London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 31 JULY 2018 AT 09:00-13:45, COUNCIL ROOM (K2.29), KING'S COLLEGE LONDON, STRAND CAMPUS, STRAND, LONDON WC2R 2LS

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
09.00	**1.**	**TB/18/49** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
09.05	**2.**	**TB/18/50** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	Assurance
09.10	**3.**	**TB/18/51** Attachment	**Minutes of the meeting held in public on 24 May 2018** To approve the minutes of the meeting held on 24 May 2018.	HL	Decision
09.15	**4.**	**TB/18/52** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
09.20	**5.**	**TB/18/53** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
09.25	**6.**	**TB/18/54** Attachment	**Report from Chief Executive** To receive a report from the Chief Executive (CEO).	GE	Information
STRATEGY					
09.30	**7.**	**TB/18/55** Attachment	**Data Quality Improvement Strategy, Data Quality Policy, & Data Quality Implementation Plan** To approve the Trust's strategy, governance and plans for delivering data quality.	LB	Decision
09.45	**8.**	**TB/18/56** To follow	**North East London IUC launch** To receive assurance with regard to the Trust's readiness to launch its North East London IUC service on 1 August 2018.	FW	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
10.00	**9.**	**TB/18/57** Attachment	**Trust Board Committee Assurance Reports** To receive the reports of the Board Assurance Committee meetings that have taken place since the last meeting of the Board. **(i) Logistics and Infrastructure Committee meeting on 5 June 2018**	TdP	Assurance
		Attachment	**(ii) People and Culture Committee meeting on 12 July 2018**	PG	Assurance
		To follow	**(iii) Finance and Investment Committee meeting on 23 July 2018**	FC	Assurance
		To follow	**(iv) Quality Assurance Committee meeting on 24 July 2018**	RM	Assurance
10.45	**10.**	**TB/18/58** Attachment	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Discussion
11.00	**11.**	**TB/18/59** Attachment	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and the Corporate Risk Register	PH	Assurance
11.15	**12.**	**TB/18/60** Attachment	**Serious Incident Quarterly Thematic Report** To note declared and closed Serious Incidents across the Trust.	TB	Discussion
11.30	**13.**	**TB/18/61** Attachment	**Preparing to meet national performance standards** To receive a report on performance against national standards since the Ambulance Response Programme (ARP) implementation.	PW	Assurance
12.00	**14.**	**TB/18/62** Attachment	**Rest break policy implementation review** To receive a report about developments since the revised rest break policy implementation in December 2017, introducing greater flexibility for staff breaks.	PW	Assurance
GOVERNANCE					
12.15	**15.**	**TB/18/63** Attachment	**Report of the Trust Secretary** To receive information about an addition to the Register of Seals.	PH	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
12.20	**16.**	**TB/18/64** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
12.30	**17.**	**TB/18/65** Attachment	**Annual General Meeting preparation** To receive a report on the Trust's plans for its Annual General Meeting on 25 September 2018.	JOH, PH	Discussion
12.45	**18.**	**TB/18/66** Oral	**Staff Story** To hear about the experiences of some of the Trust's Staff Survey Champions.	PG	Information
13.15	**19.**	**TB/18/67** Oral	**Questions from members of the public**	HL	Information
13.30	**20.**	**TB/18/68** Oral	**Any other business**	HL	Information
13.35	**21.**	**TB/18/69** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
13.45	**22.**		**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 25 September 2018 at a venue to be confirmed.				

Additional reports, circulated for information and assurance only:

TB/18/70 Quality Report (Attached)
TB/18/71 General Data Protection Regulation (GDPR) Update (Attached)
TB/18/72 Trust Board informal meetings for the remainder of 2018/19 (Attached)
TB/18/73 Update on Health and Safety Action Plan (Attached)

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Thursday 24 May 2018

DRAFT Minutes of the public meeting of the Board held on 24 May at 13.00pm in 15 Hatfields, Chadwick Court, London SE1 8DJ

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Director of Finance and Performance
Fergus Cass	FC	Non-Executive Director
Jessica Cecil	JC	Associate Non-Executive Director (by telephone)
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Amit Khutti	AK	Associate Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Benita Mehra	BM	Director of Strategic Assets and Property
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		
Ross Fullerton	RF	Chief Information Officer
Philippa Harding	PH	Director of Corporate Governance
Patricia Grealish	PG	Director of People and Culture
Jamie O'Hara	JO'H	Director of Strategy and Communications

1. Welcome and apologies (TB/18/26)

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

2. Staff Story (TB/18/27)

2.1. The Board received a presentation from Amanda Mansfield (Consultant Midwife) about the work that was being undertaken by the Trust with regard to understanding the experiences of those women whom had been treated during their pregnancy or whilst about to give birth. It was noted that, whilst the Trust received approximately 8,000 calls to such patients, it had a very small number of complaints. Consideration was given to the work that was being undertaken to engage with these patients, particularly in light of the fact that maternity was one of the Trust's pioneer services, as set out in the Strategy recently approved by the Board.

3. Declarations of interest (TB/18/28)

3.1. There were no declarations of interest.

4. Minutes of the meeting held in public on 24 April 2018 (TB/18/29)

4.1. The minutes of the Trust Board meeting held in public on 24 April 2018 were approved as a true and fair record of that meeting, subject to the following amendments:

4.1.1. The penultimate sentence of paragraph 8.1 (minute ref: TB/18/08) should read "Members of this group confirmed that the work they had undertaken could provide the Board with significant assurance with regard to the impact of the strategy and commended the ELT on the manner in which Board members' comments had been incorporated into the document."

4.1.2. The third sentence of paragraph 9.1 (minute ref: TB/18/09) should read "The Board met informally to consider the draft Business Plan on 16 April 2018, since that meeting, it was considered that the most significant change to the Plan was in relation to the use of national Ambulance Quality indicators (AQIs), which were still being finalised."

5. Matters arising (TB/18/30)

5.1. The action schedule arising from previous meetings was noted.

6. Report from the Chair (TB/18/31)

6.1. The Chair referred to the recent decision, by NHS Improvement on the recommendation of the Care Quality Commission (CQC), to remove the London Ambulance Service NHS Trust (LAS) from special measures. On behalf of the Board she expressed appreciation for the efforts of the ELT to achieve this successful outcome, noting the importance of the systems and processes that had been put in place. Board members requested sight of the final report of the CQC's most recent inspection of the Trust.

ACTION: send CQC report to the Board.

6.2. In addition to the information set out within her report, the Chair reported that she would be meeting the Chair of Healthwatch England. The importance of ensuring that the Trust engaged with its patients appropriately was emphasised.

6.3. The Board agreed that the pattern of its formal meetings should be amended in light of the progress that had been made to improve the Trust's systems and processes. The Board would meet formally every other month, with informal development sessions taking place in between these meetings.

ACTION: amend forward plan for Board meetings and ensure that website reflects the amended Board meeting dates.

7. Report from the Chief Executive (TB/18/32)

7.1. GE presented his report on progress and key issues, events and activities since the Board meeting in April.

7.2. It was noted that the Chief Executive's Roadshows had recently completed. Board members were informed that there had been a palpable change in the atmosphere of these meetings since they had last been undertaken in 2017. The recent Roadshows had been much more positive than those in 2017 and indicated that members of staff perceived changes to the manner in which the Trust responded to staff members' issues of concern.

7.3. Board members noted the VIP awards event that had taken place recently and expressed their congratulations to those who had been nominated and received awards.

7.4. It was noted that a number of useful events had been scheduled by NHS Providers. The value of co-ordinating Board and ELT members' attendance at these was noted.

ACTION: consider how best to co-ordinate attendance at NHS Providers events.

7.5. The Board noted the report of the Chief Executive.

8. Annual Accountability Statements

(i) Annual Report (TB/18/33(i))

(ii) Annual Governance Statement (TB/18/33(ii))

(iii) Annual Accounts (TB/18/33(iii)

(iv) Annual Quality Account (TB/18/33(iv))

(v) Patient Experiences Annual Report (TB/18/33(v))

8.1. The annual accountability statements were presented to the Board for approval, following their detailed scrutiny by the Quality Assurance Committee and the Audit Committee. A paper was tabled providing the Board with information about a small number of proposed changes to some of these documents, following the scrutiny of these committees.

8.2. The Chair of the Audit Committee provided an oral update on the meeting of that Committee which had taken place earlier in the day. He confirmed that the Audit Committee had reviewed the Annual Accounts, the Annual Governance Statement and the Annual Report (having reviewed them in detail previously). The Committee had received assurances from the Trust's internal and external auditors with regard to these documents. In light of this, the Audit Committee had agreed to recommend them to the Board for adoption and submission to the Department of Health. Similarly the Chair of the Quality Assurance Committee confirmed that this Committee was content to recommend the approval of the Annual Quality Account and Patient Experiences Annual Report.

8.3. Subject to the amendments set out in the tabled paper, Board members confirmed that they were content to approve the annual accountability statements.

RESOLVED:

8.4. The Board resolved to approve the following annual accountability documents, subject to the amendments identified in the paper tabled at the meeting:

8.4.1. 2017/18 Annual Report

8.4.2. 2017/18 Annual Governance Statement
8.4.3. 2017/18 Annual Accounts
8.4.4. 2017/18 Annual Quality Account
8.4.5. 2017/18 Patient Experiences Annual Report

9. Board Engagement (TB/18/34)

9.1. JOH introduced the report which proposed the introduction of a 'Board to Ward' style approach to raise the visibility of the Board within each of the five Strategic Transformation Partnership (STP) sectors – both internally and externally, whilst providing frontline staff with a direct link to the senior management of the Trust. It was proposed that the approach would also provide opportunities for executives and Board members to increase their engagement with staff and stakeholders, acting as 'ambassadors' to broker relationships with key partners.

9.2. The Chair emphasised the importance of being clear about a "golden thread" through all engagement activities. In order to facilitate the consistent articulation of this it was necessary to have timely and appropriately detailed briefings. The value of "soft intelligence" was also stressed. In response to this it was proposed that a new framework for sharing information should be implemented, along the lines of that used for sharing Board papers. It was anticipated that his would ensure that the necessary information was available whenever those who faced the largest time constraints were able to access it.

ACTION: Ensure that timely and appropriately detailed briefings are available for all Board members to inform their brokering of relationships with key partners.

9.3. Board members emphasised the importance of both internal and external engagement. In addition to the manner in which internal engagement might be improved, consideration was given to the support required to enable Board members to meaningfully undertake external engagement. It was noted that the STP sectors had different engagement requirements and would require different briefings for those aligned to them. The value of sharing these briefings with other Board members was also noted. Subject to these comments, the Board confirmed that it was content to support the proposed approach.

10. People and Culture Committee Assurance Report (TB/18/35)

10.1. JM presented the report which provided the Board with an overview of the issues considered by the People and Culture Committee at its meeting on 14 May 2018.

10.2. JM commended the work that had been undertaken on the Workforce Race Equality Scheme (reported to the Board as an additional report for information).

10.3. It was noted that further work had been requested with regard the tutors required to ensure that the Trust met national requirements for B6 paramedics. It was reported that the Trust was confident that the appropriate establishment figures had been identified; however further work was required to identify and allocate budget.

10.4. Board members noted the work that had been undertaken with regard to workforce planning and that this would be reported in more detailed to the Board meeting in July.

ACTION: workforce plan to be presented to the Board in July.

11. Audit Committee Assurance Report and Annual Report (TB/18/36)

11.1. JJ presented the report which provided the Board with an overview of the issues considered by the Audit Committee at its meeting on 17 May 2018, together with the Annual Report of the Audit Committee. It was noted that he had presented an overview of the Audit Committee's meeting on 24 May 2018, during the Board's consideration of the Annual Accountability Statements (minute ref: TB/18/33).

11.2. The Committee had requested further assurance on the progress being made with regard to the General Data Protection Requirement, which was elsewhere on the agenda (minute ref: TB/18/42).

11.3. The Board noted the Annual Report of the Audit Committee, in particular the areas that had been identified for the Committee's focus in 2018/19.

12. Quality Assurance Committee Assurance Report (TB/18/37)

12.1. RM presented the report which provided the Board with an overview of the issues considered by the Quality Assurance Committee at its meeting on 22 May 2018.

13. Integrated Quality & Performance Report (TB/18/38)

13.1. The Board noted the report which provided an overview of the Trust's integrated quality and performance activities. As part of this report, FC tabled a report providing the Board with an overview of the issues considered by the Finance and Investment Committee at its meeting on 23 May 2018.

13.2. Consideration was given to the progress being made on the Trust's Cost Improvement Programmes (CIPs). It was noted that the Quality Impact Assessments for these were due to be presented to the next meeting of the Quality Assurance Committee for scrutiny. It was clear that the Trust needed to make progress with regard to its usage of agency staff, in order to ensure that it did not exceed the cap that had been set for it by NHS Improvement. This issue was being considered in detail by the People and Culture Committee.

13.3. PW provided the Board with a detailed oral update on recent operational performance. In April, the Trust had been able to deliver within the national standards across all four categories. There had been an improvement in Emergency Operations Centre (EOC) call handling, with 91% of calls answered in 5 seconds during April. However, April had not brought the Trust many challenges – there had not been any specific surges of activity and the Trust had been at REAP 1 for the month. It was likely that this would not continue into the summer.

13.4. Consideration was given to the performance of the Trust's 111 service. It was noted that this was often impacted by surges in activity on the 999 service. There had been up to a 30% increase in call volumes; however the Trust remained in the top five in the country for call answering with lower abandonment rates than anyone else. This was considered to be a clear indicator of safety.

13.5. Board members noted and condemned the increased number of assaults on staff. In response to queries about the possible reasons for these, it was reported that increased reporting had been encouraged across the Trust. This was covered through health and safety training with a view to ensure that unacceptable behaviour was challenged wherever possible.

13.6. Non-Executive Directors questioned where it was possible to learn form the Trust's good performance in April. The need to develop an understanding of the staff and vehicle numbers required to deliver according to new performance standards was emphasised. It was noted that the Finance and Investment Committee had identified a need for articulating planning assumptions to ensure that this was possible by the time that the new standards became live in September 2018. The outcome of this work was identified as a possible Board development session topic.

ACTION: planning assumptions to be considered as a Board development session topic.

14. Board Assurance Framework and Corporate Risk Register (TB/18/39)

14.1. Board members noted the paper which set out the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

15. Serious Incident Update (TB/18/40)

15.1. The Board noted the report which summarised Serious Incident (SI) activity within the Trust for the month of April and provided an overview of the main contributory factors that influenced SIs and the actions taken by the Trust to address recurring themes.

15.2. It was noted that patient safety incidents had been inaccurately reported. The trend, as expected, was that the reporting of these was increasing. This would be corrected in the next report to the Board.

16. Freedom to Speak Up Quarterly Report (TB/18/41)

16.1. Conal Percy, Freedom to Speak up Guardian, joined the meeting to present this report which provided the Board with a quarterly update on Freedom to Speak Up activity.

16.2. It was noted that the level of formal Freedom to Speak Up activity remained low in the Trust. It was, therefore, not easy to identify trends. However, bullying and harassment remained a concern for many members of frontline staff, therefore work was being undertaken with the People and Culture directorate to ensure that the work they were undertaking in this area could be highlighted through Freedom to Speak UP activities as well.

16.3. Board members noted that it was proposed that a Freedom to Speak Up Strategy should be developed. This was requested to be presented for approval at the Board meeting in September 2018.

ACTION: Freedom to Speak Up Strategy to be presented to the Board for approval in September.

17. General Data Protection Regulations (GDPR) (TB/18/42)

17.1. The Board noted the report which provided an update on the Trust's progress towards GDPR compliance. It was noted that the Audit Committee had commissioned an internal audit review of the Trust's position on this, for consideration at its meeting in September 2018.

18. Trust Board Forward Planner (TB/18/43)

18.1. The Board noted the forward plan of its meetings.

19. Questions from members of the public (TB/18/44)

19.1. There were no questions from any members of the public or staff.

20. Any other business (TB/18/45)

20.1. There was no other business.

21. Review of the meeting (TB/18/46)

21.1. It was noted that more time was required for consideration of Patient and Staff Stories. It was proposed that these should be moved to the end of Board meetings, in order to ensure that, should they overrun, this would not impact negatively on the consideration of these agenda items.

ACTION: Patient and Staff Stories to be presented at the end of Board meetings.

21.2. Board members suggested alternate venues for Board meetings in the future, such as local NHS Trusts.

ACTION: Explore further Board meeting venues.

21.3. It was noted that, the nature of the business of the meeting had been that of formal approvals, rather than issues that were conducive to challenge and debate.

Meeting close

The meeting closed at 16.19pm. The next Trust Board meeting in public will take place at 09.00am on Tuesday 31 July 2018.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/95 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	**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	31/07/18	**CLOSED**	See item on agenda
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	31/07/18	**CLOSED**	See item on agenda
TB/17/197 para 5.1a	Dates of key STP meetings to be circulated to the Board, setting out those which NEDs are expected to attend.	Jamie O'Hara	27/03/18	24/05/18	**CLOSED**	Board newsletters for July prepared. Dates for NEDs provided.
TB/17/197 para 5.1b	Briefings to be provided to NEDs attending STP meetings.	Jamie O'Hara	27/03/18	24/05/18	**CLOSED**	Produced on ad hoc basis and communicated to NEDs.
TB/18/07 para 7.2	Confirm next tranche of Chief Executive's Roadshows as early as possible	Jamie O'Hara	24/04/18		**CLOSED**	The next round of roadshows are being scheduled for the first week of October. Dates, times and venues are now in the process of being finalised and will be shared as soon as they are confirmed.
TB/18/09 para 9.4	Board development session to be arranged on Statistical Process Controls (SPCs)	Trisha Bain, Philippa Harding	24/04/18	24/06/18	**CLOSED**	This took place in June
TB/18/11 para 11.2	Take action to address the high priority internal audit recommendation relating to storage and accessibility of records, both in the sort and longer term	Ross Fullerton	24/04/18	24/05/18		
TB/18/13 para 13.3	Staff survey champions group be invited to present to the Board as a staff story	Patricia Grealish/Philippa Harding	24/04/18	31/07/18	**CLOSED**	See item on agenda
TB/18/31 para 6.1	Send CQC report to the Board.	Philippa Harding	24/05/18	25/05/18	**CLOSED**	This was circulated in correspondence

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/18/31 para 6.3	Amend forward plan for Board meetings and ensure that website reflects the amended Board meeting dates.	Philippa Harding	24/05/18	31/07/18	**CLOSED**	See item on agenda
TB/18/32 para 7.4	Consider co-ordination of attendance at NHS Providers events.	Philippa Harding	24/0518			
TB/18/34 para 9.2	Ensure that timely and appropriately detailed briefings are available for all Board members to inform their brokering of relationships with key partners	Jamie O'Hara	24/05/18		**CLOSED**	This constitutes “Business as usual standing item and applies when meetings come up and when Board Members ask for briefings.
TB/18/35 para 10.4	Workforce plan to be presented to the Board in July	Patricia Grealish	24/05/18		**CLOSED**	See item on agenda
TB/18/38 para 13.6	Planning assumptions to be considered as a Board development session topic	Heather Lawrence	24/05/18			
TB/18/41 para 16.3	Freedom to Speak Up Strategy to be presented to the Board for approval in September.	Philippa Harding	24/05/18	25/09/18	**On track**	

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Report from the Chair			
Agenda item:	05			
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

Government reshuffle (10 July)

1. Board members will be aware that, subsequent to the Brexit discussions held by the Prime Minister at Chequers on Friday 06 July 2018, two Cabinet Minister resigned, one being the Foreign Secretary, the Rt Hon Boris Johnson. This resulted in a mini reshuffle and the promotion of Rt Hon Jeremy Hunt from Secretary of State for Health and Social Care into the Foreign Secretary role.

2. The newly appointed Secretary of State for Health and Social Care is Matt Hancock, previously Secretary of State for Digital, Culture, Media and Sport. I attach information on his portfolio, biography and parliamentary career (see annex to this report).

Visit by Rob Behrens CBE, Chair and Ombudsman of the Parliamentary and Health Service Ombudsman (28 June)

3. The role of the Parliamentary and Health Service Ombudsman is to provide robust oversight and assurance to Parliament of an organisation's effectiveness and efficiency with regard to their support, advice and investigations into complaints raised with them by members of the public about services received in or by the NHS that have not been resolved locally.

4. Rob has been in post since 2017 and has made it his business to visit organisations and to listen to feedback.

5. It was an opportunity to share with Rob more about our service and the challenges we face.

Visit by Sigurd Reinton (05 June)

6. Sigurd Reinton is a Non-Executive Director (NED) at NHS Improvement (NHSI) and was Chairman of the London Ambulance Service NHS Trust (LAS) until 2008. He was interested to meet with me, Garrett Emmerson Chief Executive Officer (CEO), Ross Fullerton Chief Information Officer and Fenella Wrigley Medical Director to hear about the new strategy, the changing role of Service in the capital, the use of information technology and our transition into the digital space. Sigurd was impressed by what he heard and by the significant improvements the service has made leading to our 'Good' rating by the Care Quality Commission (CQC) and our removal from Special Measures.

7. Whilst here he also visited the control room and met with staff on the Clinical Hub to understand more fully how it now operates in support of dispatch and front line crews; and subsequently wrote a blog saying how impressed he was with the progress we have made as a Service.

NHS Confederation annual conference (13-14 June)

8. Garrett and I attended this conference which is a useful networking event. I was able to meet up with some of the Chairmen from other Ambulance Services and to discuss common themes.

9. Keynote speakers were the Rt Hon Jeremy Hunt and Simon Stevens. The main theme was (at that stage) about the potential for an NHS 70th Birthday financial award for the NHS, the progress we have made in the system to date and the expectation that there would be productivity requirements should an additional settlement be made. Other presentations focused on an evaluation of the size of award needed and the outstanding requirement to provide additional funding for social care if the health service is to be successful.

10. The other key message was that the future is about collaboration between organisations and that Sustainable Transformation Partnerships (STPs) will evolve over time into Accountable Care Organisations (ACOs) and Integrated Care Systems (ICSs). The notable difference being that the ACOs will hold and be accountable for the budget.

NHS Improvement - Chairs Advisory group (14 June)

11. This group is chaired by Baroness Dido Harding Chair of NHSI together with Peter Wyman CBE Chairman of CQC. Ian Dalton CEO of NHSI attends for part of the meeting.

12. Dido updated us on the current thinking on the integration NHSI with NHS England (NHSE). As reported previously the two organisations will remain separate statutory bodies with two Boards and two CEOs.

13. There will be seven National Directors who will be accountable to both CEOs. It is not proposed that they will have their own Chairs or Boards. The aim is to have the seven directors in post by the autumn. The aim is to go from fragmentation to integration.

14. The meeting was held the day before the announcement of the additional £20 billion for the NHS over the next five years commencing 2019/20 and before the exact percentage rise was known. Investment will be prioritised across Cancer services, Mental Health and Children's services.

15. We also discussed the Mayor's Health Inequalities initiative that will focus on children, mental health and healthy workplaces.

16. The CQC Chair (Peter Wyman) asked for feedback on the new style inspections. I provided feedback about the positive nature of the inspectors and the actual inspection. It was generally agreed that the data call was excessive. We were advised that CQC is looking to automate this process in the future.

NHS Improvement's Chair's meeting (10 July)

17. This meeting focused on the outcome of London's health economy performance for 2017/18, month one and predicted out turn for 2018/19. A focus is required on recurrent Cost Improvement Programme (CIP) delivery, elective activity and discharge planning in hospitals.

18. Dido Harding joined the meeting and the conversation focused on the Government reshuffle, the additional funding for the NHS. All Chairs fed back their views on STPs in their area and advised that lack of proper engagement with Chairs and NEDs in Provider organisations meant that expertise was not being utilised. Most STP plans will require local authorities to sign-up and the point was made that many providers had expert knowledge and relationships that could be helpful in achieving the STP plans.

NHS Improvement's Chair's and Chief Executives network (19 June)

19. Will Smart, Chief Information Officer at NHS England presented on opportunities for improving healthcare through digital innovation. There are Global Digital exemplars in the NHS with exemplar blue prints and exemplar fast followers. More money is to be provided for this agenda and will be given to STPs to allocate. I asked him to consider dealing with LAS separately and gained the impression that he was sympathetic to this.

20. Nationally 10% of people use digital communications to access NHS111.

NHS Providers meeting with Chris Hopson

21. Garrett and I met with Chris Hopson at his request to share our experience of working with the regulators whilst in Special Measures.

NHS Providers course

22. I attended a one day course re the 'Effective Chairing of Meetings' and recommend their programmes aimed which are specifically at Executive and Non-executive Directors.

23. Key messages from my course will be shared at a Board briefing session.

NHS 70 Service at Westminster Abbey

24. Jamie O'Hara Director of Strategy and Communications and I together with 20 members of staff represented the Trust at a service to recognise the 70th anniversary of the NHS. The Duchess of Wessex attended the service and the address was given by Simon Stevens.

Heather Lawrence OBE
Chair

Government reshuffle following Cabinet resignations -

On 6 July, the Prime Minister attempted to secure Cabinet agreement on the UK's future relationship with the EU after Brexit at a crunch meeting held at Chequers, her country retreat. Yet 72 hours later, two key figures had resigned, David Davis, Secretary of State for Exiting the EU and Boris Johnson, Foreign secretary. Both had supported a "hard Brexit", a position characterised by a desire for regulatory divergence from the EU and a departure from existing EU customs arrangements.

These resignations, alongside that of Brexit Minister Steve Baker, resulted in a small Cabinet reshuffle. Jeremy Hunt, who recently became the longest serving Health Secretary, had his loyalty to Theresa May rewarded with a promotion to Foreign Secretary. In January, he had refused to take on the business portfolio, instead remaining in post and securing recognition of his department's policy responsibility for social care. Having since successfully argued for an early funding uplift for the NHS, and on being offered one of the great offices of state, he clearly felt able to move on.

Dominic Raab takes over as Secretary of State for Exiting the EU. The Brexit White Paper – establishing the UK's position on the future relationship with the EU – is expected to be published on Thursday. European negotiators will await this before commenting on the deal secured at Chequers. However, commentators suggest the EU appears relaxed about the changes, having conducted most of the negotiations to date with Olly Robbins, the Prime Minister's EU advisor.

Questions about Theresa May's leadership and ability to deliver Brexit have loomed for some time, and these high-profile departures renewed speculation. For now she remains in post, with the immediate likelihood of a leadership challenge seeming to have passed, especially as Parliament will go into recess in a fortnight. Yet with the Taxation (Cross-Border Trade) Bill due to be debated in the House of Commons next week, the debate about future trade agreements will come to the fore, with the potential to test support for Theresa May's approach.

We will circulate a full update on Brexit developments, including the government white paper and developments in Europe shortly.

This briefing includes:

Biographies of the new health and Brexit ministers

Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care

Conservative MP for West Suffolk since 2010, re-elected in June 2017 with a majority of 17,063

Portfolio

The Secretary of State for Health and Social Care has overall responsibility for the business and policies of the department, including: financial control; oversight of all NHS delivery and performance; mental health and championing patient safety.

Parliamentary career

- Secretary of State for Digital, Culture, Media and Sport, Jan 2018 – July 2018
- Minister of State at the Department for Digital, Culture, Media and Sport, 2016-18
- Paymaster General and Minister for the Cabinet Office, 2015-16
- Minister of State at the Department of Energy and Climate Change; Department for Business, Innovation and Skills.
- Joint Minister of State at the Department for Business, Innovation and Skills and the Department for Education, 2013-14
- Joint Parliamentary Under-secretary of State at the Department for Education and the Department for Business, Innovation and Skills, 2012-13
- Member of the Standards and Privileges Committee, 2010-12
- Member of the Public Accounts Committee, 2010-12

Biography

- Matt Hancock backed the Remain campaign in the 2016 referendum and supported Theresa May in the subsequent Conservative Party leadership election.
- Digital technology is a key focus for him and in February he launched his own social media app to connect with his constituents.
- Before becoming an MP, he worked as an advisor for then Shadow Chancellor, George Osborne, later becoming his chief of staff.
- Hancock received First class honours in philosophy, politics and economics at Exeter College, Oxford and an MSc in economics at Christ's College, Cambridge.
- He started work in the family computer software business and later became a Bank of England economist for five years, specialising in the housing market.
- In 2011 he wrote a book on the 2008 financial crash, *Master of Nothing*, with fellow MP Nadim Zahawi.
- Hancock is an amateur jockey and went on an expedition to the North Pole to play a cricket match.

Dominic Raab MP, Secretary of State for Exiting the European Union

Conservative MP for Esher and Walton since 2010, re-elected in June 2017 with a majority of 23,298

Portfolio

The Secretary of State is responsible for the work of the Department for Exiting the European Union. Responsibilities include: supporting the UK's negotiations and establishing the future relationship between the EU and the UK; conducting the negotiations; working with devolved administrations, Parliament and other interested parties on the approach to negotiations and; leading and co-ordinating cross-government work.

Parliamentary career

- Minister of State for Housing at the Ministry of Housing, Communities and Local Government, 2018
- Minister of State at the Ministry of Justice, 2017-18
- Member of the Select Committee on Exiting the European Union, 2016-17
- Parliamentary Under-secretary of State at the Ministry of Justice, 2015-16
- Member of the Education Select Committee, 2013-15 and the Human Rights Committee, 2010-13.

Biography

- Dominic Raab backed the Leave campaign in the 2016 referendum, and supported Michael Gove in the subsequent Conservative Party leadership election.
- He read law at Lady Margaret Hall, Oxford and completed a Master's degree at Jesus College, Cambridge.
- After university, Rabb joined an international city law firm, including spending time working in Brussels advising on European Union and World Trade Organisation law.
- In 2000, he joined the Foreign and Commonwealth Office (FCO) as a civil servant, leading a team of lawyers at the International Court of Justice in the Hague.
- He left the FCO in 2006 to become Chief of Staff to the then shadow Home Secretary David Davis and next worked for Davis' successor, Dominic Grieve QC.

Department of Health and Social Care ministerial team

Matt Hancock now oversees the ministerial team put in place in January:

- Stephen Barclay MP, Minister of State for Health
- Caroline Dinenage MP, Minister of State for Care
- Lord O'Shaughnessy, Parliamentary Under-secretary of State (Lords)
- Steve Brine MP, Parliamentary Under-secretary of State for Public Health and Primary Care
- Jackie Doyle-Price MP, Parliamentary Undersecretary of state for Mental Health and Inequalities

For the biographies and portfolios of the team, see NHS Providers' January 2018 reshuffle briefing and our 2017 post-election briefing:

Other changes made in the reshuffle

- Chris Heaton-Harris has replaced Steve Baker as junior minister in the Department for Exiting the European Union.
- Kit Malthouse has replaced Domnic Raab as Housing Minister.
- Justin Tomlinson has replaced Kit Malthouse as a junior minister in the Department of Work and Pensions.
- Jeremy Wright has replaced Matt Hancock as Culture Secretary.
- Geoffrey Cox QC has been appointed as the Attorney General replacing Jeremy Wright.

A full list of government ministers is available here: https://www.gov.uk/government/ministers

NHS Providers response to the appointment of Matt Hancock

New secretary of state faces tough choices

Matt Hancock arrives at a crucial time for the NHS with the need to develop a ten-year plan and prioritise how new funding is invested.

This will require difficult decisions in balancing the need to recover lost ground after almost a decade of austerity, transforming the way services are delivered – including the digital revolution - and improving care in key areas such as cancer and mental health.

He will also need to address important concerns that fall outside the NHS funding settlement, including social care, public health and workforce development. Without investment in these areas, progress will be curtailed.

It is vital that frontline trusts have a strong voice in shaping and agreeing to all new commitments in the ten-year plan and how they are delivered. As the membership organisation for 100% of NHS acute hospital, mental health, community and ambulance trusts we look forward to playing a central role in those deliberations.

We would also like to acknowledge the contribution made by Jeremy Hunt, our longest serving secretary of state, whose commitment and determination helped to secure the long term funding settlement for the NHS.

Jeremy Hunt was a tireless champion of patient safety and helped to promote a culture of learning and improvement that will benefit the NHS for many years to come. We wish him the best of luck in his new role as foreign secretary.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report Title:	Report from the Chief Executive			
Agenda item	06			
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.

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 paper supports the achievement of the following Business Plan Work streams:	
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 from Chief Executive

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

Operational Performance

2. The June Category 1 mean returned 7 minutes 13 seconds while the Category 1 90th Centile was 11 minutes 45 seconds. The Category 1 90th Centile has remained within the standard each week since the implementation of the Ambulance Response Programme (ARP) and shows that our most critical patients are being responded to quickly. The latest nationally published data shows that the Trust is ranked 2nd in the Category 1 90th Centile measure (for the fifth consecutive month) when compared to all ambulance trusts across England.

3. June's performance was markedly challenged due to the consistent hot weather which London experienced together with a number of large scale events taking place across the month. The ending of overtime disruption payments has also impacted on our weekend performance although we should see the return of overtime to previous levels in due course.

4. In terms of the Emergency Operations Centres (EOC), 80% of all calls were answered within 5 seconds in June 2018. 50% of all calls were answered immediately while the 95th centile was 98 seconds.

5. Progress against EOC recruitment and retention continues to be scrutinised at weekly Operations Resourcing Group meetings. In addition to this, an executive-led intensive action group was initiated as a result of the last Chief Executive performance review meeting with People and Culture.

6. The high levels of demand were also experienced by the 111 service with a rise of 13.2% comparable with June 2017. The 111 service achieved 95% or more of calls answered in 60 seconds on 6 days, and exceeded 90% on a further 10 days. 111 referred the second lowest combined percentage of patients amongst all providers to ETCs and 999.

7. There was a significant focus during June on completing the delivery of mandatory licensing refresher training required by all staff.

8. Progress continues to be made with the implementation of the new operational management structure. The key points to note are as follows:

    - The Operational Restructure continues to progress with the assessments, interviews and online personality questionnaire for the Very Senior Manager (VSM), Band 8D and Band 8C posts; a situational judgement test (online); an interview with stakeholders; and a panel selection interview. Staff who expressed an interest in the Band 8B posts are being assessed through the completion of an online personality questionnaire; a situational judgement test (online); a case study exercise which will include the need to prepare a presentation; and a panel selection interview which includes a presentation.

    - Those requesting to be considered for Band 8A / Band 7 posts will be required to complete an online personality questionnaire; a situational judgement test (online); and a panel selection interview.

- The timetable for the selection arrangements is as follows:

Date	Deliverables
w/c 25 June 2018	All staff affected by change will receive letters detailing assessment/interview arrangements
w/c 2 July 2018	Psychometric test completion (online)
5 July 2018 – 16 July 2018	1:1 feedback on test results from an external assessor
13 July 2018	VSM interviews
w/c 16 July 2018	Band 8D, Band 8C and Band 8B interviews
w/c 23 July 2018	Band 8A, Band 7 interviews

9. In order to help managers to prepare for interviews and / or the assessment process, Operations have made arrangements with the People & Culture team to provide two Interview Skills Workshops on 4 and 12 July. The aim of these workshops is to assist managers with making preparations for interview, to give them an overview of assessment centres and to offer them protected time to practice their interview skills. Managers have also been reminded that the London Leadership Academy (LLA) offer a coaching and mentoring service for NHS staff who work in London and their contact details have been circulated.

Finance & Performance

10. As reported elsewhere on the agenda the Trust is £0.04m ahead of plan at the end of June (Q1). Income for the quarter was £1.4m lower than planned with incident activity 0.6% below contracted levels. Whilst call levels remain high, incidents do not appear to be delivering the assumed growth included in the initial plan.

11. Pay expenditure was £2.7m lower than plan in Q1 due to frontline vacancies partially offset by private ambulance and agency usage. The executive team continues to focus on recruitment and retention to reduce reliance on overtime and PAS to maintain safe and effective rosters.

12. The Trust delivered its required level of CIP in April (£2.5m) and work is currently underway across the organisation to continue to ensure the full £12.3m is delivered in 2018/19. The Trust forecast is to deliver its control total deficit of £1.564m in 2018/19.

Strategy

13. Significant progress was made during June in defining what our fleet and estate of the future might look like. A workshop was held with a large cross section of senior management to discuss our future fleet options which will feed into a revised fleet strategy. A separate workshop was held to look at our future estate, focussing on our frontline operations. A number of key questions were posed, the outcomes of which helped to feed into a Board briefing session on 26 June. This Board session started to identify the key priorities for our estate as well as the principles by which we will develop it. We are now developing an estates strategic intent document which will outline these priorities, principles and proposed direction of travel for our future frontline estate.

14. We have also been working with other Directors, most notably on the IM&T strategy to determine the areas that it needs to cover, the gaps that currently exist between the existing strategy and our new organisational strategy as well as the elements of staff engagement that will take place to help us develop this key enabling strategy.

15. We have completed the design work on the full strategy document which is now up on the London Ambulance Service NHS Trust (LAS) external website. We are currently in the process of designing a shorter, easy to read version which will enable more people to read and understand our new organisational strategy.

16. There are several activities either in delivery or planned to be undertaken as part of the blue light collaborative efforts. The Estate Directors for each service have met and as a result planning for an Estates Workshop is underway. The outcome of the workshop will inform a 999 Estate Strategy that will add leverage to a collective purchasing and negotiation position. Discussions are ongoing around the Romford/Hornchurch and Edmonton sites.

17. A meeting of the Heads of Response has been held and agreement to deliver on several initiatives over the coming six months has been reached. The trust has actively participated in discussions on the following initiatives:

    - London Fire Brigade (LFB) responding to collapsed behind locked doors rather than Metropolitan Police Service (MPS)
    - LFB responding to fallers
    - LFB responding to crew assist calls

18. As part of the Control Services transformation fund bid (£1.9 million for 17/18) a new programme manager (Chris Dawe) recently joined the trust. This should see the governance framework and agreed milestones established.

Quality Improvement

19. The Quality Service Improvement Redesign (QSIR) training has now commenced with the first cohort of 28 starting on the 10 July for 1 day a month until December. The next cohort will commence in January. In addition the half day NHS Elect abridged version of the QSIR training has been included in the Leadership Programme for all Band 7 and above managers.

20. The Risk Register was redesigned, reconfigured and went live on 1 July 2018. This redesign will align the Risk Management Strategy and Policy January 2018.

21. The Risk Awareness and Datix Risk Register System Training was communicated to all staff via the RIB in the issue published on the 26 July together with enrolment instructions to support staff in developing a risk aware culture. On the 6 July all GAMs were trained on the revised risk register and were informed of the new process updates.

22. The Risk Compliance and Assurance Group (RCAG) terms of reference and membership have been discussed and agreed with Philippa Harding, Director of Governance. These new terms of reference will also include the escalation and de-escalation of risks and outputs will be considered at the August meeting of the group.

23. A workshop was held on the 2 July to identify potential improvements in access, timeliness and the quality of experience when submitting a complaint to the LAS. Following this a process mapping session was held on 3 July to review the complaints process, solutions were identified and a paper has been produced together with action plans. This will be presented to the Quality Audit Committee. The actions will then be implemented which will positively impact on the length of time patients/families wait to receive a response letter and also the content of those letters (a review by the Chair and the Patients Forum will be carried out in the next few weeks).

24. Community Involvement Officers (CIOs) have been formally transferred to the Directorate under the management of the Deputy Director of Nursing and Quality with an initial team meeting held on the 13th June to agree role expectations, reporting processes and to provide reassurance regarding the changes in operational management. A workshop to review and amend the current job description to reflect their new role was held on the 18th July.

25. I am pleased to welcome three full time mental health nurses to the trust this month. Once induction and necessary training has been completed they will join EOC to strengthen the rota providing additional cover and to support the implementation of the mental health response car, both are elements of the pioneer service aims and objectives.

26. The Pioneer Services project plan has now been scoped and the new roles are currently undergoing the grading process. A project workshop and project board meeting was held in July.

27. The configuration of the SE111 Datix system includes a redesign to replicate LAS processes and National Reporting and Learning System (NRLS) is progressing and will be available when the LAS acquire the NE111 service 1 August 2018.

28. A pan London workshop to advocate the utilisation of Coordinate My Care as the repository for personalised care plans was held on 11th July by commissioners and the Healthy London Partnership. The trust is providing key support in order to advocate the patient benefits and the impact on non-conveyance rates for those palliative care patients and those with urgent and emergency care plans. This will also support the decision making process for our staff on scene.

29. As a result of the successful CQC recommendation to NHSI for the removal of the 'special measures' category to the 'good' category there has been a great deal of interest from a number of partner organisations keen to hear about our journey and achievement. Following a request from NHSI the Chief Quality Officer delivered a presentation to the attendees of the NHSI Annual Conference.

30. A successful application for a Community Behavioural Order (CBO) has been achieved in partnership with the Metropolitan Police against one of our most prolific frequent callers.

31. The Trust have had a challenging month with serious incidents – 16 have been completed and sent to the Clinical Commissioning Group (CCG) for comment – all within the 60 day timeline.

Medical Directorate

32. The final preparations for the North East London (NEL) Integrated Urgent Care (IUC) mobilisation continued; key positions are being appointed to and training is being developed. There has been close working between the IM&T, Estates and Training teams to ensure delivery of the changes required for Maritime House without disruption to the training courses and assessments which are co-located. The clinical pathways are being finalised with clinical commissioners in North East London. A number of stakeholder engagement events with Out-Of-Hours OOH Providers and General Practitioner (GP) forums have been held to introduce the LAS as the provider for the area and to review care pathways. We have employed a part-time pharmacist, to cover

maternity leave, to support the development of the IUC pharmacy guidelines and formulary.

33. The recruitment of the Advanced Practice Provider (APP) urgent care paramedics is on-going. The assessment centre was held in the second week of July.

34. Work has started on the clinical input into the development of Electronic Patient Care Record (ePCR). This project will be the most significant change to the way our crews operate. A very successful engagement event with staff was held and a project team is now in place. The sharing of learning from clinical incidents is continuing with information being shared both directly from the medical directorate and locally through Quality, Governance and Assurance Managers (QGAM) and Clinical Team Leaders. A new Clinical Update has been shared service-wide.

35. The Trust has hosted a visit from the Home Office to assess our suitability for a Controlled Drug Licence – a new requirement for ambulance services. The visit went well and thanks are extended to all those involved in the visits. There have been no unaccounted for losses of injectable morphine since the last report.

36. The LAS's Head of Clinical Audit & Research has been voted in as Chair of the National Ambulance Research Steering Group. Benchmarking figures released by the National Institute of Health Research show that LAS is performing extremely well against research activity metrics, exceeding the national averages. We have three new trials about to start and, working collaboratively with academic institutions and other NHS trusts, we have submitted four bids for research project funding. As two of our largest recruiting and largest grossing projects have come to an end, we are turning our attention to building our pipeline so that in the next 18 months – 2 years we will have other large, well-funded studies in our portfolio. In addition the Clinical Audit and Research team remain engaged with the NHS England (NHSE) team developing the new Ambulance Quality Indicators (AQI).

37. The First Responder team, under the leadership of Chris Hartley-Sharpe, has moved to the Medical Directorate. This brings together the clinical oversight of cardiac arrests from first responders to advanced paramedics. We continue to see a high rate of Return of Spontaneous Circulation (ROSC) following cardiac arrest at sites that have a public-access defibrillator. We are currently recruiting to the role of an Interoperability Development Officer to enhance our work with the Metropolitan Police who co-respond to cardiac arrest with us; the recruitment process is expected to be complete this month.

38. The Clinical Education and Standards (CE&S) team remain very busy delivering Trainee Emergency Ambulance Crew (TEAC), Emergency Ambulance Crew (EAC) and paramedic training as well as Core Skills Refresher (CSR) 18.1. The staffing establishment has now been confirmed and offers made to applicants for vacant posts which will bring CE&S to full capability to deliver the current plan. This will also support an additional I-Para course and we are exploring further TEAC courses to increase the numbers being trained. The academy program received full compliance for the annual audit review. The major change to increase numbers to 108 per annum has been submitted. Some further information was requested by the Health and Care Professions Council (HCPC), which has now been provided. A plan has been developed to move the records and paper storage from centres, and in particular free up space at the Barking site for the IUC project – this partially addresses recommendations from internal audits and the risk on the risk register. A replacement venue for the Southwark Annexe, which hosts driving programs has been identified at Tulse Hill (Defence Estates Management Group). A project to move locations has commenced.

39. The Infection Prevention Control team have undertaken validation audits at 33 more challenged stations and supported their improvements during Q1. The IPC team have supported the procurement of streamlined waste bins with a potential saving of £12,500 and negotiated accessibility/improvement to hand wash supplies at stations by crews. The immunisation catch-up programme is progressing and the IPC team are continuing to support in the management of communicable disease incidents. An Operations project lead for Filtering Facepack Protection (FFP) work stream has been identified and good progress is being made.

People and Culture

40. Our on-going engagement with managers and staff continues to deliver the highest % of users using the new ESR Portal in England and Wales and a case study of the LAS ESR Transformation Programme will feature in the National ESR Newsletter in July.

41. New e-Learning Software has been purchased (Adapt) and our e-learning team are currently re-developing our e-learning packages, ready for the launch of CSR 2018.2 on 6th August. This software will deliver an enhanced and improved user experience, particularly on mobile devices. Additionally, we are working in partnership with the Head of Business Continuity to develop two E-Learning packages to be hosted on ESR by the end of July 2018. Over 64,000 e-learning courses have been completed since go-live. Nearly 4,000 staff have set-up to use from home and these numbers will increase with the newly available auto enrolment functionality. The MyESR support desk has resolved over 7,000 calls and emails since go-live with an average resolution time of 0.45 days.

42. The ESR Project team have completed their roll-out of OLM Learning Administration to training teams in EOC, 111, Non-Emergency Transport Service (NETS), Hazardous Area Response Team (HART), Emergency Preparedness Resilience & Response (EPRR), Clinical Hub, Tactical Response Unit (TRU) and Safeguarding Supervision. Work has commenced with the Leadership and Performance Team to set up the Management Essentials Learning Path in ESR.

43. The eForms solution will deliver on-line forms for staff changes and leavers. These forms are interfaced with data from ESR and have been designed to reduce the administrative burden for managers and their teams and improve the timeliness and accuracy of data in ESR. The pilot in North Central Sector has finished and was positively received by users. All Group Stations are going live during August and the Trust wide implementation will be completed by 31st October 2018.

44. Work is underway with the Scheduling Team to review the specification and build the high level Project Plan for the ESR/GRS interface, due for implementation by 31st December 2018.

45. Statutory Mandatory Training Compliance at the end of June 2018 was as follows:
    - Trust compliance is 88.21%
    - 87.83% Operations
    - 92.1% Corporate

46. EOC, the subject of the CQC Must Do action, is at 79.7% and a specific trajectory and action plan has been agreed with the EOC management team to bring this in line. CSR.2017.2 stands at 90.3% and CSR.2017.3 is at 88.76%. CSR2018.1 is 67.93%. Also Information Governance is at 91.73% for June and will increase alongside CSR completions.

47. The illustrated Employee Journey is being finalised ready for production and use in People and Culture materials and collateral. We will also be using Inky Thinking for future People and Culture events for Apprenticeships and the WRES Co-Production Workshop on Tuesday 24 July 2018.

48. Weekly calls are being held with NHS Elect's Jim Timpson in the run up to the Visible Leader which is aimed at the (Location) Group Managers starting on 23 July 2018. Work will shortly begin on the development of the bespoke Psychological Resilience day with Cathe Gaskell and we will be working with people across the service as well as external partners/agencies to create the design and delivery methodology to ensure it best meets our objectives.

49. The mandatory elements of Management Essentials (currently at 7 days) are being reviewed, as alongside StatMan, CSRs (3 x 8 hour sessions), other Leadership Development Pathway elements (Engaging and Visible Leader are 5 day programmes) we would be creating capacity issues across the service. New elements under discussion include Strategy and Innovation and meetings are planned to commence design/delivery of this.

50. We are in the final stages of the overall Oracle Learning Management (OLM) Optimisation. This workstream will however remain open once work has finished with Learning, Education and Performance as it can then pick up any additional larges areas of training and development when identified e.g. Risk and Datix.

51. The Reverse Mentoring Programme launched with an Engagement Day with the 12 "Mentees" on 6 July 2018.

52. We have been supporting those affected by the Operations Restructure with Interviewee Skills development sessions in collaboration with the HR team as well as individual support as and when required.

53. Appraisal completions were at 87.5% at the end of June. The Appraisal Audit Paper has been completed and reported to the People and Culture Committee for noting on 12 July. An Appraisal Improvement Programme will commence in August to take forward some of the recommendations as well plan the move towards an eAppraisal system.

54. The Induction Improvement Programme continues and will shortly move into the Content Review/Improvement phase. We have also looked at incorporating extra numbers into existing programmes as well as add new programmes for new NEL111 staff from August to ensure staff are welcomed to the LAS alongside their peers across the service.

55. We are moving into the new Occupational Health contract year. People Asset Management (PAM) have agreed to carry over the remaining budget underspend allocated to the last year for this to be utilised for the purposes of the immunisation project.

56. We await a final meeting on 13 July with PAM and Procurement to finalise the new Key Performance Indicator (KPI) arrangements to allow us to closely monitor performance. The original KPIs would indicate that PAM have performed well against the contract, but in real terms this has not been the case particularly more recently. The new KPI's are extremely specific and will highlight any shortcomings, driving performance improvement over coming months and into the new contract year.

57. Our top two reasons for absence continue to be musculoskeletal injury 41% and Mental Health 11%. Both of these will be addressed as part of the Health and Wellbeing

Commissioning for Quality and Innovation (CQUIN) project and the Cost Improvement Programme (CIP) Improving Attendance work stream.

58. We have a meeting scheduled with PAM on 26 July to re-evaluate our counselling provision and to discuss where we can make improvements and improve access for our staff. This will include the launch of the dedicated trauma support line for managers and staff.

59. The staff immunisation programme is ongoing. In the last fortnight we have been delayed with the vaccination project as PAM have had a number of resource challenges; this is unfortunate due to the momentum that has been generated since roadshows. A meeting takes place with PAM on 13 July to discuss options for increasing the resource on the project.

60. We are exploring (via the Medical Director) the option of paramedics on reduced duties supporting this programme. An update on the number of staff fully immunised and number of staff still requiring further intervention is outstanding from PAM and will be updated verbally at the meeting.

61. There has been a significant number of Measles exposures reported since the last update which has been heavily supported by Infection Prevention Control (IPC) colleagues. We are now required to take this process on as part of the Occupational Health (OH) Contract Management role. A revised process is in place with PAM and has been updated on all platforms and staff will now be aware of what actions need to be followed.

62. LAS were selected to take part in the national evaluation of the Workforce Race Equality Standard (WRES). This was facilitated by Sheffield University on 19 June 2018 with a focus group of Black and Minority Ethnic (BME) employees. Attendees were invited to share their knowledge of the WRES, and whether they felt that there had been any differences in how BME staff are treated compared to non-BME staff within the Trust, and whether they have noticed any changes over the past few years.

63. LAS attended a Skills for London Strategy Launch hosted by the Mayor of London. The strategy is aimed at upskilling Londoners, with a particular emphasis on Black, Asian or minority ethnic (BAME) Londoners and those from disadvantaged areas. We are keen to tap into any funding that can be applied for to fund projects aimed at improving diversity and inclusiveness at LAS.

64. The Sponsorship Mentoring initiative was launched 12 June 2018, with an initial cohort of 18 mentors, including executive board members, non-executive directors, senior managers and paramedics.

65. The BAME Staff Meeting, the Association of Diverse and Minority Ambulance Staff (ADAMAS), was held on 28 June 2018 and was well attended by BAME staff. Key topics of discussion included rebranding the network, and the WRES co-production event planned in July.

66. As part of our WRES development work we will be reviewing and revising our WRES Action Plan for 18/19. A stakeholder engagement event is planned for the 24 of July 2018.

67. Recruitment activities supported during June include:

June 2018	**Stockwell Job Centre Plus Job fair** 155-157 Clapham Road, Stockwell 7th June 2018	EMD Role to be promoted Rep from Equalities Team	19 candidate details taken for TEMD &TEAC
	London Bridge Job Centre Plus Job fair Coburg House 63-67 Newington Causeway 19th June 2018	EMD Role to be promoted rep from Equalities Team	37 candidate details taken for TEMD/TEAC/ 111
	The ULAS Apply Event for School Leavers 27th June 2018 2pm-5pm	All frontline roles to be promoted and LAS as an employer Rep from Equalities Team	Target Audience **16-18 yro** from 300 schools across London Circa 500 school leavers

68. 16 candidates have been shortlisted for the permanent People & Culture Business Partner posts. There has been some slippage on assessment process; however, this will be clawed back and take place during July. Transitional support is being provided through the recruitment of 2 experienced Business Partners.

69. Significant support continues to be provided to senior managers who are restructuring or reorganising their teams. Additionally, resource has been identified to support the forthcoming Finance and Performance restructure.

70. Planning is underway for the design and delivery of workshops and any training identified for the roll out of business partnering across the Trust. This work will be supported by Angela Flaherty.

71. All Staff Survey Champions provided an updated progress report on their action plan. Good progress is being made across the organisation. The management re-structure was the main reason given for the delay in progressing some of the actions. Local issues such as lack of meetings, building works and staff side rejecting plans were also cited as reasons for delays in progressing/achieving the actions. The next progress reports are due 13th July.

72. A 'touch base' call was held with Group Station Managers (GSM) on 28 June to check in on their understanding of their Staff Survey Action Plan, understand whether the process has been useful to them this year and what they would like to see going forward. The discussion centred on whether the action plans contained activities / actions of sufficient weight to make a difference to their staff.

73. A Staff Survey Champion event is planned for 23 July to recognise the work of the Champions and agree next steps. Discussions will focus on 'You Said, We Did' communications and going into the Roadshows w/c 1 October 2018.

74. The pulse check and FFT ran from 5th-22nd June. 866 and 842 people completed the two FFT questions respectively. There was a significant dropout rate between the FFT and the pulse check. 626 staff completed all the questions (with an additional 52 starting the questionnaire but not answering all the questions).

75. This was publicised through the RIB, Staff Survey Champion's circulating the link to their colleagues and an all users email.

76. The responses to the FFT were:

	How likely are you to recommend the LAS to a friend/family if they needed care or treatment?		How likely are you to recommend the LAS to friends and family as a place to work?	
Extremely likely	**38.45%**		**9.50%**	
Likely	**43.19%**	**81.64%**	**32.19%**	**41.69%**
Neither likely or unlikely	11.55%		23.04%	
Unlikely	**3.46%**		**18.53%**	
Extremely unlikely`	**1.96%**	**5.45%**	**16.39%**	**34.92%**
Don't know	1.39%		0.36%	

77. Previous responses to the FFT for the past two years are provided below for comparison.

		care or treatment?		place to work?	
	Total responses	Likely	Unlikely	Likely	Unlikely
Q1_2018-19	866	81.64%	5.45%	41.69%	34.92%
Q4_2017-18	263	61.22%	22.81%	22.81%	57.41%
Q2_2017-18	421	70.07%	17.34%	24.47%	60.57%
Q1_2017-18	453	75.28%	11.70%	32.67%	53.64%
Q4_2016-17	115	53.04%	25.22%	18.26%	60.87%
Q2_2016-17	382	73.82%	11.78%	34.82%	51.31%
Q1_2016-17	483	72.88%	13.66%	33.33%	52.17%
Q4_2015-16	439	67.65%	21.64%	26.42%	58.77%
Q2_2015-16	353	58.36%	20.11%	20.40%	58.64%
Q1_2015-16	431	56.38%	25.75%	20.65%	62.65%

78. This data shows that there has been a 21% increase in the number of staff who would recommend LAS as a place to receive treatment (82%) and a 19% increase in the number of staff who would recommend LAS as a place to work (42%) in comparison to Q4 in 2017/2018. Both of these scores are higher than any time in the last 2 years. In addition, there were 600 more respondents than in Q4 2017/2018 and 359 more than the previous highest in the last two years.

79. We are implementing the Associate Ambulance Practitioner Apprenticeship Standard programme across our TEAC training. To date we have appointed to 6 cohorts totalling 74 candidates.

80. Work is continuing with the Clinical Education Team to ensure the Service is OfSTED ready. This is progressing as we follow the first cohort through the Apprentice Standard. A document log is being developed in order to support the necessary responses to OfSTED. We recently met with North West Ambulance Trust, who have successfully undergone their OfSTED visit after receiving only 2 days' notice of the visit. We intend to utilise this intelligence gathered to inform our preparations.

81. The Data return system has now been set up and the repayment of levy funds has begun. Between 27 March and 10th June 2018, the total sum of £80,000 has been "recouped".

82. Work has begun on identifying opportunities across the service to introduce apprenticeship opportunities – this includes IM&T, Procurement, Fleet and Logistics, 111, EOC and NETS.

83. We are working towards recruiting a cohort of 15 NET Apprentices for October/November on the Level 2 Health Care Support Worker Standard.

84. We are working with the Procurement team to identify training provider partner/s for the delivery of functional skills (English and numeracy at Level 2 for all Apprenticeship candidates who do not or cannot evidence that they hold qualification in these subjects, which is mandatory for apprenticeship standards, level 3 or above). We received 4 bids and the panel has decided to meet all four organisations on July 18th.

85. The Leadership and Management Apprenticeship programme has been launched, to date 24 applications have been received for programmes ranging from Level 3 to level 7. The procurement process for the selection of training partners is in progress.

86. There is a need to raise awareness of the Apprenticeships across the Service, and plans needs to be developed.

87. Work with the Recruitment team has begun. We are looking to improve/design an Apprenticeship appropriate process for assessment and interview, that will not only to attract a wider pool of potential candidates from a diverse background, but, that will ensure we recruit individuals in line with our expected values and behaviours.

Strategic Assets and Property

88. The trust were successful in being awarded £3.849m from the Department Health and Social Care to support the Ambulance Response Programme targets over the winter period. The funding is for the purchase of new ambulances in addition to the current vehicle procurement programme.

89. To accommodate the NEL 111 service the lease for Maritime House has now been signed. We currently operate training from this building in Ilford.

90. Two workshops were held with staff from the fleet, logistics and estate directorates with external speakers from Waitrose. A further development session was held with the Trust Board.

91. During August the diversity and inclusion champion and Benita will be holding Listening in Action events across all 12 fleet workshops.

Communications

92. The new Five Year Strategy featured positively in the London media. The majority of media outlets went with the theme that the trust will convey less patients to hospital as part of a more integrated approach to healthcare in London. The story was well covered in all London broadcast media, the Evening Standard and in two national newspapers. Both Fenella Wrigley, Medical Director, and I undertook broadcast interviews. We

worked closely with key members of the health trade press which is well read by key industry stakeholders and the Health Service Journal agreed to interview Fenella and subsequently wrote a very positive story on the strategy.

93. The prolonged hot weather prompted a number of communications via social media offering advice about staying safe in the warm weather and doing what is possible to reduce demand on the Trust. One tweet achieved 63.2K impressions.

94. We facilitated a filmed interview of call handler, Nichola Cruickshank and HART paramedic, Jed Farrell, in our Bow control room. Nichola is the call handler who took a 999 call from a six year old girl when her mother experienced a diabetic coma. The six year old, Malak, was put forward by us for an award from the BBC children's television show - Operation Ouch! Malak is a finalist in the show's awards. Jed Farrell was interviewed as he had visited Malak's school to teach about dialling 999 only days before Malak made the call which saved her mother's life. The interviews will feature in the show.

95. As part of NHS70 celebrations, Sky News attended Waterloo HQ to conduct a live interview with me. However due to a funding announcement by the Department of Health which announced additional monies for the purchase of ambulances the focus of the interview changed. I was therefore able to talk about the new funding as well as our significant investment programme to replace our fleet whilst reminding Londoners how busy and effective we are. The live and pre-recorded interviews took place throughout the morning with myself and EOC Manager, Craig Harman.

96. The presence of one of the vehicles from out historic fleet alongside a brand new ambulance in front of our HQ building for the day enabled us to talk effectively about how our role has developed over the years, as we have become busier and our clinical responsibilities have increased.

97. The Chair joined members of staff at a national event for NHS staff at Westminster Abbey on 5 July; I shared a video message with staff as did Simon Stevens, CEO of NHS England; and we said 'thank you' to staff by providing teams with tea party packs including NHS70 travel mugs, and holding a Big 7Tea event at our Headquarters.

98. We shared stories about our inspirational staff across internal channels and with the Press Association, achieving coverage in national media including the Times, Mail Online, BBC, ITV News, Mirror and Express.

99. BBC London TV and Sky TV spent time with us, interviewing staff about the past, present and the future – including filming our 1949 Daimler which had been made roadworthy for the celebrations and was sited outside our HQ attracting interest from both Londoner's and those visiting our city.

100. We posted extensively on our social media channels using the #NHS70 hashtag, using the opportunity to encourage people to consider working for us. We also launched a school/youth group's competition inviting children under 11 to draw an ambulance or a picture of a member of staff. The Chairman will select the winner whose school or club will receive a visit from our Patient and Public Involvement (PPI) team.

101. On 7 July I represented the service at the annual Remembrance Ceremony in Hyde Park laying a wreath on behalf of the trust.

102. Responding to staff feedback (from the Roadshows etc.) on how to increase the visibility of senior management, over the last few weeks, I have started to record a weekly video message to staff to update everyone in the organisation on key issues and my reflections on events that have taken place in the previous seven days.

103. The annual PRIDE event this year was a great success and I met a number of our staff preparing to join the parade. This year was attended by the largest contingent of our colleagues, many of them new to the service.

104. There are a number of initiatives that we are working on for the coming year, some of those are with the focus of the education and awareness of how we can better support colleagues when they are offering care to those of the Lesbian, Gay, Bisexual and Trans (LGBT) community and their families.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Data Quality Improvement Strategy, Data Quality Policy and Data Quality Implementation Plan			
Agenda item:	07			
Report Author(s):	Matthew Bishop, Contractor Jill McGregor, Director of Performance Daniella Gossage, Data Scientist Oliver Waring, Data Scientist			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Update on Data Quality Assurance following discussion at the Audit Committee in March 2017 with further presentation in September 2017 (ref AC/17/46). ELT presentation and discussion in May 2017, July 2017 and July 2018. Papers further sent in correspondence to Audit Committee and KPMG 17 July 2018.			
Status:	☒	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

Initial papers discussing Data Quality Assurance were presented to the Audit Committee and the Executive Leadership Team (ELT) in 2017, stating plans for governance, policies, best practices and data quality measures. Following discussion and audit, a series of recommendations and next steps were made. These three documents – the Strategy, the Policy, and the Implementation Plan – define Strategic Objectives from the recommendations made by ELT and the Audit Committee, set out a plan for implementation, and devise the governance and roles required for delivery of data quality within the Trust.

KPMG have reviewed and provided feedback on the three documents confirming that with Board level ownership and regular oversight the documents and processes compare well in terms of good practice and are clear and concise. All of the outstanding audit recommendations will have been completed with the approval of these documents.

As agreed, the papers have been circulated to Audit Committee members. Feedback received has been updated within the documents where possible and fed back directly to the Audit Committee.

Financial budget has been approved for the initial appointment of the Data Quality Assurance Team, who will oversee the first year of implementation. The three documents will be reviewed and updated annually. A further financial assessment will be conducted once the technical plan for Phase 2 has been completed.

The Director of Finance and Performance is currently the Trust Board lead Executive with the overall strategic responsibility for Data Quality Assurance.

Recommendation(s):

The implementation of the Data Quality Improvement Strategy is a “must do” from the CQC Quality and Improvement Plan. The Trust Board is recommended to approve the Strategy, Policy, and Implementation Plan.

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	☒

NHS
London Ambulance Service
NHS Trust

Data Quality Improvement Strategy 2018-2021

Better Data for Better Decisions

Matthew Bishop / Jill McGregor / Daniella Gossage / Oliver Waring

4th July 2018

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Document reference:

Introduction

Context

In 2017/18, the Performance Directorate presented two early phase papers to the Executive Leadership Team and to the Audit Committee proposing a preliminary Data Quality Improvement Strategy. These papers defined the challenge of ensuring the standards for data quality are met consistently and fully throughout the organisation and outlined an approach for delivering assurance which would be unified, overseen centrally, and administered amongst all of the distinct Trust departments. An internal audit further defined and reinforced challenges faced by the Trust.

Recommendations – Strategic Objectives

Following these early presentations, a set of recommendations were made. These 7 recommendations underpin the focus of this strategy paper and define our 7 strategic objectives. These strategic objectives are addressed in turn in the main section of this report.

1. Develop and maintain a Data Quality Improvement Strategy
2. Design a Data Quality Assurance Framework
3. Produce a Data Quality Assurance Implementation Plan
4. Establish a corporate governance structure for Data Quality assurance
5. Introduce a Data Quality Policy to clearly define the principles of good Data Quality, the roles, responsibilities and accountabilities to achieve them, and guide governance of Data Quality
6. Appoint a Data Quality Assurance Team
7. Improve awareness of Data Quality through the delivery of Data Quality education and training

Overview – Key Documents

The LAS Data Quality Improvement Strategy is guided by three key documents:

- Data Quality Improvement Strategy
- Data Quality Policy
- Data Quality Assurance Implementation Plan.

Together these documents enable the strategic objectives and recommendations for data quality delivery to be implemented and met by the Trust. Following best practice, these three documents are to be reviewed and updated on an annual basis.

Data Quality Improvement Strategy

The Data Quality Improvement Strategy acts as a central document to drive the implementation of data quality assurance within the Trust. The strategy addresses each of the recommendations above made by the Executive Leadership Team, Audit Committee, and internal audit body, and establishes 7 strategic objectives to ensure these recommendations are met. The Data Quality Improvement Strategy is aligned with the overall strategic direction of the Trust through support of the Trust wide LAS Strategy, which was communicated externally in May 2018, and the IM&T Digital and Analytics Strategy that is currently in development.

Data Quality Policy

The Data Quality Policy establishes the governance by which data quality assurance will be administered across all departments within the Trust. The Policy defines principles of good data quality, roles, responsibilities and accountabilities which will enable the Trust to follow the strategic objectives set out in the Strategy. The Data Quality

Policy will be reviewed and maintained by the Health Information Oversight Group (HIOG), and will link with existing policies around Information Governance and Information Security.

Data Quality Assurance Implementation Plan

This document outlines a plan for the delivery of the 7 strategic objectives, providing actions and milestones to realise the Data Quality Improvement Strategy. The document provides key deliverables and timelines for the implementation of the Data Quality Assurance Framework, the appointment and responsibilities of a Data Quality Assurance Team, and the approach for data quality training and education.

Additional Associated Documents

The following additional documents are associated with these three key documents, and will be linked and referenced here as they are developed.

- Trust wide LAS Strategy;
- IM&T Digital and Analytics Strategy;
- GDPR;
- IM&T Digital Strategy;
- Information Governance;
- Information Security.

Strategic Objectives

In this section the 7 strategic objectives presented in the introduction of this document are outlined, addressed, and defined.

1. Develop and Maintain a Data Quality Improvement Strategy

This Strategy outlines, defines and aligns the constituent documents, frameworks and plans guiding implementation of data quality improvement through the strategic objectives defined here. A highlight report will be provided to HIOG to ensure accountability for the delivery and progression of the strategic objectives in line with the Trust-wide LAS Strategy and the IM&T Digital and Analytics Strategy. This holds the Data Quality Assurance Team accountable for the delivery of the strategic objectives and the embedding of data quality principles within the Trust.

2. Design a Data Quality Assurance Framework

The aim of the framework is to provide information on data confidence in a centralised format and will enable both review and feedback processes to be clearly established and utilised.

The central framework is made up of;

- KPI Assurance Review Framework
- Systematic Assurance Framework

Providing information on the KPIs and the wider LAS information systems and data sources respectively. Both frameworks will be built in 2 phases: Phase (1) a manual solution and Phase (2) a near real-time solution.

The manual spreadsheet based solution in Phase (1) will ensure the delivery of initial reviews and prioritises the most important data quality issues. Figure 4 is an example manual framework and is attached as an Appendix to this paper.

Transition to Phase (2) is anticipated to begin in the second year of the Data Quality Improvement Strategy. This near real-time solution will be largely automated, enabling data quality issues to be addressed soon after they are identified. This second phase will provide a comprehensive range of potential data quality issues.

Following the set-up of a review process, the next step will be to set up a clearly defined feedback process to remedy identified errors. This will enable the Trust to record changes as well as monitor assurance over all aspects of its data quality. An overview will allow Board Directors to identify and address data quality issues.

It is anticipated that the output of the KPI Assurance Review Framework will be incorporated into the Integrated Performance Report and will initially include a RAG rating for data confidence determined in the review, next to each KPI. In Phase (2) there will be a link so that clicking on the RAG rating will direct the user to the details of records requiring remediation. The output of the Systematic Review will be reported via a similar progression of solutions.

An overview of this specific objective will feed into the highlight report provided to HIOG.

Further details of how the Data Quality Assurance Framework will be delivered is in the accompanying Data Quality Assurance Implementation Plan.

3. Produce a Data Quality Assurance Implementation Plan

The Data Quality Assurance Implementation Plan provides a structure for the delivery of the strategic objectives as defined by the Strategy, under the governance and guidance of the Policy. Details are contained within the supporting Plan. There is a specific focus on the delivery of three of the strategic objectives, with detailed and actionable project milestones defined. These areas of focus are:

- Design and delivery of the Data Quality Assurance Review Framework, including a technical development plan for transitioning between Phase 1 and Phase 2 of the review framework [strategic objective 2]. The technical development plan for Phase 2 should include a financial assessment.
- Team structure, employment strategy, and responsibilities of the Data Quality Assurance Team [strategic objective 6]
- Training plan for Data Quality and Information Systems [strategic objective 7]

The overarching project milestones are shown below:

Milestone	Start	Finish
Deliver DQ strategy and DQ policy	Oct 2017	Jul 2018
Establish governance	May 2018	Oct 2018
Develop KPI & Systematic assurance review	Aug 2018	Mar 2019
DQ standard marks in Trust Board report	-	Dec 2018
Advertise and recruit Data Assurance team	Jun 2018	Oct 2018
Ensure training and education is fit for purpose	Oct 2018	Mar 2019
Assurance review framework – Phase (1) manual solution available	-	Oct 2018
Assurance review framework – Phase (2) real-time solution available	Nov 2018	Jan 2020

TABLE 1 – KEY PROJECT DELIVERABLES WITH ANTICIPATED START AND FINISH MILESTONES

4. Design and Implement a Corporate Governance Structure for Data Quality Assurance

The key roles for data quality assurance are displayed in the corporate governance structure infographic below. Primary responsibility for data quality governance sits with HIOG and the Data Quality Assurance Team. Further roles and responsibilities are defined in the Data Quality Policy, and outlined in strategic objective 5.

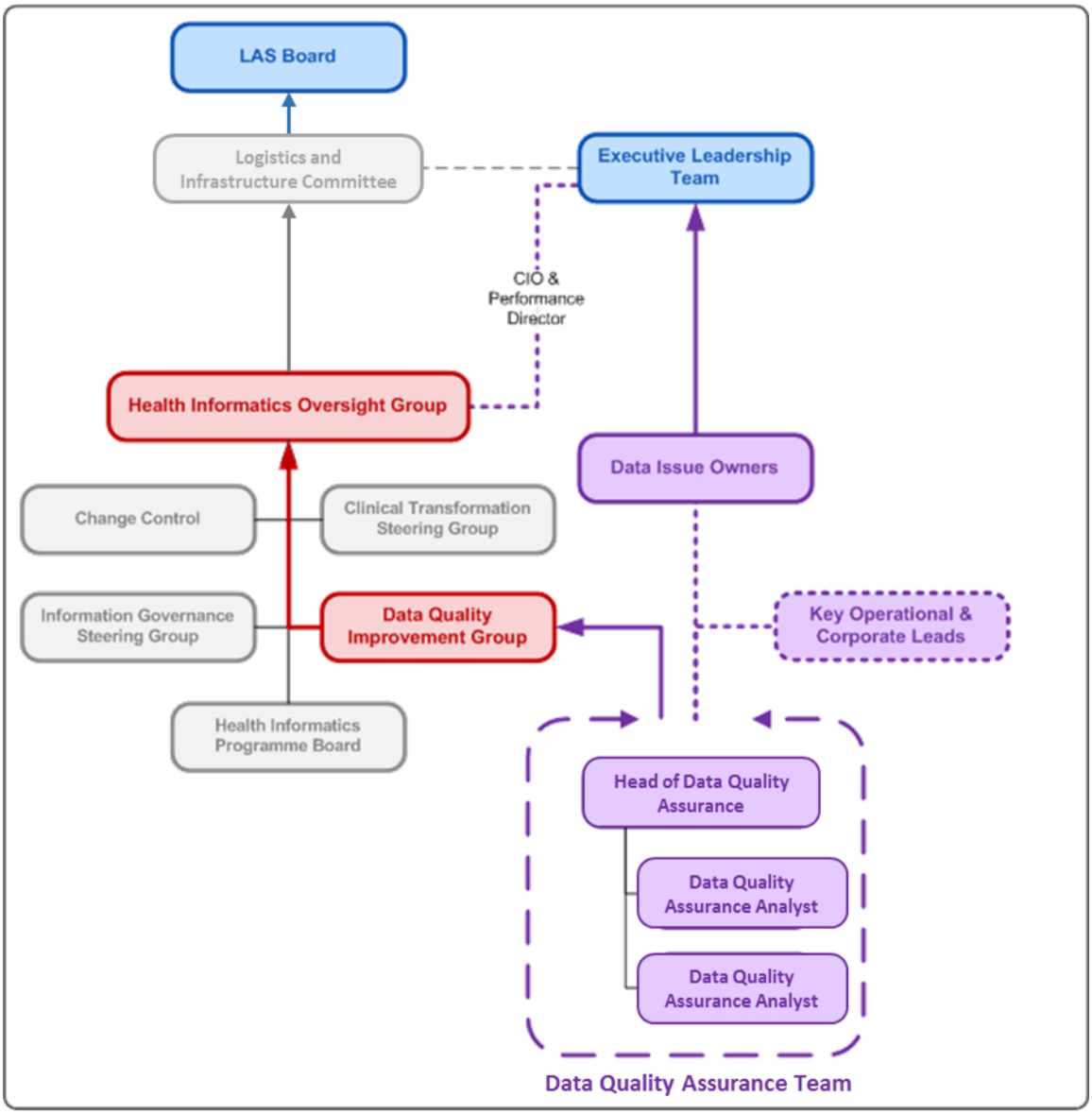


FIGURE 1 – GOVERNANCE STRUCTURE

5. Introduce a Data Quality Policy

The Data Quality policy clearly defines the principles of good data quality and the roles, responsibilities and accountabilities to enable them to be achieved. This policy will be owned by HIOG who will be responsible for reviewing and updating the policy. The Data Quality Policy will be applicable across the organisation and used by all teams.

