



MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 27 MARCH 2018 AT 09:30-14:00 LONDON AMBULANCE SERVICE NHS TRUST, 5TH FLOOR, SOUTHERN HOUSE, WELLESLEY GROVE, CROYDON, CR0 1XG

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.30	1.	TB/17/193 Oral	Welcome and apologies To welcome attendees and note any apologies received.	HL	
09.35	2.	TB/17/194 Oral	Staff Story A staff story for the Board on the changes experienced as a result of the ARP	TB	Information
10.05	3.	TB/17/195 Oral	Declarations of interest To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	4.	TB/17/196 Attachment	Minutes of the meeting held in public on 27 February 2018 To approve the minutes of the meeting held on 27 February 2018.	HL	Decision
	5.	TB/17/197 Attachment	Matters arising To review the action schedule arising from previous meetings.	HL	Information
10.15	6.	TB/17/198 Attachment	Report from the Chair To receive a report from the Chair.	HL	Information
10.30	7.	TB/17/199 Attachment	Report from Chief Executive To receive a report from the Chief Executive (CEO).	GE	Information
STRATEGY & PLANNING					
10.45	8.	TB/17/200 Attachment	A world class ambulance service for a world class city – strategy 2018/19 – 2022-23 To approve the Trust's Strategy	GE	Decision
QUALITY, PERFORMANCE AND ASSURANCE					
11.30	9.	TB/17/201 Attachment	People and Organisational Development Committee Assurance Report	JM	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
			To receive the report of the People and Organisational Development Committee meeting on 12 March 2018.		
11.40	10.	TB/17/202 Attachment	Finance and Investment Committee Assurance Report To receive the report of the Finance & Investment Committee meeting on 13 March 2018.	FC	Assurance
11.50	11.	TB/17/203 To follow	Quality Assurance Committee Assurance Report To receive the report of the Quality Assurance Committee meeting on 20 March 2018.	RMcF	Assurance
12.00	12.	TB/17/204 To follow	Integrated Quality & Performance Report To receive the integrated quality & performance report.	LB	Discussion
12.10	13.	TB/17/205 Attachment	Board Assurance Framework and Corporate Risk Register To receive the Board Assurance Framework and the Corporate Risk Register	PH	Assurance
12.20	14.	TB/17/206 Attachment	Serious Incident Management To note declared and closed Serious Incidents.	TB	Discussion
12.30	15.	TB/17/207 To follow	Rest Break Policy Implementation Review To receive an interim report on the implementation of the new rest break policy.	PW	Discussion
GOVERNANCE					
12.45	16.	TB/17/208 Attachment	Quality Account Draft Document and Quality Implementation Plan 2018/19 To consider the quality priorities that the Trust has consulted on to include in the 2018/20 Quality Strategy and annual account	TB	Discussion
12.55	17.	TB/17/209 Attachment	Quality Improvement Plan 2017/18 To receive an update on the progress of the Quality Improvement Plan.	TB	Discussion
13.00	18.	TB/17/210 To follow	Approach to Annual Report and Annual Accounts 2017/18 To receive an update on the approach to the Annual Report and Accounts 2017/18		Decision
13.15	19.	TB/17/211 To follow	Annual Corporate Governance Review	PH	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
			To receive the annual corporate governance review.		
13.25	20.	TB/17/212 Attachment	Trust Board Forward Planner To receive the Trust Board forward planner.	PH	Information
13.30	21.	TB/17/213 Oral	Questions from members of the public	HL	Information
13.45	22.	TB/17/214 Oral	Any other business	HL	Information
13.50	23.	TB/17/215 Oral	Review of the meeting To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
14.00	24.		Meeting close The meeting of the Trust Board in public closes.	HL	
Date of next meeting: The date of the next Trust Board meeting in public is on Tuesday 24 April 2018 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD.					
Additional reports, circulated for information only: TB/17/216 Quality Report					



TRUST BOARD: Public meeting – Tuesday 27 February 2018

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

Present		
Name	Initials	Role
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Fergus Cass	FC	Non-Executive Director
Jessica Cecil	JC	Associate Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
Amit Khutti	AK	Associate Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
James Corrigan	JCn	Interim Deputy Director of Finance
Ross Fullerton	RF	Chief Information Officer
Patricia Grealish	PG	Director of People and Organisational Development
Philippa Harding	PH	Director of Corporate Governance
Benita Mehra	BM	Director of Strategic Assets and Property
Jamie O'Hara	JO'H	Director of Strategy and Communications
Apologies		
Lorraine Bewes	LB	Director of Finance and Performance
John Jones	JJ	Non-Executive Director

1. Welcome and apologies (TB/17/169)

- 1.1. The Chair welcomed all to the meeting and noted the apologies that had been received.

2. Patient Story (TB/17/170)

- 2.1. It was reported that, due to forecast inclement weather conditions, the patient who had been due to join the Board meeting to tell their story had decided not to travel and had sent their apologies for non-attendance.

3. Declarations of interest (TB/17/171)

- 3.1. There were no declarations of interest.

4. Minutes of the meeting held in public on 30 January 2018 (TB/17/172)

- 4.1. The minutes of the Trust Board meeting held in public on 30 January 2018 were approved as a true and fair record of that meeting, subject to the following amendment:

- 4.1.1. Minute reference TB/17/148 (paragraph 5.1) should reflect the fact that Michael Cornett (Sector Delivery Manager) had also joined the meeting to brief the Board on the role of the Advanced Paramedic Practitioner.

5. Matters arising (TB/17/173)

- 5.1. The actions arising from the previous meeting were noted.
- 5.2. With regard to the actions relating to the amendment of the Clinical Council's Terms of Reference and clarification of its place within the Trust's governance framework (ref TB/17/149 paragraph 6.5), it was requested that these be circulated to the Board for information once they had been through the first meeting of the Clinical Council.

ACTION: circulate Clinical Council Terms of Reference to the Board.

- 5.3. Board members requested that the dates of key Strategic Transformation Partnership (STP) meetings be circulated, together with confirmation of which Non-Executive Directors were expected to attend which meetings. When Non-Executive Directors (NED) were due to attend an STP meeting, it was noted that they should receive an appropriate briefing in advance of their attendance at these meetings.

ACTION: circulate dates of key STP meetings to the Board, setting out those which NEDs are expected to attend.

ACTION: provide briefings to NEDs attending STP meetings.

6. Report from the Chair (TB/17/174)

- 6.1. In addition to the information set out in her report, the Chair referred to the recent meeting that she and the CEO had attended with Steve Russell, NHS Improvement Regional Managing Director (London). She referred to the recognition that the Trust had received from both NHS Improvement and NHS England for its handling of winter challenges; a formal letter of thanks had been received by the Trust in relation to this.
- 6.2. The Chair also provided an oral update on the outcomes of her recent visits to various Trust sites, including ambulance stations, the Emergency Operations Centre (EOC) at Bow and the 111 Control Centre in Croydon. In addition to station visits, she noted the usefulness of visiting hospital emergency departments, as this enabled meetings with a number of different ambulance crews in a relatively short period of time. She noted that, in discussion with Trust staff, a key issue that continued to be raised was rostering, particularly the manner in which the relief rota operated. Learning from incidents was improving, but members of staff needed to be encouraged to articulate

this more readily. It was noted that it had not always been clear how the Trust had learned from incidents in the past and that steps had been taken to improve this, which would be facilitated by the use of mobile devices.

- 6.3. With regard to the issues raised by staff in relation to rostering, the CEO noted that the decision had been taken not to make any changes until after the successful implementation of the Ambulance Response Programme (ARP). A report was due to be presented to the meeting of the Board on 27 March 2018, setting out initial findings with regard to the implementation of the ARP and the proposed approach to the rostering review.
- 6.4. The Board noted the report of the Chair.

7. Report from the Chief Executive Officer (TB/17/175)

- 7.1. The CEO presented his report on progress and key issues, events and activities since the Board meeting in January, referring Board members in particular to the information provided about the Trust's Leadership Development Pathway. This had been designed to offer a range of training and education interventions for different groups of employees and managers across the Trust. A fuller briefing on this programme would be made available to Board members in due course. Consideration was also being given to the manner in which the Trust's approach to apprenticeships could be also included in the programme. Board members welcomed this co-ordinated approach to leadership and development. In response to a question about how the success of the programme would be managed, it was reported that post-course evaluations would be built into each module in order to determine their impact on the organisation as a whole as well as on the individuals participating in them.
- 7.2. Board members noted the information provided with regard to the Trust's recent operational performance and asked about its preparedness for Easter. It was noted that this had been discussed recently with NHS Improvement at the Trust's Provider Oversight Meeting and that planning was advanced and was due to be complete by mid-March. In response to a query about the pressures on the Executive Leadership Team (ELT) during March (business planning, Care Quality Commission (CQC) inspection, finalisation of annual plan and planning for Easter pressures), NEDs were reminded that this reflected the level of effort required to ensure that the Trust was in the best possible position for 2018/19. Assurance was provided that ELT members were very clear about the Trust's key strategic objectives and that they ensured that work was prioritised to meet these.
- 7.3. With regard to the work being undertaken on the Trust's strategy, it was noted that good progress had been made in key areas. NEDs requested further information about the planned implementation and governance of the strategy, once it had been approved. It was confirmed that the presentation of the strategy to the Board meeting on 27 March 2018 would include proposals with regard to the implementation of the strategy and the alignment of supporting strategies that had already been approved by the Board (for example, the People and Organisational Development Strategy and the Estates Strategy). It would also include proposals on reporting the achievement of strategic objectives and review points to ensure that the strategy remained relevant.

ACTION: ensure that the presentation of the proposed strategy to the Board incorporates proposals relating to its implementation and governance and the steps that will be taken to ensure that it remains relevant.

7.4. The Board noted the report of the CEO.

8. Business Plan 2018/20 (TB/17/176)

9. Annual Financial Plan 2018/19 (TB/17/177)

- 9.1. Board members agreed to consider together the two reports which provided an update on the process (including the timescales and the current actions) for the completion of the 2018-20 Business Plan and an update on the development of the Financial Plan for 2018/19 (including a high level assessment of the overall savings requirement) respectively. The Chair noted that the productivity and efficiency programme required by the Trust in 2018/19 would be significant and that the Board would require assurance that the proposed programmes to support this would be deliverable. She emphasised the importance of focussing on the delivery of high quality services, which met the appropriate standards, within the financial envelope available.
- 9.2. Board members noted the revised control total and agency ceiling that had been issued to the Trust by NHS Improvement earlier that month. Consideration was given to the allocation of sustainability and transformation funding and the calculation of this. It was noted that national calculations had been made by NHS Improvement.
- 9.3. FC, as Chair of the Finance and Investment Committee, provided the Board with an update on the discussions that had been held at an extraordinary meeting of that Committee, which had been convened with the express purpose of reviewing the Trust's draft Annual Financial Plan and Business Plan. The Committee had considered the key risks associated with the delivery of the Annual Financial Plan to relate to the need to achieve an agreement between the Trust and Commissioners regarding activity levels and the value of the 2018/19 contract, the need to determine the level of the resources required to deliver the Trust's new operating standards in 2018/19 and the need to confirm that the Trust would be able to deliver the required efficiency savings to achieve its control total. Assurances received by the Committee related to the basis of the projection of activity levels in 2018/19 and the arrangements for establishing departments' budgets and efficiency programmes to manage delivery of financial and savings targets.
- 9.4. The Board noted the progress updates provided in both reports and the considerations of the Finance and Investment Committee. It was noted that the draft Annual Financial Plan was due to be submitted to NHS Improvement by 9 March 2018. Board members confirmed that they were content for this submission to be approved by the Chair and the CEO.

ACTION: Chair and CEO to approve submission of the draft Annual Financial Plan 2018/19 to NHS Improvement

10. Risk Management Strategy and Policy (TB/17/178)

- 10.1. TB presented the report which requested the Board's approval of a Risk Management Strategy and Policy to provide the overarching principles, framework and processes to support managers and staff in the management of risk, by ensuring that the Trust was able to deliver its objectives through the identification and management of risks, enhancing opportunities and creating an environment that added value to on-going operation activities.

10.2. It was noted that the proposed Risk Management Strategy and Policy built upon the Risk Management Framework that had been approved by the Audit Committee in November 2017, according to authority that had been delegated to it by the Board. Board members welcomed the significant progress that had been made in this area. It was noted that further work would be required with regard to the implementation of the Strategy, in order to ensure it was adopted sustainably throughout the Trust.

RESOLVED:

10.3. The Board resolved to approve the adoption of the proposed Risk Management Strategy and Policy, subject to a number of required minor drafting amendments to be approved by the Chief Quality Officer.

11. Data Quality Strategy (TB/17/189)

11.1. TB presented the report which provided the Board with an update on the delivery, progress made and strategic direction of data quality in preparation for the next CQC well-led inspection.

11.2. The draft Data Quality Strategy had been discussed by the Audit Committee at its meeting on 12 February 2018 and the Committee had considered that further work was required with regard to the clarity and strategy of the document, particularly in relation to the proposed governance framework for data quality and how the strategy would prioritise the data areas most in need of attention. Further work was, therefore, being undertaken with regard to a diagnostic exercise and the development of the Trust's approach to health informatics.

11.3. Board members emphasised the importance of ensuring the quality of the Trust's data, particularly in light of the findings of the CQC. The importance of having assurance that the Trust had the right infrastructure in place to ensure its data quality was noted, as was the importance of understanding the Trust's information assets and data flows. A strategic approach to this work was required and Board members requested a further briefing on these particular aspects of this work.

ACTION: circulate a briefing on the Trust's information assets and data flows.

12. Logistics and Infrastructure Committee Assurance Report (TB/17/180)

12.1. TdP, as Chair of the Committee, provided an overview of the meeting of the Logistics and Infrastructure Committee on 06 February 2018. The Committee had considered information about the key projects being undertaken by the fleet and logistics, estates and IM&T teams.

12.2. It was noted that the Committee had taken on joint responsibility (with the Quality Assurance Committee) for health and safety issues. In response to a question from the Chair about whether the Committee had touched on the issue of fire safety training, it was reported that a separate briefing would be circulated to Board members on this issue.

ACTION: circulate a briefing on fire safety training.

13. People and Organisational Development Committee Assurance Report (TB/17/181)

- 13.1. JM provided an overview of the meeting of the People and Organisational Development Committee on 08 February 2018. The Committee had spent a significant amount of time considering the actions being taken by the Trust to improve the rate of recruitment of frontline staff, particularly within the EOC. Updates had also been received in relation to the proposed restructure of the Operations directorate, the Trust's apprenticeship scheme, the work that had been undertaken in relation to bullying and harassment concerns and the improvement of occupational health support. It was reported that an update on rostering, rest breaks, annual leave and end of shift issues would be brought to the next meeting of the Committee, in advance of the Board's consideration of some of these issues at its meeting on 27 March 2018.
- 13.2. Board members emphasised the importance of a continued focus on recruitment, particularly in light of the level of turnover and challenges associated with conversion of applications into appointments in the EOC.
- 13.3. The Chair noted the issues which had been reported in the media with regard to Oxfam and asked whether there was assurance that the Trust's DBS and safeguarding checks were appropriate to ensure that similar issues would not arise. It was confirmed that an action plan was in place to ensure the re-checking of DBS checks and that this was being progressed. Board members requested the circulation of a briefing note on this subject.

ACTION: circulate a briefing on the Trust's approach to ensuring that DBS and safeguarding checks remain appropriate.

14. Audit Committee Assurance Report (TB/17/182)

- 14.1. TdP, on behalf of JJ, the Chair of the Committee, provided an overview of the meeting of the Audit Committee on 12 February 2018. A number of the issues considered by the Committee were elsewhere on the agenda for the Board (Risk Management Strategy and Policy, Data Quality Strategy, Board Assurance Framework). The Committee had also given consideration to the progress of internal audit activities and the planned review of corporate governance, the outcome of which was due to be reported to the Board at its meeting on 27 March 2018.

15. Finance and Investment Committee Assurance Report (TB/17/183)

- 15.1. FC had already provided an overview of the majority of the meeting of the Finance and Investment Committee on 21 February 2018 during the Board's consideration of the Annual Financial Plan and Business Plan process (ref: TB/17/176 and TB/17/177 paragraph 9.3). The Committee had also considered the Trust's proposals with regard to the tender for provision of Integrated Urgent Care services to South East London, the submission deadline for which was 13 March 2017.

RESOLVED:

- 15.2. The Board resolved to agree that authority for the approval of the tender submission for the provision of Integrated Urgent Care services to South East London should be delegated to the Chair and CEO, having consulted with the Finance and Investment Committee.

16. Integrated Quality and Performance Report (TB/17/184)

- 16.1. The Board noted the report, which related to performance during January 2018. The report provided an executive summary of the Trust's performance in relation to quality, operations, workforce and finance. It was proposed that, ahead of future Board meetings, Board members should inform the Director of Corporate Governance in advance of the meeting if they wished to raise a query about any particular aspect of the report.
- 16.2. Board members considered that the key aspects of the report had been covered through the reports from the Board Assurance Committee meetings, save that of operational performance and any clinical/quality issues. It was noted that the trust had performed well operationally at the beginning of the year; however it was also noted that February had been a challenging month.
- 16.3. The Board was provided with an update in relation to the conveyance of stroke patients to hyperacute stroke units (HASU). It was reported that there was no evidence of a significant increase in call to HASU time following the introduction of the ARP. Where stroke was the chief complaint at the time of a 999 call, the Trust conveyed 72% of patients to HASU in 60 minutes; 62% of patients overall were conveyed to HASU in the same time.
- 16.4. It was noted that there had been a significant increase in demand for the 111 services provided by the Trust. It was confirmed that the challenges experienced in the 111 service were not dissimilar to those experienced in the emergency services provided by the Trust; however the Trust was amongst the top service providers with regard to its call handling performance and its call abandonment rate was amongst the lowest.

17. Board Assurance Framework, Corporate Risk Register and Risk Appetite Statement (TB/17/185)

- 17.1. PH presented the Board Assurance Framework (BAF) for the Board's consideration.
- 17.2. Consideration was given to the proposed addition of BAF Risk 52 (the main power supply to Bow is lost as a result of UK Power Networks having a failure on their system, impacting on our ability to provide a continuous service to our control room). It was noted that this risk had a rating of 12, which was less than usual for a BAF level risk. It was agreed that this risk should be included in light of its potential impact; however further review was required and should be undertaken with the Logistics and Infrastructure Committee.

ACTION: Logistics and Infrastructure Committee to consider the controls and mitigations in place with regard to BAF risk 52 and whether it needs to remain on the BAF in light of these.

17.3. With regard to the proposed Risk Appetite Statement. It was noted that this required review; however Board members emphasised the importance of ensuring that this reflected and was reflected in the Trust's Strategy and Business Plan. In light of this it was proposed that it should be re-submitted for consideration at the meeting of the Board on 27 March 2018. Board members indicated that there was a reasonable likelihood that the Board would accept a higher level of risk in certain areas (such as innovation) than it had in the past.

ACTION: presentation of the proposed Strategy and Business Plan to the Board on 27 March 2017 to take account of proposed Risk Appetite Statement and vice versa.

17.4. The Board noted the report on the Board Assurance Framework, and the Corporate Risk Register which had been provided for information.

18. Serious Incident Management (TB/17/186)

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

18.2. The Board noted the report on serious incident management.

19. Quality Improvement Plan and CQC Preparation (TB/17/187)

19.1. TB presented this update on progress in implementing the Quality Improvement Plan (QIP) and the CQC Preparation Plan.

19.2. The Trust had made significant progress with regard to the implementation of the Quality Improvement Plan and the CQC action plan that had been drafted in conjunction with the plan indicated that everything that could be done had been in order to enable the CQC to award the Trust a "good" rating following its well-led inspection in March 2018. Feedback from recent mock interviews with Board and ELT members indicated that much had been done and thought needed to be given to the most appropriate manner of showcasing this to the CQC.

19.3. The Board noted the report on progress against the QIP and the CQC Preparation Plan.

20. Trust Board Forward Planner (TB/17/188)

20.1. The Board considered the forward planner.

21. Questions from members of the public (TB/17/189)

21.1. There were no questions.

22. Any other business (TB/17/190)

22.1. There was no other business.

23. Review of the meeting (TB/17/191)

- 23.1. Board members considered that the re-scheduling of the Board agenda to take Board Assurance Committee reports ahead of the Integrated Quality and Performance Report had enabled the discussion of the issues raised to retain a more strategic than operational focus. It was noted that, when there was no report back from the Quality Assurance Committee, care would need to be taken to ensure that clinical/quality issues were picked up through discussion of the Integrated Quality and Performance Report.
- 23.2. The meeting had been the first to trial the use of electronic Board papers. There were some challenges associated with this, but it was anticipated that these could be overcome. The quality of Board papers were considered to continue improving.
- 23.3. Board members were content with the level of debate and challenge exhibited during the meeting.
- 23.4. The value of considering messages that required immediate communication following Board meetings was noted. This could either be through the newly re-instituted Chair's blog, or through other methods of communication. Board members noted the importance of sharing information about the Board's consideration of the following issues:
- 23.4.1. The challenges being experienced in the EOC, particularly with regard to recruitment, and the actions being taken to address these;
 - 23.4.2. The preparations that had been put in place ahead of the CQC's inspections in March
 - 23.4.3. The work that had been undertaken by the People and Organisational Development directorate in the last month
 - 23.4.4. The challenges that the Trust was facing in relation to its financial and business planning for the coming year

24. Meeting close

The meeting closed at 12.15pm. The next Trust Board meeting in public will take place at 9am on Tuesday 27 March 2018.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates (i.e. why action is not resolved / completed)
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
TB/17/95 para 7.2	A full report on the impact of the new rest break policy to be brought to the Board at its meeting in July 2018, with an interim report to be brought to the Board in March 2018	Paul Woodrow	31/10/17	31/07/18	On track	See item on agenda. Further report scheduled for Board meeting on 21/07/18
TB/17/125 para 8.3	ELT to advise the Board on proposed future performance reporting	Lorraine Bewes	28/11/17	24/04/18	On track	To be incorporated into Business Planning work. Draft Business Plan on agenda for private meeting of the Board. To be presented for final approval at the Board meeting April.
TB/17/125 para 8.4	ARP briefing for the Board in March 2018	Paul Woodrow	28/11/17	27/03/18	CLOSED	See item on agenda.
TB/17/125 para 8.10	Recruitment plan, with a focus on the EOC, to be brought to the Board in Spring 2018	Patricia Grealish	28/11/17	24/04/18	On track	Dependent on skills mix work being undertaken through Business Planning activity.
TB/17/149 para 6.4	A Board session on digital strategy to be arranged.	Ross Fullerton	30/01/18	27/03/18	On track	Planned for April. Board members will be presented with a proposed schedule for strategy/development sessions at the March Board meeting
TB/17/149 para 6.5	The Clinical Council's Terms of Reference to be amended to allow for the inclusion of external expertise.	Fenella Wrigley	30/01/18		CLOSED	See TB/17/173 (para 5.2) below
TB/17/149 para 6.5	The place of the Clinical Council within the Trust's governance framework to be clarified.	Fenella Wrigley/Trisha Bain/Philippa Harding	30/01/18		CLOSED	See TB/17/173 (para 5.2) below
TB/17/151 para 8.3	Arrangements to be put in place to ensure that Non-Executive Directors are briefed about key STP meetings, and feedback from meeting is collated.	Jamie O'Hara	30/01/18	31/03/18	CLOSED	See TB/17/173 (para 5.3) below
TB/17/152 para 9.3	A plan for meeting ARP C2 and C3 targets to be brought to the Board.	Paul Woodward	30/01/18	27/03/18	CLOSED	To be considered by the Board in private session.

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates (i.e. why action is not resolved / completed)
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
TB/17/152 para 9.3	A plan for completing and implementing the rostering review within 2018/19 to be brought to the Board in March.	Paul Woodward	30/01/18	27/03/18	CLOSED	See item on agenda
TB/17/152 para 9.5	An independent review of the Trust's training arrangements to be commissioned.	Fenella Wrigley	30/01/18	31/03/18	CLOSED	Scope was discussed at Quality Assurance Committee and People and Organisational Development Committee meetings in March
TB/17/159 para 17.2	The proposal for allocating each executive and non-executive director to a designated group station to be taken forward, taking account of existing non-executive director time commitments.	Heather Lawrence, Garrett Emmerson and Jamie O'Hara	30/01/18	30/03/18	On track	An oral update will be provided at the Board.
TB/17/163 para 20.1	Input to be sought for a programme of developmental/strategy sessions for the Board.	Philippa Harding	30/01/18	27/03/18	On track	An oral update will be provided at the Board.
TB/17/173 para 5.2	Circulate Clinical Council Terms of Reference to the Board.	Fenella Wrigley	27/02/18	27/03/18	CLOSED	Circulated to the Board in correspondence
TB/17/173 para 5.3a	Circulate dates of key STP meetings to the Board, setting out those which NEDs are expected to attend	Jamie O'Hara	27/02/18	30/03/18	On track	An oral update will be provided at the Board.
TB/17/173 para 5.3b	Provide briefings to NEDs attending STP meetings	Jamie O'Hara	27/02/18	30/03/18	On track	An oral update will be provided at the Board.
TB/17/175 para 7.3	Ensure that the presentation of the proposed strategy to the Board incorporates proposals relating to its implementation and governance and the steps that will be taken to ensure that it remains relevant.	Garrett Emmerson, Angela Flaherty	27/02/18	27/03/18	CLOSED	See item on agenda
TB/17/177 para 9.4	Chair and CEO to approve submission of the draft Annual Financial Plan 2018/19 to NHS Improvement	Heather Lawrence, Garrett Emmerson	27/02/18	09/03/18	CLOSED	This took place.
TB/17/189 para 11.3	Circulate a briefing on the Trust's information assets and data flows.	Ross Fullerton	27/02/18		CLOSED	Circulated to the Board in correspondence
TB/17/180 para 12.2	Circulate a briefing on fire safety training	Trisha Bain, Benita Mehra	27/02/18		CLOSED	Circulated to the Board in correspondence
TB/17/181 para 13.3	Circulate a briefing on the Trust's approach to ensuring that DBS and safeguarding checks remain appropriate.	Patricia Grealish, Trisha Bain	27/02/18	30/04/18	On track	Report completed for submission to ELT and then to April Board.

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates (i.e. why action is not resolved / completed)
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
TB/17/185 para 17.2	Logistics and Infrastructure Committee to consider the controls and mitigations in place with regard to BAF risk 52 and whether it needs to remain on the BAF in light of these	Theo de Pencier, Benita Mehra	27/02/18		On track	Next Logistics and Infrastructure Committee meeting scheduled to take place in June. Work is being undertaken to schedule a meeting in April/May.
TB/17/185 para 17.3	presentation of the proposed Strategy and Business Plan to the Board on 27 March 2017 to take account of proposed Risk Appetite Statement and vice versa	Philippa Harding, Angela Flagherty,	27/02/18		On track	



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Report from the Chair			
Agenda item:	06			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The Chair's report provides an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened.				
Recommendation(s):				
The Board is asked to note this report.				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				

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

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

Report of the Chair

External

Care Quality Commission (CQC) Inspection (21+22 March 2018)

1. At the time of writing the Board level interviews have yet to be held with the Chief Executive Officer (CEO), Executive Directors, and a selection of Non-Executive Directors and myself as Chairman. Notwithstanding the conclusions that the CQC inspectors may come to post inspection, I would like to acknowledge the considerable progress that has been made across all five domains particularly in relation to systems and processes that are now embedded in the Trust. The operational staff have been under incredible pressure this winter, not helped by the adverse weather conditions and at the same time have continued to adopt new systems and processes to assure quality to patients. It is also the case that the Executive Directors have worked tirelessly under the CEO's direction to enable the changes that have been necessary and have been overdue.
2. Whilst we continue to have more work to do it is important to convey our appreciation to everyone whatever their role whilst we await the outcome of the CQC inspection.

Meeting with Sir Thomas Hughes-Hallett (20 Feb.)

3. Sir Thomas is Chairman of Chelsea and Westminster Hospital NHS Foundation Trust and who separately has set a new organisation - HelpForce, to accelerate involvement of volunteers in the NHS. HelpForce wants to develop new volunteer roles and a best practise model for volunteering in hospitals and other settings. There are 12 pilots, to date no ambulance services are involved.
4. One of the pilots is in Hounslow and it may be possible for us to engage with them. Board members will know that working with the Patients Forum we have tried unsuccessfully in the main to enter into this area. A key result for us would be in attracting young people not just as volunteers but as a potential opportunity to develop a career in the ambulance service. Whilst we have a successful history in a few Boroughs of volunteering in Resuscitation we have not managed so far to attract volunteers to the lower acuity end of our work where the opportunity to assist in our ability to leave people at home could be enhanced by such a scheme. Once I receive further information I will share this idea with the CEO and the Patients Forum.

Croydon Health Economy – Mike Bell

5. The CEO and I visited the Croydon Health Services NHS Trust to meet the Chairman, CEO and other key members of the Executive team. The Trust provides both hospital (i.e. Croydon University Hospital and Purley War Memorial Hospital) and community services. We were given a tour of the Edgecombe Unit and met the clinical director. The unit sees all ambulatory care, day care and acute medical assessment patients reducing the number of people attending the accident and emergency department and providing both acute, community and social care input with the aim of returning patients to the community the same day or within forty-eight hours. The population of Croydon is relatively young compared to other London Boroughs.
6. We understood that our LAS Stakeholder Engagement Manager is well known and an important contributor to the Accident and Emergency pressures discussions.

Seminar on Workforce Race Equality Standard (WRES) with Simon Stevens, CEO and Yvonne Coghill, Director, WRES Implementation – NHS England

7. The workshop was directed at Chairman and CEOs to look at the analysis of the previous year's WRES results and to hear from three Trusts that have made more progress than others to share good practice.
8. There was a focus on the likelihood of people from Black and Minority Ethnic (BME) communities to be recruited and subsequently promoted in relation to their peers.
9. Area of good practice were:
 - Clear leadership from the Board.
 - Clarity of values and taking time to explore what behaviours are expected from each.
 - Ensuring that selection panels have representation from BME personnel.
 - Where a BME member of staff is shortlisted but not selected for employment, a letter of explanation to the CEO before an appointment is made.
10. It was interesting to hear how in a Trust where both the Chairman and CEO were from a BME background it remained difficult to make significant improvements.
11. We have just received our latest WRES report and it is disappointing to see that the actions we have taken have yet to impact on how staff from a BME background feel about their employment with the LAS.
12. I will discuss this further with the CEO, Patricia Grealish, Director of People and Organisational Development (P&OD) and Melissa Berry, Equality and Inclusion Manager, WRES lead to see how our latest actions, discussed at the People and OD committee are likely to impact and what else we need to do.
13. I remain committed to making the London Ambulance Service HS Trust (LAS) an inclusive organisation irrespective of race or gender.

Internal

Visit to NHS 111 Croydon

14. I spent a morning with our team at NHS111 in Croydon and was again impressed by their professionalism and commitment to the Service and the general atmosphere. We discussed the South East London tender bid that was in the process of being completed at the time of my visit. There was an acknowledgement of the need to innovate and to mitigate risks.
15. I listened in to a call that had been referred for a clinical opinion and again was impressed with the calm manner and appropriate advice that was being given to the caller.

Visit to Cody Road

16. I spent the day meeting the teams based at Cody Rd. The Emergency Preparedness Resilience and Response (EPRR), the Hazardous Area Response Team (HART) and the Tactical Response Unit (TRU). These teams are very highly trained and undertake regular refresher training with the other emergency response services.

17. On the day in question the TRU responded to a request for support to a call where a suspect package with a liquid had been delivered. The week before two members of our HART were ready to be dispatched to Salisbury as Mutual Aid but were not required. These teams are daily prepared to set off to any venue either in London or as support to another service. They have an overnight bag packed and are ready to go as the norm. We have the facility to put up camp beds in our Cody Road base if required.
18. We discussed the issues - life expired vehicles, staffing and late finishes; they were aware that a number of vehicles are on order.
19. I acknowledged the excellent result of the recent HART external assessment of which they were rightly proud. The team were keen to say that they welcome visits by other Board members.
20. I also met the Patient and Public Involvement and Public Education team and the Patient Experiences Department (PED).
21. We have 1279 staff interested in delivering talks to schools and voluntary groups and we have delivered 431 hours since January. The team works closely with the Communications team and utilising the LAS Facebook page.
22. Two particular initiatives of interest are:
 - Working with the Police in schools to teach students about the impact of gang related and knife crime and how to avoid it.
 - LAS Youth Ambassador Scheme (I will circulate a paper on this separately).
23. The PED deal with complaints and we had an interesting discussion about these and the rising trend for complaints to be about staff attitude.
24. There has also been a rise in complaints over delays from other healthcare professionals since we implemented the Ambulance Response Programme.
25. Lastly I visited Recruitment department where the team were busy and seemed focused on the key issues that the Board has discussed and the changes being made particularly in relation to Emergency Operations Centre recruitment.

Heather Lawrence OBE
Chair



London Ambulance Service **NHS**
NHS Trust

London Ambulance Service NHS Trust

Delivery of S.106 Enforcement Undertakings

The information and evidence in this document has been drawn from a number of documents and reports. These are available on request from the LAS CQC Support and Preparation team.

cqcpmo@lond-amb.nhs.uk

London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Owner	Evidence	Commentary

London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

uality	1.1.1	Mandatory training to meet the Trust's current target. There is a lack of staff awareness of infection prevention and control measures in addition to inconsistent compliance with these measures.	PG	- Regular reporting in place tracking and ensuring compliance levels are achieved. <table border="1"> <thead> <tr> <th></th><th>21/02</th><th>26/02</th><th>02/03</th><th>12/03</th><th>Forecast end Mar</th></tr> </thead> <tbody> <tr> <td>%</td><td></td><td></td><td></td><td></td><td></td></tr> <tr> <td>Trust</td><td>77</td><td>78</td><td>80</td><td>81</td><td>86</td></tr> <tr> <td>Corporate</td><td>90</td><td>90</td><td>90</td><td>91</td><td>95</td></tr> <tr> <td>Operations</td><td>76</td><td>77</td><td>79</td><td>80</td><td>86</td></tr> </tbody> </table> - Safeguarding L1 94% compliant, L2 EOC 63% (YTD). - Compliance with IP&C training Level 1 93% and level 2 88%. Recording now on ESR and reported to QIP and to the Trust Board. <table border="1"> <thead> <tr> <th></th><th>%</th><th>01/10</th><th>01/11</th><th>01/12</th><th>01/01</th></tr> </thead> <tbody> <tr> <td>Hand Hygiene compliance</td><td>90</td><td>91</td><td>98</td><td>60</td><td>85</td></tr> <tr> <td>6 weekly Vehicle Deep Clean</td><td>90</td><td>93</td><td>95</td><td>95</td><td>93</td></tr> <tr> <td>Monthly Premises Cleaning</td><td>90</td><td>98</td><td>88</td><td>88</td><td>78</td></tr> </tbody> </table> - Where infection prevention and control (IPC) compliance levels are not appropriate, action plans have been developed to ensure compliance. 20+ IPC champions covering all areas providing support, audit and observational visits.		21/02	26/02	02/03	12/03	Forecast end Mar	%						Trust	77	78	80	81	86	Corporate	90	90	90	91	95	Operations	76	77	79	80	86		%	01/10	01/11	01/12	01/01	Hand Hygiene compliance	90	91	98	60	85	6 weekly Vehicle Deep Clean	90	93	95	95	93	Monthly Premises Cleaning	90	98	88	88	78	There is a planned trajectory to meet the targets, with Corporate having achieved their target at the end of December and Operations on Target for end of March compliance. Rates are being tracked regularly through the QIP, ELT Performance Meetings and Trust Board. As well as at local level by MyESR Managers Dashboards. Detailed breakdown by function and sector is available through the ESR dashboards and is used for monitoring progress by sector/directorate.
	21/02	26/02	02/03	12/03	Forecast end Mar																																																						
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London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

1.1.2	Timely safety checks and repairs on both vehicles and equipment, consistent with the Trust's safety policy	BM, JW	An audit of safety checks and repairs is carried out as part of a regular audit programme. Monthly reporting on compliance available through the Integrated Performance Report. Monthly reporting is available and includes: • Audit and Results tracker • Audit and Inspection Compliance • Vehicle Preparation Dashboard Vehicles prepped with all essentials equipment average across all vehicle preparation hubs achieved an average of 98%. Focussing specifically on cleaning and equipping, which was the main impetus for the project, an average improvement of 6.9% has been delivered on the vehicle cleaning side and the vehicle equipping side. The received feedback directly from staff has been encouraging with comments including: • I think that the introduction of make ready has made the beginning of shifts less stressful • Overall a huge improvement	• The maintenance for all equipment is set in accordance with the manufacturer's requirements as a minimum. • All key items of equipment are inspected by staff prior to use at the start of shift, and defects reported as necessary. • The Vehicle preparation process will clean, inspect and re-equip equipment for the safe use of that equipment on a daily basis (all DCAs currently). A comprehensive daily Vehicle Inspection record is maintained for all prepared ambulances. • Defects are notified according to policy OP25 (The Procedure for Scheduled Maintenance and Exchange of Ambulance Equipment) and a replacement item provided. • All associated inspections and audits are subject to weekly performance monitoring within the team and monthly KPI reporting through to the exec via the monthly performance report. • Make Ready roll-out currently piloting a daily electronic audit (eVDI), by the vehicle Preparation staff, providing an electronic record of equipment and location, thereby reporting by exception any missing equipment.

London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Owner	Evidence	Commentary
			Great that the small consumable bags can just be swapped and that the quartermaster can change/replace kit or bags at short notice.	
1.1.3	Safe staffing levels and appropriate skill mix and experience on DCAs	PW, PG	- Skill Mix Matrix approved July 2017 and circulated to sectors to ensure compliance to appropriate safety levels. - Safe staffing levels are monitored and reported to ensure compliance. - The Director of Operations is chairing a monthly ARP programme board in order to drive progress against the challenges and issues which have been identified pre and post ARP implementation. The programme board is further supported internally by a weekly ARP delivery board. - To ensure that the Trust has the right mix of DCAs and FRUs, along with the requisite number of staff hours in the right place at the right time, the Trust is currently scoping a review of operational rota patterns to deliver the new operating model collaboratively with frontline staff and trade unions. The modelling will provide the data we need to develop the new rota patterns and ensure safe staffing levels and appropriate skills mix.	The Trust has commissioned modelling which will inform the Trust as to the requisite number of double crewed ambulance (DCA) and fast response unit (FRU) capacity hours by hour of day and day of week (and the corresponding number of WTEs) required to deliver performance against the national standards. We expect the first draft of this modelling to be completed by 19 March.

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No	Summary of undertaking	Owner	Evidence	Commentary
1.1.4	Reporting incidents and near misses to national standards	TB	• Reporting in place providing information about the total number of low or no harm incidents • At the end of January there were 1,692 No-harm incidents (YTD against a target of 1,200) and 293 low-harm incidents (target 30). • As a proportion of total incidents, the No-harm/Low-harm increased to 86% up from 42% and is above the national benchmark. • The LAS now the second highest reporter to NRLS of ambulance trusts. • 281 staff trained in DATIX web since June 2017 including grading of incidents. • Staff survey 2017 question 'KF29' % of staff witnessing Incidents in the last month and reporting showed improvement 2017 – 84%, 2016 79% and national average 82%.	Data is presented in the monthly Quality Report where the proportion of Low/No-Harm/ Moderate and Severe incidents is monitored to ensure adequate levels of reporting are achieved.

London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

	1.1.5	Learning from incidents and near misses shared and embedded	FW/TB	Policy redesigned and approved Dec 2017 to include section on Learning Lessons In the last 6 months approximately 20 incidents have resulted in changes to practice through CSR training. Examples include spinal injuries, management of STEMI, paediatric pain management, VF AED protocol and forced extubation for tracheostomy patients. A reduction in spinal injuries has been seen. It was identified that there were a number of cases where defibrillation was being delayed during the management of cardiac arrest, this triggered a thematic analysis. Whilst it was believed that the apparent increase in incidents might be related to the increased number of defibrillator data downloads by Advanced Paramedic Practitioners (APPs) coupled with a significant drive to increase reporting of potential incidents through the online incident reporting system (Datix) it was identified that further work was needed to understand the root causes and ensure that learning to prevent recurrence was embedded across the Trust. Since the thematic analysis was published the 'further actions needed' published within the document have been completed, along with additional actions deemed necessary which has since seen a reduction	Actions taken/being taken: • Training in debrief provided to all Clinical Team Leaders and Advanced Paramedic Practitioners via the CTL conference. • Development of a Feedback Tool for use by CTLs and QGAMs • Development of a Positive Incident Reporting System – encouraging all staff to notice, appreciate and report good practice. Positive reports are reported through the governance structure to Quality Oversight Group. • Quarterly Publication of a Case-Based learning magazine <i>Insight</i> (https://thepulseweb.lond-amb.nhs.uk/corporate/insight-magazine/) – learning points from cases drawn from a wide range of sources, including from successful cases. • Publication of Infographics sharing learning from two key areas of practice with multiple clinical incidents –Ventricular Fibrillation, and Spinal Injury. • Recruitment of a Clinical Advisor to the Medical Director, tasked with embedding learning from experience, and supporting the provision of local sector Case Discussion meetings. • Examples of learning include – changes made to defibrillation, assessment of neck injuries, maternity card for critical cases, new sepsis cards

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No	Summary of undertaking	Owner	Evidence	Commentary
			in the number of cases of 'missed VF' per month but has also seen an increase in awareness resulting in frontline clinicians highlighting where there are concerns and self-reporting incidents which is commendable practice. Overdue serious incidents reports reduced from an average of 20 to zero due to a more robust process for ensuring all actions are completed within timescales. Strengthened learning from incidents including themes from Sis in Core Skills Refresher training. Significant assurance of SI process provided by the independent KPMG audit 2017 Further alignment of coronial process with SIs and action planning with 100% closure of actions.	- During Q3 18 SI reports were closed by the CCG. The average time for commissioners to sign off and close a report is currently 23 days (range 13 to 31). This is a reduction of 5 days from the previous review. The CCG have a target of 20 working days to provide comments back to the Trust for clarification or amendment. Any comments referred to the Trust must be answered within 10 working days prior to the CCG agreeing closure of the investigation. - The Trust's current position on meeting the 60-working day target for submitting SI reports is 100%. A recent external audit conducted by KPMG detailed the Trusts compliance with the SI investigation process and evidenced significant assurance. Overarching Serious Incident Themes Q3 - Following on from the previous thematic review there has been a reduction in clinical assessment errors from Q2 (n=7) to Q3 (n=1). Additionally, there has been a reduction in cases of delayed defibrillatory shocking of ventricular fibrillation from five to one when compared to the previous thematic review

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No	Summary of undertaking	Owner	Evidence	Commentary
1.1.6	Action taken in response to the independent health and safety review	TB	- The report from the review highlighted key risks and areas of non-compliance across the Trust, and recommended key actions that need to be completed to improve compliance. The report and a robust action plan was implemented to ensure compliance with Health and Safety legislation and received by the ELT in August 2017 - A total of 59 actions (categorised as high/medium/low priority) were recommended following the independent review. A total of 44 actions have been completed, (18 high/26medium) 14 actions are in progress (11 high/3 medium) and currently underway, with a further 1 outstanding (high). - Monthly trust wide and sector wide scorecards linked to action plan available to all staff and monitored via governance system. - Health and Safety Exec. attended ELT (7/3/18) very positive feedback that ELT fully engaged with Health and Safety and no further inspections required this year 2018/19. - A further audit of the Health and Safety actions has taken place and a report was produced w/c 12th March, which is available for review, with a number of positive improvements identified	Report presented to ELT with oversight from the CCG. As a result of the recent positive Health and Safety Audit, at the March Board there is a recommendation that the Health and Safety risk rating be reduced from 20 down to 12.

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	1.1.7	Medicines management, including tracking and audit, and safe storage arrangements for controlled drugs in place, consistent with the Trust's medicines management policy	FW	- Medicines management incidents continue to be tracked and audited. - During February we have carried out 1,649 inspections across 77 areas. - The average score across the organisation this month was 97% - This month 77 clinical areas had an average green score, 0 amber and 0 red. 2 areas have not had an inspection. 242 LAS inspectors carried out 1,649 inspections/audits during February - The overall trend in medicine management incidents is still up although down from the peak in November. - Unaccounted losses for controlled drugs remain consistent and stable with previous months. - Themes including staff retention documentation errors and broken ampoules. - One unaccounted for loss of syringe containing 5mg of morphine post administration - Total of 40 other controlled drugs incidents 40 recording or documentation errors or omissions - Two cases where morphine retained off-duty - No unaccounted for loss of controlled drugs from controlled drugs safes –single unaccounted for loss was post administration at a scene.	Board approval of secure drugs rooms business case on 28 November 2017. - Three initial pilot sites Brent, Ilford, Bromley in operation. - Further 27 rooms to be installed during 2018, with Training under way. - Monthly update reported to ELT and Board with issues feedback to each Sector.

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No	Summary of undertaking	Owner	Evidence	Commentary
			- No incidents of inappropriate administration of IM adrenaline by LAS staff - There has been a reduction on the number of non-controlled drugs. Themes include drug stock discrepancies, access codes written on walls and poor storage facilities.	
1.1.8	Continued progress on EPRR as evidenced by the NARU independent review.	PW	- The Trust has been assessed as ‘substantially’ compliant by NHS England (London), which is positive news and provides evidence that improvements in the Trust’s resilience (which was rated as ‘good’ by the Care Quality Commission in early 2017) are being sustained. The non-compliance identified within the report that require attention: - HART numbers are below establishment - Six HART operatives are not paramedics - The fleet is not compliant with national standards - There are challenges with the Cody Road site. An action plan has been developed with some of the areas of non-compliance already being actioned.	The following papers were presented at the February Trust Board are available for review: - NARU Report January 2018 - Paper summarising the Report and its findings - Action to ensure non-compliance issues are resolved

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No	Summary of undertaking	Owner	Evidence	Commentary																								
1.1.9	Improved staff appraisals in line with the Trust’s appraisal policy	PG	An action plan with a trajectory is in place and is reported weekly to the Executive Leadership Team and at the performance Meetings. <table><tr><td>week commencing /%</td><td>21/02</td><td>26/02</td><td>02/03</td><td>12/03</td><td>Forecast end Mar</td></tr><tr><td>Trust</td><td>62</td><td>67</td><td>64</td><td>69</td><td>85</td></tr><tr><td>Corporate</td><td>76</td><td>77</td><td>78</td><td>81</td><td>85</td></tr><tr><td>Operations</td><td>60</td><td>66</td><td>62</td><td>68</td><td>85</td></tr></table>	week commencing /%	21/02	26/02	02/03	12/03	Forecast end Mar	Trust	62	67	64	69	85	Corporate	76	77	78	81	85	Operations	60	66	62	68	85	Compliance rates have improved and are being tracked regularly at ELT and performance meetings. Detailed breakdown by function and sector is available and is used for tracking. Main areas of low completion are in Operational areas due to demand and staffing.
week commencing /%	21/02	26/02	02/03	12/03	Forecast end Mar																							
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No	Summary of undertaking	Owner	Evidence	Commentary
1.1.10	Resource action plan for consistent ARP performance across STP regions and LAS stations	PW	The Trust has continued to perform reasonably well against the new Ambulance Response Programme (ARP) standards, despite continued winter pressures across the healthcare system in London, high volumes of influenza and norovirus, and sustained periods of low temperatures and adverse weather. There remain challenges with routinely achieving the standards for Category 1, Category 2 and Category 3 and we are working hard with the limited data we have since go live to understand the nuances of this new system. Following the introduction of the ARP in November 2017, the Trust has been undertaking a preliminary review of its initial observations since 'go live' based on two months' worth of full operating data. The initial observations made as part of this preliminary review process have been submitted by the Trust as part of a national feedback exercise for the national ARP Spring Review which took place in London on 20 February. It is expected that the recommendations from this national review will be published by late April 2018.	A presentation on Ambulance Response Programme (ARP): Implementation and Next Steps will be presented at the Regional Oversight Group, 15 March 2018 and the March Trust Board by Paul Woodrow Director of Operations.

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No	Summary of undertaking	Owner	Evidence	Commentary
1.1.11	Improved uptake of equality and diversity training to meet the Trust's current target	PG	- Improved self-assessment indicator in WRES e.g. 74 BME leavers (16%) Year to date 11%. 110 BME starters (25%) Year to date. 62% of staff have completed E&D training February 2018 - WRES data summary 2017/18 LAS has reported on 8 of the 9 WRES indicators, this is an improvement from 2016/2017 data submission where 7 of the key indicators were reported on. - Staff believing that the Trust promotes equal opportunities for career progression and promotion up from 52% in 2016 to 65% in 2017. - The LAS is 18 months into its journey and progressing at pace but there is still more to be done and important to note LAS started from a very low baseline - The WRES action plan 2017/18 is currently being implemented at pace and progress against delivery is overseen by the People and Organisation committee/ Equality Committee.	Future actions include: - To hold a Board Equality and Diversity seminar, with invites to include Yvonne Coghill the National WRES Director - To drill down in to the WRES data sets by sector, so that work can be designed for specific challenges informed by the data - Review of recruitment and selection training and ensuring all hiring managers have undertaken training and any relevant refresher - Review of makeup of 'interview panels' to ensure consideration has been given to elimination of unconscious bias in selection decision

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	1.1.12	Organisational wide learning from complaints and incident reporting	TB/FW	• The organisation has historically shown good learning from incidents and this has continued. Examples include incidents involving VF arrest, forced extubation of tracheostomy patient and use of diazepam PGD which have been incorporated into CSR2017.2 training. These and others are shared with staff via Clinical Update magazine. • Patient Experiences Team produce regular reports with learning from complaints highlighted in the Quality Report and shared with both QGAMs and the staff involved. • Lessons learned are also included in Clinical Update or Insight magazine which is disseminated across the Trust. • Examples are shared with the national Ambulance network with themes and changes to practice being shared with all UK Ambulance Services at regular network meetings as well as on an informal advisory basis. • Where an issue is identified that has implications for practice for other agencies, these are shared across the wider health and social care economy. Case examples are available on our Trust website. • The 4th Serious Incident training session went ahead as planned in January. A further 15 managers were trained under the new SI process. The next training session is planned for 23rd Feb 2018 and currently has 20 managers attending.	Risk mitigation measures are put in place immediately after a Serious Incident is declared both for staff, patients and the Trust, via the Serious Incident Group. Recruitment of a Clinical Advisor to the Medical Director, tasked with embedding learning from experience, and supporting the provision of local sector Case Discussion meetings. A deep dive into the response time associated with chest pain calls was undertaken by senior clinicians within the Medical Directorate. This review will be incorporated into the clinical review of ARP. A new learning from serious incidents presentation has been developed and delivered to the paramedic trainees currently enrolled on the paramedic academy course. This session is to be incorporated into the core modules for each course in the future. Findings from the quarterly thematic review were incorporated into an intensive EOC action plan for Trust wide learning assisted in the formation

London Ambulance Service NHS Trust – Delivery of S.106 Enforcement Undertakings

No	Summary of undertaking	Owner	Evidence	Commentary
			- Quality, Governance and Assurance Team have quality assurance and closed in excess of 700 incidents within the last month and sent approximately 200 incidents back to investigating managers for further information. - Weekly overdue incident and unapproved risk reports continue to be shared with senior managers across the Trust.	of actions specifically relating to incidents within EOC

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Efficiencies & MHA	1.2.1	Improved operational performance and demand management, including handover delays at hospitals, job cycle time and multiple attendance ratios.	PW	The Trust has continued to perform well against the new Ambulance Response Programme (ARP) standards, despite continued winter pressures across the healthcare system in London, high volumes of influenza and norovirus, and sustained periods of low temperatures and adverse weather. There remain challenges with routinely achieving the standards for Category 1, Category 2 and Category 3 and we are working hard with the limited data we have since go live to understand the nuances of this new system. Following the introduction of the ARP in November 2017, the Trust has been undertaking a preliminary review of its initial observations since 'go live' based on two months' worth of full operating data. Hospital handovers Dedicated Resources The LAS nominated the Medical Director as their executive lead for hospital handovers, seconded an operational manager to support the delivery of this programme, and from December 2017 embedded a senior manager into the NHS E (London) 'Winter Room' to further strengthen the link between the LAS and wider healthcare system across London. Weekly diarised meetings with NHSE/I and LAS The LAS and NHSE/I hold weekly meetings which bring together relationship leads across London with LAS operational management to plan how this issue is	Handover work seen as exemplary across the system. LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. The Trust is currently developing a hospital handover escalation policy which will be enacted when ambulances are delayed over and above the 15-minute handover target. New patient priority 'tagging' system, based on NEWS Scores has been rolled out with positive feedback. Examples of activities to improve hospital handovers – working with our partners: Sharing of LAS predicted data Predictions of LAS activity for conveyance numbers by day of week/hour to each ED were shared to support stakeholders in their winter planning. LAS predicted activity is shared weekly with the NHS E Winter Room for inclusion in its daily update report. Key LAS contact details Key local contact details were shared with NHS E/I and EDs across London to support closer working relationships and escalation of issues. Weekly briefing

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			managed over the coming months and to link in with the wider winter plans Expectations of LAS staff when waiting to handover Guidance on the professional standards the LAS expects from its staff while waiting to handover their patient at EDs was shared with LAS frontline staff. Cohorting process Patient cohorting is a process whereby ambulance clinicians handover the care of their patient to an ED clinician immediately after triage regardless of bed availability. This can allow ambulances to become available for dispatch to another incident more quickly; it is the responsibility of Acute Trusts to implement and staff this. Ambulance-led cohorting is the same process but is implemented and staffed by the LAS because it is felt that the risk of not doing so would be to the significant detriment of the Trust and patient safety. A standard process for Cohorting across London including the triggers and reporting process for when it can be used has been designed and implemented with the agreement of NHS E. Complaints review A review of all complaints linked to handovers was also conducted (review period: June 2016-Sept 2017) 7 complaints were identified, none of which highlighted areas of learning relating to LAS processes/actions.	A briefing is sent out by the LAS highlighting key issues, such as expected busy days to the wider NHS system. Daily Handover report The LAS produces a report daily detailing the time lost at EDs to handovers greater than 15, 30 and 60 minutes for the previous day.

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No		Summary of undertaking	Owner	Evidence	Commentary
				Datix system changes Improvements have been made to the reporting process/options. The Hospital Lead is now notified of all 'handover delay' incidents for review and identification of safety issues.	

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	1.2.2	Improved understanding by staff of MHA, particularly in EOC and EPRR	PW, TB/BS	• Mental Health Act update included in <i>Clinical Update</i> with training compliance at 87%. Mental Health assessments have risen from less than 70% to above 90% in most Sectors’. • LAS are working closely with MIND supporting a pilot in 4 areas to deliver training for new entrant call handlers building their awareness of mental health and personal resilience. With 6 dates planned running for early February to April consisting of a full days training covering 3 modules: Personal resilience, Patient support during a call, MH conditions. • A survey of the support staff get from the Mental Health nurses: • 80.87% of EOC staff have found the presence of RMNs beneficial • 84.61% of EOC staff felt that RMNs have a key benefit including improved patient assessments and support • 73.03% of EOC staff felt that RMNs have improved access & communication with external agencies in relation to mental health • 50% of EOC staff felt that RMNs have impacted on their individual learning, confidence & knowledge about MH presentations.	Mental Health assessment compliance in the monthly Quality Report for the Board.

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	No	Summary of undertaking	Owner	Evidence	Commentary
				Improved pathways of Mental Health including supporting our own staff as well as callers	
Continuity & workforce	1.3.1	Business impact assessments in place for all functions and a comprehensive business continuity plan, including service delivery, control services and demand management systems across LAS, independently assured through the NARU review.	PW	- Incident Response Procedures (September 2016) updated December 2017 following recent incidents. Currently under review. - November 2017 Trust graded as 'Substantial' compliance for EPRR. Response plan being updated over 2- year period in order to achieve 'Full' compliance. - QIA policy aligned to business change process. - Strengthened Trust Business Continuity, Programme plan developed in all departments with the introduction of our Business Continuity Management Policy.	Business Continuity was addressed as an agenda item at ELT on 20th September 2017 with a further business continuity update to be provided to ELT in six months' time. The Business Continuity Steering Group will monitor the progress of the business continuity programme ensuring that on-going actions are completed within the agreed timescales. This group meets bi-monthly and reports into the Risk Compliance and Assurance Group which in turn reports to ELT.

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No	Summary of undertaking	Owner	Evidence	Commentary
1.3.2	Workforce strategy which addresses recruitment and retention, supports new models of care and underpins the ARP. Supported by an implementation plan showing progress with actions.	PG, PW	• Short-term plan for 18/19 and 19/20 on target to be in place by 30/03/18. • Strategic workforce planning approach/framework being developed, which will inform review of 18/19 and 19/20 to ensure alignment to the strategy, once approved. This will then be used for longer term planning. • Following the introduction of ARP, the Trust is currently scoping a review of operational rota patterns to deliver the new operating model collaboratively with frontline staff and trade unions. • New rosters are being developed to deliver the new operating model in 18/19 along with a review of skill mix. • Consultation on other working practices has ongoing as the implications of the ARP system and its impact on staffing is understood. • Progress is monitored through the P&OD subcommittee and implementation plan.	The People and OD Strategy has a number of recruitment improvement deliverables during 2018 to support better retention of staff including: • Recruitment events and activities that support the LAS Brand and seek to engage London communities in working for or supporting the LAS • Talent and succession management planning to support the aspirations of our people and assure the service of the LAS • Welcoming people to LAS and setting them up for success through thoughtful and thorough induction and on-boarding activities • Introduce recruitment processes that ensure that we have a responsive end to end experience that supports managers and gives the very best candidate experience • Introduce a values-based recruitment process to ensure that LAS people are recruited not only for their competencies but also for their values and attitude in support of the core values of LAS

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	No	Summary of undertaking	Owner	Evidence	Commentary
Governance	2.1.1	Effective board, committee structures and reporting lines, including: - Recruitment of substantive executives to replace interim appointments and vacancies - Board and executive team development programmes in place - Deloitte well led review in February 2017 recommendations addressed - Behaviour framework and leadership pathway designed and implemented	GE, PH, PG	- ELT now substantive - Executive development programme started in December 2017 with ongoing regular activities scheduled through 2018. - Deloitte Well Led review recommendations addressed through QIP action plan and burndown activities with evidence collected and available. - A review of Clinical Governance committees has been completed by the Chief Quality Officer. The number of quality groups have been reduced from 70 to 20 with new ToR, agendas, membership and key issues reports from sub groups disseminated up to Board via Quality Oversight Group. - The Director of Corporate Governance has reviewed and introduced a standardised format for all corporate meetings. - Behaviour work is part of the People and Culture Strategy approved by the Board in October 2017. Implementation is underway and being tracked. Through the P&OD subcommittee and implementation plan.	

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No	Summary of undertaking	Owner	Evidence	Commentary
2.1.2	Accurate, comprehensive, timely and up to date information for board and committee decision-making, including a comprehensive BAF to: • Manage risks to compliance with the conditions of the Licence • Review and approve the risk management policy and BAF and manage risks • Manage, monitor and embed at all levels within the organisation, the quality improvement plan to rectify the concerns raised in the CQC report	PH, TB	• Risk Management Strategy and Policy signed off by the Audit Committee, using delegated authority from the Board at its meeting on 06 November 2017. • BAF being used to drive agendas and discussions at Board Assurance Committees, RCAG operation being refreshed and new risk training being implemented across the organisation, evidenced by Agendas and meeting minutes. • Integrated Performance report agreed used by ELT and Board. • The Risk Policy was approved by the Board in February. • A risk management improvement plan is in place which includes training, re-designing of Datix, risk registers as part of the Quality and Assurance Directorate improvement activities. • Risks monitored by RCAG, committees, group meetings and quality report. • To complement reporting, the trust has reinstated a programme of quality assurance visits to services to test whether what is reported matches what is observed or heard. This information/data is uploaded onto Health Assure to provide real time monitoring of CQC compliance.	A new governance framework sets out clearer terms of reference work programmes and standard reporting processes for assurance to Board. Below Board, the trust has significantly strengthened the performance management approach for clinical and corporate services, with progress monitored monthly against a dashboard at monthly performance meetings chaired by CEO.

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No	Summary of undertaking	Owner	Evidence	Commentary
2.1.3	Board approval of the Trust's overarching strategy	GE, JO'H	Currently engaging widely on the Trust's Strategic Intent. The Draft Strategy and delivery plan was considered by the Board at its meeting on 29 January 2018, with final sign off of these at March Board meeting. A six-week period of consultation took place during November and December 2017, the main purpose of which has been to ensure that we fully address the needs of patients, our staff, partner NHS organisations and other Business partners across London. We are working with many of our stakeholders and business partners, including CQC to co-design our final strategy, which is due for release in early 2018.	LAS has developed a new five-year strategy through extensive research and engagement with patients, staff and stakeholders. The outline strategy was presented to the Board in October and the Strategic Intent Document issued. A stakeholder mapping exercise has been undertaken with all key stakeholders who are engaged with the strategy with all relevant meetings attended by appropriate level of representation from LAS. The final Strategy is due to be presented to Trust Board in March.

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No	Summary of undertaking	Owner	Evidence	Commentary
2.1.4	Timeline to refresh the Trust's supporting strategies	JO'H	- Strategic Intent 2018/19 -2022/23 outlines directorate priorities over the next 4-5 years. Operational plans being developed in readiness for the new financial year. - This is supported by the following strategies: - People & OD - 10/17 - Clinical Strategy - 01/17 - Assets and Property - In progress - IM&T - 01/17 - New QIP - March Board - Quality - March Board	New Director of Strategic Assets and Property only joined in February 2018 and is working on Strategy to be presented to Trust Board early 2018.
2.1.5	Board approval of the people and organisational development strategy and implementation plan showing progress with actions	PG	- Board approved P&OD Strategy on 03/10/17 - Progress for the implementation of the strategy is reported to the P&OD subcommittee.	An implementation plan has been developed and work is progressing at pace on delivering and implementing the P&OD strategy deliverables by themes.

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	2.1.6	Consult and engage with staff to: • Implement flexible rostering, rest break policy, leave policy and flexible working practices; • Manage sickness absence • Tackle bullying and harassment in line with phase two of Trust's plan • Deliver staff survey action plan and >50% response rate in the staff survey • Increase engagement score in the staff survey from the 2016 baseline	PW, PG	• Rostering/Rest Breaks • Consulting and engagement with staff is on-going. • New rest break arrangements were introduced in December and are under ongoing review. Formal Project Group has been established to look at the 'protected end of shift' arrangements and modelling being undertaken. A pilot will be run in South London, targeted for April, following a clinical impact assessment. Further work will continue with the unions to re-review the policy and align it to the end of shift times. • Improvement in the number of crews that are now able to take a rest break continues to increase. • New rosters are being developed to deliver the new operating model in 18/19 along with a review of skill mix. • Following the introduction of ARP, the Trust is currently scoping a review of operational rota patterns to deliver the new operating model collaboratively with frontline staff and trade unions. • Sickness Absence • A small improvement has been seen in the reduction of sickness absence over the last 10 months. Position as at Jan 2018: ○ Sickness all staff 5.2% ○ Short term 1.8% ○ Long term 3.4%	A full report on rest breaks and rostering will be presented with the latest status and progress at the March Board. Consultation on other working practices has ongoing as the implications of the ARP system and its impact on staffing is understood. Staff survey 2018/19 action plans being developed and actions implemented as appropriate, reported back through performance meetings, Board meetings and ELT. Response rate to staff survey above 50%. Engagement score has remained the same as previous year in a context of significant Executive changes, multiple restructuring and impact of major operational restructuring.

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No	Summary of undertaking	Owner	Evidence	Commentary
			○ Frontline sickness 5.4%. ● Bullying and Harassment ● Staff experiencing harassment, bullying or abuse by other staff down from 39% in 2016 to 32% in 2017. ● Bullying and Harassment award for 'courageous conversations'. ● Staff survey (question KF15B) showed that 77% of staff have not experienced bullying or harassment from their manager and (question KF15C) 82% from a colleague both an improvement on previous years. ● Staff Survey (question (KF20) percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has decreased 6% for white staff to 32% and 8% for BME staff to 32% ● Completion of bullying and harassment completed and transition into BAU. ● Staff Survey ● Staff survey response rate 53.6% better than 2016/17 (42%) and higher than average for other Ambulance services (47%).	
2.2	Work with the Improvement Director to support the quality improvement programme, as appointed by NHS Improvement	TB	● Confirmation of Improvement Director involvement in QIP and attend QIP board and ELT.	During 2018 due to increased confidence in the Trust, reduced attendance to on average 1 day per week but maintains regular contact via email and telephone.

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No	Summary of undertaking	Owner	Evidence	Commentary
2.3	Undertake a well led framework review and address the findings	PH	• Further review was completed by Discidium in September 2017, with the actions incorporated into an Agile / Burndown process and completed. • The Well-Led actions have been incorporated into the Quality Improvement Plan and completed/ are ongoing. • 'Deloitte well led' review in February 2017 actions completed	A detailed plan with 135 deliverables was used to track and close the actions, with evidence being provided for each of the completed actions prior to closure. Some of the actions required longer term plans e.g. P&OD strategy implementation, Rest Breaks/end of shift.

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	2.4	Complete the review of IT governance and processes and ensure sufficient capacity and capability is in place	RF	During summer 2017 PA Consulting and People & Organisational Design Partners supported the delivery of a changes to the IM&T function. This included: IT Governance IM&T reports into the Logistics & Infrastructure Board Sub-Committee. IM&T performance is reported monthly into CEO Performance Reviews. A weekly IM&T management meeting is held. Reviews IM&T performance, finance, supplier quality, risks. Standard agenda and weekly minutes for 2018/2017 available. A weekly IM&T service review meeting is held with technical leads from all teams. Standard agenda and weekly minutes for 2018/17 minutes available. IT Capacity & Capability Definition of new operating model including complete re-definition of Senior Management Team posts. The posts have introduced clear accountability and responsibility and use industry standard competency definitions. Formal restructure completed to appoint into the new senior team. The appointments were supported by a Director independent from the process. A review of posts in the organisation was completed an additional required post identified with funding agreed. Where substantive appointments have not	• Action plan in place responding to findings of the review • Tracking of progress in place to ensure achievement of action plan. • Resilient service being provided

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No		Summary of undertaking	Owner	Evidence	Commentary
				yet been made the directorate has augmented capability with managed services (for example Cognitas for Cyber Security, BT for IT architecture and network support) and interim staffing. Having appointed the Senior Team and concluded a final step of aligning remaining staff into the target organisation is currently underway. The new model has addressed specific weaknesses in the historic model. Single points of failure in technical expertise have been eliminated. Industry expertise is in place where appropriate.	
Buddy	3.1	Will co-operate and work with any partner organisations (this may include one or more 'Buddy Trusts') who may be appointed by NHSI to support and provide expertise	TB	Agreed with NHSI not to adopt Buddy scheme. However, Service works with other organisations via the NHS Improvement Director to adopt best practice.	

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No	Summary of undertaking	Owner	Evidence	Commentary
3.2	Will work with any such partner organisation on such terms as may be specified by NHSI	GE/JO'H	Working with NHSI, NHSE and acute trusts to embed a new standardised approach to significantly reduce handover times. South East London integrated care programme to ensure single point of access to provide more timely and appropriate care to patients A six-week period of consultation took place during November and December 2017, the main purpose of which has been to ensure that we fully address the needs of patients, our staff, partner NHS organisations and other Business partners across London.	

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	No	Summary of undertaking	Owner	Evidence	Commentary
Prog mgmt	4	• Sufficient programme management and governance arrangements in place to enable delivery of these undertakings • Programme management structure in place and widely understood • Board signed off enforcement undertakings • Clear action plan in place to ensure achievement of enforcement undertakings • Tracking of progress against enforcement undertakings a standing item at Board	MK	• Enduring PMO approved at ELT to support System wide improvements and re-design project. Discidium currently providing CQC and Business Planning support until end March 2018 or until post holders appointed. • QIP programme Board has been in place since October 2017 and reports progress to Trust Board and ROG. Part of the Quality Assurance Framework. • Undertakings circulated to the Board ahead of January 2018 Trust Board. • All QIP actions are covered by plans overseen by the Board. • Reporting on progress against action plan now taking place at performance meetings and Board meetings.	
Meetings & Reports		• Will attend meetings, conference calls as required by NHSI • Will provide reports as NHSI require	TB	• Improvement Director involvement in QIP • The new Director of Strategy & Communications is developing an external engagement strategy. • Reporting and update to SCB/ROG and NHSI Senior executive team	

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Appendix I – Deloitte Well-Led Recommendations

Deloitte	Under takings	Recommendation	Priority	Status
1	2.12	Identify the risks to the refreshed strategic objectives and refresh the Board Assurance Framework accordingly.	MEDIUM	Complete
2	2.12	Focus Board and committee discussions on the risks to strategic objectives, ensuring that this is reflected in agendas and assurance reporting.	MEDIUM	Complete
3	1.31	Implement a process for QIAs to be undertaken for all CIPs in a timely manner with appropriate engagement of staff and signed off by the Medical Director and the Chief Quality Officer.	HIGH	Complete
4	1.31	Ensure that CIP discussions throughout the organisation also include appropriate focus on the quality impact of schemes and that there is sufficient consideration of CIP quality impact post-implementation.	MEDIUM	Complete
5	4.0	Re-introduce an Executive portfolio which is exclusively focused on strategy and service transformation, including responsibility for cost improvements. This should be accompanied by a central PMO function with responsibility for coordinating and supporting Trust wide activities.	HIGH	Complete
6	2.1.1/2.3	Urgently appoint substantive Workforce and IT Directors and increase the pace and focus to progress the agenda in these two critical areas. The appointment of a Board level Workforce director would help with this process.	HIGH	Complete
7	2.1.1/2.3	Introduce a programmed schedule of periodic involvement of non-voting Directors in Board meetings as well as attendance at Board seminars.	MEDIUM	Complete
8	2.1.1/2.3	Create ring-fenced time away from normal Trust business to develop Executive relationships and build the team using business chemistry techniques.	HIGH	Complete/ Ongoing
9	2.1.1/2.3	Design and implement a customised development programme for the MD and DoO which gives access to other NHS organisations to provide greater visibility over what 'good' looks like. This should include the formal engagement of a peer mentor/coach as well as observations of Board and executive forums at other Trusts.	MEDIUM	In Progress
10	2.1.1/2.3	Introduce a programme of events to encourage greater interaction between NEDs outside of formal Board and committee meetings.	MEDIUM	Complete
11	2.1.1/2.3	Consider introducing a programme to further refresh NEDs over the next 18-24 months to ensure ongoing freshness of perspectives.	HIGH	In Progress
12	2.1.1/2.3	Introduce a comprehensive Board development programme aimed at team building and supporting the Board's journey towards becoming an assurance based unitary Board. This should be coupled by improved interaction between committee Chairs and relevant Executives.	HIGH	Complete/ Ongoing

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Deloitte	Under takings	Recommendation	Priority	Status
13	2.1.1/2.3	Undertake more explicit and formal succession planning in relation to Board positions.	MEDIUM	In Progress
14	2.1.1/2.3	Introduce a structured programme of BM visits to both clinical and non-clinical areas to ensure coverage of all areas within each year, with clear feedback mechanisms to managers and the Board on any points of interest.	MEDIUM	On-going
15	2.1.2	Explore other ways to improve the visibility of BMs by signalling the work of the Board, such as the Chair's blog.	MEDIUM	On-going
16	2.1.2	Introduce a rolling programme of sector leadership team presentations to QGC that focuses on quality related issues, risks, and actions being taken.	MEDIUM	Complete
17	2.1.5	Implement a structured and co-ordinated approach to leadership development and succession planning for all staff.	HIGH	Complete/ Ongoing
18	1.1.10	Implement a streamlined operational structure that is fit-for-purpose bearing in mind the needs of the organisation and the external environment.	HIGH	In Progress
19	1.1.10	Develop and implement an accountability framework that clearly sets out roles, responsibilities and accountabilities of leadership teams throughout the organisation. This should be supported by refreshed job descriptions for GSMs, ADOs, and DDOs detailing these agreed accountabilities, and agreed SLAs between corporate functions and operational teams.	HIGH	In Progress
20	2.1.2	Focus the committee reports to Board on assurance with respect to the risks to the strategic objectives and highlighting emerging issues.	HIGH	Complete
21	2.1.2	Address the areas for improvement identified from the Board and committee observations including attendance by Executives, summarising actions and meeting timings.	MEDIUM	Complete
22	2.1.2	Introduce a more formal performance management forum, which enables Executives to hold individual sector and corporate functions responsible for delivery of all aspects of their activities including finance, quality and workforce in addition to operations.	HIGH	In Progress
23	2.1.2	Introduce a consistent approach to performance management across the sectors and ensure that appropriate guidance and support is provided to ADOs and GSMs to do so.	MEDIUM	In Progress
24	3.2	Develop a structured and proactive approach to internal and external stakeholder management that is co-ordinated by one of the Executives.	HIGH	Complete/ Ongoing
25	2.1.2	Revise the Integrated Performance Report and supporting reports to address the areas of improvement notes within this section. These largely focus on: increased use of exception reporting; forward-looking narrative and	HIGH	Complete

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Deloitte	Under takings	Recommendation	Priority	Status
		forecasting focussed on assurance; early warning metrics; and increased granular information to signpost hotspots below Trust-level.		
26	2.1.2	Engage with managers throughout the Trust to promote the use of the sector level information packs to manage performance and hold to account. This recommendation supports RXXX.	MEDIUM	Complete
27	Appendix II	Develop and implement a Data Quality Assurance Framework that includes all the key performance indicators monitored by the Board, supported by a kite marking system for indicating the underlying data quality of indicators presented to the Board and throughout the organisation	MEDIUM	In Progress

Appendix II – LAS Data Quality Strategy – Update

Introduction

1. The purpose of this report is to provide an update on the delivery, progress made, and strategic direction of data quality in preparation for the next Well-led CQC inspection. There have been a number of different perspectives on the issues and the correct approach to data quality for the Trust, but there is agreement amongst the stakeholders that this is a topic of significant importance.
2. This paper aims to summarise the contextual history, actions to date and describe the next steps to bring the various viewpoints to a consolidated strategy for the organisation.
3. For reference the Audit Commission's 'Six Dimensions of Data Quality' are detailed below:

Accuracy



Validity



Reliability



Timeliness



Relevance



Completeness



CQC Inspection

4. In late June 2017, the CQC published the findings of their most recent inspection. The view of the inspectors was that the Trust required improvement and they highlighted areas where the Trust either must or should improve. There was only one area where the inspection team felt the Trust must improve - staff uptake of mandatory training subjects, and the “must do” action detailed a requirement to improve data quality:

“Importantly, the trust must [ensure]...the recording of [mandatory training subjects, including safeguarding vulnerable people and infection prevention & control]... to be more efficient and subject to scrutiny” CQC Inspection Report 29/06/2017 pg 5

5. The Trust is expected by the regulator to have acted on the challenges raised around the recording and reporting of mandatory training, demonstrate that data inconsistencies are understood and have a credible resolution plan.

Initial papers to ELT and the Audit Committee

6. Following initial feedback from the CQC, a research and best practice review was undertaken. In mid-May and mid-July 2017, papers were presented at ELT & the Audit Committee proposing a data quality assurance framework. Following feedback, a further review was conducted to:
 - prioritise assurance for organisational areas and their associated data assets (see table 1)
 - clarify and propose a governance structure
 - determine immediate next steps
 - recommend additional resource and costing for a data quality assurance team
 - clarify the roles and responsibilities of the data quality assurance team.

Immediate work from initial papers

7. The executive lead for data quality (the Director of Performance) took forward the steps to secure the finance for the data quality assurance team and formalise the full job descriptions.
8. A consultant was appointed to lead the work on the draft data quality strategy, engage with system owners and key stakeholders for priority areas, and undertake a root cause analysis on quality issues within the data for mandatory training.
9. In order to address the issues identified by the CQC with the mandatory training data, engagement has been secured and ownership agreed from finance, workforce, resourcing, and education & training. This diagnostic work is current and ongoing - formal highlight reports are to be presented to the Audit Committee.

Strategy development

Initial development and presentation at ELT

10. A draft data quality strategy was written for the forthcoming financial year to allow the vision for the Trust to be tested against the competing perspectives and a more long-term strategy to be presented in the following year. This detailed how accountability, policies and procedures, systems and processes, and people and skills would be managed in the initial phase of the Trust's growth in data quality maturity.
11. This was brought to ELT in mid-January to determine the approach for governance and it was agreed that the executive lead for data quality would report progress highlights into the Audit Committee for the short-term period. The longer-term governance structural intentions were for data quality and IM&T to identify a combined and potentially additional group for all Health Informatics related programmes.

Feedback from Audit Committee

12. The draft data quality strategy was discussed at the Audit Committee in early February and prompted a great deal of discussion. Although supported it was felt that, before the Audit Committee could fully endorse the strategy, the following areas warranted further consideration and review:
- the clarity and structure of the document with regards to the governance framework for data quality, including the roles of key players such as IM&T
 - how the strategy will prioritise the data areas most in need of attention
 - possible alternative approaches to data quality monitoring.

Next steps

13. Whilst the feedback from the Audit Committee is being progressed towards Board approval of the final strategy, the following areas of work are proposed to maintain continuity and momentum:
- facilitate a two-fold diagnostic exercise
 - an initial report from the CQC mandatory training diagnostic work will be presented at the next Audit Committee, whilst the ongoing work continues
 - a report from our internal auditors to review, assess and document the current Trust position in relation to data quality best practice
 - continue to advertise and recruit to the data quality assurance team
 - identify a combined and potentially additional group for all Health Informatics related programmes

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Table 1 – Assurance priorities for organisational areas at presentation to ELT / Audit Committee

Organisational Area	Example of Data Collected	Priority Rating for Data Quality Assurance
Performance and Operations	All historic operational data (calls, incidents, activations)	Low – existing data quality processes and auditing focus on this area.
Clinical Audit and Research Unit (CARU)	Clinical Indicators and patient outcome information.	Low – existing data quality processes and auditing.
Quality	Risks; Complaints; Safeguarding; Serious Incident reporting.	Low – existing input and data quality processes; central system.
111	Historic operational data.	Medium – integration with 999 data storage and standardised with BI.
Finance	Budget; Costs; Activity forecasts.	Medium – requires two-way data linkage with all other departments.
Workforce	Recruitment profiles; joiners; leavers; establishment; sickness.	High – focus for CQC and Audit Committee.
Resourcing	Rosters; Abstractions; Overtime.	High – critical element as helps inform tactical/operational planning.

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Fleet & Logistics	Vehicle numbers; make-ready processes; equipment replenishment.	Medium – various elements already reported on internally for assurance.
EOC	Real-time and historic data captured in control.	Low – existing data quality and operational change log processes.
Education & Training	To be scoped	Low
Communications	To be scoped	Low
Legal	To be scoped	Low



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report Title:	Report from the Chief Executive			
Agenda item	07			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The Chief Executive's report gives an overview of progress and key events within the Service since the last time the Board convened. The report is structured in sections, covering key areas of focus of the Trust and Board.				
Recommendations(s):				
The Board is asked to note this report.				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				

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

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

Chief Executive's Report

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

Operations

1. The operational management restructure consultation was launched on Wednesday 14 March 2018. Together with the Director of Operations and the Director of People and Organisational Development we presented the proposed structure, the rationale for change and how we will manage that change, to approximately 200 operational managers and clinical team leaders who were in attendance. The consultation is live until Sunday 15 April 2018 and staff whose posts are proposed to be disestablished can request a 1:1 meeting with the Director of Operations and a member of the People and Organisational Development team. A final reorganisation paper will be published following the consultation period. The timetable for completing the restructure is as follows:

Date/Week Commencing	
Wednesday 14 March 2018	• Consultation commences • Consultation document issued • Comments on proposals sought
W/C 19 March 2018	• Group and individual meetings commence • Responses to the consultation to be sent to the Director of Operations
Sunday 15 April 2018	• Consultation period ends
W/C 23 April 2018	• Response document circulated for information • Expressions of interest are requested
W/C 30 April 2018	• Commence implementation of phase 1 of the new structures. Phase 1 will involve the appointment of the most senior roles which directly report to the Director of Operations • Letters confirming assimilation are issued
W/C 7 May 2018	• Competitive interviews take place
May 2018	• Commence implementation of phase 2. This will start in late May 2018 and will involve those appointed in Phase 1 taking managerial responsibility for all those existing staff that now report into them and to start the recruitment process for the new/vacant posts which exist within their functions. A more detailed timetable for phase 2 will be published nearer the time.

2. Our Emergency Operations Centre (EOC) has been successfully re-accredited as an Accredited Centre of Excellence (ACE) in the use of Medical Priority Dispatch System (MPDS) by the International Academy of Emergency Dispatch (IAED). We are one of only three ACEs in England and one of 184 medical ACEs out of 2,976 centres across 46 countries. The accreditation is based on good levels of compliance in the use of MPDS and robust quality assurance and governance systems within EOC. MPDS is the triage system which looks at the signs and symptoms of callers and is used by Emergency Medical Dispatchers (EMDs) to quickly identify calls where a patient's life is threatened. Through the supporting system, they are linked to the emergency Computer Aided Dispatch (CAD) system which enables the fast dispatch of resources.

3. London and the South East experienced adverse weather in February, with temperatures significantly reduced compared with earlier in winter, as a result the LAS saw a marginal decline in performance for the 6 key AQI measures compared to January. The February C1 mean returned 7 minutes 28 seconds, slightly above the 7 minute national standard. The C1 90th Centile remained within the 15 minute standard at 11 minutes 48 seconds. This has remained within the standard each week since the implementation of ARP. The latest nationally published AQI data also shows the LAS ranked 1st in the C4 90th Centile measure and 3rd in the C1 90th Centile measure compared to Ambulance Trusts across England for January 2018. For all other measures we ranked 4th. This AQI benchmarking data will be refreshed with the February position following the release of new data in March.

Finance & Performance

4. As reported in detail elsewhere on the agenda the overall financial position for the Trust is £3.7m ahead of the internal plan at Month 11. The latest forecast is that the Trust will deliver a £0.6m deficit for 2017/18 against a control total deficit of £2.4m which is a significant achievement in the current financial environment across the NHS. The Trust currently has a use of resources score of 1 which is the highest available score.
5. Capital spend at the end of Month 11 was £13.8m against a YTD plan of £23.2m, £9.4m behind plan. The current forecast is to spend £21.9m vs the plan of £24.6m. Capital investment planned for 2018/19 has been brought forward in 2017/18 to utilise the slippage on capital.
6. Business planning for 2017/18 continues with successful budget review meetings held across all directorates during late February/Early March with the aim of maximising savings across corporate budgets to reduce the efficiency requirement on frontline operations.
7. In February the Business Intelligence (BI) team went through a peer review undertaken by the National Ambulance Information Group (NAIG). This review will result in a report provided to the Executive Leadership Team detailing the accuracy and consistency of the data captured for the Ambulance Quality Indicators (AQIs). The AQI measures ensure that there is a consistent dataset and set of metrics for benchmarking across Ambulance Trusts in England.
8. The BI team have also begun a departmental review of internal processes including regular reporting, documentation and continuity. This will help provide additional assurance that all essential and non-essential work is carried out to and form the basis of our departmental scorecard.
9. In order to capture the re-categorisation of calls in the Clinical Hub, considerable modifications were required and have been built into the data warehouse logic. This logic has now been deployed to the test environment and will undergo a robust checking and testing process to ensure the accuracy of timestamps etc. There are continuing discussions around the principle of re-categorisation, which will in turn support the testing and final live deployment.
10. Forecasting & Planning continue to support Easter Planning, and are monitoring current trends in Calls and Incidents to be able to provide assurance of the forecasted levels as we get closer to the long weekend. The team have also been instrumental in the NHSI activity submission for 2018/19 planning, working with Finance to provide a forecast for each category by month across the year. The Directorate have shared their activity trajectories for Easter and the Scheduling Team are ensuring operational cover over the Bank Holiday periods is optimal.

11. Work has also continued on the new, bespoke short-term forecasting model, which will begin to be rolled out to Operations this month. It provides an indication of demand, and required capacity to meet this demand, ensuring a good level of performance is maintained. The team will continue to enhance this model iteratively, and will next begin work on designing and developing an interface so that the forecasts will be accessible to senior managers across the Trust to support planning decisions. Briefing sessions will be scheduled to demonstrate the new model, and how to interpret the information it provides.
12. February has been a busy month in relation to finalising our activity numbers with Commissioners. We have had several meetings to resolve a long standing issue with the interpretation of Hear and Treat activity pre and post ARP. We are pleased to note that this is now understood and we are working on building a more appropriate terms of reference and trajectory for next year.
13. Forecasting & Planning are also currently developing full activity forecasts as part of the 2018/19 contracting round. The process first involves estimating 2017/18 outturn, then deciding and evidencing an expected annual growth rate, and finally generating an 18/19 forecast for activity. This will form a crucial part of the contract negotiations with commissioners over the coming weeks.
14. Two new scorecards have been developed for the monthly operations performance reviews, the first is the Group Station scorecard for use with Sector Operations, and the second is an EOC Watch scorecard. Both will enable greater granularity, benchmarking Group Station and watches performance against each other.
15. We also continue to work on the development of new directorate and divisional scorecards for 2018/19 as an outcome of the business planning process. We are gradually receiving initial drafts of stakeholder's thoughts of KPIs and how we integrate them into our four domains, Patients, People, Public Value and Partnerships.
16. Finally, our local Staff Survey Champion organised a recent session with all members of the Directorate to understand more about their survey feedback. We discussed ways in which we can improve key highlighted areas and have already begun to devise action plans collaboratively.

IM&T

17. During February IM&T managed two Critical Incidents: an outage of the South East London 111 in-bound telephony on 20 February and an issue with CAD which resulted in the business continuity procedures for Control Services being implemented on 21 February. Both Incidents were successfully managed, the root causes have been identified and addressed. On 18 February an external power supply failure from UK Power Networks into the St Andrews House in Bow was managed with no operational impact.
18. We attended the first London Digital Partnership Board on 28 February. This board brings together leadership from NHS Digital at a national level, NHS England for London, each STP and the Mayor's Chief Digital Officer to put in place a coherent plan for health and care digital transformation for the capital.
19. The Trust is required to be compliant with the national Data Security and Protection Requirements from April 2018. A review of our status has been completed and we expect to be compliant by the end of March. The new requirements replace the IG Toolkit. They form part of a new framework for assuring that organisations are implementing the ten data security standards and meeting their statutory obligations on data protection and data security. A full report of compliance will be issued to the Logistics & Infrastructure Committee for assurance.

20. The IM&T management team held a peer meeting with colleagues from London Fire Brigade's IT function. Several collaboration opportunities have been identified and have already generated benefit by eliminating the need for LAS to undertake independent selection and evaluation of replacement mobile phones and establishing shared procurement of an IT Service Management toolset.
21. The infrastructure renewal programme has successfully replaced the majority of infrastructure planned for this year and is on track to complete the programme within the financial year. We were successful in bidding for a further £350k from NHS England to address cyber security issues.
22. A notable highlight is the inclusion of fuel card data into the data warehouse which will enable the production of the reports necessary for the fuel management. Included in this is the import of the data from BP, data quality checks and the design of reports and a fuel dashboard. We have also kick-started a programme of sharing of defibrillator data with the LFB, i.e. from the defibrillators carried on fire trucks and soon also on officers' cars.

Strategy

23. We have been finalising our new organisational strategy which is being presented to Trust Board for consideration today. This final strategy incorporates all of the feedback which was presented to Trust Board on 30 January 2018 and is the culmination of a significant amount of work from across the organisation that has gone into developing our new strategy.
24. In support of the new strategy, we will be refreshing or finalising the organisations 'daughter documents' which will examine the implications of our strategy on all functions of the organisation and will include detailed delivery roadmaps and action plans. These daughter documents will be brought to Trust Board for sign off over the next 12 months.
25. The London Ambulance Service is looking to establish a new volunteering service. This will give members of the public a range of opportunities to get involved in what we do, to learn about the Trust and to help us to improve patient care for Londoners. Our volunteering vision is described in our new five year strategy and will involve producing a volunteering strategy and creating a volunteer charter which will describe a mutually beneficial and fair relationship between volunteers and the trust. It will summarise how we will support volunteers in their role and describe our expectations of the individuals who volunteer. We will develop a framework for the volunteering scheme with a dedicated senior lead and project management support.
26. We are currently planning two 'Whose Shoes' workshops; one for maternity service users and one with a mental health focus. The workshops revolve around a board game and are designed as a facilitation tool, allowing us to engage with staff and patient groups, and understand perceptions. This will inform development of the maternity and mental health pioneer services.
27. We have also held further meetings with our patient representative groups, including facilitating a working session with Healthwatch representatives from across London, to discuss how we can co-design the pilot services that will come out of our new strategy.
28. The LAS contributed to the successful bid to the Home Office Transformation fund to establish a programme of works to verify and validate the merits (or not) of a single control room for London. The current working title for this programme is 'Collaborative Contact and Response'. We are currently in phase 0 of this programme which sees the governance resource requirements and mandate agreed. Once complete this will be presented for ELT for discussion comment and agreement.

Quality Improvement

29. The second review of Health and Safety compliance for the Trust was undertaken during February. A draft report has been provided that shows good progress against actions. Additional actions have been highlighted and placed on the overall action plan. Areas that show limited progress relate to workshop activities. However the independent assessor agreed that the current risk of 20 should be reduced to 12. The Board will be requested to remove the risk from the BAF and it will remain on the H&S and corporate risk register.
30. The first part of the CQC inspection took place in the week beginning 5th March. The inspection team visited approximately 20 stations and interviewed various members of staff. The initial feedback was positive with the inspection team seeing significant progress across the trust. The interviews for the executive team took place on the 21st and 22nd March. We anticipate the inspection report within 6-8 weeks post review.
31. The annual Strategy and Quality account are now in draft and will be presented to the Board. Final sign off will be part of the annual accounts at the April Board. The strategy sets out the actions to support continuous quality improvement by building capacity and capability across the organisation. The quality improvement plan includes our priorities for 2018-19 and will include any further recommendations following the publication of our CQC inspection report.
32. The first meeting of the steering group to implement QI and Human Factors training met in February. The aim is to train a critical cell of staff across sectors and from corporate teams to become train the trainers. We envisage this being complete by Q2 and in conjunction we will be running 1 day human factors courses as a rolling programme for all staff to attend. The group are exploring the use of e-learning to increase the numbers of staff who have an understanding and knowledge of human factors over a shorter timescale. The programme is included in the QIP.
33. The business case to provide capacity to reduce the number of frequent callers was submitted to the CCG. The case was positively received and we anticipate financial support for this resource, we await the outcome of discussions this month.
34. The recruitment for mental health nurses to support the clinical hub has now concluded. Out of the 40+ applicants, 3 candidates were chosen and the final stages of the recruitment process is underway, all candidates should be in post within 3 months.
35. Work continues in developing the pioneering services e.g. mental health, end of life system wide pathways. These will be outlined within the Trust strategy document submitted to the Board in March. The Mental Health Trust directors of nursing will be convening a sub-group focussed on single points of access (SPA) the group will share good practice.
36. The implementation of the mental health response car is being finalised to commence Q1 following a successful trial.
37. The Schwartz rounds are being implemented across the service and the first cohort of 6 facilitators and a clinical lead will be trained by June. The purpose of these rounds is to support staff who have dealt with difficult incidents e.g. end of life care, suicides. These will support other programmes being provided by our occupational health service.

Medical Directorate

38. The Medical Director has continued communication and engagement with NHSE and NHSI to improve understanding of issues behind, and implement potential solutions to address problematic delays in handover at some hospitals across London.
39. During the last week in February, as the region was hit by a sustained period of icy weather, members of the Medical Directorate supported operational and tactical commanders in ensuring that the Trust was adequately prepared to manage a period of challenge. Specific guidance on the management of fallers in public places was issued to EOC personnel to minimise the effects of cold.
40. In response to a number of changes in availability of medicines, packing lists of drug bags were reviewed and guidance was shared with crews on a new presentation of hydrocortisone.
41. Four employees of the Trust (drawn from four directorates) have started year-long programme with University College London Partners to develop a programme to improve the understanding of Human Factors in patient safety.
42. Changes to legislation have been laid, and which come into force on 1 April, to enable paramedics to independently prescribe medicines. Whilst this represents a significant step forward for the profession, there is a considerable amount of work needed to ensure that this is safely implemented.
43. The Clinical Audit and Research Unit (CARU) continue to publish monthly and quarterly audits on time in order to improve and enhance the care provided to patients. Amongst other clinical trials, the first patient to the Arrest trial has been recruited. The study is a large-scale randomised controlled trial that compares direct transfer of post-ROSC patients without ST-elevation on their ECG to a Heart Attack Centre versus standard care.
44. Infection Prevention & Control: compliance with 6 weekly deep clean schedule continues to exceed 90%.
45. Quality assurance of 6 weekly deep clean has been completed for all 5 sectors in February; data analysed and fed back to ensure continuous improvement.
46. Good feedback was received from the CQC following the IPC interview session in early March.
47. In order to apply for an increase in student numbers for the Academy program, preparations for the 3-year HCPC audit for the existing cohort of 54 students are progressing well and should provide a favourable platform for the submission of a "Major Change" to the HCPC in early summer for the expansion of the LAS Paramedic Programme. Discussions have continued with two universities to offer access for EAC/EMTs to upskill to a registered paramedic. In addition, new partnerships are being forged with the University of West London and Buckinghamshire New University to increase paramedic degree programs to support the corporate strategy to increase the number of recruits for the paramedic pipeline, particularly from diverse communities.
48. As part of the Trust's cost improvement programme agenda, steps have been taken to prevent procuring external driving instructors, which incurs a financial risk to the Trust in the region of £51,000 per month. To mitigate this, the recruitment to 6 driving instructor posts have now commenced.

People and Organisational Development

49. My ESR continues to be a success with a move from 85% to over 92% of Trust staff (5,286) accessing the new version of the system which became available to Trusts nationally in May 2017. We continue to have the highest % of users using the new ESR Portal in London (out of 71 Trusts) and we are now the 4th highest % of users nationally (11th in February).
50. The MyESR Helpdesk has resolved 4,523 queries by email and phone since MyESR went live on the 18th September and the ESR Workforce Dashboard continues to be positively received and we have had over 10,900 views from 457 managers. There is an increased demand from our managers for the ability to export the data and this will be reviewed by the IG Committee to ensure consideration of data protection obligations.
51. At the recent ESR Project Board, we reviewed the high level plan for 2018/19 covering the following deliverables:
- eForms solution (Q1 – Pilot, Q2 – Roll Out)
 - OLM Optimisation (Q1-Q3)
 - ESR Interfaces (GRS) (Q3-Q4)
 - ESR Restructure (right people in right place) (Q1-Q2)
 - Data quality (Q1-Q4)
 - New developments (inc OWR, CISO, CPI, Safeguarding, non-payroll staff). These will be considered by the Project Board on a case by case basis depending on priority.
52. The Statutory and Mandatory Training compliance at the end of February 2018 stood at 80.47% for the Trust with Operations at 79.58% and Corporate at 93.66%.
53. CSR.2017.2 reports as 66.89% compliance and CSR.2017.3 is at 55.04%. The high level of operational demand has increased the pressure on completion of both throughout the bad weather conditions but both continue to be closely managed through the weekly CSR report by ADOs and sector compliance leads.
54. As part of the IG Audit a plan has been created to reach the 95% compliance requirements of the IG toolkit within the first month of the new financial year.
55. People and Organisational Development began a key piece of analysis work to review and understand its current organisational culture as well as help determine the Trust's desired target culture and identify steps to achieve it. The rationale for this analysis stemmed from a number of reports which identified areas for cultural improvement, including: CQC findings, staff survey results, anecdotal staff feedback and the Andrea Adams 2014 report. Seven areas of analysis were undertaken; including a staff engagement event, two tier 1 management sessions, staff survey results, CEO road-show feedback and the Pulse organisational climate check. NHS Elect were commissioned to undertake 1-2-1 interviews with our Executive Team to discuss behaviours and culture. The information collected has been analysed using the NHS Improvement culture toolkit which sets out the findings against 5 key elements of high quality care culture: vision & values, goals & performance, learning & innovation, support & compassion and team work. The findings of the analysis have been finalised for consideration by ELT along with a final report from NHS Elect.
56. Underpinning our culture, is our behaviours and values. Over the last 12 months, P&OD have developed an LAS Behaviour Model which has been developed in conjunction with staff and aligns to the NHS Leadership Academy Healthcare Leadership model and will align to the LAS Leadership Development Pathway. Going forward, with the development of our organisational purpose, vision and values, the LAS Behaviour Model will be

realigned to underpin the 4 new organisational values; setting out the behaviours, how we demonstrate them and how we don't.

57. The independent training review across the organisation is now underway. The scope and plans have been presented to the People and Organisational Development Committee for information and regular updates will be provided on progress through to presenting final recommendations in early May. The project will cover all training provision within the Trust across both corporate and clinical areas.
58. The Trust's Leadership Development Pathway continues to be developed and we are awaiting final confirmation of content as part of the outputs of the Operations Restructure Consultation after which the final version will be presented to ELT for their approval at the end of March 2018 for launch of the overall pathway in April alongside the new values and behaviours.
59. Meanwhile development of each of the Pathway elements continues including exploring potential for accreditation through ILM or as a Professional Apprenticeship.
60. The Coach to Lead programme launched on 15 March following a short delay due to the bad weather conditions. It is designed to equip managers with the skills to manage using a coaching style and will be supported in the Management Essentials offer with a half day workshop around Coaching Conversations.
61. The Sponsorship Mentoring and Reverse Mentoring projects (leadership development and inclusion initiatives) have progressed further with the Performance Coach commissioned to deliver this work. Expressions of interest for applicants for both programmes will be launched in May 2018.
62. The appraisal audit continues with a mixture of semi-structured interviews across selected areas supported with an open access survey to all staff. Results so far are encouraging with some key themes which will help the PDR Appraisal Improvement Plan, as well as define requirements for an e-Appraisal system. PDR Appraisal training for both managers and staff continues to be delivered and again yields valuable feedback on the current PDR Appraisal system.
63. The Corporate Induction improvement plan continues apace with the current weekly format to be replaced by a fortnightly joint corporate/clinical induction at a central London location. Proposed changes include alignment to values with consideration to changing the delivery methods to make the experience more engaging, for example through using an APP-based game.
64. Discussions have also commenced on the feasibility of introducing the requirement of pre-employment StatMan training, one option for ensuring key subject areas are delivered whilst making space for other subjects.
65. As a result of learning following a sharps case, PAM have revised the process to include a response 7 days/ week, this was previously set at 5 days/ week under the original contract. This will give assurance to any staff member who has a body fluid exposure particularly over the weekend, they will be contacted in a timely fashion and have received advice and support expediently.
66. In addition to the introduction counselling drop in sessions for EOC in February, other health promotion activities have commenced to support the physical and mental/ emotional health of staff in the area, including; Physio drop in and yoga classes. Other staff suggested ideas are being explored; holistic therapies, access to HEADSPACE meditation App and team building activities, to support better relationships between colleagues.

67. Following the volume of new starters being re-referred by the recruitment team to PAM, a new process has been introduced which will reduce administrative processes internally and streamline the end-to-end process. Any new employee who answers 'yes' to anything on the Fit4Jobs form will be automatically referred to OH for an appointment to see an OH advisor or Doctor, dependant on what is disclosed. Additionally, we will look to develop a Jobs Profile form which will form part of the pre-employment recruitment process. The purpose of this document is to undertake a further testing as to health suitability for a role, e.g. levels of mental robustness and resilience for roles in highly pressurised environments.
68. The immunisation project is over 80% complete in terms of reviewing staff records and establishing which staff members require an appointment, the paper exercise is due for completion by the end of March.
69. The Medical Director has approved vaccines requirements for all staff groups and a meeting took place with ADO's to agree approaches to vaccines. Planning of the physical vaccination programme is now underway, starting in the control rooms and at Brent station, these areas will be used to test several approaches that have been suggested by group station managers and ADO's including:
- Deploy the 'flu-bus' to hospitals for purposes of occupational vaccines
 - Arrange for nurses to attend the roadshows
 - Book clinics/specific appointment slots for staff vaccines
 - Arrange for nurse to attend all CSR sessions
 - Arrange for nurse to attend evening change over at stations
70. Vaccinations have continued throughout March and will take approximately 6 months to complete due to the high numbers of staff that require recalls.
71. On 5 March Patricia Grealish attended the launch of the national WRES Expert Programme in support of Agatha Nortley-Mesh who will participate on behalf of LAS (and who is co-Chair of our own BME network group). The programme is a national WRES initiative that was well attended by a range of NHS Trusts as well as CCGs and STPs. The focus will be on developing the skills of our 'Expert' over the programme to give depth to the experience they can then bring to LAS to tackle our own WRES agenda. One of the benefits is that participants on the programme will form an important network to share experiences and best practice.
72. The BME staff network met on the 22 February to agree a work plan and how to move forward, including establishing a link in to the national BME group. The group will focus on relaunching and getting more staff involved.
73. Community engagement events continue in shopping centres across London with more planned.
- 12 February The Glades in Bromley - 101 expressions of interest
 - 19 February Ealing shopping centre - 98 expression of interest.
 - 26 February Wood Green Shopping centre - 294 expression of interest.
74. Following a deep dive into the recruitment data an immediate action agreed will be to train a cohort of BME staff to participate in Super Saturday and corporate recruitment events.
75. The Bullying and Harassment Round Tables continue as cases come forward used as an alternative method to resolve conflict outside formal processes.

Communications

76. I attended the Global Awards earlier this month, where I joined Assistant Commissioner Mark Rowley from the Metropolitan Police and London Fire Brigade Commissioner Dany Cotton on stage to receive the 'News Moment of the Year' award which recognised the bravery and professionalism of our staff during last year's major incidents. I was incredibly proud to represent our Service, but also all the other ambulance services across the country that work together to ensure we are able to respond when patients need us.
77. In early March I met with David Bellamy, Chief of Staff to Mayor of London, our discussions focused on collaboration, current demand and performance and plans to green our fleet.
78. The extremely cold weather during recent weeks led to shared advice through the media and social media; Assistant Director of Operations Stuart Crichton was interviewed live on BBC London and gave a pre-recorded interview which featured on ITV national news. Messages were also shared on our corporate Twitter account.
79. A video of on-duty Paramedic Kat McKenna from St Pancras cycle response unit cycling through the snow went viral on social media, and was featured in the Evening Standard and on BBC London TV. NHS Chief Executive Simon Stevens made specific reference to Kat when he praised NHS staff for going the extra mile to provide patient care during the bad weather. Paramedic Chris Gordon, who also works on the cycle response unit, was interviewed for Heart Radio about the pressures of working in the snow.
80. Practice learning manager Jules Lockett has won the John Gilhooly Award for the Unsung Hero at the Control Room Awards 2018. The awards were held for the first time this year to recognise the life-saving and life-changing work of staff in control rooms from fire, ambulance and police, to aviation and transportation services.
81. I presented our 11 second round VIP award winners with their certificates and vouchers this month. All the winners had been nominated and recognised by their colleagues for going above and beyond, and the presentation event was an opportunity to hear about some of the great work that individuals have been doing across our Service.
82. The following are media stories of note:
 - Staffing levels in our control room: The Guardian published a story about our control room staffing levels, linking staff vacancies to our ability to respond to calls. We requested a correction to the original story, which was carried in the print version; namely that our vacancy rate was 15.3 per cent, not 20 per cent as originally reported.
 - Frequent callers: BBC News (online and TV news), the Times and the Evening Standard covered a story about frequent callers to ambulance services, with all of them quoting our Service as receiving the highest number of calls (3,594) by a single patient.

Garrett Emmerson
Chief Executive Officer



Report to:	Trust Board													
Date of meeting:	27 March 2018													
Report title:	A world class ambulance service for a world class city – strategy 2018/19 – 2022-23													
Agenda item:	08													
Report Author(s):	Angela Flaherty, Deputy Director of Strategy													
Presented by:	Angela Flaherty, Deputy Director of Strategy													
History:	There have been a number of papers and updates that have been presented to Trust Board through the development of our new strategy: <table><thead><tr><th>Date</th><th>Presentation/paper</th></tr></thead><tbody><tr><td>30 January 2018</td><td>Paper presented outlining our engagement on 'Our Strategic Intent'; including patient, staff and stakeholder feedback</td></tr><tr><td>28 November 2017</td><td>Update presentation on strategy development and engagement</td></tr><tr><td>31 October 2017</td><td>'Our Strategic Intent' presented and approved</td></tr><tr><td>3 October 2017</td><td>Paper to propose the timeline and methodology of strategy development presented and approved</td></tr></tbody></table> Further to the formal papers and presentations made at Trust Board, there have also been a number of workshops with Trust Board members to develop our strategy				Date	Presentation/paper	30 January 2018	Paper presented outlining our engagement on 'Our Strategic Intent'; including patient, staff and stakeholder feedback	28 November 2017	Update presentation on strategy development and engagement	31 October 2017	'Our Strategic Intent' presented and approved	3 October 2017	Paper to propose the timeline and methodology of strategy development presented and approved
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Status:	☐	Assurance	☐	Discussion										
	☒	Decision	☐	Information										
Background / Purpose:														
This paper seeks approval from Trust Board for our draft new five year strategy; A world class ambulance service for a world class city.														
Recommendation(s):														
The Trust Board is asked to approve our new organisational strategy														
Links to Board Assurance Framework (BAF) and key risks:														
N/A														

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
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A world class ambulance service for a world class city – strategy 2018/19 – 2022-23

1. A huge amount of work has gone in to developing this strategy from across the organisation, following best practice guidance from the NHSI strategy development toolkit, as well as following CQC Key Lines of Enquiry (KLOE) expectations. As part of the strategy development process, Trust Board have previously approved two key documents:
 - 'Our Strategic Intent' which outlined our initial strategic propositions developed through modelling, Trust Board development sessions and workshops with senior managers and subject matter experts within LAS. This document was used as the basis for our period of engagement
 - 'Summary of Engagement' which outlined the key feedback that we received from patients, staff and stakeholders through our engagement period. This feedback was all incorporated into this final strategy
2. The key elements of our new strategy are:
 - **Challenges and Opportunities** – we set out the challenges faced by the NHS system as a whole as well as the opportunities that we have identified to improve services and the role that the London Ambulance Service can play in meeting them.
 - **A world class ambulance service for a world class city** – we outline our strategic vision and introduce the three strategic themes of our strategy
 - Strategic Theme 1 - Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
 - Strategic Theme 2 - A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital
 - Strategic theme 3 - Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable
 - **The impact of our strategy** – we detail the benefits that we believe our strategy could deliver, including economic benefits and a reduction of patients requiring conveyance to emergency departments
 - **Delivering our strategy** – we outline the fundamental changes that will be required across our organisation to deliver our strategy. In achieving the new blueprint for our organisation, we will need to make key changes to our organisational structure, culture, capabilities and infrastructure.
3. Whilst this strategy details our overall ambition for the organisation, it will be supported by a number of 'daughter documents' which will examine the implications for functional areas of our organisation. Each of these daughter documents will have a delivery roadmap and detailed action plans to ensure that we can deliver this overall organisational strategy. Whilst some of these strategies already exist and some are yet to be signed off, all of them will need to be refreshed following the publication of this strategy to ensure they are fully aligned. The timeline for development of these daughter documents, and the dates of their Trust Board strategy development sessions, and eventual Trust Board sign off dates will follow.

4. Following approval by Trust Board, a far reaching communications campaign will be developed to launch the strategy with our staff, our stakeholders and to Londoners in general. An outline of this communications campaign will be brought to Trust Board in April 2018.

Angela Flaherty
Deputy Director of Strategy



London Ambulance Service
NHS Trust

A world class ambulance service for a world class city

Strategy 2018/19 – 2022/23

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Chair's introduction

The London Ambulance Service (LAS) is one of the largest and busiest ambulance services in the world. Serving a growing population of over 8.6m people in one of the most socially and culturally diverse cities on earth, our distinctive vehicles are on the road 24 hours a day, 365 days a year, ready to respond to Londoners and visitors alike, whatever their medical emergency.

As an integral part of the National Health Service (NHS) in London, we play a vital part in ensuring patients get the right emergency care at the right time when things go wrong and, where necessary are conveyed quickly and effectively to the right care pathway for onward treatment.

The NHS in London is however under more pressure from growing demand than ever before. It is therefore vital that the LAS becomes even more effective at quickly responding to and accurately triaging patients; treating people sooner whenever possible – whether on the phone in our control centres for those with more minor ailments (or, in the future, potentially online), or at the scene of incidents when we need to dispatch an ambulance, utilising the increasing capabilities of our paramedics, emergency ambulance crews and clinical support staff. We also need to work more closely than ever before with our colleagues in the wider NHS to develop and make more use of alternative care pathways that often offer our patients better, quicker and more appropriate care and, as a consequence of this, take fewer people to general emergency departments (A&Es).

To do this, we need to work with our commissioners, NHS England, NHS Improvement and London's five sustainability and transformation partnerships (STPs), playing an increasing role at the heart of the city's healthcare system as London's primary integrator of access to urgent and emergency care 'on phone', 'on scene' and 'online'.

To achieve this, the LAS Trust Board has undertaken and commissioned extensive work, both internally and externally which has led to the development of this strategy. With the help of our partners, we are confident that we can deliver further sustainable improvements in care we provide for our patients and support the wider healthcare system to deliver ever better value for money for the services we collectively provide.

Heather Lawrence

CEO's foreword

The LAS has a proud history of innovation in ambulance provision and serving the capital. Stretching back over a hundred and twenty years from the first ambulances by the London Asylum Board in the 1880s, through to the creation of the LAS as we know it today (in 1965), the service has always been at the heart of major developments in mobile medical care. Today, with over 5,000 people (and nearly 3,500 front-line clinical staff), we aim to be never more than a few streets away when you need us most.

Through recent advances in the treatment of major trauma, cardiac arrest, heart attack and stroke care, many more people survive these serious events than was the case even only a few years ago. However, the majority of our patients have less serious illnesses and injuries and we need to evolve our service to better serve all of the 1.8m people who call 999 every year in London, together with the increasing numbers of people who use our 111 service to seek help and advice on less urgent issues. To do this we need to transform our organisation, not only clinically and operationally, but also making sure we invest in our people, our fleet and estates infrastructure, as well as our IT systems and project management capability, to enable us to continue to provide the outstanding patient care that the organisation is rightly renowned for.

I have been incredibly proud to lead this organisation through one of the most challenging years in its history during 2017. We now need to build on the successes we have achieved recently to ensure that we can continue to provide this exceptional level of care and service going forward. Treating more people at home or at the scene of incidents, providing more effective care on the phone or online and enabling more people to access better care through alternative care pathways will enable us to improve the quality, effectiveness and cost efficiency of the care we provide to our patients.

As a result of advances we have made in the last few years, we have already reduced the proportion of patients we take to emergency departments from over 70% in 2011/12, down to around 63% today. I believe we must now challenge ourselves to improve on this further so that, by the end of the period covered by this document, we are nearer to only 50% of our patients needing to go to an emergency department to get the care they need. This will both improve the speed and quality of the care we provide and reduce pressure on the wider system.

This strategy, which has been the subject of one of the largest staff, public, partner and patient engagement exercises we've ever undertaken, sets out our vision to achieve this, aiming to make the LAS the genuinely world class ambulance service that Londoner's and visitors to our great city expect and deserve.

Garrett Emmerson

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1 Executive summary

1.1 Challenges and opportunities for the urgent and emergency care system

Substantial and sustained increases in the demand for urgent and emergency care arise from a variety of factors that drive the need for change. In London, planning and delivering services is made more complex by large transient and non-residential population, with many workers commuting to or through the capital every day.

The population as a whole is growing and there is a rising age profile, contributing to increases in drivers of demand including long-term conditions, mental ill health and obesity. Patients' needs are becoming more acute and more complex. At the same time, their expectations of access, convenience and use of technology are changing, meaning that we need to deliver healthcare in different places, at different times and through different channels. Recruitment challenges within front-line and support functions also make it difficult to deliver services as we do today.

Ambulance services inevitably experience the effects of growing urgent and emergency care demand, with more patients to attend and an increasing ability to treat and discharge when appropriate to do so. Pressures apply to both vehicle use and call volumes, with the former requiring clear focus on patients with the most critical needs for fastest ambulance response; and the latter requiring ability to manage growing numbers of both 999 and 111 calls.

The NHS *Five Year Forward View* and the Keogh Urgent and Emergency Care Review set a vision for care that needs the decision-making, diagnosis, treatment and referral skills of modern ambulance clinicians. There is a clear focus on avoiding unnecessary emergency department attendances and hospital admissions. For urgent physical or mental care needs, there should be highly responsive care close to home; and for more serious or life-threatening emergencies, there should be treatment at the scene and conveyance to the most appropriate facility.

An important enabler for these national and regional strategies is the development of a more integrated approach to accessing urgent care, with multidisciplinary clinical assessment via a range of channels. This will have the depth and breadth of expertise to avoid overuse of precautionary referrals, but also direct access into appropriate care pathways when clinically necessary.

We aim to play a major role in national and regional strategies to improve patient outcomes and experience – and as the only pan-London NHS provider, we have a unique opportunity to do so. Working with London's five sustainability and transformation partnerships (STPs), we will support local needs and contribute to common goals such as better prevention, improved access to acute and community care, better use of technology and rapid crisis intervention. We will also support the aim of the Healthy London Partnership to move towards clearer, more coordinated and more consistent urgent and emergency care services across all London boroughs.

We convert fewer NHS 111 calls to 999 emergency dispatches than any other 111 provider in London. South East London 111, which we run, shows a consistently low level of ambulance dispatch in comparison to other London 111 services. If all 111 services had similarly low dispatch rates, this would equate to 25,000 fewer ambulances being dispatched to patients per year.

1.2 A world class ambulance service for a world class city

Our vision is to be London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'. Our purpose is to provide outstanding care for our patients, while being a first class employer, providing the best possible value for money and optimising healthcare and emergency services provision across London. Our approach will be rooted in our values of being respectful, professional, innovative and collaborative.

Underpinning our aims, we have identified three strategic themes that will help us achieve significantly improved patient care, better use of our resources and a lower overall cost to the urgent and emergency care system.

1.3 Strategic theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients

A key principle of this theme is that the NHS should manage and coordinate the flow of patients through urgent and emergency care, rather than expecting patients to know where they need to go. Care pathways currently differ significantly depending on where people live or need access to services. Given our London-wide reach, we believe we can be the most effective coordinator of urgent and emergency care, improving both patient experience and demand management of services.

iCAT London, our integrated clinical assessment and triage service) will position us as the integrated point of access to the most appropriate care, whether patients contacts us by telephone or via a digital channel, and wherever in London they may be. This provides benefits for patients, GPs and the wider urgent and emergency care system; but is dependent on employing or seconding a wider range of clinical professionals, partnership working to access additional specialist skills and improve clinical decision-making, and effective use of technology.

1.4 Strategic theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital

The future system of integrated urgent and emergency care requires a radically different ambulance service, emphasising assessment and treatment at the scene and in community settings, faster conveyance for the most critically ill, and transfer into the most appropriate pathways of care for other patients. Being taken to hospital should no longer be the default option.

We want to focus on some specific cohorts of patients who would benefit from a different type of response: urgent care response, falls, mental health, maternity and end of life care. We know, for example, that falls and maternity account for around 12% of our responses (132,000 incidents). A more targeted approach can improve care for these patients as well as improving efficiency. We are pioneering a range of service developments to make the most of these opportunities. To deliver this increased differentiation, it will require access to a wider mix of skills and a broader range of response vehicles.

There is an opportunity to review the best and most innovative treatment options for the most critically ill patients, including those with major trauma or experiencing conditions such as cardiac arrest, stroke or sepsis.

1.5 Strategic theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

We will develop collaboration, partnership and innovation across the full range of public services in London and will support all opportunities to improve patient outcomes and experiences and improve public value.

As the only pan-London NHS provider, we have unique insight into the care that patients have available to them across London. We can help NHS England and London's five STPs to identify the services that are best able to manage demand, where there are inconsistencies and where changes to service delivery would provide benefits to patients and the urgent and emergency care sector as a whole. To enhance coordination of urgent and emergency care design and development in London, we will improve our analytics capabilities, through better data analysis, to help distil our experience and insight.

We will also work closely with other emergency services. As a Category 1 responder, we have to be able to deal with major incidents of all types and this is dependent on effective coordination with other services. We will also focus on collaboration with the Metropolitan Police Service and the London Fire Brigade, which may include prevention activities, control rooms, support functions and infrastructure including estates and technology.

1.6 Estimating the economic impact of our strategy

Our strategy will have direct clinical benefits for patients by providing more clinical care remotely by 'hear and treat' and by increasing to over a quarter the proportion of our patients who received a specialised response, discharging them on scene where possible by 'see and treat'. A reduced conveyance rate to emergency departments will mean that hospitals will deal with fewer patients who do not need to be there, which has both operational and economic benefits.

We estimate total avoided costs of £19.2m for the London iCAT and £18.9m for the pioneer services, between the London Ambulance Service and London's five health economies/sustainability and transformation partnerships (STPs). This is based on a service level model that we will refine as we develop the operational model for iCAT London and pilot the falls, mental health, maternity and end of life pioneer services, incorporating the pilot results to further update projections.

We will need to do further work to ensure that our three strategic themes are implemented with a clear understanding of the impact on patient cohorts and any potential overlap in benefits.

1.7 Delivering our strategy

Delivering our strategy will require us to deliver fundamental changes across the organisation in the way that we operate. In achieving this new blueprint for our organisation, we will need to make key changes to our organisational structure, culture, capabilities and infrastructure. Our blueprint will be enacted through a strategic framework of detailed and interconnected 'daughter documents' which will specify, function by function, the plans that we will deliver over the lifespan of this strategy.

We have created a blueprint of enhancements required against design principles that are needed to deliver the strategy. We have also identified changes in the skills mix of the workforce to support new models of care that require flexible, multi-disciplinary working across organisational boundaries. We are focussed on training, career development and also maximising opportunities with the volunteering community. We know that we need to create the conditions for evidence-led innovation and continuous quality improvement; and to improve our ability to operate as an agile commercial organisation with multiple commissioners, partners and suppliers.

We are transforming our digital capability with a focus on a patient-facing digital platform, integrated management of the urgent and emergency flow, connecting clinicians more effectively, and improving

digital interoperability with our health and social care partners. To support this transformation we are developing a technology roadmap at strategic and operational levels, which we hope will support and influence NHS Digital's national urgent and emergency care programme. We will use nationally-developed solutions where they deliver the cost effective functionality that we need, at the time we need it.

Our fleet strategy will ensure our staff have the right vehicles, they are operationally and environmentally effective and efficient, and that they are clean, well maintained and provided with all the necessary equipment and consumables. We need well equipped and low emission vehicles in strategic locations to serve the whole of London and provide a high-quality work environment for our staff.

Our estate strategy is focussed on a new model for our operational sites, state-of-the-art training and development facilities and high quality control centres. These improvements will be supported by rationalisation of our corporate estate. Our logistics strategy aims to meet operational requirements for equipment, consumables and medicines more effectively and with less frequent need for replenishment from centralised stores.

