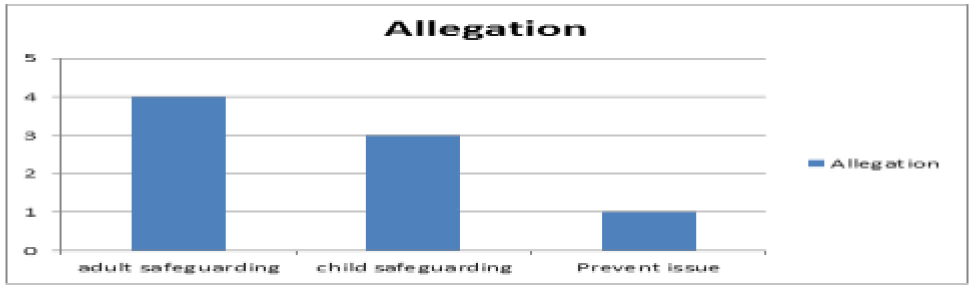
3.7 The Trust completed the Section 11 child self-assessment tool in February 2016 and identified actions which are included in the Children Action Plan.

3.8 The Trust has undertaken and led on the following audit during this financial year, Child Mental Health Safeguarding Audit: Self-Harm Referrals –quarter 1 2015

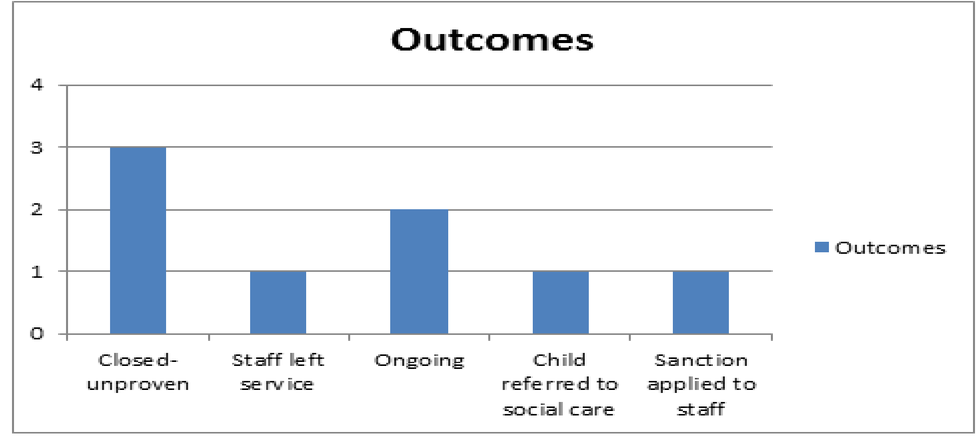
3.9 The Trust has a current Safeguarding Children Declaration which is published on the website, and confirms the Trusts commitment to care for patients, including children in a safe, secure and caring environment. The declaration details the arrangements that are in place to safeguard children.

3.10 The Trust has an obligation to inform the Local Authority Designated Officer of concerns or allegations regarding Trust staff in relation to children, and the Safeguarding Adult Manager when the concern relates to adults. This has occurred on 8 occasions during 2015-2016.

3.11 The chart below shows the reasons for the notification. Allegations made during the year that were not of a safeguarding nature are not included in these figures.



3.12 There are a range of outcomes to allegations that can be seen in the chart below. This is the first year of capturing this data.



3.13 There have been no referrals to Disclosure and Barring Service as a result of safeguarding.

3.14 120 child deaths were sent for Serious Incident (SI) consideration, 2 were declared:

3.15 Incident 1. Quality Assurance analysis showed the original 999 call was not handled correctly. There were 2 recommendations for the Trust.

3.16 Incident 2. Quality Assurance analysis showed that 2 x 999 calls were not handled correctly. There were 3 recommendations for the Trust.

3.17 There were no safeguarding recommendations.

3.18 8 adult cases were sent for SI consideration in line with best practice, 1 was declared:

3.19 Incident 1. Non conveyance incident following a fall. The serious incident investigation is on-going.

3.20 The Trust declared a SI for issues relating to DBS checks which remains under investigation.

3.21 The Safeguarding Committee has a risk register, which incorporates 2 corporate risks.

3.22 Corporate risk 426. The risk is, 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. (see chart on page 5)

3.23 Corporate risk 343. The risk is staff not recognising safeguarding indicators and therefore failing to make a timely referral (See page 16 missed referrals).

3.24 Safeguarding risks are managed through the local safeguarding risk register the risk does not sufficiently score high enough to be considered a corporate risk.

3.25 Local risk no1, 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. This will also affect the Trusts reputation.

3.26 Mitigation of Risk 1, the Trust is developing Datix Web an IT data base system which will be introduced in Q1/Q2 2016 which will enable trust to highlight previous referrals.

3.27 Local risk no 2, "there is a risk that the Trust is unable to provide assurance to CQC and other agencies that it is compliant with safeguarding training requirements for clinical and non-clinical staff. This is linked to N0 355 on the Corporate Risk Register."

3.28 Mitigation of risk 2 forms part of the Quality Improvement Plan and a system will be introduced to capture all mandatory training figures.

3.29 Local risk no 3, there is a risk that the Trust is unable to meet statutory requirements of providing safeguarding supervision, by trained professionals. This will result in an impact on staff welfare and performance and the Trust will not be complaint with the Children and Adult Acts pertaining to safeguarding.

3.30 Mitigation of risk 3 appointing a safeguarding supervisor project manager to implement safeguarding supervision in the coming financial year.

3.31 Local risk no 4, the Trust is unable to provide assurance to DH that all staff have received the required PREVENT training. This is because there is limited training capacity for the number of WTE staff. This risk has now been passed to the Deputy Director of Operations as designated operational lead for PREVENT.

CQC Report- Safeguarding

3.32 The Care Quality Commission (CQC) carried out a planned inspection of the Trust in June 2015 and their report was published at the end of November 2015. While it gave the organisation a “good‟ rating for the care of patients, it highlighted a number of areas of concern and judged the Service to be “inadequate‟ overall, and as a result the Trust were placed in “special measures”.

3.33 The report stated frontline emergency and urgent care staff had a good understanding of what safeguarding concerns might be and all were clear about the process for reporting concerns.

3.34 Safeguarding areas for improvement included improving training for staff on Mental Capacity Act assessment. Ensure all staff understand and can explain what situations need to be reported as safeguarding. This mainly relates to Patient Transport Service (PTS) and Emergency Operations Centre (EOC) staff.

3.35 As a result of the inspection the Trust has developed a Quality Improvement Plan (QIP) and the safeguarding actions are contained within the QIP.

Care Act 2014

3.36 Section 14 of the Care Act 2014 provides the legislative requirements for all agencies in relation to safeguarding Adults.

3.37 The Act ensures safeguarding is personal to the individual. Which is person led and outcome focused ensuring patients are involved fully in safeguarding considerations.

3.38 The categories of safeguarding have increased to include self-neglect and domestic violence and under the categories recognises human trafficking and internet scamming and honour based violence.

3.39 What was previously a safeguarding referral for adults is now known as a safeguarding concern.

3.40 The Act came into force on 1st April 2015

3.41 The Trust have this year provided staff with a leaflet outlining the changes and also provided face to face safeguarding refresher training for all frontline staff.

3.42 As a result of the Care Act and changes to how the Trust responds to concerns around welfare and consent, the Trust expects to see the numbers of welfare concerns fall this year. The reason is staff have been empowering patients with welfare needs to contact social services directly.

4.0 New policies procedure and guidance

4.1 The Safeguarding Adult policy has been updated to comply with the Care Act.

4.2 The guidance for staff on mental health patients and safeguarding was reviewed and amended to provide greater clarity for staff on whether to refer to social services or mental health services.

4.3 The Trust has introduced a new HR policy for Managing Allegations against Staff. This was supported with training to all HR staff and senior operations managers in April 2015.

4.4 A flow chart on staff Safeguarding responsibilities within the Trust been published on the intra net, this shows responsibility throughout the Trust from Chief Executive and Trust Board to clinical and non-clinical staff.

4.5 Safeguarding updates have been produced throughout the year providing guidance on safeguarding and procedures and have been published on our internal intranet “the Pulse”..

4.6 The Trust implemented the NHS guidance on Female Genital Mutilation (FGM); this requires all staff to record on clinical records, evidence of FGM. In addition to reporting to police disclosure of FGM by children under 18years old. We also introduced guidance on when to make a safeguarding referral for an unborn child, child or adult at risk of FGM.

4.7 The Trust has agreed the appointment of two new Safeguarding Specialists who should be in post by July 2016. The Trust also has a PREVENT lead for the Trust and a Mental Capacity Act (MCA) Lead.

4.8 The Trust has reviewed and refreshed the Terms of Reference for the Safeguarding Committee, which ensures that there is effective and high quality safeguarding practice throughout the Trust.

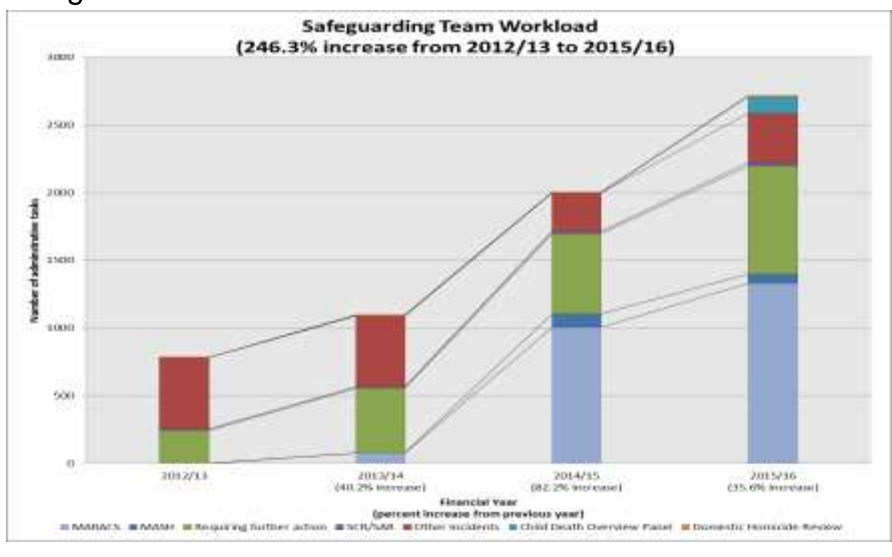
5.0 Information sharing & Incidents

5.1 The Trust has a duty to share information to protect vulnerable patients. The chart below shows the safeguarding administrative function of the Trust.

5.2 The Trust has seen a year on year increase in overall activity.

5.3 This increase has been managed this year by recruiting staff on restricted duties to support the work of the Safeguarding Officer.

5.4 During the year the Trust has had to decline to provide information for meetings due to workload and team capacity. To improve this additional administration is being recruited.



London Ambulance Service **NHS**
NHS Trust

Child Death Overview Panel (CDOP)

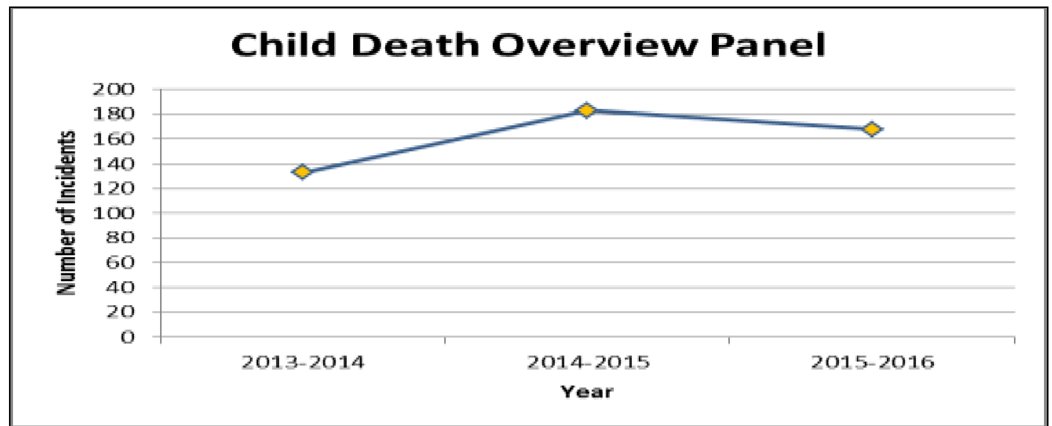
5.5 The Local Safeguarding Children Boards (LSCB) are responsible for ensuring that a review of each unexpected child death of a child normally resident in their area is undertaken by the CDOP.

5.6 The CDOP has a fixed core membership drawn from organisations represented on LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate (Working Together 2015).

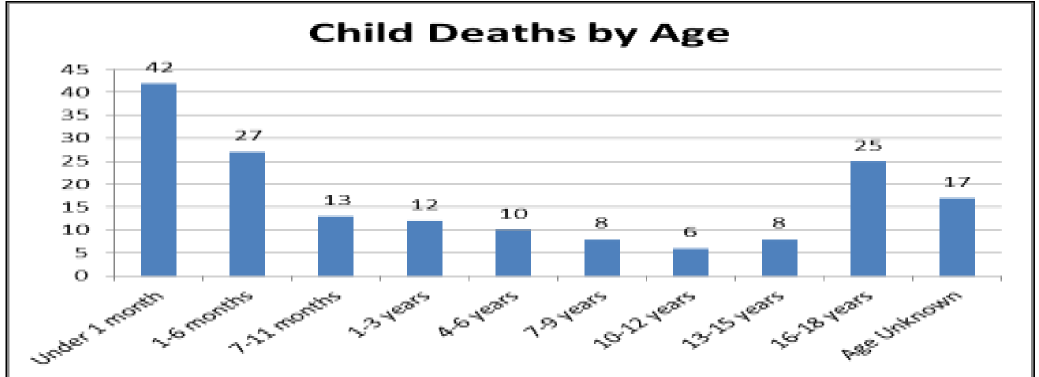
5.7 The LAS have a duty to provide information to the CDOP on child deaths we have been involved with along with attending meetings when required.

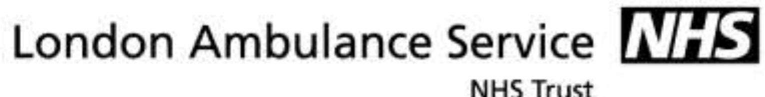
5.8 The charts below show the numbers of child deaths we have provided information for over the past 3 years and the age of the children.

5.9



5.10 The Chart below shows the ages of the sudden child deaths investigated across London that the Trust contributed to. You will note the most common ages were under 6 months old or between16yrs to 18yrs old.





Children's Serious Case Reviews (SCR)

5.11 An SCR is undertaken when abuse or neglect of a child is known or suspected; and either, the child has died or the child has been seriously harmed and there is a cause for concern about partnership working. The prime purpose of a SCR is for agencies and individuals to learn lessons and improve practice.

5.12 There were 13 child cases in 2015/16 that the LAS were asked to provide a report for.

5.13 The chart below show the details of cases for 2015/2016 and learning identified.

Age/ Gender	Borough	Trends	Description	Lessons	Status
12YOF	Barnet	Suicide	Hanging	No LAS issues	Overview report never received
1YOF	Havering	Physical Child Abuse	Carer concerns	No LAS issues	Nothing for LAS due to limited contact
8MOF	Havering	Physical Child Abuse	Carer concerns	No LAS issues	Nothing for LAS due to limited contact
2MOF	Hammersmith and Fulham	Murder	Carer concerns	No patient contact	
9MOF 1YOF 4YOF	Croydon	Neglect	No patient contact	No LAS issues	on going
6MOM	Haringey	Neglect	Carer concerns	No LAS issues	on going
4MOF	Barking & Dagenham	Physical Child Abuse	Carer concerns	No LAS issues	on going
3YOM	Harrow	Neglect	Cardiac arrest. Possible post choking	No LAS report needed	
1YOF	Hammersmith and Fulham	Murder	LAS did not attend	No LAS issues	No child contact
17YOM	Haringey	Gang	Multiple stab wounds	No LAS issues	on going
16YOM	Southwark	Gang	Stab wounds	No LAS issues	on going
1MOM	Camden	Neglect	Carer concerns	To be drafted	
17YOM	Brent	Suicide	Hanging	To be drafted	

5.14 Across London the Trust contributed to 4 SCR's for Neglect, 3 Child Abuse SCR, 2 suicide, 2 murders, 2 gang related SCR.

5.15 SCR also included adults until April 2015 when the term changed to Safeguarding Adult Reviews (SAR). There were 10 SAR cases in 2015/16.

Age/ Gender	Borough	Trends	Description	Lessons	Status
81YOM	Enfield	Neglect	Catheter issues	Internally no LA52 completion	on going
32YOM	Richmond	Mental Health	Mental health issues. Cardiac arrest.		Closed due to police investigation waiting further contact
97YOF	Kingston	Possible Neglect	Carer concerns		Initial notification received. Nothing more heard. Still holding pending further contact.
62YOF	Bexley	Self-Neglect	Patient transport due to abnormal blood results. Minimal LAS contact.		Initial notification received. Nothing more heard. Still holding pending further contact.
68YOM	Tower Hamlets	Self-Neglect	Fire. Smoke inhalation and second degree burns.		No overview report received
87YOF	Tower Hamlets	Post discharge issue			on going
72YOM	Hackney	Self-Neglect, Alcohol	Numerous falls. Smoke inhalation injuries.		Waiting final report in draft form at moment
20YOM	Haringey	Mental Health	Having psychotic issue. Jumped from roof.		on going
85YOF 91YOF	Islington	Neglect		Missed referral	on going
32YOM	Haringey	Suicide	Hanging		on going

5.16 Of the 10 adult SCR across London the Trust were involved in 6 which classified as neglect, 2 mental health, 1 suicide and 1 discharge issue.

5.17 Learning is feedback to individual staff and any trust wide learning is incorporated into the Trusts safeguarding training and education.

Domestic Homicide Reviews (DHR)

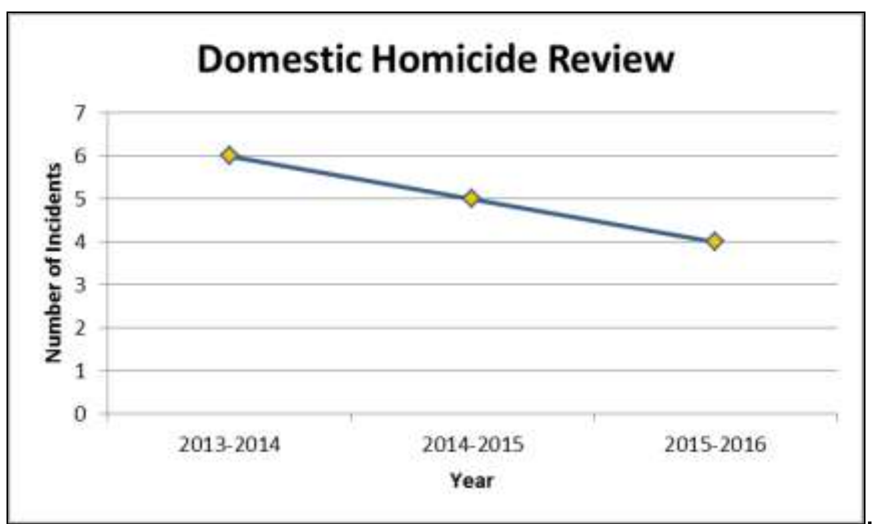
5.18 A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a

person to whom they were related or with whom they had been in an intimate personal relationship, or a member of the same household as themselves.

5.19 The local authority commission the DHR and our local managers attend when requested.

5.20 The chart below shows LAS involvement in DHR since 2013. The LAS have only been asked to provide information or attend four DHRs in 2015/16.

5.21



6.0 Education and Training

6.1 Safeguarding training is critical to protecting children, young people and adults from harm. Front-line staff must have the competencies and support to recognise signs of maltreatment and to take appropriate action.

6.2 All staff employed or contracted by the Trust have a duty to safeguard and promote the welfare of children, young people and adults and should know what to do if they have any concerns.

6.3 The Trust is currently unable to effectively capture data on mandatory training required and undertaken for clinical and non- clinical staff. This issue is on the corporate risk register and is part of the QIP. This will be resolved this year as part of the QIP and the current mitigating action is the safeguarding team are manually capturing figures on a monthly basis and inputting to datix, to produce data.

6.4 The following graph shows the number of staff trained in Safeguarding during 2015-16.

London Ambulance Service NHS
NHS Trust

Training required	Total Staff	Frequency of training	2014	Target to be trained 2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total trained 2015/16	% of target 2015/16	3 year cummulative % of total staff trained
Level One																			
Induction	various	on joining		various	28	10	14	9	0	14	19	19	17	53	0	26	209		
E Learning	1389	3 yearly	672	356	69	220	67	35	18	40	60	34	22	32	33	32	662	186%	96%
Level Two																			
New Recruits	Various	on joining		various	Nil	53	88	31	39	124	13	16	47	27	74	177	689		
Core Skills Refresher	3019	annually		3019	N/A	N/A	N/A	N/A	310	596	785	936	N/A	178	N/A	N/A	2805	93%	
EOC Core Skills Refresher	443	annually		443	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0%	
EOC new staff	Various	on joining		various	34	10	9	27	4	12	17	0	14	7	12	8	154		
PTS/NET	114	annually		114	Nil	N/A	20	N/A	25	29	N/A	N/A	N/A	N/A	N/A	N/A	74	65%	
Bank staff	390	annually	58	390		N/A	N/A	N/A	6	8	43	66	0	31	N/A	N/A	154	39%	54%
111	152	annually	101	51	9	15	3	0	1	2	16	9	5	26	1	6	93	182%	128%
Community first Responders (St John)	140	3 yearly	135	50	Nil	12	13	10	13	12	12	14	15	N/A	13	12	126	252%	186%
Emergency responders	150	3 yearly		100	Nil	Nil	Nil	Nil	Nil	29	11	Nil	69	N/A	7	10	126	126%	
Level Three																			
EBS	30	3 yearly		25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13	14	N/A	27	108%	
111	11	3 yearly	11	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0		100%
Local leads	various	3 yearly		various	6	5	N/A	N/A	N/A	7	6	12	N/A	N/A	N/A	N/A	36		
Specific training																			
Prevent- clinical staff	3019	one off		3019	N/A	N/A	N/A	N/A	310	596	785	936	0	178	N/A	N/A	2805	93%	
Prevent- Non clinical	1389	one off		0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0%	
Trust Board	17	3 yearly		17	N/A	N/A	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12	71%	
HR/ Ops managers	Various			various	29	N/A	N/A	N/A	N/A	7	N/A	N/A	N/A	N/A	N/A	N/A	36		
Private providers	450	3 yearly	226	112	26	21	13	10	19	16	14	11	6	18	21	13	188	168%	92%
Other safeguarding	various	as required			104	12	N/A	N/A	N/A	N/A	N/A	12	0	0	0	75	203		
Nil = no figures provided																	8399	total	
N/A= no course planned this month																			

6.5 The Trust has provided a range of face to face safeguarding training this year, including; all new staff receive safeguarding training on the Trust induction course. All new clinical staff, A&E and PTS, receive safeguarding level 2 training on the core training course.

6.6 All clinical staff including EOC also receive level 2 safeguarding refresher training on the Core Skills Refresher (CSR) course. EOC did not undertake CSR in 2015/16 due to recruitment but safeguarding is planned for Q1 in 2016/17.

6.7 In addition local leads, EBS, Medical Directorate and Clinical Hub staff who provided support to staff have also received level 3 safeguarding children training.

6.8 71% of the Trust Board undertook safeguarding training in June 2015 against a target of 85% and the remainder are booked for Q1 2016/17.

6.9 All non-clinical staff are required to complete the Trusts level 1 Safeguarding e-learning programme and the Trust is currently compliant with this.

6.10 This year's safeguarding refresher training consisted of Care Act, update to the LAS referral process, domestic abuse, child sexual exploitation, self-neglect, capacity and consent. In addition CSR has covered fluctuating capacity and the Mental Capacity Act.

6.11 93% of clinical staff have received the full NHS PREVENT training. Non clinical staff training is planned for 2016/17 via e-learning.

6.12 Ensuring bank staff are current with safeguarding requirements has proved difficult this year and the Executive Leadership Team are currently considering how to progress with the use of bank and the governance arrangements.

6.13 In addition to formal face to face training and e learning, regular updates and articles are published in the Safeguarding Update and Clinical News.

6.14 The Trust issued a new Safeguarding pocketbook in 2015, detailing safeguarding roles and responsibilities as well as a booklet on female genital mutilation and a pull out pen with information on the Mental Capacity Act.

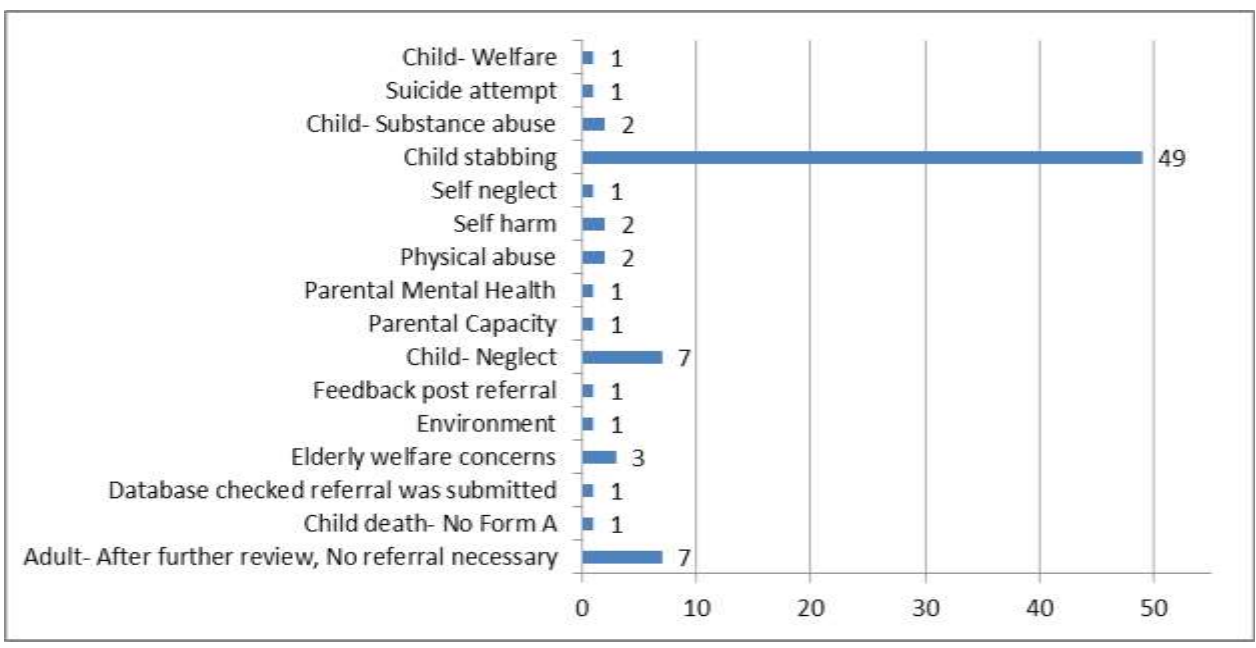
7.0 Missed referrals & learning

7.1 The Trust reviews its practice by undertaking audits, SCRs, child death reviews and DHRs. Where staff have not completed a safeguarding referral for a patient the Trust use the (LA456) Staff Safeguarding Action Plan to feedback to staff and for them to learn from the incident.

7.2 Where the Trust identifies trends in missed referrals this is included in training and bulletins, in order to improve practice. An example of this is the bulletin dated 22nd December 2015 on child stabbings to remind staff of the need to make a safeguarding referral in all cases.

7.3 The Chart below details the number of cases that were identified as missed referrals by staff during 2015/16.

7.4



8.0 Supervision

8.1 Effective Safeguarding supervision is important to promoting good standards of practice and supporting individual staff members. It has been highlighted as a fundamental requirement in the Care Act 2014, Working Together 2013 and from National Serious Case Reviews. Supervision allows time for reflective practice and is a vital component in the protection of children and adults

8.2 The Trust do not provide individual safeguarding supervision to staff, due to safeguarding team capacity. However, the LAS has been successful in securing funding from NHSE for a 1 year post to review models of supervision across ambulance trusts and to introduce supervision to relevant staff in 2016/17. The Trust is currently recruiting to this post.

8.3 The Head of Safeguarding currently receives safeguarding support from the Tavistock Group.

9.0 Safeguarding Referrals to Social Services.

9.1 Staff make referrals via the Emergency Bed Service (EBS). These are currently made by phone between 0800-2000 for children and non-conveyed adults. For conveyed adults and outside of these times staff complete a paper LA279 or LA280 and fax them through to EBS.

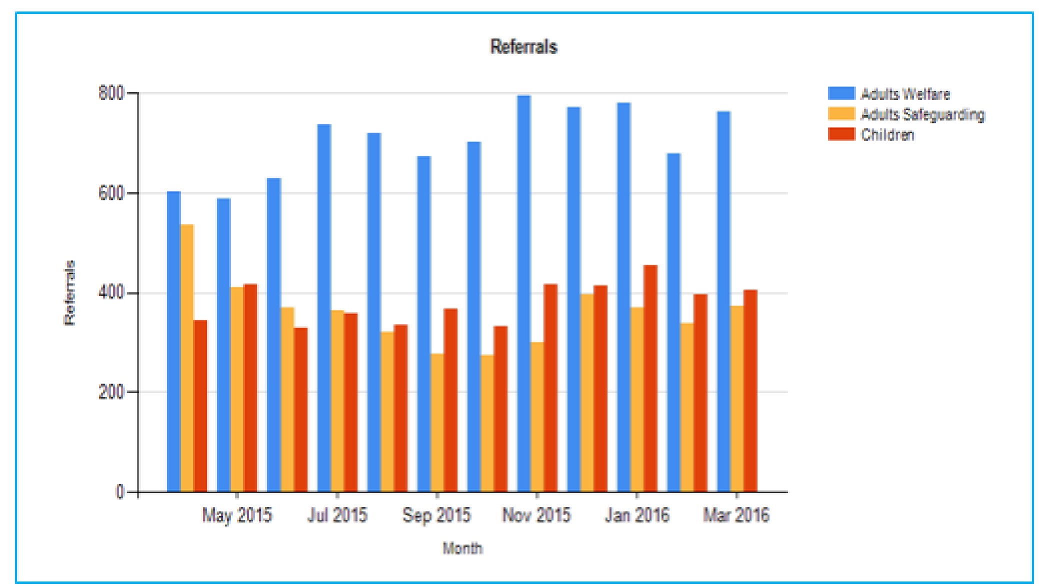
9.2 EBS currently fax all referrals to social services departments.

9.3 In quarter 1, 2016-17 the Trust is looking to move to 24/7 telephone referrals to EBS.

9.4 In quarter 1 2016-17 the Trust is planning to move away from faxing referrals to Social Services to secure email of all referrals.

9.5 For 2015/16 the LAS made 17332 referrals to the local authority. 4561 child referrals, 4331 adult referrals and 8440 adult welfare concerns. Please see chart below for monthly referral totals.

9.6



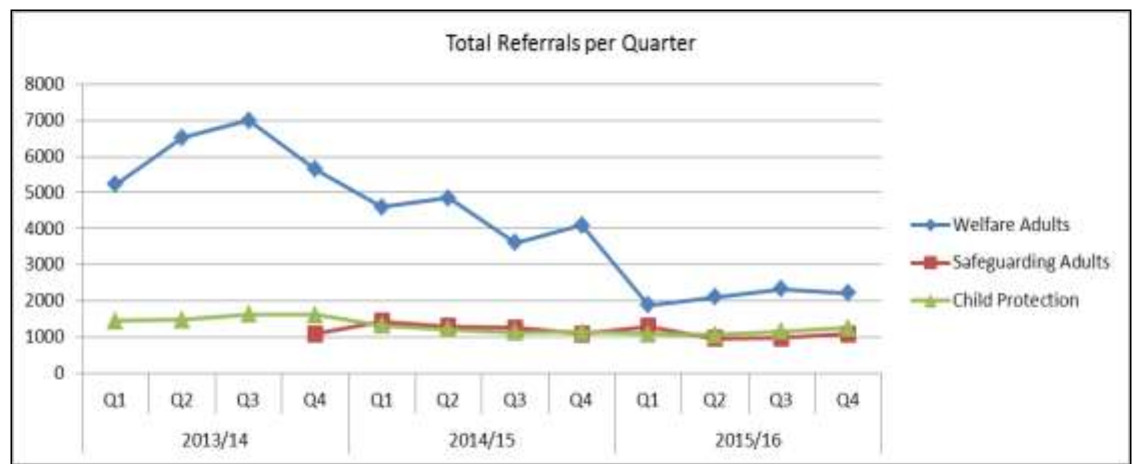
9.7 The graph over page shows a breakdown of the figures since 2013/14.

9.8 In Q4 2013/14, the trust began to record separately safeguarding and welfare calls, which is why the first part of that data series is missing.

9.9 The drop in welfare referrals at Q1 2015 was expected due to changes in the way the Trust managed welfare referrals. Staff are encouraged to empower patients to raise welfare concerns themselves with the local authority.

9.10 In Q4, 2014 we audited the quality of decision making to ensure the new process was safe.

9.11 Referrals have remained fairly stable throughout 2015/16.



9.12 Referrals when profiled by borough (Graph over page) remains similar to previous years. Green indicates the three highest referring boroughs and the lowest are shown in red.

9.13 Although there is some variation between the ratio of referrals this is fairly consistent across London and is not a cause of concern and relates to population and density of care homes etc.

