



MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST PUBLIC BOARD OF DIRECTORS

Tuesday 24 November 2020 at 9.30am – 12.00pm via video-conference

Agenda: Public session

Timing	Item	Owner	Status
9.30	1. Welcome and apologies	HL	Verbal
	2. Declarations of interest	All	Verbal
	3. Minutes of the public meeting held 29.09.20	HL	Enclosed <i>Approval</i>
	4. Matters arising	HL	Enclosed
9.35	5. Report from the Chair	HL	Enclosed <i>Information Approval</i>
9.45	6. Report from the Chief Executive	GE	Enclosed <i>Assurance</i>
9.55	7. Report from the Chief Operating Officer	KM	Enclosed <i>Assurance</i>
Director and Board Committee Reports			
10.05	8. Winter Preparedness and COVID Plan	KM	Enclosed <i>Assurance</i>
10.20	9. <ul style="list-style-type: none"> Integrated Performance Report 9.1. Quality and Clinical Care <ul style="list-style-type: none"> Directors Report (Quality) Directors Report (Clinical Care) Quality Assurance Committee meeting 	TB FW MS	Enclosed <i>Information</i> Enclosed <i>Assurance</i> Enclosed
	9.2. People and Culture <ul style="list-style-type: none"> Directors Report People and Culture Committee meeting 	GE JM	Enclosed <i>Assurance</i> To follow
	9.3. Finance & Audit <ul style="list-style-type: none"> Directors Report Finance & Investment Committee Audit Committee 	LB FC RP	Enclosed <i>Assurance</i> To Follow To Follow
11.00	9.4. Logistics and Infrastructure <ul style="list-style-type: none"> Logistics and Infrastructure Committee 	SD	To Follow <i>Assurance</i>
11.05	9.5. D999 Programme Assurance Group	SD	Enclosed <i>Assurance</i>

Timing	Item		Owner		Status
11.10		9.6 Remuneration Committee	HL	Enclosed	Assurance
11.20	10.	People and Culture 10.1. 18 month People Plan 10.2. Strategic Workforce Planning	GE KM	Enclosed Enclosed	Assurance
Finance					
11.40	11.	Finance 11.1. Annual Financial Plan 2020/21	LB	Enclosed	Approval
Governance and Risk					
11.50	12.	Board Assurance Framework	SDa	Enclosed	Approval
11.55	13.	Any other business	HL	Verbal	Information
12.00	Meeting close				
Additional reports, circulated for information only:					
<ul style="list-style-type: none">• Corporate Risk Register• Quality Report• SI Report• Freedom to Speak Up Report					



TRUST BOARD: Public meeting – Tuesday 29 September 2020

DRAFT Minutes of the public meeting of the Board held on 29 September 2020 at 09.30am, via Video Conference

Present		
Name	Initials	Role
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Chief Finance Officer
Karim Brohi	KB	Non-Executive Director
Fergus Cass	FC	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
Amit Khutti	AK	Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Khadir Meer	KM	Chief Operating Officer
Rommel Pereira	RP	Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Fenella Wrigley	FW	Chief Medical Officer
In attendance		
Syma Dawson	SDa	Director of Corporate Governance
Ross Fullerton	RF	Director of Strategy and Transformation
Antony Tiernan	AT	Director of Communications and Engagement
Jason Rosenblatt	JR	Head of Engagement
Victoria Moore	VM	Corporate Governance Manager
Apologies		
Ali Layne-Smith	ALS	Director of People and Culture
Jill Anderson	JA	Associate Non- Executive Director

Welcome and apologies

1. The Chair welcomed all to the meeting and noted that in light of the COVID-19 pandemic, the meeting was available to the public for viewing on YouTube. The Chair welcomed all members of the Public viewing the meeting.
2. The Chair noted apologies received from Jill Anderson, Non-Executive Director, and Ali Layne Smith, Director of People and Culture, and noted that Jason Rosenblatt, Head of Engagement, would be in attendance as People and Culture representative.

Declarations of interest

3. There were no interests declared in any matter on the agenda.

Minutes of the meeting held in public on 28 July 2020

4. The minutes of the meeting held in public on 28 July 2020 were approved as an accurate record of the meeting pending minor amendment.
5. The date of previously approved meeting should be corrected to 26 May 2020.

Matters Arising

6. The Board reviewed the action log and consideration was given to the action in respect of the creation of a London Ambulance Service NHS Trust (LAS) youth forum. It was acknowledged that this had been discussed and the forum was being established. The approach would be considered in line with the engagement strategy paper on the agenda. Members concluded the action was appropriate for closure.
7. The two actions in respect of training were discussed, recognising that an update which outlined the required costs had been provided with the meeting papers. The Board confirmed that the action would be closed and requested that the People and Culture Committee further consider the provided data in line with any available benchmarks to ensure that the costs are appropriate.

Action: People and Culture Committee to consider the provided training data and costs in line with any available benchmarks to ensure that the costs are appropriate.

Report from the Chair

8. The Chair's report provided an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened. Members were informed that the Chair and Chief Operating Officer had met with the London Council to discuss Low Traffic Neighbourhood interventions and that the Trust had committed to working with the proposals to ensure that patient safety is maintained.
9. Further to this the report sought approval of a revised Terms of Reference for the LAS Staff and Volunteer Advisory Panel (SVAP). Members considered the request recognising that the proposal requested amendment of the panel's membership and to defer establishment of a Co-Chair until a future date.

Resolution: Staff and Volunteer Advisory Panel (SVAP) Terms of Reference approved.

Chief Executive's Report

10. The Board received the Chief Executive's Report noting the provision of a high level summary of Trust actions since the last Trust Board meeting.
11. The Chief Executive recognised the external Communications team who had been shortlisted for the 'In-House Team of the Year (Public/Third Sector)' Award at the, PR Week Awards 2020 and wished them luck noting their support with the filming and broadcast of BBC documentary 'Ambulance'.

Report from the Chief Operating Officer

12. The Board received presentation of a report from the Chief Operating Officer. It was noted that the purpose of this report was to provide the Board with an update on the performance and delivery plans of the five operationally focussed Directorate's within the London Ambulance Service.
13. It was reported that since the July Trust Board meeting, the Trust had maintained strong levels of operational performance against national standards noting that current activity is increasing to pre-COVID levels.
14. Regular monitoring of changes in demand related to pandemic activity would continue and defined escalations in line with the COVID-19 response are in place to establish appropriate deployment of operational resilience plans when necessary.
15. The Board was asked to note that the Trust must continue to prepare further COVID-19 demand waves in 2021 and for that reason the Trust Board will be asked to consider business cases in its private session to support the response.
16. In addition to core business, the Board was asked to note that there had been significant progress made in each of the Chief Operating Officer Directorates, including; substantive appointments made to the roles of Head of Estate and Head of Fleet; joint working with the national team and local providers to deliver the 111 First model to increase referral into downstream services; launching testing phase of the new 999 Contact Centre and Clinical Assessment Hub at Waterloo HQ. This would improve and increase call handling capacity and secure Disability Discrimination Act (DDA) compliant facilities. In addition it would provide collaborative working with health service partners in the development of London's Primary Care Networks (PCNs).
17. Members discussed the report seeking assurance as to the Trust's current position in respect of preparedness for a COVID second wave and whether there were any specific concerns that the Board should be sighted on.
18. Assurance was provided that there are a number of systems, processes and resources in place which monitor and respond to the dynamic position as outlined in the reports appendices, and that the upgrade to the computer aided despatch (CAD) had increased call handling resilience.
19. Specific personal protective equipment (PPE) concerns were raised seeking reassurance that the Trust has sufficient equipment available. Reassurance was provided that there are appropriate stores of PPE and that there is a nationally mandated process that the Trust must follow in respect of stock levels that can be held.
20. The Board sought assurance that the additional resource established and available during the initial wave of COVID was still available if required. Confirmation was provided that this is the position and that the previous arrangements were still available. Further to this, the Board sought clarification of arrangements with London Fire Brigade (LFB); it was noted that a Memorandum of Understanding (MOU) had been developed and proposed and that the position was being formalised by both parties and was with the LFB for agreement.
21. Emergency Department (ED) handovers and winter streaming were discussed, specifically in respect of delays to crews and their availability. The Board recognised that associated delays were reliant on acute hospitals overcoming their challenges. There is significant work being conducted to ensure that patients get the right care in the right place and that the default is not ED Conveyance in addition to this a

collaborative system wide winter plan is being engaged to ensure these concerns are escalated and addressed.

22. Finally members recognised the operational plan to deliver flu vaccinations and the importance of emphasising the clinical benefits to Trust staff. The plan and its implementation will continue to be discussed at the Daily Senior Leadership Team (DSLTT) meetings.
23. The Board thanked the Chief Operating Officer for a valuable report and acknowledged the benefits of extended discussion.

Director and Board Committee Reports Integrated performance report

24. The Board would receive reports from the Directors and Board Assurance Committees noting any key issues, risks and items for escalation.

Quality and Clinical Care Directors Report (Quality)

25. The Chief Quality Officer presented the Quality Directors report noting the impact of COVID-19 and the measures in place to review impact and ensure that plans and lessons are embedded to support future plans.
26. Members also recognised the work in respect of End of Life, Violence Reduction and the Quality team and sought further clarification regarding complaints, particularly those associated with conduct and behaviour and the actions that the Trust takes to address. All complaints are investigated and the outcomes are shared with local managers who communicate the issues and outcomes to individuals where appropriate.
27. Members sought confirmation of proposed implementation dates for body worn cameras and were informed that the NHSE/I pilot was intended to commence 1 November 2020, with a review in January 2021 of roll out across the Trust.
28. The status of COVID-19 RIDDOR investigations were considered particularly those 57 members of staff who are not patient facing on GRS who are recorded as COVID-19 positive. It was confirmed that these investigations would be concluded by mid-November 2020.
29. It was noted that the investigations considered those staff employed by the Trust and asked if there were lessons to be learned from those who were not directly employed. It was confirmed that these cases are included in investigations where there is evidence of clusters of cases.

Directors Report (Clinical Care)

30. The Chief Medical Officer presented the Clinical Care Directors report noting that a revised London Ambulance Service Major Trauma Decision tool has been disseminated internally and externally with partner healthcare providers and that collaborative working continues with regional and local stakeholders to embed the local pathways which were established during the first peak of COVID-19 in order to ensure patients can be treated closer to home where clinically appropriate, reducing Emergency Department crowding and minimising the risk of nosocomial infection.
31. On the 4 May 2020, NHS England/Improvement published new guidance on Infection Prevention and Control (IPC) alongside this, they published the IPC Board Assurance

framework. This was designed enable providers to assess themselves against the new IPC guidance.

32. In May the LAS submitted the return rag-rated as compliant (green) for 5 domains and partially compliant (amber) for 3 domains. This assessment was submitted to the Care Quality Commission (CQC) who provided additional questions in preparation for a telephone interview with the Director of Infection Control and Chief Quality Officer after which their written assessment was shared. This found that the Trust Board can be assured that LAS has effective infection prevention and control measures in place.
33. As the Trust continues to face the COVID-19 pandemic and is entering the Winter virus period, there is a continued focus on Hand Hygiene across the operational workforce; the August Operational Workplace Review Hand Hygiene audit submissions have improved since August and the Head of Infection Prevention and Control is working closely with the Operational and Quality managers to further improve the position.
34. Members considered the report and sought further information in respect of the stroke pathway implemented with University College Hospital and whether it continued to be effective. It was confirmed that the pathway remains in place and that there is an intention to roll the approach out across London. The pathway also links to ensuring that patients receive the right car in the right place. This is being monitored through the London Clinical Advisory Group and measured by patient outcomes.

[Quality Assurance Committee meeting](#)

35. Mark Spencer (MS), Non-Executive Director, and Chair of the Quality Assurance Committee, presented a report of the most recent meeting of that Committee to the Board, noting matters for escalation and that the Committee had assured by the volumes of work that had been carried out during the pandemic response and the maintenance of quality throughout with good patient outcomes.
36. Members were asked to approve the amendment of the Committees Terms of Reference to remove the requirement for Non-Executive Directors to be in the majority.

[Resolution](#)

[Quality Assurance Committee Terms of reference approved.](#)

[People and Culture Directors Report](#)

37. The Chief Executive presented the People and Culture Director Report noting that 97% of all staff had now received a COVID risk assessment and that work would continue to monitor and address the gap.
38. People & Culture's recruitment team have worked with Ambulance Operations to create and recruit a new Assistant Ambulance Practitioner (AAP) Band 4 role. As at 31 August 358 external and 57 internal applications had been received for the 240 roles, of which 184 would be operational by February 2021 with the remainder in post by April 2021.
39. Further to this, the Trust welcomed 15 new international Paramedics from Namibia in August. Members were asked to note that international recruitment had been negatively impacted by COVID-19 as the Trust was unable to conduct its usual recruitment exercise in Australia and Australian Paramedics have been unable to travel to the UK for work. Over 50 potential international paramedics have contacted the Trust with expressions of interest stating that they wish to join as travel restrictions

are lifted and dates for training courses and HCPC registration are confirmed. This position would be monitored by the People and Culture Committee.

40. Members were informed that 13.7% of staff have completed the Staff Survey and the people and culture team are continuing to work with the internal communications team to ensure that the engagement plan is implemented.

Finance & Audit Directors Report

41. The Chief Finance Officer reported data related to the Trusts month 4 position and noted that interim national financial arrangements continue until the end of September 2020 which would ensure the Trust meets its financial target through a retrospective top-up mechanism for the first half year.
42. Additionally Trust Board was asked to approve the business plan for the remainder of the year assuming funding is in line with the M4 forecast. Which equated to an income envelope of £527m inclusive of COVID funding of £75m and a total Trust capital plan of £50.3m. The capital funding remains subject to formal notification.

Finance & Investment Committee

43. Fergus Cass (FC), Non-Executive Director, and Chair of the Finance and Investment Committee, presented a report of the most recent meeting of that Committee to the Board, noting matters for escalation, recognising that the Committee had considered both the Financial and Capital plans which the Board would also consider as a matter on the agenda.
44. The Finance and Investment Committee recommended approval of the Business cases received and considered and recognised that these would be presented to the Trust Boards private meeting for approval.

Audit Committee

45. Rommel Pereira (RP), Non-Executive Director, and Chair of the Audit Committee, presented a report of the most recent Audit Committee meeting to the Board, noting that the Committee had received and considered a lessons learnt review from out of hours immunisations, the strengthening of procurement arrangements and controls in place in respect of single tender waiver (STW), noting that the Committee requested receipt of an assurance review in respect of benefits realisation and capital controls.
46. Further to this the Committee recommended that the Board approve the proposed revised format of the Board Assurance Framework (BAF) which incorporated risk appetite gap trend reporting, and maintain the current reporting frequency.
47. In line with this the Committee requested that the executive develop a broader assurance reporting framework, review the LAS Risk Management model and how it maintains oversight of the interplay and delineation between strategic and operational risks and consider embedding risk management through process ownership. Director attestations would be introduced as part of the latter to enhance the 20/21 year-end assurance process.

Logistics and Infrastructure Logistics and Infrastructure Committee

48. Sheila Doyle (SD), Non-Executive Director, and Chair of the Logistics and Infrastructure Committee, presented a report of the most recent meeting of that Committee to the Board, noting that the committee had reviewed those business cases that would be considered by the Trust Board during its private meeting. During the

review members had noted the recurring theme in respect of additional rigour required to address links to strategic ambition and controls. It was acknowledged that these points had subsequently been addressed prior to presentation to Finance and Investment Committee.

49. Additionally the Committee had spent time reviewing IM&T resilience and were reassured by presentation of evidence to demonstrate progress and investment in these issues.

Digital 999 Programme Assurance Group

50. The Board received a paper which provided assurance across the D999 Programme, including recent developments and status of both electronic Patient Care Records (ePCR) and Computer Aided Dispatch (CAD) projects which remain in amber status due to a combination of technical challenges and resource constraints. Assurance was also provided that the dynamic position in respect of COVID-19 continued to be monitored.
51. Members received feedback from 2 paramedics who were actively using the ePCR system. The feedback was very positive and reflected initial feedback received on social media. The Chief Clinical Information Officer will continue to survey users through structured and unstructured channels.
52. The Group received a report on the first audit review conducted by PWC. The review focused on program governance and project controls and concluded that the program is progressing well with new governance arrangements reflecting good practice. The report highlighted areas of attention including stronger articulation of the strategic benefits, greater focus on benefits realisation, ensuring CAD operational processes meet LAS needs and further attention to change management and adoption.

Finance

M4 Finance Report

53. The Chief Finance Officer presented the M4 position noting that the Trust has a breakeven position as at the end of July 2020 in line with the interim financial framework established by NHS England, with a cash balance of £58.3m at the end of July and the Trust Capital Resource Limit for the remainder of the year is agreed by the sustainability and transformation partnership (STP) at £44.2m, however this requires formal notification. A further £6.1m of capital resource limit (CRL) has been identified for brokerage from within North West London Health and Care Partnership (HCP) which will increase the Trust's 2020-21 CRL limit to £50.3m.

Financial Plan 2020/21

54. The Board were presented with a paper which sought approval of a revised financial plan for the remainder of 2020/21 to support the business plan objectives following the publication of the Phase 3 planning guidance from NHS England.
55. National financial arrangements for the remainder of 2020/21 have been issued and the Trust continues to work with the NWL Healthcare Partnership system to establish a financial envelope as part of the system financial submission on 5 October 2020.
56. The Finance and Investment Committee were supportive of the plan and approach subject to caveats including confirmation of the capital plan.

Resolution.

The Financial plan 2020/21 was approved.

Capital Expenditure and programme

57. The Trust has been successful in securing agreement to proceed with a capital plan of £50.3m in recognition of the urgent need for transformation of a number of legacy estate issues.
58. The Board received a paper which outlined the revised capital plan for 2020/21 following support from North West London (NWL) Sustainability and transformation partnership (STP) to work to a capital allocation of £50.3m and noted that this had not formally been confirmed through an adjustment to the Trust capital resource limit (CRL). The paper also presented the current governance, financial risks, benefits for current programmes and prioritisation of further schemes that the Trust will over programme to ensure the full capital allocation is utilised in 2020/21.
59. Trust has still not received confirmation of the revenue funding arrangements for the remainder of 2020/21, however the revenue funding requirement has been identified through review of business cases and currently stands at £6.9m of which £5.0m is already included in the forecast position and a further £1.9m would require offsetting efficiencies from within the month 4 forecast. The Board was asked to approve the Trust capital plan subject to affordability both in terms of available capital and revenue funding.

Resolution

Capital Expenditure and Programme approved.

Business Plan

60. The Trust is still yet to receive a confirmed financial settlement for the remainder of 2020/21, therefore the content of the business plan document has been developed based on the key deliverables to be prioritised for the remainder of this financial year.
61. Taking into account the changes made in response to the first peak of the pandemic, learning from this experience, and the changes to the way that patients access healthcare, the Trust has reset the priorities for the next 5-years across six strategic themes.
62. This paper established the Trust's objectives and plan in 2020/21 to: Provide a resilient service that delivers the right care first time for our patients, every time; Deliver national performance and quality standards every day and consistently deliver financial targets and drive economic benefits in the London system.
63. The Board discussed the 6 strategic themes as presented and concluded that they were appropriate and that it was necessary to establish the measurables to appropriately assure against their delivery.
64. Members sought reassurance that there would be Board engagement in the Trust Cultural assessment; this was confirmed as the plan for the upcoming Board development session focussed on People and Culture.

Resolution

Business Plan approved for implementation.

Patients and communities engagement and involvement strategy 2020-2023

65. The context within which the Trust works has changed significantly, and will continue to change into the future. Recognising the opportunities and challenges emerging, the

2018/19 to 2022/23 organisational strategy established the Trusts intentions to achieve its ambitions and goals.

66. As part of that strategy it was acknowledged that there was an opportunity to significantly enhance the way the Trust engages with patients and communities to improve the care it provides. The Board was presented with the proposed Patients and communities engagement and involvement strategy 2020-2023 and were asked to approve the document as presented.
67. Members considered the presentation and asked how regulators are involved as they were not identified as a stakeholder group. It was confirmed that they are invited to observe the group.
68. It was acknowledged that the Strategy represented a structured improvement and that it establishes a good baseline to develop and that work should continue to embed the council with an agreed work plan with aligned priorities and sub-groups which would include a youth council.
69. The Board endorsed the strategy as presented and considered instances whereby the Patient and Public Council Chair would attend the Board. It is intended that the Council Chair would attend the Board to present the meeting notes and answer any questions.

Resolution

Patient and Communities Strategy Approved.

Trust Response to Black Lives Matter

70. Following the tragic death of George Floyd earlier this year, the Trust has produced with a wide ranging action plan to respond to the needs of its BAME staff from "Board to Ward". The Board received a summary of the progress to date which included the Black Lives Matter delivery plan currently being implemented across the Trust.
71. Achievement of the Black Lives Matter Delivery Plan will lead to positive step change for the Trust's Black and BAME staff by the end of the financial year 2020/201 which can be evidenced through to improvements in the Trust's WRES action plan and annual staff survey engagement index.
72. Board members were notified that over 700 line managers from all areas of the Trust had taken part in virtual conversations about race in groups of 100. The workshops were hosted by Garrett Emmerson, Chief Executive and Melissa Berry, Diversity & Inclusion Consultant supported by 10 facilitators from People & Culture, the BAME Network and the Executive Committee and were delivered to ensure that staff are educated about lived experiences of their BAME colleagues at work and in general. Through these sessions Trust has been able to provide a safe environment where the managers of the majority of our people were given the time and space to listen, learn and talk about racism.
73. Additionally Both the Trust Chair and Chief Executive have written to all staff outlining their stance that there is no place for racism at the London Ambulance Service and members were informed that the response to these letters has been positive.
74. Members acknowledged the positive progress and considered the metrics that would be used to track and measure outcomes. There are clear metrics in the WRES that can be used along with pulse surveys.

COVID Lessons learned report

75. The Board received a paper which formally recorded the impact of the first peak of the COVID-19 pandemic, its impact and how the Trust positively responded to the challenge. The paper also outlined how new ways of working have been embedded as a result of this experience.
76. The Trust has also reflected on the actions and decisions taken during the first peak of the pandemic, and has considered feedback from a wide range of stakeholder groups to capture the experience and to establish what went well and what could have been done differently from stakeholder perspective. These lessons learnt have been used to inform the development of resilience plans, in preparation of future surges in activity relating to COVID-19 or to manage peaks of seasonal demand.
77. Members considered the paper as presented and recognised the methods of data collection and review and that the response to the pandemic had been a testament to every level of the organisation.

Governance and Risk

Strategic risk and the Board Assurance Framework

78. The Board received a paper which set out the Trust's approach to the management of strategic risk at Board level which was in line with best practice. The proposal had been reviewed by the Audit Committee and sought approval of a new Board Assurance Framework (BAF) format.

Resolution

Board Assurance Framework new format, approved

79. Further to this this Board Assurance Framework was presented noting that changes made since the last Board meeting on 28 July 2020.
80. BAF risk 56 in respect of the ability to recruit and retain registered clinicians to core front line operations will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets. The risk had been reviewed and updated by the Director of People and Culture with a proposal made to increase the residual rating from 12 to 16, as this has now become an area of significant concern.

Resolution

BAF risk 56 residual rating increased from 12 to 16, approved

81. BAF risk 54, in respect of the risk that, the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged trained specialist resource requirements and performance which may result in the Trust not fully delivering its strategy. The Quality, Assurance Committee considered this risk and the proposal to remove BAF 54.
82. The Executive recommendation is to remove BAF 54 recognising that the risk is no longer applicable given that there is no current contract for 111. However, the Non-Executive members of the Committee requested the risk is re-worded to reflect the financial risk elements.
83. The Board debated the proposal and members concluded that it would be appropriate to close BAF risk 54 and to articulate a new risk which considers the financial risk in

terms of the 111 service. Once articulated the proposed risk should be considered by Finance and Investment Committee.

Action:

- New BAF risk to be articulated to which considers the financial risk in terms of the 111 service
- Proposed Risk to be considered by Finance and Investment Committee.

Resolution

BAF risk 54 to be closed.

Any Other Business

84. There was no other business raised

Additional Reports

The Board received the following additional reports for information only

- Corporate Risk Register
- CQC IPC Framework
- Quality Report
- SI Report
- Caldicott Guardian Report
- Register of the Seal
- Training action update

Meeting Close

The next Trust Board meeting in public will take place on 24 November 2020

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	Comments / updates <i>(i.e. why action is not resolved / completed)</i>
Training	People and Culture Committee to consider the provided training data and costs in line with any available benchmarks to ensure that the costs are appropriate.	Jayne Mee	29/09/2020	02/11/2020	To be reported at the January People and Culture meeting
Board Assurance Framework	New BAF risk to be articulated to which considers the financial risk in terms of the 111 service	Syma Dawson	29/09/2020	24/11/2020	New BAF Risks have been articulated and are presented to the Trust Board within the Board Assurance paper
Risk Approval - Assurance Committies	Proposed Risk to be considered by Finance and Investment Committee	Fergus Cass	29/09/2020	24/11/2020	New BAF Risks and actions have been articulated and are presented to the Trust Board within the Board Assurance paper



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Report from the Chair			
Agenda item:	5			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
The Chair's report provides an overview of meetings and events attended with external/internal stakeholders of the Service since the last time the Board convened.				
Recommendations for the Board:				
The Board is asked to note this report and approve the change to the schedule of meetings for the Staff and Volunteer Advisory Group.				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

Report from the Chair

External meetings

1. Integrated Care System (ICS) / Sustainability and Transformation Partnership (STP) meetings in NWL and SWL

1.1. In NWL and SWL the focus of each meeting remains on:-

Governance arrangements
Elective care and diagnostic reset
Cancer care
COVID-19
Staff wellbeing

1.2. There is an increased focus on COVID-19 phase 2 although compared to the North of England, hospital and ITU admissions remain low but have been increasing with the highest level occurring in North East London and the lowest in South West London.

1.3. I have now had separate conversations with Richard Douglas, chair of SEL ICS and Mike Cooke, chair of NCL STP. In both instances we agreed to consider LAS involvement I have a meeting scheduled with Marie Gabriel chair of NEL STP on 19 November to discuss the NEL STP.

2. Chairs Advisory Group

2.1. Received an update on the national position of COVID-19 by Professor Steve Powis who updated us on the very high levels of COVID-19 in the north of the country and the use of oximeters to measure oxygen levels three times a day of at risk patients in their own homes.

2.2. It was also reported staff sickness from COVID-19 and or from needing to go in to quarantine was causing workforce issues

2.3. Ian Dodge updated us on the proposed legislative change which remains unconfirmed as to the proposed legal status of ICS or not.

3. AACE

3.1. I attended a virtual meeting of AACE chairs where we heard from chairs in the north of the country the pressures they are facing in this second phase of the pandemic which in reality is a reversal of what was seen in the first phase.

3.2. Daren Mochrie, the new CEO chair of AACE fed back on his activities and where he is trying to influence the centre and others in relation to the impending legislation. My impression was that we were reassured he was acting in our collective interest but my challenge remains that we appear to be responding with an operational answer rather than influencing strategy.

3.3. We subsequently held a meeting between CEO and Chairs of LAS, SCAS and NWS (where Daren is CEO). This was a more strategic conversation and we concluded that in

terms of the proposed legislation and where Ambulance Trusts sit in relation to the ICSs, there would be different approaches in different geographies.

Internal Visits

4. Board Development Session

- 4.1. The Board session was focused on culture and inclusivity with 3 guest external speakers invited to attend and present:-
- Professor Edward Baker from the CQC on the approach to the Well Led Assessment.
 - Amanda Oates From Mersey Care Trust who presented on their work on developing a just and learning culture
 - John Amaechi (organisational psychologist) on inclusive leadership
- 4.2. The sessions were inspiring and relatable to. It is clear that we have made some in roads in terms of the work our chief quality officer (Trisha Bain) has introduced in to the quality agenda in terms of how we investigate potential serious incidents and the ambulance station accreditation pilots.
- 4.3. Where we have made less progress is around our disciplinary and grievance processes and this must now be a real focus of our progress towards an inclusive culture. Our CEO (Garrett Emmerson) and his team will be presenting to the Board how they intend to use the knowledge gained in these sessions to integrate these activities and approaches in to the LAS culture workstreams.
- 4.4. Since March and the issues raised by Black Lives Matter I continue to hear from members of staff on array of issues. Whilst it is clear that the organisation is for the first time holding supportive and open conversations on race and have made progress there are other equally important issues that must also be addressed to achieve the inclusive organisation that we aspire to. These issues are being raised confidentially with me and they must be addressed.

5. Staff and Volunteer Advisory Group

- 5.1. The director of corporate governance (Syma Dawson) and I met with the head of wellbeing, and chairs of the equality and diversity groups to discuss how best to gain real front line representatives. They explained how their groups work and how they recruited to the role. As a result we are using their networks and our social media channels to recruit membership.
- 5.2. It is our proposal to meet alternately with a core group existing members as set out in paragraph 2.1 of the Staff and Volunteer Advisory Panel Terms of Reference presented to the September Board with the wider group that will aim to have presentation of the whole organisation.
- 5.3. The Board is asked to note and approve this change to the schedule of meetings.

6. Board to Ward

- 6.1. At our development session I presented a revised approach to 'Board to Ward' or the 'Golden Thread written on the advice of our director of communications and engagement

(Antony Tiernan) of achieving our role whilst continuing with restricted access due to the pandemic. I would be grateful if the Board could respond to me as to which aspects you would like to be involved with.

7. Black History Month

- 7.1. Dr Agatha Nortley-Meshe led an excellent event to which I was able to contribute via a pre-recorded video.

8. Freedom to Speak up (FTSU) Week

- 8.1. I supported this important work led by our deputy FTSU guardian (Erica Greene) and FTSU co-ordinator (Carmen Peters) by pre-recording a video for use during the week. I know that they very much appreciate the support provided to them by our non-executive director lead Fergus Cass. FTSU is a key component of achieving the culture that we aspire to and I want to encourage staff to continue to raise issues but I also want to encourage our managers to listen to what Erica and Carmen are telling them they are hearing and to seek advice, take tangible professional advice and to act. The ultimate goal has to be for staff to feel that they can speak to their managers and to know that appropriate action will be taken in a safe environment.

Heather Lawrence OBE
Chairman



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Report from the Chief Executive			
Agenda item:	6			
Report Authors:	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board's attention:				
<ul style="list-style-type: none"> The Chief Executive's report provides a strategic update on the key activities and internal and external engagement by the London Ambulance Service NHS Trust (LAS) since the last time the board convened in September 2020. 				
Recommendation for the Board:				
<ul style="list-style-type: none"> The Board are asked to note the content of the Chief Executive's report. 				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		Trisha Bain
Finance	Yes	X	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer
Medical	Yes	X	No		Fenella Wrigley
Communications & Engagement	Yes	X	No		Antony Tiernan
Strategy	Yes	X	No		Ross Fullerton
People & Culture	Yes		No		
Corporate Affairs	Yes	X	No		Syma Dawson

Report from Chief Executive

1. Overview

- 1.1. Since my last report to the Board in September, we have continued to reinforce our operational resilience to enable us to respond effectively to the continued challenges of COVID-19 and the anticipated seasonal increase in demand. Our Winter Plan will be presented to the Board today. As can be seen in the Chief Operating Officer's report to the Board, our operational performance continues to be strong, with national targets consistently being met or exceeded, despite the fact that we are seeing activity increasing to pre-COVID levels and slightly increased COVID related staff sickness since September (albeit our overall staff absence rate due to sickness is below that for the same period last year). As set out in the Director of People & Culture Board report, we are working hard to ensure our staff and volunteers have had their flu vaccinations and, following the Secretary of State for Health and Social Care's announcement on 10 November 2020, we are working on plans to ensure the Trust is ready to roll out a COVID-19 vaccination programme as soon as a vaccination becomes available. We are also preparing for the roll out of twice weekly asymptomatic testing of our patient facing or business critical staff and volunteers.

2. Building a World-class Workplace

Trust Senior Leadership

- 2.1. In support of our vision to be a world-class ambulance service and London's primary integrator of access to urgent and emergency care, and in order to make significant progress in transforming the culture of the Trust, we continue to evolve our organisational structures and make small changes to functional portfolios.
- 2.2. To prepare for the retirement of our Chief Quality Officer, Dr Trisha Bain, in early 2021 and the recent departure of our Director of People and Culture, Ali Layne-Smith, and to increase and strengthen our capabilities in key areas, we are recruiting to several leadership positions.
- 2.3. We will shortly be commencing the process for the recruitment of a new Director of People and Culture. However, in the interim, I am pleased to say that Kim Nurse, currently Executive Director of Workforce and Organisational Development at West Midlands Ambulance Service University NHS Foundation Trust, will be joining us on a secondment basis from 16 November 2020 as Interim Director.
- 2.4. The recruitment to a new Associate Director of Culture Diversity and Inclusion role is progressing and we anticipate an appointment to be made by the end of November 2020.
- 2.5. We are also progressing recruitment for the Chief Paramedic and Quality Officer role, with interviews planned over November/December 2020. Our recruitment partner, Saxton Bamphylde, have identified a strong field from their candidate search I am hoping to secure an experienced senior leader to continue the fantastic work of our Chief Quality Officer, Dr Trisha Bain. I would like to take this opportunity to thank Trisha for her significant contribution to the success of the Trust over the last four years, particularly in respect of improving the quality of care for our patients and helping the Trust move from Special Measures in 2018.

Modernising our Operations

- 2.6. In October last year, we published our Estates Vision, setting out high level plans to transform our ambulance operations by replacing our existing 68 stations – some of which date back quite literally to Victorian times and many of which are unsuitable for a 21st Century ambulance service – with a network of state-of-the-art Ambulance Deployment Centres (ADC) or ‘super-hubs’ (similar to those already found in other ambulance services). The aim will be to have modern, fit for purpose facilities for all of our staff and volunteers, full ambulance make ready and vehicle maintenance facilities, as well as modern management, administrative, training and health and wellbeing facilities. Fundamentally, it will also of course help us to improve the standard of care we provide to our patients, for example, in relation to improved infection prevention control and medicines management standards.
- 2.7. We are moving forward with our plans to create our first new ADC and a business case outlining the proposals will be considered by the Board today.

Staff Engagement

- 2.8. During October and November I held 38 Virtual Roadshows, with almost 1,200 staff participating. There are two more to go in December. The Virtual roadshows were set up in recognition that the face to face at station sessions were cancelled in the spring due to the pandemic and there was a gap in more local staff engagement.
- 2.9. The virtual roadshows have proved to be extremely successful, with generally the same degree of participation as the face to face events. We’ve had participants dialling in from a range of locations – from home, from their stations, from cars and vans when on rest breaks, even when on holiday - demonstrating how technology enables collaboration across a disparate network.

Black History Month

- 2.10. Working with our B-ME staff network group, we celebrated Black History Month (BHM) by sharing staff stories from across the Service on a daily basis. Staff shared their thoughts and reflections on what BHM means for them. We were also delighted to share on our social media channels the news that Dr Agatha Nortley-Meshe, our Assistant Medical Director, was chosen by NHS London to be one of the 36 ‘faces’ of NHS Trusts in the capital. We have also supported the B-ME network ‘Black Every Month’ initiative, promoting it across all our internal communications channels including our intranet, our Facebook Group, our Routine Information Bulletins and LAS TV Live. In the spirit of the event we are continuing to celebrate our BAME staff throughout November and beyond.

Freedom to Speak Up

- 2.11. This year we promoted a collaboration between Freedom to Speak Up (FTSU) and Black History Month, profiling eight inspirational black people and demonstrating how they have used their voices to Speak Up. In addition, our FTSU Team, Carmen Peters and Erica Greene, visited ambulance stations and talked to colleagues across the service raising greater awareness of their role.

3. Our Public and Patient Engagement

Annual Public Meeting

- 3.1. On 29 September, the communications team delivered our twentieth Annual Public Meeting (APM), hosted by our Chair Heather Lawrence OBE, which due to COVID-19 was our first entirely virtual event. The APM focused on our aim to better coordinate emergency care across London, with an emphasis on our ground-breaking 'Perfect Day' pilot in North East London and our transformational approach to COVID-19.
- 3.2. We were pleased to be joined by around 650 viewers live for the event, with a further 4,500 watching the recording since then, including a range of our key stakeholders who asked our Trust Board questions during the meeting.

London Ambulance Service Public and Patients Council (LASPPC)

- 3.3. The LAS Public and Patients Council, which was launched in early 2020, has established eight new working groups to increase the involvement and engagement patient and public representatives have on our work.
- 3.4. The areas covered include the Ambulance Operations Modernisation Programme (how we deliver our estates vision), hearing from pregnant women who have used our services and supporting our research programmes.
- 3.5. The LASPPC is also supporting the establishment of our new ambulance station accreditation programme, which will assess the quality of care at station/service level, as well as a new study to manage emergency ambulance telephone callers with sustained high needs.

Ambulance

- 3.6. For eight weeks, from 16 September 2020, BBC One's Ambulance documentary aired, attracting approximately 3.8 million live viewers per episode.
- 3.7. The show was the culmination of nearly two years' work with the production company, Dragonfly, and was delivered thanks to the hard work and commitment of so many of our staff and volunteers, especially our colleagues who agreed to be 'shadowed' by the cameras.
- 3.8. To support the programme, our Communications and Engagement Directorate (supported by their operational and clinical colleagues) delivered a comprehensive media and social media plan around the broadcast schedule to support various key communications objectives, including recruitment to the Service.
- 3.9. The series has successfully addressed a number of key issues for the Trust, raising public awareness and understanding of how the organisation is responding to increasing mental health cases, unacceptable violence and aggression towards our staff, how we deal with major and significant incidents and, with an unplanned CAD outage filmed by the documentary team, how we deal with unplanned incidents. For the first time, the programme also looked at some of our 'behind the scenes' support activity, including the Fleet and Make Ready functions and the training of 999 call handlers.

- 3.10. A significant volume of social media content was published before and after each episode as well as 'live' content being shared across the hour of transmission for all eight episodes. The engagement and reach on social media has been very high – including record levels of Instagram 'likes' and post reach. The average Twitter reach from the eight Wednesdays of the broadcast period increased by 868% when compared to the daily average for the same days in 2019 and on these Wednesdays our Twitter account saw as high as a 750% increase in engagement compared to an average day. The total Twitter reach (impressions) for Wednesdays between 16 September (episode 1) and 4 November (final episode) was 6.3million – an average of around 775,000 people absorbing our content per day of episode. The daily average for Twitter reach in the same period last year was 80,000. We focused on using our social media channels to direct people to our website – especially recruitment pages - and we received the largest number of unique website page views in October on record: higher than during the peak of the pandemic in March.
- 3.11. With the series showcasing the incredible work of our staff and volunteers across the service, the team have shared the stories of the stars in each episode on our internal communications channels (for instance, LIA and LAS TV Live) and externally with coverage across national and London broadcast and print media, national titles and consumer media. Notably, the documentary series was featured on *BBC Breakfast* and *ITV's This Morning*.
- 3.12. We have also seen an increase in the number of compliments received from our patients and members of the public. Figure 1 below shows the number of thank you letters and emails received for the months of September, October and November in 2019 and only those emailed during the same months in 2020. We expect the numbers for 2020 to increase by c50 each month when adding in the correspondence received by mail. This would suggest a more than 50% increase in the thank you messages we've this year compared to last. The positive view of LAS accords with the public perception scores I set out in my last report to the Board.

	2020	2019
September	165	135
October	216	145
November (*up to 13 Nov 20)	65*	181

Figure 1

PR Week

- 3.13. The external communications team was highly commended at the leading industry annual awards, PR Week Awards. They entered the coveted in-house team of the year category and out of all the public sector PR teams in the country, they came second.

Public Access Defibrillators

- 3.14. We continue with our campaign to increase the availability and effectiveness of public access defibrillators across London. With 'Restart a Heart Day' taking place on 16 October we reached out to key stakeholders across London to raise awareness of the importance of purchasing from accredited providers to optimise the clinical benefit of defibrillators.

- 3.15. We also shared messaging on the importance of using a defibrillator or carrying out chest compressions if someone is in cardiac arrest, and how this can be done safely due to COVID-19, which we shared across our social media channels.
- 3.16. In November, we saw the Voluntary Responder Group have its first London Lifesavers Project meeting. This meeting served as a useful starting point for constructive discussion around how we set out to achieve our strategic aim of recruiting just under 100,000 new volunteers to resuscitate using defibrillators by 2023.

HSJ Patient Safety Awards 2020

- 3.17. I am delighted to report that we won two awards at the HSJ Patient Safety Awards in early November. We had been shortlisted in five categories, with our mental health team winning the Mental Health Initiative of the Year Award for the Mental Health Joint Response Car pilot, and our End of Life Care team winning the End of Life Care Award for their collaboration with Macmillan in developing the End of Life Care Coordinator network. In addition, our maternity team were Highly Commended in the Maternity and Midwifery Services Initiative Award for their incredible work in increasing maternity training across the Trust. The HSJ Awards are well-respected across the NHS, health and care and we are proud of our teams for their success.

4. Corporate Affairs

- 4.1. Complaint volumes have been increasing to the levels seen prior to the initial peak of COVID-19. Figure 2 below demonstrates the comparison of all work streams managed by our Patient Experiences Department (PED). The complaint figures in March, April and May 2020 were during the 'pause' period implemented by NHS England. Since June 2020, complaint numbers have returned to pre-Covid levels. In the period 1 June to 30 September 2020 the team has also managed 149 Quality Alerts (incident reports from health and social care professionals) and the team has received positive feedback about this process. Internal Quality alerts by Trust staff and volunteers about third party providers are on the increase. The increased reporting will help drive improvements in how we work with other providers and enable better mutual understanding of our respective roles. Figure 1 also includes the numbers of enquiries managed by our Patient Advice and Liaison Service (PALS) duty team. A high number of these related to COVID-19 offers.

Month	Complaints 2019	Complaints 2020	Quality Alerts 2019	Quality Alerts 2020	PALS 2019	PALS 2020	Enquiry spreadsheet 2020 only	Total Contacts 2020
January	91	103	31	32	398	343		343
February	89	89	20	31	295	333		333
March	100	65	24	21	367	421		421
April	88	67	17	33	337	430	140	570
May	90	66	30	31	386	258	278	536
June	89	93	30	38	325	299	304	603
July	105	100	38	45	399	365	405	770
August	82	78	43	35	366	271	351	622
Sept	102	90	30	31	324	262	390	652
Totals	836	751	263	297	3197	2982	1868	4850

Figure 2

- 4.2. The main themes of complaints made during January - September 2020 are set out in the figure 3 below:

Theme of complaint	Data	%
Conduct and behaviour	281	37%
Communication	113	15%
Non-conveyance	60	8%
Delay	66	9%
Road handling	65	9%
Clinical treatment	39	5%

Figure 3

- 4.3. As can be seen, 37% of complaints relate to staff and volunteer conduct and behaviour, especially in relation to challenging the validity of 999 calls. PED has also seen an increase in complexity of complaints requiring close liaison between Directorates across the Trust.
- 4.4. The Health Service Ombudsman is working on a new universal Complaints Standards Framework and we are one of the specially invited agencies participating in this consultation. It is expected that this guidance will form the basis for new regulations to supersede the *Local Authority Social Services and NHS Complaints Regulations (2009)*.

Health and Safety

- 4.5. The Health, Safety & Security Department are working closely with local management teams, including Estates, Infection Prevention & Control, and Trade Unions, as part of an ongoing COVID-19 secure compliance and assurance checks. This is part of a wider programme and review of site specific risk assessments across the Trust, with regular bulletins being provided to staff and volunteers with advice on COVID-19 guidance and restrictions.
- 4.6. A Working Group has been set up to be the central and strategic point of coordination for all Trust activity relating to the oversight of how respiratory protective equipment is being managed in the Trust.
- 4.7. Sadly, there were 323 assaults against staff and volunteers reported in the period April to September 2020. The two Violence Reduction Officers recently recruited to help tackle violence and aggression against staff and volunteers have been working closely with the Police as they support victims who want to take their cases to court.
- 4.8. There has been a drastic increase in physical assaults against LAS staff and volunteers in recent years. Data from 2004 to March 2020 reveals a 72% increase and in the last 12 months an estimated 12 assaults per week, 625 reported physical assaults on staff. Recorded data further indicates that the majority (approximately 60%) of reported incidents of violence and abuse experienced by crews occur outside of the ambulance, i.e. in patients' homes and public places.

- 4.9. In order to respond to this rise in assaults, the Board agreed in September 2020 to roll out Trust wide Body Worn Video Cameras as a measure to help reduce the number and impacts of assaults on crews. The tender for the provision of body worn video cameras as part of the National Body Worn Video Camera Pilot for English Ambulance Services closed on 2 November 2020 and we are hoping to have an agreed contract in place before the end of November. The project to roll out body worn video cameras will be initiated as the initial pilot progresses.

The Board is asked to note and discuss this report.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Report from Chief Operating Officer			
Agenda item:	7			
Report Author(s):	Khadir Meer, Chief Operating Officer			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
Report from the Chief Operation Officer to update on the performance and activities for September - October 2020, as well as plans and priorities for Q3 and beyond.				
Recommendation for the Board:				
<ul style="list-style-type: none"> The Board is asked to note the report. 				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes	x	No		Chief Operating Officer
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

Report from Chief Operating Officer

1 EXECUTIVE SUMMARY

Overview

The purpose of this report is to provide the Board with an update on the performance and delivery plans for the five operationally focussed Directorate's within the London Ambulance Service (LAS). The document provides a summary, by Directorate, of recent performance, current priorities and continued areas of focus in 2020/21.

Since the last Trust Board update, we have maintained favourable levels operational performance against targets, however we are seeing activity rising back to pre-Covid levels. We are regularly monitoring changes in demand relating to pandemic activity and now have in place the Winter/COVID-19 response plan that will trigger deployment of our operational resilience plans when necessary.

Alongside core business as usual operations, there has been significant progress made in each of the Chief Operating Officer (COO) directorates. Key highlights include:

1. **Workforce** – The Strategic Workforce plan has been prepared for the next 18 months for Integrated Urgent Care (IUC), Emergency Operations Centres (EOC) and Ambulance Services. Within my own team, substantive appointments made to the roles of Director of Ambulance Services and Director of Integrated Patient Care. Interim appointments have been made to the Director of Strategic Assets & Property and Director of Business Intelligence & Analytics.
2. **Performance** against national standards remains strong across IUC 111, EOC 999 and Ambulance Operations with key performance metrics being met or exceeded since May 2020.
3. **Service Changes** – We are in advanced stage of negotiation with North West London (NWL) to conclude negotiations and complete mobilisation. We continue collaborative working with health service partners across London Primary Care Networks (PCNs) to support with paramedic resource. The trial in Merton has gone live in October 2020.
4. **Capital Programme** – The capital investment priorities for the remainder of 2020/21 have been confirmed and business cases continue to be developed to support programmes of work at pace including the Programme Business Case for Ambulance Operations Modernisation Programme. We continue to deploy ePCR across the Trust with over 5000 patient records being processed to date.
5. **Resilience** – An LAS self-assessment process against NHS Core Standards for Emergency Planning, Resilience & Response (EPRR) has us assessed as fully compliant. The EU Exit Task and finish group has been relaunched, building upon previous learning to ensure LAS has appropriate arrangements ahead of UK's exit from the European Union.

In the next period, our attention will be directed towards a response to the winter demand, continued engagement with commissioners in the development of integrated services, driving forward delivery of the capital programme and workforce plan, and contributing to the group established by NHS England to agree arrangements in advance of the UK's exit from the European Union.

2 LEADERSHIP & GOVERNANCE

There is continued focus and priority to fill key posts within the COO senior leadership team. Early in October, we were fortunate to be able to strengthen the team with a number of important appointments:

After a competitive internal recruitment process, the role of **Director of Ambulance Services** has been substantively appointed to. The post holder has led the Directorate on an interim basis for over a year and brings substantial experience as a clinician and a Gold Commander.

Again, after a competitive internal recruitment process, the role of **Director of Integrated Patient Care** has also been substantively appointed to. The post holder has worked for the LAS for over two years supporting the development of 111 and latterly 111 & 999 integration. They bring over ten years of experience working at Director Level in the private, social enterprise sectors as well as the NHS.

Strategic Assets and Property colleagues provide essential services that enable outstanding patient care. While we work through externally advertising this role, I have made an interim appointment to the **Director of Strategic Assets and Property** post. The interim post holder has worked as a Director in the private and public sectors across regulation, commissioning and provision nationally and internationally.

As we are in the midst of delivering a wide programme of transformation and improvement work across the organisation for the second half of this year and beyond. I believe these appointments put us in a strong position to continue delivering the work for the benefit of LAS, its patients, people and partners.

We would also like to extend a welcome to a new addition to the COO family in the form of **Business Intelligence and Analytics**. The existing team has transferred from the Finance directorate to reflect the critical importance of data to inform Operational decision making, and recognising that the Operational Performance brief sits across the entire COO directorate. We are looking forward to stronger and closer working relationships as a result of this move.

We continue to recruit to and make substantive appointments to key roles across operational areas of the Trust to pursue development and transformation.

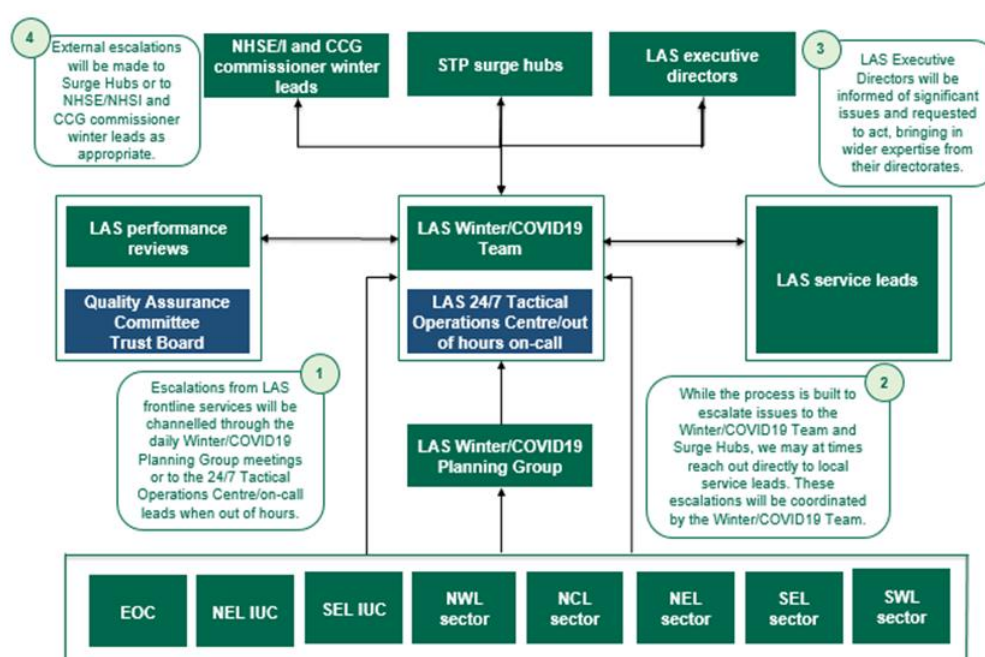
3 OPERATIONAL RESPONSE RESILIENCE

3.1 Winter/Covid

The Winter/Covid plan for 2020/21 has been shared with the Executive Committee as well as with Audit, People and Culture and Quality Assurance Committees in October and is set to be presented at Board in Parallel to this paper.

Governance and Assurance: The Chief Operating Officer has overall executive responsibility for winter preparedness and service delivery while the Director of Ambulance Services will take the role of Winter Programme Lead and will be responsible for leading and managing the arrangements for winter planning across all service lines.

Underlying principles: These will inform the manner in which the LAS winter team will interact with internal and external partners. These principles are represented as in the diagram below:



3.2 EU Exit

In 2019, the Head of Business Continuity conducted an assessment of the risks the Trusts faces in the event of a no deal departure from the EU.

Supply chain, fuel supplies, business continuity arrangements, workforce and medicines were identified as the key areas of risk and mitigating actions were undertaken.

A fortnightly EU Exit Task and Finish Group has been reinstated to review the Trust's state of readiness and will report to the Executive Committee, with the first update delivered to the Committee in October.

The Trust Gold team held an exercise in preparation for an EU Exit to consider and prepare for any possible challenges. LAS EU Exit leads will continue to engage with any EU Exit workshops/meetings arranged by NHS England/Improvement.

3.3 Low Traffic Neighbourhoods and Streetscapes Schemes

We continue to engage with Transport for London (TfL) and Local Authorities in respect of the introduction of Low Traffic Neighbourhoods (LTNs) and Streetscapes. Several politicians, residents and other stakeholders, along with local, regional and national media, have contacted us enquiring about how specific schemes or their cumulative impact are affecting our service across the capital. **There is a recognition that we share common ground, improving the health of Londoners by reducing RTCs and improving the air quality of London.** However, as the UK's busiest ambulance service we must achieve the best outcomes for our patients, including reaching them within nationally-set response times. Our Emergency Preparedness, Resilience and Response department has been working closely with TfL and Local Authorities to review the design and implementation of specific LTN schemes to improve emergency access, and providing feedback on their operation of these new schemes.

4 Integrated Patient Care

4.1 NHS 111 / Integrated Urgent Care Services

Highlights

- The LAS has been working closely with system partners to redesign access to the urgent and emergency care system prior to winter 2020/21 and to deliver the **111 First** initiative, which enables clinicians across the 111 and 999 to refer into a non-Emergency Department outcome in collaboration with ICS downstream services. This will be achieved through increased clinical validation and assessment, increased electronic appointment bookings across the NHS system and increased clinician to clinician support. Engagement with local system providers to shape clinical pathways is ongoing, with plans to be implemented by 1 December 2020, as the communications to the public around this have already begun system wide.
- Work continues on the third floor of Maritime House to double the current capacity for call handlers and clinicians.

2020/21 YTD Performance

- Strong performance continues across North East London (NEL) and South East London (SEL) 111 teams with calls answered within the 60 second target of 95% for SEL (95%) and NEL (96%), as was the abandonment rate which was within the <5% target. This resulted in a ranking of 1st and 2nd respectively out of all London providers. There was added pressure in October, which was responded to by improved forecasting and resilient staffing.

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
111 / IUC (NEL) - Calls Answered within 60 sec	> 95%	79.9%	98.3%	99.5%	98.7%	98.3%	96.0%	
111 / IUC (SEL) - Calls Answered within 60 sec	> 95%	77.3%	98.3%	99.8%	99.2%	99.0%	95.4%	
111 / IUC (NEL) - Calls Abandoned within 30 sec	< 5%	7.8%	0.1%	0.0%	0.1%	0.0%	0.7%	
111 / IUC (SEL) - Calls Abandoned within 30 sec	< 5%	8.4%	0.2%	0.0%	0.1%	0.0%	2.5%	

- For a more in depth review of performance data please see the Integrated Performance Report (IPR), present within the Board papers.

Workforce

- A revised forecasting model has confirmed the health advisor requirement for FY2020/21 is 263 Whole Time Equivalent (WTE), which will provide roster resilience and accommodates a 20% increase in demand.
- In September, the demand profile changed and pressure increased on 111 due to the return of schools. Additional dynamic response was developed in collaboration between IUC/111 leadership and Forecasting & Planning.
- Work is underway to reduce agency spend by moving agency and managed service staff to the Staff Bank or appoint to substantive positions.
- A strategic workforce plan paper was submitted to Executive Committee and People and Culture Committee, covering the recruitment plans for 111/IUC.


4.2 999 Emergency Operations Centre

Highlights

- A business case for the redevelopment and refurbishment of Bow HQ, has been developed for consideration by the Programme Management Board and Logistics and Infrastructure Committee in November. This is set to create a future-proof operating model for the Bow facility; enabling our staff to work from fit for purpose facilities, ensuring compliance with the Equality Act and providing a secure and safe home for critical IT equipment.

2020/21 Year To Date Performance

- 999 EOC continues to deliver strong levels of performance, with the 999 Mean Call Answering time within the target since May.

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
999 Mean Call Answering Time	< 5 sec	45	0	0	1	2	2	

- For a more in depth review of performance data please see the Integrated Performance Report (IPR), present within the Board papers.

Workforce

- Work is underway to review of roles within the newly proposed Tactical Operations Centre (TOC) to co-locate some core functions and enable release of staff back into critical functions, reducing reliance on overtime spend
- The Business Intelligence and Forecasting team are developing a dynamic base plan to support resourcing in EOC, which will reflect minimum staffing per hour aligned to weekly forecast to ensure relief and overtime staffing is more dynamic and only focusses to shifts with the greatest performance challenge.
- A Strategic Workforce Plan paper was submitted to Executive Committee and People and Culture Committee, covering the recruitment plans for EOC.

5 Ambulance Services

Highlights

- Delivery against our business plan objective to recruit and train c.184 non-registrant Band 4 Associate Ambulance Practitioners (AAP) by the end of March 2021 is well underway with 60 starting training in October. We have received strong interest for the latest recruitment round, with 117 candidates currently awaiting **final interview**.

- The 35 **Third Year Paramedic Students** have successfully completed their training course and are now able to book bank shifts. There is limited capacity within Clinical Education & Standards (CES) to schedule further training courses at weekends – we are following up with CES to explore options.
- To prepare for the Winter pressures all **non-patient facing clinicians** have been contacted to:
 - Inform those who have volunteered to take shifts how to book shifts over December.
 - Check our records to ensure we have an up to date list of non-patient facing clinicians in the event of another period of extreme demand.
- **EPRR Assurance:** All NHS Trust are required to submit a self-assessment against NHS Core Standards for EPRR, provided by the NHS England EPRR team. The LAS response captures our compliance status for 2019/20 as fully compliant.

2020/21 Year To Date Performance

- Performance in Ambulance Services remains favourable, with targets achieved across all categories despite rising levels of demand. The only target missed since May was the Category 4 90th centile in September.
- We have enacted plans that right-sized our resources to demand and better utilises overtime arrangements, to ensure our operations are run efficiently and deliver value for money. For the remainder of FY2020/21 our plan is to maintain a Category 2 mean performance to an average of 16 mins every day, which is still within the national performance targets and supports the wellbeing of our workforce and operational resilience.

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Trend
Category 1 Response - Mean	7 mins	00:07:10	00:05:52	00:05:46	00:05:58	00:06:22	00:06:33	
Category 2 Response - Mean	18 mins	00:23:32	00:08:54	00:09:32	00:11:10	00:14:12	00:16:53	
Category 3 Response - 90th centile	120 mins	01:34:37	00:47:32	00:51:02	01:01:11	01:21:15	01:53:51	
Category 4 Response - 90th centile	180 mins	02:12:07	01:30:16	01:39:54	02:00:01	02:25:10	03:14:14	

- For a more in depth review of performance data please see the Integrated Performance Report (IPR), present within the Board papers.

Workforce

- A Strategic Workforce Plan paper went to Executive Committee and People and Culture Committee, covering the recruitment plans for Ambulance Services.

6 Strategic Assets and Property

6.1 Estates

Highlights

- Statutory compliance figures continue to improve, however the inspection schedule for some areas may result in an apparent decrease in compliance over the course of each reporting period. This is expected to recover before the end of the year as the schedule progresses across all Trust sites.
- At the start of the pandemic, we moved quickly to consolidate the number of Ambulance stations to support operational responsiveness and ensure resilience. Of our 68 Ambulance Stations at the start of 2020, we are now operating from 41. Following a detailed review carried out by the Quality team, no quality impact, incidents or serious incidents related to the station consolidation were reported.

- The department continues to make strong progress with refurbishing and renovating the 41 consolidated sites and the refurbishment of new areas at HQ and Maritime House. As an example of this, 32 sites are receiving new boiler plant equipment, which will reliably provide heating and hot water, in a smaller physical footprint, freeing up space for Operations.
- Critical power works at HQ, St Andrews House and Maritime House continue. The building of the new Uninterruptible Power Supply (UPS) room in HQ has commenced and tenders are being prepared for new generators. St Andrews House UPS project continues however a new UPS room needs to be constructed to house critical equipment, planning permission is currently being sought.
- Work continues to consolidate all our education into two new purpose-built and best-in-class facilities, one in North London and one in South London, by the end of the financial year.
- For a more in depth review of performance data please see the Logistics and Infrastructure Committee (LIC) performance report, present within the Board papers.

Next Steps

- Capital funding has been agreed to continue improvement works at Ambulance Stations.
- Safety and Risk in conjunction with the Quality Assurance Committee continue to monitor compliance, reporting and validating performance through the Quality Report.
- Positive progress has been made in delivering the Trust's estates vision through the Ambulance Operations Modernisation Programme (AOM) to procure and fit out up to 18 brand new operating 'super-hubs' on new sites (and completely redesign and refurbish a small number of our largest existing sites) over the next 3-5 years. The business case for Hub 1 will be presented at the Finance and Infrastructure Committee in November 2020.

6.2 Fleet and Logistics

Highlights

- Throughout September and October, the Fleet and Logistics teams have maintained the deployment of 533 Double Crewed Ambulances (DCA) alongside ensuring the continued and uninterrupted supply of Personal Protective Equipment (PPE), medical consumables, equipment, medical gases and medicines.
- For a more in depth review of performance data please see the Logistics and Infrastructure Committee (LIC) performance report, present within the Board papers.
- A Bunkered Fuel policy has been developed and is currently going through the approval process. This will support the Trust business continuity processes in the face of additional peaks of Covid and EU Exit.

Next Steps

- The Logistics Support Unit (LSU) consultation process has commenced with intended benefits including improved staffing structure, fit-for-purpose roles to ensure we are able to respond to Operational demand and support patient care.
- Following staff feedback relating to equipment that regularly goes missing from Primary Response Bags, a working group has been set up to review the issue with Small High Value Items being absent from vehicles.
- A new PPE Strategy due to COVID-19 was launched by NHS England in September regarding adherence to PPE stock levels and supply chain. The management team is working through the impact on LAS.

- A number of capital schemes have been approved by the Programme Management Board (PMB), and business cases are being developed for delivery by March 2021. Capital investment projects underway include bunkered fuel, routine replacement of DCA's and Resilience & Specialist Assets vehicles, super low floor and reduced emission vehicles, a new Fleet Management System, conversion of DCA chassis and a Drugs Packing Unit to modernise our management of medicines.

7 IM&T

Highlights

- The IM&T directorate continues to progress its people plan to establish a **substantive Senior Management and Infrastructure Team** and reduce reliance on managed service agreements and contract staff. This will help move the directorate toward being a more stable and effective team with the capability to drive improvements in our IT infrastructure.
- Following an extensive period of testing, we have successfully completed the migration of the Computer Aided Dispatch (CAD) hardware to the Ark Datacentres. This relocates CAD into a state-of-the-art off site datacentre, providing reliable hosting for our most business critical system.
- Following the success of the pre-live launch of Electronic Patient Care Record (**ePCR**), training dates for all staff have been rolled out as part of Core Skills Refresher (CSR), which will ensure all clinical staff are proficient at using the new system. The team is responding to the required changes in plans on CSR training as a result of the second lockdown. So far, the 150 active users have successfully processed over 5000 Patient Care Records.
- In advance of the replacement CAD go-live in May 2021, we have worked with other UK Ambulance Services that also use the Cleric CAD system to help us understand any potential changes required to our processes and procedures and to learn from their experience of implementing the system.
- For a more in depth review of performance data please see the Logistics and Infrastructure Committee (LIC) performance report, present within the Board papers.

Next Steps

- Existing **telephony and recording platforms** are being upgraded to a single system and this will include the decommissioning of old systems to ensure consistency across all functions, reducing duplication and building efficiency. This will enable plans to increase clinical staffing in IUC as more clinicians will be able to work remotely
- We are moving forward toward a roll out of NHS mail in mid-November 2020, developing mitigations in line with the second lockdown.
- Outputs from the Data Security & Protection Toolkit (DSPT) audit were reviewed and any quick wins implemented for the 2019-20 submission to increase compliance. The remainder will be progressed for completion as part of the DSPT Cyber Action Plan. The Senior Information Risk Owner (SIRO) has signed off the DSPT Cyber Action Plan, highlighting the gaps. Partial funding has been approved for projects to increase compliance.

8 Programmes and Projects (P&P)

Highlights

- The extended capital programme was agreed at Trust Board in September, and work continues at pace to progress business case development in partnership with Finance and Procurement. The improved financial management is resulting in an increased emphasis on clearly articulating benefits and efficiencies. These will be monitored and tracked, and form part of the Trust-wide approach to benefits realisation.
- In October, a deep dive into the status of each capital project was undertaken to determine the risk to delivery and each project was RAG rated. The preferred approach is to mitigate the 'red' and 'amber' risk projects to bring them on track. Four contingency projects are also being developed in case there is still unused capital available.
- The portfolio now comprises 50 active capital programmes with 28 reporting 'green' and on track, and 18 with 'amber' status and four with 'red' status. Since the last report the resilience CAD project successfully went live, which supports the Trust as we face growing winter pressures. A notable milestone for the ePCR project is that all pre-live users are now live, and more than 5000 electronic Patient Care Records have been created. Within the revenue portfolio, the Digital Human Resources Transformation Programme saw the project to synchronise Electronic Staff Record (ESR) and the Occupational Health system successfully go live. Additionally, the Health & Social Care Network (HSCN) project, which is the new data network project and replaces N3, also went live.

Next Steps

- The capital programme deep dive is being validated with Finance, Procurement, Sponsors, and Programme Managers to ensure the risk adjusted forecast outturn reflects the true position. This will enable PMB to decide whether to activate contingency projects to enable the Trust to meet the planned capital spend. This exercise will be repeated again in December to maximise the capital budget.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Document Title:	Winter Preparedness and COVID Plan			
Agenda Item	8			
Report Author:	Brian Jordan, Deputy Director of Ambulance Services			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	People and Culture Committee 2 November 2020 Quality Assurance Committee 3 November 2020 Executive Committee 11 November 2020			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
<p>This plan provides the strategic overview of the Trust's arrangements for maintaining the effective and continued delivery of urgent and emergency care services during the 2020/21 winter period.</p> <p>The aim of the Winter/Covid-19 Preparedness Plan 2020/21 is to ensure that the people within London who need the LAS receive a timely service, while acknowledging the potential restrictions which may be caused by high demand, increased Covid-19 infection rates and adverse weather throughout the service during winter. There is also an emerging risk of the United Kingdom (UK) leaving the European Union (EU) on 31 December 2020 (when the transition period ends) without a deal which could have an impact on the Trust's business continuity.</p> <p>The Winter/Covid-19 Preparedness Plan 2020/21 builds on earlier learning from the pressures experienced during previous winter periods, as well as the learning from the first wave of Covid-19 earlier this year.</p> <p>As is the consistent theme across LAS plans, the Winter/Covid-19 Preparedness Plan 2020/21 sets out to maintain the optimum levels of service provided to service users across the capital by deploying, when and where necessary, innovative and different solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with the demand for emergency ambulances are at the heart of this plan.</p>				
Recommendations for the Board:				
<ul style="list-style-type: none"> The Trust Board is requested to review the paper as presented and take appropriate assurance 				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		



London Ambulance Service
NHS Trust



Winter/Covid-19 Preparedness Plan 2020/21



London Ambulance Service
NHS Trust

Our vision

Building a world-class ambulance service for a world-class city

London's primary integrator of access to urgent and emergency care

on scene • on phone • online

Our purpose

We exist to:

Provide outstanding care for all of our **patients**

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

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

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

Our values & behaviours

Respectful

Caring for our patients and each other with compassion and empathy

Championing equality and diversity

Acting fairly

Professional

Acting with honesty and integrity

Aspiring to clinical, technical and managerial excellence

Leading by example

Being accountable and outcomes orientated

Innovative

Thinking creatively

Driving value and sustainable change

Harnessing technology and new ways of working

Taking courageous decisions

Collaborative

Listening and learning from each other

Working with partners

Being open and transparent

Building trust

1. Purpose

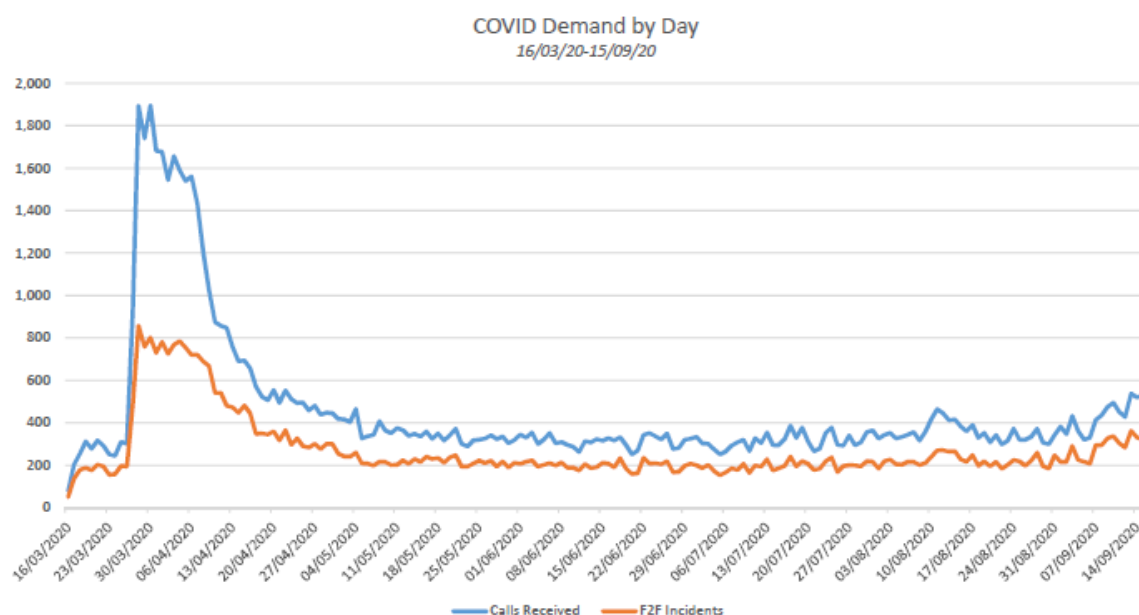
- 1.1 This plan provides the strategic overview of the London Ambulance Service NHS Trust's (LAS) arrangements for maintaining the effective and continued delivery of urgent and emergency care services during the 2020/21 winter period. All Trust support services (including Information Technology, Fleet and Logistics) will have their own supporting operating plans for winter which will be aligned with this over-arching plan.
- 1.2 The aim of the winter/Covid-19 preparedness plan 2020/21 is to ensure that the people within London who need the LAS receive a timely service, while acknowledging the potential restrictions which may be caused by high demand, increased Covid-19 infection rates and adverse weather throughout the service during winter. There is also an emerging risk of the United Kingdom (UK) leaving the European Union (EU) on 31 December 2020 (when the transition period ends) without a deal which could have an impact on the Trust's business continuity.
- 1.3 The winter/Covid-19 preparedness plan 2020/21 builds on earlier learning from the pressures experienced during previous winter periods, as well as the learning from the first wave of Covid-19 earlier this year.
- 1.4 As is the consistent theme across LAS plans, the winter/Covid-19 preparedness plan 2020/21 sets out to maintain the optimum levels of service provided to service users across the capital by deploying, when and where necessary, innovative and different solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with the demand for emergency ambulances are at the heart of this plan.

2. Introduction

- 2.1 This year's Covid-19 pandemic hit London before the rest of the UK which meant that the LAS was at the forefront of responding to this national emergency and had unprecedented demands placed on the Service throughout the period in question. Whilst 111 saw significantly increased demand throughout February (rising to around 300% of normal call volumes), Covid-19 related demand started to have a significant impact on our 999 call handling and ambulance operations from the beginning of March.
- 2.2 999 calls grew from around 5,000 a day to a peak of over 11,000 calls by the end of March and put extreme pressure on control room operations. This was compounded by increasing absence levels over this period due to sickness and the need for staff to self-isolate due to Covid-19 symptoms. By the end of March around 20% of Emergency Operations Centre (EOC) staff were either off sick or in Covid-19 related self-isolation. As a result of this, call handling times became significantly extended with an average call answering time of 3 minutes 20 seconds in March which compared to an average of 7 seconds in March 2019.

- 2.3 In relation to ambulance operations, during the initial 'containment' phase of the Government's response to the pandemic, although numbers of potentially Covid-19 positive patients were still relatively low, vehicles had to be taken fully out of service for deep cleaning after each attendance. This caused our vehicle out of service rate to double to 15% and started to put ambulance operations under significant pressure.
- 2.4 As the country moved from 'containment' into the 'delay' phase of the response, and Covid-19 patient numbers started to increase significantly, the need for road staff to have to 'don and doff' personal protective equipment (PPE), as well as decontaminate vehicles, meant that overall Job Cycle Times (JCT) began to become significantly extended.
- 2.5 This, coupled with similar Covid-19 sickness and self-isolation related absence challenges to those in EOC meant that, although we were able to maintain clinically safe response times for our sickest patients (Category 1 patients) response times for all other categories became significantly extended.
- 2.6 The graph below shows the levels of Covid-19 demand each day since mid-March.

Figure 1: Covid-19 demand by day between 16 March 2020 – 15 September 2020



- 2.7 Immediate and decisive action was taken by the Trust to address the situation with rapid upscaling of the capability and capacity of the organisation to meet the challenge of Covid-19. This enabled us to:
- Significantly increase our call answering capability (in 999 and 111) and put up to 200 additional ambulances on the road every day, an increase of over 50% in 6 weeks.

- Accelerate the 999/111 integration with the support of NHS England (national and regional) at a time when there was significant disruption to healthcare access in primary, secondary and community care.
- Implement a new streamlined operating model, changing our clinical skills mix, sourcing additional ambulances, circa 650 extra road staff, new call taking capacity with over 250 additional call takers and control room staff, transformed operational estate, fleet and logistics operations.
- Closure of nearly half (33) of our ambulance stations necessary to consolidate our operations and enable the flexible deployment of vehicles and staff and efficient operationalisation of internal supply chain management (primarily for PPE).
- Direct access to virtual GP consultations from our ambulance crews and our 111 clinicians, helping to manage patients closer to home.
- Co-design of 20 pathways with Integrated Care Systems (ICSs) to meet the needs of Covid and non-Covid patients.
- New control room and contact centre capacity, utilising space freed up by remote corporate and clinical working.
- New fast-track clinical training methods to enable rapid on-boarding of new and returning staff.
- Provision of temporary accommodation to frontline staff who moved out of their homes to protect shielding family members.
- A Critical Care Transfer Service set up for critical care patients into NHS Nightingale and to support inter hospital transfers.

2.8 As a result of these actions, the LAS was meeting national performance targets every day by 10 April. By the end of April 2020, the Trust had the capacity to handle a future Covid-19 peak of up to 10,000 calls per day (3,000 Covid / 7,000 non-Covid). The actions taken earlier this year, and the ability to manage a future Covid-19 peak of up to 10,000 calls a day, means that the Trust is well prepared to upscale this winter in the event of a second Covid-19 wave.

2.9 The winter period historically causes increased pressure within the health sector for various reasons such as seasonal flu, increased falls and respiratory illnesses which lead to increased admissions to hospitals. Historically, this period also encompasses a number of significant public and social events (such as New Year's Eve) which impact on LAS in terms of road access, large variations in population numbers and alcohol related incidents. It is however likely that these pressures will be reduced to varying degrees given the number of lockdown restrictions currently in place and confirmation from the Mayor in September 2020 that there will be no New Year's Eve event in central London this year.

3. LAS Strategic Intention for Winter 2020/21

3.1 To maintain service delivery through the period of peak winter pressures and a second wave of Covid-19 and ensure that the Trust provides a clinically safe level of service to patients.

3.2 Meeting the national performance standards every day across winter.

- 3.3 To continue to provide safe and effective response and management of major and significant incidents during the winter period.
- 3.4 To react to and manage the challenges faced throughout the winter period e.g. weather changes, flu, Covid-19 and potentially leaving the EU with no deal.
- 3.5 To protect the health and well-being of staff during one of the busiest periods of the year.
- 3.6 To work in partnership with colleagues across the wider health community to mitigate or minimise the impact of identified risks to service delivery throughout winter.
- 3.7 To maintain public and key stakeholder confidence and protect the reputation of the Trust.
- 3.8 To create a comprehensive communication plan for audiences internally, externally, and to the wider public which supports the delivery of the operational plans across the winter period.

4.0 Lessons Learned from Winter 2019/20 and the first wave of Covid-19

- 4.1 The LAS continues to champion a culture of learning and continuous improvement and has carried out a series of reviews to evaluate the Trust's response to Covid-19. There are many examples of good practice outlined within the reviews, with an overwhelming response relating to the way staff worked together, supported each other, and quickly adapted to different ways of working – the way our people worked and responded was felt to be exceptional by all groups. Key learnings from the action reviews have resulted in a number of recommendations and actions being taken forward into this winter, including:
- 4.2 A recognition that the existing Resource Escalation Action Plan (REAP) or Clinical Escalation Safety Plans (CESP) were not designed to operate under prolonged pandemic conditions. The Trust therefore introduced a Covid-19 Response Plan which has three escalation levels based on pre-defined triggers which allow the Trust to rapidly respond to changes in Covid-19 demand (see sections 8.15 – 8.17 and appendix 7 for further details).
- 4.3 Maintain the processes to rapidly increase frontline staffing resource in case of demand surge, via access to existing bank staff, external volunteers and utilising the redeployment of internal staff more effectively (see section 14 for further details).
- 4.4 Methods of communication such as Facebook Live and Microsoft Teams were important and extremely useful additions/change to modified ways of working. The launch of LAS TV Live (previously Facebook Live) has allowed a much stronger and responsive communication channel to open between LAS senior leaders and the wider workforce. It has been particularly effective as a channel

because of guidance regarding social distancing and the accessibility to those in stations and those working at home or at other locations.

- 4.5 Building resilience of the Logistics Supply Unit to enable responsive inventory management and supply chain processes able to meet elevated levels of demand, specifically relating to FIT testing and the availability of PPE (see sections 15.4 – 15.6 for further details).
- 4.6 The establishment of a Wellbeing Hub which is able to provide all LAS staff members with access to required health and wellbeing resources in times of both operational normality and demand surges (see section 17 for further details).
- 4.7 The Covid-19 Operational Leadership Team (COLT) was launched to enable responsive decision-making and leadership capability, bringing together executives and other senior leaders from across the Trust. This has been effective in allowing rapid escalation and management of issues. COLT has recently morphed into a Daily Senior Leadership Team meeting (DSLTL) using similar principles but with expanded focus on other non-Covid-19 specific issues.

5. Forecast Activity and Performance over Winter 2020/21

- 5.1 The forecasted weekly call volume between October 2020 and March 2021 is shown in Figure 2. In 2019/20 there was an increase in call activity related to Covid-19 in March and April which is reflected.

Figure 2: 2019/20 daily call actuals and 2020/21 forecast (October to March)

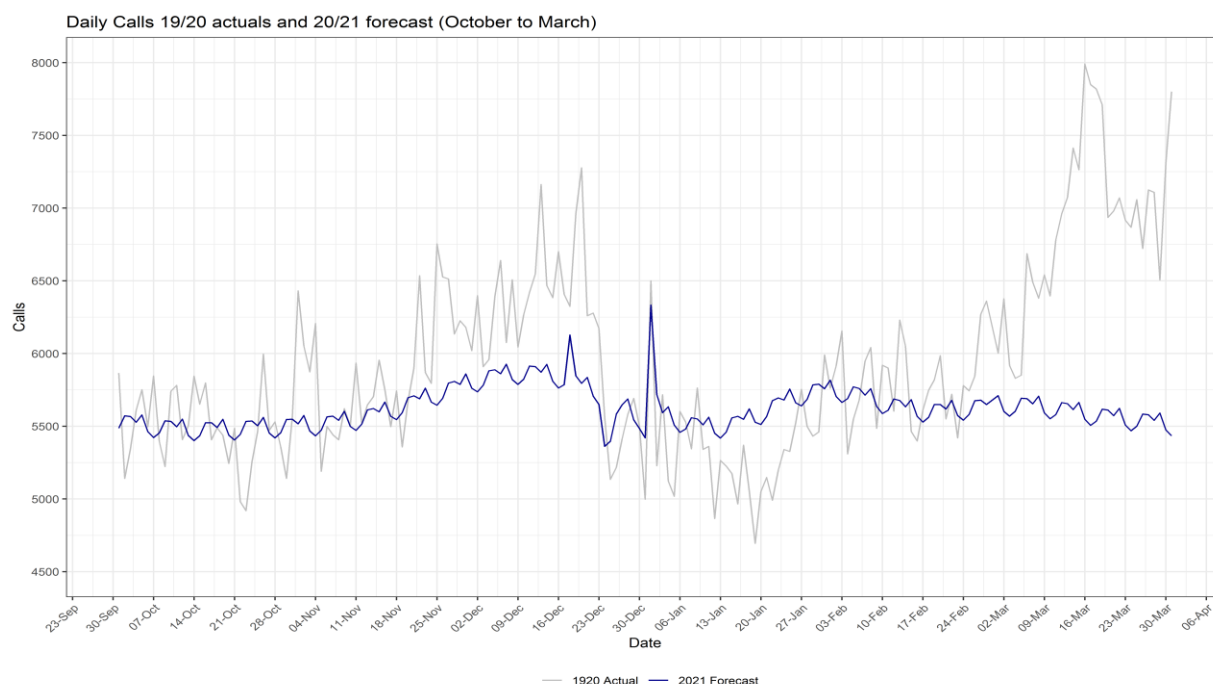
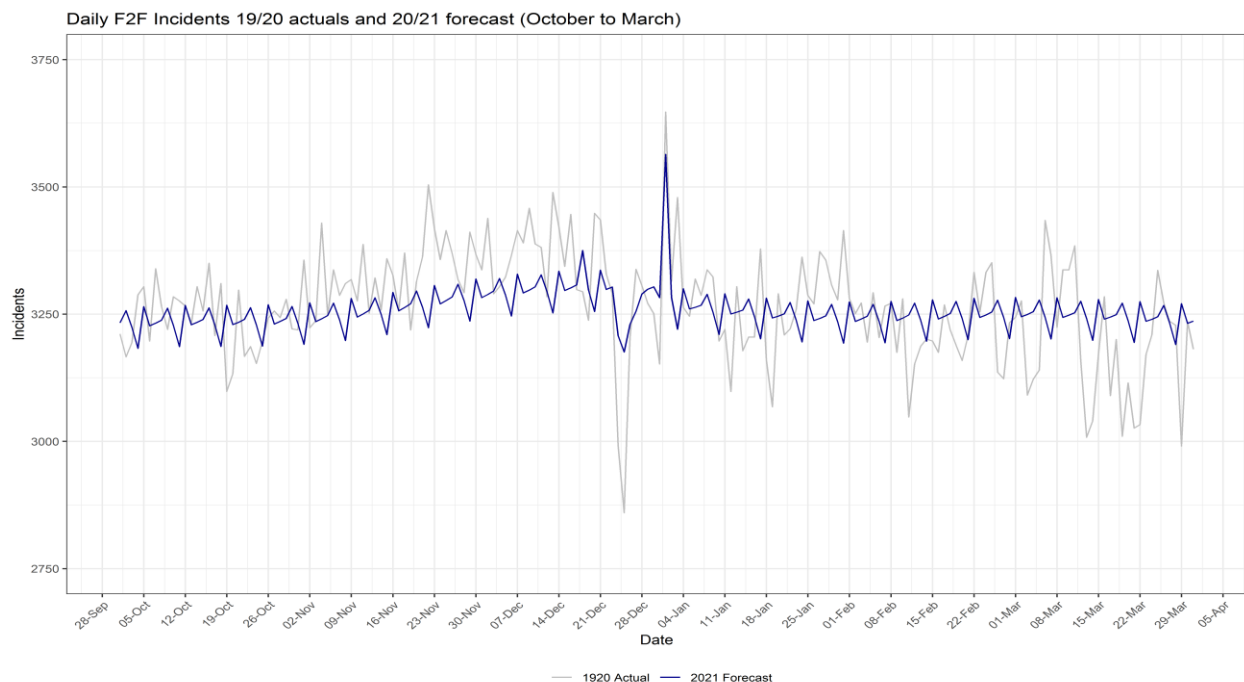


Figure 3: 2019/20 daily incident actuals and 2020/21 forecast (October to March)



5.2 Figures 2 and 3 show a lower level of activity throughout November and December compared to last year. The weekly and hourly activity profile change is showing that LAS will see the most change at weekends (5% less activity) while the start of the week, particularly Mondays, will see a 5% activity increase. Overall we are forecasting 5% less 999 calls over winter and 1,000 fewer contacts on peak days.

5.3 Covid-19 has affected our activity levels directly through sickness and indirectly through lockdown restrictions and changes to daily London life. These changes have been accounted for in the winter activity forecast through:

- Generally lower activity because of tier 2 (the level in place at the time of finalising this plan) restrictions which are limiting social events and reducing footfall into London for work. The London Resilience Forum has published statistics which show that only 6% of those who were travelling into and around London pre-Covid-19 are currently doing so. This is backed by reports that Transport for London's fare revenue has dropped by 90%.
- Our December seasonality forecast is reduced due to fewer festive events being planned such as office Christmas parties, Christmas shopping, and other festive events such as Winter Wonderland and the cancellation of the central London New Year's Eve event.
- Local authorities are developing plans to rehome circa 900 homeless people in London as part of winter/Covid-19 preparation plans.

5.4 The LAS has forecasted the daily 999 call and incident rates between November 2020 and March 2021. ***The tables which follow show the days with the highest activity in red (darker red as demand increases) while blue identifies the days with the lowest activity (darker blue as demand***

decreases). Reflecting previous years, the busiest days are forecasted to be the Fridays and Saturdays in December as well as New Year's Eve and New Year's Day. Additionally, Mondays are also expected to have a high number of incidents. It is important to note that the forecasted activity levels presented are a high-level initial forecast and will be refreshed as we move closer to the dates.

Figure 4: Forecasted number of EOC contacts by day (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	38499	5561	5452	5419	5456	5546	5548	5516
08/11/2020	38619	5574	5466	5434	5472	5565	5569	5540
15/11/2020	38918	5602	5499	5471	5514	5612	5622	5598
22/11/2020	39467	5666	5568	5545	5593	5696	5709	5689
29/11/2020	40155	5761	5666	5644	5693	5796	5808	5788
06/12/2020	40767	5859	5762	5737	5781	5880	5887	5861
13/12/2020	41054	5926	5822	5788	5824	5913	5910	5872
20/12/2020	41050	5926	5809	5763	5785	6126	5846	5795
27/12/2020	39180	5836	5706	5649	5361	5397	5584	5646
03/01/2021	39775	5687	5544	5484	5419	6332	5717	5593
10/01/2021	38697	5633	5508	5458	5481	5559	5550	5510
17/01/2021	38563	5562	5451	5418	5459	5557	5568	5548
24/01/2021	39275	5620	5528	5512	5566	5676	5695	5680
31/01/2021	40071	5755	5661	5639	5685	5783	5788	5758
07/02/2021	40116	5816	5704	5663	5690	5770	5759	5713
14/02/2021	39587	5758	5636	5587	5609	5687	5676	5633
21/02/2021	39255	5683	5567	5528	5561	5649	5649	5618
28/02/2021	39376	5678	5572	5541	5581	5675	5679	5649
07/03/2021	39522	5710	5603	5569	5604	5693	5690	5653
14/03/2021	39361	5707	5592	5551	5580	5662	5655	5614
21/03/2021	39051	5664	5547	5505	5534	5617	5611	5572
28/03/2021	38803	5623	5509	5469	5499	5584	5579	5540

Figure 5: Forecasted number of incidents by day (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	22663	3268	3231	3236	3242	3265	3232	3191
08/11/2020	22704	3272	3235	3241	3247	3271	3239	3198
15/11/2020	22774	3281	3244	3250	3257	3282	3250	3210
22/11/2020	22864	3293	3256	3263	3270	3295	3263	3223
29/11/2020	22958	3306	3270	3277	3284	3309	3277	3236
06/12/2020	23039	3319	3282	3289	3295	3320	3287	3246
13/12/2020	23094	3329	3291	3297	3303	3327	3294	3253
20/12/2020	23167	3334	3297	3302	3307	3375	3297	3255
27/12/2020	22807	3336	3298	3303	3208	3175	3230	3256
03/01/2021	23241	3290	3299	3303	3282	3564	3283	3220

10/01/2021	22844	3300	3260	3263	3267	3289	3254	3210
17/01/2021	22778	3290	3250	3254	3258	3280	3245	3202
24/01/2021	22727	3281	3242	3246	3251	3273	3238	3195
31/01/2021	22698	3276	3237	3241	3247	3269	3235	3193
07/02/2021	22694	3274	3236	3240	3246	3269	3235	3194
14/02/2021	22709	3275	3237	3242	3248	3272	3238	3197
21/02/2021	22732	3278	3240	3246	3252	3275	3241	3200
28/02/2021	22750	3281	3243	3248	3254	3277	3244	3202
07/03/2021	22754	3283	3245	3249	3255	3278	3244	3201
14/03/2021	22741	3282	3244	3248	3253	3275	3241	3198
21/03/2021	22715	3279	3240	3244	3249	3271	3237	3194
28/03/2021	22685	3275	3236	3240	3245	3267	3233	3190

Figure 6: Forecasted number of Category 1 incidents by day (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	2266	327	323	324	324	326	323	319
08/11/2020	2270	327	324	324	325	327	324	320
15/11/2020	2277	328	324	325	326	328	325	321
22/11/2020	2286	329	326	326	327	330	326	322
29/11/2020	2296	331	327	328	328	331	328	324
06/12/2020	2304	332	328	329	330	332	329	325
13/12/2020	2309	333	329	330	330	333	329	325
20/12/2020	2317	333	330	330	331	337	330	326
27/12/2020	2281	334	330	330	321	318	323	326
03/01/2021	2324	329	330	330	328	356	328	322
10/01/2021	2284	330	326	326	327	329	325	321
17/01/2021	2278	329	325	325	326	328	324	320
24/01/2021	2273	328	324	325	325	327	324	320
31/01/2021	2270	328	324	324	325	327	324	319
07/02/2021	2269	327	324	324	325	327	324	319
14/02/2021	2271	327	324	324	325	327	324	320
21/02/2021	2273	328	324	325	325	327	324	320
28/02/2021	2275	328	324	325	325	328	324	320
07/03/2021	2275	328	324	325	325	328	324	320
14/03/2021	2274	328	324	325	325	328	324	320
21/03/2021	2271	328	324	324	325	327	324	319
28/03/2021	2268	327	324	324	324	327	323	319

Figure 7: Forecasted number of Category 2 incidents by day (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	13825	1994	1971	1974	1977	1992	1971	1946

08/11/2020	13849	1996	1973	1977	1981	1996	1976	1951
15/11/2020	13892	2001	1979	1983	1987	2002	1982	1958
22/11/2020	13947	2008	1986	1990	1995	2010	1991	1966
29/11/2020	14005	2017	1995	1999	2003	2018	1999	1974
06/12/2020	14054	2025	2002	2006	2010	2025	2005	1980
13/12/2020	14087	2030	2008	2011	2015	2030	2009	1984
20/12/2020	14132	2034	2011	2014	2018	2059	2011	1986
27/12/2020	13912	2035	2012	2015	1957	1937	1970	1986
03/01/2021	14177	2007	2012	2015	2002	2174	2002	1964
10/01/2021	13935	2013	1989	1991	1993	2006	1985	1958
17/01/2021	13895	2007	1983	1985	1987	2001	1979	1953
24/01/2021	13863	2002	1978	1980	1983	1996	1975	1949
31/01/2021	13846	1998	1975	1977	1980	1994	1973	1948
07/02/2021	13843	1997	1974	1977	1980	1994	1974	1948
14/02/2021	13852	1998	1975	1978	1981	1996	1975	1950
21/02/2021	13866	2000	1977	1980	1983	1998	1977	1952
28/02/2021	13877	2002	1979	1982	1985	1999	1979	1953
07/03/2021	13880	2002	1979	1982	1985	1999	1979	1953
14/03/2021	13872	2002	1979	1981	1984	1998	1977	1951
21/03/2021	13856	2000	1977	1979	1982	1996	1975	1948
28/03/2021	13838	1997	1974	1976	1979	1993	1972	1946

6. Integrated Urgent Care Demand over Winter 2020/21

- 6.1 The Trust provides Integrated Urgent Care (IUC) services in North East London (NEL) and South East London (SEL) which covers approximately 40% of the population of London.
- 6.2 Demand on the IUC services will increase over the winter period as other services become unavailable at key festive periods (for example GP services) and therefore detailed demand profiles have been drawn up based on historical trends. In addition, prevailing call volumes are taken into account to provide assurance that forecasts are accurate.
- 6.3 Reflecting previous years, the busiest days are forecasted to be the Saturdays and Sundays over the winter period as well as Boxing Day and New Year's Day. The following tables show the expected call demand over the winter period between November 2020 and March 2021.

