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A

External Services Scrutiny Committee

Councillors on the Committee

Councillor John Riley (Chairman)
Councillor Ian Edwards (Vice-Chairman)
Councillor Teji Barnes
Councillor Mohinder Birah
Councillor Tony Burles
Councillor Brian Crowe
Councillor Phoday Jarjussey (Labour Lead)
Councillor Michael White

Date: **TUESDAY, 15 NOVEMBER 2016**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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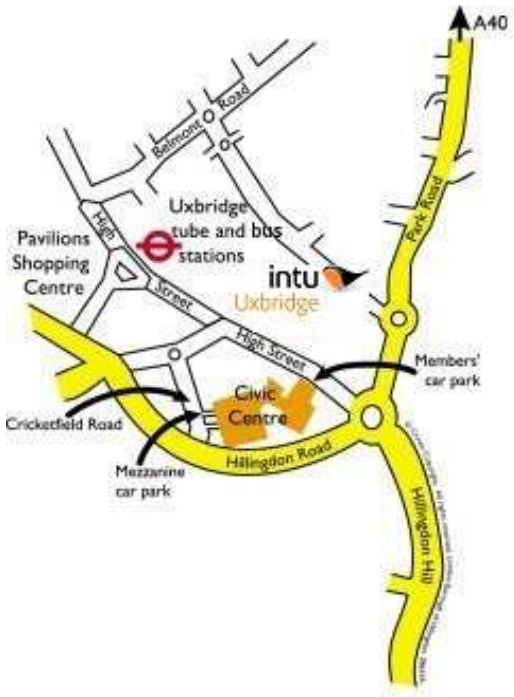

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

Chairman's Announcements

PART I - MEMBERS, PUBLIC AND PRESS

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private

PART II - PRIVATE, MEMBERS ONLY

8 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

15 September 2016

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors John Riley (Chairman), Shehryar Ahmad-Wallana (In place of Ian Edwards), Teji Barnes, Mohinder Birah, Tony Burles, Brian Crowe and Phoday Jarjussey (Labour Lead) **Also Present**: Graeme Caul, Borough Director, Central & North West London NHS Foundation Trust Richard Connett, Director of Performance & Trust Secretary, Royal Brompton & Harefield NHS Foundation Trust Pauline Cranmer, Assistant Director of Operations - West Sector, London Ambulance Service Dr Michele Cruwys, Consultant Paediatrician, The Hillingdon Hospitals NHS Foundation Trust Neil Ferrelly, Chief Finance Officer, North West London CCGs Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Caroline Morison, Chief Operating Officer, Hillingdon Clinical Commissioning Group Maria O'Brien, Divisional Director of Operations, Central & North West London NHS Foundation Trust Stephen Otter, (Healthwatch Hillingdon), Healthwatch Hillingdon **LBH Officers Present**: Kevin Byrne (Head of Policy and Performance), Gary Collier (Better Care Fund Programme Manager), Nigel Dicker (Deputy Director of Public Safety & Environment) and Nikki O'Halloran (Interim Senior Democratic Services Manager)
10.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillor Edwards (Councillor Ahmad-Wallana was present as his substitute) and Councillor White.
11.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
12.	**MINUTES OF THE PREVIOUS MEETING - 15 JUNE 2016** *(Agenda Item 4)* **RESOLVED: That the minutes of the meeting held on 15 June 2016 be agreed as a correct record.**
13.	**HEALTH UPDATES** *(Agenda Item 5)* <u>Central and North West London NHS Foundation Trust (CNWL)</u> Ms Maria O'Brien, Divisional Director of Operations at CNWL, advised that a number of

changes had been planned around community services to ensure that they were fit for purpose, supporting GP Networks and fit in with local service provision. The services had faced a number of challenges which included high appointment cancellation rates (which had been largely caused by unexpected staff absence) and operating hours (for example, the MSK physiotherapists saw patients that were predominantly of working age, mobile and needed appointments outside of office hours).

Over a 2-3 month period, CNWL had engaged with patients of the services: letters had been sent out to approximately 2,000-3,000 patients, feedback had been received and Healthwatch Hillingdon had been involved in the process. The purpose of the changes was to concentrate the services in three easy to reach centres (MSK physiotherapy would be based at Eastcote Health Centre, Uxbridge Health Centre and The Warren Practice and podiatry services would be based at the Hesa Centre, Eastcote Health Centre and Uxbridge Health Centre) so that they aligned with other relevant specialist services (for example, diabetes and tissue viability). This would enable the services to offer evening and weekend appointments and would enable patients to see more than one specialist at one location during one visit. It was noted that the podiatry home visit service would not be changed.

During the consultation period, CNWL had received about 50 responses which were predominantly concerned with where a patient would now need to go and the transport arrangements available. It was noted that the engagement process would continue over the next month and that CNWL would be working closely with transport services to ensure continued access for patients. Additional help was being provided for those patients who had not previously needed to use transport but who might now need to use this service to access the centres.

It was agreed that the rationalisation of centres from which services were provided seemed to be a reasonable move but that it was important that communication with service users about the changes and the implications was crucial. The new arrangement would offer economies of scale and help to mitigate the impact of staff shortages as a result of sickness absence.

Members were advised that there had previously been a number of administrative posts based at the centres and that a number of these had been relocated to provide room for the collocation of services. This had also provided additional flexibility and growth for the future of the services.

Although CNWL did take on students, 90% of the staff were qualified podiatrists. The footcare specialists were unqualified staff who were monitored and supervised at all times by a qualified member of staff and undertook footcare assessments. There were currently a low number of newly qualified staff and the changes to the provision of the service would enable CNWL to take on more students as they would have a greater support network in place.

Whilst CNWL provided MSK physiotherapist services to deal with issues relating to backs, shoulders, knees, etc, it also provided a home based rehabilitation service. Hillingdon Clinical Commissioning Group (HCCG) had recently agreed to extend this service to cover stroke patients. This service was being developed in consultation with the Stroke Association as a result of investment from the Hillingdon Clinical Commissioning Group (HCCG).

Ms O'Brien noted that a Trust-wide system had been put in place to manage complaints, capture all feedback and track the progress of individual complaints. A

wide campaign had been undertaken to explain the procedures for making complaints as well as providing feedback and compliments. Complaint response times had not previously been very good but, over the last 18 months, 100% of complaints had been responded to within the set timescales. The majority of complaints had been in relation to communication, lack of involvement and staff attitude. It was noted that, if a complainant was not happy with the response that they received, they were able to escalate it to the Ombudsman.

To help reduce complaints, staff had been provided with training. It was thought that the robust recruitment process, which included a Trust values test, helped to ensure that new staff held similar values to their employer. 'Back to the Floor' would also take place in November 2016 and this year's Carers Conference would focus on mental health and the elderly and responding quickly to concerns.

Mr Graeme Caul, Hillingdon Borough Director for CNWL, advised that the 'Hello, my name is' campaign had been rolled out across the Trust. Whilst participation was on a voluntary basis, about one third of CNWL staff had signed up to the campaign. As well as further publicising the campaign to encourage staff to sign up, it would be included in the Quality Roadshow and in the Trust induction.

<u>Royal Brompton and Harefield NHS Foundation Trust (RB&H)</u>

Mr Nick Hunt, Director of Service Development at RB&H, advised that the 'Hello, my name is' campaign had been rolled out across the Trust for the same reasons as it had been at CNWL. A Datafix complaints system had also been implemented at the Trust and support had been provided for staff who were on the receiving end of complaints. Complaints tended to be in relation to service waiting times and communication.

RB&H had used a film (Barbara's Story) to show staff how it felt to be a patient or family member when the communication from staff was not great. Opportunities were also available for staff to talk to one another about difficult situations so that they were better able to know how to react to individuals. It was likely that further film training would be made available to staff and some staff had undertaken training on dealing with difficult patients.

Although it was unlikely that complaints would ever be eradicated, the Trust would continue to try to reduce the number. Early intervention had helped to resolve complaints quickly and complaints at RB&H had reduced to around 90 per annum.

Members were advised that NHS England (NHSE) had written to all congenital heart departments in the country to advise that it would be decommissioning some services and gave them three days to respond (the response provided by RB&H was then deemed by NHSE to be insufficient). This had meant that adult and child congenital heart surgery would cease at RB&H from 31 April 2017. Since then, NHSE had advised that it would undertake a public consultation at the end of December 2016 with a final decision of the future of the service expected by the end of 2017. This issue would be considered by the Royal Borough of Kensington and Chelsea at its ASC and Health Scrutiny Committee on Wednesday 21 September 2016. The report included on the agenda from NHSE (representatives of which would be attending the meeting) set out proposals that had not yet been seen by RB&H.

Mr Hunt believed that this proposal was an act of vandalism by NHSE that was incomprehensible and would cost a lot of money and cause a lot of grief. The collocation of specialist paediatric services on one site was cited by NHSE as the

reason for the proposed changes but RB&H already met these standards. RB&H was the largest unit in the country and its outcomes were superb. As such, the proposal was not in the best interest of the service and the Trust was actively working to ensure the proposal failed. All and any support from the Council would be hugely welcomed by the Trust.

Although not opposed to the concentration of specialists units, Members felt that any proposal to withdraw services from a Trust that had a proven track record and excellent outcomes did not make sense. Although the final impact was unknown, decommissioning congenital heart services would result in the loss of services such as paediatric intensive care, transplants and anaesthesia. The proposal would also have an impact on staffing as the possibility that services might be decommissioned would force staff to look elsewhere for employment.

It was recognised that RB&H had possibly the largest portfolio of land/property holdings of all Trusts. To this end, a task force led by Sir Robert Naylor had written to RB&H to advise the Trust that its property was in the top 5 areas of interest to the NHS.

Mr Hunt advised that the Trust had produced a briefing note which he would forward to the Interim Senior Democratic Services Manager for circulation to the Committee. It was anticipated that this would provide further information for Members, should they decide to respond to the consultation when it was launched. The Chairman advised that the Committee needed to look at this issue in much more detail and requested that Mr Hunt provide him with any additional information that he had in relation to the proposals.

Members were wholly supportive of RB&H and recognised that, unlike most other Trusts, RB&H generated its own income. Mr Hunt advised that the NHS tariff received by RB&H was not sufficient to pay for the services provided and, as such, it had created other revenue streams (private patients, research, etc).

<u>The Hillingdon Hospitals NHS Foundation Trust (THH)</u>

Dr Michele Cruwys, Consultant Paediatrician at THH, advised that, prior to the closure of paediatric inpatient services at Ealing Hospital, there had been: 16% increase in A&E/emergency paediatric presentations at Hillingdon Hospital; 21% increase in non-elective inpatient admissions; 60% increase in bed days for children requiring critical care (with the complexity of care also increasing); and 16.9% increase in demand for outpatient services. It was noted that Ealing Hospital had retained its paediatric outpatients services and its Urgent Care Centre (UCC).

The changes had provided THH with the opportunity to improve the infrastructure within Hillingdon Hospital. To this end, a new purpose built Paediatric A&E Department had been opened (with a waiting area and bigger rooms with space for parents to stay so that they could continue to care for their child during their stay). A new Paediatric Assessment Unit (PAU) had also been opened to monitor children's condition for up to 24 hours. These changes had been instigated as a result of the Shaping a Healthier Future (SaHF) review and it was envisaged that proposals would drive up standards across North West London. It was noted that the changes had been implemented to ensure detailed and active care pathways were put in place to get children home as quickly and safely as possible.

Members were advised that Hillingdon Hospital provided Consultant delivered care 24/7 and that a Nursing Practice Development Team had been introduced. There had

also been an increase in the number of nurses on each shift for short stay patients as well as across the ward. Training and development programmes had been put in place for GPs (only 40% of GPs had received paediatric training), paediatric trainees and nurses. THH was working closely with HCCG and SaHF to have a Paediatric Consultant available 24/7 and to provide more focussed training for junior staff.

There were a number of challenges being faced by the Trust which included:

- the increasing complexity of care;
- an increased demand for paediatric services;
- staff recruitment and retention - it was suggested that more robust management and clinical approach might make the service more attractive for staff; and
- getting patients seen within 4 hours of presenting at A&E.

A number of developments were planned to meet these challenges which included:

- a 4 bed expansion of the paediatric in patient services which was due to open in October 2016;
- the introduction of GP Integrated Care Clinics in the community;
- the introduction of Rapid Access Clinics (Hot Clinics);
- the introduction of new patient pathways to ensure that patients were seen sooner; and
- working with commissioners to introduce a paediatric critical care service - although the building blocks for this were now in place, new staff needed to be recruited.

Dr Cruwys advised that paediatric staff were predominantly female and that more junior staff needed (and received) additional support. The Trust would ensure that job plans were interesting and varied and that succession planning was in place for when consultants moved on. It was anticipated that the closer working relationship between HCCG and GPs would also help.

Although language was sometime a barrier, Trust staff encouraged parents to learn English and/or used the LanguageLine service for interpretation if there were no hospital staff available that could speak the language needed.

<u>The London Ambulance Service NHS Trust (LAS)</u>

Ms Pauline Cranmer, LAS Assistant Director of Operations - West Sector, advised that she had responsibility for Hillingdon, Brent and Harrow. She noted that demand had risen significantly recently with March 2016 seeing the highest number of incidents ever. In 2015/16, the LAS had attended 20k more incidents than in 2014/2015 and performance had increased from 59.2% in 2014/2015 to 63.6% in 2015/2016 for Cat A8 calls (seriously ill and life threatening). Performance in August 2016 was 67.4%. It was noted that there had been an increase in the number of calls received each year which, in part, was impacted by the accessibility of health services.