9.14 Figures by borough

	Adults Safeguarding	Adults Welfare	Children	Total Referrals	Referrals as % of incidents
LAS	4331	8440	4561	17332	1.66%
Barking and Dagenham	107	162	189	458	1.62%
Barnet	144	259	159	562	1.34%
Bexley	120	326	146	592	2.09%
Brent	157	258	138	553	1.40%
Bromley	153	317	153	623	1.73%
Camden	109	177	72	358	1.05%
Croydon	262	458	343	1063	2.26%
Ealing	174	319	183	676	1.70%
Enfield	132	267	217	616	1.62%
Greenwich	137	274	220	631	1.93%
Hackney	128	238	113	479	1.67%
Hammersmith and Fulham	89	176	63	328	1.48%
Haringey	123	238	134	495	1.59%
Harrow	80	136	92	308	1.28%
Havering	148	205	116	469	1.42%
Hillingdon	148	260	150	558	1.32%
Hounslow	165	330	152	647	1.98%
Islington	129	240	91	460	1.53%
Kensington and Chelsea	72	155	39	266	1.42%
Kingston upon Thames	75	152	69	296	1.63%
Lambeth	185	327	188	700	1.65%
Lewisham	149	348	194	691	2.07%
Merton	108	171	111	390	1.80%
Newham	143	232	182	557	1.38%
Redbridge	121	237	125	483	1.46%
Richmond upon Thames	90	203	62	355	1.92%
Southwark	191	313	166	670	1.62%
Sutton	128	223	108	459	2.00%
Tower Hamlets	111	194	141	446	1.35%
Waltham Forest	160	309	136	605	1.96%
Wandsworth	153	238	141	532	1.67%
Westminster	98	256	58	412	0.95%

9.15 Referrals by sector 2015/16

	Adults Safeguarding	Adults Welfare	Children	Total Referrals	Referrals as % of incidents
LAS	4331	8440	4561	17332	1.76%
North	1639	3201	1785	6625	1.45%
East Central Sector	497	1031	508	2036	1.52%
North Central Sector	504	1062	568	2134	1.41%
North East Sector	258	443	316	1017	1.43%
North West Sector	380	665	393	1438	1.41%
South	2029	4273	2174	8476	1.81%
South East Sector	909	1974	1066	3949	1.87%
South West Sector	695	1342	752	2789	1.97%
West Sector	425	957	356	1738	1.51%
Other	663	966	602		
EOC/CSD	61	49	111		
IRO	1	3	6		
NETS	26	49	1		
Other	149	250	195		
PAS/VAS	426	615	289		

9.16 Referral rates are subject to some variation at sector level (Coulsdon at 2.2%, Smithfield at 1%). These outliers are less extreme than in previous years and are what would be expected for the demographics and are not a cause for concern.

9.17 Local referral information is now shared via the "portal" so that safeguarding leads, Quality Governance Assurance Managers (QGAM) and Stakeholder Engagement Managers (SEM) are able to view and use referral information.

9.18 Work has focused on EOC referrals this year to enable 24/7 telephone referrals to EBS. In addition EOC CSR training will be undertaken in 2016/17. The impact of this should result in an increase in referrals from EOC in the coming year.

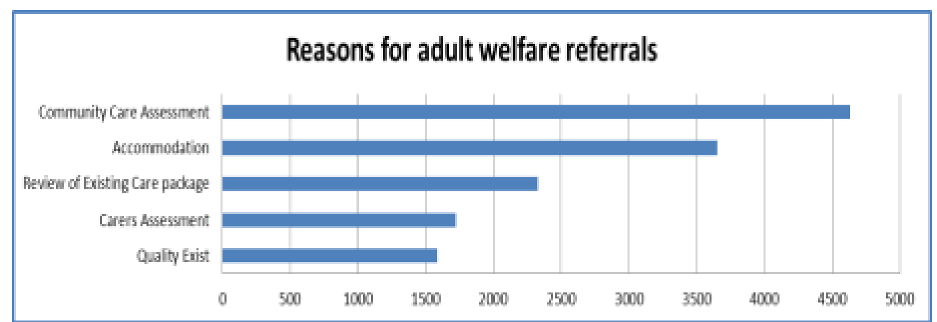
9.19 Private /voluntary staff make as many referrals as a medium sized station. This is as expected given our sustained use of private ambulance providers and demonstrates they have a good understanding of their safeguarding responsibilities.

Categories of referrals

9.20 Any specific welfare concern raised may name one or several reasons for the concern. They are all indicative of concerns relating to accommodation or care packages.

9.21 A small number are requests for carer assessment. The Care Act clearly includes carers within safeguarding. The Trust intends to raise awareness of this further in 2016/17.

9.22 The chart below shows the broad reasons why and the number of staff welfare concerns for adults. Overwhelmingly the most concerns raised are for an assessment of care need.



9.23 The graph over page shows the categories of adult abuse. The majority of adult safeguarding concerns are related to neglect and acts of omission.

9.24 Self-neglect would also rank highly, however it is difficult to clearly differentiate welfare related self-neglect from a safeguarding concern.

9.25 The Trust recently commenced formal recording of hoarding-related concerns and will shortly commence sharing these concerns with the London Fire Brigade as well as the local authority.

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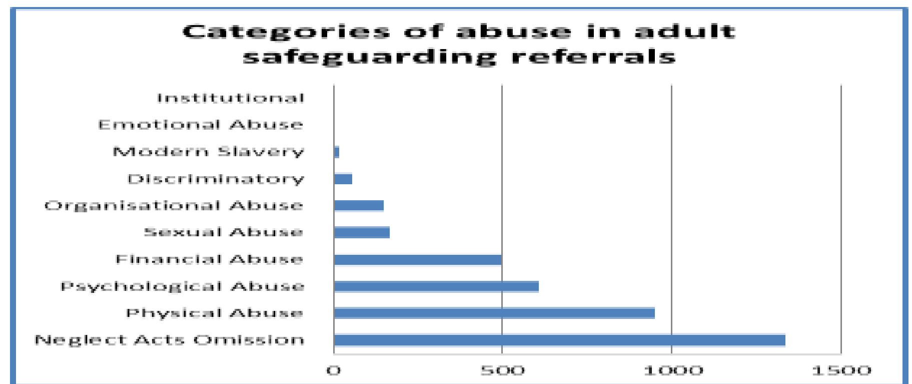

9.26 Child protection concerns will often be indicative of a number of concerns. Referrals overwhelmingly related to acts or omissions of parents.

9.27 There is a very small number of sexual abuse related referrals, this is potentially indicative of under reporting: the London Child Protection guidelines suggest this is a poorly understood area within partner agencies. The Trust will be looking at this area in the coming year.

9.28 The Trust undertook training on child sexual exploitation (CSE) in 2015/16 and will continue to raise awareness of CSE.

9.29 New referral processes were introduced for FGM and PREVENT this year. The LAS made 10 FGM related concerns 2 for adults and 8 for children. None were for confirmed cases of FGM. There has been an increase in awareness of FGM throughout the year and this is expected to rise next year although it is not an area of abuse the staff will witness but will receive declarations or have raised suspicions of.

9.30 Crews made 6 referrals for PREVENT. All PREVENT referrals are subject to review by the Safeguarding Team and LAS Prevent operational lead.

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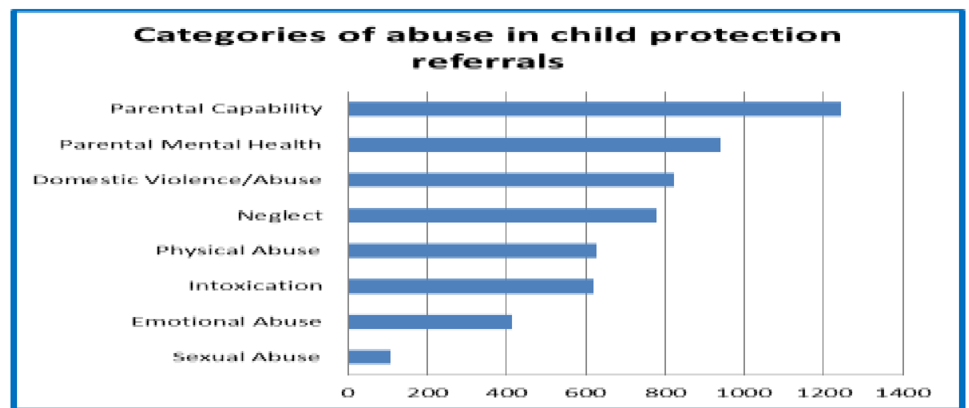
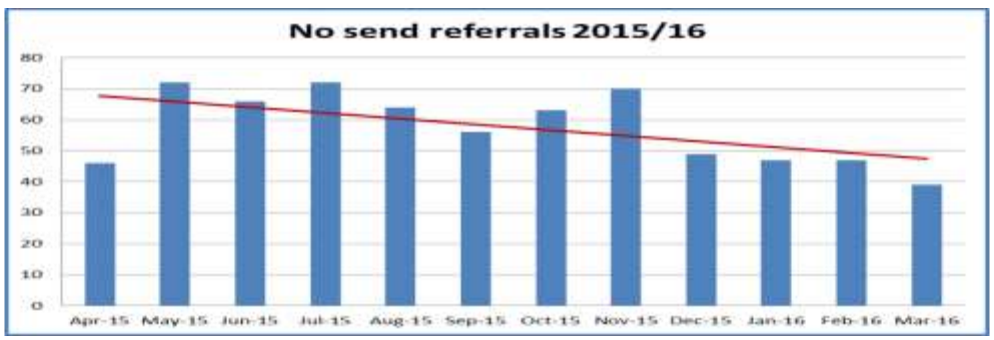


9.31 EBS receive some referrals and concerns from staff which are inappropriate (see chart below). This could be because it is the incorrect pathway e.g. mental health referrals, crew safety, clinical issue or lack of consent.

9.32 A number of referrals related to crew safety and should have been reported on the LA52 the Trusts Incident Report Form and clinical issues should be refered to the GP.

9.33 In all cases advice and signposting was provided, decision recorded and checked by a level 3 safeguarding EBS manager.

9.34 The chart indicates that education is improving and there is an incouraging downward trend.



Protected Characteristics

9.35 The following charts show a breakdown of the protected characteristics for 2015/16

9.36 The Trust record 56% of safeguarding referrals and concerns as being for white British/ White Other. This is in line with the most recent government data (2011 census) which has the figure for greater London at 60%.

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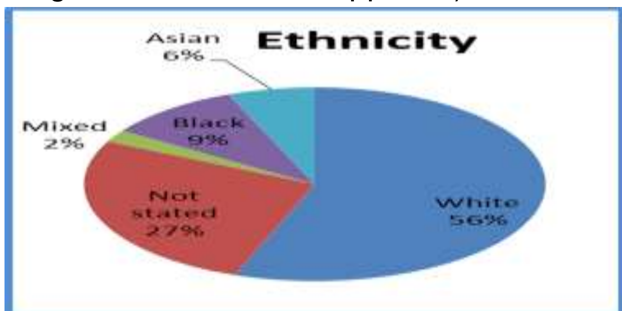
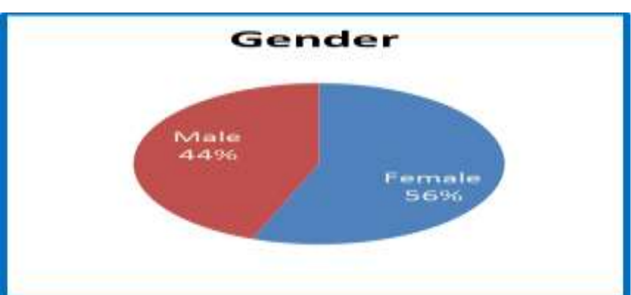
9.37 The Trust had no ethnicity recorded in over 25% of cases.

9.38 There are times when staff cannot answer this question, but improvement in this area and EBS will focus on this when the telephone referral system is fully introduced.

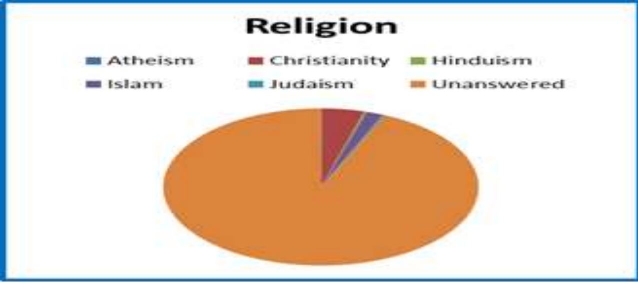
9.39 In 2016/17 work is planned to simplify the coding for ethnicity (in line with government guidance and Trust approval).



9.40 Referrals and concerns per gender is 56% female to 44% male.



9.41 The Trust safeguarding data on religion or beliefs is limited as often the information is not available to staff at the incident. For 93% of cases staff did not record religion.

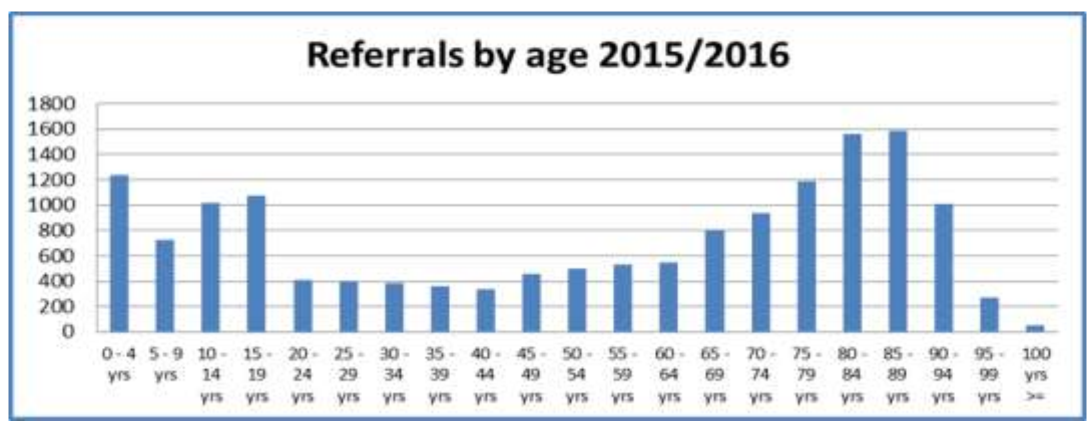


9.42 The Trust had very small number of cases where people's sexuality was recorded (only 50 referrals out of over 16000), even fewer for gender reassignment.

9.43 The move to 24/7 telephone referrals will enable EBS to ask direct questions of staff and to educate them of the need to capture this information where as on the current referral form it can just be left blank.

Referrals by age

9.44 The highest referrals are for the very young and the older members of the public.
9.45 Children under 4 years old receive the most referrals in < 18 years old.
9.46 A third of referrals for all children are related to self-harm (internal audit conducted Q1 2015).
9.47 Recommendations from the audit were to improve data collection and feedback sought on cases. These were accepted and will be implemented as part of the datix roll-out in Q1.



Type of premises

9.48 The chart below details the type of premises the adult or child lives in.
9.49 Two thirds of referrals were for patients in their own homes.
9.50 Around half of the remainder were in social housing of some kind.
9.51 In 18% of referrals staff were unable to record the type of property. (See chart below).

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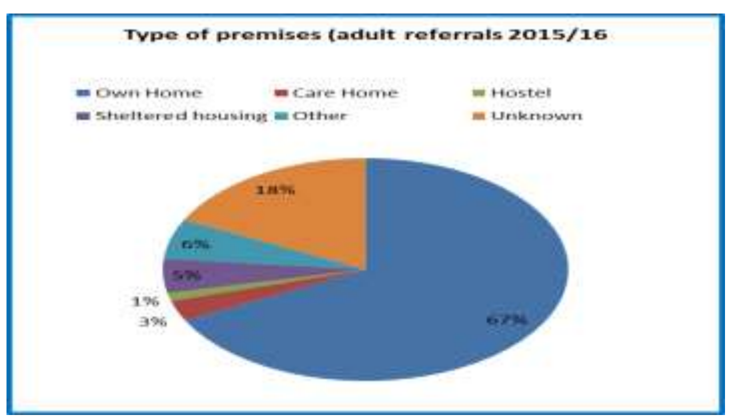


10.0 Safeguarding Action Plans

10.1 The implementation of the safeguarding action plan is monitored by the Trust's Safeguarding Committee.

10.2 The Action Plans contain the actions that are required to ensure the Trust is complaint with legislation, National documents/ recommendations and learning from incidents.

10.3 In March 2011, the Department of Health published a Safeguarding Adult and Assurance Framework to enable health trusts to identify how well they are meeting their safeguarding adult responsibilities. This was followed in 2014 by the Self-Assessment Risk Assessment Tool (SARAT). In addition there were a number of recommendations following the Savile investigation; these are all included in the Action Plan in Appendix One.

11.0 Summary

11.1 Overall self-assessment reveals that the Trust is partially complaint with CQC standards for Safeguarding, safeguarding supervision is to be addressed in 2016-17, this means the trust is unable to provide the level of support required to its staff and measures are in place.

11.2 The Trust have made progress with PREVENT training 93% of clinical staff however there remains challenges, on policy, referral pathways and non-clinical staff training completion.

11.3 The action plan has progressed slowly this year with some large system change processes included in the plan; progress continues to be monitored by the Safeguarding Committee. The impact on this is that we are non-compliant with areas of best practice and recommendations for example Savile recommendations.

11.4 The Trust need to complete a review of safer recruitment including a decision on frequency of DBS checks.

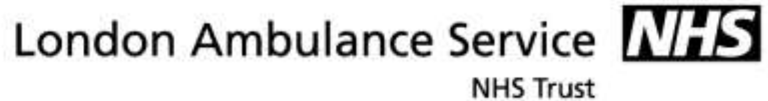
11.5 The Trusts needs to develop a system to identify who is compliant or non-complaint with mandatory safeguarding training. This is included in the Quality Improvement Programme following the CQC inspection and a resolution will be in place during the coming year.

11.6 The Trust has delivered a wide range of safeguarding training across the Trust at inductions, level 1, level 2 and level 3 during 2015-16 with 93% of clinical staff receiving safeguarding training.

11.7 The Trust engaged in 308 partnership working meetings in 2015/16.

11.8 The Safeguarding governance arrangements within the Trust are working well and providing assurance to the Board.

Alan Taylor
Head of Safeguarding



Appendix One Safeguarding Action Plan

Safeguarding Action Plan 2015/16

Final report

This is a report on the progress made with the safeguarding action plan in 2015/16. It seeks to provide details of those actions that were completed, partial completed or still outstanding. It will give completion date and length of time overdue.

The report will also highlight the risks to the Trust on those not completed and highlight the challenges that have been faced. It will also highlight those that need to be escalated to ensure compliance with requirements.

The Safeguarding committee agreed the action plan at the start of 2015 recognising that there where a large number of action to complete within the year. Several requiring system changes which often take time to achieve. Indeed many of the partial completed items include system changes that are in progress and should see completion in 2016/17.

Below provides a general overview on the progress of actions.

Overview of completion of action plan as at 31/3/16		
Number of actions completed	Number of actions partially completed	Number of actions outstanding
12	13	13

Overview of completion of action plan as at 20/5/16		
Number of actions completed	Number of actions partially completed	Number of actions outstanding
24	9	5

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Title	Improve trust referral systems and processes					
Action	**Progress**	**Achieved/ outstanding RAG**	**Completion Date**	**Impact Risk/Action**	**RAG as at 20/5/16**	**Progress**
To move from a Fax referral system to secure electronic referral system to local authority to improve data protection and reporting processes.	IM&T currently designing database. 6 boroughs are scan to email.	Outstanding Hopeful of Q2 2016 completion date.	June 2015	Carry over to 2016/17 work plan.		Reliant on Datix Web. Training for EBS staff beginning 26th May Estimated delivery June 2016
Move to 24/7 telephone referral system from crews to EBS	Currently 8-8 telephone referrals. PAS, VAS and EOC full telephone	Outstanding Hopeful of Q2 2016 completion date	June 2015	Carry over to 2016/17 work plan.		Interview for new staff 23/5/16 Estimated July delivery date.
Enable safeguarding activity database to be available to Trust managers	Establish best way of making data available	Achieved March 2016	Sept 2015			
To improve support to those at risk but ensuring we meet requirements to ensure referrals being passed to appropriate agencies/ professionals.	Agree what types of abuse required multiple referrals. FGM Domestic Abuse Hoarding Prevent	Partially Achieved Added to 2016/17 actions	August 2015	Carry over to 2016/17 work plan.		FGM, Hoarding and Prevent referrals in place, Domestic abuse Policy to ELT 1/6/16
Improve feedback on referrals to staff	Pilot to begin with Havering in March 2016. % of feedbacks up from 0.02% to 2%. Introduced Staff safeguarding action plan to evidence feedback and change of practice.	Outstanding	Nov 15	Could impact on referrals Resulting in more missed referrals Carry over to 2016/17 work plan.		Pilot begun meeting Havering 31/5/16 to review
Title	**Education & Training (Commissioned standard & CQC)**					
To approve training strategy and ascertain safeguarding is included in Trust training needs	Written agreed by Safeguarding committee. No Trust wide training Group,	Partially Achieved	Sept 15	Submit to new Training Strategy Group.		Training Strategy being reviewed by Trust

analysis yearly.	new Asst Director to implement group in Q1-2 2016.					training strategy group. Training for 2016 approved
Write safeguarding sessions for level 2 CSR training	Developed and delivered for clinical staff	Achieved	May 15			
Review EOC level 2 training	Meetings planned for March 2016 Scoping of areas undertaken Part of QIP	Partially achieved	Oct 15	Include in training session development for 2016/17		Training commenced 9/5/16
Ensure HR and Ops managers comply with Allegations against Staff policy.	HR and operations managers trained. Awaiting IRO training dates.	Partially Achieved	Dec 15	Date now agreed for May/June onward several sessions. Close.		Met HR manager 4/4/16 IRO training agreed 15/6/16
To be able to capture accurate data on all safeguarding Trust for all Trust staff and volunteers.	Part of the QIP	Outstanding	Dec 15	Unable to provide assurance on training compliance Monitor QIP progress add to 2016/17 plan.		In business plan for 2016/17 delivery as part of QIP actions due for completion 30/9/2016
Title	**To ensure Safe safeguarding practice and partnership working during operational restructure.**					
To ensure how safeguarding will be managed at a local and area level.	Confirmation with Director of operations. Operational roles for safeguarding.	Achieved	Sep 15			

To develop a database to capture local safeguarding activity.	Developed data captured monthly.	Achieved	Dec 15			
Ensure both internal and external awareness of changes to local safeguarding arrangements	Issued leaflets and new Safeguarding Pocket Book and pull out pens. Shared Nationally	Achieved	Oct 15			
Title	**Provide safeguarding supervision for staff**					
Develop safeguarding supervision policy.	Write policy awaiting supervision post and findings to review policy.	Partially Achieved forms part of supervision post agreed for 2016-17	Feb 15	Add to plan for 2016/17		
Consider who is best to provide what level of supervision to staff.	Secure funding from NHSE for a Safeguarding Supervision Project Manager to look at what is appropriate for ambulance trusts.	Partial Achieved- recruitment to post begins July 2016	Dec 15	Part of project add to project brief.		
Agree and commission supervision training	Part of NHSE funded post	Outstanding Part of supervision project	Jan 15	Part of project add to project brief.		
To use OWR to support staff and audit safeguarding practice.	Held meeting with OD who are restructuring appraisals and OWR.	Partially Achieved	Dec 15	Monitor inplementation of OWR		
Title	**Implementation of the Savile recommendations**					
All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	Policy written, rejected by SMT as too many policies need all into one policy.	Outstanding	May 15	Unable to comply with Savile recommendati on Add to work plan escalate to Quality Committee		Policy being submitted to ELT for sign off 1/6/16
All NHS trusts should review their voluntary services arrangements and ensure that: •They are fit for purpose; •Volunteers are properly recruited, selected and trained and are subject to appropriate management	Reviewed arrangements and regular reports to safeguarding committee.	Achieved	May 15			

and supervision. •All voluntary services managers have development opportunities and are properly supported.						
All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	E learning introduced for non-clinical staff. All clinical staff received annual face to face training	Achieved	Sept 15			
All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. To ensure that their arrangements are operate as effectively robust and as possible.	Service development bid submitted. CEO approved 2x Band 7 specialists to support safeguarding. Currently reviewing role of Head of Safeguarding and Administration requirements for the team.	Partially Achieved	Sept 15	Recruitment underway close on completion		Staff appointed start dates 11/6/16 & 13/7/16
All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers	Review underway by Executive Leadership Team (ELT)	Outstanding	Sept 15	Trust risk to employing unsuitable staff which could put patients at risk. Add to workplan ELT aware of issues.		Agreed in principle by ELT currently developing HR action plan for 2016/17.
All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own	Review underway by new HR Director	Outstanding	Sept 15	Trust risk to employing unsuitable staff which could put patients at risk. Add to workplan monitor Hr progress		Updated in line with new guidance from NHS Employers. Ratified by the Senior Managemen t Team

internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.				escalate if no progress		
NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director	Review underway by new HR Director	Outstanding	June 15	Trust risk to employing unsuitable staff which could put patients at risk. Change in directors So monitor progress and add to Work plan for 2016/17		Review complete and reported to Safeguardin g Committee 5/5/16
NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this	Chairman and Trust Secretary to review in March 2016. Due to Chairman leaving needs to be followed up with the new Chairman during 2016/17	Outstanding	March 2016	Very little charity work and engagement with celebrates but still as risk to trust. Change of Chairman Monitor and escalate as required. Add to work plan for 2016/17		Company Secretary confirmed that no charity work currently undertaken agreed to close action and to raise a risk for consideratio n should our charity work recommenc e
Title	**Ensure effective information sharing policies and procedures are in place.**					
Develop and agree a pan London safeguarding information sharing agreement	Pan London policy was delayed until Feb 2016 Agreed with governance team we will sign	Partially Achieved	July 15	Once LFB information sharing agreed close.		

	individual information sharing agreements when requested. Develop own ISA with LFB on sharing hoarding information					
Obtain approval from all 64 safeguarding boards/ safeguarding organisations	Pan London policy was delayed until Feb 2016 so no action to date Decision above negates need for this action	Achieved	Dec 15			
Title Prevent requirements- Adherence to NHS commissioning standard under service condition 32 in relation to Prevent						
There is a strategic plan for safeguarding adults that includes Prevent and it is an integral part of quality.	Currently sits with ADO Special Operations.	Outstanding	July 15	Risk to Trust noncompliance with contract arrangement. Add to work plan and Escalate to quality committee		Policy in draft form. Trust still to agree which directorate will take responsibility for Prevent
The service has an approved Prevent Health Wrap Trainer and sessions are being rolled out to staff.	Trainers have had NHSE training in Prevent	Achieved	July 15			
All staff receive Prevent training	93% of clinical staff trained E learning for Non-Clinical staff not launched yet.	Partially Achieved	Aug 15	Add to work plan 2016/17		
To agree appropriate referral pathway for Prevent concerns from staff.	Capture Prevent referrals on safeguarding activity report. Ensure EBS aware of appropriate pathway for referrals. Ensure appropriate information is obtained from crews. Problems agreeing with CONTEST	Partially Achieved	Oct 15	Add to work plan 2016/17		Agreed with MPS pathway for PREVENT 19/4/16

	correct referral pathway. Meeting MPS in May 16					
Title Trust has guidance and processes to govern the use of restriction and restraint and where DoLS should be considered						
Develop a Restriction and restraint policy.	Developed and approved	Achieved	June 15			
Consider any training requirements as a result of policy implementation.	Developed and covered on CSR	Achieved	July 15			
Title KPMG audit recommendations						
We recommend the Trust implement an internal database which can be updated to reflect training undertaken and monitor when individual staff are approaching the date when they are required to complete refresher training, to reduce the risk of breaches in terms of Safeguarding training.	Also identified by CQC inspection and forms part of the QIP.	Outstanding	Sept 2015	Part of early action and QIP programme. Add to work plan to monitor.		
We recommend the Trust completes a full review of recruitment policy to ensure it is up to date with current requirements and addresses the Trust's responsibilities regarding recruitment with reference to safeguarding responsibilities.	No progress to date	Outstanding	31 March 2016	Risk of employing unsuitable staff. Add to work plan and monitor escalate if no progress		Updated in line with NHS Employers Ratified by Senior Managemen t Team May 2016
We recommend the Safeguarding Team use DATIX to record the review of IMRs and chronologies. The final email which is sent to the relevant Safeguarding Board should also be maintained on DATIX to ensure a full evidence	Implemented	Achieved	30 Sept 2015			

trail is available.						
We recommend the Trust record receipt of overseas candidate's certificate of good conduct on ESR in the same manner as DBS checks. This will enable the Trust to easily identify those individuals who have not submitted a certificate of good conduct.	No progress	Outstanding	31 March 2016	Risk is being unable to assure processes. Add to work plan and monitor escalate if no progress.		Checks recorded on ESR Recruitment are currently confirming data entered correctly and an audit to be completed by Workforce Information Manager.
In line with leading NHS practice, we recommend the Trust begins to implement a rolling programme of DBS checks on all staff, to ensure this check is carried out at least once every three years. This should commence by the year end, with a focus on those staff who have never gone through the DBS clearance but require it for their role.	Awaiting ELT for decision Second Paper to ELT in Jan 2016 by HR	Outstanding	31 March 2016	Risk to patients and Trust reputation not undertaking adequate DBS checks. Add to work plan and monitor escalate if no progress		

Patient Experiences

Annual Report

2015/16

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Introduction

Our Patient Experiences team offers a single point of access and has responsibility for the following work streams:

- Complaints
- Patient Advice and Liaison Service (PALS)
- Patients with complex needs who make repeated 999 calls
- Solicitor and other requests for medical records and witness statements.

This report provides an overview and analysis of activity about PALS and complaints, including cases investigated by the Health Service Ombudsman, lessons learned and the action taken by the Trust arising from service-user feedback and complaints.

The volume of complaints this year fallen by around 25% over 2014/15 which was an extraordinarily busy year. Each complainant received a response that was personally reviewed and signed by the Chief Executive (or a deputising Director when the CEO was away from work).

Activity and themes arising are reported to the Trust Board via the Improving Patient Experience Committee Report which integrates complaints data with patient feedback from PED and the other clinical work streams, enabling a holistic approach.

PALS offer immediate assistance including liaising with other departments and agencies. During 2015/16, PALS recorded an 8% increase over 2014/15 (3567) with 3862 contacts from patients, carers, relatives and the public. This contrasts to the decrease in the numbers of complaints in the same period and highlights the importance of maintaining our PALS service in order to provide advice, support and information to patients, families and their carers.

1. Context

This year, the Trust has experienced call rates of 1,801,104 x 999 calls, approximately 0.5% lower than the previous year (1,895,588). This is relatively high daily average of 4935 x 999 calls. We attended 1,041,439 of these calls which results in a 0.10% average ratio complaints versus calls attended. This is slightly lower that the 0.13% average in 2014/15 although less calls were attended (930951).

2. Overview

Summary of complaints and PALS

The total number of enquiries added to PALS and complaints received was 8958. This comprised of 7907 enquiries of which 3863 were PALS specific and 1051 complaints. Currently, the PALS database is also used as a mechanism to record enquiries relating to safeguarding, patients with complex needs who make repeated 999 calls and requests for medical records by Solicitors. In 2016/17 we will be moving our case management database to a web based system. This includes a specific *Patient Experiences* module which will be used to record all PALS and complaints.

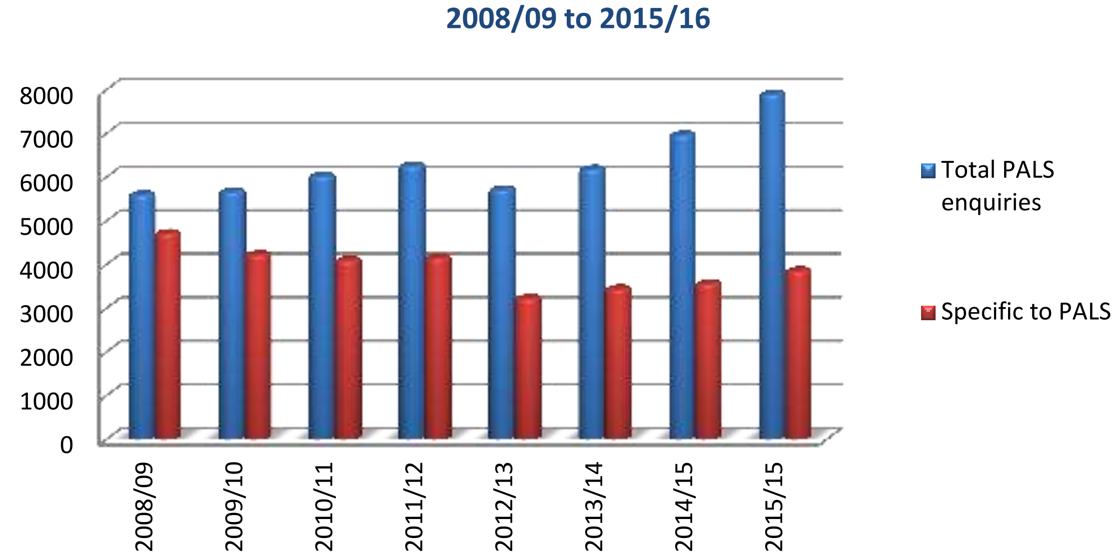
71 cases involved treating the referring professional as acting on behalf of the patient[1]. This enables the patient a recourse opportunity and advocacy assistance.

Table 1 'Section 8' cases

		Recorded under PALS				Recorded as complaints on behalf of the patient		
Title	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
s.8	2	79	51	78	21	50	82	71

The following graphs demonstrate total PALS cases received by year since 2008:

Graph 1 **PALS comparison 2008/09 to 2015/16**



We continue to work closely with our Consultant Midwife and participate in a monthly maternity summit to discuss issues arising where midwifery is the key area of the enquiry or concern. We are also part of the '*Sign up for safety*'[2] initiative focusing on maternity aspects in delivering care in the safest way possible. There were 25 such cases added to PALS during this period.