Figure 8: Forecasted number of calls by day at NEL (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	11897	1856	1616	1585	1631	1586	1966	1657
08/11/2020	11960	1869	1615	1601	1631	1598	1974	1672
15/11/2020	12047	1882	1628	1612	1646	1611	1986	1682
22/11/2020	12132	1885	1644	1614	1663	1627	2000	1699

29/11/2020	12251	1902	1662	1636	1671	1645	2019	1716
06/12/2020	12391	1929	1672	1659	1697	1658	2041	1735
13/12/2020	12560	1942	1701	1672	1725	1688	2069	1763
20/12/2020	12717	1974	1718	1706	1744	1690	2095	1790
27/12/2020	13047	1995	1753	1738	1773	1657	2313	1818
03/01/2021	13924	2204	1785	1758	1781	2057	2383	1956
10/01/2021	13920	2155	1906	1887	1912	1867	2245	1948
17/01/2021	13885	2147	1898	1880	1904	1877	2240	1939
24/01/2021	13824	2138	1889	1869	1896	1867	2231	1934
31/01/2021	13787	2127	1883	1863	1902	1860	2225	1927
07/02/2021	13730	2119	1874	1854	1895	1850	2219	1919
14/02/2021	13686	2125	1865	1846	1883	1843	2211	1913
21/02/2021	13612	2116	1854	1834	1875	1833	2199	1901
28/02/2021	13564	2105	1863	1824	1865	1823	2190	1894
07/03/2021	13487	2093	1850	1816	1851	1811	2182	1884
14/03/2021	13408	2081	1836	1802	1841	1800	2172	1876
21/03/2021	13331	2069	1825	1804	1826	1786	2159	1862
28/03/2021	13282	2069	1813	1789	1826	1788	2147	1850

Figure 9: Forecasted number of calls by day at SEL (November 2020 to March 2021)

W/Ending	Weekly Total	Mon	Tue	Wed	Thu	Fri	Sat	Sun
01/11/2020	9650	1442	1254	1269	1229	1260	1762	1434
08/11/2020	9713	1453	1267	1276	1237	1266	1772	1442
15/11/2020	9783	1461	1275	1286	1248	1279	1782	1452
22/11/2020	9872	1476	1289	1300	1259	1288	1795	1465
29/11/2020	9981	1492	1304	1314	1276	1303	1811	1481
06/12/2020	10118	1511	1321	1334	1293	1327	1832	1500
13/12/2020	10280	1534	1343	1359	1319	1351	1853	1521
20/12/2020	10452	1558	1371	1383	1344	1354	1881	1561
27/12/2020	10788	1587	1395	1412	1389	1324	2094	1587
03/01/2021	11661	1789	1424	1439	1383	1721	2181	1724
10/01/2021	11673	1739	1545	1558	1524	1549	2037	1721
17/01/2021	11620	1728	1538	1549	1515	1542	2031	1717
24/01/2021	11573	1723	1532	1543	1513	1535	2023	1704
31/01/2021	11512	1718	1527	1537	1504	1528	2016	1682
07/02/2021	11461	1711	1518	1530	1496	1523	2008	1675
14/02/2021	11398	1701	1508	1521	1490	1513	2000	1665
21/02/2021	11348	1692	1500	1513	1480	1508	1994	1661
28/02/2021	11295	1685	1493	1506	1472	1498	1987	1654
07/03/2021	11228	1676	1484	1498	1463	1488	1975	1644
14/03/2021	11147	1665	1476	1486	1454	1465	1965	1636
21/03/2021	11073	1653	1466	1476	1444	1453	1956	1625

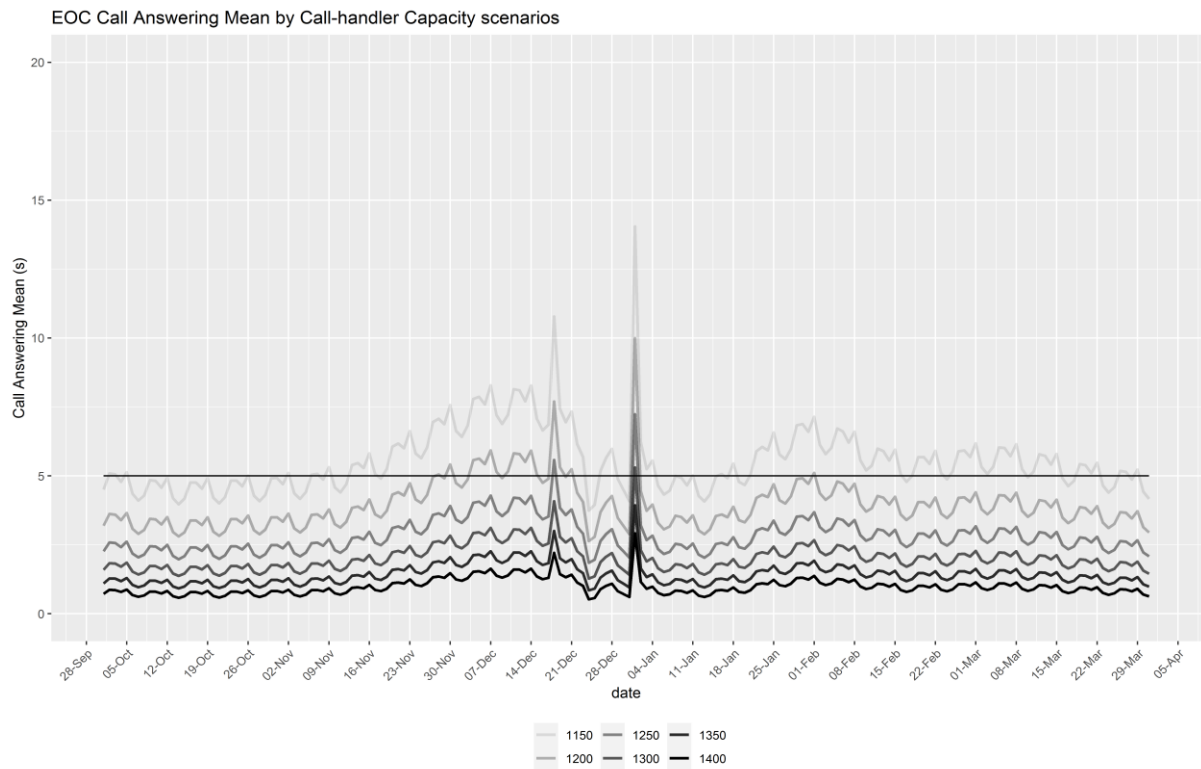
7. Predicted Daily Performance

- 7.1 At the time of preparing this plan, the Trust's 999 performance year-to-date against the Category 1 mean and 90th centile are both within the required timescales which demonstrates that the Trust's most critical patients are being responded to quickly. The Trust has been consistently ranked as one of the top performing ambulance trusts in the country.
- 7.2 This winter, the Trust is planning to provide staffing levels across its EOC and ambulance operations to deliver the following performance outturn against our forecasted demand on each day over the winter period:

Category	Performance Outturn each day
999 mean call answer	5 seconds
Category 1 mean	6 minutes, 15 seconds
Category 2 mean	16 minutes
Category 2 90 th centile	29 minutes, 16 seconds
Category 3 90 th centile	1 hour, 35 minutes
Category 4 90 th centile	2 hours, 43 minutes

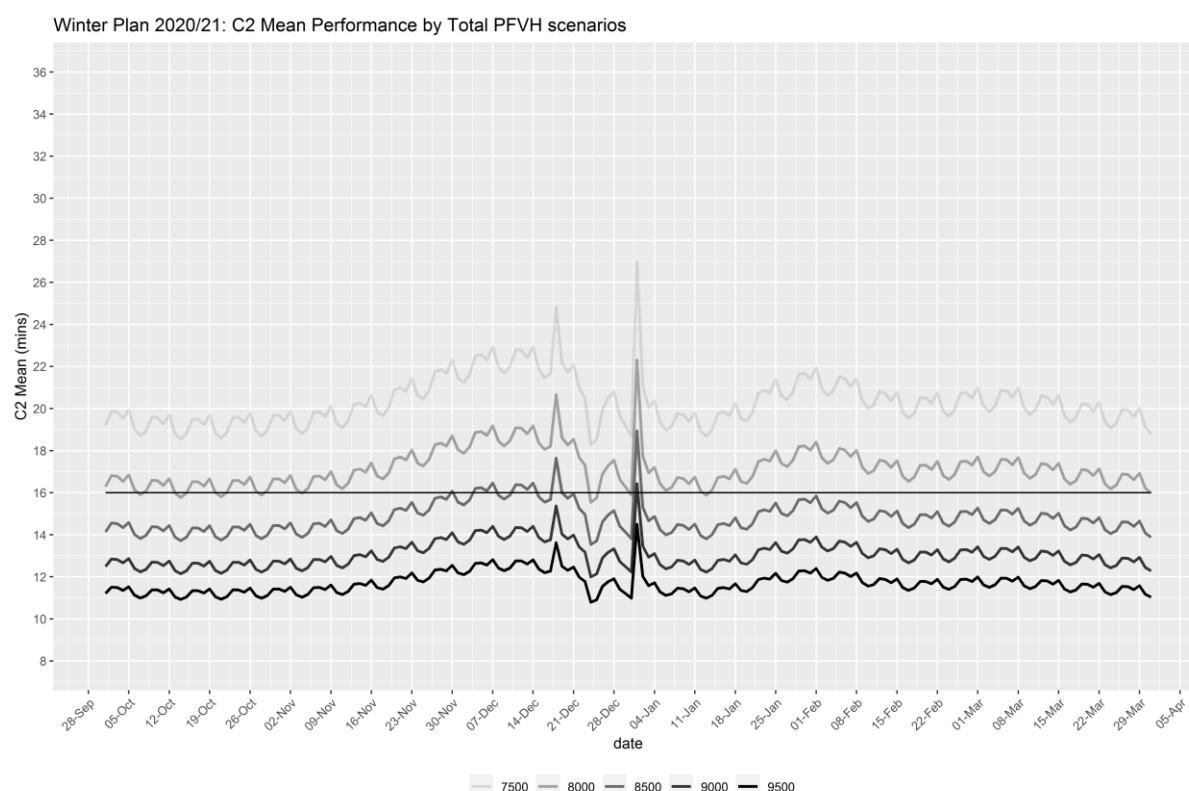
- 7.3 In terms of our 999 mean call answer, Figure 10 below shows how we have modelled our ability to deliver a 999 mean call answer of 5 seconds every day based on the numbers of 999 call handler hours we are planning to resource. We know that, depending on the different levels of demand which we have forecasted each day, we will need to resource approximately 1,200 call handler hours per day over the winter period. More detail on our plans to do this follow in section 14 (Capacity Management Strategies).

Figure 10: 999 mean call answer performance by call handler capacity scenarios



7.4 In terms of our Category 2 mean, Figure 11 below shows how we have modelled our ability to deliver a Category 2 mean of 16 minutes every day based on the numbers of patient facing vehicle hours we are planning to resource. We know that, depending on the different levels of demand which we have forecasted each day, we will need to resource approximately 8,500 patient facing vehicle hours per day over the winter period. More detail on our plans to do this follow in section 14 (Capacity Management Strategies).

Figure 11: Category 2 performance by total patient facing vehicle hours scenarios



7.5 Further demand forecasting is being undertaken to assist in the development of hourly resource and staffing plans at peak periods and to assist in providing the wider health community with intelligence of predicted ambulance arrival volumes and distributions at hospital emergency departments. Additionally, short term (two week ahead) daily and hourly forecasts – taking into account recent trends and fluctuations in demand – will be provided to the Trust’s 111, 999 and ambulance operations teams throughout the winter period in order to support dynamic decision making during evolving winter pressures.

7.6 In terms of the 111/IUC services, rostering for IUC is completed on a four week cycle and therefore, as the staffing picture improves, the performance forecast will improve. This position is monitored regularly with commissioners and the most accurate performance forecast will be available closer to the actual dates.

8. Demand Management Strategies

8.1 LAS operates with a 24 hour, 7 day a week command and co-ordination structure in place, with a Tactical Commander (Trust Silver) on duty 24 hours a day managing core delivery for the LAS. Over the winter period, the Trust will maintain the strategic, tactical and operational command structure in line with London Emergency Services Liaison Panel Manual / Joint Emergency Services Interoperability Principles.

8.2 Normal command and control procedures will apply during the winter period. A Strategic Commander (Trust Gold) will assume the position of the Trust’s

Strategic Commander on call and co-ordinate the Trust's actions during major and significant incidents. The on-duty Incident & Delivery Manager (IDM) will act as the Tactical Commander (Trust Silver) and will be based at Waterloo Headquarters or Devon's Road, Bow. If required, the on-call Tactical Commander (Trust Silver) will be recalled to take over the command of specific incidents to allow the IDM to return to managing business as usual.

- 8.3 Teleconferences will be held every four hours during the winter period to monitor the level of demand, resource availability and consider any mitigating actions. These conferences will be called by the on duty IDM.
- 8.4 An LAS Tactical Operations Centre (TOC) was first introduced during winter 2018/19 in order to support the IDMs with the management of system capacity issues and delayed handovers at hospitals. This arrangement has operated successfully at a tactical level and will therefore continue this year, flexing its size and drawing specialist staff from across the organisation to support the management of increased demand. The TOC will operate 24/7 and will be the single point of contact to escalate issues from partners within the LAS. Additionally the TOC will have clear lines of escalation internally to the wider London health system.
- 8.5 Increased mobile operational management support will also be implemented during the peak winter period to assist in the management of any delayed hospital handovers and to provide appropriate welfare monitoring for staff during what will be a period of increased activity. These extra managers will operate across the full 24 hour period.

Clinical Safety Escalation Plan (CSEP)

- 8.6 The two 999 and 111/Integrated Urgent Care (IUC) clinical safety escalation plans will be reviewed and refreshed, and signed off by the Chief Operating Officer and the Chief Medical Officer, ahead of December 2020 and ratified through the Trust's governance processes.
- 8.7 The safety escalation plans provide a demand management framework for managers to use in periods of high pressure. Implementation of these plans ensures that the sickest patients are responded to in the quickest way and provides the safest possible management of all patients.
- 8.8 Prior to implementation of any safety escalation reviews across the whole operation (999 and 111/IUC), LAS will undertake safety reviews on a continuous basis at times of peak demand in order to maintain safety and to help inform any formal decisions to invoke surge arrangements.
- 8.9 Surge escalation in 999 will look to maximise resource availability for face to face and hear and treat contacts while surge escalation in 111/IUC will be through internal call balancing initially between NEL and SEL, then through pan-London call balancing and then at a national level.

Resource Escalation Action Plan (REAP)

- 8.10 All ambulance service providers (as Category 1 responders) must ensure that they embrace best practice national guidance. The REAP plan provides a consistent and co-ordinated approach to the management of ambulance trusts during times of pressure/excessive demand.
- 8.11 In the current REAP structure, there are four levels of escalation which aim to aid ambulance services to integrate into the wider NHS surge/escalation framework. These levels are used to determine what actions are necessary to protect core services and supply the best possible level of service with the resources available. REAP is reported nationally as well as utilised within the Trust to guide escalation planning.
- 8.12 REAP is designed to 'be informed' by any disruptive challenges and 'to inform' internally and to the wider NHS/other partner agencies of the pressures facing the organisation. The considerations and actions contained within the REAP are designed to assist in protecting staff, patients and the organisation and should be viewed as guidance in challenging situations.
- 8.13 REAP triggers are formally reviewed on a weekly basis at LAS's Performance Group meeting – and at the Winter Planning Group between December and January – and are escalated as appropriate. REAP can, however, be reviewed by the on-call Strategic Commander at any time in order to ensure that the Service can mobilise more frontline resource should the need be identified outside of the weekly review.

Covid-19 Response Plan

- 8.14 It was recognised during the first wave of Covid-19 that neither the existing REAP or CSEP plans were designed to operate under prolonged pandemic conditions, therefore the Trust has introduced a specific Covid-19 Response Plan.
- 8.15 As shown in Figure 1 (page 4), Covid-19 demand has decreased over the summer months however we are starting to see the early signs of a second wave. Staffing resource rapidly increased over March and April to meet the first wave of demand and, with organisational performance stable at the time of writing this plan, we now need to ensure we are using our resource efficiently whilst also retaining capacity to respond to a second surge. This requires a good understanding of our escalation plans for a co-ordinated Covid-19 response and the trigger points which would cause us to move through these levels. We also need to plan for the levels of resource we need in order to deliver national performance standards under different demand scenarios and how quickly we can activate our surge resources.
- 8.16 There are pre-defined triggers to allow the Trust to rapidly respond to changes in Covid-19 demand. Each escalation stage will activate a series of actions to be undertaken by the Trust to prepare for changes in demand (the detailed actions can be viewed on slide 7 of the Covid-19 Response Plan attached at

appendix 7). Demand will be tracked carefully so the Trust can proactively prepare capacity increases. The decision to move between levels is made by DSLT/COLT. The three escalation levels and the triggers to move levels are as follows:

Covid Level	Description of level	Trigger to move levels
GREEN	Aim to manage expected levels of demand as business as usual with the new flexible resource base	There is limited Covid activity in London or Covid is contained within isolated groups. There are no immediately foreseeable risks of uncontrolled Covid returning to the general population in London
AMBER	Aim to manage expected levels of demand plus an agreed uplift to allow capacity in the resource plan to cope with the beginning of a surge and plan flexibly for known expected spikes	There are uncontained cases of Covid in the general population in London, including localised outbreaks and overall Covid demand is not significantly increasing and remains circa 1200 - 1500 Covid related calls per day into 999/ 111 system.
RED	Aim to manage continued surge levels of demand	There are uncontained cases of Covid in the general population in London, with either significant increases or over 1,500 Covid related calls per day into 999/111 (or both)

9. Integration of 999 and 111

- 9.1 During winter 2020/21, the 111/IUCs will maintain a high level of enhanced assessment to minimise the numbers of calls passed for ambulance response and to emergency departments. The 111/IUCs will proactively look to provide self-care advice (where appropriate) to minimise pressure within the rest of the London health system. Collaborative working will take place between NEL and SEL to ensure that both call answering and clinical staffing is maximised to meet demand.
- 9.2 The clinical hub and clinical assessment services (CASs) are key components of the 'hear and treat', 'hear and refer' and clinical advice process provided by LAS and so staffing will be closely monitored over winter to ensure there is sufficient capacity. There will be a dedicated clinician in the clinical hub to maintain the safety of held calls pan-London including Category 2, Category 3 and Inter Hospital Transfer (IHT)/Health Care Professional (HCP) patients. This will ensure that patients receive the right clinical response in the right timeframe.
- 9.3 The clinical hub will be operating from three additional locations this winter: Barking, Croydon and Pinner. Having these additional sites will help us to secure additional staffing at times of peak demand.
- 9.4 The Director of Integrated Patient Care will be responsible for the delivery of high-quality integrated care services by bringing together the current 999 emergency and 111/IUC call handling and clinical triage services including all call centre, control and despatch operations within the Service. This is supporting LAS to deliver a more collaborative approach between the 999 and 111 functions and enable us to review co-location and joint working in order to manage queues in both 999 and 111.

9.5 Opportunities have been identified ahead of winter which will enable a closer link between the clinical assessment services and the clinical hub with the aim of preventing duplication of work while improving the patient journey. These include:

- 85% of ambulance requests from pan-London 111 services will be validated prior to the request being sent to the LAS. This will ensure that the requests for ambulances are agreed prior to the request being made. In addition, the clinical hub will focus on any calls from 111 services which have not yet been validated in order to minimise unnecessary ambulance dispatch.
- An enhanced number of 999 calls will be identified for transfer to 111 clinical assessment services so that the clinical hub can focus on higher acuity patients.
- The clinical hub will have direct access to booking GP appointments as well as bookings into urgent treatment centres and emergency departments.
- Extending the use of the 111 *5 function will support frontline ambulance clinicians to access direct bookings to non-emergency department services from scene (via a 111 Health Advisor) which increases and speeds up referrals to appropriate care pathways and reduces ambulance on scene times.
- Clinicians in the clinical assessment services will be able to work remotely from home which allows for greater flexibility and responsiveness in times of peak demand.
- Clinical hub satellite desks will be based at SEL and NEL 111 sites working alongside 111/IUC clinicians.
- Video conferencing functionality will be in use in the clinical hub and the clinical assessment services to enhance assessment capability.

10. Primary and Community Care Partnership Working

10.1 The five London LAS sectors will liaise with local networks and stakeholders to ensure appropriate management plans are implemented for patients who frequently access the health system via the ambulance service.

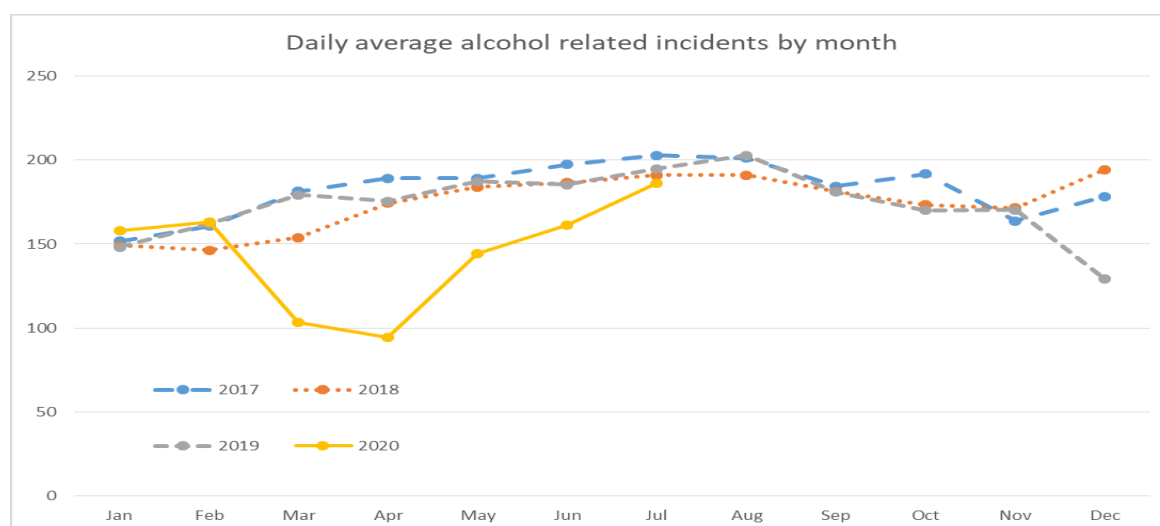
10.2 A review of local directories of services will also be required ahead of winter due to the protracted festive period and the potential impact on accessing community based services by both patients and ambulance clinicians at the scene of an incident. Any reduction in the accessibility to such pathways will have a significant impact on ambulance availability due to increased job cycle time from arranging access to remaining pathways or because of an increased number of patients being transported to hospital due to alternative care pathways (ACPs) not being available.

10.3 Sector based teams will be liaising with local emergency/urgent care networks and ICSs to ensure appropriate contingency plans are being implemented across winter and especially during the peak festive / public holiday period to ensure access to primary care and ACPs.

11. Alcohol Related Incidents

- 11.1 The graph in Figure 15 below shows the daily average number of alcohol incidents which the LAS has attended by month across the financial year. Alcohol incidents from April to July 2020 have shown a substantial decrease which is related to pub closures and the impact of lockdown. The month of August historically sees one of the highest daily averages for alcohol related incidents, with December also seeing a large number of incidents.

Figure 12: Daily average alcohol related incidents (2017-2020)



- 11.2 LAS will share alcohol consumption advice with Londoners during December as well as supporting and contributing to national and regional public health campaigns and messaging from partner agencies during winter 2020/21 where appropriate. The Trust will also support demand management by encouraging patients to choose the most appropriate NHS service with the aim to ensure that members of the public stay well over winter and receive the right treatment at the right place.

12. Winter Communications

- 12.1 LAS will continue to explore further opportunities to help manage operational demand through our media, campaigns and social media while continuing to support staff winter wellbeing initiatives, using a variety of external and internal communications channels. We will actively promote the benefits of flu vaccination, both to our own staff and to vulnerable and older people in the community. There will be a focus on the impact that winter pressures can have on the service and managing public and staff expectations. In this exceptional year, we will also be prepared for the possibility of the usual winter pressures coinciding with a second wave of Covid-19 infections, and will be ready to scale up our messaging around demand management, winter wellbeing and infection prevention advice as needed.

- 12.2 LAS will be actively signposting to the online NHS 111 resource at www.111.nhs.uk in a bid to reduce call volumes by allowing the public to get the right advice and treatment.

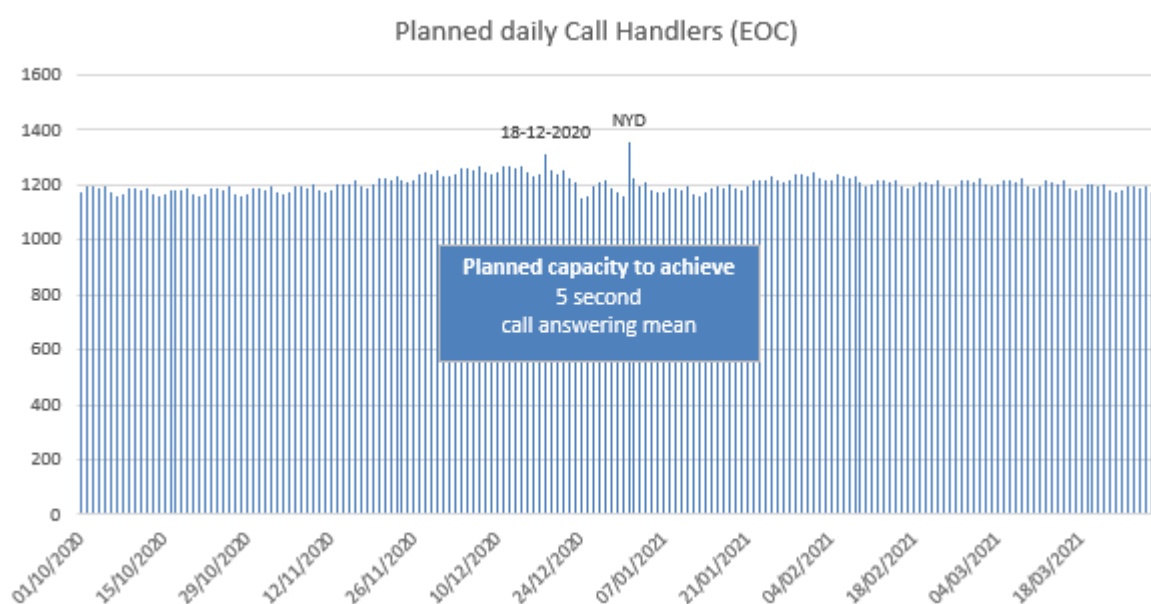
13. Public Events in London

- 13.1 London traditionally hosts a number of public events over the winter period. Remembrance Sunday (November), the Lord Mayor's Show (November), New Year's Eve and the New Year Day Parade are just a few of the well-known events that take place. Given the national measures in place to manage Covid-19, the Mayor confirmed in September 2020 that there will be no New Year's Eve event in central London this year and other public events may be cancelled, reduced in volume, prominence or move out into smaller more spread out events. This will require a resilient and more flexible approach from the LAS in terms of preparedness and staffing.
- 13.2 Emergency Planning and Resilience Officers (EPROs) are developing individual plans for remaining events. The scope, scale and resource implications will be considered as part of the overarching winter planning work.

14. Capacity Management Strategies

- 14.1 The LAS is planning to deliver a 5 second call answer mean each day over winter based on its current demand forecasts. Figure 13 below shows that, based on the current demand forecasts, the Trust will be planning to resource an average of 1,200 999 call handler hours a day in order to achieve this performance outturn.

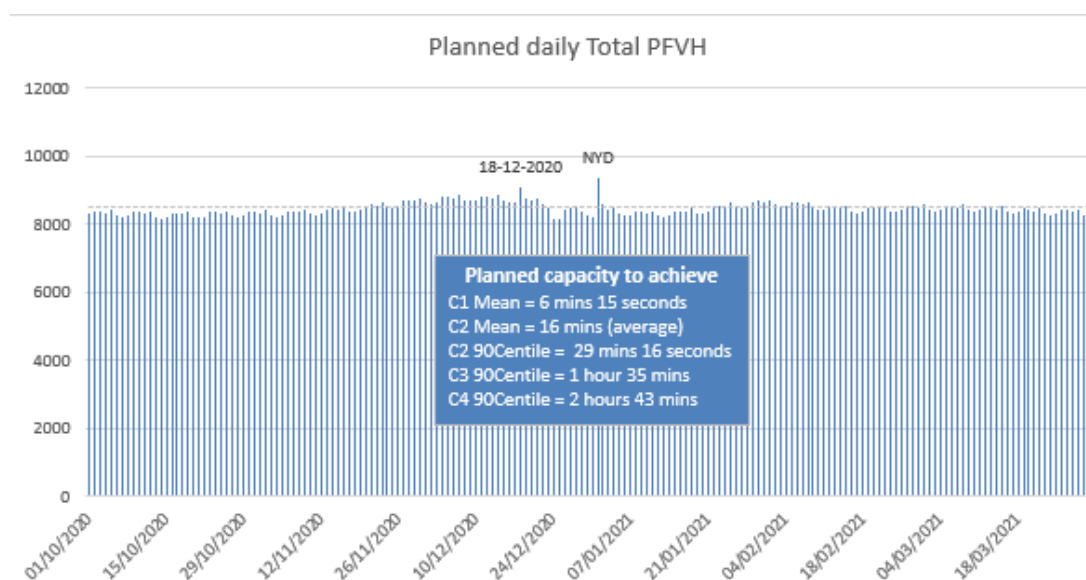
Figure 13: Planned daily total EOC call handling hours October 2020 – March 2021



- 14.2 In terms of our response to face to face patient incidents, the Trust is planning to deliver a 6 minutes, 15 seconds Category 1 mean and a 16 minute Category

2 mean each day over winter based on its current demand forecasts. Figure 14 below shows that, based on the current demand forecasts, the Trust will be planning to resource an average 8,500 patient facing vehicle hours a day in order to achieve these performance outturns.

Figure 14: Planned daily total patient facing vehicle hours October 2020 – March 2021



14.3 At the LAS NEL and SEL IUCs, we are planning to answer 95% of calls within 5 seconds each day over winter based on current demand forecasts. Figure 15 below shows that, based on the current demand forecasts, the Trust will be planning to resource between an average of 450 – 600 NEL call handler hours a day, and an average of 400 – 575 SEL call handler hours a day, in order to achieve this performance outturn.

Figure 15: Planned daily total call handling hours in NEL October 2020 – March 2021

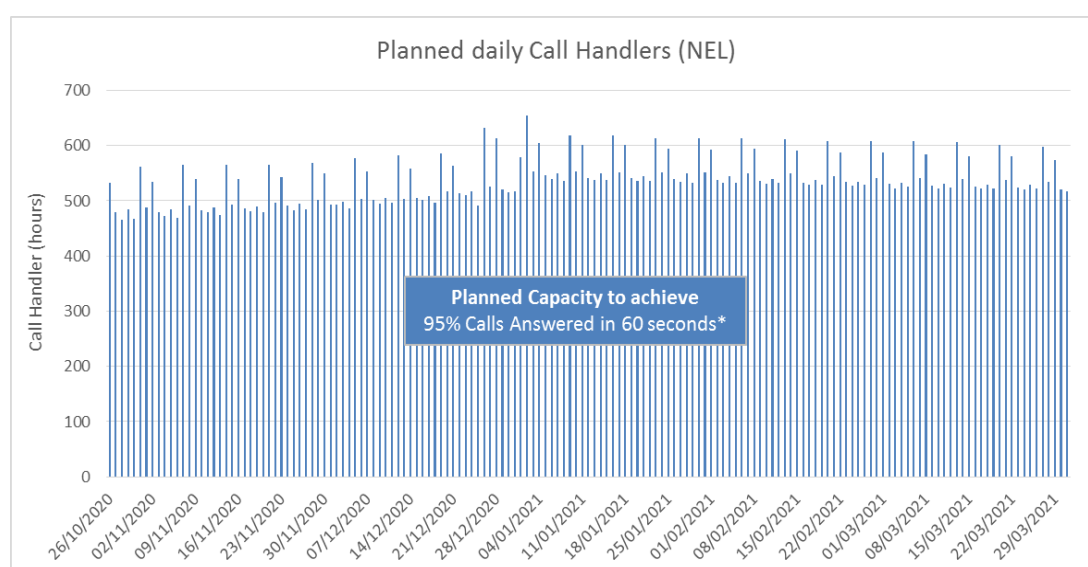
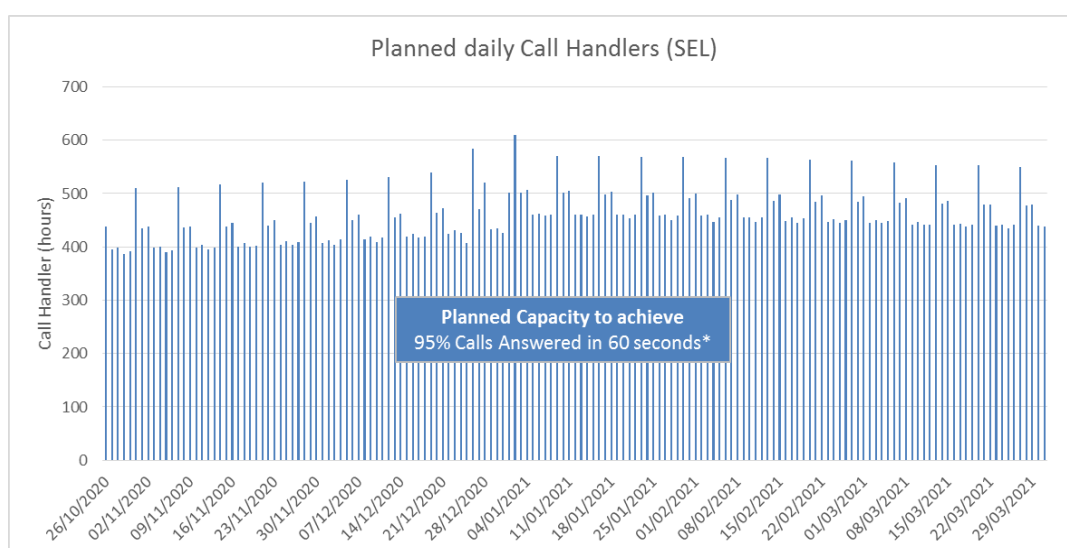


Figure 16: Planned daily total call handling hours in SEL October 2020 – March 2021



- 14.4 While LAS is planning to resource to its demand forecasts this winter, we are carefully planning for any surges in demand which a second Covid-19 wave could bring. There are many new processes and procedures which have been introduced this year as part of our Covid-19 response which have impacted positively on the organisation. The Trust intends to retain many of these enhancements as part of its winter operational delivery model and as part of its resilience plans in the event of a future surge in activity, whether this is Covid-19 or winter related or both.


999 and 111 Surge and Resilience Plans

- 14.5 Both 999 and 111 call handling operations were redesigned this year to create additional Covid-19 specific call handling capability. Specifically, following national approval for us to implement the flu pandemic 'Card 36' protocol in EOC (in advance of the rest of the country over the weekend of 28/29 March), a completely new additional 999 call handling facility was built on the first floor of LAS Waterloo headquarters. Initially 30 second year student paramedics were trained to enable it to start operating on the following Monday morning, and this started to relieve pressure on EOC call handlers by answering 'Covid-19 only' related calls. Over the next few days a further 100 second and first year students were similarly trained (third year students were deployed alongside road staff).
- 14.6 In relation to 111, similar enhanced arrangements were put in place to manage Covid-19 related calls, in part utilising additional outsourced contact centre capacity procured commercially from InHealth.
- 14.7 Enhanced arrangements to transfer calls electronically between ambulances services nationally, and between 999 and 111 services within London, have also been developed this year.

- 14.8 In the event that there is a significant surge in NHS 111 call demand due to Covid-19, then up to 1,400 call handling hours per day will be required across NEL and SEL to meet 10,000 calls and ensure 95% of calls are answered in less than 60 seconds. Answering the calls within 60 seconds is both a clinical safety and quality measure as it is not possible to predict a patient's needs until the initial assessment has been made. Plans have been developed that describe our approach to manage demand and scale capacity which include more robust call triage, integrated capacity with the EOC and drawing on external support when necessary. Further details are shown on the 111 escalation plan below.


#	Category	Description	Lead time (days)	Pref. order	Winter
1	External capacity	Establish partnerships / supplier contracts for continued support	14 days	6	Yes
2	CHUB referrals	Increase 111CAS capacity to clinically assess additional Cat 3-5 from 999/111	Ongoing	5	Yes
3	Training	Use NHS Pathways easements to increase training / coaching capacity and explore more shortened exit messaging	14 days		Yes
4	Call handling capacity	Mobilise NHS Pathways CDSS clinicians to front end calls based on status of CAS clinical queue	Real time	4	Yes
5	External capacity	Mobilise additional capacity to answer 111 calls and assess NEL/SEL inbound contacts (phone & online) and London Dental & Pharmacy	3 days	3	Yes
6	GP capacity	Increase GP workforce and incorporate capacity offered through third party organisations	24h	2	Yes
7	Contingency call handling	Mobilise contingency call handler & clinician roles to support handling and assessment of 999/111 calls	24h		Yes
8	Re-allocation	Deployment of all trained staff ad others to support, review non essential tasks, and stand-down unnecessary meetings	Real time		Yes
9	Overtime	Expand and modify staff overtime & incentives	Real time	1	Yes
10	Clinical capacity	Increased senior clinical capacity converting face to face services to telephone consultation & adding capacity	24h		Yes

'Surge' capacity



'Base' capacity

- 14.9 In the event of a significant surge in 999 call demand then the EOC would require up to 1,900 call handling hours per day to meet 10,000 calls and ensure average call answering mean remains under 10 seconds for the day end position. This additional capacity includes support from other ambulance services (mutual aid), dual trained staff working flexibly across 111 and EOC call handling as well as extended use of bank and agency staff. Further details are shown on the EOC escalation plan below.

#	Category	Description	Lead time (days)	Pref. order	Winter	
1	Call handling capacity	Contingency call taking arrangements	Ongoing	6	Yes	
2	Revise CHUB process	Protocol 36, Re-shape CHUB processes, Auto-transfer C3-C5 case referral to 111 providers	1 day	5	Yes	
3	Increase contingency capacity	Re-mobilise Contingency Call Advisors	1-2 days		Yes	
4	Call handling capacity	Increase staffing within EOC by returning EOC trained staff to role, increase staffing in the CHUB	24h	4	Yes	
5	Emergency rule	Emergency Rule / Staying on Line / PAIs/PDIs	Real time	3	Yes	
6	Expectation management	LAS Hold / Comfort Message Amendments	Real time	2	Yes	
7	Exit message	Reduction in ring backs & exit message adjustment	Real time		Yes	
8	BT filter	BT filtering to support identification of Covid calls and referred to 111 online	Real time		Yes	
9	Mutual aid	Explore and consider proactively with other ASTs	Ongoing	1	Yes	
10	Call handling capacity	Increase staffing using overtime and more shifts across EOC & CHUB	1-2 days		Yes	
11	Process changes	Open EOC Escalation Areas and Contingency Dispatch Groups	Real time		Yes	
12	Clinical capacity	Progress through stages of CSEP	Real time		Yes	
13	BT buddy site arrangements	BT automatically find other ambulance sites to take LAS calls	Real time		Yes	

14.10 IUC and EOC resilience actions to date have specifically targeted the role of clinical assessment and planned how the capacity will be sourced. A significant number of clinical staff have been recruited and provided with training to allow rapid engagement with either our 111 or 999 processes. Additionally, we have ensured access to downstream capacity that will be available to support in times of high demand. These options for additional capacity have been strengthened by the addition of remote working capabilities for our clinical teams, allowing more flexibility to those able to work for short periods. Increased collaboration from staff training and improved processes has also allowed for more integration between the 111 and 999 teams as previously described in section 9.

Ambulance Operations Surge and Resilience Plans

14.11 It was essential during the first peak of Covid-19 for LAS to deploy the maximum frontline response, therefore modifications to the ambulance deployment model were implemented to best utilise the skills of the staff and volunteer workforce, and maximise the availability of our fleet. Our double crewed ambulance (DCA) capability was maximised by stepping down a number of other types of response (including cycle, motorcycle, Non-Emergency Transport Service (NETS), Fast Response Unit (FRU) and other car based responses) and transferring those staff to work on DCAs. Volunteer emergency responders (ERs) were also transferred on to DCAs to work alongside LAS colleagues. Revised skills mix arrangements were put in place to enable the deployments of these additional resources whilst maintaining patient safety and care quality requirements which have been continuously monitored by medical and quality leads who are present at daily COLT/DSLTT meetings.

14.12 Legacy changes that have been retained as part of business as usual operations and which will support us to maximise DCA capacity this winter include:

- An ongoing commitment to a DCA led delivery model with proportionally fewer solo vehicles being regularly deployed which will deliver a more resilient and flexible way of working.
- Flexible capacity will continue in the vehicle preparation and make ready functions to service the increased number of vehicles required and to increase vehicle capacity when necessary.
- Over 300 trained London Fire Brigade (LFB) firefighters will continue to be utilised on an overtime basis to support the core DCA roster this winter (to the equivalent of 100 WTEs). A memorandum of understanding (MOU) has been developed with the London Fire Brigade (LFB) so that further LFB capacity can be quickly utilised should we see a second wave of Covid-19 this winter.
- The Trust has introduced a new Student Paramedic non-registrant role for third year student paramedics studying at our partner universities. A formal job description has been developed and a two week training course takes place in October. Initial discussions indicate that this will provide us with 280 shifts per week (equivalent to 88 WTEs) during University holidays which co-incides with our peak winter pressure period.

14.13 In the event that there is a significant surge in activity due to Covid-19, ambulance operations can deploy up to 643 DCAs during daytime and 257 overnight. The Trust can call upon different groups to provide capacity to meet a surge in demand such as paramedic students, returning non-patient facing clinicians to the frontline including Clinical Team Managers, bank staff, mutual aid from other Trusts, St John Ambulance and the London Fire Brigade. Further details are shown on the ambulance operations escalation plan below.

#	Category	Total DCAs* @3pm	Total DCAs* @3am	Lead time (days)	Surge Duration
1	NPF Paramedics (Ops)	643	257	3	days
2	Clinical Team Mgrs	637	255	3	days
3	ERs/CFRs	614	246	5	1 month
4	LFB (surge)	593	237	4	1 month
5	Bank Paramedics	561	224	5	days
6	Bank EAC	553	221	0	Dec/Jan
7	External Mutual Aid	506	202	4	2 weeks
8	REAP	470	188	0	1 month
9	Extra Overtime	467	187	3	2 months
10	St John (Mutual Aid)	391	156	0	ongoing
11	LFB (Base)	383	153	0	ongoing
12	PAS/VAS	372	149	1	ongoing
13	CRU/MRU/APP	363	145	0	ongoing
14	FRUs	363	145	0	ongoing
15	Standard DCA Roster	363	145	0	ongoing

Covid-19 Surge
(up to 643 DCAs at 3pm)

Seasonal Surge
(up to 467 DCAs at 3pm)

Baseline staffing
(up to 383 DCAs at 3pm)

- 14.14 As stated previously, minimum capacity levels for each day through the winter period have been identified. The core overtime constructs that are currently in place for 111, EOC and ambulance operations will continue throughout December and January. Increased incentives will be added to target the high risk days during the winter period (up to Christmas and up to and including New Year) to try to close the capacity gaps and reach the required resourcing levels indicated within the forecasts. These additional incentives will be costed and approved in advance of the publication of the overtime bulletins for the period. The target date for publishing the bulletins is Thursday 19 November 2020. Uptake on overtime incentives will be reviewed on a daily basis by the winter planning group while also ensuring that vehicles are available for the levels of overtime being sought. While offering overtime will be a key objective to delivering our resourcing plan, local managers will be seeking assurance that staff are taking annual leave so that they are adequately rested and our EOC will be focused on maximising the number of rest breaks each day across the winter period.
- 14.15 To further maximise capacity over the winter period, all non-essential training will be suspended for December to ensure staff can be focused on core service delivery requirements. All non-essential meetings will be also be deferred in December in order to reduce abstractions from the frontline rosters. This strategy frees both operational vehicles and managers' time to focus on core delivery of service. Both of these measures will be reviewed and may be evoked earlier than December, depending on levels of Covid-19 demand.
- 14.16 Ahead of winter, key leads from ambulance operations, EOC and the medical directorate will review the LAS response profiles in order to assure ourselves that we are not over resourcing clinicians/vehicles at particular incidents and

can utilise our resource where it is most needed. A dedicated task and finish group will commence in early October.

15. Strategic Assets and Property

Fleet

- 15.1 As part of our response to Covid-19, additional DCA vehicles were urgently sourced and procured. This included 62 brand new vehicles which were already on order and which were hurriedly completed by the supplier and commissioned within three weeks compared to the six months this would otherwise have normally taken. In addition to this, a further 51 second-hand ambulances of various types were urgently purchased and fitted out ready for use although, to date, only 13 of these have required to be used. This additional capacity will allow us to reach the peak requirement of 643 DCA vehicles referred to previously in section 14.13.
- 15.2 During the peak of Covid-19, the LAS rapidly developed a partnership with the AA who had significant surplus skilled technical capacity available due to a downturn in their workload post-lockdown. This radically enhanced our fleet workshop and on the road maintenance arrangements were put in place to improve overall vehicle availability. Together with the additional new vehicles procured, this ultimately enabled the service to regularly put on the road more than 200 additional ambulances, a near 60% increase on peak pre-Covid-19 DCA capacity.
- 15.3 In preparation for winter, we are making arrangements to procure further AA capacity to ensure our vehicle availability remains at required levels. Our operational vehicles are fitted with tyres suitable for winter conditions all year round so no specific initiative is required to deal with adverse weather. Vehicle servicing schedules and out of hours repair/support plans have been developed by the Fleet Department to ensure the maximum availability of response vehicles during the winter period.

Logistics

- 15.4 To ensure the supply and distribution of PPE, and provision of adequate management support/shift start briefings to frontline staff, ambulance operations were consolidated into a smaller number of larger hubs stations during our response to Covid-19. All 41 open ambulance stations have completed a Covid-19 compliance checklist against the latest national guidelines. Assessments have been validated by one of the central LAS Health and Safety team members. All Trust sites have been issued with a Covid-19 compliance certificate which has been published locally on-site and digitally on the intranet ensuring visibility for all staff.
- 15.5 The Trust's Deptford logistics operation was also completely redesigned and resized this year to enable it to deliver over a million pieces of PPE onto stations by the end of April. This has helped make it easier for vehicles to be removed from service for regular cleaning/restocking and more efficiently pair up single

staff and reduce wasteful movement. As the Trust heads into winter, it has a fit for purpose stock management system which accurately records the PPE which is held centrally. There are three dedicated warehouses in Deptford for the storage and distribution of PPE which can be flexed if demand, and the frequency of deliveries, increases. The department has an aspiration to hold 90 days' worth of PPE whether that be held locally at vehicle preparation hubs, within the LAS distribution hubs or with suppliers and Trust supply levels will be reviewed daily at DSLT/COLT over the winter period. The Trust is still taking PPE from the NHS stock pile where needed and has formed an agreed route to receive this which will be followed as the situation necessitates. The stock pile is currently held at Dartford in London. Over 90% of frontline staff have access to a reusable FFP3 mask which mitigates against the risk of potential supply issues with the disposable FFP3 masks.

- 15.6 The logistics team are working closely with procurement leads to source the best quality and value for money PPE from a variety of suppliers. Health and Safety leads and the Head of Infection Prevention and Control (IPC) are consulted when new items are purchased to ensure that what we receive is functional, safe and fit for purpose.
- 15.7 Ahead of winter, logistics are ensuring that there are adequate supplies of blankets. Reserve supplies of blankets will also be available for times of inclement weather.
- 15.8 Procurement arrangements for the goods/products used across the Trust (particularly business critical items) are, in the main, relatively generic. These include obvious products such as vehicle fuel, medical gas, electricity supply (for Control Services) and vehicle parts such as tyres and brake components, all of which can significantly impact on the ability of LAS to continue to operate effectively. The LAS has identified its critical supply chains in the following areas to ensure the provision of service during periods of high demand is maintained:
 - Continuous supply of ambulance medicines/drugs
 - Continuous supply of medical consumables
 - Maintain continuity of medical gas supplies
 - Maintain continuity of supplies of critical vehicle maintenance parts
 - Vehicle maintenance and repair staff and facilities
 - Vehicle fuel supplies
 - Utility supplies (electricity, gas and water)
 - Adequate levels of procurement, fleet and logistics staff to ensure the ability to process purchase orders through to delivery.
- 15.9 As part of the Trust's planning for an exit from the European Union with no deal, the Trust has mapped the supply chain for medical consumables and all of the Trust's suppliers have a UK depot. Four key suppliers hold three months' worth of stock on UK soil.

16. Reducing hospital handover delays

- 16.1 To manage Covid-19 in hospitals this winter, it is planned that there will be additional intensive care unit (ICU) capacity concentrated in a smaller number of 'ICU hub' hospitals when ICU capacity begins to be reached in individual ICSs. These hospitals will receive patients presenting with symptoms which are consistent with Covid-19 and where there are further high risk/complicating features such as underlying respiratory conditions, diabetes, being aged over 70 years/BME and other criteria. Patients who are presenting with Covid-19 symptoms but are critically unwell will still be taken to the nearest emergency department as will all other patients who need to be conveyed but are not presenting with Covid-19 symptoms. LAS will, through the Critical Care Transport Service (CCTS), support secondary transfers as needed but this plan is designed to reduce the number of secondary transfers, improve outcomes for patients and lower emergency department crowding which will delay the ambulance handovers for other patients. In order to implement this plan, LAS will need to understand the implications of extended travel times to ICU hub hospitals however it is expected that this additional time may help to offset multiple secondary transfers which are likely to place a strain on hospital resuscitation areas over the winter period.
- 16.2 In terms of transfers, LAS will continue to provide a pan-London CCTS this winter for the planned transfers of critically ill patients. 5 vehicles will initially be in place (1 for each ICS) with a surge plan in place to extend this to 10 (with 48 hours notice) and 16 vehicles (with 7 days notice) if required. The CCTS will operate from the control room at Waterloo headquarters from the beginning of October 2020 where there will be a separate critical care despatch group co-ordinating all planned transfer requests. LAS will provide the vehicles and crew but the clinicians and clinical responsibilities will be with the ICS.
- 16.3 Improving patient flow is a key requirement of the NHS for winter 2020/21 and LAS recognises the importance of engaging with A&E Delivery Boards to ensure that there is region-wide, joined up effective patient care, particularly over the winter period. LAS will ensure that there is senior clinical and operational representation at A&E Delivery Board meetings and ICS Clinical Advisory Group meetings and on other local surge hub teleconferences/meetings to support the avoidance of ambulance handover delays. Any proposed pathway changes from the ICS over winter will continue to be considered at the Trust's Patient Safety and Clinical Effectiveness Group and then the Clinical Advisory Group before sign off at DSLT/COLT.
- 16.4 To assist acute trusts in their winter planning for ambulance attendance, activity and demand forecasting data will be shared in advance of the peak festive period.
- 16.5 The Trust does and will continue to refer to the published NHS England (London) surge management framework when dealing with divert requests from acute trusts as per NHS England (London)'s Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy) which is available at appendix 8.

16.6 Capacity at London emergency departments will be closely monitored within the Trust's TOC, and where appropriate, extra ambulance stretchers will be deployed to assist with the early release of ambulance clinicians and vehicles. This will be authorised by the Strategic Commander (Trust Gold) in liaison with NHS England (London) Gold.

16.7 The most challenged part of London in terms of hospital handover delays is in the North East. As part of the post Covid-19 recovery and winter preparations, the LAS are working with the North East Acute Trusts to develop systems where patients can be appropriately referred to an alternative healthcare pathway rather than emergency departments or to an alternative emergency department to improve patient flow. Two examples of innovative solutions we have established ahead of winter are:

16.8 **Barts Emergency Access Co-ordination Hub (BEACH)**

The BEACH covers the geographical area for Whipps Cross, Newham and the Royal London emergency departments and is staffed with Emergency Medical Consultants. All patients who require immediate conveyance to Whipps Cross, Newham and the Royal London hospitals will continue to be conveyed there without pre-contact being made with the BEACH (a number of clinical exclusions exist). But for all other patients who would normally be conveyed to these emergency departments, LAS crews will instead be required to make pre-contact with the BEACH before conveyance. The process requires crews to contact the North East IUC so that the call between the crew and the BEACH can be recorded and stored. There will be five outcomes following contact between LAS crews and the BEACH which are:

1. Crew to convey to nearest emergency department
2. Crew to convey to a different emergency department
3. An emergency department appointment will be agreed for a later time in the day (e.g. at 2, 4 or 6 hours later with NETS or a taxi providing the transport)
4. A remote consultation will be arranged.
5. An alternative clinic will be arranged.

16.9 A short pilot of the BEACH commenced on Monday 5 October and will run for one week. This is focused on crews from Shoreditch Ambulance Station who would ordinarily convey patients to the Royal London's emergency department. If the pilot is successful then the BEACH model will be introduced for all LAS crews in North East London who are conveying patients to Whipps Cross, Newham and the Royal London emergency departments.

16.10 **Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)**

LAS is placing a Clinical Team Manager (CTM) in BHRUT's TOC between 11:00 – 23:00 hours, seven days a week, to help manage patient flow between their two emergency departments (Queens and King Georges) between now and the end of March 2021.

- 16.11 The CTM will monitor real time ambulance delays which are not currently available to LAS as BHRUT sites receive ambulances from both LAS and the East of England Ambulance Service. BHRUT has identified that the numbers of ambulances arriving within short succession is one of the drivers of the patient flow issues which they are experiencing and which lead to LAS being impacted by handover delays. To address the issue, LAS crews will pre-contact the CTM prior to conveying any patients with non-life threatening/serious injuries or illnesses and they will be instructed – based on current capacity levels – to either convey to Queens or King Georges or potentially to an ACP which could include BHRUT’s frailty service which has been developed for patients over 75 years of age.
- 16.12 The impact of both the BEACH and BHRUT models will be monitored closely and, if successful, we will look to model these initiatives where possible in other areas where LAS loses most of its resources to handover delays.
- 16.13 As part of the Trust’s learning from last year’s ‘perfect day’, the ‘Call A Colleague’ function will be available pan-London this winter between 8:00 and 20:00 hours (on identified days of high demand) for frontline clinicians and will be staffed by LAS senior clinicians. This function will provide a peer to peer discussion about patient pathway use, provide advice and signpost crews. This will help to support those frontline clinicians with their clinical decisions to not convey a patient. It will also help the Trust to gather live intelligence about any failed ACP referrals during the day (when most ACPs should be available) so that it can work with the relevant ICS to address the pathway failure.
- 16.14 Senior leads from the Trust’s medical and operational directorates will be exploring further opportunities with ICSs to minimise handover delays over the winter period which will focus on:
- The opportunities of rapid assessment pathways
 - Provision of additional clinics away from emergency departments
 - As well as consultant grade staff providing advice to ambulance clinicians, there may opportunities for other speciality doctors to provide support including paediatrics, elderly care and social care.

17. Health and Wellbeing of Staff

- 17.1 At the time of writing this plan, the LAS Wellbeing Strategy is being finalised to ensure that the health and wellbeing of our staff and volunteers is appropriately prioritised going into winter and beyond. A number of new initiatives have grown out of our learning from Covid-19 which will help staff to navigate the wellbeing offers and enable them to address their personal health needs.
- 17.2 The LAS Wellbeing Hub is a single point of contact for information relating to all of the Trust’s wellbeing services. Open seven days a week from 8:00 to 22:00 hours, all staff and volunteers can contact the hub by phone and email. The hub has a comprehensive directory of services which is used to signpost staff to a range of internal and external services including;

- LINC (Listening, Informal, Non-Judgemental, Confidential) – for peer support
 - AbleFutures – for external emotional and mental health support
 - PAM Assist – for a range of services including financial advice
 - Staff networks – such as B-Me, the LGBT forum and the Freedom to Speak up network of advocates
 - Unions.
- 17.3 The Wellbeing Hub may also signpost to the LAS Staff Benevolent Fund which supports its members faced with temporary hardship and has a facility to support those who require convalescence.
- 17.4 The Trust continues to benefit from the The Ambulance Staff Charity (TASC) who support present and past ambulance staff and their families in their time of need. They offer:
- Stress support through a range of services including intensive local counselling to minimise the need for travel
 - Funded support to access residential psychological wellbeing support for those with significant stress related problems or post-traumatic stress disorder
 - Access to intensive rehabilitation, in partnership with the fire and police charities for those with long standing, complex or physical recovery issues
 - Confidential phone and email support services
 - Bereavement support
 - Debt advice
 - Grants and other support.
- 17.5 The Trust's Occupational Health Service provider works in partnership with the LAS in providing expertise to ensure a safe, healthy working environment.
- 17.6 The Trust will continue to run the staff support vehicles or "wellbeing wagons" throughout winter which visit emergency departments to provide colleagues with refreshments. There are plans in place to ensure the continuity of these by working with charities and sponsors and through the use of decommissioned vehicles.
- 17.7 The Oxford University 'Supporting Hospital And Paramedic Employees' (SHAPE) trial is currently recruiting staff to take place in an evaluated, proactive psychological support programme that will help contribute to the avoidance of post-traumatic stress disorder (PTSD) and depression. This programme will provide one on one support sessions for the staff involved, and will remain a source of support for up to two years.
- 17.8 The Trust has launched the 87% App for all staff. This App is a virtual hub which enables staff to self-assess their health and wellbeing and then prompts them to access information and resources to enable them to set goals and adopt choices and tools to remain physically and psychologically well. The App contains bespoke content which the LAS manages. From this we can "push" health and wellbeing messages to users as well as sign post to the range of

services accessible to staff and volunteers. The App can be downloaded onto the iPads or personal phones so that it is easily accessible.

- 17.9 The Trust has issued '*Covid-19 Guidance for Patient Facing Staff*' to all of its frontline staff. This guidance combines the current medical directorate and IPC information and has been written in accordance with the latest Public Health England Covid-19 guidance. The content supports frontline crews to:

- Identify Covid-19 symptoms in their patients
- Wear the appropriate level of PPE in line with Public Health England guidance on PPE for ambulance staff
- Adopt the correct procedures when conveyance is required
- Manage post-conveyance decontamination of vehicles.

18. Vaccinations

- 18.1 An immunisation 'catch up' programme has commenced which will be completed prior to the start of 2020's flu season. This will help to mitigate droplet spread illnesses (such as measles, mumps, rubella) which can increase in the autumn and winter. Additionally, the programme will deliver Pertussis to a substantial proportion of the workforce as part of the ongoing programme to immunise all frontline clinicians and volunteers.
- 18.2 The Influenza (flu) vaccination is one of the most effective interventions we have to reduce pressure on the health and social care system this winter. Currently we are continuing to experience the impact of Covid-19 on the NHS and social care and this coming winter we may be faced with co-circulation of Covid-19 and flu.
- 18.3 The annual national immunisation programme helps to reduce 111 and 999 calls, ambulance attendances, unplanned hospital admissions, pressure on emergency departments, primary and social care. It is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter.
- 18.4 There is usually one period of high Influenza activity during a season which, from its emergence, will take around three weeks to peak and another three weeks to decline. In the UK this commonly occurs between December and February. Our aim is therefore to schedule all flu vaccinations for patient facing clinicians between September and November.
- 18.5 This winter as we manage the Covid-19 pandemic, it is essential that we have staff who are, as far as reasonably practicable, protected from preventable illness. This approach not only reduces their chances of becoming unwell, it also reduces their chances of catching and being extremely unwell with Covid-19.
- 18.6 It is not only frontline operational work that is affected by flu, but also EOC, 111/IUC and support services staff throughout the Service whose critical

functions maintain frontline operations. These work areas can be severely affected by decreased staff numbers.

18.7 There are three main strategies employed to stop the spread of flu which can also mitigate the effects:

- Infection prevention & control,
 - Hand Hygiene
 - Respiratory Hygiene
 - Work Space Hygiene
 - Wearing level 2 PPE at all times, when in close contact with patients
- Vaccination
- Business continuity planning.

18.8 The Trust's people and culture directorate, supported by the medical directorate, are preparing for the Seasonal Flu Vaccination Programme 2020/21 which will support the national flu programme through:

- Actively offering flu vaccination to all staff, especially those directly involved in patient care
- Aiming to vaccinate at least 90% of frontline workers with direct patient contact
- Improving uptake for those in other staff groups, particularly for those in EOC and 111/IUC
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS and sharing this information with staff and managers.

18.9 The first batch of our order of 7,000 flu vaccines was delivered to the Trust on 21 September 2020 with four further deliveries due to arrive every two weeks.

18.10 This year the uptake of the flu vaccine will be monitored centrally, with the majority of patient facing staff receiving their vaccination at their core skills refresher (CSR) course between September and November 2020. Uptake data will be reported to station groups to enable local management teams to assess the number of clinics that need to be run locally in sectors to 'mop up' those staff not vaccinated at the CSR course. By vaccinating at the CSRs, we can vaccinate approximately 100 clinicians every weekday and eliminate the stand down time which would normally be required.

18.11 Flu clinics at EOC and IUC sites will begin in early October 2020 in line with vaccine availability. NHS England recommends that Trusts should aim to schedule their flu programme to match vaccination supply which is from September with vaccinations complete by the end of November. This is in line with the LAS timetable.

18.12 More than 200 LAS paramedics have volunteered to become peer vaccinators and a team of 15 clinicians, who are currently in non-patient facing roles, have been recruited to run regular flu clinics, including those at the CSR sessions, at all Trust sites.

- 18.13 In order to ensure flexibility of location, 20 new medical grade cool boxes have been purchased to mitigate the risk of the CSR sessions being cancelled due to a second wave of Covid-19. All LAS fridges have been calibrated and serviced ahead of winter to ensure the safe storage of flu vaccines and a system is in place to ensure that the temperature of every fridge is recorded every 12 hours with compliance being monitored by the wellbeing team.
- 18.14 A communications plan for the flu programme has been approved by the Trust's Executive Committee. A staff communications campaign will run across all Trust internal channels including leaflets, posters, regular posts on our intranet, staff bulletin and staff Facebook page. Videos featuring senior members of the medical directorate will be recorded and the Chief Executive will receive his flu vaccination on LAS TV Live.
- 18.15 Flu vaccination rates will be monitored on a daily basis with weekly updates to DSLT/COLT where progress will be tracked. There is live access to the reasons for declining the flu vaccine which can then be fed back into the internal communications campaign.
- 18.16 Incentives are being offered for having the flu vaccination. Those who have their flu vaccination will be entered into a draw for an e-bike, a fit-bit watch and a healthy food hamper.
- 18.17 Sickness absence monitoring will be a key priority for operational managers over the winter period and sickness absence will be a standing agenda item during winter group meetings. Intelligence on flu levels will also be monitored through NHS England's daily winter intelligence briefings, alongside the Covid-19 monitoring.

19. Adverse Weather

- 19.1 The LAS has a detailed plan for maintaining service delivery should adverse weather occur. This plan has been refreshed ahead of winter 2020/21 and is available at appendix 4.
- 19.2 An abridged version of the activities of this plan are as follows:

Weather Reports

- 19.3 Daily weather reports are received by the Emergency Preparedness, Resilience and Response (EPRR) on-call via the Meteorological Office. Long range forecasts are also monitored by this department during the winter period and feed into the Trust's forecasting and planning group activities.
- 19.4 Current weather reports from the Meteorological Office extend for only 30 days. At this time there is no indication or intelligence of any specific adverse weather event relating to the festive period. Any changes to the alert status from the Meteorological Office will be monitored and acted on at a tactical level.

Grit and Shovels

- 19.5 Local managers will ensure that all LAS buildings have an adequate stock and supply chain of gritting salt and appropriate tools for spreading it such as snow shovels.

The Cold Weather Plan

- 19.6 In 2018, Public Health England updated *The Cold Weather Plan for England: Protecting Health and Reducing Harm from Cold weather*. This plan is designed to prepare for; alert people to; and prevent; the major avoidable effects on health during periods of severe cold weather in England. The Plan has five levels:

Cold Weather Plan levels	
Level 0	Year-round planning All year
Level 1	Winter preparedness and action programme 1 November to 31 March
Level 2	Severe winter weather is forecast – alert and readiness Mean temperatures of 2°C and/or widespread ice and heavy snow are predicted within 48hrs with 60% confidence
Level 3	Response to severe winter weather – Severe weather action Severe weather is occurring: Mean temperatures of 2°C and/or widespread ice and heavy snow
Level 4	Major incident – Emergency response Central government will declare a level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health

- 19.7 Levels 2 / 3 of the plan are triggered according to the probability of threshold conditions being met. For London this means: “*Average temperature of 2°C or less for at least 48 hours, or the Met Office anticipate issuing a warning for heavy snow or widespread ice*”.

Operational Response

- 19.8 Should adverse weather occur, all managers will make themselves available to assist in leading the delivery of operations. Non-operational managers will assist by ensuring their departments / areas of work are able to function to the best of their ability during times of adverse weather.
- 19.9 Given the possibility of adverse weather affecting transport systems, managers will liaise with their staff members to request that they consider alternative ways of getting to and from work. This includes car sharing, establishing clear routes to and from their place of work and identifying frequently affected roads/areas.

Manager Duties

- 19.10 There will be daily checks of the on-call rota (via the x-drive) to ensure the correct information is held by the IDMs.
- 19.11 When snow has been forecast, a teleconference will be arranged to ensure the Snow Operational Plan is implemented. The teleconference will be attended by the designated managers for the relevant departments with delivery responsibilities. When snow does fall, the Strategic Commander on call (Trust Gold) will convene a teleconference at the earliest opportunity during the working week. This will be at a time nominated by the Strategic Commander unless otherwise advised. This meeting will review plan compliance, current and planned levels of operational staffing (and numbers of any staff attending muster points) and any deficiencies in EOC/IUC staffing and current demand.
- 19.12 The Trust's Scheduling Department will ensure that all staff data is up to date, including home location and normal mode of transport. They will consider registering staff with 4 x 4 vehicles that are willing to provide a 'car pool' function during adverse winter weather.
- 19.13 Staff that are seconded to other departments, or are undertaking training, should be requested to be returned to core EOC/IUC duties during the period of adverse weather that is affecting LAS core response.
- 19.14 Each directorate has a business continuity plan which reflects scenarios involving reduced staff capacity, reduced or restricted access to premises and functionality disruption.
- 19.15 LAS managers ensure that local plans are reviewed and updated if necessary. Estates should assure Location Group Managers (LGMs) and other LAS site managers that central heating and water pipes are prepared for winter weather and that adequate supplies of grit are ordered in time for use during cold weather.

Recovery

- 19.16 Staff and management teams will be kept apprised of weather forecasts and other important information in order to maintain a level of resilience and to not become complacent if alert levels are lowered. A lowering of the alert levels will be communicated in the same manner as any escalation of alert levels. Actions at the revised level should be taken and where appropriate, staff transport plans (and other similar plans) should be stood down and prepared for use in the near future.

20. Fuel

- 20.1 The Trust continues to manage its in-house supply of diesel fuel and has the prescribed supply held in secure locations across London. This fuel is held in case public access fuel supplies are disrupted for any reason, including leaving the European Union with no deal at the end of December. The amount of fuel

held is in line with Department of Health guidelines for emergency services which is to hold sufficient stocks to operate for in excess of 21 days. A fuel monitoring system is installed and working to protect fuel stocks.

- 20.2 Routinely, the fuel for operational vehicles is filled by the vehicle preparation teams. Additional fuel can be purchased at the point of sale with BP agency cards which can also be used at Texaco filling stations. To provide further resilience, a number of 'supercharged' fuel cards are held centrally which permit the purchase of fuel from any forecourt. These cards are used when other normal methods of purchasing fuel are not available.

21. IT Resilience

- 21.1 Any loss of our key IT systems over winter can pose a significant risk to patient safety and our operational delivery. The IT department has reviewed the Trust's IT resilience ahead of winter and has taken, or will be taking, the following actions ahead of November 2020:
- The Trust's Computer Aided Dispatch (CAD) outage action plan is in place and has been tested. The CAD has been re-platformed and relocated to off site hosting and all CAD related systems have been tested on all sites. There will be enhanced monitoring of CAD systems throughout winter.
 - The Trust have employed Avaya to support telephony requirements across its EOCs and IUCs through the winter period. A review of the LAS telephony capacity is underway with an increased number of positions being made available at Waterloo headquarters and Maritime House ahead of winter.
 - Only emergency and essential changes will be considered from November 2020 to early January 2021. Non-essential changes will be postponed until the new year to support system stability.
 - There is daily monitoring and management of cyber compliance and security for IT services, including routine patching of admin and CAD PCs and servers as well as daily system checks of key critical networks, CAD and systems infrastructure.
 - Monitoring software (Solar Winds) has been purchased and deployed to maintain oversight of system availability.
 - Adequate IT staffing will be in place to support all EOC and IUC contact centres over the winter period and routine IT on-call arrangements throughout the winter period. Enhanced service desk times will be in place to support winter pressures.
 - All IT users across the Trust will be reminded to take active responsibility of IT equipment and report all issues/requests to IT via the self-service portal at all times.
 - Lapsafe lockers are deployed in a four key locations to allow the immediate distribution of laptops.
 - Lapsafe lockers are in place to support iPad deployment to frontline crews (including bank staff).

22. Business Continuity Plans

- 22.1 LAS undertakes an annual review of all business continuity plans which aims to provide a detailed trust-wide co-ordinated plan, compliant with NHS England's business continuity requirements. This ensures that the Service can respond to any business continuity incident and maintain critical services, and where possible, business as usual. The plan applies to all services provided and managed by LAS.
- 22.2 The Trust's business continuity plans are being reviewed and updated ahead of winter to reflect the lessons identified during our response to Covid-19. These reviews will also be tested in the context of the UK leaving the European Union with no deal at the end of December.
- 22.3 The plans will be implemented in response to business continuity incidents and not major incidents. In some circumstances, however, a major incident may trigger a business continuity incident and vice versa. It will be the responsibility of the Strategic Commander on call (Trust Gold) to identify if this is the case and ensure that the appropriate plan is invoked.

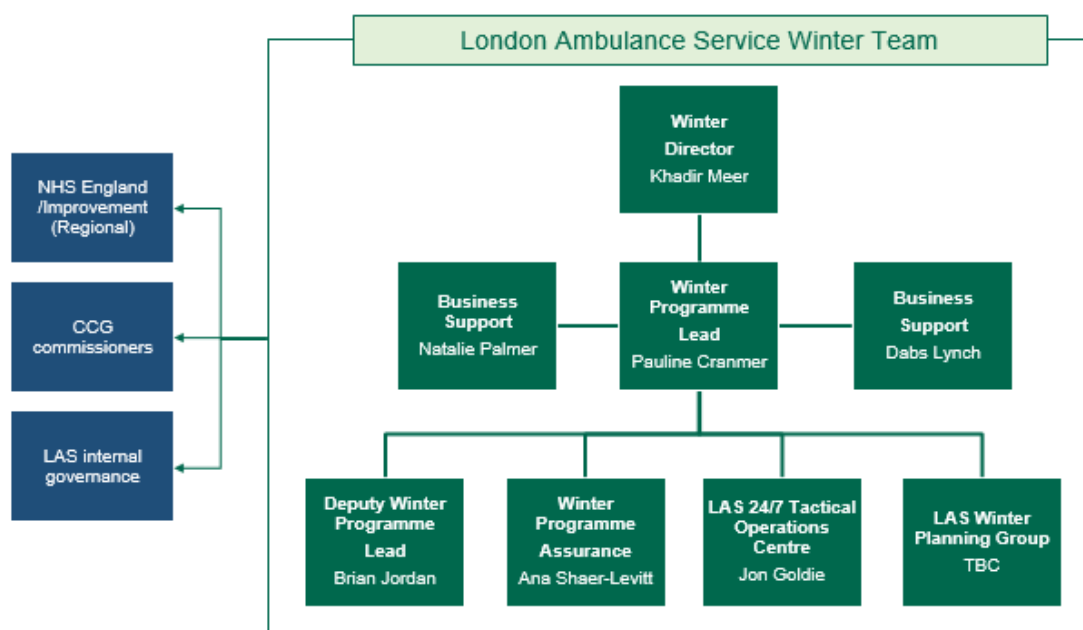
23. Preparing for EU Exit

- 23.1 The government-wide preparations that were put in place during 2019 in readiness for a departure from the EU were based on an assumption that there would be no deal in place. In preparation for this, the Trust conducted an assessment of the risks it faced in the event of a no deal departure. The Trust's supply chain, fuel supplies, business continuity arrangements, workforce and medicines were identified as the key areas of risk and mitigating actions were undertaken.
- 23.2 Following the general election that was held on 12 December 2019, and the passing of the Government's Withdrawal Agreement Bill that took the UK out of the EU on 31 January 2020, the UK formally left the EU on 31 January 2020 but entered a period known as 'the transition' until 31 December 2020. This transition period is in place to prepare the UK for its new relationship with the EU and, during this time, the UK is still following all of the EU's rules and regulations. Although the UK has ceased to be an EU member, the trading relationship remains the same and the UK continues to follow the EU's rules, such as accepting rulings from the European Court of Justice. The purpose of the transition is to enable a new wave of UK-EU negotiations to take place and these talks will determine what the future relationship will eventually look like. There is however an emerging risk that the transition period will end with no deal in place.
- 23.3 A fortnightly EU Exit Task and Finish Group, reporting to the Executive Committee, met throughout 2019 to maintain oversight of the risk assessment and actions required and this group has been stepped back up again to review the Trust's state of readiness. Members of the Trust Gold team have also held a table-top exercise in preparation for an EU Exit scenario in order to consider and prepare for any possible challenges that could arise. LAS EU Exit leads will

continue to engage with any EU Exit workshops/meetings arranged by NHS England/Improvement ahead of the transition deadline.

24. LAS Winter Roles and Responsibilities

- 24.1 The Chief Operating Officer has overall executive responsibility for winter preparedness and service delivery while the Director of Ambulance Services will take the role of Winter Programme Lead and will be responsible for leading and managing the arrangements for winter planning across all service lines.

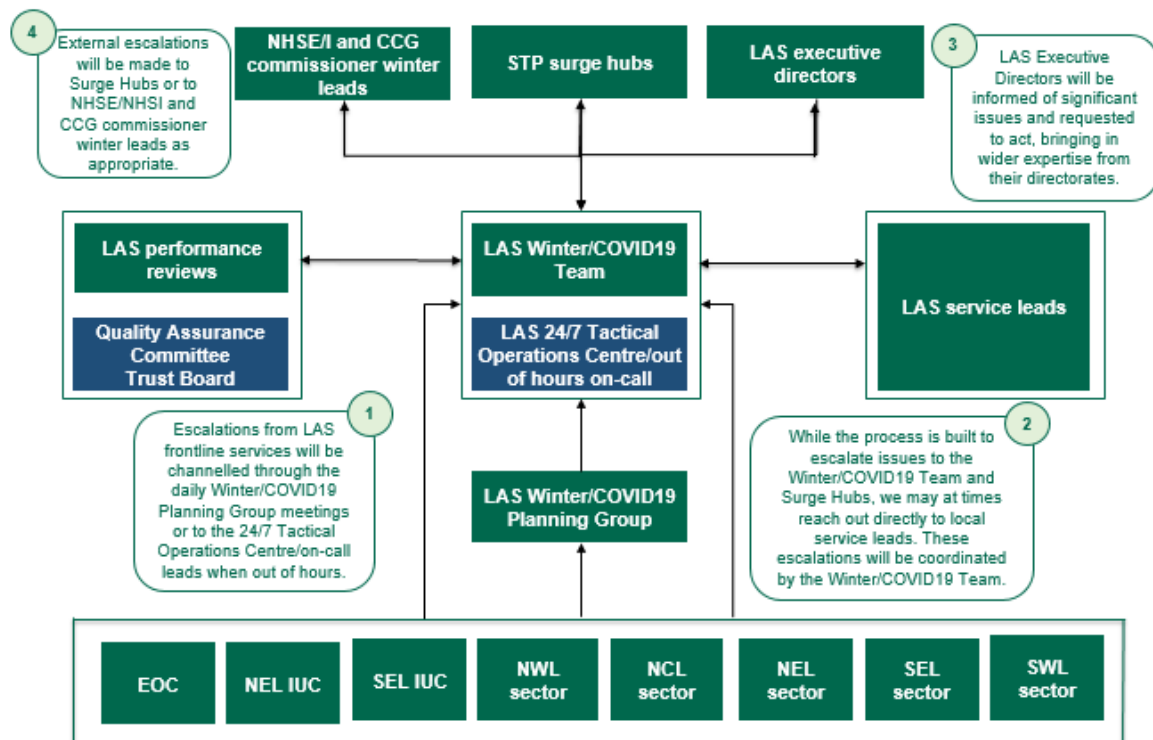


- 24.2 The following set of principles informs the manner in which the LAS winter team will interact with internal and external partners:

- Local service leads will be alerted by the winter team in the first instance when there are concerns. They will be required to manage the escalation, bringing in wider LAS functions as required.
- The winter team will act as the core in managing internal escalations. LAS service leads and their Executive Directors will always be informed, both in and out of hours, when there are significant issues.
- Where there are on-going external concerns, the winter team will engage with the wider system including acutes, ICS surge hubs, NHS England/Improvement and CCG commissioner winter leads. Other key internal partners will be invited to engage as appropriate. The winter team will also be fully engaged with external stakeholder leads for EU Exit to ensure that all risks relating to the end of the 'transition period' on 31 December 2020 are mitigated in order to avoid any impact on LAS operational service delivery this winter.
- The 24/7 TOC and on-call service leads will lead the escalation when there is a lack of traction with the system on weekends/bank holidays. The TOC will support the functions in place across all sector hubs to ensure a robust flow of PPE is maintained to the frontline.

- In terms of internal governance, performance over the winter period will be reviewed at the monthly operational performance management meetings while performance information will be included in the performance and quality reports which will be provided to the Quality Assurance Committee and the Trust Board meetings over the winter period. Daily winter updates will also be provided to the DSLT/COLT where senior operational, medical and quality leads will be present to address any immediate clinical and operational issues.

24.3 These principles can be represented as a series of process flows:



24.4 The Winter Planning Group will report to the DSLT/COLT and is established with representatives from all areas of LAS to ensure that the Trust is prepared for the annual rise in activity and demand during the winter period; is aware of the operational gaps in advance; and has mitigated the organisation's risks to maintaining patient safety as far as possible. The membership will include:

- Strategic Lead (Chair)
- Clinical Lead
- Fleet and Logistics representative
- EOC representative
- 111 & IUC representative
- Incident & Delivery representative
- Nominated officer from the operational sectors
- Finance representative
- Estates representative
- Scheduling Manager
- Resilience & Specialist Assets Business Continuity Co-ordinator
- Chair of the EU Exit Task and Finish Group

- Non-Emergency Transport Service (NETS)
- Business Intelligence/ Forecasting & Planning representative
- Information Technology representative
- Internal Communications representative
- Operational Compliance and Standards representative
- Administration support.

24.5 The winter planning group will meet on a fortnightly basis from mid-October 2020 and daily from 7 December 2020 until the end of January 2021 (although this may be extended depending on the extent of winter pressure).

25. Key Risks and Mitigations

25.1 The main risks ahead of winter 2020/21 have been identified and summarised in the table below together with how the LAS is mitigating against them:

Risk	Mitigation
Demand increases above forecast due to winter pressures and/or Covid-19 second wave	<ul style="list-style-type: none"> • Covid-19 Response Plan in place with pre-defined triggers to allow the Trust to respond to changes in Covid-19 demand. • Refreshed CSEP for IUCs/999 published before December. • REAP – reviewed weekly during winter and dynamically by Strategic Commander if necessary. • 24/7 command and co-ordination structure in place. • DSLT meetings led by the Chief Operating Officer occurring daily and will step up to COLT if second wave of Covid-19 arrives. • Incident & Delivery Manager-led telephone conferences every 4 hours. • Tactical Operations Centre operating 24/7, flexing size dependent on demand. • Increased operational management will assist with delayed handovers and operate 24/7. • A number of measures in place to integrate 111 and 999 to maximise levels of hear and treat, hear and refer and the provision of clinical advice to reduce demand on ambulance dispatch. • Pro-active primary and community care partnership working. • Communications will support national and regional public health campaigns, and alcohol consumption advice, and encourage patients to choose the most appropriate NHS service as well as signposting to 111 online to reduce call volumes. • Continued and robust planning of large scale public events which will be taking place over winter.

Staffing capacity levels could be challenged on days of high demand over winter	<ul style="list-style-type: none"> • Clear staff resourcing forecasts available for each day over the winter period for IUC, EOC and ambulance operations. • Surge and escalation plans in place for IUC, EOC and ambulance operations so that the Trust can provide staffing capacity to the same levels of demand seen during the first wave of Covid-19. • Overtime incentives targeted to days of high risk. • Non-essential training suspended in December and potentially sooner. • Non-essential meetings deferred in December and potentially sooner. • Health and well-being initiatives in place for all staff. • The LAS seasonal flu vaccination programme plans to target 90% of all frontline staff with priority focus also on EOC and IUC.
Loss of capacity due to delays in handovers at hospital	<ul style="list-style-type: none"> • ICU hub hospitals will concentrate on patients presenting with Covid-19 symptoms which will help to offset secondary transfers which will apply pressure to resuscitation areas. • The LAS Critical Care Transfer Service has the ability to scale up to 16 vehicles for the planned transfers of critically ill patients. • Strong engagement with/senior representation at A&E Delivery Boards and on local surge hub teleconferences/meetings. • Activity and demand forecasting to be shared with acute trusts in advance of peak festive periods. • Delays at emergency departments will be monitored by the TOC 24/7 with excessive delays referred to local surge hubs. • Continued reference to NHS England (London)'s surge management framework when dealing with divert requests as per NHS England's Emergency Department Capacity Management, Redirect and Closure Protocol. • The introduction of innovative solutions to manage the North East acute trusts as described in sections 16.7 – 16.12.
Fleet availability to meet capacity requirements	<ul style="list-style-type: none"> • Following the initial response to Covid-19, LAS can reach a peak requirement of 643 DCAs. The additional vehicles include 62 brand new vehicles and 51 second-hand ambulances. • Arrangements are being made to procure further AA capacity this winter to ensure our vehicle availability remains at required levels. • Our operational vehicles are fitted with tyres suitable for winter conditions all year round so no specific initiative is required to deal with adverse weather. • Vehicle servicing schedules and out of hours repair/support plans have been developed by the Fleet Department to ensure the maximum availability of response vehicles during the winter period. • Seven day cover from the majority of fleet workshops will be maintained.

	<ul style="list-style-type: none"> • Management of the Trust's in-house supply of diesel fuel with an extensive supply held in secure locations across London.
Loss of key IT systems	<ul style="list-style-type: none"> • CAD outage action plan is in place and has been tested. • CAD system re-platformed and relocated to off site hosting. System capable of further expansion. • All CAD related systems tested on all sites. • Enhanced monitoring of CAD systems throughout winter. • The Trust have employed Avaya to support telephony requirements across 999s and 111s through the winter period. • Review of telephony capacity underway with an increased number of positions made available across 999s and 111s (HQ/Maritime House) ahead of winter. • Only emergency and essential changes will be considered from November 2020 to early January 2021. Non-essential changes will be postponed until the new year to support system stability. • There is daily monitoring and management of cyber compliance and security for IT services, including routine patching of admin and CAD PCs and servers as well as daily system checks of key critical networks, CAD and systems infrastructure. • Monitoring software (Solar Winds) has been purchased and deployed to maintain oversight of system availability. • Adequate IT staffing will be in place to support all IUC and 999 contact centres over the winter period and routine IT on-call arrangements throughout the winter period. • All IT users across the Trust will be reminded to take active responsibility of IT equipment and report all issues/requests to IT via the self-service portal at all times. • Enhanced service desk times will be in place to support winter pressures. • Lapsafe lockers are deployed in a four key locations to allow the immediate distribution of laptops. • Lapsafe lockers are in place to support iPad deployment to front line staff (including bank staff).
Potential impact of a no deal departure from the EU	<ul style="list-style-type: none"> • The Trust's EU Exit Task and Finish Group has been restarted ahead of the transition period ending on 31 December. The group will meet fortnightly providing feedback directly to the Executive Committee and the Winter Planning Group. • The Trust has conducted an assessment of the risks faced by the Trust in the event of a worst case departure from the EU, in line with the framework mandated by the Department of Health and Social Care. • Members of the Trust Gold team have held a table-top exercise in preparation for an EU exit scenario in order to consider and prepare for any possible challenges that could arise. LAS EU exit leads will engage with any EU exit workshops/meetings arranged by NHS England/Improvement ahead of the transition deadline.

	<ul style="list-style-type: none"> • The Trust has business continuity plans in place which are being tested in the context of hypothetical EU exit scenario. • The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a UK depot. Four key suppliers hold 3 months' worth of stock on UK soil. • As part of a memorandum of understanding (MOU), the Trust will be able to access medicines from other NHS providers if we experience supply issues with our urgently required medicines. • Fuel stocks confirmed which address the civil contingency act requirement to hold 21 days' supply. A fuel monitoring system is installed and working to protect fuel stocks.
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Appendix 1 - Festive Period Event Calendar

Attach when ready

Appendix 2 – Incidents Conveyed to Hospital Oct 19 – March 20

Figure 17: Incidents conveyed by department by month October 2019 – March 2020

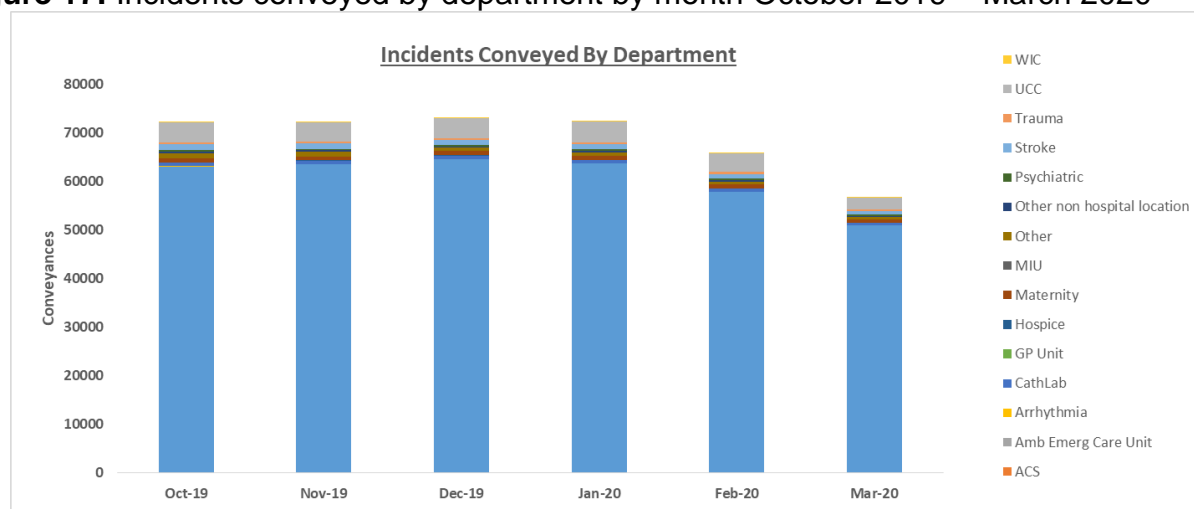


Figure 18: Conveyances by month by ED October 2019 to March 2020

ED	Month						Total
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Barnet	1,817	1,890	2,015	1,950	1,863	1,562	11,097
Charing Cross	1,645	1,617	1,590	1,710	1,536	1,348	9,446
Chelsea & Westminster	1,771	1,792	1,737	1,782	1,616	1,372	10,070
Croydon University Hospital	2,856	2,778	2,737	2,750	2,528	2,314	15,963
Ealing	1,696	1,688	1,810	1,841	1,574	1,483	10,092
Hillingdon	2,367	2,403	2,536	2,496	2,246	2,009	14,057
Homerton	1,508	1,635	1,700	1,634	1,406	1,284	9,167
King Georges, Ilford	1,606	1,487	1,562	1,666	1,410	1,219	8,950
Kings College	2,707	2,667	2,700	2,650	2,556	2,306	15,586
Kingston	2,069	2,192	2,154	2,108	1,852	1,598	11,973
Lewisham	1,838	1,895	1,976	1,770	1,757	1,553	10,789
Newham	2,314	2,397	2,550	2,312	2,096	1,801	13,470
North Middlesex	3,127	3,158	3,229	3,311	2,830	2,599	18,254
Northwick Park	3,546	3,583	3,523	3,667	3,350	3,130	20,799
Princess Royal, Farnborough	2,217	2,235	2,220	2,243	2,004	1,791	12,710
Queen Elizabeth II, Woolwich	2,954	2,959	3,166	3,005	2,838	2,442	17,364
Queens, Romford	3,532	3,502	3,528	3,258	3,101	2,860	19,781
Royal Free	2,124	2,033	2,054	2,112	1,830	1,726	11,879
Royal London (Whitechapel)	2,742	2,749	2,819	2,715	2,532	2,043	15,600
St Georges, Tooting	2,640	2,664	2,679	2,589	2,426	2,214	15,212
St Helier	1,706	1,750	1,663	1,687	1,539	1,354	9,699
St Marys, W2	2,394	2,382	2,426	2,419	2,121	1,868	13,610
St Thomas'	3,063	3,082	3,060	3,066	2,722	2,268	17,261
University College	2,288	2,188	2,225	2,176	1,974	1,487	12,338
West Middlesex	2,435	2,540	2,609	2,504	2,339	2,026	14,453
Whipps Cross	2,281	2,421	2,441	2,380	2,100	1,814	13,437
Whittington	1,788	1,761	1,761	1,804	1,669	1,416	10,199
Total	63,031	63,448	64,470	63,605	57,815	50,887	363,256


Appendix 3 – Figure 19: Summary of Cold Weather Actions for Health and Social Care Organisations and Professionals, Communities and Individuals.

	Year-round planning <i>All year</i>	Winter preparedness and action <i>1 November to 31 March</i>	Severe winter weather forecast – Alert and readiness <i>Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60% confidence.</i>	Severe weather action <i>Mean temperatures of 2°C and/or widespread ice and heavy snow.</i>	Major incident – Emergency response
Commissioners of health					All level 3 responsibilities to be maintained unless advised to the contrary.
Provider organisations					
Frontline staff – care facilities and community	<ol style="list-style-type: none"> 1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have flu vaccinations. 				
GPs and their staff	<ol style="list-style-type: none"> 1) Be aware of emergency planning measures relevant to general practice. 2) Ensure staff aware of local services to improve warmth in the home including the identification of vulnerable individuals 3) Signpost appropriate patients to other services when they present for other reasons. 	<ol style="list-style-type: none"> 1) Consider using a cold weather scenario as a table top exercise to test business continuity arrangements. 2) Be aware of systems to refer patients to appropriate services from other agencies. 3) When making home visits, be aware of the room temperature. 	<ol style="list-style-type: none"> 1) Continue level 1 actions. 2) Take advantage of clinical contacts to reinforce public health messages about cold weather and cold homes on health. 3) When prioritising visits, consider vulnerability to cold as a factor in decision making. 	<ol style="list-style-type: none"> 1) Continue level 2 actions. 2) Expect surge in demand near future. 3) Ensure staff aware of cold weather risks and can advise appropriately. 	

	Level 0	Level 1	Level 2	Level 3	Level 4
Community and voluntary sector	<ol style="list-style-type: none"> 1) Engage with local statutory partners to agree how CVS can contribute to local community resilience arrangements. 2) Develop a community emergency plan to identify and support vulnerable neighbours. 3) Agree arrangements with other community groups to maximise service for and contact with vulnerable people. 	<ol style="list-style-type: none"> 1) Test community emergency plans to ensure that roles, responsibilities and actions are clear. 2) Set up rotas of volunteers to keep the community safe in cold weather and check on vulnerable people. 3) Actively engage with vulnerable people and support them to seek help. 	<ol style="list-style-type: none"> 1) Activate the community emergency plan. 2) Activate the business continuity plan. 3) Continue to actively engage vulnerable people known to be at risk and check on welfare regularly. 	<ol style="list-style-type: none"> 1) Continue level 2 actions. 2) Ensure volunteers are appropriately supported. 3) Contact vulnerable people to ensure they are safe and well and support them to seek help if necessary. 	<p>Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office.</p>
National level	<ol style="list-style-type: none"> 1) OO will lead on coordinating cross-government work; individual government departments will work with partners on winter preparations. 2) DH PHE and NHS England will look to improve the CWP and the monitoring and analysis of winter related illness and deaths. 3) PHE and NHS England will issue general advice to the public and professionals and work closely with other government departments and other national organisations that produce winter warmth advice. 	<ol style="list-style-type: none"> 1) Cold Weather Alerts will be sent by the Met office to the agreed list of organisations and Category 1 responders. 2) PHE and NHS England will make advice available to the public and professionals. 3) NHS England will continue to hold health services to account for action and PHE will routinely monitor syndromic, influenza, Norovirus and mortality surveillance data. 	<ol style="list-style-type: none"> 1) Continue level 1 actions. 2) DH will ensure that other government departments, particularly DCLG RED, are aware of the change in alert level and brief ministers as appropriate. 3) Government departments should cascade the information through their own partner networks and frontline communication systems. 	<ol style="list-style-type: none"> 1) Continue level 2 actions. 2) NHS England will muster mutual aid when requested by local services. 3) Met Office will continue to monitor and forecast temperatures in each area, including the probability of other regions exceeding the level 3 threshold. 	<p>All level 3 responsibilities to be maintained unless advised to the contrary.</p>
Individuals	<ol style="list-style-type: none"> 1) Seek good advice about improving the energy efficiency of your home and staying warm in winter; have all gas solid fuel and oil burning appliances services by an appropriately registered engineer. 2) Check your entitlements and benefits; seek income maximisation advice and other services. 3) Get a flu jab if you are in a risk group (September/October) 	<ol style="list-style-type: none"> 1) If you are receiving social care or health services ask your GP, key worker or other contact about staying healthy in winter and services available to you. 2) Check room temperatures – especially those rooms where disabled or vulnerable people spend most of their time. 3) Look out for vulnerable neighbours and help them prepare for winter. 	<ol style="list-style-type: none"> 1) Continue to have regular contact with vulnerable people and neighbours you know to be at risk in cold weather. 2) Stay tuned into the weather forecast; ensure you are stocked with food and medications in advance. 3) Take the weather into account when planning your activity over the following days. 	<ol style="list-style-type: none"> 1) Continue level 2 actions. 2) Dress warmly; take warm food/drinks regularly; keep active. If you have to go out, take appropriate precautions. 3) Check on those you know are at risk. 	<p>Follow key public health and weather alert messages as broadcast on the media.</p>

Appendix 4 – LAS Adverse Weather Plan



London Ambulance Service 
NHS Trust

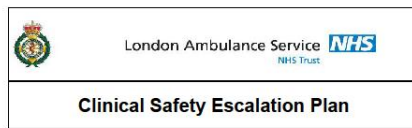
Adverse Weather Strategic Planning Framework (Including Heatwave Plan)



OFFICIAL SENSITIVE		
Date of Issue: August 2019	Review Date: September 2020	
Authorised By : Head of Resilience & Specialist Assets	To Be Reviewed By : EPRR	
Index No:	Page 1 of 64	Version 5.0

Appendix 5 – LAS Clinical Safety Escalation Plans

Official



London Ambulance Service 
NHS Trust



when it's less
urgent than 999

LAS IUC CAS DEMAND MANAGEMENT PLAN



Ref: SMP 6.3	Title: Clinical Safety Escalation Plan	Page 1 of 31
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Appendix 6 – LAS Ambulance Resource Escalation Action Plan (REAP)



London Ambulance Service Resource Escalation Action Plan (REAP)

Version	Final
Ratified by	Executive Leadership Committee (ExCOM)
Date ratified	13/03/2019

Appendix 7 – LAS Covid-19 Response Plan

Appendix 8 – NHS England (London) ED Capacity Management, Redirect and Closure Plan



NHS England (London)

Emergency Department Capacity
Management, Redirect and Closure
Protocol (ED Policy)

V8

Effective 09 December 2016



London Ambulance Service

NHS Trust

Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Integrated Performance Report			
Agenda item:	9			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board's attention:				
<p>This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across London Ambulance Service.</p> <p>This report brings together the areas of Quality, Operations, Workforce and Finance.</p> <p>It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.</p> <p>Key messages from all areas are escalated on the front summary pages in the report.</p> <p>It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.</p>				
Recommendations for the Board:				
<p>The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.</p>				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	x	No		
Finance	Yes	x	No		
Chief Operating Officer Directorates	Yes	x	No		
Medical	Yes	x	No		
Communications & Engagement	Yes	x	No		

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Strategy	Yes	x	No		
People & Culture	Yes	x	No		
Corporate Affairs	Yes		No		

London Ambulance Service – Integrated Performance Report



Report for discussion with Trust Board members

Analysis based on Year to **September 2020** data, unless otherwise stated (please see page 2 for data reporting periods)

Section	Content	Reporting Period	Pages	
Overview	Narrative Against Patients, People, Public Value & Partners	Current	3	
1. Our Patients	Trust wide Scorecard 999	Sep-20	4	
	999 Response Time Performance	Sep-20	5	
	Operational Demand	Sep-20	6	
	Operational Capacity	Sep-20	7	
	Operational Context	Sep-20	8	
	Safe Scorecard – 999 Incident Management	Sep-20	9	
	Clinical Quality Ambulance Indicators		10	
	Trust wide Scorecard IUC	Sep-20	11	
	IUC Performance	Sep-20	12	
	Safe Scorecard – IUC Incident Management	Sep-20	13	
	Safe Scorecard – Serious Incident Management	Sep-20	14	
	Safe Scorecard – Medicines Management	Sep-20	15	
	2. Our People	Trust wide Scorecard	Sep-20	16
		Vacancy Rates, Staff Turnover & Sickness	Sep-20	17
		Additional Workforce Analysis	Sep-20	18
Health & Safety – MSK RIDDOR Incidents		Sep-20	19	
Health & Safety – Physical Assaults on Staff		Sep-20	20	
Responsive Scorecard - Complaints		Sep-20	22	
3. Public Value	Trust wide Scorecard	Sep-20	23	
	Financial Position & Contract Position	Sep-20	24	
	Financial Position & Statement of Comprehensive Income	Sep-20	25	
	Cash flow Statement	Sep-20	26	
	Cost Improvement Programmes (CIPS) & Capital Plan	Sep-20	27	
4. Our Partners	Trust wide Scorecard	Sep-20	28	
	•Maximising safe non-conveyance to ED	Sep-20	29	
	•End of Life Care & Mental Health	Sep-20	32	

We have structured our management of performance and business plan around our organisational goals: **our patients, our people, our partners and public value:**

Update on performance:

Provide outstanding care for our patients

999 Performance in all national measures has remained strong since the Covid-19 measures were implemented. The Trust ranked 3rd in C1 and C2 mean; and 2nd in C3 mean nationally. The C4 90th centile was challenged in September where we ranked 6th national out of 11.

