MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST <u>PUBLIC</u> BOARD OF DIRECTORS

Tuesday 26 January 2021 at 1pm – 3.30pm via video-conference

Agenda: Public session

Timing (pm)	Item		Owner		Status
1.00	1.	Welcome and apologies	HL	Verbal	
	2.	Declarations of interest	All	Verbal	
	3.	Minutes of the public meeting held 24 November 2020	HL	Enclosed	*Approval*
	4.	Matters arising	HL	Enclosed	
1.05	5.	**Our COVID Response** 5.1. **Our People** • Welfare • Sickness • Vaccination • Communication	GE	To follow	*Assurance*
		5.2. **Quality and Clinical Care** • Maintaining Safety and Quality during COVID	FW/TB	Enclosed	*Assurance*
		5.3. **Our performance in COVID**	KM	To follow	*Assurance*
	6.	**Finance and Performance** 6.1. Finance summary (month 9)	LB	To follow	*Assurance*
		6.2. Integrated Performance Report	GE	Enclosed	*Discussion*
	7.	**Strategy** 7.1. LAS response to the NHS People Plan	KN	Enclosed	*Discussion*
		7.2. Integrated Care Systems consultation response	RF	Enclosed	*Information*
		7.3. Quality Strategy Overview and Progress	TB	To follow	*Discussion*

Timing (pm)	Item		Owner		Status
Board Committee Reports					
	8.	**8.1. Finance** • Finance & Investment Committee • Charitable Funds Committee	FC FC	To follow To follow	*Assurance* *Approval*
		8.2. Quality and Clinical Care • Quality Assurance Committee	MS	To follow	*Assurance*
		8.3. People and Culture • People and Culture Committee	JM	Enclosed	*Assurance*
Governance and Risk					
	9.	**Governance and Risk** 9.1. Board Assurance Framework	SDa	Enclosed	*Approval*
	10.	**Any other business**	HL	Verbal	*Information*
3.30	**Meeting close**				

For information only:

- Patient Safety Investigation Framework Plan
- Annual Reports – Cardiac Arrest, STEMI and Stroke
- Formal DHSC and NHSE&I Consultations

Date of next meeting: 30th March 2021

TRUST BOARD: Public meeting – Tuesday 24 November 2020

DRAFT Minutes of the public meeting of the Board held on 24 November 2020 at 9.30am, via Video Conference

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Jill Anderson	JA	Associate Non- Executive Director
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 Affairs
Ross Fullerton	RF	Director of Strategy and Transformation
Kim Nurse	KN	Interim Director of People and Culture
Jason Rosenblatt	JR	Head of Engagement
Antony Tiernan	AT	Director of Communications and Engagement
James Stanton	JS	Head of Corporate Governance (Minute taker)

Welcome and apologies

1.   The Chair opened the meeting and welcomed everyone in attendance. In particular, the Chair welcomed all the members of the public viewing the meeting online and advised that a recording of the meeting would also be publicly available on YouTube for several weeks after the meeting. The Chair noted the recent appointment of Kim Nurse to the position of Interim Director of People and Culture and welcomed her to her first Board meeting.

2.   The Chair noted that no apologies for absence had been received.

Declarations of interest

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

Minutes of the meeting held in public on 29 September 2020

4.   The minutes of the meeting held in public on 29 September 2020 were approved as an accurate record.

Matters Arising

5.   The Board reviewed the action log. The updates on the three actions were noted and could be closed pending the discussion of the BAF risks later in the meeting and the consideration of training data and costs by the People and Culture Committee at its meeting in January 2021.

Report from the Chair

6.   The Board noted the Chair's written report and the overview of meetings and events provided.

7.   The Chair advised the meeting of the work around culture and inclusivity that the Board had undertaken as part of its recent development session. This had included a presentation from Amanda Oakes on how MerseyCare had introduced a 'Just and Learning Culture'. Board members had considered the potential benefits to the Trust of adopting this approach and it was noted that the Executive Committee would be taking this forward. The Chair also noted the inspiring contributions that had been received as part of the Board's development day, including from John Amaechi, which gave added focus to the work going forward.

8.   The Chair informed the meeting of the steps being taken to encourage the voices of even more frontline staff to be heard as part of the work of the Staff and Volunteers Advisory Panel. To ensure that the Chair and Panel could take counsel from as diverse a range of views as possible, it was proposed that the Panel's meetings alternate between the existing core membership group and wider, more informal meetings from frontline staff from January 2021. The Chair noted that some concerns had been received from staff side representatives as to whether this was a new group which would replicate existing arrangements. She advised that this was not the case. The arrangements for the Staff and Volunteer Advisory Panel would not affect or interfere with existing management or staff side arrangements. This development formed part of the Board's commitment to the 'Golden Thread' between the boardroom and the frontline.

Resolution:

The Board approved the proposed changes to the Staff and Volunteers Advisory Panel and its schedule of meetings.

9.   The Chair noted the celebrations that had been taking place within the Trust relating to Black History Month, Freedom to Speak Up, anti-bullying week and against Islamophobia. The Chair expressed support for these events and the opportunity to improve aspects of culture and advised that she hoped that all would continue to get involved as and when they occurred.

10.   Board members discussed the feedback arrangements following their recent development session on the 'Golden Thread'. Further responses would be shared with the Chair. Board members were encouraged to listen to the management broadcasts on Mondays, Wednesdays and Fridays as an opportunity to engage with staff. It was

also suggested that a visit take place, by arrangement, to crews at a hospital ramp as part of further developing a 'Board to ward' culture.

Resolution:

The Board noted the report.

Chief Executive's Report

11. The Board received the Chief Executive's Report and noted the high-level summary of actions since the last meeting.

12. The Chief Executive advised the Board on the progress that had been made on recruitment to several leadership positions. The process of appointing to the post of Associate Director of Culture Diversity and Inclusion was underway and a further update would be given during the private session. He also highlighted the work that had taken place to engage with staff widely across the Trust, including making use of technology to hold a successful programme of virtual roadshows.

13. The Chief Executive drew attention to the Trust's success in winning two awards and being nominated in five categories at the HSJ Patient Safety Awards. The Trust's mental health team had won the Mental Health Initiative of the Year Award for the Mental Health Joint Response Car pilot and the End of Life Care team had won the End of Life Care Award for their collaboration with Macmillan in developing the End of Life Care Coordinator network. In addition, the 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 Board joined with the Chief Executive in recording their congratulations on the teams for their success.

14. The Chief Executive also expressed his thanks to all involved in the production of the BBC's Ambulance series. The Communications and Operations teams in particular had put in a huge amount of work to make the initiative a success. It was noted that the series had had a massive impact in raising interest in the organisation. In addition to increased interest in working for the Trust, the series had highlighted what the service did and helped to bring focus on key issues such as the verbal and physical abuse of staff. The Board recorded their thanks for the work that staff had put into the success of the series.

15. Board members considered the update on patient complaint statistics. 37% of complaints were noted to relate to staff and volunteer conduct and behaviour, particularly in relation to challenging the validity of 999 calls. Board members sought assurance that follow-ups took place following investigations to identify whether quality of care for patients was affected or if the complaints related to the categorisation of calls. Complaints were taken very seriously and feedback given to staff on all incidents. In relation to the 281 conduct complaints, it was noted for context that the service responded to two million 999 and a further one million calls. The Trust was supporting the Health Service Ombudsman's development of new universal Complaints Standards Framework and this was expected to lead to new regulations.

Resolution:

The Board noted the Chief Executive's report and the celebrations and success stories contained within it.

Report from the Chief Operating Officer

16.   The Board received the report of the Chief Operating Officer. Members noted the update on the performance and delivery plans of the five operationally focussed directorates within the London Ambulance Service.

17.   The Chief Operating Officer provided further updates on the latest operational developments. The Trust was noted to have become the lead provider of 111-call handling for North West London following the mobilisation of the new service the previous week. The switchover had gone very well and all involved were thanked for the huge effort.

18.   The Trust had also gone live with the Electronic Patient Record the previous morning. The organisation and the wider health system would benefit directly from the move away from over one million paper records. In addition, over 9,000 email inboxes within the Trust had been migrated to nhs.net. This move to the NHS standard email system would provide benefits in increased patient confidentiality.

19.   Board Members noted the progress and trajectories for the Trust to be fully migrated to electronic patient records. More frontline staff were moving to the new system on a daily basis and it was anticipated that the vast majority would be transferred by the end of 2020. It was agreed that the Quality Assurance Committee should revisit what the new system would mean for improving patient pathways.

Action:
Quality Assurance Committee to receive an update on Electronic Patient Care Records and improving patient pathways.

20.   The Board agreed that their thanks should be recorded for all involved in delivery of the Electronic Patient Care Record (ePCR). It was noted that discussions had taken place at a Digital 999 meeting about the potential that this development had to enable transformational improvements for the Trust's patients. It was agreed that an update would be provided at a future pre-meeting. This would include clinical as well as non-clinical benefits.

Action:
An update on the opportunities arising from the introduction of the Electronic Patient Care Record to be presented at a future pre-meeting.

21.   The Chief Operating Officer also provided an update to the Board on the work which had been undertaken to survey the Trust's estate for Reinforced Aerated Autoclaved Concrete (RAAC). Further work was planned to address the site where RAAC had been identified.

22.   In response to queries about performance statistics and care home pathways, it was noted that times had gradually increased. Activity levels had risen however, the Board received assurance that the Trust remained resourced to meet demand and expected performance standards. The allocation of Trust resources was focused on putting capacity towards the parts of the system where increased demand was predicted. It was anticipated that the 111 First initiative would lead to an increase in usage of the service. It was expected that work would take place during the summer months to employ and train workforce. Covid and winter pressures had presented additional complexity in the current year and increased activity was expected.

23.   The Board discussed PPE supply arrangements and the NHS England strategy. Members were advised that the wider service had now geared up in response to Covid and the Trust had strong supply arrangements through North West London and the national supply process. The NHS England PPE Strategy applied to PPE stock levels

and supply chain. The management team had been working through the impact on the Trust. An update could be provided to Board members in writing.

24.   It was noted that, following the Trust's self-assessment as fully compliant against NHS Core Standards for Emergency Planning, Resilience & Response (EPRR), a desktop exercise would be held by regulators in the New Year. It was agreed that a quarterly update on HART would be provided to Board members.

Action:
An update on HART would be provided to Board members on a quarterly basis.

Resolution:

The Board noted the Chief Operating Officer's report.

Winter Preparedness and COVID Plan

25.   The Chief Operating Officer presented the Trust's Winter Preparedness and COVID Plan. He noted that the Trust had a strong track record on winter planning. Opportunities had been taken to learn from the experiences of the first Covid wave, the pressure that had been placed on 111 and 99 services and the ability to ramp up capacity at short notice.

26.   The Board noted that the planning process has also incorporated the potential impact of EU exit scenarios on the supply chain and medicines. Four key suppliers had maintained several months of stock. Additional work was noted to be ongoing and the potential impact would continue to be monitored on a daily basis. Members agreed that increased visibility would be useful on the preparations in place around the supply chain and the preparedness of smaller supplies. It was noted that a further announcement was due the following week and that this would help to inform a risk based approach. It was agreed that a further update would be provided to Board Members, potentially at a Board development session.

Action:
An update on EU exit arrangements would be provided to Members.

27.   Board members noted that the main challenges currently expected in the event of an exit from the EU transition period without a further deal would be around congestion in Kent and the impact this might have on staff getting to work. Plans were in place to support staff and it was noted that many were able to work in more agile ways following the first Covid wave. No immediate strategic risks were anticipated in this area and it was noted that the People and Culture Committee had been comfortable that resourcing issues had been addressed.

28.   The Chief Operating Officer provided further assurance on the support being given to patient facing colleagues in the move to ePCR. Staff were aware of the potential safety net of reverting to the paper records if required in the short term. It was noted that colleagues had been inclusive, supportive and understanding about the adoption of digital technology.

29.   The Board noted that the second wave Covid national lockdown was due to transition to a local tiered approach on 2 December 2020. The Chair queried whether the proposed opening of the tiers from 22-28 December 2020 could potentially cause a surge in activity in January and whether forecasts needed to be revisited to consider this. The Chief Operating Officer advised that planning continued and assumptions were revisited on an ongoing basis in the light of new information. The announcements

on the relaxation of tier restrictions over the holiday season and the start of the 111 First initiative were both being considered as part of the ongoing review.

30. The Board noted the information set out in the paper and the additional details presented at the meeting and agreed that it was assured on the planning arrangements in place for winter and Covid.

Resolution

The Board noted report and agreed that it was assured on the arrangements.

Director and Board Committee Reports
Integrated performance report

31. The Board noted the Integrated Performance Report.

Resolution

The Board noted the report.

Quality and Clinical Care
Directors Report (Quality)

32. The Chief Quality Officer presented the Quality Director's report. Quality performance remained strong with the targets for the different response categories being met for the majority of the period up to the end of September 2020. Variations in demand were noted to be reflected in similar patterns across incidents. This would continue to be reviewed on a daily basis. The increase in delays during shift handovers was noted. Trialling and rotating shift patterns were being looked at as ways of addressing this. Some delays had also been experienced in the coroners' process. The directorate's main focus had been on building the quality and assurance processes. Work had taken place with the ePCR team to develop triggers and this highlighted the advantages of the new system.

33. Members considered the report and queried the reasons underpinning the survival statistics for patients with cardiac arrest. This was noted to be a complex area where pre-hospital treatment had improved the survival rates to hospital over time, including the more serious cases that might not have been immediately survivable in the past, at which point medicine took over. The Board was advised that one of the key factors related to understanding patients' underlying conditions. Work was taking place to improve access to this knowledge and the ePCR system would help with this. Close working was also taking place with cardiac centres to learn from and expand pathways, ensuring that patients get to the most appropriate treatment first time.

34. Members noted that PDR completion rates were below the Trust standard. The Chief Operating Officer noted that he had been actioned to review and produce a recovery plan and agreed this would take place. Members advised that the action plan should include a trajectory and expected completion dates for PDR standards to be met.

Action:
KM to ensure PDR trajectory.

35. Board members noted that progress was underway with the business case and provider for body worn cameras. The business case would be considered by the Portfolio Management Board prior to coming to the Board for approval.

Directors Report (Clinical Care)

36. The Chief Medical Officer presented the Clinical Care Director's report and noted the ongoing collaborative work around pathways. Collaborative working was continuing with the regional and local stakeholders to embed many of the local pathways that had been set up during the first peak of COVID-19. This would ensure that patients could be treated closer to home where clinically appropriate, reducing Emergency Department crowding and minimising the risk of infection. Health and social care information was being brought together for the first time.

37. The Chief Medical Officer also noted that three senior clinicians had completed the prescribing course and that this programme would continue to be rolled out with the next cohort. The directorate had also welcomed senior nursing clinicians into the team and recruitment was underway for two new Consultant Paramedic posts. The Chief Medical Officer also recorded her thanks to Paul Gates for his work.

Quality Assurance Committee meeting

38. The Chair of the Quality Assurance Committee presented a report of the most recent meeting of the Committee. The Committee had supported the reinstatement of BAF 62, as there was a risk to service disruptions due to EU exit on 31 December 2020, although they had concluded that the risk score might be too high as there were mitigations in place to reduce the impact on the Trust. This would be considered under the BAF discussion later in the meeting.

39. The Quality Assurance Committee had considered an update on winter planning, in particular in relation to predicting activity and the Trust response, for assurance. The Committee Chair noted that the Trust was ahead of where it was the previous year. He also drew the Board's attention to the work that had been taking place on the Service Quality Accreditation pilot.

40. Members noted that an update on flu vaccination numbers would be given later in the meeting. It was also noted that further updates would be made to the Committee in January 2021.

Action:
A further update would be provided to Board Members on the Flu Programme.

People and Culture
Directors Report

41. The Chief Executive presented the People and Culture Director Report noting that further improvements had been made towards the Trust's target of its workforce reflecting London in terms of the number of BAME colleagues. There had been some increase in staff absences however, they remained significantly lower than the previous year. The Trust was reportedly one of the best performing in the NHS for flu

vaccinations, with 68.4% of staff having had the vaccine and over 80% having been offered it.

42.   The Board discussed the report and, in particular, the implementation of the resolution framework and how recent discussions around the MerseyCare model might be incorporated. The success of the resolution framework would be judged on a decline in the number of cases. It was noted that the experience of MerseyCare had been that it took a year for the number of formal grievances to reduce. Members noted that this would improve the position going forward but also sought assurance on how the number of outstanding grievance cases would be brought down. A review into the backlog of cases had revealed that a number were related to significant timekeeping issues. The Chief Executive advised that consideration had been given to an amnesty however, in virtually all cases, it was not felt to be appropriate. The Director of People and Culture would review the position and provide an update to the People and Culture Committee on expected timescales and trajectories.

Action:
KN to update People and Culture Committee on trajectories and timescales for reducing the number of outstanding grievance cases.

43.   The Chair noted the Board's expectation that the number of outstanding cases would not go up and that suspensions needed to be limited to 14 days (followed by a review and, if necessary, a further 14 days).

Resolution

The Board noted the report.

People and Culture Committee meeting

44.   The Chair of the People and Culture Committee presented a report of the most recent meeting of the Committee. The Committee had supported the reinstatement of BAF 62, in relation to the EU exit arrangements, and had requested that the Board consider the proposed new BAF risk in respect of immunisation and vaccinations. These would be considered later in the meeting.

45.   The Committee had considered the Trust's 18 month People Plan, noted to be the first time that the Trust had carried out this work, and the NHS People Plan. Following a review of the draft gap analysis of the Trust's position, the Committee had asked that those gaps be formalised and incorporated into 18 month People Plan. The Committee Chair advised that the Committee had also held a very useful discussion about Freedom to Speak Up and Dignity at Work.

Resolution

The Board noted the report.

Finance & Audit
Director's Report

46.   The Chief Finance Officer presented the report. It was noted that the risk in relation to achieving the Trust's Plan had been removed as national contingency funding had been confirmed. The Chief Finance Officer also advised the Board that she had taken up the position of Chair of the AACE National Ambulance Finance Directors group and would be representing the national finance directors on the Ambulance Improvement and Implementation Board. These appointments would enable the Chief Finance

Officer to play an active role as the groups moved towards implementation of Lord Carter's report on NHS ambulance trusts.

Resolution

The Board noted the report.

Finance & Investment Committee

47. The Chair of the Finance and Investment Committee, presented a report of the most recent meeting of that Committee to the Board. In relation to BAF risks to be considered later in the meeting, the Committee had requested an update of assurances around the procurement implications of the end of the Brexit transition period.

48. The Finance and Investment Committee had met jointly with the members of the Logistics and Infrastructure Committee to consider and recommend approval of Trust business cases. The business cases would be presented during the Trust Board's private meeting for consideration.

49. The Committee had also recommended a longer-term financial framework, including a plan for the delivery of cost improvement targets in 2021/22 and beyond and a strategy for investment in property assets, giving guidance on whether these should be leased or owned.

Resolution

The Board noted the report.

Audit Committee

50. The Chair of the Audit Committee presented a report of the most recent Audit Committee meeting to the Board.

51. The Committee had considered a new first and second line of defence assurance report from Corporate Governance, Finance and Operations and recommended the preparation of an assurance map based on the three lines of defence model. This would provide greater clarity by codifying Board, Committee and executive responsibilities.

52. The Board agreed that quotes be sought from external consultancy firms on a Well-Led review as phased deep dives over a period of time. It was noted that the scope of Internal Audit's review of the BAF would be reconsidered in the light of this and "Golden Thread"/Board to ward assurance, to optimise synergy and benefit.

Resolution

The Board agreed that quotes be sought from external consultancy firms as part of a Well-Led review.

53. The Committee had also considered Emergency Preparedness, Resilience and Response (EPRR) arrangements. The Board was asked to confirm whether EPRR should be a matter reserved to the Board or whether delegation to the Audit Committee would be appropriate. Following discussion, the Board agreed that EPRR should continue to be a matter for the Board in order to avoid duplication. The Chair noted that there was a role for non-executive directors in the culture of EPRR.

Resolution

The Board agreed that EPRR remain a matter reserved to the Board.

54.   The Committee had received the draft unaudited annual report and financial statements, as considered by the Charitable Funds Committee and agreed that they be recommended for approval.

Resolution

The Board noted the report.

Logistics and Infrastructure
Logistics and Infrastructure Committee

55.   The Chair of the Logistics and Infrastructure Committee presented a report of the most recent meeting of that Committee to the Board, noting that members of the Committee had also taken part in a meeting with the Finance and Investment Committee to consider Trust business cases.

56.   The Committee Chair advised the Board of a number of important business threads that the Committee had asked to be kept informed of. The Committee had requested an update on stock level and supply chain implications in relation to the UK's departure from the EU. The Committee had also asked for strategic financial modelling of the options for leasing versus buying to support the Ambulance Operations Modernisation business case. In relation to plans to develop the next generation of ambulance, aligning with the national specification for a zero emissions, lightweight, accessible vehicle, it was noted that funding would be from the national ambulance vehicle programme.

57.   In relation to risks, it was noted that the wording of the BAF risks had been reviewed and updated at the Committee's request to ensure that they reflected the current risk position.

Resolution

The Board noted the report.

Digital 999 Programme Assurance Group

58.   The Chair of the Programme Assurance Board presented the report.

59.   The program remained at Amber status. It was noted that an update on ePCR had been given elsewhere on the agenda. Discussions had taken place as to how to make the best use of CAD. Further consideration was being given as to whether that would mean reconfiguring the system or adapting ways of working.

60.   The Trust Chair noted the particular importance of communication with the Digital 999 Programme. The good progress was noted and the team was thanked. While an element of risk was noted to remain, it was agreed that the programme was looking more robust.

Resolution

The Board noted the report.

Nomination and Remuneration Committee

61. The Trust Chair, as Chair of the Nomination and Remuneration Committee, updated the Board on the meetings of the Committee.

62. The Committee had met four times since April 2020. It had fulfilling its responsibilities in its Terms of Reference by:

    - reviewing through use of external benchmarking data Very Senior Manager (VSM) remuneration;
    - Considering the balance of the Board in agreeing to appoint a Chief Quality and Paramedic Officer including the job description and search and selection process;
    - Approving the appointment of a new post - Associate Director of Culture, Diversity and Inclusion; and
    - Reviewing and considering the recruitment process and appointments of existing posts the Director of Ambulance Operations as well as the Director of Integrated Patient Care.

63. The Committee had requested that a policy be established to outline its approach for making such decisions; this policy would be considered at the next meeting.

64. Board members noted with appreciation the work that Wayne Donaldson had carried out in this area.

Resolution

The Board noted the summary provided and agreed that it was assured that the Nomination and Remuneration Committee was fulfilling its responsibilities as set out in its terms of reference.

People and Culture
18 month People Plan

65. The Chief Executive presented the 18 month People Plan.

66. The Board noted that the Plan represented a comprehensive, high level approach to how the Trust would deliver its workforce over the next 18 months. Board members expressed support for the progress that had been made. Members enquired as to how the metrics present in the Plan could be further developed. The development of a scorecard was suggested and the availability of survey tools noted.

Action:
GE to take forward suggestions for the further development of the metrics and available tools outside of meeting.

67. Members noted the work that was still to be done. The results of the current staff survey would be an opportunity to capture feedback from initial improvements, with next year's survey showing the results of change. The Trust was investing in mentoring staff, including the coaching and mentoring of executive directors. It was acknowledged that further consideration needed to be given as to whether this was being fully utilised as an organisational development tool in a structured approach.

Resolution

The Board noted the report.

Strategic Workforce Planning

68. The Chief Operating Officer presented the paper and noted the work that had gone into addressing the challenges ahead.

69. The plan was noted to be dynamic and ambitious. It looked to significantly increase some of the Trust's workforce establishments including urgent care, call handling and ambulance response. Learning from the Trust's experiences with Covid had been incorporated in the assumptions underpinning the plan. Finances were still being negotiated and so it had been developed on an assumption of continued levels of funding. Going forward, there would also be a need to identify and understand wider systems ambitions.

70. The Board noted the importance of the work aligning with the financial plan and views on reduced conveyance. The success of workforce planning would need to be considered alongside its deliverability, impact on efficiency improvements and the importance of its setting within the financial framework. The Chief Finance Officer noted that the next step would be to identify the specifics in terms of productivity gains and a benefits realisation plan. Members were agreed that there was a need to see this piece of work together with the longer-term plan, cost base and the delivery of infrastructure changes.

71. In relation to workforce accommodation, it was noted that work on call centres and patient facing operations, which took place on the road, would be considered as part of the wider Ambulance Modernisation programme.

Resolution

The Board:
- reviewed and approved the workforce plan (pending the agreement of the Trust Business plan later in the year), noting that there was a need to align this with other key pieces of work;
- supported the continuation of recruitment and training before the Trust 2021/22 Business Plan is agreed; and
- supported the creation of a Workforce Planning group to coordinate and oversee delivery of this workforce plan.

Finance
Annual Financial Plan 2020/21

72. The Chief Finance Officer presented the Annual Financial Plan 2020/21, noting that the Plan had been approved by the Board in September 2020 subject to finalisation and agreement of financial arrangements for the remainder of the year with North West London STP.

73. The Chief Finance Officer highlighted the changes from the previous version of the Financial Plan. The settlement agreed for the remainder of the financial year would set an income envelope of £522.2m. This was £5.1m less than the previous plan due to the exclusion of £5m COVID 19 surge costs. The settlement was not subject to system incentives and benefits for the elective recovery programme and confirmation of the Cost Improvement Programme (CIP). The Trust was now expected to deliver a control total surplus of £2.3m following the inclusion of additional non-NHS income contribution that had been assumed to be funded by NHS England.

74. It was noted that the NWL STP Plan had not been requested for resubmission by NHS England. The Financial Plan was predicated on a CIP of 1%. It was necessary

for the level of the CIP to increase to cover the costs of business cases of changes that had been approved by the Trust. The Trust had agreed a £2.4m cost improvement contribution to NWL STP and required a further £1.9m cost improvement to fund the additional revenue costs of the capital programme. This would require a total cost improvement of £4.3m. This would be the minimum target that the Trust would aim for and there was confidence that the main components were in place to give assurance for 2020/21. It was noted that a large element of the cost improvements was non-recurring.

75.   The Chief Finance Officer advised that, due to the confirmation of funding arrangements, the BAF risk in this area had been largely mitigated.

76.   The Chair of the Finance and Investment Committee informed the Board that the Committee supported endorsing the Financial Plan. The Committee had also highlighted the importance of bringing the cost pressures around 111 IUC back on track. The Chief Operating Officer advised that additional funding of £3m had been received for mobilisation and he had confidence that the risks could be mitigated.

77.   The Chief Finance Officer advised the Board that the national settlement level for the capital programme had been £41.8m. This was below the £50.3m of capital projects presented in the previous version of the Financial Plan. Whilst the approved figure was more than double the Trust's usual capital budget, the shortfall meant that reprioritisation of the proposed projects would need to take place.

78.   The Board was advised that the list of capital projects had been risk adjusted to £45m, leaving a significantly smaller gap to be found. It was proposed that the authority be delegated to the Chair to enable the capital programme to be reprioritised in line with the submission timetable. The Chair advised that she would need to be provided with assurance that the proposal did not affect the BAF or risk register and that the Chairs of the Assurance Committees could provide assurance on aspects such as quality and safety. Deliverability within the financial year was also raised as potential issue.

Action:
LB and KM to produce paper for Assurance Committee Chairs prior to consideration by the Trust Chair.

Resolution

The Board noted the remaining risks and approved the Trust financial plan for 2020/21 subject to the approval of the reprioritisation of the capital programme being delegated to the Trust Chair following consultation with the Assurance Committee Chairs.

Governance and Risk
Board Assurance Framework

79.   The Director of Corporate Affairs presented the Board Assurance Framework (BAF) to the Board, noting the changes made since the previous Board meeting on 29 September 2020.

80.   The Board noted the BAF risk updates provided and the consideration given to changes in risk ratings by the Assurance Committees. The Board considered three additional BAF risks. These were in relation to the UK's exit from the EU (to be reinstated as a BAF risk), the uncertainty around funding arrangements and the risk arising from asymptomatic testing of staff. The Chief Executive advised that the position regarding asymptomatic testing had moved on and this was now considered

to be of a lower level of risk (a rating of 8 rather than 12). It was noted that this would not affect the overall risk rating, as the operational risk remained at 12. Members also noted that the risk rating for BAF risk 63 was 15 (5x3) and not 10 as referenced in part of the paper.

81. The Chief Operating Officer advised the Board that he had agreed with the Audit Committee Chair that a deep dive would be held into our NHS 111 services.

Action:
KM to hold deep dive on our NHS 111 services.

Resolution

The Board:
- noted the updated information on BAF risks 45, 56, 58 and 61; and
- approved new BAF risks 62, 63 and 65 for addition to the BAF.

Any Other Business

82. There was no other business raised

Additional Reports

The Board received the following additional reports for information only:

- Corporate Risk Register;
- Quality Report;
- SI Report; and
- Freedom to Speak Up Report

Meeting Close

The next Trust Board meeting in public will take place on 26 January 2021.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	Comments / updates *(i.e. why action is not resolved / completed)*
Annual Financial Plan	LB and KM to produce paper for Assurance Committee Chairs re-prioritisation of the capital programme prior to consideration by the Trust Chair.	Lorraine Bewes and Khadir Meer	02/11/2020	26/01/2021	An update will be provided prior to the meeting.
NHS 111 services	KM to hold deep dive on NHS 111 services.	Khadir Meer	02/11/2020	TBC	The deep dive review of 111 remains a key priority, however with the disruption of the second wave of COVID the deep dive is currently more operationally focussed to deliver a number of improvement initiatives to: • ensure we regain delivery of performance targets to manage elevated levels of demand • stabilising our core capacity with the high number of staffing absences as a result of sickness or COVID isolations • introduction of an organisation structure to improve oversight and management of 111 In the near future we will look to continue the deep dive of services, including how we will continue to operate 111 services within the contract envelope and ongoing improvement and integration plan.

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	Clinical and Quality Oversight during Covid
Agenda item:	5.2
Report Author(s):	Dr Patricia Bain, Dr Fenella Wrigley, Helen Woolford
Presented by:	Jointly Dr Bain and Dr Wrigley
History:	QAC and NHSE/I

Purpose:	☒ Assurance	☐ Approval
	☒ Discussion	☐ Noting

Key Points, Issues and Risks for the Board's attention:

- The report provides and overview of the current clinical safety and quality mechanisms that are in place to monitor the current impact of Covid on patient safety and quality.
- The report outlines the key areas which delays may occur, the monitoring and oversight of daily patient safety and quality reporting, governance mechanism both internally and across the system and national partnership collaboration.
- The Structured Judgement Review process will be outlined and current position in relation to the trust wide vaccination programme will be provided.
- The information has been shared with NHSE/I and has been received positively.

Recommendation for the Board:

The Board is recommended to discuss and note the systems and processes to provide assurance that the impact of Covid is being monitored, acted upon and reported in a robust manner.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	x	No		QOG and QAC , NHSE/I
Finance	Yes		No		
Chief Operating Officer Directorates	Yes	x	No		CQO
Medical	Yes	x	No		CMO
Communications & Engagement	Yes		No		Pauline O'Brien
Strategy	Yes		No		

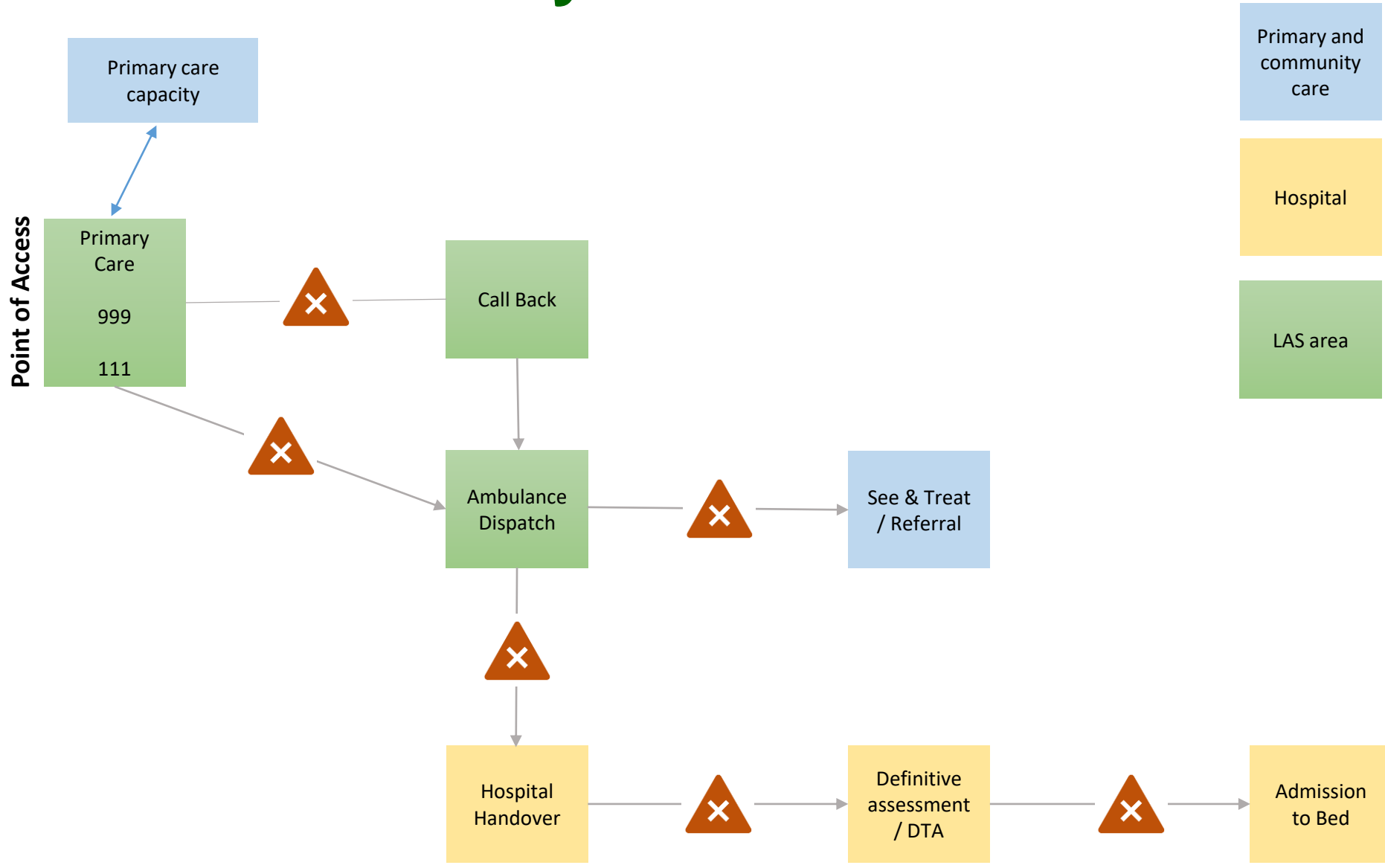|				
People & Culture	Yes		No	
Corporate Governance	Yes		No		Syma Dawson

Maintaining clinical safety & quality during COVID December 2020 – January 2021

Dr Trisha Bain, Chief Quality Officer,

Dr Fenella Wrigley, Chief Medical Officer

Helen Woolford, Head of Quality Improvement and Learning

Potential Points of Delay

What does this mean for patients

- There are four categories:

- **Category one**: for life-threatening injuries and illnesses, specifically cardiac arrest. Average time of seven minutes, and the 90th centile* in 15 minutes.

- **Category two**: for emergency calls, such as stroke patients. Average time of 18 minutes, and the 90th centile* in 40 minutes. **National safety threshold – 80 minutes**

- **Category three:** for urgent calls such as elderly fallers abdominal pains. These will be responded to at least 9 out of 10 times within 120 minutes. – **National safety threshold –240 minutes**

- **Category four:** less urgent calls such as diarrhoea and vomiting and back pain. These less urgent calls will be responded to at least 9 out of 10 times within 180 minutes.

LAS safety and quality oversight

- 4 times per day Clinical Safety review calls to oversee the current operational position of the Trust and safety of patients waiting for an ambulance

- Daily review of incidents reported onto DATIX by quality governance team – look at patient related, staff related, Trust related and other and escalated to SIG as needed

- Daily longest held 999 and 111 report with CAD numbers for clinical review

- Continuous re-contact audit (hear and treat) - Number of re-contacts by Sector within 24 hours of initial discharge at scene, where patient was pre-alerted or died unexpectedly upon re-contact

- Complaints triangulation and oversight

- Quality alerts from wider health system review

- Learning from deaths reviews

- Additional senior clinical presence in EOC and on call to support the despatch decisions and crews on scene

Structured Judgement Review (SJR) Process

SJR Review (Review Team):
Incident and patient details: date, CAD, age, gender, outcome, presenting complaint, location (i.e. own home, care home etc.), determinant/MPDS code, Category of call, overall response time, first on scene (SOLO/DCA).
Review also contains following sections:
- Call answering details
- Call dispatch details
- ROLE details
- LfD priorities

Review BI data (QI&L Team):
'Long delay' and deceased on scene
Delay of more than the 90th centile and pre alert to HAC with STEMI, HASU* or ED for the treatment of an OD
Delay in 999 call answering of >2 minutes for a patient in cardiac arrest**

Second Review (clinician):
Detailed review of the patient journey including a review of the care provided and the handling of the 999 call.

Care and/or service delivery problems in addition to the delay which has contributed to patient harm to be escalated to SIG for consideration to declare incident as an SI

Care and/or service delivery problems in addition to the delay which has not contributed to harm to be managed as a local investigation

Serious Incident Group (SIG) & SJR Decision (Trust):
Present the number of patient safety incidents for 'long delays' and delays in 999 call answering. (These are to be added to the list for an SJR)
Provide the information of each patient safety incident for the delays of more than the 90th centile and pre alert category. (These may be added to the list for an SJR depending on the SIG discussion)

SJR outcome (QI&L team):
Was there any care and/or service delivery problems identified aside from the delay?
If yes - refer for a second review
If no - no further action required

Log an Incident (QI&L Team):
Search incident management system (Datix) to check that the incident has not already been reported
Log as a patient safety incident and indicate that it is for review by the Serious Incident Group (SIG)

* Those conveyed who, as a result of the delay, are outside of the 'treatment window' (4.5 hours).

**Exclusions include those who are obviously deceased on scene or have a DNARCPR in place.

This aligns to the London Ambulance Service's Patient Safety Incident Response Framework (PSRIF) which is currently being piloting for ambulance services nationally.

The LAS data is reviewed by applying filters the following filters:

	Filters Applied	Inclusion criteria
Delayed response and deceased on scene	Disposition 9008 & DoH Category C1 Sort Call Connect/Start To First Response Arrival (hh:mm:ss) from longest time (Z-A)	Call Connect/Start To First Response Arrival (hh:mm:ss) of >15 minutes
	Disposition 9008 & DoH Category C2 Sort Call Connect/Start To First Response Arrival (hh:mm:ss) from longest time (Z-A)	Call Connect/Start To First Response Arrival (hh:mm:ss) of >80 minutes
	Disposition 9008 & DoH Category C3 Sort Call Connect/Start To First Response Arrival (hh:mm:ss) from longest time (Z-A)	Call Connect/Start To First Response Arrival (hh:mm:ss) of >240 minutes
Cardiac Arrests	Final Determinant code 9 (Cardiac arrest protocol) select all options from protocol 9 (all determinants with a 9 prefix) Sort Call Connect to Call Start (hh:mm:ss) from longest time (Z-A)	Delay in call answering of more than 2 minutes
Non Covid19 Patient Groups	Final Determinant Code 10 (Chest pain protocol) – select all options from protocol 10 (all determinants with a 10 prefix) Bluecall Y	Delay of more than the 90th centile and conveyed to a CATH lab (blue call details are on the EOC log tab of call log)
	Final Determinant Code 28 (Stroke protocol) – select all options from protocol 28 (all determinants with a 28 prefix) Bluecall Y	Delay of more than the 90th centile and suggestion that the patient is no longer in the window (4.5hours) from onset of symptoms
	Final Determinant Code 23 (Overdose protocol) – select all options from protocol 23 (all determinants with a 23 prefix) Bluecall Y	Delay of more than the 90th centile and evidence that the patient has taken an overdose

Agreed system wide approach to oversight

- LAS, EoE, SECAMB and SCAS working to develop the Structured Judgement Review approach to provide a more systematic and robust process including how to risk assess and identify both immediate and longer term harm.

- Learning from the process will feed into system wide partnership meetings and national ambulance service reviews

- In addition the handover delays assessment has been reviewed by National Quality Governance and Risk Directors (QGARD) and National Ambulance Service Medical Directors (NASMED) and national audit tool has been agreed whereby each service will audit delays at a point in time to assess any potential harm.

- In conjunction with NHSE London, LAS has agreed COVID and non COVID cohorting processes which will be supported by the use of a systematic approach to identify deteriorating patients.

LAS governance oversight

- Dynamic decisions are made using the Clinical Safety Escalation plan (CSEP) where clinical recommendations are made to the Gold Commander.

- Resource Escalation and Action Plan is reviewed weekly

- Decisions are supported by a Joint Decision Making document and Quality Impact Assessment completed by Gold Commander

- Ambulance skill mix matrix level for use is approved

- All new clinical pathways for LAS are approved through LAS Clinical Advisory Group and Daily Senior Leadership Group

- All new clinical pathways are overseen though the Patient Safety and Clinical Effectiveness Group (PSCEG) which reports to the Quality Oversight Group (Executive level) and Quality Assurance Committee (Board Assurance)

- Clinical Pathway changes for pan London or a sector of London are ratified via NHSE Clinical Advisory Group (CAG) - see next slide

- NASMED and QGARD engagement for consistent and standardised approaches.

System briefing and clinical engagement

Regional and National engagement CEO, COO, CMO, CQO

- Regular meetings with Regional CEOs, Medical Directors and ICS leads
- Nightingale 2 - workshops and meetings
- Regional COVID vaccination meetings
- Oxygen resilience meetings
- NHSE Clinical Advisory Group
- Critical Care transport meetings
- NHSE London briefings
- Emergency Medicine Clinical Leaders
- National ambulance groups

ICS level

ADO and SSCL attending local meetings with:

- AE delivery boards
- Local clinical advisory groups
- Working with hospitals and ICS to develop cohorting plans and local plans to manage patient flow
- Hospital Ambulance Liaison Officer support at key sites
- SCG

Integrated Urgent Care

- Stakeholder and provider engagement
- Downstream
- Engagement with community and primary care and Out of Hours providers to increase

What we have collectively done to maintain safety across London

- Support with senior clinicians to make decisions early in the patient journey – 999, 111 and in community to reduce Emergency Department crowding
- Development COVID and non COVID ambulance cohort areas
- COVID assessment hubs / hot hubs
- COVID clinical team to support COVID@home and self management advice
- All current and new community pathways on the DOS
- Increased access to OOH provision and primary care
- Increased Integrated Urgent Care IUC / 111 provision – 111*5, 111*6
- Clinical support into nursing homes
- Increased social care to avoid re-attendance and readmission
- Mental health access for early triage and support / access to crisis teams
- Collaborative plans for delivery of COVID vaccination to Healthcare workers

London Pathways in place

- Close working with local ICS leaders to develop and implement pathways to support bed capacity, oxygen supplies and centralisation of some services (ITU / critical care; paediatrics)

- Examples:

  - Domino redirects to manage capacity (all 5 ICS)

  - 111*5 and ED revalidation

  - Opening up of appointments in community / OOH / primary care for CHUB and IUC

  - Centralisation of some beds (paediatrics NCL and NEL)

  - COVID@Home

  - Cohorting and Red SDEC for COVID patients

  - Critical Care Transport Service

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	Integrated Performance Report
Agenda item:	6.2
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance
Presented by:	Lorraine Bewes, Chief Finance Officer
History:	N/A

Purpose:	☒	Assurance	☒	Approval
	☒	Discussion	☐	Noting

Key Points, Issues and Risks for the Board's attention:

This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendations for the Board:

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

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	

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	**Agreed**			**Relevant reviewer [name]**

London Ambulance Service – Integrated Performance Report

Report for discussion with Trust Board members

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

Contents Page

Overview

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:

Achievements since the last report (November 2020)

Provide outstanding care for **our patients**

999 Performance in all national measures has remained strong since the Covid-19 measures have been implemented. The Trust was 1st in C1 and 2nd for C2 mean; finishing 1st in C3 mean nationally. The C4 90th centile was within target in November where we finished 3rd nationally.

111 Performance on calls answered within 60 seconds was outside target for North East London (NEL) and within target for South East London (SEL) with increased call demand in November. The abandonment rate at both sites are within target. The Trust is continuing to see the increase in call demand and are monitoring this rise in trend. This is due to the increase of overall Covid-19 cases in London during November and higher reliance on the service during the second national 4 week lockdown; along with winter pressures and the introduction of 111 First.
The Trust has been commissioned to undertake the 111 services for NWL and has rolled out phase 1 of its service provision with London Central & West Unscheduled Care Collaborative ('LCW') and Practice Plus Group (PPG) as mandated sub-contractors, from mid November.

- *The Trust is preparing for the introduction of '111 First' in December 2020 and have received funding for £2.9m to assist with delivery of this programme.*

- *The Station Quality Accreditation Pilot has been conducted. The aim is to drive quality standards by empowering front line staff to make improvements in line with the CQC standards, with 4 stations achieving 'Gold' accreditation levels at the end of the pilot. Further development of this programme continues.*

- *The Quality Improvement (QI) hub model has been trialed in IUC services. The model will align to the ambulance modernisation programme to develop a quality business unit model. This will achieve the strategic aim to embed improvement into daily operations and further develop our patient safety culture.*

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

We continue to 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 for Ambulance Services has increased from 3.5% in September to 3.9% in November and we are forecasting an end of year operational gap of 3.3% (111fte) posts. Our turnover rate has continued to improve from 8.6% to 8.4% since the last report. The monthly Trust wide sickness has remained at 4.8%, below the rate for the same period last year (5.7%). Trust compliance in statutory and mandatory training has marginally reduced from 84% to 83% whilst appraisals are continually improving, now sitting at 76% from 67% in September. Response to the Mental Health first aid training has been positive, seeing 400 colleagues sign up in November.