2 Challenges and opportunities for the urgent and emergency care system

The NHS continues to face substantial and sustained rises in the demand for urgent and emergency care. This section sets out the challenges of the system, the opportunities to improve services and the role that the London Ambulance Service needs to play in meeting this demand.

A number of factors, explained below, have an impact on the whole health system:

- The population is growing and aging, meaning more patients and greater complexity, increasing overall demand for our services and longer treatment times
- An increasing prevalence of acute and complex long term conditions requiring coordinated care
- The need for care of critically ill patients is growing at a higher rate, which impacts upon the resources available for patients with less acute needs
- The way that patients are accessing the care system is changing fast and new technologies are becoming available that can improve the way we care for our patients
- Recruitment challenges within front-line and support functions

These pressures mean that changes to the urgent and emergency care system are essential. Working with our patients and system partners, we will play a critical part in shaping and delivering the changes required to make the urgent and emergency care system more sustainable in London.

2.1 The national perspective

The NHS is struggling to deal with rises in demand for urgent and emergency care. Average emergency department waiting time performance in England has slipped from an average of 95.7% in four hours or less (exceeding the national target of 95% in four hours) in 2013/14 to 89.1% in 2016/17¹. This has partly been due to the challenges in admitting patients due to the difficulty that hospitals sometimes face in discharging their patients when an appropriate care plan has not been put in place.

Hospitals have finite capacity, and care provided in hospitals is much more expensive than care provided in the community because of the higher level of specialism of clinicians and the more advanced range of diagnostics and treatments that can be provided. As a result, there has been for many years an overarching objective to simplify and organise urgent and emergency care services, making them easier to navigate, so that more care is provided in primary and community settings, usually closer to home, reducing unnecessary attendances at emergency departments and enabling hospitals to focus on patients who are the most ill or who have the most complex conditions.

Ambulance services have delivered significant improvements to the standard of clinical care and services to patients over recent years despite demand increasing year-on-year. Patient experiences of 999 emergency services are consistently positive with patients having a high level of trust and confidence in the clinicians who attend them. Ambulance clinicians continue to develop from their

¹ [Quarterly time series 2004/05 onwards, A&E Attendances & Emergency Admissions](#), NHS England

historical role of delivering first aid and transportation to hospitals, towards a greater emphasis on decision-making, diagnosis, treatment and referral.

The NHS *Five Year Forward View*² (2014) recognised this development in clinical capability. It built on the vision and recommendations set out in Professor Sir Bruce Keogh's review of urgent and emergency care services in England³ (2013) and explained the need to redesign service for people of all ages with physical and mental health problems by improving out-of-hospital services so that we deliver more care closer to home and reduce unnecessary hospital attendances and admissions.

The national vision for urgent and emergency care is:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families
- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated at the scene and then in centres with the right expertise and facilities to maximise the prospects of survival and good recovery

NHS England's national strategy, *Safer, faster better: good practice in delivering urgent and emergency care*⁴ (2015) identified six key changes which are needed in order to deliver an improved system of urgent and emergency services:

1. Providing better support for people and their families to self-care or care for their dependants
2. Helping people who need urgent care to get the right advice in the right facilities, first time
3. Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments
4. Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery
5. Ensuring parity of esteem for all patients
6. Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts

2.1.1 Integrated urgent care

NHS England's new service specification for integrated urgent care⁵ (IUC) responds to the need for simpler, better coordinated access to urgent care. NHS England's objective is for high quality clinical advice to be provided patients over the telephone, video call and digital messaging with the aim of reducing the number of patients advised to go to their GP or to an emergency department as a precautionary measure. Importantly, however, clinicians will be able to make appointments or direct referrals for patients across the range of local services so that patients only need to contact the NHS once. IUC sits behind the existing NHS 111 telephone number, providing specialist clinical advice, and unifying 24/7 access to local urgent care services including out of hours GP services, and face-to-face services such as general practice, community services, social care, ambulance services, urgent care centres and emergency departments.

At the core of the specification is a new 'clinical assessment service' which will provide clinical advice to patients, call handlers and mobile health professionals working in the community. The service will be staffed by GPs, with a range of specialist clinicians including, paramedics, advanced nurse

² *NHS Five Year Forward View*, NHS England, 2014

³ *Review of urgent and emergency care services in England*, NHS England, 2013

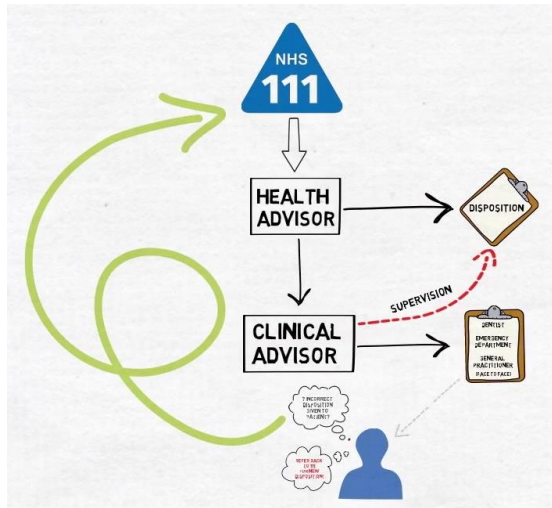
⁴ *Safer, faster better: good practice in delivering urgent and emergency care*, NHS England, 2015

⁵ *Integrated Urgent Care Service Specification*, NHS England, 2017

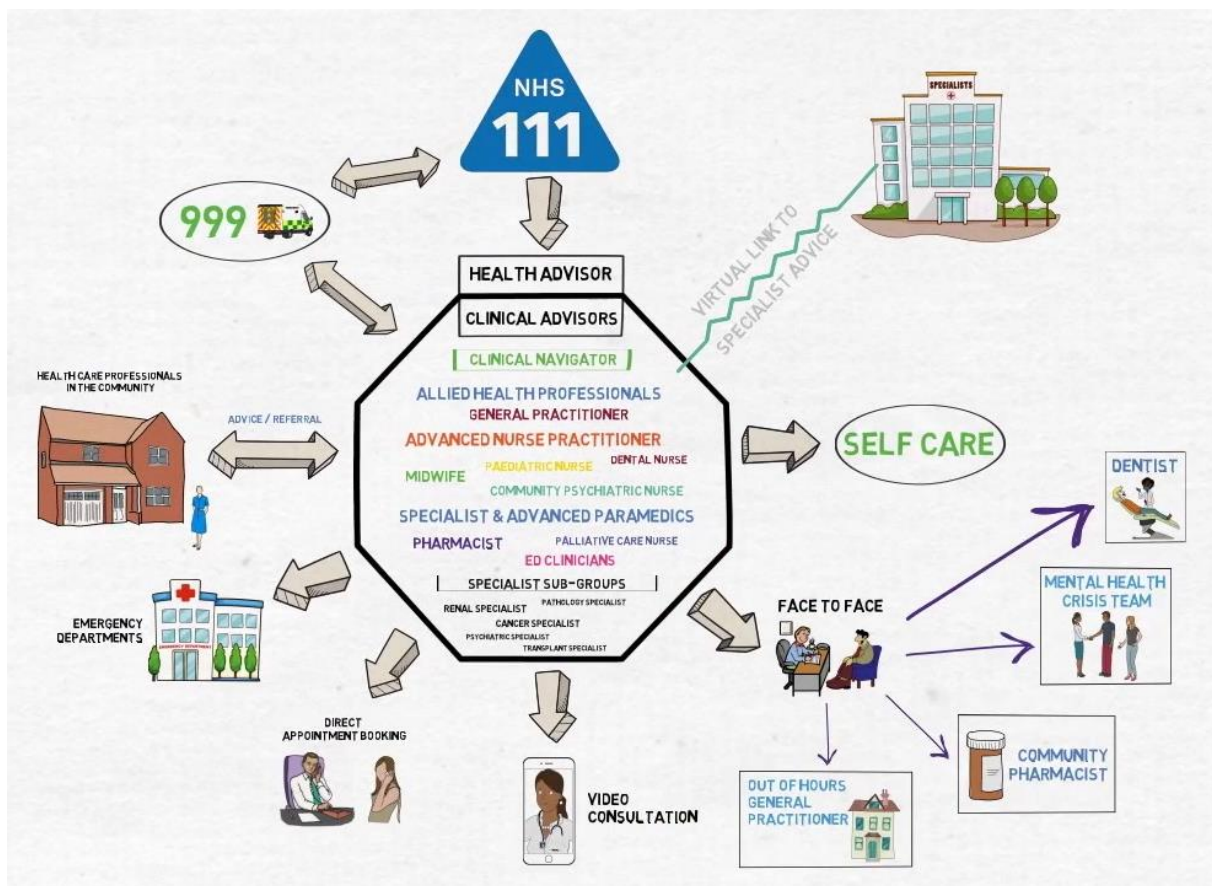
practitioners, pharmacists, dental nurses, mental health nurses, palliative care nurses according to local demand, and will have access to advice from hospital specialists.

Figure 1: Transforming NHS 111 into integrated urgent care (Source: NHS England)

Current service



Integrated urgent care (including clinical assessment service)



DN: Text in diagram to be enhanced (overlaid)

2.1.2 Emergency ambulance services

*Safer, faster better*⁴ recognises that ambulance services play a central role in the provision of urgent and emergency care. It states:

Ambulance services and their commissioners should work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital.

The strategy goes on to list a number of principles of good practice for ambulance services, which we summarise here:

- **Staffing ‘clinical hubs’ in control rooms with a range of clinicians** (including pharmacists, midwives, palliative care nurses and specialist or advanced trained paramedics) to ensure the appropriateness and timeliness of responses provided to patients by offering ‘hear and treat’ care to patients and clinical support to paramedics on scene
- **Using senior clinical decision makers** (such as specialist or advanced paramedics/nurses) to care for patients through ‘see and treat’, referral to community services or other pathways, to give better clinical outcomes and reduce the need for attendance or conveyance for non-critical 999 calls
- **Developing and evaluating alternatives to conveyance to hospital** (as a local healthcare system) so that paramedics have routine access to community health and social care services and can safely manage more patients at scene, either treating and discharging or referring onward to other appropriate services
- **Enabling ambulance services to have real time access to patient care plans** to develop a whole systems approach to patient management and flow
- **Minimising handover times for patients taken to hospital by:**
 - Sending patients’ details ahead to the receiving emergency department and implementing electronic patient handovers
 - Using alternative vehicles to convey patients to the emergency department, thus keeping paramedic staffed ambulances available
 - Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises
 - Ensuring that delays are reviewed systematically and jointly by ambulance operations managers, hospital managers and clinicians

2.2 The regional perspective in London

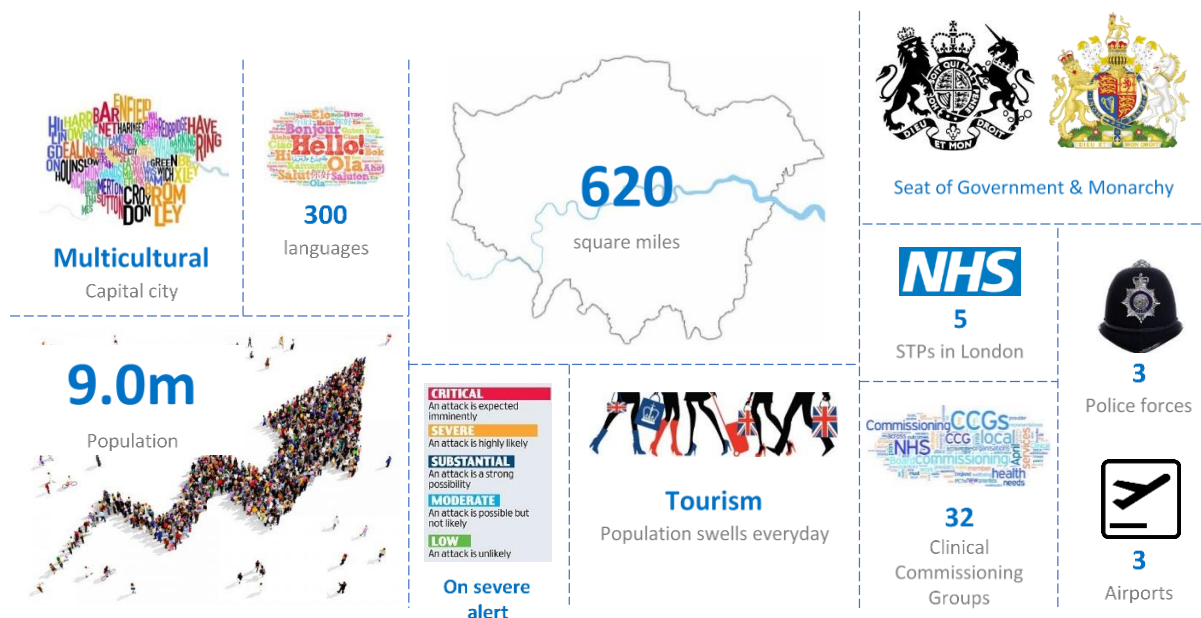
2.2.1 London’s vision and specification for urgent and emergency care

Sustainability and transformation partnerships

The NHS and local authorities have formed sustainability and transformation partnerships (STPs) in 44 areas covering England, enabling commissioners and providers of health and social care to work together at a larger scale to improve the health and wellbeing of the populations in their localities. Each STP has developed ‘place-based’ proposals focussed on their own population, which mean they vary according to specific local needs, demographics and geographical differences. London has five STPs: North West London, North Central London, North East London, South East London and South West London.

There are some unique factors in London that affect demand for health and social care services. London is a major centre for tourism, with the seat of national government, national landmarks and a concentration of the UK's airports. It also has the highest rate of non-residential population in the country, with many workers commuting to or through the capital every day.

Figure 2: London and its population



Common goals for urgent and emergency care across all of London's STPs include:

- Investment in and promotion of healthy living initiatives, preventative care and self-management, with a particular focus on older adults, who may need greater support to remain healthy and living in their own homes
- Improved access to primary and community care – through extended hours, out of hours, and out of hospital hub services (which bring together community nurses, GPs, other NHS specialists and social care staff in the same building)
- Provision of urgent care centres as a mid-level step between community care and hospital services for patients who have urgent but not emergency or life-threatening conditions
- Enhanced 111 services to meet the national integrated urgent care specification, which will provide patients with information through a wider range of channels and enable them to receive clinical advice and assessment from a wider range of experienced clinicians– with the aim of resolving more calls without the need for follow-up appointments
- Making better use of available technology to enable patients to speak with clinicians online or via a video link from a smartphone
- Avoiding high-end need through crisis intervention, for example through rapid response teams and dedicated mental health crisis services

London has a history of being at the forefront of implementing specialist emergency care models that improve outcomes for patients, including major trauma centres, hyper acute stroke unit (HASUs) and heart attack centres. As a result, in recent years cardiac arrest survival rates have risen from 5% to 30%, nine out of 10 patients diagnosed with heart attacks by ambulance clinicians leave hospital within five days following treatment at specialist centres, and stroke patients in London are almost three times more likely to receive thrombolysis treatment.

Healthy London Partnership

The Healthy London Partnership (HLP) provides an infrastructure for STPs to work with regional bodies to design and achieve consistency services across London, including urgent and emergency care. It was formed in 2015 by the 32 London Clinical Commissioning Groups, NHS England (London), Public Health England, London Councils, Health Education England, the Greater London Authority and the Mayor of London.

HLP was established in response to the NHS *Five Year Forward View* and the London Health Commission's report *Better Health for London*⁶. Its aim is to improve the health of Londoners and make London the healthiest city in the world.

HLP carried out an extensive survey and interviews in 2015 which demonstrated that the urgent and emergency care system is confusing to navigate, especially when it comes to the availability and different types of out of hospital services.

Coordinated, consistent and clear urgent and emergency care

In November 2017, the HLP published *Coordinated, consistent and clear urgent and emergency care*⁷, a vision and specification for the urgent and emergency system care in London. It seeks to formalise the relationships and interdependencies between urgent and emergency care services and the organisations that provide them. It also outlines aspects of services and facilities that should be consistent across London.

The document sets out three priorities “to improve patient outcomes and experience through high quality and consistent urgent and emergency care services that are available seven days a week”:

1. Developing **responsive, effective and personalised urgent care with 111 as the ‘front door’** of the urgent and emergency care system providing the public with access to the right advice in the right place, first time – any hour of the day and any day of the week.
2. Developing a facility **specification for consistent urgent care centres** to reduce public confusion and developing specifications for emergency centres and emergency centres with specialist services for those with more serious or life-threatening emergency needs to ensure access to the best expertise and facilities to reduce risk and maximise chances of survival and good recovery.
3. Developing **urgent and emergency care networks** to provide overarching coordination and accountability for the system around all urgent and emergency care services.

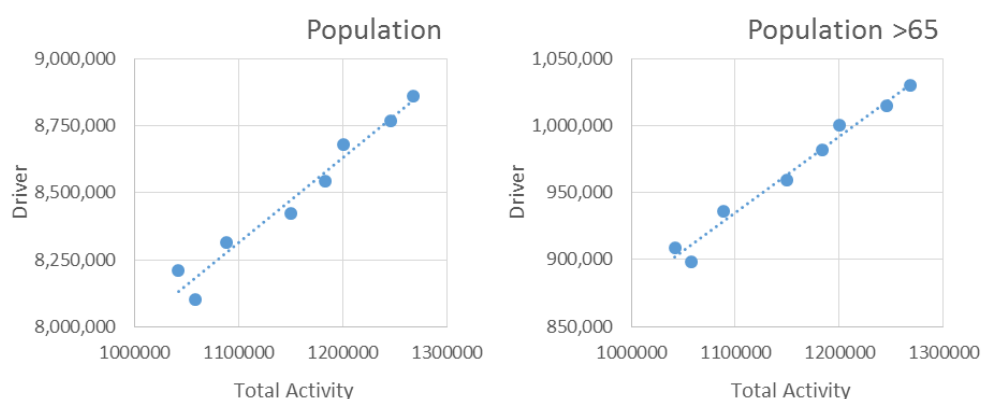
2.2.2 The population is growing and aging, meaning more patients and greater complexity, increasing overall demand for our services and longer treatment times

London's health system, as well as the wider NHS, is being challenged with substantial and sustained rises in the demand for urgent and emergency care, which is driven in part by increases in population and a changing demographic mix. Increases in demand for urgent care, emergency department services and emergency admissions have all been above population growth over the past three years.

⁶ *Better Health for London*, London Health Commission, 2014

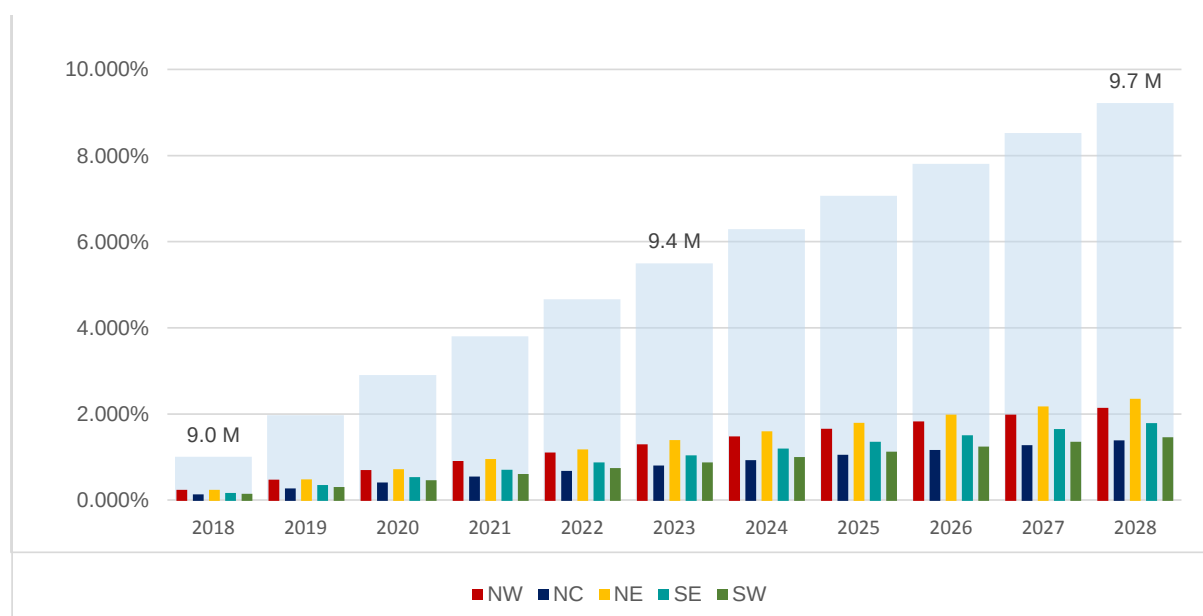
⁷ *Coordinated, consistent and clear urgent and emergency care*, Healthy London Partnership, 2017

Figure 3: There is a clear linear relationship between population (total and over 65) to LAS activity making it a key driver of modelling projections of LAS activity



London's population is expected to rise from 9.0m in 2018/19 to 9.4m in 2022/23⁸ and to 9.7m in 2028/29. With population growth being experienced across the capital, most keenly in North West and North East London, we know that demand for our services is also going to significantly increase. Figure 4 shows the projected cumulative growth of London population over the next 10 years.

Figure 4: Shows London population growth projection, 2018/19–2028/29, most starkly seen in North West and North East London



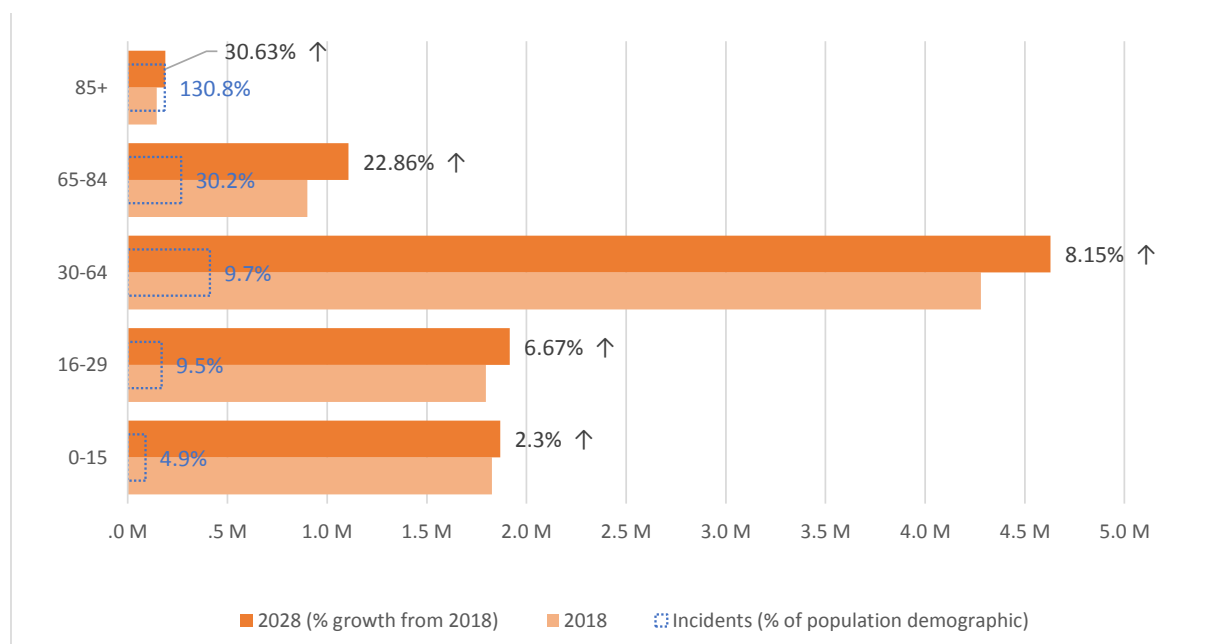
As a proportion, the largest population increases are in the 85+ age range (31%) and in the 65–84 age range (23%), who are typically the most significant users of health services and with whom we need to spend more time (on-scene time). These cohorts will grow at a faster rate than the population as a whole, resulting in a disproportionate increase in demand for our services.

Figure 5 shows population growth by age band (orange bars), and the anticipated growth in activity associated with each band (dotted blue lines). This highlights the faster growth of the older age population, which account for a disproportionate number of incidents⁹. In the 85+ age cohort there are over 1.3 incidents per year for every member of the population: 185,000 incidents for the 145,000 people older than 85.

⁸ [GLA population projections](#)

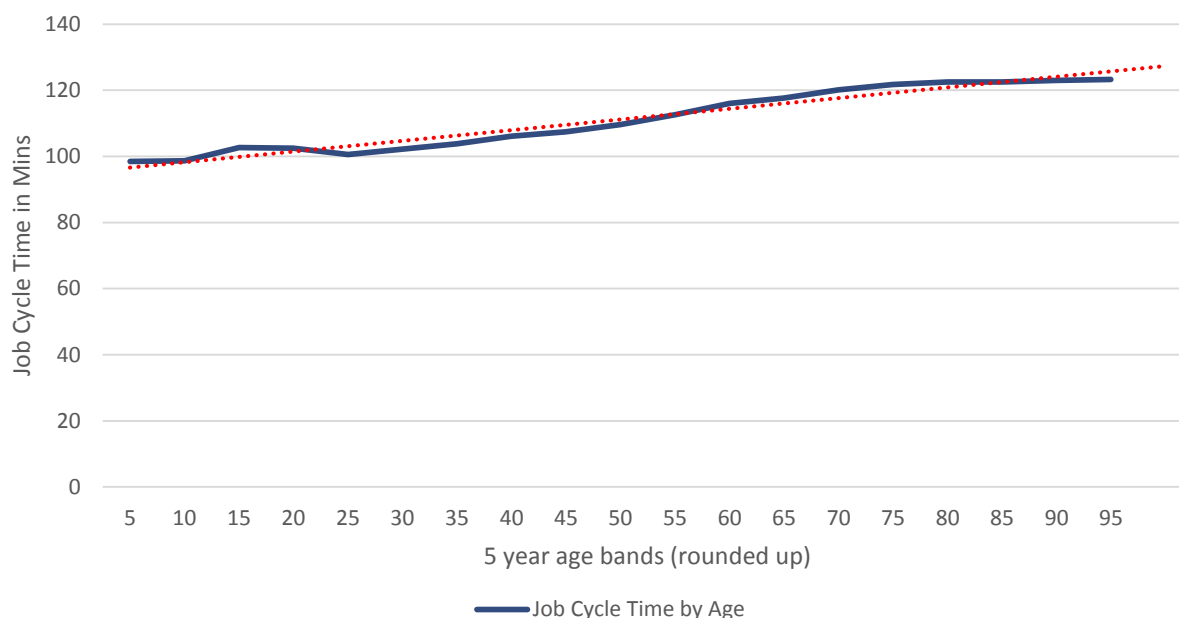
⁹ "Incidents" are 999 calls we respond to physically by sending a clinician to the patient

Figure 5: Shows London population growth from 2018/19–2028/29 by age band. The older age bands, which have a disproportionate volume of incidents, show a faster growth rate.



Age is also major factor in how much time we spend on scene with patients. Figure 6 shows 'job cycle time', which is a measure for the time from the start of a call-out until an ambulance is available to attend their next patient, increases with the age of patients. This shows that an aging population will result in our staff spending more time with each patient on average and therefore increase staffing requirements.

Figure 6: Shows an increasing average 'on-scene time' by patient age from LAS 2017 incidents statistics (red dotted trend line)



There is an opportunity for us respond to the complexity of managing a growing and aging population by using a wider range of specialised staff and to deliver more care through our telephone services and in the community to avoid unnecessary emergency department attendances and hospital admissions.

2.2.3 An increasing prevalence of acute and complex long term conditions requiring coordinated care

Changes in the prevalence of complex physical and mental health conditions affecting the population require health and social care services to respond differently to meet the needs of Londoners. Hospital is not always the most appropriate place for many people.

A growing number of patients have complex healthcare needs. In England, more than 15 million people have at least one long-term condition. This number is set to increase over the next ten years, with a significant rise in the number of patients with three or more conditions. London's ethnic diversity means that there are significant numbers of patients with genetically-linked conditions such as sickle cell disorders.

We are also at a hugely exciting juncture in healthcare and medicine with major advances being made on a regular basis. However, this has a knock-on effect on demand for our services, as the numbers of patients with very complex care needs such as cardiac assist devices (left ventricular assist device) and children with life-limiting congenital conditions increase.

Table 1: Landscape of complex conditions

Stroke	Nearly 40% of men and 30% of women have high blood pressure, a key risk factor for stroke
Obesity	63% of adults and 34% of under 11s are obese or overweight
Mental health	1 in 4 people in the UK will experience a mental health problem each year
Dementia	The number of people with dementia is expected to more than double over the next 30 years
Long term conditions and co-morbidity	Around 15 million people in England have one or more long term condition, with care for these conditions accounting for 55% of GP appointments, 68% of outpatient and emergency department attendances and 77% of inpatient bed days ¹⁰
Deprivation	Some people in deprived areas will have multiple health problems 10–15 years earlier than people in affluent areas

There is an opportunity for us to further integrate ambulance services with community health teams and social care hubs, co-located or connected virtually to enable robust, high quality and cost effective coordination of the delivery of urgent and social care.

2.2.4 The need for care of critically ill patients is growing at a higher rate, which impacts upon the resources available for patients with less acute needs

Following the largest clinical ambulance trials in the world, NHS England announced a new set of response time measures for ambulance services¹¹. The changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time. This includes providing call handlers with more time to assess 999 calls that are not immediately life-threatening, enabling them to identify patients' needs better and send the most appropriate response.

¹⁰ [Managing the care of people with long-term conditions](#), House of Commons Health Committee, 2014

¹¹ [New ambulance standards](#), NHS England

The new Ambulance Response Programme (ARP) standards will ensure early recognition of life-threatening conditions, particularly cardiac arrest. A new set of pre-triage questions is now asked so that when you dial 999, those patients in need of the fastest response are quickly identified. New nationally set response times will free up more vehicles and staff to respond to emergencies.

There are four categories of call:

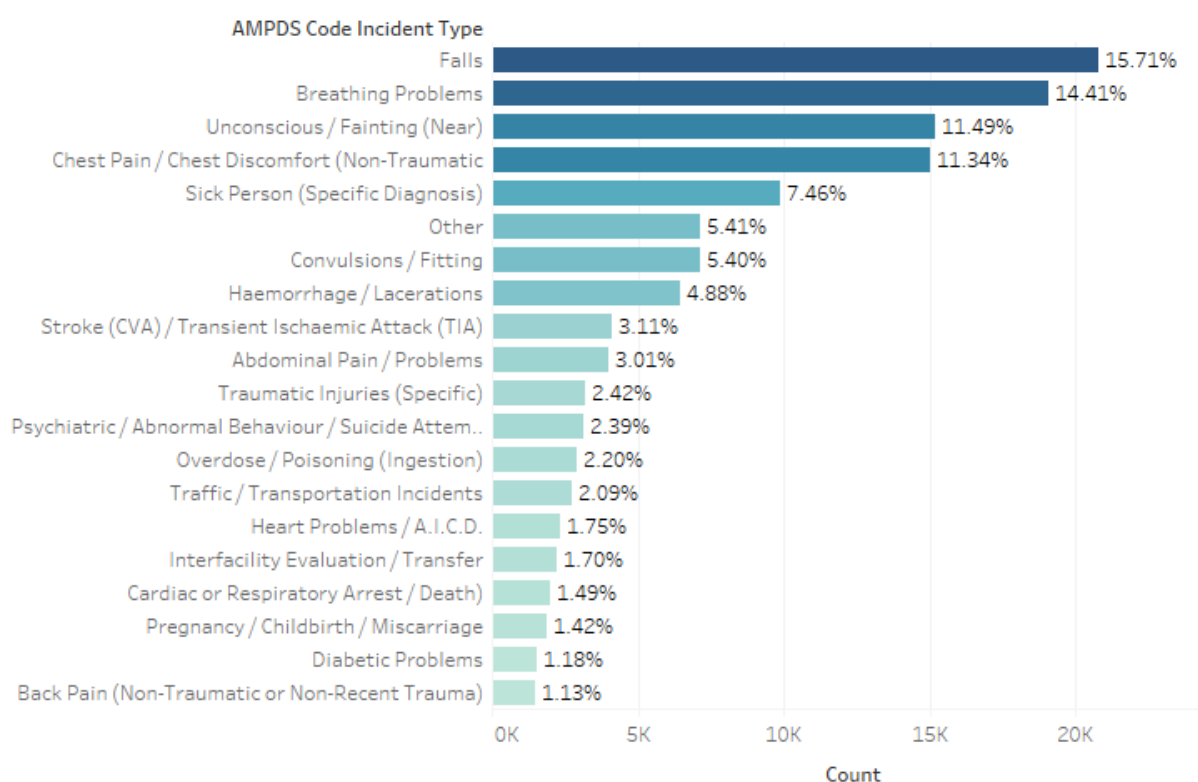
1. Calls from people with life-threatening illnesses or injuries (average response in 7 minutes)
2. Emergency calls (18 minutes response)
3. Urgent calls (120-minute response)
4. Less urgent calls (180-minute response)

We implemented these changes on 31 October 2017. As a result of the additional time allowed for less urgent calls, we have been able to get to the highest category of call more quickly.

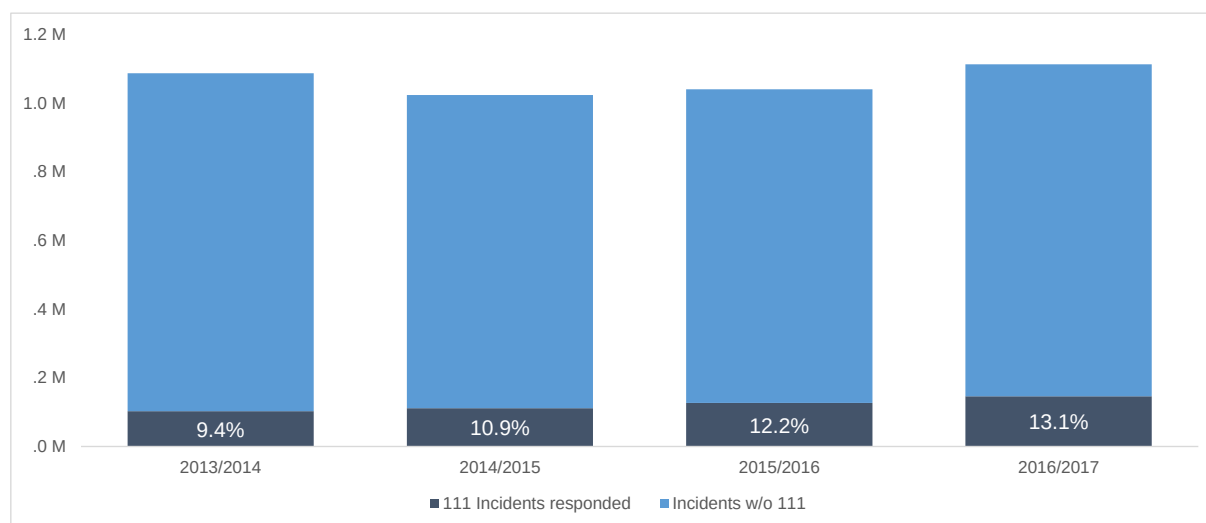
Increase in 999 and 111 call volumes

We provide 999 emergency services across London. The volume of 999 calls we receive has been growing at a year-on-year average of 2.0% over the last three years. NHS 111 is a non-emergency number that was introduced nationally in April 2013. We provide the 111 service in South East London and will be taking over the service in North East London in August 2018. The volume of 111 calls we receive has been growing at a year-on-year average of 8.7% over the last three years.

Figure 7: Case mix of 999 incidents for top 20 advanced medical priority dispatch system (AMPDS) codes

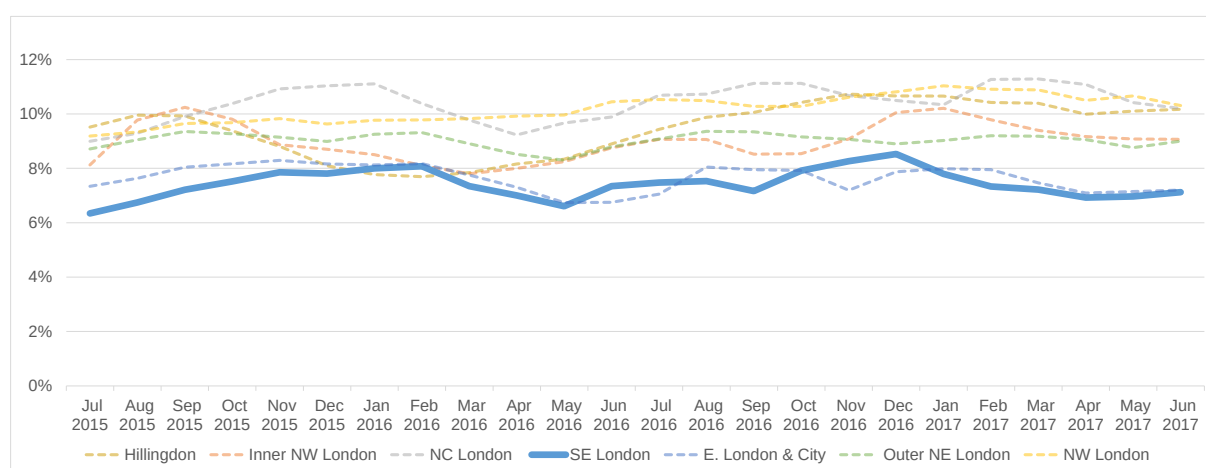


Calls escalated to 999 from all five 111 services in London, which are then responded to as emergency calls, now make up roughly 13% of our total 999 calls. The volume of escalated calls we receive is growing at a faster rate than 999 calls made directly to us. Figure 8 shows a total 999 incidents since 2013/14 with a growing proportion of incidents that come from 111 transfers. These are currently triaged outside the 999 system and sent immediately for dispatch.

Figure 8: Shows growing percentage of 999 incidents that are 111 transfers

The London Ambulance Service convert fewer NHS 111 calls to 999 emergency dispatches than any other 111 provider in London because our teams understand how each other work, have a better understanding of the different levels of response that we can provide and are supported by the same set of senior clinical managers. This is of particular benefit during periods of high demand such as over Christmas and the New Year. Once we establish our North East London service we anticipate we anticipate being able to achieve the same benefits that we currently achieve for South East London.

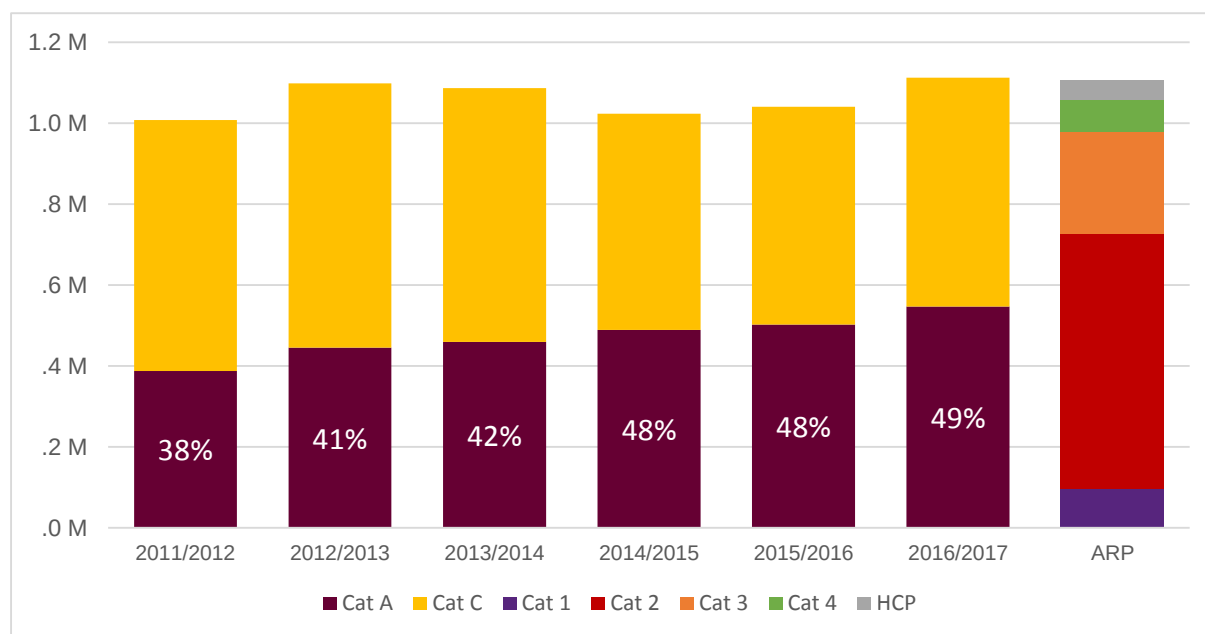
Figure 9 shows the proportion of 111 calls escalated to 999 for all 111 services in London. South East London 111, which we run, shows a consistently low level of ambulance dispatch in comparison to other London 111 services. If all 111 services had similarly low dispatch rates, this would equate to 25,000 or 2.2% fewer incidents that required a physical response to patients per year.

Figure 9: Shows performance of LAS 111 service in minimising 999 escalation in comparison to other London 111 providers. Line charts show % of 111 calls (3 month rolling average) from London's NHS 111 minimum data set

Increase in acuity of 999 calls

The proportion of 999 calls prioritised into our highest category has been increasing at a year-on-year average of 6% over the last three years. Figure 10 shows the significant historical growth of Category A incidents (the highest acuity call before the ambulance measures changed in November 2017), accounting for nearly half of all incidents in 2016/17¹².

Figure 10: Shows the growing rate of Category A incidents as a proportion of total number of incidents before the transition to current ARP categories provided for comparison

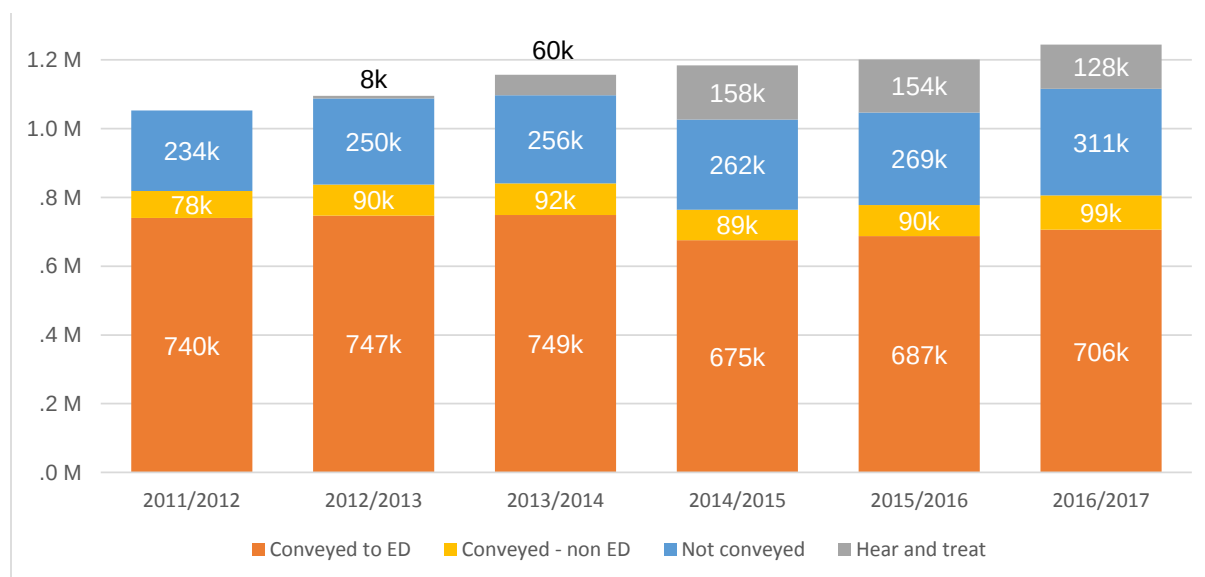


Note to table: HCP incidents are those with a non-emergency conveyance where a 1, 2, 3 or 4 hour response has been agreed, without triage in response to a call from a healthcare professional. As these are not ARP targets and do not sit within Categories 1–4, they are counted separately.

While the acuity of incidents has been increasing, we have become more successful at treating lower acuity patients in ways that avoid unnecessarily conveying them to hospital, including our 'hear and treat' service where patients are discharged from our care through telephone advice provided by an experienced clinician. Figure 11 shows that, while the level of activity is rising, we have been able to reduce the number of patients who we have conveyed to hospital through utilising our 'hear and treat' service and making better use of alternative conveyance locations such as urgent care centres.

¹² It is not possible to compare statistics for activity before and after the ARP transition took place as the new ambulance response measures are not directly comparable

Figure 11: Shows the outcomes of activity, incidents have increased in volume by 7.4% over the period, even with the introduction of hear and treat

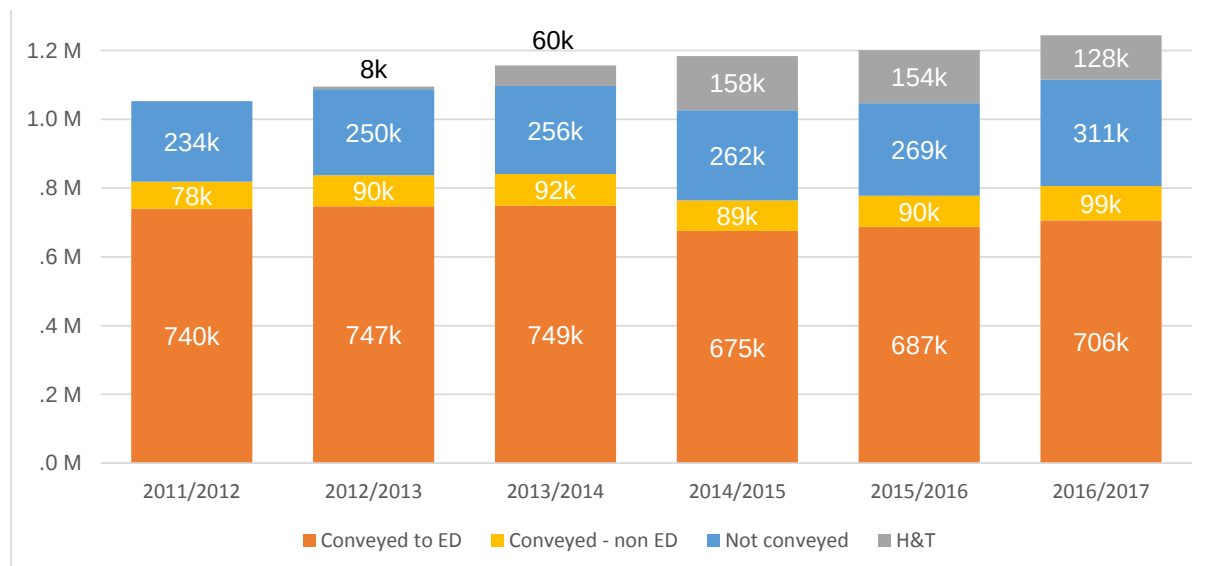


In 2016/17 we resolved approximately 10% of 999 calls without the need to send an ambulance.

Increase in number of emergency incidents and conveyances

The overall number of true emergency incidents we attend has been increasing at a year-on-year average of 2.8% over the last three years. While this has occurred we have reduced both the proportion of people we convey to the emergency department and the absolute number by 62,000 patients, an 8% reduction.

Figure 12: Shows a falling proportion of incidents conveyed to the emergency department by year



Our longer term forecasting shows that if we do not take any action to manage demand on us we can expect total weekly calls to increase to c.39,000 by 2022/23 (+9% from 2016/17).

There is an opportunity for us to increase the use of our 'hear and treat' and 'see and treat' services, and work with London's five STPs to seek other ways to manage or mitigate demand on the urgent and emergency care system.

2.2.5 The way that patients are accessing the care system is changing fast and new technologies are becoming available that can improve the way we care for our patients

Patients' expectations of health and social care services are changing. Patients expect services to be conveniently located and available at times that suit them rather than the clinicians. London is also one of the most connected cities in the world: more than half of our 999 calls are made from mobile devices. Patients expect services to use modern technology, to be coordinated and connected so that clinicians can share information and patients only need to have a discussion once. The convenience of taxi and takeaway apps needs to be brought into how we respond to patients requiring urgent or emergency care.

There are generational and demographic differences. While many people may be comfortable and confident using mobile technology to find out about and access services, those who have not yet learned how to use technology confidently – or can't afford it – are at risk of 'digital deprivation'. Some patients prefer to see the same clinician, with whom they have built a relationship over time; for others, convenience or timeliness is more important and they are happy to have a more transactional relationship with a number of clinicians. The larger the number of clinicians involved in a patient's care, the more obvious it is that there must be a shared care record for continuity of care. Coordination becomes very important, which is why 111 services are being developed into 'integrated urgent care'.

The telephone will always be a core channel for us, however the majority of our patients are only currently able to get in touch with 111 or 999 services by telephone. We provide 'text type' for people with hearing difficulties, however patients may not always have access to the equipment they need to access this.

There is an opportunity for us to transform our services to take advantage of a wider range of digital technology so that patients can contact us in the way that best suits their needs and preferences

2.2.6 Recruitment challenges within front-line and support functions

Like all parts of the NHS we are constantly looking for new and innovative ways of recruiting staff and retaining the people who already for our service. There is a national shortage of paramedics which has been a key recruitment challenge for us over the past few years, and we will continue to look creatively at how we can attract new clinicians to our organisation, or how we can 'grow our own'. Similarly, we have a number of other areas of our organisation where we have recruitment challenges such as within IM&T and our fleet workshops. All of these areas are crucial to the delivery of our service and therefore priorities for our organisation to fix.

Front-line vacancies increase pressures on operational staff, meaning that they have higher than planned utilisation rates. This leads to higher stress and sickness levels, and lower staff satisfaction and morale resulting in greater retention problems. This can therefore become a vicious circle. Recruitment and retention problems are not confined to road staff: call-taking staff in Control Services also experience stressful working conditions leading to turnover and a constant requirement to recruit and train new staff.

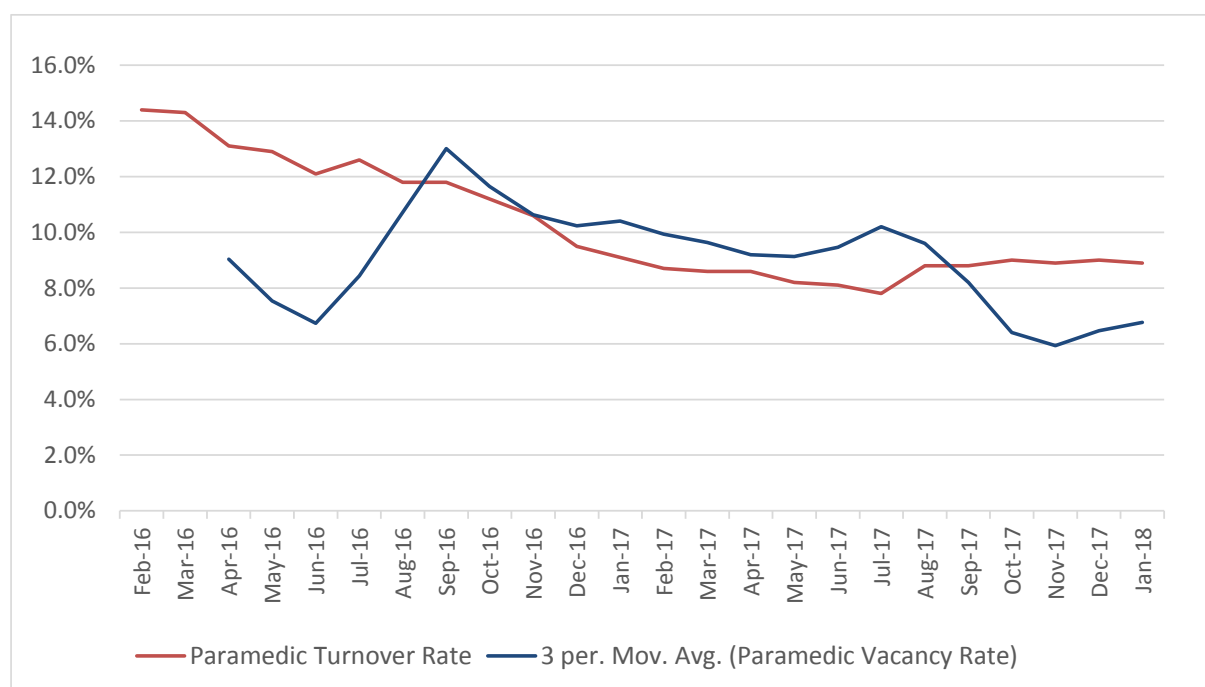
Our paramedic vacancy rate has averaged around 8% over the last year¹³, which is below the recent national average of 10%¹⁴. In the past paramedics have only been able to find employment in ambulance trusts. However this is no longer the case as other health settings have realised the considerable skills that paramedics can bring and we are now facing competition for paramedics from

¹³ Source: Workforce Planning Team, London Ambulance Service

¹⁴ NHS Ambulance Services, National Audit Office, 2017

other settings including GP surgeries and urgent care centres¹⁵. Figure 13 shows that we have made significant progress over the last few years in bringing down our vacancy and turnover rates.

Figure 13: Shows a falling paramedic turnover rate (rolling 12 months) against front-line paramedic vacancy rate as a 3 month rolling average.



There is an opportunity for us to further improve recruitment and retention so that we can continue to attract the best staff in the country.

2.3 Responding to the opportunities in London

Our ambition with this strategy is to set out how the London Ambulance Service will play a major role in delivering the objectives of core national and regional strategies to improve patient outcomes and experience. As the only pan-London NHS provider, and a member of each of London's five STPs, we are ideally placed to integrate access to urgent and emergency care, and identify variation in services across London as well as what works best.

We also have valuable data covering patients across London. We can play an important role in shaping a consistent approach to improving urgent and emergency care, offering more care in or close to patients' homes and reducing unnecessary hospital attendance and admissions.

An overarching principle for urgent and emergency care is to treat patients in the most appropriate setting for the acuity of their condition. Local people told South West London's STP in a survey that "too many people use emergency departments because they can't get an appointment with their GP or they don't know where else to go", and that "very few people had heard of NHS 111"¹⁶.

¹⁵ The future of primary care: Creating teams for tomorrow, Primary Care Workforce Commission, 2015

¹⁶ South West London Health and Care Partnership: One Year On, 2017

There are opportunities for us to:

- Respond to the complexity of managing a growing and aging population by using a wider range of specialised staff and to deliver more care through our telephone services and in the community to avoid unnecessary emergency department attendances and hospital admissions
- Further integrate ambulance services with community health teams and social care hubs, co-located or connected virtually to enable robust, high quality and cost effective coordination of the delivery of urgent and social care
- Increase the use of our 'hear and treat' and 'see and treat' services, and work with London's five STPs to seek other ways to manage or mitigate demand on the urgent and emergency care system
- Transform our services to take advantage of a wider range of digital technology so that patients can contact us in the way that best suits their needs and preferences
- Further improve recruitment and retention so that we can continue to attract the best staff in the country

In the next section we set out how we will respond to these opportunities.

3 A world class ambulance service for a world class city

As the only London-wide healthcare provider, we are uniquely placed to become the capital's primary integrator of access to urgent and emergency care. This section sets out our vision for the future and previews the three strategic themes described in sections 4, 5 and 6 that will enable us to realise our vision by 2022/23.

3.1 Our vision and three strategic themes

The London ambulance service has four goals:

- Provide outstanding care for our **patients**
- Be a first class employer, valuing and developing the skills, diversity and quality of life of our **people**
- Provide the best possible value for the tax paying **public**, who pay for what we do
- **Partner** with the wider NHS and public sector to optimise healthcare and emergency services provision across London

Our vision is:

To be a world class ambulance service for a world class city: London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'

Our strategy is an essential part of delivering on the goals of coordinating urgent and emergency care pathways, delivering more care on scene and avoiding unnecessary attendance at emergency departments. We will provide the right care at the right time, enabling rapid access to the most appropriate patient care, through three strategic themes:

1. Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
2. A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital
3. Collaborate with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

Delivering these three strategic themes will result in significantly improved patient care, a reduction in unnecessary conveyances to emergency departments and better use of our resources and best value for money for the urgent and emergency care system and the taxpayers who pay for it. The collective benefit of these initiatives will reduce the number of crew hours required to respond to increasing demand, allowing for more efficient use of our resources. Over time we will review the make-up of our fleet and estate to ensure that our resources are helping us to deliver the response required by our population.

4 Strategic theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients

At the heart of our strategy is the idea that we want to manage and coordinate the flow of patients through urgent and emergency services, making it as easy as possible to access the help that they need. Our response is to develop an integrated clinical assessment and triage service: iCAT London, which will sit behind both NHS 111 and 999, providing integrated urgent and emergency care.

A world class ambulance service needs to be at the forefront of using all technology and digital innovations to provide the best possible service to London, using public money as responsibly and efficiently as possible. We not only want to use available technology, we want to lead the way in developing, piloting and utilising new technology. We are forging a strong relationship with NHS Digital and NHS England leads and want to work with them to design and pilot initiatives that can benefit the sector as a whole.

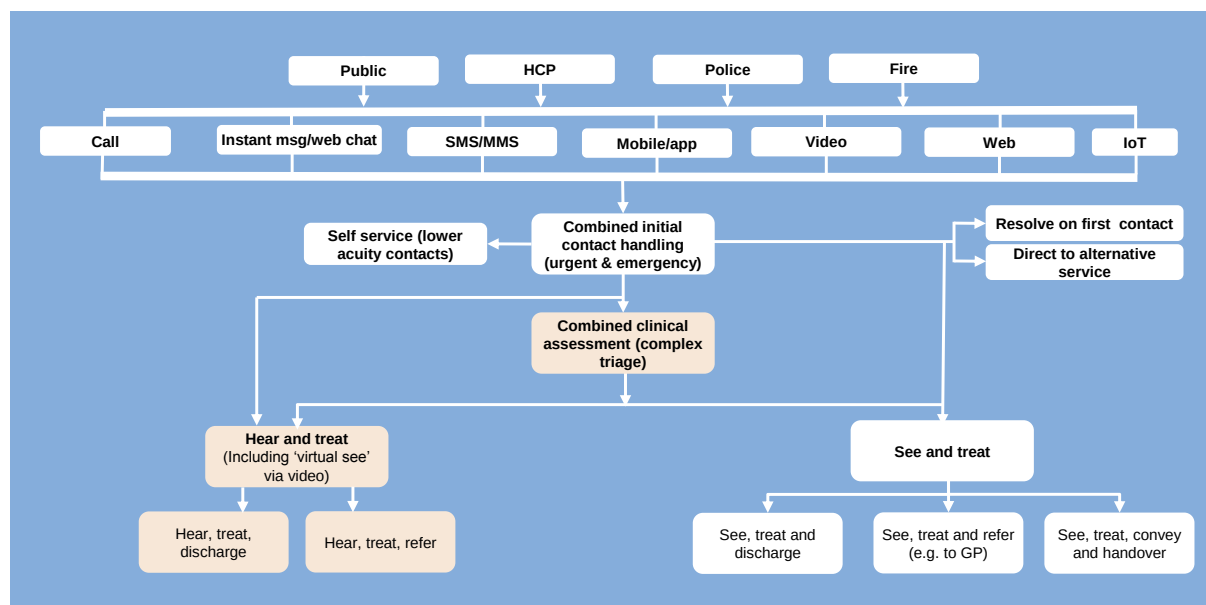
4.1 Service summary

iCAT London is our proposed integrated clinical assessment and triage service. It will be a fully integrated service behind 999 and 111 which delivers consistent, safe and efficient care seamlessly accessing pathways ensuring that patients receive the most appropriate care, at the earliest stage, to meet their needs whatever entry point they access. Our integrated service will encompass all aspects of urgent and emergency care, coordinated so that the patient's experience is one of a single health service and that there is consistency across London. This will mean:

Table 2: iCAT London service summary

Service delivery (patient-facing)	Service implementation (staff-facing)
- Improving the availability of high quality clinical information available to patients through variety of digital means, utilising emerging artificial intelligence technology to assist with initial triage - Development of online self-triage systems linking to clinical self-care information, and connecting to the clinical queue where further assessment is required - Multidisciplinary clinical assessment service, utilising a broad range of clinicians, enabling the service to manage a high proportion of calls via 'hear and treat' using an evidence-based clinical decision support system, reducing the number of unnecessary onward referrals - Well-governed referral pathways with smooth transfer of information between providers reducing the need for patients to repeat themselves - Post event messaging/discharge summary to a patient's GP to provide information about the assessment and management plan as well as recommendations for follow-up	- Full inter-operability between the 999 and IUC services facilitating seamless referrals and greater economic benefits of scale and scope - Shared access to clinical records supporting safe prescribing and tailored clinical management - A comprehensive directory of services populated with primary/secondary/community/voluntary sector services, facilitating appropriate referral - Electronic information transfer, prescribing and appointment booking in real-time with information following the patient - Central oversight of clinical queues with alert systems and a demand/capacity dashboard monitored to maintain patient safety - Opportunities for clinical workforce development/sharing clinical resources across the system

This approach of unifying access to urgent and emergency care across London can only be delivered by the London Ambulance Service.

Figure 14: Integrated clinical assessment and triage

HCP Calls from healthcare professionals MMS Multimedia (photo) message

SMS Text message IoT Internet of things – internet-enabled devices such as wearables, monitors and detectors

iCAT London will use technology that allows us to better assess and treat patients as well as allowing patients to access our services in a variety of ways. Currently all 999 calls are received over the phone in one of our two control rooms. 111 calls are received via telephone in our 111 call centres or via 111 online. We will expand the methods of access to include video calls from home and mobile, web-chat, online self-care advice and text based messaging: iCAT London will have true multichannel access. By introducing these methods we will enhance the service that we are able to provide as well as making our service more accessible to those with hearing or communication difficulties.

4.2 Service model

Our current clinical hub, which provides expert clinical advice to our 999 call-takers, is staffed by experienced and skilled paramedics, alongside a small number of registered mental health nurses. We will expand the number of different professions we have working as part of our clinical hub to make it a truly multi-disciplinary team. At the core of iCAT London will be a new '*integrated* clinical assessment service' which will provide clinical advice to patients, mobile health professionals working in the community as well as to our own staff. The service will be staffed by a range of specialist clinicians including GPs, paramedics, advanced nurse practitioners, midwives, pharmacists, dental nurses, mental health nurses, palliative care nurses according to local demand, and will have access to advice from hospital specialists.

NHS England's specification for integrated urgent care (IUC) contains a 'clinical assessment service', which will provide advice to NHS 111/integrated urgent care call-takers. As a fully integrated service, iCAT London will be supported by a fully integrated clinical assessment service (CAS), going well beyond the national specification.

iCAT London is our unique way of joining together our 111/IUC and 999 services, including multichannel access, integrated clinical queue, integrated CAS and integrated dispatch system.

4.2.1 iCAT London

The service will endeavour to provide clinical management via a 'hear and treat' model wherever possible, via the telephone and a number of digital channels. Where referrals need to be made, these will be supported by access to the directory of services which is a live resource providing information on appropriate care pathways, suited to individual patient needs.

The CAS will provide the clinical expertise to manage complex patients with comorbidities; access to clinical notes will allow safe prescribing and referral. Through improved information sharing of patient records, we will be able to support a holistic model of care for patients with long-term conditions so that their care continues to be seamless across multiple providers within the system. We will utilise appropriate care pathways and the directory of services to refer patients to community teams such as rapid response, falls teams, district nursing teams to facilitate care closer to home and avoid unnecessary admissions.

Clinicians within the CAS will provide enhanced assessment and specialist advice to patients accessing our IUC and 999 services as well as to our call-takers and front-line staff, and other clinicians external to the service. Technology will allow clinicians to provide peer support and advice to each other (e.g. real time access to specialist consultants, mental health nurses, pharmacists or GPs for advice regarding a case).

From our 999 clinical hub, we have experience in dispatching specialist resources including advanced paramedic practitioners in urgent care and critical care. We will continue to work with London commissioners to develop similar resources according to local need that can be dispatched via our CAS.

4.2.2 Integrated clinical assessment service

Our integrated CAS will operate as one system across 999 and IUC, using the same clinical decision support tool (CDSS), which will add resilience to the clinical support by providing clinical decision support while allowing clinical autonomy and empowering utilisation of their knowledge and skills. The CAS will comprise GPs, advanced practitioners nurses, paramedics, and pharmacists who will be supported by a wider range of specialist clinicians including mental health nurses and midwives. Specialist 999 resources such as our air ambulance dispatch desk will sit within our CAS.

CAS clinicians will be able to work from any London Ambulance Service control room and will use the CDSS as well as their own clinical expertise to triage calls. They can also work remotely where in order to support the system in times of surge. Their training will encompass development of an understanding of the urgent care system as a whole (including how 999 and IUC services integrate with the urgent care system). They will have access to records via locally agreed shared records as well as care plans including Coordinate My Care, to aid clinical decision-making; and will have access to clinical advice from secondary care where required.

Our system will have the capability to conduct video assessment and receive photographs to support joint assessment with external clinicians for example our front-line 999 clinicians who have recently been issued with hand-held electronic devices, community nurses or nursing home staff. Longer term, the system will be able to access telehealth data in order to support decision-making within in patient contacts and to provide outreach assessment to patients triggering with acute changes to their clinical parameters.

Clinical navigators in the CAS will ensure that patients are allocated correctly to the right clinician and that clinical prioritisation models are followed, supporting clinical decision-making, patient safety and case prioritisation. The clinical navigator will review the lower acuity calls which have not yet received a response to identify calls that might need a more urgent review. Cases will then be allocated to clinicians depending on patient need, demand and capacity. They will also advise and support health advisors and clinicians. There will be oversight of all urgent and emergency care demand across the service

Prescribing clinicians will issue medications via electronic prescribing where clinically appropriate, allowing prescriptions to be sent to a local pharmacy. This will reduce unnecessary further referrals to other services which will improve patient experience by being able to meet all their needs in one place. Access to patient records, prescribing decision support and online resources will support clinical decision-making and prescribing. The prescribing system will be supported via medicines optimisation software that will facilitate decision-making at the point of prescribing, enhancing patient safety and efficiency of the service by incorporating prompts for staff around allergies, contraindications, interactions and compliance with the local formulary and clinical guidelines.

4.2.3 Governance and support

iCAT London will be supported by a senior clinical on-call structure which provides senior leadership and clinical accountability at an operational level 24/7. This meets national objectives of “no decision in isolation” while ensuring that necessary auditing and compliance monitoring is a protected aspect of the service.

We will encourage clinical staff to undertake regular face-to-face clinical shifts to continue to develop and maintain their clinical skills. We will support and facilitate this by arranging cross-organisational agreements where required and allowing portfolio contracts.

Clinical leadership and governance team within the IUC service will be supported by our medical directorate, which incorporates multiple clinical specialties including general practice, emergency medicine, general and mental health nursing, pharmacy, midwifery and consultant paramedic level clinicians.

Our dedicated clinical assessment service will continue to be developed and refined to meet the needs of the public and patients from London, and the wider urgent and emergency care system. Using the activity data from iCAT London we will be able to consider trends and patterns of how patients behave and use the system, and therefore inform different ways of working to continually adapt and meet the needs of our population.

4.3 Summary of potential benefits

Successfully implementing iCAT London would deliver the following benefits:

Table 3: iCAT London – summary of potential benefits

Providing multichannel access	Optimising initial contact handling
• Improved ease of contact for patients Having multiple contact channels available allows vulnerable patients to contact the service via their preferred method. Some of these channels will allow easier provision of information responses by call handlers such as text or email. Up to 1% of current 999 calls require information only. • Improved outcomes from better data capture Having all contacts being registered in one system gives the opportunity to capture and recall data to improve patient experience. Understanding past contacts and medical history has the potential to reduce call times through faster initial triage.	• Artificial intelligence improving triage Trials across England for the NHS online app have shown the feasibility of utilising artificial intelligence to partially or fully automate initial triage. Initial trials have shown that this can reduce onward referrals on to a primary care professional by 30%, and that up to 20% of contacts can be handled automatically. • Providing optimal response to contact Integrated call handling will allow LAS to determine the urgency and categorisation of calls more effectively which will reduce the level of unrequired handovers and increase the chance of using a non-physical response where appropriate. Currently around 50,000 calls per year are transferred to 999 from 111 but don't require a physical response. • Efficiencies from a single integrated team Increasing the size of the call handling team to an integrated 999/111 pan-London team would provide efficiency savings of around 20% by improving call demand coverage.

Expanding clinical triage	Supporting physical response performance
Optimising patient triage An integrated clinical assessment service will ensure that emergency triage is not used for non-urgent patients and vice versa. This will optimise time taken for each triage and improve patient quality by reducing the need for transfers. Treating more patients remotely A larger volume and range of calls will allow for an expanded clinical assessment service. A wider range of clinicians will be able to take more types of call and prevent the need for a physical response. For example an additional 20% of maternity calls and 3% of mental health calls could be dealt with remotely by the appropriate clinician.	Treating more patients remotely By increasing the number of 'hear and treat' responses this would decrease the number of 'see and treat' responses required. Improving patient quality, but also improving response time performance as more vehicles become available. Ambulance dispatches could be reduced by up to 2%. Improve information for physical response teams Providing additional information to the on scene team to determine most appropriate clinical response and where it's best to convey patients.
Using data to improve performance	
Inform analytically driven decisions Capturing further data will improve prescriptive and predictive analytical abilities to maintain performance across the service.	

5 Strategic theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital

Meeting the challenges of improving London's urgent and emergency care requires an ambulance service which places a clear emphasis on assessment and treatment at scene and in community settings, with transport to alternative care settings where required to access established pathways of care. Transport to hospital should be used for those patients who require the assessment and treatment skills and equipment available only within an emergency department.

We will continue to provide high quality care to all patients, especially those most critically ill and injured. Providing enhanced treatment at scene will enable us to use our staff and vehicles in the most effective way, preventing escalation and helping to manage demand on the system as a whole.

5.1 Innovating for our most critically ill patients

We will continue to ensure that our patients with the most serious or life-threatening conditions receive appropriate pre-hospital assessment and treatment in centres with the right facilities and clinical expertise in order to maximise their chances of a good recovery. While a relatively small proportion of the patients we treat (just 8.7% of 999 incidents are Category 1), the care of patients with life-threatening and life-changing emergencies remains a core priority for us.

There are a number of principles that are consistent and key to reducing death and long-term disability that we will focus on in the coming years:

- Rapid recognition of critical illness or injury at the point of first contact with iCAT London
- Timely response by appropriately trained and skilled clinicians including continued development of the paramedic clinical team leader and advanced paramedic practitioner (critical care) roles
- Prioritisation of lifesaving interventions over non-essential activities
- Support, where needed, by clinicians with enhanced skills and additional experience, either in person or through iCAT London, utilising technology including video calls
- Minimising time spent on-scene for time-dependent clinical conditions
- Transport to definitive care, with a pre-alert call to activate an appropriate response
- Direct transfer to tertiary care centres for specific conditions, including stroke, heart attack and major trauma

As a Category 1 responder, we have a statutory obligation to be prepared to deal with serious and major incidents of all types and sizes. Our incident response plan has been prepared in light of guidance from the Department of Health, Home Office and builds on the Civil Contingencies Act 2004 guidance, lessons identified by the London Ambulance Service itself, Coroner's inquests and subsequent 'prevention of future death' reports, and in particular the findings of the inquest into the events of the London bombings on the 7 July 2005.

The trust is committed to continued engagement with its partner agencies and with the local and regional resilience forums to ensure joined up multi-agency emergency preparedness and resilience which ensures a rapid response, with appropriately skilled clinicians to ensure the best clinical outcomes for the most patients affected.

5.1.1 Major trauma

London has a world-class major trauma system that consistently now sees patients survive major trauma that would not have done 5–10 years ago. Early identification of these patients and direct transfer to major trauma centres play a very important role in both improving survival and minimising long-term disability.

Over the past five years it has become clear that the face of major trauma has changed. While sadly, penetrating injury in young people is still common, the major trauma population in the UK is becoming more elderly. While major trauma makes one think of major accidents, the most common cause of major trauma is a fall of less than 2 meters. It is therefore not surprising that the current average age of major trauma cases is 60, and with an ageing population, it is predicted that within the next few years the over 75s will be the single largest cohort suffering major trauma.

Our priorities:

- Enhance the education for 999 and 111 emergency medical dispatchers to ensure that they have the underpinning knowledge to recognise mechanisms which may indicate a more serious injury
- Use video technology on the 999 clinical hub to help in the remote triage and assessment of trauma patients
- Deploy, where appropriate, advanced paramedic practitioners to support crews in managing complex scenes and patients, and ensure that the APP skillset meets the needs of this cohort of patients

Improving response for times for major trauma patients

We work in collaboration with London's Air Ambulance to treat some of the most serious major traumas in London. The air ambulance service is funded through charitable donations and operates a helicopter during the day and a fast response vehicle at night.

We have a formal service level agreement with the London's Air Ambulance and second our paramedics to their service for nine month rotations, which includes shifts in the helicopter or on the car as well as dispatching the air ambulance service from our control room. This secondment includes advanced training on the additional equipment and drugs that the air ambulance service carries and enables our paramedics to learn and consolidate new skills through this partnership.

By working in partnership with the air ambulance service we are able to identify the patients most in need to receive more advanced, lifesaving, clinical interventions than they would otherwise be able to receive. For example, the London air ambulance service performed the world's first pre-hospital REBOA (resuscitative endovascular balloon occlusion of the aorta) which is a pioneering technique to prevent major trauma patients bleeding to death very quickly.

5.1.2 Cardiac arrest

Ensuring that patients who suffer from a cardiac arrest get the right treatment quickly is vital for their survival and longer term clinical outcomes and quality of life. Over the last decade, we have been at the forefront of developing care for this cohort of patients and has seen a steady rise in survival from out-of-hospital cardiac arrest, consistently reporting some of the best outcomes amongst UK ambulance services. We recognise that improving the care that patients in cardiac arrest get before the ambulance arrives is central to improving survival. Over the last year we have worked closely with the Metropolitan Police Service and the London Fire Brigade to develop co-responder schemes, and have continued our development of Community First Responder networks around London to ensure early defibrillation.

Our priorities:

- Work with the community and partner agencies to increase the number of public access defibrillators across London, targeting schools, sports clubs, transport hubs, shopping centres, large businesses and industrial complexes

- Use technology, such as the GoodSAM app and automated external defibrillator (AED) locators to improve community response to cardiac arrest
- Continue to roll-out mechanical chest compression devices to support the management of cardiac arrest on scene and en route to hospital where appropriate, and increase the role of clinical team leaders in the management of these patients
- Ensure that effective leadership on scene of these calls is provided through key staff having regular exposure to this cohort of patients ensuring the patient is consistently managed in the optimum way every time
- Participate in further high quality pre-hospital care research, for example multi-centre randomised control trials to establish to role of adrenaline in the management of pre-hospital cardiac arrest

5.1.3 Heart attacks and cardiac arrhythmias

We are committed to ensuring that patients suffering a heart attack are recognised promptly and treated with all clinically appropriate tools we have at our disposal before being transferred for assessment and specialist treatment in heart attack centres without delay.

We have agreed pathways for patients with cardiac arrhythmias which allows direct access for some conditions – this has shown improved outcome for these patients and further collaboration is required.

Our priorities:

- Work closely with the London cardiovascular networks to continually review services and improve timely access to specialist facilities for our patients
- Continue to improve and audit the outcome for patients conveyed to specialist centres with other cardiac conditions e.g. cardiac arrhythmia and Kawasaki disease
- Through involvement in research, develop further appropriate care pathways for a wider cohort of cardiac patients to ensure they are taken the right hospital to manage their condition.

5.1.4 Stroke

Stroke remains a significant cause of morbidity and mortality across the UK, accounting for 11% of all deaths and affecting 230 people per 100,000. London already has a world-class stroke service in which all patients with a new-onset stroke have direct access to hyperacute care, 24 hours a day. We convey approximately 1,000 patients directly to a hyperacute stroke unit every month.

Our priorities:

- Ensure early identification of a stroke by our 999 and 111 emergency medical dispatchers including those with atypical presentation e.g. speech deficit or loss of balance
- Work with hyper acute stroke units (HASUs) to minimise the 'door to needle' time for patients undergoing thrombolysis
- Work with the London HASUs to establish network arrangements for interventional neuroradiology and thrombectomy, and explore ways of identifying the patients that are most likely to benefit from this procedure

5.1.5 Sepsis

Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. It is caused by the body's immune response to a bacterial or fungal infection commonly originating from the urinary tract, respiratory tract or skin. We have an important role to play in recognising the signs and symptoms of potential sepsis both at call handling (999 and 111), and during the face-to-face assessment. Early recognition of sepsis and prompt management saves lives and improves the long-term outcome for patients.

Our priorities:

- Continue to improve the recognition of potential sepsis at call-handling (999 and 111) to ensure early dispatch of an appropriate vehicle to convey the patient to definitive care
- Use screening tools to improve recognition of sepsis and identify 'red flag' sepsis, where there is a high risk of death and a requirement for urgent treatment
- Ensure that patients with red flag sepsis are rapidly treated in the pre hospital environment and transported to a hospital with the appropriate facilities to provide their onward care.
- Explore the use of point-of-care testing by appropriate clinicians to guide management of patients with specific infections, administering antibiotics where indicated, and referring the patient to appropriate community services

5.1.6 Vascular disease

As with many life-threatening emergencies, timely delivery of definitive care in a specialist centre is vital in reducing mortality from vascular emergencies such as a ruptured abdominal aortic aneurysm (AAA) or vascular compromise in limbs. It is important that the services required to treat these patients are located in centres that have the skill and expertise and are accessible to the ambulance service directly. There is an evolving network of vascular centres in London, in which surgical expertise is available 24/7.

Our priorities:

- Support the transfer of patients with a suspected leaking aortic aneurysm from local hospitals to tertiary facilities, providing a high priority response for the most at-risk patients
- Work with the appropriate units to ensure that these patients are rapidly identified and that a transfer arrangement is made to the best unit that can provide care.
- Work with vascular centres to study and understand how best to recognise and triage patients with a possible leaking aneurysm, shortening the time to definitive care
- Continue to work with NHS England (London) to develop vascular network and bypass arrangements for both aortic aneurysms and other vascular emergencies e.g. acute vascular compromise in limbs

5.1.7 Sickle cell disorders

Sickle cell disorders are a group of inherited conditions that affect the red blood cells. The most serious type is called sickle cell anaemia. Sickle cell disorders mainly affects people of African, Caribbean, Middle Eastern, Eastern Mediterranean and Asian origin. In the UK, they are particularly common in people with an African or Caribbean family background. Sickle cell disorders are serious and lifelong conditions, although long-term treatment can help manage many of the problems associated with it.

We have been working closely with the London Sickle Cell Community and are committed to continuing this engagement, using lived experience to shape our services and have a number of developments focussed on this area of care. We will continue to work with groups across the London community, to share developments, ensure there is meaningful and ongoing engagement between our staff and those with lived experience and that all of our staff are sickle cell competent – in the control room and on response vehicles – providing the highest quality care to any individual experiencing a sickle cell crisis.

Our main priority is the providing further training to our staff on the care and treatment required to support someone experiencing a sickle cell crisis, including:

- Handling 999 calls from patients
- Paediatric pain management and patient assessment
- The important of care planning

5.2 Introduction to our pioneer services

In order to meet the challenges of increased demand for urgent and emergency care and improve outcomes for patients, we now need to go further and provide a more specialised response to a greater proportion of our patients. We have selected five patient cohorts for whom changing the way we respond will deliver a significant improvement in quality of care and patient experience and reduce unnecessary conveyance to an emergency department:

- Urgent care response
- Mental health
- End of life
- Falls
- Maternity

We have called the services we propose to provide to these cohorts our ‘pioneer services’.

5.2.1 How we propose to change services

In order to improve the care we provide for all of our patients, we need to:

- **Treat more people on-scene and in the community closer to home** – by providing a differentiated response, patients that are currently taken to an emergency department would have rapid access to alternative pathways of care:
 - A wider ‘hear and treat’ offering, via iCAT London
 - A more comprehensive on-scene ‘see and treat’ offering
 - Referral and potentially transfer to an urgent care centre/integrated care centre rather than an emergency department
- **Deploy a wider mix of skills and professions** – deploying paramedics and other professionals with varying skills, for example:
 - Advanced paramedic practitioners with an enhanced scope of practice to manage patients with urgent care needs
 - Paramedics with further training in assessment and management of falls
 - Mental health professionals to those with mental health crises
 - Midwives, when we are called to a birth or obstetric emergency and there isn’t already a midwife on-scene
- **Use a wider range of response vehicles** – by better matching the vehicle to the incident, a more targeted response could be offered that improves patient outcomes and/or reduces conveyances:
 - Rebalancing between bicycles, motor bikes, fast response units and standard double-crewed ambulances (DCAs)
 - Vehicles with different staffing and equipment with a greater focus on chronic conditions, mental health and older adults, for example mobile assessment vehicles where clinicians can sit and assess patients

Career progression for paramedics will support continued improvement in staff turnover rate with opportunities to work in specialist areas, and advanced paramedic practitioner being placed at a higher pay grade.

Changing the way we deliver services will require us to change the way we work with partners. We will need access to expert clinical advice in order to triage patients and we want to work with partners to be creative in how we resource clinical staff. For example, it may be possible to offer rotations for midwives and mental health nurses onto our pioneer services rather than employing them directly.

5.2.2 How we have identified suitable patient cohorts

Figure 7 in Section 2.2.4 shows the case mix of 999 incidents for the top 20 advanced medical priority dispatch system (AMPDS) codes. We have used these codes to identify the cohorts of patients who may be suitable to receive a pioneer service.

Table 4: Mapping of pioneer services to advanced medical priority dispatch system (AMPDS) codes

Pioneer service	Identification by AMPDS code	Comment
Urgent care response	Various	Advanced paramedic practitioners for urgent care response (APP-UCs) are deployed across a large range of incidents covering many AMPDS codes.
Falls	Falls	Serious falls such as falls from heights would not be included in pioneer response.
Mental health	Psychiatric, abnormal behaviour, suicide attempt	Includes incidents where a physical trauma is registered as primary caused but described as mental health in the incident description.
Maternity	Pregnancy, childbirth, miscarriage	Maternity incidents are sometimes flagged under other incident codes and we have adjusted for this.
End of life	Palliative care	The current system does not provide comprehensive identification of end of life care and so will be identified under many AMPDS codes, such as breathing problems. Identification of the range of incidents will take place as part of the pilot. For the purposes of modelling a cohort, we have used the 'palliative care' code and conveyances to hospices.

We describe in the subsections below how we propose to respond differently to the patients.

We will continue to work with STPs to identify other opportunities for better managing demand that we can act upon locally or across London.

5.3 Urgent care response pioneer service

Aim: to be able to appropriately treat more patients at the scene of an incident ('see, treat and discharge') meaning that fewer patients need to be conveyed to an emergency department.

The London Ambulance Service will always be the first port of call for people who are experiencing or witnessing potentially life threatening or life changing emergency situations. However, more and more, the public and NHS expectations are changing and our responses to 'urgent care' patients now makes up the majority of our workload. Our urgent care patients are not those experience life threatening or changing events, but may still be in a great deal distress or pain.

In 2017 we launched an urgent care pilot in Croydon where advanced paramedic practitioners for urgent care (APP-UCs), who had received additional training, were dispatched to a targeted cohort of lower acuity urgent care patients. APP-UCs are able to perform enhanced clinical assessments and manage lower acuity injuries and illnesses in patients' homes. This provides a better quality of service to patients and reduces the need to convey these patients to hospital. This has system wide benefits in providing prompt treatment to patients, reducing multiple hand-offs between clinicians, and reducing unnecessary hospital admission.

The pilot has been extremely successful and has demonstrated that there are significant benefits to patients, our organisation and the sector as a whole for an expansion of this role across London. Overall, the APP-UCs managed approximately 63% of identified patients without the need to convey them to hospital. This compares favourably against an average for London of 36.6%.

5.3.1 Service summary

Our urgent care response service is focussed on lower acuity patients with complex needs, and manages more patients in their own home using additional tests and treatments. It will be delivered by urgent care advanced paramedic practitioners (APP-UC), who receive a significant amount of

additional specialist training to develop their skills in assessment, clinical decision-making and managing patients with urgent care needs.

5.3.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/dispatch	An APP-UC in the control room will be specifically looking to identify the calls that would be most suitable for the operational APP-UCs to attend
See and treat	An APP-UC, with additional training, will attend patients who have been identified as requiring urgent care and may be suitable for treatment at scene
Referrals and additional care	- Direct referral to hospital specialties, reducing delays where patients require hospital - Direct access to tertiary facilities such as medical assessment units

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	See and treat
People	APP-UC identifying calls	APP-UC response
Process	- Process of identifying calls which should be routed straight through to the new service - Process of dispatching the right vehicle for a 'see and treat'	
Infrastructure		- Mobile device to provide access to summary care records - Fast response car with standard paramedic equipment - Range of additional diagnostic tools such as point of care testing, ophthalmoscope and otoscope - Additional drugs such as pain relief, steroids, antibiotics and anti-sickness medication

5.3.3 Summary of potential benefits

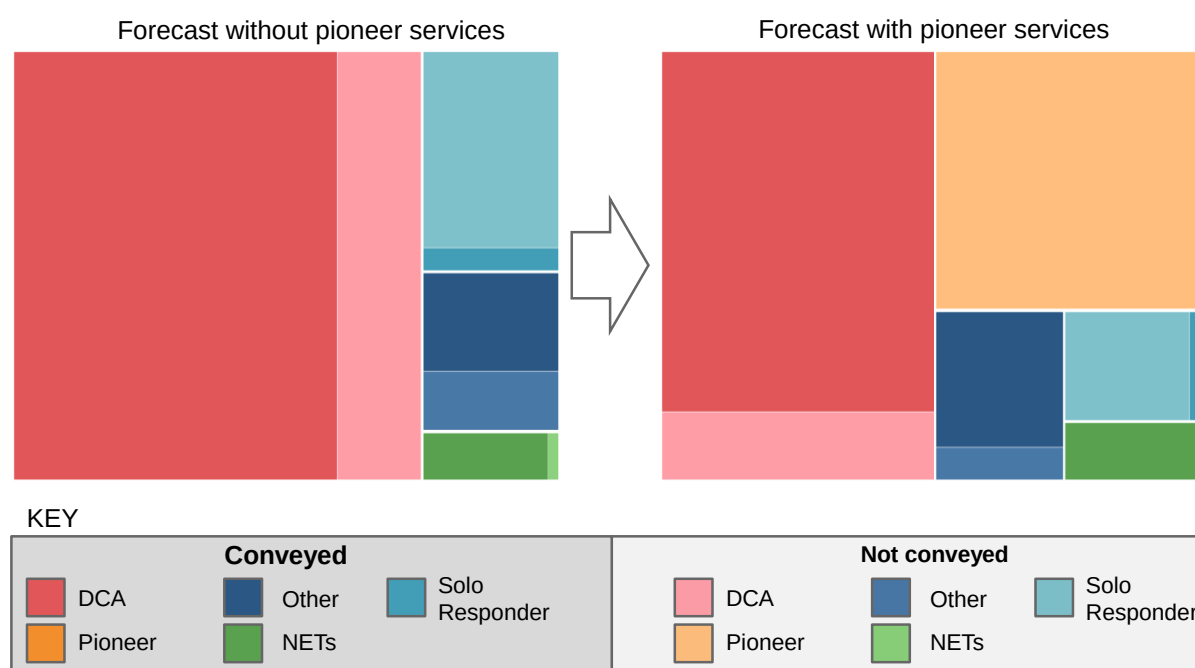
Table 5 shows the potential benefits for the cohort we have identified could receive this pioneer service, based on the incident profile seen in the pilot. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 5: Urgent care response pioneer service – summary of potential benefits

Quantitative benefits (projected for 2023)	Qualitative benefits
213,000 patients could benefit from this service (based on incident profile seen in pilot), of which: 72,600 (34.1%) would be 'see and treat'/referred 140,400 (65.9%) would be conveyed 75,500 (35.4%) would be conveyed to emergency department Performance A reduction in emergency department conveyance rate from 57.0% to 35.4% for a selected cohort	- Our APP-UCs are able to treat patients on scene and in their own homes, avoiding the need to convey them to hospital and potentially waiting for a significant amount of time before they are able to be treated. - Our staff want more options to develop their clinical practice, to become more skilled clinicians. In the past there have been very limited options for paramedics, but our two advanced paramedic practitioners (critical care and urgent care) and clinical team leader roles provide additional routes of progression for our staff.

The following area plot, and subsequent plots in Section 5 show incidents as a percentage of the whole, proportional to area. They are similar to pie charts but are better at showing small volumes.

Figure 15: Shows the cohort of incidents that would be applicable for this pioneer service according to data from the pilot (excludes Cat 1 and 2 interventions to stop impact on ARP performance metrics)



5.3.4 Neil's story – an urgent care case study



5.4 Falls pioneer service

Aim: to provide a quicker response to patients who have fallen, to safely help them up from the floor, assess their physical condition and identify the reason for their fall. This pioneer service will provide effective assessment and timely referrals to community services and falls prevention services to support the patient's wellbeing and reduce the risk of further falls.

We are often called by patients, their family or carers, where a fall has occurred. Falls account for around 11% of our total calls each year. When we attend these patients, we conduct a physical assessment to see whether they have any injuries and try to identify why they might have fallen. One of the key activities that we undertake is to safely assist these patients up from the floor and then to determine whether the patient needs further treatment in hospital. While the majority of fallers are over the age of 65, we also attend patients with physical disabilities or long term conditions, such as multiple sclerosis, that mean that they are at higher risk of experiencing a fall.

Elderly patients that fall are a high risk cohort of patients and we know that they can experience particularly poor outcomes if they remain on the floor for long periods of time. People over the age of 65 have the highest risk of falling, with over 50% of people aged over 80 years falling at least once per year. The ageing population means that falls are one of the most common reasons for calls to the ambulance service and we expect this number to increase to around 133,400 by 2023 (10% increase from 2017/18).

Falls are often an indicator of underlying complex illness, general health decline or acute illness. It is recognised that falls in older people, or patients with underlying health problems, are linked to a significant increase in morbidity and mortality, but that, with careful assessment and safety-netting, many of these patients can have their needs met by care in the community. Falls are one of the most common reasons for patients becoming frequent callers. Addressing patients' needs holistically, and dealing with the reasons for falling, will be of significant benefit to both patients and the service in reducing the likelihood of them falling again.

5.4.1 Service summary

Currently, we send two members of staff in an ambulance to patients who have fallen as they need to assist them up from the floor and, more often than not, convey these patients into hospital. This pioneer service will target fallers who we think are less likely to need conveying to hospitals and a specialist falls paramedic, supported by an assistant practitioner, will be dispatched. By targeting this dedicated falls pioneer service we can increase the effectiveness of our response and reach fallers more quickly.

Our falls pioneer service will see a paramedic who has received additional specialist falls training, paired with an assistant practitioner, attend patients who have fallen and while not seriously injured, may not be able to get up off the floor on their own.

5.4.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/dispatch	• The control room specifically looking to identify calls that would be suitable for the falls pioneer service • Occupational therapy and physiotherapy specialists in iCAT London to provide telephone advice to patients and support crews • Specialist roles will also provide expert advice to the organisation, supporting the design of the service and building level of expertise across the organisation
See and treat	• A falls specialist paramedic (band 6) will be accompanied by an assistant practitioner (band 3) who would be a non-clinical member of staff with blue-light driving training. This assistant would allow the paramedic to work as efficiently and effectively as possible • The assistant practitioner would receive training to assist the clinician with some tasks such as manual handling and recording observations
Referrals and additional care	• The falls specialist paramedic will be able to make appropriate referrals to or links with further care or support networks, to enable the patient to remain in their own home. These referral options could include: – Occupational therapy – Rapid response teams – Social care – Falls prevention services – Charity support networks e.g. Age UK

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	See and treat
People		• Solo falls specialist paramedic (band 6) will be accompanied by a blue light driver, to allow the clinician to undertake the role more quickly and work while traveling between patients (band 3) • The driver could assist with other tasks such as manual handling
Process	• Process of identifying calls which should be routed straight through to the new specialist falls service • Process of dispatching the right specialist with a driver for a 'see and treat' • Process of dispatching the right vehicle for a 'see and treat'	
Infrastructure		• Mobile device to provide access to summary care records • Response vehicle will have the capability to convey patients, if needed, who are able to sit up for the journey • Suitable equipment for assisting fallers off of the floor

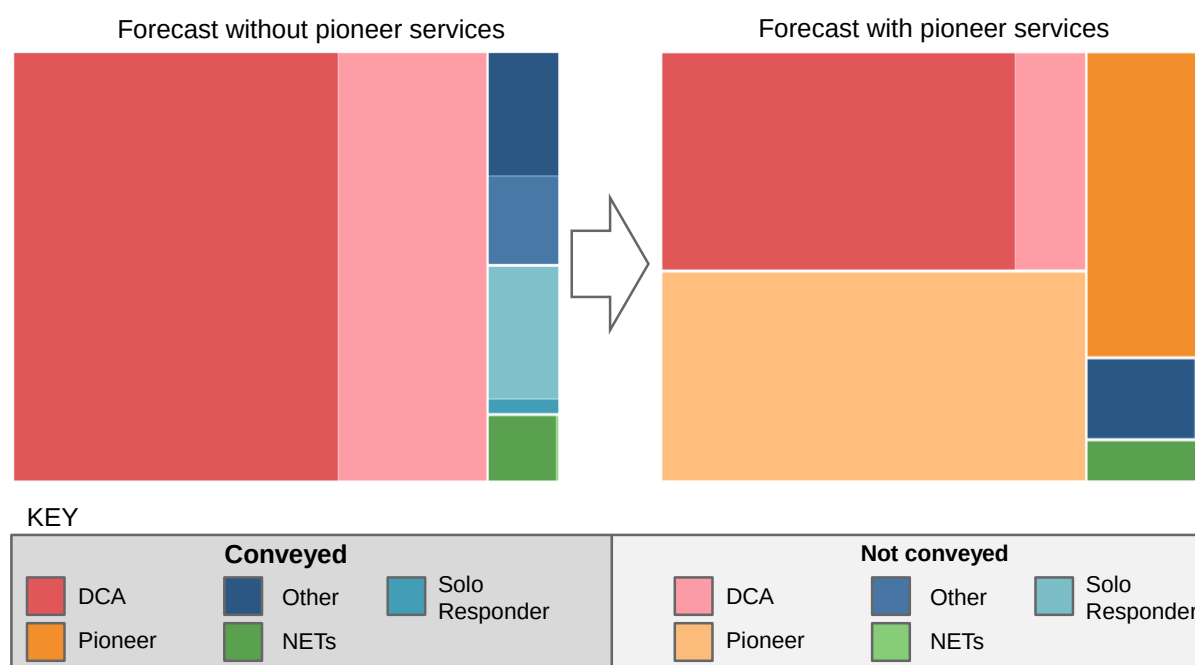
5.4.3 Summary of potential benefits

Table 6 shows the potential benefits for the cohort we have identified could receive this pioneer service, based on figures from 2017 incident data classification. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 6: Falls pioneer service – summary of potential benefits

Quantitative benefits (projected for 2023)	Qualitative benefits
94,700 patients could benefit from this service (based on figures from 2017 incident data classification), of which: • 39,800 (42%) would be 'see and treat'/referred • 54,900 (58.0%) would be conveyed • 44,400 (46.9%) would be conveyed to emergency department Performance A reduction in emergency department conveyance rate from 52.8% to 46.9% for a selected cohort	• A quicker response to patients who have fallen, to safely help them up from the floor, assess their physical condition and identify the reason for their fall. • Enhanced referrals to an expanded range of community services, occupational therapy, rapid response teams, social care, falls prevention services and provide wider health promotion to help facilitate a patient's full recovery from their fall and help them remain in their own home rather than needing to go to hospital for treatment.

Figure 16: Shows the cohort of incidents classified by Advanced Medical Priority Dispatch System code as 'falls' (see Figure 7) and how the vehicle response and conveyance outcome would change as a result of this pioneer service, significantly reducing DCA responses



5.4.4 Enid's story – a falls case study



5.5 Mental health pioneer service

Aim: to provide an appropriate emergency response to patients who experience a mental health crisis. Our aim is for patients to receive a higher level of care from all paramedics, and appropriate triage, assessment and referral where appropriate by qualified mental health nurses.

999 and NHS 111 are often the first point of care for patients experiencing a mental health crisis. We have a crucial role in risk assessment, and in signposting patients to the most appropriate point of care or service. These calls are often complex, and take time and specialist expertise to manage effectively. Patients experiencing a mental health crisis may also be suffering from substance misuse which compounds the challenges faced by staff in carrying out a full assessment of the patients presenting condition and needs.

We have greatly improved the quality and quantity of mental health training over the past few years and have employed mental health nurses on our clinical hub to provide telephone advice to patients. Our crews sometimes have difficulty accessing appropriate care pathways for patients experiencing a mental health crisis. This is especially true 'out of hours' and often leads to patients being conveyed to an emergency department, which is rarely the correct environment for their effective assessment, management and a positive experience of care, and is often associated with extremely long lengths of stay and escalation of their presenting condition. In 2017/18, 54.3% of our mental health patients were conveyed to an emergency department.

We ran a set of workshops with service users, who identified that they would most value being able to access a specialist mental health clinician at the point of their crisis. Patients experiencing a mental health crisis should have parity of esteem with patients experiencing physical health conditions and should therefore have access to suitable mental health crisis services twenty four hours a day, seven days a week, including appropriate places of safety.

5.5.1 Service summary

Our mental health pioneer service will see a registered mental health nurse (RMN), paired with another ambulance clinician respond to patients who have been identified as experiencing a mental health crisis, or requiring a specialist mental health response.

A registered mental health nurse (RMN) would be able to provide specialist care and support to patients experiencing a mental health crisis. They would also be able to navigate the appropriate mental health pathways, especially out of hours, and would have the skills and knowledge to discuss risk assessments, recommended management plans and presenting condition with approved medical practitioners and mental health units. An RMN providing specialist assessment details can effectively access a wide range of appropriate alternative care pathways. There is the potential to increase the range of medicines available to support safer care and an enhanced patient experience. This will all mean that patients are able to be treated in the most appropriate way to meet their needs.

5.5.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/dispatch	- We will continue to have mental health nurses working in our clinical hub providing telephone advice to patients as well as assisting crews but increasing their numbers and coverage to ensure we maximise hear and treat where appropriate - This mental health nurse will also look to identify calls that would be suitable for the mental health pioneer response - The mental health nurses will also support calls from crews on scene and support call handlers with complex 999 calls from patients experiencing a mental health crisis
See and treat	- A registered mental health nurse (RMN) would be paired with an ambulance service clinician - The RMN would be able to provide a specialist assessment of the patient's mental health needs - Patients in mental health crisis may have also sustained a physical injury and the clinician would be able to provide the appropriate care for any physical injuries or illnesses - The RMNs will also have an essential role in delivering training to front-line staff both in the control rooms and on the road
Referrals and additional care	- We will, where possible refer patients to their local mental health trusts to ensure continuity of care - The RMN will have knowledge of, and access to all of the local mental health crisis services in order to ensure that the patient receives the most appropriate care for their needs - The mental health pioneer response will links with communities or charities that can provide additional ongoing support such as the Samaritans

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	See and treat
People	New role of a mental health nurse would be added in the control room. This would be a Band 6 or 7 mental health specialist who would have contacts transferred through to them for specialist triage/assessment	A mental health nurse in a response car accompanied by a paramedic to be able to assess and treat a range of mental and physical health needs
Process	- Process of identifying calls which should be routed through to a mental health nurse - Process of dispatching the right specialist or combination of specialists for a 'see and treat' - Process of dispatching the right vehicle for a 'see and treat'	
Infrastructure	Ability to warm transfer to a specialist triage/mental health single point of access	- Mobile device to provide access to summary care records and up to date information on which mental health pathways are open and available for their patients - Response vehicle will have the capability to convey patients, if needed, who are able to sit up for the journey, and provide a safe and private space to safely assess a patient

A crucial element of our work to improve outcomes and experiences for our mental health patients is by working closely with mental health trusts across London to strengthen links with their crisis services, single points of access, places of safety and new services such as crisis cafes and clinical decision units as well as their local mental health and crisis teams. While we are building our mental health expertise within our organisation, wherever possible we want to ensure that those patients

already known to mental health services are linked back to their mental health trust supporting their care to ensure their ongoing needs are met.

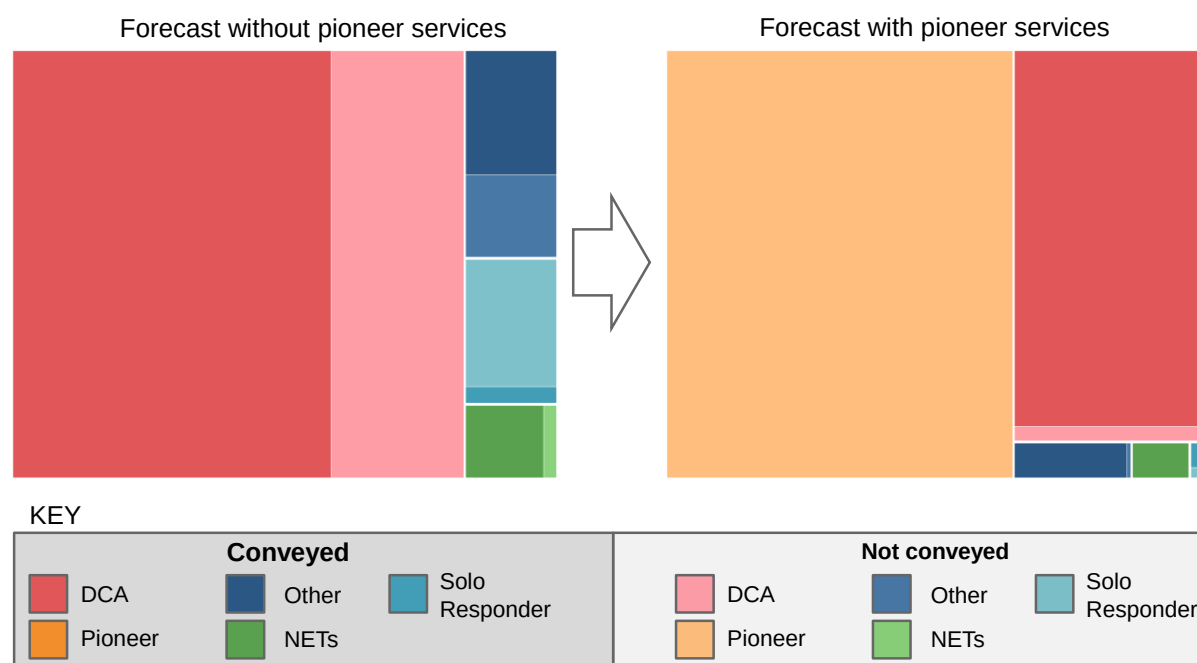
5.5.3 Summary of potential benefits

Table 7 shows the potential benefits for the cohort we have identified could receive this pioneer service, based on figures from 2017 incident data classification. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 7: Mental health pioneer service – summary of potential benefits

Quantitative benefits (projected for 2023)	Qualitative benefits
101,500 patients could benefit from this service (based on figures from 2017 incident data classification), of which: 1,900 (2.2%) would receive 'hear and treat' discharge (over current) 56,300 (66.5%) would be 'see and treat'/referred 26,400 (31.2%) would be conveyed 9,300 (11.0%) would be conveyed to emergency department Performance A reduction in emergency department conveyance rate from 54.3% to 11.0% for a selected cohort	- Specialist mental health response consistently seven days a week - A wider range of responses available to patients who need one such as face to face assessments, in the same way that we provide a specialist response for those with physical health needs - Patients less likely to be conveyed unnecessarily to an acute hospital when that is not the best place to meet their needs - Better referral to appropriate mental health pathways

Figure 17: Shows the cohort of incidents classified by Advanced Medical Priority Dispatch System code as 'mental health' (see Figure 7) and how the vehicle response and conveyance outcome would change as a result of this pioneer service, significantly reducing DCA responses



5.5.4 Robert's story – a mental health case study

Robert is a 45-year-old IT specialist with a history of personality disorder. Unfortunately, he's just been fired following a long-running disciplinary and has met with his old friend Anna on Saturday evening for a drink. Anna quickly realises that Robert is struggling to cope and acting strangely. She calls 111 for advice.



5.6 Maternity pioneer service

Aim: we want to provide a higher quality of care for patients by using multi professional teams with dedicated expertise to provide more specific gynaecological and maternity specific care.

For the vast majority of women, pregnancy and birth are normal life events, however, occasionally emergencies can occur when birth occurs unexpectedly. Emergencies either before, during, or after birth need to be managed quickly and responsively to ensure the safety of both mother and her baby. We often send a large number of ambulance clinicians to maternity patients due to the complexity of the situation and the need to be able to treat a mother and her baby.

In 2017 we responded to around 2,250 birth imminent calls and delivered around 800 babies, where the mother was not able to get to an appropriate maternity facility and/or where a midwife was unable to attend. Our staff attend a range of birth emergencies including birth of twins, babies born in the “bottom first” position (breech birth), and those where the birth requires further support to enable a safe outcome.

For this pioneer service we are trialling an innovative method of service user and staff engagement: ‘Whose Shoes’. This method of engagement is designed to explore patient and staff experiences, so that we ‘walk in the shoes’ of the people we serve and those who will deliver the service¹⁷.

5.6.1 Service summary

A two person response in a rapid response vehicle, consisting of a registered midwife and an appropriately skilled clinician would be able to provide advanced midwifery care including new-born life support. We will have midwives in the control room to provide expert telephone advice to callers.

We are the only ambulance service in the UK that employs a consultant midwife and we are therefore in a unique position to influence the care provided to pregnant women. We are already recruiting two practice development midwives to start further building the level of skill and expertise in the organisation of providing safe and high quality care to women at this important time of their life. These practice development midwives will be crucial in setting up the maternity pioneer service.

5.6.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/ dispatch	• We will have midwives in our control room to provide specialist advice over the phone • The midwife in the control room will be able to advise and reassure women who do not need an emergency response • They will also be able to guide and reassure women while an emergency response is on its way
See and treat	• A registered midwife would be paired with an ambulance clinician with additional maternity specific training
Referrals and additional care	• The maternity pioneer response will have access to local maternity care providers and community midwifery services so that, if the woman does not need to be taken into hospital, they can arrange for a community midwife to visit in an appropriate time • The midwife will be able to directly refer the woman to her chosen unit ensuring follow up assessment

¹⁷ When we have used this method for our maternity pioneer service, we will look to roll out similar approaches for the other pioneers

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	See and treat
People	• A registered midwife • Call handling training • Potentially a gynaecology nurse also in the hub to assess bleeding	• A midwife responder consisting of a registered midwife (band 7) • An ambulance clinician (band 6)
Process	• Process of assessing categorisation of calls • Process of accessing the right specialist in the clinical hub	• Process of being able to register the birth so that the trust is eligible for payment of the births which is delivers • Process of dispatching the right specialist for a 'see and treat'
Infrastructure	• Access to summary care records	• Mobile device to provide access to summary care records • A vehicle equipped to keep both mother and baby warm and will have the capacity to convey patients if needed • Enhanced maternity and new-born equipment including additional warming facilities for new-born babies

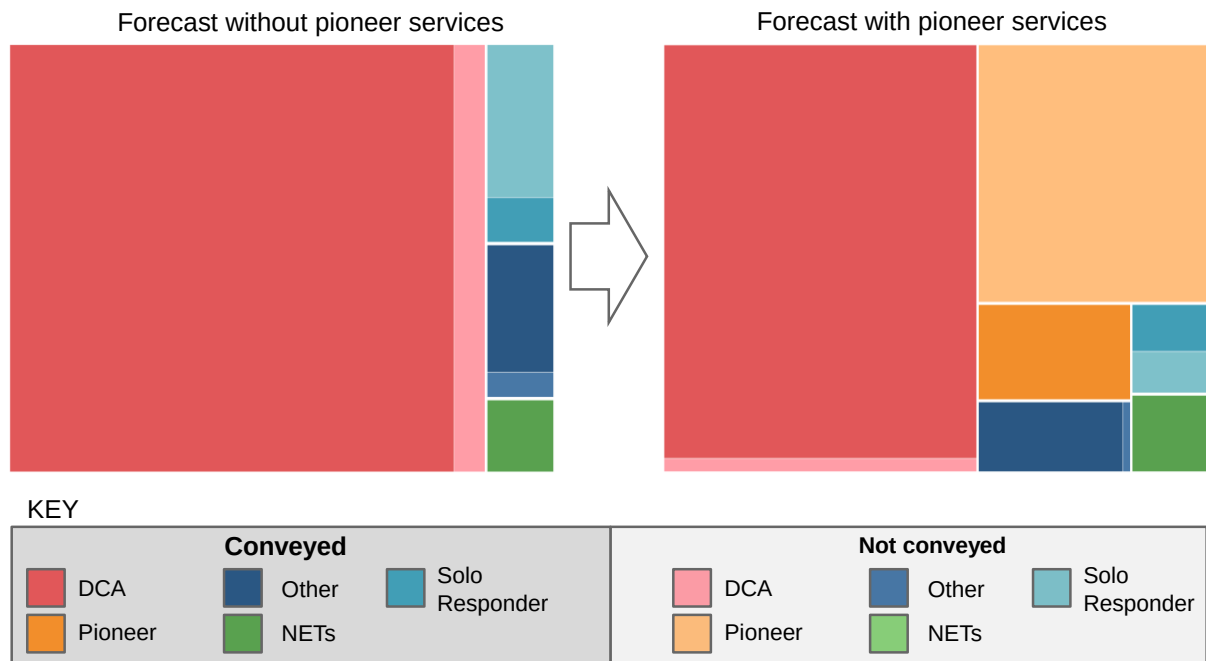
5.6.3 Summary of potential benefits

Table 8 shows the potential benefits for the cohort we have identified could receive this pioneer service, based on figures from 2017 incident data classification. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 8: Maternity pioneer service – summary of potential benefits

Quantitative benefits (projected for 2023)	Qualitative benefits
10,700 patients could benefit from this service (based on figures from 2017 incident data classification), of which: • 2,200 (20.6%) would receive 'hear and treat' discharge (over current) • 2,800 (26.2%) would be 'see and treat'/referred • 5,800 (54.2%) would be conveyed • 1,900 (17.8%) would be conveyed to emergency department Performance A reduction in emergency department conveyance rate from 21.5% to 17.8% for a selected cohort	• Specialist midwifery advice through iCAT London will enable patients to have assurance and confidence about their symptoms when it is not an emergency requiring a face to face response • Where a response is necessary, a skilled and experienced midwife will be able to provide more advanced care for mothers and their baby before, during or after the birth • A midwife on scene will reduce the need for such a large number of other staff to attend and they will also be able to provide additional assurance and confidence to the mother and the maternity team

Figure 18: Shows the cohort of incidents classified by Advanced Medical Priority Dispatch System code as 'pregnancy, childbirth or miscarriage' (see Figure 7) and how the vehicle response and conveyance outcome would change as a result of this pioneer service, significantly reducing DCA responses



5.6.4 Nylah's story – a maternity case study

Nylah is 33 and pregnant with her second child. One week from her due date she suddenly goes into labour at 4am and progresses quickly with contractions getting closer and closer. Her husband is working a night shift over an hour away and she doesn't think she can get to hospital on her own in time. She calls 999 for help.



5.7 End of life pioneer service

Aim: to improve the care we are able to provide to patients in the last phase of life through enhanced skills and knowledge of staff, improved pathways to support patients with a plan of care to receive their care at home or in a community setting to avoid conveyance to hospital and to improve access to at home medications and specialist teams to help support symptom management.

We are often called to patients in the last stages of their life, when their symptoms have become unmanageable, for example following a sudden crisis, deterioration or worsening symptoms when emergency pharmacological support is required such as pain relief. Ambulance clinicians may be presented with situations in which they have to make decisions about starting a resuscitation attempt and whether it would be appropriate and in the patient's best interests. These decisions may need to be made on the basis of limited information and in the context of a distressed friends and family.

In end of life care situations, the priority is commonly palliative symptom control, ensuring that patients are comfortable and not in any avoidable distress. Common symptoms resulting in an ambulance being called relate to pain, secretions, breathlessness and nausea. Increasingly patients coming towards the end of their life have been suffering from a chronic condition and have made a decision about where they want to die. As the very last wish for these patients, it is crucial that we help this to happen wherever possible. When we are attending end of life patients, we need to ensure that we are not only taking care of the patient, but giving consideration to their families who are saying goodbye to loved ones.

5.7.1 Service summary

We will enhance our education and training for all front-line staff to improve the skills, knowledge and confidence of all staff in providing end of life care to patients. We will also develop stronger links with hospices and end of life care pathways across London and review our range of pharmacology available to our clinicians. The ultimate aim of this service is to reduce unnecessary resuscitation attempts and conveyances for patients at the end of their lives and to make the final stages of life as comfortable, pain free and dignified for them and their families as possible.

We will invest in education and training around end-of-life care, ensuring that our crews have a clear understanding of trust policy and the legal and ethical basis of decisions made in these circumstances, and that crews understand how and when to use prescribed anticipatory care medications.

Additional pharmacology would allow for enhanced pain relief and treatment for excessive secretions and breathlessness which may include alterations to prescribed usage for drugs already carried by registered clinicians. Training in both the pharmacology of administration of anticipatory medicines alongside developing enhanced skills in difficult conversation management will be central to the training provided.

We will also improve integration with, and access to specific Coordinate My Care end of life plans so that ambulance clinicians have early access to these care plans as early as possible to support decision-making and ensure the patient receives the right level of care, in the right place.

The cohort for this pioneer service is not well defined, but expected to be larger than the modelling size which is based on palliative care incidents.

5.7.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/dispatch	• All of our control room staff will receive additional training to improve their skills in identifying calls where crews might be attending end of life care patients • We will have a specialist in the clinical assessment service (CAS) with advanced end of life care training who can provide advice to callers and can also assist crews • We will have a pharmacist in the CAS who will be able to advise crews on appropriate drug use
See and treat	• All of our front-line crews will receive additional training to improve their skills and confidence in treating patients in the last phase of their life
Referrals and additional care	• We will work to forge strong working relationships with hospices, palliative care teams and charity organisations • We will work with these organisations to agree consistent pathways, identifying which patients could be referred to other services and at which point in the care pathway

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	See and treat	Referrals and additional care
People	• Training for all call handlers on the signs to look for with End of Life patients and the referral options available pan-London	• Training for all responders on End of Life patients and the referral options available pan-London • Further education and support will be provided to all front-line clinicians from a dedicated end of life care specialists	• Enhanced pathway understanding across teams in contact handling and response
Process	• Process of identifying contacts which should be directed to specialists in the CAS • Process of identifying calls which should be routed to other referral points pan-London	• Introduction of Schwartz Rounds® to support staff wellbeing	• Additional pathways will be further developed and audited with palliative care teams, hospices and third parties
Infrastructure	• Having the right data available to ensure that all staff have the knowledge of the patient and referral points available to them when they need it	• Mobile device to provide access to end of life care records • We will review the medications that our clinicians have at their disposal to treat end of life care patients and the symptoms that they can experience which cause pain and distress	

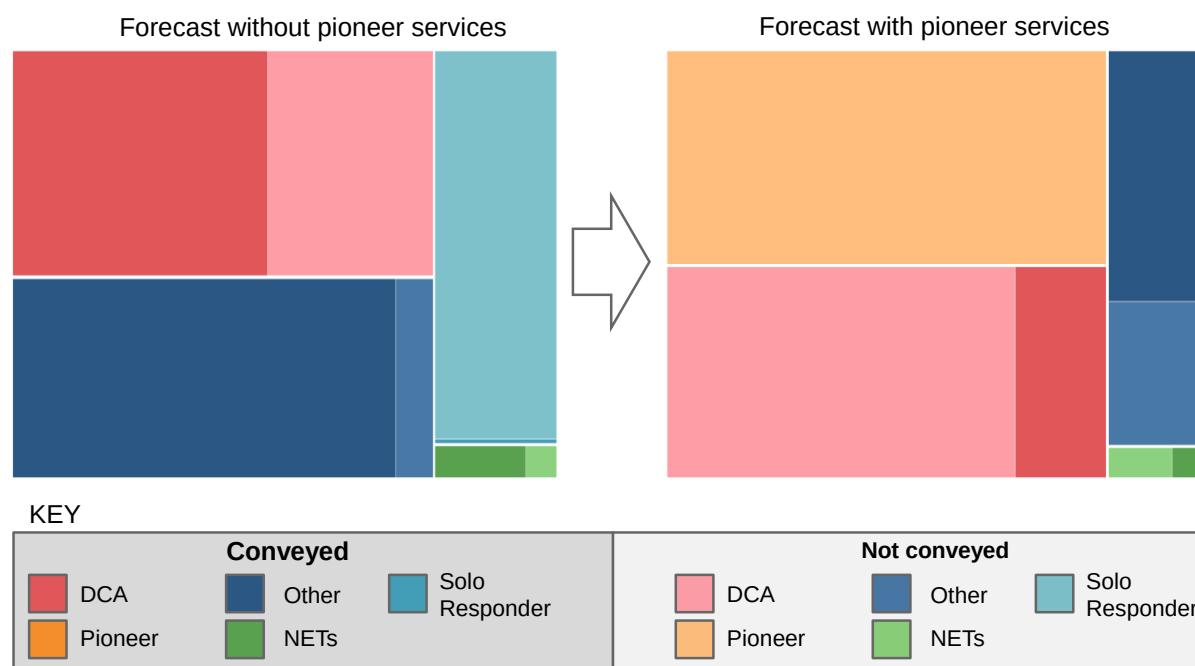
5.7.3 Summary of potential benefits

Table 9 shows the potential benefits for the cohort we have identified could receive this pioneer service. This cohort is not well defined, but is expected to be larger than the modelling size which is based on palliative care incidents. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 9: End of life pioneer service – summary of potential benefits

Quantitative benefits (projected for 2023)	Qualitative benefits
5,100 patients could benefit from this service (based on palliative care incidents only), of which: • 4,000 (90.9%) will be 'see and treat'/referred • 500 (11.4%) will be conveyed • 200 (4.5%) will be conveyed to emergency department Performance A reduction in emergency department conveyance rate from 19.6% to 4.5% for a selected cohort	• We will review the range of drugs that our crews are able to administer in these situations to enable them to treat patients more effectively. • Specialist palliative support beyond the emergency episode through development of effective, consistent pathways that we can refer to with community and palliative care providers. • Improved skills and confidence for our whole front-line workforce in dealing with end of life patients, including training on resuscitation guidance and associated documentation to ensure that staff are fully aware of and confident with the relevant documents and their impact on decision-making.