111 Performance on calls answered within 60 seconds SLA was outside target for both North East London (NEL) and South East London (SEL) due to increased call demand in September, while the abandonment rate at both sites are within target. While the abandonment rate was within target during September for NEL and SEL, The Trust is beginning to see an increase in abandonment rates inline with increased call demand and are closely monitoring this. Despite being outside the national target, the Trust has ranked 2nd and 3rd place for Call Answering and Calls Abandoned. We were outside target for calls closed with no onward referrals for both sites. For calls recommended to ED, SEL just missed the target of 10% by 0.8% and NEL within target at 9.8%.

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

Our overall vacancy rate has remained within target (5%) at 2.2%. We have a strong staffing position in both Emergency Operations Centre (EOC) and Integrated Urgent Care Services (IUC) and are currently reporting no vacancies. Our in-ops vacancy rate has decreased from 3.9% in July to 3.5% in September and we are forecasting an end of year operational gap of 100fte posts. We had a total of 66 starters in September and nearly half were from a Black Asian Minority Ethnic (BAME) background. Our turnover has continued to improve from 8.9% to 8.6% since the last report. The monthly Trust wide sickness has marginally increased from 4.6% to 4.9% since July, slightly below the rate for the same period last year (5.4%). Trust compliance in Statutory and Mandatory training has remained unchanged at 84% and appraisals also remains the same at 67% since July. A paper detailing the plan to improve appraisal compliance has been drawn up and will be presented at ExCo during October. The Trust is embarking on a new exciting pilot across the London borough of Merton supplying 2 paramedic practitioners per GP group. The project supports the NHS [Long Term Plan](#) in its ambition to provide a more community based integrated care to patients.

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

In line with the financial framework in place up to September, the Trust reported a breakeven position on an adjusted financial performance basis in month 6, £96k surplus year to date (YTD) before measurement of adjustments in relation to donated assets), and is forecasting a £2.4m surplus in line with NW London STP planning. The amount of additional M6 retrospective top up requested to balance the Trust's position was £8.575m (YTD: £49.916m). This is higher than the Trust's M6 reported COVID costs of £7.758m (YTD: £48.358m).

Capital spend was £6.8m YTD (primarily on COVID-19 response requirements £5.5m) with a full year forecast capital expenditure is £50.3m in line with the Trust's latest capital plan submitted to NHSI with the addition of £6.1m of CRL identified through NWL partners. The month end cash position was £64.6m.

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

Work is ongoing to improve on our Patient handover metric through continuous dialogue between our Stakeholder Engagement Managers and hospital management teams pan London. The Trust continue to achieve a robust performance around Handover to Green (H2G). While maintaining this strong performance in H2G, we are beginning to see a marginal increase, since June, in line with increasing demand. Similarly, the Emergency Department (ED) conveyance during September was in a good position, continuing on the trend from May.

As business planning and target setting have been delayed due to Covid-19, the comparison are currently based against the 2019/20 targets and actual performance. LAS performance for Hear & Treat was the 5th best nationally and 0.9% better than the national average of 7.7%. LAS ranked 6th for ED conveyance. The variance between Ambulance Trusts for this metric is small, with us just finishing at 0.7% lower than the national average of 54.1%.

Achievements since the last report (July 2020)

- September saw the continuation of strong performance for most 999 performance metrics.
- NEL/SEL has shown reduced performance in call answering. This resulted in a review of the forecasts moving forward and increased responsiveness in the form of staffing changes.
- Trust Executive are signing off plans for response to additional Covid-19 demand; forecasted Winter activity and the potential impact of the EU Exit.

- Staff Turnover rates have further improved from 9.1% in July to 8.6% (within target).
- The 'in-ops' vacancy rate for our frontline registered and non-registered staff has reduced from 3.9% in July to 3.5%.
- Sickness has marginally increased from 4.6% in July to 4.9%.
- Stat and mandatory remains unchanged at 84% against our 85% target

- The Trust has been operating under an adjusted financial framework for April to September 2020 which involved pausing business planning and contracting processes, and the receipt of block income supplemented by monthly standard and retrospective top up income allowing COVID expenditure to be funded.
- From month 7 onward this framework is being replaced with fixed income envelopes managed at STP level, and will require the achievement of a 1% efficiency plus an additional efficiency, required to match new approved spend (currently £1.9m, total efficiency of £4.3m).

- ED conveyance performance in September was within target at 54.2% against the agreed contract figure of 57%
- Hear & Treat performance saw us achieve 8.6% during September, which is significantly better against the same month last year where we attained 6.7%
- Trust continues to work with system partners to improve on these metrics, both of which are included in the LAS Business Plan for 2020/21.



Patients Scorecard

September 2020

September 2020				Current Performance					Benchmarking (Month)		
Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	National Data	Best In Class	Ranking (out of 11)
Category 1 response – Mean	mm:ss	Sep-20	●	07:00	A	00:06:33	00:06:19	00:06:54	07:16	06:19	3
Category 1 response - 90th centile	mm:ss	Sep-20	●	15:00	A	00:11:03	00:10:42	00:11:44	12:55	11:00	2
Category 1T response – 90th centile	mm:ss	Sep-20	●	30:00	N	00:16:44	00:14:58	00:18:38			
Category 2 response – Mean	mm:ss	Sep-20	●	18:00	A	00:16:53	00:14:10	00:21:49	22:32	13:15	3
Category 2 response - 90th centile	mm:ss	Sep-20	●	40:00	A	00:33:42	00:25:58	00:45:59	00:46:03	00:24:36	3
Category 3 response – Mean	h:mm:ss	Sep-20	●	1:00:00	A	00:47:19	00:33:20	00:56:45	01:06:49	00:39:50	2
Category 3 response - 90th centile	h:mm:ss	Sep-20	●	2:00:00	A	01:53:46	01:13:10	02:15:04	02:37:06	01:29:11	2
Category 4 response - 90th centile	h:mm:ss	Sep-20	●	3:00:00	A	03:14:14	02:14:23	03:28:58	03:27:55	02:10:16	6
Call Answering Time - 90th centile	ss	Sep-20	●	24	I	1	2	71			
ROSC at Hospital	%	Jun-20	●	31%	N	31.1%	Cannot produce YTD or 12 Month Rolling data due to inconsistent release of CAQI data from NHSE		27.6%	34.4%	2
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Jun-20	●	95.0%		92.5%			80.6%	92.5%	1

Benchmarking Key

Top 3

Ranked 4-7

Ranked 7+

Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

- G KPI on or ahead of target
- A KPI off target but within agreed threshold
- R KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Note: **Sepsis** is measured quarterly

*National average YTD

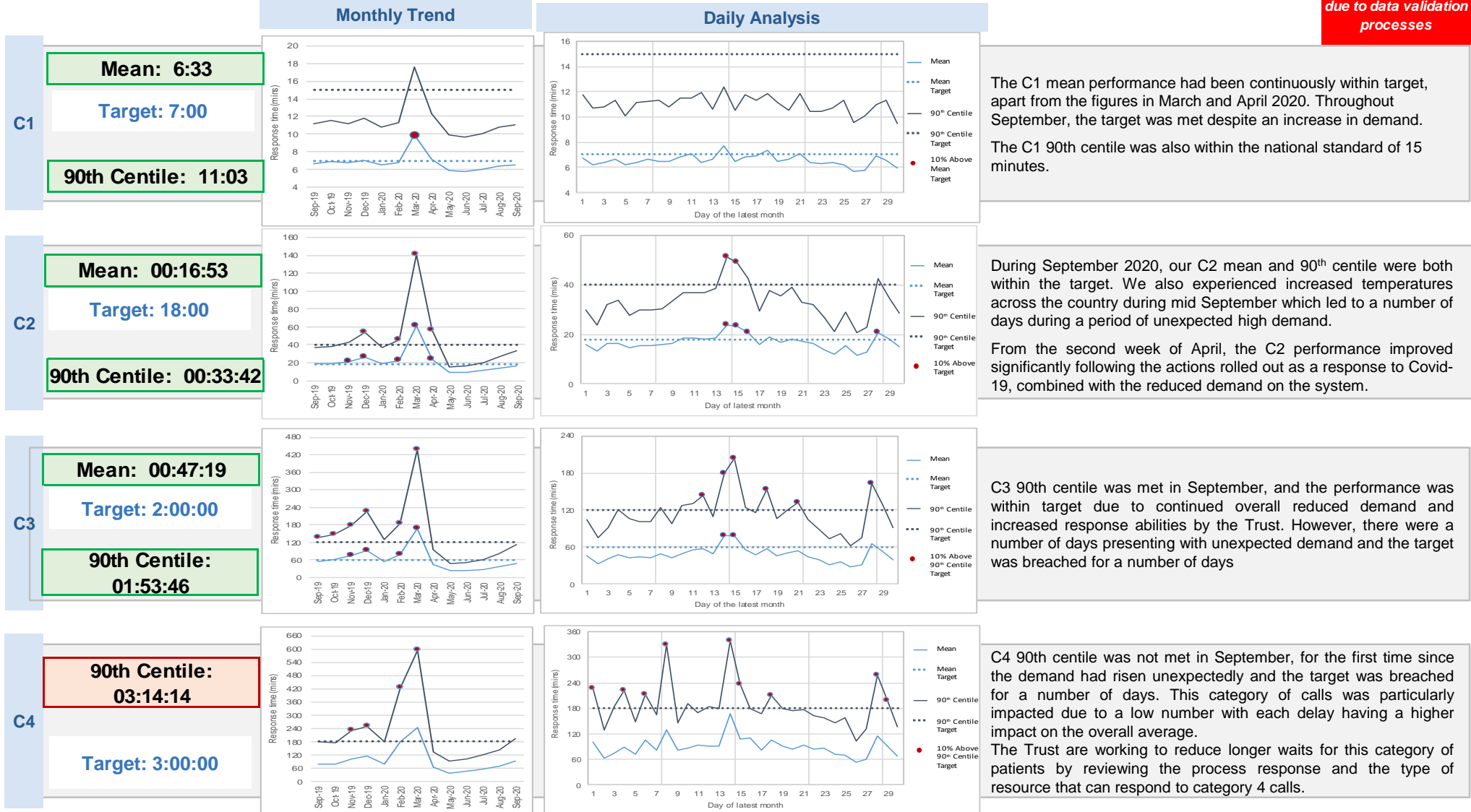
1. Our Patients

999 Response Time Performance



Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

The Category 1 mean in September returned 6 minutes and 33 seconds while the Category 1 90th centile was 11 minutes and 03 seconds. The Category 1 90th centile had remained within the standard each week since the implementation of the Ambulance Response Programme (ARP), until the Covid-19 impact and shows that our most critical patients are being responded to quickly. The latest nationally published data shows that the Trust is ranked third in the Category 1 mean measure and ranked second in the Category 1 90th centile measure when compared to all Ambulance Trusts across England. An incident of note witnessed during the September month was the increased temperatures and warm weather throughout the country; thus impacting on our demand across the performance categories.



1. Our Patients

999 Response Time Performance

Operational Demand



Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

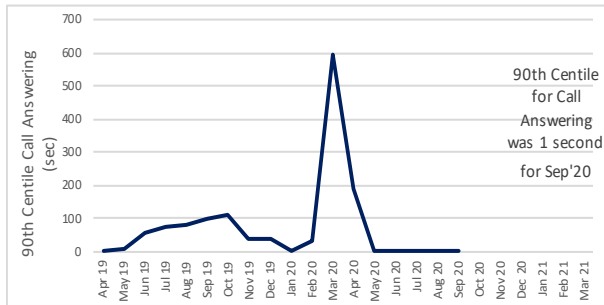
The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: **1) Calls Received**, **2) Incidents and Response Type (incl. Hear & Treat, See & Treat, See & Convey)**, **3) Incident Category**

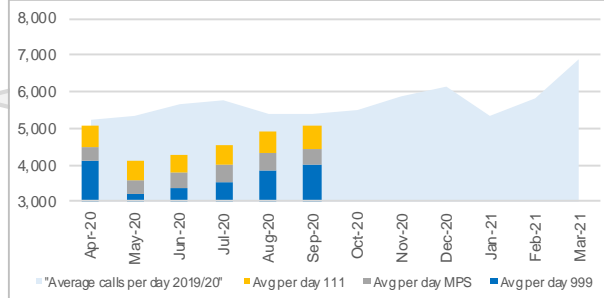
999 Calls Received

September 2020 saw a number of calls nearing the number in the equivalent period in 2019/20. As a result of the demand and increased staffing, call answering performance has been significantly better against our target on call answering 90th centile, which is less than 24 seconds

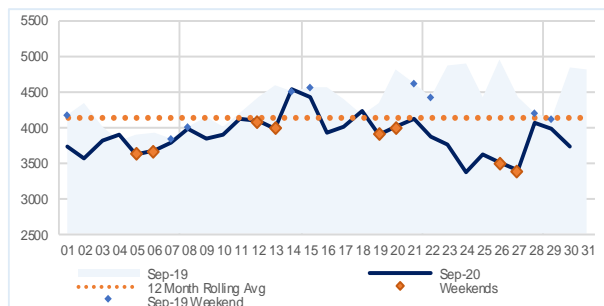
Performance (90th Centile)



Average Calls Per Day



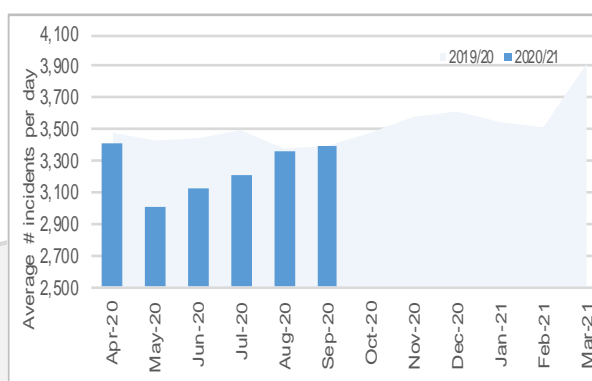
Daily Calls Answered



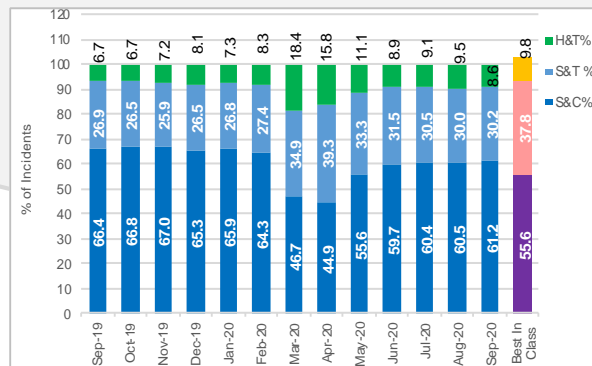
Incidents and Response Type

In September 2020 the number of incidents per day was close to the 2019/20. Performance improved for ED conveyance and Hear & Treat compared to 2019/20 due to concentrated effort on these measures and a modified response from the trust to Covid-19.

Incidents



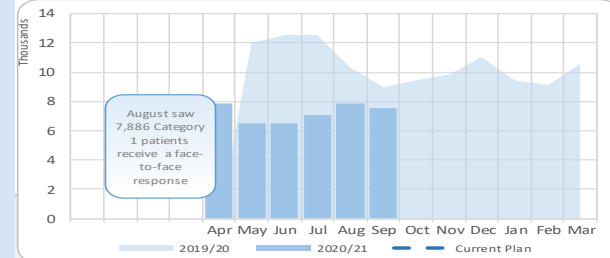
Response Type



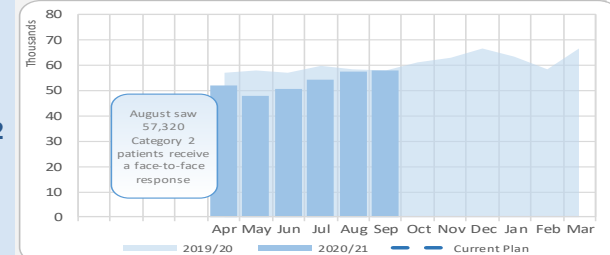
During September 2020, SWAS was best in class achieving 37.8% for See & Treat. SCAS gained 1st place and was best in class for both See & Convey and Hear & Treat categories, achieving 55.6% and an astonishing 9.8% respectively.

Incident Category (By Month)

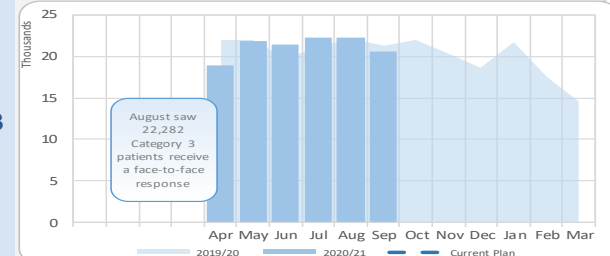
C1



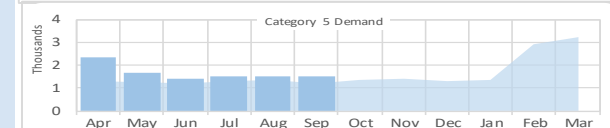
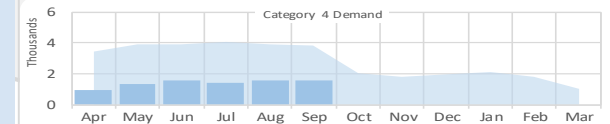
C2



C3



C4/C5

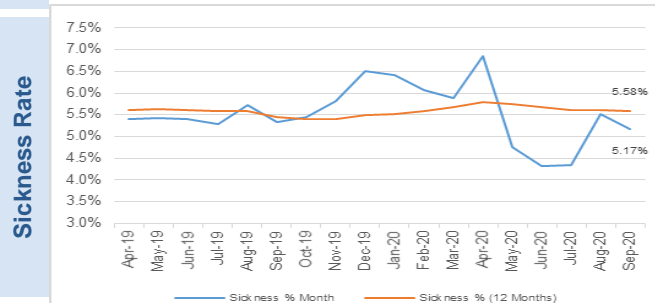
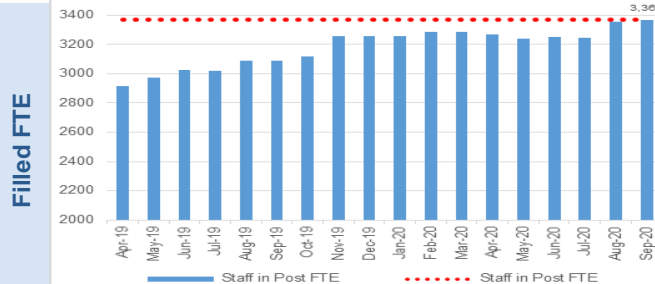




Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

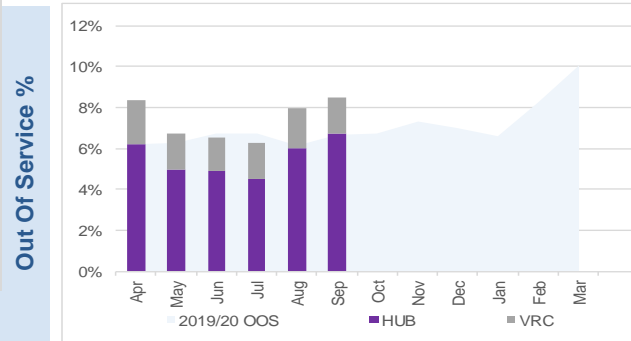
Frontline Operational Staff

The number of filled operational FTE has shown an improvement over 2020/21 and we continue to place considerable effort into our recruitment and retention activity. Overall staff in post numbers have improved compared with the same period last year. (See Our People section of this report for further detail across the organisation)



Vehicle Availability and Patient Facing Hours

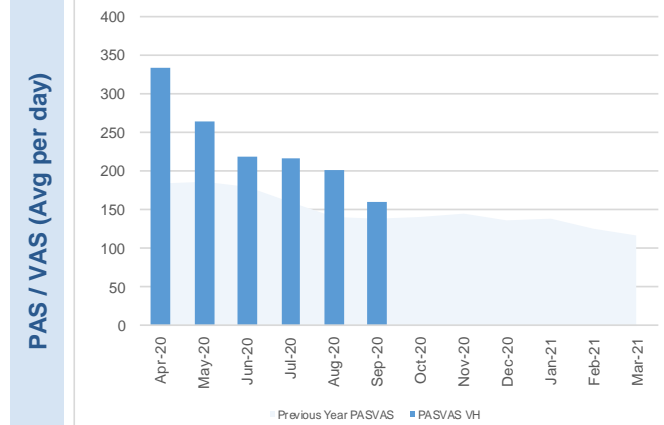
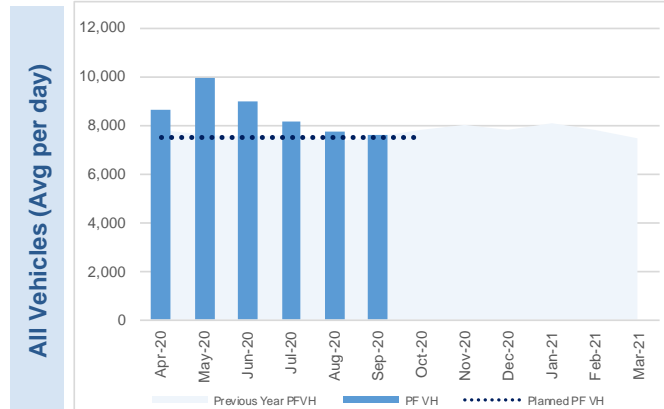
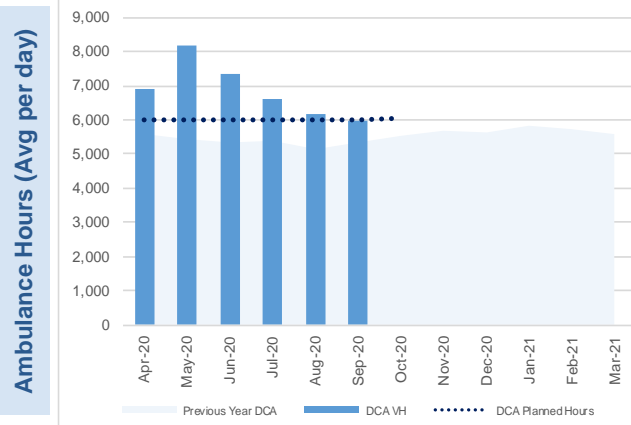
The DCA Fleet has decreased from 537 to 533, this is due to older DCAs not being cost effective to repair. The increased DCA fleet continues to support the Strategic Assets and Property Team to deliver support to frontline operational rotas delivery of patient care. The Trust provided **276,939.40hrs** patient facing hours in September 2020. The Vehicle Resource Centre maintained a high performance ensuring a DCA was in place at start of shift as reflected in the VEHNO OOS for August 2020 - 51.9hrs (**0.02 %**) and September 2020 - 37.27hrs (**0.02%**). Contributory factors to ensuring the DCA vehicle availability remains at the required levels are due to collaborative working between the Strategic Assets and Property Teams as well as the support provided by our contractors in the cleaning, prepping, movement and roadside repairs of vehicles. The Overall Out Of Service rate averaged 8.79% for September 2020 an increase of 0.58% from the previous month. In part the immunisation programme impacted upon the OOS increase with c. 2,098hrs accrued. The increased VP presence during the day at the 14 VP Hub sites continues to assist in sustaining a high DCA vehicle availability along with collaborative working between the Strategic Assets and Property Teams.



Note:

OOS HUB - This account for out of service codes related to people/crew reasons for out of service hours

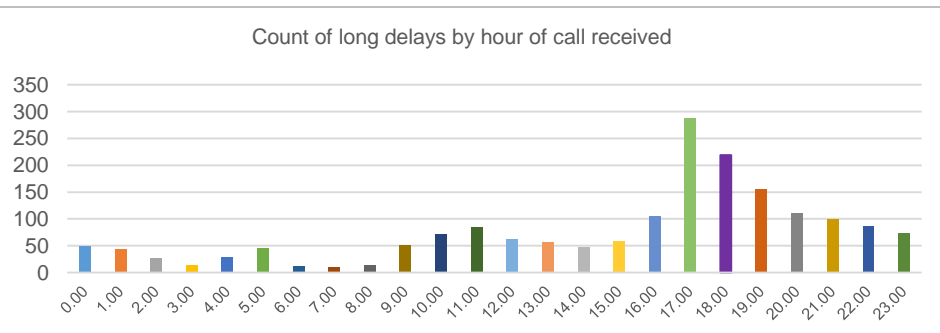
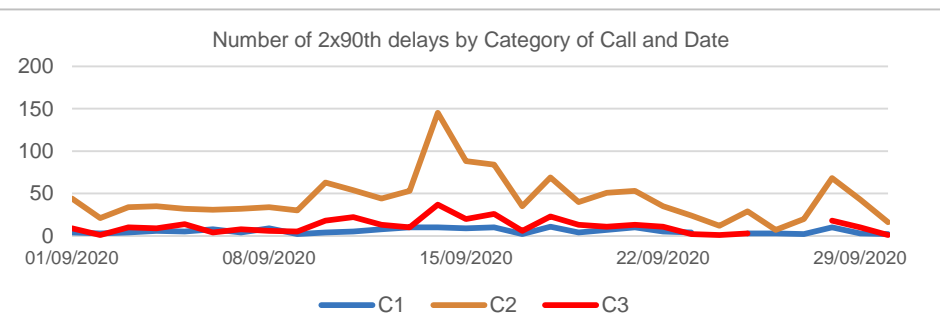
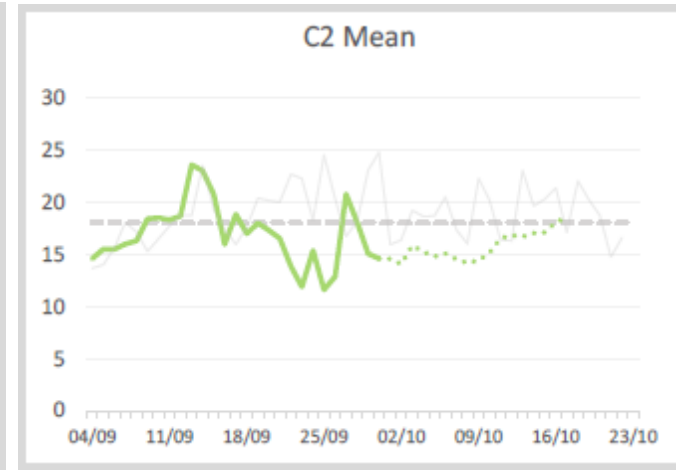
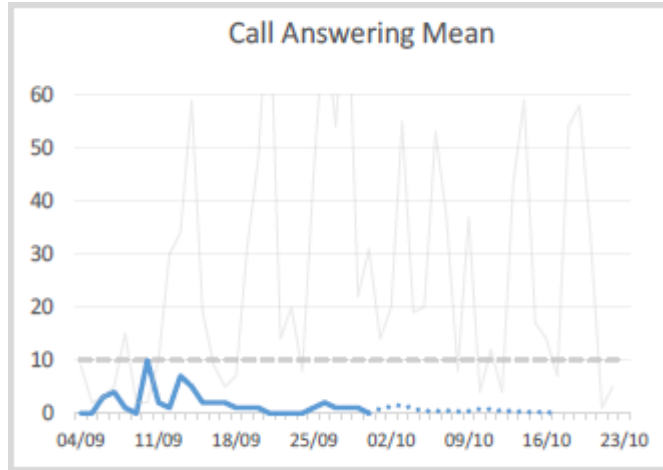
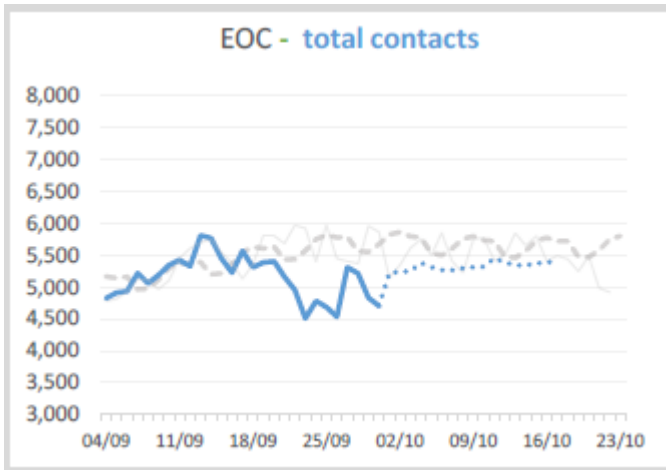
OOS VRC - This account for out of service codes related to vehicle reasons for out of service hours





The service is meeting operational delivery KPIs, with call answering and mean response times for Cat 1 and 2 returning to within national set timeframes. The National Ambulance Scorecard has rated the Trust as 100% against 13 weekly metrics including response times and long waits.

For reference only – Demand & Performance, showing 4 weeks past and 3 weeks future from today



In September there were 1817 long delays of which 7.3% resulted in a blue call.

	C1	C2	C3	Grand Total
September	167	1326	324	1817
Blue call	25	98	10	133

The top three determinants where a long delay was incurred was:

- Dx012 – (15.4% n 281) – 13 required a blue call
- Calls from the MPS (6.7% n 123) – 4 required a blue call
- 17A2G – patients whom have fallen and are still on the ground (2.9% n 53) – 4 required a blue call

All delays are reviewed daily using the parameters developed during the COVID19 review. There were no cases of concerns identified as causing harm by the delay in September.

38.9% (n 708) patient whom experienced a long delay were not conveyed and 61% were conveyed. It was also found that 34.6% (n 663) of all long delays occurred between the hours of 17:00 and 19:00.

Action being taken include:

- Forecasting and planning with updates shared at DSLT weekly
- Review of staffing for EOC and Operations
- Overtime incentives to ensure cover at predicted busy periods.
- Daily operational performance review
- Winter planning and ambulance recruitment underway

1. Our Patients

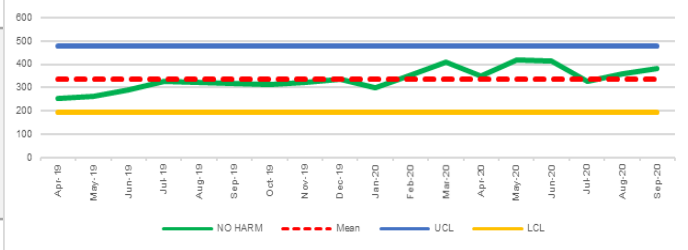
Safe Scorecard

999 Incident Management



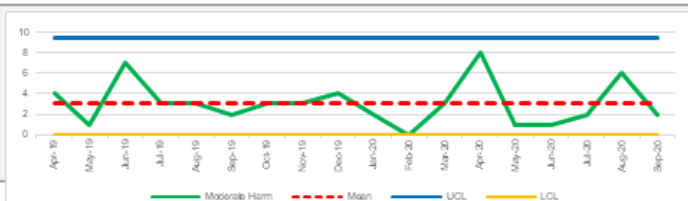
No Harm/Near Miss

Latest Month: 383



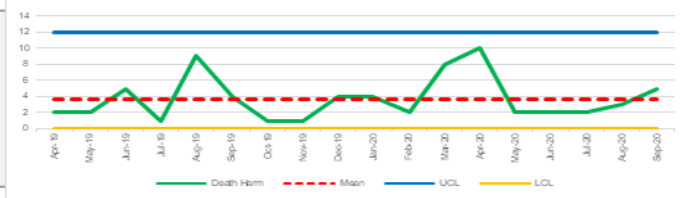
Moderate Harm

Latest Month: 2



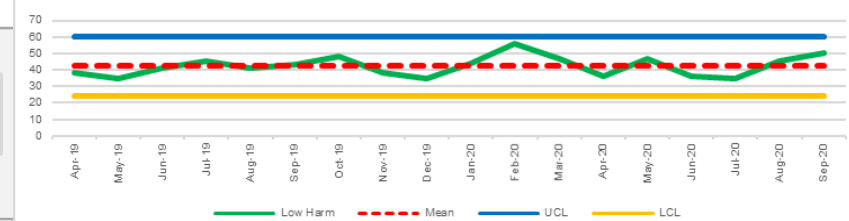
Death

Latest Month: 5



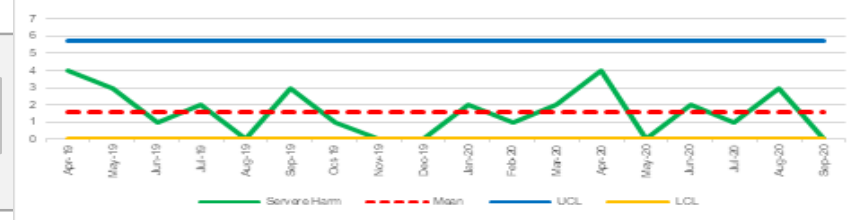
Low Harm

Latest Month: 50



Severe

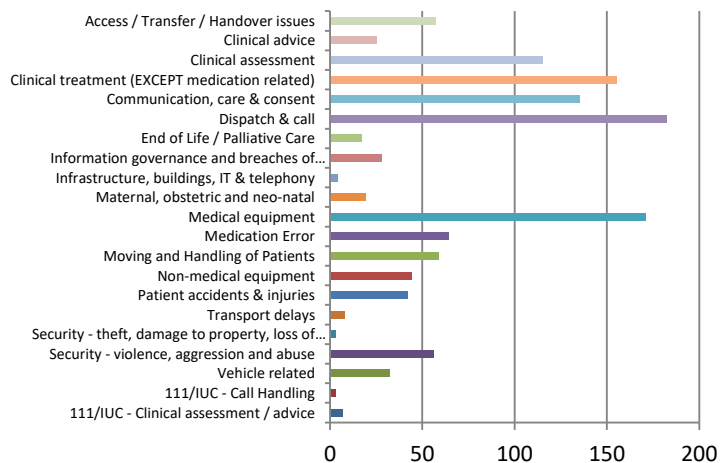
Latest Month: 0



Analysis of SPC graphs:

The number of no and low harm incidents continue to increase in reporting. The central team review these to identify themes where actions are required. The largest number of incidents reported in these severity levels is unavailability of equipment. An update on actions being taken is included in the incident category section below. In regards to moderate, severe and death incidents, the peaks on the SPC graphs matches times of seasonal demands on the service. The highest peak is seen over March/April during the height of the COVID19 pandemic in London.

Incidents by Category



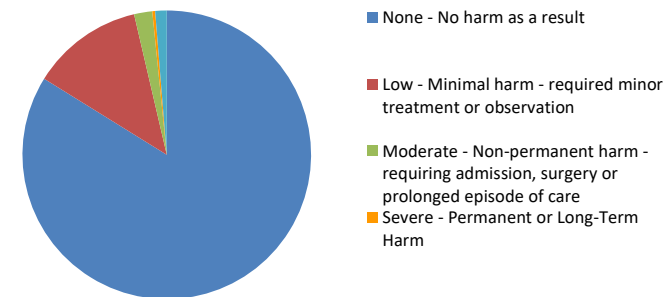
Medical Equipment, dispatch and call management and clinical treatment issues are the top three reported incidents. Actions are being taken to address these themes including:

- There is a task and finish group looking at small high value items and a trial will be begin in December which will see these items being scanned out of meds rooms to provide a level of track and trace.
- Manage the safe interruption of ECH's where required in order not to distract them from the importance of the call they are taking.
- The London Ambulance Trust is working with TfL into the traffic calming schemes and the impact it is having on the Trust.

There are 934 (as of 12/10/2020) which have been opened on the system longer than 35 working days (this excludes SIs). This breaks down to 411 patient incidents, 251 staff incidents, 28 visitor incidents and 244 Trust related incidents.

There is a focused piece of work being undertaken by QGAMs, Operational colleagues & the QI&L team. In particular the QI&L team have applied a methodology to incidents older than January 2020 which has seen a further 300 incidents finally approved.

Incidents by Severity

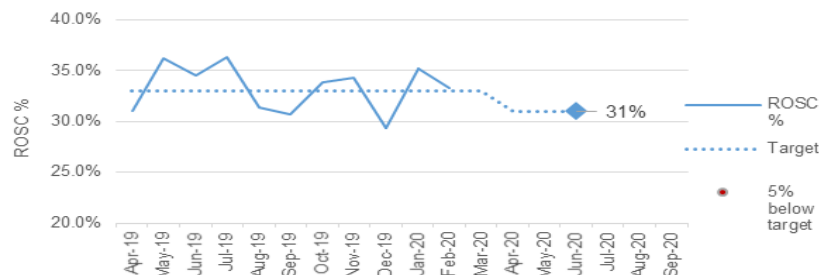


Incident Management



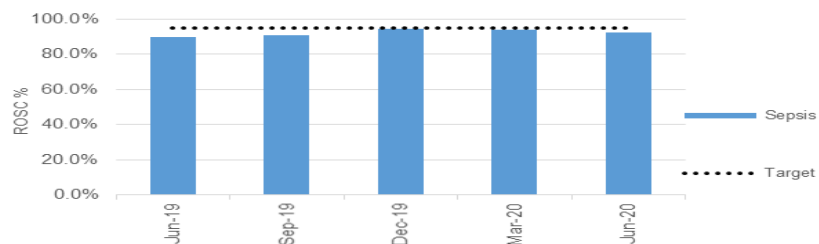
Our Trust-wide scorecard covers four of the key Ambulance Quality Indicators: Cardiac Arrest - Return of Spontaneous Circulation (ROSC) at Hospital, Sepsis - Care Bundle, STEMI - Call to angiography and Stroke - Call to door. The data presented is from **June 2020**, which is the most recent month published by NHS England. Please note: Due to NHS England suspension of AQI reporting during the first wave of the pandemic, March-May 2020 data will not be published until January 2021.

ROSC at Hospital

Month: 31.1%**Target: 31.0%****2018/19 Position:****35.7%**

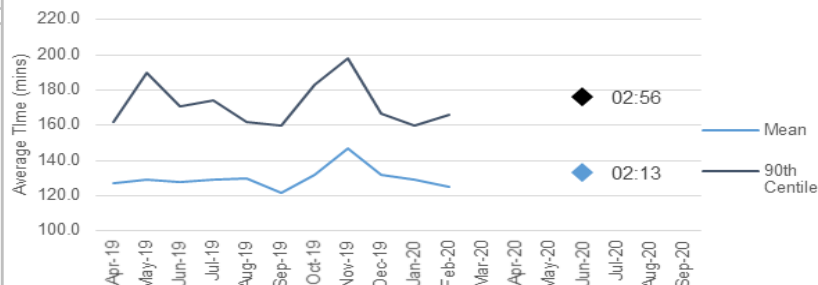
In June 2020, the LAS ranked 2nd for ROSC on arrival at hospital for the overall group with 31.1% and 3rd for the Utstein group with 56.1%, both well above the national average of 27.6% and 50.6% respectively. We remained below average for survival to discharge in both the overall (6.2%) and Utstein comparator groups (25.5%). NHS England did not publish Post-Resuscitation Care Bundle data for December, the next data due to be published will be for July (in December).

Sepsis Care Bundle

Month: 92.5%**Target: 95%****2018/19 Position:****89.5%**

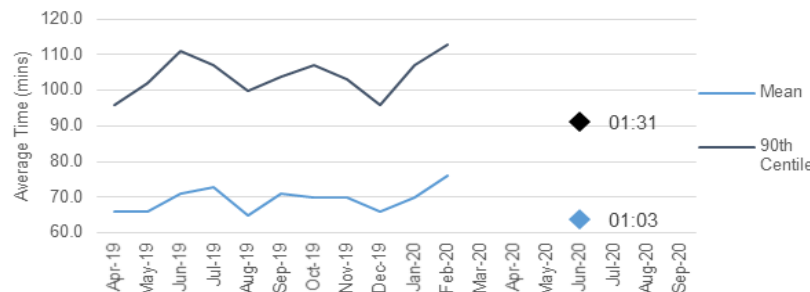
The LAS ranked 1st for the sepsis care bundle, achieving 92.5% compliance against a national average of 80.6%.

STEMI call to angiography

Mean: 02:13**Target: 02:10****2018/19 Position:****02:07**

The mean average call to balloon time for STEMI patients was 2:13 in June, which is 8 minutes longer than the most recently published figures (for February 2020). This is one minute longer than the national average (2:12). The LAS were the 5th best performing ambulance trust in England for this metric. STEMI care bundle compliance is reported quarterly and was not reported for June.

Stroke call to door

Mean: 01:03**Target: 01:10****2018/19 Position:****01:10**

The LAS ranked 1st for mean Call to Arrival at Hospital for Stroke patients (01:03), far exceeding the national average of 01:14. NHS England did not publish Stroke Diagnostic Bundle data for June, the next data due to be published will be for August (in January 2021).



Patients Scorecard (NEL IUC)

September 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	London Data	Best In Class	Ranking (Pan London)
Percentage of calls answered within 60 seconds	%	Sep-20	<div></div>	95.0%	A	83.0%	91.6%	74.4%	77.5%	87.7%	3
Percentage of Total number of calls abandoned after 30 seconds	%	Sep-20	<div></div>	5.0%	A	3.4%	2.4%	12.5%	5.0%	1.7%	3
% of calls closed with no onward referral (health advisor and clinician)	%	Sep-20	<div></div>	33.0%	A	29.9%	25.6%	26.6%			
% of calls transferred to 999	%	Sep-20	<div></div>	10.0%	A	8.0%	7.5%	7.9%	8.1%	6.4%	2
% of calls recommended to ED	%	Sep-20	<div></div>	10.0%	A	9.8%	9.8%	8.8%	10.8%	9.5%	2

Benchmarking Key

Top 3

Ranked 4-7

Ranked 7+

Patients Scorecard (SEL IUC)

September 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	London Data	Best In Class	Ranking (Pan London)
Percentage of calls answered within 60 seconds	%	Sep-20	<div></div>	95.0%	A	86.1%	91.8%	76.6%	77.5%	87.7%	2
Percentage of Total number of calls abandoned after 30 seconds	%	Sep-20	<div></div>	5.0%	A	2.1%	2.4%	10.6%	5.0%	1.7%	2
% of calls closed with no onward referral (health advisor and clinician)	%	Sep-20	<div></div>	33.0%	A	32.0%	28.3%	28.6%			
% of calls transferred to 999	%	Sep-20	<div></div>	10.0%	A	6.4%	8.0%	7.7%	8.1%	6.4%	1
% of calls recommended to ED	%	Sep-20	<div></div>	10.0%	A	10.8%	10.6%	9.4%	10.8%	9.5%	3

G KPI on or ahead of target
 A KPI off target but within agreed threshold
 R KPI off target and outside agreed threshold
 KPI not reported / measurement not started



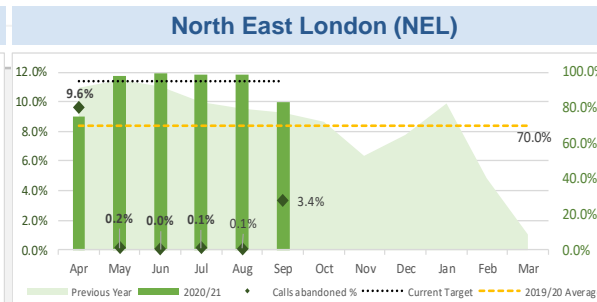
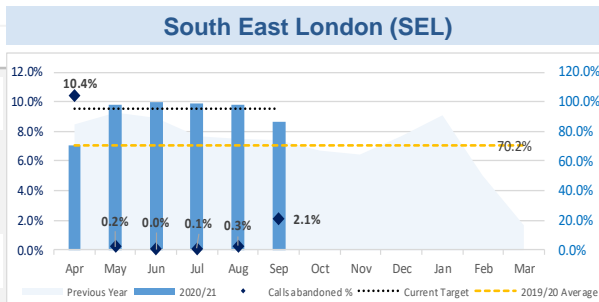
Call answering was outside target in September for North East London (NEL) and South East London (SEL) due to a rise in demand following the return to school. A large proportion of the increased activity was attributed to worried parents contacting 111 seeking guidance around testing process for their children. Both sites are within target for calls transferred to 999, where we consistently perform better than the London average. The abandonment rates were within target for September. We were challenged in the recommendation to attend ED performance for SEL.

Call Answering & Abandoned Calls

SEL: 86.1% / 2.1%

Target: 95% (CA) and 5%

NEL: 83.0% / 3.4%



The 111/IUC centres have been critically important in national Covid-19 response as any concerns were directed to 111 across England. The call demand in September increased due to schools reopening, which challenged the 111 performance.

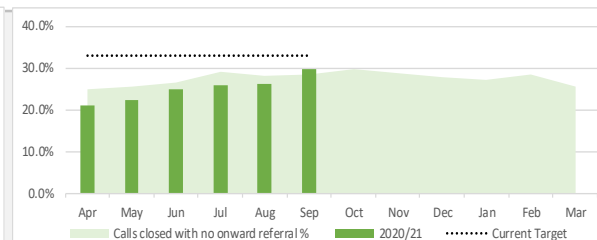
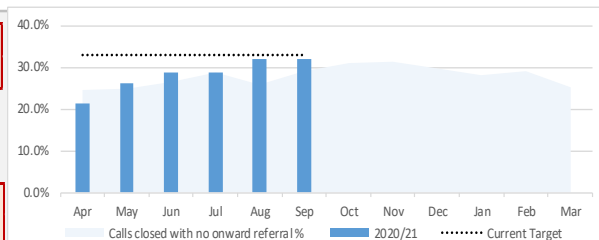
The number of calls abandoned by patients was well within the 5% target..

% of calls closed with no onward referral

SEL: 32.0%

Target: >33%

NEL: 29.9%



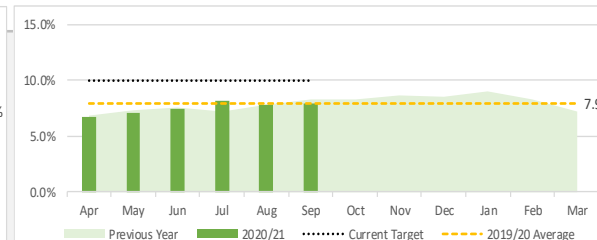
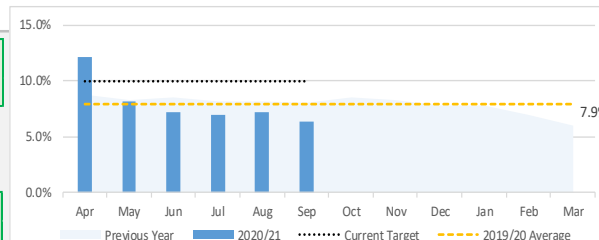
We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system.

Calls Outcome: Transferred to 999

SEL: 6.4%

Target: <10%

NEL: 8.0%



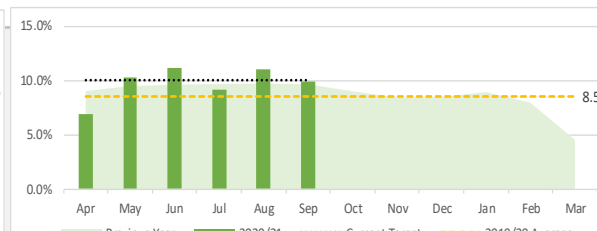
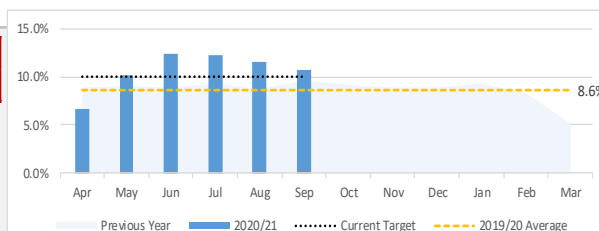
Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During September, NEL delivered 8.0%, with SEL delivering 6.4%. This performance compares positively against the London average which was circa 8%, demonstrating the benefits of a clinical assessment service (CAS).

Call Outcome: Recommended to attend ED

SEL: 10.8%

Target: <10%

NEL: 9.8%



The development of our IUC services has enabled NEL and SEL to consistently outperform other providers on A&E avoidance. The performance on this metric has been challenged while striving to give patients the most appropriate care. There is still work to do to reduce recommendation for patients to attend A&E while balancing with patient safety and the transfer to 999.

1. Our Patients

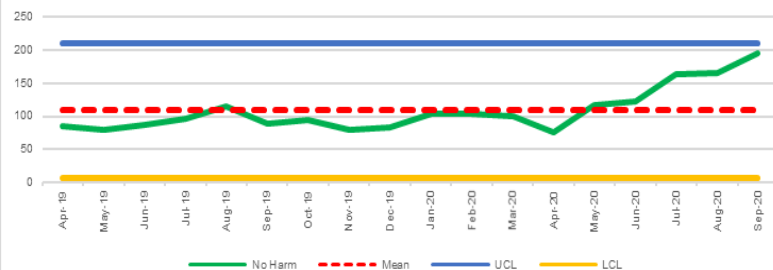
Safe Scorecard

IUC Incident Management



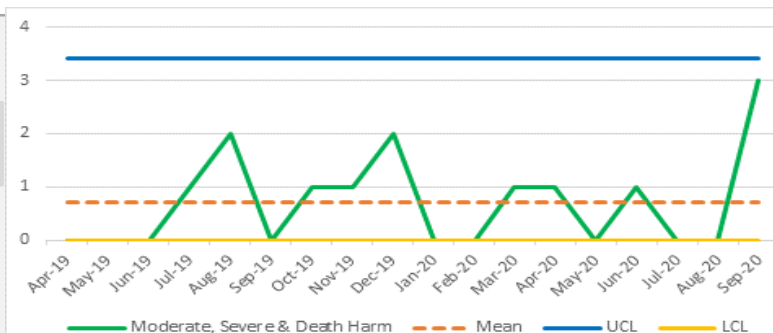
No Harm/Near Miss

Latest Month : 195

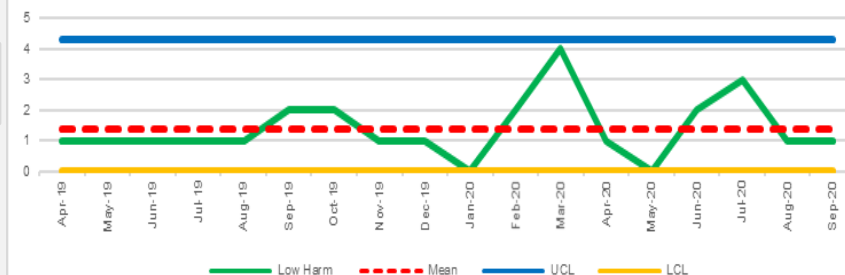


Moderate, Severe & Death Harm

Latest Month : 3



Latest Month: 1

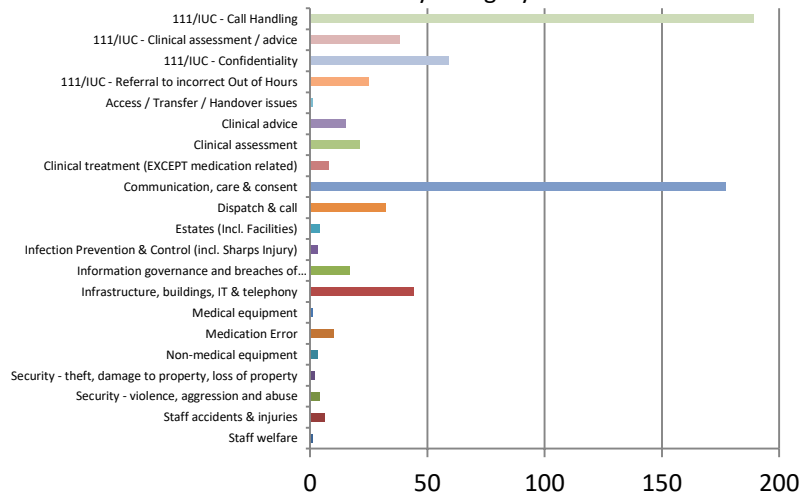


Analysis of SPC graphs:

The number of near miss and no harm incidents continue to increase in reporting. The largest number of incidents reported are regarding communication incidents. An update on actions being taken is included in the incident category section below.

In regards to moderate, severe and death incidents, these relate to call assessment errors and this theme has been included in the Patient Safety Incident Response Plan as the Trust moves over to the PSIRF. This will enable a through investigation into the contributory factors and developed quality improvement projects to address the issues.

Incidents by Category



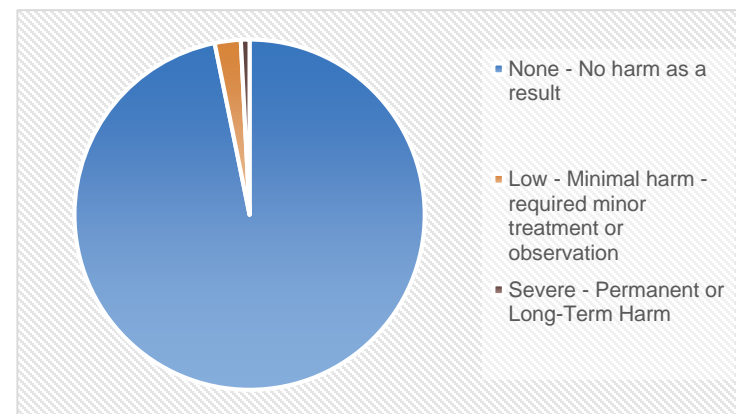
The top three category of incidents are call handling, Communication, care and consent and confidentiality.

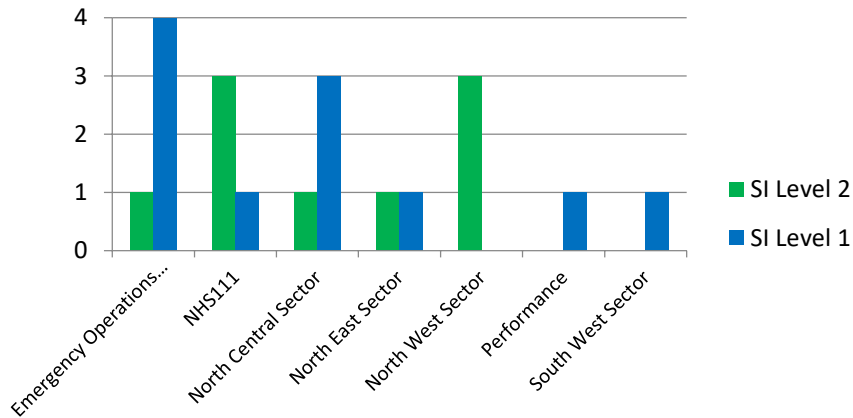
Communication incidents refer to authorized breaches in confidentiality, made under best interest decision for the patient who lacks capacity. These are routinely reported to ensure robust decision making and application of consent and capacity regulations and best practice.

To address communication incidents, the Directory of Services and downstream providers are being engaged to ensure eligibility criteria for referring patients is accurately represented on DoS, as passbacks due to unclear guidance form the majority of these incidents.

There are 125 (as of 12/10/2020) which have been opened on the system longer than 35 working days (this excludes SIs). There is a focused piece of work being undertaken by QGAMs, Operational colleagues & the QI&L team to monitor and process overdue incidents.

Incident Management



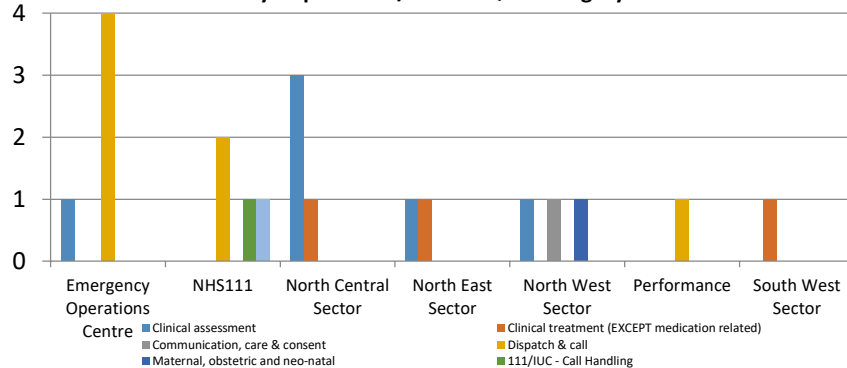


During July, August and September 2020, total of 20 (including NHS 111) reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

The Trust's Q2 SI thematic report has been produced and should be read in conjunction with this report. Q2 saw a number of call handling errors and an increased number of SIs declared where patients have been not conveyed to hospital, although the overall number of incidents declared was lower than the previous quarter.

Reviewing contributory factors from completed SIs revealed organisational factors listed highly during Q2 which can be attributed to the demand faced on the Trust during COVID-19. During the peak of the pandemic the Trust changed a number of internal processes and procedures in order to respond to the unprecedented demand. These changes were challenging for staff to maintain oversight of at times and were contributory in incidents which were closed during Q2.

SIs declared by Department/Area in Q2 – Category Breakdown



There continues to be a focus on SI actions, at the end of September there were 190 open actions, of these 48 were overdue. There are certain processes in place to monitor and encourage prompt completion of actions including:

- Action owners are made aware of the overdue action by the Datix system which send a reminder every 2 days.
- The team makes contact with the owners by various correspondence to get updates on the action, provide support where possible and ensure that actions are being addressed.
- Overdue actions are also monitored at the Safety Investigation Assurance and learning group where escalations to departments are communication, if required.

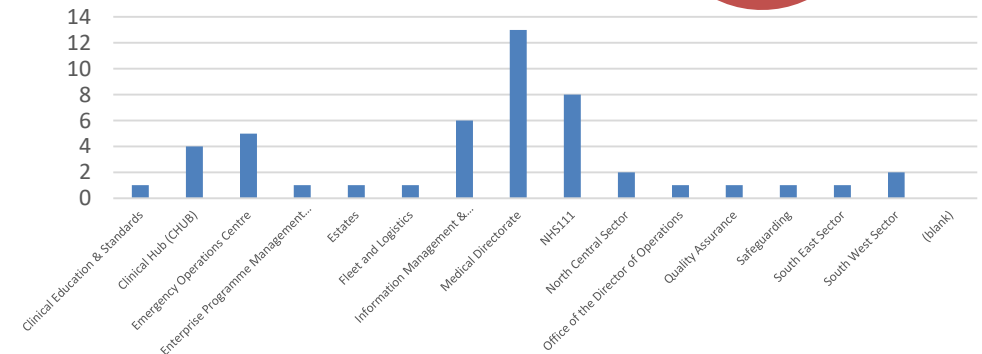
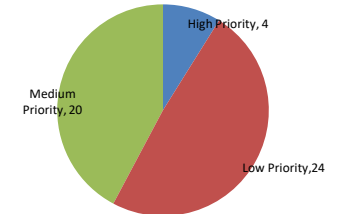
There are 4 incidents which are oldest and highest in priority:

There are two actions that relate to a CADlink failure between IUC and EOC which required an IM&T fix. The second actions relates to training of NEL IUC staff on this failure.

Update: There is no current IM&T fix for this national issue, a risk has been drafted on to the Corporate risk register and a work around is in place. The NEL staff are receiving training and the Quality Governance and Assurance Manager for IUC keeps SIALG up to date with how this action is progressing.

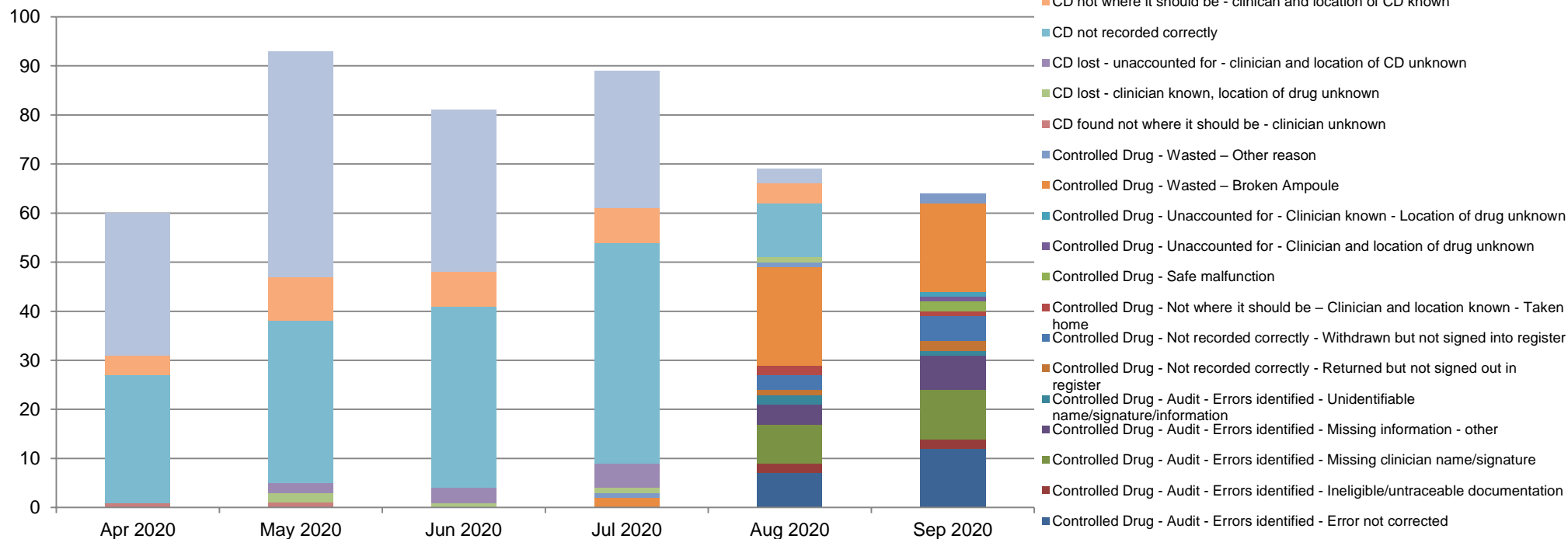
There are two further IUC actions regarding a review of compliance with completion of induction for agency and contractors in IUC and a monthly audits of 5% of all agency clinicians supplied by the managed service, in order to ensure all competencies are achieved.

Update: These are progressing as part of the IUC improvement plan and are being tested to provide assurance before closing.





BI Controlled Drug Report



- No unaccounted for loss of injectable morphine
- Total of 92 other controlled drug (CD) incidents including
 - Misuse of Abloy key (n=1)
 - Errors identified during CD audit (n=33)
 - CD recording errors (n=7)
 - CD retained off-duty (n=3)
 - CD safe malfunction or damage (n=6)
 - CD wastage, breakage or damaged packaging (n=20)
 - CD found expired (n=4), damaged (n=5) or seal broken (n=3)
 - Non-CD theft or loss (n=3) and other CD issues (n=9)
- Non-controlled drugs incidents
 - Incorrect dose of adrenaline (n=3), benzylpenicillin (n=3), dexamethasone (n=1), ipratropium (n=1), morphine (n=2), paracetamol (n=1).
 - PGD breach (n=1) relating to diazepam
 - Hydrocortisone (n=1) not indicated
 - Prescribing error by non-LAS staff (n=1)
 - Administration of out of date drug by non-LAS staff (n=1)
 - Localised allergic reaction – morphine (n=1)

Actions:

- One APP-UC member of staff has completed prescriber training with two others due to complete in November 2020.
- Further funding for prescriber development agreed with HEE
- Planned reissue of adrenaline dosing guidance and promotional material

Assurance

- Limited occasions where morphine retained off duty and all incidents identified in a timely fashion.
- No unaccounted for losses of morphine

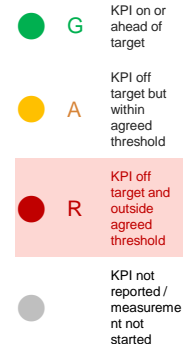


2. Our People

Trust wide Scorecard

September 2020

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Current Performance					Trajectory	Benchmarking		
					Target and Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months		National Data	Best In Class (Ambulance Trusts)	Ranking (out of 11)
In-Ops Vacancy Rate (% of establishment)	Monthly	%	Sep-20	●	5%	Internal	3.5%	4.9%	4.8%	3.5%			
Staff Turnover (% of leavers)	Monthly	%	Sep-20	●	10%	Internal	8.6%	9.4%	10.0%				
Staff Sickness levels (12 month rolling) (%)	Monthly	%	Sep-20	●	5%	Internal	5.4%	5.5%	5.4%				
Statutory & Mandatory Training (85% or above)	Monthly	%	Sep-20	●	85%	Internal	84.0%	85.0%	85.0%	85.0%			
Staff PDR Compliance (85% or above)	Monthly	%	Sep-20	●	85%	Internal	67.0%	66.0%	73.0%				
Flu Vaccination Rate (Trust Total - 55% achieved last year)	Monthly	%	Sep-20	●	80%	Internal	10.0%	10.0%	10.0%	80.0%			
% of BME Staff	Monthly	%	Sep-20	●	17.5%	Internal	17.2%	16.7%	16.0%	17.5%			
Improve leadership and management across the Trust (Visible and Engaging Leader Programmes - target of 36% of Trust Managers in 2019/20) <i>currently on hold</i>	Monthly	(n%)	Sep-20	●	36%	Internal	14.0%	14.0%	14.0%				
Level 3 Safeguarding Training Completed (90% target over 3yr period)	Monthly	%	Sep-20	●	800	National	100.0%	85.0%	85.0%				
Staff Engagement Theme Score	Yearly	(n)	Sep-20	●	6.5	Internal			6.1		6.3	6.6	
Staff Survey Response Rate	Yearly	%	Sep-20	●	≥72%	Internal			72%			72%	1
Equality, Diversity & Inclusion Theme Score	Annual	(n)	Sep-20	●	8.3	Internal	2020 results pending		8.1		8.5	9.5	
BME Staff Engagement Theme Score	Yearly	(n)	Sep-20	●	6.4	Internal			6.2				
Bullying & Harassment (Safe Environment Theme)	Yearly	(n)	Sep-20	●	7.3	Internal			7.0		7.4	7.5	



2. Our People

Vacancy Rates, Staff Turnover and Sickness

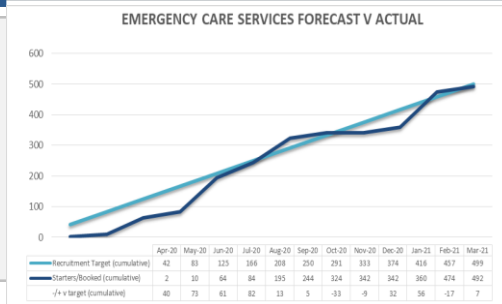


Recruitment

Month:

20FTE

Target: 20FTE



Required Frontline:
499FTE

Supply: 492FTE

Recruited gap: 7FTE

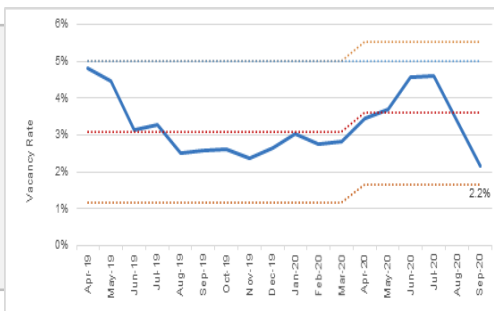
In-ops gap: 111FTE(3.3%)

People & Culture's recruitment team have worked with Ambulance Operations to create and recruit a new Assistant Ambulance Practitioner (AAP) Band 4 role with 185 planned starters in October (80) and February (104). This reduces our forecast end of year in-ops vacancy position to 111fetes (3.3%). Whilst International recruitment has been negatively impacted by COVID, we are continuing with our programme of skype interviews and exploring other international pipeline opportunities. The pilots with Merton PCN and Redbridge PCN are planned for October with the release of 6fte and 2fte band 6s respectively. This provides us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021.

Vacancy Rate

Month: 2.2%

Target: 5%



Emergency Care Services (in-ops): 3.5%

Paramedics: 0.1%

EOC: 0%

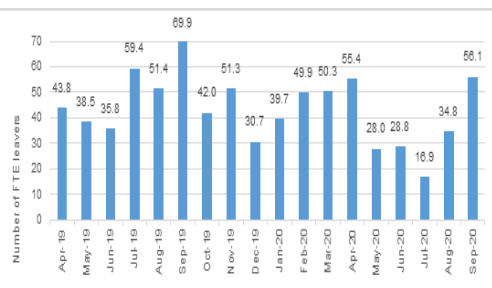
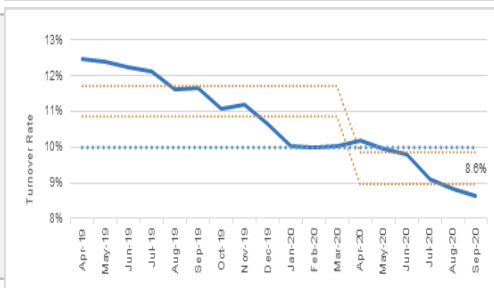
111: 0%

Our overall vacancy rate remains below target at 2.2%. We have welcomed another cohort of graduate paramedics this month and this has supported a reduction in our in-ops vacancy rate from 3.6% in August to 3.5% in September (116fte vacancies – all non-registrant). Our Paramedics in-ops rate has reduced to 0.1%. We have a strong staffing position in both EOC and 111 Services. We have recruited 16 Emergency Call Handlers in September for our 999 Services and 19 Health Advisors across our 111 Services. We had 66 starters in September, 41% of whom were from a BAME background.

Staff Turnover

12 Month Rolling: 8.6%

Target: 10%



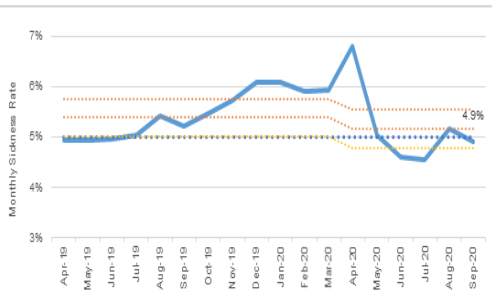
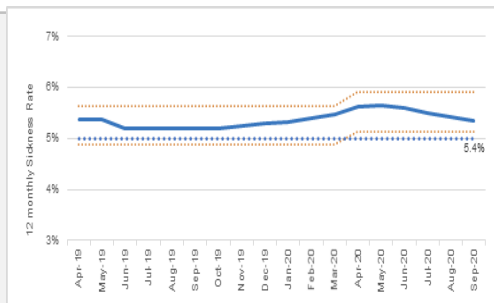
We have seen a further reduction in our turnover rates from 8.9% to 8.6% since August. We continue to see a lower number of leavers in Emergency Care Services and EOC than forecast. The one to one retention interviews with the international paramedics have continued and we have funded a number of international paramedics who wish to apply for indefinite leave to remain (five to date). We have successfully supported 22 staff to utilise the Government's automatic one year visa extension. The telephone exit interview pilot with NHS Shared Business Services was launched in July and the first reports will be available from October.

Sickness

12 Month Rolling: 5.4%

Monthly: 4.9%

Target: 5%



The monthly Trust wide sickness has decreased from 5.2% in August, to 4.9% in September, below the rate for the same period last year (5.2%). We have seen decreases in Emergency Care Services (5.5% to 5.2%) and EOC (7.8% to 7.5%). North East 111 have seen a decrease from 7.8% to 5.9% and South East 111 have also seen a decrease from 4.3% to 3.8%.

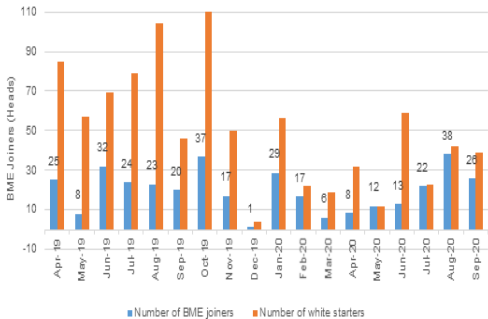


Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

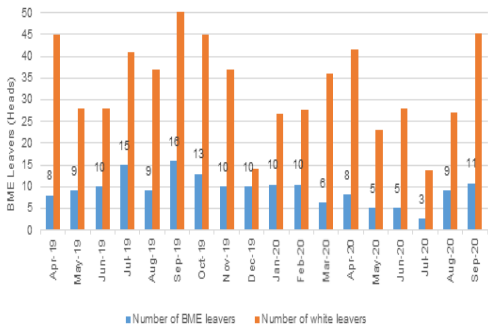
Equality, Diversity and Inclusion Standards

The Trust WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly. These graphs show the numbers of BAME starters and leavers from April 2019 to September 2020. During this period we have had 357fte BAME starters and 168fte BAME leavers, a net increase of 189fte. 28% of our total starters during this period were BAME.

BME Starters



BME Leavers



Overall numbers of BAME staff continue to increase (currently 1,100) although this representation varies at different levels in the organisation.

% of BME staff in band	
Bands 1-4	37.55%
Bands 5-7	11.07%
Band 8A to 9	14.29%

We have submitted the WRES and WDES national returns and we expect to receive a bulletin in November from NHSE/I with feedback on this year's submissions.

We have to date completed 98% of BAME risk assessments. We are now identifying themes from the assessments which will provide intelligence to support and inform our overall planning of activities to ensure that staff remain safe and protected.

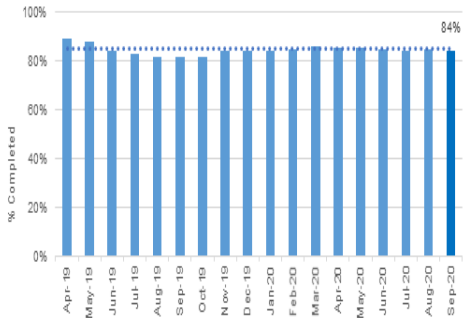
The Equality, Diversity & Human Rights (3 Years) e-learning is at 79%.

Statutory and Mandatory Training and Appraisals

Trust compliance in Statutory and Mandatory training is **84%**.

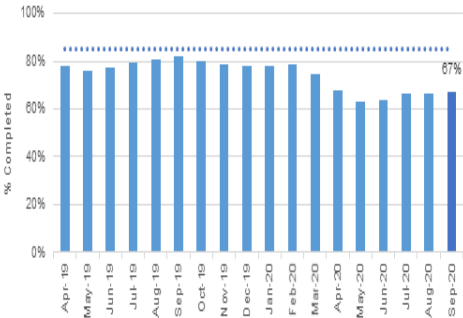
Appraisal completions at **67%** at the end of September.

Statutory & Mandatory



As at 30th September we are tracking slightly below our 85% target at 84.4%. The current CSR programme finishes at the end of November and this covers over 4,000 of our frontline staff. We therefore expect to see an increase in compliance to above target by this date. Information Governance is at 93% for September against an annual target of 95% to meet the requirements of the NHS Digital's IG Toolkit. This number will increase as a result of the CSR Programme,

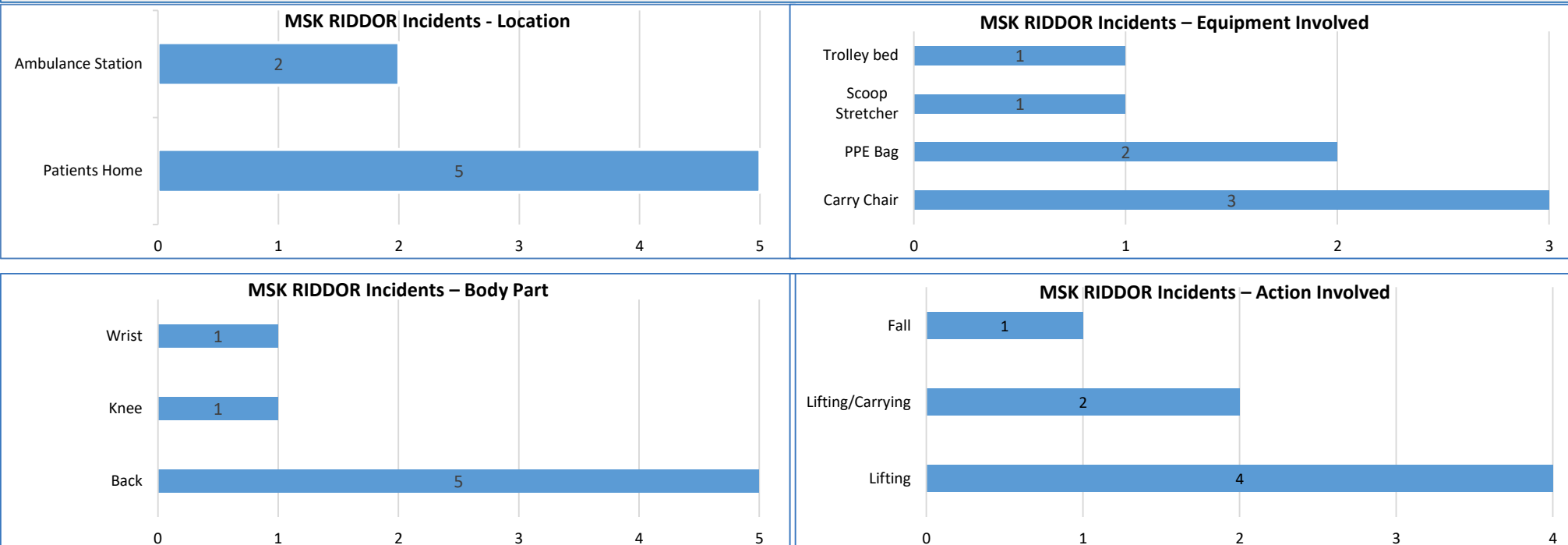
Appraisal Compliance



We have seen a reduction in the PDR rate since March 2020 when we went to REAP level 4 and PDRs were put on hold. In November we will be working with colleagues across Operations, 111, 999 and in Corporate teams to create trajectories to bring the PDR compliance rate back to the target of 85%.



Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) – September 2020



Findings

- Riddor incidents have remained fairly static since April 2020 with an average of 13 per month. The highest number of Riddor incidents for September'20 occurred in the patients home.
- The peak of reporting varies by month from sector to sector with the highest reporting during June 2020.
- There is an average of 1 reported moving and handling incident for every 2000 face to face attendances and an average of 3 working days lost per 1000 attendances.

Actions

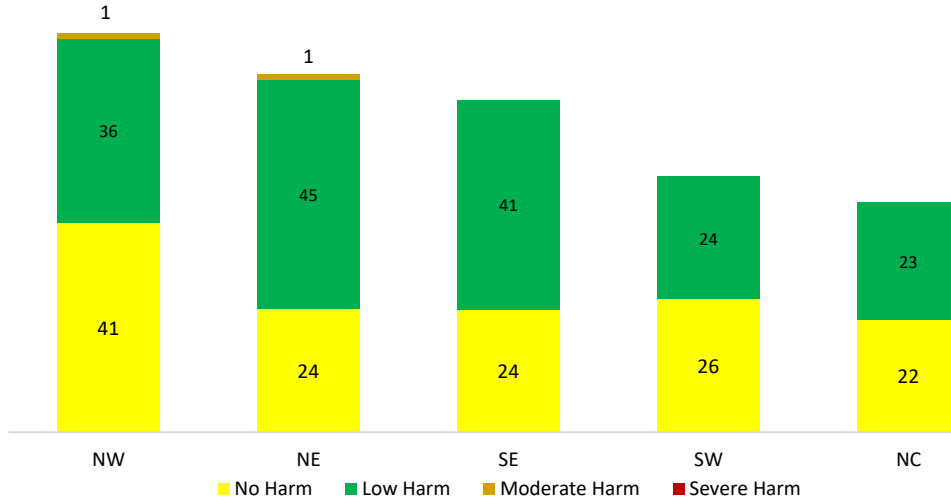
- An MSK Programme Board is due to be set up with the first meeting held before the end of November.
- Due to the increase in failures of Mangar Elk a task/finish group has been set up to identify root causes and remedial actions, we have also met with the manufacturer to improve the servicing and turnaround times going forward. Short video clips and stickers along with bulletins are to be produced around the use of the Mangar Elk to try and address some of the root causes of failure.

Assurances

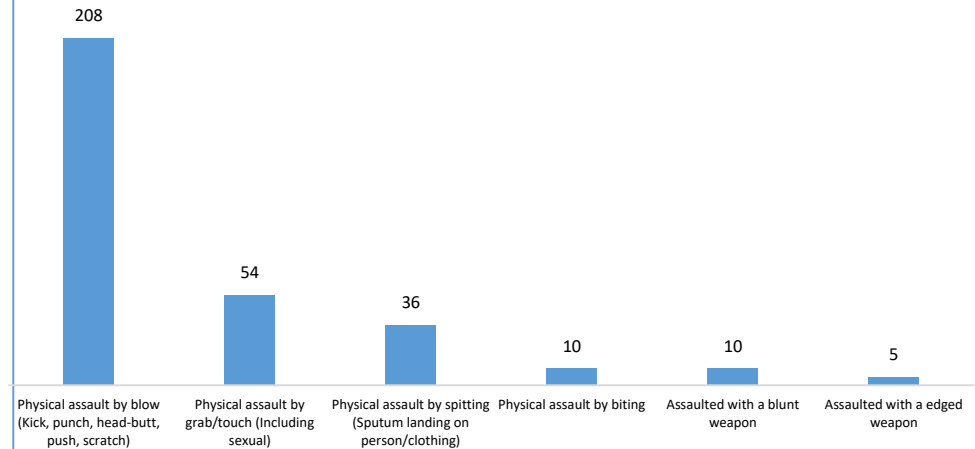
- The new Datix categories have now been in place for 3 months and are working well and making it easier to pull off thematic incident data.
- Datix incident manager investigation to be amended to provide greater depth of data.
- Incidents involving life pack straps – failure/swapping out has been identified as any area of concern and this is for further investigation by Health, Safety & Security along with Logistics and Vehicle Make Ready.
- Health, Safety & Security Department have developed an MSK Action Plan, an MSK Programme board has been setup to manage and assure that projects that sits underneath the programme meets its objectives. This covers all areas of the Trust, this is due to be converted into a QSIR project plan. An MSK Programme Board is due to be set up with the first meeting held before the end of November 2020.



Number of reported Physical Assaults on Staff by Top 5 Sectors & Severity (YTD) –2020/21



Number of reported Physical Assaults on Staff by Type (YTD) – 2020/21

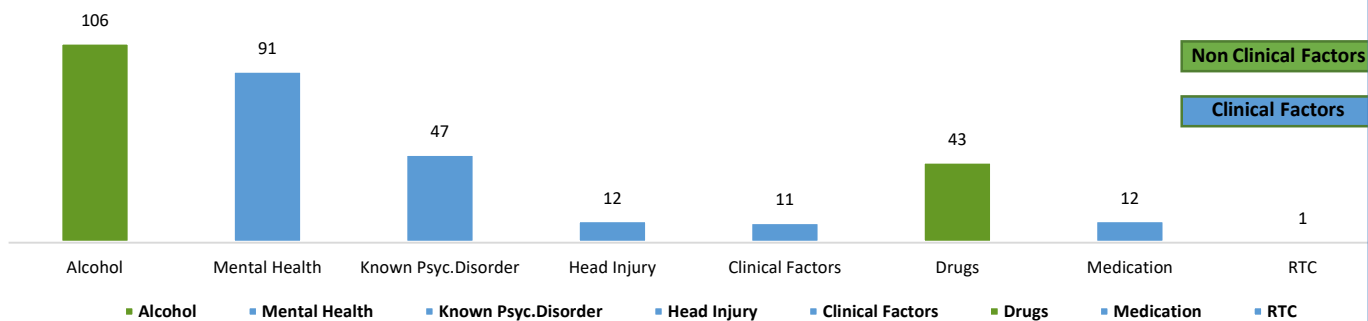
**Notes:**

- A total of 323 Physical Assaults on Staff were reported during 2020/21 (up to end September'20).
- 144 (45%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 179 incidents resulted Harm. 176 (54%) of the harm related incidents were reported as 'Low Harm and 3 (1%) incidents were reported as Moderate Harm.
- 31 out of the 323 Physical Assaults on Staff were caused by others (ex: family member of the patient / k standers etc).

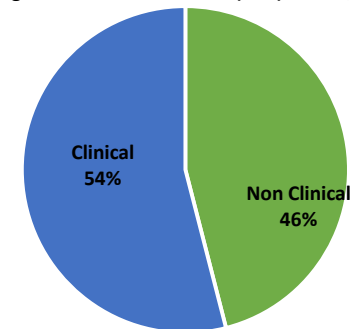
Notes:

- Physical Assault – by blows, kicks/ assault to staff (64% , n=208) accounted for the highest number of incidents reported during 2020/21 (up to end September'20).

Number of reported Physical Assaults on Staff by Influencing Factors (YTD) – 2020/21



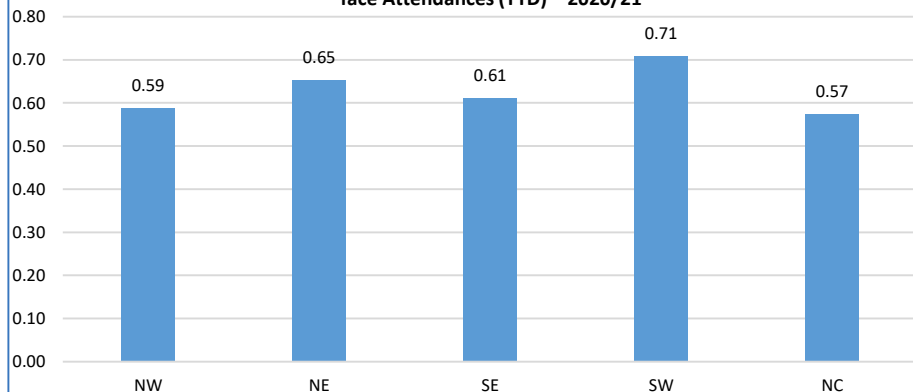
Percentage Breakdown of Factors (YTD) – 2020/21

**Notes:**

- Clinical Factor: 173 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=91), Known Psyc.Disorder (n=47), Head Injury (n=12), Clinical Factors (n=11), Medication (n=12).
- Non Clinical Factor: 150 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=106), and Drug (n=43) and, RTC (n=1).



Rate of number of reported Physical Assaults on Staff by Sector per 1000 face to face Attendances (YTD) – 2020/21



The graph and dash board (left side) provides the Rate of reported Physical Assault on Staff by Sector per 1000 face to face Attendances. According to the number of reported incidents: In all 5 sectors, approximately one physical assault incident occurred per every 2000 face to face attendances.

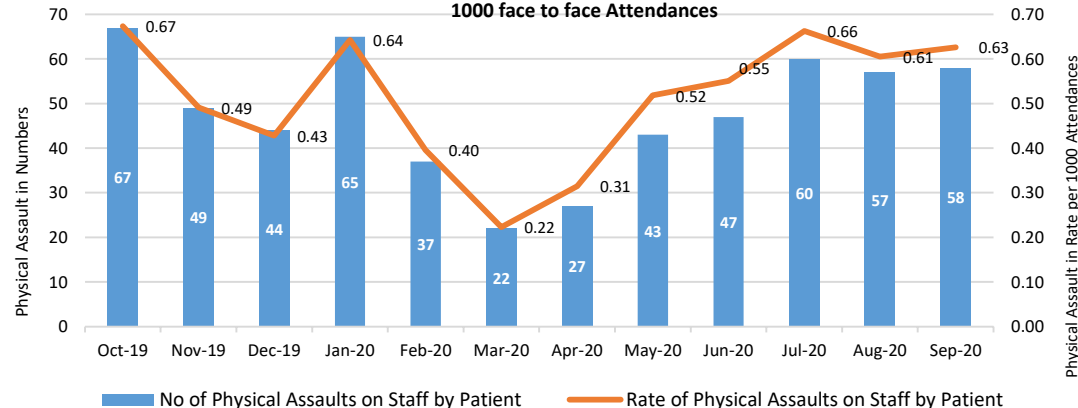
Findings

- 63 assaults reported during September '20.
- The greatest number of reported physical assaults (54%) occur due to the clinical condition of the patient;
- Police attended 71% of physical assault incidents;
- 13 successful prosecutions for assault have been recorded (year to date);

Assurances

- Datix incident manager investigation to be amended to provide greater depth of data.
- Metropolitan Police's Operation Hampshire team participate in the new LAS Criminal Justice Group.
- BWVC tender documents have been finalised and passed to procurement.
- LAS Comms have obtained National coverage of Violence Reduction Officer roles.

No of Physical Assaults on Staff by Patient vs Rate of Physical Assaults on Staff by Patient per 1000 face to face Attendances



The graph and dash board (above) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (October'2019 to September'2020).

Actions

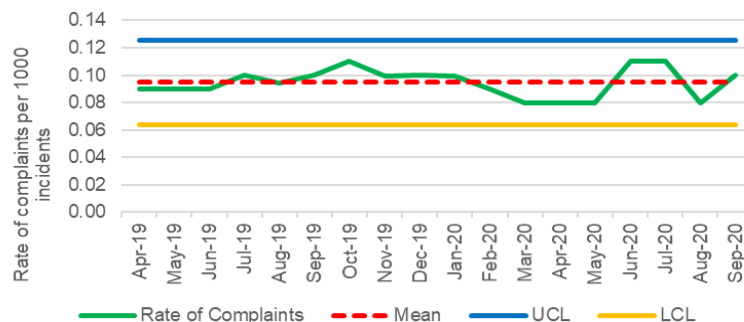
- Criminal Justice Group has met and included representation from MPS Operation Hampshire Team.
- Link established with MPS Command Centre to work together to address hate incidents and hate crimes. MPS agreed to provide awareness training to managers in EOC and 111 around hate incidents and hate crimes and appropriate action to take following these. It is intended that this work-stream will then be rolled for operational managers.
- Health, Safety & Security team working with Comms raising awareness around violence and aggression.
- Guidance for different job roles involved in assault incidents being drafted.
- Survey on staff experience of violence and support to be presented to the Violence Reduction & Staff Safety Programme Board for agreement prior to launch.
- Violence Reduction Policy has been circulated for final agreement.



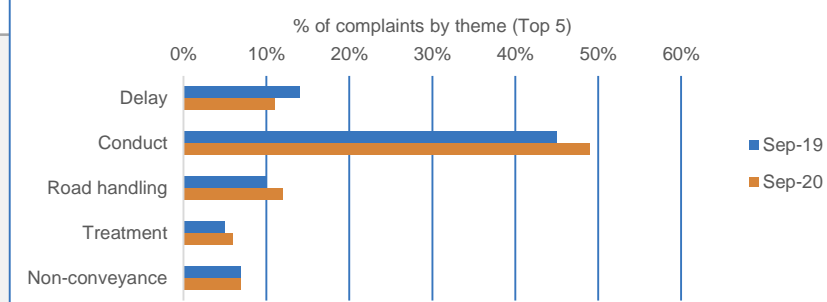
Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

Rate of Complaints

Latest Month: **0.10**



Categorisation



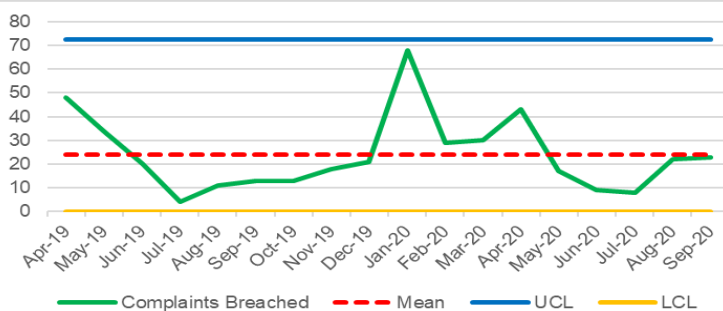
September resulted in more complaints than August (78/90).

We managed 652 PALS enquiries and continue to use the spreadsheet introduced during Covid-19 months as this has proven successful for recording more straightforward enquiries.

We managed 31 Quality Alerts in this period. Of these, ten were reported internally

Responding to complaints

Latest Month: **23**



Conduct and behaviour complaints currently account for over half of total complaints received in 2020/21 to date. There were 16 complaints attributed to NHS111 in in September, 11 related to NELIUC and 5 from SELIUC.

We are supporting the Business Partner model in the NE Sector and IUC. We are aiming to improve the process for capturing learning from complaints and are liaising with the QGAM's to improve sector based learning methods.

There were 23 complaints that breached the target response during September. The complexity of complaints results in input being necessary from Control Services as well as Operations and ultimately from the Medical Team. It is inevitable that delays in preparing response will result as all of these areas have demands elsewhere.

Currently there are 16 complaints awaiting a Quality Assurance Report, 16 awaiting a clinical opinion and 9 awaiting operational input.

We continue to receive support from the Medical Directorate to prepare clinical opinions by doubling up of duty clinicians which has improved throughput

Actions, Assurance and Learning

Patient Experience - September

The collaboration with the NE Sector and the IUC area of our portfolio is progressing with a number of improvements already identified. The full results of the trial in these two areas will be evaluated prior to consideration for Service roll out.

Due to the continued conduct theme, this has been included into the included in the Patient Safety Incident Response Plan as the Trust moves over to the PSIRF. This will enable through investigations into the contributory factors and actions to address the issues.

To assist with this process we aim to make further improvements to Datix in the way we record learning from the work we undertake.

The Ombudsman is working on the Complaints Standards Framework which sets out a single sets of standards for staff to follow and will provide standards for leaders to help them to capture and act on the learning from complaints

NHS digital will resume the collection of the KO41a data with Q1 and Q2 to be provided during October. It is their intention to publish the data they have collected on December 2020



Public Value Scorecard

September 2020

September 2020				Current Performance							Outturn		Benchmarking				
Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Latest Month Actual	Latest Month Plan	YTD Actual	YTD Plan	Rolling 12 Months		FY20/21 Forecast	FY20/21 Plan		National Data	Best In Class	Ranking (out of 11)
Control Total (Deficit)/Surplus	£m	Sep-20	●	0.000	A	0.000	(0.001)	0.000	(0.006)								
Performance Against Control Total	£m	Sep-20	●	100%	A							100%	100%				
Use of resources index/indicator (Yearly)	Rating	Sep-20	●	1	A												
% of Capital Programme delivered	%	Sep-20	●	100%	A	1%	12%	14%	31%			100%	100%				
Capital plan	£m	Sep-20	●	50.311	A	0.512	6.038	6.836	15.831			50.311	50.311				
Cash position	£m	Sep-20	●	15.1	A	64.6				46.2							
% spend against Agency Ceiling	%	Sep-20	●		A	7%	8%	42%	50%			53%	100%				
CIP Savings YTD	£m	Sep-20	●		A												
	%	Sep-20	●		A												
CIP Savings achieved - % Recurrent	£m	Sep-20	●		A												
	%	Sep-20	●		A										●	G	KPI on or ahead of target
Commercial income generation	£m	Sep-20	●		I										●	A	KPI off target but within agreed threshold
Corporate spend as a % of turnover	%	Sep-20	●	<7.0%	I	10.5%		9.1%				9.5%			●	R	KPI off target and outside agreed threshold
Cost per incident (measures to be confirmed in light of COVID)	£	Sep-20	●		I										●		KPI not reported / measurement not started
Average Jobs per shift	%	Sep-20	●	5.3	I	4.9		4.1		4.6							

●	G	KPI on or ahead of target
●	A	KPI off target but within agreed threshold
●	R	KPI off target and outside agreed threshold
●		KPI not reported / measurement not started

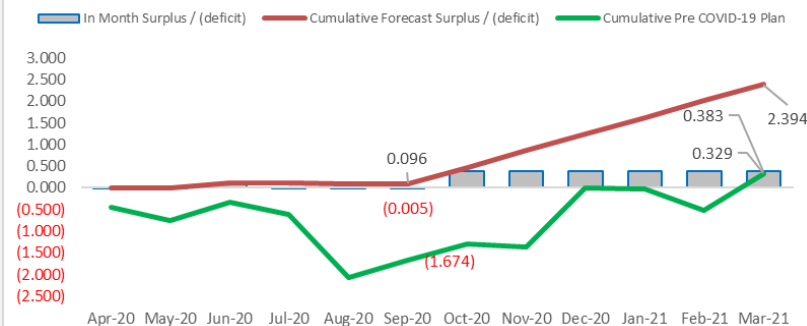


3. Public Value

Trust Financial Position and Contract Position

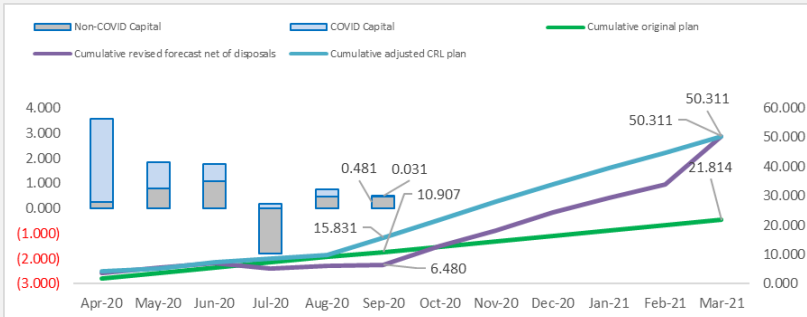
The Trust's month 6 position was on plan – breakeven on an adjusted financial performance basis (unadjusted surplus of £96k YTD) and the month end cash position of £64.6m is strong.