- *We welcome Kim Nurse who has joined us as Interim Director for People and Culture and Athar Khan who has been appointed to the position of Associate Director of Culture Diversity and Inclusion.*

- *Flu vaccination rates at 77% for frontline staff (up from 56% the previous year)*

- *Staff Survey response rate of 72% - highest ever number of responses (4,427 up by 212) and second highest amongst Ambulance Trusts.*

- *The Trust completed the scanning of 13,000 files and 2 million images as part of the Digital HR Files project and the Immunisation catch-up programme has seen over 1,000 staff receive boosters and/or blood tests.*

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

In line with plans agreed with NW London partners, the Trust reported a surplus of £862k YTD before measurement adjustments in relation to donated assets (£776k surplus on an adjusted financial performance basis) and is forecasting a £2.4m surplus in line with NW London STP planning. The amount of retrospective top up recognised covering M1-6 remained unchanged at £49.9m YTD and the Trust's M8 YTD reported COVID costs were £58.5m.

Capital spend net of disposals was £10.9m YTD (including COVID-19 phase 1 response requirement capital of £5.6m) with a full year forecast capital expenditure of £41.8m which has been reduced in conjunction with NW London partners in response to reduced capital funding availability. The month end cash position was £78.6m.

- *The Trust has been operating under an adjusted financial framework for April to September 2020 which involved pausing business planning and contracting, block income and top up income for COVID expenditure.*

- *From month 7 this framework has been replaced with fixed income envelopes managed at STP level, and will require the achievement of financial efficiencies by the Trust of £2.4m, with additional efficiency required to match new approved spend (currently £4.5m, total £6.9m).*

- *This new plan has now been reflected in revised NHSI plans and internal budgets.*

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. As we enter the winter period coinciding with additional Covid-19 demand, hospitals are beginning to face increased pressure with daily activity, especially in the North East area of London.

The Trust continues to achieve a robust performance around Handover to Green (14.9 minutes). Similarly, the Emergency Department (ED) conveyance during November was in a good position although we are continuing to see an upward trend with our conveyance to ED.

LAS performance for Hear & Treat was 8.5% and 0.6% better than the national average of 7.9%. The best in class was 10.2%. LAS attained 54.8% for ED conveyance, with us just finishing at 0.4% lower than the national average of 53.3%. The best in class for this metric was 50.2%

- *?Fenella / Agatha - re emergency and urgent care pathway?*

- *?*

- *Trust continues to work with system partners to monitor and improve hospital handover metrics, both of which are included in the LAS Business Plan for 2020/21.*

Patients Scorecard

November 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	National Data	Best In Class	Ranking (out of 11)
				Current Perfomance					**Benchmarking (Month)**		
Category 1 response – Mean	mm:ss	Nov-20	🟢	07:00	A	00:06:03	00:06:17	00:06:49	07:14	06:03	1
Category 1 response - 90th centile	mm:ss	Nov-20	🟢	15:00	A	00:10:07	00:10:37	00:11:37	12:42	10:07	1
Category 1T response – 90th centile	mm:ss	Nov-20	🟢	30:00	N	00:14:55	00:15:04	00:17:57			
Category 2 response – Mean	mm:ss	Nov-20	🟢	18:00	A	00:14:16	00:14:19	00:20:57	21:16	13:39	2
Category 2 response - 90th centile	mm:ss	Nov-20	🟢	40:00	A	00:27:08	00:26:43	00:43:38	00:42:50	00:25:29	2
Category 3 response – Mean	h:mm:ss	Nov-20	🟢	1:00:00	A	00:36:04	00:34:31	00:51:15	00:58:31	00:36:07	1
Category 3 response - 90th centile	h:mm:ss	Nov-20	🟢	2:00:00	A	01:21:35	01:17:27	01:57:07	02:18:33	01:21:35	1
Category 4 response - 90th centile	h:mm:ss	Nov-20	🟢	3:00:00	A	02:23:53	02:20:57	03:21:44	03:17:09	02:14:41	3
Call Answering Time - 90th centile	ss	Nov-20	🟢	24	I	1	2	47			
ROSC at Hospital	%	Aug-20	🟢	31%	N	33.2%	25.6%	27.8%	29.4%	37.3%	4
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Jun-20	🔴	95.0%		92.5%			80.6%	92.5%	1

*National average YTD

Benchmarking Key

Top 3	
Ranked 4-7	
Ranked 7+	

Please note: 999 performance data is correct as at 14/12/20 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*

999 Response Time Performance

The Category 1 mean in November returned 6 minutes and 3 seconds while the Category 1 90th centile was 10 minutes and 7 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 first in the Category 1 mean measure and Category 1 90th centile measure when compared to all Ambulance Trusts across England. The second national lockdown was in effect for 4 weeks from Thursday 5th November, reducing the pressure on LAS performance.

Please note: 999 performance data is correct as at 27/11/20 and is subject to change due to data validation processes

| | **Monthly Trend** | **Daily Analysis** | |

C1

Mean: 6:03

Target: 7:00

90th Centile: 10:07

The C1 mean performance had been continuously within target, apart from the figures in March and April 2020. Throughout November, the target was met. This is due to reduced demand in this category, with incidents decreased by 11% compared to October 2020.

The C1 90th centile was also within the national standard of 15 minutes.

C2

Mean: 00:14:16

Target: 18:00

90th Centile: 00:27:08

During November 2020, our C2 mean and 90th centile were both within the target. Owing to the second lockdown, demand had decreased.

From the second week of April, the C2 performance improved significantly following the actions rolled out as a response to Covid-19 pandemic, combined with the reduced demand on the system.

C3

Mean: 00:36:04

Target: 2:00:00

90th Centile: 01:21:35

Despite the increased demand in C3 activity, the trust was able to achieve the C3 90th centile national target in November.

The performance was within target due to continued overall reduction of demand and increased strategic response by the Trust. However, there were a number of days presenting with unexpected demand and the target was breached for 3 days.

C4

90th Centile: 02:23:53

Target: 3:00:00

C4 90th centile was met in November, for the first time since the demand had risen unexpectedly in this category despite the target being breached for 7 days. These category of calls are particularly impacted due to a low number with each delay having a higher impact on the overall average.

The Trust are working to reduce longer waits for this category of patients by reviewing the process response and the type of resource that can respond to category 4 calls.
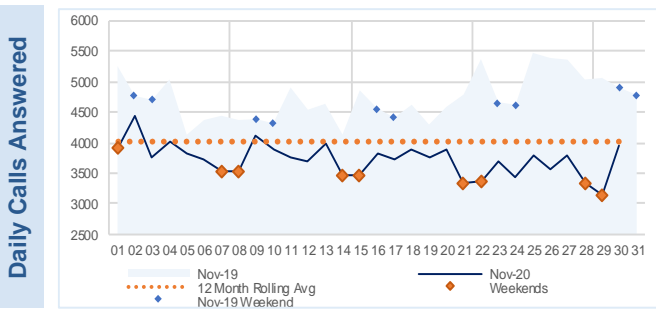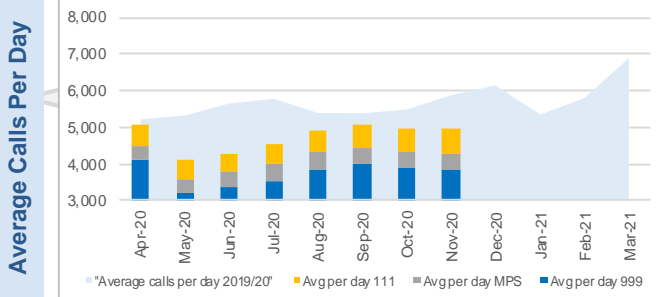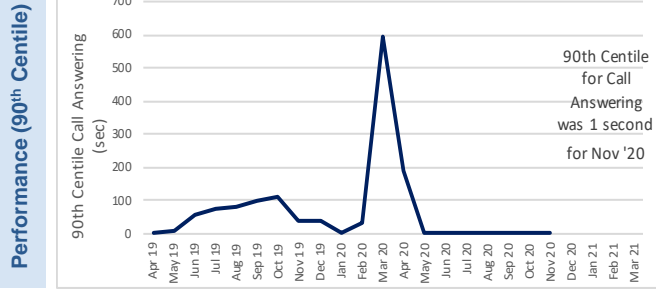
The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

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

Please note: 999 performance data is correct as at 27/11/20 and is subject to change due to data validation processes

999 Calls Received

November 2020 saw a number of calls lower than the number in the equivalent period in 2019/20. As a result of the reduced 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.
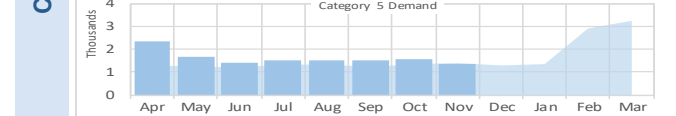

Performance (90th Centile) — 90th Centile for Call Answering was 1 second for Nov '20

Average Calls Per Day

Daily Calls Answered

Incidents and Response Type

In November 2020 the number of incidents per day was lower compared to 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
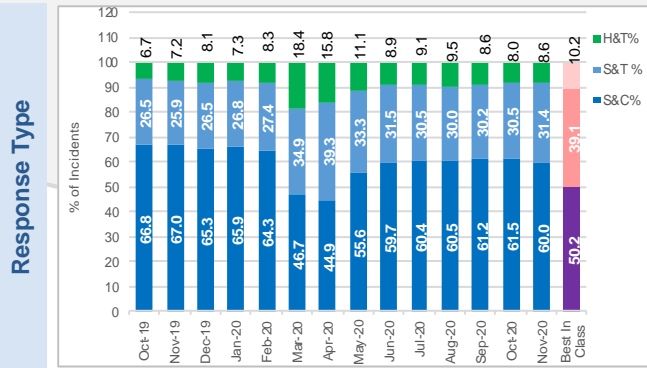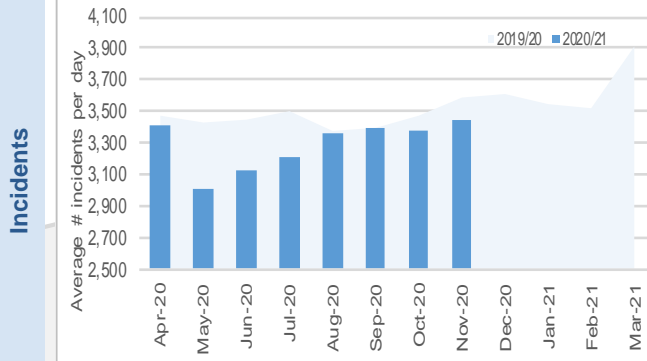
During November 2020, WMAS was best in class achieving 39.1% for See & Treat. SWAS gained 1st place and was best in class for See & Convey attaining 56.1%. NWAS reached 1st place for Hear & Treat, at 10.2%.

Incident Category (By Month)

C1 — November saw 6,531 Category 1 patients receive a face-to-face response

C2 — November saw 56,814 Category 2 patients receive a face-to-face response

C3 — November saw 25,048 Category 3 patients receive a face-to-face response

C4/C5

6
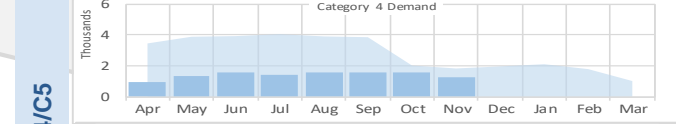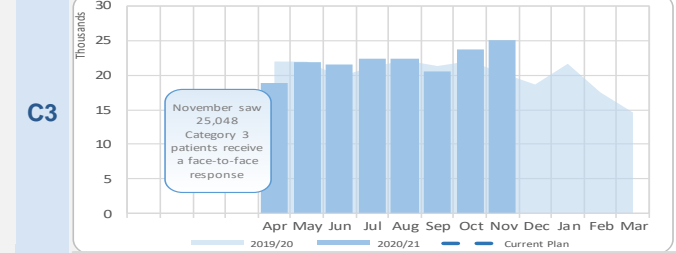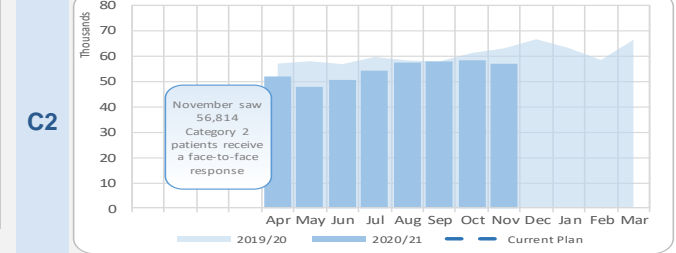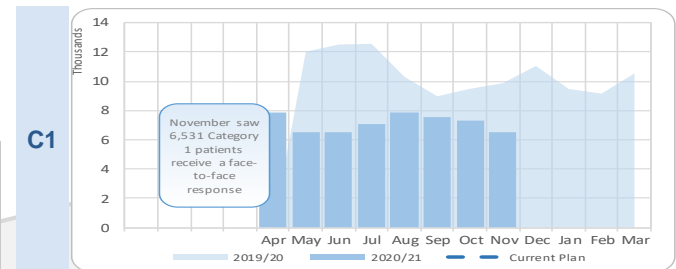
Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

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)

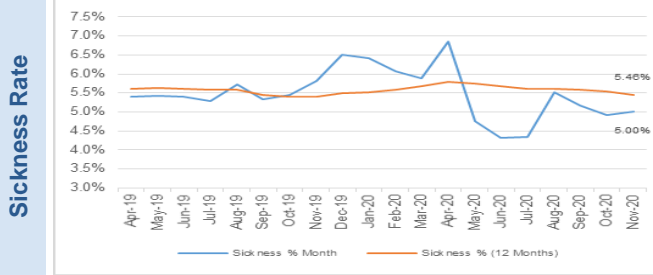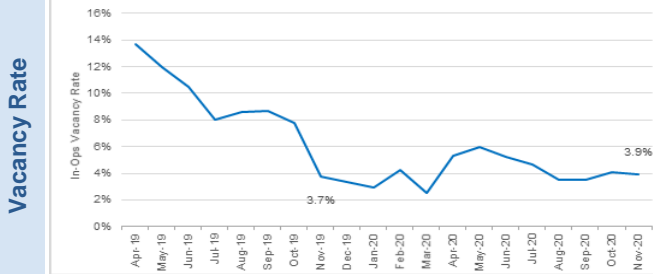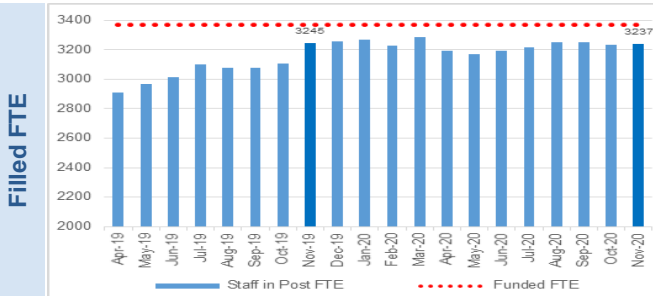### Vehicle Availability and Patient Facing Hours

The DCA Fleet stands at 532 providing sufficient DCA availability to cover the daily PVR which currently fluctuates between 350 > 420 enabling the Strategic Assets and Property Teams to support the operational frontline rotas and delivery of front line care. The Trust provided 298,061.65 patient facing hours in November 2020 an increase of c.6,000hrs from the previous month.

The Vehicle Resource Centre maintained a steady performance ensuring a DCA was in place at start of shift as reflected in the VEHNO OOS for November 2020 – 83.9hrs (0.04%).. Weekly Performance Meetings with Operational colleagues are held to discuss upcoming required operational hours and DCA numbers to provide patient care and achieve Trust targets. The average DCA PVR for October 2020 stood at 389 with an increase in November 2020 to 395. The Overall Out Of Service rate averaged 7.44% for November 2020 a decrease of 0.75% from the previous month.
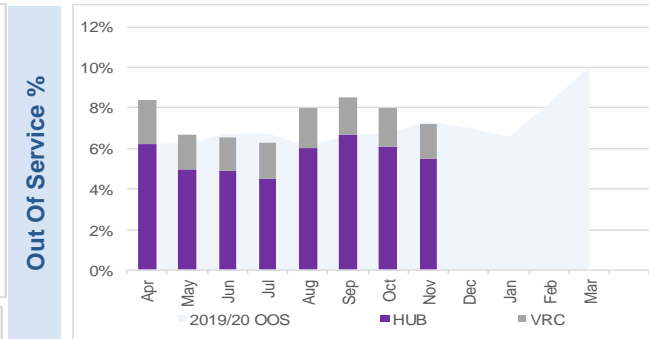
Note:

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
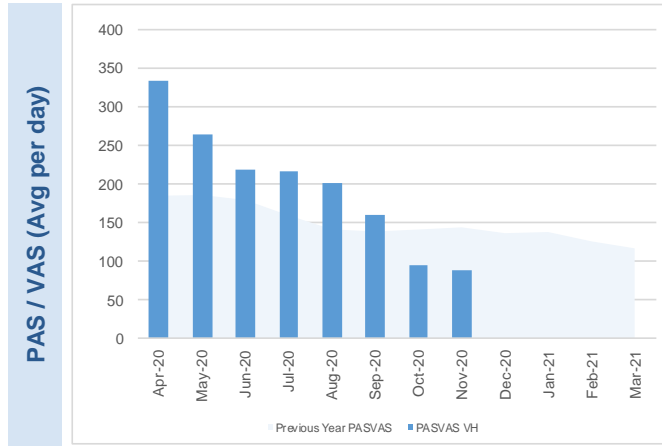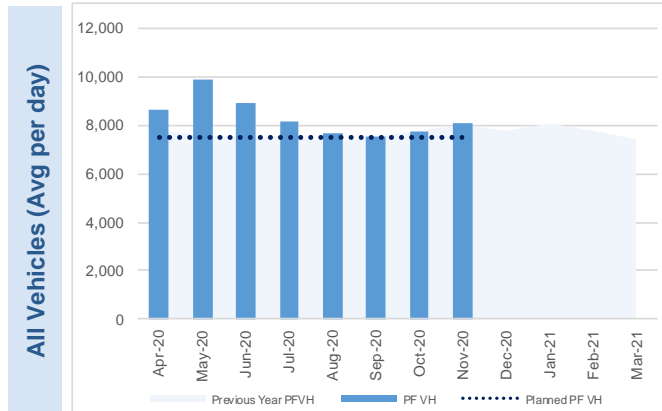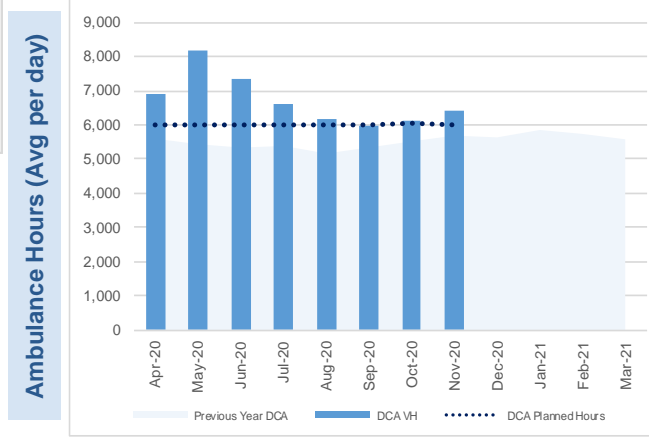
The demand on the service is impacting all areas of operational delivery, including delays in answering 999 calls, response time are consistently outside the agreed thresholds with an increase in long delays for Category 2 and 3s.

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

EOC - total contacts

Call Answering Mean

C2 Mean

Number of 2x90th delays by Category of Call and Date

Count of long delays by hour of call received
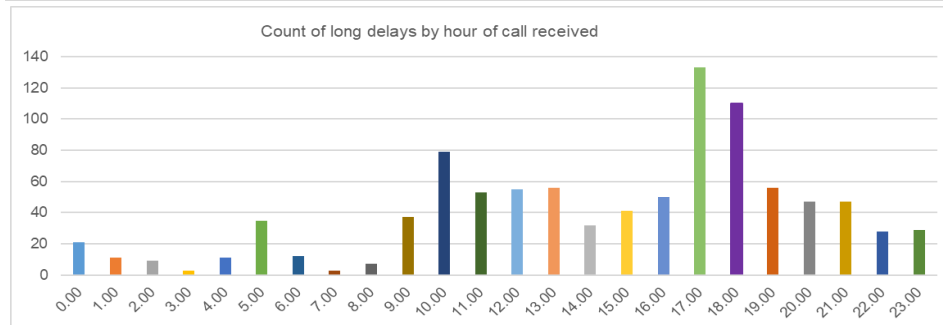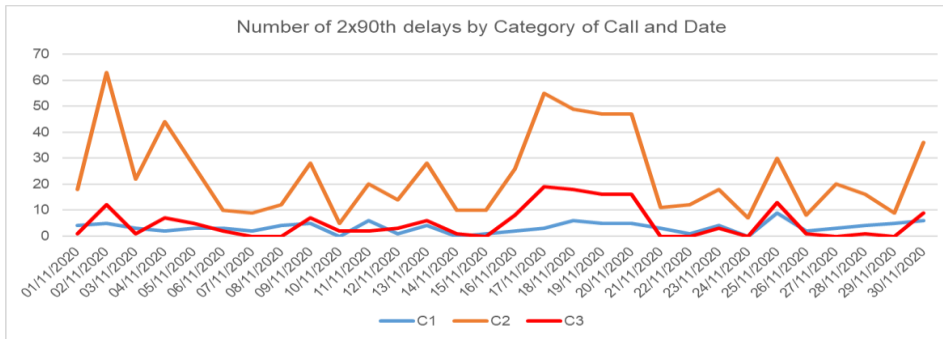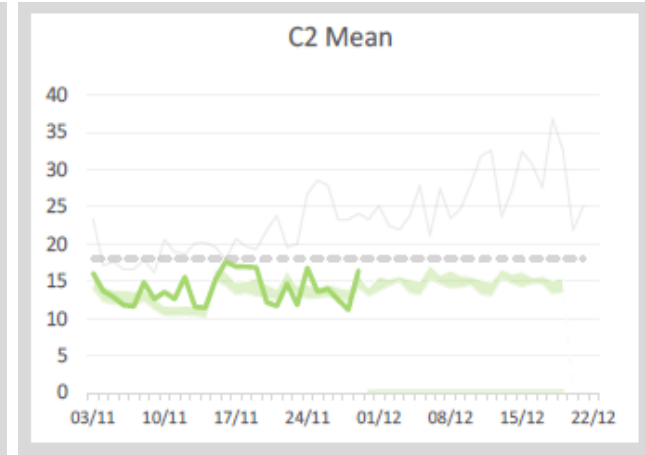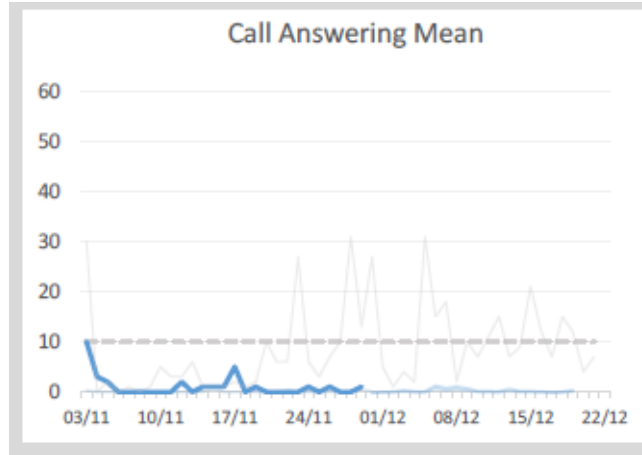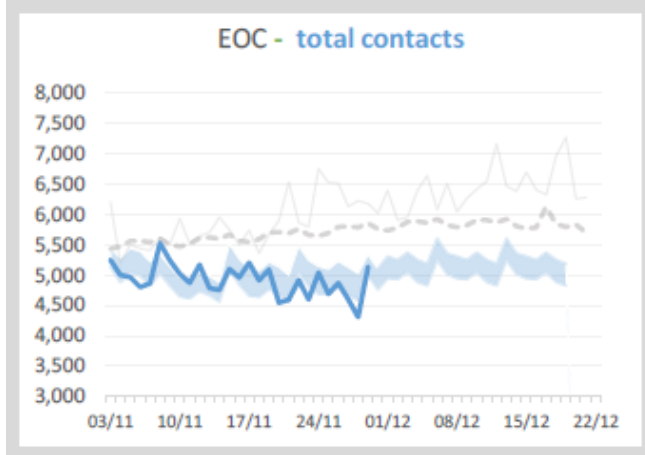
In November there were 965 long delays of which 9% resulted in a blue call.

	C1	C2	C3	Grand Total
November	101	711	153	965
Bluecall	23	59	4	86

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

- Dx012 – (16.5% n 159) – 9 required a blue call
- Calls from the MPS (7.4% n 72) – 3 required a blue call
- 17A2G – patients whom have fallen and are still on the ground (5.3% n 51) – 3 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 November.

43.4% (n 419) patient whom experienced a long delay were not conveyed and 56.9% were conveyed. It was also found that 15.6% (n 150) of all long delays occurred between the hours of 17:00 and 19:00.

Action being taken include:
Forecasting and planning and focus at DSLT
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

8

No Harm/Near Miss
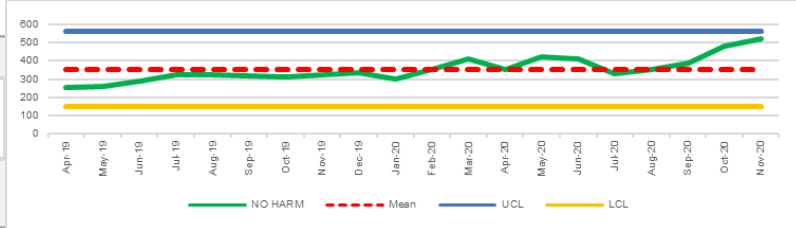
Latest Month: **518**

Low Harm

Latest Month: **53**
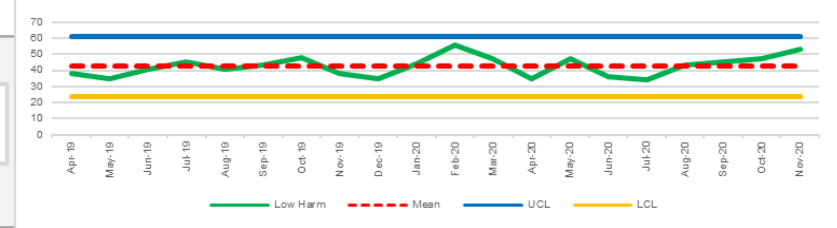
Moderate Harm

Latest Month: 5
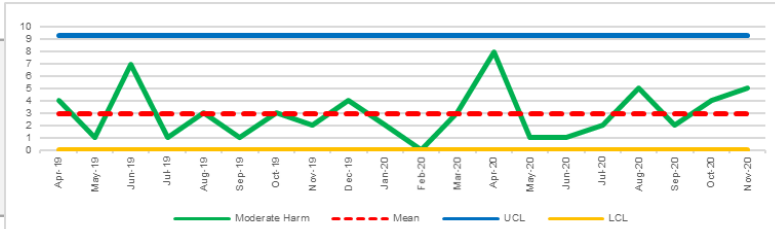
Severe

Latest Month: **1**
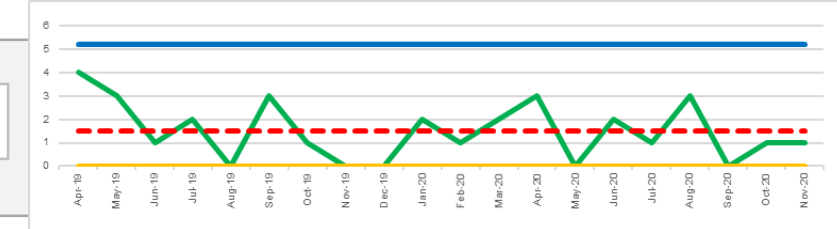
Death

Latest Month: 1
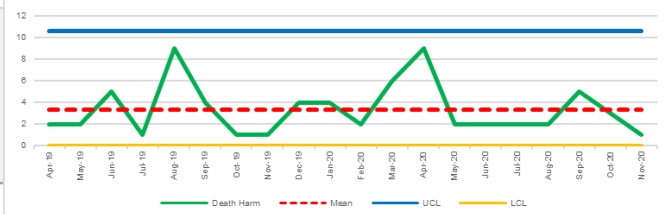
Analysis of SPC graphs:
The number of reported no and low harm incidents continue to increase with ongoing monitoring in place to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust Safety Investigations Assurance and Learning Group (SIALG).

While the numbers are small, there has been a decrease in the number of incidents with death as the severity, whereas, the number of moderate and severe incidents have increased which has seen the number of declared SIs. Key themes are around conveyance decisions and cardiac management issues.

Incident categories Oct – Dec 2020

Incidents by Category

- 111/IUC - Call Handling
- 111/IUC - Clinical assessment / advice
- 111/IUC - Confidentiality
- 111/IUC - Referral to incorrect Out of Hours
- Access / Transfer / Handover issues
- Clinical advice
- Clinical assessment
- Clinical treatment (EXCEPT medication related)
- Communication, care & consent
- Dispatch & call
- End of Life / Palliative Care
- Information governance and breaches of confidentiality
- Infrastructure, buildings, IT & telephony
- Maternal, obstetric and neo-natal
- Medical equipment
- Medication Error
- Moving and Handling of Patients
- Non-medical equipment
- Patient accidents & injuries
- Security - theft, damage to property, loss of property
- Security - violence, aggression and abuse
- Transport delays
- Vehicle related

Medical Equipment, and dispatch and call incidents are the top two 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.

- A review of the dispatch and call incidents has identified the top theme as delayed response. These incident have increased as demand/activity has increased over the last month on the Trust. A number of Trust-wide actions are being implemented (in line with REAP 3). The clinical and quality directorate are undertaking safety reviews and reviewing delays daily to identified harm.

Incident Management

There were 847 (as of 02/12/2020) which had been opened on the system longer than 35 working days (this excludes SIs). This breaks down to 379 patient incidents, 215 staff incidents, 24 visitor incidents and 229 Trust related incidents.

The majority of the moderate harm and above incidents were under the COVID19 review which has since finished and the incidents have been closed down accordingly. There is continued focus on a reduction of overdue incidents. Within sectors and those incidents in 'away for review' with other departments.

- None - No harm as a result
- Low - Minimal harm - required minor treatment or observation
- Moderate - Non-permanent harm - requiring admission, surgery or prolonged episode of care

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Ambulance Quality Indicators (Latest Reported Month)
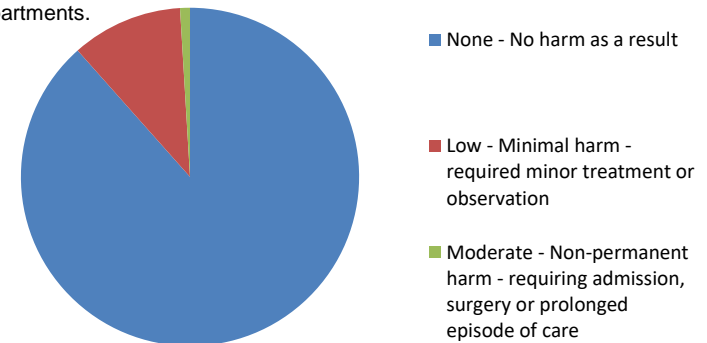
Our Trust-wide scorecard covers four of the key Ambulance Quality Indicators: Cardiac Arrest - Return of Spontaneous Circulation (ROSC) at Hospital, Sepsis - Care Bundle, STEMI - Call to angiography and Stroke - Call to door. The data presented is from __August 2020__, which is the most recent month published by NHS England.

ROSC at Hospital

Month: 33.2%

Target: 31.0%

2019/20 Position: 31.9%
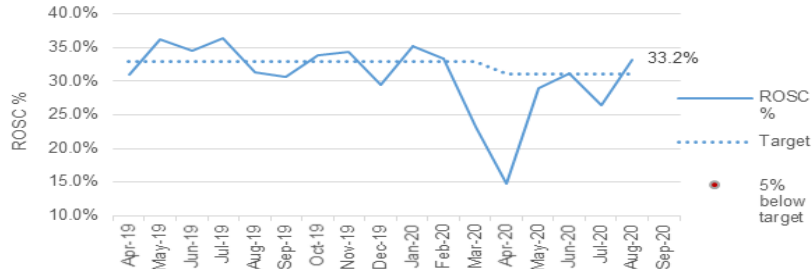
In August 2020, the LAS ranked 4th for ROSC on arrival at hospital for the overall group with 33.2% and 3rd for the Utstein group with 57.4%, both well above the national average of 29.4% and 53.0% respectively. We remained below average for survival to discharge in both the overall (7.4%) and Utstein comparator groups (26.2%). NHS England did not publish Post-Resuscitation Care Bundle data in December, the next data due to be published will be for October (in March).

Sepsis Care Bundle

Month: 92.5%

Target: 95%

2018/19 Position: 89.5%
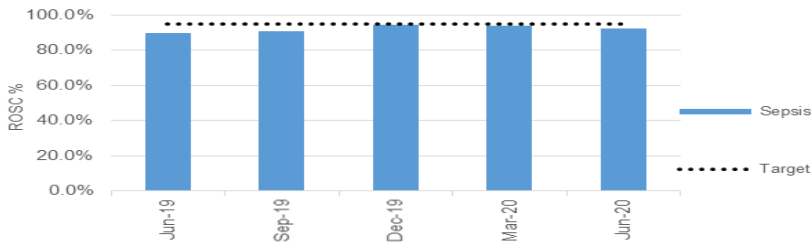
The sepsis care bundle compliance is reported quarterly and was not reported for August 2020. September 2020 data will be published in February 2021.

STEMI call to angiography

Mean: 02:09

Target: 02:10

2019/20 Position: 02:11
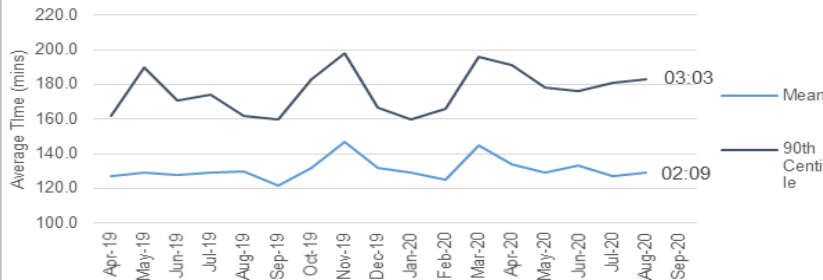
In August 2020, the LAS' mean average call to balloon time ranked 3rd in England at 02:07. This is 8 minutes shorter than the national average for this measure. NHS England did not publish data for the STEMI care bundle as this is reported on a quarterly basis, the next data due for this measure will be for October 2020 (due to be published in March 2021).

Stroke call to door

Mean: 01:06

Target: 01:10

2019/20 Position: 01:13
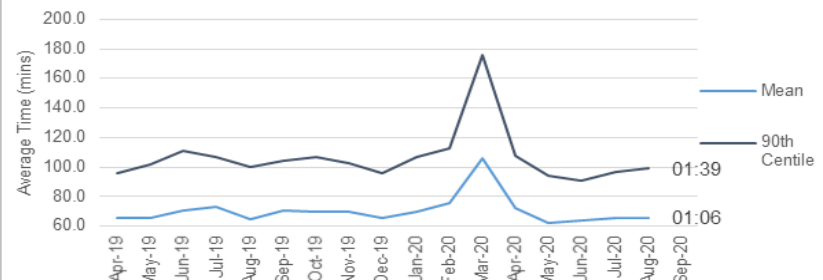
The LAS ranked best in class again for the mean call to hospital for suspected stroke patients (01:06) in August, the 3th time this financial year. The stroke diagnostic bundle for August was also published this month and shows the LAS achieved compliance of 96.7%, below the national average (98.3%). The LAS has dropped from a ranking of 8th place in May to 9th in August 2020.

Trust-Wide Scorecard – IUC

Patients Scorecard (NEL IUC)

November 2020

Benchmarking Key

Top 3	
Ranked 4-7	
Ranked 7+	

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance				Benchmarking (Month)		
				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	%	Nov-20	🔴	95.0%	A	91.7%	92.1%	79.5%	90.8%	97.0%	4
Percentage of Total number of calls abandoned after 30 seconds	%	Nov-20	🟢	5.0%	A	0.6%	1.9%	11.3%	1.22%	0.4%	3
% of calls closed with no onward referral (health advisor and clinician)	%	Nov-20	🔴	33.0%	A	25.6%	25.5%	26.0%			
% of calls transferred to 999	%	Nov-20	🟢	10.0%	A	9.6%	8.0%	8.1%	9.4%	7.9%	3
% of calls recommended to ED	%	Nov-20	🟠	10.0%	A	10.6%	10.2%	9.3%	12.2%	10.6%	2

Patients Scorecard (SEL IUC)

November 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance				Benchmarking (Month)		
				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	%	Nov-20	🟢	95.0%	A	95.1%	93.0%	81.7%	90.8%	97.0%	2
Percentage of Total number of calls abandoned after 30 seconds	%	Nov-20	🟢	5.0%	A	0.5%	1.8%	9.5%	1.2%	0.4%	2
% of calls closed with no onward referral (health advisor and clinician)	%	Nov-20	🔴	33.0%	A	28.2%	28.2%	28.1%			
% of calls transferred to 999	%	Nov-20	🟢	10.0%	A	7.9%	7.8%	7.6%	9.4%	7.9%	1
% of calls recommended to ED	%	Nov-20	🔴	10.0%	A	12.4%	11.0%	10.0%	12.2%	10.6%	5

🟢	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

Trust-Wide Scorecard – 111 North West London (NWL)

London CCGs have awarded the provision of 24/7, 365 day 111 call handling services to London Ambulance Service NHS Trust (LAS) with London Central and West Unscheduled Care Collaborative (LCW) and Practice Plus Group (PPG) as mandated sub-contractors.

The Trust has rolled out phase 1 on 17th November, which involved taking a small concentrated number of night calls. Phase 2 of the service provision has begun where the Trust is now increasing its capacity on call taking with the intention to uptake 33% of the calls through extended hours for NWL.

The scorecard below shows the performance for NWL including data from all 3 providers, combined.

Patients Scorecard (NWL IUC)

November 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	%	Nov-20	🔴	95.0%	A	93.6%			90.8%	97.0%	3
Percentage of Total number of calls abandoned after 30 seconds	%	Nov-20	🟢	5.0%	A	0.7%			1.2%	0.4%	4
% of calls closed with no onward referral (health advisor and clinician)	%	Nov-20	🔴	33.0%	A	15.2%					
% of calls transferred to 999	%	Nov-20	🟢	10.0%	A	9.4%			9.4%	7.9%	2
% of calls recommended to ED	%	Nov-20	🔴	10.0%	A	12.1%			12.2%	10.6%	3

Current Perfomance — **Benchmarking (Month)**

Benchmarking Key

Top 3
Ranked 4-7
Ranked 7+

🟢 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

111 IUC Performance

Call answering was outside target in November for North East London (NEL) and within target for South East London (SEL) although there was a reduction in the 999 demand, there was still a considerable rise in 111 contacts during the second national lockdown. The second lockdown mirrored the one that took place in March 2020 but with some key exceptions. As a result of this, more Covid related calls were received by both IUC centers, alongside the winter pressures and the demands of the newly introduced 111 First.

The abandonment rates were within target for November. Both sites are within target for calls transferred to 999, where we consistently perform better than the London average. We were challenged in the recommendation to attend ED performance for SEL.

South East London (SEL)	North East London (NEL)

Call Answering & Abandoned Calls

SEL: 95.1% / 0.5%

Target: 95% (CA) and 5%

NEL: 91.7% / 0.6%
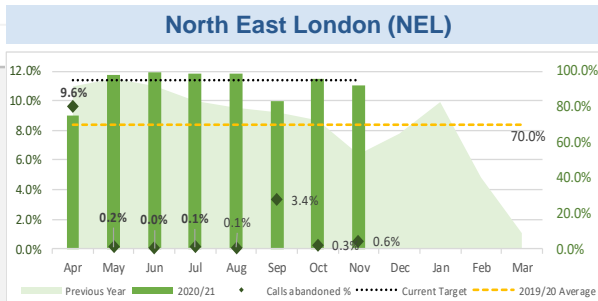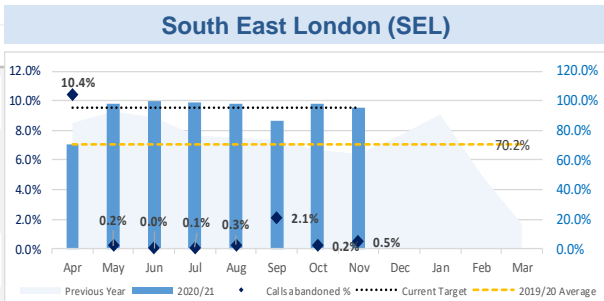
The 111/IUC centres have been critically important in the national Covid-19 response as any concerns were directed to 111 across England. The call demand during November remained high, as we entered into a 4 week national lockdown which challenged the 111 performance.

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

% of calls closed with no onward referral

SEL: 28.2%

Target: >33%

NEL: 25.6%
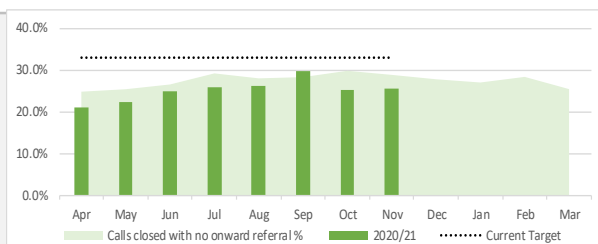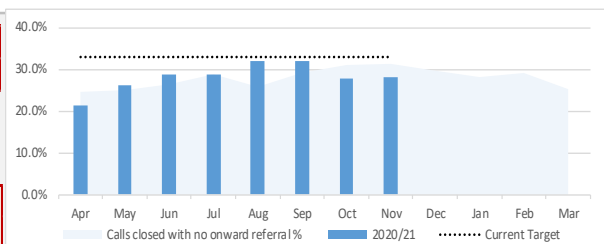
We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system.

Calls Outcome: Transferred to 999

SEL: 7.9%

Target: <10%

NEL: 9.6%
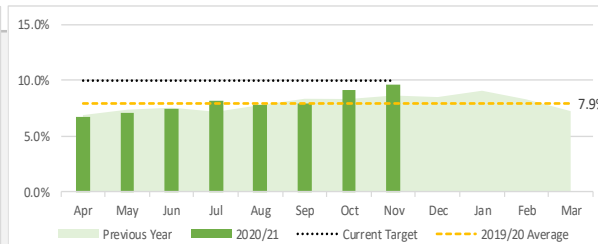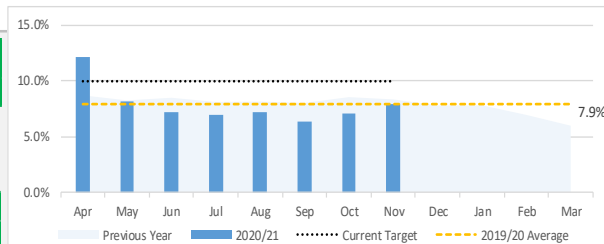
Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During November, NEL delivered 9.6%, with SEL delivering 7.9%. This performance compares well against the London average which was circa 9.4%, demonstrating the benefits of a clinical assessment service (CAS).

Call Outcome: Recommended to attend ED

SEL: 12.4%

Target: <10%

NEL: 10.6%
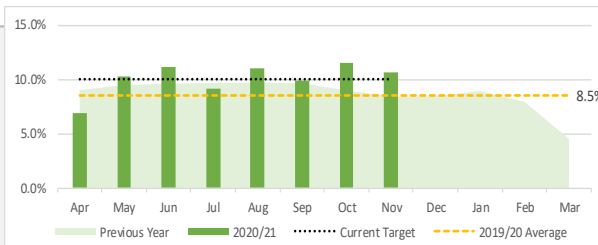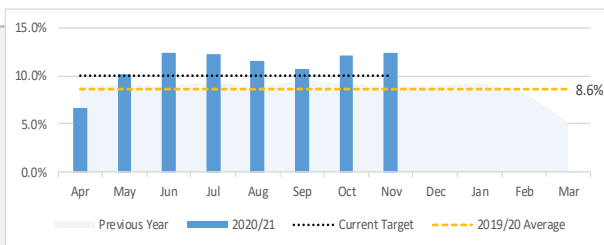
The development of our IUC services has enabled NEL and SEL to consistently outperform other providers on A&E avoidance. The performance on this metric has been challenged while striving to give patients the most appropriate care. There is still work to do to reduce recommendation for patients to attend A&E while balancing with patient safety and the transfer to 999.