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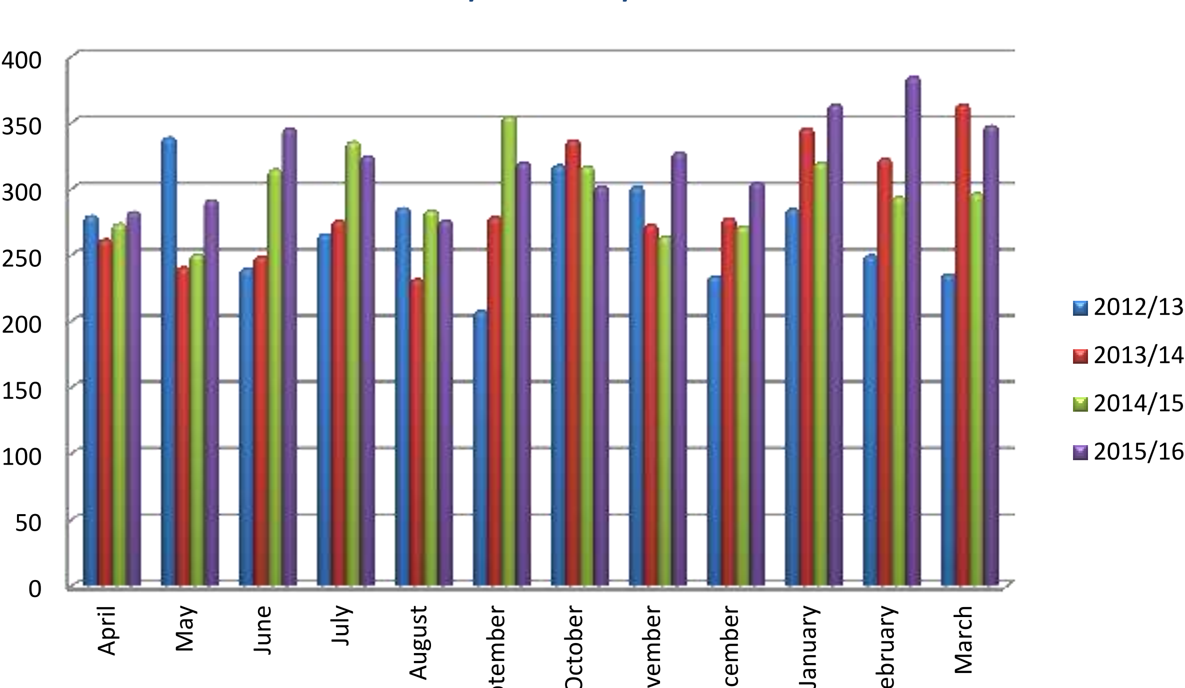
[1] This is considered best practice in the light of Section 8 of *The Local Authority Social Services and NHS Complaints (England) Regulations (2009*) as one *responsible body* (health and social care providers) cannot use the complaints procedure to 'complain' about another.

[2] https://www.england.nhs.uk/signuptosafety/

Graph 2 PALS specific enquiries 2012/13 to 2016/16



Summary of agency referrals

There was a decrease in the numbers of external agency referrals from Acute Trusts, midwives, GPs, CCGs and local authorities.

We continue to work closely with our Consultant Midwife and participate in a monthly maternity summit to discuss issues arising where midwifery is the key area of the enquiry or concern. We are also part of the '*Sign up for safety*'[3] initiative focusing on maternity aspects in delivering care in the safest way possible.

Table 2 represents external agency referrals from other health and social care professionals and incident reports by LAS staff that involved an external agency since 2008. There has been a steady decline in the numbers of such enquiries, partly in consequence of S8 of the complaint regulations – see Table 1 above.

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[3] https://www.england.nhs.uk/signuptosafety/

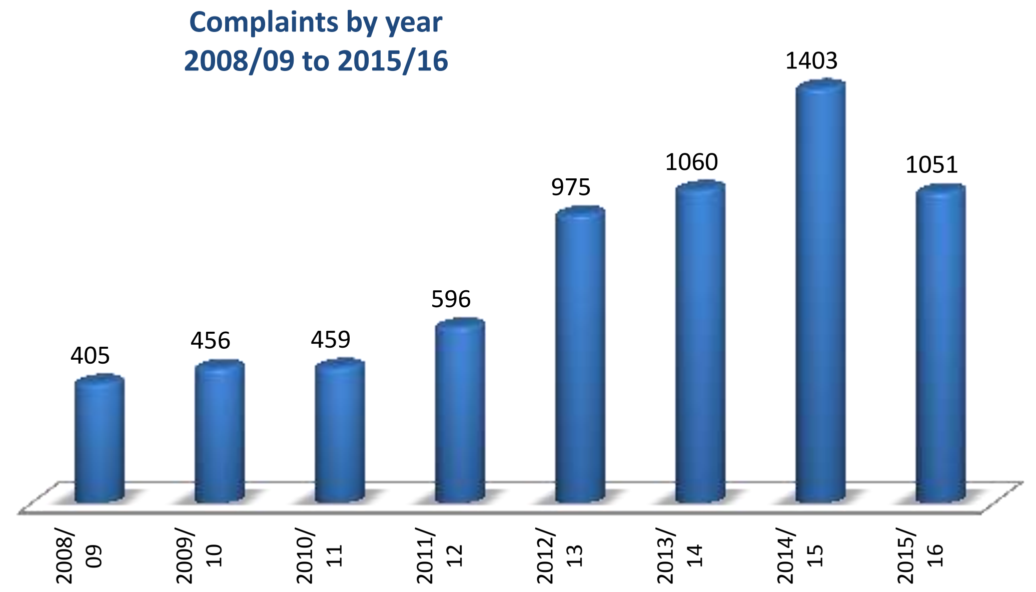
Table 2 Summary of agency referrals by year 2008/09 to 2015/16

Summary of agency referrals by year		
Year	External referral	Incident report LAS
2008/09	119	38
2009/10	102	276
2010/11	108	314
2011/12	72	78
2012/13	123	69
2013/14	181	77
2014/15	96	48
2015/16	69	26
Totals:	870	926

3. Complaints

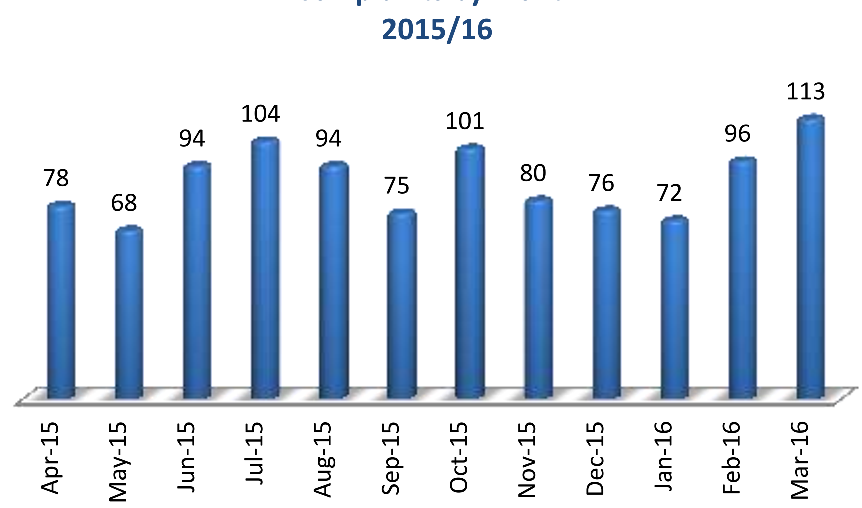
1051 complaints were received (including 71 referrals by other health and social care professionals managed as being made on behalf of the patient). This represents a 25% dip over the previous exceptional year.

Graph 3 Complaints comparison 2008 to 2016



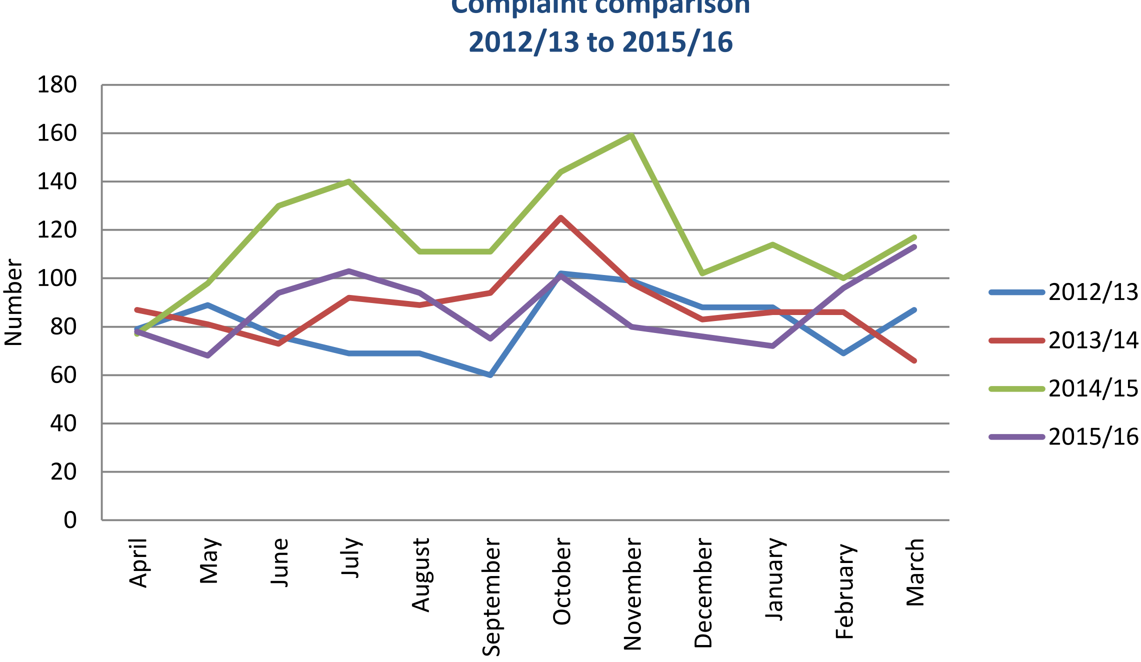
The graph below indicates volume by month. Graph 4 illustrates the complaints trend over the course of the year and Graph 5 takes a wider view, indicating the increase in volumes over a period of a number of years. 2014/15 was an unprecedented year in terms of demand to the service. 2015/16 is more comparative to 2013/14 with regards to the numbers of complaints received.

Graph 4 Complaints received by Month 2015/16

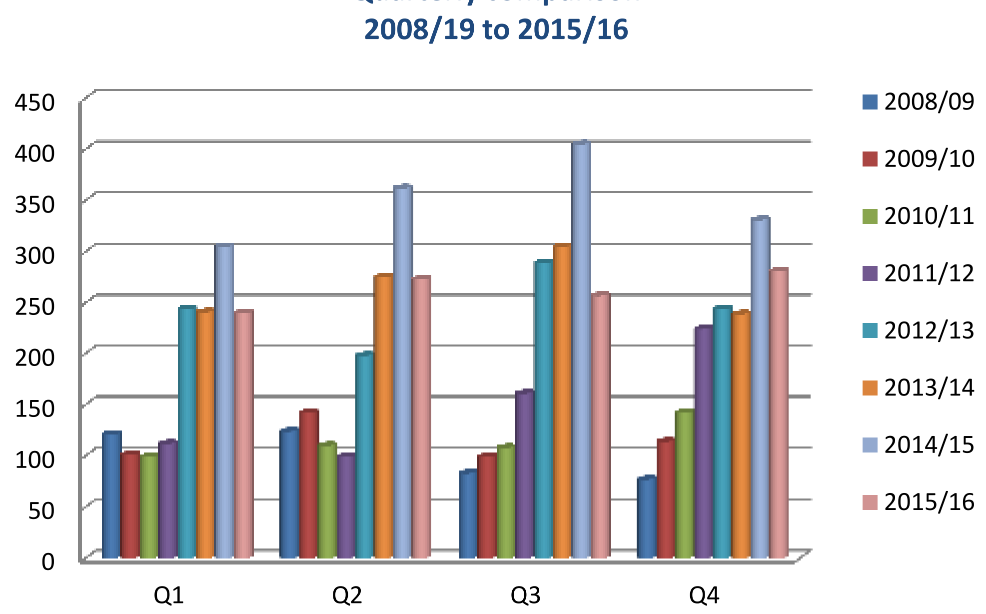


Graph 5 highlights the annual peak and flow of complaints, historically, October has been the busiest month of the financial year. However, there was an unprecedented increase in 2015/16 in complaints during March 2016.

Graph 5 Complaints comparison by month 2012/13 to 2015/16



Graph 6 **Complaints by Quarter 2008/16**



When the complaint volume is matched with the rise in demand, this indicates a fairly constant rate at 0.10%. This is illustrated in Table 3 below:

Table 3 **Complaints ratio against demand**

Month	Calls attended	Complaints received	Percentage of complaints against calls attended (rounded)
Apr-15	81523	78	0.10
May-15	84230	68	0.08
Jun-15	82847	94	0.11
Jul-15	86074	103	0.12
Aug-15	84876	94	0.11
Sep-15	82964	75	0.09
Oct-15	88283	101	0.11
Nov-15	88106	80	0.09
Dec-15	92248	76	0.08
Jan-16	91193	72	0.08
Feb-16	85605	96	0.11
Mar-16	93490	113	0.12
Totals	**1041439**	**1050**	**120.00%**
		Average	0.10%

The highest volume of complaints were about delays in an ambulance response; these are administratively attributed to the Emergency Operations Centre under the existing case management practice although clearly much depends on the available resourcing, an operational responsibility.

Table 4 Performance

Month	0-35	0-45	0-60	0-80	0-100	Total responded to within these time frames
April 2015	18	8	7	16	21	70
May 2015	18	6	9	13	12	58
June 2015	31	11	17	13	11	83
July 2015	51	17	17	13	4	102
August 2015	37	11	22	19	3	92
September 2015	35	5	14	17	2	73
October 2015	36	8	20	16	16	96
November 2015	31	12	14	18	8	83
December 2015	34	4	14	16	0	68
January 2016	27	25	11	0	0	63
February 2016	45	4	0	0	0	49
March 2016	26	0	0	0	0	26[4]
Totals:	**389**	**111**	**146**	**141**	**77**	**863**

[4] This is a notional response time as a true reflection of the 35 days cannot be reached at the time of this report

Overall performance has improved month on month. We have recruited to the vacant positions and the turnaround time has improved compared to 2014/15.

As indicated by Table 4, there are no outstanding complaints awaiting a response for more than 45 working days.

The current trajectory indicates the 35 working day response target will be met by September 2016.

Graph 7 **Graph showing the number of days we responded to complaints in 2014/15 and 2015/16**

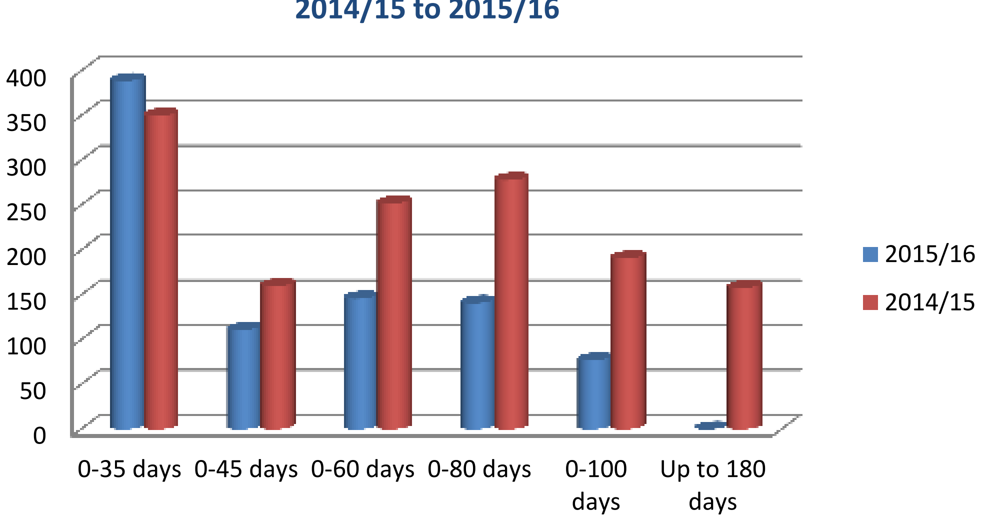


Table 5 **Complaints by Department Area**

Complaints by Area 2015/16	
Control Services (EOC, UOC, CTA etc)	462[5]

[5] All complaints regarding a delay are attributed to Control Services. However, the cause is not due to processes within control they are mainly due to resourcing across all areas.

A&E Operations - South East Sector	113
A&E Operations - South West Sector	78
A&E Operations - West Sector	63
A&E Operations - North Central Sector	56
A&E Operations - East Central Sector	52
Not our service	51
A&E Operations - North West Sector	44
A&E Operations - North East Sector	28
Patient Transport Services	24
Contracted Services	23
Unknown or No Trace	21
111 Beckenham	10
Hazardous Area Response Team	7
Clinical Hub	6
LAS Headquarters	6
Central Operations	4
Volunteer Ambulance Service	2
Community and Co Responder	1
Totals:	**1051**

Complaints: Analysis & Themes

Volumes

The number of complaints has decreased over the previous year which was a very difficult period for the Trust.

Themes

There were 15 broad themes arising from complaints. Table 6 illustrates the number of complaints by subject using these themes. They are ordered from left to right with the most common themes this year being first.

Table 6 Complaints by the main subject 2007/08 – 2015/16

Year	Delay	conduct and behaviour	Patient injury/property damage	Non conveyance	Treatment	Conveyance	Road handling	Location Alert referral	Not our Service	Clinical Incident	Aggravating factors	Clinical Equipment	Disputes regarding safeguarding referral	Assisting with external agency	Challenging paramedic referral	Complaints handling	**Total**
2007/08	138	222	38	23	70	5	0	0	45	4	5	1	0	0	0	0	551
2008/09	84	125	27	32	46	4	0	0	37	4	3	0	0	0	0	0	362
2009/10	96	147	29	74	66	18	0	0	16	6	2	1	0	0	0	0	455
2010/11	92	151	38	67	68	13	7	0	15	2	5	1	0	0	0	0	459
2011/12	193	152	45	64	62	27	10	0	33	5	2	3	0	0	0	0	596

2012/13	411	267	85	69	65	28	15	14	11	6	3	1	0	0	0	0	975
2013/14	421	250	15	86	91	24	119	15	31	2	1	1	2	2	0	0	1060
2014/15	756	303	15	91	85	19	98	9	11	1	2	2	8	2	1	0	1403
2015/16	434	325	11	57	59	15	96	11	27	6	0	4	2	3	0	1	1051
Totals:	**2625**	**1942**	**303**	**563**	**612**	**153**	**345**	**49**	**226**	**36**	**23**	**14**	12	7	1	1	**6912**

Other common themes include

- Staff challenging the validity of the 999 call
- Sequential call management errors at times of significant demand
- Failure to re-triage repeat 999 calls about the same patient
- An increasing correlation between delay and poor staff attitude (altercations arising from the delay)
- Increase in non-conveyance where the patient has been referred to an Alternative Care Pathway

4. Changes to Service Provision/case examples

Call management

1. The family of an elderly patient questioned why he was declined an ambulance on Christmas Day when there were no other means of transport. We identified that the call handler failed to recognise the significance of the patient's presenting condition of myeloma. To widen the learning all control services staff have been reminded that if they are unfamiliar with a particular clinical condition, they should seek advice from the Clinical Hub; and that where a patient cannot mobilise or is unable to get to hospital by any other means, this should be taken into account during the assessment process.

2. The family of an elderly patient questioned the delay in an ambulance attending the patient after she fell. We advised that we have now put in place a system so that automatic upgrades can be made to calls involving patients identified as 'vulnerable' to in keeping with the 60 minute schedule from the time of the initial 999 call.

3. The priority telephone at a maternity unit was relocated by the midwifery supervisor to a position where it can be answered 24 hours a day following incidents reported by EOC that they were unable to obtain a response when placing obstetric emergency calls to the unit. This will be highlighted in the monthly EOC bulletin for all staff.

4. A complaint was received via the patient's MP who raised a number of concerns including why the patient, who had experienced a seizure, was not considered a high priority. We

explained that where a patient is recovering from a seizure and they are not experiencing multiple seizures, then they are not considered a high emergency priority.

5. A complaint was received from the patient's father who was concerned that his daughter was declined an ambulance after fracturing her leg. Although the 999 call was managed in accordance with our protocols, we advised that LAS are currently reviewing how we assess patients with lower limb injuries who are unable to weight bear and this may affect a change in the assessment outcome priority in the future.

6. Complaint that patient with chest pains was advised of possible 60 minute delay. The patient was taken to hospital by independent means and confirmed as having heart attack. The advice about the delay is a routine Surge Plan outcome, following triage at C2 which was based on chest pain as consequence of vomiting. This originates from 2009 DoH evaluation. The Medical Director to lead a further review

7. A dialysis patient was experiencing vomiting and stomach and kidney pain. The patient is deaf and their neighbour rang 999 on his behalf but there was a. 7+ hour delay in responding with the neighbour being repeatedly called back by EOC throughout the night despite their not being able to help. There were a number of shortcomings in the call management during the 999, CHUB and welfare call back sequence, including that an upgrade should have been applied much sooner that it was. There should have been better coordination and cross-referencing so it was clear that the patient would be unable to hear the telephone and that the neighbour' s family were not on scene with him and could not offer any further help. Patient advised of 999 SMS facility to arrange as part of his care plan

8. The patient complained that he was advised that there could be a long wait for an ambulance after he was suffering breathing problems. He was advised that we now routinely advise callers where there may be a potential delay when the Surge Plan has been implemented so that they can make a decision as to whether they should make their own way to hospital or an alternative care pathway where possible.

9. The patient's daughter complained that her mother was declined an ambulance and that the call handler was rude and unhelpful. An apology was provided regarding the call handler's attitude and the family were reassured that all the types of patient symptoms that are categorised at a C4 priority as being suitable to be referred to NHS 111 were agreed by the Department of Health through a specialist group of experts and the categorisations are periodically reviewed accordingly.

10. The head teacher of a primary school was concerned that a patient specific protocol did not appear to have been actioned for one of the pupils. The Quality Assurance evaluation concluded that based on the information we were given, the 999 call was largely managed in

accordance with our procedures and determined at the appropriate level of priority. However, in view of the caller not being able speak very clearly during the call; the call handler may have misheard the patient's condition. Although call handlers are not clinicians, feedback has been given to the call handler concerned to ensure that they check with a supervisor if they are unclear about a condition described about a patient that may be material to their presentation.

11. A complaint was received in respect of the delay in attending a patient who had possibly fractured her hip and was in significant pain. Based on the information provided the initial 999 call was determined at the appropriate level of priority. However, the call handler should have explained that the Clinical Hub would be calling back and the time frame for them to do that. Additionally, the enhanced assessment by the clinician who called back would have been improved with a more thorough consideration of the type and nature of the patient's pain. In keeping with our learning approach, feedback will be given to the staff concerned.

12. There was a long delay in responding to a patient who had been given routine pre—arrival instructions to leave her front door unlocked. As this happened in the middle of the night and the patient lived on a housing estate, this placed her in a vulnerable situation. This matter has been referred to Control Services clinical governance forum to consider if changes could reasonably be made to the instructions to take account of the possibility of a delay in our responding.

Delay

13. A care home manager was concerned about the delay in an ambulance being sent to an elderly resident and why the patient was not considered as a priority. The patient was assessed at a lower acuity but the call handler omitted to advise that it may take up to 2 hours as the service was under pressure.

14. A patient's father complained that his son waited a considerable time for an ambulance which he feels resulted in on-going infection problems to an injury to his knee. The call handler should have matched the call with previous 999 calls from the same location, which may have prevented excessive delays and feedback will be provided accordingly. The clinical advice provided was that ambulance crews do not routinely irrigate deep wounds as this procedure is more effective when carried out in a hospital environment and best practice is to carry this out within one hour. We have asked our Medical Director to consider the risk of infection in these circumstances and whether this may affect our assessment of injuries of this nature in future.

15. Complaint about a significant delay in attending a patient who had taken an overdose of prescription meds. Where a delay occurs in overdose cases, a welfare call back must be made by a clinician to re-assess the patient's symptoms

16. Delay in responding following referral from NHS111 about patient who had taken an overdose. The referral from NHS111 via electronic link was coded at C2. We identified that

had the request been made directly 999, this would have attracted a C1 priority and the patient would have been noted as a ‘vulnerable patient’. As such, the call would have been monitored by the Clinical Hub so that an upgrade could be made as necessary with welfare and re-assessment callbacks being made. Matter referred to our Control Services Governance Group, to consider amalgamating requests of this nature from NHS 111 providers with our own ‘vulnerable patients’ protocol. All NHS 111 providers to be alerted about the outcome determinant of overdose patients with specific presentation.

17. A patient complained that he was advised that there would be a delay in an ambulance attending (this reflected the relevant Surge Plan action that there may be a 60 minute delay). We explained the purpose of the Surge Plan and that by informing callers of the possible delay, this was to enable a decision as to whether they should make their own way to hospital or access an alternative care pathway; and that the risk is mitigated in that we routinely advise patients to call 999 again where their condition changes, so that the re-triage protocol can be applied and an upgrade made as necessary.

18. The patient’s daughter complained about the significant delay in an ambulance attending her elderly mother. Aas matters stand the *elderly fallers protocol* only applies where the patient remains on the floor. CHUB Governance & Quality Manager will review the protocol to take account of elderly patients who have been assisted from the floor but have sustained a suspected injury as a result of the fall.

Treatment

19. The GP deputising service were concerned that the attending ambulance staff failed to take the patient to hospital and referred her for home care. The patient was later diagnosed with a subarachnoid haemorrhage. We found that although the care provided was of a reasonable standard, it can be difficult to determine the cause of a headache and to separate a migraine from significant cranial pathology which can rely on very specific signs. Feedback was however given to the staff concerned and the incident will be used as an anonymised case study in a Clinical Update to promote awareness of the signs of a sub-arachnoid bleed.

20. Following a review of the practice of a member of staff when attending a neonatal home birth, individual and systemic learning was identified. The hospital were advised that we will be arranging joint training to improve team working and communication with the midwifery team.

21. A patient’s husband complained that his wife was advised by attending ambulance staff to make her own way to hospital when her contractions had increased as they assessed her as being in the early stages of labour. Our Consultant Midwife has said that whilst the clinical assessment was thorough and the crew’s impression was that the patient was in the first stage of labour, spontaneous labour in women experiencing a second or subsequent child is likely to be shorter than a first birth. This would appear to be evidenced in that there was an increase in contractions between the time of the 999 call and the time the staff arrived on scene. In the absence of a vaginal examination, the progression of labour can be

underestimated and it would have been best practice to seek advice from the hospital labour ward.

Service provision

22. A patient was booked into hospital under the wrong name, having been misheard by both the call hander and the attending crew. This culminated in a missing persons enquiry led by the police. Although a most unfortunate incident, we explained that unless there is a language or speech problem or the patient is unable to communicate effectively, we would not expect ambulance staff to verify the patient's identity and that hospital are responsible for contacting relatives. The case did however illustrate the importance of listening skills and attention to detail.

23. A patient who had been injured in a road traffic collision was not taken to a major trauma centre. The attending ambulance staff had not completed the assessment record to a satisfactory standard and they failed to trigger the major trauma assessment tool. The staff will meet with a clinical tutor to discuss the issues highlighted.

24. Issue raised by a care home manager that an ambulance was requested for a resident but that a GP visit was arranged. We explained that a nurse from the Clinical Hub had intervened and called back and establishing that there was no vascular or neurological compromise so it was appropriate to refer the patient to her GP for further assessment.

25. The patient's father complained that his daughter was declined an ambulance after swallowing a coin – the child later required emergency surgery. At the time of the 999 call the child was breathing and alert; any attempt to give instructions to check to see where the coin was and/or remove it could potentially close the airway (as well as clear it). However, although as the child was crying this would indicate a clear airway, they were reported as retching which would suggest a potential blockage, which would prompt a higher prioritisation category. The Medical Director will be issuing revised guidance accordingly.

26. The patient's mother was concerned that an ambulance was not dispatched to her daughter when she experienced diabetic problems. The Medical Director is making a referral to the NAED, to ask that they bring consideration of ketone levels within the MPDS triage assessment protocol. She is also arranging to work with a diabetic specialist to review our current practice in the interim.

27. A patient raised concerns that he did not wish to go to hospital and questioned why an ambulance had been sent. The patient was informed that the attending ambulance crew had acquired a 12 lead ECG, fully documented everything on the PRF, and used a capacity tool to document their decision making around the patient's capacity to refuse treatment. This is exactly the correct course of action if they strongly feel that the patient needs to be seen at hospital. The patient had a cardiac history and presented with symptoms of a heart attack. The crew also believed the ECG to be abnormal. It would have negligent of them not to try their best to persuade the patient to travel to hospital.

28. 2 recent cases, involving complaints about challenging patients with complex needs who declined to be taken to hospital and were deemed to lack capacity to make an informed decision , have highlighted the application of the Mental Capacity Act by ambulance staff. In the first case, the request had been made by the patient's GP but as the patient was not life-threatened, the crew could not compel the patient to travel and arranged treatment in the community. In the second case, the patient had expression suicidal ideation and the crew felt it was unsafe to leave her at home alone, exercising reasonable force in removing her to the ambulance although through negotiation, they were able to calm the patient and take her to a mutually agreed hospital destination other than the local A&E. To widen the learning, it is proposed to use these cases as anonymised examples of good practice.

29. An issue arose about a patient's right to attend a hospital other than the local A&E unit where the patient has been in dispute with the local acute Trust. This is a situation that does not appear to be covered by the Trust's policy about hospital destination, which largely focuses on clinical need. The matter has been highlighted to the Learning from Experience Group to consider if any amendment to the policy should be made to take account of this situation.

5. PALS

The total number of PALS enquiries during 2015/16 was 7907. This represents a 12% increase on the previous year. Of the 3862 PALS specific enquiries, 2639 were received via the duty line facility (68%) and 1163 (32%) by email.

The most common subjects of enquiry are the hospital destination of a relative, lost property and requests for medical records; policy and practice enquiries are also common from academics, students, other health and social care agencies and members of the public.

The following graph demonstrates that there has been a steady stream in the monthly total of PALS enquiries.

Graph 8. PALS cases recorded by month 2014/15

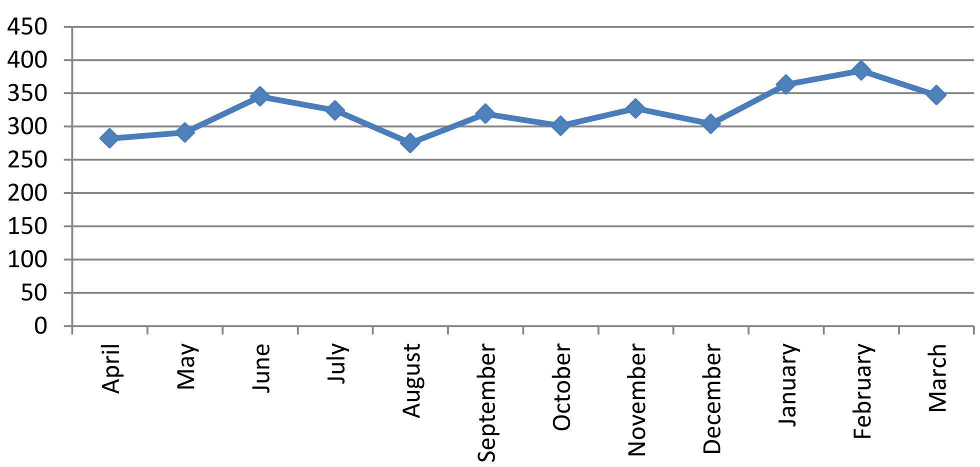


Table 7 PALS cases by category.

PALS by subject 2015/16	Number of enquiries
Information/Enquiries	2387
Lost Property	613
Medical Records (includes patient requests)	366
Appreciation	86
Access	63
Clinical	55
Explanation of Events	44
Conveyance	36
Safeguarding Adults	29
Other	25
Delay	18
Communication	16
Incident Report - Other	16
Policy/ Procedure	12
Road Traffic Collision/RTC	12
Clinical Equipment	11
Non-physical abuse	7
Locality Alert Register enquiry	6
Safeguarding Children	6
Aggravating Factors	5
Non - Clinical Equipment	5
Incident Report - GP Surgery	5
Patient Injury or Damage to Property	5
Social Services	5
External Incident Report - EOC	4

Frequent Callers	4
External Incident Report - LAS Crew	3
Information Technology	3
Incident Report - A&E	3
Non-conveyance	3
Dignity and Privacy	2
Request for Witness Statement	2
Physical Violence	1
Incident Report - Social Care	1
Referred to Local Authority	1
SUI Group Considerative	1
SUI Capacity Plan	1
Totals:	**3862**

Specialist subjects	
Safeguarding Enquiry	2685
Solicitors Medical record requests	1169
Frequent Callers	144
Requests for Witness Statements	44
Serious Untoward Incident	3
Totals:	**4045**
Overall total	**7907**

6. Solicitor enquiries

The team includes a specialist who process all requests for medical records, including those made by a solicitor acting on behalf of the patient or relatives, where legal action is not intended against the Trust. A charge of £50.00 is levied in keeping with the DPA (1998). Additionally, we facilitate requests for witness statements, which are obtained via a face-to-face interview with staff. This service attracts an hourly charge. During 2015/16, 1169 requests were made by solicitors for medical records and 44 requests to interview operational staff, generating a total of £50,566.