In Hillingdon, Cat A performance had improved from 62.78% in July 2016 to 65.87% in August 2016. It was noted that the LAS reached 75% of Cat A8 calls in Hillingdon within 9 minutes 45 seconds. However, the area continued to experience high demand with August 2016 seeing the second highest number of Cat A incidents in London.

The LAS had introduced a system of triage for 999 calls. This meant that around 3,000 callers each week were signposted back to their GP and about 60% of ambulances that were dispatched actually conveyed the patient to hospital. In Hillingdon, this had

resulted in 33 complaints (which Members had not deemed to be a high number) and a low re-contact rate.

Members were aware that the CQC had undertaken an inspection of LAS in June 2015, with its findings published in a report on 27 November 2015. Although the Trust had received a 'Good' rating for care of patients, the report had highlighted a number of areas of concern and deemed the service to be 'Inadequate' overall and put the Trust in special measures. The LAS had published its improvement plan in January 2016, setting out the steps that it would take to get out of special measures.

Following a recruitment drive, the LAS had appointed 717 new staff in 2015/2016. This meant that the Trust was able to meet its recruitment target to ensure that all 3,169 frontline posts were filled. Although this had been a huge achievement against a backdrop of increased demand across the country, it was recognised that the challenge would now be retention. To this end, the LAS was working with 4 universities to recruit graduates and it was anticipated that recruitment would be ongoing. It was noted that there were currently 12 vacancies in Hillingdon.

A Vehicle Make Ready pilot had been successfully undertaken in the North East sector, showing a reduction in out of hours service vehicles and improvements in vehicle cleanliness and equipment availability. Consideration was now being given to how this could be rolled out across the Service. Improvements had also been made to medicines management processes, including communication to all frontline staff to outline the professional requirements, clarify medicines management policies and the provision of an increased calendar of clinical audits.

60 new Fast Response Units had been in place by the end of June 2016, taking the total number of available cars to 180. 104 new ambulances were also in production so that, by 31 March 2017, half of the fleet's vehicles would be under two years old.

Senior managers had received training in leadership by Defence Medical Services (DMS) following its CQC inspection. DMS had delivered a two day training course to senior and middle managers and worked with them on a development package to support and manage staff differently. As well as delivering the training, they had also provided the LAS with a toolkit.

Other actions to improve the Service included a focus on reducing demand, recruiting staff and supporting staff to work more efficiently. It was noted that around 3,500 callers were dealt with over the phone each week and that the LAS was working with care homes to manage their requests more appropriately. A project to manage frequent callers was underway and effort was being made to recruit more frontline staff.

With regard to local improvement actions, a quality improvement plan taskforce had been set up, involving frontline staff to make a difference. The taskforce held visibility days where they could listen to the views of staff. The LAS was also working with partners in Hillingdon to look at frequent callers, care home falls training (October 2016), an urgent care streaming project and attending GP forums.

Feedback from patients, their families and the public was an important way to drive improvements in the Service. This had been captured by the Patient Experiences Team who had managed 3,800 enquiries and 1,025 complaints in 2015/2016. The LAS Learning from Experience Group had also reviewed the themes and issues that emerged from complaints and the action taken to improve services. Action as a result of feedback had included:

- amending the elderly fallers protocol;
- asking National Academy to review the way that diabetic patients were assessed; and
- reviewing the way that the LAS assessed children who had swallowed a foreign object.

It was noted that complaints were predominantly in relation to delay and staff attitude. These two issues could be deemed to be linked as any delay in the arrival of an ambulance tended to make patients unhappy which could then affect staff attitudes. Action was being taken to see how staff could calm affected patients and there had been a reduction in the number of complaints in relation to delays. Of the 37 complaints received in Hillingdon between 1 April 2015 and 31 March 2016, 32 had been addressed by providing an explanation, 2 required no further action and 3 resulted in staff reflective practice/training. Members noted that a significant amount of time had been invested locally to look at how staff could be supported when they were the subject of a complaint.

Ms Cranmer advised that Community First Responders (CFRs) had been created through a partnership between St John's Ambulance and the LAS. CFRs responded from home and provided a support service for ambulances. CFRs received a high level of training and would only be called to attend a scene if they were likely to get there ahead of an ambulance (they would only be called to deal with certain types of issues). There were 130 responders and had been first on the scene for 2,629 calls (54%) in 2015/2016. Although there were no CFRs in Hillingdon, consideration was being given to the possibility of a CFR unit in the Borough.

There were around 145 Emergency Responders (ERs) that volunteered with the LAS. They attended on-duty shifts from stations and had attended 6,920 calls in 2015/2016, 5,165 of which where they were first at the scene (74.6%). These volunteers received intermediate first person on the scene training for serious medical emergencies and traumatic injuries.

Members were advised that there were two Emergency Responder units and 35 Responders in Hillingdon. These Responders had given 2,883 hours of their time during this period and been first on the scene to 1,405 of the 1,904 calls (73.7%).

Ms Cranmer noted that regular public information recruitment evenings had been held and staff were provided with regular CPD/training which resulted in excellent mandatory training compliance.

It was noted that detailed work on repeat callers had been undertaken with HCCG, THH and GPs. Patients were now being triangulated to identify how they could be best signposted.

With regard to public driving standards, there were still times where an altercation would occur when an ambulance crossed a red light or where it was parked over someone's driveway. Members were advised that the LAS had a separate department to deal with significant driving standard issues regarding Trust staff.

<u>Hillingdon Clinical Commissioning Group (HCCG)</u>

The Sustainability and Transformation Plan (STP) set out the North West London (NWL) CCGs' shared plans for the next five years to 2020/2021 and provided a focus on each of the constituent boroughs. The STP brought together providers and

commissioners of care (both local government and NHS) to deliver a genuine place based plan for the Borough. It would act as a platform for development of a new and innovative way of funding health and social care in Hillingdon.

Ms Caroline Morison, Chief Operating Officer at HCCG, advised that the STP had been put in place to ensure that health and social care in NWL was sustainable. If no action was taken, NWL would have a £1.3b funding gap across health and care by 2020/21. The STP had identified the following five delivery areas that would deliver a more proactive model of care as well as reduce the costs of meeting the needs of the population to enable the system to be financially and clinically stable:

1. Radically upgrading prevention and wellbeing;
2. Eliminating unwarranted variation and improving long term conditions' (LTC) management;
3. Achieving better outcomes and experiences for older people;
4. Improving outcomes for children and adults with mental health needs; and
5. Ensuring we have safe, high quality, sustainable acute services.

Three gaps had been identified within the Five Year Forward view and the STP guidance (health and wellbeing; care and quality; finance and efficiency). HCCG had outlined the Hillingdon vision for closing these gaps. If the plan was successfully delivered, it would address the funding gap across health and social care of around £100m over the next five years.

It was noted that the local plan would need to be refined before it was submitted on 21 October 2016. Governance processes had been undertaken to ensure that partner Boards were sighted on the content of the local and NWL plan and the content would need to be embedded into local planning processes (CCG Commissioning Intentions, development of a three year Better Care Fund plan, etc). In addition, local governance and delivery mechanisms would need to be established.

Ms Morison advised that HCCG had been proactively working with other agencies on issues such as the older people's model of care (including care coordination, a single care plan and social isolation). Work was also being undertaken to support the delivery of care to residents in the right place at the right time which might include new ways of providing primary care. It was important to ensure the provision of planned and systematic access to services and to promote an understanding of what residents should expect. The third sector played an important part in this work.

Members suggested that a further report on the STP be brought back to a future meeting for further discussion.

<u>Healthwatch Hillingdon (HH)</u>

Mr Stephen Otter, Vice Chairman at HH, advised that the HH Annual Report highlighted the need to raise the importance of the patient experience. In addition, he suggested that, moving forward, consideration would need to be given to looking at development sites such as St Andrews and Nestle to ensure that the infrastructure put in place met the needs of the local residents.

Mr Graham Hawkes, HH Chief Executive Officer, advised that the organisation was seen as an equal partner in the Borough (which was not necessarily the case across the country). He had been pleased with the reaction from partner agencies to HH's CAMHS report and the work that had been undertaken together in relation to child health and wellbeing.

	Members were advised that there had been a lot of work undertaken through the HH shop in the Pavilions shopping centre as it provided a useful platform to receive feedback from residents. Although HH had secured a one year extension on its shop lease, it was noted that, with the imminent arrival of a large retailer in the centre, it was likely that the HH presence there would change. Mr Hawkes noted that HH was undertaking a review of hospital discharges for those aged 65+ and the community support provided thereafter. A piece of work was also being undertaken in relation to maternity services at Hillingdon Hospital. Consideration had been given by HH to a number of possible review topics which had included IVF. However, it was thought that a national approach would need to be taken to IVF. Mr Hawkes had been involved with the development of the STP and sat on the Board. He expressed concern about the short timescales given to provide plans and the impact that this had on the ability for public engagement in the process. As such, commitment had been sought to ensure a more robust involvement of the public in the STP. Insofar as access to GPs was concerned, it would be important to have frank discussions with residents to gain a better understanding of their concerns. The Chairman placed on record the Committee's thanks to Mr Jeff Maslen for the work that he had undertaken as Chair of Healthwatch Hillingdon as well as his loyal and distinguished service as a former Council employee. **RESOLVED: That:** **1. Mr Hunt forward the briefing note to the Interim Senior Democratic Services Manager for circulation to the Committee;** **2. a further report on the STP be brought back to a future meeting for further discussion; and** **3. the report and presentations be noted.**
14.	**WORK PROGRAMME 2016/2017** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme. Members discussed the issue of paediatric cardiac services at Royal Brompton and Harefield NHS Foundation Trust (RB&H). It was noted that outcomes tended to be better for patients cared for in larger specialist settings and it was recognised that withdrawal of the service would have a knock on effect on things like staffing levels and the onward pathway from Hillingdon Hospital paediatric department. It was noted that RB&H was cost effective and, to a certain extent, was effectively financially propping up other Trusts. Members were keen to gain further information about the proposals so that consideration could be given to whether or not an additional meeting should be scheduled. The Committee agreed to have an update on child sexual exploitation at its meeting on 15 February 2017. The Chairmen of the Social Services, Housing & Public Health and Children, Young People & Learning Policy Overview Committees would be invited to take part in this meeting. It was agreed that a Working Group would be set up to look at community sentencing: What had replaced probation? How effective was it? It was suggested that the review

	include witnesses such as former offenders and that it also cover reoffending. It was noted that the Fire Brigade would be invited to attend the next meeting of the External Services Scrutiny Committee as part of the Committee's bi-annual scrutiny of the Safer Hillingdon Partnership. Consideration had previously been given to the creation of a Working Group to review CAMHS. It had been suggested that this Group comprise the Chairman and Labour Lead of various relevant Council Committees. It was noted that this review was currently on hold. **RESOLVED: That:** **1. a Working Group be established to undertake a review into community sentencing; and** **2. the Work Programme be noted.**
	The meeting, which commenced at 6.00 pm, closed at 8.51 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

6 October 2016

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Alan Chapman (In place of Brian Crowe), Phoday Jarjussey (Labour Lead) and Michael White **Also Present**: Martin Wilson, London Fire Brigade **LBH Officers Present**: Nigel Dicker (Deputy Director of Public Safety & Environment), Dan Kennedy (Head of Business Performance, Policy & Standards) and Nikki O'Halloran (Interim Senior Democratic Services Manager)
15.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillor Brian Crowe (Councillor Alan Chapman had attended as his substitute).
16.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
17.	**SAFER HILLINGDON PARTNERSHIP PERFORMANCE MONITORING** *(Agenda Item 4)* Mr Dan Kennedy, the Council's Head of Business Performance, Policy & Standards, advised that the report included the information that had been presented to the Safer Hillingdon Partnership (SHP) at its September 2016 meeting. The information was correct as at the end of June 2016 (Q1) and covered three priority themes: 1. Reduce violence; 2. Reduce offending; and 3. Identify and protect vulnerable residents and locations. Over the last six months, the SHP had been reviewing its targets to ensure that they were fit for purpose. It was noted that there had been a time lag for the reporting of some information but it was anticipated that this would catch up. Although there had been an increase in robberies (84 in Q1), the overall trend over the last three years was a 16% reduction between July 2014-June 2015 and July 2015-June 2016. The Metropolitan Police Service (MPS) was confident that this target would be back on track as it tended to be skewed over the summer months. There had been an increase in the number of domestic abuse incidences reported to the police. The crime had previously been underreported so it was thought that this better reflected the current position. Figures reported earlier in the week showed that

the gap in reaching the target had reduced to 4% but consideration would still need to be given to ensure that incidences were reported correctly on the police system. It was noted that domestic abuse was one of the top police priorities locally and that a significant amount of work had been undertaken following the Domestic Homicide Reviews (DHRs).

65% of Anti Social Behaviour (ASB) cases that had been reported to the Council had been closed and the problem resolved (against a target of 75%). Members were advised that, although some cases were resolved quickly, some experienced a time delay between the action taken by officers and the case being closed which meant that the cases could span more than one period/quarter. Mr Nigel Dicker, the Council's Deputy Director Residents Services, noted that officers needed to be encouraged to resolve cases and close the incidents on the system so that the data available was up to date. It was anticipated that, as practices and procedures improved, resolutions would be found more quickly. Consideration was also being given to how the issuing of notices could be improved. However, it was recognised that there were times when, no matter what action was taken by officers, the situation could not be resolved to the residents' satisfaction. Mr Dicker agreed to provide a breakdown of these unresolved cases and the reasons why these cases had been unsuccessful.