Figure 19: Shows the cohort of incidents classified by Advanced Medical Priority Dispatch System code as 'palliative care' (see Figure 7) and how the vehicle response and conveyance outcome would change as a result of this pioneer service, significantly reducing DCA responses



5.7.4 Margaret's story – an end of life care case study



5.8 Summary of potential benefits for all pioneer services

Table 10 shows the potential benefits for the cohorts we have identified could receive our pioneer services. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 10: Overview of potential activity and consequent performance benefits for pioneer services (2023)

	Urgent care response	Falls	Mental health	Maternity	End of life ^a
Total incidents classed within incident group	439,100 ^b	133,400 ^c	101,500 ^c	14,400 ^c	5,100
Current total conveyance rate for incident group	313,400 71.4%	92,000 69.0%	69,600 68.6%	13,100 91.0%	3,300 64.7%
Current emergency department conveyance rate for incident group	250,500 57.0%	70,400 52.8%	55,100 54.3%	3,100 21.5%	1,000 19.6%
Estimate of suitable incidents for pioneer service, of which:	213,000 48.5%	94,700 71.0%	84,600 83.3%	10,700 74.3%	4,400 86.3%
• Would receive 'hear and treat' discharge (over current)	–	–	1,900 2.2%	2,200 20.6%	–
• Would be 'see and treat'/referred	72,600 34.1%	39,800 42.0%	56,300 66.5%	2,800 26.2%	4,000 90.9%
• Would be conveyed	140,400 65.9%	54,900 58.0%	26,400 31.2%	5,800 54.2%	500 11.4%
• Would be conveyed to emergency department	75,500 35.4%	44,400 46.9%	9,300 11.0%	1,900 17.8%	200 4.5%

Notes to table:

- a. This cohort is not well defined, but expected to be larger than the modelling size which is based on palliative care incidents
- b. Based on incident profile seen in pilot
- c. Based on figures from 2017 incident data classification

6 Strategic theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable

We will develop collaboration, partnership and innovation across the full range of public services in London and will support all opportunities to improve patient outcomes and experiences and improve public value.

As the only pan-London NHS provider, we have unique insight into the care that patients have available to them across London. We can help NHS England and the sustainability and transformation partnerships (STPs) identify the services that are best able to manage demand, where there are inconsistencies and where changes to service delivery would provide benefits to patients and the urgent and emergency care sector as a whole.

We are also fully committed to collaborating with the emergency services and wider London stakeholder community and have signed up to the joint intent of “making London the safest global city”.

6.1 Collaborating with health and social care partners

6.1.1 The strategy, design and development of urgent and emergency care in London

As the only pan-London NHS provider trust, we can add demonstrable value to strategy and service development across the capital. We have not done this as effectively as we could have done in the past, but, working in conjunction with each of the London’s five STPs, our new strategy aims to change this. Alongside the STPs and acute, mental health, community, social care and other providers, we want to be an integral partner in the development of the urgent and emergency care sector in London.

Led by the STPs, the urgent and emergency care sector is continually evolving and developing and there are hugely exciting initiatives that are aiming to improve patient outcomes and experiences. However, not all care pathways and services are consistent across London. There is of course a place for local variation to meet the different needs of the different populations across London, but increased consistency would provide a better patient experience and support our staff in providing patients with the most appropriate care. The increasing volume of short operating hours or small footprint pathways and protocols, mean that patients may get different types of care in different parts of London; and our staff must spend time learning what is available and where.

We will assess urgent and emergency care pathways which we interact with, working with partners to identify whether they provide the best patient outcomes and optimise efficiency for us and for the system. We can contribute our experience and evidence base about what works best and help STPs to design local pathways that are most effective and provide best value for money.

By working with system partners, using our data and analytics, in the design and development of urgent and emergency care in London, we aim to:

- Simplify and ensure consistency between unplanned care pathways – providing consistency of experience and outcomes for patients; and reducing complexity for paramedics
- Develop and implement our pioneer services – ensuring that they work well across London

- As a provider of both 111 and 999 calls, release additional value through ensuring proper use of non-emergency care pathways, helping to ease the pressures on hospital emergency department services

6.1.2 A consistent approach to alternative care pathways

While we recognise that there will always be differences in locally-commissioned services, it is our intention to work with London's five STPs to support the development of an agreed set of minimum standards for appropriate care pathways across London.

We know that by developing appropriate care pathways, that are consistent across London, we can better meet the needs of particular cohorts of patients and ensure that patients are taken to the most appropriate treatment centre for their presenting condition. Over 60% of incidents that we respond to currently result in conveyance, the majority of these to an emergency department. We are already seeing a gradual shift to alternative care pathways as more consistent options, along with greater visibility of these, are becoming available to our staff.

In line with our clinical strategy, we are working with the London's five STPs to ensure that all alternative care pathways have a minimum set of common conditions that they will see and that these are available consistently. We have now provided all of our front-line staff with tablets so that they can look up the appropriate setting for their patient before either taking them there or arranging suitable transport. We will work with STPs and provider organisations to make sure that this information is consistently updated for our staff to use.

It is important to realise that 'consistent' does not mean 'one size fits all' but rather means that each pathway enables a common set of patients to be seen by that facility consistently. This will therefore provide confidence for our staff that they can refer the patient to the right facility first time, every time.

Patients and our staff will have the following benefits from improved consistency and availability of pathways:

- Improved clinical outcomes for life threatening conditions, including by reducing on-scene time for time-dependent clinical conditions
- Reduction in the variability in response to both critical and non-critical patients across London
- Increase the range of specialist skills in our clinical hub to provide expert advice to staff and better care to patients
- Staff will have better access to up to date information when with a patient to enable appropriate decisions to be made about a patient's care and where that is best provided.
- Patients will receive care closer to home, for example from an advanced paramedic practitioner who can prescribe medications allowing that patients to be managed at home where appropriate.

6.2 Collaborating with emergency services partners

The London Ambulance Service works closely with other emergency services to keep Londoners safe and enable us to work as efficiently and effectively. With the duty to collaborate with other emergency services now established by the Policing and Crime Act 2017, we are working with the London Fire Brigade (LFB) and Metropolitan Police Service (MPS) to make London the safest global city.

As a Category 1 responder, we have a statutory obligation to be prepared to deal with serious and major incidents of all types and sizes. Our incident response plan has been prepared in light of guidance from the Department of Health, Home Office and builds on the Civil Contingencies Act 2004 guidance, lessons identified by the London Ambulance Service, Coroner's inquests and subsequent 'prevention of future death' reports.

The trust is committed to continued engagement with its partner agencies and with the local and regional resilience forums to ensure joined up multi-agency emergency preparedness and resilience

which ensures a rapid response, with appropriately skilled clinicians to ensure the best clinical outcomes for the most patients affected.

Some of the main ways in which we already collaborate with the other emergency services are:

- Joint responding with the Metropolitan Police Service
- Joint training exercises with the London Fire Brigade
- We share estates with both LFB and MPS
- Joint working on major events and incidents
- Defibrillators on police vehicles
- Joint publicity campaigns
- The Joint Emergency Services Interoperability Programme (JESIP)

6.2.1 A joint strategic intent between the three emergency services

The three emergency services have agreed a joint statement of strategic intent which sets out our combined vision to partnership, collaboration, innovation and co-operation.

Building on existing collaboration in a number of critical areas, the three services now want to work together to go further to provide a world-class service that ensures a lasting legacy for the people of London. Together we will:

- Share a common vision of ‘making London the safest global city’
- Deliver a world class emergency service to the people of London
- Ensure collaboration is at the heart of everything we do

There are six thematic areas of joint working between the emergency services, each with a range of options for how we can work better together:

Figure 20: Six thematic areas of joint working between the emergency services

Prevention	Potential areas include: • Community response teams • Safe and well visits • Intervention schemes: referral and delivery • Education teams • Central prevention strategy team • Director of Prevention for London • Information sharing • Fire as a health asset	Control rooms	Potential areas include: • Single control room service for London • Co-location of control rooms • Horizon scanning to include NHS 111, GP out of hours and 101 police non-emergency numbers • Signposting services for users/patients • Integrated technology where possible • Shared resilience
Response	Potential areas include: • Co-responding (MPS/LFB) • Joint response units (MPS/LAS) • Defibrillators in public access buildings network • Police assistance to LAS when forced entry is required • Specialist assets and services • Joint command units	Infrastructure	Potential areas include: • Estates: a shared vision/plan of London’s 999 footprint • Fuel bunkers • IM&T: software licensing for common applications, contracts • Shared technology where possible

Inclusion	Potential areas include: • Cadets and apprenticeships • Volunteers • Recruitment • Career development • Staff associations e.g. LGBT groups • Development of inclusion strategies • Staff side representative bodies	Potential areas include: • Fleet • Procurement • Logistics • HR and payroll • Uniform/personal protective equipment (PPE) e.g. servicing of chemical, biological, radiological, nuclear, and explosive PPE • Legal services • Training (blue light driving) • Shared standards

6.2.2 Existing collaboration

While Figure 20 provides the themes and agreed areas of potential collaboration, some projects are already underway. These are explained below.

Control rooms

We have worked with the Metropolitan Police Service and the London Fire Brigade to secure funding from the Home Office Transformation Fund to investigate the potential benefits that could be achieved through shared control room functions. We are at an important and exciting juncture in London, with the opportunity to fundamentally redesign and think boldly and creatively about the longer term ambition for how London's emergency services control rooms are delivered, configured and operate.

This exploratory work could identify a range of different options from sharing space to full integration. The effectiveness of the control rooms will be a key consideration but so will be reducing the duplication of expenditure across the emergency services. Each service spends a significant amount of telephony, computer aided dispatch software, radio and data provisions and integration or joint procurement exercises will be an aspect of this investigative work.

Estates

We already share space with the London Fire Brigade at their headquarters in Southwark. We also continually look to for estates collaboration that will save tax payers money. For instance, we have an agreement with LFB to park certain vehicles in central London, saving the NHS £400,000 this year

Defibrillators

We have been working with the Metropolitan Police Service to place 700 defibrillators on police vehicles across London. This has led to several successful resuscitations of patients that the police managed to reach before an ambulance. This scheme has also saved the lives of a number of police officers who have had cardiac arrests on duty.

Prevention

We have submitted a joint business case that will see the formation of a tri-service team that will deliver preventative messages to schools in London. This service will aim to reach out to over 1,800 children in its first six months of operation

6.3 Analytics to drive improvement and integration

The London Ambulance Service is the only pan-London trust and therefore has a unique view of the urgent and emergency system. We have been evolving our business intelligence and analytical modelling skills for a number of years, and are well practiced in gaining insights through sophisticated modelling approaches and crafting and communicating a story from qualitative and quantitative

information. This means we are well-placed to be able to share our learning and experience with other organisations.

A variety of daily decisions are already enabled by the wide availability of our data and due to the work we do with other non-technical teams to facilitate the interpretation of the wealth of this data. With automated access to more external data sources through new shared technology platforms (for example 111 activity data and hospital admission data), we will be able to understand the impact of care throughout the urgent and emergency care system and provide further evidence for interventions that would improve the effectiveness or efficiency of care.

In order to gain the maximum benefit from our data, we need to develop:

- Our analytics capability
- Relationships with other health and social care analytical teams across London
- Information technology to enable automated information sharing and analysis

6.3.1 Our analytics capability

As we become a primary integrator of access to urgent and emergency care we will need to strengthen our analytics capability to bring together intelligence from across London to enable us to inform system-wide policy, strategy and operations. Our ultimate goal will be to monitor the full patient pathway, supporting the needs of London's five STPs in population health management to:

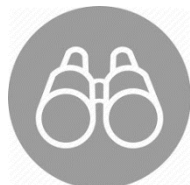
- Gain insights from data and identifying trends
- Manage care delivery in near real time
- Develop evidence-based recommendations to drive improvements in the effectiveness or efficiency of care
- Shape the design of future services

The core analytical capabilities fundamental to achieving these goals are shown in Figure 21.

Figure 21: Core analytical capabilities fundamental to achieving our goals



Benchmarking



Horizon scanning



Intelligence, reporting
and predictive
modelling



Performance
and demand
management

We already have a well-established and trusted analytics team, who ensure an efficient flow of data insight, and support decision makers with reliable evidence-based intelligence. Our business intelligence analysts and data scientists are able to understand the impact of interventions on the system, use statistical and mathematical modelling to make predictions, determine relationships between system elements or services, and model “what if” type scenarios. The strength of such a team is that the models built can be designed to be generic and reusable – bringing efficiencies and cost savings, compared to ad-hoc pieces of analysis being carried out across London.

We are expanding our internal capabilities to service all operational and corporate functions within the London Ambulance Service, to continue to support CCGs, and potentially to build up to a position where we can also supply partners with intelligence about their individual operational services which integrate with ours. This will reveal the interplay of services and their components, but will also provide transparent horizon scanning in terms of wider healthcare system forecasting.

6.3.2 Relationships with other health and social care analytical teams across London

We have not only built up partnerships with commissioners and other providers, but also have forged partnerships with academic institutions. This gives us access to cutting-edge research with a broader application than could be achieved alone in-house, extra scope and capacity for innovative projects, and appreciation of best practice analytics in other fields and industries. These benefits are applicable more widely than the London Ambulance Service, and often the appeal for universities to work with us is the quantity and richness of our data, as well as the ability to gain pan-London insight from such information. The benefits for patients would be enhanced through more integrated working across London.

There is much that can be learned from industry leaders in the analytics arena, from financial to retail sectors. Some examples of service and service-user improvements achieved from analytical insight which are applicable in a healthcare setting are shown in Figure 22.

Figure 22: Areas where analytics could be applied to improve patient care and provide more efficient insight for staff

Demand management	Disney is a pioneer of customer satisfaction and demand management, monitoring demand in real time and dynamically deploying resources where they are needed to manage the customer experience. Disney also use this insight strategically to forecast for the future and to determine capacity. <i>The transferable learnings here apply not only to our mission of being a high quality service provider, but in understanding the pathway and full system</i>
Performance management	Many household-name supermarkets and retailers have experience in performance management and understanding the equity of their service provision. They make use of innovative analytical techniques to monitor data and recommend improvements in specific areas. <i>It is important to us that new models of care are equitable and managed effectively to provide the best care to patients across London. Intelligence and insight will be produced</i>
Service-user satisfaction	Businesses such as British Airways and John Lewis are renowned for their customer satisfaction scores and service quality. Analytics are a pivotal part of informing business strategies in these companies. <i>As an emergency care provider, we support and serve the population of London in their greatest moment of need. We can use insight from the evaluation of patient and staff satisfaction to recommend ways to improve. This branch of</i>
Personalised service	In the finance sector many companies generate marketing based on intelligence from customer data and target specific individuals with products and services they believe will be most useful/relevant. <i>Applied to healthcare, this means using ensuring that we: understand our patients' needs by using business intelligence and analytics to make accurate predictions; and respond to patients in the most appropriate way, referring them to the right</i>
Centralised intelligence	The Ministry of Justice has a Data Lab that generates evidence for change. The Department of Health provides guidelines for employing analytics and making use of insight and expertise. And NHS Digital has established a centre of excellence in big data and data science. <i>We aim to enhance our own in-house capabilities, from what is already a sound base, to increase the value that we add from analytics and statistical modelling to support</i>

We should all aim to use analytics and technology hand in hand to better integrate with other public services, ensuring patient care is well-coordinated, equitable and consistent. Creating sustainable, automated and near real-time links with external data sources and partner intelligence will be key to the delivery. Partnerships with other organisations, where analytical investigations using shared data are conducted to benefit all parties, will also reduce commonly seen issues around data accessibility, transfer and interpretation.

Pan-London data sharing agreements have already been discussed and need to be progressed to completion.

6.3.3 Information technology to enable automated information sharing and analysis

Developing the analytics capability we describe above depends on having joined up data and common patient records. We describe in Section 8.4.1 how we intend become a fully digital organisation. With available and planned technology to be deliver over the lifetime of our strategy, the following will become possible:

- Linking of emergency, urgent and hospital admission data will allow us to model and interpret full pathways to understand the flow of our patients and impact of response and pathway on patient outcomes for both emergency and non-emergency patients.
- Seeking to work with Transport for London to gain a real-time understanding of traffic flows in London to make better dispatch choices; additionally to help planning by understanding where demand might arise based on historic travel patterns and commuter routes.
- Deep data insights around demography, weather, transport and infrastructure required to enable us to better predict demand. It is important to also understand the equity in the services provided throughout London and perhaps the impact on patient outcome in different areas. This can be done within our existing capabilities, but requires additional capacity to fulfil the investigation.
- Tracking of the NHS workforce across London. For example, looking at trends in paramedics within the education system, those likely coming into local recruitment populations, the existing paramedic cohort, and those retiring. Such staff grouping information would allow us to model the full workforce pathway, and horizon scan for imbalances in supply and demand of specific skills across emergency and urgent care services across London.
- Automated, interactive dashboards, available to our partners for viewing and exploring data.

7 Estimating the economic impact of our strategy

Our strategy will have direct clinical benefits for patients by providing more clinical care remotely by ‘hear and treat’ and by increasing to over a quarter the proportion of our patients who received a specialised response, discharging them on scene where possible by ‘see and treat’. A reduced conveyance rate to emergency departments will mean that hospitals will deal with fewer patients who do not need to be there, which has both operational and economic benefits.

We have discussed qualitatively the potential benefits that we expect our strategy to deliver by theme in sections 4, 5 and 6. In this section we examine the economic impact that we hope to deliver for our own organisation and for London’s five health economies/sustainability and transformation partnerships (STPs). This is based on a service level model that we will refine as we develop the operational model for iCAT London and pilot the falls, mental health, maternity and end of life pioneer services, incorporating the pilot results to further update projections.

7.1 Economic impact of strategic theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients

7.1.1 London Ambulance Service

The principal economic benefit to the London Ambulance Service of implementing iCAT London is a reduction in ambulance dispatches, with additional benefit from improved utilisation of call handlers and clinical advisors.

- Calls transferred from NHS 111 to 999 have a smaller proportion of Category 4 incidents compared to those made directly to 999. We believe this to be due to more appropriate triaging for lower acuity calls by 111 services, including the ability to re-triage. The difference accounts for **£11.6m per year** in ambulance dispatches, assuming a ‘hear and treat’ cost instead. Our clinical experts suggest that it should be the aim to reduce as many Category 4 physical responses as possible.
- As described in Section 2.2.4, South East London 111, which we run, shows a consistently low level of ambulance dispatch in comparison to other London 111 services. If all 111 services had similarly low dispatch rates, this would save 25,000 ambulances per year, worth a minimum of **£2.3m per year**, assuming ‘hear and treat’ rather than ‘see and treat’.
- Having all 111 calls handled by a single workforce would significantly improve utilisation. Our analysis shows that while 550,000 calls in North East London would require 21 call handlers, the 1.44m calls across London would require only 40 call handlers. We estimate a conservative saving of **£1.4m per year** using North East London utilisation, but believe the saving could be larger as most London 111 services are smaller than North East London.
- Similarly to call handlers (above), we have estimated there is a conservative total opportunity to improve utilisation of clinical advisors of **£3.9m per year**.

There are two other important potential sources of economic benefit which have not yet been quantified – we will make estimates as we develop the operating model for iCAT London:

- Reduction in the volume of calls dealt with by call handlers owing to use of artificial intelligence. NHS Digital 111 online trials shows ambulance dispatch reducing from 23% to 20% and primary care referrals reducing from 59% to 40%.
- Reduction in time spent handling calls owing to better data capture, clinical triage and the use of evidence-based clinical decision-making tools. We are already looking at opportunities to improve in this area.

7.1.2 London region

The principal economic benefits of implementing iCAT London accrue to the London Ambulance Service. There are however, three potential sources of additional economic benefit that we have not yet quantified:

- Time and manpower savings from direct booking into integrated systems
- Multichannel access opening up a range of educational benefits for the community by helping patients to inform each other about appropriate services and how to access them
- The London Ambulance Service as a provider of data analysis and insight to improve urgent and emergency care across the wider system

It is difficult to estimate the benefit to the London region from avoided emergency department attendances or admissions *over and above* those already anticipated from the implementation of integrated urgent care (IUC), which CCGs and providers will already have documented in service business cases.

7.1.3 Summary of potential economic benefits

Table 11: iCAT London – summary of potential economic benefits (revenue) from 2023

Beneficiary	Benefit area	Source of benefit	Avoided costs (£m)
London Ambulance Service	Ambulance dispatches	Avoided ambulance dispatches (999)	11.6
		Avoided ambulance dispatches (111)	2.3
	Utilisation	Improved utilisation of call handlers	1.4
		Improved utilisation of clinical advisors	3.9
London region	Reduction in number of urgent and emergency contacts	Direct booking into integrated systems	a
		Multichannel access	a
	Identification of opportunities to improve effectiveness admissions avoidance	Provision of data analysis and insight to STPs	a
Total^b			19.2

Notes to table:

- To be quantified in further work as we develop the operating model for iCAT London
- Implementation costs, including the costs of new technology and change management, have not been quantified

7.2 Economic impact of strategic theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital

Our five proposed pioneer services focus on delivering care closer to home through ‘hear and treat’ and ‘see and treat’, which will reduce both the number of incidents we attend and the number of people we convey to emergency departments. This will release capacity within the London Ambulance Service and emergency departments within London’s five STPs to deal with higher acuity patients.

There are trade-offs between staffing for the pioneer services and reducing the conveyance rate: as we increase the number of staff, the conveyance rate falls but so does utilisation of those staff. We have modelled a number of scenarios to understand how the increase in staffing would improve the conveyance rate. Of the scenarios modelled, we present the scenario that optimises the overall benefit to the London region health economy, capturing 79% of incidents suitable for a pioneer response, which is 26% of total incidents attended by 2023.

In developing each pioneer service, we have run a series of workshops attended by the clinical leads for each of our pioneer services, senior clinical staff, front-line staff, and representatives from the wider system. These workshops were used to generate assumptions about the volume and type of incidents appropriate for a pioneer dispatch and the likely change in conveyance rate. These assumptions have been further informed by historical incident data and the findings of our advanced paramedic practitioner for urgent care (APP-UC) pilot.

7.2.1 London Ambulance Service

The pioneer services aim to change the incident outcome primarily for Category 3 and 4 incidents where there is opportunity to avoid dispatch of a vehicle, or resolve an incident without need for conveyance. Our modelling also accounts for occasions when we might send a member of staff allocated to a pioneer service to a higher acuity call in a double-crewed ambulance (DCA) when this would improve the quality of our response to a patient. A good example of this would be an emergency response to a birth complication when we might send a midwife along with the ambulance crew.

Service performance

The key performance benefits of the pioneer services are:

- **103,000 fewer patient conveyances** (to all destinations) in 2023 compared to current forecasts, with 37,000 fewer patient conveyances (to all destinations) compared to 2017 figures. As well as relieving pressure on the wider system this improves LAS productivity as job cycle times are 30% lower where a patient is not conveyed.
- Reduction in double-crewed ambulances (DCA) vehicle usage of **294,000 hours per year**, equivalent to 34 ambulances running 24/7, replaced with a pioneer response emphasising ‘see and treat’

There is potential for expansion of scope of two pioneer services as they are developed and piloted:

- Urgent care response: advanced paramedic practitioners have been used for Category 3 and 4 incidents and there may be scope to use them in a wider role. We would need to carefully examine the risk of impacting on Category 2 performance metrics.
- End of life: current data for incidents classified as end of life is of poor quality and a minimal number of flagged incidents have been used as a baseline (palliative care only), but clinical experience indicates a significantly larger proportion of all work.

Figure 23: Shows the profile of incidents, highlighting the reduction in emergency department and overall conveyance attributable to the pioneer services

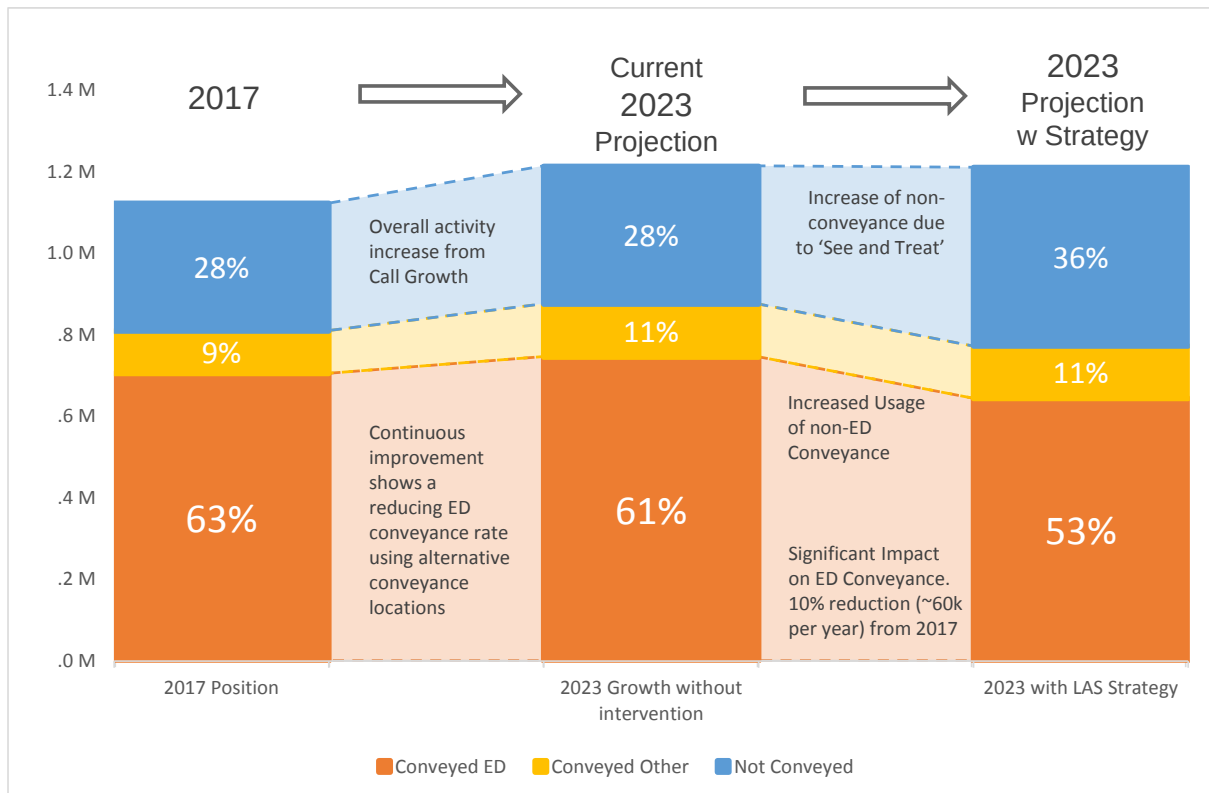


Figure 24: Shows the impact on outcomes compared to the baseline as proportions. The pioneer services deliver an overall reduction in emergency department conveyance from 63% to 53% in 2023.

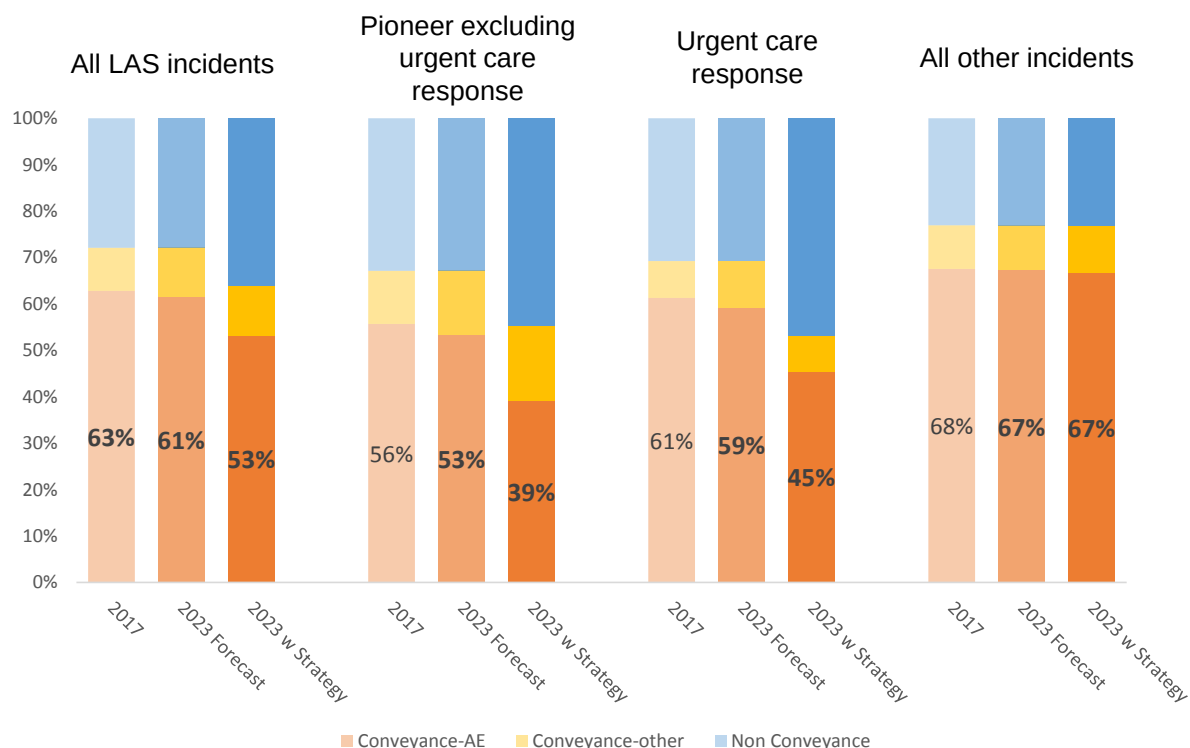


Figure 25: Shows the impact on outcomes compared to the baseline as absolute volumes: 103,000 fewer patient conveyances (to all destinations) in 2023 (37,000 fewer patient journeys compared to 2017 despite overall growth in incidents).

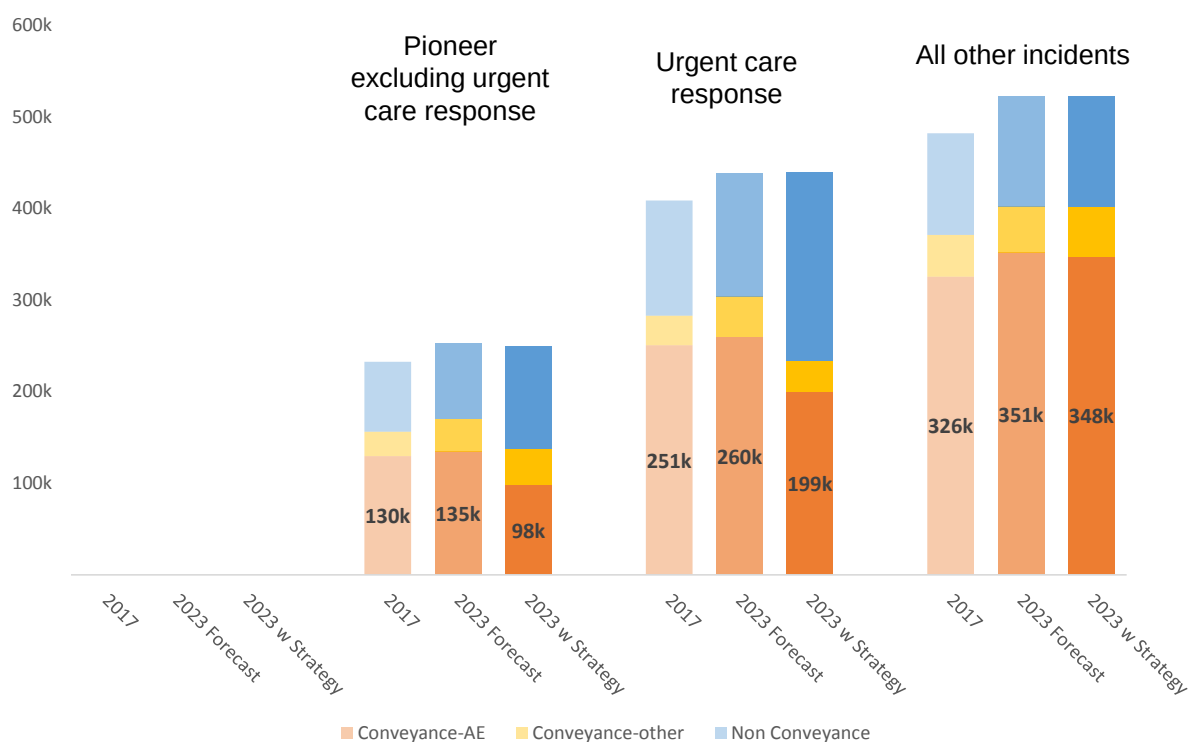
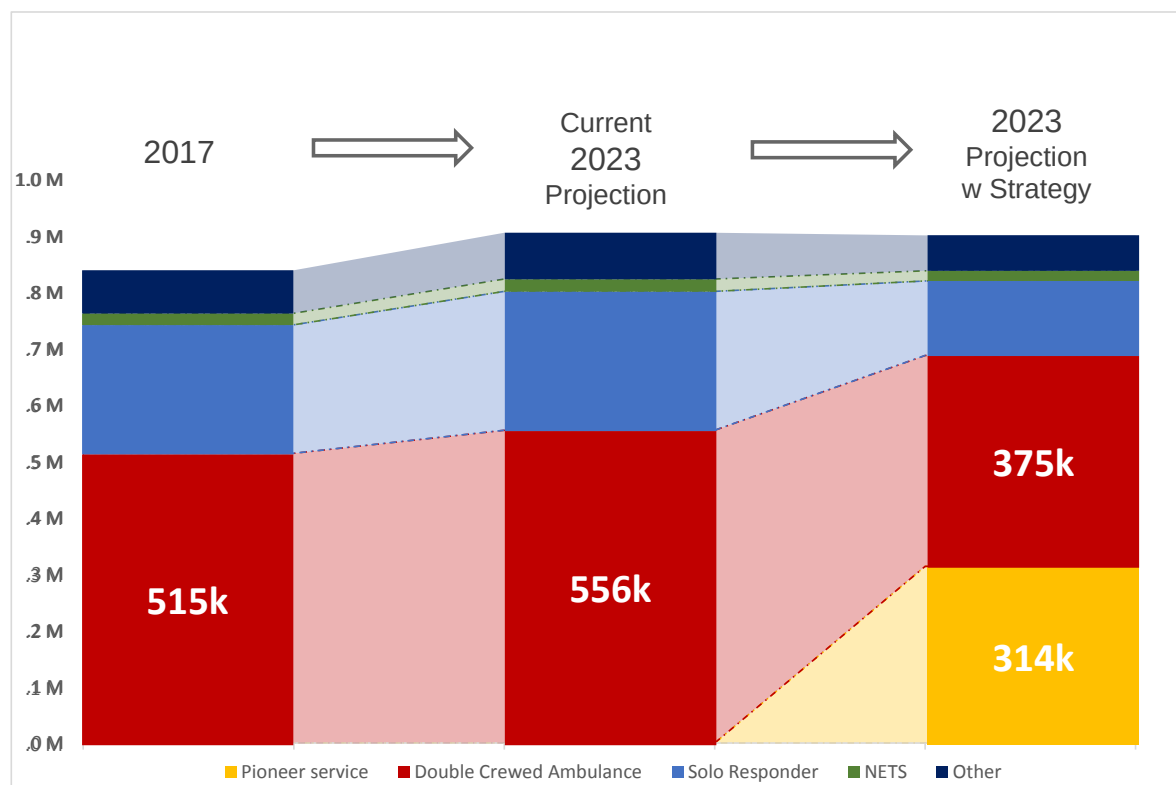


Figure 26: Shows the reduction of 180,000 DCA responses due to the pioneer services. Total vehicle response increase potential conveyance requirements of patients. This will have a low performance metric impact due to concentration on lower acuity.



Productivity

Clinician productivity (the number of calls that a clinician would be able to respond to on a given shift) is a key factor in the viability of our pioneer services. There are two key drivers. One is the improved confidence and decision-making of staff to deal with incidents and discharge patients at scene rather than convey them. The second is ensuring that specialist staff would have a sufficient stream of calls to respond to (either as 'see and treat' or 'hear and treat') to ensure they are fully utilised on a shift.

We have modelled likely productivity levels to understand the impact on resource requirements. Our resource model assumes increased productivity of our clinical experts, which is supported by evidence from our advanced paramedic practitioner for urgent care (APP-UC) pilot. To understand the likely distribution of incidents for pioneer services, we have used historical incident data at an STP level and run a Monte Carlo simulation to model the likely utilisation for different staffing levels. Our modelling does not comprehensively account for that fact that we could (while still meeting performance targets) delay some lower acuity responses in order to provide an appropriate pioneer service.

Our modelling shows we need around 88 clinicians and 63 vehicles dedicated to pioneer services at any one time. This modelling will be refined as we pilot the pioneer services, and different rostering and scheduling options can be considered. The resulting financial impact of our optimal scenario is shown in Table 10:

Table 9: Pioneer services – net cost avoided by LAS from 2023 (analysis of staff and vehicle requirement)

Financial impact	£m
Cost of existing services	37.0
Cost of pioneer services	31.6
Net cost avoided by LAS	5.4

7.2.2 London region

The principal economic benefits of implementing the pioneer services accrue to emergency departments in the London region from avoided emergency department attendances or admissions. We estimate that **101,000 fewer patients would be conveyed to an emergency department** per year in 2023 (37,000 fewer patient journeys compared to 2017 despite overall growth in incidents). We also hope to reduce re-contact rates through closer ties into appropriate local pathways. We will test this during the pioneer pilots.

Assuming low-end tariffs of £91 for an emergency department, and £262 for a non-elective admission, this could help London's five STPs to avoid costs of £10.3m in attendances and a further £3.2m in non-elective admissions.

7.2.3 Summary of potential economic benefits

Table 12: Pioneer services – summary of potential economic benefits (revenue) from 2023

Beneficiary	Benefit area	Source of benefit	Avoided costs (£m)
London Ambulance Service	Conveyance	Net cost avoided from lower conveyance rate	5.4
London region	Reduction in number of hospital contacts	Avoided ED attendances	10.3
		Avoided non-elective admissions	3.2
Total			18.9

Note to table: implementation costs, including the costs of new technology and change management, have not been quantified.

7.3 Economic impact of strategic theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

Close collaboration with our partners is essential to realising the potential economic benefits described in our strategy – it does not yet, in and of itself, release additional economic benefits. Our aim is to work with health and social care, emergency services and London system partners to identify opportunities to make further improvements to the consistency, efficiency and equitability of services.

7.4 Overall impact of strategy

We have assessed the benefit of each of our three strategic themes separately, highlighting anticipated quantitative benefits and qualitative benefits. These are based on initial modelling which will be refined as we develop the operational model for iCAT London and pilot the falls, mental health, maternity and end of life pioneer services, incorporating results to update projections.

We will need do further work to ensure that our three strategic themes are implemented whilst monitoring potential overlap in benefits between iCAT London and the pioneer services. Our focus is on providing definitive care to patients as soon as possible after contact, which will reduce the need for provision of care at later stages of the urgent and emergency care pathway. We will design our pilots to understand these synergies and how they impact upon projected volumes of activity.

Figure 27: Shows the overall impact of our strategy, at a number of stages, on the flow of patient journeys. A significant increase in overall call total is mitigated by iCAT London and our pioneer services to limit the impact on LAS.

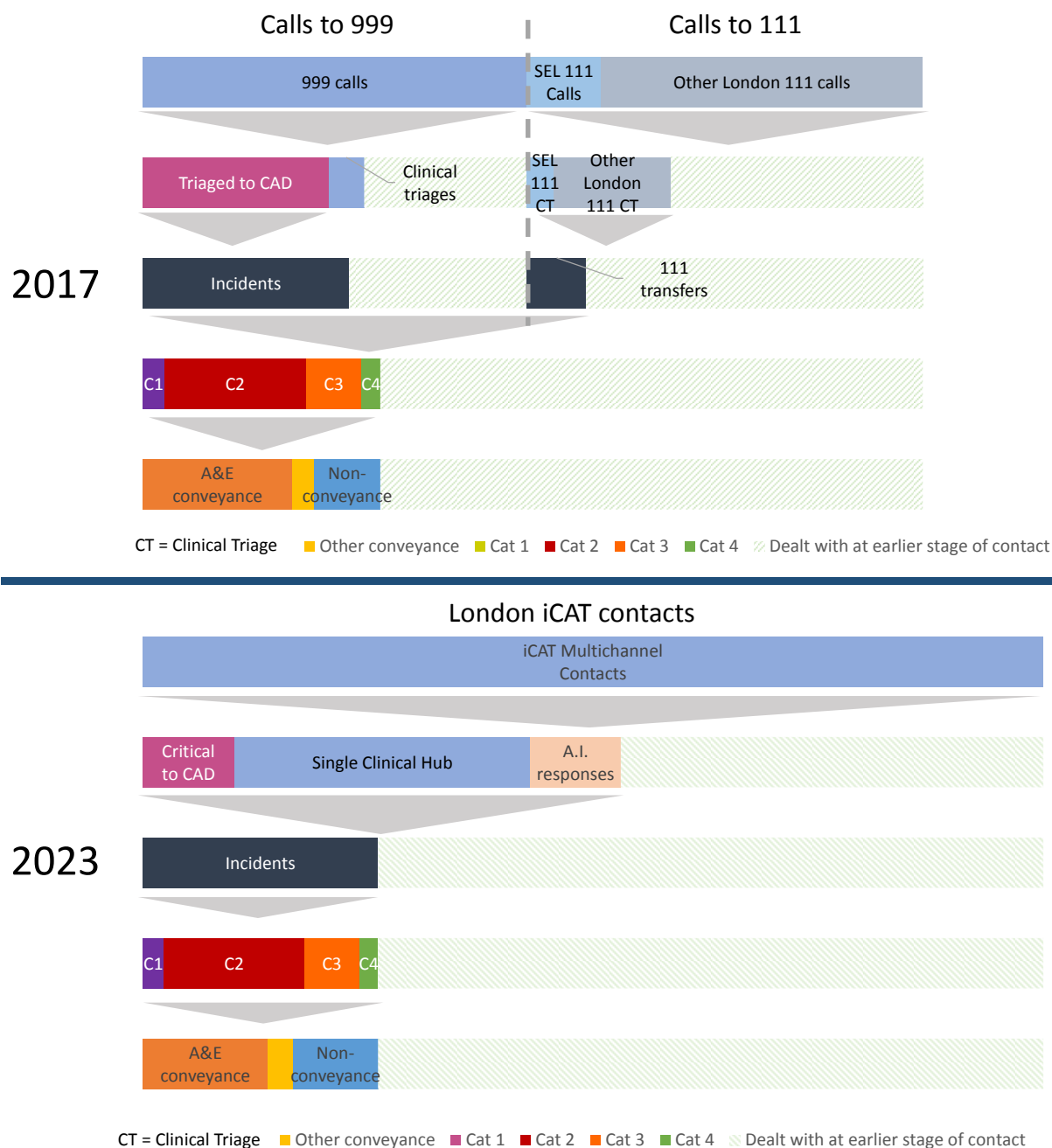


Figure 27 provides our best understanding of the overall impact on activity and conveyance. We do not provide an overall financial impact to ensure we do not overstate potentially overlapping benefits. For example: successful benefit realisation in iCAT London would reduce mental health calls becoming incidents through increased deployment of mental health nurses within the integrated clinical assessment service. This would impact the volume of mental health vehicle responses resources required. Similarly our success of reducing conveyance to the emergency department is partially dependent on collaborating with partners to maximise use of alternative conveyance destinations

8 Delivering our strategy

Delivering our strategy will require us to deliver fundamental changes across the organisation in the way that we operate. In achieving this new blueprint for our organisation, we will need to make key changes to our organisational structure, culture, capabilities and infrastructure. Our blueprint will be enacted through a strategic framework of detailed and interconnected ‘daughter documents’ which will specify, function by function, the plans that we will deliver over the lifespan of this strategy.

This section details the changes that we need to make to achieve our new organisational blueprint, as well as how we identified what those changes are and how we will deliver them.

8.1 A new blueprint for our future organisation

We have used a business design approach to articulate the new organisational blueprint that demonstrates how our new strategic themes come together. This approach helps us to ensure that the design for our future organisation is:

- Driven by a clearly articulated strategic vision that has been developed collaboratively by affected stakeholders
- Founded on a solid understanding of the underlying capabilities needed to be successful
- Integrated, with seamless connections between components such as people, processes, systems and data

The first stage in developing our blueprint has been to identify a set of core design principles that that will guide all changes and improvements that we are going to make to enable us to achieve our vision and implement our strategy.

Table 13: Blueprint design principles

Design principle <i>The design must...</i>		Rationale <i>... in order to...</i>	Potential operating model improvements <i>... and may feature...</i>
1.	Deliver a better and more consistent and equitable patient experience	• Ensure each patient can access the service in the way that they choose and receive the most appropriate response for their needs, regardless of their point of access • Ensure a fair and equitable response to the patient from a quality and safety perspective	• Improving access through a broad mix of multichannel options • Integration of urgent and emergency care contact handling, initial triage and one clinical hub
2.	Ensure organisational flexibility and adaptability	• Be able to better react to changes in patterns of demand, e.g. due to seasonality	• Flexible approaches to sourcing the skills we need as an organisation e.g. contracted resource • Multiskilling staff to cover a range of clinical requirements • Integrating/creating flexible resource pools

Design principle <i>The design must...</i>		Rationale <i>... in order to...</i>	Potential operating model improvements <i>... and may feature...</i>
3.	Optimise the efficiency and effectiveness of contact handling and initial triage	• Provide better assessment and improved resolution of patients concerns and conditions through one point of contact • Reduce human effort required to handle low acuity contacts in order to increase focus on developing complex triage and resolution capability	• Alternative options for delivery including better use of technology to enable self-service, lower cost locations/lower cost providers
4.	Ensure fewer patients are conveyed to hospital	• Get the right clinical response that is most appropriate for the patient and most cost effective for the system	• Better complex clinical triage • Increasing the range of skills in the clinical hub to provide expert advice to staff and better care to patients • Improving links into other services outside in the wider system
5.	Exploit new technology to help make lower acuity contacts more efficient and improve the effectiveness of clinical assessments	• To improve patient experience and efficiency of delivery across our service	• Alternative ways to access the organisation, increased use of automation for less urgent contacts and enabling staff to use technology to work virtually e.g. 'see and treat' without needing to be on the scene
6.	Enable consistent interfaces and agreed minimum standards across London	• Better meet the needs of patients across London through more consistent care pathways	• Increase the focus on pan-London care pathways and working with the wider system to ensure that a set of minimum care standards are in place and adhered to by the London Ambulance Service • Clear referral options from the clinical assessment service to the right place in the system
7.	Ensure compliance with NHS England's integrated urgent care specification	• To ensure that we are compliant, while remaining in control of the design and ensuring it is aligned with the wider organisational strategy	• Adherence to the guidelines but ensuring that our strategy is reflected in the design through areas such as the pioneer services
8.	Balance short term requirements with longer term strategic ambition	• To ensure design supports the short term priorities for the North East London and South East London contracts/bids as well as the strategic intent of covering the whole of London	• Prioritisation of critical resources which are specified by contracts in the short term while building wider capability for the long term
9.	Ensure organisational scalability	• To be able to absorb additional demand from expansion across other geographies	• Considering alternative sourcing options to cope with potential future demand • Using technology to manage demand in a more efficient and effective way

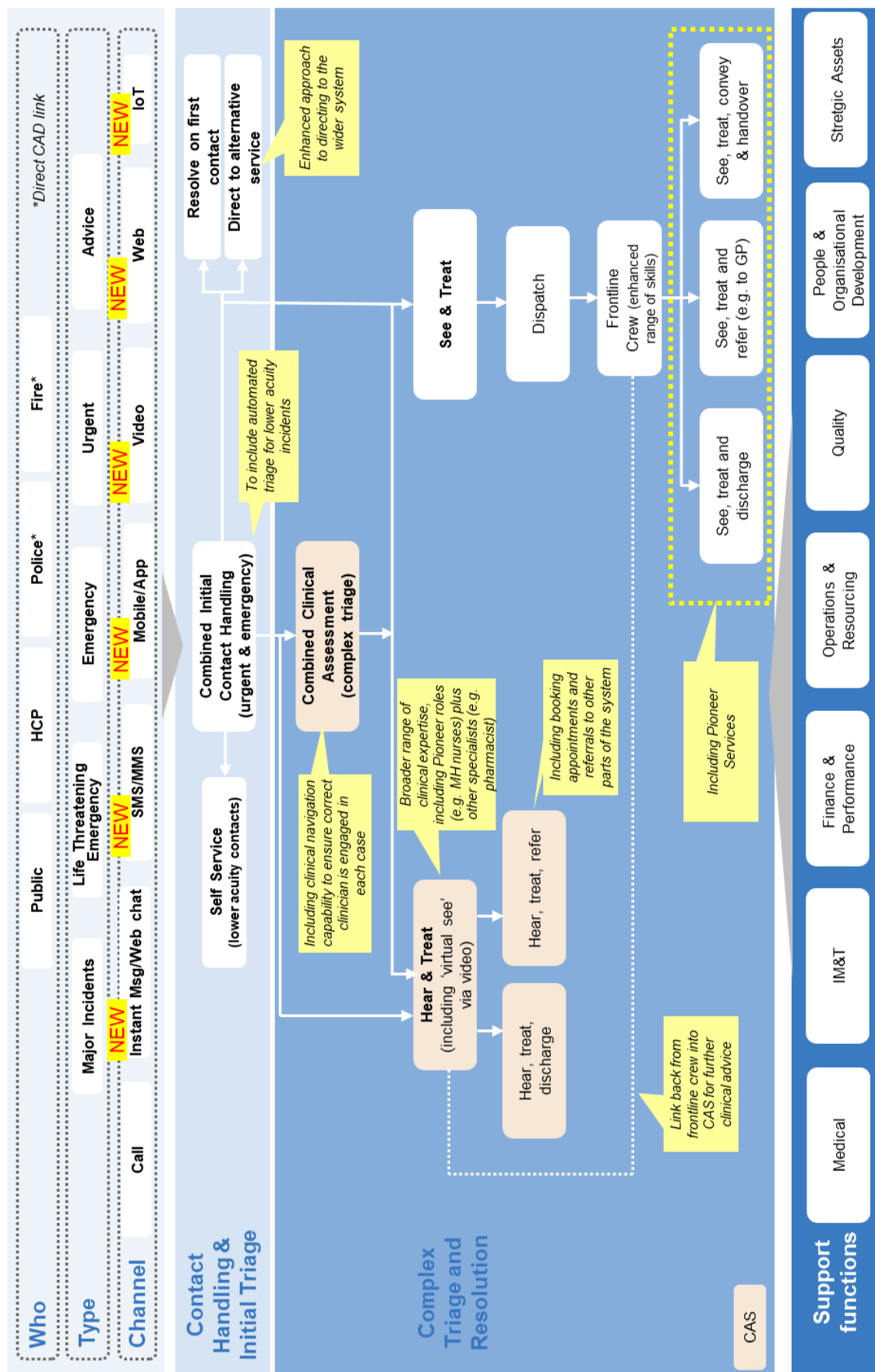
Our proposed blueprint describes the functional elements of our future organisation, which will have multichannel access to a single contact handling and initial triage team and a single clinical assessment service. It delivers a series of key enhancements which will transform delivery of our services in the future.

The blueprint includes a range of improvements to the operating model including the key changes below:

- Truly multichannel access to iCAT London
- Better information and artificial intelligence to support self-care or direct patients to appropriate services
- Combined initial contact handling across urgent and emergency contact (999 and 111)
- Automated triage for lower acuity incidents
- Combined clinical assessment with an enhanced range of clinical skills, including GPs, mental health nurses and dental nurses
- An enhanced range of skills and vehicle options for front-line crews including pioneer field operations options (e.g. falls specialists, mental health nurses, midwives)

Figure 28 below shows the key changes to our operating model that will be necessary to implement iCAT London.

Figure 28: Key changes to our operating model (highlighted in yellow)



8.1.1 New organisational structure

As our organisation evolves and develops, so must our structure. We have historically had a very hierarchical ‘command and control’ structure where decision-making was predominantly made at senior manager levels. This is neither modern nor efficient and we are proactively looking to change this structure as we modernise our organisation.

One of the key principles of our new structure is to be ‘flatter’, with fewer layers of management. The shorter the chain of command, the quicker decision-making can be and the more tendency there is for unity to break free from working in silos¹⁸.

As we develop our new structure, there are a number of principles that we will seek to achieve:

- A ‘flatter’ structure, with fewer layers of management, empowering people at all levels of the organisation to make appropriate decisions
- Creating a more agile, flexible and joined up organisation
- Improving collaboration, developing trust and our ability to work and learn from others
- Implementing flexible ‘matrix’ management approaches
- Implementing business partner models in People & Organisational Development, Finance and IM&T to support operational deliver

Ensuring accountability from Board to front-line, while we work together across the organisation to enhance collaboration across directorates

Our organisational structure is not simply the technical specification for how our organisation is organised and how management responsibilities are planned. Our organisational structure is a key enabler to achieving our vision and encouraging our staff to display the behaviours that we want them to demonstrate. Section 8.2 identifies our values and behaviours which will be supported by our new organisational structure.

8.1.2 Changes in workforce skill-mix

The future system of integrated urgent and emergency care requires an ambulance service that places a clear emphasis on assessment and treatment at scene and in community settings, with transport to alternative care settings, where required. Transport to hospital should be for those patients who require the level of assessment and management skills available only within an emergency department.

New models of care require flexible, multi-disciplinary working across organisational boundaries, supported by enhanced educational programmes and workforce development to support this. Developing a sense of a ‘single clinical team’ will require a shift in our culture and our governance. We will work with our feeder universities and Healthcare Education England to influence the curriculum to ensure that there is a sufficient coverage specifically on urgent as well as emergency care.

Our proposed response will depend on being able to deploying professionals with different skills, for example:

- Mental health professionals to those with mental health crises
- Midwives, when we are called to a birth and there isn’t already a midwife on-scene

We need to have a broader range of skills available to help patients in order to provide the right care at the right time, first time. Multi-disciplinary working will also provide opportunities for our staff to learn new approaches to dealing with different situations and helping patients in different ways.

¹⁸ Smart Design for Performance, A new approach to organizational design, Boston Consulting Group, 2016

8.2 Our organisational culture

DN: This section is under review

“Culture is the way we do things around here. It is the norms, rituals, expected behaviours and unwritten rules within a work organisation. Culture is vital because it shapes our behaviour and values at work”

Having a strong organisational culture which supports staff is crucial in our ability to implement our strategy. Not only do we need the buy in from our staff in implementing the changes that we need to make, but we need them to be our champions. We need our staff to be the advocates of the changes that we are making, with each other and with other people from the wider NHS system who they work with and speak to on a regular basis. This will only happen if the culture of our organisation supports this.

8.2.1 How we identified our desired future organisational culture

We have carried out a key piece of analysis to review and understand our current organisational culture, as well as determine our desired culture. This analysis was undertaken using the King’s Fund¹⁹ and NHS Improvement²⁰ toolkits, with the support of NHS Elect.

We worked directly with staff across the organisation in a number of ways on this piece of work:

- Tier 1 management sessions (top 60 managers meeting)
- 1-2-1 interviews facilitated by NHS Elect with our Executive Leadership Team
- An ‘organisational climate check’ on our intranet
- CEO roadshow feedback
- Staff engagement event
- 2017 staff survey results

Through these elements of staff engagement and the work supported by NHS Elect, we identified the elements of our desired culture which have been translated into our new organisational values and behaviours.

8.2.2 Our values and behaviours

We can only realise our vision through the adaptability, flexibility, hard work and engagement of our people. How our people feel about working for the trust, how new people feel about coming to work here and how engaged we all are in our work and our commitment to patients are vital to us to achieve outstanding care to our patients.

Our new values and behaviours articulate how we as an organisation and as individuals should work. Our values demonstrate the qualities that we embody and our new set of organisational behaviours detail how we demonstrate these values on a daily basis.

¹⁹ [Improving NHS culture](#), the King’s Fund

²⁰ [Create a culture and leadership programme](#), NHS Improvement, 2016

Figure 29: Our values and behaviours

DN: To follow – new section describing values and behaviours

DN: To follow – new section describing interaction of values and behaviours with employee journey

8.3 Developing capabilities for delivery

As well as having the right culture, having the right organisational capabilities will enable us to implement our strategy and support our vision to be a world class ambulance service. In this section we focus on a core number of these capabilities that we will need to strengthen over the coming years:

- Training and educating our workforce
- Operating as an agile commercial organisation
- Innovating for continuous improvement
- Involving the public in our work: our volunteer community

8.3.1 Training and educating our workforce

Our leadership development pathway for all staff

Delivering world class training and education is not only a capability on its own, but is the tool by which we ensure our staff have the capabilities that they need in order to carry out their jobs to the highest possible standards.

We have developed a leadership development programme to offer a range of training and education opportunities for our staff across all functions of the organisation. The leadership pathway is offered across five key areas:

- **Leaders of Tomorrow** for aspiring leaders to support skills development and progression of our identified future leaders

- **Management Essentials** is for bands 4–6 and as refresher sessions for all leaders and will form part of a Management Induction programme
- **The Engaging Leader** intended for bands 6–8
- **The Visible Leader** intended for bands 8–9
- **The Transformational Leader** intended for ‘very senior manager’/executive leaders

Each of the levels have been designed to allow us to develop and map skills and knowledge alongside the trust’s values and behaviours. We will use our leadership development pathway to identify the training needs of our staff that we can support in order for them to develop their skills and competencies to lead our organisation now and in the future. The figure below identifies how our leadership pathway will be available to and targeted for all of our people, no matter whether they are apprentices or our most senior managers.

We also want to make sure that our leadership development pathway supports our desire to ensure that our workforce is more representative of the people that we serve, particularly within leadership positions. **Sponsorship Mentoring for BAME Staff** (a leadership development and inclusion initiative working in partnership) is a programme designed to enable greater access for BAME (black, Asian and minority ethnic) staff at bands 2–7 to more senior roles across the organisation with the support of a sponsorship mentor. This will be piloted and evaluated between May 2018 and September 2019.

Similarly, we will pilot a scheme for ‘reverse mentoring’; another leadership development and inclusion initiative working in partnership. Through a paired relationship of a senior member of staff with a more junior member of staff within the BAME workforce it seeks to enable opportunities to “walk in the shoes” of BAME colleagues and identify some of the barriers that may exist in the organisation which prevent BAME staff from progressing through the organisation. This model could also be rolled out more widely so that a more junior member of staff mentors a senior member of staff to support sharing mutual knowledge and experience and improving service performance and staff morale as a result.

Figure 30: Leadership development pathway

	LAS Leaders of Tomorrow	Leadership Essentials	The Engaging Leader	The Visible Leader	The Transformational Leader
Aligned to NHS Leadership Academy Healthcare Leadership Model	Talent Management Programme	Essential	Proficient	Strong	Exemplary
Banding					
VSM					
9					
8d					
8c					
8b					
8a					
7					
6					
5					
4					
3					
2					
Apprentices					
General	NHS Employers / Zeal Solutions - Supportive Leadership & Management Behaviours which could also incorporate the LAS Behaviour Model going forward to help engage and embed it across the organisation				

World class clinical education

In order to deliver on the objectives outlined in our clinical strategy, one of the daughter documents to this strategy, it is vital that our operational staff, both in the control centres and out on the road, receive high quality training and education throughout their careers with the London Ambulance Service. We are going to improve the training and education that our staff receive by changing the construct of our education centres, improving access to electronic and mobile learning and by increasing the amount of dedicated time that our operational staff have for training and education.

As our workforce becomes more multidisciplinary, so will our training. Through our plans for our integrated clinical assessment and triage service (iCAT London) service and our new pioneer services, we will have a much broader range of skills within our organisation. Our training and education will reflect this, through embedding human factors principles into our programs and bringing together different groups of staff where possible in order to generate a greater understanding of the specific challenges faced and specialist skills each role brings to our organisation.

Training and education centres

In order to provide the highest quality education for our staff we will be consolidating our six main education sites to two new centres. These two sites will be contemporary places of learning with state of the art facilities to enable us to use the most appropriate and effective teaching methods with our staff. Some of the facilities and teaching methods that we will be able to utilise in our centres of excellence are:

- Simulation labs
- Digital enhanced spaces
- Immersive suites
- Large auditoriums
- Break out rooms
- Skills labs
- Driving simulators
- Video analysis of scenarios
- Quiet study areas
- Augmented reality

These centres of excellence will also provide a better, more inclusive environment for our staff as well as an ability to streamline all administrative processes. For example our centres of excellence will include occupational health rooms, prayer spaces, uniform fitting rooms and e-learning facilities.

Consolidating our main programs to two sites will create an opportunity for team teaching and improved peer support, which will give the teaching staff the ability to specialise in areas of interest and develop the expertise to enhance the London Ambulance Service as a learning organisation.

High quality mobile training: Ed-u-Pod

Our centres of excellence will deliver all of our large group and classroom based training, however we have a mobile workforce and we therefore need mobile education and training. Our mobile classroom, the 'Ed-u-Pod' will bring training and education to staff at stations. This Ed-u-Pod will carry out small group meetings and training sessions without the need for our staff to travel to one of our centres of excellence for what would be a short session.

We know that there is no 'one-size-fits-all' for education and training. By introducing this mobile training facility, we can make sure that an element of the training we provide to our front-line staff is targeted to their locality. We can use this facility to make sure that crews know about the local innovations and different care pathways available to them when they are with patients, identifying which is the best place to take them to meet their specific needs.

A career with the London Ambulance Service

It is crucial that we provide a clear career development pathway through our organisation.

For a number of our staff, the prospect of a career with the London Ambulance Service starts at University. We have been working with universities for a number of years and will continue to do so to recruit high quality graduate paramedics. However, we are now working in a more targeted way, ensuring that our university partners are helping us to recruit a more diverse workforce, with different backgrounds so that we can better reflect the population that we serve.

We note that there is a high level of interest in working in a clinical role in the London Ambulance Service, and believe in supporting different routes into the trust, and enhanced clinical career pathways for our staff. We are working with the universities to develop a degree programme that will allow people with existing relevant degrees to convert to paramedicine. This will not only provide an additional avenue for recruitment, but broaden the skill sets of the people within our organisation. We are also formalising our clinical career pathways to allow transition across clinical roles and create a career structure. Where possible this will align with formal qualifications.

For those of our staff who are keen to progress to a more senior role, the career pathway will commence at point of entry and transition to more senior roles.

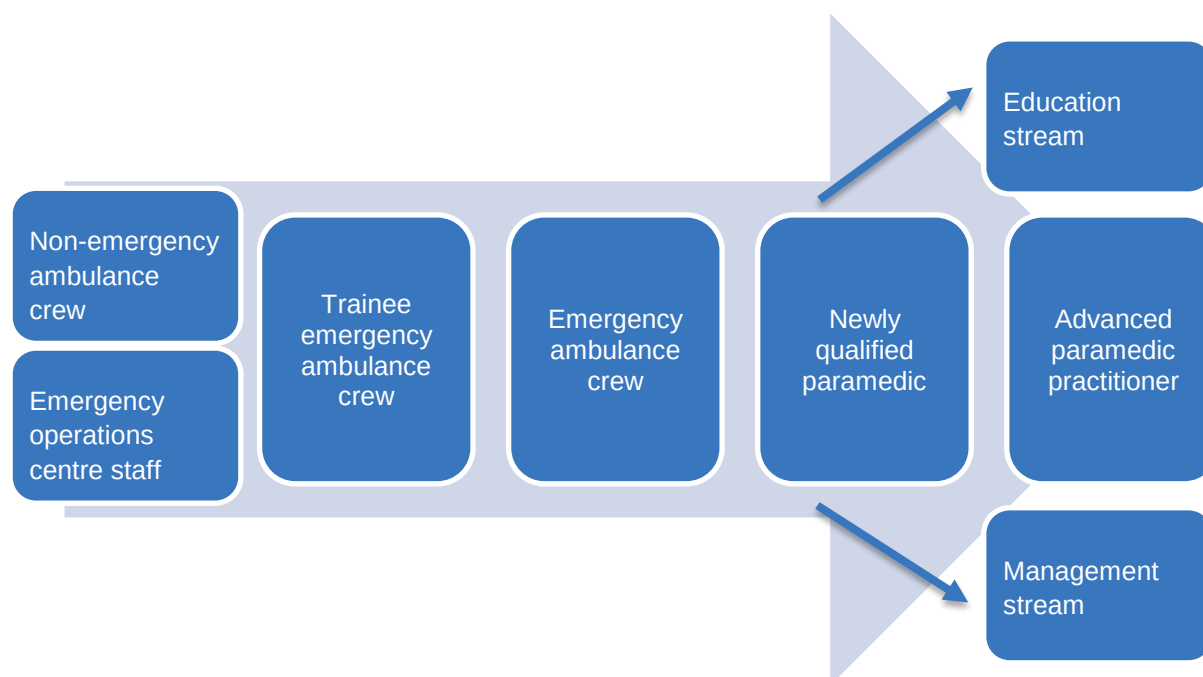
For those of our staff who are keen to progress to a more senior role, the career pathway will commence at point of entry and transition to more senior roles. Some of the key elements of our clinical career pathway are:

- Our Trainee Emergency Ambulance Crew (TEAC) program is accredited within a national framework, providing a Level 4 Associate Ambulance Practitioner course. This course is also offered as an Apprenticeship.
- The London Ambulance Service Academy has established a pathway for Emergency Ambulance Crews (EAC) and Emergency Medical Technicians (EMT) to transition to Paramedics, through a

fully funded, 2 year internal course. Currently we offer 54 spaces each year, with the desire to increase this, pending HCPC approval, to 100

- The Newly Qualified Paramedic (NQP) program was rolled out across the LAS, so that every new paramedic receives direct support and guidance while they develop expertise in practice.
- Through Health Education England our staff can access bursary funding to help access further education programmes
- We have also secured additional bursary funding for BAME, EAC and EMT staff to progress to becoming paramedics

Figure 31: Our clinical career pathway



8.3.2 Operating as an agile commercial organisation

To achieve our aim of being London's primary integrator of access to urgent and emergency care, we need to develop and maintain ever more effective relationships with commissioners, partners and suppliers. While of course we already manage a broad range of relationships, we anticipate that delivery of our ambitious strategy will require a different level of capability in commercial processes.

The London Ambulance Service has an executive leadership team with substantial commercial experience, enhanced through recent appointments. Our executive leadership team have a diverse range of experiences and backgrounds from the public and private sectors. Developing the commercial skills of the organisation will be a priority of our people and organisational development strategy.

In a thought piece entitled *Improving commercial ability helps us all*²¹ (2017), Sir Jeremy Heywood, Cabinet Secretary and Head of the Civil Service, emphasises the importance of commercial skills in government and the public sector, noting that the best outcomes are achieved when the commercial requirements of strategic goals are understood from the outset. He recognises that good commercial outcomes result from the work of a wide range of staff but that, increasingly, some specialist skills are required. We need a more focussed capability to leverage the knowledge and skills of others in the

²¹ [Improving commercial ability helps us all](#), Sir Jeremy Heywood, Civil Service Blog, 2017

organisation who are not commercial specialists, to ensure that we can make the most of commercial processes in delivering our strategy.

The range of commercial processes that we need to support includes responding to tenders, identifying beneficial partnership opportunities, and procurement and contracting; as well as the strategic review and planning required to identify and prioritise how these processes can best be used. We recognise that commercial processes make an important contribution to improving NHS services, for example by enabling positive service changes, emphasising and rewarding quality improvement, and supporting integration. Yet they can add complexity to arrangements and require access to a broad set of skills to manage them effectively. The National Audit Office has previously identified some of the skills required to manage more complex services, including financial and business analytical skills; evaluative and economic skills; insight and information skills; and commercial law skills.

As the King's Fund points out in *Leading across the health and care system*²² (2017), "it can be tempting for organisations to look after their own interests and performance rather than to work in partnership with others, which is a major missed opportunity to transform delivery of care to meet the changing needs of the population". We want to use our unique position to act as a leader in the transformation of urgent and emergency care, and we want to make full use of opportunities to contract, partner and procure for the benefit of patients and the wider system in which we operate. We also want to do this in a way that enables the London Ambulance Service to meet the corporate and financial objectives expected by our regulators.

8.3.3 Innovating for continuous improvement

We want to be a learning organisation, continually looking to identify risks or issues and prevent harm resulting from errors and adverse events. Increasingly, we are focusing more of our time and efforts on proactive rather than reactive learning. Learning organisations search for ever better ways of working toward and achieving results that improve the lives of patients, families, and staff.

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

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

Quality assurance framework

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

The direct benefits for our patients are:

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

²² [Leading across the health and care system: lessons from experience](#), King's Fund, 2017

The direct benefits for our staff are:

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

We will also continue to use ‘deep dive programmes’ to identify areas in which more in-depth review is required based on the risks to the organisation.

Quality improvement and service innovation

We use the Institute of Healthcare Improvement’s model for improvement²³. The methodology is nationally and internationally accepted as best practice across NHS organisations. The model combines three questions and a plan, do, study, act (PDSA) cycle for testing change to assess whether or not they lead to improvement:

- Plan: plan the test or observation, including a plan for collecting data
- Do: try out the test of change (using various improvement methods)
- Study: analyse the data and study the results
- Act: refine the change, based on the learning from the test

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

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

International evidence from IHI suggests that for an organisation of our size, that a commitment to training 1% of the workforce in improvement methods is required for continuous improvement. A programme to identify and prioritise appropriate staff at all levels and utilisation of ‘train the trainer’ techniques will build the capacity required.

We have a ‘business partner’ model that aligns to the five sector teams to support the investigation of incidents and risk management within each sector. Key staff in each sector work closely with the teams to share learning and increase capacity and capability and embed change through agreed sector quality improvement plans. The benefits of this model are:

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

²³ Model for Improvement, Institute for Healthcare Improvement, 2009

- Improved accountability and responsibility

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

Clinical audit and research

Clinical audit is a quality improvement process that systematically reviews the delivery of care and recommends changes to practice where the need is identified. We will continue to use a programme of clinical audit to ensure that we deliver the highest standard of care, improve clinical quality and patient outcomes and minimise clinical risk. Our clinical audit programme will focus on areas of care that are important to us as a trust, our staff and our patients. It will measure quality in a number of ways including adherence to clinical guidelines; health outcomes; appropriate transfer of care to another healthcare provider; speed of response, and patient satisfaction.

We are proud to be a leading pre-hospital research organisation. The large and diverse population we serve, with a variety of health needs, affords us the ability to have a wide ranging research portfolio. By developing and hosting research studies we contribute to an evidence base that informs and improves emergency medical care and outcomes in the UK and worldwide.

8.3.4 Involving the public in our work: our volunteer community

We already use volunteers effectively on the front-line to support our service. We have a well-established system of voluntary responders who are dispatched alongside our crews. This includes:

- **Community first responders (CFRs)** – we currently work in partnership with St John Ambulance on a scheme whereby volunteers respond from home in their own cars. Their role is to help provide basic interventions and provide appropriate care until the ambulance crew or first responders arrive to take over the management of the patient.
- **Emergency responders (ERs)** – the ER model is run solely by London Ambulance Service. These are uniformed volunteers (a variation on our standard uniform) and they sign on for shifts from a local ambulance station. They drive blue light vehicles and many have a background in the police force or military services.

Volunteer responders can assess the scene, administer care, calm the situation, take preliminary observations, and liaise with staff in our Emergency Operations Centre while waiting for the crew to arrive. For solo paramedics on scene, CFRs and ERs act as a second pair of hands which is particularly important when a patient has suffered a cardiac arrest. CFRs and ERs often arrive at incidents before ambulance crews which contributes us being able to meet national targets.

The ER model was recently enhanced and the team has since seen a 76% improved output from the same number of volunteers.

‘Life Changers’: our volunteer community

The London Ambulance Service has identified an exciting opportunity to enhance our service by establishing a volunteering scheme. Our intention is that it will not only benefit us and our volunteers, but also contribute more widely by bringing clinical benefits for the health and social care sector and having a positive health impact for Londoners.

We know there is an appetite and enthusiasm amongst members of the public to volunteer and to give back to the community. Organisers of the London Olympics in 2012 created a highly effective volunteering scheme by signing up ‘Games Makers’ and ‘Ambassadors’. We intend to be just as ambitious and to set up a community of ‘Life Changers’. Some will have roles within the London Ambulance Service and others, such as trained first aiders, will play more of a role in the community.

In establishing our volunteer scheme, we will continue to work closely with third sector organisations, such as Age UK and Samaritans, on joint projects which use volunteers to achieve positive health outcomes. This will enable us to focus on certain patient cohorts, such as frequent fallers, by helping them get the right care in a proactive way rather than a reactive way. This should have a positive impact by reducing demand and making ambulance crews more readily available for patients with life-threatening injuries and illnesses who need a time-critical response.

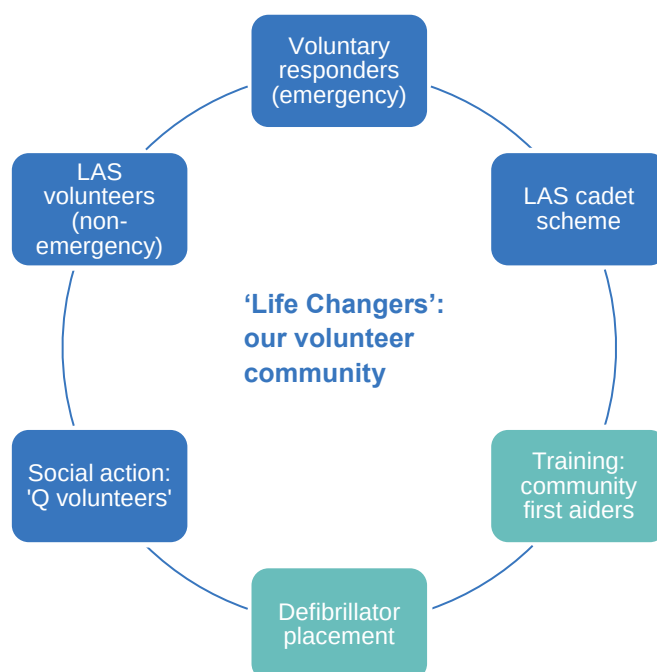
In line with our aspiration to be a world-class service, we are ambitious in our plans and intend to sign up 1% of the London population in one way or another as a 'Life Changer'. While 1% does not sound a lot, with a population of 9m, by recruiting just under 10,000 new volunteers, we can make a huge impact on people's lives across London.

We will take the following steps in establishing a 'Life Changers' volunteering scheme:

- **Produce a volunteer strategy** – this will outline our strategic intentions for volunteering in order to achieve positive health outcomes. We will co-produce the strategy with volunteers, staff and patient groups. We have a growing number of dedicated staff who give up their own time to volunteer, either on behalf of the London Ambulance Service or for other causes they are passionate about. Our volunteer strategy will reflect this.
- **Create a volunteer charter** – this will describe a mutually beneficial and fair relationship between volunteers and the trust. It will summarise how we will support volunteers in their role and describe our expectations of the individuals who volunteer.
- **Set up a volunteering scheme** – we will develop the framework for the volunteering scheme, research best practice, explore partnership and sponsorship opportunities, taking into account governance and safeguarding matters. We will then begin implementation.

There are six key areas which we intend to develop as part of our volunteering scheme. As well as volunteer opportunities, this also includes other areas of interest which we believe complement volunteering and will assist in our desire to create a community of 'Life Changers'.

Figure 32: 'Life Changers': our volunteer community



We have identified a number of opportunities within these areas. This involves building upon some of the excellent work that is already being carried out, but we are also keen to introduce a range of new volunteering opportunities.

Volunteers: non-emergency

We intend to expand our pool of volunteers by introducing a range of new roles whereby members of the public can get involved in what we do, learn about the ambulance service and help us to improve patient care for Londoners.

Our new volunteer strategy will outline these opportunities, which may include assisting us with infection prevention and control audits, volunteer drivers for non-emergency calls and helping at public education events. We will explore the idea of having a role similar to Police special constables: a non-emergency responder in a public facing role. This might be to assist with intoxicated patients outside nightclubs or checking on frequent callers, allowing ambulances to be more readily available for patients with life-threatening illnesses or injuries.

We currently have two volunteer project managers; one who assists with our GoodSAM app (it alerts volunteers to a cardiac arrest and signposts to the nearest defibrillator) and the other delivers resuscitation training and is looking to develop new courses. They have particular 'life skills' which are invaluable to us. We will create similar office based roles and there will be opportunities for us to do some skill-matching.

We intend to understand best practice from other national and international ambulance services and there is also an opportunity for blue light collaboration with our fellow emergency services.

Case study: Volunteering at South Australia Ambulance Service

South Australia Ambulance Service (SAAS) has an extensive volunteer base with more than 1500 volunteers in over 80 volunteer teams. With such a large geographical area to cover, ambulance volunteers help the ambulance service provide professional emergency ambulance and patient transfer services within their communities.

Volunteers must be over the age of 18 and have a full driver's license. They volunteer at their local station as a 'volunteer ambulance officer' and attend emergency and non-emergency ambulance calls, as well as carrying out other duties as required. SAAS ran a targeted 'skills for life' campaign to attract recruits from all walks of life.



Cadet scheme

Our ambition is to set up a cadet scheme, giving young people an opportunity to volunteer with us. The trust will provide them with exciting learning opportunities such as spending time in the control room and receiving resuscitation training. They will also take part in community-focussed initiatives and we will look to recruit a diverse base of cadets.

The Police have volunteer cadets, for example junior cadets (13–15 year olds) and senior cadets (16–18 year olds). We will look to understand best practice from other emergency services that operate cadet schemes.

Our cadet scheme will be an ideal avenue for recruiting new staff once cadets are old enough to apply for apprenticeships or substantive roles.

Q volunteering: health connectors and community connectors

We plan to introduce 'Q volunteering', which is a social action scheme. The concept involves recruiting volunteers who will work alongside publicly-funded health and social care providers to help promote self-care.

'Q volunteers' will be trained to work in their communities helping to promote self-care with a focus on long-term health conditions such as cardio-vascular disease (CVD), diabetes, hypertension, stroke and COPD. Working with these communities will help encourage people to attend events about these conditions. This in turn will help contribute to the use of alternative care pathways to support frequent callers to the ambulance service, and identifying and helping people find the appropriate help for their condition.

We are already actively engaged with numerous third sector partners. We focus on specific patient groups, e.g. mental health and end of life care, delivering joint training programmes with volunteers, and developing direct referral pathways or specific service developments.

Case study: The town that's found a potent cure for illness

Frome in Somerset has seen a dramatic fall in emergency hospital admissions since it began a collective project to combat isolation.

With the help of the NHS group Health Connections Mendip and the town council, a GP practice set up a directory of agencies and community groups. This let them see where the gaps were, which they then filled with new groups for people with particular conditions. They employed "health connectors" to help people plan their care, and most interestingly trained voluntary "community connectors" to help their patients find the support they needed.

Sometimes this meant handling debt or housing problems, sometimes joining choirs or lunch clubs, participating in exercise groups or writing workshops or 'men's sheds' groups (where men make and mend things together). The point was to break a familiar cycle of misery: illness reduces people's ability to socialise, which leads in turn to isolation and loneliness, which then exacerbates illness.

Source: The Guardian, 21 February 2018



Defibrillators and GoodSAM

When someone suffers from a cardiac arrest, the longer they go without defibrillation, the poorer their chances of survival become. Whereas in the past it has only been the emergency services and clinical settings that had defibrillators, we now want to have static defibrillators in as many places across London as possible.

Defibrillators

The cardiac arrest survival rate in London is 9.5%. The survival rate for cardiac arrests that occur in close proximity to a static defibrillator site increases to 52%. We know from our defibrillator data that the number of out of hospital cardiac arrest survivors in London increases proportionately to the number of static defibrillators around London.

Since 2013, when we launched our 'Shockingly Easy' campaign, we have hugely increased the number of defibrillators in London from 995 to 4,486 by the end of 2016/17. This means that each year there are about 40 cardiac arrest survivors in London who would have been unlikely to have survived without a public access defibrillator. We have now reached a stage where defibrillators are commonplace across London and we believe that the right approach is to target specific types of places. The main types are:

- **Areas of high footfall**, e.g. shopping centres, community centres, train stations and night clubs
- **Areas of high risk**, e.g. GP surgeries, sports centres, gyms and care homes
- **Mobile defibrillators**, e.g. working with TfL to place defibrillators on London taxis, or with Uber to place defibrillators on their vehicles. This could also include specific training for their staff

If we were able to increase the number of defibrillators that we have across London, focussing our efforts on those three categories, we can further increase the number of people whose lives are saved by bystander defibrillator use. This will include identifying defibrillators that are already in the community, but not yet on our database.

We will launch a targeted defibrillator campaign, working with stakeholders in London to influence successful placements of defibrillators. Our Patients' Forum have been persistent in their campaign for shops in London to have defibrillators and we will work with them to campaign on this issue together.

GoodSAM

We were the first ambulance service in the UK to roll out a community emergency life support app: GoodSAM. GoodSAM allows us to notify up to three GoodSAM registered volunteer responders to

cardiac arrests that they are nearby. Our ability to dispatch volunteers who are within 200m of the incident to the patient is crucial in improving outcomes for these patients.

Over the course of this strategy we will look into enhancing how we can use GoodSAM, including by enabling video calls which will be linked into iCAT London. This will allow our clinical hub clinicians to better provide expert guidance to those volunteers who are attending patients while they wait for an ambulance crew to arrive.

Training: first aiders in the community

We want to greatly increase the number of Londoners trained in resuscitation skills. For many years, we have delivered basic life support training, largely through the British Heart Foundation 'Heartstart' programme. We also moved from a position where we predominantly directly trained members of the public to a 'train the trainer' programme. This was hugely effective. As an example we trained a dentist who was a member of a Mosque, who then proceeded to train around 1000 members of his Mosque through a course of structured sessions.

However more recently our training rates have fallen due to other priorities. We want to reverse this trend. As part of our 'Life Changers' scheme, we want to enhance the basic life support and defibrillator training across London. We will do this largely by returning to a 'train the trainer' programme and proactively target the sort of groups where the greatest benefits would be seen. These groups could include: religious groups, community groups, youth clubs and volunteer organisations.

We will also use our communication channels such as Twitter to target those who have already undertaken training; a 'call to action' asking for trained first aiders with resuscitation skills to contact us so that we have a large pool of volunteers in the community who can respond to our GoodSAM alerts. This will be a key contributor in helping us to sign up 1% of the London population as 'Life Changers'.

Future

- **Community first responder model** – we intend to create a bespoke CFR model which is run solely by the London Ambulance Service and would benefit from having a structure similar to the ER model.
- **CFR and ER recruitment** – we will look to recruit more widely from across all London boroughs, using communication channels such as our website and Twitter. Our desire is for the volunteer responders to reflect the diversity of the London population and to therefore have more impact on reaching communities with known health issues.
- **Voluntary responder group charity** – we will explore options for fundraising and sponsorship to be able to fund additional responder vehicles and training.

8.4 Our organisational infrastructure

In order to make the ambitious changes that we have identified within this strategy that we need to make over the coming years, we need to make sure that our staff have the right high quality infrastructure to support them.

Through our estate and fleet we want to enable the efficient and timely deployment of the right mix of well-trained medical professionals in suitable, reliable, and well-equipped and low emission vehicles from strategic locations to serve the whole of London.

The three key elements of our infrastructure that will go through transformational changes over the lifespan of this strategy are:

- Becoming a fully digital organisation
- Developing our estate
- Specifying future fleet and equipment

8.4.1 Becoming a fully digital organisation

Effective emergency and urgent care services must be supported by accurate real-time digital patient and management information that can be shared across providers. We are undergoing a transformation in digital capability focussed on five key elements:

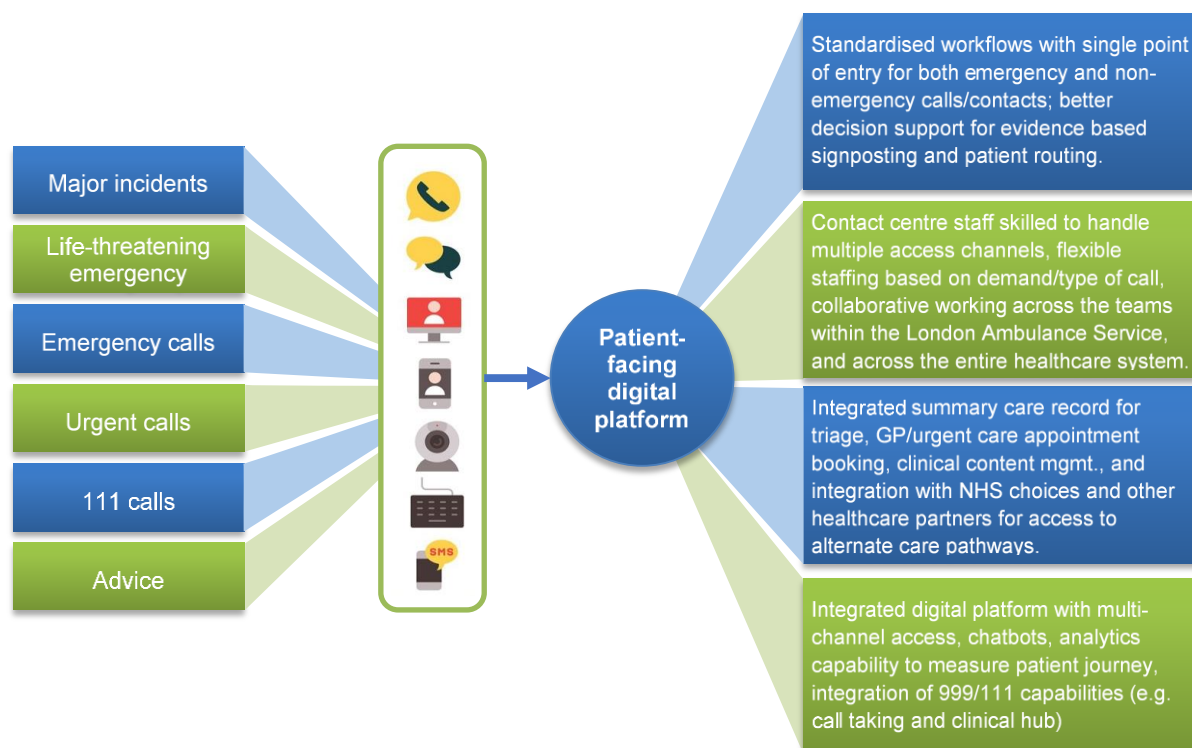
- Patient facing digital platform
- Integrated management of the urgent and emergency flow
- Connecting clinicians
- Interoperability
- Our approach to sourcing solutions

Patient facing digital platform

Our new patient facing digital platform is likely to be how patients will first engage with the outputs of our strategy. Patients increasingly want to communicate with us in different ways to access a range of services. Patients will be able to access our services via a unified platform across telephone, the web, apps and common text and video messaging platforms. Putting patients at the centre of the way we design our services enables us, and the NHS providers we work with, to provide the most appropriate care to meet each individual patients' needs. By introducing these methods we will enhance the service that we are able to provide as well as making our service more accessible to those with hearing or communication difficulties.

A key component of our digital platform will be a self-triage tool powered by artificial intelligence software. A number of apps for 111 services are already available in London. As we implement integrated urgent care (IUC) through iCAT London we want to extend this to all of our services. We know that around 20% of contacts made through the Babylon platform are for information or self-triage through an app. Artificial intelligence will be an important part of providing efficient and affective IUC services in London.

Figure 33: A unified patient-facing digital platform will support iCAT London



Integrated management of the urgent and emergency flow

As an integrator of access to services, we must be able to prioritise all types of contact so that we can provide the right response to patients and clinicians. Having an integrated queue across 111 and 999 services is essential for us to maximise the clinical and economic benefits of managing urgent and emergency contacts together. 111 and 999, along with other contact channels, will give an indication of priority; and our call handlers will be refine the prioritisation regardless of the method of contact. As mentioned in Section 2.2, 13.1% of our 999 calls are escalated from 111 providers in London.

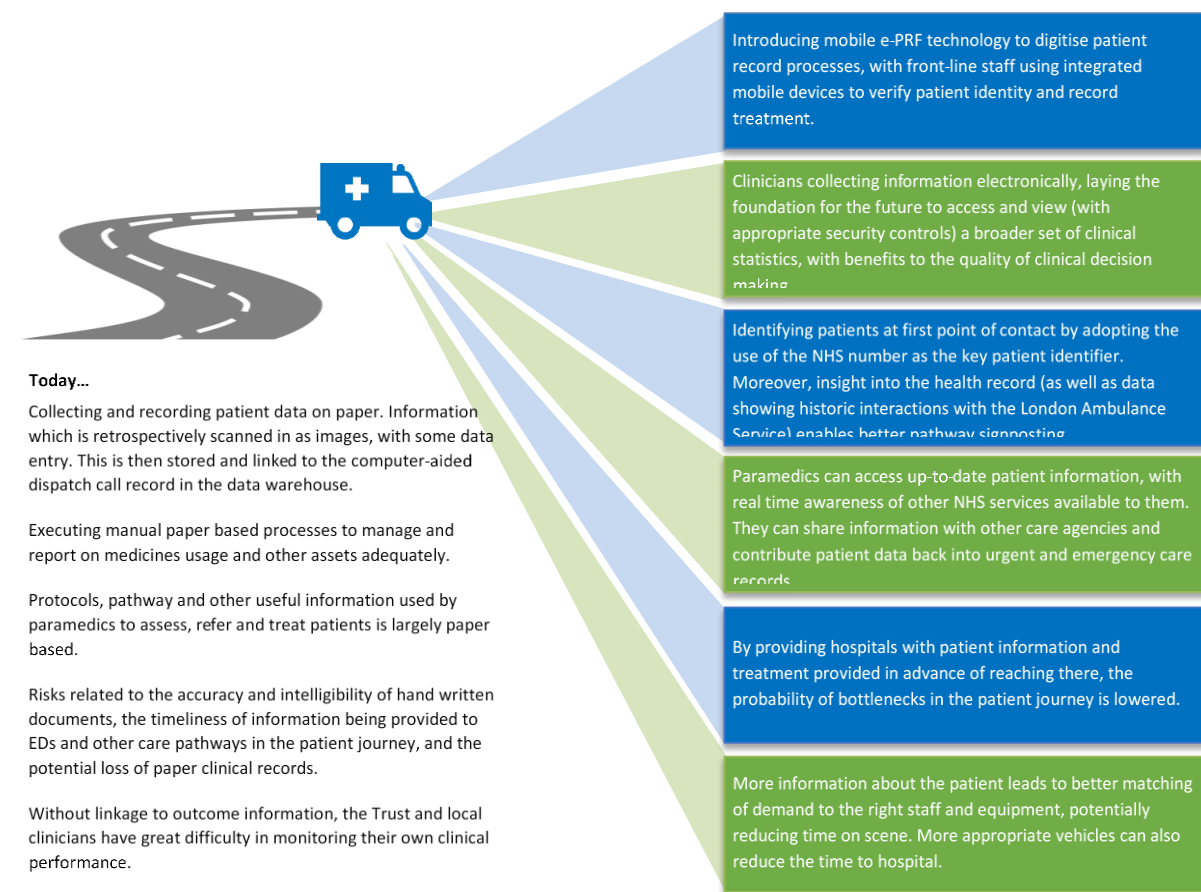
We will commission an appropriate system that supports an integrated clinical queue for iCAT London and the CAS that provides patients and clinicians with clinical advice.

Connecting clinicians

More than for any other healthcare provider in London, our work depends on effective mobile technology. We are already investing in new technology infrastructure that will support our transformation as an organisation – both within our operations centres and within our vehicles. We are currently rolling out tablet computers to our front-line clinicians that will provide future digital connectivity including location-aware directories of local pathways and access to e-learning.

Our 'connecting clinicians' programme brings huge benefits for our staff, for the London healthcare system and to patients. It is a complex multiyear programme that will transform how the London Ambulance Service, providers, commissioners and other key stakeholders, manage and share clinical information.

- We are migrating from paper to a digital clinical records system that integrates with the wider London healthcare system encompassing an electronic patient report form, access to the NHS spine, summary care records, special patient notes or 'Coordinate My Care' and allow seamless interoperability with the CAS.
- Additional clinical decision-making support tools and better access to advice and support from the CAS will help our staff to provide better care at scene and prevent unnecessary conveyance to hospital.
- We are also engaging with technologies that provide tools for healthcare professionals. These include decision support, the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.

Figure 34: Connecting clinicians

Interoperability

There is a clear need for more effective information sharing between care settings, organisations and geographies, as well as between professionals and citizens, to optimise patient outcomes and quality of care. This is reliant on the ability of IM&T systems across health and care to be interoperable with one another, and is key to the delivery of the future vision of care in England²⁴.

If we are to enable our clinicians to access summary care records, share information with colleagues and provide records of treatment to hospitals and GPs, our systems in London must be interoperable. It will also be essential for effective population health management – both on a STP and pan-London basis.

In London, we are collaborating with regional health and care partners to become a Local Integrated Care Record Exemplar. This means that London will be one of the first regions in the country to benefit from full interoperability. Benefits will include:

²⁴ [Personalised health and care 2020: a framework for action](#), National Information Board, 2014

Table 14: Benefits of a local integrated care record

Clinical quality and effectiveness	Performance and efficiency
• Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care • Safer and timely medicines management and effective electronic prescribing • Key information transferred between teams in a structured way which survives stress/time constraints/distractions • Comprehensive access to local clinical pathways • Improved patient experience as there is a seamless transfer of information • Digital handover reduces adverse incidents in some settings • Promotes structure through checklist format – reduced reliance on memory • Improved linkage between the urgent and emergency care we provide and patient outcome information	• Improve ambulance turnaround times at EDs • Lower conveyance to EDs • Lower spend on paper stock, storage and transportation • Enabling providers to improve efficiency and meet their business goals Improving the utilisation of resources to focus on patients • Support the availability of response vehicles
	Information assurance: the right information available to the right people at the right time • Securely sharing electronic information with patients and other clinicians • Enabling a consistent integrated digital record of care across London • Storage and protection of patient data • Secure from non-authorised users • Easy access to comprehensive information

Our approach to sourcing solutions

We have identified a number of design principles that will drive our technology and digital transformation:

1. Evidence based design around patients and users
2. Agile delivery and culture
3. Design at the health system level – end to end pathways and experience
4. Work with other organisations for mutual advantage
5. Building in resilience: design for failure
6. Automate, exploit machine learning and big data
7. Cloud first
8. Collaborate to reuse proven solutions

Through the refresh of our IM&T strategy, we will develop a detailed technology roadmap to support our organisational transformation, including both the big strategic themes and day to day IM&T services that support our stations and offices.

Our approach will be to support and influence NHS Digital's national urgent and emergency programme and to take nationally-developed solutions where they deliver the cost effective functionality that we require at the time that we will need it.

8.4.2 Developing our estate

Our estate is a key strategy enabler, we will transform our estate to better support our new operating model while also providing better working environments for our teams and reduced costs and improved environmental performance. The adoption of smart working principles across our different estate will aid us to use space and time efficiently, whether this be the effective deployment of ambulance crews, delivering state of the art training or in our management and leadership roles.

Our estate strategy involves four separate, but interconnected, activities aimed at providing:

- **A new model for our operational estate** – enabling rapid and efficient preparation and deployment of our medical teams while also providing the right facilities to support to ambulance crews and others during their work
- **Innovative, state of the art, training and development facilities** – involving both dedicated training centres and mobile training provision that supports our paramedics in locations that are right for them
- **Resilient, high quality, control centres** – providing effective environments with the necessary capacity and resilience to respond to events
- **Transformed corporate estate** – that provides a far better office environment that supports effective individual and team working while reducing costs by more efficient and better utilised office areas

Each element of our strategy is described further below, however, some of the key themes that are common to each work stream are:

- Providing the best possible working environment and reducing our running costs and environmental impact by using efficient and well managed buildings
- Effective integration with other services to support our new operating model. For example, our estate must support our IM&T strategy and also take advantage of the opportunities presented by the use of new technologies and information sharing platforms
- Use of smart working principles across the estate focusing on the more intensive use of better quality estate and providing our teams with greater flexibility about how they work
- Collaboration with partners with whom we can usefully share estate, improving its utilisation and creating benefits for all
- Focusing investment in the right locations that enable us to work efficiently and provide the best value for money
- Prioritising the provision of the best facilities for each of our distinctly different activities, recognising that they each have different requirements

We will continue to develop the detail of our new estate strategy during the first half of 2018 ensuring it reflects the new operating model and provides a sound, efficient and flexible platform for our activities.

Future operating model for operational estate

Our operational estate is at the heart of our service delivery. Our estates and fleet teams have made great progress in implementing the 'Make Ready' process across our operating locations, but we want to push this further and secure more benefits by placing it at the heart of our stations. We will be reviewing how our stations can best be designed to maximise their ability to support our staff and to efficiently deploy vehicles that are in excellent condition and fully stocked for the requirements of the shift.

This may involve freeing up space in some stations by relocation of activities (e.g. training) that could be delivered elsewhere, often more efficiently, in other instances stations may need to be rebuilt to maximise their potential. By focusing these key operational sites on their core functions of preparing and supporting our teams to serve their community we will be able to increase the reliability and resilience of the operational fleet, reduce the time wasted by our medical teams at the start of their work. These efficient facilities we enable us to meet growing demand and respond to changes in the pattern of service delivery.

It is important that our staff have locations where they can rest and recuperate during their shifts, we will develop a network of locations where this can happen with the nature of the provision reflecting the varying opportunities and requirements across London. Our intention is to work with a range of partners to provide a flexible network of support points in addition to our own sites.

Innovative learning and development facilities

To support increased demand for training and to help maintain our enviable reputation for the quality of our development programmes, we will seek to consolidate our planned training into dedicated facilities. These include the use of shared services and training centres where our requirements are compatible with others.

As well as freeing-up valuable space in our stations, this change in delivery will help further improve our training activities by bringing together our training teams so they can work in co-ordinated fashion.

Much of our training activity comprises shorter refresher and update courses and onsite assessments. We will ensure that this training is trainee centred and recognise that this may involve trainers visiting staff in locations that work for them. We are therefore scoping the delivery of a mobile training service where our tutors are able to rapidly visit trainees bringing with them all necessary resources. As well as enabling our training to be responsive and accessible it will ensure the availability of necessary training materials and waste associated with the need to keep training resources across the estate.

Resilient, high quality, control centres

To support iCAT London strategy we aim to enhance the effectiveness of all of our control centres by investing in improving the working environment and ensuring resiliency in our capability to respond. We will be examining options to enhance the utilisation of our control centre locations without impacting their operations or their ability to respond to events.

Together with London's other blue light services we are examining varying approaches to sharing resources and investments in our centres.

Transformed corporate estate

Our headquarters and other corporate estate can be much more space efficient and effective in helping us work productively. In collaboration with IM&T and others we will help implement smart working practices across our estate. This new way of working will help us to work more efficiently, with greater flexibility and in the right places thereby minimising the costs of a central London location and giving our staff greater choice.

We will begin the transformation of our corporate estate by reducing the number of headquarters annex buildings we have by relocating teams into our core buildings. This will reduce costs and improve communications. Rather than seeking to squeeze desks together to accommodate more people, we are looking to open up cellular spaces, including our executive offices, creating flexible space while also increasing access to meeting rooms and other collaboration spaces. However, this is just the start of the process and our aim is to ensure that all our staff work in a high quality and productive environment and to provide a greater choice of working environments that are consistent with our operational needs.

Benefit for staff and patients

Our estate strategy will enable us to provide a firm platform for our new operational model underpinning our ability to provide the services patients need.

- All our staff will have high quality, safe and secure working environments
- Smart working will help our staff to work more effectively and flexibly improving their wellbeing and productivity
- Providing facilities that enhance our Make Ready service will reduce the waste of our medical professionals' time because vehicles are not ready for use
- Our training facilities and mobile training will help us deliver trainee focussed, state of the art training

- Our estate will provide the flexibility and capacity for our service to respond to future demand and our new response model

8.4.3 Specifying future fleet and equipment

Fleet and logistics functions are a vital in enabling us to provide a mobile healthcare service every hour, of every day across the capital. We want our staff to be proud to work for us as a world class ambulance service and that means having a world class fleet with the right equipment to do their job. As we invest in and modernise our fleet we would expect to see increased job satisfaction as measured by the NHS staff survey or the 'Friends and Family' test.

Our patients will receive a better service from us, as we make sure our vehicles are well maintained and subsequently spend less time off the road, meaning that we will safeguard the number of vehicles we have available to be utilised to provide a response to our patients. By better matching the vehicle to the incident, a more targeted response can be offered that improves patient outcomes or reduces conveyances.

To respond to the needs of the 9 million people in London, the current fleet consists of more than 1000 vehicles comprising front-line double crewed ambulances (DCAs), marked fast response units (FRUs), our non-emergency transport service (NETS), motorcycle response units (MRUs), hazardous area response team (HART), neonatal transport vehicles and other operational vehicles such as training, logistics, incident response vehicles.

Our fleet strategy will ensure that our staff have the right vehicles, that they are operationally and environmentally effective and efficient and that they are well maintained and provided clean and with all the necessary equipment and consumables. In so doing they will help our teams provide the best possible care for our patients; while reducing the impact of our carbon footprint on the environment.

Our fleet strategy is inextricably linked with our wider operating model which will influence the future of our vehicle mix and specification, and also our estate. Many of the benefits of our estate strategy, that further the effective implementation of the Make Ready process, are important in enabling the fleet to be effectively maintained and prepared for our medical teams.

Key components of our fleet strategy are:

- **Fleet composition and specification** – ensuring we have sufficient available capacity of the right vehicles in the right locations to meet our future operating requirements. Each will provide an effective working environment that supports staff and patient welfare while being easy to maintain and manage and reducing the environmental impact of our service
- **Fleet maintenance and management** – recognising our fleet and equipment are the key tools for delivering the service, we will use efficient processes and facilities to provide to medical teams with clean, reliable, and fully equipped vehicles that can be used for a full shift without resupply or refuelling
- **Inventory specification, management and logistics** – through an enhanced Make Ready process we will be able to streamline the approach to equipment supply while also improving resilience and security. We will seek further benefits in each area by standardising specifications and layouts wherever appropriate and by using modern inventory tracking systems.

Each element of our strategy is described further below, however, some of the key themes that cut across each component are:

- Enhancing staff and patient welfare. Beyond ensuring that vehicles are maintained to very high standards and fully supplied with the right equipment, this will also include reviewing designs to incorporate features that improve safety, infection control, comfort and usability. Introduction of in vehicle Wi-Fi and power points and enhanced space for storage of staff belongings will provide essential support to staff through out their shift

- Standardisation of specifications and processes. Using common vehicles and equipment will deliver substantial savings in maintenance costs by introducing consistent maintenance processes, reducing equipment and parts inventory.
- Improved environmental performance, most directly through the use of lower emission vehicles, but also by ensuring the vehicles are operating efficiently and by reducing vehicle miles through increased use of 'hear and treat' and 'see and treat' services.
- Minimising the time lost through unavailability of vehicles or equipment. By designing our processes around effective maintenance and preparation we will reduce lost operational hours.

Fleet composition and specification

We know that our response model is changing and that this will impact on the demands on our fleet and its composition. We will continue to invest in improving the quality of our ambulance fleet and will respond to future requirements for different vehicle types. While ambulances will remain at the core of the fleet, we envisage the introduction of a wider range of other vehicle classes that are suitable for different types of care such as physiotherapy, mental health, midwifery or other support.

As we modernise the fleet, beginning with the oldest and least efficient vehicles, we will use the opportunity to implement new standards for the design and performance of our vehicles based on assessment of their whole life cost. We will move to progressively lower emission engines with new vehicles meeting London's ultra-low emission standards, with the aim of moving to hybrid and electric vehicles. A change in vehicle type is a major step for a fleet service, and especially for one where performance and ability to respond are key, therefore we will be trialling hybrid and fully electric vehicles so that we can learn how best to integrate them into our fleet and operational activities. Retro-fitting older vehicles with electric drives could be a staging post to our future fleet.

Figure 35: Retro-fit of electric drive to utilise older fleet to extend life and reduce emissions



Our crews spend long periods of time in their ambulances and just as if they spent their time in an office, these staff deserve a high quality, comfortable and safe working environment. We will incorporate improved and more flexible internal layouts together with new technologies to make ambulances more comfortable and safer for staff and patients.

Our fleet will also be specified with ease of maintenance and preparation in mind. This will extend from seeking common standards across vehicle types for frequently replaced parts to design of interiors that are easier to access, clean and resupply.

Figure 36: Design concept for fully electric ambulance designed from the ground up around patient needs

Fleet maintenance and management

Further embedding the Make Ready process into our approach to deployment of operational vehicles will bring further savings. We will aim to refine our processes, maximising the utilisation of the space in stations, increasing the number of vehicles that can be prepared from each centre. Co-location of our workshop support with our Make Ready centres will help us deliver effective preventative maintenance and rapidly address issues with vehicles so that we increase proportion of the fleet that is operational and reduce the downtime and consequential impact on services and costs of repairs.

We will work closely with our estates teams, and our staff, to design Make Ready Centres that work effectively for our staff and provide a professional environment in which they can deliver a quality service. As we progressively introduce low emission vehicles to our fleet we will ensure that our stations have the capabilities to fuel, charge and maintain them effectively so that our medical teams can concentrate on their operational activities.

Inventory specification, management and logistics

By further developing our Make Ready process we will be able to meet our immediate equipment, consumables and medicines requirements from these sites with less frequent need or replenishment from centralised stores. We will also critically examine the scope of our logistical operations ensuring it is focussed on those activities that are specific to the needs of an ambulance service.

We will implement closer control of equipment and supplies using tools such as RFID tags and barcoding/QR labelling so that we can manage and secure our inventory and effectively control stock levels.

8.5 Daughter documents

Our strategy will be supported by a number of “daughter documents” that examine the implications for functional areas of our organisation. Each will have a delivery roadmap and will be published in due course.

- Clinical
- Clinical education and training
- Estates
- Fleet and equipment
- IM&T
- Operational transformation plan
- Partnerships
- People and organisational development
- Quality
- Volunteering
- Workforce

8.6 How we will monitor and deliver our strategy

8.6.1 Strategic programmes and projects

We will refresh our strategy on at least an annual basis. The Programme and Project Management Office (PPMO) will hold the ring on the delivery of the strategy by ensuring that all programmes and projects are aligned and prioritised with sufficient resources to realise delivery of the desired benefits. The following programmes, projects and respective senior responsible officer have been identified:

Table 15: Strategic programmes and projects

Strategic programmes		Projects
1.	Integrated clinical assessment and triage (iCAT London)	• SEL IT CQC requirements • SEL tender • NEL mobilisation • Integrated urgent care design, development and delivery • ELCHP/SEL 111 clinical assessment service design • Merge ELCHP/SEL 111 with 999 clinical hub • IUC/999 integrated contact handling and triage • Digital and technology
2.	Pioneer services	• Urgent care response • Falls • Mental health • Maternity • End of life • Other conditions
3.	Spatial development	• Developing new blueprint – operational estate • Smart working – corporate estate • Innovative learning & development – training estate • Building resilience – EOC/control rooms • EOC reconfiguration
4.	Connecting clinicians	• Electronic patient records ePRF – end-to-end digitisation
5.	Ready, set, go (medicine management)	• Secure drugs room • Primary response bag • Vehicle based drugs pack • Internal order drug system • Kit prep/perfect ward enabling apps
6.	Payment approaches and contractual form	• Currency development • Tariff development • Service offer • Contractual form

8.6.2 Programme and Project Management Office

The Programme and Project Management Office (PPMO) will provide advice, support and quality assurance to all programmes and projects underway throughout the trust. Specifically, the PPMO will:

- Inform senior management decision-making on prioritisation, dependencies, risk management and deployment of resources to deliver strategic/business objectives and benefits
- Support delivery of programmes and projects within time, cost, quality and other constraints
- Underpin identification and realisation of outcomes and benefits via programmes and projects

This will in turn necessitate an approach focussed upon the following:

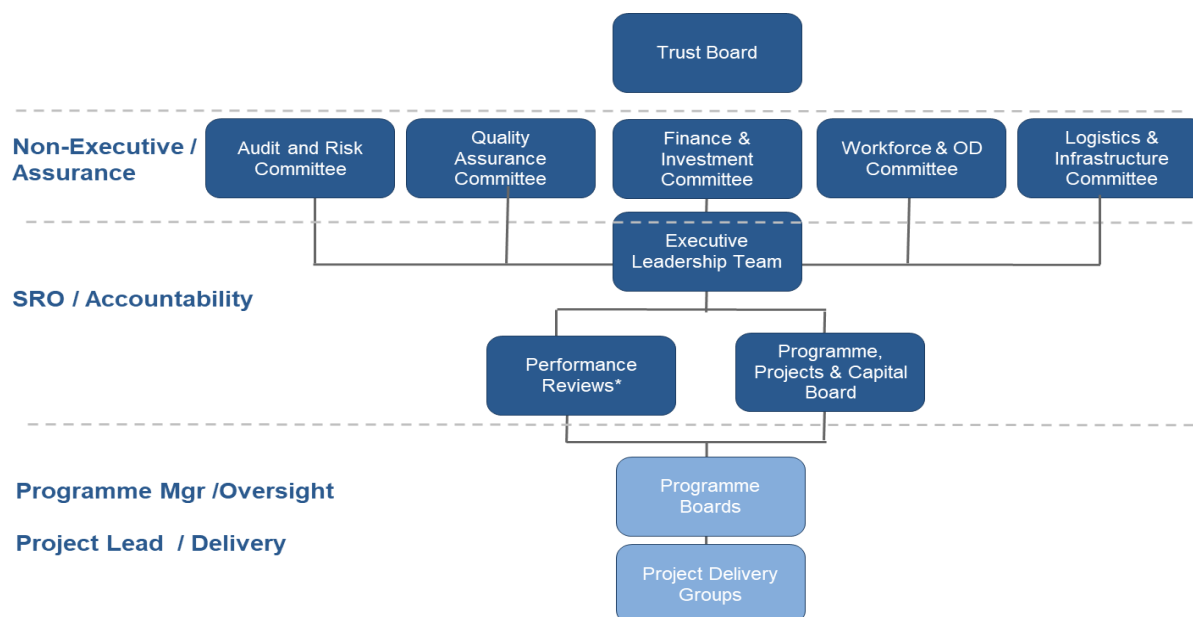
- **Portfolio management** – Provide the Executive Leadership Team with a clear line of sight about what is in the portfolio of change initiatives including what it is costing, what risks are faced, delivery status, the impact upon business as usual and contribution to the strategic objectives
- **Programme management** – Coordinated organisation, direction and implementation of a range of change initiatives to achieve outcomes and realise benefits that contribute to the strategy
- **Project management** – Delivery of one or more outputs that can be used by the organisation to support the realisation of the desired benefits that contribute towards the organisation's strategy

8.6.3 Programme governance

In parallel to the establishment of a PPMO the trust has initiated a governance structure to provide assurance of the management, delivery, oversight and governance arrangements in respect of all transformation. The governance structure detailed in Figure 37 below must achieve the following:

- Promote an open culture that supports transformation, and that emphasises financial awareness with focus on the development, training and knowledge of colleagues across the trust
- Understand who is responsible for the delivery of Programmes and Projects at Director and Manager level
- Be aware of the impact of any potential change upon quality, and be formally assured that all projects have been suitably assessed
- Be able to demonstrate that learning, experience and organisational memory about change delivery is suitably retained

Figure 37: Governance structure



Appendices

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A Glossary

111	See 'NHS 111'
999	UK emergency telephone number
AAA	Abdominal aortic aneurysm
AED	Automated external defibrillator
AMPDS	Advanced medical priority dispatch system
AI	Artificial intelligence
APP	Advanced paramedic practitioner
APP-UC	Advanced paramedic practitioner for urgent care
ARP	Ambulance response programme
BAME	Black and minority ethnic
Band x	Pay band x on the NHS 'Agenda for change' pay scale
CAS	Clinical assessment service
CCG	Clinical commissioning group
CEO	Chief executive officer
CFR	Community first responders
CSU	Clinical support unit
CVD	Cardiovascular disease
DCA	Double-crewed ambulance
EAC	Emergency ambulance crew
ED	Emergency department (A&E)
ELCHP	East London Care and Health Partnership
ELT	Executive leadership team
EMT	Emergency medical technician
EOC	Emergency operations centre
ePRF	Electronic patient record form
ER	Emergency responders
FRU	Fast response unit
HART	Hazardous area response team
HCP	Healthcare professional
HCPC	Health and Care Professions Council
HLP	Healthy London Partnership
iCAT London	London Ambulance Service's integrated clinical assessment and triage service
Incident	A 999 call we respond to physically by sending a clinician to the patient
IM&T	Information management and technology
IoT	Internet of things – internet-enabled devices such as wearables, monitors and detectors

IUC	Integrated urgent care
JESIP	Joint emergency services interoperability programme
Job cycle time	A measure for the time from the start of a call-out until an ambulance is available to attend their next patient
LAS	London Ambulance Service
LFB	London Fire Brigade
MiDoS	The directory of services for our staff
MMS	Multimedia (photo) message
MPS	Metropolitan police service
MRU	Motorcycle response unit
NCL	North Central London STP
NEL	North East London STP
NETS	Non-emergency transport service
NHS 111	A non-emergency number for urgent healthcare in England
NQP	Newly qualified paramedic
NWL	North West London STP
PDSA	Plan, do, study, act cycle
PPMO	Programme and project management office
RMN	Registered mental health nurse
SEL	South East London STP
SMS	Short message service (text message)
STP	Sustainability and transformation partnership
SWL	South West London STP
TEAC	Trainee emergency ambulance crew

B How we developed our strategy

We have followed established best practice in developing our strategy and have undertaken substantial engagement with our staff, patients and the public, partners and stakeholders throughout. This has ensured we have been able to benefit from the insight of those who deliver and those who experience our services when arriving at a view of how our organisation needs to change. It also means that these groups have invested in, and own, our strategy.

B.1 Strategy development approach

In writing this strategy we have ensured that we have reviewed best practice guidance and developed our strategy in accordance with those guidelines as well as the Care Quality Commission (CQC) expectations for strategy development. NHS Improvement's strategy development toolkit²⁵ identifies the seven stages of strategy development.

Figure 38: Overview of NHS Improvement strategy development toolkit



At the point in time that this strategy is being published, we have completed five out of the seven stages:

1. Frame – we have determined the important strategic decisions that need to be made, and the criteria and constraints for making them
2. Diagnose – we have established detailed insight on the trust's baseline position and the elements that determine performance
3. Forecast – we have created a clear view of the potential future in which our organisation will operate
4. Generate options – we have developed, explored and evaluated our strategic ideas and options for change
5. Prioritise – we have made choices about the strategic ideas for change and have built them into one single strategy

The two elements that we have not yet completed will take place following the publication of this strategy:

6. Deliver – we will create a detailed programme, supported by comprehensive communications, that will deliver our strategy

²⁵ [Strategy development: a toolkit for NHS providers](#), Monitor, 2015

7. Evolve – We will continually monitor the implication and impact of our strategy and refresh or recreate where situations, either internally or externally to our organisation, necessitate

B.2 Our strategic intent

Through the initial stages of strategy development, we produced *Our Strategic Intent*²⁶, which outlined our strategic thinking and our emerging strategic themes. We wanted to produce a fully formed document on which to base our engagement period so that our staff, patients and stakeholders could fully understand our direction of travel and could give us their views.

B.3 How we engaged on our strategy

In seven weeks, we conducted a wide ranging, extensive engagement exercise with our staff, patient representatives and key external stakeholders, the largest of its kind in our recent history. Our ambition was to ensure that our final strategy was co-designed with the people who use our service, the people who deliver our service and the people or organisations who commission, partner with or otherwise have an involvement in the delivery of our service. Our engagement approach was based on the NHS Improvement's strategy development toolkit as well as on the Care Quality Commission's guidance.

We set out three key outcomes that we were looking to achieve:

- Understanding of our ambition and strategic intent
- Alignment with local, regional and national NHS strategy
- Co-designing our strategy, providing feedback and ideas on how we can improve our services for patients in the future

Throughout our engagement period, the different methods and forums that we used fitted into three categories:

- Informing, including CEO managers' briefings, CEO roadshows, information on our website and posters sent to all of our stations and corporate and support sites
- Seeking feedback and co-design, including engagement events with staff, union representatives, patients and stakeholders
- Detailed Development, including detailed design workshops with staff and subject matter experts

B.3.1 Our engagement with patients

We held a number of meetings with the Patients' Forum, as the main representative of patient views for our organisation, to share our emerging vision. We found the Patients' Forum advice invaluable in ensuring that the document is accessible to the public and patient-centric.

We also were pleased to discuss our strategy with a number of patient representative and community groups at our main strategy engagement day. The groups that joined us at the event were:

- The Patients' Forum
- Healthwatch Enfield
- Healthwatch Barnet
- Healthwatch Harrow
- Alzheimer's Society
- Southwark Carers

B.3.2 Our engagement with staff

We engaged extensively with our staff. We know that in order for our new strategy to be a success, it needs to be one that our staff have helped to develop, and has broad support across our workforce. With that in mind we worked extremely hard to engage with as many staff as possible. Across all

²⁶ [Our Strategic Intent](#), London Ambulance Service NHS Trust, 2017

aspects of our staff engagement we have had over 1,600 separate contacts with staff. This has only been possible by proactively seeking all opportunities to engage with staff across the organisation, at whatever location is suitable for the staff groups, this included:

- CEO roadshows
- Staff strategy survey
- Strategy engagement day
- Managers' briefings
- LAS leadership event
- Strategy design workshop
- Team meetings
- Union meetings
- Directorate away days

B.3.3 Our engagement with stakeholders

We have engaged with 25 separate organisations about our strategic intent. We initially held a sustainability and transformation partnership (STP) event on 1 November 2017 where we worked with STP leads to refine *Our Strategic Intent*. Table 16 below shows all the stakeholder organisations that we have engaged with:

Table 16: Stakeholder organisations

Health and social care	Emergency services	London wide stakeholder community
• Barts Health NHS Trust • Brent CCG • Care Quality Commission • Central London Community Healthcare • Hammersmith and Fulham CCG • Healthy London Partnerships • London Air Ambulance • London North West London Community Healthcare • NHS Digital • NHS England • NHS Improvement • North Central London STP • North East London CSU • North East London STP • North West London STP • Public Health, Kingston • Royal College of Paramedics • South East London STP • South West London STP • Southwark CCG • St John Ambulance	• London Fire Brigade • Metropolitan Police Service	• Greater London Authority • Mayor's Office • Transport for London

B.3.4 Our strategy engagement day

The most significant event of the engagement period was our strategy engagement day, which took place on 7 December 2017. This day comprised of three separate engagement events, the first with patient representatives, the second with staff and the third was with stakeholders. At each event working sessions took place, targeted to the specific audience, so that we could use the expertise in the room to help shape our strategy.

B.4 Key themes from our engagement

This feedback that we received from our patients, staff and stakeholders through our engagement has been directly incorporated into this strategy. The key themes from our engagement, now incorporated within our strategy, are discussed below.