Table 8 Solicitor summary

Month	2011/12	2012/13	2013/14	2014/15	2015/16
April	69	118	122	110	101
May	78	121	100	103	91
June	98	96	109	100	108
July	94	107	123	114	120
August	79	135	94	90	80
September	117	100	108	124	83

October	80	138	149	119	101
November	109	124	141	96	86
December	66	87	83	88	102
January	94	125	104	101	89
February	104	120	128	92	104
March	109	116	96	126	111
Totals	**1097**	**1387**	**1357**	**1263**	**862**

The following sums have been received since April 2013:

2013/14	£60,645
2014/15	£52,541
2015/16	£50,566

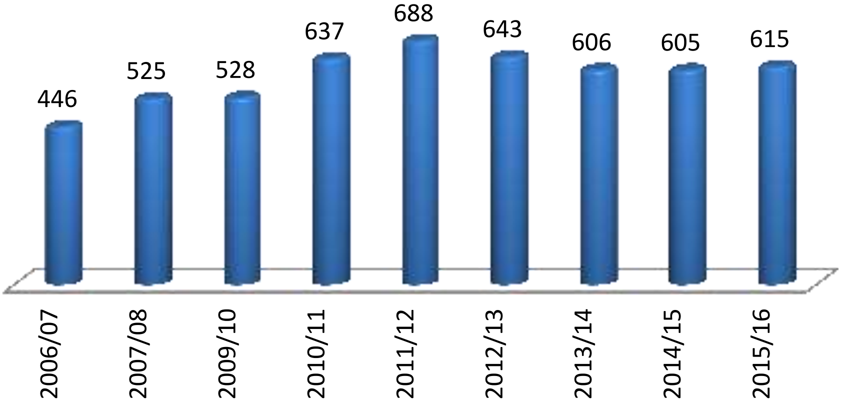
The future of the process is to be updated with the planned discontinuation of the use of cheques by the larger banks and greater use of BACS; this has yet to be implemented. We are also currently trialling a questionnaire with specific questions based on typical requests.

7. Lost Property

We continue to engage with the SMARTbags™ team and design improvements have been made to the property bags.

Graph 9 evidences the total lost property item enquiries received by year.

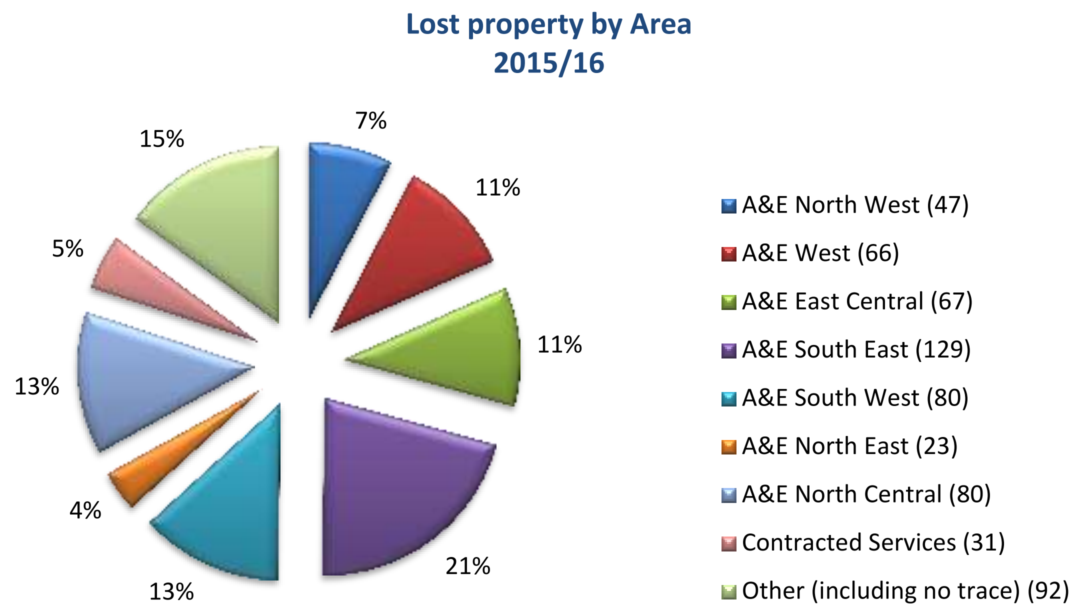
Graph 9. Lost Property.



An evaluation has shown that greater involvement of station administrators as a contact point has improved outcomes although it is not wholly possible to completely evaluate this as the database is not currently shared with local administrative staff. We are planning to make the web version available to all complex admin staff which should improve audit and outcome analysis.

The table below identifies lost property cases by operational area. This indicates that the South Area received a higher proportion of lost property enquires during 2015/16 (27%)

Pie chart 1 Lost Property by Area.

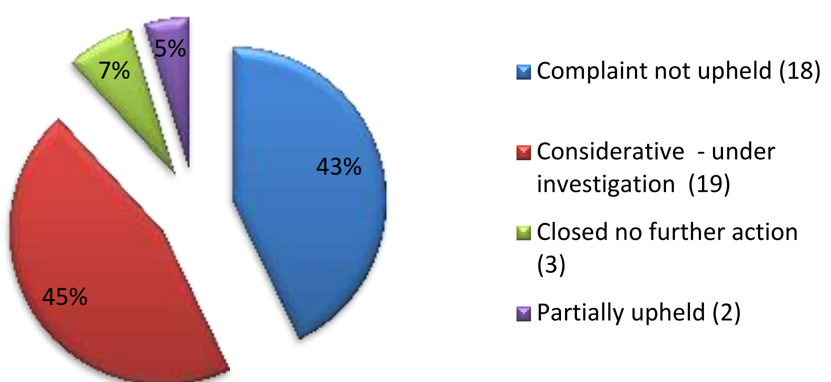


8. Ombudsman cases

42 cases were considered by the Health Service Ombudsman. This includes complaints where the incidents in question that may have occurred earlier but were considered by the Ombudsman during 2015/16.

We await notification on 19 cases, 21 have been completed. 2 have been partially upheld but there were no significant learning points.   In recent weeks there has been a huge surge in requests for our files by the Ombudsman (11 in March 2016) hence the current status of awaiting notification.

Pie chart 2 Cases Requested by the Ombudsman



Ombudsman Case Example

Complaint that there was a delay in attending a patient in cardiac arrest who later died.

The call was triaged at a Red priority. A Fast Responder was on scene within 16 minutes and an ambulance within 35 minutes. The Ombudsman accepted that although the Red target was missed, all reasonable steps were taken to send the nearest available resource.

Although the Ombudsman did not find any failings in the complaint handling, they agreed there were shortcomings in the way the calls were triaged; although they agreed that we had identified and acknowledged these, they felt we needed to do more to demonstrate learning.

We explained that it had not been possible to give feedback to the call handler who managed the second and third 999 calls as the person concerned had since left the Trust. We also explained in greater detail the nature of the feedback exercise with the call handler of the initial 999 call which is completed by either a Quality Assurance manager or the call handler's direct line manager.

The complainant had raised a typographical error in paragraph 5 of our response to the complaint in that the Fast Responder was reinstated at 21:23, not 22:23. We explained the proof-reading process but that occasionally, inadvertent mistakes of this nature slip through and there is a balance to be struck as naturally the review process can already be time consuming when the department is under acute pressure of demand.

The Ombudsman was primarily concerned that we had identified successive triage errors but not sufficiently explained what action we were taking. We explained we are currently developing additional training for call handlers about obstructed airways, agonal breathing and peri-arrest to improve recognition when callers are describing these symptoms. This initiative is being led by the Senior Quality Assurance Manager and the Practice Learning Manager (Control Services) and is scheduled to be completed by the end of the 2015. This is because the training programme will include an e-learning initiative which requires support from Information Technology department. We also need to arrange dedicated training with support by both the Clinical Hub and Quality Assurance teams, so this is a significant project.

The value of the Quality Assurance report in this case should not be underestimated, especially at a time when throughput of complaints is under scrutiny and we are being encouraged to limit the threshold for a QA review.

We also recommended that the Trust Board supports the project indicated by making a commitment to ensure resourcing and inter-departmental cooperation so this can implemented on target.

9. Governance

We provided summary activity reports to the Clinical Quality Safety & Effectiveness Committee, Safeguarding Group and Learning from Experience Group. The new Improving Patient Experiences Committee receives bi-monthly updates

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Patient & Public Involvement and Public Education Annual Report 2015-2016
Report Author(s):	Margaret Luce
Presented by:	Briony Sloper
Contact Details:	Margaret.luce@lond-amb.nhs.uk Briony.sloper@lond-amb.nhs.uk
History:	*Presented to PPI Committee on 26th April 2016 and the Quality Governance Committee on 17th May 2016.*
Status:	*For information*

Background/Purpose

This report highlights key activities and achievements in the areas of patient and public involvement (PPI) and public education during the year 2015-16.

A one-year Patient and Communities Action Plan was developed, taken from the overall Patient and Communities Engagement Plan, which forms part of the overall Communication and Engagement Strategy (2014-2017). Activities prioritised for the year were those which built on the achievements of the previous year, and those which related to the Trust's priorities for the year 2015-16.

In addition to the activities identified in the Patient and Communities Engagement Plan, the 2015-16 plan also included sections on:

- developing and implementing a patient engagement plan for people with mental health problems and dementia
- strengthening the patient and public voice within the LAS, and
- supporting staff to undertake public education work.

This report provides a summary of activity against the plan during the year, and also provides an overview of the PPI and public education team's other activities over the year.

Action required

The Trust Board is asked to *note* the report.

Key implications

None

Key implications and risks arising from this paper	
Clinical and Quality	

Performance	
Financial	
Workforce	**X**
Governance and Well-led	**X**
Reputation	**X**
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**X**
Achieving Good Governance	**X**
Improving Patient Experience	**X**
Improving Environment and Resources	
Taking Pride and Responsibility	**X**

Patient & Public Involvement and Public Education

Annual Report 2015-2016

Introduction

This report highlights key activities and achievements in the areas of patient and public involvement (PPI) and public education during the year 2015-16.

A one-year Patient and Communities Action Plan was developed, taken from the overall Patient and Communities Engagement Plan, which forms part of the overall Communication and Engagement Strategy (2014-2017). Activities prioritised for the year were those which built on the achievements of the previous year, and those which related to the Trust's priorities for the year 2015-16.

In addition to the activities identified in the Patient and Communities Engagement Plan, the 2015-16 plan also included sections on:

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This report provides a summary of activity against the plan during the year, and also provides an overview of the PPI and public education team's other activities over the year.

Patient and Communities Engagement Plan

Consistent with the other aspects of the overall communication and engagement strategy, the Trust's approach in its patient and communities engagement plan has four key components:

1. **Take action on insight** and feedback from local views and experiences **-** record, analyse, prioritise and take action on feedback from people's experiences of the Trust.

2. **Communicate our story, (strategic narrative) and co-design plans for change -** communicate where the organisation is going to and engage on and communicate the organisations' plans to get there. Engage on change, being clear what can be influenced and adapted by patients' views.

3. **Positively influence perceptions and behaviour -** as a result of bespoke communication on strong relationship management. This will encompass individual participation, forming links with organisations who have trusted relationships with specific groups and communities, working with Clinical Commissioning Groups (CCGs), e.g. to co-design targeted information for specific communities, and using patient stories in staff training.

4. **Communicate accountability to** the people we serve, including our patients and communities. The concept of *You Said: We Did* - evidence that action is being taken as

a result of listening to people's experiences and views on plans for change and the future.

This section of the report demonstrates achievements against the plan in each area. The action plan can be found as an appendix to this document.

1. Take action on insight

Action	Achievements in 2015-16
Map and document the full range patient experience evidence we have access to.	• Agreed with the Head of Governance & Assurance that patient and public engagement activities would regularly be included in his quarterly Learning from Experience Reports and triangulated with other evidence through that mechanism. • Discussed the possibility of the PPI team using Datix to record evidence of its activities, to make it easier to correlate with other evidence available. This was agreed in principle, and the detail is currently being considered.
Increase the amount of patient experience data we collect by working with local providers and commissioners.	• The commissioning team is represented on PPI Committee. • Pre-hospital Emergency Department (PHED) project based on working with acute trusts to share data. • Mental Health focus groups and Dementia focus groups involved working with other providers. • Monthly review of posts on the Patient Opinion website. • Patient Representative Reference Group (now Partnership Reference Group) incudes Healthwatch and voluntary sector.
Increase the amount of patient experience data we collect by working with Healthwatch.	• Discussed possible data sharing with Healthwatch (London), and the challenges associated with this (the 32 London Healthwatch groups use different systems). • Other links between the LAS and Healthwatch included: o Involvement with the Patient Representative Reference Group (PRRG)/ Partnership Reference Group (PRG). o LAS contributed to Healthwatch newsletters. o Healthwatch members attended Patients' Forum meetings and the LAS Quality Summit. o Stakeholder Engagement Managers started to develop relationships with their local Healthwatch groups.
Increase the amount of patient experience data we collect by undertaking an annual telephone survey.	• Two telephone surveys were carried out in 2015-16: o Clinical Hub (CHUB) survey of Hear & Treat patients. o Survey of patients sent a taxi response rather than an ambulance.
Action	**Achievements in 2015-16**
Insight and Feedback Report and Action Plan to Board.	• Presented annual report to Quality Governance Committee (May 2015); this also went to the Trust Board. • Patient engagement activity reported routinely in Quality Report.

2. Communicate the strategic narrative

Action	Achievements in 2015-16
Establish a proactive community outreach programme.	• 805 events requested; 597 attended (74% attendance rate). • 1,016 LAS staff have expressed an interest in public

	engagement; 276 have been active since January 2015.
Engage with the seven Community Involvement Officers (CIOs).	• Monthly meetings have been held with the Community Involvement Officers (CIOs). • Support has been provided for them during the period of their restructure (ongoing).
Engage Foundation Trust Membership.	• PPI & Public Education Team members took part in Life Saving Skills Foundation Trust (FT) members' event (July 2015). • FT members invited to participate in Pre-hospital & Emergency Department Data Sharing (PHED) project. 50 applicants. 3 layers of involvement: patient panel (12), advisory group (2) and reference group (2). • Joint meeting held between PPI and Governance teams to discuss joint working on FT member events and future plans. • Peter Nicholson (Head of Governance & Assurance) invited to join PPI Committee.
Establish a volunteer Community Champions network.	• Item discussed at PPI Committee in July 2015. Ideas included developing roles for community responders, police community ambassadors, Foundation Trust members, Community Involvement Officers. • Equality & Inclusion Manager followed up with Metropolitan Police re. police community ambassadors. • Further discussion at PPI Committee (Oct 2015) led to a decision that it would be better to use existing champions (e.g. Patient Representative Reference Group (PRRG) members, community responders) rather than create another group. • Agreed to send out key messages to existing contacts, e.g. PRRG members and potential Governors. • Reviewed PRRG invitation list, with a view to increasing attendance from voluntary sector organisations. This group has not fully achieved the desired outcomes and is being kept under review.

3. Positively influence perceptions and behaviour

Action	Achievements in 2015-16
Link with organisations who have trusted relationships with specific patient groups and communities.	• Contact list produced of key organisations. • Patient Representative Reference Group (PRRG) meeting in October focused on plans for the winter, including how partner organisations could get messages out to their members. • Secured agreement from colleagues in Communications team that we would receive regular key messages for our groups and communities. • Attended Stakeholder Engagement Manager (SEM) meetings and SEM representative requested for PPI Committee. • Review of PRRG invitation list included targeting priority groups and organisations.
Work with CCGs to tap into existing Patient Navigators programmes.	• Conducted a search for existing Patient Navigator programmes via commissioners, internet and other contacts (e.g. Medical Directorate). • Responses indicated that schemes are variable across London, based in Trusts, with a mixture of volunteers and paid staff, and either focused on specific groups or on more general information-provision. • Common theme arising from replies indicated that the most benefit may be derived from focusing on frequent callers. Meeting arranged (April 2016) to take this forward. • This action is therefore partially achieved, but is more complex than initially thought, so development work is ongoing.
Co-design targeted information for specific communities.	• Range of guidance notes produced for different age groups, knife crime work, road safety, careers etc. • Approached to pilot careers database with Greater London Authority. • List of target groups agreed at PPI Committee and contact list created; awaiting further information from Communications about which groups and messages to target. This part of the action is within the Communication & Engagement Strategy. • Agreed between Communications and PPI Committee that resources will be designed on an ad-hoc basis when required (i.e. business as usual).

Action	Achievements in 2015-16
Use patient stories in staff training and induction.	• Paramedic education programme involved patients in Health & Care Professions Council approval event (approval received). • Feedback from the mental health focus groups indicated that involving this group of patients in staff training would be particularly beneficial. Fed into mental health action plan. • A patient story was included in the Patient Care Conference. • The quality assurance process in the Emergency Operations Centre includes using case studies when reviewing incidents of note. • The Sickle Cell Society, via the Patients' Forum, have offered to be involved with staff training.

4. Communicate accountability

Action	Achievements in 2015-16
"Nothing About us Without Us" – patient engagement in service change – a process and a culture.	• Patients involved in two large-scale projects (Pre-hospital and Emergency Department data sharing, paramedic education). • Patient "representatives" attended Quality Summit. • Patients' Forum involved in NHS England review of ambulance response protocols. • Patient involvement suggested for elements of the Quality Improvement Plan (Patient Transport Service developments and complaints process). • New patient engagement strategy drafted, bringing together the Patient & Communities Action Plan and the Patient Voice Strategy.
Establish a Patient Representative Reference Group.	• Patient Representative Reference Group meeting held (October 2015) on planning for winter. • Reviewed membership / invitation list to this group and agreed new approach: to focus on Healthwatch and voluntary sector partners, and to make it more of a partnership reference group / stakeholder reference group. • Event planned for April 2016 with new group (Partnership Reference Group) on Quality Improvement Plan, with discussion sections on mental health and complaints.
Patient representatives on assurance committees within the Service.	• Discussions held with Executive Leadership Team members (Director of Corporate Affairs and Director of Nursing & Quality) about increasing the numbers of patient representatives on committees. • Process suggested and agreed.

5. Develop and implement a patient engagement plan for people with mental health problems and dementia

Action	Achievements in 2015-16
To carry over actions from the 2014/15 mental health patient experience survey and focus groups and use the results to inform the mental health action plan.	• Produced a report outlining recommendations from the mental health patient survey, and suggested further actions. • Recommendations accepted and a series of focus groups were held (see section below).
To conduct Focus Groups with mental health patients across London, and with LAS staff.	• A series of focus groups were held and written up, and the report presented to the Mental Health Committee and Trust Board. • Actions and recommendations arising from the report have been included in the mental health action plan.
Engage with voluntary sector organisations to get the views /experiences of dementia patients and carers.	• A series of focus groups were held with people with dementia and their carers. • A report was produced and presented to the Mental Health Committee.
Review the mental health CPI: focus group with staff to be used to explore staff views on use of the MH CPI.	• The staff mental health focus group included questions on the completion of the mental health Clinical Performance Indicator, and findings were fed back to the Trust's Mental Health Advisor.
Develop a process to ensure patients' stories are heard by the Trust Board.	• Process developed and agreed. • Patient stories identified and arranged for all Trust Board meetings except March 2016 when the speaker cancelled at short notice.
Advise and support colleagues on patient involvement and experience aspects of projects, e.g. pre-hospital data sharing, paramedic education programme.	• Advised on patient involvement in Pre-hospital and Emergency Department data sharing project and paramedic education approval process. • Advised Clinical Hub colleagues on Hear & Treat survey. • Attended Stakeholder meetings for Paramedic Programme (NHS Academy) and advised on future patient involvement.

6. Strengthen the patient and public voice within the LAS

Action	Achievements in 2015-16
Implement a systematic, co-ordinated approach to the involvement of patients, the public and the wider community in service delivery, design and redesign.	• Draft policy and procedure produced; this was later incorporated into a new Patient Engagement Strategy. • Suggestions for patient involvement in the Quality Improvement Plan accepted.

7. Support LAS staff to take part in public education work

Action	Achievements in 2015-16
Provide information, advice, support, guidance and materials to staff involved in public engagement work on behalf of the Trust.	• 805 events requested; 597 attended (74% attendance rate). • 1016 staff on list of those interested in public engagement; 276 active since January 2015. • PPI & Public Education Co-ordinators provide support, guidance and materials, and record the information for reporting purposes.
Provide LAS contribution to multi-agency road safety, knife crime and careers events and activities.	• Public Education Officers (x 2) lead on these areas of work and are involved in a number of projects, events and initiatives. • Information on work with schools submitted to Greater London Authority (GLA). • Agreed to pilot new careers database with GLA.

Patient & Public Involvement and Public Education Team activities

The PPI and Public Education Team is made up of two co-ordinators and two public education officers. Their objectives are to support the trust's public engagement activities by co-ordinating events across London and to engage particularly with children and young people around priority topics such as knife crime, reducing death and serious injury on the roads, and careers in the ambulance service.

Co-ordination of activities

In the year 2015-16 the co-ordinators supported staff from across the Service to take part in local patient engagement activities. This involved:

- Receiving requests from external groups or organisations
- Documenting them on the database
- Providing guidance notes, materials and information to the staff attending
- Supporting staff to complete a risk assessment.
- Collating feedback after the visit or event
- Recording numbers of patients/the public in attendance.
- Ensuring documentation is complete for recording purposes.

In the year 2015-16 805 events were requested, and 597 were attended (74% attendance rate). Activities were wide-ranging, demonstrating engagement with a variety of groups and individuals. There are 1016 staff on the list of those interested in public engagement, and 276 were active during the last year. Feedback from organisers was positive in each case.

Surveys, including the Friends & Family Test

In the year 2015-16 the main survey activities in the team's objectives were:

- Clinical Hub survey – support with design and methodology
- To carry out a survey of patients conveyed to hospital by taxi
- To implement the Friends & Family Test for Patient Transport Service and See & Treat patients, and report the results to NHS England

The co-ordinators assisted with survey design, carried out telephone surveys, managed queries and collated the results for analysis and reporting.

In the year 2015-16 renewed efforts were made to increase the response rate to the Friends & Family Test, with regular internal communication and publication of feedback. Despite these efforts, the numbers of responses to the Friends and Family Test question were low; the total number received in the year 2015-16 was 158. Almost all patients who responded to the question said they would either be "extremely likely" or "likely" to recommend their friends and family to the LAS if they needed similar care or treatment.

The reasons for the low response rate were considered and explored, both within the LAS and nationally. The challenges in implementing FFT in ambulance services have been reported to NHS England, and this is likely to lead to a change in guidance and practice during the next financial year.

Focus groups

The PPI and Public Education Team also led on the organisation and facilitation of focus groups for people with mental health problems and dementia. These have yielded useful data about the experiences and views of patients and their carers, and the recommendations have been incorporated into the Mental Health Action Plan.

Knife Crime

The Public Education Officers focus on activities aimed at young people, often in hard to reach groups. One leads on knife crime awareness activities, working with schools, colleges, youth offending teams, pupil referral units and voluntary sector organisations. In the year 2015-16 he continued an ongoing programme of activities to deliver messages to these groups of young people on the likely consequences of carrying knives and the possible physical outcomes of sustaining a knife injury.

Road safety

The other Public Education Officer focuses more on road safety activities, working closely with various London boroughs and pan-London organisations such as Transport for London. There are almost 3,000 people each year who are killed or seriously injured on the roads of London. The LAS supports a number of projects aimed at reducing these numbers in three main groups of road users: young drivers and passengers, cyclists, and motorcyclists.

The Public Education Officer is the London co-ordinator of a national project (Safe Drive, Stay Alive) which is aimed at 16-17 year olds. This project brings together all the emergency services, the borough, a survivor of a serious road traffic collision and a bereaved parent. Each contributor gives an account of a serious road traffic collision from their perspective, with video footage used to support a fictional story. This is a powerful production, and feedback from young people has been overwhelmingly positive.

Both knife crime awareness and road safety initiatives benefit the LAS by being part of a network of stakeholders and partners across London, which leads to other opportunities to engage through other projects. These activities are good ways of accessing a very hard to reach age group, on topics which are of direct interest to them. Finally, by taking part in these initiatives, the LAS is playing a part in reducing the numbers of young people being killed or seriously injured, either on the roads or through gang and knife crime.

Careers

The Public Education Officers also take part in careers events, encouraging young people to choose a career in the ambulance service, and take the lead on co-ordinating the Service's involvement in Junior Citizen schemes across London. These both give wide exposure and raise the profile of the LAS with children and young people, who will be its future patients and staff.

Conclusion and next steps

Patient involvement has a higher profile within the Trust now than it did in the past, and most of the activities identified in previous plans have been completed or become 'business as usual'.

Good progress has been made against the current plan, and any outstanding actions have been carried forward, together with the approach outlined in the Patient & Public Voice Strategy, into a new Patient Engagement Strategy.

Whilst it is currently in draft form, the new Patient Engagement Strategy (2016-2019) focuses on:

- Increasing meaningful engagement with patients so that their views influence service changes and strategic decision-making, as well as decisions about their care.
- Increasing the commitment to patient engagement across the organisation.
- Ensuring the Trust is prepared to respond to changes in external requirements in the field of patient engagement.

The Strategy provides guidance on the standards for patient engagement, and an outline of accountabilities and responsibilities of individuals within the LAS. It describes the Trust's responsibilities for patient engagement at an individual level, at an organisational level and at the public level.

An action plan sets out individual actions to be undertaken in order to deliver the Strategy.

The PPI & Public Education Team will continue to support this important activity, with the continued support of the senior team, as well as the invaluable contribution made by LAS staff from across the Service who make such a wide range of public engagement activities possible.

Margaret Luce
Head of Patient & Public Involvement and Public Education
April 2016

APPENDIX

Patient & Public Involvement Action Plan 2015-16

1.	**Implement the patient and communities engagement plan**				
Number	**Action**	**Progress & Assurance**	**Timetable**	**Lead**	**Monitoring process**
1.1	Map and document the full range of patient experience evidence we have, to generate insight, to triangulate and inform our service improvement.	• Produce list of evidence available, e.g. Friends & Family Test, survey and focus group feedback, community outreach work, HealthWatch, social media, complaints and incidents. • Develop process for identifying themes and trends from these sources. • Agree reporting mechanism and commence regular reporting.	Sept 2015 Sept/Oct 2015 Oct/Nov 2015	ML	PPI Committee and Improving Patient Experience
1.2	Increase the amount of patient experience data we collect by working with local providers and commissioners (e.g. asking them include LAS questions in their patient surveys).	• Information-sharing initiated with other providers.	Sept 2015	ML	PPI Committee and Improving Patient Experience
1.3	Increase the amount of patient experience data we collect by working with HealthWatch to share their data.	• Regular information received from HealthWatch, via their data collection sources.	March 2016	ML	PPI Committee
1.4	Increase the amount of patient experience data we collect by undertaking an annual telephone survey.	• Telephone survey undertaken and results analysed.	March 2016	ML	PPI Committee and Improving Patient Experience

Number	Action	Progress & Assurance	Timetable	Lead	Monitoring process
1.5	Insight and Feedback report and action plan to Board.	• Annual report produced and submitted through Trust committees to Board.	April 2016	ML	PPI Committee, Improving Patient Experience, Quality Governance Committee and Trust Board
1.6	Deliver a proactive community outreach programme.	• Community outreach activities recorded, supported and feedback obtained. • Database complete and up to date.	March 2016	RL	PPI Committee
1.7	Run network meetings with the Community Involvement Officers	• Evidence of monthly meetings.	March 2016	ML	PPI Committee and Improving Patient Experience
1.8	Foundation Trust membership events and activities	• Evidence of FT membership events. • Evidence of FT members involved in other PPI initiatives.	March 2016	ML	PPI Committee
1.9	Establish a volunteer Community Champions network	• Scoping paper produced. • Agreement to pilot scheme in one or two areas.	March 2016	ML	PPI Committee and Improving Patient Experience
1.10	Stakeholder engagement with organisations who have trusted relationships with specific groups	• Plan to engage with representative organisations for specific target groups.	Dec 2015	ML	PPI Committee
1.11	Scope involvement with Patient Navigator programmes	• Scoping paper produced.	Dec 2015	ML	PPI Committee
1.12	Co-design targeted information for specific communities	• List of target groups and contact details for relevant organisations. • Information produced for 3 target groups.	March 2016	ML	PPI Committee
1.13	Include patients and patient stories in staff training and induction	• Patient involvement in paramedic education programme. • Patient involvement in mental health committee action plan, to include patients in training.	March 2016	ML	PPI Committee Mental Health Committee Improving Patient Experience

Number	Action	Progress & Assurance	Timetable	Lead	Monitoring process
1.14	Patient engagement in service change	• Evidence of patient involvement in change programmes (e.g. paramedic education, PHED data sharing project).	March 2016	ML	PPI Committee Improving Patient Experience
1.15	Engage with Patient Representative Reference Group	• Evidence of information distributed and events held.	March 2016	ML	PPI Committee Improving Patient Experience
1.16	Patient representatives on assurance committees	• Evidence of patient representatives on key committees.	March 2016	ML	PPI Committee Improving Patient Experience

2.	**Develop and implement a patient engagement plan for people with mental health problems and dementia (Mental Health Action Plan)**				
Number	**Action**	**Progress & Assurance**	**Timetable**	**Lead**	**Monitoring process**
2.1	To carry over actions from the 2014/15 mental health patient experience survey and focus groups and use the results to inform the mental health action plan.	• Report outlining recommendations from the mental health patient survey. • Actions and recommendations agreed by Mental Health Committee.	April 2015	ML/KD	Mental Health Committee PPI Committee
2.2	To conduct Focus Groups with mental health patients across London, and with LAS staff.	• Evidence of focus groups planned and completed. • Feedback from Focus Groups written into report and submitted to Mental Health Committee.	April 2015 Oct 2015	ML/KD ML/KD	Mental Health Committee PPI Committee Improving Patient Experience

Number	Action	Progress & Assurance	Timetable	Lead	Monitoring process
2.3	Engage with voluntary sector organisations to get the views /experiences of dementia patients and carers.	• Action plan produced for engaging with patients with dementia and their carers, e.g. via the voluntary sector. • Evidence of participation and engagement with voluntary sector organisations. • Findings from focus groups/surveys used to inform mental health action plan.	Aug 2015	KD/ML	Mental Health Committee PPI Committee Improving Patient Experience
2.4	Review the mental health CPI: focus group with staff (see 2.2) to be used to explore staff views on use of the MH CPI.	• Issues with the MH CPI identified and reported to MH Committee, with recommendations for improvement.	Nov 2015	KD/ML	Mental Health Committee Improving Patient Experience

3.	Strengthen the patient and public voice within the LAS				
Number	**Action**	**Progress & Assurance**	**Timetable**	**Lead**	**Monitoring process**
3.1	Implement a systematic, co-ordinated approach to the involvement of patients, the public and the wider community in service delivery, design and redesign.	• Patient & Public Voice strategy or procedure.	August 2015	ML	PPI Committee Improving Patient Experience
3.2	Develop a process to ensure patients' stories are heard by the Trust Board.	• Process agreed and implemented.	August 2015	ML	PPI Committee Improving Patient Experience
3.3	Advise and support colleagues on patient involvement and experience aspects of projects, e.g. pre-hospital data sharing, paramedic education programme.	• Evidence of patient involvement in key projects.	March 2016	ML	PPI Committee Improving Patient Experience

4.	Support LAS staff to take part in public engagement work				
Number	**Action**	**Progress & Assurance**	**Timetable**	**Lead**	**Monitoring process**
4.1	Provide information, advice, support, guidance and materials to staff involved in public engagement work on behalf of the Trust.	• Evidence of patient engagement activity.	March 2016	ML	PPI Committee Improving Patient Experience
4.2	Provide LAS contribution to multi-agency road safety, knife crime and careers events and activities.	• Evidence of involvement in knife crime, road safety and careers events.	March 2016	ML	PPI Committee Improving Patient Experience

London Ambulance Service NHS
NHS Trust

Report to:	Finance & Investment Committee
Date of meeting:	**21st July 2016**
Document Title:	**Finance Report Month 3 (July) Part 1**
Report Author(s):	**Andy Bell**
Presented by:	**Andy Bell**
Contact Details:	**Andy.bell@lond-amb.nhs.uk**
History:	***This document has previously been reported to ELT***
Status:	The Committee is asked to note this paper.

Background/Purpose

Headline:

Year to date the position is £0.4m adverse to plan, The year end position of £6.7m deficit is seen as challenging but achievable. As requested the Trust has submitted a revised plan to NHSI in June. This reflected a revised control total (£6.7m deficit) and adjusted income and expenditure to reflect the £10m of QIP expected from CCGs.

5 key Points

- Plan / Target – The Trust has a planned deficit target of £6.7m (Amber). The revised Control Total and associated changes in income and expenditure have been accepted by the Board.
- Year to date the Trust reports £0.4m adverse variance from the original plan of £2.2m deficit (Amber).
- Year to date CIPs are on plan. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes. (Amber)
- Capital spend is £0.3m against a revised Capital plan of £0.5m. DCA replacement have been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14m of the £19m CRL requested. (Amber)
- Cash is £17.6m, £1.5m adverse to plan. The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year. (Amber)

Action required

The FIC is requested to review and note the Financial Results provided.