An overview of the data quality characteristics, data quality feedback principles, and core accountabilities and responsibilities is included here for reference. For details please refer to the Data Quality Policy.

Data Quality Characteristics

As endorsed by the Audit Commission the LAS has adapted six characteristics of data quality: accuracy, validity, reliability, timeliness, relevance, and completeness.

FIGURE 2 – DATA QUALITY CHARACTERISTICS

Data Quality Feedback Principles

Introduction of Data Quality "RAG style" rating standard marks will be embedded within Trust Board and performance reporting to highlight the data quality status of specific metrics.

FIGURE 3 – DATA QUALITY FEEDBACK PRINCIPLES

6. Appoint a Data Quality Assurance Team

A new Data Quality Assurance Team has been approved to represent data quality within the organisation. The objectives for the team are;

(1) To deliver the Data Quality Improvement Strategy

(2) To assist the delivery of the Data Quality Assurance Framework

(3) Work with operational and corporate teams to deliver remediation of smaller data quality issues

(4) To attend committees and performance reviews representing and promoting data quality

(5) To maintain a physical presence within the operational and corporate teams

Achieving these objectives will influence the way the organisation runs by supporting the use and maintenance of tools provided in the Data Quality Assurance Review Framework. It will also ensure the organisation is well supported to meet the principles, roles and responsibilities of the Policy. Overall, the Team will help to ensure that decisions consider the context of the quality of the underlying information.

Further details of how the Data Quality Assurance Team will be established and structured can be found in the accompanying Data Quality Assurance Implementation Plan.

7. Improve Awareness of Data Quality through Delivery of Data Quality Education and Training

IM&T are the existing main information system owners and are responsible for ensuring that their systems have the appropriate level of training materials to cover the Data Quality risks for the system, as well as delivering training.

With the introduction of the Data Quality Assurance Team, the new team will be responsible for ensuring that all staff have an understanding of the principles of data quality that are appropriate to their role within the organisation. This will be achieved by;

(1) Adapting the current organisational induction training for new employees to cover the characteristics of data quality principles and their application from the Policy. Training will also include the principles of feedback.
(2) Create bespoke training for different staff groups which better contextualise the examples used during induction training. For example, covering data quality correction principles for staff groups who are validating and correcting records with data quality issues.

(3) Provide periodic “refresher” training exercises to build on the learnings of the induction training, with additional training made available in future years for individuals with higher rates of error. The proposed Phase (2) of the Data Quality Review Framework will be able to identify these individuals automatically, and can escalate directly to the line managers when required.
(4) Provide a training package for each information management system identified in the Systematic Review Framework. Training should be provided before access is provided and at least 95% of users should have received training. A set of Standard Operating Procedures should accompany the training.
(5) Cover the roles and responsibilities of the Data Quality Assurance Team to ensure all staff are aware of their responsibilities to the organisation and contribution to good data quality practices.
(6) Ensure the ongoing review of education and training resources so they remain fit for purpose.

Challenges

A number of challenges to achieving the 7 strategic objectives have been identified.

Confirmation of Priorities

The initial areas of organisational focus for data quality are those that were prioritised as high or medium during the early phase papers supporting this Data Quality Improvement Strategy. It is likely this is now an outdated view where progress may have been made in priority areas over recent months.

A review of the initial priorities is required in order to confirm those areas believed to be high or medium priority. This will direct the first phase of work for the Data Quality Assurance Team.

Data Quality Measurement

To ensure that all information systems are currently fit for purpose, all system owners need to confirm that they meet the data quality principles defined in the Policy. This is likely to present additional work for individuals and may require investment from senior management to support the system owners within their departments. A communication plan alongside the governance structure is necessary to improving our capability for data quality measurement across the organisation.

In building the near real-time solution, there will be some data quality measures for which the data is not available in the Trust data warehouse. The unavailability of these datasets will prevent data quality measurement. It is the responsibility of information management system owners to fulfil this prerequisite for data quality assurance.

Data Linkage

Users hope to connect their data from different information systems to allow for data to be easily aligned and correction easily effected. Without this, users need to log onto multiple systems and correlate records between them in order to maintain data quality and correct errors, increasing the cost of data capture and validation as well as the risk of data quality issues.

Capacity

There will be limited capacity within the Data Quality Assurance Team for correction activity. This amount of resource will be insufficient to tackle some of the larger data quality issues within the Trust. There will be a requirement for individual directorates to assist with data correction within their own departments or to present a business case for additional resource needs.

Summary

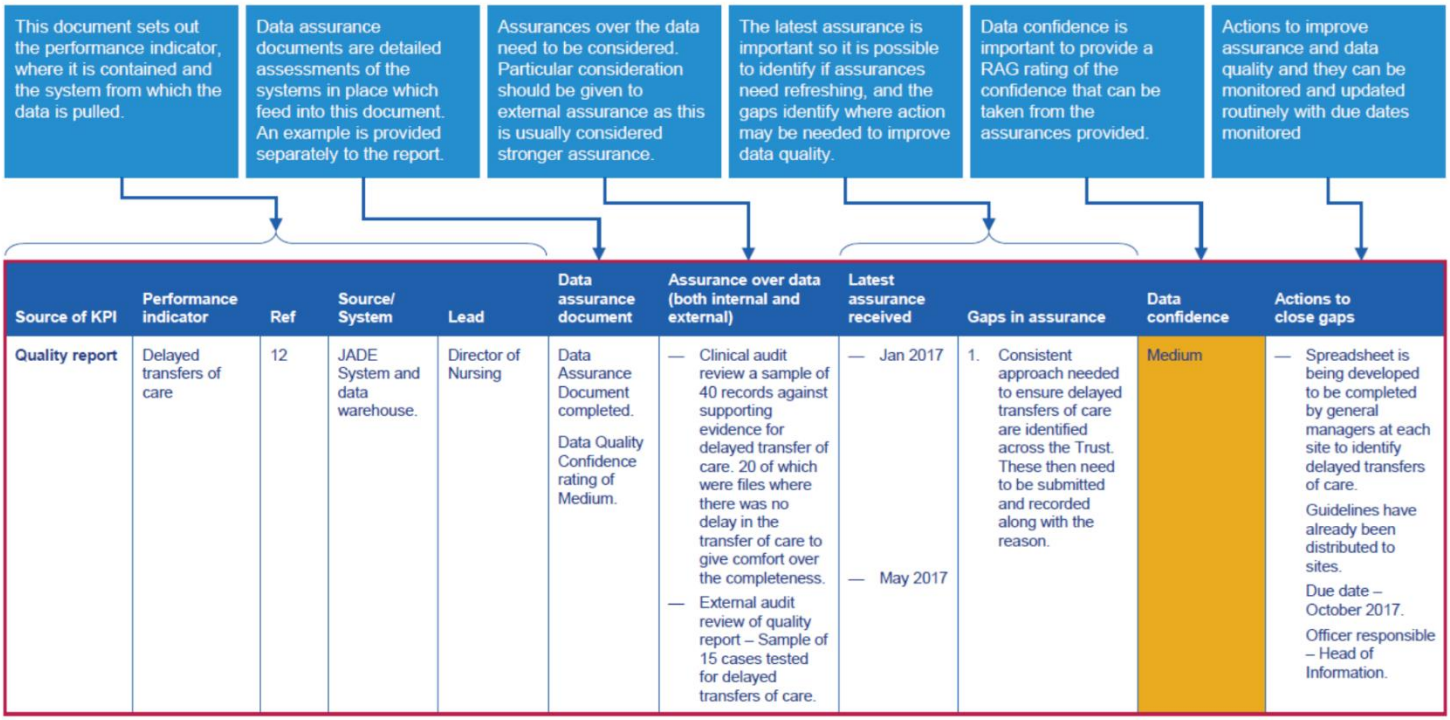
The supporting documentation, the Policy and the Assurance Implementation Plan, which accompanies this Strategy helps shape the next steps for data quality implementation and improvement. Additionally, materials to support the practical delivery of the strategy are in development, including team training materials, guidance, reporting specifications and induction documents.

Maintaining the structured and stable approach in this Strategy will lead the Trust towards meeting the 6 core principles of data quality over the coming years, and transforming the quality of our data to ensure that the intelligence we use to help shape our service is the standard of a world class ambulance service.

Appendix

Assurance Review Framework: Manual Approach Example

An example template for a manual Data Quality Assurance Review Framework is provided below. Initially a report will be developed to support the Data Quality Assurance Team in progressing the Strategy, structured similarly to the below.



Source of KPI	Performance indicator	Ref	Source/ System	Lead	Data assurance document	Assurance over data (both internal and external)	Latest assurance received	Gaps in assurance	Data confidence	Actions to close gaps
Quality report	Delayed transfers of care	12	JADE System and data warehouse.	Director of Nursing	Data Assurance Document completed. Data Quality Confidence rating of Medium.	— Clinical audit review a sample of 40 records against supporting evidence for delayed transfer of care. 20 of which were files where there was no delay in the transfer of care to give comfort over the completeness. — External audit review of quality report – Sample of 15 cases tested for delayed transfers of care.	— Jan 2017 — May 2017	1. Consistent approach needed to ensure delayed transfers of care are identified across the Trust. These then need to be submitted and recorded along with the reason.	Medium	— Spreadsheet is being developed to be completed by general managers at each site to identify delayed transfers of care. Guidelines have already been distributed to sites. Due date – October 2017. Officer responsible – Head of Information.

FIGURE 4 – EXAMPLE MANUAL APPROACH ASSURANCE REVIEW FRAMEWORK

London Ambulance Service
NHS Trust

Data Quality Policy 2018-2021

Better Data for Better Decisions

Matthew Bishop / Jill McGregor / Daniella Gossage / Oliver Waring

4th July 2018

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Version no: 1.7

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Lead Executive Contact: Lorraine Bewes, Dir. Finance & Performance

Document reference:

Introduction

Overview

This document sets out the Data Quality Policy for London Ambulance Service NHS Trust. All NHS organisations have a responsibility to ensure their data is accurate in compliance with the Data Protection Act 1998, and is fit for purpose, as directed by NHS Digital.

The availability of complete, valid, relevant, accurate, reliable and timely data is fundamental in supporting patient care, clinical and corporate governance, management and service agreements, and strategic and business planning. Good quality information is essential to making decisions relating to quality improvement for the running of the Trust and to maximise utilisation of resources. Furthermore, healthcare planning across the wider NHS system is dependent on being able to make effective decisions from reliable data. This Policy sets out the Trust's commitment to data quality.

This Data Quality Policy is one of three guiding documents which support the 7 new strategic objectives and recommendations for Data Quality across the Trust. The other two documents are:

- Data Quality Improvement Strategy
- Data Quality Implementation Plan

These three documents are linked through the focus on delivering the 7 strategic objectives below, but are standalone documents.

1. Develop and maintain a Data Quality Improvement Strategy
2. Design a Data Quality Assurance Framework
3. Produce a Data Quality Assurance Implementation Plan
4. Establish a corporate governance structure for Data Quality assurance
5. Introduce a Data Quality Policy to clearly define the principles of good Data Quality, the roles, responsibilities and accountabilities to achieve them, and guide governance of Data Quality
6. Appoint a Data Quality Assurance Team
7. Improve awareness of Data Quality through the delivery of Data Quality education and training

Purpose

The purpose of the Policy is to support the delivery of the Strategy by outlining the governance and principles around Data Quality. This Policy is designed to ensure that all staff employed by the Trust understand the importance of data quality. It applies to all members of staff and will:

- Describe the meaning of data quality.
- Establish the Trust's commitment to data quality and responsibility for its maintenance and improvement.
- Describe methods by which data quality assurance and improvement should be achieved.
- The principles of this Policy should be reflected in all aspects of activity carried out within the Trust, to demonstrate corporate consistency across all areas and services.

This Policy also supports the Trust's four goals:

1. Provide outstanding care for all of our patients
2. Be a first class employer, valuing and developing the skills, diversity and quality of life of our people
3. Provide the best possible value for the tax paying public, who pay for what we do

4. Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London

Definitions

The following definitions apply:

- **Data** is a collection of facts from which information is constructed via processing or interpretation
- **Information** is the result of processing, gathering, manipulating and organising data in a way that adds to the knowledge of the receiver
- **Data quality** is a measure of the degree of usefulness of data for a specific purpose, as defined by the data quality characteristics presented in this Policy.

Governance and Reporting Structures

Governance Structure

A new governance structure for data quality assurance has been developed and is presented in Figure 1. This structure ensures that quality underpins the Trust's governance arrangements and that assurance is provided to the Trust Board.

The structure includes the Health Informatics Oversight Group and the Data Quality Improvement Group. Both groups require highlight reports to ensure essential review and feedback processes are implemented. This includes review reports from the Assurance Frameworks which falls under Strategic Objective 2.

The introduction of a new Data Quality Assurance and Implementation Team is also 1 of the 7 Strategic Objectives. Their role in the structure includes the most wide-ranging responsibilities for data quality within the organisation. Specifics including team objectives are set out in the Data Quality Improvement and Implementation Plan.

Primary responsibility for data quality governance and the maintenance and ownership of the Data Quality Policy sits with the Health Informatics Oversight Group and the Data Quality Assurance Team.

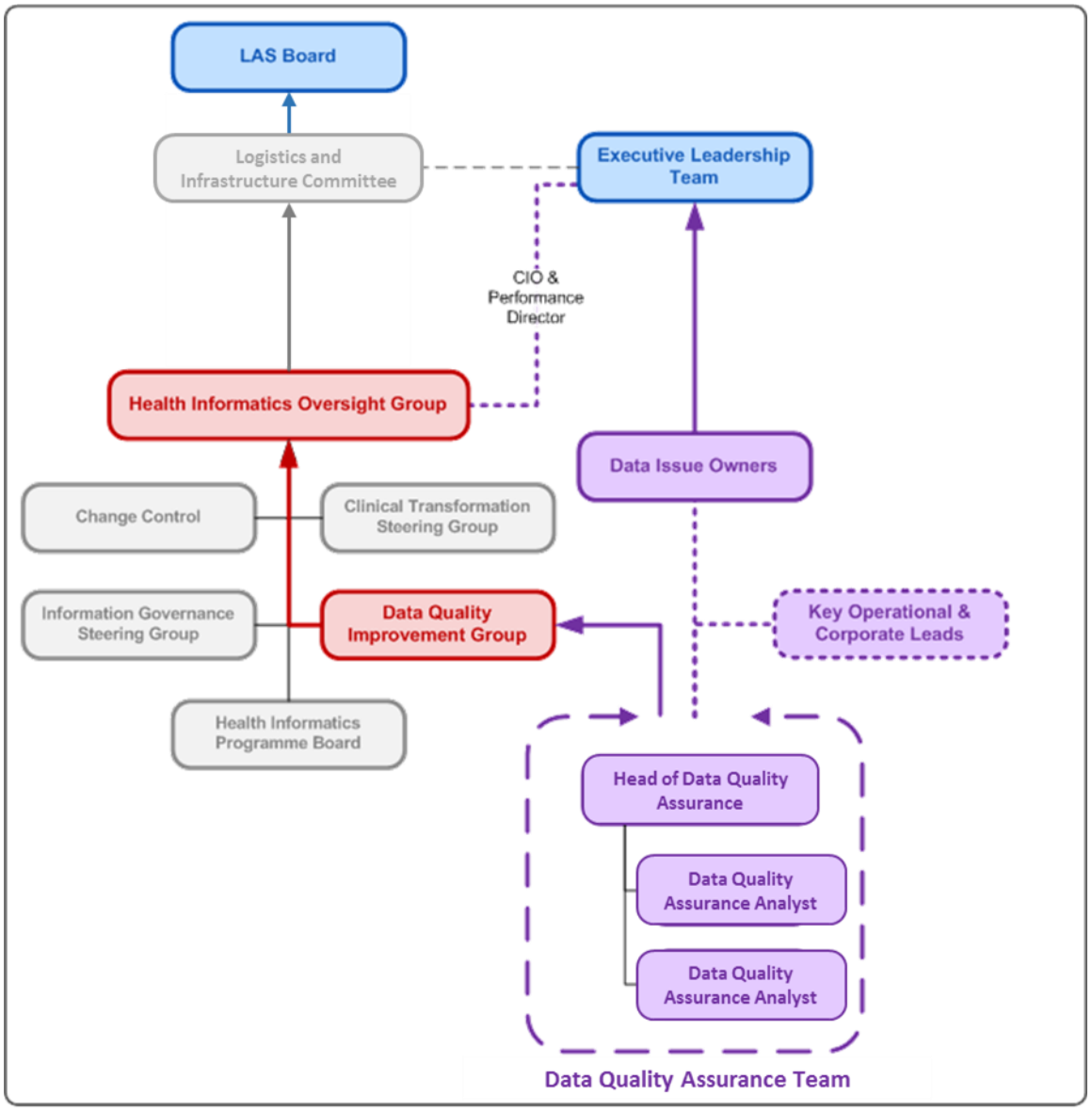

FIGURE 1 – GOVERNANCE STRUCTURE

Roles and Responsibilities

Staff with appropriate levels of seniority, responsibility and expertise are assigned to the key roles in Data Quality assurance. Their core accountabilities and responsibilities are set out below.

Core Accountabilities

Board Directors

- Responsible for sign-off of the Data Quality Policy following presentation at the Health Informatics Oversight Group;
- Board Directors are individually accountable for remediation of data quality issues related to KPIs under their ownership.

Logistics & Infrastructure Committee

- Provide oversight of issues and risks in relation to implementation of the Data Quality Strategy, Policy and Implementation Plan for escalation to Trust Board
- Oversee the review of the Data Quality Strategy, Policy and Implementation Plan on an annual basis
- Receive exception reports from the Health Informatics Oversight Group

Health Informatics Oversight Group

- Accountable for progress of the Data Quality Improvement Strategy, through the monthly highlight report;
- Responsible for the review and delivery of the Data Quality Policy;
- Reports directly through to the Logistics and Infrastructure Sub-Committee of the Trust Board.

Core Responsibilities

Director of Performance

- Responsible for the delivery of the KPI assurance review as part of the Data Quality Assurance Framework, reported as part of the highlight report to the Corporate Health Informatics Oversight Group.

Chief Information Officer

- Responsible for the delivery of the Systematic Assurance Review Framework of Data Quality in all information systems and ensuring the list of systems is maintained and up to date. This is reported as part of the highlight report to the Corporate Health Information Oversight Group;
- Accountable for ensuring principles of data quality are upheld in information management systems;
- Responsible for aligning data quality policies relating to the General Data Protection Regulation (GDPR).

Data Quality Assurance Team

- The Data Quality Assurance Team and the Head of Data Quality Assurance are primarily involved in delivering the Data Quality Improvement Strategy through a work stream specified in the Data Quality Implementation Plan;
- Details on structure of the team as well as a breakdown of their provisional work schedule are also provided in the Plan;
- The team is required to work within but also to widely communicate the principles of good data quality as outlined in this document. The team is responsible for ensuring all staff are trained to the same level of data quality competency as part of the Data Quality Training and Education Plan outlined in the Data Quality Implementation Plan.

Data Quality Improvement Group

- A monthly meeting chaired by the Head of Data Quality Assurance that is responsible for administering governance at a local level.

Data Issue Owners

- Individuals or teams that are responsible for correcting data quality issues that have been assigned to them.

Information Management System Owners

- The system owner is responsible for ensuring that the system in use has the appropriate level of training materials available for users.

Managers

- Managers are responsible for ensuring that this Policy is built into local processes and that there is on-going compliance;
- Managers are responsible for ensuring all staff input accurate and complete data in a timely manner and addressing any data quality issues as soon as possible and escalating appropriately. They are responsible for monitoring staff competencies and training needs, ensuring that staff attend appropriate training.

Data Owners - All Staff

- All staff are considered to be data owners;
- The fundamental principle of data quality is that data should be right first time, which means that the responsibility is held at the point at which it is collected and recorded, whether the recorder is clinical, technical or administrative. All staff are therefore responsible and accountable for the quality of data they collate and record;
- All staff, whether permanent, temporary or contracted are responsible for attending and refreshing their data quality training.

Principles of Good Data Quality

Characteristics of Data Quality

When reviewing data quality, it is beneficial to use a pre-defined set of data quality characteristics to evaluate issues in order to more clearly articulate what the issue is and how it can be identified within the data. Drawing upon expertise from the Audit Commission, the LAS has adopted their six characteristics of data quality, as follows:

FIGURE 2 – THE 6 DATA QUALITY CHARACTERISTICS

1. Accuracy (A)

Data should be sufficiently accurate for their intended purposes. Data should be captured once only, although may have multiple uses. Accuracy is most likely to be secured if data are captured as close to the point of activity as possible. When based on accurate data, reported information provides a fair picture of performance and can enable informed decision making.

The need for accuracy must be balanced with the importance of the uses for the data, and the costs and effort of collection. For example, it may be appropriate to accept some degree of inaccuracy where timeliness is important. Where compromises are made on accuracy, the resulting limitations of the data should be clear to their users. This must be a judgement determined by local circumstances and is unlikely to be appropriate in the case of the data supporting published performance indicators.

2. Validity (V)

Data should be recorded and reported in accordance to its definition and purpose. Where proxy data is used organisations must consider how well this satisfies the intended purpose.

3. Reliability (R)

Data should reflect stable and consistent collection processes across collection points and over time, whether using manual or computer-based systems, or a combination. Managers and stakeholders should be confident that progress toward targets reflects real changes rather than variations in data collection approaches or methods.

4. Timeliness (T)

Data should be captured as soon as possible after the event or activity and must be available for the intended use within a reasonable time period. It must also be available frequently enough to support information needs and to influence the appropriate level of service decisions. It must be able to meet agreed contractual reporting schedules.

5. Relevance (RV)

Data captured should be relevant to the purposes for which it is used. This entails periodic review of requirements to reflect changing needs. It may be necessary to capture data at the point of activity which is relevant only for other purposes, rather than for the current intervention. Quality assurance and feedback processes are needed to ensure the quality of such data.

6. Completeness (C)

Data requirements should be clearly specified based on the information needs of the organisation and data collection processes matched to these requirements. Monitoring missing, incomplete, or invalid records can provide an indication of data quality and can also point to problems in the recording of certain data items.

Data Capture Principles

Data capture is the first step of data quality assurance. In order to provide a good foundation of information sources, a number of data capture principles apply:

- Ensure users are appropriately trained for the information management systems they are using
- Every information system should have a training package and all users should be trained in how to use it. Errors of validity are most commonly made when users are misinformed on the correct use of an information system. Training significantly reduces the chance of errors being.
- Record data via the relevant information system as soon as possible
- Check what has been recorded against the source information before the data is saved to the system
- If transcribing information from paper, or another system, users should make all efforts to ensure and double check the completed record matches with the original source.
- Databases will often aim to save time for the users by auto-filling some fields – users should always check to ensure they are correct.
- Do not skip over fields, unless you are absolutely sure they are unnecessary
- Completeness is easier to achieve in the moment than going back to correct it retrospectively.

Data Quality Measurement Principles

Following data capture, the next step is to measure the quality of the source. Underlying principles address the value of each measures making sure that they are actionable, specific, owned, consistent and distinct:

- Every data quality measure must be actionable, each having a documented correction or validation outcome process
- Every data quality measure must be specific to the real-life data quality issue
- Every data quality measure must have a Data Issue Owner responsible for correcting errors

- Build data quality measures around pieces of information which highlight an inconsistency or gap in the data
- Measure data quality as frequently as possible

Data Quality Feedback Principles

Feedback is critical in data quality to inform where errors have occurred, where they impact upon our information for decision making, and allow us to report back errors we have discovered. The following principles will apply:

- Integrate data quality into the Trust Board and performance reporting using Data Quality standard marks. The Trust will employ the three Data Quality standard marks (Figure 3) to guide the degree to which a KPI should be trusted when making a decision;

FIGURE 3 – DATA QUALITY STANDARD MARKS ASSISTING FEEDBACK PRINCIPLES

- Develop an analytical report logging the frequency of where issues are arising. This allows exploration of where data quality issues may be particularly prevalent in order to focus and prioritise validation and re-training efforts;
- Build and integrate detailed reporting showing all the records for each data quality issue and all the issues for each data quality record;
- Develop a process where users capture the outcomes of data validation for a record.

Data Quality Correction Principles

To ensure reliability in the application of verification, validation, and correction techniques, the following data quality correction principles should be implemented:

- Data should not be corrected outside of the source system;
- A record should be corrected once where possible;
- Continuous correction should be used preferentially over periodic correction – aim to correct data quality issues in a timely manner after they are identified;
- Instigate root cause investigations where appropriate.

Data Quality in Information Management Systems Principles

To ensure that best practice data quality processes are implemented across all information management systems within the organisation, consideration should be given to the three further characteristics. These characteristics provide specific value and suitability to data quality issues associated with systems procurement, upgrade and reconfiguration (Figure 4).

FIGURE 4 – THE 3 DATA QUALITY PRINCIPLES OF INFORMATION MANAGEMENT SYSTEMS

1. Coherence (CH)

Data coherence enables consistent historical comparability of datasets, and linkage of data amongst both internal and external sources. To promote data coherence, standardisation of processes involving data collection, interpretation, and reporting should be invoked where possible. Additionally, standard recognised classifications, consistent time frames (e.g. fiscal year), and consistent methodologies should be utilised to best assist data linkage internally and externally, ensuring privacy and confidentiality rules related to record linkage are adhered to.

2. Adaptability (AD)

It is important that data and data structures are adaptable, as this enhances the ability to stay current, inform emerging issues, and adapt to procedural and policy updates as the Trust evolves. Where practical, data should be collected at the finest level of detail, raw data should be preserved.

3. Clarity (CL)

Clear documentation of data source, manipulation, and analysis should always be supplied for analytical work, both internal and external. Documentation of minor and significant changes to concepts or methods should be maintained in a consistent and timely manner and should be readily accessible. Such issues should be identified and caveated when conducting trend analysis to assist the examination of changes in key data elements over time.

Summary

Maintaining this Policy document in line with the Improvement Strategy and Implementation Plan ensures governance around data quality will be embedded and improved within the Trust, helping shape our service to the standard of a world class ambulance service.

NHS
London Ambulance Service
NHS Trust

Data Quality Assurance Implementation Plan 2018-2021

Better Data for Better Decisions

Matthew Bishop / Jill McGregor / Daniella Gossage / Oliver Waring

4th July 2018

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Introduction

Context

The Data Quality Assurance Implementation Plan provides direction for the delivery of the 7 Strategic Objectives, providing actions and milestones to realise the Data Quality Improvement Strategy. The aim of the document is to provide key deliverables and timelines for the implementation of the Data Quality Assurance Framework, the appointment and responsibilities of a Data Quality Assurance Team, and the approach for data quality training and education. The Plan sits alongside the Data Quality Improvement Strategy and the Data Quality Policy documents which collectively guide the strategy, implementation, and governance of data quality within the Trust.

Overview – How this Plan Delivers the Strategic Objectives

The Data Quality Improvement Strategy defines 7 strategic objectives driving Data Quality implementation. Three of these objectives (3, 6 and 7 below) are delivered through this Implementation Plan, whilst the other objectives principally remain the focus of the Strategy and Policy associated with this document. The way in which the 7 objectives are delivered is outlined below:

1. Develop and maintain a Data Quality Improvement Strategy

Delivered as the Data Quality Improvement Strategy to Trust Board in July 2018.

2. Design a Data Quality Assurance Framework

The design and implementation of the Data Quality Assurance Framework is delivered through this Implementation Plan, and is detailed in the section “Data Quality Assurance Review Framework”. The central Framework constitutes a KPI Assurance Review Framework, and a Systematic Assurance Review Framework. The Plan describes a two-phase approach for delivering the frameworks; firstly by a manual solution which can be implemented swiftly, and secondly by a real-time solution which provides more frequent feedback on data quality issues. The subsequent section “Technical Development Plan for Phase 2 of the Framework” describes a detailed, technical approach for incorporating the real-time capability within the framework.

3. Produce a Data Quality Assurance Implementation Plan

Delivered by the Data Quality Improvement Strategy through this associated Data Quality Assurance Implementation Plan. The focus of this document is to outline, action, and timeline the key deliverables relating to the Strategy through the 7 strategic objectives.

4. Establish a corporate governance structure for Data Quality assurance

Delivered by the Data Quality Improvement Strategy through the associated Data Quality Policy, written in coordination with the Strategy and this Plan in July 2018. The Policy delivers this objective by establishing governance and defining a corporate governance structure by which data quality assurance is administered across all departments within the Trust.

5. Introduce a Data Quality Policy

Delivered by the Data Quality Improvement Strategy through the associated Data Quality Policy, written in coordination with the Strategy and this Plan in July 2018. This document delivers this objective through clear policy relating to the 6 data characteristics, the principles of good data quality, and the roles, responsibilities and accountabilities which enable the Trust to follow the 7 strategic objectives.

6. Appoint a Data Quality Assurance Team

This objective is delivered through this Implementation Plan in the section "Data Quality Assurance Team". This Plan defines a team structure, presents an employment strategy, and set out key responsibilities and likely initial workload of each role within the team.

7. Improve awareness of Data Quality through delivery of Data Quality Education and Training

This objective is delivered through this Implementation Plan in the section "Data Quality Training and Education Plan". This Plan prescribes a resource for data quality and information systems training. This training focussed on educating data quality principles and responsibilities as governed by the Data Quality Policy, in order to develop data quality education throughout the entire organisation.

Implementation Timelines

Project Milestones

The overarching project milestones are shown below:

TABLE 1 - KEY PROJECT DELIVERABLES WITH ANTICIPATED START AND FINISH MILESTONES

Milestone	Start	Finish
Deliver DQ strategy and DQ policy	Oct 2017	Jul 2018
Establish governance	May 2018	Oct 2018
Develop KPI & Systematic assurance review	Aug 2018	Mar 2019
DQ standard marks in Trust Board report	-	Dec 2018
Advertise and recruit Data Assurance team	Jun 2018	Oct 2018
Ensure training and education is fit for purpose	Oct 2018	Mar 2019
Assurance review framework – Phase (1) manual solution available	-	Oct 2018
Assurance review framework – Phase (2) real-time solution available	Nov 2018	Jan 2020

Data Quality Assurance Review Framework

Overview

The aim of the framework is to provide information on data quality confidence in a centralised format and enable both review and feedback processes to be clearly established and utilised.

The central framework is made up of:

(1) A KPI Assurance Review Framework
(2) A Systematic Assurance Framework

Both frameworks will be built in 2 phases, Phase (1) is a manual solution and Phase (2) a near-time solution. Details are presented in this upcoming section.

KPI Assurance Review Framework

The KPI review will provide information on the underlying data confidence for the KPIs that measure the Trusts performance. The guidelines are for it to be undertaken at minimum annually but may more frequent for particular KPIs whose underlying data quality may be changing. The review will be led by the Director of Performance, who will be responsible for its delivery.

The Phase (1) manual solution is spreadsheet based. The team that undertake the review can determine any modifications and how best to approach this under the leadership of the Director of Performance. Phase (1) which will ensure the expedient delivery of the first reviews. However there are limitations and in comparison to the Phase (2) near-real time solution, will likely be less comprehensive.

Phase (1) includes a data assurance document that is required to cover an assessment of each KPI including:

- An assessment of data quality for that KPI
- Details of the errors that are known
- Why those errors occur
- What remediation options there are
- What plans there are to reduce the incidence of those errors and correct the prevalence of the errors

Using the outcomes of data testing, the document will need to provide an overall assurance RAG rating of the data quality confidence for the KPI. The method of how the data was tested to determine the data quality confidence will need to be documented and the results summarised and reported. Any gaps in the testing should be clearly documented and potential testing improvements noted.

Phase (2) involves a higher tech tool that will provide a more frequent up to date view of data quality for any KPI over a much more comprehensive range of potential data quality issues than the manual review does. Initial delivery of Phase (2) is anticipated to be in the second year of the Strategy following a transition from the manual solution. Whilst the responsibility for this will remain with the Director of Performance, the delivery will be largely automated and the work will involve configuration of the mechanism.

Systematic Assurance Review Framework

The systematic assurance review will give information on the underlying data confidence across all the Trust's information systems and data sources. Like the KPI assurance review, Phase (1) is a manual solution which will be transitioned Phase (2) a real-time assurance measurement system over the period of the strategy.

This review will be led by the CIO, who will be responsible for its delivery. It should be undertaken at least annually, but it may more frequent for particular systems whose underlying data quality may be changing, the systems that require this will be determined by the CIO.

It is anticipated that the Phase (1) review will be based on the example KPI spreadsheet solution from the internal audit. The team who undertake this review will be at liberty to modify the template, as they see fit, with the approval of the CIO.

In order to ensure completeness of the review, a complete list of systems will need to be delivered. This should include paper-based systems and non-enterprise solutions, such as spreadsheets being used as a database and MS Access databases. The CIO will determine which of these non-enterprise solutions are a "system" in order to avoid a requirement to review each electronic document in the Trust. This should align with the requirement to identify information systems to comply with the GDPR regulations.

Like the KPI review, each information system will need to have a data assurance document written for it, which will describe the assessment of data quality for that system, with the same details as for the KPI document. The method of

how the data was tested to determine the data quality confidence will need to be documented and the results summarised and reported. Any gaps in the testing should be clearly documented and potential testing improvements noted.

Using the outcomes of data testing, the document will need to provide an overall assurance RAG rating of the data quality confidence for the system; the output of this review will be used to determine which information systems require more robust training and processes.

In Phase (2) the real-time data assurance measurement will be largely automated and provide a more frequent up to date view of data quality for information systems over a much more comprehensive range of potential data quality issues than the manual review does. As with the KPI review initial delivery of Phase (2) will likely be in the second year of the strategy.

Overall as a part of the feedback process for the Data Quality Assurance Review Framework, it is expected the output of the reviews will be manually embedded into the Trust Board report.

Technical Development Plan for Phase 2 of the Framework

Technical deliverables underpin the process of progressing the KPI and Systematic Assurance Reviews from a periodic process to a real-time assurance review framework. The technical development plan for Phase 2 should include a financial assessment.

Initial Real-Time Assurance Measures

A library of measures will be constructed proposing measures to be delivered initially, focusing on data quality issues with headcount data, statutory-mandatory training data, appraisals data, sickness and absence data, and incidents data. This proposal will be reviewed and signed-off by the Data Quality Improvement Group.

It is likely that, as these initial measures are explored, further secondary data quality issues are uncovered. These secondary issues will need to be developed into the library of measures as they are discovered as they will underpin the ability to assure the primary measures.

Data Flows

There are 5 main data sources that have been identified to deliver the initial real-time assurance measures:

1. eFinancials
2. GRS
3. ESR
4. Datix
5. Spreadsheets used by the training department

Data flows will need to be built for a number of data tables in the data warehouse to allow these systems to be brought into the real-time assurance review framework. It is expected this work will be done in collaboration with the Information Management and Business Intelligence teams. The specification will be evolutionary at first and will likely require a number of iterations before it's completed. It is therefore suggested that this is specified at the point where data is needed by a real time assurance measure.

Establish Data Quality Reporting for System Owners

This reporting has already been developed and is operational within the test environment at LAS. It requires peer review and information governance approval before it can be recommended to the Health Informatics Oversight Group for implementation in the Trust production environment. Once this is approved, the reporting will scale, without additional work, to the real-time assurance measures that are built within the assurance review framework. There will, however, be maintenance required to assign measures to information systems. Thus reporting can be configured to drill down to

each individual system, and system owners can filter the data quality summary to see only the measures that implicate their system.

Implement Data Quality Reporting in the Trust Board and Performance Reports

Although there is a structure within the real-time assurance framework to allow measures to be connected to Trust Board and Performance KPIs, the mechanism to automatically RAG rate each KPI is yet to be built.

This will be done once the data assurance team are familiar with the technical structure of the real-time assurance review framework, once there are sufficient measures in the framework, and once the manual assurance review has helped ascertain the dynamics of how to RAG rate KPIs on the basis of their underlying data quality issues.

Validation Outcomes Capture System

There is a need for a clearly defined formal feedback mechanism to highlight errors discovered during reporting and validation processes. This includes validation performed in response to the real-time data assurance measurement, validation performed as part of reporting processes, audit of records, and validation of manually corrected data.

This will require a system that can facilitate requirements, taking its output from the real-time assurance measurement. In order to facilitate the capture of amendments to manually collected data, this will require the manual data to be loaded with the validation system capturing amended values. The specification for this system has not yet been drafted and it will be the responsibility of the Head of the Data Quality Assurance Team to produce the draft specification for review for sign-off by the Health Informatics Oversight Group.

Data Quality Assurance Team

A Strategy Objective as defined in the Strategy is to appoint a Data Quality Assurance Team. Team structure, recruitment strategy, and provisional workload are detailed below. Core responsibilities and accountabilities of the team are detailed in the Policy.

Team Structure

Financial funding and approval is in place to recruit a Band 8A Head of Data Quality Assurance and two Band 7 Data Quality Assurance Analysts.

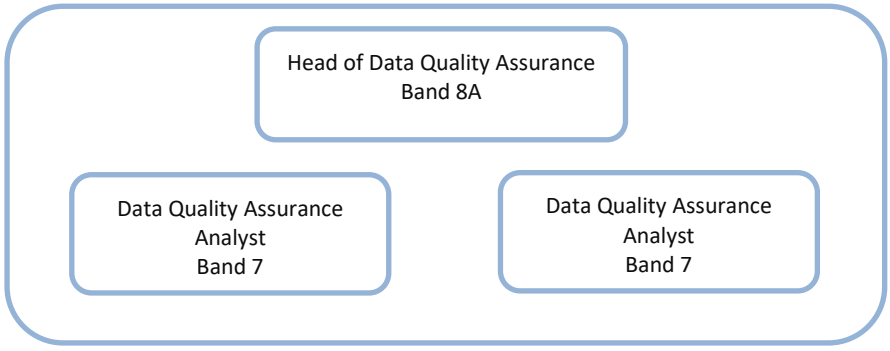

FIGURE 2 – STRUCTURE OF INITIAL DATA QUALITY ASSURANCE AND IMPROVEMENT TEAM

Job descriptions and bandings have been fully assessed and approved for these roles. These roles and now to advertised and recruited in to. Designing appropriate interview tests is necessary to determine whether the candidates have the desired qualities and characteristics. Candidates, principally the analysts, must be able to demonstrate their skills and experience in a measurable way.

The team induction will involve details of the Data Quality Improvement Strategy and Policy, and will include a timetable of meetings with stakeholders to establish their core communication network. The target is for the team to have arranged regular meetings with the key stakeholders, established basic co-location rotas, setup their 1-1 executive meetings and started to prepare materials and plan for delivery of data quality training within the first 20 days.

Provisional Work Schedule

It is estimated that the Data Quality Assurance Team will assign their monthly resources as below. The number of days are averaged from a standard annual contract of 230 days and approximately 15% headroom has been left for ad-hoc tasks. This schedule is not prescriptive and can be changed, but should assist the team with achieving their responsibilities within the Data Quality Policy.

TABLE 2 – HEAD OF DATA QUALITY ASSURANCE AND IMPROVEMENT PROVISIONAL CORE MONTHLY WORK SCHEDULE

Task	Days per month
Corrections	4
Performance Review Meetings (prep, attendance & debrief)	1
Committee Meetings (prep, attendance & debrief)	1
1-1 Stakeholder Meetings (prep, attendance & debrief)	3
Team Admin	3
Business Case Preparation	3
Issues Escalation	1

TABLE 3 –DATA QUALITY ASSURANCE ANALYST PROVISIONAL CORE MONTHLY WORK SCHEDULE

Task	Days per month
Corrections	8
Incidence Reduction	5
Performance Review Meetings (prep, attendance & debrief)	2
Committee Meetings (prep, attendance & debrief)	2
Team Admin	4
Investigations (1 per week)	2
Quantifications (1 per week)	8
Issues Monitoring & Escalation	1

Provisional Highlight Reporting for the Health Informatics Oversight Group

A highlight report for HIOG is required to enable them to provide the proper governance over the Data Quality Improvement Strategy. This should focus on the Strategic Objectives as defined in the Strategy, and implemented through the Policy and Implementation Plan.

Data Quality Training and Education Plan

The Data Quality Assurance Team are responsible for ensuring that all staff have an understanding of the principles of data quality that is appropriate to their role within the organisation. This section addresses a plan for delivery of data quality and information systems training and education throughout the Trust.

Data Quality Training

Choose a Resource for Training Delivery

Before the training materials are produced, the resource that will be used to deliver the training must be chosen. An online training course will be preferable, to avoid the need for human resource to deliver the training, although this has not yet been scoped. Ideally training will be administrated via ESR OLM to ensure that the training record is captured as a part of the staff record. Once the delivery medium is known, the materials can be designed to fit the medium.

Create Induction Training Materials to Teach All Staff Core Data Quality Principles

The induction training will cover the characteristics of data quality and data capture principles from the data quality policy. This should be delivered to all staff that use an information system to provide a basic understanding of data quality and how this understanding can help reduce the incidence of data quality issues.
This training will cover a wide staff base who use different information systems as a part of their role, so versions will need to be created for different staff groups that contextualise the examples used in their training.

Create Data Quality Training (Validation & Correction)

In addition to the core principles delivered in the induction training, the data quality training will also cover the data quality measurement principles and data quality correction principles to provide sufficient understanding for staff groups who are validating and correcting records with data quality issues.

Create Data Quality Assurance Team Training (Review, Assessment & Remediation)

To provide a full understanding of the data quality principles, the data assurance team training will also cover the data quality feedback principles, data assurance embedding and representation principles, and data quality in information management systems principles. This training will also cover the roles and responsibilities of the Data Quality Assurance Team from the Data Quality Policy to ensure all staff are aware of their responsibilities to the organisation.

Delivering Training

Once the training materials have been produced, they will be reviewed and signed off by the Health Informatics Oversight Group (HIOG). Operational and corporate management will need to be consulted to decide a roll-out plan to ensure that the training targets can be achieved without unnecessary disruption to workforce productivity. Progress against the training targets will need to be monitored by the HIOG.

Training Refreshers

Periodic refresher re-training of the induction training will be required for all staff, with additional training made available for personnel who require further support and have been identified for formal re-training by their line manager or by the Data Quality Assurance Team. As the real-time data assurance measurement system makes it possible to identify users who are making errors, the periodic induction training will move to error focused re-training, principally targeting users who are making mistakes, improving the efficiency of the training effort.

Information System Training

The Information Management system owners are responsible for ensuring that their systems have the appropriate level of training materials to cover the data quality risks for the system as well as delivering training for the system. This will ensure a systems-focused approach where it is required. A resource for training delivery again must be chosen.

Review and Create Information Systems Training & SOPs

Every information system identified by the systematic assurance review should have a training package which is reviewed at a minimum on an annual frequency. Training should be provided by the Information Management system owner before access to the system is provided and at least 95% of users should have received training. A set of standard operating procedures ("How-to guides") should accompany the training.

All training materials should be functional in their nature and designed around the workflows of the system. Areas of particular focus which should be reinforced during the training include:

- Mandated records, system bugs and the required workflow to avoid them
- Common errors in accuracy and validity
- Data items sensitive to late data entry.

Training Refreshers

Training refreshers will be delivered in the same manner as with the data quality training, with ownership lying with the Information Management system owners.

Delivering Training

Similarly to the data quality training, training will follow the same review process through HIOG for review, sign-off, and roll-out.

Summary

Maintaining this Implementation Plan in line with the Improvement Strategy and Policy ensures the delivery and improvement of data quality within the Trust, helping shape our service to the standard of a world class ambulance service.

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	East London Health Care Partnership Integrated Urgent Care Assurance Update			
Agenda item:	8			
Report Author(s):	Nic Daw			
Presented by:	Fenella Wrigley			
History:	Insert names and dates of meetings to which report has previously been presented or where the same issue has been discussed here			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The attached documentation is for the Trust Board to note. The LAS were required to attend the critical go/no go assurance meeting with NHSE and the attached documentation was required from us to give assurance. We successfully passed this assurance, with NHSE satisfied that we on track for go live on 1 August 2018. There was recognition that there are 3 areas of testing to be completed by Monday 30th July and a further assurance checkpoint call will be held on Tuesday 31st July. The COO for NHSE Urgent Care has passed the decision making of this final checkpoint to the NHSE Head of Urgent and Emergency Care.

Recommendation(s):

Trust Board to note the evidence supplied to NHSE as part of the assurance process and the subsequent result.

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

Insert a short paragraph here setting out the key risks associated with the issues raised in the report and how these relate to the BAF

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

Reputation	☒
Other	☒
This 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	☒

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Steve Dawson

Pre-Requisites required to be completed before any assurance takes place
1. Access to Locations:
- Southern House, Croydon
- Maritime House, Barking
2. All systems in place and provider tested

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Physical space	There is enough space for staff at workstations and the environment isn't too overcrowded meeting min centre standards.	Desk space inc PC's, & phones to meet go-live capacity and capability to deliver max seats required at peak periods during the contract e.g. xmas and bank holiday periods. This should be the maximum number of seats (workstations/telephones) that would be required on the busiest day of the year.				
Environment	The working environment is suitable to promote a healthy and motivated workforce	Correct levels of light and heat/cooling Clean and dry environment		See photos		

Facilities	The facilities provided meet the staff needs for periods of working	Access to drinks, food and suitable rest area's Facilities cleaned on a regular basis (toilets/kitchens/working areas)		See photos		
Clinical visibility	Are non-clinical and clinical staff accessible so that immediate support can be provided.	Clinical supervisors are accessible to offer direct and immediate support.		- Supervisor Pod; Floor Plan - See Photos		
Reference Material	Can the user access Standard Operating Procedures and understands what they contain?	Access to SOPS		- Shared drive for SOPs. - Reference materials on desks		
	Can the user access Local Operating Procedures and understands what they contain?	Access to LOPS		N/A - LOPS 'not used' as same as SOPs and Trust policies		
IUC values and branding	IUC branding visible and a sense that the values have been embedded	Branding in place and local information provided on key local services/geographical locations		See Comms tab		
Wall Boards	Performance wallboards in place for all sites and information % answered in 60, average wait to answer, amount waiting to be answered, call volumes (total and amount waiting to be answered), call back queues, staff type available/on call, CHub activity	Wallboards in place		- Wallboard in place - testing in progress		
	Information available on real time performance and resources login.	111 and OOH teams have access to key information including real time information on call back queue and staff logged onto each site		- Wallboard in place - testing in progress		

	Test wall boards are working by testing incoming lines			- Wallboard in place - testing in progress		
Connectivity	Location # 1	1) Evidence is provided the service can connect to Adastra 2) Evidence the service can connect to the telephone system and the call can be recorded. 3) Confirmation each base has a DDI set up and tested. 4) DDI number confirmed		- See test scripts at the Application-111 Tab		
	Location # 2	1) Evidence is provided the service can connect to Adastra 2) Evidence the service can connect to the telephone system and the call can be recorded. 3) Confirmation each base has a DDI set up and tested. 4) DDI number confirmed		N/A		
Bridge Access (111 / Clinical Hub)	Review access of clinical navigator and access to system including testing ability to prioritise clinical queue	1) Access and view of clinical queue 3) Access and ability to prioritise and utilise resource across GPs and clinical queue resource		- See test scripts at the Application-111 Tab		
	Review clinical navigator role across clinical queues e.g. interim and final dispositions			- Management of Clinical Queue SOP in SOP tab		

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Simon Vaughan

Pre-Requisites required to be completed before any assurance takes place
1. All SOPs to be available
2. All LOPS to be available
3. Access to Voice Recording application with appropriate user rights

				Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Telephony System	Test all speed dials in LOP Including GPOOHs	Correct telephone rings / answered		Covered in SIT		
	Test hunt group and review loggings for clinical desk for green ambulance and ED retrieve.			Covered in SIT		
	Test hunt group for clinical desk for green ambulance and ED retrieve when resource busy on one site, will the system hunt for the resource at next site?	Hunt group works across two sites and sites work as one if using Croydon and Barking		Covered in SIT		
	Test all speed dials to clinicians	All hunt groups and speed dials have been set up and tested e.g.		Covered in SIT		
		GP in CAS		Covered in SIT		
		ANP		Covered in SIT		
		Pathways clinician		Covered in SIT		

		Pharmacist		Covered in SIT		
		Supervisors		Covered in SIT		
		Supervisors in Croydon		Covered in SIT		
		Green ambulance validation		Covered in SIT		
		Ambulance Validation		Covered in SIT		
	Test overflow works if no clinical staff available and what message and hunt group the call flows to	GP in CAS		Covered in SIT		
		ANP		Covered in SIT		
		Pathways clinician		Covered in SIT		
		Pharmacist		Covered in SIT		
		Supervisors		Covered in SIT		
		Green ambulance validation		Covered in SIT		
		Ambulance Validation		Covered in SIT		
	Understand visibly of who is logged on e.g. Pharmacist, ANP,GP, Pathways Clinician	ANP in clinical hub		Covered in SIT		
		Pharmacist in clinical hub		Covered in SIT		
		GP in clinical hub		Covered in SIT		
	Test Supervisor DDI and how set up works between both call centres.			Covered in SIT		
	Test DDI for Ambulance service -	Correct telephone rings / answered		Covered in SIT		
	Test DDI for Ambulance service	Correct telephone rings / answered		Covered in SIT		
	Test hunt groups for Service Advisors			Covered in SIT		
	Test hunt group for service advisors overflow to call advisors	Correct telephone rings / answered		Covered in SIT		
	Test hunt groups for call handlers	Correct telephone rings / answered		Covered in SIT		

	Test hunt groups for all clinicians	Correct telephone rings / answered		Covered in SIT		
	Test hunt groups when all call handlers are engaged and message provided	Correct telephone rings / answered		Covered in SIT		
	Test hunt groups when all clinicians engaged	Correct telephone rings / answered		Covered in SIT		
	Check fax is available - incoming & outgoing	Fax works & number corresponds with LOPs and MOU		Not Covered (not in scope)		
	Key local Providers					
	DDI into CHUSSE	Correct telephone rings / answered		Not applicable		
	DDI into Newham	Correct telephone rings / answered		Not applicable		
	DDI into PELC	Correct telephone rings / answered		Not applicable		
	DDI into Tower hamlets	Correct telephone rings / answered		Not applicable		
	DDI into LCW	Correct telephone rings / answered		Not applicable		
	DDI into Care UK	Correct telephone rings / answered		Not applicable		
	DDI into Vocare	Correct telephone rings / answered		Not applicable		
Test IVR routing **needs to reflect our routing**	Medication Enquirers	Dental shows up on the display this is a repeat prescription ~~patient~~ and goes to a Service Advisor		Covered in SIT		
	Dental enquiries	Dental shows up on the display this is a dental patient and goes to a Service Advisor		Covered in SIT		

	HCP	HCP shows up on the display this is a HCP and goes to a Service Advisor		Covered in SIT		
	*5			Covered in SIT		
	*6			Covered in SIT		
	*7			Covered in SIT		
	Worsening Conditions			Covered in SIT		
	CMC			Covered in SIT		
	Frailty			Covered in SIT		
	Call Back	Call back shows up on the display this is a call back and goes to a Service Advisor		Covered in SIT		
	Health	Health shows up on the display this is a health call and goes to Health Advisor		Covered in SIT		
Call recording retrieval	Place 4 test calls on system from 4 different loggings and retrieve call			Covered in SIT		
	Log in from 2 separate base locations and retrieve calls			Covered in SIT		

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Pre-Requisites required to be completed before any assurance takes place
1. Agree with local GPOOH what tagged patients need to be transferred
2. Agree with CMC team what CMC records they will be sharing
3. Obtain a list of test patients that have SCR available
4. Obtain a list of test patients that have Health Information Exchange records available
5. Obtain a list of test patients that have CPIS records available
6. Provide a list of GPOOH/hubs/UTC sites that can have appointment booked into them
<Add a pre-reqs>

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Health Advisor	Are you able to complete a case as a Call Handler?	Case is saved into the database and moved to the appropriate queue	Pass		05/07/2018	
	Are you able to perform a PDS trace?	NHS number retrieved GP Practice retrieved Information stored Information sent via ITK message	Pass		19/07/2018	
	Are you able to view any special patient notes?	Ability to see a SPN		Requires spine connectivity. Will test on Live		

Are you able to view a CPIS record?	Ability to see a CPIS record		Requires spine connectivity. Will test on Live		
Are you able to view any CMC notes?	Ability to see a CMC note exists		Requires spine connectivity. Will test on Live		
Are you able to access the Repeat Caller Database	Ability to see the Repeat Caller Flag		Requires spine connectivity. Will test on Live		
Are you able to access HIE records	Ability to see the HIE record		Not for this release to come in 3.26		
Are you able to send an automatic ambulance dispatch message?					
Are you able to view manual ambulance dispatch messages?		Pass		05/07/2018	
Are you able to do a guided Transfer from a Service Advisor to a Health Advisor		Pass		05/07/2018	
Are you able to send a Guided Transfer/Warm Transfer case to a clinician?		Pass		05/07/2018	
Are you able to access an unsuccessful Guided Transfer/Warm Transfer case?		Pass		05/07/2018	
Are you able to successfully send a case using DoS via ITK?					
Are you able to successfully send a case using DoS via Email?		Pass	Fires the DoS the email is more operational process	05/07/2018	
Are you able to successfully send a case using DoS via Telephone?		Pass	Fires the DoS the telephone is more operational process	05/07/2018	

	Are you able to successfully send a case using a 'Direct Link' to each service?					
Clinical Advisor	Are you able to view the SPN?	Ability to see a SPN		Requires spine connectivity. Will test on Live		
	Are you able to view SCR?	Ability to see a SCR		Requires spine connectivity. Will test on Live		
	Are you able to view the Primary Care Record?	Ability to see a record		Requires spine connectivity. Will test on Live		
	Are you able to view any EOLCR notes?	Ability to see a EOLCR note		Requires spine connectivity. Will test on Live		
	Are you able to view a CPIS record?	Ability to see a CPIS record		Requires spine connectivity. Will test on Live		
	Are you able to view a Repeat Caller	Review process for Repeat Callers		Requires spine connectivity. Will test on Live		
	Are you able to submit to the Repeat Caller database	Case is submitte added to the Repeat Caller database		Requires spine connectivity. Will test on Live		
	Are you able to access HIE records	Ability to see the HIE record		Not for this release to come in 3.26		
	Are you able to send a Guided Transfer/Warm Transfer case to a clinician?		Pass		05/07/2018	
	Are you able to access an unsuccessful Guided Transfer/Warm Transfer case?		Pass		05/07/2018	

Service Advisor	Are you able to view the SPN?	Ability to see a SPN		Requires spine connectivity. Will test on Live		
	Are you able to view SCR?	Ability to see a SCR		Requires spine connectivity. Will test on Live		
	Are you able to view any CMC notes?	Ability to see a CMC note		Requires spine connectivity. Will test on Live		
	Are you able to view a CPIS record?	Ability to see a CPIS record		Requires spine connectivity. Will test on Live		
	Are you able to view a Repeat Caller	Review process for Repeat Callers		Requires spine connectivity. Will test on Live		
	Are you able to access HIE records	Ability to see the HIE record		Not for this release to come in 3.26		
	Are you able to send a Guided Transfer/Warm Transfer case to a clinician?		Pass		05/07/2018	
	Are you able to access an unsuccessful Guided Transfer/Warm Transfer case?		Pass		05/07/2018	
	Are you able to process a Repeat Prescription case?		Pass		05/07/2018	
	Are you able to process a Dental case?		Pass		05/07/2018	
	Are you able to process a HCP case?		Pass		05/07/2018	
	Are you able to process a Call Back		Pass		05/07/2018	

	Are you able to send a Guided Transfer/Warm Transfer case to a Health Advisor?		Pass		05/07/2018	
	Are you able to access an unsuccessful Guided Transfer/Warm Transfer case?		Pass		05/07/2018	
DOS	Provide the DOS profile name and ITK primary and COPY endpoints	All other local services that have an endpoint defined have been tested (Select 3 services to test) (DoS leads to confirm other services that can receive ITK referral or email end point)	Pass		16/07/2018 to 23/07/2018	
	For Downstream Providers - Provide the DOS profile name and ITK primary and COPY endpoints	All other local services that have an endpoint defined have been tested (Select 3 services to test) (DoS leads to confirm other services that can receive ITK referral or email end point)	Pass		16/07/2018 to 23/07/2018	
Special Patient Notes sharing	Access SPN from Vocare	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Care-UK	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from LCW	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Bexley	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from PELC	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		

	Access SPN from Croydon Trust	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from CHUHSE	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Tower Hamlets	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Newham	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Waltham Forest	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access SPN from Bromley	Access to SPN from desktop / mobile		Requires spine connectivity. Will test on Live		
	Access to Health Information Exchange			Not for this release to come in 3.26		
	PRM					
Appointment Booking	For CHUHSE - Test all DX codes can be booked into each OOH base and appointment button appears.	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For Tower Hamlets - Test all DX codes can be booked into each OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For Newham - Test all DX codes can be booked into each OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue	Pass		16/07/2018 to 23/07/2018	

	For PELC - Test all DX codes can be booked into each OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	Waltham Forest - Test all DX codes can be booked into OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For all hubs - Test all DX codes can be booked into each OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For all UTCs - Test all DX codes can be booked into each OOH base and appointment button appears	Appointment button appears, slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
Home Visiting	For CHUHSE - Test all DX codes can be booked into each HV queue	Slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For Tower Hamlets - Test all DX codes can be booked into each HV queue	Slots are shown and once selected the patient details arrive in appropriate queue	Pass		16/07/2018 to 23/07/2018	
	For Newham - Test all DX codes can be booked into each HV queue	Slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	For PELC - Test all DX codes can be booked into each HV queue	Slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		
	Waltham Forest - Test all DX codes can be booked into each HV queue	Slots are shown and once selected the patient details arrive in appropriate queue		Awaiting test Update		

999 Referrals	Ability to send an intial message to the 999 service	An initial message is sent to the 999 service and is received	Pass		16/07/2018 to 23/07/2018	
	Ability to send an updated message after scence safe questions	The scene safe question is sent to the 999 service				
	Ability to send a final update message	Once the case is finisihed the 999 service receive the final update message		Cannot test as not valid test condition		
	Review how the failed messages to the Ambulance service are viewed	For any technical failures the users should be prompted to contact the 999 service. This should link to local SOPs	Pass		24-Jul	
	Review the Message Queue for failed messages	Ensure that staff are using the Message Queue for any failures and ensure that the monitoring of the message are in the SOPS	Pass		06-Jul	
	Once you have reached an ambulance disposition, change the patient's address and make a 999 referrals	Ensure that the ambulance service receive the new (updated) address	Pass		06-Jul	
NHS Pathways	Access to NHS Pathways v15	Staff trained and the system is able to use Pathways 15	Pass		06-Jul	
Patient Pathways	Pharmacy/medication enquiries	A patient follows the the correct pathway	Pass		06-Jul	
	Repeat Prescriptions	A patient follows the the correct pathway	Pass		06-Jul	
	Dental	A patient follows the the correct pathway	Pass		06-Jul	
	Mental Health	A patient follows the the correct pathway		Still to be tested		
	Green Ambulance	A patient follows the the correct pathway	Pass		06-Jul	

	Emergency Department	A patient follows the the correct pathway		Still to be tested		
	Health Information	A patient follows the the correct pathway	Pass		06-Jul	
	Contraception advice	A patient follows the the correct pathway		Still to be tested		
	Under 1’s	A patient follows the the correct pathway and early exit, allows case to be warm transferred or placed in clinical queue	Pass		06-Jul	
	Over 75’s	A patient follows the the correct pathway and early exit, allows case to be warm transferred or placed in clinical queue	Pass		06-Jul	
	HCP Calls	A patient follows the the correct pathway and are passed to the CAS	Pass		06-Jul	
	Specific Flagged Patients/Groups including End of Life and those with specific care plans	A patient follows the the correct pathway		Still to be tested		
	Complex Cases	A patient follows the the correct pathway	Pass		06-Jul	
	Poisons and overdose advice	A patient follows the the correct pathway		Still to be tested		
	Minor illness	A patient follows the the correct pathway	Pass		06-Jul	
	Social Care	A patient follows the the correct pathway		Still to be tested		

Disposition Code Mapping (CA & HA)	Dx010 – Red 1 Dispatch for Potential Cardiac Arrest	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999	Pass		06-Jul	
	Dx011 – Red 2 An Ambulance is being dispatched to arrive in 8 minutes.	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		
	Dx011 – Red 2 for patient outside of London using Hertfordshire Postcode An Ambulance is being dispatched to arrive in 8 minutes.	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		
	Dx012 – Green 2 Emergency Treatment and Transport	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		

	Dx013 – Green 4 Assistance needed at home due to fall	HA - Ability for cases to be passed to a CA. Access to SOPS CA - Ability to make an automatic dispatch		Still to be tested		
	Dx013 – Green 4 - Assistance needed at home due to fall	HA - Ability for cases to be passed to a CA. Access to SOPS CA - Ability to make an automatic dispatch		Still to be tested		
	Dx014 – Green 4 - Crew arrived before a disposition was reached	HA - Ability for cases to be passed to a CA. Access to SOPS CA - Ability to make an automatic dispatch		Still to be tested		
	Dx016 – Green 4 Transport To Emergency Department	HA - Ability for cases to be passed to a CA. Access to SOPS CA - Ability to make an automatic dispatch		Still to be tested		
	Dx016-Non-emergency Ambulance Response (Green 4 locally determined)			Still to be tested		
	Dx0161-Non-emergency Ambulance Response possible Viral Haemorrhagic Fever (Green 4)			Still to be tested		
	Dx0162-Transport to an Emergency Treatment Centre within 1 hour (Green 4)	HA - Ability for cases to be passed to a CA as a warm transfer. Access to SOPS CA - Ability to make a referral via DOS		Still to be tested		

	Dx02-Attend Emergency Treatment Centre within 1 Hour (Green 4)	HA - Ability for cases to be passed to a CA as a warm transfer. Access to SOPS CA - Ability to make a referral via DOS		Still to be tested		
	Dx021 - Attend Emergency Treatment Centre within 1 hour possible Viral Haemorrhagic Fever (Green 4)	HA - Ability for cases to be passed to a CA as a warm transfer. Access to SOPS CA - Ability to make a referral via DOS		Still to be tested		
	Dx03 - Attend Emergency Treatment Centre within 4 Hours (Green 4	HA - Ability for cases to be passed to a CA as a warm transfer. Access to SOPS CA - Ability to make a referral via DOS		Still to be tested		
	Dx05-To contact a Primary Care Service within 2 hours	Referral via the DOS	Pass		09-Jul	
	Dx06-To contact a Primary Care Service within 6 hours	Referral via the DOS	Pass		09-Jul	
	Dx07-To contact a Primary Care Service within 12 hours	Referral via the DOS	Pass		09-Jul	
	Dx08-To contact a Primary Care Service within 24 Hours	Referral via the DOS	Pass		09-Jul	
	Dx09-For persistent or recurrent symptoms: get in touch with the GP Practice for a Non-Urgent Appointment (Green 4)	Referral via the DOS	Pass		09-Jul	
	Dx10 - MUST contact own GP Practice for a Non-Urgent appointment (Green 4)	Referral via the DOS	Pass		09-Jul	

	Dx11-Speak to a Primary Care Service within 1 Hours	Referral via the DOS to LASIUC CAS and case arrives in queue	Pass		09-Jul	
	Dx12,-Speak to a Primary Care Service within 2 Hours	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	Dx13-Speak to a Primary Care Service within 6 Hours	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	Dx14-Speak to a Primary Care Service within 12 Hours	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	Dx15-Speak to a Primary Care Service within 24 Hours	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	Dx111 - Speak to a Primary Care Service within 1 hour possible Viral Haemorrhagic Fever (Green 4)	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	Dx16-For persistent or recurrent symptoms: get in touch with the GP Practice within 3 working days (Green 4)	Referral via the DOS to LASIUC CAS and case arrives in queue		Still to be tested		
	In-hours Dental					
	Dx17 - To contact a Dental Practice within 1 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx19 - To contact a Dental Practice within 6 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx20 - To contact a Dental Practice within 12 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx21 - To contact a Dental Practice within 24 hours (Green 4)	Referral via the DOS		Still to be tested		

	Dx22 - To contact a Dental Practice within 5 working days (Green 4)	Referral via the DOS		Still to be tested		
	Out of hours Dental					
	Dental pathways electronic referal direct to SMILE	Not via DOS but direct point to point		Still to be tested		
	Dental pathways electronic referal direct to SMILE	Not via DOS but direct point to point		Still to be tested		
	Dental pathways electronic referal direct to SMILE	Not via DOS but direct point to point		Still to be tested		
	Dx28- Contact Pharmacist within 12 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx30-Speak to Midwife within 1 hour (Green 4)	Referral via the DOS		Still to be tested		
	Dx31 - Contact Genito-Urinary Clinic or other local service (Green 4)	Referral via the DOS		Still to be tested		
	Dx32-Speak to a Clinician from our service Immediately (Green 3)	Warm Transfer to a CA	Pass		09-Jul	
	Dx34-Speak to Clinician from our service within 30 minutes (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx35-Speak to Clinician from our service within 2 hours (Green 4)	Warm Transfer to a CA		Still to be tested		
	DX38-Speak to Clinician from our service for home management advice (Green 4)	Warm Transfer to a CA		Still to be tested		
	DX39 - Symptom Management Advice (Green 4)	Call is completed by the HA		Still to be tested		
	Dx45-Provide Service Location Information (Green 4)	Referral via the DOS		Still to be tested		

	DX46-Refer to Health Information within 24 hours	Referral via the DOS		Still to be tested		
	DX47-Refer to a Community Healthcare Professional (Green 4)	Referral via the DOS		Still to be tested		
	DX49-999 for police (Green 4) (Green 4)	Referral via the DOS		Still to be tested		
	DX50-Speak to Midwife or Labour Suite immediately (Green 4	Referral via the DOS		Still to be tested		
	DX52 - The call is closed with referral to the Police only (Green 4)	Call is completed by the HA		Still to be tested		
	Dx58,-No Service Clinician available refer for urgent 20 minutes	Cold Transfer to a CA		Still to be tested		
	Dx59-No Service Clinician available refer for 60 minutes primary care clinical assessment	Cold Transfer to a CA		Still to be tested		
	DX60 - Contact Optician next routine appointment within 72 Hours (3 days from now) (Green 4)	Referral via the DOS		Still to be tested		
	DX63 - Refer to Flu line (Green 4)	Call is completed by the HA		Still to be tested		
	DX64 - Speak to the Primary Care Service within 2 hours for antiviral assessment (Green 4)	Referral via the DOS		Still to be tested		
	Dx75 - MUST contact own GP Practice within 3 working days (Green 4)	Referral via the DOS		Still to be tested		
	Dx76 - Call back by Healthcare Professional within 30 minutes	Referral via the DOS		Still to be tested		

	Dx77 - Call back by Healthcare Professional within 60 minutes	Referral via the DOS		Still to be tested		
	Dx78 - Receive report of results or tests from laboratory	Referral via the DOS		Still to be tested		
	Dx80 - Repeat Prescription required within 6 hours	Referral via the DOS		Still to be tested		
	Dx81 -Contact own GP Practice next working day for a repeat prescription (Green 4)	Referral via the DOS	Pass		09-Jul	
	Dx82-Medication Enquiry (Green 4)	Referral via the DOS		Still to be tested		
	Dx85-Repeat prescription required within 2 hours (Green 4)	Referral via the DOS	Pass		09-Jul	
	Dx86 - Repeat prescription required within 12 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx87-Repeat prescription required within 24 hours	Referral via the DOS		Still to be tested		
	Dx88 - Speak to a Dental practice within 2 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx89 - Speak to a Dental practice within 2 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx91-Unexpected death (Green 4)	Warm Transfer to a CA		Still to be tested		
	Dx92 - Attend Emergency Treatment Centre within 1 hour for Mental Health Crisis Intervention (Green 4)	Referral via the DOS		Still to be tested		
	DX93-Speak to the GP Practice within 1 hour (3 calls within 4 days) (Green 4)	Referral via the DOS		Still to be tested		

	Dx94 - Attend Emergency Treatment Centre within 1 hour for Sexual Assault Assessment (Green 4)	Referral via the DOS		Still to be tested		
	Dx96-Refer to Health Information within 12 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx106 - A Clinician from our Service will call the individual back immediately to assess the problem (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx108 - The call is closed with no further action needed (Green 4) This	Call is completed by the HA		Still to be tested		
	Dx110 - Community Nurse within 4 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx111 - Community Nurse within 24 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx112 - Community Nurse next working day (Green 4)	Referral via the DOS		Still to be tested		
	Dx113 - Health Visitor next working day (Green 4)	Referral via the DOS		Still to be tested		
	Dx114 - Community Midwife next working Day	Referral via the DOS		Still to be tested		
	Dx115 - Contact own GP Practice next working day for an appointment (Green 4)	Referral via the DOS	Pass	Still to be tested		
	Dx116 - Speak to a Primary Care Service within 6 hours for Expected Death (Green 4)	Referral via the DOS		Still to be tested		
	Dx117 - Speak to a Primary Care Service within 6 hours for Expected Death (Green 4)	Referral via the DOS		Still to be tested		

	Dx118 - Attend Emergency Dental Treatment Centre within 4 hours	- Added		Still to be tested		
	Dx321-Speak to a Clinician from our service Immediately – Refused Ambulance Disposition (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx322-Speak to a Clinician from our service Immediately – Refused Emergency Treatment Centre Disposition (Green 3)	Warm Transfer to a CA		Still to be tested		
	DX323-Speak to a Clinician from our service Immediately – Refused Primary Care Service Disposition (Green 3)	Warm Transfer to a CA		Still to be tested		
	DX324-Speak to a Clinician from our service Immediately – Refused Disposition (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx325-Speak to a Clinician from our service immediately – Toxic Ingestion/Inhalation (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx326,-Speak to a Clinician from our service immediately – Frequent Caller (Green 3)	Warm Transfer to a CA		Still to be tested		
	Dx327,-Speak to a Clinician from our service immediately – Chemical Eye Splash (Green 3)	Warm Transfer to a CA		Still to be tested		
	DX328-Speak to a Clinician from our service Immediately – Management of Dying Individual (Expected) (Green 3)	Warm Transfer to a CA		Still to be tested		

Disposition Code Mapping (CA only)	Dx017 – Green 4 Emergency Ambulance for Clinical Reasons	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		
	Dx018 – Green 4 Emergency Ambulance for Transport Reasons	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		
	Dx0181 - Emergency Ambulance due to Clinical. Reasons (Green 2)	System configured and appropriate prompts returned for automatic dispatch (Where appropriate and message fails manual dispatch message is indicated). All DX codes to ambulance service must be tested and received by LAS999		Still to be tested		
	Dx18 - To Contact a Dental Practice within 2 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx23 - Contact Orthodontist next working day (Green 4)	Referral via the DOS		Still to be tested		
	Dx25 - Home Management (Green 4)	Call is completed by the CA		Still to be tested		

	Dx42 - Child protection Vulnerable Adult immediate referral (Green 4)	Call is completed by the CA		Still to be tested		
	Dx43 - Child protection / Vulnerable Adult non immediate referral (Green 4	Call is completed by the CA		Still to be tested		
	Dx51 - Speak to Midwife within 2 hours (Green 4)	Referral via the DOS		Still to be tested		
	Dx73 - Refer To Social Services Immediately (Green 4)	Referral via the DOS		Still to be tested		
	Dx74 - Refer To Social Services Routinely (Green 4)	Referral via the DOS		Still to be tested		
	Dx83 - Clinician Home Management of Dying Individual (Expected) (Green 4)	Call is completed by the CA		Still to be tested		
	Dx84 - Refer to Another Agency (Green 4)	Call is completed by the CA		Still to be tested		
	Dx97 - Emergency Contraception required within 2 hours (Green 4)	Referral via the DOS	Pass		05/07/2018	
	Dx98 - Emergency Contraception required within 12 hours (Green 4)	Referral via the DOS	Pass		05/07/2018	
Clinical Queue priority mapping	Place all DX codes into clinical queue and review priority mapping is correct and cases change colour when breaching		Pass		05/07/2018	
Clinical queue visibility	Test all clinical views and ability of supervisors to: 1) Move cases 2) Change Priority 3) Merge queues 4) Assign Cases			N/A		

Pre-Requisites required to be completed before any assurance takes place
<Add a pre-reqs>

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Self-assessment via 111 online, using five patient scenarios:	i. Female, 20 years old, contraceptive cap lodged in vagina.	111 online outcome = call back from 111 clinician		**See User Acceptance Test Scripts**		
	ii. Male, 46 years old, Toxic Ingestion, nature of substance unknown and no intent to self-harm.	111 online outcome = call back from 111 clinician				
	iii. Male, 13 years old, cough with difficulty breathing.	111 online outcome = speak to GP within 6 hours				
	iv. Female, >75, cold and flu.	111 online outcome = speak to GP within 6 hours				
	v. Male, 6 years old, swallowed an object.	111 online outcome = book a clinical call back from IUC CAS				
	vi. Mental Health – do we have a scenario?					
	2. DoS search and results display (for scenarios 1, 2, 3 & 4)	Results displayed				
	3. Arrival of ITK message in 111 clinical queue (for scenarios 1, 2)	Arrival of ITK message				
	4. Opening of case in 111 clinical queue (for scenarios 1, 2, 3 & 4)	Case opened				
	5. Completion of assessment (for scenario 1)	Clinical assessment				

	6. Final Adastra record (for scenario 1)	Adastra record updated				

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Simon Vaughan

Pre-Requisites required to be completed before any assurance takes place
1. Agree with local GPOOH what SPN notes (patient) they will be sharing
2. Agree with Black Pear / EOLCR team what SPN they will be sharing
3. Obtain a list of test patients that have SCR available
4. Obtain a list of test patients that have MIG records available
5. Obtain a list of test patients that have CPIS records available
6. Provide a list of GPOOH sites that can have appointment booked into them
<Add a pre-reqs>

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Clinician	Are you able to view the SPN?	Ability to see a SPN		**See User Acceptance Test Scripts**		
	Are you able to view SCR?	Ability to see a SCR				
	Are you able to view the Primary Care Record?	Ability to see a record				
	Are you able to view any EOLCR notes?	Ability to see a EOLCR note				

	Are you able to view a CPIS record?	Ability to see a CPIS record				
	Are you able to view a Repeat Caller	Review process for Repeat Callers				
	Are you able to submit to the Repeat Caller database	Case is submitted to the Repeat Caller database				
	Are you able to access an unsuccessful Guided Transfer/Warm Transfer case to a GPOOHs?	Access available				
EOLCR / Palliative Care Notes sharing	Access to Black Pear Palliative Care Notes (if this is used in the area)	Access to SPN from desktop / mobile				
Special Patient Notes sharing	Access Pan-London Special Patient Notes	Access to SPN from desktop				
Incoming Dispositions repeated for each DOS service via ITK	Able to receive a DX07-The disposition is: To contact the GP practice or other local service within 12 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX08-The disposition is: To contact the GP practice or other local service within 24 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX11-The disposition is: Speak to the GP Practice within 1 hour	Case appears with the correct case-type, priority and status				
	Able to receive a DX12-The disposition is: Speak to the GP Practice within 2 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX13-The disposition is: Speak to the GP Practice within 6 hours	Case appears with the correct case-type, priority and status				

	Able to receive a DX14-The disposition is: Speak to the GP Practice within 12 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX15-The disposition is: Speak to the GP Practice within 24 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX64-The disposition is: Speak to the GP Practice within 2 hours for antiviral assessment	Case appears with the correct case-type, priority and status				
	Able to receive a DX80-The disposition is: Repeat prescription required	Case appears with the correct case-type, priority and status				
	Able to receive a DX82-The disposition is: Medication Enquiry	Case appears with the correct case-type, priority and status				
	Able to receive a DX07-The disposition is: To contact the GP practice or other local service within 12 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX08-The disposition is: To contact the GP practice or other local service within 24 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX11-The disposition is: Speak to the GP Practice within 1 hour	Case appears with the correct case-type, priority and status				
	Able to receive a DX12-The disposition is: Speak to the GP Practice within 2 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX13-The disposition is: Speak to the GP Practice within 6 hours	Case appears with the correct case-type, priority and status				

	Able to receive a DX14-The disposition is: Speak to the GP Practice within 12 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX15-The disposition is: Speak to the GP Practice within 24 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX64-The disposition is: Speak to the GP Practice within 2 hours for antiviral assessment	Case appears with the correct case-type, priority and status				
	Able to receive a DX80-The disposition is: Repeat prescription required	Case appears with the correct case-type, priority and status				
	Able to receive a DX82-The disposition is: Medication Enquiry	Case appears with the correct case-type, priority and status				
	Able to receive a DX07-The disposition is: To contact the GP practice or other local service within 12 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX08-The disposition is: To contact the GP practice or other local service within 24 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX11-The disposition is: Speak to the GP Practice within 1 hour	Case appears with the correct case-type, priority and status				
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	Able to receive a DX12-The disposition is: Speak to the GP Practice within 2 hours	Case appears with the correct case-type, priority and status				
	Able to receive a DX13-The disposition is: Speak to the GP Practice within 6 hours	Case appears with the correct case-type, priority and status				

Incoming specific Pathways	GP Speak to	Receive a case for this patient pathway				
	Pharmacy/medication enquiries	Receive a case for this patient pathway				
	Repeat Prescriptions	Receive a case for this patient pathway				
	Dental	Receive a case for this patient pathway				
	Mental Health	Receive a case for this patient pathway				
	Green Ambulance	Receive a case for this patient pathway				
	Emergency Department	Receive a case for this patient pathway				
	Health Information	Receive a case for this patient pathway				
	Contraception advice	Receive a case for this patient pathway				
	Under 1's	Receive a case for this patient pathway				
	Over 75's	Receive a case for this patient pathway				
	HCP Calls	Receive a case for this patient pathway				
	Specific Flagged Patients/Groups including End of Life and those with specific care plans	Receive a case for this patient pathway				
	Complex Cases	Receive a case for this patient pathway				
	Poisons and overdose advice	Receive a case for this patient pathway				
	Minor illness	Receive a case for this patient pathway				

	Social Care	Receive a case for this patient pathway				
Referrals (Home Visits)	For PELC - Refer a patient for a Home Visit using interlinkage	The Home Visit should appear in the Despatch queue at the GPOOH				
	For CHUSSE - Refer a patient for a Home Visit using interlinkage	The Home Visit should appear in the Despatch queue at the GPOOH				
	For Newham - Refer a patient for a Home Visit using interlinkage	The Home Visit should appear in the Despatch queue at the GPOOH				
	Tower Hamlets - Refer a patient for a Home Visit using interlinkage	The Home Visit should appear in the Despatch queue at the GPOOH				
	Waltham Forest - Refer a patient for a Home Visit using interlinkage	The Home Visit should appear in the Despatch queue at the GPOOH				
Referrals (Base Visits)	For PELC - Refer a patient for a Home Visit using interlinkage	The Appointment Scheduler should appear and the case should be passed to that location				
	For CHUSSE - Refer a patient for a Base Visit using interlinkage	The Appointment Scheduler should appear and the case should be passed to that location				
	For Newham - Refer a patient for a Base Visit using interlinkage	The Appointment Scheduler should appear and the case should be passed to that location				
	Tower Hamlets - Refer a patient for Base Visit using interlinkage	The Appointment Scheduler should appear and the case should be passed to that location				

	Waltham Forest - Refer a patient for a Home Visit using interlinkage	The Appointment Scheduler should appear and the case should be passed to that location				
Referrals (other)	Ability to refer to the 999 service	Using a DDI contact the ambulance service				
	Repeat Prescriptions	The patient is referred for a repeat prescription				
	A&E	The patient is referred to A&E				
	Dental Appointment	The patient is referred for a dental appointment				
	Self-care	The patient is given self-care advise				
	Safeguarding	The patient is referred to the safeguarding team				
	GP In hours	The patient is Booked to a GP in hours				
	WIC / MIU	The patient is booked to a WIC / MIU				
	Pharmacy / Optician	The patient is referred to Pharmacy / Optician				
Queue Management	The Bridge is managing the case load for the Clinical Hub	The Bridge can view all cases lists and queues		LAS clinical Queue processes do not align to criteria		
	The Bridge can transfer cases from the CA to the GP	The Bridge can move a case from the 111 CA queue to the Clinical Hub queue				
	The Bridge can transfer cases from the GP to CA	The Bridge can move a case from the Clinical Hub to the 111 CA queue				
	The Bridge are managing outgoing messages	Monitor any messages that have failed and action as appropriate				
DOS	Access the DOS for service information	Show that the clinician can access the DOS				

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Anne Jones

Pre-Requisites required to be completed before any assurance takes place
1. Surgery available to accept ITK CDA
2. Surgery available to accept ITK email
3. Surgery available to accept DTS
4. Surgery available to accept Email

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Reporting	Ability to produce NQR Reports	Produce report		**Reporting examples to be presented at Checkpoint Review**		
	Ability to produce 111 MDS	Produce report				
	Ability to produce monthly reporting as required	Produce report				
	Ability to produce Daily Situation Reports	Produce report				
	Hourly reports are automatically produced	Produce report				
	Clinical hub reporting capability has been tested and ability to report signed off by commissioners	Produce report				
	All agreed KPIs reports can be run	Produce report				

	Test data submitted and signed off	Produce report				
Post Event Messaging (111)	Ability to send a message via COPY ITK CDA (using the DOS)	PEM sent and a printed copy supplied.		**See User Acceptance Test Scripts**		
	Ability to send a message via COPY email (using the DOS)	PEM sent and a printed copy supplied.				
	Ability to send a message via DTS (using local database)	PEM sent and a printed copy supplied.				
	Ability to send a message via Email (using local database)	PEM sent and a printed copy supplied.				
	No surgery should be profiled to use a fax	Information on the number of surgeries that have fax numbers profiled on the local database				
	PEM (Condensed)	The PEM should be condensed in line with national PEM standards				
	PEM Suppression	PEM should be supressed when a referral is sent to the Clinical Hub. The clinical hub or GPOOH should be sending the message.				
		PEM should be supressed when a referral is sent to the GPOOH. The GPOOH should be sending the message.				
	PEM Failure	Access to the PEM Failure email inbox				
Post Event Messaging (Clinical Hub)	Ability to send a message via COPY ITK CDA (using the DOS)	PEM sent and a printed copy supplied.		**See User Acceptance Test Scripts**		
	Ability to send a message via COPY email (using the DOS)	PEM sent and a printed copy supplied.				
	Ability to send a message via DTS (using local database)	PEM sent and a printed copy supplied.				