No Harm/Near Miss
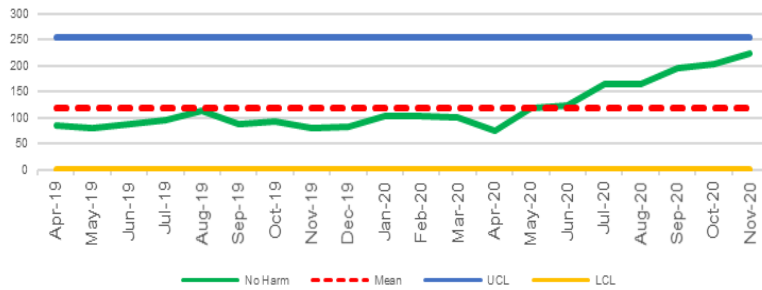
Latest Month : **233**

Low Harm

Latest Month :**1**
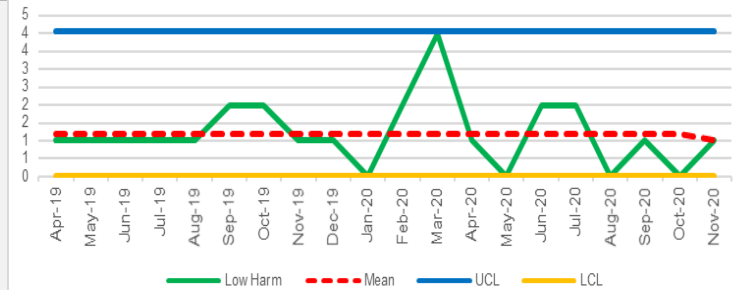
Moderate, Severe & Death Harm

Latest Month : **1**
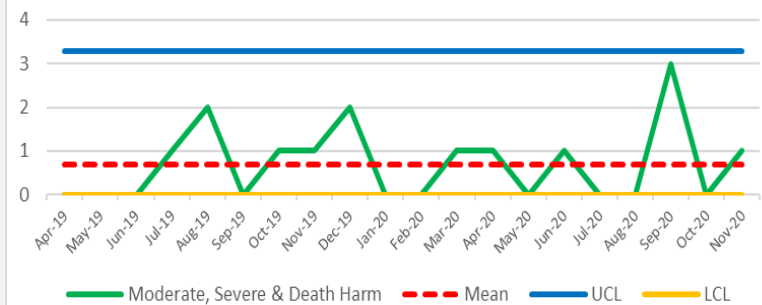
The number of reported incidents continues to be positive in reporting numbers particularly in regards to no harm incidents. This is a sign of a good reporting culture.

There has been 1 moderate harm and above incidents reported over the last two months. This was subsequently declared as an SI and relates to the clinical assessment of a patient.

Incident categories Oct – Dec 2020

Incidents by Category
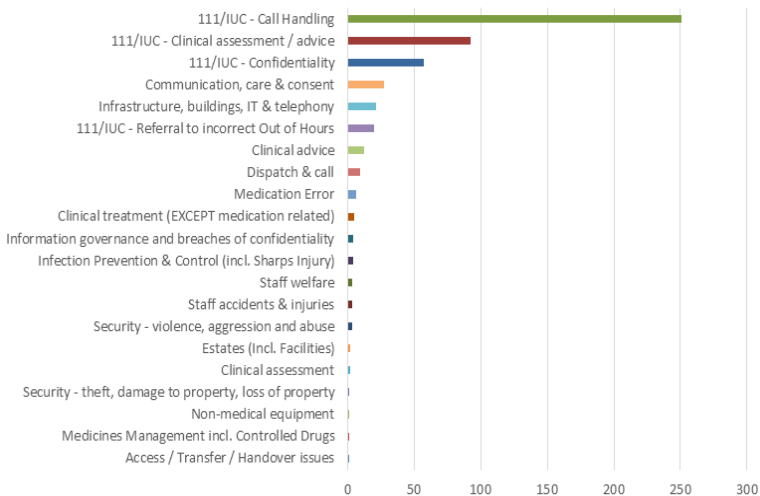
Call handling, Clinical assessment / advice and Confidentiality are the top three categories. Actions are being taken to address these themes including:

- A pilot QI project is being undertaken to refine the way demographics are taken to reduce instances of inaccurate information capture. Although paused, conversations are ongoing to identify if this wok can continue.

- Regular Clinical CPD sessions have recommenced, individual feedback is provided and deep dives into practice occur to ensure any trends are addressed.

- Consent is routinely monitored to ensure principles of consent and capacity are adhered to. There is good use of these Acts within IUC

Incident Management

There are 156 (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.

SI Analysis

Fig. 1 — SI Level 2 / SI Level 1 by department
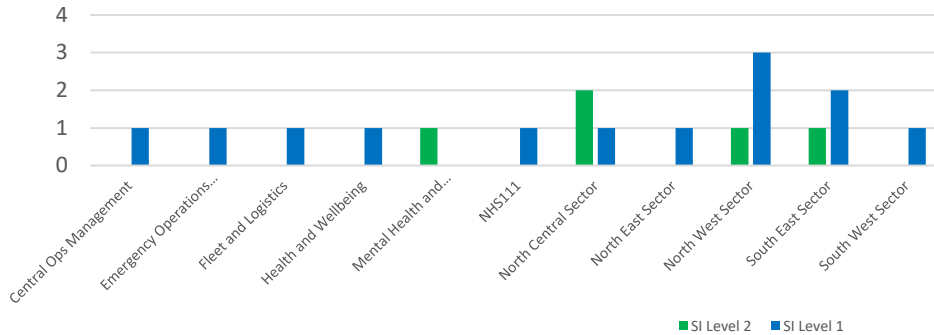
During October and November 2020, total of **18** (including NHS 111) reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

The graph above indicates that the North West Sector has the highest number of SIs declared. This is often seen when comparing the North west against other Sectors as the North West has the largest geographical area with the highest volume of calls. In October and November 25.6% of all face to face incidents occurred in the North West Sector.

Of note

- 8 incidents were declared based on the face to face clinical assessment/treatment undertaken and the supporting documentation.
- 2 incidents involved a delay of greater than four minutes in a patient receiving defibrillation for VF. These were the first incidents declared involving delayed defibrillation since December 2019.
- 1 incident involved a critical distraction during the handling of a 999 call which resulted in the call handler not hearing that a defibrillator was available (two further incidents were declared in relation to this issue in September).

Mitigating actions that have taken place:

- Communications have been sent out to all staff who work in EOC, including the Critical Care Advanced Paramedic Practitioner cohort, highlighting the potential risk when interrupting a call handler mid triage.
- Communications were sent out on LIA following the two cases of delayed defibrillation to reiterate the use of AED mode and adequate chest preparation.
- The training slides which are delivered during ALS CSR has been updated to cover adequate chest preparation.
- Themes from declared SIs have been shared with managers via the monthly managers SI and Learning meeting which is hosted by the Quality Improvement and Learning Team. This has also included themes from incidents which have not met the threshold for SI but still required further investigation and mitigation.

SI Actions

There continues to be a focus on SI actions, at the end of November there were 173 open actions, of these 45 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 2 incidents which are oldest and highest in priority:

One is to rreview the IUC CAS Escalation process to consider actions to be taken earlier in the escalation stages to prevent considerably prolonged waiting times within the CAS. **Update:** Since this action, various pan London initiatives have been introduced (EDDI, 111First, BEACH) that this needs to be reviewed in line with new initiatives. This is going to be reviewed with all LAS IUC sites. Due date amended to reflect this. The COVID escalation plan was finalised in 31/03/2020 so there is currently an updated escalation plan considering COVID19 in place.

The other is to develop a clear EOC training plan that is tailored to each department needs to be developed where queries/concerns can be recorded (including attendance) and fed into a central register for actioning and oversight. **Update**: Since this action, a Link tutor role has been established as part of this new role the job description now includes:
• Maintain accurate records/archiving systems of all training / course documentation ensuring that returns and statistical information are provided for collation centrally.
• Take a lead in the training for updates to processes and systems within EOC, and ensure that all staff are updated accordingly.

Pie chart: High Priority, 7; Low Priority, 20; Medium Priority, 18
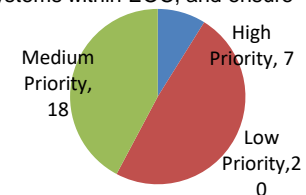
Overdue actions by Department
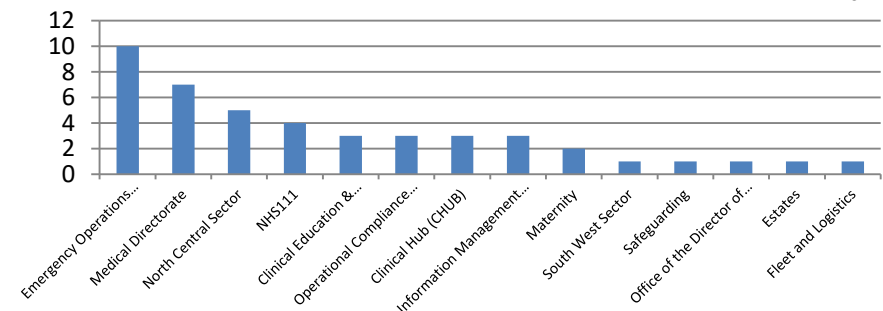
BI Controlled Drug Report

Legend:
- CD wasted / broken ampoule
- CD not where it should be - clinican and location of CD known
- CD not recorded correctly
- CD lost - unaccounted for - clinician and location of CD unknown
- CD lost - clinician known, location of drug unknown
- CD found not where it should be - clinician unknown
- Controlled Drug - Wasted – Other reason
- Controlled Drug - Wasted – Broken Ampoule
- Controlled Drug - Unaccounted for - Clinician known - Location of drug unknown
- Controlled Drug - Unaccounted for - Clinician and location of drug unknown
- Controlled Drug - Safe malfunction
- Controlled Drug - Not where it should be – Clinician unknown
- Controlled Drug - Not where it should be – Clinician and location known - Taken home
- Controlled Drug - Not where it should be – Clinician and location known - Held for longer than authorised - other
- Controlled Drug - Not recorded correctly - Withdrawn but not signed into register
- Controlled Drug - Not recorded correctly - Returned but not signed out in register
- Controlled Drug - Audit - Errors identified - Unidentifiable name/signature/information
- Controlled Drug - Audit - Errors identified - Missing information - other
- Controlled Drug - Audit - Errors identified - Missing clinician name/signature
- Controlled Drug - Audit - Errors identified - Inelligible/untraceable documentation

- No unaccounted for loss of injectable morphine
- Total of 64 other controlled drug (CD) incidents including
  - Loss of Abloy key (n=1)
  - Errors identified during CD audit (n=59)
  - CD usage unaccounted (n=3)
  - CD retained off-duty (n=2)
- Non-controlled drugs incidents
  - Medicines found unsecure (n=2)
  - Kitprep errors (n=12)
  - Breakages (n=7) or losses (n=4)
  - Stock shortage (n=3)
  - Temperature breach (n=2)
  - Medicine out of date (n=1)
  - Incorrect dose of adrenaline (n=1), dexamethasone (n=1), paracetamol (n=1), diazepam (n=2), morphine (n=2)
  - Inappropriate administration of atropine (n=1), morphine (n=1), Entonox (n=2), ondansetron (n=2)
  - Non-LAS prescriber error (n=7)
  - PGD breaches midazolam (n=1), TXA (n=1), quadrivalent vaccine (n=1)
  - Reaction to quadrivalent vaccine (n=1) and morphine (n=1)

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

Actions
- Four APP staff have completed prescriber training
- Further funding for prescriber development agreed with HEE
- Support for operationalising prescribing in 999 environment in conjunction with HEE

People Scorecard

November 2020

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	FY20/21 Trajectory	National Data	Best In Class (Ambulance Trusts)	Ranking (out of 11)
					Current Performance					**Trajectory**	**Benchmarking**		
In-Ops Vacancy Rate (% of establishment)	Monthly	%	Nov-20	🟢	5%	Internal	3.9%	4.4%	4.0%	3.5%			
Staff Turnover (% of leavers)	Monthly	%	Nov-20	🟢	10%	Internal	8.4%	9.2%	9.5%	8.0%			
Staff Sickness levels (12 month rolling) (%)	Monthly	%	Nov-20	🟡	5%	Internal	5.2%	5.5%	5.4%				
Statutory & Mandatory Training (85% or above)	Monthly	%	Nov-20	🟡	85%	Internal	83.0%	85.0%	85.0%	85.0%			
Staff PDR Compliance (85% or above)	Monthly	%	Nov-20	🔴	85%	Internal	76.0%	68.0%	71.0%	85.0%			
Flu Vaccination Rate (Trust Total - 55% achieved last year)	Monthly	%	Nov-20	🟢	80%	Internal	77.3%	77.3%	77.3%	80.0%			
% of BME Staff	Monthly	%	Nov-20	🟢	17.5%	Internal	17.5%	17.1%	16.6%	17.5%			
Improve leadership and management across the Trust (Visible and Engaging Leader Programmes - target of 36% of Trust Managers in 2019/20) - *currently on hold*	Monthly	(n/%)	Nov-20	🟡	36%	Internal	14.0%	14.0%	14.0%				
Level 3 Safeguarding Training Completed (90% target over 3yr period)	Monthly	%	Nov-20	🟢	800	National	100.0%	85.0%	85.0%				
Staff Engagement Theme Score	Yearly	(n)	Nov-20	⚪	6.5	Internal	2020 results pending		6.1		6.3	6.6	
Staff Survey Response Rate	Yearly	%	Nov-20	🟢	≥72%	Internal	72.0%		72%			72%	1
Equality, Diversity & Inclusion Theme Score	Yearly	(n)	Nov-20	⚪	8.3	Internal			8.1		8.5	9.5	
BME Staff Engagement Theme Score	Yearly	(n)	Nov-20	⚪	6.4	Internal	2020 results pending		6.2				
Bullying & Harassment (Safe Environment Theme)	Yearly	(n)	Nov-20	⚪	7.3	Internal			7.0		7.4	7.5	

🟢 **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

Vacancy Rates, Staff Turnover and Sickness

Recruitment

Month:

22FTE

Target: 22FTE

EMERGENCY CARE SERVICES FORECAST V ACTUAL

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Recruitment Target (cumulative)	42	83	125	166	208	250	291	333	374	416	457	499
Starters/Booked (cumulative)	2	10	64	84	195	244	324	342	342	360	474	492
-/+ v target (cumulative)	40	73	61	82	13	5	-33	-9	32	56	-17	7
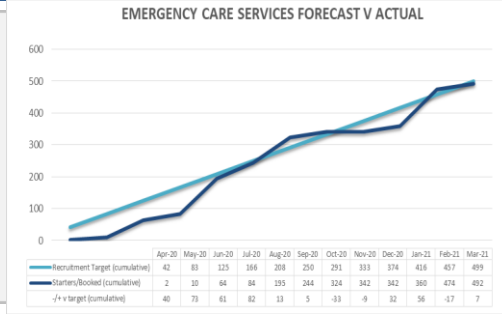
Required Frontline: 499FTE

Supply: 505FTE

Recruited gap: -6FTE

In-ops gap: 111FTE(3.3%)

People & Culture's recruitment team continue to work with Ambulance Services and Clinical Education to deliver a strong pipeline of registered and non-registered staff. Whilst we have recruited up to our level of 3,370fte, our in-ops rate is currently at 3.9% with 108 Assistant Ambulance Practitioners and 32 Paramedics in classroom training (down from 4% in October). This compares favourably with the same period last year where we had a 7.8% in-ops vacancy rate. We have an end of year 'in-ops' forecast for frontline staffing of 3.3% (111ftes all non-registrant). Whilst International recruitment has been negatively impacted by COVID, we are continuing with our programme of skype interviews and exploring other international pipeline opportunities.

Vacancy Rate

Month: 3.5%

Target: 5%
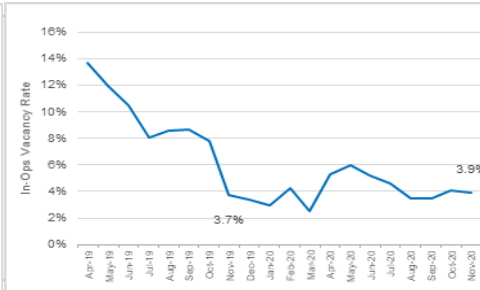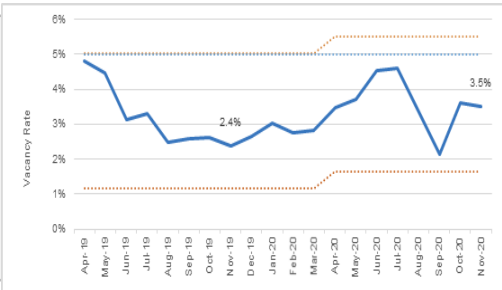
Our overall vacancy rate remains below target at 3.5%. We have a strong staffing position in both our EOC and 111 Services and recruited 19 Health Advisors across our 111 Services in November. We have strong pipelines for 111 and 999 call handling which will support our 20/21 workforce plan. We had 28 starters in November, 48% of whom were from a BAME background. The current paramedic pilots with Merton PCN and Redbridge PCN will provide us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021.

Staff Turnover

12 Month Rolling: 8.4%

Target: 10%
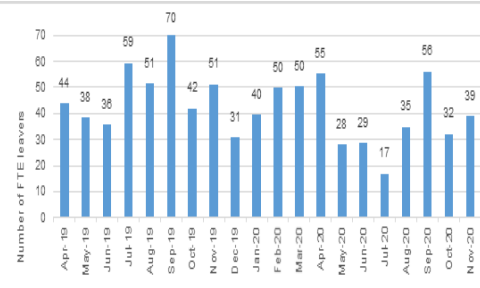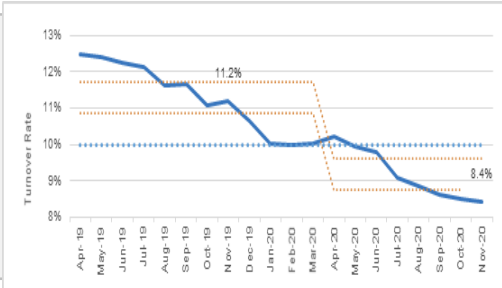
We have seen a further reduction in our turnover rates from 8.5% to 8.4%. We continue to see a lower number of leavers in Emergency Care Services and EOC than forecast. We have a number of retention activities in place including one to one retention interviews with our international paramedics, funding indefinite leave to remain and supporting staff to utilise the Government's automatic one year visa extension. Also, the telephone exit interview pilot with NHS Shared Business Services is now in it's 4th month and the first feedback report will be available in November.

Sickness

12 Month Rolling: 5.2%

Monthly: 4.8%

Target: 5%
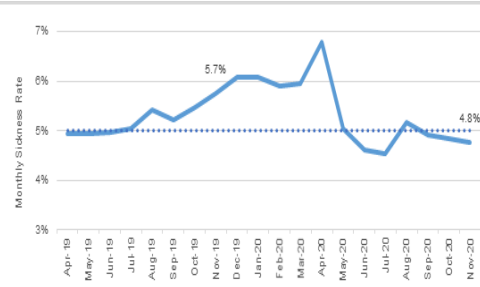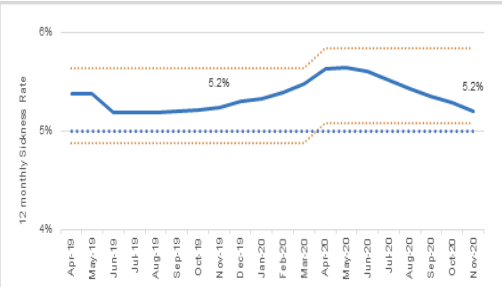
The monthly Trust wide sickness has remained at 4.8% in November, 0.9% below the rate for the same period last year (5.7%). Our 12 monthly rate has reduced from 5.3% to 5.2%. We have seen decreases this month in South East 111 (5% to 4.5%) and EOC (7.8% to 7.1%). Emergency Care Services has remained at 5% and there has been an increase at North East 111 (5.2% to 6.9%). At 30th November there were 314 Covid related absences (up from 153 in October) with 287 staff self-isolating and 27 staff with sickness. In total this represents 5% of the total LAS headcount.

Additional Workforce Analysis

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

These graphs show the numbers of BAME starters and leavers from April 2019 to November 2020. During this period we have had 390fte BAME starters and 187fte BAME leavers, a net increase of 203fte. 28% of our total starters during this period were BAME. This has improved to 34% from April 2020 to date.

Statutory and Mandatory Training and Appraisals

Trust compliance in Statutory and Mandatory training is **83%.**

Appraisal completions at **76%** at the end of November.

BME Starters

Number of BME joiners   Number of white starters
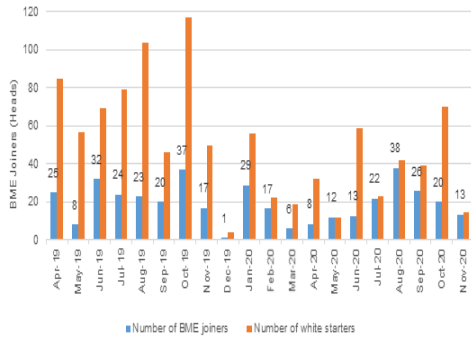
Overall numbers of BAME staff continue to increase (currently 1,155) although this representation varies at different levels in the organisation.

% of BME staff in band	
Bands 1-4	40.3%
Bands 5-7	12.8%
Band 8A to 9	13.2%

We are awaiting the WRES and WDES National reports from NHSi which are normally released in November/December each year.

Statutory & Mandatory
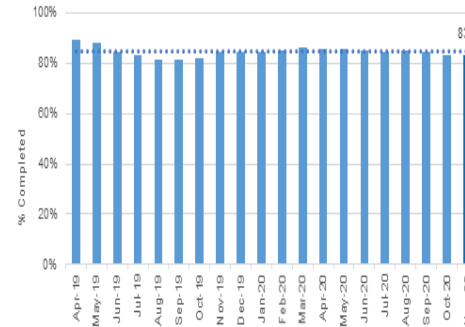
As at 30th November we are tracking slightly below our 85% target at 83%. Information Governance is at 93% for October against an annual target of 95% to meet the requirements of the NHS Digital's IG Toolkit. This number will increase as a result of the CSR Programme,

We have seen an improvement in PDR rates during October which has increased the compliance from 72% to 76%.

BME Leavers

Number of BME leavers   Number of white leavers

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 has remained at 82%.

Appraisal Compliance
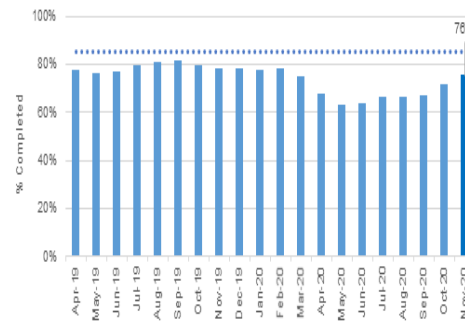
We are working closely with Corporate teams who have lower compliance levels than frontline teams to improve their compliance levels to the required level of 85%. To support this, Corporate Directors are receiving weekly PDR reports for their teams highlighting those who have an expired PDR date and those who are due to expire in the coming three month period.

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

MSK RIDDOR Incidents - Location

MSK RIDDOR Incidents – Equipment Involved

MSK RIDDOR Incidents – Body Part

MSK RIDDOR Incidents – Action Involved
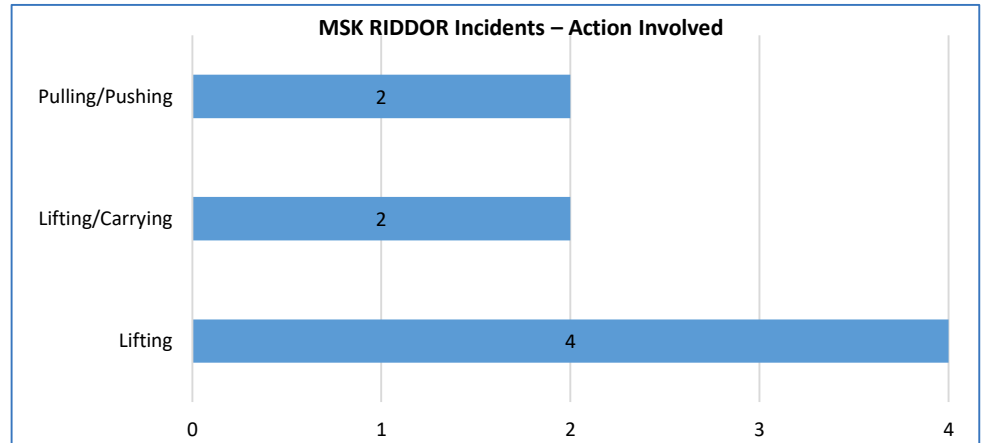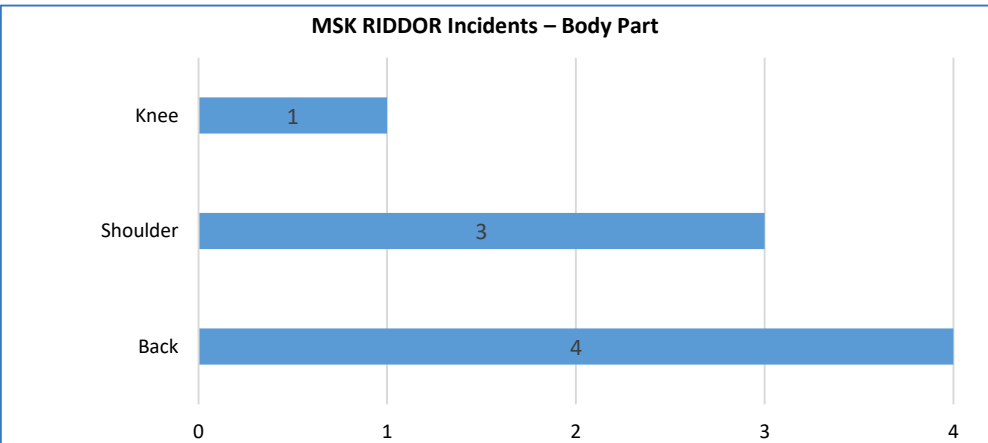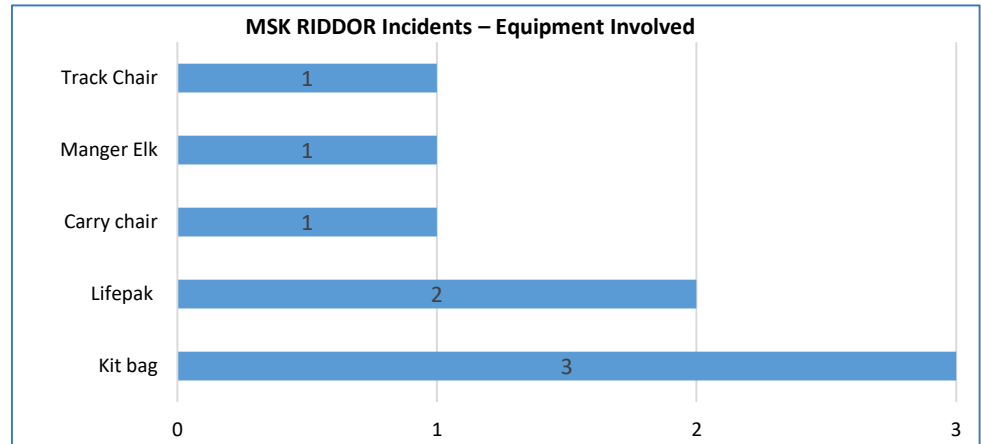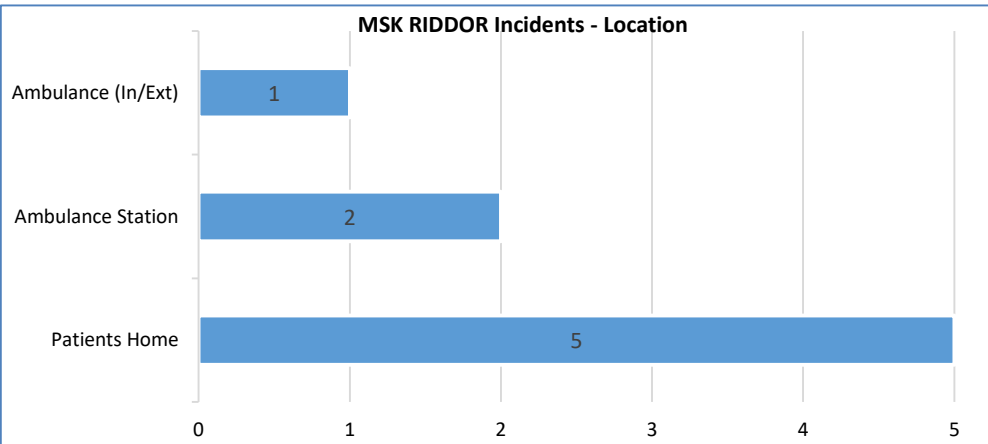
The above graphs provide details from the thematic analysis of 8 reported RIDDOR incidents in November 2020 (2 incidents occurred in October, and 6 incidents occurred in November). These relate to Manual Handling (MSK):

1. 5 reported RIDDOR incidents occurred in Patients Home (n=5), 2 in Ambulance station (n=2) and in Ambulance (n=1).

2. 3 reported RIDDOR incidents involved carrying Kit bag (n=3), 2 incidents involved carrying Life Pak and 1 incident each occurred while handling Carry chair, Manger Elk and Track chair (n=1).

3. 4 reported RIDDOR incidents resulted in Back injury (n=4), 3 incidents resulted in Shoulder injury (n=3), and 1 incident resulted in Knee injury (n=1).

4. 4 reported RIDDOR incidents occurred during lifting (n=4), 2 incidents occurred during Lifting/Carrying (n=2) and 2 other incident occurred during Pushing/Pulling (n=2).

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

Legend: No Harm, Low Harm, Moderate Harm, Severe Harm

Sector	No Harm	Low Harm	Moderate Harm
NW	56	47	4
SE	41	59	
NE	33	54	1
SW	30	39	2
NC	34	32	
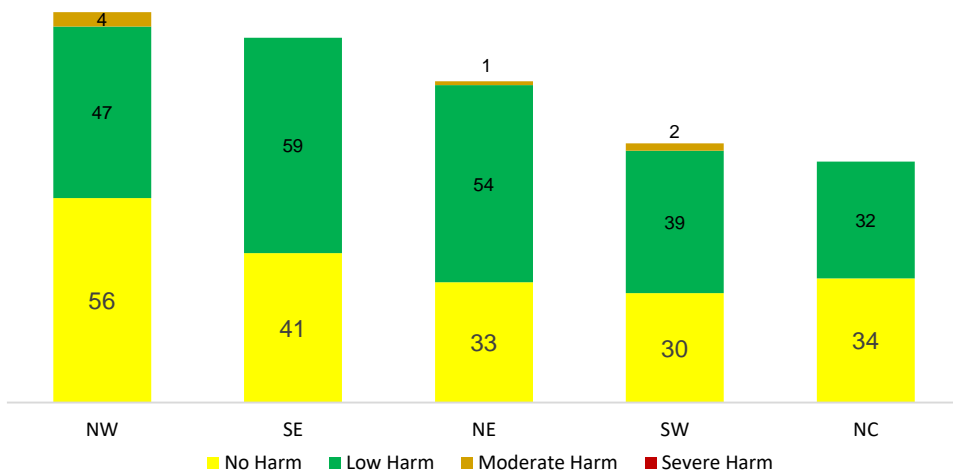
Number of reported Physical Assaults on Staff by Type (YTD) – 2020/21

Type	Count
Physical assault by blow (Kick, punch, head-butt, push, scratch)	282
Physical assault by grab/touch (Including sexual)	84
Physical assault by spitting (Sputum landing on person/clothing)	49
Physical assault by biting	16
Assaulted with a blunt weapon	16
Assaulted with a edged weapon	7
Assaulted with a firearm	1
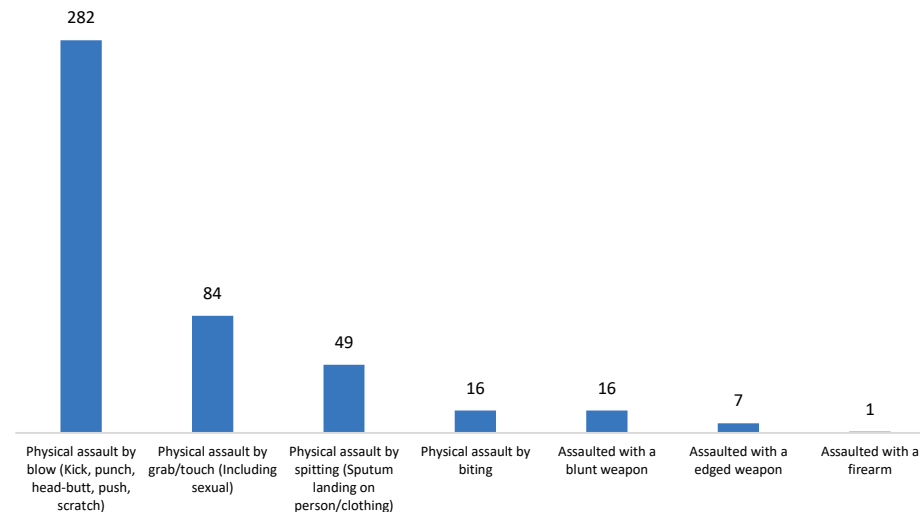
Notes:
- A total of 455 Physical Assaults on Staff were reported during 2020/21 (up to end November'20).
- 207 (46%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 248 incidents resulted in Harm. 240 (53%) of the harm related incidents were reported as 'Low Harm and 8 (1%) incidents were reported as Moderate Harm.
- 33 out of the 455 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc.).

Notes:
- Physical Assault – by blows, kicks/ assault to staff (62% , n=282) accounted for the highest number of incidents reported during 2020/21 (up to end November'20).

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

Non Clinical Factors | Clinical Factors

Factor	Count
Alcohol	146
Mental Health	135
Known Psyc.Disorder	54
Head Injury	18
Clinical Factors	17
Drugs	70
Medication	14
RTC	1

Legend: Alcohol, Mental Health, Known Psyc.Disorder, Head Injury, Clinical Factors, Drugs, Medication, RTC
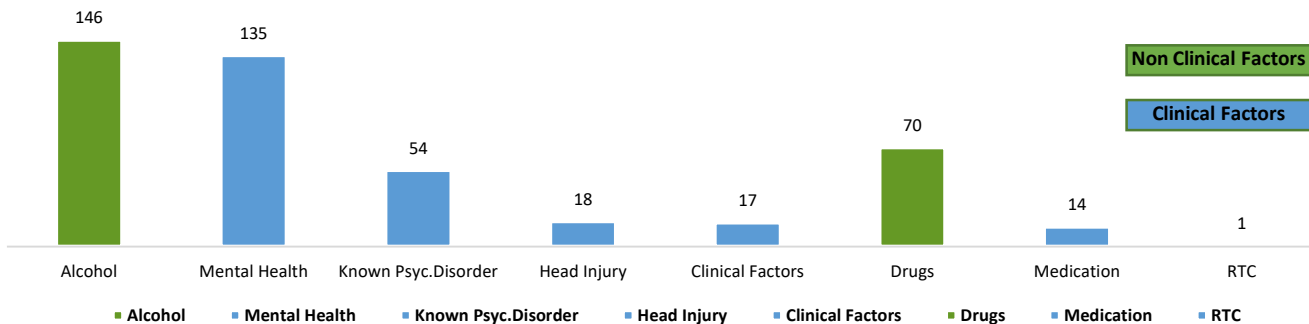
Percentage Breakdown of Factors (YTD) – 2020/21

Clinical 53% | Non Clinical 47%
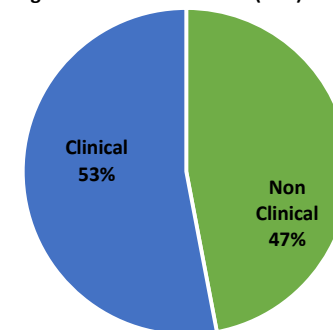
Notes:
- Clinical Factor: 238 (53%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=135), Known Psyc.Disorder (n=54), Head Injury (n=18), Clinical Factors (n=17), Medication (n=14).
- Non Clinical Factor: 217 (47%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=146), and Drug (n=70) and, RTC (n=1).

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

Bar chart values:
- NW: 0.59
- SE: 0.70
- NE: 0.60
- SW: 0.74
- NC: 0.62
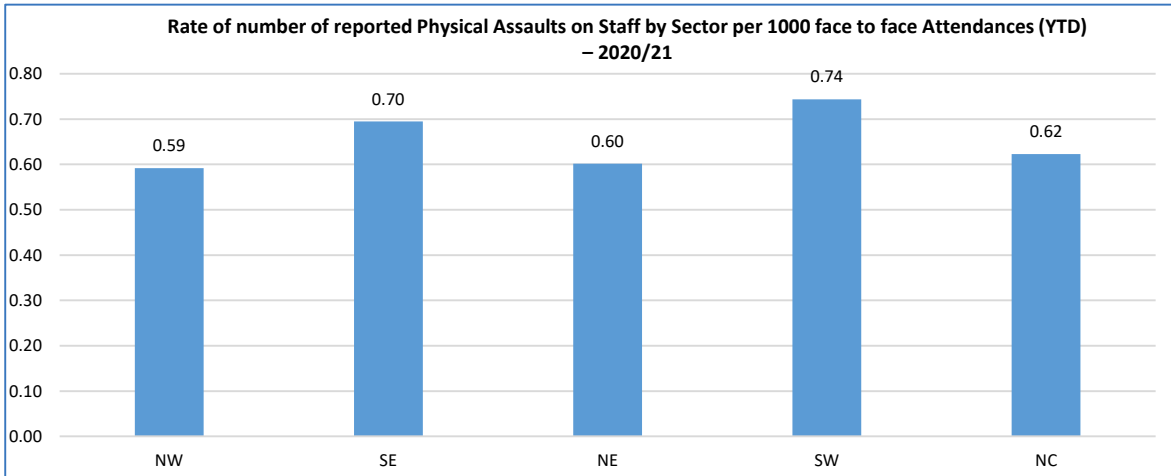
Sector	Rate of Physical Assaults on Staff
NW	0.59
SE	0.70
NE	0.60
SW	0.74
NC	0.62

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

Legend: No of Physical Assaults on Staff by Patient | Rate of Physical Assaults on Staff by Patient
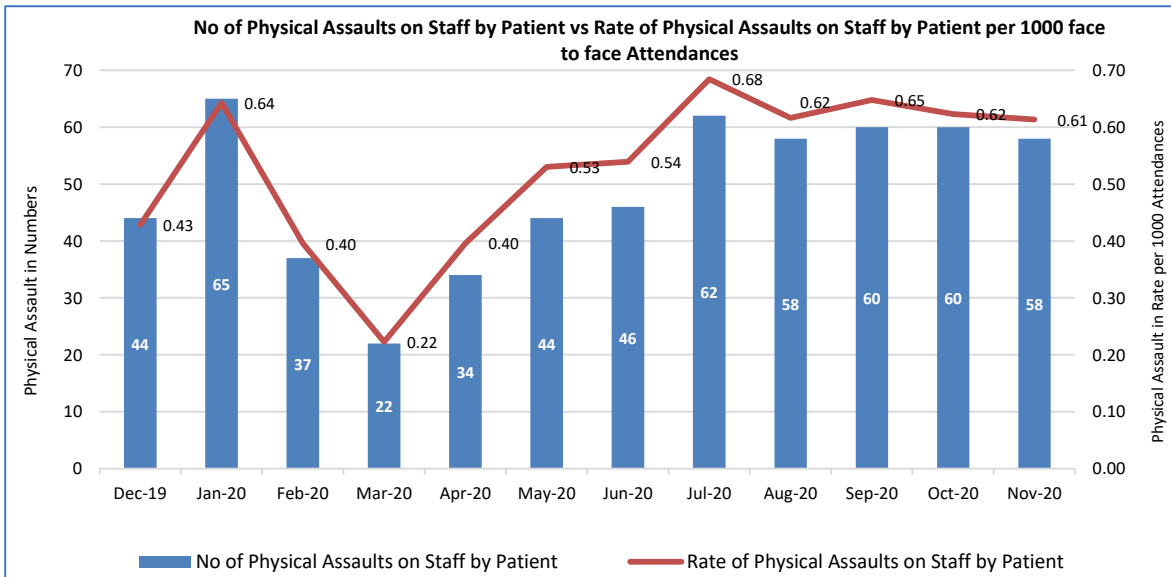
Month	No of Physical Assault on Staff by Patient	Rate of Physical Assault on Staff by Patient
Dec-19	44	0.43
Jan-20	65	0.64
Feb-20	37	0.40
Mar-20	22	0.22
Apr-20	34	0.40
May-20	44	0.53
June-20	46	0.54
July-20	62	0.68
Aug-20	58	0.62
Sep-20	60	0.65
Oct-20	60	0.62
Nov-20	58	0.61

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 (December'2019 to November'2020).

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: **0.09**

Legend: Rate of Complaints, Mean, UCL, LCL

Categorisation

% of complaints by theme (Top 5) — Delay, Conduct, Road handling, Treatment, Non-conveyance. Series: Nov-19, Nov-20
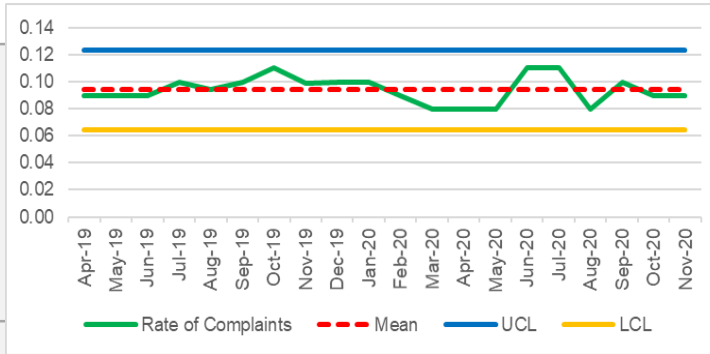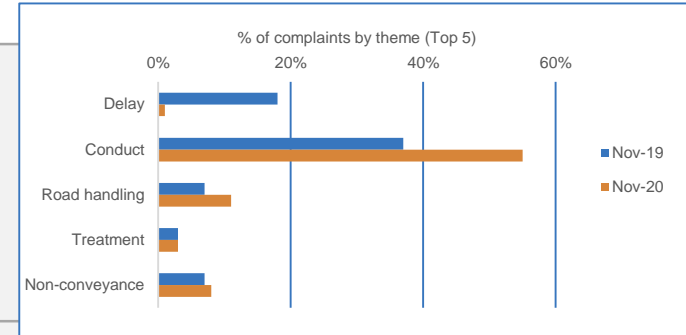
Complaints (including those recorded as concerns) were once again slightly lower than the average for this time of year at 87. Average for November for past five years is 90.

There were 541 PALS enquiries which includes 324 added to the duty spreadsheet that did not require any further actions other then referring the enquiry to the correct team.

We managed 36 Quality Alerts of which 9 were from LAS staff.

One complaint was managed for the NWLIUC provider. We anticipate an increase in this area in the forthcoming months

Maintaining Business as Usual is paramount whilst the IT Department address the issues the team have been experiencing

The Ombudsman's new guidance 'Making Complaints Count' is due for publication in early 2021. We have been invited to be one of the Trusts potentially involved as an early adopter site. It is anticipated that this will establish the basis of a new regulatory framework.

Responding to complaints

Latest Month: 9

Legend: Complaints Breached, Mean, UCL, LCL

Only 9 complaints due for a response in November breached the target response.

We anticipate that the annual trajectory of complaints will be lower than last year at approximately 1000 for 2020/21

We are hoping to set up a small Task and Finish group to review the high numbers of complaints relating to staff attitude and behaviours and to look at ways in which we can address the key issues

Actions and Learning

Patient Experience – November 2020
We have assumed responsibility for the management of a designated cohort of complaints as part of the LAS management of the NWLIUC 111 function . We are liaising with the strategic lead and have made changes to Datix. We anticipate a rise in the number of NHS111 complaints as a result of this.

The Health Service Ombudsman has advised that there are likely to be delays in responding to complaints (up to several months) that are brought to their attention because of the unprecedented issues with Covid-19. We currently have 4 cases with the PHSO, all under active investigation.

We have submitted our Business Plan template endorsing that performance should be measured using triangulation methodology and that patient feedback should be used as a driver for change

Our team continue to liaise with Business Partners in accordance with the trial of the Business Partner Model. Functionality has been hindered this month with the implementation of the NHS Mail system. Duty messages have failed to generate for a number of the team and our Business Continuity Plan was invoked

Despite the IT problems, turnover has been very good during November. Current annual percentage of complaints (not including concerns) responded to within 35 working days is now 73%

Aim & Benefits of the accreditation scheme

The aim is to drive quality standards by empowering front line staff to make improvements in line with the Care Quality Commission's (CQC) fundamental standards.

Benefits include:

- Safe care & improved patient experience
- Improved front line staff engagement in the quality agenda a sense of collective leadership & pride in care delivered
- Clear standardised approach and expectations in terms of quality standards of care

Standards assessed

Safe CQC KLOES e.g. compliance with IPC, safeguarding, meds management, stat & man training, Datix etc.	**Caring KLOES e.g. involving patients in decisions about their care & treatment**
Effective CQC KLOES e.g. CPI, MCA, PDRs	**Well Led KLOES e.g. local staff enragement, risk management, information management, vision & strategy that aligns with the wider trust vision & strategy**
Responsive CQC KLOES e.g. complaints response rates, timely care	

The pilot run between 1 Sept & 30 Nov 2020. Independent assessments took place between 30 Nov & 4 Dec . Independent assessments were led by CCG Quality leads from all the 5 London STPs and public representatives. QGAMs facilitated the sessions

Participating stations	Awards achieved at the end of the pilot
Hanwell station	Gold
Wimbledon station	Gold
Camden station	Gold
Newham station	Gold
Brixton station	**TBC**
SEL IUC	Assessments were postponed due to operational pressures

Accreditation levels

Key

Gold	Meeting all assessed quality standard's and is deemed excellent
Silver	Meeting most quality standards with plans to improve
Bronze	Meeting basic quality standards

Next Steps

- Stations will receive their Awards in January
- QGAMS will conduct a pilot evaluation which will be reported to QOG & QAC to inform decisions on roll out across the Trust
- Potential roll out from April 2021
- Further development of the accreditation programme

ER Excellence Reporting
Excellence is everywhere

In November 92 *Excellence Reports* were submitted and the team provide high level themes around the types of reports that are received. The themes help share learning when they are used in our communication with staff such as INSIGHT magazine to learn from excellence.

Key themes identified from November reports includes:

❑ Thank you
❑ Outstanding patient care
❑ Working above and beyond
❑ Cardiac arrest management

Key Themes November 2020

■ Call Handling ■ Cardiac Arrest Management ■ End of Life Care ■ External ■ Mentoring/Teaching
■ Outstanding Patient Care ■ Scene Management ■ Staff Support/Welfare ■ Thank you ■ Working Above and Beyond

Call Handling , 3
Mentoring/Teaching , 3
Scene Management , 2
End of Life Care, 1
External, 1
Staff Support/Welfare , 1

Thank you, 23
Outstanding Patient Care, 21
Working Above and Beyond, 21
Cardiac Arrest Management, 16

Thank you

A *big thank you* to the crew who offered to attend a Cat 1 call that I had GB'd even though they were XRAY.