YTD outturn vs budget



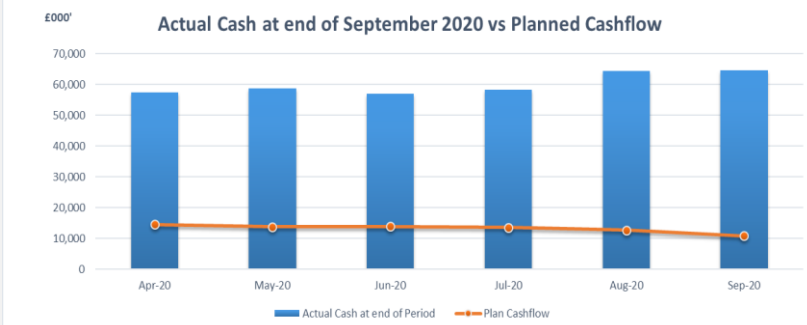
- **YTD Position:** The month 6 position was breakeven position on an adjusted financial performance basis (£96k surplus before measurement adjustments) as required under the current financial framework. The YTD position incorporated £48.4m of costs in relation to the Trust's response to COVID-19, and a retrospective income top up to balance the Trust's financial position of £49.9m.
- **Full year forecast:** The full year forecast position at month 6 is a £2.4m surplus in line with NW London STP planning. This forecast position takes into account M7-12 fixed income envelopes managed at STP or ICS level, the required achievement of financial efficiencies and incorporates £75.1m of costs in relation to the Trust's response to COVID-19, and combined retrospective income top ups and fixed COVID income of £78.2m.

Financial Position Metrics



- **Use of Resources:** NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). No use of resources scores are currently available under the interim financial framework arrangements.
- **Capital:** YTD capital expenditure net of disposals is £6.5m YTD (£6.8m pre disposals) compared to planned capital expenditure of £15.8m (£9.4m behind plan net of disposals). Full year forecast capital expenditure net of disposals is £50.3m in line with the expected increase in its CRL limit, but will require significant acceleration of capital projects to meet this target. The majority of the Trust's YTD capital spend relates to its phase 1 response to the COVID-19 pandemic with £5.5m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment. The Trust's YTD capital spend position has been impacted in prior months by the reversal of £2.3m of capital work in progress costs in connection with the Trust Board approved CAD replacement project.

Cash position



- **Cash:** Cash was £64.6m as at 30 September 2020, £53.8m above pre-COVID plan. The main reason for the favourable position was the payment in advance of one month's block contract income between April and September. Cash balances are expected to reduce from September onwards as this arrangement ceases in the present form at that point.
- **Better Payment Practice Code:** The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days. The NHS and Non-NHS performance by volume for September 2020 was 65.4% and 93% respectively. The Trust has a high volume of overdue invoices waiting to be approved and Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.



Our Statement of Comprehensive Income reports the Trust's financial performance over a specific accounting period. Financial performance is assessed by giving a summary of how the Trust incurs its income and expenses through both operating and non-operating activities. It also shows the net surplus or deficit incurred over a specific accounting period.

Statement of Comprehensive Income (Month 6 – September 2020)

	Month 6 2020-21 £000			YTD Month 6 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance to budget fav/(adv)
Income									
Income from Activities	36,935	34,555	(2,380)	222,183	204,391	(17,792)	446,018	411,650	(34,368)
Other Operating Income	1,127	11,520	10,393	3,088	68,261	65,173	5,933	112,785	106,852
Total Income	38,061	46,074	8,013	225,271	272,652	47,381	451,951	524,435	72,484
Operating Expense									
Pay	(26,808)	(31,387)	(4,579)	(161,488)	(183,156)	(21,668)	(320,359)	(358,992)	(38,632)
Non Pay	(9,172)	(12,398)	(3,226)	(55,287)	(79,269)	(23,983)	(110,168)	(141,056)	(30,888)
Total Operating Expenditure	(35,980)	(43,785)	(7,805)	(216,775)	(262,426)	(45,651)	(430,527)	(500,048)	(69,521)
EBITDA	2,081	2,289	208	8,496	10,226	1,730	21,424	24,388	2,964
EBITDA margin	5.5%	5.0%	(0.5%)	3.8%	3.8%	(0.0%)	4.7%	4.7%	(0.1%)
Depreciation & Financing									
Depreciation & Amortisation	(1,290)	(1,843)	(553)	(7,800)	(7,095)	704	(16,356)	(16,276)	80
PDC Dividend	(388)	(464)	(76)	(2,328)	(2,670)	(342)	(4,656)	(5,340)	(684)
Finance Income	8	0	(8)	48	(4)	(51)	100	(4)	(103)
Finance Costs	(15)	(2)	13	(90)	(22)	68	(182)	(34)	148
Gains & Losses on Disposals	0	16	16	0	(340)	(340)	0	(340)	(340)
Total Depreciation & Finance Costs	(1,685)	(2,294)	(608)	(10,170)	(10,130)	40	(21,095)	(21,994)	(899)
Net Surplus/(Deficit)	395	(5)	(400)	(1,674)	96	1,770	329	2,394	2,064
NHSI Adjustments to Fin Perf									
Remove Donations I&E Impact	3	5	2	19	(96)	(115)	38	(68)	(106)
Adjusted Financial Performance	399	0	(399)	(1,655)	(0)	1,655	368	2,326	1,958
Net margin	1.0%	(0.0%)	(1.0%)	(0.7%)	0.0%	0.8%	0.1%	0.5%	2.8%

Year to Date Position

The YTD position is a £96k surplus (breakeven on an adjusted financial performance basis) in line with NHSE/I requirements.

Forecast Full Year Position

The full year position is forecast to be a £2.4m surplus in line with NWL STP planning.

Key Drivers of Position

Income:

- Income from activities is primarily comprised of the Trust's block contract income under the current interim financial arrangements with £34m being received each month – lower than pre-COVID plan by £17.8m YTD and £34.4m FY forecast.
- Other operating income is favourable to pre-COVID plan by £65.2m YTD (£106.8m full year forecast) due to the inclusion of monthly top up, retrospective top up and fixed COVID income (£65.9m YTD and £109.4m full year forecast) which covers the Trust's COVID response related expenditure and ensures a breakeven position.

Pay Expenditure:

- Pay expenditure is currently £21.7m adverse to pre-COVID plan YTD, and forecast to end the year £38.6m adverse to pre-COVID plan primarily due to COVID-19 response costs (£20m YTD and £37m FY forecast).

Non-Pay Expenditure:

- Non pay expenditure excl depreciation and finance costs is £24m adverse to pre-COVID plan YTD, and forecast to end the year £30.9m adverse to pre-COVID plan primarily due to COVID-19 response costs (£28m YTD and £37.2m FY forecast).
- Depreciation and finance costs are in line with pre-COVID plan YTD, but are forecast to be £0.9m unfavourable full year due to losses on disposal (£0.3m) and higher PDC in relation to the expanded capital programme (£0.7m).



Our Cashflow Statement summarises the amount of cash and cash equivalents entering and leaving the Trust. It measures how well the Trust manages its cash position, meaning how well the Trust generates cash to pay its debt obligations and fund its operating expenses.

Cashflow statement (Month 6 – September 2020)

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Sep-20	Sep-20	
	Actual	Actual	Actual	Actual	Actual	Actual	YTD Move	YTD Plan	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	25,964	57,387	58,796	57,028	58,338	64,534	25,964	25,964	0
Operating Surplus	1,360	1,319	1,465	2,259	1,531	2,289	10,223	10,223	0
(Increase)/decrease in current assets	(8,741)	(2,906)	2,709	2,168	1,223	(8,435)	(13,982)	(13,982)	0
Increase/(decrease) in current liabilities	46,479	4,778	(3,108)	(4,349)	3,514	7,220	54,534	54,534	0
Increase/(decrease) in provisions	93	88	213	(198)	284	817	1,297	1,297	0
Net cash inflow/(outflow) from operating activities	39,191	3,279	1,279	(120)	6,552	1,891	52,072	52,072	0
Cashflow inflow/(outflow) from operating activities	39,191	3,279	1,279	(120)	6,552	1,891	52,072	52,072	0
Returns on investments and servicing finance	(4)	0	(8)	0	0	0	(12)	(12)	0
Capital Expenditure	(7,764)	(1,870)	(3,039)	1,430	(356)	(1,922)	(13,521)	(13,521)	0
Dividend paid	0	0	0	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	107	107	107	0
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	(7,768)	(1,870)	(3,047)	1,430	(356)	(1,815)	(13,426)	(13,426)	0
Movement	31,423	1,409	(1,768)	1,310	6,196	76	38,646	38,646	0
Closing Cash Balance	57,387	58,796	57,028	58,338	64,534	64,610	64,610	64,610	0

Operating Position

Due to COVID-19, NHSE and NHSI suspended the financial planning process for 2020/21. Given this, the plan is depicted here as equivalent to the outturn statement of financial position.

There has been a net inflow of cash to the Trust of £38.6m, this is due to NHSI paying one months block income in advance each month.

Cash funds at 30 September stand at £64.6m and the operating surplus is on target.

Current Assets

- The movement on current assets is (£14.0m).
- The movement is due to a increase in trade receivables (£0.7m), increase in accrued income (£12.3m) and prepayments (£1.0m).

Current Liabilities

- The movement on current liabilities is £54.5m.
- The movement is due to an increase in deferred income £36.7m (block contract payments in advance), increase in accruals £20.6 and decrease in payables (£2.8m).

Provisions

- The movement on provisions was £1.3m which relates to legal and international student payments.

Capital Expenditure

- Capital cash movement was an outflow of £13.5m.



To prepare our Trust for the future we need to ensure we manage our costs effectively and where possible reduce the costs of running the Trust whilst maintaining the absolute best care for our patients. We also need to strategically invest year on year in our estate, fleet and technology capability so that we can continue to offer a world-class ambulance service.

Cost Improvement Programmes (CIPS)

- The Trust is operating under an adjusted financial framework for April to September 2020 in response to the COVID-19 pandemic.
- This has involved pausing business planning and Cost Improvement Programmes and as such no CIP data will be available across this period.
- Under the new financial framework to be put in place over the second half of the financial year, a £2.4m efficiency will be needed to meet the fixed income available, along with matched efficiencies for newly approved spend (currently £1.9m, total £4.3m), and projects are being developed to meet this need.

FY Forecast:
N/A

FY Target:
£4.3m

CIP Savings

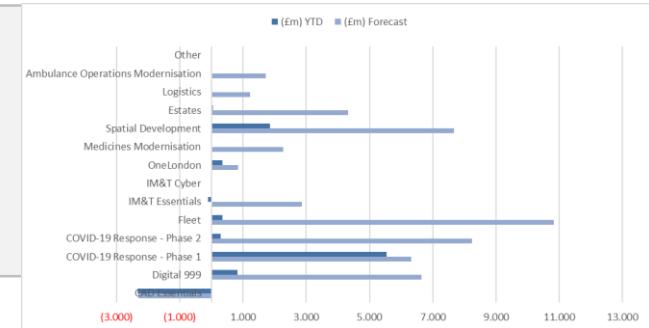
Capital Plan

- YTD capital expenditure net of disposals is £6.5m (excluding disposals £6.8m) compared to planned expenditure of £15.8m (£9.4m behind plan) primarily due to the prior month reversal of £2.3m of capital work in progress in conjunction with the CAD upgrade project.
- Full year forecast capital expenditure is £50.3m in line with the Trust's latest capital plan submitted to NHSI with the addition of £6.1m of CRL identified through NWL partners.
- The majority of the Trust's YTD capital spend relates to its phase 1 response to the COVID-19 pandemic with £5.5m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment.

YTD: £6.5m

FY Plan:
£50.3m

Capital Plan Breakdown

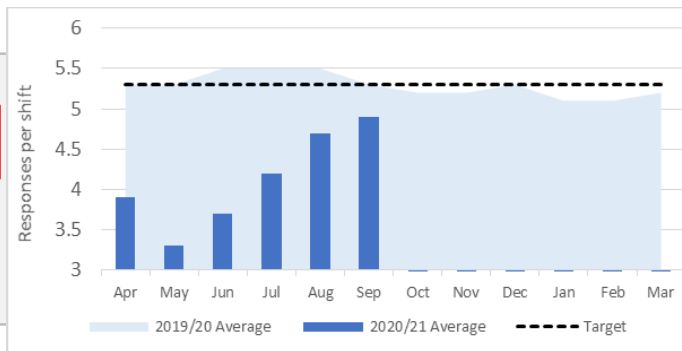


Jobs per shift (DCA)

Actual: 4.9

Target: 5.3

Average jobs per 12 hour shift



Operations are tracking the performance of jobs per shift on a monthly basis and are consistently hitting the agreed target. While there is no programme of work focusing solely on this metric, a number of our efficiency and productivity schemes will impact this number. For example success in improving Handover to Green times and reducing OOS CIPs would improve the Jobs per shift measure



Partners Scorecard

September 2020

Indicator (KPI Name)	Data		Target Status	Target and Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	National Data	Best In Class	Ranking (out of 11)
	Basis	From Month									
Hospital handover	minutes	Sep-20	<div></div>	18.0	I	18.8	18.3	20.7			
Post-handover (Handover 2 Green)	minutes	Sep-20	<div></div>	15.5	I	14.7	14.6	14.2			
See and Convey – to ED (Contractual Position) *	%	Sep-20	<div></div>	57.0%	C	54.2%	51.0%	53.1%	54.1%	49.4%	6
Hear and Treat % **	%	Sep-20	<div></div>	8.39%	I	8.6%	10.5%	10.0%	7.7%	9.8%	5
Hear and Treat (n) **	%	Sep-20	<div></div>	108,073	I	8,763	62,543	125,398			
Savings delivered to wider urgent & emergency care system through management of IUC services (£m) – Still being developed	£m			TBC		This metric has proved difficult to ascertain in a way that can be tracked on a regular basis. As part of the long term financial plan development we are refreshing our strategy modelling over July and August and the specifics for this metric will come out of that work in a way that can be tracked on a regular basis through the IPR.					
CQC rating - Overall	Annual Rating			O / S	N	TBC	Awaiting CQC Inspection				
CQC rating - Well-led	Annual Rating			G	N	TBC					
Cyber Essentials Plus Accreditation	%		<div></div>	100				TBC			

Benchmarking Key

Top 3

Ranked 4-7

Ranked 7+

Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

- G KPI on or ahead of target
- A KPI off target but within agreed threshold
- R KPI off target and outside agreed threshold
- KPI not reported / measurement not started

4. Our Partners

Maximising safe non-conveyance to ED



Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.

Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We saw a higher number of delays in September, compared to August, with the overall number of hours lost has gone up to 888 hours lost from our arrival to patient handover over 30 mins. North Middlesex, Whipps Cross and Queens Romford had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the highest number of lost hours over 30 minutes, at 273 hours for the month.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,450	1,432	232	16%	47.0	22.2
	North Middlesex	2,563	2,512	562	22%	80.3	23.0
	Royal Free	1,600	1,563	144	9%	14.8	19.8
	University College	1,280	1,257	53	4%	4.4	15.9
	Whittington	1,368	1,339	130	10%	23.7	18.4
North East	Homerton	1,320	1,285	26	2%	1.9	14.3
	King Georges	1,120	1,094	130	12%	10.6	20.8
	New ham	1,691	1,635	317	19%	44.8	23.5
	Queens Romford	2,846	2,764	965	35%	272.6	30.3
	Royal London	1,864	1,780	146	8%	9.7	19.7
North West	Whipps Cross	1,671	1,618	395	24%	153.9	26.7
	Charing Cross	1,194	1,169	8	1%	1.1	12.3
	Chelsea & West	1,310	1,271	9	1%	1.2	15.3
	Ealing	1,133	1,113	11	1%	1.2	12.9
	Hillingdon	1,702	1,677	35	2%	4.6	13.3
South East	Northwick Park	3,202	3,167	128	4%	33.1	14.2
	St Marys	1,660	1,610	115	7%	14.2	17.6
	West Middlesex	2,012	1,979	41	2%	6.2	15.0
	Kings college	1,986	1,933	242	13%	32.0	21.6
	Lewisham	1,434	1,356	96	7%	9.8	18.5
South West	Princess Royal	1,879	1,813	146	8%	36.6	17.1
	Queen Elizabeth II	2,313	2,263	48	2%	9.4	12.9
	St Thomas'	2,199	2,146	102	5%	7.8	17.8
South West	Croydon	2,164	2,120	151	7%	16.1	19.2
	Kingston	1,599	1,558	71	5%	9.1	18.6
	St Georges	1,821	1,767	246	14%	25.0	20.8
	St Helier	1,222	1,198	72	6%	14.4	18.3
TOTAL		47,603	46,419	4,621	10%	886	18.8

Max average breach value
Value >10 mins per breach

Patient Handover to Green

In September, we saw handover to green performance slightly worse than in to August, with 15.1 average. Over 2,300 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus as well as a cost improvement programme to recover this situation with action plans focusing on clarification of targets, improving the process and sharing good practice across sector.

Sector	Station Group	Handovers to Green	Handovers Exceeding 14 mins	% over 14 mins	Total Time Lost (hours)	Avg Time PH to Green	90th Centile PH to Green	Avg mins lost per breach
North Central	Camden	1,240	606	49%	102.3	14.7	28.9	10.1
	Edmonton	2,007	1,041	52%	163.6	15.4	29.0	9.4
	Friern Barnet	1,215	680	56%	92.5	15.0	28.1	8.2
North East	Homerton	1,536	798	52%	158.1	15.8	32.0	11.9
	New ham	2,057	1,206	59%	241.8	17.0	33.9	12.0
	Romford	2,312	1,262	55%	174.3	15.0	28.1	8.3
North West	Brent	2,405	1,235	51%	185.8	15.1	27.0	9.0
	Fulham	1,575	870	55%	123.8	15.9	28.9	8.5
	Hanwell	1,803	992	55%	112.1	14.8	25.8	6.8
	Hillingdon	1,037	528	51%	66.4	14.8	25.6	7.5
	Westminster	1,062	478	45%	57.8	13.2	24.3	7.3
South East	Training	844	491	58%	81.2	16.7	29.0	9.9
	Bromley	1,811	991	55%	113.8	15.0	25.4	6.9
	Deptford	2,949	1,414	48%	162.4	14.0	24.0	6.9
South West	Greenwich	1,545	958	62%	113.6	16.5	26.9	7.1
	Croydon	1,450	822	57%	96.9	14.9	25.6	7.1
	New Malden	842	461	55%	59.6	15.3	26.2	7.8
	St Helier	819	457	56%	48.2	14.9	25.6	6.3
Other	NULL	80	39	49%	7.3	15.9	23.0	11.2
	IRO	3	1	33%	1.0	15.1	62.9	60.0
	NETS	1,117	819	73%	118.6	16.7	27.8	8.7
	Other	530	321	61%	62.7	10.6	34.7	11.7
	Training	844	491	58%	81.2	16.7	29.0	9.9
TOTAL		30,239	16,470	54%	2343.8	15.1	27.6	8.5

Max average breach value
Value >7 mins per breach

4. Our Partners

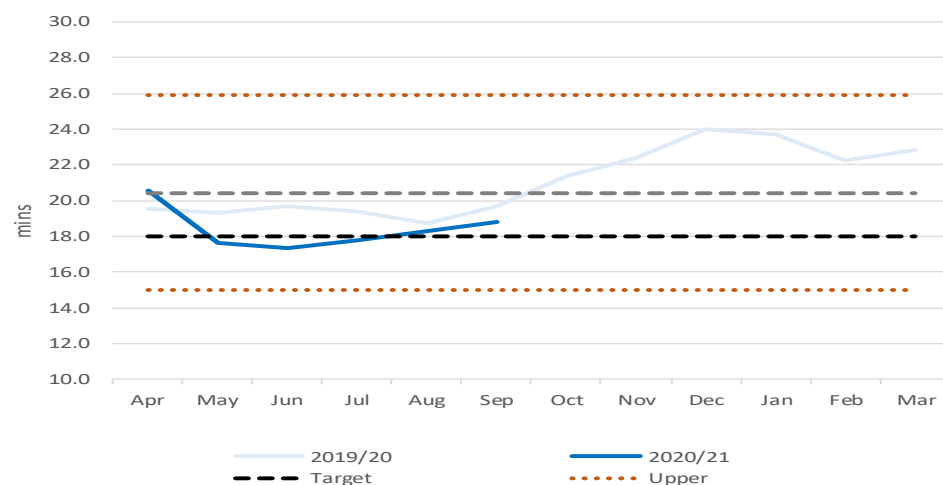
Maximising safe non-conveyance to ED



Arrive at Hospital to Patient Handover (**Emergency Departments only & Excluding blue calls)

	Jul-20	Aug-20	Sep-20	Year-end Target
Arrive at Hospital to Patient Handover (mins)	17.8	18.3	18.8	18.0

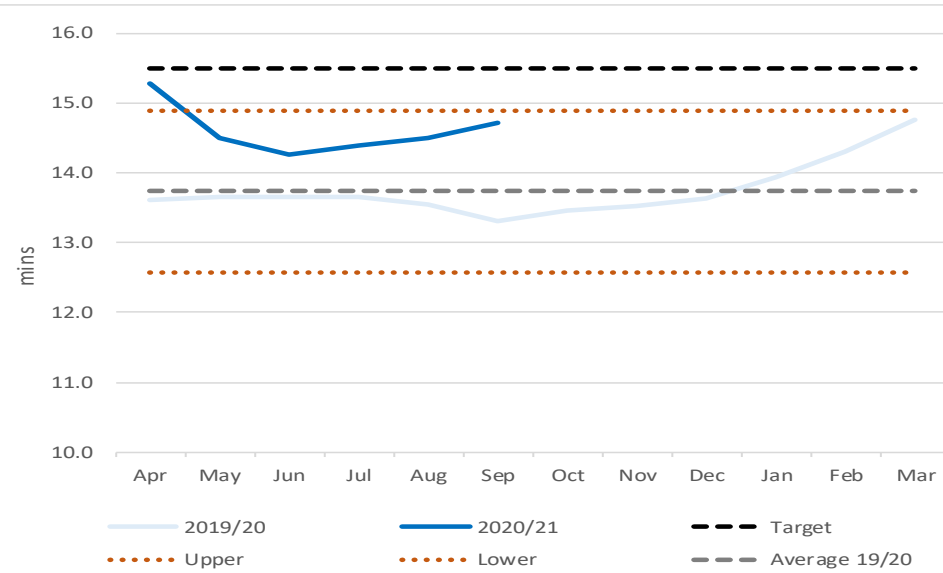
Hospital Handover performance is currently outside of target. Since June we have been seeing a steady increase on this metric, due to increasing overall demand and pressure on the hospitals as a result, impacting the Trusts teams ability to hand patients over.



Patient Handover to Green (**Emergency Departments only & Excluding blue calls)

	Jul-20	Aug-20	Sep-20	Year-end Target
Patient Handover to Green (mins)	14.4	14.5	14.7	15.5

Handover to Green performance has been within target, but above the 19/20 average since April 2020. In August and September we are seeing a slow increase in H2G times in line with the increasing overall demand.



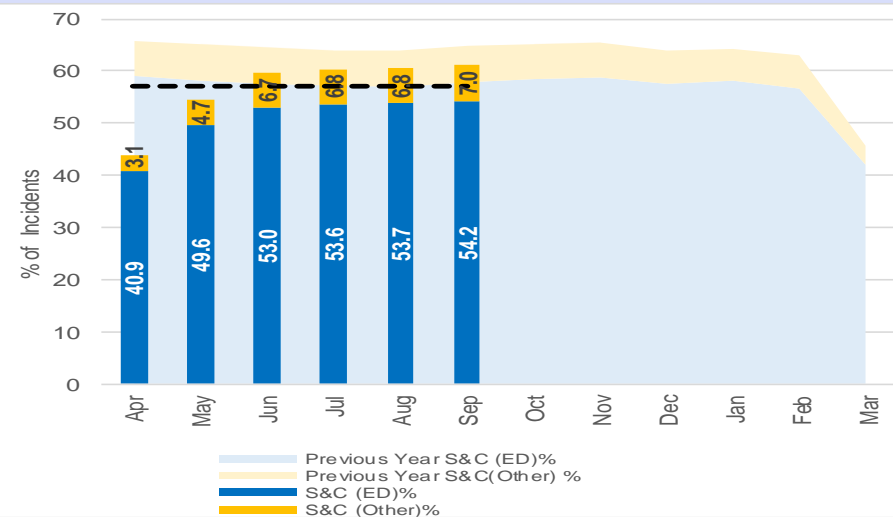
Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes



See and Convey to Emergency Department

		Sep-20	Year To Date	Year-end Target
See & Convey ED %	LAS	54.2%	51.0%	
	Target			57.0%

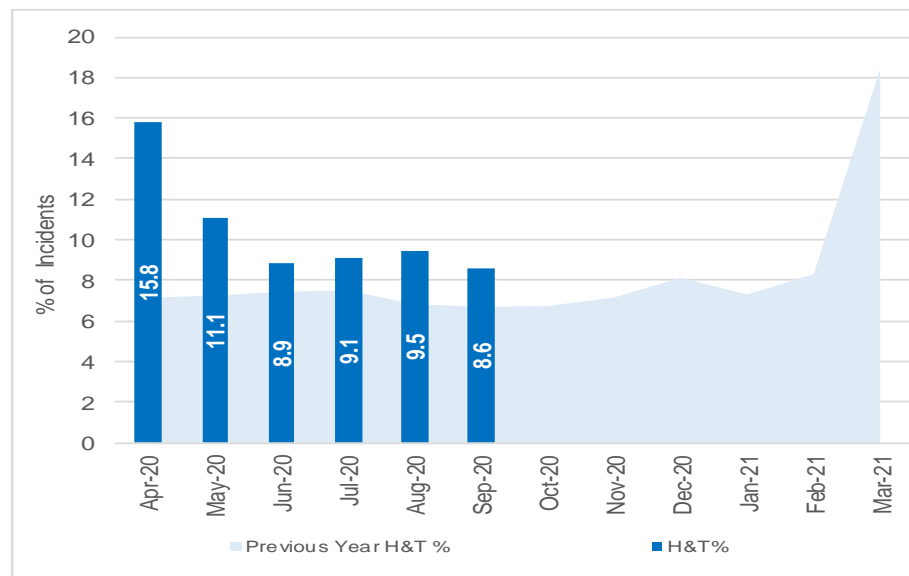
The conveyance to emergency departments target (57.0%) was delivered in September (54.2%). A steady profile of demand has allowed us to achieve this metric month on month. While ranking 6th nationally, it is worth mentioning that the variance between Ambulance Trusts for this metric is small, with us finishing at 0.7% lower the England National figure of 54.1%. A number of efficiency and productivity schemes will impact this number with Operations closely monitoring activity around this metric as we head into the winter period.



Hear and Treat %

		Sep-20	Year To Date	Year-end Target
Hear & Treat %	%	8.6%	10.5%	
	(n)	8,763	62,543	TBC

Hear and treat delivered 8.6% in September. Following a reduction of Covid patient related calls which was exceptionally high during March – May 2020, our Hear & Treat rate saw a steadying trend from June onwards. In 2020/21 year to date, the performance in the metric has been strongly within the 2019/20 target (7.9%) and continue to outperform last year's benchmark of 6.7%. Hear & Treat remains a key focus for the Trust as we enter the winter period, allowing robust delivery on our conveyance rates and keeping frontline resources available for our most critically ill patients.



Please note: 999 performance data is correct as at 28/10/20 and is subject to change due to data validation processes

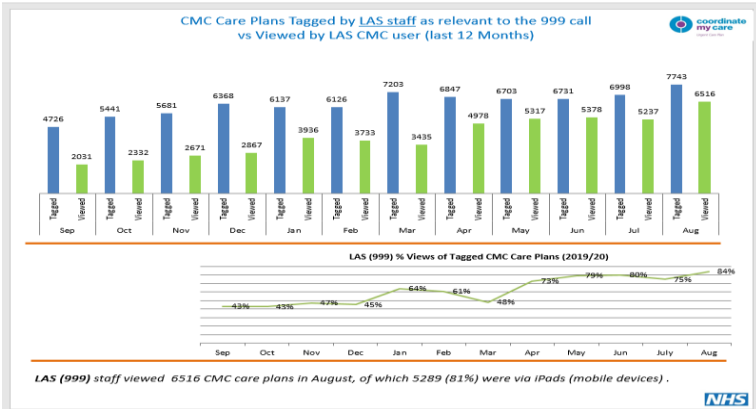
4. Our Partners

End of Life Care & Mental Health



LAS views are compared to tagged care plans – as any other kind of flag for the address or any address in the building raises a CMC flag at LAS – rendering Flagged figures meaningless

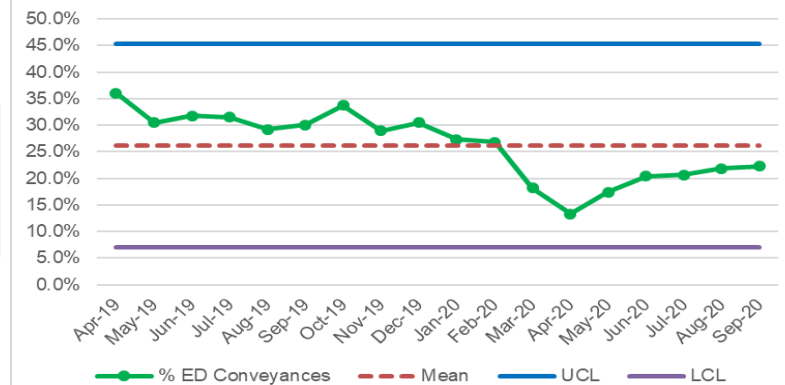
Note: Due to name & address issues at time of call and scope for inaccuracies, the tagging is likely to be on the conservative side. Therefore the LAS views may be a few % points higher than shown.



The CMC viewing figures continue to improve. Action: Pilot role of CMC in EOC has changed parameters to address current CMC risk of plans without flags

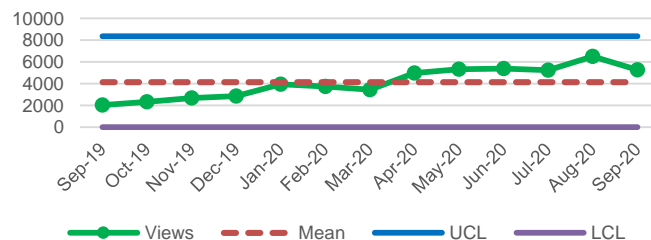
ED Conveyance

Latest Month (Sep): 22.3%



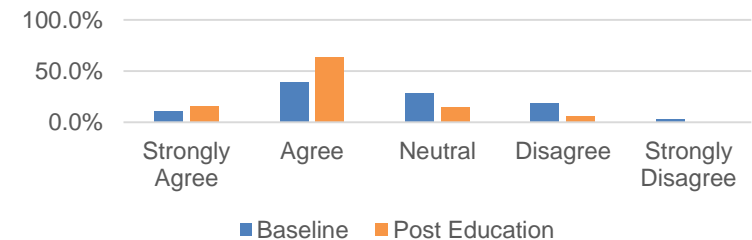
ED conveyance continues to be lower than earlier in the year. coordinator Action: Re-audit of EoLC in LAS completed and for analysis

CMC Views



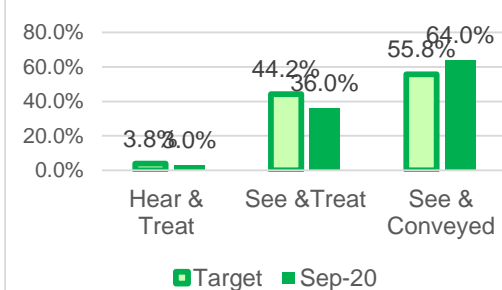
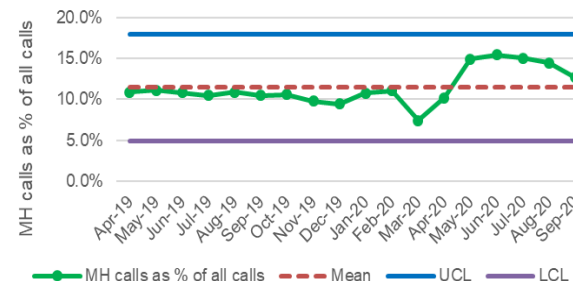
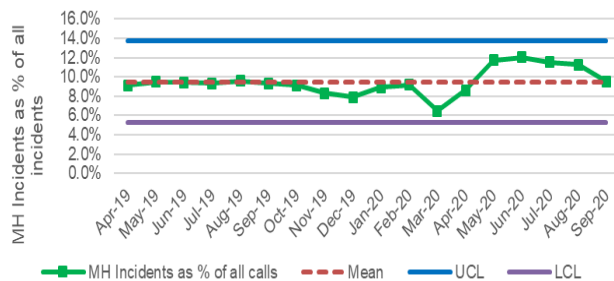
Staff Confidence

80% staff post education felt confident
30% increase from baseline



The EOL Team have supported the development of the 87% App as part of the Wellbeing hub

Creation of more appropriate care pathways for advice and support.



Following on from the publication of the Evaluation of the Mental Health Joint Response Cars (MHJRC) we are discussing next steps regarding funding. We have presented the model nationally via an NHS England webinar on the Long Term Plan monies for ambulances and at a Royal College of Psychiatrists event. We are also due to feature in the HSJ. We have trained new paramedics and they start week commencing the 12th October so we will have maximum coverage of MHJRC. The team have reported an increase in acuity of presentations which may correlate to the increase in conveyance rate.



PUBLIC BOARD OF DIRECTORS MEETING

Executive Director Report: Quality and Assurance Directorate

The Quality and Assurance Directorate recently started its transition to align to the Chief Paramedic & Quality Officer accountabilities. This has seen the Health, Safety and Security team, the Patient Experience team and the Legal team transfer to the Corporate Governance Directorate. Additionally, the Nursing teams, Maternity, End of Life and Mental Health, have also transitioned into the Clinical Directorate. The Directorate would like to thank those teams for their hard work and dedicated whilst under the Quality Directorate.

To strengthen the quality agenda, the 999 Quality Governance and Continuous improvement team have now join the Directorate which will ensure a consistent approach to quality is provided to all areas of the Service.

1. Quality Assurance – key outcomes September 2020 (IPR and Quality report November 2020)

The Directorate's quality assurance systems identifies key issues as well as areas where assurance can be provided in relation to the status of various quality topics/systems. The key issue are highlighted below:

- Performance remains strong with the targets for the different response categories being met for the majority of the timeframe (up to end September). Monitoring of delays over the 90th and 2 x 90th centile continues and the numbers show a steady reduction, all incidents are analysed using the structured judgement review process utilised during the last COVID19 peak. None have been approved as SI at the Serious Incident Group. Over 2,600 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus to continue improving on the metric with action plans focusing on clarification of targets, improving the process and sharing good practice. PDR/Appraisal remain below trust target. Staff and managers continue to receive reminders.
- Incidents: There is evidence of a positive reporting culture for no and low harm incident. The peaks in moderate, severe and death incidents matches times of seasonal demands on the service. The highest peak was seen over March/April during the height of the COVID19 pandemic in London.
- There is clear oversight of serious incidents actions plans, 46 overdue.
- A key focus has been to ensure that Mental Capacity Act (MCA) training Level 2 is rolled out across the organisation, Level 1 is currently e-learning. The development of the training package using a blended approach; e-learning and MS Teams is under development by the Safeguarding team. Level 2 requires face to face training. The package has now been included in CSR programmes from the end of March 2021, this will meet regulatory requirements. EPCR will have mandated field for MCA assessments.
- Safeguarding level 3 training: Level 3 training trajectory is at 44% (1118 staff out of 2500 for 2020-2021. This has been adjusted from 3000 due to coronavirus outbreak).

A training delivery plan has been agreed and commenced this month. 99% of staff who require DBS checks have had them.

- Medicines management: Medicines related incidents are monitored at all sector quality governance meetings and audits are in place with good oversight and follow up of actions
- Infection Prevention & Control: IPC audits are in place and are consistently monitored. The latest OWR hand hygiene compliance (for September 2020) is 97% which is well above the Trust target of 90% for the group station that submitted data (161 submissions). 18/18 Group Stations/Services submitted their premise cleaning audit data and overall the score exceed the Trust performance target of 90%.
- Health & Safety: Continuous focus on violence reduction with work progressing on introduction of body worn cameras. The trial and Trust wide roll out programme are being planned to start in November and costs currently being identified within the capital budget.
- Patient outcomes for Cardiac Arrest: LAS ranks 8th in Survival to discharge for both the Overall and Utstein group (5.9% and 14.3%) both are below the national average of 7.2% and 20.0% respectively.

2. Patient Safety

Patient Safety Incident Responses Framework (PSIRF)

The PSIRF Steering Group have met three times and collaboratively developed the Patient Safety Incident Response Plan (PSIRP) for the Trust. The incidents prioritised for ongoing safety incident investigations will be

- Resource Availability for patients waiting over the required response times, and/or where patients have had an enhanced telephone assessment and believed to be less acutely ill.
- Call handling triage incidents including those which has resulted in the delay in response which has caused harm.
- Behaviour and attitude which has resulted in a patient safety incident.
- Face to Face Clinical Assessment where patients have been managed down an incorrect pathway and/or an incorrect decision about ongoing care have been made.
- Enhanced Telephone Clinical Assessment which has resulted incorrectly in home management advice.
- Clinical Assessment of Spinal Injuries which led to a patient not receiving immobilisation where it was clinically indicated.
- Medicine management incidents occurring during the preparation or administration of medicines with or without the presence of patient harm.

The draft PSIRP was discussed at the recent Quality Oversight Group and ratified by the membership. The PSIRP has also been reviewed by the National PSIRF team at NHS England and Improvement. The team are now finalising the document following recent feedback. This will then be reviewed and ratified at the Quality Assurance Committee and at Trust Board. Once approval has been received by the Trust Board, a move over to the new framework will commence.

Alongside the PSIRP is a detailed communication plan which outlines how the Trust will internally begin to communicate the new framework to all staff across the Trust. Our

commissioning colleagues will support the Trust to ensure that externally through to all CCGs and other healthcare providers.

Current themes from Serious Incidents and data analysis

During quarter two, the main themes from incident analysis relate to:

- Q2 has seen a continued trend of incorrect triage of calls and an increased number of SIs declared where patients have been not conveyed to hospital.
- Four incidents relating to the management of obstetric emergencies were identified and a comprehensive review of all of these incidents in the form of a thematic is being undertaken to be able to identify the contributory factors and implement appropriate mitigation.
- An emerging theme has been identified with regards to the timeliness of Emergency Call Handlers providing defibrillation instructions. The EOC Senior Leadership team have been made aware of this emerging theme and are working to mitigate against this risk.
- The concept of primacy of care has also been discussed at the Serious Incident Group as cases have been reviewed where it was not evident that the registrant always retained primacy of care during the patient management. The Clinical Directorate have reviewed the current guidance and released communications to staff.

The first in a series of Learning Briefings have taken place throughout September where operational managers are invited to attend a session dedicated to the SI process, the learning from recent SIs. A SI learning event was also held for all staff where six serious incidents were discussed in a case study format in addition to the findings of the COVID-19 review. These event were evaluated by those who attended to identify areas of improvement and the results were positive with 96% of participants would recommend the SI case review session to a colleague or friend.

3. Safeguarding

Implementation of the National Child Protection Information Sharing System in the Trust continues with SE & NE IUC go live on 2nd November joining the Clinical hub. Discussions are ongoing to introduce at See and Treat by end of financial year. This will enable information on where children on a safeguarding plan or looked after are accessing care and provide vital information to local authority to help protect them.

The Trust was very active in National Ambulance Safeguarding week, tweeting key safeguarding messages to public and staff as well as providing education on a range of safeguarding topics including professional boundaries, domestic abuse, communicating with disabled patients, fluctuating capacity & Substance misuse, Self-neglect and non-accidental injuries in children. This was very positively received by staff with several hundred attending the training.

Safeguarding level 3 MS Teams training begun in October and we agreed a new trajectory with commissioners for 2500 staff to be trained by end of 2020-21.

Two of the Safeguarding Specialists are taking part in the Quality Improvement Hub Pilot which is enabling safeguarding improvements within the areas. All Safeguarding Specialists are aligned to a designated area and support staff and managers with safeguarding assurance and are working to improve safeguarding compliance in their areas. The hubs are aligned to the quality and estates strategic objectives and Ambulance modernisation programme.

The Safeguarding team are continuing to work with the EPCR implementation team to move safeguarding referrals and concerns to an electronic process this will enable staff to be accountable and have greater ownership of their safeguarding concerns and streamline the process and ultimately improve patient care and communication with partner agencies whilst realising a cost reduction. This is expected to be introduced in Q1 2021-22.

4. Quality Account Priorities

The trust agreed a total of 18 quality priorities for this financial year. These priorities are monitored by the Quality Governance & Assurance team and reported to the Quality Oversight Group. 17 of the 18 priorities are on track and making good progress. The only exception relate to the roll out of tempus monitors for MRU and CRU responders. Both services were taken off the road during Covid-19 high demand. Motorbike Response Unit (MRU) remain off the road and CRU re-started on 21st September 2020, however in a much smaller capacity with only 8 riders. This has impacted on the progress to roll out of trust wide tempus monitors to MRU. The objective will be re-assessed and revised.

5. Quality Improvement and Assurance: Operational Models

The new operational model for quality governance, assurance and improvement trial, which started on the 1 September is on track. This is a trial of a hub and spoke quality delivery model within sectors/services; where by all quality departments come together to create a hub of business partners to jointly deliver the quality agenda within sectors. This model is aligned to the Trusts quality and estates strategic objectives of Ambulance Modernisation. A mid pilot check point was undertaken last month to review progress against the implementation plan and early indication are that this is the most effective way to deliver the quality agenda. Some of the achievements so far include;

- Closer working with operational colleagues which is attributed to increased profile of the quality agenda and improved communication across teams
- Better sector/service tailored support from the quality team as improved intelligence sharing has led to a more targeted approach.
- Further development of operational ownership of the quality agenda

The trial will be completed by the end of October 2020 with a full report and business case to agree requirements for full roll out during 2021.

6. Station Accreditation Trial

The station accreditation trial commenced on the 1 September. This programme of work is focussed on engaging and supporting stations to achieve accreditation status in the context of quality/regulatory standards. Station accreditation is a concept grounded in frontline leadership and is aimed at not only meeting the expected quality standards but also, at encouraging innovation and transformation.

Each sector put forward one station to take part in the trial. The station involved are Newham, Camden, Brixton, Wimbledon, Hanwell and SEL for IUC. The quality governance

& assurance Managers have engaged extensively with local operational teams to develop and implement improvement action plans in line with this trial's implementation plan.

The trial will conclude at the end of November with independent assessments led by local commissioners and public representatives. Possible awards are Bronze (for stations meeting basic standards), Silver (for stations meeting most expected standards with clear plans for improvement) & Gold (for stations meeting all standards and deemed excellent).

7. Care Quality Commission

Gap Analysis into East of England Recent Inspection

The Directorate has undertaken a gap analysis to provide assurance on the trust position against various issues found at the East of England Ambulance Trust by the CQC as reported last month.

The key points founds of this review revealed:

- The Trust is in a much stronger position in relation to various areas of concern for EEAST.
- There is a strong focus on staff wellbeing, freedom to speak up, equality & diversity and governance & risk management in general. Within the LAS there is evidence that systems are in place in relation to these functions. In relation addressing behaviours within LAS there are systems and processes that address these if they are not found to be consistent with Trust values. The Board has commissioned and received external independent reviews and has clear action plans to address the findings – this is positive when compared to EEAST whereby the Board were not either aware or acting on such behaviours.
- Further work is needed to strengthen some of the reporting processes for volunteer responders and private ambulance service, to provide assurance of robust oversight.
- There is also a need to develop and strengthen some of the HR policies to support practice. In addition there remains instability within the people and Culture department with regard to senior leadership roles, this has been the case for some time and is an area of concern and similar to the position in EEAST. This is acknowledge and actions are being taken to address this.

The CQC's new strategy

The CQC's emerging strategy is focused on the well led & safe domains. This approach recognises that when organisations are well-led, generally everything follows. It is important to note that all the other CQC domains remain as important and will be inspected if intelligence indicate a certain level of risk in those domains. There are four themes in the new strategy, which are:

- PEOPLE: the regulation will be driven by what people expect and need from the service rather than how providers want to deliver services
- SMART REGULATION: The CQC will implement a more dynamic approach to regulation, harnessing information from all sources to continually assess the quality of care.
- SAFE: The CQC will focus on checking that services are promoting a strong safety culture; this includes transparency and openness that takes learning seriously –both

when things go right and when things go wrong, with an overall vision of achieving zero avoidable harm.

- IMPROVE: The CQC will play a much more focused role in ensuring services improve

The underlying theme is an ambition to improve people's care by looking at health and care systems and how they're working together to reduce inequalities.

The Trust has established systems and process that will align with the CQC's new strategy. However, further work is needed to explore how the organisation can proactively use patient & public feedback in service delivery as this is a major focus of the CQC's strategy. The recently approved LAS strategy therefore needs to be implemented and embedded within the organisation. LAS also needs to ensure further improvements in the development of quality assurance systems and processes within new and developing services are established.

8. Looking forward

Further development of the 'Hub' models to ensure that we have robust quality assurance and improvement frameworks for any new service i.e. PTS, IUC expansion, is critical and work is underway to develop these with key stakeholders. The Heads of Quality Assurance for 999s and IUC are working closely to agree the structures, both people and systems and processes, in the new contract for North West London IUC and across and within North East London and South East London IUCs.

The directorate are working closely with the Estates and operational teams in embedding the quality Improvement and assurance 'hubs' are integral to the Ambulance Modernisation Programme.

Ensuring that the 2021/22 quality priorities reflect the expansion of the services and assurance framework reflect the changing nature of Care Quality Commission inspection regimes (consultation on this is expected by early 2021, Health Service Journal September 2020)



PUBLIC BOARD OF DIRECTORS MEETING – November 2020

Executive Director Report: Chief Medical Officer

Hot topics

- The nurses for Mental Health, Maternity and End of Life Care have now joined the Clinical Directorate. The increased skill level and mix is expected to bring further benefits to the clinical knowledge of the Directorate, as well as increasing the remit of trust wide programmes to ensure all ambulance clinicians have the most up-to-date clinical knowledge, and confidence to practice.
- Collaborative working is continuing with the regional and local stakeholders to embed many of the local pathways which were set up during the first peak of COVID-19 in order to ensure patients can be treated closer to home where clinically appropriate, reducing Emergency Department crowding and minimising the risk of nosocomial infection
- Recruitment is underway for two new Consultant Paramedic posts. One consultant paramedic will work 50% in the clinical directorate and 50% as a clinical sponsor to the strategy and transformation team. The second consultant paramedic will be focussed on Integrated Patient Care.

Pathway Development

As London prepares for Winter, with the additional demands of an ongoing Pandemic, close working with system partners is ongoing to ensure the development of healthcare pathways to ensure that every patients has access to the right care pathway. The Clinical Directorate continues to work closely at a local and regional level to support these developments and ensure that they are accessible to ambulance clinicians and are going to improve patient outcomes. An internal Clinical Advisory Group has been set up to provide the appropriate clinical governance for pathway changes.

As part of the national and regional response to the Covid-19 pandemic, and further to emerging opportunities to integrate emergency care pathways, essential changes are required to provide patients with the right emergency care in the right place, first time. Specific changes are also required to reduce the risk of nosocomial infection through the provision of socially-distanced emergency healthcare where possible, and by reducing the number of contacts with healthcare professionals, especially for those that are clinically vulnerable.

In partnership with the Royal London Hospital, LAS are undertaking a pilot of the Barts Emergency Access Coordination Hub (BEACH). The purpose of the BEACH is to enhance the delivery of safe and timely emergency care, and to improve patient experience by reducing the number of patients waiting for assessment or treatment in the Emergency Department and thus enable maintenance of appropriate social distancing and reduce the risk of spreading COVID-19. Together LAS and Barts Health will develop collaborative and integrated pathways for emergency patients and strengthen the partnership between Barts Health and London Ambulance Service for delivering high quality emergency care in northeast London. It is expected that this partnership model will enable higher levels of patient satisfaction with their care, as well as improved staff satisfaction in delivery of care.

Another new Pathway in outer North East London has been implemented as we know that best place for our vulnerable patients is not always A&E. The King George's Hospital Beech Frailty Unit is a specialist centre designed to meet the needs of older patients with an



integrated team of physiotherapists, occupational therapists, nurses, a case manager, doctors with geriatric expertise, social workers and pharmacists. Conveying suitable patients to the Frailty Unit instead of A&E can potentially avoid admission and allow for a coordinated and integrated treatment plan and long-term follow up

Clinical digital innovation

The Chief Clinical Information Officer and team have been working collaboratively as part of the 'OneLondon' London Health and Care Record Exemplar which is a partnership of NHS organisations and local government across London, working together with citizens to transform London's health and care services by joining up information to support fast, effective and safe care. They are now working with the LAS Communication team, on pan London communication on '*what is OneLondon*'. The frequency of the communication will be increased over the next few weeks, and we are working with the supplier on a mobility option to enable LAS front line staff to view.

The way clinical information is shared is continuously evolving and changing. The Chief Clinical Information Officer and team continue to work with local health and care systems across London to provide more consistent, efficient services to Londoners to improve patient outcomes. Working alongside our partners, patient information is becoming more joined-up. Putting the right information in the hands of doctors, nurses, and other health and care professionals at the right time can save lives and improve patient care.

For clinicians, being able to access information about a patient is vital to provide the right care at the right time. For example, clinicians currently have access to Summary Care Records (SCR), an electronic record that is accessed from their personal issue iPad. The SCR includes patient information which is held securely, allowing staff to remotely access patients' summary care records. This is important in helping our clinicians review patients' medical history, key personal information and any current illnesses when they have not met the patient previously. Work is also underway with NHS Digital to make CMC care plans available via the Summary Care Record Application which will enable easier access to this vital clinical information.

The London Care Record is being introduced which builds on existing local care records and data sharing initiatives. This follows an 18-month public engagement programme to build public trust and confidence in how the health system is joining-up. The London Care Record enables local care teams to see relevant health and care information about a person that is held by organisations in other London geographies. For example, if someone from Clapham (South East London) is admitted to the A&E at University College Hospital (North Central London), clinical teams can access the clinical information they need to treat that person quickly and safely. The information held on the London Care Record will be accessed via a Portal link and will include key information like allergies, current medications, existing long-term conditions, and previous investigations.

In February and March 2020 OneLondon hosted a Citizens' Summit on uses of health a care data. There was overwhelming support from the public for joining up health and care data. 97% of participants expected all health and care organisations in London to join-up identifiable information to support the provision of care to individuals.

The pre go-live testing of the LAS electronic-Patient Care Record (ePCR) has begun and is continuing for whilst some minor synchronisation issues are resolved. In readiness for the full roll out 2500 clinicians have now been trained in the use of ePCR and further training continues through the Core Skills Refresher courses. Feedback from the pre-live clinicians has been positive and this feedback is providing key learning to further refine and enhance the product.



We have now discontinued the digital pocket guide and all clinical guidelines and bulletins are now shared via the JRCALC plus app, which is available to clinicians via their i-PADs. Governance of the JRCALC plus app is through the Patient Safety Group, and information is channelled through the Clinical Advisors and Chief Clinical Information Officer before being uploaded Trust Wide, ensuring a safe and auditable process of dissemination. This means the historical paper bulletins, which were more difficult to version control, are no longer issued.

The Clinical Directorate is continuing to take an active part in the new CAD development supporting configuration workshops which engages all stakeholders in finding solutions and which are being well attended and received.

Medicines Management and Advanced Practice

Following a review of the medicines packing and distribution function a program of work was commissioned in July 2020 – namely the Medicines Modernisation and Innovation Program. Business cases have been approved for: medicines packing unit, inventory management systems and falsified medicines directive, automated temperature monitoring systems and the Logistics Team restructure. Tender processes are soon to start and a staff restructure consultation has undertaken and feedback is being reviewed.

The medicines management team have been working closely with the Head of Health and Well-Being to ensure safe systems and processes for the storage, handling and administration of influenza vaccines for the seasonal flu vaccine program. In addition, the team have started preparation for the imminent mass Covid-19 vaccination program.

The Chief Pharmacist has been working with the Trust EU Exit Working Group to provide updates on the potential impact and mitigations, in the event of the UK leaving the EU without a Trade Deal Agreement.

Prescribing in Integrated Urgent Care continues to be monitored and audited. The Trust has sustained good prescribing practices, in particular persistently achieving national targets for antimicrobial prescribing.

The first consultant and advanced paramedics have completed independent non-medical prescriber training as part of a pilot support by Health Education England and more will undertake the training over the next year. Non-medical prescribing reduces the need for patient group direction (PGD) drug protocols, and facilitates more efficient and individualised care for patients without the need for further consultation or onward referral.

The Independent Non-Medical Prescribing working group is now reviewing the existing medicines policies and operating procedures to ensure there is appropriate governance and infrastructure in place to support this independent prescribing in line with current legislation. It is anticipated that an electronic system will be needed in order to ensuring best practice in auditing the prescriptions.

Revised and additional patient group directions for use by Advanced Paramedic Practitioners have been developed including antibiotics, analgesics and clot busting drugs. These medicines will extend the range of treatments available to patients and improve clinical outcomes in areas such as the management of open fractures as per the British Orthopaedic Association Standards for Trauma (BOAST) and End of Life Care medications for the Urgent Care APPs.



Clinical Audit and Research

Research

Many of the existing research projects that were temporarily suspended in March 2020 due to COVID-19 have now re-opened to recruitment. CARU are also supporting various COVID-19 related research projects including staff wellbeing projects and Oxford University's PRINCIPLE study, which has been identified to be an urgent Public Health Study by the UK Chief Medical Officers.

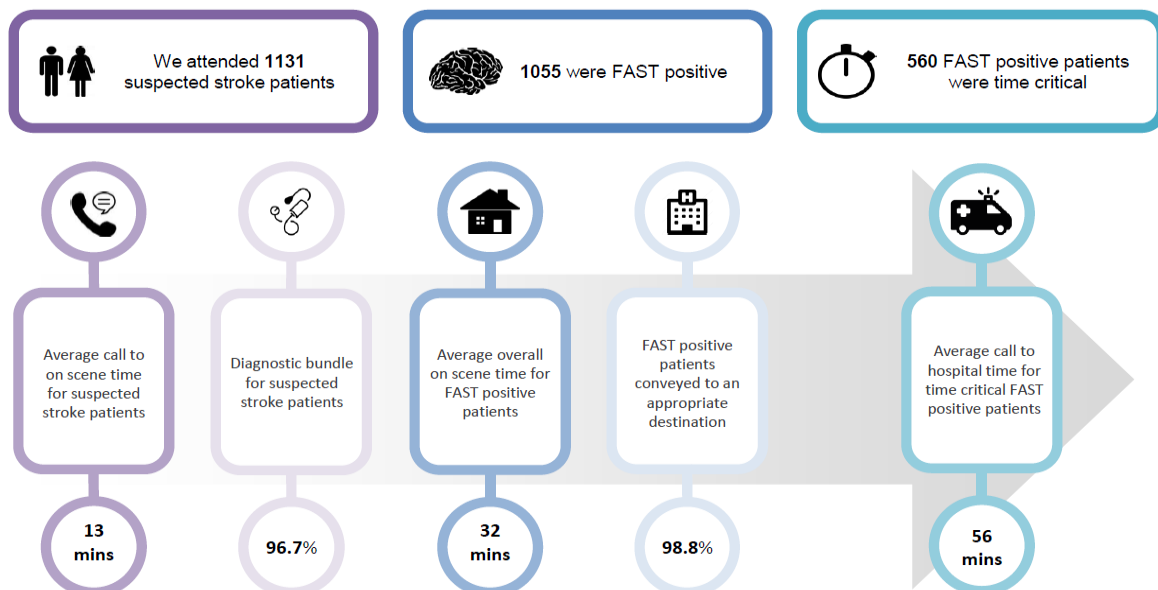
The following research studies are currently active within the Trust:

- **AIR-CGM** - assessing the impact of using continuous glucose monitoring in Type 1 Diabetes
- **ARREST** - a British Heart Foundation funded randomised controlled trial looking at the best post-resuscitation care pathway following Out of Hospital Cardiac Arrest
- **MATTS** - an National Institute for Health Research funded study evaluating the major trauma triage decision tools in use in the NHS which we reopened in June 2020
- **PRINCIPLE** - a randomised trial and Urgent Public Health study looking at treatments for COVID-19
- **STRETCHED** - examining the effectiveness and safety of case management approaches for patients who frequently use the ambulance service

Clinical Audit

Internally, CARU has continued to review the care provision for cardiac arrest, ST Elevation Myocardial Infarction and stroke patients. The internal Care Packs are shared with Clinical Team Managers to facilitate clinical feedback and learning within their teams.

Stroke Care (July 2020)



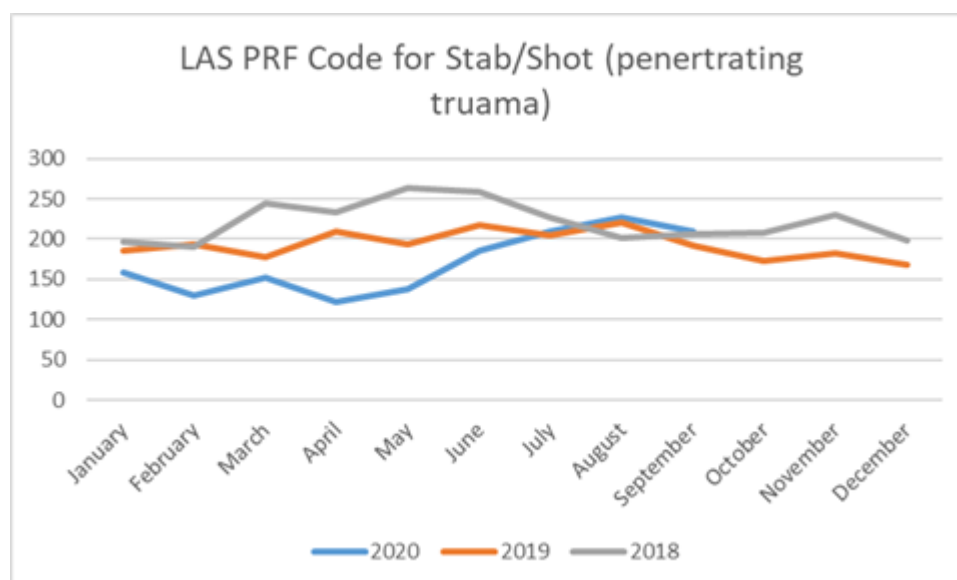


The LAS continuous recontact audit has continued to be undertaken to ensure that the care provided to any patients who needed to recontact LAS within 24 hours is reviewed. These recontacts remain very low indicating LAS clinicians are making safe decisions about non-conveyance of patients.

Sector	June 2020		July 2020	
	Re-contacts per 1000 Face to Face patient incidents	Re-contacts per 1000 patient Non-Conveyances	Re-contacts per 1000 Face to Face patient incidents	Re-contacts per 1000 patient Non-Conveyances
NC	1.4	3.8	1.3	3.9
NE	0.9	2.6	1.3	3.9
NW	1	3.1	0.8	2.5
SE	1	3.1	0.9	2.8
SW	1.1	3.5	1.1	3.6

CARU has continued to undertake internal audits and share the learning through the clinical education and via the Sector Senior Clinical leads.

LAS has also reviewed the number of patients attended with serious incised wounds. It is evident that numbers reduced during the national lockdown in April and May 2020.



Reporting of the Ambulance Quality Indicators (AQI) was suspended by NHS England due to the COVID-19 pandemic but a recovery plan is in place to return to timely submissions. The June national ambulance quality indicator for return of spontaneous circulation after a cardiac arrest shows LAS 31.1% (target 31%) with LAS placed 2nd of the 11 Ambulance Trusts. The June 2020 severe sepsis AQI showed that whilst LAS was ranked 1st of the UK ambulance services there was a slight reduction in



compliance to 92.5% (target 95%) and this will be addressed through the Sector Senior Clinical Leads and Clinical Team Managers. There is always a time lag in receiving end-to-end patient data.

Clinical Education and Standards

The Training Centre Consolidation Project Board has made huge progress towards materialising the Trust's estates consolidation strategy. Against significant criteria suitable sites have been shortlisted and contract negotiations are moving at pace. The project team is now being supported by an education centre designer to ensure a robust and contemporary design that is suitable for both tutors and learners. Simultaneously the Clinical Education and Standards Team restructure was launched in September has closed to consultation responses. The restructure will bring the department forward to meet the change in estate as well as create an opportunity within the department for more specialised roles and development experiences.

The Clinical Education and Standards team has surpassed its achievement of inducting almost 100 Newly Qualified Paramedics at Wembley over the summer. Inaugural in its own right, has been the implementation of the Assistant Ambulance Practitioner (AAP) programme, which provides another step in the LAS' paramedic career structure and will encourage more Londoners to commence the paramedic pathway. This will support the resilience of London's and wider health economy and critically help to address and meet the COVID response.

Clinical Education and Standards gained registration status to deliver the level 3 diploma in Ambulance Emergency and Urgent Care Support (L3DAEUCS) to the AAP programme. This involved writing and review of the course material. We are pleased to say that subsequent to this, the first cohort of 80 AAPs commenced the course on 26th October 2020 at Docklands, within the COVID-compliant framework.

Looking forward

- To support the development of patient centred care pathways to support care delivery over the winter and ensure plans are in place to ensure there is sufficient capacity for the sickest patients in London over winter.
- To support the preparation for the LAS COVID Vaccination programme to ensure that the appropriate assurances around the training of vaccinators and governance of the vaccine supply chain are in place for when a vaccine is available
- To complete the consultation processes for the Logistics and Clinical Education and Standards teams and support staff into new roles.
- In December to commence the advanced practice training for 22 Urgent Care Advanced Paramedic Practitioners and 8 Critical Care Advanced Paramedic Practitioners



Assurance report: Quality Assurance Committee

Date: 03/11/2020

Summary report to:	Trust Board	Date of meeting:	24/11/2020
Presented by:	Mark Spencer, Non-Executive Director, Chair of Quality Assurance Committee	Prepared by:	Mark Spencer, Non-Executive Director, Chair of Quality Assurance Committee

Matters for escalation:

Members supported the reinstatement of BAF 62, there is a risk to service disruptions due to EU exit on 31 December 2020 although they concluded that the risk score may be too high as there were mitigations in place to reduce the impact on the Trust.

Other matters considered:

Members received an update on winter planning which provided a strategic overview of the Trust's arrangements for maintaining the effective and continued delivery of urgent and emergency care services during the 2020/21 winter period.

Update was provided on the immunisations programme which had been instigated to address a specific list of people who required a specific set of interventions as well as give as many people as possible the Pertussis Vaccine.

The Flu Programme began at the end of September 2020 and an updated project plan was presented which provided detailed information to the end of December and mitigations in the event of further London-wide lockdowns.

The Service Quality Accreditation pilot started on the 1 September 2020 and the committee received an update in respect of the actions taken and in progress. It was recognised that the main challenge has been limited capacity within the team and that this is being managed by utilising staff who have limited duties because of C-19 risk.

The first presentation of Data Quality reporting was provided noting the review of 11 key systems that feed into the indicators adopted in the Integrated Performance Report had been carried out as part the 2019 internal audit recommendations.

Key decisions made / actions identified:

The Trust reviewed the 18 quality priorities. These priorities are monitored by the Quality Governance & Assurance team to ensure they remain on track to achieve by the end of the financial year. There is good progress on 17 out of the 18 priorities. The only exception in the report is the quality priority relating to the roll out of tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients.

Members challenged the suspension of the tempus monitors quality priority as they are being used by APPs in small numbers and it was felt that this was something that could continue to be deployed

Risks:

The Committee received presentation of Board Assurance Framework (BAF): BAF 54 in respect of the Trusts inability to meet 111/IUC KPI's as contracted and BAF 61 in respect of COVID-19 impact and were asked to recognise changes since previous presentation outlined in red.

Further to this members were asked to recognise and support the reinstatement of BAF 62, there is a risk to service disruptions due to EU exit on 31 December 2020. This risk was previously included on the BAF and was de-escalated to the Corporate Risk Register in January 2020 following discussion by the Trust Board. As the UK is approaching the end of the transition period in its departure from the EU single market and custom union.

Members considered BAF 62 and supported the recommendation to reinstate although they concluding that the risk score may be too high as there were mitigations in place to reduce the impact on the Trust.

Assurance:

Members received a paper which provided assurance on the trust position against various issues found at the East of England Ambulance Trust (EEAST) by the CQC.

Further to this assurance that the trust's quality assurance systems are aligned with the CQC's new strategy.



PUBLIC BOARD OF DIRECTORS MEETING

Executive Director Report: People and Culture November 2020

1. Key Updates

The Directorate has continued to work on its **18 month strategy**, which sets out the strategic themes and areas of focus for the team. It responds to the NHS National People Plan, national Workforce Race Equality Standards and Workforce Disability Equality Standards guidance, and the key deliverables in the Trust Business Plan. These strategic themes will shape the operating model for the Directorate. The strategic themes in the plan:

1. Culture, Diversity & Inclusion
2. P&C Operations
3. Health and Wellbeing
4. Workforce Planning
5. Talent Management and Organisational Development

The 18 month strategy is being presented to the Board today.

The Trust has prepared a Strategic **Workforce Plan** setting out workforce ambitions for the next 18 months and the current resourcing challenges to be overcome. To continue to provide high quality care for patients and remain resilient in the face of exceptional demand volatility, the Trust aims to significantly increase the resource available for 111 IUC, 999 EOC and Ambulance Services.

In addition, the Trust will continue to support the Primary Care Networks to provide care within communities and reduce pressure on the acute sector. These resource increases will take the form of substantive staff, carefully managed overtime to prevent staff burnout, and other resourcing options such as support from the London Fire Brigade. The Directorate is supporting the Chief Operating Officer who is leading on the Plan for the Trust. A paper is being presented to the Trust Board today.

On Friday 6 November 2020, we hosted our first ever Virtual Jobs Fair via Zoom. There were two sessions held which promoted our 999 Call Handler and 111 Health Advisor roles and the Assistant Ambulance Practitioner and NETS roles. The Fair was publicised via the LAS website with the assistance of the Communications Team, and via our partners (The Princes Trust, Job Centres and Housing Associations). The aim of the sessions were to give better insight into the London Ambulance Service and the life changing, exciting and unique career opportunities we have to offer. The recruitment team was supported by a number of staff, some of whom featured in the BBC Ambulance Series.

We are delighted that the feedback received from the circa 180 attendees indicates that we are on the right track to recruiting people who want to make a real difference to the community we serve.

2. Culture, Diversity & Inclusion

As mentioned in the Chief Executive's report, there have been changes to the senior leadership of the Directorate, requiring a number of interim line management changes. Pending the recruitment of a new Associate Director of **Culture, Diversity and Inclusion**, the

team is working on updating the following action plans and ensuring that they are relevant and aligned to the NHS People Plan:

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Behaviours and Civility at work
- Black Lives Matter (Trust-wide and specific location plans)

The new Associate Director for CDI will take ownership for coordinating the responses to these action plans when appointed.

Our percentage of Black Asian Minority Ethnic (BAME) staff has improved to 17.2%, against our end of year target of 17.5%. Our overall BAME staff numbers continue to increase (currently 1,100) although this representation varies at different levels in the organisation as follows:

% of BME staff in band	
Bands 1-4	37.55%
Bands 5-7	11.07%
Band 8A to 9	14.29%

3. P&C Operations

Staffing Position

Our overall vacancy rate has remained within target (5%) at 2.2%. We have a strong staffing position in both Emergency Operations Centre (EOC) and Integrated Urgent Care Services (IUC) and are currently reporting no vacancies.

Our in-ops vacancy rate has decreased from 3.9% in July to 3.5% in September and we are forecasting an end of year operational gap of 100 FTE posts. We had a total of 66 starters in September 2020, with nearly half from a BAME background. Our turnover has continued to improve from 8.9% to 8.6% since the last report.

Staff Absences

The Trustwide sickness position has marginally increased from 4.6% in August to 4.9% in September, however, this is below the sickness rate for the same period last year (5.4%). Absence for Covid-related reasons (isolating) accounts for 38% of the overall sickness figure. There has been a steady decline in COVID-related staff absences since a peak in March and up to the end of August. We have seen an increase in September, which has been maintained (see figure 1 below).

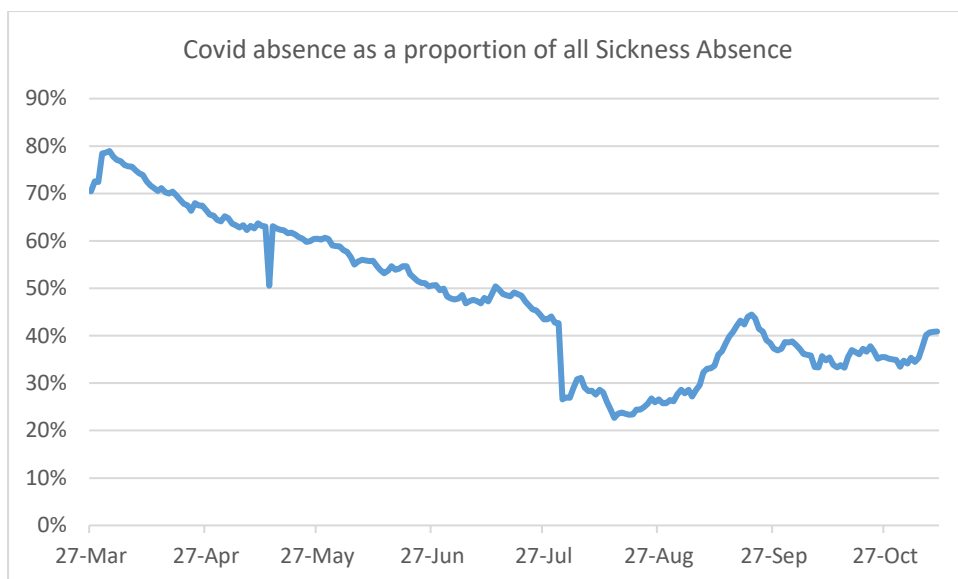


Figure 1 – COVID-related absences as a proportion of all sickness

99% of BAME staff, 97% of vulnerable staff and 98% of all other staff have had a risk assessment completed. We are now identifying themes from the assessments which will provide intelligence to support and inform our overall planning of activities to ensure that staff remain safe and protected.

Statutory Mandatory Training

Trust compliance in statutory and mandatory training has remained unchanged at 84%. PDR compliance has increased to 72% (as at 9 November) from 67% in July.

Resolution Framework

The Resolution framework is close to being launched and it has the objective of:

- Supporting managers to maintain a workforce that adopts the values, behaviours and standards of conduct expected of them and if they fall short of these standards, to help and encourage improvement where this is possible.
- Ensuring that there is a consistent and fair treatment of staff in relation to resolving concerns and any action taken in response to allegations of unacceptable conduct
- Ensuring that relevant legislation, ACAS and the Equality and Human Rights Commission codes and good management practice are followed during the implementation of this policy.

The Directorate is aiming to finalise the Trust's new Resolution Framework by 1 December 2020. However, we are keen to learn any lessons from the work of Mersey Care NHS Foundation Trust on its 'Just and Learning Culture', which has delivered a significant reduction in disciplinary investigations over a two year period.

Figure 2 below shows the number of open disciplinary cases and grievances month on month from the beginning of the financial year that are recorded in our Employee Relations Tracker. Case numbers peaked in the summer as we came out of the immediate COVID-19 peak response, and following the death of George Floyd and our 'Big Conversation' with core leaders and staff on race and racism. Twelve race-related cases have been raised since that time. We have now dealt with all of these at the first hearing stage and will address any appeals or further processes. In order to support the volume of work we are developing

greater standardisation of documentation, developing the ER Tracker system functionality to utilise some of the tools (letter generation from templates) , and developing plans for management reporting allowing for case open times against benchmarks to be shared.

		Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Disciplinary	Number of open cases	35	52	74	73	59	63	61
	Cases closed	3	1	9	3	12	5	7
Grievance	Number of open cases	16	19	16	21	18	21	21
	Cases closed	2	1	5	1	1	0	0
Suspensions	Number of open suspensions					11	8	8
	Average suspension length (calendar days)					83	100	100

Figure 2 – Grievance and Disciplinary cases April – October 2020

4. Health and Wellbeing

NHS Staff Survey

As at 9 November 2020, over 3,700 (60%) staff had responded to the NHS Staff Survey. The closing date for the survey is Friday 27 November 2020, and we are aiming to achieve a higher response rate than last year (71%). Each department achieving a 70% response rate will receive £1,000 for staff improvement initiatives.

Flu Immunisation Programme

The Trust has launched its 2020 flu campaign which aims to see all staff receive a vaccination. Internal communications has created a holistic communication plan which includes interviews and videos from clinical staff, survivors of flu and several of the 200 peer vaccinators who have been trained to deliver the vaccines across the Trust. AS at 9 November 2020, 55% of the workforce have been vaccinated.

Occupational Health Service

The contract for the Trust's Occupational Health service is due to end in the summer of 2021. We are currently framing our requirements for future services and determining the best approach to procuring this. An update will be provided to the People & Culture Committee and Trust Board as this workstream develops.

Wellbeing Hub and Support to Staff

The number of contacts to the wellbeing hub has continued to increase, with almost 100 in October 2020, up from 80 September. Questions have been around COVID-19, immunisations, and mental health support. The hub has also been able to support the flu immunisation programme, assist with contact tracing, and the administration for the 400 colleagues who have signed up for mental health first aid (MHFA) training. This is the first time the Trust has offered MHFA training on such a wide scale and colleagues will learn to recognise the signs and symptoms of a variety of mental health conditions, as well as how to support each other. The Wellbeing Hub is staffed by front line colleagues on alternative duties, mainly as a result of COVID-19.

5. Talent Management and Organisational Development

Leadership, Education and Performance (LEAP) currently have adapted a number of training offerings to run via Zoom, including Giving and Receiving Feedback; Coaching Conversations; PDR Skills for Managers; Completing Job Applications; Interview Skills; and Time Management.

The corporate induction has also been adapted for the virtual setting and is now delivered via Zoom to participants directly as well as into the Clinical Education and Standards training classrooms.

More focused pieces of work within specific areas of the organisation include:-

- Management Information (MI) Team – due to the introduction of ePCR we are supporting the MI team with transitional support around career conversations, CV writing and applications forms, interview skills and 1:1 support with career coaching.
- EOC/111 – working with the Integrated Patient Care (IPC) leadership team and an external provider, Impact Consulting Psychologists, we are progressing a management development programme for EOC and 111 IUC managers. This will build on and develop leadership skills and is aimed at promoting and embedding positive leadership behaviours. Initial diagnostic conversations with all line managers have taken place and Impact are finalising plans for the first skills building workshop. Following this we will have a joint briefing to plan and deliver cohort-based MBTI sessions prior to two further workshops and a final output creating agreed values and behaviours based ways of working across sites.
- An initial Fleet Engagement workshop was held on 30 October 2020, where staff were invited to come along to begin to create development plans and align ways of working. Two further workshops will be held virtually to gain further insight. Working alongside the new Head of Fleet this work is concentrating on overall development plans and ways of working to cover all sites and will require PMO involvement to support delivery.
- We are progressing plans with Resilience and Specialist Assets to encompass the focus area of HART, which will again aim to embed consistent values and behaviours based ways of working. Coaching support has been identified through the coaching faculty of our leadership development partners, NHS Elect.

We are continuing to develop a bespoke LAS Supportive Leadership 360 Degree Questionnaire, working with Zeal Solutions who provide the national programmes of work with NARU and NHS Employers. It is proposed that the 360 degree questionnaire will be based on LAS values and behaviours and provide: reporting; gathering of anonymised intelligence; and organisational themes. It will also include training for feedback facilitators and one year's unlimited licence.

Garrett Emmerson / Wayne Donaldson
For Director of People & Culture
November 2020



PUBLIC BOARD OF DIRECTORS MEETING

Executive Director Report: Finance M6

- [Hot Topic Updates](#)

- Interim national financial arrangements ended on 30 September which ensured the Trust met its financial target through a retrospective top-up mechanism for the first half year.
- The Trust has been working in partnership with our host ICS, NW London Health Care Partners (HCP), to agree planning assumptions which informed the system financial envelope for the remainder of the year. The financial envelope for the remainder of 2020/21 has now been agreed by NWL ICS and financial plans submitted to London region on 22 October. Trust finances will need to be managed within this envelope.
- The settlement agreed for the remainder of the financial year will set an income envelope of £522.2m for the full year based on the month 4 forecast. This is £5.1m less than the previous plan due to the exclusion of £5.0m COVID 19 surge costs which is agreed in principle to be accessed through a break glass against either national or local system contingencies should another surge happen. The Trust has received confirmation from NWL STP that the settlement is not subject to system incentives and benefits for the elective recovery programme and has confirmation of the CIP requirement at 1% in line with all other NHS organisations in the ICS.
- The only other change from plan is that the Trust is now expected to deliver a surplus of £2.3m following the inclusion of additional non NHS income contribution assumed to be funded by NHS England.
- The remaining risk following clarification of the NWL STP assumptions for the system level contingency, in particular to note is that the NWL contingency of £59.5m, against which LAS would bid for Covid surge costs, is itself contingent upon an assumption of central funding of £61.6m for lost non-NHS income. This will be confirmed as part of the regional sign off of the STP plan.
- The Trust is now working to a Capital plan of £41.8m following agreement with NWL ICS. Work is ongoing internally to assure delivery of the £41.8m in year and continues to discuss requirements with NWL ICS from a system management perspective.

- [M6 Finance Position](#)

- The Trust has a breakeven position as at the end of September 2020 in line with the interim financial framework established by NHS England.

- Full year income has increased from the £522.2m to £524.4m due to a higher than forecast COVID claim in month 6 which will be funded through the retrospective top up arrangements to the end of September 2020.
- The full year forecast at month 6 is to deliver a year end surplus of £2.3m on the basis that the Trust receives an additional £2.3m of non NHS income from NHS England.
- £48.4m of Covid-19 revenue expenditure has been incurred cumulatively to Month 6 and retrospective claims to M5 have all been funded in full excluding a £2.6m write back of CAD costs, which is within approved budget.
- The Trust has a cash balance of £64.6m at the end of October.
- The Trust capital resource limit for the remainder of the year is agreed by the STP at £44.2m, however this requires formal notification. A further £6.1 m of CRL has been identified for brokerage within NWL HCP which will increase the Trust's 20/21 CRL limit to £50.3m. A total of £6.8m has been spent to M6, with significant ramp up projected in the forecast. Since month 6 the agreed capital resource limit has been reduced to £41.8m as mentioned above
- [Looking forward](#)
 - I have taken up the Chair of the AACE National Ambulance Finance Directors group from last month and will be representing the national FDs on the Ambulance Improvement and Implementation Board (previously Ambulance Improvement Review Board) which reports to the national Joint Ambulance Improvement Programme and the System Improvement Board. This group is responsible for providing effective oversight of the delivery of the recommendations from Lord Carter's review in 2018 of unwarranted variation in NHS ambulance trusts in infrastructure areas of fleet, control centres, make ready and the model ambulance service portal.
 - The corporate services transformation programme, aiming to provide efficiency at scale, has been developed in outline. A proposal has been developed to invite bidders to scope the opportunity, create a detailed programme and business case; in order to ensure the Trust successfully ensures long term efficiencies and a fit for purpose corporate services structure.

Lorraine Bewes OBE
Chief Finance Officer
November 2020



Assurance report:

**Digital 999 Programme
Assurance Board**

Date: 12/11/2020

**Summary
report to:**

Trust Board

**Date of
meeting:** 24/11/2020

**Presented
by:**

**Sheila Doyle, Non-Executive
Director, Chair of Digital 999
Programme Assurance Board**

Prepared by: Sheila Doyle

Matters for escalation:

The program remains at Amber status. The ePCR pre-live testing has been extended in order to resolve 2 technical issues. The CAD configuration workshops are slightly behind schedule due to supplier resource constraints.

Both projects are tracking well within the expected FY21 budget.

The Director of Strategy & Transformation presented the D999 Digital Strategy Alignment paper. Members were assured that the capabilities provided by D999 are a critical enabler to the Trust strategy and lay the foundations to realising wider patient care and system benefits.

Members reviewed the benefits realisation strategy and plan which is still under development. Good progress has been made in providing a detailed breakdown of benefit types and delivery forecast.

The ePCR pre-live user feedback as of 23rd October continues to provide positive feedback with key points of attention being 1) iPad battery performance, 2) hospital handovers.

The CAD configuration workshops and end-to-end process mapping have not identified any major system changes. The lack of major customisation and the acceptance of that position by the EoC user group represents a major step forward, including a reduction in development risk.

Key decisions made / actions identified:

A deep dive of the CAD change management plan is scheduled for the January PAG.

The full benefits realisation plan to be reviewed in January.

Risks:

Covid19 second wave could impact the CAD project timelines. The team continues to monitor the situation.

The timing of Cleric input and prioritisation may be limited due to demands from other clients. Mitigations are under active consideration.

Assurance:

Assurance of D999 Digital Strategy Alignment.

Partial assurance on benefits realisation. Clear ownership of benefits to be re-affirmed by the senior management team over the next period.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Remuneration Committee			
Agenda item:	9.6			
Report Author(s):	Syma Dawson, Director of Corporate Affairs			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee s attention:				
<p>The Nomination and Remuneration Committee is constituted to oversee the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and to establish and monitor the reward levels and structures for the Trust's Executive Directors and Very Senior Managers, ensuring transparency, fairness and consistency.</p> <p>The Committee has met four times since April 2020; fulfilling its responsibilities in its Terms of Reference by:</p> <ul style="list-style-type: none"> Reviewed through use of external benchmarking data Very Senior Manager (VSM) remuneration; Considered the balance of the Board in agreeing to appoint a Chief Quality and Paramedic Officer including the job description and search and selection process; Approved the appointment of a new post - Associate Director of Culture, Diversity and Inclusion; and Reviewed and considered the recruitment process and appointments of existing posts the Director of Ambulance Operations as well as the Director of Integrated Patient Care. <p>The Nomination and Remuneration Committee has requested that a policy is established to outline its approach for making such decisions; this policy is due to be received at the next meeting.</p>				
Recommendation(s) / Decisions for the Board / Committee:				
<p>The Trust Board is asked to note the summary and take assurance that the Nomination and Remuneration Committee is fulfilling its responsibilities in its terms of reference.</p>				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes	x	No		Director of Corporate Affairs



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	18 Month people plan			
Agenda item:	10.1			
Report Author(s):	Wayne Donaldson, People and Culture Consultant			
Presented by:	Kim Nurse, Director of People and Culture Khadir Meer, Chief Operations Officer			
History:	People and Culture Committee 2 November 2020			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board's attention:				
<p>The London Ambulance Service NHS Trust 18 month people plan has been produced in line with a number of drivers that have helped to shape the, these include:</p> <ul style="list-style-type: none"> • The NHS National People plan • National WRES and WDES guidance • LAS Business plan 2020/21 <p>The People and Culture directorate's 18 month plan reflects the support and leadership needed to help the Trust deliver under its strategic themes within the business plan. The themes are cultural change, health safety and well-being, back to basics, enhance patient experience, operational modernisation and corporate modernisation.</p> <p>The document sets out key workforce initiatives that build on the work that began before the outbreak of the Covid-19 pandemic but also takes account of lessons learnt during this difficult period. These plans will all contribute to our purpose:</p> <p><i>"To be a first-class employer, valuing and developing skills, diversity and quality of life for our people".</i></p>				
Recommendation for the Board:				
The Board is asked to review and discuss the 18 month People Plan.				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	x	No		Chief Quality Officer
Finance	Yes		No		
Chief Operating Officer Directorates	Yes	x	No		Chief Operating Officer
Medical	Yes	x	No		Chief Medical Officer
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes	x	No		Director of People and Culture
Corporate Affairs	Yes	x	No		Director of Corporate Affairs



People & Culture: 18 Month Plan

October 2020 to March 2020

Introduction

The COVID-19 pandemic has affected staff across the entirety of the LAS, both front-line and corporate, bringing into focus issues such as Health & Wellbeing, organisational culture, and challenges to our traditional ways of working. There is a requirement for People & Culture to maintain the swift and effective momentum from COVID-19, establishing and developing initiatives introduced to cope with the surge in demand, but also restarting the good work in place before the pandemic.

Key drivers

There are a number of drivers that have helped to shape this 18 month plan and these include:

The NHS National People plan

National WRES and WDES guidance

LAS Business plan 2020/21

In July 2020, the National People Plan was published and has set some important milestones for the next 12 months; the plan also includes Our People Promise, which outlines behaviours and actions that staff can expect from NHS leaders and colleagues to improve the experience of working in the NHS. Alongside these national programmes LAS has its own People Plan that brings together all of our people related activities to ensure alignment with the LAS strategy.

The National WRES and WDES guidance aims to improve the experience of staff and volunteers through core HR processes such as recruitment & selection, training and disciplinary action and there is a specific delivery plan to tackle matters affecting BME staff.

The People and Culture directorate's 18 month plan reflects the support and leadership needed to help the Trust deliver under its strategic themes within the business plan. The themes are cultural change, health safety and well-being, back to basics, enhance patient experience, operational modernisation and corporate modernisation.

We now need to put in place the building blocks for the delivery of our People Plan. We need to create an environment where everyone can grow, collaborate, be proud of what we do and have fun. We all need to show increased compassion, inclusivity and civility. We want to be a magnet organisation, attracting and retaining high calibre and motivated people. We will need to change our operating model and provide the best possible value for the tax paying public, who pay for what we do. The changes we are seeking from our people are as exciting as they are challenging.

This document sets out key workforce initiatives that build on the work that began before the outbreak of the Covid-19 pandemic but also takes account of lessons learnt during this difficult period. These plans will all contribute to our purpose:

“To be a first-class employer, valuing and developing skills, diversity and quality of life for our people”.

People & Culture Workstreams for the next 18 months

People & Culture have identified five clear work streams for the next 18 months, combining transformational goals, robust initiatives to ensure the LAS remains resilient in the face of another peak in demand, be that COVID or other, and taking into consideration the NHS National People Plan, refresh of the model of care and the LAS operating model. These work streams focus on establishing and embedding a distinct LAS culture, improving and centralising operational processes and workforce planning, and ensuring staff have the right skill mix and training to carry out their roles. In addition People & Culture will continue to embed the role and expertise of HR Business Partners.

The People & Culture Work Streams for the next 18 months focus on:

- 1. Culture, Diversity & Inclusion**
- 2. P&C Operations**
- 3. Health and Wellbeing**
- 4. Workforce Planning**
- 5. Talent Management and Organisational Development**

The aims of each of these work streams have been articulated in this paper, as well as an outline of a range of initiatives which fall under each of these. This list is not exhaustive and further detailed planning will be required.

NB The National People Plan has set broad narrative targets for the rest of financial year 2020/21 and specific targets are due to be set for each provider organisation within the coming weeks. Some elements of alignment with the National People Plan's "People Promise" are highlighted in this document. However, this document needs to be read in conjunction with the Trust's response to the NHS National People Plan as there are additional requirements for delivery by March 2021 which are not detailed in this document.

People & Culture Directorate Structure

Given the level of transformational change the Trust will experience as it delivers its strategy over the next 2 – 3 years, we need to complete the restructure of the directorate to build capability and capacity in areas that will enable the rest of the Trust to achieve the ambitions and initiatives outlined in the Trust strategy.

The restructure will reposition the role of HR Business Partners, change our operating model with regards to transactional processes and HR Operations, embed the Wellbeing Hub and associated strategy, create a resolution team to implement the resolution framework and "just culture" we are seeking, and embed a new team focused on delivering all aspects of our cultural, staff and volunteer engagement, diversity and inclusion priorities.

The implementation will lead to a more efficient directorate which has staff who are more engaged with a clear sense of direction.

1. Culture, Diversity & Inclusion

Aim: We are committed to ensure that LAS is recognised as a fair, open and inclusive organisation, with an engaged and collaborative workforce that reflects the city it serves.

We will embed the LAS values of respect, professionalism, innovation and collaboration into day to day practice so that they are embodied by our people and reflected in what we do. We will create a culture where our staff are enthusiastic about their work more effectively together to deliver world class patient care.

We strive to build an organisation that staff will feel proud to work for and that exceeds their expectations.

To assist in achieving this we will be working to get the basics right particularly in relation to our HR processes which can be seen as over complicated.

We will also seek to empower our managers by eliminating unnecessary bureaucracy and taking ownership, this will be a feature built into management training courses.

We have established a Staff and Voluntary Advisory Group which has been set up to listen to the views of staff and volunteers and which will review progress of the culture change programme. The group comprises colleagues from across a range of representative groups across the organisation and is chaired by the Trust Chair.

Being a pan-London service, it is important the LAS represents the rich diversity of the city it serves. Staff of all backgrounds and beliefs should feel welcome within the organisation, and have access to pre-existing channels, forums and support networks across the organisation.

We will continue to build our staff networks and use these to ensure they contribute and inform our decision-making process on our D&I agenda. We will take action to eliminate bullying, harassment, discrimination and abuse against staff and volunteers.

Our data shows that we have not yet removed the ethnicity gap when it comes to the numbers of BAME staff entering the formal disciplinary process. We will need to address this as a matter of urgency and we have already put in place proposals to create a resolution team who will review all casework before it becomes formal – our aim is to tackle issues at a root and branch level and informally where possible.

We have already used our WRES and WDES data as our baseline from which to develop our local action plans and these are reflected in our “Black Lives Matter” action plan.

LAS has a rich history and heritage of which we should be proud. We have an agreed set of values and behaviours and we need to continue to embed these consistently in all that we do. As we ask our staff to help us achieve our transformational ambitions, we also need to give them the tools to lead the transformation and build their resilience in a way that can excite and help them deliver improvements in the service we offer – and create an environment where coming to work is rewarding and fun.

1.1 The areas of priority are:

- **Cultural Development**

During the coming year, building on the work we have already done under the umbrella of ‘Building a World Class Workplace’ we will launch the LAS cultural change programme defining

an “LAS Way” of doing things aligned to our corporate values . We will develop a collective and distributed leadership style and expect our leaders to be compassionate and inclusive. They will help LAS embed our behaviours and values and establish a culture based on integrity and trust. We will have conversations with our staff regarding our destination culture and will undertake an in-depth cultural assessment which will form the baseline for our future cultural change plans.

- **Inclusion**

The Diversity and Inclusion agenda has grown significantly over recent months and has highlighted the need for more investment in this area hence the new role of Associate Director of Culture, Diversity and Inclusion has been created and a team with expertise in these areas will be recruited. Having the correct organisation structures is just a starting point but the team will provide a dedicated focus promoting diversity and inclusion and ensure the LAS is the respectful and fair employer it strives to be. We will offer a fair and safe place to work for all our staff and will embed the diversity and inclusion agenda throughout the work we lead across LAS.

- **Staff Engagement**

Greater attention will be given to staff engagement and will be a priority for all managers within LAS. We will use the NHS staff survey and the cultural assessment tool as a starting point for our discussions and the basis for ongoing evaluation. To ensure that we obtain the best quality feedback data from our staff we have developed a robust and comprehensive staff survey comms plan which should provide a platform for developing an action plan to improve the staff engagement index.

In addition we will also be developing the actions arising from the Civility report linked to the issues of bullying and harassment.

Some of this work has already begun with sector leadership conferences being held from February 2020 with local management teams and staff survey champions attending with the purpose of developing local action plans to improve engagement, communication and leadership.

Our aim will be to put LAS in the upper quartile for the staff engagement index of the Ambulance sector in the NHS Staff Survey in 2021.

1.2 Initiatives for Culture, Diversity and Inclusion

Ref	Indicative Initiatives	Baseline	Timing	Target / KPIs	Comments
CDI1	People & Culture & Strategy directorates to work with an external partner to conduct a cultural assessment to identify LAS' destination culture	2019 staff engagement index – 2 nd to bottom of ambulance trusts	By 2021 NHS Staff Survey	Subset of key metrics to be agreed to include: <ul style="list-style-type: none"> - Appraisal completion - Incidence of bullying & harassment - Grievance count - Sick absence - Staff churn - Working condition - Positive Health and Well being score 	Overall targets Upper Quartile in NHS Staff Engagement Index. Upper quartile Public sector engagement index Subsets to target positive movement during monitoring periods
CDI2	Launch the “LAS Way” cultural transformation programme.	N/A	4Q FY 20/21	Metrics and indicators of success to be created and monitored These will include the KPIs set out in CD11 above	Destination culture achieved when metrics are positive and meet or exceed the staff index upper quartile ambulance trusts

CDI3	People & Culture & Internal Communications directorates to launch "Stamp out Racism" campaign.	Current WRES and staff survey indicators relating to racism to form a core part of the message. Benchmark national Ambulance Trusts data	January 2021	Campaign will be extended to include all protected characteristics	Target staff composition to reflect London wide BME profile. Target reduction between white and BME staff in key WRES indicators reflecting adverse staff experience. Target positive comparisons against Ambulance Trust
CDI4	Commission and deliver mandatory anti-discrimination training to all staff	D&I Strategy requirement – yet to be implemented	March 2021	Part of the Black Lives Matter follow up plan	All staff receive mandatory anti-discrimination training
CDI5	Diversity & Inclusion team to implement the NHS Carer's passport and create a Carer's staff network	Carer's passport not yet implemented	March 2021		Carer's passport implemented and Carer's staff network created

This workstream covers the following areas of the NHS People Promise:

We are a team	X	We each have a voice that counts	X
We work flexibly		We are recognised and rewarded	
We are always learning		We are compassionate and inclusive	X
We are safe and healthy			

2. P&C Operations

Aim: To strengthen the People & Culture directorate so it is better equipped to deliver the Trust's strategy, goals, and vision.

The P&C directorate is “easy to do business with” and acts as a role model of fair, compassionate and inclusive leadership.

Our core HR processes are our bread and butter – it is what we are measured on internally and has a great impact on our people if we do not get it right. The current delivery of some of our workforce functions are not meeting our employee's expectations and few are available 24/7 thus not accessible for a significant number of our staff.

We will be looking to provide a 24/7 service for our staff and managers through the use of technologies such as employee and manager self-service and we will be introducing a one-stop-shop “People and Culture Hub” which will drive a significant change in the way we deliver these services.

P&C will ensure that all employment processes are optimised, and documentation is straightforward for managers and staff to access. An emphasis will also be placed upon the digitisation of numerous repetitive tasks in order to free up time and resource to concentrate on more value-adding activity. This will require investment in technology but will bring about efficiencies in service. By re-engineering our systems and automating processes, we will be better placed to deliver cost reductions in our transactional activities as required as part of the national target to reduce costs by 30% by end 2025/26.

We recognise that our framework of HR policies has grown over time and can lack coherence. They focus on process as opposed to outcome and are seen by staff and their representatives as overly punitive and negative in both tone and language. They do not provide a backdrop to adequately support constructive employee relations. This is exacerbated by lack of experience and skills on the part of line managers, resulting in prolonged processes with unsatisfactory outcomes for all parties. There is a need to reposition our approach to policy design and its application which facilitates healthy workplace relationships and promotes informal resolution, before initiating formal process.

Our recruitment and resourcing processes are improving but are still not responsive enough to the needs of the service.