	Ability to send a message via Email (using local database)	PEM sent and a printed copy supplied.				
	No surgery should be profiled to use a fax	Information on the number of surgeries that have fax numbers profiled on the local database				
	PEM (Condensed)	The PEM should be condensed in line with national PEM standards				
	PEM Suppression	PEM should be supressed when a referral is sent to the Clinical Hub. The clinical hub or GPOOH should be sending the message.				
		PEM should be supressed when a referral is sent to the GPOOH. The GPOOH should be sending the message.				
	PEM Failure	Access to the PEM Failure email inbox				

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Healthy London Partnership

Provider Representatives
Nic Daw

Pre-Requisites required to be completed before any assurance takes place
<Add a pre-reqs>

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Rota Planning	Share completed rota's for 1 August onwards (min 4 weeks)	At least 95% filled		Rotas and GRS demonstration to be presented at Checkpoint Review		
	Rota planning for September onwards	At least 50% filled		Rotas and GRS demonstration to be presented at Checkpoint Review		
	Rota planning for Xmas and New year	More shifts rostered		Rotas and GRS demonstration to be presented at Checkpoint Review		
	Shared resources across IUCP	What shared resources are available		Rotas and GRS demonstration to be presented at Checkpoint Review		
	Do you have a rota planning tool?	Demonstration		Rotas and GRS demonstration to be presented at Checkpoint Review		
	Can staff access rotas?	Clarity on access for staff		Rotas and GRS demonstration to be presented at Checkpoint Review		

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Fiona Claridge

Pre-Requisites required to be completed before any assurance takes place
1. Communications plan agreed and signed off by all parties

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Stakeholder engagement	External communications plan in place - patients, public, CCGs, Acute Trusts, NHS England, MPs, Healthwatch, OSCs, LMCs, LPCs, local authorities, pharmacies, mental health providers	Communications with patients and public, commissioners, Acute Trusts ensuring awareness of new service, how to access it and what it does		- Comms Plan - Copies of Comms assets - newsletters and other Comms materials to be presented at Checkpoint Review		NEL 111 comms plan update July.docx
	Internal communications plan in place - GPs, call centre staff, GP staff other than GPs, patient network groups, Virtual Patient Network	Communication with staff ensuring all necessary training completed, awareness of requirements of new system		NEL IUC newsletter July 2018.pdf North East London IUC message GPs July 2018.docx		London Ambulance Service News NEL 111 (2).docx
	Branding - 111 call centre, OOHs work places, notice boards all digital and printed assets, communications around IUC	Consistent branding ensuring looks like one fully integrated urgent care service				

	Website - fully branded, translatable and operational. To include: • Information about using 111 • Feedback forms/electronic survey/FFT • Link to NHS Choices • Twitter feed/Facebook account • Translation, typetalk, sign language options • News/updates • HCP/staff areas including feedback forms/surveys/results	Consistent branding ensuring looks like one fully integrated urgent care service. Easy to access information for patients				
	Print collateral/literature - any required literature or print collateral to inform and educate patients and public on the new service	Consistent branding ensuring looks like one fully integrated urgent care service Easy to access information for patients Build brand, identity and confidence with public and patients		To be provided at review meeting		
	Patient feedback - telephone surveys, online surveys, compliments and complaints, feedback section of website, focus groups, engagement with Virtual Patient Network	Patient voice is heard in development of service				

	Patient engagement - • working with Patient Participation Groups (PPG) and GPs • collaborating on service improvement/redesign • holding providers to account • cascading marketing campaigns to relevant organisations to distribute to appropriate stakeholder groups • online, print, text and telephone surveys • work with VPN	Patient voice is heard in development of service				
	Social media (Facebook and Twitter) engagement and plans to ensure online presence of IUC	Online presence for IUC - easy access for patients and public				
	Engagement with vulnerable and hard to reach stakeholder groups through E.g. Dementia Action Alliance, Carers Trust, etc.	No gaps in communication with stakeholders/no risk of missing important stakeholder groups				
Media	Pre-written media statements/holding statements covering eventualities such as: System crash Patient safety Performance issues	Media enquiries quickly and efficiently addressed				
	Media and PR plans	Management of media interest to ensure no risk of reputational damage to service				
	Media monitoring	Manage service reputation				

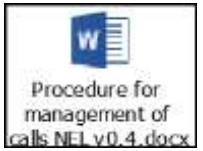
Collaborative working	Communications leads from providers linked in and actively engaging with each other to deliver an integrated service	Outward appearance of one integrated service. Communications channels / mechanisms established and ready to be utilised when needed whether required to deliver performance or communications				

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Anne Jones

Pre-Requisites required to be completed before any assurance takes place
1. All SOPs signed off
2. All LOPs signed off

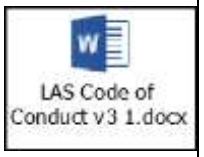
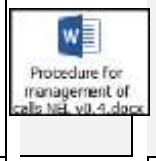
Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Business Continuity	LAS Internal BCP	Management of downtime / escalation / evacuation for the LAS 111 Service		**BCP Plan** **Demand Management**		
Clinical Hub	CA transfer into the Clinical Hub	How an NHS Pathways trained clinician can transfer complex cases to the Clinical Hub		**Demand and Clinical Call Back Queue Management v0.5**		
	Clinician transfers within the Clinical Hub	How a Hub Clinician can refer cases within the Clinical Hub (i.e. MH Nurse to a GP)		**Demand and Clinical Call Back Queue Management v0.5**		as above
	Dental Nurses within the Clinical Hub	Process for role and management of cases for Dental Nurse	N/A	NA - refer out - PAN London Dental contract		

	Mental Health Nurses in the Clinical Hub	Outlining the role and management of cases for Mental Health Nurses	N/A	NA - refer out - Crisis Line SOP		
	Mobile DOS User Guide	Instructions how to use Mobile DOS, and how to get a login to access.	N/A	- N/A Will not be used in IUC-CAS but used in 999 - Copy of guide		
	OOH Booking from Clinical Hub	How to book a downstream appointment		In final review pending Adastra & DOS mapping review on 23JUL18		To be provided post 25JUL18
	Pharmacists in the Clinical Hub	Outlining the role and management of cases for Pharmacists		- Prescribing & Safe Handling of prescriptions procedure		
	Prescribing in the Clinical Hub	Outlines the process and prescribing policy whilst working in the CHub		- Prescribing & Safe Handling of prescriptions procedure	See above	See above
	Requests for Repeat Prescriptions	Outlines the process and prescribing policy for repeat prescriptions whilst working in the CAS ~~CHub~~		**Procedure for management of calls NEL v0.4 section 25**		
	Toxic Ingestion	Process for Toxic Ingestion (including overdose) cases, including Toxbase log in details.		**Procedure for management of calls NEL v0.4 section 19**	See above	See above
Patient Management - Complex Callers	Abusive / Offensive Callers	How a staff member can best manage an abusive or offensive caller		**Procedure for management of calls NEL v0.4 section 7**	See above	See above
	Anonymous Callers	How to best manage a case when the caller is giving no / limited information		**Procedure for management of calls NEL v0.4**	See above	See above

	Callers from an unknown location	When a caller is unable / unwilling to provide location information		**Procedure for management of calls NEL v0.4**	See above	See above
	Interpreter Service	How to manage a case when the caller cannot speak English		**Procedure for management of calls NEL v0.4**	See above	See above
	Out of Area Patients	How to manage a case when the caller is calling from outside the NEL area		**Procedure for management of calls NEL v0.4**	See above	See above
	Repeat, Frequent and Regular Callers	How to manage patients who have called : - Repeat : >3 in 96 hours - Frequent : >4 in 28 days - Regular : >10 a month over 2 or more consecutive months		**Procedure for management of calls NEL v0.4** Note: 'Regular' lable not used by LAS	See above	See above
	Type Talk & BSL Application for Deaf Callers	How to manage deaf callers who have access to Type Talk or the BSL application.		**Procedure for management of calls NEL v0.4 section 9**	See above	See above
	Unregistered / Overseas Patients	How to manage callers who are : - Registered in the UK but not in their registered CCG area - Unregistered - Overseas Visitors		**Procedure for management of calls NEL v0.4 section 10.16 and section 11**	See above	See above
Patient Management - Safeguarding	Safeguarding Adults	Guide for identification of safeguarding concerns in adults, and referrals.		**- Safeguarding Adults SOP** **- LAS Safeguarding Children and Young People Policy**		
	Safeguarding Children	Guide for identification of safeguarding concerns in children, and referrals		See **Safeguarding Children and Young Adults SOP 2016 above**	See above	See above

	Safeguarding London	Local Safeguarding Guide for the NEL area		**- Safeguarding Adults SOP** **- LAS Safeguarding Children and Young People Policy**	See above	See above
Patient Management : Emergency Scenarios	Manual Ambulance Dispatches	How to refer a patient to the Ambulance Service when it cannot be sent automatically.		**Procedure for management of calls NEL v0 4 section 14**	See above	See above
	Referral to other Emergency Services	Referrals to police, fire brigade, coastguard etc.		**Management of calls to other Emergency Services v2.2**		
	Terrorist Calls and Bomb Threats	How to best manage a case where someone is threatening a terror incident, or bomb threat		**Procedure for management of calls NEL v0 4 section 14** **111/IUC Local Business Continuity Plan section 3, includes METHANE report to include bomb threats or terror incident.**	See above	See above
	Validation Line	For Health Advisors to manage Green Ambulance and Emergency Department Referrals	N/A	- do not have a separate clinican for this		
Patient Management - Processes	Dealing with Deaths	Management of callers reporting a death		**The Management of Expected and Unexpected Deaths v0.3**		
	Failed Contacts	Management when callers do not answer the phone at the time of call-back		- **Management of Clinical Queue and No Reply and Management of Online 111 Calls section 8**		

	Patients with Special Patient Notes	Management of patient with Special Patient Notes		**Procedure for management of calls NEL v0 4 section 27.2**	See above	See above
	Test Results	Management of pathology / haematology results and onward referral		**Procedure for management of calls NEL v0 4 section 26**	See above	See above
Patient Experience and Incidents	Patient and Healthcare Professional Feedback	Management of complaints / compliments and HPFs		**Management of Complaints SOP** 		
	Serious Incidents	Management of Serious Incidents within 111		**Incident Management v1 1 and 111 Incident Management IM&T NEL v1.0**  		
	Serious Incidents : LAS Workflow	Workflow for management of Serious Incidents		See Incident Management v1.1 and 111 Incident Management IM&T NEL v1.0 above	See above	See above
	Audit Process	How auditors record audits for NHS111 Staff		Call Audit & Feedback		
Operational Processes	CAS Alerts Process	How all clinicians working within NHS 111 and Clinical Hub are informed of updates in CAS and MHRA		BCP Plan 		
	Failed PEMS	How administrators manage failure of Post-Event Messages sent to GP Surgeries		**Management of Post Event Messages (PEMS) v2.6** 		

	Smartcard Policy	User guide and policy for management of Smartcards		**LAS Registration Authority Policy v3.1**		
	Smartcard Lost or Damaged	Management when a Smart Card has been lost or damaged		**LAS Registration Authority Policy v3.1**	See above	See above
	Dress Code	Guidance for dress code in the call centre		**LAS OP/001 Uniform, Work Wear and Office Wear Policy** and **LAS NHS 111 Code of Conduct v3.1**		
Staff Processes	Home Working	Management of calls when taken from home (NHS 111 Staff Only)	N/A	NA - Future possibility		
	Local Guide	Guide of the local NEL area		**Induction Process**		
	Personal Electronic Devices	Policy of use of Personal Electronic Devices (eg. mobile phones and tablets) within the call centre		**Code of Conduct v3.1**		
	Remote Working	Management when calls are taken from a remote base (Clinical Hub Staff Only)		**Procedure for management of calls NEL v0.4**		
	Service Advisor Roles	Processes for the Service Advisors.		**Procedure for management of calls NEL v0.4 section 4.5**		

Regional / Local Commissioning Assurance Team
Healthy London Partnership

Provider Representatives
Nic Daw

Pre-Requisites required to be completed before any assurance takes place
1. Training plan in place

Category	Assurance Criteria	Expected Result	Pass / Fail	Comments / Actions (inc. case reference and test patient details)	Date Tested	Assured using: Evidence / Scenario / Visual
Clinical Staff	All clinical staff on-boarded	Training Log current and all clinical staff shown as trained		**Training Plan -See attached**		
	All clinical staff trained			**Training Plan -See attached**		
Non-Clinical Staff	All clinical staff on-boarded	Training Log current and all non-clinical staff shown as trained		**Training Plan -See attached**		
	All clinical staff trained			**Training Plan -See attached**		

Croydon Staff	All relevent staff trained on new processes	Training Log current and all Croydon staff shown as trained		**Training Plan -See attached**	03/07/2018	all staffed trained as part of V15 downtime

London Ambulance Service NHS Trust

Assurance report:	**Logistics & Infrastructure Committee**	**Date:**	**05/06/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**31/07/2018**
Presented by:	**Theo de Pencier, Non-Executive Director, Logistics & Infrastructure Committee Chair**	**Prepared by:**	**Theo de Pencier, Non-Executive Director, Logistics & Infrastructure Committee Chair**

Matters for escalation:

- The Committee questioned the IM&T team's capacity to take ownership of the proposed broader IM&T strategy and fulfil business as usual requirements, considering the organisational drive to reduce the use of external resources. The Committee requested that this was brought to the Board's attention.

Other matters considered:

- The Committee received reports on activity within the Strategic Assets and Property and IM&T directorates.
- An update was provided on the progress of strategy work in these areas.
- Reports were presented on the work being undertaken by the organisation in relation to cyber security and procurement.
- The Committee considered the Trust's health and safety update and scorecard and noted that significant progress had been made in progressing the Trust's health and safety action plan.
- The Committee discussed the potential shortfall in achieving the budgeted CIP savings.

Key decisions made / actions identified:

- In regards to reporting on performance, it was agreed that an amended reporting structure/approach would be circulated for members' input and agreement ahead of the next meeting.
- The Committee sought clarity regarding the responsibility for ensuring effective contract management was carried out, particularly in light of the level of efficiency savings that could be achieved through this route. It was requested that the ELT

	give more detailed consideration to this ahead of the next meeting of the Committee.
Risks:	• In regards to the upcoming uninterruptible power supply (UPS) work at the Trust's Bow site, a risk remains in the unlikely event of a power failure at both LAS' Bow and HQ sites; however details were provided on mitigating actions. • A timeline was requested to provide assurance on the roll out of new Mobile Data Terminals (MDTs) and satellite navigation by October 2018; however the Committee took some assurance from an oral update provided at the meeting. • In regards to cyber-security, further work is to be undertaken, particularly regarding prevention of service attacks and up-to-date patching of computer systems. • In light of assurance being provided by the Cabinet Office, the Committee agreed that BAF risk 51 should be redrafted as a generic risk as the Trust held other similar third-party contracts. It is anticipated that, as a result of this, it will be recommended for de-escalation from the BAF, whilst remaining on the Trust Corporate Risk Register. • In regards to the Trust's CIPs, it was noted that other savings opportunities needed to be identified and delivered if the Trust was to meet its efficiency target.
Assurance:	• The Committee took assurance from the level of performance information being considered by the executive in relation to the areas of its focus. However, further work is required to ensure that appropriate levels of information are provided to the Committee. • In regards to the timing of the planned UPS work, the Committee was advised that the risks of waiting until September 2018 had been assessed and that the UPS was frequently monitored to ensure that indications of failure were identified and responded to quickly. The Committee was reasonably assured on the timing of its planned work as a result.

London Ambulance Service NHS Trust

Assurance report:	**People & Culture Committee**	**Date:**	**12/07/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**31/07/2018**
Presented by:	**Patricia Grealish, Director of People & Culture (in the absence of Jayne Mee, Non-Executive Director, People & Culture Committee Chair)**	**Prepared by:**	**Jayne Mee, Non-Executive Director, People & Culture Committee Chair**

Matters for escalation:

- Several issues were discussed in regards to the summary presentation of the independent training review. Given the broad remit of the review, and the number of stakeholders engaged, the Committee agreed that it was important for the Executive Leadership Team (ELT) to feedback the outcomes to the staff who were involved and create a plan of how to address the issues outlined by the training review. These should be presented to the People & Culture Committee at a future meeting.
- The agency plan presented to the Committee was not yet financially comprehensive enough to provide assurance. It was agreed that the next iteration to be presented to the Committee on 6 September 2018 would include the financial savings already achieved and the forecast of what was to be achieved with timescales to provide greater assurance that the agency cap would not be in danger of being breached.

Other matters considered:

- The Committee considered the implications of apprenticeships on the Trust's long-term workforce modelling, acknowledging that apprentices may require more ongoing support than other staff.
- The Committee were updated on the progress of the pilot Trainee Emergency Medical Dispatcher (TEMD) online assessments. It was noted that more data was required to draw any conclusions from the pilot and a more detailed analysis would be provided at the Committee on 6 September 2018 (the approach had only been in use since May 2018).

Key decisions made / actions identified:	• The Committee agreed that, in order to provide the appropriate assurance to the Trust Board, the People & Culture scorecard was to be further developed to provide commentary and mitigating actions alongside the metrics. This will be presented to the People and Culture Committee on 6 September 2018. • The Committee saw the most up to date version of the 10 year Workforce Plan which the Chair asked be shared with Heather Lawrence before the private Board meeting where it would be discussed with the board in detail. • In relation to the staff survey, it was noted that a criticism of the staff survey champions model was the time that frontline staff had been stood down to undertake their responsibilities as champions, which it had been argued could potentially have negative financial implications for the Trust. It was noted that any cost associated with the champions should be offset against the potential benefits and that the staff survey champion model should be costed before its re-implementation next year. • In relation to the growing number of post-traumatic stress disorder (PTSD) cases at the Trust resulting in frontline staff being stood down, the Committee heard that plans were underway for an academic piece of work to research and promote resilience amongst frontline staff at the Trust (particularly EOC).
Risks:	• The Committee acknowledged that recruitment gaps, highlighted in the workforce model and recruitment plan, presented a risk to the Trust if plans were not managed sufficiently in order to close those gaps. • It was noted that the agency plan did not yet outline how the Trust intended to manage spend within the Agency Cap. Therefore there could be a potential risk to the Trust's finances. • The Committee acknowledged that BAF Risk 47 regarding low Emergency Operations Centre (EOC) staffing levels at Bow and Waterloo remained a risk.

Assurance:	• The Committee were assured that the Trust was on track in its implementation of the B6 Paramedic Job Description, the transition of the 'trapped group' of NQPs and the Fast Track process.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	31 July 2018			
Report title:	Integrated Quality and Performance Report			
Agenda item:	10			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Key Leads from Quality, Finance, Workforce, Operations and Governance			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the 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):

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

July 2018

* All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout June 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 13 minutes. LAS ranked 2nd in Cat 1 90th centile compared to other Trusts.
Paramedic vacancies have improved from 6% to 5%. Frontline turnover has reduced from 10.4 to 10%
Overall financial position YTD and forecast is on plan with rising risks under consideration on 999 contract income, agency expenditure and agenda for change pay settlement.

OUR PATIENTS

		Jun-18	
ROSC at Hospital	(* data from Jan-18)	38.7%	⇧
STEMI Care Bundle	(* data from Feb-18)	72.0%	⇧
Stroke Care Bundle		97.0%	⇔
Positive compliments received	(* per 1000)	1.14	⇔
The average time lag for reporting RIDDOR incidents in June was 11 days – a sustained decrease and successfully within target since March.			⇧
15 investigations have been submitted to the CCG and are awaiting closure or comments with no breaches – This is a significant number of SIs to be submitted in any one month.			⇧
Over 700 patient incidents have been incorrectly categorized as a 'Trust' incident instead of patient safety. These will be re-assessed and categorized correctly.			⇔
Premises cleaning audit submissions from Stations requires improvement.			⇩

OUR PERFORMANCE

	Jun-18	YTD		
Category 1 response - Mean	00:07:13	06:59:00	performing within the national standard	⇧
Category 2 response - Mean	00:20:02	18:34:00	marginally outside the national standard	⇧
Category 3 response - 90th centile	02:22:50	02:08:03	marginally outside the national standard	⇧
Category 4 response - 90th centile	02:28:17	02:28:23	performing within the national standard	⇔
Call answering - 999 (less than 5 seconds) *Target subject to change	80.0%			⇔
Call answering - NHS 111 (less than 60 seconds)	87.9%		Deteriorating slightly compared to the previous month.	⇩

OUR MONEY

	YTD	Forecast		
Control Total	£2.46m deficit	£1.5m deficit	Both on plan	⇔
CIP savings	£2.4m	£12.3m	On plan with risk	⇔
Use of resources	3	2	On plan, likely to exceed	⇔
% of Capital Programme Delivered	16.5% vs 29% plan	100%	Recovery plan in process	⇩
CQUIN	Q1 on target	TBC	Work to be completed	⇔

⇩ Financial risks worsening: 999 contract income; agency expenditure; agenda for change pay settlement

OUR PEOPLE

	Jun-18		
Vacancy rates	6%	remaining steady	⇔
Staff Sickness levels	5.2%	remaining steady	⇔
% of BME Staff	13.7%	remaining steady	⇧
Statutory & Mandatory Training (85% or above)	88.4%	positively increasing	⇧
Staff appraisal compliance (85% or above)	87.6%	positively increasing	⇧

⇧	Increasing concern	⇩	Decreasing concern
⇧	Increasing negatively	⇩	Decreasing negatively
⇧	Increasing positively	⇩	Decreasing positively
⇔	Remains steady	⇔	Information only

Our Patients

Safety

- No unaccounted morphine losses
- Joint Maternity Training delivered with South Coast Ambulance Service and the LAS
- Additional maternity equipment procured to enable training opportunities
- Completed the targeted 7 ED audits as per audit programme in Q1
- Targeted stations with poor compliance history (33)
- 15 investigations were been submitted to the CCG and are awaiting closure or comments with no breaches – This is a significant number of SI's to be submitted in any one month.
- The average time lag for reporting RIDDOR incidents in June was 11 days – a sustained decrease and under target since March

Actions & Assurance

- Maintain medicines audit programme
- Continue roll out of secure drugs rooms
- Further Joint Maternity Training to be delivered 07/18
- All Education Centres maternity training equipment aligned

Effectiveness

- As a result of the additional features built into the CPI database, in May five auditors completed a Datix report as they had clinical or safety concerns and eight auditors placed a retrospective safeguarding referral.
- Inaugural meeting of the Royal College of Midwives and College of Paramedics to work together to improve pre hospital maternity care – LAS hosted
- A Clinical Performance Indicator for undiagnosed psychiatric problems was launched

Actions & Assurance

- A video outlining the key principles of the Mental Capacity Act was developed and published on the LiA face book page for staff.
- LAS to lead on standards for Joint Maternity Training

Caring

Actions & Assurance

Our Patients

Safety

- Ongoing issue with excessive doses of adrenaline
- Limited capacity for consultant midwife to deliver maternity training
- Existing response profile to Health Care Professional requests (midwives) escalated to the Clinical Quality Review Group
- Premises cleaning audit submissions from Stations requires improvement
- VP 6 weekly deep clean missed target for the second month 94% against 95%
- The new KPI's for incident reporting requires 700 no harm incidents per quarter and 150 low harm incidents per quarter. To date the Trust has not met these KPIs for Q1 2018/19 - (action – over 700 patient incidents have been incorrectly categorized as a 'Trust' incident. This data will be re-validated and the figure is likely to improve by next month).
- There are currently 17 SI actions that are outstanding

Actions & Assurance

- Promotional posters highlighting risks re-issued
- Discussion regarding role of safety syringes
- 6 Further LAS Paramedics/Team Leaders & 2 Maternity Educations Leads to undertake training to build Maternity Training Capacity – 07/18
- Agreement by Chief Quality Officer & Medical Director to implement mitigation plan 07/18
- Over 700 patient incidents have been incorrectly categorized as a 'Trust' incident. This data will be re-validated and the figure is likely to improve by next month.
- Action owners are contacted by the Quality, Governance & Assurance team on a regular basis to request they are updated / closed

Effectiveness

- Outstanding Obstetric Emergency audit
- Current datix analysis of maternity risk not reported

Actions & Assurance

- Bulletin to be circulated based upon OP35 Maternity Care Policy highlighting minimum standards 07/18
- Agreement of new maternity datix reports to be agreed 8/18
- 100% of maternity related incidents to receive specialist review

Caring

Actions & Assurance

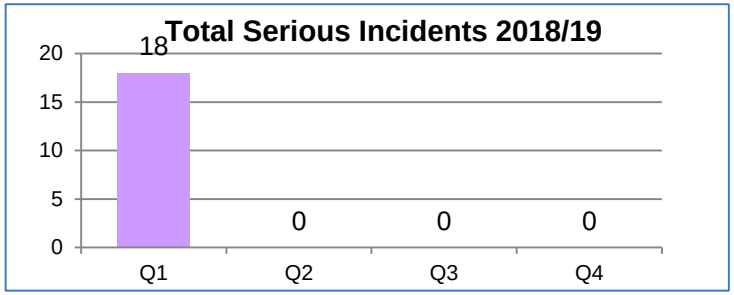
Patient Safety

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

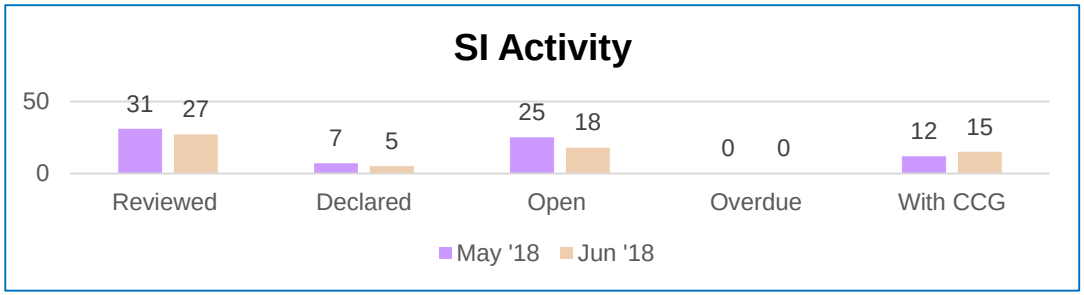
Measures	Target / Range	YTD 18/19	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	96%	98.0%	93.1%	0.0%	↓			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	2.7	2.7	2.9	2.5	↓					
Patient related Adverse Events - NO HARM	100	567	185	213	169	↓					
Patient related Adverse Events - LOW	40	84	26	29	29	↔					
Patient related Adverse Events - MODERATE	25	47	14	17	16	↓					
Patient related Adverse Events - SEVERE		12	5	2	5	↑					
Patient related Adverse Events - DEATH		26	10	10	6	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	3.5	3.9	3.8	2.9	↓					
Staff related Adverse Events - **NONE**		551	193	211	147	↓					
Staff related Adverse Events - **LOW**		414	154	142	118	↓					
Staff related Adverse Events - **MODERATE**		10	4	4	2	↓					
Staff related Adverse Events - **SEVERE**		1	0	0	1	↑					
Controlled Drugs - Other Reportable Incidents		0	0	0	0	↔					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	0%	92%	95%	90%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month		18	6	7	5	↓					
Serious Incidents breaching 60 days	0	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	0%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events		6%	4.2%	7.4%	6.7%	↓					
Needle Stick Injuries as % of Staff Adverse Events		1%	0.6%	2.0%	1.5%	↓					
Never Events	0	1	0	1	0	↓					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	0%	0%	0%	0%	↓					
Missing Equipment Incidents as % of all reported incidents		3%	3%	4%	3%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents		10%	10%	10%	9%	↓					
Number of NRLS uploads In-Month	1	3	1	1	1	↔			LQ21		

Patient Safety

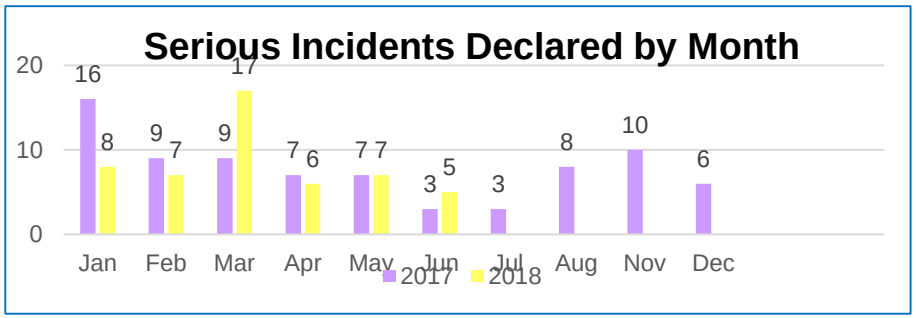
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

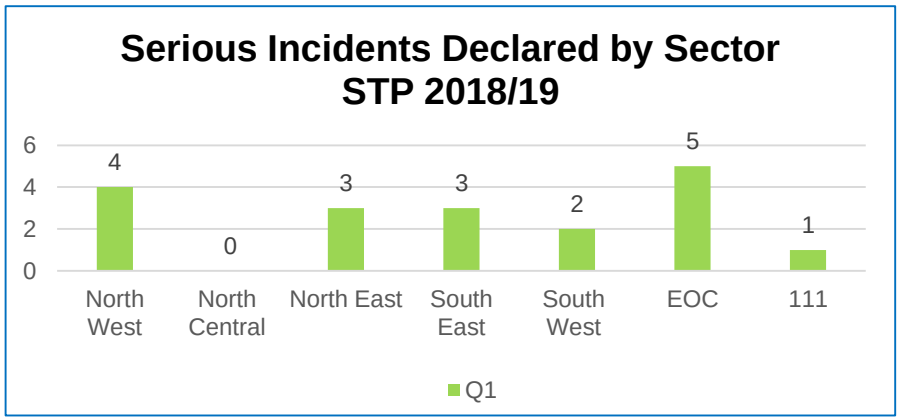


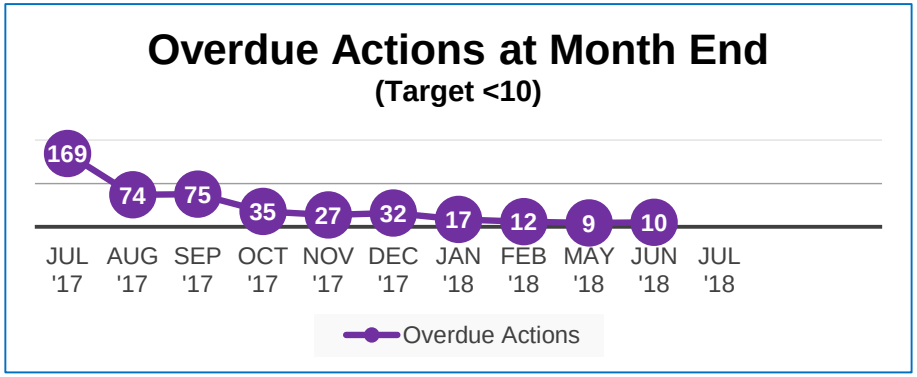
18 serious incidents were declared in Q1 '18/19. The Trust exceeded the number of SI declared compared to Q1 2016/17 by one.



A total of 27 incidents were reviewed by SIG in June of which 5 were declared as SIs. Of the 17 SIs declared in March, 2 were de-escalated. The remaining 15 investigations were submitted to the CCG and are awaiting closure or comments with no breaches. One SI has been granted a four week extension due to the complexity of the incident.



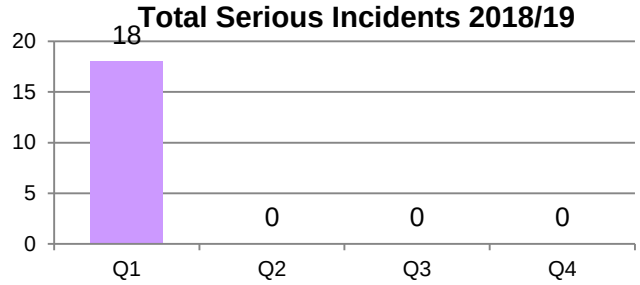




- There are currently 10 SI actions that are outstanding. 3 x EOC, 5 x Operations, and 2 x LAS 111
- The majority of actions that are overdue are part of larger service improvement programmes or are affected by rota patterns and staff absence.
- Action owners are contacted by the Quality, Governance & Assurance team on a regular basis to request they are updated / closed.

Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



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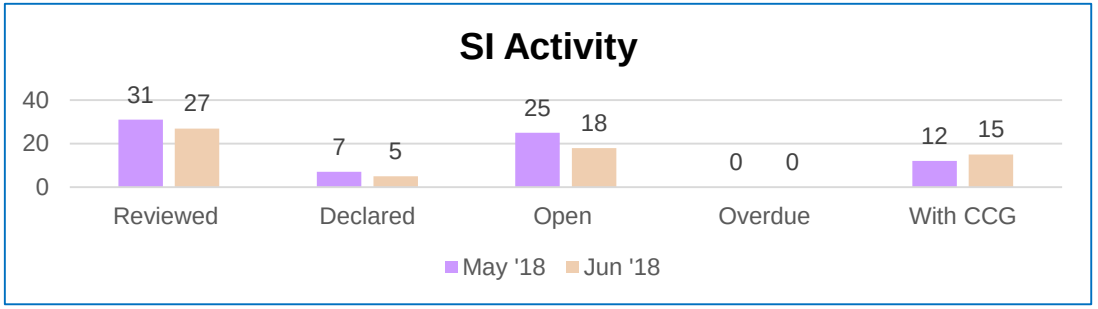

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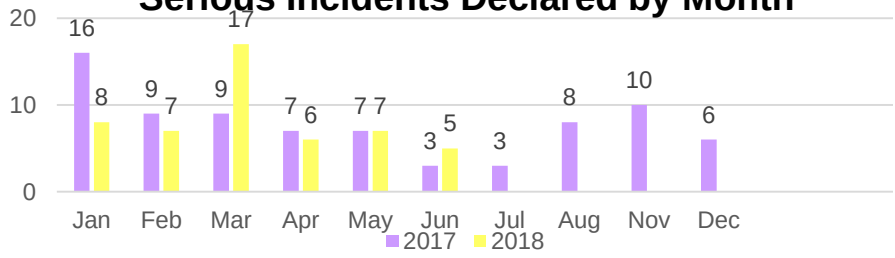

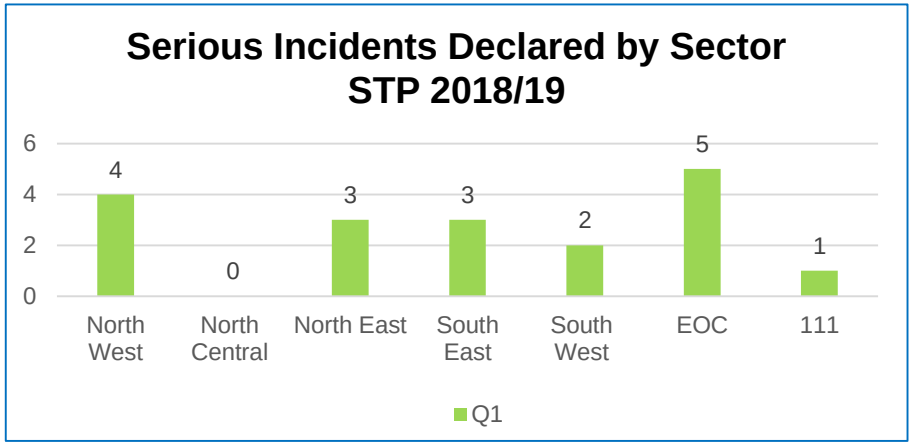

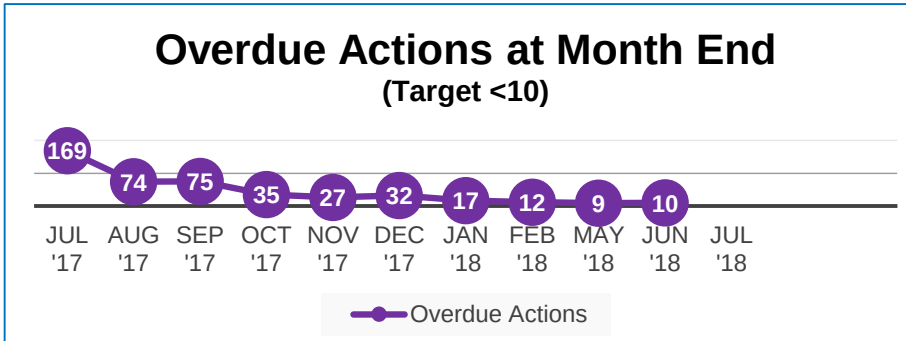

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- The majority of actions that are overdue are part of larger service improvement programmes or are affected by rota patterns and staff absence.
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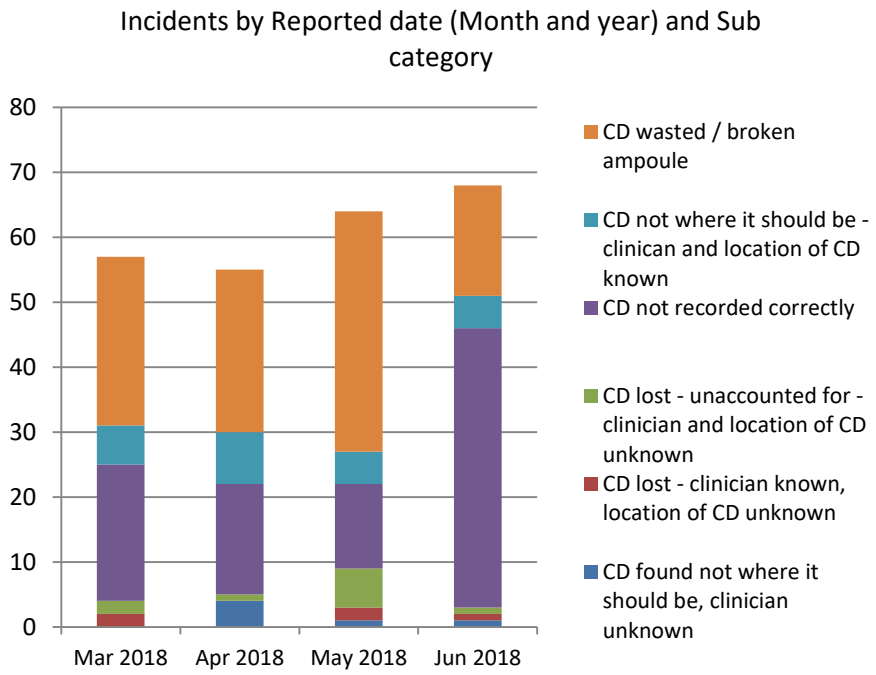
Medicines Management

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



- No unaccounted for losses of injectable morphine
- Total of 67 other controlled drug incidents including:
  - Wastage or breakages (n=17)
  - Documentation errors (n=44)
  - Morphine retained off duty (n=2)
  - LAS morphine found unsecured (n=2)
  - Drugs room found open (n=2) or access codes visible (n=2) ***in relation to stations without secure drugs rooms – these incidents are detected by the regular drug audits we have in place with perfect ward reporting**
- Non-controlled drugs incidents
  - RIGHT2 drugs trial pack missing (n=1)
  - Medical gases left at scene (n=2)
  - Drugs usage forms incomplete (n=2)
  - KitPrep app malfunction or discrepancy (n=22) ***these are reported via kit prep. A Programme Implementation Manager is working with KitPrep to resolve and also to renegotiate the new contract with them**
  - Incorrect administration of adrenaline (n=3), paracetamol (n=1), oxygen (n=1), rectal diazepam (n=1), syntometrine (n=1) & hydrocrotisone (n=2)
  - Prescribing errors by other healthcare professionals (n=2)
  - Inadequate supply or stock (n=2)
  - Allergy to morphine (n=1) and penicillin (n=1)

Actions

- Ampoule trays distributed to reduce incidence of morphine ampoule breakages
- Discussion with safety and risk regarding role of safety syringes in ongoing adrenaline 1:1000 dosing errors
- Continuing roll out of secure drugs rooms to enhance medicines management

Assurance

- No unaccounted for losses of injectable morphine
- Rapid identification and return of morphine retained off duty

Effectiveness (Clinical Measures)

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

Measures	Target / Range	RAG	YTD 17/18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	31%	39%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	63%					↔			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%	89%					↑			LQ2b		
STEMI care bundle (AQI)		G	70%						↔			LQ2c		
Stroke to HASU within 60 minutes (AQI)		G	67%	54%	52%				↔			LQ3a		
Stroke Care Bundle (AQI)		G	97%	97%					↔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	00:32				↔					
Survival to Discharge (AQI)			10%	9%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	17%					↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:41				↓					
Call to angiography (mean hh:mm)				02:41										
Call to arrival at hospital (hh:mm)				01:18										
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	90%	87%				↔		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	29.12%	35.0%				↔			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98.0%				↔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	G	92%	94%	94.0%	95.0%	94.0%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97.0%	98.0%	97.0%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96.0%			↔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)		G	0%			91.0%	90.0%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		98.0%		↑			LQ12		

Actions

As a result of the additional features built into the CPI database, in May five auditors completed a Datix report as they had clinical or safety concerns and eight auditors placed a retrospective safeguarding referral.
In May, eight paramedics on restricted duties received CPI training.

Assurance

In May, LAS CPI completion decreased slightly compared with April. The proportion of CPI audits completed by Team Leaders continued to decline for the second month in a row and at 52% was the lowest since December 2017.
The standard of care provided by the LAS to patients under the Discharged at Scene, Cardiac Arrest, Glycaemic Emergencies and Severe Sepsis CPIs remained high in May, as well as the standard of general documentation.
Care provided by the LAS to patients with an undiagnosed psychiatric problem in May was lower than those with diagnosed psychiatric problems in April (May was the first month of looking at undiagnosed psychiatric problems).

In May, 469 members of staff (12% of all LAS frontline clinicians) received a face-to-face feedback session; 48% of the expected number of staff across the LAS overall, taking into account the face-to-face feedback target and scheduled requirements for Team Leaders to fulfil patient facing duties this month.

Responsive

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

Measures	Target / Range	RAG	YTD 18/19	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.66	3.9	3.5	3.6	↑				
CMC records viewed			1309	393	497	419	↓			LQ30	
Friends and Family Test Recommending LAS as % of total responses	94%	G	89%	66%	100%	100%	↔			LQ27	
Friends and Family Test Response Rate			0.00	0.0	0.0	0.0	↔			LQ28	

Frequent Caller Team (FCaT) June 18 updates:

Last month the Frequent Caller Management Database (FCMD) identified 578 new & existing frequent callers meeting the national definition. 100% of patients were matched with their NHS numbers.

The Frequent Caller Team continue to work with the Community Involvement Officers (CIOs) who have now joined the Frequent Caller Team.

The Frequent Caller Team (FCaT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS.

FCaT supports a range of requests for data, including ED Frequent Attender meetings; CCG Forums, Mental Health Multi Disciplinary meetings, GP meetings, and NE sector STP work on frequent callers & attenders.

Frequent Caller Team (FCaT) challenges:

A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and Emergency Department plans. About to be piloted internally.

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*

Case one:

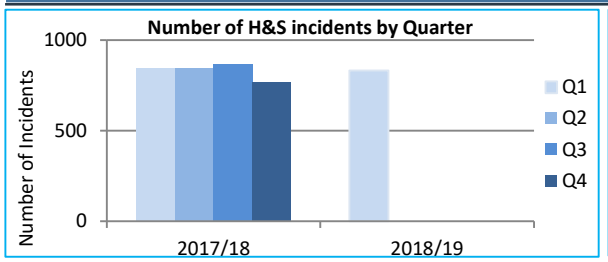
39 year old white British male. Has called LAS and Met police regularly for the past 10 years, often with suicide threats, & involves 3rd party callers in public areas. Escalating risk to others. De-registered from GP due to high risk behaviour. Regularly evicted from supported accommodation due to behaviour. Mental Health services and A&E Depts. supported prosecution for misuse of emergency services. Patient given a 2 year Criminal Behaviour Order. No calls to LAS and no inappropriate A&E attendances since court process began.

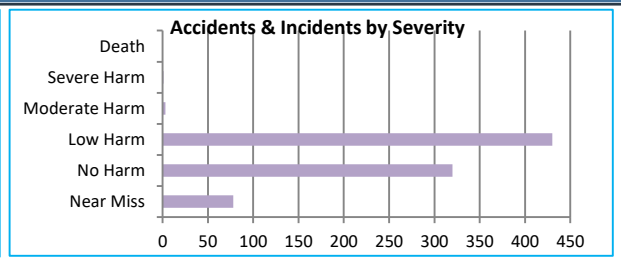
Case two:

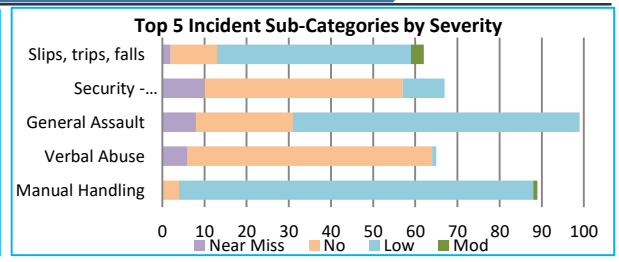
65 year old white British male with learning disabilities whose attendance to A&E had increased due to his local authority care package being reduced. Living independently but not coping. Selected by CCG project to offer intensive support. Lambeth CCG have commissioned two full time support workers to work with Lambeth's cohort of A&E Frequent Attenders. Immediate drop in call rate and A&E attendances. A more comprehensive care package was recommended with support form the new CCG project. A full evaluation of the case will be completed in time. No calls received since CCG support worker started short term intensive working.

Health & Safety Scorecard

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







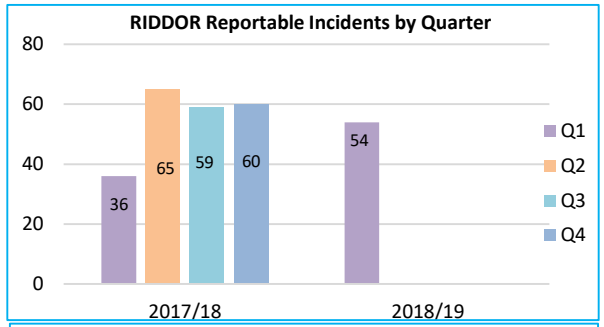
832 incidents have been reported across the Trust during Q1 2018/19. 245 incidents were reported in June 2018 . These H&S related incidents account for 37% of all the incidents reported across the Trust in June 2018.

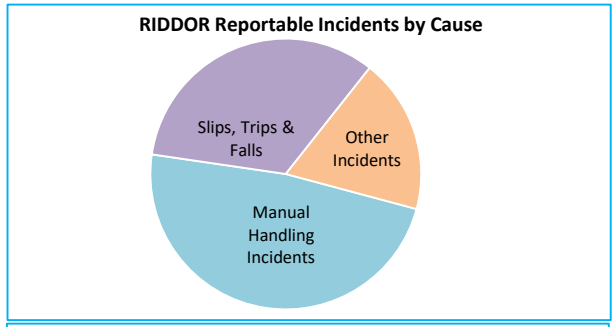
430 (52%) of the H&S related incidents reported during Q1 resulted in low harm. 4 (0.5%) incidents resulted in Moderate or Severe harm. 398 (47%) of the incidents were reported as 'No Harm/Near misses'.

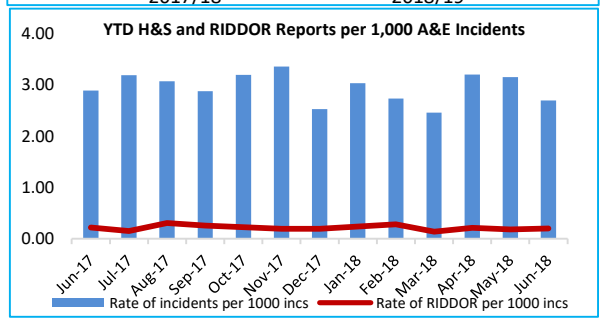
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported during June 2018.

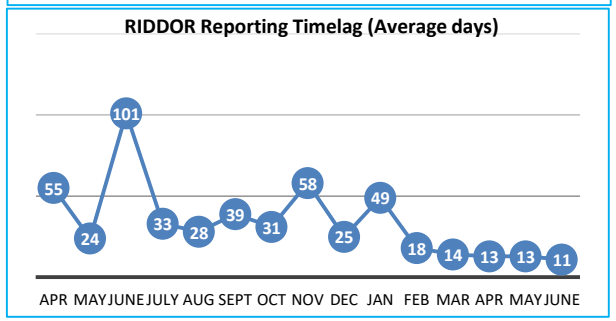
Key Updates:

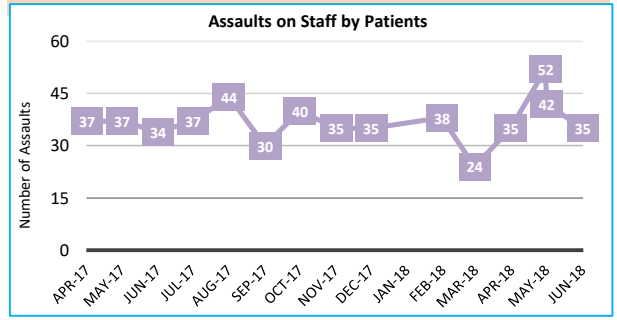
1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. 91 MH - lifting patient incidents have been reported in Q1. Some of the contributory factors included the lack of equipment or failure a piece of equipment resulting in the manual handling of patients.
3. 146 incidents relating to the lack of or failure of equipment have been reported across the Trust during Q1, 2018/19.
4. The provision of practical MH Training to relevant frontline and support services staff is ongoing.
5. A review is ongoing to evaluate additional measures that can be implemented to further mitigate the security related incidents reported across the Trust.
6. Work is on-going to progress the actions identified on the Health and Safety Action Plan. **49 out of the 69** identified actions have now been completed.











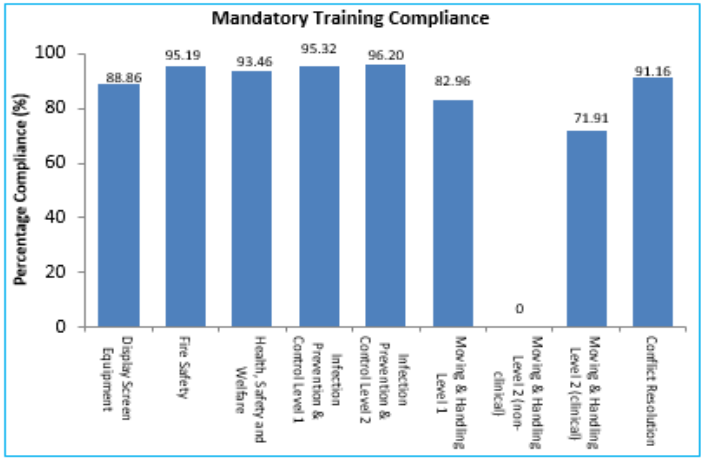
7. The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to June 2018.
8. No benchmark/comparable data was received from any of the other ambulance Trusts during June 2018.

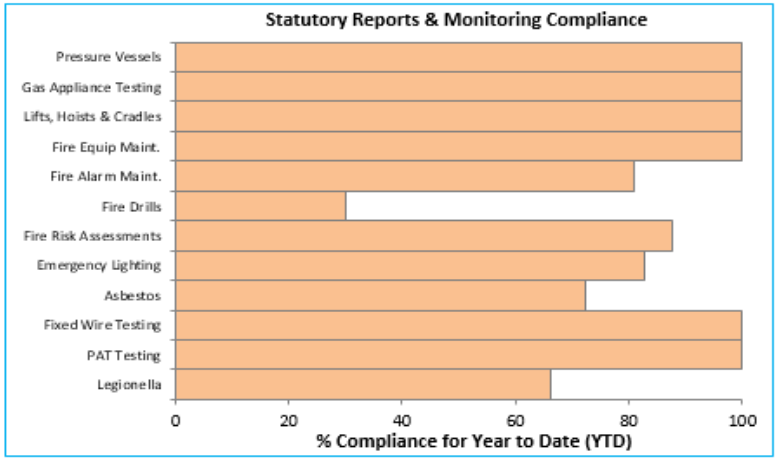
9. 54 RIDDOR incidents were reported to the HSE in 2018/19. 18 RIDDOR incidents were reported in June 2018.
10. The average time lag for reporting RIDDOR incidents in June was **11 days.** 2 out of the 18 RIDDOR incidents were reported out of time in June 2018.

11. There was a decrease in the number of assaults on staff by patient related incidents in June 2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Health & Safety Scorecard

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





12. The practical MH Level 2 (non-clinical) training is a new course put in place since April 2018 for non-operational (support services i.e. IM&T, Fleet, Estates) staff who undertake MH activities. 118 members of staff have been identified as requiring this training, and training dates have been circulated through the Learning and Development Team.

13. Trust-wide compliance for the Manual Handling Training (Clinical) in June 2018 was at 71.91%. Practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.

14. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q4 – 2017/18 Jan	Feb	Mar	Q1 Apr	May	Jun	Target Risk Rating	Key changes/updates since last review
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	15	9	An audit of the practical manual handling training that is being delivered to staff via CSR 1: 2018 will be undertaken in July 2018. The feedback from the audit will be used to further develop future training provided to staff. The H&S Department monitor MH related incidents on a regular basis and a review is currently ongoing to look into and address the equipment related failures reported across the Trust.
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	12	12	12	12	4	Programme of annual audits approved by the CQO. Agreement around the Terms of reference for Corporate H&S Committee deferred until the July Corporate H&S Committee meeting and following the ACAS review of Trade Union numbers.
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	12	6	No updates since last review.
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	9	9	3	3	The average RIDDOR reporting timelag reduced to 11 days in June 2018. It is recommended that this risk should be downgraded and closed but monitored on a monthly basis by the H&S Team.
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	9	3	No updates since last review.
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	8	4	No updates since last review.
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	6	3	Substantive recruitment into the Health and Safety Department is ongoing.

Learning from Complaints

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

Complaints by subject 2015/18	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Total
Delay	16	14	26	9	22	33	19	17	40	21	21	17	11	266
Conduct	24	19	19	16	17	25	20	22	23	20	18	23	20	266
Road handling	13	14	10	7	14	9	7	6	10	6	5	8	8	117
Treatment	5	1	7	5	16	8	9	8	14	4	9	13	8	107
Non-conveyance	4	12	0	1	6	1	7	6	3	4	6	5	9	64
Totals (above)	62	60	62	38	75	76	62	59	90	55	59	66	56	820
Totals per month	76	73	86	51	94	85	84	74	102	76	77	77	70	1025

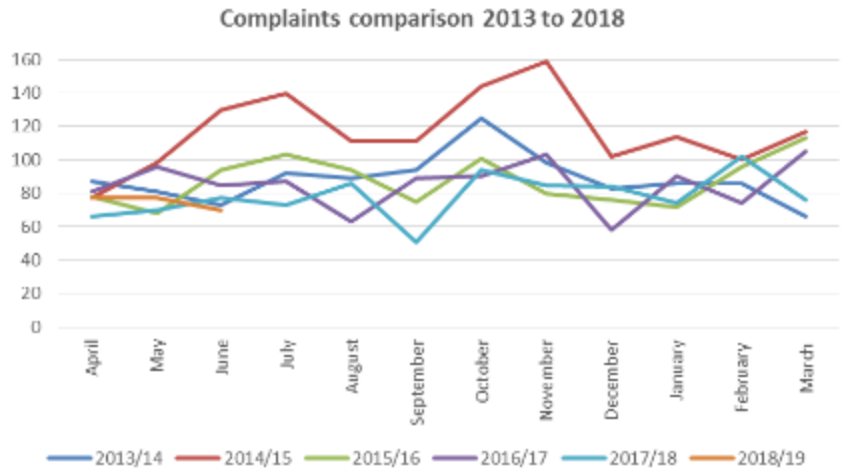
Assurance and learning

- We are seeking guidance from the Medical Directorate regarding the management of Health Partner Alerts where a clinician to clinician discussion would be more beneficial.
- The Ombudsman is currently investigating 10 of our referred complaints, five of which involve a deceased patient.
- During June we received 369 PALS enquires. Comprised of 257 general enquiries, 51 lost property, 33 requests for medical records, and 28 appreciations.
- We are still receiving fees from Solicitor's for records requested prior to the implementation of GDPR (circa £66,000 in 2017/18). This will reduce to nil over the coming months.
- Seven complaints are being managed in conjunction with Governance as they have been declared as Serious Incidents.

Review of June 2018

- The overriding good news for June was the successful visit to the London Ambulance Service by the Parliamentary Health Service Ombudsman on 28 June
- The ombudsman stated that “LAS offers a vital public service, one which we should all be proud of……Their dedication to learning from complaints means patients should get the answers they need while also helping to drive improvements throughout the service”
- Unfortunately, due to escalation to REAP 3, the ombudsman was unable to spend time in EOC but he was able to discuss how we plan for unpredictable emergency events with the Head of Resilience & Special Operations
- In June we received 70 complaints , this included 1 on behalf of the patient from a HCP and 4 regarding NHS111
- This represents 0.08% against face to face incidents during June of 90,907
- There were 23 Health Partner Alerts in June of which 7 have been resolved. A total of 29 HPA’s remain under investigation
- Complaints where conduct and behaviour are the key head of complaint continue to increase (20 this month, annual average = 22 per month)

Complaint numbers June 2013 to June 2018



Learning from Complaints

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

Month	Total complaints remaining open/re-opened as at time of report each month	Closed during the month	opened complaints by month
Jan-18	106	98	74
Feb-18	109	91	102
Mar-18	131	70	76
Apr-18	108	93	77
May-18	105	70	77
Jun-18	107	78	70
Totals	666	500	476

- There were 15 out of time complaints where the response was due in June that have been concluded
- There are 12 complaints where the response has exceed 35 working days and await conclusion. Of these, 4 await QA reports, 4 are being drafted by the case officer, 2 are awaiting clinical opinions, 1 is awaiting operational input and 1 has been referred back fro SIG as non declared
- Two complaints have had time frames extended due to the complexity and nature of the complaint (not included in above numbers)

Assurance & Learning

- A small working group in the team will be redesigning some of the information on the website with an FAQ facility. We are waiting to liaise with the new web officer to achieve this
- A complaints process mapping team has been established to take forward a number of issues including meeting the needs of complainants and ensuring that our complaints processes are patient centred.
- During Quarter 1, 2018/19, 85 complaints have not been upheld, 8 have been upheld and 12 partially upheld.
- We are continuing to review how we can improve throughput with contributing departments (i.e. QA) with improved use of Datix to streamline case management
- Management of Health Partner Alerts is working well but we are hoping it will improve further as it becomes more embedded
- We have submitted the relevant documentation to improve resourcing within the department and await the approval of that
- We continue to justify our need for a dedicated clinician and QA officer to assist with complaint management and thus throughput

Categories of complaint calls

June 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	3
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	15
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	14
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	10
Category A Red 1 - 8 min response	2
Category C1 45 min response	1
Category C2 60 min response	1
Not CAD related (i.e. NHS111/driving issues) /Info awaited	24
Total	70

Case example

Example one

The patient's mother complained that an ambulance was not sent for her son who had collapsed suddenly injuring his head.
The Quality Assurance review of the 999 call indicated that the call handler of the initial call should have applied the Traumatic injuries protocol to assess head injury which would have achieved a higher priority outcome being determined. The EMD will receive extensive feedback.

Example two

Complaint from care home manager who is upset at the attitude of the clinician who called the patient back.
The Clinical Advisor was unprofessional in the management of the call and should not have persisted with asking the caller to lift the patient off the floor once advised that it was not their company policy. Feedback will be offered to the clinician concerned.

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No
North West	12
North Central	8
North East	13
South East	14
South West	7
Outer London/PPI	6
Total	**60**

Events in June include:

- Road safety: Biker Down, Driven by Consequences and a cycling festival
- Junior Citizen Schemes (ages 10-11)
- Women's groups
- Brownies visit
- Knife crime workshops and events
- School and college visits
- Job and careers fairs
- CPR and defibrillator training
- Summer fetes, fairs and fun days
- Multi-agency community engagement events

Public Engagement activities

Supplementary information	
Public engagement: no. of hours (June 2018)	697
Approximate audience numbers (June 2018)	16,285
No. of public engagement events: year to date (April 2018 – June 2018)	124
No. of staff on LAS Public Education Facebook group	740
No. of staff on contact list	1,305
Widespread promotion and publicity internally and externally through the pulse, Twitter, Facebook and staff bulletins.	

Staff Awards

- The Service has won an award for the Best Use of ESR at the Healthcare People Management Awards (HPMA).
- Higher Education Programme Manager Paul Bates has been awarded a Fellowship to the College of Paramedics for his outstanding contribution to the professional body and to the education and development of the paramedic profession.
- Twenty five members of staff were recognised at a special event in June to celebrate staff who had completed training through the LAS Academy, others who had achieved postgraduate qualifications and two who have completed 35 years of service.

Staff Recognition

- In June one of our paramedics were awarded a High Commendation from the Metropolitan Police Commissioner after helping detain an armed man. The paramedic, who has worked for the Service for 13 years, was nominated by a senior police officer for their quick thinking and actions when attending an incident and coming across an armed man.
- Over £11,000 has been raised for charities following the emergency services boxing night that took place earlier this month. Seventeen members of staff represented the Service and went head to head with colleagues from London Fire Brigade and the Metropolitan Police in front of 1,500 spectators at the O2 arena. Although no overall winner was announced, it was a successful night all round with our team taking 8 wins, 6 draws and 3 losses.

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%	• 60 minutes mean response time • 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 90th Centile (00:15:00)	C1T Mean (00:19:00)	C1T 90th Centile (00:30:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
Previous month (May 18)	00:06:54	00:11:21	00:11:51	00:19:57	00:18:43	00:38:13	00:56:22	02:12:34	02:24:50
Last month (Jun 18)	00:07:13	00:11:45	00:12:30	00:21:03	00:20:02	00:40:52	01:01:16	02:22:50	02:28:17
Current YTD (2018/19) *	00:06:59	00:11:26	00:11:59	00:20:15	00:18:34	00:37:30	00:55:05	02:08:03	02:18:23

*from 1st April 2018

Demand

- **91,077** Incidents were provided with a face-to-face response.
- **8,943 C1** incidents were provided with a face-to-face response.
- **50,591** incidents were categorised as **Category 2** and provided with a face-to-face response.

Performance

- The **C1 Mean** performed marginally above the 7 minute target, at 7 minutes 13 seconds however.
- **C1 90th** continues to remain **within** the 15 minute target for **June** as well as the **year to date** position.
- **C3 Mean** performed **marginally above** the target of one hour.

Performance Overview
Response Times by Category

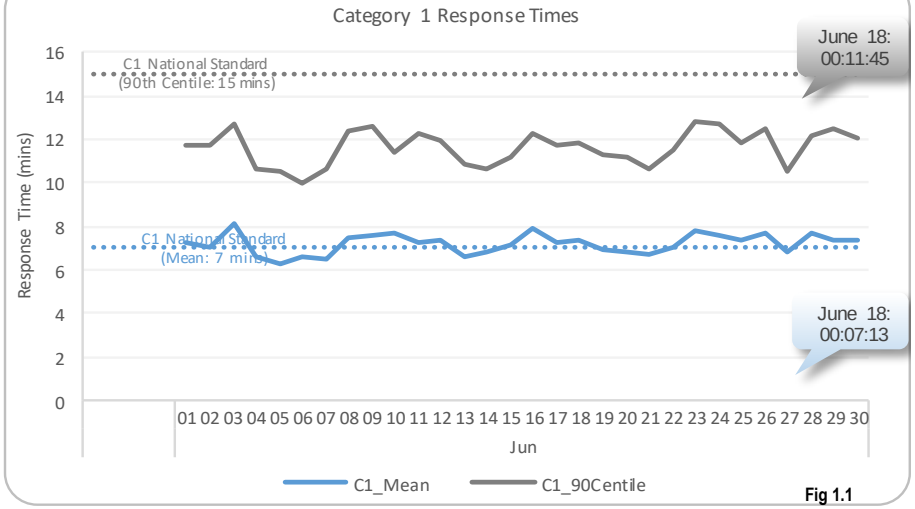


Fig 1.1

Category 1

The NEW Category 1 (C1) measure is expected to comprise 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.

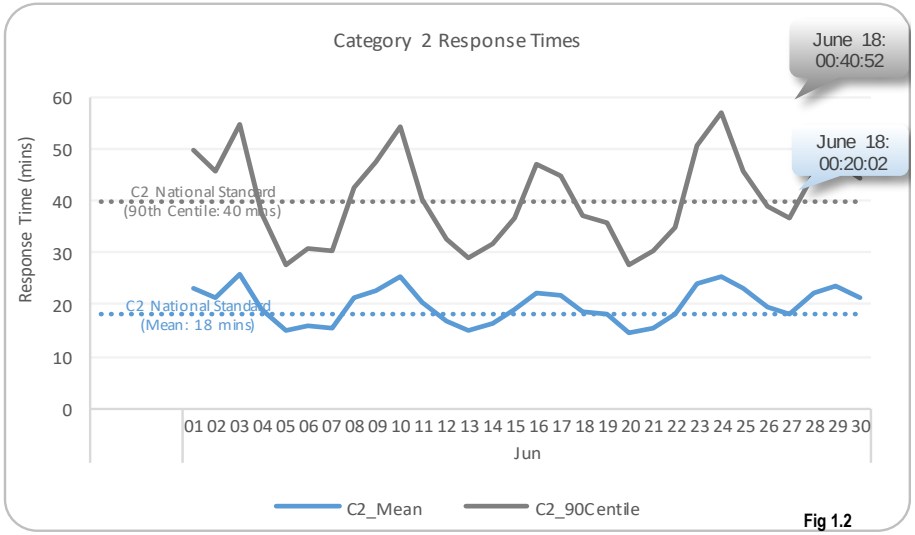


Fig 1.2

Category 2

The NEW Category 2 (C2) measure is expected to comprise 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.