The situation had changed since I had put out the GB and it was likely the call would not be as given. Despite me advising that crew of this they were still happy to attend If I needed them and after considering my options I chose not to send them.

What really stood out to me was the crew then RTS'd again once back on station to find out if all was ok with the call and if I was ok also. Thankfully the call wasn't as given but the fact they *offered to assist* even when they didn't have to was very appreciated. Thank you!

Cardiac Arrest Management

We all attended a cardiac arrest this afternoon. Everyone that attended this job *worked together* in the upmost professional and respectful manner. We all worked as a team and *supported* each other during the arrest and after. Considering this is a very emotive job, everyone played their role to give the best care and chance to the patient. The APP commented to me that this was one of the best managed paediatric arrested he has seen. This is purely because we all worked together and remained calm under extreme stress.

Working Above and beyond

There was nothing clinically wrong with this person, his carer added he is quite prolific in his calls to LAS for many non-specific ailments to have an attendance. But the crew didn't let this hamper their approach, they gave him complete *dedication* and compassion, all the while AIQ with effectively, someone who isn't a patient in their own time somewhat. But they very visibly made his day with a welcoming chat and friendly face, holding true to the service *vision and values* and were, as always, a credit to the trust.

Outstanding patient care

He efficiently assessed the patient and identified the need for paramedic specific analgesia early and subsequently requested paramedic attendance. His swift actions and clinical thinking ensured the patient received adequate and appropriate pain relief in a reasonable time frame. His knowledge and abdominal assessments are holistic and beyond his current scope of practice and expected knowledge. I believe that his *compassion*, knowledge and *willingness* to learn is testament to facilitate his progression from EAC to Paramedic.

ER Excellence Reporting

Excellence is everywhere

This provides an overview of Sectors/Group Stations to support locally based learning and indicates where most of the reports are being reported.

Some examples of excellence reports from November:

Her made a decision to appropriately continue with a safeguarding referral for a patient with concern of coercion and domestic violence where his consent was not clearly given. Social services informed us that they have concerns for the patient given past history and the crew referral. Police were arranged and ambulance crew attended for the second time in two days. This time, the patient has opened up about the abuse and wanting to receive help.

Her decision making and processing of this referral means a vulnerable member of society will now receive the help and support he needs. Her knowledge of safeguarding is excellent so her referrals to social services are always very thorough. Well done!

She got a running call on her way home from shift and stopped to help a man who had fallen over. I took the call in EOC and was in awe of how kind she was and the way she reassured and spoke to him. It was freezing cold and she was probably really tired after a long shift, but stayed with him the whole time. Her kindness really made my shift.

They displayed excellent communication and team working skills in a hostile and noisy environment when treating a patient who had been stabbed within a dark estate.

When I arrived, there were clearly MPS officers affected by the trauma of the situation, however the crew were calmly and effectively treating with an effective resuscitation. They had managed to work with the police to obtain 360 degree access and coach them into undertaking effective chest compressions. I received an excellent hand over and both worked as an integral part of a multi-disciplinary team during a Thoracotomy. Both displayed resilience which enabled them to manage the human factors and the challenging environment to deliver excellent care.

29 year old near-fatal asthma patient in respiratory arrest, all 3 staff members were fantastic and performed difficult skills such as needle-chest decompression and other advanced techniques to return patients SpO2 from <50% to 100%, after repeated ADX, nebs and other drug treatment the patient stabilised and improved so much that he didn't require RSI at hospital! Releasing the tension pneumothorax saved the patients life. Big pat on the back!

November Excellence Reports

Legend: North Central, North West, North East, South East, South West, Other
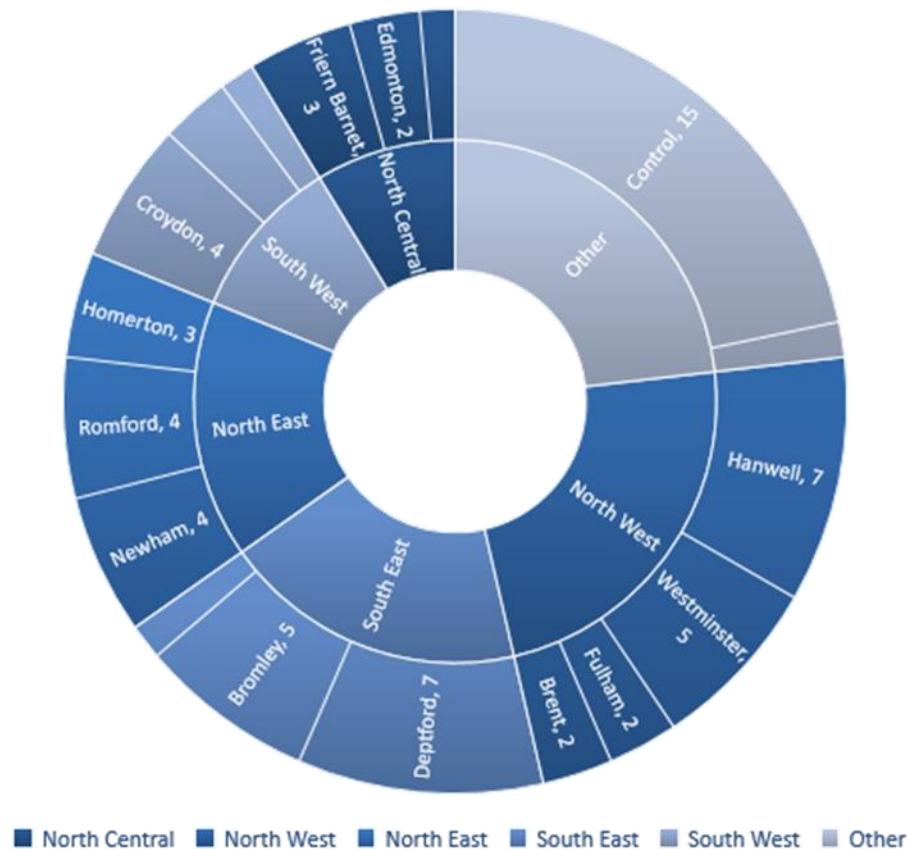
Public Value Scorecard

November 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Current Perfomance					Outturn		Benchmarking		
---	---	---	---	---	---	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)
Adjusted Financial Performance Total (Deficit)/Surplus	£m	Nov-20	🟢	2.326	A	0.388	0.388	0.776	0.776		2.327	2.326			
Performance Against Adjusted Financial Performance Plan	£m	Nov-20	🟢	>=0	A	0.000	0.000	0.000	0.000		0.001	0.000			
Use of resources index/indicator (Yearly)	Rating	Nov-20	⚪	1	A										
% of Capital Programme delivered	%	Nov-20	🔴	100%	A	7%	14%	26%	63%		95%	100%			
Capital plan	£m	Nov-20	🔴	44.211	A	3.278	6.038	11.278	27.907		41.800	44.211			
Cash position	£m	Nov-20	🟢	15.1	A	78.6				53.6					
% spend against Agency Ceiling	%	Nov-20	🟢		A	5%	8%	54%	67%		67%	100%			
CIP Savings YTD	£m	Nov-20	⚪		A										
	%	Nov-20	⚪		A										
CIP Savings achieved - % Recurrent	£m	Nov-20	⚪		A										
	%	Nov-20	⚪		A										
Commercial income generation	£m	Nov-20	⚪		I										
Corporate spend as a % of turnover	%	Nov-20	🟡	<7.0%	I	10.6%		9.2%			9.5%				
Cost per incident (measures to be confirmed in light of COVID)	£	Nov-20	⚪		I										
Average Jobs per shift	%	Nov-20	🔴	5.3	I	4.7		4.2		4.5					

🟢 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

The Trust's month 8 position was on plan – a £862k surplus (£776k surplus on an adjusted financial performance basis) and the month end cash position of £78.6m is strong.

YTD outturn vs budget
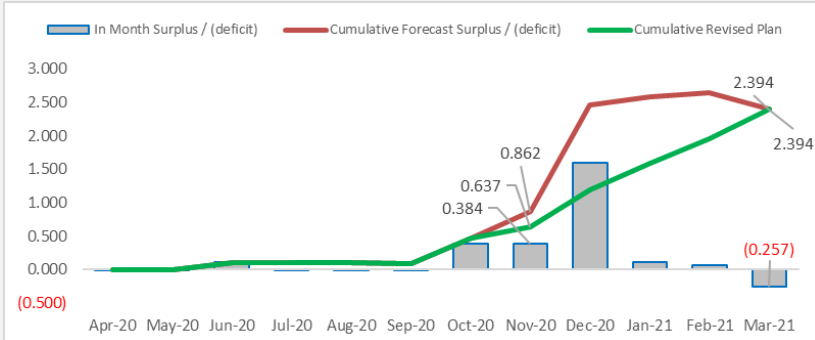
- **YTD Position:** The month 8 position was a £862k surplus (£776k surplus on an adjusted financial performance basis) in line with NWL STP planning. The YTD position incorporated £58.5m of costs in relation to the Trust's response to COVID-19, and a retrospective income top up unchanged from month 6 of £49.9m.

- **Full year forecast:** The full year forecast position at month 8 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 £74m 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
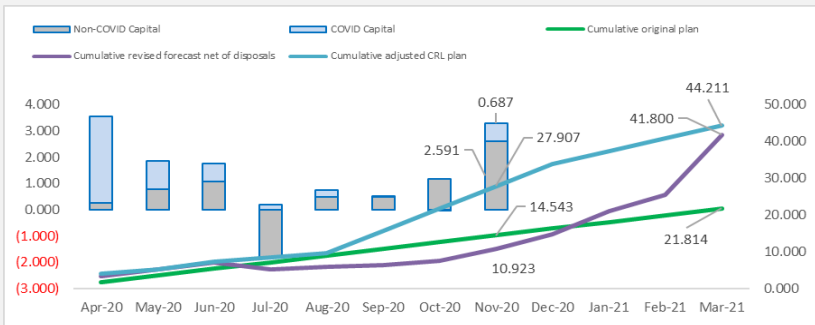
- **Use of Resources:** NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). No use of resources scores are currently available under the interim financial framework arrangements.

- **Capital**: YTD capital expenditure net of disposals is £10.9m YTD (£11.3m excl disposals) compared to previously planned capital expenditure of £27.9m (£17m behind plan net of disposals). Full year forecast capital expenditure net of disposals has been reduced in conjunction with NW London STP partners given constrained capital availability and is now £41.8m. Significant acceleration of capital will be needed to meet this target. Capital spend on the Trust's phase 1 response to the COVID-19 pandemic is £5.6m YTD (primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment), with other significant spend on Spatial Development, Fleet and Digital 999 programmes. 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
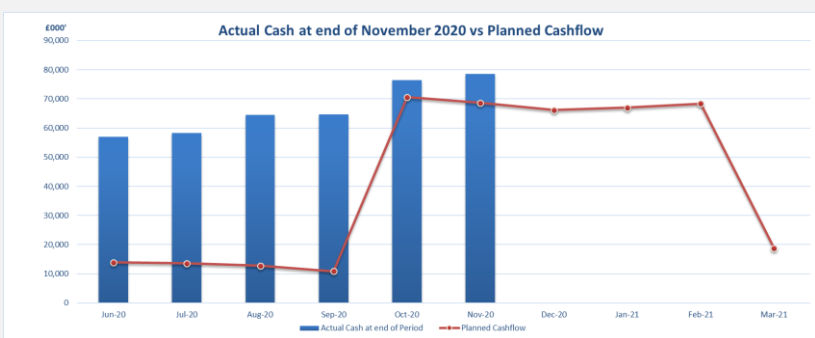
- **Cash:** Cash was £78.6m as at 30 November 2020, £10.0m above the revised plan. The main reason for the favourable position was the continuing payment in advance of one month's block contract income between April and November. Cash balances are expected to remain high until the end of February 2021 when this arrangement ceases.

- **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 November 2020 was 100.0% and 94.7% 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. During the COVID period there has been a focus on paying invoices within 7 days wherever possible. Whilst only 15.2% of invoices were paid within 7 days based on their invoice date (21.9% based on date received), invoices are put on the next payment run regardless of due dates as soon as they are authorised for payment, with two payment runs to suppliers each week.

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 8 – November 2020)

	Month 8 2020-21 £000			YTD Month 8 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	42,669	40,085	(2,584)	289,986	287,110	(2,876)	463,886	463,431	(455)
Other Operating Income	213	232	19	68,653	68,780	127	69,289	70,216	927
Total Income	**42,882**	**40,317**	**(2,565)**	**358,639**	**355,890**	**(2,749)**	**533,175**	**533,647**	**472**
Operating Expense									
Pay	(29,441)	(28,378)	1,063	(241,847)	(240,948)	898	(361,487)	(362,273)	(786)
Non Pay	(11,362)	(9,822)	1,540	(102,190)	(100,750)	1,440	(147,284)	(147,445)	(161)
Total Operating Expenditure	**(40,803)**	**(38,200)**	**2,603**	**(344,037)**	**(341,698)**	**2,339**	**(508,771)**	**(509,718)**	**(947)**
EBITDA	**2,080**	**2,117**	**37**	**14,602**	**14,192**	**(410)**	**24,404**	**23,929**	**(475)**
EBITDA margin	4.8%	5.3%	0.4%	4.1%	4.0%	(0.1%)	4.6%	4.5%	(0.1%)
Depreciation & Financing									
Depreciation & Amortisation	(1,473)	(1,287)	186	(10,035)	(9,402)	634	(16,293)	(15,819)	474
PDC Dividend	(445)	(445)	0	(3,560)	(3,560)	0	(5,340)	(5,340)	0
Finance Income	0	0	0	(4)	(4)	0	(4)	(4)	0
Finance Costs	(2)	(2)	(0)	(26)	(26)	0	(34)	(34)	(0)
Gains & Losses on Disposals	0	1	1	(340)	(339)	1	(340)	(339)	1
Total Depreciation & Finance Costs	**(1,920)**	**(1,733)**	**187**	**(13,965)**	**(13,330)**	**635**	**(22,010)**	**(21,536)**	**475**
Net Surplus/(Deficit)	**159**	**384**	**225**	**637**	**862**	**225**	**2,394**	**2,394**	**(0)**
NHSI Adjustments to Fin Perf									
Remove Donations I&E Impact	5	5	(0)	(87)	(87)	(0)	(68)	(68)	(0)
Adjusted Financial Performance	**164**	**388**	**225**	**551**	**775**	**225**	**2,326**	**2,326**	**(0)**
Net margin	0.4%	1.0%	0.6%	0.2%	0.2%	0.1%	0.4%	0.4%	(0.0%)

Year to Date Position

The YTD position is a £0.9m surplus (£0.8m surplus on an adjusted financial performance basis) in line with NHSI NWL STP planning assumptions, and £0.2m ahead of revised budgets.

Forecast Full Year Position

The full year position is forecast to be a £2.4m surplus in line with NHSI NW London STP planning assumptions. The forecast position incorporates expected COVID response requirements over the remainder of the financial year.

Key Drivers of Position

Income:
- Income from activities is primarily comprised of the Trust's block contract income under the current interim financial arrangements, along with M8-12 top up and fixed COVID income. It is £2.9m behind budget YTD due to deferral of COVID and 111 First income, and adjustment of expected PRU income, and £0.5m unfavourable to budget full year forecast due to adjustment of expected PRU income.
- Other operating income is broadly on plan YTD (favourable to budget by £0.1m) and £0.9m favourable to budget full year forecast due to the notification of £1.1m of education and training income from Health Education England offset by slightly lower expected apprenticeship levy income.

Pay Expenditure:
- Pay expenditure is currently £0.9m favourable to budget YTD due to lower than expected numbers of staff in training as well as staff cost capitalisations and delayed recruitment to vacancies, and forecast to end the year £0.8m adverse to budget primarily due to increased operational management resource levels and forecast increased frontline control resourcing.

Non-Pay Expenditure:
- Non pay expenditure excl depreciation and finance costs is £1.4m favourable YTD due to lower than budgeted IUC resource use, realignment of expected make ready costs to adjusted service levels, lower private ambulance use and lower than expected uniform requirements. The full year forecast is to end the year broadly on plan (£0.2m adverse to budget).
- Depreciation and finance costs are favourable to budget (£0.6m YTD and £0.5m full year forecast) due to slippage on the Trust capital programme.

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 8 – November 2020)

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Nov-20 YTD Move	Nov-20 YTD Plan	Nov-20 Var
	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	58,796	57,028	58,338	64,534	64,610	76,394	25,964	25,964	0
Operating Surplus	1,465	2,259	1,531	2,289	1,849	2,117	14,189	14,828	(639)
(Increase)/decrease in current assets	2,709	2,168	1,223	(8,435)	8,512	2,247	(3,223)	(1,399)	(1,824)
Increase/(decrease) in current liabilities	(3,108)	(4,349)	3,514	7,220	2,397	4,700	61,631	48,976	12,655
Increase/(decrease) in provisions	213	(198)	284	817	(86)	(240)	971	1,297	(326)
Net cash inflow/(outflow) from operating activities	1,279	(120)	6,552	1,891	12,672	8,824	73,568	63,702	9,866
Cashflow inflow/(outflow) from operating activities	1,279	(120)	6,552	1,891	12,672	8,824	73,568	63,702	9,866
Returns on investments and servicing finance	(8)	0	0	0	0	0	(12)	(12)	0
Capital Expenditure	(3,039)	1,430	(356)	(1,922)	(888)	(3,880)	(18,289)	(21,165)	2,876
Dividend paid	0	0	0	0	0	(2,718)	(2,718)	0	(2,718)
Financing obtained	0	0	0	107	0	0	107	107	0
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	(3,047)	1,430	(356)	(1,815)	(888)	(6,598)	(20,912)	(21,070)	158
Movement	(1,768)	1,310	6,196	76	11,784	2,226	52,656	42,632	10,024
Closing Cash Balance	57,028	58,338	64,534	64,610	76,394	78,620	78,620	68,596	10,024

Operating Position

There has been a net inflow of cash to the Trust of £52.7m, this is £10.0m higher than the planned inflow £42.7m and cash funds at 30 November stand at £78.6m.

The operating surplus at £14.2m is £0.6m below plan.

Please note: Following the revision of NHSI plans during October, plan figures included here (which previously the outturn statement of financial position) have now been replaced with updated plan figures.

Current Assets

- The movement on current assets is (£3.2m), (£1.8m) higher than the planned movement
- Current assets movement was due to receivables (£1.2m), accrued income (£1.5m), prepayments £1.1m and inventories (£0.1m)

Current Liabilities

- The movement on current liabilities is £61.6m, a £12.7m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables £0.1m, accruals £4.3m and deferred income at £8.2m. The deferred income increase is due to additional block contract income and IUC income being paid in advance

Dividends

- The movement on dividend paid is (£2.7m), the timing of the payment was not known when the plan was prepared.

Provisions

- The movement on provisions is £1.2m, which is £0.1m lower than the planned movement.

Capital Expenditure

- Capital cash movement was an outflow of £14.4m which is £1.8m below plan due to capital slippage.

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 was operating under an adjusted financial framework for April to September 2020 in response to the COVID-19 pandemic. This involved pausing business planning and Cost Improvement Programmes and as such no CIP data was available.
- Under the new financial framework to be put in place over the second half of the financial year, a £2.4m efficiency to meet the fixed income available to the Trust, and projects are being developed to meet this need. Additional efficiencies will need to be identified to match any new approved spend with a further £4.5m currently expected bringing the total to £6.9m and reporting for these is being developed.

CIP Savings

FY Forecast: N/A

FY Target: £6.9m

Capital Plan

- YTD capital expenditure net of disposals is £10.9m (excluding disposals £11.3m) compared to planned expenditure of £27.9m (£17m behind plan) partially due to the reversal of £2.3m of capital work in progress in relation to the CAD upgrade project.
- Full year forecast capital expenditure is £41.8m which has been reduced in conjunction with NW London STP partners given constrained capital availability.
- Capital spend on the Trust's phase 1 response to the COVID-19 pandemic is £5.6m YTD primarily on expanding IT and telephony systems, IT equipment and clinical equipment, with other significant spend on Spatial Development, Fleet and Digital 999 programmes.

Capital Plan Breakdown

YTD: £10.9m

FY Plan: £41.8m

Jobs per shift (DCA)

Average jobs per 12 hour shift

Actual: 4.7
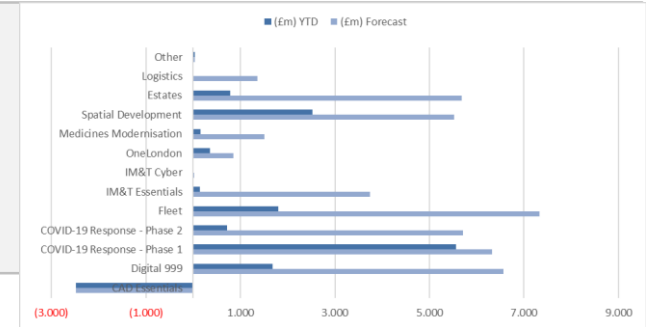
Target: 5.3

Operations are tracking the performance of jobs per shift on a monthly basis. However, owing to the ongoing pandemic, jobs per shifts continue to be outside target levels and this can be seen on the graph on the left.

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

November 2020

Benchmarking Key

Top 3	
Ranked 4-7	
Ranked 7+	

Please note: 999 performance data is correct as at 14/12/20 and is subject to change due to data validation processes

Indicator (KPI Name)	Basis	Data From Month	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)
						Current Perfomance			**Benchmarking (Month)**		
Hospital handover	minutes	Nov-20	🟡	18.0	I	19.4	18.5	20.5			
Post-handover (Handover 2 Green)	minutes	Nov-20	🟢	15.5	I	14.7	14.6	14.3			
See and Convey – to ED (Contractual Position) *	%	Nov-20	🟢	57.0%	C	53.7%	51.8%	52.3%	53.3%	50.2%	8
Hear and Treat % **	%	Nov-20	🔴	8.39%	I	8.6%	9.9%	10.2%	7.9%	10.2%	6
Hear and Treat (n) **	%	Nov-20	⚪	108,073	I	8,875	**79,787**	127,701			
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	%		⚪	100			TBC				

Benchmarking legend:

🟢 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

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.

Arrival at Hospital to Patient Handover

We saw a higher number of delays in November, compared to October, with the overall number of hours lost has gone up to 1,283 hours lost from our arrival to patient handover over 30 mins. Queens Romford, Whipps Cross and King Georges had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the had the highest number of lost hours over 30 minutes, at 315 hours for the month.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 M ins		Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,534	1,512	252	17%	62.9		22.7
	North Middlesex	2,641	2,591	539	21%	88.6		22.4
	Royal Free	1,482	1,444	200	14%	26.9		21.5
	University College	1,228	1,200	28	2%	2.8		15.1
	Whittington	1,458	1,433	156	11%	35.2		19.8
North East	Homerton	1,283	1,233	28	2%	3.4		14.8
	King Georges	1,224	1,194	354	30%	99.1		28.4
	New ham	1,725	1,648	426	26%	56.5		25.0
	Queens Romford	2,552	2,474	1,044	42%	315.9		32.8
	Royal London	1,839	1,756	135	8%	15.6		20.5
	Whipps Cross	1,447	1,404	434	31%	224.6		31.3
North West	Charing Cross	1,253	1,234	6	0%	0.5		11.6
	Chelsea & West	1,390	1,353	12	1%	0.6		15.5
	Ealing	1,239	1,228	30	2%	4.6		13.8
	Hillingdon	1,804	1,772	56	3%	13.6		13.2
	Northwick Park	3,182	3,126	204	7%	65.7		15.7
	St Marys	1,749	1,705	93	5%	11.5		16.8
	West Middlesex	1,977	1,954	58	3%	7.3		15.5
South East	Kings college	1,961	1,904	242	13%	33.9		21.7
	Lewisham	1,350	1,274	88	7%	12.4		18.4
	Princess Royal	1,807	1,710	200	12%	90.4		19.9
	Queen Elizabeth II	2,293	2,225	37	2%	14.7		13.3
	St Thomas'	1,987	1,924	77	4%	5.9		17.2
South West	Croydon	2,140	2,084	181	9%	47.8		20.2
	Kingston	1,556	1,523	57	4%	5.0		18.8
	St Georges	1,826	1,741	245	14%	26.9		20.7
	St Helier	1,257	1,224	67	5%	10.3		18.5
TOTAL		47,184	45,870	5,249	11%	1,283		19.6

Max average breach value
Value >10 mins per breach

Patient Handover to Green

In November, we saw handover to green performance similar to that in to October, 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

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

	Sep-20	Oct-20	Nov-20	Year-end Target
Arrive at Hospital to Patient Handover (mins)	18.8	19.4	19.6	18.0

Hospital Handover performance is currently outside of target. Since June we have been seeing a steady worsening of performance on this metric, due to increased hospital pressure with the demands of Covid in addition to normal winter pressures. As a result, this impacts on the Trusts ability to hand patients over allowing our Ambulance crews to be deployed back into the community for other incident responses.
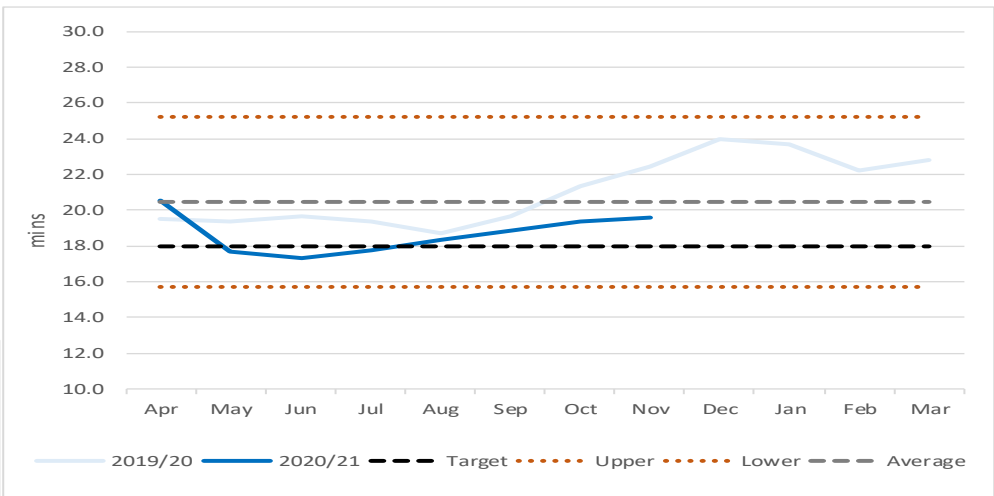
Patient Handover to Green (**Emergency Departments only & Excluding blue calls)

	Sep-20	Oct-20	Nov-20	Year-end Target
Patient Handover to Green (mins)	14.7	14.7	14.6	15.5

Handover to Green performance has been within target, but above the 19/20 average since April 2020. Since September we continue to achieve an average of 14.6 minutes for this metric. As we enter the winter period, the Trust will continue to monitor and review this metric as we anticipate an upward trend attributed to winter pressure and demands, along with Covid activity.
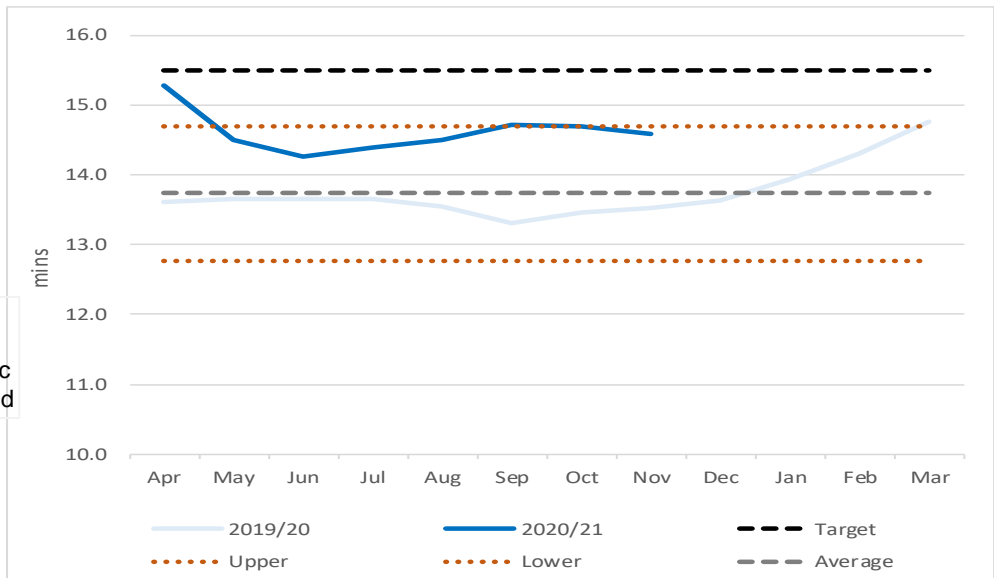
Please note: 999 performance data is correct as at 14/12/20 and is subject to change due to data validation processes

34

Maximising safe non-conveyance to ED

See and Convey to Emergency Department

		Nov-20	Year To Date	Year-end Target
See & Convey ED %	LAS	53.7%	51.8%	
	Target			57.0%

The conveyance to emergency departments target (57.0%) was delivered in November (53.7%). A steady profile of demand has allowed us to achieve this metric month on month. While ranking 8th nationally, it is worth mentioning that the variance between Ambulance Trusts for this metric is small, with us finishing at 0.4% away from the England National figure of 53.3%. 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.
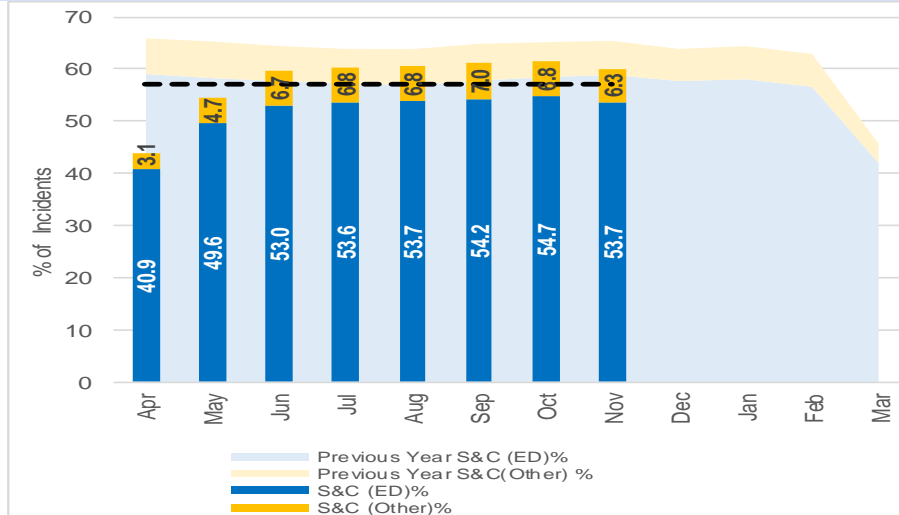
Hear and Treat %

		Nov-20	Year To Date	Year-end Target
Hear & Treat %	%	8.6%	9.9%	
	(n)	8,875	79,787	TBC

Hear and treat delivered 8.6% in November. 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.
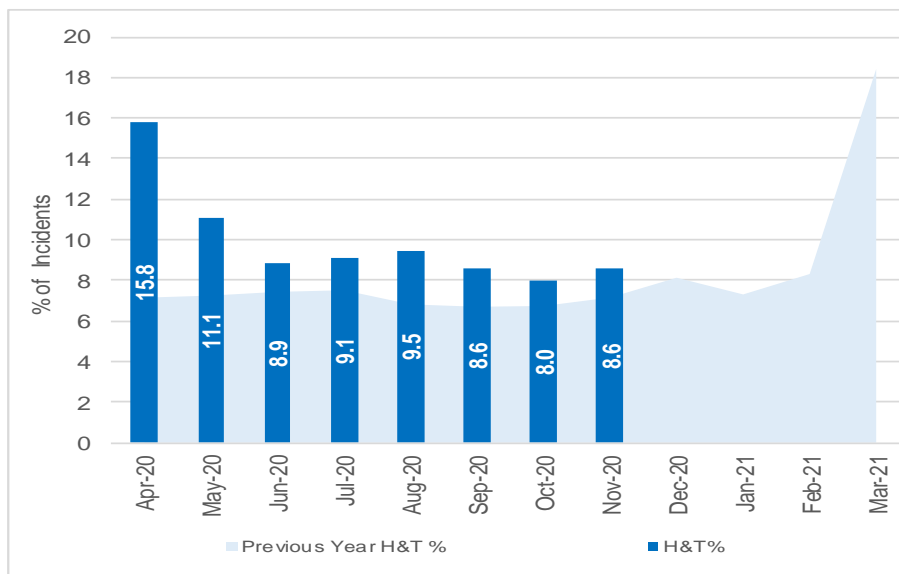
LAS views are compared to tagged care plans – as any other kind of flag for the address or any address in the building raises a CMC flag at LAS – rendering Flagged figures meaningless

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.

CMC Care Plans Tagged by LAS staff as relevant to the 999 call vs Viewed by LAS CMC user (last 12 Months)

coordinate my care

Month	Tagged	Viewed
Dec	6368	2867
Jan	6137	3936
Feb	6126	3733
Mar	7203	3435
Apr	6847	4978
May	6703	5317
Jun	6731	5378
Jul	6998	5237
Aug	7743	6524
Sep	7171	5279
Oct	7650	6233
Nov	7592	6065

LAS (999) % Views of Tagged CMC Care Plans (2020/21)

Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov
45%	64%	61%	48%	73%	79%	80%	75%	84%	74%	81%	80%

LAS (999) staff viewed 6065 CMC care plans in October, of which 5184 (85%) were via iPads (mobile devices). This is similar to 86% in October.

NHS

ED Conveyance

Latest Month (Nov): 20.9%

% ED Conveyances — Mean — UCL — LCL
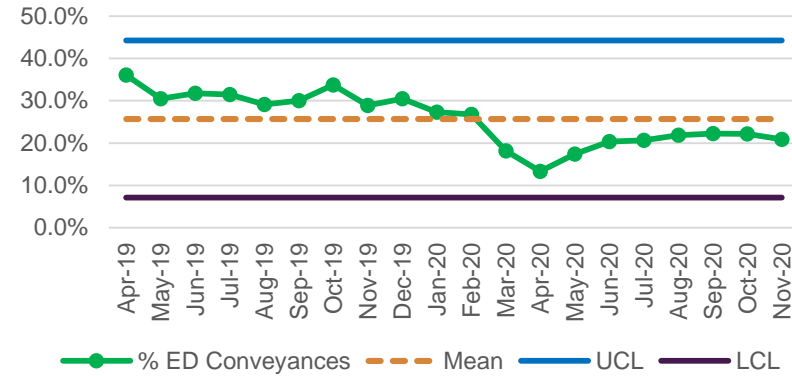
Coordinator Pilot evaluation released to key stakeholders

ED conveyance continues to decline below the mean indicating special cause variation

CMC Views

Views — Mean — UCL — LCL
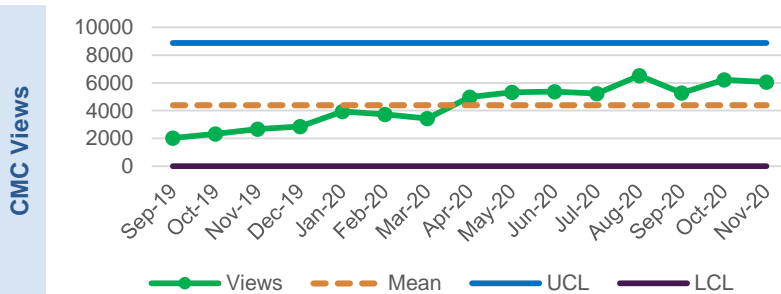
Staff Confidence

78% staff post education felt confident

28% increase from baseline

Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree

Baseline / Post Education
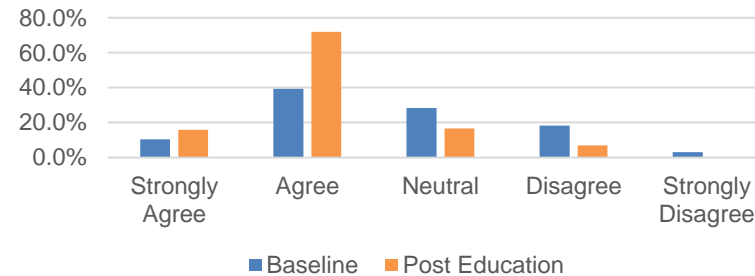
Presentation at Ambitions partnership conference on programme
Business case for continuation of End of Life team discussed with commissioners

Final evaluation of programme commenced

MH Incidents as % of all incidents — MH Incidents as % of all calls / Mean / UCL / LCL

MH calls as % of all calls — MH calls as % of all calls / Mean / UCL / LCL

	Hear & Treat	See & Treat	See & Conveyed
Nov-20	3.8%	44.9%	55.1%
Target	3.0%	36.0%	64.0%

Nov-20 / Target
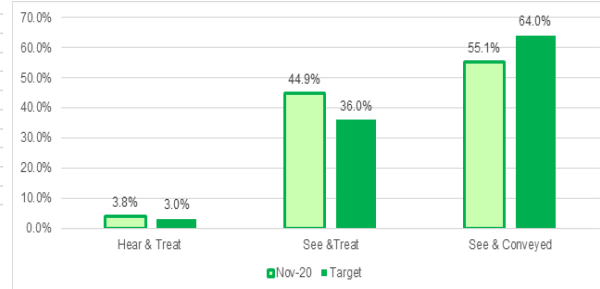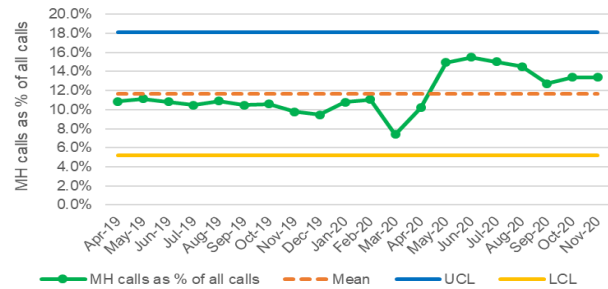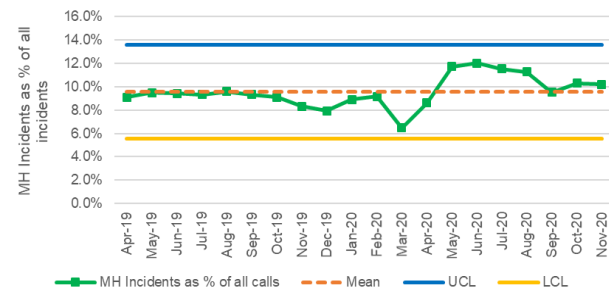
We continue the discussion around the next steps regarding funding for the Mental Health Cars with our lead commissioners and some of the mental health providers.
The team were honoured to win a HSJ Patient Safety Award and London Region Parliamentary award.
The team have been offering CPD training on the Mental Capacity Act and case based discussions.

Strategic Vision

Our LAS vision and strategic objectives set out in our 5-year strategy (2018 -2023) is to be "**a world class ambulance service for a world class city and London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line".**

The Ambulance Operations Modernisation (AOM) Programme

As part the LAS Strategic Vision, we have developed exciting plans to consolidate, transform and modernise our operational estate through our AOM programme. This programme will develop and implement our Estates Vision. We aim to replace 68 highly dispersed sites with fewer but larger, high quality "hub-based" Ambulance Deployment Centres (ADCs) across London, which are fit for a modern 21st century ambulance service. This will enable a fundamental change in the way LAS operates – designing our operations around patient demand and promoting a more supportive and inclusive operational culture focused directly on patient care and staff well-being, training and development.

Progress Update - We have appointed a supplier to develop a programme Business Case which will be presented to our Trust Board for agreement in March 2021. The programme team has now been mobilised. We are undertaking work to identify where our estates would be located and we have appointed a supplier to develop detailed simulation and modelling capabilities to help us shape the future.

Next Generation Ambulance

Work is ongoing to develop our next generation ambulance in collaboration with NHSE&I as agreed at the Ambulance Improvement Implementation Board (AIIB) on 29th October 2020. The LAS will lead on this development working collaboratively with other Trusts across the country to stimulate the market and develop a zero emission, lightweight ambulance with improved accessibility and digital enablement for the UK. This will be designed around the needs of our patients and staff and comply with current and proposed emissions standards.

Business Planning

We are developing a five year Business Plan to ensure that our organisation is efficient, effective and fit for purpose for the future as well as for today. Our Business Plan identifies six strategic themes to support our organisational ambition. The six themes are: 1. Culture Change, 2. Enhancing patient experience, 3. Health, safety & wellbeing, 4.Operational modernisation, 5. Setting a strong foundation and 6. Corporate modernisation. Our Executive and their teams are currently planning their proposed deliverables for the next five years and the intention is for a Board Development Session to focus on the Business Plan in the New Year with sign off in March 2021.

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	LAS response to the NHS People Plan
Agenda item:	7.1
Report Author(s):	Sukhjit Kadri, Business Support Manager
Presented by:	Kim Nurse, Director of People and Culture [Interim]
History:	People Plan published July 2020, amended 6 August 2020.

Purpose:	☒	Assurance	☐	Approval
	☐	Discussion	☒	Noting

Key Points, Issues and Risks for the Board's attention:

The publication of the NHS People Plan was finally published 6 August 2020. Its publication was delayed by the initial impact of COVID-19, but NHSEI have utilised this time to further shape the key principles within it.

The Plan set out actions to support transformation across the whole NHS. It uses language that the NHS may not always be used to, such as: focussing on how we look after each other and fostering a culture of inclusion and belonging. The plan also refers to actions that will support the growth in our workforce, a focus on training our people, and on working together differently to deliver patient care.

The document makes note of the significant impact on the workforce in terms of resilience, wellbeing, morale, new ways of working, and also the positive public opinion of the NHS and the potential for this to have an impact on recruitment.

In order to address these key principles it is recognised that the NHS needs more people, working differently, in a compassionate and inclusive culture.   The People Plan therefore set out practical actions that Trusts should take, as well as the actions that NHS England and NHS Improvement and Health Education England would introduce over the remaining part of 2020/21.   These steps focused on:

- **Looking after our people** - stating particularly the actions that should be taken to keep our people safe, healthy and well – both physically and psychologically.

- **Belonging in the NHS**, which highlighted the support and actions needed to create an organisational culture where everyone feels they belong.

- **New ways of working** and delivering care, with an emphasis on making effective use of the full range of our people's skills and experience to deliver the best possible patient care.

- **Growing for the future**, thought building renewed interest in NHS careers, to expand and develop our workforce, as well as taking steps to retain colleagues for longer.

- **Supporting our people.** The people promise commitments are shown below.

The attached Project Map was first developed for LAS during the summer of 2020, based on a London template. This document was utilised to scope where LAS was currently positioned against each of the key priorities of the People Plan and to identify those gaps and measures that were required to successfully address these.

At the Trust Board meeting on 24 November 2020, members further received and approved the People and Culture 18 Month Plan.

To ensure all key priority areas were sufficiently comprehensive, a mapping exercise has been undertaken to identify the consistency and gaps between these two strategic documents. The originally agreed Project Map has therefore been expanded so that it now includes references to the 18 month plan, as well as depicting a RAG rated status against each activity area, to provide assurance of progress and ongoing actions required, at a glance.

This document is expected to be kept under continued monitoring, both to capture successful delivery of these agreed measures, as well as to reflect further enhancements introduced by the Trust against each of these key priority areas. It is also expected that the planned NHSEI initiatives due this financial year, may be delayed due to the current pandemic demands. However, as they come on- stream, they will need to be captured and reflected within this document.

Recommendation for the Board:

The Board is asked to consider this Project Map, seeking clarification where necessary.

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	X	No		People and Culture Committee
Corporate Affairs	Yes		No	

NHS People Plan: Actions - Part One

In each area of the NHS People Plan, the document sets out actions for employers, national bodies and systems.