We will need to focus on implementing best practice in HR management in resourcing, processing transactions, pay, pensions, policy and employee relations. A key enabler will be the implementation of the Digital HR transformation programme supported by the Projects and Programmes directorate. All change initiatives undertaken by P&C will have effective project governance and change management procedures in place to successfully embed the change across LAS.

2.1 Four focus areas have been identified:

- **Recruitment**

We will process map our current employee and volunteer recruitment experiences and identify where we need to make improvements to maintain “Business as Usual” recruitment, “Just-in-Time” on boarding of expanded workforce, Bank workforce recruitment and management, and fulfilling our annual resourcing plans.

We will publish a recruitment “RASCI” for each type of recruitment activity so it is clear who is **Responsible, Accountable, Supports, is Consulted** and **Informed** as each stage of each process.

We will create Service Level Agreements with recruiting managers in the Trust and monitor our performance against them.

- **HR Policies**

We will continue to review and update policies to ensure the LAS develops and embeds a fair and just culture where we focus on our people first before process. In addition to the policies themselves, we will create user friendly templates and user guides so that managers and staff are confident to progress policy related activities.

- **HR Digital Transformation**

We will deliver the HR Digital Transformation programme approved by PMB and supported by the Projects & Programme Directorate. This includes the creation of digitisation of paper personal files and the RPA automated process project.

We will partner with IMT and Procurement to commission an interactive microsite where staff and managers can request support, have their query logged and review its progress, and access support for terms and condition related queries. A different solution may be required for volunteers.

We will seek to automate all processes where possible and move to paperless working to allow for ease of auditing and access to support for all staff outside of standard working hours. These changes will respond to the recommendations of the Carter report and deliver the required 30% reduction in transactional and support costs by the end of financial year 2025/26.

SLAs for key HR processes

We will develop a suite of Service level agreements in consultation with relevant stakeholders to ensure that service delivery can be measured against stakeholder expectation.

2.2 Initiatives for P&C Operations

Ref	Indicative Initiatives	Baseline	Timing	Target / KPIs	Comments
CHR1	P&C directorate restructure consultation and appointment in roles	Existing structure in place	January 2021 new structure implemented	New structure in place	
CHR2	Digital HR Transformation project delivered	Projects on track and monitored through PMB	April 2021 new operating model confirmed	Projects completed	Further commissioning of software and system may be required to meet required levels of digitisation
CHR3	HRBP role confirmed and repositioned within the Trust	2 HRBP vacancies and continued focus on employee relations	As part of new structure and appointments into key roles	New HRBP structure in place with focus on strategic change management and leadership development	
CHR4	Resolution Team implemented	Resolution Framework being rolled out. No dedicated resolution team in place	End of calendar year 2020	Reduction in ETs, formal disciplinary and grievance cases. Improved staff survey scores in related areas.	New team to be appointed as part of new structure and appointments made into key roles

CHR5	New operating model for the P&C Hub created and associated requirements commissioned	Temporary COVID P&C Hub stood down but available to ramp up if required	April 2022	Project and timeline for full deployment of the P&C Hub is approved	Implementation of the full P&C hub will require commissioning of new services, systems and ways of working.
CHR6	Process efficiency improvement – Deliver SLAs for core processes in consultation with key stakeholders	SLAs to cover the following: <ul style="list-style-type: none"> - Payroll & pension query turnaround - General recruitment timeline to appointment - Grievance and disciplinary timeline - PDR completion 	End 2020 calendar year	SLA for each process to be agreed	SLAs to be agreed with key stakeholders with periodic reviews (quarterly).

This workstream covers the following areas of the NHS People Promise:

We are a team	x	We each have a voice that counts	x
We work flexibly	x	We are recognised and rewarded	x
We are always learning	x	We are compassionate and inclusive	x
We are safe and healthy	x		

3. Health and Wellbeing

Aim: to ensure that the LAS adopts and maintains optimal health and wellbeing strategies for LAS staff and volunteers.

We are committed to creating a safe environment for all our staff where management teams actively encourage wellbeing and help reduce workplace stress. This is not always easy, and the demands of COVID-19 has brought the health and wellbeing of our staff into sharp focus. Ensuring our staff are both mentally and physically healthy must be a top priority for the organisation moving forward, especially after a time of such prolonged adversity which has been felt across the organisation.

We have already started to bring all health and wellbeing initiatives into a central Wellbeing Hub to ensure that we optimise the resources we have and focus our attention on those areas that bring greatest benefit to staff. This will require cross directorate strategic leadership across a range of internal and external partners, including the Medical Directorate, Health and Safety, Public Health England and NHSI/E.

Our recently appointed Non-Executive Health and Wellbeing Guardian will support our Head of Wellbeing to ensure the Wellbeing strategy is delivered. Our People Plan will focus on two early priorities

- **Embed the “Wellbeing Hub”**

We will embed the “Wellbeing Hub” and the new Health & Wellbeing strategy to provide one point of access to welfare and support for staff and volunteers.

The Strategy also aims to - improve visibility and accessibility of the well being provision ; ensure that the well being services reflect the diverse needs of the staff; develop and establish training and services that promote the maintenance of positive physical emotional and mental well being; promote collaboration between managers, staff and volunteers and provide a robust oversight and assurance of all the well being activities to align with the vision of a world class ambulance service.

There will be a range of measures put in place to evaluate whether the strategy is having a positive effect on staff and volunteers.

- **Extended mental health support**

We will increase the level of mental health support to our staff, to build resilience in recognition of the long-lasting effects COVID-19 may have on our workforce. We will create an environment where staff have sufficient breaks from work and are encouraged to take their leave in a managed way. We will ensure that staff have a safe rest space to process the physical and psychological demands of work and offer access to a broad range of psychological support, as required

3.1 Initiatives for Health and Wellbeing

Ref	Indicative Initiatives	Baseline	Timing	Target / KPIs	Comments
HWB1	Launch Health & Wellbeing Strategy	Existing strategy requires updating	November 2020	New strategy approved	Strategy is being finalised by H&W and Strategy teams
HWB2	Re-tender the Occupational Health contract	Current contract expires June 2021	Before the contract expires	New Occupational Health contract in place	
H&WB3	Enhance and expand mental health support across the full range of the physiological spectrum			Full range of mental health and psychological support in place	Incorporate H&WB elements of NHS People Plan
H&WB4	Staff survey	Relevant H&WB and H&S related questions	Annual	To improve year on year scores in specific H&WB and H&S areas	

This workstream covers the following areas of the NHS People Promise:

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We are always learning	x	We are compassionate and inclusive	x
We are safe and healthy	x		

4. Workforce Planning

Aim: To establish a workforce planning system which ensures the LAS has the right number of staff available to work, with the right skills, values, and behaviours.

Through business intelligence and workforce analytics our strategic workforce plan needs to bring together our clinical strategic operating model, training and recruitment plans, to ensure that we have the right numbers and types of staff and volunteers to respond to peaks and troughs in activity. To oversee this we have established a Strategic Workforce Planning Board, chaired by the Deputy CEO.

LAS has a workforce of around 7,500 staff and volunteers across frontline crews in our ambulance stations, people in our control rooms, and hundreds of support staff based in our offices across the city. We need to deploy our staff effectively and understand our demographics internally and externally to ensure that our workforce represents the communities we serve. Using our data properly, we can better plan our current and future resource requirements and take action to ensure we develop pipelines of talent across the Trust and deploy our staff flexibly.

Using data effectively and well, workforce capacity and planning should be able to tell our organisation where we have potential workforce and skills gaps and be able to forecast future requirements and create plans to address them. It will allow LAS to take corrective actions ahead of time.

The following focus areas have been identified:

- **Workforce Planning Capability**

We will explore software that will assist in the predictive modelling of our resource requirements and will examine the dimensions of skills and capabilities alongside the demographic of our workforce including race, tenure, age and other protected characteristics to ensure that our plans reflect the changes we need to see in our workforce composition. We will build this capability within the P&C and Business Intelligence functions and provide support to our directorates in the development of more local workforce plans. The aim is to enable the LAS to manage its resources more efficiently providing greater resilience at peak demands.

Skills Matrix

Our aim is to establish an overarching and comprehensive skills matrix for all clinical and non-clinical roles within the LAS aligned to the new model of care and operating model. If LAS is to meet its ambitious and innovative vision to become London's primary integrator of access to urgent and emergency care "on scene", "on phone" and "on line" then we need to ensure we have a workforce with the competencies to deliver this in an agile way – the skills matrix will help set out the competencies and provide a clear framework for staff who are seeking career development.

- **Workforce Models**

Each directorate is responsible for developing their local recruitment plans, but we currently lack visibility of the collective picture. As we support the divisions to plan more effectively, we will also consolidate information to track and monitor our recruitment activity against plans. This will allow us to take corrective action at an earlier stage and be more tactical in our approach to targeting recruitment activity.

4.1 Initiatives for Workforce Planning

Ref	Indicative Initiatives	Baseline	Target	Timing	Comments
WP1	Strategic Workforce Planning Group to oversee the creation of short, medium and long term resourcing plans and model skill mix opportunities	5 separate workforce planning groups in place	Workforce plans exist for all directorates to determine resource requirements	December 2021	Plan to draw up workforce plan / strategy
WP2	Implement e-rostering pilot in collaboration with the other ambulance trusts	Fixed roster in place	e-rostering pilot evaluated for further deployment across the Trust	March 2021	Already an element of the ambulance operations transformation plan
WP3	Collaborate with regional or national partners create a plan to implement the NHS People's Plan "flexibility by default" requirements	Flexible working already in place in parts of the Trust	Principles of assessing roles for flexible working in place	March 2021	

This workstream covers the following areas of the NHS People Promise:

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We are always learning	x	We are compassionate and inclusive	
We are safe and healthy			

5. Talent and Organisational Development

Aim

To strengthen LAS' leadership DNA to underpin improved staff engagement and embed cultural and transformation change

We will take a holistic approach to Talent and Organisational development ensuring that there is synergy between senior recruitment, leadership development and organisational design.

Harnessing and nurturing the talent of the LAS's leaders will always be fundamental to improving the performance and development of the organisation. Leadership Development equips leaders with skills that can help them enhance the engagement of their teams and improvement of service to our patients. We will raise our leadership and line management capability developing compassionate and inclusive leaders who are trusted for their motivation as well as their capabilities.

As we move forward, it will be important for LAS to develop a coherent strategy and implementation plans for leadership, learning and talent across our business. We will work to create appropriate leadership interventions that create great leaders and managers and a healthy pipeline of talent for the future.

The Talent and Organisational Development strategy will incorporate all of the key components of the organisational development framework. This includes relevant and effective senior level recruitment processes, leadership development aligned to organisational development. It will also include performance management where there will be direct alignment between individual output and organisational priorities.

Ensuring the correct leadership development, as well as succession planning structures, are in place will not only provide operational continuity, but also ensure our staff have a clear pathway for progression. We will invest in the appointment of a new post of Head of Talent & Organisational Development, our commitment to supporting retention, identification of talent, and the assessment and development of our current and aspiring leaders.

The role of our line managers is essential to providing a supportive work environment. We are committed to investing in our staff so that our managers feel confident and competent in their ability to make sound people management decisions. We will refresh our leadership and development strategy and make further use of the apprenticeship levy and funds available from HEE to build a stronger bedrock of confident and inspiring leaders and managers.

We will offer extended access to learning and development courses and materials through digital platforms, allowing our staff to improve their skills, consequently enhancing the level of care we deliver to our patients. Our generic workforce development offer remains under-developed and as well as addressing this issue, we also need to create opportunities to develop within roles and for the advancement of staff. This may be accelerated by working with regional and national NHS partners.

5.1 The following focus areas have been identified for Talent and Organisational Development:

- **Performance management and Development**

Performance management is critical for an organisation's success. Employees need to understand what's expected of them, and to achieve those goals they must be managed so that they're motivated, have the necessary skills, resources and support, and are accountable. Performance management is the activity and process that focuses on these areas to maintain and improve employee performance in line with an organisation's objectives.

Managers are central to performance management. Ideally, they reinforce the links between organisational and individual objectives and give feedback that motivates employees, helps them improve, and holds them to account.

We will introduce a suite of performance management systems such as performance appraisals, key objectives and reward structures to facilitate the performance management process linked to staff development and greater business efficiencies.

- **Talent management & Succession planning**

We will identify business-critical roles for which potential successors are needed. We will introduce Succession planning schemes which will focus on individual senior or key positions, or take a more generic approach by targeting a 'pool' of positions for which similar skills are needed

We will take a structured approach to identifying individuals with the potential to step into these posts as short-term or longer-term successors. There will be a proactive development through job moves or secondments to provide a source of future leaders.

In relation to Talent management we will seek to implement systems that attract, identify, develop, engage, retain and deploy individuals who are of particular value to LAS, either in view of their 'high potential' for the future or because they are fulfilling operation-critical roles.

- **Leadership Academy**

We will review and refresh our leadership development strategy and develop and design a talent management programme that creates a healthy pipeline of talent based on our current and future needs. We will create a virtual Leadership Academy that will equip our leaders and managers with the tools to carry out their roles effectively. We will collaborate with Ambulance Sector colleagues, national programme leads, North West London ICS and HEE to draw down on existing programmes and will collaborate on new programmes.

- **Learning Delivery**

We will put in place an organisational structure that will enable LAS to widen access to training and development programmes, using technology and digital platforms as an enabler.

5.2 Initiatives for Talent and Organisational Development

Ref	Indicative Initiatives	Baseline	Target	Timing	Comments
LDT1	Introduce Talent Development and Succession Planning action plans for people at Band 7 and above	Inconsistent approach to talent development and succession planning	Talent Development and Succession Planning action plans process in place	March 2021	Utilise work from 2019 Workforce maturity (Talent Management) Self-assessment
LDT2	Reposition existing Learning & Development programmes to embed the Trust's values and behaviours	Visible, Engaging Leaders and CTM programmes in place	Calendar of revised L & D programmes launched	December 2020	Utilise technology and virtual tools to deliver blended programmes
LDT3	Introduce standards for good quality PDR process	PDR discussion to include <ul style="list-style-type: none"> - SMART objectives - Constructive feedback - H&WB discussion - Career and Learning & Devpt goals 	To achieve upper quartile NHS positive feedback	December 2021	Pulse survey
LDT4	Implement revised PDR / Appraisal process to accommodate performance related pay.	67% PDR compliance as at September 2020	85% PDR compliance	December 2021	This is a national requirement as part of Agenda for Change
LDT5	Introduce 360 degree feedback as a development tool for all people managers	360 degree used in some parts of the Trust	360 degree feedback available as a development tool for all people managers	December 2021	

This workstream covers the following areas of the NHS People Promise:

We are a team	x	We each have a voice that counts	x
We work flexibly		We are recognised and rewarded	x
We are always learning	x	We are compassionate and inclusive	x
We are safe and healthy			



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Strategic Workforce Plan			
Agenda item:	10.2			
Report Author(s):	Chris Randall, Head of Workforce Analytics Brian Jordan, Deputy Director Ambulance Services			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	Discussed at Executive Committee, Operations Resourcing Group and Chief Operating Officer's SMT People and Culture Committee 2 November 2020			
Purpose:	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board's attention:				
<ul style="list-style-type: none"> To ensure resilience in the face of future demand rises and future waves of Covid, the Trust has set the ambition to meet performance standards every day in 2020/21 and prepared a business plan accordingly. There is a lead time of 6 months between recruitment starting and staff being available to operations. Therefore the Trust needs to agree a 2021/22 provisional workforce plan now to allow the pace of recruitment and training to continue with no break. The 2021/22 Workforce Plan shall be updated as the 2021/22 Business Plan is developed and agreed. <p>Integrated Urgent Care (IUC)</p> <ul style="list-style-type: none"> Due to demand increases in year, the IUC is already recruiting above the formal pre-Covid establishment level. The Workforce plan calls for significant call handling recruitment in both NEL (108 WTE) and SEL (97 WTE). For the CAS, there is currently a significant dependency on costly agency staff, so the plan requires recruitment in NEL (80 WTE) and SEL (75 WTE), recognising that recruitment to this role should not inadvertently deplete Ambulance Operations. <p>Emergency Operations Centre (EOC)</p> <ul style="list-style-type: none"> To meet performance every day and backfill leavers, the plan proposes to recruit 130 WTE, recruited and trained in six cohorts throughout the year. The Trust plans to recruit slightly over 				

the establishment level, recognising that some new staff will be in training and therefore not available for operations.

Ambulance Operations:

- The demand has been modelled to meet performance every day and the capacity required varies per month (i.e. more resources needed in December than April).
- The workforce plan proposes an increase in Ambulance Operations establishment by 400 WTE. The remaining capacity will be provided by flexible resource such as PAS/VAS, extra overtime, Paramedic Students etc
- In addition to the 400 extra posts, the Trust will provide support to the 198 Primary Care Networks (PCN) in London. The Trust expects to provide c. 1 paramedic per PCN, at Band 6 and above.
- These resource demands, together with expected leavers, means the Trust must recruit c. 1,072 new patient facing staff. This will be from UK Paramedic Graduates, TEACs, AAPs and restarting international recruitment.

Delivering these workforce changes

- Recognising the challenges in delivering workforce changes of this scale during a pandemic and given the other transformations happening across the Trust, we propose to form a programme with dedicated resource under the governance of PMB to coordinate multiple Directorates to deliver this work.
- We have identified and defined workstreams to build on this workforce plan, coordinate substantive recruitment in the UK & Overseas and link with the existing PCN work. In addition, we shall examine other sources of resource (e.g. St John Ambulance, Emergency responders, LFB, Students).
- An indicative six month plan has been defined and will be overseen by a new Workforce Planning Group, co-chaired by the Director of Ambulance Services and Director of Integrated Patient Care. This will oversee delivery of the Workforce plan across EOC, IUC and Ambulance Services and then report to this Committee.

Recommendations for the Board:

- The Board is requested to:
 - review and approve the workforce plan (pending the agreement of the Trust Business plan later in the year);
 - support the continuation of recruitment and training before the Trust 2021/22 Business Plan is agreed; and
 - support the creation of a Workforce Planning group to coordinate and oversee delivery of this workforce plan.

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		Trisha Bain
Finance	Yes	X	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Medical	Yes	X	No		Fenella Wrigley
Communications & Engagement	Yes	X	No		Anthony Tiernan
Strategy	Yes	X	No		Ross Fullerton
People & Culture	Yes	X	No		Ali Layne-Smith
Corporate Affairs	Yes	X	No		Syma Dawson



London Ambulance Service
NHS Trust



Operations Strategic Workforce Plan 2021/22

October 2020

Contents

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1. Context and purpose of the document
2. Workforce breakdown
 1. 111 IUC
 2. 999 EOC
 3. Ambulance Services
3. Next steps



Covid-19 has highlighted the need for the Trust to have a resilient workforce

The Trust saw significant demand in spring 2020 and may do so again. To meet this, the Trust requires a workforce with the scale and capability to remain resilient in the face of exceptional demand

- The Covid-19 pandemic caused **significant increases** in demand across the Trust.
 - 111 IUC saw **significant increases in demand and changes to the weekly profile**, with significant peaks on Saturday (in spring) being replaced with Monday peaks (in autumn).
 - EOC saw **exceptional demand in March / April** with over 10,000 contacts per day.
 - Ambulance Services saw consistent demand, though this may rise in future Covid-19 waves.
- To ensure resilience in the face of future demand rises or future waves of Covid-19, the Trust must be capable of servicing up to **10,000 EOC calls** per day and associated number of incidents.
- To meet this demand and **maintain high quality patient care** for the people of London, the Trust requires an Operational workforce that has the scale and capability to deliver sustainable performance and remain resilient.



The 2020-21 Business Plan includes a significant increase in resources for Operations

To continue to deliver high quality and timely patient care for patients, the Trust Board agreed to increase front line resources in this year

- To ensure resilience and maintain high performance, the Trust Business Plan includes an **additional £62.7m FTE Funding** requirement (see appendix)
- This includes **significant increases** in 111 IUC, 999 EOC Operations and Ambulance Operations (up to 16% increase)
- These increases have been modelled to deliver the following in 2020/21:
 - 111 Call Answering at **95% <60 seconds every day**
 - 111 CAS at **95% for each KPI**
 - EOC 999 Call Answering of **<5 seconds every day**
 - Ambulance Services meeting **C2 mean <18 every day**



However, there are challenges to delivering workforce increases

The Trust faces a number of challenges to creating a scaled and resilient workforce

Operations Directorate	Challenge to delivering workforce increases
All Directorates	<ul style="list-style-type: none">The Training Estate is in a state of transition from former training centres to a new temporary facility in the docklands to two new fit-for-purpose facilitiesThe Recruitment and CES teams (in particular the trainer capacity) may need to expand to meet any significant expansion in our workforceAn increase in staff headcount may require more Managers (e.g. CTMs) to support, advise and manage the staff.
111 IUC	<ul style="list-style-type: none">There are planned changes to the 111 system across London, including North West London complicating any planningWorkforce increases may require additional software licenses – to be confirmed
999 EOC	<ul style="list-style-type: none">There are planned software changes (CAD, Operating system) that will occur in parallel to workforce increases
Ambulance Service	<ul style="list-style-type: none">Ambulance Services training and recruitment was significantly impacted by Covid-19, with an extended period at REAP 4 and significant reduction in overseas recruitment.There is a finite supply of new Paramedic Science graduates in the UK with only c. 219 paramedics currently in the third year of their training with our Partner Universities (see appendix).The Trust has historically recruited paramedics from overseas, in particular Australia. Due to current travel restrictions, the Trust is unable to run recruitment events in person and it is unclear when restrictions will be lifted.The Primary Care Networks (PCNs) will require support from up to 200 registered Paramedics (Band 6 and above) from 2021-22.



A Workforce Plan is needed to deliver the resources to meet performance every day

A draft workforce plan for 2021-22 is required to allow recruitment and CES to develop plans for 2020-21 and this document sets out a proposed plan and next steps

Why is a Workforce plan needed?

- Meeting establishment levels is critical for the Trust to **meet performance standards and provide resilience** in the event of demand increases
- A **single, clear workforce plan** is required to set out the forecast demand and workforce requirements for the year and align Operations, recruitment, CES and Finance around one plan
- There is a **minimum of 6 months lead time*** to plan recruitment and training for patient facing staff, so the shape of the 2020-21 workforce plan needs to be documented and agreed to allow recruitment and training to continue into April with no loss of momentum. (Noting that Graduates will be available over summer)
- Due to the lead time for recruitment, this **Workforce plan is prepared before the Business plan** is agreed by the Trust and before the Financial settlement is agreed with commissioners. This plan allows recruitment and training to begin with no loss of momentum. The plan shall be revisited after the financial envelope is agreed.

Objectives of this document

- Set out the **current workforce and 2020-21 establishment levels for Ambulance Services, 111 IUC and 999 EOC**
- Set out a **proposed establishment level** for 2021-22, including number of staff in each role, and the recruitment profile over time (pending agreement of the Business Plan).
- Set out **next steps** to continue to develop and implement this plan, including securing Finance approval and inclusion in the 2021-22 business plan

**This assumes that factors outside our control (HCPC registration, C1 Driving License) are not delayed*

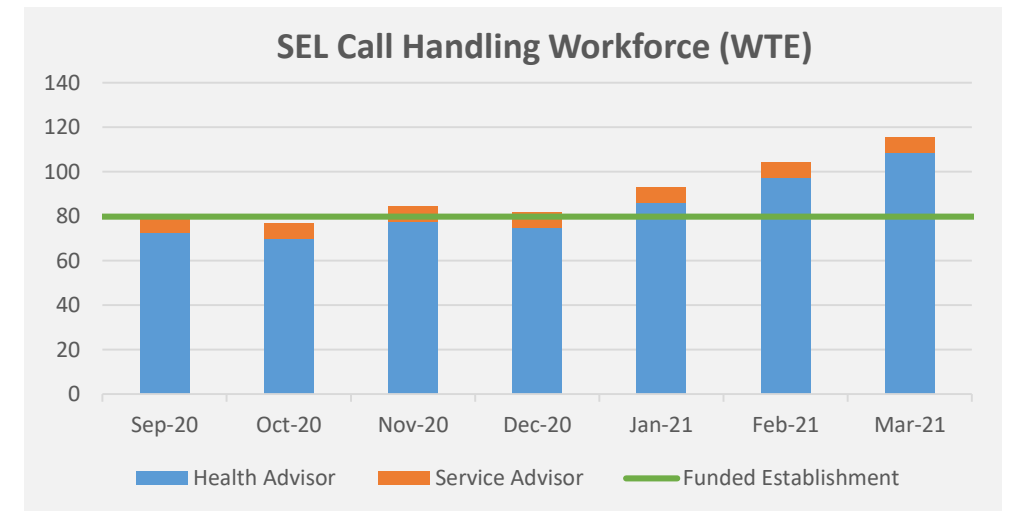
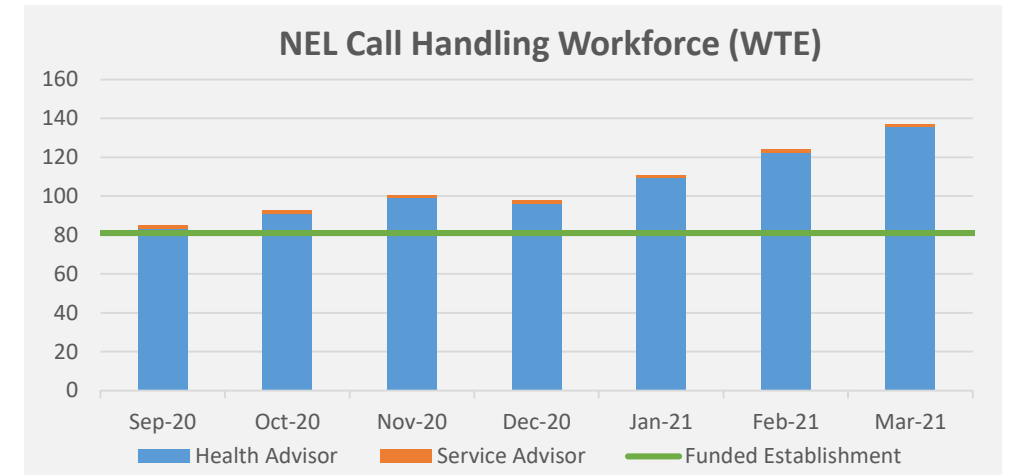


111 IUC

IUC will end the year in a strong resource position for Call Handling

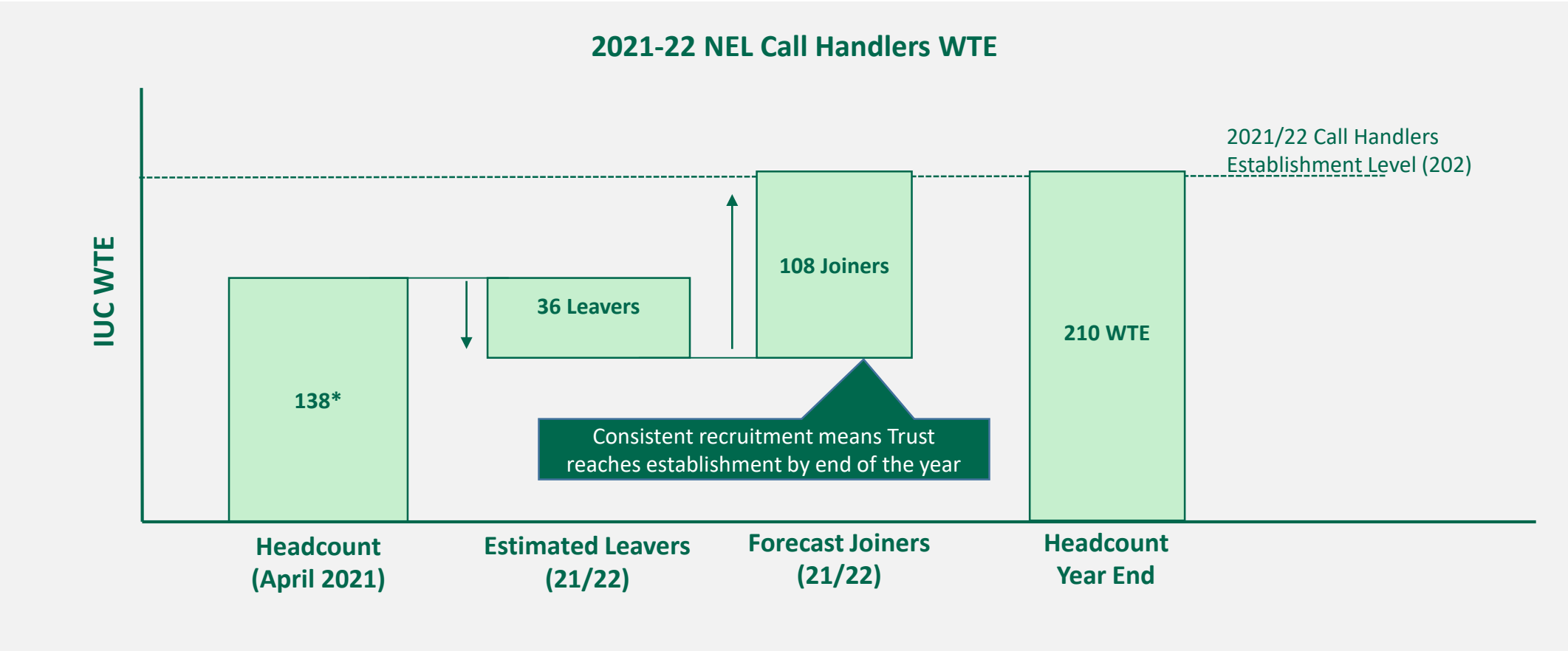
To respond to increased demand for 111 due to Covid-19, the Trust has been steadily increasing the IUC staffing through 2020-21

- The 2020/21 Establishment was set **before the impact of the Covid-19 was realised**.
- To ensure that the Trust can continue to **deliver performance** in line with the national standards and **ensure resilience** against future Covid-19 waves, the Trust has **deliberately exceeded the pre-Covid Establishment level**.
- **The pre-Covid Call Handling establishment was:**
 - North East London: 81 WTE
 - South East London: 80 WTE



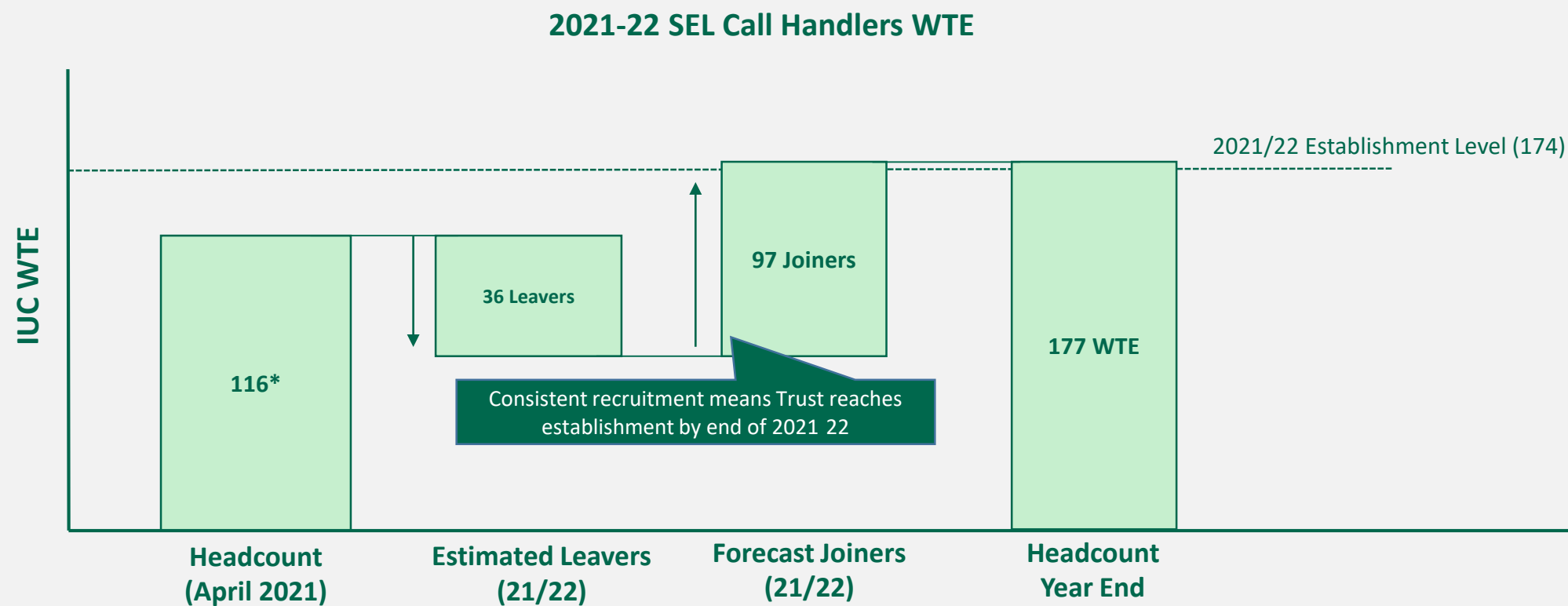
NEL Call Handling Workforce will increase in 2021-22

The Trust aims to recruit consistently through the year to meet and slightly exceed the proposed establishment level: 202 WTE



SEL Call Handling Workforce will increase in 2021-22

The Trust aims to recruit consistently through the year to meet and slightly exceed the proposed establishment level: 174 WTE

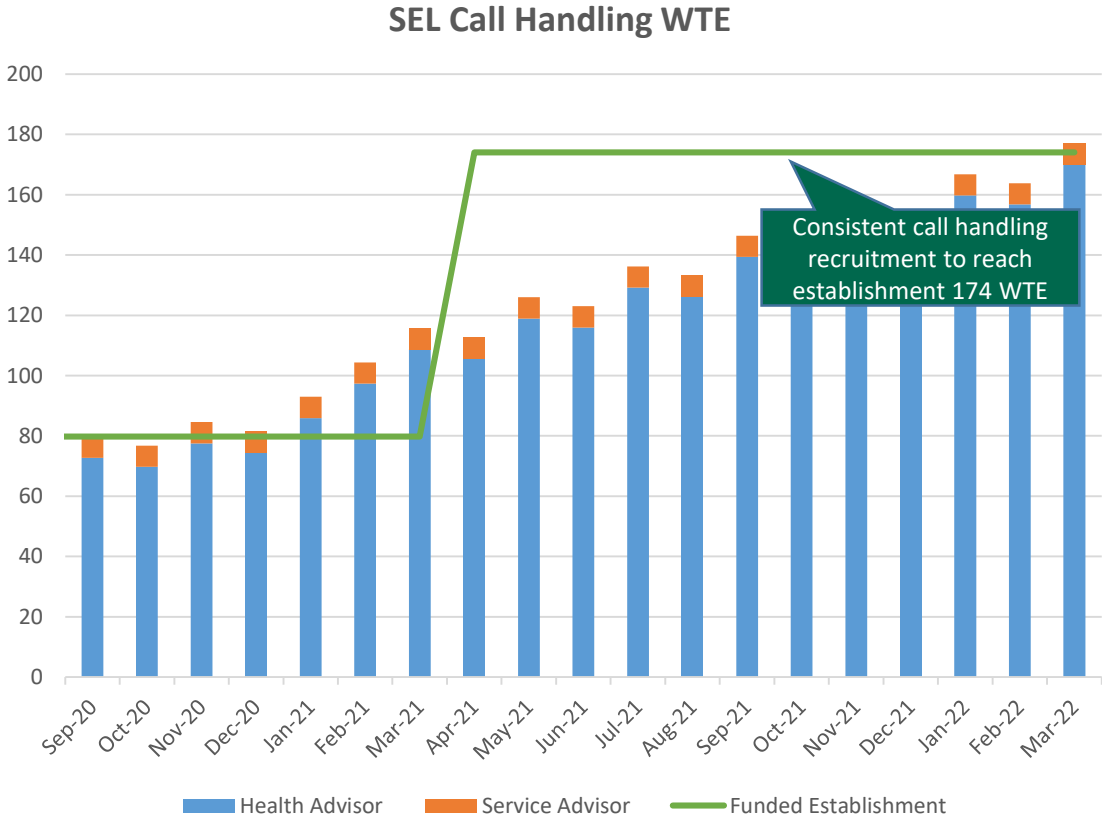
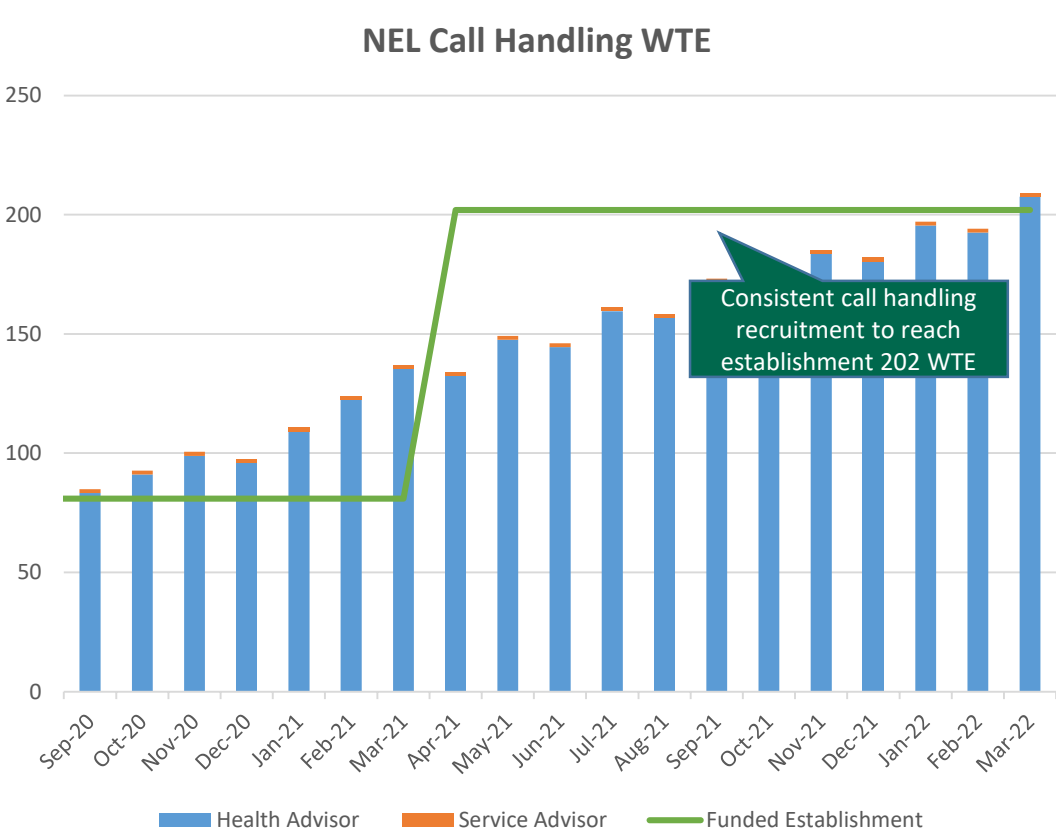


* To be confirmed



Call Handling headcount shall increase consistently through the year

The Trust is expected to increase the number of substantive staff in 2020-21 and reduce the vacancy gap to almost zero



Clinical Assessment Service (CAS) establishment shall increase

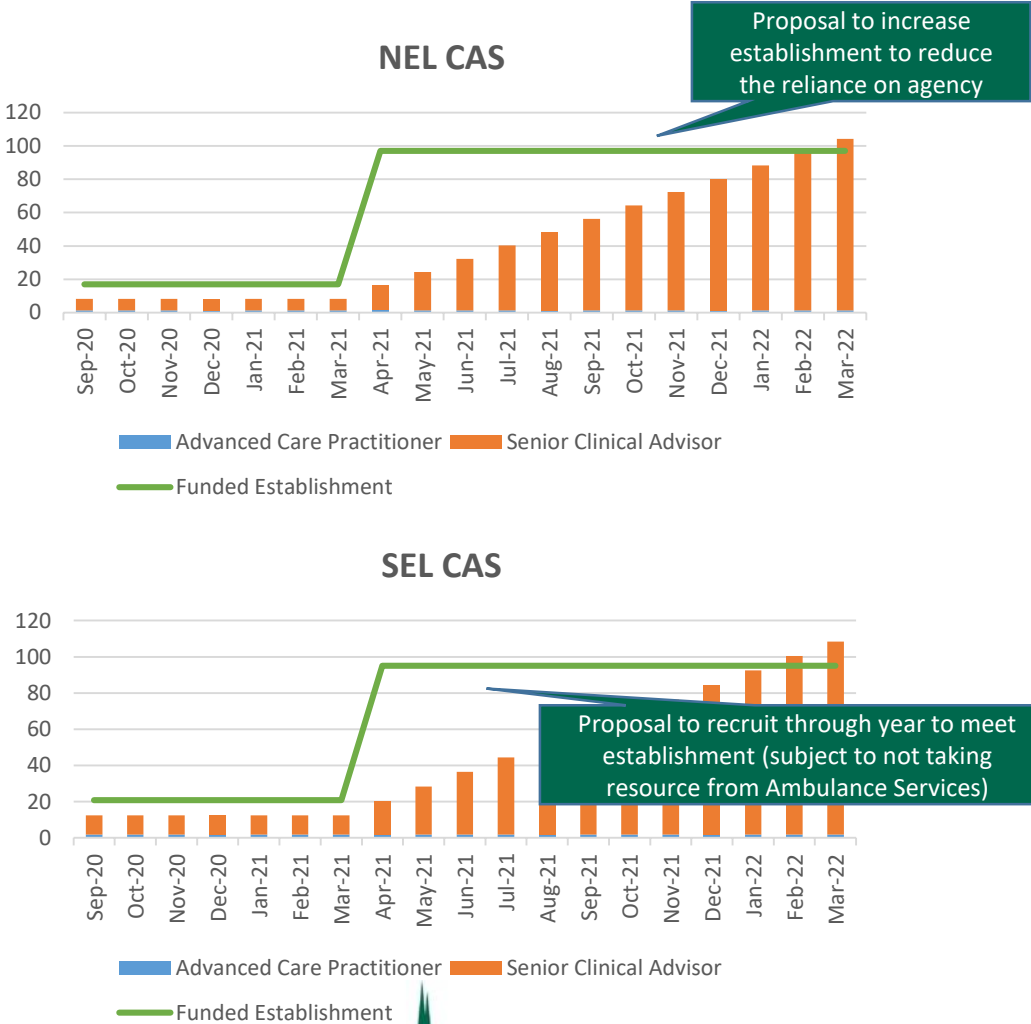
The CAS headcount shall increase significantly to meet forecast demand and reduce dependency on agency staff

The CAS establishment WTE shall **increase significantly** to meet forecast demand and reduce dependency on agency staff.

Many **agency staff are GPs**, with significant rates per day.

A proposed recruitment plan could **reach the establishment level** and remove the need for agency staff by end of 2021/22.

However, the role is **popular with paramedics** so we need to ensure it is not depleting staff in Ambulance Operations.



Discussion items

- 1) Do you agree with the new establishment?
- 2) What needs to be in place to support recruitment and training?



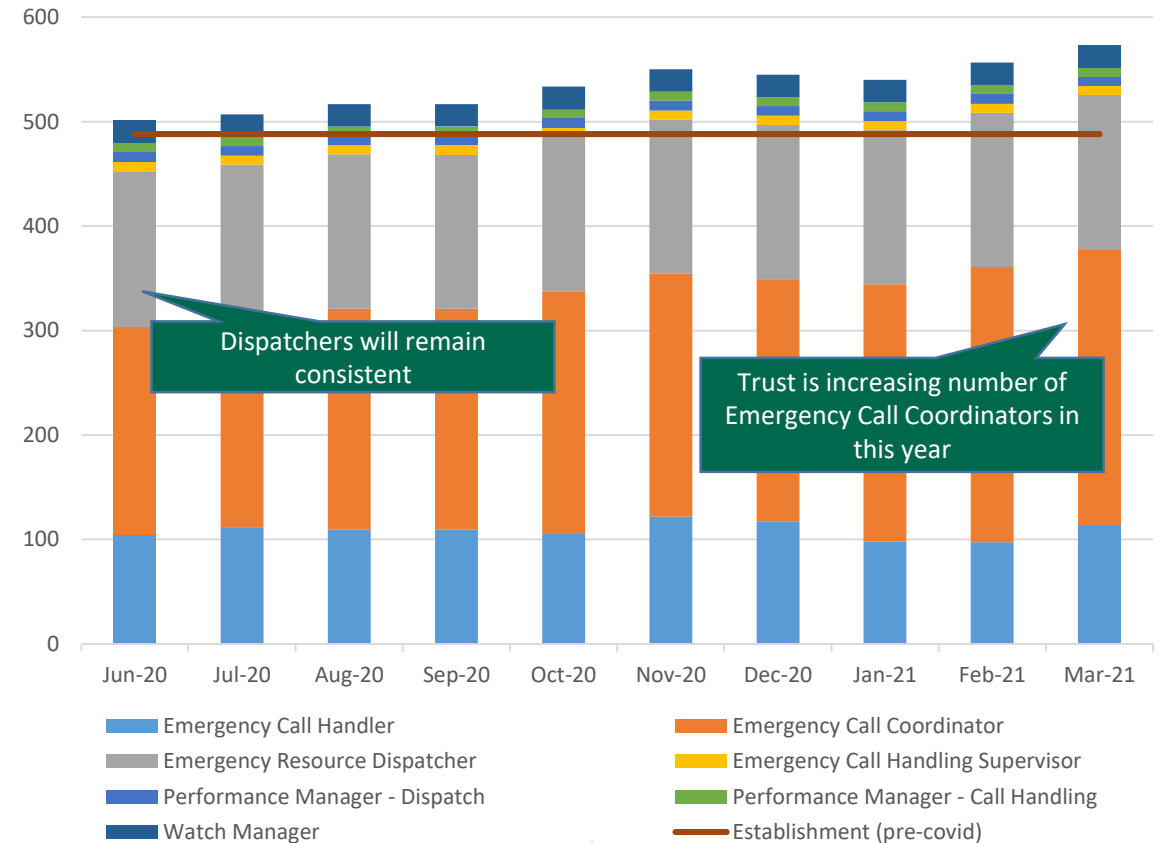
EOC 999

EOC 999 will end this year in a strong workforce position

To respond to increased demand for 999 services due to Covid-19, the Trust is continuing recruitment and will end the year in a strong position

- The 2020/21 Establishment was set **before the impact of the Covid-19 was realised**.
- To ensure that the Trust can continue to **deliver performance** in line with the national standards and **ensure resilience** against future Covid-19 waves, the Trust will deliberately exceed the formal establishment level
- The formal establishment level (pre-Covid) is **438 Staff and 50 Supervisors / Managers = 488 WTE in total**
- The Trust **recruited above the pre-Covid establishment level** to maintain resilience in the face of increased Covid-19 demand
- The new CAD is planned for summer 2021, and the new joiner training will be **coordinated with the CAD cutover** so that new joiners receive the correct training

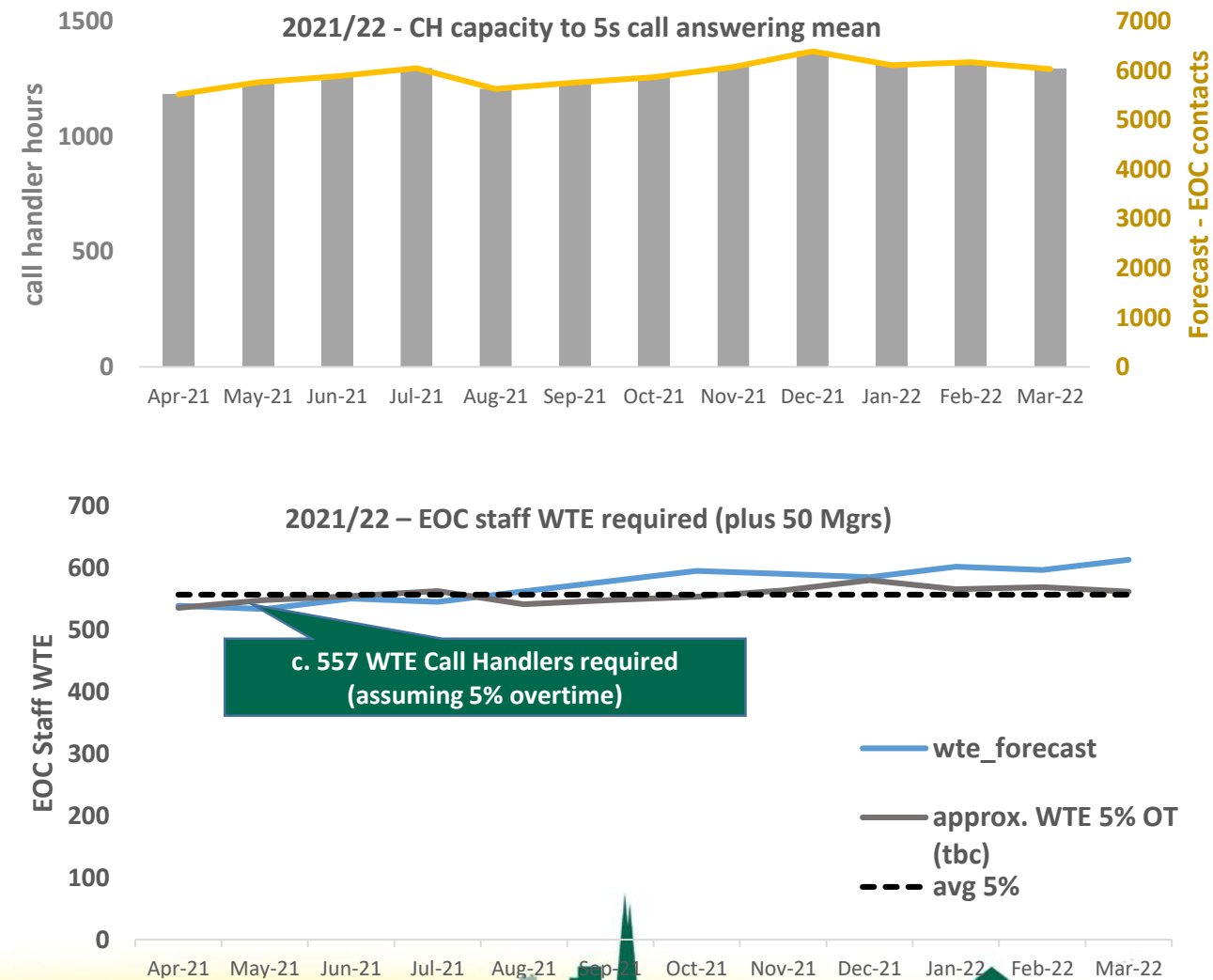
EOC Staffing vs Establishment 2020-21



The Call Handling establishment level will need to increase further in 2021/22

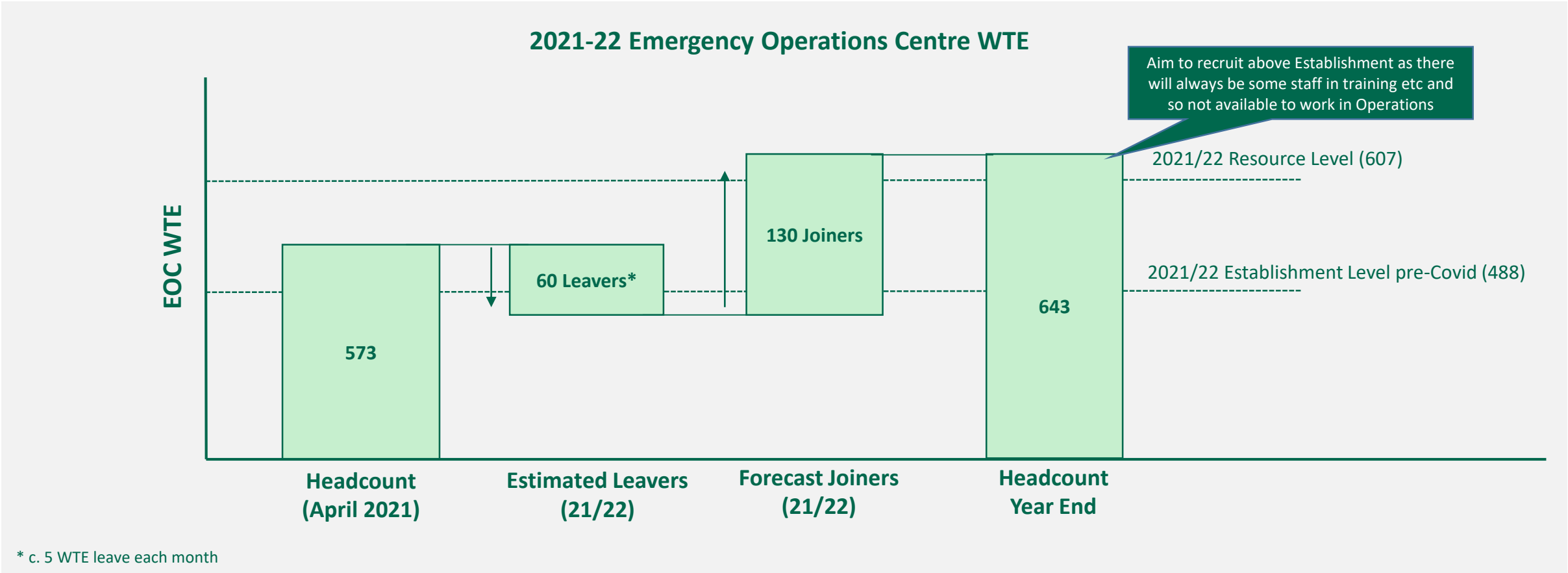
The establishment level should increase by 119 WTE to account for increased demand

- The required **call handling demand** has been forecast for 2021-22
- This demand has been translated into **EOC Staff required**
- A total of 557 WTE staff are required (plus 50 Managers = 607 WTE)
- This represents an **increase of 119 WTE**



Workforce Changes in 2021-22

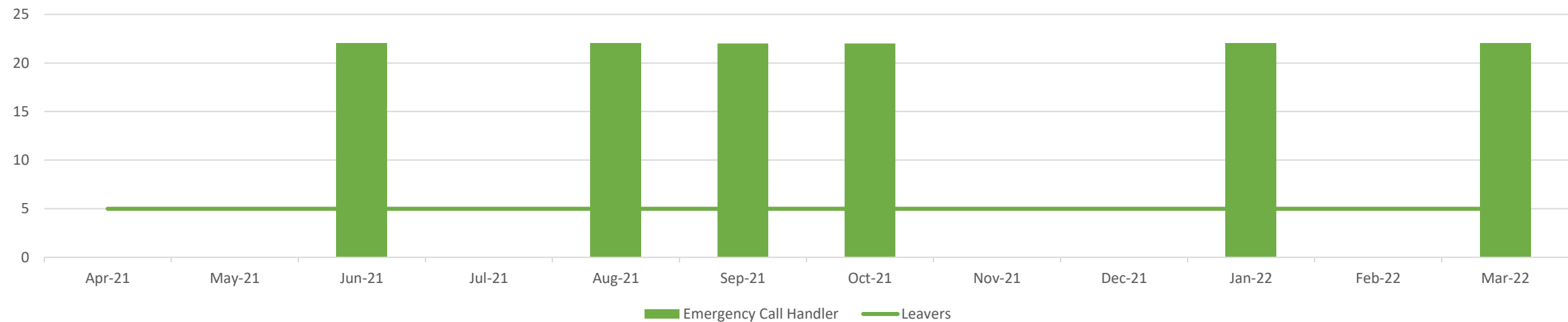
The Trust aims to recruit slightly above establishment so there is sufficient staff available for operational duties



We shall run six recruitment cohorts through the year

The Trust will run six courses across the year so 130 WTE join, while only c.60 WTE leave

Forcast New Joiners & Leavers (2021-22)



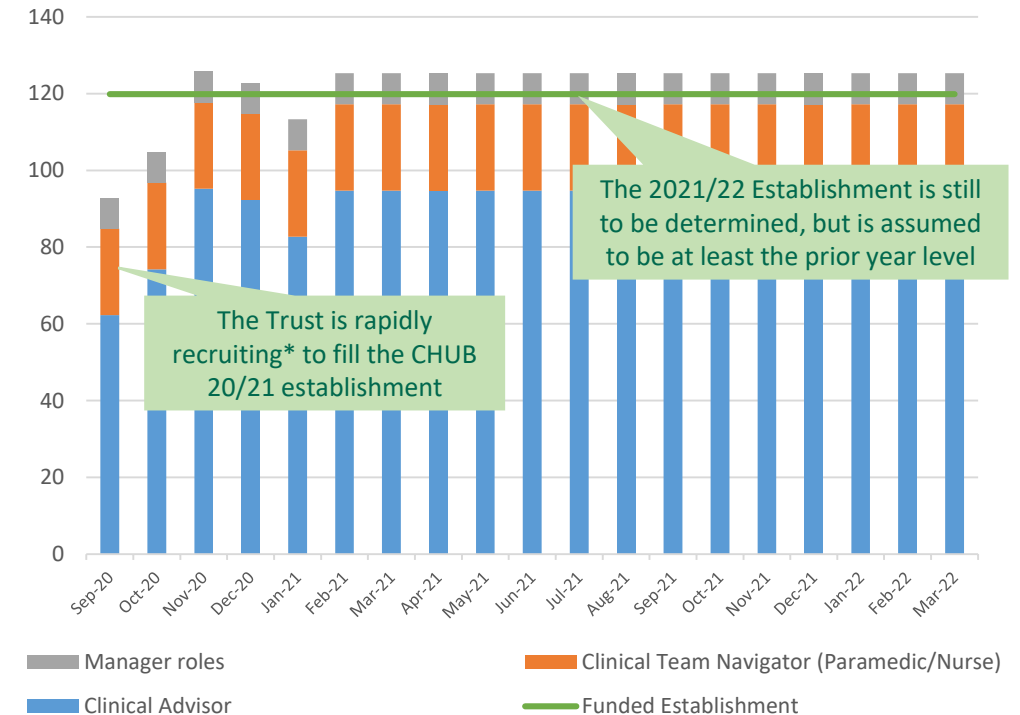
Date Starting at Trust	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Total	Total
	Forecast													
Emergency Call Handler	0	0	22	0	22	22	22	0	0	22	0	22	130	130
	Forecasted Leavers													
Forecast Leavers	5	5	5	5	5	5	5	5	5	5	5	5	60	60

The CHUB

The establishment level for the CHUB in 2021-22 has not been determined, in the meantime the Trust shall continue to recruit to reach the current establishment

- Based on current demand forecasts, the **establishment in the CHUB** is 119 WTE for 2020/21 (Clinical Advisors, Navigators and Managers)
- The Trust will continue to **recruit to reach the establishment level** by the end of the current year
- The **CHUB establishment level** will be determined over the coming weeks and confirmed as part of the business planning process.

CHUB Profile



* Where clinicians they come from Ambulance Ops, then these are listed as a leaver from Ambulance Ops

Discussion items

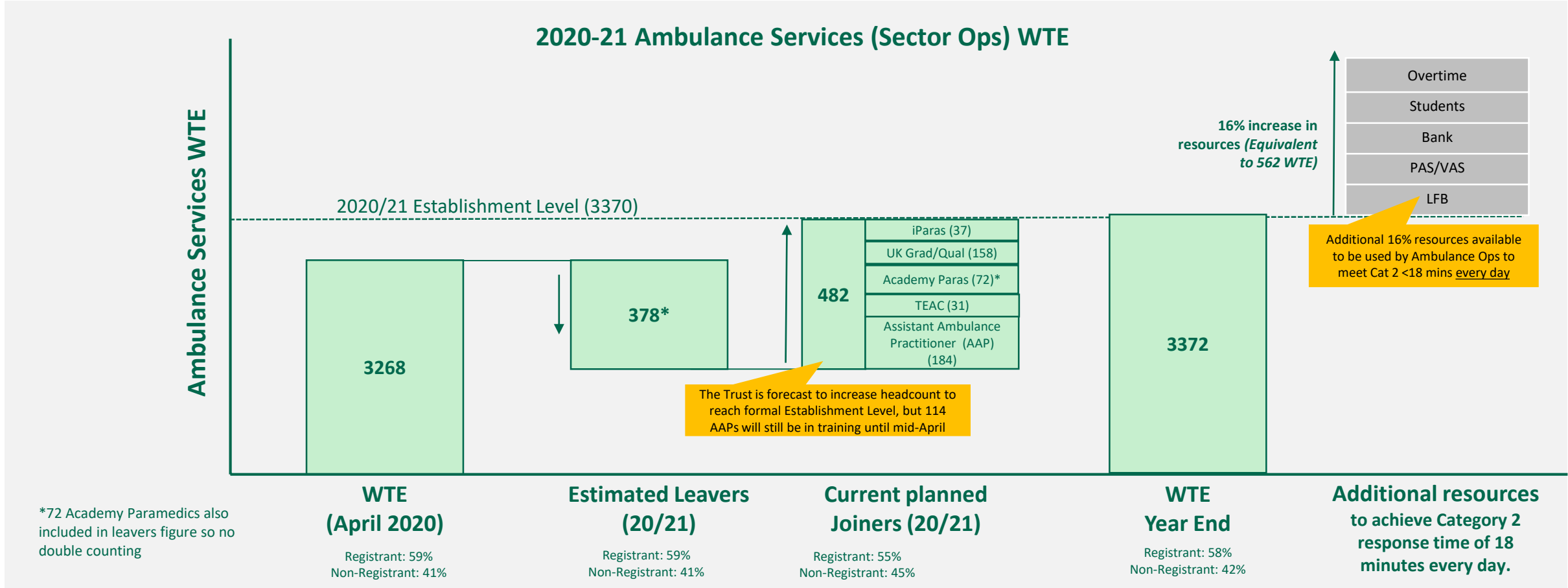
- 1) Do you agree with the proposed establishment level and recruitment profile?
- 2) What else needs to be in place to support recruitment and training to deliver these workforce increases?



Ambulance Workforce

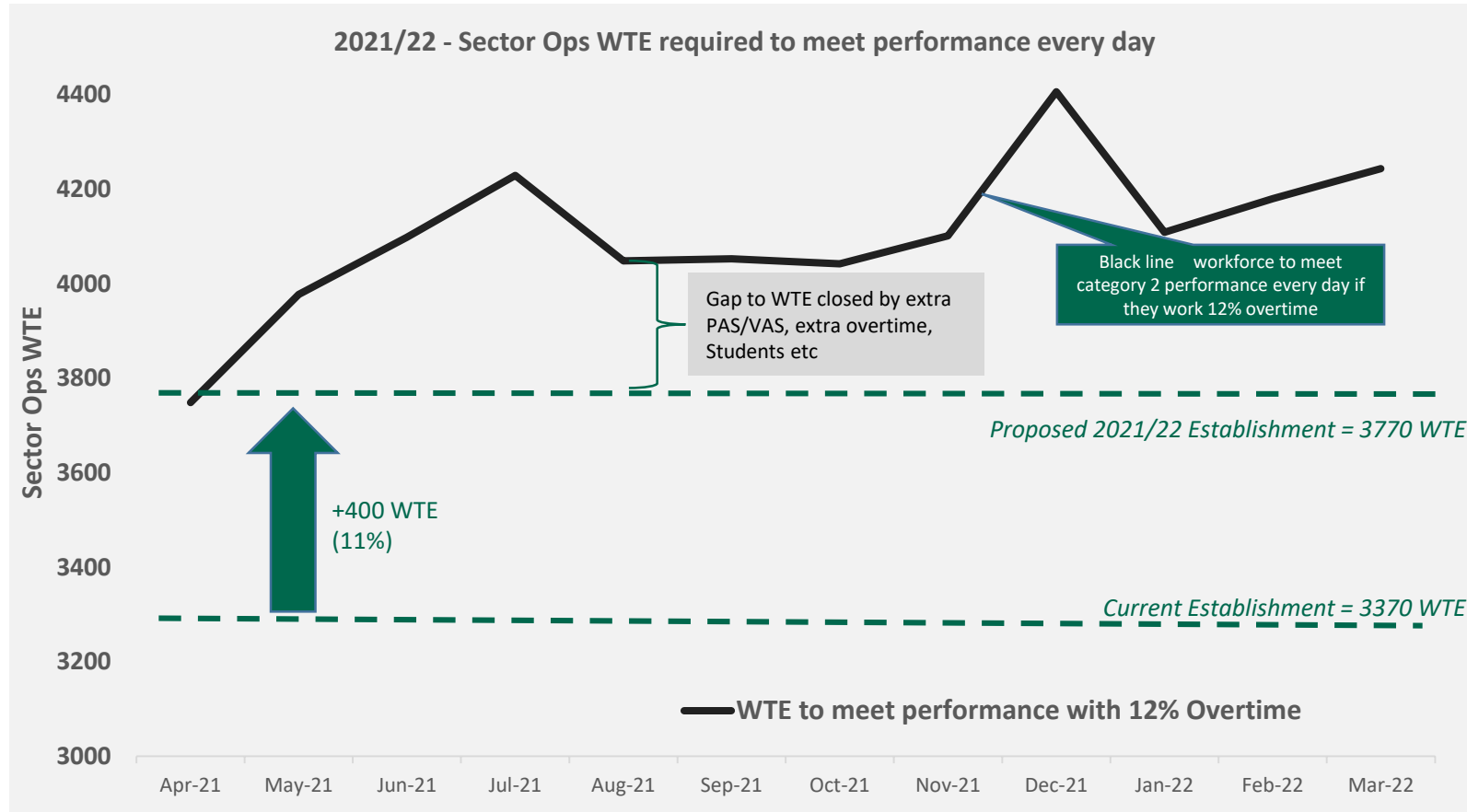
Current year position (2020/21)

Ambulance Ops (Sector Ops) have a 2020/21 establishment level of 3,370 and will achieve this by year end In addition, there are an additional 16% resources available to achieve Category 2 response time every day.



Setting the 2021-22 establishment level to achieve performance every day

To meet performance every day, this plan proposes to increase the 2021-22 Establishment level by 400 WTE to 3,770 WTE

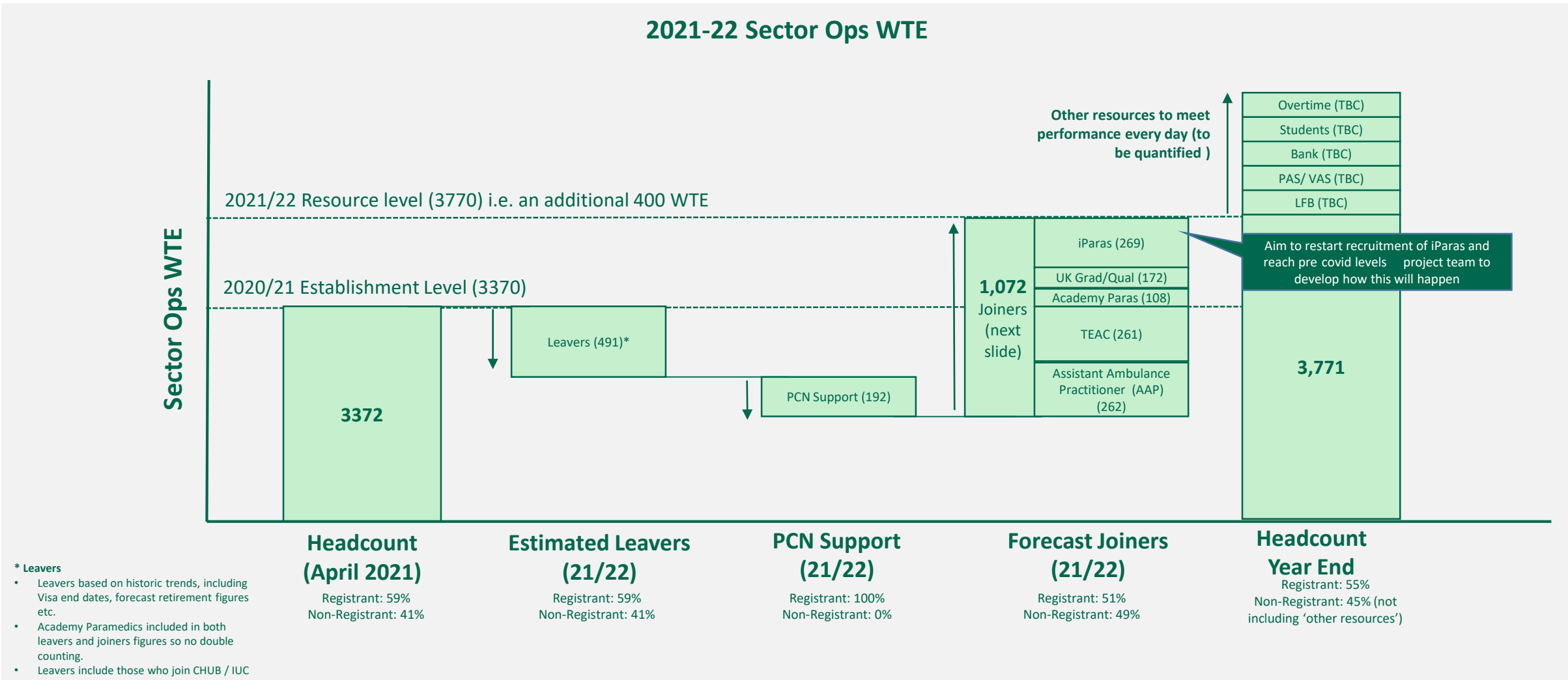


- The workforce required to meet **performance every day** varies month by month.
- Based on demand forecasts, we expect that between c. 3700 (April) to c. 4400 WTE (December) are required to meet performance every day
- As a working plan, the non-PCN workforce shall be **increased by c. 400 WTE** (subject to Finance approval)
- The gap to required WTE, will be filled by extra PAS/VAS, extra overtime and students etc. This will be confirmed and refined based on the finance settlement in year.

- This assumes there are 150 hours of PAS/VAS per day and all staff work 12% overtime – these are in line with 2019/20 levels
- The c. 200 WTE for Primary Care Networks is separate to this model

Workforce Changes in 2021-22

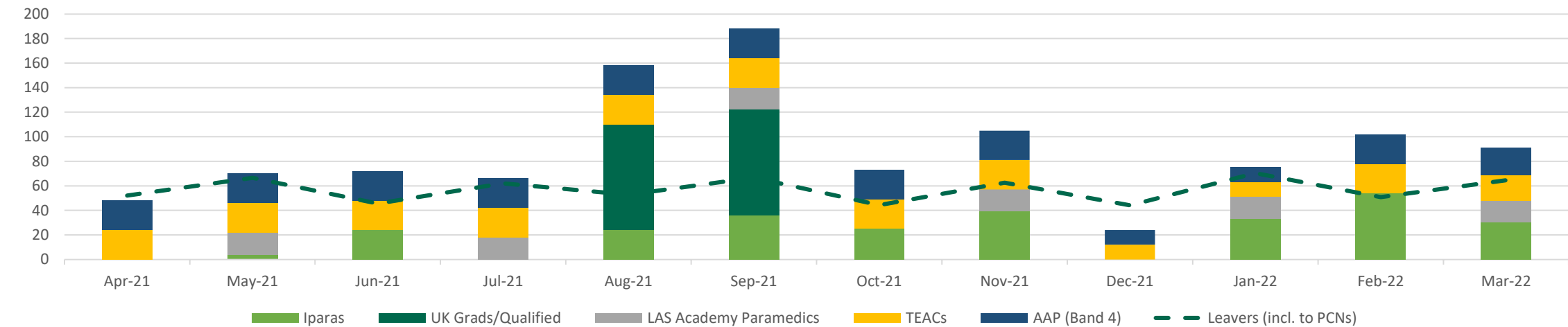
Given the additional recruitment required to reach 18 minute category 2 response time ever day and the limited number of graduate paramedics available, even a small increase in establishment requires a significant recruitment of non-registrant



Planning our workforce changes across the year

The Trust is expected to increase the number of substantive staff in 2020-21 and reduce the vacancy gap to almost zero

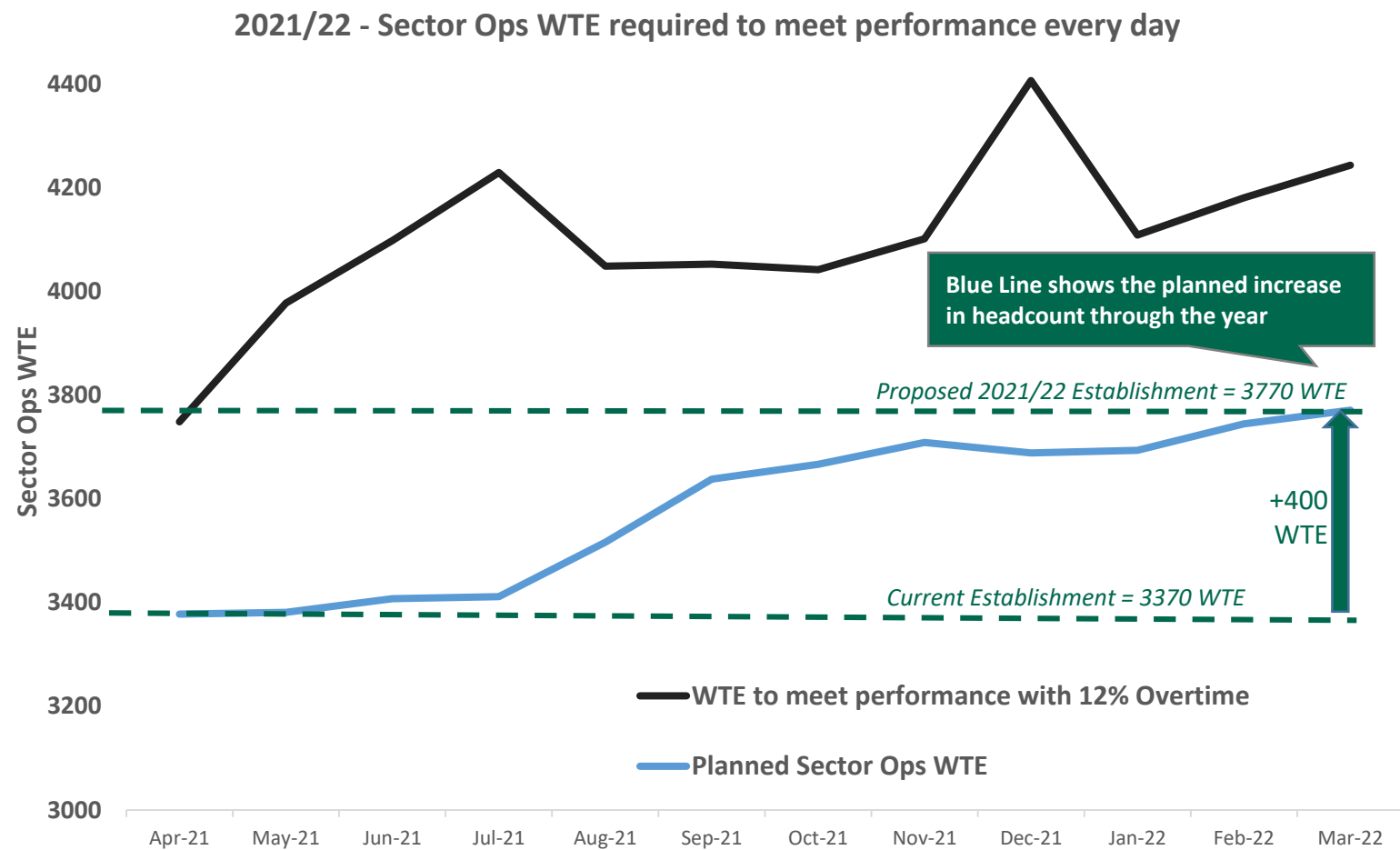
Forecast New Joiners & Leavers (2021-22)



Date Starting at Trust	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Total	Total
	Forecast													
Iparas		4	24		24	36	25	39		33	54	30	269	1072
UK Grads/Qualified					86	86							172	
LAS Academy Paramedics		18		18		18		18		18		18	108	
TEACs	24	24	24	24	24	24	24	24	12	12	24	21	261	
AAP (Band 4)	24	24	24	24	24	24	24	24	12	12	24	22	262	
Forecasted Leavers														
Forecast Leavers (including to PCNs)	52	67	46	62	53	67	44	63	44	70	51	65	683	683

Staffing vs required WTE

To meet performance every day, this plan proposes to increase the 2021-22 Establishment level by 400 WTE to 3,770 WTE



Discussion items

- 1) Is the proposed Establishment an appropriate balance between Establishment and other resources?
- 2) What actions are required to meet this establishment increase (from recruitment & Clinical Education)
- 3) How can we increase the number of registrants? Both UK and overseas?



Next steps

A Programme is required to take forward this work and deliver the benefits

To deliver this ambitious workforce plan, a programme is required to coordinate all streams of work

The Trust needs to build on the progress so far, **continue the delivery momentum** and take rapid action to:

- 1) Finalise the workforce plans
- 2) Deliver the substantive staff required
- 3) Deliver the other Ambulance Ops resources required (e.g. students, LFB etc)

This will require **close working from across the organisation**, including:

- 1) People & Culture (Recruitment, Talent, Workforce Analytics)
- 2) Clinical Education & Standards
- 3) Ops (111 IUC, 999 EOC, Ambulance Operations)
- 4) Finance
- 5) Data Science / forecasting

Given the **scale of recruitment required**, the unique challenges that must be overcome and pace we must work at, we propose to **establish a programme, under the governance of PMB to coordinate this work.**

This will provide **structure and control** to the work and allow for **clear coordination** across the Directorates as the Trust commences recruitment for 2021/22.



This programme will bring together many streams of work

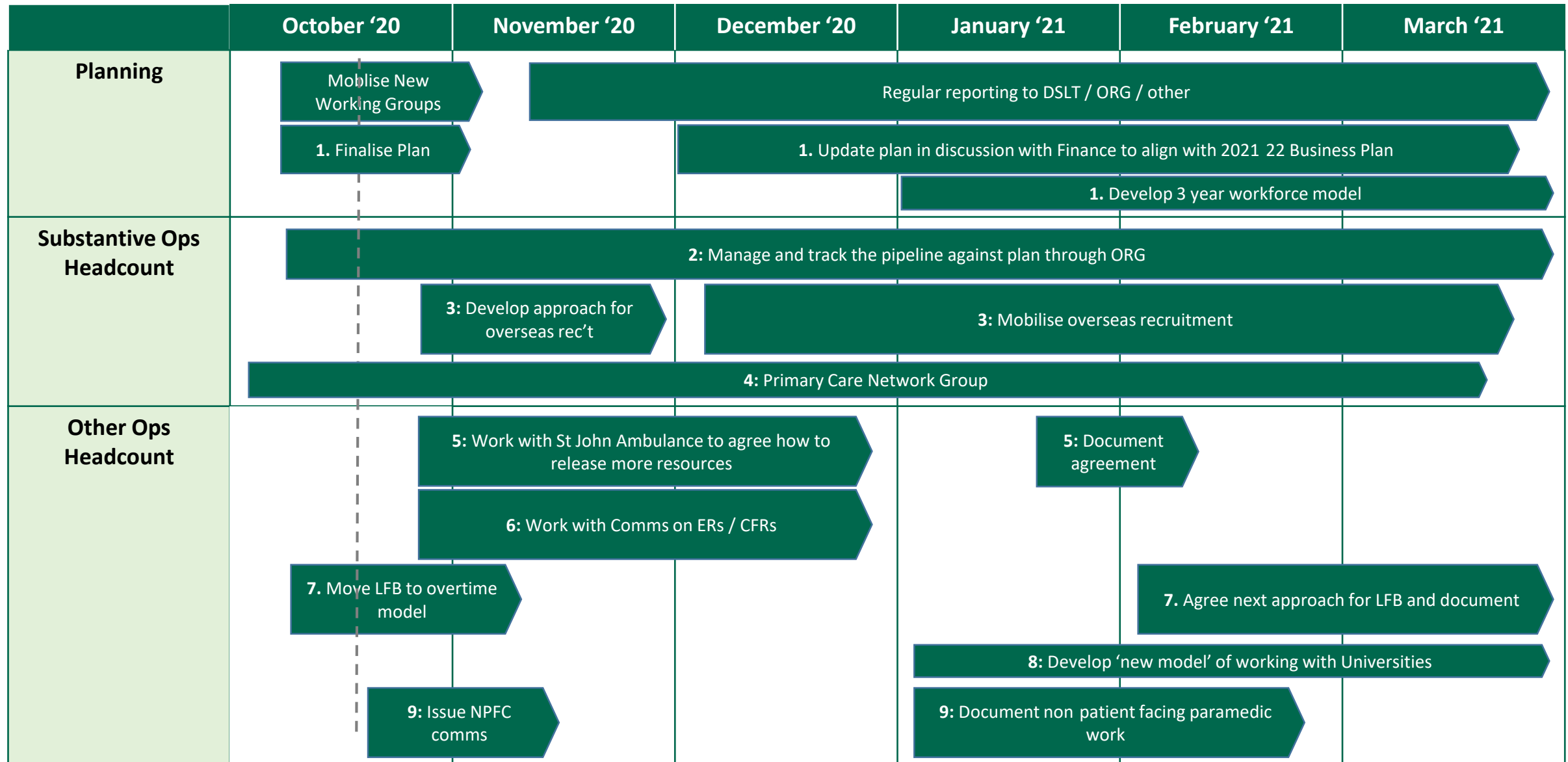
A set of proposed workstreams will allow the Trust to finalise plans, increase headcount and increase other Operations resources to allow the Trust to meet performance standards every day

Category	#	Workstream / Group	Actions	Lead
Planning	1	Planning team [Existing]	<ul style="list-style-type: none"> Finalise plans for 2020-21 and align with Finance and the Business Plans Develop high level recruitment plans for the next three years to identify issues early Confirm when resources will be available to start with Ops (given the delay between starting employment at Trust and starting shifts) 	People & Culture
Substantive Ops Headcount	2	Managing the pipeline [ORG]	<ul style="list-style-type: none"> Track 111 IUC, 999 EOC, Ambulance Ops Recruitment and Training and troubleshoot issues Track progress on Self Rosters, Annualised Hours and Relief Roster changes Collate where additional resources are required for Recruitment & CES to support ambitions and agree requests with DSLT/ other Exec Groups Model impact on Managers and propose next steps given that staff to manager ratio will increase without changes Report weekly to DSLT and other Exec groups as required 	People & Culture Ambulance Ops EOC 999 IUC 111
	3	Overseas Recruitment Working Group [NEW]	<ul style="list-style-type: none"> Run a series of workshops to identify how to recruit from overseas Develop plan, implement plan, track progress and report to DSLT 	People & Culture
	4	Primary Care Network Group [Existing]	<ul style="list-style-type: none"> Continue to work through how to support Primary Care Networks Ensure assumptions feed into workforce model 	Dedicated team
Other Ops Resources	5	St John Ambulance [NEW]	<ul style="list-style-type: none"> Approach St John Ambulance to understand how to increase support from them Develop plan, implement plan, track progress and report to DSLT 	Ambulance Operations
	6	Emergency Responders [NEW]	<ul style="list-style-type: none"> Ops to work with Comms & Engagement to better understand ER / CFR resources Explore how to better integrate ERs/CFRs closer with Ops to enable an increased level of support 	Ambulance Operations
	7	LFB [Existing]	<ul style="list-style-type: none"> Finalise current agreement with LFB and move to overtime model Develop approach for next phase from 1 April 2021 	Ambulance Operations
	8	Students [Existing]	<ul style="list-style-type: none"> Document agreements with Universities Develop new model for 2021-22 including recruiting students as they enter University (not when they leave) – <i>in progress</i> Track Covid EAC numbers and next steps – to be confirmed where this sits 	Ambulance Operations
	9	Non-Patient Facing Paramedics [Existing]	<ul style="list-style-type: none"> Contact all clinicians and update lists Document approach, processes and lists from this year – to make ready for following winter 	Ambulance Operations

All Supported by Project Management / PMO support for mobilising groups, reporting and driving forward actions

An indicative timeline has been proposed until the end of this year

A proposed timeline for each of our main workstreams over winter; this will be refined and overseen using the governance groups proposed later in this pack.



The major risks have been identified

We have identified the major risks and mitigations to delivering this workforce plan

#	Risk <i>'There is a risk that...'</i>	Before Mitigation		Mitigation	After Mitigation	
		Probability	Impact		Probability	Impact
1	The Trust does not have the spare recruitment and training capacity to meet the workforce plan set out here.	M	H	Early development of this plan gives teams time to develop plans and create resource requests to increase team sizes to deliver plans	L	L
2	The Trust cannot access sufficient non-establishment resources e.g. PAS/VAS, overtime, students, Firefighters etc to meet the ambition to deliver Category 2 under 18 mins every day	H	H	Early development of this plan gives teams time to develop plans and resource requests to meet these plans	M	M
3	The new training facilities are delayed and this impacts training in 2021	L	M	Close monitoring of progress and rapid mitigation of issues through the Estates Programme Board	L	L
4	As paramedics gain new skills in Primary Care, this may create an argument for band creep, thus creating a financial risk to the trust	L	H	Influence national stakeholders to create PCN job description in line with Band 6 roles	L	M

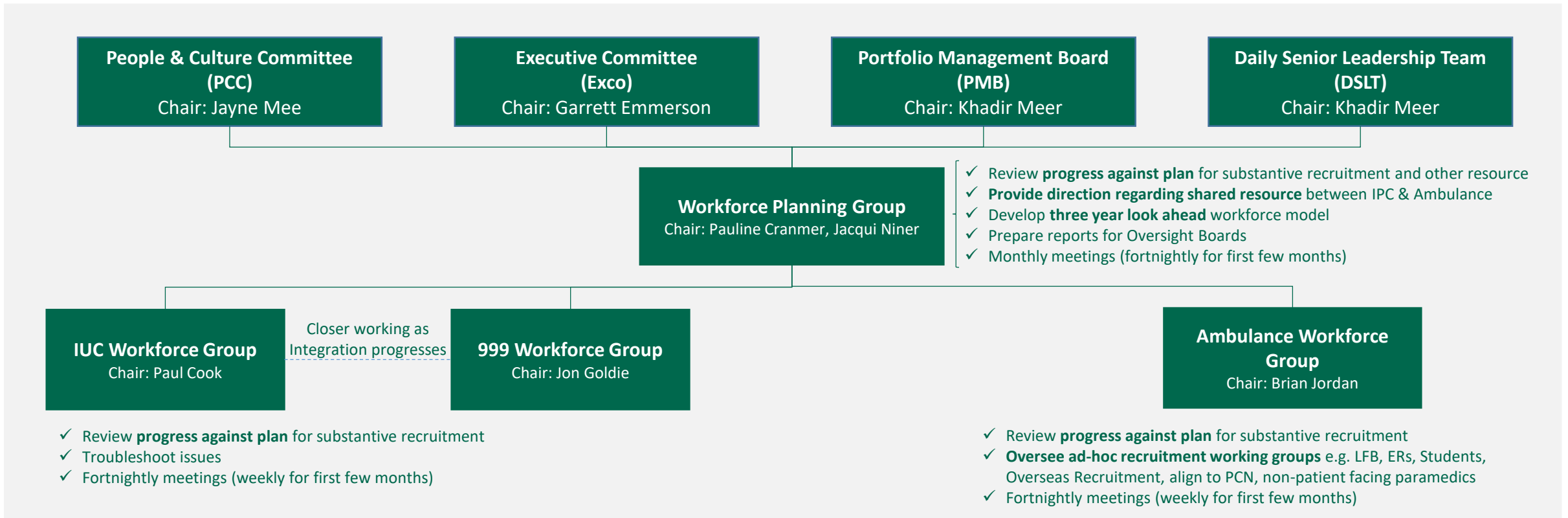


A reporting structure is proposed to provide visibility of all work

A reporting structure is defined to provide regular updates on progress and allow rapid escalation of issues and blockers

Design Principles

- IUC, EOC and Ambulance Ops to have **oversight and accountability** regarding their workforce
- There will be one **group to coordinate updates** and ensure that shared resource (e.g. paramedics) is used optimally
- At the start, **meetings will be more regular** to build momentum and fully mobilise the work
- Working Groups can be formed and dissolved where required with no formal governance



Immediate next steps are suggested to build on the momentum

Next steps to mobilise this work and continue recruitment into 2021/22 with no break in momentum

- Review this document at **People & Culture Committee**
- Develop Programme approach and take to **Portfolio Management Board**
- **Mobilise new meetings / groups** where required – where possible *focus on agile working groups rather than formal sessions*
- Ensure that workstreams are **properly resourced** to deliver in line with the Trust's needs
- Develop **Recruitment and Clinical Education plans** to deliver increased numbers of staff and continue commence recruitment for 21/22



Appendix

Paramedic Science pipeline

Across our five Partner Universities, we have 917 Paramedic Science students training to become Paramedics. Assuming that 15% of these students drop out, we expect that c. 780+ will graduate and be eligible to work for the Trust

University	Y O Entry	Award	Started	Graduation	2021	2022	2023
Hertfordshire	Sep-18	BSc	50	Sep-21	37		
Greenwich	Sep-18	BSc	53	Sep-21	41		
St Georges	Sep-18	BSc	88	Sep-21	81		
Anglia Ruskin	Sep-18	BSc	60	Sep-21	60		
Hertfordshire	Sep-19	BSc	74	Sep-22		84	
Greenwich	Sep-19	BSc	57	Sep-22		61	
St Georges	Sep-19	BSc	114	Sep-22		114	
Anglia Ruskin	Sep-19	BSc	69	Sep-22		68	
West LDN	Feb-20	MSc	10	Feb-22		10	
Hertfordshire	Sep-20	BSc	55	Sep-23			55
Greenwich	Sep-20	BSc	70	Sep-23			70
St Georges	Sep-20	BSc	110	Sep-23			110
Anglia Ruskin	Sep-20	BSc	75	Sep-23			75
West LDN	Feb-21	MSc	32	Feb-23			32
Totals			917		219	337	342
Total (after 15% drop out)			780				



The Trust Business Plan includes additional funding to achieve consistent performance

	999 Ops			ECS	111		FOT Funding Requirement	FYE Funding Requirement
	EOC Call Handlers	EOC Dispatchers	CHUB	Ambulance Services	111 Call Handlers	111 CAS		
2019/20 WTE plan	298	150	100	3,380	140	74	£451.7m (2020/21 plan)	£451.7m (2020/21 plan)
							+	+
Demand Uplift: One-off resource increase to meet annual demand ¹ increase (incl post covid change) and performance in line with 2019/20	4%	4%	4%	4%	18%	18%	£53.6m ⁴	£33.2m ⁴
							+	+
Option A: One-off resource increase in order to meet contractual performance ² requirements in 2020/21	4%	4%	12%	3%	4%	10%	£5.7m	£7.6m
							+	+
Option B: One-off resource increase to consistently achieve performance every day ³	8%	8%	12%	16%	8%	12%	£16.4m	£21.9m
							=	=
TOTAL							£527.4m FOT	£514.4m FYE

Planning Assumptions for FOT:

¹ **2020/21 Demand** – the STP guidance set out an activity growth rate of 3.27% which was included in the LAS financial submission on 5 March 2020. LAS demand forecasts suggest a more likely demand increase of 4% in ambulance services and 18% (including new covid activity) in 111. Current exclusions from this plan is the onboarding on North West and South West London IUC Services, and any additional activity relating to 'Think 111' which is unspecified at this time, funding to support this increased activity will be in addition to the options set out in the table above.

² **Meet Contractual Performance** - For the remainder of 2020/21, meeting contractual performance requirements has been modelled to resource: (a) 111 Call Answering at 95% <60 seconds every day (b) 111 CAS at 95% average across all KPIs (c) EOC 999 Call Answering Mean of <5 seconds on 75% of days across the year (d) Ambulance Services meeting C2 mean on an average <18 minutes per quarter

³ **Consistently achieve performance every day** - For the remainder of 2020/21, consistent achieving performance every day has been modelled to resource: (a) 111 Call Answering at 95% <60 seconds every day (b) 111 CAS at 95% for each KPI (c) EOC 999 Call Answering of <5 seconds every day (d) Ambulance Services meeting C2 mean <18 every day

⁴ **Demand related costs** – includes 9/12 of the cost of: (a) new covid activity above 2019/20 plan totalling £4.6m (including one off pro rate HR and governance infrastructure uplift of £1.5m) (b) variable non-pay costs of covid totalling £16.6m (including AA, InHealth, PPE costs, consumables) (c) estimated cost of additional covid surge for 1 month of £5m and (d) covid surge costs of £27.4m for M1-3 (FOT only and detailed in slide 8).

Primary Care Networks

From April 2021, the 198 Primary Care Networks can apply for funding for up to 2 paramedics.

As part of the NHS Long Term Plan, the role of GPs is being significantly expanded. GPs have been encouraged to form Primary Care Networks (PCNs), collective groupings of GPs that are formed largely in line with geographical, or Clinical Commissioning Group (CCG) boundaries. PCNs have been tasked with expanding skill sets and roles to include Pharmacists and Paramedics, amongst others. There are approximately 198 PCNs across London, with guidance for PCNs to have 1-2 Paramedics each, however, ultimately the roles are optional.

From April 2021, each PCN can apply for funding for up to 2 Paramedics (currently indicated as mid-band 7 with no High Cost Area Supplement) for each PCN. From initial discussions with PCNs and regulators, we expect each PCN to require an average of 1 Paramedic each. Total: c. 200-230 Paramedics (to note this number could fluctuate as the roles are not mandated and PCNs can recruit independently).

LAS Approach

To provide career development opportunities for our staff, and manage the finite supply of Paramedics across London, LAS wish to provide paramedic staff to PCNs; as opposed to Paramedics leaving and being directly employed by PCNs.

Merton Trial

There is currently a trial underway in Merton, with Paramedics supporting the Local Primary Care Network. The results of this are being monitored by LAS for further deployment in 2021-22.