Performance Overview
Response Times by Category

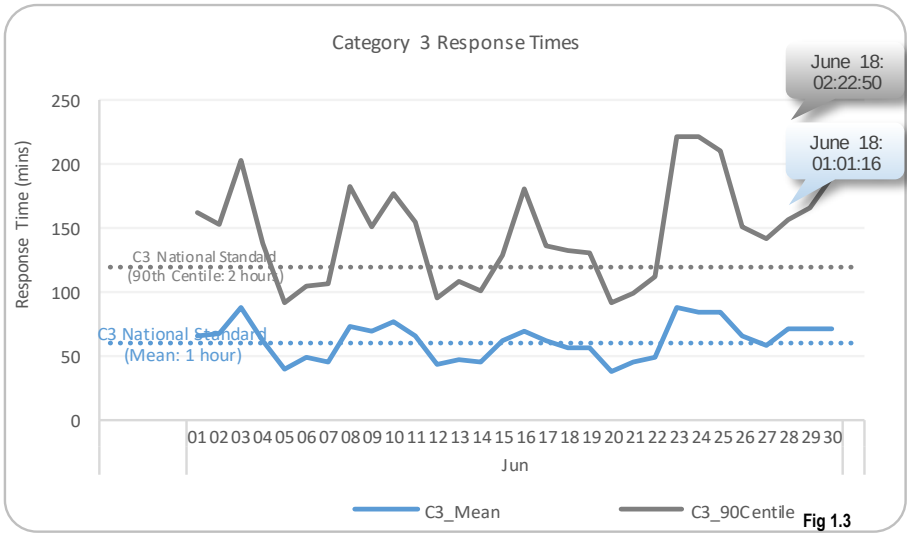


Fig 1.3

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.
  - The dotted blue line shows the National Standard of 60 minutes (1 hour) average (mean) response time. This is as a result of the recently updated specification for Ambulance Quality Indicators released in May 2018 by NHS England.

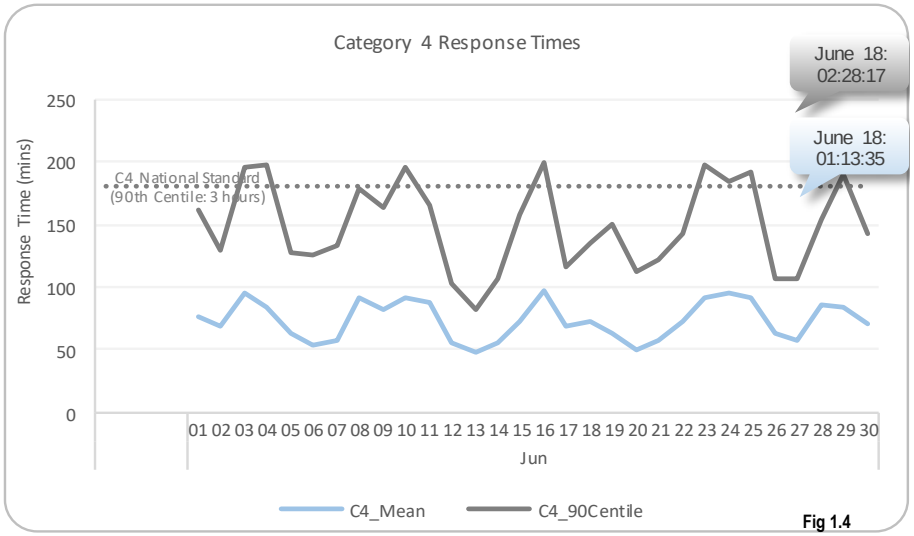


Fig 1.4

Category 4

The NEW Category 4 (C4) measure is expected to comprise 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

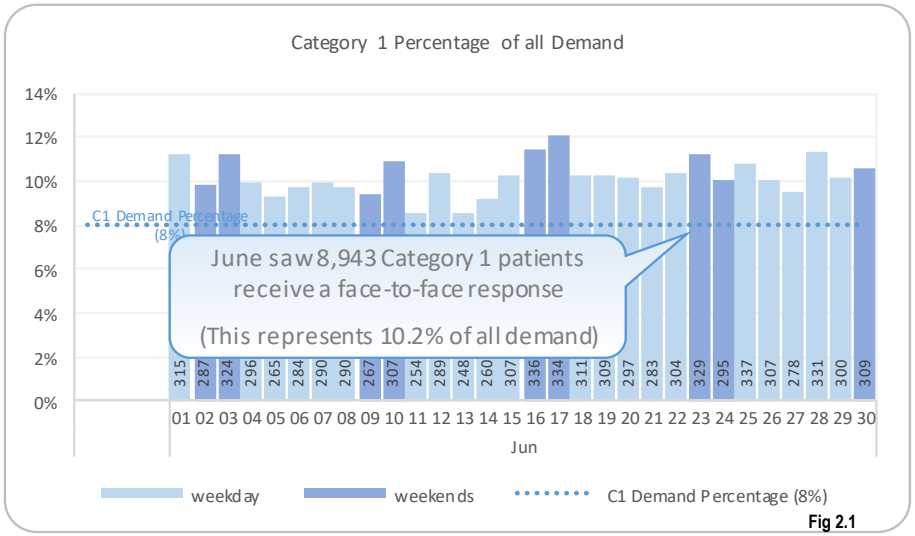


Fig 2.1

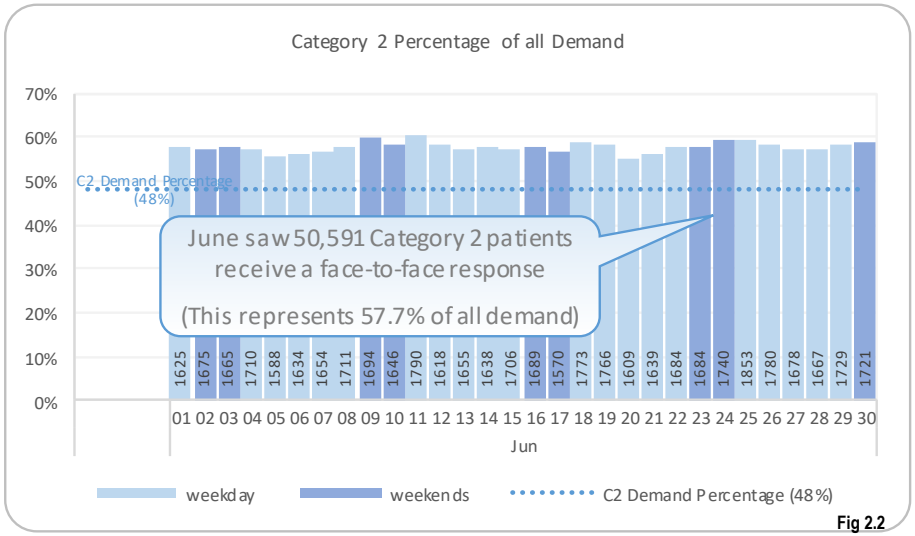


Fig 2.2

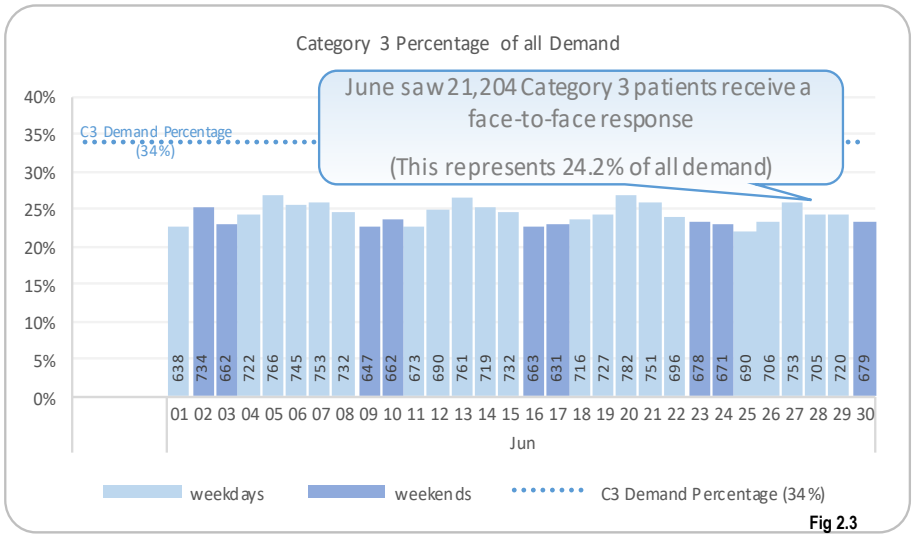


Fig 2.3

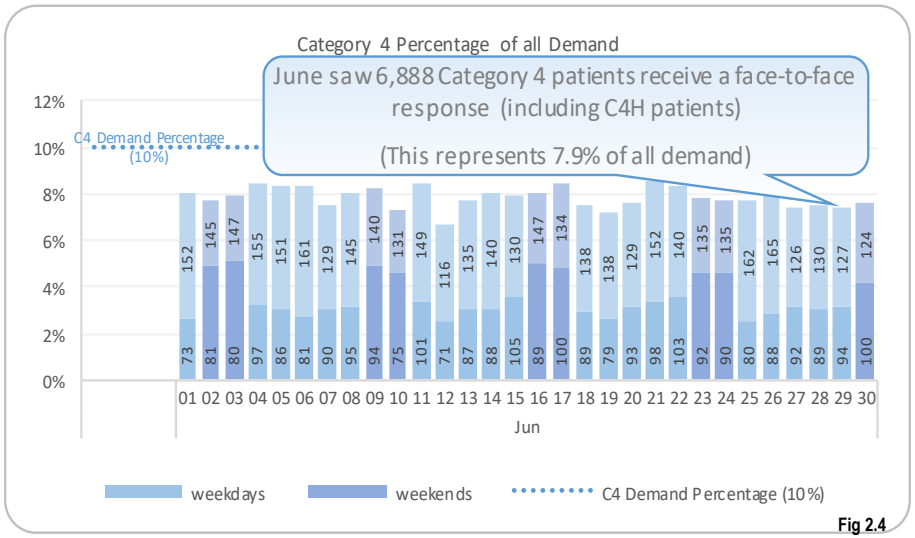


Fig 2.4

Performance Overview
90th Centile Performance

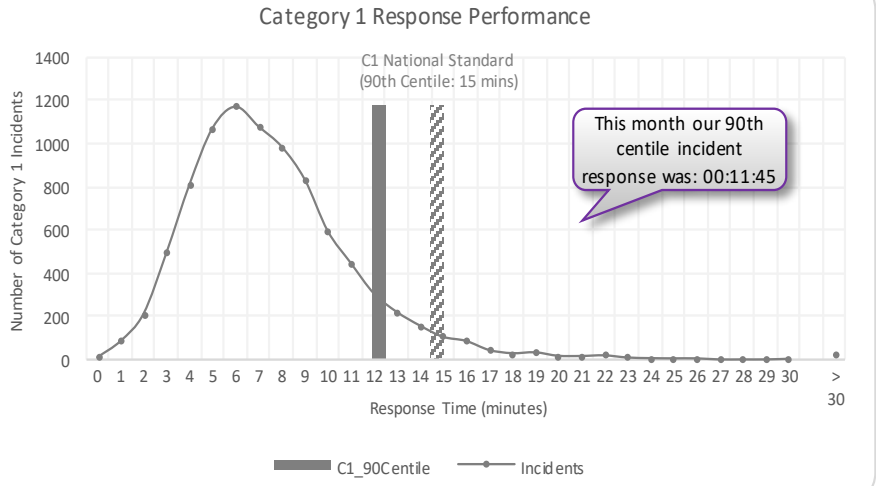


Fig 3.1

- Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The 90th centile response time in **June** was **00:11:45** minutes, **within** the 15 minute National Standard as set out in the guidelines by NHSI.

Of the 8,943 incidents requiring a Category 1 response, 8,047 incidents received a face to face response within 00:11:45 minutes.

The LAS 90th centile has been **consistently within the 15 minutes** standard **each week** since ARP was implemented.

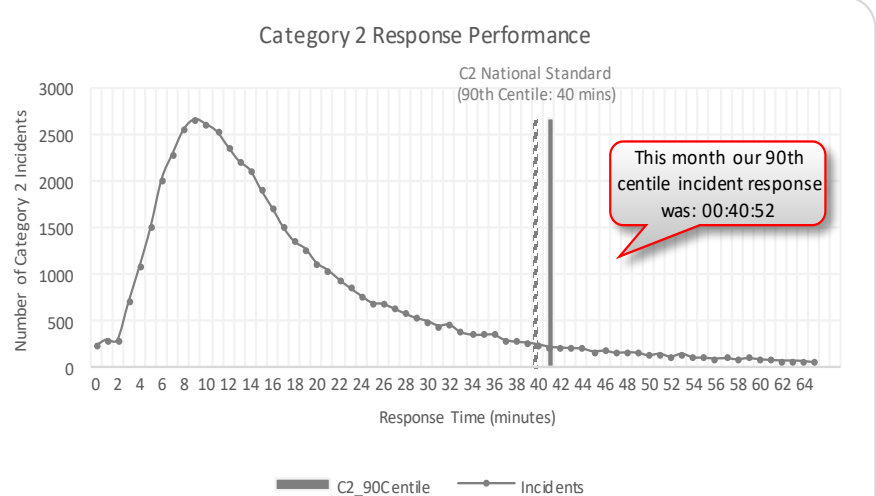


Fig 3.2

- Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The 90th centile response time in **June** was **00:40:52** minutes, above the 40 minute National Standard as set out in the guidelines by NHSI.

Of the 50,591 incidents requiring a Category 2 response, 45,525 incidents received a face to face response within 00:40:52 minutes.

Performance Overview
90th Centile Performance

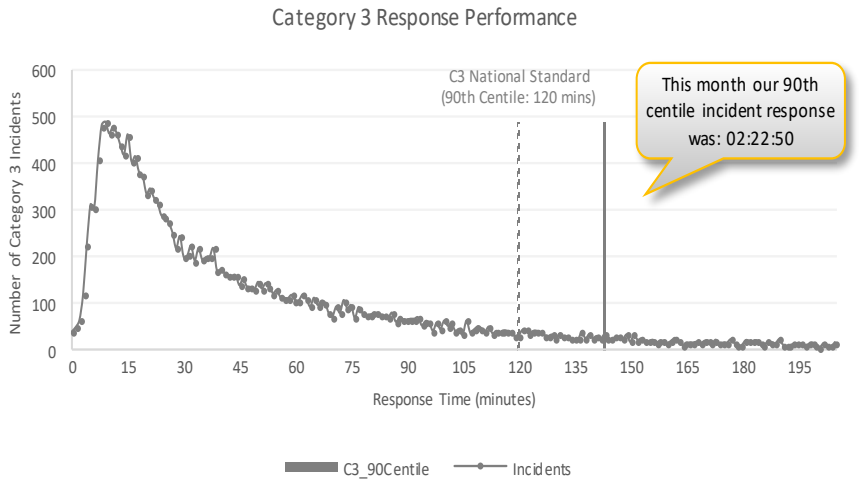


Fig 3.3

- Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The 90th centile response time in **June** was **02:22:50** minutes, above the 2 hour National Standard as set out in the guidelines by NHSI.

Of the 21,204 incidents requiring a Category 3 response, 19,176 incidents received a face to face response within 02:22:50 minutes.

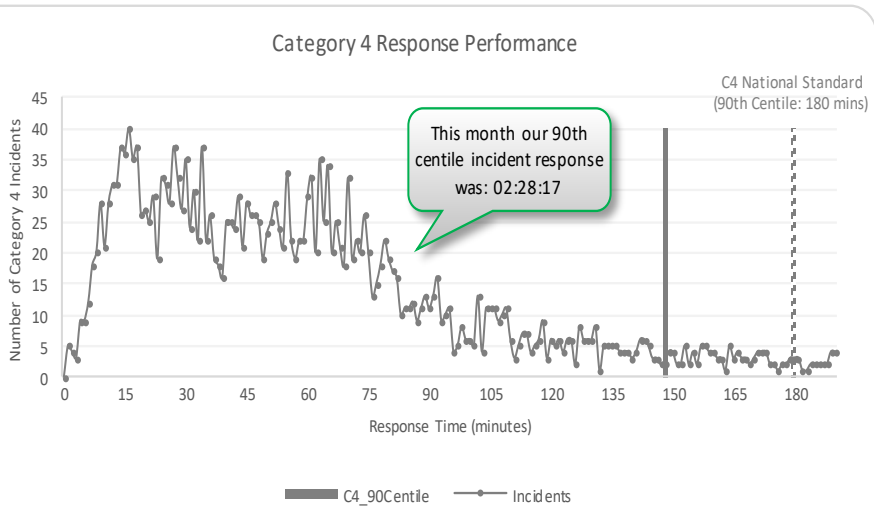


Fig 3.4

- Fig 3.2 Demonstrates the response distribution for Category 4 incidents.

The 90th centile response time in **June** was **02:28:17** minutes, **within** the 3 hour National Standard as set out in the guidelines by NHSI.

Of the 2,680 incidents requiring a Category 4 response, 2,412 incidents received a face to face response within 02:28:17 minutes.

The LAS 90th centile has been well **within** the 3 hour standard for the 6 **months** since ARP was implemented.

Performance Overview
Key Metric Variance

Category	Measure	LAS Monthly Performance (Jun 18)	National Standard	Variance
Category 1	Mean Response Time	**00:07:13**	7 minutes	**00:00:13**
	90th centile	**00:11:45**	15 minutes	**00:03:15**
Category 2	Mean Response Time	**00:20:02**	18 minutes	**00:02:02**
	90th centile	**00:40:52**	40 minutes	**00:00:52**
Category 3	Mean Response Time	**01:01:16**	60 minutes	**00:01:16**
	90th centile	**02:22:50**	120 minutes (2 hours)	**00:22:50**
Category 4	90th centile	**02:28:17**	180 minutes (3 hours)	**00:31:43**

Performance Overview
National Picture

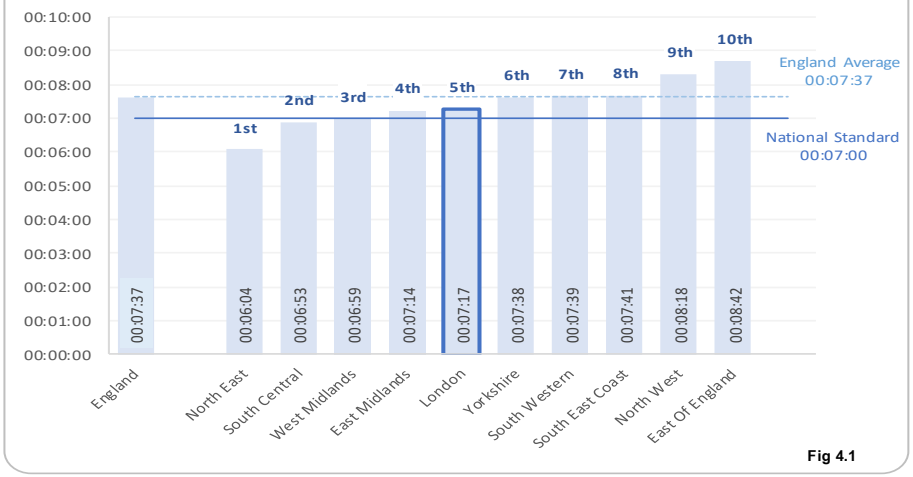


Fig 4.1

- Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England.

Additional information also displayed :

- The National Standard
- The average for England
- The ranking position for each Trust

- LAS achieved **7 minutes 17 seconds** for the **mean** response time for **Category 1** patients. This is **above** the 7 minute national standard.

- LAS performed **within** the England average.

Fig. 4.2 Displays the six key ARP performance measures for each Ambulance Trust across England.

- This is the **fifth consecutive** month, **LAS ranked 2nd** in the **Category 1 90th Centile** performance measure, compared to the other Trusts.

- For the **Category 4 90th Centile**, LAS ranked **4th**.

	Mean	90th Centile	Mean	90th Centile	Mean	90th Centile	90th Centile
June 2018	**Category 1**	**Category 1**	**Category 2**	**Category 2**	**Category 3**	**Category 3**	**Category 4**
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	01:00:00	02:00:00	03:00:00
England	00:07:37	00:13:19	00:21:38	00:44:35	01:00:15	02:20:01	03:15:38
East Midlands	00:07:14	00:12:56	00:31:10	01:05:49	01:10:21	02:51:47	02:14:04
East of England	00:08:42	00:15:40	00:26:14	00:53:06	01:24:05	03:25:19	04:02:53
London	00:07:17	00:11:46	00:20:01	00:40:52	01:00:52	02:22:52	02:28:36
North East	00:06:04	00:10:17	00:17:39	00:36:13	01:00:07	02:17:47	02:16:35
North West	00:08:18	00:14:11	00:23:29	00:51:42	01:02:30	02:27:41	03:03:11
South Central	00:06:53	00:12:39	00:15:12	00:30:02	00:47:17	01:40:08	02:49:27
South East Coast	00:07:41	00:14:22	00:17:39	00:33:14	01:16:37	02:55:30	04:58:23
South Western	00:07:39	00:14:23	00:26:41	00:56:24	01:15:58	02:58:38	05:50:15
West Midlands	00:06:59	00:12:03	00:12:27	00:22:22	00:35:01	01:17:02	02:08:26
Yorkshire	00:07:38	00:12:55	00:21:30	00:45:08	00:56:58	02:12:53	02:43:11
Isle of Wight	00:10:36	00:18:34	00:14:03	00:35:50	00:33:44	01:21:12	03:33:08

Fig 4.2

Performance Overview

Performance by STP

These tables show 6 key performance measures for May and June 2018 profiled by STP.

All STP areas remained well **within** the national standard for **2 key measures**.

- The **C1 90th centile** continues to perform within the 15 minute national standard across all STPs.
- The **C4 90th centile** also continues to perform well within the 15 minute national standard across all STPs.
- **C3 Mean (**1 hour standard introduced following the spring review**)** remained within the national standard across 3 STPs during June.

June 2018 STP Position	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:07:29	00:11:41	00:22:34	00:47:37	01:12:48	02:49:34	02:30:25
North East	00:07:12	00:11:55	00:18:25	00:35:49	00:57:50	02:17:27	02:26:39
North West	00:07:16	00:11:49	00:21:16	00:44:22	01:07:21	02:45:42	02:59:21
South East	00:07:04	00:11:41	00:18:58	00:38:31	00:53:10	02:01:39	02:03:09
South West	00:07:03	00:11:30	00:18:59	00:38:19	00:57:20	02:13:01	02:13:41

May 2018 STP Position	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:07:09	00:11:48	00:20:05	00:42:20	01:04:35	02:33:20	02:51:13
North East	00:07:03	00:11:37	00:17:04	00:33:31	00:52:41	02:08:03	02:14:17
North West	00:06:43	00:11:06	00:19:48	00:40:34	01:01:06	02:29:40	02:43:29
South East	00:06:47	00:11:12	00:17:33	00:35:48	00:48:29	01:56:55	02:22:56
South West	00:06:49	00:11:10	00:19:09	00:39:27	00:54:27	02:05:26	02:14:02

Performance Overview
Call Answering Performance

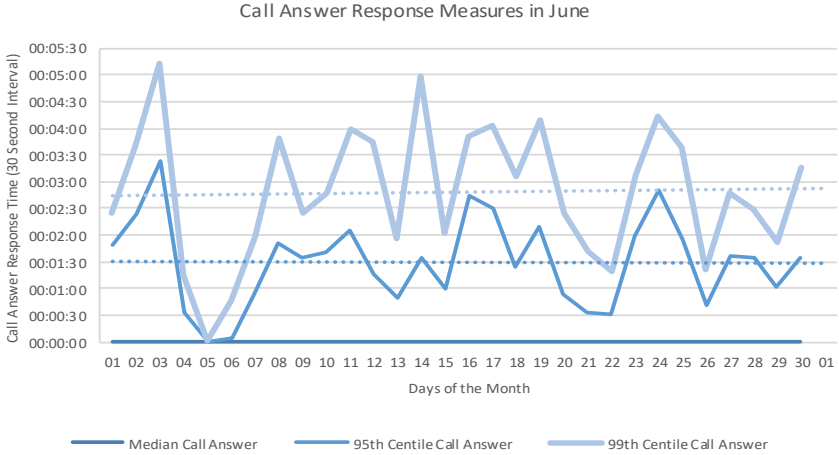


Fig 5.1

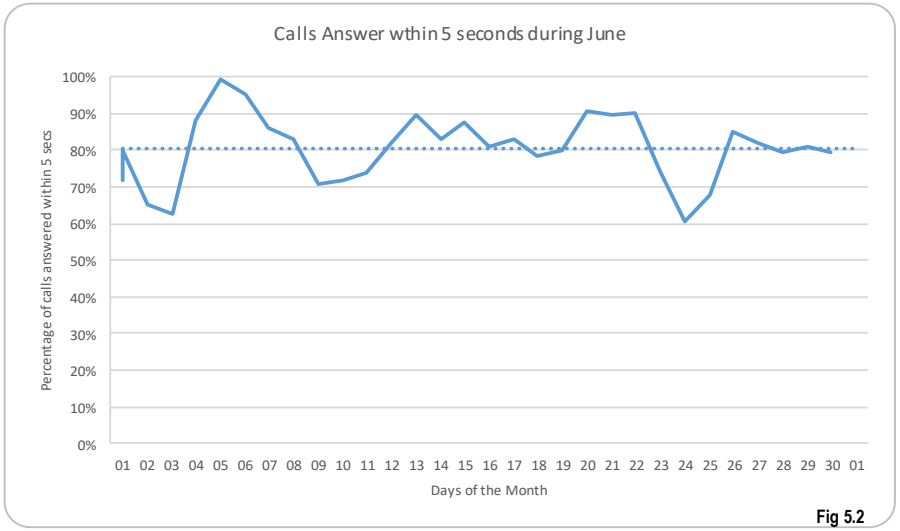


Fig 5.2

- Figure 5.1 demonstrates **three key measures** for call answering under the Ambulance Response Programme (ARP).

- During June 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 **98 seconds**.
  - In other words 95 out of every 100 calls were answered in less than 98 seconds.

- Figure 5.2 shows the percentage of calls answered within five seconds.

The new ARP standards no longer use this performance measure and for that reason there is longer a requirement to report it.

However, to illustrate the graph shows the daily call taking performance in the month.

- In June **80%** of all **calls** received into the EOC were answered **within five seconds**.

Hospital Handover Summary

Hospital Conveyance Lost Hours

Non-blue calls. Arrival at hospital to patient handover, June 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)	Total Handovers Over 30 mins	Total Handovers Over 60 mins	12 Week Trend
Barnet	1514	1456	439	30%	6	46	49	0	
North Middlesex	2406	2299	1367	59%	9	204	250	5	
Royal Free	1459	1362	962	71%	13	201	285	37	
University College	1777	1693	1026	61%	10	169	217	14	
Whittington	1433	1364	603	44%	7	75	71	5	
Homerton	1375	1326	396	30%	4	29	18	0	
King Georges	1187	1113	982	88%	12	202	347	1	
Newham	2054	1901	1496	79%	10	248	353	4	
Queens Romford	3009	2908	2242	77%	10	355	436	3	
Royal London	2178	2068	1262	61%	8	169	213	3	
Whipps Cross	1821	1716	1282	75%	10	218	325	3	
Charing Cross	1190	1124	643	57%	5	59	27	0	
Chelsea & West	1331	1264	532	42%	6	50	33	0	
Ealing	1256	1192	438	37%	7	50	49	0	
Hillingdon	1766	1695	1307	77%	15	319	478	37	
Northwick Park	2908	2793	1298	46%	14	293	419	23	
St Marys	1879	1787	1187	66%	8	165	166	4	
St Thomas'	2336	2165	1403	65%	7	168	141	1	
West Middlesex	1850	1794	807	45%	7	90	68	2	
Kings College	2278	2157	1656	77%	9	250	253	3	
Lewisham	1539	1416	845	60%	7	100	78	2	
Princess Royal	1877	1755	575	33%	8	76	84	9	
Queen Elizabeth II	2482	2411	445	18%	7	49	45	8	
Croydon	2037	1932	1338	69%	9	203	218	13	
Kingston	1432	1366	852	62%	5	76	24	0	
St Georges	2068	1937	1261	65%	8	160	169	0	
St Helier	1256	1186	736	62%	8	99	95	9	
LAS TOTAL					8	4,123			

Non-blue calls. Patient Handover to Green, June 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)	Total Handovers Over 30 mins	Total Handovers Over 60 mins	12 Week Trend
Barnet	1331	1264	737	58%	7	84	60	5	
North Middlesex	1877	1755	824	47%	4	60	30	1	
Royal Free	2068	1937	974	50%	6	100	74	13	
University College	1821	1716	854	50%	7	95	85	4	
Whittington	0	0	0	0%	0	0	0	0	
Homerton	2278	2157	1003	46%	6	104	72	4	
King Georges	1432	1366	654	48%	5	50	32	0	
Newham	2908	2793	1382	49%	6	136	77	3	
Queens Romford	2178	2068	1204	58%	7	145	119	3	
Royal London	1256	1186	565	48%	5	44	16	2	
Whipps Cross	0	0	0	0%	0	0	0	0	
Charing Cross	2037	1932	1029	53%	5	86	30	2	
Chelsea & West	1256	1192	569	48%	5	49	25	1	
Ealing	1375	1326	731	55%	8	101	92	7	
Hillingdon	1187	1113	516	46%	6	50	47	5	
Northwick Park	2482	2411	1019	42%	3	55	35	0	
St Marys	1777	1693	1016	60%	8	133	120	6	
St Thomas'	1850	1794	832	46%	5	69	40	4	
West Middlesex	1433	1364	729	53%	8	93	80	6	
Kings College	1539	1416	626	44%	5	54	33	4	
Lewisham	2406	2299	1320	57%	8	172	158	10	
Princess Royal	3009	2908	1609	55%	7	176	161	10	
Queen Elizabeth II	1459	1362	678	50%	7	76	57	4	
Croydon	1766	1695	770	45%	6	71	40	4	
Kingston	2054	1901	940	49%	7	114	101	3	
St Georges	1879	1787	912	51%	7	100	70	4	
St Helier	2336	2165	1157	53%	6	124	107	2	
LAS TOTAL					6	2,339			

Hospital Handover Summary
Hospital Conveyance by Location

This map shows the relative location of each ED hospital across London.

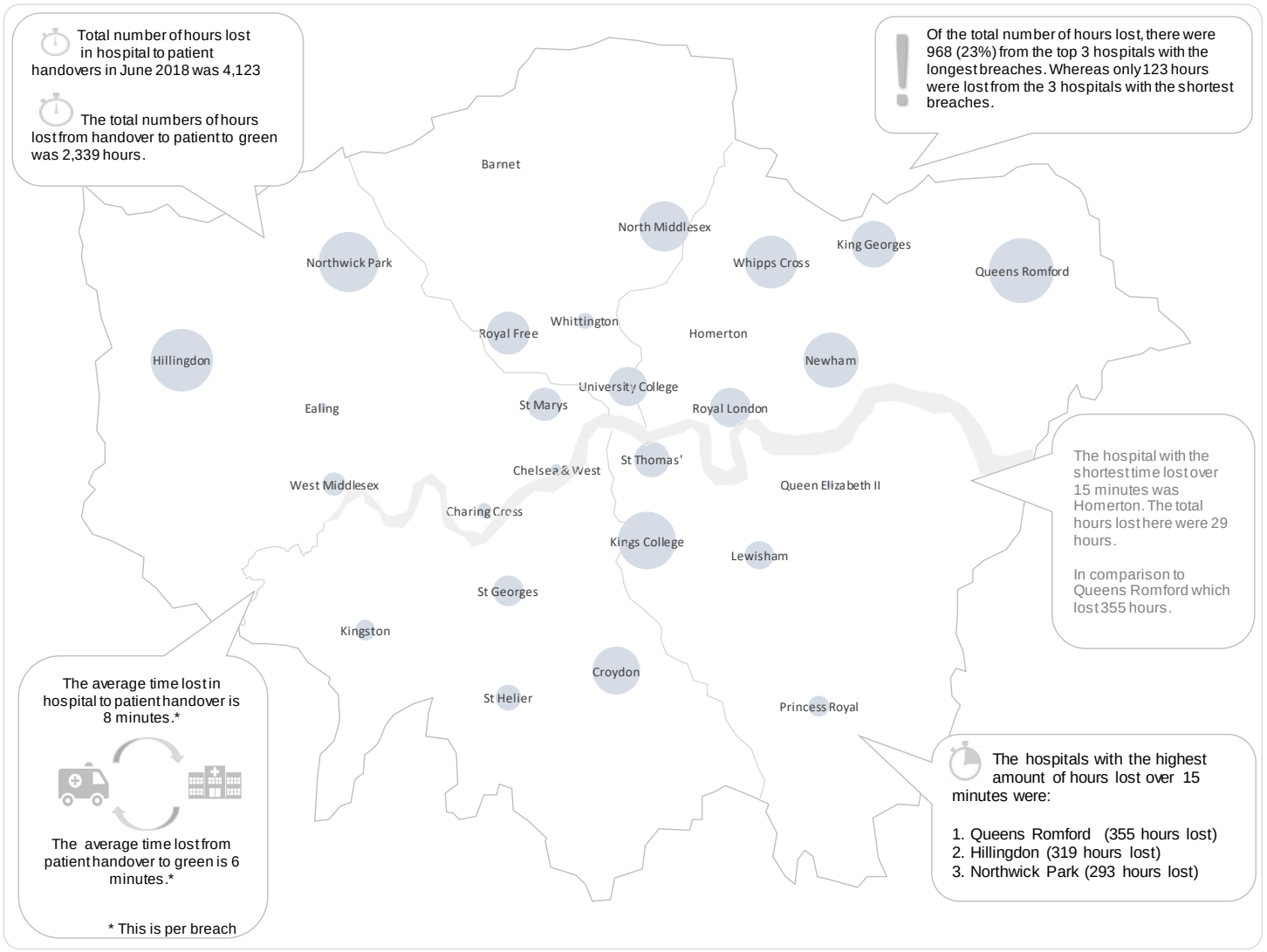
The size of the bubble relates to the comparative hours lost* at that hospital.

- The smaller the bubble, the fewer hours lost at hospital.
- The larger the bubble, the more hours lost at hospital.

* Total time accrued after 15 minutes, for arrival at hospital to patient handover.

Highest number of hours lost.

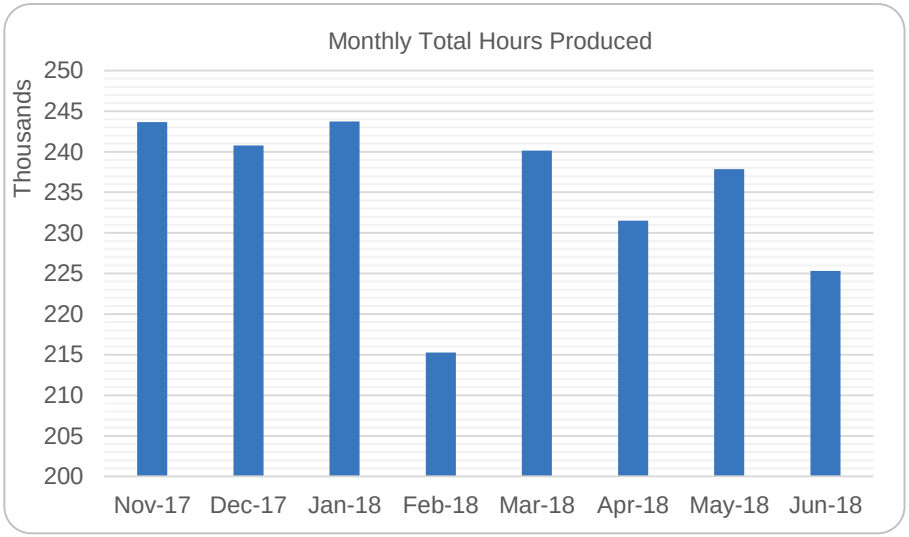
Lowest number of hours lost.

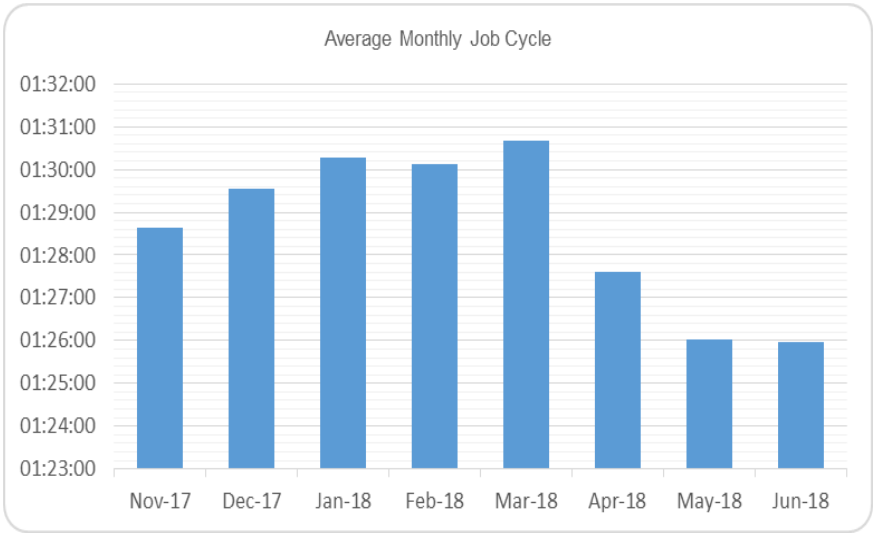


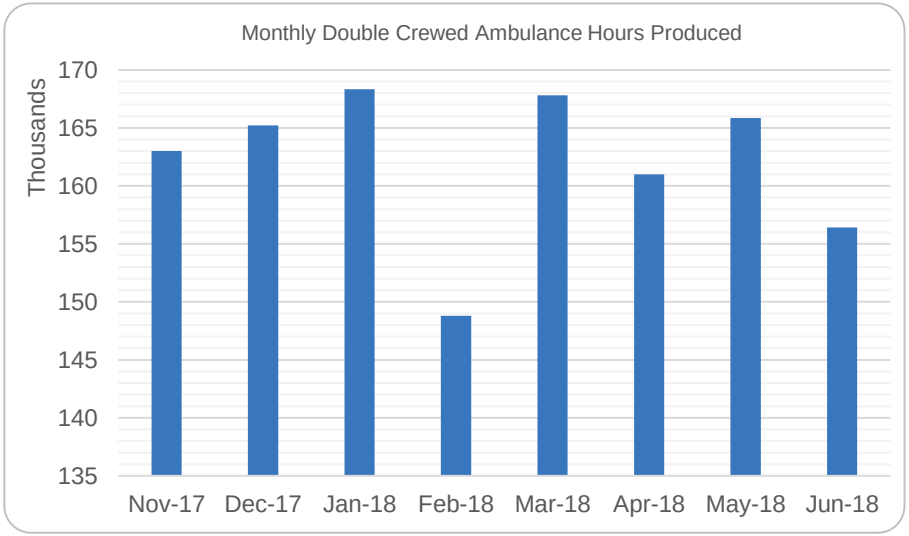
Job Cycle & Capacity
Ambulance Response Programme

- The graphs below shows the Job Cycle Time on average per month since the implementation of the Ambulance Response Programme.
    - It demonstrates that the JCT has improved from the previous month with a slight decrease and remains steady.

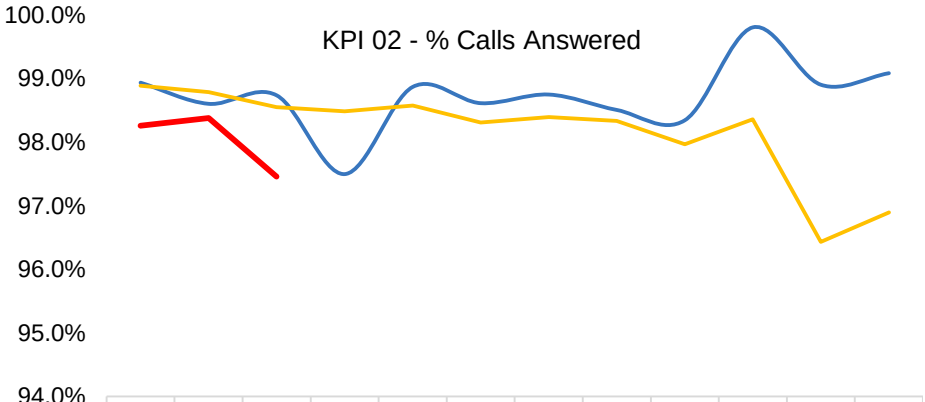
- The graphs opposite show the number of hours produced on average per month since the implementation of the Ambulance Response Programme.
    - June shows a slight decrease of 6% in Total Hours Produced.







LAS 111 (South East London)
Demand and Capacity



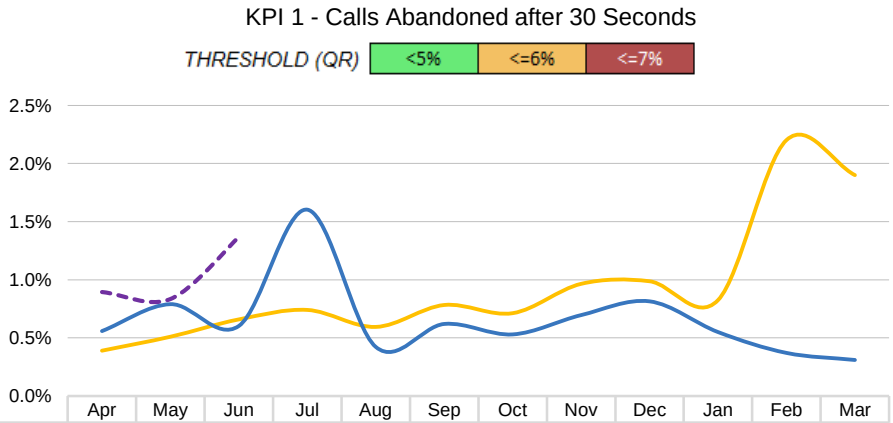
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
%16/17	98.9%	98.6%	98.7%	97.5%	98.9%	98.6%	98.8%	98.5%	98.3%	99.8%	98.9%	99.1%
%17/18	98.9%	98.8%	98.6%	98.5%	98.6%	98.3%	98.4%	98.3%	98.0%	98.4%	96.4%	96.9%
%18/19	98.3%	98.4%	97.5%									

Demand: Call volume was slightly less than the previous month but 13.2% higher than in June 2017.

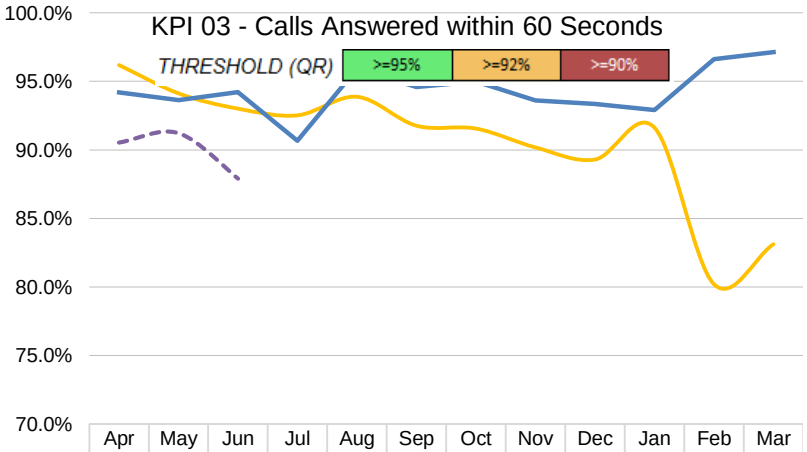
Capacity: Demand exceeded capacity throughout May. There was a large volume of National Contingency Activation and Pan-London Call Balancing. Throughout June staff have been required to completed 7.5 hours of mandatory training for licensing reasons which has further impacted frontline capacity.

Efficiency: The percentage of calls answered in 60 seconds was 87.9% in June, with the 95% target achieved on 5 days. A new process of automatic front ending was introduced in June to attempt to achieve a higher percentage and use resources more effectively in times of differing demand.

Service Projects: The service focus throughout June has been the completion and sign off of two new cohorts of new starters requiring full induction into the Service and in the use of the Clinical Decision Software Support.

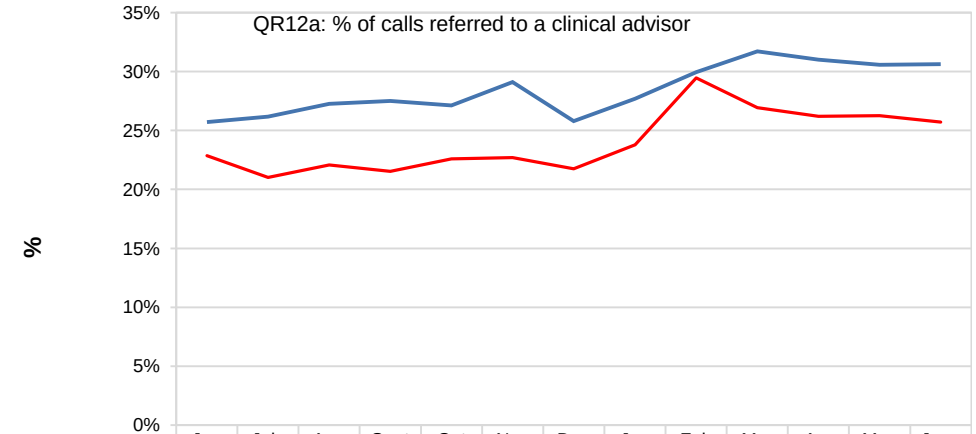


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.9%	0.8%	1.4%									
16/17	0.4%	0.5%	0.7%	0.7%	0.6%	0.8%	0.7%	1.0%	1.0%	0.8%	2.2%	1.9%
15/16	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	90.5%	91.2%	87.9%									
17/18	96.2%	94.1%	93.0%	92.5%	93.9%	91.8%	91.6%	90.2%	89.3%	91.6%	80.2%	83.1%
16/17	94.2%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%

LAS 111 (South East London)
Call Destinations

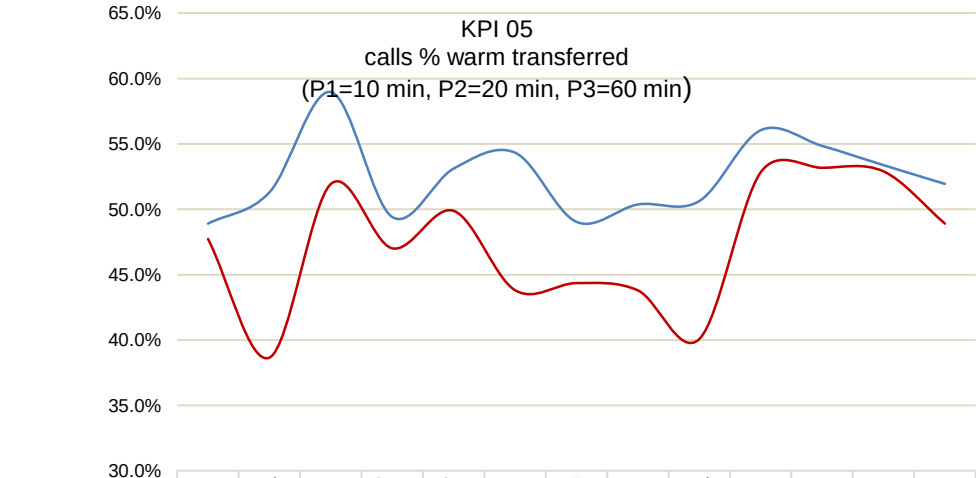


	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
current year	25.7%	26.2%	27.3%	27.5%	27.1%	29.1%	25.8%	27.7%	29.9%	31.7%	31.0%	30.6%	30.6%
Prev Year	22.9%	21.0%	22.1%	21.5%	22.6%	22.7%	21.7%	23.8%	29.5%	26.9%	26.2%	26.3%	25.7%

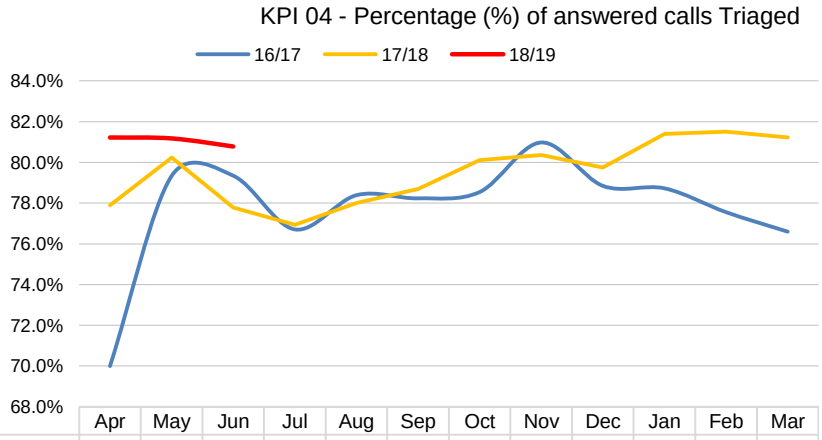
Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Green ambulance outcomes and availability of Clinical Advisors to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

Safety: There were 87 Incidents in Datix with completed investigations in June. Of these, 30% (n=26) related to authorised breaches in confidentiality including safeguarding referrals made without patient consent, 5% (n=4) to failure to follow procedure, 44% (n=38) to delay in care. 2% (n=2) were due to poor handover to external agency and the remaining 19% (n=17) closed with no further action required. Incidents are under investigation and feedback is given to staff where appropriate.

No Serious Incidents (SIs) were identified and the service received seven complaints, no HCP feedback, one compliment. Four complaints were received about another organisation.



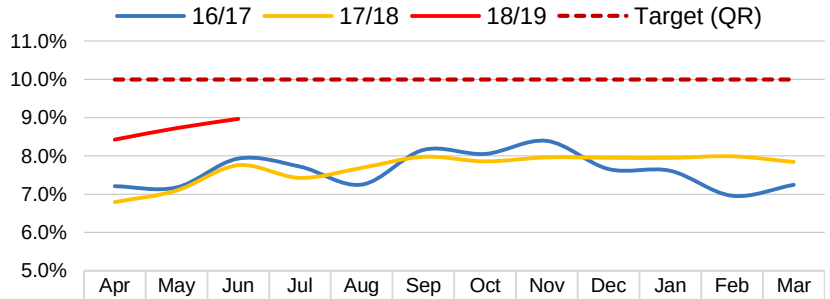
	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
current year	48.9%	51.3%	59.0%	49.4%	53.1%	54.3%	49.0%	50.4%	50.6%	56.0%	54.9%	53.4%	51.9%
prev year	47.7%	38.7%	51.9%	47.0%	49.9%	43.8%	44.4%	43.8%	40.1%	52.8%	53.2%	52.9%	48.9%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	70.0%	79.3%	79.3%	76.7%	78.4%	78.2%	78.5%	81.0%	78.8%	78.7%	77.6%	76.6%
17/18	77.9%	80.2%	77.8%	76.9%	78.0%	78.7%	80.1%	80.4%	79.8%	81.4%	81.5%	81.2%
18/19	81.2%	81.2%	80.8%									

LAS 111 (South East London)
Triage Destinations

KPI 10 - Percentage of answered calls transferred to 999



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%
17/18	6.8%	7.1%	7.8%	7.4%	7.7%	8.0%	7.9%	8.0%	8.0%	7.9%	8.0%	7.8%
18/19	8.4%	8.7%	9.0%									
Target (QR)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

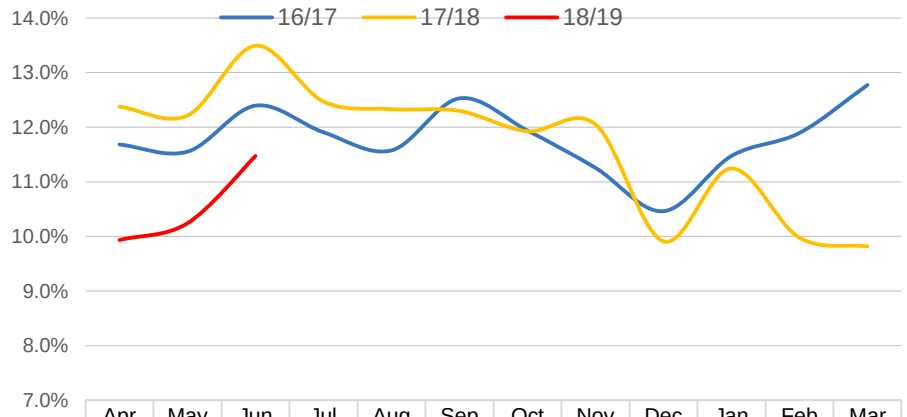
LAS 111 had the second lowest referral rate to 999 in London and second highest percentage of enhanced re-assessment for Green ambulance outcomes.

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 is referred the 2nd lowest number of calls overall.

Work has started to audit the appropriateness of ambulance and ETC outcomes to determine the root cause of the increase in referral to these services.

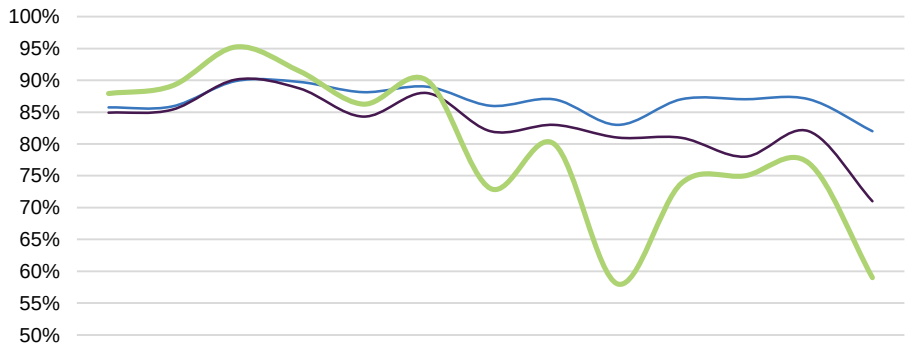
Call back performance for Priority 1 patients dropped by 5% in June and performance also fell for Priority 2 and 3 versus previous months. This may be due to the introduction of a new way of working during second part of June and is being monitored.

KPI 11 - Percentage of patients advised to attend Emergency Treatment Centre



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%
17/18	12.4%	12.2%	13.5%	12.5%	12.3%	12.3%	11.9%	12.1%	9.9%	11.2%	10.0%	9.8%
18/19	9.9%	10.2%	11.5%									

KPI 7,8,9 Call Backs and warm transfers
(P1=10 min, P2=20 min, P3=60 min)



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
P1 (10)	86%	86%	90%	90%	88%	89%	86%	87%	83%	87%	87%	87%	82%
P2 (20)	85%	85%	90%	89%	84%	88%	82%	83%	81%	81%	78%	82%	71%
P3(60)	88%	89%	95%	91%	86%	90%	73%	80%	58%	74%	75%	77%	59%

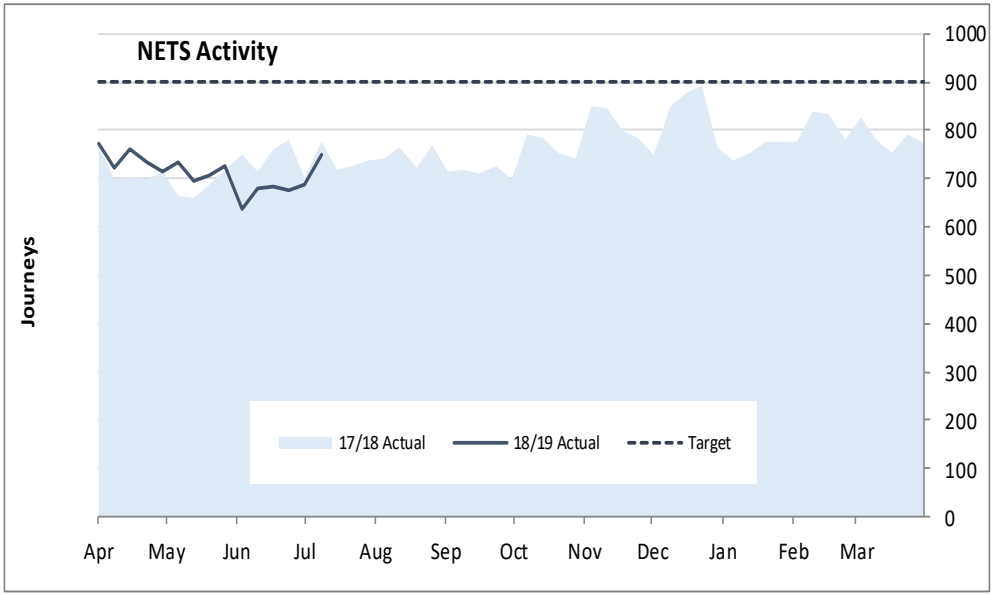
LAS 111 (South East London)
London and National Comparison

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 June 2018.

June 2018									
Description	Target	LAS	Care UK	LCW	PELC	Vocare	London	LAS ranking (pan-London)	England
Total calls answered	N/A	29,631	24,579	30,657	35,142	25,431	156,655		1,201,830
% of Calls answered within 60 seconds	95%	87.91%	96.26%	88.47%	84.25%	83.18%	87.73%	3	83.04%
% of Calls abandoned after 30 seconds	5%	1.37%	0.35%	2.38%	4.52%	3.29%	2.57%	2	3.83%
% of Calls transferred to, or answered	N/A	30.63%	23.63%	26.72%	26.10%	32.72%	27.90%		25.22%
Of calls transferred, percentage transferred	N/A	51.79%	20.78%	77.09%	46.89%	39.05%	48.74%		30.76%
Of call backs, percentage within 10	100%	45.41%	46.02%	34.68%	44.47%	51.06%	45.74%	3	37.62%
% of Calls referred to 999	10%	8.97%	10.42%	10.97%	8.33%	9.91%	9.65%	2	11.13%
% of Calls referred to Emergency Department	N/A	11.47%	11.03%	11.80%	11.86%	10.72%	11.43%	3	9.62%

*Modified clinical call back model agreed with commissioners. Contract QR target does not reflect this
*Ranking is from 1-5 with 1 representing the best performance in that area. **Data is provided up till 31st May 2018**

Non-Emergency Transport Service



Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
07/05/2018	962	6	261	695
14/05/2018	888	4	178	706
21/05/2018	1005	16	262	727
28/05/2018	830	12	179	639
04/06/2018	962	8	275	679
11/06/2018	951	16	251	684
18/06/2018	961	9	273	679
25/06/2018	996	15	293	688

Non-Emergency Transport Update

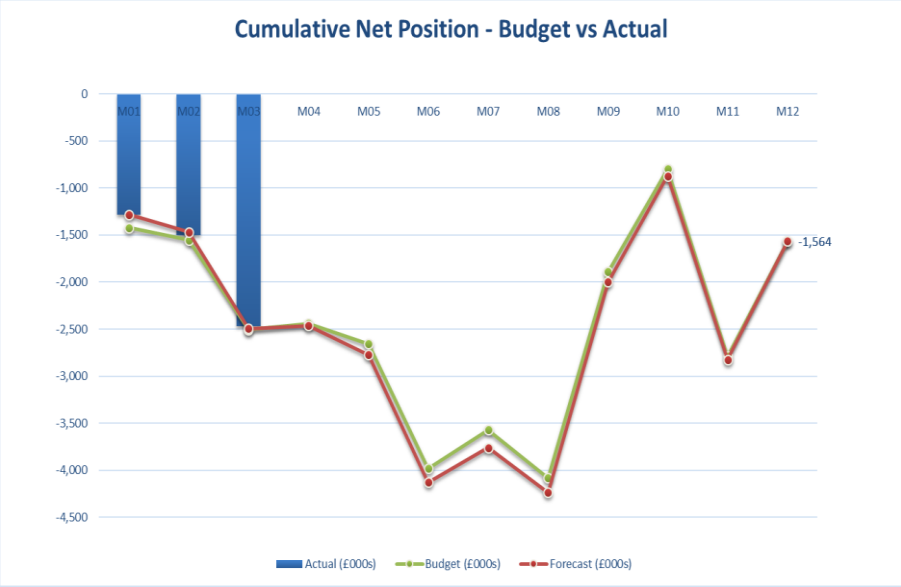
- NETS saw a decrease in the month and delivered an average of 683 journeys per week for the month, down from the previous month average of 692.
- During June we saw the NETs overall weekly performance being maintained at a level in line with the impacts of resources, activity levels and waiting times.
- 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 increased from last months 921 calls per week to 967 calls per week for the month.
- NETS staffing/resourcing was also impacted by high rates of both short & long term sickness over the month averaging at 7.0%, up from last months 6.5%.
- Performance continued to suffer due to increasingly lengthy handover times at hospitals with specific issues with Queens, PRU and Hillingdon 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.

Our Money

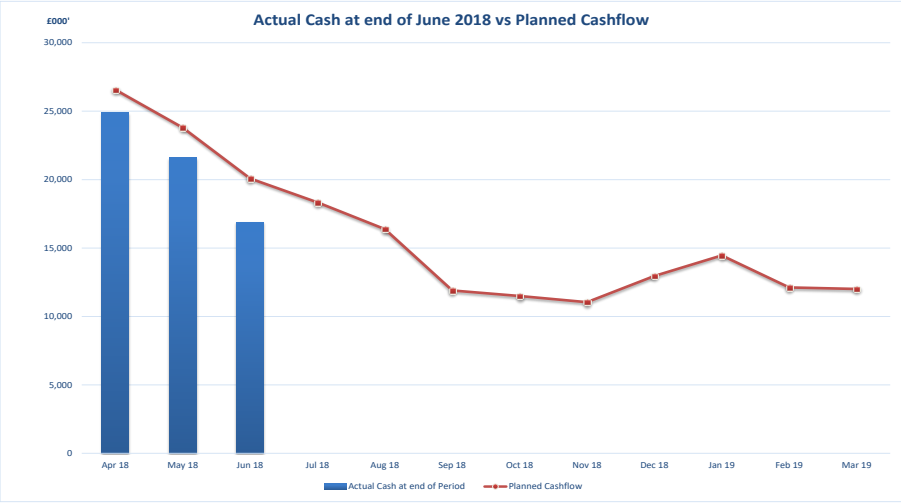
Financial Indicator	Summary Performance	Forecast Outturn	Current Month	Previous month
Surplus / Deficit (Year to date and Forecast)	Year to date the position is on plan. The Trust is forecasting achieving its control total of £1.564m deficit. Key issues in the position are: • Income is £1.4m behind budget due to demand activity in month is 0.55% behind contract as measured against the 1.7% over performance included in the plan. • On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued demand pressure.	GREEN	GREEN	GREEN
Income	In month income is £0.6m adverse due to: • Income is £0.7m behind budget due to demand activity in month is 0.55% behind contract as measured against the 1.7% over performance included in the plan. • Costs of £181k have been included for NEL 111 matched by income. The full year income and costs of £7m have been included in forecast.	AMBER	AMBER	GREEN
Expenditure (incl. Financial Charges)	In month expenditure is £0.5m favourable to plan due to: • Vacancies in frontline covered by overtime. • Depreciation behind plan due to slippage in capital programme £0.1m.	GREEN	GREEN	GREEN
CIPs	In month CIP was £0.8m and YTD £2.5m both on plan. Delivery of the full year target of £12.3m remains a risk and will continue to be closely monitored for the remainder of the year.	AMBER	AMBER	AMBER
Balance Sheet	Capital spend is £2.8m in M3 which is £2m behind plan YTD. Full year capital plan is £17m.	GREEN	GREEN	AMBER
Cashflow	Cash is £16.9m, £3.2m below plan. This is made up of a number of offsetting variances. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.0m below planned, there are higher than planned creditor payments of £5.4m that are being offset by under payments of £1.4m on capital, £1.5m on pay and £0.3m on provisions. .	GREEN	GREEN	GREEN
BPPC	Non-NHS 72%, NHS 91% performance (volume) for this month, performance is still below 95% target.	AMBER	AMBER	AMBER

Executive Summary – Key Financial Metrics

Owner: James Corrigan | Executive Lead: Lorraine Bewes



	Month 3 2018-19 £000			YTD Month 3 2018-19 £000			Full Year 2018-19 £000
	Budget	Actual	Variance fav / (adv)	Budget	Actual	Variance fav / (adv)	Budget
Surplus / (Deficits)	(953)	(970)	(17)	(2,507)	(2,469)	38	(1,564)
EFL				10,219	13,402	(3,183)	18,288
CRL				4,987	2,801	2,186	17,126
Suppliers paid within 30 days - NHS	95%	91%	(4.0%)	95%	95%	0.0%	95%
Suppliers paid within 30 days - Non NHS	95%	72%	(23.0%)	95%	83%	(12.0%)	95%
EBITDA %	2.3%	1.9%	(0.4%)	2.7%	2.3%	(0.4%)	5.1%
EBITDA	684	558	(127)	2,412	2,063	(349)	18,725
NRAF (net return after financing)				(0.83%)	(0.53%)	0.3%	(1.9%)
Liquidity Days				(2.90)	(0.57)	2.33	(2.21)
Use of Resources Rating				3.0	3.0	0.0	2.0



- Year to date the position is on plan. The Trust has a full year outturn plan of £1.564m deficit.
- Income is £1.4m behind plan due to the budget including over activity at 1.7% and actual activity being 0.55% behind plan.
- The Trust is £2m behind a capital plan of £4.9m YTD. The CRL will be confirmed at the end of June 2018.
- Cash is £16.9m, £3.2m below plan. This is made up of a number of offsetting variances. An analysis of the cash position shows that receipts from income (includes prepayments of income) are £1.0m below planned, there are higher than planned creditor payments of £5.4m that are being offset by under payments of £1.4m on capital, £1.5m on pay and £0.3m on provisions.
- Non-NHS 72%, NHS 91% performance (volume) for this month, performance is still below 95% target.

Statement of Comprehensive Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Month 3 2018-19 £000			YTD Month 3 2018-19 £000			Full Year 2018-19 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance fav/(adv)
Income									
Income from Activities	29,542	29,006	(536)	88,946	87,670	(1,276)	362,427	367,632	5,204
Other Operating Income	276	202	(75)	745	581	(164)	5,663	4,483	(1,180)
Total Income	**29,818**	**29,207**	**(611)**	**89,691**	**88,251**	**(1,440)**	**368,090**	**372,115**	**4,025**
Operating Expense									
Pay	(22,752)	(21,467)	1,285	(68,078)	(65,398)	2,681	(272,420)	(272,421)	(0)
Non Pay	(6,382)	(7,183)	(801)	(19,201)	(20,791)	(1,590)	(76,945)	(81,544)	(4,599)
Total Operating Expenditure	**(29,134)**	**(28,650)**	**484**	**(87,280)**	**(86,189)**	**1,091**	**(349,365)**	**(353,965)**	**(4,599)**
EBITDA	**684**	**558**	**(127)**	**2,412**	**2,063**	**(349)**	**18,725**	**18,150**	**(575)**
EBITDA margin	2.3%	1.9%	(0.4%)	2.7%	2.3%	(0.4%)	5.1%	4.9%	(0.2%)
Depreciation & Financing									
Depreciation & Amortisation	(1,291)	(1,159)	132	(3,875)	(3,474)	401	(16,129)	(15,514)	614
PDC Dividend	(350)	(350)	0	(1,050)	(1,050)	0	(4,200)	(4,200)	0
Finance Income	6	10	4	13	22	8	67	72	5
Finance Costs	(2)	(1)	1	(7)	(3)	4	(27)	(23)	4
Gains & Losses on Disposals	0	(27)	(27)	0	(27)	(27)	0	(27)	(27)
Total Depreciation & Finance Costs	**(1,637)**	**(1,527)**	**110**	**(4,918)**	**(4,532)**	**387**	**(20,289)**	**(19,692)**	**597**
Net Surplus/(Deficit)	**(953)**	**(970)**	**(17)**	**(2,507)**	**(2,469)**	**38**	**(1,564)**	**(1,542)**	**22**
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	0	10	10	(0)	38	38	(0)
Remove STP funding 2016/17	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance	**(950)**	**(967)**	**(17)**	**(2,497)**	**(2,460)**	**38**	**(1,526)**	**(1,504)**	**22**
Net margin	(3.2%)	(3.3%)	(0.1%)	(2.8%)	(2.8%)	(0.0%)	(0.4%)	(0.4%)	0.3%

Income

- Year to date demand is currently running at 0.55% behind contract baseline. This is below the budgeted level of activity included in the Trust's plan of 1.7%, and as such main contract variable income is £1.5m below budget.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £2.7m lower than plan, due primarily to frontline vacancies.
- The underspend on frontline pay is partially offset by private ambulance expenditure and agency spend £1.4m.

EBITDA

- The Trust delivered an EBITDA of £2,063k in June which represents EBITDA margin of 2.3%.

Depreciation and Financing

- Overall Financial Charges are £0.1m favourable at the end of June due to slippage in the Capital programme.

Main Contract Variable Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Month:	Jun-18	2018-19 YTD Contract Plan	2018-19 YTD Actual Activity	2018-19 Actual Activity Increase / (Decrease) vs Contract Base	Total Incidents Difference to Contract Base (%)	£ 239.37	CCG Split Based on Incident Difference
Area	CCG Names	Total Incidents	Total Incidents	Total Incidents		Total Additional Charge or (Credit) at 75% Margina	
NEL	NHS City and Hackney CCG	9,262	9,480	218	2.35%		52,183
NEL	NHS Newham CCG	10,194	10,469	275	2.70%		65,827
NEL	NHS Tower Hamlets CCG	8,589	8,843	254	2.96%		60,800
NEL	NHS Waltham Forest CCG	7,691	7,858	167	2.17%		39,975
NEL	NHS Barking and Dagenham CCG	7,184	7,330	146	2.03%		34,948
NEL	NHS Havering CCG	8,651	8,751	100	1.16%		23,937
NEL	NHS Redbridge CCG	8,624	8,831	207	2.40%		49,550
NEL	**NEL Total**	**60,195**	**61,562**	**1,367**	**2.27%**	**327,219**	**327,219**
NCL	NHS Barnet CCG	10,964	10,615	-349	-3.18%		(83,540)
NCL	NHS Camden CCG	9,105	8,622	-483	-5.30%		(115,616)
NCL	NHS Enfield CCG	9,825	10,012	187	1.90%		44,762
NCL	NHS Haringey CCG	8,112	8,336	224	2.76%		53,619
NCL	NHS Islington CCG	7,843	7,823	-20	-0.26%		(4,787)
NCL	**NCL Total**	**45,849**	**45,408**	**-441**	**-0.96%**	**(105,562)**	**(105,562)**
NWL	NHS Brent CCG	10,691	10,457	-234	-2.19%		(56,013)
NWL	NHS Harrow CCG	6,642	6,685	43	0.65%		10,293
NWL	NHS Hillingdon CCG	11,473	11,077	-396	-3.45%		(94,791)
NWL	NHS Central London (Westminster) CCG	9,837	9,417	-420	-4.27%		(100,535)
NWL	NHS Ealing CCG	11,047	10,564	-483	-4.37%		(115,616)
NWL	NHS Hammersmith and Fulham CCG	6,306	6,217	-89	-1.41%		(21,304)
NWL	NHS Hounslow CCG	8,380	8,219	-161	-1.92%		(38,539)
NWL	NHS West London CCG	7,672	7,495	-177	-2.31%		(42,368)
NWL	**NWL Total**	**72,048**	**70,131**	**-1,917**	**-2.66%**	**(458,872)**	**(458,872)**
SEL	NHS Bexley CCG	7,632	7,628	-4	-0.05%		(957)
SEL	NHS Bromley CCG	9,534	9,627	93	0.98%		22,261
SEL	NHS Greenwich CCG	8,567	8,940	373	4.35%		89,285
SEL	NHS Lambeth CCG	10,865	10,880	15	0.14%		3,591
SEL	NHS Lewisham CCG	9,057	8,947	-110	-1.21%		(26,331)
SEL	NHS Southwark CCG	10,859	11,009	150	1.38%		35,906
SEL	**SEL Total**	**56,514**	**57,031**	**517**	**0.91%**	**123,754**	**123,754**
SWL	NHS Croydon CCG	12,760	12,487	-273	-2.14%		(65,348)
SWL	NHS Kingston CCG	4,846	4,554	-292	-6.03%		(69,896)
SWL	NHS Merton CCG	5,807	5,744	-63	-1.08%		(15,080)
SWL	NHS Richmond CCG	4,864	4,758	-106	-2.18%		(25,373)
SWL	NHS Sutton CCG	6,236	6,033	-203	-3.26%		(48,592)
SWL	NHS Wandsworth CCG	8,441	8,333	-108	-1.28%		(25,852)
SWL	**SWL Total**	**42,954**	**41,909**	**-1,045**	**-2.43%**	**(250,142)**	**(250,142)**
London Total		**277,560**	**276,041**	**-1,519**	**-0.55%**	**(363,603)**	**(363,603)**

Cash flow Statement Full Year

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Apr-18 Actual £000	May-18 Actual £000	Jun-18 Actual £000	Jun-18 YTD Move £000	Jun-18 YTD Plan £000	Jun-18 Var £000
Opening Balance	**30,300**	**24,876**	**21,585**	**30,300**	**30,300**	**0**
Operating Surplus	226	1,280	505	2,011	2,032	(21)
(Increase)/decrease in current assets	716	(5,174)	2,640	(1,818)	(399)	(1,419)
Increase/(decrease) in current liabilities	(2,805)	4,667	(5,814)	(3,952)	888	(4,840)
Increase/(decrease) in provisions	402	(673)	(287)	(558)	(1,752)	1,194
Net cash inflow/(outflow) from operating activities	(1,461)	100	(2,956)	(4,317)	769	(5,086)
Cashflow inflow/outflow from operating activities	**(1,461)**	**100**	**(2,956)**	**(4,317)**	**769**	**(5,086)**
Returns on investments and servicing finance	0	12	8	20	12	8
Capital Expenditure	(3,963)	(3,403)	(1,739)	(9,105)	(11,000)	1,895
Dividend paid	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0
Cashflow inflow/outflow from financing	**(3,963)**	**(3,391)**	**(1,731)**	**(9,085)**	**(10,988)**	**1,903**
Movement	(5,424)	(3,291)	(4,687)	(13,402)	(10,219)	(3,183)
Closing Cash Balance	**24,876**	**21,585**	**16,898**	**16,898**	**20,081**	**(3,183)**

There has been a net outflow of cash to the Trust of £13.4m.

Cash funds at 30th June stand at £16.9m.

Operating Surplus

- The operating surplus at £2.0m is on target.

Current Assets

- The movement on current assets is (£1.8m), (£1.4m) higher than planned movement.
- Current assets movement was higher than planned due to receivables (£2.4m), accrued income £2.2m and prepayments (£1.2m).

Current Liabilities

- The movement on current liabilities is (£4.0m), a £4.8m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£7.1m), accruals £1.3m and Deferred income £1.0m.

Provisions

- The movement on provisions is (£0.6m), is a £1.2m lower than planned movement.

Capital Expenditure

- Capital cash outflow is £9.1m, is a £1.9m below plan.