The data in relation to reducing the number of arson fires, carrying out free home fire safety visits (HFSV - the London Fire Brigade (LFB) could provide specialist alarms for the deaf, arson proof letter boxes and fire retardant throws and bedding for smokers who were bed bound) in priority postcodes and reducing the number of dwelling fires had not yet been reported. Mr Martin Wilson, the LFB Hillingdon Borough Commander, advised that he would be liaising with Hillingdon's Social Services and community partnerships such as Meals On Wheels to raise awareness of the HFSVs and associated interventions. He would also forward the outstanding data to Democratic Services for circulation to the Committee.

Mr Wilson advised that he would be looking more closely at arsons in the Borough as there appeared to be too many vehicle arsons which, he suspected, might be linked to a prolific arsonist from a few years ago.

With regard to improving confidence with the Police by 10%, Hillingdon had achieved 58% against a target of 69%. Mr Kennedy noted that a task group had been established to strengthen confidence, particularly in the Hayes area, and an event would take place on 19 October 2016 to engage the Somali community and deal with any queries. As there was a relatively low crime rate in Hillingdon, it was thought that there must be other issues that were affecting residents' satisfaction (improving overall satisfaction with the police had achieved 79.8% in Q1 against a target of 82%). As such, engagement work would be key to further improvements.

Mr Kennedy and Mr Dicker had met with the MPS Borough Commander's team to discuss residents' confidence in the police. Fly tipping had been identified as an issue and incidents had been mapped out across the Borough showing that they were more concentrated in certain areas. Consideration would need to be given to what constituted fly tipping (for example, should it include bin bags put out by residents on the wrong day?) and whether something should be classed as ASB as it currently depended on the way that it was reported. Although the MPS recognised its role in deterring fly tipping with increased patrols in the areas of prevalence (CCTV was controlled by the Council), a more joined up approach was needed. The Council was also taking a stronger approach to ensuring that businesses had contracts in place for the disposal of their waste.

Members were aware that everyone, including residents, needed to have pride in their areas and take responsibility for their own behaviour rather than the Council regularly clearing up after them. As young people tended to be concerned about their immediate environment, it was suggested that work be undertaken to raise awareness of the fly tipping issue in schools and colleges.

Repeat ASB offences were usually in relation to noise, overgrown gardens and blocked drains and were often related to mental health issues. If the issue was in relation to a property, it was dealt with in piecemeal fashion and legal advice might be sought. In addition, Community Protection Notices could be used to address low level behaviours and case reviews were regularly undertaken in relation to well known offenders and, where necessary, other agencies could be consulted. Mr Kennedy's team would be able to plot ASB occurrences using GIS if required.

The Committee requested that, by its meeting on 15 February 2017, Members be provided with information on the 10 main objectives (and performance against these) for each of the following organisations in relation to crime and disorder:

1. London Borough of Hillingdon (Youth Offending Service, Community Safety and ASBIT);
2. Metropolitan Police Service;
3. London Fire Brigade;
4. Hillingdon Clinical Commissioning Group; and
5. Public Health.

Once this information had been received, Members would be able to request further information on specific issues. It was agreed that the Committee would like representatives from the following organisations to attend its meeting on 15 March 2017:

1. Safer Neighbourhood Team (SNT);
2. London Probation Area; and
3. British Transport Police.

With regard to the reduction of violent crime, the Committee queried whether knife crime had been included, whether this was an issue in the Borough and, if it was, what action was being taken to address it.

Mr Wilson advised that, as the London Ambulance Service (LAS) was stretched, the LFB had been assisting. Four London boroughs had been taking part in a pilot since April 2016 to deal with medical emergencies such as cardiac arrest. All front line fire appliances already carried defibrillators so the equipment was available and had been carried by the LFB for several years prior to the trial. Fire engines in the pilot boroughs could be called out to a cardiac arrest if it was thought that they could arrive quicker than the LAS. Ambulance staff would also respond to the call and take over from the LFB once they had arrived at the scene. The fire engines would be dispatched fully manned so that, if needed, they could take a fire related call directly after dealing with a medical call. It was noted that all fire officers undertook a 3/4 day course on how to use a defibrillator as part of the LFB's normal training programme.

Although the results of the pilot were looking positive, it was unclear how many lives had been saved as a result and consideration was being given to whether the pilot should be rolled out across London and whether it should be extended to other medical conditions. If other conditions were added, further training would need to be provided for the fire officers.

Mr Wilson noted that some drivers still failed to give way to fire engines. He suggested

	that this might be as a result of loud music, ignorance or because they didn't want to receive a ticket for going through a red light or box junction. Out of the 3,000 calls received by the four Hillingdon fire stations in a year, 50 were hoax calls. It was not thought that this figure was excessive and had reduced over the last 5-6 years. As the majority of hoax calls had previously been made after school and when pubs closed, it was thought that the Junior Citizen Scheme and 'call challenge' had helped to reduce this number. With regard to repeat callers, Mr Wilson advised that he would be taking a closer look at two individuals. It was noted that it was not always easy to resolve issues that spanned more than one service. As such, information sharing and communication between the services needed to be clear. Mr Dicker advised that the police provided the Council with a list of repeat callers. However, information sharing between the local authority and A&E was more difficult and a change in the law would be needed to allow certain information to be shared. **RESOLVED: That:** **1. Mr Dicker provide a breakdown of unresolved cases and the reasons why they had been unsuccessful;** **2. Mr Wilson forward the outstanding LFB data to Democratic Services for circulation to the Committee; and** **3. the presentations be noted.**
18.	**WORK PROGRAMME 2016/2017** *(Agenda Item 5)* <u>Crime and Disorder</u> Consideration was given to the Committee's Work Programme and it was agreed that the London Borough of Hillingdon, Metropolitan Police Service, London Fire Brigade, Hillingdon Clinical Commissioning Group and Public Health each be asked to provide information on their top ten crime and disorder priorities and any progress made against them for consideration at the External Services Scrutiny Committee meeting on 15 February 2017 (there would be no need for representatives to attend this meeting). Members requested that representatives from the Safer Neighbourhood Team, London Probation Area and British Transport Police (BTP) be invited to attend the meeting on 15 March 2017. It was suggested that, if there were no issues forthcoming from BTP, representatives from the Youth Offending Service be invited to attend instead. <u>Royal Brompton & Harefield NHS Foundation Trust (RB&H)</u> The Chairman advised that Mr Nick Hunt had agreed to forward information about NHS England's proposal to withdraw paediatric cardiac services from RB&H. The Chairman would also speak to the Cabinet Member for Social Services, Housing, Health and Wellbeing about the proposal as he was also the Chairman of Hillingdon Health and Wellbeing Board. **RESOLVED: That the Work Programme 2016/2017 be agreed.**
	The meeting, which commenced at 6.00 pm, closed at 7.25 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

THE LONDON AMBULANCE SERVICE NHS TRUST - CARE QUALITY COMMISSION INSPECTION

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: CQC Inspection Report
Appendix B: LAS 2016-2017 Quality Improvement Programme

REASON FOR ITEM

To enable the Committee to question representatives of The London Ambulance Service NHS Trust (LAS) in relation to the report published on 27 November 2015 by the Care Quality Commission (CQC) with the findings of its inspection.

OPTIONS OPEN TO THE COMMITTEE

Members may question representatives of the LAS and seek clarification on issues in relation to its performance and the CQC report.

INFORMATION

CQC Inspection - June 2015

1. The London Ambulance Service NHS Trust (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London, which has a population of around 8.6 million people. The Trust employs around 4,251 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across London.

2. The main role of LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by LAS include: patient transport services (PTS) for non-emergency patients between community provider locations or their home address; NHS 111 non-emergency number for urgent medical help and/or advice which is not life-threatening; and resilience services which includes the Hazardous Area Response Team (HART).

3. The CQC announced inspection of LAS took place between 1 and 5 June 2015 and between 17 and 18 June 2015 with unannounced inspections on 12, 17 and 19 June 2015. The inspection was carried out as part of the CQC's comprehensive inspection programme.

4. The CQC inspected four core services:
    - Emergency Operations Centres
    - Urgent and Emergency Care
    - Patient Transport Services
    - Resilience planning including the Hazardous Area Response Team

5. The CQC did not inspect the NHS 111 service provision during this inspection.

6. Overall, the Trust was rated as Inadequate. Caring was rated as Good. Effective, and Responsive were rated as Requires improvement. Safe and Well-led were rated as Inadequate.

Overall rating for this Trust	Inadequate	
Are services at this Trust safe?	Inadequate	
Are services at this Trust effective?	Requires improvement	
Are services at this Trust caring?	Good	
Are services at this Trust responsive?	Requires improvement	
Are services at this Trust well-led?	Inadequate	

CQC inspections & ratings of specific services		
Emergency and urgent care	Inadequate	
Patient transport services (PTS)	Requires improvement	
Emergency operations centre (EOC)	Requires improvement	
Resilience	Inadequate	

7. CQC's key findings were as follows:
   - The Trust was making efforts to recover from a decline in performance which had worsened in late 2014. At the time of the CQC inspection, the interim chief executive was appointed substantively to the post. This was seen as a positive move by many front line staff to assist stability. There had been two previous chief executives in post or appointed since 2012.
   - The Trust was operating with a shortage of trained paramedics in the light of a national shortage and due to paramedics leaving its service for a number of reasons including better pay elsewhere. It had conducted recruitment of paramedics from as far afield as Australia and New Zealand to combat this.
   - The CQC had significant concerns about a reported culture of bullying and harassment in parts of the Trust. The Trust had commissioned an independent report into this which it had received in November 2014. However, this was only presented to the Trust Board in June 2015.
   - The CQC had similar concerns about the Trust's provision and use of HART paramedics and the Trust's ability to meet the requirements of the National Ambulance Resilience Unit (NARU).
   - The Trust had been facing increased contractual competition for its patient transport services (PTS) leading to a diminishing workload. It was trialling a new non-emergency transport service (NET) which had begun in September 2014.
   - During the CQC inspection, staff were found to be highly dedicated to and proud of the important work they were undertaking. At the same time, they were open and honest about the challenges they were facing daily. They were largely supportive of their immediate managers but found some senior managers, executives and board members to be remote and lacking an understanding of the issues they were experiencing.

8. The CQC saw several areas of good practice including:
    - The Trust's intelligence conveyancing system to help prevent overload of ambulances at any particular hospital emergency department.
    - Good levels of clinical advice provided to frontline staff from the Trust's clinical hub.
    - The CQC observed staff to be caring and compassionate, often in very difficult and distressing circumstances.
    - The percentage of cardiac patients receiving primary angioplasty was 95.8% against an England average of 80.7%
    - Good multi-disciplinary working with other providers at Trust and frontline staff levels.

9. However, there were also areas of poor practice where the Trust needs to make improvements. Importantly, the Trust must:
    - develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
    - recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
    - recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
    - improve its medicines management including:
    - formally appoint and name a board director responsible for overseeing medication errors and formally appoint a medication safety officer.
    - review the system of code access arrangements for medicine packs to improve security.
    - set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
    - set up control systems for the issue and safekeeping of medical gas cylinders.
    - improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
    - address under reporting of incidents including the perceived pressure in some departments not to report incidents.

10. In addition, the Trust should:
    - review and improve trust incident reporting data.
    - ensure all staff understand and can explain what situations need to be reported as safeguarding.
    - review the use of PGDs to support safe and consistent medicines use.
    - improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
    - ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
    - ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
    - set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
    - ensure adequate and ready provision of protective clothing for all ambulance crews.
    - ensure equal provision of ambulance equipment across shifts.
    - improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.

- ensure full compliance with bare below the elbow requirements.
- review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- set up a system of regular clinical supervision for paramedic and other clinical staff.
- ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- review patient handover recording systems to be more time efficient.
- provide NICE cognitive assessment training for frontline ambulance staff.
- improve training for staff on Mental Capacity Act assessment.
- ensure all staff receive annual appraisals.
- review development opportunities for staff.
- improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- review maintenance of ambulances to ensure all are fully operational including heating, etc.
- review arrangements in the event of ambulances becoming faulty at weekends.
- review and improve patient waiting times for PTS patients.
- ensure PTS booking procedures account for the needs of palliative care patients.
- develop operational plans to respond to the growing bariatric population in London.
- review operational guidelines for managing patients with mental health issues and communicate these to staff.
- ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- communicate clearly to all staff the trust's vision and strategy.
- develop a long term strategy for the (Emergency Operations Centres (EOCs).
- increase the visibility and day to day involvement of the trust executive team and board across all departments.
- review trust equality and diversity and equality of opportunity policies and practice to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas.
- review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

11. The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

WITNESSES

Representatives from the Trust have been invited to attend the meeting to answer questions from Members.

SUGGESTED SCRUTINY ACTIVITY

Members review the evidence collected during the year and, following further questioning of the witnesses, decide whether to submit commentaries to the CQC.

BACKGROUND INFORMATION

None.

KEY LINES OF ENQUIRY

Following its inspection of LAS, a Quality Improvement Programme has been created to address the areas for improvements identified by the CQC. The Committee is interested in the action that has been taken to address the issues identified in the inspection report as well as:

- What issues identified in the inspection report have not yet been addressed (and why)?
- What are the barriers to implementing actions and how will these be overcome? If the intended action cannot be taken, what alternative action will be taken?
- How are the actions being monitored?
- With regard to actions that have been implemented, what impact have they had on finances, staff and patients?

