



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

Tuesday 25 May 2021 at 9.30am – 12.30pm via video-conference

Agenda: Public session

Timing	Item	Owner	Status
9.30	1. Welcome and apologies	HL	Verbal
	2. Declarations of interest	All	Verbal
	3. Minutes of the public meeting held 30 March 2021	HL	Enclosed <i>Approval</i>
	4. Matters arising	HL	Enclosed
9.30	5. Report from the Chair	HL	Enclosed <i>Information Approval</i>
9.45	6. Report from the Chief Executive	GE	Enclosed <i>Assurance</i>
9.55	7. Report from the Chief Operating Officer	KM	Enclosed <i>Assurance</i>
Director and Board Committee Reports			
	8. <ul style="list-style-type: none"> Integrated Performance Report 		Enclosed <i>Information</i>
10.10	8.1. Quality and Clinical Care <ul style="list-style-type: none"> Directors Report (Quality) Directors Report (Clinical Care) Quality Assurance Committee meeting 	JMa FW MS	Enclosed <i>Assurance</i> Enclosed Enclosed
10.20	8.2. People and Culture <ul style="list-style-type: none"> Directors Report People and Culture Committee meeting 	KN JMe	Enclosed <i>Assurance</i> Enclosed
10.30	8.3. Finance & Audit <ul style="list-style-type: none"> Directors Report Finance & Investment Committee Audit Committee 	LB AK RP	Enclosed <i>Assurance</i> Enclosed Verbal
10.40	8.4. Logistics and Infrastructure <ul style="list-style-type: none"> Logistics and Infrastructure Committee Logistics and Infrastructure ToR 	SD SD	Enclosed <i>Assurance</i> Enclosed <i>Approval</i>
10.50	8.5. D999 Programme Assurance Group	SD	Verbal <i>Assurance</i>

Timing	Item	Owner	Status
11.00	8.6 LAS Patient and Public Council	AT	Enclosed <i>Assurance</i>
Governance Annual Reporting			
11.05	9. 9.1 Annual Report 9.2 Annual Governance Statement	GE	Enclosed <i>Approval</i>
11.25	10. Self-Certification of Compliance with Provider Licence	TB	Enclosed <i>Approval</i>
Finance			
11.35	11 Finance 11.1 Draft Annual Financial Account 11.2 M12 Finance Report	LB LB	Enclosed Enclosed <i>Approval Assurance</i>
Quality			
11.45	12 Annual Quality Account	JMa	Enclosed <i>Approval</i>
11.55	13 System Oversight Framework consultation – LAS Response	AF	Enclosed <i>Information/ Approval</i>
Risk			
12.05	14 Board Assurance Framework	TB	Enclosed <i>Approval</i>
Concluding Matters			
12.25	15. Any other business	HL	Verbal <i>Information</i>
12.30	Meeting close The Chair shall bring the meeting to a close and exclude representatives of the press and other members of the public having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).		
Additional reports, circulated for information only:			
<ul style="list-style-type: none"> • Corporate Risk Register • Quality Report • Freedom to speak up Annual Report • Patient Experiences Annual Report 			



TRUST BOARD: Public meeting – Tuesday 30 March 2021

DRAFT Minutes of the public meeting of the Board held on 30 March 2021 at 9.30am, via Video Conference

Present		
Name	Initials	Role
Heather Lawrence	HL	Chair
Jill Anderson	JA	Associate Non- Executive Director
Lorraine Bewes	LB	Chief Finance Officer
Karim Brohi	KB	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
Amit Khutti	AK	Non-Executive Director
John Martin	JMa	Chief Paramedic and Quality Officer
Jayne Mee	JM	Non-Executive Director
Khadir Meer	KM	Chief Operating Officer (items 1-7)
Rommel Pereira	RP	Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Fenella Wrigley	FW	Chief Medical Officer
In attendance		
Ross Fullerton	RF	Director of Strategy and Transformation
Kim Nurse	KN	Interim Director of People and Culture
Antony Tiernan	AT	Director of Communications and Engagement
James Stanton	JS	Head of Corporate Governance (Minute taker)
Apologies		
Syma Dawson	SDa	Director of Corporate Affairs

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 via YouTube and advised that a recording of the meeting would be available to view for several weeks on the site.
2. The Chair noted that apologies for absence had been received from Syma Dawson, Director of Corporate Affairs. Dr John Martin was welcomed to his first formal meeting of the Trust Board since his appointment as Chief Paramedic and Quality Officer.

Declarations of interest

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

Minutes of the meeting held in public on 26 January 2021

4. The minutes of the meeting held in public on 26 January 2021 were approved as an accurate record.

Matters Arising

5. The Board reviewed the action log and noted the updates provided in the paper. During a discussion of the action log, the following points were made:
 - NHS 111 Services – it was agreed that a discussion should take place with the Chair of the Audit Committee to agree the additional assurance required from a deep dive, noting that a review of finances had previously taken place. This action would be picked up by the Audit Committee and the outcome reported to the Board in due course. It was agreed that this should take place quickly to provide assurance of the maintenance of a viable service.

Action: KM and RP to discuss assurance to be brought to Audit Committee

- Integrated Performance Report – it was noted that the People and Culture Committee had agreed to send any further questions in writing. It was agreed that this be closed as a Board action.
- The LAS response to the NHS People plan, including appropriate engagement with staff and ownership by managers, would form part of the Resolution Framework to be considered as part of the agenda for the meeting. The action was closed.
- Integrated care systems consultation – it was confirmed that a response had been sent by the Trust and the action was closed.
- Clinical presentations to the Board – the format and timing of these presentations will be agreed by the Chief Medical Officer and the Chief Paramedic and Quality Officer.
- LAS Charity – A letter had been sent by the Chief Executive to Sean Ash to thank him for his achievement in raising over £80k for the LAS Charity. It was noted that Sean was continuing to raise funds and a further walk, to include the Chief Medical Officer, was planned over the roof of the Millennium Dome. The action was closed.
- Board Assurance Framework – It was noted that the BAF risks had been reviewed and would be considered as part of the main agenda. The action was closed.

Report from the Chair

6. The Chair's presented her report which provided an overview of meetings and events attended with internal and external stakeholders since the previous meeting of the Board in public.
7. The Board was advised of the progress which had been made in the appointment of a successor to Fergus Cass as a Non-Executive Director of the Trust. A recommendation has been made to NHS Appointments and it was anticipated that an announcement would be possible in the near future. The Chair advised that Amit Khutti, Non-Executive Director had agreed to chair the Finance Committee on an interim basis prior to a more complete review of assurance committee arrangements later in the year. It was noted that Amit Khutti had also accepted the role of Lead Non-Executive Director for Freedom to Speak Up.

8. The Board received an update on the Chair's meeting with staff and those issues which had been discussed as part of the new arrangements for the meetings of the Staff and Volunteer Advisory Group. The Chair advised that the first meeting had been three hours long and that she would like to keep flexibility in the meeting arrangements going forward. The Board was asked to approve changes to the schedule of meetings for the Staff and Volunteer Advisory Group.
9. The Chair informed the Board of the work which would be taking place to ensure that the Trust responded to the wider awareness of, and conversation on, the treatment of women, which had been stimulated by the murder of Sarah Everard. Sarah was a 33 year old woman, who had been abducted from a busy and well-lit area of the city, having walked home from a friend's house. Sarah's murder and the circumstances around it, had stimulated a wider awareness of, and conversation on, the treatment of women, including within the workplace. In a similar way to its response to the challenge of Black Lives Matter in 2020, the Service would be re-doubling its efforts to respond to the fact that some women may feel uncomfortable, threatened and discriminated against in the workplace.
10. The Chair, together with the Chief Executive, wanted to ensure that the Trust actively listens and ensure women's voices and concerns are heard. To start this process, the Chair would lead an initial series of informal drop in sessions for women across the Service to share their experiences, concerns, hopes, fears and aspirations for, and about, life within London Ambulance Service NHS Trust (LAS). This would then facilitate a Trust-wide 'big conversation' led by the Chief Executive so that all can better understand the issues and together make positive change.

Resolution:

The Board noted the paper and approved the changes to the schedule of meetings for the Staff and Volunteer Advisory Group.

Report from the Chief Executive

11. The Chief Executive presented his report and provided strategic update on the key activities and internal and external engagement by the Trust since the previous Board meeting.
12. The huge challenges which had been faced from the second wave of Covid and the steps which had been taken to enable the Service to respond really well to these were highlighted. Call handling capability had been significantly improved, as had vehicle availability. The ability to service ambulances fast enough to meet the exceptional demand levels had been a consistent challenge.
13. The Chief Executive formally recorded his thanks to all staff and volunteers for all their hard work in responding to the peak of the pandemic over winter. The London Fire Brigade and Metropolitan Police Service were also thanked for their support during this period. Service data showed that Category 1 response handling had peaked at just over seven minutes. It was important to note the level of performance set against the greatest challenge the NHS had ever faced. The 3,700 incidents recorded on New Year's Day was 500 more than had been received at the height of the first Covid peak. A National Day of Remembrance, marking a year since the first national Covid lockdown, had been marked in a moving ceremony held at Deptford ambulance station with the Leader of Opposition, Sir Kier Starmer, in attendance. The Trust had also received a visit from their Royal Highnesses The Duke and Duchess of Cambridge, who visited Newham Ambulance Station to thank staff and volunteers for their work throughout the pandemic.

14. The Executive Team had welcomed Dr John Martin, Chief Paramedic and Quality Officer and had appointed Damien McGuinness to become the Trust's new Director of People and Culture starting on 14 June 2021. Kim Nurse, the Interim Director of People and Culture, would be remaining with the Trust in an ongoing role as a strategic advisor for the Ambulance Operations Modernisation programme.
15. The Chief Executive also advised that the Welsh Ambulance Trust had joined the Association of Ambulance Chief Executives (AACE) and he looked forward to working with them on matters which the Trusts had in common.
16. The Board was advised that National Planning Guidance had been issued. The six priorities which had been set for the year ahead were:
 - Supporting the health and wellbeing of staff and taking action on recruitment and retention;
 - Delivering the NHS COVID vaccination programme and continuing to meet the need of patients with COVID-19;
 - Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services;
 - Expanding primary care capacity to improve access, local health outcomes and address health inequalities;
 - Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay; and
 - Working collaboratively across systems to deliver on these priorities.
17. The Trust would be approaching business planning in two parts, with the first six months based on a rollover of current financing arrangements. The second half of the financial year would be based on the usual business planning approach and work on this was noted to be ongoing.
18. In response to questions from Board Members, the Chief Executive advised that it was anticipated that the introduction of body worn cameras would both improve prosecution rates and act as a deterrent to reduce the number of assaults on ambulance crew. There was also noted to be the potential for learning and conflict resolution. The Chief Paramedic and Quality Officer advised that a review of conflict resolution training would take place and noted the importance of realistic scenarios in training. Learning from the patient interface and resolution scenarios could also have a role to play in considering the number of complaints received around communications. Complaint data would be considered in the context of surrounding years, noting that the statistics for the past year may not be representative due to the circumstances created by Covid. It was noted, however, that there had been an overall reduction in the number of complaints.

Resolution:

The Board noted the paper.

Report from the Chief Operating Officer

19. The Chief Operating Officer presented the paper. The Board was advised that the effect of the second wave of the pandemic had resulted in the most challenging month in the Trust's history. The impact of the second wave had meant that the level of service demand and incidents had risen above forecast levels until the resumption of the national lockdown.

20. The Board was advised of the steps which had been taken to protect staff welfare. In early February 2021, a gradual decline in demand had presented the Trust with an opportunity to offer staff respite from the intense operational pressure experienced during the second wave of the pandemic. The welfare and wellbeing of staff had been of particular focus during February and March 2021, specifically in ensuring that individuals had the opportunity to take annual leave.
21. Further planning activity was being undertaken to prepare the Trust for the easing of lockdown restrictions in line with the Government's four-step roadmap. The Trust was making preparations for expected levels of demand to gradually return from early March 2021 with the opening of workplaces and schools. The Trust's expectation was that levels of seasonal demand would resume by mid-June 2021.
22. In partnership with NHS England/Improvement, a series of after action reviews had been initiated which would reflect on the Trust's experience of the second Covid wave. This would include learning from the actions and internal decisions made by the Trust as well the system approach taken to respond to the pandemic.
23. In response to questions from Board Members, it was confirmed that work was continuing with NHSE/I in relation to developing a London plan for cohorting patients. This involved working through the reviews and lessons learnt, both within organisations and at system level, to develop an approach to minimise handover delays during any future wave. Board Members expressed their appreciation for the amount of work which had gone into delivering the service. Board Members acknowledged that there had been times during December 2020 and January 2021 when the Trust would have wanted to deliver better response times for Category 2 patients. Support was expressed for capturing the learning which would help to determine the level of capacity which would need to be built into the Trust's day to day operations, particularly in the context of developing the Workforce Plan. Clinical work was also taking place to ensure that patients were being directed to the emergency departments by ambulance on the right occasions. This would include the need for the Service to have direct access to treatment centres and integrated pathways with GPs.
24. The Trust Board noted that the four key areas of focus for 2021/22 would be:
 - Maintenance of resilience including deployment of surge responses;
 - The journey towards recovery and return to business as usual; Championing positive cultural improvements and responding to our staff; and
 - The refocus on strategic aims to continue to make rapid progress on the integration of 111/999, development of ambulance operations modernisation programme
 - Implementation of D999 programme.
25. The Chair noted the hard work which had been done to date and that there was likely to be more to come in the future.

Resolution:

The Board noted the paper.

Director and Board Committee Reports

- Integrated Performance Report

26. The latest Integrated Quality and Performance Report (IPR) was presented. This provided an Executive Summary for the Board and gave an organisational oversight of all key areas across the London Ambulance Service including Quality, Operations, Workforce and Finance.

27. It was noted that the IPR was based on data from January 2021 and that events had been moving at pace. The IPR was provided to the Board in the context of background supporting evidence to the assurance updates which would be given in each area from the Executive Directors and Board Assurance Committees.

Resolution:

The Board noted the Integrated Performance Report.

Quality and Clinical Care

- Director's Report (Quality)

28. The Trust Board received the first report presented by Dr John Martin, the recently appointed Chief Paramedic and Quality Officer. The report included a summary of recent directorate activity in respect of patient safety, safeguarding and quality assurance, utilising the Integrated Performance Report (IPR) and quality report for the January 2021 reporting period.
29. The Chief Paramedic and Quality Officer updated the Board on the work he had undertaken to visit different parts of the Service. This included visiting portfolio areas which had recently been added to the Quality and Assurance Directorate such as the 999 quality governance and continuous improvement teams.
30. The number of reported incidents remained positive, indicating a good reporting culture. As a Trust, there had been an increase in incidents graded moderate harm and above in December and January. This was associated with the second wave of Covid-19 and the corresponding significant increase in activity and demand.
31. Board Members noted the links between the issues raised in the area of quality and operational reporting in terms of Category 2 response times. The importance of ensuring high quality decisions to convey and promoting a wider public understanding of the particular role of the ambulance service and emergency departments in the healthcare system was discussed. The Chief Executive noted that the Trust's strategy was based on a 50% conveyance rate and that this was currently being achieved.

Action: JMa/GE to discuss putting public engagement around decisions to convey on the agenda of a future Patient and Public Forum.

32. In response to a question, the Chief Paramedic and Quality Officer advised on the work of the Quality and Continuous Improvement team in auditing calls and progressing opportunities for improvements. Call handling was noted to be an area which had featured as a factor in previous Serious Incident reporting and would be an area for further work.

Resolution:

The Board noted the Report.

- Director Report (Clinical Care)

33. The Chief Medical Officer updated the Trust Board on the work of the Clinical Care Directorate since the previous presentation in November 2020.
34. Work with the Integrated Care Systems (ICS) was highlighted including a number of projects on the development of improved models of care. These included the Clinical Directorate clinically supporting a pilot, in partnership with Primary Care Networks, of paramedics rotating between the ambulance service and primary care in preparation

for the role out of First Contact Practitioners. This would support paramedics to stay within the ambulance sector whilst enhancing their clinical knowledge.

35. Further to this support had been provided to manage the flow of patients into the Emergency Departments in order to ensure patients were taken to the right healthcare facility, the first time. These pathways, overseen by NHSE London, had been agreed between the ICS, LAS operations and LAS clinical, had been assessed as safe and had delivered better patient care. The work taking place around the Frailty Unit in Ilford was highlighted as an example where patients with frailties were able to get better care by being taken to a site which had a multi-disciplinary team to assess them. This helped these patients to access the right care packages and reduced the need for them to be admitted to hospital. The learning and benefits of these projects and pathways were being assessed and would inform future operational and clinical delivery models to ensure improved access and outcomes for all patients.
36. Engagement with regional and national stakeholders had strengthened throughout the Pandemic. LAS had worked closely with the national team around Covid at home pathways and had been integral in the rapid development of the Oximetry@Home pathway across London. The pathway was designed to provide a consistent clinical pathway to safely enable lower risk patients with COVID-19 to remain at home with systems in place to identify any deterioration in the condition at an early stage through oxygen saturation monitoring. Expansion of this methodology was been looked at to potentially include patients with chronic respiratory illness and Diabetes. These were patients with chronic conditions but who tended to understand their disease and for whom hospital admission was not always the best thing for them and preferred to be treated outside a hospital setting.
37. It was noted that there were some hospitals where the Service could not directly access the Urgent Treatment Centres and work was continuing with NHS England to ensure that this would be resolved.
38. The Clinical Audit and Research Unit (CARU) had continued to review the care provision for patients with cardiac arrest, ST- Elevation Myocardial Infarction and stroke. It was noted that it was likely that the Out of Hospital Cardiac Arrest data would now be reported at 30 days post admission rather than 6 months. This would enable improved data flow and enable improvements to care, whilst also enabling the long timeframe to continue to be followed in shadow form.
39. The Chief Medical Officer also updated on work which had been taking place with special care groups to embed pioneering services. This included work around the mental health car, shortlisted for a Health Service Journal award, the embedding of End of Life Care team and the identification of high risk maternity patients and those at risk of Covid.
40. The work on maternity had been recognised in a national visit from NHS England's Chief Midwife in March 2021. The Chair joined the Chief Medical Officer in recognising the achievement of the Trust's consultant midwife, Amanda Mansfield, in being awarded a Gold award for exceptional achievements and contribution from a career in midwifery. The Chair also noted how impressed the NHS England team had been by both paramedics and call handlers, who dealt with often very difficult maternity cases, during their visit. The learning which the Trust had taken from listening to patient experiences had helped to guide its maternity service and this, in turn, had been shared with other ambulance Trusts.
41. The Chair updated the Board on work which had been taking place at the ICS level on how primary care might work more with GPs about Hospital at Home. Support was expressed for the way which the Trust's work had met the national priorities. The Chair also welcomed the additional focus on clinical care in the Board's papers.

Resolution:

The Board noted the Report.

- **Quality Assurance Committee**

42. The Chair of the Quality Assurance Committee presented a report of the most recent meeting of the Committee. The number of Metropolitan Police Controlled Drug Liaison Officers had been reduced and this had been reflected in a reprioritisation of their activity. This had not affected their work with the Trust to date, however the Chair of the Committee would be writing to recognise the value of their activity to the Trust and concerns about the impact that this cut might have in the support available.

Resolution:

The Board noted the Report.

People and Culture

- **Directors Report**

43. The Interim Director of People and Culture updated the Board on the work of the People and Culture Directorate. It was noted that work continued on the approved 18 Month Strategy and focussing on the strategic themes, including responses to the NHS National People Plan, national Workforce Race Equality Standards and Workforce Disability Equality Standards and the key deliverables in the Trust Business Plan. Work also included measures to protect staff welfare during Covid, such as 1-1 wellbeing conversations, and work to address the length of disciplinary and grievance processed (the proposed Resolution Framework was to be considered later in the meeting).
44. The Board noted the update on the results of the annual NHS staff survey. 72% (4,427) of Trust staff completed the survey in 2020, compared to 71% (4,215) in 2019. Despite the restrictions during the pandemic, an increasing number of staff had been willing to participate in this survey year on year. The London Ambulance Service was noted to be the second highest scoring ambulance trust in terms of response rate.
45. The Board discussed the proposals for finding additional staff over the coming year, noting the challenges faced in terms of Covid and visas. It was acknowledged that a substantial amount of further work was required to meet the existing projected need. Following a discussion about the potential for international recruitment from countries such as Australia, Namibia and New Zealand, the Chair advised of particular concerns which had been raised with her with regard to the visa situation.
46. During a consultative meeting of the Staff and Volunteer Panel, members of staff had raised concerns about the impact of Covid on international recruitment and retention, citing Australia in particular. Several members of international staff had expressed an interest in returning to their home country and advised that the restrictions placed on working visas, ie allowing only one month out of the UK without needing to reapply, would mean that many would be unlikely to return. Staff had suggested that a 'sabbatical' type arrangement of three months would allow them to return home, recover and return more easily. The Chief Paramedic and Quality Officer confirmed that the current visa requirements prevented this arrangement and that change would be required at a government level. It was agreed that such an allowance to reflect the extraordinary contribution of staff during Covid and to encourage retention was desirable however the window to implement such a change was challenging.

Action: GE to raise visa issue at national level as a matter of priority.

47. The Board discussed how workforce planning issues would be addressed. It was noted that the People and Culture Committee received regular updates on the risks and mitigations involved in delivering the workforce plan, however other Board Members might not be as sighted on the details. The links between the operating model and the workforce plan were noted and it was agreed that it would be useful to have a more in depth discussion on the details. This could also include developments such as the resilience of non-frontline staff and the processes in place for new ways of working (including taking calls from home).

Action: KM and KN (and involving the newly appointed Director of People and Culture if possible) to organise briefing session on workforce, including the staff survey, for Non-Executive Directors (particularly those who were not members of the People and Culture Committee).

Resolution:

The Board noted the Report.

- People and Culture Committee

48. The Chair of the People and Committee presented a report of the most recent meeting of the Committee.
49. An update on immunisations had been provided as part of the Chief Medical Officer's report. It was the Trust's responsibility to ensure that all staff were immunised in line with Green Book requirements. It had previously been identified that there were significant gaps that needed be addressed and that this represented a significant risk to the health and safety of staff. It was noted that a paper was being drafted which would propose options available to resolve the position and that this would be presented to the Executive Committee for consideration. Members were supportive of the proposals and requested that further update was provided to the May People and Culture Committee or sooner via correspondence if possible.
50. A further update was provided in relation to the procurement of an Occupational Health provider. It was noted that the Interim Director of People and Culture had interviewed a potential occupational health specialist since the date of the previous Committee meeting and that work was ongoing to bring them into the organisation to provide expert support.
51. Board Members advised that it was important to understand how performance would be monitored in between staff surveys.

Resolution:

The Board noted the Report.

Finance and Audit

- Directors Report

52. The Chief Finance Officer presented an update on the Trust's Month 10 Finance position and drew the Board's attention to changes since the previously reported position. Month 10 had seen a stand down of some additional resilience and access to contingency. The Trust had agreed a further allowable deviation from its control total in M11 as part of the North West London (NWL) system forecast. The planned £2.3m surplus had seen movement in two areas. A figure of £3.6m had been set in relation to the accrual of staff leave during the Covid pandemic and a national settlement of £2.6m had been agreed in relation to overtime arising from the Flowers case. This

would move the full year outturn to a £3.7m deficit and was an agreed position with NWL and NHSE/I.

53. The CRL had been increased to include NHS Digital funding for technology investments such as iPads. This was noted to be one of the most challenging areas for delivery against the financial plan. Many of the capital works had been backloaded towards the end of the year and Covid restrictions had impacted on the ability of surveyors and others to carry out work. Despite these challenges, a £2m underspend was forecast in line with the plan.

Resolution:

The Board noted the Report.

- Finance and Investment Committee

54. The Chair of the Finance and Investment Committee presented a report of the February and March meetings of the Committee.
55. In respect of the March meeting, the Committee had been presented with the Finance Plan for the first half of 2021/22 and financial assumptions for the second half of the year. It had noted that the NHS was still waiting for national guidance for the second half of the financial year and so a full-year budget and plan could not yet be set. The Committee had supported the immediate implementation of cost improvement plans and that work continue to identify resilient and affordable levels of staffing.
56. Proposed changes to the Hub 1 business case were discussed and assurance was provided that the selected location was the best option. The Committee Chair noted that the Committee had also recognised the importance of ensuring that the Trust had access to the right subject matter experts to advise it on its future plans.
57. The Finance and Investment Committee had recommended the following items on the agenda to the Board for approval:
 - The statement of comprehensive income (SOCl), statement of financial position (SOFP) and cash flow for the half year April-September 2021/22 to allow budgets to be issued by 01 April 2021;
 - The Make Ready Business Case;
 - A revised overall financial envelope for the Hub 1 business case and presentation of the anticipated final specification; and
 - Acceptance of BAF risk 61 Financial sub risk score reduction to 5 (5 x 1) due to the mitigations in place to secure the funding required.

Resolution:

The Board noted the report and recommendations.

- Audit Committee

58. The Chair of the Audit Committee presented a report of the most recent meeting of the Committee. It was noted that, following a year of unprecedented pandemic uncertainty and acceleration of the Trust's transformation agenda, the Audit Committee had recommended the completion of an assurance mapping exercise and a review of the effectiveness of the three lines of defence model. The Committee Chair advised that the results would be brought back in due course and would be tied into governance changes to take place later in the year. This would strengthen the existing assurance framework, including the Board Assurance Framework which had been recognised as providing 'significant assurance' in a recent review by Internal Audit.

59. The Chair of the Audit Committee advised that, in the context of the integrated IUC strategy, the Committee would be looking to give consideration to the growth of 111 capacity. This growth had been due in part to ICS demand and further exacerbated by Covid pressures. It had been agreed to look at the finances in place around the 111 service and the Chair advised that the Board would welcome a timely outcome of that piece of work.

Resolution:

The Board noted the report.

Logistics and Infrastructure

- Logistics and Infrastructure Committee

60. The Chair of the Logistic and Infrastructure Committee presented a report of the most recent meeting of the Committee and noted that the Make Ready retender had been recommended to the Trust Board for approval.
61. A holistic, Trust wide approach to capturing benefits and benefit realisation was under development. The Committee would keep a watching brief on this programme and would receive an update at its next meeting. Substantial improvements were noted in statutory compliance performance, particularly in Estates. The Committee had also considered an update on the cyber technology remediation programme and data assets, noting good progress and the need for further work to ensure that cyber awareness was embedded across the Trust. An update on the People, Values and Behaviours programme which set out the work to improve culture and leadership for Fleet, Estates and Logistics had also been discussed. The work involved had been commended and recommended to the People & Culture Committee.

Resolution:

The Board noted the report.

D999 Programme Assurance Group

62. The Chair of the D999 Programme Assurance presented a report of the most recent meeting of the Group.
63. Independent reviews and assurance had been conducted by PwC and had reported that very good governance was in place. Three actions had been identified and addressed. It was noted that good progress had been made since ePCR had gone live in November 2020. The drive to increase adoption had been temporarily placed on hold due to Covid. Adoption rates had since begun to rise again and had been reported at 64%. Full adoption was expected by the end of April 2021.
64. The Committee Chair advised that progress with the Computer Aided Dispatch (CAD) system had been slowed to cope with pressures during the recent Covid wave. A reset plan had been developed which proposed a new 'go live' date of November 2021. The proximity of the proposed launch date to the Winter Flu season was discussed. It was noted that the launch of CAD would only proceed if it successfully passed through the gated assurance process of feasibility reviews due in June and September. The implementation period for CAD would be considered as part of this process.

Action: An integrated change roadmap across the different portfolio areas of change to be developed in consultation with the People and Culture Committee.

Resolution:

The Board noted the report.

Finance

Financial Plan update 2021/22

65. The Chief Finance Officer presented an update on the Finance Plan. The Board was asked to consider the update provided on business and financial planning for 2021/22 and approve the Statement of Comprehensive Income (SOCl), Statement of Financial Position (SOFP) and cash flow for H1 to allow budgets to be issued by 1 April 2021. The Finance and Investment Committee had considered the paper and had recommended approval by the Trust Board.
66. National planning guidance had recently been published for 2021/22. The Chief Finance Officer noted that the guidance had been broadly in line with the assumptions made in the paper and so the proposed financial envelope was recommended for approval.
67. The plan had been developed for the first six months of the year (H1) which the Board was asked to approve to ensure that budgets could be issued in April 2021. The envelope for the first six months of the year was £268m. The Plan set out proposals for a break even position which would enable the Trust to carry on with a rollover of existing planning.
68. Work would take place with NWL at the system level to complete the plan and submit the return by early June 2021. A process would be in place to deliver the internally generated capital requirement. The Board discussed the arrangements for capital spending in 2020/21 and the potential impact on the 2021/22 budget. It was confirmed that the total capital programme would be provided in year with the agreement of the NWL system. Work was noted to be ongoing to validate cost pressures and include in the plan for submission.
69. The Chair noted the importance of the Executive Directors ensuring that Cost Improvement Plans were delivering and that the Trust must not finish the year with a deficit. The Chief Finance Officer advised that the financial plans had been worked up well and represented a better position than in previous years.

Action: Executive Committee to provide Board Members with details of Cost Improvement Plans (CIPs).

Resolutions:

The Board:

- Noted the business and financial planning update for 2021/22; and
- Approved the SOCl, SOFP and cash flow for H1 to allow budgets to be issued by 1 April 2021.

M11 Finance Report

70. The Board received an update on the financial position for the Trust as at 28 February 2021 (month 11).
71. The Board was asked to note the key points including a Year to Date deficit of £5.7m as at 28 February 2021. The current forecast was for a £3.7m deficit (£6m deficit against £2.4m plan surplus). As discussed earlier in the meeting, this represented an allowable deterioration in outturn due to increased annual leave remaining compared to 2019/20 outturn (£3.6m) and the write back of CCG income included in 2019/20

following recent guidance from NHSE/I on how annual leave payments would be managed. The only residual risk to the forecast outturn was noted to be higher than planned Covid 19 costs in relation to the most recent surge.

Resolution:

The Board noted the financial position and forecast outturn for the Trust for the period ending 28 February 2021.

Quality

Quality Account and Quality Priorities

[This item was deferred to a future meeting].

People and Culture

Resolution Framework

72. The Interim Director of People and Culture presented the Trust's proposed Resolution Framework. This would replace traditional Grievance, Dignity at Work and Disciplinary policies and sought to mirror the values of the organisation by ensuring that adult conversations took place to resolve issues at the earliest opportunity. The Resolution Framework offered a timely, supportive and proactive approach for resolving workplace issues and was designed to secure constructive and lasting outcomes.
73. The LAS Resolution Framework incorporates both informal and formal resolution processes, although greater emphasis is given to informal remedies or what is referred within this document as early resolution. Employees must continue to act in accordance with the values and behaviours of the Trust policies, national standards of professionalism and clinical practice from any relevant body.
74. The Resolution Framework had been considered and endorsed by both the People and Culture Committee and the Executive Committee. The importance of training and staff representatives to the success of the new policy was noted and training would begin in April 2021. Resolution advocates would be trained as part of the roll out of the new system. The appeal process would be conducted in house and those involved in the current disciplinary or grievance processes would be asked to transfer to the new approach. In response to a question, it was clarified that, where a member of staff was unable to attend work, they would be offered the opportunity to use the resolution process subject to them being well enough.
75. The Board discussed the role of Non-Executive Directors in the Resolution Framework and, in particular, their role in matters relating to Executive Directors. It was agreed that this would be made clearer in the guidance.

Action: KN to clarify guidance around NED involvement as part of the Resolution Framework.

76. Board Members welcomed the framework and advised that they looked forward to a large reduction in grievance and disciplinary related cases.

Resolution:

The Board approved the Resolution Framework for implementation.

Governance and Risk

Board Assurance Framework

77. The Chief Executive presented the Board Assurance Framework (BAF). It was noted that the headline picture presented by the BAF was in relation to the decline in Covid related risks from their recent peak. The strategic risks around Covid 19 had risen during the second pandemic peak over winter and had since been seen to be coming back down. This had helped the Trust to close the assurance gap between its risk appetite and the unique scale of the strategic challenge faced by the initial waves of the pandemic.
78. Following a request at the previous Board meeting, BAF risks had been reviewed in relation to workforce / training, finance / innovation and the Ambulance Operations Modernisation Programme with the relevant directors. This work was noted to be ongoing to ensure that the BAF not only appropriately captured current strategic risks, but was also fit for the future and supported the Board with the required levels of assurance as the Trust continues to meet the challenges faced by Covid 19 and progresses its transformation agenda.

Resolution:

The Board:

- Noted the current position of BAF risks;
- Agreed the recommended changes in risk ratings, as endorsed by the Board Assurance Committees;
- Requested that the Executive Committee consider the timeline and milestones that would need to be met going forward for the incorporation of the Covid related risks into ongoing strategic risks and report back to the Trust Board at a future meeting; and
- Noted that Executive Directors continue to develop the Trust's approach to transformation programme risks and governance and that proposals would be brought to a future meeting.

Any Other Business

79. There was no other business raised.

Additional Reports

80. The Board received the following additional reports for information only:
 - Corporate Risk Register
 - Quality Report
 - Register of the Seal

Meeting Close

81. The Chair and Board Members reviewed the meeting. The Trust's Executive was reported to feel both supported and sufficiently challenged from the discussion.
82. The Chair noted that the meeting had considered the busiest periods in the history of the Trust and commended teams on their hard work. The Trust would need to continue to build on its level of resilience and ensure that assurance was in place for the challenges ahead.

83. The Chair brought the meeting in public to a close and it was resolved to exclude representatives of the press and other members of the public having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

The next Trust Board meeting in public will take place on 25 May 2021.

DRAFT

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	Comments / updates <i>(i.e. why action is not resolved / completed)</i>
NHS 111 services	KM to hold deep dive on NHS 111 services. Updated action 30/3/21 - KM and RP to discuss assurance to be brought to Audit Committee	Khadir Meer	02/11/2020	25/05/2021	A briefing on IUC services was discussion at FIC on 13 May, members noted <ul style="list-style-type: none"> • The developments made in the 111 service over the past few years • The direction of travel for Integrated Patient Care, in particular the expansion of the LAS 111 service and further integration with the 999 service • The potential savings from across the system from 999 integration and 111 service expansion • The proposed steps to review the 111 internal processes, controls and associated finances; this may be done through the Lean Methodology through an external provider who knows and understands the LAS IUC service
Clinical presentation to Board	FW to arrange for clinical presentations to the Board, similar to the Quality presentation at this meeting, in future	Fenella Wrigley	26/01/2021	25/05/2021	Following discussion with the Chair on the format this should take, the Chief Medical and Chief Quality and Paramedic Officers will take appropriate action and ensure attendance is identified when suitable
Director's Report (Quality)	JM/GE to discuss putting public engagement around conveyancing decisions on the agenda of a future Patient and Public Forum.	JMa GE	30/03/2021	25/05/2021	Verbal update to be provided
International staff working visas	GE to raise visa issue (making it easier to return to UK after longer stay in home country) at national level as a matter of priority.	GE	30/03/2021	25/05/2021	Home Office contacted and awaiting a response from policy team. Guidance on COVID-19 - worker and temporary worker sponsors provides that sponsorship does not need to be withdrawn if an employee is absent from work without pay for more than 4 because of personal reasons due to COVID.

Ref.	Action	Owner	Date raised	Date due	Comments / updates <i>(i.e. why action is not resolved / completed)</i>
Board briefing session on workforce	KM and KN (and involving the newly appointed Director of People and Culture if possible) to organise briefing session on workforce, including the staff survey, for Non-Executive Directors (particularly those who were not members of the People and Culture Committee).	KM KN	30/03/2021	25/05/2021	Under the revised arrangements for Trust's transformation portfolio, the executive sponsor for the Workforce Development Programme has transferred to the Chief Paramedic and Quality Officer who may be better placed to jointly lead workforce discussions with the Dir of P&C going forward.
D999 / Change roadmap	An integrated change roadmap across the different portfolio areas of change to be developed in consultation with the People and Culture Committee	TBC	30/03/2021	25/05/2021	Although no named lead, I understand this will be led by the strategy team under the revised arrangements for Trust's transformation portfolio
CIPs	Executive Committee to provide Board Members with details of Cost Improvement Plans (CIPs).	ExCo LB	30/03/2021	25/05/2021	This information was circulated by correspondence 04.05.2021
Resolution Framework	KN to clarify guidance around NED involvement as part of the Resolution Framework.	KN	30/03/2021	25/05/2021	Verbal update to be provided



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Report from the Chair			
Agenda item:	5			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
The Chair's report provides an overview of meetings and events attended with external/internal stakeholders of the Service since the last time the Board convened.				
Recommendation(s) / Decisions for the Board / Committee:				
The Board is asked to note this report.				

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

Report from the Chair

Internal Meetings

1. Board development

- 1.1. On the 27 April we held a Board development session facilitated by Mike Farrar CBE (leads prior SHA Chief Executive and leads non-executive development for Price Waterhouse Coopers) which set out the context in which we are working in relation to the White Paper and the formation of Integrated Healthcare Systems, the concept of Provider Collaboratives and the concept of Place.
- 1.2. The purpose of the session was to arrive at a shared understanding of the Ambulance Operations Modernisation business case and how the Executives' six transformation programmes would enable us to deliver the trust strategy whilst also transforming our service.
- 1.3. It was agreed that the three strategic aims remained relevant:-
 - 1.3.1. 1) Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
 - 1.3.2. 2) A world-class urgent and emergency response with enhanced treatment at scene, and for critically ill patients, a faster conveyance to hospital
 - 1.3.3. 3) Collaborate with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services
- 1.4. The transformation programmes were discussed in the context of the digital agenda, capacity and capability and good governance.
- 1.5. The Ambulance Operations Model (AOM) business case was determined as a proof of concept, direction setting out how modernisation of fleet and vehicles will lead to modernisation and efficiencies within the LAS and the health economy. Given the constraints on capital we agreed to seek alternative sources of funding such as those available through Digital and the Green agenda.
- 1.6. We focused our attention and initial action to be taken forward as:
 - 1.6.1. The importance of co-production with staff, and describing the staff offer
 - 1.6.2. The interdependencies of existing projects underway and our capacity and capability to deliver them whilst delivering business as usual and how we monitor this
 - 1.6.3. A strategy refresh setting out a framework that pulls across priorities and sequencing in particular where AOM is in this.
- 1.7. Each of these strands of work were allocated to small task and finish groups of combined NED and Executive input.
- 1.8. This work will be taken forward and reported back initially through the June Board Development session.

2. Staff and Volunteer Chairs' Advisory Group

2.1. We continue to have productive dialogue about the issues that staff face on a day by day basis. The last meeting started with some positive feedback from staff who were grateful for the Wellbeing Day. Most of the issues relate to perceived fairness, equity, culture and transparency. To my mind these issues have direct relevance to our staff survey results and require the focus of the executive.