Please find below a summary of the London Ambulance Trust response to these actions:

HEALTH AND WELLBEING

	Action	LAS Status	Timeline (Where Available)	Comments and Actions	Inc.18 Month P&C Plan	RAG	Owner
1	Put in place effective infection prevention and control procedures.	• Trust recently inspected by CQC for IP&C and rated compliant with no key actions • I&PC monitored through I&PC Committee	Complete	**ACTION COMPLETED**			KC
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	• Processes in place to provide staff access to PPE and required training • Designated BAME PPE champion at each group station • PPE stock levels monitored daily and concerns over supply raised through Daily Senior Leadership Team (DSLT) meetings	Ongoing	**ONGOING MONITORING**	√		KM
3	All frontline healthcare workers should have a vaccine provided by their employer.	• Flu vaccine campaign starts 1st September with associated communications plan. • A comprehensive Staff Immunisation programme continues to ensure 2,300 staff receive the appropriate level of immunisations. 58% of Staff currently immunised.	September 2020 launch	**CONTINUING TO:** Provide staff immunisations and flu vaccines. Flu programme owned by the Wellbeing Steering Group and monitored through DSLT, ExCo, and People & Culture Committee (P&CC)			KC
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	As at 25.08.20 the following staff have risk assessments in place: • 98% BAME • 96% vulnerable staff • 97% all staff	November 2020	**CONTINUOUS REVIEW AND MONITORING:** Risk assessments to be updated as required by the individual.			JR
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Laptops and essential IT equipment and MS Teams rolled out during COVID to enable more Corporate and support staff to work from home.	Dec 2020	**ACTION REQUIRED:** Home Working policy to be updated to reflect a range of flexible and agile working opportunities to our staff. Ensure consistent provision of support to staff including equipment, H&S, and access to remote wellbeing support .			JR/ED
6	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.	• Arrangements for annual leave carry over and post-holiday quarantine are available on Trust intranet "PULSE" • Line managers receive monthly updates of annual leave taken and booked by their staff • Monthly focus on encouraging staff to take their annual leave at DSLT	Ongoing	**ACTION COMPLETE &ONGOING MONITORING:** Monitor rest break arrangements for ambulance operation staff post COVID	√		JR

7	Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.	• Bespoke intervention plans in place in B&H hotspots. • Dignity at Work Lead Facilitator role appointed • 60+ D@W facilitators deployed across the Trust and in receipt of refresher mediation training. • Launch LAS Cultural Transformation programme built around our values and NHS People Promise	Ongoing	**ACTION REQUIRED:** • Monitor effectiveness of existing B&H reduction plans and course correct as necessary. • Update plans to incorporate the Civility Report and actions • Revise metrics to measure improvement as required and add metrics for improvement. • Review progress in this area through staff survey results	√		**JR**
8	Prevent and control violence in the workplace – in line with existing legislation.	• Participating in a body worn camera pilot. Once pilot completed the action is to roll BWC out across Ambulance Operations • Zero tolerance approach for verbal, physical and racist abuse of our staff and work together with the Metropolitan Police to pursue convictions under recent legislative changes • Both Call Centre and Ambulance Operations staff expected to report any form of abuse through DATIX	Ongoing	**ACTION REQUIRED:** Aim to start to rollout of BWC by 31st March 2021			**KM**
9	Appoint a wellbeing guardian.	Jayne Mee, Non-Executive Director and Chair of People and Culture Committee, appointed as Wellbeing Guardian in July 2020	complete	**ACTION COMPLETED**	√		**HL**
10	Continue to give staff free car parking at their place of work.	As part of station consolidation car parking provided at each station.	complete	**ACTION COMPLETED**			**KM**
11	Support staff to use other modes of transport and identify a cycle-to-work lead.	• TFL arrangement in place to claim back Congestion Charge. • Membership of NHS/local government car parking in restricted areas scheme. • Tax efficient cycle to work scheme already in place.	Complete	**ACTION COMPLETED**			
12	Ensure that all staff have access to psychological support.	• "87%" staff wellbeing app launched. • "How are you Doing" health & wellbeing survey will continue to run every 2 months. • Benchmark established for monitoring staff morale and who is accessing support mechanisms currently. • Mental Health specialist repositioned within Wellbeing department • Wellbeing hub established to create single point of access and signpost to existing services	Ongoing	**ACTION REQUIRED:** • Provision of bespoke BAME Mental Health Counselling services to be explored. • Continued focus on suicide prevention in collaboration with AACE	√		**KC**
13	Identify and proactively support staff when they go off sick and support their return to work.	• Review of the Trust's Management of Attendance Policy by Staff side and P&C team members is in progress. • New positions within the LAS such as wellbeing team enable staff to work from home or in non-patients facing roles	Ongoing	**ACTION REQUIRED:** Ensure OH service specification meets LAS requirements.	√		**JR**

		• A redeployment role established to support staff that may require alternative roles • Discussion have commenced to design the OH specification ahead of tendering in 2021.			(orange)	
14	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	• As part of station consolidation dedicated socially distanced rest room facilities in place at stations and office locations. • Education programme on "sitting" planned through the Wellbeing Steering Group. • Trust Garden of the Year competition 2020 conducted "virtually" this year • Provide equipment to stations and EOCs that will encourage movement at workstations and breaks • Restart organized activities when able to do so e.g. Yoga across different sites	Ongoing	**ONGOING REVIEW AND MONITORING:** Reward lead in P&C to review local gym membership options for staff at discounted rates or similar Identify equipment that is within H&S standards and requested by staff.	√ (orange)	KC
15	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	• Creation of new wellbeing teams for managers and debrief steering group will assist managers to recognise wellbeing needs of staff • New stress policy and Mental Health first aid training now being offered to all staff. • Arrangements for annual leave carry over and post-holiday quarantine published in bulletins during COVID. • DSLT focus on encouraging staff to take their annual leave	Ongoing	**CONTINUOUS REVIEW AND MONITORING**	√ (green)	KC
16	Every member of NHS staff should have a health and wellbeing conversation.	• Interim Head of Wellbeing appointed and Wellbeing Hub established to provide one point of entry for staff and managers with Wellbeing queries or concerns • Wellbeing support and resources available to all through "PULSE" • All managers were offered training in resilience conversations and these were rolled out to staff across the Service in July and August	31 March 2021	**ACTION REQUIRED** Interim Head of Wellbeing to introduce annual Wellbeing conversations for all staff. These conversations to include personal wellbeing needs, and to learn about their experience of inclusion, bullying & harassment.	√ (red)	KC
17	All new starters should have a health and wellbeing induction.	Interim Head of Wellbeing to work with colleagues to design a health and wellbeing induction programme.	31 March 2021	**ACTION REQUIRED:** Recruitment, wellbeing, and leadership development teams to ensure health & wellbeing is built into our Induction programmes	(red)	KC
18	Provide a toolkit on civility and respect for all employers.	As per Item 7 above	March 2021	**ACTION REQUIRED:** Update B&H reduction plans to incorporate the "Civility and Respect Toolkit"	√ (red)	JR

19	Pilot an approach to improving staff mental health by establishing resilience hubs.	• Interim Head of Wellbeing appointed and Wellbeing Hub established to provide one point of entry for staff and managers with Wellbeing queries or concerns	Complete	**ACTION COMPLETED**	√		KC
20	Pilot improved occupational health support in line with the SEQOHS standard.	• As per Item 13 above • Occupational Health contract re-tender in progress	Ongoing	**ACTION REQUIRED:**	√		KC

FLEXIBLE WORKING

LAS TO COLLABORATE WITH AMBULANCE SECTOR TO INTRODUCE FLEXIBLE WORKING PROVISIONS OF THE PEOPLE PLAN ACROSS TE SCETOR

	Action	LAS Status	Timeline (where provided)	Comments and Actions	Inc.18 Month P&C Plan	RAG	Owner
1	Be open to all clinical and non-clinical permanent roles being flexible.	• Flexible working available for most corporate staff when approval from line managers • Self-rostering and flexible rotas available for clinical staff where possible. Decision made by the local management teams.	Dec 2020	**ACTION REQUIRED:** Working from Home Policy needs to be updated in light of People Plan aspirations that flexibility is assumed for all.	√		JR/ED
2	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Staff can request a flexible working arrangement through direct line managers.	31 March 2021	**ACTION REQUIRED:** Leadership & Performance team to include section on flexible working for discussion as part of local induction.	√		JS
3	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	As per policy all staff can request flexible working.	Complete	**NO ACTION**	√		**JR**
4	Board members must give flexible working their focus and support.	As per policy all staff can request flexible working.	Complete	**NO ACTION REQUIRED**			**GE**
5	Roll out the new working carer's passport to support people with caring responsibilities.	No current actions in this area	March 2021	**ACTION REQUIRED:** • Research starting a Carers' Staff Network Group as per other organisations. • Director of Culture, Diversity & Inclusion to lead the introduction NHS Working Carers' Passport	√		AK

EQUALITY AND DIVERSITY

LAS IS ALREADY IMPLEMNETING A ROBUST AND COMPREHENSIVE DIVERSITY & INCLUSION ACTION PLAN WHICH IS DESIGNED TO STAMP OUT RACISM

	Action	LAS Status	Timeline (where provided)	Actions and Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	• LAS has a good track record of recruitment activities at a local and national level • Conclude Task & Finish group which is reviewing promotion and recruitment processes and practices	By November 2020	**ACTION REQUIRED:** Implement the findings of the recommendations of the recruitment Task & Finish group	√		**AL/AK**
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.	As per H&W item above	Ongoing	**ACTION REQUIRED:**	√		JS/KC/AK
3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.	LAS representation of BAME staff at band 8c and above is 19%. BAME staff in overall workforce is 18% (Figures as of 31st October 2020)	Ongoing	**ACTION REQUIRED:** Action plans to be put into place to deliver initiatives that insures that our staff composition reflects the communities that we serve.			AK
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	Roll out and embed "Resolution Framework" in response to Baroness Harding letter and requirements of "A Fair Experience for All" and the "Just Culture" approach	Ongoing	**ACTION REQUIRED:** • Refocus leadership development to focus on compassionate and inclusive leadership with line managers at Band 5 and upwards • Agree baseline metrics from which to measure improvement	√		AK

CULTURE AND LEADERSHIP

	Action	LAS Status	Timeline (where provided)	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	Staff networks are consulted and included on key appointments	December 2021	**ACTION REQUIRED:** Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	√		**AK**

NEW WAYS OF DELIVERING CARE

	Action	LAS Status	Timeline (where provided)	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	During COVID 2 dedicated redeployment leads were appointed to identify redeployment opportunities for vulnerable staff, those self-isolating and where substantive roles were stood down. This arrangement also covered pregnant staff and those with long term conditions who were able to work from home or in another capacity.	March 2021	**MONITORING REQUIRED:** • Embed redeployment roles into the recruitment team • Maintain central list of all those who require redeployment • Create and update list or redeployment opportunities and distribute to HRMs monthly		🟩	**AL**
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	Existing career progression routes include EOC / 111 / NETS / EMT4 to AAP. LAS Academy Fast track to Paramedic degree and APP programme. Apprenticeship levy is fully utilised. Non-Clinical - programme elements re-designed and delivered F2F, virtually and via eLearning to ensure accessible to all staff. Further programmes under development including re-establish new versions of the Leadership Development Pathway post winter pressures February 2021	Ongoing	**ACTION REQUIRED:** During 2021/22, identify strategic organisational development themes for delivery to ensure focus remains on developing a workforce that fully meets the Trusts future transformation agenda.	√	🟧	**JS**
3	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	Key requirement of the Trust's Education & Learning Strategy which was published in 2019. Zoom Pro now utilised for Corporate Induction during COVID to maintain social distancing whilst accommodating a larger number of attendees. Use of ESR OLM platform for all eLearning in order that training is tracked on learning histories and reportable.	Ongoing	**ACTION REQUIRED:** • Utilise HEE's online Learning Hub and continue to work with HEE/ESR Central team to ensure there is availability of all modules via ESR to enable reporting and CPD tracking for staff. • Utilise HEE's e-learning materials including simulations, created in response to COVID	√	🟧	**JS**

GROWING THE WORKFORCE

	Action	LAS Status	Timeline (where provided)	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and	• Clinical education continues as scheduled. • Increased utilisation of paramedic students to support pandemic service response. • Establishment of a Bank for student paramedic workers	Complete	**NO ACTION REQUIRED**	√	🟩	TI

						RAG	
	providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	• Continued engagement with university partners • Continued development of clinical mentors.				🟩	
2	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Ongoing as part of LAS' CSR training programme calendar	Ongoing	**CONTINUOUS REVIEW AND MONITORING REQUIRED**		🟩	TI

RECRUITMENT

	Action	LAS Status	Timeline (where provided)	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	We have introduced the new Assistant Ambulance Practitioner role. This is a band 4 and is seen as the start of the Paramedic career pathway. We have also introduced a Student Paramedic Bank role specifically for 3rd year university students	Ongoing	**ACTION COMPLETED** We are continuing to run a bridging course which will allow internal staff to obtain Level 4 which is required to undertake the Apprentice Paramedic role.		🟩	TI
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	LAS already fully utilises the apprenticeship levy – mostly in clinical areas. We have a number of individuals undertaking academic studies using Apprenticeship programmes All posts are considered for apprenticeship programmes prior to advertising the role.	Ongoing	**CONTINUOUS REVIEW:** Apprenticeship continues to explore apprenticeship options for Fleet and Corporate areas.	√	🟩	JS
3	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.	International recruitment undertaken for Paramedic roles only at this stage.	Ongoing	**ONGOING REVIEW AND MONITORING:** We attend NHS London Head of Resourcing network. If opportunities arise to collaborate they are explored		🟩	**AL**
4	Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.	We are working closely with Merton to trial Paramedics in PCNs. The LAS is developing a training programme in line with the National recommendation to equip PCN Paramedics with the necessary skills to be signed off at level 7	FY 21/22	**ACTION REQUIRED.** Learning from the PCN pilot to inform the national roll out from April 2021		🟧	JS
5	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	People Hub established during COVID and scope of Bank arrangement expanded to recruit returners and more people.	Ongoing	**CONTINUOUS REVIEW AND MONITORING:** Internal campaigns run to encourage returning staff to transfer from COVID bank onto LAS bank or permanent positions.		🟩	**JR**

RETAINING STAFF

	Action	LAS Status	Timeline (where provided)	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Continue career conversations as part of the PDR appraisal process.	2021/22	**ACTION REQUIRED:** Introduce retention conversations as part of management 1:1's.	√		JS
2	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Continue career conversations as part of the PDR appraisal process.	2021/22	**ACTION REQUIRED:** HR and OD career milestone check in to be introduced. Review accuracy of annual forecasting data for leavers and retirees across all directorates.	√		JS
3	Ensure staff are aware of the increase in the annual allowance pension's tax threshold.	• Staff made aware of the increase through enquiry to the pensions department. • Staff directed to relevant resources and/or NHS employers/NHS Pensions	Complete	**NO ACTION REQUIRED**			CR
4	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	• Information available on request • Information available on trust intranet platform	Complete	**NO ACTION REQUIRED**			CR

RECRUITMENT AND DEPLOYMENT ACROSS SYSTEMS

	Action	LAS Status	Timeline (where provided)√	Actions & Comments	Inc.18 Month P&C Plan	RAG	Owner
1	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.	Existing school, college and university visits as part of Public Education and Patient Involvement with LFB and MPS. Some focus on BAME students required to fill pipeline of future student Paramedics	Ongoing	**ACTION REQUIRED:** • Culture, Diversity & Inclusion team and Recruitment department to create attraction programme for students form BAME backgrounds • Review the NHS Ambassadors programme and incorporate into outreach plans for children and young people • Restart the Youth Ambassador scheme, encourage young people from diverse backgrounds to join.	√		AT/AL

2	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.	Strong track record of working with volunteers, apprentices, and direct entry students and fast track routes into the Trust.	Complete	**ACTION COMPLETE**	√		**JR**
3	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.	Memoranda of Understanding arrangements in place with other London Trusts and the London Fire Brigade during COVID Pandemic.	Ongoing	**ONGOING REVIEW AND MONITORING:** Explore utilisation of the NHS passport			JR
4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.	Bank arrangements expanded to recruit returners and more people	Ongoing	**CONTINUOUS REVIEW AND MONITORING**	√		JR

Staff Key

JR	Jason Rosenblatt	KM	Khadir Meer
JS	Julia Smyth	TI	Tina Ivanov
KC	Katy Crichton	GE	Garrett Emmerson - CEO
AK	Ats Khan	HL	Heather Lawrence - Chair
AL	Averil Lynch		
ED	Elizabeth Dighton		

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	NHSE/I engagement on integrating care
Agenda item:	7.2
Report Author(s):	Ross Fullerton, Director of Strategy and Transformation
Presented by:	Ross Fullerton, Director of Strategy and Transformation
History:	N/A

Purpose:	☐ Assurance	☐ Approval
	☒ Discussion	☒ Noting

Key Points, Issues and Risks for the Board's attention:

- NHS England and NHS Improvement (NHSE/I) launched an engagement process "building a strong, integrated care system across England" inviting discussion about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance including many much-needed reforms. This aim is to deliver against the NHS Long Term Plan (LTP) in supporting greater collaboration between partners in health and care systems.

- This paper provides our response to the ICS engagement process and reflects the leading role that the Trust plays across the capital's five STP/ICSs, helping to shape service delivery, improve care pathways and participate in system developments to provide better care for patients in each locality. Without amendment the proposals from NHSE/I do not support the integration of urgent and emergency care for Londoners.

- We work across the capital providing an emergency response to Londoners and as part of the capital's well-coordinated category-1 incident response. We work daily with our partners at London Fire Brigade and the Metropolitan Police Service. And our NHS111 services support patients by delivering safe and effective services once-for-London. These benefits have been brought into focus during the COVID-19 pandemic where our scale and reach has contributed to the safe provision of outstanding patient care.

- Our response to NHSE/I sets out three workable options for commissioning a pan-London service. These options align with the intent of the paper from NHSE/I and provide a robust framework for effective ongoing delivery of urgent and emergency care that the public expect.

Recommendation for the Board:

The Board is asked to note the LAS response to the ICS engagement process.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes				Trisha Bain
Finance	Yes				Lorraine Bewes
Chief Operating Officer Directorates	Yes				Khadir Meer
Medical	Yes				Dr Fenella Wrigley
Communications & Engagement	Yes				Antony Tiernan
Strategy	Yes				Ross Fullerton
People & Culture	Yes				Kim Nurse
Chief Executive Officer	Yes				Garrett Emmerson

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**

London Ambulance Service response to NHS England & Improvement paper: "building a strong, integrated care system across England"

8th January 2021

The paper ""building a strong, integrated care system across England" from NHS England & Improvement sets out an important vision for the integration and delivery of health & care including many much-needed reforms. London Ambulance Service NHS Trust (LAS) is proud to play a leading role across the capitals five STP/ICSs and Category-1 emergency response provision. We are a highly visible blue-light emergency service working across the city. Uniquely in London we also have specific oversight from and accountability as a Category-1 responder to the Mayor of London.

While we have a key role in *place-based systems of care* alongside Primary Care Networks, we also operate with London's *five Integrated Care Systems*, across the *London region*, and our service is of strategic importance *nationally*. The events of the COVID-19 pandemic demonstrate that ambulance services in general, and specifically in London, are primarily overseen nationally and regionally. Throughout the pandemic our engagement has been with regional leaders and has involved daily scrutiny from national NHS England Directors. No other provider trust in London, and possibly nationally, has this level of strategic visibility nor the routine national and regional oversight.

Without amendment, the proposals in the consultation paper <u>do not</u> support integration of urgent and emergency care for patients in this complex environment. Our cross-system role provides a unique set of challenges that cannot readily be managed within one single ICS. We are pleased to provide an approach for consideration which we believe aligns with the intent of the national direction and supports the ongoing work we do locally and pan-London.

This paper sets out three workable options for commissioning a pan-London strategic service which align with the intent of the paper from NHS England and provides a robust framework for effective ongoing delivery of urgent and emergency care expected by the public.

LAS supports the establishment of Integrated Care Systems

Following the publication of the NHS Long Term Plan and the evolution from STPs to ICSs, LAS has been working across the London Health and Care System to shape service delivery, improve care pathways and participate in system developments to provide better care for patients in each locality.

The move away from 5 STPs and 32 CCGs in London towards a system of five ICSs, each responsible for commissioning and service delivery within their areas is a welcome simplification and should enable ICSs to improve care provision across their geographies. For the vast majority of service delivery, LAS agrees that 'working at place' will lead to better outcomes. Whilst later in this paper we detail our proposals for commissioning to take place at a regional level, we already and will continue to work closely with system partners at a place level. Some of these arrangements include:

- Working in partnership with the 10 London Mental Health Trusts to staff and run our Joint Mental Health Response Car (MH Trust nurse dispatched alongside LAS paramedic)
- Collaborating with Primary Care Networks to provide Paramedics as part of the Additional Reimbursable Roles Scheme, focussing their development and tasks to deliver the greatest benefit to the local population
- Working with each Hospital Trust to address local issues including reducing hospital handover delays

- Participating in and influencing local pathway development at a local level to ensure the pathways best meet the needs of the population

We also agree that there are some services, including ambulance services where they can "only be planned and organised effectively over a larger area than place" and need to "operate at a whole ICS footprint – or more widely where required" (Integrating Care document section 1.18 & 1.19).

Response to the consultation questions

This letter sets out our formal response to the consultation paper and should be read alongside the national submission provided by the Association of Ambulance Chief Executives. At a high level, our responses are as follows:

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

While it is agreeable that ICSs having a statutory footing is helpful, there are many questions that remain unanswered regarding the implications of the changes which will require engagement and consultation across the sector.

It is clear that ICSs now have overall responsibility for planning care in their local geographies and should have the necessary commissioning and other statutory responsibilities and authority. The NHS has significant challenges to overcome over the coming years; continuing to respond to the Covid-19 pandemic, maintaining non-Covid care and service provision, financial constraints, demographic changes and continued increases in demand.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We agree that ICSs should be enshrined in legislation 'without triggering a distracting top-down re-organisation'. It is important that the changes being made offer long term clarity and stability, including system leadership and accountability. We therefore agree that option 2 is the preferred option.

Q3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

We agree that there should be flexibility for systems to shape their own governance arrangements to best suit their population needs.

Q4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We agree that there are likely to be a number of NHSE commissioned services that can be transferred or delegated to ICS bodies, particularly where those services are delivered within ICS boundaries. As acknowledged in the consultation paper, decisions on these sorts of services will need to be made at a regional or national level. However, there is currently insufficient information about how services delivered across multiple ICS geographies will be commissioned, including how different ICSs will come together to jointly make decisions that best service the populations of a *whole region*.

Anticipated outcome of consultation

It appears undeniable that formally establishing ICSs as the key decision making and commissioning bodies within the ICS is the right direction of travel for the NHS and will ultimately provide better outcomes for patients. From the consultation paper and the questions being asked (particularly question 4) we can infer that under these new legislative arrangements NHS provider Trusts will be aligned to individual ICSs. We agree that this will be the right thing for the vast majority of provider Trusts and even a number of services currently within NHSE specialist commissioning.

However, we do not believe that this would be the right commissioning arrangement for the London Ambulance Service. The following sections detail why LAS is in a unique situation and the commissioning arrangements that we believe would be aligned to the proposals that have been set out and also in the best interests of the population of London.

LAS has a unique position as a pan-London NHS provider and emergency service

As a local partner

Our work is all about providing care to patients when they need it most. This works best when done in collaboration with local partners and we have numerous examples of improving patient outcomes from locally-led initiatives. For example our Mental Health response car started as a pilot in south London. It was developed with the local Mental Health trust, CCGs and patients groups. Patients receive specialist care, can access specialist mental health pathways and where possible are treated away from the emergency department.

Our visibility of the access to and effectiveness of pathways across London helps to drive service improvement. As a shared learning partner we have helped local systems and PCNs establish dozens of pathways that improve care and deliver better outcomes. This work can't be done within a single-system; it requires continual engagement and collaboration across the entire geography and population that we serve.

As a pan-London NHS provider

The London Ambulance Service is the only pan-London NHS provider trust in London.

We believe that it is a fundamental principle that we should deliver a consistent and equitable service to our most critically ill and injured patients across London and this requires a pan-London approach. In particular responding to our sickest 'category 1' patients, such as those in cardiac arrest or suffering major trauma, is a service that should be done on a 'once for London' approach. This is similar to some of the acute pathways such as for major trauma and stroke networks.

There are a large number of elements of our service provision and infrastructure where the economies of scale and scope mean that it is only logical for this to be commissioned and managed once for London. This includes our 999 control room infrastructure and our key IT systems including our patient triage platform and Computer Aided Dispatch (CAD) system. Replicating this five times for London would lead to significant extra expense for the NHS system.

Our NHS111 services are efficient, economic, resilient and effective as a result of the scale of delivery we are able to achieve. We have on several occasions been asked to step-in and rescue local provision of service when overwhelmed with demand or when commercial services have failed. Our services are clinician-led and bring innovation across the system in ways that the previous locally managed services have found more difficult.

Our ongoing response the Covid-19 pandemic has demonstrated the criticality of our services being viewed from a pan-London perspective. At the height of the pandemic in early 2020 and once again in the current peak we are engaged on a daily basis with the national Director of Urgent & Emergency Care and regional colleagues. We participate in numerous regionally-led groups chaired, for example, by the Chief Medical Officer for NHS England – London to manage the provision of care for all Londoners.

We were able to flex our resources across the capital depending on where the peaks in demand were and also had the ability to quickly form partnerships with other organisations to support our care for patients across the Capital.

These agreements included rapidly scaling up NHS111 services to handle demand from across London, partnering with the LFB for firefighters and MPS for police officers to drive our ambulances and a partnership with the AA to support fleet maintenance. Our ability to 'ramp up' our response was quicker and more effective because these decisions only needed to be made once, rather than having separate discussions across London for each sector.

As an emergency service and category 1 responder in London

Whilst the London Ambulance Service is proud to be an NHS organisation, we are also an emergency service and have a responsibility to be closely aligned to London's police services and London Fire Brigade (LFB). LAS is the only ambulance trust or NHS provider in England that has a specific responsibility to a devolved regional government. As part of this devolution, we are the only ambulance trust that shares a geographic footprint with the regional fire brigade and police service, albeit not with the same direct accountability to the Mayor of London.

As an emergency service, we also have a 'statutory duty to collaborate' with the other emergency services, as stated within the Policing and Crime Act 2017[1]. Again our response to Covid-19 has highlighted the value of collaboration with other bodies while also demonstrating the complexities of decision making. The continued support of firefighters has, for example, required approval from the Home Office and the Mayor of London.

Importantly, our responsibility to the devolved regional government (through the London Resilience Forum) as a Category 1 responder means the way we respond to significant or major incidents within London requires LAS to respond in a partnership approach with the other emergency services. The LAS view is that this can only be done effectively if these Emergency Preparedness, Resilience and Response (EPRR) functions are commissioned and organised at a pan-London Level, similarly to the LFB and Police. We receive additional funding from commissioners, agreed by NHSE EPRR to fund our Tactical Response Unit (TRU) to respond to Marauding Terrorist Attacks (MTA), reflecting the unique position of being an ambulance service in the Capital City.

Unfortunately terrorist and other major incidents in London have been a common occurrence over the past few years affecting every corner of the city. Our pan-London service provision allows us to quickly and effectively respond to each of these major incidents whilst maintaining a robust level of 'ordinary' service delivery across the rest of London by dynamically moving our resources across London. A move to a more local model of service delivery could significantly weaken our ability to respond to major incidents across the Capital.

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[1] https://www.legislation.gov.uk/ukpga/2017/3/part/1/enacted

A move to the London Ambulance Service being commissioned independently by the five ICSs in London would be inefficient and generate risks to patient care

Whilst not explicitly suggested as an option within the Integrating Care paper, we wanted to take this opportunity to express the LAS view that any move to a position of five separate commissioning arrangements with each separate ICS would be inefficient and detrimental to patient care.

If this commissioning arrangement was implemented, LAS would likely need to establish five separate business functions, each serving a different ICS. Whilst some of the corporate functions would remain joined, there would inevitably be duplication of processes, systems and organisational structures and would ultimately demonstrate poorer value for money and cost the NHS more overall.

For example, some of our functions such as our 999 Clinical Hub provide a service for our entire pan-London service delivery. Duplicating this five times would be hugely inefficient, whilst there would also be costs involved with developing service level agreements between the ICSs to fund a 'once-for-London' Clinical Hub.

We believe that particularly for our most critically ill and injured patients, we must provide a consistently excellent level of service delivery. Often our crews end up responding to 'category 1' incidents well outside of their area and a more fragmented model would either risk this response, or increase the administration or bureaucracy in maintaining it as one ICS would likely seek to recoup costs for 'cross-border' service delivery.

Options for future LAS commissioning arrangements

The information outlined previously in this paper lead us to the conclusion that LAS should not be commissioned by a single ICS.

We have identified three viable options for future commissioning arrangements that would meet the national objectives of working as integrated care systems, provide the 'once for London' approach necessary, and enable place-based engagement to develop services and delivery quality improvements. These options have been developed with the principles of the consultation in mind, specifically principle 2 (page 25, section 2.72) which states: *"Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national. For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions."*

The options are (1) an integrated care organisation, (2) specialist commissioning by NHS England's London regional team, and (3) establishing a pan-ICS strategic commissioning board.

Option 1 – LAS as an integrated care organisation

> This would see LAS evolve from an NHS Trust to become an 'Integrated Care Organisation or Provider' (ICO or ICP). An ICO/ICP would support the strategic vision of the London system to have an 'integrator of access to urgent and emergency care across London'. As well as our 999 emergency services we provide or work with others to provide NHS111 and IUC services in four out of the five London ICSs. We envisage that by working collaboratively with existing providers as an ICO/ICP we can improve the consistency and quality of care delivered for patients in London who call 111 for help and maximise the effectiveness of our 999 services.

This would provide a 'once for London' approach, which would strengthen our ability to plan and deliver services that truly need a regional approach such as responding to major incidents or quick and effective response to our most critically ill and injured patients. It would also support the collaboration and ability to act with pace across the region to implement sustainable improvements in care in an efficient and effective manner.

Option 2 – Specialist commissioning by the region

Alternatively LAS could be designated as a specialist provider and commissioned accordingly by NHSE London Region. There are already specialist providers commissioned at a regional or national level where that is more appropriate than being organised at a more local level. This would potentially be the simplest and least bureaucratic option for commissioning and whilst the direction of travel is for devolution of specialist services to ICSs, this could still be a suitable option for LAS commissioning arrangements.

Regional commissioning would provide a 'once for London' approach as outlined for option 1 and simplify the governance arrangements by providing clear regional accountability for the commissioning of urgent and emergency care services provided by LAS.

Option 3 – pan-London Strategic Commissioning Arrangements

The third option is to establish a 'strategic commissioning board' with representatives of the five London ICSs and NHSE London Region with a requirement for each member to fully participate at a senior level. To minimise bureaucracy and complexity, it is suggested that a single ICS would manage, chair and administer the board but decisions would be made by the full membership. To further enhance the comprehensive nature of this board, we suggest that a representative from the Mayor of London could be invited to attend the board. This would ensure that the full scope and responsibilities of the London Ambulance Service would be considered in a single commissioning forum.

A pan-London commissioning board would enable ambulance services to be designed and planned at the appropriate level, it would ensure all ICSs had equal responsibility for LAS commissioning, funding and decision making and would also maintain alignment on a local level so that, where appropriate, services could be tailored to best meet the needs of local populations.

Work is required for each of the above to develop the arrangements in more detail. We suggest that formal local arrangements should be set up and maintained with each of the five London ICSs to ensure alignment and manage local variations and appropriate to best meet the needs of local populations.

Conclusion and recommendation

The London Ambulance Service is supportive of the formal establishment of Integrated Care Systems and we believe that this will provide the strong foundations necessary for the NHS to continue to improve patient care over the coming years.

However, in this paper we have demonstrated that there are a number of important and unique aspects of the London Ambulance Service that mean alignment to a single ICS would result in fragmentation, inefficiencies, increased costs and would lead to a lack of consistency and quality of patient care across London. Additionally, operating at a pan-London level ensures we maintain our ability to respond quickly and effectively to major incidents, whilst maintaining our care for patients

across other parts of London. Operating on a smaller geographical basis would diminish our ability to do this.

From our perspective each of the options articulated in the paper are deliverable and achievable. They directly align with principle 2 of the consultation paper (page 25, section 2.72) and deliver the improvements in care and system coordination being sought.

Whilst aligning with a single ICS is the right thing for the vast majority of NHS Trusts, it is our opinion that this is not the case for the London Ambulance Service. We believe that the options outlined above would both meet the needs of the population we serve in London and our preferred route of a strategic commissioning board fully aligns with the establishment of ICSs and the principles introduced in the consultation document. We would welcome the opportunity to discuss this in further detail with NHSE/I colleagues.

London Ambulance Service NHS Trust

Assurance report:	People and Culture Committee	Date:	14/01/2021
Summary report to:	Trust Board	Date of meeting:	26/01/2021
Presented by:	Jayne Mee, Non-Executive Director, Chair of People and Culture Committee	Prepared by:	Jayne Mee, Non-Executive Director, Chair of People and Culture Committee

Matters for escalation:	**Workforce planning**
	Members noted that the Trust continues to report a good position in respect of workforce planning with Ambulance services recruitment above plan for 2020/21 and will exceed planned recruitment by 18wte.
	To maintain resilience and improve performance LAS intends to substantially increase the resources available for Ambulance Operations for 2021/22. However, it is recognised that there are only circa 200 Paramedic Science students graduating from our partner Universities, and it is therefore necessary to explore other options.
	In response the LAS require 269 international paramedics to reach the 2021/22 workforce plan, however the approach to international recruitment would require significant change as Australia has exceptionally tight travel restrictions in place.
	It has been agreed to use an external recruitment agency that has access to local resources across the world and could provide alternative sources of recruitment for the Trust (e.g. New Zealand, Canada, Poland, Philippines). This agency would also be able to identify the candidates, conduct pre-screening, book interviews and support with HCPC registration. The Committee expressed that it would be important to move forward with this quickly in order to recruit for later this calendar year.
	Similarly, the Strategic Workforce Plan aims to significantly increase the number of staff recruited and trained in 2021-22. This includes a significant increase in the number of TEACs compared to prior year. This would not be possible to deliver without increasing the capacity in Recruitment and Clinical Education & Standards and it will be necessary to engage with an external partner.
	Members supported both approaches and were reassured that the training costs would be covered by accessing the apprentice levy.

Other matters considered:	**Culture, Diversity and Inclusion** Following the appointment of Athar Khan (AK) as Associate Director of Equality and Diversity, the committee received a paper which provided an early update on culture, diversity and inclusion within the London Ambulance Service NHS Trust (LAS). Members recognised the work that had taken place to date and the volume of work required in the future. An overarching document/plan would be presented to the March meeting. **Staff Survey** Members received a verbal update in respect of the staff survey, recognising that the Trust had achieved its highest response rate and that with the context of COVID and an increased workforce it was evidence of a strong collective input from across the Trust. It was also reported that the Trust were the 2nd highest Ambulance Service. The detailed results are currently embargoed so the Committee will receive a full report and the plans for communication and addressing outliers at the March meeting **Wellbeing** The wellbeing support update was provided recognising the progress of the vaccinations programme and that 2100 staff members had been vaccinated to date with 4100 who had consented. Members discussed the actions and considered those staff members who did not want the vaccine and the actions which could be taken, including the use of targeted messaging to address specific concerns and the requirement to contextualise the benefits of the vaccination. In addition, the Committee discussed accommodation, recognised this was available and that a robust plan was in place. Members considered the, mental health support available, and shared concerns that prolonged shielding, working from home and required pandemic response are continuing to be impacted. The Trusts approach, support and availability was outlined and this offering would continue to be developed as appropriate. **Resolution Framework** The Resolution Framework offers a timely, supportive and proactive approach for resolving workplace issues and is designed to secure constructive and lasting outcomes and the provided paper established the process that a manager should follow and aims to resolve cases before progression to formal hearing Members discussed when training would commence to ensure the framework could be implemented and it was acknowledged that Covid had delayed the initial progress, but this would be planned as soon as Covid pressures eased. In the short term it would be necessary to implement a two-tier process as historic cases are closed, and the new framework is launched. The Unions had been consulted and it was

confirmed that they had been involved and engaged throughout the process.

Employee Relations
The committee received an update report on the current status of employee relations activity across the Trust and a further update will be provided in March by which time further progress is expected.

Sickness

Data was shared with members that showed current 2020/21sickness compared to 2019/20 and members agreed that it was a valuable comparison and that it was necessary to establish the causes included within the 'other' categories to compare effectively.
In particular, the Committee asked for an update in March on the management of long-term sickness which was in hand.

Key decisions made / actions identified:	See other commentary.

Risks:	**Board Assurance Framework** The Board assurance framework was provided for information with the meeting pack, however in response to discussions at other Board Assurance Committees members were asked to consider the risk score of the Covid Sub Risk assessment and whether in line with current operational pressures the score should be increased. Members agreed the score should be increased to 20.

Assurance:	Assurance that we are looking after the wellbeing of our people was provided and in particular the rollout of the vaccination programme. The Committee offered their thanks for the extraordinary work delivered. Assurance was provided that we now have a resolution framework, the implementation will now be critical. Assurance of a robust workforce plan was provided, whilst there will be challenges in recruitment to the plan, in particular internationally for this calendar year.

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	Board Assurance Framework (BAF)
Agenda item:	9
Report Author:	Frances Field, Risk and Audit Manager
Presented by:	Syma Dawson, Director of Corporate Affairs
History:	N/A
Purpose:	☒ Assurance	☒ Approval
	☒ Discussion	☐ Noting

Key Points, Issues and Risks for the Board's attention:

- **BAF risk 61 – COVID-19 Impact:** The Board is asked to consider whether the overall residual rating be increased from 12 (4 x 3) to 20 (4 x 5) to reflect the increased pressure on the organisation due to COVID.
  - Finance sub-category risk for COVID-19: Due to the second wave of COVID there is a requirement to increase the financial resources required. The Finance and Investment Committee agreed to increase the residual risk score from 10 (5 x 2) to 15 (5 x 3) at its meeting on 19 January 2021.
  - Operational sub-category risk for COVID-19: The Quality Assurance Committee considered a proposal to increase the residual risk score from 12 (4 x 3) to 16 (4 x 4) at its meeting on 14 January 2021 and agreed that the risk should instead be increased to 20 (4 x 5) due to pressures with performance due to COVID cases.
  - Clinical safety sub-category risk for COVID-19: Residual risk score updated 8 January 2021 and increased from 8 (4 x 2) to 20 (4 x 5) with the support of the Quality Assurance Committee at its meeting on 14 January 2021.
  - Quality sub-category risk for COVID-19: The Quality Assurance Committee considered the proposed increase at its meeting on 14 January 2021 and recommend an increase in the sub category risk to (4 x 5) 20 due to current pressures on the organisation and on London wide healthcare system.
  - People and Culture sub-category strategic COVID-19 risk: People and Culture Committee considered the sub-category risk at its meeting on 14 January 2021 and recommended an increase in the residual risk score from 12 (4 x 3) to (4 x 5) 20.

- **BAF risk 56** – No change to risk score. 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. Risk reviewed by Director of People and Culture with amendments made to controls, residual risk score remains at 16 (4x4).

- **BAF risk 62** - There is a risk that the Trust will experience service disruption due to supply chain, workforce and financial and issues in the event of a no deal departure from the EU on 31st December 2020. This risk was considered by the Trust Board on 24 November 2020 and reinstated on to the BAF with a residual risk score of 16 (4 x 4). The risk was reviewed by the Chief Operating Officer in December 2020 who proposed a reduction in the residual risk score to 12 (4 x 3) due to the mitigations in place. The Board is asked to consider whether this risk can now be removed from the BAF.

- **BAF risk 63** – No change to risk score. 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. The risk was considered by the Trust Board on 24 November 2020 and approved for addition to the BAF with a residual risk of 15 (5 x 3).

- **BAF Risk 65** – No change to risk score. 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. Following consideration by the Quality Assurance Committee, a more strategic level BAF risk was drafted for this area with a proposed residual risk score of 16 (4 x 4). The risk was approved by the Trust Board on 24 November 2020 for addition to the BAF.

- **New BAF Risk (66)** – A BAF Risk on Ambulance Operations Modernisation, as requested by Board Members, will be produced and proposed for adoption by the Board following the resumption of the programme from March 2021.

Recommendations for the Board:

The Board is asked to:

1. Approve the Board Assurance Framework;

2. Consider the residual and sub-category ratings for BAF risk 61 – COVID-19 Impact and whether the overall category risk be increased from 12 (4 x 3) to 20 (4 x 5) to reflect the increased pressure on the organisation due to COVID; and

3. Agree that BAF risk 62 - service disruption in the event of a no deal departure from the EU – be removed from the BAF.

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		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes	X	No		Syma Dawson, Director of Corporate Affairs

Board Assurance Framework: January 2021

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~~ 20	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	16	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	12	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	⬌
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	⬌

BAF Risk reporting Trend – 2020/2021

	Target	Residual				
		Jan '20	April '20	July '20	Oct '20	Jan '21
BAF 61 COVID 19	8	16	16	16	12	20
BAF 58 IT failure	4	12	12	16	16	16
BAF 45 - Cyber Security	10	15	15	15	15	15
BAF 56 Recruitment/Retention	8	12	12	12	16	16
BAF 62 - EU Exit	8	16	16	16	16	12
BAF 63 - Future Funding	5				15	15
BAF 65 - Immunisation	8				12	12
Total risk score		71	71	75	102	106
Residual to target gap	51	33	33	37	51	55
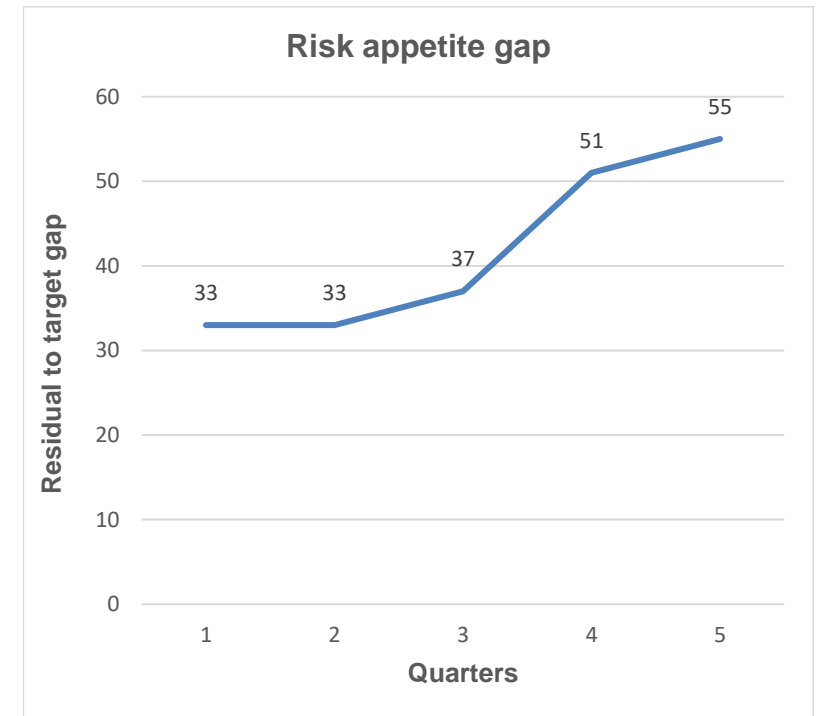
Risk appetite gap

Commentary:
Risk appetite gap has increased due to the increased levels of COVID risk on BAF 61

	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** 1. Strategic Recovery Group worked with each directorate and developed action plans for future resilience and sustainability. 2. Ongoing conversations with our suppliers, ensuring we are aware of any emerging issues with supplies and can respond to those. 3. Pandemic business continuity plans being developed, incorporating lessons learned and preparing for any potential peaks in future. 4. 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. 5. 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. 6. 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 7. Membership of regional and national network bodies (e.g. Ambulance HRD	16 26.05.20 12 11.11.20 **20** 08.02.20 ⬆	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**	

forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working

8. Australian recruitment programme regularly reviewed and approach updated as necessary.

9. 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

10. 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

11. 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.

12. Patient Safety and Risk Hub established to collate incidents and risks, and other quality data as well as produce the daily safety and risk hub report.

13. 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)

14. Worked with CQC and NHSI and agreed SI process whilst recognising the scale of investigations required to meet LfD regulatory requirements

15. 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.

16. 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
17. 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.
18. The Trust agreed its resource and cash requirements for the rest of the year relating to Covid 19 based on month 4 forecasts.
19. In addition to the agreed resource and cash requirements for the remainder of the year, a surge funding case has been presented to NWL STP which needs to be agreed for an amount between £6.4M – £7.3M per month. The total amount is dependent on duration of the second wave of COVID-19, but for the remainder of this year is between £19.3M - £21.9M.
20. Budget based approved financial plan including CIP has been 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

Assurances
1. Reports are provided to the Board Assurance Committees on COVID-19 related activities.
2. Reports provided to Executive Committee who sign off strategic risks and actions.
3. Status reports provided to the Trust Board via weekly NED calls and monthly Trust Board meetings.

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 & Culture			**Assuring Committee** People and Culture Committee				
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	**16** 23.05.19	Controls 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 – recruited 180 graduate and qualified paramedics this year. 3. The Strategic Workforce Planning Group is meeting on a monthly basis supported by a number of workstreams including IUC, EOC and Ambulance Operations. These workstreams are developing Trust plans for an Operating Model for Ambulance Services and for 999 and 111 integration across call handling and telephony based clinical services. 4. Engagement in national HEE workforce planning group to influence debate on challenges of English Ambulance Trusts with funded paramedic places.	~~12~~ 23.05.19 **16** 29.09.20 ↔	**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.** 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.	Actions 1-2: Ongoing Action 3: 3 March 21	**6-10**	

			█	5. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation 6. The Trust has developed a paramedic apprenticeship programme to attract and retain non clinical employees. 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 July 21. 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 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. 10. Pilots with Merton PCN and Redbridge PCN commenced in October 2020 and will provide us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021. 11. Ambulance services have developed (signed off at ExCo), an 18 month recruitment plan for paramedics and	█			

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 delayed due to Government restrictions.

12. 20/21 UK Graduate recruitment in place – the Trust successfully recruited 180 (98 in Aug and 82 Sept) UK Partner Paramedic students into NQP posts.

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.

14. Covid Paramedic bank to LAS Bank - procedure now in place to help support front-line resourcing.

15. We have developed Ambulance Ops, 111 and 999 workforce sustainability Plans.

Assurances

1. The International recruitment campaign is ongoing via skype interviews for 2020/21 subject to available training places.

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.

3. The Strategic Workforce Planning Group is meeting on a monthly basis supported by a number of workstreams including IUC, EOC and Ambulance Operations.

				4. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo.					