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London Ambulance Service NHS Trust

Quality Report

220 Waterloo Road
London
SE1 8SD
Tel: 020 7921 5100
Website: www.londonambulance.nhs.uk

Date of inspection visit: 1-5;17-18 June 2015.Unannounced visits on 12,17,19 June 2015
Date of publication: 27/11/2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The London Ambulance Service NHS Trust (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London, which has a population of around 8.6 million people. The trust employs around 4,251 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across London.

The main role of LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by LAS include patient transport services (PTS) for non-emergency patients between community provider locations or their home address; NHS 111 non-emergency number for urgent medical help and/or advice which is not life-threatening; and resilience services which includes the Hazardous Area Response Team (HART).

Our announced inspection of LAS took place between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12, 17 and 19 June 2015. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team:

We did not inspect the NHS 111 service provision during this inspection.

Overall, the trust was rated as Inadequate. Caring was rated as Good. Effective, and responsive were rated as Requires improvement. Safe and Well-led was rated as Inadequate.

Our key findings were as follows:

- The trust was making efforts to recover from a decline in performance which had worsened in late 2014. At the time of our inspection the interim chief executive was appointed substantively to the post. This was seen as a positive move by many front line staff to assist stability. There had been two previous chief executives in post or appointed since 2012.
- The trust was operating with a shortage of trained paramedics in the light of a national shortage and due to paramedics leaving its service for a number of reasons including better pay elsewhere. It had conducted recruitment of paramedics from as far afield as Australia and New Zealand to combat this.
- We had significant concerns about a reported culture of bullying and harassment in parts of the trust. The trust had commissioned an independent report into this which it had received in November 2014. However this was only presented to the trust board in June 2015.
- We had similar concerns about the trust's provision and use of HART paramedics and the trust's ability to meet the requirements of the National Ambulance Resilience Unit (NARU).
- The trust had been facing increased contractual competition for its patient transport services (PTS) leading to a diminishing workload. It was trialling a new non-emergency transport service (NET) which had begun in September 2014.
- During our inspection we found staff to be highly dedicated to and proud of the important work they were undertaking.At the same time they were open and honest about the challenges they were facing daily.They were largely supportive of their immediate managers but found some senior managers and executives and board members to be remote and lacking an understanding of the issues they were experiencing.

We saw several areas of good practice including:

- The trust's intelligence conveyancing system to help prevent overload of ambulances at any particular hospital emergency department.
- Good levels of clinical advice provided to frontline staff from the trust's clinical hub.
- We observed staff to be caring and compassionate often in very difficult and distressing circumstances.

Summary of findings

- The percentage of cardiac patients receiving primary angioplasty was 95.8% against an England average of 80.7%
- Good multi-disciplinary working with other providers at trust and frontline staff levels.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- improve its medicines management including:
- formally appoint and name a board director responsible for overseeing medication errors and formally appoint a medication safety officer.
- review the system of code access arrangements for medicine packs to improve security.
- set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- set up control systems for the issue and safekeeping of medical gas cylinders.
- improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- address under reporting of incidents including the perceived pressure in some departments not to report incidents.

In addition the trust should:

- review and improve trust incident reporting data.
- ensure all staff understand and can explain what situations need to be reported as safeguarding.
- review the use of PGDs to support safe and consistent medicines use.
- improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
- ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- ensure adequate and ready provision of protective clothing for all ambulance crews.
- ensure equal provision of ambulance equipment across shifts.
- improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- ensure full compliance with bare below the elbow requirements.
- review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- set up a system of regular clinical supervision for paramedic and other clinical staff.
- ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- review patient handover recording systems to be more time efficient.
- provide NICE cognitive assessment training for frontline ambulance staff.
- improve training for staff on Mental Capacity Act assessment.
- ensure all staff receive annual appraisals.
- review development opportunities for staff.
- improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- review maintenance of ambulances to ensure all are fully operational including heating etc.
- review arrangements in the event of ambulances becoming faulty at weekends.
- review and improve patient waiting times for PTS patients.
- ensure PTS booking procedures account for the needs of palliative care patients.
- develop operational plans to respond to the growing bariatric population in London.

Summary of findings

- review operational guidelines for managing patients with mental health issues and communicate these to staff.
- ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- communicate clearly to all staff the trust's vision and strategy.
- develop a long term strategy for the (Emergency Operations Centres (EOCs).
- increase the visibility and day to day involvement of the trust executive team and board across all departments.
- review trust equality and diversity and equality of opportunity policies and practice to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas.
- review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

On the basis of this inspection I have recommended that the trust be placed in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to London Ambulance Service NHS Trust

London Ambulance Service NHS Trust (LAS), was established in 1965 from nine previously existing services. It became an NHS Trust on 1 April 1996 and covers the capital city of the United Kingdom, which has a population of around 8.6 million people. The trust employs around 4,251 WTE staff.

London Ambulance Service provides an emergency department service to respond to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency; a patient transport service (PTS), for non-emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 and NHS 111 calls were received, clinical advice is provided and emergency vehicles dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART).

The trust covers the most ethnically diverse population in the country. In the 2011 population census, the three main ethnic groups were: White (59.79%), Asian or Asian British (18.49%) and Black or Black British (13.32%).

Life expectancy at birth for both males and females in London is greater (better) than that for England. However, life expectancy at birth for males in London is lower (worse) than that for females. Life expectancy at birth for females in London is the highest in the country.

In the following local authorities, life expectancy at birth for males is lower (worse) than that for England; Barking and Dagenham; Greenwich; Hackney; Islington; Lambeth; Lewisham; Newham; Southwark and Tower and Hamlets. In addition, life expectancy at birth for females is lower (worse) than that for England in the following local authorities; Barking and Dagenham and Newham.

Our inspection team

Our inspection team was led by:

Chair: Dr Andrew Welch

Head of Hospital Inspections (Interim): Robert Throw, Care Quality Commission

London Ambulance Service was visited by a team of 54 people including CQC inspectors, inspection managers, national professional advisor, pharmacist inspector, inspection planners and a variety of specialists. The team of specialists comprised of paramedics, urgent care practitioners, operational managers and call handlers.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCGs), the Trust Development Authority, NHS England, and the local Healthwatches.

Summary of findings

We held interviews, focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records.

We carried out the announced inspection visit between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12 and 19 June 2015.

What people who use the trust's services say

Hear and Treat survey

LAS performed similar to other ambulance trusts in all questions in the ambulance 'Hear and Treat' survey.

Patients' Forum

There is an independent patients' forum which works proactively to monitor all aspects of service provided by the trust. Amongst its focus are issues around equal access to services, clinical partnerships with other providers, access to training for paramedics, additional use of 111 services, services for people with mental health issues, services for people with dementia, standards of PTS services, emergency response times, Duty of Candour, category C call performance and dealing with patient falls.

Local Healthwatch

Several locations contacted us across London and the majority of responses were favourable about user experience although concerns were raised in relation to response and waiting times.

Patients' views during the inspection

During the inspection, we spoke with a number of patients across all services. Patients also contacted CQC by telephone and wrote to us before and during our inspection. The comments we received were mainly positive about their experiences of care. The main concerns raised with us were in relation to delays in transport for patients using PTS.

Facts and data about this trust

The London Ambulance Service (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London. It employs up to 4251 WTE staff who are based at ambulance stations and support offices across London.

Their main role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. Other services they offer include providing pre-arranged patient transport and finding hospital beds.

LAS works closely with other emergency services including the police and the fire services to provide emergency services during major events and in response of any major incidents.

The trust serves entire population Greater London.

Activity:

- The emergency and urgent care service made over 1.4 million vehicle responses to incidents in 2014-15
- The EOC received around 1.9 million 999 calls which averages 5,193 calls per day, in 2014-15
- The PTS made around 115,468 journeys transporting patients across London, in 2014-15

Staff (WTE December 2014): 4251

– 2864 Qualified ambulance service staff

– 1287 Support to clinical staff

– 86 NHS infrastructure support

– 14 Qualified nursing, midwifery & health visiting staff

• **Locations:** 86

• **Financial Performance**

• Fiscal Year 2014/2015

Summary of findings

• Income **£301,874,000**

• Full Costs **£300,874,000**

• Surplus **£1,000,000**

Currently the LAS Operations Directorate is being transformed in a formal reorganisation.

Three geographical areas and the other elements in Operations have been made into four Operational Divisions, each managed by a Deputy Director of Operations.

North and South Divisions deliver the operational core response across the LAS operational area.

Central Operations is a pan London division responsible for Emergency Planning Resilience and Response Department, Cycle and Motor Cycle response units as well as operationally responding managers. Control Services Division also provides the Emergency Operations Centre across London and 111 Call Centre function at Beckenham.

The trust has a total of 70 ambulance stations across London which, for management purposes, currently sits within 26 local operational areas, known as complexes.

Overall performance indicators:

Safe:

95% of 557 incidents reported to NRLS between Jan 2013 and Feb 2015 are reported as 'Low' or 'No' harm.

• There were 26 incidents reported as 'Moderate' harm.

Effective:

LAS performed better than the England average with ROSC overall and Utstein Comparator Group although this has recently dropped below the England average.

• LAS performed best amongst ambulance trusts in England for the provision of Primary Angioplasty within 150 minutes.

• LAS performed similar to other ambulance trusts in all other Clinical Indicators.

Caring:

LAS performed similar to other ambulance trusts in all questions in the ambulance 'Hear and Treat' survey.

• The number of written complaints received by LAS has increased every year and has doubled over the last five years.

Responsive:

LAS performed much better than the England average and best amongst ambulance trusts in England for call abandonment.

• LAS had the best (lowest) re-contact rate with 24 hours for patients discharged from care by phone.

• LAS performed much better than the England average and best amongst ambulance trusts in England for emergency calls resolved by telephone advice

• LAS performed better than most trusts in the time taken to answer calls.

- LAS has a slightly higher frequent caller rate than the England average.

• LAS slightly worse than the England average for incidents managed without the need to transport to an A&E Dept.

• LAS performed similar or slightly worse than other trusts in time to treatment of Category A calls.

- LAS is the worst performing ambulance trust for getting to Category A calls within eight minutes and has failed to reach the 75% target since May 2014.

• LAS has also failed to reach the 95% target for Category A calls reached within 19 minutes since May 2014 and is worse than the England average.

• LAS had the worst (highest) re-contact rate with 24 hours for patients following treatment and discharge at the scene.

Well led:

- LAS staff sickness rate has risen above the England average since May 2014 and has continued to rise.

• The 2014 staff results show 29 negative findings with only one positive and one neutral.

- The trust has had more than two changes in chief executive in recent years. At the time of our inspection its interim chief executive was appointed to the post substantively.

Summary of findings

Our judgements about each of our five key questions

Rating

Are services at this trust safe?

Inadequate

There were limited measures and monitoring of safety performance. A culture of under-reporting of incidents was evident. There was little evidence of learning from incidents or actions taken to improve safety.

LAS was affected by a national shortage of paramedics which resulted in a high number of vacancies.

Levels of staff participation in the mandatory training were inconsistent. Training was affected by operational pressures and scheduled training was at times cancelled to a due low number of attendees.

Equipment and vehicle checks were not always regularly carried out. We saw no systems, checks or regular audits in place to ensure medicines removed from paramedic or general drug packs had been administered to patients.

Incidents

The reporting, investigation, learning and feedback of incidents across the trust were inconsistent. The trust did not have good quality incident data. Reporting of incidents by front line staff was paper based and there were often delays in the paper forms reaching the trust safety and risk management team. The safety and risk management team had a backlog of incidents to input into Datix.

We found that there was an under reporting of incidents across the trust. The safety and risk management team could not be assured that there was consistent and accurate reporting by all members of staff. Several frontline staff told us they under reported incidents due to the lack of time to complete the forms during their shifts. Some staff were clear that incident reporting should also include near misses and non-harm related incidents; but this was not consistent.

Staff did not identify with learning from incidents, such as changes to practice, equipment or policy, because they were not presented as being as a direct result of an incident. Most staff told us there was little learning from incidents. It mainly required staff to have access to a computer. However, there were few computers at ambulance stations. However PTS staff told us the learning from incidents and near misses was communicated during monthly “Team talk” meetings and via the “PTS directorate bulletin” which was circulated on an ad hoc basis.

Summary of findings

We did find several examples where changes had been made as a result of repeat adverse events.

We found that when we questioned frontline staff about the principles of the 'Duty of Candour', this was not well understood by them.

There was a major incident plan to ensure that the trust was capable of responding to major incidents of any scale in a way that delivered optimum care and assistance to the victims. The plan was prepared in light of guidance from the Department of Health, Home Office and Civil Contingencies Act 2004.

Mandatory training

Staff completion of mandatory training was variable across the trust. In frontline emergency and urgent care we were told training had effectively stopped in recent years due to operational pressures. Many staff reported not having received mandatory training for a number of years.

Staff were paid for 24 hours (three days) per year to undertake mandatory training. This was paid at the beginning of the financial year. If staff did not complete the training, they were 'challenged' by their managers and either had the days deducted from their pay or worked extra days to cover the payment. In these circumstances the mandatory training was not completed.

Levels of mandatory training in PTS and in the emergency operation centres were higher though not reaching the trust target of 100%. Records provided by the trust indicated that 83% of EOC staff completed mandatory training in 2013/2014 and 41% in 2014/2015. We saw an internal PTS computerised spreadsheet which showed a wide range of training was provided. The recorded dates of staff training were largely within the past year.