3. Meeting with women in the Trust post Sarah Everard's death

3.1. All of the meetings have been very balanced and concerns can be categorised as those relating to safety and those relating to what can be described as how women are treated differently to men in the Trust. There is recognition that the Trust has made significant progress from 20 years ago but it is lamentably not where should be. Alison Blakely, Consultant Paramedic, and Angela Flaherty, Associate Director of Strategy, prepared a presentation to share with the wider leadership group. This has now occurred and I will leave the CEO to report on what action he has taken to address these issues.

External Meetings

4. Contributing to the debate on the role of Ambulance Trusts in the implementation of Integrated Care Systems once the White paper is approved by Government

4.1. As discussed previously, the White Paper is silent on where Ambulance Trusts fit in the Integrated Care System and to that end I have contributed to meetings of AACE, AACE with the NHS Confederation and representatives from NHSE/I to explain our role in Urgent Care, NHS111 in addition to the Ambulance service and the need for us to be central to the strategic planning of these services. We all cover as a minimum four ICS geographical footprints and in London, five. Capital is a constraint and those aligned to a key ICS where the ICS has a large deficit results in a less than favourable capital allocation to the ambulance trust. In most ICS' there is a large demand on capital for maintenance and a lack of understanding of the need for fleet replacement, modern ambulance stations and well developed digital capability if we are to meet the needs of patients safely in the community without recourse to an Accident and Emergency department. I do believe that we are now making some progress in influencing the solution for our services. There is now a proposal from us collectively that Ambulance Trusts are commissioned and receive capital via a Regional Board with a lay chair.

4.2. Through these meetings I have also proposed that some Urgent Care Services are commissioned across a region, with an initial agreed pathway for 3-5 areas building on the work of Dame Ruth Carnall who gained agreement for the Major Trauma, Stroke and Heart Attack pathways in London. Other pathways could be Primary Care Network specific and delivered at Place, an example of this being elderly fallers.

4.3. Lastly, I have proposed that we offer up the idea of Get it Right First Time (GRIFT) across Urgent Care pathways and across Providers. Lorraine Bewes, Chief Finance Officer, is now the chair of the AACE Finance Directors group and we have proposed to the Chair of ACCE that there should be a pilot to be evaluated along the GRIFT principles and Lorriane is taking this to her group of Finance Directors.

5. NHS Confederation work with Chairs and CEOs on Paramedics in Primary Care

5.1. I continue to join the national debate about how to take this development forward in a way that is developmental for paramedics, meets the needs of Primary Care Networks, and is deliverable and affordable.

6. London Region, NWL and SWL ICS Chairs meetings

6.1. I continue to represent LAS at the above meetings where the main discussion is in relation to the COVID-19 vaccine, cancer and surgical reset. Work is also underway to set out the governance arrangements in advance of central guidance on Provider Collaboratives and ICS rules of engagement.

6.2. I will be joining a meeting specifically set up for Ambulance Trust CEO/Chairs which I will be able to report on at the Board meeting.

7. Chief Midwifery Officer visit

7.1. On 29 March the Chief Midwifery Officer for England, Professor Jacqueline Dunkley-Bent and her deputy Jessica Reid visited our HQ. They met with teams across the Service to learn about how we are improving the care for mothers, their partners and babies. They also presented a gold Chief Midwifery Officers Award to our Consultant Midwife, Amanda Mansfield for her significant contribution to midwifery in ambulance services.

Heather Lawrence OBE
Chairman



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Report from the Chief Executive			
Agenda item:	6			
Report Authors:	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting

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

- The Chief Executive's report looks back over the last year and provides a strategic update on the key activities and internal and external engagement by the London Ambulance Service NHS Trust (LAS) since the last time the board convened in March 2021.

Recommendation for the Board:

- The Board are asked to note the content of the Chief Executive's report.

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

Directorate	Agreed			Relevant reviewer [name]
	Yes	No		
Quality	Yes	No		John Martin
Finance	Yes	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes	No		Khadir Meer
Medical	Yes	No		Fenella Wrigley
Communications & Engagement	Yes	No		Antony Tiernan
People & Culture	Yes	No		Kim Nurse
Corporate Affairs	Yes	No		Trisha Bain

Report from Chief Executive

1. The year in Review

- 1.1. Today's Trust Board will review our end of year position and performance over the last 12 months, with our Annual Reports and Accounts featuring later on the agenda. I'd therefore like to start by reflecting on the last 12 months for the London Ambulance Service (LAS); a year in which we and the wider NHS have faced an unprecedented period of sustained demand and change. We have continued to respond to the challenge of COVID-19, arguably the greatest healthcare challenge faced by the NHS since it came into being in 1948, and strived to provide the best possible care for our patients. The pandemic has undoubtedly stress-tested the resilience of our operations and our people and I am very proud of our response. A response only made possible by the dedication, flexibility and exceptional hard work of our staff, who themselves faced incredible pressures and repeatedly had to deal with heartache, tragedy and trauma in both professional and personal capacities.
- 1.2. In December 2020, we saw the second wave of the pandemic, with the virus spreading far more quickly than forecasting had predicted. The volume of patients needing our help increased dramatically, as did the infection rates amongst our own staff. At the peak, despite stringent PPE and social distancing measures, the Trust had around 800 staff members absent and nearly 600 isolating - around a fifth of our entire workforce. On New Year's Day in 2021, ambulance crews treated 3,764 patients – the highest number of patients we have ever seen face-to-face. At the same time, Emergency Departments were dealing with unprecedented numbers of patients and there were delays in handing over our patients at hospital; at one point about 25% of our ambulances were waiting in queues outside of emergency departments. The Mayor declared a major incident in London on 8 January 2021.
- 1.3. In response to this, we built upon the additional capacity we had introduced in the first wave (the strengthening of our leadership team to operate 7 days a week; maximising the number of clinicians on the front line; increasing our volunteer workforce and calling on the support of many key partners such as LFB, TfL, AA, Virgin Atlantic, British Airways to name but a few). We increased our call taking capacity in both 111 and 999 services through mutual aid and partnership working, allowing us to answer more 999 calls and triage more patients than ever before. We continued to operate from consolidated ambulance station hubs and our redesigned and expanded logistics warehouses. We also trained Metropolitan Police Service officers who, with London's firefighters, joined our substantive ambulance crews enabling us to deploy up to 500 ambulances per day. AA mechanics joined our fleet technicians, working 7 days a week, to keep our vehicles on the road. We also increased the number of clinicians in our 999 clinical hub to undertake enhanced clinical assessments of patients to ensure their safety whilst waiting for an ambulance, or redirect those that did not to alternative care pathways.
- 1.4. As can be seen from the Integrated Performance Report, throughout this period we have continued to meet our Category 1 mean performance target of 7 minutes. We ended the year 2020/2021 just outside of the Category 2 mean response target of 18 minutes (19:39 minute for the 12 month period), but met our category 3 and 4 targets. We worked with system partners to help develop new care pathways, including hospital at home for patients suffering COVID-19. In 2020/21 almost 11% of our patients were assessed through hear and treat, 25,000 more patients than in the previous year; we have also increased the number of patients we have been able to treat on scene – known as 'See and Treat'. In

2020/21 our crews were able to treat and discharge 32% of patients on scene, up from 27% the previous year. The increase in both 'See and Treat' and easier access to alternative pathways has meant fewer hospital journeys – down to 51% of all the 999 calls we attend.

- 1.5. NHS England and Improvement launched the NHS 111 First programme to reduce the number of walk-in ED attendances in 2020. It was designed to protect NHS staff and patients by reducing the risk of infection caused by overcrowded waiting rooms. The scheme encouraged patients to call NHS 111 before attending ED to allow our teams to assess their need and, where possible, carry out a clinical assessment using telephone or video consultation to provide appropriate care. Our North East London (NEL) and South East London (SEL) Integrated Urgent Care (IUC) services saw an 11% increase in calls from patients compared to last year. Despite this we have improved performance for call answering and call abandonment and transfer of calls to 999.
- 1.6. As outlined in the Annual Report from our Patient Experiences Department (PED), which features later on the Trust Board agenda, 2020/21 has been a challenging year for NHS Trusts and, in line with guidance from NHS England and the Health Service Ombudsman, we have had to introduce 'pauses' to our NHS complaints process, allowing us to release staff to focus on frontline duties. The pause allowed us more time to investigate and respond to complaints but did not negate to do so.
- 1.7. Despite a significant increase in demand, our total complaints for 2020/2021 were slightly lower than the previous year (1050 complaints in 2020/21 compared to 1125 in 2019/20). The average percentage of complaints received against calls attended is 0.10%, with the top 5 subjects of complaints being conduct and communication issues; non conveyance, road handling; delay, and treatment.
- 1.8. In November 2020, we added an online complaints form to our website, together with improved signposting, and complainants have been increasingly using this method of contact.

2. Building a World-class Ambulance Service

- 2.1. In the face of all of these challenges, we have continued to further our strategic vision and progress the delivery of our Clinical Strategy (further detail in the Chief Medical Officer's report to the Board) to become the primary integrator of urgent and emergency care in London, including by becoming the lead provider of IUC services in North West London (NWL). In addition, our project management and estates teams have delivered our biggest ever capital infrastructure programme – re-engineering buildings to facilitate new ways of working and social distancing, building new training, logistics and medicines management facilities, transforming our health and well-being capabilities to support our incredibly stretched work-force (further detail in the Chief Operating Officer's report to the Board). The result of all of this rapid change is that we have become, a far more innovative and 'can do' organisation. We have massively accelerated many long-planned initiatives that have undoubtedly improved the care we provide for our patients. The result is that, more than ever, we have been able to play our part in coordinating and integrating access to NHS urgent and emergency care for the 4.5 million plus patients that call 999 or 111 in London every year.

Trust Strategy Refresh 2022/23 – 2027/28

- 2.2. Since our current Trust Strategy was agreed in 2018, we have seen fundamental shifts in the external environment with far reaching implications for the way that we operate as an organisation. This includes the long-term health, social and economic impacts of the COVID-19 pandemic; moves to rapidly embed ICS system working and provider collaboration; new requirements for NHS environmental sustainability; and the development of new models of delivering place-based care.
- 2.3. In this same period, and as mentioned above, we have also successfully delivered against many of the major commitments of the strategy, including: launching Integrated Urgent Care (IUC) services in North East and South East London and playing a leading role in 111 services across North West and South West London; developing our Clinical Hub and Clinical Advisory Service to enable low acuity patients to be referred onto the most appropriate care pathways; mobilising new pioneer services to improve the quality of our patient care for specific pathways, including mental health, maternity and end of life care; and working more closely with our system partners, particularly in response to the COVID-19 pandemic.
- 2.4. Given our achievements and the radical shifts to our external environment, it is now necessary to develop a Trust Strategy Refresh for 2022/23 to 2027/28 to re-align our commitment to our three strategic themes in the context of new opportunities and threats, and to articulate an updated set of ambitious and realistic strategic commitments that enable us to modernise our organisation. The Trust Strategy Refresh will be developed with extensive engagement across internal and external stakeholders, and will be signed off early in 2022 before the end of this financial year.
- 2.5. Our Trust Strategy Refresh will be supported by six enabling strategies that describe how our overarching vision will be delivered through the modernising of our: clinical and operating models, our culture, our workforce; our assets; and how we can ensure long-term financial sustainability. These strategies will be underpinned by robust delivery programmes coming together within an executive Modernisation Portfolio to ensure the realisation of both system-wide and organisational benefits.
- 2.6. As outlined in our Chief Paramedic and Quality Officer's report, it is also the right time to refresh our Quality Strategy, incorporating learning from COVID-19 and given CQC changes in approach and introduction of ICSs, with a focus on quality improvement and learning.

3. Building a World-class Workplace – Our People

- 3.1. The impact of COVID-19 has inevitably taken a toll on our people and we will continue to focus on their health and wellbeing needs. As outlined in the report of our Director of People and Culture, a range of initiatives and support services have been made available to our staff and volunteers, including through our Wellbeing Hub. A new health and wellbeing strategy and delivery plan is being developed to cover the next four years.
- 3.2. Cultural change remains one of our key areas of focus and will therefore be one of the six enabling strategies that will support the delivery of our refreshed Trust Strategy (para 2.5 above). We have, since reviewing the 2019 staff survey results, put considerable effort into improving engagement with our core leaders, improving our communication and the visibility of our senior managers, including through LAS TV Live, daily operational briefings and sector conferences with local management teams. As noted in the annual report (which

features later on the Trust Board agenda) and in my recent reports to the Board, 72 per cent of our staff responded to the 2020 staff survey and we saw improvements in relationships with managers, staff wellbeing, safety culture and in reducing bullying and abuse from managers and colleagues.

3.3. However, there is still more to be done, including in respect of equality, diversity and inclusion. The murder of George Floyd and the Black Lives Matter movement prompted us to hold a Trust-wide 'big conversation' on the experiences of our black and minority ethnic colleagues, on which we built an immediate action plan to help address some of the discrimination and inequality experienced. We have, more recently initiated similar conversations in respect of women's experience of the workplace, which we will build on. Our Director of People and Culture's report to the Board provides further updates on our work in the area of Culture, Diversity and Inclusion. In addition, through our modernisation programme and development and delivery of our enabling strategies, we will strengthen and support the development of our people, including through ongoing education and continued professional development, and by providing opportunities through our evolving clinical model of care and our work with system partners in the ICSs.

3.4. We do have much to be proud of and I would like to put on record my thanks to our incredible staff and volunteers who have worked tirelessly across the Service over the last year. To celebrate some of these successes, I was very proud to co-host with Antony Tiernan, our Director of Communications and Engagement, our annual VIP Awards on 14 May 2021. These VIP Awards are themed around the Trust's core values (Collaboration; Innovation, Professional, and Respectful) and recognise staff and volunteers who have gone above and beyond for our patients and their colleagues. This year's awards ceremony was a virtual event, with hundreds of staff and volunteers joining us online to watch the ceremony and see who had won. I would like to congratulate our award winners:

- **Collaboration Award** - The End of Life Care Coordinators, recognising their contribution to improving the quality of care the Service provides to patients nearing their end of life and for supporting the wellbeing of their colleagues.
- **Innovation Award** - Clinical Directorate for their work on introducing a clot-bust drug to the Advanced Paramedic Practitioner (APP) drug pack, enabling them to assist patients in a non-hospital environment and giving patients a higher chance of recovery.
- **Professional Award** – Flavia Dolan, Performance Manager (Dispatch) in our Emergency Operations Centre (EOC) for displaying professional qualities, understanding and maturity. Flavia was recognised for her drive, passion and ambition and for being incredibly professional and hardworking.
- **Respectful Award** – Tony Ogden, Emergency Responder, for his compassion, care and dedication in providing the very best patient care possible. He gives up time to help with training and provides mentoring and guidance to new Emergency Responders.

Ambulance Leadership Forum award

3.5. I would also like to congratulate student paramedic, Beeshman Sivakumaran, who was recognised by the Association of Ambulance Chief Executives (AACE) for outstanding dedication and commitment in the 'Exceptional Pre-registration Student Paramedic' award at the Ambulance Leadership Forum in May.

3.6. This year, with the event taking place virtually, ambulance trusts were asked to present awards to winners locally. I was delighted to present Beeshman with his award at his Education Training Centre in Fulham, and to hear from his Tutors first-hand about his passion for, and commitment to, being a paramedic at the Service.

Remembering our Colleagues

- 3.7. Sadly, we have also experienced the immeasurable sadness of losing some of our colleagues and friends. Nineteen members of the London Ambulance Service staff and contractors passed away in 2020 and 2021, some with COVID-19. Our thoughts continue to be with their families and friends and we have recently completed the installation of a new memorial garden at our Waterloo Headquarters. The garden was designed to be a space for our staff and volunteers to be able to reflect and remember the colleagues we have lost over the years. On the afternoon of 13 May, we came together at the Memorial Garden, lowering our flag to half-mast and laying wreaths to remember the colleagues we have lost during the pandemic and their significant contribution to the people of London. When the COVID-19 restrictions have been lifted, we will be inviting the families of those we have lost to see the garden and to join us to remember their loved ones and recognise the service and dedication of their loved ones. As an act of commemoration, and with permission of families, we are also adding the names of staff and volunteers that have died onto new ambulances.

Volunteer Recognition Day

- 3.8. More now so than ever we have seen how Volunteers play a vital role in our Service. On Volunteer Recognition Day (20 April) we paid tribute to all our volunteer responders for giving their time and being there for Londoners in need. In the first three months of 2021, our volunteer Emergency Responders 'donated' 5,630 hours of their time responding to patients.

London Lifesavers funding

- 3.9. We were extremely pleased in March when NHS Charities Together gave us a grant of £895,000 to support our London Lifesavers scheme. This funding will help us deliver against a major element of our ambitious 2019 volunteering strategy, increasing the number of volunteer responders supporting the Service from 40,000 to 100,000. We will also increase the number of public access defibrillators we support from 6,000 to 10,000. The scheme currently saves approximately 40 lives a year. This funding will help us increase it to approximately 100.
- 3.10. Our charitable work has increased over the last year and we have managed to secure significant funding to support our work, including to improve the working lives of our staff and volunteers. In March, the LAS Charity issued a range of colleague grants, including to support a station wellness room, furniture for station gardens, football kits for staff teams, a number of mess room TVs and a memorial bench.
- 3.11. To support this work, we have recently advertised for a Head of Charity Development and hope to appoint in the summer.

4. Our Public and Patient Engagement

London Ambulance Service Public and Patients Council

- 4.1. The London Ambulance Service Public and Patients Council held its latest meeting on 4 May. The group, which is made up of 20 patient and public representatives, focused on a range of subjects including the Station (Quality) Accreditation Programme and our new Patient Safety Incident Response Framework. The notes of the February meeting are included with today's papers.

Chief Midwifery Officer for NHS England visit

- 4.2. In March, our Chair welcomed Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer for England to our HQ in Waterloo, to meet with teams across our Service and learn about the work we have, and continue to do, to enhance care for mothers, their partners and babies.
- 4.3. During the visit, Professor Dunkley-Bent presented our Consultant Midwife Amanda Mansfield with the prestigious Chief Midwifery Officer's Gold Award to recognise a lifetime achievement in midwifery. The Chief Midwifery Officer also presented our 'stork badge' awards to three of our 999 call handlers who provided the necessary guidance to support the safe delivery of a baby over the phone.

5. Corporate Affairs

Information Governance

- 5.1. I am pleased to announce that we have appointed Nicki Maher as Head of Information Governance and Data Protection. Nicki joins us from the Welsh Ambulance Services and will lead our Information Governance programme.
- 5.2. During April 2021, one personal data breach was reported to the UK's Supervisory Authority, the Information Commissioner's Office, which is being assessed in line with Trust Policy. The Trust's Information Governance mandatory training compliance is 93% against a 95% standard. A newly appointed Information Governance Manager continues to progress a number of data sharing agreements and Data Protection Impact Assessments, which assess and minimise data privacy risks at an early stage of a new project, system or business change.

Health, Safety & Security

- 5.3. The Health, Safety & Security Department (HS&SD) continues to work closely with local management teams, including Estates, Infection Prevention & Control, and Trade Union Health and Safety Representatives as part of the programme to review and update site specific risk assessments (SSRA), which have been updated to incorporate COVID-19 secure requirements. The HS&SD also continues to investigate Covid-19 related cases for analysis and action. Currently, we have two cases that have been reported under RIDDOR that are now being reviewed by the Health and Safety Executive.
- 5.4. Throughout 2020/21 a total of 650 physical assaults on staff were reported (compared to a total of 625 for 2019/2020), which our Violence Reduction Officers (VROs) have reviewed and followed up. As reported in March, 27 cases have been successfully prosecuted and a further 23 cases are awaiting trial. It should be noted that some cases would not necessarily be taken forward for prosecution owing to extenuating circumstances relating to the patient's clinical condition. The trial of Body Worn Cameras is progressing with anecdotal evidence that staff feel supported and safer whilst using them.
- 5.5. The HS&SD are leading on the development of the Occupational Health Service Specification and Standards covering Physiotherapy and musculoskeletal (MSK) injuries. This includes meetings with the current OH provider and The Physio Network, to improve data reporting. The HS&SD along with Clinical Education have developed a manual handling of persons training video, along with top tips for using the small handling aids.

Legal Services

- 5.6. The Legal Services Manager (LSM) will be linking with the Coroner's Court to discuss better ways of working collaboratively to create effective working relationships. The LSM is also working with Panel Firms and NHS Resolution to establish trends for Inquests and Claims and ensure that learning is shared and disseminated through the Directorates and organisation reporting functions, enabling triangulation of data across the Trust.
- 5.7. Fishmonger's Hall Inquest is still on-going. All staff giving evidence on behalf of the Trust have been prepared and supported accordingly.

The Board is asked to note and discuss this report.



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Report from Chief Operating Officer			
Agenda item:	7			
Report Author(s):	Khadir Meer, Chief Operating Officer			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<p>This report updates the Board on activities undertaken in COO Directorates since the last meeting and draws the Board's attention to any other issues of significance or interest.</p>				
Recommendation(s) / Decisions for the Board / Committee:				
<ul style="list-style-type: none"> For noting 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	x	No		Chief Operating Officer
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

Report from Chief Operating Officer

1 EXECUTIVE SUMMARY

Further to the last update to the Board in March 2021, the directorates within the COO Group continue to focus on four key areas previously set out alongside continued delivery of operational performance.

Maintaining Resilience

The Trust continues to manage the pandemic through existing business continuity processes ensuring service readiness as lockdown restrictions continue to lift in line with the Government's roadmap. Patient demand for our urgent and emergency care services has returned to pre pandemic levels. This is in advance of the full government unlock of mid-June 2021. Ongoing pandemic preparedness has included:

- Collaboration with NHSEI on **two After Action Reviews (AARs)** to gain a shared understanding of lessons identified during the second wave of covid, from both a Trust perspective and system experiences which will help to inform future planning.
- Our forecasting and planning team has been working closely with NHSEI to identify a **trigger profile for Covid-19 demand in London**, which will provide early alerts to emerging increases in demand that would allow us to mobilise additional resources ahead of increasing Covid demand.
- Agreements in place with both the **Metropolitan Police and the London Fire Brigade** that will allow in extremis to draw upon additional blue light driving resources if required.
- Strategic partnerships formed with providers outside of London for **reciprocal call taking arrangements for 111** to develop and grow current service provision and provide future resilience.
- Continued **working with NHSEI and system partners to develop a London-wide plan for patient cohorting at EDs** to minimise delays experienced at hospitals during elevated demand. NHSEI are currently in discussion with London providers to seek their support for the proposal, whilst in parallel the Trust is making internal arrangements to operationalise plans once this is approved by the London Clinical Advisory Group.

Our journey towards recovery

It is essential as part of organisational sustainability we maintain the right senior leadership and management structures to drive forward organisational recovery plans. Key developments in this area have included:

- Appointment to key **senior leadership posts in Integrated Patient Care** to drive forward our plans to bring 111 and 999 control room services closer together, with four new Deputy Directors now in post.
- Launch of a **restructure in Ambulance Services** in order to deliver a more agile and flexible staffing structure, including disaggregation of the Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity functions that will report directly to the Accountable Emergency Officer going forward.
- A thrice weekly **Senior Leadership Delivery Group** with representation from all directorates across the Trust to ensure priority activities to support recovery are overseen and delivered in a timely manner, including staff welfare initiatives.

Responding to our staff

In recent weeks we have put our energies into supporting our staff, in order to keep them safe and well. As part of this we have:

- Continued support and encouragement of colleagues to engage in the **COVID-19 vaccination** and the lateral testing programmes.
- Monitoring rates of **staff sickness absence**, with each Director working with senior managers to ensure staff are engaged in a timely manner and provided the necessary support in order to return to work safely wherever possible.
- We continue to make a concerted effort to **improve the safety and comfort of our ambulance stations and 111 sites**, with an investment of £3.9 million of additional works over and above £1.4 million of committed spend in 2020/21. A further £3m is expected to be spent on works to improve stations this financial year.
- Staff survey action plans in place for each directorate, which look to champion positive cultural improvements across COO Directorates by sharing the positive learning across our teams and to take action where improvements can be made.
- Strong progress made to increase the number of PDR conversations, giving staff and managers an opportunity to discuss individual needs and opportunities for development and support. Over 81% of staff within the COO Directorates have been completed PDRs to date.

To refocus on our strategic ambitions

In 2020/21 the Trust delivered an ambitious capital transformation portfolio in order to mitigate catastrophic failure in response to the pandemic.

Accelerated progress to **deliver our multi-year capital programmes** will continue, with plans to launch in this financial year:

- The **London Urgent and Emergency Care Coordination Centre** (previously the Tactical Operations Centre) in order to support London wide 999 and 111 patient demand and management during July 2021.
- **A new control room in Newham in replacement of the Bow control room** which is a core component of our control room transformation plans during October 2021
- **Delivering a new CAD (Computer Aided Dispatch) system for delivery in November 2021** which will improve operational efficiency and interoperability with other Trusts and the London Care Record
- Two new **Education Centres** to provide training capacity to increase workforce capacity, and to improve the quality, delivery and efficiency of education during May 2021
- Securing new warehouse premises that are suitable and provide fit-for-purpose accommodation for the **Logistics Supply Unit** during August 2021
- A new **Medicines Packing Unit** which is compliant against statutory and regulatory requirements for the packing, distribution, and storage of medicines during September 2021
- Installation of a new **Crew Safety System Unit** into vehicles capable of capturing, tracking and monitoring activity to provide a mechanism for safeguarding our staff and patients, and managing fleet and assets during September 2021
- **Progressing Hub 1 based in Romford** as a proof of concept site for subsequent Hubs and the AOM programme

We have specifically made major improvements in **digitising the patient journey**, with:

- front-line ambulance operations are now entirely paperless following the **roll-out of EPCR** now at 90% adoption
- the **use of NHS Numbers** through EPCR allows us to capture and link patient data and improving our ability to deliver current and future services
- the implementation of **video-calling functionality in our Clinical Advice Service and Clinical Hub** allows our clinicians to assess and diagnose patients, and ensure that patients receive the most appropriate treatment.

Significant progress has been made to **modernise and use our estate more efficiently**:

- A recent review of the **consolidated ambulance operational estate**, which has recommended the reopening of four sites including Hayes, Putney, Tottenham, and Woolwich.
- A **refresh of the Trust’s agile working policy and proposed changes to ways of working** is now underway in order to review the workspace model and embed sustainable flexible working arrangements and improved utilisation of corporate estate post pandemic.
- **Refurbishment and renovation at Waterloo HQ** has been completed to expand the availability of space and capacity, and has included the installation of a memorial garden at the front of the building recognising staff we lost during over the last year, and improved disability access to our site

Continued delivery of the Trust’s transformation journey will be incorporated into the portfolio of six transformation programmes to be overseen by the Executive Transformation Board going forward.

2 OPERATIONAL PERFORMANCE UPDATES

3 Integrated Patient Care

Indicator (KPI name)	Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
111/IUC (NEL) - Calls answered within 60 sec	> 95%	98.3%	99.5%	98.7%	98.3%	96.0%	95.5%	91.7%	65.0%	63.1%	95.1%	87.6%	81.2%	
111/IUC (NEL) - Calls Abandoned within 30 sec	< 5%	0.1%	0.0%	0.1%	0.0%	0.7%	0.3%	0.6%	6.7%	8.6%	1.7%	0.9%	0.9%	
111/IUC (SEL) - Calls answered within 60 sec	> 95%	98.3%	99.8%	99.2%	99.0%	95.4%	98.2%	95.1%	69.1%	64.4%	94.2%	90.2%	80.2%	
111/IUC (SEL) - Calls Abandoned within 30 sec	< 5%	0.2%	0.0%	0.1%	0.0%	2.5%	0.2%	0.5%	5.5%	7.2%	3.7%	4.3%	3.9%	
111/IUC (NWL) - Calls answered within 60 sec	> 95%	N/A	N/A	N/A	N/A	N/A	N/A	93.6%	80.9%	71.8%	94.1%	88.9%	80.9%	
111/IUC (NWL) - Calls Abandoned within 30 sec	< 5%	N/A	N/A	N/A	N/A	N/A	N/A	0.7%	3.9%	5.6%	1.8%	0.9%	1.1%	
999 Mean answering time	< 5 sec	0	0	1	2	2	1	1	39	23	0	1	0	

Highlights:

- **NHS 111 call centres:** The trust has consistently delivered strong operational performance against the national standard for call abandonment. However, levels of performance for call answering within 60 seconds have seen some deterioration driven by volatility in demand. A key focus currently is to recover performance consistently across all three sectors to meet performance targets utilising the support of our strategic partners in parallel to a targeted improvement programme across all existing LAS sites.
- **999 Control Room:** The last quarter has seen strong call answering performance. Based on demand and capacity forecasts to the end of May, the Trust is expected to maintain the daily call answering mean below 5 seconds.

4 Ambulance Services

Indicator (KPI name)	Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Category 1 Response - Mean	7 mins	00:05:52	00:05:46	00:05:58	00:06:22	00:06:33	00:06:20	00:06:03	00:07:30	00:07:09	00:05:51	00:05:21	00:05:38	
Category 2 Response - Mean	18 mins	00:08:54	00:09:32	00:11:10	00:14:12	00:16:53	00:15:13	00:14:16	00:44:48	00:41:30	00:11:14	00:13:14	00:16:32	
Category 3 Response - 90th centile	120 mins	00:47:32	00:51:02	01:01:11	01:21:15	01:53:51	01:31:31	01:21:35	04:12:06	03:32:00	01:01:59	01:17:41	01:48:44	
Category 4 Response - 90th centile	180 mins	01:30:16	01:39:54	02:00:01	02:25:10	03:14:14	02:51:29	02:23:53	06:37:06	05:07:26	02:19:27	03:21:19	04:14:41	

Highlights:

- The Trust continues to experience uncertainty in the number of incidents expected, which is a consequence of the volatility we have seen since lockdown policy started changing. Despite this, the Trust has seen strong performance across key response time standards during March and April
- There have been some challenges in the delivery of Category 4 response times. To understand these challenges, a review has been commissioned by the Quality Directorate in carry out a root cause analysis and agreed action plan to recover this shortfall in performance.

5 Strategic Assets and Property

5.1 Estates

Description	Aug-20	Sep-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Gas appliances testing - Annual test	95%	95%	95%	95%	95%	95%	73%	Not available	
Insurance inspection by contractor and Allianz - inspection annually - Fleet underlies the safety check.	90%	90%	89%	81%	78%	94%	97%	Not available	
Biannual check on tanks	95%	95%	95%	95%	95%	100%	100%	Not available	
Insurance inspection for compressors - Annual Test	92%	92%	87%	75%	75%	81%	96%	Not available	
Allianz inspection and contractor - put equipment through a test biannually	95%	95%	95%	95%	95%	95%	100%	Not available	
Service operational sites (556 Control rooms / 1111 control rooms - biannually Office spaces - annually	75%	75%	79%	97%	82%	87%	95%	Not available	
Five yearly check of lined wires	94%	94%	94%	94%	95%	95%	95%	Not available	
5 yearly check for each site. Spot checks also done. More than 800,000kg annual audit	90%	91%	91%	94%	100%	100%	100%	Not available	
In depth - annual audit	97%	97%	95%	95%	100%	100%	100%	Not available	

Description	Aug-20	Sep-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Fire Risk Assessment	95%	95%	95%	95%	100%	100%	100%	Not available	
Fire Alarm Tests	97%	98%	98%	97%	100%	100%	99%	Not available	
Fire Fighting Equipment	98%	98%	98%	94%	98%	98%	98%	Not available	
Fire Drill	98%	98%	97%	98%	98%	98%	98%	Not available	
RAT Tests	98%	98%	98%	98%	98%	98%	98%	Not available	
Asbestos	94%	94%	94%	95%	95%	95%	95%	Not available	
Emergency Lighting	95%	95%	95%	95%	95%	95%	95%	Not available	
Legionella Risk Assessments	95%	95%	95%	95%	94%	94%	97%	Not available	
Lighting Protection	100%	97%	97%	97%	100%	100%	100%	Not available	

Highlights:

- **Significant improvement in the statutory/mandatory compliance** has been achieved in the past 2 months with renewed focus and rigour on key operating licence requirements.
- We have achieved **93.2%** Statutory compliance across our estate portfolio and conducted **98.4%** of our workforce PDR's.
- SA&P have introduced a **new Planning & Modernisation department**, which will oversee the modernisation of Fleet, Supply & Distribution and Estates.
- The requirement to comply with **secure drug room requirements** continues with 14 out of 15 now in place

5.2 Fleet and Logistics

Measurable	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Total Number of Ambulances In Service	450	508	507	503	503	503	510	541	542	541	
Maintained Hrs. Covered at Workshops Incl. Overtime hrs.	>90%	85%	87%	88%	100%	94%	100%	99%	98%	100%	
Dns. Of Service (DOS) due to No vehicle (hrs)	<1%	0.02%	0.02%	0.02%	0.04%	0.07%	0.08%	0.08%	0.08%	0.07%	
Average number of DCAs unavailable due to Road Traffic Collisions (RTC) per day	<15	20.2	9.3	9.4	11.0	10.0	10.5	15.1	17.1	15.8	
Q&E Authorised Costs		This is a new measure starting from Jan-2021					£ 132,359.89	£ 85,454.83	£ 80,679.96	Not Available	

Highlights

- **Ambulance and fleet availability** has remained above required levels and **PPE stock has maintained** 14 day over throughout March/April.
- We have mobilised **new DCAs into frontline service** and working with internal stakeholders to introduce a reserve fleet, which we can bring to a state of operational readiness within 72hrs.
- Key **collaborations with external partners** (AA) and internal teams (Make Ready) have enabled LAS to maintain above capacity fleet availability throughout February - April.
- LAS has launched the **Fleet Modernisation project** to redesign ambulance vehicles around four key themes – zero emission, lightweight, more accessible and digitally enabled.
- **Bunkered fuel** now in use at 15 out of the expected complexes across the Trust with a further one to be implemented. This assists the vehicle preparation teams to supply a more robust prep process, time saved attributes to an increase in the number of Double Crewed Ambulances (DCAs) managed through the vehicle preparation process.

6 IM&T

Service Availability (RAG)	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Key
Control Services - EOC – Emergency Operations Centre													No Service Interruption Service interruption
Control Services - Quality Assurance													
Control Services - EBS – Emergency Bed Services													
Operations - Service Improvement Team													
Operations - Sector Services													
Operations - Non emergency transport (NETS)													
Operations - Resourcing													
Medical & ICU - NHS 111													
Corporate Services - IT Infrastructure Services													
Corporate Services - Security Services													

Highlights

- **TEAMS migration to NHS.net** took place in the beginning of May providing the Trust with a reliable messaging service as part of a national NHS-wide programme to enhance collaboration across different Trusts, safeguard our data better and save us money at a national scale.
- The IM&T directorate continues to progress its people plan to establish a **substantive Senior Management and Infrastructure Team** and reduce reliance on managed service agreements and contract staff. This will help move the directorate toward being a more stable and effective team with the capability to drive improvements in our IT infrastructure.

7 Programmes and Projects (P&P)

Highlights

- Further to the 22 capital programmes delivered in the previous financial year, the current portfolios of programme now **comprises 37 capital projects**.
- With the introduction of the new Executive Transformation Board, there is a review of the current operating model **for the Programme and Projects Directorate** to ensure the function is aligned with the new governance arrangements for priority programmes going forward.



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Integrated Performance Report			
Agenda item:	8			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Key Leads from Quality, Finance, Workforce, Operations and Governance			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting

Key Points, Issues and Risks for the Board / Committee’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.

Since the last report:

Since the last report we introduced some changes that allows a clear understanding of the **reporting period** for each of the 4Ps and a few step changes allowing for clear and transparent timelines located on the **contents page in slide 2**.

The Corporate Reporting team continue to attend peer review sessions with the Chief Finance Officer, reviewing the IPR contents, forming part of the evaluation and sign-off process prior to the formal submission to ExCo / Trust Board / Convene.

IPR is presented to Directors / Chief Of’s for review and approval prior to formal submission to ExCo and Trust Board.

Key points, issues and risks for discussion:

Our People

➤ **Workforce Performance**

- Can we give assurance on Staff Survey action plans?
- To note that we propose to include with key messages, the following indicators: Staff survey results, Flu vaccinations, BME WRES results

➤ **Sickness**

- Have we appropriately explained drivers for sickness?
- Should we include specific assurance on how we are managing people with long Covid?

➤ **Annual Leave**

- Is there a risk relating to annual leave back log – Corporate vs Frontline issues

Public Value

- CFO will comment in her ED report on the financial reset as we return to business as usual setting, coming out of adjusted financial framework following our response to the COVID-19 pandemic, to highlight **Cost Improvement Programmes** progress and **Business Planning** forum.

Organisation Performance Management meeting:

Executive Committee members are asked to confirm that they are content with key messages in summary sheet and IPR overview slide 3, and that all relevant issues for Executive Director reports arising from the Organisational Performance Meeting Trustwide reviews have been captured.

Appendix 1 located on page 3 summarises the OPM actions captured during 30/04/2021 Trustwide reviews

Recommendation(s) / Decisions for the Board / Committee:

The Trust 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		
Strategy	Yes	x	No		
People & Culture	Yes	x	No		
Corporate Affairs	Yes	x	No		



London Ambulance Service – Integrated Performance Report



Report for discussion with Trust Board members

Analysis based on Year to **March 2021** data, unless otherwise stated (please see page 2 for data reporting periods)



Section	Content	Reporting Period	Pages
Overview	Narrative Against Patients, People, Public Value & Partners	Current	3
	Trust wide Scorecard 999	Mar-21	4
1. Our Patients	Trust wide Scorecard NEL & SEL IUC	Mar-21	5
	Trust wide Scorecard NWL IUC	Mar-21	6
	999 Response Time Performance	Mar-21	7
	Operational Demand	Mar-21	8
	Operational Capacity	Mar-21	9
	Operational Context	Mar-21	10
	Safe Scorecard – 999 Incident Management	Mar-21	11
	Clinical Quality Ambulance Indicators	Dec-20	12
	111 IUC Response Time Performance	Mar-21	13
	Safe Scorecard – IUC Incident Management	Mar-21	14
	Safe Scorecard – Serious Incident Management	Mar-21	15
Safe Scorecard – Medicines Management	Mar-21	16	
2. Our People	Trust wide Scorecard	Mar-21	17
	Vacancy Rates, Staff Turnover & Sickness	Mar-21	18
	Additional Workforce Analysis	Mar-21	19-20
	Health & Safety – MSK RIDDOR Incidents	Mar-21	21
	Health & Safety – Physical Assaults on Staff	Mar-21	22-23
	Responsive Scorecard - Complaints	Mar-21	24
	Well Led - Excellence Reporting	Mar-21	25-27
3. Public Value	Trust wide Scorecard	Mar-21	28
	Trust Financial & Contract Position	Mar-21	29
	Statement of Comprehensive Income	Mar-21	30
	Cash flow Statement	Mar-21	31
	Cost Improvement Programmes (CIPS) & Capital Plan	Mar-21	32
4. Our Partners	Trust wide Scorecard	Mar-21	33
	Maximising safe non-conveyance to ED	Mar-21	34-36
	End of Life Care & Mental Health	Mar-21	37
5. Strategic Themes	Strategic Themes Update	Current	38

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:

999 Performance in national measures, apart from Cat 4 90th centile were met in March 2021. Call demand and face to face incidents were stable and rose as a response to school returns, some warm days and further lockdown easing. For the FY2021 the Trust delivered and improved upon all of the 999 national measures, with the exception of C2 mean which while delivery was significantly improved on last year, was outside the national standard due to the severe Covid surge pressures.