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
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	**16** 28.7.20	**Controls** 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 **Assurances** 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.	**16** 28.7.20 ⟷	1. CAD Replacement Strategy 1 -. Replacement of existing HW including move to external DC's - Completed successfully on 15/09/2020. - Decommissioning in progress and scheduled for completion end of November. 2. CAD Replacement Strategy 2 – Replacement of the CAD System (HW/SW) – targeted June 2021 (D999). 3. Define and agree remediation plan for UPS. - New HQ UPS install completed 18/10. - Bow new UPS/Configuration to be scheduled post Tender (targeted March 2021) - HQ new Generator to be scheduled post tender (targeted March 2021). 4. Complete project review and lessons learnt for UPS programme. - 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.	Complete 01/08/21 30/04/21 Complete	6-10	

			6. Outline business cases. 7. Project boards established for replacement of critical systems 8. Capital allocation of funds for corrective actions. 9. D999 Programme Board established and overseeing key projects 10. Issues with systems discussed at all levels of the Trust		**5.** Business cases to be developed / approved to determine the voice solution relating to Avaya architecture fall back arrangements and resilience for current and proposed Avaya systems. going forward (Avaya CM7)	Complete
					6. Review CISCO telephony platform and create a plan for transitioning from the current system.	Complete
					7. CAD Essentials Board has been superseded by the IMT Delivery Board	Complete
					8. CAD dashboard to be implemented and reviewed at IMT Delivery Board	31/10/20
					9. Cyber to be moved to ICT and a clear roadmap developed to resolve outstanding issues including patch management	Complete
					10. Completion of build of new hardware platform for existing CommandPoint to be completed at Crown Hosting Centres	Complete
					11. IT Priorities reassessed and focused on key areas	Complete
					12. IT Structure to be reviewed and areas of capacity and capability identified and corrected - Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place. Tactical/Strategic Telephony and LAS Infrastructure Business Cases under review and CAD	Complete

					Replacement Strategies in progress to address	01/04/21		
					13. Network configuration to be reviewed and upgraded to include resilience			
					14. Primary network site of Bow to be relocated to Waterloo	01/04/21		
					15. Relocate all hardware platforms out of Bow data centres and into Crown Hosted Data Centres	01/04/21		
					16. Relocation of all Trust services from systems in Bow to new hardware platforms in Crown Hosted Data Centres	30/11/21		

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

No.	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** 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** 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 ⟺	1. Deliver technical control/assurance projects: 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: 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 Complete	**6-10**	

			IM&T's KPIs,reported to IM&T SMT & ExCo monthly				

STRATEGIC GOAL 4 :	Provide the best possible value for the tax paying public, who pay for what we do							
Executive Lead Chief Operating 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
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	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 31st 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 **Assurances** 1. Exit from the EU to be a standing item on	16 16.07.19 22.10.20 12 22.12.20 ⬇	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. 2. Communication plan to be circulated to stakeholders and staff on Trust's state of readiness. 3. Oversight of staff ability to travel to place of work due to congestion in the Kent Area.	Complete End Dec 20 From Jan '21	6-10	

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	Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a mimumum 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 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.	**5x4=20** 11.11.20	**Controls** 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	**5x3=15** 11.11.20	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. 7. A surge funding case has been presented to NWL STP which needs to be agreed for an amount between £6.4M – £7.3M per month. The total amount is dependent on duration of the second wave of COVID-19, but for the remainder of this year is between £19.3M - £21.9M. 8. The Head of Income and Financial Controller are members of the NWL STP group assessing the financial gap for 2021/22.	31/03/21 31/01/21 Complete 31/03/21 Complete TBC 31/01/21 31/03/21	12-16	

	within resources available has been developed and is being tracked weekly. 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. 8. A surge funding case has been presented to NWL STP which needs to be agreed for an amount between £6.4M – £7.3M per month. The total amount is dependent on duration of the second wave of COVID-19, but for the remainder of this year is between £19.3M - £21.9M. **Assurances** 1. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn. 2. Bi-monthly Integrated Performance Reports to the Trust Board			

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
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 **Source** Recent review of OH records indicate transfer of vaccination record information between previous providers does not provide assurance of immunity. Lack of evidence of immunity may result in recommendation for restricted attendance or isolation following exposure.	16 3.11.20	Immunisation catch up programme commenced. Records are now captured in ESR Analysis of immunisation records to identify any gaps Contract tracing processes in place to identify and protect staff at risk of lack of immunisation /immunity Initiation of work through the ESR Account Manager and local/regional user groups to create a reporting framework in ESR. 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. **Gaps in controls** Some staff have no results from historic immunity testing. 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. No systems in place for periodic immunity reviews.	12 3.11.20	Data analysis using OHIO/ESR to understand the full scope of the issue. Design and deliver clear concise factual communications to staff about: • The issues • The risks • The solutions Development of a Phase 2 Immunisation programme Delivery of the Phase 1 immunisation catch up programme will be completed in December 2020 Design and implement immunisation assurance reports from OHIO. Task and finish group- Review & redesign the approach to immunisations, timings of checks and processes starting at the pre employment. Review the clinical evidence for periodic immunity reviews. Complete delivery of Phase 2 of the immunisation catch up programme. Review and revise the Workforce Immunisation Policy in line with the evidence for or against periodic	Complete Complete 28/02/21 Complete 31/12/21 31/1/21 31/3/21 31/3/21 28/2/21	6-10	

					Date		
		■	There is a cohort of staff for whom we can't demonstrate that we have offered vaccines due to lack of records. There is lack of staff uptake of immunisations and personal record keeping There are no systems in place for risk assessments of "non or low responders" to vaccines. ESR does not currently report in a format which provides assurance on immunisation status.	■	immunity reviews.		
					Launch new processes enabling staff to take personal responsibility to attend appointments , keep up to date and maintain personal immunisation records.	1/4/21	
					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.	30/6/21	
					Ensure the OH contract award includes the requirement for a live bi-directional OH interface with ESR.	30/6/21	
					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.	30/8/21	
					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.	Ongoing timeline for delivery not yet defined by NHSE/I	

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	Patients	LAS has a LOW risk appetite for risks that may compromise the delivery of outcomes for patients.	6-10
Reputation	Partners Public	LAS has a MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	12-16
Innovation (clinical & financial)	Partners Our People	LAS has a HIGH risk appetite for innovation that does not compromise quality of care.	20-25
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~~ **15**	**5**

Risk reviewed on 13 January 2021 with rating increased from (5 x 2) = 10 to (5 x 3) = 15.

Strategic Risk Description:

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.

Underlying Cause

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 identififed as required to meet the revenue consequences of the Trust's Capital Plan. The settlement was itself contingent upon an assumption of central funding of £61.6m for lost non-NHS income which has been confirmed as part of the regional sign off of the STP plan. Due to the second wave of COVID there is a requirement to increase the resources required, to respond to the surge. This has been estimated to be for an amount between £6.4M – £7.3M per month for the duration of the surge.

1. Fails to capture the material financial impacts of COVID 19. Cannot recover the full income required for COVID 19 from NHS England/Improvement.
   Actions taken:
   - 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 with 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 has been 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.
   - Due to the second wave of COVID and the increase in need for resources to respond a surge funding case has been presented to NWL STP which needs to be agreed for an amount between £6.4M – £7.3M per month. The total amount is dependent on duration of the second wave of COVID-19, but for the remainder of this year is between £19.3M - £21.9M

2. Is unable to identify and sustain cost efficiencies from opportunities post Covid-19
   Actions taken
   - 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.

COVID-19 - Sub-category Strategic Risk Assessments

Responsible Director: Lorraine Bewes	**Financial**

3. Is unable to identify and sustain innovation and improvements during and post Covid-19 i.e. CAD replacement/EPCR implementation.

Actions taken
- Secured capital of £41.8M to support the capital programme for transformation requirements in 20/21.

4. Experiences an increase in loss of assets due to fraud and theft (tracking and receipting of goods to be enhanced)

Actions taken
- 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.

Additional action against mitigation of risks 1-5
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.
6. Revenue bridge for STP CFO has been agreed across NWL STP.
7. Review of monthly Covid spend by Directorate
8. Development of downside mitigation plan
9. Development of a BAU and transformation efficiencies plan

Assurance of controls
1. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn.
2. Bi-monthly Integrated Performance Reports to the Trust Board

3. Daily Senior Leadership Team priority theme for July is Budget resilience

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	~~16~~20	8

Risk reviewed on 14 January 21 at QAC. Residual risk score proposed to be increased from a (4 x 4) = 16 to a (4 x 5) = 20 due to pressures in performance as a result of COVID cases.

Operational Risk Description:

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 respond to the additional peak combined with the usual winter pressures.

The three main strategic aims that the activities listed below cover:

- 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.

Key activities and actions to mitigate risk:

- 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 following the increasing pressure over December the Daily Performance Group was stood up.
- Daily performance meeting is taking place to address specific pressure points to allow a daily exec oversight of trust position and decision making, focusing on: Alignment and joint working with the system, operational and performance oversight, resource availability and staff absence and Fleet and PPE status.
- We are operationally supporting a wide programme of vaccinations to staff.
- 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.
- 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.

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	~~16~~20	8

- 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.
- 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:
  - ✓ 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. Maintain regular contact with suppliers to ensure their position has not changed and that the suppliers remain in a position to supply us.
- 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 in view of the increasing pressure in December.

COVID-19 Strategic Risk Assessments

Responsible Director : Kim Nurse		People and Culture	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	~~12~~ **20**	8

The risk was reviewed by the People and Culture Committee on 14 January 2021 – residual risk score increased from (4 x 3) = 12 to (4 x 5) = 20.

1. **Not enough staff to meet increased service demand due to incrementally increased staff COVID related sickness and self-isolation absence.**
   Key activities and actions to mitigate risks:

   - 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. We have a programme of on-going call handling recruitment in place to March 2022.
   - Partnership arrangements with LFB are under discussion to provide business as usual and surge support as needed.
   - Engaged with and employed 3rd year Paramedic Students to undertake bank shifts.

2. **Limited welfare and wellbeing support to meet staff's physical, emotional and mental wellbeing requirements.**
   Key activities and actions to mitigate risks:
   - 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.

COVID-19 Strategic Risk Assessments

Responsible Director : Kim Nurse		People and Culture	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	~~12~~ **20**	8

- The Trust has started to test asymptomatic workers for COVID 19 this may result in a withdrawal of front line workers of between 10-15% (currently 3% as at 5th January 2021). Rostering and scheduling *as well as ongoing impact on the operational performance* will need to be reviewed as testing progresses.
- Completed individual risk assessments Trust wide.

3. **Possible safety and reputational risk through the rapid recruitment of significant additional staff and volunteers to be deployed to frontline and support areas.**
   Key activities and actions to mitigate risks:

- 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.

4. **Impact on BAU Recruitment especially the Australian Paramedic programme**
   Key activities and actions to mitigate risks: (reflected in BAF risk 56)

- 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.

5. **Ensure new and redeployed staff receive the training and equipment they require to fulfil new and existing roles safely**
   Key activities and actions to mitigate risks:

COVID-19 Strategic Risk Assessments

Responsible Director : Kim Nurse		People and Culture	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	~~12~~ 20	8

- 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
- 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:

- 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 (DSLT) 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:

- 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

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	~~16~~ 20	**2x3= 6**

Risk reviewed on 14 January 2021 at QAC increased from   (4 x 4) = 16 to (4 x 5) = 20 with current pressures on the organisation and on London wide healthcare system

Current Risk

Current demand from second wave and issues with resources, handover delays mean that the number of patients waiting for a response over the target is increasing in all categories. The patient experience is not what we would want and the clinical safety risks are high.

Key activities:

- COVID19 risk register ongoing risks have now been embedded into BAU processes from previous wave.
- 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. This does bring a risk in terms of improving our regulatory quality rating.
- Produce weekly high level quality report
- All compliance and standards audits continue for the moment although quality reviews have been ceased and will be reviewed in 4 weeks' time (Feb 1st)
- COVID19 Review for patient harm has been re-established and learning will be taken forward.
- All risks captured and be monitored via BAU e.g. RCAG and Board.
- Demand has increased significantly, number of incidents back to position in first wave and continue to be monitored via daily safety hub and SIG.
- Plans for managing clinical SJR review process in place now internal teams rotating to provide support to the process and establish this as BAU
- Deteriorating patient process trialled in 2020 re-introduced to provide information to prioritise patients waiting at ED departments, also provides evidence of harm – also being taken forward nationally via QGARD

Controls to identify and mitigate risk:

- Patient Safety and Risk Hub established to collate incidents and risks, and other quality data as well as produce the 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
- All quality assurance systems assessed to maintain oversight whilst reducing pressure on operational staff – i.e. audits , serious incidents (BAU processes)

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	~~16~~ 20	2x3= 6

- 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, IUC
- 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 that include operational support and support in EOC
- Business plans included additional resources required e.g. QI for future management of resources and delivery of agenda.

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 20	8

Strategic Risk Description:

Risk of reduced patient outcomes or experience from the COVID pandemic surge and response.

Due to significant increases in demand due to Winter pressures and 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. Although we knew that a second spike during Winter would be difficult, and we were preparing for it, we could not have predicted the new variant, the increased rate of transmission and the volume of sick patients. Managing this surge has required the use of novel internal and external pathways that require close governance to minimise any associated risks.

Key activities and actions to mitigate the risk:

- Expanded the CHUB and CAS to enable greater hear and treat (where appropriate) and maintain oversight of held calls including utilising appropriate senior clinicians from across the organisation and supported by doctors from NHSE and the ICS under the NHSE COVID staff sharing agreement in place for London.
- Increased senior clinical support in EOC to provide clinical support to the different specialist functions including clinical guidance for front line crews on cardiac arrest care and decision making, intelligent conveyance, hospital diverts.
- Utilisation of advanced paramedic urgent care clinicians in the ICS area where the highest demand is to manage patients closer to home.
- Use of the Clinical Safety Escalation Plan (CSEP), with additional COVID measures, to safely manage the 999 calls in EOC and maximise guiding patients to the right place for care to meet their clinical need. The level and actions of the CSEP are reviewed by the Gold Commander four times per day and decisions logged.
- 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 navigators at 111 to oversee the CAS queue and ensure prioritisation of the sickest patients
- Increase in cover on the 24-hour senior clinical on call to include an additional shift from 10 – 19 to support the senior clinical on call as part of the Trust Strategic Command.
- 24 hour on call Strategic Medical Advisor and Senior Clinical Leadership.
- 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 and access from both hear and treat and see and treat.
- Working with each ICS to support the development of pathways to enable timely off-loading of ambulance handovers to enable the next 999 patient to be attended.
- All LAS clinical pathway changes taken through LAS Clinical Advisory Group and then changes monitored through Patient Safety and Clinical Effectiveness Group.
- LAS engagement in review of regional and national pathway and processes through NASMED and the NHSE Clinical Advisory Groups, both at regional and director level of all clinical decision making.

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 20	8

- 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)
- Structured judgment review for patients who have experienced to delay in call answering or waited 2 x 90th centile for a frontline response.
- Serious incident panel met weekly throughout to review any incidents raised via internal systems, quality alerts or via the patient experiences team.
- Direct support to crews who have been in contact with a confirmed COVID-19 patient through the welfare team, with input from the Wellbeing Hub.
- 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.
- 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.
- 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

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.

Residual risk score updated 8 January 2021 and is increased to 20 (Almost certain x major). Actions have been updated to reflect all to processes, which have been put in place to mitigate the risks

Patient safety incident response plan 2021/22

London Ambulance Service NHS Trust

Contents

1. Purpose, Scope, Aims and Objectives

1.1 Purpose

1.1.1   This patient safety incident response plan (PSIRP) sets out how London Ambulance Service NHS Trust (the Trust) will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

1.1.2   This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

    a.   Refocusing PSII towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues.

    b.   Focusing on addressing these causal factors and the use of improvement science[2] to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

    c.   Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents.

    d.   Demonstrating the added value from the above approach.

1.2 Scope

1.2.1   A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

1.2.2   This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

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[1]   The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.

[2]   "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) https://www.health.org.uk/publications/improvement-science.

1.2.3   We have developed the planning aspects of this PSIRP with the assistance and approval of our local commissioner(s) including the North West London Clinical Commissioning Group and the North East London Clinical Commissioning Group covering our NEL Integrated Urgent Care Service. The involvement with these key groups/individuals was to also enable cascade of the development through established communication channels to all STPs/ICS across London.

1.2.4   The aim of this approach is to continually improve. As such this document will be reviewed annually and approved by the Trust and local commissioners.

1.3 Strategic aims

1.3.1   Improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it.

1.3.2   Further develop systems of care to continually improve their quality and efficiency.

1.3.3   Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

1.3.4   Improve the use of valuable healthcare resources.

1.3.5   Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

1.4 Strategic objectives

1.4.1   Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

1.4.2   Develop a climate that supports a just culture[3] and an effective learning response to patient safety incidents.

1.4.3   Develop a local board-led with commissioners and integrated care system (ICS)/sustainability and transformation partnership (STP) assured architecture

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[3]   A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.

around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

1.4.4 Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements

- engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors

- develop and implement improvements more effectively

- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

2. Situational analysis – national

2.1   Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

2.2   When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

2.3   Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

    a.   Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident.[4] As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[5]

    b.   There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.[20]

2.4   An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have

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[4]   Health and Safety Executive (2014) Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals.
[5]   Vincent C, Adams S, Chapman A et al (1999) A protocol for the investigation and analysis of clinical incidents.

become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[6,7,8,9,10]

2.5   In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (e.g. professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

2.6   Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (e.g. the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

2.7   We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (eg mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

   a.   improving the quality of future PSIIs
   b.   conducting PSIIs purely from a patient safety perspective
   c.   reducing the number of PSIIs into the same type of incident
   d.   aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

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[6]   Public Administration Select Committee (2015) *Investigating clinical incidents in the NHS. Sixth report of session 2014–15*.
[7]   Parliamentary and Health Service Ombudsman (2015) *A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*.
[8]   Care Quality Commission (2016) *Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*.
[9]   NHS Improvement (2018) *The future of NHS patient safety investigation*.
[10] NHS Improvement (2018) *The future of NHS patient safety investigation: engagement feedback*.

2.8   This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a.   being explored and addressed as a priority in current PSII work or

b.   the subject of current improvement work that can be shown to result in progress or

c.   listed for PSII work to be scheduled in the future.

2.10   As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

a.   professional conduct/competence – referred to human resource teams

b.   establishing liability/avoidability – referred to claims or legal teams

c.   cause of death – referred to the coroner's office

d.   criminal - referred to the police

2.11   In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

3. Situational analysis – local

3.1 Results of a review of activity and resources

3.1.1   Patient safety incident investigation (PSII) activity: Jan 2017 to Dec 2019:

	2017/18	2018/19	2019/20	Ave
Never Events	0	0	0	0
Serious Incident investigations*	87	85	130	101
Other RCA investigations (internal/departmental level investigations)**	13	30	2	15
			TOTAL	116

* This includes the number of coroner investigations notified to the Trust which were reported as serious incidents

** Includes internal RCAs and directorate level investigations, but not routine Datix incident reports

3.1.2   Estimate of current Serious Incident (SI) resources: 2019 (a snapshot, baseline measure):

For SI investigations	Grade(s)	Hours/year	~£/year
Patient safety team hours dedicated to SI-level PSIIs	8a (2) 7 6	150/52= 7,800	£193,881.000
Risk management team hours dedicated to SI-level PSIIs	-	-	-
Complaints team resources dedicated to SI-level PSIIs	8(b) 8(a) 7 6	20/52=1040	£31,200
Patient Advice and Liaison Service (PALS) team resources dedicated to SI-level PSIIs	6	10/52= 520	£10,400
Duty of Candour/'being open' resource (if not included above) dedicated to SI-level PSIIs	8b	7/52= 364	£214.97
SI-related PSII panels	Director 8d (4) 8c (3) 8b (3) 8a (3)	2/52= 104	£53,078.48

For SI investigations	Grade(s)	Hours/year	~£/year
SI leads/Supervisors	8b 8(a) 7		
SI-related PSII subject matter experts	-	-	-
Staff involvement in SI-level PSIIs	-	-	-
SI-related PSII reviewers	Included in SI-Level PSII leads		
Board/executive team sign-off of SI-level investigations	CQO CMO		
Solution/improvement identification, design and development costs (action planning) – resulting from SI-level investigations (if not included above)	-	-	-
Solution/improvement implementation costs – resulting from SI-related investigations	-	-	-
Solution/improvement monitoring/review – resulting from SI-level investigations (if not included above)	-	-	-
PSII trainer time/training fees (for SI-level courses)	Included in patient safety team figures		

3.1.3   The patient safety incident risks for the Trust has been profiled using organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, SIs, mortality reviews, case note reviews, staff survey results, claims and risk assessments. Resources mined for this data include:

a. staff survey explorer tool results:

–   https://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/

b. organisation patient safety reports:

–   https://report.nrls.nhs.uk/ExplorerTool/Report/Default

–   https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/

3.2 Conclusions from review of the local patient safety incident profile

3.2.1   The current top 8 local priorities/risk register are:

	Incident type	Specialty
1	Delays	Trust wide
2	Call handling	EOC/IUC
3	Civility (Behaviour and Attitude)	Trust wide
4	Clinical Assessment	Trust wide
5	Medicine Management	Trust wide
6	Delayed Defibrillation	Ambulance Services
7	IT Infrastructure	Trust Wide
8	Medical Equipment	Ambulance Services/Logistics

3.3 Gap analysis

3.3.1   In line with the national PSII standards the following resources have been identified to enable delivery of the potential investigation programme, that is:

a.   National priorities:

- Never Events

- 'Learning from Deaths'-related incidents (identified via structured judgement review to be more likely than not due to problems in care)

- unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.

b.   Local priorities identified in 3.3.1 above.

c.   Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

3.3.2 The table below outlines the different stages of the investigation process and the resource required for each patient safety incident investigation. The exact resources required will depend on the specific incident, and therefore the resources stated are estimations. It also provides an indication on the differing resource requirements for the relevant staff groups.

Investigation Stage	Responsibility	Estimated Resource (HRs)
1. Plan the investigation		
a. Appoint investigators who are trained, competent, have secure protected time and sufficient support. b. Inform and engage with the patient/family and staff involved in agreeing scope.	QIL Team Investigation Supervisor and/or Lead	
2. **Gather and map the information** (**WHAT** Happened**)**		
c. Identify the WHO, WHERE and WHEN of the incident. d. Identify WHAT happened e. Map the incident timeline from the HCR, incident report and/or complaint letter. f. Add further detail and achieve mutual understanding via meetings/interviews with the patient/family and staff involved	Lead Investigator/ Investigation Supervisor	
3. **Identify Problems (HOW it happened and variations from what was expected to happen)**		
g. Identify and reference good practice requirements (work as imagined) h. Identify the key problems arising	Lead Investigator/ Investigation Supervisor /Subject Matter Expert	
4. **Analyse contributory and causal factors** (**WHY** these key problems arose**)**		
i. Observe and discuss how work is routinely done (work as done) j. Search for contributory and causal factors for each key problem (deep-seated reasons WHY)	Lead Investigator/ Investigation Supervisor	
5. **Write Investigation Report-** with clarity, openness and in full consultation with patient/family and staff		
k. Write investigation report	Lead Investigator/ Investigation Supervisor	
6. **Develop Recommendations and Action Plan**		
l. Identify and develop strong systemic improvements (using HF principles) m. Develop action plan. n. Review effectiveness of actions/improvements in reducing or preventing repeat incidents	Lead Investigator/ Investigation Supervisor QIL Team/Safety Investigation Assurance and Learning Group	

3.4 Strategic plan

3.4.1   The PSIRF Task and Finish group along with the PSIRF Steering Group have developed a strategic plan to address the above findings. Consultation on the Trust's prioritisation plan has been undertaken internally via the Trusts Safety Investigation Assurance and Learning Group, the Quality Oversight Group, the Quality Assurance Committee, Trust Board and externally with Trust's Clinical Commissioning Group (CCG).

a. A patient safety incidents register has been developed identifying those which present the greatest risk (severity, likelihood, concern, and cost) and the greatest opportunity for new knowledge and improvement. This register will be reviewed periodically to ensure the Trust's plan remains up to date.

b. Based on analysis of current and committed resources the Trust has planned to undertake 65 system-based patient safety incident investigations during 12 months. With 25 investigations agreed for each priority area to enable meaningful thematic analysis.

c. Based on historic incident reporting data it is anticipated that 40 will be 'national priority' patient safety incident investigations during the 12 month period.

d. The Trust has therefore identified 5 priority areas for "local priority" patient safety incident investigations for the next 12 months. The 5 priority areas are outlined within section 4.6.1 of this document.

e. Based on historic incident reporting data, the Trust will undertake PSIIs on priority incidents reported across a range of severities/outcomes, including at least one incident reported to have resulted in near miss/no or low harm.

f. All subsequent incidents falling into each priority area will be reviewed by one of the alternate measures outlined in Table 1. The exception being if it is felt that there is potential for significant new learning then a full patient safety incident investigation will be undertaken.

g. It has been agreed that incidents regarding resource availability, civility, medical equipment, delayed defibrillation and IT infrastructure have or require active improvement delivery plans in place based on learning identified from previous patient safety incident investigations or included in the. This includes the recent COVID19 wave 1 review and the current review being undertaken for COVID19 wave 2 within the Trust.

h. If an incident does occur which has the potential for significant new learning then these incidents can be declared a PSII via the emergent are of high risk investigation route.

i. Delivery of these improvement plans will be monitored by the Quality Improvement and Learning team, and via the Safety Investigation Assurance and Learning Group (SIALG). A combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

j. Clinical effectiveness processes such as clinical audits, national reviews and Learning from Death data will continue to be monitored to ensure any new patient safety risks are identified and acted upon in a timely manner. This data will also be used to inform the Trust's patient safety incident risk profile.

k. Different review techniques will be utilised for all incidents that fall outside the patient safety investigation plan, but require action or new insight, this is described in section 5 of this document.

l. The summary PSIRP will be available on the Trust's website making it accessible to Patients, Families and wider stakeholders.

3.5.2 For each comprehensive PSII the Trust will:

a. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose investigation supervisors is an experienced Band 8 and above who has received a minimum of two days' training.

b. Undertake PSII in line with the national PSII standards and conduct PSIIs as per the plan and in line with national good practice for PSII.

c. Use the national standard template to report the findings of the PSIIs.

d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

3.5.3 For each group of PSIIs dedicated to a similar/narrow focus incident type the Trust will:

a. Design strong/effective improvements to sustainably address common interconnected causal factors.

b. Develop an action plan for implementation of the planned improvements.

c. Monitor implementation of the improvements.

d. Monitor effectiveness of the improvements over time.

3.5.4 The Trust will also monitor the quality of PSII findings and progress against this PSIRP. This will include consideration and evidence required to answer the following questions:

a. Are the actions likely to achieve improvement?

b. Is there evidence of improvement?

4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1   PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.1.2   There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

4.1.3   There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

4.2 Selection of patient safety incidents for PSII

4.2.1   In view of the above, the selection of incidents for PSII is based on the:

    a.   actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)

    b.   likelihood of recurrence (including scale, scope and spread)

    c.   potential for new learning in terms of:

- enhanced knowledge and understanding of the underlying factors
- improved efficiency and effectiveness (control potential)
- opportunity to influence wider system improvement.

4.3 Timescales for patient safety PSII

4.3.1   Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

4.3.2   PSIIs should ordinarily be completed within one to three months of their start date.

4.3.3   In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation and the patient/family/carer.

4.3.4   No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

4.4 Nationally-defined priorities to be referred for PSII or review by another team

4.4.1   The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are:

a.   **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)

- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme

- all perinatal and maternal deaths must be referred to MBRRACE

b.   **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the

relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

g. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation.

e. **incidents in screening programmes:**

- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

h. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally-defined incidents requiring local PSII

4.5.1 Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

a. **incidents that meet the criteria set in the** Never Events list 2018

b. **incidents that meet the** 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care.

4.6 Locally-defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by the Trust for the period of 12 months.

   a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

   b. **Locally-predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified through analysis of local data and intelligence from the past three years, and agreed with the commissioning organisations as a local priority in line with the following guidance:

   - **Criteria for selection of incidents for PSII:**

      a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.)

      b. likelihood of recurrence (including scale, scope and spread)

      c. potential for learning in terms of:

         – enhanced knowledge and understanding

         – improved efficiency and effectiveness (control potential)

         – opportunity for influence on wider systems improvement.

4.6.2 A local priority of incidents for PSIIs is detailed in the table below. Each incident type has been allocated a set number of PSIIs which will be conducted in the set 12 month period.

4.6.3 A PSII will be declared where the criteria (listed above) is met as well as taking into account any similarly PSIIs already being investigated and the area in which the incident occurred. This will ensure that PSII are selected for incidents occurring across the Trust as well as allowing actions from previous PSIIs to be implemented.

	Incident type Specific risk (or incident subtype) identified through risk assessment process and described with the support of patient safety teams, executive team, patient groups and clinical commissioning groups		Number of PSIIs	Planned response for specific incident type - selected based on risk assessment and particularly on potential for new learning or insight
1	Call handling	Errors in 999 call handling which has led to a patient receiving a delayed response attributed to probable harm	6	3 PSIIs will be undertaken into each specific incident type to identify key common interlined causal factors.
		Errors in 111/IUC call handling which has led to a patient receiving a delayed response attributed to probable harm		
2	Face to Face Clinical Assessment	Clinical assessment which led to a patient being managed down an incorrect pathway	9	3 PSIIs will be undertaken into each specific incident type to identify key common interlinked causal factors.
		Face to face assessment which resulted in an incorrect decision to not convey the patient. The non-conveyance is attributed to probable harm.		
		Face to face assessment which resulted in the conveyance to hospital but not to definitive care; where there was clear indication for the patient to have been conveyed to a specialist centre.		
3	Enhanced Telephone Clinical Assessment	Enhanced telephone clinical assessment incorrectly resulting in home management advice. The management of the patient down this pathway resulted in probably harm.	3	3 PSIIs will be undertaken to identify key common interlinked causal factors.
4	Clinical Assessment of Spinal Injuries	Clinical assessment which led to a patient not receiving immobilisation where it was clinically indicated	3	3 PSIIs will be undertaken to identify key common interlinked causal factors.
5	Medicine management	Medication error	4	4 PSIIs will be undertaken to identify key common interlinked causal factors.
		Errors occurring during the preparation or administration of medicines with or without the presence of patient harm		

4.6.4   The following process will be followed by the Trust to review incidents under the Patient Safety Incident Response Framework:

a.   All incidents with the severity of moderate harm and above will be discussed with the Quality Improvement and Learning team who will review the incidents against the framework and agree a planned approach for each incident. This will include reviewing and planning appropriate review techniques for incidents outlined in section 5. Priorities for 'being open' conversations and Duty of Candour include:

- all patient safety incidents leading to moderate harm or above
- all incidents for which an investigation is undertaken.

b.   The Quality Improvement and Learning team will meet weekly with the Executive leads to discuss and agree the planned approach for these incidents.

c. The Quality Improvement and Learning team will ensure agreed PSII's will be logged on the Strategic Executive Information System (StEIS).

d. A 72 hour reports will be completed for every PSII declared for investigation. The report will contain the known facts relating to the incident and be sent to the CCG within the 72 hours following the identification of the SI. The purpose of the 72 hour report is to recognise and mitigate immediate risks at an early stage of the investigation.

e. The Trust will used the national developed designated PSII template. The template will be shared will all LI's by their supporting supervisor.

f. Some incidents may trigger a specific type of multi-agency review and/or PSII to ensure system wide learning. The Trust will co-ordinate and lead cross-system PSIIs through their internal systems and teams. Where required, the Trust will engage early with commissioning teams and/or relevant teams within the wider sustainability and transformation partnership (STP), ICS or local maternity system (LMS) to support the co-ordination of a cross-system PSII within a local system.

g. Datix is the electronic system utilised by the Trust to report and record incidents. The Trust's incident reporting policy is 25 working days to review, investigate and close all clinical and non-clinical incidents. Exceptions to this being those declared as PSII's. Each declared PSII will be recorded in Datix and assigned an identification number. The Datix record will hold all relevant documents, progress notes, internal communications and the final report. It will be the responsibility of the supervisors to ensure the records are accurate and up to date.

h. The Executive Team Members will review and approve all final PSII reports prior to the report being submitted to the CCG. Any feedback required from the Executive Panel will be communicated to the relevant SI supervisor for review and amendment. The three nominated Executive Leads are:
   - Chief Paramedic & Quality Officer
   - Medical Director
   - Chief Operating Officer

i. Once the report has been approved by the Executive Team Members the ongoing management of PSIIs including action completion, Trust wide learning and monitoring of ongoing compliance with completed actions/changes will be undertaken via the Trust's Safety Investigation Learning and Assurance Group (SILAG).

4.7 Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents

4.7.1   Once a number of PSIIs have been completed, a valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a few (three to six) recent and very similar incidents and investigate each individually with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2   The findings from each individual investigation are then collated, compared and contrasted to identify common causal factors and any common interconnections or associations upon which effective improvements can be designed.

4.7.3   Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

4.8 Patient safety improvement plans underway

4.8.1   The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, organisations must be able to apply knowledge of the science of patient safety and improvement to identify:
   • where improvements are needed
   • what changes need to be made
   • how changes will be implemented
   • how to determine if those changes have the desired impact (and if they do not, how they could be adapted).

4.8.2   The Trust uses the standardised approach to improvement via the Quality, Service Improvement Re-design (QSIR) programme to ensure staff have the tools they need to sustain improvement.

4.8.3   A number of strategic programmes and projects as well as locally designed patient safety improvement plans are underway across the Trust. These relate to full plans, rather than individual actions, designed and prescribed to address known issues

with all of them incorporating previous PSIIs, review, audit or risk assessment findings (e.g. national suicide prevention plan).

4.8.4　The below is an overview of these Trust's programmes, projects and current quality improvement plans:

	Strategic Programmes and Projects improvement plan	Specialty	Monitoring Committee/Group
1	IT Infrastructure	Integrated Patient Care Services/IM&T/Ambulance Services	Programme Monitoring Board (PMB)
	Local patient safety incident improvement plans titles	Specialty	Monitoring Committee/Group
1	Delayed Defibrillation	Ambulance Services	SIALG/QOG/QAC
2	Missing Equipment	Ambulance Service/Fleet and Logistics	SIALG/QOG/QAC
3	Nature of Call (NoC)	Ambulance Services	SIALG/QOG/QAC

4.8.5　It is important to take a proactive approach and be dynamic to patient safety risks to achieve continuously improvement. The Trust's main role in developing this plan was to involve key stakeholders across the clinical and quality agenda. This was to ensure and address common interconnected contributory factors. As a result, the below two themes were identified (with work commenced) for improvement projects/improvement plans in the 12 month period:

	Patient safety incident improvement plan/projects	Specialty	Monitoring Committee/Group
1	Delays in high demand – including improvements identified from the thematic COVID19 review in wave 1 & the thematic review currently being undertaken for wave 2.	Trust wide	SIALG/QOG/QAC
3	Civility (Behaviour and Attitude) a proactive approach to understand this theme via patient safety issues as well as complaints and patient feedback.	Trustwide	SIALG/QOG/QAC

5. Selection of incidents for review

5.1.   Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

5.2.   A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

5.3.   Different investigation techniques can be adopted, depending on the intended aim and required outcome. The Trust will use the following investigation techniques:

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'**Being open**' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Structured Judgment Review for delays	Clinical documentation review	This approach will be used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
Debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by

Technique	Method	Objective
		understanding the expectations and perspectives of all those involved and capturing learning to share more widely.

5.4. Where incidents result in a death, a Learning from Deaths (LfD) review will be undertaken to assess where any care and service delivery problems occurred. There may be the requirement to undertaken a further specialist review of these and below are the review techniques that could be used:

Technique	Method	Objective
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	To review the care of a person with a learning disability (recommended alongside a case note review).
Perinatal mortality review tool	Specialist review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Learning from Death review	Specialist Review	Review the care of a person who died under the care of the service.

5.5. In all incidents there maybe the need to undertake active monitoring and ensure that actions taken to address incident are effective. All incidents are monitored via the Trust Safety Investigation Assurance and Learning Group and the following techniques that could be used:

Technique	Method	Objective
Process audit	Audit	To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended
Outcome audit	Audit	To systematically determine the outcome of an intervention and whether this was as expected/intended
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	Proactive hazard identification and analysis	To determine the likelihood of an identified risk and its potential severity (e.g. clinical, safety, business).

6. Roles and Responsibilities

6.1   This Trust describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

6.2   **Chief Executive**

- The Chief Executive has overall responsibility for the effective management of all patient safety incidents, including contribution to cross-system/multi-agency reviewed and/or investigations where required.
- With the executive and non-executive team, models behaviours that support the development of patient safety reporting, learning and improvement system.
- Ensure that systems and processes are adequately resourced including; funding, management time, equipment and training.

6.3   The **Chief Paramedic & Quality Officer**, supported by the **Chief Medical Officer**, is the executive lead responsible for supporting and overseeing implementation of the Patient Safety Incident Response Framework (PSIRF) and includes;

- Ensuring processes are in place to support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Oversee development and review of the Trust's PSIRP.
- Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families and carers where required.
- Ensures the Trust complies with the national patient safety investigation standards.
- Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards.
- Develops professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management.

6.4   **The Quality Improvement and Learning Safety Team**

- Ensures that patient safety investigations are undertaken for all incidents that require this level of response (as directed by the Trust's PSIRP)

- Develops and maintains local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Ensures the Trust has procedures that support the management of patient safety incidents in line with the Trust's PSIRP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).
- Established procedures to monitor/ review investigation progress and the delivery of improvements.
- Works with executive lead to address identified weaknesses/areas for improvement in the Trust's response to patient safety incidents including gaps in resource including skills and training.
- Supports and advises staff involved in the patient safety incident response

6.5 **Investigation Supervisors**
- Ensure that investigations are undertaken in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

6.6 **Lead Investigators**
- Under the direction of investigation supervisor undertake investigations in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

6.7 **Duty of Candour/Being Open**
- The LI and/or the supervisor will be the main point of contact for the patient families and carers to ensure they are fully supported and informed of the investigation and its progress
- Identify those patients, families and carers affected by patient safety incidents and provide them with timely and accessible information and advice
- Ensure they are provided with an opportunity to access relevant support services

- Act as liaison between patients, families and carers and investigation teams to help manage expectations.

All main contacts for patients, families and carers must have;

- Received appropriate training in communication of patient safety incidents including 'being open' and Duty of Candour.
- Sufficient time to undertake their role; that is they should be staff dedicated to the role or with dedicated time for this role.
- More information can be found in the Trust's Being Open (Duty of candour) Policy.

6.8 **Supporting Staff**

- Staff will be support by their local management team, where required or requested can potentially arrange for LINC workers.
- The LI and/or the supervisor will be the main point of contact for staff involved in a patient safety incident investigation.
- Provide advice and support throughout the investigation process to staff affected by a patient safety incident.
- Facilitate their access to additional support services as required.
- Act as liaison between these staff and investigation team as required.

6.9 **Department Leads/managers**

- Encourage reporting of all patient safety incidents including near misses and ensure all staff in their area is competent in using the Datix reporting system and are provided sufficient time to record incidents and share information.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in investigations as required.
- Liaise with the patient safety team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

6.10 **All Staff**

- Understand their responsibilities in relation to the Trust's PSIRP.
- Know how to access help and support in relation to patient safety incident response process.

7. Patient Safety Incident reporting arrangements

7.1 The reporting of all incidents is essential so that, when things go wrong or could have gone wrong, we can learn and take action to reduce the risk of harm to patients and staff, and improve the quality of our services.

7.2 All members of staff must report (or ensure that a colleague has reported) all incidents in which they are involved or become aware of.

7.3 Incident Reporting Systems are considered to be a major tool in the way the Trust manage risks; their purpose:

- To ensure that all incidents/accidents (actual and near miss) are reported, recorded and managed
- To prevent the recurrence of preventable adverse clinical and non-clinical events
- To provide 'early warning' of complaints/claims/adverse publicity
- To ensure that sufficient information is obtained:
  a) to meet internal and external (e.g. NHS England, HSE) reporting requirements
  b) to respond to complaints and litigation should these ensue
  c) for trend analysis which in turn is intended to facilitate the identification and 'learning of lessons' from incidents/mistakes made

7.4 The process of complying with both internal and external notification requirements for the reporting of patient safety-related incidents can be found within the Trust's Incident Management Policy (TP117).

8. Procedures to support patients, families and carers affected by PSIs

8.1   The Trust is open with patients and relatives when errors are made and ensures that the principles of Being Open and Duty of Candour (DoC) are applied, and adhered to.

8.2   This is integral to the response to incidents, complaints, legal and safeguarding processes. Being open is part of a 'just" culture required of all healthcare providers and is fundamental to being a learning organisation.

8.3   Local arrangements for supporting patients, families and carers are detailed within the Trust's Being Open (Duty of Candour) Policy and associated documents.

9. Procedures to support staff affected by PSIs

9.1   It is essential that with any PSI the staff involved are genuinely supported throughout the entirety of the process. It is well documented that staff that are involved in such incident are potentially a 'second victim' and clear procedures to ensure and escalate the appropriate support is pivotal to the developed PSIIRF.

9.2   In keeping with the ethos of 'just culture' staff should be informed as soon as possible that an incident they have been involved in is to be investigated as a PSI. Significantly a clear explanation of the 'how's and whys' the incident is to be investigated needs to be explained in a transparent way to ensure the staff are confident that the investigation is fair and appropriate.

9.3   The initial acknowledgement to staff is important and can 'set the tone' of the perceived investigation to follow in the eyes of the staff. Rather than being too prescriptive the initial contact should be based on 'best for staff' utilising local management knowledge of said individuals. A verbal and 'face to face' discussion with the staff should always be followed up with an 'individualised' written response to follow.

9.4   Key components that should be explained to staff at the onset and indeed reinforced in written follow up:
- Just culture
- Emphasis is on identifying organisational learning
- Staff to be provided with a copy of the national PSII standards to which the investigation will be completed
- Emphasis that their input / questions and contribution is pivotal to any investigation
- Shared understanding of the potential stress associated (staff should absolutely be provided with written evidence of support options available)
- Clear time frames explained (avoid the possible concern that periods of 'no news is bad news')
- Emphasis that there is no hidden agenda, transparency is key. (Access to FTSU given)
- Regular 'touch base' periods built in to any investigation.
- Draft reports to be shared with staff (see point 7) to encourage feedback and promote the ethos of transparency.
- Final report to be shared and debrief arranged as required.

10. Mechanisms to develop and support improvements following PSIIs

10.1 The Trust utilise the Quality, Service, Improvement and Redesign (QSIR) quality programme through their Royal Academy of Improvement. The Academy provides training, education and support for a wide variety of improvement projects.

10.2 There is a cohort of QSIR practitioners who have undergone training to support teams throughout the Trust with implementing improvements/solutions arising from patient safety incident investigations.

11. Evaluating and monitoring outcomes of PSIIs, Thematic Reviews and Incident reporting.

11.1 Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

11.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

11.3 Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

11.4 Reports to the board will be monthly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view
- results of surveys and/or feedback from patients/families/carers on their experiences of the Trust's response to patient safety incidents
- results of surveys and/or feedback from staff on their experiences of the Trust's response to patient safety incidents.

12. Complaints and appeals

12.1 Patient experience and feedback offer learning opportunities that allows us to understand whether our services are meeting the standards we set and addressing patients' expectations and concerns. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously, clearly identifying any lessons and using these to improve our service.

12.2 We report trends and emerging themes through the Trust's governance processes and to widen the learning, we publish anonymised case examples on the Trust website. With the implementation of PSIRP we will continue to manage complaints in the usual way in accordance with Trust Policy and the NHS Complaint Regulations, with close liaison with the Quality Improvement and Learning Team in relation to any complaints about incidents that are also the subject of a thematic review.

12.3 Local arrangements for complaints and appeals relating to the Trust's response to patient safety incidents are detailed within the Trusts Complaints Policy.

Contact us:

NHS Improvement   **NHS England**

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

 @NHSEngland

This publication can be made available in a number of other formats on request.

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Cardiac Arrest Annual Report: 2019/20

December 2020

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ londamb.Caru.Enquiries@nhs.net

Contents

Cardiac Arrest infographic: April 2019 – February 2020 inclusive

Cardiac Arrest Overview | 2019- 2020

Demographics

11,183
Total number of patients seen

39%
Had resuscitation attempted
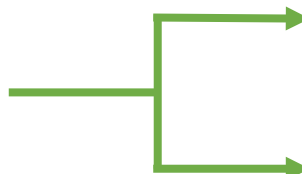
66%
64 years*

34%
71 years*

*Median age

Response times (mins)

Excluding March 2020

999 call to

04:00
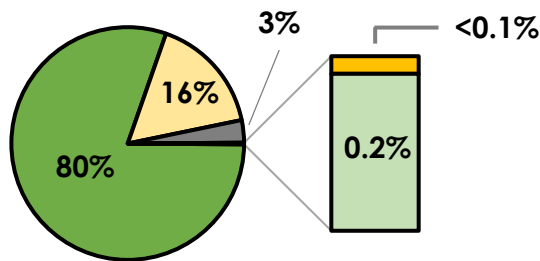Call taker Hands on Chest

10:15
Arrive scene

09:29
LAS CPR

10:15
LAS defibrillation

Call category

3%

<0.1%

16%

80%

0.2%

☐ Cat 1 ☐ Cat 2 ☐ Cat 3 ☐ Cat 4 ☐ Cat 5

Profile of arrest

Location

73%	27%
Private	Public

Witnessed

52%	16%	32%
Bystander	LAS	Unwitnessed/ Not documented

Bystander CPR

67%	33%
Bystander CPR	No Bystander CPR

Aetiology

5%

74%		21%
Presumed Cardiac	Trauma	Other

Initial rhythm
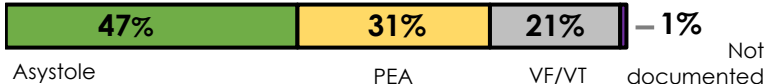
47%	31%	21%	1%
Asystole	PEA	VF/VT	Not documented

Outcomes

Excluding March 2020

ROSC to Hospital

Utstein
59.1%

Overall
33.0%

Utstein
31.0%

Overall
10.0%

Survival to discharge
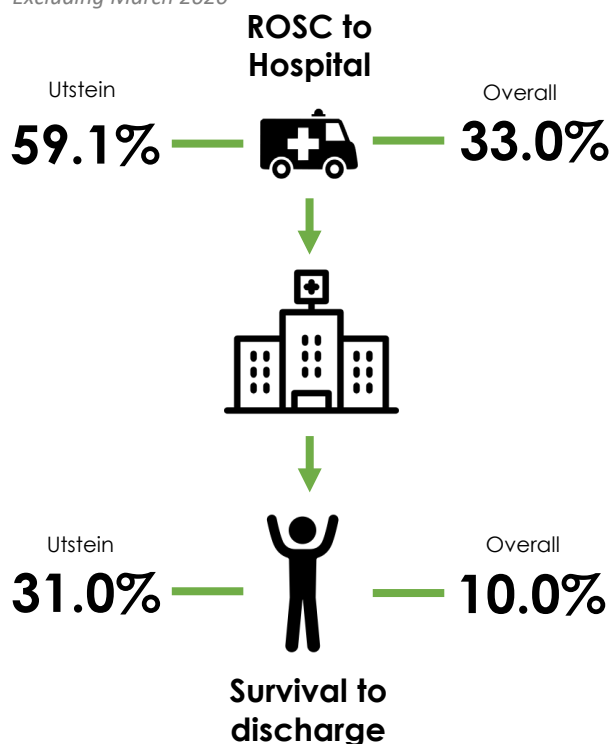
1   Introduction

Between 1st April 2019 and 31st March 2020, the London Ambulance Service NHS Trust (LAS) attended 11,183 patients in out-of-hospital cardiac arrest (OHCA). Our clinicians attempted resuscitation for 4,355 (38.9%) patients; 4,563 patients were recognised as deceased on arrival of our clinicians, and the remaining 2,265 had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) order, an advanced directive or equivalent, or the patient's death was expected.