CQUINs

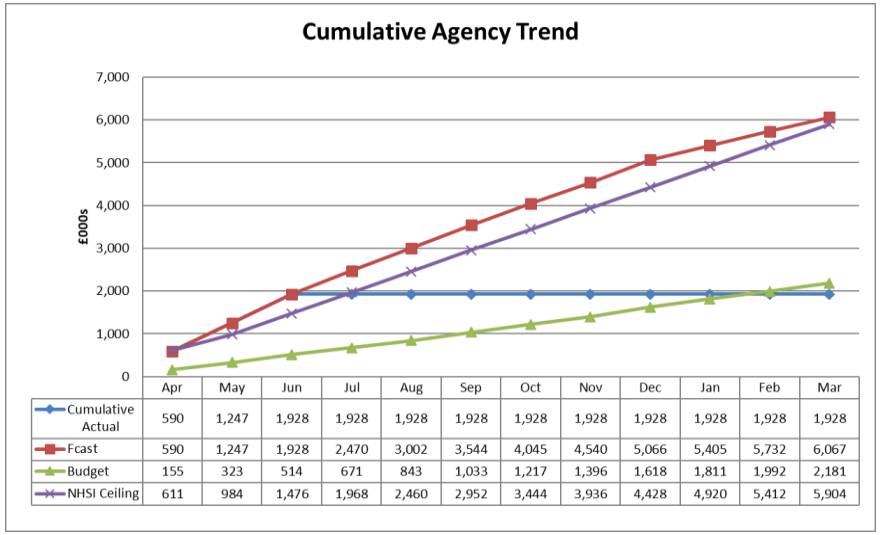
Owner: James Corrigan | Executive Lead: Lorraine Bewes

CQUIN Title	YTD Plan	YTD Actual	YTD Variance	Full year Forecast	Full year Provision
National: 1a Staff Health and Well-being	0	0	0	267	0
National:1b Healthy food for NHS staff, visitors and patients	0	0	0	267	0
National: 1c Improving the uptake of flu vaccinations for front line staff within Providers -75%	0	0	0	267	0
National 12: Ambulance Conveyance	0	0	0	801	0
STP Engagement	801	801	0	3,205	0
Local - Digitalisation SDIP CQUIN	801	801	0	3,205	0
	1,602	1,602	0	8,012	0

Q1 is on target but will not be confirmed until completion of Q1.

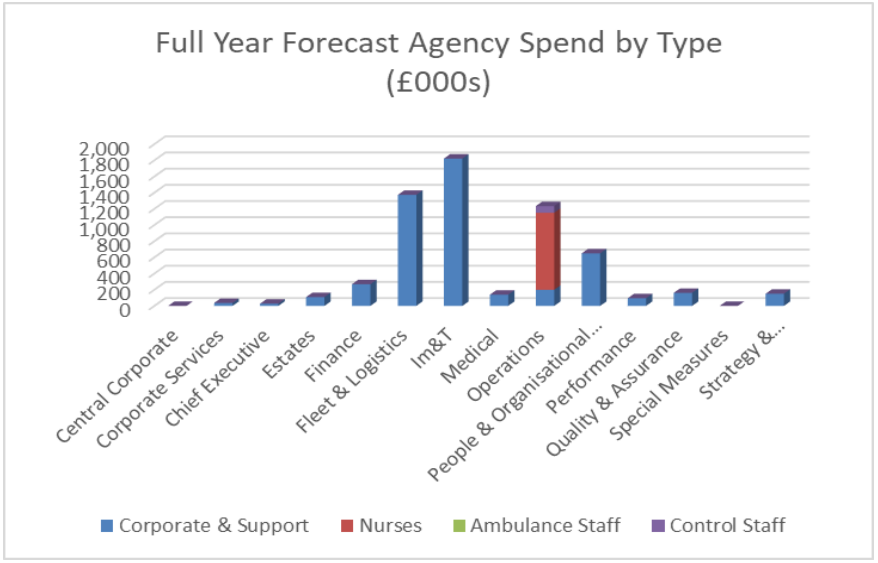
Agency Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Actual	590	1,247	1,928	1,928	1,928	1,928	1,928	1,928	1,928	1,928	1,928	1,928
Fcast	590	1,247	1,928	2,470	3,002	3,544	4,045	4,540	5,066	5,405	5,732	6,067
Budget	155	323	514	671	843	1,033	1,217	1,396	1,618	1,811	1,992	2,181
NHSI Ceiling	611	984	1,476	1,968	2,460	2,952	3,444	3,936	4,428	4,920	5,412	5,904

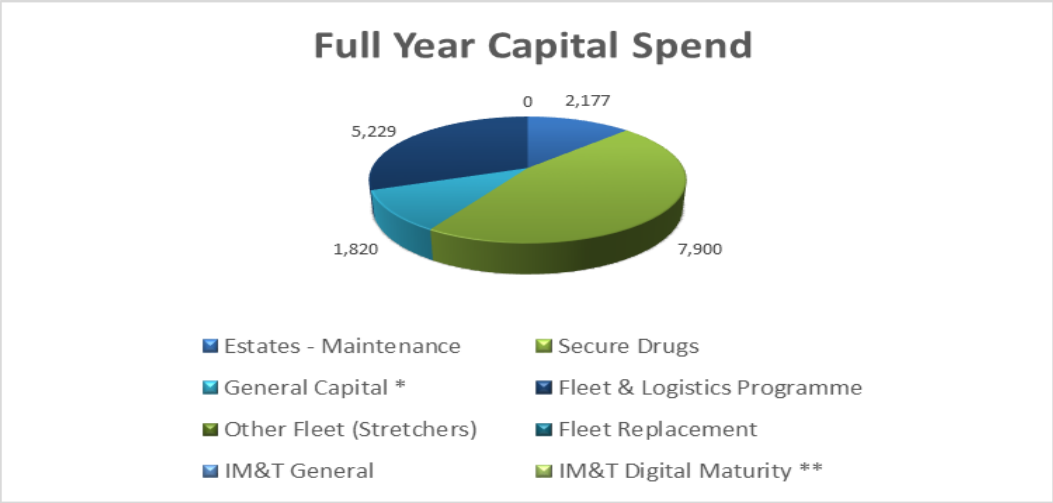
Agency Summary by Division & Type	Full Year Forecast (£000s)			
	Corporate & Support	Nurses	Ambulance Staff	Control Staff
Central Corporate	0	0	0	0
Corporate Services	36	0	0	0
Chief Executive	28	0	0	0
Estates	109	0	0	0
Finance	268	0	0	0
Fleet & Logistics	1,374	0	0	0
Im&T	1,822	0	0	0
Medical	139	0	0	0
Operations	199	951	0	83
People & Organisational Dev	650	0	0	0
Performance	96	0	0	0
Quality & Assurance	161	0	0	0
Special Measures	0	0	0	0
Strategy & Communications	151	0	0	0
Total	**5,033**	**951**	**0**	**83**



- The Trust's NHSI agency spend ceiling is £5.9m. Agency spend in excess of this level would result in the loss of planned STF income, and ineligibility for further STF funding announced.
- A paper has been presented to People and Culture Committee outlining the issues and proposed actions, including a detailed action plan for reducing agency spend.
- The NHSI Agency Team has been contacted regarding the adjustment of the ceiling transfer of NEL 111 and a response is awaited.

2018/19 Capital Plan/Spend Full Year – Month 1 Summary

Owner: James Corrigan | Executive Lead: Lorraine Bewes



Capital Programme	Exec Lead	Operational Lead	Month 3 Plan £'000	Month 3 Actual £'000	Month 3 Variance £'000	Full year Plan £'000	Forecast Outturn £'000
Expenditure Plan:							
Estates	B Mehra	S Dawson	503	327	176	2,177	2,177
IM&T	B Mehra	S Dawson	2,395	770	1,625	7,900	7,900
Fleet	B Mehra	J Wand	571	1,441	(870)	1,820	1,820
Fleet Replacement	B Mehra	J Wand	1,428	0	1,428	5,229	5,229
General	L Bewes	L Bewes	0	301	(301)	0	0
							0
Capital Expenditure Plan			**4,897**	**2,839**	**2,058**	**17,126**	**17,126**

- Capital spend is £2.8m against a budget of £4.9m, £2m behind plan.
- The Trust CRL has been confirmed for internally generated capital.

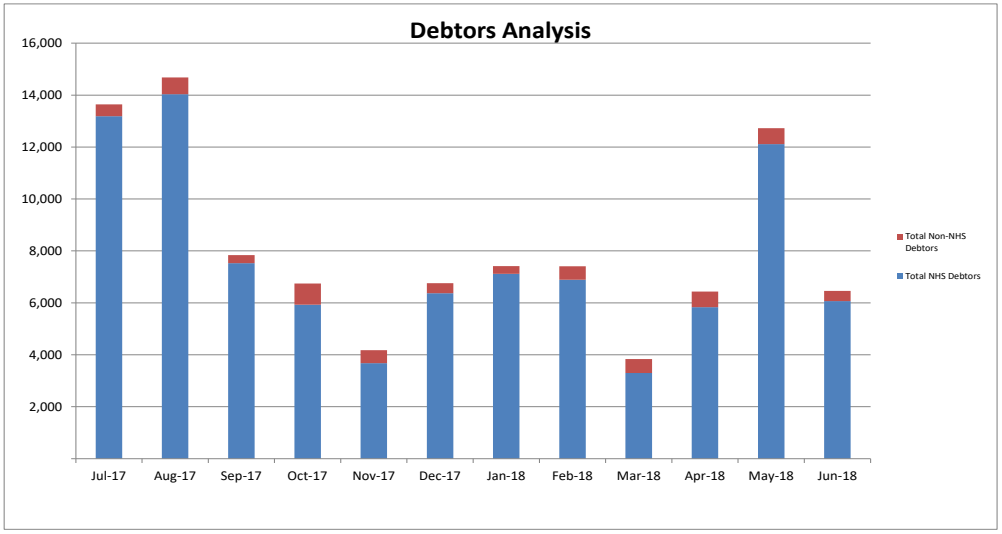
Debtors Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Aged debtors Summary 30th June 2018

	Note	Total	Days Overdue 0 - 30	31 - 60	61 - 90	Over 91 days
		£'000	£'000	£'000	£'000	£'000
NHS Debtors						
NHS Bromley CCG	1	702	652	43	7	-
NHS Wandsworth CCG	1	642	97	39	507	-
NHS Ealing CCG	1	453	146	48	254	5
St Georges University Hospitals NHS FT	2	332	-	-	93	239
NHS Bexley CCG	1	308	104	37	156	11
NHS Barnet CCG	1	305	180	52	74	-
<£305,000	1	3,328	2,972	265	0	91
Total NHS Debtors		**6,070**	**4,150**	**484**	**1,090**	**347**
Non-NHS Debtors						
Heathrow Airport Ltd	3	109	109	-	-	-
Unison	4	42	-	5	5	33
London Stadium 185	5	18	18	-	-	-
Chelsea Football Club	6	16	16	-	-	-
Twickenham RFU	7	14	14	-	-	-
<£14,000	8	189	53	0	5	131
Total Non NHS Debtors		**388**	**210**	**5**	**10**	**163**
TOTAL DEBTORS 30th June 2018		**6,457**	**4,360**	**489**	**1,100**	**510**

Source: Debtors Ledger 30th June 2018



Debtors Position: 30th June 2018

Total outstanding NHS and Non-NHS debtors as at 30th June 2018 amounted to £6.5 million. The NHS over 60 day's figure of £1.4m includes amounts due from both CCGs £1m and NHS Trusts £0.4m.

1. NHS Debtors over 60 days.

- PTS Non-Contract Activity - £84k – 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. £15k has been paid in June from various CCGs.
- Out of London (A&E ECJ) Journeys - £0.1m – 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. £10k has been paid in July by various CCGs.
- Neonatal Transfer Service - £61k – 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. £5k has been paid in June by various CCGs.
- Paramedic Re-Banding Income - £0.8m (22 CCGs) – We are liaising with the CCG's to clear the outstanding invoices.
- Q3 and Q4 Over Activity Billing 2017-2018 October 17 – March 18 - £0.3m - The CCGs have raised an issue about the treatment of taxi journeys included in activity. The Trust has agreed to refund £0.3m funding received for taxi journeys which were being paid for through both the block contract and over performance .

The Trust is actively pursuing the outstanding debts.

2. St Georges University Hospitals NHS FT – £332k (18 Invoices). St George's currently have a significant deficit and are paying their debt extremely slowly to manage their cash flow.
3. Heathrow Airport Ltd - £109k (1 invoice) is due on the 25th July.
4. Unison - £42k (7 invoices) All invoices paid on the 5th July 2018.
5. London Stadium 185 - £18K (4 invoices) All invoices have been paid on the 4th July 2018.
6. Chelsea Football Club - £16k (4 invoices) – Invoices have been approved for payment on the 27th July 2018.
7. Twickenham RFU - £14k (4 invoices). 1 invoice £2k was paid on the 3rd July 2018. The remaining £12k (3 invoices) will be paid on the 20th July 2018.
8. Non-NHS Debtors - £189k consists of; £115k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £40k of stadia events, the stadiums have been chased for payment on a regular basis. The remaining £34k is due from local Government bodies and other miscellaneous organisations.

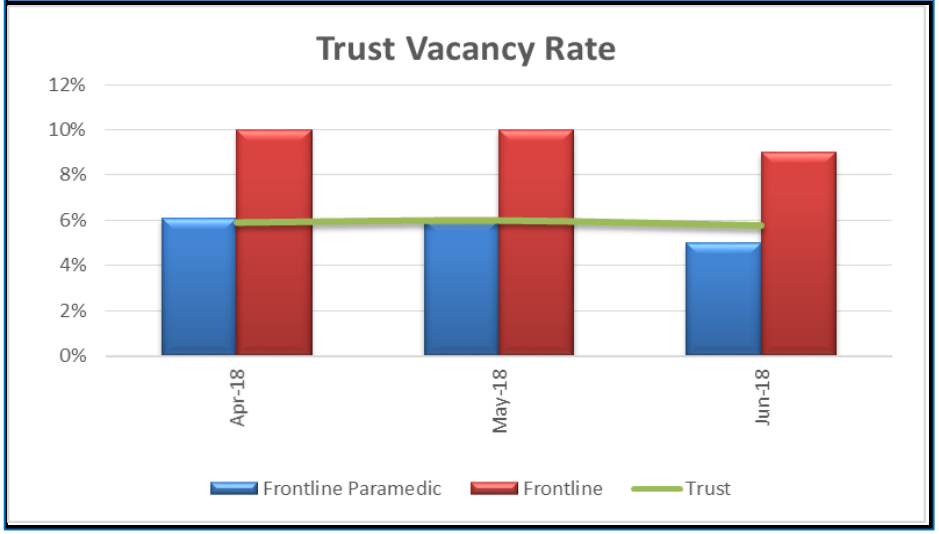
The graph to the left shows the debtors trend for the last 12 months.

Our People

Section	Key Headlines From Each Section.	June	May	April
Vacancy and Recruitment	• Frontline Paramedic Vacancy rate is 5% • Frontline non-paramedic vacancy rate is 14%. • Overall frontline vacancy rate is 9% • EOC EMD vacancy rate is 13%	5.7%	6%	6%
Turnover	• Total Trust turnover has increased from 11.1% to 11.2% against a threshold of 10%. • Frontline turnover has decreased from 10.4% to 10.0% Please note this does not include Control Room or NHS 111 leavers. • Frontline paramedic turnover has remained at 11.3%.	11.2%	11.1%	11.2%
Sickness	• Sickness in June has remained at 5.2%. • Sector Operations sickness remains at 5.7%.	5.2%	5.2%	5.2%

Trust wide
Vacancy

VACANCY RATE



FRONTLINE AND EOC VACANCY RATES

	Establishment	In post (recruited) (as at 30th June)	Vacancy wte	Vacancy %
Total Frontline (Sector)	3,380.00	3,073.85	306.15	9.1%
Frontline (Sector) Paramedics	1,859.00	1,760.28	98.72	5.3%
Frontline (Sector) Non-Paras	1,521.00	1,313.57	207.43	13.6%
EOC (EMD)	378	328.44	49.56	13.1%

EOC recruitment (Emergency Medical Dispatchers)

- Recruitment target of 171 FTE - forecast end of year gap of 38 FTE.
- An ELT led task and finish group is looking to achieve double new employee intake to address gap. One of the deciding factors to achievement will be trainer and mentoring capacity.
- Pre-employment checks and selection process streamlined, including re-assessing pass rates and introduction of online assessments (pilot from 1st May to 31st July 2018).
- EOC restructure – in planning stage for end July/early August consultation and a key element to retention.
- The recruitment team continue to plan and attend a wide range of recruitment and engagement activities to attract people to core frontline roles. Professional apprenticeship pathways are being considered to improve retention and to be built into the apprenticeship delivery model.

Paramedics

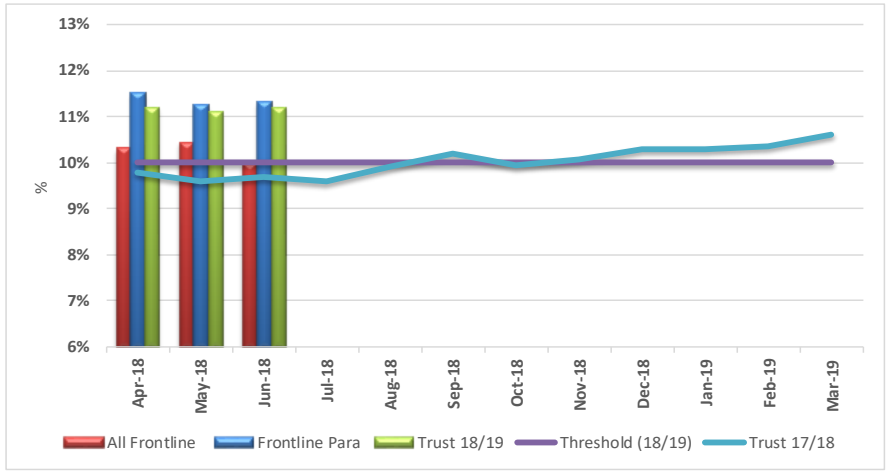
- Recruitment target of 469 FTE - recruitment supply of 370 FTE with forecast end of year gap of 99 FTE. Initiatives in progress identified to close the gap include: Skype interviews, sourcing agencies to support recruitment in Australia and Poland, a recruitment visit to Ireland in October and reviewing capacity for training placements.

Trainee Emergency Ambulance Crew,

- Recruitment target of 381 FTE - recruitment supply of 261 FTE with forecast end of year gap of 120 FTE.
- Initiatives underway include TEAC Super Saturday events, continued funding for TEAC C1 licence, significant programme of domestic recruitment events and a review of capacity for training placements for Q4.

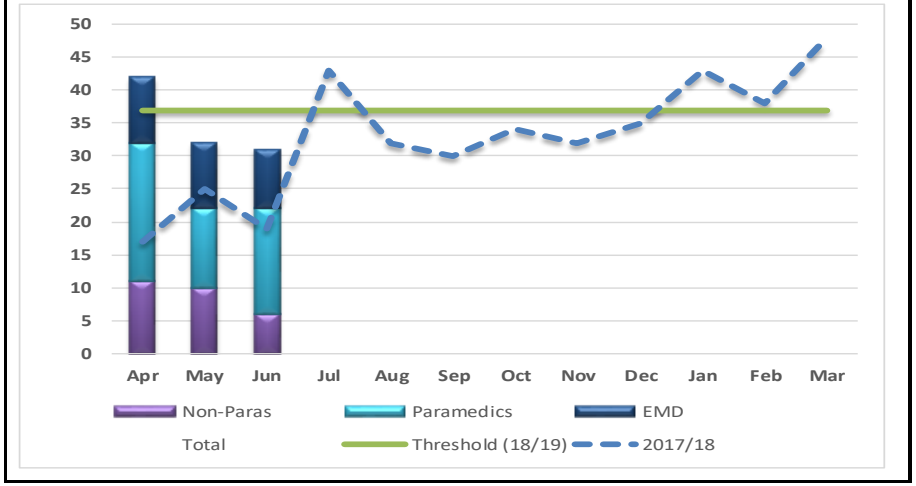
Trust wide
Turnover/Leavers

TURNOVER



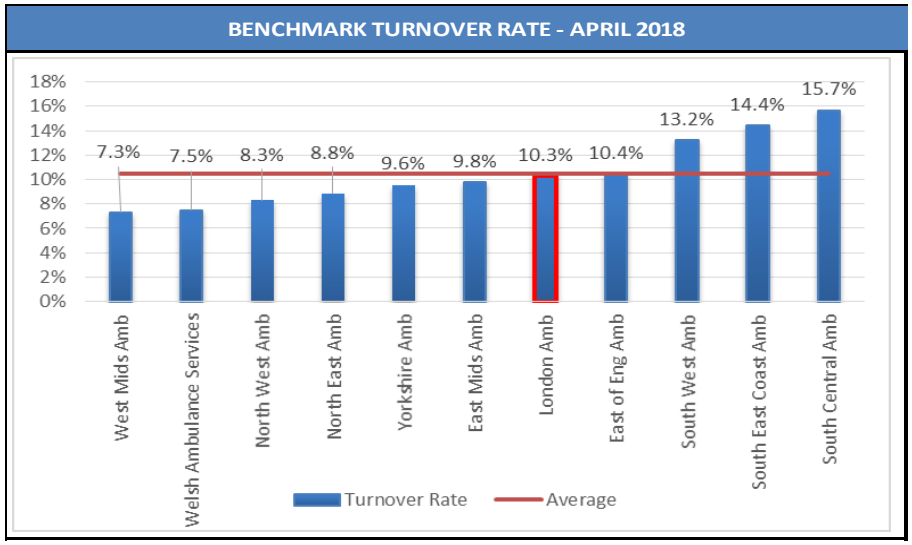
- The total Trust turnover has increased from 11.1% to 11.2% (12 month rolling figure).
- Frontline turnover (Sector Ops) has decreased from 10.4% to 10%.
- Frontline paramedic turnover has remained at 11.3%.
- EOC turnover has increased from 20% to 21%, NHS 111 turnover has reduced from 17% to 16%. Corporate Directorates turnover has remained at 12%.
- There were 31 frontline leavers in June (see table).
- 87% of the frontline leavers (27 staff) were resignations i.e. unplanned. 9 of the 16 paramedics left for reasons of relocation and 2 left before reaching one year's service.

FRONTLINE LEAVERS



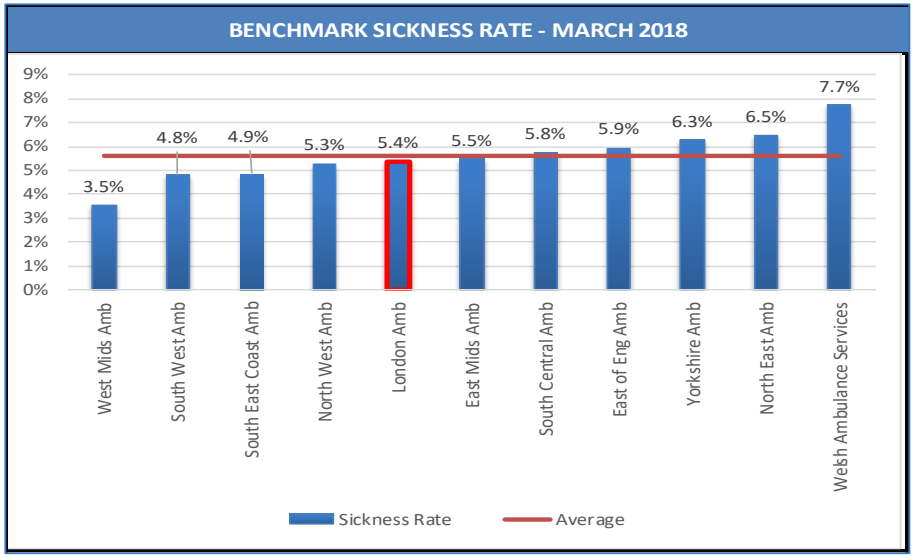
- Our retention efforts focused predominantly on our EOC team and we have a number of activities including a restructure of EOC teams to address some legacy issues around role clarity and lack of progression, the introduction of a part time roster, the introduction of a range of well-being initiatives to support employees and improve attendance and the consideration of professional apprenticeship pathways.
- Other initiatives to improve our retention include a new eForms system to improve the completeness of our leavers data in ESR, more fully utilising the ESR exit questionnaire functionality (EOC team is an early adopter) and a wide ranging programme of works including role redesign that will enhance career pathways for both paramedics and other allied healthcare professionals, a leadership development programme and an effective and pro-active well being strategy.

Trust wide
Benchmarking Turnover/Sickness



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has remained in 7th place.
- The LAS is below the national average of 10.48%.

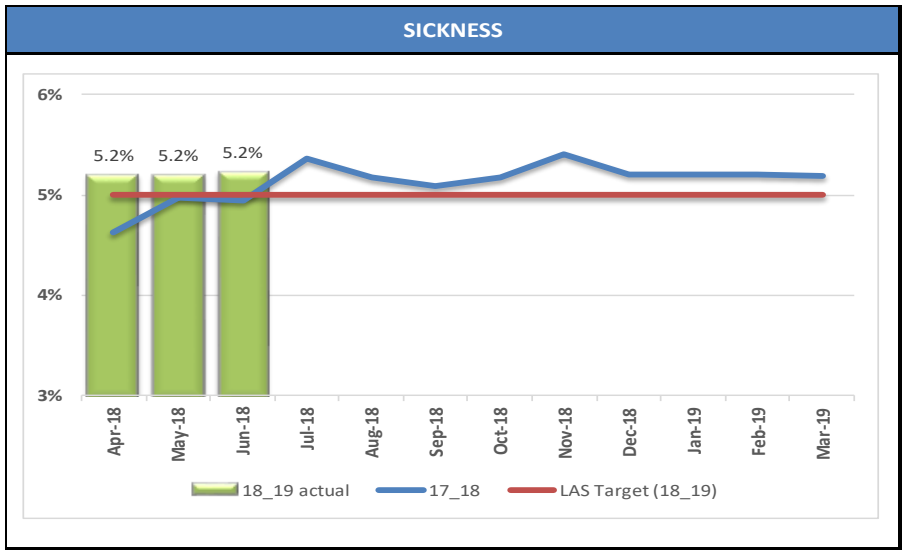
Source of data: NHS Health and Social Care Information Centre – data as at 30th April 2018. Data is available two months in arrears.



- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has remained in 5th place.
- The LAS is below the national average of 5.59%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st March 2018. Data is available three months in arrears.

Trust/Sector level
Sickness Absence

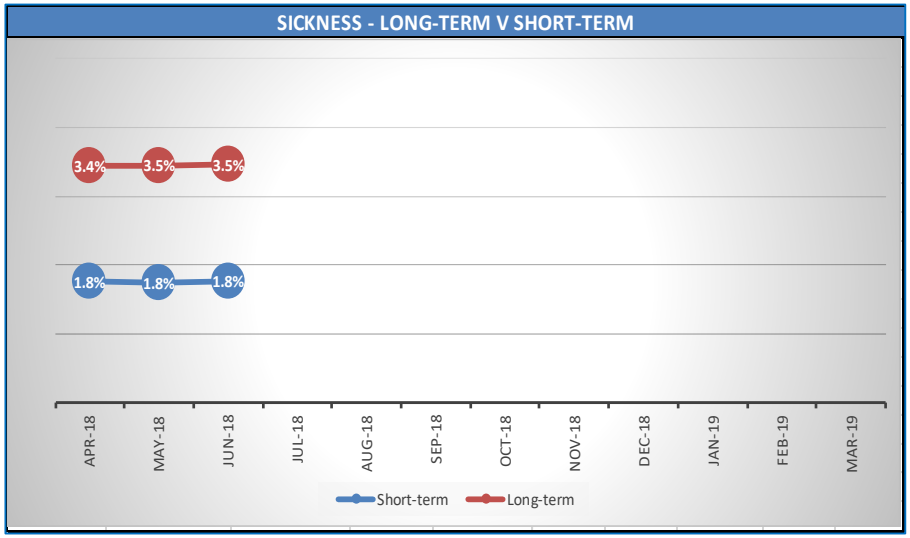


(The figures stated for sickness absence are for a 12 month rolling period)

Trust wide sickness for June has remained at 5.2%. Sector Operations sickness has remained at 5.7%. EOC sickness has increased from 6.8% to 7.2%. NHS 111 sickness has remained at 7.6%. Corporate sickness has remained at 2.9%.

Our top two reasons for absence continue to be musculoskeletal injury 41% and Mental Health 11%. Both of these will be addressed as part of the Health and Wellbeing CQUIN project and the CIP Improving Attendance work stream.

Other wellbeing initiatives include a continued focus on achieving high compliance for our immunisation programme, improvements to counselling provision through dedicated trauma support and a refresh and strengthening of our approach to internal resolution of conflict.



This graph shows the sickness rate for all staff split by short-term and long-term sickness.

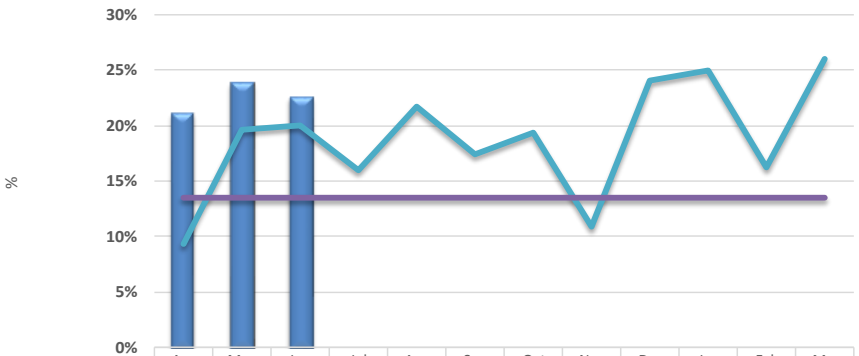
The LAS 18/19 target for sickness is 5% made up of 2% short-term, 3% long-term. In June, the short-term sickness has remained at 1.8%. The long-term sickness has also remained at 3.5% compared to the previous month.

Long-term sickness accounts for 75% of all sickness.

NB. Long-term sickness is any continuous episode of sickness lasting for 28 days or longer.

Workforce Race Equality Standard (WRES)

BME STARTERS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	21%	24%	22%	0%	0%	0%	0%	0%	0%	0%	0%	0%
BME (heads)	16	16	22									
2017/18	9%	20%	20%	16%	22%	17%	19%	11%	24%	25%	16%	26%
TRUST BME %	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%

The LAS WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly.

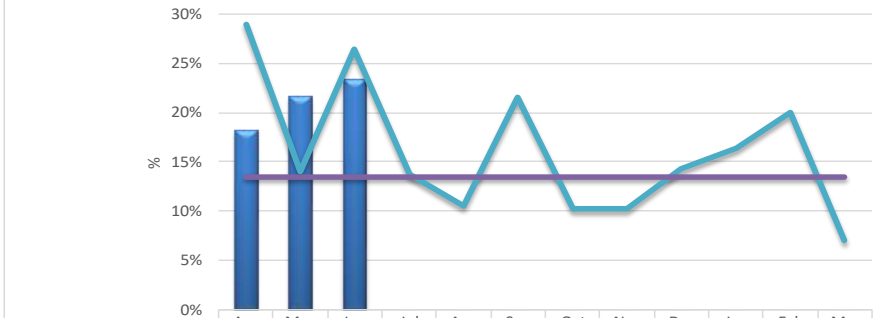
These graphs show the numbers of BME starters and leavers from April 2017 to June 2018 compared to the current Trust BME profile.

In June 2018 we had 22 BME starters including 10 Emergency Medical Dispatchers (EMDs) and 4 111 staff. There were 98 starters in total.

In June 2018 we had 10 BME leavers including 4 EMDs. There were a total of 43 leavers in June.

This year we have recruited 54 BME staff and 28 BME staff have left (+26 year to date).

BME LEAVERS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	18%	22%	23%	0%	0%	0%	0%	0%	0%	0%	0%	0%
BME (Leavers HC)	10	8	10									
2017 / 18	29%	14%	26%	14%	11%	22%	10%	10%	14%	16%	20%	7%
TRUST BME %	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%

WRES action plan – co-production event planned for 24th July.

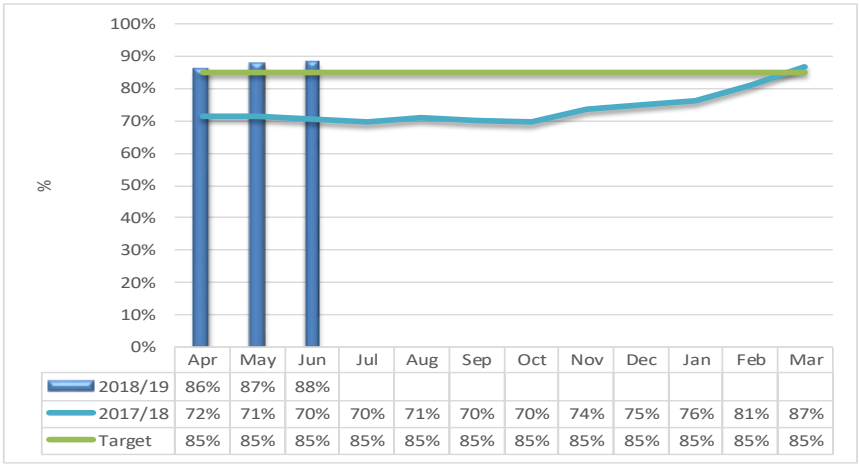
Focus on recruitment to improve BME starter levels including domestic recruitment events, training interviewers, having representative panels and reviewing decisions where BME candidates have failed assessments.

LAS attended a Skills for London Strategy Launch hosted by the Mayor of London, aimed at upskilling Londoners, with a particular emphasis on BAME Londoners and those from disadvantaged areas. We are keen to tap into any funding that can be applied for to fund projects aimed at improving diversity and inclusiveness at LAS.

The Sponsorship Mentoring initiative was launched on 12 June 2018, with an initial cohort of 18 mentors, including executive board members, non-executive directors, senior managers and paramedics.

Statutory and Mandatory Training & Appraisals

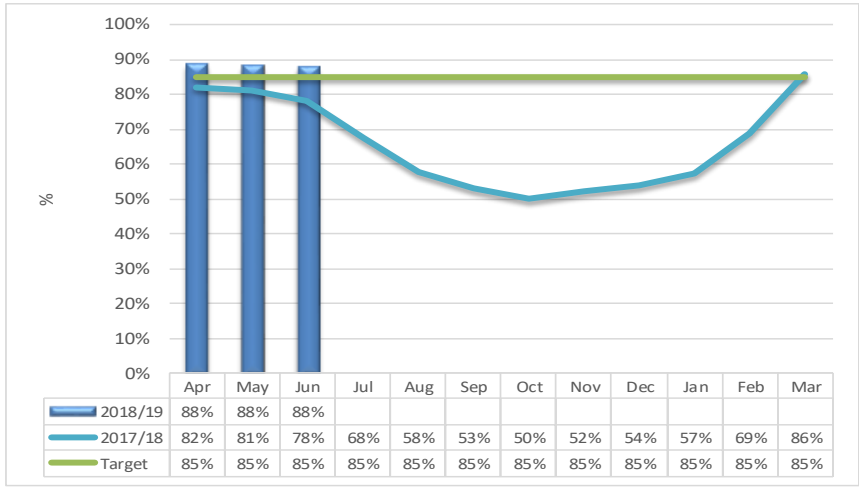
STAT AND MAND TRAINING COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	86%	87%	88%									
2017/18	72%	71%	70%	70%	71%	70%	70%	74%	75%	76%	81%	87%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- Over 64,000 e-learning courses have been completed since go-live. Nearly 4,000 staff have set-up to use from home and these numbers will increase with the newly available auto enrolment functionality.
- EOC, the subject of the CQC MustDo action, is at 79.7% and a specific trajectory and action plan has been agreed with the EOC management team to bring this in line.
- Trust compliance is 88%, Corporate compliance 92.14% and Operations is at 87.84%.
- CSR.2017.2 stands at 90.3% and CSR.2017.3 is at 88.76%. CSR2018.1 is 67.93%.
- Information Governance is at 91.73% for June and will increase alongside CSR completions.

APPRAISAL COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	88%	88%	88%									
2017/18	82%	81%	78%	68%	58%	53%	50%	52%	54%	57%	69%	86%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- Appraisal completions at 87.5% at the end of June.
- PDR trajectories for Sector Operations frontline staff have been developed for 18/19 to ensure that PDR dates are spread more evenly across the year and that all areas remain above the 85% compliance target.
- PDR dates have been adjusted and updated on ESR to deliver a higher compliance rate in June, July and September and lower compliance rates in August, November, December and January.
- As a result of the Appraisal Audit an Appraisal Improvement Programme will be commenced in August to take forward recommendations as well as plan move towards an eAppraisal system.

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

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

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

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

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	11			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
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:

The Board are asked to note 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

1. There are currently five risks on the BAF three of which have a net rating of 15 or above, they are set out below in descending order of severity.

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 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	
Risk proposed for removal from the BAF				
	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	Proposed for removal from the BAF

Risk discussions since May

Board Assurance Committees

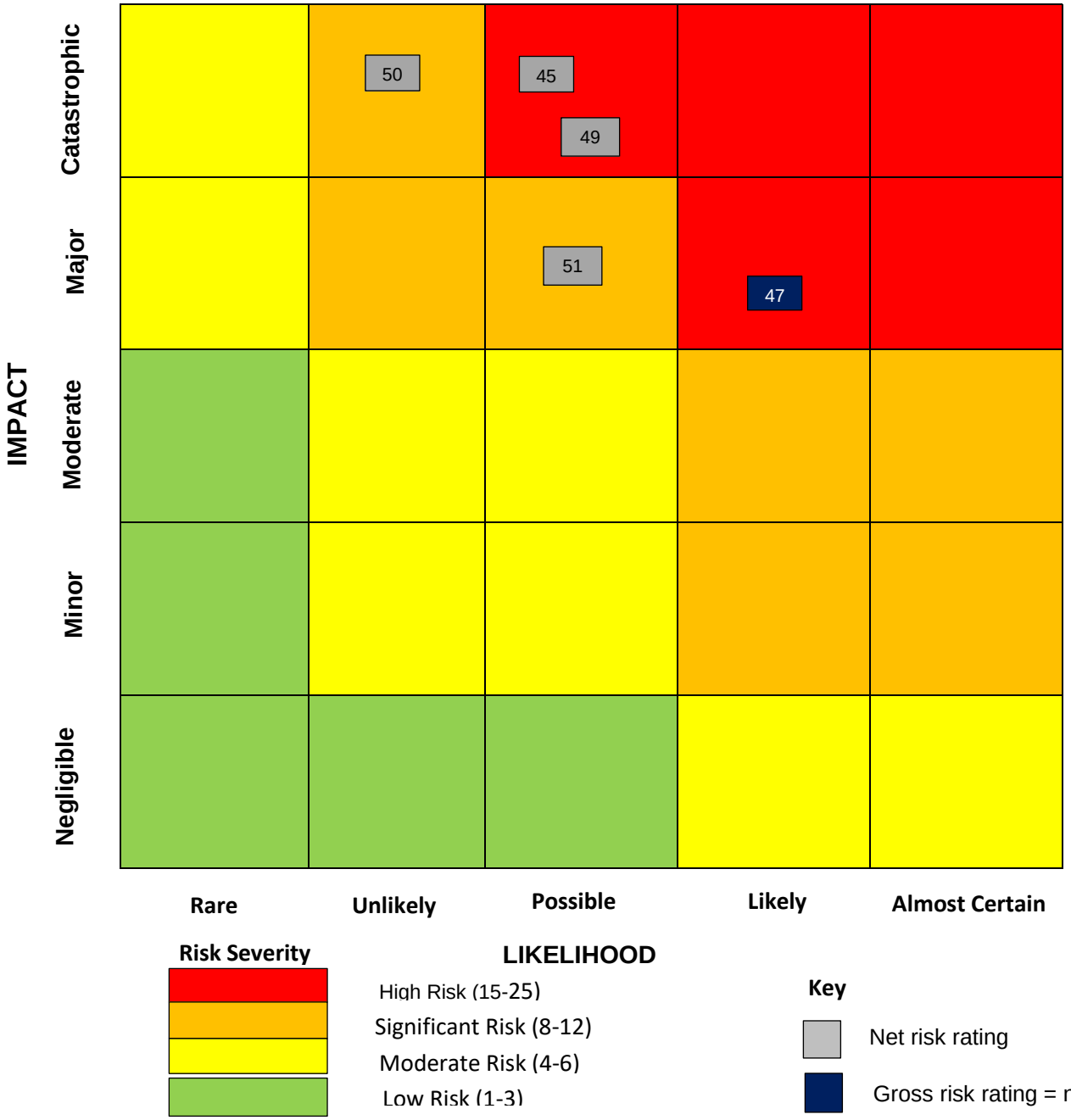
2. The Board last reviewed the BAF and CRR at its meeting on 24 May 2018. At this meeting it was agreed that no further changes to the BAF should be proposed at the current time.

3. At its meeting on 12 July 2018, the Logistics and Infrastructure Committee considered the de-escalation of 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). Although the Committee was assured by the level of work that had been undertaken to mitigate this risk, it was considered appropriate that it should remain on the BAF until the work required to remove it was undertaken as planned in September 2018.

4. The Logistics and Infrastructure Committee also considered the de-escalation of 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). Subject to receipt of further information about the level of the Trust's exposure to such third party suppliers, the Committee was content to recommend the de-escalation of this risk from the BAF.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – July 2018



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.

BAF Risk 50
Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.

Proposed for removal from the BAF

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

GOAL 1	**Provide outstanding care for our patients**

DELIVERABLE	1. We will deliver the key deliverables in our Quality Plan for 2018/19 to improve patients' experience and quality of care for patients using our service. 2. We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards. 3. We will continue the roll-out of our urgent care Advanced Paramedic Practitioner service across all five STP areas to improve patient care and reduce the need for patients to go to hospital and develop a new paramedic practitioner role. 4. We will complete our new five-year strategy document and publish new or revised 'daughter documents' containing detailed plans on how we will deliver it. 5. We will pilot the new 'Pioneer Services' set out in our new strategy. 6. We will implement a 'frequent caller plan' to improve the care we provide those patients to better meet their needs and reduce the impact of their calls on our wider patient response times. 7. We will continue to improve the quality and security of our drug management through the roll-out of our Secure Drugs Room project, primary response bags, vehicle based drugs pack, internal order drug system and enabling applications. 8. We will improve the quality of care we deliver to patients and our work with partners across the system by introducing new capability that builds on the roll out of iPads to our front-line clinicians.

Links to Deliverables	BAF Risk	**Further mitigation required**

GOAL 2	**Be a first class employer, valuing and developing the skills, diversity and quality of life or our people**

DELIVERABLE	9. We will complete our recruitment plan to fully establish our front-line and newly enlarged Emergency Operations Centre structures. 10. We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate,. 11. We will embed our new Vision, Purpose, Values and Behaviours (set out in our new strategy document) across the organisation and fully align our competencies to the employee journey at LAS in: recruitment, promotion, training and development and appraisals. 12. We will complete action plans across all functional and operational areas of the business to respond to the key issues identified in the 2017 Staff Survey and implement the planned actions in time for the 2018 Staff Survey. 13. We will continue to deliver our Workforce Race Equality Standard (WRES) Action Plan, together with other measures, to improve diversity, inclusivity and equality across all areas of the organisation. 14. **We will continue to implement our Clinical Education Strategy.** 15. **We will develop and roll-out training and development for all our people across functional and operational teams.**

Links to Deliverables	BAF Risk	**Further mitigation required**
9, 10	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

GOAL 3	Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London	**DELIVERABLE**	16. We will continue to work with our commissioners and STP partners to lower demand, improve access to, and use of, Appropriate Care Pathways (ACPs) and lower overall conveyance to Emergency Departments, developing the use of technology to provide faster access to patient care through digital means where appropriate. 17. We will mobilise the North East London Integrated Urgent Care (111) contract and continue to seek a greater role in the London-wide integration of access to emergency and urgent care, including retaining the South East London 111 service. 18. We will work closely with London acute hospital trusts, NHSI and NHSE to further reduce delays to patients and our crews at hospitals, especially during times of peak pressure on the wider system (e.g. during periods of high demand such as adverse weather). **19. We will work closely with other emergency services and partners (e.g. the Greater London Authority family and London's boroughs), fulfilling our statutory obligations to collaborate, innovate and maximise the efficiency of our combined public service provision.**

Links to Deliverables	BAF Risk	**Further mitigation required**

GOAL 4	**Provide the best possible value for the tax paying public, who pay for what we do**

DELIVERABLE	20. We will deliver our control total and maintain our use of resources rating with NHSI. 21. We will deliver Cost Improvement Programme (CIP) efficiency savings of £12.3m in 2018/19 and develop a programme of further efficiencies to inform our business planning for 2019/20 and 2020/21. 22. We will complete the review of business resilience across the organisation and implement measures to effectively manage risk and ensure the continuity of our services during times of disruption, including GDPR compliance and Cyber risk assurance. 23. We will manage and deliver our proposed capital programme of £15.5m to support the delivery of our overall strategic objectives. **24.** We will ensure the delivery of our agreed CQUIN's (as agreed with our core contract commissioners) to improve the quality and value of the services we provide on their behalf.

Links to Deliverables	BAF Risk	Further mitigation required
20, 21, 23, 24	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
22	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
22	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.

PROPOSED TO BE REMOVED FROM THE BAF

22	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. **Gaps in Controls** 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. 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%) **Gaps in Assurance** To be assessed	8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy. 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. 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. 1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impect assessment on Quality and Performance as part of Business Planning	31/08/2018 30/04/2018 30/04/2018 30/04/2018 31/03/2018 30/04/2018 31/07/2018 31/01/2018

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 31/10/2018**	

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 (NWAS 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. 13. EOC restructure to commence May 2018, full completion September 2018. **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). 5. Online assessment project now live. **Gaps in Assurance** None identified	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 estabilsh best practice and mutual ways of working	31/03/2018 31/10/2018 31/10/2018 30/04/2018 31/03/2018

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 recent 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.	Instigate phase 2 of the Cyber Programme for 2018-19 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 NHSD for Cyber funding Capital (Bid 2) Implementation of a Cyber program of works (to include the recommendations from the PA Consulting report) Obtain approval for Phase 2 of the Cyber programme into 2018/19 Deliver Phase 2 of the cyber programme Initial Bid to NHSD for Cyber funding Capital (Bid 1)	04/06/2018 31/05/2018 01/03/2018 01/03/2018 01/04/2018 31/05/2018 16/05/2018 16/05/2019 03/11/2017

Signed: Ross Fullerton

BAF Risk no. 50 Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.

Risk Classification: Strategic Assets and Property	**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:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
Existing UPS is undersized for the demand requirement in the building	**15**	**10**	**5**

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
Reduction in UPS dependence by transfer of demand to non-essential supply (where possible) Maintenance of existing UPS equipment Design of new provision and purchase of upgrade equipment Engagement with UKPN to mitigate risks associated with essential network repairs or known service interruptions - Schedule of OP66 events (2018) - 17/04, 19/06, 07/08, 24/10 **Gaps in Controls** To be confirmed	- Ongoing monitoring of UPS demand - No degradation of service experienced during unplanned network power outage (18/02/18) - UPS maintenance contract in place - Generator maintenance and test schedule in place - Regular Project Group meetings **Gaps in Assurance** To be confirmed	Project team in place to investigate/manage upgrade project and identify window for upgrade works IM&T migration programme to Cloud based services - Development of EOC Business Continuity Plan	30/03/2018 21/09/2018 28/09/2018

Signed: Benita Mehra

Proposed to be removed from the BAF

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: Strategic Assets and Property	**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** **16**	**Current/Net Rating** **12**	**Target Rating** **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.		June 2018
Signed: Benita Mehra				

ID	Description	Opened	BAF Reference:	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Summary of 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	Grimshaw, Andrew	30/05/2018	12	Significant	1, Review case to retain ambulances following introduction of 140 new vehicles 2, Retain 20 FRU cars to increase size of fleet to 180 3, Review additional ambulance capacity to support roll out of new Vehicle Preparation Scheme	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
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	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.	Bain, Trisha	04/07/2018	12	Significant	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) . Deadline: 31/12/2018. 2. Agree Terms of Reference for the Corporate Health and Safety Committee ensuring appropriate representation. Deadline: 25/07/2018.	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
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.. 2. Loss/decline of staff morale. 3. Increase in staff absences thereby impacting on service delivery. 4. Negative reputational damage to the LAS as an employer. 5. 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	Bain, Trisha	04/07/2018	12	Significant	1. H&S Team to liaise with Wellbeing Team regarding the implementation of stress audits. Stress work group being formed. Deadline - 31/08/2018. 2. LSMS to work with Training/Operations regarding the timely issue of stab vests to new starters. Deadline -10/07/2018.	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.	4	Moderate

ID	Description	Opened	BAF Reference:	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Summary of Actions	Assurance	Rating (Target)	Risk level (Target)
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 2017/18, 558 out of the 3327 health and safety incidents reported on Datix related to manual handling incidents. 523 of the incidents reported resulted in low/moderate harm. 127 of the 220 incidents reported as RIDDOR were due to manual handling injuries. 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.	20/09/2017	47	15	High	1. Manual Handling Group in place – Chaired by a DDO. 2. Manual handling policy implemented across the Trust. 3. Awareness training provided to all front line staff during their Corporate Induction to the Trust. 4. Monitoring of incidents, trends and compliance undertaken by the Corporate Health and Safety Committee. 5. Small handling kits available on all vehicles to aid the easy handling of patients. 6. Specialist MH equipment e.g. Manger Elk, trolley beds, Ferno Tracked Carry Chairs e.t.c are available to all front line staff. 7. Trust-wide incident reporting and management system in place through Datix. 8. Additional support available for staff where they are unable to safely lift a patient or equipment. 9. Risk assessments has been completed for high risk manual handling activities. 10. TOR for Manual Handling Group has been finalised and agreed. The group does not currently report to any of the	Bain, Trisha	04/07/2018	15	High	1. Audit the availability and use of small handling aids kit by frontline/operational staff. Deadline: 30/08/2018 2. Review of current Datix incident categories to ensure these accurately capture/reflect incidents reported. Deadline: 01/08/2018 3. H&S Department to monitor the effectiveness of arrangements implemented to reduce the number of incidents relating to failure of medical equipment such as track chairs/mangar elks/tail lifts. Deadline: 31/08/2018.	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
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	Bewes, Lorraine	30/05/2018	12	Significant	1, Trial of alternative vehicle to be undertaken with ramp in place of tail lift. - trial to commence June 2016.Organised by C Vale 2, 140 New ambulances to be delivered in 2016/17 with new external tail lift. 50% of fleet will have been replaced in two years. by Nick Pope to be completed by March 2018	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
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	Bewes, Lorraine	30/05/2018	12	Significant	The risk needs to be properly clarified and comprehensively detailed and reviewed	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	26	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	Bewes, Lorraine	30/05/2018	12	Significant	1, email Justin Wand to see if he thinks this risk should be merged with risk 121 2,Roll out enhanced VP to rest of service, Owner to be confirmed 3,Ensure adequate stocks of consumables and equipment are available to VP staff, Owner to be confirmed 4,Fully develop equipment database reports to indicate where any equipment is missing, Owner to be confirmed 5. Enhanced daily vehicle check	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

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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	25	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	Bewes, Lorraine	30/05/2018	12	Significant	1, Roll out VP proposal to LAS area 2, Implement working group to review personal issue kit – check status of any existing work with CEG 3, look at merging this risk with risk 120, GD to email JW	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
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	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.	Bewes, Lorraine	09/03/2018	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. Revenue and Capital financing options to be identified. 5. Confirm programme resource budget to deliver strategy. 6. Review Finance structure and prepare case to Trust Board to enable business partnering support. 7. Develop budget and business case training 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
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	Future space requirements are being considered as part of the Estates strategy. The current lease is being extended until December 2019 due to being unable to identify an appropriate alternative location and, also, due to the pressures on IM&T to support the move. IM&T also operate within the site and, again, would have required alternative space provision. A formal specification of EOC training requirements is to be created and alternative locations to be identified. To accommodate lead times for a relocation to new premises, a new location will need to be identified and agreed by August 2019.	Bewes, Lorraine	06/04/2018	16	High	An agreement to draw up and present a business case. Support in the location of a future proof and appropriate venue that suits both training and supports meeting room and CAD team support	DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downard aware and supportive of the urgent review of premises and continued co-located situation.	4	Moderate
448	There is a risk that… not all EOC functions are able to continue in the event of planned or unplanned CAD outage, as there is insufficient space within the EOC estate. Therefore, some non-critical (but BAU) functions will cease during this time.	11/06/2016		12	Significant	Current actions identified are: 1. Priority list of NON Critical functions to be stopped is circulated. 2. Watch Managers tasked to dynamically assess requirements 3. Non-critical EOC functions are now included in the revised OP66 which is pending sign off. (AJE)	Cranmer, Pauline	17/05/2018	12	Significant	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	8	Significant
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	29/06/2018	12	Significant	1. Review of business continuity plan 2. Review of staffing forecasting against predicted demand 3. Ongoing recruitment to reduce vacancies 4. Consideration to a roster review to improve staffing levels at times of high demand, assist in the work-life balance of staff, increase retention and recruitment	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

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775	Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.	16/03/2018	50	15	High	Reduction in UPS dependence by transfer of demand to non-essential supply (where possible) Maintenance of existing UPS equipment Design of new provision and purchase of upgrade equipment Engagement with UKPN to mitigate risks associated with essential network repairs or known service interruptions - Schedule of OP66 events (2018) - 17/04, 19/06, 07/08, 24/10	Dawson, Steve		10	Significant	- Project team in place to investigate/manage upgrade project and identify window for upgrade works (Julia Hilger-Ellis: March 2017) - Ongoing investigations to consider interim repairs (Steve Dawson: March 2018) - IM&T migration programme to Cloud based services (Ross Fullerton: September 2018) - Development of EOC Business Continuity Plan (Sarah Rodenhurst-Banks: In Progress)	- Ongoing monitoring of UPS demand - No degradation of service experienced during unplanned network power outage (18/02/18) - UPS maintenance contract in place - Generator maintenance and test schedule in place - Regular Project Group meetings	5	Moderate
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	12/06/2018	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	There is a risk that... the Trust will not be able to maintain a full patient record (and manage quality and standards), should the 999 recording system fail into and out of the EOCs.	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	17/05/2018	10	Significant	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 Update 29/05/13. Current system (Witness) no longer fully supported. Tendering for new system at end May 13, probable implementation early 2014. This system will provide all recording requirements and storage needed across the service. Until that time, risk will continue. Oct 2015 - Update - Contract now awarded and work is on-going by IM&T to finalise the specification. Feb 2016 - Update. Specification now finalised and the work should be completed and the system operational by May 2016 Jun 2016 - Update. The new system has been delivered to LAS but implementation is now for July 2016 Nov 2016 - Update. Delayed due to 111 implementation 26/09 - 999 and Airwave to be migrated to Redbox by March 2017 The	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
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. Agent status report as been developed by 3rd party (Comstice) alongside the new live wallboard. Access to historical individual performance monitoring (IPM) remains a functional gap	Fullerton, Ross	29/06/2018	10	Significant	1. Site visit to NWAS who are currently working on the same telephony platform and are experiencing similar issues. Visit to share information and workarounds. 2. Deployment of new visual management tools (wallboards etc.)	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** Key customer requirements that have not been met are being captured and signed off as part of the new telephony build due to go live in support of a successful SEL contract. The requirements captured for the North East IUC mobilisation are shared with the South East London contract	2	Low
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	12/06/2018	12	Significant	The new MDT3 software will allow IM&T to explore other device options that will be able interact with the Garmin Sat Nav. The national MDVS solution scheduled to be announced in 2018, however, this has now been delayed until 2020.	Telent are under contractual obligation to manages the MDT assets.	3	Low

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701	There is a risk that the GRS Service may not be recovered within business expected timeframes as a result of the current support model. Specifically: - There is a reliance on business senior users for support of the service which is not documented or formally agreed. - Due to single points of knowledge, IM&T may not be able to support/maintain system at required service level (Critical system with 24x7 support)	17/10/2017		12	Significant	Cross training/skilling GRS is supported 24x7 by IM&T, and any loss or degradation of service is supported by the IM&T incident/on-call management processes.	Fullerton, Ross	12/06/2018	12	Significant	Review support model: 1) Review ownership of third-party support contracts. 2) Document Service level and operating level agreements. 3) Document gaps in support and implement actions plans to address gaps.	Incident management and on-call processes well documented and known. Recently reviewed and updated by IM&T service delivery (completed September 2017)	4	Moderate
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	11/06/2018	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. As a precautionary measure the existing Sat Nav mapping software will be updated to the latest version. 5. 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
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	02/07/2018	12	Significant	1. Perform an exercise to identify the IT information assets (systems, applications) owned by the Trust and assign owners to them to enable better asset management. 2. Introduce a policy to assign an owner (individual/department) to every new and existing IT information asset that is purchased at the Trust.	Risk discussed and monitored by IM&T SMT	3	Low
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	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	Fullerton, Ross	02/07/2018	15	High	1. Initial Bid to NHSD for Cyber funding Capital (Bid 1) 2. NHS Digital led review of LAS cyber security 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 recommendations from PA Consulting report as part of a wider Cyber program of works. 6. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS	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.	10	Significant
771	International paramedics are finishing training and are not able to work as paramedics which impacts on providing operational hours as under the terms of their visa they cannot work in any role except as patient facing paramedic or in a training role.	05/03/2018		16	High	1. International paramedics are required to apply for HCPC registration as part of the pre-employment process. 2. The request to apply to HCPC is sent to a least 8 weeks before the date of their course start date by the recruitment team. 3. A recent change to the process requires the Paramedic to notify the Recruitment Team when the Scrutiny Fee has been submitted to HCPC in order for them to be allocated to a course. 4. As part of the new process Paramedics are sent guidance on the HCPC application process with regular follow ups. 5. A meeting with the HCPC resulted in a temporary agreement for limited support to provide a weekly check/update of an LAS generated tracker spreadsheet showing progress of submitted applications 6. The Clinical Education team and operational colleagues have worked out a programme to continue the 'training status' of the paramedics until they are registered	Grealish, Patricia	11/04/2018	12	Significant	-Meeting with LAS and HCPC held 5/3/2018 -Deploying into an observational capacity (supernumerary). Normal process would be 2 NQP0 would work with 1 OPC paramedic mentor (band 6) for 300 hours. (9152) This group of staff currently would be attend only as they do not hold C1 driving licence. -Daily monitoring and updating HCPC registration status for all Cohorts -Matter is discussed weekly at ORG and A&E Resourcing and mitigating actions agreed upon by all relevant stakeholders	• LAS have continuous contact with international paramedics (2-3 times per week) to encourage speedy completion of the HCPC application process. • LAS provide clear guidance to the international paramedics on the importance of making an accurate application and of paying their scrutiny fee as soon as possible • HCPC are providing support to check status of application (weekly) processing for all international paramedics against a schedule provided by LAS (weekly) • Education and operational teams have devised a solution to deploy the paramedics that have completed their training and are not registered to ensure they do not breach the terms of their visa Matter is discussed weekly at ORG and A&E Resourcing and mitigating actions agreed upon by all relevant stakeholders	4	Moderate

ID	Description	Opened	BAF Reference:	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Summary of Actions	Assurance	Rating (Target)	Risk level (Target)
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	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	Grealish, Patricia	11/05/2018	16	High	1. The END Role will be included as part of planned recruitment campaign. 2. Meet relevant people at Met Police to share and establish best practice and mutual ways of working. 3. Review feasibility of online assessment for EOC recruitment and run pilot. 4. EOC Recruitment Project Meetings are taking place. 5. Allocate appropriate resource to interview and assessment activities. 6. To plan and roll out the EOC restructure, including incentives to address retention.	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). 5. Online assessment project now live.	8	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	Further training has been put in place by the Quality Governance Team for risk awareness and Datix training.	Harding, Philippa	19/03/2018	12	Significant	1. Risk owners to set up a programme of regular meetings to feed updates to the Risk and Audit Manager in line with policy 2. Risk and Audit Manager to advise risk owners of the timetable for SMT, EMT, TDA etc. meetings (if this is not known already) so that risks can be planned into directorate meetings for the most up-to-date information to get to the necessary parties.	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	24/05/2018	12	Significant	1. Procurement and Installation of new equipment by 31/3/17 2. Investigate conversion of DAT tapes into a modern media 31/3/17	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
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. The Trust can also not be assured that driving standards can be maintained, as we do not have enough capacity to provide a regular review programme.	11/05/2017		20	High	Depending on budgetry 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	05/06/2018	12	Significant	1) Continue to liaise with external providers 2) Confirm budgetry constraints for 2017/18 3) Develop long-term DI development strategy 4) Review existing secondment activity to ensure best distribution of resources	The risk and controls relating to it will be reviewed at the monthly Risk Review meeting. External providers are regualrly communicated with to ascertain the ability to cover current and future requirements. The long-term strategy will be discussed at the senior mangement team meetings.	1	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	16/07/2018	12	Significant	Implementation of an electronic student management system to support administration of all clinical education programs and tracking and reporting of the student journey.	Standardisation committee Credentialing committee	6	Moderate

ID	Description	Opened	BAF Reference:	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Summary of Actions	Assurance	Rating (Target)	Risk level (Target)
302	The Trust is unable to access some clinical training records of operational members of staff. Records are kept on separate and remote sites, are kept primarily as paper (not electronic) copies, and are not archived / processed within the framework of a recognised student management system. It is difficult to defend legal claims against the Trust with the paucity of evidence we have available that staff have undertaken their core and statutory / mandatory training.	01/06/2005		16	High	An archiving system was in place to organise historic records at the Fulham administration archive site, but does not have the capacity to incorporate new documents 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. However, these do not integrate with a student management system to identify whether the stored training records are located.	Ivanov, Tina	16/07/2018	12	Significant	1. Develop plans to move to the electronic storage of all operational training records generated within the LAS 2. Further develop the plans to create a central management hub (currently Fulham) to support and underpin the provision and quality of all Clinical Education & Development activity throughout the Trust. This will include the review of Fulham CE&S administrative staff levels, so as to ensure that sufficient capacity exists to fulfil the requirements of the new training record management system. 3. Scope the potential and options for the back scanning of existing training record documentation. 4. source sufficient estate to house all training records in one location with traceable/identifiable information	Reviewed at monthly departmental Risk review meeting	8	Significant
762	There is a risk that uniforms are not being supplied to some new entrant students in time for their operational placements and / or driving courses. This is due to a very limited timeframe between uniform being ordered and the 1st placements, and limitations on the provision of available stock from the two providers. This can prevent students going out on placement, and can therefore delay students from moving to operational duties at the end of their course, if placements are rearranged. This will ultimately delay the provision of new operational staff to Operations.	20/02/2018		16	High	Education Managers contact other sites to see if there is any spare uniform unissued from current course students or retained from previous course students Operations are contacted to see if there is any spare uniform available.	Ivanov, Tina	16/07/2018	12	Significant	Completion of departmental ordering responsibility and uniform ordering process meetings; new processes to be agreed. Completion of uniform stores proposal.	A meeting has been undertaken to review the ordering of uniform, including departmental responsibility and timing. If the learner is measured for their uniform earlier in their induction process, and the order is placed earlier, this may prevent some of the supply issues specifically related to timing from occurring. A sizing kit will be procured for all education sites, to ensure that learners can try on actual garments and check the required size. The proposal of a uniform store is being investigated currently by CE&S managers.	8	Significant
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		9	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	24/05/2018	9	Significant	Request to be made so that major incident plan is updated to formalise that Gold has responsibility to provide the communications team with accurate, timely information about patient numbers and conditions.	This issue has been discussed with former Director of Operations and EPRR lead.	6	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.	Wand, Justin	30/05/2018	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
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	7	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	09/04/2018	12	Significant	Implement new Rest Break Policy as agreed with Trades Unions 04/12/2017 Enact end of shift protection arrangements 31/03/2018 757 - Out of Service (OOS) Hub implemented. Central Support Unit (CSU)on PD33 deals with all OOS requests - COMPLETE 753 - Agree the process for the rest break arrangements to be implemented. Working group to take this forward - COMPLETE 754 - Recruit frontline staff to 3169 by March 2016 - COMPLETE 755 - The skill mix model was updated in January 2015 to include international recruits. This was reviewed in August 2015 and published in September 2015 - COMPLETE	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

ID	Description	Opened	BAF Reference:	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Summary of Actions	Assurance	Rating (Target)	Risk level (Target)
753	There is a risk that ongoing delays in ambulance crews handing over their patients at Hospital EDs across London will reduce operational cover in the surrounding area and compromise patient care.	06/02/2018		15	High	1. Delays at hospitals monitored 24/7 by LAS Incident & Delivery Managers (IDM). 2. IDMs dispatch Incident & Response Officers (IRO) to EDs that are under pressure. 3. LAS have seconded senior manager to work in NHS E Winter Room to focus on link between LAS and wider Healthcare system with regards to hospital delays over winter 2018. 4. Operational manager has been seconded to lead on work to address hospital issues over winter 2018. 5. Regular Hospital Handover meetings held between LAS/ECIP and NHS I Improvement and Relationship managers focusing on handover delays. 6. Intelligent Conveyance (IC)desk in EOC runs to smooth out spikes in ED conveyance monitoring arrivals over a rolling 60 minute window. 7. LAS SEMs work with local EDs to review handover processes, flow and address issues	Wrigley, Fenella	05/04/2018	12	Significant	1. Daily, weekly and monthly hospital lead shares data with NHSE 2. Fortnightly, Medical Director, Deputy Director of Operations and hospital lead meet with NHSE, NHSI and other stakeholders 4. Finalise and circulate cohorting Standard Operating Procedure which is currently in draft form 5. Review risk monthly and identify trends in hospital delays early 6. Ensure local teams progressing actions on local linked risks at the Sector Services Risk Review Meeting 7. Agree/undertake LAS actions for the NHS I 2018/19 Hospital Handover Programme	1. IDMs report on hospital issues in their daily shift reports. 2. IROs report to IDM on hospital issues in real time during their site visits. 3. ECIP and NHS I relationship managers feedback to Hospital Handover meetings held by LAS/NHS I. 4. IC monthly report on activity 5. Daily winter sit rep sent out by NHS E Winter Room	6	Moderate

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Serious Incident Quarterly Thematic Report			
Agenda item:	12			
Report Author(s):	Kaajal Chotai, Deputy Director for Quality, Governance and Assurance Michael Ward, Head of Quality Governance and Assurance			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

This report provides an overview of the incidents reported and declared to the Trust's Clinical Commissioning Group (CCG), and a thematic analysis of serious incidents (SIs) submitted to the CCG and closed in Q1 2018/19.

The SI thematic review provides an analysis of category and key contributory factors for incident activity across the trust and each STP / sector. The findings are compared with those from the previous quarters, with the aim of identifying key themes for action.

Recommendation(s):

The Board is asked to note the report which summarises the findings from the quarter one thematic review of serious incidents (SIs).

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

Operational Risk 21 - 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.

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

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

Serious Incidents Update - Quarterly Review: 2018-19 – Q1

Introduction and Background

1. This paper provides an overview of the incidents reported and declared to the CCG and a thematic review of serious incidents closed and submitted to the CCG in Q1. The thematic review is specifically focussed on serious incidents (SI) by category and key contributory factors.

Context

2. During Q1, from a total 2285 reported incidents, 18 incidents (0.8%) were declared as SIs. Of these, two SI investigations have been submitted to the CCG and are awaiting closure, one has been de-escalated and one de-escalation request has been submitted to the CCG for consideration. The remaining 14 cases are currently under investigation.

3. 13 SIs in total were closed by the CCG in Q1. These are for SIs declared and submitted to the CCG in Q4 (2017/18).

4. The Trust's current position on meeting the 60 working day target for submitting SI reports to the CCG remains at 100%.

5. The average time for commissioners to sign off and close a report is currently 51 days (ranging from 17 to 92 days). The CCG have a target of 20 calendar 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. We have met with commissioners to support the timely review and closure of reports. The CCG have asked for our patience and understanding following an internal process change, whereby SI reports undergo a two stage peer review process before presentation at the Serious Incident Review Group (SIRG). This new process requires time for adjustment and is hoped will have settled in the coming weeks.

6. The Quality, Governance and Assurance (QGA) team have been working on more effective methods for embedding learning from contributory factors. To this end, the National Patient safety Agency tool – 'Contributory Factors Classification Framework' has been reviewed to incorporate the tool into analysis performed by the QGA Team. As the tool was primarily created for governance work in the acute sector, some incident categories are either missing or inadequate for the ambulance service, and have been reformatted. The tool has been utilised for this report and will be moving forward. Any discrepancies or anomalies will be addressed in the body of the report.

Thematic Review

Serious Incidents by Sector/STP (comparison Q4 2017/18 – Q1 2018/19)

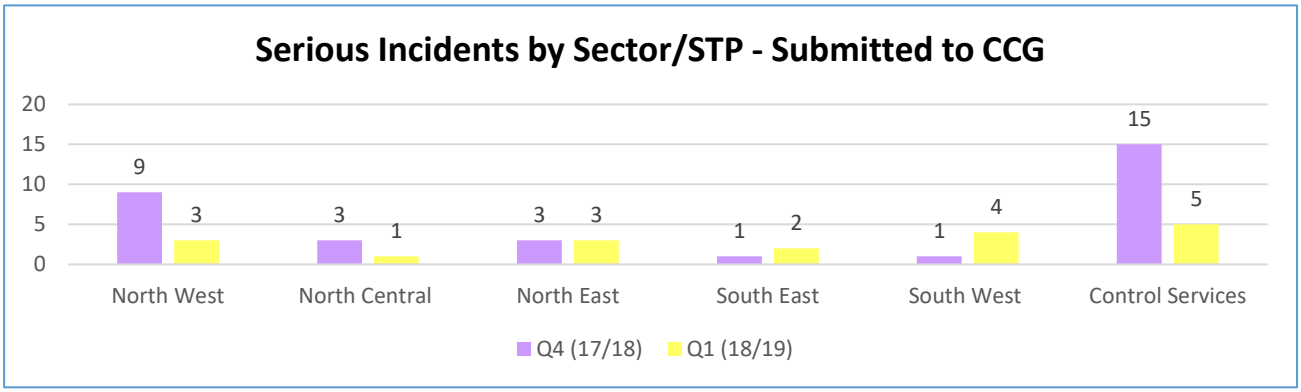


Figure 1

7. Fig 1 illustrates a decrease in serious incidents in the North West and EOC, whilst in the South West an increase has been observed. The remainder of the Trust remains steady. SIs relating to resource availability have previously been allocated to Control Services, however, following feedback these are now aligned to sector services for improved oversight. The Trust has an ongoing programme of change in order to meet the new requirements of the new national ambulance standards (ARP) and to ensure the most appropriate vehicle (and response) is provided to the patients that need them. The Trust incident management system is being updated to include several new incident sub-categories with the aim to differentiate between delays caused by resource availability, and perceived errors and omissions within the Control Services environment.

Serious Incidents by CCG – Declared (comparison Q4 2017/18 – Q1 2018/19)

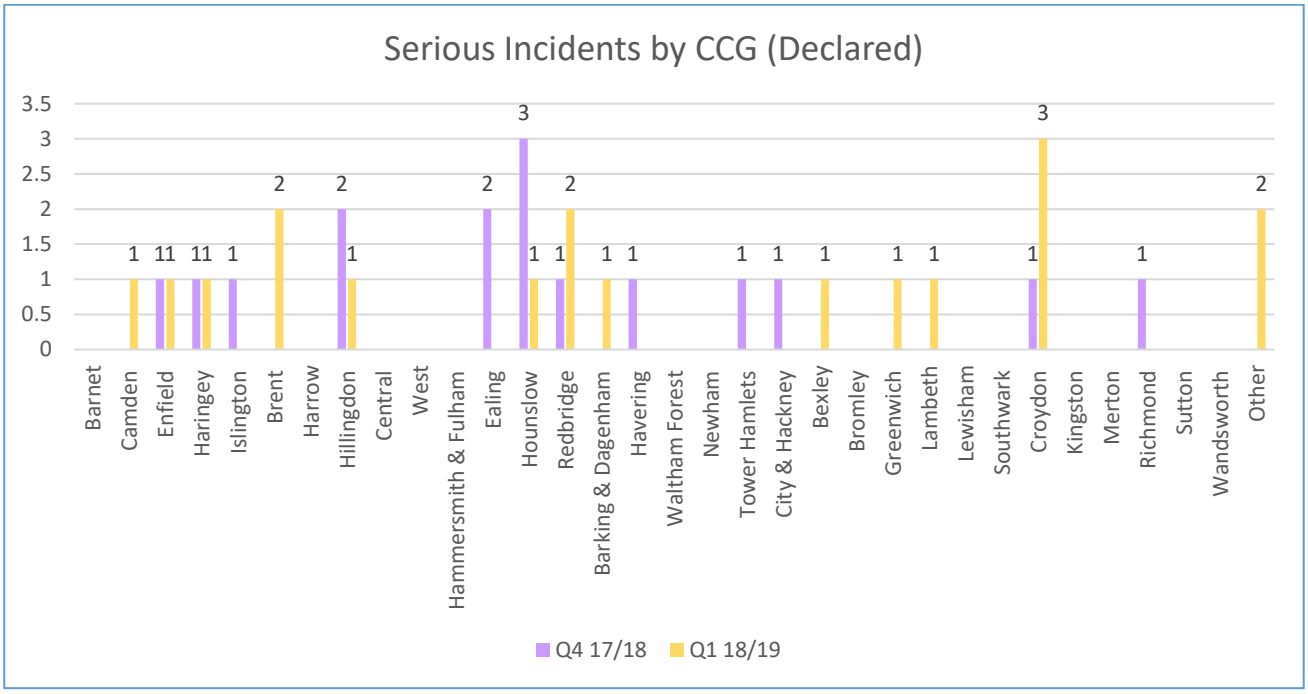


Figure 2

8. Fig. 2 demonstrates the distribution of serious incidents by CCG.

Contributory factors and Declared SI's by Sector/STP

9. The following pages describe the contributory factors in SI's submitted to and closed by the CCG (predominantly SI's declared in Q4 2017/18), along with a summary of the incident categories for which we declared SI's in Q1 (2018/19).

10. It should be noted that SI's declared in Q1 are currently under investigation by the Trust. The summary provided has been obtained from the initial incident report therefore the root cause is yet to be ascertained.