In March, the influx of 111 calls stabilised and contracted targets for Call Abandonment and Calls Transferred to 999 were met, however, due to the demand pressure, the Call Answering targets were not achieved. This was in line with the full year performance delivery. 111 Performance on calls answered within 60 seconds was just outside the targets, however, the abandonment rates were met. Calls Recommended to ED remained challenged due to the demand pressures. The Trust responded quickly to the increasing demand, implementing lessons learnt from the first Covid wave. The Trust is analysing the impact of lockdown easing and working with NHS England Regional colleagues to identify external indicators that will help recognise any future wave of Covid related demand further ahead of time.

In March the People & Culture Team have continued to support frontline colleagues with their staffing requirements and are reporting positive staff positions in EOC and an Ambulance Operations in-ops vacancy rate of 3.4%. On track to achieve a full call handling establishment in September (NEL, SEL, NWL) and are looking at options to bring this forward. The turnover rate has improved from 8.4% to 8.3% since the last report with less leavers than forecasted. The monthly Trust wide sickness (including both covid and non-covid) has decreased from 6.7% to 6% with non-covid sickness at 5.3%. Trust compliance in statutory and mandatory training was held at 82% whilst appraisals are now sitting at 77%, up from 72% in February. Following the release of the 2020 Staff Survey Results, a review of the 75 questions has been undertaken compared with the previous year. There was significant improvement in 30 questions, no change for 41 questions and a deterioration in 4 questions. The Flu vaccination programme finished in December 2020, achieving a vaccination rate of 77.3% against an 80% target. This was a significant improvement from the previous year (55%) and reporting will start from the next programme, later this year. The national WRES results have been received and have been benchmarked against the Trust's indicators. Seven out of the nine indicators either remained the same or declined compared with the previous year.

The Trust is reporting a full year surplus of £1.160m (£0.257m surplus on an adjusted financial performance basis) which is consistent with the target position agreed with NW London partners due to the reversal of accrued COVID retrospective top up income (£5.35m), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£7.3m). The position incorporates costs of additional resourcing to meet COVID surge requirements of £12.7m. The amount of retrospective top up income recognised decreased by £5.35m in M11 (full year £44.564m). Total COVID costs YTD (excluding centrally provided consumables and equipment) are £85.8m. Capital spend net of disposals and excluding donated assets was £43.3m for the year (including COVID-19 phase 1 and 2 response spend of £19.3m) and the month end cash position was £39.8m.

For the FY2021 the Trust delivered and improved on Hear & Treat, See & Convey to ED and Post-handover (Handover 2 Green), with the exception of Hospital Handover which was outside the standard due to the severe Covid surge pressures. The Trust's performance for Hear & Treat and Post-handover (Handover 2 Green) were met. See & Convey to ED had improved significantly which saw a 6% reduction in the Trust's patient conveyance to ED. Work is ongoing to improve on our Patient handover metric through continuous dialogue with hospital management teams pan London. In March 2021, the additional Covid-19 demand had reduced and pressure on hospitals had dropped.

Achievements since the last report (March 2021)

- *March saw the continuation of strong performance for most 999 performance metrics.*
- *All IUC contracts experienced rising levels of activity, but through a combination of our dynamic rostering and our assurance processes, IUC was able to better identify and target resources to where it was required. Ongoing work to recruit additional resource will help to consolidate that position going forwards, particularly during periods with historically high levels of activity.*
- *The Trust Leadership was focused on responding to the continued demand and Covid calls and incidents, working closely with system partners to understand potential future developments and impact of lockdown easing.*

- *Over 90% of Trust staff have engaged and 75% have received their first Covid vaccination with 44% fully vaccinated. Over 3,000 staff have engaged with the lateral flow testing and 45% started testing.*
- *Continued a series of weekly themed Wellbeing Webinars and delivered Wellbeing Training sessions to more than 150 CTMs.*
- *Supporting managers in managing Covid absence focussed work on returning short and long term absentees to work across the organisation.*
- *Resolution Framework has been agreed, with a May implementation following the rollout of training to managers.*
- *Drop in sessions for female staff have been organised, led by our Chair and other female Directors, to share their experiences and ideas and help to shape a better and more inclusive LAS.*

- *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.*

- *The Trust continues to work with system partners to develop cohorting arrangements at particularly pressured sites.*
- *The Trust created resilience by means of call taking arrangements for 111 with providers outside of London (Derbyshire Health United and Hertfordshire Urgent Care)*
- *The Trust continued to deliver a multi provider contract for North West London 111 services as key provider, working with sub contractors to deliver the service.*

Provide outstanding care for our patients

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

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

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



Patients Scorecard

March 2021

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Performance				Benchmarking (Month)		
				Target & Type (Internal / Contractual / National / All)	Latest Month	Year To Date (From April)	Rolling 12 Months	National Data	Best In Class	Ranking (out of 11)
Category 1 response – Mean	mm:ss	Mar-21	●	07:00 A	00:05:21	00:06:15	00:06:15	06:47	05:21	1
Category 1 response - 90th centile	mm:ss	Mar-21	●	15:00 A	00:08:57	00:10:35	00:10:35	11:58	08:57	1
Category 1T response – 90th centile	mm:ss	Mar-21	●	30:00 N	00:14:10	00:15:25	00:15:25			
Category 2 response – Mean	mm:ss	Mar-21	●	18:00 A	00:13:01	00:19:39	00:19:39	18:24	12:14	2
Category 2 response - 90th centile	mm:ss	Mar-21	●	40:00 A	00:24:07	00:38:22	00:38:22	00:36:16	00:22:15	2
Category 3 response – Mean	h:mm:ss	Mar-21	●	1:00:00 A	00:33:47	00:42:43	00:42:43	00:49:21	00:28:24	2
Category 3 response - 90th centile	h:mm:ss	Mar-21	●	2:00:00 A	01:16:46	01:33:40	01:33:40	01:53:37	01:00:29	2
Category 4 response - 90th centile	h:mm:ss	Mar-21	●	3:00:00 A	03:23:05	02:51:48	02:51:48	02:54:34	01:37:16	7
Call Answering Time - 90th centile	ss	Mar-21	●	24 I	0	4	4			
ROSC at Hospital	%	Dec-20	●	31% N	21.7%	26.0%	26.8%	21.5%	28.6%	5
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Dec-20	●	95.0%	94.0%			85.5%	94.0%	1

Benchmarking Key

Top 3

Ranked 4-7

Ranked 7+

Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes

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

Note: **Sepsis** is measured quarterly

*National average YTD



Patients Scorecard (NEL IUC)

March 2021

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Performance					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	%	Mar-21	●	95.0%	A	87.8%	87.0%	87.0%	85.1%	90.7%	4
Percentage of Total number of calls abandoned after 30 seconds	%	Mar-21	●	5.0%	A	1.6%	2.8%	2.8%	1.94%	0.8%	4
% of calls closed with no onward referral (health advisor and clinician)	%	Mar-21	●	33.0%	A	21.6%	24.5%	24.5%			
% of calls transferred to 999	%	Mar-21	●	10.0%	A	6.6%	8.3%	8.3%	8.2%	7.0%	1
% of calls recommended to ED	%	Mar-21	●	10.0%	A	12.3%	10.5%	10.5%	13.9%	12.3%	2

Benchmarking Key
Top 3
Ranked 4-7
Ranked 7+

Patients Scorecard (SEL IUC)

March 2021

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Performance					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	%	Mar-21	●	95.0%	A	90.4%	88.0%	88.0%	85.1%	90.7%	1
Percentage of Total number of calls abandoned after 30 seconds	%	Mar-21	●	5.0%	A	1.1%	2.6%	2.6%	1.9%	0.8%	2
% of calls closed with no onward referral (health advisor and clinician)	%	Mar-21	●	33.0%	A	27.5%	28.2%	28.2%			
% of calls transferred to 999	%	Mar-21	●	10.0%	A	7.0%	7.8%	7.8%	8.2%	7.0%	2
% of calls recommended to ED	%	Mar-21	●	10.0%	A	13.8%	11.9%	11.9%	13.9%	12.3%	4

● 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



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. Further detail when available will allow us to provide a further detailed analysis in this report, as with our other 2 contracts.

Patients Scorecard (NWL IUC)

March 2021

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Performance				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	%	Mar-21	●	95.0% A	88.9%			85.1%	90.7%	3
Percentage of Total number of calls abandoned after 30 seconds	%	Mar-21	●	5.0% A	1.6%			1.9%	0.8%	3
% of calls closed with no onward referral (health advisor and clinician)	%	Mar-21	●	33.0% A	13.3%					
% of calls transferred to 999	%	Mar-21	●	10.0% A	7.4%			8.2%	7.0%	3
% of calls recommended to ED	%	Mar-21	●	10.0% A	12.9%			13.9%	12.3%	3

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

1. Our Patients

999 Response Time Performance

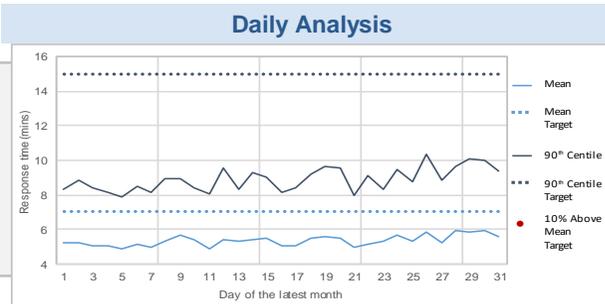
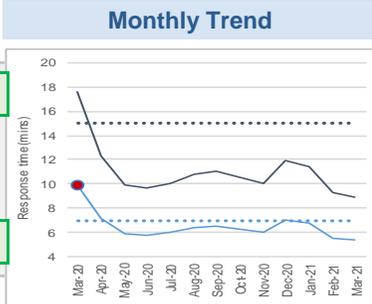


Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes

The Category 1 mean in March returned 5 minutes and 21 seconds while the Category 1 90th centile was 8 minutes and 57 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 both the Category 1 mean measure and the Category 1 90th centile measure when compared to all Ambulance Trusts across England. Mobilisation of additional resources and reducing demand due to the drop in Covid rates and trust sickness levels meant we were achieving targets in March.

C1

Mean: 5:21
Target: 7:00
90th Centile: 8:57

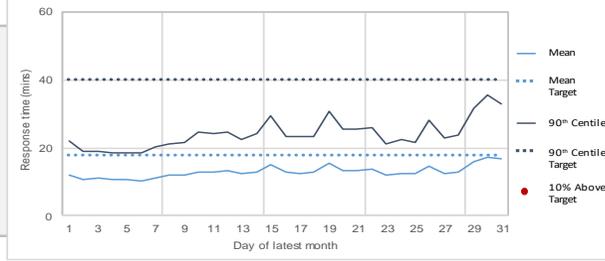
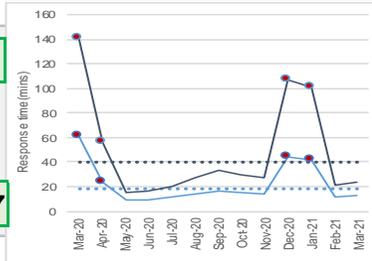


The C1 mean performance had been continuously within target, apart from the peaks of Covid demand in March - April 2020 and December 2020 – January 2021. Throughout March, the target was met, despite a slow increase in demand following school opening and other lockdown easing.

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

C2

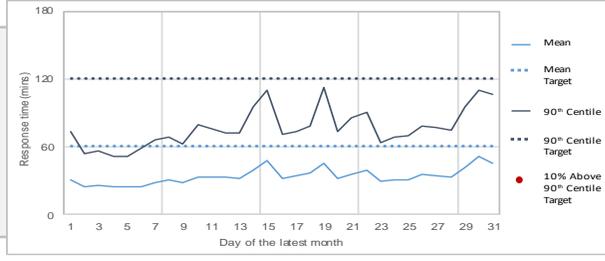
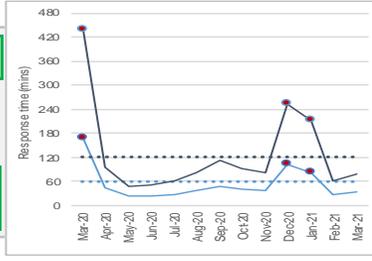
Mean: 00:13:01
Target: 18:00
90th Centile: 00:24:07



During March 2021, our C2 mean and 90th centile were both within the target. March was characterised by reducing sickness rates, and reducing handover times in hospitals, all together allowing us to reach patients within the target times. However there was a beginning of a return to higher demand following schools reopening and other lockdown easing.

C3

Mean: 00:33:47
Target: 2:00:00
90th Centile: 01:16:46

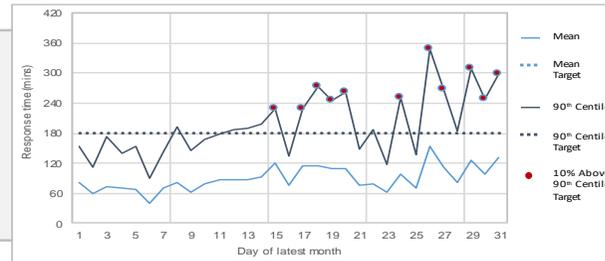
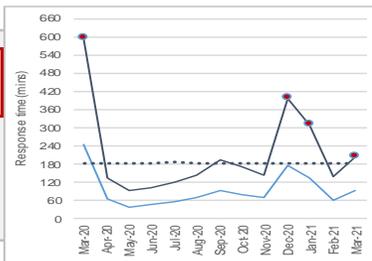


C3 90th centile was met in March, while the demand on the system started returning to normal levels.

Actions based on the learning from the first wave continued to be rolled out as a response to the second wave in March.

C4

90th Centile: 03:23:05
Target: 3:00:00



C4 90th centile was not met in March due to increased pressure on the higher categories. This category of calls was particularly impacted due to a low number with each delay having a higher impact on the overall average.

Work is on-going to improve C4 by reconfiguration and realignment of rosters to best fit call demand on lower acuity calls.



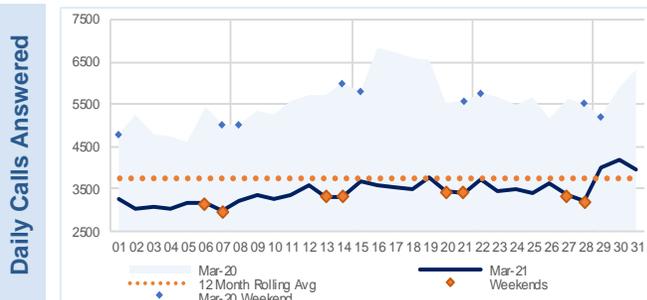
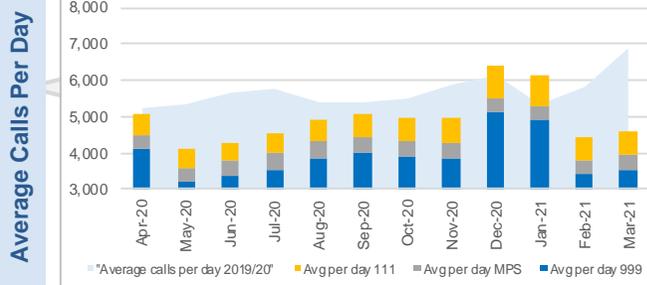
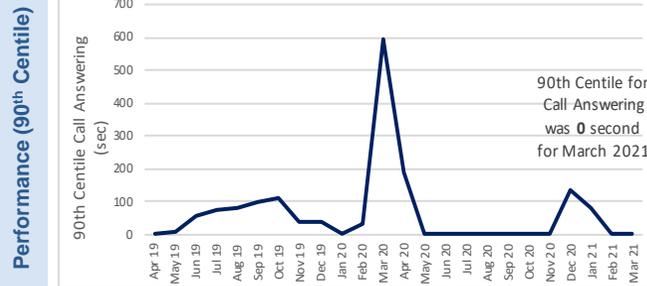
Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes

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

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

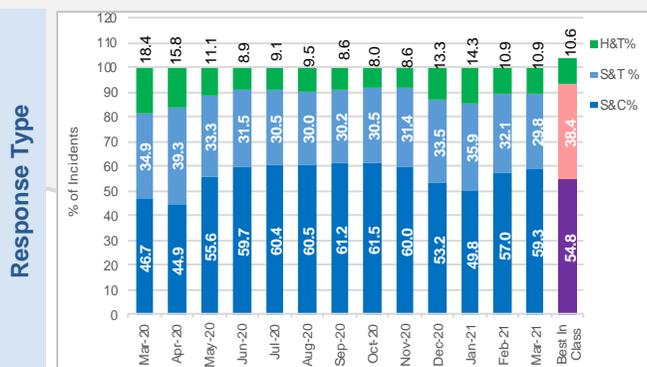
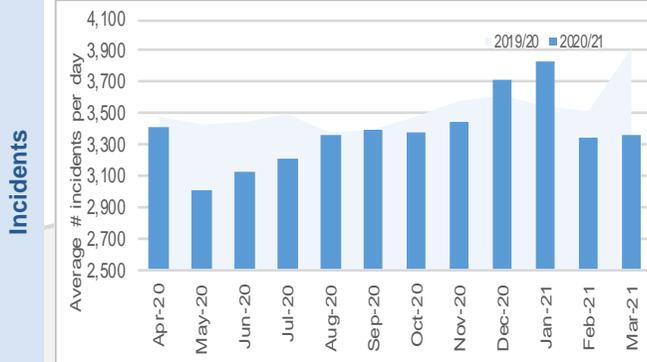
999 Calls Received

March 2021 saw a reduced number of calls compared to the equivalent period in 2019/20. As a result of the stable demand and increased staffing, call answering performance has been significantly better against our target on call answering 90th centile, which was less than 24 seconds



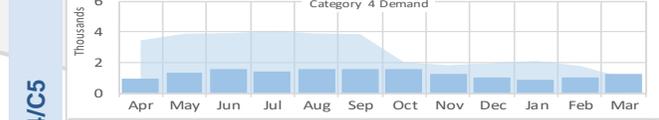
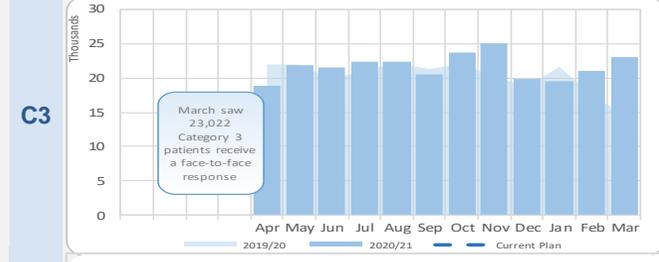
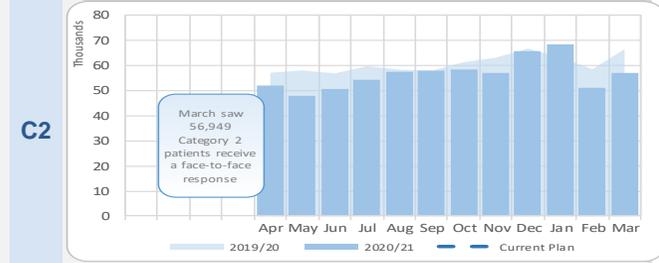
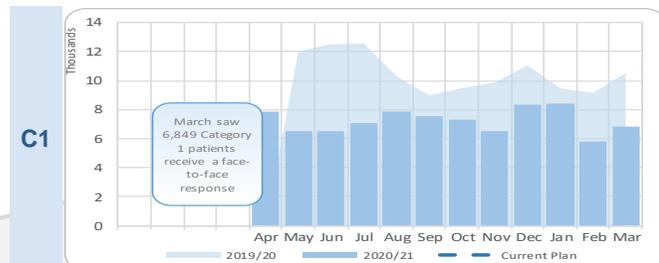
Incidents and Response Type

In March 2021 the number of incidents per day was lower than in 2019/20. Performance improved for ED conveyance and Hear & Treat was better than the target due to concentrated effort on these measures and a modified response from the trust to Covid-19.



During March 2021, SWAS was best in class achieving 38.4% for See & Treat. SCAS gained 1st place and was best in class for See & Convey and Hear & Treat achieving 54.8% and 11.9% respectively.

Incident Category (By Month)

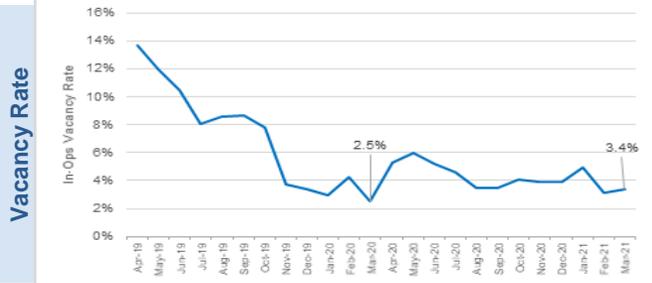
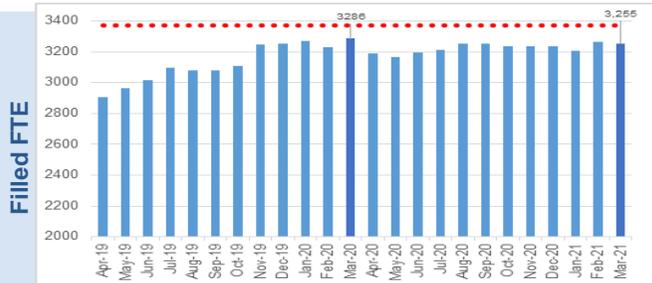




Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

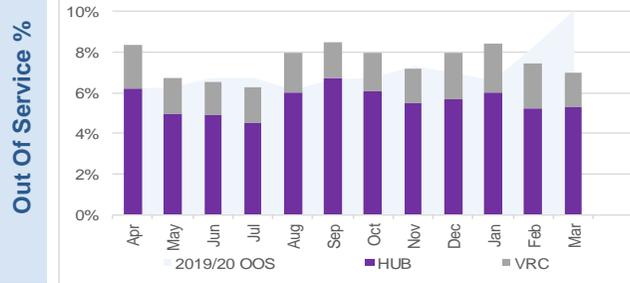
Frontline Operational Staff

The operational vacancy rate has increased from 3.1% in February to 3.4% in March with an increase from 106fte in classroom training.

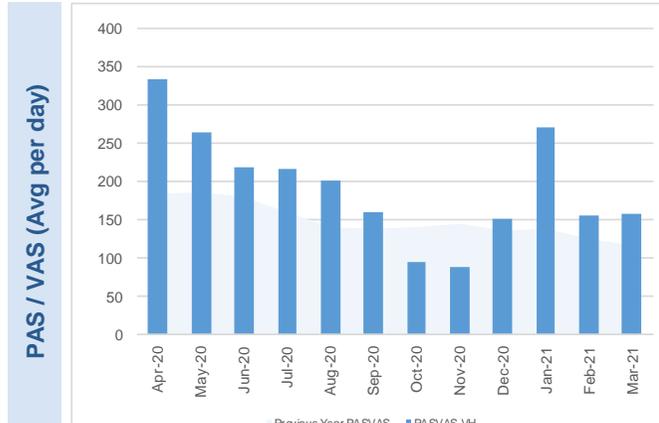
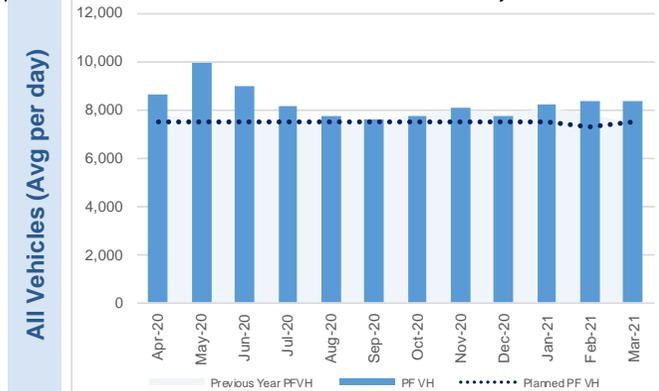
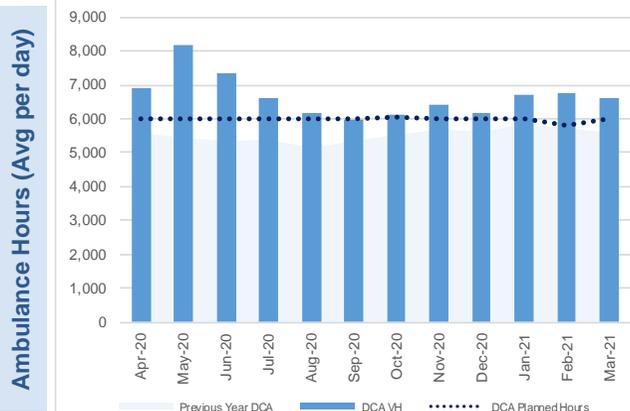


Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate averaged **7.28%** for March 2021, a decrease of **0.35%** from the previous month. The Trust has provided an average of **9,992hrs** patient facing vehicle hours per day in March 2021, a decrease from February 2021 which averaged **10,312hrs**. Although reduced the PVR remains a high level – February 2021 **435** > March **404**. The SA&P Teams supported the Operational rotas incurring limited downtime, this is demonstrated by a healthy DCA vehicle availability which is evidenced in the VRC Performance reflecting a total of **56.80hrs (0.02%)** accrued against OOS category **VEHNO** (no vehicle at start of shift) against total DCA and OPC hours for March 2021 of **216,016.87hrs**. We continue to work with our external partners, the **AA** work overnight to boost DCA vehicle and the **VP Hospital Day Teams** assist crew turnaround at 2 hospital locations across London. We maintained our PPE Stock target of 14 days stock at our distribution centre and continue to receive weekly deliveries from the NHS Push Stock. Our teams continue to respond to operational demand to ensure we maximise the availability of ambulances and minimise avoidable down-time.



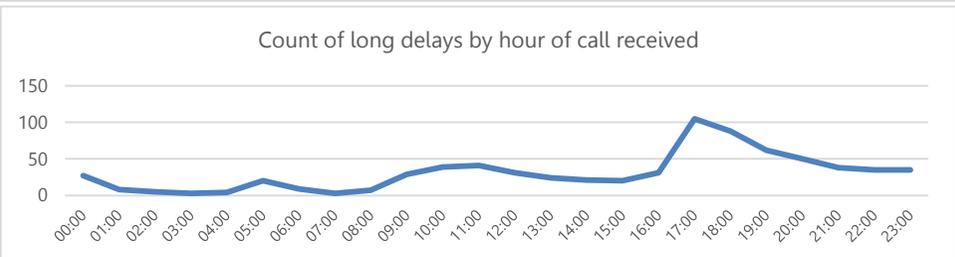
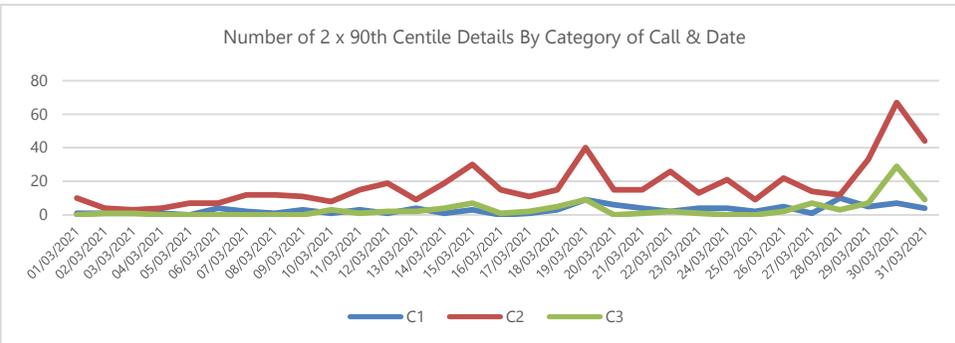
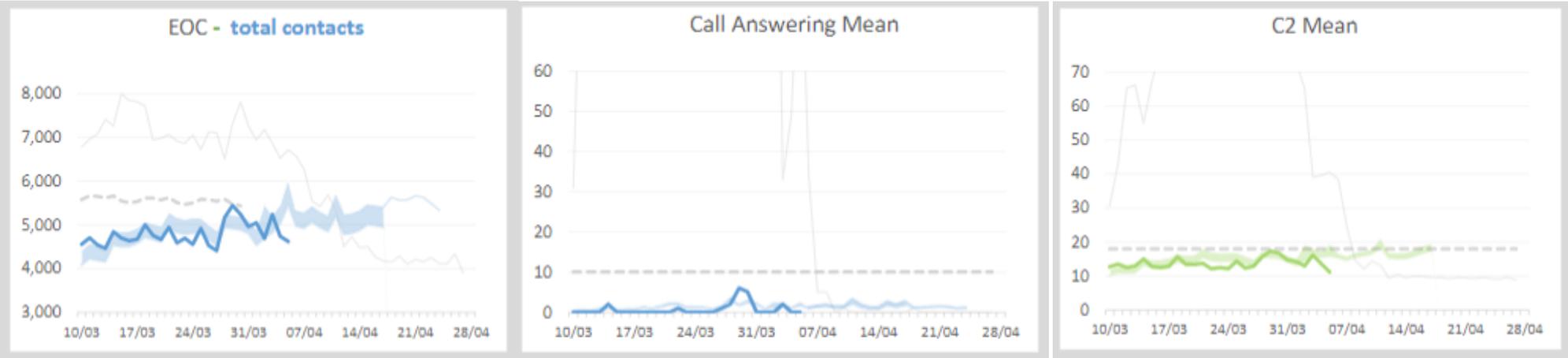
Note:
OOS HUB - This account for out of service codes related to people/crew reasons for out of service hours
OOS VRC - This account for out of service codes related to vehicle reasons for out of service hours





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

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



In March there were 735 long delays of which 8% resulted in a blue call.

	C1	C2	C3	Grand Total
Total	94	542	99	735
Blue Call	20	41	1	62

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

- DX012 - Emergency Ambulance Response (Category 3) (16% n = 115) – 5 required a blue call
- Unknown (10% n = 77) – 5 required a blue call
- DX0121 - Emergency Ambulance Response (Category 3) (3% n = 22) – 4 required a blue call

55% (n=402) patient whom experienced a long delay were not conveyed and 45% were conveyed. It was also found that 35% (n 255) of all long delays occurred between the hours of 17:00 and 19:00.

Action being taken include:

Forecasting and planning focus at DSLT

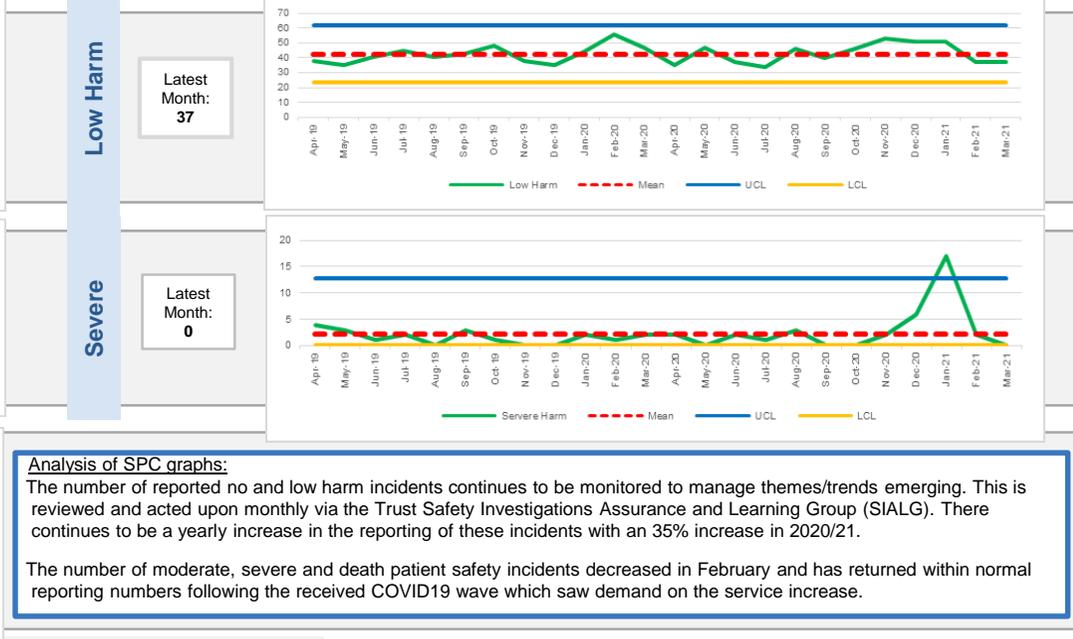
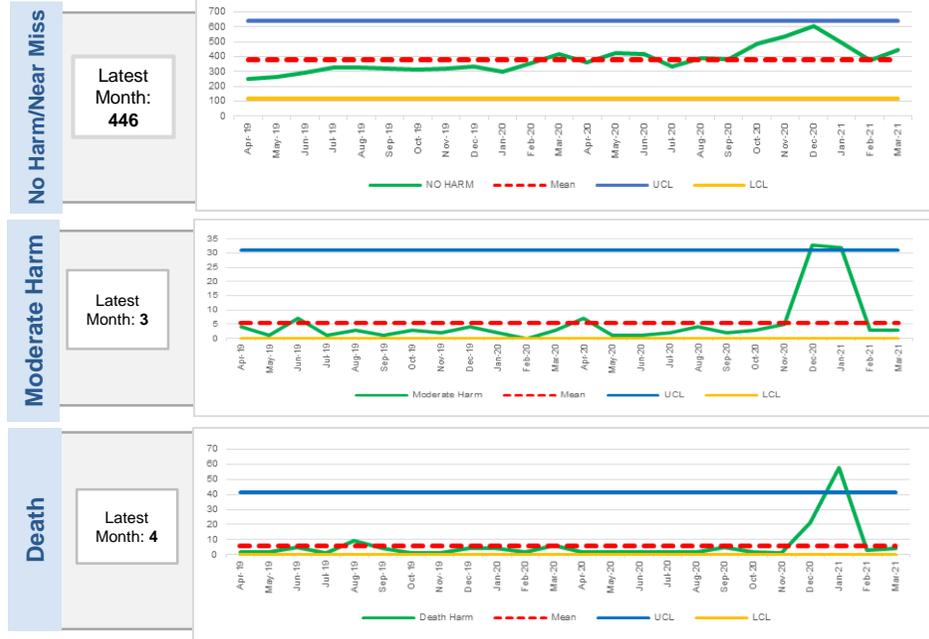
Overtime incentives to ensure cover at predicted busy periods.

Daily operational performance review and actions

1. Our Patients

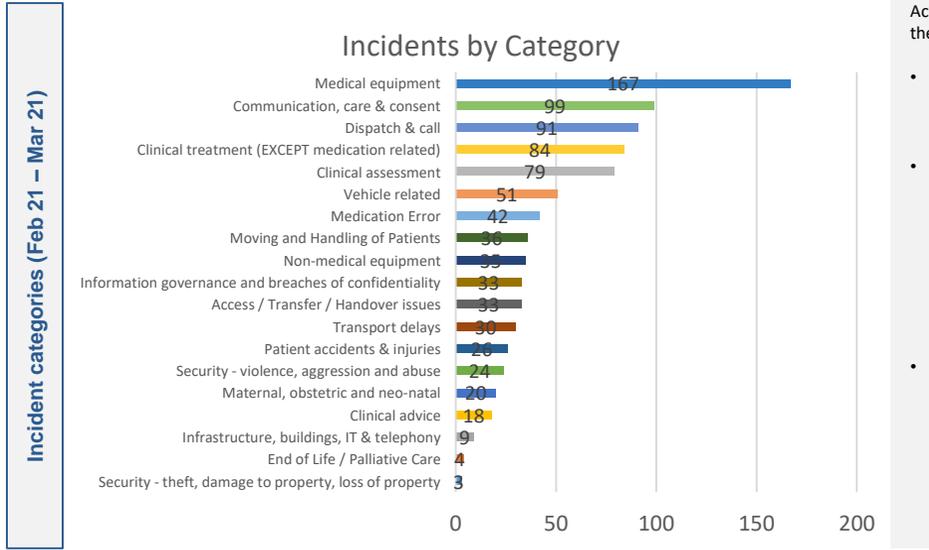
Safe Scorecard

999 Incident Management



Analysis of SPC graphs:
The number of reported no and low harm incidents continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust Safety Investigations Assurance and Learning Group (SIALG). There continues to be a yearly increase in the reporting of these incidents with an 35% increase in 2020/21.

The number of moderate, severe and death patient safety incidents decreased in February and has returned within normal reporting numbers following the received COVID19 wave which saw demand on the service increase.

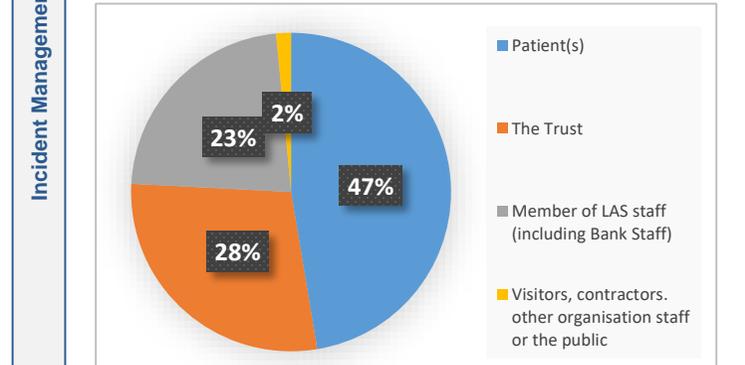


Actions are being taken to address these themes including:

- Incidents relating to medical equipment's are reviewed by F&L to ensure equipment is replaced.
- There is a risk on the Corporate (TW) Risk Register regarding missing equipment. An education and training piece of work is being undertaken between operations and logistics. The Trust is establishing an assess tracking system to support and monitor this issue going forwards.
- There has been a recent trend of incidents regard communication channels not being monitored between clinicians on scene and EOC. Work is underway to ensure that communications are monitored correctly within EOC for staff safety purposes.