Data presented within this report were sourced from the LAS's Out-of-Hospital Cardiac Arrest Registry and refers to the **4,355** patients where resuscitation was attempted. Where appropriate, in order to differentiate the impact of COVID-19, data are reported for the first 11 months of the year (April 2019 – February 2020) separately from March 2020 when the first peak of COVID-19 disrupted our response to patients.

2   Profile of arrests

Gender, n (%)	
Male	2,859 (65.6)
Female	1,494 (34.3)
Unknown	2 (<0.1)

Age, mean (median) in years	
Overall	63 (66)
Male	62 (64)
Female	66 (71)

Location, n (%)	
Private location	3,178 (73.0)
Home	*2,995 (94.2)*
Care home	*183 (5.8)*
Public Location	1,177 (27.0)

Race, n (%)	
White	2,538 (58.3)
Black	350 (8.0)
Asian	384 (8.8)
Mixed	25 (0.6)
Other	190 (4.4)
Unknown	868 (19.9)

Chief complaints at the 999 call, n (%)	
Cardiac arrest	2,323 (53.3)
Unconscious/fainting	503 (11.6)
Breathing problems	385 (8.8)
Falls	150 (3.4)
NHS 111 transfer	83 (1.9)
Other †	911 (20.9)

Peak occurrence		
Time of day (hh:mm)	**Day of week**	**Month of year**
08:00-11:59	Monday	March
22.3% (n=973)	15.2% (n=660)	12.0% (n=521)

The total percentages do not equal 100% due to rounding; † Includes HCP admissions (n=26)

Table 1: Profile of cardiac arrests where resuscitation was attempted (n=**4,355**)

- Numbers of cardiac arrests varied throughout the year, with **March** seeing the highest proportion (**12.0%**) when London experienced the first wave of the COVID-19 pandemic. The next highest incidence rate was in December (9.2%), and the lowest in September (7.1%).

- For the whole year, the profile of cardiac arrests was similar to last year, with most patients being **male** (**65.6%** vs. 65.0% in 2018-19) and the majority of arrests occurring in **private locations** (**73.0%** vs. 72.9% in 2018-19).

- However, there were some differences seen in demographics during **March** compared to the other 11 months of the year. In March more patients were female (36.3% vs 34.0%), older (mean age 65 vs 63 years) and more likely to be from a BAME group (26.7% vs 21.0%). Not surprisingly, as lockdown occurred, we saw even more cardiac arrests occurring in private locations (82.3% vs 71.7%).

3   LAS response times

We report two types of response interval:

1. Ambulance Response Programme (ARP) intervals (Table 1) – these are measured using 'Clock Start' and 'Clock Stop' as defined nationally by NHS England's Ambulance Quality Systems Indicators (https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/)

2. 999 call - arrival at scene (Table 2) - is an international definition for reporting the response interval of clinical significance and starts at the time the 999 call is connected to the ambulance service, ending when the first vehicle's wheels stop turning upon arrival at scene (https://www.ahajournals.org/doi/pdf/10.1161/01.CIR.84.2.960).

ARP response intervals will usually be shorter than '999 call – arrival at scene' due to differences in the start and end points used in both calculations, and also because the ARP 'Clock Start' time is reset when a call category is upgraded. ARP provides a measure of the system's response, whereas '999 call - arrival at scene' provides a picture of the response as experienced by the patient, but does not adjust for calls that come in initially as a lower priority and are subsequently upgraded.

3.1 Response by call category

Category	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Category 1	3,059 (79.8)	05:37	05:14	435 (83.5)	07:33	06:22
Category 2	644 (16.8)	14:35	09:54	71 (13.6)	28:21	19:03
Category 3	121 (3.2)	16:56	10:02	15 (2.9)	14:52	07:06
Category 4	1 (<0.1)	16:56	-	0 (0.0)	-	-
Category 5^	9 (0.2)	29:22	14:38	0 (0.0)	-	-
Overall	**3,834**	**07:32**	**05:36**	**521**	**10:36**	**06:56**

The total percentages do not equal 100% due to rounding.^ Patients allocated Category 5 are mainly managed by the LAS Clinical Hub as they are often suitable to be best dealt with via Hear and Treat.

Table 2: ARP response intervals by call category (mm:ss)

Category	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Category 1	3,059 (79.8)	08:31	07:05	435 (83.5)	17:59	10:05
Category 2	644 (16.8)	16:02	11:53	71 (13.6)	40:58	23:26
Category 3	121 (3.2)	20:56	10:16	15 (2.9)	14:51	08:13
Category 4	1 (<0.1)	20:52	-	0 (0.0)	-	-
Category 5^	9 (0.2)	37:24	24:01	0 (0.0)	-	-
Overall	**3,834**	**10:15**	**07:36**	**521**	**21:02**	**10:34**

^ Patients allocated Category 5 are mainly managed by the LAS Clinical Hub as they are often suitable to be best dealt with via Hear and Treat. The total percentages do not equal 100% due to rounding.

Table 3: '999 call – arrival at scene' response interval by call category (mm:ss)

- **Overall** response intervals:
  - The mean ARP response in the first 11 months of the year was **07:32**, rising to **10:36** in **March** due to operational pressures associated with COVID-19.
  - The mean '999 call – arrival at scene' was **10:15** in the first 11 months, rising to **21:02** in **March**.

- **Category 1** response intervals:
  - The vast majority of patients (79.8%) received a Category 1 response.
  - The mean ARP response intervals were **05:37** during the first 11 months of the year, increasing to **07:33** in **March**
  - The mean '999 call – arrival on scene' response intervals were **08:31** for the majority of the year rising to **17:59** in **March**.

3.2   Key clinical time intervals

Time interval	April 2019 – February 2020		March 2020	
	Mean	**Median**	**Mean**	**Median**
999 call^ – Call taker Hands on Chest@	04:36	04:00	06:45	04:57
999 call^ – LAS CPR*	11:37	09:29	22:22	13:11
999 call^ – LAS defibrillation*~	11:37	10:15	13:54	11:53

*^ Time the 999 call was connected to the Emergency Medical Dispatcher; @ Time the 999 call was connected to the EMD to the time of the first EMD assisted chest compression; * Excludes LAS witnessed arrests; ~ Based on an initial rhythm of VF/VT*

Table 4: Key clinical time intervals from 999 call (minutes)

- There were minimal changes compared to last year in the median time from 999 call to LAS CPR which **reduced by 6 seconds**, and the median time to defibrillation which **reduced by 23 seconds** in the first 11 months of this year.

- Both intervals from 999 call to LAS CPR and LAS defibrillation were significantly longer in **March**.

- The median time to dispatcher-assisted CPR (hands on chest) for patients who had resuscitation attempted by LAS was **4 minutes** between April 2019 and February 2020. This **increased** by almost a minute in **March**.

4   Bystander interventions
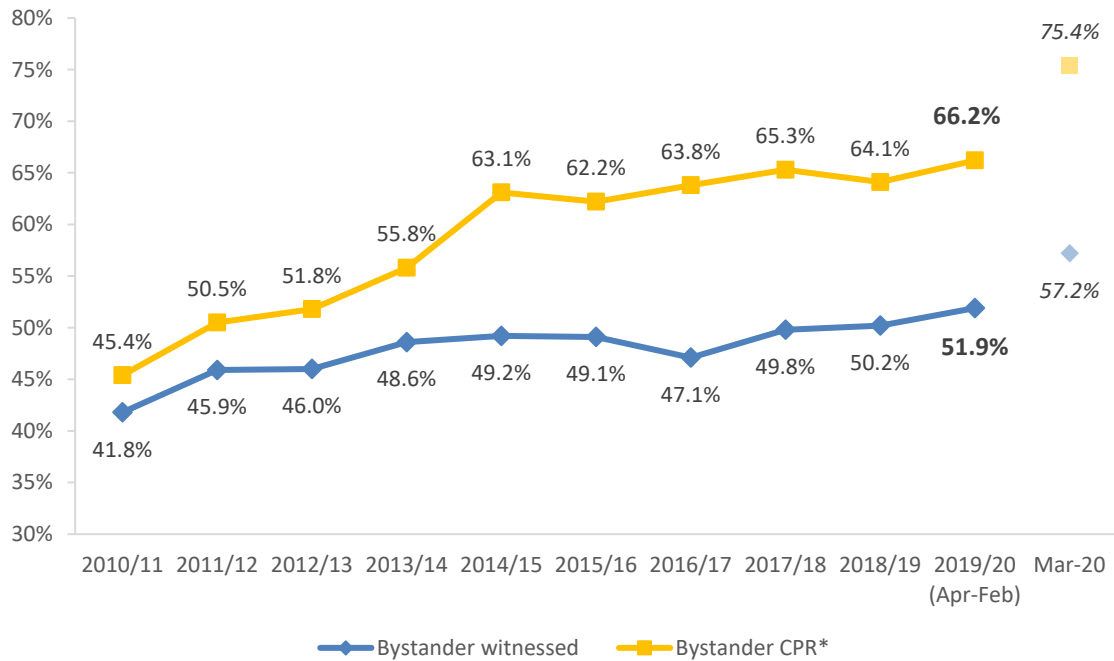
4.1   Bystander witnessed and CPR rates

Figure 1: Bystander witnessed arrests and bystander CPR by year

*Excludes LAS witnessed arrests

- For the second year in a row, **more than half** (52.5%) of patients had their cardiac arrest witnessed by a bystander. This increased from **51.9%** between April 2019 and February 2020 to **57.2%** in March 2020.

- **Over two thirds** of patients (67.4%) received bystander CPR, which is a **3.3% increase** from last year and the **highest figure we have seen to date.** Of particular note, this figure increased from **66.2%** between April 2019 and February 2020, to **75.4%** in March 2020 as more people remained at home due to the COVID-19 pandemic.

4.2   Public Access Defibrillator (PAD)

	Number of deployments	Cases where PAD shock delivered n (%)	ROSC Sustained to Hospital n (%)*	Survival to Hospital Discharge n (%)*†
LAS accredited PAD	70	52 (74.3)	34 (65.4)	17 (35.4)
Non-LAS accredited PAD	231	83 (35.9)	36 (43.4)	20 (25.3)
All PAD deployments	301	135 (44.9)	70 (51.9)	37 (29.1)

*includes only cases where a shock was delivered; † excludes incidents where outcome is unknown (n=8)

Table 5: Public access defibrillator use
For patients who remained in cardiac arrest on arrival of LAS and for whom we commenced resuscitation

- A public access defibrillator (PAD) was used on **301 occasions,** with a shock delivered to **135 (44.9%)** patients prior to arrival of LAS, giving these patients the best possible chance of survival.

- **29.1%** of those who received a PAD shocked **survived to leave hospital**, almost half of these involved the use of an LAS accredited PAD.

- The use of LAS accredited PADs decreased slightly compared to last year. This varied throughout the year, with no indication that it was affected by the COVID-19 pandemic. The highest number of activations were in January (n=10) and the lowest in both July and August (n=3).

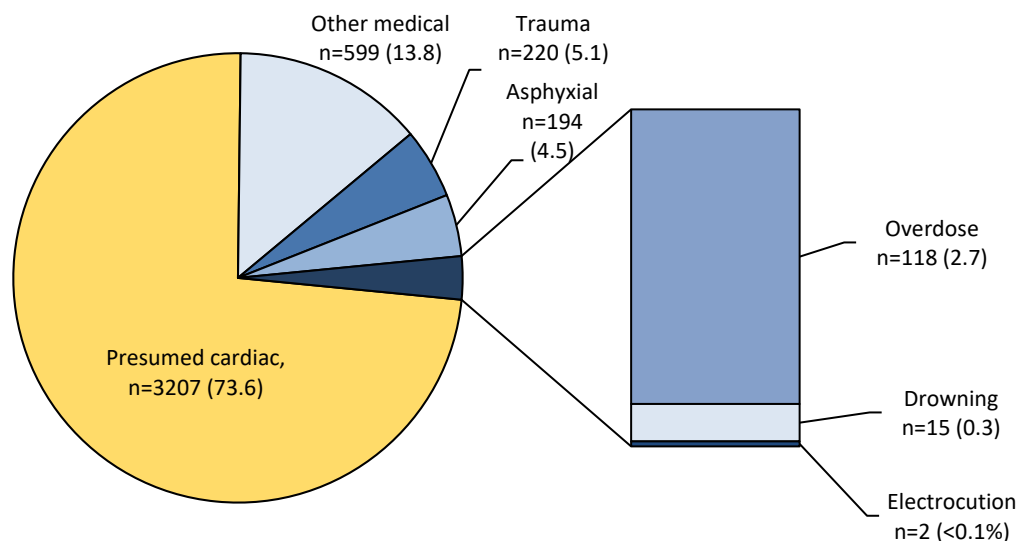## 5   Clinical Presentation

5.1   Aetiology

Figure 2: Breakdown of cardiac aetiology for full year (2019-20)

.

Aetiology	April 2019 – February 2020		March 2020		Overall	
	n	%	n	%	n	%
Presumed cardiac	2,882	75.2%	325	62.4%	3,207	73.6%
Other medical	448	11.7%	151	29.0%	599	13.8%
Trauma	206	5.4%	14	2.7%	220	5.1%
Asphyxial	177	4.6%	17	3.3%	194	4.5%
Overdose	106	2.8%	12	2.3%	118	2.7%
Drowning	13	0.3%	2	0.4%	15	0.3%
Electrocution	2	<0.1%	0	0.0%	2	<0.1%

The total *percentages do not equal 100% due to rounding*

Table 6: Aetiology breakdown within year

- **Presumed cardiac** remains the predominant cause of cardiac arrest in London (**73.6%**).

- In **March 2020**, the number of patients presenting with a **presumed cardiac** cause was lower (**62.4%**) whilst the number of **other medical** presentations increased (**29.0%**), indicating that the COVID-19 pandemic may have affected the annual aetiology breakdown.
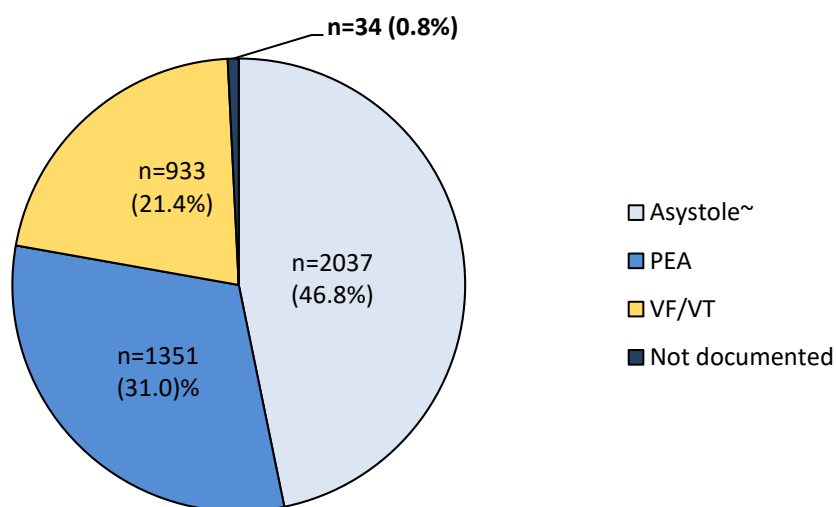
5.2   Initial Rhythm

Figure 3: Breakdown of initial arrest rhythm for full year (2019-20)

~ Includes paediatric bradycardia (n=1).

Aetiology	April 2019 – February 2020		March 2020		Overall	
	n	%	n	%	n	%
Asystole	1,742~	45.4%	295	56.6%	2,037~	46.8%
PEA	1,204	31.4%	147	28.2%	1,351	31.0%
VF/VT	856	22.3%	77	14.8%	933	21.4%
Not Documented	32	0.8%	2	0.4%	34	0.8%

The total *percentages do not equal 100% due to rounding; ~ Includes paediatric bradycardia (n=1)*

Table 7: Initial rhythm breakdown across the year

- **Asystole** remains the most common presenting rhythm (46.8%).

- The proportion of patients presenting in **shockable rhythms (VF/VT)** decreased very slightly compared to last year, by **0.5%** with the **lowest number** of cases seen **in March** (14.8%).

6   Outcomes

6.1   Conveyance
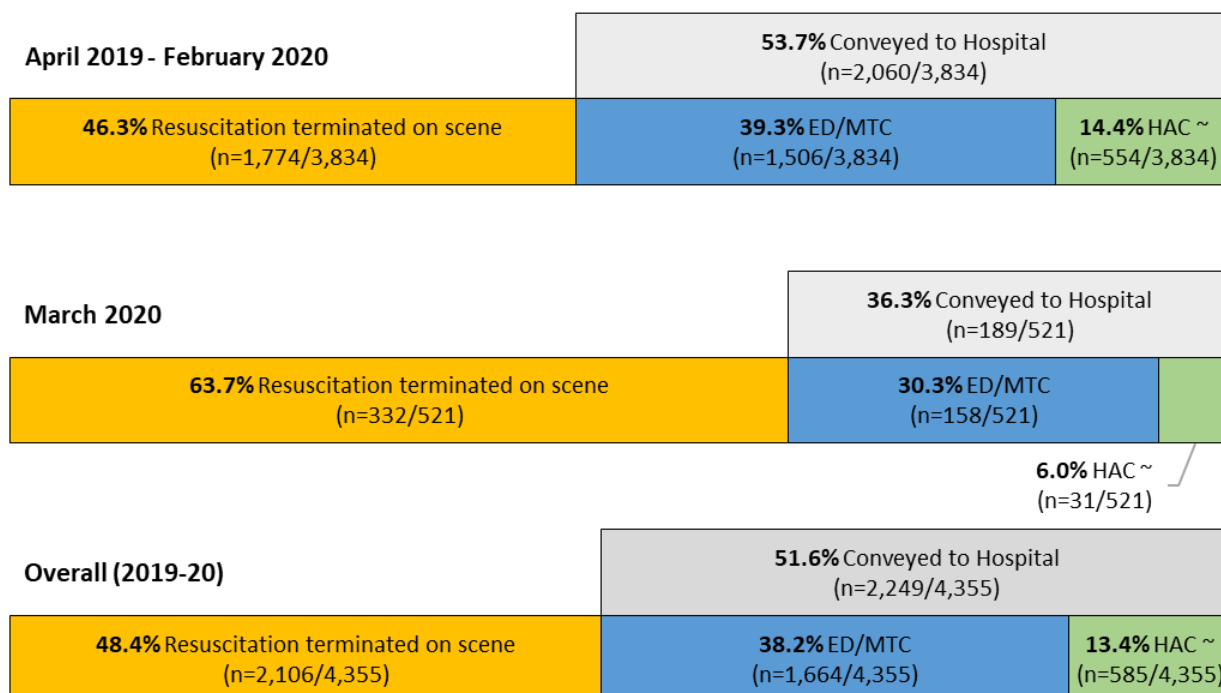
Resuscitation terminated on scene does excludes cases where resuscitation was not attempted including where a DNAR was present. ~ Includes all patients regardless of whether a STEMI was identified.

Figure 4: Breakdown of conveyance by destination

- Between April 219 and February 2020, **46.3%** of resuscitations were terminated on scene, an **increase of 2.8%** compared to last year.

- **March** saw the **highest number** of resuscitations terminated on-scene at **63.7%**. This was **9.7% higher** than September, which had the next highest number. There was a pattern of steady increase towards the end of March.

- The proportion of patients conveyed to a **Heart Attack Centre** (HAC) between April 2019 and February 2020 **remained consistent** with 2018-19 (**14.4%** vs 14.7%). However, in **March** 2020, only **6%** of patients were conveyed to a HAC.

- 1.3% of patients (n=58) were conveyed to a Major Trauma Centre (MTC) across the whole year, with eight of these occurring in March 2020 (1.5%).

6.2 ROSC and Survival

ROSC sustained to hospital arrival and survival to discharge figures are reported for two groups:

1. **Overall group**: all patients where resuscitation was attempted.

2. **Utstein comparator group**: a sub-group of patients for whom resuscitation was attempted following a cardiac arrest of a presumed cardiac cause, which was bystander witnessed, and presented in a shockable rhythm.
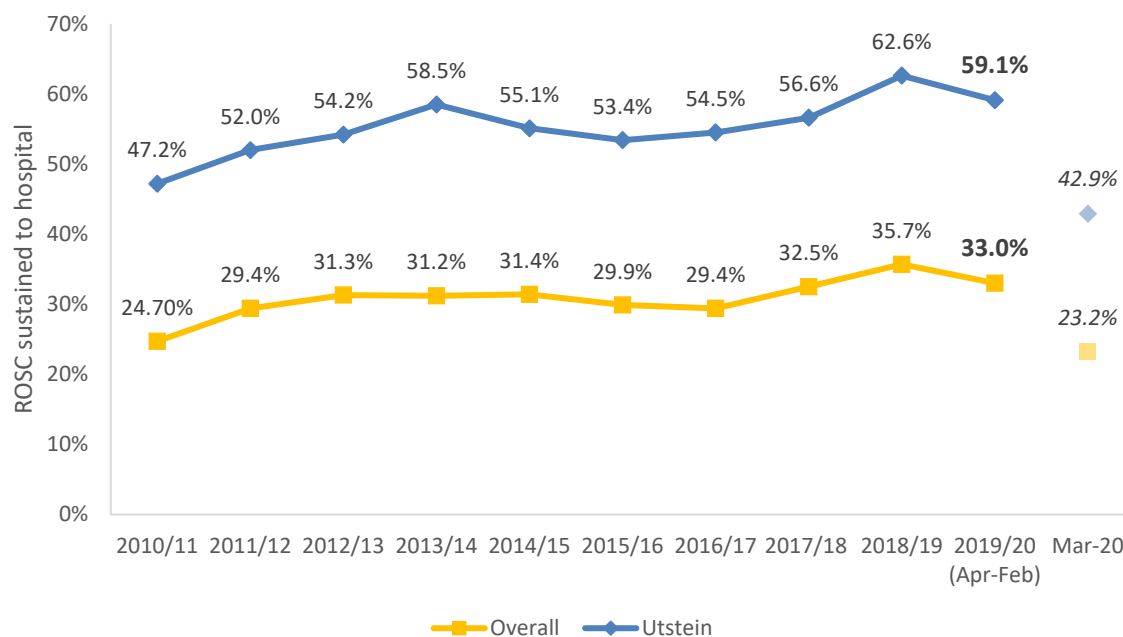

Figure 5: ROSC sustained to hospital per year for all patients where resuscitation was attempted

- When comparing the first 11 months of 2019-2020 to last year, we found ROSC **decreased by 2.7%** and **3.5%** in both the overall and the Utstein groups respectively. Despite this drop, both figures are the **second highest** we have reported to date.

- ROSC rates **decreased** significantly during **March 2020**.

- For the full 12 months of 2019-20, ROSC sustained to hospital rates were **31.8%** (overall) and **57.7%** (Utstein).

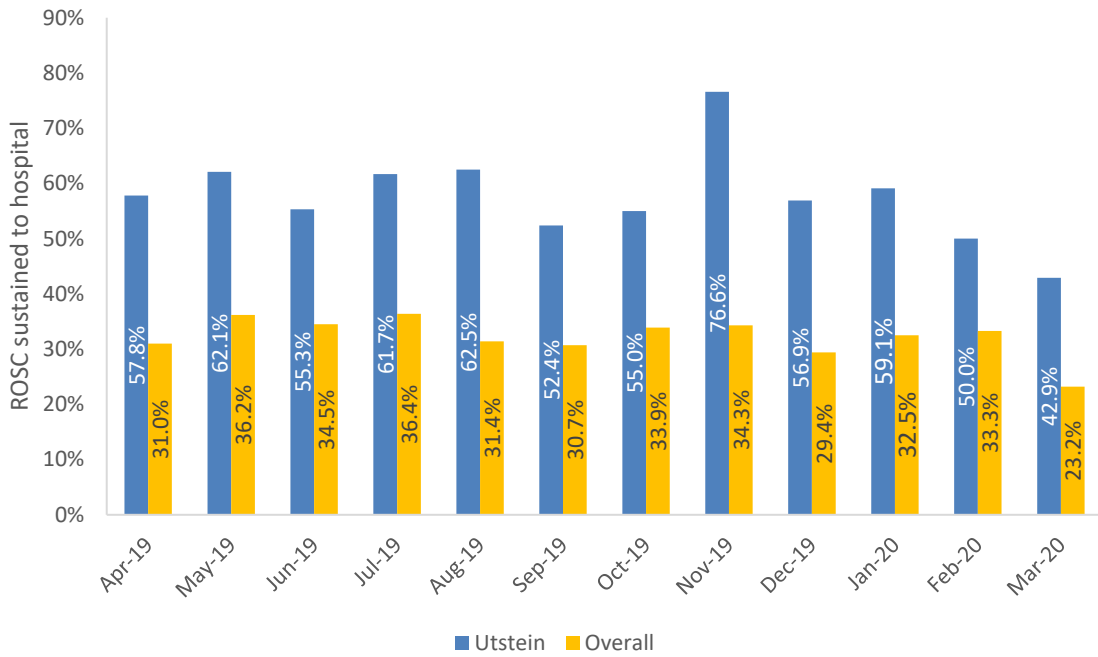- A breakdown by each month is provided in Figure 6 below.

Figure 6: Monthly ROSC sustained to hospital for all patients where resuscitation was attempted
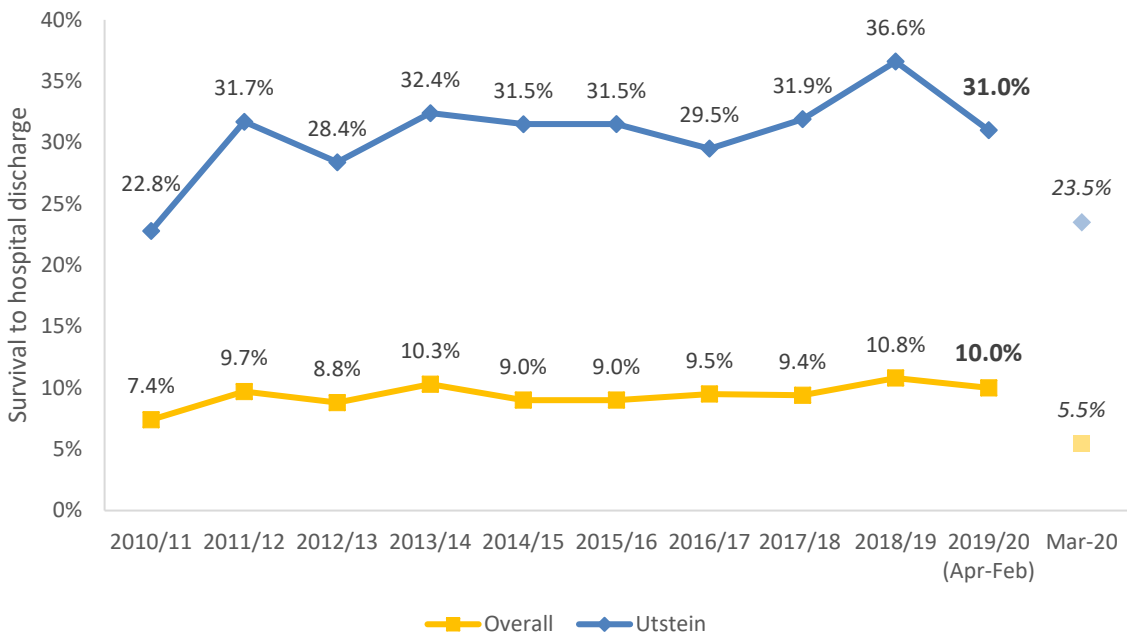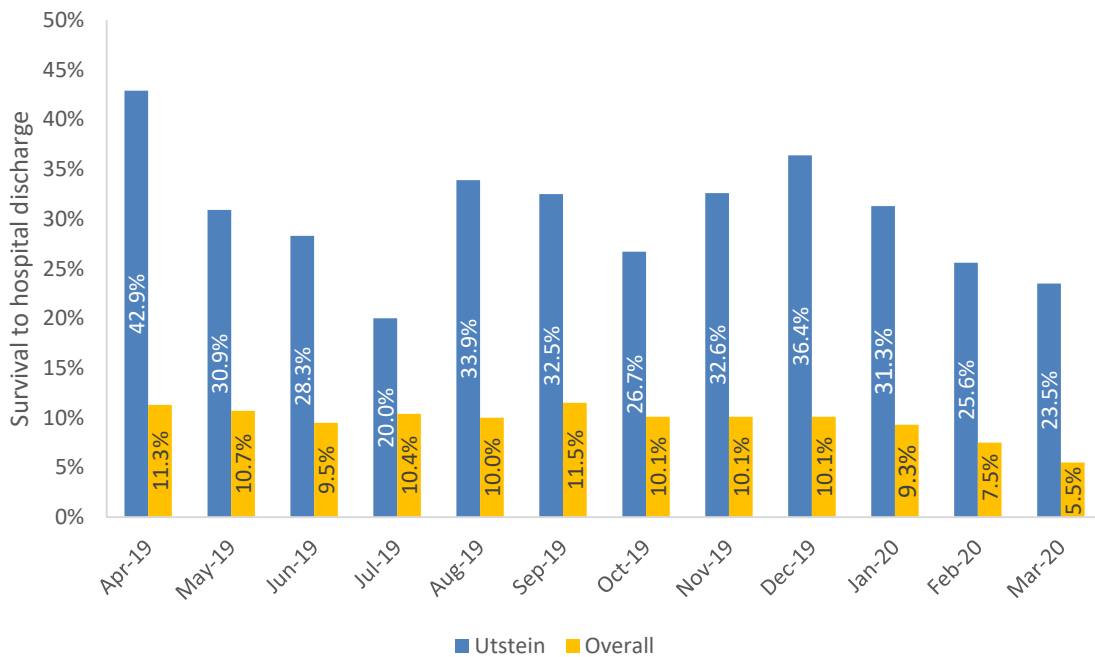

Figure 7: Survival to hospital discharge per year for all patients where resuscitation was attempted

- Compared to 2018-2019, survival to hospital discharge in the first 11 months of this year was **lower** by **0.8%** in the overall group and **5.6%** in the Utstein group.

- There was a significant **decrease** in survival in **March 2020,** with overall survival halved compared to the rest of the year.

- For the full 12 months of 2019-20, **9.5%** of patients in the overall group and **30.4%** in the Utstein group (Figure 9) survived to leave hospital.

- A breakdown by month is shown in Figure 8.

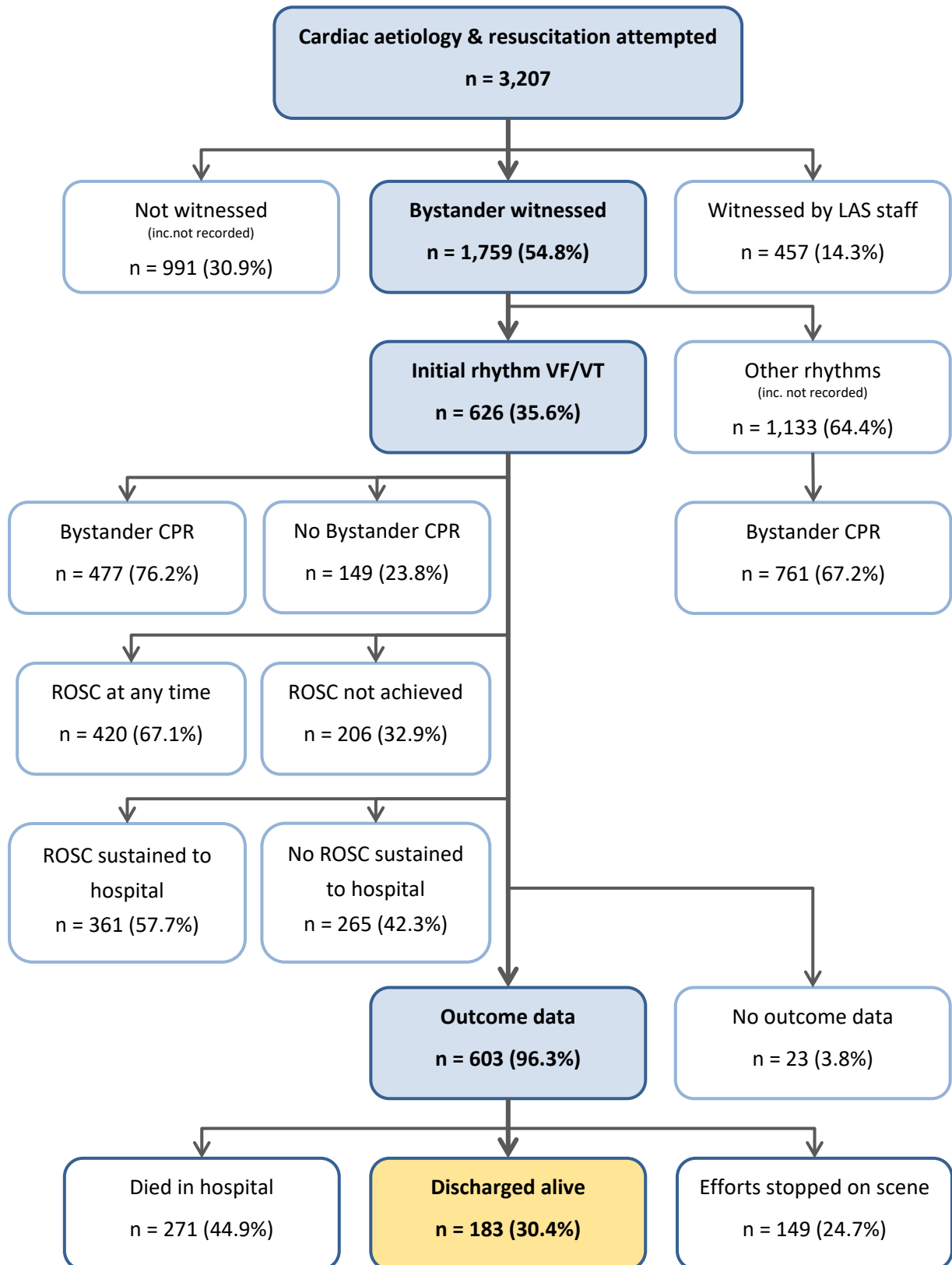Figure 8: Monthly survival to hospital discharge for all patients where resuscitation was attempted

Figure 9: The Utstein Survival Template (Full year 2019-20)

7   Conclusions

There has been an overall reduction in the numbers of patients achieving ROSC and surviving to leave hospital this year, with an increase in the number of resuscitation attempts terminated on scene. Our data shows that the COVID-19 pandemic, which developed in London in the early months of 2020, is likely to have contributed to some of this year's findings, with fewer patients presenting in shockable rhythms and more patients presenting with non-cardiac aetiologies. However, this year we have observed our highest ever rates of bystander CPR, equivalent to a 48.5% increase over the last 10 years, showing the benefits of continued initiatives to increase the uptake of this lifesaving intervention by members of the public.

We have continued our focus on increasing early bystander CPR and defibrillation prior to arrival of our clinicians, and have an aspirational aim of reaching 7,500 PADs in London by the end of 2022/23. Additionally, during 2019/2020 all of our frontline clinicians received refresher training in resuscitation as part of their Core Skill Refresher Training. We continue to improve staff awareness of, and access to, patient care plans through CMC and the work of the Macmillan End of Life Care Team.

Stroke Annual Report
April 2019 – March 2020

January 2021

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ londamb.CARU.enquiries@nhs.net

Contents

London Ambulance Service
NHS Trust

Stroke Overview | 2019-20

13,223
total number of suspected stroke patients

49%
69 years*

51%
71 years*

* mean average

58%
symptoms started within 4.5 hours

Diagnostic Bundle

F
A
S
T

99.8%   **98.5%**   **99.3%**
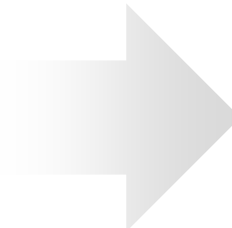
☑ **98.0%**
received a full diagnostic bundle

Conveyance

99.4%
Conveyed to the most appropriate destination

Timings (April 2019-February 2020)

999 call to arrive scene
25 mins

Overall on-scene
31 mins

Journey to HASU
18 mins

1 Introduction

This report presents information on the care provided by the London Ambulance Service NHS Trust (LAS) to adult patients (aged 16 and above) who were identified by our clinicians as suffering a suspected stroke between 1st April 2019 and 31st March 2020.

Data were sourced from the LAS's Suspected Stroke Registry, which holds clinical and operational information sourced from the LAS Patient Report Forms (PRFs; completed on-scene by clinicians), the Emergency Operations Centre (EOC) Call Logs and vehicle Mobile Data Terminals (MDTs).

Where appropriate, in order to differentiate the impact of COVID-19, data are reported for the first 11 months of the year (April 2019 – February 2020) separately from March 2020 when the first peak of COVID-19 disrupted our response to patients.
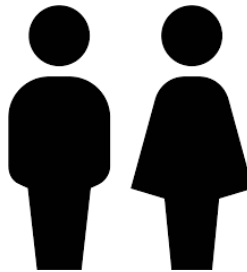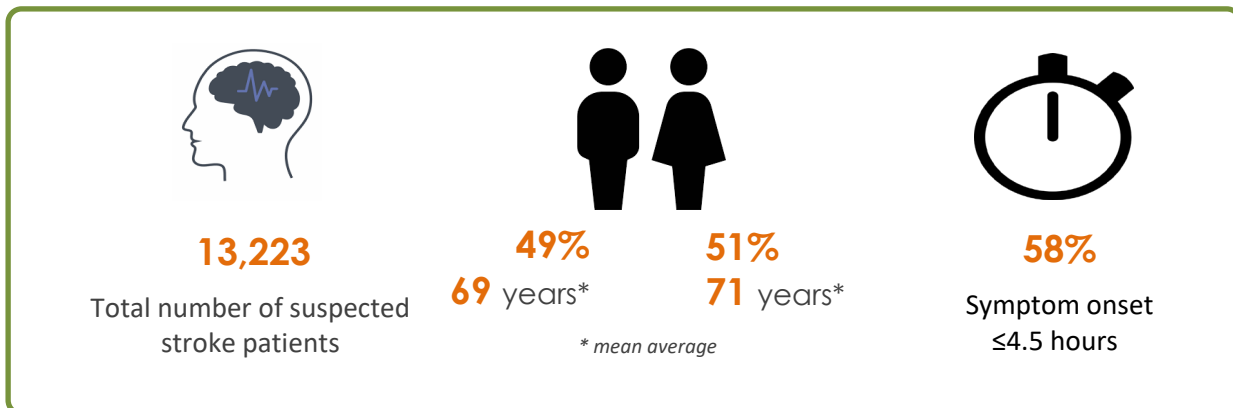
2 Findings

2.1 Patient demographics

13,223
Total number of suspected stroke patients

49%
69 years*

51%
71 years*

* mean average

58%
Symptom onset ≤4.5 hours

± *measured from symptom onset to leaving scene*

Figure 1: Patient overview

- LAS clinicians attended a total of **13,223** suspected stroke patients, which is a **4.6% increase** from last year's figure of 12,650.
- Consistent with last year, 58% (n= 7,730) had symptom onset within 4.5hrs of leaving scene - the timeframe for which they are eligible to be considered for thrombolysis therapy at hospital.
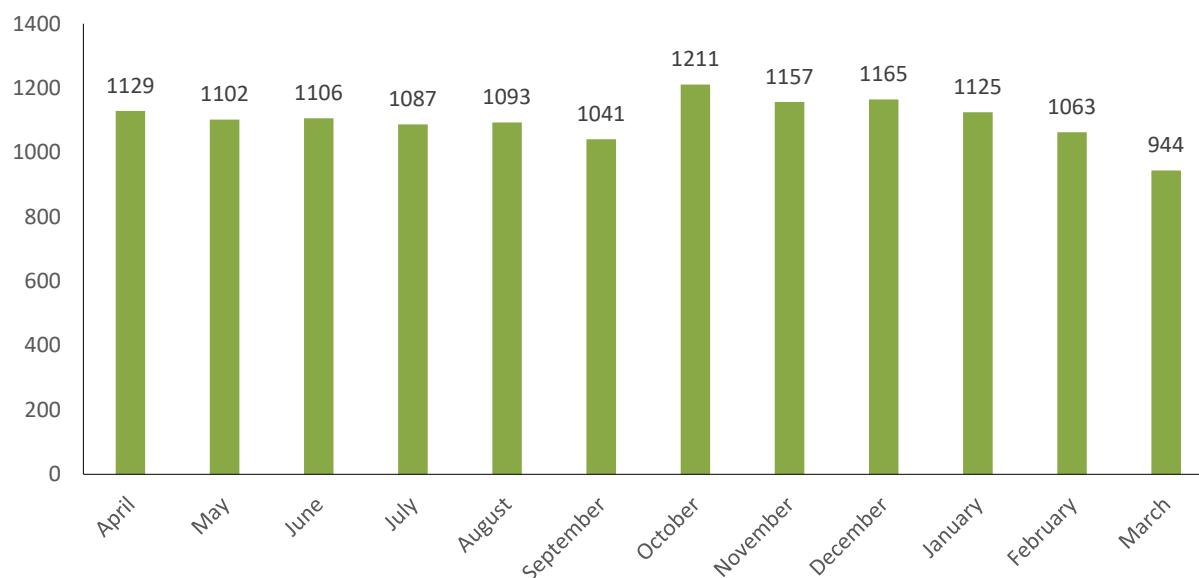
Figure 2: Patients per month

- There was a slight **reduction** in stroke patients seen in **March** 2020 (Figure 2), which may be due to the public's reluctance to travel to hospital amid the COVID-19 pandemic.

2.2 LAS response times

We report two types of response interval:

1. Ambulance Response Programme (ARP) intervals (Table 1) – these are measured using 'Clock Start' and 'Clock Stop' as defined nationally by NHS England's Ambulance Quality Systems Indicators (https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/)

2. 999 call - arrival at scene (Table 2) - is an international definition for reporting the response interval of clinical significance and starts at the time the 999 call is connected to the ambulance service, ending when the first vehicle's wheels stop turning upon arrival at scene

ARP response intervals will usually be shorter than '999 call – arrival at scene' due to differences in the start and end points used in both calculations, and also because the ARP 'Clock Start' time is reset when a call category is upgraded. ARP provides a measure of the system's response, whereas '999 call - arrival at scene' provides a picture of the response as experienced by the patient, but does not adjust for calls that come in initially as a lower priority and are subsequently upgraded.

Category	April 2019 - February 2020			March 2020		
	n (%)^	Mean	Median	n (%)^	Mean	Median
Category 1	938 (8.3%)	06:00	05:39	64 (7.1%)	08:24	06:59
Category 2	9,176 (81.0%)	18:33	13:37	742 (82.8%)	47:06	29:10
Category 3	1,093 (9.7%)	44:03	23:51	76 (8.5%)	02:11:49	01:18:45
Category 4	57 (0.5%)	01:05:47	33:34	1 (0.1%)	01:27:24	01:27:24
Category 5	58 (0.5%)	33:39	21:29	13 (1.5%)	01:24:14	31:20
Overall	11,322	20:17	13:10	896	52:07	28:23

Due to rounding, the percentages do not add up to 100%. ^Healthcare Professional admissions (n=1,005) are excluded from the response time figures as they request a response within a specific time frame.

Table 1: ARP response times by call category (hh:mm:ss)

Category	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Category 1	938 (8.3%)	11:15	08:13	64 (7.1%)	23:58	11:55
Category 2	9,176 (81.0%)	22:44	16:57	742 (82.8%)	54:09	33:03
Category 3	1,093 (9.7%)	49:13	27:54	76 (8.5%)	02:22:39	01:22:21
Category 4	57 (0.5%)	01:07:26	37:32	1 (0.1%)	01:31:24	01:31:24
Category 5	58 (0.5%)	43:34	30:22	13 (1.5%)	01:58:55	58:19
Overall	11,322	24:40	16:47	896	01:00:29	33:24

^ One incident was not allocated a call category, but is included in the overall figure in this table

Table 2: '999 call – arrival at scene' response intervals by call category (hh:mm:ss)

- **Over 80%** of calls were allocated a **Category 2** response.

- The mean ARP response interval between April 2019 and February 2020 was **20:17**, which **increased to 52 :07 in March** due to operational pressures associated with the COVID-19 pandemic (Table 1).

- The mean '999 call – arrival at scene' interval was **24:40**, which was also much higher in **March 2020** at **60 minutes** (Table 2).

2.3 On-scene times

First vehicle on scene	April 2019 - February 2020			March 2020		
	n^ (%)	Mean	Median	n^ (%)	Mean	Median
Solo responder	1,489 (12%)	39:26	36:10	101 (11%)	46:20	39:39
Double-crewed ambulance	10,713 (88%)	30:08	27:25	837 (89%)	32:34	29:56
Overall	**12,202**	**31:17**	**28:24**	**938**	**34:03**	**30:42**

^Patients who were not conveyed to hospital (n=83) are excluded from on-scene time figures.

