# LAS BOARD MEETING - OCTOBER 2<sup>ND</sup> 2017

## **Key Points**

- 1) Learning lessons for better care following a death or poor outcome for patients a Morbidity and Mortality Committee has been set up by the LAS to look at these events in more detail and ensure that the LAS improves its practice where necessary. Lead is Dr Fenella Wrigley.
- 2) Sepsis there is now greater awareness of danger of sepsis in both adults in children. NICE produced guidance in 2016 and Public Health England has just produced guidance relating to children. <a href="https://sepsiscurrentawareness.wordpress.com/2017/10/05/new-guidance-from-public-health-england-on-sepsis-in-children/">https://sepsiscurrentawareness.wordpress.com/2017/10/05/new-guidance-from-public-health-england-on-sepsis-in-children/</a>

### 3) STPs – (Strategic Transformation Partnerships).

LAS Executive Directors and Non Executives are attending STP meetings. The Chief Executive Garrett Emmerson is attending the majority of these meeting. Theo de Pencier, a NED reported on attending the North East London STP and participating in discussions regarding workforce. It is not clear what the LAS strategy is towards STPs. A new strategy for the LAS is being developed and hopefully this will include clear objectives about how STPs can be influenced in relation to the resources needed for effective urgent and emergency care.

### 4) Recruitment of Paramedics in London

The LAS is about to go to Australia again to recruit paramedics. However it was reported to the Board that there is a commitment to recruiting staff in London either as paramedics or as Emergency Ambulance Crew who can be trained through the Academy to become paramedics.

#### 5) Hand-Held Devices

Funding has at last been made available enabling all staff by the end of 2017 to have hand held computers/phone/IT devices to enable them to communicate effective with NHS colleagues in acute and community care and access clinical data about patients in the same way as NHS community nurses can. It as revolution.

#### 6) Investigation of Serious Incidents

60 days are allowed for the investigation of serious incidents and in the past the LAS has often not been up to speed. Trisha Bain, the Chief Quality Officer, assured the Board that most reports and resulting actions are now being dealt with within 60 days. Trisha said that every element of serious

incidents are being tracked and clinical leads informed about outcomes and the need to develop services where this is indicated by the investigation.

## 7) Training of Staff

It was reported that the training of staff is putting a huge pressure on the LAS because there is a great deal of statutory and mandatory training as well as clinical updates, learning about the ARP, complaints, serious incident investigations and learning to use hand held devices. The Chair said: "Professionals must be prepared to train in their own time".

## 8) Complaints

There were 87 complaints in August and increase of 87% over July and many of these complaints were about delays in patients receiving a response from the LAS. The Chair asked:"When we don't hit targets, how long to patients have to wait?". There was no answer. But it might be a good idea for the Forum to gather such data and do a few A&E Enter and Views with Local Healthwatch.

### 9) Investigation of Major Incidents

There was also a discussion about the lessons learnt from major incidents like Grenfell and London Bridge – a paper has been prepared by Paul Woodrow on this issue. There is a great deal of concern about the long term consequences for the health of staff who worked at Grenfell and other major incidents. We will seek a meeting with Fatima Fernandes, Staff Support, Counselling and Occupational Health Services Manager.

#### 10) LAS Strategy

The new strategy is being led by Angela Flaherty. We are meeting her on October 17<sup>th</sup> to discuss patient and public involvement in this strategy. It is expected to be completed by mid December and signed off with a delivery plan by February 2018.

## 11) January 1<sup>st</sup> Outage

Ross Fullerton, the Chief Information Officer, presented a report on the delivery of recommendations arising from the investigation of this incident. He said that all 32 actions have been completed to prevent further outages. Available on request.

### 12) Other Key Papers Presented

- a) People and Organisational Development Strategy Patricia Grealish
- b) Winter Plan 2017/8
- c) Quality Improvement Plan and Preparation for the CQC

Prepared by Malcolm Alexander, Chair, PF