There are 935 incidents (as of 01/04/2021) which have been opened on the system longer than 35 working days (this excludes Sis and COVID 19 reviews). This breaks down to 443 patient incidents, 212 staff incidents 14 visitor incidents and 266 Trust related incidents.

This remains a focus of QGAMs to support operational colleagues investigate and close down incidents accordingly.





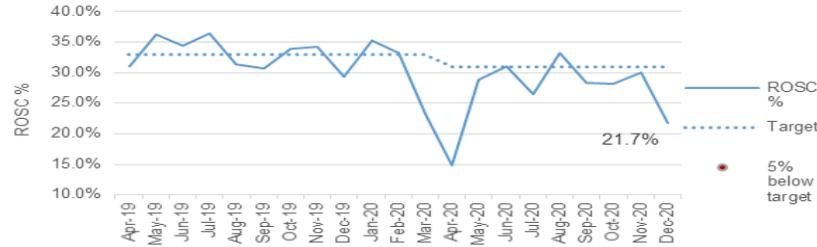
Our Trust-wide scorecard covers four of the key Ambulance Quality Indicators: Cardiac Arrest - Return of Spontaneous Circulation (ROSC) at Hospital, Sepsis - Care Bundle, STEMI - Call to angiography and Stroke - Call to door. The data presented is from **December 2020**, which is the most recent month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

ROSC at Hospital

Month: **21.7%**

Target: **31.0%**

2019/20 Position: **31.9%**



In December, the LAS ranked 5th nationally for ROSC on arrival at hospital for the overall group (21.7%) and 2nd for the Utstein group (47.7%), both of which are above the national average of 21.5% and 43.1% respectively.

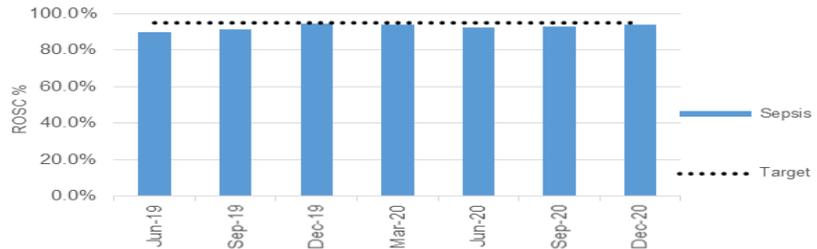
We ranked 10th for both Survival to Discharge for the overall group with 1.3% and the Utstein group with 2.9%, both below the national average of 5.5% and 19.1%.

Sepsis Care Bundle

Month: **94.0%**

Target: **95%**

2018/19 Position: **89.5%**



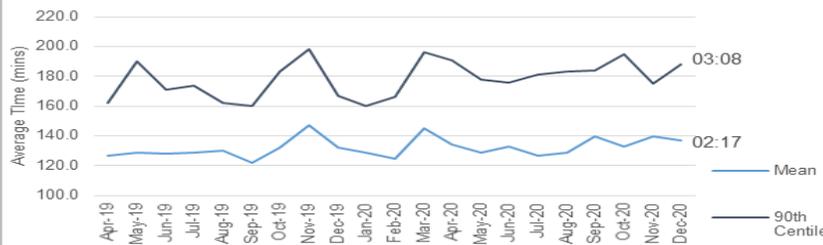
In December the LAS delivered the Sepsis Care Bundle for 94% of eligible patients, ranking us in 1st place and well above the national average of 85.5%

STEMI call to angiography

Mean: **02:17**

Target: **02:10**

2019/20 Position: **02:11**



For the call to angiography measure, the LAS achieved a mean average time of 02:17 in December 2020, which ranked 3rd in England overall. This time is also 4 minutes shorter than the national average.

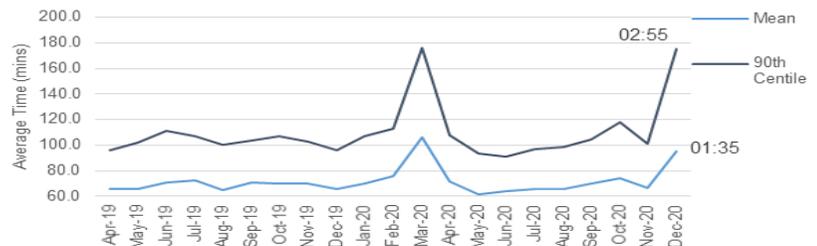
STEMI Care Bundle data was not required by NHS England this month; data is next due to be published in June (relating to January 2021).

Stroke call to door

Mean: **01:35**

Target: **01:10**

2019/20 Position: **01:13**



In December 2020, for the LAS was ranked 7th in England in terms of our mean call to door time for suspected stroke patients (01:35). This was 4 minutes longer than the national average (1:31).

NHS England did not publish Stroke Diagnostic Bundle data for December, the next data due to be published will be for February (in July 2021).

1. Our Patients

111 IUC Performance



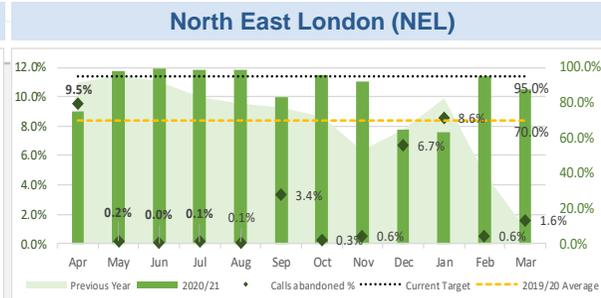
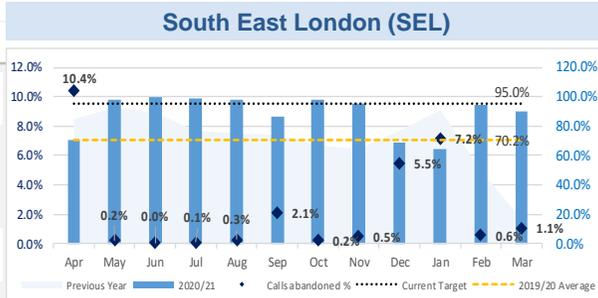
Call answering was outside target in March for North East London (NEL) and South East London (SEL) due to a steady level of demand and increased call levels following school return and other lockdown easing. Both SEL and NEL were within target for calls transferred to 999. The abandonment rates were within target for March across the board. We were challenged in the recommendation to attend ED performance for both SEL and NEL.

Call Answering & Abandoned Calls

SEL: 90.4% / 1.1%

Target: 95% (CA) and 5%

NEL: 87.8% / 1.6%



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

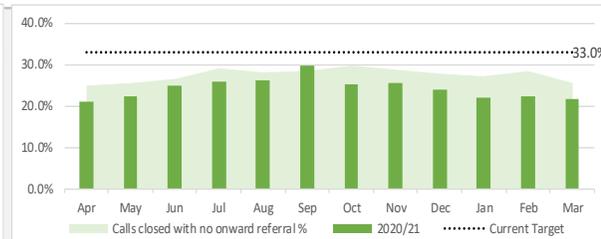
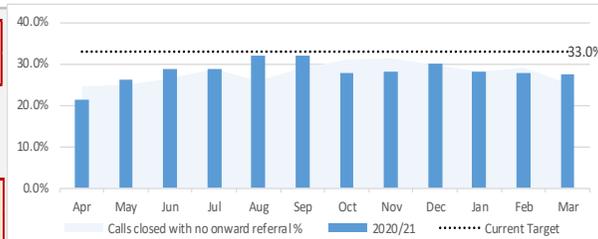
The number of calls abandoned by patients was well within the 5% target..

% of calls closed with no onward referral

SEL: 27.5%

Target: >33%

NEL: 21.6%



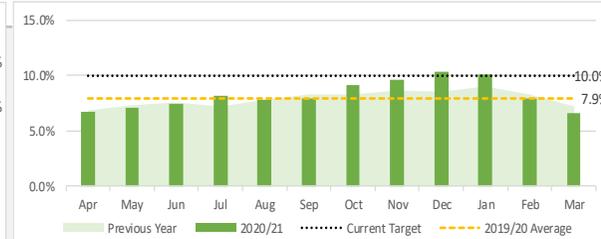
We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases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

Calls Outcome: Transferred to 999

SEL: 7.0%

Target: <10%

NEL: 6.6%



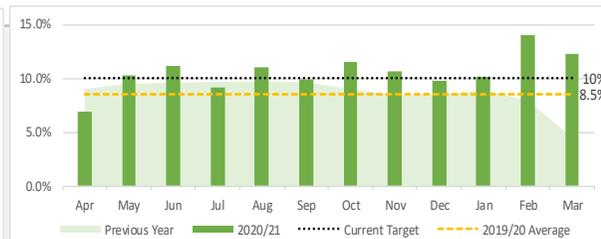
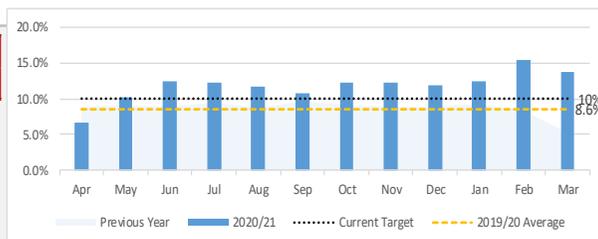
Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During September, NEL delivered 6.6%, with SEL delivering 7.0%. This performance compares positively against the London average which was 8.2%, demonstrating the benefits of a clinical assessment service (CAS).

Call Outcome: Recommended to attend ED

SEL: 13.8%

Target: <10%

NEL: 12.3%



The performance on this metric has been challenged while striving to give patients the most appropriate care during the pandemic as the clinical profile of calls changed. There is still work to do to reduce recommendation for patients to attend A&E while balancing with patient safety and the transfer to 999.

1. Our Patients

Safe Scorecard

IUC Incident Management



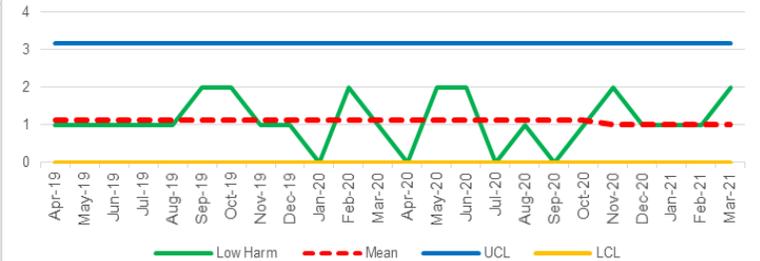
No Harm/Near Miss

Latest Month: **163**



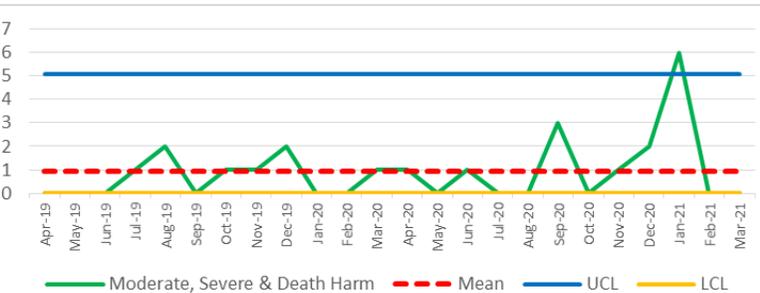
Low Harm

Latest Mo2th: **1**



Moderate, Severe & Death Harm

Latest Month: **6**

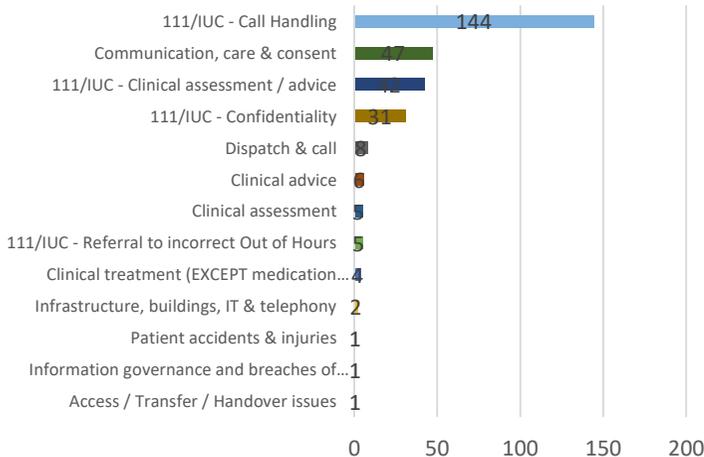


Analysis of SPC graphs:

The number of reported no and low harm incidents continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust Safety Investigations Assurance and Learning Group (SIALG). There continues to be a yearly increase in the reporting of these incidents with a 75% increase in 2020/21.

The number of moderate, severe and death patient safety incidents decreased in February returning to normal reporting numbers following the received COVID19 wave which saw demand on the service increase.

Incidents by Category



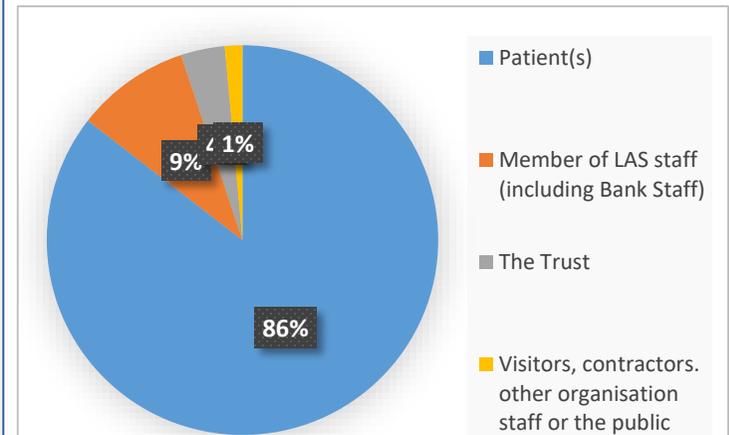
Call handling, Clinical assessment / advice and Confidentiality are the top three categories.

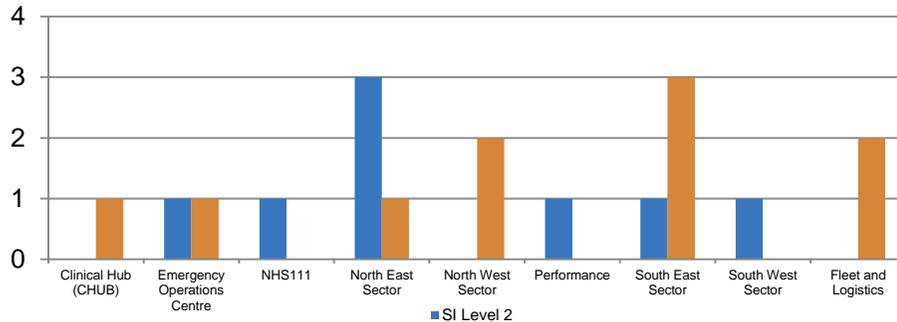
Actions are being taken to address these themes including:

- Regular Clinical CPD sessions have recommended, 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
- The vast majority of the incidents fit into the call handling category. The service actively promote all staff in the reporting of incidents, once investigated all cases are fed back for learning and if any trends are identified, further retraining is provided. In comparison of incidents vs call volumes the % is considered low.

Incident Management

There are 138 incidents (as of 01/04/2021) which have been opened on the system longer than 35 working days (this excludes SIs & COVID 19 reviews). This breaks down to 118 patient incidents, 13 staff incidents 2 visitor incidents and 5 Trust related incidents.





During February and March 2021, 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.

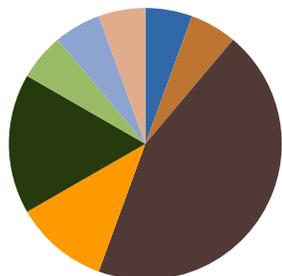
Of note

- 8 incidents were declared based on the face to face clinical assessment undertaken. Specifically 3 incidents related to the management of patients who had sustained traumatic injuries. .
- 1 incidents involved the management of a patients airway, specifically endotracheal intubation.
- 1 incident involved a 999 call which was not triaged where MPDS triage was indicated.
- 1 incident involved a delay in obtaining a Category 1 response priority, and subsequently delivering CPR instructions.
- 1 incident involved a vehicular issue where the boot of an FRU was not able to be opened and a defibrillator not able to be retrieved.

Mitigating actions that have taken place:

- Communications have been sent out to FRU staff notifying them of the quick boot release button in the rear of the vehicle.
- The Clinical Update to contain education on Silver Trauma.
- The Education and Standards Team reviewed all teachings in relation to silver trauma to ensure that they are up to date and delivered to all clinical staff.
- 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.

Feb and March 2021 SI Categories



- 111/IUC - Call Handling
- Clinical advice
- Clinical assessment
- Clinical treatment (EXCEPT medication related)
- Dispatch & call
- Medicines Management incl. Controlled Drugs
- Patient accidents & injuries
- Vehicle related

There continues to be a focus on SI actions and at the end of March there were 149 open actions, of these 20 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 (SIALG) where escalations to departments are communication, if required.

There are 2 incidents which are oldest and highest in priority:

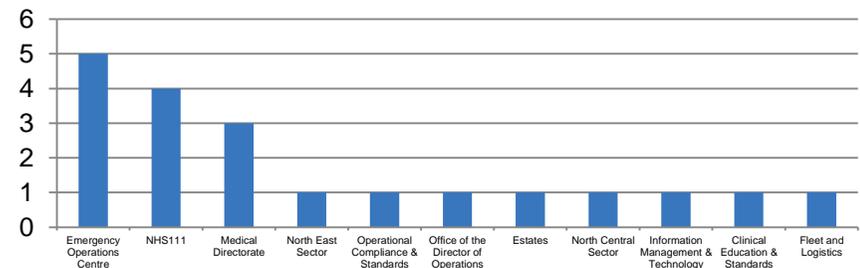
1. The Trust to increase internal logging of usage of/access to data which should provide a further deterrent against inappropriate access to data; and allow the Trust to monitor usage of data.

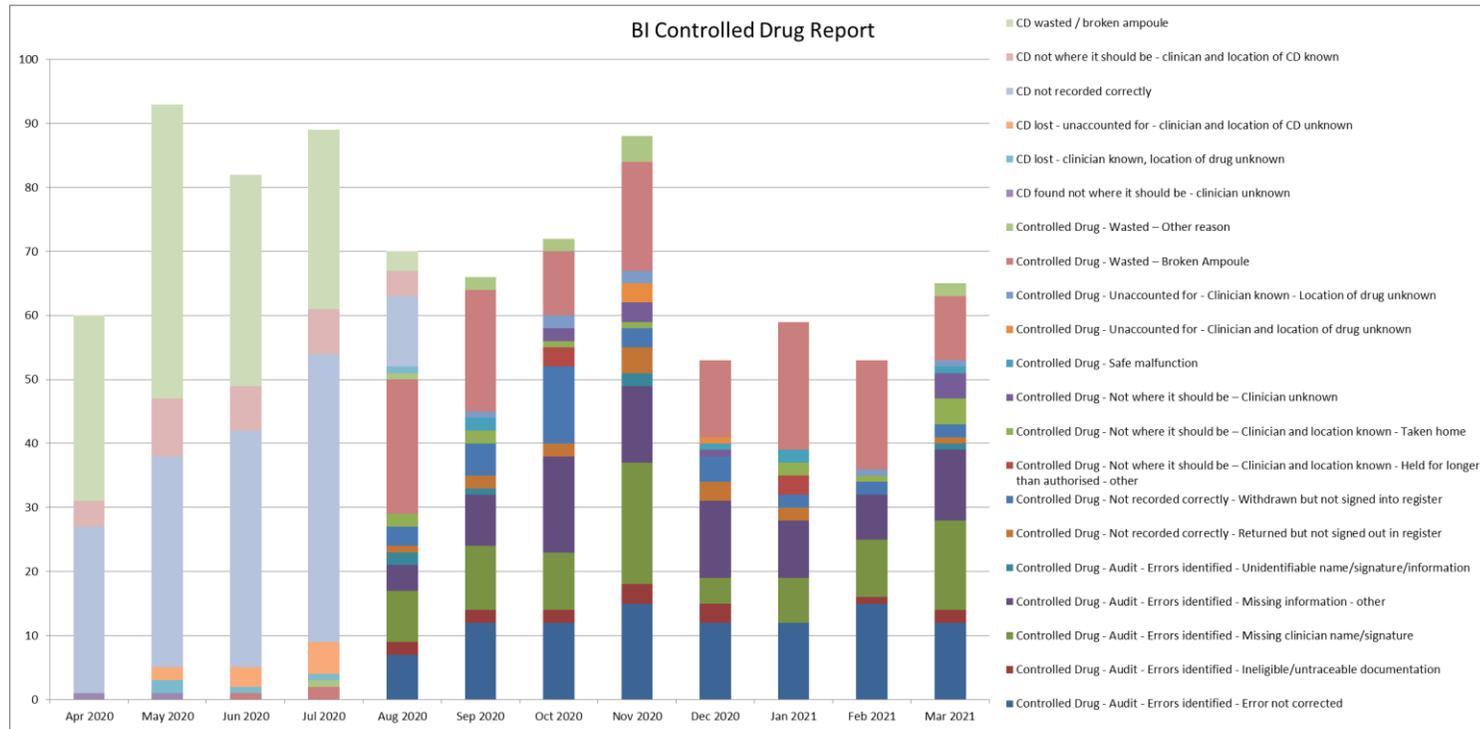
Update: It had been identified that the Trust should have improved logging on the Windows Server infrastructure. As part of Cyber Essentials project 'Security Information and Event Management' (SIEM) had been budgeted. This is now encompassed as part of the Solarwinds project incorporating SIEM which is in progress.

2. The Trust should consider moving towards electronic access system for all LAS buildings. There are some stations where this facility in place which has been enabled however not all operational stations have this facility in place. This will ensure that local managers have oversight of individuals who have accessed their stations, reduce workload on the resource co-ordinators and local management when changing door codes. Additionally access to LAS buildings can be restricted should a member of staff leave the Trust.

Update: This action will be addressed via the long term strategy aims regarding estates which includes the ambulance modernisation programme. The action deadline will be extended to reflect this ongoing programme of work.

Overdue actions by Department





- Single loss of syringe of morphine (8mg) in hospital ward.
- Total of 74 other controlled drug (CD) incidents including
 - Medicines left unsecured (n=8)
 - Documentation error (n=43)
 - CD damage, breakages or losses (n=12)
 - CD retained off duty (n=9)
 - Abloy key loss (n=1)
- Non-controlled drugs incidents
 - KitPrep discrepancy (n=7)
 - Breakage (n=9), damage (n=2), loss (n=1) or out of date (n=3) drugs
 - Drugs usage form discrepancies (n=5)
 - Drug pack unsealed (n=1) or drugs unsecured (n=1)
 - Inappropriate administration of dexamethasone (n=2), aspirin (n=1), diazepam (n=3), glucagon (n=1), midazolam (n=1), naloxone (n=1), ondansetron (n=1), paracetamol (n=5), salbutamol (n=1).

Assurance

- Incidents where morphine retained off duty identified and resolved promptly. This means that controlled drugs remain secure and accounted for.
- Single unaccounted for loss of morphine in hospital environment – likely disposal.

Actions

- Audit of medicines packing unit underway given recent reports of drug pack and form discrepancies
- Ongoing development of new medicines packing unit – will enhance medicines management.
- Procurement of Buttercups medicines training for medicines packing unit staff to improve drug handling and supply management.



People Scorecard

March 2021														
Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status against current month	Current Performance					Trajectory	Target Status against trajectory	Benchmarking		
					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)
In-Ops Vacancy Rate (% of establishment)	Monthly	%	Mar-21	●	5%	Internal	3.4%	4.3%	4.3%	3.5%	●			
Staff Turnover (% of leavers)	Monthly	%	Mar-21	●	10%	Internal	8.3%	8.9%	8.9%	8.4%	●			
Staff Sickness levels (12 month rolling) (%)	Monthly	%	Mar-21	●	5%	Internal	5.6%	5.4%	5.4%	5.5%	●			
Statutory & Mandatory Training (85% or above)	Monthly	%	Mar-21	●	85%	Internal	82.0%	84.0%	84.0%	82.0%	●			
Staff PDR Compliance (85% or above)	Monthly	%	Mar-21	●	85%	Internal	77.0%	70.0%	70.0%	75.0%	●			
% of BME Staff	Monthly	%	Mar-21	●	17.5%	Internal	18.1%	17.3%	17.0%	18.0%	●			
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/%)	Mar-21	●	36%	Internal	14.0%	14.0%	14.0%	14.0%	●			
Level 3 Safeguarding Training Completed (90% target over 3yr period)	Monthly	%	Mar-21	●	800	National	100.0%	85.0%	85.0%	85.0%	●			
Staff Engagement Theme Score	Yearly	(n)	Mar-21	●	6.5	Internal	6.2		6.1		●			
Staff Survey Response Rate	Yearly	%	Mar-21	●	≥72%	Internal	72%		72%		●			
Equality, Diversity & Inclusion Theme Score	Annual	(n)	Mar-21	●	8.3	Internal	8.0		8.1		●			
BME Staff Engagement Theme Score	Yearly	(n)	Mar-21	●	6.4	Internal	TBC		6.2		●			
Bullying & Harassment (Safe Environment Theme)	Yearly	(n)	Mar-21	●	7.3	Internal	7.1		7.0		●			

- 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

2. Our People

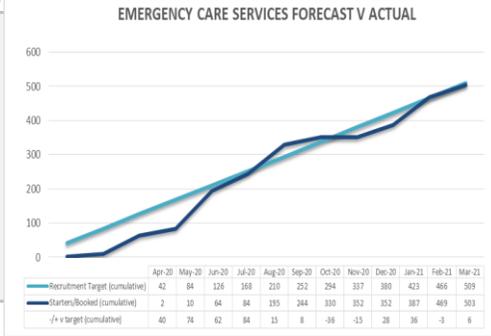
Vacancy Rates, Staff Turnover and Sickness



Recruitment

Month:
11FTE

Target: 11FTE



Required Frontline:
509FTE

Supply: 503FTE

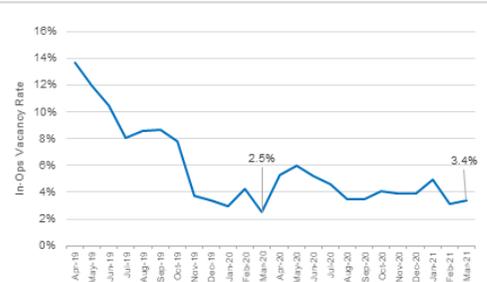
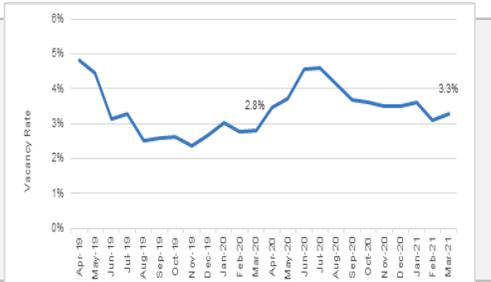
Recruited gap: 6TE under
In-ops gap: 108FTE(3.4%)

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. The in-ops rate has increased from 3.1% in February to 3.4% in March with 99 Assistant Ambulance Practitioners and 9 Paramedics in classroom training. The tender process to procure an external international recruitment provider is in progress and the timeline will allow the supplier to go live by June 2021 to allow as much time as possible for them to meet the ambitious recruitment targets for 2021-22 (269 international paramedics). To support the non-registrant requirements for 2021/22 the Trust has procured a new external TEAC provider to deliver the planned TEAC numbers. This will release capacity within Clinical Education Services and maximise staff for operations. The first TEAC cohort will commence in May 2021.

Vacancy Rate

Month: 3.1%

Target: 5%

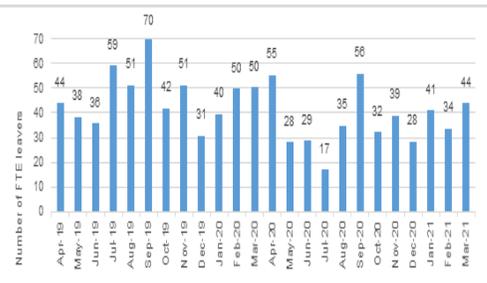
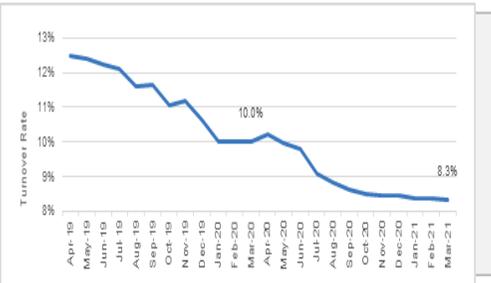


Our overall vacancy rate remains below target at 3.3%. There are significant activities in progress to deliver increased resources in both our EOC and 111 call handling services. We are currently fully established in EOC and maintaining this level in preparation for the new CAD later this year in October. We are on track to achieve a full call handling establishment in September (NEL, SEL, NWL) and are looking at options to bring this forward. The current paramedic pilots with Merton PCN and Redbridge PCN will provide the opportunity to test arrangements for PCNs and apply any lessons learned in advance of a fuller launch in 2021/22.

Staff Turnover

12 Month Rolling: 8.4%

Target: 10%

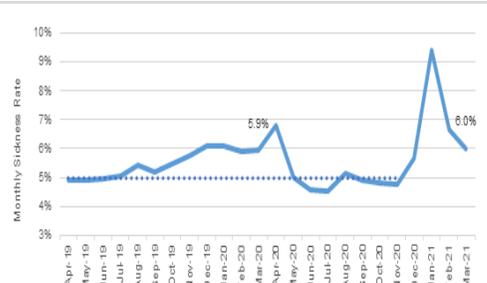
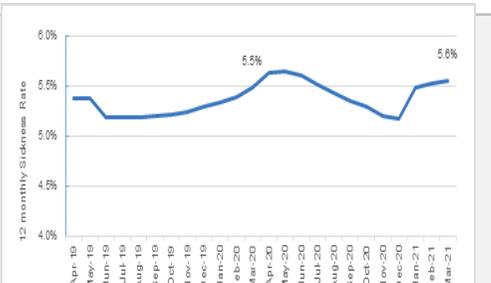


The turnover rate has reduced from 8.4% to 8.3%. The Trust continues to see a lower number of leavers in Emergency Care Services, 111 and EOC than forecast. There are a number of retention activities in place for frontline staff, led by the Ambulance Ops Retention Group. This includes the recent launch of the iPara engagement survey, planned focus groups, funding indefinite leave to remain, supporting staff to utilise the Government's automatic one year visa extension, promotion of retirement options improvements in reason for leaving data quality.

Sickness

12 Month Rolling: 5.5%
Monthly: 6.7%

Target: 5%



The monthly Trust wide sickness has decreased from 6.7% in February to 6.0% in March. Non-covid sickness is 5.3% and Covid related sickness accounts for 0.7%. The 12 monthly rate has increased from 5.5% to 5.6%. We are seeing a number of staff absences extended due to delays in NHS treatment due to the Covid-19 pandemic and we are now seeing a handful of significant 'long-covid' cases which we are managing sensitively and supportively. The P&C teams are working with managers to support them with return to work interviews, welfare checks on absent colleagues and more engagement with OH.



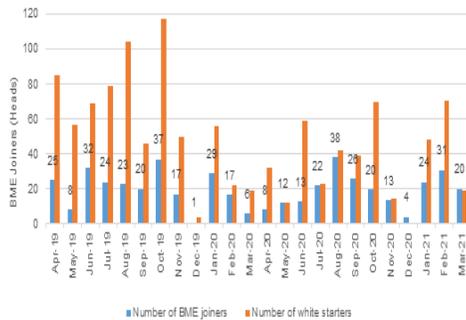
Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

Equality, Diversity and Inclusion Standards

These graphs show the numbers of BAME starters and leavers from April 2019 to March 2021. During this period the Trust has recruited 469fte BAME starters and 216fte BAME leavers, a net increase of 253fte.

In 2019/20, 25% of total starters were BAME. For the year 2020/21, this has improved to 35%.

BME Starters

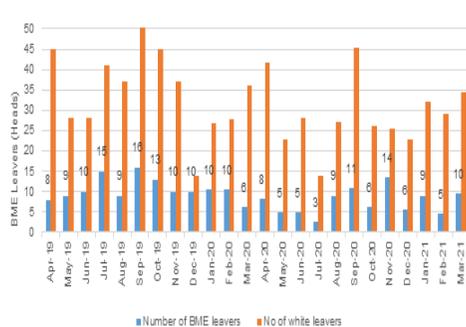


Overall numbers of BAME staff continue to increase (currently 1,189) although this representation varies at different levels in the organisation.

% of BME staff in band	
Bands 1-4	40.4%
Bands 5-7	12.9%
Band 8A to 9	14.2%

We have now received the National WRES report and are reviewing the results to benchmark against the Trust's data. We are still awaiting the WDES National report.

BME 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.

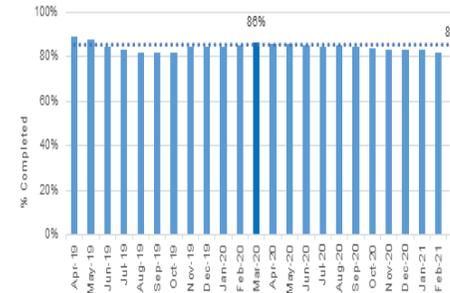
The Equality, Diversity & Human Rights (3 Years) e-learning has improved to 82%.

Statutory and Mandatory Training and Appraisals

Trust compliance in Statutory and Mandatory training is **82%**.

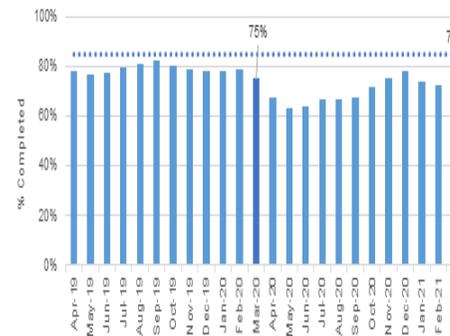
Appraisal completions at **77%** at the end of March.

Statutory & Mandatory



As at 31st March we are tracking below our 85% target at 82%. Information Governance is at 93% for March against an annual target of 95% to meet the requirements of the NHS Digital's IG Toolkit.

Appraisal Compliance



We have seen an increase in PDR rates during March which has improved the compliance from 72% to 77%. 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.



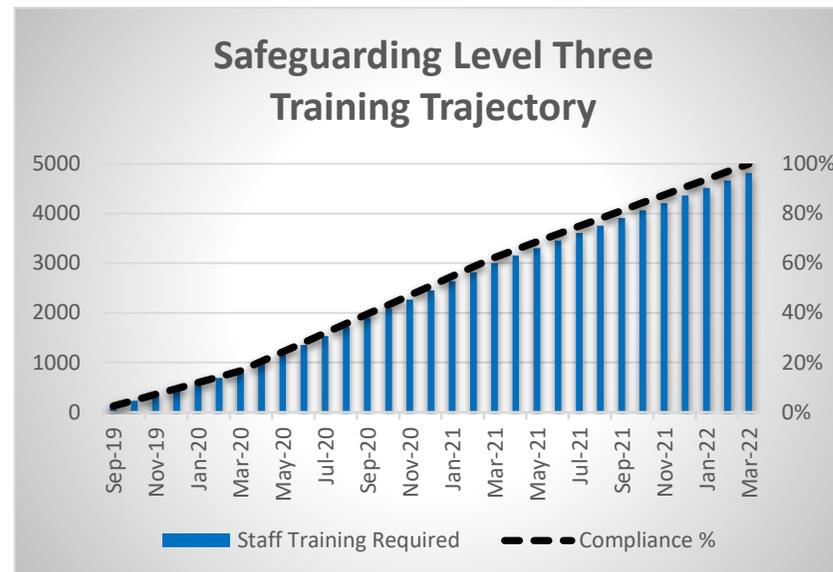
Current position

- Safeguarding Level 3 is now a National Requirement for all paramedics/clinical staff as of the 1st April 2019.
- There are 4,816 staff who need to be trained.
- A training plan was agreed with our Commissioners to deliver the training to all clinical staff by March 2022, and targets have been set for each of the years 2019/20, 2020/21 and 2021/22 as follows:
- For year one we achieved 103% completion with 913 having completed the Level 3 training.

	Year Start	Year End	Compliance Target	% Completed
Year 1	Apr-19	Mar-20	800	17%
Year 2	Apr-20	Mar-21	3,000	62%
Year 3	Apr-21	Mar-22	4,816	100%

- As a result of Covid 19 and the changes required to training we are currently seeking agreement to the new compliance target for year 2 of 2500 compliance whilst still completing full compliance by end of year 3.
- This training is part of the CSR hours of allocation and 8 hours was given to safeguarding.
- We are currently developing a mixture of e learning and virtual training via teams that equates to 8 hours. Just awaiting operations agreement to the new delivery plan.

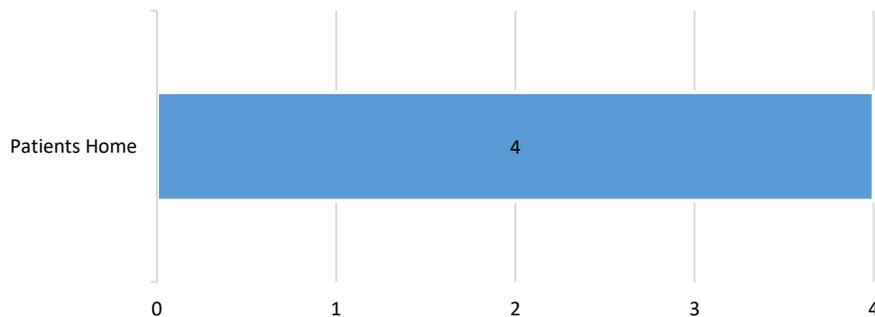
Safeguarding Trajectory





Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) by Sector –March 2021

MSK RIDDOR Incidents - Location



MSK RIDDOR Incidents – Equipment Involved



MSK RIDDOR Incidents – Body Part



MSK RIDDOR Incidents – Action Involved



Findings

- Riddor related incidents have remained fairly static since April'2020 with an average of 13 per month. The highest number of Riddor incidents for March'21 occurred in the patients home.
- The peak of Riddor related incidents reporting varies by month from sector to sector with the highest reporting during June'2020.
- There is an average of 1 reported moving and handling incident for every 2000 face to face attendances and an average of 3 working days lost per 1000 attendances.