Key implications

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	Review of the Financial Position by this sub-committee will provide assurance to the Trust Board
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	
Improving Patient Experience	
Improving Environment and Resources	**X**
Taking Pride and Responsibility	

London Ambulance Service NHS Trust
Finance Report - Part 1 – 2016/17
Month 3: June

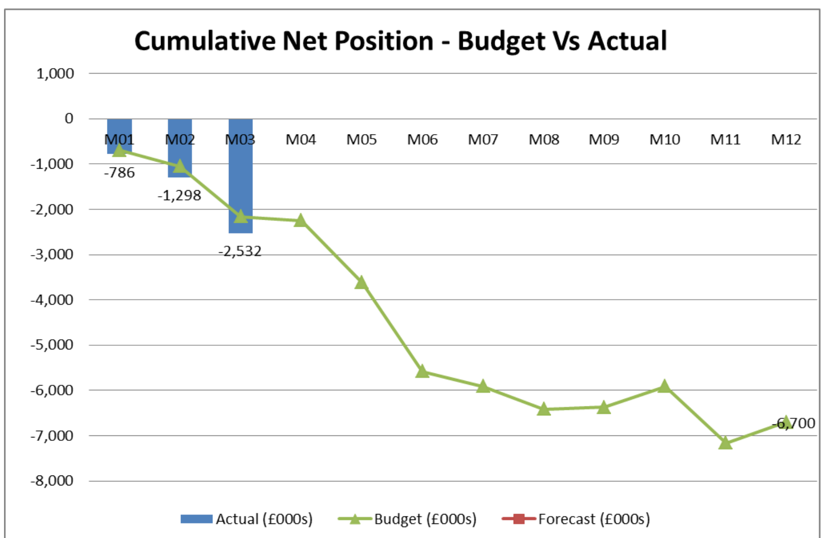
ELT Meeting – 20th July 2016
Trust Board – 26th July 2016
FIC – 21st July 2016

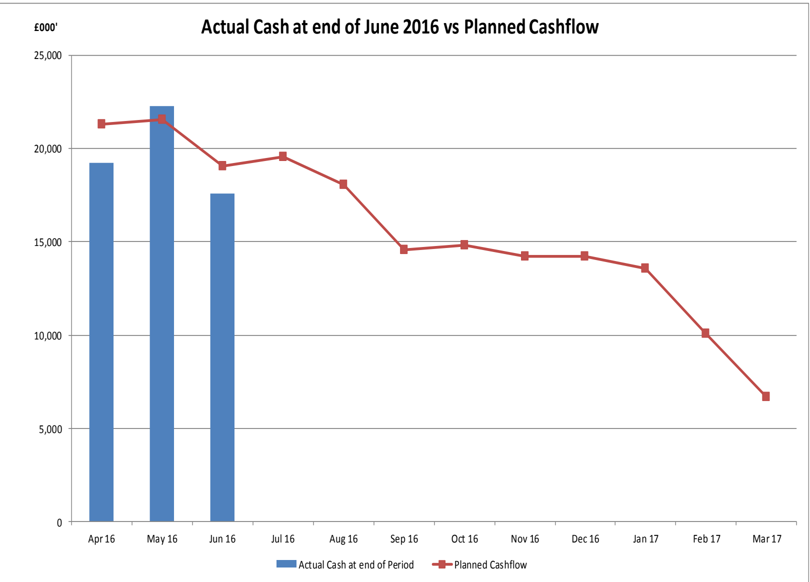
Andrew Grimshaw
Finance Director

Finance Summary: M3 (2016/17)

Financial Indicator	Summary Performance	Current Month	Previous month
Surplus (Year to date)	Year to date the position is £0.4m adverse to plan, The year end position of £6.7m deficit is seen as challenging but achievable. As requested the Trust has submitted a revised plan to NHSI in June. This reflected a revised control total (£6.7m deficit) and adjusted income and expenditure to reflect the £10m of QIP expected from CCGs. The adverse position is driven by: • Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1. Demand is currently running at 3+% above contracted activity growth (4%). • This overspend is partly offset by underspends in other areas.	AMBER	AMBER
Income	Income is on plan in month and £0.4m adverse YTD. • Education & Training Income is currently below the expected plan YTD by £0.2m. This could recover throughout the year if bids area successful. • 111 Income is £0.2m adverse due to reducing 111 contracts and activity. This is offset against reduced cost	GREEN	AMBER
Expenditure (incl. Financial Charges)	In month expenditure is £0.1m adverse to plan, YTD the position is £0.4m adverse to plan. The key drivers for this position are: • £1.6m Favourable in Frontline substantive pay due to ongoing vacancies • £0.7m Favourable in Operational Management due to vacancies in Training and Team Leader roles • £0.2m Favourable in Non Operational Pay • £2.8m Adverse in Private ambulance usage used to offset frontline pay vacancies and support additional demand pressures. • £0.4m Favourable in other non pay areas	AMBER	AMBER
CIPs	Year to date CIPs are on plan. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.	AMBER	AMBER
Balance Sheet	Capital spend is £0.3m against a revised Capital plan of £0.5m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14m of the £19m CRL requested.	AMBER	AMBER
Cashflow	Cash is £17.6m, £1.5m adverse to plan. The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year.	AMBER	AMBER

Executive Summary - Key Financial Metrics





	2016/17 - Month 3			Year to Date			FY 2015/16
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(1,114)	(1,234)	(119)	(2,166)	(2,530)	(365)	(9,025)
EFL				1,137	2,622	(1,485)	8,648
CRL				507	219	288	20,664
Suppliers paid within 30 days - NHS	95%	71%	(24.0%)	95%	81%	(14.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	85%	(10.0%)	95%	85%	(10.0%)	95%
Monitor							
EBITDA %	1.6%	1.1%	(0.4%)	2.9%	2.5%	(0.4%)	6.3%
EBITDA on plan	421	304	(117)	2,441	2,064	(377)	12,217
Net Surplus	(1,114)	(1,234)	(119)	(2,166)	(2,530)	(365)	(9,025)
NRAF (net return after financing)				(0.3%)	(1.3%)	(1.0%)	-6.90%
Liquidity Days				(4.92)	(2.76)	2.2	(10.86)
FSRR (Financial Sustainability Risk Rating)				2.0	2.0	0.0	2.0

- In Month the position is £0.1m adverse to plan . YTD the Position is £0.4m adverse to plan
- The adverse position is driven by:
  - Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1. Demand is currently running at 3+% above contracted activity growth (4%).
  - This overspend is partly offset by underspends in other areas.
- Cash is £17.6m, £1.5m below plan. The trust is currently The trust is currently invoicing based on last years lower recurrent income total while awaiting the outcome of contract negotiations for this year.
- CRL position – The capital plan is £0.3m behind target.
- FSRR is on target.
- In Month the Trust only paid 71% of its NHS suppliers within 30 days. This is below the national KPI but is not seen as material. The Trust paid invoices to the value of £6.4m in Month 3 of which only £0.2m related to NHS suppliers. As such the total Value of invoices paid outside of the 30 day limit was 15 invoices totalling a value of £59k.

Statement of Comprehensive Income

2016/17 - Month 3			Description	Year to Date			FY 2015/16
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000		£000	£000	£000	£000
		fav/(adv)				fav/(adv)	
			Income				
24,816	26,724	1,907	Income from Activities	77,261	77,261	0	307,718
1,828	(109)	(1,937)	Other Operating Income	5,722	5,283	(440)	22,921
26,644	**26,615**	**(29)**	**Subtotal**	**82,983**	**82,544**	**(439)**	**330,640**
			Operating Expense				
20,539	19,723	816	Pay	62,177	59,694	2,483	252,380
5,684	6,587	(903)	Non Pay	18,365	20,786	(2,421)	66,042
26,223	**26,310**	**(88)**	**Subtotal**	**80,542**	**80,480**	**62**	**318,422**
421	**304**	**(117)**	**EBITDA**	**2,441**	**2,064**	**(377)**	**12,217**
1.6%	1.1%	-0.4%	**EBITDA margin**	2.9%	2.5%	(0.4%)	3.7%
			Depreciation & Financing				
1,182	1,185	(3)	Depreciation	3,545	3,523	22	14,668
350	350	0	PDC Dividend	1,051	1,050	1	4,204
4	2	1	Interest	11	21	(10)	42
1,536	**1,538**	**(2)**	**Subtotal**	**4,607**	**4,594**	**12**	**18,914**
(1,114)	**(1,234)**	**(119)**	**Net Surplus/(Deficit)**	**(2,166)**	**(2,530)**	**(365)**	**(6,697)**
(4.2%)	-4.6%	-0.5%	**Net margin**	-2.6%	-3.1%	-0.5%	-2.0%

The overall financial position is £0.4m adverse to plan YTD. This relates primarily to additional incentivised overtime and PAS capacity to support frontline delivery.

Income

- Income is on plan in month and £0.4m adverse YTD.
- Education & Training Income is currently below the expected plan YTD by £0.2m. This could recover throughout the year if bids area successful.
- 111 Income is £0.2m adverse due to reducing 111 contracts and activity. This is offset against reduced cost

Operating Expenditure (excl. Depreciation and Financing)

- Overall £0.1m adverse in month and £0.1m favourable YTD due to:
  - Ongoing vacancies in Frontline Pay (incl EOC)
  - Offset by high PAS usage in Q1

Depreciation and Financing

- Overall Financial Charges are on plan in month and YTD

Divisional Expenditure (excludes Income)

2016/17 - Month 3			Description	Year to Date			FY 2016/17
Budg	Act	Var		Budg	Act	Var	Budg
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Operational Divisions				
12,116	14,015	(1,899)	Core Frontline (Rostered)	36,363	40,467	(4,103)	144,863
1,503	1,252	251	Core Frontline (Non Rostered)	4,510	3,790	719	18,015
0	0	0	Other Frontline	0	0	0	0
1,998	1,858	141	EPRR	5,995	5,546	449	23,711
0	0	0	Resource Centre	0	0	0	0
2,413	2,055	358	EOC	7,240	6,401	839	28,954
144	216	(72)	PTS	462	579	(117)	1,531
689	368	321	NETS	2,067	1,320	747	8,278
547	507	40	111 Project	2,022	1,721	301	6,704
19,410	**20,271**	**(860)**	**Subtotal**	**58,659**	**59,824**	**(1,165)**	**232,057**
			Support Services				
2,119	2,310	(192)	Fleet & Logistics	6,454	6,364	90	25,488
932	975	(43)	IM&T	2,795	2,715	80	11,126
402	457	(55)	HR	1,206	1,374	(168)	4,822
0	0	0	Education & Development	0	0	0	0
793	794	(1)	Estates	2,180	2,253	(73)	9,685
18	34	(16)	Support Services Management	55	56	(1)	219
4,264	**4,571**	**(307)**	**Subtotal**	**12,689**	**12,762**	**(72)**	**51,341**
			Corporate				
240	216	24	Chief Executive & Chair	724	779	(55)	2,885
377	369	8	Corporate Services	1,130	1,069	61	4,522
0	0	0	Business Development	0	0	0	0
84	71	13	Strategic Communication	251	223	27	1,002
338	497	(158)	Finance	1,015	1,169	(154)	4,060
3	0	3	Project Management	8	0	8	33
127	134	(8)	Nursing & Quality	380	382	(2)	1,521
125	177	(52)	Transformation & Strategy	374	386	(12)	1,495
588	883	(295)	Clinical Education & Standards	1,764	2,719	(955)	6,571
281	266	15	Medical	842	822	19	3,367
2,162	**2,612**	**(450)**	**Subtotal**	**6,488**	**7,550**	**(1,061)**	**25,457**
			Central				
1,916	407	1,509	Central Corporate	7,291	4,927	2,365	28,401
7	(11)	18	Other Central Costs	21	14	7	84
1,923	**396**	**1,527**	**Subtotal**	**7,312**	**4,941**	**2,371**	**28,485**
27,758	**27,849**	**(91)**	**TOTAL**	**85,149**	**85,076**	**73**	**337,340**
26,644	*26,615*	*(29)*	*Income Memorandum*	*82,983*	*82,544*	*(439)*	*330,640*
(1,114)	***(1,234)***	***(120)***	***NET POSITION MEMORANDUM***	***(2,166)***	***(2,532)***	***(367)***	***(6,700)***

Operational Divisions

- Expenditure is currently £0.9m adverse in month and £1.2m adverse YTD
- This is driven by continued high spends on PAS and Overtime to support frontline capacity in Q1. Some overtime costs will be partially offset against other areas (non rostered front line, EPRR, EOC)
- NETS is favourable due to timing differences between planned and actual spend as the service is developed.
- PTS is currently showing a small negative variance (£0.1m). This is however offset by positive income.

Support Services

- Support Services is adverse to plan £0.3m in month and £0.1m YTD.
- Fleet is underspent £0.1m YTD mainly due to variation in maintenance spending .
- HR is £0.2m adverse due to ongoing high levels of agency usage to support recruitment and payroll.
- Estates are £0.1m adverse to plan due to fluctuations in estates maintenance costs.

Corporate

- Overall Corporate divisions are £0.4m adverse in month.
- Finance is £0.2m adverse to plan due to consultancy fees for PMO support for QIP. Permanent recruitment is currently underway.
- Clinical education is £0.3m adverse in month and £1m adverse YTD due to the number of frontline staff currently being held in training. This will be offset with an allocation of the Fallow time QIP budget which is currently reporting in Central Corporate.

Central

- Central Corporate is favourable mainly due to the management of the Trust reserves position

Income

- Income is as per the Statement of Comprehensive Income (SOCI)

Statement of Financial Position: YTD

	Mar-16	Apr-16	May-16	Jun-16	Jun-16		
	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000			
Non Current Assets							
Property, Plant & Equip	143,403	142,682	141,776	140,886	140,984	(98)	-0.07%
Intangible Assets	8,704	8,341	8,116	7,900	8,140	(240)	-2.95%
Trade & Other Receivables	0	0	0	0	0	0	
Subtotal	152,107	151,023	149,892	148,786	149,124	(338)	-0.23%
Current Assets							
Inventories	2,999	3,014	3,012	2,995	2,999	(4)	-0.13%
Trade & Other Receivables	14,461	16,016	14,754	20,012	13,571	6,441	47.46%
Cash & cash equivalents	20,209	19,210	22,243	17,587	19,072	(1,485)	-7.79%
Non-Current Assets Held for Sale	101	44	44	44	44	0	
Total Current Assets	37,770	38,284	40,053	40,638	35,686	4,952	13.88%
Total Assets	189,877	189,307	189,945	189,424	184,810	4,614	2.50%
Current Liabilities							
Trade and Other Payables	(33,495)	(33,514)	(34,919)	(35,766)	(32,974)	(2,792)	8.47%
Provisions	(4,609)	(4,586)	(4,481)	(4,311)	(4,081)	(230)	5.64%
Borrowings	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	
Net Current Liabilities)	(38,104)	(38,100)	(39,400)	(40,077)	(37,055)	(3,022)	8.16%
Non Current Assets plus/less net current assets/Liabilities	151,773	151,207	150,545	149,347	147,755	1,592	1.08%
Non Current Liabilities							
Trade and Other Payables	0	0	0	0	0	0	
Provisions	(9,796)	(10,016)	(9,866)	(9,902)	(9,829)	(73)	0.74%
Borrowings	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	
Total Non Current Liabilities	(9,903)	(10,123)	(9,973)	(10,009)	(9,936)	(73)	0.73%
Total Assets Employed	141,870	141,084	140,572	139,338	137,819	1,519	1.10%
Financed by Taxpayers Equity							
Public Dividend Capital	58,016	58,016	58,016	58,016	58,016	0	0.00%
Retained Earnings	28,120	27,352	26,840	25,606	24,069	1,537	6.39%
Revaluation Reserve	56,153	56,135	56,135	56,135	56,153	(18)	-0.03%
Other Reserves	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	141,870	141,084	140,572	139,338	137,819	1,519	1.10%

Non Current Assets

- Non current assets stand at £148.8m, (£0.3m) below plan. This is due to capital slippage.

Current Assets

- Current assets stand at £40.6m, £5.0m above plan.
- Cash position as at June is £17.6m, £1.5m below plan. The trust is currently raising invoices based on last years recurrent income while awaiting the outcome of contract negotiations for this year.
- Within Trade & Other Receivables , Receivables (debtors) at £8.4m are £4.2m , accrued income at £7.2m is £1.8m and prepayments at £4.4m are £0.5m are all respectively above plan. The SLA for 2016/17 has not been agreed so the trust is invoicing at last years lower contract values and accruing to the expected contract value.

Current Liabilities

- Current liabilities stand at £40.1m, a £3.0m increase on plan.
- Payables and accruals at £33.5m, a £0.6m increase on plan.
- The Trust has a high volume of unapproved trade payables at £4.9m.
- Current provisions at £4.3m are £0.2m higher than plan.
- Deferred Income at £2.2m are £2.1m above plan.

Non Current Liabilities

- Non current provisions and borrowings are on plan.

Taxpayers Equity

- Taxpayers Equity stands at £139.3m, £1.5m lower than plan.
- Retained Earnings at £25.6m, £1.5m lower than plan.

Cashflow Statement YTD

	Apr-16	May-16	Jun-16	YTD Move	YTD Plan	Var
				Jun-16	Jun-16	Jun-16
	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000
Opening Balance	20,209	19,210	22,243	**20,209**	**20,209**	**0**
Operating Surplus	550	1,011	303	1,864	2,239	(375)
(Increase)/decrease in current assets	(1,570)	1,264	(5,241)	(5,547)	1,053	(6,600)
Increase/(decrease) in current liabilities	766	1,109	469	2,344	(1,484)	3,828
Increase/(decrease) in provisions	185	(267)	(145)	(227)	(528)	301
Net cash inflow/(outflow) from operating activities	(69)	3,117	(4,614)	(1,566)	1,280	(2,846)
Cashflow inflow/outflow from operating activities	**(69)**	**3,117**	**(4,614)**	**(1,566)**	**1,280**	**(2,846)**
Returns on investments and servicing finance	8	7	10	25	24	1
Capital Expenditure	(938)	(91)	(52)	(1,081)	(2,441)	1,360
Dividend paid	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(930)**	**(84)**	**(42)**	**(1,056)**	**(2,417)**	**1,361**
Movement	(999)	3,033	(4,656)	(2,622)	(1,137)	(1,485)
Closing Cash Balance	**19,210**	**22,243**	**17,587**	**17,587**	**19,072**	**(1,485)**

There has been a net outflow of cash from the Trust of £2.6m.
Cash funds at 30 June stand at £17.6m.

Operating Surplus

- The operating surplus is £0.4m lower than planned due to a higher than planned deficit.

Current Assets

- The ytd movement on current assets is (£5.4m), a (£6.6m) increase on plan.
- Current assets movement was lower than planned due to an increase in receivables (£4.2m), increase in accrued income (£1.8m) and increase in prepayments (£0.4m).

Current Liabilities

- The ytd movement on current liabilities is £2.3m, a £3.8m increase on plan.
- Current liabilities movement was higher than planned due to trade and other payables £0.8m, accruals £0.9m and deferred income £2.1m.

Provisions

- The ytd movement on provisions is (£0.2m), a £0.3m above plan.

Capital Expenditure

- Capital cash outflow is £1.4m behind plan for the year.

London Ambulance Service **NHS**
NHS Trust

Report to:	**Trust Board**
Date of meeting:	**26th July 2016**
Document Title:	**2016/17 Control total**
Report Author(s):	**Director of Finance**
Presented by:	**Director of Finance**
Contact Details:	
History:	**Reviewed by FIC**
Status:	**For approval**

Background/Purpose

All NHS trusts are set a financial control total by NHSI to help ensure the overall position of the NHS is both understood and can be managed. NHSI issued LAS with a revised control total in June 2016, and was asked to confirm acceptance by 30th June 2016.

Discussions were held with the members of the Trust Board in the last week of June regarding the revised target. It was agreed that the revised target be accepted. The revised total is a deficit of £6.7m, an increase of £2.25m on the previous control total.

Action required

The Board is asked to approve the revised control total.

Key implications

The impact of this change on 2016/17 are to:

1. Increase the overall deficit reported by the Trust. It does not change any other element of the income and expenditure plan. This allows service delivery to be maintained despite the reduced income received.
2. Reduce the amount of cash retained by the Trust at the end of the year as a consequence of the increased deficit.

The increased deficit does not fundamentally change the financial challenge for 2017/18 as the income in question was non-recurrent in 2016/17.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	Yes
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	Yes
Improving Patient Experience	
Improving Environment and Resources	Yes
Taking Pride and Responsibility	Yes

Trust Board 26th July 2016

2016/17 Control Total

Introduction

All NHS trusts are set a financial control total by NHSI to help ensure the overall position of the NHS is both understood and can be managed. NHSI issued LAS with a revised control total in June 2016, and was asked to confirm acceptance by 30th June 2016.

Discussions were held with the members of the Trust Board in the last week of June regarding the revised target. It was agreed that the revised target be accepted.

This paper provides a report on that to the July Board, the next formal meeting of the Board.

Revised control total

On 22nd June NHSI wrote to LAS indicating a revised control total of £6.7m deficit had been set for 2016/17, and asked that confirmation of acceptance was provided by 30th June.

The revised control total increased the control total deficit from £4.45m to £6.7m. This adjustment in the deficit related to a reduction in planned income that would not be achieved.

The impact of this change on 2016/17 are to:

3. Increase the overall deficit reported by the Trust. It does not change any other element of the income and expenditure plan. This allows service delivery to be maintained despite the reduced income received.
4. Reduce the amount of cash retained by the Trust at the end of the year as a consequence of the increased deficit.

The increased deficit does not fundamentally change the financial challenge for 2017/18 as the income in question was non-recurrent in 2016/17.

Acceptance of the revised control total would enable the Trust to receive Sustainability and Transformation Funding, which had already been included within the control total.

This increase in the deficit while unwelcome did not fundamentally alter the financial plan for 2016/17.

Following the receipt of the letter from NHSI on 22 June the Director of Finance discussed the issue with the Chair and Chief Executive. He recommended that that revised control total was accepted. The Finance Director then contacted each member of the Board to discuss the issue and seek their agreement. This was received.

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26 July 2016
Document Title:	Report from the Finance and Investment Committee (FIC)
Report Author(s):	Director of Finance
Presented by:	Chair of the FIC
Contact Details:	
History:	*This paper summarises the agenda for the FIC meeting of the 25 July for the Trust Board.*
Status:	*Assurance*

Background/Purpose

This paper details the agenda for the FIC meeting of the 25th July. It is not possible to prepare a detailed paper between this date on the Trust Board papers being issued. The Chairman of the FIC will update the Trust Board on key items discussed at the meeting and any items requiring approval.

Action required

To note the agenda for the FIC of 25th July.

Assurance

This paper details the published agenda for the FIC.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	Management of the Trust's financial position and performance.
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	Yes
Achieving Good Governance	Yes
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	Yes

Trust Board 26th July 2016.
Report from the Finance and Investment Committee (25th July 2016).

The following table summarises the agenda for the FIC meeting planned for the 25th July. The table details;

1. The action the FIC was requested to take for each agenda item.
2. Any potential action that the Trust Board is requested to take or note in relation to the discussion at the FIC.

The Chairman of the FIC will provide a verbal update to the Trust Board at the meeting on the 26th July.

ITEM	SUBJECT	Purpose at FIC	Potential Action for Trust Board
3.	3.1 Finance Report Month 03 2016/17 3.2 Rolling 03 Months Cash Flow 3.3 Forecast 2016/17	Note Note Note	Note paper to Trust Board
4.	4.1 2016/17 Plan Update 4.2 Costing & SLR Update 4.3 Business Case: Lease Training Centre 4.4 Business Case: Hart Vehicles 4.5 Business Case: NETS Station 4.6 PTS Strategy 4.7 Make Ready Business Case 4.8 Band 6	Note Note Approve Approve Approve Approve Approve Approve	Note paper to Trust Board Note paper to Trust Board Note if FIC Approved Note paper to Trust Board Note if FIC Approved Note if FIC Approved Note if FIC Approved Note if FIC Approved
5.	5.1 Review of Assurance Framework Review 5.2 Review Range & Quality of Financial Reporting	Note Note	Note Paper to Trust Board
6.	6.1 Technical Releases	Info	Note Paper to Trust Board
7.	7.1 Agenda Planner 2016/17	Note	Note Paper to Trust Board

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board
Date of meeting:	26th July 2016
Document Title:	Assurance report from the Workforce and Organisational Development Committee
Report Author(s):	Fergus Cass, Non-executive director and Chair of the committee
Presented by:	Fergus Cass
Contact Details:	
History:	N/A
Status:	Assurance report from the meeting held on 18th July 2016

Background/Purpose

The Workforce and Organisational Development Committee is a Board committee with oversight of workforce, education, training and organisational development. The committee meets bi-monthly and this is the assurance report from the meeting held on 18th July 2016.

Action required

To receive assurance from the committee and to note any areas of concern.

Key implications

The Trust Board takes its assurance from Board committees and needs to consider any areas of concern raised and take assurance that these are being addressed.

Key implications and risks arising from this paper	
Clinical and Quality	**The committee has oversight of clinical education and will bring to the attention of the Board any potential risks to quality and safety from workforce matters.**
Performance	**The committee considers the impact/implications of workforce on performance.**
Financial	
Workforce	**The committee has oversight on matters relating to workforce, education, training and organisational development.**
Governance and Well-led	**Providing assurance on workforce matters.**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	**Yes**
Improving Environment and Resources	
Taking Pride and Responsibility	**Yes**

Meeting of the Workforce & Organisational Development Committee, 18 July 2016

The Committee held its second meeting on 18th July 2016. This coincided with a meeting of the Regional Oversight Group and, as a result, Executive members of the Committee were represented by deputies or senior colleagues. The Committee -

- noted that its **Terms of Reference** have been approved by the Board but that certain aspects need to be fine tuned, including the Committee's role in relation to clinical training and clarification of which Executive directors would be members
- requested that certain **administrative aspects** of its work should be finalised, including the programme of "deep dives" and clarification of links with other workforce-related committees
- noted progress with **workforce elements of the QIP plan** and positive trends in **workforce KPIs**: there have been further improvements in the vacancy rate, turnover, and the sickness rate; a significant number of appraisals have taken place; the numbers participating in workshops and training relating to bullying and harassment have exceeded target; and CSR training is on track
- was briefed about actions in response to **workforce issues raised in the NHS Improvement clinical review**; noted that operational management now review vacancies and staffing by station, and that pathways for different types of recruit are being applied; noted also that detailed reporting of vacancies to ELT and to the Board is under consideration; discussed difficulties experienced by some stations in recruiting staff, especially Emergency Ambulance Crew (TEAC/EAC); and encouraged action to remove hurdles to staff becoming fully operational (e.g. blue light driving qualification)
- received an update on **frontline workforce planning**, covering projections to March 2017 and indicating the impact of leavers, internal training, expiry of the visas of overseas recruits, and intake from UK universities; noted the gap that is likely to emerge in 2017, and was informed that plans to fill this gap will be presented to ELT and to the next meeting of the Committee; also noted that recruiting to 100% rather than 95% of establishment is being discussed
- recommended **additional workforce KPIs**, drawing on a set of indicators developed by KPMG and including agency spend, time to recruit, and progress in handling employee relations cases; noted that resource and data constraints may affect the speed with which these can be introduced
- discussed the **Strategic Review of Equality and Diversity** prepared by a consultant; noted that performance against key indicators is unsatisfactory as indicated by the % BME overall and at higher levels, and by staff survey responses regarding discrimination and opportunities for career progression; recommended urgent action, led from the top; noted that recommendations are being finalised and will be presented to ELT and the Board; and encouraged the engagement of staff in developing solutions and holding the organisation to account
- recommended a significant improvement in **data collection and reporting** related to BME staff and others with protected characteristics (e.g. participation of female staff at each level)
- reviewed the draft **Workforce Race Equality Standard (WRES) Action Plan,** which will be refined and presented to ELT and the Board; noted the need for effective implementation; supported appropriate and sustained resource input; and advocated realism in the timing of actions
- once again postponed discussion of **Organisational Development**, while noting a paper summarising progress and plans
- noted that policy in relation to **DBS checks** has been agreed and will be implemented.

20-7-16

Report to:	Trust Board
Date of meeting:	26th July 2016
Document Title:	Board Assurance Framework and Corporate Risk Register 15+
Report Author(s):	Frances Field
Presented by:	Sandra Adams
Contact Details:	Sandra.adams@lond-amb.nhs.uk
History:	N/A
Status:	Trust Risk Register and Board Assurance Framework current as at 18th July 2016
Background/Purpose	

Trust Risk Register (TRR) and Board Assurance Framework (BAF)

The Trust has made significant progress with embedding the management of risk at a local level in the last six months and all directorates and areas have established forums where they discuss risks which fall under their respective areas for review and update. All directorates and areas have been migrating their local and Trust risks onto the risk Module on Datix, which they will be using to update and extract reports from in the future. The Governance and Assurance Team have been working with individuals who have been entering the risk data, providing feedback where additional information or amendments are required to ensure that the quality of the data input meets the required criteria. Guidance and support will continue to be provided to staff with working with the Risk Module on Datix through weekly 'Datix surgeries' which have been established by the Governance Team. On-going Risk Management Training is being provided for staff requiring it and a Risk Management page has been set up on the Pulse, which contains links to the relevant policies, procedures and forms to assist them with the risk management process.

In order to maintain this 'risk managed' approach the Governance and Assurance Team are working with directorates and areas to ensure that they are reviewing and updating their risks within their established forums and update the information on Datix.

The Governance and Assurance Team will carry out quarterly audits on the integrity of the data added to the risk module and progress will be reported to the Risk Compliance and Assurance Group (RCAG), who will be monitoring compliance with this process.

BAF risk activity in June 2016

The BAF was reviewed towards the end of June by the responsible leads and updates were submitted to Datix.

Three risks were approved by the RCAG for re-grading in June 2016, which have now been removed from the BAF (BAF risks 16, 24 and 27). One new risk was approved by the RCAG in

June 2016 for addition to the BAF (BAF risk 35).

Strategic risk and risk appetite
Work continues on the strategic risks and mitigations and on developing the risk appetite statements and matrix. These will be discussed in a Board seminar in early September with a view to final sign off.

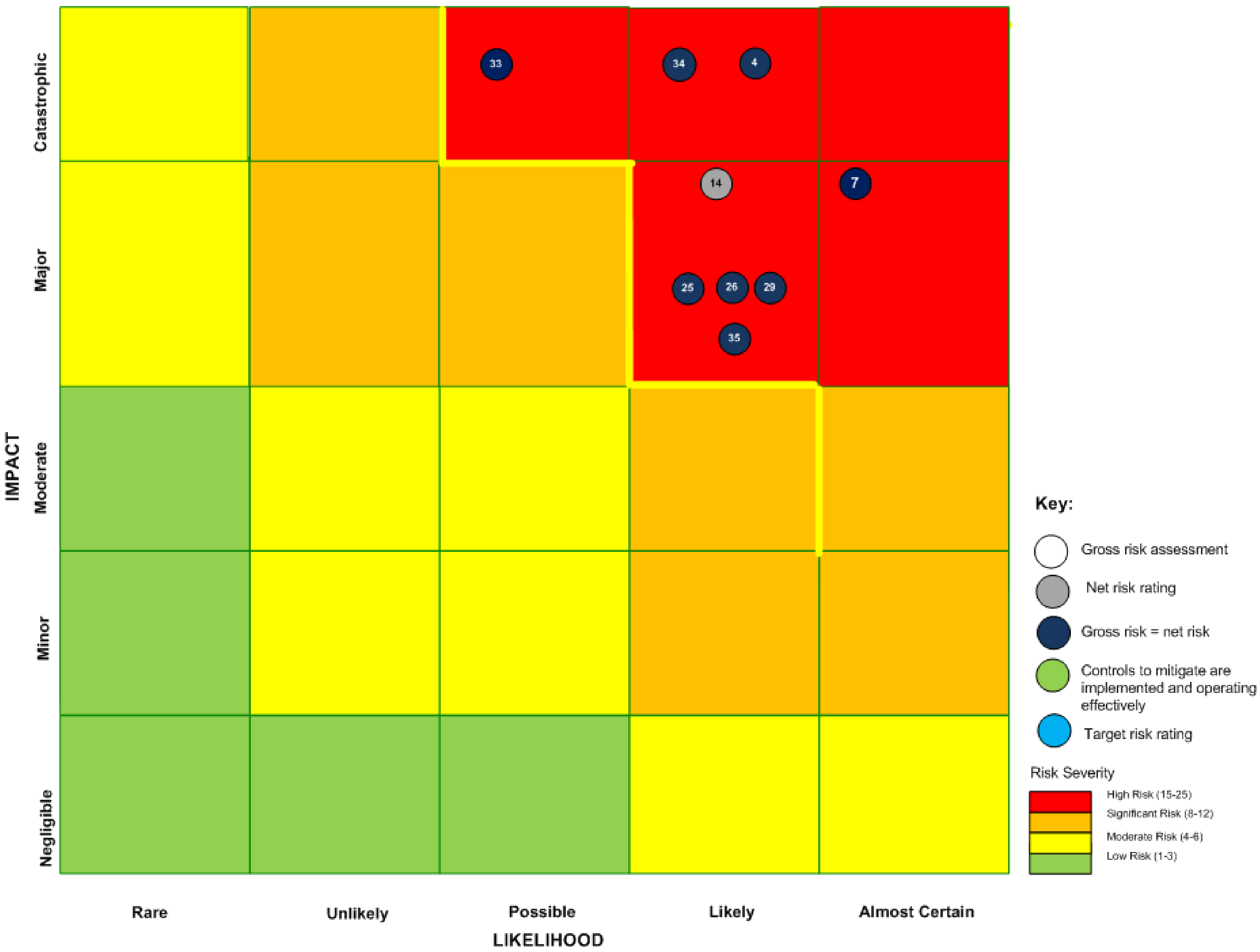
Action required

To note the progress made with mitigating controls and actions for risks included in the Board Assurance Framework.