Risks and impact to 2021-22 Workforce Plan

#	Risk <i>[There is a risk that...]</i>	Mitigation
1	PCNs will attract paramedic staff destabilising our workforce [National funding for Paramedic staff is Band 7, whereas LAS Paramedics are generally Band 6 plus high cost area supplement]	LAS working with HLP, NHSE to review PCN resource plans. LAS engaging regulators to secure their buy in to our approach (LAS to provide the resources) & engagement with ICS's.
2	Due to the ambitious 2021-22 Workforce plans, the Trust does not have sufficient Training & Education capacity to develop paramedics to support PCNs	LAS to work with HEE and training hubs to explore external capacity
3	Staff will expect LAS to provide transport options for them to visit	Preference is for staff to use their own vehicles and be reimbursed for the mileage and wear & tear

IUC Workforce Assumptions

To meet the increase in Establishment, the Trust has developed the following principles to guide recruitment

#	Assumption	Rationale
1	Both NEL and SEL have 3 FTE Call Handling leavers each month	Based on historic trends
2	Both NEL and SEL have 2 FTE CAS/Other leavers each month	Based on historic trends
3	c. 20 CAS WTE in each NEL and SEL	From current workforce data



EOC Workforce Assumptions

To meet the increase in Establishment, the Trust has developed the following principles to guide recruitment

#	Assumption	Rationale
1	Emergency Call Handlers (Band 3) will be promoted to Emergency Call Coordinators (Band 4) following 12 months in role and successful completion of a four day course. (At an extra cost of £2000 per year)	Existing EOC procedure to develop our workforce
2	That there are c. 5 WTE leavers from the EOC each month (including internal transfers)	Based on historic trend
3	CES have capacity to run one course for 24 people every other month	Based on previous years
4	CES can run six courses for promotion from ECH (Band 3) to ECC (Band 4)	Based on previous years
5	CES will still have capacity to run development courses for existing staff e.g. mentoring training etc.	Based on previous years
6	There will be no training courses in April / May 2020 to allow for CAD training	Based on discussion with CAD Project team



Ambulance Workforce Assumptions

To meet the increase in Establishment, this plan sets out the following principles to guide recruitment

#	Category	Assumption	Rationale
1	To develop establishment level	The Trust will aim to achieve 18 minutes every day or 16 minutes on 75% of days (Option B in business plan).	In line with 2020/21 Business Plan agreed by Trust Board
2		In addition to the contracted hours, substantive patient facing staff will undertake an additional 12% overtime on top of their existing hours	This is in line with historical trends (not including 2020-21)
3		PAS & VAS will provide 150 patient facing hours per day	In line with historical trends (not including 2020-21),
4	To develop Recruitment Plan	We will prioritise recruitment of Paramedics Science Graduates (UK and Overseas)	We shall prioritise registered clinicians to reflect their Clinical Education
5		We shall aim to recruit the same number of iParas as we planned for 2019-20 before Covid. A project team shall be needed to explore options to deliver this given the international travel restrictions.	Assumption that a project team can overcome current recruitment barriers
6		75% of graduates from our partner Universities will choose to work for LAS	Assumption based on historical trends
7		The number of leavers will remain consistent with past years, but note that an increased number of international paramedics have their visa's expiring in 2021/22	Assumption based on previous years trends and analysis of visa expiry dates
8		We shall split non-registrant recruitment between AAPs and TEACs	Working assumption, to be revisited after further discussions within Ops
9		That 200 paramedics (Band 6's) will support the Primary Care Networks in 2021-22 with consistent release of staff throughout the year (c. 17 per month)	Assuming 1 paramedic per Primary Care Network and 200 across London
10		We shall increase the number of CTMs in line with the number of WTE front line resources – but this shall need further work to review and change workforce model	We wish to maintain the same ratio of Manager to staff to continue support for staff





Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Annual Financial Plan 2020/21			
Agenda item:	11.1			
Report Author(s):	James Corrigan, Financial Controller			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	Executive Committee on 16 September 2020 Finance and Investment Committee on 22 September 2020 Trust Board (Private) on 29 September 2020			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
<p>This paper sets out for approval the final agreed financial plan for the remainder of 2020/21 to support the business plan objectives following the publication of the Phase 3 planning guidance from NHS England.</p> <p>The Executive Committee, Finance and Investment Committee and Trust Board approved the Financial Plan for the remainder of 2020/21 subject to finalisation and agreement of financial arrangements for the remainder of the year with North West London STP.</p> <p>The Trust has now finalised its Phase 3 plan with NWL STP. The final agreed STP wide plan is due for submission to NHS England on 20 October 2020 and the Trust will submit its plan on 22 October 2020.</p> <p>Key points to note are:</p> <ol style="list-style-type: none"> 1. The settlement agreed for the remainder of the financial year will set an income envelope of £522.2m for the full year based on the month 4 forecast. This is £5.1m less than the previous plan due to the exclusion of £5.0m COVID 19 surge costs, which, as flagged at the closed Trust Board on 29 September, is agreed in principle to be accessed through a break glass against either national or local system contingencies should another surge happen. The Trust has received confirmation from NWL STP that the settlement is not subject to system incentives and benefits for the elective recovery programme and confirmation of the CIP. 2. The only other change from plan is that the Trust is now expected to deliver a surplus of £2.3m following the inclusion of additional non NHS income contribution assumed to be funded by NHS England. 				

3. The risk assessment has been updated (section 5.0) following clarification of the NWL STP assumptions for the system level contingency, in particular to note that the NWL contingency of £59.5m, against which LAS would bid for Covid surge costs, is itself contingent upon an assumption of central funding of £61.6m for lost non-NHS income. This will be confirmed as part of the regional sign off of the STP plan.

As per the update at the Trust Board closed session, the Trust has agreed to a £2.4m cost improvement contribution to NWL STP and requires a further £1.9m cost improvement to fund the additional revenue costs of its capital programme. I.e. a total cost improvement of £4.3m.

In line with the guidance issued for Phase 3 Planning the final submission will be checked by the regional and national teams for consistency between providers and the STP submissions and to ensure they are in line with discussions between the STP and regional teams following the initial submission. These submissions will then become the plan on which the Trust is monitored for the remainder of the year.

Recommendation for the Board:

The Trust Board is asked to approve the Trust financial plan for 2020/21, noting the remaining risks to the plan.

Routing of Paper Impacts of recommendation considered and reviewed by:

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes	X	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

1.0 Background

The Trust has received funding for the first six months of 2020/21 through the nationally mandated process of a core allocation and central top up based on the Trust's expenditure run rate for months 8-10 2019/20 adjusted for inflation. The Trust currently also receives a retrospective top up to ensure income matches expenditure (largely COVID 19 related costs).

The phase three planning guidance retains the core allocation and central top up on the same basis, however the retrospective top up is being replaced by a COVID 19 allocation (or budget) for the remainder of year. The value of this allocation has now been finalised and agreed across the NWL STP and this paper provides an update on the revisions to the previous plan submission with clarification on the risks to delivering the agreed financial outturn.

The performance, activity and workforce assumptions previously agreed remain unchanged with the exception of the removal of COVID 19 surge which is detailed in the paper. .

Forecast assumptions

The Trust included a number of assumptions in developing the month 4 forecast as previously reported.

Key demand assumptions driving the forecast outturn remain as follows:

- 2020/21 Demand – the STP guidance set out an activity growth rate of 3.27% which was included in the LAS financial submission on 5 March 2020. LAS demand forecasts suggest a more likely demand increase of 4% in ambulance services and 18% (including new covid 19 activity) in 111. Current exclusions from this forecast are the Critical Care Transfer Service and on boarding of North West and South West London IUC Services, and any additional activity relating to regional/national service developments such as transfer of PTS service and 'Think 111' which is unspecified at this time, funding to support this increased activity will be in addition to the forecast outturn.
- Meet Contractual Performance - For the remainder of 2020/21, meeting contractual performance requirements has been modelled to resource: (a) 111 Call Answering at 95% <60 seconds every day (b) 111 CAS at 95% average across all KPIs (c) EOC 999 Call Answering Mean of <5 seconds daily (d) deliver a C2 mean of <18 min on a daily basis for the remainder of the year.
- Demand related costs – includes 9/12 of the cost of: (a) new covid 19 activity above 2019/20 plan totalling £4.6m (including one off pro rate HR and governance infrastructure uplift of £1.5m) (b) variable non-pay costs of covid 19 totalling £16.6m (including AA, InHealth, PPE costs, consumables) (c) Covid surge costs of £33.7m for M1-4 (as per COVID 19 retrospective arrangements).

2.0 Statement of Comprehensive Income

The table below sets out the revised forecast Statement of Comprehensive Income updated to reflect the agreed changes in allocation for the remainder of the year. The agreed adjustments are noted below:

	Phase 3 Initial Submission	Agreed Adjustments	Phase 3 Final Submission
	£'000	£'000	£'000
Income			
Income from Activities	411,276		411,276
Other Operating Income ¹	115,978	(5,074)	110,904
Total Income	527,254	(5,074)	522,180
Operating Expense			
Pay	(355,992)	6,234	(349,758)
Non Pay	(149,599)	1,166	(148,433)
Total Operating Expenditure²	(505,591)	7,400	(498,191)
EBITDA	21,663	2,326	23,989
Depreciation & Financing			
Depreciation & Amortisation	(15,863)		(15,863)
PDC Dividend	(5,340)		(5,340)
Finance Income	(4)		(4)
Finance Costs	(34)		(34)
Gains & Losses on Disposals	(354)		(354)
Total Depreciation & Finance Costs	(21,595)	0	(21,595)
Net Surplus/(Deficit)	68	2,326	2,394
Notes:			
¹ Includes:	removal of £5.0m surge funding to be funded during surge and £2.4m additional CIP requirement		
	removal of £2.4m to be delivered as additional CIP requirement		
	addition of £2.3m non NHS income loss assumed to be funded centrally		
² Includes:	removal of £5.0m surge expenditure		
	inclusion of £2.4m cost improvement target		

The table below sets out the monthly run rate to the end of July and the forecast for the remainder of the year as reported in the month 4 forecast adjusted to the agreed amendments to the forecast

	Apr-20 (£k)	May-20 (£k)	Jun-20 (£k)	Jul-20 (£k)	Aug-20 (£k)	Sep-20 (£k)	Oct-20 (£k)	Nov-20 (£k)	Dec-20 (£k)	Jan-21 (£k)	Feb-21 (£k)	Mar-21 (£k)	Total (£k)
Income:													
Block Income	34,084	34,084	34,084	34,084	34,084	34,084	34,084	34,084	34,084	34,084	34,084	34,084	409,002
Top Up Income	2,657	2,657	2,657	2,657	2,657	2,657	2,657	2,657	2,657	2,657	2,657	2,657	31,886
Retrospective Top Up Income	10,733	8,110	7,592	9,368	7,059	5,575	5,310	5,310	5,310	5,310	5,310	5,310	80,299
Other Income	861	879	1,544	337	555	598.34	579.62	760.77	606	13	647	484	993
Forecast Income at M4	48,335	45,730	42,788	46,445	44,355	42,914	42,631	41,290	42,658	42,064	41,404	41,567	522,180
Expenditure:													
Pay Expenditure	29,441	29,908	30,946	30,179	28,838	28,613	29,430	28,061	29,302	28,569	28,172	28,299	349,758
Non Pay Operating Costs excl Depr & Amort	17,529	14,503	10,380	14,006	13,734	12,518	10,898	10,927	11,053	11,125	10,863	10,899	148,433
Depreciation and Amortisation	915	983	955	1,291	1,341	1,341	1,473	1,473	1,473	1,539	1,539	1,539	15,863
PDC and Financing Costs	453	339	391	973	447	447	447	447	447	447	447	447	5,731
Forecast Expenditure	48,338	45,732	42,672	46,450	44,360	42,918	42,248	40,907	42,275	41,681	41,021	41,184	519,786
Forecast Surplus / (Deficit)	-	3	2	115	5	5	383	383	383	383	383	383	2,394

It should be noted that delivery of the forecast requires an in year cost improvement plan of £4.3m which is £2.4m NWL STP requirement and £1.9m revenue impact of capital programmes identified to date.

3.0 Cash flow

The cash flow remains largely unchanged except for the inclusion of additional non NHS income £2.326m which will not be utilised and allow the Trust to generate a small surplus.

The table below sets out the revised cash forecast using the following assumptions:

- Covid-19 expenditure and income have been ignored in the cash flow on the basis that we will receive full reimbursement for any Covid-19 expenditure or capital purchases for 2020/21. There is a risk to the cash flow if the reimbursements are delayed.
- The Flowers legal case will not be settled before 31 March 2021.
- Annual leave carried forward into 2020/21 will be taken rather than paid in lieu.

	Apr-20 (£k)	May-20 (£k)	Jun-20 (£k)	Jul-20 (£k)	Aug-20 (£k)	Sep-20 (£k)	Oct-20 (£k)	Nov-20 (£k)	Dec-20 (£k)	Jan-21 (£k)	Feb-21 (£k)	Mar-21 (£k)
Opening Cash Balance	25,969	57,780	59,085	57,357	58,338	57,833	51,980	9,080	8,398	17,090	20,012	20,969
Cash Receipts												
Block Income	73,370	36,685	36,685	36,685	36,685	36,685	0	36,685	36,685	36,685	36,685	36,685
Retrospective Top Up Income	0	6,948	10,733	8,110	7,592	9,368	7,059	5,575	10,323	3,932	5,317	4,754
Other Income	2,184	2,513	1,226	1,014	611	654	636	686	669	637	608	641
Vat Recovered (COS) & QBE	488	609	476	878	417	417	417	417	417	417	417	1,017
PDC rec'd for Capital Investment									5,945	5,945	5,945	5,947
Total Cash Receipts	76,042	46,755	49,120	46,687	45,305	47,124	8,112	43,363	54,039	47,616	48,972	49,044
Payments												
Employee Salaries	26,021	27,653	28,211	29,126	28,838	28,613	34,635	28,267	29,508	28,775	28,378	28,505
Supplier Payments	15,431	13,832	19,398	15,823	14,161	15,995	11,509	11,538	11,664	11,737	11,474	11,510
Capital Payments	2,713	3,913	3,154	583	2,522	5,411	4,579	3,951	3,887	3,893	7,874	10,839
PDC Payable and Financing Cos	0	0	0	0	0	2,670	0	0	0	0	0	2,670
Other Payments	66	52	85	174	289	289	289	289	289	289	289	5,489
Total Payments	44,231	45,450	50,848	45,706	45,810	52,978	51,012	44,045	45,348	44,694	48,015	59,013
Net Cash inflow\ (Outflow)	31,811	1,305	-1,728	981	-505	-5,854	-42,900	-682	8,691	2,922	957	-9,969

4.0 Capital Plan

The capital plan remains unchanged. The Trust Board approved a capital plan of £44.2m for 2020/21 in July 2020 subject to the programme detail presented at the August Development session. The Trust subsequently received confirmation from NWL STP to utilise up to £50.3m capital in 2020/21 on the assumption that both COVID-19 submissions would be fully funded by the central team and therefore the £6.1m NWL system support would be available in addition to the £44.2m.

Source of Capital	Jul £'000	Memo	Aug £'000	Type
Internally Generated Capital	20,429		20,429	CRL
HSLI	1,670		1,670	PDC
Grant (Low Floor Ambulance Project)	316		316	Grant
LHCRE	850		850	PDC
2019/20 COVID 19	6,358		6,358	PDC
2020/21 COVID 19 - of which:	14,588		14,588	
NWL transfers		6,100	6,100	CRL
Balance awaiting confirmation		8,488		PDC
Total Source	44,211	14,588	50,311	

It is important to ensure the additional funding is utilised in year and any slippage in planned projects is covered by bringing forward future year projects. This will

ensure availability of internally generated capital in future years to complete projects and maintain the asset base.

The table below sets out the latest update of existing and new projects by programme against the originally approved plan in July 2020.

	Original Capital Plan (£k)	Business Case Capital Approved (£k)
Existing Projects		
Digital 999	6,740	7,261
Estates Consolidation	1,400	1,400
Fleet	3,260	3,261
IM&T	913	1,134
Medicines Modernisation	81	81
Other	7,158	7,158
Spatial	4,738	4,738
Existing projects (Total)	24,290	25,033
New Projects		
Estates Consolidation	8,665	11,639
Estates	300	359
Fleet	4,500	4,504
IM&T	4,029	2,723
Medicines Modernisation	2,429	1,934
New projects (Total)	19,923	21,159
Grand Total	44,213	46,192

The Trust has brought forward a number of further schemes that it would need to undertake in future years to enable it to cover any slippage in the agreed capital plan and ensure it delivers the full £50.3m capital resource signalled as available by NWL STP. These are set out in the table below:

	Business Case Capital Not Approved (£k)
Additional Projects	
Clinical Equipment	671
Estates Consolidation	6,051
Fleet	3,385
Logistics	3,387
Spatial	2,600
Additional Projects Total	16,094

The Trust continues to develop business cases to support all these projects so that they are approved subject to available funds and can then be mobilised immediately once the overall financial forecast for capital is updated on a monthly basis. The Portfolio Management Board will then decide which projects can be mobilised quickly enough to ensure capital is utilised in year. The Portfolio Management Board (as a sub-committee of the ExCo) will be accountable for assuring that the additional projects are within available funds and forecasts.

The total revenue requirement for the programme for 2020/21 is £6.9m of which £5.0m is already included in the forecast position and a further £1.9m would require

offsetting efficiencies from within the month 4 forecast. The revenue impact by programme is set out as follows:

Programme	Revenue Impact (£k)
Clinical Equipment	0
Digital 999	2,355
Estates	
Consolidation	1,418
Fleet	170
IM&T	516
Logistics	486
Medicines	
Modernisation	1,698
Other	134
Spatial	122
Grand Total	6,900

The Trust has submitted its revenue forecast as at month 4, which includes the assumption of £5.0m for the known revenue consequences of the capital plan to NHS London Region.

5.0 Risk Assessment and Mitigation

There are a number of risks to the plan as presented. These are as follows:

- There is a risk that the Trust either does not receive all of the non NHS income (£2.326m) from NHS England as planned or is unable to deliver the required level of cost improvement for the remainder of the year £4.3m and would therefore not be able to deliver its new planned surplus.

The current assumption in the NWL STP plan is that a contingency reserve (£59.5m) has been established on the basis that the lost contribution from non-NHS income (£61.6m) will be funded centrally. If non NHS income is not funded by NHSE then the contingency would be used to fund non NHS income loss, then COVID 19 surge costs and then the cost of any new developments in that order.

The Trust continues to develop an efficiency plan for implementation from the end of October for the remainder of the financial year to optimise the level of performance that can be delivered within available resources once finalised.

- There is a risk that the Trust does not receive the planned level of Capital allocation to deliver its capital programme once NHS England/Improvement confirms capital allocations. The Trust continues to develop programmes and projects to ensure delivery of the full £50.3m capital allocation; however, these will have to be further prioritised once capital allocations are confirmed if any shortfall arises. The Trust is also increasing focus on benefit identification and realisation across programmes and projects.
- Whilst there is not risk to the Trust from system incentives and benefits for the elective recovery programme and confirmation of the CIP, there is a reputational

risk to the Trust if does not continue to deliver the agreed performance standards given the level of funding uplift compared to Trusts from other sectors.

5.0 Conclusion and Recommendations

The Trust Board is asked to approve the Trust financial plan for 2020/21.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Board Assurance Framework			
Agenda item:	12			
Report Author:	Frances Field, Risk and Audit Manager			
Presented by:	Syma Dawson, Director of Corporate Affairs			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
Board Assurance Framework (BAF) risks are presented to the Board for review.				
Recommendations for the Board:				
<p>1. The Board is asked to note the following:</p> <ul style="list-style-type: none"> BAF risk 61 – COVID-19 Impact. - The residual rating of the COVID-19 BAF was proposed for downgrade to 12 (4x3) by the Executive Committee (ExCo) on 11 November 2020 to reflect the highest level of risk carried by the People and Culture element which has a residual rating of 12 (4x3). <ul style="list-style-type: none"> Finance sub-category risk for COVID-19 was considered by ExCo on 11 November 2020, who proposed regrading this to 10 (5 x 2) due to the mitigations in place, including securing its forecast resource requirement for the remainder 2020/21. There is a residual risk that costs cannot be contained within that forecast and the Trust is unable to identify and deliver sufficient CIPs. The risk was further considered by the Finance and Investment Committee on 17 November 2020 who agreed with the proposal to regrade the residual risk to a 10 (5 x 2). Operational sub-category risk for COVID-19: has been reviewed and updated with changes made to the controls but no change to the residual risk score of 12 (4 x 3). Clinical safety sub-category risk for COVID-19: has been reviewed with no changes to controls or the residual risk score 8 (4 x 2). Quality sub-category risk for COVID-19: has been reviewed and updated with no changes to the controls or the residual risk score 9 (3 x 3). People and Culture sub-category strategic COVID-19 risk – This risk was considered by ExCo on 11 November 2020 where it was proposed that the residual rating should be increased to 12 (4 x 3) from 8 (4 x 2) due to the impact of testing asymptomatic staff for COVID-19 which may result in a withdrawal of front line workers of between 10-15%. 				

- **BAF risk 56** - The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets. This risk was reviewed and updated by the Director of People and Culture in September and a proposal was made to increase the residual rating from 12 (4 x 3) to 16 (4 x 4), as this has now become an area of significant concern. This proposal was accepted by Chair's action as the Committee did not meet in September 2020 and was approved by the Trust Board on 29 September 2020.
- **BAF risk 58** – There is a risk of catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients. This risk has been reviewed and updated by the Chief Information Officer, residual risk rating remains at 16 (4 x 4).
- **BAF risk 45** - A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. This risk has been reviewed and updated by the Chief Information Officer, residual risk rating remains at 15 (5 x 3).

2. The Board is asked to approve the following proposed new risks for addition to the BAF:

- **BAF risk 62** - There is a risk that the Trust will experience service disruption due to supply chain, workforce and financial issues in the event of a no deal departure from the EU on 31st December 2020. This risk was previously included on the BAF and was de-escalated to the Corporate Risk Register in January 2020 following discussion by the Trust Board. As the UK is approaching the end of the transition period in its departure from the EU single market and custom union, it is being proposed for addition to the BAF at the Trust Board meeting on 24 November 2020. Significant actions have been undertaken by the Trust to mitigate against the risks from the end of the EU Exit transition period however, there is significant reliance on the plans of external partners and suppliers, issues are compounded by the risks from COVID and the 2nd lockdown period in November 2020. It was considered by the EU Exit Group members at their meeting on 5 November 2020 that due to the uncertainty this causes, the residual risk score should remain at 16 (4 x 4).
- **BAF risk 63** – Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a minimum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards. This risk has been drafted following consideration by the Trust Board on 29 September 2020 that a risk remained to the Trust break even objective and that it may be appropriate to propose a new risk in respect of the Trusts financial position and delivery of services in an efficient and economical way. This was discussed further by ExCo on 11 November 2020 where it was considered that the finance risk should incorporate funding risk post April 2021 which may pose a risk for us to deliver against national standards and can reference NEL / SEL 111 as well as 999. The risk is proposed with a residual risk score of 10 (5 x 2).
- **BAF risk 65** - There is a risk that the health and wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease. This risk has been drafted following consideration by the Quality Assurance Committee that the risk in this area constitutes a more strategic level BAF risk with a proposed residual risk score of 16 (4 x 4).

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		Trisha Bain, Chief Quality Officer
Finance	Yes	X	No		Chief Finance Officer
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer, Chief Operating Officer Barry Thurston, Chief Information Officer
Medical	Yes	X	No		Fenella Wrigley, Chief Medical Officer
Communications & Engagement	Yes	X	No		Antony Tiernan, Director of Communications and Engagement
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes	X	No		Syma Dawson, Director of Corporate Affairs

Appendix 1

Board Assurance Framework: October 2020

Purpose

The purpose of the Board Assurance Framework (BAF) is to present the Trust's risk assurance framework in the context of the strategic objectives based on the Goals and deliverables set out in the Strategic Plan 2018 – 2023.

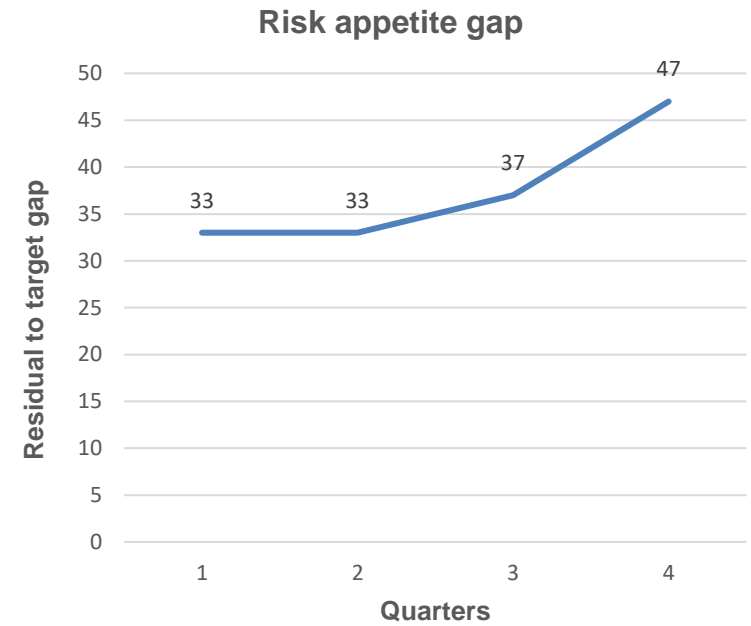
The Board is asked to note the changes highlighted in red and in particular the risks exceeding the Board tolerance scores as shown in the table below.

Summary of current position

Strategic Risk	Initial Risk Score	Residual Risk Score	Risk Tolerance	Risk exceeding tolerance?	Change in risk score
COVID-19 Impact	20	12	Low (6-10)	Yes	↓
Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients	16	16	Low (6-10)	Yes	↔
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	20	15	Low (6-10)	Yes	↔
The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets.	16	12	Low (6-10)	Yes	↑
There is a risk that the Trust will experience service disruption due to supply chain, workforce and financial issues in the event of a no deal departure from the EU on 31st December 2020	16	16	Low (6-10)	Yes	↔
Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a minimum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards.	20	15	Moderate (12-16)	No	New Risk
There is a risk that the Health and Wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease	16	12	Low (6-10)	Yes	New Risk


BAF Risk reporting Trend 2020

	Target	Residual			
	Jan	April	July	Oct	
BAF 61 COVID 19	8	16	16	16	12
BAF 58 IT failure	4	12	12	16	16
BAF 45 - Cyber Security	10	15	15	15	15
BAF 56 Recruitment/Retention	8	12	12	12	12
BAF 62 - EU Exit	8	16	16	16	16
BAF 63 - Future Funding	5				15
BAF 65 - Immunisation	8				12
Total risk score		71	71	75	98
Residual to target gap	51	33	33	37	47



STRATEGIC GOAL 1: Providing outstanding care for our patients


Executive Lead Chief Executive Officer Assuring Committee: Board

No. and Risk description		Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
61	COVID-19 Impact	20 26.05.20	Controls 5. Strategic Recovery Group worked with each directorate and developed action plans for future resilience and sustainability. 6. Pandemic business continuity plans being developed, incorporating lessons learned and preparing for any potential peaks in future. 7. The Winter/Covid-19 plan for LAS has been written, taking into account potential pressure from high demand, increased Covid-19 infection rates and adverse weather during winter. 8. Post COVID considerations led by the CFO, COO and Director of Strategy and Transformation to agree the optimal operating model including resources and estates requirements, identify and retain efficiencies and operating opportunities across all areas of operations. 9. Utilise Joint Decision Making (JDM) / Decision Log protocols to capture decisions made / authorisation levels etc. during the COVID period Regular contact with EPRR teams to seek advice on the above 10. Membership of regional and national network bodies (e.g. Ambulance HRD forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working	46 26.05.20 12 11.11.20 	1. COVID-19 decision making review underway. 2. To review and assess the Trust's Strategy and strategic risks following COVID 3. The organisation has been asked to set out its position including funding to deliver health care at system level.		6-10	

- | | | | | | | |
|--|--|--|--|--|--|--|
| | | <ul style="list-style-type: none"> 11. Australian recruitment programme regularly reviewed and approach updated as necessary. 12. Appointment of dedicated COVID Wellbeing lead with remit for creating the Trust's COVID staff wellbeing delivery plan and working with internal and external partners to deliver the plan 13. Interim Head of Wellbeing has been appointed and the Wellbeing Hub has been set up to provide one point of entry for all staff covering their health and wellbeing needs 14. The Trust has set up a strategic Incident Room (COVID 19 cell) to plan and monitor impacts of COVID 19 on the Trust in alignment with the Pan London Strategic Coordination Group and planning assumptions for London (this has been stood down with the reduction of demand, however there are plans to reinstate it as required). 15. Working with CQC and NHSI to agree SI process meet whilst recognising the scale of investigations required to meet LfD regulatory requirements 16. The Trust has established a COVID 19 Resource Tracking template to be completed for all COVID 19 related resource requests, these are all approved by Trust Gold and reported to ExCo and FIC on a regular basis. 17. In year monthly financial reporting and forecasting continues to provide assurance on underlying financial position of the Trust and to ensure all material COVID 19 expenditure has been captured 18. The Trust continues to fully document all COVID 19 related expenditure to ensure it will with stand the scrutiny of both internal audit and parliament. | | | | |
|--|--|--|--|--|--|--|

			<p>19. The Trust has agreed its resource and cash requirements for the rest of the year relating to Covid 19 based on month 4 forecasts.</p> <p>20. Budget based approved financial plan including CIP is being issued to Directorates based on month 6 forecast and is being monitored with focus on Covid spend to determine ongoing run rate and bear down on any unnecessary spend</p> <p>Assurances</p> <p>21. Reports are provided to the Board Assurance Committees on COVID-19 related activities.</p> <p>22. Reports provided to Executive Committee who sign off strategic risks and actions.</p> <p>23. Status reports provided to the Trust Board via weekly NED calls and monthly Trust Board meetings.</p>						
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STRATEGIC GOAL 2 :	Be a first class employer, valuing and developing the skills, diversity and quality of life of our people
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No. and Risk description	Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
56	The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets	<p>Initial risk score: 16 23.05.19</p> <p>Controls</p> <ol style="list-style-type: none"> 1. The Trust has historically built strong pipelines for paramedic recruitment overseas which will allow it to respond to an under supply in the UK market. These activities have been on hold due to the pandemic and Government restrictions. We are exploring the options available to the Trust to establish international pipelines. 2. 20/21 UK Graduate recruitment in place - a proposal to bulk recruit 96 UK Partner Paramedic students. 3. The Strategic Workforce Planning Group is currently under review and not meeting, however, there are a other work streams underway focussing on operational resourcing including; Third Year Student Working Group, Non-Patient Facing Clinicians Working Group, Recruitment Working Group and the LFB Working Group to support the Ambulance Ops Sustainability Plan (e.g. sustainability over winter and to support a second peak). Also the Operational Resourcing Group (ORG) restarted in Sept 2020, the focus of which is to lead on strategic workforce plans for 111 IUC, 999 and Ambulance Services. 4. Engagement in national workforce planning group to influence debate 	<p>Residual risk score: 16 23.05.19 29.09.20</p> <p></p>	<p>Due to Covid-19, the roll out of these activities is delayed and there are now a number of unknowns in regards to the longer term planning.</p> <ol style="list-style-type: none"> 1. Determine skill mix to support patient requirements and operational delivery within the financial budget available. 2. Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers. 3. Develop and agree design for an Operating Model for Ambulance Services. Develop Trust plan for 999 and 111 integration across call handling and telephony based clinical services. 	<p>Actions 1-2: Ongoing</p> <p>Action 3: 3 March 21</p>	6-10	

			<p>on challenges of English Ambulance Trusts with funded paramedic places</p> <p>5. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation</p> <p>6. The Trust has developed a paramedic apprenticeship programme to attract and retain non clinical employees.</p> <p>7. The Trust is developing accessible career pathways for non-registered clinical roles. Introduced new Band 4 role (Assistant Ambulance Practitioner) There will be two cohorts, one will be operational in Feb 21 and the second cohort in April 21.</p> <p>8. We are working on a new Band 5 TEAC / Future Paramedic programme at Band 5. The LAS academy is coming to an end and we will move to the partnership with Cumbria for an apprenticeship programme which provides a level 5 qualification</p> <p>9. The Trust will hold primary authority for the supply of Paramedics to the 220 London Primary Care Networks. This has been built into the recruitment plans for 2021/22.</p> <p>10. Pilots with Merton PCN and Redbridge PCN are planned for October 2020 and this provides us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021.</p> <p>11. Ambulance services have developed (signed off at ExCo), an 18 month recruitment plan for paramedics and</p>					
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			<p>non-registrants which takes into account the expected requirement over the year, as well as the PCN requirement from April 2021. A number of these activities are currently on hold due to Government restrictions.</p> <p>12. 20/21 UK Graduate recruitment in place – the Trust successfully recruited 147 (98 in Aug and 49 Sept) UK Partner Paramedic students into NQP posts.</p> <p>13. One to one retention interviews with international paramedics approaching their three year anniversary with the LAS have continued and we have funded a number of international paramedics who wish to apply for indefinite leave to remain. We have successfully supported staff to utilise the Government's automatic one year visa extension.</p> <p>14. Covid Paramedic bank to LAS Bank - procedure now in place to help support front-line resourcing.</p> <p>15. We have developed Ambulance Ops, 111 and 999 workforce sustainability Plans.</p> <p>Assurances</p> <p>1. The International recruitment campaign is ongoing via skype interviews for 2020/21 subject to available training places.</p> <p>2. ExCo led Strategic Workforce Planning Group (SWPG) put in place to develop and agree a three year strategic workforce plan which takes into account internal and external priorities is currently under review.</p>					
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			<p>3. The Operational Resourcing Group (ORG) restarted in Sept 2020, the focus of which is lead on strategic workforce plans for 111 IUC, 999 and Ambulance Services.</p> <p>4. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo.</p>					
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STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do	
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Executive Lead	Chief Information Officer	Assuring Committee Logistics and Infrastructure Committee
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Executive Lead	Chief Information Officer	Assuring Committee Logistics and Infrastructure Committee
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No. and Risk description	Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
58	Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients	<p>16</p> <p>28.7.20</p> <p>Controls</p> <ol style="list-style-type: none"> 1. Completed a review of CAD infrastructure, vulnerabilities and weakness, Report provided to COLT and LIC and recommendations accepted 2. Report on telephony system in EOCs completed and submitted to COLT and LIC and recommendations accepted 3. Contract set up with Northrop Grumman to carry out daily checks on the CAD database put in place 4. Regular monitoring of CAD performance in place and ongoing 5. New generator provided at HQ prior to lockdown 6. ITK links established with all English Trusts and the Trust now receiving updates from all. 7. Contractor appointed to oversee UPS implementation – plan developed. 8. CAD system replicated across both sites – site switchover in the last 12 months 9. Significant internal knowledge of systems <p>Assurances</p> <ol style="list-style-type: none"> 1. Regular reporting to committees, sub committees and groups. 2. IT Delivery Board established with Terms of Reference 3. Draft roadmap developed and is being socialised with operations 4. Commissioned independent reports. 5. Routine planned maintenance. 	<p>16</p> <p>28.7.20</p> <p>↔</p>	<p>1. CAD Replacement Strategy 1 -. Replacement of existing HW including move to external DC's Completed successfully on 15/09/2020.</p> <p>- Decommissioning in progress and scheduled for completion end of November.</p> <p>2. CAD Replacement Strategy 2 – Replacement of the CAD System (HW/SW) – targeted June 2021 (D999).</p> <p>3. Define and agree remediation plan for UPS.</p> <p>- New UPS install completed 18/10.</p> <p>- Bow new UPS/Configuration to be scheduled post Tender (targeted March 2021)</p> <p>- Bow new Generator to be scheduled post tender (targeted March 2021).</p> <p>4. Complete project review and lessons learnt for UPS programme.</p> <p>- IM&T Lessons from Bow UPS work in 2019 drafted by Mark Pugh April 2020; is focused on telephony and not UPS as a whole but has been shared with new team in place. Complete replacement of UPS enables opportunity for replan.</p>	<p>30/11/20</p> <p>01/08/21</p> <p>30/04/21</p> <p>Complete</p>	<p>6-10</p>	

					Replacement Strategies in progress to address			
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STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do

Executive Lead Chief Information Officer


Assuring Committee Logistics and Infrastructure Committee

No. and Risk description	Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	20 14.12.17	Controls <ol style="list-style-type: none"> 1. Technical cyber protection, detection and remediation solutions are deployed but require review. 2. The continuation of a professional cyber security team as a managed service to deal with incidents and cyber response e.g. Royal Surrey ransomware notification. Information Security Management support in Corporate Affairs. 3. Auditable set of documents covering people, processes, procedures and technical controls; reviewed by NHSD and third parties at least twice a year 4. Broad set of real-time security reporting and alerting with ability to take immediate action 5. NHS specific intelligence feed from NHS Digital implemented in technical controls and cyber responses Assurances <ol style="list-style-type: none"> 1. Compliance-based cyber security KRIs/KPIs (reported to IM&T SMT and monthly CEO performance review) 2. Performance reporting to L&IC through IM&T 3. Internal Audit and independent audit against DSPT 4. Additional NHSD assurance support through CORS programme 5. CareCert notifications performance measured and reported as part of the 	15 15.1.18 	<ol style="list-style-type: none"> 1. Deliver technical control/assurance projects: <ol style="list-style-type: none"> a. Network segregation and access control (Cisco ISE and TrustSec) b. Hardening of internet-facing systems (configuration and improved access control) c. N365 – Underpinned by the IG Compliance monitoring and data loss prevention (potential requirement for license upgrade) d. SolarWinds Logging solution and Security Information & Event Management (SIEM) 2. Leverage NHSD funded opportunities: <ol style="list-style-type: none"> a. Cyber Risk Framework workshops to enable enterprise integrated cyber risk management b. CORS Support – Supplier cyber management process, training needs analysis, baseline security architecture patterns, cyber cultural vision statement c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised qualifications. 3. Recruitment of substantive IG and Information Security resource at 2nd line of defence. 	CIO Aug-2020 June 21 March 21 April 22 Feb 21 CIO Nov-2020 Jan 21 Complete Complete	6-10	

			IM&T's KPIs,reported to IM&T SMT & ExCo monthly			Dir of Corp Aff Nov 2020		
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Proposed New BAF Risks

Repealed New EAF Risks

STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do								
Executive Lead		Khadir Meer						
Assuring Committee Logistics and Infrastructure Committee								
No. and Risk description		Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
62	There is a risk that the Trust will experience service disruption due to supply chain, workforce and financial issues in the event of a no deal departure from the EU on 31 st December 2020	16 16.07.19 22.10.20	Controls 1. The Trust conducted its assessment of the risks faced by the Trust in the event of a worst case scenario following the end of the transition period on 31 st December 2020, in line with the framework mandated by the Department of Health and Social Care. 2. The Trust's standing orders allow for urgent decisions to be taken when necessary. 3. The Trust has business continuity plans in place which have been tested in the context of hypothetical EU exit scenarios. 4. The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a UK depot. Four key suppliers would hold 3 months' worth of stock on UK soil. 5. A fuel monitoring system is installed and working to protect fuel stocks. 6. There is a National PPE Strategy in place to ensure sufficient PPE is available 7. Fuel stocks confirmed which address the civil contingency act requirement to supply 20 days' supply. 8. Annual leave for Directors and direct reports is now available through GRS, providing visibility of senior staff availability. 9. National mitigation strategies are in place to reduce the risk of medicine and medical consumable supply chain issues	16 16.07.19 22.10.20 	1. The Trust is reviewing the supply chains to confirm that all the Trust's suppliers have a UK depot, or appropriate mitigation in place.	Complete	6-10	

Assurances

1. Exit from the EU to be a standing item on the Executive Committee agenda going forward.
2. A focus group is in place which is meeting fortnightly providing feedback to the Executive Committee on the actions being taken to manage any risks identified with standing reports on logistics, fleet parts and fuel, procurement, drugs supplies including Frimley Park, communications and EPRR and Business Continuity.
3. The Trust has identified a Director to be the Senior Officer responsible for the Trust's preparedness for the UK's exit from the EU.
4. The Trust has been advised they are considered a priority service by the government for the supply of fuel in the event of a shortage.
5. National EU Exit preparedness strategies in place to mitigate against risks to supply chain, utilities, fuel, food and social care
6. Internal audit review noted significant areas of assurance from the implementation of focus groups, executive leadership and business continuity plans in place.

Gaps in Control:

1. Although within LAS we have completed all the reasonable activities to mitigate the risk, there is a high level of uncertainty due to our supply chain being heavily reliant on external contracts.

STRATEGIC GOAL 4: Provide the best possible value for the tax paying public, who pay for what we do								
Executive Lead		Chief Finance Officer		Assuring Committee		Finance and Investment Committee		
No. and Risk description		Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
63	<p>Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a minimum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards.</p> <p>This risk relates to all commissioned services including 999 and IUC /111 services covering both existing NEL and SEL prospective services in NWL onboarding from Nov 20.</p>	<p>4x5=20</p> <p>11.11.20</p>	<p>Controls</p> <ol style="list-style-type: none"> 1. Case made to regulator and ICS system leaders for investment in ambulance operations modernisation programme to realise Carter identified efficiency opportunity over 3-5 years. 2. Seeking minimum income guarantee for new NWL 111 service model to ensure income in line with current expenditure run rate. 3. Comprehensive resource model developed which links workforce, frontline fleet capacity, finance, and demand to forecast ability to deliver national response performance standards. 4. Income for remainder of 2020/21 agreed with ICS with agreement of receipt of non NHS income and additional surge costs excluded. Capital budget doubled in recognition by NWL ICS of need to invest in infrastructure to pump-prime modernisation. 5. Efficiency Delivery Programme established with oversight over all CIP programmes, with best practice approach to benefits realisation captured from external review of Digital investment programme and improved governance put in place to ensure effective identification, implementation and tracking of CIPs. 6. A 999 operational winter plan to ensure delivery of national performance trajectories agreed with commissioners 	<p>3x5=15</p> <p>11.11.20</p>	<ol style="list-style-type: none"> 1. Develop 5 year financial plan 2. Identify components of the strategic efficiency plan to PID level. 3. Monthly reporting of downside or worst case scenarios included in the Finance Report. 4. Implement service line reporting and finance transformation plan. 5. Complete on-boarding and due diligence on NWL IUC/111 service 6. Work with pan-London ICS leadership to achieve buy in to modernisation programme. 	<p>31/03/21 31/01/21</p> <p>Nov 20</p> <p>31/03/21</p> <p>20 Nov 20</p> <p>TBC</p>	12-16	

			<p>within resources available has been developed and is being tracked weekly.</p> <p>7. CFO linking with national tariff setting, National Ambulance Implementation and Improvement Board and commissioner CFO group to ensure transparency and ongoing awareness of cost to deliver expectations set through NHSE & Regional directives</p> <p>Assurances</p> <p>1. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn.</p> <p>2. Bi-monthly Integrated Performance Reports to the Trust Board</p>					
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STRATEGIC GOAL 2 : Be a first class employer, valuing and developing the skills, diversity and quality of life or our people
Executive Lead Director of People and Culture Assuring Committee People and Culture Committee / Quality Committee

No. and Risk description	Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
<p>65 There is a risk that the Health and Wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease</p> <p>Source Recent review of OH records indicate transfer of vaccination record information between previous providers does not provide assurance of immunity.</p> <p>Lack of evidence of immunity may result in recommendation for restricted attendance or isolation following exposure.</p>	<p>16 3.11.20</p>	<p>Immunisation catch up programme commenced.</p> <p>Records are now captured in ESR</p> <p>Analysis of immunisation records to identify any gaps</p> <p>Contract tracing processes in place to identify and protect staff at risk of lack of immunisation /immunity</p> <p>Initiation of work through the ESR Account Manager and local/regional user groups to create a reporting framework in ESR.</p> <p>A task and finish group commenced work to review the systems and processes pre & in early employment to improve the opportunities for immunisations prior to commencement in roles where the risks are the highest.</p> <p>Gaps in controls Some staff have no results from historic immunity testing.</p> <p>There have been periodic Occupational Health provider changes, where the transfer of records from one third party provider to the next was incomplete, missing or corrupted.</p> <p>No systems in place for periodic immunity reviews.</p>	<p>12 3.11.20</p>	<p>Data analysis using OHIO/ESR to understand the full scope of the issue.</p> <p>Design and deliver clear concise factual communications to staff about:</p> <ul style="list-style-type: none"> • The issues • The risks • The solutions <p>Development of a Phase 2 Immunisation programme</p> <p>Delivery of the Phase 1 immunisation catch up programme will be completed in December 2020</p> <p>Design and implement immunisation assurance reports from OHIO.</p> <p>Task and finish group- Review & redesign the approach to immunisations, timings of checks and processes starting at the pre employment.</p> <p>Review the clinical evidence for periodic immunity reviews.</p> <p>Complete delivery of Phase 2 of the immunisation catch up programme.</p> <p>Review and revise the Workforce Immunisation Policy in line with the evidence for or against periodic</p>	<p>30/11/20</p> <p>30/11/20</p> <p>31/11/20</p> <p>31/12/20</p> <p>31/12/21</p> <p>31/1/21</p> <p>31/3/21</p> <p>31/3/21</p> <p>28/2/21</p>		

			<p>There is a cohort of staff for whom we can't demonstrate that we have offered vaccines due to lack of records.</p> <p>There is lack of staff uptake of immunisations and personal record keeping</p> <p>There are no systems in place for risk assessments of "non or low responders" to vaccines.</p> <p>ESR does not currently report in a format which provides assurance on immunisation status.</p>		<p>immunity reviews.</p> <p>Launch new processes enabling staff to take personal responsibility to attend appointments , keep up to date and maintain personal immunisation records.</p> <p>Scope and tender process underway for a proactive and flexible OH service which strives for continuous quality improvement and uses the "Making Every Contact Count" principles to assess health and lifestyle choices, including immunisation status awareness and checks through every staff interaction. This has commenced and is noted for completion by 30 June 2021.</p> <p>Ensure the OH contract award includes the requirement for a live bi-directional OH interface with ESR.</p> <p>Complete a validation audit with the appointed OH contract holder to validate records transferred to them with those in ESR prior to switching on the bi-directional interface for vaccination data. No other OH data will be shared.</p> <p>Continue to engage with NHSE/I as they develop digital "immunisation passports". Provide information and lobby for this to interface with OH records &/or ESR.</p>	<p>1/4/21</p> <p>30/6/21</p> <p>30/6/21</p> <p>30/8/21</p> <p>Ongoing timeline for delivery not yet defined by NHSE/I</p>		
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Appendix 2

Risk Appetite Statement

The London Ambulance Service NHS Trust (LAS) recognises that it delivers an integral part of the National Health Service (NHS) in London by ensuring patients get the right emergency care at the right time and as such operates in a high risk environment. Its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its patients, people, public and partners. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to all safety and compliance objectives, including public and patient harm and employee health and safety. The Trust has a moderate risk appetite for the pursuit of its operational objectives, including reputational risks and financial risks involving value for money. The Trust has a higher risk appetite when seeking opportunities for innovation (clinical and financial) within the constraints of the regulatory environment.

Risk appetite score matrix

Risk Appetite	Score
Low	1 - 10
Moderate	12 – 16
High	20 - 25

Key Risk Categories – risk appetite and risk tolerance scores

Risk Category	Link to 4 Ps in LAS strategy	Risk Appetite	Risk Appetite Score
Quality/ Outcomes			
Reputation	Partners Public		
Innovation (clinical & financial)	Partners Our People	LAS has a HIGH risk appetite for innovation that does not compromise quality of care.	
Financial/VFM	Partners Public	LAS has a MODERATE risk appetite for financial/VFM risks which may ensure the achievement of the organisation's strategy whilst ensuring that the risk of financial loss is minimised and statutory requirements are complied with.	12-16
Compliance/ Regulatory	Partners Our People	LAS has a LOW risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	6-10

COVID-19 - Sub-category Strategic Risk Assessments

Responsible Director: Lorraine Bewes		Financial	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	10	5
<p><u>Strategic Risk Description:</u></p> <p>There is a risk that the Trust is unable to deliver its key performance metrics due to insufficient Covid funds being secured for the second half of 20/21.</p> <p><u>Underlying Cause</u></p> <p>The financial arrangements for the remainder of 20/21 have now been finalised with NWL STP. The Trust has secured the forecast outturn as at month 4 excluding £5M for COVID surge which has been set aside within the NWL STP contingency fund. The total settlement for the remainder of the year secures a total income of £522M. The Trust is required to deliver a surplus of £2.3M and to deliver this is required to deliver efficiency savings of £2.4M in addition to the £1.9M already identified as required to meet the revenue consequences of the Trust's Capital Plan. The settlement is itself contingent upon an assumption of central funding of £61.6m for lost non-NHS income which will be confirmed as part of the regional sign off of the STP plan. Therefore £5m for Covid surge remains a risk as well as delivery of the £4.3m efficiency. The revised assessment is that this is unlikely, which gives a residual risk of $2 \times 5 = 10$.</p> <p>1. Fails to capture the material financial impacts of COVID 19. Cannot recover the full income required for COVID 19 from NHS England/Improvement.</p> <p>Actions taken:</p> <ul style="list-style-type: none"> The Trust has established a COVID 19 Resource Tracking template to be completed for all COVID 19 related resource requests, these are all approved by Trust Gold and reported to Exco and FIC on a regular basis. The Trust continues to fully document all COVID 19 related expenditure to ensure it will stand the scrutiny of both internal audit and parliament. An inventory management system has been procured and implemented in Deptford for COVID 19 related stock management. Budget based approved financial plan including CIP is being issued to Directorates based on month 6 forecast and is being monitored with focus on Covid spend to determine ongoing run rate and bear down on any unnecessary spend. <p>2. Is unable to identify and sustain cost efficiencies from opportunities post Covid-19</p> <p>Actions taken</p> <ul style="list-style-type: none"> The Trust is developing an efficiency programme, building in benefits realisation principles from PWC audit of D999 programme to deliver savings to meet the 1% CIP requirement expected of all organisations plus cost pressures that have arisen in the 2nd half. A total opportunity of £11m has been identified of which £4.3m is currently assessed as deliverable and a stretch target of £7m is being evaluated. <p>3. Is unable to identify and sustain innovation and improvements during and post Covid-19 i.e. CAD replacement/EPCR implementation.</p> <p>Actions taken</p> <ul style="list-style-type: none"> Secured capital of £50M to support the capital programme for transformation requirements in 20/21. 			

COVID-19 - Sub-category Strategic Risk Assessments

Responsible Director: Lorraine Bewes	Financial
<p>4. Experiences an increase in loss of assets due to fraud and theft (tracking and receipting of goods to be enhanced)</p> <p>Actions taken</p> <ul style="list-style-type: none"> • Case for urgent Covid funding includes investment in asset tracking of key equipment and kit required for ambulances to be functional across the whole organisation and deployment points to track and manage inventory and reduce the risk of fraud. • The Trust is maintaining its existing control environment across segregation of duties, adherence to SFIs, Scheme of Delegation and procurement controls. <p>Additional action against mitigation of risks 1-5</p> <p>5. We have expanded senior Finance capacity: CFO full time with further proposal to review senior finance and procurement in light of transformation timeline and post COVID.</p> <p>6. Revenue bridge for STP CFO has been agreed across NWL STP.</p> <p>7. Review of monthly Covid spend by Directorate</p> <p>8. Development of downside mitigation plan</p> <p>9. Development of a BAU and transformation efficiencies plan</p> <p>Assurance of controls</p> <p>10. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn.</p> <p>11. Bi-monthly Integrated Performance Reports to the Trust Board</p> <p>12. Daily Senior Leadership Team priority theme for July is Budget resilience</p>	

Risk reviewed by ExCo on 11th November – rating reduced to 10.

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	8
<p>Operational Risk Description:</p> <p>As a result of the Covid-19 pandemic, all operational areas in LAS suffered from reduced ability to deliver timely responses to the 999 / 111 / IUC demand. In addition to failing to deliver service, there are risks of gaps in IM&T response to the changing situation, supply chain gaps, business continuity, and emergency preparedness. The three main strategic risk components are: risk of reduced infrastructure availability to support demand; reduced staffing capacity to respond to demand and reduced responsiveness in with a view of circumstances change. The current concern is focused on the need to potentially respond to an additional peak combined with the usual winter pressures.</p> <p>The three main strategic aims that the activities listed below cover:</p> <ul style="list-style-type: none"> Increased capacity and capabilities in terms of infrastructure; including in times where the Trust is undergoing development and transformation. Responsive staffing across different LAS services and impact on staffing availability from transformation work as well as BAU. Increased process responsiveness to changes in situation (both internally and through collaboration with system partners). This includes operational focus to recover activities during times of reduced Covid-19 impact and then returning to a full capacity operation as well as a pattern of recurring peaks in demand that is forecasted. <p>Key activities and actions to mitigate risk:</p> <ul style="list-style-type: none"> COLT was set up to support information sharing, enable a resilient response to the situation and robust decision making. This has been converted into a BAU daily Exec-led group, and COLT will be reinstated if the Covid situation requires it. Winter planning is undertaken by the trust to cover the response to demand expected during November 2020 to March 2021. The plan covers: Lessons learned from previous winters, forecast of demand and response times across the 999 and 111 services, demand management strategies, capacity management strategies including overtime/incentives, business continuity plans and key risks and mitigations. Winter planning group has been stood up to support planning and oversight over the winter period. Priorities in development that will drive the Exec group focus over the next 9-12 months. Sustainability plans developed to cover operational response in the next 18 months. Review of the current recruitment position across the Trust to ensure we are able resiliently to respond to additional peaks combined with winter pressures. The Trust has set up a Strategic Incident Room (COVID 19 cell) this has been stood down with the reduction of demand, however plans are in place to reinstate it as required. Wrote a Covid-19 response plan of operational and clinical response based on different levels of expected impact on the service. Operational recovery planning is ongoing to shape the response for decreasing pressure, in view of the forecast. Some of the actions are to be implemented at the end of the incident and some after LAS is after the peak. 			

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	8
<ul style="list-style-type: none"> • Close review of performance and the impact of the various actions undertaken through a response for Covid-19. This will be used to inform the plans for operational response to additional peaks of Covid-19 demand. • Ongoing review of specifically Covid-19 related risks and response to those. • Oversight of CAD stability: <ul style="list-style-type: none"> ✓ CAD Essentials board to be restarted and control room risks will be an agenda item ✓ Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place ✓ Audits of telephony system ✓ CAD dashboard to be implemented and reviewed at CAD essentials board • IM&T to respond to Trust requirements where a change in practice is requiring a technological change, as part of this increasing the availability of remote working via TEAMS. • IM&T to provide assurance that bandwidth capacity is available to enable higher numbers of staff to work remotely. • The Trust has rolled out a staffing plan to deploy non-standard ambulance to simplify scheduling and increase oversight of delivery levels. • The Trust conducted its assessment of the risks faced by the Trust in the event of a <u>worst case</u> sickness levels across LAS and the wider system, in line with the framework mandated by the Department of Health and Social Care. This risk assessment has now been published, available for the public. • Expansion of the DCA fleet to maximise the vehicle availability to respond to increasing demand. • Incorporated a wide range of volunteers into the 999 and 111 services to support continued service delivery, retained the capability and systems to increase the number of volunteers if required by demand. • Expansion of 999 control room capabilities and capacity to respond to calls. • Separated out the Covid-19 calls from 999 and 111 to allow a specialised response. • Fuel stocks confirmed which address the civil contingency act requirement to supply 24 days' supply. And a fuel monitoring system is installed and working to protect fuel stocks. New Fuel policy and procedure to support business continuity to be rolled out. • The trust rolled out a plan for distribution and testing of FFP3 masks as well as plans for acquiring further supply, with systems in place to source additional PPE as required to respond to changing demand • Engagement with CCG's NHSE&I, PHE and all system partners throughout the planning, preparedness, response and recovery to maintain confidence across the system of robust arrangements within the London Ambulance Service. • Continue adapting the plan clinically and operationally as the situation develops. • To seek assurance from third party suppliers to the Trust that they have a robust Business Continuity Plan to provide supplies to the Trust. • With the focus of the organisation on COVID 19 and the potential staffing impacts of this, other business has been assessed for its viability during this period. • Review of the impact on staff capacity and availability as a result of transformation projects and development of services by the Trust. 			

Risk reviewed 11 November 2020 with changes made to controls. Residual risk score remains a major impact x possible likelihood = 12.

COVID-19 Strategic Risk Assessments

Responsible Director : Ali Layne-Smith		People and Culture	
Risk assessment using NHS risk matrix *	Initial Rating	Current Rating	Target Rating
	16	8 12	8
<p>1. Not enough staff to meet increased service demand due to incrementally increased staff COVID related sickness and self-isolation absence.</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Departmental business continuity plans created to map provision of business critical activities at 25 / 30 / 50 / 50% + sickness absence • Daily sickness absence monitoring and reporting of COVID / non-COVID sickness absence to allow for trend analysis once sufficient data is available. Resourcing plans then adjusted in anticipation of trend • Early access to national testing programme to enable staff to return sooner if self-isolating and have a negative result • National contact tracing arrangements in place for crew members and co-workers • Covid bank to LAS Bank - procedure now in place will allow for rapid recruitment of additional volunteers and Bank staff to provide backfill in operational frontline areas to offset workforce resourcing gaps as a result of increased sickness absence, and increased call and ambulance demand to help support front-line resourcing. • A new Assistant Ambulance Practitioner (AAP) band 4 role is being recruited to fill the gaps identified by the Ambulance Ops Sustainability Plan. We plan to have recruited 184 AAPs by March 2021. The first cohort of 80 started in October 2020. • 111 and EOC have been increasing their staffing levels to meet the anticipation of increased demand. • Partnership arrangements with LFB are under discussion to provide business as usual and surge support as needed. • Engaging 3rd year Paramedic Students to undertake bank shifts <p>2. Limited welfare and wellbeing support to meet staff's physical, emotional and mental wellbeing requirements.</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Interim Head of Wellbeing has been appointed and the Wellbeing Hub has been set up to provide one point of entry for all staff covering their health and wellbeing needs. • Appointment of dedicated COVID Wellbeing lead with remit for creating the Trust's COVID staff wellbeing delivery plan and working with internal and external partners to deliver the plan • Prioritisation of additional mental health support across the Trust – publicise and bolster existing services, identify and rapidly introduce new internal and external support routes • Provision of clinical advice to line managers and staff relating to self-isolation and testing • Provision of food for staff self-isolating, unwell or unable to access refreshments on shift • Provision of accommodation of staff who have vulnerable relatives at home, or need to self-isolate away from home. • Increase availability of staff and partners with mental health and psychology backgrounds to our staff at group stations, call centres and office locations. • Introduction of the 'How are you Doing Survey' provided a base line of staff morale so that initiatives can be identified to respond to staff needs. • When the Trust starts to test asymptomatic workers for COVID 19 this may result in a withdrawal of front line workers of between 10-15%. Rostering and scheduling as well as ongoing impact on the operational performance will need to be reviewed as testing progresses. 			

COVID-19 Strategic Risk Assessments

Responsible Director : Ali Layne-Smith		People and Culture	
Risk assessment using NHS risk matrix *	Initial Rating	Current Rating	Target Rating
	16	8 12	8
<ul style="list-style-type: none"> Completed individual risk assessments Trust wide. 			
<p>3. Possible safety and reputational risk through the rapid recruitment of significant additional staff and volunteers to be deployed to frontline and support areas.</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> Utilise national “fast track” arrangements put in place for the NHS with agencies such as DBS, UK Visa, Utilise existing services such as NHS Passport to verify employment history, statutory and mandatory training, qualifications and registration or existing and returning NHS staff members Expand existing Bank arrangements to hire staff and reduced risk of co-employment exposure Require individual/departmental risk assessments that confirm supervisory requirements, limited access to restricted areas Establish and accelerated Occupational Health declaration process for new staff and volunteers Incorporate requirements for 3rd party resource providers to verify and guarantee staff have the correct authorisation to work, qualifications, registrations, DBS etc. 			
<p>4. Impact on BAU Recruitment especially the Australian Paramedic programme</p> <p>Key activities and actions to mitigate risks: (reflected in BAF risk 56)</p> <ul style="list-style-type: none"> Departments encouraged to review all current and planned recruitment at the beginning of the COVID period and decisions made to pause, delay or stop recruitment BAU recruitment resource redirected to focus on priority recruitment areas such as call handlers, blue-light drivers, C1 licence holders through the dedicated “Personnel hub”. Australian recruitment programme regularly reviewed and approach updated as necessary. Current status – planning to continue on a Skype basis as international travel to conduct interviews is not possible. This will require training of non-operational staff to conduct interviews. 12 to 18 month Workforce plan created incorporating additional skills types and volunteers that will enable surge capability as required. One to one retention interviews with international paramedics approaching their three year anniversary with the LAS have continued and we have agreed to fund any international paramedics who wish to apply for indefinite leave to remain. We have supported staff to utilise the Government’s automatic one year visa extension. Training identified for international paramedics for inbound Australian paramedics when they are able to enter the UK. 96 UK graduates joined the LAS in August 2020 and are now operational as newly qualified paramedics. 			
<p>5. Ensure new and redeployed staff receive the training and equipment they require to fulfil new and existing roles safely</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> Bespoke training programmes created to equip staff to carry out new roles safely e.g. EOC support call handler Buddying and supervisory shifts implemented before new starters work in “live” environment 			

COVID-19 Strategic Risk Assessments

Responsible Director : Ali Layne-Smith		People and Culture	
Risk assessment using NHS risk matrix *	Initial Rating	Current Rating	Target Rating
	16	8 12	8
<ul style="list-style-type: none"> • Induction days for specific role types e.g. London Fire Brigade vehicle orientation • Home working Health & Safety guidance provided for those now working from home for the first time and risk assessments completed • Additional IT resources provided – laptops, heads sets, MSTeams rolled out 			
6. Governance risk Key activities and actions to mitigate risks: <ul style="list-style-type: none"> • Utilise Joint Decision Making (JDM) / Decision Log protocols to capture decisions made / authorisation levels etc. during the COVID period • Regular contact with EPRR teams to seek advice on the above • Membership of regional and national network bodies (e.g. Ambulance HRD forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working • Extraordinary staffside / management consultation arrangements in place • People & Culture Committee short form process established • Membership of COVID, Daily Senior Leadership Team (DSLTL) represented at GOLD meetings and calls, daily submission of metrics and reports with regards to P&C elements e.g. sickness absence, accommodation required, and staffing 			
7. Future impact on our culture of actions taken and behaviours adopted through COVID period. Key activities and actions to mitigate risks: <ul style="list-style-type: none"> • Continuing FTSU arrangements in place • Regular contact between P&C HR Managers, HR BPs, line managers and staff side to ensure issues captured and addressed quickly and fairly as most hearings and investigations are paused (now back to BAU Staff Council held every other month, weekly OPF, hearings now taking place) • Resolution framework recommended is being implemented to provide swift resolution of staff issues supported by external mediation resource. • National reporting for WRES, WDES and staff survey has recommenced 			

The risk was reviewed by ExCo on 11 November 2020 where the recommendation was made for the residual rating to be increased from an 8 to a 12 due to the impact of testing of asymptomatic staff which may reduce resource levels by 10-15%

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Trisha Bain		Quality	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	3x3= 9	2x3= 6

Key activities and actions to mitigate risk:

- COVID19 risk register was developed and those ongoing risks have now been embedded into BAU processes)
- Produce weekly flash scorecards for monitoring by Extended Leadership Group that reflect any new risks that have been raised.
- Review all assurance quality and risk processes to ensure they remain at minimum value level.
- Produce bi-monthly quality report
- Develop and implement real-time web based tool for all 'hubs' and directorates.
- All compliance and standards audits have been re-established. Quality assurance programme re-commenced for all sectors/services to identify any gaps in controls and immediate actions taken.
- COVID19 Review for patient harm has been completed and learning will be taken forward.
- All risks captured and be monitored via BAU e.g. RCAG and Board.
- Demand has reduced significantly, number of incidents back to expected position and continue to be monitored via daily safety hub and SIG.
- Plans for managing a potential second peak have been developed therefore an increase SI position is not expected.

Controls to mitigate risk:

- Patient Safety and Risk Hub established to collate all incidents, risks, complaints, and other quality data.
- Daily safety and risk hub report
- COVID19 risk register (inc. EPPR risk register) – now embedded into BAU processes
- Minutes of direct reports meetings
- Daily monitoring of Datix (COVID19 and non-COVID19) by corporate teams and weekly gathering of soft intelligence via QGAMS (this has become a BAU processes)
- Daily report to all senior managers on themes and actions
- Weekly quality directorate call held to collate issues/escalations
- Daily direct reports to escalate any issues
- SIG monitoring and reporting all Serious incidents – COVID19 and non-COVID19 related – monthly end to end review of patient pathway incidents (IUC and Emergency pathways)
- Worked with CQC and NHSI and agreed SI process whilst recognising the scale of investigations required to meet LfD regulatory requirements
- Real-time web based decision tool (In-Phase) developed/staff trained from all areas to collate all decisions ensure risk/QIA assessed, identification of policies/SOPs, clinical sign off – automated link to risk register creation of an information library (now become a BAU process)
- All quality assurance systems assessed to maintain oversight whilst reducing pressure on operational staff – i.e. audits , serious incidents (now back to BAU processes)
- Working with national leads for safeguarding, coroners to maintain oversight whilst reducing operational pressures.
- Review of structures and resources to include additional service e.g. NNWL
- Re-assessment of resource with new teams joining the directorate and impact of EpCR e.g. EBS . to ensure utilise skills and re-deploy staff as needed to deliver the agenda
- QGAMS – time commitments agreed and planned into work load

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Trisha Bain		Quality	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	3x3= 9	2x3= 6
<ul style="list-style-type: none"> Business plans included additional resources required e.g. QI <p><u>Risk reviewed on 11 November 2020 to consider impact of the winter plan, staffing, capacity and the transformation programme. Updates were made to controls but no change to residual risk rating which remains at a 9.</u></p>			

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director/s : Fenella Wrigley		Clinical Safety	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	16	8	8
<p>Strategic Risk Description:</p> <p>Risk of reduced patient outcomes or experience from the COVID pandemic surge and response.</p> <p>Due to demand from COVID-19, patients may have a delayed response resulting in worsening clinical outcomes or a poor patient experience, and which may affect Ambulance Quality Indicators. Managing the surge has required the use of novel internal and external pathways that require close governance to minimise any associated risks.</p> <p>Key activities and actions to mitigate the risk:</p> <ul style="list-style-type: none"> Expanded the CHUB and CAS to enable greater hear and treat (where appropriate) and maintain oversight of held calls including utilising advanced Paramedics in Urgent Care, Critical Care, MRU, CRU, CTMs and specialist clinical teams. Audits for new clinicians and call handlers in the IUC using accredited audit tools looking at compliance to NHS Pathways (for call handlers and NHS Pathways clinicians), clinical assessment, management and prescribing for clinicians and overall performance Increased senior clinical support in the CHUB and CAS – 2 navigators at 111 and APP / senior clinical support in the HUB (APP no longer in the HUB as no longer required, but will be reviewed in the event of a further peak) Increased senior clinical support in EOC to provide guidance on cardiac arrest care and decision making (senior clinical support no longer in EOC as no longer required, but will be reviewed in the event of a further peak) 24-hour senior clinical on call led by Strategic Medical Advisor, and a new Senior Clinical Leadership on call rota, which included 12 hours on duty cover as part of the Trust Strategic Command when Gold was sitting. (Senior Clinical Leadership no longer running, but will be reviewed in the event of a further peak) Working with pan-London, Clinical Networks to provide updated patient pathways in real time, and communicating those to changes to the Operations Directorate. Clinical guidance to provide support to crews in decision making taking into account the ambulance service environment.; All clinical guidance was disseminated on multi-media platforms, to ensure wide and timely distribution to frontline staff. Working with NHSE London and HLP to rationalise and agree patient pathways Direct support to crews who have been in contact with a confirmed COVID-19 patient through the welfare team, with input from the Head of Health Strategy, Policy and Operational Improvement. Robust and dynamic review of PHE guidance by the Head of Infection Prevention Control to ensure our staff, and in turn patients, were protected as much as possible through updated PPE guidance. Peer review of processes through NASMED and the NHSE Clinical Advisory Groups, both at regional and director level of all clinical decision making. A Critical Care Transfer service, to provide an essential service for patients requiring advanced clinical assistance whilst being transported to Nightingale Hospital, without impacting on the 999 emergency calls. (This service has been suspended with the stand down of the Nightingale Hospital). Re-contact audits to review any patients who made a second contact with the LAS 999 service within 24 hours of being discharged on scene after assessment and where, on second contact, their condition had deteriorated significantly (ie requires pre-alert to ED or had died) 			

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director/s : Fenella Wrigley		Clinical Safety	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	16	8	8
<ul style="list-style-type: none"> • Serious incident panel met weekly throughout to review any incidents raised via internal systems, quality alerts or via the patient experiences team (The Serious incident panel now meets fortnightly) • Review of patients where there was a delay to answer the 999 call or respond and where this delay may have impacted on their outcomes <p><i>CAVEAT: The Board recognises that due to the overwhelming nature of the pandemic on London healthcare, suboptimal outcomes must be considered in the context of the whole response and the provision of high quality care to the largest number of patients possible.</i></p>			

Residual risk score reviewed 21 October 2020 and remains a major x unlikely = 8. No change to controls.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Corporate (Trust Wide) Risk Register			
Agenda item:	For Information			
Report Author:	Lisa Gibb, Risk Manager			
Presented by:	Trisha Bain, Chief Quality Officer			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
<p>Corporate (Trust Wide) Risks rated 15 and above were considered by the Risk Compliance and Assurance Group (RCAG) on 6th October 2020.</p> <p>Risk Escalation</p> <ul style="list-style-type: none"> Risk ID 910 There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business. <u>Update:</u> The date for the UK to leave the EU is now much closer and the RCAG members recommended this risk to be considered for inclusion as a Board Assurance Framework risk. <p>New Risk</p> <ul style="list-style-type: none"> There were no new risks for inclusion in the Corporate (Trust wide) Risk Register. <p>Current Risk</p> <ul style="list-style-type: none"> Risk ID 872 - There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM. <u>Update:</u> The Group were updated that an external company had delivered a programme of immunisations and this was completed in September. It was highlighted that the quality of data held by the OH provider was making it difficult to fully assess the extent of the issue. A paper is to be taken to DSLT for next steps. The risk and score has remained unchanged during the last quarter. Risk ID 973 - There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned 				

financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.

Update: The Group were updated that there continues to be stations with security issues. The Health, Safety and Security team were undertaking and collating trends from the mystery shopper audit. The business cases for the ambulance modernisation programme would be presented to PMB in October. The risk and score has remained unchanged during the last quarter.

- Risk ID 1032 – There is a risk that EOL hardware is unsupported due to a lack of funding. It is now imperative that we immediately replace the system server hardware platforms on which essential LAS services run (Ambulance station servers, webmail, email, file shares, SQL and DMZ) etc. The existing hardware is no longer supported by dell because the hardware is now more than 7 years in production (obsolete). This is also required to provide storage requirement not only for essential services and also for CAD ancillary services such as hospital handover, CAD link, Diba etc.

Update: The Group were informed that the CIO has engaged analyst Masons to formally review end of life process and build business case for equipment that requires replacement. The risk and score has remained unchanged during the last quarter.

- Risk ID 1050 – There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the new response bags due to packing errors by VP or being diverted by staff which could lead to failure or delay in patient care.
Update: The Group noted that a trial process of using the Kitprep app had been scoped and agreed which aims to address the issue. The trial would begin in December. This was added to the Corporate (TW) Risk Register in June and the risk and score has remained unchanged.

- Risk ID 1112 - There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.

Update: The Group were informed that a new project team for upgrade of Avaya telephone system via external contractor SPG was to take over the project management with the aim of completion in first quarter of next year. The risk and score has remained unchanged during the last quarter.

- Risk ID 1131 – There is risk that the management of medicines could be severely compromised due to the contract for Kitprep, which is due to expire on 31/10/20, either not being renewed or renewal with restricted terms by the supplier or LAS not renewing the contract which would cause prolonged use of the business continuity arrangements and therefore failure to comply with legal and regulatory requirements and damage to the reputation of the Trust if not properly managed.

Update: The group were informed that it had been agreed for the contract and licences to be renewed for 12 months but it was unclear where the budget for the renewal would come from. There was an action for the budget to be discussed and agreed with finance support. This risk was added to the Corporate (TW) Risk Register in August and the risk and score has remained unchanged.

- Risk ID 1133 - There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact

on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers.
Update: The Group were informed that there have been multiple no/low harm incidents reported and an increase to on scene to hospital times. TfL would be also introducing 24 hour bus lanes which is likely to have an impact. The Trust are in talks with TfL regarding the schemes. This risk was added to the Corporate (TW) Risk Register in August and the risk and score has remained unchanged.

Tolerated Risk

- Risk ID 1081 - There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed.

Update: The Group noted there was no further update to this risk while awaiting the new drug packing unit to come online. The risk and score remains unchanged but the group agreed to tolerate the risk and review in 6 months.

Risk De-escalation

- Risk ID 945 - There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.

Update: The Group were updated that the data issues in the clinician app would be resolved by November and a further meeting with the supplier was planned. It was proposed and agreed that the risk score be reduced to 12.

- Risk ID 967 - There is a risk that patient experience will be adversely impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times for category 2/3 calls.

Update: The Group agreed that the risk score could be reduce to a score of 12 due to staffing levels and performance improving considerably in Q1 with further ongoing recruitment to the new AAP role.

Closed Risk

- There were no risks for closure.

Recommendations for the Board:

- The Trust Board is asked to note the Corporate (Trust Wide) Risk Register.

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		RCAG
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

ID	Sector / Department	Description	Risk level (current)	Controls in place	Risk Lead	Risk Owner	Last review date	Assurance	Risk level (Target)	Progress Notes
872	HR / Workforce	There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM to carry out immunisations which could lead to staff being exposed to infection or staff declining to attend jobs where there is risk of infection which could impact on performance.	16	1. PAM monthly performance review meetings with Account Manager (LAS representatives, Nicola Bullen and Julia Crossey, Sharon Edgell, H&S) 2. KPI Dashboard provided by PAM, monthly 3. Monthly CEO Performance meetings including progress update and on Imms progress 4. Formal letter to PAM setting out concerns of performance against contract 5. Monthly immunisation report provided by PAM to track progress 6. As needed meetings with recruitment as the major user of OH service	Ali Layne-Smith	Ali Layne-Smith	06/10/2020	1. Ongoing engagement direct with employees via various channels to get direct feedback on service (Nicola Bullen) 2. PAM survey of customer experience (PAM Account Manager). To be included in contract meeting 3. Follow up meeting with PAM Managing Director and Account Manager (December 2018) 4. PAM nurse to provide update on outstanding imms 5. Active management of OH issues escalated and future action identified to clarify and resolve	8	06/10/20 Reviewed at RCAG and on 07/10/20 the risk was reviewed at P&C Risk Review. Programme of work by external immunisations company was completed in September 2020. Issues found with records that PAM holds. Review risk controls. Paper to be presented to DSLT for next steps.
910	Finance	There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.	16	The Trust has conducted its assessment of the risks faced by the Trust in the event of a worst case departure from the EU on 31 October 2019, in line with the framework mandated by the Department of Health and Social Care. 2. The Trust's standing orders allow for urgent decisions to be taken when necessary. 3. The Trust has business continuity plans in place which are being tested in the context of hypothetical EU exit scenarios. 4. The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a UK depot. Four key suppliers would hold 3 months' worth of stock on UK soil. 5. Fuel stocks confirmed which address the civil contingency act requirement to supply 20 days' supply. 6. A fuel monitoring system is installed and working to protect fuel stocks	Lorraine Bewes	Khadir Meer	06/10/2020	Exit from the EU to be a standing item on the Executive Committee agenda going forward. 2. A focus group is in place which is meeting fortnightly providing feedback to the Executive Committee on the actions being taken to manage any risks identified with standing reports on logistics, fleet parts and fuel, procurement, drugs supplies including Frimley Park, communications and EPRR and Business Continuity. 3. The Trust has identified a Director to be the Senior Officer responsible for the Trust's preparedness for the UK's exit from the EU. 4. The Trust has been advised they are considered a priority service by the government for the supply of fuel in the event of a shortage. 5. IUC/111 clinicians in the CAS are receiving increased requests for longer prescriptions which is being mitigated through a medicines bulletin being sent to staff. 6. Internal audit review noted significant areas of assurance from the implementation of focus groups, executive leadership and business continuity plans in place. 7. The Trust has clarified and agreed its SECAMB mutual aid that was requested.	8	06/10/20 Reviewed at RCAG. Risk raised at EU exit meeting. Group would like to propose to the Trust Board at next meeting in November for the risk to be escalated to the BAF as the date to exit gets closer. This is a Business Continuity Risk and could be combined with COVID risk.
973	Estates	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.	15	1.Security Management Policy implemented. 2.Organisational procedure on station duties in place and communicated to staff. 3.Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4.Security surveys being carried out on vulnerable sites. 5.Support available from the Metropolitan Police where acts of theft, damage, vandalism are reported. 6.Security awareness training incorporated into H&S training delivered across the Trust. 7.Engagement of security guards at sites where delays in garage door/shutter repairs are outstanding	Justin Wand	Justin Wand	16/10/2020	1. Incidents reported on Datix. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Regular review of incidents by Trust LSMS.	4	16/10/20 Reviewed at Estates risk review. Security Management Specialist collating trends from mystery shopper audits for leads of the Estates Modernisation Programme. Senior Operational Compliance Support Manager reviews info from incidents. 06/10/20 Reviewed at RCAG. Senior Operational Compliance Support Manager discussed ambulance modernisation and consolidation programme which is being undertaken across operations to secure Ambulance Estate. Business cases will be presented to PMB this month. Senior Building Services Engineer raised security risk with estate such as low walls and parking for Trust vehicles and HART vehicles as staff vehicles are parked.

1032	Information Management & Technology (IM&T)	There is a risk that EOL hardware is unsupported due to a previous lack of funding. It is now imperative that we immediately replace the system server hardware platforms on which essential LAS services run (Ambulance station servers, webmail, email, file shares, SQL and DMZ) etc. The existing hardware is no longer supported by dell because the hardware is now more than 7 years in production (obsolete). This is also required to provide storage requirement not only for essential services and also for CAD ancillary services such as hospital handover, CAD link, Diba etc.	16	A replication infrastructure is in place at the secondary site however some of the hardware are EOL as well.	Tim Fowler	Barry Thurston	16/10/2020	No assurance can be given due to no funds made available for two consecutive finance years	8	06/10/20 Reviewed at RCAG. Head of IT Service Management updated that the risk could be reduced once moved over to the new CAD. Plan to identify all EOL equipment to replace. The Head of Infrastructure leading on this.
1050	Fleet and Logistics	There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the vehicle or primary response bags due to errors by Vehicle Preparation Team or being misplaced by staff during the treatment of patients which could lead to failure or delays in patient care.	16	Staff should check bag at start of each shift. VP are replacing all missing pieces of equipment and will place a note in the bag if any supply chain issues.	Mandy Green	Justin Wand	06/10/2020	QA checks on completion of packing and at VP hubs on delivery by LGMs, quartermasters and project team. Staff sign the tag on each sealed bag to state who has packed bag for audit trail Project group are receiving data regarding incidents.	4	06/10/20 Reviewed at RCAG. Trial plan has been scoped out but due to constraints regarding use of Kit prep from resourcing issues the trail is scheduled for December.
1081	Fleet and Logistics	There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed.	16	A review is underway, which was commissioned by the COO. Chief Pharmacist has carried out a detailed review of the medicines packing function in line with Good Distribution Practice criteria.	Justin Wand	Justin Wand	06/10/2020	Chief Pharmacist has carried out an initial assessment.	2	06/10/20 Reviewed at RCAG. Semi absorbed by the Medicine modernisation programme to roll out new medicine packing unit. Risk will still remain while trust apply for new license. Completion due end March, although staff need to be trained extending this to end of May. Regional QA team and MHRA are involved in discussions. Agreed to tolerate risk and review in 6 months.
1112	NHS111	There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.	16	On a daily basis all unmanned phones are checked once per shift to ensure they are logged off. Incidents are raised if an unmanned phone is left logged in and staff member notified. All patients whose calls have been missed and not noted to have recontacted the service will be called back	Neil Hobson	Jon Goldie	08/10/2020	Incidents are raised on Datix to document when phones are left unmanned but logged in. All patients whose calls have been missed and not noted to have recontacted the service will be called back	4	06/10/20 Reviewed at RCAG. Project manager has left and completion has been delayed. A new project team for upgrade of Avaya telephone system via external contractor SPG will take over the project management in the hope of completion in first quarter of next year.
1131	Medical Directorate	There is risk that the management of medicines could be severely compromised due to the contract for Kitprep, which is due to expire on 31/10/20, either not being renewed or renewal with restricted terms by the supplier or LAS not renewing the contract which would cause prolonged use of the business continuity arrangements and therefore failure to comply with legal and regulatory requirements and damage to the reputation of the Trust if not properly managed.	16	Paper system as part of business continuity if Kitprep were to fail. Alan Bristow has had a contract review meeting with the supplier Perfect Ward. Specification for system has been agreed.	Gavin Mooney	Fenella Wrigley	06/10/2020	Business continuity plan in place if Kitprep fails but not long term solution.	8	06/10/20 reviewed at RCAG. The contract and licenses are in the renewal process. Queries raised regarding budget and support from finance to follow up.

1133	South East Sector	<p>There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes and also the introduction of Low traffic Neighbourhood Schemes LTNs. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers.</p>	15	<p>Bulletin circulated to crews Return CRU to certain areas of London Emergency Services Group established and meeting monthly with LAS, LFB, MPS, sub director of streets and TfL head of traffic flow. LAS COO has formally written to TfL and Local Authorities to express concern (LFB has also formally written) and PFD notice from Leeds City Council shared LAS consistently objecting to calming measure that put physical barrier in place (planters or lockable bollards)</p>	Darren ORourke	Khadir Meer	06/10/2020	<p>Review of performance and impact on job cycle times Monitor incidents via Datix</p>	5	<p>06/10/20 reviewed at RCAG. Still receiving numerous no/low harm incidents. Notification received regarding the 24 hour bus lanes which have come into effect and will impact staff coming to work and ambulances caught out by the exemption. Increase seen in on scene to hospital times.</p>
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London Ambulance Service

NHS Trust

Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Quality Report			
Agenda item:	For Information			
Report Author(s):	Trisha Bain, Chief Quality Officer			
Presented by:	Trisha Bain, Chief Quality Officer			
History:	Approved from the Quality Oversight Group (QOG)			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
<p>These papers provide an overview in relation to quality performance and contains:</p> <ul style="list-style-type: none"> - Quality and Sector compliance reports <p>The Quality and Compliance reports provide a review of all relevant quality KPIs and information with regards to the quality improvement agenda across the organisation.</p>				
Recommendations for the Board:				
The Trust Board is asked to note and consider the information provided within these reports.				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer
Quality	Yes	x	No		Chief Quality Officer – Quality Oversight Group
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes	x	No		Chief Medical Officer- Quality Oversight Group
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		



London Ambulance Service – Quality Report



Report for discussion at the Trust Board

Analysis based on September 2020 data, unless otherwise stated



Section	Content	Pages
Executive Summary	<ul style="list-style-type: none"> Quality Assurance Summary 999 Operational Context Scorecard IUC Operational Context Scorecard 	3 4 5
1. Safe	<ul style="list-style-type: none"> Patient Safety Scorecards Medicine Management Scorecards Safeguarding Scorecards Infection Control Scorecard Health and Safety Scorecards Legal and Claims Scorecards Quality visits scorecard Statutory and Mandatory scorecards 	7-9 10-11 12-13 14 15-19 20-21 22 23
2. Effective	<ul style="list-style-type: none"> AQI and Clinical Audit Scorecards Handover to green scorecard PDR & MCA Training 	25-26 27 28
3. Caring	<ul style="list-style-type: none"> Caring Scorecards 	30-31

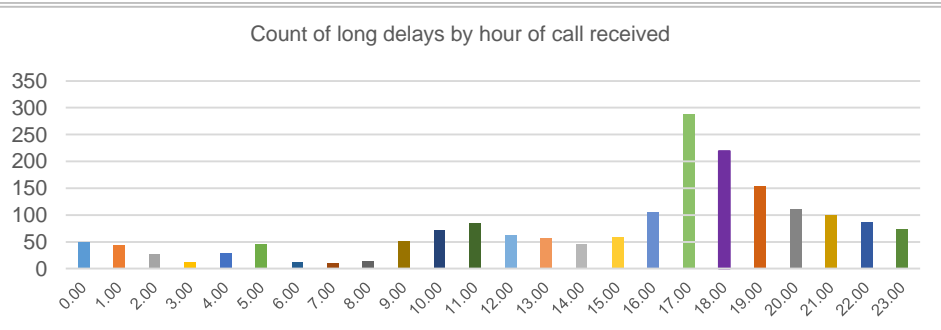
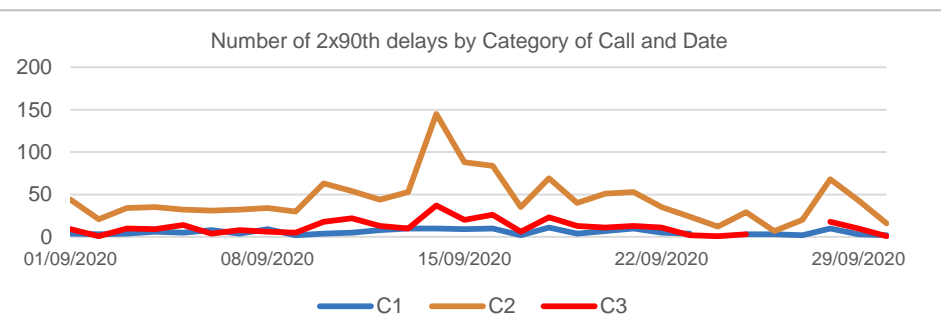
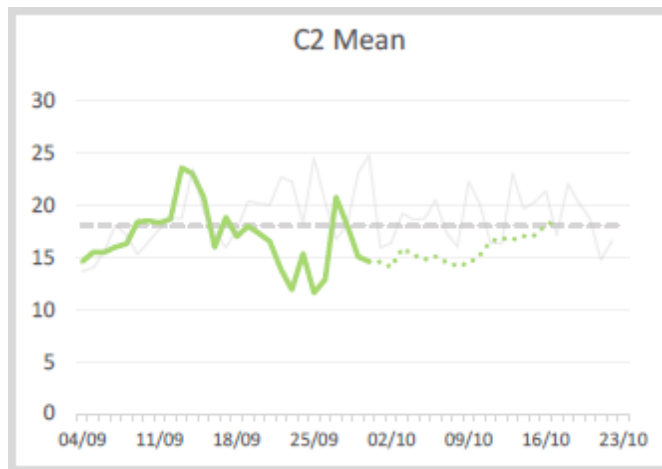
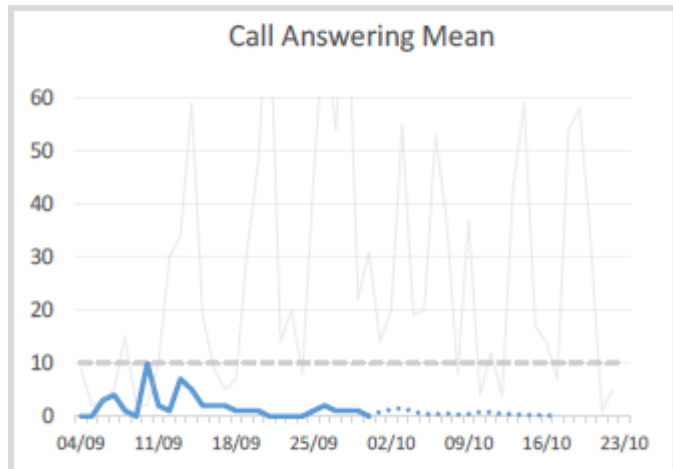
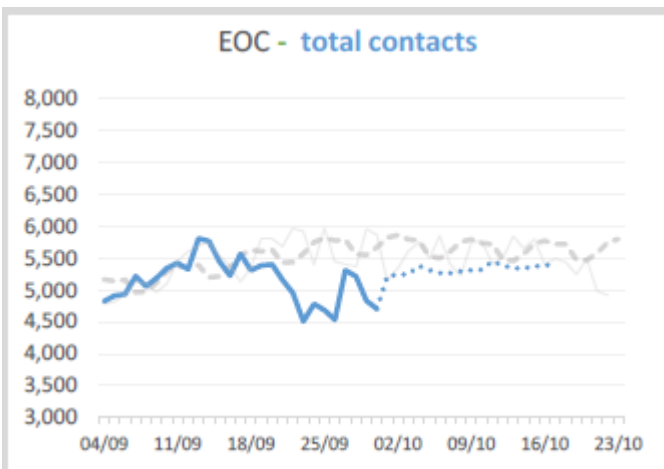
Section	Content	Pages
4. Responsive	<ul style="list-style-type: none"> Frequent Callers Complaints scorecard 	33 34
5. Well Led	<ul style="list-style-type: none"> Learning from Excellence Risk Management scorecard Organisational Learning during Q2 	36-37 38 39



Quality Domain	Highlights from this report by quality domain	Potential concerns and action
Safe	<ul style="list-style-type: none"> Incidents: There is evidence of a positive reporting culture as demonstrated by a consistent increase in reporting of no harm/low harm patient & staff safety incidents both across ambulance services and integrated patient care. There is clear oversight of serious incidents and actions plans Medicines management: Medicines related incidents are monitored at all sector quality governance meetings and audits are in place with good oversight and follow up of actions Safeguarding: Safeguarding levels 1 & 2 training are well above the target and 99% of staff who require DBS checks have had them completed. Infection Prevention & Control: IPC audits are in place and are consistently monitored. The latest OWR hand hygiene compliance (for September 2020) is 97% which is well above the Trust target of 90% for the group station that submitted data (161 submissions). 18/18 Group Stations/Services submitted their premise cleaning audit data and overall the score exceed the Trust performance target of 90% . Health & Safety: Continuous focus on violence reduction with work progressing on introduction of body worn cameras. 	<ul style="list-style-type: none"> Statutory & mandatory training: This is just below target at 84% (target is 85%) . All teams are sent regular reminder and performance is monitored by both the people & culture directorate & the Quality Assurance team. Safeguarding level 3 training: Level 3 training trajectory is at 44% (1118 staff out of 2500 for 2020-2021. This has been adjusted from 3000 due to coronavirus outbreak). A training delivery plan has been agreed and commenced this month. Environment & equipment: 21 station/service quality visits were completed in September and average compliance was 87.37% which is below the target of 90%. Areas that require further work include availability of key posters signage and security of vehicles & premises.
Effective	<p>Response times for STEMI; the average call to balloon time for STEMI patients was seven minutes faster than the national average. (This is based on February data which is the latest available)</p> <p>Clinical audit activity CARU granted approval for four new areas of clinical audit activity:</p> <ul style="list-style-type: none"> ❖ IUC CAS Anti-Microbial Prescribing Practice Monthly Review ❖ IUC CAS Repeat Medication Prescribing Practice Monthly Review ❖ IUC CAS Medication of Potential Misuse Prescribing Practice Monthly Review ❖ IUC CAS High Risk Medication Prescribing Practice Monthly Review 	<ul style="list-style-type: none"> Patient outcomes for Cardiac Arrest: LAS ranks 8th in Survival to discharge for both the Overall and Utstein group (5.9% and 14.3%) and both are below the national average of 7.2% and 20.0% respectively. Competent staff: PDR/Appraisal remain below trust target. Staff and managers continue to receive reminders. The Trust wide OWR compliance is 43.45% with a target of 85%. Multidisciplinary working: over 2,600 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus to continue improving on the metric with action plans focusing on clarification of targets, improving the process and sharing good practice across sectors. MCA training: Work is underway to implement level2 MCA training which requires face to face delivery.
Caring	<p>Compassionate care:</p> <ul style="list-style-type: none"> ❖ End of Life care CMC viewing figures continue to improve and ED conveyance continues to be lower than earlier in the year. ❖ The Mental health team have trained new paramedics who started week commencing the 12th October.. ❖ Maternity team continue to provide expert advise in the event of challenging maternity care episodes. <p>All the above teams are taking part in the quality hub model pilot led by QGAMs in the NE sector & IUC</p>	<ul style="list-style-type: none"> Funding for the Mental Health Joint Response Cars (MHJRC) is still under discussion following the evaluation report. The team have reported an increase in acuity of presentations which may correlate to the increase in conveyance rate Capacity to deliver maternity training is currently limited. A business case for Band 7 Practice Development Midwife has been submitted and feedback is awaited
Responsive	<p>Complaints: The PED team are also taking part in the quality hub delivery model pilot in the NE Sector and the IUC area and this has seen a number of improvements including improved communication links with local teams. PED is linked into the PSIRF project to ensure triangulation of themes. To assist with this process, the team is making further improvements to documentation & recording Datix</p> <p>Meeting people's individual needs: Increased numbers of new CMC records are being uploaded for frequent caller patients pan-London. The Frequent Caller Team attended the initial LAS Criminal Justice Group, and are hopeful this forum will help escalate complex patients who require legal boundaries. SIM project (mental health & police) frequent callers in both Camden & Islington, and Enfield, have shown downwards trends in call rates since January 2020.</p>	<p>To support further work with frequent callers, there is a need for Business intelligence support for the team.</p>
Well led	<p>Risk management</p> <ul style="list-style-type: none"> 86.9% of risks have been reviewed within the last 3 months – target 90% 90.9% of all risks approved within 1 month in September– target 90% <p>Culture: the staff survey for 19/20 was launched in September and will run until the 27th November as at 12 Octobers 31% of staff had completed it</p>	<p>Governance: 66 Policies are overdue (43 overdue policies & 23 overdue but under review)</p>

The service is meeting operational delivery KPIs, with call answering and mean response times for Cat 1 and 2 returning to within national set timeframes. The National Ambulance Scorecard has rated the Trust as 100% against 13 weekly metrics including response times and long waits.

For reference only – Demand & Performance, showing 4 weeks past and 3 weeks future from today



In August there were 1153 long delays of which 6.8% resulted in a blue call.

	C1	C2	C3	Grand Total
September	167	1326	324	1817
Blue call	25	98	10	133

The top three determinants where a long delay was incurred was:

- Dx012 – (15.5% n 179) – 5 required a blue call
- Calls from the MPS (8.8% n 102) – 2 required a blue call
- 17A2G – patients whom have fallen and are still on the ground (3.2% n 37) – 0 required a blue call

All delays are reviewed daily using the parameters developed during the COVID19 review. There were no cases of concerns identified as causing harm by the delay in August.

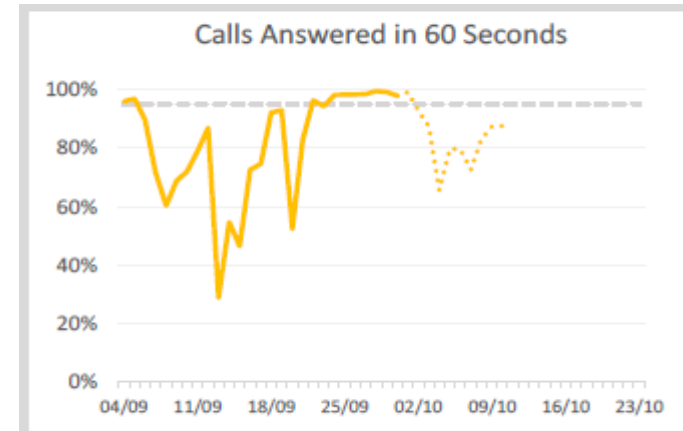
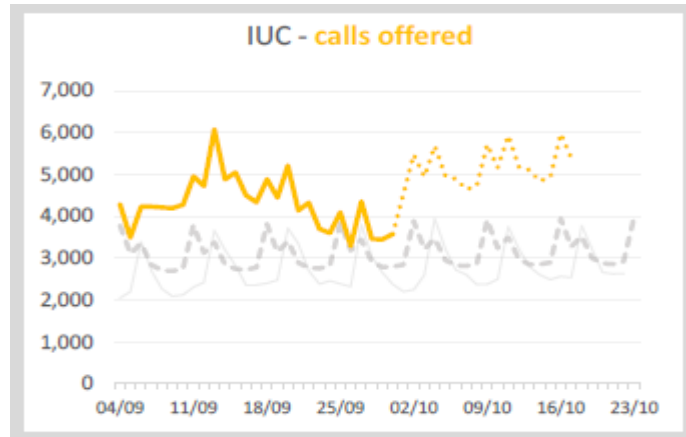
38.1% (n 440) patient whom experienced a long delay were not conveyed and 61.9% were conveyed. It was also found that 28.1% (325) of all long delays occurred between the hours of 17:00 and 19:00.

Action being taken include:

- Forecasting and planning with updates shared at DSLT weekly
- Review of staffing for EOC and Operations
- Overtime incentives to ensure cover at predicted busy periods.
- Daily operational performance review
- Winter planning and ambulance recruitment underway

Operationally, the Trust is beginning to see performance return within set performance targets/thresholds for IUC in SEL/NEL.
The performance of 111 call handling against strategic objectives is being monitored closely to ensure performance is being managed.