11. At the meeting of the Trust Board in May 2018 (item 16, TB/18/15), it was requested that for clarity, the definition of Human Factors be provided in subsequent reports to the Board. The definition of human factors in health care is:

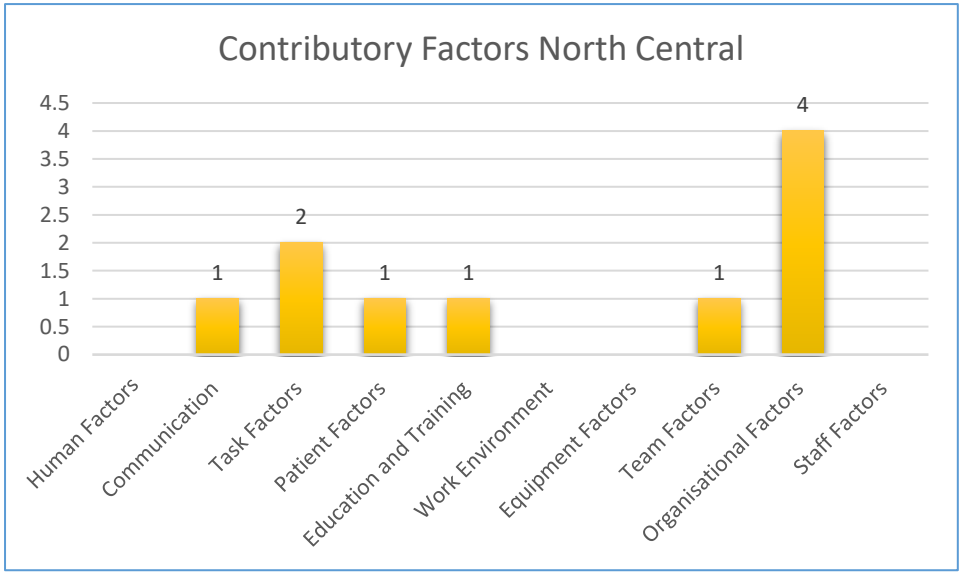
"Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings" [1]

[1] *Catchpole (2010), cited in Department of Health Human Factors Reference Group Interim Report, 1 March 2012,* National Quality Board, March 2012.

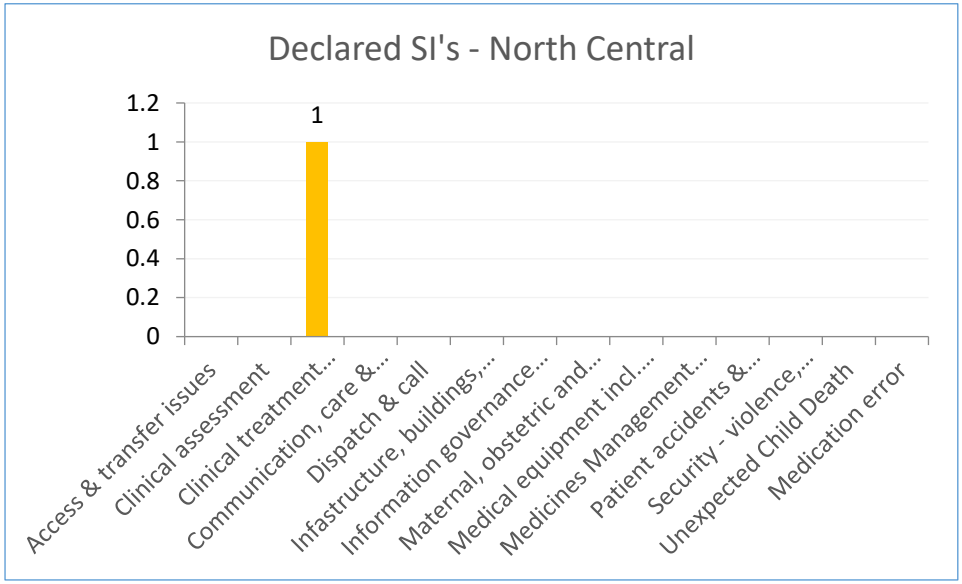
Source: Human Factors In Healthcare: a concordat from the National Quality Board.

12. Please see the National Patient Safety Agency (NPSA) Contributory Factors Classification Framework (part of our root cause analysis investigation tools) at the end of this report for further details of all contributory factors.

North Central



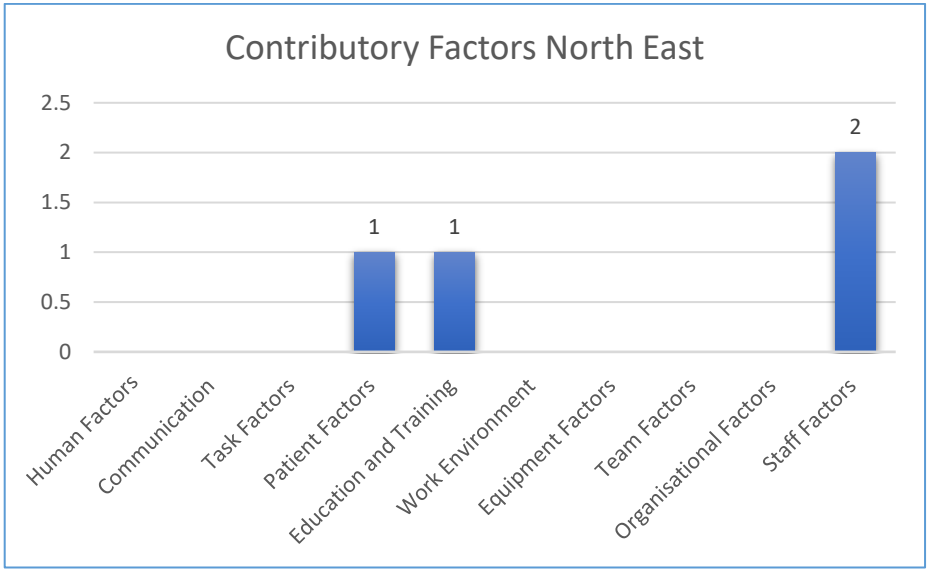
There were three closed SI's relating to incidents in the North Central sector in Q1.
Organisational Factors were the dominant contributory factor for SI's in North Central, specifically: limited resource availability due to a period of high demand, poor staffing levels in EOC, and the challenges faced with our current fleet profile whereby the ratio of Fast Response Units (FRU) to Double Crewed Ambulances (DCA) does not align to the new national ambulance standards.
In addition, a failure to follow policy and procedure was a contributory factor in one SI where the staff did not use the defibrillator in AED mode, resulting in a delay to defibrillate Ventricular Fibrillation (VF). It was also found that poor communication between the staff on scene also contributed to the management of the cardiac arrest.



There was one SI declared in the North central sector for the quarter.

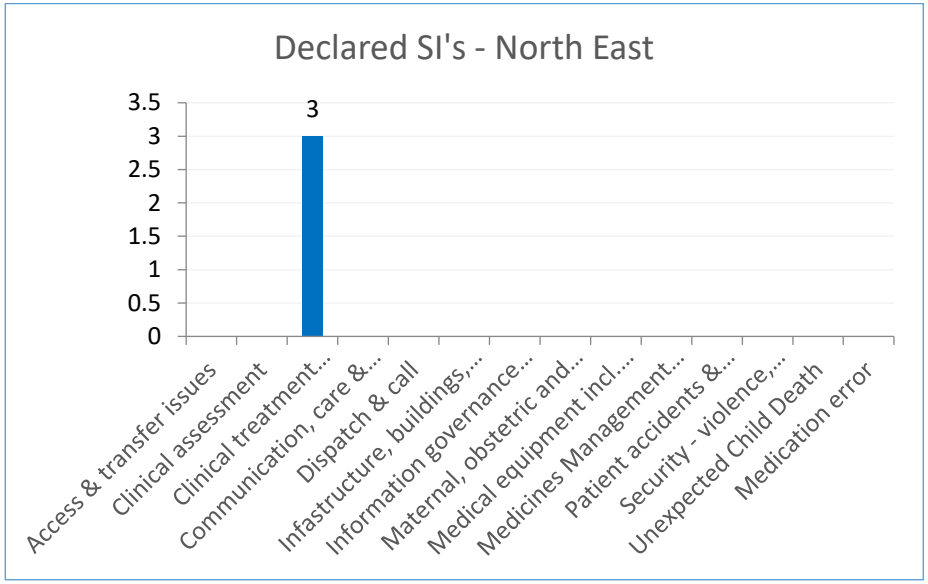
This SI relates to a delay to defibrillate a patient in a timely manner. It is currently being investigated by the Trust, the findings of which will be shared upon closure by the CCG. It should be noted that a number of actions have been undertaken by the Trust to mitigate the risk of further occurrence. A detailed action plan has been shared with the CCG who have communicated their confidence in the Trust oversight of this specific risk.

North East



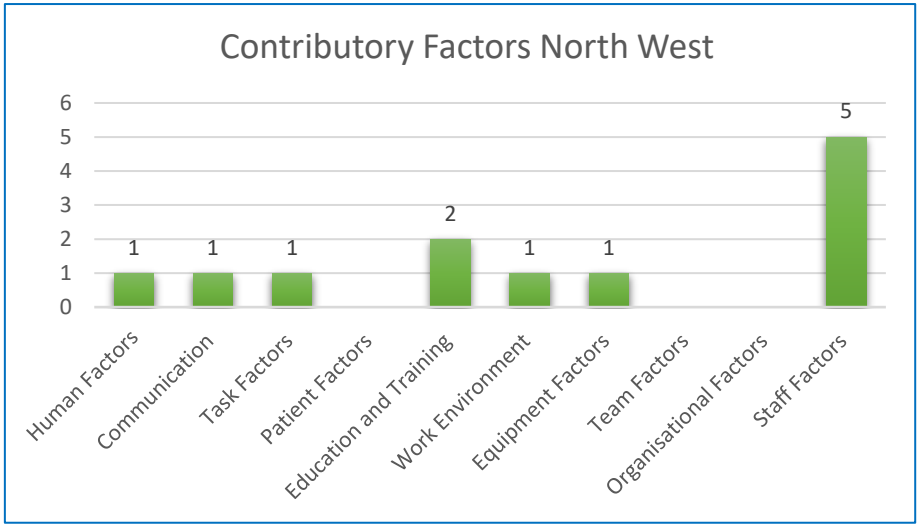
Staff Factors were the dominant contributory factor for SI's in North East.

One SI investigation was completed and submitted to the CCG from the North East sector during Q1, which concerned the case of a child who sadly died from asthma. There was some learning to support our dispatch and call training, as call taking staff had limited understanding of the seriousness and potential fatal consequences of asthma.



Of the three SI's declared in the North East, one relates to an apparent failure to adequately manage the airway of a patient in cardiac arrest - specifically the use of laryngoscopy to visualise a foreign body obstruction. In another case, a paramedic failed to follow Trust policy regarding primacy of care.
All incidents are currently under investigation with one also being investigated alongside the Trust Disciplinary Policy.

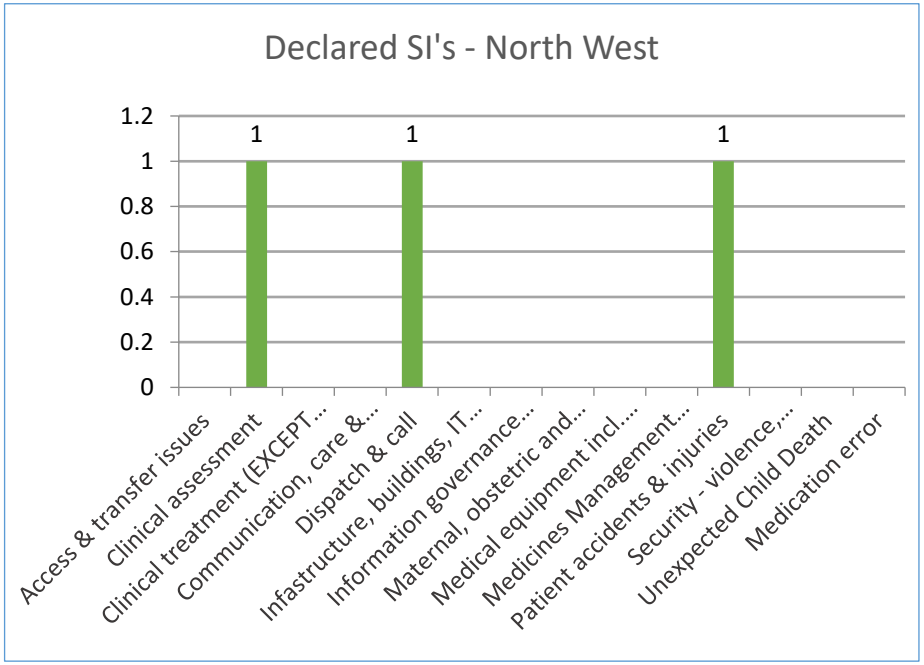
North West



Of the three serious incident investigations that took place in the North West, staff factors were highlighted to be the main influence to the root cause. Confirmation bias featured in several reports whereby staff did not appreciate the potential differential diagnoses of symptoms patients had experienced before, for example musculoskeletal pain vs atraumatic chest pain.

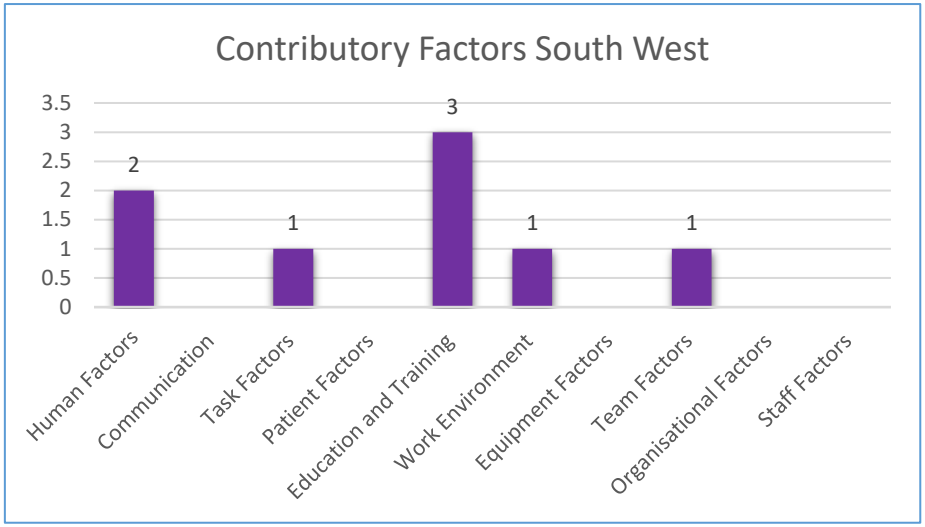
Two of the incidents were attributed to delays on scene and factors included equipment factors (lack of resources)

Education and training also featured as a theme for example; a patient with a particularly difficult airway that is rarely encountered, quickly deteriorated and this proved challenging for the attending staff to manage.



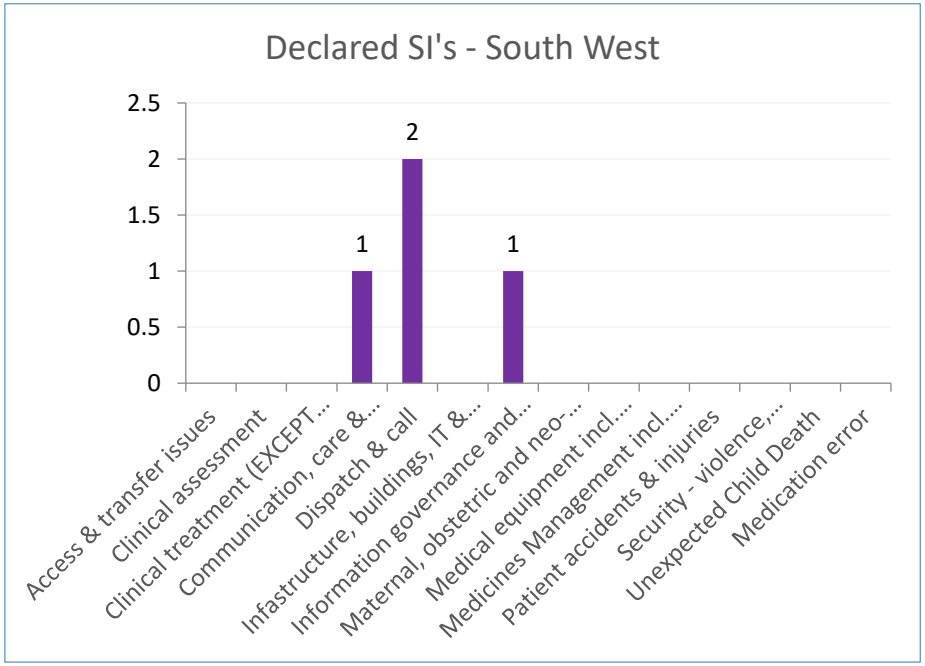
Of the three SI's declared in the North West, one was identified as a Never Event by the Trust and was declared immediately upon receipt of the incident report. In this incident, a patient fell from the seat of a moving ambulance and sustained an injury.
In another case a complaint received by the Trust highlighted an incident whereby a patient who had fallen was not immobilised pending further assessment and investigation in the Emergency Department.
The other case relates to a delayed response.

South West



The prevailing contributory factors identified for serious incidents in the South West sector were Education and Training Factors and Human Factors.

As with a number of other SI's, common contributory factors were identified including staffing levels, policies that required modification to reflect current practice and matching the transport vehicle with the clinical condition of the patient. An example where Human factors were cited as a contributory factor was where staff collectively failed to confirm the reading on a monitor.

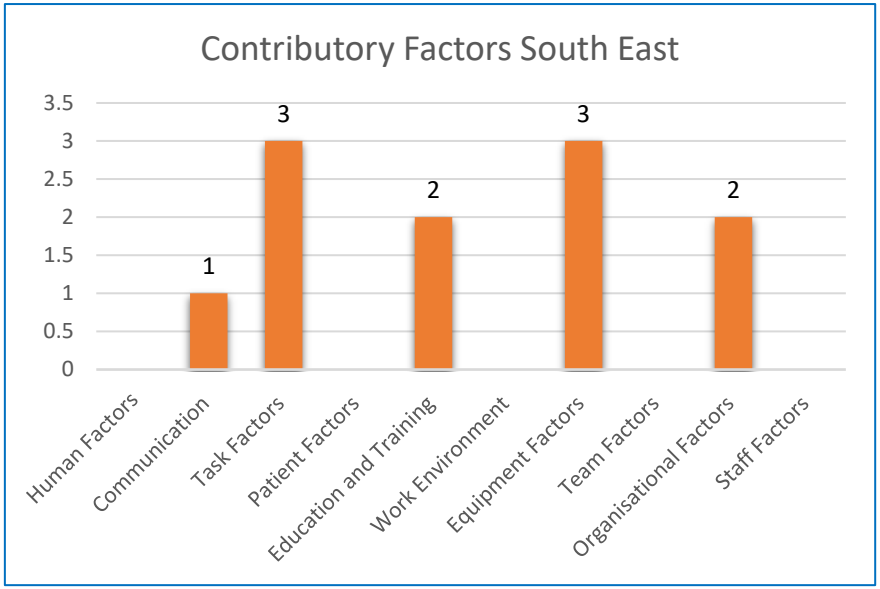


Four SI's were declared in the South West in Q1. Two cases relate to a delayed response, which on first review, appears to be due to a lack of resource availability.

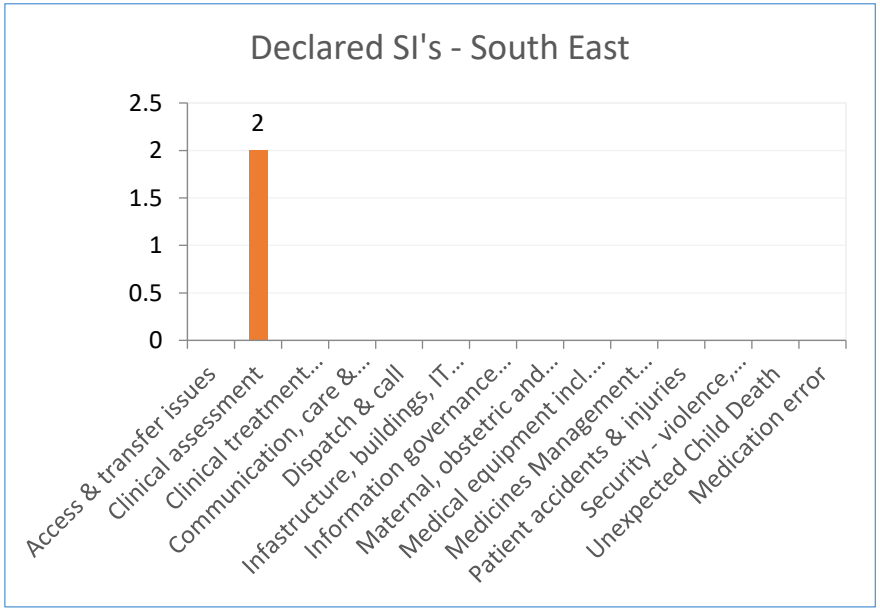
One case relates to the management of an unplanned home birth where poor communication and task factors appear to have been a contributory factor.

In another case, six Patient Report Forms (PRFs) were discovered to be missing upon routine daily audit. Shortly after the discovery a member of the public approached the station with the missing PRFs stating they were found in the street. This case has also been declared to the Information Commissioners Office.

South East

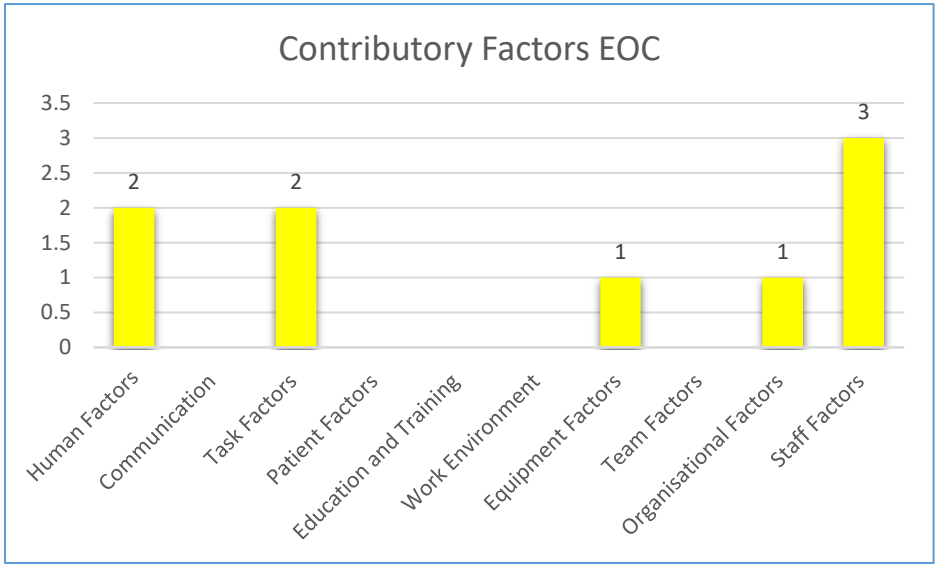


Both Task Factors and Equipment factors are the key contributory factors for incidents in the South East sector, followed closely by Operational and Education & Training Factors.
All equipment factors pertain to the same incident where two different defibrillators were used during the management of a cardiac arrest. The differing modes of operation and confusion as to which mode (manual vs automatic) the devices were in led to a delay in defibrillation. It was also believed the amplitude of VF displayed on the screen differed from the printout. This has been referred to the device manufacturer for comment.
The organisational factor in one case has been highlighted on a number of occasions and is believed to be related to the new national ambulance standards and the response provided to patients with chest pain. In order to mitigate the risk, the Trust implemented a change within the dispatch system in order to provide a timely

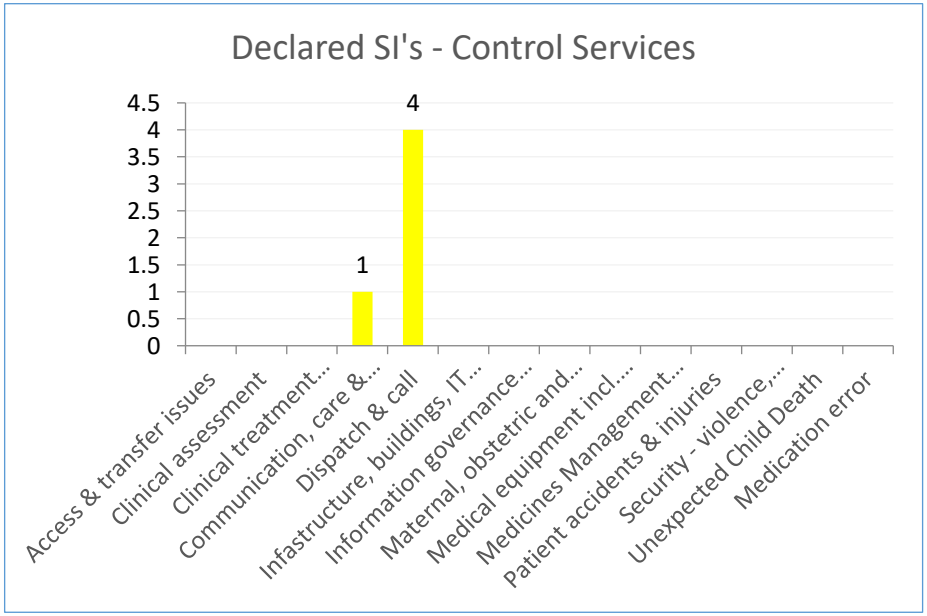


Two SI's were declared in the South East in Q1 both of which relate to the clinical assessment of patients.
In one case, an unwell child with a chronic condition was not conveyed to hospital as they had an appointment with their usual physician the following day. They deteriorated and required admission to intensive care. This case was brought to the attention of the Trust in the form of a Health Partner Alert from the admitting hospital.
The other case relates to the referral of a 999 call to NHS 111 for further assessment but which subsequently represented to the Trust with the attending staff identifying the patient was critically unwell.

Control Services



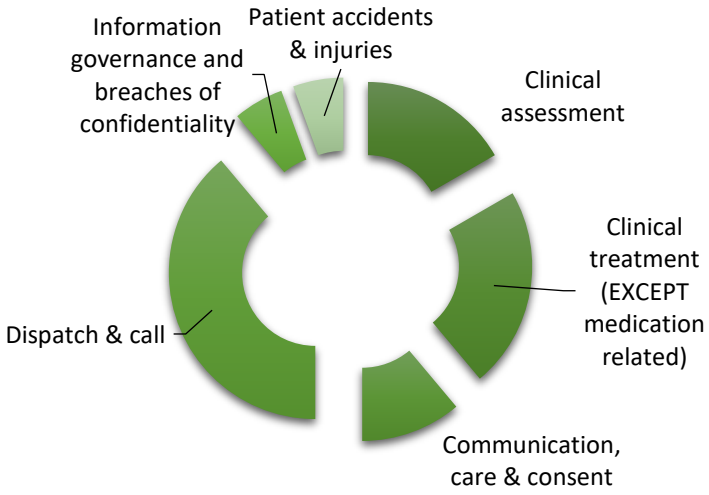
They key contributory factor identified for EOC is Staff Factors, followed by Human Factors and Task Factors.
An emerging theme was identified in a number of cases pertaining to the use of pre-triage in order to establish the nature of the call. In response to this a detailed educational video is being produced for new and existing EOC staff providing further guidance on ineffective breathing.
Task Factors continue to be a common theme in the root cause of an incident. All investigations noted a lack of operational resources with which to send assistance and/or too few staff to check on the patient's welfare whilst awaiting the dispatch of a resource.



Five SI's were declared in Control Services for Q1. Of these call management, delayed dispatch and failure to follow correct process were common themes.
One case relates to an information processing failure by the Emergency Bed Service whereby a number of patient referrals were significantly delayed following the use of an email address that was no longer in use.

Overarching Serious Incident Themes

13. The incident theme(s) for the quarter:

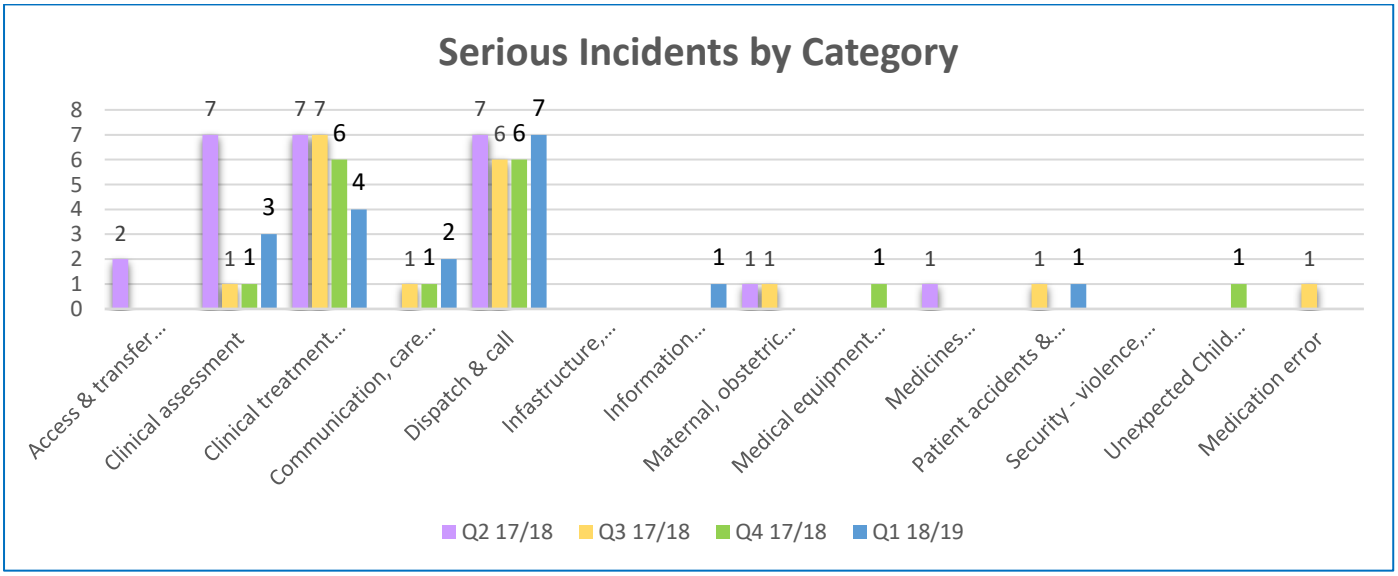


Noted changes in incident theme for the quarter

14. Following on from the previous thematic review there has been a further reduction in clinical treatment errors from Q4 (n=6) to Q1 (n=4). However, dispatch and call handling errors has increased slightly (n=1).

Category	Q3	Q4	Q1
Dispatch and Call	6	6	7
Clinical Treatment	7	6	4

15. The main incident categories identified during Q1 18/19 remain consistent the thematic reviews for Q2, Q3 and Q4 (17/18):

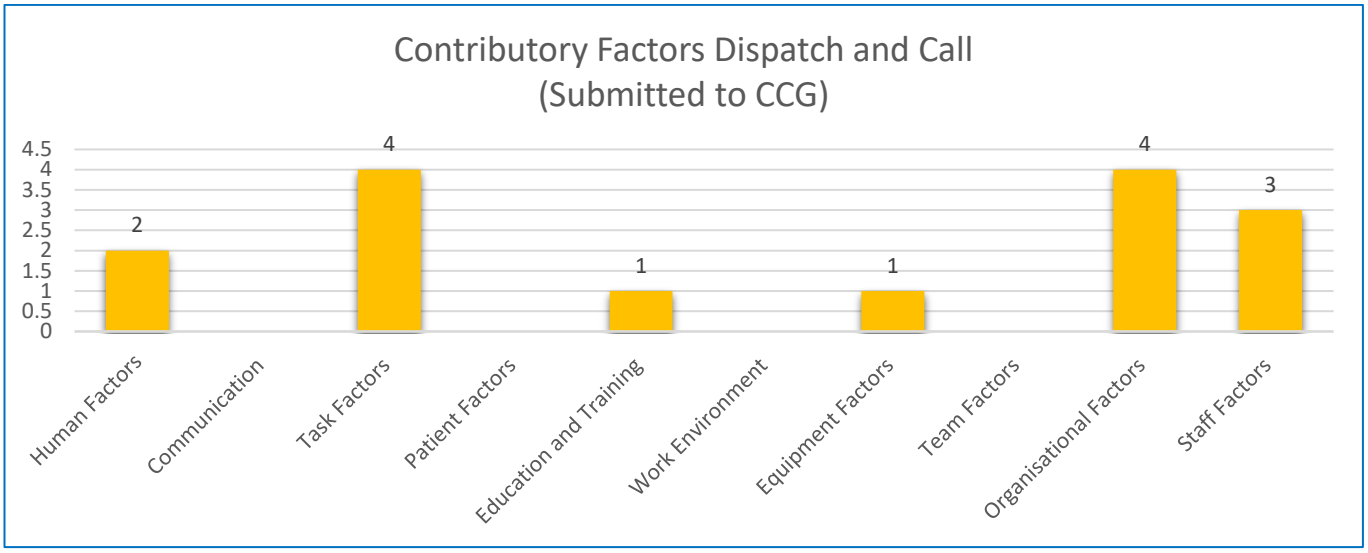


Review of key incident themes

Dispatch and Call

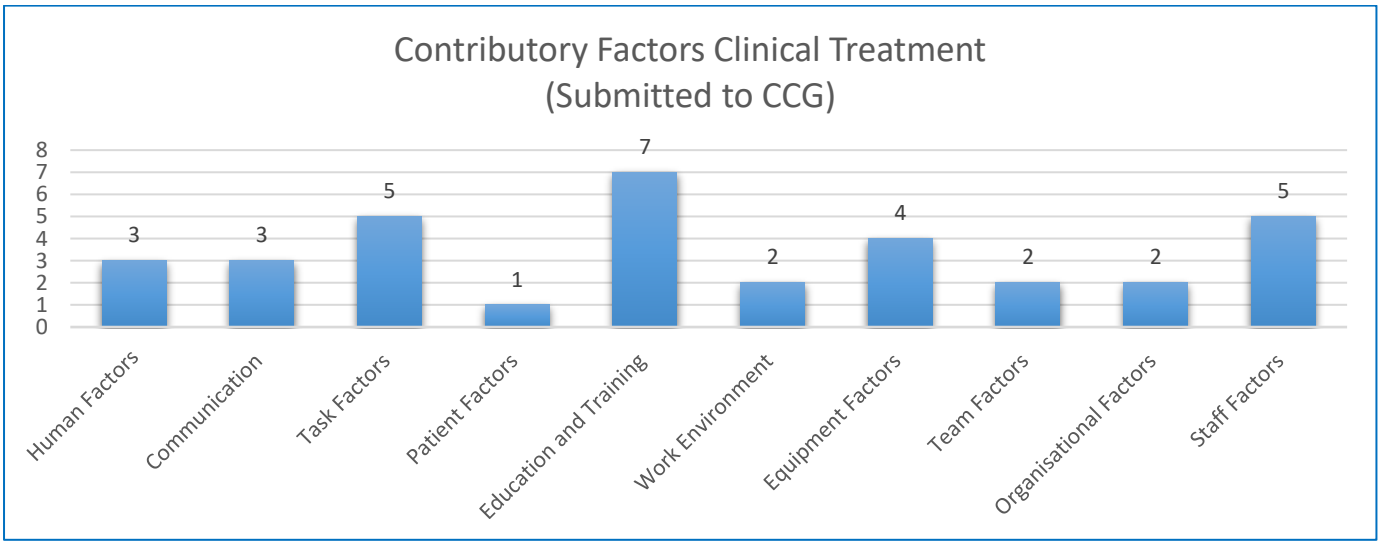
16. A review of the contributory factors that have influenced the root cause of incidents relating to dispatching resources and managing 999 calls highlighted mainly education and training along with staff factors. Failure to follow Trust issued guidance and confusion regarding the pre-triage of emergency calls (specifically the descriptors of ineffective breathing in MPDS vs the varying different phrases used by callers) are key themes in incident investigations.

17. Additional issues related to service demand include the current resourcing model not aligning with ARP and issues managing complex 999 calls continue to cause concern, along with staffing levels.



Clinical Treatment Issues

18. Of the five SI investigations undertaken relating to clinical treatment errors, a review of the contributory factors showed that issues relating to staff factors, education and training and patient factors (condition more complex than originally identified) were considered to have contributed to the root cause of the incidents.



Staff Factors

19. Issues relating to staff factors typically included:

- Cognitive Factors

20. Of those identified as relating to staff, eight were around cognitive factors – perception and mind-set – including working as part of a group and sharing the group conformational biases, and situational awareness.

    Example: A crew failed to recognise VF and the investigation identified that the scene had been chaotic, the airway had been difficult to manage, cannulating the patient had proved problematic and there had been poor communication between team members. The environment was wet and cold, in a public space with many bystanders. The crew failed to put the LP15 into automatic mode and, in relying on their own timing to properly conduct ALS, lost track of time and focus on checking the rhythm.

Education and Training

21. Issues relating to education and training typically included:

- Lack of experience in the clinical condition

    Example: A nine year old child collapsed with a severe asthma attack and in triaging the call, the call-taker failed to appreciate how dangerous this condition is. Training will look at increasing familiarity with asthma and breath sounds.

Work Environment

22. The work environment factor now encompasses issues such as lack of staff and poor skill mix, as well as work load/hours of work in line with the NPSA framework.

23. Example: In some instances, protocol based call-backs from the CHUB did not happen for Cat 3 delayed calls due to staffing issues.

Horizon Scanning

24. This quarter saw the publication of a number of reports of interest to the Service:
    - Professional Standards Authority report into the Nursing and Midwifery Council's failure to act on complaints and concerns raised around Furness General Hospital
    - Williams Rapid Review of Gross Negligence Manslaughter in Healthcare
    - Gosport War Memorial Hospital report

25. Copies of these are available from the QGA Team.

Conclusion

26. The key contributory factors identified for Q1 2018/19 across the Trust are:
    - Staff Factors
    - Education and Training Factors
    - Task Factors

27. The key contributory factors identified by sector are:

Sector	Contributory Factors for Q1 2018/19
North Central Sector	Organisational Factors
North East Sector	Staff Factors
North West Sector	Staff Factors
South West Sector	Education and Training Factors and Human Factors
South East Sector	Task Factors and Equipment Factors
Emergency Operations Centre	Staff Factors, Task Factors and Human Factors

28. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the Serious Incident Group and assurance processes, and are now actively working on disseminating learning from incidents by a number of methods across the organisation. The sector Quality, Governance and Assurance Managers will lead on addressing key areas within their sectors as part of their local governance processes.
29. We have evidenced that interventions identified from themes from pervious investigations have been used to influence change within the organisation, namely the dispatch profile for particular MPDS determinants.

30. We continue to maintain our target of 60 working days to submit completed SI investigations. SI action plan compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required.

Trisha Bain
Chief Quality Officer

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Preparing to meet national performance standards			
Agenda item:	13			
Report Author(s):	Brian Jordan, Business Manager to the Director of Operations Leanne Smith, Head of Forecasting and Planning			
Presented by:	Paul Woodrow, Director of Operations			
History:	Not applicable			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

As the Trust Board is aware, the Ambulance Response Programme (ARP) was implemented on 1 November 2017 and, at that time, new national performance standards were introduced (attached at Appendix A for ease of reference). Since then, Ambulance Trusts have been given time to adapt their operating model to the new ARP system. NHS England has however set an expectation that Ambulance Trusts should be meeting each of the performance standards by 1 October 2018.

The purpose of this paper is to therefore remind the Board of the Trust's performance since the implementation of ARP and to review our performance forecasts at October 2018 and over the remainder of 2018/19. The paper also sets out the number of projects/initiatives which are being undertaken across the Trust, and with our external partners, to strengthen and protect performance against the national standards and maintain patient safety.

Recommendation(s):

The Board is asked to note the content of the paper.

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	☒

Preparing to meet national performance standards

1. As the Trust Board is aware, the Ambulance Response Programme (ARP) was implemented on 1 November 2017 and, at that time, new national performance standards were introduced (attached at Appendix A for ease of reference). Since then, Ambulance Trusts have been given time to adapt their operating model to the new ARP system. NHS England has however set an expectation that Ambulance Trusts should be meeting each of the performance standards by 1 October 2018.

2. The purpose of this paper is to therefore remind the Board of the Trust's performance since the implementation of ARP and to review our performance forecasts at October 2018 and over the remainder of 2018/19. The paper also sets out the number of projects/initiatives which are being undertaken across the Trust, and with our external partners, to strengthen and protect performance against the national standards and maintain patient safety.

3. National oversight of our preparations to meet national performance standards is being managed through NHS England's Ambulance Integration Programme (AIP). The AIP is accountable to the Ambulance Improvement Programme Board and will take responsibility for the oversight of progress towards meeting the ARP performance and clinical standards and progress against reducing unnecessary conveyances to emergency departments. Our regional NHS England and NHS Improvement partners are due to report to the AIP on the Trust's progress in September 2018 and therefore the content of this paper will be used to inform their national update.

Performance to date against national standards

4. The Trust has performed reasonably well against the new national performance standards since the implementation of ARP. This is despite the 2017/18 extended winter pressures which were experienced across the healthcare system in London, and which included high volumes of influenza and norovirus as well as sustained periods of low temperatures and adverse weather. This summer's performance has also been markedly challenged due to the consistent hot weather and a significant number of large scale events which have taken place affecting demand across the capital. This has included events related to the national football team progressing to the final stages of the World Cup.

5. The recent ending of overtime disruption payments has started to impact on our weekend staffing although it is anticipated that this is a temporary effect and the Trust will see the return of overtime to previous levels in due course.

6. The Category 1 90th Centile has remained well within the 15 minute standard each month since the implementation of ARP and shows that our most critical patients are being responded to quickly. The nationally published performance data has consistently shown the Trust ranked second in the Category 1 90th Centile measure each month.

7. Despite this, there are challenges with routinely achieving the standards for Category 1, Category 2 and Category 3 incidents and the Trust is using the growing data which it has collected since 'go live' to understand the nuances of the new system.

8. It should also be noted that the historic and forecasted performance reported by the Trust, and mentioned throughout this paper, is subject to change. The Trust does not currently foresee being able to fully implement all national ambulance quality indicator (AQI) standards by October 2018 and the underlying logic for some of the AQIs is yet to

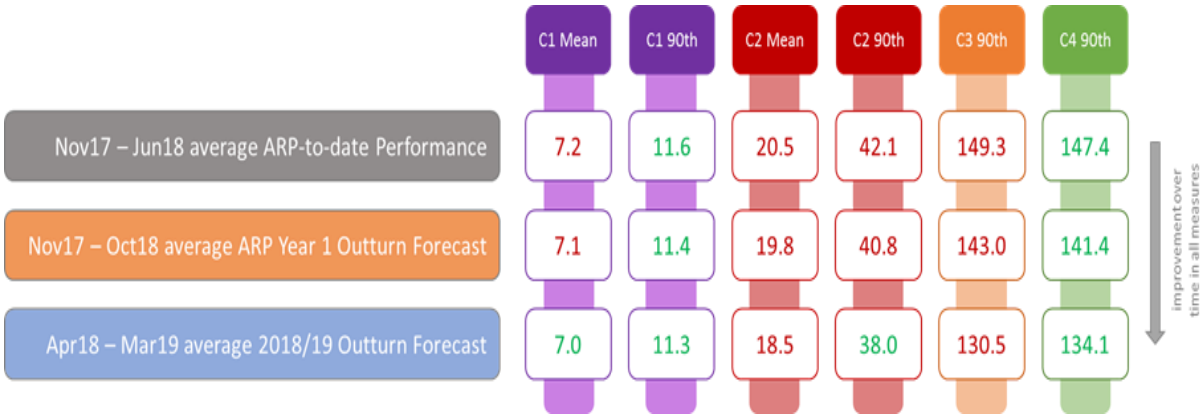
be verified. Technical solutions within the computer aided dispatch (CAD) software system and Trust data storage facilities are already being sought for:

- Changes to the re-categorisation process for calls
- Calculating response time for patients arriving on inbound flights at London airports
- The introduction of Category 5.

Performance Projections – 2018/2019

9. The Trust's Forecasting and Planning Department has forecasted the performance outturn for the 2018/19 financial year. They have concluded that the Trust can expect to see a continued improvement in performance over time as the Trust adapts to the requirements of ARP and strengthens its position. This is supported by the modelling which has been conducted to predict both ARP year 1 outturn and 2018/19 outturn, using the eight months of data obtained so far.

10. The graphic below shows the Trust's performance ARP-to-date, the expectation for October 2018 and the full expected 2018/19 performance outturn. The results quoted are response time performance in minutes (RAG rated against their targets), showing that by October 2018, two of the six performance metrics will meet the national standards, increasing to four by March 2019 with the remaining two only slightly off target.



11. A fuller graphical representation of the actual and forecasted performance over time for each Category is provided at Appendix B.

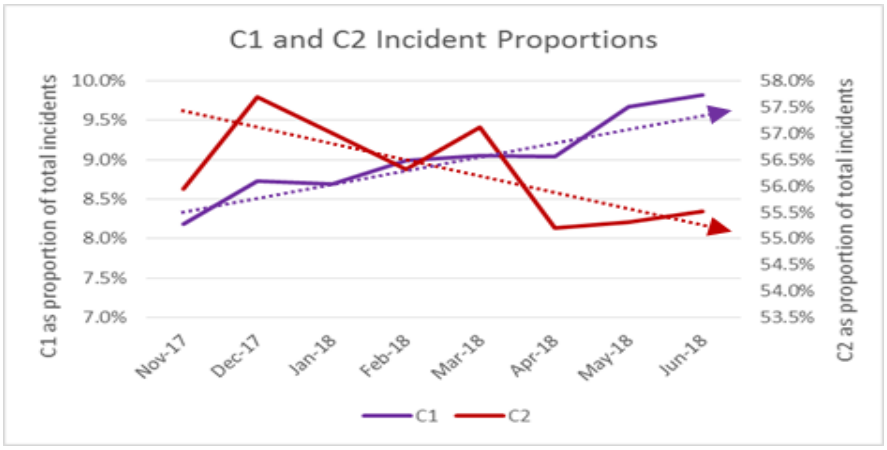
12. In summary, our initial prediction for 2018/19 outturn, based on ARP year-to-date, is:

- Category 1 and 2 mean will remain close to the national standards
- Category 1, 2 and 4 90th Centiles will be within target
- Category 2 mean will begin to more consistently meet the national standard from October 2018
- Category 3 90th percentile will also be near the 120 minute target in October 2018
- Bringing Category 3 90th Centile within target will continue to be an area of challenge
- Given the pressures of winter, it is anticipated that both Category 2 and Category 3 will see a rise in response times again from December 2018, slightly affecting the overall 12 month averages.

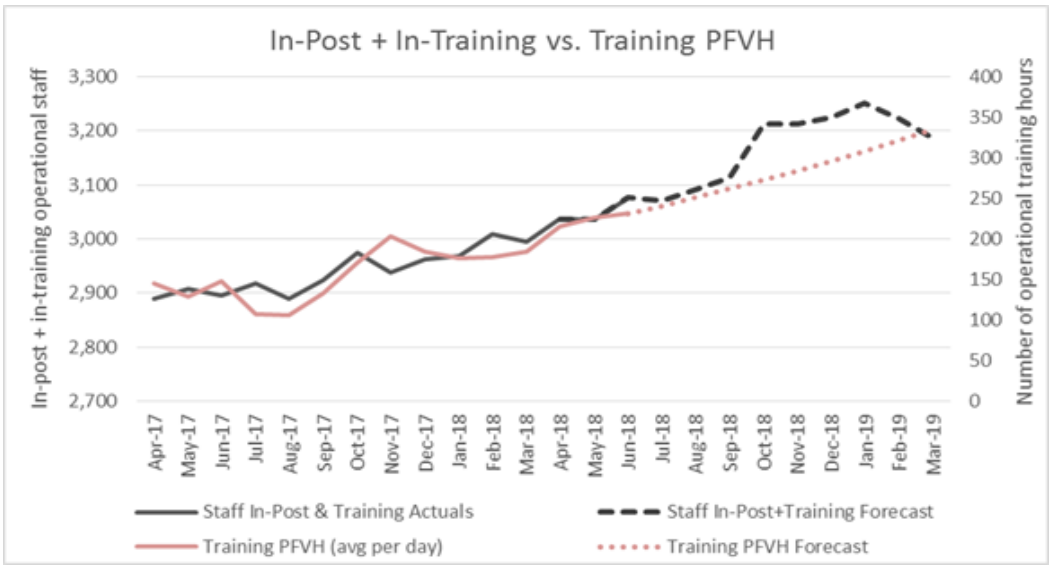
13. As for the ARP year 1 outturn (i.e. the Trust position come October 2018, after the first full 12 months since ARP implementation), we see improvement on the current year-to-date average performance which suggests that, in the coming months (from July 2018), performance is expected to be less challenged than earlier this year and during the winter months.

14. The models used to generate these performance predictions are built on: an incident forecast for the year; predicted capacity levels – more explicitly Patient Facing Vehicle Hour (PFVH) levels; and an expected seasonal job cycle time (JCT) profile.

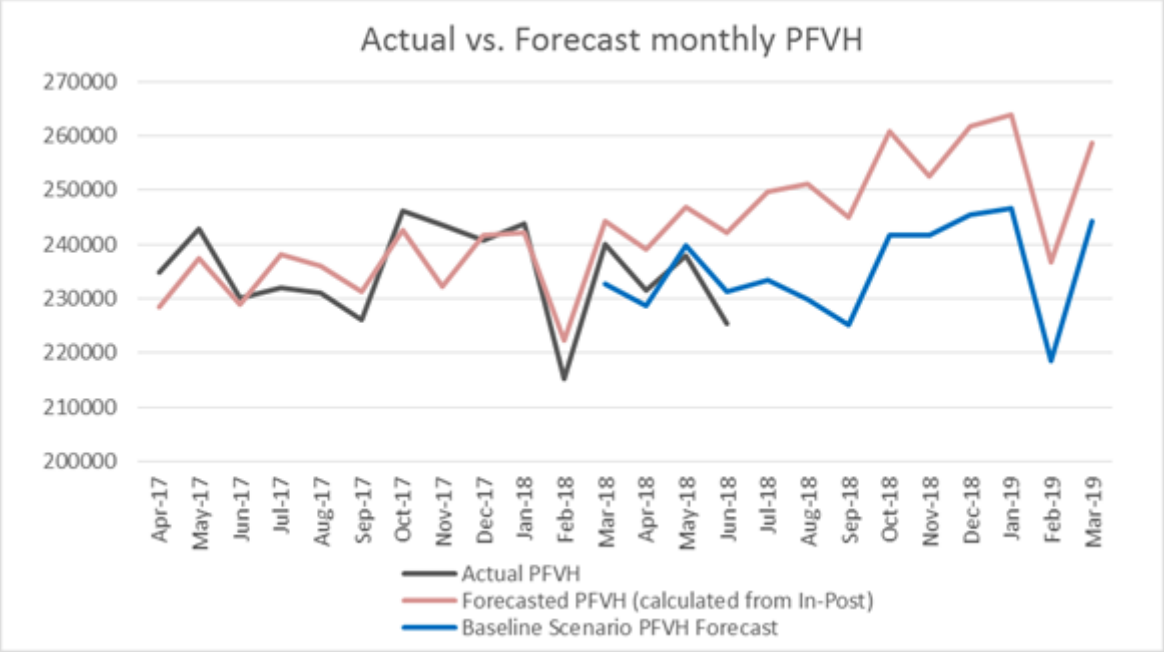
15. It should also be noted that Category 1 activity has far exceeded national and local forecasts, and has been growing at a fast rate. At ARP go-live in November 2017, Category 1 was approximately 8% of overall incident volume while in June 2018 it had risen to almost 10%.



16. The Trust's establishment position has been improving with more staff in-post and in-training this year compared to last, and is growing at a steady rate. This pattern is mirrored in the amount of total PFVHs made up by training crews. The in-post forecasts generated by the Workforce Analytics team reflects the expected number of joiners and leavers each month over the coming year, UK graduates becoming qualified, and considers the Trust's education timeframes and schedules.



17. It is possible to use the recruitment profile for the purposes of forecasting ahead PFVH by converting in-post and in-training staff into operational people hours, and people hours into vehicle hours through a defined set of logic. This method produces a PFVH forecast similar to the actual trend witnessed in 2017/18, however, shows a gap against actual levels in recent months. While there is an increasing number of staff in-post compared with 2017/18, the uptake of overtime has been down on average by 1000 hours per week since April 2018. Contributing factors to the diverging trend between in-post staff and PFVH trends could be the reduction of overtime incentives this financial year, and the fact that relief is currently required at a higher rate than the level built into the rotas.



18. One alternative to using the recruitment pipeline to create the 2018/19 PFVH forecasts – as has been used in the performance modelling within this paper – is to assume a similar level of annual PFVHs to those produced in 2017/18 with a typical seasonal profile. If the uptake of overtime remains low this could become a reality despite an improving establishment position. It is however expected that the Trust will target its reduced overtime incentive budget to the more pressured winter months. The Trust is also expecting an intake of UK graduate paramedics during September and October in line with the completion of university courses which will also strengthen the staffing figures from November 2018 onwards.

Performance improvement measures

19. There are a number of projects and interventions which are currently being undertaken internally, and with external partners, in order to improve operational performance and efficiencies. Some key examples included within this paper are as follows:

- Reduction in conveyance rates
- Changes following the ARP Spring Review and to Ambulance Quality Indicators
- Reducing Out of Service
- Roster review
- Vehicle requirements
- Tier points
- Category 1 Improvements (including Signals from Noise)

- Hospital handover delays
- London Urgent and Emergency Co-ordination Centre
- Review of intelligent conveyance

Reduction in conveyance rates

20. The Trust has planned to reduce unnecessary ambulance conveyances to emergency departments by 1% in 2018/19. This will be achieved by:

    - The introduction of Advanced Paramedic Practitioners (Urgent Care)
    - The introduction of mobile devices, particularly iPads, to improve access to alternative care pathways (ACPs) and clinical guidance
    - Increased usage of alternative care pathways (ACPs) where these are available
    - Developing ACPs in partnership with commissioners
    - Holding a workshop with senior operational managers to identify the current barriers to increasing see and treat rates and by identifying a number of 'quick win' solutions
    - Ensuring frontline staff are pro-actively contacting, and being supported by, the clinical hub in order to increase see and treat rates. The Trust is also exploring the set-up of additional clinical hubs in Croydon and in the North West sector.

21. Changes in conveyance rate can be expressed in the performance forecasting model by changes to JCT. Reducing conveyance rates by 1-2% would yield a change in JCT of around 10-20 seconds which provides the following impact:

    - Improving Category 1 Mean performance by just a few seconds
    - Improving Category 2 Mean performance by 5 – 10 seconds
    - Improving Category 2 90th Centile by 5 – 20 seconds
    - Improving Category 3 90th Centile by 30 – 80 seconds
    - Improving Category 4 90th Centile by 120 – 150 seconds

22. Over a sustained period of time (e.g. if conveyance improvements were achieved from July 2018 onwards), this could positively impact on the average performance predictions in all four categories for 2018/19 outturn.

Changes following the ARP Spring Review and to Ambulance Quality Indicators

23. From a review of ARP locally and nationally, the 'Dangerous Haemorrhage Medical Bleed' determinant has been agreed to be classified at a lower acuity than originally deemed necessary. Although it is unclear the impact the change in triage to these patients will have on the Category 1 response time performance for the Trust, we can model the change in volume from Category 1 to Category 2. This equates to a reduction in Category 1 volumes by nearly 8% and a resulting increase in Category 2 volumes by just over 1%. The overall impact is expected to improve Category 1 response times but during modelling has demonstrated a small negative effect on Category 2 mean response performance (of less than 1 minute overall) due to the increased volume.

Reducing Out of Service

24. A dedicated project has been established to reduce the Trust's 'out of service' levels. This project is focused on a number of the issues which result in 'out of service' including the cleaning of ambulances; the changing of uniforms; the completion of child

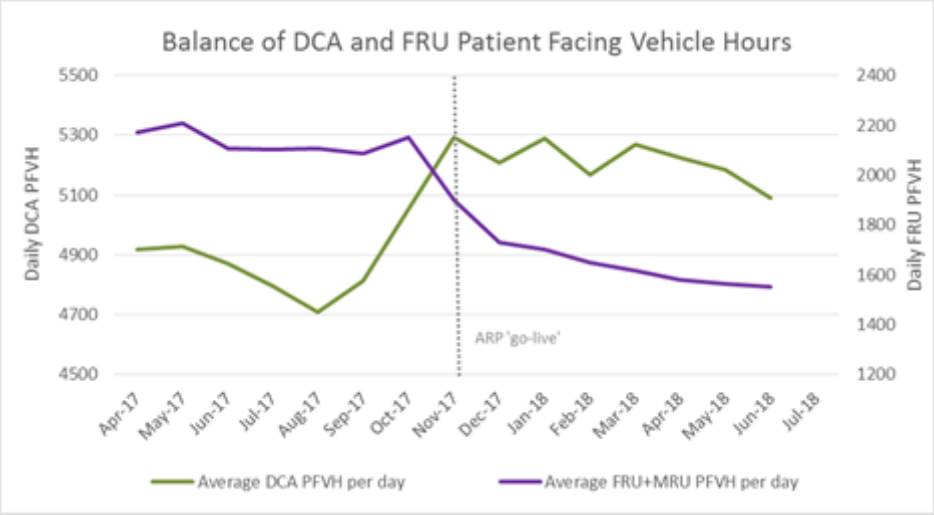
protection/vulnerable adults' reports; refuelling; and delays which arise from awaiting for vehicles.

Roster review

25. To ensure that the Trust has the right mix of double crewed ambulances (DCAs) and fast response units (FRUs), along with the requisite number of staff hours in the right place at the right time, the Trust is currently developing new operational rota patterns to deliver the new operating model collaboratively with frontline staff and trade unions. The roster review team are currently working with frontline operational staff to design the new roster patterns which will go live across all 18 station groups in February 2019.

Vehicle requirements

26. The Trust has known for some time that it requires fewer FRUs in the operating model to meet the new standards. This was pre-empted before ARP 'go-live' with an effort to step-up DCA levels from October 2017, as well as on an on-going basis sequentially reducing FRU hours to put additional DCA hours in to the plan to manage Category 2 activity.



27. Operations is working closely with the Trust's fleet team to scope the revised requirements in terms of physical numbers of DCAs to service the new model. Further to this we are scoping the requirements of an intermediate size vehicle that will allow us to deliver greater levels of see and treat, and reductions in emergency department conveyance, through the development of Paramedic practitioners. These resources will assist in creating further operational capacity for our DCA provision to enhance our response to Category 2 patients who require conveyance for definitive treatment.

28. The Department of Health and Social Care confirmed in July 2018 that the Trust will receive an additional £3.849m this year for 25 new ambulances which will arrive in the last quarter of 2018/19.

Tier points

29. The Trust needs to ensure that a higher number of our FRUs are activated from our dedicated tier points across London and that our FRUs should only be used for Category 1 calls and a small sub-section of Category 2 calls. This efficiency measure

has been included on the Operations balanced scorecard to ensure compliance with this measure.

Category 1 Improvements (including Signals from Noise)

30. The senior Operations team has established a Category 1 improvement group. This group is working with new technology called Signals from Noise which provides a comprehensive view (via statistical process control charts) of every component of the Category 1 process from end to end and the timings associated with each part of the process to drive improvement. At the present time this work is focused on call handling and triage processes which we believe has the potential to improve our current Category 1 mean performance by 42 seconds.

Working in partnership to improve performance

Hospital handover delays

31. Significant progress was made in reducing hospital handover delays last winter. A comparison between 1 October – 9 February 2016/17 and 2017/18 showed that there had been a 31% reduction in the number of 60 minute breaches and a 14.7% reduction in the time lost to handovers over 15 minutes.

32. NHS England and NHS Improvement are working with Acute Trusts to reduce the 60 minute patient handover standard to 30 minutes. In recent months, hospital handovers have been further improving however in May and June 2018 for (all non-blue) hospital handovers at London emergency departments, the total number of hours lost above 30 minutes was 2,080. Assuming the proposed 30 minute target was able to be achieved, this suggests approximately 230 hours per week could be instead used for responding and treating at scene. Modelling this assumption for the remainder of 2018/19 to predict outturn suggests a performance forecast improvement of:

    - 6 seconds for Category 1 Mean and 90th Centile performance
    - 10-30 seconds for Category 2 Mean and 90th Centile performance
    - Over 1 minute for Category 3 90th Centile performance
    - Just under 3 minutes for Category 4 90th Centile performance

London Urgent and Emergency Co-ordination Centre

33. The Trust is currently working in partnership with colleagues from NHS England and NHS Improvement on the national requirement for each region to have an Urgent and Emergency Care Co-ordination Centre. The function of the co-ordination centre is to provide a real time view of the resilience of the London health system and current levels of performance. The function extends to identifying early warning signs of systems facing escalating pressure. When this happens the co-ordination centre will work to ensure that appropriate action is taken.

34. The co-ordination centre is headed by the NHS England and NHS Improvement jointly appointed Director of Urgent and Emergency Care. As such there may also be activities expected of the co-ordination centre which focus on co-ordinating consistency of operating practice across London in the urgent and emergency care system.

35. The focus, and therefore resource requirements, of the co-ordination centre will be responsive to pressures and challenges in the system. As such, the centre's capacity

and out of hours offering will be increased over winter compared to core function in summer months.

Review of intelligent conveyance

36. Intelligent conveyance is a function which helps to reduce the surge impact of ambulance arrivals at emergency departments across London during peak hours by monitoring the flow of ambulances and utilising suitable alternative locations when available. The Trust is currently working in partnership with colleagues from NHS England and NHS Improvement to review the current thresholds for London emergency departments and is engaging with London Sustainability and Transformational Partnerships (STPs) on all aspects of the function.

Improved performance over time

37. The rolling performance picture below shows that there is fairly steady improvement over time in all categories, due in part to the assumed improving capacity picture, and the fact that the Trust will have adapted its fleet and skill mix to better deal with ARP and will therefore be in a stronger position this winter compared to last (assuming that this year's winter sees growth comparable to 2017/18 on 2018/19).

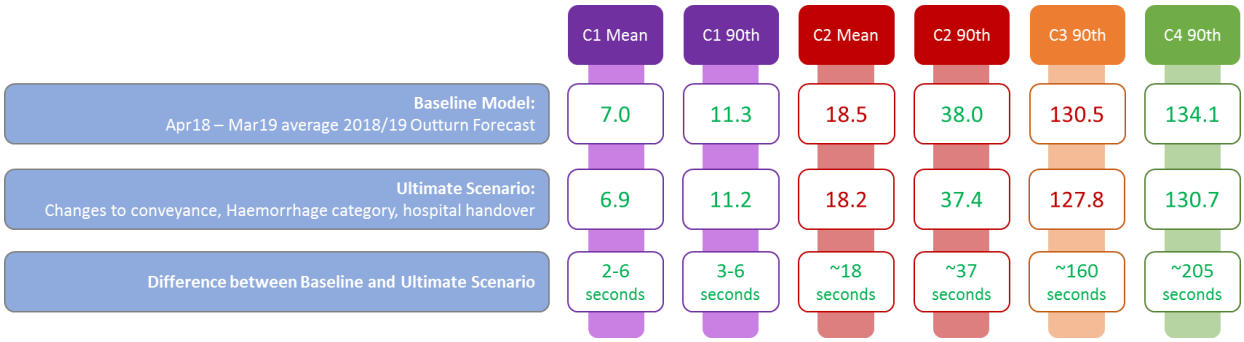
38. The baseline scenarios do not yet predict us meeting the national standards in all metrics by the end of March 2019 however the two measures which will be above target (Category 2 mean and Category 3 90th percentile) will still be fairly close.

Key points to note:

- The 12-month rolling average (using 52 week rolling forecasts) for Category 1 mean will gradually improve from a starting position of average 7.1 minutes in October 2018, decreasing down to 7.0 minutes by March 2019.
- Category 2 90th percentile rolling average will cross below the target level in January 2019.
- Category 2 mean and Category 3 90th percentile prove to remain a challenge over the next 9 months, although do show steady improvement.
- Category 1 90th percentile and Category 4 90th percentile are already, and will remain consistently below the target levels according to the forecasts.

39. Using the performance forecast model, it is possible to model an ultimate scenario, whereby we use the baseline forecasts as above, and include estimates for some of the Trust's improvement initiatives mentioned in the earlier sections of this paper. The following results are for a 2018/19 outturn scenario which assumes from July 2018 onwards, the Trust will see:

- A 1% improvement in conveyance, meaning an improvement in modelled JCT
- A change to the Haemorrhage card as proposed by the ARP Spring Review, meaning a reduction in Category 1 volumes by 8%, but a negative impact on Category 2 performance due to an increase in its volume by 1%
- A further reduction in hospital handover delays, delivering an additional 230 PFVH per week on average.



40. Again, this forecast shows improvement in all metrics and a set of performance measures which are consistently below or very close to target come March 2019. It should however be noted that some of the logic changes which are expected to be implemented to the way the Trust reports against the AQIs (mentioned earlier) will further affect this position and, in some cases, may be backdated for historic performance data.

Next steps

41. The new Category 3 mean standard, which has been introduced following the ARP Spring Review, will need to be forecasted so that the Trust can understand the impact of its improvement initiatives on this group of lower priority incidents.

42. The new senior operational management structure is scheduled to be implemented by September 2018. The Head of Emergency Care Services will be tasked, on appointment, with implementing the cross-directorate performance improvement plan. In the meantime, the Director of Operations will continue to chair a monthly ARP programme board in order to drive progress against the challenges and issues which have been identified and detailed within this Trust Board update. The programme board is further supported internally by a weekly ARP delivery board.

43. Further scrutiny of performance against national standards, and the efficiency measures required to deliver against the standards, will take place at the monthly Chief Executive performance review meetings.

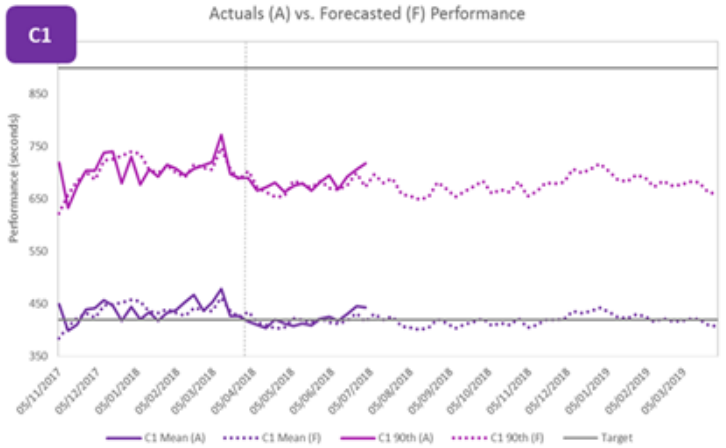
44. Progress reports will continue to be provided routinely to the Executive Leadership Team and to the Trust Board.

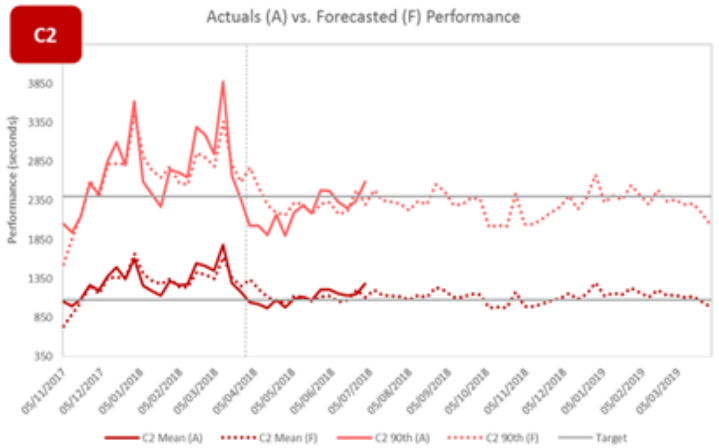
Paul Woodrow
Director of Operations

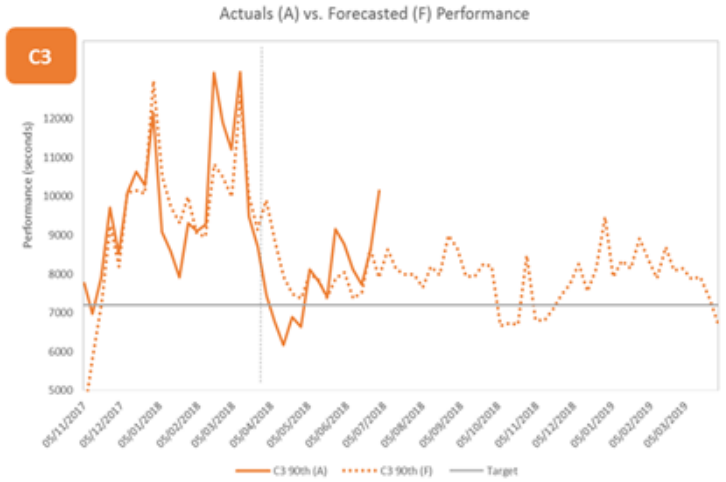
Appendix A: ARP national performance standards

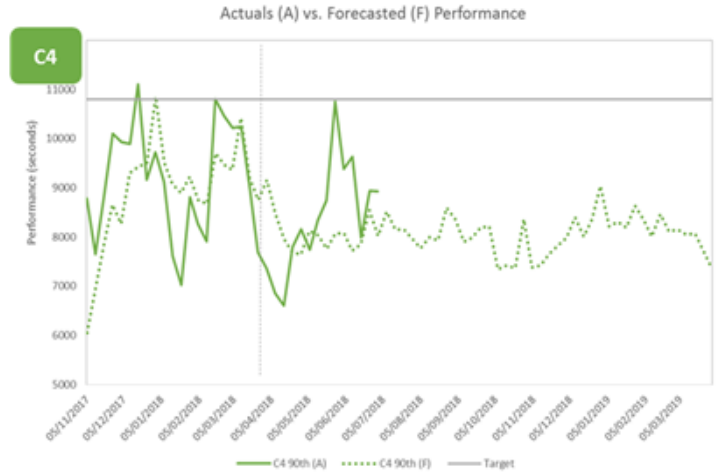
Category	Percentage of calls per Category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	• 7 minutes mean response time • 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being 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%	• 60 minutes mean response time • 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.

Appendix B: Actual and forecasted performance by Category









London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Rest break policy implementation review			
Agenda item:	14			
Report Author(s):	Brian Jordan, Business Manager to the Director of Operations			
Presented by:	Paul Woodrow, Director of Operations			
History:	This paper is a further update following the Trust Board meeting in March 2018			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This paper informs the Trust Board about the developments which have occurred since the revised rest break policy was implemented in December 2017. The revised policy introduced the option for staff to take a 'flexible' break at a location of their choice rather than have to be returned to their base station.

The paper includes details about:

- Developments since December 2017
- Evidence of improved rest break allocation
- Evidence of improved performance in the shift handover period
- Early findings from the end of shift pilot
- The next steps to further improve rest break allocation.

Recommendation(s):

The Board is asked to note the content of the paper.

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

Developments since December 2017

1. A revised rest break policy was implemented in December 2017 which introduced the option for staff to take a 'flexible' break at a location of their choice rather than have to be returned to their base station. This option helps to save travel time back to station.

2. Flexible breaks were not initially embraced to the levels anticipated. The hypothesis for this low take up was associated with staff still not being confident that they would finish their shift on time. It should also be noted that the winter of 2017/18 was particularly challenging and the Trust was under significant pressure for a considerable period of time following the revisions to the rest break policy being introduced.

3. Following a meeting between executive directors, control services managers and representatives from the medical directorate in February 2018, it was agreed that the following actions would be implemented in March 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.

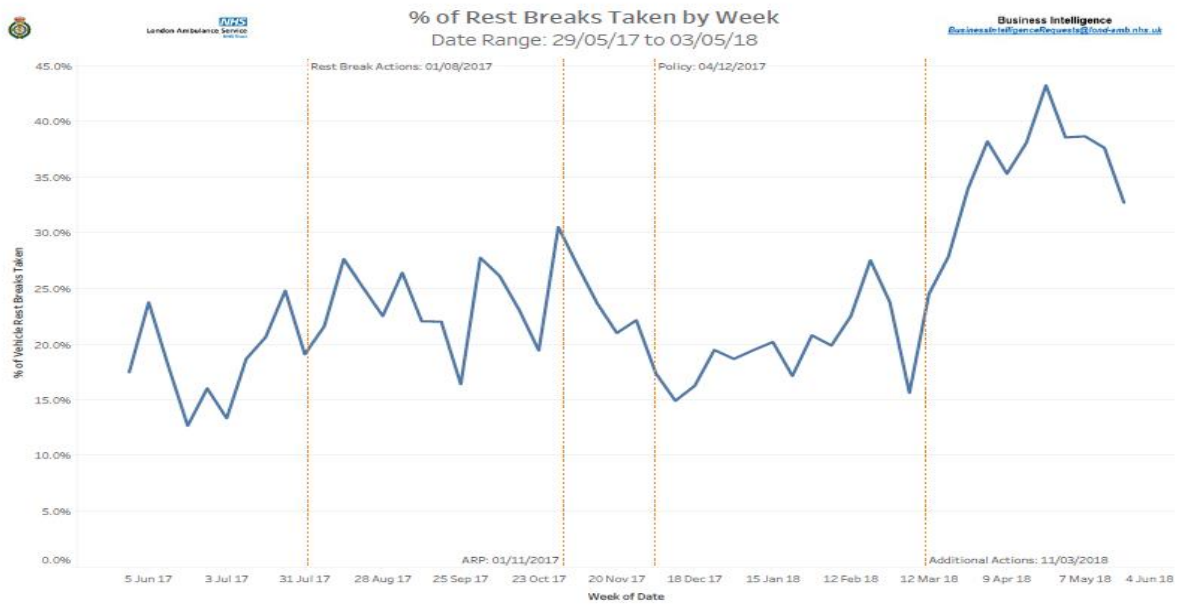
    - Incentivising extra DCA shifts to cover 11:00/23:00 so that additional cover is in place over the peak rest break window period which will in turn protect the allocation of breaks.

    - The development of a clear clinical safety process would be made available to support dispatch staff at times of reduced DCA availability.