Safeguarding

Front line emergency and urgent care staff had a good understanding of what safeguarding concerns might be and all were clear about the process for reporting concerns. However, most of the staff we spoke with had not undertaken any form of safeguarding training but felt they could benefit from undertaking such training

Awareness of safeguarding processes and procedures was variable among PTS staff; some were able to describe what would constitute a safeguarding concern and provide examples, whereas other staff were unfamiliar with the term and what they would do if they were worried about a patient they were transporting.

Appropriate cases were referred to the safeguarding authorities in documents we looked at. Emergency Operations Centre staff did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety.

Cleanliness, infection control and hygiene

We found variable standards of cleanliness, infection control and hygiene across the areas visited. Some frontline staff confirmed they had not been trained on infection control. In addition, LAS stipulated that staff should receive annual refresher training on infection control. However some staff had not attended this training for over four years.

Allowing for the fact that ambulances are in repeated use and out in all weathers there was inconsistency in the cleanliness of the ambulances we viewed. We found some were visibly clean, whilst others were not.

We saw most staff wearing gloves during patient contact. However we did not observe staff using disposable plastic aprons when appropriate when attending to patients.

Cleaning of vehicle equipment after use was variable; we observed some staff cleaning equipment thoroughly, whereas others returned equipment to the vehicle after using it with a patient without cleaning it.

We found most ambulance stations we inspected not to be clean. Some were contaminated with black dust. This dust covered boxes which contained medical supplies. In some stations the cupboards where sterile supplies were kept were not closed nor locked.

There was no infection control policy but information about infection control was available to staff via the trust's intranet 'The Pulse'. There was also an infection control handbook given to each member of staff. There were up to date protocols which advised staff on special measures and how to respond to certain high risk infectious diseases and there was a process in place for call handlers to alert ambulance crews to specific patient infection risks.

Environment and equipment

Provision of equipment on ambulances appeared not to be evenly spread in some cases. For example vehicles on early shift were fully stocked but late shift crews sometimes found themselves short of equipment. This sometimes delayed or prevented vehicles going out or crews had to make a decision to go out not fully stocked. LAS had a policy that a paediatric advanced life support (PALS) pack should be carried on all response vehicles. However, we found some ambulances did not have these in place.

Some staff reported a lack of blankets, pillows, finger probes for pulse oximeters (to measure oxygen in blood) and ECG leads (to measure heart rhythm). However, others told that there were enough supplies at the central store of each station and that the supply of consumables was said to have improved in recent months.

Defibrillators were available on all PTS vehicles. Emergency ambulance crews told us they would not start work without them.

The trust used a flexi-fleet system, where vehicles were used service wide, and no individual station had control of any vehicle. With flexi-fleet, there was no personal accountability for vehicles therefore it was difficult to ascertain how and when damage to a vehicle or equipment may have occurred.

Restocking of ambulances, other than the 24 hour ambulances, was carried out by external contractors; however staff told us the thoroughness of this was variable. We were told that if there was a problem with an ambulance at weekends, there was no one to report it to or to fix the vehicle.

Call handling staff working at the Waterloo EOC complained that the environment they worked in was very dark. They felt it was not suitable for long shifts. The room had very limited day light and was located on a lower ground floor. Both EOCs had suitable staff welfare facilities.

Medicines

The trust followed the NHS Protect guidance; security standards and guidance for the management and control of controlled drugs in the ambulance sector.

Paramedic staff were administering medicines under the legal group authority that entitles paramedics to administer some prescription only medicines without a prescription. However the authority to administer some medicines that were used was less clear. Subsequent to our inspection the trust undertook to review these arrangements and ascertain if a PGD (a written instruction for the administration of medicines to a group of patients who may not be individually identified before presentation for treatment) may be needed for some of these circumstances.

The trust had no systems, checks or regular audits in place to check that medicines removed from paramedic or general drugs pack had been given to patients, this included oral morphine solution and diazepam injection.

At the time of our inspection the trust did not have identified a board level director to have responsibility to oversee medication

error incident reporting. It also did not have a formally appointed Medication Safety Officer. The MSO role had been informally delegated to the chair of the medicines management committee, until a permanent arrangement was in place.

The trust was not following the NHS protect guidance on the requisition, distribution, security and storage of medical gas cylinders and medical gas stock.

Records

Completed patient record forms (PRFs) were transferred for safe storage at ambulance stations. However we did find some examples across the trust where patient record forms were in unsecured vehicles.

There was no effective system for auditing records and most staff we spoke with were not aware of any patient records audit being undertaken by the service.

Patient handover records at hospital A and E were paper based, time consuming and often involved some duplication. Although there were electronic systems available the trust viewed these as not economically viable.

The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. We observed these were not easily accessible through the MPDS data system used. Staff told us ambulance crews on occasion complained as they could not access documents directly from their mobile data terminals and needed to be instructed over the telephone.

Assessing and responding to patient risk

The trust had a clear pathway for ambulance crews to follow when responding to life threatening conditions, emergency or responding to non-life threatening conditions. There were processes in place for transporting bariatric patients.

Ambulance crews were alerted by the control centre if a patient they were transporting had a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order in place. Crews told us they would also confirm upon arriving to collect a patient whether or not the patient was for resuscitation.

The medical priority dispatch system (MPDS) was used by call handlers to make decisions related to dispatch appropriate aid to

medical emergencies, it allowed for systematised caller interrogation and pre-arrival instructions. The Manchester Triage System (MTS) supported decisions made by clinicians working in the 'clinical hub'.

The dynamic risk assessment framework (DRAM) required all PTS and NET staff to complete a visual assessment of mobility and frailty as well as other patient risks when arriving to collect a patient. This was a situational assessment prior to moving the patient which involved assessing the surroundings, such as property access difficulties, like the presence of clutter or the size of doorways.

Staffing

London Ambulance Service was affected by a national shortage of paramedics which resulted in a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months.

We were told by all the ambulance crew members we spoke with that there were insufficient numbers of appropriately trained staff with the necessary skills mix to ensure that patients were safe and received the right level of care. Typically during our inspection of 280 ambulances scheduled to be operational only 234 were operational due to staff shortages.

The trust had problems with staff retention due to pressure of work with increased responsibility and a lack of opportunity for career progression. Most of the paramedic staff we spoke with said they were still being paid on a band five (5), whereas some counterparts elsewhere in the country were being paid at band six (6) for an equivalent job.

Average staff turnover rates within the emergency operation centre department were high at 15% in 2014/ 2015. The highest turnover was reported among emergency medical dispatcher level 1 staff (EMD) at 28%, and nursing staff at 41%. The lowest turnover was among EMD allocators (5%), managers (7%), and sector controllers (6%).

Serious concerns were identified about how the trust had been fulfilling their responsibilities to deliver a HART capability to the NARU specification. Team members told us that they did not meet this specification. Managers also told us they struggled to meet this specification, but that HART staffing was "risk assessed" and always "capable". However, our examination and initial analysis of rotas for May 2015, led us to believe that the trust was not always able to fully provide this function.

Major incident awareness and training

Summary of findings

Major incident protocols, although following requirements of the Civil Contingencies Act, were not up to date. The document stated that it was to be reviewed at least annually by the department for emergency preparedness, resilience and response. However, it had not been amended since July 2012. There was a tiered structure of command to be implemented according to the severity of an incident.

Some staff we spoke with were aware of the LAS major incident procedures and how such incidents were escalated to the incident command centre. However, other staff we spoke with were unaware of the major incident procedures and most ambulance crews had not been trained in major incident procedures apart from rehearsals for the London Olympics in 2012.

Are services at this trust effective?

Requires improvement 

LAS performed better for EOC call abandonment than the England average and was best amongst ambulance trusts in England. The EOC performed better than all ambulance trusts in the time taken to answer calls.

The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust in England.

There was good coordination with other providers allowing for better patient experience.

Clear patient eligibility criteria were in place and key performance indictors (KPI) were identified for each PTS contract. PTS achieved slightly below the KPI target of 95% throughout 2014/15.

PTS crews received regular teaching sessions delivered by work based trainers. However for emergency and urgent care ambulance staff this was inhibited by lack of time to undertake the training as there was no in-built training session during a shift. Staff had access to information via the personal digital assistant on each vehicle and could access trust policies and procedures via the trust internet.

The LAS followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The service had effective relationships with the emergency department and other wards at acute hospitals where they conveyed patients to and from those facilities.

However, London Ambulance response times for Red 1 and Red 2 category A calls was one of the worst in the country. Since May 2014 there had been a significant decline in the number of Category A calls attended within the target time of eight minutes.

Summary of findings

Evidence-based care and treatment

NICE guidelines were circulated to staff through electronic bulletins, clinical updates and directives and staff bulletins. Training rooms and e-learning facilities were available at some stations, where training aids were available and ready for use across the patch and to support the development of JRCALC and NICE guidance.

The trust had specific contracts in place with various organisations within London. Each agreement outlined certain eligibility criteria for using PTS, based on national guidelines for the non-emergency transportation of patients.

Procedures for the dispatch of resources by the EOCs were up to date and informed by relevant guidance.

Assessment and planning of care

The trust followed medical protocols in assessing patients and planning their care. It used a variety of care pathways, in line with what was agreed with different local clinical commissioning groups (CCGs).

Standards and expectations of the PTS service were stipulated in service level agreements.

All calls to the EOCs were categorised in line with the national guidance. For example Red1 calls which required response within eight minutes (classified as immediately life threatening).

Response times

The trust was consistently the best performing region in the country for category A calls until March 2014. However since then there had been a substantial decline in performance and the target time had not been met in the required percentage of calls. EOC staff were frequently unable to dispatch crews due to lack of availability of paramedics and general staff shortages.

The trust performed better than all ambulance trusts in the time taken for EOC to answer calls with 50% of all calls being answered in less than one second and 95% in less than two seconds. 99% of calls answered below 37 seconds which was slightly better than the England average of 48 seconds.

Patient outcomes

The trust achieved 31.6% for return of spontaneous circulation (ROSC) at the time of arrival at hospital following cardiac arrest (April 2013 to November 2014), which was better than the England average of 27.5%.

Summary of findings

The trust had the highest proportion of cardiac patients receiving primary angioplasty within 150 minutes (April 2013 to November 2014). They achieved 95.8%, which was better than the England average of 80.7% and was the best performing ambulance trust. However, in relation to the number of patients who achieved an appropriate care bundle for angioplasty, LAS achieved 72.6%, which was worse than the England average of 80.7%, and was the worst performing ambulance trust nationally.

The proportion of stroke patients receiving thrombolysis within 60 minutes by LAS (April 2013 to November 2014) was 60.1%. This was just below the England average of 60.6%.

The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust from April 2014 to February 2015 (13.3%). The trust performed better than the England average (8%).

The trust had the lowest telephone re-contact rate of patients within 24 hours after discharge of care, at 2% (England average 7.8%).

Competent Staff

Most frontline staff we spoke with had not received an appraisal in the last three years. This was due to operational pressures and staff shortages which did not allow for staff to be taken off the road for their appraisals. There was a mixed view from staff on the effectiveness of appraisals.

All the ambulance crews we spoke with were registered with the Health Professional Council and therefore had received appropriate clinical supervision for their revalidation requirement. The trust used the clinical hub desk (CHUB) to train senior paramedics.

Many staff expressed a lack of confidence working within the Mental Capacity Act 2005 (MCA) and working with mental health patients.

Some of the staff we spoke with lacked understanding in relation to 'reasonable restraint' permitted by the MCA generally and Mental Health Act (MHA) during the conveyance of patients liable under the MHA.

Several gaps were identified in the overall skill, training and competence of HART paramedics. For example, low numbers of staff had undertaken training in 'confined space' and initial operational response (IOR); and there had been no physical competency assessment of staff in the past two years.

Coordination with other providers

The trust's command and control system was linked electronically with the equivalent system for London's Metropolitan Police.

Call handlers were provided with information on when to redirect callers to the 111 service (NHS non-emergency number) or transfer calls and how to respond when patients were handed over to LAS from 111.

We saw examples of how staff worked with other providers of health and social care such as; pre-alerting A&E departments or services who may request urgent ambulance transfers including for patients with mental health conditions or being detained under the Mental Health Act. We saw several handovers where information relevant to the patient, including any special notes, was explained in detail to the receiving emergency department staff

PTS staff liaised closely with staff at various centres that provide care, such as clinics and hospices.

Multidisciplinary working

The emergency departments, urgent care unit, maternity units, critical care units and other departments within the acute hospitals were positive about the coordination of care with the LAS staff. They were all positive about the service provided by the LAS and reported that the co-operation between frontline staff and emergency department staff was very cordial and professional.

EOC staff knew what type of calls should be allocated to the hazardous area response team (HART). We observed overall good multidisciplinary team working between the ECTs, clinical advisors and dispatch staff.

Access to information

General information for staff was through the "Pulse" intranet site and was accessible through the computers in ambulance stations. This contained updates to medical information. Some services on The Pulse could be accessed by staff from their home computers.

The medical priority dispatch system (MPDS) used by call handlers to make decisions on dispatching appropriate aid to medical emergencies, provided staff with patient specific information. It allowed for systematised caller interrogation and providing pre-arrival instructions.

The Manchester Triage System (MTS) provided staff with information and supported decisions made by clinicians working in the 'clinical hub'.

LAS emergency ambulances, response cars and other vehicles were fitted with mobile phones, two-way transceiver radios, global positioning systems (GPS) and an automatic vehicle location system (AVLS) through mobile data terminals on each vehicle. Ambulance

crews had access to special notes including advanced care plans/ directives and 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders through the EOC and were always informed of this before they arrived on the scene.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Paramedics received training in the Mental Capacity Act (MCA) 2005 as part of their induction and mandatory training. LAS provided e-learning on the MCA. There was annual core service refresher training that included the MCA. When we spoke with staff we found variations, with some staff being more confident in using the MCA and completing MCA assessments than others.