Actions

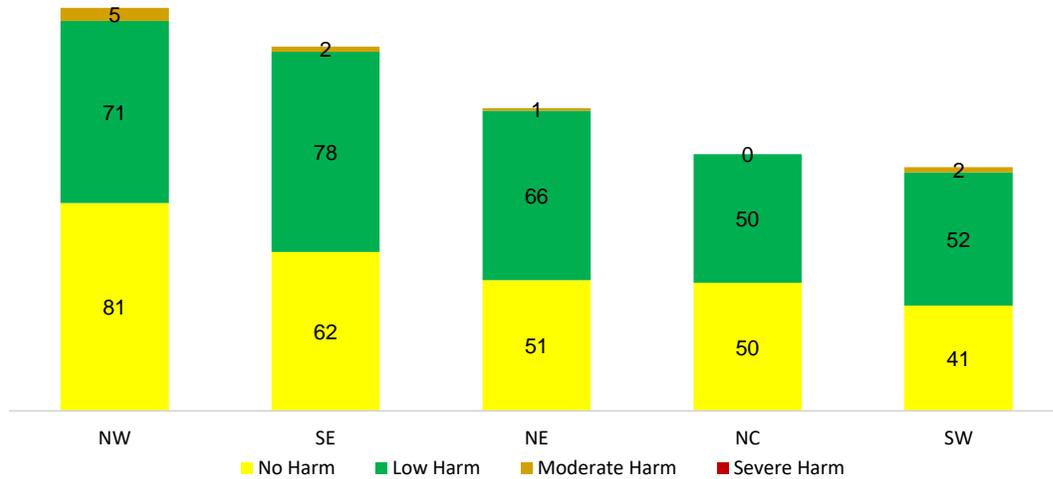
- The Wellbeing Strategy has been presented for approval, there are many aspects of the MSK Action Plan embedded within this strand of work.
- We are currently working on a video based electronic learning platform for CSR due to the pandemic face to face training is not practical, the videos include best practice in regards to moving and handling of persons. Along with some tips and tricks for using the small handling aids.
- Representation and feedback into the new Occupational Health re-tender is taking place and Physiotherapy and MSK requirements are being incorporated.
- Meetings with the current OH provider and the Physio Network have been taking place with requests for data being made, so that we can understand where the MSK damage is occurring and what remedial/proactive solutions can be undertaken going forward.
- MSK action plan has been updated and will be the focus of the steering group, along with the MSK workshop.

Assurances

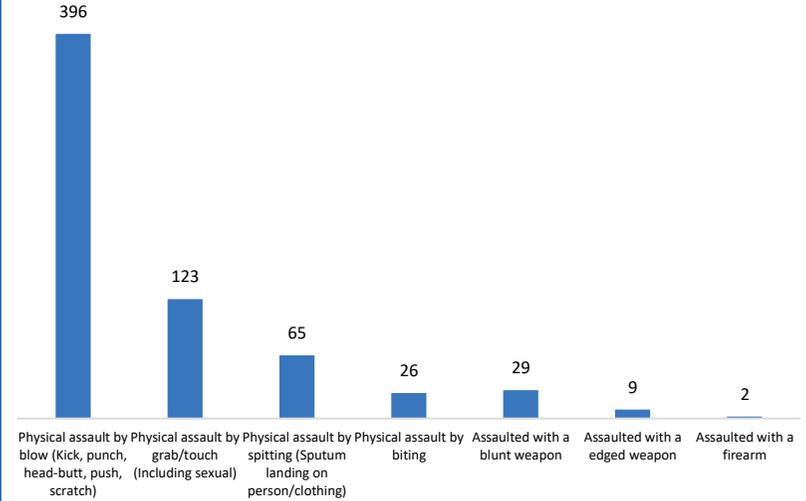
- Under the Manual Handling Steering Group we are feeding into the OH re-tender. OH re-tender project board including MSK KPIs into the OH performance reporting. Currently all work is being addressed through Manual Handling Steering Group.



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



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



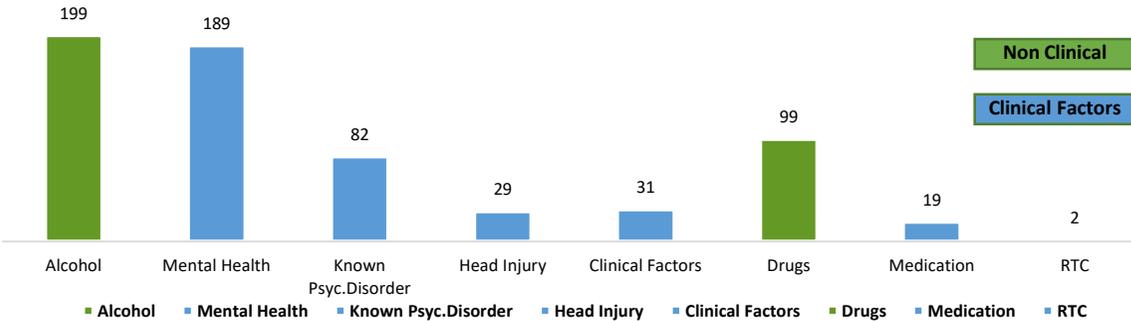
Notes:

- A total of 650 Physical Assaults on Staff were reported during 2020/21 (up to end March'21).
- 304 (47%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 346 incidents resulted in Harm. 334 (51%) of the harm related incidents were reported as 'Low Harm and 12 (2%) incidents were reported as Moderate Harm.
- 41 out of the 650 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc.).

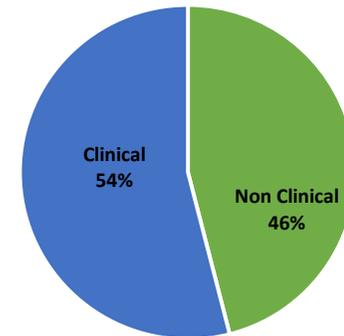
Notes:

- Physical Assault – by blows, kicks/ assault to staff (61% , n=396) accounted for the highest number of incidents reported during 2020/21 (up to end March'21).

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



Percentage Breakdown of Factors (YTD) – 2020/21

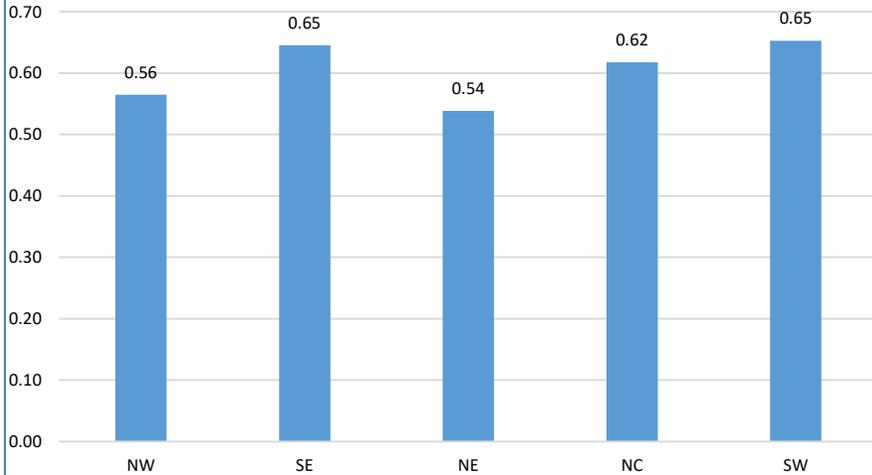


Notes:

- Clinical Factor: 350 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=189), Known Psyc.Disorder (n=82), Head Injury (n=29), Clinical Factors (n=31), Medication (n=19).
- Non Clinical Factor: 300 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=199), and Drug (n=99) and, RTC (n=2).



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

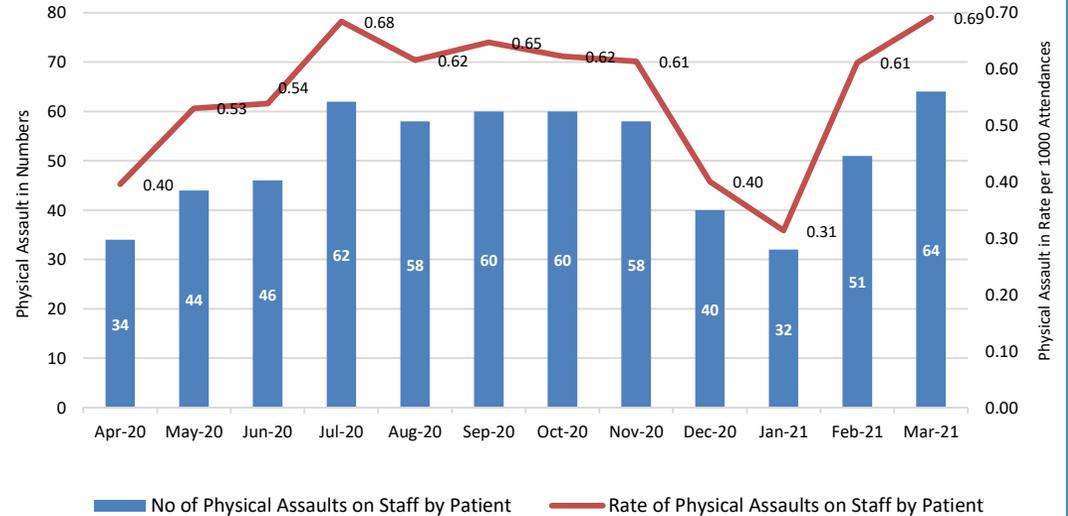


The graph and dash board (left side) provides the Rate of reported Physical Assault on Staff by Sector per 1000 face to face Attendances. According to the number of reported incidents: In all 5 sectors, approximately one physical assault incident occurred per every 2000 face to face attendances.

Findings

- 65 assaults reported during March'21.
- The greatest number of reported physical assaults (54%) occur due to the clinical condition of the patient;
- Police attended 69% of physical assault incidents;
- 27 successful prosecutions for assault have been recorded (year to date); and further 23 cases are awaiting trial.

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



The graph and dash board (above) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (April'2020 to March'2021).

Actions

- Close liaison with MPS Operation Hampshire continues to support victims through the criminal justice process.
- LAS and MPS information sharing agreement being produced to help facilitate VROs in liaising with MPS to support and update victims.
- A VPRS Plan has been developed and has been presented to the P&C Committee, and will be presented to the CHSWBC for agreement.

Assurances

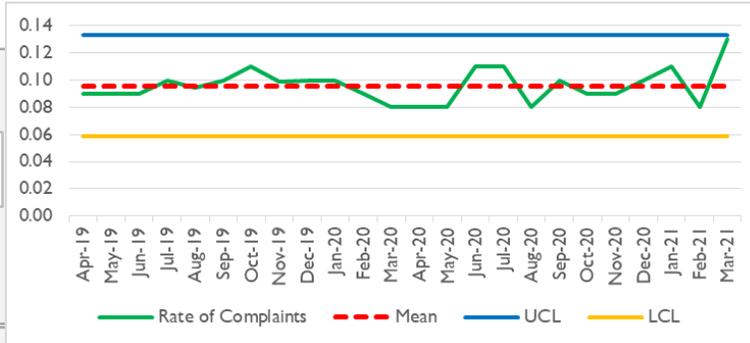
- Violence Reduction – Violence Reduction Officers (VROs) continue to provide support and guidance to both victim and management, following incidents of violence and aggression.
- BWVC trial continues
- Further funding from NHSE/I provided at short notice for BWVC trial.
- BWVC further funding enabling uplift in camera quantity from 219 to 1060.
- BWVC monitoring and governance group being established initial usage of cameras.
- LAS Violence Prevention and Reduction Standards work plan.



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:
0.13



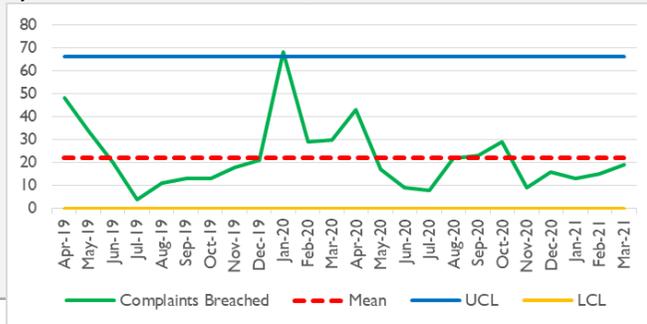
Complaints (including those recorded as concerns) was at the highest level for March since 2014. (120/117).

There were 390 x PALS enquiries which includes 158 added to the duty spreadsheet that did not require any further actions other than referring the enquirer to the correct team.

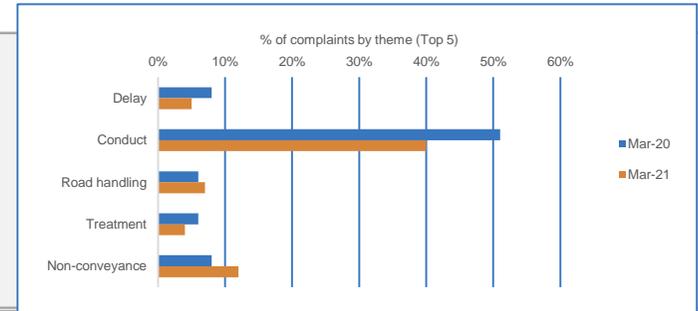
We managed 41 Quality Alerts of which 14 were from LAS staff.

Responding to complaints

Latest Month:
19



Categorisation



Total complaints for 2020/21 were 1052 – 6% less than the previous year (1125) but in line with our expected trajectory due to the Covid pause period during March to June 2020 when complaint numbers dipped.

Patient Experiences Department (PED) team will manage any complaint involving the service provided by HUC 111 where the call has been generated via LAS with effect from 14 April 2020.

We will be working alongside the P&C Business Support Manager to provide input into the new agile working policy for the LAS. Service mobile phones have been provided for the team so that personal phones are no longer used to manage calls from the public. This is especially important whilst the team continue to work remotely.

We are in liaison with the End of Life team preparing a feasibility report for the recruitment of a Bereavement Counsellor in the Trust to support operational staff and other colleagues who have been affected by death. Our team have managed a significant number of such complaints and enquiries during 2020/21 with a high percentage linked to the impacts of Covid-19.

Actions and Learning

Patient Experience – March 2021

The Ombudsman's Complaints Standards Framework was published at the end of March 2021. This model complaint handling procedure sets out how organisations providing NHS services should approach complaint handling. They apply to all NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

The guidance is being tested in pilot sites during 2021 and will be refined and introduced across the NHS in 2022. LAS has been selected as one of the early adopters and we are liaising with NASPEG to feed back on the recommendations.

We continue to abide by the guidance from NHS EI that during the Covid pandemic all healthcare organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The guidelines are effective from 01 February to 30 April and every effort should be made to avoid developing a backlog of complaints where it is possible to investigate and respond to the issues raised.

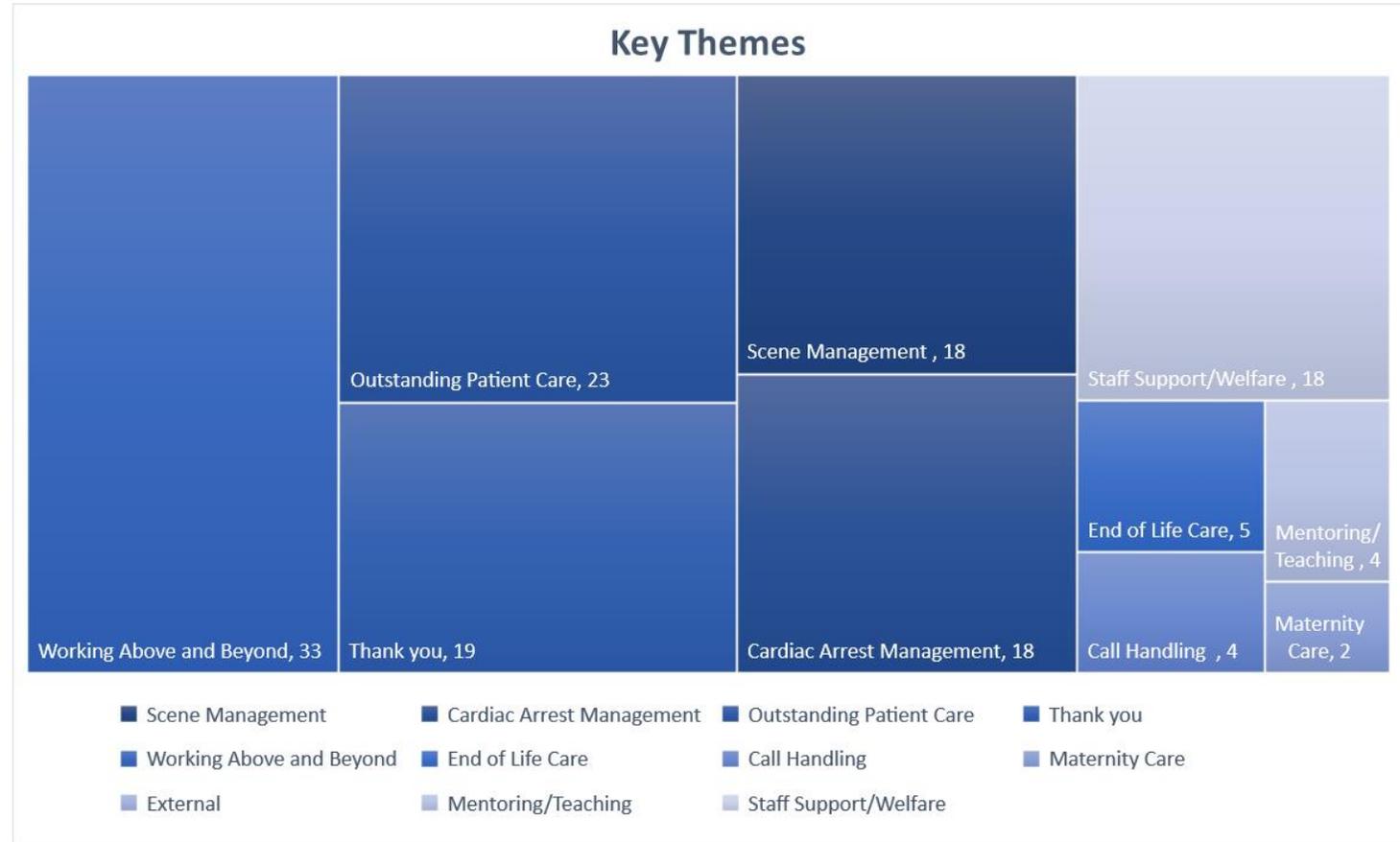
A number of Trusts have been impacted by this due to staff redeployment and increased absences due to Covid which in turn has affected our responses in some instances where complaints are hosted elsewhere.



In March 2021 144 *Excellence Reports* submitted were submitted which is the largest number ever received in one month.

Key themes identified from March reports include:

- Working Above and Beyond
- Outstanding Patient Care
- Thank you





Working Above and Beyond

This crew attend a fire in the roof of a 5 storey block of flats. A female was reported by the LFB to be bed bound in her flat on the fourth floor requiring to be evacuated on an orthopaedic stretcher. The LFB reported that they would not be able to fight the fire until the female was removed as the water damage would cause her bedroom ceiling to collapse on her. The crew were aware that they only had a short window of opportunity before the fire became out of control **act swiftly, professionally, and as a team.** they effected a rapid evacuation of the female and her husband without incident. They then **cared** for them both whilst exploring suitable accommodation. eventually conveying the patient to hospital as a final option as this was the only place of safety left available to them. The LFB later reported as predicted the bedroom ceiling had collapsed.

Whilst on scene of sudden infant cot death, this IRO arrived on scene showing **true leadership** that is a credit to himself and the LAS. Not only did the IRO have the challenging job of organising scene management of family members, Police, and pets in an emotionally charged area, he was also comforting LAS staff making sure we were his number one priority. They went **above and beyond the call of duty** in his welfare after the incident had been handed to the hospital. Words can not thank the IRO enough for the words of encouragement, his comfort and help offered. **A true NHS hero.**

On this CAD, the call was triaged as Cat 5. The Clinician picked up the call in CHUB and conducted a ring back. Following her telephone assessment the call was upgraded appropriately to a Cat 2. The Clinicians **excellent** clinical assessment meant that a critically ill patient, who was rapidly deteriorating, received medical intervention in a timely manner. Patient given BenPen by crew and blued to ED with meningitis. ED consultant also **commended** all involved for rapid assessment and treatment of a critically unwell 30 year old female.

They attended a Patient who had been stabbed, they treated the patient in a very **efficient, timely** and **professional** manner. The patient at the time was not exhibiting any signs or symptoms of being acutely unwell but unbeknown to us was bleeding internally. Their **rapid assessment** skills coupled with the recognition of a possible life threatened condition (unknown at the time, but possible) dictated a prompt response of conveyance to hospital continuing treatment of life saving drugs on route, which I believed **saved the patient's life.**

I called West Ham Workshop regarding a Critical Care Transfer Service ambulance needing repair, **very soon** I received a call back from the workshop informing me the parts were available for the vehicle. The ambulance was moved to West Ham. In a short time, the workshop informed me the repair had been completed. This **efficient rapid** repair minimised out of service time and enabled us to maintain our Critical Care Transfer capability.

Thank you to the crew for their assistance on a call. We were called to a young girl with breathing difficulties and we handed over this patient to you on your arrival. Both of you showed **true compassion, dedication** and **competence** when dealing with the patient and when **collaborating** with us in the treatment. **Thank you** for your positivity and making it this a good experience for us and the patient.

They have worked hard and shown a **passion** to set up the well being room at Greenwich giving us all a relaxing space to have fun and boost morale. For her **infectious happiness** and recreational sports (table tennis, & darts) she has worked hard to provide, I feel she deserves high praise and this excellence report. **Thank you!**



Some examples of excellence reports from March:

Cardiac Arrest Management–

This crew attended a 14 year old paediatric cardiac arrest. They were first on scene and within literally seconds of arrival, had identified cardiac arrest, had placed pads on, and delivered a shock. This one shock resulted in a ROSC, which later on led to respiratory effort. The outstanding speed of defibrillation was confirmed on APP download, and the continued quality of CPR till next pulse check was impressive.

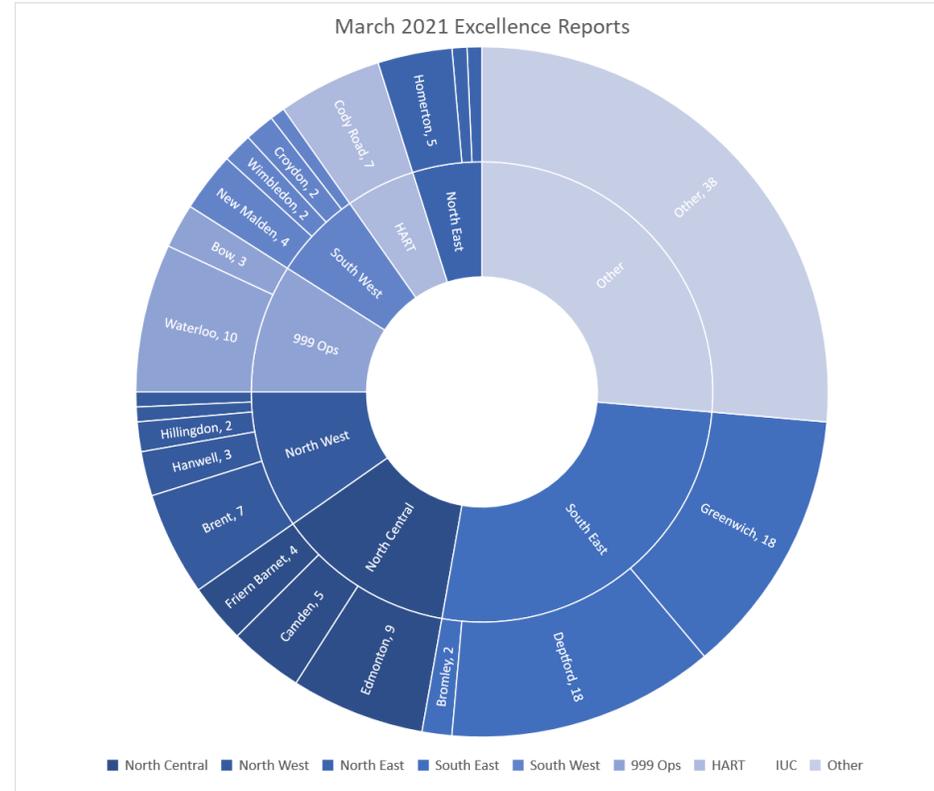
Call Handling–

They did an excellent handover to a clinician on a warm transfer using the SBAR process. What she had found during her pathways assessment and the recommendation from the clinical navigator was very clear, giving the clinician a good background into the reason for the call and her concerns. Well done!

Bystander CPR observed by the first crews on scene was clearly effective. Staff on scene at the care home informed crews that call handler had kept them calm and made them feel supported. Staff also felt that they were doing the right thing and were grateful of the call handlers support and competence.

Scene Management–

They were the team leader on scene when we arrived (3rd resource) to a multi patient assault with four patients all with stab wounds. I felt she had excellent management skills. In such a chaotic environment she managed the scene well and ensured we all felt supported in our patient care. As a result of her great management the job went well and was well coordinated.





Public Value Scorecard

March 2021

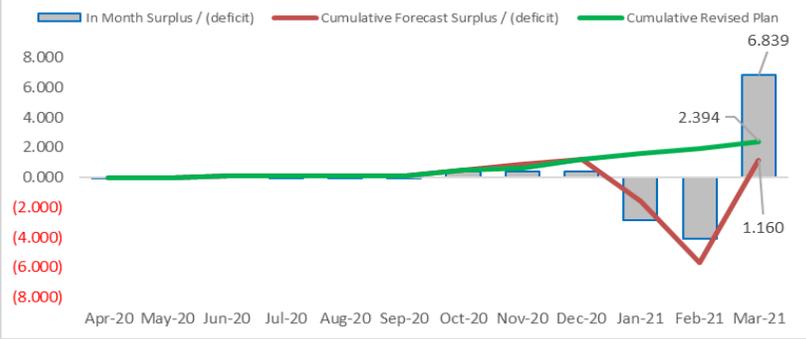
Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Performance						Outturn		Benchmarking			
				Target and Type (Internal / Contractual / National / All)	Latest Month Actual	Latest Month Plan	YTD Actual	YTD Plan	Rolling 12 Months	FY20/21 Forecast	FY20/21 Plan	National Data	Best In Class	Ranking (out of 11)	
Adjusted Financial Performance Total (Deficit)/Surplus	£m	Mar-21	●	0.000	A	6.008	0.387	0.257	2.326		0.257	2.326			
Performance Against Adjusted Financial Performance Plan	£m	Mar-21	●	>=0	A	5.621	0.000	(2.069)	0.000		(2.069)	0.000			
Use of resources index/indicator (Yearly)	Rating	Mar-21	●	1	A										
% of Capital Programme delivered	%	Mar-21	●	100%	A	48%	8%	99%	100%		98%	100%			
Capital plan	£m	Mar-21	●	44.211	A	21.364	3.410	43.805	44.211		43.343	44.211			
Cash position	£m	Mar-21	●	15.1	A	39.8				67.1	39.8				
% spend against Agency Ceiling	%	Mar-21	●		A	9%	8%	75%	100%		75%	100%			
CIP Savings YTD	£m	Mar-21	●		A										
	%	Mar-21	●		A										
CIP Savings achieved - % Recurrent	£m	Mar-21	●		A										
	%	Mar-21	●		A										
Commercial income generation	£m	Mar-21	●	1.00	I	0.75	0.08	1.88	1.00	N/A	N/A	1.00			
Corporate spend as a % of turnover	%	Mar-21	●	<7.0%	I	9.1%		10.1%			10.1%				
Cost per incident (measures to be confirmed in light of COVID)	£	Mar-21	●		I										
Average Jobs per shift	%	Mar-21	●	5.3	I	4.3		4.3		4.3					

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



The Trust's full year position was a £1.160m surplus (£0.257m surplus on an adjusted financial performance basis), and the month end cash position of £39.8m is good.

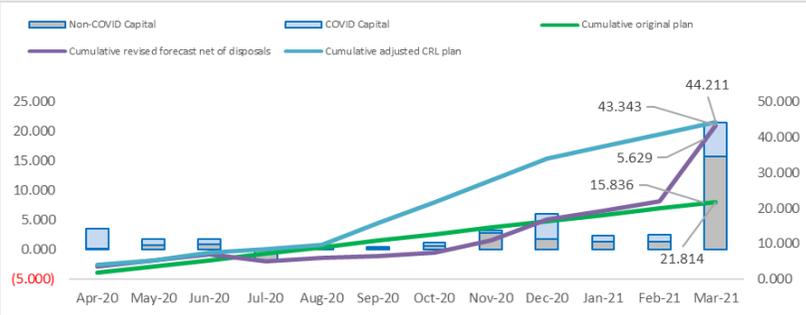
YTD outturn vs budget



- Full year Position:** The full year position at month 12 is a £1.160m surplus (£0.257m surplus on an adjusted financial performance basis) which is consistent with the target position agreed with NW London partners due to the reversal of accrued COVID retrospective top up income (£5.35m), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£7.3m).

The position incorporates costs of additional resourcing to meet COVID surge requirements of £12.7m and total COVID costs YTD (excluding centrally provided consumables and equipment) are £85.8m, with £7.6m recognised in M12 primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, and operational support services.

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:** Full year capital expenditure net of disposals and donated assets was £43.3m (£44m before disposals) compared to previously planned capital expenditure of £44.2m (£0.9m behind plan net of disposals). Very significant capital project spend was able to be recognised in M12 enabling forecast spend to be met. Capital spend on the Trust's phase 1 and 2 COVID-19 responses was £19.3m (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 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 £39.8m as at 31 March 2021, £21m above the revised plan. The main reason for the favourable position was the high level of accrued expenditure at year end. Cash balances have decreased in March compared to February due to the cessation of payment of block contract income in advance.
- 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 March 2021 YTD was 83% and 94.1% respectively. The Trust has a high volume of overdue invoices waiting to be approved and Directorate managers and staff are regularly sent lists of invoices that are outstanding and require approval.



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

Statement of Comprehensive Income (Month 12 – March 2021)

	Month 12 2020-21 £000			YTD Month 12 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	43,109	74,846	31,737	463,886	496,419	32,533	463,886	496,419	32,533
Other Operating Income	159	5,829	5,670	69,289	71,204	1,915	69,289	71,204	1,915
Total Income	43,268	80,675	37,407	533,175	567,623	34,449	533,175	567,623	34,449
Operating Expense									
Pay	(29,853)	(52,609)	(22,756)	(361,732)	(389,971)	(28,239)	(361,732)	(389,971)	(28,239)
Non Pay	(10,939)	(18,759)	(7,821)	(147,039)	(156,689)	(9,650)	(147,039)	(156,689)	(9,650)
Total Operating Expenditure	(40,792)	(71,368)	(30,576)	(508,771)	(546,660)	(37,889)	(508,771)	(546,660)	(37,889)
EBITDA	2,476	9,307	6,831	24,404	20,963	(3,441)	24,404	20,963	(3,441)
EBITDA margin	5.7%	11.5%	5.8%	4.6%	3.7%	(0.9%)	4.6%	3.7%	(0.9%)
Depreciation & Financing									
Depreciation & Amortisation	(1,596)	(2,804)	(1,208)	(16,293)	(16,023)	270	(16,293)	(16,023)	270
PDC Dividend	(445)	323	768	(5,340)	(3,432)	1,908	(5,340)	(3,432)	1,908
Finance Income	0	0	0	(4)	9	13	(4)	9	13
Finance Costs	(2)	68	70	(34)	36	70	(34)	36	70
Gains & Losses on Disposals	0	(55)	(55)	(340)	(394)	(54)	(340)	(394)	(54)
Total Depreciation & Finance Costs	(2,043)	(2,468)	(425)	(22,010)	(19,803)	2,207	(22,010)	(19,803)	2,207
Net Surplus/(Deficit)	433	6,839	6,406	2,394	1,160	(1,234)	2,394	1,160	(1,234)
NHSI Adjustments to Fin Perf									
Remove Asset Donations I&E Impact	5	(407)	(412)	(68)	(480)	(412)	(68)	(480)	(412)
Remove AME Impairments	0	1,473	1,473	0	1,473	1,473	0	1,473	1,473
Remove Donations from DHSC Bodies	0	(1,896)	(1,896)	0	(1,896)	(1,896)	0	(1,896)	(1,896)
Adjusted Financial Performance	438	6,009	5,571	2,326	257	(2,069)	2,326	257	(2,069)
Net margin	1.0%	8.5%	7.5%	0.4%	0.2%	(0.2%)	0.4%	0.2%	(3.6%)

Full Year Position

The full year position is a £1.160m surplus (£0.257m surplus on an adjusted financial performance basis) which is £1.123m behind plan due to the reversal of accrued COVID retrospective top up income (£5.35m), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£7.3m).

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 was £32.5m favourable to budget full year due to £13.1m of notional income for central NHSE pension contributions on behalf of LAS staff, additional COVID related income from NW London Commissioners (£7.3m), Flowers case income (£5.6m) and annual leave accrual movement funding (£4.8m) from NHSE, Critical Care Transfer Service income (£0.5m) and IUC income (£0.5m).
- Other operating income was £1.9m favourable full year due to notional income for consumables and equipment provided by DHSC during the pandemic (£4.4m), the notification of an additional £1.9m of education and training income from Health Education England and £0.6m of additional charity, recharge and capital asset grant income offset by the reversal of £5.35m of accrued COVID retrospective top up income that the Trust was been notified will not be received.

Pay Expenditure:

- Pay expenditure was £28.2m over budget full year due to the recognition of £13.1m of notional cost for central NHSE pension contributions on behalf of LAS staff, £5.6m of accrued cost in relation to settlements in relation to the Flowers case for 2019-20 and 2020-21 overtime and additional COVID surge resourcing (£9.3m).

Non-Pay Expenditure:

- Non pay expenditure (excl depreciation and finance costs) was £9.7m adverse full year due to additional COVID support to respond to the impact of the new COVID-19 variants (£3.3m), dilapidation provisions (£2.1m), centrally provided stock and equipment costs (£2.4m) and higher general supplies and services spend (£2m) largely in relation to professional service support and projects.
- Depreciation and finance costs are £2.2m favourable to budget full year due to slippage on the Trust capital programme and subsequent PDC cost adjustments, offset by property impairment costs (£1.5m).



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 12 – March 2021)

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Mar-20	Mar-20	Mar-20
	Actual	Actual	Actual	Actual	Actual	Actual	YTD	YTD	YTD
	£000	£000	£000	£000	£000	£000	Move	Plan	Var
Opening Balance	64,610	76,394	78,620	86,719	80,572	84,806	25,964	25,964	0
Operating Surplus	1,849	2,117	1,677	(1,519)	(2,694)	7,298	18,951	24,242	(5,291)
(Increase)/decrease in current assets	8,512	2,247	7,024	(3,985)	7,279	(13,363)	(6,268)	9,380	(15,648)
Increase/(decrease) in current liabilities	2,397	4,700	1,807	1,836	4,547	(38,141)	31,680	711	30,969
Increase/(decrease) in provisions	(86)	(240)	(1,265)	(104)	402	959	963	(3,903)	4,866
Net cash inflow/(outflow) from operating activities	12,672	8,824	9,243	(3,772)	9,534	(43,247)	45,326	30,430	14,896
Cashflow inflow/(outflow) from operating activities	12,672	8,824	9,243	(3,772)	9,534	(43,247)	45,326	30,430	14,896
Returns on investments and servicing finance	0	0	0	12	0	1	1	(12)	13
Capital Expenditure	(888)	(3,880)	(1,144)	(2,387)	(5,300)	(11,853)	(38,973)	(45,665)	6,692
Dividend paid	0	(2,718)	0	0	0	(1,474)	(4,192)	(5,392)	1,200
Financing obtained	0	0	0	0	0	11,555	11,662	13,480	(1,818)
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	(888)	(6,598)	(1,144)	(2,375)	(5,300)	(1,771)	(31,502)	(37,589)	6,087
Movement	11,784	2,226	8,099	(6,147)	4,234	(45,018)	13,824	(7,159)	20,983
Closing Cash Balance	76,394	78,620	86,719	80,572	84,806	39,788	39,788	18,805	20,983

Operating Position

There has been a net inflow of cash to the Trust of £13.8m, this is £21m higher than the planned outflow of £7.2m. Cash funds at 31 March stand at £39.8m.

The operating surplus at £19.0m is £5.3m 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 (£6.3m), (£15.7m) lower than the planned movement
- Current assets movement was due to receivables (£0.4m), accrued income (£12.1m), prepayments (£1.3m) and inventories (£1.9m)

Current Liabilities

- The movement on current liabilities is £31.7m, a £31.0m higher than planned movement.
- Current liabilities movement was lower than planned due to trade and other payables £3.8m, accruals £26.0m and deferred income at £1.2m. The accruals increase is due to an increase in activity and delays in suppliers sending their invoices for payment.

Dividends

- The movement on dividends paid is (£1.2m), the lower payment is due to higher daily cash balances during the year.

Provisions

- The movement on provisions is £1.0m, which is £4.9m higher than the planned movement. This is due to the payment for the Flowers case being deferred until next year.

Capital Expenditure

- Capital cash movement was a net outflow of £39.0m which is £7.0m 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.

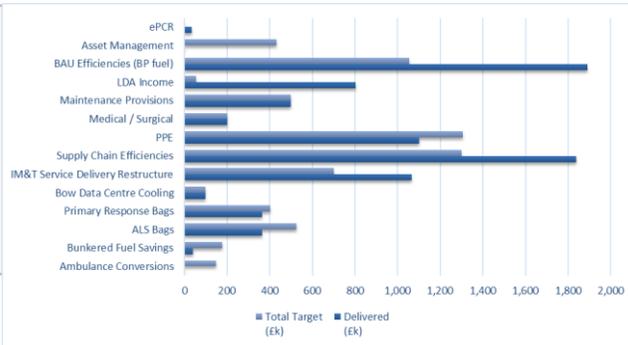
Cost Improvement Programmes (CIPS)

- 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 were developed to meet this need. Additional efficiencies were also identified to match further approved spend with £4.5m added bringing the total target to £6.9m which was achieved.