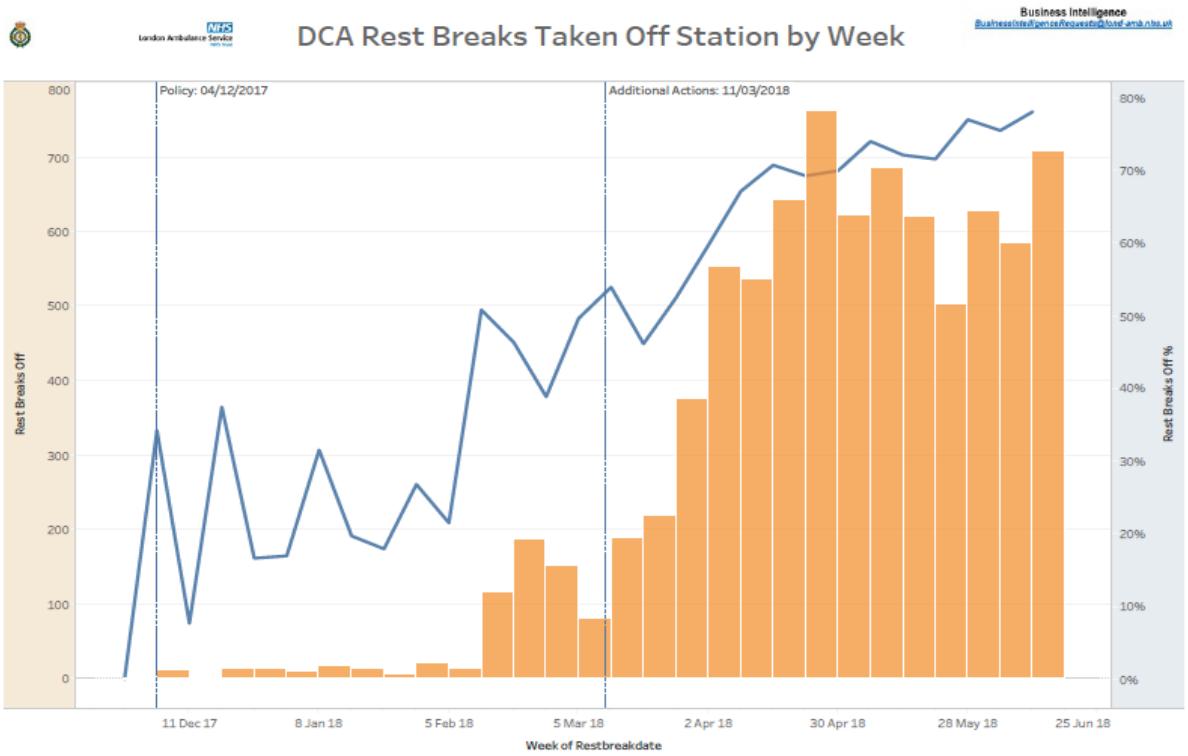
Improved rest break allocation

4. The actions implemented in March 2018 have led to rest breaks increasing from an average of 21.8% in 2017/18 to a current year to date average of 37.7%. A new record of 52.57% was achieved on 12 June 2018.

5. The graph below shows the significant improvement which has been made in terms of rest break allocation over the last 12 months.



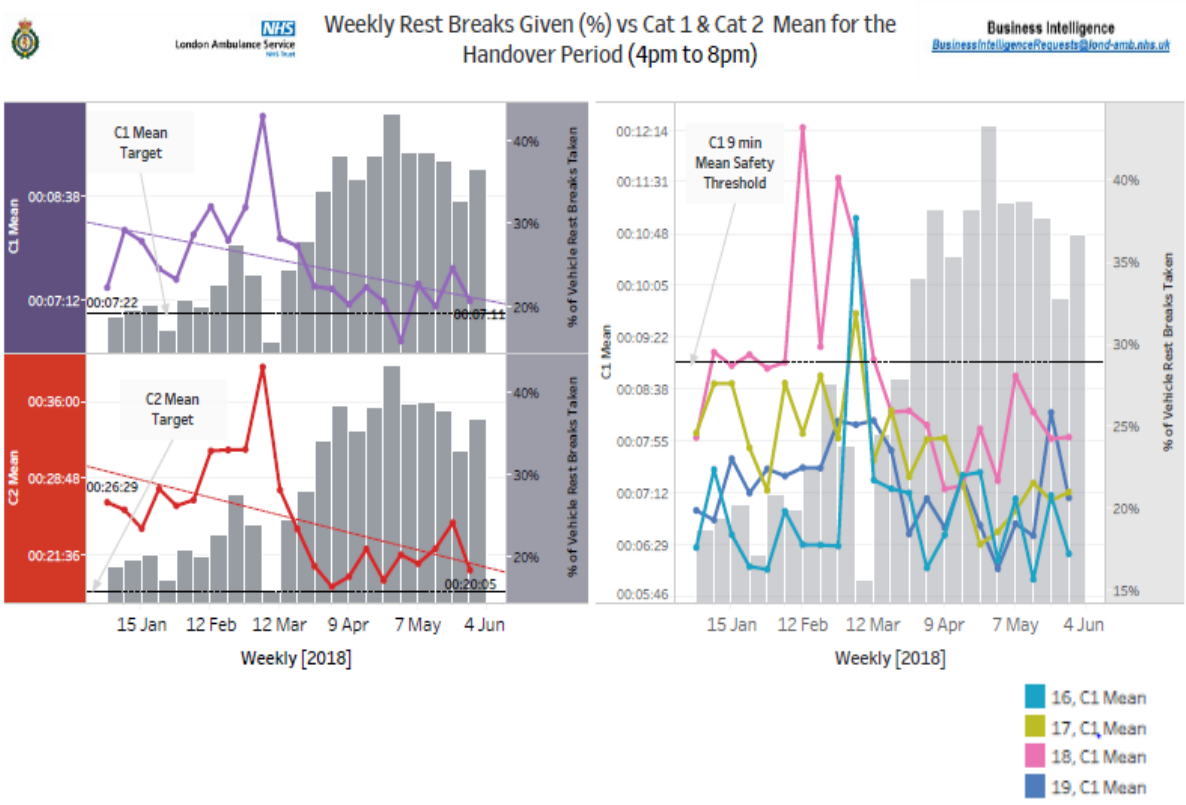
6. An increased number of ‘flexible’ breaks are now being taken since the revised rest break policy was introduced in December 2017. As can be seen in the graph below, nearly 80% of all rest breaks taken are now ‘flexible’.



Improved performance in the shift handover period

7. The charts on the left hand side of the graphic below are comparing the percentage of rest breaks given against Category 1 and Category 2 mean during the handover period between 16:00 and 20:00 hours. Although there are many factors which influence the Category 1 and 2 mean, these charts clearly show that, since March 2018, it has greatly improved (Category 2 mean in particular) while the percentage of rest breaks has increased. Although the mean has been slightly above the national standard in those hours, Category 1 mean does see a drop below 7 minutes whilst the lowest point for Category 2 mean is 18 minutes 32 seconds.

8. The chart on the right hand side of the graphic below is comparing the percentage of rest breaks given against the Category 1 mean by hour of the day. Since mid-March 2018, the improvement in Category 1 mean against rest breaks given is seen during all hours of the handover period. From mid-March 2018, the weekly hourly mean has not breached the Category 1 9 minute safety threshold whereas before this there were several breaches, mainly in the 18:00 hour.



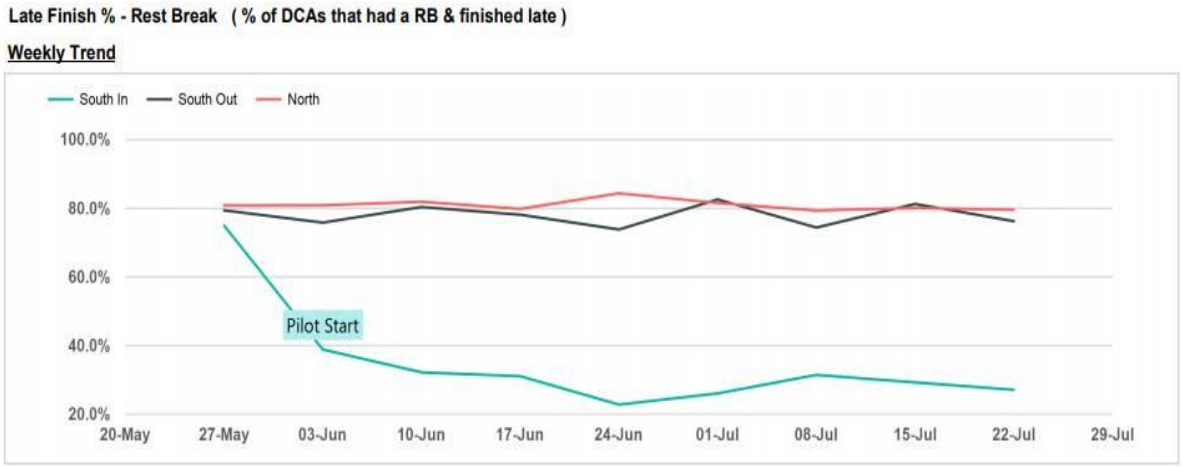
9. The Trust continues to monitor patient safety at times of shift change and has not identified any related serious incidents. Indeed a recent review of serious incidents in June 2018 has shown that there is no greater risk for patient safety at end of shift than in the middle part of the shift.

The End of Shift Pilot

10. 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.

11. An end of shift pilot which focuses on three station groups in South London (Croydon, New Malden and Deptford) launched on 30 May 2018 and attempts to protect staff during the last 30 minutes of their shift. Regular safety checkpoint reviews are taking place and the Trust's Operations Board is also reviewing progress on a monthly basis.

12. In the meantime, early results from the pilot are encouraging. Patient waiting times are comparable with those areas not in the pilot and only 25% of crews which took a rest break during their shift are going home late compared to 78% of crews in areas outside of the pilot.



Next steps

13. At the Trust Board meeting in March 2018, it was agreed 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) would be reconvened to consider the current position in more detail and to agree the Trust Board position prior to a review meeting with the Trade Unions. The Trust Board sub-group subsequently met on 19 June 2018 and agreed the following Trust Board position:

    - To seek the trade union's agreement to extend the current rest break window from two and a half hours to four hours in order 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.
    - To seek a number of minor amendments to the wording in the rest break policy in order to reduce ambiguity and enable the EOC to enact the policy more easily.
    - To continue to monitor the number of flexible rest breaks being taken and review the position again in December 2018. Flexible rest break arrangements are currently on a volunteer basis only and the Trust may need to gain agreement in the future to mandate flexible breaks when the crew are an unreasonable distance away from their base station.

14. The Director of Operations and the Director of People and Culture have arranged to review the outcome of the revisions that were made to the rest break policy in December 2017 with the trade unions in early August. The Trust Board will be notified of the outcome of this meeting in due course.

Paul Woodrow
Director of Operations

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Report of the Trust Secretary to receive the Register of Seals			
Agenda item:	15			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	NA			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Trust's Standing Orders state that "The Trust Secretary shall keep a register in which shall be entered a record of the sealing of every document and every such entry shall be signed by those present when the document is sealed. The entries in the register shall be consecutively numbered and any additions reported at the next regular Board meeting." This report advises the Board of a recent application of the Trust's seal.

Recommendation:

The Trust 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	☒

Background

1. It is a requirement of Standing Order 34 that all sealings entered into the Sealings Register are reported to the next meeting of the Trust Board.

2. Standing Order 33 requires that the fixing of the seal of the Trust shall be authenticated by the signature of the Chairman or some other such person authorised generally or specifically by the Trust for that purpose and one other director. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive and an Executive Director.

3. On 19 June 2018, in the presence of the Chief Executive, the Director of Finance and Performance, the Director of Strategic Assets and Property and a representative of the Trust Secretary, the seal of the Trust was affixed to the following lease contract:

   Maritime House, Linton Road, Barking Essex IG11 8HG, between London Ambulance Service NHS Trust and Dooba Investments III Ltd.

Recommendation

4. The Trust Board is asked to note this report and the entry to the Sealings Register.

5. Board Members may inspect the register after this meeting should they so wish.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	16			
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: 2018/19

Area	September - Tuesday 25 September 2018
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update Freedom to Speak Up Strategy
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	November - Tuesday 27 November 2018
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report Logisitics & Infrastructure Cttee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Business Plan progress review
Governance	Report from the Trust Secretary Trust Board forward planner
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	January - Tuesday 24 January 2019
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	March - Tuesday 26 March 2019
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	31 July 2018			
Report title:	Annual General Meeting preparation			
Agenda item:	17			
Report Author(s):	Fiona Claridge, Head of Stakeholder Communications			
Presented by:	Jamie O'Hara, Director of Strategy and Communications			
History:	N/A			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Service holds an Annual General Meeting (AGM) each year, looking at performance in the previous financial year, financial governance and clinical quality. In recent years the AGM has been poorly attended and has focused on reiterating the information contained with the Annual Report.

The meeting provides us with an opportunity to engage the public and stakeholders and gives them an opportunity to scrutinise our work. To encourage engagement we plan to deliver a more engaging AGM that will also offer opportunities for people who cannot attend in person to engage with us.

This report provides an overview of the plans for the AGM.

Recommendation(s):

The Board is asked to review the approach set out in the plan.

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

The Annual General Meeting provides the public with an opportunity to scrutinise the running of the Service and provides assurance on quality governance and financial 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 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	☒

Annual General Meeting

Background

1. The Annual General Meeting (AGM) provides an opportunity for us to showcase our work to the public and stakeholders and provides them with an opportunity to scrutinise us.

2. In previous years the AGM has been poorly attended, with the audience largely consisting of members of the Patients Forum. The agenda has been based on the content of the annual report, which is available online in advance of the meeting. The meeting has also taken place during the day making it difficult for many people to attend the meeting.

3. In order to increase engagement, showcase our work more effectively and provide a better forum for members of the public and stakeholders we have made significant changes to the format of the AGM. We also intend to use technology more effectively, making the AGM an open public meeting that than be watched online.

The AGM

4. The AGM will be used to review the year, looking back at our performance, accounts and quality report for 2017/18, as well as showcasing our mental health work and the new strategy.

5. Mental health will be a significant focus of the meeting with a keynote speaker, a service user experience, staff experience and partner/ charity experience.

6. The space will be used for information stands on the strategy; highlighting the pioneer services and enabling attendees with learn more about our plans. The stands will be manned by staff members. There will also be time for networking.

7. Members of the public will be able to submit questions in advance of the meeting via our communications channels. Questions can also be taken on the night. The Chair will host this session, with Board members and Executive Leadership Team providing responses to the questions.

8. The meeting takes place at 5.30pm on the evening of Tuesday 25 September 2018. It will be held at the Union Street offices, which the London Ambulance Service shares with the London Fire Brigade.

9. Further information about the agenda for the meeting can be found below:

The agenda

Timing	Duration	Session	Lead	Session Content
5.30pm	10	Welcome from Chair	HL	
5.40pm	5	NHS70 film	HL	HL to intro NHS70 London Ambulance Service through the ages film
5.45pm	10 10 10	Annual Report: A year in retrospect Standing Accounts Quality account	GE LB TB	GE to provide an overview of the past year and plans for the future
6.15pm	10	Strategy	GE	Introduce strategy
6.25pm	30	Showcase		• Mental health professional • Service user experience • Charity view
6.55pm	15	General Questions	HL	Questions from the public
7.10pm	5	Closing remarks	HL	Summary of evening, thanks
7.15pm	45	Networking		Refreshments/ stands
8pm		CLOSE		

Communications and engagement plan

10. We will publicise the AGM through our communications channels, using twitter, Facebook and the website to inform the public of the AGM and offer them an opportunity to submit questions to the Board in advance of the meeting. We also plan to work with local Healthwatches to promote it through their channels to patients and members of the public.

11. Stakeholders will be invited to attend; this will include Strategic transformation Partnerships, Members of Parliament and London Assembly Members, other NHS Trusts, Local Authority Health Directors and other key stakeholders. Given the focus on mental health we will also specifically target mental health organisations to attend, including mental health trusts and mental health charities.

12. We will also promote the AGM to staff, encouraging their participation. We will use the Pulse, Routine Information Bulletin and LiA Facebook, as well as specifically inviting staff involved in developing the pioneer services.

13. We are looking at two options for recording the AGM. Either a standard recording that can be added to the website following the meeting or a Periscope recording, which will enable users to watch it live and can also be downloaded.

Jamie O'Hara
Director of Strategy and Communications

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	Quality Report			
Agenda item:	Additional report circulated for information and assurance only			
Report Author(s):	Dr Trisha Bain Chief Quality Officer			
Presented by:	Dr Trisha Bain Chief Quality Officer			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report outlines June's position in relation to quality performance.

Recommendation(s):

The Trust Board is asked to note and consider the content of this report.

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

All Board Assurance Framework risks relating to quality governance and risk frameworks.

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

Quality Report

July 2018

All data pertains to June 2018 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

Legend
- Above Target
- Within 5% of Target
- Over 5% from Target

Executive Summary: Exception Report (Positive)

Safety

- No unaccounted morphine losses
- Joint Maternity Training delivered with South Coast Ambulance Service and the LAS.
- Additional maternity equipment procured to enable training opportunities
- Completed the targeted 7 ED audits as per audit programme in Q1
- Targeted stations with poor compliance history (33)
- 15 investigations were been submitted to the CCG and are awaiting closure or comments with no breaches – This is a significant number of SI's to be submitted in any one month.
- The average time lag for reporting RIDDOR incidents in June was 11 days – a sustained decrease and under target since March

Actions & Assurance

- Maintain medicines audit programme
- Continue roll out of secure drugs rooms
- Further Joint Maternity Training to be delivered 07/18
- All Education Centres maternity training equipment aligned
-

Effectiveness

- As a result of the additional features built into the CPI database, in May five auditors completed a Datix report as they had clinical or safety concerns and eight auditors placed a retrospective safeguarding referral.
- Inaugural meeting of the Royal College of Midwives and College of Paramedics to work together to improve pre hospital maternity care – LAS hosted
- A Clinical Performance Indicator for undiagnosed psychiatric problems was launched

Actions & Assurance

- A video outlining the key principles of the Mental Capacity Act was developed and published on the LiA face book page for staff.
- LAS to lead on standards for Joint Maternity Training

Caring

Actions & Assurance

-

Executive Summary: Exception Report (Improvement Required)

Safety

- Limited capacity for consultant midwife to deliver maternity training
- Existing response profile to Health Care Professional requests (midwives) escalated to the Clinical Quality Review Group
- Premises cleaning audit submissions from Stations requires improvement
- VP 6 weekly deep clean missed target for the second month 94% against 95%
- The new KPI's for incident reporting requires 700 no harm incidents per quarter and 150 low harm incidents per quarter. To date the Trust has not met these KPIs for Q1 2018/19 - (action – over 700 patient incidents have been incorrectly categorized as a 'Trust' incident. This data will be re-validated and the figure is likely to improve by next month).
- There are currently 17 SI actions that are outstanding

Actions & Assurance

- 6 Further LAS Paramedics/Team Leaders & 2 Maternity Educations Leads to undertake training to build Maternity Training Capacity – 07/18
- Agreement by Chief Quality Officer & Medical Director to implement mitigation plan 07/18
- Over 700 patient incidents have been incorrectly categorized as a 'Trust' incident. This data will be re-validated and the figure is likely to improve by next month.
- Action owners are contacted by the Quality, Governance & Assurance team on a regular basis to request they are updated / closed

Effectiveness

- Outstanding Obstetric Emergency audit
- Current datix analysis of maternity risk not reported

Actions & Assurance

- Bulletin to be circulated based upon OP35 Maternity Care Policy highlighting minimum standards 07/18
- Agreement of new maternity datix reports to be agreed 8/18
- 100% of maternity related incidents to receive specialist review

Caring

Actions & Assurance

SAFE – Dashboard

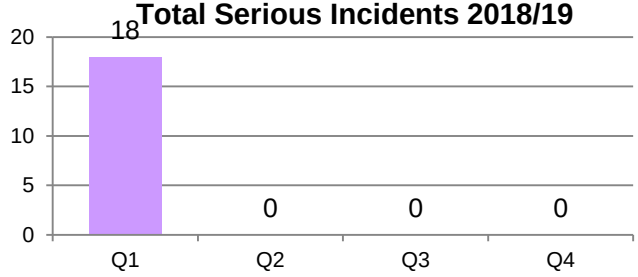
Exec Lead: Dr. Trisha Bain

Measures	Target / Range	YTD 18/19	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	96%	98.0%	93.1%	0.0%	↓			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	2.7	2.7	2.9	2.5	↓					
Patient related Adverse Events - NO HARM	100	567	185	213	169	↓					
Patient related Adverse Events - LOW	40	84	26	29	29	↔					
Patient related Adverse Events - MODERATE	25	47	14	17	16	↓					
Patient related Adverse Events - SEVERE		12	5	2	5	↑					
Patient related Adverse Events - DEATH		26	10	10	6	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	3.5	3.9	3.8	2.9	↓					
Staff related Adverse Events - **NONE**		551	193	211	147	↓					
Staff related Adverse Events - **LOW**		414	154	142	118	↓					
Staff related Adverse Events - **MODERATE**		10	4	4	2	↓					
Staff related Adverse Events - **SEVERE**		1	0	0	1	↑					
Controlled Drugs - Other Reportable Incidents		0	0	0	0	↔					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	0%	92%	95%	90%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month		18	6	7	5	↓					
Serious Incidents breaching 60 days	0	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	0%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events		6%	4.2%	7.4%	6.7%	↓					
Needle Stick Injuries as % of Staff Adverse Events		1%	0.6%	2.0%	1.5%	↓					
Never Events	0	1	0	1	0	↓					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	0%	0%	0%	0%	↓					
Missing Equipment Incidents as % of all reported incidents		3%	3%	4%	3%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents		10%	10%	10%	9%	↓					
Number of NRLS uploads In-Month	1	3	1	1	1	↔			LQ21		

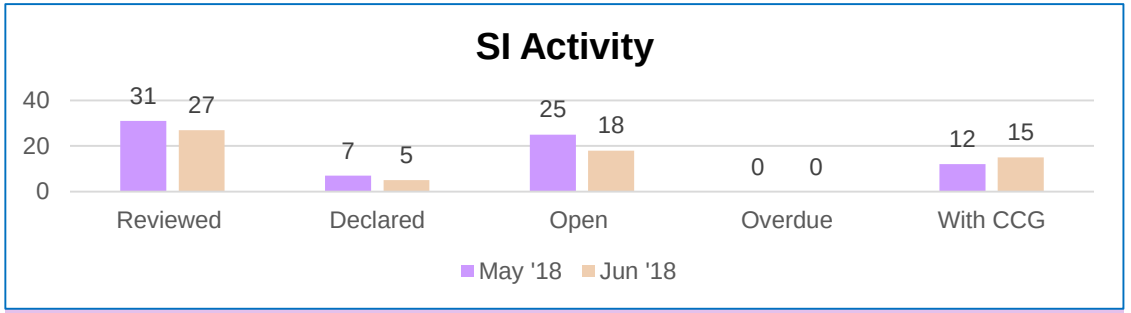
This data is subject to change pending validation.

SAFE - Patient Safety

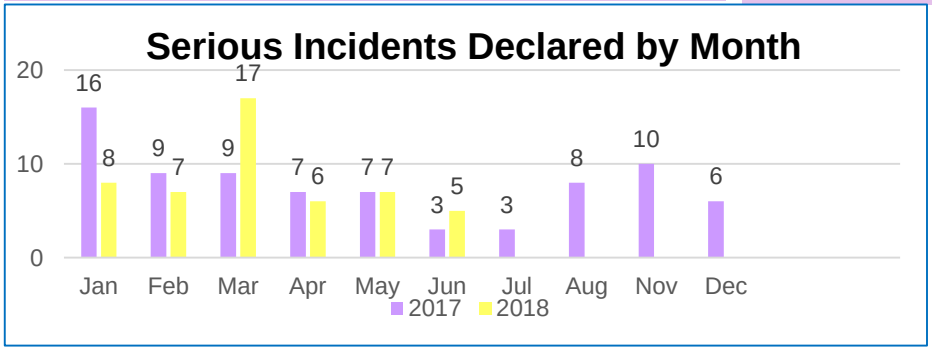
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

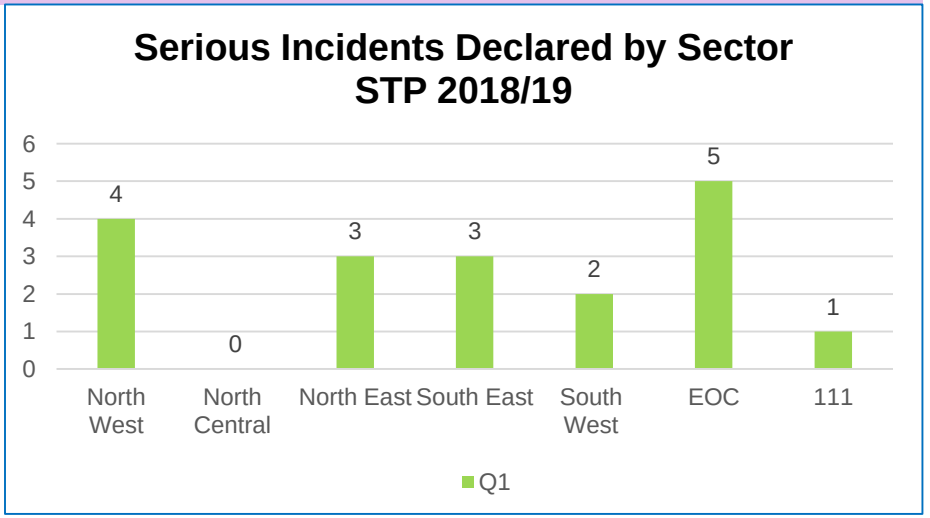


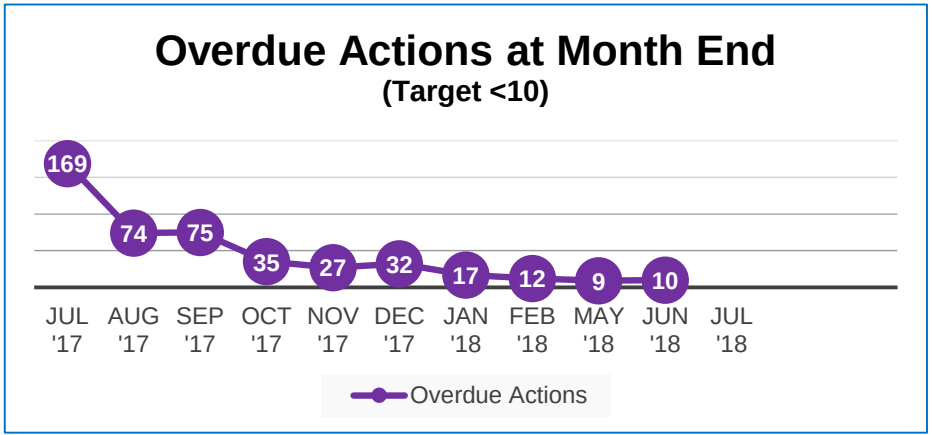
18 serious incidents were declared in Q1 '18/19. The Trust exceeded the number of SI declared compared to Q1 2016/17 by one.



A total of 27 incidents were reviewed by SIG in June of which 5 were declared as SIs. Of the 17 SIs declared in March, 2 were de-escalated. The remaining 15 investigations were been submitted to the CCG and are awaiting closure or comments with no breaches. One SI has been granted a four week extension due to the complexity of the incident.



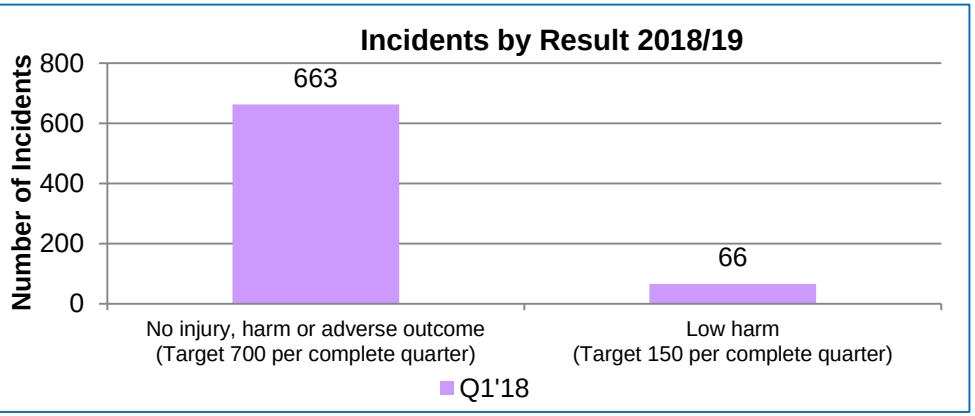


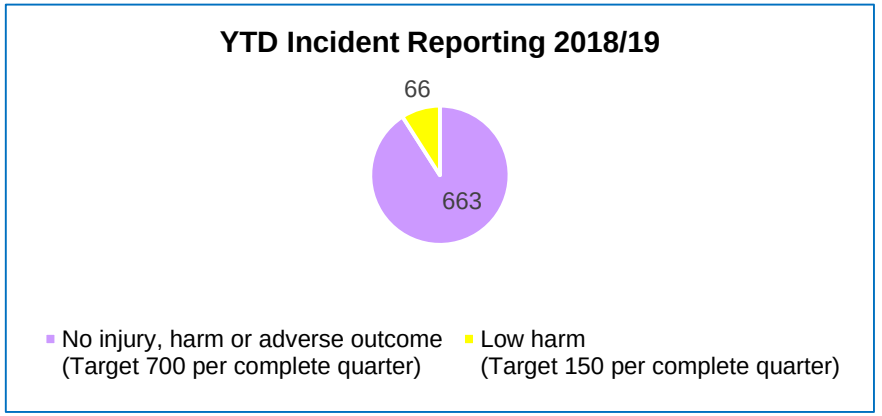


- There are currently 10 SI actions that are outstanding. 3 x EOC, 5 x Operations, and 2 x LAS 111
- The majority of actions that are overdue are part of larger service improvement programmes or are affected by rota patterns and staff absence.
- Action owners are contacted by the Quality, Governance & Assurance team on a regular basis to request they are updated / closed.

SAFE - Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain





The Trust has set an annual target for the reporting of incidents that have been graded as either no harm or low harm. The new KPI's for incident reporting requires 700 no harm incidents per quarter and 150 low harm incidents per quarter. To date the Trust has not met these KPIs for Q1 2018/19 however this data is subject to revalidation and it is expected this value will change.

Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q4		Q1			
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Feb	Mar	Apr	May		
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	12	9	6	6	The published CQC report gave an overall rating of good. In addition the CCG have shared that they are assured the Trust has oversight and consistent management of SI's and incidents. The team have appointed to the band 6 vacancy which will focus on thematic analysis of incidents. Recruitment is ongoing for the risk management and two senior governance managers.
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. The team have appointed to the band 6 position which includes incident management.

Monthly IPC Training Compliance May 2018 (Target: 90%)

IPC training compliance for Level 1 and Level 2 is monitored via ESR. This continues to improve and currently exceeds the target of 90%.

Performance (June 2018):

- Level 1 – 95.02% compared to May 2018 (95.55%)
- Level 2 – 95.73% compared to May 2018 (96.38%)

Assurance:

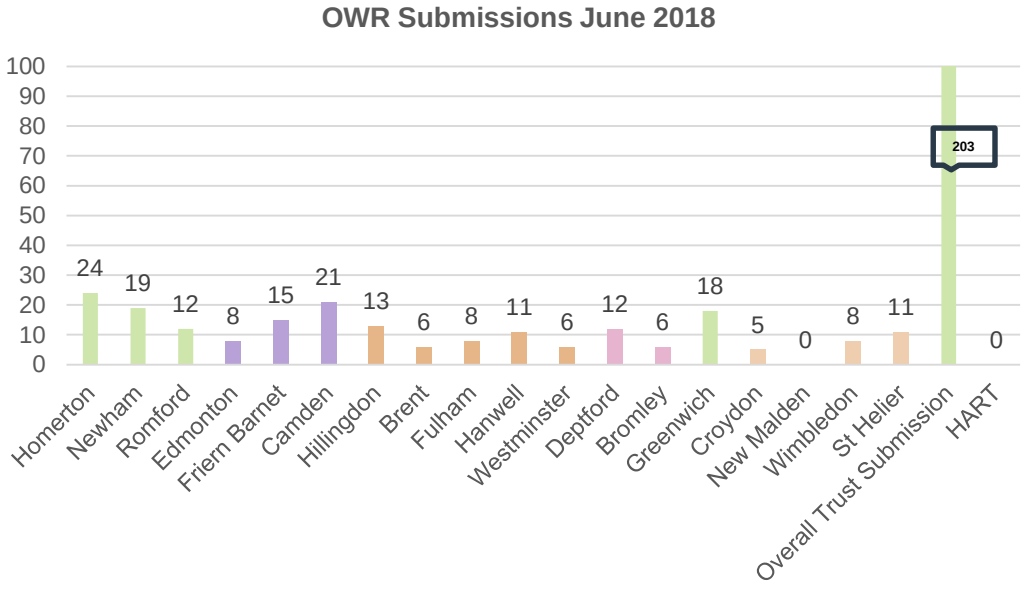
- Monitored via ESR
- Monthly Quality Report
- Oversight at Quarterly ICDG, IPCC and QOG

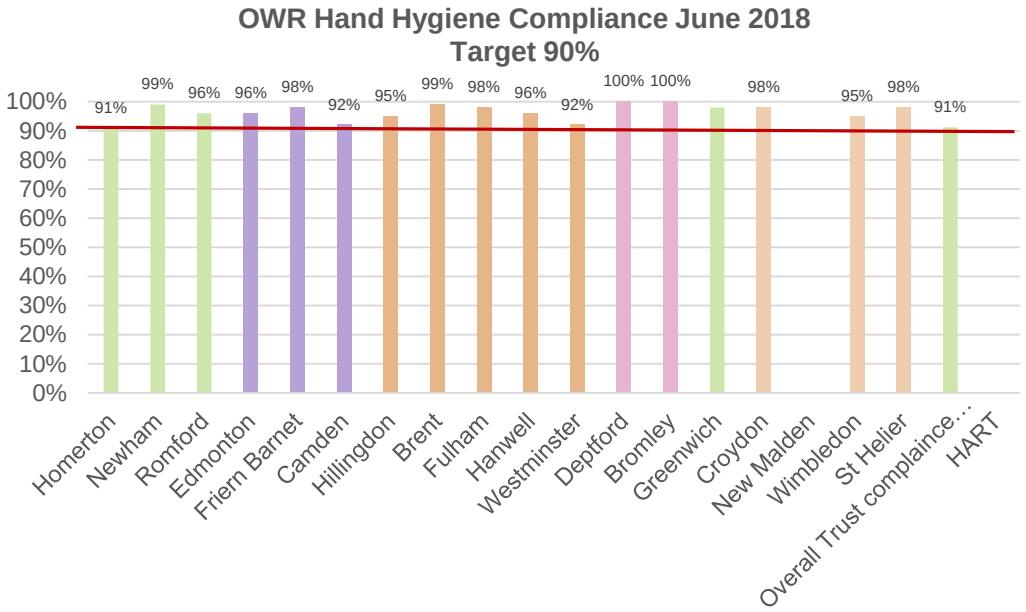
Actions taken:

- Shared good practice with SECAMB
- Monitoring process in place

Safety (Infection Control)

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





Hand Hygiene Performance

- New methodology for analysis of hand hygiene data was implemented in April 2018
- 17 group stations submitted their OWR data for hand hygiene; New Malden and HART did not submit data
- Of the 17 submissions, the Trust compliance for June 2018 was 91.17%, down from May (93.06%)
- Cumulative rolling submissions to date: 1919; as all front line staff are reviewed by their CTLs using the OWR tool annually

Assurance

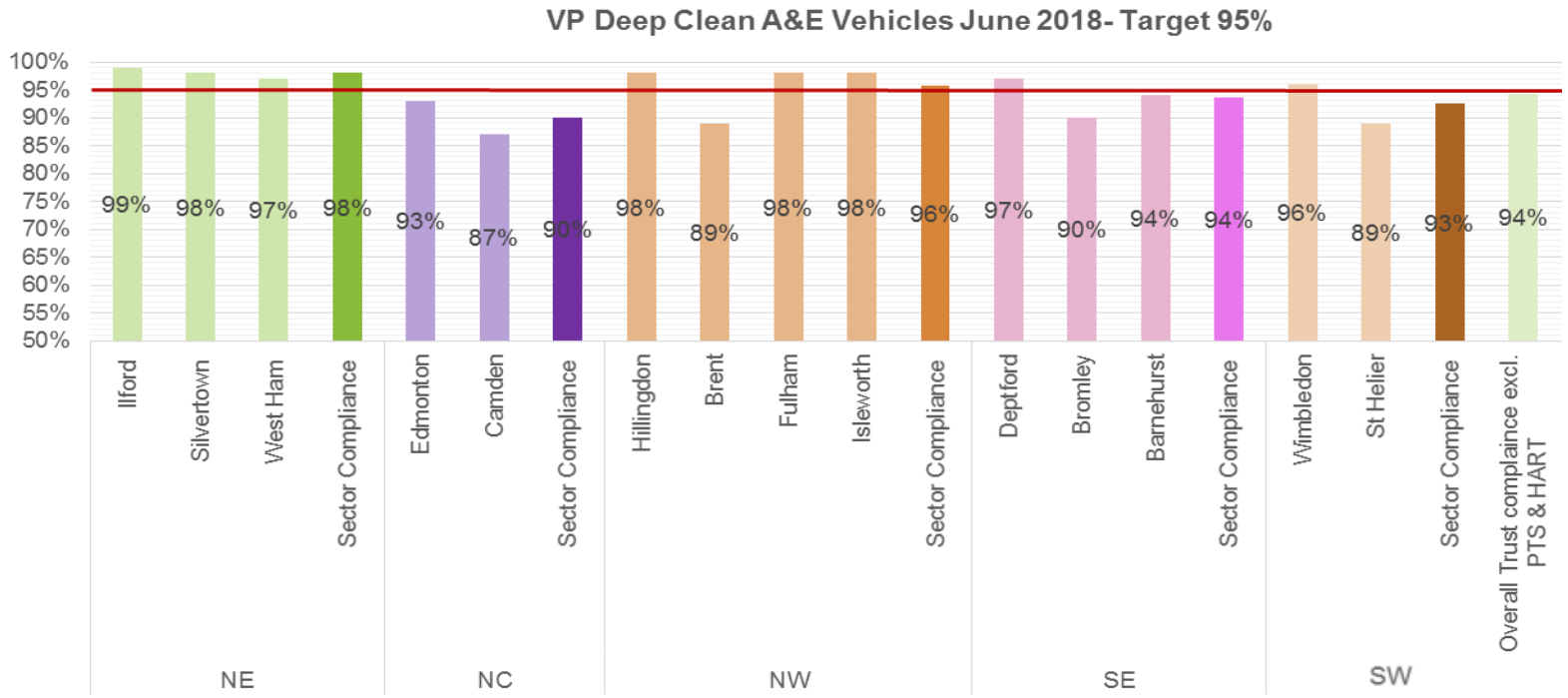
- Monthly Quality Report, CEO Performance Reviews, Quarterly Sector Quality Meetings
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Visits to EDs in London to audit and discuss hand hygiene standards continues.
- IPC Champions role to raise standards and ownership at local stations by providing practical Hand Hygiene at stations.

Actions

- Continue with Audits at EDs in London as per audit programme
- QGAMs to ensure Group Stations submit their OWR data in a timely way
- Report to Sector Quality Meeting
- Agree submission compliance and denominator figures for Operational Workplace Reviews

Safety (Infection Control)

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



Performance

- Data for each Group Station, Service (21) submitted by the VP Contract Manager, data analysed by the IPC team
- Trust compliance for June 2018 was 94%, the same as May 2018, against a contractual target of 95%
- PTS (NETS) scoring 84%, down from 87% in May
- HART achieved 92% against 87% in May

Assurance

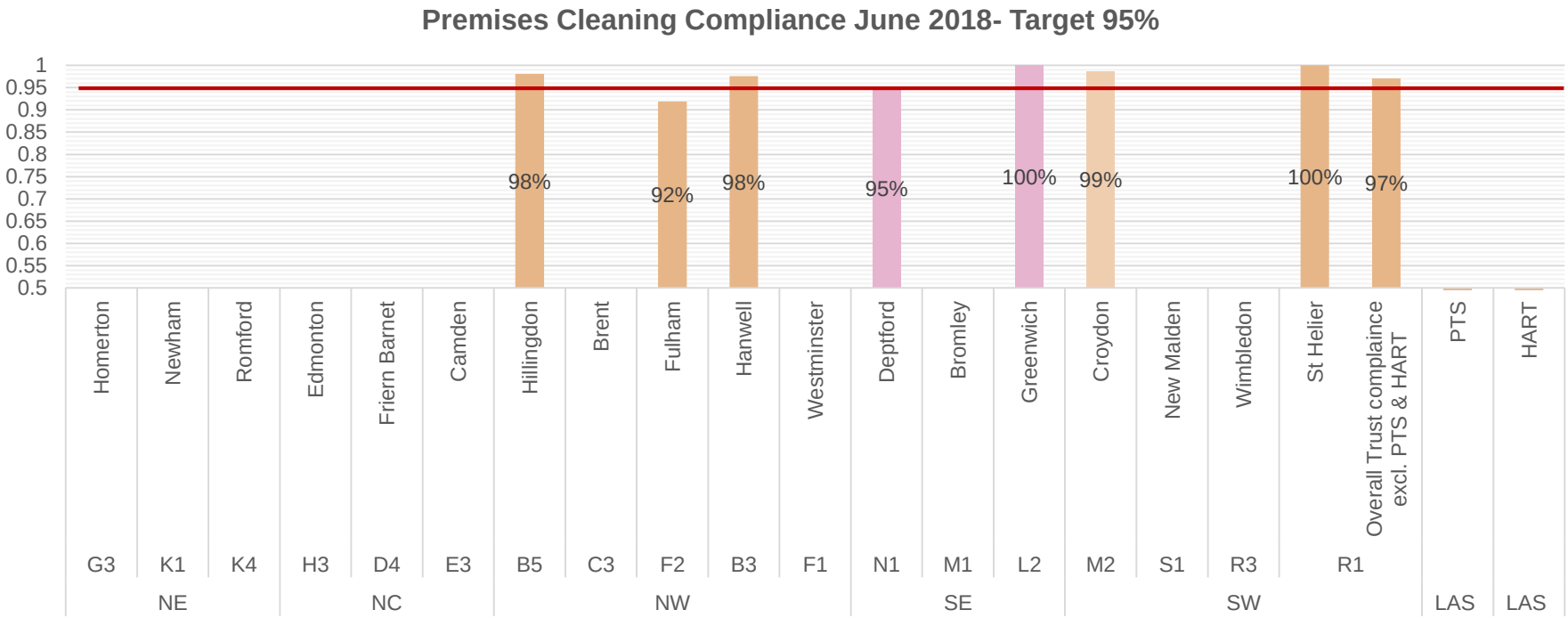
- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Logistics managers have regular contract meeting with contractors; action plan for low compliance; regular stakeholder meetings established

Actions

- Logistics to monitor action plans to improve low scores
- IPC continue to monitor the performance monthly and seek progress to actions taken by Logistics manager

Safety (Infection Control)

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



Performance

- 8/20 Group Station submissions were received by IPC team for analysis
- Trust compliance for June 2018 was 97% however this was based on a limited number of submissions. Further data is required in order to provide an accurate reflection of current compliance pan-London.

Assurance

- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Estate contract managers have regular contract meeting with contractors; Contract managers and Contractors also undertake audits to ensure standards are maintained

Actions

- QGAMs oversight and action required for non-submissions - QGAMs to ensure Group Stations submit data in a timely way
- IPC continue to undertake validation audits, monitor monthly to provide additional assurance
- Report performance to Sector Quality Meeting

Sharps and Body Fluid Exposure (BFE) incidents April – June 2018

Type of incident	Q1 (April-June)
Bite	1
Contact with sharps (including needles)	2
Contact with sharps (non-medical sharps injury)	4
Exposure to bodily fluids	39
Injury involving broken ampoules / vials	12
Lancets - clean	1
Needlestick - cannula clean	0
Needelstick - IM clean	1
Razors - clean	6
Lancet - contaminated	1
Needlestick cannula - contaminated	6
Needlestick - IM contaminated	2
Needlestick subcutaneous contaminated	0
Razor - contaminated	1
TOTAL	76

Performance

- Cumulative incidents for Q1 (April to June) – 76
- 39/76 (51%) were BFE incidents

In Q1, of the 4 contaminated sharps incidents, 2 were near misses, 2 resulted in actual injury and presenting an infection risk

- 2 near misses -used Lancet and EZ-IO needle were not disposed of correctly
- 2 actual injuries - Putting cannula into sharps box, used Razor not disposed of correctly
- 11/39 BFEs, 8 actual incidents; 3 near misses
    - 3 of 4 Splashback incidents were due to cannulation/intravenous drug administration process; 4 body fluids to face/hands
    - 3 Near misses = blood on documentation, equipment, exposure to communicable disease

Assurance

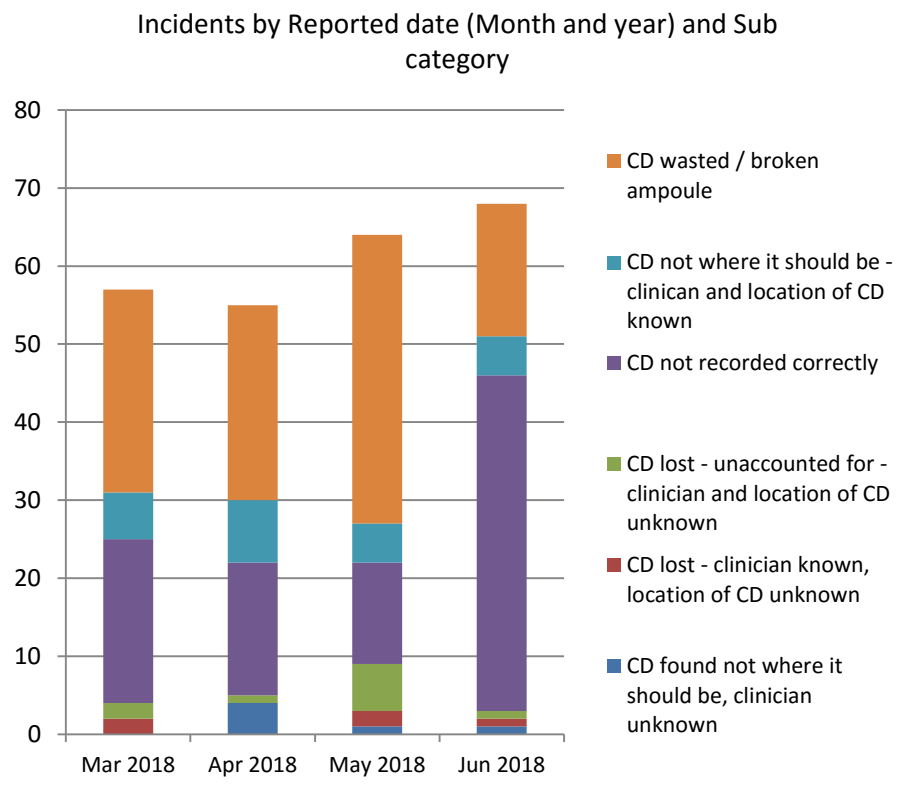
- Regular Bulletins e.g. safe practice in administration for IV fluids through cannula port
- Enhanced personal PPE implementation
- Datix incident follow-up and Datix Risk Reporting
- Completion of Immunisation status project and immunisation catch-up programme

Actions

- Daily review of incidents and appropriate investigations and feedback; prompt risk reporting and provision of bulletins as appropriate

SAFE - Medicines Management

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



Medicines Management Update

- No unaccounted for losses of injectable morphine
- Total of 67 other controlled drug incidents including
  - Wastage or breakages (n=17)
  - Documentation errors (n=44)
  - Morphine retained off duty (n=2)
  - LAS morphine found unsecured (n=2)
  - Drugs room found open (n=2) or access codes visible (n=2) ***in relation to stations without secure drugs rooms – these incidents are detected by the regular drug audits we have in place with perfect ward reporting**
- Non-controlled drugs incidents
  - RIGHT2 drugs trial pack missing (n=1)
  - Medical gases left at scene (n=2)
  - Drugs usage forms incomplete (n=2)
  - KitPrep app malfunction or discrepancy (n=22) ***these are reported via kit prep. A Programme Implementation Manager is working with KitPrep to resolve and also to renegotiate the new contract with them**
  - Incorrect administration of adrenaline (n=3), paracetamol (n=1), oxygen (n=1), rectal diazepam (n=1), syntometrine (n=1) & hydrocrotisone (n=2)
  - Prescribing errors by other healthcare professionals (n=2)
  - Inadequate supply or stock (n=2)
  - Allergy to morphine (n=1) and penicillin (n=1)

Actions

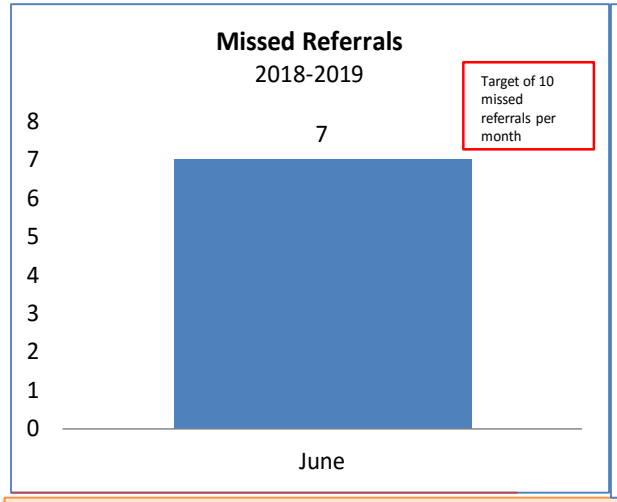
- Ampoule trays distributed to reduce incidence of morphine ampoule breakages
- Discussion with safety and risk regarding role of safety syringes in ongoing adrenaline 1:1000 dosing errors
- Continuing roll out of secure drugs rooms to enhance medicines management

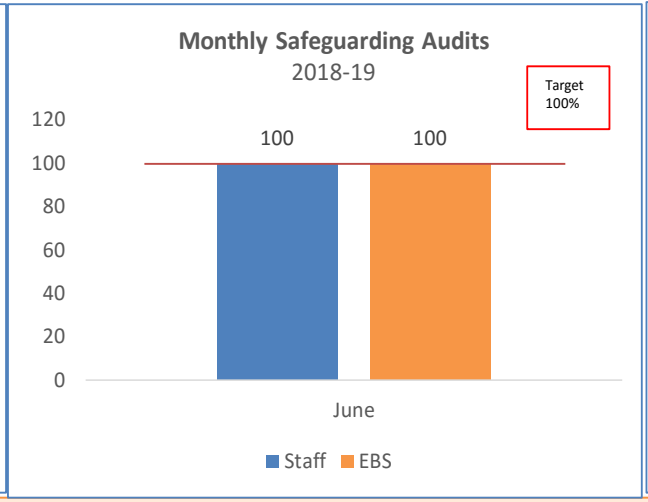
Assurance

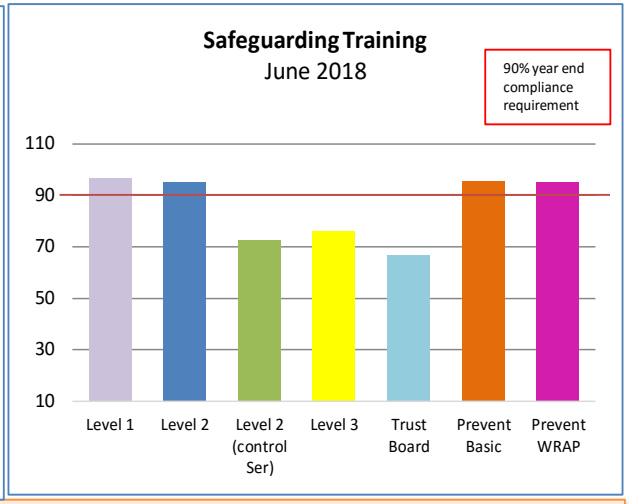
- No unaccounted for losses of injectable morphine
- Rapid identification and return of morphine retained off duty

Safeguarding

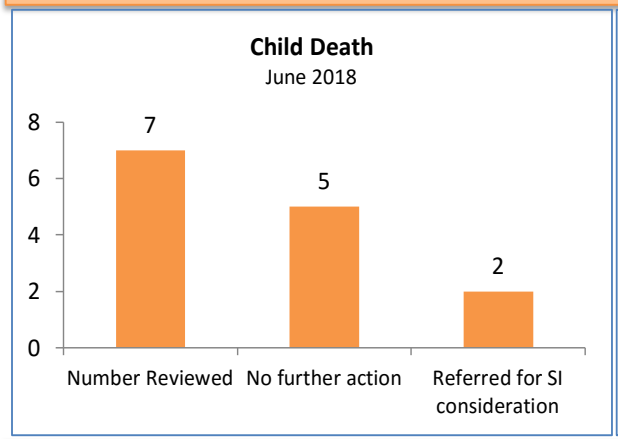
Owner: Alan Taylor | Executive Lead: Dr. Trisha Bain

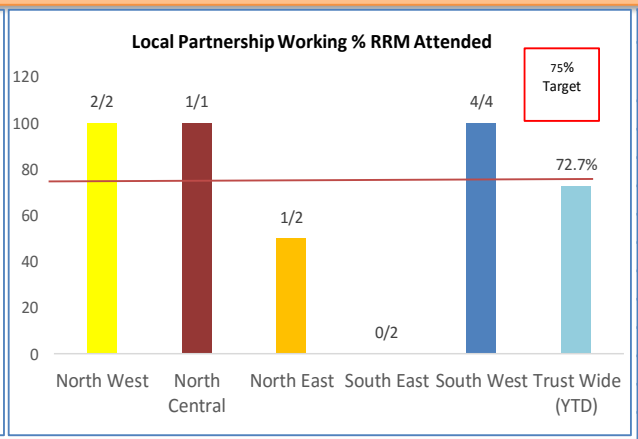






Missed Referrals (Shadow KPI) 5 children 2 adults **Knowledge and Retention Audits** review staff learning across the Trust have a target of 13 per month = 100%. EBS Quality of referral audit 1 per staff member per month = 100% staff understanding of FGM duty showing as mixed covering in 2018 CSR. **Safeguarding Training** level 3 reduced due to new members of staff within EBS course planned for Aug. Control services figures currently under review.





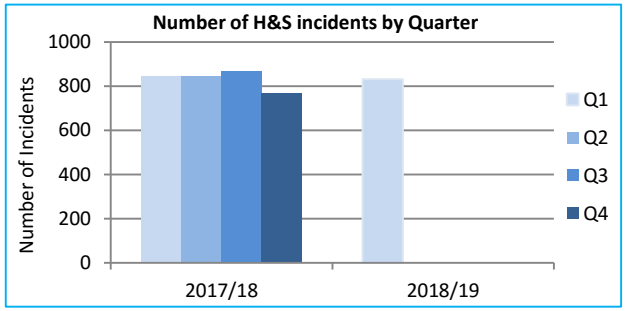
Trust safeguarding referrals and concerns raised

Month	Adults Safeguarding	Adults Welfare	Children	Total Referrals	% incidents
Apr-18	393	650	637	1650	1.8%
May-18	414	588	822	1824	1.9%
Jun-18	457	609	846	1912	2.1%
Jul-18					
Aug-18					
Sep-18					
Oct-18					
Nov-18					
Dec-18					
Jan-19					
Feb-19					
Mar-19					

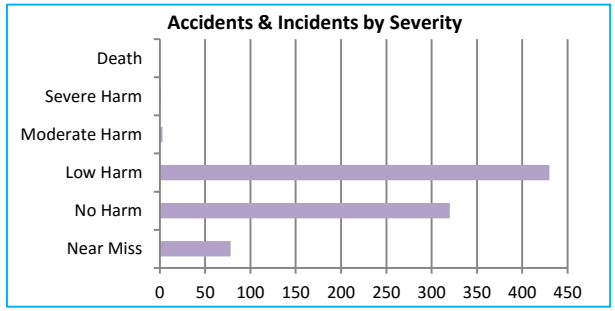
Child Death: 100% were processed within 3 weeks of receiving 1 referred to SIG was declared : **Local Partnership Working**. Good compliance in all areas. **Trust Safeguarding Referrals & Concerns Raised:** Referrals remain within expected levels .

Health & Safety Scorecard

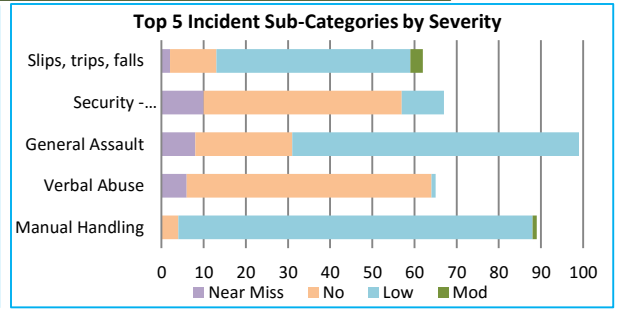
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain



832 incidents have been reported across the Trust during Q1 2018/19. 245 incidents were reported in June 2018 . These H&S related incidents account for 37% of all the incidents reported across the Trust in June 2018.



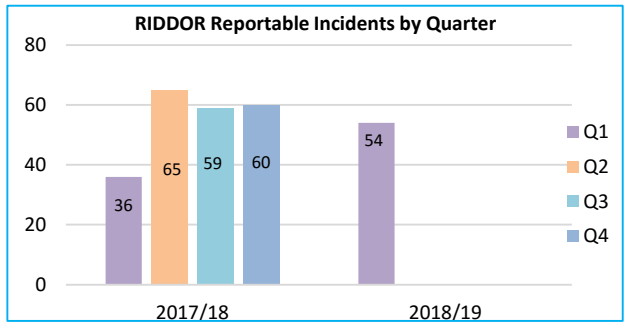
430 (52%) of the H&S related incidents reported during Q1 resulted in low harm. 4 (0.5%) incidents resulted in Moderate or Severe harm. 398 (47%) of the incidents were reported as 'No Harm/Near misses'.

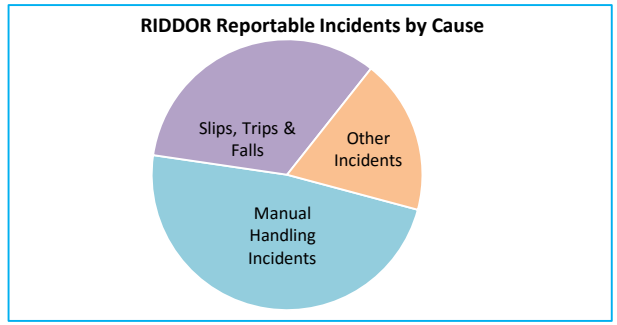


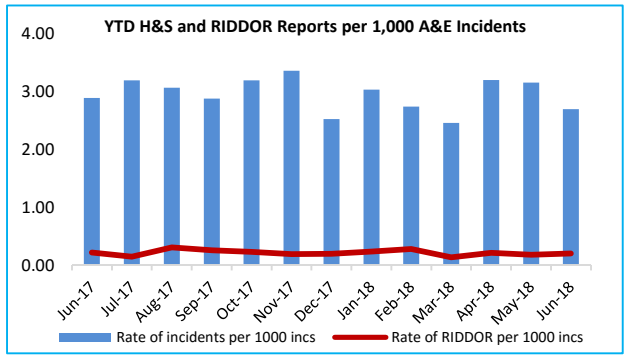
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported during June 2018.

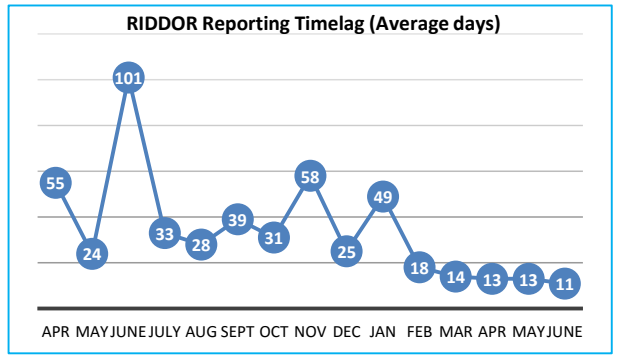
Key Updates:

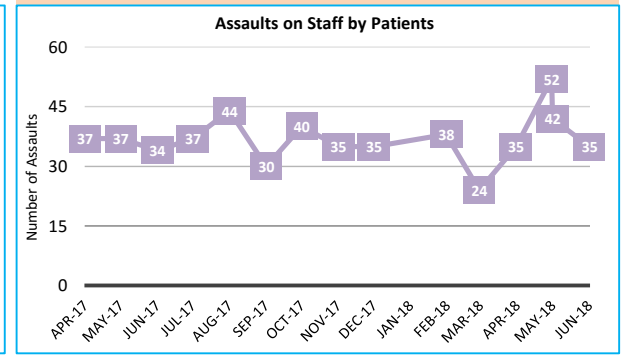
1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. 91 MH - lifting patient incidents have been reported in Q1. Some of the contributory factors included the lack of equipment or failure a piece of equipment resulting in the manual handling of patients.
3. 146 incidents relating to the lack of or failure of equipment have been reported across the Trust during Q1, 2018/19.
4. The provision of practical MH Training to relevant frontline and support services staff is ongoing.
5. A review is ongoing to evaluate additional measures that can be implemented to further mitigate the security related incidents reported across the Trust.
6. Work is on-going to progress the actions identified on the Health and Safety Action Plan. **49 out of the 69** identified actions have now been completed.











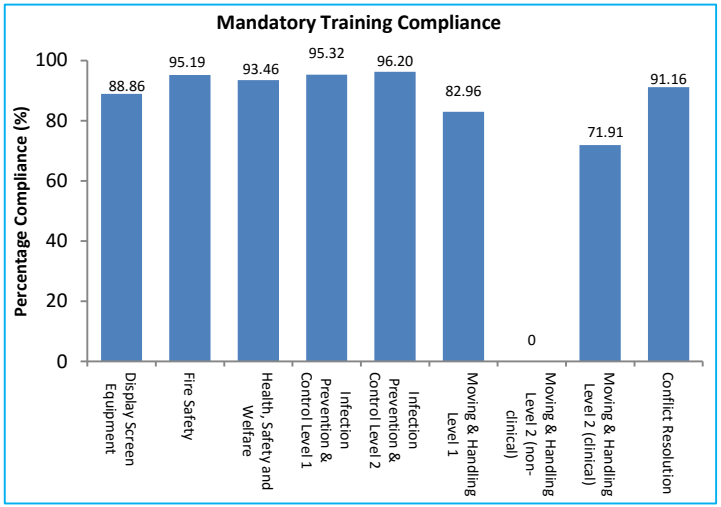
7. The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to June 2018.
8. No benchmark/comparable data was received from any of the other ambulance Trusts during June 2018.

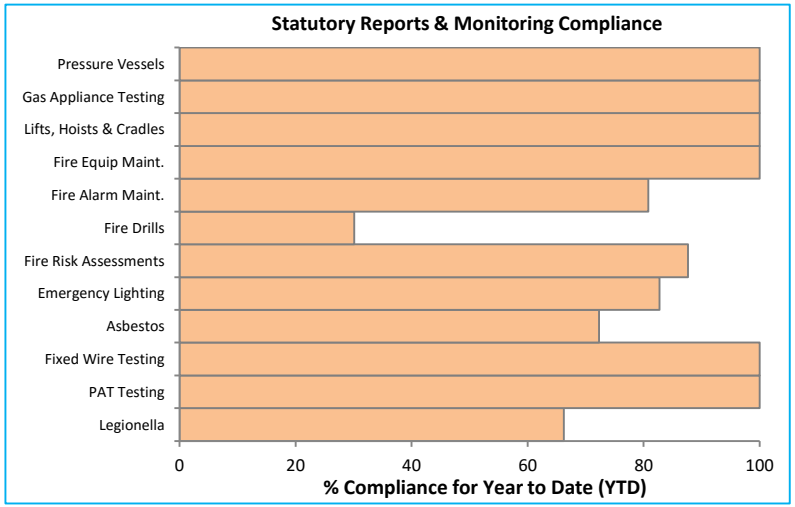
9. 54 RIDDOR incidents were reported to the HSE in 2018/19. 18 RIDDOR incidents were reported in June 2018.
10. The average time lag for reporting RIDDOR incidents in June was **11 days.** 2 out of the 18 RIDDOR incidents were reported out of time in June 2018.

11. There was decrease in the number of assault on staff by patient related incidents in June 2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Health & Safety Scorecard

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





12. The practical MH Level 2 (non-clinical) training is a new course put in place since April 2018 for non-operational (support services i.e. IM&T, Fleet, Estates) staff who undertake MH activities. 118 members of staff have been identified as requiring this training, and training dates have been circulated through the Learning and Development Team.

13. Trust-wide compliance for the Manual Handling Training (Clinical) in June 2018 was at 71.91%. Practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.

14. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q4 – 2017/18 Jan	Feb	Mar	Q1 Apr	May	Jun	Target Risk Rating	Key changes/updates since last review
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	15	9	An audit of the practical manual handling training that is being delivered to staff via CSR 1: 2018 will be undertaken in July 2018. The feedback from the audit will be used to further develop future training provided to staff. The H&S Department monitor MH related Incidents on a regular basis and a review is currently ongoing to look into and address the equipment related failures reported across the Trust.
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	12	12	12	12	4	Programme of annual audits approved by the CQO. Agreement around the Terms of reference for Corporate H&S Committee deferred until the July Corporate H&S Committee meeting and following the ACAS review of Trade Union numbers.
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	12	6	No updates since last review.
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	9	9	3	3	The average RIDDOR reporting timelag reduced to 11 days in June 2018. It is recommended that this risk should be downgraded and closed but monitored on a monthly basis by the H&S Team.
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	9	3	No updates since last review.
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	8	4	No updates since last review.
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	6	3	Substantive recruitment into the Health and Safety Department is ongoing.

EFFECTIVE – Dashboard

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

Measures	Target / Range	RAG	YTD 17/18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	31%	39%					⇔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	63%					⇔			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%	89%					↑			LQ2b		
STEMI care bundle (AQI)		G	70%						⇔			LQ2c		
Stroke to HASU within 60 minutes (AQI)		G	67%	54%	52%				⇔			LQ3a		
Stroke Care Bundle (AQI)		G	97%	97%					⇔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	00:32				⇔					
Survival to Discharge (AQI)			10%	9%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	17%					↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:41				↓					
Call to angiography (mean hh:mm)				02:41										
Call to arrival at hospital (hh:mm)				01:18										
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	85%	90%	87%				⇔		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	29.12%	35.0%				⇔			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98.0%				⇔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97.0%	97.0%	97.0%		⇔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	G	92%	94%	94.0%	95.0%	94.0%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97.0%	98.0%	97.0%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96.0%			⇔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)		G	0%			91.0%	90.0%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		98.0%		↑			LQ12		

Actions

As a result of the additional features built into the CPI database, in May five auditors completed a Datix report as they had clinical or safety concerns and eight auditors placed a retrospective safeguarding referral.
In May, eight paramedics on restricted duties received CPI training.

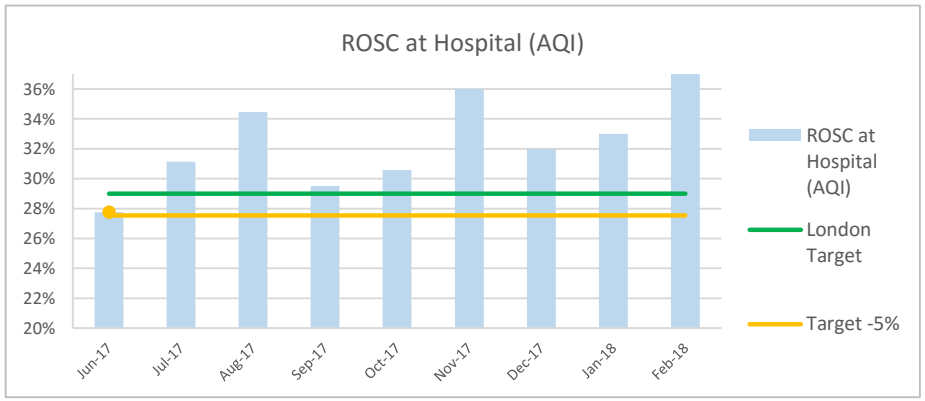
Assurance

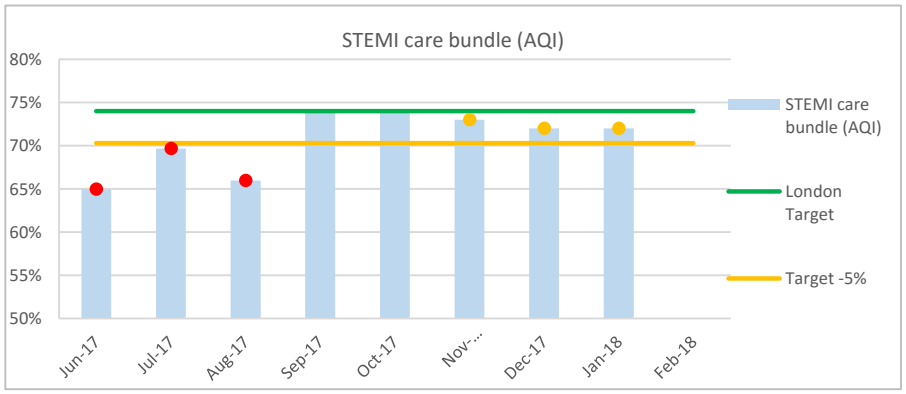
In May, LAS CPI completion decreased slightly compared with April. The proportion of CPI audits completed by Team Leaders continued to decline for the second month in a row and at 52% was the lowest since December 2017.
The standard of care provided by the LAS to patients under the Discharged at Scene, Cardiac Arrest, Glycaemic Emergencies and Severe Sepsis CPIs remained high in May, as well as the standard of general documentation.
Care provided by the LAS to patients with an undiagnosed psychiatric problem in May was lower than those with diagnosed psychiatric problems in April (May was the first month of looking at undiagnosed psychiatric problems).

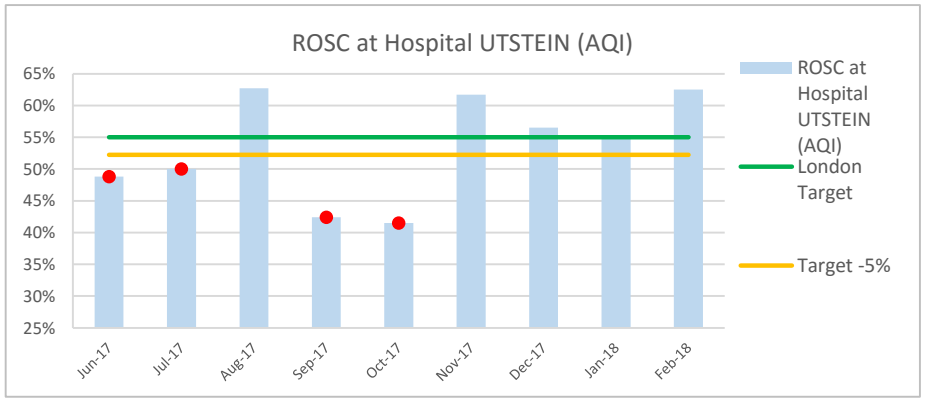
In May, 469 members of staff (12% of all LAS frontline clinicians) received a face-to-face feedback session; 48% of the expected number of staff across the LAS overall, taking into account the face-to-face feedback target and scheduled requirements for Team Leaders to fulfil patient facing duties this month.

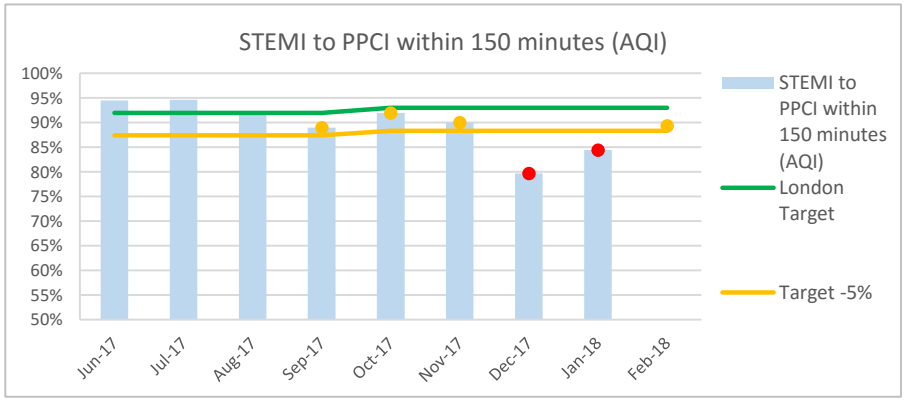
EFFECTIVE - Clinical AQIs

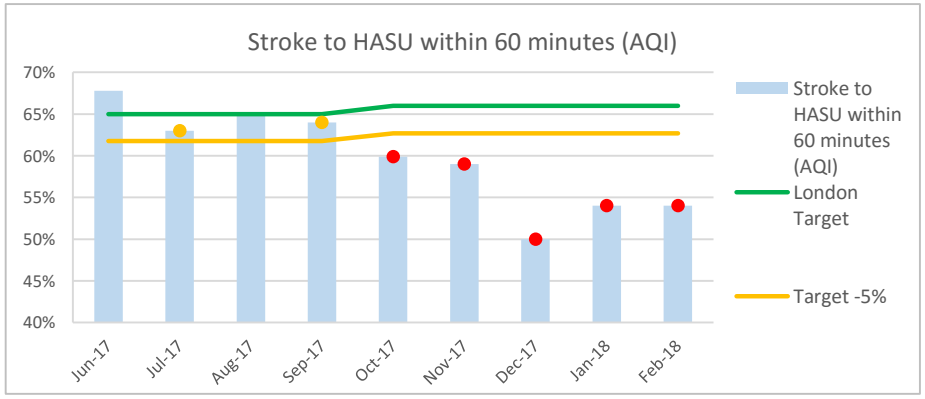
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

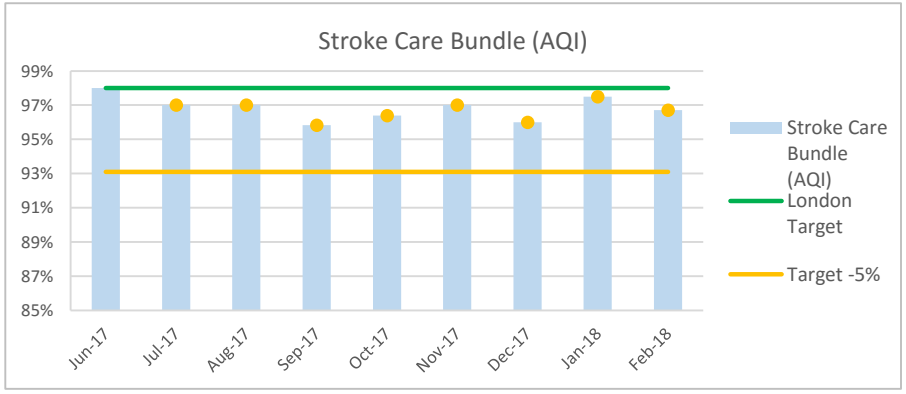








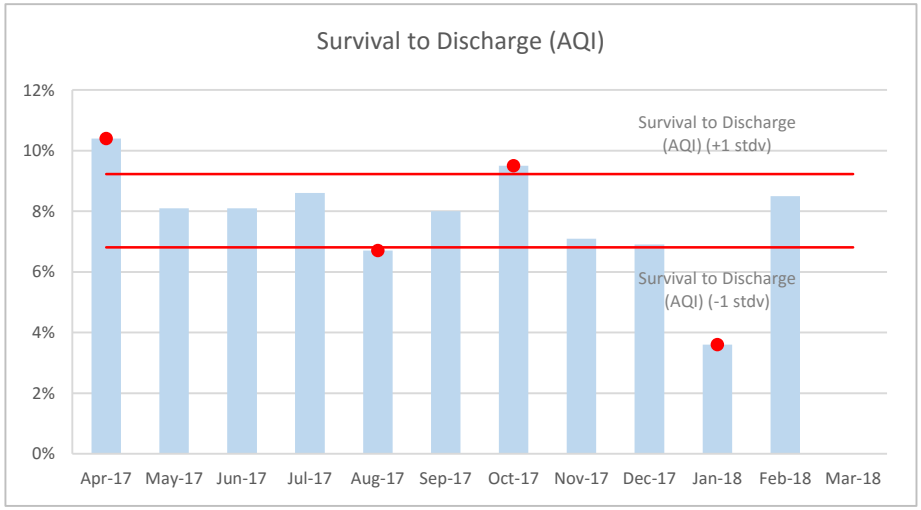


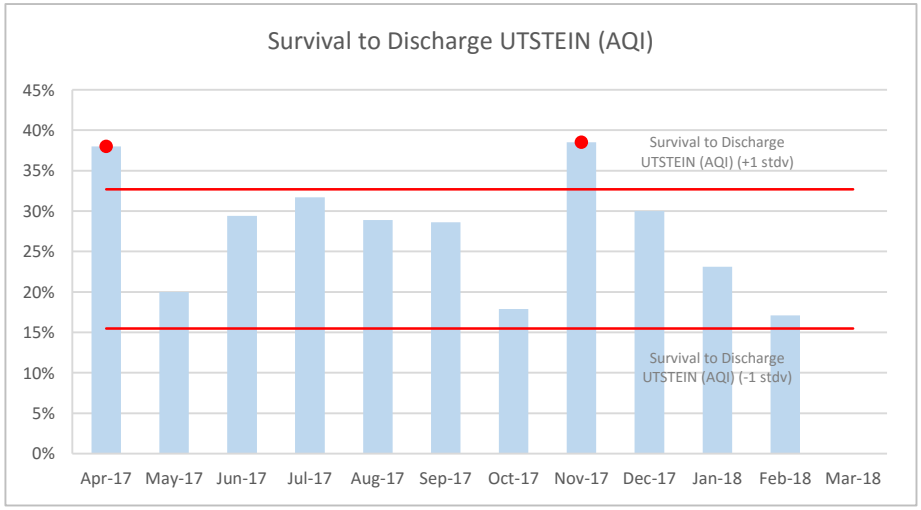


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

EFFECTIVE - Clinical AQIs

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





AQI: Narrative

In February, ROSC on arrival at hospital for both the overall group and the Utstein comparator group increased considerably in comparison with previous months at 39% and 63% respectively. The survival to hospital discharge figures for both groups has also increased from previous months at 8.5% for the overall group and 27.1% for the Utstein group. Defibrillator downloads decreased by 6% from 21% in April to 15% in May.