There was an algorithm for dealing with mental health patients by ambulance crews. However, most of the ambulance staff we spoke with said they were not confident in dealing with mental health issues. There was guidance on conveying mental health patients, which all staff had to adhere to for their safety and security.

There were mental health nurses able to provide advice related to patients with a mental health problem, Mental Health Act, and Mental Capacity Act. However, this service was not routinely provided 24 hours a day with occasional shifts being left uncovered.

Are services at this trust caring?

Good

We observed staff talking to people in a compassionate manner and treating them with dignity and respect. Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treat people.

The London Ambulance Service participated in the 'hear and treat' survey for 2013/ 2014. Overall the trust was performing similar to other trusts that took part in the survey.

Compassionate Care

EOC staff spoke to people in a compassionate manner and treated them with dignity and respect. They listened carefully to what was being said and rechecked information when necessary and were sensitive and supportive whilst on the phone.

The London Ambulance Service participated in the 'hear and treat' survey for 2013/2014. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 321 patients for the London Ambulance Service NHS Trust.

PTS and NET staff maintained patient dignity at all times, ensuring patients were suitably dressed or covered during their journey.

Summary of findings

We observed patients being treated with respect by ambulance staff throughout our inspection. Ambulance crews consistently showed patience and sensitivity to the needs of patients. Ambulance crews asked how patients wanted to be addressed and introduced themselves.

Understanding and involvement of patients and those close to them

Patients and those close to them reported being involved in their care and treatment. Ambulance crews explained what they were doing and the care and treatment options available, such as being treated at the scene followed by discharge or being conveyed to a hospital if that was the assessed as the most appropriate option.

Patient forums were hosted by the trust, during which patients had the opportunity to provide feedback about the service and make suggestions for future improvements. Some patients we spoke with were aware of this forum; most of these patients were regular service users.

In the 'hear and treat' survey the trust scored 8.7 out of 10 for patients who felt that the call handlers understood what they were being told and the trust scored 8.8 out of 10 for patients who received understandable advice from a clinical advisor when an ambulance was not being sent.

Emotional support

All the patients we spoke with said ambulance crews consistently reassured them. The 'hear and treat' survey indicated that 7.8 out of 10 for patients who spoke to a second person who had any anxieties or fears, had the opportunity to discuss them with a clinical advisor.

We observed ambulance crews being very calm and supportive to distressed patients and their relatives. Ambulance crews told us how they supported families and people close to patients who died in their care and stayed with them until it was appropriate to leave.

The trust had a bereavement booklet the ambulance staff gave to relatives if they attended a call to someone who had died.

Are services at this trust responsive?

Requires improvement

The emergency and urgent care ambulance service was dealing with an increasing number of emergency calls and action was being taken on long waiting times for ambulances. LAS had also introduced measures to ensure that people were monitored while waiting and high-priority calls took precedence over non-urgent calls.

Summary of findings

The service had limited specialist vehicles for obese or bariatric patients. However, new vehicles were being introduced which were able to convey these patients.

The call handling system allowed alerts to be recorded for frequent callers, patients with complex needs, and learning disabilities as well as for patients from other vulnerable groups. However, it was not effective and did not allow to access important information promptly.

There were limited opportunities for learning from complaints. Patients' complaints were not routinely discussed to prevent future occurrences or improve the quality of the service in response.

There was a very active patients' forum which met regularly to discuss patient issues.Trust officials attended these meetings but more as observers than as active participants.

Service planning and delivery to meet the needs of local people

The trust had developed initiatives to respond to over 124,000 calls routed to them annually by the Metropolitan Police.

Each of the EOC call staff and emergency ambulance crews had a small geographical area allocated to them to improve local knowledge and call response efficiency.

There was a control services surge management plan to ensure that at times of sustained high pressure the EOC provided a consistent service to 999 callers.

The trust had introduced a more advanced triage system resulting in an increased use of the 'hear and treat' system. This improved responsiveness as patients were able to receive faster care and treatment through more appropriate pathways.

Meeting people's individual needs

We saw a number of care pathways used to redirect appropriate patients with minor ailments and minor injuries to health centres.

There was a flagging system for addresses for a number of issues, for example, where there were risks of violence to ambulance staff; where drugs were misused, or where specialist equipment had been used in the past.

We did not see evidence of operational plans to respond appropriately to the growing bariatric population in London or to train staff in the assessment of patients and the use of specialist

manual handling and clinical equipment during their care and treatment of this group of patients. The trust had limited specialist vehicles for obese or bariatric patients although new vehicles were being introduced which had this capacity.

The trust had commissioned focus groups with the Alzheimer's Society and Age Concern to hear about how the services could improve.

Access and flow

LAS had a low rate of abandoned calls, so most callers were able to make contact with the ambulance service. However, London also had a higher than average number of frequent callers.

Shortage of ambulance crews was a limiting factor in the responsiveness of the service. Significant financial incentives were offered to front line staff prepared to work overtime to increase the number of staff on the road. Staff were also encouraged to join the staff bank to work extra hours if and when they wanted to.

Eligibility criteria for PTS were determined by the organisations which had commissioned the service, based upon on national guidelines for the non-emergency transportation of patients.

There was an intelligence conveyance desk (ICD) at each of the emergency operation centres to support management of pressures at London emergency departments (ED). The aim was to proactively balance the arrival of ambulances across London trusts to reduce the surge of ambulance attendance at busy hospitals.

Learning from complaints and concerns

Most complaints related to delays in ambulance dispatches and long waits; others were from patients who were referred to NHS111 when they believed their condition was very serious.

There were limited learning opportunities from complaints for staff. Patient complaints and cases were not routinely shared with all staff although some staff did receive feedback. In some but not all cases there were examples of actions taken by the trust and learning from complaints.

There was no information on how to make a complaint in ambulances. Frontline staff did not have any information to give to patients or relatives about how to make complaints, but said that if asked, they would advise people to contact the headquarters or look at the LAS website.

Summary of findings

Are services at this trust well-led?

Inadequate 

The LAS had a vision and strategy for the way in which they wanted to provide the service. However, most ambulance staff were not clear about what this was and were not engaged with the development of the service's vision and strategy. There was no long term strategy for the EOC. The restructure of the EOC had not been managed well.We were told that there had been no staff involvement and that it had been imposed from the top down.

The PTS management team had a thorough understanding of the diminishing workload PTS was facing and had presented a structured exit plan in early 2015.There was a limited approach to obtaining views from the patients.

There was a recognised issue with bullying and harassment and a perception of discrimination. Staff told us that the trust did not act proactively to address this. An external report into bullying and harassment produced in November 2014 was only presented to the board in June 2015.

There was a lack of operational grip from the board downwards on day to day management issues affecting how staff operated the overall service.There was demonstrable inconsistency of service oversight within emergency and urgent care and PTS management. In the EOCs there was insufficient operational overview, management of appraisals and overall performance of the function.

Risks were not managed well and the risk register was not kept up to date. Individual stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/satellite stations. This meant the Duty Station officers (DSOs) and other staff had no way of monitoring their risks.

We saw the trust's risk register related to emergency preparedness. Insufficient HART staff was not listed on the register, but inadequate training of staff and managers in major incident procedures was.

There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. The NHS staff survey 2014 showed that the trust rated worse than average in 29 of the 30 findings.

We wrote to the trust after the inspection to see what actions they were taking in relation to governance and in relation to the poor results in the latest staff survey. Their response included continued emphasis on recruitment and future actions to review the trust performance management policy, establish an effective appraisal system based on the next agreed business plan and to make improvements to team talk.

Summary of findings

There was a limited approach to obtaining views from patients. Public engagement activity took place in many forms including community liaison, school and local fayres and presentation to other stakeholders.

Vision and strategy

Most of the ambulance crews we spoke with demonstrated their passion and drive to provide of a high quality and safe service; however they were not aware that the trust's values included supporting and developing staff. PTS staff were aware of the trust values but told us these had been recently updated and this had failed to be communicated to the PTS part of the organisation until several weeks later. Some EOC staff advised us the trust's values had changed recently and it was communicated via the trust's staff intranet page:"Pulse". Others we spoke to in the EOC were not aware that the values had changed.

Information about the service vision and strategy were not displayed anywhere within the stations we visited.

Governance, risk management and quality measurement

Individual ambulance stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/ satellite stations. This meant the duty station officer (DSO) and staff had no way of monitoring their risks. Ambulance crews and other office-based administrative staff we spoke with had no knowledge of what their risks were. However, we were told that operational managers monitored their risks through incident reporting and real-time data about demands on the service, but this information was not shared with the staff at local level. A PTS risk register was maintained and senior management staff met to discuss and review this on a quarterly basis.

The last risk identified on the EOC risk register was in April 2013 and this had not been regularly updated. We did not see that all risks were listed, for example the failure of the computer based Command Point system in the EOC. The system had failed in May 2015 which resulted in the EOC having to resort to paper based systems.

Performance was monitored and reported at ambulance station level. The Resourcing Escalator Action Plan (REAP) level was displayed in stations and managers received comparative performance data on stations.

EOC Call handlers told us 1% of all their calls should be monitored. However, there was no standardised system to ensure this was the

case and calls were selected at random. Staff working in the clinical hub advised us that they would undertake daily peer reviews, listening in to each other's calls. Check sheets were used and they would constructively feedback to colleagues.

There was insufficient operational overview and management of staff training development and appraisals. Some managers told us support received from human resource department was inadequate which made tackling poor performance and frequent staff absence difficult.

Leadership

Several members of staff told us the management style of the interim chief executive had helped improve the organisation performance targets and boost staff morale.

Some of the staff we spoke with thought local leadership was good. Operational staff said they rarely saw senior managers based at the headquarters. They were less favourable towards more senior managers and members of the executive team whom they saw less regularly and who they thought lacked understanding of the day to day reality of their working lives.

The trust informally announced in January 2014 the plan to restructure its management tier by September 2014. However,formal consultation began in October 2014 and the reorganisation of the workforce had not been completed at the time of our inspection in June 2015.

Staff turnover rate within the emergency operation centre department was 15% in 2014/2015. The highest turnover was reported among emergency medical dispatcher level1 staff (EMD), at 28%.

Culture within the service

Some staff reported a culture of fear amongst frontline emergency and urgent care ambulance staff. Some staff stated they felt unwilling to use their initiative when appropriate or raise concerns with their managers out of fear of repercussions.

Bullying and harassment was reported to us by several frontline staff, and a few black and minority ethnic staff stated that at times they felt 'humiliated' and 'ignored' by managers. Some claimed that they were overlooked for promotion.

During the inspection, we were made aware of the findings of an independent external review into bullying and harassment in LAS, which was undertaken in October and November 2014. The reason

for the review was the rise in reported incidents of bullying and harassment in the 2014 LAS results from the NHS Staff Survey. Despite the executive team having sight of this report since November 2014, it was only presented to the board in June 2015.

Following the inspection we wrote to the trust to ask the trust what action they were taking in relation to the issue of bullying and harassment as outlined to us and contained in the report that they had commissioned. In their reply they outlined actions which had been completed or part competed which included two group sessions for senior managers and the executive team with proposed follow up sessions for those unable to attend; one to one coaching sessions for those senior managers specifically named in the bullying and harassment report and the creation of a bullying and harassment helpline set up by an outside agency which the trust reported a few staff had contacted. Future actions planned but not yet completed included scoping of a dignity at work strategy, training in early intervention for managers, training for investigation officers, a review of the trust bullying and harassment policy and a survey of employees within a further 6 months.

Some ambulance staff told us there was an open and friendly culture at station level. They felt confident to raise concerns with their team leaders and DSOs. Many loved their jobs, however, they were frustrated with changes imposed by the top level management and did not feel valued by the organisation.

PTS staff told us they felt proud to represent the service and of their work in PTS.However they did not believe they were valued within the wider organisation, outside of the PTS management stream.

EOC staff felt that they had an important role. However they were unable to openly challenge each other and they felt the management of the service was not supportive. Others told us some of their colleagues had left the department as they did not feel they were valued by their managers and the trust.

Public and staff engagement

Outreach work by the LAS across London was proactive and extensive. For example, the ambulance service had recently taken part in fayres organised by local councils. Staff engagement took place through the 'Routine Information Bulletin' (RIB) and monthly 'Team Talk' newsletter. Management communicated with staff via emails and mobile phones in addition the RIB and Team Talk newsletters. Despite this, many of the staff said they felt disengaged from the management of the service.

There was an independent Patient Forum that monitored ambulance services performance which met monthly. It is made up

of members of the public. The Patient Forum held their meetings on the premises of LAS and was supported the organisation's leadership. Their monitoring information was made public on their website. Where they identified concerns about the care of the elderly and other vulnerable patients, they presented these to the LAS management team. Other concerns by the members of the forum included delays in ambulance handover to emergency department staff and inappropriate equipment for bariatric patients.

Quick question cards were instigated to obtain feedback from patients using PTS.

Innovation, improvement and sustainability

The trust was involved in research projects led by St Georges University of London (SGUL). A mobile phone app showing care pathways was a useful innovation enabling staff to have ready access to information.

A communications book for people with learning disabilities or speaking other languages was regularly used and a helpful aid to clarifying patients' needs.

A significant innovation within PTS was the implementation of the NET trial which began in September 2014. NET services facilitate the transportation of non-emergency category three and four patients who need to be taken to receive medical care.