B.4.1 Collaborating with partners

- We can play a crucial role in identifying where there are inconsistencies and working alongside STPs and providers to improve this
- It is crucial that we engage consistently and at the appropriate levels with each of London's five STPs. Every new service offering we are developing should be done in conjunction with STPs to ensure no duplication and alignment with other services in development
- We should use our unique position as a pan-London provider and the 'helicopter view' that provides us to play a critical role in providing the evidence that is needed for pathway development. We should also be proactive in identifying and sharing best practice across London
- MiDoS (the directory of services for our staff) is crucial for our staff across London in avoiding unnecessary hospital admissions, and we should work with all providers to ensure that it is kept up to date at all times
- Mental Health pathways were consistently cited as the most problematic, in particular out of hours. This should be a key focus of our work with partners and providers
- Urgent care centres were also a key theme from feedback. There would be great value in a greater level of consistency of what they will and won't accept across the different areas of London

B.4.2 Patient access to the urgent and emergency care system across London

- Patients often find the urgent and emergency care system confusing and we should look to make it as simple as possible
- We should bring 999 and 111 together across London as far as possible
- We should utilise technology to improve the service we can offer patients, in particular using video calls
- We should, supported by NHS England, embark on a wide ranging communication and public education campaign if we materially change the way we respond to patients, including offering more ways to get in touch
- An Integrated Clinical Assessment and Triage service needs to be linked in with the rest of the health system, so we can access patient records and inform GPs when their patients have contacted us

B.4.3 Our clinical response to patients

- There is consensus that we should bring in more healthcare professionals and staff are excited about learning by working alongside them.
- However, staff are anxious about whether this will lead to de-skilling our current front-line workforce if only specialists are sent to these patient groups
- Some staff commented that *Our Strategic Intent* does not adequately reflect the dedication and experience of our current skilled clinical workforce
- *Our Strategic Intent* does not include reference to our advanced paramedic practitioner for urgent care (APP-UC) pilot. This has been very successful and should be rolled out more widely
- All of our pioneer services are reliant on the right pathways being available at the right time
- We need to make sure that we are working at STP level in the development of these services to ensure alignment with other initiatives and to avoid any duplication

B.4.4 Clinical responses to specific patient groups

- Any falls service should include elderly fallers as well as other physical conditions including multiple sclerosis, epilepsy and physical disabilities
- GPs need to be made aware of when their patients fall, especially when they do so repeatedly
- Staff would see any falls service as a high risk one so will need to be staffed by experienced clinicians
- We need to work with mental health trusts and tie in with their 24/7 crisis lines before recreating anything similar ourselves
- There is huge positivity about bringing in more mental health professionals, and providing a different response for patients with mental health needs
- Staff felt that they would like more mental health training, which would help them provide a parity of service to patients with physical needs
- We should use midwives to attend non-complicated births to reduce the number of women that are automatically conveyed to hospital
- More midwives in the clinical hub could provide the greatest benefit, with a service like a 'labour line' preventing the need for dispatching crews unnecessarily
- It is vital that any end of life care service ties in with local services such as district nursing, hospices and support organisations such as Macmillan and Age UK
- We should investigate whether paramedics could provide stronger pain relief than they currently do for end of life care patients, which would enable patients to remain in their chosen place of care
- Staff should have access to end of life care specialists, whether directly in our control rooms, or through dedicated lines to other organisations

C Reference case

Full separate technical document

[Back cover]



Assurance report:

People & Organisational Development Committee

Date: **12/03/2018**

Summary report to:

Trust Board

Date of meeting:

27/03/2018

Presented by:

**Jayne Mee, Non-Executive
Director, People &
Organisational Development
Committee Chair,
Patricia Grealish, Director of
People & Organisational
Development**

Prepared by:

**Jayne Mee, Non-Executive
Director, People &
Organisational Development
Committee Chair**

Matters for escalation:

- Band 6 update – the Committee received an update on the London Ambulance Service NHS Trust's (LAS') status against key milestones in relation to the implementation of the B6 Paramedic Job Description. The Committee was informed that, whilst the LAS was on track to meet the majority of the key milestones required, it would not achieve the requirement of personal development plans with each staff member by 31 March 2018, as a result of Winter Pressure plans, REAP levels and the fact the cycle for PDRs in LAS had already progressed. All other ambulance trusts are in the same position, and a significant piece of work has been done to anticipate the likely requirements of each staff group for meeting identified gaps, and the training plans. However, the Committee could not be assured at this point in time that the LAS would be able to demonstrate that it had met all the necessary requirements to be awarded the total funding associated with the implementation of the B6 Paramedic Job Description. The Committee has requested further information as to whether the timelines may be extended or whether there will be a shortfall in the funding the LAS (and most other ambulance trusts) will be awarded.
- Workforce planning – in response to a request from the Committee, a short paper on the LAS' 5 year planning assumptions was presented. This led to a discussion about the potential outcome of the spring review of the Ambulance Response Programme (ARP), its possible outcomes and the impact that these might have with regard to the skill mix we will need in the future. The Committee proposed that in advance of this information becoming available a planning assumption of a 60/40 (paramedic to non-paramedic) split should be used for the purposes of modelling. The outcome of this will be considered by the Committee at an extraordinary meeting that is due to take place in April. The Committee expects that this will then be presented to the Board for its consideration.

Other matters considered:

- Recruitment report – the Committee continues to focus on the Trust's recruitment activities, particularly in relation to the recruitment into the Emergency Operations Centre (EOC). It is clear that a significant number of activities are going on and that progress has been made on filling all available training places. The Committee now needs to be assured about the outcomes of that activity. There are some indications that recruitment is improving in this area – since January 2018 38 EMD1 Call Handlers have been recruited with a further 20 confirmed to start in March.
- Operational Activities – the Committee received an update on work being undertaken in the Operations directorate in relation to the implementation of the new Rest Break Policy and Roster Review. This is due to be discussed by the Board at its meeting and further information can be found elsewhere on the agenda.
- The restructure of the Operations Directorate is now being consulted upon.
- Independent training review – an external review of all of the trust's training activities will be undertaken in April. The scope was considered by the People and OD Committee and will also be tabled at the Quality Assurance Committee, as it will encompass all training provided by the Trust; including clinical education.

Key decisions made / actions identified:

- The Committee supported the approach that was being proposed with regard to minimising the number of agency workers that the LAS employs. This will ensure that we stay under the ceiling that has been imposed upon us. A further report is due back to the Committee in May.
- The Committee agreed to have an extraordinary meeting in April to review the outcome of the staff survey and the proposed actions to be taken in response. This will then be reported to the Board at its April meeting.
- Terms of reference – the Committee is proposing that its name and Terms of Reference change to reflect the proposed new name and structure of the People and Organisational Development Directorate. These are presented to the Board as part of the Corporate Governance Review.

Risks:

- The Committee considered the people-related BAF risk and considered that it remained appropriate, with key actions providing appropriate mitigation. No other potential risks were identified.

Assurance:

- The Committee has asked for further information to provide assurance where it has not yet been able to do so (in relation to the implementation of the B6 Paramedic Job Description and recruitment activities for the EOC).



Assurance report:

Finance and Investment Committee

Date:

13/03/2018

Summary Report to:

Trust Board

Date of
meeting:

27/03/2018

Presented by:

Fergus Cass
Non-Executive Director,
Finance & Investment
Committee Chair
Lorraine Bewes
Director of Finance and
Performance

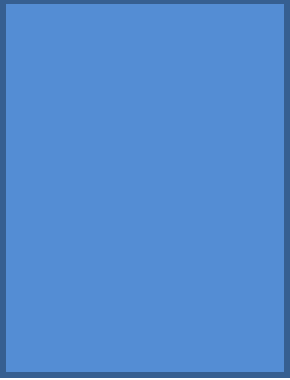
Prepared by:

Fergus Cass
Non-Executive Director,
Finance & Investment
Committee Chair

Matters for escalation:

- At the end of February 2018, the net position was £3.7m ahead of budget. The forecast outturn is a deficit of £0.6m, £1.8m better than plan. The expected release of the CQUIN reserve will yield a further improvement of £1.6m plus a £ for £ bonus. The favourable outcome compared with budget reflects the net effect of factors that include, on the one hand, an underspend on salaries due to front line vacancies, and, on the other, increased spending on private ambulance services and a shortfall in the CIP.
- Capital expenditure to the end of February, at £13.8m, is £7.4m below plan. The total spend for the year is forecast at £21.9m.
- Cash is £10.4m ahead of plan for a number of reasons, including the shortfall in capital expenditure; it is forecast to stay positive over the next 12 months.
- The draft financial plan for 2018/19 has been submitted to NHS Improvement (NHSI). It indicates that the Trust will achieve the required control total deficit of £1.6m. Work has progressed in four main areas: contract negotiation; departmental budget setting; CIP development; and capital budgeting. Following budget reviews the CIP requirement stands at £12.3m. The Committee discussed assurances that would be helpful to Board approval of the final plan that will go to NHSI in April. Current issues include:
 - reaching agreement with Commissioners on the activity level to be funded;
 - confirming that the patient-facing hours delivered under the agreed budget for frontline staff are sufficient to support planned activity growth;
 - assessing via a consultants' study whether planned resources can deliver the nationally mandated goal of full achievement of Ambulance Response Programme (ARP) targets by September 2018;
 - elaborating CIP projects to a point that confirms the likelihood of delivery;

	completing capital budgets.
Other matters considered / decisions made / actions identified:	• The Committee congratulated the team that prepared the bid to provide Integrated Urgent Care Services in South East London: the bid was submitted on time and is within the financial cap. The Committee noted the strength of the clinical and operational aspects of the bid and the way in which the financial risks identified earlier have been managed or mitigated. • The Committee discussed a draft of the timetable for preparation of business cases and of the process that will be followed. It noted that the programme is substantial and is likely to require prioritisation. • The Committee agreed that its May meeting will consider two items originally planned for discussion in March: the format and content of the integrated performance report; and progress with the five year financial strategy. • The Committee reviewed progress in implementing Internal Audit recommendations relating to finance and investment. Actions to improve the identification, planning monitoring and reporting of CIPs were noted. Significant outstanding recommendations relate to: controls over fleet ordering; procurement arrangements; and contract management. Work is underway in these areas and the Audit Committee and the Logistics and Infrastructure Committee will follow-up to assure completion. • The Committee noted the latest report on recent accounting, legal and regulatory developments. The report discussed at the Committee's January meeting had indicated that IM&T are preparing a gap analysis relating to the General Data Protection Regulation (GDPR); this analysis, together with an action plan, will be presented to the Board in April.
Risks:	• The Committee considered the finance-related risks in the Board Assurance Framework (BAF). Currently there is one: that the Trust may not have sufficient capacity and capability to deliver the efficiency programme needed to achieve the control total target for 2018/19. The estimated scale of this programme is £12.3m. While efficiencies to that level have been identified, more work is needed to confirm that the relevant projects have a high probability of being delivered. Also, some projects may not realise their full potential in 2018/19. The Committee therefore recommends that this risk should remain on the BAF for the time being. • As noted above, there are other risks and issues relating to the financial plan for 2018/19, many of which should be resolved as the plan is developed. • The Committee did not identify any new risks to be considered for inclusion in the BAF but will review the position when the financial plan is finalised.
Assurance:	• The Committee reviewed financial performance, cash flow and capital expenditure to the end of February 2018. It received explanations regarding variances from budget, CQUIN delivery, capital projects and expectations for the remaining weeks of the financial year. On the basis of these explanations and of the reports presented, the Committee was



assured that the forecast outturn and cash flow will be achieved. It noted that work is ongoing to achieve forecast capital expenditure.

- In its consideration of the financial plan for 2018/19 and the related CIP the Committee was encouraged by the approach being taken to budget setting and to the agreement of CIP projects. The aim is to achieve accountability and reliable delivery, supported by strong programme management and effective monitoring. Assurance in relation to financial planning processes will be revisited when the plan is finalised, and again as the year progresses.



Assurance Quality Assurance report: Committee

Date: 27/03/2018

Summary report to: Trust Board

Date of meeting: 20/03/2018

Presented by: NonExecutive director

Prepared by: Robert McFarland

Matters for escalation:

There were no new issues for escalation to the Board

Other matters considered:

Report from North Central by Alex Ewings and Sophie Hill (Quality, Governance & Assurance Managers)

The Committee was presented with the rationale and results of the “tethering” pilot in North Central in August 2017. Key findings were:

- It is possible to enact a tethering of DCA in sector (within careful guidelines) without risk to safety in that sector nor adjacent sectors
- Improved Cat A response times for the North of North Central sector were not demonstrated as had been hoped.
- However, there was an improvement in Cat C response times and the pilot was popular with staff who recognized a benefit in culture and efficiency.
- A parallel “end of shift” FRU pilot was regarded as successful by crews.
- These findings will contribute to the current operations review.

Both QGAMs were enthusiastic and committed to their role and felt that there had been a major culture change over the time they had been in post and that this sense was shared by other QGAMs, their ADO, GSMS and Team leaders with examples of improved practice and local training initiatives.

Quality Report

- The improvement in Quality indicators on the dashboard was noted
- The red flag for infection control (handwashing) is caused by a failure to report from several stations (recorded as 0%) whereas those that do report are on target. It is expected the organisational restructure will improve OWR completion.
- STEMI outcome is back close to target
- Stroke (60 Minutes to HASU) is still below target (especially in N. Central sector where travel time to HASU is greater).

Serious Incidents

- The improvements in timely investigation and reporting was noted
- A significant delay in attendance had adversely affected one clinical outcome
- Substantial work is underway to address the issue of delayed defibrillation including education and an increased facility to download recordings.

Clinical Strategy

- Phase 1 objectives (2017) are complete. The Clinical Strategy is due for review in the context of the work around the Integrated Clinical Hub initiative and the updated Business plan for the Service.

Deep Dive Plans for 2018/2019

- In discussion it was felt important to clearly distinguish plans for Internal Audit by our Formal Internal Auditors (previously KPMG and now being discussed with the newly appointed Grant Thornton); other audits or diagnostic work by independent external consultants; and reviews by our own teams. There should also be time for progress reviews in relevant areas.
- It is felt that the subjects for Deep Dive should be considered quarterly to address whatever current issues are of concern. Plans for the first Quarter of next year will be brought to the next meeting.

Patient Specific Protocols (PSP)

- A web-based system for recording PSPs has been developed in house to make them available to crews attending patients. The review and transfer of current PSPs to the new system has been delayed but should be accomplished within three months. The long-term aim is that these would be available through a London wide system (such as Coordinate My Care (CMC)) but this will not be in place for a time, hence the need to develop our own system.

Key decisions made / actions identified:

Quality Strategy and Annual Quality Account

- These were presented in draft and observations were taken and further detailed comment will be by email to Trisha Bain. The committee can recommend this draft in principle to the Board. The final draft will be completed when the full annual figures are available.

Independent Training Review

- The Committee supported the plans for an independent external Training Needs Assessment covering all training. This will be monitored by the People and Organisational Development Committee with regular briefing to this committee on quality aspects – especially regarding clinical training.

Risks:

- BAF Risk 46 (Lack of compliance with Health and Safety requirements.....). Much progress has been made although there is still much to do (now to include HART and workshop areas). However, there are now robust systems in place and progress is monitored on the Quality dashboard. The Committee was therefore able to support a proposal that this risk be downgraded and could be removed from the BAF.
- Previous BAF Risk 7 (Patients could suffer avoidable harm across shift change.....). Current performance figures show no fall in performance at handover time (nor during the rest break window). A recent review of Serious Incidents has found none that can be attributed to delay around handover time. The Committee was therefore able to endorse the decision taken by the Board at its meeting on 30 January 2018 to downgrade this risk and remove from the BAF.

Assurance:

The Winter 2017/2018 Clinical Safety Review concluded that the Trust continued to ensure resources were prioritized to the most serious patients although the lower acuity patients did experience a delayed response. We were assured that the rolling programme of real-time clinical review meant that clinical safety was maintained when under pressure.



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report Title:	Integrated Quality and Performance Report			
Agenda Item:	12			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Executive Leadership Team members and Board Assurance Committee Chairs			
History:	Executive Leadership Team			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This high level Integrated Performance Report serves to provide an Executive Summary for Trust Board and give organisational oversight of all key areas across London Ambulance Service. This report brings together the areas of Quality, Operations, Workforce and Finance. It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust. Key messages from all areas are escalated on the front summary pages in the report. It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.				
Recommendation(s) to Trust Board:				
The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.				
Links to Board Assurance Framework (BAF) and key risks:				
This report contains an overview of Trust risks directly linked to the BAF but does not itself raise any risks.				

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

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



London Ambulance Service

NHS Trust



INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

March 2018

- * All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout February 2018 unless otherwise stated.



Delivery of care continues to be safe, but the ongoing demand pressures on the system remains challenging.

Cat 1 Mean was 7 minutes 28 seconds. LAS ranked 2nd in Cat 1 90th centile compared to other Trusts. The adverse weather effected response times.

Trust vacancy rates have decreased from 7.2% to 6%. Appraisal rates have improved from 57% to 69%.

The YTD position is £3.6m ahead of plan and £3.7m ahead of re-phased budget. In February the Trust has a Use of Resources score of 1 (highest available score).

OUR PATIENTS

↔ Compliance with 6 weekly deep clean schedule, continues to achieve 90%.

↔ Reviews of Infection Prevention Control incidents, reported on Datix have resulted in positive changes in practice.

↔ Case management of complaints has been affected by the recent escalation to REAP 3, an increase in SURGE and recent poor weather as all clinical managers have been deployed to support frontline operations.

OUR MONEY

↔ At the end of February 2018, the net position was £3.7m ahead of budget. The forecast outturn is a deficit of £0.6m, £1.8 better than plan, which equates to a Use of Resources rating of 1 (the highest level).

↑ Capital expenditure to the end of February, at £13.8m, is £7.4m below plan. The total spend for the year is forecast at £21.9m.

↔ Cash is £10.4m ahead of plan for a number of reasons, including the shortfall in capital expenditure; is it forecast to stay positive over the next 12 months.

↔ The draft financial plan for 2018/19 has been submitted to NHS improvement (NHSI). It indicates that the Trust will achieve the required control total deficit of £1.6m.

OUR PERFORMANCE

↓ Category 1 Mean for February was 7 minutes 28 seconds, this is 28 seconds above the national standard however this is a marginal increase when compared to the previous month.

↑ 86,296 Incidents were provided with a face-to-face response. Category 2 incidents reached 48,695 incidents. This accounts for 59% of face-to-face responses.

↓ LAS ranked 2nd for Category 4 90th centile compared to the other Trusts.

↑ There was an 11.6% increase in Hours Produced by Double Crewed Ambulances from January to February, however this could be due to February being a shorter month.

OUR PEOPLE

↓ Vacancy rates have decreased from 7.2% to 6%.

↑ Overall turnover has increased from 10.4% to 10.6%.

↔ The monthly sickness position for February remains at 5.2%.

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

Demand for 111 was exceptionally high during February however service delivery remains safe with no Serious Incidents declared. Delivery was maintained against a background of continued recovery from current winter pressures and adverse weather conditions.

LAS 111 (SOUTH EAST LONDON)

- ↓ The 111 service achieved 80% in the calls answered in 60 seconds in February.
- ↔ Call demand was 23.5% higher than predicted in February, by up to 37% on weekdays and 25% at weekends which added to the challenge of achieving the target for calls answered in 60 seconds(>95%).
- ↔ Referrals to 999 remain successfully and consistently low with a reduction in referrals to emergency treatment centres.
- ↔ February had a significant focus on submission of our bid for the South East London 111 and Integrated Urgent Care Service.
- ↔ Of the five London Providers, LAS SEL 111 was ranked 1st for Calls Answered within 60 seconds.

LAS IMPROVEMENT

Single Oversight Framework

The purpose of the Single Oversight Framework (SOF) is to identify where providers may benefit from, or require, improvement support across a range of areas. The five themes are: Quality of care, Finance and Use of Resources, Operational Performance, Strategic Change, and Leadership and Improvement Capability.

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

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

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

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

PATIENT TRANSPORT SERVICE

- ↓ February saw a stable level in the number of journeys with a total of 1,586 journeys being delivered as compared to the January total of 1,757 journeys.
- ↔ PTS now have only two contracts operating; St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March / April 2018.

OUR RISKS

BAF Risk 49

The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

BAF Risk 46

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

BAF Risk 47

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

BAF Risk 45

There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

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

Key Performance Indicator Report Summary



	Key Performance Indicator	Feb-18	Jan-18	Dec-17	Chart
QUALITY	Adverse Incidents (Patient)	↓	↓	↑	
	Adverse Incidents (Staff)	↓	↑	↓	
	Potential Serious Incidents referred to SI Group	↓	↑	↑	
	Serious Incidents (LAS Declared)	↓	↑	↓	
	Serious Incidents (LAS Declared) Overdue	↔	↔	↓	
	Regular Reporting of Incidents - Shared Learning	↔	↔	↔	
	Total Complaints	↑	↓	↓	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↑	↓	↑	
	Controlled Drug Incidents - Not reportable to LIN	↓	↑	↓	
	All LIN Reportable Incidents	↔	↔	↓	
	Overall Medication Errors	↓	↑	↑	
	Missing Equipment Incidents	↑	↓	↑	
	Failure of Device/Equipment/Vehicle Incidents	↑	↓	↑	
	CPI - Completion Rate*			↓	

	Key Performance Indicator	Feb-18	Jan-18	Dec-17	Chart
111	Calls answered within 60s	↓	↑	↓	
	Calls abandoned after 30s	↑	↓	↔	
	Percentage of calls referred to 999	↑	↓	↔	

	Key Performance Indicator	Feb-18	Jan-18	Dec-17	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↓	↑	
	Vacancy Rate (Frontline)	↓	↓	↑	
	Vacancy Rate (Trust)	↓	↑	↓	
	Turnover Rate (Frontline Paramedic)	↑	↔	↑	
	Turnover Rate (Frontline)	↑	↑	↑	
	Turnover Rate (Trust)	↑	↑	↔	
	Sickness (Trust)	↑	↔	↓	
	Sickness (Frontline)	↑	↓	↓	
		↑	↓	↓	

*These KPIs are reported one month in arrears

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

A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. These Key PERFORMANCE measures will be included from January onwards and, continued to be monitored in this document.

	Key Performance Indicator	Feb-18	Jan-18	Dec-17	Chart
PERFORMANCE	A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. The six key performance measures are listed below, which will be monitored in this document.				
	The arrows show the movement in the measures when compared to the performance from the previous month.				
	Cat 1 Mean	↑	↓	↑	
	Cat 1 90th Centile	↑	↓	↑	
	Cat 2 Mean	↑	↓	↑	
	Cat 2 90th Centile	↑	↓	↑	
	Cat 3 90th Centile	↑	↓	↑	
	Cat 4 90th Centile	↑	↓	↑	

	Key Performance Indicator	Q1	Q2	Q3	Q4
FINANCE	Financial Stability Risk Rating (FSRR)	↔	↔	↔	
	Capital Service Capacity	↔	↔	↔	
	Liquidity Days	↔	↔	↔	
	Key Performance Indicator	Feb-18	Jan-18	Dec-17	
	Cash Balance - Monthly Profile - £000s	↓	↑	↓	
	Income and Expenditure Deficit by Month - £000s	↓	↓	↑	
	Income and Expenditure Deficit Cumulative - £000s	↓	↑	↑	
	Income Variance from re-phased budget - £000s	↓	↓	↑	
	CIP Delivery Against Plan - £000s	↓	↑	↑	
	CIP Forecast Against Plan - £000s	↓	↑	↓	
	Forecast Capital Spend Against the CRL - £000s	↑	↑	↑	
	Debtor Days	↔	↓	↑	
	Creditor Days	↔	↑	↔	
Agency spend against plan - £000s	↑	↑	↑		

Our Patients



Safety

- Compliance with 6 weekly deep clean schedule continues to meet 90%.
- Quality assurance of 6 weekly deep clean has been completed for all 5 sectors in February; data analysed and fed back to ensure continuous improvement.
- IPC Training met compliance in February for Level 1 & 2.
- Aseptic technique video completed and uploaded to the Pulse to support operational staff and CTLs during OWR.
- Reviews of IPC Datix incidents have resulted in changes in practice.
- Quarterly IPC station audit tool has been transformed into an e-tool (Perfect Ward).
- Immunisation status of all clinical staff is currently being reviewed. To date 75% of staff records have been assessed by the Trust Occupational Health provider.
- IM adrenaline administration – dose and/or route errors.
- Map my maternity project – To develop overall contact information about maternity unit, and checking of correct pre-alert numbers – Work collaboratively with MiDos development team – ongoing.

Effectiveness

- Audit of maternity care commenced in February 2018 – To review the following:
 - Maternal care
 - Newborn care
 - Management of “Obstetric Emergencies”
 - Management of neonatal resuscitation

Caring

- Quality Alerts from other healthcare providers continue to rise.
- Emergency Medical Dispatcher Consultant Midwife to be supporting potential applicants for the Practice Lead position. This is to shadow her to gain insight into the maternity emergency pre-hospital setting.
- “Whose Shoes” Maternity staff and stakeholder engagement event planned for May/June. Funded and will align to maternity pioneer service and Quality Improvement Objectives for Maternity Care.

Actions & Assurance

- Examples of progress resulting from of an analysis of incident reports include improved quality of investigation and reporting. It has also informed decision making when selecting various items of personal protective equipment.
- No further reported incidents following poster campaign and training via CSR e-learning package.
- Project to continue until complete coverage of units is available to EOC and front line staff.

Actions & Assurance

- Outcomes of audit to influence
 - Ongoing Core Skills Refresher – Maternity component
 - Maternity Education Leads in local communication and delivery
 - Positive feedback to staff and areas for improvement

Actions & Assurance

- In order to manage these effectively a Business Case has been made for an increase in establishment.
- Consultant Midwife to be invited to talk at Control Services Governance Meeting and discuss the role of the Practice Lead for Pre-Hospital Maternity Care and delivery of maternity education to EOC and Clinical Hub clinicians.

Our Patients



Safety

- Variable standards in IPC practice still being observed.
- Training sessions currently provided by non-IPC specialist requires quality assurance content and delivery (similar to OFSTED).
- Encourage personal accountability and responsibility regarding adherence to IPC standards - introduce IPC discussions at One to Ones and PDRs, team meetings, OWRs to change practice and attitudes; benchmarking for stations.
- Encourage regular competency checks (peer review), role modelling by key influencers e.g. mentors, senior staff.
- Continue to improve integrated working, closer engagement with Estates, Fleet and Logistics, Procurement, Operations (ensure IPC is woven like a golden thread into processes to meet the quality and safety agenda).
- Total waste compliance oversight.
- Completion of Risk actions associated with Tight-fitting Respirator masks.
- Flu masks for staff - FFP3 fit testing/recording.
- Health Care Professional Line – Request for Community Midwives (at homebirth or stand alone birth centre) response times present a safety challenge for those requests where “foetal distress” is present.

Effectiveness

Caring

- Case management has been affected by the recent escalation to REAP 3, an increase in SURGE and recent poor weather as all clinical managers have been deployed to support frontline operations.

Actions & Assurance

- As REAP returns to normal operating levels and Clinical Team Leaders return to their normal duties there will be additional focus and support to ensure an increase in hand hygiene compliance.
- Escalate through the Patient Safety Group and Director of Operations and Medical Director.
- Paper to be formulated detailing the existing response categories and potential impact upon women / newborn care and safety.

Actions & Assurance

Actions & Assurance

- As demand normalises and managers return to their usual roles it is expected that delays to the Trust management of complaints and enquiries will reflect aspirational timeframes.

Patient Safety

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



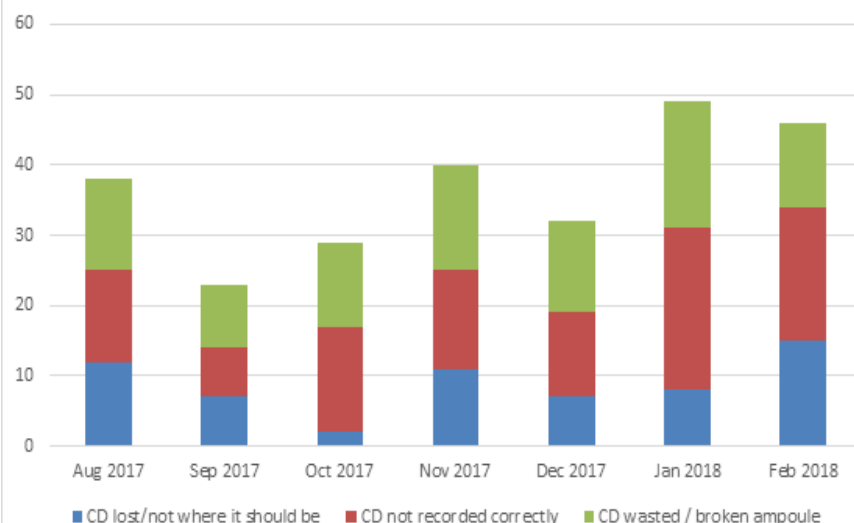
Measures	Target / Range	RA G	YTD 17/18	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data quality
Hand Hygiene OWR compliance	90%	R	83%	59.5%	85.0%	78.4%	↓			LQ18	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	3.0	2.3	2.5	↑					
Patient related Adverse Events - NO HARM	1200	G	2299	188	173	161	↓					
Patient related Adverse Events - LOW	500	G	272	38	25	27	↑					
Patient related Adverse Events - MODERATE		G	168	29	8	11	↑					
Patient related Adverse Events - SEVERE			74	12	6	2	↓					
Patient related Adverse Events - DEATH			129	26	9	16	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.3	2.9	3.3	2.7	↓					
Staff related Adverse Events - NONE			1945	170	195	127	↓					
Staff related Adverse Events - LOW			1403	106	125	102	↓					
Staff related Adverse Events - MODERATE			74	10	4	7	↑					
Staff related Adverse Events - SEVERE			3	0	1	1	↔					
Controlled Drugs - Other Reportable Incidents			347	31	49	43	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	3	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	92%	92%	95%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			357	39	46	26	↓					
Serious Incidents declared in-month			68	5	8	7	↓					
Serious Incidents breaching 60 days	0	G	24	0	0	0	↔					
Serious Incidents breaching 40 days	0	G	27	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			5%	5.5%	9.0%	6.0%	↓					
Needle Stick Injuries as % of Staff Adverse Events			2%	2.4%	1.5%	2.1%	↑					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	3	0	0	0	↔			LQ25	✓	
Safeguarding Adults & Children Level 1 (3 Years)	90%	G	76%	92.1%	93.5%	94.3%	↑					
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	G	79%	83.8%	88.0%	91.1%	↑					
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	42.0%	57.6%	63.9%	↑					
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	78%	78.4%	76.9%	88.5%	↑					
Safeguarding Trust Board (3 Years)	90%	G	100%	100.0%	100.0%	94.4%	↓					
Total Inquests where LAS asked to give evidence - In-Month			62	4	3	6	↑					
Total Inquests where LAS asked to give evidence - Year to Date			388	53	56	62	↑					
Missing Equipment Incidents as % of all reported incidents			3%	4%	2%	3%	↑					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	9%	8%	10%	↑					
Number of NRLS uploads In-Month	1	G	11	1	1	1	↔			LQ21		



Medicines Management

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

Controlled Drugs Incidents by Month



Medicines Management Incidents

- One unaccounted for loss of 2x morphine ampoules from CD safe
- Total of 42 other controlled drugs incidents
 - Documentation errors (n=18)
 - Breakages (n=13)
 - Morphine retained off-duty (n=7)
 - CD in wrong location – morphine (n=2) & diazepam (n=2)
 - Stolen APP bag returned with CD ampoules intact (n=1)
 - Concerns reported re packaging of morphine for transfer (n=1)
 - Shortage of diazepam 2.5mg PR & hydrocortisone 100mg
- Non-controlled drugs incidents
 - Drug usage forms not completed on arrival at LSU (n=12)
 - Medical gases in wrong location (n=3) or inadequate stock (n=3)
 - Drug cabinets open (n=2) or access codes visible (n=1)
 - Failure of Perfect Ward (n=1) & KitPrep apps (n=1)
 - Delay in drug delivery (n=1), missing key (n=1), breakage (n=1)
 - Drugs contraindicated (n=5) or excessive dose (n=3)
 - Non LAS pharmacy issue (n=1) & air in giving set (n=1)

Actions

- Alternative preparation of hydrocortisone sourced and information bulletin issued
- Reduction in quantity of diazepam 2.5mg PR packed into paramedic drugs packs and information bulletin issued.
- Ampoule trays sourced to reduce incidence of broken ampoules during withdrawal of morphine from CD safes
- Proposal evaluated for KitPrep app to incorporate warning message to prompt staff to return all drugs including morphine
- TED drugs bag procedures to be extended to incorporate LSU deliveries in tandem with secure drugs rooms programme

Assurance

- No further incidents involving use of IM adrenaline
- Rapid identification and timely return of all morphine retained off-duty
- Reduction in number of instances where access codes visible



Effectiveness (Clinical Measures)

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

Measures	Target / Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	36%	32%	33%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	62%	57%	55%		↓			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	73%	72%	73%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	59%	50%	54%		↑			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:31	00:31	00:32		↑					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:36	00:40	00:40		↓					
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	94%	92%			↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	14.4%	16.8%			↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.0%	98.0%			↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%			↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	92.0%	93.0%			↑		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97.0%	97.0%			↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%			↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%				↑			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	87%	92%	86%	86%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						49%	67%	↑			LQ11	✓	

Actions

- In January, CARU trained six members of staff on restricted duties, three mentors and one Team Coordinator
- February's Journal Club was attended by 28 members of staff who critically appraised a paper looking at how paramedics perceive the care provided to patients who self-harm

Assurance

- In January, care delivered to patients discharged at scene, in cardiac arrest or presenting with severe sepsis remained of a good standard across the LAS, along with the general standard of documentation
- Care provided to patients experiencing a glycaemic emergency was of the highest standard since May 2017
- Care provided to patients with a diagnosed psychiatric problem remained at 93% for the second month in a row
- The LAS considered safeguarding concerns for the most patients since June 2017

Caring

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



Measures	Target / Range	RAG	YTD 17/18	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	R	93%	100%	100%	0%	↓			LQ27	
Friends and Family Test Response Rate			1.8	0.0	0.0	0.0	↔			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	151	24	14	21	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.8	0.9	0.8	1.2	↑			LQ29c	
Positive Feedback Compliments			1037	80	74	125	↑			LQ29e	
Mental Health related calls as percentage of all calls			8%	6.6%	7.2%	7.0%	↓				
Mental Health related MPS calls as percentage of all calls			2%	1.7%	1.9%	1.7%	↓				
Mental Health related Incidents as percentage of all calls			5%	3.7%	4.4%	5.7%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.2%	0.3%	0.4%	↑				
Rate of Frequent Callers per 1,000 Calls			3.22	3.2	3.6	3.8	↑				
CMC records viewed			3622	1458	307	303	↓			LQ30	

Assurance

We continue to work closely with the users by experience patient group from Oxleas MH Trust. We are currently co-producing guidance and support for call handlers in relation to remaining on the line with patients expressing suicidal ideation. A group of lived experience practitioners are attending HQ on two dates in April to meet with call takers.

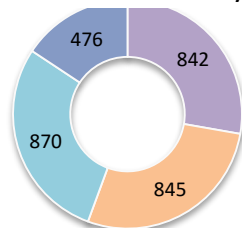
Mental capacity assessments continues to be a theme where staff have asked for additional support and guidance. An LA5 (Mental Capacity Act Form) First task and finish group held on 06/03 with follow up meeting booked for 27/03. A survey has been circulated on LiA Facebook page to gain staff feedback – has had over 120 responses.



Health & Safety Scorecard

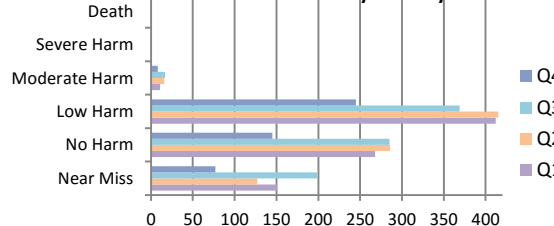
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain

Number of H&S incidents by Quarter



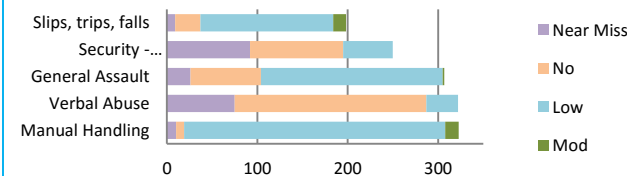
3033 health and safety related incidents have been reported during 2017/18. The incident data for Q2 & Q3 have been updated following investigation. Total YTD H&S incidents account for 39% of all incidents reported during the year.

Accidents & Incidents by Severity



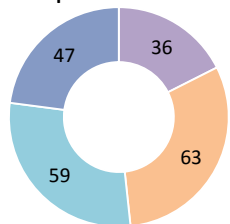
1441 (47.5%) of the H&S related incidents reported during 2017/18 resulted in low harm. 53 (1.7%) incidents resulted in Moderate and 1 severe Harm. 1538 (50.7%) of the incidents were reported as 'No Harm/Near misses'.

Top 5 Incident Sub-Categories by Severity (YTD)

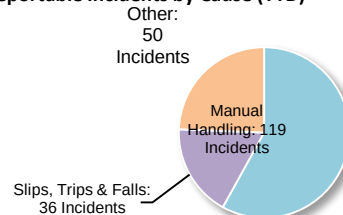


Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

RIDDOR Reportable Incidents by Quarter



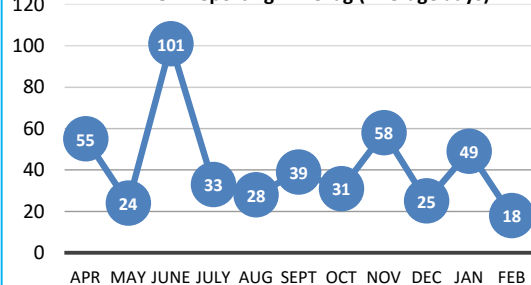
RIDDOR Reportable Incidents by Cause (YTD)



Key Updates:

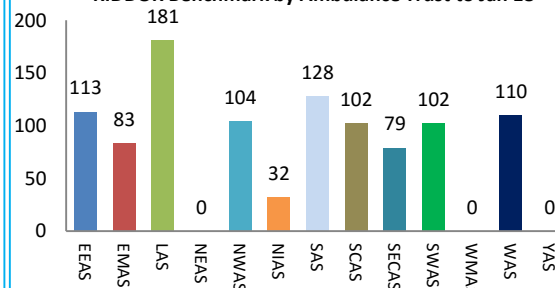
- MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Practical MH refresher training will be provided to all patient/load handling staff from April 2018.
- Business case for the replacement of Version 1 Mangar Elks has been approved and orders for the replacement equipment placed. 12 weekly maintenance plan implemented for all equipment including tail lifts and track chairs supported by 6 weekly visual inspection checks.
- GRS RIDDOR Reporting/flagging process updated during February 2018 and championed by QGAMs and Sector Managers. The new process is aimed at enabling the prompt flagging of any potential RIDDOR incidents to the Health and Safety Department for reporting to the HSE. **Significant improvement in the reporting time lag (18 days) during February 2018.**
- Fire risk assessment contract – under tender. Fire Marshal training being organised for nominated representatives in April 2018.
- A re-audit of Trust-wide H&S arrangements commenced on 29/01/2018 to assess progress made since the June 2017 independent H&S review.

RIDDOR Reporting Time lag (Average days)



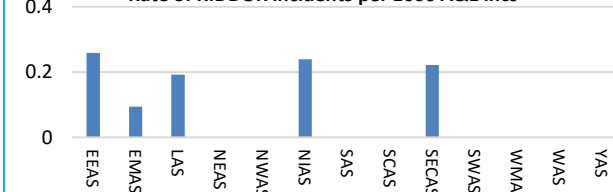
6. The average time lag for reporting RIDDOR incidents across the Trust in February was **18 days**. This demonstrates significant progress in the timeliness of RIDDOR reporting compared to previous months. **6 out of the 24 RIDDOR incidents were reported out of time in February 2018.**

RIDDOR Benchmark by Ambulance Trust to Jan 18



7. The above data was provided by the National Ambulance Risk & Safety Forum. The LAS has reported 181 RIDDOR incidents from April – January 2018 however 21 of the incidents occurred in 2016/17 and were reported retrospectively during 2017/18.

Rate of RIDDOR incidents per 1000 A&E incs



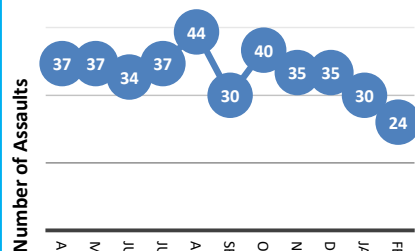
8. The above table highlights the rate of RIDDOR incidents per 1000 A&E incidents attended by each of the above Ambulance Trusts. **NB:** No A&E attendance data was received for the Trusts represented with blank data on the graph above.



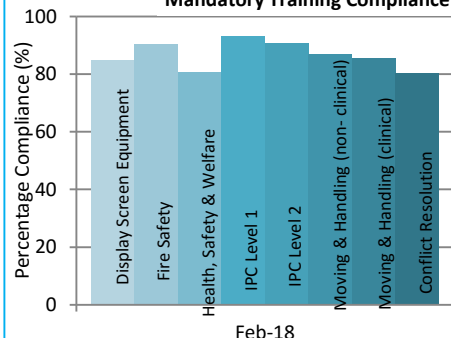
Health & Safety Scorecard

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

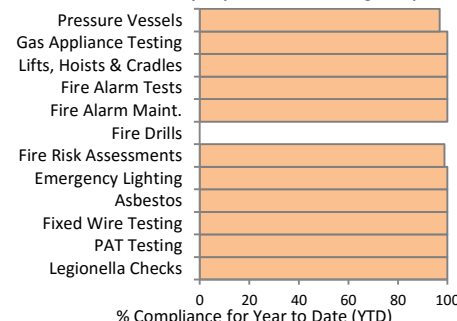
Assaults on Staff by Patients



Mandatory Training Compliance



Statutory Reports & Monitoring Compliance



9. There was a reduction in the number of patient assault related incidents in February 2018. 24 incidents were reported compared to 30 reported in January. Some common causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

10. Trust-wide compliance for February 2018 highlights that only 2 of the 8 mandatory health and safety training courses were below 85%.

11. Training for nominated fire marshals to commence in April 2018.

Health and Safety Risk Tracker					Initial Risk Rating	Current Risk Rating					Target Risk Rating	Key changes/updates since last review
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Q3			Q4			
						Oct	Nov	Dec	Jan	Feb		
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Audit of Trust-wide H&S arrangements to assess progress made since the independent H&S review conducted in June 2017 commenced on 29 th January 2018.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	15	9	Key training in practical manual handling has been delivered to Clinical Tutors in the Clinical Education Department. Practical manual handling refresher training to be provided from CSR 1 – April 2018. Business Case to replace all version 1 Mangar Elk approved. 12 – weekly maintenance programme implemented for all track chairs and tail lifts.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments approved at January H&S Committee meeting.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	3	GRS RIDDOR Reporting/flagging process updated with support from QGAMs and Sector Managers during February 2018. The average RIDDOR reporting timelag reduced to 18 days in February 2018. This highlights a significant improvement in RIDDOR reporting timescales.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Risks approved by H&S Committee and RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q4, 2017-18.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is currently under review. LSMS in regular liaison with staff and sites where security related incidents have been reported. Where required, incidents are reported to the Metropolitan Police for investigation.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	6	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. Recruitment ongoing.



Learning from Complaints

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

Top 5 themes 2017/18

Complaints by subject 2015/17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	234
Conduct	16	19	24	19	19	16	17	25	20	22	23	220
Road handling	12	11	13	14	10	7	14	9	7	6	10	113
Treatment	1	2	5	1	7	5	16	8	9	8	14	76
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	43
Total these subjects	53	49	62	60	62	38	75	76	62	59	90	686
Overall Totals	66	70	76	73	86	51	94	85	84	74	102	861

Review of February 2018

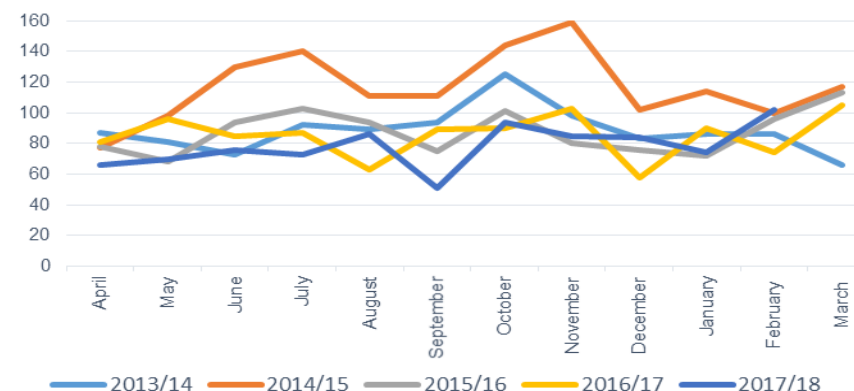
- The number of complaints relating to 'delay' has increased over the annual average of 19 per month to a yearly high of 40.
- Complaint numbers are currently 0.08% of calls attended by the Trust over the year, however during February this increased to 0.12% against the monthly total of calls attended
- Quality Alert numbers have increased this month (20), 14 remain under investigation. These have time frames to ensure timely responses
- During February we received 102 complaints. 6 of these were classed as HCP issues on behalf of the patient and 7 were from LAS111
- During this month where ARP was used, 5 related to ARP 1, 28 to ARP 2, 24 to ARP 3 and 18 to ARP 4 (see table on next slide)
- A record number of requests for medical records was received from solicitors this month (165). This may increase with the implementation of the DPA

Assurance and learning

- 91 complaints were closed this month including 23 of those received during February.
- Outcome categories – 59 not upheld, 16 partially upheld, 13 upheld and 3 referred to other agencies.
- We continue to receive just under 400 PALS enquiries per month and are planning to add a number of signpost links on the new website which should assist enquirers
- A number of complaints recommended reflective practice and future performance monitoring. Compensation was offered to one complainant whose door was forced when the 999 call was left open in error.
- Reimbursement of taxi fees was offered when non emergency transport failed to arrive

Complaint summary April 2013 to February 2018

Complaints comparison - 2013 to 2018



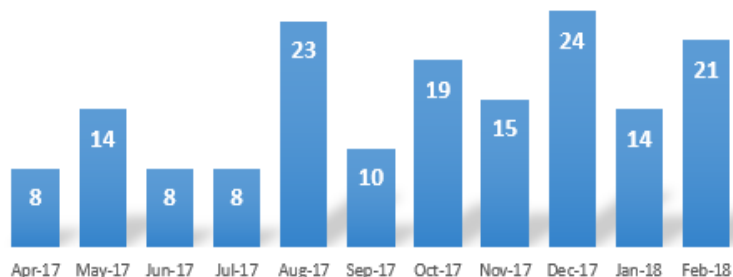


Learning from Complaints

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

Performance against 35 day response target (February)

Complaints over 35 working days at the time of the report



Categories of Complaint Calls

Call category February 2018	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	5
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	28
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	24
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	18
Category A Red 2 - 8 min response	2
Not CAD related	18
Information awaited	7
Total	102

Assurance and learning

- Since the introduction of ARP we have received 205 complaints where this was used. The ratio of call categories is as follows:
 - ARP 1 = 14 complaints
 - ARP 2 = 93 complaints
 - ARP 3 = 57 complaints
 - ARP 4 = 41 complaints
- We will be preparing an end of year review in April of all calls matched to ARP and sharing this with G&A
- There have been no recent requests from the Ombudsman but a report on the full outcome of 2017/18 requests will be provided in the April report.
- The PHSO is planning to visit the Trust at the end of March.
- HCP information will be updated on the website with a go live date of April 2018.
- We expect numbers of Quality Alerts to increase.

Case example

- Case example :**
Complaint from patient who is upset at the treatment provided. Concerns have also been raised about inappropriate comments made by the crew to the patient. Local management team to discuss the incident with member of staff in the context of a reflective practice exercise.
A key feature of this will be concerned with how effective communication with patients is a vital part of care provision. In addition, member of staff has been placed with a very experienced paramedic to supervise clinical decisions and performance monitoring, meetings have been arranged with team leaders. Supervising responsibilities for the period of this professional development have been curtailed.
The complainant has been invited to address the Trust Board.



Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No.	Topics included:
North West	10	➤ School and college visits ➤ Cubs, Brownies and Scouts ➤ Knife Crime events ➤ Police cadets ➤ Careers/recruitment events ➤ Road safety e.g. Biker Down / Driven by Consequences ➤ Tri-borough Falls event ➤ Children with learning disabilities
North Central	3	
North East	17	
South East	8	
South West	4	
Outer London / PPI	9	
Total	51	

Public Engagement activities

Supplementary information	
Public engagement: no. of hours (Feb 2018)	287
Approximate audience numbers (Feb 2018)	1200
No. of public engagement events: year to date (April 2017 – February 2018)	450
No. of staff on contact list	1276
No. of staff on LAS Public Education Facebook group	665

Staff Awards

Two cycle paramedics received the Assistant Commissioners Commendation for Innovation at a ceremony at Wood Street Police Station in recognition for their work with police to keep patients out of hospital during the festive party season in December. The cycle teams responded to 41 patients over three weekends and saved 28 ambulance journeys to hospital. Cycle paramedics usually only work during the day but they did extra night shifts during December to deal with the increase in demand during the party season

Staff Recognition

It is recognised our staff rise to an extraordinary challenge on a daily basis and that can sometimes take its toll. In February the Trust continued its support for the mental health and well being of staff by taking part in Time To Talk Day 2018 in a bid to remove the stigma and encourage staff to look out for one another

Our Performance



Since February 2015, three other ambulance services - South West, Yorkshire and West Midlands - have been involved in trials led by NHS England of the new standards. They focused on four main areas:

- Identifying the most seriously ill patients as early as possible through processes known as Pre-Triage Sieve and Nature of Call.
- Giving control room staff more time (up to 240 seconds) to assess incidents through a process known as Dispatch on Disposition.
- Developing new clinical code sets and response categories using the best available clinical evidence.
- Developing new targets, indicators and measures.

The trials have also been independently reviewed by the University of Sheffield.

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

The new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response
- Ensure national response targets to apply to every patient for the first time – so ending 'hidden waits' for patients in lower categories
- Ensure more equitable response for patients across the call categories
- Improve care for stroke and heart attack patients through sending the right resource first time.

Due to the nature and impact of these changes, the previous performance measures are not comparable.

However, NHS England have published National Standard for a number of the key measures which are included here.



Ambulance Response Programme

Performance Summary

	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
Last month (Feb 18)	00:07:28	00:11:48	00:23:21	00:49:20	02:59:18	02:34:17
Previous month (Jan 18)	00:07:08	00:11:43	00:20:23	00:42:05	02:24:59	02:19:05
Current YTD (2017/18) * * from 1st November 2017	00:07:18	00:11:51	00:22:02	00:46:10	02:40:30	02:36:02



Demand

- **86,296** Incidents were provided with a face-to-face response.
- **Category 2** incidents reached **48,695** incidents. This accounts for **59%** of face-to-face responses.
- **7,772** incidents were categorised as **Category 1** and provided with a face-to-face response.



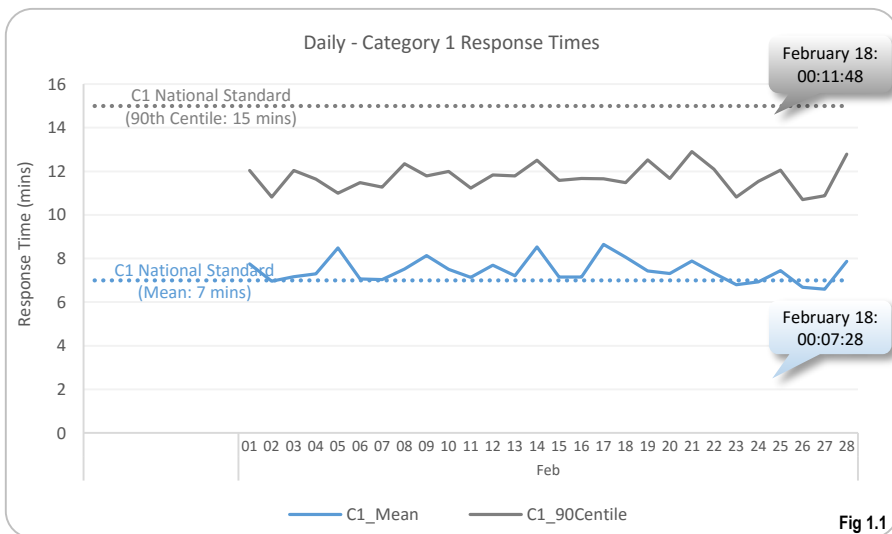
Performance

- The Mean response time for C1 was **7 minutes 28 seconds**. This is a marginal increase when compared to the previous month.
- The C1 90th Centile was **11 minutes 48 seconds**. This has remained **within the 15 minute** national standard each **week** since the implementation of ARP.
- The Mean response time for C2 was **23 minutes 21 seconds**, this is above the 18 minute national standard



Performance Overview

Daily Response Times by Category



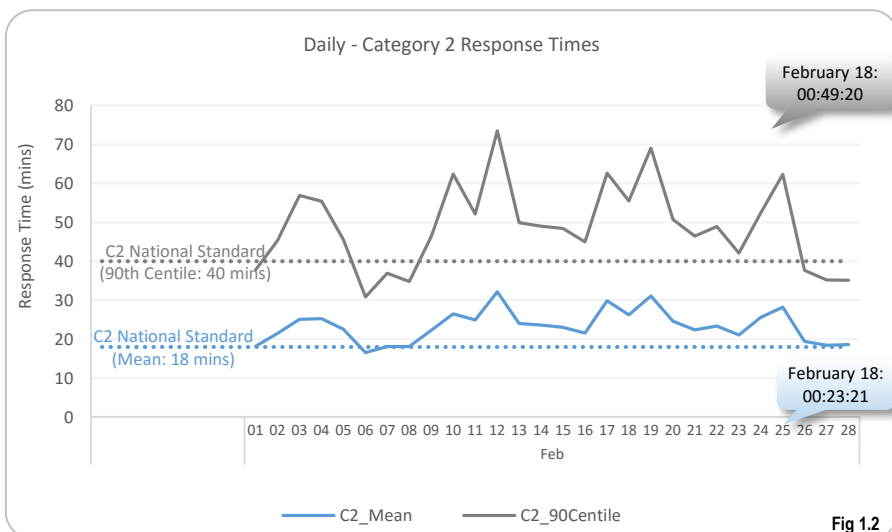
Category 1

The NEW Category 1 (C1) measure comprises of approximately 8% of all incidents and covers a wider range of conditions than the former Red 1 category. These will be responded to within an average time of seven minutes.

Fig 1.1 shows the time taken to respond to patients triaged as Category 1 (C1)

- The grey line shows the LAS 90th centile response time.
 - The dotted grey line shows the National Standard of 15 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
 - The dotted blue line shows the National Standard of 7 minutes average (mean) response time.

C1 performance was fairly consistent over the month and reducing towards the end, with the mean close to the national standard, and the 90th centile performing well within the target.



Category 2

The NEW Category 2 (C2) measure comprises of approximately 48% of all incidents. These will be responded to within an average time of 18 minutes.

Fig 1.2 shows the response time for patients triaged as Category 2 (C2)

- The grey line shows the LAS 90th centile response time.
 - The dotted grey line shows the National Standard of 40 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
 - The dotted blue line shows the National Standard of 18 minutes average (mean) response time.

Daily C2 mean saw a slight increase during a few weeks in February, but began to show an improvement towards the end of the month. The 90th Centile fluctuated during the month but also showed a considerable reduction towards the end of the month. The fluctuations could be attributed to half term and take up of annual leave.



Performance Overview

Daily Response Times by Category

Daily - Category 3 Response Times

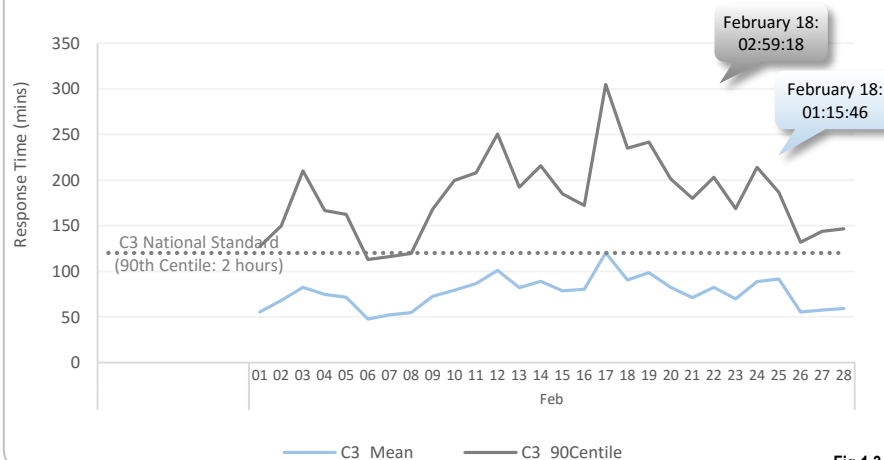


Fig 1.3

Category 3

The NEW Category 3 (C3) measure comprises of approximately 34% of all incidents.

Fig 1.3 shows the time taken to respond to patients triaged as Category 3 (C3)

- The grey line shows the LAS 90th centile response time.
 - The dotted grey line shows the National Standard of 120 minutes (2 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
 - There is no National Standard for the mean response time.

Daily - Category 4 Response Times

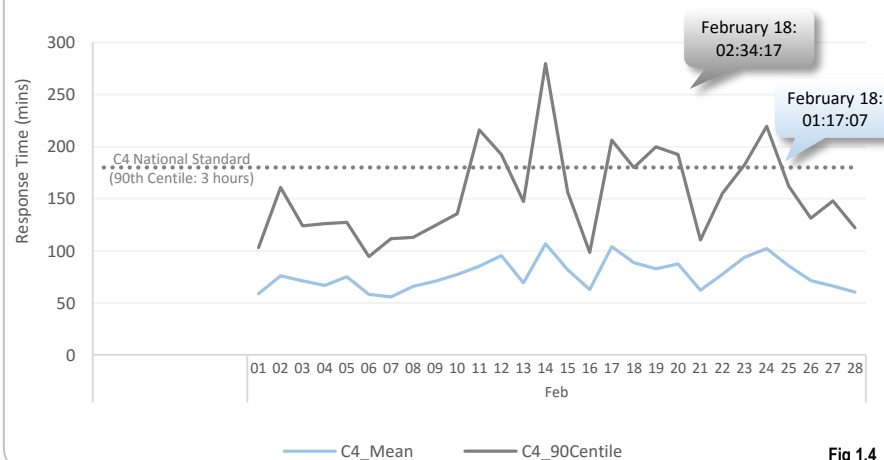


Fig 1.4

Category 4

The NEW Category 4 (C4) measure comprises of approximately 10% of all incidents.

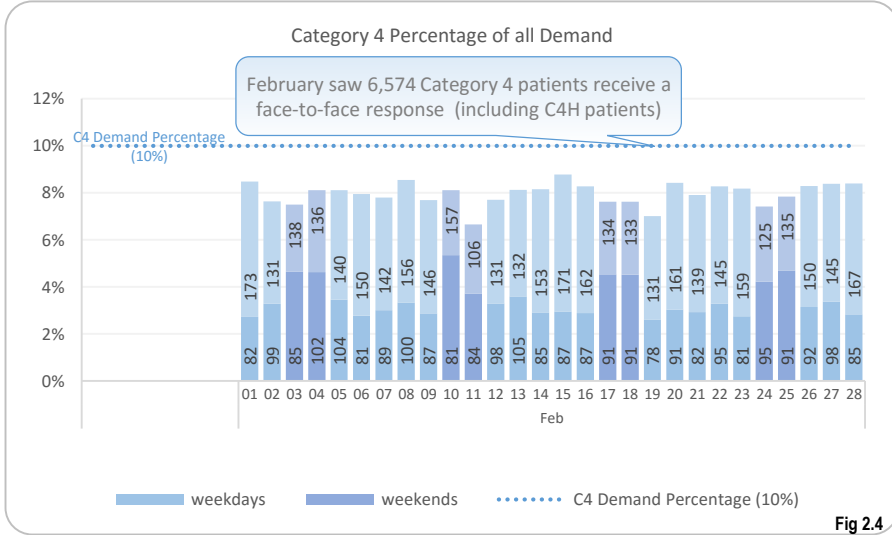
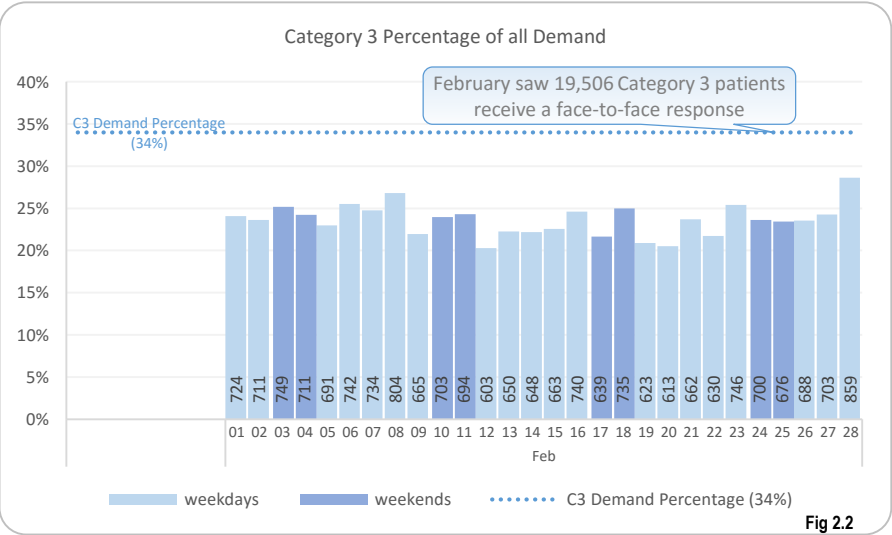
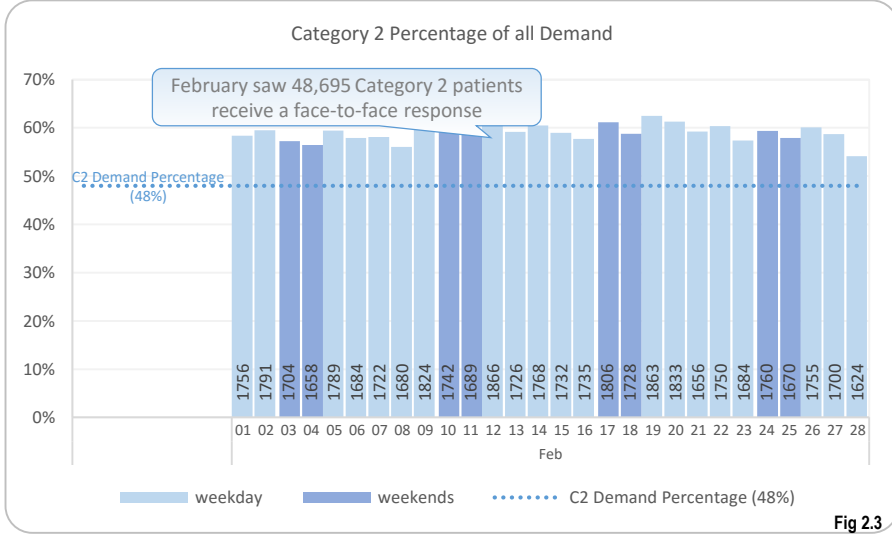
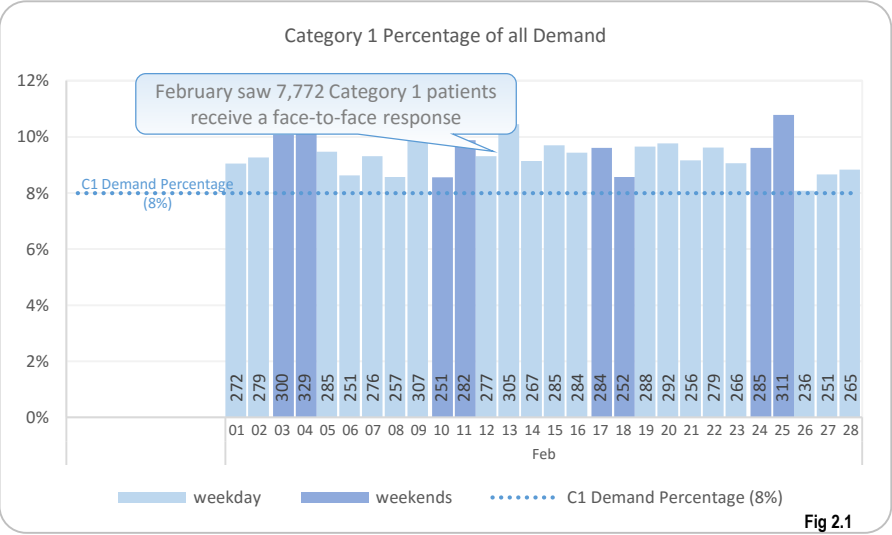
Fig 1.4 shows the response time for patients triaged as Category 4 (C4)

- The grey line shows the LAS 90th centile response time.
 - The dotted grey line shows the National Standard of 180 minutes (3 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
 - There is no National Standard the mean response time.



Performance Overview

Demand by Category





Performance Overview

90th Centile Performance

Category 1 Response Performance

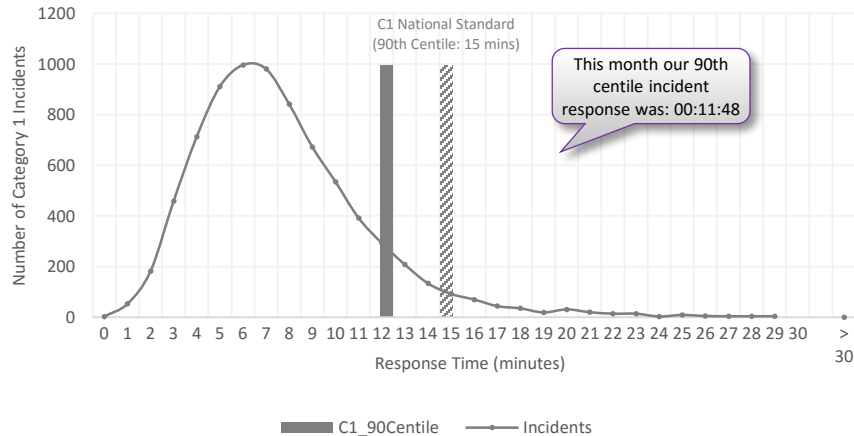


Fig 3.1

■ Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The 90th centile response time in **February** was **00:11:48** minutes, **within** the 15 minutes National Standard as set out in the guidelines by NHSI.

Of the 7,772 incidents requiring a Category 1 response, 6,994 incidents received a face to face response within 00:11:48 minutes.

This has remained similar to January (00:11:43).

The LAS 90th centile has been **consistently within the 15 minutes** standard **each week** since ARP was implemented.

Category 2 Response Performance

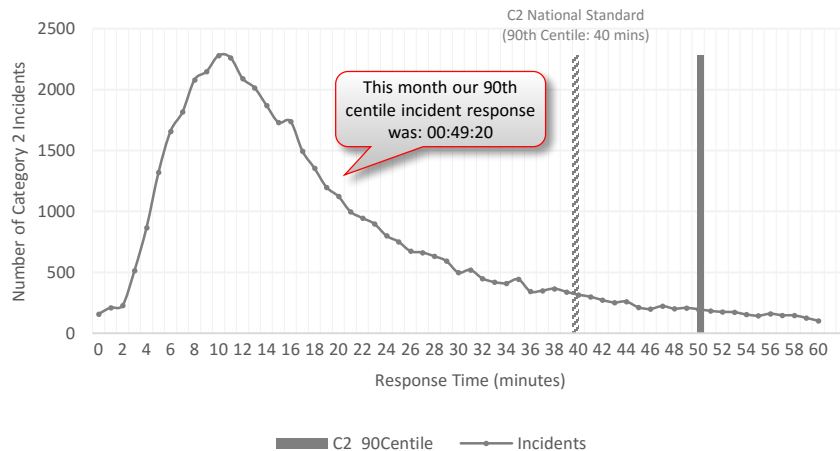


Fig 3.2

■ Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The 90th centile response time in **February** was **00:49:20** minutes, **above** the 40 minutes National Standard as set out in the guidelines by NHSI.

Of the 48,695 incidents requiring a Category 2 response, 43,817 incidents received a face to face response within 00:49:20 minutes.



Performance Overview

90th Centile Performance

Category 3 Response Performance

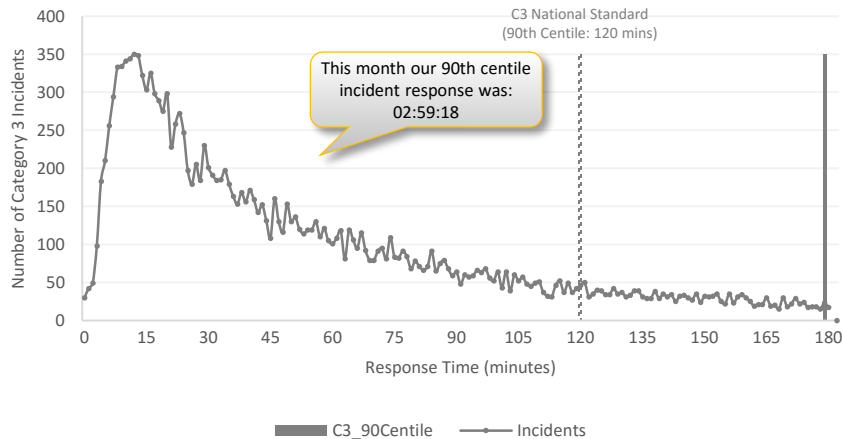


Fig 3.3

■ Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The LAS 90th centile response time in **February** was **02:59:18**. This is above the 120 minutes (2 hours) National Standard as set out in the guidelines by NHSI.

This is an increase of over **30 minutes** compared to January (02:24:59).

Of the 19,506 incidents requiring a Category 3 response, 17,621 incidents received a face to face response within 02:59:18 minutes.

Category 4 Response Performance

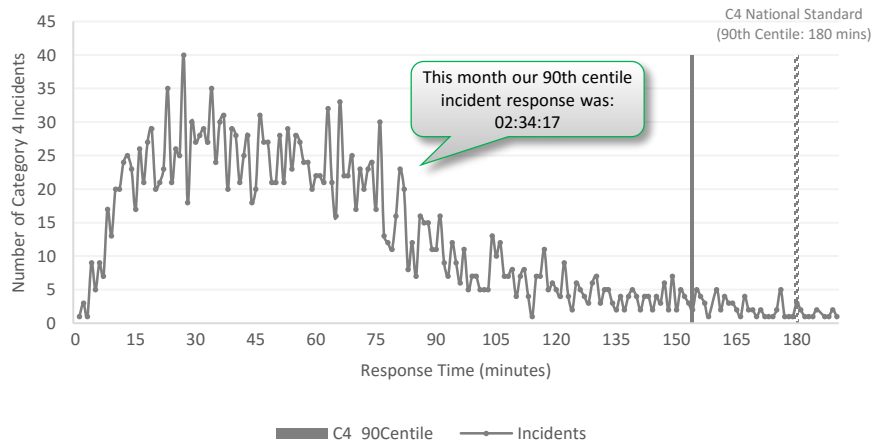


Fig 3.4

■ Fig 3.2 Demonstrates the response distribution for Category 4 incidents.

The 90th centile response time in **February** was **02:34:17** minutes, **within** the 3 hours National Standard as set out in the guidelines by NHSI.

This is a increase of 15 minutes compared to January (02:19:05).

Of the 2,526 incidents requiring a Category 4 response, 2,273 incidents received a face to face response within 02:34:17 minutes.

The LAS 90th centile has been well **within** the 3 hour standard for **16 weeks** out of 18 since ARP was implemented.



Performance Overview

Key Metric Variance

Category	Measure	LAS Monthly Performance	National Standard	Variance
Category 1	Mean Response Time	00:07:28	7 minutes	00:00:28
	90 th centile	00:11:48	15 minutes	00:03:12
Category 2	Mean Response Time	00:23:21	18 minutes	00:05:21
	90 th centile	00:49:20	40 minutes	00:09:20
Category 3	90 th centile	02:59:18	120 minutes	00:59:18
Category 4	90 th centile	02:34:17	180 minutes	00:25:43



Performance Overview

National Picture

February 2018

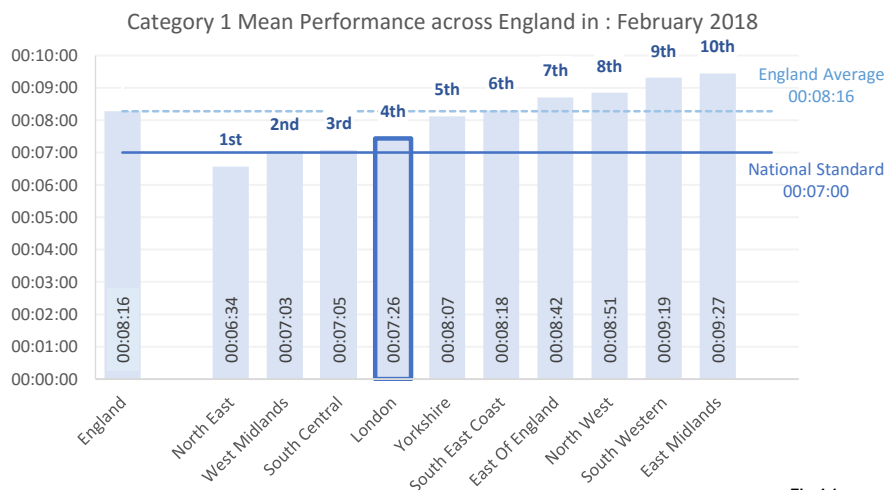


Fig 4.1

■ Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England during February 2018.

Additional information also displayed :

The National Standard (00:07:00)
The average for England (00:08:16)
The ranking position for each Trust *

- LAS achieved **7 minutes and 26 seconds** for the **mean** response time for **Category 1** patients. This is marginally above the 7 minute national standard.
- LAS ranked **fourth** when compared to 10 Ambulance Trusts across England. *
- LAS also performed **within** the England average by **50 seconds**.
- One Trusts performed within the National Standard.

* Isle of Wight not ARP compliant until Spring 2018
Data from NHS England

Fig. 4.2 Displays the six key ARP performance measures for each Ambulance Trust across England during February 2018.

- LAS ranked **2nd** in the **Category 1 90th centile** performance measure, compared to the other Trusts.
- For **Category 4 90th centile**, LAS ranked **2nd** compared to the other Trusts.

February 2018	Category 1	Category 1	Category 2	Category 2	Category 3	Category 4
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00
England	00:08:16	00:14:17	00:25:34	00:53:57	02:41:50	03:29:16
East Midlands	00:09:27	00:16:29	00:41:27	01:30:32	04:04:27	02:27:40
East of England	00:08:42	00:15:38	00:26:53	00:56:02	03:07:36	04:01:05
London	00:07:26	00:11:48	00:23:21	00:49:21	02:59:27	02:34:17
North East	00:06:34	00:10:55	00:19:57	00:40:26	02:50:44	03:01:26
North West	00:08:51	00:14:53	00:31:59	01:12:05	03:02:00	03:10:54
South Central	00:07:05	00:12:56	00:16:16	00:32:19	02:12:39	03:10:01
South East Coast	00:08:18	00:14:57	00:17:40	00:33:03	03:19:44	05:41:05
South Western	00:09:19	00:17:03	00:31:47	01:05:26	02:39:38	04:41:59
West Midlands	00:07:03	00:12:06	00:13:14	00:24:22	01:36:47	02:42:23
Yorkshire	00:08:07	00:13:57	00:25:08	00:55:13	02:24:28	03:33:15
Isle of Wight	-	-	-	-	-	-

Fig 4.2



Performance Overview

Performance by STP

February 2018

These tables show 6 key performance measures for January and February 2018 profiled by STP.

February performance reflects the impact of the adverse weather experienced across London. This resulted in small increases in response times.

Despite this, all STP areas remained within the 9 minute safety standard for the C1 mean.

- The **C1 90th Centile** remained **within the 15 minute** national standard across **all areas**.
- **C4 90th Centile** performed **within** the 3 hour national standard, in **4 of the 5 STP areas**
- **North East C3 90th centile increased by 47 minutes**, from 2 hours 27 minutes to 3 hours 14 minutes.
- **South West STP C1 mean** performance was **within the national standard of 7 minutes**.

January 2017 STP Position	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
North Central	00:07:13	00:11:48	00:21:08	00:43:25	03:06:36	02:32:42
North East	00:07:14	00:11:52	00:21:24	00:43:41	02:27:15	02:52:32
North West	00:06:58	00:11:28	00:20:10	00:41:24	02:26:55	02:12:23
South East	00:07:14	00:12:08	00:19:16	00:40:13	02:04:46	02:00:31
South West	00:07:04	00:11:16	00:19:51	00:41:25	02:01:45	01:56:58

February 2018 STP Position	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
North Central	00:07:37	00:12:24	00:24:31	00:51:25	03:42:28	03:17:46
North East	00:07:45	00:11:50	00:25:45	00:54:33	03:14:55	02:49:53
North West	00:07:34	00:11:47	00:23:51	00:51:18	03:12:56	02:42:06
South East	00:07:14	00:11:33	00:19:55	00:40:43	02:18:08	02:06:48
South West	00:06:55	00:11:27	00:21:56	00:45:05	02:36:10	02:01:38



Performance Overview

Call Answering Performance & BT Connections

February 2018

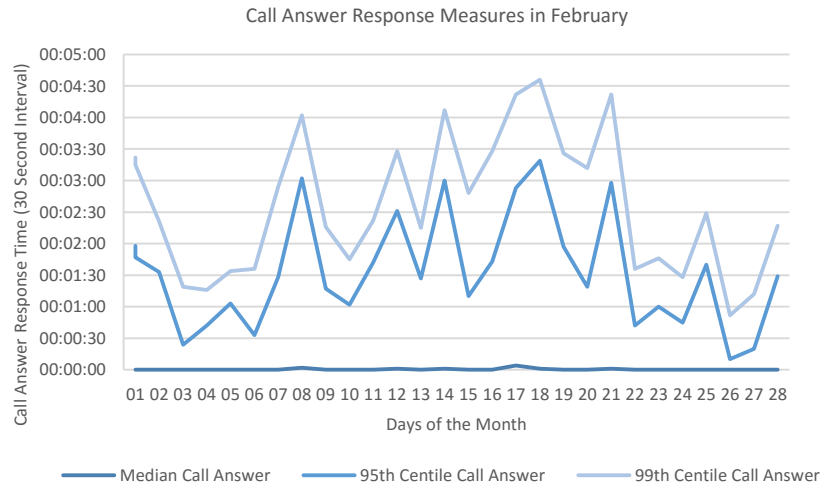


Fig 5.1

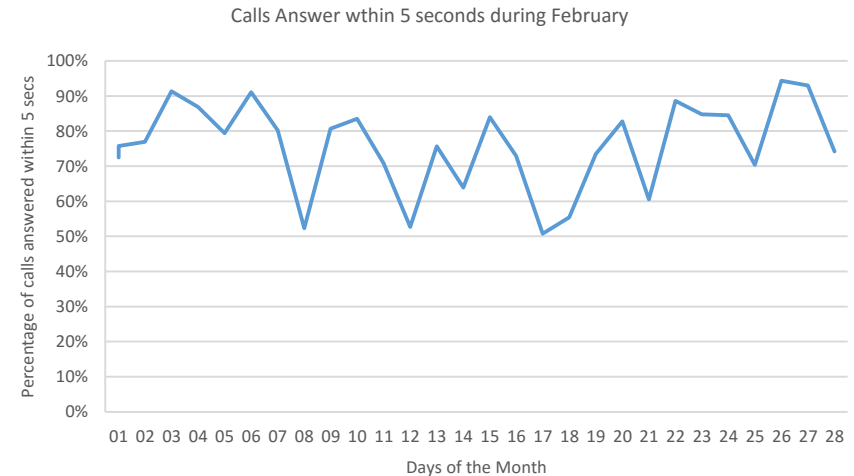


Fig 5.2

■ Figure 5.1 demonstrates **three key measures** for call answering under the Ambulance Response Programme (ARP).

- During February the median call answering was **zero seconds**.
 - This means **50% or half** of all calls received into the Emergency Operations Centre (EOC) were answered **immediately**.
- The **95th centile** was 1 minute and 29 seconds.
 - In other words 95 out of every 100 calls were answered in less than 1 minute and 29 seconds.

■ Figure 5.2 shows the percentage of calls answered within five seconds.

- In February **76%** of all **calls** received into the EOC were answered **within five seconds**.

This measure is not monitored under ARP, it is an internal measure.



Hospital Handover Summary

Hospital Conveyance Lost Hours

February 2018

In February a total of **6,199 hours** were lost at hospital.

Similar to last month, the most hours were lost at **Queens Romford** with **765** (12%) hours lost.

Ranking second highest was **Hillingdon** with **508** (8%) hours lost. Over the last 12 weeks Hillingdon has ranked in the top 8, this is a notable shift.

Northwick Park ranked third highest in with **474** (8%) hours lost.

The above 3 hospitals are responsible for **28% (1,747)** of hours lost at hospital, across London in February.

There was a marginal increase in lost hours during the half-term period (12th-18th) but then returned to circa 1,500 hours each week in February.

Non-blue calls. Arrival at hospital to patient handover, February 2018

	Arrived to Handover						
	Total Conveyances	Total Handovers	Handovers exceeding 15 mins	% over 15 mins	Overrun per breach (mins)	Total time lost over 15 mins (hrs)	12 Week Trend
Barnet	1504	1425	770	54%	16	202	
North Middlesex	2338	2213	1417	64%	12	277	
Royal Free	1430	1289	922	72%	15	237	
University College	1616	1496	1023	68%	15	255	
Whittington	1428	1328	700	53%	9	111	
Homerton	1262	1188	366	31%	5	29	
King Georges	1189	1072	956	89%	15	247	
Newham	1931	1650	1427	86%	14	335	
Queens Romford	2602	2449	2064	84%	22	765	
Royal London	2011	1808	1173	65%	8	161	
Whipps Cross	1793	1638	1258	77%	13	276	
Charing Cross	1142	1071	684	64%	7	83	
Chelsea & West	1298	1200	573	48%	6	60	
Ealing	1327	1272	662	52%	10	109	
Hillingdon	1604	1506	1182	78%	26	508	
Northwick Park	2790	2653	1365	51%	21	474	
St Marys	1797	1685	1112	66%	9	165	
St Thomas'	2024	1874	1312	70%	7	163	
West Middlesex	1694	1625	767	47%	7	93	
Kings College	1981	1857	1433	77%	10	233	
Lewisham	1390	1272	856	67%	11	163	
Princess Royal	1673	1522	867	57%	29	412	
Queen Elizabeth II	2211	2121	703	33%	10	119	
Croydon	1953	1862	1319	71%	10	217	
Kingston	1506	1438	961	67%	7	108	
St Georges	1948	1839	1260	69%	9	195	
St Helier	1217	1121	748	67%	16	204	
LAS TOTAL							
					13	6199	

Non-blue calls. Patient Handover to Green, February 2018

	Handover to Green						
	Total Conveyances	Total Handovers To Green	Handovers exceeding 14 mins	% Over 14min	Overrun Per Breach (Mins)	Total Time Lost Over 14 Minutes (Hrs)	12 Week Trend
Barnet	1504	1425	777	55%	6	83	
North Middlesex	2338	2213	1199	54%	8	151	
Royal Free	1430	1289	593	46%	7	68	
University College	1616	1496	895	60%	8	120	
Whittington	1428	1328	709	53%	7	82	
Homerton	1262	1188	654	55%	7	73	
King Georges	1189	1072	506	47%	6	54	
Newham	1931	1650	717	43%	7	80	
Queens Romford	2602	2449	1363	56%	8	179	
Royal London	2011	1808	999	55%	8	135	
Whipps Cross	1793	1638	823	50%	6	86	
Charing Cross	1142	1071	490	46%	6	49	
Chelsea & West	1298	1200	687	57%	6	70	
Ealing	1327	1272	545	43%	5	47	
Hillingdon	1604	1506	685	45%	5	59	
Northwick Park	2790	2653	1252	47%	7	153	
St Marys	1797	1685	841	50%	6	87	
St Thomas'	2024	1874	1057	56%	8	133	
West Middlesex	1694	1625	711	44%	4	50	
Kings College	1981	1857	945	51%	7	118	
Lewisham	1390	1272	599	47%	5	51	
Princess Royal	1673	1522	761	50%	5	68	
Queen Elizabeth II	2211	2121	933	44%	4	59	
Croydon	1953	1862	917	49%	5	76	
Kingston	1506	1438	671	47%	5	51	
St Georges	1948	1839	902	49%	5	77	
St Helier	1217	1121	496	44%	4	36	
					6	2292	



Hospital Handover Summary

Hospital Conveyance by Location

February 2018

This map shows the location of each ED hospital across London.

The size of the bubble relates to the comparative hours lost* at that hospital.

The larger the bubble, the more hours lost at hospital.

For example, during the reporting week, the highest hours lost were at Queens, Romford.

The fewest hours were lost at Homerton, as the bubble can barely be seen.

Total number of hours lost in hospital to patient handovers in February 2018 was 6199

The total numbers of hours lost from handover to patient to green was 2292 hours.

The hospital with the shortest time lost over 15 minutes was Homerton. The total hours lost here is 29 hours. In comparison to Queens Romford which lost 765 hours.

The average time lost in hospital to patient handover is 13 minutes.*



The average time lost from patient handover to green is 6 minutes.*

* This is per breach

Of the total number of hours lost, there were 1747 (28%) from the top 3 hospitals with the longest breaches. Whereas only 172 hours were lost from the 3 hospitals with the shortest breaches, representing 3% of the breaches.

The hospitals with the highest amount of hours lost over 15 minutes were:

1. Queens Romford (765 hours lost)
2. Hillingdon (508 hours lost)
3. Northwick Park (474 hours lost)

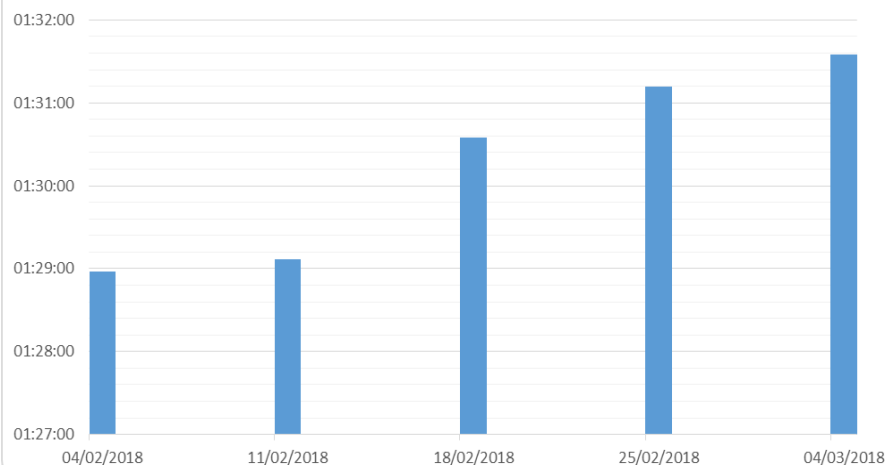
* Total time accrued after 15 minutes, for arrival at hospital to patient handover.



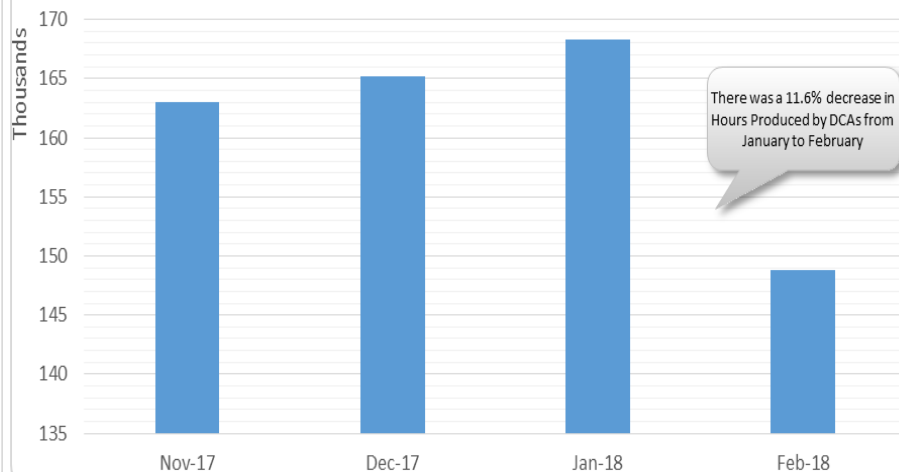
Job Cycle & Capacity Ambulance Response Programme

February 2018

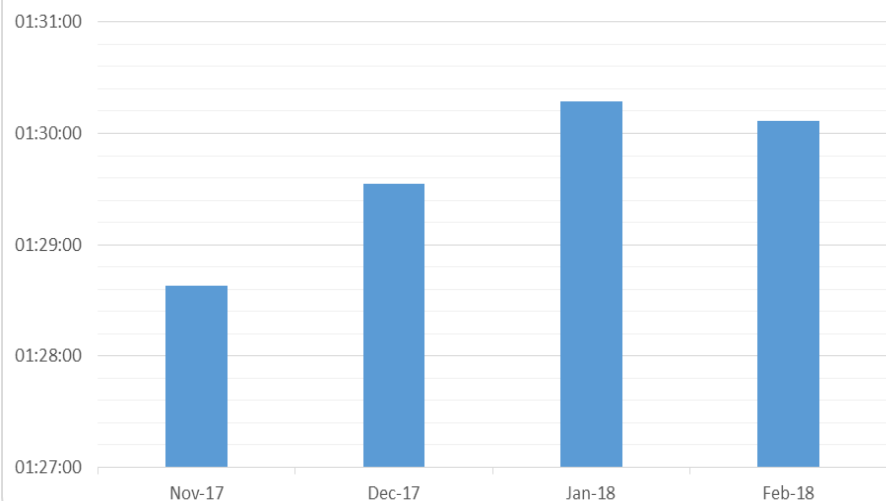
Weekly Average Job Cycle



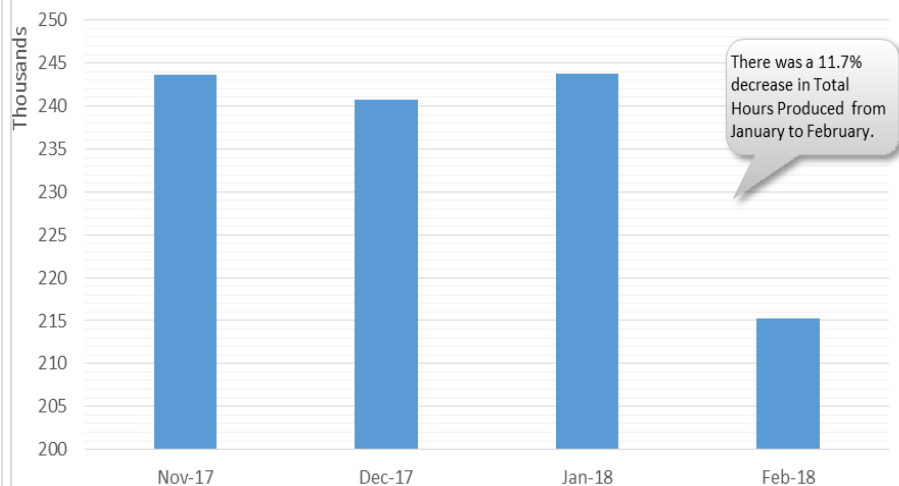
Monthly Double Crewed Ambulance Hours Produced



Average Monthly Job Cycle



Monthly Total Hours Produced

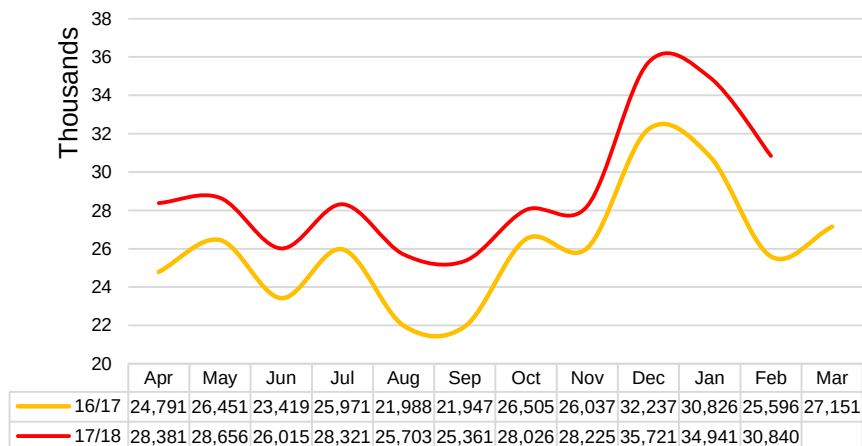




LAS 111 (South East London)

Demand and Capacity

QR02 - Calls Answered



Demand: Call volume was slightly lower than January 2018 and 19% higher than in February 2017.

Capacity: Demand exceeded capacity through our February. Additional agency Call Handler induction mapped in advance of Easter pressures in order to meet demand.

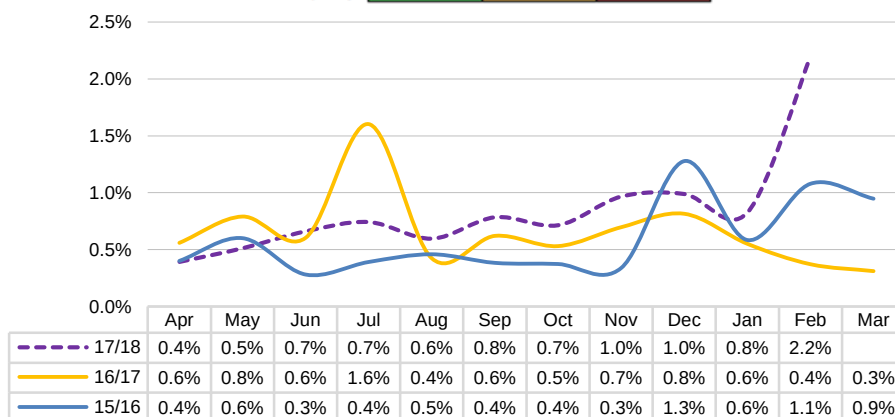
Efficiency: The percentage of calls answered in 60 seconds was 80.2% in February, with the target achieved on only 2 days. The operational focus has been on balancing access to the service and minimizing time to clinical call back and saw an increase in call backs achieved within 10 minutes.

Service Projects: The service focus throughout February has been on reducing demand on EDs through introduction of enhanced assessment of Emergency Treatment Centre dispositions.

February had a significant focus on submission of our bid for the South East London 111 and Integrated Urgent Care Service.

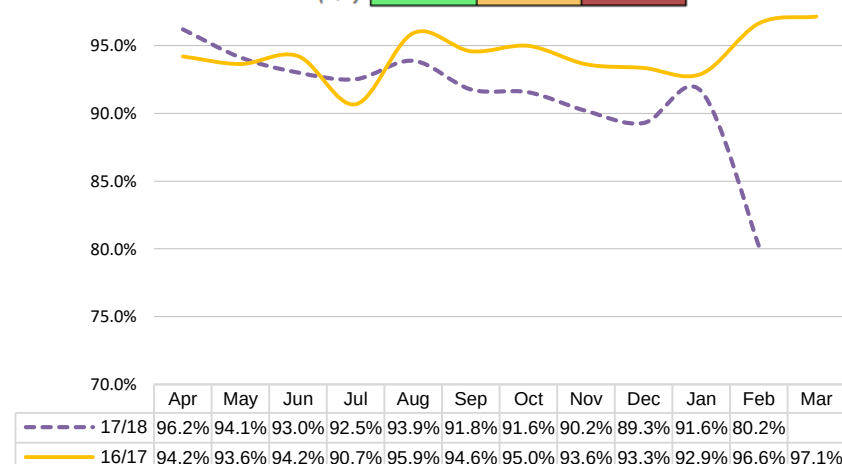
KPI 1 - Calls Abandoned after 30 Seconds

THRESHOLD (QR) <5% <=6% <=7%



KPI 2 - Calls Answered within 60 Seconds

THRESHOLD (QR) >=95% >=92% >=90%

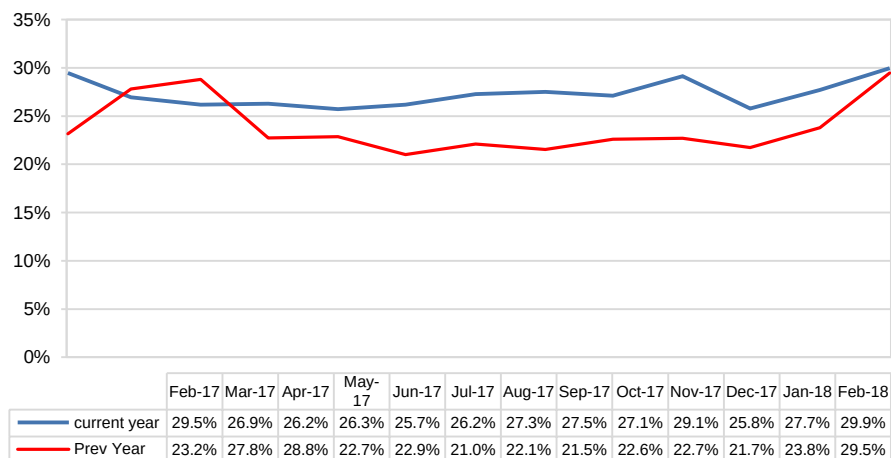




LAS 111 (South East London)

Call Destinations

QR12a: % of calls referred to a clinical advisor

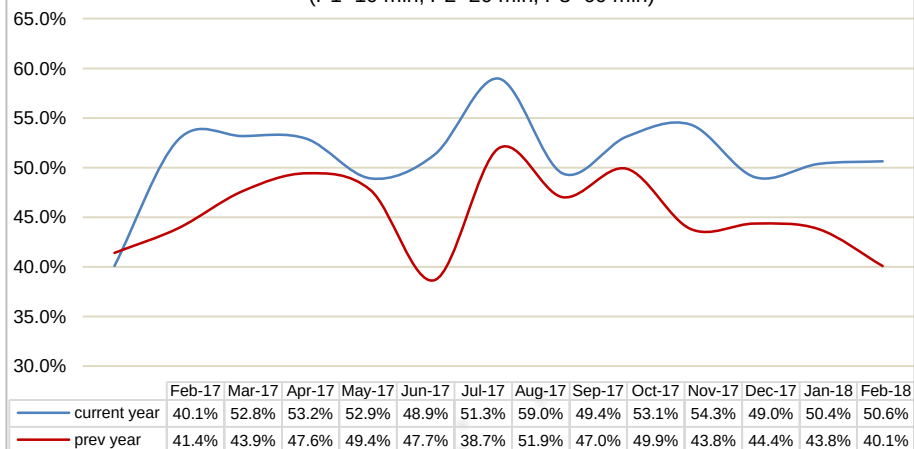


Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green ambulance outcomes and availability of Clinical Advisors to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

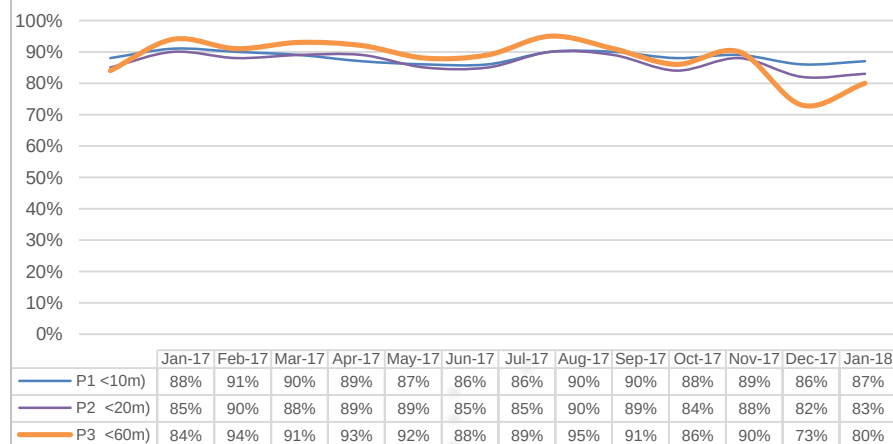
Safety: There were 56 Incidents in Datix with completed investigations in March. Of these 25% (n=14) related to authorised breaches in confidentiality including safeguarding referrals made with our patient consent, 19.6% (n=37) to failure to follow procedure, 39.2% (n=22) to delay in care. 1.8% (1) due to telephony issue and the remaining 14.3% (n=6) closed with no further action required. Incidents are under investigation and feedback given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received six complaints, three compliments, feedback from three HCPs and three complaints received about other organisations.

KPI 5
calls % warm transferred
(P1=10 min, P2=20 min, P3=60 min)



QR14 Call Backs and warm transfers
(P1=10 min, P2=20 min, P3=60 min)

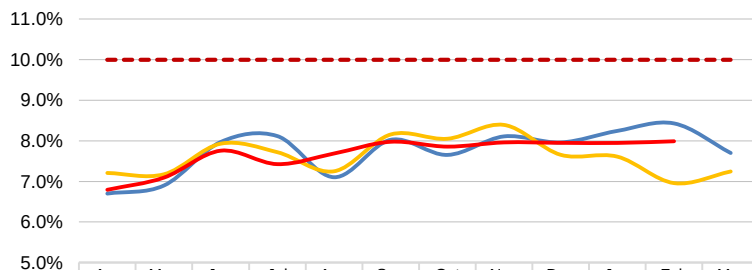




LAS 111 (South East London)

Triage Destinations

KPI 10 - Percentage of answered calls transferred to 999



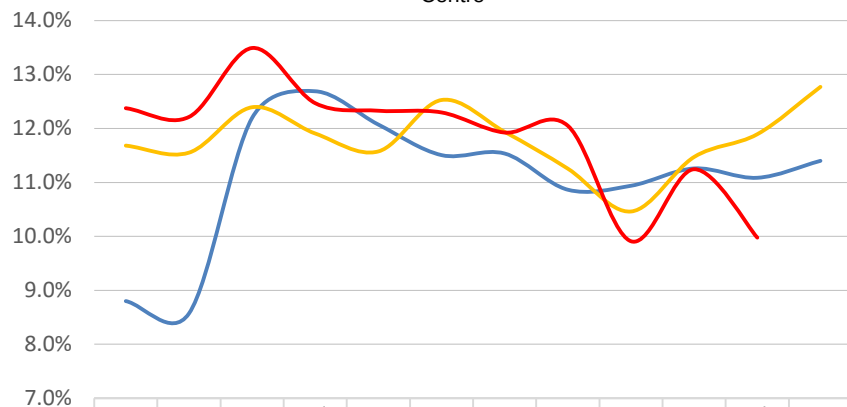
LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for Green ambulance outcomes.

Enhanced reassessment of Emergency Treatment Centre dispositions was introduced on 7th February and has resulted in a reduction in onward referrals, this figure includes Urgent Care Centres and Walk-in Centres.

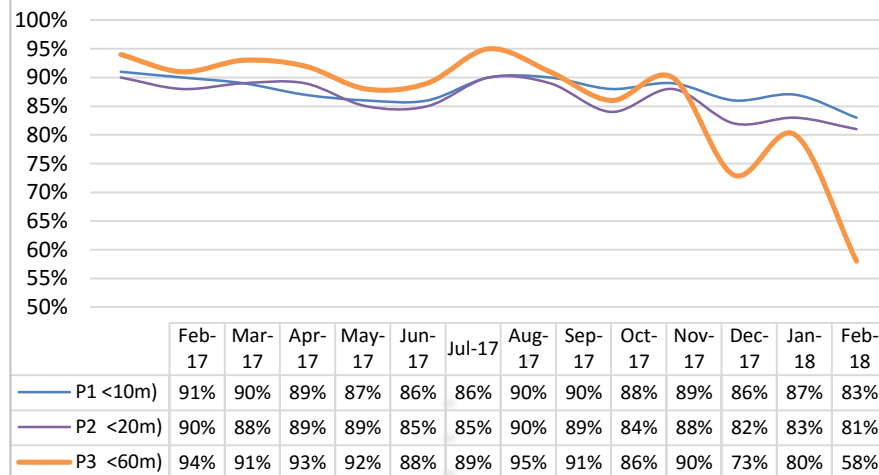
When combined, this gives an indication of the impact on Emergency and Urgent Care. LAS 111 refers the lowest number of calls overall.

Reduction in call back performance was due to increased demand and balancing access through clinicians taking call at front end and call back.

KPI 11 - Percentage of patients advised to attend Emergency Treatment Centre



KPI 7,8,9 Call Backs and warm transfers
(P1=10 min, P2=20 min, P3=60 min)





LAS 111 (South East London)

London and National Comparison – February 2018

The table below shows LAS performance on key Quality Requirements (QRs) agreed in Schedule 12 contract of the SEL CCGs contract for providing 111 services. It shows a comparison to that of the other three London providers and the regional and national totals.

Our ranking is out of five London providers.

Data is taken from the weekly NHS England 111 Situation Report, and is collated for February 2018.

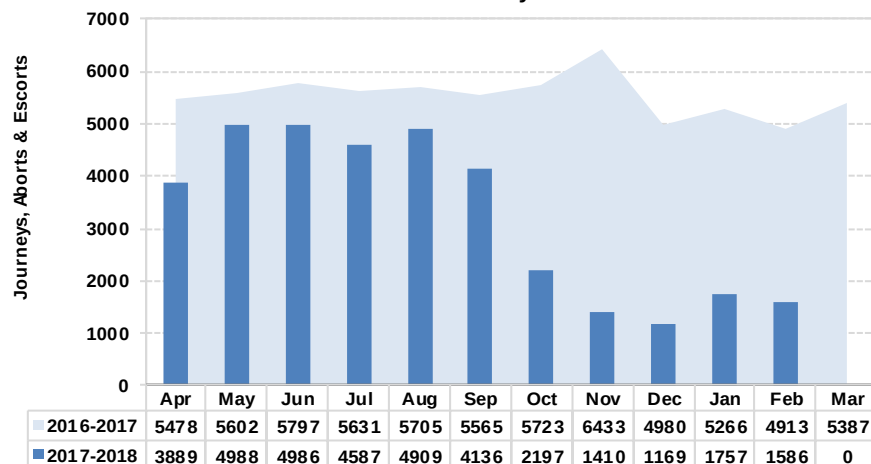
Description	Target	LAS	Care UK	LCW	PELC	Vocare	London	LAS ranking (pan-London)	England
Total calls answered	N/A	30,840	18,951	32,044	37,072	28,106	156,655		1,122,001
% of Calls answered within 60 seconds	95%	80.20%	67.28%	63.18%	79.31%	71.31%	72.90%	1	70.74%
% of Calls abandoned after 30 seconds	5%	2.20%	4.68%	8.73%	5.77%	6.06%	5.77%	1	6.70%
% of Calls transferred to, or answered by a clinical advisor	N/A	29.37%	22.90%	32.15%	26.12%	24.42%	27.38%		23.56%
Of calls transferred, percentage transferred warm	N/A	49.70%	25.05%	81.03%	65.25%	35.64%	56.41%		34.55%
Of call backs, percentage within 10 minutes	100%	45.85%	49.38%	35.72%	58.10%	48.80%	48.47%	4	38.92%
% of Calls referred to 999	10%	7.79%	11.19%	12.26%	9.42%	10.04%	10.04%	1	11.38%
% of Calls referred to Emergency Department	N/A	10.02%	8.97%	10.75%	10.45%	10.21%	10.21%	2	8.10%



Patient Transport Service

Activity Update and Profitability Update

PTS Total Activity - Contracted, A&EReferrals and Extra Contractual Journeys



February saw a stable level in the number of journeys with a total of 1,586 journeys being delivered as compared to the January total of 1,757 journeys.

Delivery was maintained against a background of continued recovery from current winter pressures and adverse weather conditions.

PTS now have only two contracts operating; St Georges Community in South West London and North East London Mental Health in East London. Both of these contracts are expected to finish by March / April 2018.

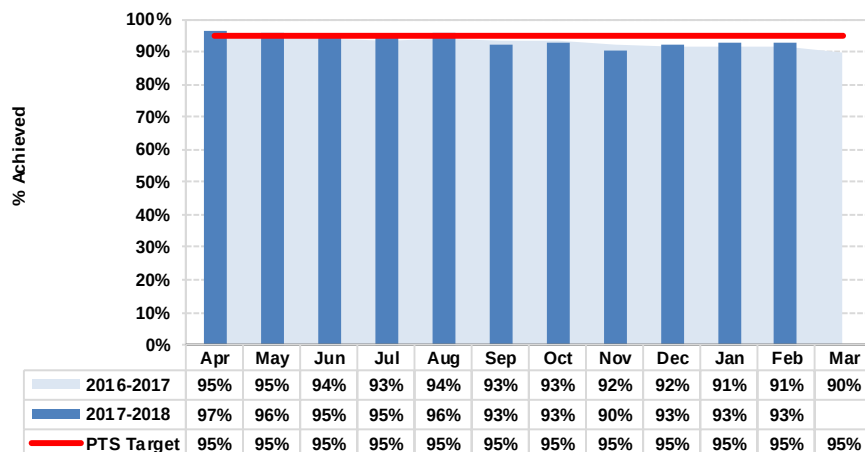
Month	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Apr	15044	13227	8495	5478	3889
May	15987	13164	7943	5602	4988
Jun	14852	10129	8967	5797	4986
Jul	16481	10508	8923	5631	4587
Aug	14401	9028	5457	5705	4909
Sep	15002	9602	6097	5565	4136
Oct	16739	10957	5841	5723	2197
Nov	15981	10063	5989	6433	1410
Dec	13986	9250	4943	4980	1169
Jan	16409	9753	5103	5266	1757
Feb	15232	9787	5306	4913	1586
Mar	13978	10520	5264	5387	
Total	184092	125988	78328	66480	35614



Patient Transport Service

KPI Update

Arrival at Hospital Against Appointment Time

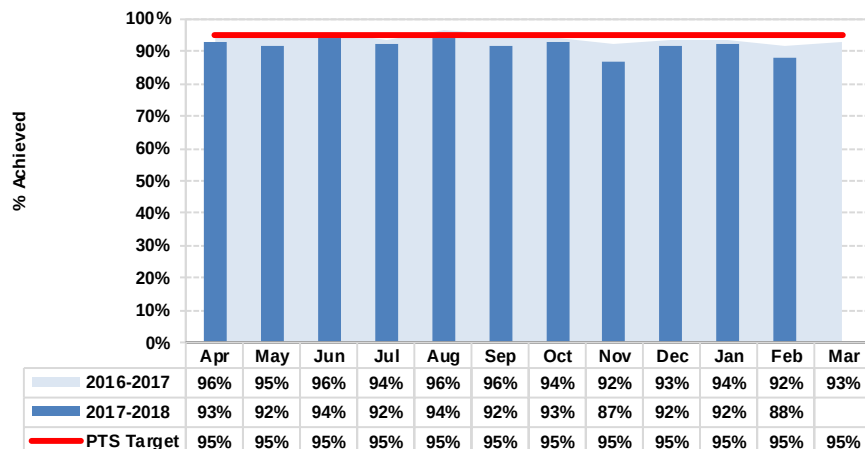


The arrival at hospital against the appointment time was maintained at 93% in February, but was below the 95% target.

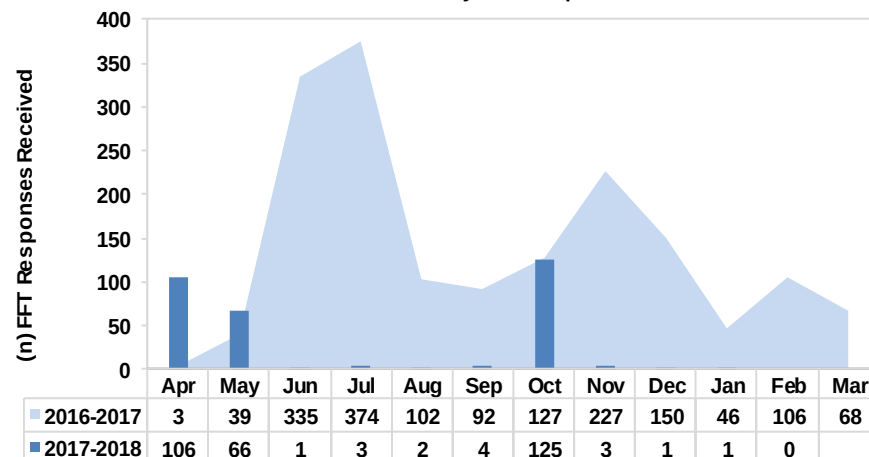
Our activity profile is linked to one of the remaining two contracts where we are providing transport in the community settings with longer distances and spread of care centres where patients are being taken to.

Departure against patient ready time saw a drop to 88% for February against the background of activity as given above. This was below the target of 95%.

Departure Against Patient Ready Time

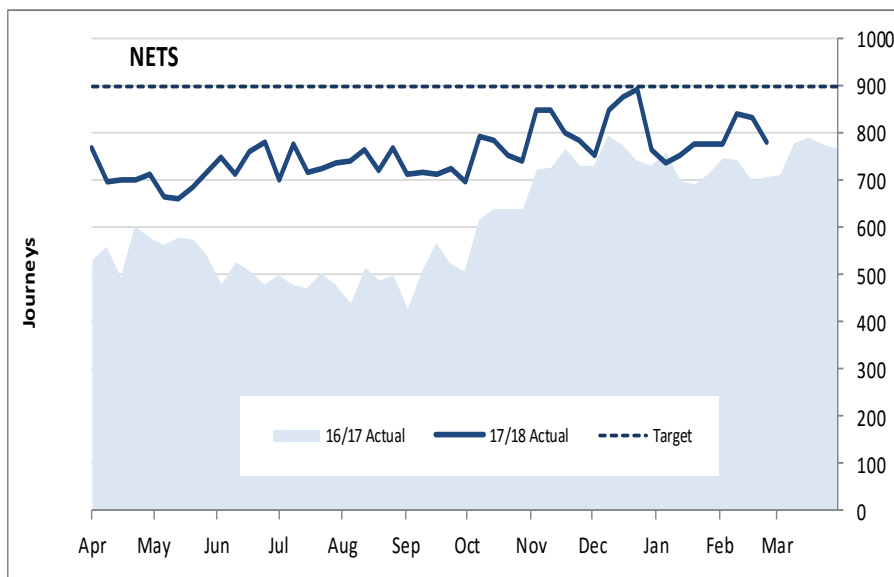


PTS Friends & Family Test Responses Received





Non-Emergency Transport Service



Non-Emergency Transport Update

NETs saw an increase in the month and delivered an average of 818 journeys per week for the month, up from the previous month average of 765.

During February we saw the NETs overall weekly performance being maintained at a level in line with the impacts of resources, activity levels and waiting times.

The team maintained its continued focus in ensuring the quality and number of calls to the NETS dispatch group was maintained. The average number of calls passed to NETS also increased from last months 1,036 per week to 1,156 calls per week for the month.

NETS staffing/resourcing was also impacted by high rates of short term sickness over the month averaging at 4.5%.

Performance continued to suffer due to increasingly lengthy handover times at hospitals with specific issues with North West London hospitals.

From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETS and completed.

Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
01/01/2018	1136	7	394	735
08/01/2018	934	7	173	754
15/01/2018	1032	8	244	780
22/01/2018	1042	12	251	779
29/01/2018	1037	4	260	773
05/02/2018	1170	14	318	838
12/02/2018	1066	9	226	831
19/02/2018	1212	13	415	784
26/02/2018	1177	17	339	821

Our Money



Financial Indicator	Summary Performance	Forecast Outturn	Current Month	Previous month
Surplus / Deficit (Year to date and Forecast)	Year to date the position is £3.6m ahead of plan and £3.7m ahead of re-phased budget. The Trust is forecasting a deficit of £0.6m at the end of 2017/18.	GREEN	GREEN	GREEN
	Key issues in the position are: - Income is £2.4m adverse compared to re-phased budget due to the budget including over activity at 3% and only 1.8% being achieved YTD. - On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued demand pressure			
Income	Income is £0.1m adverse in month, and £3m adverse year to date compared to re-phased budget due to: - PTS £0.1m favourable variance in month as contract was initially budgeted to have ended in July. - Main contract activity for M11 YTD is 1.9% higher than the contract baseline, and the variable income in relation to this (£4.1m) has been recognised in the Trust accounts. - The risk regarding the central funding for the Paramedic band 6 re-banding previously removed following confirmation that LAS meets all the requirements in 2017/18 may need to be reinstated following discussions at P&OD, the Trust will consider whether further provision is required in month 12.	AMBER	GREEN	GREEN
Expenditure (incl. Financial Charges)	In month expenditure is £0.6m favourable to re-phased budget in month, and £5.6m favourable YTD. The key drivers for this are: - On-going vacancies in operational pay (incl. EOC) (£2m favourable in month, £22.2m favourable YTD) - PAS overspends to compensate for vacancies (£0.6m unfavourable in month, £5.1m unfavourable YTD) are offset by various underspends in budgeted services spend	GREEN	GREEN	GREEN
CIPs	Year to date CIPs are £8.2m behind plan and are currently offset by non recurrent underspends on pay budgets. The Trust will now not deliver the full £17.8m planned CIP recurrently in 17/18 and has improved governance for recurrent efficiency programme implementation and tracking in 2018/19.	RED	RED	AMBER
Balance Sheet	Capital spend is £13.8m against the initial Capital plan of £23.2m, £9.4m behind plan. The forecast is to spend £21.9m vs the plan of £24.9m. In month 7 the Trust revised its Capital plan and this spend is £7.5m behind this plan. In addition to the previously reported confirmation of the carry forward and Digital Maturity funding, the Trust has received a further £0.64m to fund improvements to Cyber Security.	GREEN	GREEN	AMBER
Cashflow	Cash is £31.8m, £10.4m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £6.4m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £0.7m above planned, DH have not approved the original £5.5m of central capital funding in the plan and there are higher than planned creditor payments of £7.1m. These movements are being offset by under payments of £11.1m on capital, provision of £1.0m and £10.3m on pay.	GREEN	GREEN	GREEN
BPPC	Non-NHS 72%, NHS 76% performance (volume) for this month, performance is still below 95% target. The financial computer system upgrade in December has contributed to the fall in performance, there is a delay in scanning invoices at our shared service supplier. The matter has been escalated to their operations director.	AMBER	AMBER	AMBER



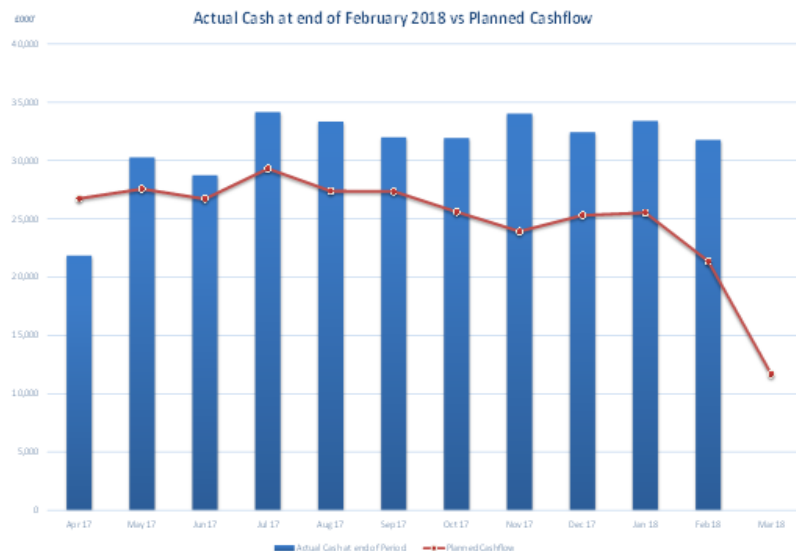
Executive Summary – Key Financial Metrics

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Cumulative Net Position - Budget vs Actual



Actual Cash at end of February 2018 vs Planned Cashflow



	Month 11 2017-18			YTD Month 11 2017-18			Full Year 2017-18
	£000			£000			£000
	Re-phased Budget	Actual	Variance fav / (adv)	Re-phased Budget	Actual	Variance fav / (adv)	Plan
Surplus / (Deficits)	(1,768)	(1,204)	564	(4,267)	(569)	3,698	(2,438)
EFL				(1,290)	(13,057)	11,767	12,538
CRL				20,695	14,100	6,595	28,806
Suppliers paid within 30 days - NHS	95%	76%	(19.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	72%	(23.0%)	95%	85%	(10.0%)	95%
EBITDA %	-0.5%	1.0%	1.5%	3.9%	4.6%	0.7%	5.0%
EBITDA	(139)	285	424	12,837	15,110	2,273	18,185
NRAAF (net return after financing)				0.41%	2.95%	2.5%	1.2%
Liquidity Days				(2.65)	2.03	4.68	(9.90)
Use of Resources Rating				2.0	1.0	1.0	2.0

- Year to date the position is £3.6m ahead of plan and £3.7 ahead of re-phased budget. The Trust has a full year outturn plan of a £2.4m deficit. The month 11 forecast outturn is £0.2m deficit, £1.8m better than plan.
- Income is £0.1m adverse in month due to adjustments made to the phasing of contract income and CQUIN.
- On-going vacancies in core frontline staff groups offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued high demand.
- Demand is currently running above 2017-18 contracted baseline activity (2016-17 contract activity plus 6%) by circa 1.9% YTD, lower than the level included in the budget of 3%. This figure differs from the figures quoted in the weekly performance packs as the weekly performance data includes activity for dates outside the reporting period (i.e. week 1 includes 2016/17 activity and the YTD activity in the weekly performance packs will not align exactly to the end of each month).
- CRL position – the capital plan is £9.4m behind target.
- Cash is £31.8m, £10.4m above plan. This is made up of a number of offsetting variances. The Trust has overdue debts of £6.4m. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £0.7m above planned, DH have not approved the original £5.5m of central capital funding in the plan and there are higher than planned creditor payments of £7.1m. These movements are being offset by under payments of £11.1m on capital, provision of £1.0m and £10.3m on pay.
- Non-NHS 72%, NHS 76% performance (volume) for this month, performance is still below 95% target. The financial computer system upgrade in December has contributed to the fall in performance, there is a delay in scanning invoices at our shared service supplier. The matter has been escalated to their operations director.