NHS England have published STEMI call to angiography for January and February, which shows an increase for both the mean and 90th centile to 2 hours 12 minutes and 2 hours 41 minutes respectively in February. The STEMI care bundle has moved to reporting one month every quarter with the next month of submission due to be reported in September based on April data. The average on-scene time increased by 1 minute to 39 minutes in May but remain below the 2017/18 average.

For the stroke call to hospital AQI, NHS England have published data for December to February inclusive. The mean and 90th centile in February was 1 hour and 18 minutes and 1 hour and 59 minutes respectively. In February, 97% of patients received the diagnostic bundle, which is consistent with the year to date average for the LAS.

AQI: Actions

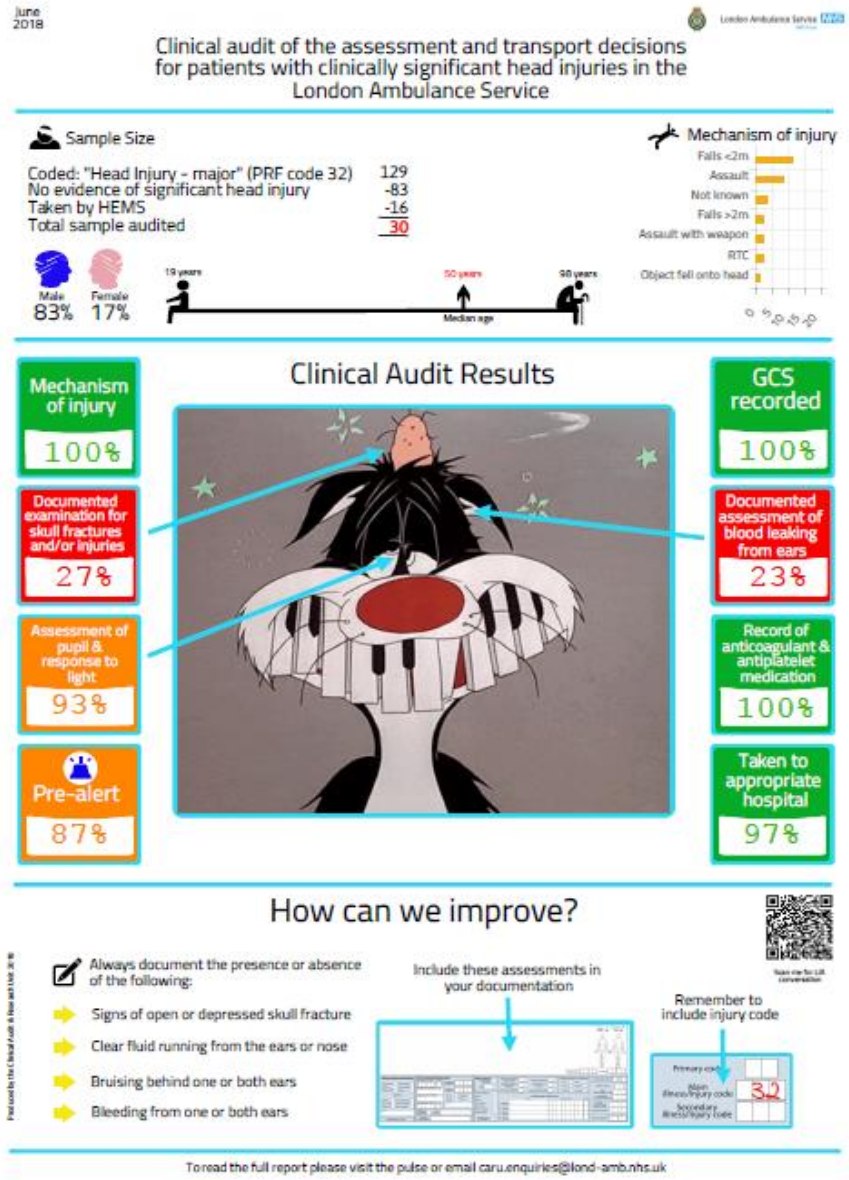
CARU, on behalf of all ambulance services, have been working with NHS England to develop the AQI's and review the current criteria for existing measures.

Note: From April, AQI data presented is NHS England's published data; not the provisional data previously presented. This therefore represents a 4.5 months time lag for: cardiac arrest (ROSC & survival); stroke (call to hospital & diagnostic bundle), and STEMI (call to angiography & care bundle). For the remaining measures, timelines are one month behind in line with Care Packs.

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

Clinical Audit Performance

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



Clinical Audit: Actions & Assurance

Three clinical audit actions were completed in May and June:

- A video outlining the key principles of the Mental Capacity Act was developed and published on the LiA face book page for staff
- A Clinical Performance Indicator for undiagnosed psychiatric problems was launched
- An infographic outlining the findings and recommended areas for improvement from the Head Injuries Clinical Audit was produced for LiA, the Pulse and sent to ambulance stations

As a result of our Continuous Re-contact Clinical Audit, in June:

- 48 crews were recommended for feedback (15 positive & 33 constructive)
- 3 Clinical Advisors were recommended for constructive feedback
- 1 re-contact was shared with the Frequent Callers Team due to multiple calls (The team were already aware of the patient)
- 4 incidents were reported on Datix (2 unexpected deaths were not declared by SIG; 2 were investigated locally)

Research Actions & Outcomes

We have recruited 38 patients into the ARREST trial. We are planning to go live across the whole of the LAS area in September 2018.

The Clinical Research Network has released comparative performance data for the year to date. LAS are performance extremely well:

- 100% of LAS studies now closed to recruitment, met their recruitment targets (the national figures for all NHS trusts is 75%)
- 100% of LAS studies that are currently open are recruiting to 'time and target' (the national figure is 31%).

CARING – Dashboard & Mental Health

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

Measures	Target / Range	RAG	YTD 18/19	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Mental Health related calls as percentage of all calls			8%	7.5%	7.9%	7.9%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.1%	2.1%	2.1%	↓				
Mental Health related Incidents as percentage of all calls			5%	4.7%	4.9%	4.9%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.3%	↑				

Staffing

Recruitment – 3 full time Mental Health Nurses commenced in post 02/07. They are currently in a period of induction.

Bespoke Mental health training has been delivered to NHS 111 in Croydon.

Partnership Working

The first 10 sessions of the Mental health simulation training are open for booking with a good uptake. The session is run by the Maudsley Simulation centre and will be run in conjunction with Police colleagues.

We represented the service at the 'Mental Health on the Frontline' conference organised by NHS Resolution. It was well received and we have been invited back to speak at a further conference in September.

We delivered a session on the ambulance service's role in a Mental Health Crisis to police officers and East London NHS Foundation Trust.

Innovation

We are in early discussions with Capsticks to collaborate on some written guidance for staff around the Mental Capacity Act.

Patients

We continue to work closely with the users by experience patient group from Oxleas MH Trust to support service redesign and training delivery meeting them on a monthly basis to progress programmes of work.

We are currently planning a 'Whose Shoe's' event – key stakeholders, patients and staff will attend to help shape the future of Mental Health Care within LAS.

Maternity – Good to Outstanding

Owner: Amanda Mansfield | Exec Lead: Dr. Trisha Bain

Improvement plan

	RAG	Update
1	Complete	• 2 Actions are complete and closed down
2	Green	• 3 have completion dates in the future
3	Amber	• 0 Actions in the past but action plans in place
4	Red	• 0 dates have past with no plans in place

Key risks

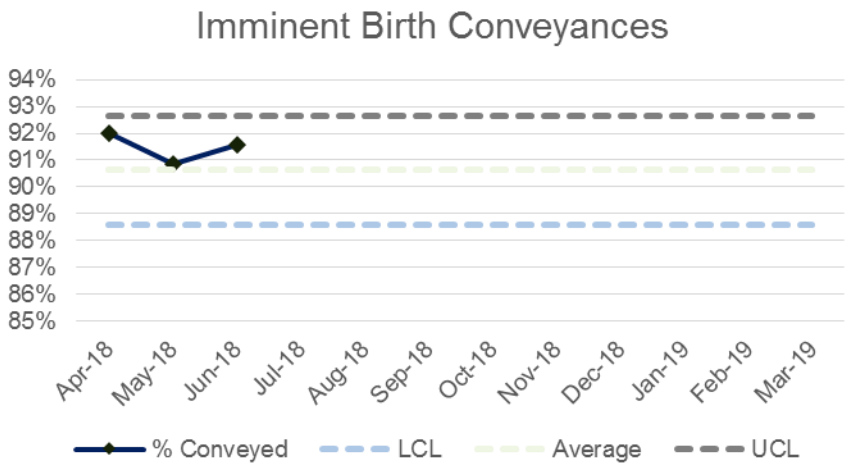
#	Risk	Action	RAG
1	During Induction to the LAS the Practice Leads for not able to deliver maternity education	Consultant Midwife to provide 2 sessions per month 10 LAS members of staff to be sent on 2 day Obstetric training in 07/18 to increase capacity	
2	Maternity Risk Oversight could be compromised due to capacity	Consultant Midwife to review 100% maternity related incidents	

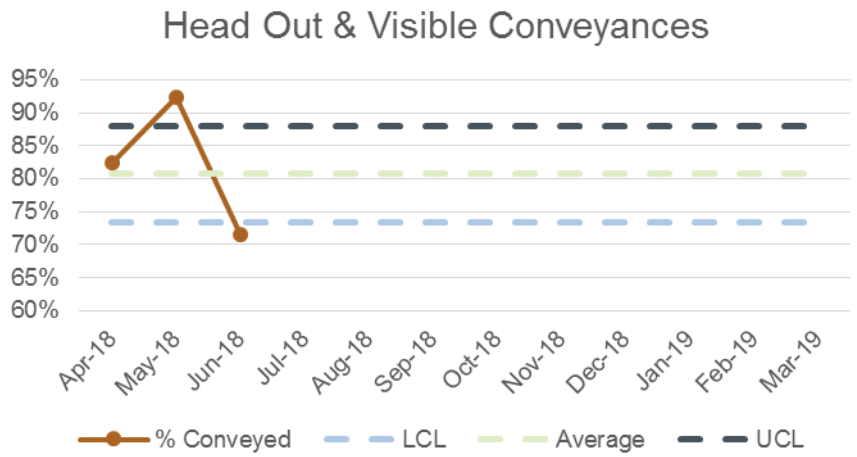
Quality Domain	Objective	Action	Progress
Safe	Deliver system-wide Maternity Training	2.0 WTE Employed - August 2018	Review of Training Needs Analysis Maternity Training with Maternity Education Leads 09/18 KPI based upon 4 Training Sessions per Month
Effective	Reduction in ambulance conveyance (20%) q4 18/19	Establish monitoring framework to measure reduction across the ARP response categories 08/18	Aligned to phase 1 Maternity Pioneer Service Introduction Midwives into the control room. Midwives JD to workforce panel 07/18
Well Led	Strategic intent for Maternity and midwifery structure known across the system	Midwifery structure agreed at Clinical Council 06/18	Sector wide allocated Midwifery and Maternity Education Leadership 10/18
Caring	Establishment of LAS Maternity Voices Partnership (MVP) aligned to the Pioneer Service	Identified lead from Patient Public Involvement First MVP 10/18	Planning meeting 09/18 - Patient's Forum/Staff/Chair
Responsive	Deliver the Maternity Pioneer Service Implement the Maternity Safety Summit	Business Case for ELT - 08/18 Commence 09/18	Programme board establised 09/18 Recirculate Terms of Reference for Maternity Safety Summit 08/18

KEY
Red (O) = Overdue - will miss/has missed due date
Amber (R) = Recoverable - at risk of missing due date
Green (T) = On Target
Blue (C) = Complete

Maternity – KPIs

Owner: Amanda Mansfield | Exec Lead: Dr. Trisha Bain





Using standard deviation we have used: LCL – Lower limit of conveyances last year UCL – Upper limit of conveyances last year

Birth Imminent, conveyance rates and birth imminent calls are presented as measures that we look to align specific improvements to the Maternity Pioneer Services
The existing clinical determinant of Haemorrhage after 24 weeks does not have a target benchmark

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No
North West	12
North Central	8
North East	13
South East	14
South West	7
Outer London/PPI	6
Total	**60**

Events in June include:

- Road safety: Biker Down, Driven by Consequences and a cycling festival
- Junior Citizen Schemes (ages 10-11)
- Women's groups
- Brownies visit
- Knife crime workshops and events
- School and college visits
- Job and careers fairs
- CPR and defibrillator training
- Summer fetes, fairs and fun days
- Multi-agency community engagement events

Public Engagement activities

Supplementary information	
Public engagement: no. of hours (June 2018)	697
Approximate audience numbers (June 2018)	16,285
No. of public engagement events: year to date (April 2018 – June 2018)	124
No. of staff on LAS Public Education Facebook group	740
No. of staff on contact list	1,305
Widespread promotion and publicity internally and externally through the pulse, Twitter, Facebook and staff bulletins.	

Staff Awards

- The Service has won an award for the Best Use of ESR at the Healthcare People Management Awards (HPMA).
- Higher Education Programme Manager Paul Bates has been awarded a Fellowship to the College of Paramedics for his outstanding contribution to the professional body and to the education and development of the paramedic profession.
- Twenty five members of staff were recognised at a special event in June to celebrate staff who had completed training through the LAS Academy, others who had achieved postgraduate qualifications and two who have completed 35 years of service.

Staff Recognition

- In June one of our paramedics were awarded a High Commendation from the Metropolitan Police Commissioner after helping detain an armed man. The paramedic, who has worked for the Service for 13 years, was nominated by a senior police officer for their quick thinking and actions when attending an incident and coming across an armed man.
- Over £11,000 has been raised for charities following the emergency services boxing night that took place earlier this month. Seventeen members of staff represented the Service and went head to head with colleagues from London Fire Brigade and the Metropolitan Police in front of 1,500 spectators at the O2 arena. Although no overall winner was announced, it was a successful night all round with our team taking 8 wins, 6 draws and 3 losses.

RESPONSIVE – Dashboard & Frequent Callers

Owner: Briony Sloper Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Apr-18	May-18	Jun-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.66	3.9	3.5	3.6	↑				
CMC records viewed			1309	393	497	419	↓			LQ30	
Friends and Family Test Recommending LAS as % of total responses	94%	G	89%	66%	100%	100%	↔			LQ27	
Friends and Family Test Response Rate			0.00	0.0	0.0	0.0	↔			LQ28	

Frequent Caller Team (FCaT) June 18 updates:

Last month the Frequent Caller Management Database (FCMD) identified 578 new & existing frequent callers meeting the national definition. 100% of patients were matched with their NHS numbers.

The Frequent Caller Team continue to work with the Community Involvement Officers (CIOs) who have now joined the Frequent Caller Team.

The Frequent Caller Team (FCaT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS.

FCaT supports a range of requests for data, including ED Frequent Attender meetings; CCG Forums, Mental Health Multi Disciplinary meetings, GP meetings, and NE sector STP work on frequent callers & attenders.

Frequent Caller Team (FCaT) challenges:

A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and Emergency Department plans. About to be piloted internally.

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*

Case one:

39 year old white British male. Has called LAS and Met police regularly for the past 10 years, often with suicide threats, & involves 3rd party callers in public areas. Escalating risk to others. De-registered from GP due to high risk behaviour. Regularly evicted from supported accommodation due to behaviour. Mental Health services and A&E Depts. supported prosecution for misuse of emergency services. Patient given a 2 year Criminal Behaviour Order. No calls to LAS and no inappropriate A&E attendances since court process began.

Case two:

65 year old white British male with learning disabilities whose attendance to A&E had increased due to his local authority care package being reduced. Living independently but not coping. Selected by CCG project to offer intensive support. Lambeth CCG have commissioned two full time support workers to work with Lambeth's cohort of A&E Frequent Attenders. Immediate drop in call rate and A&E attendances. A more comprehensive care package was recommended with support form the new CCG project. A full evaluation of the case will be completed in time. No calls received since CCG support worker started short term intensive working.

Frequent Callers

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

Cluster	CCG	Patients	Calls last month	Calls last quarter	Calls last 12 months	Patients with NHS no.	% of patients with NHS no.
NE	BARKING AND DAGENHAM CCG	15	140	373	1087	15	100%
NC	BARNET CCG	30	182	649	2127	30	100%
SE	BEXLEY CCG	16	141	458	1161	16	100%
NW	BRENT CCG	17	135	521	1122	17	100%
SE	BROMLEY CCG	10	59	184	418	10	100%
NC	CAMDEN CCG	14	97	380	1224	14	100%
NW	CENTRAL LONDON (WESTMINSTER) CCG	13	223	522	1191	13	100%
NE	CITY AND HACKNEY CCG	31	336	888	2899	31	100%
SW	CROYDON CCG	27	261	728	1607	27	100%
NW	EALING CCG	25	229	676	2817	25	100%
NC	ENFIELD CCG	24	296	831	1837	24	100%
SE	GREENWICH CCG	24	266	635	2030	24	100%
NW	HAMMERSMITH AND FULHAM CCG	15	160	413	1363	15	100%
NC	HARINGEY CCG	26	294	1630	3417	26	100%
NW	HARROW CCG	16	138	354	1173	16	100%
NE	HAVERING CCG	15	245	759	2331	15	100%
NW	HILLINGDON CCG	23	220	584	1344	23	100%
NW	HOUNSLOW CCG	15	117	1370	3397	15	100%
NC	ISLINGTON CCG	17	252	639	1908	17	100%
SW	KINGSTON CCG	6	34	100	345	6	100%
SE	LAMBETH CCG	25	259	718	2025	25	100%
SE	LEWISHAM CCG	10	149	502	1251	10	100%
SW	MERTON CCG	9	49	156	549	9	100%
NE	NEWHAM CCG	24	240	588	1545	24	100%
NE	REDBRIDGE CCG	13	102	368	1011	13	100%
SW	RICHMOND CCG	8	174	411	1058	8	100%
SE	SOUTHWARK CCG	24	197	823	2242	24	100%
SW	SUTTON CCG	18	90	357	891	18	100%
NE	TOWER HAMLETS CCG	12	158	339	1112	12	100%
NE	WALTHAM FOREST CCG	18	326	735	1567	18	100%
SW	WANDSWORTH CCG	13	112	453	1081	13	100%
NW	WEST LONDON CCG	20	266	807	2045	20	100%
	Top 5	**573**					
NW	HOUNSLOW CCG	F	26	1040	2364		Anxiety & chest pain
NC	HARINGEY CCG	F	27	809	864		Mental health issues
NW	WEST LONDON CCG	M	120	317	529		COPD & Difficulty in breathing
NE	HAVERING CCG	F	42	259	697		Mental health issues
NW	CENTRAL LONDON (WESTMINSTER) CCG	F	126	233	413		Difficulty in breathing

Learning from Complaints

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

Complaints by subject 2015/18	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Total
Delay	16	14	26	9	22	33	19	17	40	21	21	17	11	266
Conduct	24	19	19	16	17	25	20	22	23	20	18	23	20	266
Road handling	13	14	10	7	14	9	7	6	10	6	5	8	8	117
Treatment	5	1	7	5	16	8	9	8	14	4	9	13	8	107
Non-conveyance	4	12	0	1	6	1	7	6	3	4	6	5	9	64
Totals (above)	62	60	62	38	75	76	62	59	90	55	59	66	56	820
Totals per month	76	73	86	51	94	85	84	74	102	76	77	77	70	1025

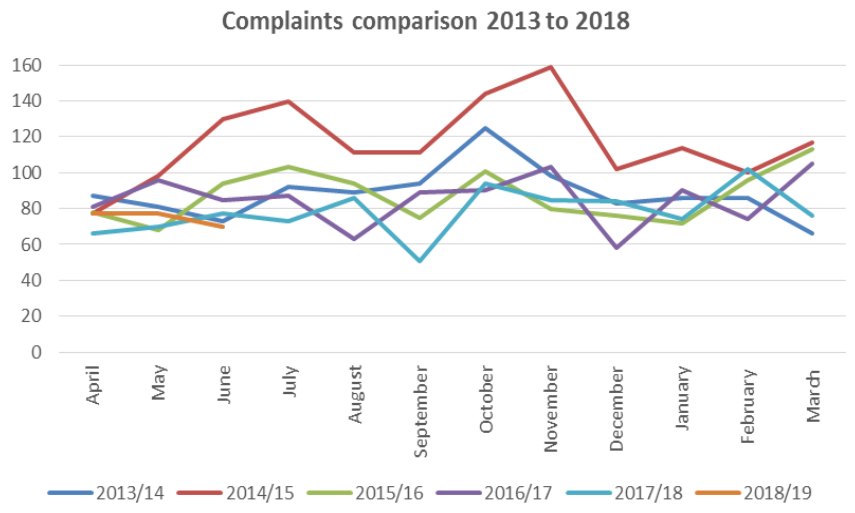
Assurance and learning

- We are seeking guidance from the Medical Directorate regarding the management of Health Partner Alerts where a clinician to clinician discussion would be more beneficial
- The Ombudsman is currently investigating 10 of our referred complaints, five of which involve a deceased patient
- During June we received 369 PALS enquires. Comprised of 257 general enquiries, 51 lost property, 33 requests for medical records, and 28 appreciations.
- We are still receiving fees from Solicitor's for records requested prior to the implementation of GDPR (circa £66,000 in 2017/18). This will reduce to nil over the coming months
- Seven complaints are being managed in conjunction with Governance as they have been declared as Serious Incidents.

Review of June 2018

- The overriding good news for June was the successful visit to the London Ambulance Service by the Parliamentary Health Service Ombudsman on 28 June
- The ombudsman stated that “LAS offers a vital public service, one which we should all be proud of…….Their dedication to learning from complaints means patients should get the answers they need while also helping to drive improvements throughout the service”.
- Unfortunately, due to escalation to REAP 3, the ombudsman was unable to spend time in EOC but he was able to discuss how we plan for unpredictable emergency events with the Head of Resilience & Special Operations.
- In June we received 70 complaints , this included 1 on behalf of the patient from a HCP and 4 regarding NHS111
- This represents 0.08% against face to face incidents during June of 90,907
- There were 23 Health Partner Alerts in June of which 7 have been resolved. A total of 29 HPA’s remain under investigation
- Complaints where conduct and behaviour are the key head of complaint continue to increase (20 this month, annual average = 22 per month)

Complaint numbers June 2013 to June 2018



Learning from Complaints

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

Complaint response times – June 2018

Month	Total complaints remaining open/re-opened as at time of report each month	Closed during the month	opened complaints by month
Jan-18	106	98	74
Feb-18	109	91	102
Mar-18	131	70	76
Apr-18	108	93	77
May-18	105	70	77
Jun-18	107	78	70
Totals	666	500	476

- There were 15 out of time complaints where the response was due in June that have been concluded.
- There are 12 complaints where the response has exceed 35 working days and await conclusion. Of these, 4 await QA reports, 4 are being drafted by the case officer, 2 are awaiting clinical opinions, 1 is awaiting operational input and 1 has been referred back fro SIG as non declared
- Two complaints have had time frames extended due to the complexity and nature of the complaint (not included in above numbers)

Categories of complaint calls

June 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	3
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	15
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	14
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	10
Category A Red 1 - 8 min response	2
Category C1 45 min response	1
Category C2 60 min response	1
Not CAD related (i.e. NHS111/driving issues) /Info awaited	24
Total	70

Assurance & Learning

- A small working group in the team will be redesigning some of the information on the website with an FAQ facility . We are waiting to liaise with the new web officer to achieve this
- A complaints process mapping team has been established to take forward a number of issues including meeting the needs of complainants and ensuring that our complaints processes are patient centred.
- During Quarter 1, 2018/19, 85 complaints have not been upheld, 8 have been upheld and 12 partially upheld.
- We are continuing to review how we can improve throughput with contributing departments (i.e. QA) with improved use of Datix to streamline case management
- Management of Health Partner Alerts is working well but we are hoping it will improve further as it becomes more embedded
- We have submitted the relevant documentation to improve resourcing within the department and await the approval of that
- We continue to justify our need for a dedicated clinician and QA officer to assist with complaint management and thus throughput

Case example

Example one

The patient's mother complained that an ambulance was not sent for her son who had collapsed suddenly injuring his head.
The Quality Assurance review of the 999 call indicated that the call handler of the initial call should have applied the Traumatic injuries protocol to assess head injury which would have achieved a higher priority outcome being determined. The EMD will receive extensive feedback

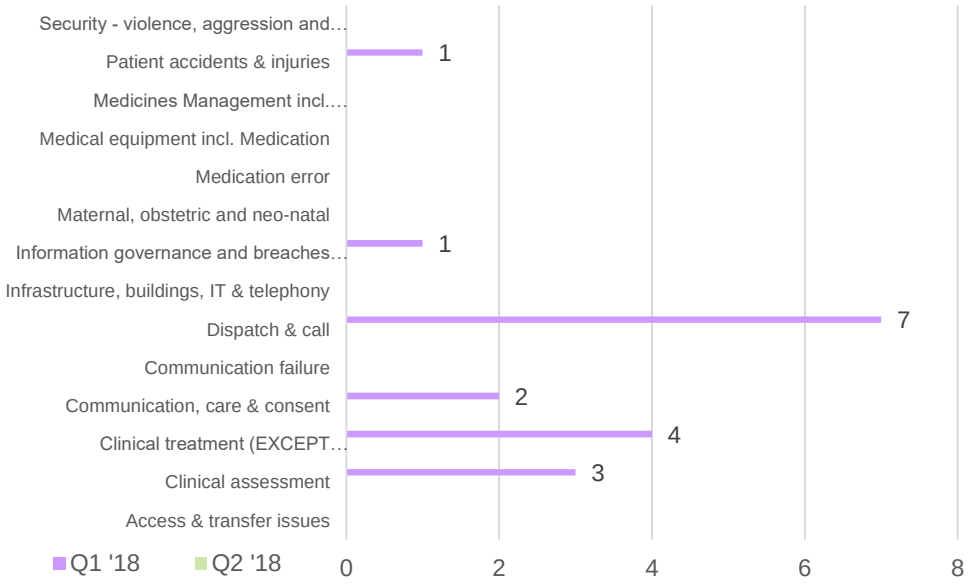
Example two

Complaint from care home manager who is upset at the attitude of the clinician who called the patient back.
The Clinical Advisor was unprofessional in the management of the call and should not have persisted with asking the caller to lift the patient off the floor once advised that it was not their company policy. Feedback will be offered to the clinician concerned

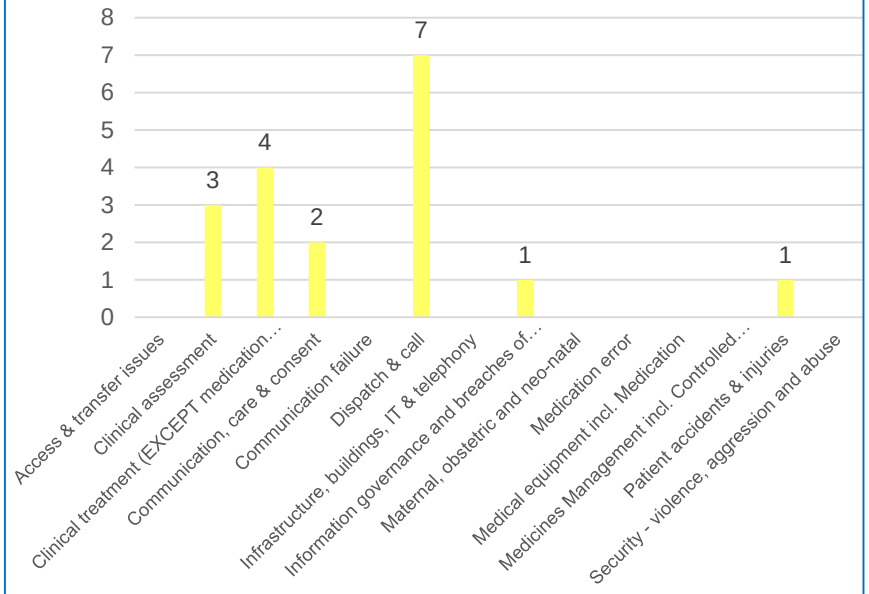
WELL-LED - Learning from Incidents

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

Serious Incidents by Category

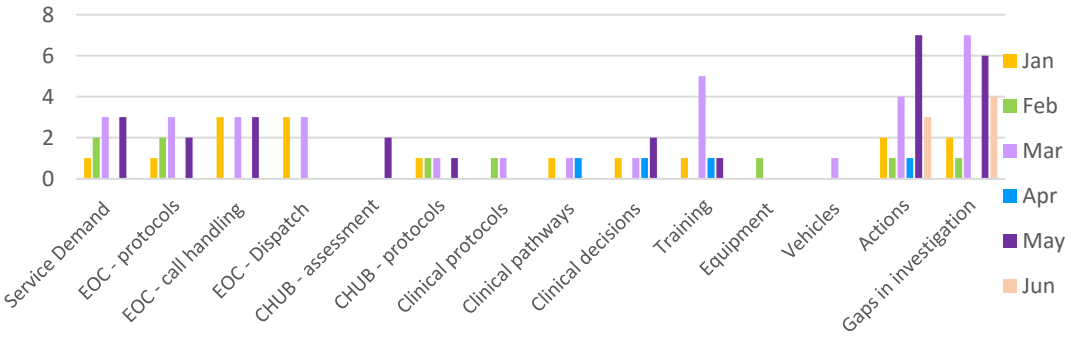


Serious Incidents by Category YTD 2018/19



Dispatch and call and the clinical management of a patient remain the recurrent themes in the majority of SI investigations. The majority of the incidents declared regarding dispatch and call issues concern delayed ambulance responses. It should be noted that this difficulty is not isolated to EOC and is believed to be related to our current fleet profile being misaligned to the requirements of the new national ambulance standards.

CCG Comments



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.
Gaps in the investigation and action plans continues to be a theme in the types of comments received from the CCG. It should be noted that the gaps in the investigations are largely related to Trust-wide organizational learning and not included in the terms of reference for the SI which primary looks at the isolated incident. The Trust undertakes a quarterly thematic review to look at system learning and Trust wide learning.
Gaps in the action plans are largely related to organisation learning and are taken into consideration. The importance of organizational learning is being emphasised on the LI training course and the team have requested allocated time on the patient safety conference to discuss learning from incidents, SIs, claims and inquests.

Learning From Deaths, Inquests and Claims

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

Inquests – figures and learning

	2017/18			2018/19		
	Apr-17	May-17	Jun-17	Apr-18	May-18	Jun-18
Total Prevent Future Deaths In-Month	1	1	0	0	0	0
Total Inquests where LAS asked to give evidence - In-Month	4	6	4	5	5	6
Total Inquests where LAS asked to give evidence - Year to Date	4	10	14	5	10	16

Inquests – actions and learning

Learning from Inquest:-

- Her Majesty's Coroner (HMC) issued the Trust with a Schedule 5 Notice outlining evidence to be produced to enable an Inquest to proceed.
- The Patient Report Form (PRF) required by the Court had not been sent to Management Information (MI) and was initially deemed lost/missing.
- The loss of the PRF made it difficult for the attending Paramedic to write a witness statement addressing a specific query raised by HMC.
- The PRF was eventually found in the archive store room on station along with other paperwork for that day.
- An investigation in the SE is to take place looking at the processes in place for logging PRFs and ensuing that they are sent to MI in a timely manner.

Major Incidents

- Westminster Bridge Deaths – Inquests have been listed to commence on 10th September with a time estimate of one month.
- London Bridge Deaths – Inquests to start shortly after Easter of 2019 with a time estimate of two months.

Claims – figures and learning

The NHS Resolution Quarterly Report, Q1 of 18/19 for the Clinical Negligence Scheme for Trusts and the Liabilities to Third Parties Scheme for Trusts shows the following:-

No of Claims	Total Claim	Total Damages Reserve	Total Claimant Costs Reserve	Total Defence Costs Reserve	Total Outstanding Estimate	Total Payments
44	£65,817,125	£57,839,912	£6,391,258	£1,585,955	£57,060,624	£8,756,500

No of claims	Total Claim	Damages Reserve	Claimant Costs Reserve	Defence Costs Reserve	Outstanding Estimate	NHSLA Funded Payments	Total Payments
55	£2,977,164	£2,076,295	£693,469	£207,400	£2,254,765	£692,854	£722,399

Claims – actions and learning

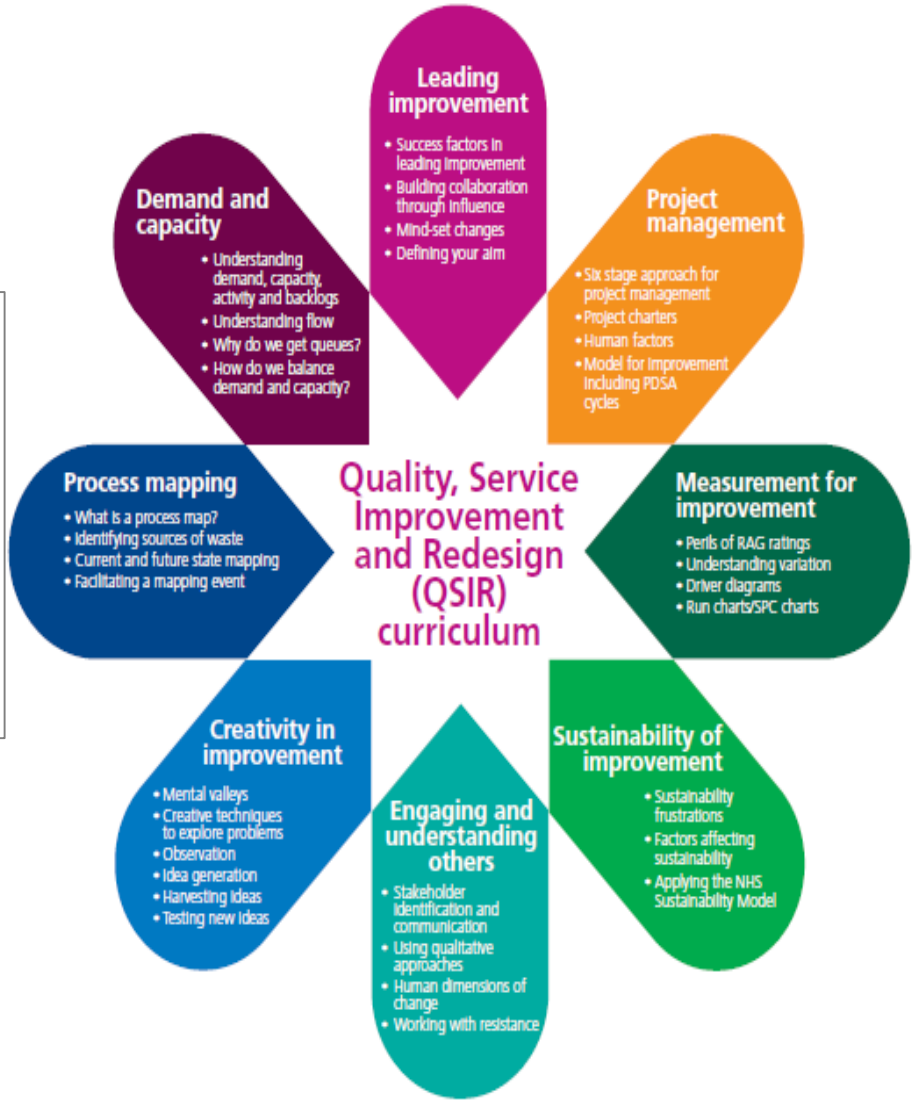
- Seven new claims have been opened this month, four employer liability claims and three clinical negligence claims.
- The employer liability claims relate to two cases of defective work equipment (tail lift and Ferno track chair), one case involving manual handling (lifting oxygen bag) and another involving a defective door on an ambulance vehicle.
- The clinical negligence claims relate to two cases of delay in attendance/conveyance and one case involving treatment.
- The Head of Legal Services is to meet with the Head of Healthcare at Panel Solicitors to discuss the settling of claims out of court in a timely manner where liability for the injury is admitted by the Trust.
- A monthly report is to be provided to the Deputy Director of Operations providing a breakdown of claims by sector to inform further action and learning.

Projects – QSIR Training

Owner: Briony Sloper | Executive Lead: Trisha Bain

The Quality, Service Improvement and Redesign (QSIR) Programme 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 there is a consist approach to change becomes the way of doing things in the Trust. The staff attending this training will support the Trust overall Strategic Plan championed by the Executive Leadership Team.



Assurances

23 staff from across the organisation attended the first day of the QSIR programme covering leading improvement and project management representing a wide range of roles and departments.
Detailed feedback is required to be collated and analysed by the QSIR faculty following each delivery day and Day 1 was extremely positive evaluated with the majority scoring 5/5 for the day and the remaining scoring 4/5 for the day.
A detailed analysis using an accredited tool is currently being undertaken. The ability to share learning from across the organisation, participate in group discussion and the experience and knowledge of the presenters were the key themes.

Actions

Day 2 will take place on the 11th September focussed on Measurement of Improvement and slides will be localised to highlight current AS reporting tools and scorecards to stimulate discussion. UCLHP have provided a trainer to help co-deliver with the Deputy Director of Nursing and Quality.

We anticipate 2 additional members of staff proceeding to undertake the teaching assessment programme to become faculty members to support delivery in a sustainable way for the future.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report title:	General Data Protection Regulation (GDPR) Update			
Agenda item:	Additional report circulated for information and assurance only			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Update reports to the Trust Board meeting in public on 24 May 2018 (TB/18/42) and to the Audit Committee on 17 May 2018 (AC/18/29).			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose

This paper provides the Board with an update on the organisation's progress with preparations for GDPR compliance.

Recommendation(s)

The Board is asked to note the progress being made with regard to the implementation of GDPR.

Links to Board Assurance Framework (BAF) and key risks

Compliance with GDPR has not been identified as a BAF risk but it is a corporate risk that the Audit Committee and the Board has identified requires mitigation.

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 Work streams:	
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	☒

Background

1. The General Data Protection Regulation (EU) 2016/679 (or GDPR for short) came into effect in the UK on the 25 May 2018 replacing the existing Data Protection Act 1998 (DPA) with which LAS has complied with until then.

2. GDPR represents the biggest change in Data Protection Law for 20 years and impacts every aspect of LAS business activities that processes personal information about patients, staff, customers of training, suppliers, website visitors, research subjects and donors who respond to LAS fundraising activities.

3. The Trust is now in the second tranche of work to ensure that complete compliance to the GDPR is met. There is a dedicated team to ensure that its GDPR maturity and posture are increased as the programme continues to make definite and concise changes to the practises at the Trust. The team has management support and good reporting channels to the Executive Leadership Team, the London Ambulance Service NHS Trust continues to meet its legal obligations and safeguard its data to the best of its ability.

4. The project has now entered the implementation phase, with appropriate project governance in place. A project team has been deployed comprising a programme manager, project manager, subject matter expert, business analyst. A review of the work completed prior to the previous audit has been completed and an action plan based on the recommendations from the KPMG report is being prepared.

5. Activities since the last report to the Board are:

    - Production of a clear implementation plan, the key deliverables of which are:
        - Verification of the information asset register and data workshop
        - Trust-wide GDPR communications plan

    - Production of key project artefacts (cost plans, RAIDs etc.)

    - Weekly project progress meetings are scheduled

Indicative activities / timescales

6. Phase 1 Milestones:

    - Project governance set up complete 24/07/2018

    - Group wide communications:
        - Group Wide E-mail – 25/07/2018
        - Directorate briefing Pack completed – 02/08/2018
        - RIB articles published by – 25/07/2018
    - Start Information Asset Owner (IAO) workshops – 04/09/2018

Dependencies

- Access to IAOs to attend GDPR Data processing workshops

- Verification of the application landscape

- Access to relevant teams to undertake a data cleaning exercise
- Access to relevant teams to verify the data flow

7. A more detailed update will be provided to a dedicated Board Briefing Session (to be arranged), and the Audit Committee at its meeting on 3 September 2018.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	31 July 2018			
Report title:	Trust Board informal meetings for the remainder of 2018/19			
Agenda item:	Additional report circulated for information and assurance only			
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:

Following the Board's decision to move to bi-monthly meetings. This report provides information about the manner in which it is envisaged that the informal Board meeting slots will be used for the remainder of 2018/19.

Recommendation(s):

The Board is asked to note the information provided within 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	☒

Trust Board informal meetings for the remainder of 2018/19

1. The Trust Board agreed at its meeting on 24 May 2018 to move to bimonthly Board meetings, with the intervening dates to be taken up with informal sessions. The Trust Board Chair has identified the following types of informal meeting:

   Board Development session – provides the Board with the opportunity to develop itself, together with the ELT. This should follow a programme of activities agreed by the Board and demonstrate progress against the Well Led Framework.

   Board Strategy Development session – provides the Board with an opportunity to steer the development of our enabling strategies, which are fundamental to the delivery of our overall Trust strategy. Trust Board will decide how and when they would like to be involved as this may differ from strategy to strategy. To support the board strategy session, which would take place in advance of any formal sign off, Trust Board may also request additional approaches to strategy development including:

   - Briefing meetings with a smaller group of non-executive directors
   - One to one meetings with relevant Directors and/or subject matter experts
   - Briefing papers
   - Briefing sessions(see below)

   The strategy sessions should adopt the following framework:

   - Linkage to vision and values
   - Linkage to seven strategy related CQC KLOEs
   - Linkage to corporate objectives
   - Anticipated outputs and next steps

   A summary of the outcome of the strategy session will be provided to Trust Board by the strategy team following each session

   Briefing session – provides the Board with an opportunity to develop its understanding of certain developments or issues that will have an impact on the operation of the organisation and its strategic decision-making. These will be short sessions, often with an external facilitator. They may be stand alone and arranged on an ad hoc basis, or arranged to inform a strategy session.

2. All sessions and briefing documents are to be agreed with the Chair and Chief Executive in advance.

3. The table below sets out the initial list of strategy and development sessions that have provisionally been identified for the remainder of 2018/19.

August	• IMT & Digital Strategy • Freedom to Speak Up Strategy
October	• Clinical and Clinical Education • Volunteering
December	• Commercial & Partnerships
February	• TBC

4. The following sessions are to be scheduled:

Strategy	**Development**	**Briefing**
Fleet and Logistics	Board Development Programme	Competition/integrated care opportunities and issues
Business Planning (October)	Servant Leadership Model	GDPR briefing
Demand understanding and management	Roles and Responsibilities of Board and ELT	Safeguarding Training
Risk	Board to Board meetings	Mentoring
Public and User Involvement	Diversity within the LAS	CQC
		Carter

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	31 July 2018			
Report Title:	Update on Health and Safety Action Plan			
Agenda item:	Additional report circulated for information and assurance only			
Report Author(s):	Ayodeji Adeyemi, Head of Health and Safety			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The purpose of this report is to provide an update on the current status of the actions recommended in the Health and Safety Independent Review Report, and to provide assurance/highlight issues that may impact on the successful implementation of the recommended actions. The report is supported by the following documents:

Appendix 1: Updates on actions 'In Progress and on schedule'

Appendix 2: Health and Safety Scorecard – providing an overview of the Trust's health and safety performance in June 2018.

Recommendation(s):

The Board is asked to note the report, and support the Health and Safety team to address the barriers highlighted within the report.

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

Links to Datix risk 676 – relating to the lack of Trust-wide compliance with statutory health and safety requirements. Risk Rating: 12

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	☐

Health and Safety Update

Introduction & Background

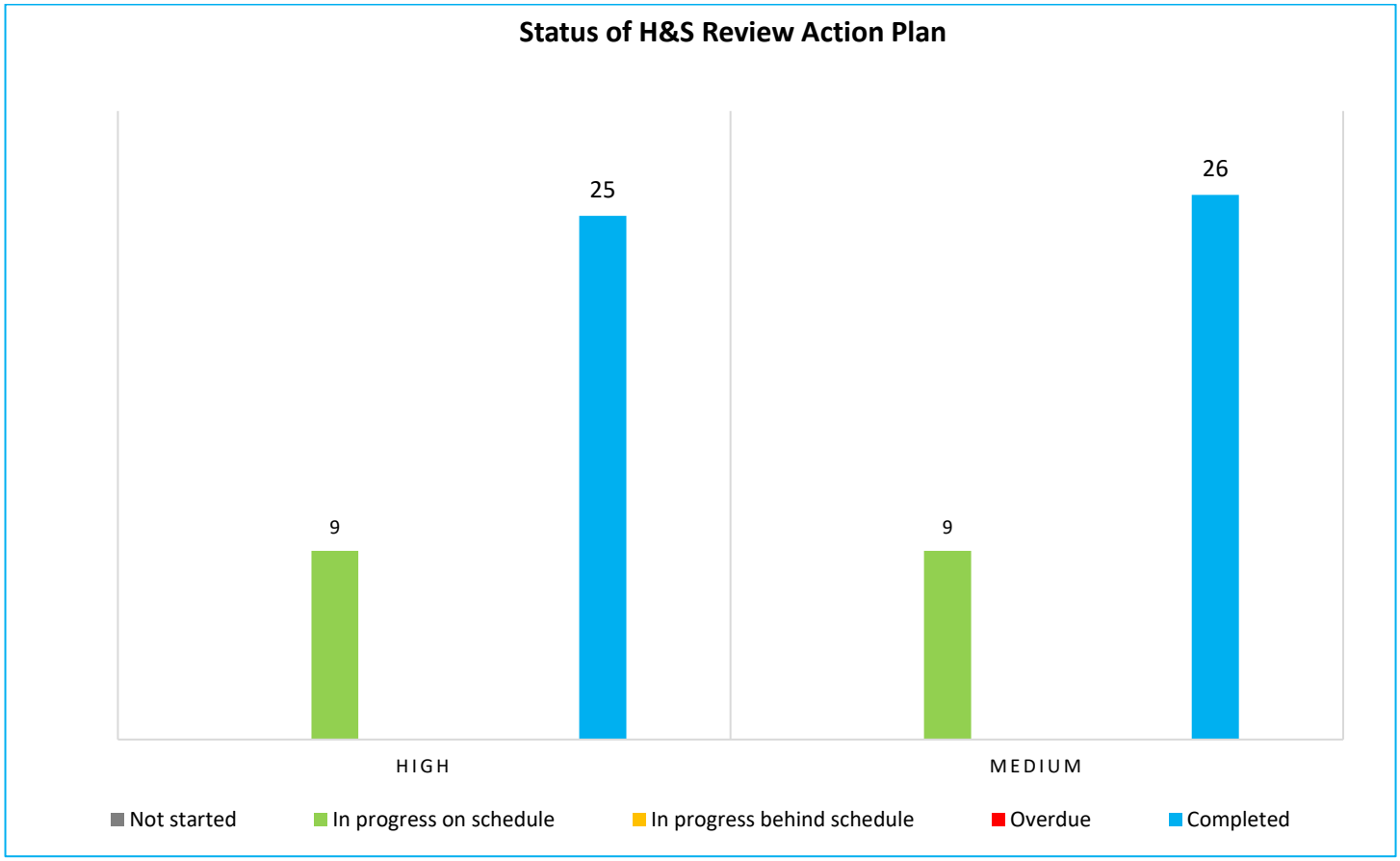
1. Two (2) independent audits were completed in 2017/18 to assess the Trust's arrangements for health and safety. The objective of the audits were to assess the level of the Trust's compliance with health and safety legislation/statutory requirements. The report from the audits identified key areas of risk and areas of improvement, and recommended key actions that need to be completed to improve compliance.

2. This report aims to provide an update on the current status of open actions (yet to be completed) recommended in the Health and Safety audit reports, and to provide assurance/highlight issues that might impact on the successful implementation of the recommended actions.

Highlight of actions recommended

3. A total of 59 actions (categorised as high/medium priority) were recommended following the audit conducted in June 2017. 10 additional actions were recommended following the March 2018 audit and have been added to the action plan. This brings the total number of actions to 69.

4. A total of 51 actions have been completed, 18 actions are in progress and currently underway. No actions are overdue. A breakdown of the current status of the actions is provided below:



Updates on the H&S Review Action Plan

Overdue actions:
No actions are overdue.

Closed/Completed Actions: An overview of the actions that were closed/completed since the May 2018 report is provided below:

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
1.13	Ensure appropriate risk assessments are completed under COSHH and DSEAR for hazardous and flammable substances used across the Trust including in workshops and by HART	High	Justin Wand	Benita Mehra	Action superseded by ongoing Health and Safety review of the Fleet and Logistics Service which will take into account all aspects of the service's health and safety compliance. Full report of review to be produced and received once completed.	Jun-17	31/07/2018	Completed
14	Address issues raised regarding workshop safety - specifically risk assessments, COSHH, work at height, equipment checks, PPE, communication, Datix access and use.	High	Justin Wand	Benita Mehra	Action superseded by ongoing Health and Safety review of the Fleet and Logistics Service which will take into account all aspects of the service's health and safety compliance. Full report of review to be produced and received once completed.	Mar-18	30/06/2018	Completed

Updates on Health and Safety Compliance

Manual Handling:

5. The provision of LAS specific practical manual handling refresher training to all patient/load handling staff is on-going as part of CSR 1:2018. The Health and Safety Department will be undertaking an audit of the training provided via CSR in July 2018, in order to assess the delivery of the course and to identify areas where the course can be improved on.

6. Practical training has also been put in place for support services (IM&T, Estates, Fleet and Logistics) staff who undertake manual handling activities.

7. Manual Handling competency assessments have been developed in conjunction with the Operations Directorate. These assessments will be implemented in September 2018, and will be incorporated into the annual OWR process.

8. There was a reduction in the number of equipment related incidents involving Mangar Elks, track chairs and tail lifts during Q1, 2018/19. 35 equipment failure related incidents were reported in June compared to 54 incidents in April and 57 in May 2018.

9. **Manger Elks** – The installation of the new version 3 Mangar Elks has been completed.

10. **Provision of bariatric service**: Capability development as well as vehicle and equipment design scoping project for the delivery of the Bariatric Service will commence in August/September 2018.

Management of Health and Safety Risks:

11. The average time lag for reporting RIDDOR incidents in June 2018 was 11 days – which is within the specified reporting timeframe.

12. Trust-wide compliance for the completion of fire drills is currently at 35%. Fire Drills need to be undertaken at 54 stations/sites across the Trust.

13. The specification and tender strategy for the Trust's fire risk assessment contract is in the final review stage. The contract tender will commence once the specification and strategy have been agreed.

Training:

14. The Managing Health and Safety Course for Managers was re-launched in April 2018, and has become mandatory for Managers. The training will provide Managers with an understanding of their health and safety responsibilities as well as highlight key requirements for ensuring compliance with Health and Safety Legislation.

15. The Trust's health and safety mandatory training compliance rate in June 2018 was 79.45%.

Barriers/Issues

16. There has been difficulty recruiting into the Health and Safety Department and the difficulties experienced have impacted on the pace of delivery for some of the key actions identified in the H&S independent review. It is however anticipated that this should improve with the ongoing recruitment of 2 additional Team members.

Conclusion

17. Progress is being made to implement the health and safety systems that are required to improve the Trust's compliance with health and safety legislation. The 18 outstanding actions are being monitored on a regular basis to ensure that updates can be provided to the ELT and the Corporate Health and Safety Committee.

18. An overview of the Trust's health and safety performance in June 2018 is provided in the Health and Safety Scorecard (Appendix 2).

Dr Trisha Bain
Chief Quality Officer

APPENDIX 1 - Updates on actions 'In Progress and on schedule'

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
1.10	Complete and implement assessments for facilities i.e. site specific risk assessments. This should consider traffic flows and location of equipment such as pressure gauges.	High	Ayodeji Adeyemi	Trisha Bain	Process and templates for completing site specific risk assessments developed. In order to mitigate the current capacity issues within the H&S Team, additional resources are being recruited into the Health and Safety Department to help undertake this task. The completion date for this action has been extended to Q4 2018/19 to allow the H&S Team undertake the assessment of all sites across the Trust.	Jun-17	31/03/2019	In progress on schedule
1.2	Ensure human factors including fatigue, alcohol, drugs, night-working and stress are considered in the risk assessment process	High	Ayodeji Adeyemi	Trisha Bain	The Trust's Stress Management Policy is currently under review by the Health and Safety Department. A stress management group will be set up to provide input into the development of the Stress Management Policy, process for undertaking stress risk arrangements as well as develop arrangements for identifying, monitoring and escalating workplace stressors in line with the HSE Stress Management Standard. Human Factors training is also being provided to key staff across the LAS.	Jun-17	30/09/2018	In progress on schedule
2.1	Update Health & Safety Policy document in line with good practice and clearly define responsibilities for Directors, HS&S team, Heads of departments and managers.	High	Ayodeji Adeyemi	Trisha Bain	The draft trust-wide Corporate Health and Safety Policy has been written and sent out for consultation. The policy was tabled at the April 2018 Corporate H&S Committee meeting for approval however it was agreed that further discussion was required before the policy can be approved. Policy approval has been deferred to 25/07/2018 Corporate H&S Committee meeting.	Jun-17	31/07/2018	In progress on schedule
2.7	Define process for managing legionella risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Steve Dawson	Benita Mehra	Action log completed where risk assessments are completed - this is Managed via Estates. Updates provided to monthly performance review meetings. Action log with updates to be provided to July Corporate H&S Committee.	Jun-17	31/07/2018	In progress on schedule

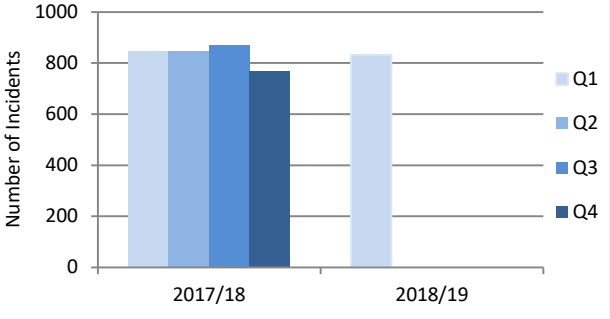
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
2.8	Define process for managing fire risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Ayodeji Adeyemi	Benita Mehra	The tender specification for the fire risk assessment contract has been drafted - Tender document is currently being produced by the Procurement Department. The tender process will commence in June 2018 with the intention to have a new contract set up by Q2, 2018.	Jun-17	31/07/2018	In progress on schedule
3.14	Define and communicate requirements for PPE maintenance and replacement. This should include head protection, fall protection and stab vests.	High	Ayodeji Adeyemi	Trisha Bain	Trust-wide PPE policy is currently under review - to be completed and a tabled at July Corporate H&S Committee meeting for approval.	Jun-17	31/07/2018	In progress on schedule
3.15	Implement monitoring regime to verify effectiveness of training provided to staff.	High	Peter McKenna	Paul Woodrow	A manual handling audit template has been drafted by the Health & Safety department to be used for conducting manual handling competency assessments following the delivery of practical manual handling training to staff. The competency assessment programme will be commence in October 2018 as part of the OWR, once CSR 2018.1 is completed. Qualitative feedback from staff following training sessions is collected and reviewed by the P&OD Department.	Jun-17	31/10/2018	In progress on schedule
3.3	Ensure systems are implemented to monitor staff competence after training and to ensure that training requirements are achieved and maintained.	High	Peter McKenna	Paul Woodrow	A manual handling audit template has been drafted by the Health & Safety department to be used for conducting manual handling competency assessments following the delivery of practical manual handling training to staff. The competency assessment programme will be commence in October 2018 as part of the OWR, once CSR 2018.1 is completed. Qualitative feedback from staff following training sessions is collected and reviewed by the P&OD Department.	Jun-17	31/10/2018	In progress on schedule

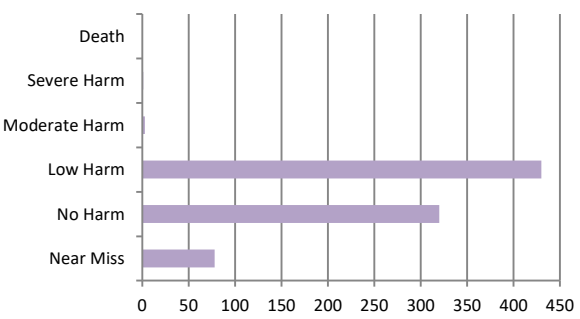
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
3.6	Develop system for and maintain clear records associated with training in use of equipment	High	Tina Ivanov	Fenella Wrigley	CES have performed initial scoping of student management systems and is continuing to work with IT and Procurement in relation to an identified system that has the potential to be used for recording equipment training. Further scoping has identified the need for corporate support. Meetings with suppliers are ongoing as well as modelling around LAS requirements. Subject to full scoping and appropriate approval, the aim is to procure a system within Q3 of the 2018/19 financial year. In view of the likelihood for a bespoke system and multi-faceted buy-in required, the estimated time scale is now 31st December 2018. The associated risk on the risk register is risk 675 “Management of the student journey”.	Jun-17	31/12/2018	In progress on schedule
3.7	Confirm refresher period requirements for driver training.	Med	Keith Miller	Fenella Wrigley	Confirmation received from Head of Driving Standards that agreement is in place to implement a programme of driver refresher training for all frontline staff across the Trust every 5 years. The Clinical Education Department are in the process of recruiting 6 FTE driving instructors to provide capacity, and to undertake the refresher training in house. These staff would have completed the recruitment process by July 2018. Training programme to be developed once training instructors are in post. The process for recruiting Driving Instructors was transferred to the Clinical Education Department. Action due date to be revised to July 2018.	Jun-17	31/07/2018	In progress on schedule

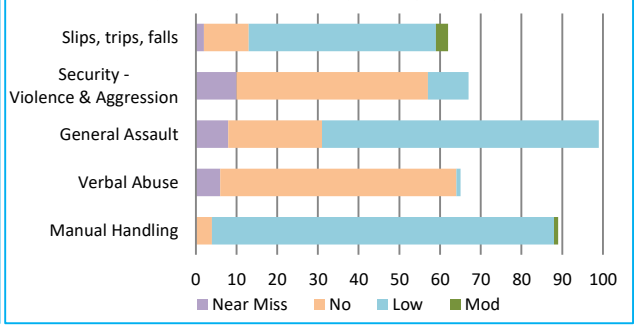
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
3.9	Provide guidance and training to staff on how to effectively use Datix	Med	Helen Woolford	Trisha Bain	The training package has been developed. The PO&D team to be approached for assistance in turning this into an e-learning package. The plan is to launch in Q3 2018/19.	Jun-17	31/12/2018	In progress on schedule
4.8	Ensure that local station managers have access to statutory checks regarding facilities. These are the people who are directing staff to work in the premises and must be assured they are in good condition and are aware of their responsibilities.	Med	Steve Dawson	Benita Mehra	Estates still have further works to do regarding communications and a central repository of information may not be possible at any time in the near future due to the various contractors and the disparate systems they operate. Records management will be considered as part of the department's planned Asset Management system implementation (this financial year).	Jun-17	31/03/2019	In progress on schedule
8	Undertake review of bariatric provision across the Trust – with aim of reducing manual handling risks to staff.	High	Kevin Bate	Paul Woodrow	Capability development as well as vehicle and equipment design scoping project for the delivery of the Bariatric Service to commence in August/September 2018 with a view of agreeing vehicle and equipment design to enable the placement of orders during the next financial year.	Jun-17	30/09/2018	In progress on schedule
11	Define role and responsibilities for the non-executive for H&S	Med	Ayodeji Adeyemi	Trisha Bain	The role and responsibilities of the non-executive for H&S has been defined within the draft H&S Policy which is out for consultation and will be tabled at the April Corporate H&S Committee Meeting.	Mar-18	31/07/2018	In progress on schedule
15	Confirm from occupational health that there is a process in place for monitoring and addressing any gaps relation to staff immunisation.	High	Nicola Bullen	Patricia Grealish	The staff immunisation programme is ongoing. C4000 staff have been identified as requiring further intervention. Targeted campaigns continue in South East due to measles outbreaks in that area, as well as North West. A full programme has been prepared for July and another is being prepared for August. However we do have some challenges currently with PAM meeting the demand of this project and an approach has been made to the Medical Director/ PAM to see whether Paramedics could support with this program with the necessary permissions to expedite the completion. We await an update on the number of staff fully immune versus those that still require a nurse intervention.	Mar-18	30/09/2018	In progress on schedule

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
16	HART: Ensure SOPS and risk assessments not only reflect changes in NARU standards but also consider any changes in LAS policies, including format for risk assessments.	Med	Marc Rainey	Paul Woodrow	All national SOPs are assessed for compliance against LAS policies before implementation. Risk assessments to be reviewed with Safety and Risk. Date TBC	Mar-18	31/08/2018	In progress on schedule
17	HART: Develop and implement appropriate system to assess staff health conditions to ensure that they are able to continue to work safely.	Med	Marc Rainey	Paul Woodrow	The Resilience and Capability Survey being developed for this year's NARU survey will be broken down as follows: 1. Individual - The individual report will allow each member of HART to obtain a basic summary of their results. The reports will also provide any guidance to support continuous enhancements to their health and well-being. 2. Team - The team reports will provide an aggregated view of the team's health on various key factors. It will also highlight any areas where the team needs to focus to help strengthen its approach. 3. Unit - The Unit reports will not only provide an aggregated view of the entire Unit, it will also help managers to compare teams and roles and take targeted action so it can have the most beneficial impact. 4. National - The national report will provide NARU with an aggregated view of the data across all Units. This will allow a greater understanding of mental health issues and satisfaction at work for all staff. Work on an initial psychological assessment has not yet been progressed nationally.	Mar-18	31/12/2018	In progress on schedule
18	HART: Work with Zeal Solutions as well as P&OD Directorate to implement appropriate process to ensure psychological fitness for work and good mental health of staff, from recruitment.	Med	Marc Rainey	Paul Woodrow	Staff on application are not assessed for psychological fitness. This issue has been discussed at the national operations group with national HR input but there are perceived difficulties in implementing such systems. Hence there is no movement on this action currently.	Mar-18	31/08/2018	In progress on schedule

Health & Safety Scorecard – June 2018



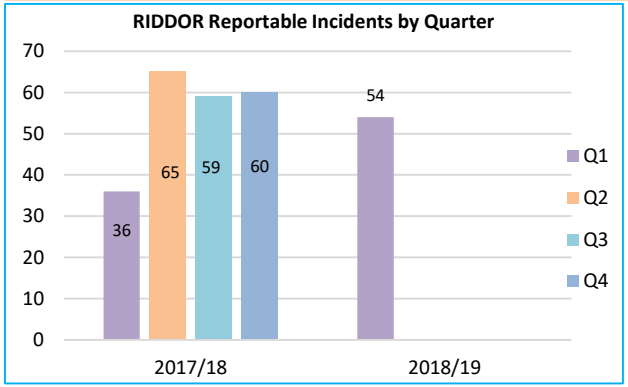


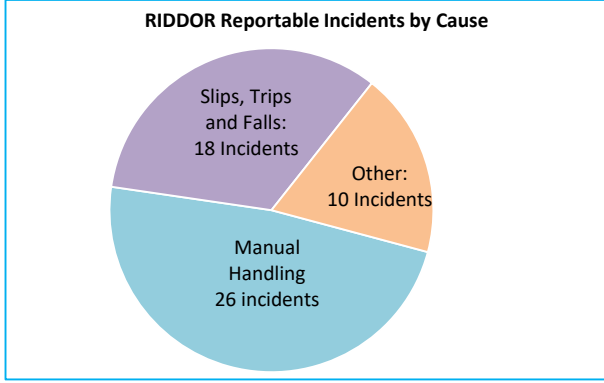


832 incidents have been reported across the Trust during Q1 2018/19. 245 incidents were reported in June 2018 . These H&S related incidents account for 37% of all the incidents reported across the Trust in June 2018.

430 (52%) of the H&S related incidents reported during Q1 resulted in low harm. 4 (0.5%) incidents resulted in Moderate or Severe harm. 398 (47%) of the incidents were reported as 'No Harm/Near misses'.

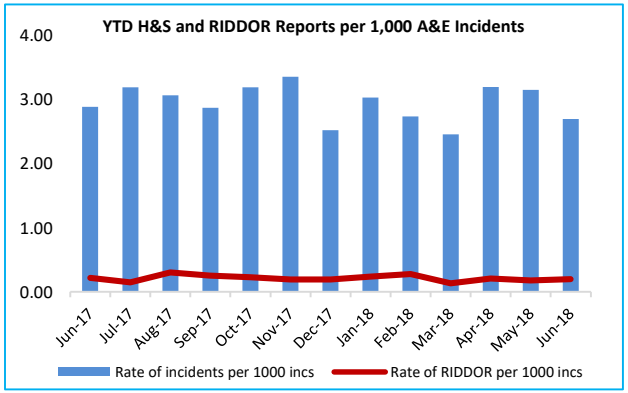
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported during June 2018.

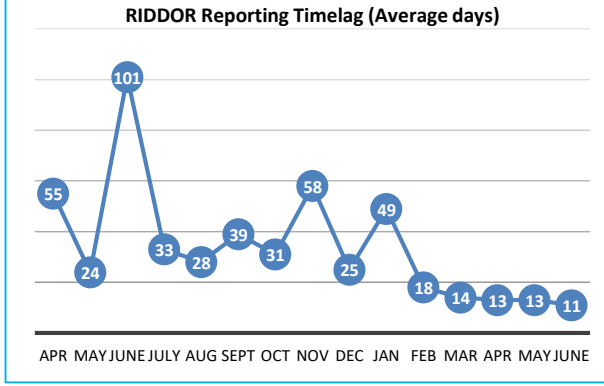


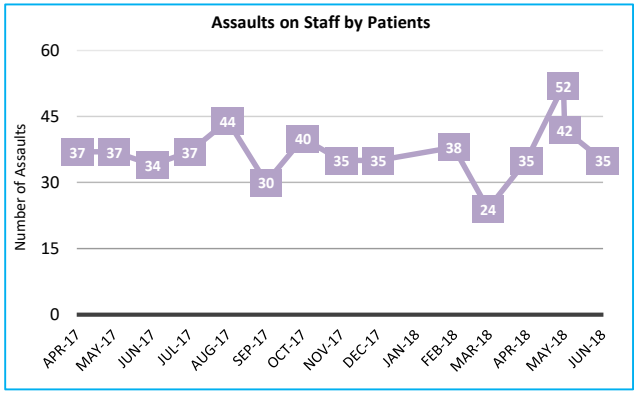


Key Updates:

1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. 91 MH - lifting patient incidents have been reported in Q1. Some of the contributory factors included the lack of equipment or failure a piece of equipment resulting in the manual handling of patients.
3. 146 incidents relating to the lack of or failure of equipment have been reported across the Trust during Q1, 2018/19.
4. The provision of practical MH Training to relevant frontline and support services staff is ongoing.
5. A review is ongoing to evaluate additional measures that can be implemented to further mitigate the security related incidents reported across the Trust.
6. Work is on-going to progress the actions identified on the Health and Safety Action Plan. **49 out of the 69** identified actions have now been completed.



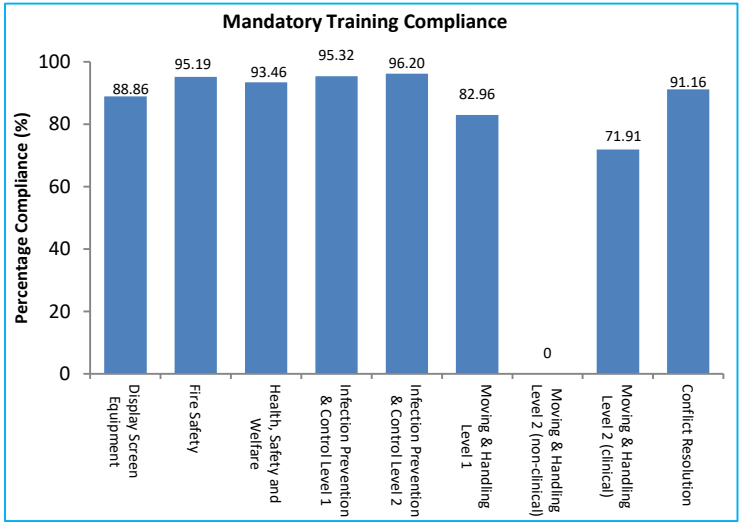


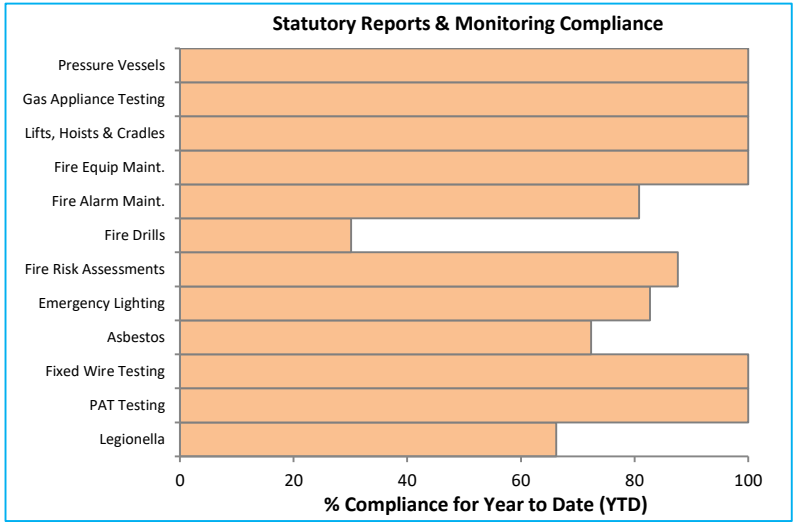


7. The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to June 2018.
8. No benchmark/comparable data was received from any of the other ambulance Trusts during June 2018.

9. 54 RIDDOR incidents were reported to the HSE in 2018/19. 18 RIDDOR incidents were reported in June 2018.
10. The average time lag for reporting RIDDOR incidents in June was **11 days.** 2 out of the 18 RIDDOR incidents were reported out of time in June 2018**.**

11. There was decrease in the number of assault on staff by patient related incidents in June 2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.





12. The practical MH Level 2 (non-clinical) training is a new course put in place since April 2018 for non-operational (support services i.e. IM&T, Fleet, Estates) staff who undertake MH activities. 118 members of staff have been identified as requiring this training, and training dates have been circulated through the Learning and Development Team.

13. Trust-wide compliance for the Manual Handling Training (Clinical) in June 2018 was at 71.91%. Practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.

14. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating						Target Risk Rating	Key changes/updates since last review
						Q4 – 2017/18			Q1				
						Jan	Feb	Mar	Apr	May			
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	15	9	An audit of the practical manual handling training that is being delivered to staff via CSR 1: 2018 will be undertaken in July 2018. The feedback from the audit will be used to further develop future training provided to staff. The H&S Department monitor MH related Incidents on a regular basis and a review is currently ongoing to look into and address the equipment related failures reported across the Trust.
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	12	12	12	12	4	Programme of annual audits approved by the CQO. Agreement around the Terms of reference for Corporate H&S Committee deferred until the July Corporate H&S Committee meeting and following the ACAS review of Trade Union numbers.
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	12	6	No updates since last review.
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	9	9	3	3	The average RIDDOR reporting timelag reduced to 11 days in June 2018. It is recommended that this risk should be downgraded and closed but monitored on a monthly basis by the H&S Team.
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	9	3	No updates since last review.
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	8	4	No updates since last review.
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	6	3	Substantive recruitment into the Health and Safety Department is ongoing.