Key implications

The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives.
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	The Trust Risk Register and Board Assurance Framework provide the Trust Board with information on how the organisation is currently managing its risk and provides an opportunity for scrutiny and escalation where required.
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	


Board Assurance Framework – July 2016
IMPACT
Catastrophic
Major
Moderate
Minor
Negligible
LIKELIHOOD
Rare
Unlikely
Possible
Likely
Almost Certain
33
34
4
14
7
25
26
29
35
Key:
Gross risk assessment
Net risk rating
Gross risk = net risk
Controls to mitigate are implemented and operating effectively
Target risk rating
Risk Severity
High Risk (15-25)
Significant Risk (8-12)
Moderate Risk (4-6)
Low Risk (1-3)

BAF Risks Summary Sheet

BAF risks matched to Quality Improvement Plan 4: Improving Environment and Resources

Risk ID: 26	Description:		
Linked Risk(s): 120	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care.	**Risk opened:**	21/05/2015
	Risk Owner: Director of Finance	**Expected risk closure:**	March 2017
		Is this risk on track for closure?	Yes

Low Risk	**Medium Risk**				**High Risk**			
6	8	9	10	12	15	16	20	25
T						G N		
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Risk ID: 25	Description:		
Linked Risk(s): 121	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care.	**Risk opened:**	121/05/2015
	Risk Owner: Director of Finance	**Expected risk closure:**	2016
		Is this risk on track for closure?	Yes

Low Risk	**Medium Risk**				**High Risk**			
6	8	9	10	12	15	16	20	25
T						G N		
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Risk ID: 34	Description:		
Linked Risk(s): 214	The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.	**Risk opened:**	17/11/2015
	Risk Owner: Director of Finance	**Expected risk closure:**	TBC
		Is this risk on track for closure?	

Low Risk	**Medium Risk**				**High Risk**			
6	8	9	10	12	15	16	20	25
			T				G N	
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Risk ID: 14	Description:		
Linked Risk(s): 217	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.	**Risk opened:**	10/04/2014
	Risk Owner: Director of Finance	**Expected risk closure:**	TBC
		Is this risk on track for closure?	

Low Risk	**Medium Risk**				**High Risk**			
6	8	9	10	12	15	16	20	25
T						N	G	
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

BAF Risks Summary Sheet

Risk ID: 33	Description:
Linked Risk(s): 420	420/BAF33 Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services. **Risk Owner:** Chief Information Officer

Risk opened:	01/07/2016
Expected risk closure:	TBC
Is this risk on track for closure?	

Low Risk	Medium Risk				High Risk			
5	8	9	10	12	15	16	20	25
T					G N			
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Risk ID: 35	Description:
Linked Risk(s): 428	**There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead** **Risk Owner:** Paul Woodrow

Risk opened:	14/07/2016
Expected risk closure:	31/12/2016
Is this risk on track for closure?	No

Although discussions with Trade Unions are occurring at a national level, there is no indication at this stage as to when the ballot for industrial action will take place, and if agreed the timeframe for industrial action to occur

Low Risk	Medium Risk				High Risk			
5	8	9	10	12	15	16	20	25
		T				G N		
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

BAF risks matched to Quality Improvement Plan Work stream 3: Improving Patient Experience

Risk ID: 7	Description:
Linked Risk(s): 430	There is a risk that at staff changeover times, LAS performance falls. **Risk Owner:** Director of Operations **Also linked to QIP Work stream 2 and 4**

Risk opened:	08/12/2006
Expected risk closure:	TBC
Is this risk on track for closure?	

Low Risk	Medium Risk				High Risk			
6	8	9	10	12	15	16	20	25
	T						G N	
Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
20	20	20	20	20	20	20	20	20

Risk ID: 4	Description:
Linked Risk(s):	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand. **Risk Owner:**

Risk opened:	31/07/2006
Expected risk closure:	TBC
Is this risk on track for closure?	

Low Risk	Medium Risk				High Risk			
6	8	9	10	12	15	16	20	25
				T			G N	

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

			Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
337	Director of Operations **Also linked to QIP Work stream 4**	To be reviewed making clear difference between trajectory and National Target of 75%.	20	20	20	20	20	20	20	20	20

Risk ID: 29	**Description:**	**Risk opened:**	10/05/2015	**Low Risk**	**Medium Risk**				**High Risk**			
	There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.	**Expected risk closure:**	TBC	6	8	9	10	12	15	16	20	25
Linked Risk(s):		**Is this risk on track for closure?**						T		G N		
338	**Risk Owner:**			Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016
	Director of Operations			20	20	20	20	20	20	20	20	20

Legend: G = Gross Rating | N = Net Rating | T = Target Rating

BAF Risk no. 26 There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care

Risk Classification: Infrastructure	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Fleet and Logistics Risk Review Group		
Underlying Cause/Source of Risk:		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		16	16	6

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1, Serial numbers on all re-usable equipment that can be accurately tracked. 2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role 8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 9, Current VP contract reviewed and any immediate changes are agreed 10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed 11, Pilot project in NE area to provide and resupply equipment store implemented. **Gaps in Controls**	1. Clinical Equipment Group 2. Asset tracking report 3. VP reports 4. VP Contract 5. Equipment Process 6. Project completion	**501**	1. Complete electronic VDI pilot to provide improved reporting. Ensure all equipment has bar code or serial number. 2. Roll out pilot and fully develop equipment database reports to indicate where any equipment is missing 3. Roll Out NE VP pilot to include secure local equipment stores and day time "Quartermaster" role 4. Roll out enhanced VP to rest of service from June 2016 5. Ensure Interserve provide feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 6. Ensure adequate stocks of consumables and equipment are available to VP staff – south are a rolled out – NE pilot area by 1st March and rest of area by end of April 16 7. Review current VP contract and agree any immediate changes 8. Agree essential equipment, plan and implement a process to make key items available centrally to -restock 9. Plan rollout of and implement complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided 10. Implement pilot project in NE area to provide and resupply equipment store – see 3	Complete Q2 2016/17 Complete December 2016 Complete End Q1 16/17 Complete Superseded by 6 Complete Complete

Signed: **Date Reviewed:** 27th June 2016

BAF Risk no. 25 There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care

Risk Classification: Infrastructure	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Fleet and Logistics Risk Review Group		
Underlying Cause/Source of Risk: This was risk 442 on the old risk register		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		16	16	6

Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Agreed vehicle equipment lists including re-usable v disposable in place 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit 6, A "core" equipment list for DCA & FRU has been defined and agreed 7, funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed 8, An equipment amnesty and physically review all stations and complexes for "retained" equipment has been undertaken 9, an new paper based VP VDI form has been introduced 10, Pilot to assess benefits of VP proposal carried out **Gaps in Controls**	Progress made in agreement of core equipment and further equipment amnesty. Decontamination of equipment commenced. Analysis of asset tracking systems being undertaken.	**498** **499** **607**	Roll out VP proposal to LAS area Implement working group to review personal issue kit – check status of any existing work with CEG	20/07/2016 20/07/2016 20/07/2016

Signed: **Date Reviewed:** 27th June 2016

BAF Risk no. 34 The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.					
Risk Classification: Finance	**Risk Owner:** Grimshaw, Andrew	**Scrutinising Committee:** Finance & Investment Committee			
Underlying Cause/Source of Risk: Failure to achieve this will mean the Trust is in deficit and will see deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.		**Gross Rating**	**Current/Net Rating**	**Target Rating**	
		20	20	10	
Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**	
1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles 2. Clear view on operational capacity required to deliver ambulance performance targets 3. Clear view of achievable productivity targets which support performance targets 4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered 5. Funding from CCGs is consistent with capacity, productivity and demand assessments 6. Other factors such as investment for CQC are clearly understood, and associated funding identified 7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered. 8. Inflationary pressures are understood and managed within the overall financial position 9. Capital investment plans and their revenue consequences are understood. **Gaps in Controls**	1. Planning has started with CCGS regarding 2016/17 demand, capacity, productivity and funding. 2. CQC costs being developed	1 Demand: Build a demand model and agree with CCGs 2 Capacity: Build an operational model to forecast staff numbers required to support given levels of performance based on a range of demand and productivity metrics 3 Productivity: Develop a clear understanding of productivity and how it can be influenced and managed. JCT deep dive 4 Recruitment: Clear recruitment plan in place which identifies all associated costs. 5 Funding: Appropriately funded contract in place with commissioners 6 All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan. 7 Efficiency targets have scoped, stress tested and clear plans are in place to deliver. 8 Inflationary pressures are understood 9 Local development pressures have been identified, costed, reviewed and prioritised. Areas to be progressed are agreed. 10 5 year capital investment plans for, funding and associated revenue implications are defined and agreed.		Complete Complete 30/06/16 Complete 31/03/16 revised to 31/05/16 31/03/16 revised to 31/05/16 30/04/16 revised to 30/06/16 Complete 30/04/16 30/06/16	
Signed:	**Date Reviewed:** 18/03/2016				

BAF Risk no. 14 **It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.**

Risk Classification: Finance | **Risk Owner:** Grimshaw, Andrew | **Scrutinising Committee:** Finance & Investment Committee

Underlying Cause/Source of Risk: • Appropriate supporting evidence not available
• CIPs not supported by detailed milestone plan.
• CIPs not embedded in budgets.
• CIPs not owned by relevant manager.
• Benchmarking of CIPs not undertaken.
• CIP governance not clearly defined and in place.
• Board/FIC scrutiny of CIP planning and delivery not in place.
• CIPs not delivering in line with expectations.
• Capacity and capability not available to support delivery.

Gross Rating	Current/Net Rating	Target Rating
20	20	6

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments. **Gaps in Controls** As per underlying causes	1. On-going reporting to CIP Programme Board, FIC and Quality Committee. 2. On-going review of CIP opportunity takes place.	1 Engage additional support to drive the CIP Programme. 2 Ensure all schemes have clear project plans. 3 Embed all CIPs in budgets. Ensure managers sign off. 4 Review current benchmarking information. 5 Review and confirm CIP governance	30/09/15 Revised 30/06/16 30/09/15 Revised 30/06/16 30/09/15 Revised 30/06/16 On-going Revised 30/09/16 31/03/16 revised to 30/06/16

Signed: **Date Reviewed:** 18/03/2016

BAF Risk no. 4	**There is a risk that service performance may be adversely affected by the inability to match resources to demand**		
Risk Classification: Performance	**Risk Owner:** Woodrow, paul	**Scrutinising Committee:** Audit Committee	

Underlying Cause/Source of Risk: Recruitment; Attrition; Growing vacancy factor; Increased demand; Patient Safety and Financial Penalties	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	20	**20**	**12**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**	**Due Date**
1. On-going training to operationalise newly recruited staff; recruitment target reached. 2. Use of voluntary and private sector at times of peak demand. 3. New rosters implemented successfully. 4. Q2 overtime incentives have been published and will disruption payments available will be reduced from September as more new staff become operational. 5. Surge plan in place and has been reviewed. 6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories 7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls i.e. auto back up pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene. 8. Use of agency Paramedics to enhance bank scheme. (On-going) 9. Use of private sector ambulances continues and will reduce by 25% from September, as new staff become operational. **Gaps in Controls** 1. Use of private sector ambulances to be reviewed. Agreed plan in place until end of March 16 for private provision. 2. Targeted use of incentive based overtime and disruption payments to be reviewed. Uptake of overtime has reduced and corresponds to the reduction in disruption payments due to the financial context of the Trust. 3. Surge plan will be reviewed again in January 2016. 4. Annual leave review - a revised annual leave policy has been drafted and is awaiting agreement. 5. The incident management desk is not open consistently 24/7 due to sub-optimal staffing.	1. Recruitment activity reviewed fortnightly at ELT 2 Weekly forecast & planning meetings 3. A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016 4. Plans for non-auto dispatch back-up have been developed and are in place 5. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review. 6. NETS now in place with 108 staff in post. 7. Staff are being trained for FRU response to increase numbers of people who can work on a car.	1. Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at January 2016 is 5%. Monitoring to continue	Target Reached
		2. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. The LAS have taken part in 'grad fairs' with UK Universities since Jan 2016 and this is on-going in a monthly basis to recruit graduates. A team returned to Australia in May 2016 and made conditional offers to 151 candidates. The target for recruiting to 3169 frontline staff by March 2016 was completed	Complete
		3. Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. NETS usage has increased from 600 to 700 per week against a target of 1200. Project plan being finalised to stabilize the system to 800 per week which can then be added to on a daily basis to reach the required 1200. Plan was delivered at the Tripartite meeting on 7th April.	October 2016
		4. Ambulance Response Programme, previously dispatch on disposition pilot, is on-going. Effectiveness is reviewed bi-weekly. Extends resource allocation time from 60 to 180 seconds allowing more effective decisions to be made. Ends for LAS Sept 2016	In place
		5. IMD incident management desk – to manage incidents.	In place

Signed: **Date Reviewed:** 27/06/2016

BAF Risk no. 35 **There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead.**

Risk Classification: Operational	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Quality Improvement Programme Board	
Underlying Cause/Source of Risk: This is a national dispute, and if the industrial action goes ahead the affected parties will include: LAS staff; patients; hospitals and other healthcare providers	**Gross Rating** 16	**Current/Net Rating** 16	**Target Rating** 9

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
LAS are aware of discussions to date and further information will be available as to whether the industrial action will eventuate following a ballot on 31/05/2016	An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Boa	There are plans underway to design a proposal to introduce Band 6 paramedics. The proposed approach has been agreed in principal, however detailed work is required to fully understand the operational and financial implications of introducing Banad 6 paramedics, which is heavily predicated on required funding to be agreed with Commissioners	31/07/2016

Signed: **Date Reviewed:** June 2016

BAF Risk no. 29 **There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.**

Risk Classification: Clinical & Quality	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:** Audit Committee		
Underlying Cause/Source of Risk:		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		16	16	12

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs. 2. Additional technical support to prompt re-categorisation and contact. 3. New ring back status monitors. 4. New information within EOC to be able to properly inform patients of the likely wait time for a response. 5. Staff removed from call handling to undertake ring backs when capacity allows. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care. 6. Two call-handling courses took place in October 2105 which brought a maximum of 32 new staff to EOC pre-Christmas. Complete. – New training plan for 2016/17 for 12 call handling courses. Gaps in Controls 1. On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high. 2. ORH report received has been presented to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level. 3. Additional front line resources are required.(covered by BAF risk 265 and 388)	Patients who are most at risk are flagged via the hub to focus the ring backs.	1 ORH report received, paper has been to ELT and Trust Board. Full project plan being created and funding secured, but capacity to deliver the full additional staffing within 2016/17 is not achievable within current plans. 2 EOC improvement programme commenced alongside increased recruitment to ensure maximum efficiencies as well as additional resource.	2016/17

Signed: Millard, Katy **Date Reviewed:** 27/06/2016

BAF Risk no. 33 420/BAF33 Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services

Risk Classification: Information Governance	**Risk Owner:** Watson, Andrew	**Scrutinising Committee:** IM&T Senior Management Team		
Underlying Cause/Source of Risk: As the CAC network does not have access to the internet or email, it is less likely that attacks will come directly from these external sources, but it may be possible to introduce an attack through infected USB drives, CD/DVDs, or other removable media (even if LAS-approved devices). Alternatively, an attacker could leverage one of the security vulnerabilities present on the other networks (external Internet facing network or Admin network) as a pivot point to launch attacks into the CAC. Patching (on the Command and Control network) Patching refers to updating software or its supporting data to help remediate known issues, such as security vulnerabilities. KPMG review has revealed that patching is limited for devices on the Command and Control (CAC) network (where the 999 call centre is located) as Comandpoint is unable to run on up-to-date Microsoft devices. Additionally, updates to third party software (java in particular) interfere with the running of Commandpoint. As mitigation, these devices do not have email or internet access. Review also highlighted that PCs on the CAC network have never been patched. (highlighted by KPMG Cyber Audit -October 2013)		**Gross Rating** **15**	**Current/Net Rating** **15**	**Target Rating** **5**
Existing Controls	**Positive Assurance of Controls**	**Further Actions**		**Due Date**
1. Enterprise antivirus monitoring CAC desktops 2. Desktop ports disabled (i.e. USB, DVD) 3. No access to internet /email for CAC desktops **Gaps in Controls**	**Gaps in Assurance**	**624** **625** **626** **627**	Implement Firewall between CAC and LAS corporate Networks Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed. RCAG approval of report and format Additional information, such as patches applied /	31/12/2016 01/04/2016 01/04/2016 01/04/2016
Signed: **Date Reviewed:** **June 2016**				

BAF Risk no. 7 . There is a risk that at staff changeover times, LAS performance falls

Risk Classification: Performance	**Risk Owner:** Woodrow, Paul	**Scrutinising Committee:**	
Underlying Cause/Source of Risk: potential ballot on pay and conditions.		**Gross Rating**	**Current/Net Rating**	**Target Rating**
		20	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Daily monitoring of rest break allocation to resolve end of shift losses. 2. Use of bridging shifts for VAS/PAS. 3. Roster reviews/changes include staggered shifts. 4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies on sufficient EOC resourcing (ORH review). **Gaps in Controls** 1. There is no allocation process to ensure loss is spread evenly across the day to manage impact. No current progress with ELT/staff side to change rest break arrangements. Without a change this risk is unlikely to be mitigated effectively. It may reduce as staffing improves. 1. The incident management desk is not open consistently 24/7 due to sub-optimal staffing.	An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Boa	1 Agree the process for the rest break arrangements to be implemented. 2 Recruiting frontline staff to 3169 by March 2016 3 Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015 4 On-going rigorous management of out of service. We are unlikely to meet the final target by the end of the Programme (end March 2016), however what was felt to be achievable is a target of 2.2% (vehicle element). 5 Out of service HUB implemented.	30/09/2016 Completed Completed March 2016 Completed

Signed: **Date Reviewed:** June 2016

London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Staff Survey Action Update
Report Author(s):	Mark Hirst
Presented by:	Mark Hirst
Contact Details:	Mark.Hirst@lond-amb.nhs.uk
History:	*Results of the staff survey have been presented to both the Executive Leadership Team (ELT) and the Workforce Committee (on behalf of the Board). This update paper highlights progress in relation to the Staff Survey key actions.*
Status:	*For information and assurance*

Background/Purpose

The Staff Survey results were presented to ELT (16 March 2016) and the Workforce Committee (16 May 2016), where it was agreed by all parties that the Quality Improvement Programme (QIP) incorporated all actions required to address the key areas for improvement arising from the 2015 staff survey results.

The QIP was approved by the Board in February 2016. This report provides assurance and update on progress relating to the high level actions arising from the NHS staff survey results, all of which are identified in the QIP.

Action required

The Board needs to ensure that a robust communication plan is implemented to share the success of QIP actions with all staff prior to the 2016 staff survey, in order to achieve significant improvements in the next staff survey.

Key implications

It is likely that larger improvements may be seen in subsequent years, once improvements have become embedded and benefits have been achieved for all staff.

Key implications and risks arising from this paper	
Clinical and Quality	There is a substantial amount of evidence that the experiences of staff, particularly in the form of support received from supervisors and others, and staff engagement, are associated with the care provided to patients, in the form of patient satisfaction, health outcomes, and ratings of quality of care, as well as staff absenteeism and turnover
Performance	The staff survey is a measure of performance used by a number of NHS bodies, used to benchmark the Trust with regards to progress on historical performance and against other Ambulance Trusts
Financial	
Workforce	Actions support 'making the LAS a great place to work'
Governance and Well-led	Evidence from the staff survey can be used to support improvements in the governance and well-led domains
Reputation	Staff survey results are published nationally and are in the public domain. Results impact the Trust's reputation and influence prospective employees decision LAS as an attractive employer
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**Yes**
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	**Yes**
Taking Pride and Responsibility	

Staff Survey 2015 – Actions Update

1.1 Overview

1.1 A total of 4,547 staff were eligible to complete the 2015 staff survey. 1,600 individuals returned a completed questionnaire, giving a response rate of 35.2%; this was higher than the national Picker Ambulance Trust average (34.6%).

1.2 A total of 60 questions were used in both the 2014 and 2015 surveys. Compared to the 2014 survey, the LAS is:

- significantly better in 43 questions,
- significantly worse in 4 questions
- showed no significant difference on 13 questions.

1.2 Key results

1.2.1 Best performing areas

Problem Area	% of Staff in your trust that said this in 2014	Whereas % of Staff in your trust that said this in 2015	% Better
Organisation does not act on concerns raised by patients/service users	34	9	+25
Immediate manager does not take a positive interest in my health & well-being	50	29	+21
Never/rarely look forward to going to work	42	25	+17
Care of patients/service users is not organisation's top priority	54	38	+16
If friend/relative needed treatment would not be happy with standard of care provided by organisation	35	20	+15
Not able to do my job to a standard am pleased with	34	21	+13
Would not recommend organisation as place to work	62	49	+13

1.2.2 Worst performing areas

Problem Area	% of Staff in your trust that said this in 2014	Whereas % of Staff in your trust that said this in 2015	% Worse
Appraisal/performance review: training, learning or development needs not identified	45	53	-8
Last experience of harassment/bullying/abuse not reported	58	66	-8
Do not receive regular updates on patient/service user feedback in my directorate/department	51	56	-5
Do not know who senior managers are	21	26	-5
Put myself under pressure to come to work despite not feeling well enough	88	91	-3
Last experience of physical violence not reported	35	37	-2
Feedback from patients/service users is not used to make informed decisions within directorate/department	33	34	-1

1.2.3 The results were presented to ELT (16 March 2016) and the Workforce Committee (16 May 2016), where detailed discussions took place. The results of the 2015 staff survey reflected many of the key findings of the CQC inspection. It was therefore agreed by ELT and the Workforce Committee that the key areas where scores are unsatisfactory are being explicitly addressed as part of the Quality Improvement Programme (QIP).

1.2.4 On behalf of the board, the chair of the workforce committee was reassured that the comprehensive QIP addressed all key areas requiring progress and will ensure that intense focus is given to making the necessary improvements.

2. Actions

2.1 ELT and the Workforce Committee are satisfied that the planned actions embedded into the single QIP are adequate to deal with areas where the scores are particularly unsatisfactory, notably those relating to bullying, harassment and abuse by staff, discrimination at work, and equal opportunities for career progression or promotion. The table below links the areas of the staff survey in which the Trust performed worst, with the elements of the QIP plan which will address them.

2.2 Key areas to focus

Key Areas to Focus	QIP Actions (July v.1)
Issues with appraisals/performance reviews: Staff are not having them; Training, learning or development needs not identified; and Organisational values have not been discussed	1.33-1.36
People not reporting harassment, bullying and abuse, nor physical violence	1.06-1.13
Staff do not know who the senior managers are	1.27-1.28 & 1.31
Not receiving regular updates on patient feedback, though it does seem to be collected more than in 2014	2.32, 2.34 -2.35
Not having adequate supplies and equipment to do one's job	4.03 & 4.10-4.13

3. Progress on actions to date

3.1 The Trust has started to make progress and in some instances completed on a number of the QIP actions. The likely trajectory of the QIP will aim to improve employee experience in these areas, delivering improved survey results for the 2016 staff survey.

3.1.1 The Trust launched its new vision and values in 2014-15 and a communication campaign is underway to increase their visibility and embed them within the organisation.

3.1.2 The Trust has launched its new PDR process and associated documentation to support staff in identify training, learning and development needs and assist with embedding the Trust's vision and values within the Trust.

3.1.3 Five of the eight actions relating to the bullying and harassment workstream have been successfully completed. The remaining three remain on-track.

3.1.4 All of the actions relating to improving senior manager visibility have been implemented.

3.1.5 One of the three actions relating to improving communication of patient feedback has been completed; the remaining two should be completed in the next month.

3.1.6 All of the actions relating to staff not having the appropriate equipment to undertake their role have been completed.

4. Next steps

4.1 The next staff survey is due to be launched in September 2016.

4.2 A communications plan needs to be implemented highlighting all of the improvements made as a result of the 2015 Staff Survey, prior to the launch of the 2016 survey. Communications should be integrated with the QIP communications strategy, as the staff survey has been identified as a method of measuring QIP progress in a number of areas.

4.3 The Trust has set itself a target of increasing the response rate for the 2016 Staff Survey to at least 40% of eligible staff.

5. Related documents

5.1 The full staff survey Picker Report

Staff Survey 2015
Exec Summary Repor

5.2 Executive summary Picker Report

London Ambulance
Service Presentation

5.3 Picker Presentation

Staff Survey 2015

LONDON AMBULANCE SERVICE NHS TRUST

Executive Summary

JANUARY 2016

TRUST ID: RRU SURVEY ID: UKSTA15AMB

How are your results reported?

The Picker Institute presents your survey results in a form of **problem scores.** The problem score shows the percentage of staff who gave a negative response for each applicable question.

A detailed explanation of how problem scores are calculated is provided in Section 1 of the full survey report, but the following should be kept in mind when looking at your results:

- **Lower problem scores are better**
- Problem scores highlight issues that need **further investigation**
- Problem scores are a **simple summary** measure used for comparison and for helping to focus on areas for improvement
- Problem scores are an **interpretation of results** by the Picker Institute – NHS England will not see problem scores

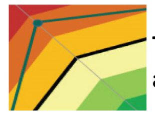
Introduction

This document summarises the findings from the Staff Survey 2015, carried out by Picker Institute Europe, on behalf of London Ambulance Service NHS Trust. The NHS England report is due for publication in February 2016.

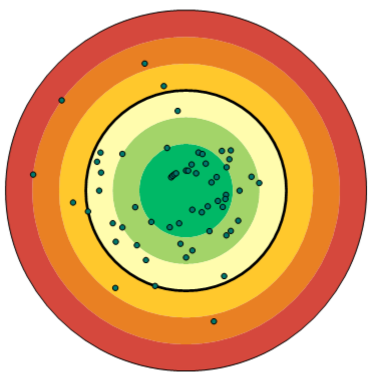
The Picker Institute was commissioned by 6 ambulance trusts to undertake the Staff Survey 2015. A total of 4585 staff from your Trust were sent a questionnaire of which 4547 were eligible to complete the survey, 1600 returned a completed questionnaire, giving a response rate of 35.2%. The average response rate for the 6 'Picker' ambulance trusts was 34.6%.

Your results at a glance

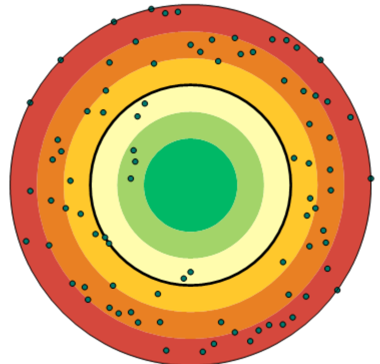
This score is considerably improved/better than average



This score is considerably worse than average/last year



Historical changes for all questions



Differences from the average for all 'Picker' ambulance trusts - All questions

Each dot indicates a score on a question The thick black line shows the base line, 0% change/difference In the first half of the report, Historical Changes, this is where there has been no change since the previous year on a question In the 2nd half of the report, this shows where the trust performance is the same as the 'Picker average for that question'	
	Worsened by more than 8% since last year / More than 8% worse than the 'Picker average'
	Worsened by 4%-8% since last year / Between 4-8% worse than the 'Picker average'
	Worsened by 0%-4% since last year / Between 0-4% worse than the 'Picker average'
	Improved by 0%-4% since last year / Between 0-4% better than the 'Picker average'
	Improved by up to 4%-8% since last year / Between 4-8% better than the 'Picker average'
	Improved by more than 8% since last year / More than 8% better than the 'Picker average'

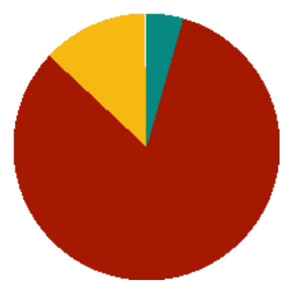
Have we improved since the 2014 survey?

A total of 60 questions were used in both the 2014 and 2015 surveys.
Compared to the 2014 survey, your Trust is:

- Significantly BETTER on 43 questions
- Significantly WORSE on 4 questions
- The scores show no significant difference on 13 questions

How do we compare to other trusts?

In this year's survey, a comparison can be drawn between your Trust and the average for all 'Picker' ambulance trusts on a total of 86 questions.
The survey showed that your Trust is:



- Significantly BETTER than average on 4 questions
- Significantly WORSE than average on 71 questions
- The scores were average on 11 questions

Understanding your results

The following section summarises your Trust's results. It details which problem scores have changed significantly over the last year and how your Trust compares to the average for all 'Picker' ambulance trusts.

NB. Where fewer than 50 staff have answered a particular question, the problem score will be shown within square brackets, for example [23%]. If this is the case, the result should be treated with caution, as the number of staff answering is relatively small.

Compare results over time - have you improved since the 2014 survey?

The Trust has improved significantly on the following questions:

Lower scores are better

		2014	2015
2a	Never/rarely look forward to going to work	42 %	25 %
2b	Never/rarely enthusiastic about my job	27 %	15 %
2c	Never/rarely does time pass quickly when I am working	32 %	21 %
3a	Do not always know what work responsibilities are	23 %	14 %
3b	Do not feel trusted to do my job	27 %	18 %
3c	Not able to do my job to a standard am pleased with	34 %	21 %
4a	Opportunities to show initiative infrequent in my role	37 %	27 %
4b	Not able to make suggestions to improve the work of my team/dept	43 %	36 %
4c	Not involved in deciding changes that affect work	65 %	59 %
4d	Not able to make improvements in my area of work	59 %	52 %
4f	Do not have adequate materials, supplies and equipment to do my work	58 %	50 %
4g	Not enough staff at organisation to do my job properly	81 %	71 %
5a	Dissatisfied with recognition for good work	64 %	53 %
5b	Dissatisfied with support from immediate manager	35 %	30 %
5c	Dissatisfied with support from colleagues	11 %	7 %
5d	Dissatisfied with amount of responsibility given	25 %	18 %
5e	Dissatisfied with opportunities to use skills	35 %	26 %
5f	Dissatisfied with extent organisation values my work	68 %	59 %
5g	Dissatisfied with my level of pay	71 %	61 %
6a	Dissatisfied with quality of care I give	22 %	13 %
6b	Do not feel my role makes a difference to patients/service users	13 %	7 %
6c	Unable to provide the care I aspire to	36 %	25 %
7a	Immediate manager does not encourage team working	31 %	25 %
7b	Immediate manager cannot be counted upon to help with tasks	29 %	23 %
7c	Immediate manager does not give clear feedback	47 %	36 %
7d	Immediate manager does not ask for my opinion	55 %	47 %
7f	Immediate manager does not take a positive interest in my health & well-being	50 %	29 %
8b	Communication between senior management and staff is not effective	65 %	59 %
8c	Senior managers do not try to involve staff in important decisions	69 %	64 %
8d	Senior managers do not act on staff feedback	64 %	57 %
9c	Felt unwell due to work related stress in last 12 months	65 %	55 %
9e	Felt pressure from manager to come to work despite not feeling well enough	61 %	52 %
9f	Felt pressure from colleagues to come to work despite not feeling well enough	15 %	12 %
11a	In last month, saw errors/near misses/incidents that could hurt staff	42 %	38 %
11b	In last month, saw errors/near misses/incidents that could hurt patients	43 %	35 %
13a	Do not know how to report unsafe clinical practice	16 %	12 %
13c	Would not feel confident that organisation would address concerns about unsafe clinical practice	34 %	27 %
20a	No appraisal/KSF review in last 12 months	63 %	59 %
21a	Care of patients is not organisation's top priority	54 %	38 %
21b	Organisation does not act on concerns raised by patients/service users	34 %	9 %
21c	Would not recommend organisation as place to work	62 %	49 %

21d	If friend/relative needed treatment would not be happy with standard of care provided by organisation	35 %	20 %
22a	No patient/service user feedback collected within directorate/department	22 %	14 %

The Trust has worsened significantly on the following questions:

Lower scores are better

		2014	2015
8a	Do not know who senior managers are	21 %	26 %
9g	Put myself under pressure to come to work despite not feeling well enough	88 %	91 %
15d+	Last experience of harassment/bullying/abuse not reported	58 %	66 %
20f	Appraisal/performance review: training, learning or development needs not identified	45 %	53 %

Compare results with others

The Picker Institute ran staff surveys for 6 ambulance trusts in 2015. Your results are shown alongside the average for all 'Picker' ambulance trusts.