Table 3: On-scene times by first vehicle to arrive on scene (mm:ss)

- For **88%** of stroke calls (89% in March) a conveying **ambulance** was the first vehicle to arrive on scene.
- The overall mean **on-scene** time (measured from first vehicle arriving to conveying vehicle leaving) was **31:17,** which remains the same as in 2018/2019.
- Average on-scene times were **nearly 3 minutes longer in March** most likely due to the additional challenges posed by staff needing to don and doff Personal Protective Equipment (PPE) during COVID-19 pandemic.

2.4 Onset of symptoms at the time of leaving scene
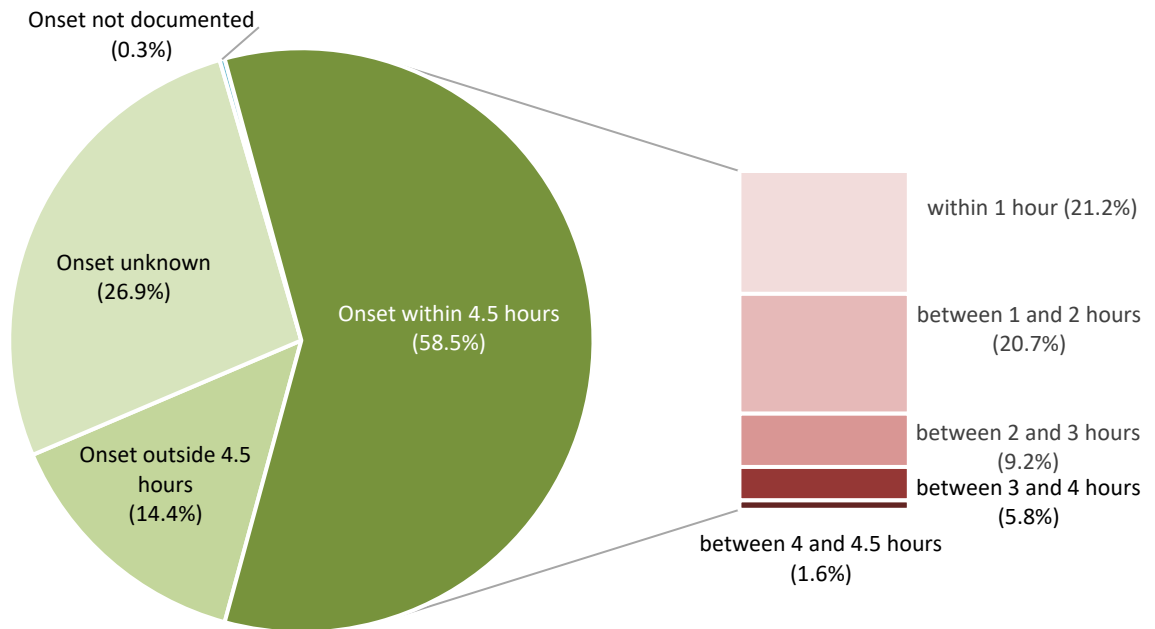

Figure 3: Onset of symptoms to leaving scene intervals

- The majority of stroke patients (**58.5%**) had a **symptom onset within 4.5 hours** of leaving the scene, making them potentially eligible for thrombolysis.
- Symptom onset could not be established for 26.9% of stroke patients. This was mostly due to patients waking up with a stroke or being unable to recall the time of onset.
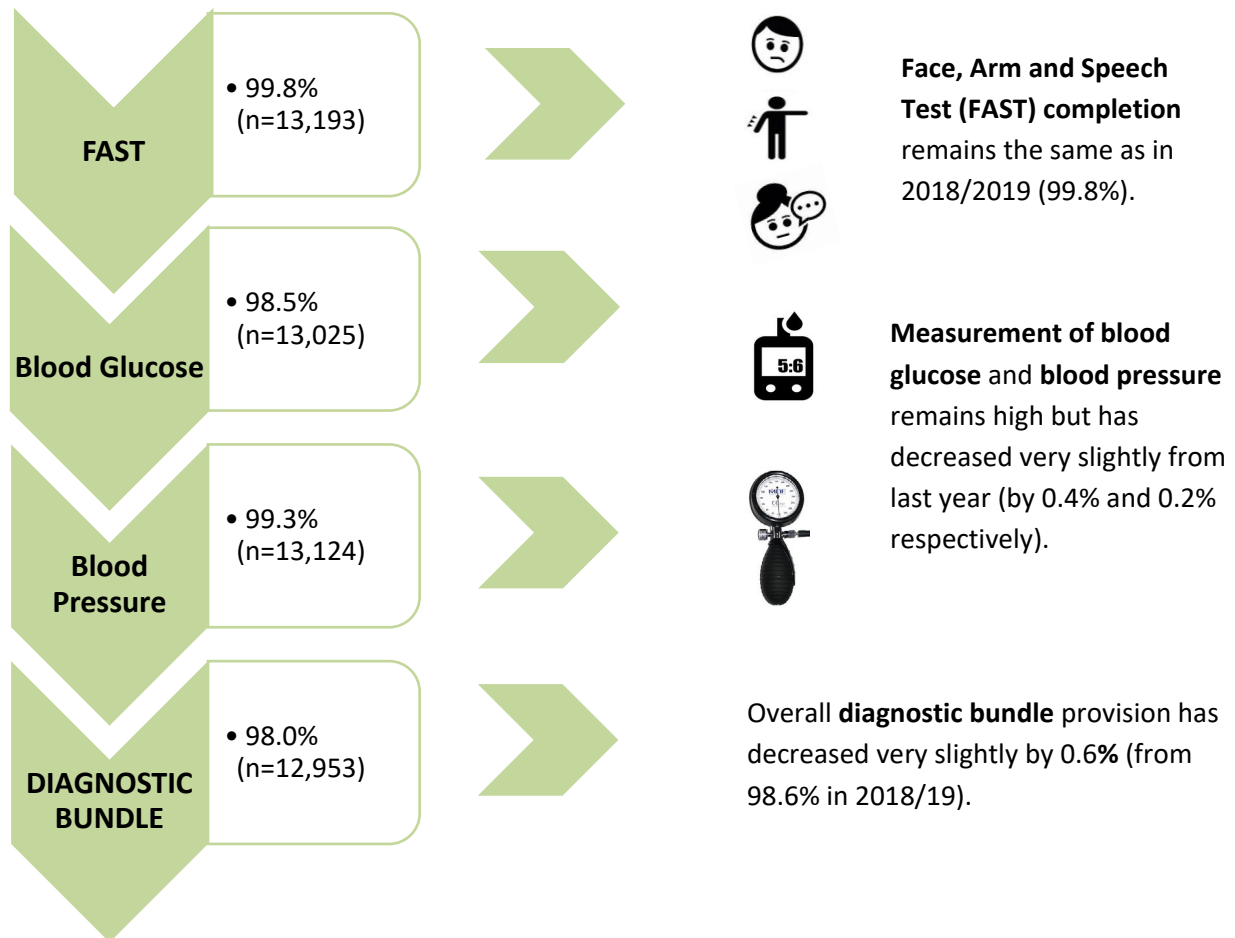
2.5 Diagnostic bundle compliance

FAST
- 99.8% (n=13,193)

Blood Glucose
- 98.5% (n=13,025)

Blood Pressure
- 99.3% (n=13,124)

DIAGNOSTIC BUNDLE
- 98.0% (n=12,953)

Face, Arm and Speech Test (FAST) completion remains the same as in 2018/2019 (99.8%).

Measurement of blood glucose and **blood pressure** remains high but has decreased very slightly from last year (by 0.4% and 0.2% respectively).

Overall **diagnostic bundle** provision has decreased very slightly by 0.6**%** (from 98.6% in 2018/19).

Figure 4: Diagnostic bundle administration

	April 2019 - February 2020	March 2020
Full diagnostic care bundle	12,027 (97.9%)	926 (98.1%)
FAST recorded	12,250 (99.8%)	923 (99.9%)
BP recorded	12,187 (99.3%)	937 (99.3%)
BM recorded	12,095 (98.5%)	930 (98.5%)

Table 4: Diagnostic bundle administration during the year

- The delivery of care was of an exceptionally high standard and was **not affected** by the COVID-19 pandemic **in March**.

2.6 Conveyance

Suspected stroke patients in London should be conveyed to a Hyper Acute Stroke Unit (HASU) for specialist care (with a prealert if symptom onset is within 4.5 hours at the point of leaving scene). In some instances, transport to an Emergency Department (ED) may be appropriate (e.g. if their condition is considered unstable by the LAS clinicians or a Health Care Professional has arranged admission).
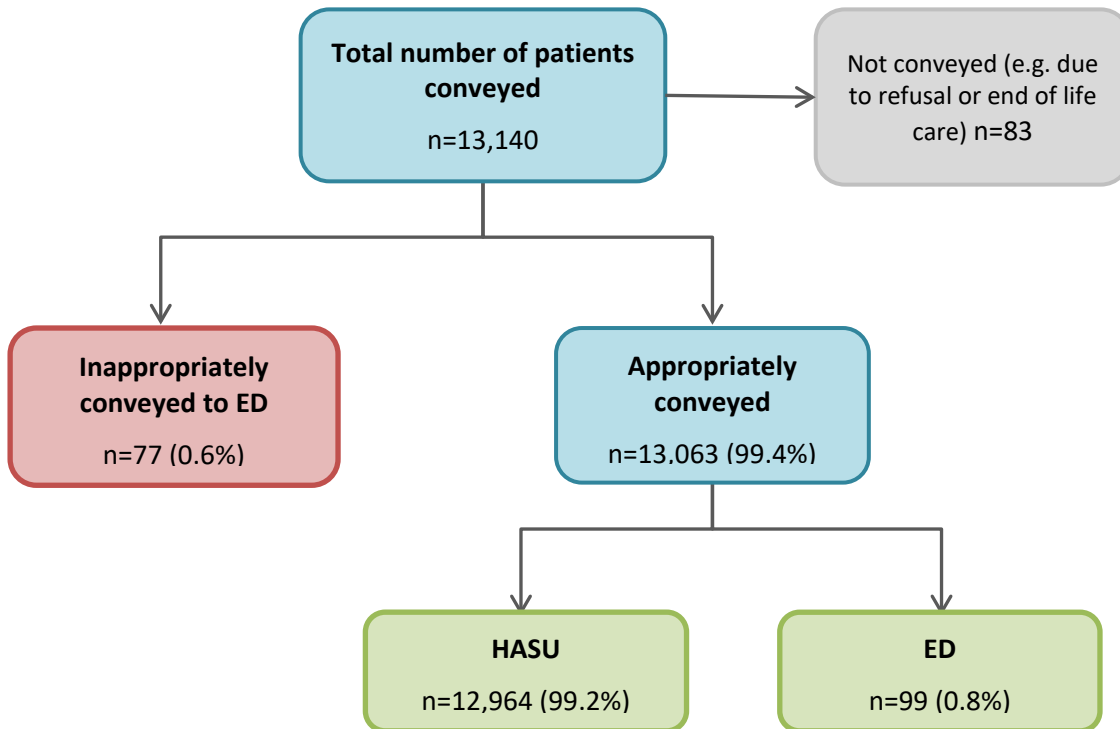
```
┌─────────────────────────┐          ┌──────────────────────┐
│ Total number of patients│          │ Not conveyed (e.g. due│
│         conveyed        │ ───────→ │ to refusal or end of  │
│                         │          │ life care) n=83       │
│        n=13,140         │          │                       │
└─────────────────────────┘          └──────────────────────┘

┌──────────────────┐            ┌──────────────────┐
│ Inappropriately  │            │  Appropriately   │
│ conveyed to ED   │            │    conveyed      │
│                  │            │                  │
│  n=77 (0.6%)     │            │ n=13.063 (99.4%) │
└──────────────────┘            └──────────────────┘

                    ┌──────────────────┐   ┌──────────────────┐
                    │      HASU        │   │       ED         │
                    │                  │   │                  │
                    │ n=12,964 (99.2%) │   │  n=99 (0.8%)     │
                    └──────────────────┘   └──────────────────┘
```

Figure 5: Patient destination

Destination	April 2019 - February 2020	March 2020
HASU	12,044 (98.7%)	920 (98.1%)
ED appropriately	88 (0.7%)	11 (1.2%)
ED inappropriately	70 (0.6%)	7 (0.7%)

Table 5: Patient destination during the year

- The vast majority of suspected stroke patients were conveyed to **the most appropriate destination** for their condition. This **did not change during March**.
- 99 patients were appropriately conveyed to an Emergency Department (ED), but 77 were not.
- **Hospital pre-alerts** were placed for **99%** (n=7,601) of patients who had symptom onset within 4.5hours.

2.7 Journey to HASU times

Destination		April 2019 - February 2020			March 2020		
		n^	Mean	Median	n^	Mean	Median
HASU	All HASU patients	12,041	17:55	15:26	918	18:36	16:07
	Symptoms onset ≤4.5 hrs*	7,154	15:15	13:55	510	15:06	14:06
ED	All ED patients	158	16:38	14:51	18	15:12	13:24
	Symptoms onset ≤4.5 hrs*	30	15:47	12:47	4	08:35	09:06

*^ Patients conveyed to HASUs outside London (n=5) are excluded from these figures. * Measured at the point of leaving scene.*

Table 6: Journey to HASU times (leaving scene – arrival at hospital) (mm:ss)

- The mean journey time to a **HASU** for those whose symptom onset was **within 4.5 hours** was **15 minutes**, which is consistent with last year's figures and remains well within the aspirational 30 minutes target set by the London Stroke Network. Journey times were slightly **shorter in March**.

- The mean journey time to hospital for patients who went to **ED** and had symptom onset **within 4.5 hours** was nearly **16 minutes** in April 2019 – February 2020, but less than **9 minutes** in **March** 2020 (although based on only 4 patients).

2.8 Total time – 999 call to arrival at HASU

Destination		April 2019 - February 2020			March 2020		
		n^†	Mean	Median	n^†	Mean	Median
HASU	All HASU patients	11,125	1:09:11	01:02:17	871	01:44:04	01:21:51
	Symptoms onset ≤4.5 hrs*	6,784	1:01:34	57:09	495	01:18:52	01:10:12

*^ Patients conveyed to HASUs outside London (n=5) are excluded from these figures. †Healthcare Professional admissions (n=968) are excluded from these figures. * Measured at the point of leaving scene.*

Table 7: Call to HASU times (hh:mm:ss)

- The mean overall 999 call to arrival at HASU was **1 minute slower** than last year for all patients as well as those whose symptom onset was 4.5 hours or less at the point of leaving the scene. Times were longer in March.

3 Summary

The findings of this report show that the LAS has continued to provide excellent care to stroke patients in London, with improvements seen on previous years. The LAS has continued to respond within aspirational targets, our clinicians have provided comprehensive assessments on-scene and ensured that nearly all patients received a rapid transport to the most appropriate destination for their condition. Furthermore, we can report that while our response times were negatively impacted by the COVID-19 pandemic, the delivery of care to our suspected stroke patients remained of an exceptionally high standard.

To ensure we continue to provide excellent care to our stroke patients we will continue to highlight instances where patients were not conveyed to an appropriate destination for investigation and feedback to staff. Details of all incidents where full stroke diagnostic bundles are not provided to the patient will continue to be shared with local management teams for feedback and on-going education. We will also continue to submit data to NHS England as part of the Ambulance Quality Indicators programme to enable benchmarking against other ambulance services across the country.

ST Elevation Myocardial Infarction Annual Report
April 2019 – March 2020

December 2020

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ londamb.Caru.Enquiries@nhs.net

Contents

STEMI Overview | 2019-20

3,415
Total number of
suspected STEMIs

25%
71 years*

75%
60 years*

* Mean average

46%
Anterior STEMI
on ECG

999 call to scene
20 minutes†

On scene
39 minutes†

Journey time
18 minutes

999 call to hospital
81 minutes

Care Bundle

✓ Aspirin
✓ GTN
✓ 2 Pain Assessments
✓ Analgesia

79%
Received full bundle or
had valid exceptions

92%
STEMIs confirmed at
hospital had pPCI

93%
Survived to leave hospital

131 minutes
999 call to catheter
insertion time

† Excluding March 2020

1   Introduction

This report presents information on the care provided by the London Ambulance Service NHS Trust (LAS) to patients with a suspected ST-Elevation Myocardial Infarction (STEMI) between 1st April 2019 and 31st March 2020.

Data were sourced from the LAS Acute Coronary Syndrome (ACS) registry, which combines information from LAS clinical and operational records as well as external sources, including national databases and hospital records. Where appropriate, in order to differentiate the impact of COVID-19, data are reported for the first 11 months of the year (April 2019 – February 2020) separately from March 2020 when the first peak of COVID-19 disrupted our response to patients.

2   Findings

2.1   Overview

3,415

Total number of suspected STEMIs

25%
71 years*

75%
60 years*

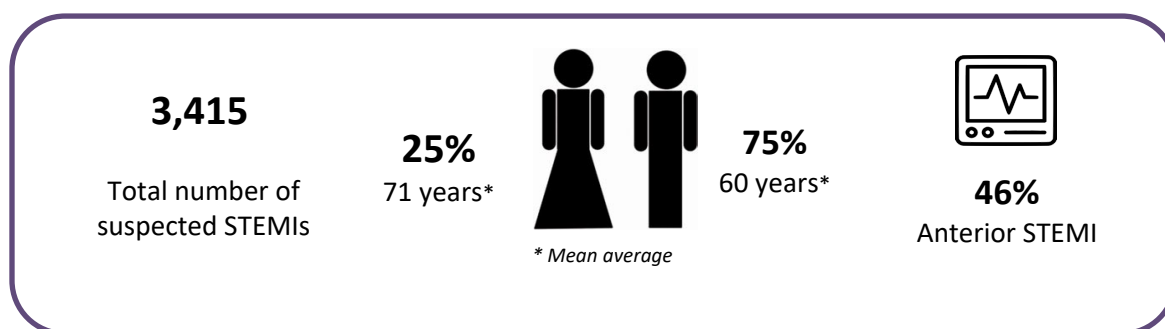* Mean average

46%
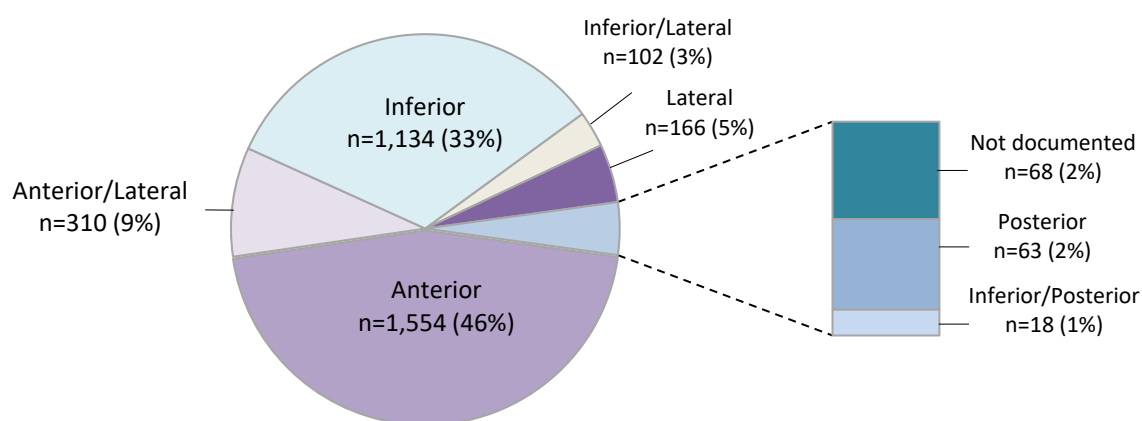Anterior STEMI
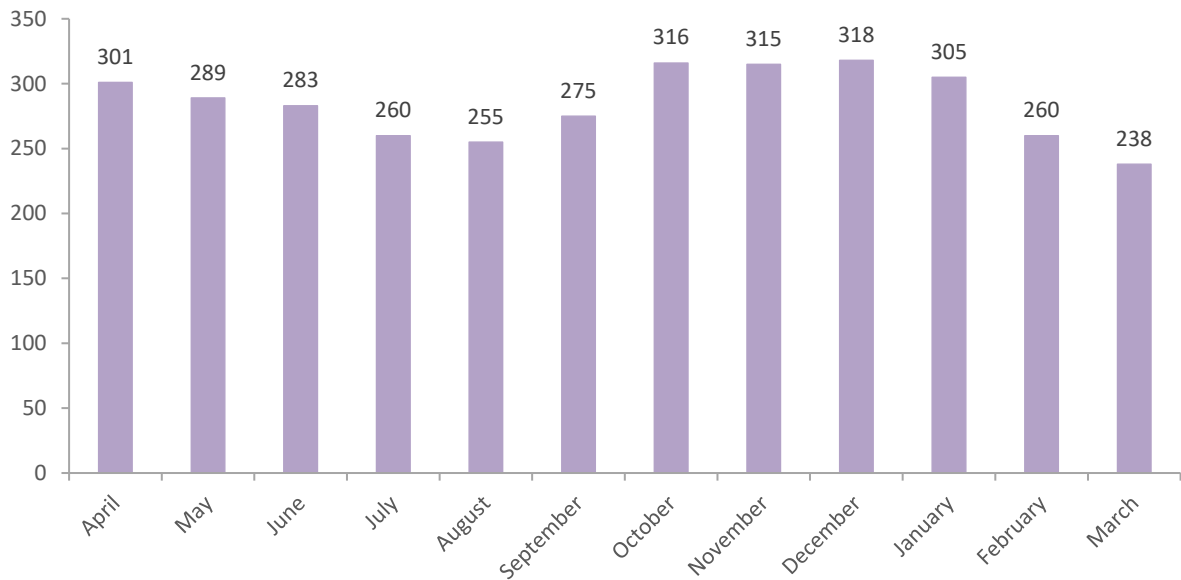
Figure 1: Patient overview

Figure 2: Location of infarct

- The majority of infarcts involved the anterior region of the heart, with 46% (n=1,554) affecting the anterior region alone, and a further 9% (n=310) also involving the lateral region.

Figure 3: Numbers of patients attended each month

- Numbers of STEMI patients peaked from October to December 2019, declining in the last quarter of the year, with **80 fewer patients** in **March** compared to December (238 vs 318).

2.2 Response information

We report two types of response interval:

1. Ambulance Response Programme (ARP) intervals (Table 1) – these are measured using 'Clock Start' and 'Clock Stop' as defined nationally by NHS England's Ambulance Quality Systems Indicators (https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/)

2. 999 call - arrival at scene (Table 2) - is an international definition for reporting the response interval of clinical significance and starts at the time the 999 call is connected to the ambulance service, ending when the first vehicle's wheels stop turning upon arrival at scene.

ARP response intervals will usually be shorter than '999 call – arrival at scene' due to differences in the start and end points used in both calculations, and also because the ARP 'Clock Start' time is reset when a call category is upgraded. ARP provides a measure of the system's response, whereas '999 call - arrival at scene' provides a picture of the response as experienced by the patient, but does not adjust for calls that come in initially as a lower priority and are subsequently upgraded.

Category	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Category 1	445 (14.0)	05:44	05:24	40 (16.8)	07:38	05:32
Category 2	2,572 (81.0)	18:49	14:11	185 (77.7)	51:42	29:57
Category 3	149 (4.7)	41:37	23:53	11 (4.6)	216:25	111:00
Category 4	5 (0.2)	54:56	49:29	0 (0.0)	-	-
Category 5	5 (0.2)	09:42	07:55	2 (0.8)	62:57	-
Overall	3,177^	18:06	12:33	238	52:00	25:24

^ *One incident was not allocated a call category, but is included in the overall figure in this table*

Table 1: ARP response intervals by call category (mm:ss)

Category	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Category 1	445 (14.0)	09:11	07:12	40 (16.8)	17:45	08:52
Category 2	2,572 (81.0)	20:43	16:09	185 (77.7)	55:34	30:37
Category 3	149 (4.7)	43:41	24:04	11 (4.6)	240:34	151:29
Category 4	5 (0.2)	58:17	54:22	0 (0.0)	-	-
Category 5	5 (0.2)	26:15	24:08	2 (0.8)	55:11	-
Overall	3,177^	20:17	15:01	238	57:45	26:11

^ *One incident was not allocated a call category, but is included in the overall figure in this table*

Table 2: '999 call – arrival at scene' response interval by call category (mm:ss)

- The majority of calls (**81%**) were allocated a Category 2 response.

- The mean ARP response interval between April 2019 and February 2020 was **18:06**, which **increased to 52 minutes in March** due to operational pressures associated with the COVID-19 pandemic (Table 1).

- The mean '999 call – arrival at scene' interval was **20:17**, which was also much higher in **March** at **57:45** (Table 2).

2.3 On-scene times

First vehicle on scene	April 2019 – February 2020			March 2020		
	n (%)	Mean	Median	n (%)	Mean	Median
Solo responder	661 (20.8)	47:28	43:40	55 (23.1)	55:42	45:01
Double-crewed ambulance	2,516 (79.2)	37:19	34:50	183 (76.9)	41:37	38:45
Overall	3,177	39:26	36:11	238	44:53	40:30

Table 3: On-scene times by first vehicle to arrive on scene
Reported as the time interval from the first vehicle arriving on scene to the transporting vehicle leaving scene

- Between April 2019 and February 2020, the first vehicle to arrive on scene was a double-crewed ambulance in **79%** of cases, which is consistent with last year.

- The overall mean on-scene time (from arrival of the first LAS vehicle) for the first 11 months of the year was **39:26**, which is similar to last year. This **increased** to **44:53 in March**.

2.4 STEMI patient care

2.4.1 Care bundle compliance

79%
Full care bundle (or valid exceptions)

Aspirin
98%

GTN
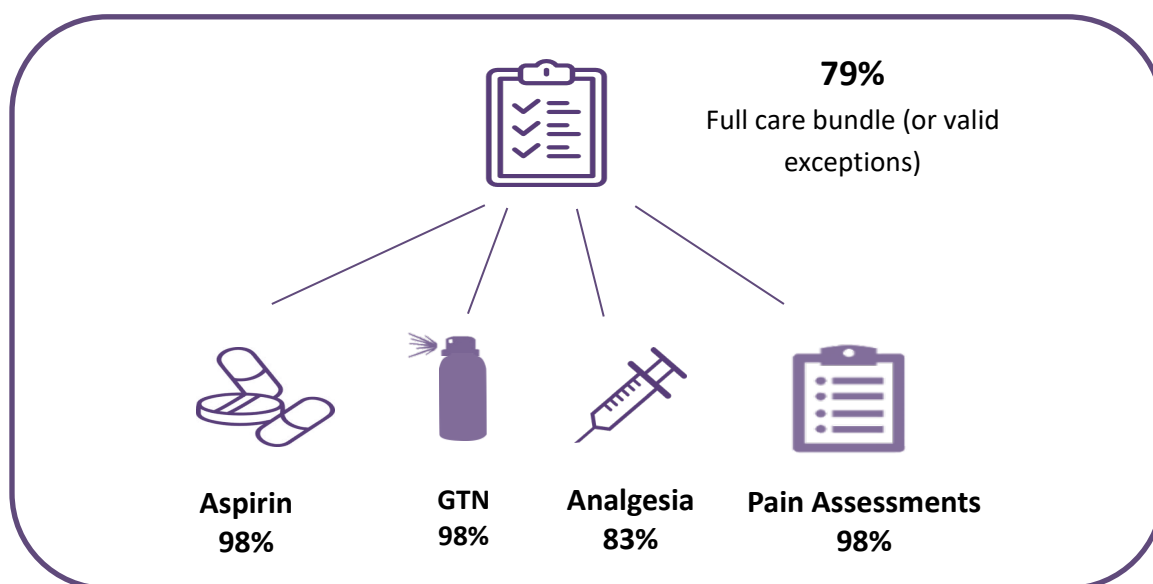98%

Analgesia
83%

Pain Assessments
98%

Figure 4: Compliance to the full care bundle and each individual element

- **79%** (n=2,701) of patients received a complete care bundle or had a valid exception - a **1% increase** from last year.

- Compliance was **98% for all individual elements**, with the exception of analgesia where compliance was **83%**, the same as in 2018/19.

- Overall care bundle compliance was **77%** in **March,** but this figure that varied month on month and was, in fact, lower in July 2019 at 73%.
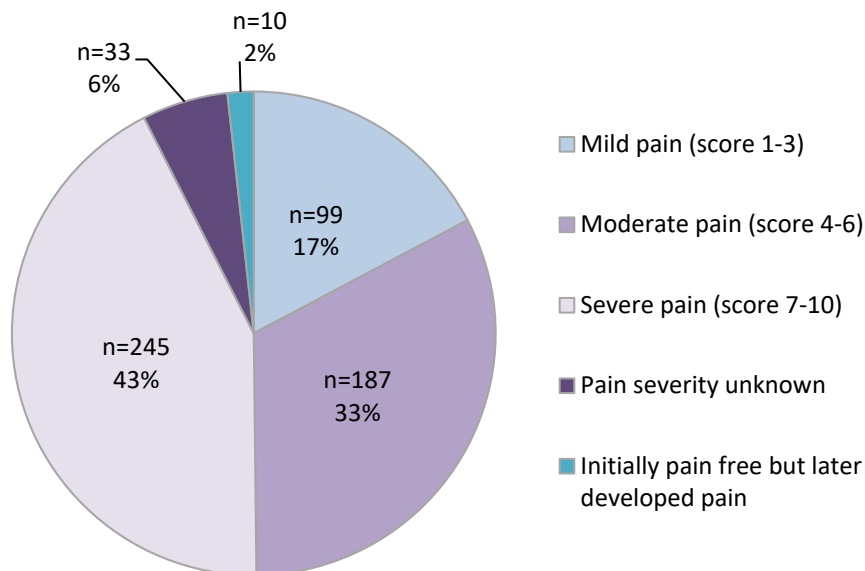
2.4.2 Patients who did not receive analgesia

Figure 5: Initial pain level of patients who did not receive analgesia as part of the STEMI care bundle

- **43%** (n=245) of the 574 patients who **did not receive analgesia** as part of the STEMI care bundle presented with **severe pain**.

- The administration of analgesia varied throughout the year, with the highest compliance in October 2019 (86.7%) and the lowest in July 2019 (78.5%). March saw the second lowest compliance level at 79.4%.
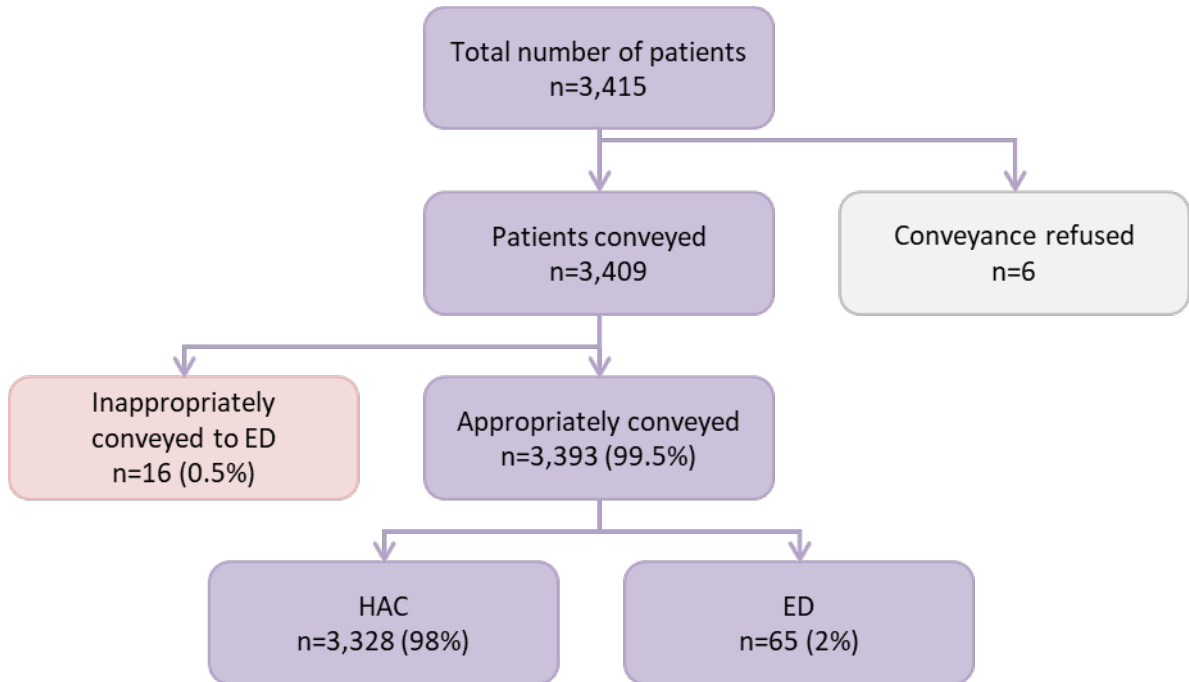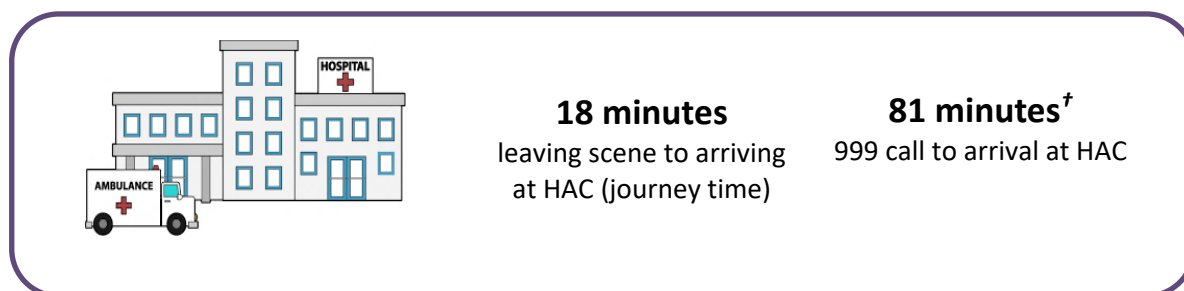
2.5   Conveyance

Figure 6: Patient destination

- Over **99%** of patients were conveyed to an **appropriate destination**, remaining consistent with previous years. This figure **did not change in March 2020.**

- 98% (n=3,328) of patients were transported to a Heart Attack Centre (HAC).

- In certain circumstances (such as an unmanageable airway, uncontrolled seizures, or a patient refusing to go to a HAC), it may be appropriate for the patient to be transported to the nearest Emergency Department (ED). 65 patients were appropriately conveyed to an ED, and 16 were not.

2.6   Journey and Call to HAC times

18 minutes
leaving scene to arriving at HAC (journey time)

81 minutes†
999 call to arrival at HAC

† *calculated from the time that the 999 call was connected to the Operator.*

Figure 7: Mean journey and call to hospital times for patients conveyed to HACs

- Mean journey times for patients conveyed directly to a HAC **remained at 18 minutes**, with a median of 17 minutes. Journey times **did not change during March 2020.**

- The overall mean average time from 999 call to arriving at a HAC increased by **4 minutes** from last year to 81 minutes (with a median time of 74 minutes).

- Between April 2019 and February 2020, the call to arrival at HAC interval was 78 minutes, which in **March 2020 increased to 120 minutes**.

2.7   Reperfusion and patient outcomes

1,175
Patients received pPCI treatment

131 (124) mins†
Average time from 999 call to catheter insertion
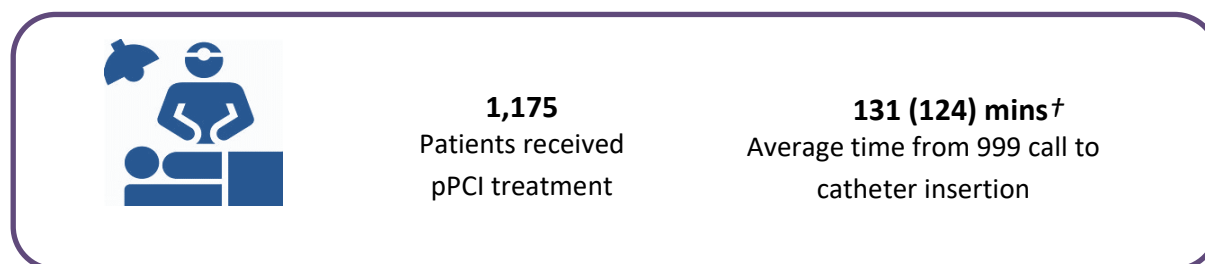
† *calculated from the time the 999 call was connected to the Operator; data available for 99% of casses*

Figure 8: Reperfusion

- The mean 999 call to catheter insertion time was 130 minutes between April 2019 and February 2020, this **increased** to **147 minutes in March 2020**.

- The overall figure for the year was **131 minutes**, which sits comfortably within the national target of 150 minutes.

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        ┌─────────────────────────────────────┐
        │  Suspected STEMI patients with      │
        │      outcome information available  │
        │             n=1,430                 │
        └─────────────────────────────────────┘
                    │
        ┌───────────────────────────────┐    ┌──────────────────────────┐
        │ Confirmed diagnosis of STEMI  │    │ Other/unknown diagnosis  │
        │        by hospital            │    │      n=151 (11%)         │
        │      n=1,279 (89%)            │    └──────────────────────────┘
        └───────────────────────────────┘
```

| Other reperfusion n=46 (4%) | pPCI n=1,175 (92%) | No reperfusion n=58 (4%) |

```
        ┌──────────────────────────┐
        │  Discharge data available│
        │     n=1,161 (99%)        │
        └──────────────────────────┘
```

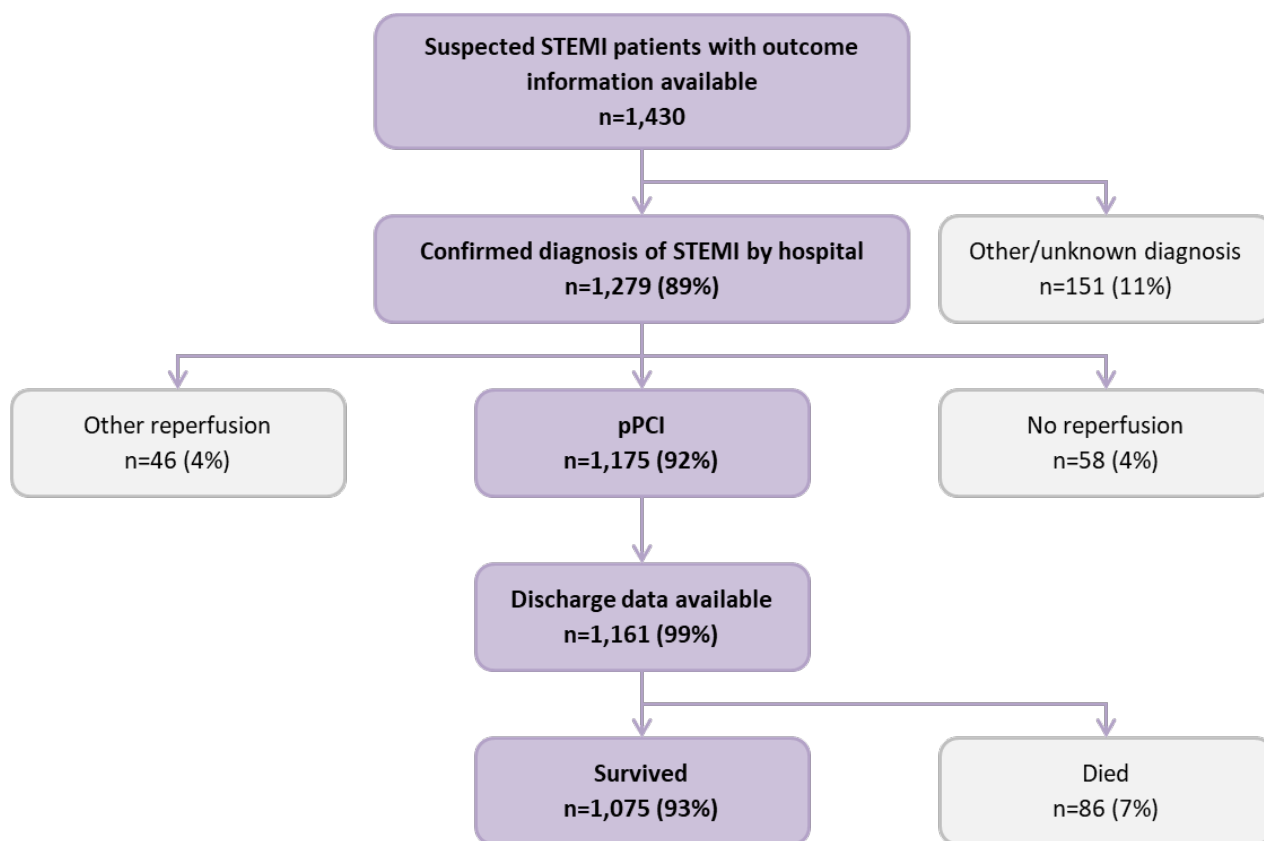| Survived n=1,075 (93%) | Died n=86 (7%) |

Figure 9: Outcomes for suspected STEMI patients

- Outcome information was available for 1,430 patients:
  - 89% of STEMI diagnoses were confirmed at hospital, an **increase of 11%** from last year
  - 92% of confirmed STEMI patients received pPCI treatment in hospital, an **increase of 3%** from last year
  - 93% of patients who received pPCI treatment were discharged from hospital alive, **1% more** than last year.

- There was **no significant change** to the outcomes of patients **during March** 2020 compared with the rest of the year.

3 Summary

The LAS continues to maintain a high standard of care with a rapid response and conveyance to specialist pathways for ongoing treatment, with the treatment delivered and patient outcomes not being negatively affected during March, despite the impact the COVID-19 pandemic had on response times. While pain assessment and treatment using aspirin and GTN remains high, the administration of analgesia requires improvement. To address this, we now provide feedback on incomplete care bundles to Sector Clinical Leads for individual staff feedback via CTMs where appropriate, and plan to increase our focus on any specific areas for which further improvement may be required. We continue to meet regularly with the London ACS Advisory Group to monitor care provided to STEMI

patients in London and to ensure optimum pathways and protocols are in place. We also continue to submit data to NHS England as part of the Ambulance Quality Indicators programme to enable benchmarking against other ambulance services across the country.

Report to:	Trust Board
Date of meeting:	26 January 2021
Report title:	Formal DHSC and NHSE&I Consultations
Agenda item:	For information only
Report Author(s):	Angela Flaherty, Deputy Director of Strategy
Presented by:	Ross Fullerton, Director of Strategy and Transformation
History:	n/a

Purpose:	☐ Assurance	☐ Approval
	☐ Discussion	☑ Noting

Key Points, Issues and Risks for the Board's attention:

There are currently two formal consultations underway:

1) **Transformation of urgent & emergency care: models of care and measurement**

   NHS England &Improvement's report sets out the final recommendations on the urgent and emergency care (UEC) standards from the Clinically-led Review of NHS Standards (CRS). The consultation proposes both new measures and a new approach to measuring them. We are developing a response from LAS and contributing to an AACE response. [Deadline 12th February]

   www.england.nhs.uk/clinically-led-review-nhs-access-standards/clinical-review-of-standards-consultation/

2) **Reforming the Mental Health Act**

   The Department of Health and Social Care (DHSC) has published a white paper with their full response to an independent review of the Mental Health Act. Recommendations were made for improving this legislation and the government is seeking views on proposed changes. The Trust will respond as part of a National Mental Health Leads group, which is chaired by LAS Mental Health Consultant Nurse, Carly Lynch. [Deadline 21st April]

   www.gov.uk/government/consultations/reforming-the-mental-health-act

Further detail is provided below. Responses will be developed and submitted in accordance with the timescales specified in the consultation documents.

Recommendation for the Board:

The Board is presented with this paper for information only.

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	

Summary of consultations

1) <u>**Transformation of urgent & emergency care: models of care and measurement**</u>

   - **What is changing?** - NHSE&I are seeking views on their proposal to change the current 4 hour access standard to a new 'bundle of standards' which measures performance across the whole system
   - **Consultation report** - sets out final recommendations on the urgent and emergency care (UEC) standards from the Clinically-led Review of NHS Standards (CRS)
   - **Learning from Covid-19** – the report also sets out how the proposed measures align with the strategy for transforming UEC provision, drawing on the learning from Covid-19 and building on the longstanding vision for the services
   - **Stakeholder engagement** - patients, clinicians and the public are invited to respond to these findings in a consultation. AACE and the College of Paramedics are responding on behalf of their members.

   Ambition of the reform
   - To strengthen the offer for patients, delivering improved access and outcomes
   - To address health inequalities and give a better experience of care
   - To introduce improved ways of accessing care online and on the phone - from NHS 111, at home from a paramedic, and providing booked time slots for care in an emergency department
   - To change the way that the urgent and emergency care system is both perceived and accessed by the patient
   - To drive the next step change in improvements in patient care and experience whilst helping to maintain Covid-secure ways of working

   Consultation period: 15 Dec 2020 - 12 Feb 2021

2) <u>**Reforming the Mental Health Act**</u>

   - **Background** -A package of wide ranging reforms has been set out in the Reforming the Mental Health Act white paper, which builds on the recommendations made by Sir Simon Wessely's Independent Review of the Mental Health Act (MHA) in 2018. The review made a series of recommendations to the Government to overhaul current outdated legislation which allows people with mental health problems to be held against their will ('sectioned') in certain circumstances.

   - **Co-production** – changes are based on 4 principles that have been developed with people with lived experience of the MHA:

1) **Choice and autonomy** – ensuring service users' views and choices are respected
2) **Least restriction** – ensuring the MHA's powers are used in the least restrictive way
3) **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the MHA
4) **The person as an individual** – ensuring patients are viewed and treated as individuals

- **Proposed changes** – these include:
  - Giving legal weight to people's choices and preferences about their care and treatment.
  - Choosing which family member or friend is given particular rights to be involved in their care.
  - Providing culturally appropriate advocacy and a wider range of support from advocates to better help people from a range of different ethnic and cultural backgrounds to express their thoughts and wishes about the care they receive.
  - More opportunities for tribunals to discharge people, scrutinise and make certain changes to their care.

- **Stakeholder engagement** – the government is seeking views on the proposed changes including from people who have been detained under the Mental Health Act

Consultation period: 13 Jan 2021 – 21 Apr 2021