For reference only – Demand & Performance, showing 4 weeks past and 3 weeks future from today



Indicator (KPI Name)	Status	W/C 07/09/2020	W/C 14/09/20	W/C 21/09/20	W/C 28/09/2020	Sparkline
SEL IUC Priority 1 - % LAS 35 minutes safety threshold	●	87.0%	87.7%	79.5%	82.0%	
SEL IUC Priority 2 - %las 75 minutes safety threshold	●	92.6%	85.1%	82.9%	85.1%	
SEL IUC Priority 3 - %LAS 150 minutes safety threshold	●	87.6%	76.0%	55.6%	69.8%	
SEL IUC Priority 4 - %las 260 minutes safety threshold	●	92.8%	77.0%	64.5%	73.2%	
SEL IUC Priority 6 - %LAS 420 minutes safety threshold	●	93.5%	94.3%	88.1%	93.0%	
SEL IUC Priority 7 - %LAS 540 minutes safety threshold	●	95.5%	84.8%	65.6%	71.6%	

Indicator (KPI Name)	Status	W/C 07/09/2020	W/C 14/09/20	W/C 21/09/20	W/C 27/07/2020	Sparkline
NEL IUC Priority 1 - % LAS 35 minutes safety threshold	●	92.2%	81.3%	82.4%	82.2%	
NEL IUC Priority 2 - %LAS 75 minutes safety threshold	●	82.7%	59.2%	58.4%	58.0%	
NEL IUC Priority 3 - %LAS 150 minutes safety threshold	●	75.0%	42.8%	34.5%	34.2%	
NEL IUC Priority 4 - %LAS 260 minutes safety threshold	●	84.7%	38.1%	38.0%	37.5%	
NEL IUC Priority 5 - %LAS 360minutes safety threshold	●	91.4%	57.6%	64.7%	64.2%	
NEL IUC Priority 6 - %LAS 420 minutes safety threshold	●	90.3%	59.8%	45.0%	44.1%	

- KPI on or ahead of target
- KPI off target but within agreed threshold
- KPI off target and outside agreed threshold
- KPI not reported / measurement not started

1. Safe

We must ensure we protect our patients and staff from abuse and avoidable harm. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

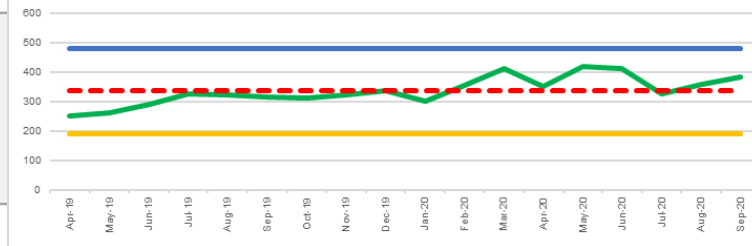
For further assurance we then provide additional data and analysis on:

- Patient Safety
- Infection Control
- Medicine Management
- Safeguarding
- Health and Safety
- Clinical & Non Clinical Claims and Legal Inquests
- Outcome of Quality Visits (Environmental & Equipment)
- Statutory and Mandatory Training

Outstanding Characteristic: People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

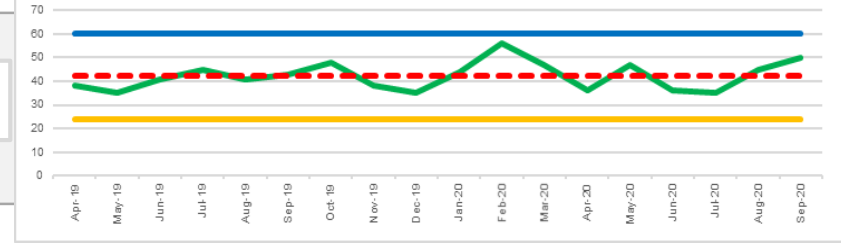
No Harm/Near Miss

Latest Month: **383**



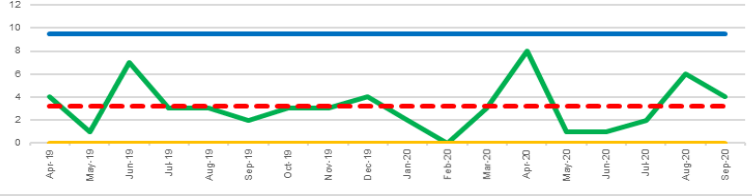
Low Harm

Latest Month: **50**



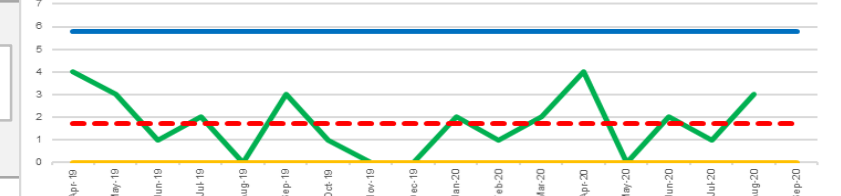
Moderate Harm

Latest Month: **4**

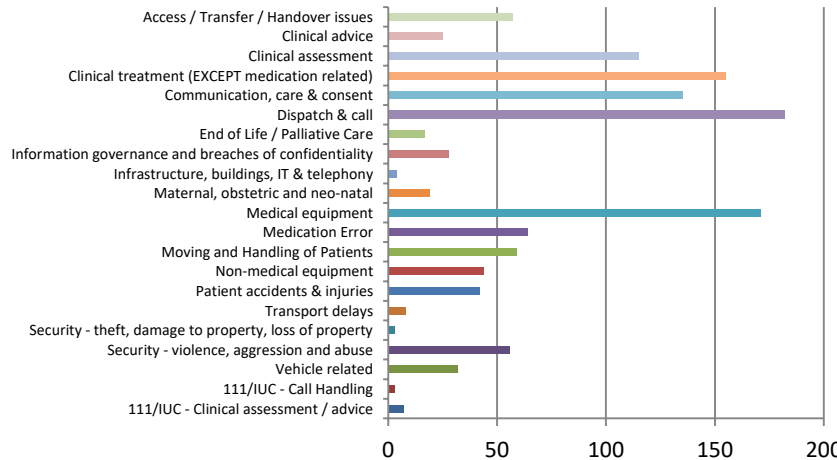


Severe

Latest Month: **0**



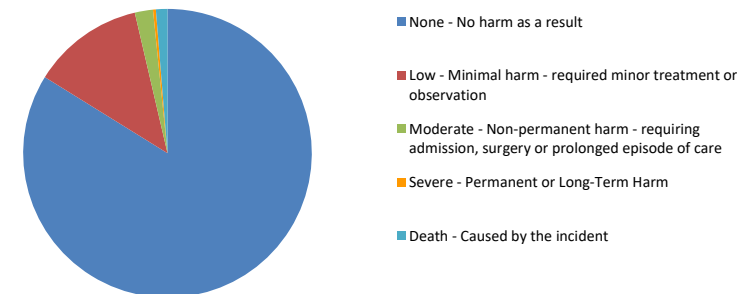
Incidents by Category

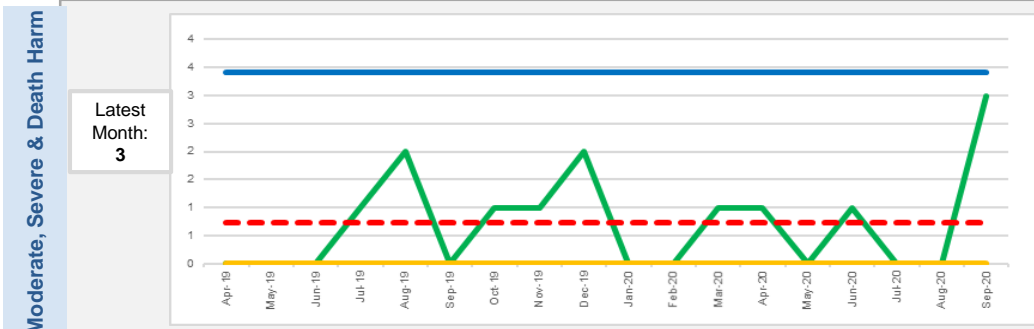
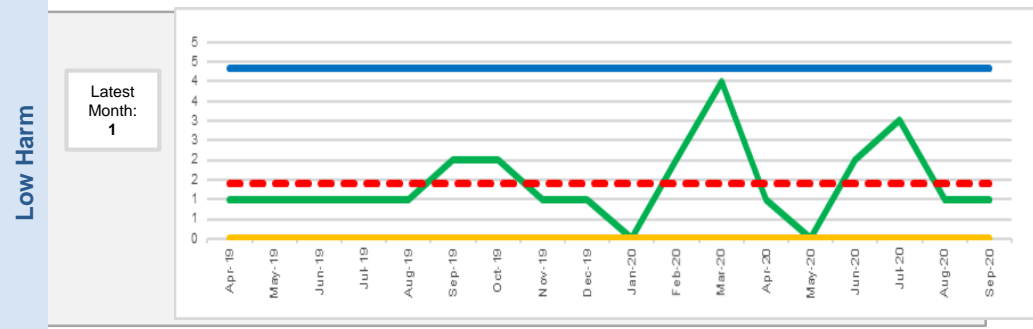
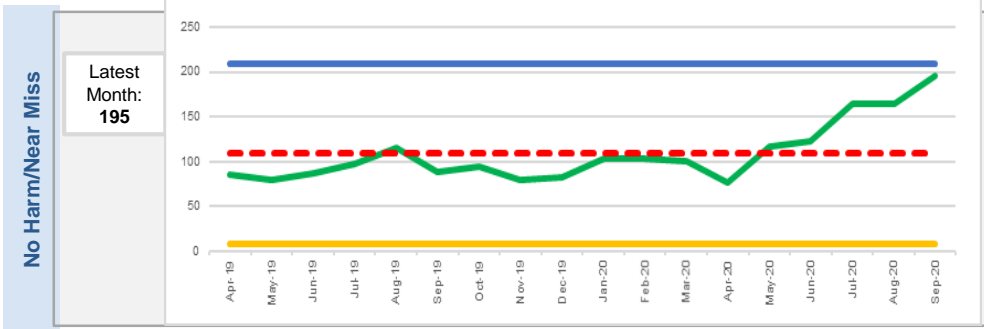


There are 934 (as of 12/10/2020) which have been opened on the system longer than 35 working days (this excludes SIs). This breaks down to 411 patient incidents, 251 staff incidents, 28 visitor incidents and 244 Trust related incidents.

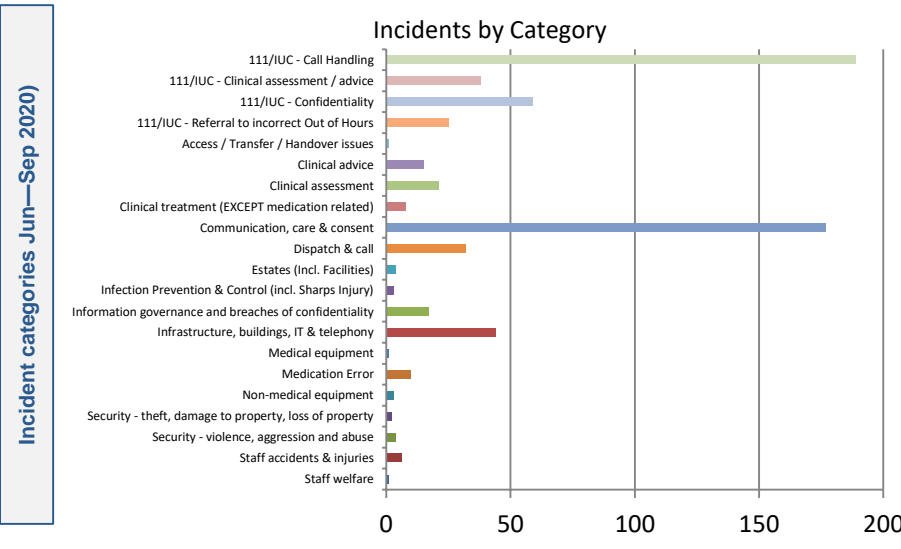
There is a focused piece of work being undertaken by QGAMs, Operational colleagues & the QI&L team. In particular the QI&L team have applied a methodology to incidents older than January 2020 which has seen a further 300 incidents finally approved.

Incidents by Severity





The number of reported incidents continues to be positive in reporting numbers particularly in regards to no harm incidents. This is a sign of a good reporting culture.

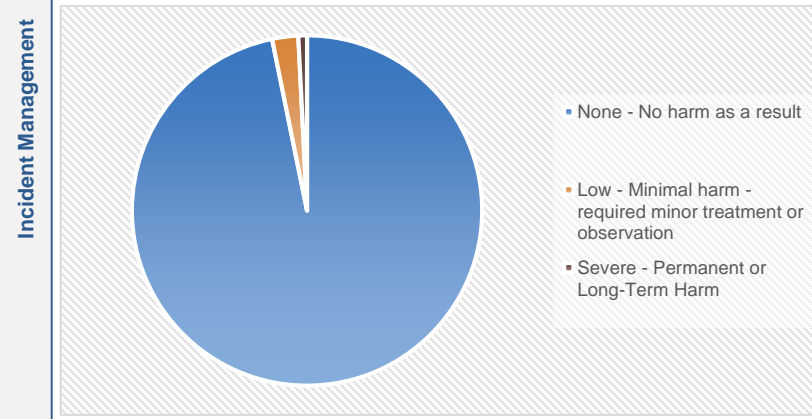


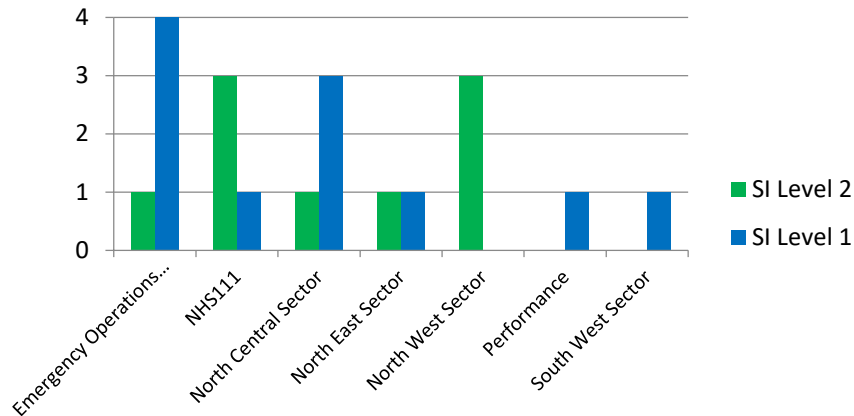
The top three category of incidents are call handling, Communication, care and consent and confidentiality.

Communication incidents refer to authorized breaches in confidentiality, made under best interest decision for the patient who lacks capacity. These are routinely reported to ensure robust decision making and application of consent and capacity regulations and best practice.

To address communication incidents, the Directory of Services and downstream providers are being engaged to ensure eligibility criteria for referring patients is accurately represented on DoS, as passbacks due to unclear guidance form the majority of these incidents.

There are 125 (as of 12/10/2020) which have been opened on the system longer than 35 working days (this excludes SIs). There is a focused piece of work being undertaken by QGAMs, Operational colleagues & the QI&L team to monitor and process overdue incidents.



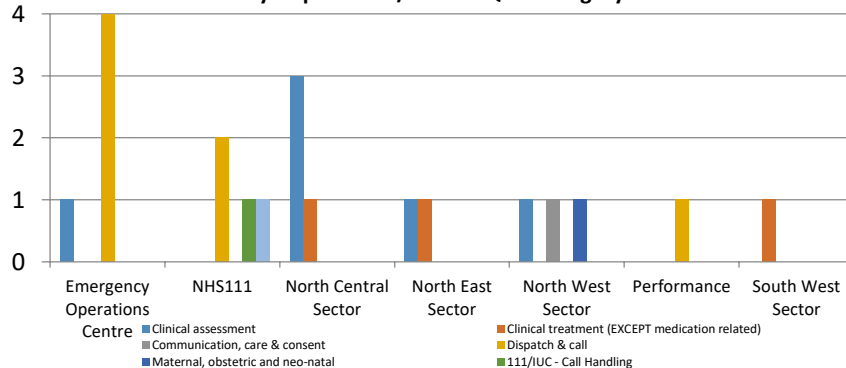


During July, August and September 2020, total of 20 (including NHS 111) reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

The Trust's Q2 SI thematic report has been produced and should be read in conjunction with this report. Q2 saw a number of call handling errors and an increased number of SIs declared where patients have been not conveyed to hospital, although the overall number of incidents declared was lower than the previous quarter.

Reviewing contributory factors from completed SIs revealed organisational factors listed highly during Q2 which can be attributed to the demand faced on the Trust during COVID-19. During the peak of the pandemic the Trust changed a number of internal processes and procedures in order to respond to the unprecedented demand. These changes were challenging for staff to maintain oversight of at times and were contributory in incidents which were closed during Q2.

SIs declared by Department/Area in Q2 – Category Breakdown



There continues to be a focus on SI actions, at the end of September there were 190 open actions, of these 48 were overdue. There are certain processes in place to monitor and encourage prompt completion of actions including:

- Action owners are made aware of the overdue action by the Datix system which send a reminder every 2 days.
- The team makes contact with the owners by various correspondence to get updates on the action, provide support where possible and ensure that actions are being addressed.
- Overdue actions are also monitored at the Safety Investigation Assurance and learning group where escalations to departments are communication, if required.

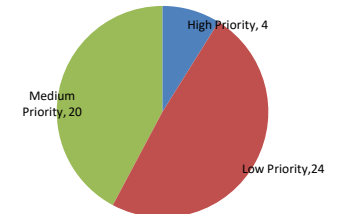
There are 4 incidents which are oldest and highest in priority:

There are two actions that relate to a CADlink failure between IUC and EOC which required an IM&T fix. The second actions relates to training of NEL IUC staff on this failure.

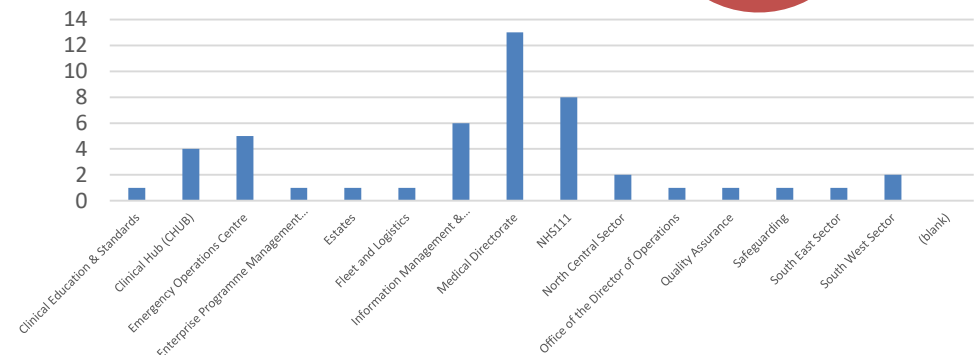
Update: There is no current IM&T fix for this national issue, a risk has been drafted on to the Corporate risk register and a work around is in place. The NEL staff are receiving training and the Quality Governance and Assurance Manager for IUC keeps SIALG up to date with how this action is progressing.

There are two further IUC actions regarding a review of compliance with completion of induction for agency and contractors in IUC and a monthly audits of 5% of all agency clinicians supplied by the managed service, in order to ensure all competencies are achieved.

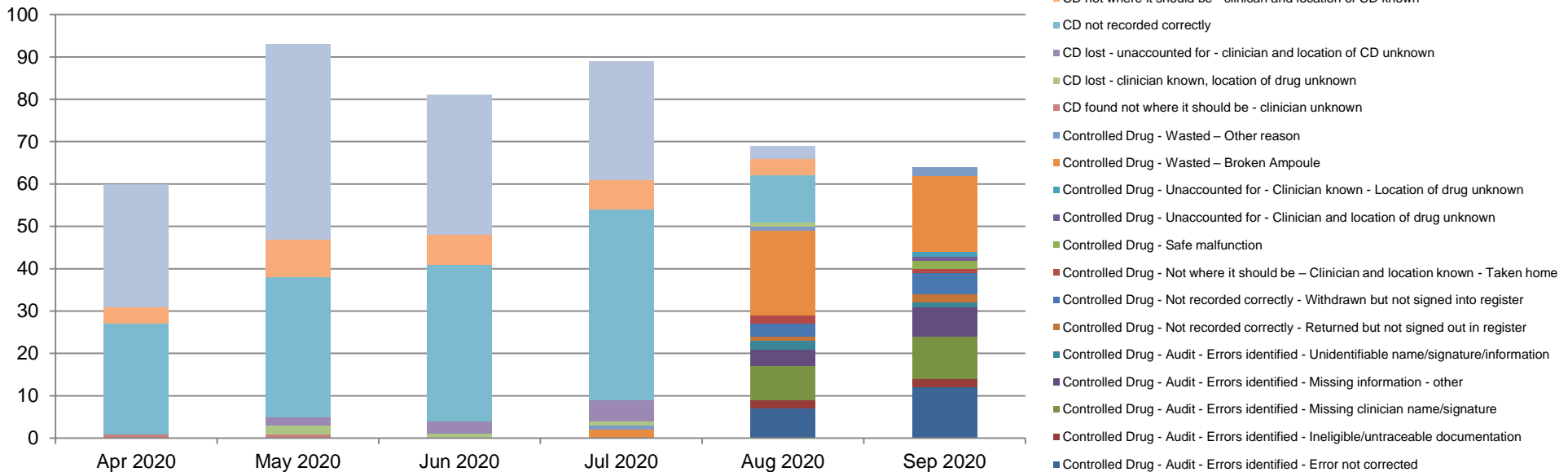
Update: These are progressing as part of the IUC improvement plan and are being tested to provide assurance before closing.



Overdue actions by Department



BI Controlled Drug Report



- No unaccounted for loss of injectable morphine
- Total of 92 other controlled drug (CD) incidents including
 - Misuse of Abloy key (n=1)
 - Errors identified during CD audit (n=33)
 - CD recording errors (n=7)
 - CD retained off-duty (n=3)
 - CD safe malfunction or damage (n=6)
 - CD wastage, breakage or damaged packaging (n=20)
 - CD found expired (n=4), damaged (n=5) or seal broken (n=3)
 - Non-CD theft or loss (n=3) and other CD issues (n=9)
- Non-controlled drugs incidents
 - Incorrect dose of adrenaline (n=3), benzylpenicillin (n=3), dexamethasone (n=1), ipratropium (n=1), morphine (n=2), paracetamol (n=1).
 - PGD breach (n=1) relating to diazepam
 - Hydrocortisone (n=1) not indicated
 - Prescribing error by non-LAS staff (n=1)
 - Administration of out of date drug by non-LAS staff (n=1)
 - Localised allergic reaction – morphine (n=1)

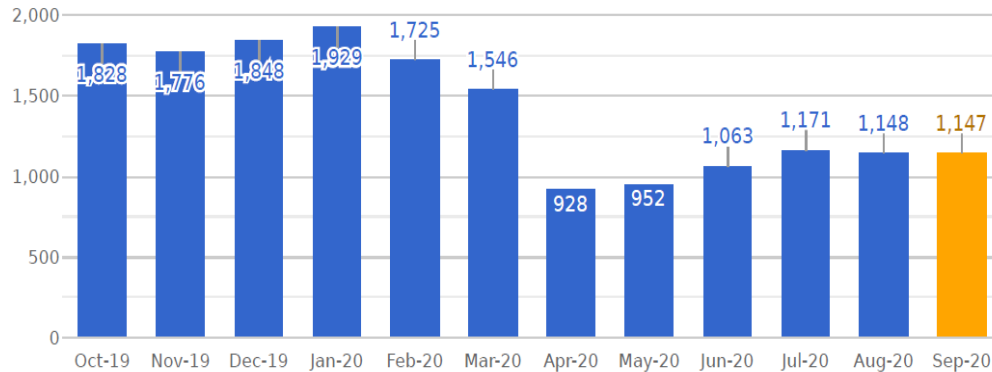
Actions:

- One APP-UC member of staff has completed prescriber training with two others due to complete in November 2020.
- Further funding for prescriber development agreed with HEE
- Planned reissue of adrenaline dosing guidance and promotional material

Assurance

- Limited occasions where morphine retained off duty and all incidents identified in a timely fashion.
- No unaccounted for losses of morphine

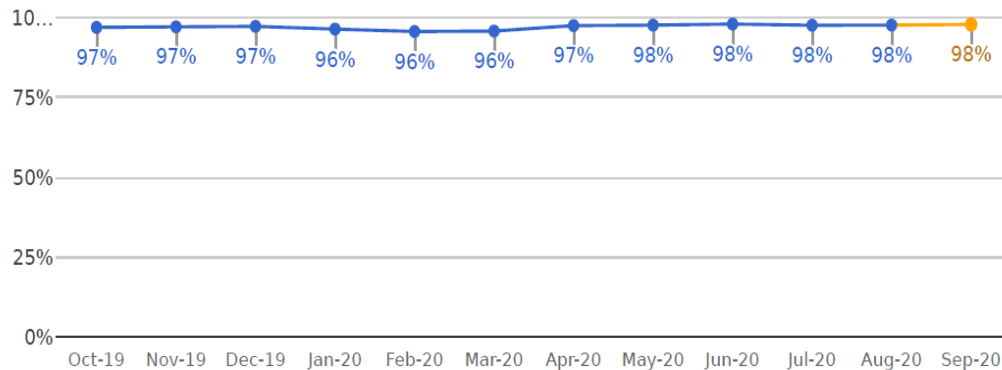
Total monthly inspections (last 12 months)



The PW inspection results are based on the numbers of inspections which take place only. The Meds team are reviewing with the supplier about attributing the score relative to the number of inspections that are scheduled instead of taking place.

Generally scores remain high but variance exists between inspectors. A review of the actions undertaken in the audit requires scheduling with the Quality Team. Any drop in scores has not been for anything of major significance in this month's report.

Average score (last 12 months)



Highest Scoring Clinical Areas

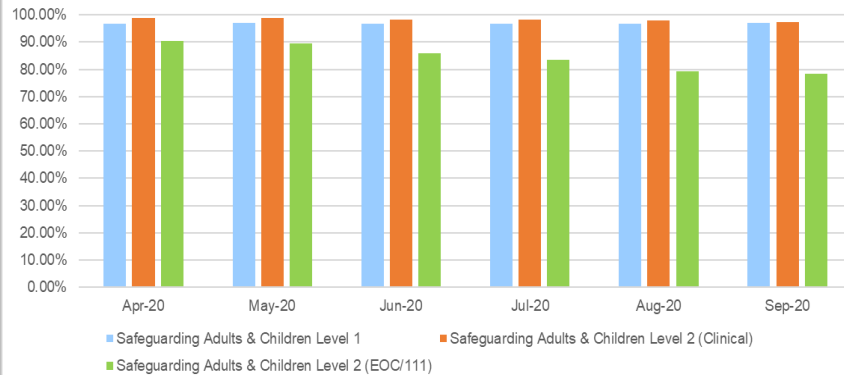
Rank	Area	Score this month	Score last 12
1	APP Brent	100% (1)	99% (16)
2	APP Ilford	100% (3)	100% (34)
3	APP Croydon	100% (2)	100% (34)
4	Twickenham	100% (1)	97% (171)
5	APP Westminster	100% (3)	100% (37)

Lowest Scoring Clinical Areas

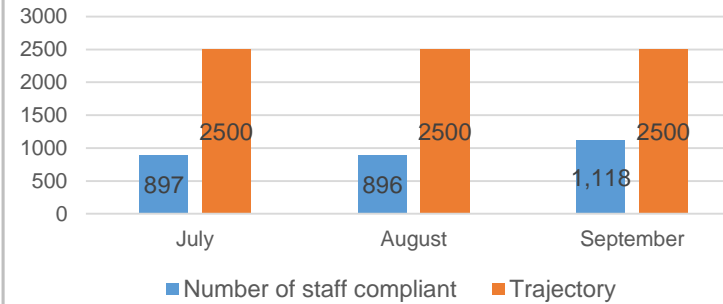
Rank	Area	Score this month	Score last 12
46	Deptford	96% (22)	95% (267)
47	Fulham	96% (16)	97% (170)
48	St Johns Wood	96% (13)	97% (204)
49	Shoreditch	95% (30)	95% (275)
50	Oval	93% (27)	92% (331)

Numbers in brackets show number of inspections score is calculated from.

Delivery of Training



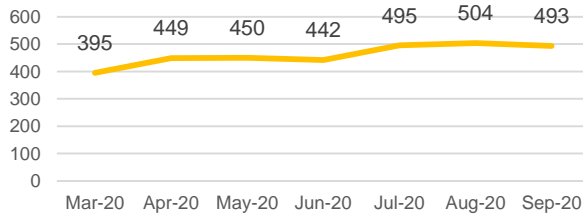
Safeguarding Adults & Children Level 3 Training



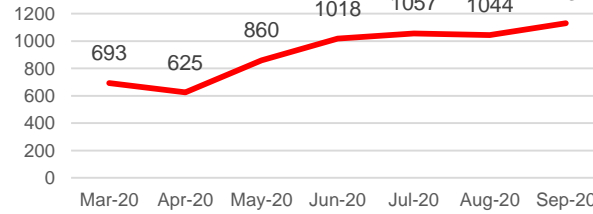
Month	L3 %
Jul-20	35.88%
Aug-20	35.84%
Sep-20	44.72%

Level 3 training trajectory is at 44% ; 1118 staff out of 2500 for 2020-2021. This has been adjusted from 3000 due to coronavirus outbreak. The remainder of the year we have 1382 staff to train.

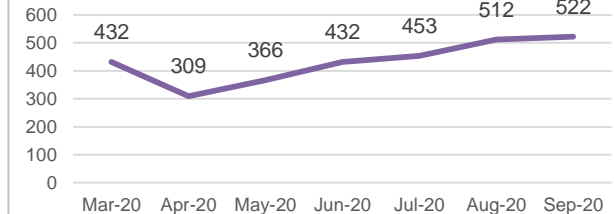
Adult Safeguarding Referrals



Child referrals



Welfare referrals

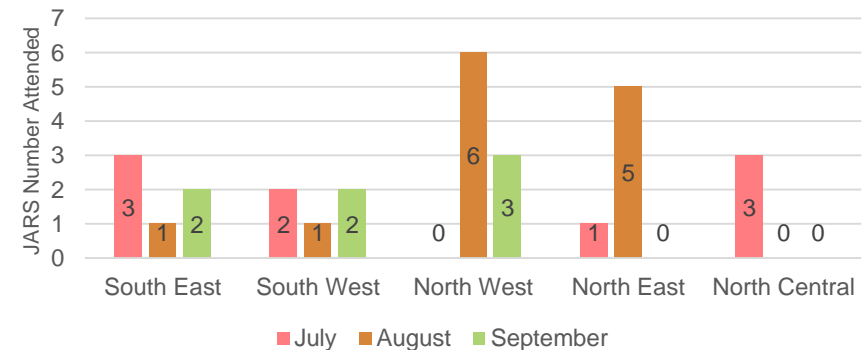
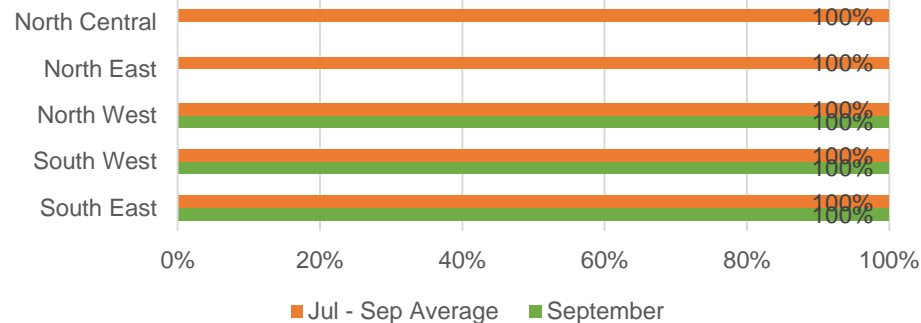


Adult safeguarding referral remain within normal range

Child referrals are within normal range

Welfare concerns are beginning to rise and return to normal reporting.

Joint Agency Response Service



The Joint Agency response meetings are now managed directly by the Safeguarding Team. These are now virtual and as a result we have so far been able to attend 100% of these Multi agency meetings.

DBS Checks Assurance Template - As at 30th September 2020

	Total number requiring DBS checks	Total number of recorded DBS checks	Percentage	Starters	Recorded DBS but older than 3 years
Ambulance Services	4076	4054	99%	22	49
Integrated Patient Care	1108	1089	98%	19	16
Non-Clinical (Corporate Teams)	350	339	97%	11	3
Ambulance Services (Bank)	279	275	99%	4	
EOC (Bank)	25	23	92%	2	
Total	5838	5780	99%	58	68
Contractor safer recruitment assurance 111/IUC (Hayes)	Number engaged TBC				
How do we seek assurance Clinical starters with risk assessment don't move to operations without DBS?	All staff in Ambulance Operations start with a risk assessment if no DBS is in place. In some cases we also have a DBS from a previous organisation at the same level. Usually we would expect the DBS check to be completed within 4 weeks of starting. Clinical Education are notified by Recruitment via the course register where someone starts on a risk assessment and they are notified when the DBS is completed. All iParas start with an Overseas Police Check.				
Trainee ECH start with risk assessment assurance how do we assure they don't move to operations without DBS?	Staff can only start with a risk assessment in place with proof of a previous DBS and a current DBS in progress. They are not allowed to take 999 calls until the current DBS has been received. The 999 team are kept up to date by the Recruitment team regarding the status of the current DBS check.				

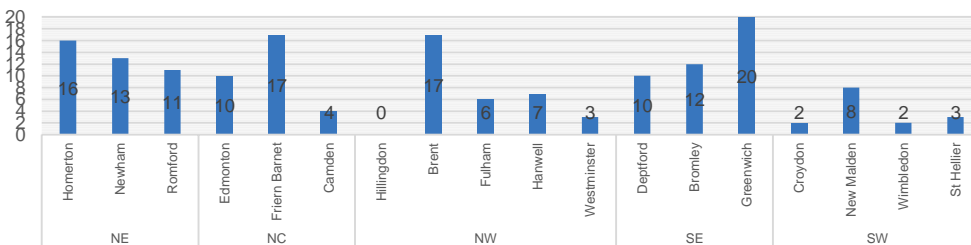
Non-Clinical

308 C&E Communications & Engagement L4
 308 CHX Chief Executive L4
 308 COO Chief Operating Officer Management L4
 308 ITS IT & Technical Services L4
 308 P&P Programmes & Projects L4
 308 PER Performance L4
 308 SAP Strategic Assets & Property L4
 308 CORP Corporate Affairs L4
 308 FIN Finance L4
 308 MED Medical L4
 308 NED Chairman & Non Executive L4
 308 P&C People & Culture L4
 308 Q&A Quality & Assurance L4
 308 S&T Strategy & Transformation L4

Actions:

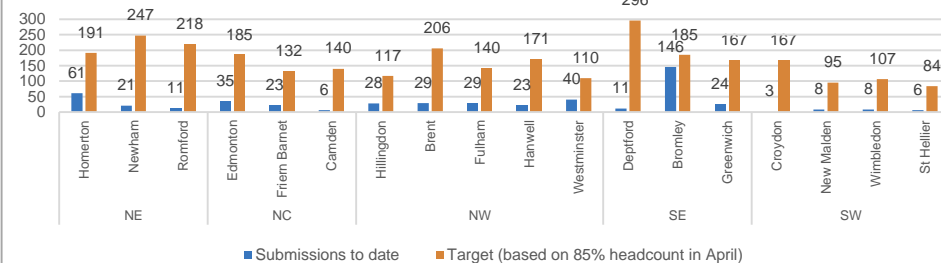
- Working with the HR teams on the remaining 68 employees who have a recorded DBS check but have not completed the DBS rechecking process. We have introduced a new monthly HR compliance report which we are launching tomorrow to the HR teams and this covers DBS, right to work, Fixed term contracts and professional registration checks.
- Seeking assurance around the DBS checking for Hays staff 111 agency staff.

OWR Hand Hygiene Submissions - September 2020
Overall Trust Submissions - 161



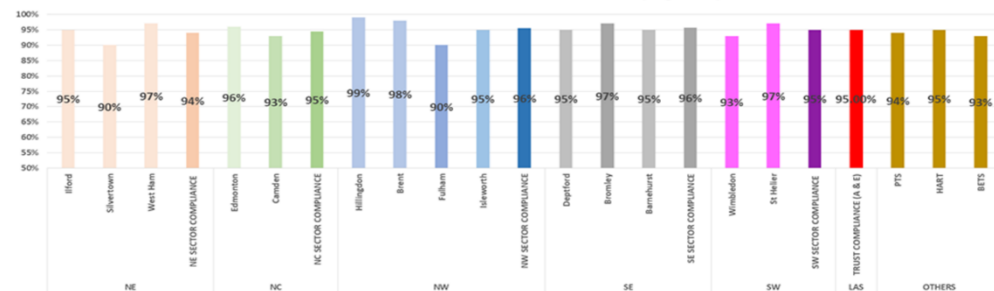
Overall the Trust OWR hand hygiene compliance for September 2020 is 97% compared with 95% in August.. Compliance exceeds the expected Trust target of 90% for the group station that submitted data. **Actions:** Reinforcing the importance of compliant Hand Hygiene practice has been communicated as part of the IPC programme of work, Audits have been undertaken by link practitioners since mid June, Assurance audits undertaken by IPC commenced mid Sept.

OWR Hand Hygiene Submissions - YTD



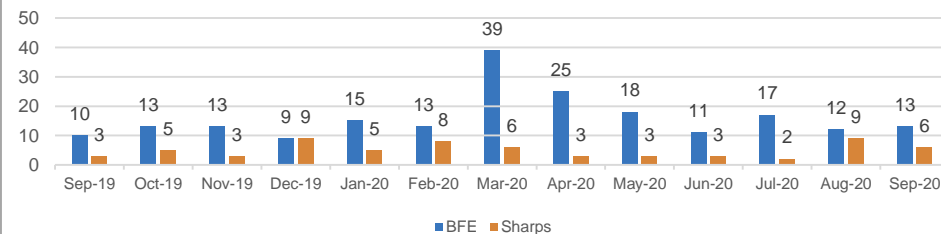
17/18 group stations submitted OWR data for September 2020 compared to 15/18 in August. *Overall submissions have increased to 161, compared to 130 submissions in August. This still requires improvement in order to achieve overall data submission targets. **Actions:** Group station managers were contacted to review low audit submissions, Highlighted at OPM the importance of continued audit for preparedness and prevention.

VP DEEP CLEAN A&E VEHICLES SEPTEMBER, 2020 (Target 95%)



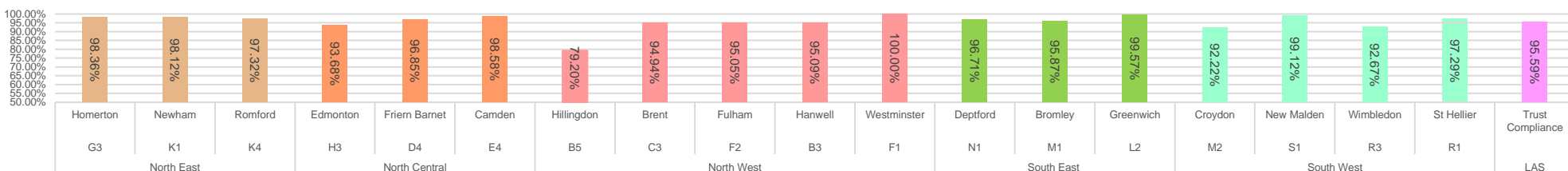
Trust compliance in September is reported at 95%, this meets the Trust target of 95%. In response to COVID-19, 6 vehicle decontamination hubs were organised at Brent – NW Sector, Isleworth – NW Sector, Bromley – SE Sector, St Helier – SW Sector, Ilford – NE Sector, Silvertown – NE Sector - was the hub where the Nightingale vehicles were cleaned.

DATIX reported Bodily Fluid Exposure(BFE) and contaminated sharps Incidents SEP-19 to SEP-20



The reported data of incidents is for contaminated sharps and BFE only- *clean sharps incidents have been extracted as these fall within Health & Safety remit, not IPC.* 13/19 incidents reported in September were as a result of exposure to body fluids (BFE). 6/19 incidents reported in September were as a result of contaminated sharps injuries

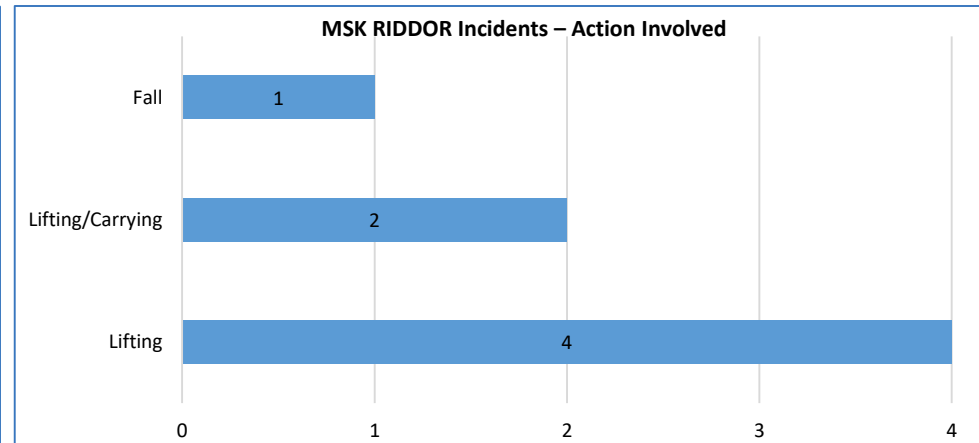
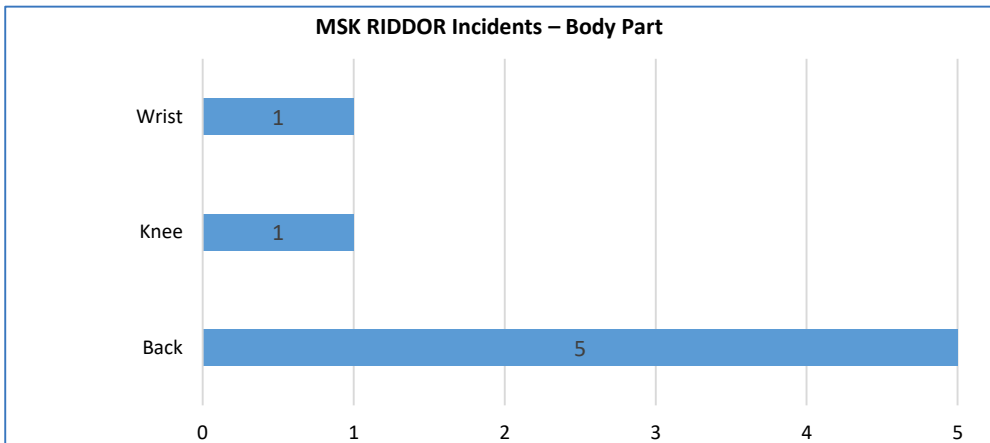
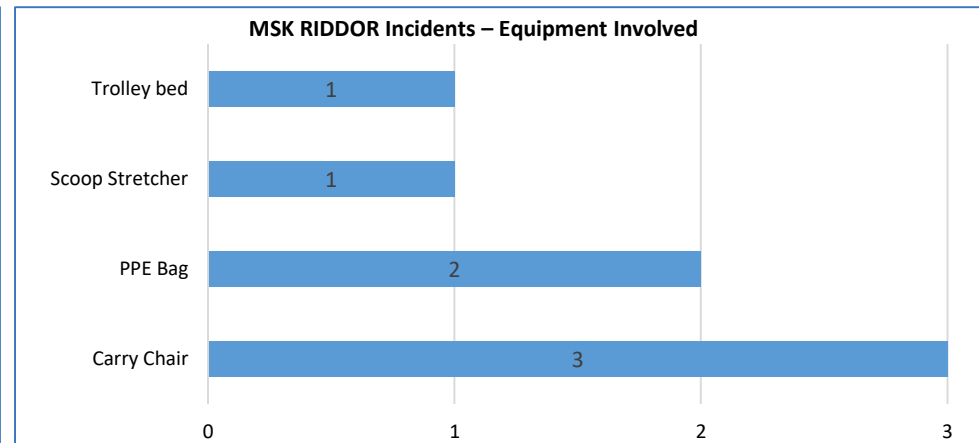
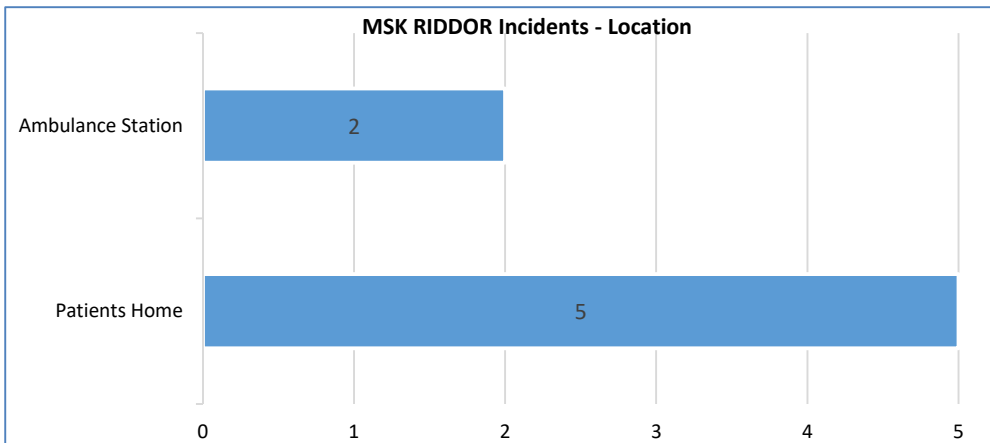
Premises Cleaning Audit - September 2020 (Target 90%)



18 /18 Group Stations/Services submitted data for analysis in September 2020, Overall Trust compliance for September remains constant at 95%. This score continues to exceed the Trust performance target of 90% In response to the COVID-19 situation, some Ambulance station premises have been temporarily closed to consolidate resources and therefore not all group stations were occupied. In those instances cleaning audits were not carried out. Stations that failed to achieve the required performance target of 90% have been escalated to the facilities manager, who has been asked to establish why this has happened and what remedial actions have been put in place by the contractor, Lakethorne.. **Actions:** Scores below 90% -escalated to facilities manager



Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) – September 2020



The above graphs provide details from the thematic analysis of 7 reported RIDDOR incidents in September 2020 (4 incidents occurred in August'20 and 3 incidents occurred in September'20). These relate to Manual Handling (MSK):

- 5 reported RIDDOR incidents occurred in Patients Home (n=5) and 1 in Ambulance station (n=1).
- 3 reported RIDDOR incidents involved using Carry chair (n=3), 2 incidents involved carrying PPE bag, 1 incident involved using Scoop stretcher (n=1) and 1 incident involved using Trolley bed (n=1).
- 5 reported RIDDOR incidents resulted in Back injury (n=5), 1 incident resulted in Knee injury (n=1) and 1 incident resulted in Wrist injury (n=1).
- 4 reported RIDDOR incidents occurred during lifting (n=4), 2 incidents occurred during lifting/carrying and 1 incident occurred due to fall (n=1).

**Violence & Aggression Incidents (Physical Assaults on Staff) Report– Findings & Actions - 2020/21 (up to end September'20)**Findings

- 63 assaults reported during September '20.
- The greatest number of reported physical assaults (54%) occur due to the clinical condition of the patient;
- Police attended 71% of physical assault incidents;
- 13 successful prosecutions for assault have been recorded (year to date);

Actions

- Criminal Justice Group has met and included representation from MPS Operation Hampshire Team.
- Link established with MPS Command Centre to work together to address hate incidents and hate crimes. MPS agreed to provide awareness training to managers in EOC and 111 around hate incidents and hate crimes and appropriate action to take following these. It is intended that this work-stream will then be rolled for operational managers.
- Health, Safety & Security team working with Comms raising awareness around violence and aggression.
- Guidance for different job roles involved in assault incidents being drafted.
- Survey on staff experience of violence and support to be presented to the Violence Reduction & Staff Safety Programme Board for agreement prior to launch.
- Violence Reduction Policy has been circulated for final agreement.

General

- Datix incident manager investigation to be amended to provide greater depth of data.
- Metropolitan Police's Operation Hampshire team participate in the new LAS Criminal Justice Group.

Latest Updates

- BWVC tender documents have been finalised and passed to procurement.
- LAS Comms have obtained National coverage of Violence Reduction Officer roles.



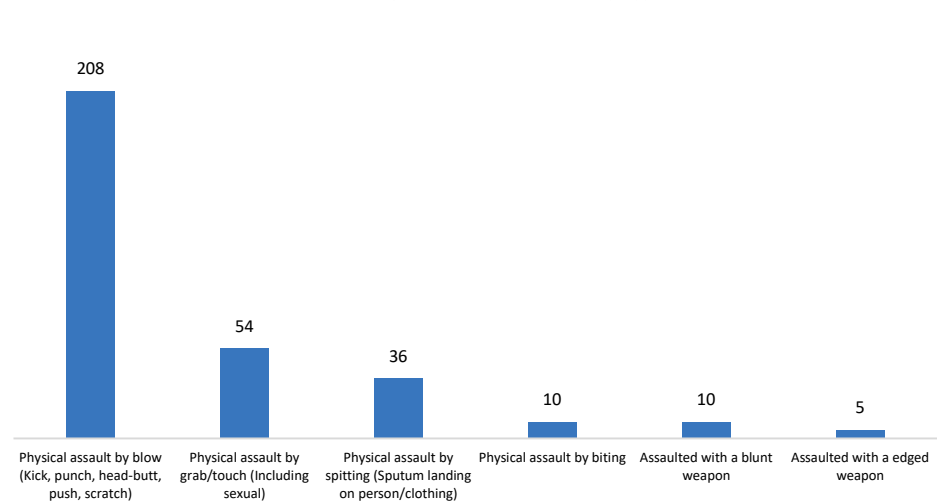
Number of reported Physical Assaults on Staff by Top 5 Sectors & Severity (YTD) – 2020/21



Notes:

- A total of 323 Physical Assaults on Staff were reported during 2020/21 (up to end September'20).
- 144 (45%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 179 incidents resulted in Harm. 176 (54%) of the harm related incidents were reported as 'Low Harm and 3 (1%) incidents were reported as Moderate Harm.
- 31 out of the 323 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc).

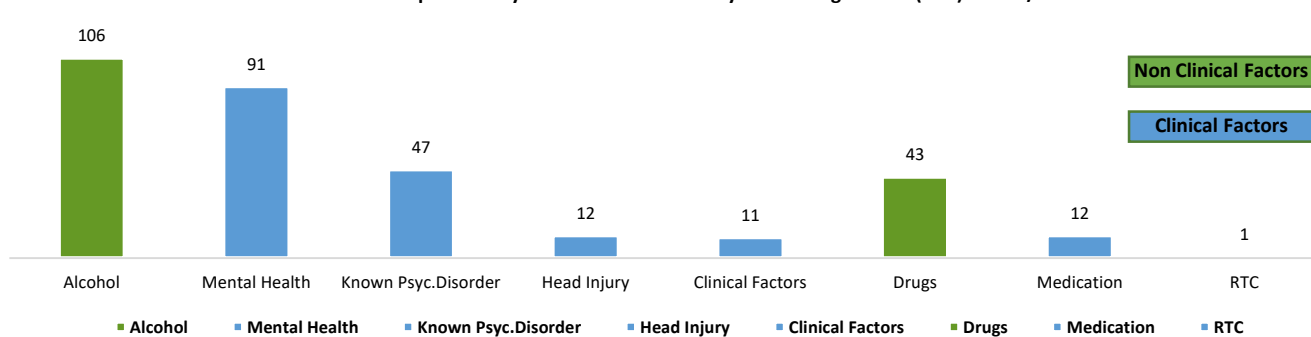
Number of reported Physical Assaults on Staff by Type (YTD) – 2020/21



Notes:

- Physical Assault – by blows, kicks/ assault to staff (64% , n=208) accounted for the highest number of incidents reported during 2020/21 (up to end September'20).

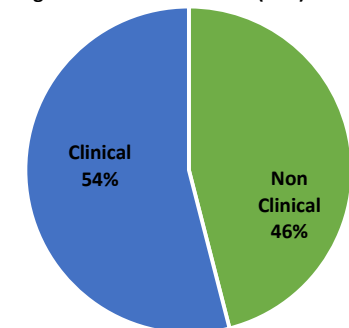
Number of reported Physical Assaults on Staff by Influencing Factors (YTD) – 2020/21



Notes:

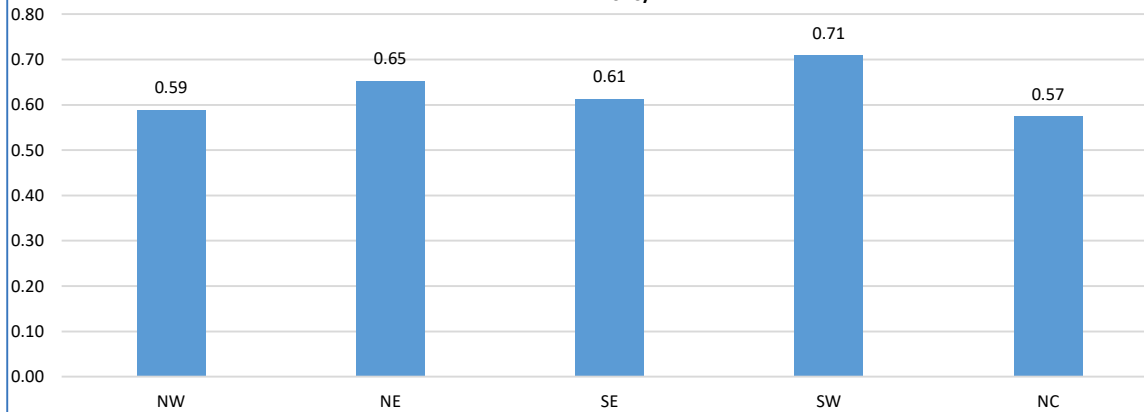
- Clinical Factor: 173 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=91), Known Psyc.Disorder (n=47), Head Injury (n=12), Clinical Factors (n=11), Medication (n=12).
- Non Clinical Factor: 150 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=106), and Drug (n=43) and, RTC (n=1).

Percentage Breakdown of Factors (YTD) – 2020/21





Rate of number of reported Physical Assaults on Staff by Sector per 1000 face to face Attendances (YTD)
– 2020/21

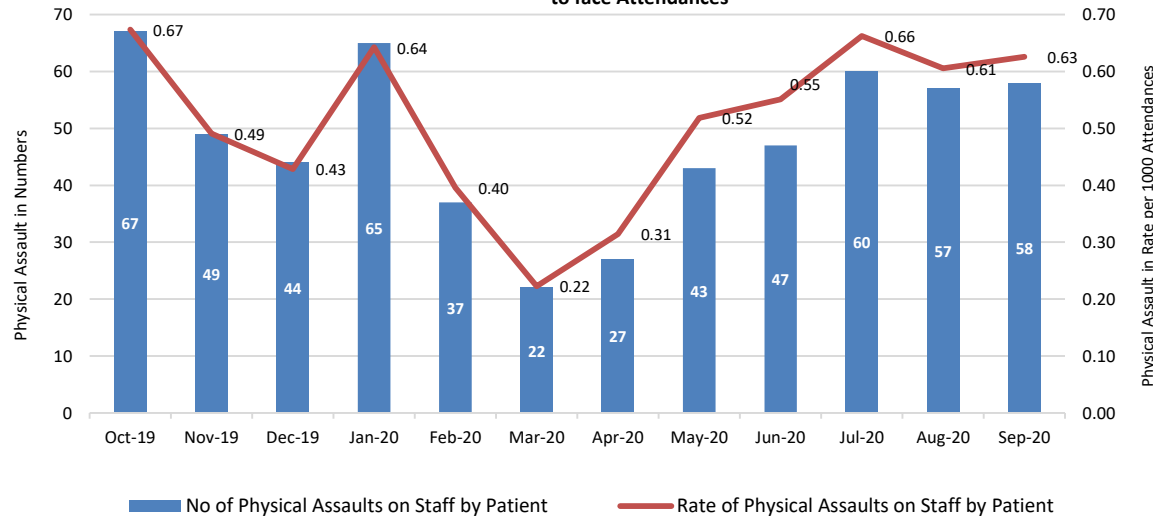


Sector	Rate of Physical Assaults on Staff
NW	0.59
NE	0.65
SE	0.61
SW	0.71
NC	0.57

Notes:

- The graph and dash board (left side) provides the Rate of reported Physical Assault on Staff by Sector per 1000 face to face Attendances.
- According to the number of reported incidents: In all 5 sectors, approximately one physical assault incident occurred per every 2000 face to face attendances.

No of Physical Assaults on Staff by Patient vs Rate of Physical Assaults on Staff by Patient per 1000 face to face Attendances



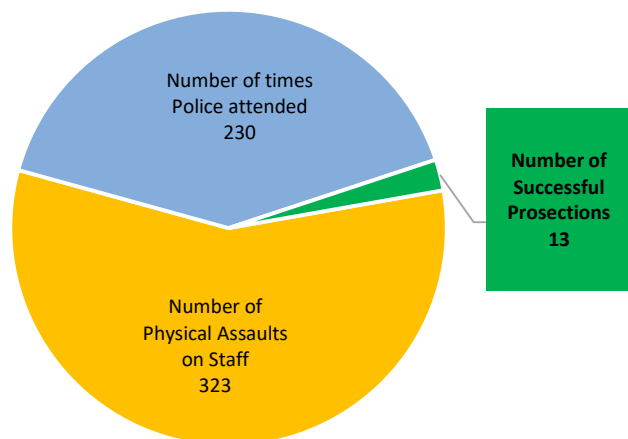
Month	No of Physical Assault on Staff by Patient	Rate of Physical Assault on Staff by Patient
Oct-19	67	0.67
Nov-19	49	0.49
Dec-19	44	0.43
Jan-20	65	0.64
Feb-20	37	0.40
Mar-20	22	0.22
Apr-20	27	0.31
May-20	43	0.52
June-20	47	0.55
July-20	60	0.66
Aug-20	57	0.61
Sep-20	58	0.63

Notes:

- The graph and dash board (above) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (October'2019 to September'2020).



Number of: Physical Assaults - Police Attended - Successful Prosecutions (YTD) – 2020/21



Total Number of Successful Prosecutions (2020-21)

13

Number of LAS Victims

16

Notes:

- Total of 260 physical assaults on staff reported during 2020/21 (up to end of September'20).
- Police were attended 184 occasions out of the 260 incidents.
- 13 cases were successfully prosecuted during 2020/21 and the outcome of the prosecution are given in the dash-board below.
- Further 11 cases are awaiting trial.

Prosecution Outcomes (2020-21)

Suspect got custodial sentence	11
Compensation awarded	5
Average compensation awarded per victim	£140

Breakdown of Prosecution Outcomes (2020-21)	Total
4 weeks imprisonment	1
28 days prison suspended for 12 months & £200 compensation	1
12 weeks imprisonment	1
12 weeks prison suspended for 12 months & £100 compensation	1
16 weeks imprisonment suspended for 12 months	1
3 months imprisonment suspended for 12 months	1
20 weeks imprisonment	1
26 weeks imprisonment	1
34 weeks imprisonment	1
7 months imprisonment	1
8 months imprisonment & £200 compensation	1
community order & £75 compensation	1
Conditional discharge for 9 months	1

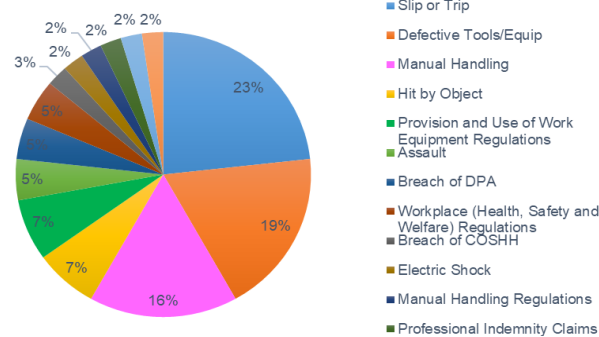
Claims:

Currently there is no claim made by staff member due to physical assault.

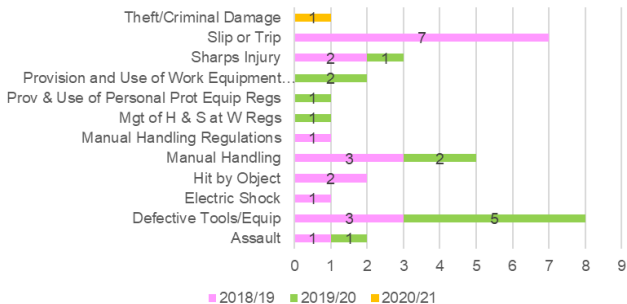


Owner: Sue Watkins Exec Lead: Dr Trisha Bain

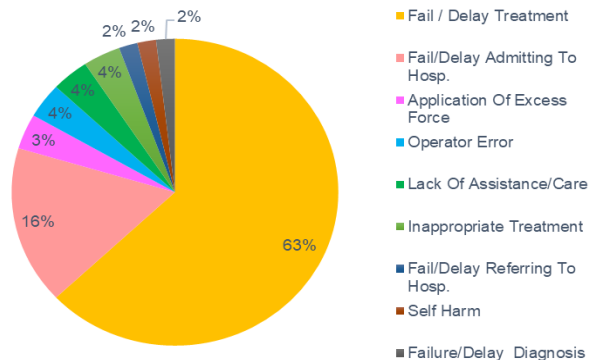
Current Non-Clinical Open Cases by Cause



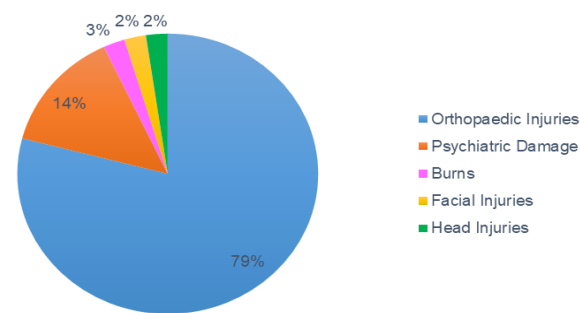
Closed Non-Clinical Claims by Cause



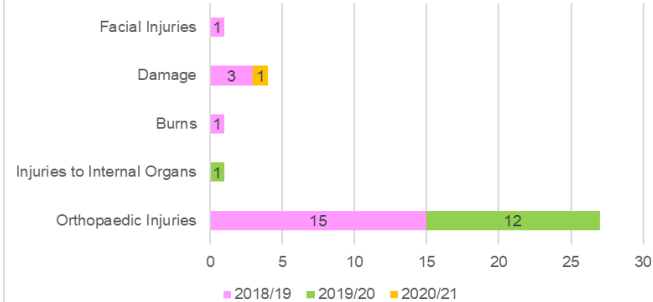
Current Clinical Open Cases by Cause



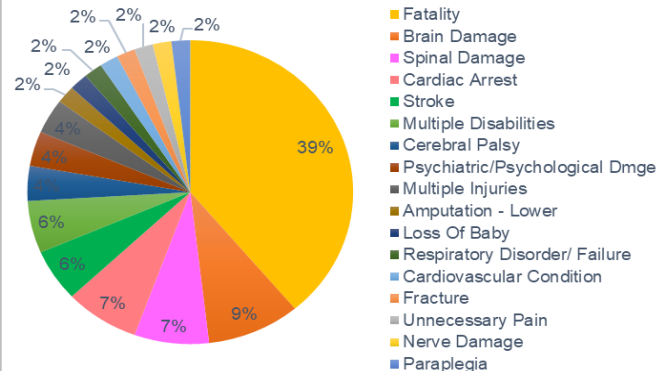
Current Non-Clinical Open Cases by Injury



Closed Non-Clinical Claims by Injury



Current Clinical Open Cases by Injury



Closed Non-Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	2019/20	2020/21	Grand Total
Assault	0	0	0	0
Defective Tools/Equip	£3,812.11	£9,564.00		£13,376.11
Electric Shock	£5,179.00			£5,179.00
Hit by Object	£2,233.30			£2,233.30
Manual Handling	£0.00	£4,523.00		£4,523.00
Manual Handling Regulations	£0.00			£0.00
Mgt of H & S at W Regs		£0.00		£0.00
Prov & Use of Personal Prot Equip Regs		£0.00		£0.00
Provision and Use of Work Equipment Regulations		£2,822.00		£2,822.00
Sharps Injury	£10,567.00	£7,573.80		£18,140.80
Slip or Trip	£26,991.60			£26,991.60
Theft/Criminal Damage			£0.00	£0.00
Grand Total	£48,783.01	£24,482.80	£0.00	£73,265.81

Closed Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	Number of Cases
Fail / Delay Treatment	£21,554.09	2
Fail/Delay Admitting To Hosp.	£3,724.65	1
Grand Total	£25,278.74	3

**New Inquest Activity – Q2**

A total of 413 Level 1 inquest were received for handling in Q2. Crew attendance has been required at 11 of these inquests, with the majority (during Covid) being held remotely, or not requiring any LAS clinical staff present. Statements and call records are provided for every inquest request. Representation was made to the Chief Coroner to consider making allowances for crew witness statements and attendance owing to the increased pressure on frontline services.

12 cases further cases were escalated to a level 2 problematic inquest.

No Level 3 Major Incidents has occurred, been opened in Q2 this year.

Active Inquest listings Q2

During Q2, a total of 202 Level 1 inquest and 13 Level 2 inquest were held.

An exceptional amount has been done in Q2 by the Legal team for some very difficult, high profile and problematic inquests for the Trust. These hearings commence late September and early October 2020.

Regulation 28 (Preventing Future Death) Reports

Non received in Q2 2020

September: 21 Quality Visits Completed
 87.37% average compliance (target: 90%)

Areas of positive outcomes

Offices – 90.58% overall compliance

- 95.24% - Clean and tidy
- 100% - No security codes or passwords on display
- 95.24% - Desks clutter free to enable cleaning and disinfecting to be undertaken

Kitchen – 95.18% overall compliance

- 95.24% - Clean and tidy
- 95.24% - Compliant with no unwrapped food on display
- 95.24% - Were displaying the cleaning contractor specifications

Garages & Equipment – 94.66% overall compliance

- 100% - Equipment inspected and tested
- 100% - Condemned equipment has been correctly disposed of
- 94.74% - Storage areas clean and tidy
- 95.00% - Fire Exits unobstructed

Dirty Utility Area – 91.23% overall compliance

- 94.74% - Clean and tidy
- 94.74% - Were displaying the cleaning contractor specifications

Areas of concern

Security - 85.90% overall compliance

- 60% - not challenged on site
- 50% - not challenged when entering the building
- 43.75% - vehicles were not locked inside garage/site

Medicines Management – 83.09% overall compliance

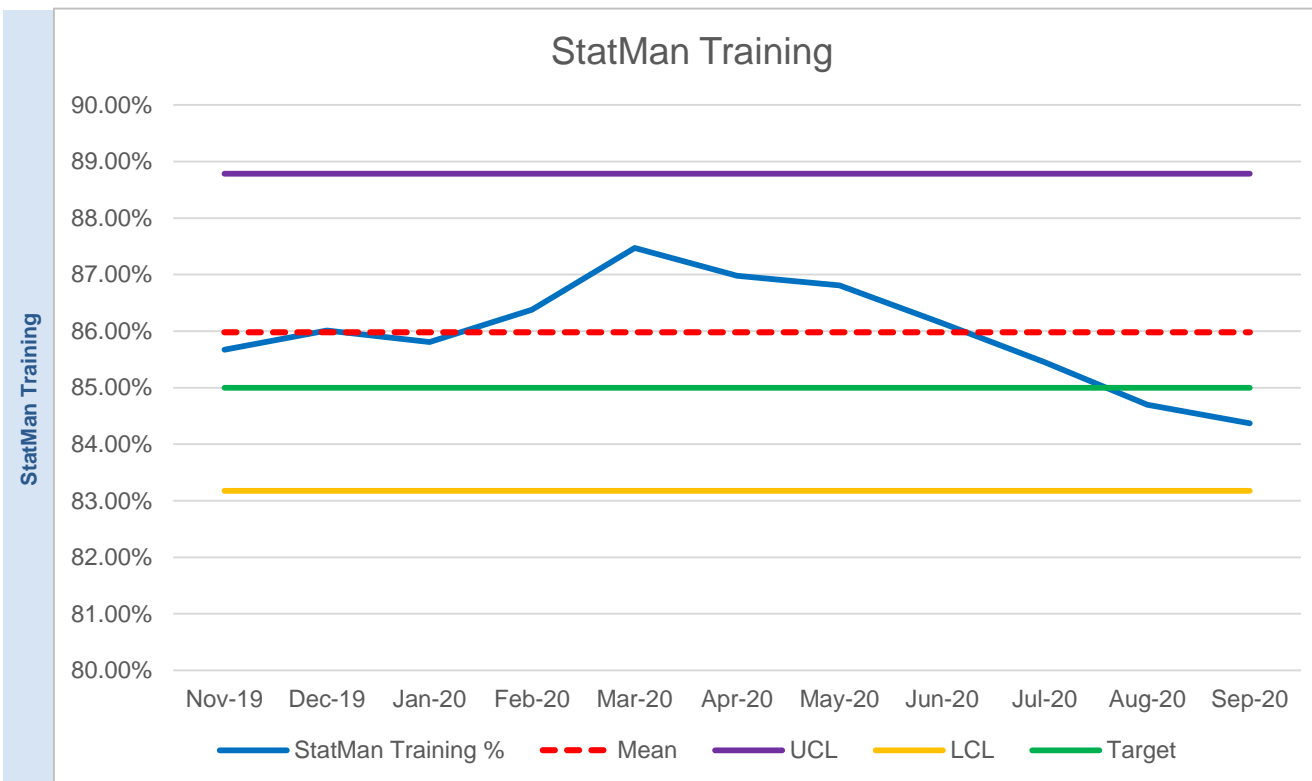
- 70.59% - No “shut it, lock it, prove it” posters visible
- 28.57% - medicines stock did not match Kit Prep
- 40% - no daily temperature checks carried out in drugs room

Noticeboards – 65.80% overall compliance

- 80.95% - No risk register on display
- 28.57% - No FTSU poster on display
- 38.1% - No Fire Marshall Named and displayed
- 57.14% - No information displayed on who the local team are
- 66.66% - No information displayed about the staff survey
- 14.29% - No Covid secure posters on display
- 19.05% - No IPC top tips on display
- 28.57% - Posters were not laminated
- 14.29% - No contractor cleaning audit results displayed

Covid Secure – 79.28% overall compliance

- 28.57% - felt there could be more Covid signage
- 33.33% - surface wipes were not available in all rooms with workstations/desks
- 42.86% - No max occupancy if rooms on display
- Unable to audit frequent touch points, as no clear process on requirements



- Statutory and Mandatory training – as at 30th September we are currently tracking slightly below our 85% target at 84.4%. The current Core Skills Refresher programme finishes at the end of November. This covers over 4,000 of our frontline staff and includes e-learning. We therefore expect to see an increase in compliance to above target by the end of November.:

Training Type	Jul %	Aug %	Sep %
Display Screen Equipment (3 Years)	85.23%	84.81%	85.71%
Duty of Candour (3 Years)	95.08%	95.13%	95.27%
EPRR Incident Response (Clinical) (1 Year)	66.34%	74.12%	80.21%
EPRR Incident Response (EOC) (1 Year)	86.20%	85.54%	86.04%
EPRR JESIP Awareness E-Learning (1 Year)	90.08%	69.32%	57.29%
EPRR JESIP Commander Classroom (3 Years)	60.00%	60.00%	60.00%
EPRR LAS Tactical Commander Foundation Course (3 Years)	80.00%	80.00%	80.00%
EPRR Operational Commanders (2015 to 2020) (3 Years)	40.78%	39.92%	34.53%
EPRR Tactical Commanders (Old Course) (3 Years)	0.00%	0.00%	0.00%
Equality, Diversity & Human Rights (3 Years)	80.43%	80.77%	81.56%
Fire Safety (2 Years)	93.84%	93.55%	94.11%
Fraud Awareness (No Renewal)	83.12%	83.03%	83.40%
Health & Safety Trust Board (1 Year)	63.64%	63.64%	63.64%
Health, Safety & Welfare (3 Years)	96.04%	95.77%	96.15%
Infection Prevention & Control Level 1 (3 Years)	95.96%	96.16%	96.44%
Infection Prevention & Control Level 2 (1 Year)	95.96%	95.54%	95.56%
Information Governance (1 Year)	90.89%	84.74%	91.18%
Medicines Management (1 Year)	96.67%	96.42%	95.99%
Medicines Management (NETS) (1 Year)	22.09%	22.09%	22.22%
Mental Capacity Act Level 1 (3 Years)	97.36%	97.05%	95.97%
Moving & Handling Level 1 (3 Years)	93.94%	92.98%	93.43%
Moving & Handling Level 2 (Load Handling) (3 Years)	79.38%	78.57%	77.55%
Moving & Handling Level 2 (People Handling) (1 Year)	91.57%	75.50%	56.36%
NHS Conflict Resolution (3 Years)	94.88%	94.68%	93.70%
Prevent Level 1 (3 Years)	95.66%	95.73%	95.85%
Prevent Level 2 (3 Years)	94.92%	94.54%	93.52%
Resuscitation Level 1 (1 Year)	72.66%	72.08%	73.06%
Resuscitation Level 2 Adults (1 Year)	87.80%	89.02%	88.96%
Resuscitation Level 2 Paediatrics (1 Year)	87.80%	89.02%	88.96%
Resuscitation Level 3 Adults (1 Year)	65.03%	65.26%	63.06%
Resuscitation Level 3 Newborn (1 Year)	64.88%	65.12%	63.04%
Resuscitation Level 3 Paediatrics (1 Year)	64.88%	65.12%	63.04%
Safeguarding Adults & Children Level 1 (3 Years)	96.78%	96.73%	97.02%
Safeguarding Adults & Children Level 2 (Clinical) (3 Years)	98.37%	98.05%	97.34%
Safeguarding Adults & Children Level 2 (EOC/111) (3 Years)	83.60%	79.40%	78.28%
Safeguarding Adults & Children Level 3 (3 Years)	22.95%	24.63%	24.52%
Safeguarding Trust Board (3 Years)	54.55%	54.55%	54.55%

2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Clinical Ambulance Quality Indicators
- NICE and JRCALC Guidance Updates
- Clinical Audit Performance
- Handover to Green
- PDR & MCA Training

Outstanding Characteristic: Outcomes for people who use services are consistently better than expected when compared with other similar services.



2. Effective

Clinical Ambulance Quality Indicators

Exec Lead: Dr. Fenella Wrigley

AQI: Narrative

Measures	Target / Range	YTD 19/20	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Movement	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	30%	33%	34%	29%	35%	33%		↔		LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	59%	77%	57%	59%	50%		↔		LQ1b		
Stroke on scene time (CARU continual audit)	00:30	31	32	32	32	32		↔				
Survival to Discharge (AQI)		8%	8%	7%	8%	6%		↔				
Survival to Discharge UTSTEIN (AQI)		26%	29%	27%	28%	14%		↔				
STEMI- On scene duration (CARU continual audit)		40	41	41	41	40		↔				
Call to Angiography - Mean (hh:mm)		02:09	02:27	02:12	02:09	02:05						
Stroke - Call to Arrival at Hospital - Mean (hh:mm)		01:10	01:10	01:06	01:10	01:16						
CPI - Completion Rate (% of CPI audits undertaken)	95%	90%	92%	84%	91%	87%		↔	✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD		7%	22%	27%	33%	37%		↔		LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	98%	98%	98%	98%	98%		↔	✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	97%	94%	94%	95%	95%		↔	✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	95%	94%	95%	94%	95%		↔	✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	97%	96%	96%	96%	96%		↔	✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)	95%	94%	94%	94%	94%	94%						
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%			98%		98%		↔		LQ12		

Cardiac Arrest

For February, 33.3% of OHCA patients had ROSC sustained to hospital (50% in the Utstein comparator group). This was down from 35.2% in January (59.1% in the Utstein comparator group). The LAS ranks 8th in Survival to discharge for both the Overall and Utstein group (5.9% and 14.3%) and both are below the national average of 7.2% and 20.0% respectively. Defibrillator downloads were submitted for 28% of patients in February.

STEMI

The average call to balloon time for STEMI patients was 2:05 in February, down from 2:09 in January. This was seven minutes faster than the national average (2:12) and LAS were the 5th best performing ambulance trust in England for this metric. STEMI care bundle compliance is reported quarterly and was not reported for February

Stroke

Mean call to hospital for suspected stroke patients was 1:16 in February which is second best in the country. The stroke diagnostic bundle for February was also published this month and shows the LAS achieved compliance of 97.8% which is below the national average of 98.3%. The LAS has therefore dropped from 7th in November 2019 to 8th in February 2020.

Sepsis

NHS England did not publish Sepsis Care Bundle data for February, the next data due to be published will be for June 2020 (in November). The latest data available is for December 2020, which saw the data at 94.4%, ranking 1st amongst all the ambulance services.

In response to the Covid-19 pandemic, the National AMBCO reporting from NHS England was suspended temporarily. Reporting has now recommenced and NHS England have published their catch up plan which sees full reporting resumed as of January 2021.

The LAS also suspended the Clinical Performance Indicators. These were reinstated on the 1st July 2020.

NICE Guidance:

NICE guidance is received and reviewed at the Patient Safety and Clinical Effectiveness Group (PS&CEG). The group recently reviewed the August updates and an initial review indicated that there was no guidance that would affect practice within the LAS.

JRCALC Updates:

JRCALC September clinical guidelines updates, consisting of five updates (Trauma, Head injury, IV fluids in adults, Limb trauma and sodium chloride) plus an introduction for vascular emergencies with changes. These updates are enhancements to relayed information. There had been no JRCALC updates for about a quarter.



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

Clinical Audit Update

- We finalised our re-audit examining the assessment of intoxicated patients. This 2020 re-audit evaluated whether actions implemented as a result of the previous clinical audits have improved the assessment of alcohol intoxicated patients. Although the vast majority of patients had a full initial assessment completed, documentation of a full event history continues to be an area of improvement for the LAS. Preliminary results of this clinical audit informed the amendment of the CSR 2019.2 Health Promotion mandatory e-learning, to focus on recording each element of the history of current event for intoxicated patients. To determine whether this, as well as the introduction of ePCR leads to improvements in the assessment of intoxicated patients, a further re-audit will be proposed.
- CARU granted approval for four new areas of clinical audit activity:
 - IUC CAS Anti-Microbial Prescribing Practice Monthly Review
 - IUC CAS Repeat Medication Prescribing Practice Monthly Review
 - IUC CAS Medication of Potential Misuse Prescribing Practice Monthly Review
 - IUC CAS High Risk Medication Prescribing Practice Monthly Review
- As a result of the Continuous Re-contact Clinical Audit, in August and September 2020:
 - 50 potential incidents were reported via Datix
 - 173 crews/clinicians were recommended for feedback (171 constructive and 2 positive)
 - 1 potential missed safeguarding referral was identified
- The CPI Guidance Notes were reviewed in line with changes resulting from the introduction of ePCR and version 8.3 was published in August. CPI training was delivered to 40 paramedics on restricted duties, three paramedics from the Clinical Hub (CHUB) and one paramedic from an Operational Placement Centre (OPC) in August and September. CPI auditors reported 11 potential incidents via Datix and contacted EBS to discuss the potential for 10 retrospective safeguarding referrals in August and September. CPI auditors are now able to view ePCR case summaries through the CPI database for the purposes of completing CPI audit. A technical issue prevented some users from viewing ePCR case summaries through the CPI database early September, but this has now been resolved.

Research Update

- A new research paramedic has joined our team and we are currently recruiting into a second vacancy. These paramedics will work on the ARREST trial as well as supporting the set up and delivery of future research projects.
- Good progress is being made on resuming recruitment into the ARREST trial after it was suspended due to COVID19 with most hospital sites now happy for us to resume recruitment. We are working towards resuming recruitment in October.
- We continue to liaise with the Sponsors of the AIR-CGM to work towards re-opening of this study.
- Staff Wellbeing in Ambulance Personnel (SWAP): The SWAP study's online survey was closed on 23rd September at which point 347 LAS staff had completed the survey in total. This well exceeds our given target of 100 surveys.
- What TRIage model is safest and most effective for the Management of 999 callers with suspected Covid-19 (TRIM): In September we sent BI data relating to 999 calls and a completed survey on our triage model to Swansea University as part of our participation in this study.
- STRategies to manage Emergency ambulance Telephone Callers with sustained High needs – an Evaluation using linked Data (STRETCHED): We confirmed capacity & capacity for STRETCHED on 27th August, marking the official opening of the study at our site.
- Sarscov2 Immunity & REinfection Evaluation: The impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in healthcare (SIREN): In September we liaised with the local Clinical Research Network (North West London) and the other Clinical Research Networks in London (South London, North Thames) to determine whether any acute NHS Trusts in the area have the capacity to offer antibody testing to our staff.
- We are working with academic and ambulance service partners to develop a number of future research projects and are anticipating joining the CRASH4 study as a pilot site towards the end of this year. This study will investigate the role of Tranexamic Acid in the management of elderly patients with mild symptomatic head injury.
- The launch of the new Major Trauma Triage Tool in London has potential implications for our delivery of the MATTS (Major Trauma Triage Tool Study) research project which we are participating in, and which is due to introduce a revised tool into one part of London in 2021.
- MIRACLE₂: The Head of Clinical Audit & Research co-authored a paper published in the European Heart Journal in July 2020 looking at a new risk-score to allow the early identification of neurological outcome after out-of-hospital cardiac arrest. There has been growing media coverage of the paper's findings and the tool has gained global interest. The aim is to now validate the tool across different healthcare settings which may lead to future clinical trials and potential incorporation into clinical guidelines.
- Student research: The start of the new academic year has brought an influx of student applications for Trust research approval. As the HRA is currently not accepting applications for undergraduate or MSc degrees, we have been working closely with students to provide advice on research governance and help them develop alternative proposals which do not require approval from the HRA, the NHS Research Ethics Committee (REC) or Confidentiality Advisory Group (CAG).

2. Effective Handover to Green

Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.

Please note: 999 performance data is correct as at 29/09/20 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We saw a slightly higher number of delays in August compared to July, with 688 hours lost from our arrival to patient handover over 30 mins. Queens Romford, North Middlesex and Whipps Cross had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the highest number of lost hours over 30 minutes, at 212 hours for the month.

Sector	Station Group	Handovers to Green	Handovers Exceeding 14 mins	%over 14 mins	Total Time Lost (hours)	Avg Time PH to Green	90th Centile PH to Green	Avg mins lost per breach
North Central	Camden	2,093	1,048	50%	139.7	14.6	26.6	8.0
	Edmonton	2,983	1,585	53%	195.2	15.1	26.3	7.4
	Friern Barnet	1,922	996	52%	106.1	14.5	24.4	6.4
North East	Homerton	2,688	1,352	50%	166.7	14.2	25.5	7.4
	Newham	3,305	1,783	54%	250.7	15.6	28.3	8.4
	Romford	3,571	1,923	54%	192.3	14.6	24.0	6.0
North West	Brent	3,744	1,822	49%	215.0	14.6	24.3	7.1
	Fulham	2,301	1,105	48%	119.3	14.3	23.5	6.5
	Hanwell	3,035	1,554	51%	131.7	13.8	22.3	5.1
	Hillingdon	1,623	731	45%	67.3	13.8	21.9	5.5
	Westminster	1,865	949	51%	103.5	14.3	24.7	6.5
South East	Bromley	2,915	1,605	55%	150.3	14.4	24.1	5.6
	Deptford	4,008	1,991	50%	197.1	13.9	23.3	5.9
	Greenwich	2,009	1,177	59%	93.2	14.9	22.5	4.8
South West	Croydon	1,967	1,127	57%	116.5	15.0	24.8	6.2
	New Malden	1,441	761	53%	69.7	14.4	23.0	5.5
	St Helier	1,484	859	58%	73.0	14.8	22.3	5.1
	Wimbledon	1,602	848	53%	87.4	14.4	23.9	6.2
Other	NULL	1,174	817	70%	75.6	14.5	23.9	5.6
	IRO	6	4	67%	1.1	20.4	36.1	16.5
	Other	668	384	57%	47.1	14.2	27.4	7.4
	Training	861	432	50%	49.5	14.5	24.1	6.9
	Bromley	2,915	1,605	55%	150.3	14.4	24.1	5.6
TOTAL		47,265	24,853	53%	2648.0	14.5	24.4	6.4

Patient Handover to Green

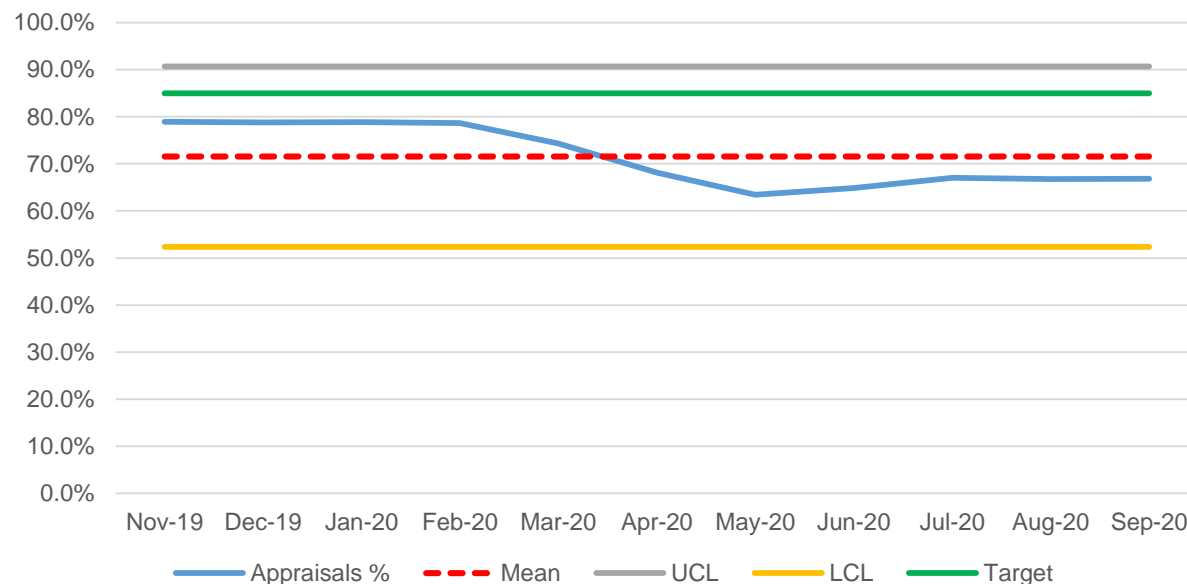
In August handover to green performance was similar to July, with a 14.5 minute average. However, over 2,600 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus to continue improving on the metric with action plans focusing on clarification of targets, improving the process and sharing good practice across sector.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,471	1,448	164	11%	16.2	20.3
	North Middlesex	2,612	2,573	533	21%	80.9	22.7
	Royal Free	1,703	1,653	180	11%	18.2	20.0
	University College	1,376	1,347	39	3%	4.8	15.2
	Whittington	1,350	1,313	69	5%	12.9	16.8
North East	Homerton	1,307	1,273	22	2%	2.5	14.4
	King Georges	1,178	1,153	176	15%	19.2	21.7
	Newham	1,754	1,689	190	11%	17.5	21.3
	Queens Romford	2,819	2,757	1,017	37%	214.7	29.4
	Royal London	1,787	1,705	123	7%	10.8	18.8
	Whipps Cross	1,714	1,665	369	22%	104.7	24.1
North West	Charing Cross	1,219	1,193	8	1%	0.9	13.0
	Chelsea & West	1,401	1,365	19	1%	1.5	15.6
	Ealing	1,330	1,310	29	2%	2.9	13.6
	Hillingdon	1,725	1,690	35	2%	3.5	12.7
	Northwick Park	3,106	3,058	103	3%	23.5	13.5
	St Marys	1,645	1,600	134	8%	17.0	17.7
	West Middlesex	2,076	2,031	36	2%	5.7	15.2
	Kings college	2,069	1,999	224	11%	20.7	21.4
South East	Lewisham	1,436	1,367	69	5%	9.0	17.4
	Princess Royal	1,897	1,802	119	7%	27.6	16.6
	Queen Elizabeth II	2,266	2,221	48	2%	5.7	13.0
	St Thomas'	2,182	2,117	88	4%	7.3	17.4
South West	Croydon	2,190	2,137	84	4%	9.6	18.2
	Kingston	1,659	1,615	54	3%	5.3	18.3
	St Georges	1,937	1,883	231	12%	25.9	20.3
	St Helier	1,320	1,301	97	7%	19.7	19.1
TOTAL		48,529	47,265	4,260	9%	688	18.3

2. Effective PDR & MCA Training

Appraisals

Latest Month: **66.9%**

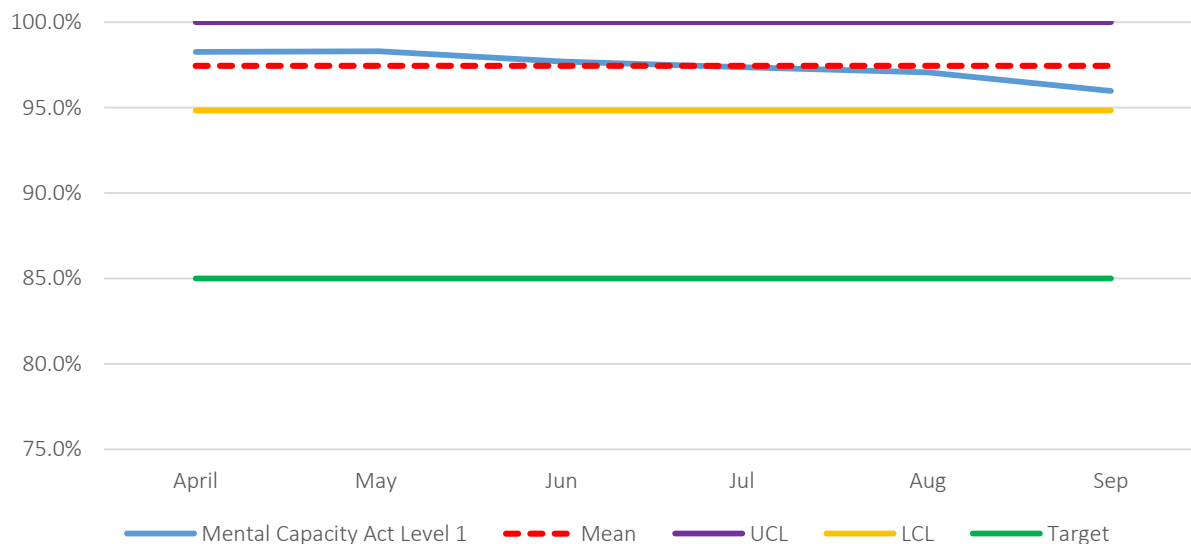


PDRs – we have seen a reduction in the PDR rate since March 2020 when we went to REAP level 4 and PDRs were put on hold. We are in the process of working with colleagues across Operations, 111, 999 and in Corporate teams to create trajectories to bring the PDR compliance rate back to the target of 85%.

The Trust wide OWR compliance is 43.45% against a target of 85%.

MCA Training

Latest Month: **96.0%**



We are currently not delivering Level 2. We are working with Clinical Education and plans are underway to include in 2021-22 CSR programme

3. Caring

We must ensure that the service involves and treats people with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Mental Health
- Maternity
- End of Life

Outstanding Characteristic: People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

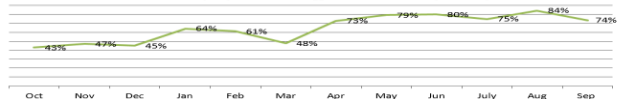
CMC Care Plans Tagged by LAS staff as relevant to the 999 call vs Viewed by LAS CMC user (last 12 Months)

LAS views are compared to tagged care plans – as any other kind of flag for the address or any address in the building raises a CMC flag at LAS – rendering flagged figures meaningless.



Note: Due to name & address issues at time of call and scope for inaccuracies, the tagging is likely to be on the conservative side. Therefore the LAS views may be a few % points higher than shown.

LAS (999) % Views of Tagged CMC Care Plans (2019/20)

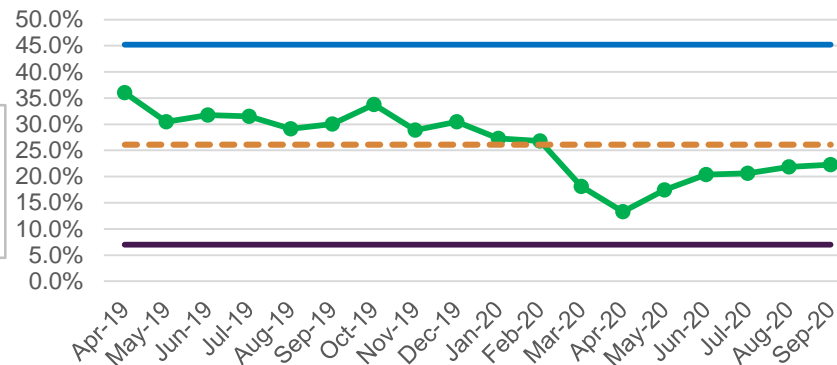


LAS (999) staff viewed 5279 CMC care plans in September, of which 4496 (85%) were via iPads (mobile devices).



ED Conveyance

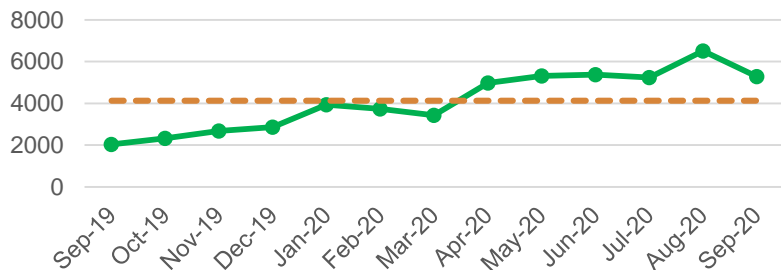
Latest Month (Sep):
22.3%



The CMC viewing figures continue to improve. Action: Pilot role of CMC changed parameters to address current CMC risk of plans without flags

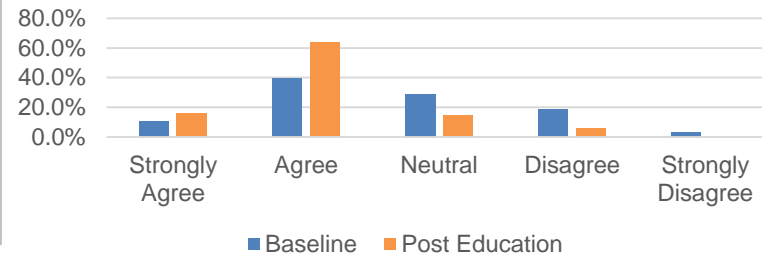
ED conveyance continues to be lower than earlier in the year. coordinator in EOC has Action: Re-audit of EoLC in LAS completed and for analysis

CMC Views



Staff Confidence

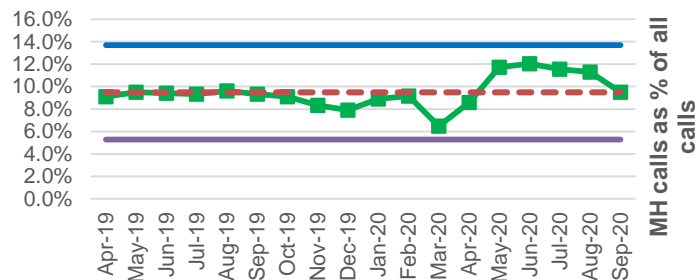
80% staff post education felt confident
30% increase from baseline



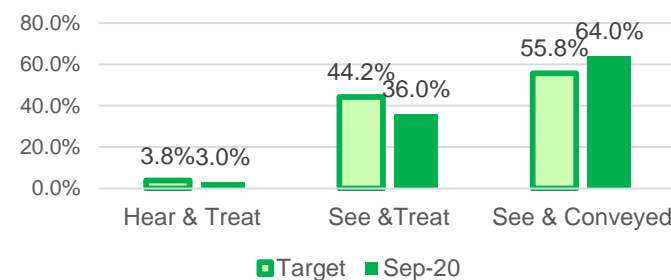
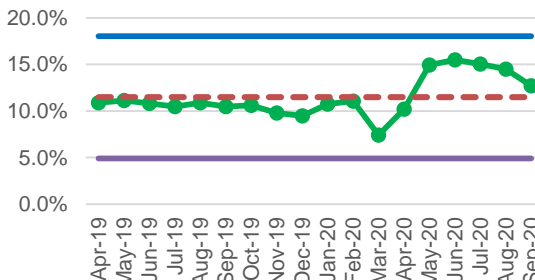
The EOL Team have supported the development of the 87% App as part of the Wellbeing hub

Creation of more appropriate care pathways for advice and support.