Forecast and CIP Outturn (I&E)

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Performance Review Meetings - Financial Proforma

Divisional Budget Summary

2017/18

Division	Income and Expenditure					
	YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Central Corporate	23,058	17,409	5,649	25,634	21,265	4,369
Central Income	(315,629)	(311,252)	(4,377)	(346,668)	(346,093)	(575)
Chairman & Non-Executives	102	98	3	111	107	4
Chief Executive	2,882	2,561	321	3,112	2,776	335
Corporate Services	4,310	3,984	327	4,702	4,379	323
Estates	9,572	9,474	99	10,400	10,457	(57)
Finance	3,143	2,575	568	3,435	2,892	543
Fleet & Logistics	24,980	29,377	(4,397)	27,188	32,672	(5,483)
IM&T	13,043	11,628	1,415	14,478	13,256	1,222
Clinical Education & Standards	12,349	8,811	3,538	13,336	10,406	2,929
Medical	4,564	3,718	845	4,975	4,356	619
111 Service	(68)	(233)	165	(94)	(176)	82
Central Operations	21,348	19,810	1,538	23,265	21,908	1,357
Control Services	21,400	22,316	(916)	23,400	24,282	(882)
Core Frontline Central	19,156	39,252	(20,097)	20,388	42,578	(22,191)
South East Sector	32,142	29,114	3,028	35,062	31,833	3,230
South West Sector	20,708	19,626	1,082	22,589	21,378	1,210
North West Sector	34,641	30,518	4,123	37,789	33,389	4,400
North Central Sector	23,353	20,082	3,271	25,475	21,989	3,485
North East Sector	30,914	26,146	4,768	33,721	28,598	5,123
Non Emergency Transport	6,363	5,874	489	6,937	6,471	465
Patient Transport Service	(331)	(509)	177	(331)	(492)	161
Performance	1,101	793	308	1,201	850	351
Quality & Assurance	3,050	2,658	392	3,351	2,968	384
Special Measures	0	0	0	0	0	0
Communications	946	866	80	1,032	976	55
Support Services Senior Mngmnt	0	(0)	0	0	(0)	0
Strategy	1,437	726	711	1,643	943	701
People & Organisational Development	5,736	5,148	588	6,317	6,220	98
Total	4,267	569	3,698	2,446	188	2,258

Memorandum Items Cost Improvement Plan

	YTD			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
	(2,599)	(2,228)	(371)	(2,899)	(2,741)	(158)
	(2,000)	0	(2,000)	(2,225)	0	(2,225)
	0	0	0	0	0	0
	(231)	(591)	360	(250)	(610)	360
	0	0	0	0	0	0
	(231)	(236)	5	(250)	(255)	5
	0	0	0	0	0	0
	(1,129)	(584)	(545)	(1,257)	(582)	(675)
	0	0	0	0	0	0
	(160)	0	(160)	(250)	0	(250)
	0	0	0	0	0	0
	0	0	0	0	0	0
	(440)	(1,978)	1,538	(500)	(1,352)	852
	(1,880)	(1,002)	(878)	(2,000)	(1,126)	(874)
	(5,805)	0	(5,805)	(6,550)	0	(6,550)
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	(889)	(1,272)	383	(1,000)	(1,454)	454
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
	(546)	(319)	(227)	(600)	(380)	(220)
	(15,910)	(8,210)	(7,700)	(17,781)	(8,500)	(9,281)

Year to date CIPs are £7.7m behind plan and are currently offset by non recurrent underspends on pay budgets. Program planning with operational, support and corporate managers continues, however enhanced governance and tracking of CIP delivery is required to ensure the Trust achieves the full year plan of £17.8m.

NB: Forecast above is before month 11 performance review updates.



Statement of Comprehensive Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Month 11 2017-18 £000				YTD Month 11 2017-18 £000					Full Year 2017-18 £000		
	Plan	Re-phased Budget	Actual	Re-phased Budget Variance fav/(adv)	Plan	Re-phased Budget	Actual	Plan Variance	Re-phased Budget Variance fav/(adv)	Re-phased Budget	Forecast	Re-phased Budget Variance fav/(adv)
Income												
Income from Activities	28,162	28,394	28,288	(105)	317,341	326,311	323,335	(4,006)	(2,976)	358,182	355,444	(2,738)
Other Operating Income	287	287	356	69	2,384	2,385	3,434	1,050	1,049	2,673	4,754	2,080
Total Income	28,449	28,681	28,645	(36)	319,725	328,696	326,768	(2,957)	(1,928)	360,855	360,198	(658)
Operating Expense												
Pay	(22,013)	(22,335)	(21,299)	1,237	(247,781)	(246,992)	(235,956)	11,825	11,036	(269,210)	(259,312)	9,898
Non Pay	(5,939)	(6,285)	(7,061)	(776)	(67,301)	(68,867)	(75,703)	(8,402)	(6,836)	(74,968)	(83,873)	(8,905)
Total Operating Expenditure	(27,952)	(28,620)	(28,360)	460	(315,082)	(315,859)	(311,658)	3,424	4,200	(344,178)	(343,184)	994
EBITDA	497	(139)	285	424	14,643	12,837	15,110	467	2,273	16,677	17,013	336
EBITDA margin	1.7%	(0.5%)	1.0%	1.5%	4.4%	3.9%	4.6%	0.2%	0.7%	4.6%	4.7%	(0.3%)
Depreciation & Financing												
Depreciation & Amortisation	(1,497)	(1,275)	(1,101)	174	(14,890)	(13,212)	(11,934)	2,956	1,279	(14,487)	(13,107)	1,380
PDC Dividend	(350)	(350)	(350)	0	(3,850)	(3,854)	(3,850)	0	4	(4,204)	(4,200)	4
Finance Income	8	8	14	6	88	87	89	1	2	95	92	(3)
Finance Costs	(11)	(11)	(2)	9	(121)	(126)	(25)	96	100	(137)	(27)	110
Gains & Losses on Disposals	0	0	(49)	(49)	0	0	41	41	41	0	41	41
Total Depreciation & Finance Costs	(1,850)	(1,629)	(1,489)	140	(18,773)	(17,105)	(15,679)	3,094	1,425	(18,733)	(17,202)	1,532
Net Surplus/(Deficit)	(1,353)	(1,768)	(1,204)	564	(4,130)	(4,267)	(569)	3,561	3,698	(2,056)	(188)	1,868
NHSI Adjustments to Fin Perf												
Remove Depr on Donated assets	3	3	3	0	33	35	35	2	0	38	39	1
Remove STP funding 2016/17	0	0	0	0	0	0	(419)	(419)	(419)	(420)	(419)	1
Adjusted Financial Performance	(1,350)	(1,765)	(1,200)	564	(4,097)	(4,232)	(953)	3,144	3,279	(2,438)	(569)	1,869
Net margin	(4.8%)	(6.2%)	(4.2%)	2.0%	(1.3%)	(1.3%)	(0.2%)	1.1%	1.1%	(0.6%)	(0.1%)	0.6%

Actual and Forecast Expenditure by Month



Income

- YTD the Trust has achieved £4.1m of its annual Cquin of £7.8m. The month 11 forecast has provided £691k against the annual total.
- Main contract activity for M11 YTD is 1.9% higher than the contract baseline, and the income relating to this (£4.1m) has been recognised in the Trust accounts.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £11m under re-phased budget, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure (£5.1m YTD) in non-pay. This underspend is expected to reduce with targeted recruitment.
- Private Ambulance expenditure is overspent by £5.1m (this is offset by vacancies as noted) and rent, leases costs and training and recruitment related expenditure are underspent due to differences in the phasing of the budget vs actual expenditure.

EBITDA

- The Trust delivered an EBITDA of £0.3m in February which represents 1%. This was due to increased income in January through over performance.

Depreciation and Financing

- Overall Financial Charges are £1.4m favourable YTD to re-phased budget due to lower than budgeted depreciation and slippage in the capital programme.

Risks

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



Main Contract Variable Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Month:	Feb-18	2017-18 Monthly Contract Base (2016-17 Plan plus 6%)			2017-18 Actual Activity			2017-18 Actual Activity Increase / (Decrease) vs Contract Base			Total Incidents Difference to Contract Base (%)	CCG Split Based on Incident Difference
Area	CCG Names	Cat A	Cat C (incl Othe	Total Incidents	Cat A	Cat C (incl Othe	Total Incidents	Cat A	Cat C (incl Othe	Total Incidents		
NEL	NHS City and Hackney CCG	16,740	17,245	33,985			34,360			375	1.10%	£ 79,125.00
NEL	NHS Newham CCG	19,945	19,373	39,318			38,234			-1,084	-2.76%	£ 228,724.00
NEL	NHS Tower Hamlets CCG	16,798	15,297	32,095			31,845			-250	-0.78%	£ 52,750.00
NEL	NHS Waltham Forest CCG	15,406	14,698	30,104			28,937			-1,167	-3.88%	£ 246,237.00
NEL	NHS Barking and Dagenham CCG	13,478	14,075	27,553			26,888			-665	-2.41%	£ 140,315.00
NEL	NHS Havering CCG	15,243	16,692	31,935			32,275			340	1.06%	£ 71,740.00
NEL	NHS Redbridge CCG	16,324	15,811	32,135			32,171			36	0.11%	£ 7,596.00
NEL	NEL Total	113,934	113,191	227,125	0	0	224,710	0	0	-2,415	-1.06%	£ 509,565.00
NCL	NHS Barnet CCG	20,066	20,544	40,610			40,975			365	0.90%	£ 77,015.00
NCL	NHS Camden CCG	16,735	16,257	32,992			33,447			455	1.38%	£ 96,005.00
NCL	NHS Enfield CCG	19,877	17,197	37,074			37,022			-52	-0.14%	£ 10,972.00
NCL	NHS Haringey CCG	15,392	14,806	30,198			30,564			366	1.21%	£ 77,226.00
NCL	NHS Islington CCG	14,075	14,991	29,066			29,091			25	0.09%	£ 5,275.00
NCL	NCL Total	86,145	83,795	169,940	0	0	171,099	0	0	1,159	0.68%	£ 244,549.00
NWL	NHS Brent CCG	19,742	18,610	38,352			39,716			1,364	3.56%	£ 287,804.00
NWL	NHS Harrow CCG	11,442	11,709	23,151			24,809			1,658	7.16%	£ 349,838.00
NWL	NHS Hillingdon CCG	18,817	22,023	40,840			42,409			1,569	3.84%	£ 331,059.00
NWL	NHS Central London (Westminster) CCG	17,380	16,007	33,387			35,706			2,319	6.95%	£ 489,309.00
NWL	NHS Ealing CCG	19,321	18,815	38,136			41,190			3,054	8.01%	£ 644,394.00
NWL	NHS Hammersmith and Fulham CCG	10,772	10,306	21,078			23,375			2,297	10.90%	£ 484,667.00
NWL	NHS Hounslow CCG	15,878	15,713	31,591			31,139			-452	-1.43%	£ 95,372.00
NWL	NHS West London CCG	13,166	13,146	26,312			28,186			1,874	7.12%	£ 395,414.00
NWL	NWL Total	126,518	126,329	252,847	0	0	266,530	0	0	13,683	5.41%	£ 2,887,113.00
SEL	NHS Bexley CCG	12,835	14,584	27,419			28,491			1,072	3.91%	£ 226,192.00
SEL	NHS Bromley CCG	16,016	18,859	34,875			35,313			438	1.26%	£ 92,418.00
SEL	NHS Greenwich CCG	15,438	16,316	31,754			32,035			281	0.88%	£ 59,291.00
SEL	NHS Lambeth CCG	19,149	22,021	41,170			40,029			-1,141	-2.77%	£ 240,751.00
SEL	NHS Lewisham CCG	15,671	16,750	32,421			33,641			1,220	3.76%	£ 257,420.00
SEL	NHS Southwark CCG	18,497	21,587	40,084			40,040			-44	-0.11%	£ 9,284.00
SEL	SEL Total	97,606	110,117	207,723	0	0	209,549	0	0	1,826	0.88%	£ 385,286.00
SWL	NHS Croydon CCG	21,512	24,018	45,530			47,656			2,126	4.67%	£ 448,522.70
SWL	NHS Kingston CCG	7,724	9,686	17,410			18,069			659	3.79%	£ 139,049.00
SWL	NHS Merton CCG	9,203	11,822	21,025			21,621			596	2.83%	£ 125,756.00
SWL	NHS Richmond CCG	7,753	10,042	17,795			17,886			91	0.51%	£ 19,201.00
SWL	NHS Sutton CCG	9,695	12,503	22,198			23,218			1,020	4.60%	£ 215,220.00
SWL	NHS Wandsworth CCG	14,346	16,473	30,819			31,291			472	1.53%	£ 99,592.00
SWL	SWL Total	70,233	84,544	154,777	0	0	159,741	0	0	4,964	3.21%	£ 1,047,340.70
London Total		494,436	517,976	1,012,412	0	0	1,031,629	0	0	19,217	1.90%	£ 4,054,723.70

Initial reported activity ay M11 YTD was 1.9% above the contract baseline. This is 1.1% lower than the planned level of activity in the Budget (3%).

On this basis the LAS would be able to invoice £4.1m of additional variable income. This has been recognised in the accounts at month 11.

The YTD activity is based on April, May, Jun, Jul, Aug, Sep, Oct, Nov & Dec Freeze and Jan and Feb flex figures.



Cash flow Statement YTD

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Feb-18	Feb-18	Feb-18
	Actual	Actual	Actual	Actual	Actual	Actual	YTD	YTD	Var
	£000	£000	£000	£000	£000	£000	Move	Plan	£000
Opening Balance	33,342	31,985	31,916	33,997	32,414	33,374	18,637	18,700	(63)
Operating Surplus	181	2,454	875	3,395	1,498	284	15,102	14,644	458
(Increase)/decrease in current assets	5,815	(1,826)	1,999	(1,761)	730	(82)	15,732	15,208	524
Increase/(decrease) in current liabilities	(3,355)	229	407	(1,899)	1,717	562	2,305	(1,599)	3,904
Increase/(decrease) in provisions	(630)	(120)	15	83	(2)	128	(338)	(270)	(68)
Net cash inflow/(outflow) from operating activities	2,011	737	3,296	(182)	3,943	892	32,801	27,983	4,818
Cashflow inflow/outflow from operating activities	2,011	737	3,296	(182)	3,943	892	32,801	27,983	4,818
Returns on investments and servicing finance	5	18	6	9	13	14	89	88	1
Capital Expenditure	(1,324)	(824)	(1,221)	(1,410)	(2,996)	(2,524)	(17,722)	(28,843)	11,121
Dividend paid	(2,049)	0	0	0	0	0	(2,049)	(2,100)	51
Financing obtained	0	0	0	0	0	0	0	5,520	(5,520)
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/outflow from financing	(3,368)	(806)	(1,215)	(1,401)	(2,983)	(2,510)	(19,682)	(25,335)	5,653
Movement	(1,357)	(69)	2,081	(1,583)	960	(1,618)	13,119	2,648	10,471
Closing Cash Balance	31,985	31,916	33,997	32,414	33,374	31,756	31,756	21,348	10,408

There has been a net inflow of cash to the Trust of £13.1m.

Cash funds at 28 February stand at £31.8m.

Operating Surplus

- The operating surplus at £14.6m is higher than planned.

Current Assets

- The YTD movement on current assets is £15.7m, £0.5m higher than planned movement.
- Current assets movement was higher than planned due to receivables (£1.2m), accrued income £2.0m and prepayments (£0.2m).

Current Liabilities

- The YTD movement on current liabilities is £2.3m, a £3.9m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£0.5m), accruals £2.3m and deferred income £2.1m.

Provisions

- The YTD movement on provisions is (£0.3m), is a (£0.1m) decrease on plan.

Capital Expenditure

- Capital cash outflow is £11.1m behind the initial NHSI plan for the year. This is due to capital slippage and a high level of work-in-progress.

Financing obtained

- DH have only approved £1.7m of the £5.5m central capital funding requested by the Trust. The £1.7m funding is expected in March 2018.



CQUINs

Owner: James Corrigan | Executive Lead: Lorraine Bewes

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

#	CQUIN Indicator title	ELT lead	Local lead	Final indicator period	Annual value	Qtr 1	% Achieved Q1	Qtr 2	% Achieved Q2	Qtr 3	% Achieved Q3	Qtr 4	% Achieved Q4 TBC 29.05.2018	Total Estimated Achievement for 2017/18	Risk/ Issue/Notes
Note all CQUINs follow a two year contract period and so apply across 2017/18 – 2018/19. The below outlines commitments and funding related to 2017/18 financial year only.															
1a	National CQUIN 1a: Improvement of health and wellbeing of NHS staff	Patricia Grealish	Jessica Bochenek	Final Period – Q4 17-18	£260,562	Q1 = 0% £0		Q2 = 0% £0		Q3 = 0% £0		Q4 = 100% £260,562.00	25% £65,140.50	25% £65,140.50	Preliminary view that LAS have failed on two of the three indicators. Improvement on the third only attracts a partial payment of 25% - clarified with NHSE.
1b	National CQUIN 1b: Healthy food for NHS staff, visitors and patients	Lorraine Bewes	Nicola Smith	Final Period – Q4 17-18	£260,562	Q1 = 0% £0		Q2 = 0% £0		Q3 = 0% £0		Q4 = 100% £260,562.00	100% £260,562.00	100% £260,562.00	Q4 view is that we are on target. Paper required to go to Board for full achievement.
1c	National CQUIN 1c: Improving the uptake of flu vaccinations for front line staff within Providers	Fenella Wrigley	Neil Thomson Julia Hilger-Ellis	Final Period – Q4 17-18	£263,701	Q1 = 0% £0		Q2 = 0% £0		Q3 = 0% £0		Q4 = 100% £263,701.00	25% £65,925.25	25% £65,925.25	CQUIN flu season closed on the 28/02/2018. Current progress suggests expected achievement of 25% payment. Awaiting final forms from vaccinators to complete counts.
12	National CQUIN 12: Ambulance Conveyance	Paul Woodrow	Craig Harman	Final Period – Q4 17-18	£784,825	Q1 = 0% £0		Q2 = 0% £0		Q3 = 30% £235,447.50	30% £235,447.50	Q4 = 70% £549,377.50	65% £510,136.25	95% £745,583.75	Q3 report submitted 22.01.2018 - expect full achievement for Q3 - formal confirmation delayed due to CQRG cancellation. Delay in getting Adastra into Chub will effect Q4 achievement - potential to effect achievement against training element - forecast reflected to show this.
STP 1	National CQUIN: STP Engagement	Jamie O'Hara	Fiona Claridge	Final Period – Q4 17-18	£1,569,650	Q1 = 0% £0		Q2 = 0% £0		Q3 = 50% £784,825.00	46% £722,039.00	Q4 = 50% £784,825.00	45% £706,342.50	91% £1,428,381.50	Q3 report submitted 22.01.2018. Expected achievement for Q3 = 45%, based on initial feedback from commissioners & potential clawback. Expectation that commissioners will become stricter on meeting measures in Q4.
STP 2	National CQUIN: STF Delivery (Control Total)	Lorraine Bewes	James Corrigan	Final Period – Q4 17-18	£1,569,650	Q1 = 0% £0		Q2 = 100% £1,569,650	100% £1,569,650.00	Q3 = 0% £0		Q4 = 0% £0		100% £1,569,650.00	Achieved, based on 16/17 control total. LAS provided written confirmation to commissioners that the funding will be held in reserve until further notice and have subsequently provided further confirmation that the funding is still being held in reserve.
L1	Mobile Devices	Ross Fullerton	Ian Golding	Final Period – Q4 17-18	£3,139,299	N/A		N/A		Q3 – 50%* £1,569,649.50	50% £1,569,649.50	Q4 – 50%* £1,569,649.50	47% £1,451,925.79	97% £3,021,575.29	Q3 report submitted 22.01.2018 - expect full achievement for Q3 - confirmation delayed due to CQRG cancellation. Potential challenge in Q4 re Data and Intervention - if current issues are not resolved shortly. Assumption of partial payment for mobile roll-out deliverable: inherent risk around volume
Total Value Available (2.5% of contract value)					£7,848,249.00	£0		£1,569,650		£2,589,922		£3,688,677			
Total Value Achieved					-	-			£1,569,650.00	-	£2,527,136.00		£3,060,032	£7,156,818	

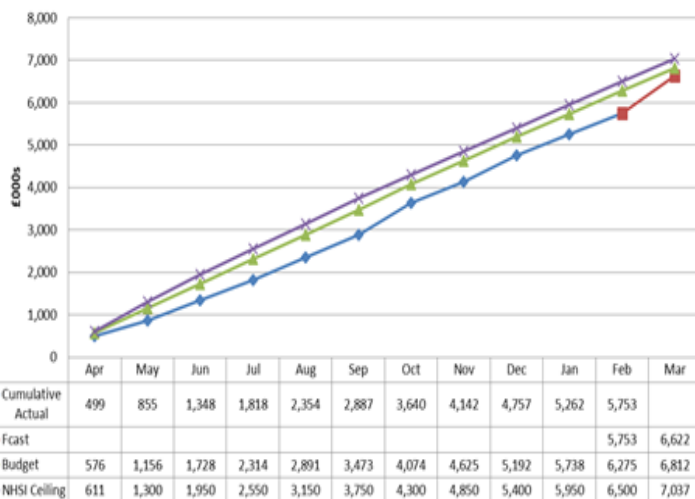
Key - RAG status	
INTERNAL RAG (for ELT / monitoring)	
Red	denotes: CQUIN not achieved
Amber	denotes: partial achievement
Green	denotes: CQUIN expected full achievement
Blue	denotes: Achieved in full



Agency Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

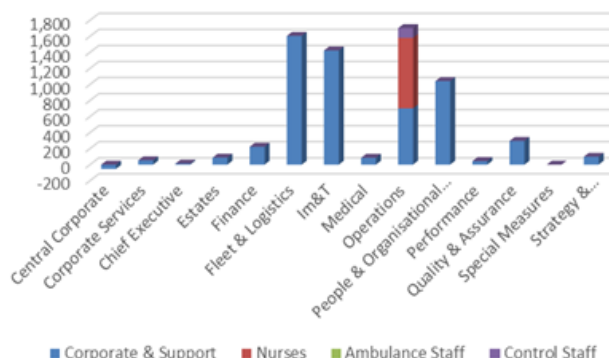
Cumulative Agency Trend



Agency Compliance												
Rule	Measurement			Description			Target	Achieved	Variance			
Agency Ceiling	Forecast agency spend (£000s) vs agency ceiling			Is the Trust on Track to deliver on or below its agreed agency ceiling?			7,037	6,838	199			
Framework	% Agencies used on Framework			Are all agencies used on an approved framework?			100%	91.20%	(8.8%)			
Agency Summary by Type	Month 11 2017-18				YTD Month 11 2017-18				Full Year 2017-18			
	Budget £000s	Actual £000s	Variance £000s	WTE	Budget £000s	Actual £000s	Variance £000s	Average WTE	Budget £000s	Forecast £000s	Variance £000s	Forecast WTE
Operational												
Nurses	101	45	56	7	1,021	829	192	11	1,123	878	244	11
Ambulance Staff	0	0	0	0	0	0	0	0	0	0	0	0
Control Staff	0	21	-21	3	0	99	-99	2	0	121	-121	2
Subtotal	101	66	35	10	1,021	928	94	14	1,123	1,000	123	14
Non Clinical												
Managers & Professionals	252	272	-20	37	2,753	2,639	113	24	2,995	3,256	-260	25
Admin & Clerical	171	141	29	52	2,250	1,692	558	48	2,421	1,829	591	48
Maintenance & Works	23	26	-3	11	251	495	-244	13	274	538	-264	13
Other	0	0	0	0	0	-1	1	0	0	-1	1	0
Subtotal	445	439	6	100	5,253	4,826	428	85	5,690	5,622	68	86
Total	547	505	41	110	6,275	5,753	521	99	6,812	6,622	191	99

Agency Summary by Division & Type	Full Year Forecast (£000s)			
	Corporate & Support	Nurses	Ambulance Staff	Control Staff
Central Corporate	-52	0	0	0
Corporate Services	54	0	0	0
Chief Executive	13	0	0	0
Estates	88	0	0	0
Finance	223	0	0	0
Fleet & Logistics	1,605	0	0	0
Im&T	1,423	0	0	0
Medical	85	0	0	0
Operations	703	878	0	121
People & Organisational Dev	1,041	0	0	0
Performance	45	0	0	0
Quality & Assurance	296	0	0	0
Special Measures	0	0	0	0
Strategy & Communications	99	0	0	0
Total	5,622	878	0	121

Full Year Forecast Agency Spend by Type (£000s)



The Trust's NHSI agency spend ceiling is £7.037m. Agency spend in excess of this level would result in the loss of planned STF income, and ineligibility for further STF funding announced.

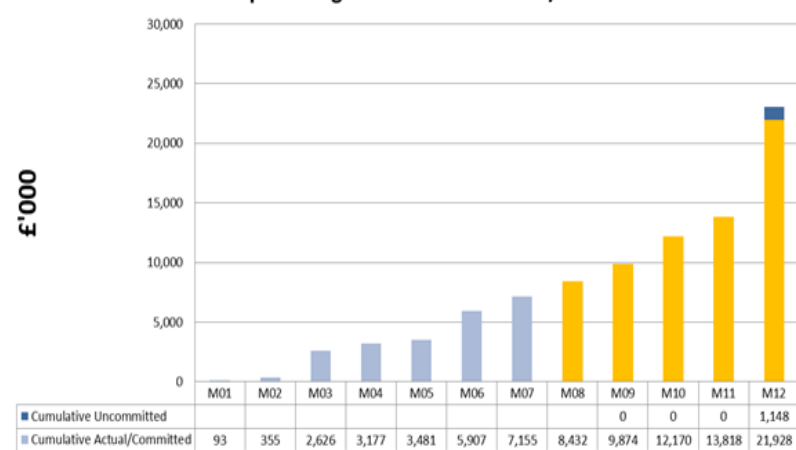
At present the Trust is forecast to stay within its NHSI agency ceiling for 2017-18. The current run rate is in excess of the 2018/19 ceiling and an action plan is urgently required to ensure this is not exceeded in 2018/19



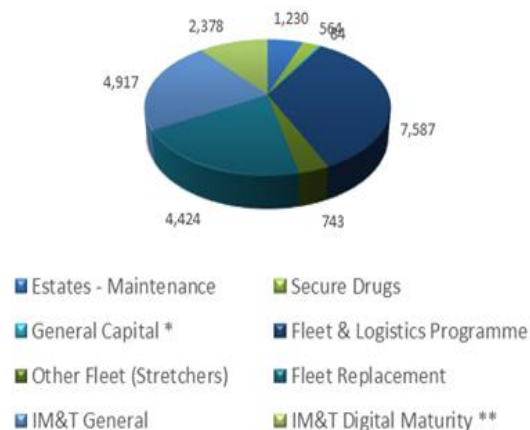
2017/18 Capital Plan/Spend YTD – Month 11 Summary

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Capital Programme Forecast 2017/18



Forecast Full Year Capital Spend



Capital Programme	Exec Lead	Operational Lead	Month 11			Forecast Out turn
			Revised Plan	Actual	Variance	
			£'000	£'000	£'000	
Expenditure Plan:						
Estates - Maintenance	L Bewes	M Nelhams	1,468	992	476	1,230
Secure Drugs	L Bewes	M Nelhams	380	427	(47)	564
General Capital *	L Bewes	L Bewes	1,196	84	1,112	84
Fleet & Logistics Programme	L Bewes	J Wand	9,926	5,848	4,078	7,587
Other Fleet (Stretchers)	L Bewes	J Wand	807	743	64	743
Fleet Replacement	L Bewes	J Wand	1,229	887	342	4,424
IM&T General	R Fullerton	J Downard	4,021	2,889	1,132	4,917
IM&T Digital Maturity **	R Fullerton	R Fullerton	2,200	1,947	253	2,378
Capital Expenditure Plan			21,225	13,816	7,409	21,927

- The latest capital plan shows £21.9m of committed Capex. The plan has been profiled in month 11 to reflect forecast profile spend as agreed with operational leads.
- £24.9m has been confirmed as the Trusts capital resource limit for 17/18.
- Since month 5 the Trust has had confirmation of the £6.9m carry forward from 2016/17 and an additional £641k for Cyber security.
- The initial capital plan assumed £5.5m Central Programme funding. The Trust has received confirmation that it will receive only £0.998m in 2017/18. The shortfall in funding created by this has been met from the General Capital allocation.



Debtors Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Aged debtors Summary 28th February 2018

Note	Total	Current	Days Overdue					
			1 - 30	31 - 60	61 - 90	91 - 180	181 - 365	> 365
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Debtors								
NHS Brent CCG	1	3,505	-	19	3,408	76	2	-
NHS Sutton CCG	1	574	2	567	1	-	4	-
NHS Bromley CCG	1	533	115	418	-	-	-	-
West Midlands Ambulance Service NHS FT	2	529	529	-	-	-	-	-
St Georges University Hospitals NHS FT	3	250	-	140	45	64	-	-
NHS Trust Development Authority	4	217	-	217	-	-	-	-
<£238,000	1	1,281	41	330	122	339	44	245
Total NHS Debtors		6,888	687	1,692	3,576	479	50	245
Non-NHS Debtors								
Heathrow Airport Ltd	5	217	217	-	-	-	-	-
Arsenal Football Club	6	84	59	25	-	-	-	-
Unison	7	23	23	-	-	-	-	-
Chelsea Football Club	8	12	-	12	-	-	-	-
Twickenham RFU	9	11	-	11	-	-	-	-
<£11,000	10	169	32	3	8	1	13	38
Total Non NHS Debtors		517	332	52	8	1	13	75
TOTAL DEBTORS 28th February 2018		7,406	1,019	1,744	3,583	480	63	283

Source: Debtors Ledger 28th February 2018

Aged debtors Summary 28th February 2018

Note	Total	Current	Days Overdue					
			1 - 30	31 - 60	61 - 90	91 - 180	181 - 365	> 365
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
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Source: Debtors Ledger 28th February 2018

Debtors Position: 28th February 2018

Total outstanding NHS and Non-NHS debtors as at 28th February 2018 amounted to £7.4 million. The NHS over 60 day's figure of £0.9m includes amounts due from both CCGs £0.7m and NHS Trusts £0.2m.

1. NHS Debtors over 60 days.

- Q1 & Q2 Over Activity Billing 2017-2018 April to September - £15k. Brent CCG have approved £76k invoice for payment on 15/03/18. The remaining 2 CCGs are currently in credit £61k due to Q2 Activity being below plan.
- PTS Non-Contract Activity - £90k - The PTS ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues. £13k has been paid in March by various CCGs.
- Out of London (A&E ECJ) Journeys - £121k - The A&E ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts and EOC team are liaising with the CCG's to resolve the issues. £37k has been paid in March by various CCGs.
- PTS Contract Activity - £374k - Organisations have paid £90k in March. We are continuously liaising with the organisations to clear the outstanding invoices.
- Neonatal Transfer Service - £175k - The NTS invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues. £25k has been paid in March by various CCGs and NHS Trusts.

The Trust is actively pursuing the outstanding debts.

1. Brent CCG - £3.4m (1 invoice), the CCG has requested supporting information (17/18 plans) for the invoice. The LAS contracts team and Deputy Director of Finance have provided this information and payment is expected on 15 March 2018.

1. Sutton CCG - £567k & Bromley CCG £418k outstanding amounts were paid on 9th March 2018.

2. West Midlands Ambulance Service NHS FT - £529k - payment was received on the 2nd March 2018.

3. St Georges University Hospitals NHS FT - £250k overdue (12 Invoices). The organisation is waiting for PO number to be allocated to the invoices. We are liaising with the trust to clear the outstanding invoices as soon as possible.

4. NHS Trust Development Authority - £217k - The TDA queried the value of the invoice. A credit note will be issued for £69k as one of the projects was not approved that was included on the invoice.

5. Heathrow Airport Ltd - £217k (2 invoices) has been approved and will be paid on the 16th of March.

6. Arsenal Football Club - £84k (3 invoices) £25k was paid on the 2nd of March. £59k has been approved and payment will be received at the end of March.

7. Unison - £23k (5 invoices) payment is being withheld as Unison are querying the secondment recharges, Human Resources are dealing with this query.

8. Chelsea Football Club - £12k was paid on the 2nd of March 2018.

9. Twickenham - £11k (4 invoices) have been approved and will be paid by the 16th of March.

10. Non-NHS Debtors - £169k consists of; £108k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £14k of stadium events, the stadiums have been chased for payment on a regular basis. The remaining £47k is due from local Government bodies and other miscellaneous organisations.

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

Our People

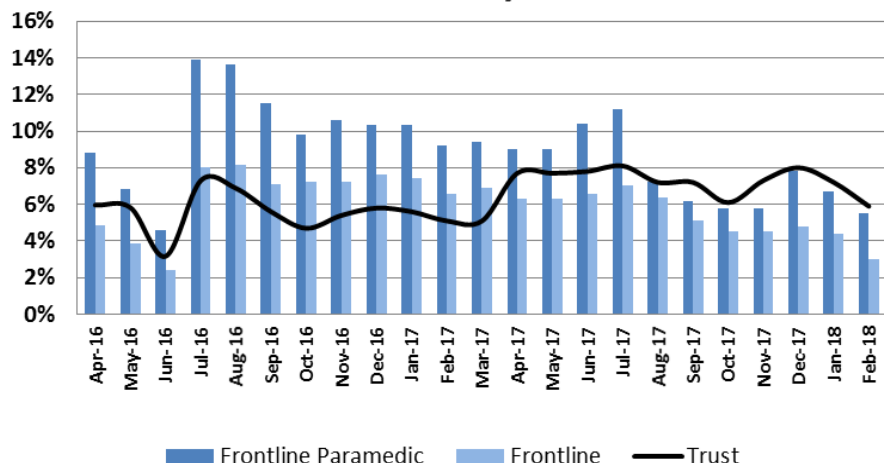


Section	Key Headlines	Feb	Jan	Dec
Vacancy and Recruitment	- The overall vacancy rate has decreased from 7.2% to 5.9% against a 5% target. - We have identified additional core front line posts to deliver the 17/18 increased demand. Work is in progress with colleagues in Operations to determine how these posts should be allocated across the Sectors. Please note that the vacancy rates for both paramedics and the total frontline will increase as a result of these additional posts.	6%	7.2%	8.0%
Turnover	- Total Trust turnover has increased to 10.6% against a threshold of 10%. - Frontline turnover has increased from 8.9% to 9.3% Please note this does not include Control Room or NHS 111 leavers. - Frontline paramedic turnover has increased from 9.9% to 10.5%.	10.6%	10.4%	10.3%
Sickness	- Sickness for February remains at 5.2% against a target of 5%. - Sector Ops sickness has remained at 5.7%.	5.2%	5.2%	5.2%



Trust wide Vacancy

Trust Vacancy Rate



EOC Recruitment (Emergency Medical Dispatchers)

Against our recruitment plan of 186 for 17/18 we have to date recruited 126 EMDs.

Applicant numbers remain encouraging, and improvements developed as part of the EOC Action Plan are showing an improvement in the take up of training place.

EOC are in discussion with LAS partner universities to explore options for UK Graduate paramedics to be trained and work in EOC during the summer.

We have advertised roles via online Job Boards to attract candidates.

We are seeking to overfill training places to allow for drop out.

A new part-time rota has been designed to address the demographic in the team and to support recruitment and retention.

EMD on-line assessment (using approach developed successfully by another Ambulance Trust) – we are proposing to run the pilot from 2nd April to 31st July assessing up to 500 candidates.

The Sector Ops planned establishment is based on the 3,365fte and a 60% paramedic and 40% non-paramedic skill mix

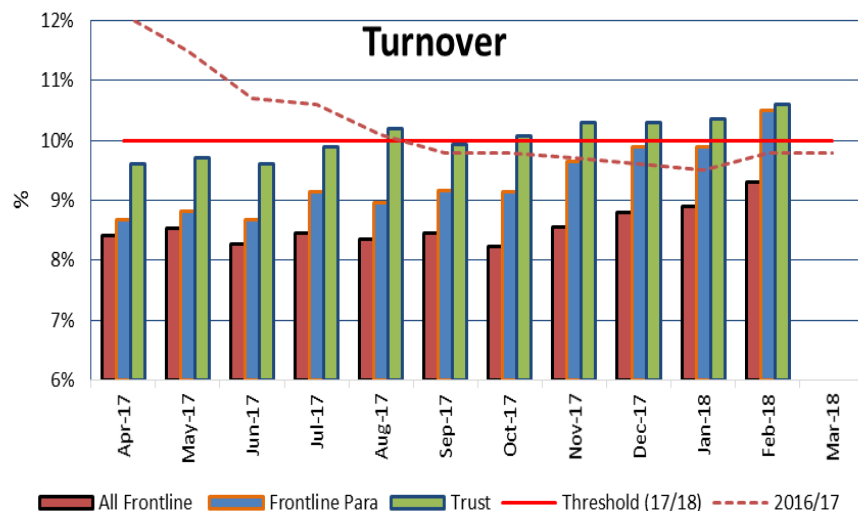
	Establishment	In post (as at 28 th February)	Vacancy wte	Vacancy %	Vacancy % Sector Ops 'planned' establishment
Trust Total	5,419.93	5,100.68	319.25	5.9%	10.2%
Total Frontline (Sector)	3,103.00	3,009.81	93.19	3.0%	10.6%
Frontline (Sector) Paramedics	1,821.24	1,721.40	99.84	5.5%	14.8%
Frontline (Sector) Non-Paras	1,281.76	1,288.42	-6.66	-0.5%	4.3%
EOC	502.00	436.11	65.89	13.1%	
Other staff (including Corporate)	1,814.93	1,654.75	160.18	8.8%	

Trainee Emergency Ambulance Crew recruitment - Against our 17/18 plan of 375, we have filled 287 TEAC training places to date and we have 83 candidates in the pipeline. In order to unblock our pipeline, we have agreed to fund C1 licence costs for our TEAC recruits - we have contacted all eligible candidates and offered them this incentive of which 60 have indicated that they are interested. Our recent advert attracted 254 applications and 155 have been invited for assessment 7th & 23rd March and 6th April 2018. 41 offers were made at the Super Saturday event on 24th February.

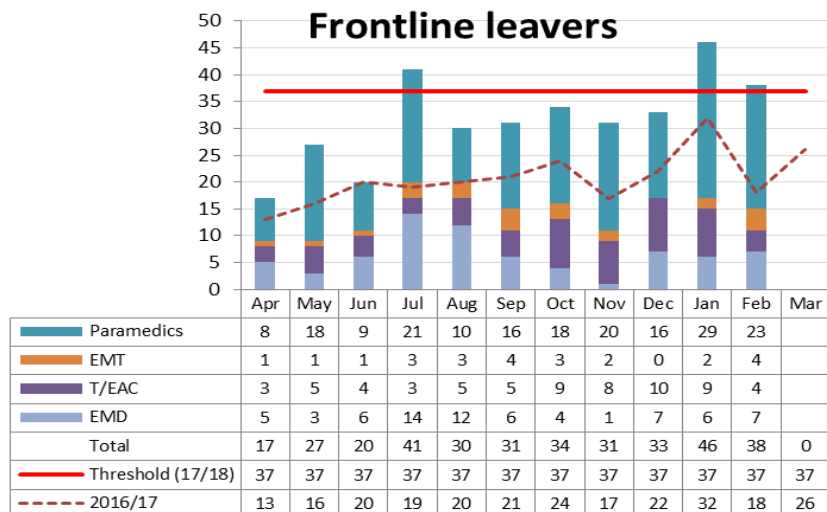
Paramedic Recruitment – Against our 17/18 plan of 294, we have filled 234 training places to date. To date we have filled all but 3 iPara places in Q1. We have 31 remaining iParas awaiting start dates in Q2, and of this original cohort of 166, 48 have withdrawn (29% attrition rate). We have recruited 106 UK Graduate and Qualified Paramedics against our target of 90, all of whom have started. From assessments held in February, 14 Paramedics have been appointed with another 81 booked to attend assessments between 10th March to 14th April 2018.



Trust wide Turnover/Leavers



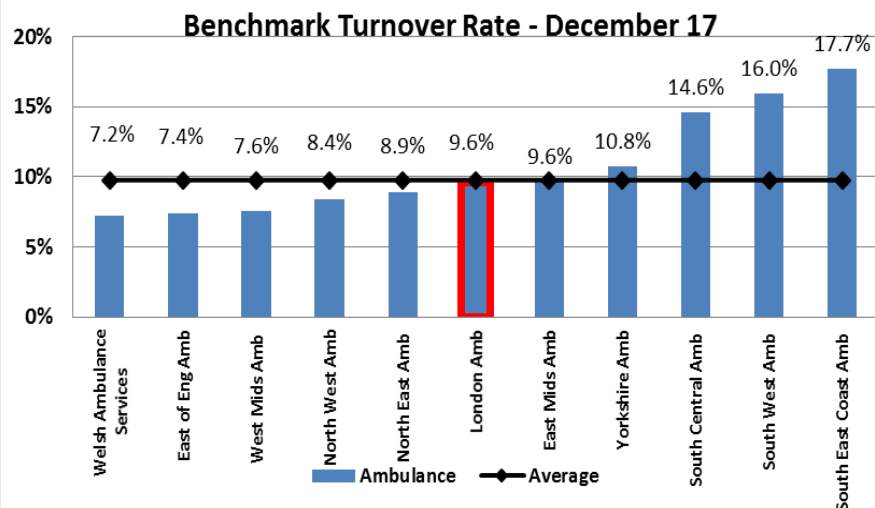
- The total Trust turnover has increased from 10.4% to 10.6% (12 month rolling figure).
- Frontline turnover (Sector Ops) has increased from 8.9% to 9.3%.
- Frontline paramedic turnover has increased from 9.9% to 10.5%.
- EOC turnover has remained at 17.6%.
- NHS 111 turnover has reduced from 16.8% to 16.3%.
- Corporate Directorates turnover has increased from 14% to 15%.



- There were 38 frontline leavers in February (see table opposite).
- 92% of the frontline leavers (35 staff) were resignations i.e. unplanned.
- 73% (17) of paramedics left for reasons of relocation.
- 52% of paramedics had two year's or less in the service.
- Year to date there have been 186 paramedic and 69 EAC leavers (255 total). This is below the total of 297 FTE (year to date) that we had built into the planning model for 17/18.

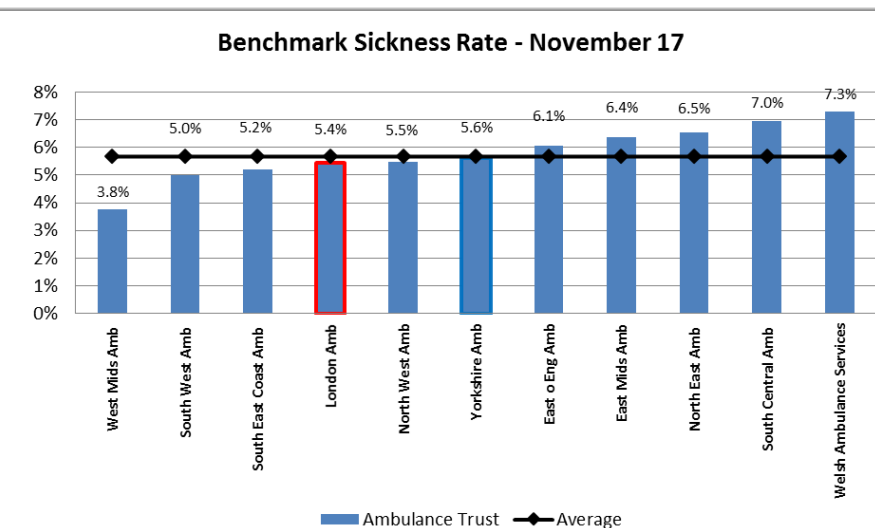


Trust wide Benchmarking Turnover/Sickness



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has moved from 7th to 6th place.
- The LAS is below the national average of 9.7%.

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

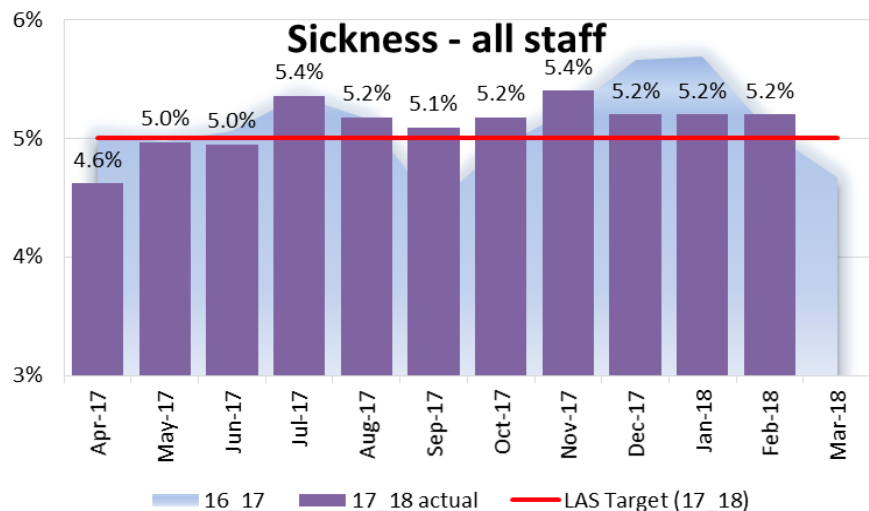


- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has moved from 3rd to 4th place.
- The LAS is below the national average of 5.7%.

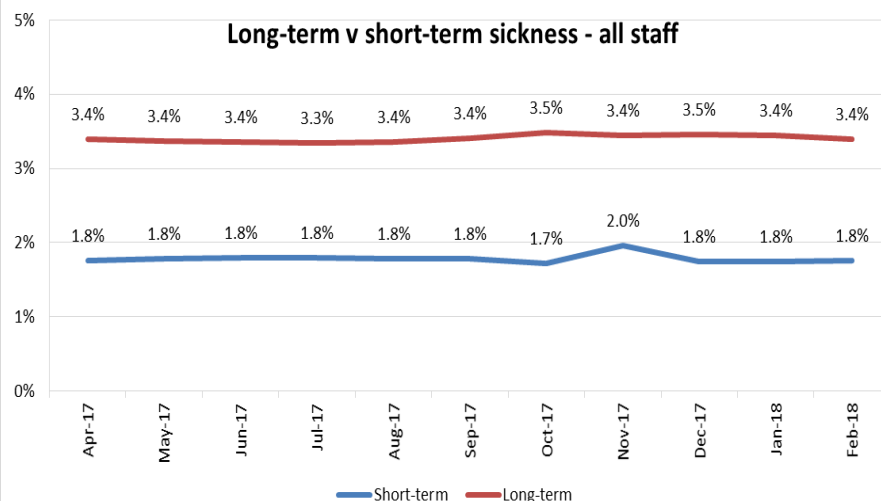
Source of data: NHS Health and Social Care Information Centre – data as at 30th November. Data is available three months in arrears.



Trust/Sector level Sickness Absence



- Trust wide sickness for February remains at 5.2%.
- Frontline sickness (non-corporate) has remained at 5.7%.
- Corporate sickness has increased from 3% to 4%.

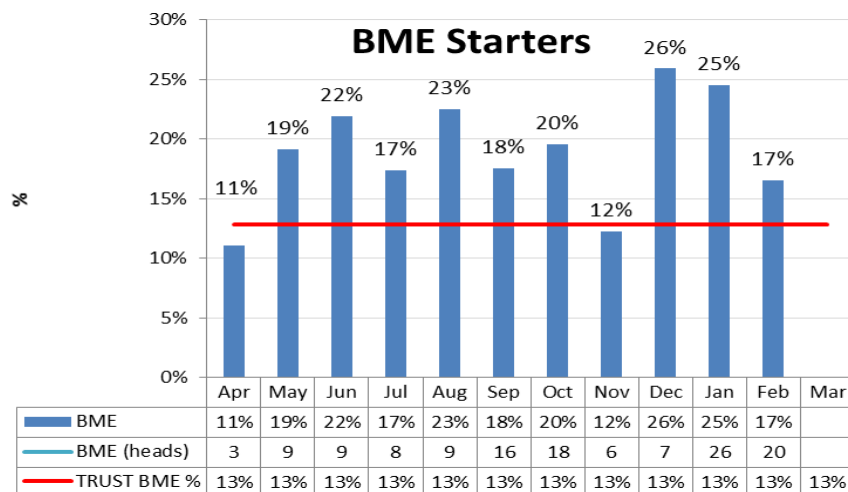


- This graph shows the sickness rate for all staff split by short-term and long-term sickness.
- The LAS 17/18 target for sickness is 5% (2% short-term, 3% long-term), a reduction of 0.5% from 16/17.
- In February, the short-term sickness has remained at 1.75% and the long-term sickness has remained at 3.39%.
- Long-term sickness accounts for 67% of all sickness.

NB. Long-term sickness is any continuous episode of sickness lasting for 28 days or longer.

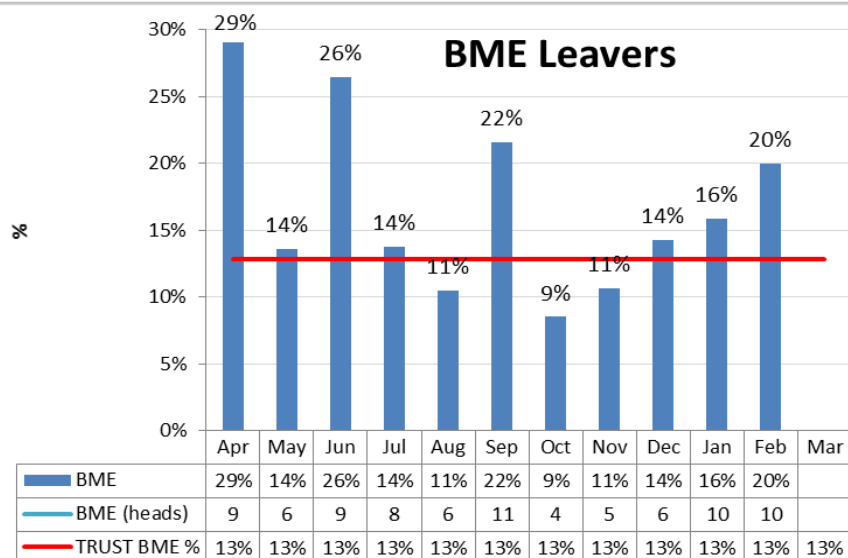


Workforce Race Equality Standard (WRES)



As part of the WRES action plan and the People & OD Strategy we are required to report on our monthly starters and leavers and quarterly on our recruitment and disciplinary data. These show the numbers of BME starters and leavers from April 2017 to February 2018 compared to the current Trust BME profile.

- In February we had 20 BME starters in 111 (10%), Corp (10%), EOC (40%) and Operations (40%).
- In February we had 10 BME leavers, 8 of whom were in frontline roles covering 111, EOC and Ops.
- Year to date we have had 131 BME starters (19% of all starters).
- Year to date we have had 84 BME leavers (16% of all leavers).



On 5th March Patricia Grealish attended the launch of the national WRES Expert Programme in support of Agatha Nortley-Mesh who will participate on behalf of LAS (and who is co-Chair of our own BME network group). The programme is a national WRES initiative that was well attended by a range of NHS Trusts as well as CCGs and STPs. The focus will be on developing the skills of our 'Expert' over the programme to give depth to the experience they can then bring to LAS to tackle our own WRES agenda. One of the benefits is that participants on the programme will form an important network to share experiences and best practice.

The BME staff network met on the 22nd February to agree a work plan including establishing a link in to the national BME group. The group will focus on relaunching and getting more staff involved.

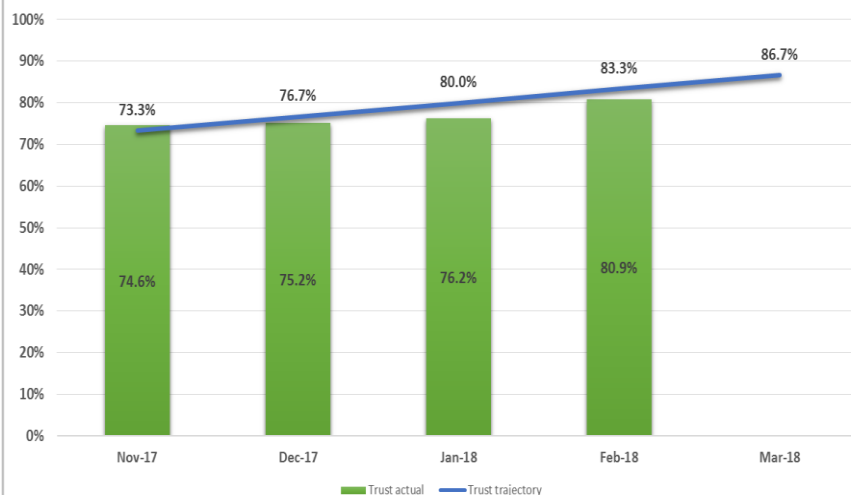
Community engagement events continue in shopping centres across London with more planned throughout March. We have had a total of 494 expressions of interest during February.

Following a deep dive into the recruitment data an immediate action agreed will be to train a cohort of BME staff to participate in Super Saturdays and corporate recruitment events.



Statutory and Mandatory Training

Stat and mand training - Trust level (as at 28th February 2018)

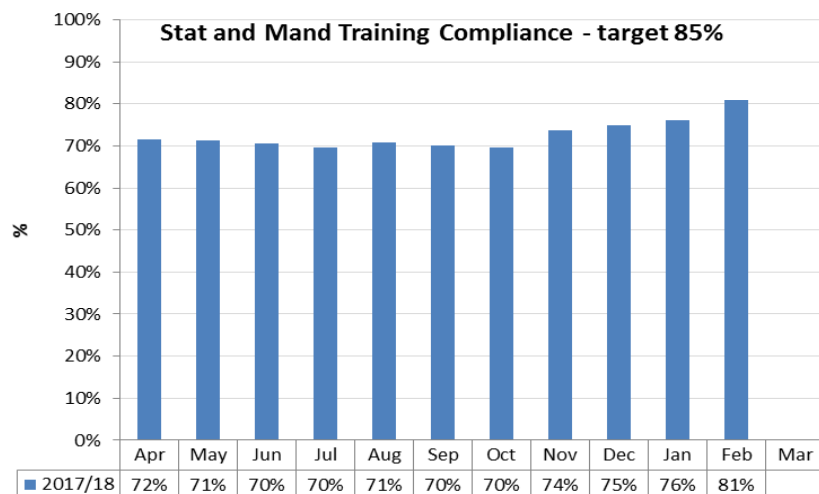


The launch of My ESR has been a success with over 92% of Trust staff (5,286) accessing the new version of the system which became available to Trusts nationally in May 2017. We have the highest % of users using the new ESR Portal in London (71 Trusts) and we are the 4th highest % of users nationally.

During this time over 36,000 e-learning modules have been completed by LAS staff covering 131 different courses and this includes 800 non-Stat and Mand course completions for CPD courses. The first ever online e-learning CSR 2017.2 was launched in October 2017 and over 2,377 staff have successfully completed this to date.

- Current Trust statutory and mandatory compliance is 80.9% as at the end of February 2018.
- Corporate compliance is currently 94% (Target 100%).
- Current Operations compliance is 79.58%.

Stat and Mand Training Compliance - target 85%



CSR.2017.2 compliance is being monitored weekly with reports sent to DDOs which is followed up by ADOs in their sectors with compliance leads chasing completions.

CSR.2017.2 stands at 66.89% and CSR.2017.3 is at 55.04%. Demand has increased pressure on completion of both throughout the bad weather conditions with its repercussions but both continue to be closely managed through the weekly CSR report by ADOs and sector compliance leads.

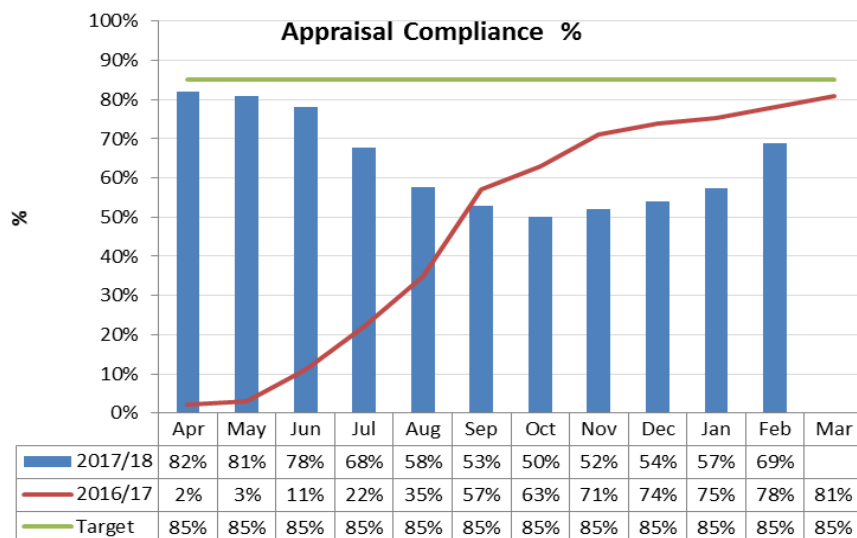
As part of the IG Audit a plan will be created by 12 March 2018 to reach the 95% compliance requirements of the IG toolkit within the first month of the new financial year.

The ESR Project Team are continuing their optimisation phase of ESR Oracle Learning Management with teams across the organisation.

NETS data is currently being collated and due for upload to ESR.



Appraisal/Bullying & Harassment

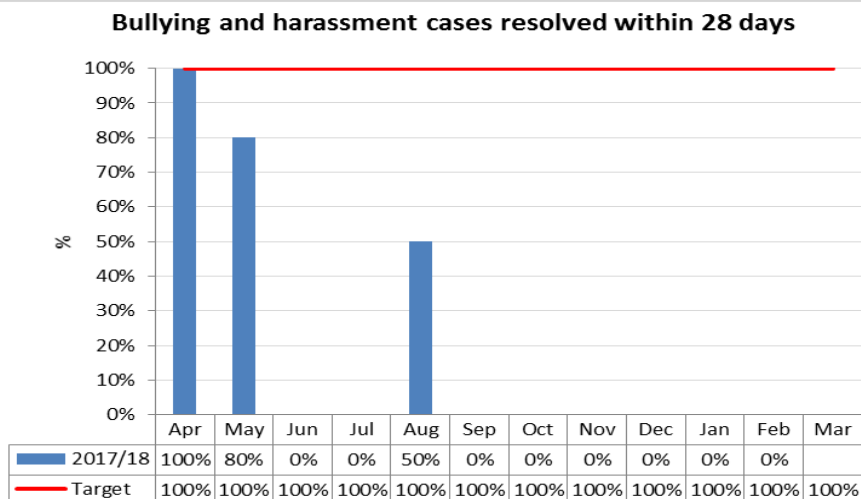


The appraisal rate has improved from 57% in January to 69% in February.

From 1st March 2017 to 28th February 2018 there have been 3,244 appraisals completed out of 4,678 eligible staff (we exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at LAS).

A series of communications have been sent to all employees during January and February 2018. The communication emphasised the importance of quality of appraisal. In order to support quality, an appraisal audit will take place in March 2018. This will include semi-structured interviews which will take place across selected areas. The interviews will be supported by a questionnaire to all staff. The results of both will be analysed and recommendations made in April 2018.

Appraisal training for both managers and staff is being delivered throughout February and March 2018.



Round tables - Cases continue to come forward as an alternative method to resolve conflict outside formal processes.

- Open Cases - 2 sent to mediation with TCM and 5 outstanding
- Delays due to changing one of the facilitators, waiting for GSM to stand crew down, scheduling the conflicts of the people in conflict, facilitator scheduling.

These outstanding cases have exceeded the recently set time limit of reaching an outcome (30 days) and have resulted in timeframes being more clearly set. 5 recent requests are being allocated to facilitators.

- The key themes for round tables between peers is around communication and missed opportunity to have a courageous conversation. Personality conflicts and unclear boundaries are two themes that stand out. The theme for round tables between line manager and staff members are regarding the perception of adherence to policies.
- In February, there was one open formal bullying and harassment case and this has breached the 28 day target.

OUR RISKS



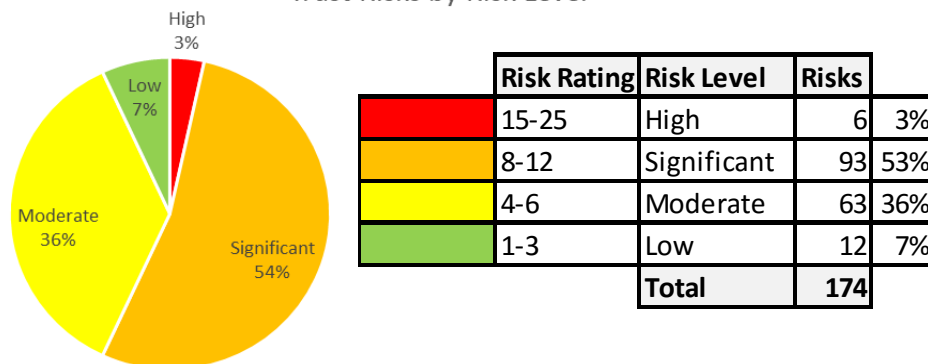
There are 6 risks on the Board Assurance Framework (BAF) and 2 other highly rated risk which are not included on the Corporate Risk Register (CRR); Finance and Performance (1), Quality Directorate (2) People and Organisational Development (1) IM&T (1), Operational (1) and Logistics & Infrastructure (2) . The highest risk scores at 20, with the others at 15 or 16. These risks are:

Section	Risks
Finance	BAF 49 – CRR 713 -The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19 – current rating 15.
People and Organisation Development	BAF 47 – CRR 704 -The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo – current rating 16.
IM&T	BAF 45 – CRR 734 - A cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period – current rating 15.
Logistics & Infrastructure	BAF 51 – CRR 767 – Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready, could be vulnerable to market volatility leaving the Trust without a service provider at short notice – current rating 12. BAF 51 – CRR 768 - The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system, impacting on our ability to provide a continuous service to our control room– current rating 10.
Quality	BAF 46 – CRR 676 –Lack of compliance with Health and Safety requirements– current rating 20. CRR 677 –Risk of musculo-skeletal injuries to front line staff – current rating 15.
Operations	CRR 706 – Lack of capacity to deliver training through reliability, space and insufficient facilities – current rating 16.



Our Risks

Trust Risks by Risk Level



The register of risks approved showed the following at 9th March 2018:

- 56% of the Trusts risk register has a risk level of High or Significant.
- Just under a third of the overall Trusts risks are Operations risks (29%), with Health and Safety risks accounting for 12%, Information Governance risks accounting for 6%, Finance risks accounting for 10%, Clinical risks accounting for 7% and Human Resources risks accounting for 7%.

Top 4 Risks:

BAF Risk 49

The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

BAF Risk 47

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

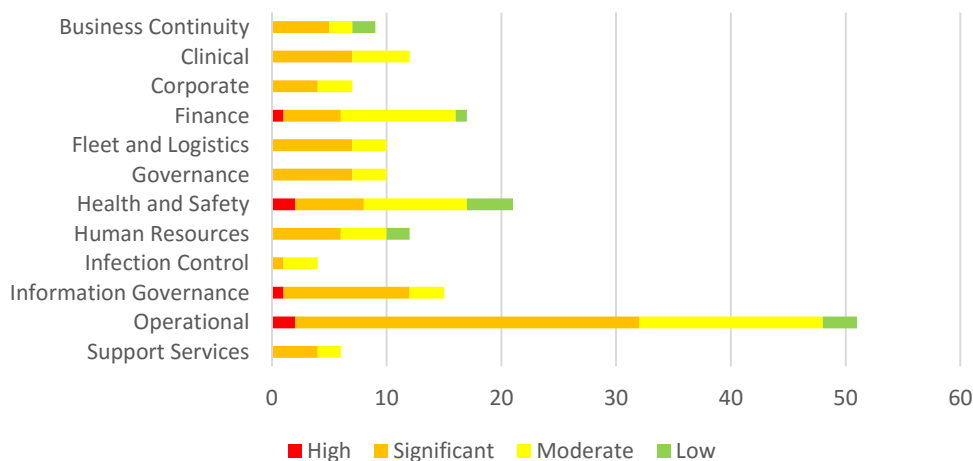
BAF Risk 45

There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

BAF Risk 46

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

Risks by Subtype





London Ambulance Service

NHS Trust



INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary





Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description	Acronym	Meaning / Description
ADO	Assistant Directors of Operations	HAC	Heart Attack Centres
ARP	Ambulance Response Program	HART	Hazardous Area Response Teams
APP	Advanced Paramedic Practitioners	HASU	Hyper Acute Stroke Unit
AQI	Ambulance Quality Indicator	HCP	Health Care Professional
BME	Black and Minority Ethnic	iPara	International Paramedic
CARU	Clinical Audit and Research Unit	JCT	Job Cycle Time
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System	KPI	Key Performance Indicator
CCG	Clinical Commissioning Group	LIN	Local Intelligence Network
CD	Controlled Drugs	LINC	Listening Informal Non-Judgemental Confidential
CDLO	Controlled Drugs Liaison Officers	MAR	Multiple Attendance Ratio
CISO	Clinical Information & Support Overview	MRU	Motorcycle Response Unit
CPI	Clinical Performance Indicator	MTC	Major Trauma Centre
CPD	Continuing Professional Development	NETs	Non-Emergency Transport
CQUIN	Commissioning for Quality and Innovation	NRLS	National Reporting and Learning System
CRL	Capital Resource Limit	OOH	Out Of Hours
CRU	Cycle Response Unit	OWR	Operation Workplace Review
CSR	Core Skills Refresher (Training)	PAS / VAS	Private / Voluntary Ambulance Services
DBS	Disclosure & Barring Scheme	PED	Patient Experiences Department
DOC	Duty of Candour	PGD	Patient Group Directions
EAC	Emergency Ambulance Crew	PFVH	Patient Facing Vehicle Hours
ED	Emergency Department	PRF	Patient Record Form
ELT	Executive Leadership Team	PSP	Patient Specific Protocol
EMD	Emergency Medical Dispatcher	PTS	Patient Transport Service
EMT	Emergency Medical Technician	QGAM	Quality, Governance and Assurance Manager
EOC	Emergency Operations Centre	QR	Quality Requirement
ESR	Employee Service Record	RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)	ROSC	Return of Spontaneous Circulation
FFT	Friends and Family Test	SI	Serious Incident
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale	SIG	Serious Incident Group
FRU	Fast Response Unit	STEMI	ST-Segment Elevation Myocardial Infarction
GCS	Glasgow Coma Scale	TEAC	Trainee Emergency Ambulance Crew
GTN	Glyceryl Trinitrate	TRU	Tactical Response Unit
		YTD	Year to Date
		WTE	Whole Time Equivalent



Integrated Performance Report – Glossary

Other Terminology	Meaning
Green ambulance outcomes	Lower acuity ambulance outcomes

LAS 111 (South East London)			
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?

Other London 111 service provider	Areas Covered
London Ambulance Service (LAS)	1. South East London
Care UK	1. Hillingdon, 2. North West London
Partnership of East London Co-operatives (PELC)	1. East London & City. 2. Outer North East London
London Central & West (LCW)	1. Inner North West London, 2. North Central London
Vocare	1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	13			
Report Author(s):	Frances Field, Risk and Audit Manager			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Leadership Team and Board Assurance Committees			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This paper provides the Board with an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).				
Recommendation:				
Board members are asked to comment on this report.				
Links to Board Assurance Framework (BAF) and key risks:				
This paper sets out the content of the BAF and the CRR.				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	☒			
Performance	☒			
Financial	☒			
Workforce	☒			
Governance and Well-led	☒			
Reputation	☒			
Other	☒			
This paper supports the achievement of the following Business Plan Workstreams:				
Ensure safe, timely and effective care	☒			
Ensuring staff are valued, respected and engaged	☒			
Partners are supported to deliver change in London	☒			
Efficiency and sustainability will drive us	☒			

Board Assurance Framework (BAF)

Current BAF Risks

- There are currently six risks on the BAF, four of which have a net rating of 15 or above, they are set out below in descending order of severity. Following review by the Executive Leadership Team (ELT) and Quality Assurance Committee, it is proposed that one of these should be de-escalated from the BAF (this is set out below):

Severity	Risk	Risk Owner	Scrutinising Committee	Comments
1	BAF Risk 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 2018/19.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	
3	BAF Risk 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre (EOC).	Patricia Grealish, Director of People and Organisational Development	People and Organisational Development Committee	
4	BAF Risk 45 A cyber-attack could materially disrupt the trust's ability to operate for a prolonged period.	Ross Fullerton, Chief Information Officer	Logistics and Infrastructure Committee	
5.	BAF Risk 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	Benita Mehra, Director of Assets and Property	Logistics and Infrastructure Committee	
6.	BAF Risk 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	Benita Mehra, Director of Assets and Property	Logistics and Infrastructure Committee	Anticipate that this will be de-escalated within the next month

Risk that ELT proposes should be removed from the BAF				
	BAF Risk 46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Trisha Bain, Chief Quality Officer	Corporate Health and Safety Committee and Board	Proposal supported by Quality Assurance Committee at its meeting on 20 March 2018

Risk discussions in February and March

Board Assurance Committees

2. BAF risks 50, and 51 were added to the BAF following discussions at the Logistics and Infrastructure Committee on 6 February 2018 and recommendation to the Trust Board on 27 February 2018 that they should be accepted as BAF risks.
3. At its meeting on 08 February 2018, the People and Organisational Development Committee discussed the potential risk identified by ELT at its meeting on 31 January 2018 relating to whether the Trust's training capacity was sufficient. Following this discussion it was considered that this was not a BAF-level risk, although the review of this capacity is due to be scrutinised by both the Quality Assurance Committee and the People and Organisational Development Committee at future meetings.
4. It was noted at the Risk Compliance and Assurance Group on 08 March 2018 that a significant improvement had been made in the review of current risks and escalation of new risks to the CRR.
5. At its meeting on 20 March 2018, the Quality Assurance Committee considered the Health and Safety Action Plan and external assurance provided by a re-inspection report, which led to the Committee supporting the proposed de-escalation of BAF Risk 46.
6. The Quality Assurance Committee also noted that BAF Risk 7 (agreed by the Board for de-escalation at its meeting on 30 January 2018) had not been considered by the Committee ahead of its proposed de-escalation. The Committee confirmed that it was content with the evidence that had resulted in the proposal to de-escalate

Executive Leadership Team

7. BAF risk 50 has been identified by the ELT as the BAF risk of lowest severity. It is anticipated that this risk will be proposed for de-escalation at the next meeting of the Board, in light of the business continuity arrangements that are being put in place to mitigate this risk.

Corporate Risk Register

8. The Corporate Risk Register is attached for the Board members' information.

Philippa Harding

Director of Corporate Governance

Board Assurance Framework – March 2018

IMPACT	Catastrophic		50	45 49			In order of severity: BAF Risk 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19. BAF Risk 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo. BAF Risk 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.
	Major			51	47	46	BAF Risk 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room BAF Risk 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice
	Moderate						
	Minor						
	Negligible						Proposed to be removed: BAF Risk 46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust
		Rare	Unlikely	Possible	Likely	Almost Certain	

Risk Severity

	High Risk (15-25)
	Significant Risk (8-12)
	Moderate Risk (4-6)
	Low Risk (1-3)

LIKELIHOOD

Key

	Net risk rating
	Gross risk rating = net risk rating

GOAL 1 Patients Receive Safe, Timely & Effective Care

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

Links to Objectives	BAF Risk	Further mitigation required
1, 2, 3	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service. • Continuation of the support offered to recruitment for shortlisting, assessment space and interviews.
1, 2, 3	45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
1, 2, 3	50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	• A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.
1, 2, 3	51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	• We are developing a tender for services which we will be taking to market in the next four months.
PROPOSED TO BE REMOVED:		
1, 2, 3	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	• Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) • Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements

GOAL 2 Staff are Valued, Respected & Engaged

OBJECTIVES

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

Links to Objectives	BAF Risk	Further mitigation required
1	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo.	- Consideration to be given to an additional recruitment campaign. - Continuation of the project meetings to maintain the level of scrutiny required by the service. - Continuation of the support offered to recruitment for shortlisting, assessment space and
PROPOSED TO BE REMOVED:		
2, 4	46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust	- Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately) - Implement robust arrangements to enable oversight and scrutiny of Trust-wide health and safety arrangements

GOAL 3 Partners are Supported to Deliver Change in London

OBJECTIVES

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

Links to Objectives

BAF Risk

Further mitigation required

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

Links to Objectives	BAF Risk	Further mitigation required
1, 2, 4	49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19	• Review Finance structure and prepare case to Trust Board to enable business partnering support • Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme
3	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
4	50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	• A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.
4	51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	• We are developing a tender for services which we will be taking to market in the next four months.

BAF Risk no. 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

Risk Classification: Finance	Risk Owner: Lorraine Bewes	Scrutinising Committee: Finance & Investment Committee		
Date risk opened: 17/011/2017	Date risk expected to be removed from the BAF: September 2018			
Underlying Cause/Source of Risk: 1. Unknown Target Operating Model. 2. Size of and pace of delivery of recurrent CIPs will need to increase - need to be driven by evidence-based, relevant benchmarking metrics in order to achieve full efficiency opportunity. 3. Need for appropriate programme approach/resource to deliver efficiency projects. 4. Up until 2017/18, the LAS operated within a block contract and fixed income financial envelope and has been in special measures over the last year, with the result that priority could not be given to developing financial and commercial awareness of budget holders to develop a devolved service level management model in line with the norm in other NHS organisations, which will accelerate delivery of value improvement. 5. Instead, budget control has largely been achieved through central management and contingency accounting so need to develop more mature financial framework and capability for budget delivery. 6. The Trust has delivered only £6m of the £17.8m CIP recurrently in 17/18 due to insufficiently robust governance and project management capability.		Gross Rating	Current/Net Rating	Target Rating
		25	15	10
Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process. Gap in Controls Contract for 18/19 not yet agreed.	1. Trust Board and FIC finance reports 2. Capital Programme action plans 3. Detailed review of budget by CEO and CFO has reduced headline CIP from £18.6m (5.3%) to £12.9m (3.64%)	1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency). 3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impact assessment on Quality and Performance as part of Business Planning 5. Design and confirm programme resource budget to deliver strategic intent Yr 1 enablement, service development, business process improvement and efficiency programme. 6. Establish programme management office		31/07/18 31/03/18 1st cut completed Dec 17. 2nd cut to be completed after publication of Carter report in April 18 Completed ~~31/03/18~~ 30/04/18 ~~31/03/18~~ 30/04/18

		7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy.	~~31/03/18~~ 30/04/18 ~~31/03/18~~ 30/04/18
Signed: Lorraine Bewes			

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

Risk Classification: People & OD		Risk Owner: Patricia Grealish	Scrutinising Committee: People & OD Committee		
Date risk opened: 17/11/2017		Date risk expected to be removed from the BAF: ~~31/03/17~~ 31/10/2018			
Underlying Cause/Source of Risk: Recruitment: Competition for similar roles is strong and offer higher salaries (in the vicinity of HQ and Bow). Retention: The working environment in control rooms is frequently pressurised and staff turnover is high compared to other roles in the Trust			Gross Rating	Current/Net Rating	Target Rating
			16	16	8
Existing Controls		Positive Assurance of Controls	Further Actions		Due Date
1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. A monthly EOC Board tackles underlying causes of recruitment and retention, with a weekly call update to ensure progress is being made. This meeting is chaired by the Deputy Director of Operations (Control Services). 3. The existing recruitment process has been discussed and reviewed to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment function to ensure specialist knowledge in the recruitment team to allow good decisions on passing candidates through the shortlisting process. 7. A range of recruitment activities throughout Q1 will specifically target recruitment to EOC. 8. EMDs have been released to support job fairs to promote the role. 9. EMDs support EOC Training team delivering Open Evenings for potential candidates interested in joining 10. EOC are participating in the ongoing Talent Review which will look at the end to end process and identify improvements / gaps. 11. The team are currently looking at an alternative online assessment (NWA currently use this approach) and will look to pilot a scheme should it prove affordable and of value 12. ELT task and finish group to bring focus and decision-making to challenges. Gaps in controls None identified.		1. Monthly recruitment meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support from PLM, Control Services 4. Recruitment activity added to weekly tracker reported to Operational Resourcing Group (Chaired by Director of Operations, deputy chair Director of People and OD).	1. Role will be included as part of planned recruitment campaign.		31/03/2018
			2. Meet relevant people at Met Police to share and establish best practice and mutual ways of working.		31/03/2018
			3. Review feasibility of online assessment for EOC recruitment and run pilot.		30/04/2018 Completed
			4. EOC Recruitment Project Meetings to take place.		31/10/2018
			5. Allocate appropriate resource to interview and assessment activities.		31/10/2018
Signed: Patricia Grealish					

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

Risk Classification: IM&T	Risk Owner: Ross Fullerton	Scrutinising Committee: Logistics & Infrastructure Committee		
Date risk opened: 01/06/2017	Date risk expected to be removed from the BAF: ongoing			
Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats has accelerated rapidly in the last 5 years; cyber-attacks are regularly successful at disrupting many organisations in ways that weren't considered possible only a short time ago. This is compounded by an under-investment in IT security at LAS over the same time frame. As a consequence there is a deficiency in the overall awareness of cyber risk inside and outside of IM&T and we lack the skillsets, processes, governance and tools to mitigate the evolving threat profile effectively.		Gross Rating	Current/Net Rating	Target Rating
		20	15	10
Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Existing defences have mitigated threats to-date; these include various technical and procedural elements 2. Independent review by PA Consulting has identified necessary mitigations for CAD system Gaps in Controls The existing controls do not meet good practice requirements as defined by HMG's National Cyber Security Centre.	1. Reports to Information Governance Group of cyber-related incidents each quarter – Reporting will be tied to Key Performance Indicators and services. 2. Reports from IGG to RCAG – All work carried out as part of the Cyber Security Improvement Programme will be reported to the IGG and RCAG. 3. To align with the NCSC guidance we will look to comply with Cyber Essentials by the end of February 2018. Gaps in Assurance The gaps are being investigated by the Cyber Security Improvement team and pragmatic/practical recommendations and an action roadmap will be drawn up.	1. Initial Bid to NHSD for Cyber funding Capital (Bid 1) 2. NHS Digital led review of LAS cyber security (November 2017). 3. Implementation of HMG good practice in cyber controls (Cyber Essentials) 4. Potential second bid to NHSD for Cyber funding Capital (Bid 2) 5. Implementation of a Cyber programme of works (to include the recommendations from the PA consulting report) 6. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS	30 Nov 2017 Successfully Completed 01/03/18 01/03/18 01/04/18 31/05/18 31/05/18	
Signed: Ross Fullerton				

BAF Risk no. 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room

Risk Classification: Estates	Risk Owner: Benita Mehra	Scrutinising Committee: Logistics & Infrastructure Committee

Date risk opened: 20/02/2018	Date risk expected to be removed from the BAF: June 2018

Underlying Cause/Source of Risk: Existing UPS is undersized for the demand requirement in the building	Gross Rating	Current/Net Rating	Target Rating
	15	10	5

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. The current UPS has until this point been effective when a power failure occurred. This was tested recently when the UK Power main supply failed.	1. No degradation of service materialised during the power failure.	1. A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.	June 2018

Signed: Benita Mehra



BAF Risk no. 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice

Risk Classification: Estates and Fleet and Logistics	Risk Owner: Benita Mehra	Scrutinising Committee: Logistics & Infrastructure Committee		
Date risk opened: 20/02/2018	Date risk expected to be removed from the BAF: June 2018			
Underlying Cause/Source of Risk: 1. External influences to the market volatility affective service provider’s ability to function.		Gross Rating	Current/Net Rating	Target Rating
		16	12	4
Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Business continuity plan is in place which includes Legal and People and OD feedback.	1. The business approach is being discussed with NHSI and the Cabinet Office bi weekly.	1. We are developing a tender for services which we will be taking to market in the next four months.		4 months subject to OEJU requirements.
Signed: Benita Mehra				

PROPOSED FOR REMOVAL FROM THE BAF

BAF Risk no. 46 Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust				
Risk Classification: Health and Safety		Risk Owner: Trisha Bain	Scrutinising Committee: Corporate Health and Safety Committee	
Date risk opened: 17/11/2017		Date risk expected to be removed from the BAF: 31/03/18		
Underlying Cause/Source of Risk: The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance.		Gross Rating	Current/Net Rating	Target Rating
		20	20	4
Existing Controls	Positive Assurance of Controls	Further Actions		Due Date
1. Corporate Health and Safety Committee in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in place through Datix. 7. ELT/Board oversight for H&S compliance through the Trust's committee reporting structure. 8. Regular update reports are provided for Trust-wide committees. 9. Responsible Director for Health and Safety in place for the Trust. 10. Regular reporting of H&S action updates through the monthly Quality Report, Quarterly Health and Safety Committee and the Quality Oversight Group. 11. Senior Management Level H&S Training completed by ELT/Board Members. 12. Health & Safety Strategy agreed by the Board. 13. Non-Executive Director appointed for Health & Safety.	1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 4. Non-Executive Director appointed for Health & Safety. Gaps in Controls 1. Lack of capacity within the Health and Safety Department to support the Trust, and to ensure Trust-wide H&S compliance. 2. A large number of the Trust-wide H&S policies require updating as they refer to out dated processes, legislation or to staff who have left the Trust. 3. The health and safety training provided is limited with gaps in areas such as manual handling refresher training, general health and safety refresher training for Managers. 5. Lack of robust arrangements for monitoring/checking the effectiveness of the training provided to staff as well as staff competency.	1. Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed seperately) .		31/03/2018
		2. Conduct review of H&S compliance during Q4, 2017/18 in order to assess progress with Trust-wide H&S Performance.		31/03/2018
		3. Agree Terms of Reference for the Corporate Health and Safety Committee ensuring appropriate representation.		31/03/2018
		4. Implement a system of annual health and safety audits to identify and address areas of gaps in Trust-wide H&S performance.		~~31/03/2018~~ 25/04/2018
Signed: Trisha Bain				

Corporate Risk Register as at 9th March 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
706	Lack of capacity to deliver training through reliability, space and insufficient facilities This has been through age, fair wear and tear.	27/10/2017		20	High	Martin Nelhams looked at viable space - nothing suitable for use across LAS or collaboration premises. Replacement of faulty equipment ongoing. Work carried out by estates to rectify surface issues. Viewing of 8 local venues with the capacity to be able to develop an appropriate training centre - but not able to be sponsored by LAS estates team. Utilisation of alternative desk space at different locations.	Bewes, Lorraine	28/12/2018	16	High		DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downward aware and supportive of the urgent review of premises and continued co-located situation.	4	Moderate
704	The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centres at Bow and Waterloo.	17/11/2017		47	16	High	Grealish, Patricia	09/03/2018	16	High	Include role in planned recruitment campaign EOC Recruitment Project Meetings take place Allocate appropriate resource to interview and assessment activities Review feasibility of online assessment for EOC recruitment and run pilot Meet relevant people at Met Police to share and establish best practice and mutual ways of working	1. Monthly recruitment meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services 3. Daily contact with Recruitment EMD lead during first weeks for support from PLM, Control Services 4. Recruitment activity added to weekly tracker reported to Operational Resourcing Group (Chaired by Director of Operations, deputy chair Director of People and OD).	8	Significant
713	There is a risk that... The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.	17/11/2017		49	25	High	Bewes, Lorraine	08/03/2018	15	High	1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency). 3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impact assessment on Quality and Performance as part of Business Planning 5. Design and confirm programme resource budget to deliver strategic intent Yr 1 enablement, service development, business process improvement and efficiency programme. 6. Establish programme management office 7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy.	1.Trust Board and FIC finance reports 2.Capital Programme action plans 3.Detailed review of budget by CEO and CFO has reduced headline CIP from £18.6m (5.3%) to £12.9m (3.64%)	10	Significant
734	There is a risk that a cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period.	14/12/2017		45	20	High	Fullerton, Ross	23/02/2018	15	High	Introduce scenario planning and rehearsals a cyber attack on LAS NHS Digital led review of LAS cyber security Implementation of HMG good practice in cyber controls (Cyber Essentials) Potential second bid to NHS for Cyber funding Capital (Bid 2) Implementation of a Cyber program of works (to include the recommendations from the PA Consulting report) Initial Bid to NHS for Cyber funding Capital (Bid 1)	1.Reports to Information Governance Group of cyber-related incidents each quarter - Reporting will be tied to Key Performance Indicators and services. 2.Reports from IGG to RCAG - All work carried out as part of the Cyber Security Improvement Programme will be reported to the IGG and RCAG. 3.To align with the NCS guidance we will look to comply with Cyber Essentials by the end of February 2018.	10	Significant
677	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments. In 2016/17, 506 out of the 3309 health and safety incidents reported on Datix related to manual handling incidents. 486 of the incidents reported resulted in low/moderate harm. 75 of the harm related incidents were reported as RIDDOR. The impact of this risk includes: 1. Moderate/severe harm to staff. 2. Staff injury claims. 3. Impact on patient care and the delivery of services due to staff absences/shortage of resources. 4. Damage to organisational reputation. 5. Potential breach of statutory duty. 6. Litigation and increased financial costs from claims and compensation.	20/09/2017		47	15	High	Bain, Trisha	06/03/2018	15	High	1. Review of Trust TNA and clinical education training plan to reflect practical MH training frequencies for all staff involved in undertaking MH tasks (including Estates, Fleet & Logistics). 2. Review use of small handling aids kit. 3. Review of current Datix incident categories to ensure these accurately capture/reflect incidents reported. 4. Deliver practical manual handling refresher training to all frontline operational staff during CSR 1 of 2018/19. 5. Send Manual Handling policy to PMAG for approval. 6. Ensure arrangements are in place to deliver practical manual handling training to staff in support services such as IM&T, Fleet, Logistics e.t.c. 6. Fleet & Logistics to commence the process for purchasing/replacing all version 1 Mangar Elk equipment.	1. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 2. Review and oversight by Manual Handling steering group.	9	Significant

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
676	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust. The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance some of which are listed below: 1. Lack of arrangements to clearly identify, assess and manage significant risks associated with manual handling, lone working and driving. 2. Outstanding actions from the HSE Improvement Notice issued to the Trust in 2010. 3. Lack of arrangements to effectively manage human factors associated with alcohol, drugs, fatigue or night work and their impact on HS&S performance. 4. Lack of clearly defined management systems. 5. Limited verification that controls or training are effective. 6. Limited performance reporting, monitoring or clear governance arrangements.	20/09/2017	46	20	High	1. Corporate Health and Safety Committee meeting structure in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in place through Datix. 7. ELT/Board oversight for H&S compliance through the Trust's committee reporting structure. 8. Regular update reports are provided for Trust-wide committees. 9. Responsible Director for Health and Safety in place for the Trust. 10. Regular reporting of H&S action updates through the monthly Quality Report, Quarterly Health and Safety Committee and the Quality Oversight Group. 11. Senior Management Level H&S Training completed by ELT/Board Members. 12. Health & Safety Strategy agreed by the Board. 13. Non Executive Director appointed for Health & Safety.	Bain, Trisha	21/03/2018	12	High	Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed separately). Conduct review of H&S compliance during Q4, 2017/18 in order to assess progress with Trust-wide H&S Performance. Agree Terms of Reference for the Corporate Health and Safety Committee ensuring appropriate representation. Implement a system of annual health and safety audits to identify and address areas of gaps in Trust-wide H&S performance.	1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group and monthly CEO Performance Meetings. 4. Non Executive Director appointed for Health & Safety.	4	Moderate
288	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients.	14/11/2002		20	High	1. Monitor level of CSR training and delivery. 2. CPs are used to monitor the standard of assessments provided. 3. Incident reporting is in place and reports are provided to the Clinical Safety & Standards Committee (CSC) and the Area Governance Groups. 4. The Operational Workplace Review has been reviewed and will now include ride outs. 5. A system for clinical updates is in place. 6. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 7. Introduction of Paramedic Pathfinder – an adaptation of the Manchester Triage System to safely identify the most appropriate destination for individual patients. 8. Introduction of reflective practice (as part of Module J programme). 9. Dissemination of learning from clinical incidents and Serious Incidents. 9. Medical Directorate and CARU monitor trends and themes via audit and incident reporting. 10. Clinical team leader and clinical manager updates completed (2015). 11. Deputy Director of Education and Standards directly oversee delivery of CSR 2016/2017 and content of the CSR sessions.	Wrigley, Fenella	12/02/2018	12	Significant	Undertake a review of the Capacity tool and training delivered to clinicians 2. Design processes to audit and monitor the effectiveness of the pathfinder tool. Incorporate a defined clinical career structure within the clinical strategy New risk to be submitted to SMT/ELT to reflect current clinical risk for ongoing clinical supervision. Core Skill Fresher Training 2016/17	CPI reports OWRs CSEC EMT/TB reports Learning from Experience	9	Significant
430	There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	08/12/2006		20	High	1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 25 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Robust implementation of the existing rest break policy 6. On-going rigorous management of out of service.	Woodrow, Paul	19/01/2018	12	Significant	1. 757 - Out of Service (OOS) Hub implemented. Central Support Unit (CSU) on PD33 deals with all OOS requests. 2. Recruit additional frontline staff. Review management and EMD capacity within EOC. 2. Agree the new rest break policy with Trade Unions. 3. Current rest breaks arrangements to be reviewed. 4. Update skill mix model. 5. An end of shift working group which includes trade union representatives commenced in early January and will publish its plan by 1 February 2018. 6. Implement new rest break policy. 7. Current rest break arrangements to be robustly applied. 8. Out of service HUB implemented Agree the process for the rest break arrangements to be implemented. 9. Recruiting frontline staff to 3169 by March 2016. 10. 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. 11. Increase rest break window to allow more time for the allocation of breaks Move 5 identified DCAs per hour and per sector onto an 'out of service' code so that it is only possible for them to be interrupted for a Category 1 call. 12. Identify 15 - 30 ambulances to provide extra DCA shifts between 11:00 and 23:00 hours (bridging shifts) so that additional cover is in place over the rest break window to protect the allocation of breaks. 13. Launch a robust communications strategy for internal and external parties which will explain the rationale for changes being implemented from 1 February 2018. 14. Development of a clear clinical safety process to support dispatch staff at times of reduced DCA availability. 15. Formal review of the number of rest breaks/flexible breaks taken three months after implementation. 15. Commence operational roster review. 16. Implement new rest break policy. 17. On-going rigorous management of out of service.	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the Operations Board on progress and compliance 5. Rest break allocation rates are reviewed at Chief Executive performance reviews 6. A task and finish group which includes executive directors, control services managers and medical directorate representatives are monitoring rest break allocation rates and have agreed the actions which are due to be delivered by 1 February 2018. 7. An operational roster review has commenced with ten stations due to go live with new rosters in September 2018 with the following 8 group stations going live in March 2019.	8	Significant
630	We do not have enough qualified Driving Instructors to train the amount of new entrant staff that we employ in emergency response ambulance driving. This has a significant impact on the Trust's Cost Improvement Programme, by having to fund the provision of external Driving Instructors at a representative monthly cost [December 2017] of £57,118, exclusive of VAT.	11/05/2017		20	High	Depending on budgetary constraints, we are able to fund the provision of external driving instructors. We are currently developing six clinical Tutors. We have some previous departmental DI trained staff working for us on an occasional basis.	Ivanov, Tina	09/03/2018	12	Significant	Source DI / tutor job description Advertise additional DI tutor posts Complete JD banding for Driving Instructor Role	The risk and controls relating to it will be reviewed at the monthly Risk Review meeting. External providers are regularly communicated with to ascertain the ability to cover current and future requirements. The long-term strategy will be discussed at the senior management team meetings.	8	Significant

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands	10/06/2016		16	High	1, Forward view of fleet requirement for next 5 years. 2, Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that unplanned maintenance levels do not adversely affect fleet capacity and the provision of safe environment to operational staff. 3, Ensure capital investment is committed to support fleet volume and replacement. 4, External/stakeholder support in place as required. 5, Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan. 6, Have an agreed vehicle specifications. 7, Agree and maintain adequate headroom in fleet numbers to manage variation. 8, BC 140 new vehicles agreed. 9, DCA and FRU specification signed off. 10, Revised fleet monitoring. 11, DCA fleet increased to support VP roll out. 12, 20 DCA vehicle held back for events/training. 13, Vehicle allocations to complex being revisited to assess against areas with excessive out of service time. Re-allocation and consideration of holding spares at Sector level to be considered. 14, Business case for 140 new ambulances is finalised for submission to TDA by DoF. 15, DCA & FRU specification agreed & signed off by Head of Fleet and Logistics. 16, Delivery of 60 new FRUs in 2016. 17, Development of a bid for 25 APP vehicles. 18, Development of BC for additional 60 FRU to be planned in for 2017. 19, BC for DCA approved by NHSI November 2016 impacting on delivery on 16/17. 20, Review of requirement for IRO's and GSM's. 21, Draft fleet strategy developed and distributed for comment Nov 2016	Benita Mehra	31/01/2018	12	Significant	Retain up to 50 ambulances following introduction of 140 new vehicles Manage roll out of 60 new FRU cars Progress Business Case for further FRU cars Review case to retain ambulances following introduction of 140 new vehicles Retain 20 FRU cars to increase size of fleet to 180 Review additional ambulance capacity to support roll out of new Vehicle Preparation Scheme Delivery of 140 new vehicles throughout 2017 Draft and implement action plan to ensure all potential capacity can be realised from the existing fleet	1, Forward view of fleet requirements 2, Plan in place to move current fleet to under 7 years 3, Capital investment requirement understood and reflected in LTFM 4, vehicle specification in place.	9	Significant
117	There is a risk that the equipment for front line vehicles may not be properly maintained. This may result in clinical failure due to faulty equipment	21/05/2015		16	High	1, Replacement equipment budgets in place, process agreed and adhered to. 2, Maintenance/Replacement of kit undertaken when required 3, Process for maintenance of equipment reviewed 4, asset database showing maintenance records	Benita Mehra	18/01/2018	12	Significant	introduce improved asset tracking to improve location tracking of equipment Clarify the risk and totally review Roll out of vehicle preparation project	Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet Reports and OOS reports	6	Moderate
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	21/05/2015		16	High	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, Vehicle Preparation HUB scheme in place - vehicles checked nightly for missing equipment. 5, Audit system in place for missing equipment. 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, Interservice 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. 12, Business case for the roll out of VP pan London has been agreed. 13, Project board and working groups established. 14, Review of delivery standards completed. 15, New KPIs reported through to QIP. 16, Deep dive by QIP panel completed. 17, Preparation of tender documents and standard commencing DEC2016. 18, Contract variations being developed to increase scope of works to include FRU and NETS vehicles. 19, Proposal developed for the implementation of a depot based make Ready managers and 2 Make Ready Operations Managers to oversee the delivery of the contractor, coordinate more effectively with Fleet Workshop managers and local operational management teams on a daily basis. 20, Additional equipment is being sourced to facilitate the roll out where needed. 21, Vehicle equipment being recovered pan Trust. To date E350K (Nov2016). 22, Implementation of 'managed stock' project across the Trust in line with VP roll out. 23, Approval of BC for new vehicles for delivery during 2017. 24, VP hub project fully rolled out with nightly audit of equipment and replacement	Benita Mehra	18/01/2018	12	Significant	Enhanced daily vehicle check Roll out Vehicle Preparation to rest of service Ensure adequate stocks of consumables and equipment are available to VP staff Fully develop equipment database reports to indicate where any equipment is missing	1, Clinical Equipment Group; 2, Asset tracking report; 3, VP reports; 4, VP Contract; 5, Equipment Process; 6, Project completion 7, Board reports and meeting minutes.	8	Significant
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	21/05/2015		16	High	1, Agreed 'standard load list' of vehicle equipment 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 physical review all stations and complexes for "retained" equipment has been undertaken. 9, A new paper based VP VDI form has been introduced. 10, Pilot to assess benefits of VP proposal carried out and documents describing benefit drafted. 11, BC for roll out of VP system pan London developed. 12, Board approval gained for BC 13, Project board and working group developed 14, Project plan defined and agreed 15, Additional equipment purchased to support roll out 16, project reclaiming, decontaminating and resupplying medical equipment established. 17, 'Managed stores' system established to support VP and daily supply of medical consumables 18, 'Blanket' trial and evaluation established and recommendations developed. 19, KPIs developed and monitored for the completion of wash and stocking of vehicles 20, Medicines management programme defined encapsulating all aspects of prep, supply and delivery, collection and disposal. 21, Development of Bag Review Group in April 2017 working schedule to review and replace modular bags as required and for personal issue equipment to be phased out	Benita Mehra	18/01/2018	12	Significant	Implement enhanced asset tracking system Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG Email Justin Wand to see if thinks this risk should be merged with 120	1, Progress made in agreement of core equipment and further equipment amnesty. 2, Decontamination of equipment commenced and robust. 3, Analysis of asset tracking systems being undertaken. 4, VP VDI improved 5, Ops VDI process changed and LA1 updated 6, required committees and working groups have been established to review	8	Significant

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
240	Archiving space for training records is insufficient and now decentralised	20/06/2016		16	High	1) Systems are in place to organise existing documents but don't incorporate new documents	Ivanov, Tina	09/03/2018	12	Significant	Transfer risk to corporate risk register Compose an options paper Construct gating template review risk and its activity with Deputy Director, Clinical Education Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting Gain formal project management support for this risk	Reviewed at monthly managers meeting	8	Significant
289	There is a risk that the management of controlled & non-controlled drugs at Station level is not in accordance with LAS procedure (TP/008 Policy & Procedure for the Use of Medicines by LAS Staff).	21/10/2008		16	High	1. Policy reminder to be reinforced by bulletins from Director of Operations/M edical Director. 2. Independent audits to be carried out throughout the Trust.4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 5. Daily audit checks. 6. The policy itself defines individual responsibility 7. Area governance reports to CQSEC. 8. Mandatory IIN reports to CCG. 9. Unannounced visits by MPS. 10. Annual attendance by MMOG to AO update days. 11. MMOG reports to ELT and Trust Board 12. Meds mgt events for Station Group management teams ongoing. 13. Seconded paramedic for audit / information collation and staff engagement. 14. findings from unannounced MPS visits shared with DDO's and ADO's. 15. Medicines management update for CSR2016.1 has been completed. 16. LAS pharmacist now in post, has conducted full estate review and has made recommendations on action to be taken. 17. Perfect Ward implemented pan-London and audits routinely conducted. 18. MedMan drugs usage monitoring portal - completion of form in drugs bag ensures drugs removed from drugs bags have been given to patients, enables drugs can be married up by ML. 19. OP079 - produced and signed off - go live 13th Nov policy on the transportation of control drugs (specifically schedule two medicines). 20. 'Secure drugs on station' project continues	Woodrow, Paul	09/02/2018	12	Significant	Trust Pharmacist to undertake review of operational estate to access suitability for storage and security of medicines Estates department to review and audit operational sites to look at feasibility of secure drugs rooms with CCTV/swipe card access Review process for managing controlled drugs Convert or create secure drugs rooms in the 24 stations identified for completion by end of 17/18 Funding request for LAS pharmacist and subsequent recruitment to post	1. Internal Audit 2. Independent Audit (MET Police carrying out spot checks) 3. IIN oversight of system 4. MMOG to CQSEC, EMT and Trust Board 5. New Medicine Safety Officer will carry out unannounced spot checks and provide feedback	8	Significant
302	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system. NOTE: Risk ID 205	01/06/2005		16	High	1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc. 2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system	Ivanov, Tina	09/03/2018	12	Significant	Management of student records Transfer risk to the corporate risk register. Construct gating template Compose an options paper Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting Gain formal project management support for this risk	Manager Governance responsible for: 1) Records are stored safely and securely, are identifiable and easily accessed, and meet all records management policies. 2) Records are archived in a timely manner as per information Governance policy	8	Significant
380	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	11/06/2014		16	High	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies. 3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available.	Fullerton, Ross	09/03/2018	12	Significant	1. The current MDT software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 & 3. 2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above. 3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process. 4. Obtain 2nd hand SatNavs from other Trusts.	IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweigh the volume of units required. In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles.	4	Moderate
559	there is a risk that ongoing delays in ambulance crews handing over their patients at Northwick Park Hospital ED will reduce operational cover in the surrounding area and compromise patient care.	05/12/2016		16	High	1. Intelligent conveyance desk 2. 24/7 monitoring of London EDs by Incident and Delivery Manager (IDM) 3. Regular hospital visits by Incident Response Officers 4. Regular meetings with NWP and NW SEM 5. Trolley bed vehicle can be deployed to EDs where there are significant problems	Woodrow, Paul	21/02/2018	12	Significant	Hospital Meetings Raise hospital issues at CCG meetings attend daily NWL surge conference calls Daily contact with NWP Staffing of performance cell Attendance at daily LAS performance meetings staff communication Provide updates on NWP patient Cohort nurse Deep dive analysis System review attend meetings Frequent caller activity Standardise ACP raise profile of handover delays work with STP	1. Intelligent conveyance report - including crew compliance 2. IDM shift report 3. Report by exception in the IDM shift report 4. feedback at the weekly NW Sector performance meeting 5. Strong local links with NWP senior/Exec Management team Archived: 6. Trust Performance cell running for 16hours daily which monitors ED activity/build up. 7. 2 x daily performance meetings/conference calls 8. Daily NWL Surge conference calls attended by SEM 9. Daily visits/contact with NWP by SEM (completed)	4	Moderate
589	There is a risk that the Clinical Hub are unable to achieve optimal staff retention which will decrease its capacity to carry out the required functions and therefore may impact on patient care.	26/01/2017		16	High	1/ Staff are given clinical shifts at every opportunity. A second FRU has been sourced and equipped for clinical shifts. Work is on-going to source a second DCA. Staff are aware that we are looking at options to present a rota that will incorporate clinical time. Individual staff are prioritised for clinical shifts if their PDR / action plan prescribes it as an issue. CTLs use a 97 call sign when there are enough staff on the desk which allows them to respond to critical calls or those to support staff on scene. 2/ CTLs have been given the opportunity to undertake office shifts on one of their relief lines (where staffing allows) allowing them to carry out their management functions. 3/ Work is underway to trial a remote site at either Croydon or New Malden control room. 4/ No controls currently in place for Band 6 issue except all of the above making staff want to remain with the CHUB.	Cranmer, Pauline	19/02/2018	12	Significant	Source and equip a second ambulance Rota review to include clinical shifts Remote site working	1/ Actively working with the DDO Logistics who is very keen to improve the CHUB clinical issues and wants CHUB to assist with equipment trials. Preparing information for DDO Control Services to consider around staffing options. 2/ 12 Field Ops CTLs to CHUB recently - recruitment for CAs just completing - CHUB CTL advert has been placed. All will likely improve staffing. 3/ Close working is on-going with IMT to review requirements for a remote site. Survey results will determine the effectiveness of this trial. 4/Team will review all Band 6 information to determine CHUB impact.	4	Moderate

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
650	There is a risk that the management of bank workers is not meeting current standards relating to training, governance and management.	04/07/2017		16	High	1. There is a co-ordinator in post to manage Bank Workers. For performance management Bank Workers are allocated to a sector, central control will be held by Resourcing who will ensure compliance with necessary checks (driving licences, DBS and training). 2. New Terms of Engagement have been completed and have now been issued to all Bank Workers. This sets out expectations on remaining compliant with the Trust's StatMan training. 3. Bank Workers found not to be compliant with training obligations have been removed from the Register until they have completed the training or provide evidence of acceptable standards from work with other Trusts. 4. All external Bank Workers go through full recruitment process (in the same way as substantive employees). External bank workers (i.e. not ex LAS) are Paramedics required to uphold their professional registration. Core skills must be maintained to successfully re-register. 5. DBS re-checks are prioritised as part of the DBS re-checking project agreed by the Trust in 2017. 6. A process has been set out to manage the recruitment and employment checks for Bank Workers	Grealish, Patricia	21/01/2018	12	Significant	Stat + Mand training Recruit Bank Coordinator DBS check all Bank workers	1. Bank Worker contracts, reviewed by Beachcroft, are now in use 2. Only 'active' Bank Workers – who have worked a shift within the last 12 months will be on the active register (they will be required to give evidence of training to remain 'active')	4	Moderate
767	Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	26/02/2018	51	16	High	Business continuity plan is in place which includes Legal, people, and OD feedback.	Ward, Justin		12	Significant	We are developing a tender for services which we will be taking to market in the next four months	The business approach is being discussed with NHSI and the Cabinet Office bi weekly	4	Moderate
388	Capacity and capability planning The lack of capacity and capability to design and consolidate a sustainable future architecture, accommodating future needs, will result in an unsustainable infrastructure with failures and patient implications.	28/06/2016		15	High	1) A Technical Design Authority (TDA) role has been introduced as part of the interim IM&T structure with overall accountability for the definition of the Enterprise Architecture, Application and Technical Architecture roadmaps to enable the Trust's business objectives. 2) there is existing co-ordination of technical approach, which to date has been conducted through the IM&T SMT team. 3) there is technical monitoring of some aspects of the Trusts infrastructure, with reactive (lag) capacity measures being implemented as and when necessary. 4) ongoing capability and capacity management - linked to portfolio of IM&T projects and initiatives	Fullerton, Ross	08/03/2018	12	Significant	Propose introduction of TDA as part of IM&T Strategy Obtain funding to introduce and IM&T TDA Implement TDA	1) demonstrate reduced failure 2) demonstrate continual monitoring and consequential decisions / actions without the need for critical /emergency changes 3) Periodic audit of the process and measures.	3	Low
708	EMDs remaining on line for mental health callers or patients threatening suicide is impacting on call answering performance.	27/10/2017		15	High	While EMDs have attended mental health awareness session Mental Health Nurses work in EOC	Cranmer, Pauline	19/02/2018	12	Significant	Reviewing types of calls and frequency. To review what support can be given in EOC. QA to include in their audit/feedback of such calls how long EMDs stay on the line if unnecessarily.	Further discussion at the Quality and Business Group meeting	9	Significant
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement	27/05/2016		12	Significant	Risk management training sessions for managers was rolled out across the Trust from November 2015 and monthly sessions are still on-going. Risk registers are reviewed quarterly by the Governance and Assurance Team and areas of non compliance are reported to the Risk Compliance and Assurance Group. The Governance and Assurance Team provide support to areas and directorates through the attendance at meetings and 1:1 support where required.	Harding, Philippa	09/02/2018	12	Significant	Review areas review processes with reviewing and updating risks Review progress with risk management of higher level risks within directorates. Audit of local risk registers to be presented to RCAG each month for escalation of non compliance.	Compliance with the process is reviewed by the Risk Compliance and Assurance Group and areas of non compliance are escalated to the appropriate Directors.	4	Moderate
28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule. The impact of this may be: * adverse publicity / reputation * court order for specific disclosure which has financial implications; * adverse finding by HM Coroner / trial judge; * financial implication of settling claim as a result of not having any evidence to rebut allegations which could be disproved with the benefit of accessing voice recordings.	10/02/2016		12	Significant	Whilst the call log provides a summary of information noted this is not deemed to be an adequate control. Work is being undertaken by IM&T to source parts to keep the system running as and when required	Harding, Philippa	08/03/2018	12	Significant	Provide update for Risk Register HWH from R Clifford? Speak with IM&T re 111 risk Speak with Pauline Cramer re risk of over-recording Revert to RC for more detail Procurement and installation of new equipment Investigate conversion of DAT tapes to a modern media	IM&T are working on two projects to convert existing tapes and to procure and install new equipment and to investigate conversion of DAT tapes into a modern media	8	Significant
411	There is a risk that the lack of ownership of and responsibility for information assets will increase the likelihood of a security breach or data loss incident occurring.	08/10/2014		12	Significant	None	Fullerton, Ross	23/02/2018	12	Significant	Create and launch IA management framework Identify the IT information assets and owners Introduce a policy to assign an Information Asset owner (individual) to every new and existing IT information asset	Risk discussed and monitored by IM&T SMT	3	Low

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
439	There is a risk that tail lift failures on operational ambulances will impact on patient care. Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07/10/2013			12 Significant	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis (Updated 11/15 – S.Westrope amended maintenance schedule for A&E – every 12 weeks). 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with Loler compliance. Additionally independent inspections by the Freight Transport Association are undertaken. These are on a 10% inspection basis. 4. Reduce age of vehicles as the tail-lift is being used past the “designed life”. 5. Ambulance design reviewed to include tail lift (from further actions) 6.Alternative tail lift has been fitted to a small percentage of vehicles (from further actions) 7.Training programme for workshops on fault finding organised (from further actions) 8. Signage placed in Ambulances to indicate the type and correct operation of the tail lift in question. (from further actions) 9. Instructional video demonstrating the procedure to operate the tail-lift in an emergency – placed on the “Pulse” June 2015 plus notes in “RIB” (from further actions) 10, 104 new A&E Ambulances to replace 67 x 12yr old units.(from further actions) 11, new tail lift design being implemented as part of New DCA specification (140 vehicles) Contract management in place Contract let to specialist contractor supporting maintenance	Bewes, Lorraine	18/01/2018		12 Significant	Fit new parts and springs to tail lifts at LOLER safety checks 6 week saety check on tail lift Fit new springs and covers to vehicles at next service and then at MOT Change tail lift springs annually and place protective cap on mechanism. 140 new ambulances with new external tail lift l	1. Motor risk management group review identified incident related to operational vehicles. 2. Corporate Health and Safety Group review all incident statistic trends. 3. Fleet management meet on a weekly basis and also review vehicle incident rate trends.	8	Significant
448	Due to the expansion of functions in Control Services, there is a risk that in the event of a planned or unplanned CAD outage or need to move to single site working, there is insufficient space to adequately accommodate all EOC functions. As a result, a decision will be required as to what NON-CRITICAL functions will not be undertaken should the above occur.	11/06/2016			12 Significant	Current actions identified are: Priority list of NON Critical functions to be stopped is circulated. Watch Managers tasked to dynamically assess requirements	Cranmer, Pauline	19/02/2018		12 Significant	Review of CRITICAL and NON CRITICAL functions of EOC Review of the Trust/EOC Business Continuity Plan Review of EOC estate capacity issues Identify potential suitable sites for expansion, both internally and externally Review relevancy of current dispatch model Review numbers of staff required for each function	Plan for paper operations (OP66) is up to date and is available on The Pulse Dates are planned to test the Control Services plan for paper operations Control Services representation is included in the BC / DR steering group	6	Moderate
468	Risk that the communications team is unable to obtain accurate, timely information about casualties from Gold during a major incident, which leads to inaccurate information being put into the public domain, risking a drop in public and stakeholder confidence in our ability to manage major incidents.	14/09/2016			12 Significant	1. Communications team attend Gold meetings during a major incident. 2. It has been agreed that Gold will be the link for the communications team in terms of providing casualty numbers and details. e. Communications team policy is not to work with the lowest figure provided regarding casualties and provide a round number, for example, over xx casualties.	Patton, Angela	17/01/2018		12 Significant	Meet with Ops to clarify risk and identify mitigation - post RCAG 12 May 2017 Request that process re provision of casualty figures is added to major incident plan	This issue has been discussed with former Director of Operations and EPRR lead.	6	Moderate
475	There will be a detrimental impact on service delivery targets at times of high demand. Unexpected and unplanned increase in call volume which outstrips staffing capacity may have a detrimental effect on the service delivery.	23/09/2016			12 Significant	1. Demand management plan in place to manage acute changes in demand 2. Operational managers on duty 24/7 to monitor performance, changes in demand and escalation to relevant parties when required 3. On call access to LAS111 senior management, EOC Incident Delivery Managers, Gold on call Directors and NHSE representatives 4. Business continuity plan in place with escalation procedure documented	Daw, Nicholas	23/02/2018		12 Significant	1. Review of business continuity plan Review of staffing forecasting against predicted demand Ongoing recruit to fill vacancies Roster review Build break relief into rosters Review of business continuity plan Review of staffing forecasting against predicted demand Review Recruitment Plan for 111 Roster review	1. Current staffing matched against forecast planning 2. Continual use of agency staff to cover gaps 3. Roster review commenced to include training and relief addition to forecast.	8	Significant
580	There is a risk that the Attobus MPC-2 Mobile Data Terminals (MDT), currently installed in fleet vehicles will become unserviceable. This is due to the age of the units and the withdrawal from the market place. This would result in delayed response times, impacting on operational efficiency, and the potential for vehicles to remain Out of Service (OOS) if the existing unit cannot be repair and no other spare unit is available.	16/01/2017	45		12 Significant	The current spares holding is at an acceptable 10% of the active fleet. Approx. 70 units. This is actively monitored by the third party supplier Telent. However, if fleet planned to grow the number of frontline vehicles and require additional units, the likelihood score will increase.	Fullerton, Ross	08/03/2018		12 Significant	Confirm Telent spares stock	Telent are under contractual obligation to manages the MDT assets.	3	Low
675	There is a risk that the management of the student journey is reduced due to the reliance on local databases for recording activities, leading to decreased accuracy in, and restricted accessibility to, progress details.	19/09/2017			12 Significant	Recording of all activities on a student database, held centrally. Utilising other electronic systems where possible such as OLM, ESR, GRS and Moodle Scanning and electronic storing files and copies of documents in common drives	Ivanov, Tina	09/03/2018		12 Significant	Set up a meeting for a demonstration of the Intrepid database	Standardisation committee Credentialing committee	3	Low
678	Risk of physical and non-physical assault to frontline staff who come into contact with patients and members of the public during the course of their work. The impact of these incidents include: 1. Emotional, psychological distress to staff members. 2. Physical harm/injury to staff members where they are physically assaulted. 3. Loss/decline of staff morale. 4. Increase in staff absences thereby impacting on service delivery. 5. Negative reputational damage to the LAS as an employer. 6. Increase in claims and litigation to the Trust.	20/09/2017			12 Significant	1. Security Management Policy implemented. 2. Violence Avoidance and Reduction Procedure in place. 3. Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4. Local management support, LINC and counseling services are available to staff. 5. Monitoring of incidents via the Trust's Health & Safety Committee where incident trends are reviewed and actions agreed to mitigate risks to staff. 6. Specialist advice available across the Trust via the LSMS and Health, Safety & Security Team. 7. High risk address flagging procedure in place and communicated to all relevant staff. 8. Air Wave radios and panic alarm systems implemented for all front-line staff. 9. Where appropriate, IRO and Police support available for staff. 10. Operational monitoring of incidents at Sector Level through the QGAMs and GSMs. 11. Conflict resolution training is provided to all frontline staff at induction and refreshed every 3 years. 12. Obstructing Emergency Worker legislation in place. 13. Post Violence Support Procedure in place to support staff. 14. Stab vest and relevant PPE are provided to A&E and NETs staff. 15. H.S & S Team pro-actively monitors all incidents reported to ensure appropriate follow up, investigation, and share lessons/alerts across the Trust. 16.LSMS ensures regular communication and follow up of incident trends with Sector QGAMs, GSMs and staff. 17.H.S&S Department to provide extra training to Team Leaders who will support staff affected by incidents where requested. 18. Trust-wide lone working arrangements and risk assessments reviewed and implemented.	Bain, Trisha	08/02/2018		12 Significant	H&S Team to liaise with Wellbeing Team regarding the implementation of stress audits. Stress work group being formed. LSMS to work with Training/Operations regarding the timely issue of stab vests to new starters. H&S Team to support Ops with implementing lone working arrangements across the Trust with the view of implementing robust risk assessments that addresses the risks associated with lone working. H&S Team to incorporate security training into the Trust H&S Induction Training Sessions.	1. Incidents reported on the Datix System. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Periodic review of High Risk addresses by the Operations Team.	6	Moderate

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
681	There is a risk that the Trust will be unable to meet it's statutory RIDDOR reporting requirements due to: 1. lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. delayed reporting of incidents received or reported retrospectively.	20/09/2017		12	Significant	1. Daily monitoring of Datix incident reports to highlight and follow up on likely RIDDOR incidents. 2. Support and expertise available from the Health and Safety Team. 3. Training provided to all Team Leaders and Managers as part of the Managing Health & Safety course. 4. Highlight reports from GRS relating to staff members who are injured at work. 5. Datix incident reporting system in place to capture RIDDOR incidents when reported across the Trust - all paper reporting forms withdrawn. 6. Monitoring of RIDDOR incidents through the Corporate Health and Safety Committee. 7. Trust wide Sector based H&S reports provided to ELT and to Trust Senior Management. 8. Bulletin and communications sent out to all staff via the RIB to increase awareness of RIDDOR reporting. 9. Datix system updated with guidance to support staf when reporting RIDDORs. 10. Regular review of RIDDOR reporting performance at monthly Sector Governance Meetings.	Bain, Trisha	06/03/2018	12	Significant	1. H&S Team to reinforce the importance of reporting incidents to staff through training, bulletins e.t.c. 2. Corporate health & Safety Committee to monitor overdue/outstanding incident investigations and escalate to relevant managers to ensure closure.	1. Review and oversight of RIDDOR incident reporting by the Corporate Health and Safety Committee. 2. Gaps in RIDDOR reports provided to Committee due to the timeliness of identifying RIDDOR incidents and reporting to the HSE.	3	Low
699	The Supplier of the Redbox recording system for 999 and 111 calls, does not proactively, manage O/S and security updates from Microsoft. Therefore if Microsoft release a security update for its servers or an O/S patch. Redbox do not test these patches or updates first to ensure that they will work with a customers configuration. Therefore the customer takes the risk of applying these patches/ OS upgrades and if they cause an issue only at that time will Redbox work with us to produce a solution. We do not have a test environment currently in place to test any new patches or O/S updates	11/10/2017		12	Significant	A test environment will need to be put in place to ensure that any updates from Microsoft for their servers can be tested before being released to the Redbox servers	Downard, John	30/01/2018	12	Significant	a test environment to be provided to test new patches.	A test environment will ensure that we can control and test and patches in a safe environment.	4	Moderate
246	Failure of the 999 line recording system to record all calls into and out of the Control Suites will compromise the Trust's ability to maintain a full Patient Record, to manage quality or respond or learn from queries, complaints and investigations.	15/03/2012		15	High	1. Review by IM&T of all lines to be recorded and provision of extended service to EBS 2. Testing of recording at Bow to ensure consistency of service	Fullerton, Ross	19/02/2018	10	Significant	Provide links for Access to Airwaves recordings via Redbox Ongoing monitoring of the system, particularly at Bow, where problems have been experienced. IM&T to work to ensure all critical lines recorded at both sites.	1. On-going monitoring of the system, particularly at Bow, where problems have been experienced. 2. IM&T to work to ensure all critical lines recorded at both sites	5	Moderate
712	There is a risk that the Trust remains subject to Special Measures as a result of not having made sufficient sustained improvement in its CQC ratings	17/11/2017		15	High	Quality Improvement Programme	Harding, Philippa	30/01/2018	10	Significant	Additional activities required to successfully complete the Quality Improvement Programme	On-going reporting to the Board and ELT CQC re-inspection in Q4 2017/18	10	Significant
768	The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	26/02/2018	50	15	High	The current UPS has until this point been effective when a power failure occurred. This was tested recently when the UK Power main supply failed.	Nelham, Martin		10	Significant	A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.	No degradation of service materialised during the power failure	5	Moderate
481	Limited live reporting tools are available to 111 operational management (wallboard, Individual Monitoring etc.) The performance wall board used to monitor the number of calls waiting to get through to LAS111, the abandonment rate, SLA and staff activity by skill set has not been available since the 31st March 2016. This impacts the Operations Supervisors ability to proactively manage service demand. There is a risk that calls waiting to get through to LAS111 will be delayed.	23/09/2016		10	Significant	Operations Supervisors use 'calls waiting' metric to monitor real service access, this is present on the current iteration of the wallboard. Also in use is the additional functionality within Cisco Supervisor Desktop (CSD)- this allows ops supervisors to measure staff 'not ready' status.	Fullerton, Ross	23/02/2018	10	Significant	To install new visual managent tools within the SEL 111 contact centre NWAS Visit Add evidence from NWAS visit to risk record	There is a known problem whereby the reports that are available are not updating in a timely way. This is with principle suppliers for further investigation under problem ref: 40010105 **This has been resolved - JW 11/04/2017**	2	Low



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Serious Incident Update			
Agenda item:	14			
Report Author(s):	Kirstie Smith, Clinical Advisor to Legal & Governance Michael Ward, Head of Quality, Governance & Assurance			
Presented by:	Trisha Bain, Chief Quality Officer			
History:	Quality Assurance Committee meeting on 20 March 2018			
Status:	☒	Assurance	☐	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This paper includes an outline of the current status in relation to serious incident (SIs) and aims to provide assurance to the Board that actions from closed investigations are complete or on track for completion within the provided timeframe. An analysis of SI activity will be provided in the following formats: SI activity by month Number of SIs by sector and STP Clinical Commissioning Group (CCG) feedback Category type (theme) Number of outstanding (overdue) actions by sector Additionally this paper will provide a monthly summary of the SI investigations that were submitted as final to the CCG and the executive summaries from these reports (appendix 1). An overview of the Trust Duty of Candour compliance will be provided.				
Recommendation(s):				
The Board is asked to note the attached report				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				

Please indicate which Board Assurance Framework (BAF) risk it relates to:**Clinical and Quality**

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

Serious Incident Update

Context

1. During February 2018, eight Serious Incidents (SI) reports were submitted to the CCG.
2. The Trust's current position on meeting the 60 working day target for submitting SI reports is 100%.