Your results were significantly better than the ‘Picker average’ for the following questions:

Lower scores are better

		Trust	Average
9f	Felt pressure from colleagues to come to work despite not feeling well enough	12 %	14 %
18a	No training, learning or development in the last 12 months	26 %	32 %
19	No mandatory training in the last 12 months	11 %	17 %
20b	Appraisal/review not helpful in improving how do job	34 %	39 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

		Trust	Average
2a	Never/rarely look forward to going to work	25 %	19 %
2b	Never/rarely enthusiastic about my job	15 %	10 %
2c	Never/rarely does time pass quickly when I am working	21 %	14 %
3a	Do not always know what work responsibilities are	14 %	10 %
3b	Do not feel trusted to do my job	18 %	10 %
3c	Not able to do my job to a standard am pleased with	21 %	15 %
4a	Opportunities to show initiative infrequent in my role	27 %	20 %
4b	Not able to make suggestions to improve the work of my team/dept	36 %	26 %
4c	Not involved in deciding changes that affect work	59 %	48 %
4d	Not able to make improvements in my area of work	52 %	41 %
4e	Cannot meet conflicting demands on my time at work	49 %	43 %
4f	Do not have adequate materials, supplies and equipment to do my work	50 %	34 %
4g	Not enough staff at organisation to do my job properly	71 %	64 %
4h	Team members do not have a set of shared objectives	24 %	16 %
4i	Team members do not often meet to discuss the team's effectiveness	63 %	54 %
4j	Team members do not have to communicate closely with each other to achieve the team's objectives	24 %	19 %
5a	Dissatisfied with recognition for good work	53 %	42 %
5b	Dissatisfied with support from immediate manager	30 %	23 %
5c	Dissatisfied with support from colleagues	7 %	6 %
5d	Dissatisfied with amount of responsibility given	18 %	15 %
5e	Dissatisfied with opportunities to use skills	26 %	20 %
5f	Dissatisfied with extent organisation values my work	59 %	47 %
5g	Dissatisfied with my level of pay	61 %	55 %
5h	Dissatisfied with opportunities for flexible working patterns	39 %	36 %
6a	Dissatisfied with quality of care I give	13 %	9 %
6b	Do not feel my role makes a difference to patients/service users	7 %	4 %
6c	Unable to provide the care I aspire to	25 %	19 %
7a	Immediate manager does not encourage team working	25 %	18 %
7b	Immediate manager cannot be counted upon to help with tasks	23 %	18 %
7c	Immediate manager does not give clear feedback	36 %	27 %
7d	Immediate manager does not ask for my opinion	47 %	35 %
7e	Immediate manager not supportive in personal crisis	14 %	11 %
7f	Immediate manager does not take a positive interest in my health & well-being	29 %	20 %
7g	Immediate manager does not value my work	24 %	17 %
8a	Do not know who senior managers are	26 %	16 %
8b	Communication between senior management and staff is not effective	59 %	49 %
8c	Senior managers do not try to involve staff in important decisions	64 %	55 %
8d	Senior managers do not act on staff feedback	57 %	48 %
9a	Organisation does not take positive action on health and well-being	35 %	25 %
9b	In last 12 months, experienced musculoskeletal (MSK) problems as a result of work activities	50 %	42 %
9c	Felt unwell due to work related stress in last 12 months	55 %	49 %

9d	In last 3 months, have come to work despite not feeling well enough to perform duties	77 %	68 %
9e	Felt pressure from manager to come to work despite not feeling well enough	52 %	42 %
11a	In last month, saw errors/near misses/incidents that could hurt staff	38 %	28 %
11b	In last month, saw errors/near misses/incidents that could hurt patients	35 %	29 %
12a	Organisation does not treat fairly staff involved in errors	30 %	23 %
12b	Organisation does not encourage reporting of errors	13 %	7 %
12c	Organisation does not take action to ensure errors not repeated	24 %	17 %
12d	Staff not given feedback about changes made in response to reported errors	36 %	29 %
13a	Do not know how to report unsafe clinical practice	12 %	8 %
13b	Would not feel secure raising concerns about unsafe clinical practice	25 %	17 %
13c	Would not feel confident that organisation would address concerns about unsafe clinical practice	27 %	20 %
14a	Physical violence from patients/service users, their relatives or other members of the public	39 %	31 %
15a	Harassment, bullying or abuse from patients/service users, their relatives or members of the public	53 %	45 %
15b	Harassment, bullying or abuse from managers	31 %	20 %
15d+	Last experience of harassment/bullying/abuse not reported	66 %	62 %
16	Organisation does not act fairly: career progression	28 %	22 %
17a	Discrimination from patients / service users, their relatives or other members of the public	21 %	12 %
17b	Discrimination from manager / team leader or other colleagues	15 %	12 %
18b	Training did not help me do job more effectively	15 %	9 %
18c	Training has not helped me stay up-to-date with prof. requirements	14 %	9 %
18d	Training has not helped me deliver a better patient / service user experience	15 %	9 %
20a	No appraisal/KSF review in last 12 months	59 %	35 %
20e	Appraisal/performance review: organisational values not discussed	44 %	29 %
21a	Care of patients is not organisation's top priority	38 %	31 %
21c	Would not recommend organisation as place to work	49 %	36 %
21d	If friend/relative needed treatment would not be happy with standard of care provided by organisation	20 %	12 %
22a	No patient/service user feedback collected within directorate/department	14 %	10 %
22b	Do not receive regular updates on patient/service user feedback in my directorate/department	56 %	37 %
22c	Feedback from patients/service users is not used to make informed decisions within directorate/department	34 %	23 %
27b	Disability: organisation not made adequate adjustments(s) to enable employee to carry out work	35 %	24 %

Setting priorities for action

These are areas where your Trust's performance is better than average **and** you have demonstrated improvements since last year.

The Trust has positive results on the following questions:

Lower scores are better

		Average	2014	2015
9f	Felt pressure from colleagues to come to work despite not feeling well enough	14 %	15 %	12 %

These are areas where your Trust's score is worse than average **and** performance has slipped since 2014.

The Trust has poor results on the following questions:

Lower scores are better

		Average	2014	2015
8a	Do not know who senior managers are	16 %	21 %	26 %
15d+	Last experience of harassment/bullying/abuse not reported	62 %	58 %	66 %

Areas where staff report most problems

Questions where more than 50% of staff who responded gave a negative response are listed below.

Legend		Key	
+	scores significantly better than average	**Trust**	The problem score for your Trust
−	scores significantly worse than average	**Average**	Average score for all 'Picker' trusts

Lower scores are better

		Trust	Average	
9g	Put myself under pressure to come to work despite not feeling well enough	91 %	92 %	
9d	In last 3 months, have come to work despite not feeling well enough to perform duties	77 %	68 %	−
4g	Not enough staff at organisation to do my job properly	71 %	64 %	−
15d+	Last experience of harassment/bullying/abuse not reported	66 %	62 %	−
8c	Senior managers do not try to involve staff in important decisions	64 %	55 %	−
4i	Team members do not often meet to discuss the team's effectiveness	63 %	54 %	−
5g	Dissatisfied with my level of pay	61 %	55 %	−
20a	No appraisal/KSF review in last 12 months	59 %	35 %	−
4c	Not involved in deciding changes that affect work	59 %	48 %	−
8b	Communication between senior management and staff is not effective	59 %	49 %	−
5f	Dissatisfied with extent organisation values my work	59 %	47 %	−
8d	Senior managers do not act on staff feedback	57 %	48 %	−
22b	Do not receive regular updates on patient/service user feedback in my directorate/department	56 %	37 %	−
9c	Felt unwell due to work related stress in last 12 months	55 %	49 %	−
5a	Dissatisfied with recognition for good work	53 %	42 %	−
15a	Harassment, bullying or abuse from patients/service users, their relatives or members of the public	53 %	45 %	−
20f	Appraisal/performance review: training, learning or development needs not identified	53 %	49 %	
4d	Not able to make improvements in my area of work	52 %	41 %	−
9e	Felt pressure from manager to come to work despite not feeling well enough	52 %	42 %	−
4f	Do not have adequate materials, supplies and equipment to do my work	50 %	34 %	−
9b	In last 12 months, experienced musculoskeletal (MSK) problems as a result of work activities	50 %	42 %	−

Next Steps

Once priorities have been identified:

- Look at **internal benchmarks** (directorates/departments) in the main report – compare results within the Trust to help identify problem areas
- Tie in with **other surveys** - staff FFT/exit interviews/PALS/complaints/patient surveys
- Look at **respondent comments** for details and suggestions – available on-line (https://www.picker-results.org)
- Develop an **action plan**
- Raise awareness about the Staff Survey – **publish** results and action plans
- **Additional analysis** available from the Picker Institute on request - including demographic/trust type breakdowns

Picker will email you additional reports including Staff Engagement reports and Spider Chart reports as soon as these are available in January 2016.

If you need further assistance with understanding your results, or on any other aspect of the Staff Survey please contact **Jaana Kosunen, Sarah Hobbs** or another member of the staff survey team at the Picker Institute (Tel: 01865 208100), who will be happy to help you.

Full contact details are listed overleaf.

Contacting Picker Institute Europe

For more information about your Staff Survey 2015 Report please contact the Project Manager, Jaana Kosunen or another member of the Picker Institute Survey Team.

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Charity Registration No: 1081688

Quality Assurance and Information Security Management:
Picker Institute Europe has UKAS accredited certification for ISO20252:2012 (cert. no. GB08/74322) and ISO27001:2013 (cert. no. GB10/80275). Picker Institute Europe is registered under the Data Protection Act 1998 (Z4942556).

Quality Assurance & Information Security

Picker Institute Europe is wholly committed to delivering high quality surveys, research and service improvement in a way that ensures patient confidentiality and protects the reputation of our clients. To meet this commitment we will maintain our current certifications to ISO 20252 and ISO 27001, providing a guarantee that we handle all information securely and that we comply with the Data Protection Act 1998 and the Market Research Society's (MRS) Code of Conduct.

Our systems and processes include a thorough approach to assessing and mitigating risk, and ensuring business continuity. We have procedures in place to ensure that any sub-contractors we use conform to our quality and information security systems.

Our quality and information security management system seeks to continually improve the ways in which we work and the products we deliver to our clients. Picker Institute Europe aims to be an intelligent as well as a committed organisation that is always learning and developing new approaches.

In addition to the regular surveillance visits carried out by external bodies we have our own auditing and quality and information security management team. With the help of feedback from our clients, the team continuously monitors the quality of service we provide.

Quality Assurance and Information Security Management System Certificates

Picker Institute Europe operates an integrated quality system and is certified by SGS United Kingdom Ltd. to ISO20252:2012, the international standard for organisations conducting market and social research (certificate number GB08/74322). SGS are an UKAS accredited organisation No. 005 to EN 45012:1998 for management systems certification.

Picker Institute Europe has UKAS accredited certification for its information security management system (ISO27001:2005) from SGS (certificate number GB10/80275).

Picker Institute Europe is registered under the Data Protection Act 1998 (Z4942556).

Storage and retention of primary data

Paper questionnaires and qualitative recordings are retained for six months unless another retention period is agreed with the client. Any sensitive or confidential material is stored securely in line with our data protection policy (see above).

After six months these records are destroyed securely.

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London Ambulance Service NHS
NHS Trust

Report to:	London Ambulance Service Trust Board
Date of meeting:	26th July 2016
Document Title:	Patient Engagement Strategy
Report Author(s):	Margaret Luce
Presented by:	Margaret Luce / Briony Sloper
Contact Details:	LAS email
History:	First draft presented to ELT, this amended version tabled for forthcoming ELT meeting. Presented to Improving Patient Experience Committee 29th June 2016 and approved. Presented to Quality Governance Committee 12th July 2016.
Status:	For information, discussion and agreement

Background/Purpose

This strategy outlines the London Ambulance Service's (LAS) commitment to patient and public engagement over the next four years to 2020. It draws on the patient involvement elements of the NHS Five Year Forward View (NHS England, 2014) and the Trust's own five year strategy.

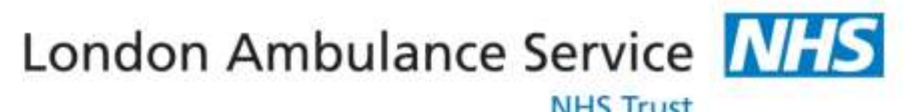
The Care Quality Commission's inspection report into the LAS (November 2015) did not identify any specific actions or improvements to be made in relation to its patient engagement activities. However, the Quality Improvement Plan (January 2016) arising from the inspection includes activities which will benefit from patient involvement. These are also outlined in the strategy.

Finally, the strategy will outline the key priorities for patient and public engagement to 2020, as far as these are currently known and acknowledging that the strategy and subsequent action plans will need to reflect changes in the internal and external environment.

The aim of this strategy is improve engagement and relationships with partner agencies, patient and community groups and individuals, e.g. by providing information, involving patients in the Trust's activities, and teaching life-saving skills. Implementation of the strategy will lead to greater visibility externally and an improved reputation amongst a wide range of organisations and groups, as well as improved patient experience. Involving staff in these activities is one way of improving staff recruitment, development and retention. The strategy also aims to ensure the Trust meets its statutory and other external requirements, enabling the LAS to derive the maximum benefit from engaging with patients and the public in meaningful ways.

This second version of the strategy includes the amendments suggested by ELT members in May, including the addition of an action plan as an appendix.

Action required	
Trust Board members are requested to consider and note the strategy.	
Key implications	
The document sets out the Trust's future approach to patient engagement.	
Key implications and risks arising from this paper	
Clinical and Quality	Patient engagement improves the quality of service we provide.
Performance	
Financial	
Workforce	
Governance and Well-led	The strategy sets out the Trust's approach to patient engagement, which is an aspect of governance.
Reputation	Good quality public engagement enhances the Trust's reputation.
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**X**
Achieving Good Governance	**X**
Improving Patient Experience	**X**
Improving Environment and Resources	
Taking Pride and Responsibility	**X**



Patient Engagement Strategy 2016 – 2020

1. Introduction

1.1 This strategy outlines the London Ambulance Service's (LAS) commitment to patient and public engagement over the next four years to 2020. It draws on the patient involvement elements of the NHS Five Year Forward View (NHS England, 2014) and the Trust's own five year strategy.

1.2 The Care Quality Commission's inspection report into the LAS (November 2015) did not identify any specific actions or improvements to be made in relation to its patient engagement activities. However, the Quality Improvement Plan (January 2016) arising from the inspection includes activities which will benefit from patient involvement. These are also outlined in the strategy.

1.3 Finally, the strategy outlines the key priorities for patient and public engagement to 2020, as far as these are currently known and acknowledging that the strategy and subsequent action plans will need to reflect changes in the internal and external environment. An action plan for the first year of the strategy, 2016-17, is attached as an appendix.

1.4 The aim of this strategy is improve engagement and relationships with partner agencies, patient and community groups and individuals, e.g. by providing information, involving patients in the Trust's activities, and teaching life-saving skills. Implementation of the strategy will lead to greater visibility externally and an improved reputation amongst a wide range of organisations and groups, as well as improved patient experience. Involving staff in these activities is one way of improving staff recruitment, development and retention. The strategy also aims to ensure the Trust meets its statutory and other external requirements, enabling the LAS to derive the maximum benefit from engaging with patients and the public in meaningful ways.

1.5 Delivery of the strategy will be overseen by the Patient & Public Involvement Committee, which will report to the Improving Patient Experience Committee. An annual report will be submitted at the end of each financial year to the Quality Governance Committee.

2. Five Year Forward View

2.1 NHS England's Five Year Forward View sets out a clear direction for the NHS. There is a strong emphasis on partnership working and patient and public engagement throughout this document.

2.2 The Forward View notes the improvements made in the NHS in recent years, including the increase in patient satisfaction levels. However, it notes that quality of care can be variable, preventable illness is widespread, and health inequalities deep-rooted. It highlights that patients' needs are changing, new treatment options are emerging, and that there are particular challenges in areas such as mental health, cancer and support for frail older patients.

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2.3 The Forward View emphasises the importance of prevention and public health, and sets out plans for national action on obesity, smoking, alcohol and other major health risks. In future, patients gain greater control of their own care and that the NHS will work more closely with voluntary organisations and local communities.

2.4 Across the NHS in future, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Improvements will be made in how patients interact with the NHS.

2.5 This strategy takes into account the key elements of the Forward View and reflects the priorities identified within it, particularly focusing on patients having more control over their own care, having opportunities to provide feedback and engage in a variety of ways, and strengthening the Trust's engagement with local communities and voluntary sector organisations.

3. Purpose and Values

3.1 The Patient Engagement Strategy has been built on the foundation of the Trust's purpose and values. The Trust's purpose is to care for people in London: saving lives; providing care; and making sure they get the help they need.

3.2 The Trust's values state that, in everything we do, we will provide:

- **Care**
  Helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

- **Clinical excellence**
  Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

- **Commitment**
  Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; Learning and growing to deliver continual improvement.

3.3 Engaging with patients and the public in a meaningful way; listening to their feedback, involving them in their care and in the Trust's activities, will demonstrate our commitment to these values.

4. Caring for the Capital

4.1 The Trust's five-year strategy, Caring for the Capital, was published in 2014/15.

4.2 Caring for the Capital outlines some of the challenges facing the LAS and how these will be addressed, as well as identifying ways of capitalising on the many strengths of the organisation.

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4.3 It highlights the quality issues identified in other studies and reports, such as the Francis Report which exposed distressing examples of poor care at Mid Staffordshire and called for NHS organisations to ensure that patients are at the heart of what they do. Through the Francis Report's recommendations, the LAS was reminded of the importance of a positive, open culture where issues raised by patients or staff were listened to, addressed and resolved.

4.4 Some of the challenges for patient engagement are highlighted in Caring for the Capital. Over eight million people live in London, with many more coming into the city to work or visit every day; over 150 languages are spoken; the population is transient; there are extremes of wealth and poverty; and significant variations in quality and health outcomes.

4.5 Caring for the Capital summarises Sir Bruce Keogh's review into urgent and emergency care, which made a series of recommendations for improvement. These include the need to provide highly responsive, effective and personalised services outside of hospital where possible, minimising disruption and inconvenience for patients and their families.

4.6 Sir Bruce Keogh's report outlines five key elements for the future of urgent and emergency care services. These include providing better support for people to self-care, and to help them get the right advice in the right place. These elements of the report will be met by continuing and extending the Trust's public engagement activities, so that information can be provided to patients first-hand by LAS staff.

4.7 Caring for the Capital notes recent changes in the health needs and expectations of Londoners. Demand is increasing, there are constant changes in the make-up of London's population, and many residents do not speak English as their first language. It suggests that long term campaigns to educate people on London's health services do not achieve the desired outcomes, as many people have moved on.

4.8 Public health challenges such as obesity and mental illness are increasing in London, and the Trust is focusing its attention on these conditions as clinical priorities. Other groups of patients with increased numbers are those with chest pain, dyspnoea (difficulty in breathing) and alcohol-related calls. The Trust's public engagement activities enable staff to engage with these groups of patients and offer advice about accessing NHS services and managing their own conditions.

4.9 Caring for the Capital highlights the Trust's intention to listen to patients and use their feedback and experiences to improve the services we provide. We will do this by:

- Increasing the amount of patient experience information we collect.
- Continuing and extending our public engagement programme of activities, targeting specific communities.
- Engaging with groups of patients and patient representatives on strategic decisions and changes to the service.

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These activities are all reflected in the action plan, which can be seen in the appendix.

4.10 The Trust's clinical priorities are patients requiring emergency care, urgent care, who have mental health problems, the frail elderly, those with long-term conditions and people who are at the end of their lives.

4.11 The strategy will be shown to have been successful when, in 2020, it can be demonstrated that:

- Patient feedback is positive and shows that they value the care and treatment received.
- Patients have a strong voice within the Service and are shaping its discussions and decisions.

5. Quality Improvement Plan

5.1 The CQC inspection report in 2015 included positive observations of patient involvement and engagement across the Trust.

5.2 The Quality Improvement Plan arising from the inspection ("Moving Forward Together") includes elements that will require patient engagement, in the Achieving Good Governance and Improving Patient Experience workstreams. These are:

- Achieving Good Governance: ensuring patients have access to the right information so they know how to feedback complaints or compliments about the Service. The project will also establish systems to gain feedback on the complaints process to make sure this is clear and easy to use. The ways in which complaints feedback is fed into Service committees, so that we learn from those experiences, will be reviewed.

- Improving Patient Experience: there are three key improvement projects under this theme that will collectively improve the experience of LAS patients. They relate to improving the Patient Transport Service, ensuring the service meets people's needs and improving response times. There are projects within these three key areas which will enable the Trust to demonstrate improvements to a range of patient groups.

6. Other key priorities for patient and public engagement

6.1 In addition to the areas of improvement identified in the previous sections, there are a number of other key priorities for patient engagement between now and 2020. These are reflected in the action plan, which is an appendix to this document.

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6.2 The LAS has a good record of engaging with patients and the public. It has an active and engaged Patients' Forum, an independent lay organisation that continuously reviews the work of the LAS and the wider urgent and emergency care system from the point of view of service users, carers and the public. The Patients' Forum acts as a "critical friend" of the LAS and are regular attendees at a range of committees.

6.3 A wide range of other methods of engagement are also used, including focus groups and surveys, and events involving a partnership reference group and 10,000 'members' who have taken an interest in getting involved in the LAS.

6.4 The Trust also runs a programme of public and community events (approximately 60 per month across London). These activities are co-ordinated centrally and reported within the Trust's committee structure. Over 1,000 staff have expressed an interest in volunteering to take part. Each event is evaluated and feedback sought.

6.5 The Patient & Public Involvement (PPI) team is made up of four staff and one head of department. These resources, along with the non-pay budget already allocated for this area of work, will be sufficient to deliver the strategy. Therefore no additional financial or human resources are required at present. If new activity or priorities are identified during the course of this strategy, additional resources will be applied for at that time, in line with the Trust's existing processes and procedures.

6.6 The Trust's existing activities will be strengthened and developed, taking into account the increased external requirements to involve patients in service change and the expectation that patient feedback will be triangulated with other sources of information and lead to change. Information about patient engagement activities and the feedback received will be communicated regularly throughout the LAS through the Routine Information Bulletin, both to increase awareness and to share positive stories and examples of engagement.

6.7 The Trust will continue to engage meaningfully with patients so their views influence improvements in patient experience. It will ensure that patients will have a stronger voice in influencing service changes and strategic decision-making, as well as decisions about their care as individuals.

6.8 The Trust will ensure that the Board and senior leadership commit to changing the culture of the organisation to think about patient engagement in a different way: "nothing about us without us".

6.9 The Trust will continue to respond to external requirements for patient engagement, working in partnership with other organisations, e.g. emergency departments, the other blue light services and commissioners, to ensure the best value for money and to avoid duplication. The LAS will learn what works well from the perspective of other organisations, in order to derive the maximum benefit from patient engagement activities.

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6.10 Patient engagement activities led by different teams within the organisation (e.g. the PPI team and the First Responder team) will be brought closer together in a shared action plan. This will enable the LAS to demonstrate its commitment and developments in the area of patient engagement in a more cohesive way.

7. Standards for patient engagement

7.1 Patients, carers, and members of public who use the London Ambulance Service, or will potentially use it, are defined as the community served by the LAS. Other stakeholders, including community organisations and statutory bodies, also fall within the scope of people who are part of the LAS community.

7.2 The Trust will foster a planned and strategic approach to involving patients and members of the public in service design or re-design projects. Projects will set out the purpose and remit for patient engagement at an early stage in the plan, and colleagues leading on change or improvement projects will be guided on the levels of patient and public involvement and engagement that represent best practice.

7.3 The Trust will ensure that traditionally excluded people will be supported to participate as patient representatives and in engagement events. This will be delivered through existing partnerships such as Healthwatch groups across London, the LAS Patients' Forum, the Partnership Reference Group and other specialist voluntary sector organisations supporting people from hard to reach communities.

7.4 Patients will be involved at an individual level, an organisational level and at a public level. These levels of engagement are described in the following sections.

8. Patient engagement at the individual level

8.1 At an individual level, the Trust aims for patients to be involved in their own care and treatment, and for their carers to be involved and informed as appropriate. The Trust will continue develop and embed a culture of involving patients in decisions about their care and treatment.

8.2 Carers are a vital source of support for patients, and can play a key role in providing information. The Trust will support staff to ensure they have the competencies to involve both patients and carers in clinical decision making.

8.3 The opportunity for patients to give the Trust feedback is one element of involving them in their care and treatment. The Trust has existing mechanisms for raising concerns and making complaints, via the Patient Experiences Team, and for expressing their thanks, through the Communications Team. The Friends & Family Test is available for See & Treat patients and Patient Transport Service patients. Surveys are targeted at specific patient groups for various initiatives and developments.

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8.4 The Trust will continue to seek opportunities to elicit information about patients' views and experiences, and involve them as individuals. This will build on the existing methods of involving individuals by hearing their stories at Trust Board meetings, and by inviting them to speak about their experiences at events and conferences.

8.5 Individuals may be involved in the Trust in a variety of other ways, e.g. by becoming a community first responder, or signing up for the GoodSAM app so they can contribute directly to patient care.

9. Patient engagement at the organisational level

9.1 Organisational level involvement is about patients and members of the public being welcomed into the organisation to ensure involvement in programmes and projects. Involvement at this level includes membership of Trust committees and groups. A number of groups and committees already have patient representatives, and the Trust intends to extend this level of involvement.

9.2 The Trust is committed to maintaining and increasing this level of public participation. Each involvement opportunity should be planned and supported, with the flexibility to enable all to participate without barriers. Where barriers to participation exist by virtue of any of the protected characteristics listed in the Equality Act 2010, the Trust will take action to overcome these.

9.3 The LAS will ensure that patient involvement activities will lead to improved patient experience, and that this can be demonstrated through evidence.

9.4 Engagement at the organisational level includes working with other organisations on joint activities, such as other health partners and the blue light services, and through initiatives such as the community defibrillator and emergency responder programmes.

10. Patient engagement at the public level

10.1 The Trust's intention for engagement at a public level is to emphasise its commitment to looking outside the boundaries of the organisation for opportunities to involve and engage. As the only pan-London NHS Trust, the LAS has a significant contribution to make to London-wide health strategies, and to make connections between projects and initiatives in different parts of London.

10.2 At a formal level, the LAS has a role in participating in pan-London (e.g. Greater London Authority) and local (e.g. Clinical Commissioning Group) committees and groups. The Trust will ensure there is a coherent and systematic approach to London-wide and borough-level developments which impact on the LAS, or where LAS involvement is required.

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11. Monitoring and evaluation

11.1 Monitoring of the delivery of the strategy will be overseen by the Patient & Public Involvement Committee, which meets quarterly. In turn, the PPI Committee will report quarterly to the Improving Patient Experience Committee.

11.2 An annual report will be submitted at the end of each financial year through PPI Committee and Improving Patient Experience Committee to the Quality Governance Committee and Trust Board.

11.3 The action plan for the year 2016-17 is attached as an appendix. This comprises actions from all the sources identified above, actions carried forward from the previous plan, and introduces elements from the work plan of the First Responder team.

11.4 Each item on the plan will be reviewed quarterly by the PPI Committee, and assessed against the intended outcomes. Any causes for concern will be discussed and remedial action agreed by the PPI Committee, and will be escalated to the Improving Patient Experience Committee as appropriate.

Margaret Luce
Head of Patient & Public Involvement and Public Education
June 2016

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Appendix: Patient Engagement Action Plan 2016-17

Number	Action	Progress & Assurance	Outcome	Timetable	Responsible
1	Demonstrate that action is taken by the Trust as a result of patient experience data and evidence.	• Source data from e.g. Friends & Family Test results, survey and focus group feedback, community outreach work, Healthwatch groups, social media, complaints and incidents.	Changes made and/or actions taken as a result of patient experience data collated, included in reports and published as appropriate.	Quarterly	PPI Team / Patient Experiences Team
2	Increase information-sharing and joint patient engagement opportunities with partner organisations such as local health providers, Healthwatch organisations, local authorities and commissioners.	• Explore and initiate opportunities for information-sharing and partnership working with a range of organisations, e.g. LFB and Met Police through Blue Light Collaborative. • Develop relationships with local Healthwatch groups, including membership of the Partnership Reference Group and local engagement via Stakeholder Engagement Managers.	Evidence of joint working with partners across the NHS and other agencies, leading to improved relationships and avoidance of duplication of effort.	Scoping April - Sept 2016 Then ongoing	PPI Team / Stakeholder Engagement Managers / Stakeholder Comms. Team
3	Annual report to Quality Governance Committee and Trust Board	• Annual report produced and submitted through Trust committees to Board.	Annual report submitted and noted, containing key activities and achievements from the previous year.	April / May each year	PPI Team (ML)
4	Rename Foundation Trust membership group (to "Friends of the LAS") and re-engage with them.	• Approval gained of new name and Terms of Reference. • Evidence of engagement through e.g. newsletters, events and invitations to participate in patient engagement activities (e.g. patient panels / representatives on Trust committees).	Successful handover of FT membership information from Governance Team to PPI Team. Relationship with members / "Friends of the LAS" maintained and ongoing commitment secured.	April- July 2016	PPI Team / Governance Team

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Number	Action	Progress & Assurance	Outcome	Timetable	Responsible
5	Explore opportunities to develop LAS volunteers (e.g. community first responders) and increase their role as 'LAS ambassadors' in their areas.	• Evidence of discussions with Head of Community First Responders and other interested parties. • Submit proposal for discussion at PPI Committee and First Responder steering group.	Increased capacity to engage with local communities. Increased engagement of CFRs, and enhancement of their role.	April-Oct 2016	PPI Team / Community First Responder Team
6	Scope involvement with Patient Navigator programmes.	• Scoping paper produced. • Submit bid to NHS England. • Pilot project developed in line with resources available. • Evidence of benefits collected and reported.	Improved patient outcomes for selected patient group (e.g. frequent callers). Improved joint working with partner agencies.	April-Oct 2016	PPI Team / Frequent Caller lead
7	Identify opportunities to include patients and patient stories in staff training.	• Evidence of discussions with education providers and consideration given to inclusion of patients in development and delivery of training (e.g. sickle cell)	Staff benefit from hearing patient stories first-hand and being able to ask questions. Content of staff training improved. Improved joint working with partner agencies.	Ongoing	PPI Team / Education & Development team.
8	Patient engagement in service change, service delivery, design and redesign.	• Evidence of patient involvement in Quality Improvement Plan projects. • Promotion by Board/ELT to encourage project leads to include patients in project structure and strategies. • Approval of Patient Engagement Strategy.	Ability to provide good quality examples of patient engagement, leading to positive external perception. Projects and developments will benefit from patient engagement and statutory requirements will be met.	Ongoing	Executive Leadership Team leads / PPI Team

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Number	Action	Progress & Assurance	Outcome	Timetable	Responsible
9	Engage with Partnership Reference Group	• Evidence of two events per year. • Evidence of information distributed between events.	Key partner organisations (Healthwatch and relevant voluntary sector groups) informed of LAS developments. Improved ongoing relationships with those groups.	Biannually	PPI Team / Stakeholder Comms. Team / Stakeholder Engagement Managers
10	Patient representatives on assurance committees.	• Evidence of patient representatives on key committees.	Trust will meet statutory requirements and other external standards. Benefits realised of good quality patient engagement in discussions and decision-making.	April-June 2016	PPI Team / Corporate Affairs / Chairs of key committees
11	Provide information, advice, support, guidance and materials to staff involved in public engagement work on behalf of the Trust.	• Evidence of patient engagement activity. • Evaluation of activities and feedback provided to staff and their managers. • High level of staff engagement.	Large number of opportunities to engage with the public locally. Staff support and recognition leading to improved staff satisfaction and retention. Positive impact on external and internal reputation. Key information provided to wide range of community groups and individuals.	Ongoing	PPI Team / staff volunteers

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Number	Action	Progress & Assurance	Outcome	Timetable	Responsible
12	Proactive LAS contribution to multi-agency road safety, knife crime and careers events and activities.	• Evidence of involvement in knife crime, road safety and careers events. • Development of marketing materials for careers events	Reduction in knife crime / stabbing / RTC incidents attended by the LAS. Ongoing attendance at careers events and activities leading to successful recruitment. Improved partnership working and relationship-building with key statutory and voluntary sector organisations. Positive reputation externally and in the media.	Ongoing	PPI Team / Recruitment Team / staff volunteers
13	Run Public Engagement Staff Development Programme	• One course with 12 delegates per year.	Staff appropriately trained and equipped to undertake patient engagement activities. Improved staff retention due to investment in development. High quality patient engagement work leading to positive feedback and good reputation externally and with community groups.	October each year	PPI Team with support from Comms., Operations and other teams
14	Roll out use of GoodSAM app to the wider general public	• Identify appropriate individuals to target with GoodSAM app. • Promote use of GoodSAM with those individuals. • Link with other groups and activities, e.g. when relevant training has been passed.	Increased numbers of people downloading and using the app. Evidence of use of app leading to improved patient outcomes.	2016 – 2017	First Responder team

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Number	Action	Progress & Assurance	Outcome	Timetable	Responsible
15	Review list of LAS staff who are Heartstart trainers	• Contact individuals on the current Heartstart list and establish whether they are still operating as Heartstart trainers. • Ensure any update training is provided as necessary. • Where staff no longer wish to take part in Heartstart training, recover any LAS equipment relating to this. • Re-launch for Restart the Heart Day (18th October)	Up to date list of staff with appropriate training will maximise the Trust's contribution to Heartstart activities. More lives saved.	October 2016	First Responder team
16	Increase support and management of Community First Responders	• Effective collaboration with St John Ambulance. • Improve retention of CFRs by reviewing initial and refresher training, involving them in other activities and providing increased support from LAS (First Responder team and Operations management teams).	CFRs retained and appropriate training provided. Increased support from LAS leading to low turnover. Increased ability/capacity for LAS to respond to incidents appropriate for CFRs.	June 2016 to March 2017, then ongoing	First Responder team
17	Increase support and management of Emergency (blue light) Responders	• Increase capacity of ERs by providing new vehicles and increasing staffing. • Explore possibilities of internal/external recruitment to ER scheme. • Review training requirements and develop internal trainers to deliver.	Increased ability/capacity for LAS to respond to incidents appropriate for ERs. ERs appropriately trained and supported.	June 2016 to March 2017, then ongoing	First Responder team
18	Consolidate benefits of Defibrillator Accreditation Scheme and Defibs in Public Places	• Review membership of Accreditation Scheme and link with new requirements. • Review effectiveness of both schemes and ensure benefits can be demonstrated. • Review performance reporting.	More high profile organisations will sign up to DAS. Benefits of public access defibs demonstrated.	April 2016 – March 2017, then ongoing	First Responder team

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London Ambulance Service **NHS**
NHS Trust

Report to:	**Trust Board**
Date of meeting:	**26th July 2016 2016**
Document Title:	**Workforce Race Action Plan**
Report Author(s):	**Melissa Berry (Interim Equality & Inclusion Manager)**
Presented by:	**Mark Hirst (Interim Director of Workforce)**
Contact Details:	**Mark.hirst@lond-amb.nhs.uk**
History:	**Workforce and Organisational Development Committee; Executive Leadership Team**
Status:	***For discussion and approval***
Background/Purpose	

The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015. It was included in the NHS standard contract 2015/16.