MH Incidents as % of all incidents



MH calls as % of all calls



Following on from the publication of the Evaluation of the Mental Health Joint Response Cars (MHJRC) we are discussing next steps regarding funding. We have presented the model nationally via an NHS England webinar on the Long Term Plan monies for ambulances and at a Royal College of Psychiatrists event. We are also due to feature in the HSJ. We have trained new paramedics and they start week commencing the 12th October so we will have maximum coverage of MHJRC. The team have reported an increase in acuity of presentations which may correlate to the increase in conveyance rate.

Maternity Performance Review Dataset:

First meeting with data scientists and Business Intelligence Team

- Understand the overall maternity incidents and those resulting in ambulance dispatch and ED conveyance
- Present key metrics where service improvement can be measured and appraised
- Share dashboard with other ambulance services to establish best in class

Highlights and Our Service Values:

Respectful

Staff support provided by Maternity Team in the event of challenging maternity care episodes

Innovative

Registration with Care Quality Commission for maternity services – pilot standards to be developed with CQC for ambulance services

Professional

Maternity specific Clinical Team Manager Training
Maternity Thematic Review including external panellist to provide learning and assurance

Collaborative

NEL Pilot for Maternity Improvements including test of dedicated maternity Clinical Team Manager

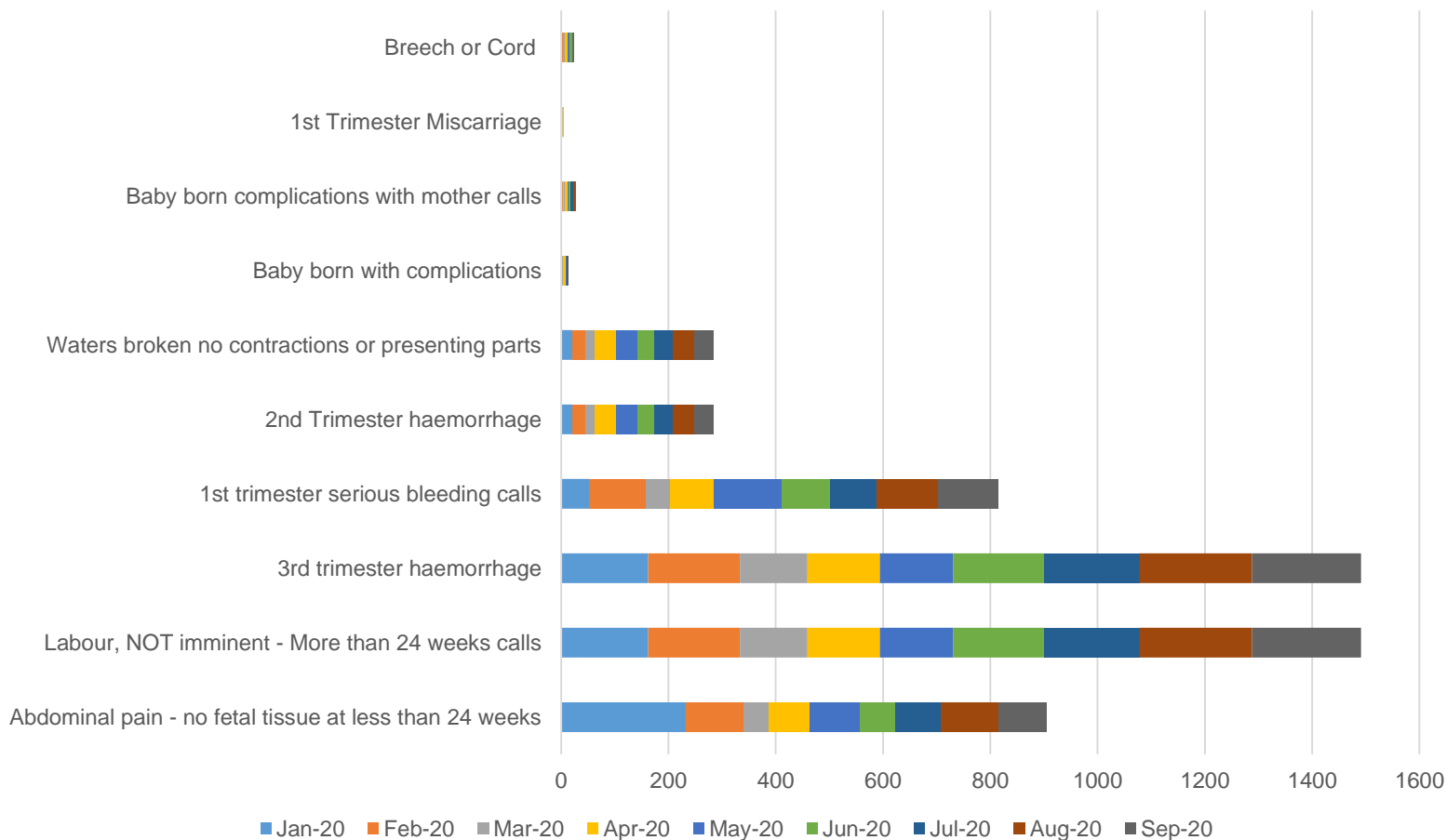
Exceptions (Improvement required):

Healthcare Safety Investigation Bureau – Review of reports and learning challenging team capacity – Plan for Business case submission for Practice Development Midwife

Outstanding

- Maternity dataset
- Capacity to deliver maternity training – Awaiting update in regards to business case submission for Band 7 Practice Development Midwife
- Updating website due to change over to new platform

Maternity Calls Jan'20 - Sep'20



Maternity 3 Top Priorities:

- 1) Test new PPH Screening and Action Tool
- 2) Transfer of online maternity training onto Oracle Learning Management System aligned to ESR
- 3) Annual training education plan

4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Frequent Callers
- Complaints

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*

National definition of a **frequent caller** is anyone aged 18+ years who:

- Calls 5+ times in one month from a private dwelling; or
- Calls 12+ times over a three month period from a private dwelling

New & existing callers	647
NHS numbers matched	100%
Stakeholder meetings online	62

Highlights:

- Increased numbers of new CMC records are being uploaded for frequent caller patients pan-London.
- The Frequent Caller Team attended the initial LAS Criminal Justice Group, and are hopeful this forum will help escalate complex patients who require legal boundaries.
- SIM project (mental health & police) frequent callers in both Camden & Islington, and Enfield, have shown downwards trends in call rates since January 2020.

Lowlights:

- Awaiting dedicated BI input.

Plans for October:

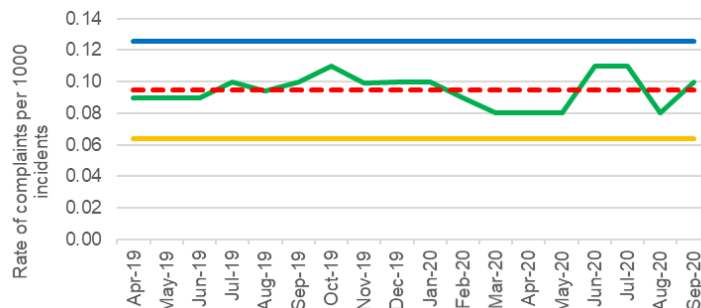
- Paper being presented at CQRG re. frequent callers, CMC and SIM plans, and Restricted Send trial (Dr Tim Lightfoot).
- Frequent Caller Team Intro/Q&A session being offered to NEL ops staff.

Cluster	CCG	Patients	Sep-20	Calls last quarter	Calls last 12 months	12 month cost
NC	ENFIELD CCG	35	518	1351	4355	£508,557
NE	CITY AND HACKNEY CCG	39	476	1338	3303	£431,039
NC	HARINGEY CCG	30	384	981	2846	£340,835
NW	EALING CCG	30	355	1217	3132	£433,953
NE	WALTHAM FOREST CCG	28	351	790	1913	£220,857
SE	LAMBETH CCG	22	328	985	3070	£331,257
NE	HAVERING CCG	14	313	850	1961	£233,323
NE	REDBRIDGE CCG	22	306	798	2970	£264,433
SW	CROYDON CCG	31	294	827	2146	£341,525
NC	BARNET CCG	33	270	861	2294	£305,933
NW	HILLINGDON CCG	25	268	652	1660	£241,753
NW	WEST LONDON CCG	26	264	822	2141	£283,989
SE	SOUTHWARK CCG	24	248	692	1804	£249,604
SW	WANDSWORTH CCG	19	248	661	1588	£192,669
NE	NEWHAM CCG	25	246	705	2023	£288,017
NE	BARKING AND DAGENHAM CCG	15	245	726	1642	£228,275
SE	GREENWICH CCG	18	243	794	2180	£268,647
NW	HOUNSLOW CCG	15	237	681	1844	£183,322
NW	BRENT CCG	18	231	521	1009	£130,846
SE	LEWISHAM CCG	21	211	752	2230	£308,965
SE	BROMLEY CCG	16	191	474	1253	£201,191
NW	HARROW CCG	17	190	424	1414	£190,595
NC	CAMDEN CCG	16	176	532	1635	£207,517
SE	BEXLEY CCG	19	159	559	1528	£173,456
NW	HAMMERSMITH AND FULHAM CCG	18	153	421	952	£140,802
NW	CENTRAL LONDON (WESTMINSTER) CCG	13	129	345	1147	£156,239
NC	ISLINGTON CCG	15	123	421	969	£141,897
NE	TOWER HAMLETS CCG	9	113	302	1323	£182,487
SW	RICHMOND CCG	11	105	278	680	£98,016
SW	MERTON CCG	9	77	281	973	£161,659
SW	KINGSTON CCG	6	45	106	295	£55,668
SW	SUTTON CCG	8	44	160	435	£83,920

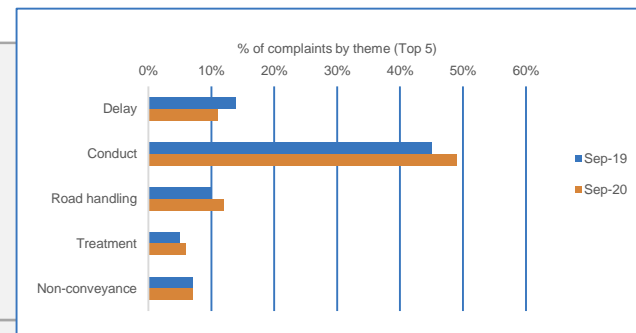
Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

Rate of Complaints

Latest Month:
0.10



Categorisation



September resulted in more complaints than August (78/90).

We managed 652 PALS enquiries and continue to use the spreadsheet introduced during Covid-19 months as this has proven successful for recording more straightforward enquiries.

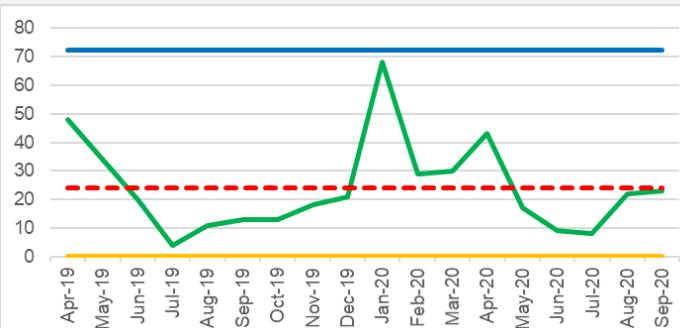
We managed 31 Quality Alerts in this period. Of these, ten were reported internally

Conduct and behaviour complaints currently account for over half of total complaints received in 2020/21 to date. There were 16 complaints attributed to NHS111 in in September, 11 related to NELIUC and 5 from SELIUC.

We are supporting the Business Partner model in the NE Sector and IUC. We are aiming to improve the process for capturing learning from complaints and ae liaising with the QGAM's for this.

Responding to complaints

Latest
Month: 23



There were 23 complaints that breached the target response during September. The complexity of complaints results in input being necessary from Control Services as well as Operations and ultimately from the Medical Team. It is inevitable that delays in preparing response will result as all of these areas have demands elsewhere.

Currently there are 16 complaints awaiting a Quality Assurance Report, 16 awaiting a clinical opinion and 9 awaiting operational input.

We continue to receive support from the Medical Directorate to prepare clinical opinions by doubling up of duty clinicians which has improved throughput

Actions and Learning

Patient Experience - September

The collaboration with the NE Sector and the IUC area of our portfolio is progressing with a number of improvements already identified. The full results of the trial in these two areas will be evaluated prior to consideration for Service roll out.

As part of the PSIRF project we have submitted a number of cases examples and continue to participate in the project which will shortly be advertised to all staff

To assist with this process we aim to make further improvements to Datix in the way we record learning from the work we undertake.

The Ombudsman is working on the Complaints Standards Framework which sets out a single sets of standards for staff to follow and will provide standards for leaders to help them to capture and act on the learning from complaints

NHS digital will resume the collection of the KO41a data with Q1 and Q2 to be provided during October. It is their intention to publish the data they have collected on December 2020

5. Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*

5. Well Led Learning From Our Actions



Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley



In September 87 **Excellence Reports** were submitted
The number of **Excellence Reports** has maintained over the last few months.

Key themes identified from September reports includes:

NQPs:

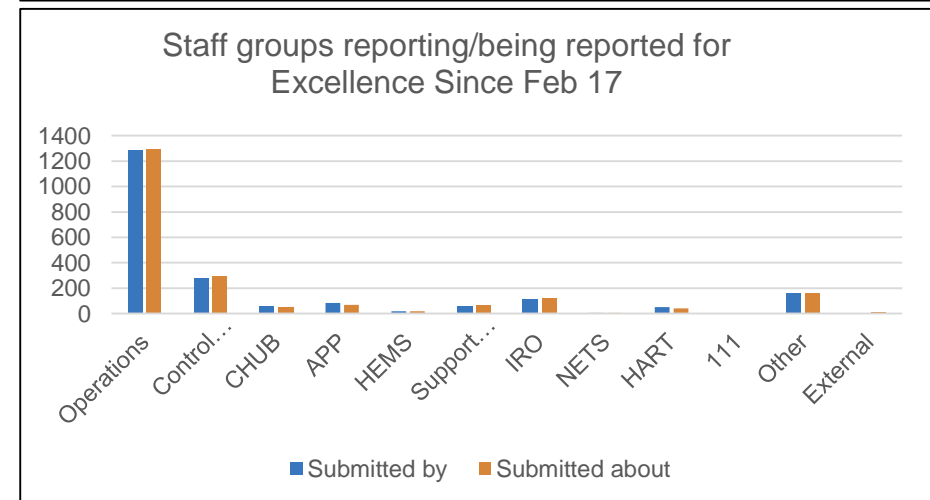
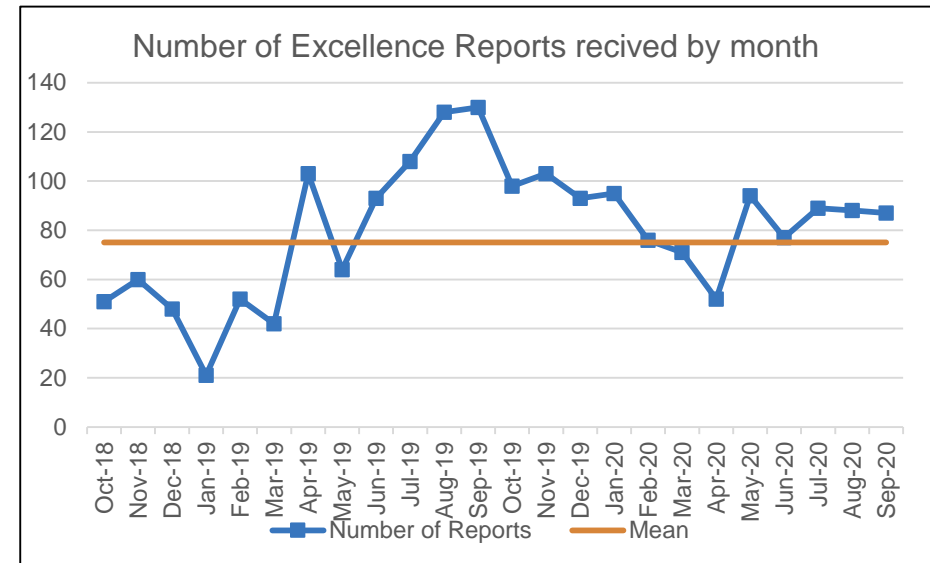
- ☐ Feeling supported and guided throughout difficult jobs
- ☐ Showing initiative and using ACPs in the best interests of the patient
- ☐ Excellent scene management on cardiac arrests

Cardiac arrest management

- ☐ The actions the crews took before my arrival were critical to ROSC being achieved. These interventions were thought through and undertaken rapidly.
- ☐ She set out roles including a sterile zone with a sterile member of staff to move equipment, while carrying out extended skills on this traumatic cardiac arrest.
- ☐ Paediatric arrest treatment on scene before conveyance, resulting in ROSC of patient
- ☐ Great leadership on scene with clear instructions

Team work:

- ☐ Excellent management of a life threatening 5 year old asthmatic.
- ☐ The communication and team work on this call was of the highest standard, with all colleagues working together within their given roles to provide the patient with the best care possible.
- ☐ They dealt with a very confusing situation by setting out a plan, and achieving it without fuss or creating any further distress to the patient or family on scene.





Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley

Some examples of excellence reports reported in September:

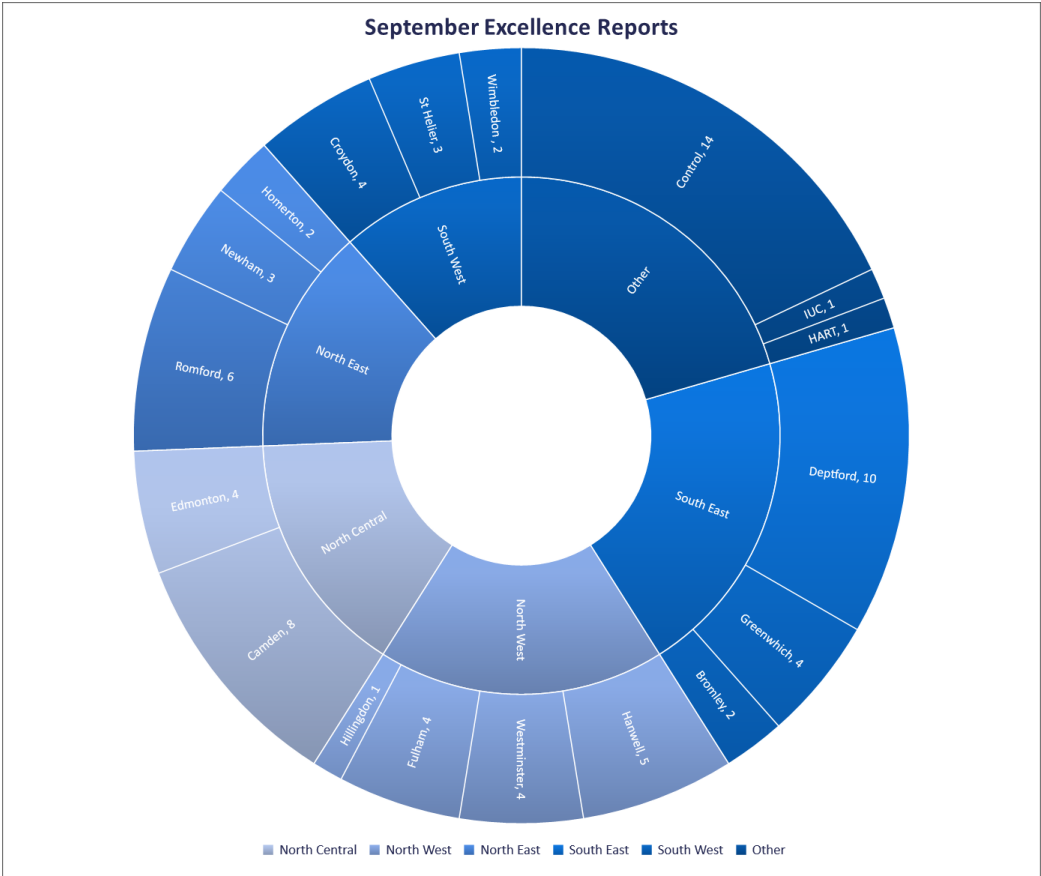
This was his first time working on paper and he quickly got into the flow, demonstrated his adaptability to different situations and very quickly became the star of night. He was always smiling, always happy to help and always knew which vehicles were off the road, where they were and what he needed to do.

Arriving on scene, donning PPE and arriving at hospital was only 34 minutes, which included a 17 minute travel time. Fast recognition of critically unwell patient, short on-scene time, early treatment of hypoxia, stepwise airway management and cardiac arrest management. Adrenaline 1:1000 IM administered correctly as patient critically unwell with a sudden onset of DIB of unknown origin. Excellent clinical care was administered to this patient and the crew should be commended.

Attending an elderly female complaining of an acute loss of mobility. His bedside manner with the patient was of the highest standard, demonstrating his vast experience to build a rapport with the patient. I was so impressed at how respectful and professional he was, whilst making us all laugh at the same time. His approach to assessing this patient should be championed and I'm sure many students could learn a lot from how he put's a patient a ease. I'm sure the patient had a positive experience with our service, much of this was due to his communication skills.

He recognised an opportunity to build relationships with educators from local hospital trusts and set about arranging some continuous professional development sessions.

Even during these difficult times these CPD events still managed to go ahead. I am informed that these CPD days were of a very high calibre and the team members that attended found the events very beneficial.



Risk Management Scorecard

Risk Management

Against the Trust KPIs:

86.9% of risks have been reviewed within the last 3 months – target 90%
 90.9% of all risks approved within 1 month in September– target 90%

The risk team have begun to devolve risks to local management level starting with risks being reviewed and updated by sector teams at the Sector Quality Governance meetings. The risk team continue to review and support corporate areas with their management of risk, there has been some changes in leadership and these individuals are being trained which will see further movement of some overdue risks.

Corporate Trustwide Risk Register

	Negligible	Minor	Moderate	Major	Catastrophic	Total
Almost certain	0	0	0	0	0	0
Likely	0	1	2	7	0	10
Possible	0	0	6	7	2	15
Unlikely	0	0	0	0	1	1
Rare	0	0	0	1	0	1
Total	0	1	8	15	3	27

Risk Assurance and Compliance Group (RCAG)

The RCAG review all red (15 and above) scored risks on a monthly basis, including those held in the Corporate Trustwide Risk Register as well as those held on other risk registers across the Trust.

The group have started to review the risks monthly in terms of movement to ensure that risks are, where relevant, moving as required, tolerated or escalated for actions through the Trust.

In the last month, there were 9 red risks on the Corporate risk register with one risk de-escalated and closed. This is demonstrated in the movement table to the right of this text.

ID	Sector / Department	Description	Initial Risk Score	August Risk Score	September Risk Score	Current Risk Score	Change in Risk Score:	Progress Notes:
844	Fleet and Logistics	There is a risk of project slippage due to an undefined technical solution (Kit prep / Wifi) for medicines packing and management at Logistics Support Unit Deptford.	20	16	Closed	8	↓	Closed Risk
910	Finance	There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU.	16	16	16	16	↔	Due for 6 month review in October
949	Medical Directorate	There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected.	15	15	15	15	↔	End to end review conducted. Flaws in system due to be resolved by October.
973	Estates	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons	15	15	15	15	↔	Ambulance modernisation programme to address risk.
1032	Information Management & Technology (IM&T)	There is a risk that EOL hardware is unsupported due to a previous lack of funding. I	16	16	16	16	↔	CIO has engaged analyst Masons to formally review end of life process and build business case
1050	Fleet and Logistics	There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the vehicle or primary response bags due to errors by Vehicle Preparation Team or being misplaced by staff	16	16	16	16	↔	Trial process agreed but due to Kitprep resourcing will be delayed until December.
1081	Fleet and Logistics	There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence.	16	16	16	16	↔	Licence can be applied for once new packing unit complete and registered staff are in post.
1112	NHS111	There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Awaya system	16	16	16	16	↔	Work is yet to start to upgrade each phone.
1131	Medical Directorate	There is risk that the management of medicines could be severely compromised due to the contract for Kitprep, which is due to expire on 31/10/20	16	16	16	16	↔	Contract agreed for renewal for 12 months but need to source new platform/supplier
1133	South East Sector	There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes	15	15	15	15	↔	Incidents being collated. LAS attending Emergency Services Working Group with TfL and Local Authorities. CEO met with Mayor of London.

The LAS has a tiered system for incident learning, which encompasses individual learning via specific support and feedback, sector level monitoring and action on incidents to higher level thematic / strategic learning within sectors, and across the Trust.

The Trust also ensures that those involved in complaints and SIs receive face to face discussion, personal reflection and feedback. The Quality Governance and Assurance Managers (QGAMS) support learning alongside Senior Sector Clinical Leads with local operational team meetings and Sector Quality Meetings. All teams are now thinking differently with regards to how learning can be shared whilst adhering to social distancing measures.

Incident and SI Learning Events

The first of a series of Learning Briefings took place on the 18th September where operational managers were invited to attend a session dedicated to the SI process, the learning from recent SIs and the COVID-19 review. This was very well received by those who attended and the slides were disseminated to all operational managers to share with their respective teams. A second event is planned for October to provide the same insight to Control Services managers with a view that November's meeting will be attended by managers from all areas of the Trust.

The first virtual SI case review event took place 29th September where six serious incidents were discussed in a case study format in addition to the findings of the COVID-19 review. 68 members of staff from across the organisation attended and engaged in the session where the cases were presented by lead investigators and members of the Quality Improvement and Learning team. The session was interactive with the use of polls and the encouragement of group participation. A short survey was completed by participants at the end of the session to identify areas of improvement. The results identified that:

- 96% of participants would recommend the SI case review session to a colleague or friend.
- 97.5% of participants rated the session as very good or excellent.
- 52.5% of participants were from a clinical setting with 15% from EOC. No participants were from the 111/IUC service.
- 87.5% of participants advised that the length of the session was 'about right' (2 hours).
- When asked what they liked about the event, participant comments included:
 - "good focus on improvement and not scrutinisation"
 - "variety of information and real life experience to learn from"
 - "The chosen cases were something we could all relate to. Great selection for EOC and road clinicians"
 - "I liked how everyone was respectful and we all had a chance to contribute"
 - "The case selection was really good and I liked that it involved cases involving 999, 111, COVID call handling and Ops. I also think having a mixed group of EOC, IUC and Ops staff attendees is really good for insight into the working challenges of others."
 - "The openness and promotion of coming forward without being subject to punishment."




Complaints

Complaint via SELIUC from the patient regarding the failure of the Text Relay Service to call her back

The review has found that this is a national issue with Adastra, the clinical patient management system for urgent healthcare settings, including NHS 111, out-of-hours clinics and community pharmacies. Adastra shortens the length of the telephone number when it is added with a text relay number. When the telephone number comes into Adastra, only the first 11 numbers appear.

Therefore when the clinician attempted to call the patient back, they were unable to do so as the number was incorrect.


This was a previously unidentified technical issue with Adastra which has now been raised and escalated locally and with Adastra nationally to ensure a solution can be found.



Serious Incident Case Discussion

Quality Improvement and Learning Team

September 2020



Safeguarding

As part of National Ambulance Safeguarding Awareness week during 14th -18th September, the Trust provided training to staff as well as externally Tweeting using #Ambsafeguarding on a range of national topics including,

- Professional standards and conduct,
- Communicating with Vulnerable Patients
- MCA Fluctuating Capacity & Substance Misuse

The following learning points were also shared across the Trust:

- Allegations of abuse or neglect against staff should not be recorded on datix.
- Staff and managers should follow HR39 policy
- If staff have a concern about a colleague or an allegation is made against a colleague this should be reported directly to their line manager and it should be reported directly to the Head of Safeguarding & Prevent.
- Managers should refrain from informing other managers. The Head of Safeguarding & Prevent and the Executive will discuss actions with senior managers in the relevant area.
- The investigation will be undertaken locally via the disciplinary procedure.
- The Head of Safeguarding & Prevent will when necessary inform the Local Authority Designated Officer & Police colleagues and will also ensure appropriate external reporting.
- Following investigation the investigating manager should inform the Head of Safeguarding & Prevent of outcome.
- The Head of Safeguarding & Prevent will review all open cases with the executive review team.
- Following investigation HR Managers will be responsible for informing DBS, Professional bodies and other organisations if appropriate.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Serious Incidents (SIs) and SI Thematic Reviews			
Agenda item:	For Information			
Report Authors:	Helen Woolford, Head of Quality Improvement and Learning April Wrangles, Senior Quality Governance Manager			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	Update on SIs closed by CCG and quarterly thematic report			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
<p>These papers provide an update on Serious Incident Investigations and includes:</p> <ol style="list-style-type: none"> Executive summaries of SIs closed in August and September 2020 Q1 SI thematic report. 				
Recommendations for the Board:				
The Trust Board is asked to note the information provided within the report, and provide feedback to the Head of Quality Improvement and Learning.				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	x	No		Chief Quality Officer
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		



Executive Summaries of 8 Serious Incidents closed by the Clinical Commissioning Group in August 2020

Incident description:

2020/2117 – ID 36240

The London Ambulance Service (LAS) received a 999 call to attend a 72 year old male who was reported to be not alert with an elevated capillary blood glucose reading of 39 (Hyperglycaemic). The call was triaged and was assigned a Category 2 response priority which has a target mean response time of 18 minutes and a 9 in 10 response time of 40 minutes. A Doubled Crewed Ambulance (DCA) was dispatched to the call and arrived on scene achieving an overall response time of 36 minutes.

It was reported by family members the patient had been struggling to control his glucose levels and was experiencing a reduced appetite. The patient was known to be a Type II Diabetic for which he was medicated with Gliclazide, Metformin and Insulin.

It was identified that the patient was having an episode hypoglycaemia (low blood glucose levels) and the patient was encouraged to eat carbohydrates as well as a sugary drink. The clinicians identified that the patient's blood glucose monitor was faulty and had produced an incorrect reading.

Once the glucose levels were back to a normal range, a referral was made to an out of hours (OOH) General Practitioner (GP) who advised the patient to reduce their insulin administration and speak to their own GP when the surgery next opened (three days' time).

Eight hours later, and the following day, a second call was received reporting that the patient's blood glucose level was unstable and that the patient had been incontinent of urine. During the call the patient deteriorated into cardiac arrest and the call was triaged reaching a Category 1 response priority which has a mean target response time of 7 minutes and 15 minutes in 9 out of 10 occasions. Multiple resources were dispatched with the first arriving on scene achieving a response time of four minutes.

The patient was resuscitated and a return of spontaneous circulation was achieved and was conveyed under emergency conditions to the nearest emergency department. The patient was sadly reported to have died the same day.

Immediate risk mitigation:

Supported feedback and learning was provided to the staff involved.

Findings of investigation:

The patient's hypoglycaemic episode was correctly identified and appropriately reversed.

Paramedic A and EAC A correctly recognised that the patient required further assessment at hospital and recommended transportation. The patient declined conveyance which was not clearly articulated in the PRF but identified during the course of the investigation.

A GP referral was appropriately sourced to safety net the patient.

The GPs acceptance of the referral and limited concerns raised, implied to Paramedic A and EAC A that transportation was not required and no further attempts were made to convince the patient or to further explain the risks of non-conveyance.

Paramedic A and EAC A did not refer to the Known Diabetic Hypoglycaemic Referral Tool as they assumed that the patient did not meet the criteria for a welfare or RST referral. Had they reviewed the document at the time then they would have identified that the patient was eligible for both.

The investigation identified that reviewing the document would have been challenging as it is not located in an intuitive place on the staffs Service issue iPad and equally has not been updated since its release in 2014.

It is not clear whether a referral for a welfare ring back or to the RST would have made a difference in the patient outcome considering the aspirational timeframe of a welfare ring back being two hours and the patient's deterioration into cardiac arrest occurring eight hours later.

Recommendations:

The 'Known Diabetic Hypoglycaemic referral tool' and RST tool should be reviewed and updated where necessary. This was last published in October 2015.

The 'Known Diabetic Hypoglycaemic referral tool' and RST tool, once reviewed and updated, should be added to JRCALCplus under the 'Glycaemic Emergencies in Adults and Children' section.

The 'Known Diabetic Hypoglycaemic referral tool' and RST tool, once reviewed and updated, should be embedded into the electronic Patient Care Record (ePCR) as additional access to the tool.

The findings of this report should be shared with the GP.

The Education and Development Team to consider the topic of Hypoglycaemia on future mandatory training.

The findings of this report should be shared across the Trust

Incident description:

2020/5244 – ID 39445

On the 17th February 2020 at 16:11 a call was received into the SEL IUC service from the son on behalf of his 86 year old mother (the patient). The patient's son explained that his mother had been experiencing a sore throat since 26th January and now had nausea which had started 24hrs previously. The patient was unable to perform her normal daily activities. This call concluded that the patient required contact with a primary care service within the next two hours. The patient's son felt that it would be difficult for the patient to attend her GP or a UCC due to her condition. As a result a clinical call back was arranged for the patient with an IUC clinician.

A call back was attempted at 22:34 which was unanswered. There was a subsequent attempt to call the patient at 00:47 which again was unanswered. At 01:34 another call was placed which was answered by the patient herself. She declined to complete the assessment as she was asleep and it was late.

At 07:30 on 20th February the patient's son called SEL IUC as his mother was still unwell. A clinical call back was arranged which takes place 07:53 with a Clinical

Advisor. This assessment concluded that the patient required contact with a primary care service within two hours.

The patient's son reiterated that he did not feel his mother was well enough to attend a GP or UCC due to her condition. The Clinical Advisor advised that a home visit from her GP would be appropriate and that the symptoms provided do not give an indication of requiring an ambulance.

The patient's daughter contacted her mother's GP surgery to arrange a home visit. This was agreed to take place after the doctor's morning clinic. At 10:25 the GP called the patient's son and asked to speak to the patient. The patient had difficulty speaking at this point but was able to talk to the GP who advised that the patient had a chest infection and that he would prescribe antibiotics.

After this telephone assessment the patient's son went to collect his mother's prescription. On his return home the patient had deteriorated further and was delirious. At 14:09 the patient's son called 999 and a category 2 ambulance response was confirmed.

At 14:30 the LAS crew arrive with the patient. A diagnosis of sepsis was made and the patient was conveyed under blue light conditions to Queen Elizabeth Hospital. The patient was subsequently on ICU for approximately two weeks ultimately recovering from her illness and discharged on 1st April 2020.

Immediate risk mitigation:

Quality Assurance reports were obtained for the IUC calls. The staff involved received feedback as part of this process.

Findings of investigation:

The clinical outcomes reached following the patient's assessments with the IUC service were appropriate given the information that was provided during triage. The wait the patient experienced following her son's first call to the service was in breach of the expected response times. There were significant pressures across the service due to the increase of activity in light of the COVID-19 pandemic which impacted the service's ability to respond within the expected timeframes.

The patient did not receive a home visit from their GP which was the advice given by the IUC service. This further elongated the time it took for a diagnosis of sepsis to be made.

The treatment that the patient received from an LAS crew following the 999 call on 20th February was in accordance with LAS and national clinical practice guidelines.

Recommendation:

The report to be shared with the teams involved.

SI report to be shared with the patient's GP for learning purposes.

Incident description:

At 08:53 on 17th March 2020 a call was received into the NHS 111 South East London (SEL) service and was placed into a queue. This call lasted for a total of 3 minutes and two seconds and was not answered by SEL 111 team.

At 08:59 a further call was received and was on hold for a total of 64 minutes and 42 seconds and was not answered by the SEL 111 team.

At 10:04 the same caller, a mother of a 3 year old male, called 999 reporting that her son was breathing very quietly. When Emergency Call Handler (ECH) A attempted to ascertain whether he was awake, the mother advised that her sons lips and ears were turning blue but that he was moving.

The call was triaged and obtained a Category 2 priority which has a mean target response time of 18 minutes and a 9 in 10 response time of 40 minutes.

10 minutes after ending the call the mother call back to report that her son had stopped breathing and that her husband was undertaking mouth to mouth resuscitation.

The call was triaged as a Category 1 priority and two Fast Response Units (FRUs), a Double Crewed Ambulance, an Incident Response Officer and a Critical Care Advanced Paramedic Practitioner were dispatched.

The two FRUs arrived on scene achieving an overall response time of 20 minutes and five minutes from when the second 999 call had been received.

The patient was resuscitated and a return of spontaneous circulation was achieved.

The patient was conveyed under emergency conditions (blue lights and sirens) to the nearest emergency department. The patient sadly died two days later.

Immediate risk mitigation:

ECH A was provided with supported feedback in relation to the incorrect categorisation of the call.

Findings of investigation:

2020/ 5998– ID 40665

The mother of a three year old, who was described as mottled, turning blue and not awake, was in a queue to the LAS SEL 111 service for circa one hour prior to calling 999.

The delay in answering the 111 call is attributed to the unprecedented demand that COVID-19 placed on the Trust which manifested not only in regards to an increase in call volume, but also due to staff sickness and absences associated with the illness.

Once through to the 999 system, ECH A missed a key ineffective breathing trigger phrase (turning blue) due to being task focused on ascertaining whether the patient was awake.

The demand within the 999 system, where call handlers were answering more than twice the number of 999 calls per hour when compared to 2019, meant that ECH A was not able to engage their active listening skills also contributing to the error.

The call was triaged as a Category 2 whereas it should have received a Category 1 priority.

10 minutes after ending the call, the mother called 999 a second time advising that her son was not breathing.

This call was correctly triaged and received the correct instructions on how to undertake CPR. The overall response time was 20 minutes, and five minutes from

when the second 999 call was received. The care provided on scene was in line with Trust and National guidelines.

Recommendations:

The LAS IUC sites to review its response to COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The findings of this report to be shared across the organisation.

The EOC management team to review the NoC thematic action plan to ensure that no additional mitigating actions are required.

Incident description:

2020/6978 – ID 42206

A 999 call was received reporting that a 63 year old male had breathing problems. The call was transferred to the COVID-19 Call Centre. 3 minutes later a further CAD was generated by an ECC as the patient was in cardiac arrest.

Multiple resources were dispatched with the first arriving on scene achieving a response time of 4 minutes. The patient was recognised life extinct after a period of resuscitation.

Immediate risk mitigation:

Calls reviewed and incident referred to SIG.

Findings of investigation:

A 999 call was received reporting that a 63 year old male had breathing problems. The call was transferred to the COVID-19 Call Centre. 3 minutes later a further CAD was generated by an ECC as the patient was in cardiac arrest. Multiple resources were dispatched with the first arriving on scene achieving a response time of 4 minutes. The patient was recognised life extinct after a period of resuscitation.

The Quality Assurance review established that ECH A should have clarified the patient's level of consciousness and breathing status.

As there was indication that the patient was breathing abnormally, the call should not have been transferred to the COVID-19 hub.

It is not possible to ascertain when the patient went into cardiac arrest therefore it is unknown if there was a detrimental delay in CPR being started.

A review of the care and treatment provided by the clinicians once on scene was correct and compliant with guidelines and policies.

Recommendations:

All staff who undertake call handling duties be briefed on the importance of clarification and taught effective questioning techniques.

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions.

This report should be shared with all EOC Managers and supervisors so that the importance of clarification and recognising cardiac arrest be reinforced.

Incident description:

2020/6074 – ID 41133

A 999 call was received from a neighbour of a 46 year old male who was reported to be experiencing difficulty in breathing and confusion. The call was triaged as a Category 2 (C2) which has a target mean response time of 18 minutes and 90th (9 in 10) response time of 40 minutes.

Two further calls were received and both treated as Estimated Time of Arrival (ETAs).

A doubled crewed ambulance (DCA) A staffed by Paramedic A and Emergency Ambulance Crew (EAC) A was dispatched and arrived on scene achieving a response time of two hours and three minutes.

On arrival the crew were unable to gain access to the patient's room within a multi occupancy building, and the Metropolitan Police Service were requested to attend.

On gaining entry the patient was found in cardiac arrest and was recognised as life extinct.

Immediate risk mitigation:

Supported feedback and reflection was undertaken with ECH B.

Findings of investigation:

The initial call was triaged correctly and obtained a C2 priority.

The second 999 call, which was received 22 minutes after the completion of the first, presented as a missed opportunity to have obtained a C1 priority. ECH B became distracted in conversing with the caller about the long ambulance waits and high demand, and missed that the caller had used the ineffective breathing trigger phrase "can't breathe at all".

Additionally, ECH B reported feeling under an intense pressure due to the significant volume of calls which was 80% higher than what was experienced the same day in 2019.

The Trust was operating at CSEP level 3 which denotes that the CHUB should attempt to ring back C2 calls within 30 minutes. Despite significant additional staffing the ring back timeframe was not achieved which was due the extreme number of C2 calls being held (an average of 199 between 18:00 and 21:00).

Once the call was reviewed by the CHUB, and their notes added to the call log advising that a face to face response was required, an ambulance was dispatched within two minutes. The overall response time to this patient was two hours and three minutes.

The investigation found that EOC and ambulance staffing was reduced due to high number of COVID-19 associated absence. Additionally there was an

increase in the number of vehicles out of service for deep cleaning post potential contamination.

Delays experienced whilst ambulances waited to hand over their patients at emergency departments also further depleted the availability of resources. The care provided on scene was in line with Trust and National guidelines.

Recommendations:

The findings of this investigation should be fed back to the hospitals with regards to the impact that delayed handovers have on waiting patients.

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The findings of this investigation should be shared across the Trust.

The EOC management team to review the NoC thematic action plan to ensure that no additional mitigating actions are required.

Incident description:

2020/6720 – ID 41723

On the 25th March 2020 a 999 call was received the mother of a 13 year old male who reported that her son had had a fever for three days. The call was triaged as a Category 2 response which has a mean target response time of 18 minutes and a 90th centile (9 in 10) response time of 40 minutes.

A DCA was dispatched and arrived on scene achieving an overall response time of 1 hour 45 minutes and after an assessment, using the Trust's COVID-19 guidance for patient facing staff, the patient was subsequently discharged on scene. A further 21 hours later a further call was received and triaged as a Cat 2.

A second DCA was dispatched and arrived on scene achieving an overall response time of 18 minutes. The patient was conveyed under normal road conditions to the ED. The patient died five days later of suspected COVID-19 Pneumonia.

Immediate risk mitigation:

The COVID-19 Guidance for patient facing staff was updated to reflect that the flow chart to assist clinicians identify patients who required conveyance to hospital should not be used in patients under 16 years of age.

Findings of investigation:

The investigation found that there was a 13 minute delay in answering the first 999 call and a delay in dispatching an ambulance as an overall response time of 1 hour 45 minutes was achieved. During this time the service was under extreme pressure due to the COVID-19 pandemic. This meant the service was experiencing an unprecedented high number of calls. The delay is not thought to have been contributory to any harm caused to the patient.

The investigation also found that the Trust had issued guidance to assist in the response to the COVID-19 pandemic and the management of patients presenting

with symptoms of the infection. This guidance provided a flowchart to assist clinicians identify patients who required conveyance to hospital. The flowchart utilised the NEWS2 scoring system which is not to be used in individuals under the age of 16 years. The clinicians appear to have applied the flowchart to the patient which resulted in the decision not to convey the patient to hospital. On balance, it was reasonable for the clinicians to consider the infection to be COVID-19 which would have provided a source of the infection. As such the clinicians may have been reassured that this was not a pyrexia from an unknown origin.

The clinical opinion also confirmed that the guidance provided by the Trust at the time of the call did not specifically mention then management of children (those under 16 years) and how to modify the flow chart accordingly which was subsequently rectified.

Recommendations:

Trust has commenced a review of COVID-19 patient safety incident to ensure that lessons are learnt and this report should be included in that review. Any actions arising from this review should be implemented.

✓ The clinical directorate to consider the development of a checklist to ensure that the learning from the changes made to the guidance is captured and used in the development of future bulletins.

Incident description:

2020/6977 ID 42085

A 999 call was received reporting that a 1 year old male had breathing problems with flu symptoms. The call was triaged as a Category 3 priority which has a target response time of 120 minutes.

Three minutes after the call completed the Clinical Hub reviewed and upgraded the call to a Category 2 priority which has a mean target response time of 18 minutes and a 9 in 10 response time of 40 minutes.

A DCA arrived on scene achieving a response time of 1 hour 23 minutes. Due to challenges locating the address and considering the climate of COVID-19, the clinicians contacted EOC and enquired whether patient could be brought down to the ambulance for the assessment.

Whilst the DCA was outside, a further 999 call was received reporting that the patient was in cardiac arrest.

The clinicians located the patient and commenced resuscitation.

The patient was conveyed to the nearest Emergency Department with active resuscitation in progress and died five days later.

Immediate risk mitigation:

ECH A was provided with support and feedback in relation to the triage of the call.

Findings of investigation:

Whilst the first call was initially incorrectly triaged, the clinical safety netting of the call was successful and the call was upgraded from a Category 3 to a Category 2 response within three minutes of the call completing.

The availability of vehicles at the start of the shifted impacted on the ability to send a response. The issues identified included; vehicles at the start of shift not contacting EOC with their available fleet numbers, a vehicle not identifying that they were single staffed and unavailable to respond, and three vehicles in the immediate area being unavailable whilst they restocked PPE.

The overall demand on the day impacted on the Trust's ability to meet its performance targets with the breaching the mean response times for Category 1 and Category 2 response times.

Once on scene the location of the address was not easily identified and that, combined with concerns regarding COVID-19 and the initial call detailing that the patient was conscious and breathing, led to EAC A requesting that the patient be brought down to the ambulance for an assessment. The investigation has concluded that the request was reasonable based on the information that was available to them at the time.

A clinical opinion sought for the investigation found that the clinical care provided was in accordance with LAS and national clinical practice guidelines.

Recommendations:

The key learning points from this incident with regards to human factors should be shared amongst EOC staff.

Review of operational guidance for staff actions at the start of shift.

Review and update process of when Scheduling communicate staff deficiencies to the Central Support Unit (CSU).

The findings of this investigation should be shared across the Trust.

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

Incident description:

2020/6961 ID 42013

At 18:11 on 3rd April 2020 a call was received in Emergency Operations Centre (EOC) by SCAS 111, this call was referred to the Clinical Hub and assessed by a Clinical Advisor for home management.

At 17:10 on the 5th April a 999 call was received for a patient who had been experiencing COVID-19 symptoms. Initially the caller described the patient as not breathing but later it was clarified that the patient was upstairs and not answering. At 17:16 the call was transferred to the COVID-19 Call Assessor Hub. During the call assessment by the COVID-19 Call Assessor, the caller made contact with the patient and established the patient was not breathing.

At 17:26 the call was transferred back into the Emergency Operations Centre where the call was upgraded to a Category 1 response which has a mean target response time of 7 minutes and a 9 in 10 response time of 15 minutes. A Fast response Unit (FRU) and Double Crewed ambulance was dispatched.

The FRU arrived on scene achieving a response time of 24 minutes from the original call and 8 minutes from when the call was upgraded to a Category 1 response.

Basic life support and Advanced life support commenced and on discussion with the family and a Critical Care Advanced Paramedic Practitioner in EOC resuscitation attempts ceased and Recognition of Life Extinct was pronounced.

Immediate risk mitigation:

No immediate actions were identified at the time.
The COVID-19 Call Assessor Hub is currently not operational due to 999 call taking demand reducing.

Findings of investigation:

The initial contact with the patient on the 3rd April was appropriately managed based on the information supplied by the patient.

The second emergency call received on the 5th April was inappropriately transferred to the CCA Hub. This was due to the process not clearly being defined for a patient's whose status on consciousness and breathing were not ascertained.

There was a delay where the COVID-19 Call Assessor was trying to establish the patient's condition which was due to a challenging call and their lack of experience in managing these types of calls.

When it was verified that the patient was not breathing the call was transferred back into Emergency Operations Centre where a Category 1 response
The clinical care provided to the patient on scene regarding the management of the cardiac arrest was in accordance with LAS and national clinical practice guidelines.

Recommendations:

To review the process of calls being transferred to the COVID-19 Call Assessor Hub

To review the process of when a COVID-19 Call Assessor should seek support from a Clinical Supervisor

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The findings of this report to be shared across the organisation.



Executive Summaries of 9 Serious Incidents closed by the Clinical Commissioning Group in September 2020

Incident description:

2020/6957 – ID 41929

A 999 call was received into the LAS for a 58 year old male who was not alert and had poor observations which had been documented by the nursing home. The call was triaged and obtained a Category 2 priority with a mean target response time of 18 minutes or less.

A double crewed ambulance (DCA) was dispatched staffed by a paramedic and an Emergency Medical Technician and arrived on scene 1 hour and 7 minutes following the call.

They assessed the patient and felt the patient did not require conveyance to the Emergency Department and provided advice to the nurses on site to contact the LAS should the patient's condition deteriorate.

At approximately 3 hours and 15 minutes after the initial ambulance left scene, a further 999 call was received for the same patient. The staff at the nursing home had called back advising that the patient had become confused and drowsy and his observations were still abnormal.

A DCA was dispatched and arrived on scene within 47 minutes and, following assessment, pre alerted the patient to the nearest Emergency Department with hypoxia and a reduced level of consciousness.

The patient sadly died six weeks later on the 17th May 2020

Immediate risk mitigation:

The initial attending staff were made aware of the incident which was discussed with a Clinical Team Manager. Concerns regarding the non-conveyance and the standard of documentation was fed back to the staff involved where supported learning and reflection has taken place.

Findings of investigation:

In regards to both calls, the Trust exceeded the required response time frames which was due to the unprecedented demand on the service caused by COVID-19.

The initial attendance did not demonstrate that an adequate assessment of the patient, or exploration into the abnormalities in the observations found, was undertaken. This was largely due to confirmation bias where the patient's low oxygen saturations were attributed to COPD and patient positioning. This was further enforced when nursing home staff confirmed that the patient appeared their 'normal self' and re positioning the patient improved the oxygen levels, albeit to a level still classed as low.

The ongoing response to COVID-19 further influenced the clinician's decision to not convey the patient due to a perceived requirement to manage patients at home.

The PRF was completed to a poor standard and did not fully reflect the patient encounter.

The patient did not meet the criteria for suspected COVID-19 in line with the guidance that was in place at the time of this incident.

The management of the patient by the second crew was appropriate.

Recommendations:

The Trust has commenced a review of COVID-19 patient safety incident to ensure that lessons are learnt and this report should be included in that review. Any actions arising from this review should be implemented.

The findings of the investigation should be shared across the organisation.

Incident description:

2020/9515 – ID 43564

On 27th March 2020 at 06:51 an emergency call was received by the LAS Emergency Operations Centre for a 70-year-old male patient who had drunk drain cleaner and had laboured breathing. The call was categorised as a Category 2 priority call with a target mean response time of 18 minutes.

The Trust was under extreme pressure during this time, experiencing unprecedented levels of demand following the declaration of COVID-19 as pandemic, and the lockdown of the United Kingdom which was instigated 5 days earlier on 23rd March 2020. As the 7am shift commenced there were over 400 calls awaiting dispatch, and more than half of these were Category 2 priority. The mean response to Category 2 calls for that hour was 3 hours 19 minutes, far in excess of the 18 minute target.

As a result of delayed response the patient's partner called back at 08:00 stating that the patients breathing was worse and that he was wheezing. ECH B correctly re-triaged the call reaching a Category 2 priority.

For patient safety an Extended Clinical Hub was in operation, running a Clinical Safety Cell staffed by clinicians tasked with undertaking clinical review of Category 2 calls awaiting dispatch, and ringing back where necessary.

At 09:25: QGAM A working in the Extended Clinical Hub called back the patients partner to conduct an assessment of the patient's condition. This resulted in a request for a face to face assessment by an ambulance crew with a Category 1 priority, the highest available, with a mean response target of 7 minutes, at 09:33

Fast Response Unit Callsign D450 crewed by Paramedic A was dispatched at 09:33 arriving on scene at 09:36 Double Crewed Ambulance D403, crewed by Paramedic B and EAC A, was cancelled from a lower category call and was dispatched at 09:34, arriving on scene at 09:41.

The patient was transported to Barnet Hospital Emergency Department, leaving scene at 10:11 and arriving at 10:16.

This call was identified for investigation from a retrospective review of calls during the COVID-19 pandemic. The response time for this call was 2 hours 44 minutes. The patient suffered significant chemical burns and subsequently died.

Immediate risk mitigation:

A number of mitigating actions were adopted throughout the Trusts response to COVID-19 which are explored in detail throughout the report.

Findings of investigation:

The demand that was being placed on the Trust during the peak of the COVID-19 pandemic in London was such that there was an unprecedented workload placed on the LAS. Despite enacting the highest level of REAP, CSEP level 3, and the numerous additional mitigation measures put in place by the Trust, the workload remained challenged for much of the week commencing 23rd March.

There was reduced front line resource availability, meaning calls were waiting considerably longer than typical for a vehicle response. This was due to increased numbers of staff off sick, due to COVID-19 infection, isolation or shielding. Further, the necessity of PPE usage resulted in increased job cycle time, supporting the discharge of patients from hospital which became the role of the statutory ambulance service and the cleaning of vehicles post- COVID-19 patient transport increased the out-of-service hours for front line vehicles reduced availability of frontline resource.

When the E-CHUB opened at shift start 07:00 on Friday 27th March, there was an unprecedented volume of Category 2 calls to review, numbering around 225 of 440 calls awaiting dispatch. The number of calls awaiting dispatch had remained very high over the night shift; the EOC were unable to despatch on the previous days calls as demand remained very high and more calls came in. Furthermore, many patients with only COVID-19 symptoms were being triaged on the Chest Pain or Breathing Difficulties protocols of MPDS, achieving a Category 2 priority. The Pandemic protocol was introduced to EOC on the afternoon of 27th March, having been approved for release by the NHSE on the night of the 26th March. With the Pandemic protocol in place, patients that were contacting the service for only COVID-19 symptoms were triaged on a dedicated protocol, which reduced the number of calls being triaged as Category 2.

There were not enough staff trained and ready to be brought into bolster the numbers of clinical advisors in the CHUB at short notice, meaning that there was a delay in increasing these numbers whilst staff were rapidly trained in a condensed Clinical Advisor course. In the meantime senior clinicians from other parts of the organisation were brought in, in many cases with minimal experience of clinical telephone assessment, and operated a clinical safety cell located in the E-CHUB. This was a newly established structure and the procedures were yet to be embedded.

Recommendations:

The work undertaken to rapidly formulate new processes and procedures during the peak of COVID-19 activity in LAS should be retained and revisited over the coming months to ensure the processes are formalised and robust and ready for rapid deployment when next required.

The increased staffing capacity achieved through rapid training of clinical advisors during the peak of COVID-19 activity in LAS is retained so that this new baseline of staff able to undertake clinical advisor roles within the CHUB are able to be bolster numbers when next required.

The Trust has commenced a review of COVID-19 patient safety incident to ensure that lessons are learnt and this report should be included in that review. Any actions arising from this review should be implemented.

The findings of the investigation should be shared across the organisation

**Incident
description:**

2020/6954 – ID 42171

On the 24th March a 999 call was received from the mother of a 7 week old female described as struggling to breathing and suffering with a cough. The call was triaged as a Category 2 priority which has a mean target response time of 18 minutes and a 9 in 10 response time of 40 minutes.

A Double Crewed Ambulance (DCA), staffed by Paramedic A and Emergency Ambulance Crew (EAC) A arrived on scene achieving a response time of 33 minutes.

Paramedic A preceded to obtain a history from the patient's mother and completed a set of clinical observations. Aside for an elevated heart rate, the clinical observations were identified as being within normal limits. A blood glucose measurement and oxygen saturations were not obtained due to not having the suitable equipment available. EAC A contacted the Clinical Support Desk (CSD) within the Clinical Hub at to seek advice regarding the patient's treatment plan and to consider leaving them at home.

The Clinicians operating on CSD advised they could do a GP referral owing to the current climate of COVID-19.

Paramedic A spoke with the patients GP who agreed with the proposed management plan and issued a prescription for baby formula to encourage feeding. The mother was provide with worsening care advice which involved calls the GP back if the problem persists and if concerned that the patient develops difficulty in breathing, to call 999.

Later that day the patient's condition deteriorated resulting in contacting the GP who arranged admission to the Evelina London Children's Hospital. At hospital the patient received IV antibiotics for presumed sepsis and was subsequently treated for suspected bacterial meningitis. Following treatment the patient was discharged from hospital.

**Immediate risk
mitigation:**

Supported feedback was provided to the clinical staff involved.

**Findings of
investigation:**

The Trust has a clear policy mandating that all paediatric patients under two years old are conveyed to hospital. The policy was not followed in this case owing to the clinician's belief that it was safer to treat the patient at home due to COVID-19. The decision to not convey the patient was a patient-centred one where Paramedic A believed that the benefits of leaving the patient at home outweighed the perceived risks. This was supported by advice from clinicians based in the Clinical Hub.

Given the demand on the NHS and the risk of exposing patients to the infection at the time this was not an unreasonable concern. Additionally, the call was received the day after the national lockdown was imposed.

There was not change in this guidance during COVID-19. The clinical advice

provided by CSD Clinician B was incorrect and based on a 'word of mouth' belief that the Trust had relaxed the under two policy in the light of the pandemic. The investigation acknowledges that, at the time, guidance documents and bulletins were released on a daily basis which may have added to this confusion.

Paramedic A and EAC A ensured that the patient was safety netted by speaking to a GP who agreed that non conveyance, in this circumstance, was appropriate. The accepting of this referral, reinforced to the clinician's that their decision making was correct.

The crew did not complete a BM or Pulse Oximetry test therefore the decision not to convey the patient was based on incomplete information. The clinical opinion concluded that it was unlikely that the addition of these two monitoring assessments would have changed the clinician's decision making in regards to conveyance as there was no other clinical indication to suggest that these would have been abnormal. The PRF states that the absence of a BM reading was explained to the referring GP who remained satisfied that the patient remain at home.

Recommendations:

The Patient Safety and Clinical Effectiveness Group to consider and resolve the issue of infant oxygen saturation probes.

The learning from this report must be shared pan-London through established governance structures and governance meetings.
The LAS to undertake a review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The report to be shared with the GP involved in the incident.

Incident description:

2020/10046 – ID 43851

On 22nd May 2020 at 03:59 the LAS received a 999 call for a patient who had awoken with chest pain and breathlessness and who subsequently collapsed on the sofa. There was difficulty obtaining the correct address for the patient as the caller repeatedly gave the incorrect postcode. This was further complicated as English was not their first language and they were understandably in a distressing situation, with a very sick relative and keen for help to arrive as soon as possible. The Emergency Call Handler (ECH A) did not access the Trust translation service on this occasion.

During the 999 call, the caller stated the patient was not breathing but this was not heard or acted upon by ECH A and the call concluded with a Category 2 priority and an Medical Priority Dispatch System (MPDS) determinant of 6D1, indicating a patient who was not alert with breathing problems. Category 2 calls are classified as Emergency calls. They are for serious problems such as chest pain and patients having difficulty breathing which may require rapid assessment and/or urgent transport. The national standard states that ambulance trusts should aim to respond to Category 2 calls in an average time of 18 minutes from the point the final determinant is obtained. The determinant was obtained at 04:05 and a DCA

(call sign R338) was dispatched immediately arriving on scene at 04:17. Our response time to the patient was therefore 13 minutes.

Once on scene, the crew of R338 staffed by Paramedic A and Emergency Ambulance Crew (EAC) A put on Level 2 Personal Protective Equipment (PPE) and made their way to the patient. There was a delay due to construction works at the entrance nearest the patient. The crew of R338 therefore had further to walk to get to the patient. Once inside the building there was a further short delay as the caller had provided the wrong door number during the 999 call.

Once at the patient's side (at 04:24), they immediately recognised the patient was in cardiac arrest and attached a defibrillator to the patient. This indicated the patient was in a non-shockable rhythm (Pulseless Electrical Activity or PEA). Both Paramedic A and EAC A withdrew from the scene and returned to the ambulance to put on Level 3 PPE. They returned to the patient's side 11 minutes later to find their condition had deteriorated further and that a resuscitation attempt would have been futile as the patient had not received CPR from the point of the 999 call through to returning to the patient after withdrawing to put on Level 3 PPE.

The patient was sadly recognised as deceased at 04:36

Immediate risk mitigation:

A debrief on scene was undertaken by the attending Advanced Paramedic Practitioner. This debrief included providing clarification on the LAS Guidance for Patient Facing Staff, in particular the actions that should be taken when arriving on scene and finding a patient in cardiac arrest unexpectedly.

Paramedic A and EAC A also spoke to a Clinical Team Manager (CTM) once they returned to their station to discuss the incident.

Findings of investigation:

The initial call was triaged correctly and obtained a C2 priority. The second 999 call, which was received 22 minutes after the completion of the first, presented as a missed opportunity to have obtained a C1 priority. ECH B became distracted in conversing with the caller about the long ambulance waits and high demand, and missed that the caller had used the ineffective breathing trigger phrase "can't breathe at all".

Additionally, ECH B reported feeling under an intense pressure due to the significant volume of calls which was 80% higher than what was experienced the same day in 2019. The Trust was operating at CSEP level 3 which denotes that the CHUB should attempt to ring back C2 calls within 30 minutes. Despite significant additional staffing the ring back timeframe was not achieved which was due the extreme number of C2 calls being held (an average of 199 between 18:00 and 21:00).

Once the call was reviewed by the CHUB, and their notes added to the call log advising that a face to face response was required, an ambulance was dispatched within two minutes. The overall response time to this patient was two hours and three minutes.

The investigation found that EOC and ambulance staffing was reduced due to high number of COVID-19 associated absence. Additionally there was an increase in the number of vehicles out of service for deep cleaning post potential contamination.

Delays experienced whilst ambulances waited to hand over their patients at emergency departments also further depleted the availability of resources. The care provided on scene was in line with Trust and National guidelines.

Recommendations:

The findings of this investigation should be fed back to the hospitals with regards to the impact that delayed handovers have on waiting patients.

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The findings of this investigation should be shared across the Trust.

The EOC management team to review the NoC thematic action plan to ensure that no additional mitigating actions are required.

Incident description:

2020/8666 – ID 42888

On the 28th March, 2020 a call was received into the London Ambulance Service (LAS) Emergency Operations Centre (EOC). The incident was passed by South West Ambulance Service under the “buddy system” at 23:33.

The details provided included that a 62 year old male was believed to be in cardiac arrest with cardiopulmonary resuscitation in progress.

The call was assigned a Category 1 priority which has a mean target response time of seven minutes. Four resources to the incident with the first arriving on scene achieving a response time of six minutes.

After a period of resuscitation including the administration of intravenous adrenaline and the securing of an advanced airway, the patient was recognised as life extinct.

It was established that the patient’s family had been ringing and on hold for a considerable amount of time (circa two hours 47 minutes) prior to the call being directed and answered by South West Ambulance Service.

An initial investigation into call answering delays identified that some calls were going through to a telephone switch that was unstaffed, and the patient’s telephone number was one of those identified.

The issue was established as being longstanding, commencing at a failed attempt to implement a telephony upgrade in November 2019 affecting over 1700 calls between November 2019 and April 2020 when the error was discovered.

Immediate risk mitigation:

The DDI numbers forwarded to the unmanned CM7 switch were immediately cancelled and an investigation carried out to ensure no other numbers terminated on the CM7.

Call forward for all numbers was placed on the CM7 switch back to CM5 and

therefore if any lines were missed, they would automatically be rerouted back to the manned CM5 switch.

Analysis of call answering performance was strengthened to ensure any subsequent long answer times were immediately investigated.

Findings of investigation:

Investigations into the delay discovered that the caller had been put through to a telephone switch within EOC that was not in operation for emergency control room work and, as a consequence, was unstaffed and could not have been answered by anyone in the control room.

This occurred as a result of a failed attempt to migrate the control rooms from an old unsupported system (CM5) to a new telephone system (CM7) on November 16th, 2019. During the go live period at this time it was noticed that even though the emergency control room had migrated to the new telephone system the old system continued to ring due to a number of telephone numbers being held in various external directories. To resolve the issue a decision was made to forward ranges of numbers that were ringing to the new CM7 switch.

A number of hours later the CM7 switch developed a number of unresolvable errors and a decision was made for the emergency control rooms to fall back to the old telephone system (CM5) but unfortunately the numbers that had been forwarded were not cancelled and continued to connect to the new system between November 16th and late March 2020 when the error was discovered.

This was largely due to the being insufficient documentation pertaining to the decision to forward these lines. Additionally the Trusts poor call handling performance over the subsequent five months meant that the 1739 calls which were diverted to this line were unnoticed amongst the performance metrics. /Due to the exceptional demand that all Emergency Authorities experienced as a result of COVID-19, BT developed a new process whereby, if callers are not distressed and consented, an automated message will be played allowing the BT operative to be released to answer the next emergency call. This had the consequence that the length of the delay was not realised by BT who would have been able to switch the call to an Alternative 'buddy line' once the call had been waiting for more than seven minutes.

Recommendations:

The actions associated with STEIS reference 2019 26297 must be implemented.

The Trust lacks a comprehensive directory of numbers including critical DDIs. Reduce and rationalise the number of DDI numbers used in the Trust and cease lines that are no longer required

Ensure that all projects have a clear go live plan that includes how changes are to be agreed on the day.

Ensure that all projects have a clear go live plan that includes leadership arrangements for the day.

Involve control ops in the planning arrangement for any project that will have an impact on their ability to deliver effective patient care. Project in EOC should be

collaborative and include the opportunity to feedback on proposals Training plans and familiarisation plans should be developed for all major control room projects.

The project to replace the system should be initiated as soon as possible and should include external oversight and inclusion of lessons learnt from previous SIs. Moving to a new telephony platform will ensure that the Trust have access to the best available tools to measure performance appropriately.

On a number of occasions during the pressure period brought about by COVID-19 activity BT were getting an engaged tone when ringing the primary 999 lines to the Trust and had to move to secondary lines. The Trust should ensure that their capacity is equal to that volume of calls routinely received through April 2020.

Incident description:

2020/8162 – ID 41560

On the 28th March 2020, a Care UK NHS 111 call was received from the wife of a 51 year old diabetic gentleman who had been suffered with COVID-19 symptoms for a week and a half. The call was triaged and obtained an outcome of requiring an ambulance response. The call was transferred to the LAS via an electronic link with a Disposition Code of Dx01214 - Emergency Ambulance Response for Potential COVID-19. This attracts a Category (Cat) 3 priority with a target mean response time of 120 minutes. Two ETA calls were received before the patient was contacted by a Clinician in the Clinical Hub 5 hours later who, after an assessment, provided home management advice.

A further call was made to the Care UK NHS 111 service in between the two 999 calls. However, due to an exception high call volume, the call was still in the assessment pool the following day.

29 hours after the first 999 call, a further call was received reporting that the patient was in cardiac arrest. Multiple resources were dispatched with the first arriving on scene achieving a response time of 5 minutes.

The patient was recognised as life extinct on scene.

Immediate risk mitigation:

None were identified at the time.

Findings of investigation:

All COVID-19 calls required an assessment by a LAS clinician prior to the dispatch of a resource. The call was transferred to the Clinical Desk Dispatch Group (CDDG) for a Clinical Hub (CHUB) Assessment. The investigation found that this assessment was not compliant as the patient was audibly short of breath, had a higher risk due to his diabetes and had had symptoms for a week and a half. A face to face assessment would have been the most appropriate outcome from the MTS assessment. The investigation believe that confirmation bias occurred and resulted in not all the factors being considered equally by the LAS clinician.

The investigation also found that three 999 calls made by the family were found to

be complaint with both MPDS and Trust guidelines and triaged correctly. Two of these calls were ETA calls during the night of 28th and 29th March as the demands of COVID-19 on the service delayed the ring back from a clinician. One of these calls was on the 30th March when the patient was found not breathing. A clinical opinion was sought for the care provided on the scene by LAS crews and this was also found to be was in accordance with LAS and national clinical practice guidelines.

The NHS 111 internal investigation into this case has identified a number of areas where there was a deviation from what would be an acceptable norm. Whilst the COVID-19 pandemic and subsequent call volumes have undoubtedly been a contributory factor here, there are episodes of individual learning which will be taken on board and shared across the service.

Recommendations:

The CHUB clinician to undertake further MTS and clinical hub training to support them in their role.

The key learning points from this incident with regards to human factors (confirmation bias) should be shared amongst CHUB staff and the wider Trust.

The LAS has commenced a review of COVID-19 patient safety incident to ensure that lessons are learnt. Any actions arising from this review should be implemented.

The CA and HA C to undertake undertakes supportive reflective learning to support them in their role.

The learning from this incident should be shared across the Care UK NHS 111 organisation

Incident description:

2020/6955 – ID 41899

A 999 call (CAD 4804) was received at 17:04 on 22nd March 2020, reporting that a 37 year old male was not alert, and had 'lower back pain, difficulty in breathing, and confusion; with a history of brain tumour and lung infection.

On attendance the patient was discharged at scene with advice to call GP, although SpO2 (oxygen saturation) readings could not be completed due to failure of the pulse oximetry probe.

Re-contact was made by the family of the patient on 23rd March 2020 (CAD) 963; when the patient was in a critical condition with oxygen saturations of 50%, requiring conveyance to ED as a priority.

The LAS was later advised by SW London CCG, that the patient had subsequently died due to COVID-19 related pneumonia.

Immediate risk mitigation:

Case was flagged by LAS safeguarding team for consideration of declaration as Serious Incident. No immediate risk mitigated was deemed necessary.

Findings of investigation:

The investigation found that the oxygen saturation probe carried by the crew in this case appeared to have an intermittent fault, and failed in use on two separate occasions. A potential opportunity was missed to have identified this fault in advance, as the crew did not complete a serviceability check, although the investigation recognises that the probe was fully functioning during the first patient contact of the shift.

An opportunity was missed to exchange the faulty probe while the crew were out of service, following the first case of failure, and on returning to station. This was due to competing priorities, and the non-availability and focus on replacing other items of essential Personal Protective Equipment and the human factors involved in managing the previous case which was a cardiac arrest.

The patient in this case was at risk of worse clinical outcomes, due to the presence of multiple pre-existing co-morbidities and clinical assessment was more challenging, due to the presence of a language barrier and learning difficulties.

While the failure of the probe was problematic, it was not considered to have been critical, in that the patient's clinical picture was otherwise one of low clinical risk. There is no evidence to suggest that the patient was hypoxic at the time of attendance, and it should not be assumed that because the pulse oximeter did not produce a reading, that this was the case.

Given the wider circumstances (with regard to COVID-19 pandemic) and the manner in which the patient presented, advice to contact the patient's GP was acceptable. Ultimately, a decision was required regarding a management plan, and despite the absence of a saturation reading, the plan was reasonable on the basis of other indicators and risk factors.

Recommendations:

The lessons learnt from the report should be shared across the Trust.

The LAS to undertake a review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

Incident description:

2020/11095 – ID 44542

At 01:42 on the 14th March 2020 a 999 call was received reporting that a 90 year old female had abdominal pain and was on the verge of passing out.

The call was triaged and assigned a Category 3 priority which has a mean target response time of 120 minutes. The call was placed in a queue for an ambulance and due to the extreme pressure on the Trust and its move to CSEP level 2, the caller was advised to expect a telephone clinical assessment.

Two hours 40 minutes later a welfare ring back was undertaken from within the Emergency Operations Centre (EOC) where it was identified that there was no change in the patient's condition.

Three further 999 calls were received, two were re triaged and obtained Category 3 response priorities and one was treated as an Estimate Time of Arrival (ETA)

query.
The call was reviewed by a Clinical Advisor who was working within the Clinical Hub and the call was marked as being suitable for the Non-Emergency Transport Service (NETS) and assigned a timeframe of within one hour.
A NETS vehicle arrived on scene achieving an overall response time of 11 hours 12 minutes.
The patient was conveyed to a local Emergency Department where they died the same day.

Immediate risk mitigation:

All call handlers have completed reflection and learning with QA managers.

Findings of investigation:

Four 999 calls were received over the course of circa 9 hours 30 minutes with a caller reporting increasing concern for their 90 year old relative who was unwell with abdominal pain and was reported to be weak and on the verge of passing out.

A Quality Assurance review of the calls identified some areas of learning namely a potential missed opportunity to have upgraded the second 999 call to a Category 2 with the caller describing the patient as being disorientated. This was found to have been confused by the caller further advising that the patient was "100% alert". Clarification of the patient's level of alertness was not sought by the call handler.

The Trusts ability to meet the Category 3 response time of 120 minutes was hampered by COVID-19 in terms of an unprecedented surge in call volume where in excess of 200 calls, the majority of which were of equal or high priority, were awaiting an ambulance to be dispatched throughout the time this call was held.

A Clinical Advisor within the CHUB identified that the call had been holding for an extensive period of time and transferred the call to NETS requesting a one hour response timeframe. This was undertaken outside of standard procedure as no advanced telephone assessment was completed.

The NETS resource arrived on scene achieving an overall response time of 11 hours 12 minutes. Considering the demand on the Trust, and the number of calls waiting for a resource to be sent, sending a NETS resource was likely to have produced a faster response than waiting for a front line DCA.

The NETS staff managed the patient appropriately and in line with the scope of practice.

Recommendations:

OP060 should be reviewed to ensure that there is clarity regarding the process of re triaging calls

The LAS to undertake a thematic review of patient safety incidents which occurred during COVID-19 to ensure that all appropriate actions were taken and, should another peak be experienced, appropriate mitigating actions are in place.

The findings from this report must be shared across the organisation.

Incident description:

2020/8160 – ID 40940

At 08:32 on the 20th March 2020 a 999 call was received by London Ambulance Service (LAS). The call was triaged as a 'Category 2' call and the ambulance response arrived on scene in under eight minutes within the national target for 'Category 2' calls.

The patient presented with a five-day history of febrile illness, cough, diarrhoea and vomiting along with a headache and generalised aches and pains. This met the contemporary diagnostics threshold for suspected COVID-19 based on the history of a cough and febrile illness.

The patient's initial NEWS 2 score was 7, but with the most minimal interventions at 20 minutes post, the NEWS 2 score had reduced to 2. The patient was assessed using this latter NEWS 2 score and the COVID-19 decision tool. The patient was not conveyed to hospital and was discharged at scene with some worsening advice.

Approximately 30 hours later, on the afternoon of the 21st March the 2020, the LAS received a further 999 call from the patient's husband reporting that he had found the patient not breathing. The LAS attended within six minutes, a full resuscitation attempt was undertaken but the patient did not recover and was sadly verified deceased at 16:06 on the 21st March 2020.

Immediate risk mitigation:

The Paramedic has been supported to complete a statement in respect of their management and has reflected on the incident.

Findings of investigation:

As the patient's observations normalised so quickly, it was deduced that this decision to leave the patient at home was not felt to be wholly unreasonable, as these at the time, would have reflected the contemporaneous clinical presentation of the patient.

The investigation concluded that the initial set of clinical observations should have been used to inform the triage decision.

The investigation also found that the COVID-19 clinical decision support tool in operation at the time was not followed. However, on balance the investigation conclude that the initial set of clinical observations should have been used to inform the triage decision. Despite the COVID-19 clinical decision support tool

indicating that a referral to a GP was indicated (or the advice of NHS 111), this was not undertaken.

The investigation has noted some shortcomings in respect of the clinical 'red flag' and safety net information that was provided to the patient.

Recommendations:

Guidance is provided in the LAS Clinical Update Publication around the information that should be recorded where a patient is not conveyed to hospital to remind clinicians to ensure key information is provided to patient including specific 'red flags' which would prompt the patient to seek further clinical input recorded within the clinical notes. This should also be fed into the 'perfect PRF' and ePCR work stream being undertaken by the governance and clinical information team.

The Clinical Directorate consider whether there is any greater clarity required, during the development of any clinical tools, around what is meant by referral e.g. if there is an expectation that the clinician contacts the referral pathway directly, wherever possible or if it is sufficient to advise a patient to do so if they do not improve.

The senior sector clinical lead arranges for the paramedic involved to attend a clinical review, reflection session to ensure any learning is captured and the paramedic is supported to move forward.

The investigation report is shared with the HCPC.



Report to:	Trust Board			
Date of meeting:	24 November 2020			
Report title:	Freedom to Speak Up update			
Agenda item:	For Information			
Report Author:	Erica Greene, Freedom to Speak Up Guardian			
Presented by:	Erica Greene, Freedom to Speak Up Guardian			
History:	Previous report issued 16 July 2020 People and Culture Committee 2 November 2020			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board s attention:				
This report was provided to Trust's People and Culture Committee to update on the status of Freedom to Speak Up as at 18 October 2020.				
Recommendation to the Board:				
The Board is asked to note the report.				

Routing of Paper Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		



Freedom to Speak Up Quarterly report

Background

1. It is a requirement in the standard NHS contract that NHS Trusts appoint a Freedom to Speak Up (FTSU) Guardian. Guardians can be approached by any worker in confidence, at any time, to discuss concerns about any risk, malpractice or wrongdoing which they believe is harming the service.
2. In July 2018 Katy Crichton was appointed as permanent part time FTSU Guardian to: raise the profile of FTSU across the organisation; continue to deliver a FTSU service across the Trust; and to represent the LAS at national and regional speaking up events. Due to the large volume of new concerns raised in Q2 and Q3, Katy took on the Guardian role full time in December 2018. Paramedic Erica Greene was recruited into the new part time post of FTSU Co-ordinator in September 2019. In June 2020, Erica Greene was seconded into the FTSU Guardian post for six months while Katy Crichton undertook a secondment as The Interim Head of Wellbeing. During this time, Carmen Peters began a full-time secondment as the FTSU Co-ordinator. FTSU temporarily moved into the People and Culture directorate when the previous director Philippa Harding left the service, it has now moved back to Corporate Affairs.
3. This report provides information about FTSU activities that have taken place within the London Ambulance Service NHS Trust (LAS) and nationally since the last Board update in July 2020.

LAS FTSU casework:

4. In line with the standard NHS contract, the LAS is required to report quarterly details of Freedom To Speak Up cases to the National Guardian's Office (NGO). In quarter one 2020/21, 83 cases were raised. In quarter two of 2020/21, 60 concerns were raised.
5. The trend of cases so far during the year 2020/21 is shown below:

Q1	Q2	Q3	Q4	Total
83	60			143

6. By way of comparison, the trend of cases during the year 2019/20 is shown below:

Q1	Q2	Q3	Q4	Total
67	66	71	75	279

7. 118 cases were raised during Q1 – Q4 2018-19.



8. No data from this year has been published yet so we are unable to draw comparison with other Trusts for this year.
9. The data below shows a comparison with other ambulance trusts from Q4 of 2019/20. This is the most recent published data from the NGO.

<i>Trust</i>	<i>Total Cases</i>	<i>Anonymous</i>	<i>Patient Safety</i>	<i>B&H</i>	<i>Suffered detriment from raising a concern</i>
EMAS	No data	No data	No data	No data	No data
EEAST	11	1	3	5	0
LAS	75	1	5	6	0
NEAS	3	1	1	2	0
NWAS	67	5	2	13	4
SCAS	22	0	2	6	0
SECAMB	22	2	2	18	0
SWAST	11	0	0	0	0
WMAS	0	0	0	0	0
YAS	9	0	1	3	0

10. The sources of FTSU concerns in Q1 20/21 are shown in the following table:

<i>Source</i>	<i>Number of concerns</i>
Sectors	25
EOC	39
IUC/111	0
Corporate	13
Ancillary	5
UK	1
Total	83

11. The sources of FTSU concerns in Q2 20/21 are shown in the following table:

<i>Source</i>	<i>Number of concerns</i>
Sectors	29
EOC	12
IUC/111	4
Corporate	8
Ancillary	7
UK	0
Total	60



12. 53% of concerns came from Male members of staff.
13. The main themes of the concerns raised in Q2 can be broken down as follows:

<i>Theme</i>	<i>Percentage of concerns</i>
Process	38%
Management	32%
Bullying and harassment	10%
Patient safety	10%
Staff safety	8%
Other	2%

14. Process remains the largest category of concern. This is broadly due to internal processes not being user-friendly for staff, extended delays to get information, and failure to communicate adequately for example, a number of staff raise concerns about recruitment and HR processes being lengthy, unclear and sometimes perceived as unfair.
15. 28% of concerns in Q2 were raised by BME colleagues while BME staff represent 17% of the workforce. The NGO has indicated that nationally there is a tendency for BME staff to raise fewer concerns than would be expected from their share of the workforce; hence the higher percentage in LAS may be a positive. However, the situation will be kept under review.
16. Between 1st June 2020 and 1st July 2020, 9 FTSU concerns with elements of racism were raised. Of these, 1 was from Bow EOC, 5 were from HQ EOC and the other 3 from other areas of the service.
- This indicates that in the context of staff reporting racism via FTSU, racism related concerns were disproportionately higher amongst EOC than anywhere else in the service.
 - Some of the concerns from EOC HQ came from different staff members but were relating to the same issue.
17. Concerns raised in Q2 contributed to:
- A fairer payment of overtime for some staff working in 111
 - Early resolution of conflict between two members of staff
 - Uptake of the use of dignity at work champions to resolve a conflict between a member of staff and their manager
 - A change in process to allow Clinicians in the CHUB to see when calls have been previously triaged by a clinician in 111 prior to being transferred.
 - A bulletin being published to remind all operational staff of what equipment they should be routinely taking in to all patients.



- A review in to the processes by which the service recruits senior managers and staff to secondments.
 - Raising the profile of racism and discrimination within the service
 - Supporting students who had their start dates moved at very short notice.
 - Contributing to the discussion about new sites for the education departments.
18. Of the 60 concerns raised in Q2, one was raised anonymously. Feedback was obtained for 9 concerns that were closed in the period, 8 of which answered 'yes' in response to the question 'would you speak up again?' and one who answered 'I don't know'. No staff reported that they had suffered any detriment as a result of speaking up.
19. As of the end of Q2, concerns remaining open from 2020/21 were as follows:

<i>Date of concern</i>	<i>Number of open concerns</i>
Q1	6
Q2	12
Total	18

Progress against LAS FTSU Strategy:

20. **Theme 1 - Engaging senior leaders to ensure that FTSU is given appropriate prominence within the Trust**

What we have said we will do:

- a) We will work with the Trust's senior leaders to ensure that they take an interest in the Trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.
 - b) We will work with the Trust's senior leaders to ensure that they can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.
 - c) We will work with the Trust's senior leaders to help them to use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.
21. What we have done since the last report to the Board:
22. The FTSU Deputy Guardian continues to have regular meetings with the CEO and members of the executive team in order to share and triangulate information. The deputy guardian has strong communication channels with the executive team that ensures serious and urgent concerns are escalated in a timely fashion.



23. Theme 2 - Ensuring that all members of staff know and understand about FTSU and the role of the Guardian

What we have said we will do:

- a) We will establish a network of FTSU advocates to support the FTSU Guardian and ensure that dissemination of FTSU information is more widespread.
- b) We will have a clear communication plan that tailors and ensures appropriate FTSU communications to different groups of staff.
- c) We will ensure that learning from concerns is clearly communicated.

24. What we have done since the last report to the Board:

25. During Q1 and Q2, the Guardian maintained a presence at both EOC sites where there was a particular need for staff support during the early stages of the Covid-19 pandemic. Service-wide communications via LIA, the Pulse and the RIB have remained regular and ongoing with particular focus on encouraging staff to continue to speak up during the pandemic. Learning from concerns continues to be published on the FTSU Pulse page. During Q2 Carmen Peters was recruited on a secondment as The FTSU Coordinator to support the deputy guardian with a focus on communicating the message of FTSU to all staff. The Deputy and Coordinator continue to have a presence at all LAS inductions.

26. Theme 3 - Ensuring that the systems/process/structures are in place to support raising concerns and responding to these and leaning from them

What we have said we will do:

- a) We will review our FTSU Policy to ensure that it remains appropriate and easily accessible.
- b) We will clarify the systems and processes underpinning the routes through which different claims can be made.
- c) We will ensure that there are links between all parts of the organisation where concerns may be raised, to avoid casework being duplicated or missed.

27. What we have done since the last report to the Board:

28. The FTSU policy has been reviewed and some minor amendments made to it. A FTSU process flowchart was developed and is now visible on the FTSU pulse pages and a copy of it is attached to all initial correspondence with staff raising concerns to ensure that they understand the process. The Guardian has continued to build good communication channels with relevant teams and stakeholders in the trust such as Human Resources, Dignity at Work and the Unions to ensure a more efficient and streamlined approach is taken to handle concerns.



29. Theme 4 - (With the People and Culture Directorate) facilitating cultural change

What we have said we will do:

- a) We will work with the People and Culture Directorate to ensure that FTSU is reflected in all of the work undertaken to implement the People and Culture Strategy.
- b) We will ensure that there are ongoing coherent evaluations of the FTSU environment within LAS.
- c) Activities undertaken to establish a picture of the understanding of FTSU within LAS.

30. What we have done since the last report to the Board:

- 31. The deputy guardian took part in a discussion about culture and behaviour change within the trust. The deputy guardian took part in a panel review of formal investigations to evaluate fairness in the way that BAME staff are treated. The deputy guardian is part of the working group implementing the resolution framework. The deputy guardian facilitated a number of breakout groups in the Core Leaders Sessions on Race equality.
- 32. FTSU and senior HR managers are working closer together to ensure that those concerns that require HR involvement are dealt with under the proper procedures.
- 33. FTSU are planning to undertake some work with managers across the service to educate them on the role of FTSU and to understand why staff are raising concerns via FTSU that could be raised with them.

Q2 2020/21 Feedback:

- 34. *'All letters received with such a brilliant outcome. Hopefully, it won't affect future employees this way again as it was a terrible experience. Thank you so much for taking the time and effort to listen and communicate on our behalf, you were great! In the nicest way possible, i hope i won't have to contact and pester you again anytime soon, but if i do, i'll have complete confidence in doing so.'*
- 35. *'Generally I feel that I am now not on my own with regards to problems that arise within the Management team or the Organisation in general etc. and that is a good thing for me, so yes if things begin to change again to the way they were, or I see things which are 'not right', I wouldn't hesitate to contact the Speak up Team.'*



36. *'I must say, you are absolutely fantastic, always ready to help/assist fellow staff members with various issues they may have, along with carrying out your paramedic role. A true asset and ambassador for the LAS. I bet you are amazing at the scene of a clinical incident/ RTC etc. Patients/onlookers/relatives etc. must be in ore of the way you conduct yourself/others in a kind caring professional manner. Thank you for arranging the meeting with Khadir, and indeed all your marvellous help you have given me throughout, it really has made me feel a lot better.'*
37. *'no i have no issues with my request or problem, i would raise more with you but feel some things are just kept quiet.'*
38. *No,I haven't suffered any detriment by raising this issue,,and don't feel I'm likely too as I'm now reluctantly complying with the policy. Yes,I'd definitely raise another concern through FTSU if I feel necessary in the future.*
39. *This is good news. Thank you for helping me with this. Yes, the concern I have is now gone. 1. Have you suffered any detriment as a result of speaking up? None 2. Would you raise a concern through FTSU in the future? Yes, without a doubt.*
40. *Thank you for all of your help.I appreciate the things that you guys do helping staff.*

National Guardian's Office (NGO):

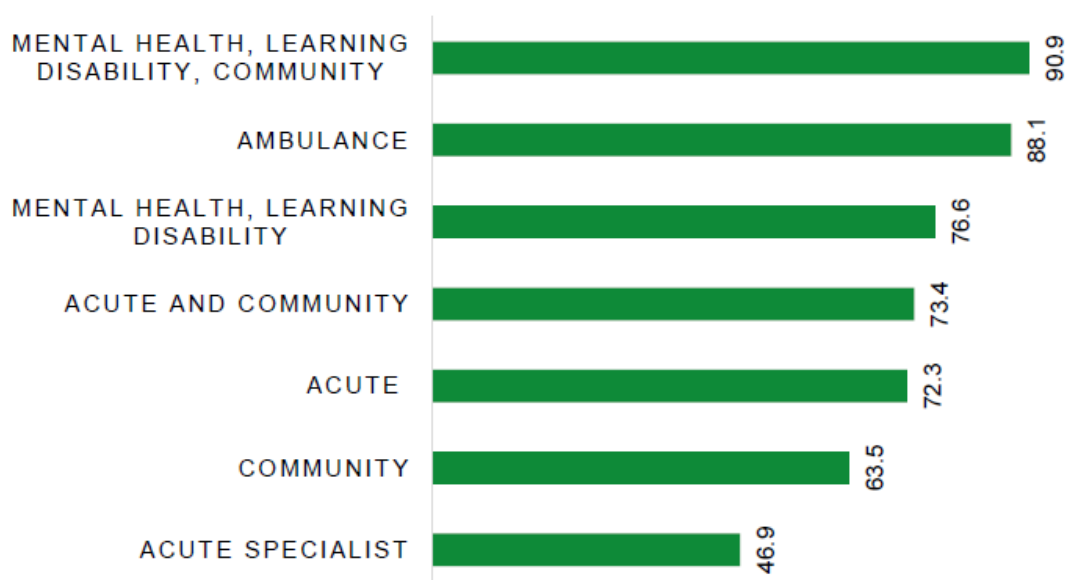
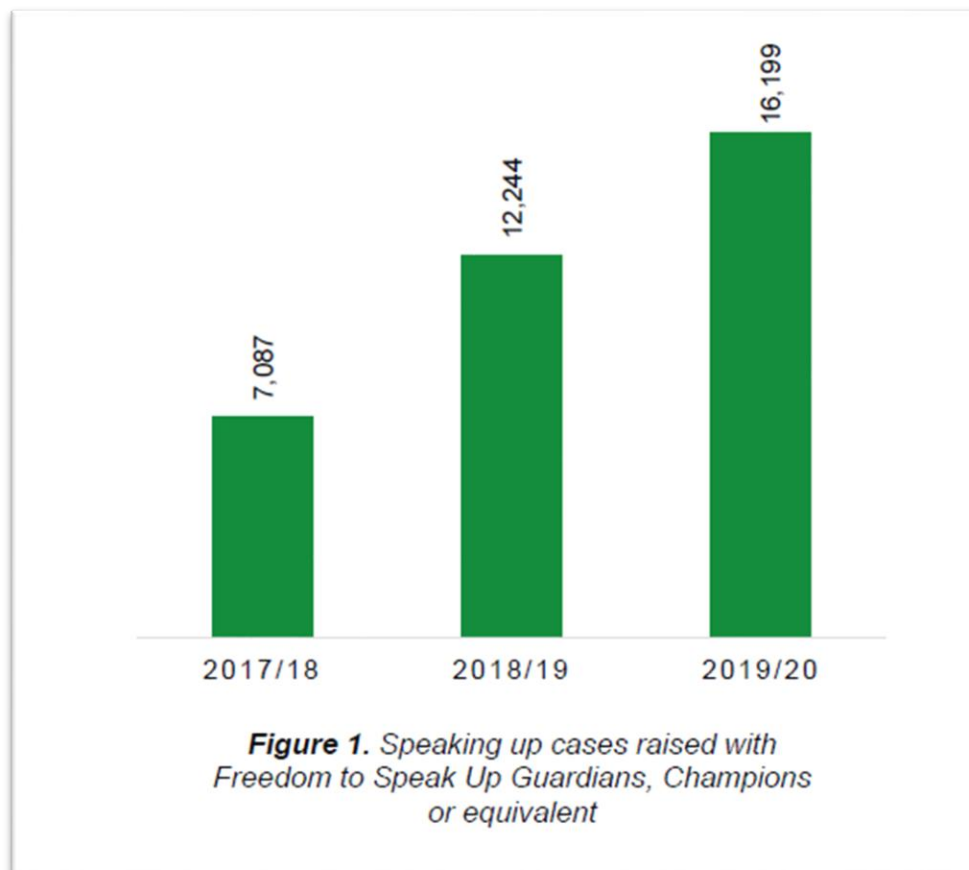


Figure 3. Average number of speaking up cases raised with Freedom to Speak Up Guardians, Champions or equivalent by trust type in 2019/20



41. Between 1 April 2019 to 31 March 2020, **16,199 speaking up cases** were raised with Freedom to Speak Up Guardians. This was a 32 per cent increase compared with the previous year in which 12,244 speaking up cases were raised with Freedom to Speak Up Guardians.



42. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the second year in a row we have published the FTSU Index.
43. London Ambulance Service scored 73.9% in the FTSU Index in 2020.
44. As mentioned above, the index suggests a positive speaking up culture is associated with higher performing organisations as rated by the CQC. This correlation is less apparent with ambulance trusts which tend to perform comparatively less well in the index despite most of them receiving 'good' ratings by the CQC. We will be undertaking a piece of work later this year to work with ambulance trusts and our partners to understand why ambulance trusts tend to perform comparatively less well in the index. We will also be working with ambulance trusts and our partners to develop a better understanding of the relationship between the FTSU index and CQC ratings.



National Ambulance Network of Guardians (NAN):

- 45. The National Ambulance Network (NAN) of Guardians meets quarterly to share good practice and provide mutual support. The meetings are held in different regions and include an element of CPD as well as an opportunity to network and share information.
- 46. The LAS FTSU Guardian is co-chair of the NAN and during the pandemic related lockdown has been participating in virtual meetings with other members in order to continue to provide support and share information. The Deputy Guardian has continued to be present at the NAN throughout Q1 and Q2.

Conclusion

- 47. The LAS continues to have a high level of engagement with the NGO, the National Ambulance Network and the London Region Network of Guardians.
- 48. The FTSU team have created a wide reaching plan for staff engagement during FTSU month in October to build on the work previously undertaken.
- 49. The efforts made by the LAS to expand the reach of the Guardian, promote Freedom to Speak Up activities and create an environment in which staff feel safe to raise concerns are reflected in the increased number of concerns raised. There is still more to do with regard to the Trust also promoting a culture of “listening up”
- 50. The Non-executive director for FTSU, Fergus Cass, continues to provide assurance and guidance to the guardian and escalates issues at board level.
- 51. The Committee is asked to note the contents of this report.

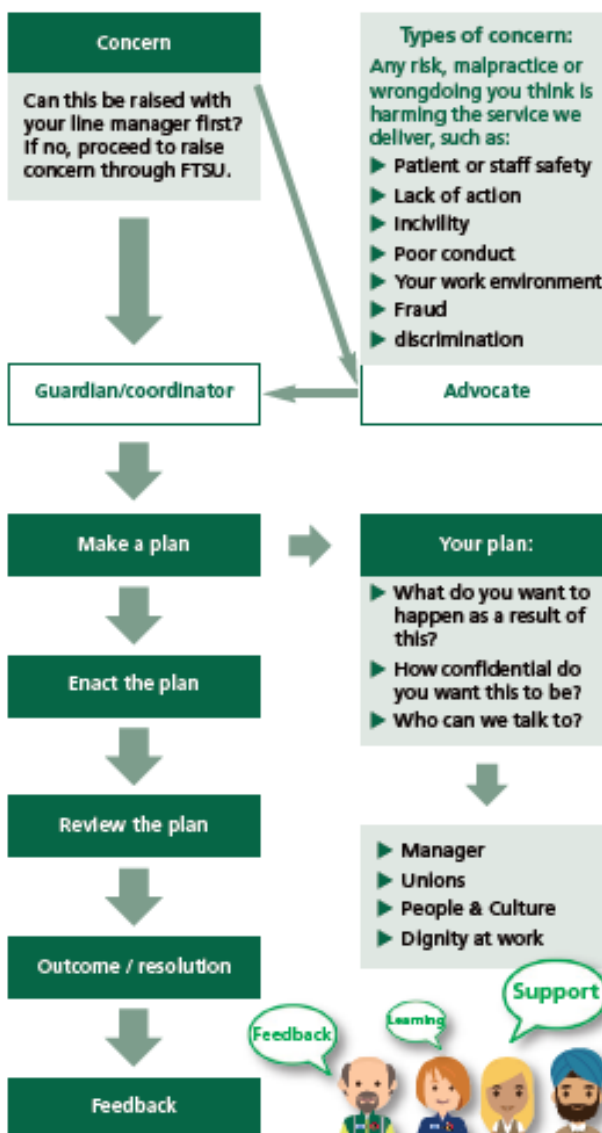
Erica Greene

Freedom to Speak Up Guardian



What happens when you raise a Freedom to Speak Up concern.

* Confidentiality will have to be broken if a member of staff or patient are at immediate risk of danger.



For more information please see the FTSU pulse pages and the FTSU policy.