Investigation Update

3. Summary of SIs activity: SI investigations submitted to the CCG during February 2018.
4. Of the 33 actions detailed below 48% have been completed and closed (n=16). 15 are currently in progress and are within the assigned deadline (45%) and two have breached the assigned deadline due to staffing availability and shift patterns but will be completed by the end of March 2018.
5. Executive summaries of all closed SI's can be found in Appendix A

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescale (60 days)
2017/28832	Clinical advice	EOC	22.11.2017	Paramedic A to complete reflective practice and discuss with CTL if clarification is needed about how best to request information from EOC	31 March 2018	21.02.2018	Submitted by deadline
				EMD B and EMD C should have a meeting with their Watch Manager to remind them of the reasons behind exchanging names with call takers when details are passed	Complete		
				Responsible manager for the roll out and implementation of iPads should ensure that the Director of Services is as easily accessible as possible on the iPads	Complete		
				Review to be undertaken to identify improvements to PD09 desk	31 May 2018		
				The CCG to pick with Hospital A for not identifying that patient	N/A		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescale (60 days)
				should not be conveyed there.			
				Review of OP022 and ratification through Policy Monitoring and Assurance Group	31 May 2018		
				Meeting to be held with Hammersmith Hospital with the intention of securing agreement to release LAS crews more quickly following arrival at the hospital with patients	31 May 2018		
				Governance Team to meet with EOC Senior management to discuss how contact should be made with EOC staff for SI investigation purposes	31 May 2018		
2017/28219	Unexpected child death	North East	15.11.2017	Ensure policy is fit for purpose after introduction of ARP	Complete	14.02.2018	Submitted by deadline
				Ensure all EOC staff are aware of procedures around dispatching of resources	30 April 2018		
				Ensure that all EMDs have a good working knowledge of A&P particularly suited to their role	30 April 2018		
				Will provide a 'real life' example of obstructed breathing and ineffective breath sounds to EMDs	30 April 2018		
				Map to BAF risk 47 on the insufficient staff in EOC	Complete		
2017/27537	Clinical treatment	West	08.11.2017	Feedback to be provided to the EMD to ensure pre-arrival instructions are provided in all cases where required.	Complete	06.02.2018	Submitted by deadline
				Paramedic A should be reminded it is acceptable to use AED mode if required	05 March 2018 Delayed due to staff		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescale (60 days)
					availability		
				A supportive clinical roundtable discussion to be undertaken with the responding staff	05 March 2018 Delayed due to staff availability		
				This report be shared with CEWG	Complete		
2017/28770	Dispatch and call	EOC	06.12.2017	Continuation of the ongoing Trust wide improvement program – Trust risk 337	Complete	20.02.2018	Submitted by deadline
				Ensure policy (OP/023) is fit for purpose after introduction of ARP	Complete		
2017/28247	Clinical treatment	West	15.11.2017	To implement a competency based special training package for all staff involved which will include cardiac arrest management recognition of VF, its associated variants and presentations	Complete	14.02.2018	Submitted by deadline
				Provide a supportive mentoring plan for Paramedic B which will be led/overseen by a relevant experienced expert clinician	Complete		
				Review current relevant guidance's efficacy including the 2017/3147 thematic review's action plan for VF and implement any identified areas of improvement with a re-launch	Complete		
				Continue to increase organisational awareness of Human Factors by embedding this in all aspects of clinical training including advanced life	Complete		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescale (60 days)
				support and core skills refresher courses which will emphasise the need for all paramedics to understand the command gradient concept and how to avoid it to facilitate effective communication and challenge on clinical decisions between differing levels of staff.			
				Use this incident as a case study for sharing at various local patient safety platforms, e.g. Clinical update, Insight to promote learning across the Trust.	30 March 2018		
2017/28774	Dispatch and call	EOC	23.11.2017	Hospital A should be advised that transfers should be booked at the earliest opportunity especially when there is a treatment window	Complete	20.02.2018	Submitted by deadline
				Feedback should be given to Hospital A that the agreed inter hospital transfer times are a guide and response times can vary depending on the demand the trust is facing and any ongoing incidents in the area	Complete		
				The outcome of this SI should be fed back to Hospital A highlighting that accurate information should be given at the time of the call and any subsequent updates on the patient's condition should be relayed to the control room as it may affect the category of the	30 March 2018		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescale (60 days)
				call.			
				That the family of the patient should have a copy of the finished report.	Complete		
2017/28852	Dispatch and call	EOC	19.11.2017	To continue with the trusts plans for resourcing linked to the Trust risk 337 - Service Performance may be adversely affected by the inability to match resources to demand.	Complete	21.02.2018	Submitted by deadline
2017/29393	Clinical assessment	North Central	22.11.2017	Issue specific guidance in the form of a bulletin regarding the management of discharges	30 March 2018	21.02.2018	Submitted before deadline
				Local managers are directed to disseminate the bulletin and monitor staff uptake	30 March 2018		
				Review and re-issue of TP 017 and adherence to the implementation plan	30 March 2018		
				Clinical Audit and Research Group add staff educational audits to their programme	30 March 2018		

SI Activity by Month

- During February seven SIs were declared. Fig. 1 shows the monthly distribution of declared SIs across the Trust compared to the previous year.
- The noticeable increase in declared serious incidents in January 2017 related to the 2 SI's linked to the CAD outage and 2 SI's for unaccounted loss of controlled drugs.

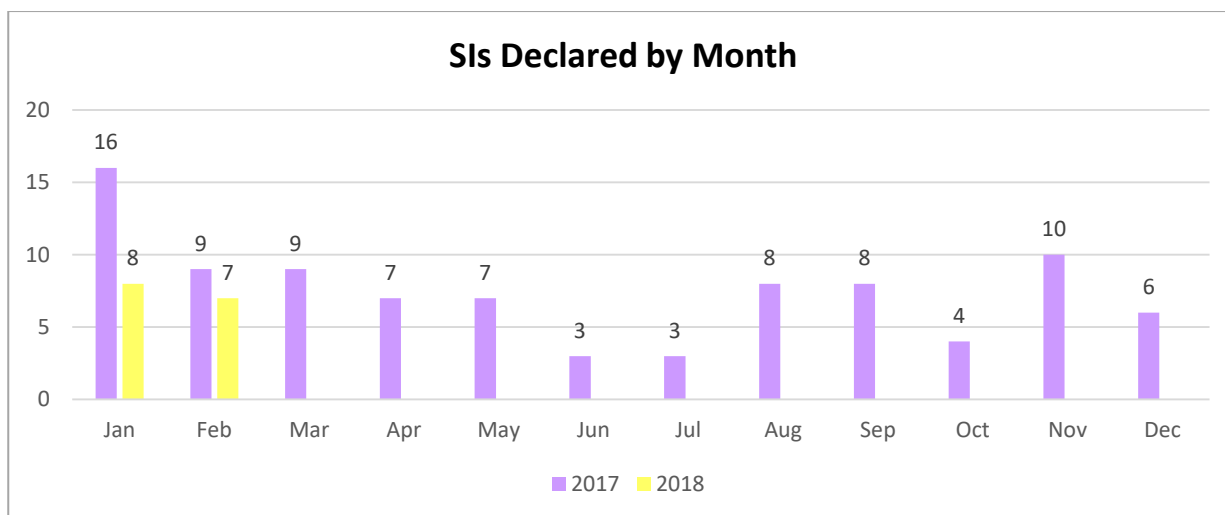


Fig. 1: Serious Incidents Declared/Month

CCG Feedback – February 2018

8. It is considered that by capturing themes in the comments the Trust receives from the CCG prior to the closure of a report may assist in the identification of gaps in our investigations or a lack of clarity that can be used to improve the quality of the investigations, reports and actions.
9. During February 2018 the CCG raised several questions regarding service demand and the current protocols within EOC. Specifically they raised questions around Operational Policy OP/023 – Procedure for the Dispatching of Resources by EOC and the management of calls awaiting an emergency response.
10. Additional questions were raised around the risk mitigation considered before the implementation of the Ambulance Response Programme and organisational learning.
11. Clarification around clinical protocols and equipment concerned the management of cardiac arrests and the LifePak 15 monitors.
12. All questions referred to the Trust by the CCG were responded to before the provided deadline.
13. The Quality, Governance and Assurance Team will continue to monitor the comments for recurrent themes and trends. Anticipated actions for the Team include inviting the Commissioners into the Trust to enhance their understanding of the protocols and processes within EOC.

SI Category Themes – February 2018

14. As reported in the quarterly thematic review, minor issues in call handling and dispatch have been identified. As a result the Quality, Governance and Assurance Team have provided feedback to support the EOC action plan. Of note, three EOC Policies have been reviewed and updated to reflect learning from SIs. It is expected that the number of SIs relating to out of date policies will reduce by quarter four.
15. Actions completed this month:
 - a. Operational Policy (OP/060) – Control Services Call Taking Procedure has been updated and published

- b. Operational Policy (OP/023) – Procedure for the Dispatch of Resources by EOC has been updated and approved by PMAG ready for publishing
 - c. Operational Policy (OP/066) – Operational Procedure for the use of Paper Operations within Control, is currently under review by subject matter experts
16. A learning from SIs training session has been developed and delivered during all core skills refresher days for all members of staff working within EOC. The training is being delivered by the Head of Quality, Governance and Assurance and the Clinical Advisor for Legal and Governance. The aim of the training is to ensure that all members of staff are familiar and aware of the SI investigation process within the Trust, including how incidents are identified and declared. Specifically, learning from incidents that concern EOC is presented and discussed. To date five training sessions have been provided throughout January and February 2018 with a further two sessions are planned for March 2018.
 17. A clinical safety review of the management of calls referred to the Trust by Healthcare Professionals and the use of the Non-Emergency Transport Service was completed during February and submitted to the CCG on 7th March. The findings of this investigation will be provided in the March report.
 18. The focus of the Quality, Governance and Assurance Team over the coming months will be on the clinical treatment and assessment issues identified.
 19. To date the team have provided learning from SI investigations and contributory factors training to the Paramedic Academy students and will continue to provide this training for future courses.
 20. High level reports are presented to individual meetings on a monthly and bi-monthly basis to ensure learning from incidents is considered when proposed changes across the Trust are discussed. Examples include the Patient Safety Group, Clinical Standards Working Group and Infection Prevention and Control Committee. More recently the team have been asked to provide a similar report for the Clinical Education and Standards Group.

SI Action Compliance

21. Following the identification of a significant number of outstanding actions from closed SI investigations in July 2017, there has been a noteworthy decreased in the number of actions that are have currently breached the assigned deadline.
22. Whilst there remains 12 actions that are yet to be completed, the Quality, Governance and Assurance team have been communicating on a weekly basis with the accountable managers and providing support where required. (Fig. 2)
23. The majority of actions that are currently overdue are in progress however some have been delayed due to factors outside of the control of the responsible manager. Staff absence and shift patterns have delayed the ability to provide additional training and/or feedback however these are expected to be completed in the coming month.

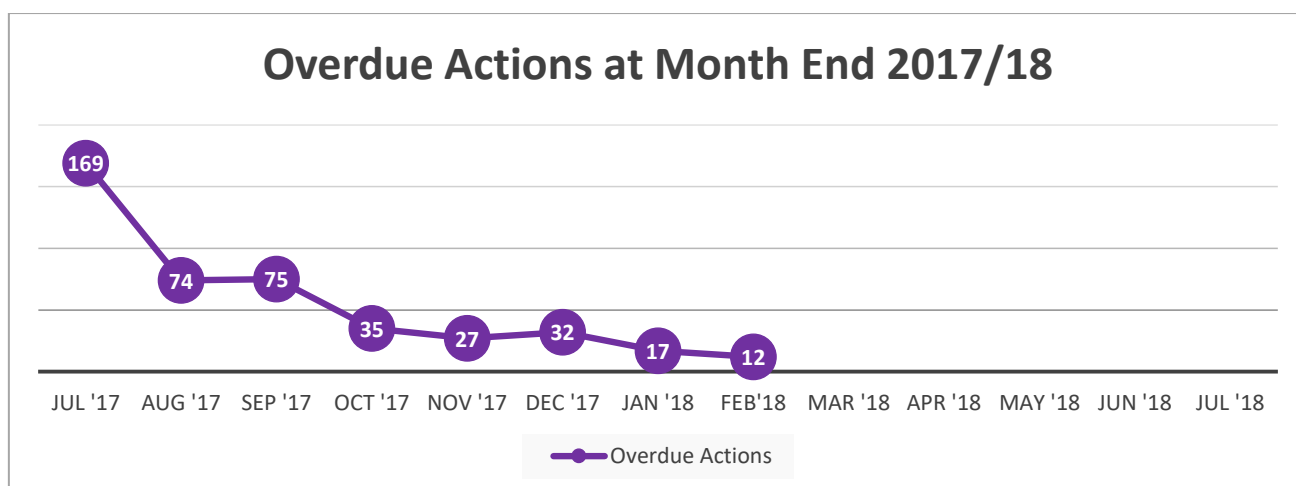


Fig. 2: Outstanding Actions/Month

Duty of Candour Compliance – February 2018

24. The Duty of Candour is a statutory requirement applicable to all declared SIs within the Trust.
25. Fig. 3 demonstrates the Trust current Duty of Candour compliance for serious incidents declared during quarter 3.
26. Of note the initial apology was not provided for seven incidents as the Quality, Governance and Assurance Team were unable to make contact with the patient's next of kin despite significant efforts. Method used to ensure compliance included telephoning the patients documented next of kin, voice mail messages, communications with the hospital and/or the patients last known location (care home, nursing home, hostel etc.) and cross checking the provided next of kin details with the patients GP or utilising the NHS Spine.
27. Formal letters were sent for 14 of the 18 SIs investigated. Where this was not achieved the Trust had not been provided with, or managed to obtain a forwarding address for the patient's next of kin.
28. Currently eight reports are with the CCG awaiting official sign off before the final stage of the Duty of Candour process will be completed.
29. Additionally there were two investigation where the patient next of kin expressly stated that they did not want to be involved in the investigation process including receiving a copy of the final report.

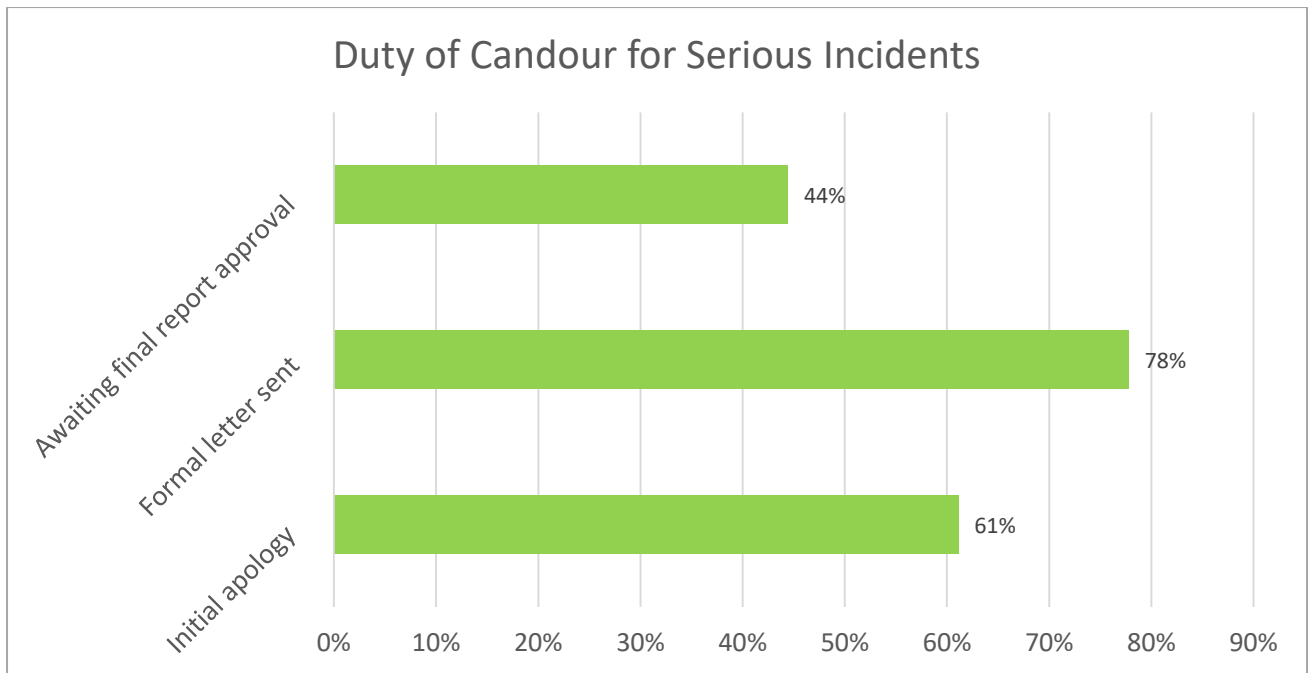


Fig. 3: Duty of Candour Compliance 1

Incidents

- 30. The Trust has set a year to date trajectory for the reporting of incidents that have been graded as no harm and low harm.
- 31. Fig. 4 provides a summary of the incidents reported by quarter and Fig. 5 demonstrates the year to date reporting figures for no and low harm incidents.
- 32. The target for no harm incidents is 1200 per year which the Trust has exceed.
- 33. The target for low harm incidents is 500 per year with the Trust is currently on track to achieve.

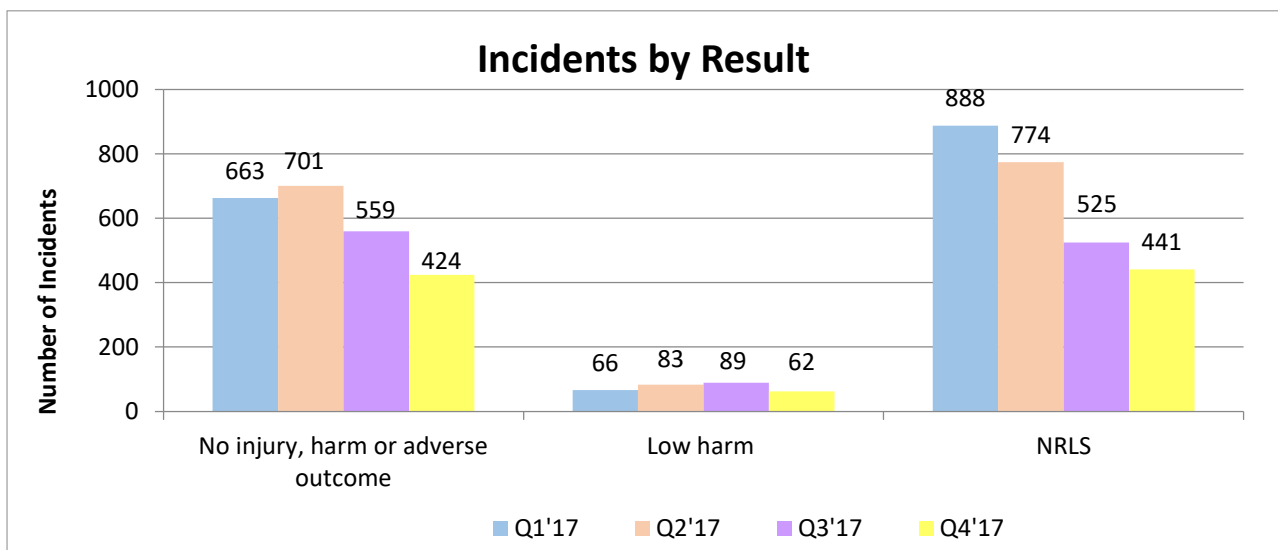


Fig. 4 No, Low & NRLS Reporting 1

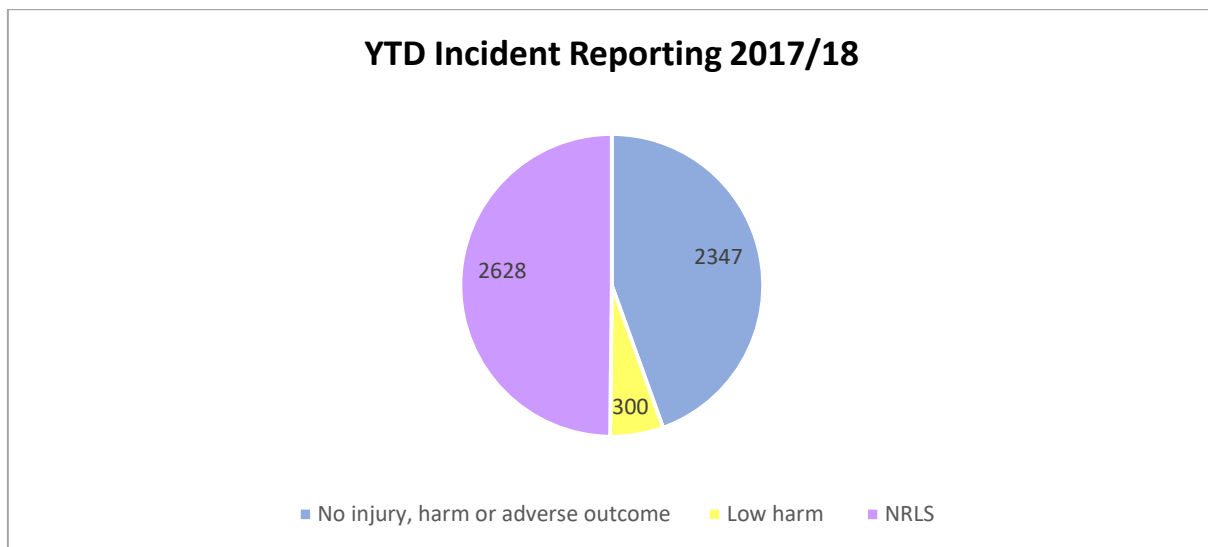


Fig. 5: Year to Date incident reporting 1

Actions & Assurance

34. We are maintaining our targets of 60 working days in relation to submitting completed SI investigations.
35. SI action compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required.
36. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the serious incident group and assurance processes.
37. Additionally, by monitoring comments received from the CCG it is thought that the Trust can learn from identified themes to improve our investigations and reports.

Dr Patricia Bain
Chief Quality Officer

Appendix 1 – Executive Summaries for SIs Submitted to CCG February ‘18

STEIS: 2017/28832

Incident description:

Following the identification that a patient needed to be conveyed to a Heart Attack Centre (HAC) the crew contacted the Emergency Operation Centre (EOC) to request the location of the closest specialist unit.

The EMD provided the incorrect location, resulting in the patient being transferred to the Local Emergency Department (ED) before later being taken to the nearest HAC resulting in a 20 minute delay to arriving at definitive care. The patient suffered a cardiac arrest and died following handover at the HAC.

Immediate risk mitigation:

Crew provided with a list of the cardiac care pathways across London and completed by Clinical Team Leader (CTL) during debrief with crew.

Findings of investigation:

- There was a miscommunication between the crew and Emergency Medical Dispatcher A (EMD A) resulting in the wrong location being provided to the crew
- No clinical errors were made by the crew in this incident
- The crew did not follow the ideal process for locating and pre-alerting hospitals. However, this was not a breach of formal policy or procedure
- There was a lack of decision making tools for the crew and the EMDs (EMD B and EMD C) working on PD09 desk (the desk responsible for placing pre-alerts to hospitals). These decision making tools could have reduced the risk of this error occurring

Recommendations:

1. Paramedic A should complete their reflective practice to include details on the best ways to request information in similar situations from EOC
2. EMD B and EMD C should be reminded of the requirement to exchange names with call takers at hospitals when details are passed
3. LAS should ensure that the Directory of Services is easily accessible on iPads that will be fully rolled out by the end of March 2018. If not already the case, an icon should be automatically placed on the home screen of each iPad. If this is not technically possible then a bulletin should be circulated encouraging all staff to do so. This will reduce the need for calling EOC for location information and reduce the risk of human error
4. EOC Senior management should review whether any improvements could be made to assist PD09 in ensuring that the right location is identified for the conveyance of patients. Considerations should include readily available, easy to understand decision making aids on the PD09 desk as well as the physical location of the desk in proximity to the Clinical Hub (CHUB)
5. It is suggested that the Clinical Commissioning Group (CCG) might ask the Local Hospital A to also investigate this incident, particularly looking at who might have taken the call and whether there was an opportunity to advise that the patient should

be taken elsewhere.

6. EOC Senior management should review OP022 to identify whether any clarifications would be useful to specify how crews should identify appropriate conveyance locations. This review should also identify whether any guidance could be provided to both frontline and EOC staff to ensure that the risk of miscommunication is minimised
7. The Clinical Adviser to the Medical Directorate specialising in cardiac care should meet with the Hammersmith hospital to discuss the delays to treatment and the delays in releasing LAS crews back onto the road following arrival at the hospital

Post investigation risk score:

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

Action plan/owner:

- Paramedic A to complete reflective practice and discuss with CTL if clarification is needed about how best to request information from EOC **Owner: CTL**
- EMD B and EMD C should have a meeting with their Watch Manager to remind them of the reasons behind exchanging names with call takers when details are passed **Owner: Watch Manager EOC**
- SRO for the roll out and implementation of iPads should ensure that the Director of Services is as easily accessible as possible on the I pads **Owner: ADO Performance Improvement**
- Review to be undertaken to identify improvements to PD09 desk **Owner: Deputy Director of Operations EOC**
- The CCG to pick with Hospital A for not identifying that patient should not be conveyed there. **Owner: CCG - Brent**
- Review of OP022 and ratification through Policy Monitoring and Assurance Group **Owner: Senior Quality Assurance Manager**
- Meeting to be held with Local Hospital B with the intention of securing agreement to release LAS crews more quickly following arrival at the hospital with patients **Owner: Clinical Advisor to Medical Directorate**
- Governance Team to meet with EOC Senior management to discuss how contact should be made with EOC staff for SI investigation purposes **Owner: Head of Quality Governance and Assurance**

Incident description:

An emergency call was received into the EOC of the LAS for a patient with breathing problems. An error was made during the handling of the 999 call which resulted in the call receiving a category two priority response that attracts a response time of 18 minutes. From the Quality Assurance report provided, the call should have received a category one priority response which attracts a response time of seven minutes.

On arrival of the LAS responder the patient was found to be in cardiac arrest. The overall response time for the call was 16 minutes.

Basic and Advanced Life Support was undertaken by the attending crews. The patient was conveyed under emergency conditions by ambulance to hospital. Resuscitation efforts were stopped at the hospital and the patient was declared deceased.

Immediate risk mitigation:

The event was immediately raised as a concern by the attending Incident Response Officer (IRO) owing to the age of the patient, the outcome and the response time.

An EOC Quality Assurance report was requested and immediate feedback on the call was given to the Emergency Medical Dispatcher (EMD) who took the first 999 call.

Findings of investigation:

1. There was a 112 second delay in answering the first emergency call
2. The initial 999 call was mis-triaged at a lower category
3. Dispatch protocols were not followed

Recommendations:

1. Procedure for dispatch of resources by EOC (OP23) to be reviewed and reissued
2. This particular call to be used as a training tool to assist EMDs in recognising obstructed and ineffective breathing

Post investigation risk score:

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

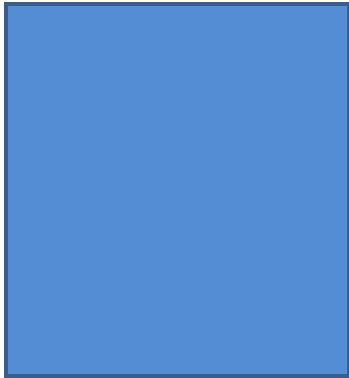
Action plan/owner:

Ensure policy is fit for purpose after introduction of ARP

Owner: Head of Quality Assurance

Ensure all EOC staff are aware of procedures around dispatching of resources

Owner: Senior Quality Assurance Manager



Ensure that all EMDs have a good working knowledge of A&P particularly suited to their role
Owner: Practice Learning Manager

Will provide a 'real life' example of obstructed breathing and ineffective breath sounds to EMDs
Owner: Practice Learning Manager

Research possibility of having pool of staff available to take calls remotely during periods of exceptional demand
Owner: Deputy Director of Control Services

STEIS: 2017/27537

Incident description:

The LAS received a call from a member of the public for a male collapsed in the street

who was reported to be unconscious. It was identified by the Emergency Medical Dispatcher (EMD) taking the call the patient was in cardiac arrest. The call was categorised as a Category 1. This category has a target response time of 7 minutes (mean response time 15 minutes 90th centile). This incident was responded to in 6 minutes 45 seconds.

During the 999 call it became apparent there was a large crowd of people surrounding the patient. The caller reported they appeared to be under the influence of alcohol and were hampering the bystanders attempt to provide aid. This also meant the caller was unable to get close enough to the person assisting the patient in order for the EMD to provide cardiopulmonary resuscitation (CPR) instructions. As is normal procedure for all cardiac arrests in a public place (OP/061), the police were requested to attend the scene by staff in the Emergency Operations Centre (EOC). Due to the reported crowd and potential scene safety issues the police were updated and asked to treat this as an urgent request.

The patient had collapsed in a pedestrianised area of the high street. The nearest parking place for responding vehicles mean staff were required to collect their equipment and make the rest of the journey to the patient on foot (approximately 100-150 metres). This was not felt to be excessive in the context of most other emergency calls.

The first vehicle to arrive on scene, a Fast Response Unit (FRU) staffed by an Emergency Medical Technician (EMT A) reported the patient was in cardiac arrest and immediately began providing Basic Life Support (BLS). The police arrived and assisted by performing CPR in order for EMT A to organise the necessary equipment required for a cardiac arrest. There was a delay attaching the defibrillator as the patient had multiple layers of thick clothing on requiring the use of cutting equipment in order to expose the patient's chest. Three subsequent vehicles arrived to provide support to the resuscitation attempt. The patient was defibrillated once and Advanced Life Support (ALS) was initiated. The patient was conveyed to the Emergency Department (ED) at the local hospital as a priority where, after a continued attempt to restart his heart, was pronounced deceased by the medical team.

Immediate risk mitigation:

Following the handover of care at hospital. The IRO (Incident Response Officer) facilitated a debrief with all staff in attendance where the delay of attaching the defibrillator was discussed. The attending staff stated they were focussed on delivering high quality chest compressions whilst simultaneously trying to expose the patient's bare chest by cutting through the layers of clothing. The first responding member of staff was encouraged to complete an incident report and to reflect on the incident.

Findings of investigation:

The investigation has shown that the attending staff faced a chaotic scene and a number of significant challenges. Several of which were beyond their control, in particular the location of the patient and the crowd that had formed around him as well as the number of layers of clothing that required several people to cut through them which resulted in a delay of 7 minutes in attaching the defibrillator.

Once the defibrillator was applied to the patient, there was a 3 minute delay to delivery of a defibrillatory shock. Paramedic A explained they were focussed on delivering high quality chest compressions as well as a number of other tasks (i.e. managing a severely soiled airway and obtaining intravenous access in order to administer medications) However, all other aspects of care after this point were in-line with the expectation of the Trust and within national clinical practice guidelines.

Recommendations:

1. Confirm feedback has been provided to the EMD to ensure pre-arrival instructions are provided in all cases when they are required.
2. Whilst the application of the defibrillator in manual mode was not in contravention of the medical directorate bulletin issued to staff on 9th May 2017 (MDB 186), Paramedic A should be reminded that in cases where the scene is particularly complex and they are the only registrant in attendance the use of AED mode would be acceptable.
3. A supportive clinical roundtable to be chaired by the Lead Investigator with the responding staff. The focus of this meeting should be to encourage a culture of openness, clinical discussion, identifying individual weaknesses and learning from experience. As a result of this meeting, further recommendations may be made that will be added to the corresponding incident record on Datix.
4. This case should be shared with the Clinical Practice Working Group (CPWG) to ensure that as part of the introduction of vehicle based bags, robust governance procedures are in place that reduces the likelihood of bags being inadequately stocked.

Post investigation risk score:

A: Potential impact / severity (1-5)	B: Likelihood of recurrence at that severity	C: Risk (C = A x B)
4 (major)	3 (possible)	12

Action plan/owner:

Emphasis should be placed on highlighting the potential for issues to be identified by a caller even in cases where they cannot get alongside the patient.

Owner: Head of Quality Assurance

In cases where the scene is particularly complex the use of AED mode allows practitioners to 'take a step back' when under extreme pressure

Owner: Lead Investigator

The focus of this meeting should be to encourage a culture of openness, clinical discussion, identifying individual weaknesses and learning from experience

Owner: Lead Investigator

To ensure that as part of the introduction of vehicle based bags, robust governance procedures are in place

Owner: Lead Investigator

STEIS: 2017/28770

Incident description:

The patient called London Ambulance Service and explained that they previously

had been diagnosed with Addison's Disease, a rare and potentially fatal illness.

The patient went onto complain about severe abdominal pain and vomiting. The incident was triaged correctly as a Category 3 call, requiring assessment and/or transport (not life threatening or serious, but needs assistance) which should have elicited a response within 120 minutes, 90th centile response time. Category 3 calls should also elicit a call-back or a return telephone call to the reporter every 90 minutes.

The patient called again to report new problems of difficulty in breathing and that he had fallen over. An Ambulance was dispatched but did not arrive on the scene until four hours and fifty-seven minutes following the first call for assistance. The first crew called for urgent assistance from colleagues after the patient collapsed, and the patient arrived in hospital six hours and sixteen minutes after first requesting help.

The patient underwent surgical repair of a perforated bowel, was taken to the intensive care unit and died ten days after the incident.

Immediate risk mitigation:

The Emergency Medical Dispatcher (EMD) has been shadowed by the Watch Manager and the Consultant Paramedic for the Emergency Operation Centre (EOC) has been asked to review the procedures in the Clinical Hub (CHUB) to ensure that clinical oversight is maintained across the sectors of held calls.

Findings of investigation:

Due to demand at the time, operational resources were being targeted to higher acuity calls in order to respond to our sickest patients first.

There was no call-back from EOC as per OP23 after 120 minutes which may have identified the patient's deteriorating condition.

Recommendations:

1. This is a risk known to the LAS and is being managed through the Board Assurance Framework.
2. There will be continuation of the on-going Trust wide improvement program.

Post investigation risk score:

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

Action plan/owner:

Continuation of the on-going Trust wide improvement program

Owner: Director of Operations

Operational Policy (OP23) Procedure for the Dispatching of Resources by EOC to be reviewed

Owner: Head of Quality Assurance

STEIS: 2017/28247

Incident description:

The LAS received a call for patient in cardiac arrest. The call was correctly triaged as a Category 1 call and LAS resources arrived within 4 minutes.

The patient was reported to have been complaining of chest pain prior to being found

collapsed.

Upon establishing that the patient was in cardiac arrest, the defibrillator was attached and Automatic External Defibrillator (AED) mode was initiated as per Trust guidelines. The defibrillator indicated that a shock was advised and charged to do so. Despite this defibrillator instruction, no shock was delivered for 10 minutes.

The resuscitation attempt was continued for about 50 minutes. The situation was reviewed and a decision was made that continued resuscitation would be futile and the Recognition of Life Extinct (ROLE) process was initiated.

Immediate risk mitigation:

Paramedic B made the Advanced Paramedic Practitioner (APP) aware of the incident immediately after they finished attending to the patient.

As part of the post-incident debrief led by the APP, all staff involved had the opportunity to reflect on their practice. The crucial requirement of utilising and following the instructions of AED mode (in keeping with current guidelines including Cardiac Care Circular 007) was stressed. The crew logged an incident on Datix and had a discussion with the Assistant Medical Director followed by a notification email to the Serious Incident Group (SIG) for review.

A Clinical Team Leader (CTL) went through an AED education session with the crews involved and an additional special training package was scheduled with a designated clinical tutor.

During the investigation period, the crews involved were restricted from working in a solo capacity. Paramedics A, B and C, Emergency Ambulance Crew (EAC) A and B have all completed the training and demonstrated competency in current use of the AED.

Findings of investigation:

There was a delay in delivery of potentially life-saving treatment to a patient suffering a Ventricular Fibrillation (VF) cardiac arrest. The defibrillator indicated that a shock was advised and charged to do so. Despite this indication, no shock was delivered for 10 minutes.

The overall response time for this call was 4 minutes. Several emergency resources were dispatched to the call. The second resource was a Fast Response Unit (FRU) with Paramedic B, third resource was another Double Crew Ambulance (DCA) with Paramedic C and EAC B and an Advanced Paramedic Practitioner (APP) was the fourth resource.

A combination of contributory factors were identified by the investigation;

- i. All crews had completed the required life support training. However, paramedics have varying exposure to and hence experience of implementing their training in cardiac arrest situations and length of time in the role does not necessarily indicate more experience in this area. The average LAS paramedic attends 2-3 cardiac arrests per year, in most cases taking a supporting role rather than being the first on scene or undertaking a leading role.
- ii. A deficit of experience/ knowledge on the part of Paramedic B who initially led the resuscitation before the arrival of the APP as the senior clinician on scene. They recognised that the AED was advising a shock but did not follow the AED instruction to shock the patient in line with empiric local guidelines, *LAS Cardiac Arrest Guidelines-Adult Advanced Life Support (ALS), September 2016* as they believed that the AED was incorrect and was misinterpreting compression artefact as VF.
- iii. There was a difference of recall in what challenges were made by Paramedic A and

- the perception and non-acceptance of this by Paramedic B with no change in plan achieved, would indicate that communication had not been effective in this case.
- iv. Paramedic A, C and EAC A and B all indicated that they were aware that the AED advised shocks should have been delivered.
 - v. On arrival of Paramedic C and EAC B, while Paramedic B at first explained their ongoing rationale for not shocking, group discussion led by Paramedic A appears to have been effective in convincing them to reconsider and to follow the AED advice.

Recommendations:

1. To implement a competency based special training package for all staff involved which will include cardiac arrest management recognition of VF, its associated variants and presentations.
2. Provide a supportive mentoring plan for Paramedic B on delivering dynamic resuscitation to patients in cardiac arrest utilising the pit crew approach which will be led/ overseen by a relevant experienced expert clinician.
3. Consider a review of current relevant guidance efficacy including the 2017/3147 thematic review's action plan for VF and implement any identified areas of improvement with a re-launch.
4. Continue to increase organisational awareness of Human Factors by embedding this in all aspects of clinical training including advanced life support and core skills refresher courses which will emphasise the need for all paramedics to understand the command gradient concept and how to avoid it to facilitate effective communication and challenge on clinical decisions between differing levels of staff.
5. Reminder to staff involved about their professional code of conduct which requires them to challenge possible incorrect practice as patient advocates.
6. Use this incident as a case study for sharing at various local patient safety platforms, e.g. Clinical update to promote learning across the Trust.

Post investigation risk score:

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

Action plan/owner:

1. To deliver a bespoke competency based training package for all staff involved which will include cardiac arrest management recognition of VF, its associated variants and presentations.
 - Review and amend relevant competencies with criteria for achievement
 - Design a sign off tool for evidence of completion.**Owner: Training Manager.**
2. Provide a supportive mentoring plan for Paramedic B on delivering dynamic resuscitation to patients in cardiac arrest utilising the pit crew approach which will be led/overseen by a relevant experienced expert clinician.
 - Devise an appropriate learning contract with embedded practical experience timelines.**Owner: Local Management Team.**
3. Review of current relevant guidance's efficacy including the 2017/3147 thematic review's action plan for VF and implement any identified areas of improvement with a

relaunch.

- Form a working party to devise a practice improvement programme led by front-line clinician.

- Raise relevant guidelines' awareness through campaigns and various media.

Owner: Medical Directorate.

4. Undertake simulated ALS training with a particular emphasis on human factors and crew resource management related to resuscitation and decision making with clear on scene leadership guidance.

Owner: Training and Education Department.

5. Use this incident as a case study for sharing at various local patient safety platforms, e.g. Clinical update, Insight.

- Write a case study based on the incident for use as a training tool.

Owner: Medical Directorate.

STEIS: 2017/28774

Incident

The LAS received a 999 call from Hospital A for an Inter-hospital transfer to Hospital B

description:

with Hyper Acute Stroke Unit (HASU). The call was to a patient who was showing signs of a stroke.

The onset time of the Stroke was given over the phone. The call made was given the Category "Hospital Transfer 1" which is an 18 minutes response time as per the LAS Hospital Transfer Flow Chart Version 11.4.

Despite attempts to dispatch an ambulance during this 18 minute target the LAS failed to dispatch an ambulance for 1 hour and 13 minutes after the request was made. Transfer of the patient to a HASU within the 4 hour 30 minute thrombolysis optimal treatment window did not take place.

The CT scan taken the next day at Hospital B showed that the patient had a significant cerebral infarct and subsequently was not indicated for thrombolysis; the patient died later that week.

Immediate risk mitigation:

The Deputy Medical Director raised this incident at the last meeting of the Critical Care Network Group.

Findings of investigation:

- The findings of this investigation are that the initial call to the LAS from Hospital A was triaged correctly and thus coded as a Transfer 1.
- There was a delay in sending an ambulance to Hospital A to transfer the patient to Hospital B with HASU.
- During the extended wait for an ambulance the hospital made multiple calls to the Ambulance Control room and no clinical deterioration was raised.
- Whilst waiting for the ambulance the patient was in a safe place and was being monitored. Despite the delay the patient was not suitable for thrombolysis and therefore the delay did not contribute to her outcome.

Recommendations:

1. In order to prevent future occurrences of confusion over the hospital transfer policy, the new guidance (LAS Hospital Transfer Flow Chart- Version 11.4) should be shared again with all Emergency Operations Centre (EOC) staff and Clinical hub (CHUB) staff for consolidation.
2. This SI document should be shared with the patients Next Of Kin (NOK) for their information.
3. This SI document should be shared with Hospital A as per the action plan.
4. All acute hospitals in London should be sent the updated LAS Hospital Transfer Flow Chart- Version 11.4) to ensure they have the most up to date version.

Post investigation risk score:

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

Action plan/owner:

Hospital A should be advised that transfers should be booked at the earliest opportunity especially when there is a treatment window.

Owner: Stakeholder Engagement Manager- NW London

Feedback should be given to Hospital A that the agreed inter hospital transfer times are a guide and response times can vary depending on the demand the trust is facing and any ongoing incidents in the area.

Owner: Stakeholder Engagement Manager- NW London

The outcome of this SI should be fed back to Hospital A highlighting that accurate information should be given at the time of the call and any subsequent updates on the patient's condition should be relayed to the control room as it may affect the category of the call.

Owner: Stakeholder Engagement Manager- NW London

Share the final report with the family of the patient.

Owner: Nominated Contact QGAM – NW London

STEIS: 2017/28852

Incident

LAS received a 999 call requesting an inter hospital transfer for a patient with an issue

description:

with their spine which required further investigation and possible surgery.

The call received a Hospital transfer 2 priority requiring a 1 hour emergency response. On the arrival of the first emergency resource the overall response time for the call was 3 hours and 55 minutes.

During the wait for an ambulance response the hospital contacted the LAS a 6 times. Each call was appropriately managed and the patient's condition checked including obtaining advice from the Clinical Hub (CHUB)

Immediate risk mitigation:

Nil identified as resourcing and demand is on the Trusts risk register and is monitored regularly.

Findings of investigation:

- The LAS was under significant pressure on the day in question leading to a number of calls being held and a number of attempts were made to find a resource to dispatch.
- This call was regularly updated and the patient's condition checked throughout.
- The patient came to no harm as a result of the delay.
- There have been improvements made for the oversight of Health Care Professional (HCP) calls by the CHUB
- ARP has been implemented and has an ongoing review process to provide continuous improvement of quality.
- The LAS requested a de-escalation of this SI with the Clinical Commissioning Group (CCG) and provided the CCG with a significant amount of information as part of that request. At the point of writing and submitting this report the CCG have not made a definitive decision on the de-escalation request.

Recommendations:

- To continue with the trusts plans for resourcing linked to the Trust risk 337 - Service Performance may be adversely affected by the inability to match resources to demand.

Post investigation risk score:

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

Action plan/owner:

To implement all the planned actions set out in Risk 337.
Owner: Deputy Director of Operations (Sector Services)

STEIS: 2017/29393

Incident description:

A patient and friend were attended upon on two separate occasions and subsequent to

this, a complaint letter was received from the friend. The complaint questioned the decision by the first attending crew not to convey the patient to hospital, and asked if the outcome for the patient would have been different had this occurred.

In the initial attendance, a 999 call was received regarding an accidental overdose. The call was triaged correctly and the crew attended within the required response time.

On scene the crew established the patient had liver disease and had recently been discharged from hospital. Advice had been sought from the National Health Service (NHS) 111 line regarding the overdose, who opined that the patient would be fine but to take the patient to hospital if the condition worsened. The crew documented that the patient preferred not to go to hospital.

Relying on the stability of the patient's observations; an assumed low risk relating to the overdose; a previously arranged General Practitioner (GP) appointment within 36 hours and the patient's reluctance to go to hospital, the patient was left at home with a friend. No other onward referral was made to any other Health Care Professional (HCP).

Eleven hours after the first call, a further 999 call was received. On arrival, the crew established the patient's condition had deteriorated. The patient was conveyed to The local Hospitals Emergency Department (ED). The patient had a cardiac arrest on arrival and died in intensive care the following morning. The cause of death was decompensated alcohol liver disease, which occurs in patients with cirrhosis.

Immediate risk mitigation:

Email sent to the Deputy Director of Operations to reinforce the discharge responsibilities for all staff discharging patients on scene.

Findings of investigation:

The decision not to convey was based on limited history, incomplete documented assessment and lack of expert advice regarding the impact of the overdose on a patient with obviously advanced liver disease.

It was not unreasonable for the crew not to convey the patient purely on the accidental overdose.

The documentation relating to the visit by the crew was inadequate with critical information missing.

Six experienced members of staff were questioned and did not know about a discharge protocol.

It is not possible to say if the outcome for the patient would have been different had they been conveyed to hospital at the first call. The nature and advancement of the patient's illness means that rapid deterioration as occurred between the first and second calls is possible and difficult to anticipate.

Recommendations:

1. The LAS ensure all non-registered staff are aware of the Paramedic Pathfinder Tool and the referral tool and gain assurance in this regard
2. Record keeping standards are reviewed and implemented
3. The above are included in the clinical audit programme to give assurance to the

Trust Board.

Post Investigation Risk
Score:

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

Action plan/owner:

Issue specific guidance in the form of a bulletin regarding the management of discharges
Owner: Medical Directorate

Local managers are directed to disseminate the bulletin and monitor staff uptake
Owner: Consultant Paramedic

Review and re-issue of TP 017 and adherence to the implementation plan
Owner: Deputy Director Clinical Education & Standards

Clinical Audit and Research Group add staff educational audits to their programme
Owner: Deputy Director Clinical Education & Standards



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Rest Break Policy Implementation Review			
Agenda item:	15			
Report Author(s):	Brian Jordan, Business Manager to the Director of Operations			
Presented by:	Paul Woodrow, Director of Operations			
History:	N/A			
Status:	☒	Assurance	☐	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This update has been prepared for the Trust Board to provide information about: • Recent developments • Evidence of progress • Plans for continued improvement • Patient safety • Next steps.				
Recommendation(s):				
The Board is asked to note the content of the report. It is also recommended that the Board sub-group (that was formed by the Chairman when seeking agreement on the original revisions to the rest break policy before it was implemented in December 2017) is reconvened to review the current position in more detail and to agree the Trust Board position prior to the next meeting with the Trade Unions.				
Links to Board Assurance Framework (BAF) and key risks:				
No BAF risks are associated with the content of this paper.				

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

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

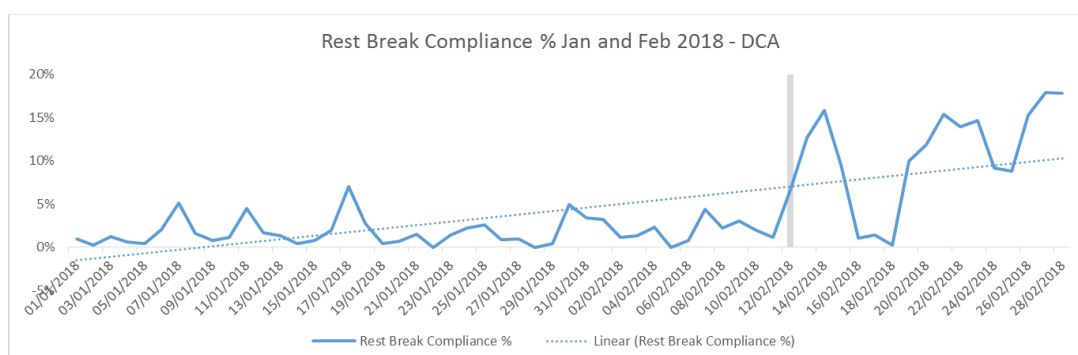
REST BREAK POLICY IMPLEMENTATION REVIEW

Recent Developments

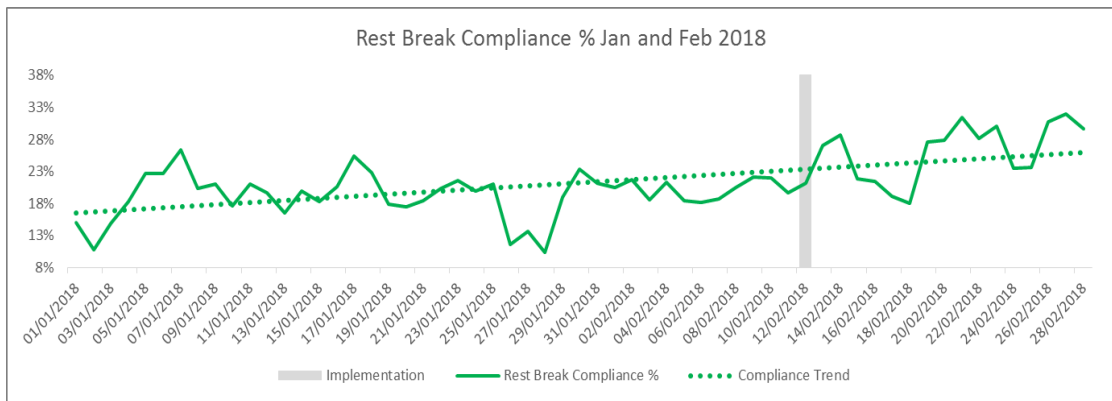
1. Good progress on allocating rest breaks was seen during 2017 when the number of breaks rose from circa 13% in January 2017 to circa 40% in the summer months.
2. A revised rest break policy was implemented in December 2017 which introduced the option for staff to voluntarily take a flexible break at a location of their choice. This was not however embraced to the levels anticipated. The hypothesis for this low take up is associated with staff still not being confident that they will finish their shift on time. It should also be noted that this winter has been particularly challenging and the Trust has been under significant pressure for a considerable period of time since the revisions to the rest break policy were introduced.
3. Following a meeting between executive directors, control services managers and representatives from the medical directorate in early February 2018, it was agreed that the following actions would be implemented on 12 February 2018:
 - Move five identified double crewed ambulances (DCAs) per hour, and per sector, onto an 'out of service' code so that it is only possible for their breaks to be interrupted by a Category 1 call.
 - Incentivising extra DCA overtime shifts to cover 11:00/23:00 so that additional cover is in place over the peak rest break window period which will try to protect the allocation of breaks.
 - The development of a clear clinical safety process would be made available to support dispatch staff at times of reduced DCA availability.

Evidence of Progress

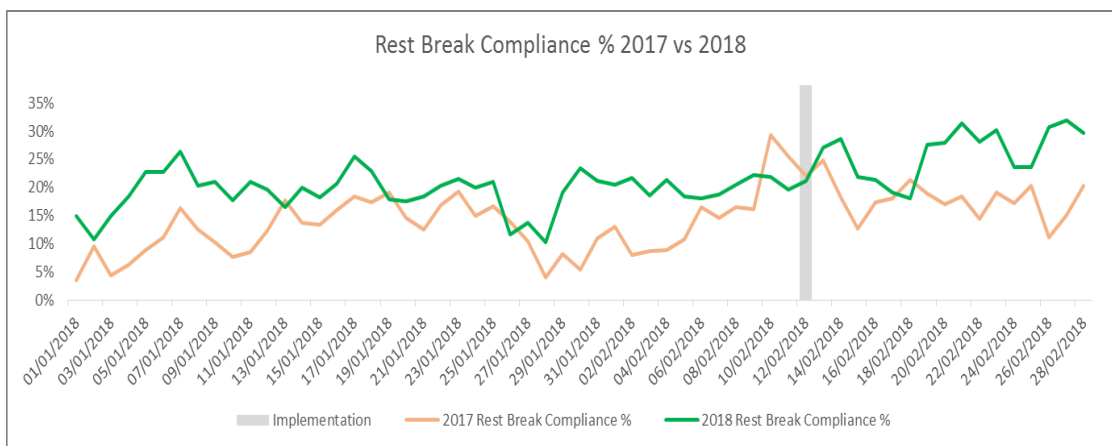
4. The graph below shows that the actions taken to increase DCA rest breaks have had an impact since 12 February 2018:



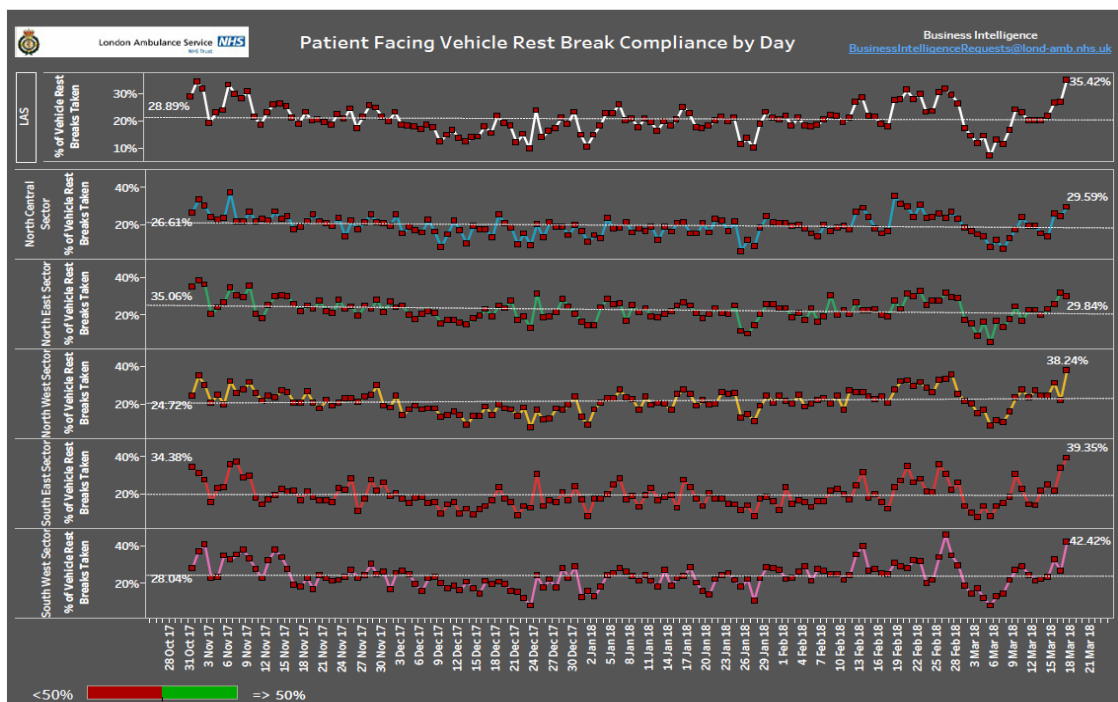
5. The overall number of rest breaks allocated since 12 February 2018 has increased as shown below:



6. The graph below shows improved rest break allocation when comparing January/February 2017 to January/February 2018:



7. The daily rest break dashboard below shows a wider range of rest break allocation between October 2017 and the position at the time of preparing this report (the last week ended at 35.42% Trust-wide):



Plans for Continued Improvement

8. It is recognised internally that rest breaks are avoided due to staff wanting to finish their shift on time and that delivering an end of shift arrangement is the key to unlocking this. The Trust's end of shift working group is due to present their plan for a new end of shift pilot in April 2018.
9. It is anticipated that the end of shift pilot will cover the whole of South London and will attempt to protect staff during the last 30 minutes of their shift. As part of the formation of this plan, the end of shift group are currently modelling the potential impact on performance and undertaking a clinical impact assessment.
10. In the meantime, the Director of Operations and the Director of People and Organisational Development are due to review the outcome of the revisions that were made to the rest break policy in December 2017 with the trade unions. One of the key areas identified for discussion is the changes we made to the rest break window to try to ensure that staff received a break at a more reasonable time in their shift. It is apparent that these times are having a limiting effect on the total number of rest breaks that can be allocated. We will be seeking the union's agreement to extend this window by an agreed period to create additional time for the Emergency Operations Centre (EOC) to allocate rest breaks while still trying to allocate rest breaks at a reasonable time within the shift.
11. The second key area concerns the issue that flexible rest break arrangements are currently on a volunteer basis only. The Trust will be seeking to gain agreement to mandate flexible breaks when the crew are an unreasonable distance away from their base station.
12. There is a continued focus to increase the number of DCA shifts covering 11:00/23:00 so that additional cover is in place over the peak rest break window period to protect the allocation of breaks.
13. A Rest Break Compliance Group was established in March 2018 which includes senior managers from control services and business intelligence as well as computer aided dispatch (CAD) system specialists. The group are trying to develop a more simple way for EOC staff to record rest breaks (taken on and off station) as they currently have to type details which is not efficient and is also causing issues for business intelligence in terms of their data collection. The group are aiming to develop an automated function through Northrop Grumman (NG), the CAD provider, so that rest breaks (on and off station) can be recorded at the touch of a button. The group has estimated that, given the current recording process in EOC and the issues being identified by business intelligence, the Trust could be under recording rest breaks by 5 – 10%.

Patient Safety

14. The Trust continues to monitor patient safety at times of shift change and has not identified any related serious incidents. On this basis, the Trust Board recently agreed the down scoring of the related risk on the Board Assurance Framework (BAF).

Next steps

15. It is recommended that the Trust Board sub-group (that was formed by the Chairman when seeking agreement on the original revisions to the rest break policy before it was implemented in December 2017) is reconvened to review the current position in more detail and to agree the Trust Board position prior to meeting with the Trade Unions.

16. This is an interim update report to the Trust Board with a further update due in June 2018.

Paul Woodrow
Director of Operations



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Document Title:	Quality Account Draft Document and Quality Implementation Plan 2018-19			
Report Author(s):	Dr P Bain, Chief Quality Officer			
Presented by:	Dr P Bain, Chief Quality Officer			
History:	Priorities feedback : CQRG, Staff ELT, Patients Forum Healthwatch			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The draft 2018-19 Quality Account outlines the quality priorities that the Trust has consulted on to include in the 2018-20 Quality Strategy and annual account. The priorities have been circulated to commissioners, Patient Forum members and will be consulted on via survey monkey to staff during February. Feedback has been collated and included in the report. The report outlines; • Our quality strategy and its alignment to overarching strategy • Our quality priorities for 2018-19 • Our progress against 2017-18 quality account priorities • Our statements of assurance as set out by DH regulations 2018 • Quality Improvement Plan (QIP) – LAS vision 20:20 An overarching QIP will be developed during March and monitored via the Quality Oversight Group in 2018-19.				
Recommendation(s) :				
The Board is asked to approve the draft content prior to Board being asked to ratify at March Board.				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality			☒	

Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐

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



DRAFT 2

NHS

London Ambulance Service
NHS Trust

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019



70
YEARS
OF THE NHS
1948 - 2018

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2016/17

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Forward

The London Ambulance Service is the only pan London Trust and is the busiest ambulance service in the country responding year on year to increasing demands. Our Trust was inspected February 2016 by the CQC, who gave us an overall rating of 'requires improvement' in their final report. The care we give to patients was rated as outstanding, a number of services were rated as 'good' but the standards observed were not consistent nor of the quality the Trust aspires to deliver. During the year we have delivered a comprehensive action plan and external assessment confirms what we know, that our services have improved over the last two years. However we also know there is further improvement to make to achieve our vision of providing a world class service. Through this strategy, we want to strive for 'outstanding' Care Quality Commission (CQC) rating across our sites and services by 2020.

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing and growing population. However, with these challenges, we have an exciting opportunity when it comes to improving healthcare quality. We hope our commitment to improvement and our determination to get things right for our patients, people and stakeholders is clear in this strategy. We are working to harness opportunities to continuously improve in order to provide safe, high quality, patient-centred care for all our patients. In addition we need to ensure that our staff are provided with the skill and support to deliver the right care and feel motivated and able to do so.

To achieve this, we are rolling out a programme of quality improvement and human factors training and support to build an organisation-wide culture of continuous improvement. At the same time, patients have a stronger voice than ever before, and we have begun and will continue to work more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

This strategy is the plan by which we will continue our journey to achieve our ambitions and a positive outcome in subsequent CQC inspections as continuous quality improvement becomes our business as usual.

Dr Patricia Bain
Chief Quality Officer

Statement of Directors responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHSI has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporates the above legal requirements) and the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account. The London Ambulance Service, whilst not a Foundation Trust has prepared the annual quality account in line with this guidance ensuring directors have taken steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2017 to March 2018
 - papers relating to quality reported to the board over the period April 2017 – March 2018
 - feedback from commissioners dated May 2018
 - feedback from Overview and Scrutiny Committee dated May 2018
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
 - the 2017 national staff survey
- The quality report presents a balanced picture of the NHS trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Chair

Date

Chief Executive

Date

Introduction to our Quality Strategy and Accounts 2018/19

The quality strategy for the Trust, aims to bring together our plans in line with our overarching strategy, business planning process and the CQC quality assessment framework. The purpose of the strategy is to set out the goals and targets for London Ambulance Service (LAS) in providing high-quality services over the next two years and, therefore, delivering our vision and objectives.



The Trust's vision

The London Ambulance Service is uniquely placed to play a wider role within the London health economy.

Our ambition is to become a world-class ambulance service for a world-class city: London's primary integrator of access to urgent and emergency care on scene, on phone and online.

This vision will be delivered through the achievement of the Trust's strategic objectives, which are:

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

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

Developing our Trust strategy

We recently published a document entitled 'Our strategic intent 2018/19 – 2022/23', it sets out our ambition and describes how we plan to evolve in order to achieve improved outcomes and a better experience for patients.

It is not our final trust strategy. It formed the basis for a six-week period of consultation that took place with internal and external stakeholders during November and December 2017, the main purpose of which has been to ensure that we fully address the needs of patients, our staff, partner NHS organisations and other business partners across London.

We are working with many of our stakeholders and business partners, including the CQC, to co-design our final strategy, which is due for release early 2018.

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.

Our trust strategy focuses on improvement, and therefore supports delivery of our vision and objectives. It sets out a number of the key enablers and examples of the projects required to improve performance to illustrate the breadth of our work programme.



What is the Quality Strategy?

Our quality strategy is the plan through which we focus on the quality of clinical care and to ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of everything that we do.



This strategy sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number one priority. It sets out our five domain quality goals and associated targets and a number of projects which we must focus on to ensure we can evidence that our services are safe, effective, caring, well led and responsive. It also describes the governance arrangements to ensure delivery and sustainability over three years from 2018/19. The strategy also outlines our current position, showing improvements we have made in our 2017-18 Quality Account priorities and what we are building on going forward.

It is ambitious, setting out our commitment to make quality central to all that we do. It also reinforces that wherever possible, our focus will be on embracing new ways of working to improve care for patients and integrating healthcare across the wider integrated urgent and emergency care system.

It provides a modern approach to continuous improvement and acknowledges that our people are central to delivering our strategy.

We will use the implementation of the Quality Strategy to strengthen confidence and pride in the services we provide. We want patients to be confident that the Trust is among the best in the world.

We want people working in and with the Trust to be confident that they are providing the best service they can, are valued and are important. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so. We want a shared pride in the Trust and assurance that it is the very best it can be.

How we developed the strategy

The strategy has been informed by the reports and recommendations

from key stakeholders, staff and patient representatives and the CQC framework. We also assessed our progress against priorities in our last quality account.

Comparison was also undertaken of trends and variation from a range of intelligence including:

- Patient surveys
- Staff surveys
- Governance data, e.g. incidents, complaints, claims and audit

This was then merged with feedback from key stakeholders, including our patients, members of the public, our people and our commissioners.

We have therefore been careful to develop goals and targets that are measurable whilst trying to encapsulate our commitment to the qualitative elements of our work. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and reportable goals to aim for. These targets will be redefined each year in our annual quality account, with progress monitored through the Trust's governance system. We believe that if we can meet our targets under each quality domain, we will see significantly improved outcomes for our patients and a better working environment for our people. Our goals and targets have been selected to have the highest impact across the Trust and are purposely challenging.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. A series of Trust-wide improvement projects, informed by our CQC inspection action plan and a review of the key lines of enquiry that the CQC use, have been established to deliver specific time bound programmes of work.

What is our definition of quality?

We have based our definition of quality on [the CQC's framework](#), which draws on the Francis, Keogh and Berwick reviews and recommendations, and incorporates public consultation.

Our approach aligns Berwick's six improvement principles which are safe, effective, caring, responsive and well led. The combination of performance in each of the five domains determines the overall quality of the healthcare we provide. We believe that we can improve services only by supporting continuous improvement in all areas hence our commitment to this driver.

The previous quality account and improvement programme for the Trust focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our next CQC inspection, this strategy and our priorities for 2018-19 and beyond will strive to bring the trust to an 'outstanding' rating.

The quality domains

The quality domains are outlined below, together with the descriptor of what these mean. The domains match those used by the CQC to ensure we are focused on making improvements which are aligned with our regulatory body's expectations.

Safe

People are protected from abuse and avoidable harm

Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Responsive

Services are organised so that they meet people's needs

Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Delivering the Strategy:

How will the strategy be delivered and progress monitored?



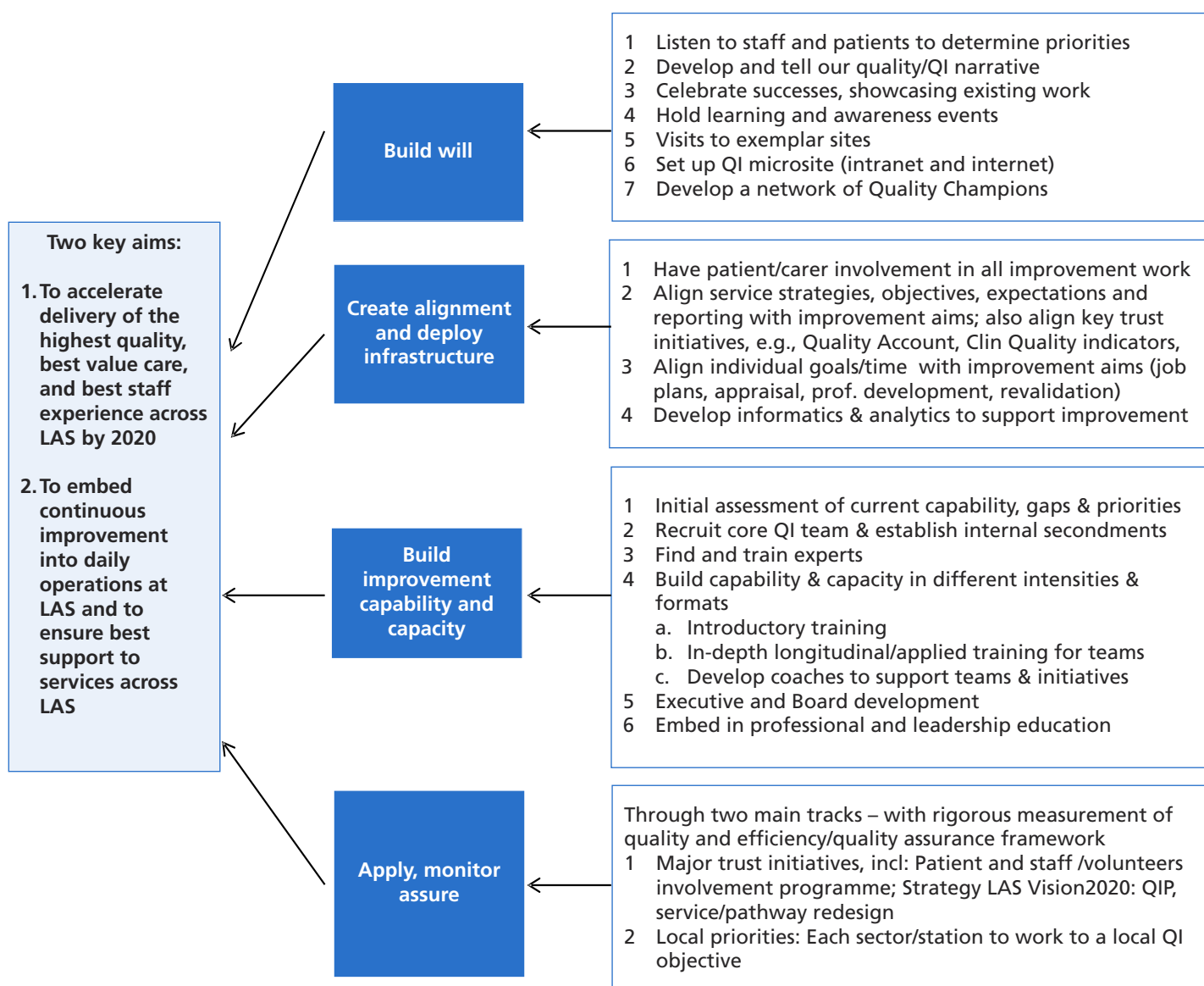
Quality Goals and Targets

The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. These are outlined below under each quality domain and have been chosen to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our goals and targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff. The goals and targets under each domain will be incorporated into the

performance scorecards, ensuring they can be tracked from station to board. This will provide clarity on the Trust's priorities and will show the impact of the improvements we have made.

Building Delivery Capacity and capability

Delivering the strategy will be predicated on ensuring we have the right skills and capacity across the organisation. The outline plan below sets out the key activities to achieve this aim and build a culture of continuous improvement within and across the organisation. A detailed implementation plan has been produced.



Building the Will

Integral to all programmes must be the aim of robust patient and staff involvement so they support the development of what represents a high quality and efficient service. It is important that we continue to explore further ways of getting feedback from staff via Quality Champions, patient and carers and community groups, in addition to our continued engagement with the Patients Forum. The Patient involvement teams will develop a framework to ensure these aims and the successes they have already achieved are embedded.

The importance of ensuring that we take every opportunity to engage with exemplar sites partners in the redesign of services and pathways in order to secure the right outcomes is articulated in our organisational strategy. Supporting this programme will be a communication strategy that includes intranet and internet development.

Creating alignment

Alongside the quality goals and targets, we have developed measurable and structured improvement projects aligned to our strategic and business objectives. These projects have been informed by analysis of a number of measures of our performance including:

- Our strategic intent
- current performance against national and local targets
- our quality account
- areas of known risk
- our CQC inspection and report during 2018
- review of the key lines of enquiry that the CQC publish.

Each project has been assessed for their potential to positively impact on the Trusts strategic goals and targets and we are confident that we have the necessary work in

progress to deliver the required improvements. Progress with these improvement projects will be reported via the Trust's governance and performance management structures. This will allow us to measure and monitor the milestones, outcomes and timeframes of the projects, with clear lines of accountability and responsibility to the project owners. Executive oversight of quality of care in the Trust is through the Quality Oversight Group, which will report quarterly progress and exception to the Quality Assurance Committee. Trust board reporting will occur on a quarterly basis. Our annual Quality Account will report on progress against the three-year strategy and confirm the targets for the following year.

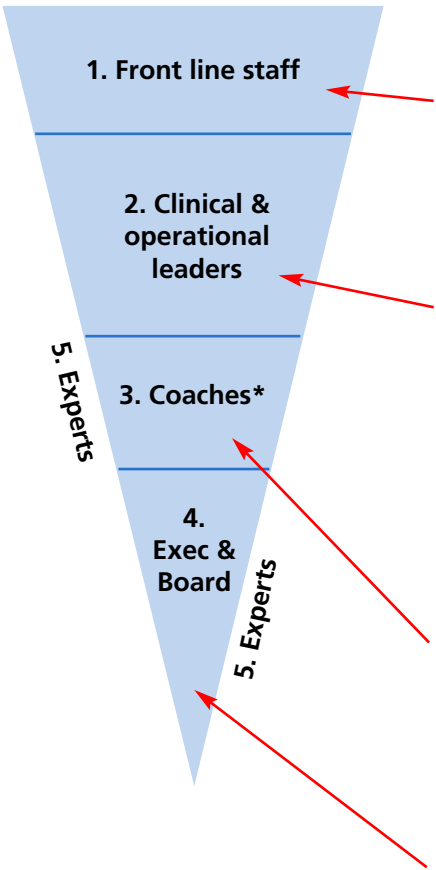
Building Capability to deliver the strategy

We recognise that our staff are the key to delivering the strategy and we need to train and support people to make continuous improvement and improve systems and processes. We have therefore agreed to adopt a standardised approach to improvement Plan, Do, Study, Act (IHI Improvement model) to ensure staff have the tools they need to sustain improvement. The capabilities needed to drive this system of wide improvement and which staff will be trained in includes:

- An understanding of Human Factors
- Concept of safety systems
- Driver diagram development
- Improvement methodologies, including Plan Do Study Act (PDSA), Lean, Patient flow studies
- Change management principles
- Measurement skills and knowledge
- Flow and service re-design management

Evidence internationally (IHI) suggest for an organisation the size of LAS that a commitment to training at a minimum, 1-3% of the workforce in improvement methods is required for continuous improvement (Table 2 below) A programme to identify and priorities the appropriate staff at all levels and utilisation of 'train the trainer' techniques will build the capacity required. A small team of staff trained in providing QI methodology and Human Factors approaches will provide the staff with the skills and tools to empower them to lead their own QI projects. QI improvement plans will be developed by staff at every level, with the focus to build capacity across, the workforce.

QI capability model for LAS – by staff group and role



	Total potential	Eventual coverage needed	Knowledge/skills needed	What's involved
1. Front line staff	5,000	1-3%	• Introduction to improvement & model for improvement • Identifying issues, developing & testing ideas • Measurement & variation	• Introductory e-learning sessions (incl. at induction) • Online/self-accessed
2. Clinical & operational leaders	400	100	• Deeper understanding of improvement methods, variation and measurement • Goal-setting, leading and managing for improvement	• Applied learning in teams over time linked to opportunities in real work • Access to coaching • Embedding into existing programmes
3. Coaches*	n/a	50	• As above, plus sophisticated enabling and coaching skills for individuals and teams	• Applied learning and reflection in coaching teams supported by classroom programme
4. Exec & Board	3	3	• Direction-setting, "mood" & leading for improvement • Link to strategy and overall priorities; appreciation of systems; making variation and trends visible	• Self-determined but typically includes: mix of individual/group; sessions with external experts; peer visits/"Board-to-Station"; quality assurance visits"
5. Experts	n/a	At least 20	• Deep Dive methodology incl. of QI theory and science • Spread and implementation • Coaching/mentoring, teaching • Knowledge-generation and research	• Careful objective-setting, review and planned (career) development • Applied learning through doing/coaching • Reflection and peer support • "Masterclasses" • Individually-tailored

* Coaches drawn from wide variety

Table 2 QI Capability Model

High Impact Innovations (DH 2012) requires NHS Trusts to prove to commissioners that they are implementing technological and innovative solutions to improve quality. As a Trust we are already exploring the use of technology via the roll-out of hand held devices to frontline staff, e-PRF development, tele-medicine/skype. Opportunities to explore technology further are outlined in our IM&T strategy.

Applying continuous assessment and improvement

Major trust initiatives, with rigorous measurement of quality and efficiency programmes and local

sector and station QI objectives will be designed. Monitoring and reporting on our programmes and ensuring we respond to any emerging risks will be achieved via our quality assurance framework. The main response to the outcomes from these various reporting mechanisms will be:

- Immediate risk mitigation if necessary) and review/update of risk registers
- Identification of a quality improvement activity: station, sector and trust wide using an agreed criteria and methodology
- Consideration of 'intensive support programme' in areas that are not consistently meeting

standards – using the approach that is currently in place for the North East sector.

- Consideration of a Deep Dive review

The streamlining of governance and 'floor to Board' assurance structures will support the delivery of high quality and efficient care with early identification of risks, monitoring performance issues quickly to ensure we are meeting our legally required standards. The further development and embedding of these frameworks will continue through to 2018- 2019 and will support the development of a continuous improvement and learning culture.

Looking Forward: Our Quality goals and targets 2018-19

Our goals are set out under each of the quality domains. The targets which support the delivery of these goals have been developed for our year one of the strategy. Each year we will review progress and ensure our targets are focused on areas where improvement is most needed and will be defined within our annual quality account.



Safe

People are protected from abuse and avoidable harm

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable.

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal will be to be below the national average for the number of incidents causing severe and

extreme harm in year one and continue to reduce the number throughout the three years of the strategy. Throughout year one of our Quality Strategy, we will be focusing on achieving sustainable improvements in the target areas outlined below; these targets aim to reduce avoidable harm in specific priority areas and set the trajectory to ensure that we can achieve our goal of eliminating avoidable harm by the end of year three.

Target 1

We will implement Health Assure reporting and Monitoring system to ensure that we have real-time monitoring of our compliance against the CQC key lines of enquiry, clinical audits, NICE guidance, national alerts, at every level in the organisation.

This system will provide assurance to the Board and our regulators and patients that we are meeting the high standards of care consistently across the whole organisation. Scorecards will be available from station to Board and will be used to monitor progress via our governance and assurance processes. We will be able to identify areas for improvement more quickly and focus our effort in these areas. Our regulators will be able to see, assess and access evidence with regard to our improvement status at the 'touch of a button'.

90% implementation of Health Assure functions by October 2018, 100% CQC function by May 2018.

Target 2

Improving Hospital Handover Delays
National emergency care performance metrics set a standard for emergency patients arriving at

hospital by ambulance to be handed over to, and the ambulance trolley cleared by, the receiving acute Trust within 15 minutes of arrival to enable the ambulances to respond to the next 999 patient.

Ambulance handover performance across London remained challenging throughout 2015/16 and 2016/17; this continued into 2017/18 with patients frequently experiencing handover delays in excess of 15 minutes following their arrival at emergency departments (EDs). Between January and September 2017, 62% of the patients conveyed by the London Ambulance Service (LAS) to an ED experienced a delay, waiting beyond the target of fifteen minutes for handover to on-going care. In the context of productive ambulance cover hours beyond that fifteen minute target, 49,494 hours were lost while delayed at an ED and this equates to 4,125 lost twelve hour ambulance shifts in the same period.

It is recognised that hospital handover delays is a multi-factorial system problem and we need to work together to identify issues at each stage and resolve them. The LAS will continue to work with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London during 2018-19.

Handovers over the 15, 30 and 60 minute target and total time lost, to reduce quarter on quarter against the same period in 2017/18

Target 3

During 2016-17 the Trust made significant improvements in medicines management in terms of ensuring the tracking and monitoring of drugs at station level. The next phase is to ensure that we have the most secure environments to store and monitor drug usage. The second phase of the secure drug room programme, that entails re-designing the station environment, fitting CCTV cameras and more secure locking systems will be rolled out across 2018-19. In addition we have re-designed the vehicle based bags that paramedics and other staff use when attending patients. This provides the teams with more secure storage and an ability to store all equipment that is required on scene in one holdall.

100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations

Target 4

During the latter half of 2016 it became apparent that there were a number of cases where defibrillation was being delayed during the management of cardiac arrest. This trend continued into early 2017 and triggered a thematic analysis. Whilst it was believed that the apparent increase in incidents might be related to the increased number of defibrillator data downloads by Advanced Paramedic Practitioners (APPs) coupled with a significant drive to increase reporting of potential incidents through the online incident reporting system (Datix) it was

identified that further work was needed to understand the root causes and ensure that learning to prevent recurrence was embedded across the Trust.

It is clearly recognised that the challenges of managing a pre-hospital cardiac arrest are very different to in-hospital where the cardiac arrest team is made up of different clinicians with per-determined and specific roles and who will have worked as a team together. The crew resource management challenges of pre-hospital cardiac arrest cannot be underestimated – the crews may never have met each other, there will be public and family to support

and manage and the equipment will initially be remote from the patient. The LAS has been accepted on human factors train the trainer programme supported by UCLH. During 2018-19, in conjunction with all other aspects of risk reduction and pathway development, we will deliver training to relevant staff to improve the management of these difficult scenarios with the aim of reducing these incidents further.

Increase the number of defibrillator downloads year-on-year to 20% by end of 2019.



Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Goal: To provide our patients with the best possible experience. Improving the care we give to vulnerable groups.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience, we need to listen to our patients, their families and carers, and respond to their feedback.

We will aim to improve our position, with our goal being to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently. The indicators outlined below will support this goal and help us determine whether our services are caring and patient centred in all aspects.

Target 1

Our work supporting patients with mental health and in sometimes complex medical conditions has been acknowledged as exemplary. As part of our Strategic Intent, we are aiming to improve and develop services that be recognised as 'pioneering' in relation to this patient group. Our aim is to ensure we have system wide collaboration with all healthcare services to provide 'seamless', timely and the most appropriate care for these patients.

We will continue to work with key stakeholders to provide the best possible outcome for these patients. This work will include supporting patients who frequently call the service during crisis or to request help that is not necessarily provided by the emergency services. We will be increasing our resource internally to enable our expert staff to work closely with providers for example, social services, to put key interventions in place more rapidly and consistently across the pan-London service provision.

Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline

Target 2

Our strategy to become London's primary integrator of access to urgent and emergency care on scene, on phone, on line, requires significant changes to the way in which we deliver services to our patients. As part of this strategy is the recognised need to widen and increase our patient involvement in both the development of these new services and the monitoring of their success. The Trust will therefore develop a Patient Involvement Framework (PIF), with the support of patients, public, specific patient groups to ensure we have genuine involvement and participation and that the view of these groups are considered in any wide scale changes that we make. The new framework will also enable us to capture feedback from a more diverse patient population through the introduction of new surveys, use of information technology, that will enable the trust to directly compare how different groups respond to and identify specific issues and the interventions to improve these.

Evidence of patient involvement in all QI and service re-design programmes.

Target 3

Developing Maternity Capacity and Capability across the London Ambulance Service (LAS) 2018.

The LAS currently provides care to up to 9000 women a year at different stages in pregnancy, the service covers 26 maternity units and three standalone birth centres.

The services is recruiting the first Practice Leads for Pre Hospital Maternity Education across the LAS, and in the UK. They will form the Maternity team, alongside the Consultant Midwife, to lead the development of the Pan London Maternity Pioneer Service.

Maternity Pioneer Service:
The pan London maternity model will aim to:

1. a) Provide midwifery expertise within the control room environment allowing the ability to reduce the number of ambulance conveyances (up to 20% reduction)

b) Provide a midwife advice line to provide a resource to staff both in the control room and on scene at a maternity episode of care (increasing expert advice capacity to 50% of calls fitting criteria).
2. Provide midwifery expertise within a response vehicle alongside ambulance clinicians to be dispatched to imminent birth calls

Develop a commissioning model for pre-hospital birth, when provided by midwives within the emergency services.

The pan London model will pilot the response model in a sector across London (aligned to the Local Maternity System/STP footprint).

Alongside the Pioneer Model, a co-designed and co-developed patient and staff engagement model will be

used to drive quality improvement across the maternity care model.

Reduce the number of ambulance conveyance (20%). Employ two whole time equivalent practice developments midwives and deliver a training programme 2018-19.



Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Goal: Ensure staff complaints in providing 'best practice' care and to be in the top quartile for all national clinical audit outcomes.

Clinical audit is a key improvement tool through which we continually monitor and improve the quality of care that we provide. By fully taking part in national clinical audit programmes, we are able to benchmark our performance against our peers, ensure the care we provide is evidence-based and measure improvements on a

year-by-year basis.

We aim to be in the top quartile for outcomes for all those national clinical audits in which we are eligible to participate and where data is analysed this way. This enables us to have evidence that each of our services is effective and promotes a good quality of life for our patients. Further assurance of this will be provided by compliance and training that meets the changing nature of service delivery.

Target 1

We have chosen this target to ensure that we get the best clinical outcomes for our patients. Changing the way in which we deliver care and increasing the delivery of care using a multi-disciplinary approach requires a fundamental review of the type and quality of training that we provide to our staff. In addition it is important that we ensure staff have the time to attend training, a constant pressure with the increasing demand on delivering the service we provide. We will carry out a root and branch review during the early part of 2018 to inform an improvement programme to ensure that : systems and processes are robust with strong governance frameworks, the training is appropriate and easily accessible, a revised training programme to include any further training requirements highlighted to meet the changing nature of delivery, the programmes of training align to operational delivery and to ensure that staff are released to attend training and meet statutory requirements, we identify potential income generation via identification of potential opportunities and that we have an identified 'training brand'. Ultimately the aim is to ensure our staff continue to provide clinically effective care based on best practice guidance.

Root and branch independent review completed. Implementation plan developed.

Target 2

During 2017-18 the LAS, as with all other ambulance services, implemented the Ambulance Response Pilot (ARP). The new response targets set out different response categories and set out an approach that requires Trusts to report on new quality indicators. During 2018-19 the LAS will work with the business intelligence team to ensure that we develop methods to collate and report on these new indicators. In doing so we will have clear evidence of areas where we have improved patient outcomes and also have the ability to highlight areas where we may not be meeting the standards of care that we strive to deliver.

New quality Indicators developed and being reported via performance scorecards by December 2018

Target 3

We recognise that people are the key to delivering our quality strategy. We therefore must make sure that we are supporting and training our people to make improvement continuously as well as carrying out their roles. We want to implement new ways of working to improve our processes, systems and services with transparent measurement and track progress. We have therefore decided to adopt a standardised approach to quality improvement to make this possible. The NHSI (IHI) methodology is designed to support and encourage our staff by providing them with the tools they need to make sustained improvements. We want this to stimulate a culture of learning and development in improvement and ensure that change becomes the way of doing things in the Trust. As part of this process, the Trust has gained financial support during 2017-18 to increase the capability in relation to both Quality Improvement and Human Factors training programmes. We will set out an implementation plan that enables a critical mass of staff to be trained and also ensure this is aligned to our quality assurance processes to provide continual feedback, reporting and learning (see outline plan in section 1).

QI training plan agreed and 100% of identified key cohorts trained by September 2018

Target 4

The changing nature of our operating model, requires us to review the way in which our staff are allocated to their shifts. The Director of Operations will continue to work with colleagues to roll out this significant piece of work supported by our new Forecasting & Planning Team. A Trust-wide review of rosters will be completed by March 2018 with implementation due in summer 2018.

At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019



Responsive

Services are organised so that they meet people's needs

Goal: To consistently meet all relevant national performance targets standards through responsive patient pathways in year one, and exceed them by year three.

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events

have shown that our patients agree.

To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

As well as the national targets above, we will focus on the following targets to improve our responsiveness as a Trust to patients who complain.

Target 1

Over the last 12 months the Trust has consistently been one of the strongest performing ambulance services. It is currently the third highest national performer in implementing the new ARP standards. The Patient Experience Team is working with the sector teams to provide feedback and actions to enable learning from complaints. We continue to respond within timelines for complaints, meeting the majority of patient response within 35 days.

Additional recurrent funding has been secured over the last six months for additional frontline and Emergency Control Services staff, and we have also introduced an additional Incident Response Team to further strengthen our resilience capability.

We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP and new AQLs.

Target 2

Throughout 2018-19 we will focus on improving further our processes in dealing with complaints from the patients and public we serve. We will undertake a review of our complaints responses, supported by our Patient Forum, to ensure that our complaints responses include the appropriate information and express our apologies in a genuine way. We will aim to further improve the turnaround time for our letters and include more information in

relation to the lessons we have learned. In addition we will continue with our patient and staff stories at the Board, which have been instrumental in making sure the executive team understand better the experiences of our patients and staff.

Less than 1% of complaints letter being responded to over the 35 day timescale



Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Goal: To increase the percentage of our people who have been trained and provided with leadership development.

Evidence shows that people who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their

patients. Our goal is to increase the percentage of people who would recommend our Trust as a place of work. By supporting our people to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a patient. This goal will be supported by the targets outlined below.

Well led

During 2017-18 we have strengthened our leadership team, our governance systems and processes and set out key strategies e.g. People and Organisational Development, IM&T, which will act as key enablers going forward to the delivery of our strategic objectives.

Target 1

Our statutory and mandatory training programmes ensure the safety and well being of staff and

patients. During 2017-18 we moved the majority of our training to on-line e-learning and also implemented a new reporting tool on ESR to improve the ability to monitor and report compliance. We have chosen a target of 95% compliance to demonstrate that our staff comply with statutory and mandatory requirements which have a direct impact on patient safety.

95% compliance with statutory and Mandatory training

Target 2

Fully implement our leadership development programmes at all levels and develop a culture of professionalism, with all staff clear about their roles and responsibilities.

Leadership programme developed and implementation plan in place



Looking Back: Quality performance 2017-18

The progress against our targets and goals we set out in our Quality Account 2017-18 are outlined here, under the quality domain headings.



Quality Priorities 2017-18

The priorities for 2017-18 as set out in our previous Quality Account (2016) are highlighted below against the 3 domains for quality, Patient Safety, Experience and Effective care. Progress against each of the domains is provided, where relevant impact key performance indicators are included

Patient Safety

During 2017-18 we introduced and established a new integrated quality & governance directorate which aligns quality functions into one directorate. Recruitment to new posts has now concluded and the structure bring both an increase in capacity and capability to the quality agenda across the trust. Quality governance frameworks have been reviewed and rationalised with clear lines of reporting via new Terms of Reference, minutes and key issue reports to provide assurance and allow escalation of issues from 'floor to Board'. A risk management improvement programme has also been developed and continues to be implemented to identify key safety and quality risks more accurately and to ensure staff are trained in identifying risks and regularly review and assess risks to patient safety and quality of care.

Target 1: Development of pathways for patients

who fall, have mental health issues, are at the end of life and bariatric.

Our strategic intent document, developed during 2017-18, sets out the further system wide pioneering services we aim to develop and deliver during 2018-20 and onwards. This year work has progressed in relation to mental health support, with increased training, alternative care pathway development, data sharing alongside the recruitment of an additional 3 mental health professionals to provide advice in the clinical hub and support the initiation a mental health response car. This is a pilot to enable mental health clinicians to work alongside paramedics to respond to patients undergoing a mental health crisis, and commenced in December 2017. This will be evaluated and, if successful, rolled out to other sectors.

In addition the Trust has been successful in gaining funding for three full time staff to provide dedicated support to End of Life care providing advice and training for staff in giving support to families and patients on end of life care In addition to clinical audit, alternative care pathway utilisation and service development.

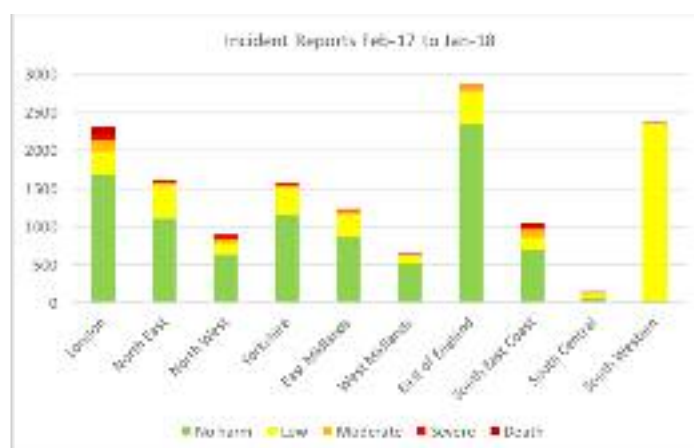
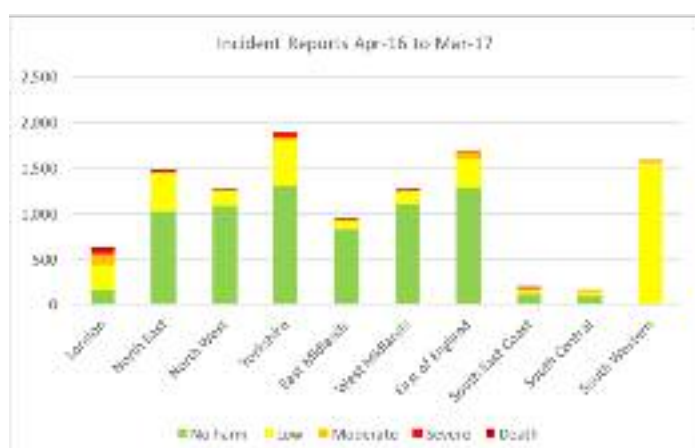
A Bariatric equipment business case is being presented to ELT at the end of February 2018, this outlines a 1.6

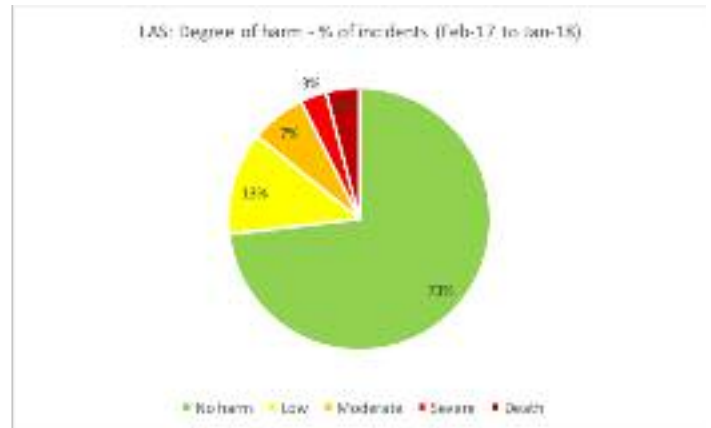
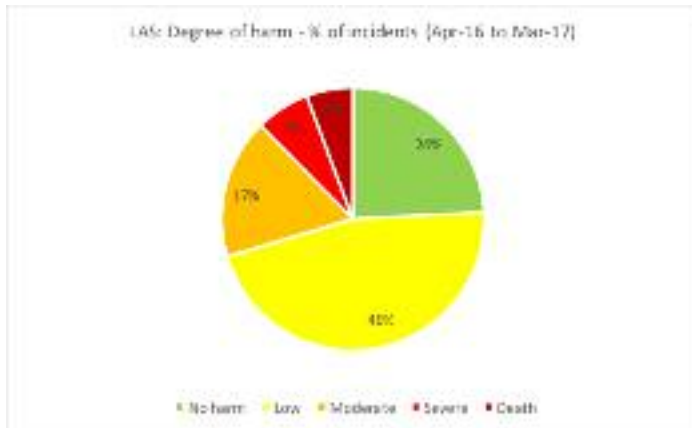
million investment and will need to align to the current logistics work programmes and consider the impact of the ARP future operating models in the type of equipment and support we require to ensure these patients have effective and dignified care.

Target 2: Improve and embed learning from incidents

A learning and quality improvement framework was agreed by the Board in November 2017 and is now being implemented, supported by a communication strategy. Implementation will be complete by March 2018 and continuous embedding of the framework will continue, supported by the revised quality assurance framework. In addition monies to train a cohort of staff in quality improvement methodology and human factors was also provided by NHSI. This programme of work will start in January 2018 and continue throughout 2018.

We have evidence of learning from incidents from the inclusion of feedback in core skills refresher courses, various changes to working practices, i.e. ventricular fibrillation, managing patients with spinal injuries. During 2017-18 we had an independent review by our internal auditors (KPMG) who gave the Trust Significant Assurance rating with regard to the serious incident investigation and learning process.





In addition our no/low harm reporting rates have improved to a currently in the higher quartile compared to national benchmarked levels during 2017-18. LAS are now reporting over 90% of incidents within the no/low harm category (see tables below).

Target 3: Improve outcomes for patients with critical conditions

Introduce best practice guidance to improve care delivery for patients with critical conditions. **INSERT**

Patient Experience

Target 1: Effective and consistent risk assessment completed for patients presenting with a mental health crisis

Revision to the risk assessment tool and training have been introduced during the year, we have seen an improvement in the quality of mental health assessments, with a current average of 91% of core criteria being recorded as demonstrated through the monitoring of monthly clinical performance indicators. In addition bespoke training has been delivered by our mental health nurses to staff within our emergency operation centres, call handling staff and clinicians; to specialist response teams such as the joint response unit; to specific cohorts of staff such as incident response officers and clinical team leaders (with over 200 staff trained in specific areas such as mental capacity). We anticipate the introduction of mobile devices will further improve our ability to carry out and record assessments real-time with guidance immediately available from various 'apps' that staff can access quickly on-scene.

Target 2: Improved compliance with Infection Control standards

Infection control issues identified internally and through CQC, have improved significantly, we are seeing the majority of sectors showing over 90% compliance against their monthly performance on hand hygiene. Infection control practices at A&E have also improved, vehicle cleaning remains an area of focus as does hygiene standards in some identified stations. These are being closely monitored through regular quality assurance visits. We will utilise more fully the Perfect Ward app to allow digital uploads of data from station visits during 2018-19

INSERT GRAPH

Target 3 : Ensure patients have timely and appropriate access to services

System wide demand management projects to improve care and experience of patients have seen improved response times, with the Trust meeting the majority of targets consistently.

Work undertaken with specific frequent callers has shown considerable reductions utilising a multi-agency approach to case management to our highest volume callers. However we are reviewing the resources required to support the delivery of a programme of to increase the potential of reducing the significant impact this patient group have on demand in 2018-19. The aim will be to enable case management to be undertaken for a larger number of cases through increasing capacity within the current dedicated frequent caller team, allowing increased involvement in system wide initiatives, evaluation of interventions on patient outcomes, patient experience, operational and system wide performance.

INSERT GRAPHS with different categories

Clinical Effectiveness

Target 1: Improve outcome as reported Ambulance Quality Indicators

We have implemented and are constantly measure best practice models of care following the introduction of the Ambulance Response Programme (ARP) in October 2017. Currently we are 3rd best performing ambulance trust nationally against these indicators. These are reported in Section 3 under clinical effectiveness outcomes.

Specifically in relation to Stroke and STEMI patients we have maintained our performance in delivering stroke bundles and STEMI bundles of care.

INSERT DATA AND ACTIONS

Target 2: Standardise hospital handovers including the use of NEWS for the sickest patients

We recognised that hospital handover delays is a multi-factorial system problem and we needed to work together to identify issues at each stage and resolve them. The LAS has worked with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London.

ED Site visits up to October 2017

The Emergency Care Improvement Programme (ECIP) were tasked to complete a series of site visits and assessments leading to improvement recommendations at various acute hospitals. Follow up visits commenced in October/November to measure progress against the individual recommendations made by ECIP. This work has also included widespread sharing of Patient Flow guidance with operational leads at each acute site and the identification of LAS contacts for trusts.

LAS engagement managers have worked with their local EDs to support ECIP led initiatives designed at reducing the potential for handover delays to occur. By identifying patients who could either wait or be seen in a hospital chair (#fit2sit). Or through reviewing the conveyance choices made by LAS clinicians (Front Door Challenge); for example could their patient of been seen in another area of the department, or have been conveyed/referred to an alternative pathway.

Sharing of LAS predicted data
Predictions of LAS activity for conveyance numbers by day of week/hour to each ED were shared to support stakeholders in their winter planning. LAS predicted activity is shared weekly with the NHS E Winter Room for inclusion in its daily update report

Cohorting process

Patient cohorting is a process whereby ambulance clinicians handover the care of their patient to an ED clinician immediately after triage regardless of bed availability. This can allow ambulances to become available for dispatch to another incident more quickly; it is the responsibility of Acute Trusts to implement and staff this. Ambulance-led cohorting is the same process, but is implemented and staffed by the LAS because it is felt that the risk of not doing so would be to the significant detriment of the Trust and patient safety. A standard process for Cohorting across London including the triggers and reporting process for when it can be used has been designed and implemented with the agreement of NHS E.

NEWS is based on a simple scoring system which allocates a score to physiological measurements in adult patients. The aggregate NEWS score provides an indication of how unwell the patient is. Patients are assessed and attributed a score and category (Red ≥ 7 , Amber 5-6 and Green <5) the categories are regarded as high, medium and low risk respectively. During periods of delayed handovers at Northwick Park ED patients will have their NEWS assessed. The trial started on 21.12.17, a NEWS card is attached to the patient whilst waiting where handover is delayed and/or Cohorting is implemented. The card is contained within a plastic wallet, an elastic band is used to attach the

2017-18*			2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)

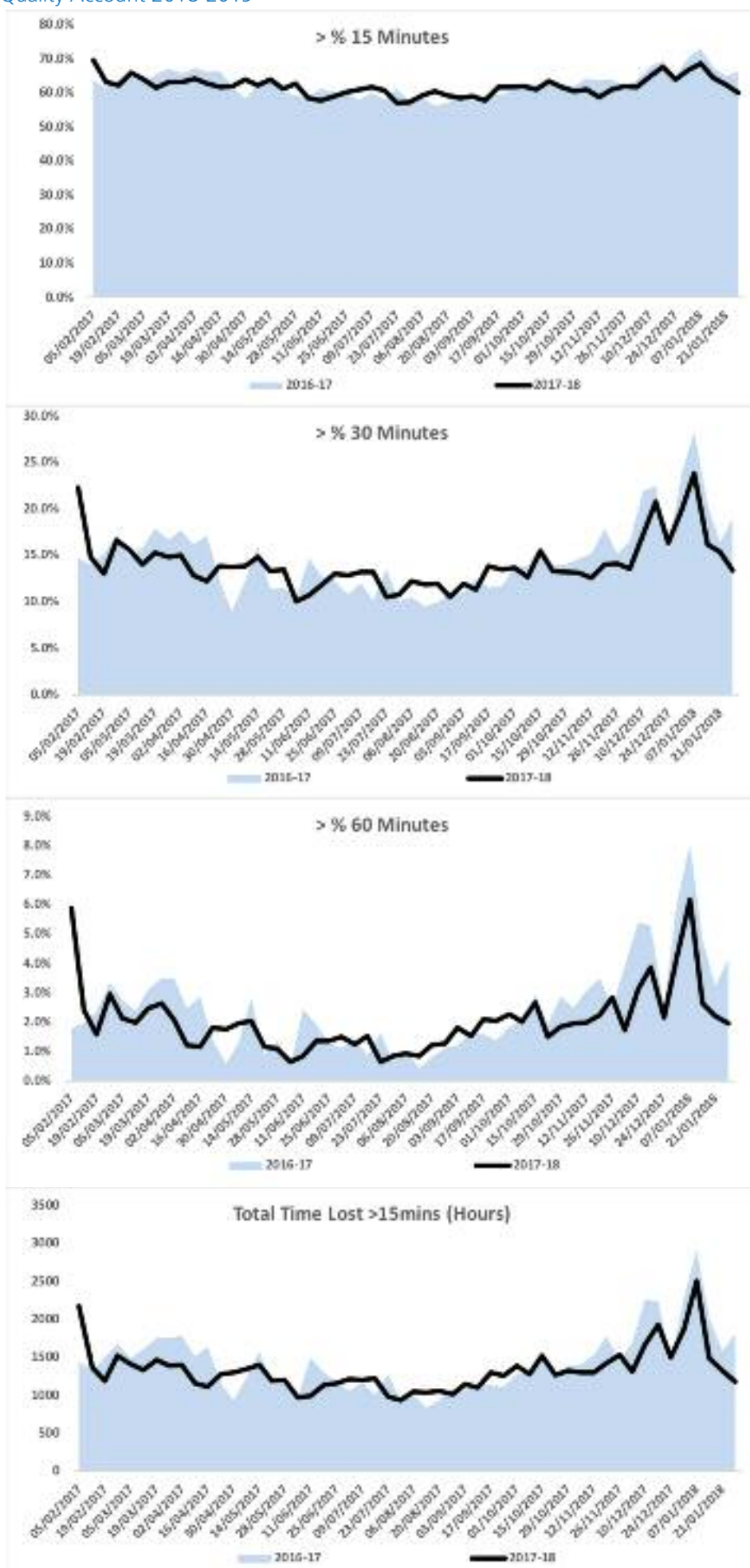
*At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.

card to the patient's wrist. The card is folded to ensure that the appropriate red, amber or green page is visible before being placed into the plastic wallet which is then attached to the wrist of the patient. It is intended that staff would commence use of NEWS cards where the anticipated wait is likely to exceed 30 minutes and in all cases where Cohorting is commenced. The NEWS is reassessed every 30 minutes until the patient is handed over to ED staff. The trial aims to assess the impact of handover delays on patients, assisting in the identification of unwell or deteriorating patients.

5. Performance update Jan 2018

As the following tables highlight hospital performance in 2017/18 when measured by handovers over the 15, 30 and 60 min target and total time lost has improved against the same period in 2016/17

Our work on hospital handovers has been recognised as outstanding practice and has played a significant role in reducing waiting times for patients, we will continue this work through 2018-19.



Target 2: Develop a mortality and morbidity review process

We have introduced a mortality review group to ensure information is available in relation to specific groups/themes to target learning and improvement. We are also working with other ambulance trust to ensure we have a standardised approach and to share learning across different organisations. The outcome of the analysis is aggregated with information from SIs, incidents, complaints, claims to provide identification of themes and focus improvement efforts. Preventing Future Deaths notices are now reported into this group and also discussed at Quality Oversight Group to enable thematic analysis of trends across all incidents.

We are also working with other ambulance services to agree a standardised approach to mortality reviews and to share learning across different services.

Conclusion

Our progress during 2017-18 has been significant and has brought about much improved outcomes for our patients, as demonstrated in this section of the report. We will strive to continually improve and sustain that improvement through our quality improvement plans for 2018-19 and beyond.



Section 3: Statements of assurance from the Board

Statements mandated by NHS England

Each year we are required to report a number of mandatory statements, which you will find reported in this section:

Data Quality Assurance

The London Ambulance Service manages data quality for Accident & Emergency information, using a bespoke application developed internally. All information received from the 999 CAD system, Command Point, Mobile Data Terminals (MDT) and Patient Report Forms (PRFs) is processed through this application. Within the application, records that satisfy any of the pre-defined validation rules are presented for reviewing, and can be amended where necessary, if there is adequate evidence available to do so.

Records are reviewed for

- Illogical time sequences between timestamps
- Unlikely gaps between timestamps
- Incorrect hospital codes
- Missing timestamps where one would be expected
- Conveyances by non-conveying vehicles
- Patient Handover breaches at hospital
- Mismatched Patient Report Forms (PRFs)
- Discrepancies between Command Point, MDT, and PRF data

A facility is available to allow staff outside of Management Information to request a review of any data items. These data quality queries are submitted via the Business Intelligence (BI) Portal for consideration by the Data Quality team to ensure that they meet agreed rules. No-one outside of the

Data Quality team within MI can make amendments to any records. There is an audit history for any record flagged for reviewing, and all changes and actions taken (or not taken as the case may be) are logged with the username/change made/date/time.

All reports produced by the Business Intelligence team follow a pre-determined check list to ensure accuracy and compliance with Ambulance Quality Indicator guidance. Every report is peer reviewed and approved by a senior member of the team prior to publication

A report demonstrating compliance against the Ambulance Quality Indicators (AQI) guidelines is submitted annually to Executive Leadership Team (ELT) for approval. A data quality strategy is under development to be approved by the Trust Board in 2018.

Income

The income generated by the NHS services reviewed in 2017 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2017/18.

Clinical Effectiveness and Audit

The London Ambulance Service NHS Trust has a robust clinical audit and research programme that focuses on both local and national areas of priority. In 2017/18 the LAS examined the care provided to a wide range of patients including those that had a heart attack, cardiac arrest, stroke, trauma, mental health related conditions and paediatric care. Our research programme continued to grow and alongside our existing cardiovascular studies (including the world's largest randomised controlled trial of adrenaline in cardiac arrest), we launched a new randomised control trial examining whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest.

In addition to continuously assessing the care provided to

cardiac, stroke and trauma patients, during 2018-19 we will focus on sepsis care with the introduction of a new continuous registry. We will also continue to audit the appropriateness of decisions made for patients who are discharged at scene and then re-contact the Service within 24 hours having severely deteriorated or died unexpectedly.

Clinical audit

During 2017/18, only one national clinical audit and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audit and national confidential enquiries that the London Ambulance Service NHS Trust was eligible to participate in during 2017/18 are as follows:-

NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:

- Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
- Outcome from cardiac arrest – Survival to discharge
- Outcome from acute ST-elevation myocardial infarction (STEMI)
- Outcome from stroke

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

The London Ambulance Service NHS Trust submitted the following

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
NHS England AQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 1,962 b) 263	a) 1,962 b) 263	100%
NHS England AQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 1,881 b) 235	a) 1,881 b) 235	100%
NHS England AQI: Outcome from acute STEMI a) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. b) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 658 b) 1,531	a) 658 b) 1,531	100%
NHS England AQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 3,737 b) 6,411	a) 3,737 b) 6,411	100%

2017-18*			2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)
*At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.				

information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2017/18 and 2016/17.

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: data are captured by the LAS from clinical records completed by ambulance staff attending patients as part of on-going clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The reports of the above national clinical audits were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust has taken actions to improve the quality of healthcare provided as set out in Appendix 1.

CQUINS

A proportion of London Ambulance Service NHS Trusts income in 2017/18 was conditional on achieving quality improvement goals within the contract. The 2017/18 CQUIN schemes were set according to the Commissioning for Quality and Innovation payment framework and either set nationally, or agreed with the lead Commissioner, Brent CCG, acting on behalf of the pan-London CCGs. Further details of the agreed goals for 2017/18 are detailed in Appendix 2. Achievement will be confirmed following the final Q4 submission, due in April 2018.

Proposed and national CQUINs for 2017-19 are detailed in Annexe 1.

Serious Incidents (SIs)

A total of XXX cases were reviewed by the Serious Incident Group in 2017/18. Of these, XXX incidents were deemed to meet the criteria to be declared as serious to NHSE.

In July 2017 the SI investigation process was reviewed and significant changes made. The process was launched in August 2017. Improvements were made to the DatixWeb system to enable clearer monitoring and enhance compliance with internal and external deadlines. Current Lead Investigators across the Trust attended an update/refresher training day and the Quality, Governance and Assurance Team provide serious incident investigation training each month for new investigators. As of March 2018 a total of XX managers have been trained to investigate serious incidents. To assist in times of high operational demand, significant efforts have been made to utilise managers from other areas of the Trust. Of the XX trained investigators XX are operational managers and XX are from non-operational backgrounds.

Currently the Trust does not have any serious incident investigations that have breached the 60 working day deadline to the CCG. During January 2018, the Trust instructed KMPG to undertake an independent audit of the revised serious incident process. The outcome of this

provided significant assurance that the Trust was investigating incidents effectively, actions were taken in a timely manner, patients and relatives were informed and staff were supported.

Quarterly thematic reviews have shown issues concerning call handling and dispatch and clinical treatment. Themes from the reviews have been shared across the Trust and actions to address the concerns have been incorporated into an intensive actions plan for the Emergency Operations Centre (EOC). Additional actions have been taken in relation to the clinical treatment concerns and are detailed below.

Learning from experience

Below show some examples of where the Trust have made improvements as a result of serious incident investigations:

- 1 Change in practice regarding the management of cardiac arrests as a result of a significant number cases concerning delayed defibrillation
- 2 Changes within the Gazetteer system to improve the accuracy of locations across London
- 3 Policies that have been identified to be unfit for purpose have been reviewed and updated
- 4 Improved training, compliance audits and the development of a new policy for the management of breached Patient Group Directions

- 5 Guidance issued to staff on the management of paediatric patients with particular focus on the measurement of oxygen saturations
- 6 Development of a feedback mechanism of all maternity related incidents to the maternity training programme
- 7 Process for investigating and managing thematic reviews of similar incidents. For example; delayed defibrillation and the Non-emergency Transport Service
- 8 Equipment concerns highlighted to the equipment replacement programme which assisted in the development of business cases to replace specific pieces of equipment
- 9 Learning from incidents training delivered to all EOC staff and included on the paramedic academy courses
- 10 Incorporation of case studies to the internal leaning from incidents Insight magazine
- 11 Changes to practice included in core skills refresher courses for both EOC and frontline operations

12 Case studies included in the internal Clinical Update magazine

Future developments

During 2016/17 the Chief Quality Officer led an in-depth review of the serious incident process with the objectives to review the time taken to investigate incidents and improve the sharing of learning from investigations. Additionally the executive review process was amended and three nominated Executive Directors now form a panel for reviewing and signing off reports.

The focus for 2018/19 will be centred on the development of the Quality Governance and Assurance Team. To date the team has a newly appointed Head of Quality Governance and Assurance, current roles have been reviewed, job descriptions developed or updated and clear lines of responsibility have been assigned. Work will continue to appoint a dedicated risk manager and a team of business partners to provide an additional level of support to the serious incident process and lead investigators.

Duty of Candour

Duty of Candour training is part of the mandatory training for all relevant members of staff and is valid for three years. Currently **XXXX** members of staff have completed the training. Additionally all Lead Investigators are provided with the regulation 20 compliance requirements, its place within the serious incident process and the history of the regulation.

The role of the Business Partner will include the requirement to have a robust working knowledge of the Duty of Candour process and these individuals will be responsible for ensuring compliance will all investigations assigned to them. Further support regarding the Duty of Candour is found in both the revised Duty of Candour Policy and Serious Incident Policy. To improve the monitoring of Duty of Candour compliance in relation to serious incidents and those graded as moderate harm, the Datix Web system was developed to include a section dedicated to the individual stages and allows for compliance reports to be reviewed.



CQC

Following the June 2016 Care Quality Commission (CQC) inspection of the service, the LAS developed a Quality Improvement Programme (QIP) which was a single overarching plan to address quality improvement in the Trust. A clear programme of delivery, accountability and governance was established, led by the Chief Quality Officer and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our QIP via Executive Leadership Team meetings and via Quality Oversight group, Quality Assurance Committee and Board.