The main purpose of the WRES is to help local and national NHS organisations to review their data against the nine WRES indicators. Enabling them to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff, and to improve BME representation at the Board level of the organisation.

LAS submitted the baseline WRES data in July 2015 however no action plan was provided to accompany this and very few initiatives have been delivered on the BME staff agenda in the last twelve months.

Analysis of the available evidence demonstrates a prolonged historical trend of the LAS workforce under representing the BME population it serves, with the senior management team also under representing the BME workforce.

A new and robust action plan is proposed (see section 8), setting out a number of incentives that, over the next twelve months will bring about the change required to make improvements around the nine WRES indicators.

To address these issues, the LAS will need to consider allocating significant resources, including financial investment, to the Equality and Inclusion Team. This journey should not be seen as a short term one, as the starting point means that it will be a long road for the LAS. However, research demonstrates that the benefits to the LAS of increasing diversity in the workforce and leadership would include improved innovation and effectiveness.

The LAS is likely to be under a microscope, including from the CQC, as the current data shows that a great deal of work needs to be done.

Action required
ELT is asked to discuss and agree the actions and associated dates, for submission to the DH/NHS England as part of the WRES return. The actions will be submitted to the board for final agreement on Monday 18 July. They will then be submitted to the DH/NHS England on 01 August
Key implications
The benefits can be considerable for staff, for organisational finances and productivity and above all patient care. Simon Stevens NHS England CEO stated that 'The chronic lack of non-white faces in senior positions meant the NHS was missing out..;. Yet diversity in leadership is associated with more patient centred care, greater innovation, higher staff morale and access to a wider talent pool'. Actions will need to be implemented as soon as possible in order to improve and impact positively on the data collation for the 2016/17 submission. Key to progress this will be learning from the growing examples of good practice across the NHS.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

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Workforce Race Equality Action Plan 2016-2017

Foreword

The Five Year Forward View set out a direction for travel for the NHS which depends on ensuring the NHS is innovating, engages and respects staff, and draws on the immense talent in our workforce.

The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME staff in the NHS, so this is an issue for patient care, not just for staff. Yet it is strikingly clear that the NHS still has an immense amount to do to genuinely act on this insight. The lessons of previous efforts to tackle this challenge show that a focussed natural and local effort will be essential if we are to make the progress we need.

That is why, although we hope and expect NHS organisations will make the changes the research evidence and best practice suggest are needed, the Equality and Diversity Council- representing the major national organisations in the NHS – proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

The “business case” for race equality in the NHS, and for the Workforce Race Equality Standard, is now a powerful one. NHS England, with its partners, is committed to tackling race discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients.

We cannot afford the cost to staff and patient care that comes from unfairness in the appointment, treatment and development of a large section of the NHS workforce. We also know that research shows that diverse teams and leaderships are better for innovation and increase the organisation effectiveness the NHS needs. We know that we do best when healthcare organisations' leadership broadly reflects the communities we serve.

I welcome the support the Workforce Race Equality Standard has received and look forward to seeing the changes it seeks to achieve.

Simon Stevens
CEO NHS England

Workforce Race Equality Action Plan 2016-2017

1. Workforce Race Equality Standard Action Plan 2016 -2017

1.1 The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a wide range of NHS organisations across England. It was included in the NHS standard contract 2015/16, and NHS trusts produced and published their WRES baseline data in July 2015.

1.2 The main purpose of the WRES is to help local and national NHS organisations to review their data against the nine WRES indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff and to improve BME representation at the Board level of the organisation.

2. The NHS Constitution and the WRES

2.2 The NHS is founded on a core set of principles and values that bind together the diverse communities and people it serves – the patients and public – as well as the staff who work in it. The NHS Constitution establishes those principles and values of the NHS across England. It sets out the rights, to which all patients, communities and staff are entitled, and the pledges and responsibilities which the NHS is committed to achieve in ensuring that the NHS operates fairly and effectively. Working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.

3. The WRES indicators

3.1 There are nine WRES indicators, which are set out in full in section 5.

3.2 Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Boards.

3.3 The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

3.4 Based on feedback from the WRES baseline data returns and from engagement with the NHS, including via regional NHS WRES workshops conducted during 2015/16, the wording for two of the WRES indicators has been revised.

3.5 WRES Indicator 1 now asks for the percentage of BME staff in each of the Agenda for Change bands and very senior management (VSM) (including executive Board members), as opposed to just in bands 8a-9 and VSM. This will help organisations to identify career progression blockages that surface within bands 1-7, in addition to potential blockages within the senior management bands.

3.6 WRES Indicator 9 now requires the percentage difference between the organisations' BME board voting membership and its overall BME workforce. The previous indicator

9 was vague and focused upon comparison of the Boards' BME representation with the BME population served. It is widely acknowledged that the 'population served' boundaries for many NHS organisations are not always clear. Many organisations cover a number of regions, or parts of regions. The revised indicator is based upon the goal of organisations moving towards having workforces that are representative of the local populations served, and Boards that are reflective of those workforces.

4. NHS Contract for Providers

4.1 Since April 2015, the WRES has been included in the NHS standard contract for providers. The contract requires almost all providers of NHS services (other than primary care) to address the issue of workforce race inequality by implementing and using the WRES. The 2016/17 NHS standard contract states the following in relation to the WRES:

4.1.1 The full-length Contract (SC13.5-6) requires providers to implement the national Workforce Race Equality Standard (WRES).

4.2 To monitor progress against the WRES, NHS England is seeking approval for a new Information Standard which will, in time, mandate WRES data submissions by providers. In the meantime, Trusts are being strongly encouraged to report during 2016/17 using a WRES report template and publishing this on their websites. The next WRES return was originally due in 01 July 2016. This has been extended nationally to 01 August 2016.

5. The Workforce Race Equality Standard indicators

	Workforce indicators For each of these four workforce indicators, compare the data for White and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for White and BME staff
9.	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator

6. Scope

6.1 This document sets out the current position for the London Ambulance Service NHS Trust (LAS). Analysis of the available evidence demonstrates a prolonged historical trend of the LAS workforce under representing the BME population it serves, with the senior management team also under representing the BME workforce.

6.2 LAS submitted the baseline WRES data in July 2015 however no action plan was provided to accompany this and only a limited number of initiatives have been delivered on the BME agenda in the last twelve months.

6.3 A new and robust action plan is proposed (see section 8), setting out a number of incentives that, over the next twelve months will bring about the change required to make improvements around the nine WRES indicators.

6.4 To address these issues, the LAS will need to consider allocating significant resources, including financial investment, to the Equality and Inclusion Team. This journey should not be seen as a short term one, as our starting point means that it will be a long road for LAS. However, research demonstrates that the benefits to the LAS of increasing diversity in the workforce and leadership would include improved innovation and effectiveness.

6.5 The LAS is likely to be under a microscope, including from the CQC, as the current data shows that a great deal of work needs to be done.

7. Transparency

7.1 Availability of data

7.1.1 Equality and diversity activities are heavily reliant on data. Unfortunately, the data the trust will need in order to report on the nine performance indicators has significant gaps at present. For example, recruitment data is only available from December 2015, following the introduction of a robust recruitment system (TRAC). There is also currently no data available for training with regards to BME staff, so the LAS is unable to report on indicator 4 at all.

7.1.2 Previous National Staff Survey results have yielded minimal responses from employees who have identified themselves as being from a BME background, resulting in a small BME response rate. At LAS we have 601 members of staff that identify themselves as being BME. In 2015, 180 respondents identified themselves as BME, while only 17 did so in 2014.

7.1.3 The London Ambulance Service NHS Trust is committed to working from a position of transparency, accepting that the current position for BME staff is a challenge and requires significant improvement in order to achieve better outcomes for BME staff and the communities we work with going forwards. We are committed to working with all staff, including BME staff groups, local unions and other organised staff groups in achieving improvements.

7.2 WRES and Care Quality Commission inspections

7.2.1 The WRES is designed to prompt, and where necessary require, inquiry and root cause analysis of the differences in the WRES indicator data for BME and White staff.

7.2.2 The WRES indicators are difficult to 'game' and the cultural challenges that the WRES unearths (bullying culture, blame culture, 'club' culture) are ones that all organisations proclaim they wish to tackle in the interests of patient outcomes and organisational performance.

7.2.3 Inclusion of the WRES in Care Quality Commission (CQC) inspections has therefore been deemed appropriate and necessary.

7.2.4 From April 2016 onwards, progress on the WRES will be considered as part of the "well led" domain in CQC's inspection programme for all NHS trusts and independent healthcare providers contractual obliged to carry out the WRES. In 2015-16 the CQC piloted its approach to using the WRES in a number of their comprehensive inspections of NHS Trusts and independent healthcare providers. In particular, the organisation's completed WRES Reporting Template and accompanying action plan were analysed as part of the evidence used in the inspections. Providers inspected are also asked how they were addressing any issues arising from their respective WRES data and a variety of methods were tested to engage BME staff – so the data is 'triangulated' by qualitative findings from both providers and employees.

7.3 CQC recommendations and Quality Improvement Plan (QIP)

7.3.1 The CQC, following the 2015 inspection of the Service, made the following recommendation:

"Review trust equality and diversity and equality of opportunity policies and practice to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas"

7.3.2 In response to the CQC's recommendation, the Trust's Quality Improvement Plan (QIP) includes 5 objectives related to equality and diversity. These are summarised in the table below, along with some proposed amendments. Unfortunately, the Trust has been without an Equality and Inclusion manager for some time and as a result, some deadlines have been missed and support is therefore also sought for revised time scales.

Current Action	QIP Due Date	Proposed amended action	Proposed amended Due Date	Proposed Lead
To undertake baseline assessment against the Equality Delivery System 2 and Workforce Race Equality Standard	March 16	Workforce Race Equality Standard with associated action plan, agreed by the Board	1 Aug 2016	E&I lead
To review current recruitment and promotion practices to ensure best practice and compliance with legislation requirements	Q1	Take a deep dive into why there is currently a difference between the % of shortlisted staff from BME backgrounds and the % of appointed staff from BME backgrounds. Reporting should be established on a monthly basis and reviewed at the workforce and OD committee.	1 Dec 2016	E&I lead Head of recruitment Workforce lead
To review current recruitment and selection training attendance and deliver recruitment master classes	Q2	Mandate and roll out recruitment and selection training for all staff on recruitment panels, including refresher training every 2-3 years for panel chairs	1 Dec 2016	E&I lead
Roll out equality and inclusion mandatory training followed by regular refreshers for all line managers	Q1, Q2, Q3, Q4	To review the equality and inclusion training and have a plan of action to roll out training, followed by regular refreshers for all line managers	1 Feb 2017	E&I lead
Develop local links with BME community groups, schools and support organisations	Q2	Make links with the patient forum. Work towards developing links with 4 community BME organisations over the next twelve months	Rolling Programme with separate time line date	E&I lead

7.4 Risks

7.4.1 The WRES needs to have clear ownership, and sufficient capacity is secured to deliver the WRES agenda. There is a risk we won't deliver on the QIP which carries a risk in terms of the existing special measures in place.

8. WRES Action Plan

Indicator	Data for reporting year 2014-2015	Data for previous year 2013-2014	Narrative the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date
Workforce Representation						
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1	0.72 : 1	BME Staff at LAS are proportionately over-represented in Bands 2 and 3 by 20% and under-represented in bands 5 upwards including VSM.	Ensure all staff undertake a PDR and appraisal; this will enable managers to support BME staff to identify any training needs and further their careers.	Julia Smyth, Head of People and Organisational Excellence	March 2017
				Clinical Team Leader programme for band 6 Team Leaders to include equality and inclusion training to assist managers in managing all staff effectively and inclusively	Julia Smyth, Head of People and Organisational Excellence	January 2017
				Talent Management programme (bands 2-7) - with a focus on identifying BME talent.	Julia Smyth, Head of People and Organisational Excellence	January 2017
				Empowerment programme for BME staff to support BME staff in their current roles. Review stand-down opportunities to enable frontline BME staff to undertake BME specific activities including training e.g. paying overtime to staff who attend BME events, or provide backfill.	Equality and Inclusion lead	March 2017
				Review recruitment process and look at ways of reducing the gap between shortlisted and appointed – recruitment and selection training needs to be mandated for staff on recruitment panels, including refresher training every 2-3 years for panel chair.	Julie Cook, Head of Recruitment	October 2016

				Aspire to having a trained pool of BME staff to be involved in all future appointments at band 8a and above, so that recruitment panels are more reflective of the population served, as recommend in the national WRES guidance.	Julie Cook, Head of Recruitment	October 2016
				Reverse mentoring programme, set up with Board members and senior team to mentor LAS BME staff. Aim: to empower emerging and established leadership to mutually mentor one another.	Equality and Inclusion lead	December 2016
				WRES working group set up with executive chair to monitor delivery of WRES action plan.	Mark Hirst, Interim Director of Workforce Equality and Inclusion lead	September 2016
Recruitment						
2. Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff Relative likelihood of White staff being appointed from interview compared to BME staff	3 times more likely to be appointed if you are white. Shortlisted 45% BME, Starting 22%.	Not available	Data for Dec 15 – March 16 (4 months only)	Review recruitment process, analysis data to understand the blocks and challenges to BME applicants and look at reducing the gap between shortlisted and appointed – Recruitment and selecting training needs to be mandated for staff on recruitment panels. Regular reporting every 3 months to measure and monitor establishment of progress in this area.	Data generated by Workforce Information Team, for review by Head of Recruitment.	Quarterly
				Recruitment and selection training to be mandated for staff on recruitment panels, including refresher training every 2-3 years for panel chair.	Recruitment Manager & Equality and Inclusion lead	March 2017
				Unconscious Bias training rolled out (Appendix 2)	Equality and Inclusion lead	March 2017
				Work in conjunction with the universities to develop a BME Access Programme to encourage BME applicants to apply for student Paramedic posts. Working with the university's Equality & Diversity leads and partnering with them on how to increase BME applications and	Link Tutors Link Tutors Equality and Inclusion lead	March 2017 March 2017

				success.		
				Access course to be developed for BME applicants and also to provide career opportunities for Trust staff to aid their progression, building on the good practice model developed by West Midlands Ambulance Service.	Head of Recruitment Julie Cook	April 2017
				Review and update recruitment training in line with current best practice to place greater emphasis on value based recruitment.	Head of Recruitment Julie Cook	April 2017
Disciplinary action and Performance Management						
3. Relative likelihood of White staff entering the formal disciplinary process, compared to that of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	BME 15-16 18%	BME 14-15 24%	Total Disciplinary cases 14-15 = 61 of which 13 (24%) were BME staff Total disciplinary 15-16 = 60 of which 11 (18%) were BME staff This would indicate that over the 2 years 18% of cases were brought against BME staff when they only make up	Human Resources to share an overview of this disciplinary data with line managers and to work with them to try and encourage them to address conduct issues earlier and at a more informal level where appropriate.	Tracey Watts, Senior HRM	September 2016
				Redesign disciplinary and performance management training to increase awareness of equality issues and how they relate to the disciplinary process.	Tracey Watts, Senior HRM	September 2016
				Ensure that existing 'open' disciplinary data held in the current Excel spread sheet is migrated to Electronic Staff Record (ESR) to enable a comprehensive review of to be undertaken.	Tracey Watts, Senior HRM	September 2016

			12% of the work force	To undertake more in depth analysis of the qualitative and quantitative data to identify any issues and trends by department/directorate, by profession and by band.	Chris Randall, Workforce Information Manager	October 2016
				Engage with BME staff via the BME network to gain greater understanding of this issue and seek feedback on how we can ensure that the disciplinary policy is applied consistently and fairly to all staff groups. This would include seeking feedback on: a) How well they feel the organisation deals with disciplinary matters generally. b) The main reasons they feel staff from BME backgrounds are disciplined. c) Aspects of the disciplinary processes they felt might place BME staff at a disadvantage. d) Suggested ways to improve the situation for BME staff. e) Ways to help improve the situation for managers	Equality and Inclusion lead HR Directorate	March 2017
Access to Training						
4. Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	No data	No data	As we don't have the data we have been unable to reach a conclusion on this indicator	Introduce the effective use of the Oracle Learning Management (OLM) system for the LAS.	Julia Smyth, Head of People and Organisational Excellence	October 2016
				Following the full implementation of OLM a more detailed plan needs to be developed on this indicator with timelines for ensure date and monitoring of when BME Staff access training – this indicator should report directly to the Workforce and OD Committee.	Julia Smyth, Head of People and Organisational Excellence	January 2017
				Monitor emerging training data when its becomes available to compare BME Staff accessing non-mandatory training compared to white staff, and review staff ability to undertake non statutory and	Workforce planning and performance Manager	March 2017

				mandatory training.		
				Implement positive action to encourage BME staff to apply for frontline positions, and the LAS Paramedic Academy. Ensure clear career pathways from EOC to TEAC and EAC roles.	Tina Ivanov, Deputy Director Clinical Education and Standards	January 2017
National Staff Survey Indicators						
5. KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 56% BME: 34%	White: 57% BME: 69%	1,600 eligible staff returned a completed questionnaire in 2015. The staff survey was open to all 4,585 staff. 2015 saw a reduction of 35% in the number of BME staff indicating experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months when compared with 2014. 17 respondents from BME background in 2014 180 respondents	LAS liaise with local and National Press to publicise security initiatives and the prosecutions of offenders.	Martin Nicholas LAS Security management specialist	On going
				LSMS to continue to raise awareness of support and follow up and investigate incidents of violence and abuse against staff, liaising with MPS, LAS Management, supporting staff, attending court.	Martin Nicholas LAS Security management specialist	On going
				Develop an agreed plan to increase the staff survey response rate, target to be agreed by the Workforce and OD Committee, e.g. increase response rate by 2% year on year.	Mark Hirst, Interim Director of Workforce	September 2016
				Issuing of spit kits to assist with prosecutions where individuals experience abuse, to deter abuse from members of the public and patients. All staff who have been a victim of a violent incident can access support services, LSMS to continue to raise awareness of support and follow up and investigate incidents of violence and abuse against staff.	Martin Nicholas LAS Security management specialist	On going

			from BME background in 2015			
				The organisation ensures that staff whose work brings them in to contact with NHS patients are trained in prevention and management of clinically related challenging behaviours, in accordance with NHS Project's guidance. Training is monitored, reviewed and evaluated for effectiveness.	Martin Nicholas LAS Security management specialist	October 2016
6. KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 38% BME 40%	White: 29% BME: 50%	Due to the increase in the number of BME respondents, the validity of the data has increased. As a result a reduction of 10% of BME staff indicated reporting experiencing harassment, bullying or abuse from staff in the last 12 months when compared with 2014. By contrast the	In response to the results of the 2013 NHS Staff Survey, which highlighted issues around bullying and harassment in LAS, the Senior Management of the Trust commissioned an external independent specialist organisation to carry out a review.	Cathe Gaskell Bullying and harassment specialist	October 2016
				This review has since been published and the recommendations fully accepted with a comprehensive action plan drawn up to address this.	Cathe Gaskell Bullying and harassment specialist	October 2016
				This links to the LAS Equality Objective 3 "We will act on the results of the staff survey and develop both corporate and localised actions to improve key problems identified by 2016."	Cathe Gaskell Bullying and harassment specialist	October 2016

			proportion of white staff reporting experiencing this increase by 9%. 17 respondents from BME background in 2014 180 respondents from BME background in 2015	The Trust has committed to the following actions in regards to addressing this issue in the QIP: 1. Appoint a Non-Executive Director to enhance leadership to demonstrate the Trust Board's commitment for tackling bullying & harassment 2. Design and set up staff bullying & harassment workshops to raise awareness across the organisation 3. Put in place a programme of bullying and harassment awareness training for all levels of management 4. Develop and deliver a training programme for internal bullying & harassment investigators 5. Revise the bullying & harassment policy and re-launch 6. Deliver bullying & harassment awareness sessions at a range of local forums as requested by teams and managers 7. Design and deliver an on-going specialist communication plan to raise awareness of bullying & harassment throughout the organisation	Cathe Gaskell Bullying and harassment specialist	October 2016
7. KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White: 63% BME: 42%	White: 65% BME: 9%	The percentage of BME reporting believing that the Trust provides equal opportunities for career progression or promotion has increased by 33%, this result should be treated with	BME Staff conference – to engage with BME staff and listen to BME staff experience's and set out the commitment of LAS and commitments for BME staff moving forward.	Equality and Inclusion lead	January 2017
				Working alongside local schools and Jobcentres to promote opportunities to BME communities.	Equality and Inclusion lead	March 2017
				Ensure Trust literature and imaging reflects BME communities.	Director of Strategic Communications Charlotte Gawne	March 2017

			caution given the low number of respondents in 2014. 17 respondents from BME background in 2014 180 respondents from BME background in 2015	Clear guidance on recruitment decisions (post interview/assessment centres), scoring and meaningful feedback given to candidates.	Head of Recruitment, Julie Cook	January 2017
				Listening events were directors and non-executive directors attended to hear BME staff experiences.	Equality and Inclusion lead	January 2017
				Facilitate stand-downs for frontline staff to attended networking meetings and training.		
8. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader	White: 13% BME: 25%	White: 14% BME: 29%	The percentage of BME staff reporting having in the last 12 months personally experienced discrimination at work from their manager/team leader or other colleague has reduced by 4%	Re-launch of the BME Staff network, to be given a voice in LAS and represented at key meetings. With support provided by the Equality & Inclusion team.	Equality and Inclusion lead	December 2016
				Look at why BME staff feel more discriminated against at work.	Equality and Inclusion lead	December 2016
				Hold specific listening events for BME staff with E&I lead, with Executive and Board members attending BME listening events to understand what it's like to be a BME staff member at LAS.	Equality and Inclusion lead	December 2016
				BME staff stories shared and heard by senior team.	Equality and Inclusion lead	December 2016
				Mandatory Bullying and Harassment training for all management roles and associated 360 degree feedback is planned over the coming year. A Dignity at Work Strategy is being scoped, which will include the appointment of champions at Executive and Senior Management level. The Trust is also a member organisation of Race for Opportunity and is proactively using this membership to assist with any relevant positive action initiatives.	Cathe Gaskell, Bullying and Harassment Specialist	October 2016
Board Representation						

9. Percentage difference between the organisations' Board voting membership and its overall workforce	BME: 0% Board:12%	BME: 0% Board:12%		Board seminar on WRES to be led by Yvonne Coghill and Roger Kline, NHSE Jointed WRES Programme Directors. Board level unconscious bias training.	Mark Hirst, Interim Director of Workforce Equality and Inclusion lead	October 2016
				Reverse mentoring programme, set up with Board members and senior team to mentor LAS BME staff. The benefit of this is to empowers emerging and establish leadership to mutually mentor one another.	Equality and Inclusion lead	December 2016
				Recruit a BME associate non-exec and associate exec posts to the board, as no vacancies currently exist in which to recruit a substantive BME non-exec or exec Director, this is part of the WRES national guidance	Heather Lawrence, Chair	January 2017

Appendix 1: Pay Band by Ethnicity

Staff in post by band				
Band	**BME**	**Not Known/ specified**	**White**	**Heads**
Band 2	32%	13%	55%	31
Band 3	32%	3%	65%	512
Band 4	12%	10%	77%	1065
Band 5	8%	2%	89%	2484
Band 6	9%	1%	91%	509
Band 7	10%	1%	89%	294
Band 8a	11%	3%	86%	70
Band 8B	6%	4%	90%	51
Band 8C	0%	5%	95%	22
Band 8D	0%	0%	100%	10
Band 9	0%	0%	100%	1
N/A	13%	13%	73%	15
VSM	0%	0%	100%	9
Other	33%	0%	67%	3
Grand Total	12%	4%	84%	5,076

Appendix 2: Unconscious Bias Training Explained

Unconscious bias refers to the stereotypes, both negative and positive, that exists in our subconscious and affects our behaviour.

The main purpose is to help individuals take conscious control of their actions, behaviours, and cultural contributions.

Unconscious biases are the automatic, mental shortcuts used to process information and make decisions quickly. At any given moment individuals are flooded with millions of bits of information, but can only consciously process about 40- 50. Cognitive filters and heuristics allow the mind to unconsciously prioritise, generalise, and dismiss large volumes of input. These shortcuts can be useful when making decisions with limited information, focus, or time, but can sometimes lead individuals astray and have unintended consequences in the way they deliver healthcare and behaviours.

Unconscious bias can prevent individuals from making the most objective decisions. They can cause people to make decisions based on their bias, undermine individual potential, and create a less than ideal work experience for their patients and colleagues. By understanding unconscious bias and overcoming it at critical moments, individuals can make better decisions - from finding the best talent (no matter what the background) to acknowledging a great idea (no matter who it came from) - and build a workforce and workplace that support and encourages diverse perspectives and contributions.

TRUST BOARD FORWARD PLANNER 2016

2nd February 2016

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Finance Report M9** **Report from Finance and Investment Committee** **BAF and Corporate Risk Register**	2016/17 Business and financial planning process Fleet Replacement business case	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Quality and Governance Committee – 12th January Finance and Investment Committee – 21st January	

29th March 2016

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Risk Management Strategy and Policy review** **Finance Report M11** **Report from Finance and Investment Committee**	2016/17 Business Plan	Board Declarations Report from Trust Secretary Trust Board Forward Planner Register of interests	Audit Committee – 15th February Strategy Review and Planning - 23rd February Quality Governance Committee – 15th March Finance and Investment Committee – 24th March	

31st May 2016 – 2pm

Standing Items	Annual Reporting	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Annual Report and Accounts 2015/16 including Annual Governance Statement** **Quality Account 2015/16 for approval** **Audit Committee Assurance Report** **Annual Report of the Audit Committee 2015/16** **BAF and Corporate Risk Register** **Patient Voice and Service Experience Annual Report 2015/16** **Infection Prevention and Control Annual Report 2015/16** **Annual Safeguarding Report 2015/16**	Integrated Board Performance Report Clinical Directors' Joint Report Quality Governance Committee Assurance Report Finance Report Report from Finance and Investment Committee Risk Management Strategy and Policy Review	2015/16 Business Plan - summary report	Report from Trust Secretary Trust Board Forward Planner	Audit Committee – 18th April, 19th & 31st May Board seminar - 26th April	

26th July

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Quality Governance Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M3** **Report from Finance and Investment Committee** **Workforce and Organisational Development Assurance Report**	Patient Engagement Strategy Job Cycle Time	Report from Trust Secretary Trust Board Forward Planner and 2017 dates Quality Improvement Programme Assurance Report Security Management Annual Reports: - Safeguarding - Infection Prevention Control - Patient Experience - Patient and Public Involvement and Public Education	Board seminar - 28th June Quality Governance Committee – 12th July Finance and Investment Committee – 25th July Workforce – 18th July	

4th October 2016

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M5** **Report from Finance and Investment Committee** **Report from Quality Governance Committee** **Workforce and Organisational Development Assurance Report**	Business planning 17/18 Review of 2016/17 Business Plan	Report from Trust Secretary Trust Board Forward Planner Equality Inclusion Annual Report Quality Improvement Programme	Audit Committee – 5th September Quality Governance Committee – 13th September Finance and Investment Committee – 22nd September Annual General Meeting – 27th September Workforce and Organisational Development – 26th September	

29th November 2016

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Quality Governance Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M7** **Report from Finance and Investment Committee** **Workforce and Organisational Development Assurance Report**	6 month review of business plan	Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement Quality Improvement Programme	Board seminar - 25th October Audit Committee – 7th November Quality Governance Committee – 15th November Finance and Investment Committee – 24th November Workforce and Organisational Development – 28th November	

Board Seminar	Topic
26th April 2016	**Financial and business planning 2016/17** **KPIs** **Strategic risk**
28th June 2016	**Strategy review**
6th September 2016	**Strategy – risk appetite**

25th October 2016	TBC
13th December 2016	TBC

2016 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair		2	29		31 pm		26			4	29		9.00 - 14.00
Private Trust Board (Strategy Review and Planning)	Trust Chair		23		26		28			6	25		13	9.00 - 14.00
Annual General Meeting	Trust Chair									27				14.00 - 15.30
Charitable Funds Committee	Trust Chair													
Nominations and Remuneration Committee	Trust Chair													
Audit Committee	John Jones		15		18	19 pm/ 31 am				5		7		14.00 - 17.00
Finance and Investment Committee	Nick Martin	21		24		19		21		22		24		
Quality Governance Committee	Bob McFarland	12		15		17		12		13		15		13.00 - 16.00
Workforce and Organisational Development Committee	Fergus Cass					19		18		26		28		
Quality Improvement Programme Board	Trust Chair				14	17	14	14	11	15	11	10	15	
Risk, Compliance and Assurance Group (RACAG)	Chief Executive Officer			8	11	12	3	5	16	6	3	14	15	
Improving Patient Experience Committee	Director of Nursing and Quality		16		19		29		16		18		12	14.00 - 16.00
Clinical Safety and Standards Committee	Medical Director		17		28			28		1		1		14.00 - 16.00
Executive Leadership Team (ELT)	Chief Executive Officer	Every Wednesday 9.00 - 12.00												9.00 - 12.00
Environment and Resources	Director of Finance													
Operations Board	Director of Operations													
Workforce	Director of Human Resources													

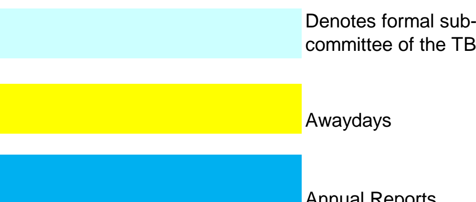
Legend	
	Denotes formal sub-committee of the TB
	Awaydays
	Annual Reports

Trust Board will take place from 1pm on 31st May 2016.

Audit Committee will take place from 9am on 31st May 2016

2017 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**31**		**28**		**25**			**1**		**3**	**28**		9.00 - 14.00
Private Trust Board (Strategy Review and Planning)	Trust Chair		**28**		**25**		**27**				**31**		**12**	9.00 - 16.00
Annual General Meeting	Trust Chair									**26**				14.00 - 15.30
Charitable Funds Committee	Trust Chair													
Nominations and Remuneration Committee	Trust Chair													
Audit Committee	John Jones		**15**		**17**	**18 pm/ 25pm**				**4**		**6**		14.00 - 17.00
Finance and Investment Committee	Nick Martin	**19**		**23**		**25**		**20**		**21**		**23**		
Quality Governance Committee	Bob McFarland	**10**		**14**		**16**		**11**		**19**		**14**		13.00 - 16.00
Workforce and Organisational Committee	Fergus Cass	**23**		**20**										
Quality Improvement Programme Board	Fergus Cass													
Risk, Compliance and Assurance Committee	Trust Chair			**9**			**6**			**5**			**5**	
Improving Patient Experience Committee	Director of Nursing and Quality		**14**		**18**		**20**		**15**		**17**		**7**	14.00 - 16.00
Clinical Safety and Standards Committee	Medical Director	**17**		**7**		**9**		**4**		**12**		**7**		14.00 - 16.00
Executive Leadership Team (ELT)	Chief Executive Officer	**Every Wednesday 9.00 - 12.00**												9.00 - 12.00
Environment and Resources	Director of Finance													
Operations Board	Director of Operations													
Workforce	Director of Human Resources													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Trust Board Register of Interest - July 2016

Name	Date	Nil declaration	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Heather Lawrence	05/04/2016		✓	Chairman Apos Medical Ltd healthcare					
Jessica Cecil	25/02/2015		✓				On the advisory board of IntoUniversity, a charity aimed at getting disadvantaged young people to university	One sister is an NHS physiotherapist who also sees patients privately; another sister is a public health reseracher at Imperial College.	
John Jones	04/02/2015	✓							
Fergus Cass	04/03/2015		✓	Book Aid International - Charity - Trustee; Hospices of Hope - Charity - Trustee; Hospices of Hope Trading Limited - Charity related chain of shops - Chair Melton Court Parking Limited: company managing parking spaces at block where I live: Director			As noted above, I am a trustee of Hospices of Hope, a charity supporting hospice care in Romania and neighbouring countries		
Nicholas Martin	24/02/2015		✓	Cambridge Guarantee Holdings (Director); A2Dominion Housing Association (Director)			Chair, City of Westminster College		
Robert McFarland	05/02/2015	✓					Trustee and Chair of the European Doctor's Orchestra.		
Theo de Pencier	04/03/2015		✓	Non-executive directorat Transport Focus					
Sandra Adams	04/02/2015	✓							
Karen Broughton	05/02/2015	✓							
Andrew Grimshaw	05/02/2015		✓	Director of LSO Consulting Ltd.					
Charlotte Gawne	17/03/2015		✓	Director – Vannin Consulting (currently a dormant IT consultancy)					
Fionna Moore	05/03/2015		✓	Medical Director, Location Medical Services.			Member Executive Committee, Resuscitation Council (UK)		
Paul Woodrow	10/02/2015	✓							
Zoe Packman	09/03/2015		✓					Honorary senior clinical fellow, Kingston University and St George's University of London	
Jill Patterson	18/02/2016		✓	Tall Poppies Management Ltd	Tall Poppies Management Ltd	Tall Poppies Management Ltd			
Andrew Watson	04/05/2016	✓							
Mark Hirst	12/07/2016		✓	Managing director of Point Clear Consulting Ltd	Managing director of Point Clear Consulting Ltd			Undertaking current interim role through Rethink Recruitment	
Fenella Wrigley	14/02/2015		✓				Regional Professional Lead for Doctors - St John Ambulance London Region		Expert Clinical Advisor to UKBA; Consultant in Emergency Medicine, Barts Health NHS Trust