CIP Savings

FY: £8.3m

FY Target: £6.9m



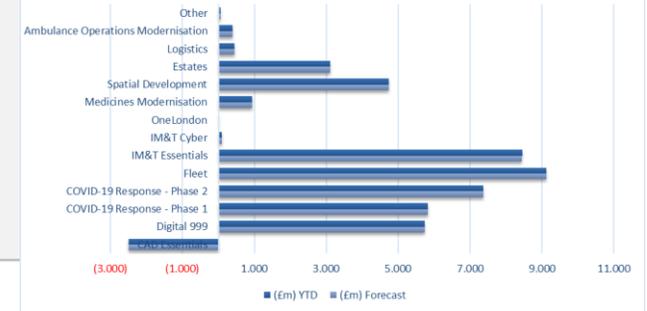
Capital Plan

- Full year capital expenditure net of disposals and donated assets was £43.3m (£44m before disposals) compared to previously planned capital expenditure of £44.2m (£0.9m behind plan net of disposals) which includes the reversal of £2.3m of CAD upgrade project related capital work in progress.
- Capital spend on the Trust's phase 1 and 2 responses to COVID-19 is £19.3m 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: £43.3m

FY: £43.3m

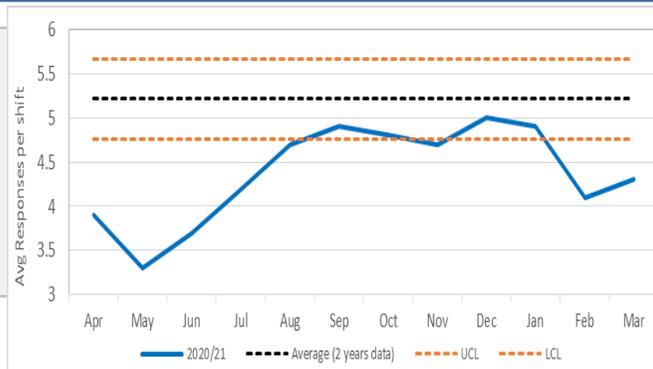


Jobs per shift (DCA)

Average jobs per 12 hour shift

Actual: 4.3

Target: 5.3



Operations are tracking the performance of jobs per shift on a monthly basis. 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

March 2021

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Current Performance			Benchmarking (Month)		
						Latest Month	Year To Date (From April)	Rolling 12 Months	National Data	Best In Class	Ranking (out of 11)
Hospital handover	minutes	Mar-21	●	18.0	I	19.6	20.3	20.3			
Post-handover (Handover 2 Green)	minutes	Mar-21	●	15.5	I	15.3	14.8	14.8			
See and Convey – to ED (Contractual Position) *	%	Mar-21	●	57.0%	C	52.9%	51.0%	51.0%	54.0%	49.6%	5
Hear and Treat % **	%	Mar-21	●	8.39%	I	10.9%	10.8%	10.8%	8.3%	11.9%	2
Hear and Treat (n) **	%	Mar-21	●	108,073	I	11,284	133,598	133,598			
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 Key

Top 3

Ranked 4-7

Ranked 7+

Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes

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

4. Our Partners

Maximising safe non-conveyance to ED



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

Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

Patient Handover to Green

We saw a further drop in the number of delays in March, with the overall number at 930 hours lost from our arrival to patient handover over 30 mins. Queens Romford, Whipps Cross, and North Middlesex had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the highest number of lost hours over 30 minutes, at 209 hours for the month.

In March, we saw handover to green performance again within the target, with 15.3. However, close to 3,500 hours were lost due to patient handover to green exceeding the 14 minute threshold. Handover to Green received organisational focus through the Covid response team and will be given renewed focus as part of planning and recovery.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,645	1,581	215	14%	47.9	22.1
	North Middlesex	2,603	2,486	713	29%	146.9	25.8
	Royal Free	1,487	1,399	184	13%	25.1	21.9
	University College	1,176	1,126	28	2%	5.0	14.3
	Whittington	1,528	1,406	222	16%	30.9	21.4
North East	Homerton	1,264	1,143	41	4%	5.1	16.5
	King Georges	1,074	1,003	258	26%	34.9	25.5
	New ham	1,685	1,504	412	27%	39.0	25.3
	Queens Romford	2,741	2,608	1,110	43%	209.5	30.3
	Royal London	1,815	1,629	171	10%	17.1	21.5
	Whipps Cross	1,640	1,466	489	33%	119.0	28.3
North West	Charing Cross	1,271	1,215	17	1%	1.8	12.4
	Chelsea & West	1,321	1,201	9	1%	1.0	15.4
	Ealing	1,205	1,179	10	1%	0.6	11.2
	Hillingdon	1,828	1,728	49	3%	6.5	13.8
	Northwick Park	3,294	3,146	102	3%	26.8	14.5
	St Marys	1,710	1,622	105	6%	9.5	17.6
	West Middlesex	2,090	2,023	90	4%	13.7	16.3
South East	Kings college	1,950	1,844	276	15%	34.0	22.2
	Lewisham	1,485	1,311	86	7%	20.4	18.0
	Princess Royal	1,845	1,614	175	11%	72.4	20.0
	Queen Elizabeth II	2,312	2,092	24	1%	3.7	13.2
	St Thomas'	1,885	1,785	60	3%	5.6	17.9
South West	Croydon	2,214	2,072	72	3%	14.0	18.0
	Kingston	1,551	1,435	52	4%	4.2	19.5
	St Georges	1,888	1,633	232	14%	23.7	20.6
	St Helier	1,295	1,228	77	6%	12.1	19.0
TOTAL	47,802	44,479	5,279	12%	930	19.6	

Sector	Station Group	Handovers to Green	Handovers Exceeding 14 mins	% over 14 mins	Total Time Lost (hours)	Avg Time PH to Green	90th Centile PH to Green	Avg mins lost per breach
North Central	Camden	2,047	1,206	59%	197.3	16.1	30.4	9.8
	Edmonton	3,095	1,891	61%	300.5	16.9	30.7	9.5
	Friern Barnet	1,821	1,091	60%	148.0	16.0	27.7	8.1
	Homerton	2,320	1,394	60%	238.7	16.0	31.1	10.3
North East	New ham	2,966	1,803	61%	318.9	16.2	32.2	10.6
	Romford	3,252	1,885	58%	204.3	14.8	25.2	6.5
	Brent	3,839	2,252	59%	293.0	15.8	27.1	7.8
North West	Fulham	2,286	1,318	58%	179.9	15.7	27.5	8.2
	Hanwell	2,911	1,618	56%	177.5	15.1	24.5	6.6
	Hillingdon	1,549	817	53%	77.0	14.2	22.8	5.7
	Westminster	1,407	893	63%	133.1	16.8	29.2	8.9
South East	Bromley	2,540	1,498	59%	173.0	14.3	25.8	6.9
	Deptford	4,024	2,282	57%	263.5	14.7	25.8	6.9
	Greenwich	1,856	1,080	58%	105.1	14.1	24.2	5.8
South West	Croydon	1,856	1,177	63%	137.1	15.4	26.0	7.0
	New Malden	1,386	871	63%	100.5	15.5	26.4	6.9
	St Helier	1,471	897	61%	95.1	15.2	24.8	6.4
	Wimbledon	1,193	712	60%	99.7	13.9	28.2	8.4
Other	NULL	831	659	79%	77.3	15.4	27.7	7.0
	IRO	5	4	80%	1.5	24.4	44.4	22.5
	Other	482	246	51%	31.0	12.4	24.3	7.6
	Training	1,342	712	53%	93.8	14.6	26.9	7.9
TOTAL	44,479	26,306	59%	3445.8	15.3	27.4	7.9	

Max average breach value
Value >10 mins per breach

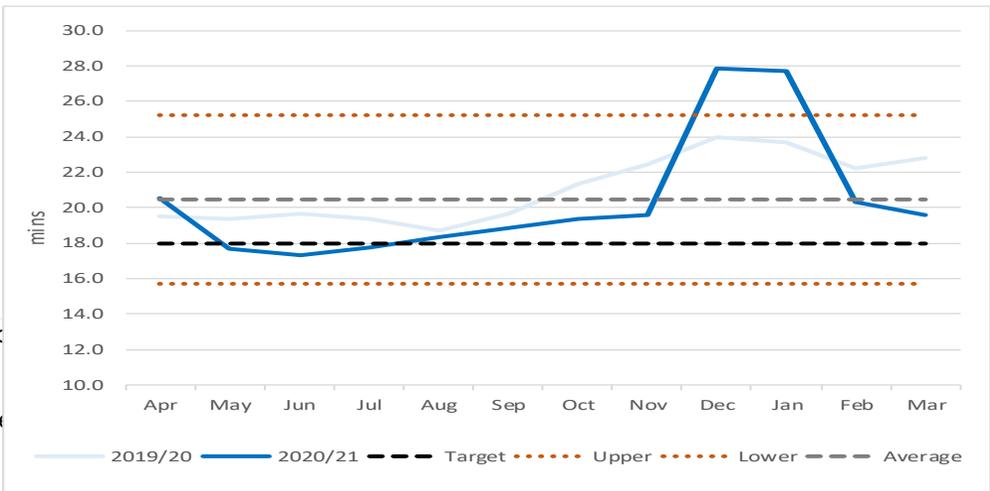
Max average breach value
Value >7 mins per breach



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

	Jan-21	Feb-21	Mar-21	Year-end Target
Arrive at Hospital to Patient Handover (mins)	27.7	20.3	19.6	18.0

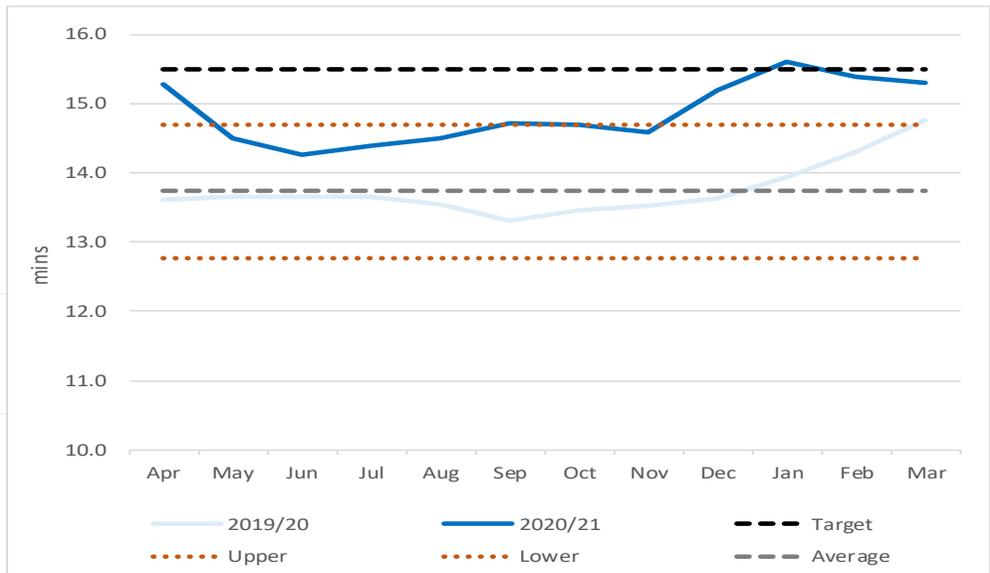
Hospital Handover performance is still outside of target, despite an improvement compared to the winter months. Since June we have been seeing a steady worsening of performance on this metric, due to increasing overall demand and pressure on the hospitals as a result, impacting LAS teams ability to hand patients over. After January, which was a particular outlier due to operational pressures on the EDs stemming from the second wave of Covid, March showed a return to September performance as some of the pressure remains.



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

	Jan-21	Feb-21	Mar-21	Year-end Target
Patient Handover to Green (mins)	15.6	15.4	15.3	15.5

Handover to Green YTD performance has been within target, but above the 19/20 average since April 2020. In March we are seeing performance within the target after a drop in performance due to operational pressures in December and January.



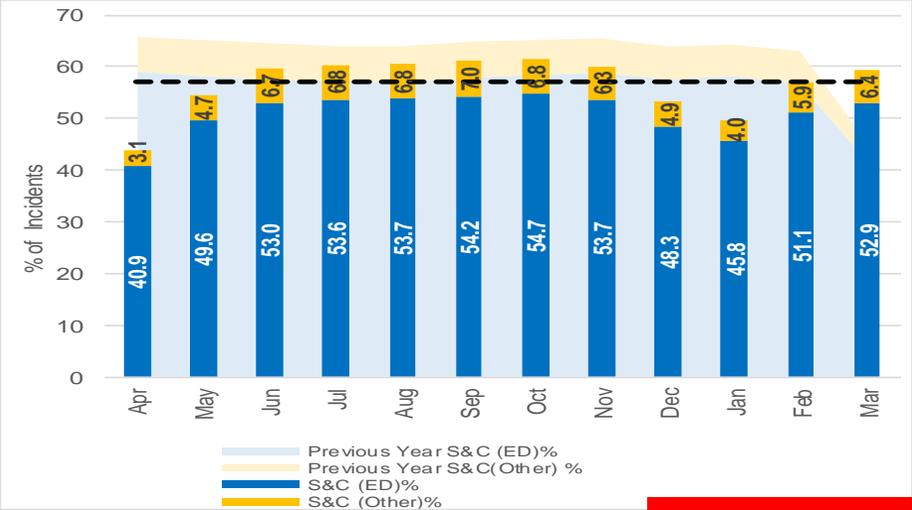
Please note: 999 performance data is correct as at 26/04/21 and is subject to change due to data validation processes



See and Convey to Emergency Department

		Mar-21	Year To Date	Year-end Target
See & Convey ED %	LAS	52.9%	51.0%	57.0%
	Target			

The conveyance to emergency departments target (57.0%) was delivered in March (52.9%). A steady profile of demand has allowed us to achieve this metric month on month. LAS ranked 5th nationally as the Covid profile demand changed, with the proportion of patients than usual, the best clinical decision was to not convey and be overseen by the clinical hub reducing our conveyance to ED. While 5th, it's worth noting that the best in class was at 49.6%, which was 3.3% away from the LAS result.

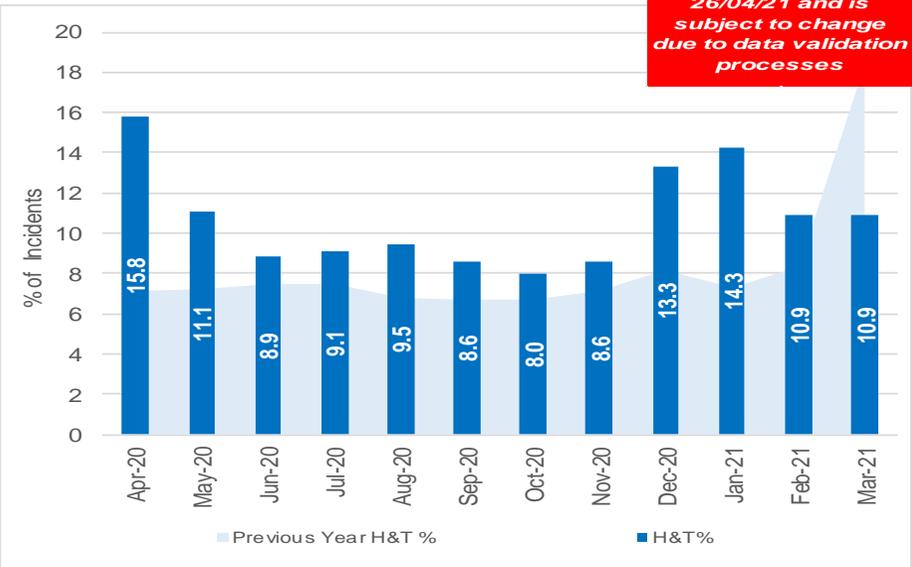


Hear and Treat %

		Mar-21	Year To Date	Year-end Target
Hear & Treat %	%	10.9%	10.8%	TBC
	(n)	11,284	133,598	

Hear and treat delivered 10.9% in March. Following an increase of Covid patient related calls in December, our Hear & Treat rate saw a sharp increase compared to June – November and is now slowly reducing. Since the Covid profile demand was higher in London and for a larger proportion of patients than usual, the best clinical decision was to not convey and be overseen by the clinical hub, with patients advised to call back if their condition deteriorates.

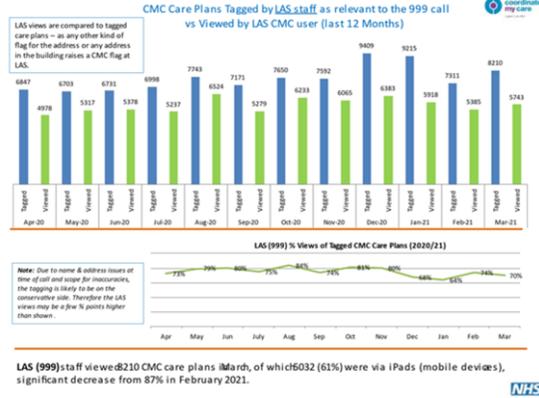
In 2020/21 year to date, the performance in the metric has been strongly within the 2019/20 target (7.9%) and continue to outperform last year's benchmark of 8%. Hear & Treat remains a key focus for the Trust, allowing robust delivery on our conveyance rates and keeping frontline resources available for our most critically ill patients.



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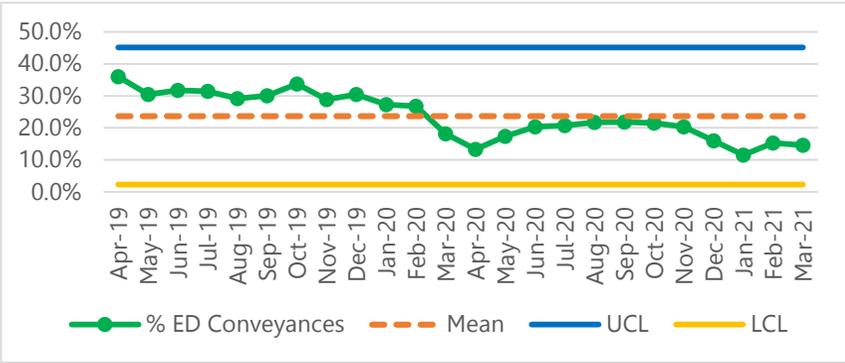
4. Our Partners

End of Life Care & Mental Health



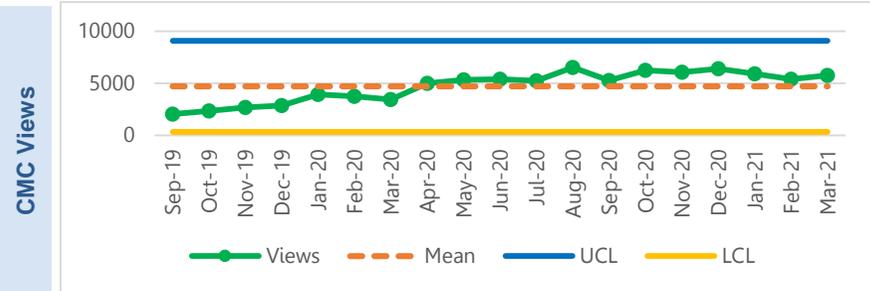
ED Conveyance

Latest Month (Mar): **14.6%**



Clinical audit presented to CARSG with EoLC CPI approved

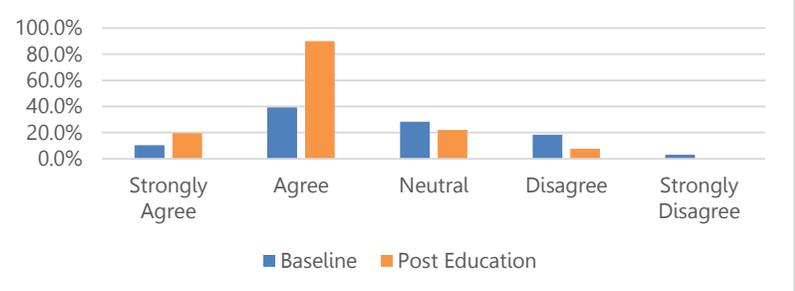
Evaluation dissemination at sector meetings



Staff Confidence

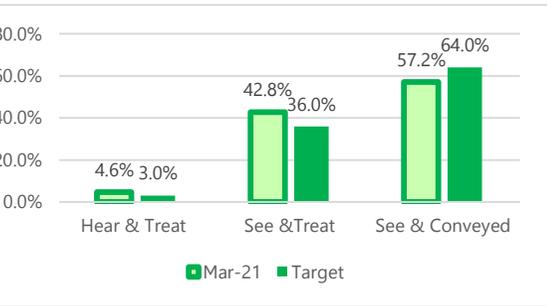
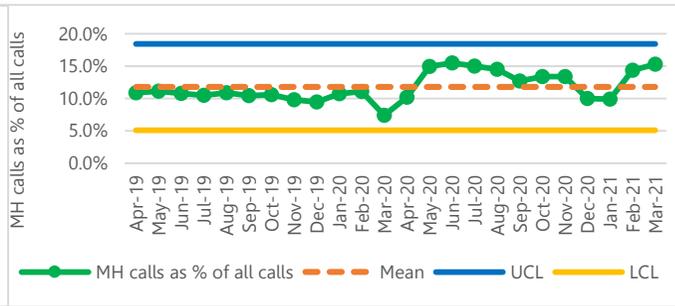
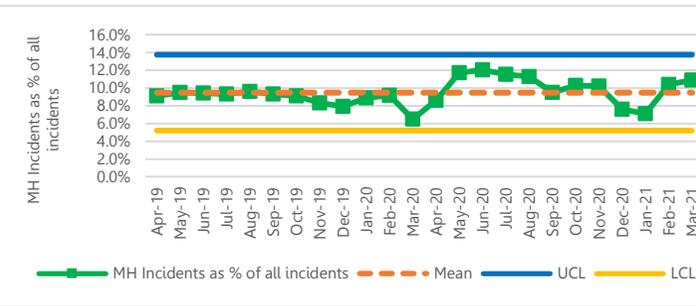
78% staff post education felt confident

28% increase from baseline



Substantive team recruited, due in post May 2021
New EoLC coordinators in post April 2021

E-learning package for 111/EOC call handlers completed
Updated Advance Care Planning guidance for additional clarity.



The team were shortlisted for the HSJ Value Award .
We continue to engage with stakeholders regarding ongoing funding for the Mental Health Joint response Cars.
We have new staff starting with us in April which will help build resilience.



Strategic Transformation Portfolio

The LAS is developing six Transformation Programmes to help us to deliver our Trust Strategy. They are:



The Transformation Programmes will set out how we will deliver our model of care to improve (1) patient outcomes, (2) inclusion and wellbeing, (3) sustainability and (4) productivity and efficiency.

Reforming the Mental Health Act – Consultation Review

We have submitted the Trust's response to the Department of Health and Social Care's consultation on proposed changes to the Mental Health Act. The Act proposes wide-ranging reforms to deliver a modern mental health service.

Metropolitan Police Service (MPS) Suicide Prevention Policy

We reviewed the MPS Suicide Prevention Policy and Guidance document which aims to enhance the knowledge of MPS staff who encounter persons who are reported to be suicidal, are threatening to commit suicide and those who are bereaved by suicide. The policy will support officers in offering crisis intervention to individuals at risk of suicide and help them to respond professionally and effectively in the unfortunate occurrence of suicide.

Ambulance Operations Modernisation (AOM) Programme

We continue our work to develop the programme business case for the AOM programme and the realisation of our Estates Vision to ensure we consistently and resiliently deliver outstanding patient care, improve our operational facilities, support the wellbeing of our staff and work towards meeting the requirements of the NHS Green Plan. Our plans to create our first new Ambulance Deployment Centre (ADC) referred to as HUB1 is also progressing. A proposed site has been selected for HUB1 and negotiations with the landlord are continuing.

Next Generation Ambulance Project Update

The Next Generation Ambulance Project has received over 440 responses from the staff survey on how we could improve our future ambulance design. The feedback will be discussed at the working group and taken forward to the national specification task and finish group that LAS is leading on. The Net Zero ambulance group is progressing the competition format with Innovate UK and NHSE&I procurement while funding is being confirmed by the Greener NHS. LAS has analysed data from all ambulance journeys in 2020 showing that it would have been possible to have completed the trips on a zero emission vehicle with modelling for different battery sizes and charging frequency.



PUBLIC BOARD OF DIRECTORS MEETING

Report of the Chief Paramedic and Quality Officer

Alongside quality assurance, improvement and safeguarding the directorate now incorporates the Clinical Education and Standards (CES) department. With a new director and changed portfolio, focus across the last two months has been on team development and establishing plans. Following the second wave of Covid-19 it has been increasingly possible to return to normal activity including governance meetings, development and forward planning. The Trust has also seen activity and associated patient safety incidents, and governance reviews return to normal levels. The Patient Safety Improvement Response Framework (PSIRF) went live across the Trust on the 1st April 2021 and the two new education centres are on-track to open in May. The Child Protection Information Sharing System (CP-IS) has also been implemented and following the pilot the station/service accreditation process is now underway.

This report summarises the directorate activity utilising the Integrated Performance Report (IPR) and quality report for the March 2021 reporting period.

1. Developing a refreshed Quality Strategy

The previous quality strategy was launched in 2018 to cover a two year period and to focus on two key aims:

1. To accelerate delivery of the highest quality, best value care, and best staff experience across LAS by 2020
2. To embed continuous improvement into daily operations at LAS and to ensure best support to services across LAS

With the learning from Covid-19, operating in a post-pandemic era, Care Quality Commission (CQC) changes in approach and Integrated Care System (ICS) implementation, now is an appropriate time to refresh the strategy.

The plan is to co-produce this across the organisation and with stakeholders over the next four months to encompass how we ensure we meet all the domains of quality; safe, effective, patient centred, timely, efficient and equitable.

It will include a focus on quality improvement and learning, with a link to our culture as well as outlining the governance structures needed to deliver high quality.

2. Care Quality Commission (CQC)

The Trust continues to engage with the CQC through routine virtual engagement meetings. The latest meeting took place on the 16th of April 2021 and the following areas were discussed:

- Senior management changes
- Hospital turnaround times
- Clinical audits
- Inquests
- Safeguarding
- Serious Incidents and introduction of PSIRF
- Risks
- Station accreditation

These are all standing items, and no specific areas of concern were raised.

The Trust registration with the CQC was updated in March to account for changes to the Nominated Individual. The updated registration certificate was issued and received by the Trust in April 2021.

The Trust took part in the CQC sexual safety survey which closed on the 22nd April 2021. The survey included questions relating to policies and procedures for recruitment, complaints, safeguarding, resolution and training as well as procedures for working with other agencies when sexual safety concerns are raised. There were also sections to highlight areas of good practice and opportunities for improvement.

Overall, the Trust has clear processes and systems to safeguard patients and staff. However, further work is needed to explicitly include sexual safety in all relevant policy and procedural documents.

3. Quality Account

The directorate has led the development of the Quality Account for the 2020/21 reporting period. This year, ten quality priorities across the five CQC domains are proposed. These priorities were identified through quality data analysis and engagement with a number of teams across the organisations. Discussions were held at the Quality Oversight Group (QOG) and Quality Assurance Group (QAC) to ensure both groups were involved in agreeing the priorities.

The proposed priorities are:

- Implementation of the Patient Safety Incident Response Framework (PSIRF)

- Improving staffing levels, productivity and efficiency across Integrated Patient Care service
- Improving the management of clinical equipment
- Medicines management & storage
- Patient & Communities engagement & involvement
- Delivery of the Clinical Strategy
- Integrating the 999 and 111 Clinical Assessment Service (CAS) systems
- Implementation of the station/service quality accreditation programme
- Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy
- Staff health & wellbeing

The Quality Account has been drafted for board approval and despite the pandemic, significant progress has been made on 17 of the 18 priorities set for last year. This has been reported to the QOG, QAC and commissioners for information and feedback.

4. Clinical Education and Standards

Clinical Education and Standards (CES) has undertaken significant changes recently and is ready to support and deliver the Trust's clinical education programmes under one structure with face-to-face elements undertaken from three London centres based at Docklands in the east, Brentford in the west and the existing site at Barking.

The final phase of IT work for the new education centres is due to be completed in May 2021 with a view to incorporating contemporary simulation-based learning technology. Subject to completion of the works the new centres will open before the end of May 2021 with student courses planned.

4.1 Leadership and Management Development

A bespoke development program for the senior management team is mid-stream and aligns the department's strategic direction to the Trust's wider strategic framework. Benefits are already being realised and will support the department's transition, drive an improvement culture and an inspiring learning environment.

4.2 Development of Clinical Workforce

The CES department has successfully delivered an enhanced scope of clinical education (core skill refresher and courses) and spans the NETs to the Advanced Paramedic Practitioner groups.

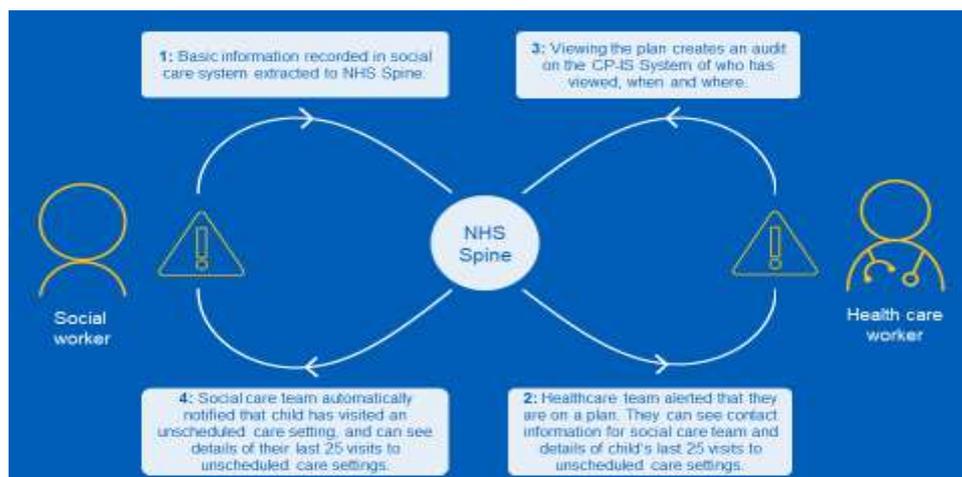
A second cohort of the Assistant Ambulance Practitioner (AAP) group is due to graduate in May 2021 and the paramedic degree apprenticeship pathway has been started with Cumbria University.

The Trust's workforce plan for 2021/22 translated to a significantly increased plan over the preceding year that could not be met internally. To meet the increased demand the department will collaboratively deliver trainee emergency ambulance crew (TEAC) programmes in conjunction with an external provider.

5. Safeguarding

The Child Protection Information Sharing System (CP-IS) is a national programme that is being implemented across unscheduled care in the NHS and includes Local Authority Children's Services as well as Emergency Departments, Walk-in Centres, Minor Injury Units, Ambulance services, GP, Out of Hours, Direct access to Paediatric wards and Maternity Units.

The concept is to close the information gap by providing limited information on looked after children, children on a child protection plan or who will be subject to one when born. Therefore, checking the system should be undertaken when engaging with all children & those who are pregnant.



From the 1st April 2021 CP-IS went live in front line ambulance services, having previously been introduced within 999 Hear and Treat and 111 Integrated Urgent Care. The Trust is amongst one of the first English ambulance services to fully introduce CP-IS across all its services.

CP-IS is an aid for staff to consider when planning treatment for the patient and for local authority to be aware of when children in their care are accessing unscheduled services. It does not replace the need to raise a safeguarding concern.

Communications continue and have included attendance on LAS TV Live, bulletins, inclusion in safeguarding training and discussions at area governance meetings.

6. Quality Assurance

The Directorate's quality assurance systems identifies key issues as well as areas where assurance can be provided in relation to the status of various quality topics. The following are the key points based on quality data analysis and intelligence collated between February 2021 & March 2021.

- The Trust continues to see consistent incident reporting which indicates a good reporting culture as well as a culture of openness. In the previous report (January 2021), an increase in incidents graded as moderate harm and above was reported which was attributed to increase in demand due to Covid-19 wave 2. This has since returned to normal reporting levels.
- There is assurance that there is effective systems for identifying drugs retained off duty and resolving issues promptly.
- Hand hygiene compliance for March 2021 is 94% remaining above the expected Trust target of 90% for the group station that submitted data. Vehicle preparation deep clean compliance of Accident & Emergency vehicles is at 99% which exceeds the target of 95%.
- Safeguarding level 1 is at 95.5% achieving the overall annual target.
- March saw the highest number of excellence reports submitted (144) across the Trust. These reports are used in learning events held within the Trust.

Current areas of focus are:

- Medical equipment continues to be the highest reported category of incident. The majority of these are failure of devices rather than missing devices which had previously been seen over the course of the year. Actions being taken include an education and training review being undertaken between operations and logistics. Also a deep dive review into these incidents to ensure any further actions are identified. This review will be presented to Safety Investigation Assurance and Learning Groups (SIALG) in May. The Trust is purchasing an asset tracking system and implementing a new make ready contract to support and monitor the issue going forwards.
- Safeguarding level 2 & 3 training is below the Trust target of 90%. Plans are in place to ensure sufficient places on training course throughout the coming year.
- Statutory & mandatory training is tracking below the 85% target at 82%. Regular reports are sent to managers and individuals to remind them of when training is due. Compliance is being reviewed with a paper due to the People and Culture committee shortly. Operations are piloting a new combined process which may improve the compliance further.
- Out of date policies, as there are 10 overdue for review & 72 currently under review. The team are continuing to work with stakeholders to ensure that the position is resolved quickly to reduce any consequences of operating with out of date policies. The trust wide review of policies is being monitored at the Senior Leadership Development Meeting (SLDM).

7. Quality Improvement and Learning

The Trust's compliance against national Serious Incident (SI) timescales remains positive with 100% of reports submitted to the CCG within agreed timeframes. All SI actions are monitored by the Trust's SIALG to ensure that there is evidence of implementation. There are 61 actions assigned to these SI investigations and of these, 21 have been completed and 40 are underway.

The Trust is a leading ambulance service in reporting Patient Safety Incidents to the National Reporting and Learning System (NRLS). A high level review has revealed that the data quality is consistent and reflects our internal system.

The quarter 4 SI thematic review outlines that 2,028 patient safety incidents were reported on the Trust's risk management system. Of these, 32 incidents (1.6%) were declared as SIs following review. The rate of face to face incidents per 1000 episodes of care was 0.01.

The top three categories of incidents being declared as SIs continue to be Clinical Assessment, Dispatch and Call & Performance (delays). Within the clinical assessment category there remains an ongoing theme of patients having been inappropriately non-conveyed. A review of causal factors from relevant SI investigations to identify QI projects to take forward into 2021/22 is underway. In the past two quarters three incidents related to endotracheal intubation has been identified as not being undertaken in line with Trust guidance. This presents as an emerging theme and is to be discussed at SIALG.

In December and January, the Trust experienced a second wave of Covid-19 which resulted in unprecedented demand on the service. The Quality Improvement and Learning team re-initiated the Covid-19 review process which identified 150 delays in attendance and call answering being investigated via a structured judgement review (SJR). The review has now been completed and a further collaborative review is to take place across Integrated Patient Care, Clinical and Ambulance Services Directorates to review elements of the Trusts response to Covid-19 and ascertain any further learning for the Trust.

Learning briefings have continued to be produced to update staff regarding themes in SI declarations, learning from closed SIs and also learning from incident management as well as embedding human factor principles including psychological safety and just culture. A virtual case review event was attended by 126 members of staff from across the organisation. In the session cases were presented by the lead investigators and members of the Quality Improvement and Learning Team. Additionally, a staff member who was involved in one of the SIs presented their own case and told their 'story' which strengthened the learning messages and reinforced the Trust's developing approach to 'Just Culture'.

8. Looking forward

The team continue to communicate and implement the new PSIRF through cycles of improvement. The team remain linked into NHSE/I to provide feedback and learning on the implementation of the new process.

Development of quality improvement plans are being undertaken to include working on key priorities set for patient safety specialists nationally to implement within Trusts which includes, just culture, improving quality of incident reporting and patient safety education and training.

We continue to roll out the station accreditation programme. At the time of writing this report six stations had put themselves forward to participate in the programme. These are Oval, Edmonton, Friern Barnet, Brent, Croydon & Brixton.

Moving into the two new education centres and embedding the new CES structure to achieve the workforce plan.

Focussed work with the Frequent Caller team which has moved into the directorate to establish objectives. The team are supporting the increasing numbers of external stakeholders starting to use Coordinate My Care (CMC) for frequent caller patients.

Strategic development

Developing improved models of care

Despite the COVID-19 pandemic there has been significant progress in delivery against both the Trust Strategy 2018-2023 our Clinical Strategy (2016-2023 (2019 refresh) including:

- Development of our integrated clinical assessment and triage service sitting behind both 111 and 999 across London, which has expanded the range of methods for patients to contact us for assistance with urgency and emergency complaints
- Leading the integration of access to Urgent and Emergency Care by managing 4 out of 5 London regions 111 service and moving away from a traditional ambulance service to a mobile provider of urgent and emergency care.
- Implemented a range of specialist resources for specific patient groups to improve equity of access to care including Urgent Care (Advanced Paramedic Practitioners – Urgent Care), Mental Health, Maternity and Palliative and End of Life whilst continuing to ensure those most critically ill and injured receive the right resources and conveyed to specialist centres for treatment as quickly as possible.
- Using our insight as the only pan-London NHS provider, to play an increasingly pivotal role in the development of services across London working with our system wide partners.

As part of our on-going service transformation the Right Care, Right Place programme will be focussed on setting the standard to deliver clinical best practice, to support the implementation of operational changes to realise the clinical ambition, and to agree the design and functionality of the digital infrastructure to improve internal and external interoperability. Importantly we will use evidence base reviews to respond to the identified health and social inequalities in society and the direct causal link these have to health outcomes. With over 3 million patients contacts LAS is in a prime position to understand, support and influence improvements

The continued delivery of the Our Paramedics in Primary Care pilots continue, with participants beginning to work through the Health Education England (HEE) Roadmap to Practice as First Contact Practitioners (FCPs). This supports our strategic aim to provide a responsive service delivering care as close to home as possible, avoiding unnecessary conveyances to emergency departments and ensuring patients are referred into the most appropriate service for their needs. Aside from the patient care benefits this scheme offers potential benefits in terms of recruitment and retention – all of which will be reviewed in the evaluation which will then inform the strategic model of care, workforce plan and operating model for the coming years.

In partnership with St John Ambulance (SJA) we are working with colleagues in preparing a pilot scheme which sees Community First Responders attend patients who have fallen, with no injury or illness and require assistance to get up from the ground. This is intended to reduce the time people spend on the ground, and improve timely care for this patient group.

System Wide Collaboration

Engaging with Integrated Care Systems

We are working with system partners in South East London, who are a regional accelerator site for the new Urgent Crisis Response (UCR) standards. We are developing new pathways with partners in order to care for patients in their own home and reduce the need for hospital admission.

The mental health joint response units (a mental health nurse working alongside a paramedic) made the shortlist for the HSJ Value Award (Mental Health Service Redesign). We are working with stakeholders and commissioning team to discuss funding for the Mental Health Joint Response Cars to ensure we continue to prioritise the care we provide mental health patients. We are working collaboratively with ICS partners to enhance existing pathways and clinical assessments for our pregnant patients and mothers and babies following an unplanned community delivery.

Regional & National Research

Our research activity has continued to go from strength to strength

- The MIRACLE2 risk scoring tool that predicts early neurological outcomes after cardiac arrest and was developed through our research collaboration with King's College London, has been incorporated into the national British Cardiovascular Intervention Society clinical guidelines.
- We are recruiting to an Urgent Public Health study being run by Oxford University that aims to find treatments for COVID-19 that are suitable for use in the community.
- In collaboration with the London School of Hygiene and Tropical Medicine, we have developed and are currently implementing the CRASH4 study, a national prehospital drug trial for older patients with mild head injury.
- Working with the University of Warwick, we have begun the initial set-up of a national interventional study to investigate the best route of drug administration in out-of-hospital cardiac arrest.