This Quality Improvement plan has been delivered the majority of actions detailed, with a number of actions being incorporated into business as usual for Directorates; projects of a more complex nature, which are yet to be completed, are being incorporated into the 2018/19 Business Plan.

The CQC has conducted a Well-Led inspections of The London Ambulance Service NHS Trust on March 21st and 22nd 2017 . Two unannounced visits were also carried out in:
Emergency Operations Centres
Urgent and Emergency Care sites
Well-led review

The final report will not be available prior to the publication of the annual Quality Account, however initial feedback suggests:

Staff Survey

For 2017 the survey was sent to all Trust staff electronically for the first time. Of 4970 eligible employees 2664 questionnaires were completed, giving an overall response rate of 54%. This is the highest ever response rate for the Trust and supports the determination of the Executive Team to gain extensive feedback on the employee experience to inform developments and focus for 2018/19.

The average response rate across all Ambulance Trusts was 46%. LAS' response rate is therefore significantly higher than other Ambulance Trusts.

The main published report sees the findings of the questionnaires summarised by the national survey centre Picker Europe, on behalf of the Department of Health, presented in the form of 32 Key Findings (KF). This year the Key Findings are presented under nine themes listed below:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

Overall indicator of staff engagement

The staff engagement score ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their Trust) and 5 indicating that staff are highly engaged.

The Trust score was 3.36 compared with 3.39 in 2016.

The overall indicator for staff engagement is calculated using three key findings:

- Staff recommendation for the Trust as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute towards improvements at work

The first two sub-dimensions showed no change since the 2016 survey but staff members' perceived their ability to contribute to improvements at work has reduced by 4% and this accounts for the decrease in the overall staff engagement score.

The Trust acknowledges that the impact of the extensive change right across the organisation is reflected in this outcome and this will be a key area of focus for the Executive team in 2018/19.

Summary of Key Improvements and Developments

The categories where the Trust has performed better are:

- Working patterns
- Patient care and experience

The categories where the Trust performed less well are:

- Violence, harassment and bullying
- Equality and Diversity

The key findings which benchmarked higher than other Ambulance Trusts were:

- % satisfied with the opportunities for flexible working
- Effective team working

By key finding, the areas where the Trust needs to focus improvement is:

- % staff appraised in last 12 months
- % believing the organisation

provides equal opportunities to career progression/promotion

- % reporting good communication between senior management and staff
- % agreeing that their role makes a difference to patient/service users
- % experiencing harassment, bullying or abuse from staff in last 12 months
- % reporting most recent experience of harassment, bullying or abuse

Key staff groups

Gender

Women had more positive scores overall than men (26 out of the 32 key findings). Women had a staff engagement of 3.43 compared with 3.34 for men. Slightly less women had appraisals (73% v 75%) and also scored higher in levels of work related stress and attending work despite feeling unwell. None of these scores were statistically significant differences.

Black and Ethnic Minority staff

In 21/32 key findings BME staff had a more positive response than white staff. An additional 2 key findings had the same score. BME staff had a staff engagement score of 3.43 compared with 3.36 for white staff.

BME staff had higher levels of job satisfaction except for their perceived ability to contribute towards improvements at work. BME staff reported higher rates of experiencing bullying and harassment from white staff (38% v 31%) and a slightly lower rate of reporting (30% v 31%). Levels of appraisal were 5% less for BME staff and they also rated the quality of training lower.

The scores with the most significant difference were in relation to Equality and Diversity. 37%

reported experiencing discrimination at work compared with 26% of white staff and 47% felt that the organisation provides equal opportunities for career progression and promotion compared with 62% of white staff.

LAS survey scores since 2013

Over the last 5 years 16/32 key findings have shown improvements.

Of those results given as a % and using Picker's measure of 3% as being statistically significant there are 3 areas which have decreased

- % believing the organisation provides equal opportunities for career progression (by 14%)
- % able to contribute towards improvement at work (by 4%)
- % reporting good communication between senior management and staff (by 3%)

Of those results scored on a scale of 1-5 those which have decreased are:

- Organisation and management interest in and action on health and wellbeing (from 3.24 to 3.20)
- Staff recommendation of the organisation as a place to work or receive treatment (from 3.46 to 3.41)
- Recognition and value of staff by managers and the organisation (from 3.02 to 2.98)

The remaining 10 key findings showed little variation.

Taking Action

A network of Staff Survey Champions has been identified to create and deliver action plans locally across all areas of the Trust. Champions have been encouraged to work with their local union reps in taking forward this work. Each Champion has been provided with a survey report for their area and will engage with their colleagues to identify the areas for improvement

and potential actions. It was recommended that each action plan focused on 3 actions.

Champions came together to provide them with an overview of the staff survey outcomes and a toolkit to support the development of action plans. Follow up events will be planned during the year to provide an opportunity to update on progress, share ideas and provide support in the development and delivery of action plans. Basecamp (an online sharing platform) has been set up as a document repository and as an area to share information and provide peer support.

As each local area has been asked to identify 3 actions, the Trust decided upon a Corporate action plan to supplement this with 3 Service wide actions based on the 3 key findings which had a statistical decrease in 2017.

These are:

- % believing the organisation provides equal opportunities for career progression (by 14%)
- % able to contribute towards improvement at work (by 4%)
- % reporting good communication between senior management and staff (by 3%)

Charts to be inserted

Freedom to speak up

Freedom to Speak Up Guardians have been introduced in each NHS Trust, as a result of the recommendations in the Francis Report. A Guardian was appointed at the LAS in October 2016, and undertook this role in addition to her core role as Head of Patient & Public Involvement and Public Education. She stepped down at the end of December 2018, to be replaced by a full-time interim Freedom to Speak Up Guardian, who was tasked with promoting the role in the Trust and facilitating the recruitment of a permanent Guardian.

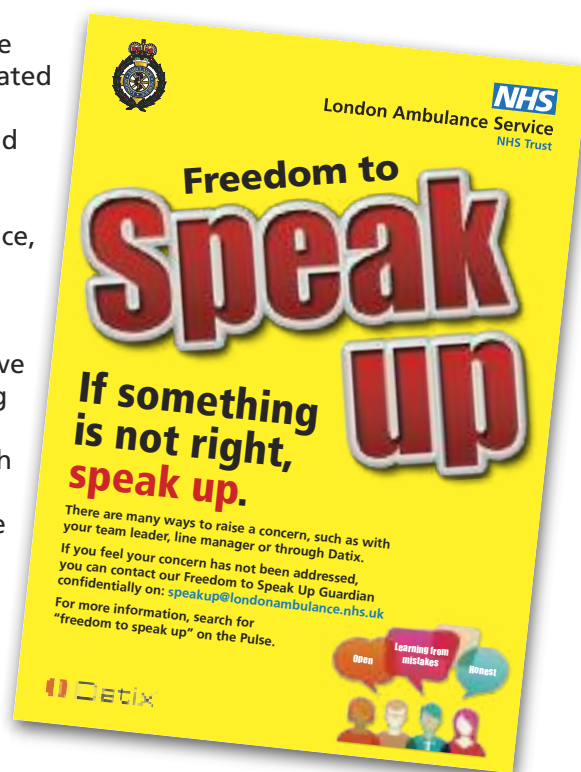
Since the role was introduced the Trust has:

- Announced the role in the internal Routine Information Bulletin and produced a leaflet to be attached to staff payslips.
- Established a Freedom to Speak Up LAS group, with dates to meet quarterly.
- Agreed reporting arrangements to the Trust Board.
- Designed a secure recording and reporting module on Datix, which is only visible to the Freedom to Speak Up Guardian.
- Hosted a successful visit by colleagues from the National Guardian's Office.
- Had its Freedom to Speak Up arrangements audited by KPMG. The LAS was the first NHS organisation to have taken this action.

The LAS Guardian has attended the national launch and undertaken the Freedom to Speak Up training. He is a member of the London regional network and national ambulance network for Freedom to Speak Up Guardians.

Since the role has been introduced, a total of xxx concerns have been reported. The majority of these have related to a bullying culture

across a team or part of the organisation, two have related to trust processes, two to patient safety concerns, and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements. Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.



Information Governance

London Ambulance Service NHS
Trust Information Governance
Assessment Report overall score for
2017/18 reached 83% satisfactory,
Level 2 for all requirements.

National Reporting

London Ambulance Service NHS
Trust did not submit records during
2016/17 to the secondary users
service for inclusion in the Hospital
Episode Statistics.

London Ambulance Service NHS
Trust was not subject to the
Payment by Results clinical coding
audit during 2016/17 by the Audit
Commission.

Section 4: Reporting on core indicators

In October 2017/18 the ambulance response categories changed following the national implementation of Ambulance Response Programme. The figures below will therefore represent the category achievements to October and the changed categories from October to March 2018.

April to October categories

Cat A These are calls or incidents categorised as immediately life threatening, Cat A subdivides into Red 1 and Red 2. The categories are based on AMPDS codes provided by the Department of Health.

Category A % reached in 19 mins:

The percentage of Cat A incidents where any responder capable of conveying a patient arrived at the scene of an incident within 19 minutes. This is measured from clock start to when the first conveying vehicle (MRU/CRU - if only vehicle) arrives on scene. The target is 95% within 19 minutes.

Red 1

This is a subcategory of Cat A, these are the category of calls that are deemed the most time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from call connect to when the first responder arrives on scene.

Red 2

This is a subcategory of Cat A, these are the category of calls that are deemed serious but less immediately time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from either first dispatch, determinant or 240 seconds and the clock stops when the first responder arrives on scene.

	A8			A19		
	R1	R2	A	R1	R2	A
Apr-17	79.38%	73.63%	73.83%	98.98%	95.44%	95.56%
May-17	73.71%	71.90%	71.96%	98.60%	94.94%	95.06%
Jun-17	73.61%	69.75%	69.88%	98.38%	94.26%	94.39%
Jul-17	72.51%	68.55%	68.69%	98.64%	94.01%	94.17%
Aug-17	74.47%	72.05%	72.14%	98.54%	94.32%	94.47%
Sep-17	70.70%	68.47%	68.54%	98.23%	93.75%	93.90%
Oct-17	73.28%	68.65%	68.82%	98.90%	94.79%	94.94%
2017/18	73.90%	70.40%	70.52%	98.61%	94.50%	94.64%

Table 3 demonstrates our achievement of these category calls during 2017-18 from April to October.

Table 3

The month on month performance for A8, A19 and the year end position. As the Ambulance Response Programme was implemented on the 1st November 2017, year end position is calculated from April to 31st October 2017. By way of comparison, the 2017/18 year end position shows a considerable improvement at the same point for 2016/17. (from April to October 2016). This improvement is more noticeable for the A8, Red 1 (R1) and Red 2 (R2) measures. The overall A8 measure increased by 4.51% from 66.01% in 2016/17 to 70.5% in 2017/18. Red 1 performance increased by 5.27%, from 68.64% in 2016/17 to 73.9% in 2017/18. Red 2 performance improved by 4.47% from 65.93% to 70.40%.

System Indicators Post ARP implementation	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
November 2017	00:07:03	00:11:28	00:18:25	00:36:28	02:13:10	02:28:48
December 2017	00:07:23	00:12:04	00:24:07	00:51:08	02:58:23	02:51:44
January 2018	00:07:08	00:11:43	00:20:23	00:42:05	02:24:59	02:19:05
Current YTD (2017/18)*_ * From 1 st November 2017 – 11 th February 2018	00:07:13	00:11:46	00:21:14	00:44:13	02:32:34	02:31:55

System Indicators – Post ARP Implementation

The above table shows the six key indicators and our performance since the Ambulance Response Programme was implemented (November 2017). Performance in all 6 measures improved in January 2018, seeing a reduction of the time taken to respond to patients compared to December. The most significant improvement was seen in categories 3 and 4 where there was a reduction of over 30 minutes for C3 and C4 90th centiles. The C1 mean performance has been stable week on week since November 2017, which is reflected in the monthly performance. January 2018 shows a reduction by 15 seconds to 7 minutes and 8 seconds. This is marginally above the national standard of 7 minutes. C1 90th centile shows each monthly performance successfully within the national standard of 15 minutes, this is also reflected in the year to date position at 11 minutes and 46 seconds. C2 mean is above the 18 minutes by a few minutes each month. The year to date position shows 3 minutes and 14 seconds above the national standard. C4 90th centile has remained within the national standard of 3 hours every month since the implementation of ARP. The year to date performance is within the national standard by a substantial 28 minutes and 5 seconds.

Complaints and Patient Advice & Liaison (PALS)

Introduction

Patient experience and feedback is a rich source of information that allows us to understand whether our services are meeting the standards we set ourselves and meeting patients' expectations. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously and do our best to offer a comprehensive response, clearly identifying any lessons and using these to improve our service, where appropriate.

It is important to ensure that patients' voices can be heard. To this end, and to compliment the information we already have available, this year we introduced two new leaflets under the banner of 'Talking With Us'. The first is available on all ambulances, providing information about how to make a complaint or to thank our staff; the second is sent out with every complaint response, inviting complainants to feedback on their experience of making a complaint.

Activity

Year ending March 2018, the volume of complaints dropped slightly, totalling 824 against 1016 in 2016/17. Enquiries continue to increase 10% against 4215 being received in 2016/17. The PTS service has reduced dramatically, now operating as NETS. NHS 111 complaints (via LAS) are also hosted by the team.

The Resource Escalation Action Plan (REAP) was used during persistent periods of high 999 call demand meant that the REAP level for this year was mostly implemented at *moderate* or *severe*. The daily average for 999 calls is currently 10. The average percentage of complaints received against calls attended is [0.08%].

Complaint risk score – to 21/02/18

During 2017/18, 15 complaints and one PALS enquiry were referred to the Serious Incident Group. Of these, six were declared as a Serious Incident.

Risk grade 2017/18	Data
Low	709
Moderate	109
Significant	5
High	1
Total	824

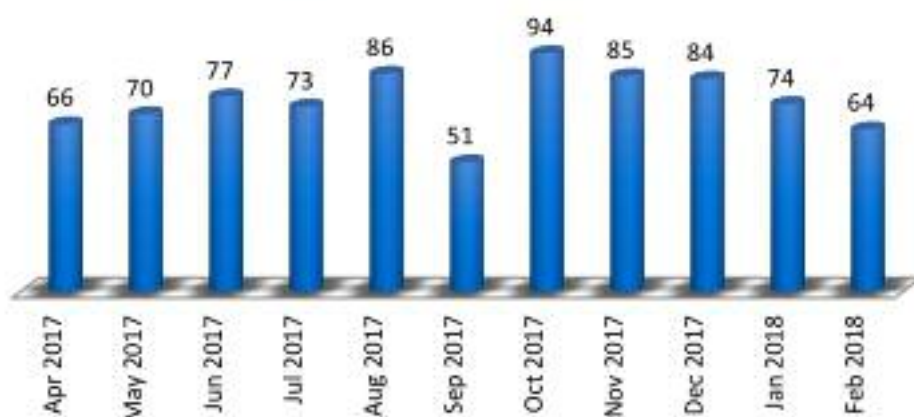
Complaint outcomes

If a complaint is upheld, learning will be noted and actioned accordingly. This can involve a range of measures including feedback, reflective practice and bespoke training held locally, with emerging themes reported to the relevant department/Governance Committee to consider action. The Patient Experience Annual Report, published later this year, will provide a comprehensive analysis.

Table showing complaint outcomes of **closed** complaints 2017/18 (as at 20/02/18)

2017/18	Data
Not upheld	415
Partially upheld	103
Referred to other Agency	89
Upheld	72
Actioned	26
Under investigation	119
Total	824

Month on month
April 2017 to 21/02/2018



Complaints by subject 2015/17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Total
Delay	21	17	16	14	26	9	22	33	19	17	194
Conduct	16	19	24	19	19	16	17	25	20	22	197
Road handling	12	11	13	14	10	7	14	9	7	6	103
Treatment	1	2	5	1	7	5	16	8	9	8	62
Non-conveyance	3	0	4	12	0	1	6	1	7	6	40
Total these subjects	53	49	62	60	62	38	75	76	62	59	596
Overall Totals	66	70	76	73	86	51	94	85	84	74	759

Themes

These continue to be dominated by delay and staff conduct. However, many complaints increasingly involve multiple issues, for example, call management + a delayed response + attitude of crew staff + care provided.

The top five key subjects were as follows – to 21/02/18

Performance

We have been able to achieve a significant improvement in throughput performance targets. Year to date performance is 81% responses within 35 working days. To achieve this the following measures have been actioned

- Improved resourcing to Quality Assurance team
- Closer relationship with QGAMs
- Changes in some of the methodological processes the team use
- Changes in administrative practice at the Executive Office.
- Weekly review of complaints against target response times

We do however continue to experience external factors that can influence performance, for example telephony and IT problems.

Examples of learning

Complaints continue to be a powerful tool to describe patients' experiences and the learning that has resulted are presented to the Patient Feedback and Learning Group.

Staff attitude

Our practice when we receive a complaint about staff attitude and behaviour is to additionally review the care provided, which has often demonstrated a correlation.

Examples –up to 5 available

Ombudsman cases

The Ombudsman continues to investigate a high proportion of complaints across all NHS Trusts, especially where a death has occurred.

Pie chart showing requests by the Ombudsman and outcomes:

Complaint files requested by the Ombudsman
June 2015 to January 2018



Patient Engagement

The LAS Patients' Forum

The Trust continues to work closely with its Patients' Forum, an independent lay organisation that takes an overview of the Trust from the point of view of service users, carers and the public. The Forum provides representatives for all the Trust's governance committees and its own monthly meetings are hosted at LAS Headquarters, supported by the Patient & Public Involvement Team.

In the year 2017-18, Patients' Forum meetings included the following topics and speakers:

- Delivering safe and effective emergency and urgent care in London, presented by the Director of Operations

- Developing higher quality care, presented by the Deputy Director of Nursing & Quality
- Demand management, presented by the Deputy Director of Operations (Emergency Operations Centre)
- The CQC report findings, presented by the Chief Quality Officer
- Race equality in the LAS, presented by the Director of People and Organisational Development
- The Ambulance Response Programme, presented by the Assistant Director of Operations for Service Improvement
- Patient & Public Involvement in the LAS, presented by the Head of Patient & Public Involvement
- The flu epidemic and vaccination

campaign, presented by Dr Sam Perkins from Public Health England

Patients' Forum members meet regularly with senior LAS colleagues, LAS commissioners and other key organisations such as the CQC, to highlight areas of good practice and areas where development is required.

Patients' Forum members have been directly involved throughout the year in the development of the LAS Academy. Together with staff from the Academy, they have formed a Patient and Public Involvement Panel, and attend steering group meetings. They have developed a teaching programme detailing patient and public involvement in the Academy's syllabus, and take part in assessment centres for the recruitment of students.



Friends and Family Test (FFT)

The Trust continues to record Friends & Family Test (FFT) responses from Patient Transport Service and See & Treat patients, although the response rate remains low. The total number of FFT responses received in the year 2017-18 was **xxx**. 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 National Ambulance Service Patient Experience Group is in discussions with NHS England and NHS Improvement, to highlight the limitations of this methodology for ambulance service patients and discuss alternative methods of patient engagement.

Community Engagement Events

The LAS remains committed to supporting a wide range of patient engagement and public education events with LAS presence requested at **xxx** events in the year 2017-18. Of these, we were able to attend **xxx**, **xxx**% of all requests made. This is due to the ongoing support of over 1,200 staff on our database, with **xxx** individuals taking part in multiple events, often in their own time.

We have created a closed Facebook group for staff involved in public engagement, as another method of communication. Through this group we provide information about the team and about forthcoming events, and staff can post their own ideas and questions for members of the team to answer. This has been extremely successful and the group has over 600 members.

The four part-time Public Education Officers continue to focus mostly on activities involving children and young people, such as awareness sessions on the dangers of carrying knives and of using alcohol and other legal highs, careers in the LAS, and multi-agency road safety events



such as Safe Drive Stay Alive and Biker Down. Many of these are carried out with partner organisations.

Blue Light Collaboration

We are working closely with our partners on the "prevention" sub-group of the Blue Light Collaboration project, to ensure we make the best use of the resources available and share good practice. The Head of Patient & Public Involvement and Public Education is an active member of the steering group and has now also facilitated the inclusion of the LAS Head of First Responders in the group.

One of the Public Education Officers has led on a key project as part of this work, piloting a scheme which involved all the blue light services attending schools in the London Borough of Haringey. Pupils participated in a range of sessions, rotating between them during a

school day. The London Ambulance Service sessions focused on the consequences of carrying knives, and CPR (basic life support) training. The pilot has been evaluated and has been shown to be highly effective. A bid is now being submitted, with the aim of rolling out the scheme to other London boroughs.

Co-production and co-design activities

Co-production and co-design are powerful ways to maximise the benefit of patient involvement, both for patients and for staff.

Following the Insight Project, funded in 2016-17 by the NHS England Insight Team, a range of co-production activities have continued to gather momentum. These have focused on three specific patient groups: those with sickle cell disease, COPD (chronic obstructive pulmonary disease) and personality disorder. Some patients from those groups (sickle cell and personality disorder) have taken part in developing and delivering training packages for LAS staff, whilst others have taken forward ideas such as carrying health information "passports" or crisis cards (COPD and sickle cell) and how to get information across in a 999 call. Members of the personality disorder group delivered a presentation at the Safeguarding Conference this year, and have made a film for use in staff training. We are talking to the Sickle Cell Society about children and young people making a film about pain, for use in the LAS Academy's module on pain management.

Discussions have commenced with Healthwatch London, with a view to commissioning a local Healthwatch group to carry out co-production and co-design activities to support the new LAS Strategy. This work is likely to focus on the four 'pioneer' services: mental health, maternity, falls and end of life care.

The Trust also hosted an event for its Partnership Reference Group (PRG), which is made up of Healthwatch and voluntary sector organisations, to get the group's feedback on its strategic intent. Earlier in the year we held a PRG event focusing on volunteering, to share information about different schemes and learn from PRG members' experiences.

Staff development and training

The Patient & Public Involvement Team ran a four-day course in October for staff who volunteer to undertake patient engagement work for the Trust. The course has been running for a number of years now and is well-established, being updated and adapted each year according to the feedback received and the Trust's changing public education priorities. The course

includes skills training (e.g. presentation skills), knowledge (e.g. disability awareness) and self-awareness activities such as an introduction to the Myers-Briggs Type Indicator (personality types). This year, because of the links made through the Blue Light Collaboration work, we were able to use the London Fire Brigade's training facilities, free of charge.

The Patient & Public Involvement Team has purchased an online disability awareness training programme, which any member of LAS staff can use at no extra cost. The course includes modules on a range of disabilities and gives practical tips and information about how best to communicate with people affected by those disabilities, and how to provide and adapt services for them.

Every other month the Trust Board hears a patient story, usually told directly by the patient involved. This helps to ensure patients feel heard by the organisation, and provides an opportunity for Board members to hear about patients' experiences first-hand.

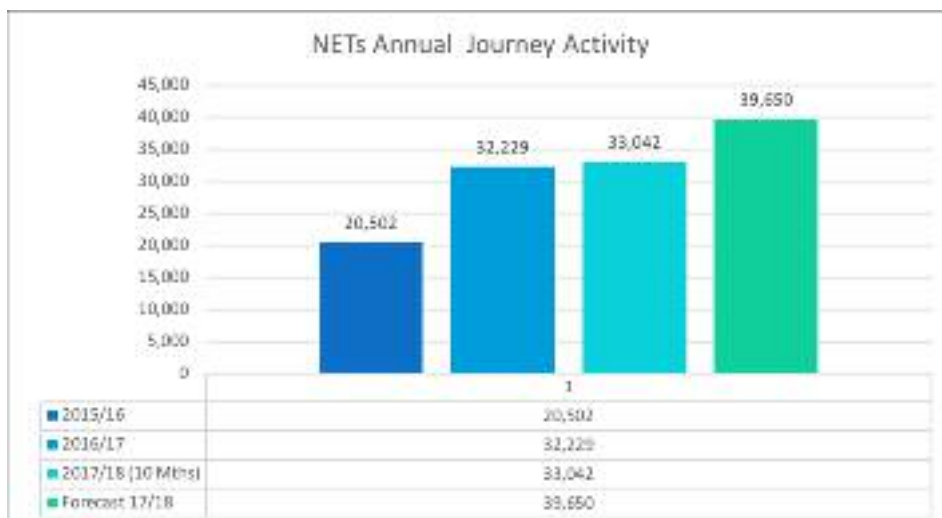
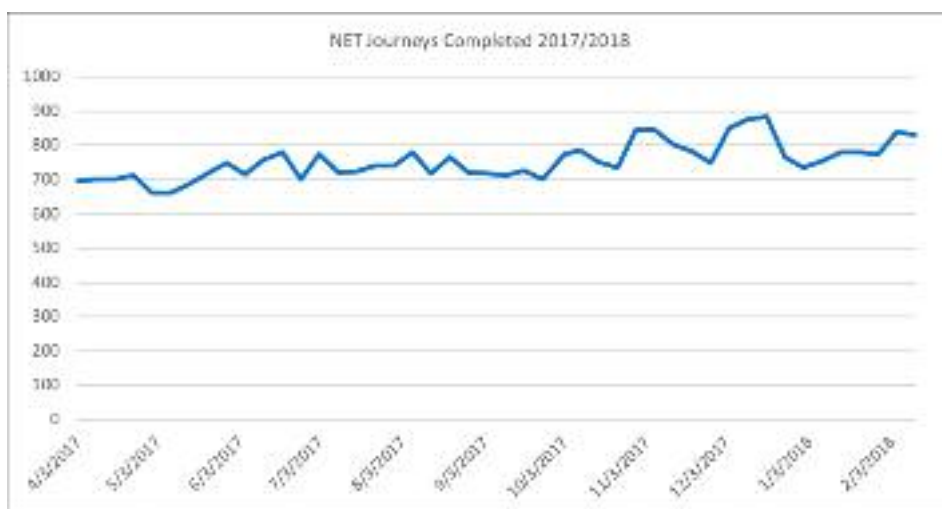


Section 5: Other services

5a : Non-Emergency Transport Services

The **Non-Emergency Transport service (NETs)** which commenced in June 2015 has continued to grow. This service supports our core A&E service in transporting the lowest acuity patients to healthcare facilities where there is little or no clinical intervention required en route. As a result we are able to increase the availability of frontline crews to attend life threatening calls made to the service and ensure lower acuity patients receive transport within an agreed timeframe providing for a better patient experience.

The number of journeys completed by NETs has continued to grow in line with the development of the service with delivery rising from approximately 100 journeys a week at commencement to approximately 800 journeys a week by the end of the financial year. We are implementing plans to reach a target of 900 journeys per week. The increase in delivery of journeys is shown in the following graph:



The NETs pre-plan mental health community assessment journey requests via our e-booking system and use have now been rolled out to all the Mental Health Trusts in London. This project has been highly successful with the majority of this cohort of mental health service users now seeing transport arriving at the commencement of their assessment or within 30 minutes. Following on from the Mental Health Transport project the Service has also seen the pre-booking of journeys for end of life care patients where journeys are time critical rolled out and this service is now operating from three hospices. The service is currently engaged in the roll out of this service to all other Hospices operating within the London area.

In line with the growth of NETs, there has been an increase in the

number of NETs operational staff from 90 to 120. The introduction of 13 apprentices last year under the national apprentice scheme have now completed their first year with us and have been employed by the Service with some working on NETs and some have been successful in applications to further progress and are now currently training to become TEACs.

All existing staff (PTS and NETs) have completed Core Skills Refresher training during the year which has included Infection, prevention & control, Safeguarding, Prevent, Sepsis, Dementia, Patient report forms and End of life care. In addition other statutory and

mandatory training was delivered by e-learning.

Both of these services are an important part of our core business and they are fully integrated into our quality governance processes.

5b: South East London 111 - 2017/18

This report has been prepared to review the activity within LAS 111 South East London (SEL) for 2017/18 and has been broken down into nine key areas.

- Care Quality Commission Update
- Workforce Transformation
- Procurement of future services
- Incidents, complaints and feedback
- Call Quality and monitoring
- Safeguarding
- Patient Experience
- Training
- Pilots and Innovation

Care Quality Commission Update

Following CQC recommendations from the inspection in September 2016 (rated "Good" overall) SEL111 has continued to improve substantive staffing, more than halving the percentage WTE vacancy rate since April 2017. A gap analysis has been undertaken and there is an IM+T Project Plan in place to address the remaining



issues. Finally open forums have commenced whereby Staff have an opportunity to meet with the HR Manager and 111 Operations Manager.

Workforce Transformation

By 31st March 2019 all NHS111 services are required to have evolved into an Integrated Urgent Care service, providing a "consult and complete" service, reducing referrals to other areas of the NHS. SEL are undertaking Phase 1 of the work required, having employed an Integrated Urgent Care Workforce Transformation Manager to oversee the process.

Procurement of Future Services

In January 2018, LAS was awarded the NHS 111 Integrated Urgent Care and clinical assessment service in North East London.

Mobilisation of the new service is in progress and LAS are due to commence Service delivery from August 2018. Future Annual Quality Account reports will include NEL Service performance.

Procurement has commenced for the future service for South East London and a bid will be submitted by 13 March 2018 for the service which is currently due to go live in October this year.

Incidents, complaints and feedback

Incident details

Two Serious Incidents were declared this year, both related to clinical advice and have been investigated, with all actions completed to ensure mitigation of future incidents. Incidents reported relate to a range of issues at LAS 111. A key trend identified over the last year has been errors in the referral of patients into an Out Of Hours

Type	Mar 18	Feb18	Jan 18	Dec 17	Nov 17	Oct17	Sep17	Aug17	July 17	Jun17	May 17	Apr 17
Serious incidents			0	0	0	0	0	0	0	0	1	1
Incidents			120	184	112	150	133	180	88	80	87	82
Complaints (formal)			8	19	3	5	7	7	5	4	2	8
HCP feedback			2	3	2	2	4	0	3	2	2	5
Compliments			4	6	1	1	3	2	3	2	0	6
Authorised confidentiality breaches			18	11	8	8	15	12	11	7	18	18
Wrong OOHs GP referrals			39	68	39	39	39	32	36	32	25	18

(OOHs) service. The process for reporting and feeding back these incidents has changed and an action plan put in place to decrease the amount of incorrect referrals.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the LAS crews and the GP Out of Hours (OOH) providers. The majority relate to the perceived inappropriateness of the referral and whilst several have been upheld, some are due to a lack of understanding of the 111 system. Considerable effort has been put into improving understanding and communication channels between the 111 and 999 services; and also improving understanding between the 111 service and OOHs services, e.g. including them in End to End reviews and engaging in workshops to promote collaboration between services.

Feedback to Health Care Professionals

12 feedback forms have been sent to other providers of care. Staff are encouraged to raise issues where the actions of other healthcare providers have resulted in a delay in patient care, or where a procedure appears to be unsafe or inappropriate. The most common issues are with regard to communication issues and handover of patients between services such as

GP OOH Providers failures to accept patient referrals due to patient location, or disputes causing delay to patient care.

Authorised confidentiality breaches

Authorised confidentiality breaches are logged when a patient has been referred to a service without their consent and/or knowledge. The breaches are used for patients where it is deemed not safe to leave them without further assistance or in the case of safeguarding, not safe to notify them i.e. domestic abuse where the assailant is still on the premises. The breaches are authorised at the time of the incident by a senior clinician within the call centre.

Compliments

Twenty-eight (28) compliments have been received relating to both the service and individuals undertaking patient contact duties. Recognition for staff has increased, as compliments continue to be published in the Trust's weekly bulletin in addition to being displayed on site noticeboards.

Call quality and monitoring

We have continued to exceed the required standard for 1% of call audits every month including the winter months where demands on the service increased. Each staff member has a minimum of 3 calls audited each month. Where

performance issues are identified the level of audit is increased. Since October 2017 compliance percentage (target 86%) has not been achieved. An action plan is in place to improve compliance with a focus on key themes identified during audits.

End to End call audits

Monthly end to end call reviews are undertaken at LAS111. This year a total of 50 calls were audited by the senior management team, including the Trust's Assistant Medical Director and South East London Clinical Lead. The audits are attended by healthcare professionals from the areas of focus which ensures their input and to improve partnership working, communication and practice. The end to end audits have all highlighted areas of good practice but also areas that require some improvement and action plans have been put in place to address concerns.

Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 415 people in total to Social Services which equates to circa 0.15% of all calls taken. Referrals for adults were predominantly for welfare concerns and for children for safeguarding issues.

Call Audit Data	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
Calls answered at 111			34,941	35,721	22,361	22,346	25,361	20,242	28,321	26,015	28,656	28,381
% Call audits (target >1%)			1.2%	1.1%	1.7%	1.6%	1.4%	1.5%	1.2%	1.5%	1.4%	1.4%
No. Call audits			423	376	378	427	356	308	341	379	406	398
No. Call Handler audits			246	218	224	254	210	191	177	211	225	223
No. Clinical Advisor audits			177	158	154	173	146	117	164	168	181	175
% Compliance (target >86%)			80%	85%	83%	84%	88%	90%	89%	90%	88%	88%

As a large proportion of referrals stem from information provided in a patient's Special Patient Notes (SPN), a deep dive into the timeliness and validity of these SPNs is underway. Early data has been presented at the South East London Clinical Governance meeting. It suggests more can be done by external agencies to increase the reliability of this information.

Patient Experience

The 111 patient surveys are sent each month to around 300 patients, an increase from 250. The average response has increased from last year to 38 a month (from 29 a month). Work is ongoing to examine new ways to enable patient feedback, including the possible use of email or text messaging. This includes engagement with the SE London patient representative to design a survey which will encourage a higher response level.

Language line

Spanish continues to be the most requested language, followed by Arabic and Portuguese. The average calls per month has increased from 106 in 2016/17 to 137 in 2017/18.

Training

All staff have undertaken mandatory training relating to changes made to the 111 call management system "Pathways" with two version updates (13 and 14) being completed, the latter in November 2017. Following the response to a Serious Incident, a TOXBASE calculation and overdose management training refresher was introduced to all clinicians. A pilot demonstrating the success of critical thinking and probing skills work shop led to the mandatory introduction of this training. This training is in addition to the full compliance to statutory and mandatory training as required by the London Ambulance Service NHS Trust. Agency staff are given all mandatory training including

safeguarding and also offered places on all workshops that are appropriate.

Pilots and Innovation

- LAS 111 has been actively involved in a number of pilots throughout the year including
- Direct booking patients under 5 years old into OOHs appointments
- Direct bookings in to GP hubs across additional boroughs
- Implementation of *567 access lines into BAU
- Expanding direct referral pathway for patients presenting with Mental Health difficulties to cover all 6 boroughs.
- Introduction of 111 online for SEL
- Enhanced clinical assessment for ED dispositions
- Working groups to introduce the ability to access additional patient records to inform clinical decision making and allow staff access to electronic prescription tracker.



Section 6: Feedback from our partners and stakeholders

We are obligated to give stakeholders the opportunity to comment on our Quality Account and to then publish their comments in full. This year we invited the following organisations/groups to respond.

- The London Ambulance Service Commissioners
- Hillingdon Oversight & Scrutiny Committee
- The London Ambulance Service Patients' Forum

We would like to thank those organisations/groups for taking the time to read and respond. Their comments are published in this section. To be inserted once received

APPENDIX 1: Clinical Audit : Learning outcomes

Below are the actions taken following audits during 2017-18:

- Continued clinical education provided to staff through face-to-face training and publication of updates in bulletins and newsletters
- Release of infographics promoting the key monthly findings
- Feedback regarding inappropriate triage decisions and extended times provided to clinical staff by Quality, Governance and Assurance Managers
- Continued use of the “Clinical Information and Support Overview” tool to facilitate discussions with clinicians and Clinical Team Leaders regarding clinical audit findings, illness coding and time spent on scene

The reports of **10 local clinical audits** were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided against each as detailed below.

Documentation of EZ-IO® Intra-osseous System use

- Distribute an infographic reporting improvements made and reiterating the importance of documenting needle size and a named anatomical site and side when gaining intra-osseous (IO) access
- Publish an article in the Trust-wide clinical newsletter to share key findings and actions
- Create a prompt card documentation reminder to be inserted in EZ-IO kit bags
- Amend the Patient Report Form (PRF) User Guide to specify that IO needle size should be documented in millimetres
- Share report with the LAS Clinical Education and Standards Department

Assessment and transport decisions of patients with major head injuries

- Define the illness codes for major and minor head injuries in the PRF User Guide
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Make the ‘Management of Minor Head Injuries’ assessment tool more available for all clinicians
- Share report with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guideline Developers and Contributors and seek further clarity regarding the assessment and management of head injuries

- Re-audit whether there has been an improvement in the recognition and management of clinically significant head injuries

Patients who severely deteriorated or died unexpectedly within 24 hours of being discharged at scene

- Declare seven serious incidents identified by this continuous audit
- Flag one case to another organisation for them to declare as a serious incident
- Provide constructive and positive feedback to individual crews, where necessary
- Share the findings of this audit with NHS England and suggest the Ambulance Quality Indicator re-contact data guidance is amended to exclude public places
- Continue with the Continuous Re-Contact Clinical Audit in 2017-2018, with the inclusion of NHS 111 referrals and Hear & Treat assessments
- Write an article for the Trust-wide clinical newsletter focussing on the importance of consistent discharge documentation
- Create a short animation focussing on consistent discharge documentation for the LAS intranet and Facebook group
- Write a case study for the LAS Insight Magazine demonstrating good patient assessment and discharge documentation and evidencing full patient assessment on the PRF
- Continue to monitor the decisions made for 50% of patients not conveyed to hospital and facilitate the provision of individualised feedback to clinicians

Administration of dexamethasone

- Share report with the JRCALC Guideline Developers and Contributors and seek further clarity regarding whether mild croup is an indication for dexamethasone
- Distribute the key findings in a Trust-wide newsletter, together with an infographic displayed in all ambulance stations
- Share the findings with the LAS Business Intelligence Team, specifically the number of times dexamethasone was miscoded in the sample
- Undertake a re-audit to assess whether there has been an improvement in documentation of indication for dexamethasone administration

Administration of ondansetron

- Share key findings and necessary actions with clinicians through the publication of an article in a Trust-wide clinical newsletter and a corresponding infographic to be displayed at all ambulance stations
- Distribute an infographic highlighting how ondansetron and other drugs should be given
- Share report with the LAS Medicines Management Group and Clinical Tutors
- Care provided to the patients with a genuine illness or injury at Exercise Unified Response
- Explore the feasibility of including event call signs in the Clinical Performance Indicator audit programme
- Consider the suitability and training needs of clinicians not normally deployed on frontline duties at events
- At events, share the LAS PRF User Guide with clinicians not normally deployed on frontline duties
- Share report with the LAS Department for Emergency Preparedness, Resilience and Response, the Medical Directorate, Cycle Response Unit and Community First Responders
- Analgesia given to adult patients
- Distribute to all ambulance stations the key findings in an infographic
- Share report with the LAS Medicines Management Group, the Medical Directorate and Clinical Tutors
- Include whether or not adequate analgesia was given in future clinical audits

Care given to patients with a suspected mental health disorder

- Consider continuously auditing the care provided to patients with an undiagnosed psychiatric problem, or carry out a re-audit once all actions have had sufficient time to take effect
- Record a Q&A session with the Service's Mental Nurses outlining the importance of undertaking a thorough patient assessment
- Share findings with clinicians in a Trust-wide clinical newsletter, together with physical conditions which may mimic a mental health condition
- Share key findings in an infographic to be displayed at all ambulance stations
- Promote the LA383 (Adult Mental Health Assessment Form) at Sector Quality Meetings
- Review the wording of the 'psychiatric problem – undiagnosed' illness code

Use of adrenaline (1:1,000) re-audit

- Produce an allergic reactions and asthma tool for the LAS Digital Pocket Guide application
- Create a short video presentation of the stages of allergic reaction and asthma, and when adrenaline (1:1,000) is indicated for publication on the Service's intranet and Facebook page
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review all training materials related to adrenaline (1:1,000)
- Share report with the LAS Medicines Management Group
- Undertake a re-audit once all actions have had sufficient time to take effect to determine whether there has been an improvement in adrenaline (1:1,000) administration

Documentation of mental capacity assessments

- Produce a guidance animation of the key principles of the Mental Capacity Act and what constitutes a thorough mental capacity assessment
- Write a case study for the LAS Insight magazine which promotes positive learning from experience
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review the current LA5 (Capacity tool documentation for the treatment of patients who are unable to consent)
- Update the downloadable LA5 on the LAS intranet and arrange removal of the old LA5s in circulation
- Share report with the LAS clinicians and Mental Health Nurses in the Clinical Hub

In addition, a further **5 local clinical audits** were started by the provider in 2017/18 as detailed below.

Management of paediatric pyrexia re-audit

The LAS 2012 Paediatric Pyrexia Clinical Audit found that patients aged 2-8 years with pyrexia of unascertained origin were often not appropriately re-assessed before a decision was made to discharge them at scene, and the patient's medical history was not always considered. Following training and raising awareness of the guidance and protocols, this re-audit assesses the appropriateness of discharge decisions for paediatric patients with pyrexia.

Decision making surrounding paediatric conveyance

Following national concerns from the Royal College of Paediatrics and Child Health regarding the amount of

infants left at home following ambulance attendance, a baseline clinical audit was undertaken on patients aged under 1 year old who were discharged at scene. As a result, the LAS issued a paediatric conveyance policy stating that: all patients under 2 years should be conveyed to a hospital; patients aged 2-5 years who are not conveyed must be referred to their GP or suitable Health Care Professional (HCP), and patients aged 6-12 years who are not conveyed should be strongly considered for referral to their GP or a suitable HCP. This clinical audit aims to assess whether conveyance decisions for patients aged 0-12 years are in line with this LAS protocol.

Administration of hydrocortisone re-audit

In 2013 the LAS Hydrocortisone Clinical Audit identified an underuse of hydrocortisone in the treatment of acute severe and life-threatening asthma. A number of actions were taken as a result. This re-audit will assess whether the actions implemented following the previous clinical audit have led to increased use of hydrocortisone for patients with acute severe and life-threatening asthma.

Transient loss of consciousness (TLoC) re-audit

The LAS 2013 TLoC Clinical Audit found that whilst some elements of history taking and assessment were well completed; aspects more specific to TLoC required improvement. A voluntary study day was run to highlight the importance of history taking and a prompt card was produced and issued to assist clinicians with the management of TLoC. Despite the initiatives to improve care, in 2016 a review of the National Institute for Health and Care Excellence (NICE) quality standard for TLoC showed improvements were still needed. In addition, in 2016/17, two incidents were reported relating to the care of TLoC patients. This clinical audit aims to determine whether patients presenting with TLoC are being assessed, treated and managed in line with the LAS, NICE and UK Ambulance Service Clinical Practice guidelines.

Management of intentional overdose

This clinical audit aims to address concerns raised by the LAS 2013 Overdose Clinical Audit which found patients triaged as having no life-threatening symptoms often received a response outside of the commissioned target, when some of them required a pre-alert to hospital. In addition, five incidents have been reported on the Trust's incident reporting system where there was a delay responding to a patient who had overdosed, two of which were declared as serious incidents. This clinical audit aims to: assess if patients who have taken an intentional overdose are being triaged appropriately; examine any reasons for longer than average on scene times, and determine if patients who have taken an intentional overdose who

are not conveyed are being appropriately assessed and referred.

The London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to six patient groups (cardiac arrest, difficulty in breathing, glycaemic emergencies, mental health, severe sepsis and patients that were discharged on scene) and quality assures the documentation on 2.5% of all clinical records completed. We also undertake five continuous audits that monitor the care provided to every patient who falls within the following groups: cardiac arrest, STEMI, stroke, major trauma, discharged at scene but re-contacted the Service within 24 hours having severely deteriorated or died unexpectedly.

The Trust also submit data to the National Out-of-Hospital Cardiac Arrest Outcomes project, a registry of out of hospital cardiac arrests in England. This registry is being used to look at the national variations in outcomes of cardiac arrest and provide evidence to help inform treatment and improve survival amongst this patient group. During 2017/18 we provided 4,432 cases to the registry.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and contributing to wider healthcare improvement. Clinical research ensures our clinical staff keep up to date with the latest possible treatment options and their active participation leads to improved patient outcomes. The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service NHS Trust in the first 3 quarters of 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 683. These patients were recruited into a range of interventional and observational studies. These studies were:

ARREST: A randomised controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest

RIGHT-2: A randomised trial that aims is to determine whether glyceryl trinitrate (GTN) improves outcome in patients with ultra-acute stroke when administered as soon as possible after onset.

In 2017/18 145 members of clinical staff received protocol training to enable them to participate in interventional and observational research at the London Ambulance Service NHS Trust.

APPENDIX 2: CQUINS 2017-18 and 2018-19 : UPDATE

Goal No.	Goal Name	Description of goal	Expected financial value of goal (£)
1A	National: Introduction of Health and Wellbeing Initiatives – Improving Staff Health and Wellbeing	Percentage point improvements to staff survey results on 3 questions against a 2015/16 baseline.	£260,562.00
1B	National: Introduction of Health and Wellbeing Initiatives – Healthy food for NHS staff, visitors and patients	Continuing improvements to healthy food provision delivered in 16/17 and extending requirements for 17/18, 18/19.	£260,562.00
1C	National: Introduction of Health and Wellbeing Initiatives – Improving the uptake of flu vaccinations for front line staff within Providers.	Achieving an uptake of flu vaccinations by frontline clinical staff of 70% for 2017/18	£263,701.00
12	National: Ambulance Conveyance	A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department.	£784,825.00
STP1	National: Supporting Local Areas	Support engagement with local STP initiatives	£1,569,650.00
STP2	National: STF Control Total	Delivery of financial controls – Risk Reserve	£1,569,650.00
L1	Local: Implementing the Digitalisation Enablers	Providing the frontline, clinical staff at London Ambulance with personal issue mobile devices.	£3,139,299.00

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019



NHS
London Ambulance Service
NHS Trust





Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Quality Improvement Plan 2017/18			
Agenda item:	17			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	QIP Programme Board			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
The purpose of this document is to provide an update on the current actions in Quality Improvement Plan (QIP) and Care Quality Commission (CQC) Preparation Plan for the next Well-Led CQC inspection.				
Recommendation(s):				
The Board is asked to review and comment. The QIP plan includes CQC must Do/Should Do actions.				
Links to Board Assurance Framework (BAF) and key risks:				
Links to BAF risk in relation to the Trusts special measures status.				

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

Quality Improvement Plan Update

Summary of Progress

1. CQC completed a Core Service Inspection over the period Monday 5th March – Thursday 8th March, inspecting 19 Ambulance Stations as well as completing a number of Ambulance ride-out, they also inspected the EOC and carried out a number of interviews of key specialist staff.
2. During the inspection, they also submitted c70 new data requests with the Trust supplying responses and over 90 documents.
3. Preparation and readiness activities have continued for the CQC Well-Inspection.
4. Various communications activities have continued with products including the staff handbook issued.
5. An information hub has been established to support and manage the CQC inspection activities during the inspection period.
6. The staff survey results have been published indicating the Trust continues to make progress in a number of areas confirming that the actions from the QIP plan are having a positive impact.

CQC Inspection Date

7. CQC completed a Core Service Inspection over the period Monday 5th March – Thursday 8th March. They inspected 19 Ambulance Stations many of which were also Vehicle Preparation hubs, as well as completing a number of Ambulance ride-outs and interviewing crews at various Hospital Emergency Departments. In addition, they also spent time observing and interviewing staff at each of the two EOCs sites and carried out a number of interviews of key specialist staff.
8. During this period, they also submitted c70 new data requests with the Trust supplying responses and over 90 documents.
9. No major issues were identified during the inspection that required immediate rectification.
10. CQC have confirmed that they will carry out a provider level inspection of 'Well-led' on 21-22 March 2018, this will take place at Waterloo HQ, when c25 interviews will take place including the ELT and some of the Non-Executive Directors.

CQC RPIR additional Information Request

11. No further requests for information following the RPIR have been made apart from those identified during the Core Service Inspection.

CQC Preparation and Readiness

12. Preparation for the Well-led Inspection has continued with, readiness sessions held with the ELT ensuring that they are well prepared and able to describe the Trust's journey and achievements since the last inspection (February 2017) as well be able to outline the activities over the next 12 months.
13. A number of supporting documents have been prepared and issued including Directorate Portfolios which outline the key activities for each Directorate on a single page, as well as a storyboard which details the Trust's journey over the year.

14. Communication materials have been developed and issued including a Staff Handbook, Senior Managers, Directors and Non-Executive Directors Handbook and an Inspectors Handbook. These handbooks include information of what to expect from and how to prepare for the Inspection as well as outlining key achievements from the last 12 months.
15. An information hub has been established to manage all inspection activities for both announced and unannounced visits ensuring that the Trust can react and rectify any issues that may be identified as well as collecting information to inform the ELT. This was successfully used during the Core Service inspection tracking Inspection activities and providing a point for information collection and reporting.
16. During week commencing 26th February a small number of station visits were completed by the LAS CQC support and preparation team. No major problems were found with the majority of the stations being compliant.

Quality Assurance Visits

17. The purpose of the quality assurance review was to measure each of our stations against the Key Lines of Enquiry (KLOEs) (focusing on Well-led) as part of the re-introduction of ongoing quarterly visits. All the stations have now been visited including both EOCs, NHS111 and the Logistics Centre.
18. The Quality Assurance visits will now continue as business as usual checks, with all stations/locations being visited on a quarterly basis.

Communications

19. Comprehensive staff communications have been developed, recognising, celebrating, and sharing achievements over the last 12 months in an engaging manner that enables all staff to feel valued and part of the bigger picture. Key documents developed and now issued include:
 - Staff Handbook
 - Board and Senior Managers Handbook
 - CQC Inspector Handbook
 - Building a 'Well-led' organisation card
 - Posters detailing the Board members and other key senior leaders



Quality Improvement Plan (2017-18)

20. The Quality Improvement Plan is the consolidated actions from the original CQC Plan and Well-led gap analysis which is aligned to the Business Plan objectives.

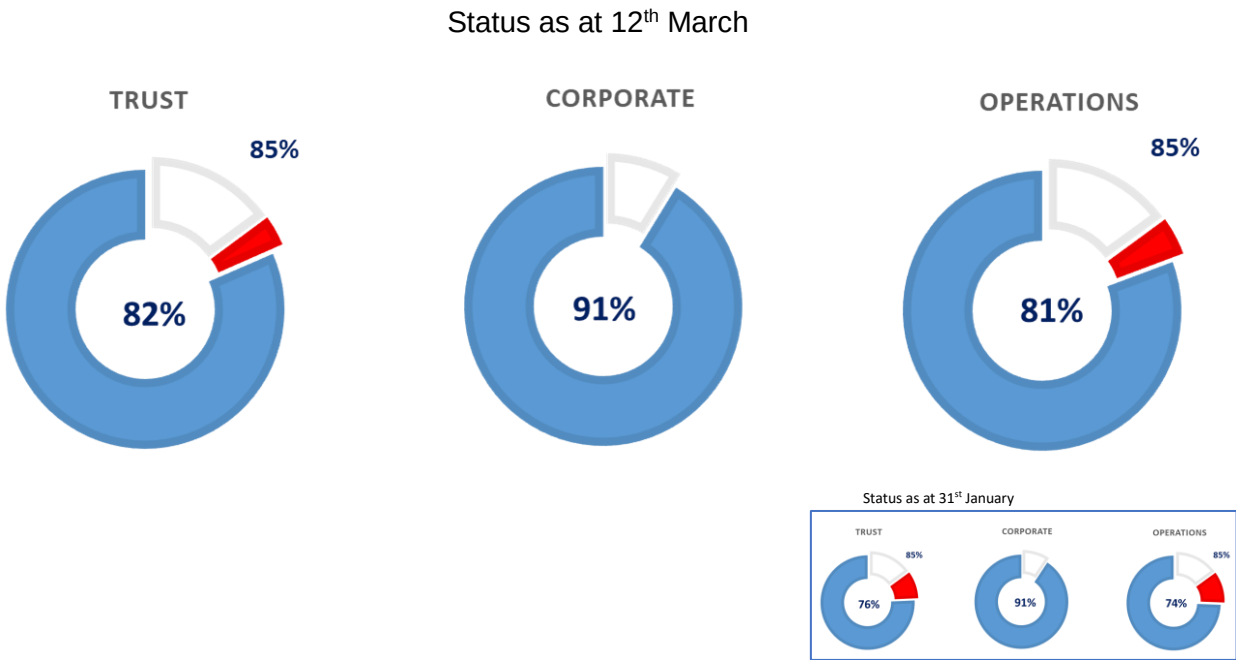
21. An agile approach was used to manage these 135 actions over a 6-week period with all of the actions either being completed or with an approved plan to achieve closure. Evidence of completion was collected from each of the action owners which was verified prior to the action being closed. Two of the actions are ongoing and being managed as part of Business as usual whilst continuing to be monitored as part of the QIP deliverables:
- Statutory and Mandatory Training (see below)
 - Management of Bank Staff

LAS Countdown Plan

22. A LAS Countdown plan identifying all the activities that need to be completed prior, during and after the CQC inspections has been developed and is tracking to plan. Activities in the plan have continued to ensure the Trust is ready for the Inspection and have been updated following confirmation of the Inspection dates.

Statutory and Mandatory Training: Action Plan status on Requirements Notice

23. Improvement in the Statutory and Mandatory Training position has continued with Trust compliance now 82% as at the 12th March against the target of 85% by end of Mar-18.
24. Corporate compliance is 91% against a target of >90% compliance by end of Nov-17 and Operations compliance is 81% as at the 12th March targeting to achieve 85% by end of March following staff completing their CSR3 training.



24. A new Bank contract has been finalised. A review of bank workers and their training has been undertaken. 167 Bank Workers have not completed a CSR course in the last rolling year and from November these bank workers were moved into a ‘do not use’ status.
25. This left the Trust with 171 on the register until others either complete one of the current CSR courses and evidence on-going training from another Trust or complete both CSR courses if they have no evidence of on-going training from another Trust.

Progress against CQC /Should Dos (aligned to Business Plan objectives)

26. The latest Impact KPIs against the various domains have been updated and are presented in the Appendix.

27. All of the actions are now complete or have an approved plan to complete.

Staff are Valued, Respected, and Engaged (Should Do)

28. Focus on Statutory and Mandatory training has continued to ensure that staff complete all required training. (see previous section for more information)
29. New rest break arrangements were introduced in December and are under ongoing review. Formal Project Group has been established to look at the 'protected end of shift' arrangements and modelling being undertaken. A pilot will be run in South London, targeted for April, following a clinical impact assessment. Further work will continue with the unions to re-review the policy and align it to the end of shift times. New rosters are being developed to deliver the new operating model in 18/19 along with a review of skill mix.
30. Following the introduction of ARP, the Trust is currently scoping a review of operational rota patterns to deliver the new operating model collaboratively with frontline staff and trade unions. Improvement in the number of crews that are now able to take a rest break continues to increase.
31. A full report on rest breaks and rostering is being presented with the latest status and progress at the March Board and ROG
32. Staff experiencing harassment, bullying or abuse by other staff down from 39% in 2016 to 32% in 2017. Bullying and Harassment award for 'courageous conversations'. The results from the Staff survey showed that 77% of staff have not experienced bullying or harassment from their manager and 82% from a colleague both an improvement on previous years. Whilst percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has decreased 6% for white staff to 32% and 8% for BME staff to 32%.

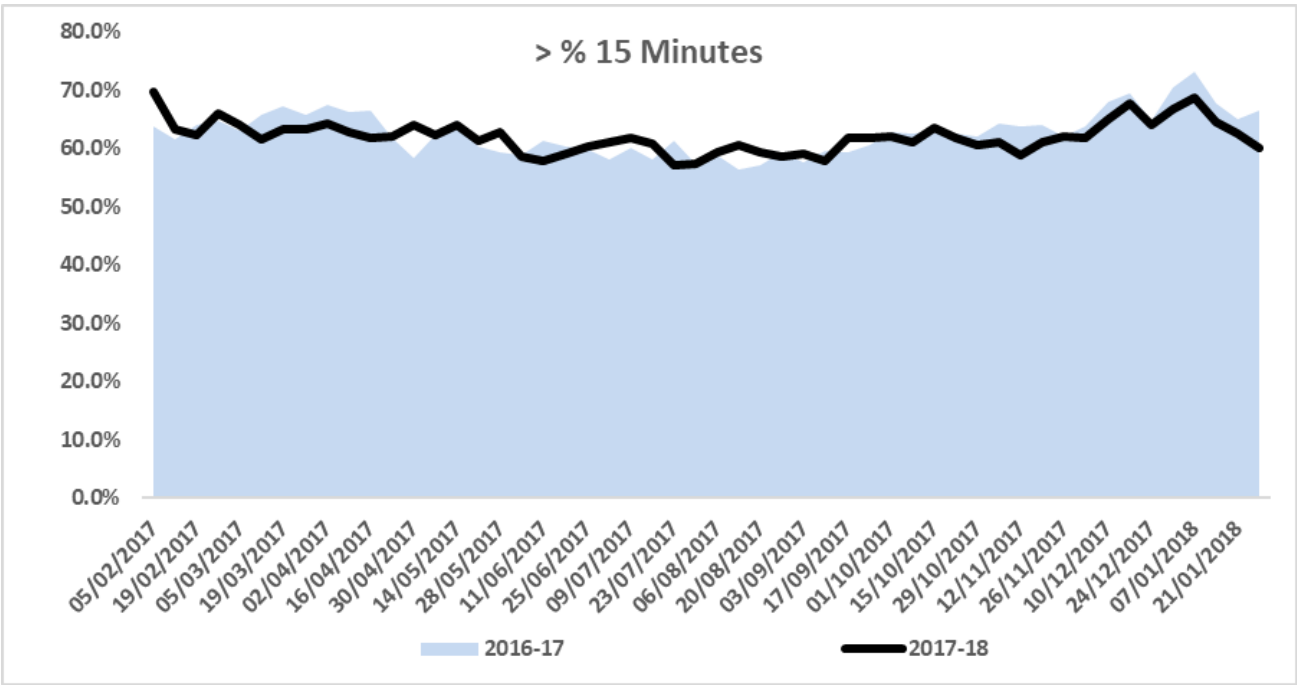
Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	27 (27)
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	0 (0)
Deliverable is at risk of missing due date, but deemed recoverable	0 (0)
Deliverable is on target to meet due date	1 (1)
Assurance Status (Evidence from Burndown w/c 4 th December)	27

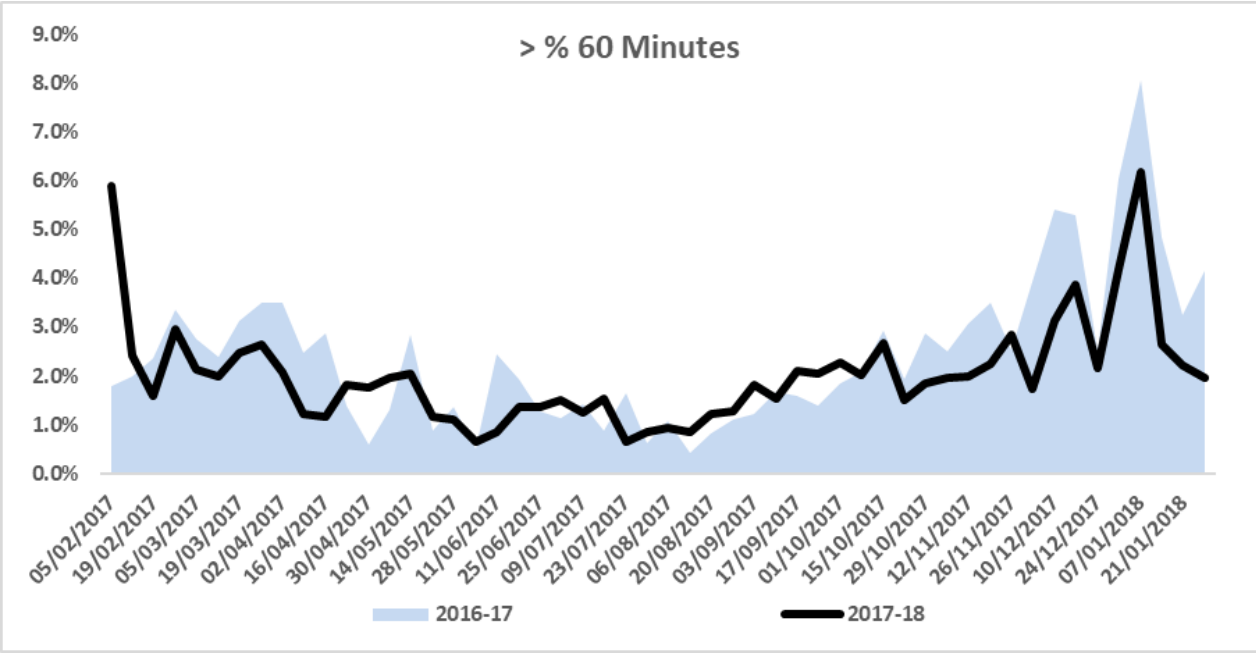
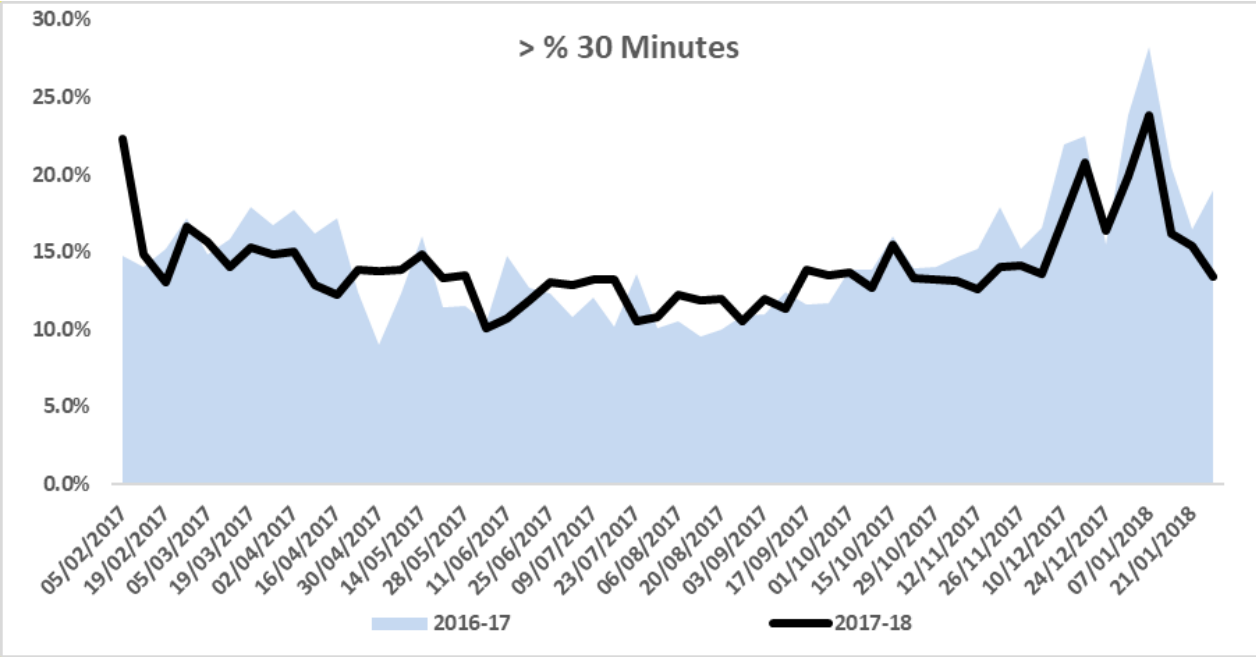
Patients Receive Safe, Timely and Effective Care (Should Do)

33. A new governance framework sets out clearer terms of reference work programmes and standard reporting processes for assurance to Board. There has been more robust separation of operational groups from assurance oversight. Below Board, the trust has significantly strengthened the performance management approach for clinical and corporate services, with progress monitored monthly against a dashboard. The trust has a rich set of individual quality data to assess individual clinical staff during 'CISO' reviews.
34. To complement reporting, the trust has reinstated a programme of quality assurance visits to services to test whether what is reported matches what is observed or heard. These visits

involve staff external to the trust and LAS senior leadership team. An expanded programme of deep dives around key areas as concern has been commissioned.

- 35. Development of the Datix system continues with a quality assurance forum implemented. The quality Assurance visits are now part of business as usual and implementation of Health Assure is scheduled for completion in early 2018.
- 36. Data is presented in the monthly Quality Report where the proportion of Low/No-Harm/ Moderate and Severe incidents is monitored to ensure adequate levels of reporting are achieved.
- 37. Staff survey showed significant improvement in confidence of staff happy to report incidents and near misses.
- 38. The roll-out of hand held devices, continues on track and is targeted to be completed by the end of March. The review of sites to agree solutions to ensure safe storage of drugs continues as part of the second phase of the medicines management programme.
- 39. LAS managers continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays. As the following tables highlight hospital performance in 2017/18 when measured by handovers over the 15, 30 and 60 min target and total time lost has improved against the same period in 2016/17.





Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	20 (16)
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	0 (1)
Deliverable is at risk of missing due date, but deemed recoverable	0 (0)
Deliverable is on target to meet due date	0 (3)
Assurance Status (Evidence from Burndown w/c 4 th December)	20

Efficiency and Sustainability Will Drive Us (Should Do)

40. The Trust has continued to perform reasonably well against the new Ambulance Response Programme (ARP) standards, despite continued winter pressures across the healthcare system in London, high volumes of influenza and norovirus, and sustained periods of low temperatures and adverse weather. There remain challenges with routinely achieving the standards for Category 1, Category 2 and Category 3 and we are working hard with the limited data we have since go live to understand the nuances of this new system.
41. Following the introduction of the ARP in November 2017, the Trust has been undertaking a preliminary review of its initial observations since 'go live' based on two months' worth of full operating data.
42. The initial observations made as part of this preliminary review process have been submitted by the Trust as part of a national feedback exercise for the national ARP Spring Review which took place in London on 20 February. It is expected that the recommendations from this national review will be published by late April 2018.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	5 (0)
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	0 (0)
Deliverable is at risk of missing due date, but deemed recoverable	0 (2)
Deliverable is on target to meet due date	1(4)
Assurance Status (Evidence from Burndown w/c 4 th December)	5

Progress against Well-led domain (Should dos)

43. ELT now substantive, with the Executive development programme ongoing with regular activities scheduled.
44. A review of Clinical Governance committees has been completed by the Chief Quality Officer. The number of quality groups have been reduced from 70 to 20 with new ToR, agendas, membership and key issues reports from sub groups disseminated up to Board via Quality Oversight Group.
45. The Director of Corporate Governance has reviewed and introduced a standardised format for all corporate meetings.
46. Behaviour work is part of the People and Culture Strategy approved by the Board in November 2017. Implementation is underway and being tracked. Through the P&OD subcommittee and implementation plan.
47. LAS has continued the development of a new five-year strategy through extensive research and engagement with patients, staff and stakeholders. The outline strategy was presented to the Board in October and the Strategic Intent Document issued. A stakeholder mapping exercise has been undertaken with all key stakeholders who are engaged with the strategy

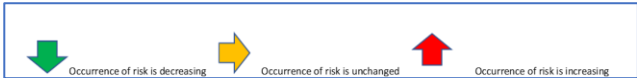
with all relevant meetings attended by appropriate level of representation from LAS. The final Strategy is due to be presented to Trust Board in March.

Description	Deliverable Status (Number in brackets is previous month)
Deliverable is complete	50 (27)
Whilst there are number of deliverable that will not be completed by the original due date or have missed the original due date, these have been rescheduled and are now due to complete by end December 2017.	0 (11)
Deliverable is at risk of missing due date, but deemed recoverable	0 (0)
Deliverable is on target to meet due date	3 (9)
Deliverable date to be confirmed	0 (6)
Assurance Status (Evidence from Burndown w/c 4 th December)	50

Risks and Issues

48. The risks from last month have been updated.

Programme	Risk/Issue	Comment	Status of Risk
All	CQC Interviewees may not present a joined up/ understanding of areas outside of their immediate directorate	QIP Project team will develop materials and arrange joint sessions to ensure all well informed and have supporting materials	
All	ELT have very busy schedules and may not have sufficient time to properly prepare for CQC inspections	Required to clear their diaries prioritise CQC preparation and delegate authority, meetings and actions to their teams as far as is possible	



Dr Patricia Bain
Chief Quality Officer

Appendix: Impact KPI's Scorecard (Must Do/Should Do and Well-Led

Jan-18 Impact KPI's Scorecard - sorted by RAG / Monthly Trend

Domain	Measure	RAG	Trend
Patient Safety	Infection, Prevention & Control: Monthly Premises Cleaning	●	▼
	Controlled Drugs: Non LIN reportable incidents	●	▲
Operational Performance	Avg. Hospital arrived to Patient Handover (mins)	●	▲
	Avg. Patient Handover to Green (mins)	●	◄►
Staff Wellbeing	Sickness/Absence - All Staff	●	◄►
	Sickness/Absence - Long-term	●	▼
	Sickness/Absence - Frontline Staff	●	▼
Patient Safety	Infection, Prevention & Control: Hand Hygiene compliance	●	▲
Operational Performance	Job Cycle Time (mins)	●	▼
Patient Safety	Incident Reporting - No Harm (Reported incidents to NRLS - 12 month rolling)	●	▲
	Incident Reporting - Low Harm (Reported incidents to NRLS - 12 month rolling)	●	▼
	No Harm / Low Harm % of Incidents (Reported incidents to NRLS - 12 month rolling)	●	◄►
Staff Wellbeing	Statutory & Mandatory Training: Trust compliance	●	▲
	Statutory & Mandatory Training: Operations	●	▲
Patient Safety	Missing equipment incidents as % of all reported incidents	●	▼
	Failure of device/equipment/vehicle as % of all missing incidents	●	▼
Operational Performance	BME% Starters	●	▼
	BME% Leavers	●	▲
Patient Safety	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean	●	▼
Staff Wellbeing	Statutory & Mandatory Training: Corporate	●	▲
	Sickness/Absence - Short-term	●	◄►
	Bullying & Harrasment cases resolved within 28 days	●	◄►
Patient Safety	Serious Incidents breaching 60 days	●	◄►
	Controlled Drugs: LIN reportable	●	◄►
Operational Performance	Rest Breaks - DCA		▼
	Ambulance Response Programme: Cat 1		▼
	Ambulance Response Programme: Cat 2		▼
	Ambulance Response Programme: Cat 3		▼
	Ambulance Response Programme: Cat 4		▼
	Rest Breaks - FRU		▲

Legend					
●	Target is not being met. Position has deteriorated since last month.	●	Target is not being met / No Target Set Position improved / static since last month.	●	Target is being met.
Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement					Fast forward. Trend not available

Operational Performance	STAFF ARE VALUED, RESPECTED & ENGAGED
Patient Safety	PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE
Operational Performance	EFFICIENCY & SUSTAINABILITY WILL DRIVE US
Operational Performance	WELL LED

Domain	Measure	Baseline		Benchmark	Target	Actual / Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	RAG	Trend	Feb-18	Mar-18
		2015/16	2016/17																	
STAFF ARE VALUED, RESPECTED & ENGAGED	Statutory & Mandatory Training: Trust compliance				85%	Actual	67%	67%	66%	65%	66%	66%	70%	74%	75%	76%	●	▲	85%	87%
	Statutory & Mandatory Training: Corporate				90%	Actual	58%	57%	58%	59%	66%	65%	67%	69%	75%	80%	●	▲		
	Statutory & Mandatory Training: Operations				85%	Actual	68%	68%	67%	66%	66%	66%	70%	73%	73%	74%	●	▲		
	Statutory & Mandatory Training: Bank				100%	Actual						tbc	tbc	tbc	tbc	tbc		▶▶		
	Sickness/Absence - All Staff			4.3%	5.0%	Actual	4.6%	5.0%	5.0%	5.4%	5.2%	5.1%	5.2%	5.4%	5.2%	5.2%	●	▶		
	Sickness/Absence - Long-term		3.3%		3.0%	Actual	3.4%	3.4%	3.4%	3.3%	3.4%	3.4%	3.5%	3.4%	3.5%	3.4%	●	▶		
	Sickness/Absence - Short-term		1.8%		2.0%	Actual	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%	2.0%	1.8%	1.8%	●	▶		
	Sickness/Absence - Frontline Staff	5.6%			5.0%	Actual	5.1%	5.5%	5.5%	5.5%	5.6%	5.6%	5.5%	5.9%	5.7%	5.4%	●	▶		
	KF17 % feeling unwell due to work related stress in last 12 mths	54%	50%	48%	Improve	Actual										53%	●	▲		
	KF19. Organisation & management interest in & action on health & wellbeing (Q7f, 9a)	2.84	3.21	3.27	Improve	Actual										3.16	●	▲		
	Q9a Organisation definitely takes positive action on health and well-being	11%	18%	21%	Improve	Actual										14%	●	▲		
	Q7f Immediate manager takes a positive interest in my health & well-being	43%	60%	58%	Improve	Actual										59%	●	▲		
	BME% of workforce		13%	BME% of London Population 45%		Actual												▶▶		
	BME% Starters		22%	-	24%	Actual	11%	19%	22%	17%	23%	18%	20%	12%	26%	25%	●	▲		
	BME% Leavers		16%	-	14%	Actual	29%	14%	26%	14%	11%	22%	9%	11%	14%	16%	●	▲		
	BME Conversion rate shortlisting to appointment					Actual	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc		▶▶		
	Staff Survey: BME response rate		12%	14%	13%	Actual										10%	●	▲		
	KF20 % Experiencing discrimination at work in last 12 months (Q17a-b)	30%	26%	19%	26%	Actual										28%	●	▲		
	Q17a % Experienced discrimination from patients/service users, their relatives or other members of the public	21%	20%	11%		Actual										22%	●	▲		
	Q17b % Experienced discrimination from manager/team leader or other colleagues	15%	10%	11%		Actual										12%	●	▲		
	KF21. % believing the org provides equal opportunities for career progression/promotion	60%	73%	71%	73%	Actual										59%	●	▲		
PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE	Bullying & Harassment cases resolved within 28 days					Actual	100%	80%	-	-	50%	-	-	-	-	-	●	▶		
	KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	38%	33%	28%	27%	Actual										32%	●	▶		
	Q15b Not experienced harassment, bullying or abuse from managers	69%	76%	83%	Improve	Actual										77%	●	▶		
	Q15c Not experienced harassment, bullying or abuse from other colleagues	81%	81%	82%	Improve	Actual										82%	●	▶		
	Serious Incidents breaching 60 days			0		Actual	7	9	5	0	1	0	0	2	0	0	●	▶		
	Incident Reporting - No Harm (Reported incidents to NRLS - 12 month rolling)			1200		Actual						1,201	1,290	1,425	1,588	1,692	●	▶		
	Incident Reporting - Low Harm (Reported incidents to NRLS - 12 month rolling)			500		Actual						395	428	314	302	293	●	▶		
	No Harm / Low Harm % of Incidents (Reported incidents to NRLS - 12 month rolling)			90%		Actual							82%	84%	86%	86%	●	▶		
	Q13a % saying if they were concerned about unsafe clinical practice they would know how to report it	86%	90%	94%	Improve	Actual										94%	●	▶		
	Q13b "I would feel secure raising concerns about unsafe clinical practice"	50%	59%	62%	Improve	Actual										63%	●	▶		
	Q13c "I am confident that the organisation would address my concern"	34%	49%	50%	Improve	Actual										49%	●	▶		
	Infection, Prevention & Control: Hand Hygiene compliance				90%	Actual	70%	85%	76%	87%	90%	93%	91%	98%	60%	85%	●	▶		
	Infection, Prevention & Control: 6 weekly Vehicle Deep Clean				90%	Actual	97%	97%	95%	94%	97%	96%	93%	95%	95%	93%	●	▶		
	Infection, Prevention & Control: Monthly Premises Cleaning				90%	Actual	96%	96%	97%	98%	79%	92%	98%	88%	88%	78%	●	▶		
	Controlled Drugs: Non LIN reportable incidents			<15		Actual	16	24	38	31	35	23	33	34	31	46	●	▶		
	Controlled Drugs: LIN reportable			0		Actual	0	0	0	0	0	0	1	1	0	0	●	▶		
	Missing equipment incidents as % of all reported incidents					Actual	3%	3%	3%	2%	2%	3%	4%	3%	4%	2%	●	▶		
	Failure of device/equipment/vehicle as % of all missing incidents					Actual	10%	12%	16%	9%	9%	8%	11%	8%	9%	1%	●	▶		
	Q4f "I have adequate materials, supplies and equipment to do my work"	32%	40%	52%	Improve	Actual										43%	●	▶		
EFFICIENCY & SUSTAINABILITY WILL DRIVE US	Ambulance Response Programme: Cat 1	7 mins (mean) (15 mins 90 th centile response time)				Actual								00:07:03	00:07:24	00:07:09		▶		
	Ambulance Response Programme: Cat 2	18 mins (mean) (40 mins 90 th centile response time)				Actual								00:18:25	00:24:07	00:20:22		▶		
	Ambulance Response Programme: Cat 3	120 mins 90 th centile response time				Actual								133 mins	178 mins	145 mins		▶		
	Ambulance Response Programme: Cat 4	180 mins 90 th centile response time				Actual								149 mins	172 mins	139 mins		▶		
	Rest Breaks - DCA					Actual								4.40%	1.30%	1.80%		▶		
	Rest Breaks - FRU					Actual								83.50%	68.70%	74.30%		▶		
	Job Cycle Time (mins)	88			78	Actual	82	82	81	81	80	81	82	89	90	88		▶		
	Avg. Hospital arrived to Patient Handover (mins)		19		15	Actual	20	20	19	19	19	20	20	20	21	22	●	▲		
	% Arrive at Hospital To Patient Handover Over 15 Mins					Actual	60%	60%	57%	57%	57%	58%	59%	58%	62%	62%		▶		
	Arrive at Hospital to Patient Handover - Total Hours Lost > 15 Mins					Actual	5018	5422	4638	4757	4751	5172	5794	5752	7269	7787		▶		
	Avg. Patient Handover to Green (mins)		17		14	Actual	18	18	18	18	18	18	18	18	18	18	●	▶		
	% Patient Handover To Green Over 14 Mins					Actual	58%	57%	57%	57%	57%	57%	57%	57%	57%	58%		▶		
	Patient Handover to Green - Total Hours Lost > 14 Mins					Actual	4878	4965	4851	4906	4805	4735	5061	5139	5476	5685		▶		
WELL LED	Exec / Non exec visits				Improve	Actual	27	14	27	14	13	19	78					▶▶		
	Q8a "I know who the senior managers are here"	65%	72%	73%	Improve	Actual										68%	●	▶		
	Q5b "The support I get from my immediate manager"	49%	63%	57%	Improve	Actual										63%	●	▶		
	Staff survey response rate	35%	42%	41%	Improve	Actual										54%	●	▶		
	Overall Staff Engagement (the higher the score the better)	3.13	3.40	3.41	Improve	Actual										3.36	●	▶		
	KF4. Staff motivation at work (the higher the score the better) (Q2a-c)	3.33	3.52	3.65	Improve	Actual										3.58	●	▶		
	Q2a Often/always look forward to going to work	40%	48%	53%	Improve	Actual										51%	●	▶		
	Q2b Often/always enthusiastic about my job	55%	63%	69%	Improve	Actual										66%	●	▶		
	Q2c Time often/always passes quickly when I am working	44%	50%	57%	Improve	Actual										52%	●	▶		
	KF7. Staff ability to contribute towards improvements at work % (Q4a-b, 4d)	37%	46%	45%	Improve	Actual										43%	●	▶		
	Q4a "There are frequent opportunities for me to show initiative in my role"	52%	58%	62%	Improve	Actual										57%	●	▶		
	Q4b "I am able to make suggestions to improve the work of my team / department"	41%	50%	53%	Improve	Actual										48%	●	▶		
	Q4d Able to make improvements happen in my area of work	25%	34%	34%	Improve	Actual										30%	●	▶		
	KF1. Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.03	3.43	3.44	Improve	Actual										3.39	●	▶		
	Q21a. "Care of patients / service users is my organisation's top priority"	45%	58%	58%	Improve	Actual										57%	●	▶		
	Q21c. "I would recommend my organisation as a place to work"	29%	42%	46%	Improve	Actual										42%	●	▶		
	Q21d. "If a friend or relative needed treatment, I would be happy with the standard of care provided by this"	56%	70%	70%	Improve	Actual										71%	●	▶		

● Target is not being met.
Position has deteriorated since last month.

● Target is not being met / No Target Set
Position improved / static since last month.

● Target is being met.

Arrow indicates trend of KPI against the previous month. Colour indicates whether this is a positive/negative/neutral movement

▶▶ Fast forward.
Trend not available



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Proposed approach to 2017/18 Annual Report and Accounts			
Agenda item:	18			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This report provides the Board with information about the approvals processes (and associated timetable) to be followed in the production of the 2017/18 Annual Report and Accounts. It also presents the Board with the proposed outline of the Annual Report (for approval) and the Annual Governance Statement (for information).				
Recommendation(s):				
The Board is asked to: • Note the approvals process for the 2017/18 Annual Report and Accounts (and associated timetable); and • Confirm that it is content with the proposed approach to drafting the Annual Report.				
Links to Board Assurance Framework (BAF) and key risks:				
The Annual Report and Accounts provide information about the organisation's assurances arrangements.				

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

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

Proposed Approach to 2017/18 Annual Report and Accounts

1. This report provides the Board with information about the approval processes to be followed in the production of the 2017/18 Annual Report and Accounts. It also presents the Board with the proposed outline for the Annual Report, for approval, and the Annual Governance Statement (AGS), for information.

2017/18 Annual Report and Accounts production timetable

2. The table below sets out the approval processes for the production of the 2017/18 Annual Report and Accounts:

Monday 16 April 2018	Audit Committee to review draft Annual Accounts and AGS
Tuesday 24 April 2018	Submission of draft Annual Report and Accounts (inc AGS) to NHS Improvement
Thursday 10 May 2018	Papers for Audit Committee meeting on 17/05/18 to be circulated to Committee members
Thursday 17 May 2018	Audit Committee to review draft Annual Accounts and AGS together with update on external audit findings to date and Head of Internal Audit Opinion
	Papers for Audit Committee meeting on 24/05/18 to be circulated to Committee members (dispensation being sought from the Chair of the Committee to circulate late)
Thursday 24 May 2018	Audit Committee to review and recommend Annual Report and Accounts (inc AGS) to the Board in light of ISA 260 Report from external auditors
	Board to approve tabled Annual Report and Accounts (inc AGS)
	CEO and Finance Director to sign Annual Report and Accounts (inc AGS)
	Annual Report and Accounts (inc AGS) to be submitted to NHS Improvement

3. Board members are asked to note this timetable.

2017/18 Annual Report – outline content

4. The proposed outline content for the 2017/18 Annual Report is set out below. Attached as an appendix is a more detailed content plan showing links to national reporting requirements.

Section	Summary of content
Chairman's foreword	Focus on thanking staff, reflection on CQC visit, BME development and reflection on staff survey results.
Chief executive's foreword	Focus on reflection as new CEO, performance summary, leadership priorities and new strategy.
About us • Services we provide • Vision, purpose and values • Performance summary	Overview of services provided and some key facts and figures. High level performance summary linking to more detail in later sections of report.
Our patients • Introduction • Who we care for • Improving services • Patient and public engagement • Friends and family test scores	Overview of different types of patients cared for across critical and urgent care. A summary of key improvement projects helping to improve quality/experience: - Vehicle preparation project - Connected clinicians project - Improving hospital handovers Brief update on patient forum and community events linking to more detail in Quality Account.
Our people • Introduction • Diversity and equality • Recruiting new people • Retaining and developing our people • Recognising our people • Volunteers • Staff survey • Freedom to speak up	Overview of staff facts and figures including actions and progress on diversity, recruitment and retention, freedom to speak up. Summary of key internal and external awards recognising staff during the year. Thanks to volunteer responders with updated figures on number of incidents supported in the year. High level summary of staff survey results with link to more detail in Quality Account and full results available online.
Our partners • Introduction • STPs • Blue light partners	Summary of key partnerships the trust is involved in.
Quality and performance • Introduction • Quality matters • 999 and 111 performance • Financial performance • Sustainability • Challenges and risks • Anti-bribery/anti-slavery	Quality: summary of quality work taken from Quality Account and providing link to full document on trust website. Performance: Performance split into two periods Apr-Oct on old KPIs and Nov-Mar on ARP. High level summary of key figures linking to full financial statements later in report. Additional statutory statements on sustainability, risk, etc
Developing our 5-year strategy	One page summary of developing strategy and core themes with link to full strategy on website.

Annual Quality Account

5. In previous years there has been a certain amount of duplication between the content of the Annual Report and the Annual Quality Account. For the 2017/18 Annual Report, it is proposed that, to avoid this duplication, readers are referred to the Annual Quality Account for further information about:

- Statement of Duty of Candour;
- Clinical incidents; and
- Clinical audit.

2017/18 Annual Governance Statement – outline content

6. The HM Treasury document “Managing Public Money” identifies inputs from the AO and the Board into the Annual Governance Statement process which include the following:

- a) the Board’s annual review of its own processes and practices, informed by the views of its audit committee on the organisation’s assurance arrangements;
- b) insight into the organisation’s performance from internal audit, including an audit opinion on the quality of the systems of governance, management and risk control;
- c) feedback from the delegation chain(s) within the organisation about its business, its use of resources, its responses to risks, the extent to which in year budgets and other targets have been met, and any other internal accountability mechanisms; including:
 - bottom-up information and assessments to generate a full appreciation of performance and risks as they are perceived from within the organisation;
 - end-to-end assessments of processes, since it is possible to neglect interdependent and compounded risks if only the components are considered;
 - a high level overview of the organisation’s business so that systemic risks can be considered in the round;
 - any evidence from internal control failures or poor risk management; and
 - potentially, information from whistleblowers.
- d) material from any arm’s length bodies (ALBs) connected with the organisation which may shed light on the performance of the organisation or its Board.

Proposed Structure of the Annual Governance Statement

7. Taking account of the inputs identified above and the guidance provided by NHS Improvement, the Audit Committee has agreed that the Annual Governance Statement should adopt the following structure:

- a) London Ambulance NHS Trust’s governance framework:
 1. Our Board;
 2. Board composition;
 3. The Non-Executive Directors and Associate Non-Executive Directors;
 4. The Executive Directors and Executive Leadership Team
 5. Deputy Chair and Senior Independent Director; and
 6. Chairman and Chief Executive.
- b) How the Board operates:
 1. Standing Orders, Matters Reserved to the Board, Scheme of Delegation and

- Standing Financial Instructions
- 2. Information required for the Board to operate;
- 3. Discharge of statutory functions; and
- 4. Provision of regulated activities.

c) Board effectiveness:

- 1. Board meetings and attendance;
- 2. Induction;
- 3. Performance evaluation and external assurance;
- 4. Compliance with corporate governance codes of good practice; and
- 5. Managing conflicts of interest

d) Board Assurance Committees:

- 1. Audit Committee;
- 2. Remuneration and Nominations Committee;
- 3. Quality Assurance Committee;
- 4. Finance and Investment Committee;
- 5. People and Organisational Development Committee;
- 6. Logistics and Infrastructure Committee

e) Executive Groups:

- 1. External directorships for Executive Leadership Team members;
- 2. Executive Leadership Team meetings and attendance; and
- 3. Corporate Committees and Groups.

f) Risk and control framework:

- 1. Purpose of the system of internal control;
- 2. Risk and control framework, including external and internal audit and LCFS;
- 3. Principal risks facing the Trust during 2017/18 as identified by the business plan (and what it did to manage these)
- 4. Capacity to handle risk; and
- 5. How the effectiveness of the Trust's system of internal control has been reviewed and the outcome of this review.

g) Significant issues:

- 1. CQC
- 2. Health and Safety Executive

8. Since the Audit Committee approved this structure, further guidance has been received from NHS Improvement which indicates a need to amend the ordering of the content listed above. However, it is still anticipated that the same information will be required.

Philippa Harding
Director of Corporate Governance

no.	section	sub-section	Section summary	Manual of Accounts section	Manual of Accounts specific wording
1	Foreword - chair		Focus on thanking staff, reflection on CQC visit, BME development and reflection on staff survey results.	NA	
2	Foreword - CEO		Focus on reflection as new CEO, performance summary, leadership priorities and new strategy.	overview - ceo performance statement	a statement from the chief executive providing their perspective on the performance of the organisation over the period
3	About us	Intro	Overview of services provided and some key facts and figures. High level performance summary linking to more detail in later sections of report.	overview - introduction	a short summary explaining the purpose of the overview section
3.1		Services		overview - statement of purpose	statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies
3.2		Vision purpose and values		overview - statement of purpose	
3.3		Performance summary		overview - performance summary	minimum requirement includes " a performance summary ". No specific guidance on what needs to be within this beyond " the overview should be enough for the lay user to have no need to look further into the rest of the ARA unless they were interested in further detail. "
4	Our patients	Intro	Overview of different types of patients cared for across critical and urgent care.	supports delivering requirements of overview and performance analysis	no specific wording requirements
4.1		Who we care for			
4.2		Improving services			
4.3		Patient and public engagement			
4.4		Friend and Family Test	- Vehicle preparation project - Connected clinicians project - Improving hospital handovers		
5	Our people	Intro	Overview of staff facts and figures including actions and progress on diversity, recruitment and retention, freedom to speak up.	supports delivering requirements of overview and performance analysis. Section provides link to "staff report" content in Governance section.	no specific wording requirements
5.1		Diversity and equality			
5.2		Recruiting new people			
5.3		Retaining and developing our people			
5.4		Recognising our people	Thanks to volunteer responders with updated figures on number of incidents supported in the year.		

no.	section	sub-section	Section summary	Manual of Accounts section	Manual of Accounts specific wording
5.5		Volunteers	Highlevel summary of staff survey results with link to more detail in Quality Account and full results available online.		
5.6		Staff survey results			
5.7		Freedom to speak up			
6	Our partners	Intro	Summary of key partnerships the trust is involved in.	supports delivering requirements of overview and performance analysis	no specific wording requirements
6.1		STPs			
6.2		Blue light partners			
7	Quality and performance	Intro		Performance report - performance analysis	Information on how the entity measures performance i.e. what the entity sees as its key performance measures, and how it checks performance against those measures, and narrative to explain the link between KPIs, risk and uncertainty. A more detailed analysis and explanation of the development and performance of the entity during the year
7.01		Quality matters	One page summary of quality work taken from Quality Account and providing link to full document on trust website.		
7.02		Performance, 999	Performance split into two periods Apr-Oct on old KPIs and Nov-Mar on ARP		
7.03		Performance, 111			
7.04		Financial performance	Highlevel summary of key figures linking to full financial statements later in report.	Overview - going concern statement Performance analysis	An explanation of the adoption of the going concern basis (see paragraphs 4.11-4.16 below) where this might be called into doubt (for example, by the issue of a report under Section 30 of the Local Audit and Accountability Act 2014 ¹⁷ for a CCG or an NHS provider). NB: given surplus position no need to include a "going concern" statement this year. This analysis is required to utilise a wide range of data including key financial information from the financial statements section of the accounts.
7.05		Sustainability	The trust's work on environmental issues	Performance analysis	Information on environmental matters, including the impact of the entity's business on the environment. Entities must also comply Compliance with mandatory sustainability reporting requirements ¹
7.06		Continuing challenges and risks	Highlevel summary of key risks facing the organisation and linking to risks listed in annual governance statement.	overview - key issues and risks Performance analysis	the key issues and risks that could affect the entity in delivering its objectives narrative to explain the link between KPIs, risk and uncertainty.
7.07		Anti-bribery/anti-slavery		Performance analysis	Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters.

no.	section	sub-section	Section summary	Manual of Accounts section	Manual of Accounts specific wording
8	Developing our 5-year strategy		One page summary of developing strategy and core themes with link to full strategy on website.	NA	
9	Annual Governance Statements		Content provided by Governance	Accountability report	
10	Financial statements		Content provided by Finance	Financial statements	



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Annual Corporate Governance Review			
Agenda item:	19			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This report provides the Board with information about the outcome of the annual review of corporate governance, proposes a number of amendments to enhance the Trust's corporate governance framework and asks the Board to confirm that it is content that the Trust remains compliant with conditions G6 and FT4 of the NHS provider licence.				
Recommendation(s):				
The Board is asked to approve the proposals set out in this report.				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				

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



Annual Corporate Governance Review

Objectives of the review

1. Based upon the approach agreed with the Audit Committee at its meeting on 12 February 2018, an internal review of the London Ambulance Service NHS Trust's (LAS') corporate governance has been undertaken with a focus upon the following objectives:

Objective 1 – establish that effective corporate governance arrangements are embedded across the organisation;

Objective 2 – identify principal risks to achievement of objectives;

Objective 3 – identify and evaluate key controls to manage principal risks; and

Objective 4 - obtain assurance on the effectiveness of key controls.

2. Achievement of these objectives provides the Board with assurance that the LAS' corporate governance framework is fit for purpose.

Findings of the governance review

3. Annex A sets out the assurances that were sought in relation to each of the objectives of the corporate governance review and the nature of the evidence that was used to support this assurance. It also sets out detailed findings in relation to each of the objectives of the corporate governance review.
4. The review confirms that the LAS has a clear and well established governance framework in place which conforms where appropriate to the best practice requirements and principles set out in key guidance documents such as the UK Corporate Governance Code, the NHS Audit Committee Handbook, the Healthy NHS Board and the Corporate Governance in Central Government Departments Code of Good Practice. This is, of course, a self-assessment and Board members are invited to test the assurances provided in Annex A to this report.
5. The assurances identified in relation to objectives 2 and 3 indicate that, whilst the LAS has developed its risk management systems and processes, further work is required to embed these in a sustainable manner. Board members have received a number of recent briefings on the work that is being undertaken in this area and the Risk Management Strategy and Policy setting out more information about this was approved by the Board at its meeting on 27 February 2018.
6. Each of the Board Assurance Committees has considered its effectiveness over the 2017/18 financial year and as part of this, work has also been undertaken to ensure the alignment of their Terms of Reference. These amended Terms of Reference, each of which have been endorsed by the appropriate Board Assurance Committee, are attached as Annex B to this report. The majority of the changes have been made to ensure consistency in the management of Board Assurance Committees and their business; however the following changes have been made with regard to the substance of Committee duties –
 - Finance and Investment Committee - Terms of Reference did not include any reference to risk, in particular the finance-related risks on the Board Assurance Framework, and it was agreed that this should be added.
 - People and Organisational Development Committee – proposed amendment to the name of the Committee (to People and Culture) to reflect the proposed name

change of the People and Organisational Development directorate and duties of the Committee, to reflect the main aspects of the LAS People Strategy.

7. The proposed membership of these Board Assurance Committees for 2018/19 is attached as Annex C to this report. The Board is asked to approve the proposed amendments to the Terms of Reference and the membership of the Board Assurance Committees.
8. Whilst the Standing Orders of the Board, Standing Financial Instructions and the Scheme of Delegation remain broadly appropriate, it is proposed that further work should be undertaken to revise these in line with changed responsibilities in the Executive Leadership Team and to reflect a number of small changes in corporate governance best practice. If the Board is content with this proposed approach, these documents will be presented for approval at the meeting of the Board on 24 April 2018.
9. Registers of Gifts and Hospitality and Declarations of Interests are in the process of being reviewed and Board members will be asked to ensure that their declarations are up-to-date over the course of the next month. It is proposed that greater transparency is brought to these registers, with quarterly review by the Board ahead of their publication on the Trust's website, together with the expense claimed by Board members.

Self-certification of compliance with the Provider Licence

10. As reported to the Board at its meeting on 30 January 2018, both NHS trusts and NHS Foundation Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution).
11. NHS Trusts are required to self-certify after the end of the financial year that they are in compliance with Conditions G6(3) and FT4(8) of the NHS provider licence:

Condition G6(3) – The Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution

Condition FT4(8) – The provider has compliance with required governance arrangements

12. The purpose of self-certification is to ensure that providers carry out assurance on whether or not they can confirm compliance. How providers undertake this process is for them to decide. The most important aspect of any process is to demonstrate that the Board understands clearly whether or not the provider can confirm compliance and that the Board can sign off to that end.

Condition G6

13. The details of condition G6 of the NHS provider licence were previously provided to the Board at its meeting on 30 January 2018 (together with a summary of the general licence conditions with which all NHS Trusts and NHS Foundation Trusts are expected to comply). Essentially, it requires that providers must have in place processes and systems which:
 - a. Identify risks to compliance with the NHS provider licence; and
 - b. Take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.
14. Providers must annually review whether these processes and systems are effective.

15. The following mechanisms were considered to have provided the Board with assurance with regard to the requirements of G6 and it is proposed that they should continue to be considered appropriate for 2017/18:
- Annual corporate governance review in advance of the preparation of the Annual Governance Statement which sets out the mechanisms of control and risk management for the Trust;
 - Corporate Risk Register and Board Assurance Framework updated on a regular basis and reported to the Board;
 - Self-assessment and various external reviews, including a CQC inspection focussing on Well Led;
 - Quality Improvement Programme and monitoring of progress against Enforcement Undertakings;
 - Monitoring by NHS Improvement and additional improvement support provided;
 - Compliance with laws and regulation
16. Having considered the assurances provided, is the Board content to approve the self-certification that the Trust is compliant with Condition G6 of the NHS provider licence?

Condition FT4

17. The detail of condition FT4 of the NHS provider licence was provided to the Board at its meeting on 30 January 2018. Essentially, it requires that providers must:
- a. review whether the governance systems they have in place achieve the objectives set out in the licence condition (i.e. are compliant with “those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS”); and
 - b. set out any risks identified to good governance and mitigating actions taken to avoid these risks.
18. The mechanisms set out above as providing assurance to the Board with regard to the requirements of G6 also provided assurance with regard to the requirements of FT4.
19. Having considered the assurances provided, is the Board content to approve the self-certification that the Trust is compliant with Condition FT4 of the NHS provider licence?

Articulation of the LAS corporate governance framework

20. It is proposed that the Trust’s corporate governance framework should be articulated in such a way that it facilitates both members of staff and the public’s interactions with it. This narrative, to be presented to the Board at its meeting on 24 April 2018 for approval, will indicate how the governance framework of the LAS addresses the main principles of the UK Corporate Governance Code (further information can be found at Annex D of this paper):
- Leadership;
 - Effectiveness;
 - Accountability;
 - Remuneration; and
 - Relations with Stakeholders.
21. The articulation of the corporate governance framework will take the following structure:

Leadership

- The Board – key responsibilities
 - Matters Reserved to the Board
 - Scheme of Delegation and Standing Financial Instructions
 - Standing Orders
- The Board – composition
 - Executive and Non-Executive Directors
 - Associate Non-Executive Directors
 - Senior Independent Director
 - Non-Executive Leads
- Executive Leadership Team

Effectiveness

- Appointments to the Board – process and role of the Nominations and Remuneration Committee
 - Board induction
 - Board appraisal and development
 - Board succession planning
- Operation of the Board – discharge of statutory duties and provision of regulated activities
 - Forward planning of business and strategy/development meetings
- Assurance
 - Board Assurance Committees
 - External Assurance
- Ensuring that information provided to the Board is timely and of a high quality

Accountability

- Trust Annual Report and Accounts
- Risk Management and Internal Control
- Audit Committee, internal auditors and external auditors

Relationships with stakeholders

- Relationship with patients and the public, including interactions with the patient forum
- Clinical Council
- Staff engagement
- Working with STPs/commissioners
- Accountability to regulators

Conclusion

22. External review of the Trust's corporate governance framework should be supplemented by internal review. The assurances identified during the corporate governance indicate that the Trust has an appropriate corporate governance framework in place. The Board is asked to comment on this finding.
23. A number of amendments are proposed to enhance the Trust's corporate governance framework, which have come to light during the corporate governance review, and the Board is asked to agree these:
24. As a result of the assurances identified during the corporate governance review, the Board is asked to agree that it is prepared to self-certify that the Trust is compliant with Conditions G6 and FT4 of the NHS provider licence.

25. It is proposed that a full articulation of the Trust's corporate governance framework is presented to the next meeting of the Board, together with any proposed amendments to the Standing Orders of the Board, Standing Financial Instructions and the Scheme of Delegation.

Philippa Harding
Director of Corporate Governance

ANNEX A – LAS CORPORATE GOVERNANCE REVIEW ASSURANCES SOUGHT AND EVIDENCE

a) Objective 1 – establish that effective corporate governance arrangements are embedded across the organisation

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
Code of corporate governance adopted	1. Principles of relevant code of corporate governance embedded within corporate governance frameworks and processes 2. Awareness of the relevant code of corporate governance	• The LAS Corporate Governance Framework reflects appropriate best practice, including the UK Corporate Governance Code • The main principles of the UK Corporate Governance Code are attached to this report to ensure Board members' awareness, they are also referenced in the Board Handbook, which has recently been established as an induction and ongoing development tool.
Review and monitoring arrangements in place	1. Corporate governance arrangements are regularly reviewed 2. There are clear arrangements for monitoring compliance with corporate governance frameworks and processes 3. An annual report on compliance with corporate governance best practice is reviewed by non-executives 4. Regular internal audit reviews of corporate governance frameworks and processes take place 5. Any corporate governance weaknesses are identified and an action plan is prepared to address them	• The organisation's corporate governance arrangements were reviewed independently under the Well Led Framework in 2017 and have also been subject to inspection by the Care Quality Commission (CQC). An internal corporate governance review is due to take place on an annual basis, for consideration by the Board ahead of each new financial year. • The Annual Governance Statement (AGS), which is part of the Annual Report and Accounts, and sets out the Trust's compliance with its own corporate governance frameworks and with the UK Corporate Governance Code is supported by an annual governance review. • The AGS is reviewed in detail by the Audit Committee and presented to the Board for approval. • The Trust's internal auditors review its corporate governance arrangements on a regular basis, including the statements made in the AGS, as part of the Annual Report and Accounts. • The Director of Corporate Governance takes the operational lead in identifying and addressing any areas for development in corporate governance weaknesses
Committee charged with governance responsibilities	1. Responsibility for overseeing corporate governance has been formally delegated to an appropriate committee 2. Committee terms of reference clearly demonstrating responsibility for corporate governance issues have been approved by the Board	• The Audit Committee has delegated authority for the oversight of corporate governance. At the executive level the Executive Leadership Team (ELT) takes the lead. • The Terms of Reference of the Audit Committee (which are approved by the Board) adhere to best practice set out in the UK Code of Corporate Governance, the NHS Audit Committee Handbook and guidance provided by the Treasury and the National Audit Office. They clearly set out the Committee's responsibilities in relation to financial reporting; internal controls, risk management systems and corporate governance; whistleblowing and fraud; internal audit; and external audit.

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
	3. Terms of reference are sufficiently comprehensive to ensure that all appropriate aspects of corporate governance are covered 4. Agenda and minutes from the committee charged with corporate governance responsibility indicate that the responsibility is being discharged adequately	• Reports of Audit Committee meetings are provided to the Board after each meeting. In 2018/19 the Board will also have access to the forward plan for agendas of each meeting and the minutes of each meeting, in order to receive detailed assurance that the Committee is discharging its duties adequately. • A review of the Audit Committee's business in 2017/18 against its Terms of Reference and Forward plan indicate that it has discharged its responsibilities appropriately in 2017/18, as do the results of a self-assessment checklist undertaken by Audit Committee members.
Governance advice and training available to key executives and non-executives	1. Induction training for key new executive and all non-executives incorporates suitable coverage on corporate governance issues according to responsibilities 2. Ongoing awareness training is provided as appropriate to key staff and all members to ensure that there is an appropriate awareness of the organisation's corporate governance frameworks and processes	• Induction plans new Board members have been reviewed to ensure that they cover all relevant corporate governance issues. A "Board Handbook" has been established for all Board and ELT members to access on an ongoing basis and this will be updated on a quarterly basis and ahead of any new appointments to the Board or ELT. This is in addition to a plan of meetings for new Board and ELT members, including meetings with the Chair and the Director of Corporate Governance who will provide information and advice on individuals' corporate governance responsibilities. • Information about the Trust's corporate governance frameworks is available to members of staff and the public on the Trust's website. The information contained in the Annual Corporate Governance Review report will be used to form the basis of new pages on the intranet in 2018/19. • The Director of Corporate Governance and the Committee Services team are able to provide information about the operation of the Trust's corporate governance framework as necessary

b) Objective 2 – identify principal risks to achievement of objectives

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
There is a written strategy and policy in place for managing risk which: - Has been formally approved at board level - Is reviewed on a regular basis - Has been communicated to all relevant staff	1. Existence of approved strategy and policy document 2. Evidence of formal approval (e.g. board/committee minutes) 3. Evidence of formal review (e.g. board/committee minutes, document version number and date) 4. Evidence of communication strategy, possibly covered in strategy document 5. Examples of dissemination e.g. induction, briefings, awareness sessions, policy and strategy published on intranet, strategic diagnostic questionnaire results	• The Board approved the Risk Management Strategy and Policy at its meeting on 27 February 2018, following a detailed review of the draft by the Audit Committee at its meeting on 12 February 2018. This replaced the Risk Management Framework that was approved by the Audit Committee using delegated authority at its meeting on 06 November 2017. • The Risk Management Strategy and Policy includes a communication plan and training strategy as an annex, to ensure that it is disseminated and all members of staff are aware of it. • The Risk Management Strategy will be kept under annual review to ensure that it remains appropriate, as part of the Trust's Annual Corporate Governance Review and will be reviewed regularly as part of the Trust's Policy Register.
Clear structures and processes for risk management which are successfully implemented and: - Board sees risk management as a priority and support it by personal interest and input - Decision making considers risk - A senior manager has been appointed to "champion" risk management - Roles and responsibilities for risk	1. Board/committee minutes 2. Internal audit reports and external audit comments on risk management system 3. Annual business plans 4. Link between internal audit and risk management functions is clearly defined in terms of reference of internal audit 5. Responsibility for risk management function is set at appropriate senior level 6. Committee reports setting out options for change include an appropriate risk assessment, including the 'no change' option 7. The corporate business plan and financial plan assess risks as appropriate and in particular take	• The Board reviews the Board Assurance Framework (BAF) at each meeting and is provided with the Corporate Risk Register in support of this. • Each BAF risk has been allocated to a Board Assurance Committee for scrutiny and these are considered at each Committee meeting. The Audit Committee considers the operation of the BAF and supporting risk systems. • Internal Audit reports and External Auditors' comments are presented to the Audit Committee at each appropriate meeting. • The Internal Audit Strategy is based upon the risks identified through Trust's BAF and Corporate Risk Register. • The ELT takes collective responsibility for reviewing the content of the BAF and horizon scanning on a monthly basis, ahead of its submission to the Board. • The Chief Quality Officer is responsible for the overall operation of the risk management system, whilst the Director of Corporate Governance is responsible for supporting the Board and ELT's consideration of risk through the BAF. • The Board reviews its Risk Appetite Statement on an annual basis and in 2018/19 has emphasised the importance of linking this with the organisation's strategy and business planning activities.

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
management have been defined - Risk management systems are subject to independent assessment - Risk management is considered in the annual business planning process	account of new and emerging risks facing the organisation	• The 2018/19 Business Plan, which is due to be presented to the Board for approval at its meeting on 27 March 2018, will include a clear link between the organisation's objectives and the risks to achieving these. • All Board and Committee reports require an assessment of the risks associated with new proposals. • A Deep Dive on Risk Management has been scheduled for early 2018/19.
The organisation has developed a corporate approach to the identification and evaluation of risk which is understood by all staff	1. Systematic procedures for risk identification and evaluation have been agreed and published in a policy document and are consistently applied across all business units and partnerships 2. Examples of dissemination e.g. induction, briefings, awareness sessions, strategic diagnostic questionnaire results.	• The procedures for risk identification and evaluation are identified within the Trust's Risk Management Strategy and Policy.
The organisation has well defined procedures for recording and reporting risk	1. Evidenced by review of risk management strategy and policy 2. Examination of corporate and partnership risk registers 3. Key risk indicators have been determined and there is evidence of monitoring against these risks 4. Evidence of regular and frequent reporting of risk to political and management board level 5. Evidence of risk based auditing being carried out 6. Evidence of risks not properly addressed identified in internal audit reports etc being fed into the risk management process	

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
	7. Environmental scanning reports are fed into the risk management process so as to identify new and emerging risks	
The organisation has developed a programme of risk management training for relevant staff	1. Training programme for risk management 2. Training needs analysis (both specialist staff development and general awareness) 3. Regular newsletter or other means of communicating risk management issues to staff 4. Induction programme includes risk management 5. management 6. Appropriate responsibilities for risk management incorporated into job descriptions and appraisals	• The training plan for risk management is set out within the Trust's Risk Management Strategy and Policy.
The committee responsible for risk management adds value to the risk management process by: - Advising and supporting management team on risk strategies - Identifying areas of overlapping risk - Driving new risk management initiatives - Communicating risk management and sharing good practice - Providing and reviewing risk management training - Regularly reviewing the risk register(s)	1. Risk management committee's terms of reference 2. Minutes of corporate risk management board 3. Reports to corporate management team 4. Low incidence of avoidable risk events occurring	• The Audit Committee's Terms of Reference include responsibility for the functioning of the Trust's Risk Management systems. It reviews the BAF and Corporate Risk Register at each meeting and reports its conclusions to the Board. • The Trust's Internal Auditors make their own regular reports to the Audit Committee, based on their own work programme. The Board discusses the most significant risks and the actions identified to mitigate them, as set out in the BAF.

Assurance	Can be evidenced by	Corporate Governance Review 2018 finding
- Coordinating the results for risk reporting		
Managers are accountable for managing their risks	1. Evidence of manager involvement in risk identification and analysis process 2. Risk owners detailed in corporate /departmental risk register(s) 3. Risk owners assigned in relation to key partnerships 4. Job descriptions of managers outline their risk management responsibilities 5. Evidence of (at least) annual review of risk at service/operational levels and of partnership risks 6. Analysis of completed control and risk self-assessment questionnaires	• This is being tested as part of the CQC Well-Led Review
Risk management is embedded throughout the organisation	1. Evidence of a general risk management culture at all levels 2. Risk management training programme 3. Evidence of managers involvement in risk management aspects of business planning 4. Results of strategic diagnostic survey to ascertain the extent to which risk management is understood by each category of officer (senior management, operational managers etc) and members	• This is being tested as part of the CQC Well-Led Review

c) Objective 3: Identify and evaluate key controls to manage principal risks

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
There are written financial regulations in place which have been formally approved, regularly reviewed and widely communicated to all relevant staff.	1. Financial regulations and instructions exist & are reviewed & updated regularly 2. Evidence of formal approval 3. Examples of dissemination e.g. induction, briefings, awareness sessions, accessible in finance manuals and/or on intranet site 4. Reports to audit committee or equivalent confirming compliance or identifying extent of non-compliance with regulations and instructions	• Standing Financial Instructions and delegated authorities are approved by the Board and reviewed on an annual basis. Updated Standing Financial Instructions are due to be presented to the Board in April for approval. • These documents are available publicly on the Trust's website and to all members of staff on the organisation's intranet. • Where delegations are to specific individuals these will be codified and presented in formal written information. • The Finance and Investment Committee and ELT are regularly provided with an update on relevant changes to external financial regulations which will affect the Trust.
There is a whistle blowing policy in place which has been formally approved, regularly reviewed and widely communicated to all relevant staff	1. Whistle blowing policy exists and has been reviewed and updated regularly. 2. Evidence of formal approval 3. Examples of communication and dissemination e.g. induction, briefings, awareness sessions, accessible on website and intranet site 4. Evidence of effectiveness of policy (e.g. reports on incidence of usage, evidence on annual declarations on fraud)	• The Trust has a Freedom to Speak Up Policy in place, which was approved by the Board and is published on the Trust's intranet and website. • The Board receives a formal quarterly report from the Freedom to Speak Up Guardian on Freedom to Speak Up activities both within the Trust and nationally. • Information about Freedom to Speak UP is disseminated through induction sessions, posters in Trust buildings, on the intranet and Routine Information Bulletins as well as on the Listening into Action Facebook group. The Freedom to Speak Up Guardian has been raising the profile of the role by visiting different parts of the Trust. • The Trust's approach to Freedom to Speak Up was reviewed in October 2017, and a new approach was approved, including the recruitment of a permanent Freedom to Speak Up Guardian (0.5 WTE) and the implementation of a hub and spoke arrangement. • A survey of staff about Freedom to Speak Up closed on 18 March 2018, this will be used to inform the activities of the permanent Freedom to Speak Up Guardian who is due to be appointed in April 2018.
There is a counter fraud and corruption policy in place which has been formally approved, regularly reviewed	1. Counter fraud and corruption policy exists and has been reviewed and updated regularly 2. Evidence of formal approval 3. Examples of dissemination (briefings, induction, awareness	• The Trust has an Anti-Fraud, Bribery and Corruption Policy in place which is published on the Trust's intranet and website. • The Local Counter Fraud Service is provided by the Trust's internal auditors, who report on the implementation of the policy and other awareness raising activities to the Audit Committee.

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
and widely communicated to all relevant staff	sessions, accessible on website and intranet site) 4. Evidence of effectiveness of policy (e.g. reports on identified frauds; annual AF70 returns to Audit Commission, reports on results of National Fraud Initiatives) 5. Review of register of gifts and hospitality	The Register of Gifts and Hospitality is maintained by the Committee Services team on behalf of the Director of Corporate Governance. An annual review of this is presented to the Audit Committee.
There are codes of conduct in place which have been formally approved and widely communicated to all relevant staff	1. Codes of conduct have been agreed, including national schemes (e.g. police officers) 2. Evidence of formal approval 3. Examples of dissemination e.g. 4. induction, briefings, awareness sessions, accessible on intranet site	A Code of Conduct, which has been approved by the Board is in existence and can be accessed on the Trust's intranet site.
A register of interests is maintained, regularly updated and reviewed	1. Inspection of register of interests (members and staff) 2. Evidence of regular updating and review by senior officer(s)	- The Committee Services team on behalf of the Director of Corporate Governance maintains a register of interests which is reviewed on a quarterly basis. - Updates to the register should be provided by Board and ELT members on a regular basis and formal requests for updates will be circulated quarterly in 2018/19.
Where a scheme of delegation has been drawn up, it has been formally approved and communicated to all relevant staff	1. Scheme of delegation incorporates adequate controls and sanctions 2. Evidence of formal approval 3. Examples of communication and dissemination e.g. induction, briefings, awareness sessions, accessible on intranet site 4. Regular reports on the operation of the scheme (e.g. compliance, budget monitoring, year-end balances)	A scheme of delegation exists and has been approved by the Board and it is available on the Trust's intranet site. It is reviewed on an annual basis and continues to be broadly appropriate, but it is proposed that changes are made, for approval by the Board at its meeting on 24 April 2018. This will also incorporate proposed approach to the dissemination of and reporting on the operation of the scheme.
A corporate procurement policy has been drawn up, formally approved and communicated to all relevant staff	1. Procurement policy exists and has been reviewed and updated regularly to take account of new initiatives e.g. drive towards wider consortia arrangements, shared services 2. Evidence of formal approval	A significant amount of work is being undertaken on the Trust's approach to procurement following the internal audit review of procurement maturity undertaken in 2017/18.

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
	3. Examples of dissemination e.g. induction, briefings, awareness sessions, accessible on intranet site 4. Evidence of effectiveness of policy (e.g. benchmarking results, best value review, internal/ external audit review)	
Business/service continuity plans have been drawn up for all critical service areas and the plans: - Are subject to regular testing - Are subject to regular review	1. Current business/service continuity plans exist covering all critical service areas and are readily accessible 2. Evidence of regular testing 3. Evidence of regular review in the light 4. of the results of testing and for changes in structures, procedures, information systems, responsibilities etc	• A business continuity plan exists and is tested regularly. It was approved by the Executive Leadership Team within the last six months and includes arrangements for regular review.
The corporate/departmental risk register(s) includes expected key controls to manage principal risks	1. Risk register sets out principal risks and sets out appropriate key controls to manage them. 2. Key controls are monitored, reviewed and updated regularly 3. Use of risk management workshops to underpin the process and review of register and key controls 4. Risk owners are assigned to manage principal risks 5. Partnership risks are considered	See section on risk management above
Key risk indicators have been drawn up to track the movement of key risks and are regularly monitored and reviewed.	1. Appropriate key risk indicators are documented 2. Evidence of regular monitoring 3. Evidence of changes in risk indicators (and reasons for change) emanating from appropriate	See section on risk management above

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
	information sources (e.g. where internal audit findings are used to change the perceived level of risk)	
The internal control framework is subject to regular independent assessment	1. Internal audit plans and reports 2. Annual report/opinion of Head of Internal Audit 3. External audit reports	See section on risk management above
A corporate health and safety policy has been drawn up, formally approved, is subject to regular review and has been communicated to all relevant staff	1. Health & safety policy exists and has been reviewed and updated regularly 2. Policy covers partnerships 3. Evidence of formal approval 4. Examples of dissemination e.g. induction, briefings, awareness sessions, inclusion of policy on website and intranet site 5. Evidence of effectiveness of policy e.g. number of cases investigated by Health & Safety Executive – and the number of cases proven 6. Review of number of reported incidences and 'near misses'	• There has been a significant focus on health and safety across the trust in 2017/18 and the Board has been updated regularly on the dissemination of and compliance with the Health and Safety Policy. This was considered to be one of the Trust's highest rating strategic risks, but it is now proposed that sufficient work has been undertaken to enable the risk to be de-escalated.
A corporate complaints policy/procedure has been drawn up, formally approved, communicated to all relevant staff, the public and other stakeholders is regularly reviewed	1. Complaints policy/procedure exists and has been reviewed and updated regularly 2. Procedure is compliant with all relevant statutory requirements 3. Evidence of formal approval 4. Examples of dissemination e.g. induction, briefings, awareness sessions, inclusion of policy on website and intranet site 5. Leaflets/posters highlighting complaints procedure 6. Complaints files	• A corporate complaints policy exists which is appropriate and reviewed regularly. The Trust has a team which co-ordinates responses to complaints and this work is reviewed by the Chief Executive and Chair on a regular basis.