There was an intelligence conveyance desk (ICD) at each of the emergency operation centres to support management of pressures at London emergency departments (ED). The aim was to proactively balance the arrival of ambulances across London trusts to reduce the surge of ambulance attendance at busy hospitals.

Overview of ratings

Our ratings for London Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Access to the service						
Emergency operations centre (EOC)	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Resilience	Inadequate	Requires improvement	Not rated	Not rated	Requires improvement	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for London Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- improve its medicines management including:
- formally appoint and name a board director responsible for overseeing medication errors and formally appoint a medication safety officer.
- review the system of code access arrangements for medicine packs to improve security.
- set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- set up control systems for the issue and safekeeping of medical gas cylinders.
- improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- address under reporting of incidents including the perceived pressure in some departments not to report incidents.

In addition the trust should:

- review and improve trust incident reporting data.
- ensure all staff understand and can explain what situations need to be reported as safeguarding.
- review the use of PGDs to support safe and consistent medicines use.
- improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
- ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- ensure adequate and ready provision of protective clothing for all ambulance crews.
- ensure equal provision of ambulance equipment across shifts.
- improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- ensure full compliance with bare below the elbow requirements.
- review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- set up a system of regular clinical supervision for paramedic and other clinical staff.
- ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- review patient handover recording systems to be more time efficient.
- provide NICE cognitive assessment training for frontline ambulance staff.
- improve training for staff on Mental Capacity Act assessment.
- ensure all staff receive annual appraisals.
- review development opportunities for staff.
- improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- review maintenance of ambulances to ensure all are fully operational including heating etc.
- review arrangements in the event of ambulances becoming faulty at weekends.
- review and improve patient waiting times for PTS patients.
- ensure PTS booking procedures account for the needs of palliative care patients.
- develop operational plans to respond to the growing bariatric population in London.

Outstanding practice and areas for improvement

- review operational guidelines for managing patients with mental health issues and communicate these to staff.
- ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- communicate clearly to all staff the trust's vision and strategy.
- develop a long term strategy for the Emergency Operations Centres (EOCs).
- increase the visibility and day to day involvement of the trust executive team and board across all departments.
- review trust equality and diversity and equality of opportunity policies and practice to address claims of discrimination and lack of advancement made by trust ethnic minority staff and staff on family friendly rotas.
- review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

We issued a Warning Notice to the trust on 1 October 2015, under Section 29A of the Health and Social Care Act 2008, requiring the trust to make significant improvements in the areas of medicines management, good governance and staffing by 30 November 2015.

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2016/17 QUALITY IMPROVEMENT PROGRAMME

Progress & KPI Report: September 2016

October 2016

CONTENTS

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

EXECUTIVE SUMMARY
September 2016

Progress this month

- A review of all milestone delivery dates was carried out in September to ensure they reflect change requests and priority actions over the forthcoming months. This resulted in 26 deliverables for September with 77% of scheduled activities completed.
- The CQC have notified the Trust that they will be undertaking a comprehensive inspection of the London Ambulance Service on 7,8 & 9 February 2017.

- The activities that are delayed or reporting at risk relate to:
  - The roll out of pan-London process for pre-booking palliative care patients which was due to be delivered at the end of July, roll out is now expected in October.
  - The implementation and the communicating of agreed protective clothing pack for staff have both been delayed. Further training options are being explored to expedite the implementation of the clothing pack.
  - The development of the Estate strategy - a change request has been submitted to the QIP Board for consideration.
  - Information Management and Technology implementation plan has been delayed as we await funding approval.

Theme	Executive Director	# Complete	% Complete	RAG
Making LAS a great place to work	Mark Hirst	6/6	100%	
Achieving good governance	Sandra Adams	8/8	100%	
Improving patient experience	Briony Sloper	0/2	0%	
Improving environment and resources	Andrew Grimshaw	4/8	50%	
Taking pride and responsibility	Fenella Wrigley	2/2	100%	

PROGRAMME SUMMARY
Forecast View

Programme:

- There are small amount of activities to be delivered by the end of October 2016. Teams will be focussing on ensuring all delayed activities are also delivered.
- The start of a series of road shows that will take place in October and November.
- Preparation and planning for the comprehensive inspection of the London Ambulance Service in February 2017.
- The roll out of the audit plan along with implementing the restructuring of the PMO to ensure resources are in place to deliver the QIP, and adequately prepare for the CQC inspection.
- The 'Speak Up' communications campaign will commence in October.

		October 2016				November 2016			
Theme	Executive Director	Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Making LAS a great place to work	Mark Hirst		3						
Achieving good governance	Sandra Adams		1				3		
Improving patient experience	Briony Sloper		-						
Improving environment and resources	Andrew Grimshaw		1						
Taking pride and responsibility	Fenella Wrigley		3						
	Total		8				3		

WORKSTREAM PROGRESS REPORTS

3.1| MAKING THE LAS A GREAT PLACE TO WORK

Executive Lead: Mark Hirst

HIGHLIGHTS THIS MONTH

Advert to Action:

- The graduate recruitment process redesign has been completed, with a guidance document currently in draft to be issued to all graduates explaining what they can expect when they join the Trust as well as any tax implications of the current package offered. A paper will be going to the Executive Leadership Team setting out the lessons learnt from the graduate recruitment for 15/16; along with the mitigations put in place to ensure there are minimal areas for improvement next year.

Bullying and Harassment:

- By the end of September 46 workshops had been delivered in total, with targeted training delivered to those departments who have shown limited attendance via our current training database. Five of these sessions have been delivered to the members of HART in response to some feedback received from this cohort of staff.
- Final session of Investigations Training for B&H was undertaken, with a cumulative total of 68 staff completing a two day course in investigation skills to drive forward the new dignity at work policy. A further 15 staff have also undertaken practical skills in mediation, which will enable staff to be able to develop their skills in dealing with conflict and round table resolutions, all of which will be supported with a newly designed suite of documents in line with the new policy.
- Planning has commenced with three operational sectors regarding developing pilots for local champions for Dignity and Respect, along with a recruitment process to ensure they are recruited in an open and transparent manner.
- A new communications plan has been drafted, setting out the priorities moving forward.

Equality and Inclusion:

- A board seminar was held with Executive and Non Executive Directors and led by the NHSE Joint WRES (Workforce Race Equality Scheme) Programme Directors, followed by a further meeting with the Chair and Interim Head of Equality and Inclusion to discuss next steps with the Workforce Race Equality Standard.
- The Executive Leadership Team has approved two additional posts to work within the Equality &Inclusion function to support future delivery.
- Lessons learnt meetings have been undertaken with the Metropolitan Police, Health Education England, the Patients' Forum and current members of the LAS BME Staff Forum to understand their experiences in developing BME staff in the workplace.

MAKING THE LAS A GREAT PLACE TO WORK

Progress – September 2016

Deliverable	Lead	September 2016		
		Complete	Delayed	At Risk
Advert to Action (Recruitment)	Tracey Watts	1		
Bullying and Harassment	Cathe Gaskell	2		
Training	Jane Thomas	1		
Equality and Inclusion	Melissa Berry	2		
Vision and Strategy	Karen Broughton			
Supporting Staff	Gill Heuchan			
Retention	Lindsay Koppenhol			
Workforce and Organisational Development	Karen Broughton			

Outstanding actions

- A paper will be going to the ELT setting out the lessons learnt from the graduate recruitment for 15/16; along with the mitigations put in place to ensure there are minimal areas for improvement next year.
- Following the review of the Recruitment function the implementation of a substantive structure over the remainder of Q3.

MAKING THE LAS A GREAT PLACE TO WORK

Forecast View

Focus for next month	Key risks and challenges
• CEO Roadshows commence with corporate services, managers and support functions across the Trust • The People and Organisational Development Strategy to be approved by the Workforce and OD Committee • Targeted B&H sessions arranged for those departments with limited attendance across the Trust • Second cohort of staff to be trained in practical skills in Mediation on 10th and 11th October, these staff were requested to send through an expression of interest with line management support	• Lack of IM&T engagement in the implementation of ESR and OLM has slowed the project, however the Project Sponsor is now meeting on a weekly basis with them to address the areas of concern, with a risk raised ensuring visibility is maintained at the Project Board chaired by the Interim Director of Workforce.

Deliverable	Lead	October 2016				November 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Advert to Action (Recruitment)	Tracey Watts								
Bullying and Harassment	Cathe Gaskell								
Training	Jane Thomas								
Equality and Inclusion	Melissa Berry								
Vision and Strategy	Karen Broughton		2						
Supporting Staff	Gill Heuchan								
Retention	Lindsay Koppenhol								
Workforce and Organisational Development	Karen Broughton		1						

3.2| ACHIEVING GOOD GOVERNANCE

Executive Lead: Sandra Adams

HIGHLIGHTS THIS MONTH

Risk Management

- Risk Register audits were carried out with 86% RAG rated as green. Those areas that were not green were addressed at RCAG on 4th October 2016. The areas that were highlighted were Workforce, Comms, Fleet and IM&T and the Chief Executive asked for them all to be updated immediately. All risks have now been migrated over to Datix and the number of local risk registers has increased.
- The Trust Board had two facilitated sessions on the Risk Appetite on 6th and 21st September.

Improving Incident Reporting

- The September Health & Safety bulletin was issued on time and focussed on the outcome of the razor box trial which has now been rolled out. The newsletter also encouraged staff to report risks and issued on Datix and included a user guide.

Duty of Candour

- The new Duty of Candour policy was launched in September with communication to staff in the RIB and on the Listening in Action Facebook page.

CQC Re-inspection

- The PMO team supported our 111 service to prepare for their CQC inspection and will use lessons learned from that work to aid our planning for the full Service inspection in February
- Work has started on ensuring all the necessary documents are up to date for the Provider Information Return (PIR) submission which we expect to receive in mid-October.
- The PMO team has now been re-focussed on activities that need to be done to prepare for the CQC inspection. This includes preparing the PIR, staff engagement, ensuring departments are prepared for the inspection and an assurance function.

Internal Audit

- Internal Audit recommendations went to ELT on 31st August and to Audit Committee on 5th September. The committee was pleased to note the good progress being made on the recommended actions.

Policy & Guidance Review

- The Policy Monitoring & Approval Group met on 14th September to review and approve seven policies which have been updated. The group also discussed an action plan for ensuring that key policies are up to date in time for the PIR submission.

ACHIEVING GOOD GOVERNANCE

Progress – September 2016

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

Outstanding actions
• No outstanding actions

ACHIEVING GOOD GOVERNANCE

Forecast View

Focus for next month	Key risks and challenges
• There is only one action for October which has already been completed. • The focus is therefore going to be on preparing for November and December's deliverables. • In particular the deliverables that will require focus will be the EOC review, the implementation of the rest break and out of service review and the Business Intelligence deliverables which are due in December. • The CQC re-inspection preparation will also be a continued focus from now until the inspection in February.	

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

3.3| IMPROVING PATIENT EXPERIENCE

Executive Lead: Briony Sloper

HIGHLIGHTS THIS MONTH

Patient Transport Service

The Palliative care pilot is still delayed due to the slow response times of the volunteer hospice. Although the LAS team is keen to move forward with the pilot we are bound by the responsiveness of the pilot organisation. A suggested start date for the pilot is now expected week commencing 17 October. The completion date of the pilot is anticipated to be in the first week of November and will be followed by evaluation. The roll out of a single process for pre-booking palliative care patients following the pilot is still expected to be delivered in December. A change request will be submitted to the next QIP Board for consideration.

Non Emergency Transport Service: We have also rolled out a pre-booked transport solution for community mental health care assessments for three Trusts and have agreed a timeline with NHS England for the remaining 6 Trusts by end of January 2017. Although this is not a direct milestone in the QIP plan, the project is an enabler for meeting mental health patients needs and is ensuring a more timely and effective service.

Mental health:

Communication to staff on continuing professional development and training opportunities continues with updates on LIA, RIB and the pulse.

The development of mental health support via Registered Nurses has also been continued.

A staff survey undertaken with staff in EOC showed that the Registered Mental health Nurses (RMN) in the control room have been utilized as a key conduit for sharing and supporting staff in the control room and the front line to interpret and apply the revised standard operating procedures (SOP) effectively – a staff survey was undertaken and the findings presented in June 2016 that demonstrated:

- 80.87% of EOC staff have found the presence of RMNs beneficial to support their interpretation and management of mental health scenarios
- 84.61% of EOC staff felt that RMNs have a key benefit including improved patient assessments and support to manage these calls effectively
- 73.03% of EOC staff felt that RMNs have improved access & communication with external agencies in relation to mental health
- 50% of EOC staff felt that RMNs have impacted on their individual learning, confidence & knowledge about MH presentations

Bariatric:

The patient representative assigned to the bariatric working group (BWG) had to decline further attendance due to other commitments; therefore the BWG proactively sought out patient forum members to obtain input and advice from outside the London Ambulance Service. A forum member was identified and has now been invited to all future meetings. There will also be a specific patient forum held on 20th October whereby other forum members will be updated on our progress and have an opportunity to provide input into the programme.

At the next BWG on 4th October we will be aiming to make a decision regarding vehicles and produce a recommended list of equipment along with justifications of benefits to patients and the service as a whole. Data collection and analysis is progressing, we will soon have CCG information for numbers and geographical locations of patients in London. This will allow us to begin planning resource allocation.

A number of the BWG travelled to South East Coast Ambulance Service NHS Foundation Trust to observe their procedures surrounding bariatric patients; this included their definition, resourcing, use and issues. This information will be used to inform our own plans.

The LAS definition for 'bariatric' has been agreed upon by the BWG and it has now gone to ELT for sign off. The LAS bariatric capability has been audited on three different occasions.