All research projects are fully external funded, with monies awarded through a process of open competition. Our current funding sources include the British Heart Foundation, the National Institute of Health Research - all three of their funding streams ('Research For Patient Benefit', 'Health Technology Assessment' and 'Health Services & Delivery Research'), and the Clinical Research Network.

Clinical Transformation

Development of the Clinical Workforce

As part of the planned realignment of Executive portfolios the Clinical Education and Standards team moved to the Quality Directorate under the Chief Paramedic and Quality Officer on 1st April 2021. On 30th April the Deputy Director of Clinical Education and Standards, Tina Ivanov, left the Trust to take up a Director of Quality post at East Kent Hospitals. Tina joined the Trust 5 years ago and during her time has strengthened the position of Clinical Education within the Trust and led the alignment of all clinical education under one management team and the design and delivery of bespoke training and learning centres which will have digital capabilities, support the delivery of enhanced digital learning and simulation-based training. The Trust thanks Tina for all her work at LAS and wishes her well in her new role.

The Clinical Directorate are leading on the development of the Clinical Team Managers (CTM) through ongoing clinical training, to ensure that their clinical supervision on scene remains up-to-date. With the increasing paramedic workforce and evolving clinical model of care it is necessary to ensure our first line clinical managers continue to feel equipped to provide the necessary clinical and professional supervision and leadership to their clinical teams and they are able to reinforce the university based education and increased multi-disciplinary working.

The clinical directorate have launched the Clinical Team Manager continuing professional development programme as part of a series of phased educational activities to support our first line clinical leaders and supervisors. As part of the clinical career structure recruitment has been completed of new Urgent and Critical Care Advanced Paramedic Practitioners and they are undertaking ongoing mentorship supported by HEE funding for programme of post-graduate development. Following the successful pilot of APP independent non-medical prescriber training the next phase of the programme has commenced addressing the operationalisation of prescribing within the ambulance environment.

A Clinical update was issued service wide as a digital document in April 2021 focusing on Management of Trauma in older patients, acute behavioural disturbance, early pregnancy and motor neurone disease. In addition updates from recent audit reports were shared.

Clinical Digital Transformation

Much progress has been made on the clinical digital transformation. NHS Digital (NHSx) have funded the replacement of nearly 5000 clinicians iPads. The new devices are the latest model with and improved mobile data solution. We will also be issuing new cases to improve the experience for our staff. We are now fully live with Electronic Patient Care Records with over 91% of our staff using ePCR. To date we have 290,000 records in our database and the patients NHS Number capture is now over 70% which enables transfer of information more readily. We are continuing to learn and improve the system and are now in a ‘business as usual’ quality improvement cycle. Coordinate My Care (CMC) care plans are now available to view in our secure ‘password-free’ Summary Care Record application (SCRa) environment. There are over 65,000 records available for our staff to view. The development of our new Computer Aided Dispatch is progressing well. Clinical care is in the heart of the development as this is the first point of contact for our 999 patients. In March we went live with the Child Protection Information Service (CP-IS) which means our NHS111 (Adatastra) and patient facing (SCRa) records are linked to the new child protection service. This will improve our child safeguarding services.

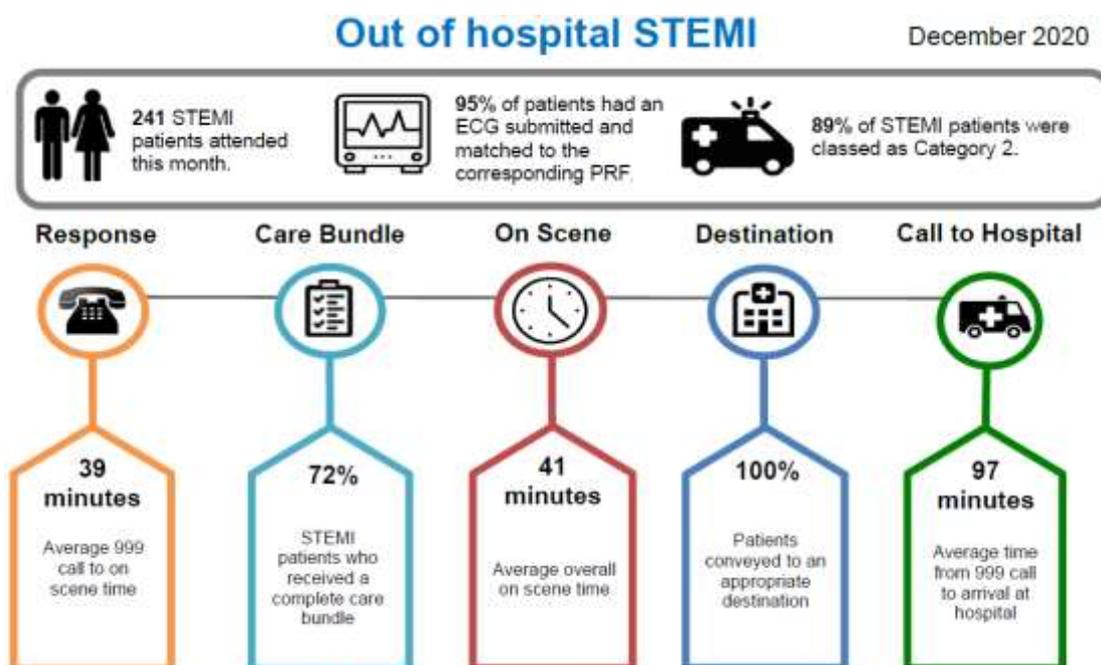
Patient Outcomes

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

Stroke Care (February 2021)



- FAST positive patients are those patients who are identified as having a deficit on one or more of the face, arm and speech elements of the FAST. The majority are category 2 - these will be responded to in an average time of 18 minutes and at least 9 out of 10 times within 40 minutes
- On scene time guidance is set by LAS at 30 minutes
- Diagnostic bundle target is 98%
- Time critical refers to FAST positive patients where the symptoms were less than 4.5 hours old when leaving the scene of the incident. Target call to hospital is 70 minutes



- Chest pain patients are categorised according to their symptoms. The majority are category 2 - these will be responded to in an average time of 18 minutes and at least 9 out of 10 times within 40 minutes
- The STEMI care bundle should be given in 74% cases
- The on scene time target for LAS is 30 minutes
- The time from call to angiography target is 130 minutes - an arrival time of 97 minutes allows time for the hospital to undertake the clinical procedures within the timeframe

National data (Ambulance Quality Indicators):

There is always a time lag in receiving end-to-end patient data and this has, understandably been impacted by COVID-19.

NHS England did not publish Sepsis Care Bundle data for November, the next data due to be published will be for December 2020 (in May 2021).

The LAS' time for the Call to Balloon measure for November 2020 was 02 hours 20 minutes which, whilst ranked 7th in England overall, is only 6 minutes longer than the best performing service in England, and is still within the national target of 02:30.

For the STEMI Care Bundle the next data due to be published will be for January 2021 (due in June).

The LAS achieved the highest ROSC on arrival at hospital for the overall group in November 2020 at 30.1% ranking 1st place amongst other ambulances services in England, above the national average of 25.5%. We also achieved a higher than average ROSC on arrival at hospital for the Utstein group (53.7% vs 47.5%), ranking 3rd place.

Due to pressures associated with the pandemic, we did not receive any outcome data from hospitals for November 2020 cases and we are therefore unable to report a survival figure in the national AQIs.

For the 4th month in a row and 6th time in the financial year (2020/2021), the LAS continues leading the rest of the country in terms of mean Stroke Call to Door time (1:07), well above the national average of 1.24.

Sector Senior Clinical leads and Clinical Team Managers facilitate local clinical feedback and learning within their teams and sharing of best practice across sites. Where needed Trust Wide briefings are shared and learning incorporated into the Core Skills Refreshers.

For the Stroke Diagnostic Bundle, the LAS has improved from a ranking of 9th place in August 2020 to 8th in November 2020 achieving this for 97% of suspected stroke patients, slightly below the national average of 97.8%.

The pharmacy team continue to support Integrated Patient Care through prescribing audit work and mentoring of pharmacy professionals employed in the service.

Medicines Management

Over the recent couple of months we have continued to progress on the Medicines Modernisation Programme. The medicines packing unit construction work started in March, we have completed the installation of automated temperature monitoring systems in all our operational ambulance stations. In addition work has progressed to expand kit prep to enhance the information collected at the point of packing medicines.

The medicines management team continue to monitor prescribing in integrated urgent care, working closely with our commissioners and auditing prescribing by prescribers working within the service.



Assurance report: **Quality Assurance Committee**

Date: **04/05/2021**

Summary report to: **Trust Board**

Date of meeting: **25/05/2021**

Presented by: **Mark Spencer, Non-Executive Director, Chair of Quality Assurance Committee**

Prepared by: **Mark Spencer, Non-Executive Director, Chair of Quality Assurance Committee**

Matters for escalation:

Quality Account

The document provided reflects on the last year's performance against the 18 priorities identified at the start of the year. Despite the pandemic, significant progress was made on 17 of the 18 priorities. The one exception was the quality priority relating to the roll out of tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients. This was suspended as a priority as both services had to be taken off the road due to COVID

The Quality Assurance Committee recommended approval and publication subject to the inclusion of mandated statements

Risk

Members considered the addition of a further BAF risk in respect of medical devices, it was agreed that there is a risk on the corporate risk register and that this would be reviewed by the Risk Compliance action Group. Members emphasised the need to have a plan in place to address the risk.

Other matters considered:

End of Life Care

Members received a presentation from Dianne Laverty, Macmillan Nurse Consultant Palliative & End of Life Care which detailed the work that is being undertaken to ensure the provision of high quality pre hospital care.

Quality Report

The Committee received the Quality report which contained March 2021 data and provided an overview of quality performance through relevant quality KPIs and information across the organisation. Members noted the missing AQI data and were reassured that this would be included once it is available.

Quality Priorities

Members received a paper which looked forward to the financial year 2021/22 and proposed 10 quality priorities to be implemented. These are priorities identified following a review of internal quality intelligence, consultation with the Quality Governance Managers across the trust,

the Medical Directorate team & members of the Quality Oversight Group.

Members considered the proposed priorities and considered that some targets required further refinement and the inclusion of targets. It was agreed this would be undertaken and that Quality Oversight Group could consider benchmarking and the baselined measures

Serious Incidents

The Committee were provided an update on Serious Incident Investigations by the executive summaries of SI's closed in February and March 2021. The paper provided information in respect of 20 Serious Incident Investigations closed by the Clinical Commissioning Group.

Health and Safety Update

The Committee received an update which highlighted key items of discussion from the Corporate Health, Safety & Well-Being Committee meeting held on 29 January 2021 and provided update on key areas of information from the Health, Safety & Security Department.

Quality Strategy 2022

Members received an introduction to the drivers for the strategy update including alignment with the CQC new approach, ICS implementation and changing NHS Landscape and considered quality improvement and governance structures.

Key decisions made / actions identified:

Medical Devices

Medical Devices updates to be provided to for future assurance

Clinical Safety Plan

The Committee received the final draft of the new Clinical Safety Plan noting the proposed approach to the clinical escalation process which was developed in response to experience gained during escalation periods utilising the previous Clinical Safety Escalation Plan.

The principles of the plan were outlined and members noted that the plan had been consulted on with strategic and tactical commanders, ambulance operations, incident delivery and EOC commanders/clinicians and Staff side and piloted for 8 weeks in February and March 2021.

Members noted the approval of the plan and recognised the clear example of joint working and the opportunity to devolve decision making and empower colleagues to anticipate demand pressures and impacts on health and safety

Right Care Right Place

Members recognised the importance of this transformation workstream and that it would be fundamental to the organisations delivery and that Right care Right Place should be considered by the July Quality Assurance Committee

Risks:

Board Assurance Framework

The Board Assurance Framework included 2 risks relating to Quality BAF risk 61 had been reviewed by March Trust Board who agreed to reduce score of all sub category risks to 12, there are no further proposed changes.

BAF Risk 65 there is a risk that the health and wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records, had also been reviewed with no proposed changes to the residual score of 12.

Members considered the addition of a further BAF risk in respect of medical devices, it was agreed that there is a risk on the corporate risk register and that this would be reviewed by the Risk Compliance action Group. Members emphasised the need to have a plan in place to address the risk.

Assurance:

CQC Engagement

The Trust met with the CQC on the 16 April 2021. Information was provided in advance and the following areas were discussed: Senior management changes, Hospital turnaround times, Clinical audits. Inquests, Safeguarding, Serious Incidents and introduction of PSIRF, Risks and Station accreditation. No specific areas of concern were raised



PUBLIC BOARD OF DIRECTORS MEETING
Executive Director Report: People and Culture May 2021

1. Introduction

The Directorate continues to work on the approved **18 month strategy**, focussing on the strategic themes, including responses to the NHS National People Plan, national Workforce Race Equality Standards and Workforce Disability Equality Standards, and the key deliverables in the Trust Business Plan.

This report is submitted to provide assurance.

2. Culture, Diversity & Inclusion

Staff survey

Work is continuing to analyse the results of the 2020 staff survey. The Culture, Diversity and Inclusion (CDI) team are focusing on the production of detailed results for each Group Station to show management teams how responses to individual questions have changed over the past few years and to identify where progress has been made and where additional focus is needed. Together with their relationships with their staff and knowledge of these issues, the survey data will allow us to work with local management to share best practice and drive improvements.

Within the People and Culture Directorate, a listening session was held where all staff were invited to give their views on what needs to be improved and to share ideas on how we can do this. The session utilized *Slido*, an online tool which enables participants to give their views anonymously. An action plan is being developed to focus on key improvements that can be made to improve the working lives of our staff. The plan will be shared at a second Directorate meeting next month.

Looking forward to the 2021 staff survey, we are working with Staff Survey Champions across the Trust who encourage their teams to complete the survey, work with the local management to plan and implement changes, while gathering feedback from colleagues. We are also planning to run Q&A sessions to ensure our staff understand the importance of completing the survey, highlighting how individuals' answers will be kept confidential and clarifying questions which have caused confusion in the past.

New Quarterly Staff Survey

As an integral part of the NHS People Promise (We each have a voice that counts), the NHS is introducing a new quarterly staff survey to track staff morale across the NHS, in a more regular or timely way. The survey will ask the nine Engagement questions that form part of the annual staff survey and will replace the existing Friends and Family Test. The survey will run in three quarters of the year, so as not to clash with the annual survey in quarter three. Bank staff will also be able to participate in the survey.

The survey has been supported by a Prime Ministerial request for more regular reporting of our NHS people's working experience. Research by the King's Fund links employee engagement to patient satisfaction, mortality rates and safety measures. Other research links employee engagement to lower sickness absence rates.

The Trust has the option of using the People Pulse, a free tool developed by NHS England, which also asks an additional eight questions about staff sentiment, but is designed to take around five minutes to complete. The Trust has the option of using an alternative method to survey staff such as the tool we use for the Friends and Family Test, but the People Pulse will automatically report the data to NHSE. The CDI team are working with the Internal Communications team to scope the most appropriate method of delivering the quarterly survey in a way that encourages participation from all staff.

Diversity and Inclusion

Work is progressing on our Black Lives Matter action plan which was formed in partnership with the LAS B-ME Staff Network, to address the concerns highlighted in the wake of the Black Lives Matter movement last summer and to support the LAS in its objective to become an anti-racist organisation. The plan now stands at 75% complete. The work so far includes:

Workshops held with our Extended Leadership and Core Leaders groups aimed at helping them to have conversations about racism with their teams; workshops were also held for White staff to learn more about race issues and the importance of being an ally to BAME (Black, Asian and minority ethnic) colleagues;

- The chairs of our B-ME Staff Network have reinvigorated the group and encouraged staff from all backgrounds to join, as well as holding drop-in sessions for BAME staff;
- A review of formal disciplinary cases was carried out to identify disproportionality between white and BAME staff.

Actions remain in the following areas:

- **Allyship Network** – a new Staff Network to support staff in becoming better allies to BAME colleagues and giving them the confidence to challenge unacceptable behaviour.
- **Anti-racism campaign** – supported by AACE, we are working with Communications and Engagement colleagues to create a “Stamp our Racism” campaign to create awareness and create opportunities for discussion and learning.
- **Recruitment and Selection** – a new training programme is being written, which is informed by a revised Recruitment and Selection policy, which will help us to embed fair recruitment principles for all roles across the Trust and sets the goal of having diverse panels for all roles.
- **B-Mentored Programme** – launches with a new cohort of mentees in June, the programme is designed to support BAME staff throughout the organisation, at all stages of their career.

Our percentage of BAME staff has improved to 18.4%, against our end of year target of 17.5%. Our overall BAME staff numbers continue to increase (currently 1,187) although this representation varies at different levels in the organisation as follows:

% of BAME staff, in each pay band	
Bands 1-4	38.5%
Bands 5-7	13.1%
Band 8A to 9	15.2%
VSM	28.6%
Board	29.4%

The safety of female colleagues was brought to the fore following the murder Sarah Everard in March. The Trust took actions including offering support and advice to colleagues through the Wellbeing Hub; reviewed the general risk assessment processes and developing a new risk assessment training course. Our Chair and female Executive Directors held drop-in sessions for female staff to share their experiences and concerns about working for the LAS. The key themes arising from these sessions included:

- dealing with “banter” in the workplace (e.g. sexual innuendo or sexist remarks);
- concerns around the consequences of speaking up;
- personal safety – particularly when working alone, or travelling to and from work on late/night shifts when parking or public transport is not close to the ambulance station;
- different standards for men and women;
- women’s health.

Following these sessions a Women’s Network will be formed to provide a forum for women to share their experiences and to help shape our equality and inclusion agenda going forward. We will also work to raise awareness of these issues amongst all colleagues; we are looking into working with the White Ribbon Campaign, which encourages men to call out sexist and abusive behaviour.

CDI team members are working with colleagues from the Estates department to visit all of our buildings as part of an audit to ensure we are fully compliant with the Disability Discrimination Act (DDA). A new fully DDA compliant access facility has recently been completed at our Waterloo Headquarters building.

We held the first meeting of our Staff Network Chairs Forum which provides a space for our Network Chairs to meet to share best practice, contribute to the Trust’s CDI agenda, as well as hold us to account. The chairs have also been invited to contribute to the wider Diversity Working Group, which is initially focused on our anti-racism campaign, but we will be able to use an intersectional and collaborative approach to drive our work forward.

Workforce Race Equality Standard (WRES) 2020-21

Our WRES data for 2020-21 was compiled last month and illustrates the challenges faced by the Trust in creating an inclusive work environment for all staff. While BAME representation has increased both overall and in our Trust Board, and BAME staff are more likely to access non-mandatory training, the remaining 6 indicators have either remained the same or got worse.

Workforce indicators

- The percentage of BAME staff across the organisation has increased from 16% in 2019-20 to 17.5% in 2020-21.
- The disparity between white and BAME staff being appointed to posts from shortlisting has increased slightly in 2020-21 to 2.1x as likely. The changes we are making to Recruitment and Selection processes and training, such as increasing the diversity of recruitment panels, aim to reduce this disparity, as well as the perception of fairness in the process.
- BAME staff remain 2x as likely to be entered into the formal disciplinary process. It is hoped the new Resolution Framework and the tools it gives our managers to resolve issues informally will reduce both the number of cases which are escalated and the disparity between white and BAME staff being entered into the formal process.
- BAME staff are again more likely to access non-mandatory training, however this is not leading to more BAME representation at higher bands.

Staff Survey Indicators

- The percentage of BAME staff experiencing harassment, bullying or abuse from patients/members of the public has increased from 43% last year to 48.6% this year. This figure is 11.5% lower than that reported by white staff, and both figures are remarkably higher than other London trusts and other ambulance trusts. Initiatives such as Violence Reduction Officers and body-worn cameras aim to reduce the abuse our staff experience at work.
- 31.7% of BAME staff reported experiencing harassment, bullying or abuse from colleagues, an increase of 1.7% from last year.
- The percentage of BAME staff who believe the LAS provides equal opportunities for career progression and promotion has decreased by 4% to 52% (18.5% lower than white colleagues).
- 19.3% of BAME staff reported personally experiencing discrimination at work from a manager or other colleagues. This has risen by 3.3% from last year.

Board Representation Indicator

- 29.4% of our Trust Board are from a BAME background, a figure significantly higher than the national and ambulance trust average

Workforce Disability Equality Standard (WRES) 2020-21

We are able to report on 11 of the 13 indicators for our 2020-21 WDES submission; the remaining two metrics will be available at the end of May.

Workforce Indicators

- The percentage of staff who have disclosed a disability has risen from 3.6% to 4.9% in 2020-21. Currently, 75% of our staff have listed their disability status on their Electronic Staff Record, an improvement on 63% last year.
- Data for indicators 2 (appointment from shortlisting) and 3 (capability process) will be available at the end of May.

National Staff Survey Indicators

- The percentage of disabled staff experiencing harassment, bullying or abuse from patients/members of the public has increased from 58.1% last year to 60.6% this year. This is 2.7% lower than that reported by non-disabled staff.
- A lower percentage of disabled staff reported experiencing harassment, bullying or abuse from managers, falling from 28.6% to 25.9%, but this figure is still nearly double that of non-disabled staff.
- The percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues fell from 26.9% to 22.8%, again this figure is 8.1% higher than that for non-disabled staff.
- 55.6% of disabled staff believe the Trust provides equal opportunities for career progression or promotion. This has fallen by 0.9% since last year.
- The percentage of disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties fell by 4.9% this year to 43.6%.
- Only 23.5% of disabled staff said that they are satisfied with the extent to which their organisation values their work. This figure has increased by 1.6% compared to last year, but is 9.8% lower than the figure for non-disabled staff.
- 60.3% of disabled staff say their employer has made adequate adjustment(s) to enable them to carry out their work, this figure has improved by 8.9% since last year.
- The staff engagement score for disabled staff in the organisation improved from 5.6 to 5.7 out of 10, compared to 6.2 for non-disabled staff. The score is based on an algorithm taking data from responses to the nine staff engagement questions in the survey.

Board Representation Indicator

- Disabled representation amongst voting members of our Trust Board remains at 0%.

3. P&C Operations

Current Staffing Position & Workforce Planning 2021/2022

The recruitment team continue to work with Ambulance Services and Clinical Education teams to deliver a strong pipeline of registered and non-registered staff. The recruitment process has delivered the year end workforce plan level of 3,370 wte staff, albeit 3.4% of staff [108 Assistant Ambulance Practitioners and 35 Paramedics] are completing their classroom training.

Moving forward to the 2021 – 2022 workforce plan, the procurement process is underway to procure an external international recruitment provider to meet the 269 international paramedics required for 2021/22. The timeline will allow the supplier to go live by June 2021 to allow as much time as possible for them to meet the ambitious recruitment targets for 2021-22. To support the non-registrant requirements for 2021/22 the Trust has procured a new external TEAC provider to deliver the planned TEAC numbers. This will release capacity within Clinical Education Services and maximise staff for operations. The first TEAC cohort will commence in May 2021.

There are significant activities in progress to deliver increased resources in both our Emergency Operation Centre (EOC) and 111 call handling services. This includes a dedicated training and recruitment plan to build pipelines to ensure we meet our 2021/22 demand

forecasts. We are currently fully established in EOC and maintaining this level in preparation for the new CAD later this year in October. We are on track to achieve a full call handling establishment in September (NEL, SEL, NWL) and are looking at options to bring this forward.

There are two rotational paramedic pilots in place, at Merton Primary Care Network (PCN) and Redbridge PCN. These will provide the trust with the opportunity to test these partnership arrangements with PCNs and apply any lessons learned in advance of a full national launch from April 2021

Retention

The turnover rate has continued to improve to 8.3%. The Trust continues to see a lower number of leavers in Emergency Care Services, 111 and EOC than forecast. There are a number of retention activities in place for frontline staff, led by the Ambulance Ops Retention Group. This includes the recent launch of the iPara engagement survey, focus groups, funding indefinite leave to remain, supporting staff to utilise the Government’s automatic one year visa extension, promotion of retirement options and improvements in reason for leaving data quality.

Staff Absences

The monthly Trust wide sickness has decreased from 6.7% in February to 6.0% in March. Non-COVID sickness is 5.3% and Covid related sickness accounts for 0.7%. The 12 monthly rate has increased from 5.5% to 5.6%. We are seeing a number of staff absences extended due to delays in NHS treatment due to the Covid-19 pandemic and we are now seeing a handful of significant Post Covid Syndrome (formally known as ‘long COVID’) cases which we are managing sensitively and supportively. The P&C teams are working with managers across the trust to provide support with return to work interviews, welfare checks on absent colleagues and more engagement with occupational health. The Wellbeing Team have introduced a Post COVID Syndrome support group which has over 25 members and meets virtually every 2 weeks in order to better understand the wellbeing needs of this group of colleagues.

Figure 1 –General sickness rates in comparison to COVID19 sickness

	November 2020	December 2020	January 2021	February 2021	March 2021
Trust wide sickness rate	4.8%	5.7%	9.4%	6.7%	6.0%
Covid sickness	0.3%	0.4%	4.0%	1.3%	0.7%
Non-Covid sickness	4.5%	5.3%	5.4%	5.4%	5.3%

Statutory Mandatory Training/Personal Development Reviews (Appraisals)

As at 31st March 2021, the overall statutory and mandatory training completed is slightly below the 85% target, at 82%. A recovery plan is in place to address this gap. Some of this has been down to a delay to get Scorm Adaptors updated due to late notice from the ESR Central Team which created eLearning accessibility issues. This has now been addressed and CSR2021.1 is back up and running again.

As of week ending 7th May 2021 Information Governance compliance will now be reported at the Senior Leaders Daily Meeting each Friday to ensure it meets its 95% compliance requirement. The Trust is currently running at 93%.

PDR compliance, based on a rolling 12 month period, has slightly increased to 77%. As with Information Governance compliance, PDR compliance is now being tracked on a weekly basis to ensure it meets its 85% target. Weekly reports will also be sent out to all Managers highlighting those who have an expired PDR date and those who are due to expire in the next three month period, to aid the effective scheduling of these reviews. (Please also see Talent Management and Organisational Development regarding plans to move to a Fixed Year Appraisal Cycle)

Resolution Framework

The resolution framework has been approved at board, People & Culture Committee and also was agreed by both trade unions on the 14th April 2021.

Work has begun on schedule on implementing the framework and the following actions have been taken:

- Training has been provided to all executive directors on the framework (including on their new responsibility to conduct appeals against dismissal).
- It is anticipated that 600 managers across the trust will receive training on the framework by the end of May 2021
- 16 internal and volunteer mediators have been recruited and the first cohort have now commenced training
- 95 resolution advocates have been recruited and the first cohort have now received their training.
- HR staff have been trained on the triage system and a practical workshop held to ensure the Resolution Hub is ready to launch.
- Publicity for the new approach has commenced on LAS TV Live and further publicity will be done on the LAS intranet pages
- Tools and templates to support the implementation of the framework for use by the Hub have been developed

Figure 2 below shows the number of open disciplinary cases and grievances month on month from the beginning of the last financial year that are recorded in our Employee Relations Tracker.

Figure 2 – Grievance and Disciplinary cases April 2020– March 2021

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of open cases (Disciplinary)	35	52	74	73	59	63	63	62	15	19	20	22
Number of open cases (Grievance)	16	19	16	21	18	21	20	20	4	13	11	9
Number of open suspensions	3	5	7	6	8	5	4	6	2	3	3	3
Number of ET's	10	8	9	10	12	11	7	6	7	6	10	10

4. Health and Wellbeing

The impact of the last year is potentially emerging in an increasing number of colleagues accessing OH counselling services and contacts to the LAS Wellbeing Hub. A range of initiatives and support services are available to staff and volunteers, and the focus on wellbeing has been reflected in the more positive 2020 staff survey, with Wellbeing as one of the only areas of significant improvement for the Trust. An update on Health and Wellbeing activities is listed below:

Wellbeing Hub - The Wellbeing Hub continues to receive a high number of contacts, averaging over 250 per month and approximately 2450 since its inception last July. The Hub remains the point of contact for PPE breaches and has now taken over from the Staff Testing Team by enrolling colleagues into the LFT pilot in order to avoid isolations. The team have also received a number of challenging mental health contacts and provide a range of signposting support for other wellbeing needs, with bereavement and financial issues becoming more prevalent.

Tea Trucks – The Tea Trucks continue to be exceptionally popular, and are entirely staffed by restricted duties colleagues who would otherwise be unable to work. Over the past few months, the tea truck operatives have started to collect feedback about the tea trucks and there have been some new additions to the stock including some Australian favourites in order to make our international colleagues feel more at home.

Wellbeing Webinars – These have continued since February and have remained popular with colleagues the popular and well attended workshops have been repeated to ensure everybody has had the opportunity to attend

Wellbeing Conversations – A pilot project has now been completed at Brent Group where 22 staff were stood down from operational duty for a 90-minute conversation with a CTM over a 3 week period. The only aim of the conversation was a “check in” with the member of staff to see how they were coping and to offer onward support services if necessary. The feedback was exceptionally positive from both CTMs and staff and there is now a piece of work being undertaken to model impact across the service if this was rolled out Trust-wide. Similar pilots are to be undertaken in EOC and P&C.

Wellbeing Training – Over 150 CTMs attended two Wellbeing Training Sessions in March and April that focussed on the support services available and the plan for wellbeing over the next year. This presentation was also shared with 40 Operation Placement Centre mentors.

Wellbeing Staff Groups – There are now monthly meetings of the Wellbeing Steering Group and the CTM Wellbeing group (with a CTM wellbeing rep per group in attendance) as well as fortnightly meeting of the Post Covid Syndrome support group and menopause support group. There is work being undertaken to establish a 111/999 managers wellbeing group and another for corporate managers.

Team Time/Schwartz Rounds – The first Team Time, a reflective safe space to share experiences at work will take place on 12th May with our EOLC team the first to take part. Further sessions are planned for P&C and EOC over the coming months.

Physical Health – The Trust has successfully bid for 1500 free “VP Go” Apps, which are motivational team-based activity trackers that aim to get people moving. These will be offered to colleagues over the coming weeks, with teams competing both internally and against external Trusts to be the first to “move” the equivalent of halfway across the world

Surge Testing – The Trust was asked by NHSE/PHE to participate in PCR surge testing in response to a particular genomic sequence of the South African variant of Covid-19. Over 600 PCRs were returned, with unused kits retained and stored for future requests of this nature.

Staff Safety when Alone –The Wellbeing team produced some communications about the variety of phone apps that are available to share your location and to act as an alarm. Further work is being done to bring together tips and information about moving around London alone and will be published on the wellbeing section of the Pulse

Flu and Covid-19 Vaccination Programmes

At time of writing, 78% of the Trust has had at least one dose of a Covid-19 vaccine, with 49% having had their second dose. Over 83% of frontline staff have had their first dose. Work is underway to ensure that second doses are available and being taken up. All colleagues under 30 who have had the Astra Zeneca vaccine have been communicated with to ensure that any concerns are minimised in the wake of the suspension of this vaccine for first doses in that age group. The LAS Covid Vaccine team has been able to identify clinics that are able to provide Pfizer or Moderna as alternatives for those yet to have the initial vaccination. Further activities, including open days, virtual meetings and shuttle buses were used to encourage areas of low uptake and BAME colleagues to have the vaccine.

Planning is now underway for a potential COVID-19 booster vaccination in September and how this may be able to be delivered internally in conjunction with the flu programme.

Health and Wellbeing Strategy

An interim wellbeing framework was first drafted in spring 2020 with a delivery plan in response to the first wave of COVID-19. The delivery plan was designed to be delivered over a two year period. The actions contained within the delivery plan have been delivered successfully as at March 2021 ahead of schedule.

A Health and Wellbeing strategy with delivery plans is now being written for the next four years covering April 2021 - March 2025.

5. Talent Management and Organisational Development

The focus on delivering interventions to support the talent management and organisational development work streams are continuing. In particular the following activities are in place:

- **Personal Development Review Appraisal – Fixed Cycle** - Options were provided to the People and Culture Committee (6 May 2021) to move to a fixed cycle for PDR Appraisals whereby they were frontloaded at the beginning of the year to ensure that objectives are aligned to the Trust's Strategic Objectives. The Committee approved Option B which would formally launch the move in 2022/23 allowing the Trust to get new policies, processes and potentially a new eAppraisal (using AtLAS) in place and align with the Incremental Progression plans. During this appraisal year 2021/22 all Band 8A above who have had an appraisal within the last 6 months would have an Objectives Update meeting where their objectives would be reviewed and aligned to the Strategic Objectives and would need to be completed by the end of June 2021. For those whose appraisal becomes due or was held longer than 6 months ago would be required to hold the full appraisal automatically aligning objectives to the Trust's Strategic Objectives.
- **New Recruitment and Selection Training** – working with colleagues in Recruitment and Culture, Diversity and Inclusion the LEaP team are finalising the new training session and will share with leads and subject matter experts for review and comment prior to launching in June 2021.
- **B-Mentored Programme** – We have now secured 20 Mentors for the programme and have extended the deadline for Mentees to join, we currently have 14. A lunch day will be held with Mentees and Mentors separately and the Mentors day will be facilitated by TPC Health which was funded by Health Education England monies.
- **Redesign of the Engaging Leader course** – Work is underway to finalise the design of the new blended programme and will be shared with leads and Subject Matter Experts for comment in the coming weeks. The redesign has been completed in collaboration with NHS Elect
- **Business Administration Apprenticeship** – Applications are now being confirmed for administration staff across the service who applied for the course.
- **Clinical Team Manager Recruitment Training Plan** – Specific dates have been set up to support candidates in the new CTM recruitment campaign in the form of Application Form Completion and Interview Skills



Assurance report: **People and Culture Committee**

Date: **06/05/2021**

Summary report to:	Trust Board	Date of meeting:	25/05/2021
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:

Immunisations

Members received an update in respect of the levels of engagement with the Covid vaccination process and that work continues to deliver and reinforce the messaging and provide targeted messaging where appropriate.

Additionally recruitment letters had been amended to indicate an expectation that once appointed new starters would comply with the required immunisations set out in the Trusts policy.

PDR

The Trust is seeking to implement an annual fixed appraisal schedule and the Committee received a paper which established two options for delivery, their benefits and the risks for implementation. The committee supported the implementation of a fixed appraisal schedule for all staff commencing 1 April 2022 and that in 2021/22 all Band 8 and above should have a PDR/Objectives Realigning discussion by end of June 2021 aligning all objectives to the Trust's Strategic objectives.

Other matters considered:

18 Month Plan update

The Committee received an update in respect of the 18 Month people plan, noting that the directorate had focussed on delivering initiatives contained within the plan.

The volume of activity was recognised with one item not yet actioned. This would be actioned once the new Director of People and Culture is in post

Further to the detailed discussion the committee recognised the positive activity however remained cautious and recognised that not all initiative had been actioned or were delivering. It is essential that the team continue to challenge themselves as to whether there is sufficient assurance available to consider and initiative achieved.

Culture Diversity and Inclusion

The Culture, Diversity and Inclusion (CDI) team have been working with colleagues across the Trust to complete the actions in the combined action plan, which brought together the Black Lives Matter (BLM) action

plan, the Fleet Civility Report action plan, the Resilience and Strategic Assets action plan, the Workforce Race Equality Standard (WRES) action plan and the Workforce Disability Equality Standard action plan. Some of these plans are over a year old and have been impacted by our response to Covid-19 and staff changes. The CDI team plan to meet with action owners to review progress, blockers, and to ensure the actions remain relevant.

The full CDI plan and commentary had not been shared, commitment was made to circulate the plan by correspondence

Freedom to Speak up Annual Report

The Committee received an overview of the activities and outputs of the Freedom to speak up team and concerns in 2020/21 noting that the Covid-19 pandemic has transformed many aspects of our ways of working but the need to listen to colleagues who speak up remains paramount.

The number of FTSU concerns raised within the LAS during 2020/21 was 155, although this is a large decrease on the previous year, it remains to be seen if this is due to improved processes and relationships with managers within the Trust or because of the pandemic.

Dignity at work

Members received a report which highlighted the situation at the Trust regarding Dignity at Work and refers to the findings of the 2020 LAS Staff Survey Management report, updates on actions following the 2019 Lewis Review, current dignity at work resolution cases and significant achievements.

Key highlights were presented noting that the staff survey demonstrated and improvement in its effectiveness in tackling harassment, bullying or abuse. Work continues to progress in specific areas of the trust to implement the actions from the 2019 Lewis Report and that recruitment of 16 internal mediators and 95 resolution advocates has completed with training arrangements confirmed. Mediators will be formally accredited on completion of training.

Further to this From May 2021 the function of Dignity at Work as well as the Dignity at Work policy and procedure would be absorbed into the Resolution Framework.

Strategic Assets and Property

The Committee was presented with a paper which summarised progress within the Strategic Assets and Property (SA&P) Directorate to address values, behaviours and relationships across the Directorate. Good progress had been made during the latter part of 2020 continues with significant improvement in statutory compliance during the last two months.

The paper presented an outline of the recovery plans for each of the 3 identified domains, People, Operations, Planning and Modernisation and recognised there is more to do to realise Directorate ambition and continue to provide safe services for staff and patients.

Key decisions made / actions identified:

Culture Diversity and Inclusion Dashboard

The proposed Culture, Diversity and Inclusion (CDI) dashboard was presented noting that this was designed to show key CDI metrics at a Trust-wide level. It has been designed to reflect the indicators which are reported as part of the WRES and WDES submissions, to enable the tracking of progress across the year and to highlight areas requiring improvement.

Members approved the proposed dashboard and requested that consideration was given to the inclusion of metrics centred on organisational culture change.

People and Culture Dashboard

The People & Culture Committee had requested that a new dashboard be produced with all workforce KPIs in one place. This would include vacancies, turnover, sickness, employee relations casework, compliance data (PDR, statutory and mandatory training), health and wellbeing, culture, diversity and inclusion. Members agreed with the approach and noted the importance of including clear commentary to support the data.

Risks:

Board Assurance Framework

BAF risk 61, COVID-19 Impact had been reviewed by the Director of People and Culture and the residual risk score remains at 12 (4 x 3).

BAF Risk 65 - There is a risk that the health and wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records had been reviewed by the Chief Medical Officer with amendments to assurance, controls and actions - residual risk score remains at 12 (4 x 3).

BAF risk 56 -The Trust's ability to recruit and retain registered clinicians to our core front line operations had been reviewed on by the Director of People and Culture with amendments made to controls and actions. Proposal to decrease the residual risk score from 16 (4 x 4) to 12 (4 x 3) due to the controls in place. Members did not support the recommendation and the score will remain 16 (4x4)

Assurance:

The Committee took much assurance from the meeting that key priorities are moving forward and will be sustained.