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
	7. Committee reports summarising complaints dealt with analysed by outcome	

d) Objective 4: Obtain assurance on the effectiveness of key controls

Example of assurance	Evidenced by	Corporate Governance Review 2018 finding
The organisation has determined appropriate internal and external sources of assurance	- Minutes of committee at which report on assurances was considered - Sources of assurance are appropriate to the organisation	- The Audit Committee considers the internal audit plan which provides the trust with external sources of assurance. - The Quality Assurance Committee considers the programme of Deep Dives undertaken by the Trust to provide assurance with regard to quality issues, these can include both internal and external sources of assurance. - The Board and ELT also agree on an ad hoc basis when external assurances are required in relation to particular issues.
Appropriate key controls on which assurance is to be given have been identified and agreed	Briefing notes, guidance, instructions etc given to appropriate managers regarding what is expected of them	This information can be found in the AGS, which is part of the Trust's Annual Report and Accounts, published on the Trust's website and its intranet.
Departmental assurances are provided	- Departmental heads sign off on adequacy of controls (i.e. provide annual governance assurance statements) - Supporting documentation provided by departmental heads re review and monitoring arrangements that key controls have been in operation for the period and will continue to operate until accounts signed off. - Structured process and standard documentation to ensure consistency of coverage and common understanding of level of assurance given. - Completed Control & Risk Self-Assessment questionnaires - Annual governance assurance statements evaluated by officer team or committee charged with the responsibility of preparing the AGS. Evaluation to include 'reality	- The Chief Executive will require his direct reports to provide an annual statement of assurance on the adequacy of controls, which is incorporated into the AGS. - Information about the operation of key controls is gathered through the BAF and Corporate Risk Register.

	checking' of sample of assurance statements	
Internal Audit Arrangements	1. Reports of Head of Internal Audit to audit committee or equivalent throughout the year 2. Annual report of Head of Internal Audit, including opinion on internal control and risk management framework	• The Audit Committee receives reports from the Trust's internal auditors throughout the year, including the Head of Internal Audit Opinion, which is presented in the Internal Auditors' Annual Report.
Corporate Governance Arrangements	1. Annual corporate governance assurance statement 2. Internal or external audit review of corporate governance arrangements 3. Monitoring reports to committee on delivery of action plans in response to reviews of corporate governance	• There is an annual review of corporate governance which feeds into the drafting of the Trust's Annual Governance Statement.
Performance monitoring arrangements	1. Annual and in-year reports on delivery of key performance indicators by internal and/or external review agencies	• The Board receives an Integrated Quality and Performance Report at each meeting. • Regular reports are provided to the Board with regard to the achievement of the objectives set out in the Trust's Business Plan. • The Chief Executive holds monthly performance reviews with individual ELT members to track delivery of key performance indicators.



Audit Committee

Terms of Reference (effective March 2018-March 2019)

1. Purpose

- 1.1 The Audit (the Committee) has been established in order to focus primarily on the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

2. Constitution

- 2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.
- 5.2 At least one member of the Committee must have recent and relevant financial experience.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Director of Finance and Performance and the Director of Corporate Governance should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.
- 7.2 The Non-Executive Chair of the Quality Assurance Committee should be invited to attend all Audit Committee meetings.
- 7.3 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.
- 7.4 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

8. Quorum

- 8.1 The meeting will be quorate provided that two Committee members are in attendance, including the Chair of the Committee, or their nominated deputy (who must also be a Non-Executive Director). In the absence of the Chair, Committee members may nominate a deputy chair for the purposes of that meeting from their midst.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated

to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 The Committee shall meet a minimum of four times per annum. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.
- 11.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12. Duties

Purpose

- 12.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.
- 12.2 The Committee shall review the corporate risk register and the Board Assurance Framework and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.
- 12.3 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- 12.4 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- 12.5 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- 12.6 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

- 12.7 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Assurance Committees of the Board and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

Internal Audit

- 12.8 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

12.8.1 approval of the appointment of internal auditors and any question of resignation and dismissal. review and approval of the Internal Audit strategy,

12.8.2 operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

12.8.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

12.8.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

12.8.5 an annual review of the effectiveness of Internal Audit.

External Audit

- 12.9 The external auditor is appointed by the Trust Board on recommendation from an Auditor Panel established through the Audit Committee.

- 12.10 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

- 12.11 The auditor panel's functions are to:

12.11.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules

- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

12.11.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed external auditor;

12.11.3 Advise (if asked) the Trust Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

12.11.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

12.11.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor

12.12 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

12.12.1 consideration of the performance of the External Auditor;

12.12.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

12.12.3 discussion with the External Auditors of their local evaluation of audit risks;

12.12.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

12.12.5 discussion and agreement on the Trust's Annual Governance Statement.

Risk and Assurance Functions

12.13 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

12.13.1 review of the work of the Quality Assurance Committee in the management of clinical risk including assurance gained from the clinical audit function;

- 12.13.2 review of the work of the Finance and Investment Committee in the management of financial risk;
- 12.13.3 review of the work of the People and Organisational Development Committee in the management of workforce risk;
- 12.13.4 review of the work of the Logistics and Infrastructure Committee in the management of risk relating to IM&T, Estates, and Fleet & Logistics;
- 12.13.5 review of the Executive Leadership Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Risk Compliance and Assurance Group;
- 12.13.6 review the Board Assurance Framework to ensure that it is focussed on the key strategic risks to the business and clearly identifies controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;
- 12.13.7 review of the findings of any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);
- 12.13.8 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

Counter Fraud

- 12.14 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

- 12.15 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 12.16 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

12.17 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

12.18 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

Whistleblowing

12.19 The Committee shall ensure that arrangements are in place for investigation of matters raised in confidence by staff relating to matters of financial reporting and control, clinical quality and patient safety, or other matters.

Other

12.20 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

- 14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on xxx



Finance and Investment Committee

Terms of Reference (effective March 2018-March 2019)

1. Purpose

- 1.1 The Finance and Investment Committee has been established in order to provide assurance and make recommendations to the Trust Board on the proposed plans of the Executive Leadership Team and to be assured of their consistency through discussion with other Board committees.
- 1.2 The Finance and Investment Committee shall conduct independent and objective review(s) of financial and investment policy and performance.

2. Constitution

- 2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust (including the Chief Executive and the Director of Finance and Performance) and shall consist of not less than five members, all of whom shall have voting rights.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Trust Chair should normally attend all Finance and Investment Committee meetings.
- 7.2 The Director of Corporate Governance and the Deputy Director of Finance should normally attend all Finance and Investment Committee meetings.
- 7.3 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance;
- 8.1.1 The Chair or Vice-Chair; and
 - 8.1.2 At least one of the two Executive Directors, one of whom must be the Chief Executive or Director of Finance and Performance.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 Meetings will be held bi-monthly with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

Financial Policy, Management and Reporting

- 12.1 To consider the Trust's 2 – 5 year financial strategy, in relation to both revenue and capital prior to its submission to the Board.
- 12.2 To consider the Trust's annual financial targets and cash flow and to monitor progress against these.
- 12.3 To review the annual financial plan before submission to the Board.
- 12.4 To review performance against the Cost Improvement Programme focussing on specific issues raised by the Board.
- 12.5 To review proposals and make recommendations to the Board for major business cases and their respective funding sources.
- 12.6 To monitor progress with the capital programme making any recommendations for changes or re-allocation of capital.
- 12.7 To commission and receive the results of in-depth reviews of key commercial issues affecting the Trust on behalf of the Board.

- 12.8 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and related contractual risk.
- 12.9 To consider the Trust's tax policy and compliance.
- 12.10 To annually review the financial policies of the Trust and make appropriate recommendations to the Board.
- 12.11 To review finance-related risks, particularly those included within the Board Assurance Framework, the adequacy of the action being taken to mitigate these and the controls in place, proposing amendments or additional risks where appropriate.

Investment Policy, Management and Reporting

- 12.12 To approve and keep under review, on behalf of the Board, the Trust's investment strategy and policy.
- 12.13 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHS Improvement's requirements.

Performance oversight

- 12.14 To review the form and content of the Integrated Performance Report to ensure it is adequately focused and acts to highlight variation from intended performance, the reason for this and action to address it.
- 12.15 To receive assurance regarding the timeliness, relevance and accuracy of the data included within the Integrated Performance Report together with recommendations for improvement.

Other

- 12.16 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

- 13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.
- 13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.
- 13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will

include an evaluation of its performance according to a standardised framework and process.

- 13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

- 14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on xxx



Logistics and Infrastructure Committee

Terms of Reference (effective March 2018-March 2019)

1. Purpose

- 1.1 The Logistics and Infrastructure Committee has been established in order to provide assurance on and oversee strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate.

2. Constitution

- 2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust (including the Director of Finance and Performance, the Chief Information Officer and the Director of Strategic Assets and Property) and shall consist of not less than six members, all of whom shall have voting rights.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Director of Corporate Governance, the Deputy Director of Fleet and Logistics, the Head of Estates, and senior representatives of the Operations and Medical Directors should normally attend all Logistics and Infrastructure Committee meetings.
- 7.2 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance;
- 8.1.1 The Chair or Vice-Chair; and
 - 8.1.2 At least one of the two Executive Directors, one of whom must be the Director of Finance and Performance, the Chief Information Officer or the Director of Strategic Assets and Property.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 A minimum of three meeting will be held per year, with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

- 12.1 To take assurance on the executive oversight of the Fleet, Estates and IM&T functions of the Trust.
- 12.2 To seek assurance that effective strategies are in place that enable the achievement of the overall Trust strategy.
- 12.3 To have oversight of the regulatory and compliance framework for each function ensuring that all requirements and reporting requirements are being met.
- 12.4 To consider and review key risks to delivery of strategic objectives within each function and to confirm the risk appetite accordingly, escalating key risks to the Trust Board.
- 12.5 To consider the capital and investment plans for each function within the overall Trust financial plan and to inform/advise the Trust Board as appropriate.
- 12.6 To review and approve for recommendation to the Trust Board and Finance Investment Committee as appropriate any outline and full business cases for development and investment within each of the functions.
- 12.7 To receive assurance that all policies relating to each function are up to date and remain relevant and complied with.
- 12.8 To receive performance/compliance/other reports from the Environment and Resources Group at each meeting.
- 12.9 To receive reports on key performance indicators for each function at each meeting, escalating any concerns to the Trust Board as appropriate.
- 12.10 To receive any external and internal assurance reports on the functions, and to take assurance from these or escalate concerns to the Trust Board.
- 12.11 To approve the annual work plan for the Environment and Resources Group.
- 12.12 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

- 13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.
- 13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.
- 13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.
- 13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

- 14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on xxx



People and Culture Committee

Terms of Reference (effective March 2018-March 2019)

1. Purpose

- 1.1 The People and Culture Committee has been established in order to assure the Board on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

2. Constitution

- 2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust (including the Director of People and Culture and the Director of Finance and Performance) and shall consist of not less than eight members, all of whom shall have voting rights.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Director of Corporate Governance, the Head of Workforce Information and Planning and an Equality and Inclusion Representative should normally attend all People and Organisational Development Committee meetings.
- 7.2 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance;
- 8.1.1 The Chair or Vice-Chair; and
 - 8.1.2 At least one of the two Executive Directors, one of whom must be the Director of Organisational Development or Director of Finance and Performance.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 Meetings will be held bi-monthly with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

- 12.1 To enable the Trust Board to obtain assurance that the Trust: achieves the following in a spirit of inclusion and diversity:

Leadership and Performance

- 12.1.1 Performance – is able to maximise the potential of its people both in delivering against their role and in developing their skills
- 12.1.2 Leadership Development – is taking appropriate steps to develop its current and future leaders
- 12.1.3 Multi-disciplinary training – has the systems and processes in place to ensure that its people are well equipped to undertake the tasks that are expected of them and that it can fulfil its workforce planning
- 12.1.4 Statutory and Mandatory training – ensures that its people have timely access to relevant statutory mandatory training and that they are compliant at all times

Healthy Workplace

- 12.1.5 Staff support – has appropriate systems and process in place to ensure the health and wellbeing of its people, occupational health offered and supporting them following their involvement in major incidents
- 12.1.6 Bullying and Harassment – is taking appropriate steps to prevent inappropriate behaviours in the workplace

Engagement

- 12.1.7 Recognition – has recognition schemes in place which recognise excellent contributions that reflect the Trust's values contributes to the accomplishment of its goals
- 12.1.8 Employee relations – has an effective strategy for dealing with employee relations and effective partnership arrangements with recognised Trade Unions

- 12.1.9 Employee voice –has effective methods of staff engagement that promote the concept of ‘you said we did’ in support of an inclusive approach to working with its people

Talent

- 12.1.10 Values based recruitment – has the systems and processes in place to ensure that it has the workforce it requires to deliver its goals
- 12.1.11 Succession planning – is able to replace people in key roles should they no longer be able (short term) or wish (longer term) to fulfil them
- 12.1.12 Equality, Diversity and Human Rights - has a dynamic workforce that reflects the diversity of its patients

Workforce Analytics

- 12.1.13 Strategic workforce planning – has appropriate people-related plans and strategies in place to enable delivery of the Trust’s strategy and business plans
- 12.2 To receive any other relevant items as identified on the Committee’s forward plan.

13. Review and reporting responsibilities

- 13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.
- 13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.
- 13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.
- 13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

- 14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on xxx



Quality Assurance Committee

Terms of Reference (effective March 2018-March 2019)

1. Purpose

1.2 The Quality Assurance Committee (the Committee) has been established in order to provide the Trust Board with assurance on the achievement of the London Ambulance Service NHS Trust's strategic objective in relation to the provision of a high quality, safe, and effective service.

1.3 The Trust's definition of quality encompasses three equally important elements:

- **Care that is safe** – working with patients and their families to reduce avoidable harm and improve outcomes.
- **Care that is clinically effective** – not just in the eyes of clinicians but in the eyes of patients and their families.
- **Care that provides a positive experience** – to patients and their families.

2. Constitution

2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust (including the Medical Director and the Chief Quality Officer) and shall consist of not less than five members (of whom three should be Non-Executive Directors), all of whom shall have voting rights.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Director of Corporate Governance should normally attend all Quality Assurance Committee meetings, with the Chief Executive invited to attend at least annually.
- 7.2 The Non-Executive Chair of the Audit Committee should be invited to attend all Quality Assurance Committee meetings.
- 7.3 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.
- 7.4 At least twice a year the appropriate Internal Auditor representative should attend Quality Assurance Committee meetings.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance;
- 8.1.1 Two Non-Executive Directors, including the Chair or Vice-Chair; and
 - 8.1.2 At least two Executive Directors, one of whom must be the Chief Quality Officer or Medical Director, or their delegated representative.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 Meetings will be held bi-monthly with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

- 12.1 To enable the Trust Board to obtain assurance that:

- People are protected from abuse and avoidable harm (*Safe*)
- People's care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible (*Effective*)
- Staff involve and treat people with compassion, kindness, dignity and respect (*Caring*)
- The leadership, management and governance of the organisation ensures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture (*Well-Led*).

- 12.2 To receive the following standing items:

- A summary of actions report relating to the appropriate Care Quality Commission (CQC) domain/s to include an update report from the

appropriate Executive Led Group/s including exceptions, notifiable events and relevant performance metrics.

- A report from the Quality Oversight Group (QOG) on any key issues and escalations.
- The Trust's corporate risk register – section relating to the appropriate domain in relation to quality and safety. To review the impact of any corporate risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion onto the Board Assurance Framework.
- The Trust's Board Assurance Framework – section relating to the strategic objectives and associated risks delegated to the Committee or that may impact on the quality and safety of services to patients and their families (quarterly).

12.3 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on xxx



Board Assurance Committee Membership 2017/18

Audit Committee	Members	Regular Attendees
	• John Jones (Non-Executive Director, Chair) • Fergus Cass (Non-Executive Director) • Theo De Pencier (Non-Executive Director)	• Lorraine Bewes (Director of Finance & Performance) • Garret Emmerson (Chief Executive Officer) • Philippa Harding (Director of Corporate Governance) • Robert McFarland (Quality Assurance Committee Chair)
	• Sheila Doyle to receive papers and provide comments ahead of meetings.	

Finance and Investment Committee	Members	Regular Attendees
	• Fergus Cass (Non-Executive Director, Chair) • John Jones (Chair of the Audit Committee) • Theo de Pencier (Chair of the Logistics and Infrastructure Committee) • Jayne Mee (Chair of the People and Organisational Development Committee) • Garrett Emmerson (Chief Executive Officer) • Lorraine Bewes (Director of Finance and Performance)	• Heather Lawrence (Trust Chair) • Philippa Harding (Director of Corporate Governance) • James Corrigan (Interim Deputy Director of Finance)

	Members	Regular Attendees
	• Theo de Pencier (Non-Executive Director, Chair) • Lorraine Bewes (Director of Finance and Performance) • Fergus Cass (Audit Committee member, Finance and Investment Committee member) • Sheila Doyle • Ross Fullerton (Chief Information Officer) • Benita Mehra (Director of Strategic Assets and Property)	• Philippa Harding (Director of Corporate Governance) • TBC (Head of Estates) • Justin Wand (Deputy Director of Fleet and Logistics) • Senior Operations directorate representative • Business Intelligence representative

	Members	Regular Attendees
	• Jayne Mee (Non-Executive Director, Chair) • Trisha Bain (Chief Quality Officer) or Deputy • Lorraine Bewes (Director of Finance and Performance) • Jessica Cecil • Patricia Grealish (Director of People and Culture) • Robert McFarland (Quality Assurance Committee Chair) • Paul Woodrow (Director of Operations) or Deputy • Tina Ivanov (Deputy Director of Clinical Education and Standards)	• Melissa Berry (Equality and Inclusion Representative) • Chris Randall (Head of Workforce Information and Planning)

Quality Assurance Committee	Members	Regular Attendees
	- Robert McFarland (Non-Executive Director, Chair) - Fergus Cass (Member of the Audit Committee) - Heather Lawrence - Trisha Bain (Chief Quality Officer) - Fenella Wrigley (Medical Director)	- John Jones (Audit Committee Chair) - Philippa Harding (Director of Corporate Governance) - Paul Woodrow (Director of Operations)
	(Jayne Mee to receive papers and provide comments ahead of meetings)	

Nominations and Remuneration Committee	Members	Regular Attendees
	- Heather Lawrence (Trust Chair, Chair) - Fergus Cass (Non-Executive Director) - Jessica Cecil (Associate Non-Executive Director) - Sheila Doyle (Non-Executive Director) - John Jones (Non-Executive Director) - Jayne Mee (Non-Executive Director) - Robert McFarland (Non-Executive Director) - Theo de Pencier (Non-Executive Director)	- Garrett Emmerson (Chief Executive Officer) - Philippa Harding (Director of Corporate Governance) - Patricia Grealish (Director of People and Organisational Development)

Charitable Funds Committee	Members	Regular Attendees
	- Fergus Cass (Non-Executive Director, Chair) - Lorraine Bewes (Director of Finance and Performance) - John Jones (Non-Executive Director)	- Philippa Harding (Director of Corporate Governance) - Michael John (Head of Financial Services) - Representation from LAS Communications team - Representation from the Voluntary Responders Group - Staff side representative

ANNEX D - Main principles of the UK corporate governance code

Leadership

- Every company should be headed by an effective board which is collectively responsible for the long-term success of the company.
- There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision.
- The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role.
- As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy.

Effectiveness

- The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively.
- There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board.
- All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively.
- All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge.
- The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties.
- The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.
- All directors should be submitted for re-election at regular intervals, subject to continued satisfactory performance.

Accountability

- The board should present a fair, balanced and understandable assessment of the company's position and prospects.
- The board is responsible for determining the nature and extent of the principal risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management and internal control systems.
- The board should establish formal and transparent arrangements for considering how they should apply the corporate reporting, risk management and internal control

principles and for maintaining an appropriate relationship with the company's auditors.

Remuneration

- Executive directors' remuneration should be designed to promote the long-term success of the company. Performance-related elements should be transparent, stretching and rigorously applied.
- There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.

Relations with shareholders

- There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place.
- The board should use general meetings to communicate with investors and to encourage their participation.



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	20			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information
Background / Purpose:				
This report provides the Board with an updated forward plan for Board meetings until the end of the 2018/19 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas. This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.				
Recommendation(s):				
The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2018/19 financial year.				
This report relates to the following Board Assurance Framework (BAF) or other risk:				
Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	☒			
Performance	☒			
Financial	☒			
Workforce	☒			
Governance and Well-led	☒			
Reputation	☒			
Other	☒			

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

Trust Board forward planner: 2017/18 + 2018/19

		20	2018/2019	
Area	Lead	April	May - Thursday 24 May 2018	
Standing items	HL		Welcome and apologies	
	All		Declarations of Interest	
	HL		Minutes of previous meeting	
	HL		Matters arising & action log	
	TB		Patient Story	
	HL		Report from the Chair	
	GE		Report from the CEO	
	All		STP Engagement Update	
Quality, Performance &	LB		Integrated Quality & Performance Report	
	JJ		Audit Committee Assurance Report	
	RM		Quality Assurance Committee Assurance Report	
	JM		People & OD Committee Assurance Report	
	FC		Finance & Investment Committee Assurance Report	
	TdP			
	PH		BAF & Corporate Risk Register	
	TB		Serious Incident Management	
	PW			
	PW			
Annual Reporting	LB, PH		Annual Report and Accounts (incl AGS)	
	PH		Self Certification of Compliance with Provider Licence	
	JJ		Audit Committee Annual Report	
	TB		Health & Safety Annual Report	
Strategy & Planning	GE			
	LB		Business and Financial Plan	
	TB			
	PG			
Governance	TB			
	PH		Report from the Trust Secretary	
	PH		Trust Board forward planner	
	PH			
	PH			
	PH		FTSUP Quarterly Report	
Concluding matters	HL		Questions from members of the public	
	HL		Any other business	
	All		Review of the meeting	
Additional reports	TB		Quality Report	
	TB			
	RF			
	PG			
			Infection Prevention and Control Annual Report	
			Safeguarding Annual Report	
			Mental Health Annual Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	June	July - Tuesday 31 July 2018	August
Standing items	HL All HL HL TB HL GE All		Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW		Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management Rest Break Policy implementation review	
Annual Reporting	LB, PH PH JJ TB			
Strategy & Planning	GE LB TB PG		Quarterly Strategy Update	
Governance	TB PH PH PH PH PH		Report from the Trust Secretary Trust Board forward planner	
Concluding matters	HL HL All		Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG		Quality Report Patitent Experience Annual Report Patient and Public Involvement Annual Report Public Education Annual Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	September - Tuesday 25 September 2018	October
Standing items	HL All HL HL TB HL GE All	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO STP Engagement Update	
Quality, Performance &	LB JJ RM JM FC TdP PH TB PW PW	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & OD Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management	
Annual Reporting	LB, PH PH JJ TB		
Strategy & Planning	GE LB TB PG	Quarterly Strategy Update	
Governance	TB PH PH PH PH PH	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report	
Concluding matters	HL HL All	Questions from members of the public Any other business Review of the meeting	
Additional reports	TB TB RF PG	Quality Report	

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	November - Tuesday 27 November 2018	December
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Staff Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
	All	STP Engagement Update	
Quality, Performance &	LB	Integrated Quality & Performance Report	
	JJ	Audit Committee Assurance Report	
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP	Logistics & Infrastructure Cttee Assurance Report	
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW		
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		
	LB	Business Plan progress review	
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH		
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	January - Tuesday 24 January 2019	February
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Patient Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
	All	STP Engagement Update	
Quality, Performance &	LB	Integrated Quality & Performance Report	
	JJ		
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP		
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW		
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE	Quarterly Strategy Update	
	LB		
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH	FTSUP Quarterly Report	
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		

Trust Board forward planner: 2017/18 + 2018/19

Area	Lead	March - Tuesday 26 March 2019
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Staff Story
	HL	Report from the Chair
	GE	Report from the CEO
	All	STP Engagement Update
Quality, Performance &	LB	Integrated Quality & Performance Report
	JJ	
	RM	Quality Assurance Committee Assurance Report
	JM	People & OD Committee Assurance Report
	FC	Finance & Investment Committee Assurance Report
	TdP	
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
	PW	
	PW	
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	Quarterly Strategy Update
	LB	
	TB	
	PG	
Governance	TB	
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	
	PH	
	PH	
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	



Report to:	Trust Board			
Date of meeting:	27 March 2018			
Report title:	Quality Report – March 2018			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer/Dr Fenella Wrigley, Medical Director			
Presented by:	Dr Patricia Bain, Chief Quality Officer/Dr Fenella Wrigley, Medical Director			
History:	Quality Assurance Committee 20 March 2018			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This paper provides the Board with the details of the current status of the quality performance and programmes in February 2018.

Recommendation(s):

The Board is asked to receive the report for information.

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

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

This report supports the achievement of the following Business Plan Workstreams:

Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒



London Ambulance Service

NHS Trust



Quality Report

March 2018

All data pertains to February 2018 performance
unless otherwise stated

All data is correct as at 10th of the month

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● Above Target
 Legend ● Within 5% of Target
● Over 5% from Target

Executive Summary: Exception Report (Positive)



Safety

- Compliance with 6 weekly deep clean schedule continues to meet 90%
- Quality assurance of 6 weekly deep clean has been completed for all 5 sectors in February; data analysed and fed back to ensure continuous improvement
- IPC Training met compliance in February for Level 1 & 2
- Aseptic technique video completed and uploaded to the Pulse to support operational staff and CTLs during OWR
- Reviews of IPC Datix incidents have resulted in changes in practice
- Quarterly IPC station audit tool has been transformed into an e-tool (Perfect Ward)
- Immunisation status of all clinical staff is currently being reviewed. To date 75% of staff records have been assessed by the Trust Occupational Health provider
- IM adrenaline administration – dose and/or route errors
- Map my maternity project – To develop overall contact information about maternity unit, and checking of correct pre-alert numbers – Work collaboratively with MiDos development team – ongoing

Actions & Assurance

- Examples of progress resulting from an analysis of incident reports include improved quality of investigation and reporting. It has also informed decision making when selecting various items of personal protective equipment.
- No further reported incidents following poster campaign and training via CSR e-learning package.
- Project to continue until complete coverage of units is available to EOC and front line staff.

Effectiveness

- Audit of maternity care commenced in February 2018 – To review the following:
 - Maternal care
 - Newborn care
 - Management of “Obstetric Emergencies”
 - Management of neonatal resuscitation

Actions & Assurance

- Outcomes of audit to influence
 - Ongoing Core Skills Refresher – Maternity component
 - Maternity Education Leads in local communication and delivery
 - Positive feedback to staff and areas for improvement

Caring

- Quality Alert s from other healthcare providers continue to rise
- Emergency Medical Dispatcher CM to be supporting potential applicants for the Practice Lead position to shadow her to gain insight into the maternity emergency pre hospital setting.
- “Whose Shoes” Maternity staff and stakeholder engagement event planned for May/June. Funded and will align to maternity pioneer service and Quality Improvement Objectives for Maternity Care

Actions & Assurance

- In order to manage these effectively a Business Case has been made for an increase in establishment
- Consultant Midwife to be invited to talk at Control Services Governance Meeting and discuss the role of the Practice Lead for Pre Hospital Maternity Care and delivery of maternity education to EOC and Chub clinicians.
- Project management team member Sarah-Joy liaising with the organisation to progress “Whose Shoes” project on.

Executive Summary: Exception Report (Improvement Required)



Safety

- Variable standards in IPC practice still being observed
- Training sessions currently provided by non-IPC specialist requires quality assurance content and delivery (similar to OFSTED)
- Encourage personal accountability and responsibility regarding adherence to IPC standards - introduce IPC discussions at One-Ones and PDRs, team meetings, OWRs to change practice and attitudes; benchmarking for stations
- Encourage regular competency checks (peer review), role modelling by key influencers e.g. mentors, senior staff
- Continue to improve integrated working, closer engagement with Estates, Fleet and Logistics, Procurement, Operations (ensure IPC is woven like a golden thread into processes to meet the quality and safety agenda)
- Total waste compliance oversight
- Completion of Risk actions associated with Tight-fitting Respirator masks
- FFP3 fit testing/recording
- Health Care Professional Line – Request for Community Midwives (at homebirth or stand alone birth centre) response times present a safety challenge for those requests where “foetal distress” is present

Actions & Assurance

- As REAP returns to normal operating levels and Clinical Team Leaders return to their normal duties there will be additional focus and support to ensure an increase in hand hygiene compliance.
- Escalate through the Patient Safety Group and Director of Operations and Medical Director
- Paper to be formulated detailing the existing response categories and potential impact upon women / newborn care and safety.

Effectiveness

Caring

- Case management has been affected by the recent escalation to REAP 3, an increase in SURGE and recent poor weather as all clinical managers have been deployed to support frontline operations.

Actions & Assurance

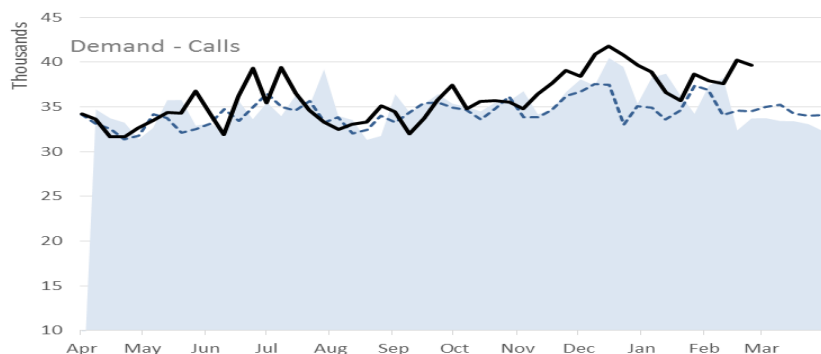
Actions & Assurance

- As demand normalises and managers return to their usual roles it is expected that delays to the Trust management of complaints and enquiries will reflect aspirational timeframes.

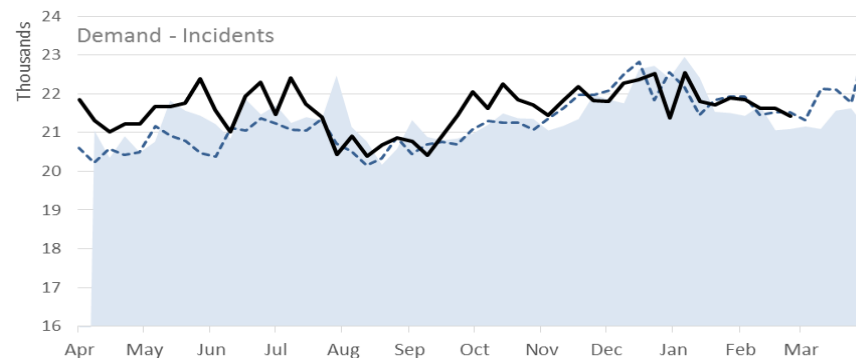
Performance Pressure



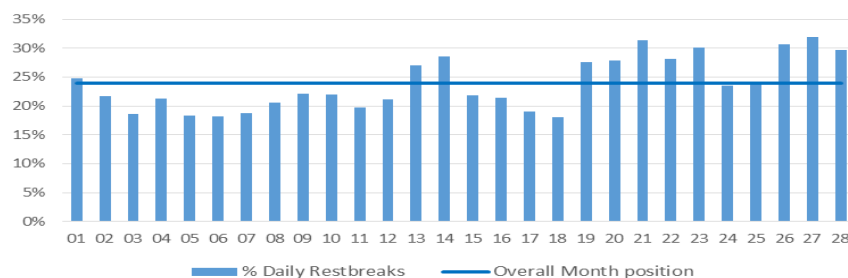
Pressures



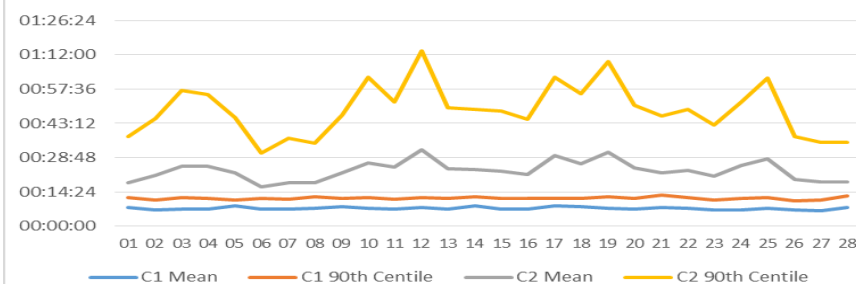
Performance



% of RestBreaks Given



Daily February Performance



- In February, demand for 999 activity began to decrease in line with forecasting following the period of winter pressure that had a significant impact across all areas of the healthcare system this year
- The winter weekly bulletin was continued in the first few weeks of February in order to maintain focus on issues specifically around hospital handovers and the 'Fit to Sit' initiative
- Following a meeting with commissioners in February, the Medical Director undertook a clinical safety review of activity over the winter period. The report included detailed information on the different ways the Trust maintained oversight of calls including monitoring long waits both in the community and at hospitals and the actions taken to mitigate the risk to patients

Patient Safety

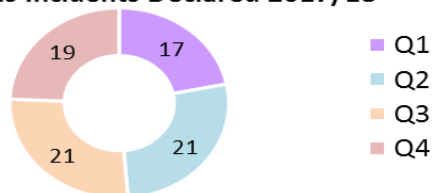
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



Measures	Target/ Range	RA G	YTD 17/18	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	R	83%	59.5%	85.0%	78.4%	↓			LQ18	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	G	2.9	3.0	2.3	2.5	↑					
Patient related Adverse Events - NO HARM	1200	G	2299	188	173	161	↓					
Patient related Adverse Events - LOW	500	G	272	36	25	27	↑					
Patient related Adverse Events - MODERATE		G	188	29	8	11	↑					
Patient related Adverse Events - SEVERE			74	12	6	2	↓					
Patient related Adverse Events - DEATH			129	26	9	16	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.3	2.9	3.3	2.7	↓					
Staff related Adverse Events - NONE			1945	170	195	127	↓					
Staff related Adverse Events - LOW			1403	106	125	102	↓					
Staff related Adverse Events - MODERATE			74	10	4	7	↑					
Staff related Adverse Events - SEVERE			3	0	1	1	↔					
Controlled Drugs - Other Reportable Incidents			347	31	49	43	↓					
Controlled Drugs - Unaccountable Losses (UN Reportable)	0	G	3	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	93%	92%	92%	95%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Potential Serious Incidents referred to SI Group			357	39	46	26	↓					
Serious Incidents declared in-month			68	5	8	7	↓					
Serious Incidents breaching 60 days	0	G	24	0	0	0	↔					
Serious Incidents breaching 40 days	0	G	27	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			5%	5.5%	9.0%	6.0%	↓					
Needle Stick Injuries as % of Staff Adverse Events			2%	2.4%	1.5%	2.1%	↑					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Total Prevent Future Deaths In-Month	0	G	3	0	0	0	↔			LQ25	✓	
Safeguarding Adults & Children Level 1 (3 Years)	90%	G	76%	92.1%	93.5%	94.3%	↑					
Safeguarding Adults & Children Level 2 - Clinical (1 Year)	90%	G	79%	83.8%	88.0%	91.1%	↑					
Safeguarding Adults & Children Level 2 - EOC (1 Year)			58%	42.0%	57.6%	63.9%	↑					
Safeguarding Adults & Children Level 3 (3 Years)	90%	R	78%	78.4%	76.9%	88.5%	↑					
Safeguarding Trust Board (3 Years)	90%	G	100%	100.0%	100.0%	94.4%	↓					
Total Inquests where LAS asked to give evidence - In-Month			62	4	3	6	↑					
Total Inquests where LAS asked to give evidence - Year to Date			386	53	56	62	↑					
Missing Equipment Incidents as % of all reported incidents			3%	4%	2%	3%	↑					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	9%	8%	10%	↑					
Number of NRLS uploads In-Month	1	G	11	1	1	1	↔			LQ21		

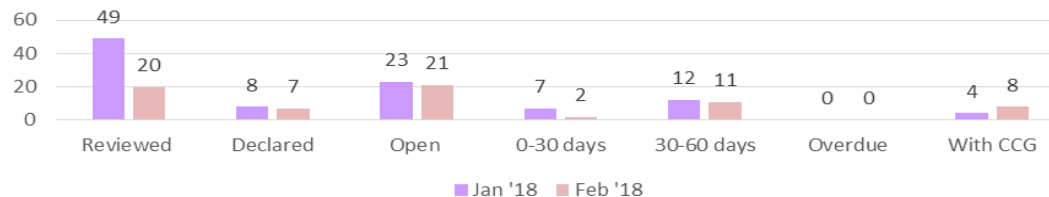


Total Serious Incidents Declared 2017/18



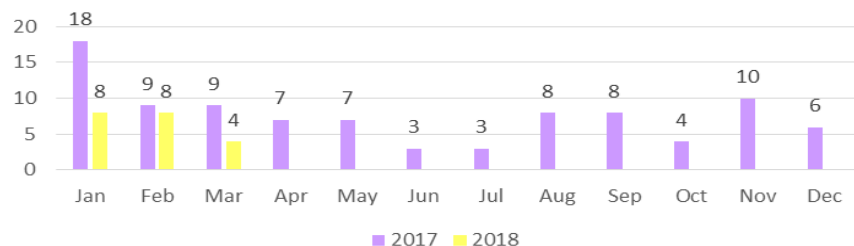
78 serious incidents have been reported during 2017/18 (by 12.03.2018). This is a reduction of 17 to date however this is expected to change by the end of March 2018.

SI Activity

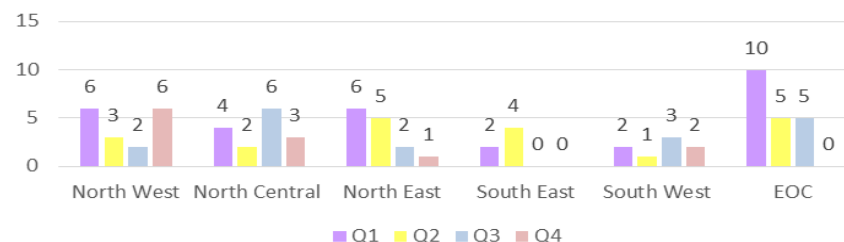


A total of 20 incidents were reviewed by SIG in February of which 7 were declared as SIs. 8 investigations have been submitted to the CCG and are awaiting closure or comments. The Trust is maintaining its contractual obligations with the CCG and currently there are no investigations that have breached the 60 working day deadline.

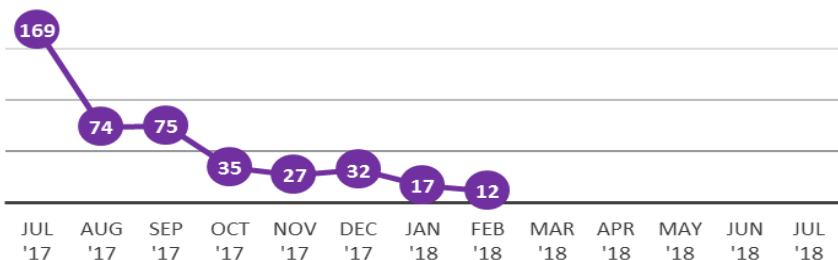
Serious Incidents Declared by Month



Serious Incidents by Sector STP



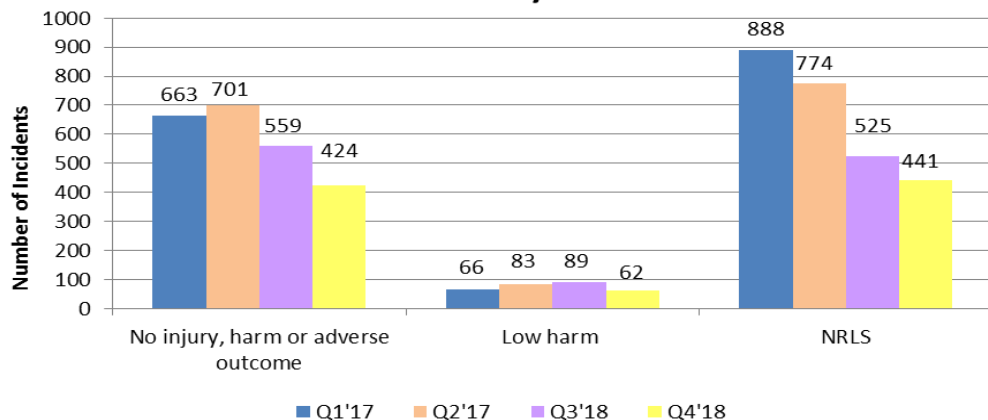
Overdue Actions at Month End 2017/18



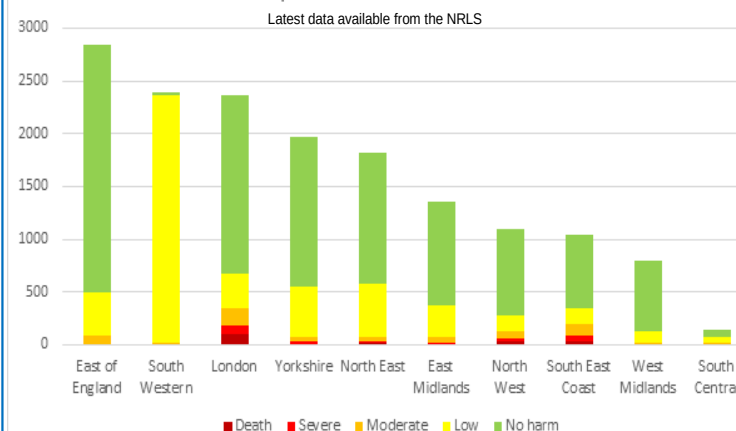
- The number of SIs declared in February 2018 is comparable to that of February 2017.
- There is evidence of a decrease in SIs across the North West, South West and South East sectors and a slight increase in the number of SIs declared in EOC and the North Central sectors.
- Of note there has been a clinical audit conducted in the North Central and North West sectors during February 2018 which has resulted in an increase number of potential incidents being referred to the SIG.
- Following the identification of a significant number of outstanding actions from closed SU investigations in July 2017, there has been a noteworthy decrease in the number of overdue actions that have breached the assigned deadline.
- Whilst there are currently 12 actions that are in progress the Quality, Governance and Assurance Team maintain contact with the accountable manager on a weekly basis.
- The majority of actions that are overdue are in progress and delayed due to operational demand, adverse weather, staff absence and shift patterns which are preventing the manager from arranging feedback, training etc.



Incidents by Result



Incidents Reported to the NRLS Jan to Jan 2018



The Trust has set an annual target for the reporting of incidents that have been graded as either no harm or low harm. To date the target of 1200 no harm incidents has been exceeded for 2017/18 and the target of 500 low harm incidents in on track to be achieved by the end of 2017/18.

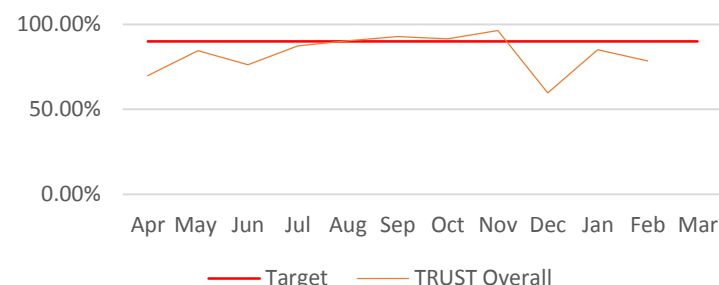
Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Q3		Q4			
						Nov	Dec	Jan	Feb		
21	Operational Risk	There is a risk that the Trust does not learn from previous serious incidents and therefore does not prevent or mitigate against similar incidents from occurring in the future.	Mike Ward	Trisha Bain	12	12	9	9	9	6	Approval required for additional work flows to cover key findings and recommendations from thematic reviews. Recent KMPG audit demonstrated significant assurance of learning from SIs.
18	Operational Risk	There is a risk that declared serious incidents are not investigated thoroughly and within the required timeframe of 60 working days.	Mike Ward	Trisha Bain	12	6	6	6	6	6	Risk closed. No SI CCG breaches since Nov 2017. Recent KMPG audit demonstrated significant assurance of learning from SIs.
14	Operational Risk	There is a risk that the Quality, Governance and Assurance Team do not receive evidence of completion of actions that arise from SIs.	Mike Ward	Trisha Bain	10	4	4	4	4	4	Risk closed. Action compliance continues to be monitored weekly by the Quality, Governance and Assurance Team and reported to Trust board monthly. Recent KMPG audit demonstrated significant assurance of learning from SIs.
673	Operational Risk	There is a risk that there will be a delay in identifying incidents that meet the SI criteria and therefore a delay in immediate risk mitigations as a result of incorrect grading or internal audit delays.	Mike Ward	Trisha Bain	9	6	6	6	6	3	There is a delay in local management reviewing incidents and ensuring the grading is correct. This is currently being mitigated by the Quality, Governance and Assurance Team undertaking daily incidents reviews whilst further training is provided to local managers.



Monthly Hand Hygiene Compliance 2017 – 2018 (Trust Compliance target: 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
TRUST Overall	69.84%	84.54%	76.24%	87.20%	90.22%	92.78%	91.44%	96.33%	59.53%	84.97%	78.42%
North East	97.40%	90.60%	60.90%	57.00%	95.30%	100.00%	67.00%	95.66%	66.66%	93.33%	100.00%
North Central	100.00%	100.00%	48.90%	89.00%	100.00%	100.00%	96.70%	95.60%	83.33%	66.66%	93.00%
North West	56.00%	73.80%	92.00%	95.00%	100.00%	76.40%	97.50%	93.40%	56.00%	68.20%	89.00%
South East	33.30%	95.80%	95.80%	95.00%	62.00%	100.00%	96.00%	100.00%	66.66%	96.66%	82.00%
South West	62.50%	62.50%	83.60%	100.00%	93.80%	87.50%	100.00%	97.00%	25.00%	100.00%	93.00%

YTD Overall Hand Hygiene Compliance 2017-2018



Performance:

- 16/18 station groups submitted Operational Workplace Reviews this month from which the Hand Hygiene data is extracted and the aggregated data (for all 18 stations) were analysed; those stations which have not submitted being allocated a score of 0%
- 10/18 group stations who submitted hand hygiene data exceeded the 90% target - achieved 100% compliance
- The overall results of the aggregated data for 18 stations were impacted by 2 stations which did not submit their audits and by the low scores of the 6 other stations
- As a result, the Trust wide-compliance in February was 78.42%, missing the target of 90% set for the third month

Assurance:

- Despite Operational challenges 16/18 station submitted their OWR data; the IPC team continue to support local station staff
- QGAMs continue to have oversight and a focus on the quality of services
- Submissions and compliance rates of the numbers of audits streams in OWR is monitored by the IPC team with prompt feedback provided to sectors and stations management
- IPC Hand Hygiene practical session was re-introduced to the non-clinical Induction Day (using UV light) from January 2018, to ensure that ALL new employees in LAS understands the importance of hand hygiene and are able to hand wash with soap and water and use hand gel correctly; personal bottles of hand gels provided
- Funding for UV lights and disclosing cream for all Group Station IPC Champions have been agreed and this will form part of the Annual Action plan for 2018/19
- The IPC team is engaging with crews at all A&Es in March/April to re-iterate the importance of hand hygiene and ensure that all frontline staff have their personal supply of alcohol hand gel to facilitate safe practice.

Safety (Infection Control)

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



Monthly IPC Training Compliance 2017 -2018 (Trust Compliance target: 90%)

TRUST Overall	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Level 1 *	87.80%	88.18%	87.96%	88.50%	91.56%	91.88%	91.31%	92.53%	93.13%	92.80%	93.45%
Level 2 *	87%	84.92%	82.30%	78.28%	78.15%	79.73%	77.41%	83.05%	84.90%	87.7%	91.19%
Level 1											
(No: trained)	4471/5093	4491/5093	4493/5108	4510/5096	4634/5061	4707/5123	4719/5168	4791/5178	4812/5167	4821/5192	4296/5271
Level 2											
(No: trained)	3383/3887	3288/3872	3200/3888	3039/3882	3018/3862	3128/3923	3081/3980	3302/3976	3335/3928	3421/3898	3600/3948

Actions

Performance:

- IPC training compliance has achieved the Trust target this month;
 - Level 1 training has met 90% target since August 2017
 - Level 2 for patient facing staff achieved 91.19%
- IPC and practical Hand Hygiene training session was re-introduced to the Corporate Induction day in January 2018.

Assurance

- IPC training figures for Level 1 and Level 2 IPC training continues to be monitored via ESR; the system allows easy access to robust data in a timely way.
- Training compliance is monitored on a monthly basis via a Monthly Performance Scorecard by the IPC team
- Performance is shared at Sector Quality meetings and IPC Champions meetings, Quality Report
- Monitored quarterly at the operational Infection Control and Decontamination Group (ICDG) and assurance provided to the Infection Prevention and Control Committee (IPCC), and onwards to the QOG, and QAC and Executive Team as well as Commissioners

Safety (Infection Control)

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



Six weekly deep clean compliance 2017 – 2018 (Compliance Target 90%)

	Apr	May	Jun	Jul	Aug*	Sep	Oct	Nov	Dec	Jan	Feb
TRUST Overall	97%	97%	94.80%	94.30%	96.80%	95.72%	93%	95%	95%	93%	91.00%
North East	95%	95%	97.80%	96.20%	96%	97.00%	98%	98%	98%	98%	97%
North Central	99%	99%	82.50%	91.20%	97%	97%	97%	90%	97%	91%	97%
North West	99%	99%	98%	98%	98%	96.00%	96%	93%	96%	98%	98%
South East	99%	98%	98.30%	95.50%	97%	98.00%	98%	96%	97%	93%	99%
South West	97%	97%	94%	94%	96%	98.00%	99%	97%	95%	95%	96%
Others							95%	95%		100%	91%
HART							65%	81%	89%	80%	65%
NETS	93%	93%	98.30%	91%		88.33%	96%	95%	83%	87%	85%

Quality assurance of Deep clean process – ATP swab of surfaces

	May-17	Jul-17	Sep-17	Nov-17	Feb-18
Total Pass:	61	62	48	92	47
Total Monitor:	11	16	9	4	2
Total Fails:	18	7	3	4	1
Total Swabs:	90	85	60	100	50
% Pass:	68%	73%	80%	92%	94%
% Monitor:	12%	19%	15%	4%	4%
% Fail:	20%	8%	5%	4%	2%

Performance

- Vehicle 6 weekly deep clean compliance continues to exceed 90% except HART and NETs due to availability of vehicles to clean.
- All 14 Hubs are operational and Phase 2 continues with cars
- ATP swabbing of equipment and environment undertaken by Logistics Manager to provide assurance of the quality of deep clean
 - All 5 Sectors have been completed for 2017/18
 - Data has been analysed and feedback provided to Logistics Contract Manager and Contractor for improvement monitoring

Assurance

- Contract Management by Logistics Manager
- Quality assurance continues with ATP swabbing continues by LAS
- Contractor undertakes their own quality assurance swabbing
- Monthly and Quarterly data submission for monitoring by the IPC team, Sector Quality Meetings, ICDG, IPCC

Safety (Infection Control)

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



Premises cleaning 2017 -2018 (Compliance Target 90%)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
TRUST Overall	96%	96.58%	96.70%	98.20%	78.65%	84.25%	98.15%	87.67%	88.00%	78%	64.64%
North East	92%	93%	95%	96%	97.30%	64.30%	96.60%	63.66%	63%	60%	62.60%
North Central	99%	99%	96%	100%	66.70%	66.70%	100%	100%	100%	100%	66.67%
North West	96%	95.40%	97%	98%	98%	94%	98%	77.80%	77.40%	57%	77.60%
South East	97%	97%	97%	98%	33%	98%	97.66%	97.66%	98.85%	99%	66.33%
South West	96%	98.50%	98.50%	99%	98.25%	98.25%	98.50%	99.25%	98.50%	73%	50%

Performance

The results for the 18 stations were impacted by 6 stations which did not submit their completed audits;

- the overall compliance score for February for all 18 station groups was 64.64%
- 12/18 (67%) stations submitted their audit data this month, a 10% decrease in submissions from last month due to operational challenges (REAP3), resulting in poor overall compliance %, as stations who do not submit are scored '0%'.
- Of those 12 station groups audits received, the overall compliance was high at 97.9% (an increase from last month's result of 96.8%)
- 23 Contractor audits were received (which included individual stations and training schools) this month, which enabled triangulation
 - of these 23 audits the compliance was 96.5%; which has provided a level of assurance
- No Estates validation audit data was available for the second month.

Assurance

- QGAMs and GSM to monitor and ensure submissions of audit data
- Increased IPC capacity enabled progress of validation audits and support to station management and staff, IPC Champions, Estates team to enhance the standards in the environment including clinical waste management
 - The quarterly IPC validations audits February/March have not identified any sustained or serious breaches
- Cleanliness standards are monitored monthly by IPC team, who also attend Contract meetings with the Contractors
- Monitored at quarterly Sector, ICDG, IPCC



Sharps and BFE incidents YTD

H&S Incidents by Sub-category	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Total
Exposure to bodily fluids	44	45	32	16	137
Incident involving broken ampoule or vial	11	11	15	2	39
Needle stick injury - Cannula (contaminated)	11	10	15	3	39
Razor injury (clean)	7	4	5	3	19
Bit by a person	4	3	9	2	18
Needle stick injury - IM (contaminated)	3	1	6	3	13
Needle stick injury - IM (clean)	0	3	2	1	6
Needle stick injury - sub-cutaneous (contaminated)	2	0	1	3	6
Lancets injury (contaminated)	3	0	0	1	4
Needle stick injury - Cannula (clean)	0	1	2	0	3
Contact with sharps (includes needle stick)	0	1	2	1	4
Razor injury (contaminated)	1	0	0	2	3
Lancets injury (clean)	1	0	0	1	2
Needle stick injury - sub-cutaneous (clean)	0	0	0	0	0
Total	87	79	89	38	293

Performance

Performance:

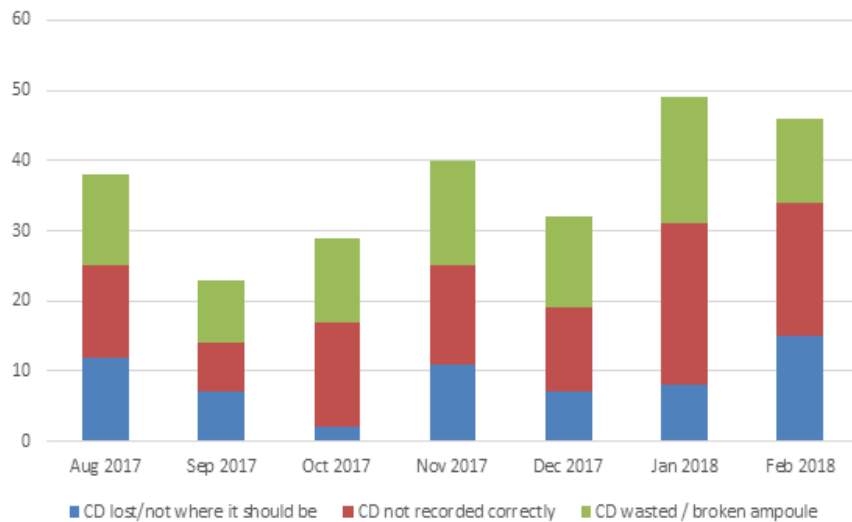
- Overall YTD total incidents 293
- Of these 137/293 (47%) were due to Body fluid exposure (BFE)
- Q4 BFE data is highlighting a decrease in numbers compared to the previous 3 Quarters
- 10 BFE incidents were reported in February; 3/10 did not wear PPE
- Of concern requiring action
 - 1 assault misclassified as a Bite
 - 1 cannulation in a moving vehicle
 - 1 breaking of a razor before disposal
 - 1 inappropriate use of alcohol hand gel to clean hands following contamination with diarrhea
 - 1 delay in OHS follow-up after BFE exposure to high risk patient

Assurance

- All Datix incidents are reviewed by the Head of Infection Prevention and Control and feedback provided
- Lessons from analyses are shared and training content amended (Evidence Bulletins/Training packages)
- Collaborative working with Health and Safety team
- Investigations are being initiated for lessons



Controlled Drugs Incidents by Month



Actions

- Alternative preparation of hydrocortisone sourced and information bulletin issued
- Reduction in quantity of diazepam 2.5mg PR packed into paramedic drugs packs and information bulletin issued.
- Ampoule trays sourced to reduce incidence of broken ampoules during withdrawal of morphine from CD safes
- Proposal evaluated for KitPrep app to incorporate warning message to prompt staff to return all drugs including morphine
- TED drugs bag procedures to be extended to incorporate LSU deliveries in tandem with secure drugs rooms programme

Medicines Management Incidents

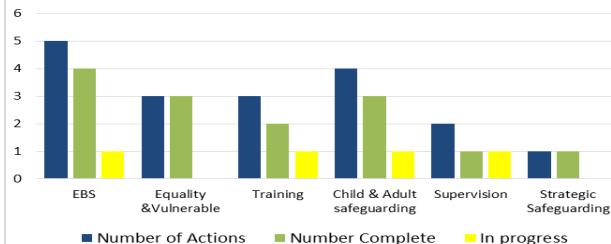
- One unaccounted for loss of 2x morphine ampoules from CD safe
- Total of 42 other controlled drugs incidents
 - Documentation errors (n=18)
 - Breakages (n=13)
 - Morphine retained off-duty (n=7)
 - CD in wrong location – morphine (n=2) & diazepam (n=2)
 - Stolen APP bag returned with CD ampoules intact (n=1)
 - Concerns reported re packaging of morphine for transfer (n=1)
 - Shortage of diazepam 2.5mg PR & hydrocortisone 100mg
- Non-controlled drugs incidents
 - Drug usage forms not completed on arrival at LSU (n=12)
 - Medical gases in wrong location (n=3) or inadequate stock (n=3)
 - Drug cabinets open (n=2) or access codes visible (n=1)
 - Failure of Perfect Ward (n=1) & KitPrep apps (n=1)
 - Delay in drug delivery (n=1), missing key (n=1), breakage (n=1)
 - Drugs contraindicated (n=5) or excessive dose (n=3)
 - Non LAS pharmacy issue (n=1) & air in giving set (n=1)

Assurance

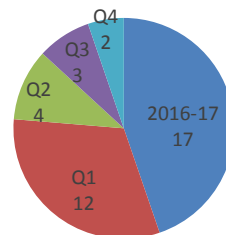
- No further incidents involving use of IM adrenaline
- Rapid identification and timely return of all morphine retained off-duty
- Reduction in number of instances where access codes visible



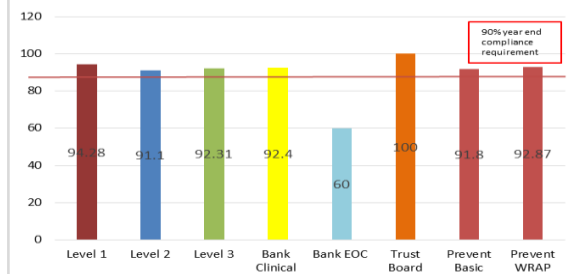
Work Plan 2017-18



Safeguarding Allegations Against Staff 2017-18

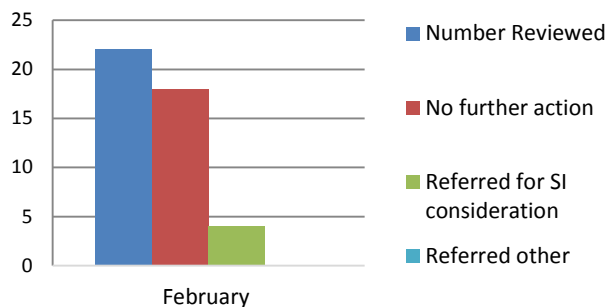


Safeguarding Training February

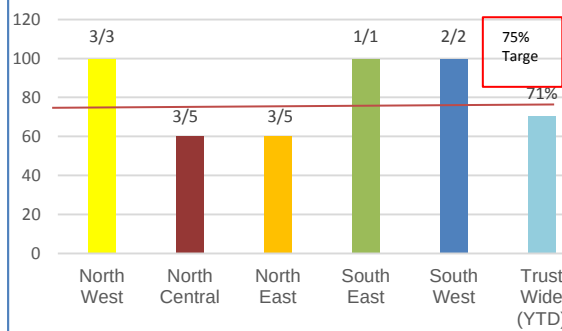


Work Plan: Supervision Policy Not on track EBS 24/7 telephone referrals and taped line. **Safeguarding Allegations Against Staff :** 2 new allegation in Feb. **Safeguarding Training** Trust wide on target to meet contracted target of 90% overall. EOC is not on target with 63.39% and EOC Bank 60% and are challenged due to resource pressures . NETS 66.43% with plan to improve. 111 79.55%

Child Death- Q4



Local Partnership Working % RRM Attended



Trust safeguarding referrals and concerns raised

Month	Adults Safeguarding	Adults Welfare	Child	Total Referrals	% incidents
Apr-17	406	595	715	1716	1.90%
May-17	366	680	753	1799	1.90%
Jun-17	385	708	787	1880	2.00%
Jul-17	379	656	735	1770	1.90%
Aug-17	366	666	622	1654	1.80%
Sep-17	369	623	667	1659	1.80%
Oct-17	421	666	732	1819	1.90%
Nov-17	420	671	692	1783	1.90%
Dec-17	464	767	674	1905	1.95%
Jan - 18	397	743	672	1812	1.90%
Feb-18	412	668	602	1682	1.95%

Child Death: 91% were processed within 3 weeks of receiving. : **Local Partnership Working** % RTM Attended North Central continues to be unable to meet the requirement to attend 75% of RRM's discussions ongoing with Area managers. Escalated to Director of Operations following Jan performance review. **Trust Safeguarding Referrals & Concerns Raised:** Referrals remain within expected levels .

Safeguarding Risk Tracker		Initial Risk Rating	Current Risk Rating						Target Risk Rating	Key Changes/Updates since last review
			Q2			Q3				
69	Compliant with safeguarding training requirements for clinical and non-clinical staff.	12	12	12	12	8	8	8	4	Trust has now moved to ESR for recording all training. Agreed to reduce risk but to keep open as ESR still not 100% reliable with names etc. at present.
Current risks held by other areas of the Trust. EBS – resourcing to enable move to 24/7 telephone referrals system and removal of fax machines. EBS- Fall back business continuity EBS- Delay installation of taped line for governance and assurance P&OD- Managers and clinical staff patient facing without current DBS (reduced to 1 staff member)										

Effectiveness (Clinical Measures)

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



Measures	Target / Range	RAG	YTD 17/18	Nov-17	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	36%	32%	33%		↑			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	62%	57%	55%		↓			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%					↑			LQ2b		
STEMI care bundle (AQI)	74%	R	70%	73%	72%	73%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	59%	50%	54%		↑			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	97%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:31	00:31	00:32		↑					
Survival to Discharge (AQI)			10%					↑					
Survival to Discharge UTSTEIN (AQI)			38%					↑					
STEMI- On scene duration (CARU continual audit)				00:36	00:40	00:40		↓					
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	94%	92%			↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	14.4%	16.8%			↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97.0%	98.0%			↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%			↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	92.0%	93.0%			↑		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97.0%	97.0%			↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%			↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%				↑			LQ12		
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.1)	85%	G	89%	87%	92%	86%	86%	↑			LQ11	✓	
Cumulative Percentage of Clinical staff completing Core Clinical Skills Refresher Training (2017.2)						49%	67%	↑			LQ11	✓	

Actions

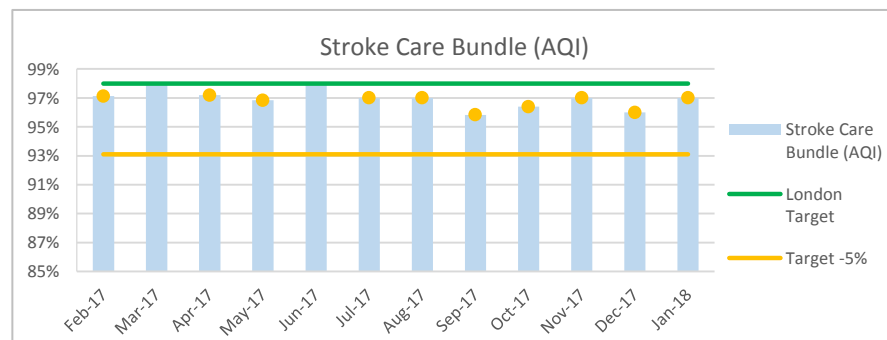
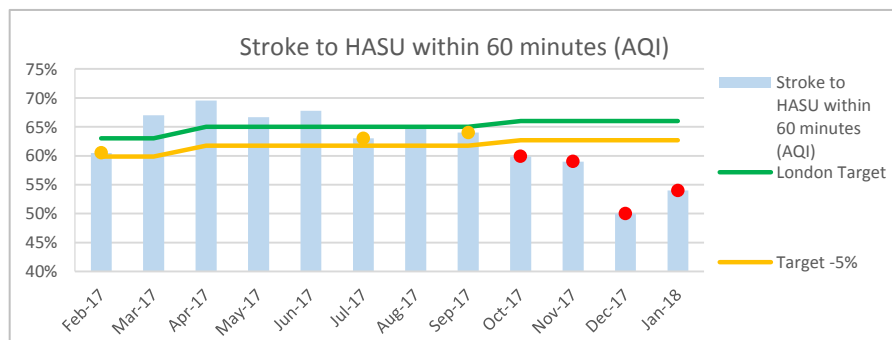
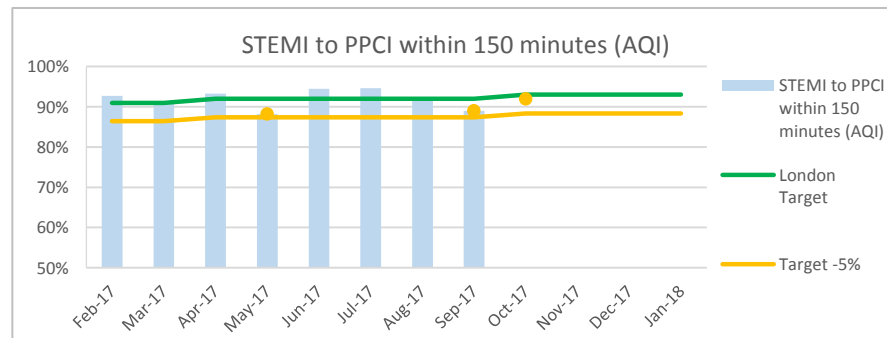
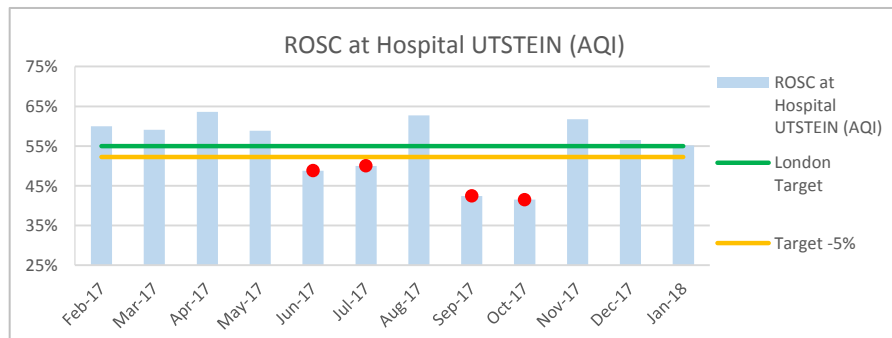
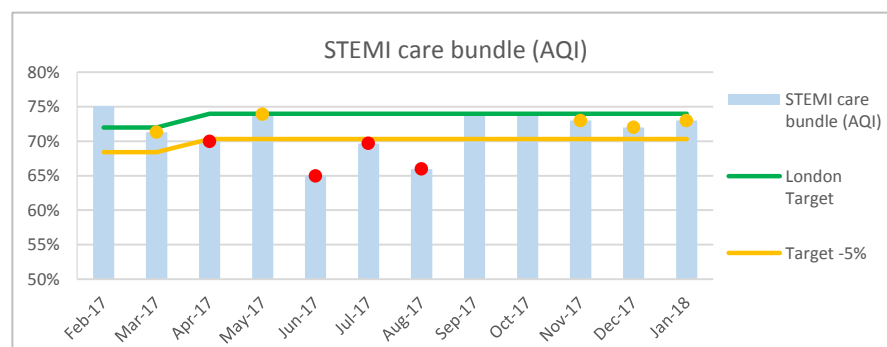
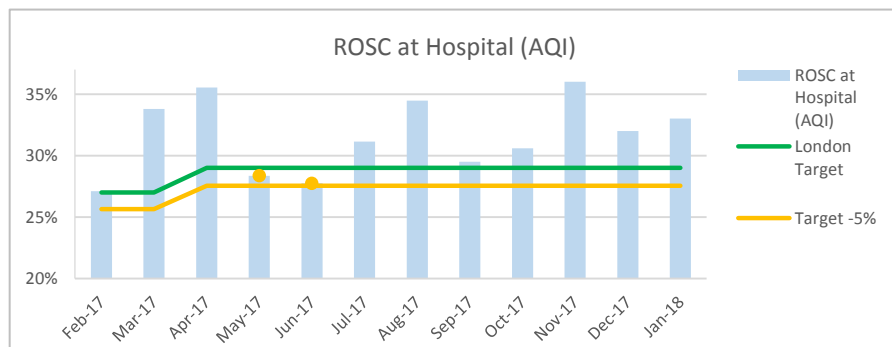
- In January, CARU trained six members of staff on restricted duties, three mentors and one Team Coordinator
- February's Journal Club was attended by 28 members of staff who critically appraised a paper looking at how paramedics perceive the care provided to patients who self-harm

Assurance

- In January, care delivered to patients discharged at scene, in cardiac arrest or presenting with severe sepsis remained of a good standard across the LAS, along with the general standard of documentation
- Care provided to patients experiencing a glycaemic emergency was of the highest standard since May 2017
- Care provided to patients with a diagnosed psychiatric problem remained at 93% for the second month in a row
- The LAS considered safeguarding concerns for the most patients since June 2017

Effectiveness (Clinical AQIs)

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



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

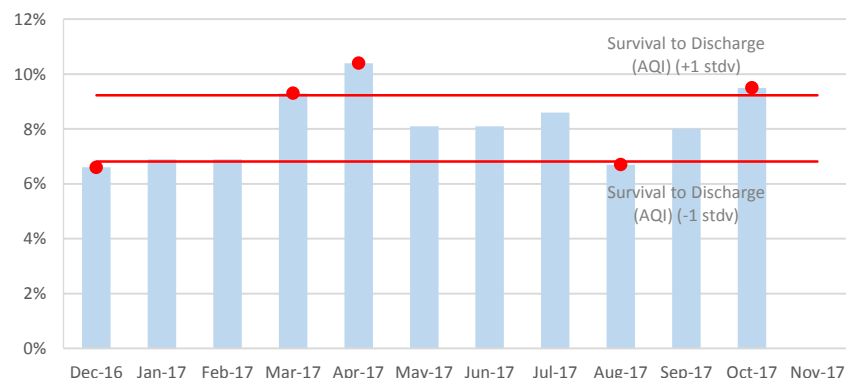
Care | Clinical Excellence | Commitment

Effectiveness (Clinical AQIs)

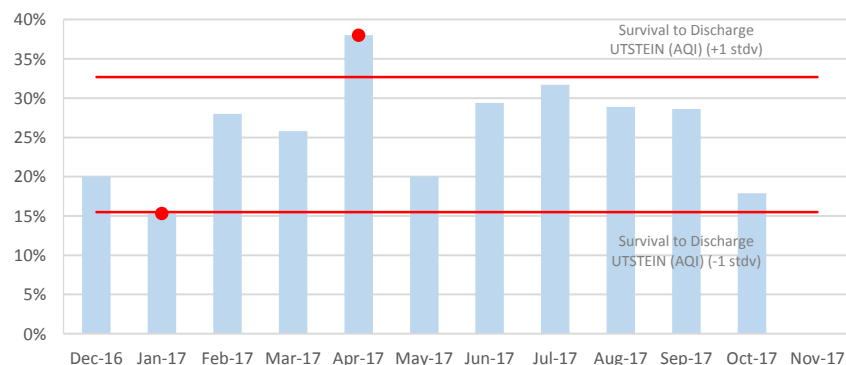
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



Survival to Discharge (AQI)



Survival to Discharge UTSTEIN (AQI)



AQI: Narrative

- In January, call to scene times for STEMI patients decreased overall by 7 minutes (from 26 minutes in December 2017 to 19 minutes). On scene times remained the same as December (at 40 minutes).
- In January, call to scene times for stroke patients decreased overall by 3 minutes (from 28 minutes in December 2017 to 25 minutes). On scene times increased by 1 minute (from 31 minutes in December 2017 to 32 minutes).
- The average call to scene time for patients identified in cardiac arrest at call taking was 7 minutes.
- STEMI care bundle completion overall has increased by 1% with a 12% increase seen in the North West. However, a decrease of 18% was seen by North Central, with analgesia being the main component not completed
- Cardiac arrest patient numbers decreased by 4% in January, following the big increase we saw in December
- ROSC and Survival to discharge figures remained consistent with previous months
- Provision of the Stroke care bundle remains high at 97% and the slightly lower on scene time continued for the third month in a row
- The percentage of patients for whom we achieved Call to HASU within 60 minutes continues to fluctuate at a lower rate than we have seen for a couple of years

AQI: Actions

- CARU are designing an infographic detailing the requirements of the STEMI care bundle which will be sent to all ambulance stations and shared on the Listening into Action LAS staff facebook page
- We are also working on process to allow us to feedback the details of incomplete STEMI care bundle to QGAMS.



Clinical Audit: Latest project summary

In February CARU published our clinical audit examining the use of dexamethasone for croup in the LAS. The results showed:

- Before the administration of dexamethasone, all patients had their respiratory rate measured, and the majority had their oxygen saturations recorded (82%) and chest auscultated (77%)
- All dexamethasone administrations were considered appropriate when compared with the NICE guidance, however where NICE includes mild croup as an indication for dexamethasone, JRCALC does not. Only 47% of PRFs had a documented indication in accordance with JRCALC. In addition, five seven year olds were administered dexamethasone
- Dexamethasone was administered orally to all patients and most were given the correct dose (98%). All patients who required hospital, and the parents agreed, were conveyed

Recommended actions to improve patient care:

- CARU will share the findings of this clinical audit with the JRCALC Guideline Developers and Contributors and ask for clarity regarding whether mild croup should be an indication for dexamethasone (as per NICE guidance)
- CARU will also write a Clinical Update article and produce an infographic to share the key findings and emphasise the indications for dexamethasone

Clinical Audit: Progress

Good progress continues to be made against the clinical audit work plan, with two clinical audit reports due to be published in March:

- Assessment and transport decisions of patients with major head injuries
- Continuous Re-contact (2015-17) which examined original discharge decisions made for patients who re-contacted 999

We are working on a further eight projects and facilitating five members of staff to undertake their own clinical audit projects.

Research Actions & Outcomes

- **ARREST** (a randomised trial controlled trial that aims to determine the best post-resuscitation care pathway for patients without ST-elevation on their ECG) is running with clinicians from Westminster, and Waterloo stations as well as critical care APPs. Eight patients have been recruited so far.
- **RIGHT-2** (a randomised trial controlled investigating the potential benefit of GTN administration in stroke): 183 patients have been recruited (exceeding our contractual target of 180 patients). We are beginning close-down procedures for this trial.

Actions & Assurance

Two clinical audit actions were completed in January:

- An 'analgesia use' infographic was designed and shared on the Listening into Action LAS staff Facebook page
- The infographic was also printed and sent to all ambulance stations and shared

As a result of our Continuous Re-contact Clinical Audit, in February:

- 34 crews were recommended for feedback (13 positive & 21 constructive)
- Two re-contacts were flagged on Datix. Following review by SIG, they were not deemed to be SIs, with one being flagged to the MPS as it may be of interest to the IPCC.



Measures	Target / Range	RAG	YTD 17/18	Dec-17	Jan-18	Feb-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Friends and Family Test Recommending LAS as % of total responses	94%	R	93%	100%	100%	0%	↓			LQ27	
Friends and Family Test Response Rate			1.8	0.0	0.0	0.0	↔			LQ28	
Complaints Acknowledged within 3 working days	100%	G	100%	100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R	151	24	14	21	↑			LQ29b	
Rate of Complaints per 1,000 Incidents			0.8	0.9	0.8	1.2	↑			LQ29c	
Positive Feedback Compliments			1037	80	74	125	↑			LQ29e	
Mental Health related calls as percentage of all calls			8%	6.6%	7.2%	7.0%	↓				
Mental Health related MPS calls as percentage of all calls			2%	1.7%	1.9%	1.7%	↓				
Mental Health related Incidents as percentage of all calls			5%	3.7%	4.4%	5.7%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.2%	0.3%	0.4%	↑				
Rate of Frequent Callers per 1,000 Calls			3.22	3.2	3.6	3.8	↑				
CMC records viewed			3622	1458	307	303	↓			LQ30	

Assurance

We continue to work closely with the users by experience patient group from Oxleas MH Trust. We are currently co-producing guidance and support for call handlers in relation to remaining on the line with patients expressing suicidal ideation. A group of lived experience practitioners are attending HQ on two dates in April to meet with call takers.

Mental capacity assessments continues to be a theme where staff have asked for additional support and guidance. An LA5 (Mental Capacity Act Form)

First task and finish group held on 06/03 with follow up meeting booked for 27/03. A survey has been circulated on LiA Facebook page to gain staff feedback – has had over 120 responses.

Frequent Callers

Owner: Briony Sloper| Exec Lead: Trisha Bain



The national definition of a frequent caller is anyone aged 18+ years who:

- *Calls 5+ times in one month from a private dwelling; or*
- *Calls 12+ times over a three month period from a private dwelling*

Frequent Caller Team (FCaT) updates:

- Last month the Frequent Caller Management Database (FCMD) identified **589** new & existing frequent callers meeting the national definition. 99% of patients (i.e. 587) were matched with their NHS number.
- The Frequent Caller Team (FCaT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behaviour, call rates, and formulate multi-agency strategies to reduce calls to LAS.
- New projects have begun trialling best practice, including the SIM (Serenity Integrated Mentoring) model in 4 London boroughs – a joint initiative between Mental Health teams and Metropolitan Police.
- Frequent callers who have died in recent months had presenting complaints including complex co-morbidity health issues, chronic alcohol dependence, and those refusing additional homecare support or detox services but who were deemed to have capacity to make such a decision. Ages ranged from 43 yrs to 82 yrs. Cold weather is an additional risk factor e.g. older or disabled patients who struggle to fund both fuel & food on a limited income; patients self-funding their own homecare can have increasing anxieties about accepting more support as they may view this as an extra financial burden. FCaT does not have a method of reliably reporting on or reviewing Frequent Caller deaths internally or with external partners.

Frequent Caller Team (FCaT) challenges:

- Insufficient staffing within the team to manage demand – a business case has been submitted, recommending additional staff.
- A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and Emergency Department plans.

Case study – Typical complex frequent callers :

- i) 73 year old female patient living alone in social housing. No family living locally, so a care package was provided by social services. The patient felt the care package was insufficient for her needs and called LAS on a regular basis. After several safeguarding referrals, and FCaT attending numerous multi-agency meetings with evidence, the patient was moved to supported accommodation with access to 24 hour carers. The patient's calls have now stopped.
- i) 85 year old female patient living in her own home with her daughter who has a learning disability. Patient's elderly brother is the main carer. Brother was admitted to hospital. As there was no other carer, patient started to call LAS (January 2018: 52 calls). The patient's other children became concerned at the lack of adequate care. Numerous safeguarding referrals were made. FCaT and local staff attended several multi-agency meetings with social services and community mental health colleagues. FCaT provided evidence of calling and costs to the service, which assisted in Local Authority funding for 24 hr care finally being approved. The patient's calls have now reduced (March 2018: 1 call).

Frequent Callers

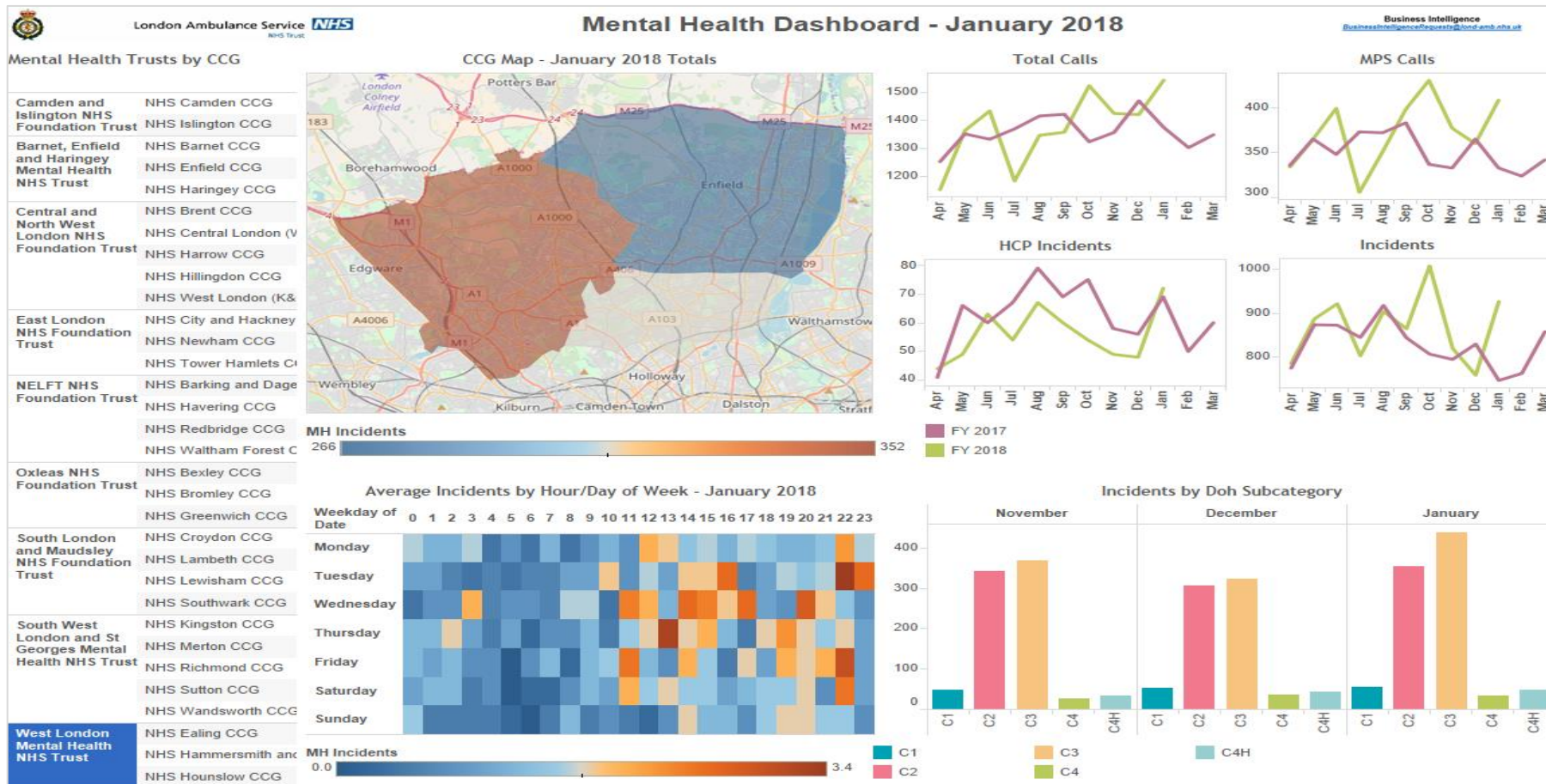
Owner: Briony Sloper| Exec Lead: Trisha Bain



Cluster		Patients	Calls last month	Calls last quarter	Calls last 12 months	% of patients with NHS no.
NE	BARKING AND DAGENHAM CCG	16	116	313	995	100%
NC	BARNET CCG	36	254	1653	5926	100%
SE	BEXLEY CCG	11	65	286	975	100%
NW	BRENT CCG	15	160	537	1279	100%
SE	BROMLEY CCG	12	76	230	567	100%
NC	CAMDEN CCG	23	189	539	1465	100%
NW	CENTRAL LONDON (WESTMINSTER) CCG	19	170	526	1583	100%
NE	CITY AND HACKNEY CCG	40	446	1278	3307	100%
SW	CROYDON CCG	24	140	640	1581	100%
NW	EALING CCG	30	254	1130	3367	100%
NC	ENFIELD CCG	22	180	591	1389	100%
SE	GREENWICH CCG	15	171	536	1545	100%
NW	HAMMERSMITH AND FULHAM CCG	22	143	497	1513	100%
NC	HARINGEY CCG	29	288	1036	3077	100%
NW	HARROW CCG	11	105	401	1246	100%
NE	HAVERING CCG	16	268	843	1902	100%
NW	HILLINGDON CCG	24	242	655	1990	96%
NW	HOUNSLOW CCG	14	536	836	2483	100%
NC	ISLINGTON CCG	21	156	637	1524	95%
SW	KINGSTON CCG	11	96	209	555	100%
SE	LAMBETH CCG	22	381	899	2216	100%
SE	LEWISHAM CCG	11	138	409	1017	100%
SW	MERTON CCG	11	44	260	819	100%
NE	NEWHAM CCG	16	175	489	1303	100%
NE	REDBRIDGE CCG	9	138	385	806	100%
SW	RICHMOND CCG	11	92	348	947	100%
SE	SOUTHWARK CCG	18	187	612	2182	100%
SW	SUTTON CCG	15	76	457	977	100%
NE	TOWER HAMLETS CCG	19	170	586	1412	100%
NE	WALTHAM FOREST CCG	15	179	586	2230	100%
SW	WANDSWORTH CCG	14	199	390	1004	100%
NW	WEST LONDON CCG	17	224	650	1681	100%
	Top 5					
NC	BARNET CCG	M	1	585	3502	
NW	HOUNSLOW CCG	F	366	442	1469	
NW	EALING CCG	F	59	294	466	
SE	LAMBETH CCG	M	111	256	294	
NE	HAVERING CCG	F	82	244	439	

Mental Health

Owner: Briony Sloper| Exec Lead: Trisha Bain



NB Due to BI validation schedule, the Dashboard is always a month behind hence available data is for January 2018.

Total MH Calls and Incidents saw an increase in January (n=1544) compared with 1421 in December 2017.

C3 calls in January were 437 compared with 323 in December 2017.

Number of calls support provided (Mental Health CHUB) for January was **328**, December **547**, November



Staffing

Recruitment – assessment centre held on Saturday 3rd March. 47 applicants, 20 shortlisted, 14 interviewed. 3 full time appointments made to commence in post summer 2018. This will allow 7/7 MH support to EOC and progression of the joint response car.

Barnet, Enfield and Haringey MH Trust are developing a rotational programme with us for a group of mental health nurses to test the concept including educational requirements and mentorship.

Drop in supervision sessions relating to Mental Health Calls have been offered to call takers following feedback form this staff group.

Mental health awareness training is being delivered for PED staff.

Partnership Working

The MH Trust Directors of Nursing group will be convening a sub-group focussed on single points of access. The group will include the LAS and the lead clinician for each SPA pan London the purpose being to share best practice, identify where there are inconsistencies and/or challenges with access experienced by the LAS.

This forum will also be reviewing preventing future deaths notifications pan London to collate themes and learning.

A series of workshops/educational events were held for staff in partnership with the police services and Healthy London Partnership to present the changes to section 136 legislation, the impact for our staff and to use case study discussion to explore legal implications of both the MCA and MHA.

Innovation

We are working with Health Education England to develop a MH Fellowship which will support a mental health nurse rotation across a range of emergency and urgent care settings. This is supported by the Metropolitan Police, Prison Services, Custody Services and Acute Trusts.

A small scale test of using simulation training was piloted at Westminster Ambulance Station with positive feedback.

A Clinical Update article and guidance is being developed with the safeguarding, mental health team and CTL paramedics around parental mental health, an area identified as being of increasing prevalence.

The rota for the implementation of the mental health response car is being finalised to commence in Q1 following the successful trial.

End of Life Care

Owner: Briony Sloper| Exec Lead: Trisha Bain



Staffing

We continue to wait for approval from the workforce panel to be able to recruit to the 3 funded posts from Macmillan – a lead paramedic, a consultant palliative care nurse and a programme manager to take forward a comprehensive programme of work to deliver our pioneer service.

Partnership working

We have been invited to be a key note speaker at the NHS England (London) End of Life Care Clinical Network and the RM Partners Palliative and End of Life Care Conference.

Our End of Life Steering Group met on Friday 16th March with representation from multiple stakeholders

Coordinate My Care records are available to view by staff on the iPad being disseminated however feedback via listening in action has identified concerns in relation to the logging in process which is being reviewed. There have been 303 patient records accessed to support end of life decision making in February 2018.

Innovation

We are implementing Schwartz Rounds across the service and the first cohort of 6 facilitators and a clinical lead will be trained by the Point of Care Foundation on the 19th April with an initial focus on mental health and well being and end of life care. Funding has been externally sourced through both HEE NWL and Macmillan to cover the costs of registering as a provider.

Funding has been secured to purchase an e-learning programme for end of life care which we are amending to meet the specific needs of the LAS.

We have received funding to support running an LAS/Hospice conference in September 2018 to share best practice in relation to the development of single points of access with palliative care to gain both specialist advice, a response service and direct admission pathway where required.

Patients

There have been 4 cases reviewed in the last month in relation to resuscitation attempts being commenced on patients with end of life care plans and do not resuscitate documents in place.

There are common misconceptions amongst staff in relation to do not resuscitate documents. An clinical update has been written and reviewed by the EOL steering group membership specifically focused on this issue, a cardiac circular disseminated and posters are in development for all stations.

We provided 105 end of life journeys for patients in February 2018 to support dying in their preferred place of death, the pre-booked NETS service continues to be well received and evaluated by hospice partners providing timely transfers for patients and families.

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain



Public Engagement events

Area	No.	Topics included:
North West	10	➤ School and college visits ➤ Cubs, Brownies and Scouts ➤ Knife Crime events ➤ Police cadets ➤ Careers/recruitment events ➤ Road safety e.g. Biker Down / Driven by Consequences ➤ Tri-borough Falls event ➤ Children with learning disabilities
North Central	3	
North East	17	
South East	8	
South West	4	
Outer London / PPI	9	
Total	51	

Public Engagement activities

Supplementary information	
Public engagement: no. of hours (Feb 2018)	287
Approximate audience numbers (Feb 2018)	1200
No. of public engagement events: year to date (April 2017 – February 2018)	450
No. of staff on contact list	1276
No. of staff on LAS Public Education Facebook group	665

Staff Awards

- Two cycle paramedics received the Assistant Commissioners Commendation for Innovation at a ceremony at Wood Street Police Station in recognition for their work with police to keep patients out of hospital during the festive party season in December. The cycle teams responded to 41 patients over three weekends and saved 28 ambulance journeys to hospital. Cycle paramedics usually only work during the day but they did extra night shifts during December to deal with the increase in demand during the party season

Staff Recognition

- It is recognised our staff rise to an extraordinary challenge on a daily basis and that can sometimes take its toll. In February the Trust continued its support for the mental health and well being of staff by taking part in Time To Talk Day 2018 in a bid to remove the stigma and encourage staff to look out for one another

Maternity

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



Performance 2018 Update

Time of Day	Jan-18	Feb-18	Grand Total
0	40	30	70
1	27	23	50
2	37	26	63
3	29	22	51
4	54	29	83
5	31	22	53
6	42	31	73
7	32	35	67
8	38	30	68
9	34	24	58
10	29	29	58
11	30	19	49
12	29	26	55
13	20	32	52
14	23	20	43
15	30	18	48
16	27	20	47
17	28	24	52
18	31	31	62
19	22	33	55
20	38	26	64
21	26	36	62
22	31	31	62
23	32	27	59
Grand Total	760	644	1404

2017 Average calls per month – 688.5

January 2018 variance - ↑10%

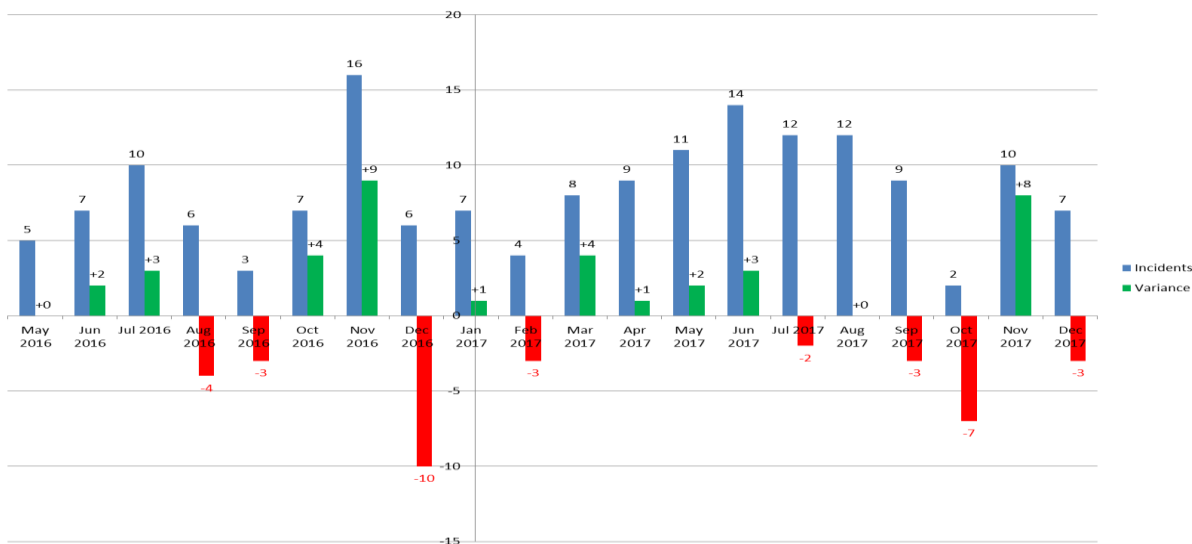
February 2018 variance - ↓6%

Clinical Performance

- Birth imminent calls – 22%
- Bleeding after 24 weeks - 31%
- Baby born/baby head out – 3% or 41 incidents

- Practice Lead for Pre Hospital Maternity Care – 2 posts banded at 8A – Interviews 24/04/2018
- Data modelling underway for Maternity Pioneer Service
- “Map my Maternity” project – developing MiDOS and EOC information around maternity units and referral points currently running
- “Whose Shoes” – User and Staff Engagement workshop funding agreed to align to Maternity Pioneer Service – May/June 2018
- Audit of Maternity care underway
- Research project between LAS/Kings College, London to evaluate the implementation differences with the LAS Maternity Screening and Action Tool
- Launch of Pan London Maternity Divert Policy at Maternal and Newborn Conference March 2018
- Maternity user to be involved in Paramedic Academy sharing the “Maternity Voice”.
- Maternity Training at Homerton Ambulance Station

Maternity Incidents by Month with Variance on previous Month



Maternity Complaints

Awaiting 2017 evidence of learning from Maternity Complaints

Understanding Category 4 Calls

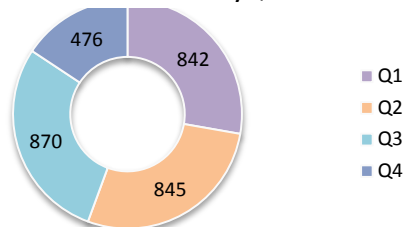
Need to understand type of Cat4 calls relevant to maternity Outcome composition for MTS 36/37 calls.

Health and Safety

Owner: Ayodeji Adeyemi | Exec Lead: Trisha Bain

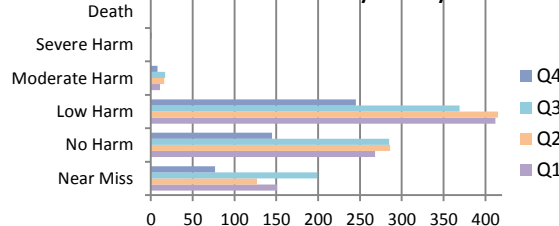


Number of H&S incidents by Quarter



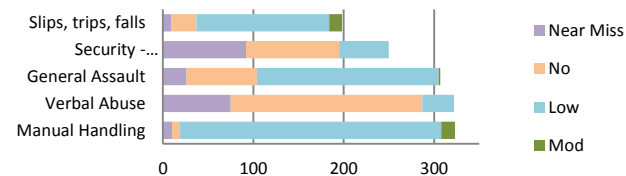
3033 health and safety related incidents have been reported during 2017/18. The incident data for Q2 & Q3 have been updated following investigation. Total YTD H&S incidents account for 39% of all incidents reported during the year.

Accidents & Incidents by Severity



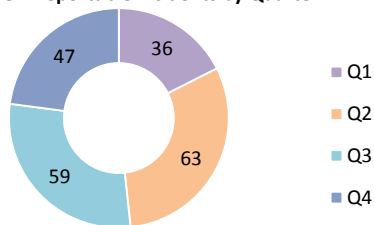
1441 (47.5%) of the H&S related incidents reported during 2017/18 resulted in low harm. 53 (1.7%) incidents resulted in Moderate and 1 severe Harm. 1538 (50.7%) of the incidents were reported as 'No Harm/Near misses'.

Top 5 Incident Sub-Categories by Severity (YTD)

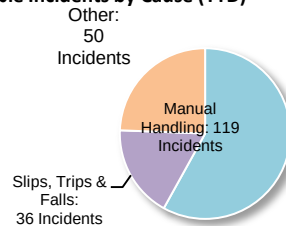


Manual Handling – lifting patients (MH), Security (violence, aggression & verbal abuse) and Slips, Trips and Falls incidents account for the highest number of incidents reported during 2017/18.

RIDDOR Reportable Incidents by Quarter



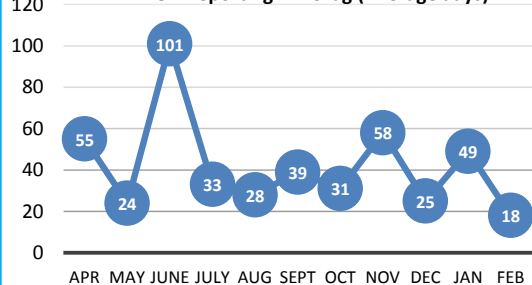
RIDDOR Reportable Incidents by Cause (YTD)



Key Updates:

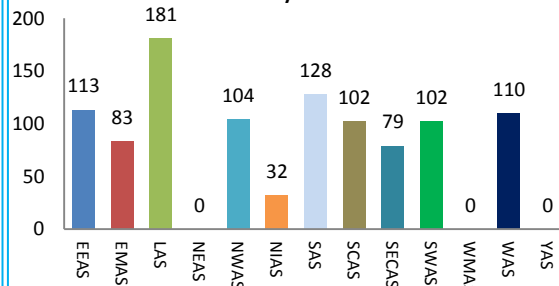
- MH injuries account for the highest number of RIDDOR incidents reported to the HSE. Practical MH refresher training will be provided to all patient/load handling staff from April 2018.
- Business case for the replacement of Version 1 Mangar Elks has been approved and orders for the replacement equipment placed. 12 weekly maintenance plan implemented for all equipment including tail lifts and track chairs supported by 6 weekly visual inspection checks.
- GRS RIDDOR Reporting/flagging process updated during February 2018 and championed by QGAMs and Sector Managers. The new process is aimed at enabling the prompt flagging of any potential RIDDOR incidents to the Health and Safety Department for reporting to the HSE. **Significant improvement in the reporting time lag (18 days) during February 2018.**
- Fire risk assessment contract – under tender. Fire Marshal training being organised for nominated representatives in April 2018.
- A re-audit of Trust-wide H&S arrangements commenced on 29/01/2018 to assess progress made since the June 2017 independent H&S review.

RIDDOR Reporting Time lag (Average days)



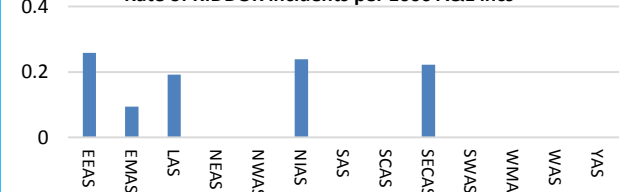
6. The average time lag for reporting RIDDOR incidents across the Trust in February was **18 days**. This demonstrates significant progress in the timeliness of RIDDOR reporting compared to previous months. **6 out of the 24 RIDDOR incidents were reported out of time in February 2018.**

RIDDOR Benchmark by Ambulance Trust to Jan 18



7. The above data was provided by the National Ambulance Risk & Safety Forum. The LAS has reported 181 RIDDOR incidents from April – January 2018 however 21 of the incidents occurred in 2016/17 and were reported retrospectively during 2017/18.

Rate of RIDDOR incidents per 1000 A&E incs



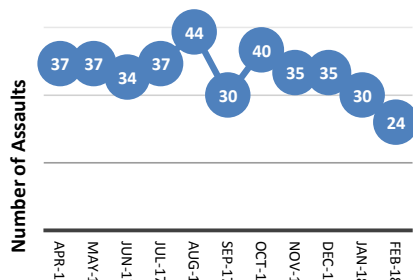
8. The above table highlights the rate of RIDDOR incidents per 1000 A&E incidents attended by each of the above Ambulance Trusts. **NB: No A&E attendance data was received for the Trusts represented with blank data on the graph above.**

Health and Safety

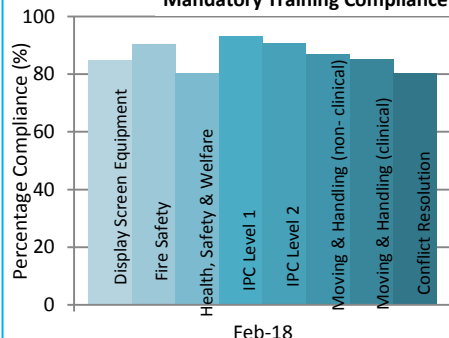
Owner: Ayodeji Adeyemi | Exec Lead: Trisha Bain



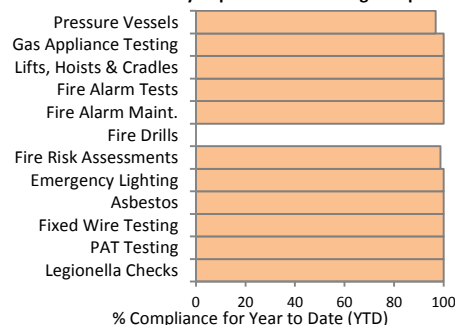
Assaults on Staff by Patients



Mandatory Training Compliance



Statutory Reports & Monitoring Compliance



9. There was a reduction in the number of patient assault related incidents in February 2018. 24 incidents were reported compared to 30 reported in January. Some common causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

10. Trust-wide compliance for February 2018 highlights that only 2 of the 8 mandatory health and safety training courses were below 85%.

11. Training for nominated fire marshals to commence in April 2018.

Health and Safety Risk Tracker					Initial Risk Rating	Current Risk Rating					Target Risk Rating	Key changes/updates since last review
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Oct	Nov	Dec	Jan	Feb		
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	20	20	20	4	Monitoring of health and safety compliance undertaken by ELT on a monthly basis. Audit of Trust-wide H&S arrangements to assess progress made since the independent H&S review conducted in June 2017 commenced on 29 th January 2018.
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	15	9	Key training in practical manual handling has been delivered to Clinical Tutors in the Clinical Education Department. Practical manual handling refresher training to be provided from CSR 1 – April 2018. Business Case to replace all version 1 Mangar Elk approved. 12 – weekly maintenance programme implemented for all track chairs and tail lifts.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing. Dynamic Risk Assessment Training has been roll-out to all frontline staff as part of CSR 2 – 2017 MAST training. Lone worker policy and risk assessments approved at January H&S Committee meeting.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	12	3	GRS RIDDOR Reporting/flagging process updated with support from QGAMs and Sector Managers during February 2018. The average RIDDOR reporting timelag reduced to 18 days in February 2018. This highlights a significant improvement in RIDDOR reporting timescales.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Risks approved by H&S Committee and RCAG. Programme of H&S inspections and risk assessments to be developed and implemented in Q4, 2017-18.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is currently under review. LSMS in regular liaison with staff and sites where security related incidents have been reported. Where required, incidents are reported to the Metropolitan Police for investigation.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	6	6	6	6	6	3	Additional resources approved to enable the Team adequately support the Trust. Recruitment ongoing.

Sector Heat Map: Quality Data



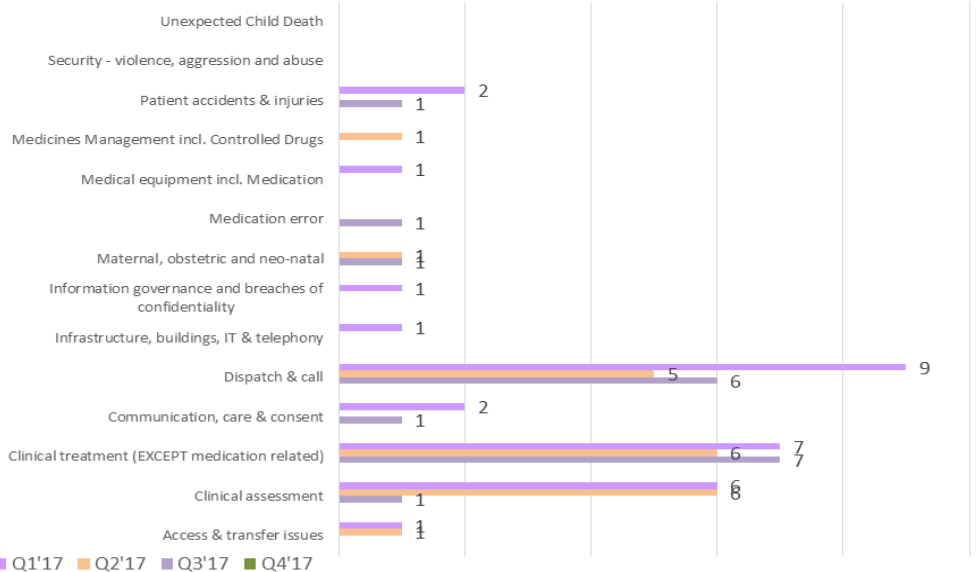
							LAS	
CQC	Key Performance Indicator	NW	NC	NE	SW	SE	Target	Ranges
SAFETY	Hand Hygiene OWR compliance	89%	93%	100%	93%	82%	90%	
	Rate of Patient related Adverse Events per 1,000 Incidents	3.1	1.9	2.4	1.9	2.3	5	
	Rate of Staff related Adverse Events per 1,000 Incidents	1.5	1.7	4.7	3.4	2.7	3	
	Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	0	
	Percentage of Incidents reported within 4 days of incident occurring	95%	98%	98%	98%	95%	85%	
	Potential Serious Incidents referred to SI Group	8	3	6	2	1		
	Serious Incidents declared in-month	1	0	0	0	0	0	
	Serious Incidents breaching 60 days YTD	0	0	0	0	0	0	
	Serious Incidents breaching 40 days YTD	0	0	0	0	0	0	
	Medication Errors as % of Patient Adverse Events	3.3%	17.4%	0.0%	4.5%	12.5%	0%	
	Needle Stick Injuries as % of Staff Adverse Events	0%	0%	4%	3%	0%	0%	
	Missing Equipment Incidents as % of all reported incidents	5%	0%	4%	5%	1%		
	Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	10%	18%	12%	14%	11%		
	Safeguarding Adults & Children Level 1	93%	96%	95%	97%	97%	90%	
	Safeguarding Adults & Children Level 2 - Clinical	89%	87%	89%	94%	93%	90%	
EFFECTIVENESS	Percentage of staff completing Core Skills Refresher 2017.1 (cumulative)	86%	90%	85%	88%	88%	90%	
	Percentage of staff completing Core Skills Refresher 2017.2 (cumulative)	55%	62%	74%	63%	70%	90%	
	* ROSC at Hospital (AQI)	38.6%	30.1%	28.6%	37.1%	31.9%		
	* STEMI care bundle (AQI)	77.1%	52.5%	78.8%	70.6%	77.3%		
	* Stroke to HASU within 60 minutes (AQI)	55.6%	36.5%	55.7%	60.9%	59.1%	65%	
	* Stroke Care Bundle (AQI)	97.9%	96.5%	97.3%	97.2%	99.6%	98%	
	** Survival to Discharge (AQI)	-	-	-	-	-		
	* CPI - Completion Rate (% of CPI audits undertaken)	82%	99%	75%	100%	100%		
	* CPI - Percentage of Staff receiving ONE Feedback Session YTD	43.3%	48.8%	43.8%	41.8%	46.0%		
	* Documented Care - Cardiac Arrest Compliance (CPI audit)	98%	98%	98%	98%	98%	95%	
	* Documented Care - Discharged at Scene Compliance (CPI audit)	97%	97%	97%	98%	96%	95%	
	* Documented Care - Mental Health Compliance (CPI audit)	94%	92%	92%	94%	97%	95%	
	* Documented Care - Severe Sepsis Compliance (CPI audit)	98%	97%	97%	98%	97%	95%	
	* Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-	95%	
	* Documented Care - Glycaemic Emergencies Compliance (CPI audit)	98%	98%	98%	98%	97%	95%	
CARING	Rate of Complaints per 1,000 Incidents	0.5	0.5	0.6	0.4	0.7		
	Mental Health Related Incidents	7%	9%	7%	7%	8%		
	Mental Health Related HCP Incidents	0.6%	0.7%	0.4%	0.6%	0.5%		
	Rate of Frequent Callers per 1,000 Calls	7.6	10.4	7.9	7.6	5.2		

* data shown refers to Feb-18

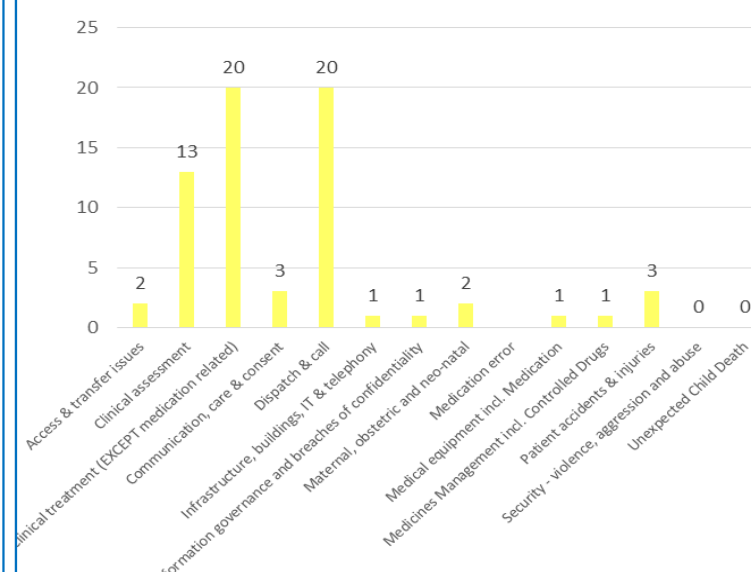
** data shown refers to Aug-17



Serious Incidents by Category

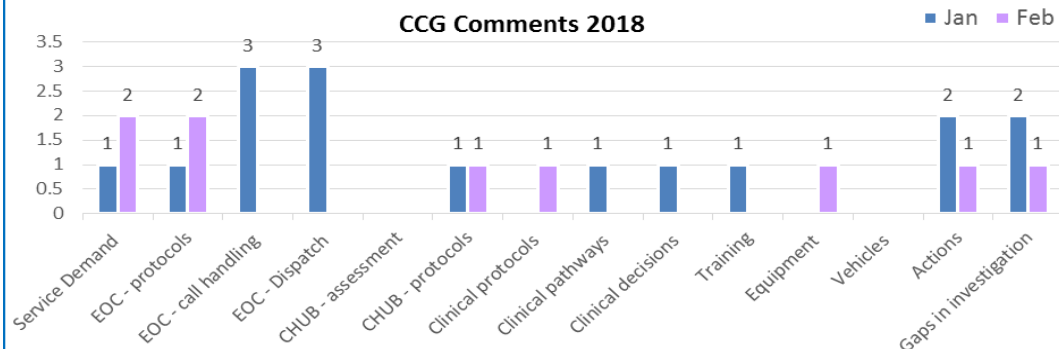


Serious Incidents by Category YTD 2017/18



Dispatch and call and error in the clinical management of a patient remain the recurrent themes in the majority of SI investigations. In response to the dispatch and call management errors the Trust has commissioned an intensive EOC actions plan which has incorporated learning from SI investigations. Additionally a recent safety review of the management to HCP calls has provided a number of organisational learning points to improve the process within EOC.

CCG Comments 2018



During February 2018 the CCG raised several questions regarding service demand and the current protocols within EOC. Specifically they raised questions around the Operational Policy (OP/023) – Procedure for the Dispatching of Resources by EOC and the management of calls awaiting an emergency response. Additional questions were raised around the risk mitigation considered prior to the implementation of the Ambulance Response Programme and organizational learning following implementation. Clarification around clinical protocols and equipment concerned the management of cardiac arrests and the LifePak 15 monitors. All questions put to the Trust were answered before the provided deadline. The Quality, Governance and Assurance Team will continue to monitor the comments received from the CCG for themes and trends. Anticipated actions for the team include inviting the Commissioners into the Trust to enhance the understanding of the protocols and processes in place within EOC, providing high level reports on identified gaps in our policies to the Executive Team and incorporating any gaps in the actions plans or investigations into the Lead Investigator training.

Learning From Deaths, Inquests and Claims

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



Inquests – figures and learning

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Total Prevent Future Deaths In-Month	1	1	0	0	0	1	0	0	0	0	0
Total Inquests where LAS asked to give evidence - In-Month	4	6	4	9	10	6	4	6	4	3	6
Total Inquests where LAS asked to give evidence - Year to Date	4	10	14	23	33	39	43	49	53	56	62

Claims – figures and learning

- As at the end of Quarter 3 2017/2018 NHS Resolution had 45 claims against LAS open under their Clinical Negligence Scheme for Trusts & 70 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- For the same Quarter in 2016/2017 NHS Resolution had 35 claims against LAS open under their Clinical Negligence Scheme for Trusts & 78 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).
- For the same Quarter in 2015/2016 NHS Resolution had 32 claims against LAS open under their Clinical Negligence Scheme for Trusts & 84 claims under the Liabilities for Third Parties Scheme (covering public/employer liability claims).

Inquests – figures and learning

- Four of the six Inquests attended in February were potentially problematic for the Trust & all involved either delay or Emergency Operations Centre concerns. No Prevention of Future Death Reports were received following the Inquests.
- Following one of the Inquests where delay was an issue, the family of the deceased asked the attending Claims Manager to pass on their thanks to the crew for their professionalism, compassion and excellent patient care.

Actions

Completed:

- The pre-trial report received from Panel Solicitors in January which suggested that signs should be displayed on ambulance stations/garages advising staff not to walk between ambulances given the tight space & how closely they are parked together was discussed with the Head of Safety & Risk. It was agreed that this goes beyond what is reasonable and is unrealistic in terms of cost and implementation.

Ongoing:

- Procedures for checking equipment, dealing with broken equipment, requesting replacement equipment & obtaining electronic or manual staff confirmation of procedures – feedback awaited from DD of Fleet

Learning from Complaints

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



Top 5 themes 2017/18

Complaints by subject 2015/17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	234
Conduct	16	19	24	19	19	16	17	25	20	22	23	220
Road handling	12	11	13	14	10	7	14	9	7	6	10	113
Treatment	1	2	5	1	7	5	16	8	9	8	14	76
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	43
Total these subjects	53	49	62	60	62	38	75	76	62	59	90	686
Overall Totals	66	70	76	73	86	51	94	85	84	74	102	861

Review of February 2018

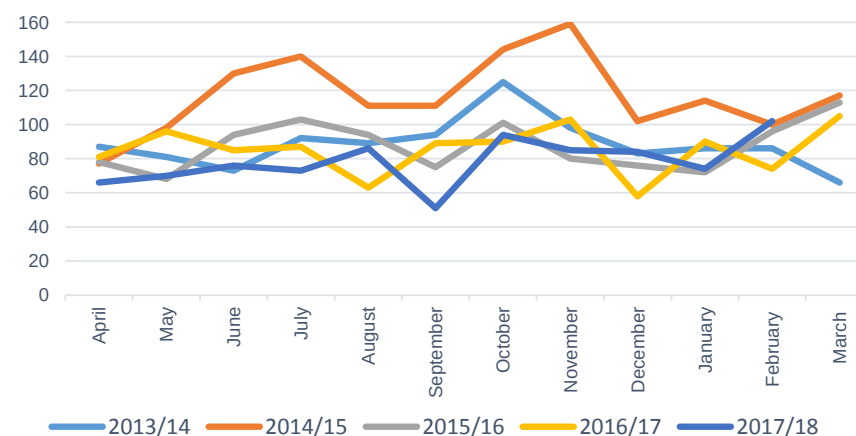
- The number of complaints relating to 'delay' has increased over the annual average of 19 per month to a yearly high of 40.
- Complaint numbers are currently 0.08% of calls attended by the Trust over the year, however during February this increased to 0.12% against the monthly total of calls attended
- Quality Alert numbers have increased this month (20), 14 remain under investigation. These have time frames to ensure timely responses
- During February we received 102 complaints. 6 of these were classed as HCP issues on behalf of the patient and 7 were from LAS111
- During this month where ARP was used, 5 related to ARP 1, 28 to ARP 2, 24 to ARP 3 and 18 to ARP 4 (see table on next slide)
- A record number of requests for medical records was received from solicitors this month (165). This may increase with the implementation of the DPA

Assurance and learning

- 91 complaints were closed this month including 23 of those received during February.
- Outcome categories – 59 not upheld, 16 partially upheld, 13 upheld and 3 referred to other agencies.
- We continue to receive just under 400 PALS enquiries per month and are planning to add a number of signpost links on the new website which should assist enquirers
- A number of complaints recommended reflective practice and future performance monitoring. Compensation was offered to one complainant whose door was forced when the 999 call was left open in error.
- Reimbursement of taxi fees was offered when non emergency transport failed to arrive

Complaint numbers April 2013 to February 2018

Complaints comparison - 2013 to 2018



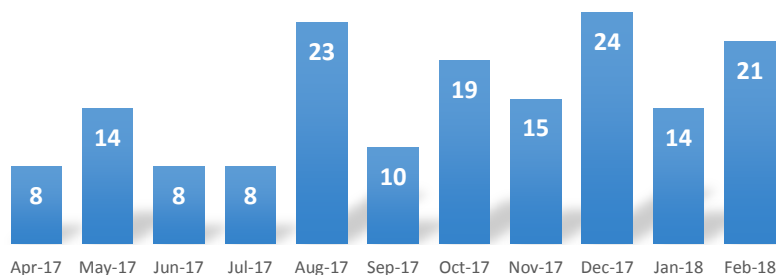
Learning from Complaints

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



Complaint response times – February 2018

Complaints over 35 working days at the time of the report



Assurance & Learning

- Since the introduction of ARP we have received 205 complaints where this was used. The ratio of call categories is as follows:
 ARP 1 = 14 complaints
 ARP 2 = 93 complaints
 ARP 3 = 57 complaints
 ARP 4 = 41 complaints
- We will be preparing an end of year review in April of all calls matched to ARP and sharing this with G&A
- There have been no recent requests from the Ombudsman but a report on the full outcome of 2017/18 requests will be provided in the April report.
- The PHSO is planning to visit the Trust at the end of March.
- HCP information will be updated on the website with a go live date of April 2018.
- We expect numbers of Quality Alerts to increase.

Categories of complaint calls

Call category February 2018	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	5
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	28
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	24
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	18
Category A Red 2 - 8 min response	2
Not CAD related	18
Information awaited	7
Total	102

Case example

- **Case example :**
 Complaint from patient who is upset at the treatment provided. Concerns have also been raised about inappropriate comments made by the crew to the patient.
 Local management team to discuss the incident with member of staff in the context of a reflective practice exercise.
 A key feature of this will be concerned with how effective communication with patients is a vital part of care provision. In addition, member of staff has been placed with a very experienced paramedic to supervise clinical decisions and performance monitoring, meetings have been arranged with team leaders.
 Supervising responsibilities for the period of this professional development have been curtailed.
 The complainant has been invited to address the Trust Board.