IMPROVING PATIENT EXPERIENCE
Progress – September 2016

Deliverable	Lead	September 2016		
		Complete	Delayed	At Risk
Patient Transport Service (NETS)	Paul Woodrow		2	
Meeting peoples needs	Briony Sloper/ Paul Woodrow	0		
Response Times	Paul Woodrow	0		
Learning from experiences	Briony Sloper	0		

Outstanding actions
Due to the pilot start date being delayed the pilot cannot be reviewed until it is complete. It is expected that despite this delay, the roll out is still expected to take place in December as per milestone plan.

IMPROVING PATIENT EXPERIENCE

Forecast View

	Key risks and challenges
• There are no milestones for this theme in October and November but work will continue to ensure all December milestones are met.	

Deliverable	Lead	October 2016				November 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Patient Transport Service (NETS)	Paul Woodrow								
Meeting peoples needs	Fenella Wrigley/ Paul Woodrow								
Response Times	Paul Woodrow								
Learning from experiences	Fenella Wrigley								

3.4| IMPROVE ENVIRONMENT AND RESOURCES

Executive Lead: Andrew Grimshaw

HIGHLIGHTS THIS MONTH

Vehicle Make Ready

- The Inaugural Project Board meeting was held and project structures and governance are now in place to ensure the project is managed in a controlled environment.
- The Fulham Gold service roll out was completed on 26 September with new ways of working now embedding. The stakeholder meetings have continued with teams at the upcoming Gold and Silver service sites including St Helier (silver), Wimbledon (silver), Hillingdon (gold), Isleworth (gold) and Brent (gold).
- The Financial Investment committee (FIC) has approved the Make Ready business case.

Vehicle Procurement

- There has been the procurement of sixty FRU vehicles this month.

Fleet Strategy

- The Fleet Strategy has been drafted and circulated to Operations Board for review. The Fleet Strategy will be finalised in January 2017, in accordance with the QIP plan.

Estate Strategy

- A change request has been submitted to change the scope and delivery time for the Estate Strategy which will be considered at the next QIP Board. As part of the change request the Director of Finance has identified and appointed external advisors to assist the Trust to complete hypothetical model for January 2017.

IMPROVE ENVIRONMENT AND RESOURCES

Progress – September 2016

Deliverable	Lead	September 2016 Complete	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw	3		
Information Management and Technology	Andrew Watson		1	
Infection prevention and control	Fenella Wrigley		2	
Facilities and Estates	Andrew Grimshaw	1	1	
Resilience functions	Paul Woodrow			
Operations Management	Paul Woodrow			
Improving operational productivity	Paul Woodrow			
Cost improvement programme	Andrew Grimshaw			
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw			

Outstanding actions

Information Management and Technology

- The handheld device business cases are currently being finalised. One case is to support limited roll out of Virtual Ward, and a second broader case for handhelds for all frontline staff. The funding for both of these options is in the process of being confirmed.

Infection prevention and control

Implement agreed protective clothing pack for staff

Communicate availability of protective clothing to all staff

- The protective clothing packs have been delivered to Greenwich. The vehicle preparation teams will begin to prepare the vehicles with the new protective clothing once they have been delivered to the site. The supporting training materials will be finalised week commencing 3 October however the training modules may not be available until January 2017; further investigations on going. This will delay the implementation of the personal protective equipment (PPE) packs as they cannot be installed on vehicles until staff training has occurred.

Facilities and Estates

Develop an estates strategy

- A change request was submitted in September for consideration at the next QIP Board. The request is for the 'Develop an estates strategy' milestone to be moved to January 2017 and changed to 'Develop Hypothetical models for the future estate'

IMPROVE ENVIRONMENT AND RESOURCES

Forecast View

Focus for next month	Key risks and challenges
Fleet/Vehicle Prep: Make Ready • Continue stakeholder meetings with upcoming roll out sites. • Trust wide communications to be rolled out. **Vehicle Procurement** • The approval of the Double Crew Ambulance (DCA) business case is currently being sought. **Infection Control and Prevention** • Identify opportunities to bring forward staff training on new protective clothing to reduce delays in rolling out the new equipment. **Frontline Equipment and Uniforms** • Complete the review of uniforms for frontline staff	**Vehicle Procurement** **Double Crew Ambulance – March Milestone** Awaiting final approval of business from NHSI, until approval received the final date of completion of 140 vehicles can not be confirmed.

Deliverable	Lead	Oct 2016				Nov 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Fleet / Vehicle Preparation	Andrew Grimshaw								
Information Management and Technology	Andrew Watson								
Infection prevention and control	Fenella Wrigley								
Facilities and Estates	Andrew Grimshaw								
Resilience functions	Paul Woodrow								
Operations Management	Paul Woodrow								
Improving operational productivity	Paul Woodrow								
Cost improvement programme	Andrew Grimshaw								
Frontline equipment and uniforms	Paul Woodrow / Andrew Grimshaw		1						

3.5| TAKING PRIDE AND RESPONSIBILITY

Executive Lead: Fenella Wrigley

HIGHLIGHTS THIS MONTH	**Medicine Management:** The new medicines management policy has been reworked and relaunched – this has involved incorporating multiple guidance documents into one overarching document. The introduction of Datix and medicines management teaching throughout CSR this financial year provides the training and means for reporting shortfalls in operations. Central Support Unit (CSU) also have a document advising what should happened if crews are missing kit including drugs and the timescales for resolving this. Operations have been working on a small review of "no drug pack availability" on stations . The outcome of the review is expected in the next couple of weeks. The information will be collected by CSU to refine Datix forms following a collaboration of CSU/Governance and Operations. **Training content** EOC and PTS safeguarding continues as does training for new clinical recruits and inductions. Clinical staff safeguarding training is planned for CSR2016.3 and is planned to be delivered as problem based learning; this is currently being developed with Clinical Education and Development. **Safeguarding supervision** Several focus groups have been held with staff and managers, and visits to several other ambulance trusts to review their safeguarding processes have been arranged. **Consent MCA:** The milestone was to deliver updated training for all patient facing staff on Mental Capacity Act as part of the 2016/2017/ CSR programme. This milestone has been completed, 3134 staff attended CSR 2016.1 which included the updated training on MCA.

TAKING PRIDE AND RESPONSIBILITY

Progress – September 2016

Deliverable	Lead	September 2016		
		Complete	Delayed	At Risk
Clinical supervision	Fenella Wrigley	1		
Consent MCA	Fenella Wrigley			
Medicine Management	Fenella Wrigley	1		
Safeguarding	Fenella Wrigley			
Quality and clinical strategy	Fenella Wrigley			
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton			
Developing the 111 Service	Paul Woodrow / Karen Broughton			

Outstanding actions
• No outstanding actions

TAKING PRIDE AND RESPONSIBILITY

Forecast View

Focus for next month	Key risks and challenges
• Completion of safeguarding milestones • There will be a continued focus on the medicine management deliverables to ensure all milestones are met	

Deliverable	Lead	October 2016				November 2016			
		Complete	On Track	Delayed	At Risk	Complete	On Track	Delayed	At Risk
Clinical supervision	Fenella Wrigley								
Consent MCA	Fenella Wrigley								
Medicine Management	Fenella Wrigley								
Safeguarding	Fenella Wrigley		2						
Quality and clinical strategy	Fenella Wrigley								
Operating model and clinical education & training strategy	Paul Woodrow / Karen Broughton								
Developing the 111 Service	Paul Woodrow / Karen Broughton								

EXTERNAL SERVICES SCRUTINY COMMITTEE - WORK PROGRAMME 2016/2017

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: Work Programme 2016/2017

REASON FOR ITEM

To enable the Committee to track the progress of its work in 2016/2017 and forward plan its work for the new municipal year.

OPTIONS OPEN TO THE COMMITTEE

Members may add, delete or amend future items included on the Work Programme. The Committee may also make suggestions about future issues for consideration at its meetings.

INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for this municipal year are as follows:

Meetings	Room
Wednesday 15 June 2016, 6pm	CR3
CANCELLED Tuesday 12 July 2016, 6pm	CR6
Thursday 15 September 2016, 6pm	CR6
Thursday 6 October 2016, 6pm	CR6
Tuesday 15 November 2016, 6pm	CR6
Thursday 12 January 2017, 6pm	CR6
Wednesday 15 February 2017, 6pm	CR6
Wednesday 15 March 2017, 6pm	CR6
Wednesday 26 April 2017, 6pm	CR6
Thursday 27 April 2017, 6pm	CR6

2. It has been agreed by Members that consideration will be given to revising the start time of each meeting on an ad hoc basis should the need arise. Further details of the issues to be discussed at each meeting can be found at Appendix A.

Scrutiny Reviews

3. Following an informal meeting on 12 July 2016, Members identified the following issues as potential review topics for future meetings:
    - ***Fire Brigade / LAS*** - *the impact of hoax calls and action being taken to deal with hoax callers. Is there provision for the Fire Brigade to provide medical services in the absence of the ambulance service?*
    - ***Child Sexual Exploitation*** - *update on the partnership work being undertaken in the Borough to address CSE.*

- ***London Ambulance Service*** *(LAS) - update on the action plan following the CQC inspection.*
- **CAMHS** - possible joint major review with Children, Young People and Learning POC in 2016/2017.
- **First responders** - is consideration being given to introducing these in Hillingdon?
- **Community Sentencing** - how many community sentences are given out, how effective is community sentencing, how does community sentencing work, what type of work is involved in a community sentence?
- **Safe and Sustainable** - update on the proposal to withdraw paediatric congenital cardiac services from the Royal Brompton Hospital.
- **Domestic Abuse** - the provision of mental health support services available to victims.
- **Utilities** - to look at the strategic provision of utility services for a growing population in the Borough.
- **Community Policing / Ward Panels / Safer Neighbourhood Board** - update.

4. Those issues highlighted in italics have been included within the Work Programme attached at Appendix A.

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2016/2017 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
15 June 2016	**Health** To receive the following updates: 1. North West London Collaboration of CCGs - NWL mental health 'Like Minded' strategy 2. Strategic service delivery plan for Out of Hospital Care
12 July 2016	**MEETING CANCELLED**
15 September 2016	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **Health** To receive a performance update and the annual report of Healthwatch Hillingdon.
6 October 2016	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health **London Fire Brigade** To receive an update on the impact of hoax calls and action being taken to deal with hoax callers. To identify whether or not there is provision for the Fire Brigade to provide medical services in the absence of the ambulance service.

Meeting Date	Agenda Item
15 November 2016	**London Ambulance Service** - update on the action plan following the CQC inspection
12 January 2017	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **Major Review 2 (2015/2016):** Consideration of final report from the GP Pressures Working Group **Major Review 1 (2016/2017)**: Consideration of a scoping report and the formulation of a Working Group to undertake a major review on behalf of the Committee
15 February 2017	**Child Sexual Exploitation (CSE)** Update on the work being undertaken by the Council to prevent CSE.
15 March 2017	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health **Major Review 1 (2016/2017):** Consideration of final report from the Working Group **Update on the implementation of recommendations from previous scrutiny reviews:** • Alcohol Related Admissions Amongst Under 18s

Meeting Date	Agenda Item
26 April 2017 (*additional meeting*)	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2016/2017 reports and to gather evidence for submission to the CQC: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Central & North West London NHS Foundation Trust 3. Local Medical Committee 4. Public Health 5. Hillingdon Clinical Commissioning Group (HCCG) 6. Care Quality Commission (CQC) 7. Healthwatch Hillingdon
27 April 2017	**Quality Account Reports & CQC Evidence Gathering** To receive presentations from the local Trusts on their Quality Account 2016/2017 reports and to gather evidence for submission to the CQC: 1. Royal Brompton & Harefield NHS Foundation Trust 2. The London Ambulance Service NHS Trust 3. Local Dental Committee 4. Public Health 5. Hillingdon Clinical Commissioning Group (HCCG) 6. Care Quality Commission (CQC) 7. Healthwatch Hillingdon

Possible future single meeting or major review topics and update reports

1. CAMHS - possible joint major review with Children, Young People and Learning POC in 2016/2017.
2. Fire Brigade / LAS - the impact of hoax calls and action being taken to deal with hoax callers. Is there provision for the Fire Brigade to provide medical services in the absence of the ambulance service?
3. First responders - is consideration being given to introducing these in Hillingdon?
4. Community Sentencing - how many community sentences are given out, how effective is community sentencing, how does community sentencing work, what type of work is involved in a community sentence?
5. Safe and Sustainable - update on the proposal to withdraw paediatric congenital cardiac services from the Royal Brompton Hospital.
6. Child Sexual Exploitation - update on the partnership work being undertaken in the Borough to address CSE.
7. Domestic Abuse - the provision of mental health support services available to victims.
8. Utilities - to look at the strategic provision of utility services for a growing population in the Borough.
9. Community Policing / Ward Panels / Safer Neighbourhood Board - update.
10. London Ambulance Service - update on the action plan following the CQC inspection.

1st MAJOR SCRUTINY REVIEW (WORKING GROUP)

Members of the Working Group:

- Councillors TBA

Topic: TBA

Meeting	Action	Purpose / Outcome
ESSC: **TBA**	Agree Scoping Report	Information and analysis
Working Group: **1st Meeting - TBA**	Introductory Report / Witness Session 1	Evidence and enquiry
Working Group: **2nd Meeting - TBA**	Witness Session 2	Evidence and enquiry
Working Group: **3rd Meeting - TBA**	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: **TBA**	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: **TBA** *(Agenda published TBA)*	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings and site visits can also be set up to gather further evidence.