PUBLIC BOARD OF DIRECTORS MEETING

Report of the Chief Finance Officer

The Finance Directorate encompasses financial control and management, procurement, commissioner contracting and costing, commercial, business planning and corporate reporting functions in support of providing the best possible value for the tax paying public.

This report summarises the directorate activity referenced in pages 28 to 32 in the Integrated Performance Report for the March 2021 reporting period.

The Trust was operating under an adjusted financial framework from April to September 2020 in response to the COVID pandemic which involved pausing business planning and cost improvement programmes in the first half of the year. The financial framework introduced fixed income arrangements funded through block payments via the host NW London ICS for the second half of the year.

The Trust's original financial target of a £2.3m surplus has been adjusted during the year, in common with every provider, to allow for agreed central adjustments for annual leave and conclusion of a national settlement on an historic dispute over annual leave on overtime payments, known as the Flowers case.

1. Financial Outturn 2020/21 (page 28)

The Trust met all its Statutory Financial Duties for 2020/21 (subject to Audit). Key points to note are as follows:

- The Trust ended the year with a surplus of £1.2m (£0.3m surplus on an adjusted financial performance basis) which met the target position agreed with NW London ICS.
- The Trust position incorporates additional resourcing to meet COVID surge requirements of £12.7m and a total of £88.4m in responding to COVID 19 during the year (£85.8m excluding centrally provided consumables and equipment)
- The Trust delivered its full capital plan for 2020/21, with closing capital expenditure of £43.3m net of disposals and excluding donated assets (£43.8m pre disposals). This was a significant achievement with a number of key infrastructure expansion and resilience projects commenced in response to COVID across IT, telephony systems, estate, fleet and our investment in digitising our patient records. These programmes address a number of legacy areas of underinvestment and the Trust plans to continue this in 21/22.
- The Trust's closing cash balance was strong at £39.8m at the end of March 2021, though this is skewed by the phasing of the capital programme and accrued expenditure and will reverse out in 21/22.
- The government sets a target to achieve 95% payment of supplier invoices within 30 days known as the Better Payment Practice Code. The Trust was just outside this

target at the year end which was a function of the volume of invoices processed in March.

- Under the financial framework that was put in place in the second half of the year as part of the NWL system plan, the Trust was set an efficiency target of £2.4m to meet the fixed income available to the Trust. This was met and additional projects were identified to match further approved spend of £4.5m bringing the total target to £6.9m, with full year achievement of £8.3m in 2021.

2. Financial and Business Planning 2021/22

The Trust has now has confirmation that the 2020/21 financial framework will continue for the first half (H1) of 2021/22 with block funding arrangements remaining in place.

These block values are based on Quarter 3 2021 spend values uplifted for 0.5% (net of 0.28% efficiency assumption) and adjusted for the increase in CNST costs, the NHS insurance scheme contributions. National guidance has confirmed that funding will be made available for the actual cost of the pay awards when they have been agreed by the Pay Review Bodies.

The Trust is planning to deliver financial balance in H1 based on the plan previously agreed by the Board. Further work is required to agree the NWL IUC Contract funding and cost for H1, which is currently excluded from the Trust plan and will be included when agreed. It is expected that agreement will be before the end of May 2021.

H1 system plans have been agreed and have been submitted to NHS England on 6 May 2021. These collate all the organisational plans at an ICS level and the Trust is required to submit its H1 plan to NHS England on 26 May 2021 in line with national guidance.

The Trust must now recommence business and financial planning for H2, 2021/22 to prioritise service developments and has already started to deliver identified efficiencies. National funding arrangements for H2 remain uncertain but, subject to confirmation of the income envelope the plan for H2 will be brought to the next Trust Board for approval.

3. Procurement Transformation update

There was good achievement on procurement savings for FY 20/21 with a Return on Investment of the Procurement budget of 4.45:1 (total revenue saving for 20/21 now totals £2.5m and £0.5m capital expenditure savings). The Trust is on target to deliver FY 21/22 CIP savings

Spend under contract improved from 41% to 64.5% of total non-pay spend over the last financial year and on track to achieve the Carter target of 80% under contract by the end of this financial year 21/22. The Trust has focused on procurement processes with compliance and governance improving and a significant reduction of single tender waivers and retrospective requests.

Procurement activity remains high in that last financial year 201 contracts have been formed with 7 procurements currently in flight, compared with 49 contracts formed in 19/20.

A three year pipeline of planned procurement activity has been agreed with budget holders for all categories of spend which will form the bases of business as usual procurement activity over the coming years and increasing strategic management of the supply chain.

Lorraine Bewes OBE
Chief Finance Officer
May 2021



Assurance report: Finance and Investment Committee (FIC) **Date:** 13/05/2021

Summary report to: Trust Board **Date of meeting:** 25/05/2021
Presented by: Amit Khutti, Non-Executive Director Chair of Finance and Investment Committee **Prepared by:** Amit Khutti, Non-Executive Director Chair of Finance and Investment Committee

Matters for escalation:

Finance Plan H2

Funding arrangements for H2 (Oct '21 – Mar '22) remain uncertain. The plan for H2 will be brought to the Board no later than September 2021 for approval.

Capital Plan

The Committee was pleased to review a draft 5 year capital plan.

For 2021/22, the Trust has been allocated an initial capital funding limit of £21.4m. Members recognised that this is only sufficient to complete in-flight projects started last year, and that further funding is essential for the Trust to embark address other high priority capital projects.

The Trust has started discussions with pan London ICSs on how it secures the required level of capital to complete its transformation and a meeting is being arranged between the ICS CFOs and the Trust COO and CFO.

111 IUC Resilience Contracts

The Committee received a request to approve additional spend in relation to three providers: Derbyshire Healthcare United (DHU), Herts Urgent Care (HUC), Integrated Care Group (ICG).

Assurance was provided that the additional spend and contract extension would provide sufficient time to undertake a thorough review of 111 IUC and to ensure that an effective procurement process could be implemented.

The Request was approved.

Going Concern

The Committee supported the preparation of the accounts on a going concern basis.

Board Assurance Framework

Members proposed the consideration of a further BAF risk in respect of Capital; the Executive will review and articulate for consideration in July 2021.

Other matters considered:

Procurement

The Committee was briefed on the Trust's procurement position and assurance was provided that all category management plans were now signed up to other than which had been delayed by diary commitments.

The Committee recognised the progress in the position and the evidence of cultural engagement with procurement processes and requested that any future issues were escalated to the Committee as necessary.

Financial Performance Report M12

The Trust ended the year with a surplus of £1.2m (£1.2m lower than planned) and had a closing cash balance of £39.8m at the end of March 2021.

Members considered the impact of Annual leave carry over and noted that the funding had been accrued for. It was considered that the majority of leave accrual had been within corporate areas and that the impact on operational areas would not be significant.

12 Month Rolling Cash Flow

The cash position has improved due to the Trust receiving funding of £5.6m from the DHSC to fund the Flowers case and £5.4m to cover the higher annual leave accrued by staff as at 31 March 2021.

Cash is £43.3m as at 31 March 2021. The main reasons for the favourable position are low levels of outstanding debts, capital slippage, high level of accruals and a high level of outstanding supplier invoices.

Key decisions made / actions identified:

NWL Financial Planning

The Committee received an update on the Financial planning process for 2021/22 recognising the block funding arrangements for H1.

The Trust is planning to deliver financial balance in H1 based on the plan previously agreed by the Committee and is required to submit its H1 plan to NHS England on 26 May 2021 in line with National Guidance. Funding arrangements for H2 remain uncertain. The plan for H2 will be brought to the Board no later than September 2021 for approval.

Business Cases and Contracts, 111 IUC Resilience Contracts

Members recognised the quality of the papers provided to support the requested approvals and concluded that the cover sheet should be used as an exemplar by others.

The document would be shared by committee services to report providers for their assistance.

Business Cases and Contracts, Body worn video cameras

The Committee received an update in respect of the Body worn video camera business case development and noted that the case would be

presented to the July Committee for consideration prior to presentation to the Trust Board in July 2021.

Members recognised that the number of cameras required would be reviewed and supported pursuit of national procurement, if possible.

Efficiency Programme

The Committee received an update in respect of the 2020/21 efficiencies delivered, status of the 2021/22 efficiency plan and status of the development of identified efficiencies for 2023/24 – 2030/31, reflecting a 10 year delivery horizon.

The 2021/22 efficiency plan includes £12.7m identified against a plan of £9.7m

The committee discussed the intent to pursue identification and tracking of non-cash releasing benefits and the associated challenges and the importance of effectively socialising the plans across the Trust with emphasis on a focus on efficient and effective patient experience and outcomes.

The Committee also considered opportunities that LAS may offer in relation to delivery of system benefits.

Technical Releases including Going Concern

No new accounting standards have been issued. However IFRS 16 leases has been deferred to 1 April 2022

The committee considered the going concern assessment and recognised that national guidance has been provided and the focus should be on the continuity of services.

It is clear from published evidence such as the spending review and the white paper on healthcare reform that NHS services including ambulance services will continue to be provided for the foreseeable future by the Trust and therefore supports the preparation of the accounts on a going concern basis.

Risks:

- Members reviewed BAF risk 61 and concluded that the reported score and mitigations required no further change.
- Members reviewed BAF risk 63 and concluded that the reported score and mitigations required no further change.
- Members proposed the consideration of a further BAF risk in respect of Capital, the Executive would take this away and consider appropriate articulation.
- Corporate Risks 775 and 1112 be further updated at Logistics and Infrastructure Committee for assurance.

Assurance:

- The finance report for M12 was received, indicating that the Trust had met all its statutory financial duties for 2020/21 (subject to audit)
- Assurance was provided that the 111 IUC Contract renewals included notice periods and were not predicated by minimum activity levels.
- 2020/21 efficiency delivery had been validated and delivered £8.3m v target of £8m (original plan £2m). Members were assured of the robustness of the information provided.



Assurance report: **Logistics and Infrastructure Committee** **Date:** **18/05/2021**

Summary report to: **Trust Board** **Date of meeting:** **25/05/2021**
Presented by: **Sheila Doyle, Non-Executive Director, Chair Logistics and Infrastructure Committee** **Prepared by:** **Sheila Doyle, Non-Executive Director, Chair Logistics and Infrastructure Committee**

Matters for escalation:

Infrastructure Modernisation Business Case

The LIC recommends that the Infrastructure Modernisation business case is approved and prioritised within the 2021/22 business and financial plan. This case requires £8.4m investment over the next 5 years with £3.2m required in 2021/22. The case will address critical infrastructure (BAF) risks, is a prerequisite to complete the relocation of the Data Centre to the Crown hosting facility and enable efficient routing of 111/999 services between the 4 core sites.

Transformation Program – People & Culture Risk

The committee received an update on 3 programs (Hub 1, Next Generation Ambulance and Newham EOC). The committee noted the positive work underway to strengthen governance arrangements. The report outlined the current status of each project including program highlights and a summary of risks and issues. People and Culture was identified as a RED risk in all 3 programs. The committee recommends the development of an holistic report outlining all people and culture changes that are required to support the various transformation programs. This report should include an assessment of the change impact, risks and mitigating actions as well as resources and expertise required.

The committee concluded that it would be appropriate to articulate a new risk that considers the People and Culture change implications of the Trust transformation programs. Once drafted, this proposed risk should be considered for inclusion on the BAF.

Revised LIC Terms of Reference

A revised Terms of Reference is presented for Trust Board approval. Members recommend that the committee quorum requirement is amended to require the presence of 2 Non-Executive Directors (NEDs) and to remove the necessity to have NED's in the majority.

Other matters considered:

**Transformation Program Update
Hub 1**

In addition to People and Culture risks the committee discussed the ambitious timelines for Hub 1 delivery and noted the work to define the

critical path and provide assurance on delivery dates. The 'go live' date for Hub 1 will be assessed at various check point meetings in July and September. Lessons learned from Hub1 will be critical input to inform the wider Ambulance Operations Modernisation strategy and delivery timelines.

Newham EOC

The critical dependency between Newham EOC and D999 CAD deployment was considered. The current plan proposes a move to Newham EOC in September followed by CAD go live in November. The committee discussed the timing of these 2 critical projects and acknowledge the need for additional work to provide assurance on project sequencing and delivery. The committee noted that additional Mechanical & Engineering work is required at Newham, which will impact the project budget. Further updates will be presented to the committee in July.

Members reflected on the recent challenges and changes to project budgets and proposed that the FIC receives a report that maps planned budget vs forecast budget for all material in-flight projects. Project portfolio cost escalation risks will be tracked alongside benefits realisation for FIC oversight.

Next Generation Ambulance

Members received a briefing on the work currently underway to deliver the Next Generation Ambulance. The project has been expanded to include all fleet modernisation dependencies in creating an ecosystem to support the implementation of a zero emissions fleet. The program is developing a new accelerated approach to deliver 150 eDCAs to comply with London ultra-low emissions by October 2023 and zero emissions in 2025. The electric vehicle charging infrastructure will need to be delivered in time for testing and delivery of the new eDCAs. A detailed update will be provided in July.

Infrastructure Modernisation & Digital Strategy

The committee discussed the importance of delivering the infrastructure modernisation program to mitigate critical infrastructure risks. This project has highlighted the need to prioritise the portfolio of change within the constrained capital budget if further funding cannot be secured. Members noted that the IM&T team is working to identify additional CIP savings to offset the increase in revenue expenditure.

Members received a report outlining performance against deliverables set out in the digital strategy. Good progress has been made in delivering key aspects of the strategy and in addressing immediate Trust needs. The strategy will be refreshed in Q2 2021/22 to reflect new drivers such as the impact of the global pandemic and to align with the Trust's clinical strategy and operating model. Substantial ongoing investment needs will be included in the 5 year capital plan.

Additional topics

Members discussed the results of the annual review of committee effectiveness and considered areas for improvement.

	<p>An update on Strategic Assets & Property culture change program and progress towards delivering staff survey action plans was presented. The committee recommends that the People & Culture Committee continue to receive updates to ensure alignment with the wider Trust People and Culture strategic initiatives.</p>
<p>Key decisions made / actions identified:</p>	<p>Noted in previous section.</p>
<p>Risks:</p>	<p>Board Assurance Framework and Corporate Risks</p> <p>Members reviewed BAF risks 61 (Covid-19 impact), risk 58 (IT failure) and risk 45 (Cyber). The residual risk scores remain unchanged.</p> <p>Corporate risks rated 15 and above were considered. The committee asked for further clarification on outstanding UPS and Power related risks. This update will be presented to the committee in July.</p>
<p>Assurance:</p>	<p>The Committee acknowledged the positive actions underway to implement robust governance and delivery expertise in support of the transformation projects.</p> <p>The strengthening of IM&T governance will address lessons learned from previous program delivery such as lack of IM&T input into the design of projects and the understatement of IT costs within some business cases.</p>



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Logistics and Infrastructure Committee Terms of Reference			
Agenda item:	8.4			
Report Author(s):	Victoria Moore, Corporate Governance Manager			
Presented by:	Sheila Doyle, Non-Executive Director, Chair of Logistics and Infrastructure Committee			
History:	Logistics and Infrastructure Committee 18 May 2021			
Purpose:	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<p>It is proposed that the Committee Quorum requirement is amended to require that two Non-Executive Directors are present and to remove the necessity to have Non-Executive Directors in the majority and is reflected as below</p> <p>8. Quorum</p> <p>8.1 The meeting will be quorate provided that the following are in attendance,</p> <p>8.1.1 Two Non-Executive members one of whom must be the Chair or nominated Chair of the Committee; and</p> <p>8.1.2 At least one of the two Executive Committee members, one of whom must be the Chief Finance Officer or the Chief Operating Officer.</p> <p>The Committee terms of reference have been updated accordingly and proposed changes marked in red.</p>				
Recommendation(s) / Decisions for the Board / Committee:				
The Trust Board is asked to approve and ratify the proposed amendment to the Committee Terms of Reference.				

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	Agreed			Relevant reviewer [name]
Quality	Yes		No	

Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes	x	No		Interim Director Corporate Affairs



Logistics and Infrastructure Committee

Terms of Reference (effective April 2020-March 2021)

1. Purpose

- 1.1 The Logistics and Infrastructure Committee has been established principally in order to provide assurance on and oversee strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate.

2. Constitution

- 2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

- 5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Director of Finance and Performance and the Chief Operating Officer) and shall consist of not less than six members, all of whom shall have voting rights.

6. Chair

- 6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

- 7.1 The Director of Corporate Governance should normally attend all Logistics and Infrastructure Committee meetings.
- 7.2 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance, ~~with Non-Executive Directors being in the majority;~~

- 8.1.1 ~~Two Non-Executive members one of whom must be~~ the Chair or nominated Chair of the Committee; and
- 8.1.2 At least one of the two Executive Committee members, one of whom must be the ~~Director of Finance and Performance- Chief Finance Officer~~ or the Chief Operating Officer.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

- 11.1 Meetings will be held bi-monthly, with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

- 12.1 To seek assurance (through the receipt of key performance indicators and other appropriate performance information) on the executive oversight of the following of the Trust's functions, in support of its operational delivery:
- 12.1.1 Fleet and Logistics;
 - 12.1.2 Estates;
 - 12.1.3 IM&T; and
 - 12.1.4 Cyber Security.
- 12.2 To seek assurance with regard to the Trust's Data Quality and information management/governance activities.
- 12.3 To seek assurance that effective supporting strategies relating to the above functions are in place that enable the achievement of the overall Trust strategy.
- 12.4 To consider and review key risks to delivery of strategic objectives within each of the above functions and to confirm risk appetite accordingly, escalating key risks to the Trust Board.
- 12.5 To have oversight of the regulatory and compliance framework for each of the above functions ensuring that all requirements and reporting requirements are being met.
- 12.6 To consider the capital and investment plans for each of the above functions, within the overall Trust financial plan and to inform/advise the Trust Board as appropriate.
- 12.7 To review and approve for recommendation to the Trust Board and Finance Investment Committee as appropriate any outline and full business cases for development and investment within each of the functions.
- 12.8 To receive assurance that all policies relating to each of the above functions are up to date and remain relevant and complied with.
- 12.9 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

- 13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

- 13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.
- 13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.
- 13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

- 14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

Approved by the Board at its meeting on 31 March 2020

Amendment proposed to Committee 18 May 2021

Presented to the Trust Board for approval 25 May 2021



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	London Ambulance Service Public and Patient Council notes – February			
Agenda item:	8.6			
Report Author(s):	Antony Tiernan, Director Communications and Engagement			
Presented by:	Antony Tiernan, Director Communications and Engagement			
History:	n/a			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<p>The London Ambulance Service Public and Patients Council (LASPPC) was established in 2020 and is one of many ways in which the Trust engages patients and local communities with its work.</p> <p>To help keep the Trust Board and Executive Committee informed of the work of the LASPPC, the notes and actions from meetings are presented for information at Board and ExCo meetings for information. Having been approved at its May meeting, the notes of the February LASPPC meeting are attached.</p> <p>I have also attached the agenda for the May LASPPC meeting. The notes will follow once they are approved.</p>				
Recommendation(s) / Decisions for the Board / Committee:				
The Board is asked to note the contents of this paper.				

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	x	No	Director Communications and Engagement
Strategy	Yes		No	
People & Culture	Yes		No	
Corporate Affairs	Yes		No	



**Meeting of the London Ambulance Service Public and Patients Council
(LASPPC) on Tuesday 9 February 2021, at 10:00am – 12.00pm,
via Teams Video Conference**

Summary

Attendees

Council

Dame Christine Beasley (CB), Chair; Dora Dixon-Fyle MBE (DD); Audrey Lucas; Lynne Strother (LS); David Law; Laura Bennett; Angela Cross-Durrant; Glenda Bonde; Dr Kathy French; Michael Bryan; Mary Leung; Patrick Burns (PB); Jacqui Morrissey; Ian Buckmaster (IB).

London Ambulance Service

Antony Tiernan (AT), Director of Communications and Engagement; Pauline Cranmer QAM (PC), Director of Ambulance Services; Stuart Crichton (SC), Chief Clinical Information Officer; Andrew Howard (AH), Violence Reduction Officer; Ross Fullerton (RF), Director of Strategy and Transformation; Jeni Mwebaze, Head of Quality Improvement and Learning; Nicola Phillips, PA to the Director of People and Culture.

Observers

Heather Lawrence OBE, Non-Executive Director; Dr Mark Spencer, Non-Executive Director; Rommel Pereira, Non-Executive Director; Dr Sheila Doyle, Non-Executive Director; Jill Anderson, Non-Executive Director, Fergus Cass, Non-Executive Director; Jayne Mee, Non-Executive Director.

Apologies

Alvin Kinch, Volunteering and Regional Network (London) Manager, Healthwatch England; Oonagh Heron, LASPPC member.

Welcome

CB welcome members, as well as a number of LAS Non-Executive Directors who were observing.

CB announced that Michael Bryan (MB) was now Co-Chair and welcomed him into his new role. A meeting would be arranged between himself, CB and AT in the near future.

- **Action:** MB to give an overview of his background at the next meeting.

Notes of the last meeting

The draft notes of the last meeting were agreed as a true and accurate account. No amendments were required.

Ambulance Operations Modernisation (AOM) programme – Ross Fullerton

RF gave a recap about the need to modernise the Service's station infrastructure. This will allow LAS to provide the right support to staff and volunteer including training and access to wellbeing facilities. It will also assist in improving productivity and efficiency.

At the last session RF reported that we were ready to develop and prepare the plans for the programme business case. We made good progress but had to slow down due to COVID during the Christmas period. The external team who are with us have made strong progress including helping us understand how to make best use of the physical assets we already have.

RF explained that there are up to 85 steps (in the current way of working) that a clinician takes before getting out to see a patient. The AOM will remove many of these steps due to having the facilities all in one hub, thus giving crews more patient facing time.

Sadly, we have made less progress in engaging the LASPPC sub-group and engaging with our workforce. This has slowed down over the past three months due to COVID.

It is really important to get support and engagement from the LASPPC sub-group over the next few months as we need to find out what the public response is as we change the way LAS operates.

RF explained that ambulances do not mainly get deployed from their station. They usually get a call from the previous patient's address, a public place or when finishing at hospital. We need to help the public understand that even though we are going to have circa 18 super-hubs (also known as Ambulance Deployment Centres (ADCs)) (down from 68 stations), it will not delay the ambulance getting to the patient as the ambulance is not generally at the station when given the call. They can be anywhere pan-London. The ADC is where the ambulances/cars are prepared, cleaned, fully kitted and ready to work.

CB stated that time spent getting people to understand cannot be underestimated. They worry this is going to affect the care of patients.

DD asked to use some of the funding for a campaign to educate people and requested that due to London's diversity, the campaign be produced in many languages. It is very important to get that information over to the people of London to reassure them.

PB suggested that we have a list of key questions from the people of the sub-group.

RF advised that the business case was originally going to be reviewed in January and finished in March but now re-planned with the draft being reviewed in March and the final review and approval be for the May Trust Board.

RF stated that we are currently operating from a smaller amount of sites than the usual 68 (41). This is to assist with the COVID pandemic. Of the 'closed stations', most are used on daily basis as a place where crews can take rest break, use facilities or attend meetings.

- **Action:** RF to organise visit to a 'super-hub' for LASPPC members.

Hub 1

RF confirmed that we are looking to create the first 'super-hub' site (also known as ADC) in the Romford area. The local authority are looking to redevelop the current Romford site. We are down to two options for sites – one is currently being used by another company. It is in the right location and is a big site. We are looking to get agreement with the landlords over the next few months after staff consultation has taken place with both their staff and ours. It will involve a change of location for our staff. The "go live" date is looking at the end 2021.

Action: To bring Hub1 updates to the sub-group and future LASPPC meetings.

Wembley and Ruislip

RF confirmed that Wembley and Ruislip are owned by NHS Property Services (NHSPS). They are looking to 'take back' these sites to develop new health care facilities for the local community i.e. GP facilities. We are working this through and will engage with staff and local stakeholders. We are currently not operating from these sites for active deployment.

Next Generation Ambulance project

RF gave an overview of how our vehicles are currently used, how many we are running, and the different types of fleet.

He explained how the new ambulance will help in reducing emissions, save fuel and hopefully help reduce accidents. Our current ambulance model has not changed in 18 years. We have agreed with NHS England and NHS Improvement to lead work to develop the new standard of ambulances.

LASPPC members have received an invite to the Next Generation Ambulance event in North Kensington Ambulance station on the 19 February.

COVID-19 update – Pauline Cranmer

PC informed members that COVID-19 demand has reduced significantly although we still do have our normal winter activity along with a proportion of COVID activity. The pressure has eased on our staff and volunteers, this is giving us some time to rest and recuperate

40% of our activity in January was COVID-19 related – today this is now down to 15%.

This has allowed us to review the resources that we have available to us i.e. Metropolitan Police Service, London Fire Brigade, other ambulance services and volunteers. We are now reducing some of the support.

The 111 services – 30-60 age range coming through now which coincides with the older generation having their vaccines.

PC outlined some of the ways in which the Trust is supporting staff and volunteers including the vaccination programme, mental health support, lateral flow tests to support staff to return to work safely and food/drink delivered to staff and volunteers at hospital sites.

AT reported that we are setting up a dedicated session at the end of February/early March for all of the 32 London Healthwatch to give them a detailed update about our response so far and PC will be attending this also.

PC spoke about staff welfare checks and how we assist staff and volunteers.

Mental Health and Integrated Care Systems – Ross Fullerton

RF gave an overview of NHS England's Integrated Care System (ICS) consultation, which concluded in January and shared the response that the LAS submitted.

He also gave an update on an urgent and emergency care consultation – how we move away from the four hour A&E target in a hospital setting.

There is also a consultation on changes to Mental Health Act, which closes in April. LASPPC members are encouraged to let us know if they have feedback.

It was agreed that we would invite our mental health and end of life care teams to a future meeting. We would also make 'live' consultations a standing item on the agenda.

Action: Invite mental health and end of life care teams to a future meeting.

RF thanked the group and explained that he was leaving the trust at the end of the month.

Station Accreditation Programme – Jeni Mwebaze

JM gave overview of Station/Service Quality Accreditation.

Thresholds were put in to what a Gold, Silver and Bronze station would look like. Four were awarded Gold and one Silver from our pilot.

The plan is to roll the programme out more widely from April 2021.

AT stated working with IB and LS to develop a visits programme with LASPPC members undertake 'enter and view' style visits. A terms of reference were in development.

Electronic Patient Care Record (EPCR) – Stuart Crichton

SC reported that 90% of staff had been trained to use the Electronic Patient Care Record (EPCR) with the system going 'fully live' on 27 October. He reported good uptake and engagement with 42% using the system by mid-December.

During the height of COVID peak two, the decision was made not to continue using EPCR if staff felt it was becoming an issue for wellbeing and patient care.

Feedback from stakeholders (A&Es and GPs) has been very positive with regards to the data they are receiving. They are also offering feedback in what else they would like to see added to the existing format. 90,000 records have now been completed (1,100 – 1,200 per day).

Looking ahead, we are re-engaging staff to get 100% staff use of EPCR.

SC is working with David Elliman on how we can engage with the public. An invite was offered to the rest of the group if they wanted to be involved with the EPCR project sub-group.

Crew Safety – Andrew Howard – Violence Reduction Officer

AH advised what the new crew safety system was made up of – telematics, radio-frequency identification to identify the driver and a video camera system.

He advised that there has been 338 staff assaults in seven month period and that the new system helps to assist obtaining evidence and to make a person think twice about assaulting the crew.

AH report that we received 81 complaints about driving standards within a nine month period. This system will help reduce this figure due to staff being more aware.

There is a six camera system – four external and two in the rear cab of the vehicle. The cameras are on a constant loop and will download any data once emergency button pressed. The system sends a warning out that the CCTV is under operation. There are also signs on the outside and inside of the ambulance explaining that there is CCTV in the vehicle.

36 vehicles are being trialled.

Action: CB requested that AH return with findings.

Next Meeting Tuesday 4th May 2021 at 10:00–12:00



Meeting of the London Ambulance Service Public and Patient's Council Meeting

Tuesday 9 February 2021

ACTIONS

Ref	Action	Owner	Date due	Status
1	Michael Bryan to give an overview of his background at the May meeting	MB	03/05/21	On agenda
2	Arrange for LASPPC members to visit a super-hub	RF (AT)	ASAP	Organise after lockdown
3	To bring a Hub1 update to the next meeting	RF (AT)	03/05/21	On agenda
4	To invite the mental health and end of life care teams to a future meeting	AT	ASAP	Scheduled for August
5	AH to return back to next LASPPC meeting with findings from Crew safety trial	AH	10/08/21	Scheduled for August



Meeting of the London Ambulance Service Public and Patients Council on Tuesday 4 May 2021, at 10:00am – 12.00pm, via Microsoft Teams

Agenda

Item		Owner		Time
1.	Welcome	Dame Christine Beasley, Co-Chair	Verbal	10.00
2.	Notes and actions of the last meeting	Dame Christine	Papers – attached Notes (001) Actions (002)	10.05
3.	Co-chair role and introduction	Michael Bryan, Co-Chair	Verbal	10.15
4.	Consultations <ul style="list-style-type: none">• The Mental Health Act White Paper• The NHS England consultation on the Provider Selection Regime (PSR)• Association of Ambulance Chief Executives (AACE)/Public Health England (PHE) thought piece on the role of ambulance services in promoting public health	Ant Scott, Head of Strategic Development	Papers - attached LAS mental health response (003) LAS PSR response (004) AACE/PHE paper (005) LAS AACE/PHE paper (006)	10.20
5.	Station accreditation programme – update and call for support	Amy Pitcher, Quality Compliance Manager and Lee Hyett-Powell, Quality Governance and Assurance Manager	Verbal	10.35

Item		Owner		Time
6.	Patient Safety Incident Response Framework (PSIRF) – update and call for support	Helen Woolford, Head of Quality Improvement and Learning	Paper – attached (007)	10.50
7.	Next generation ambulance – update and feedback from design day participants	Chris Rutherford, Next Generation Ambulance Programme Lead Oonagh Heron, LASPPC member Michael Bryan, LASPPC member	Verbal	11.10
8.	Ambulance Operations Modernisation Programme – Hub1 update	Philippa Kier, Senior Stakeholder Manager	Verbal	11.30
9.	LASPPC sub-group update	Antony Tiernan, Director of Communications and Engagement	Papers Update (008) IPC terms of reference (009) Proposal for visits programme (010)	11.40
10.	AOB	All	Verbal	11.55
	Meeting ends			12.00



Report to:	Trust Board - Private			
Date of meeting:	25 May 2021			
Report title:	Draft Annual Report including Annual Governance Statement			
Agenda item:	9			
Report Author(s):	Various			
Presented by:	Anthony Tiernan, Director of Communications and Engagement Trisha Bain, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board's attention:				
<p>The Board is requested to approve the following Annual Report and Accounts for 2020/21.</p> <p>The three-part document consists of:</p> <ol style="list-style-type: none"> 1. The Performance Report, which must include: <ul style="list-style-type: none"> • an overview 2. The Accountability Report, which must include: <ul style="list-style-type: none"> • a Corporate Governance Report (including the Annual Governance Statement, AGS) • a Remuneration and Staff Report • an Audit Report (following consideration by the Audit Committee). 3. The Annual Accounts (Draft Annual Accounts attached as agenda item 11). <p>The latest draft of the Annual Report and Accounts for 2020/21 are being presented to the Board for consideration at this meeting and are due to be submitted to NHSE/I by 15 June 2021.</p> <p>Due to the requirements of the submission timetable, the Board is asked to delegate authority for the final approval of the Annual Report and Accounts to the Audit Committee. This will enable the Committee to consider any significant issues relating to the draft Annual Accounts and AGS in light of external audit findings to date and the Head of Internal Audit Opinion at its meeting on 26 May 2021. The Audit Committee will then agree the final Annual Accounts for signing and submission in light of ISA 260 report from external auditors at its meeting on 10 June 2021.</p>				
Recommendations for the Board:				
<p>The Board is requested to delegate authority to the Audit Committee to approve the London Ambulance Service NHS Trust Annual Report and Accounts for 2020/21 at its meeting on 10 June 2021, prior to submission on 15 June 2021.</p>				

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Finance	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Chief Operating Officer Directorates	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Medical	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Communications & Engagement	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Strategy	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
People & Culture	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Corporate Affairs	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Executive Committee

ANNUAL REPORT 2020/21

SECTION ONE: PERFORMANCE REPORT

1. Chair's Foreword
2. Chief Executive's Foreword
3. About London Ambulance Service
4. Coronavirus
5. Our Priorities
6. Our Patients
7. Our Performance
8. Our People
9. Our Partnerships
10. Our Public Value
11. Risks

SECTION TWO: ACCOUNTABILITY REPORT

1. Directors' Report
2. Annual Governance Statement
3. Remuneration and Staff Report

SECTION THREE: ANNUAL ACCOUNTS – not included

SECTION ONE: PERFORMANCE REPORT

1. CHAIR'S FOREWORD

When reflecting on the extraordinary year we have had, my thoughts are with those we have lost, those who are grieving and those who have made heart-breaking sacrifices and continue to make those sacrifices.

In this year like no other, everyone across London Ambulance Service has played a crucial role in responding to COVID-19 and saving lives.

Throughout the pandemic our staff have continued to provide compassionate care to all patients and their families, which given the circumstances they were enduring is truly remarkable. My heartfelt thanks goes to staff and volunteers who have gone that extra mile, often at personal cost.

Not only have we prioritised our quality of care, but even in the darkest days of the pandemic, we strived to ensure our people felt cared for and supported at work. This has not always been easy but the pressures of responding to COVID-19 have brought the health and wellbeing of our staff into sharp focus.

One of the positives to come out of the pandemic has been the commitment and energy given to creating a safe environment for all our teams by developing our wellbeing services and trying to reduce workplace stress. This has included ensuring our people were among the first to be offered the COVID-19 vaccine.

And while we were being tested by the demands of the health crisis, we came together to talk about the very important issues highlighted by the murder of George Floyd in America and the Black Lives Matter movement. I have personally listened to our staff who shared

their stories of being a Black person living in London and the discrimination they and their families suffer often day in day out.

We are resolute in our determination to stamp out racism. We began an engagement programme to improve inclusivity, equality and diversity. Our aim is for every single person working at London Ambulance Service to feel respected and valued.

We are building an organisation everyone should feel proud to be a part of.

This year we have launched both a Public and Patient Advisory group co-chaired by Dame Christine Beasley and Michael E Bryan and a Chair's Staff Advisory Group. Listening to our staff and patients is essential in improving both our culture and the way care is delivered.

As we move into Integrated Care Systems (ICSs) and come through the pandemic, it is more important than ever for us to be a full system player in the provision of urgent and emergency care.

This year, through COVID-19, we have demonstrated the benefits of effective system working by collaborating closely with NHS England/Improvement and the five ICSs to innovate and respond to the changing needs of our patients.

This has included the integration of 999 and 111 services and the development of new patient pathways, including, most notably, our role in the hospital at home initiative for patients suffering with COVID.

Our ambition is to be a world-class ambulance service for Londoners, a vision supported by both NHSE London and the Mayor of London. The latter visited our headquarters and our new call handling training centre this year.

We have also been honoured to host visits by the Prime Minister Boris Johnson and their Royal Highnesses, the Duke and Duchess of Cambridge. All our visitors have expressed their gratitude and admiration for the work of our people throughout this crisis.

On behalf of the Board, I would like to echo that thanks to our Chief Executive, executive team, managers, staff, volunteers and partners.

2. CHIEF EXECUTIVE'S FOREWORD

The worst of times can bring out the best in people. The peaks of the pandemic were certainly some of the very worst times we have endured; but the way our people have risen to this extraordinary challenge has shown them at their very best.

The virus was spreading so rapidly in London this winter, the Mayor of London declared a Major Incident.

In the face of undeniable pressure, what we have achieved has been truly remarkable. Our staff and volunteers have proved to be resilient and resourceful throughout a time which has been frightening for us all.

Not only have we remained steadfastly focused on excellent patient care, but we have completely transformed our ways of working: we have increased our workforce and number of ambulances on the road, allowing us to help thousands of people every day.

Our performance across the whole year has remained strong. Except for some extremely busy days during the two peaks in COVID cases, including the two busiest in our history, we have been reaching patients within target times. By treating more people over the telephone and on scene, we have been able to reduce the pressure on emergency departments.

That is not to say there haven't been immense difficulties: 999 calls doubling; 111 calls tripling; younger patients in cardiac arrest; handover delays at hospitals; and huge numbers of staff and volunteers off sick or isolating. For all our staff it has often been frustrating, distressing and exhausting. However, we have continued to rise to the challenge of supporting Londoners when they need us most.

Our priority throughout has also been to keep our people healthy and safe. This meant ramping up our services to support mental and physical health; which included ensuring our staff and volunteers had the right protection as well as early access to testing and the COVID-19 vaccine.

The disproportionate impact of the virus on people from Black, Asian and minority ethnic (BAME) communities has been clear since the early days of the pandemic. This has been concerning for us, and we have worked very hard to assess the risks posed by COVID-19 to ensure we're doing everything we can to keep our people safe.

Equally concerning, from the learning we have done across the organisation in response to Black Lives Matter is the fact that our BAME colleagues haven't always felt the respect and recognition everyone deserves. We are committed to rooting out racism while improving race equality and diversity across all parts of the organisation.

We are asking senior leaders within the organisation to lead the way in delivering cultural transformation. We must empower our people, facilitate innovation and collaboration, and increase our professionalism and respect.

Nowhere has the professionalism and respect of our people been better demonstrated than in the latest series of the "Ambulance" documentary, which was broadcast on *BBC One* in the autumn. Recorded in 2019 prior to the COVID-19 pandemic, this fantastic production showcased the incredible dedication of our ambulance crews and call handlers while also shining a spotlight on those who work so hard behind the scenes.

Viewers saw the diversity of jobs we are called to, as well as some of the challenges – and the programme led to record numbers visiting our jobs pages, wanting to join us.

Some of those inspired by the series, may be among our newest Assistant Ambulance Practitioner (AAPs) recruits. This is a brand new role – only created this year – and in just a matter of months, we have recruited and trained more than 100 people who are already working on ambulances and caring for patients.

It is just this type of innovation which has led to us winning and being nominated for a host of accolades including both the Mental Health Initiative of the Year Award and End of Life Care Award at the Health Service Journal Patient Safety Awards as well as the Strategy & Design Award at the Supply Chain Excellence Awards.

None of these achievements would be possible without the support we have had from our NHS partners, our emergency services colleagues and other organisations who have enabled us to deliver the best service possible to our patients during this unprecedented year.

We are now starting to think about what recovery from this crisis will look like: we know it will be challenging. But given the dedication and commitment shown by everyone at London Ambulance Service, we know we have the very best people for the job.

3. CORONAVIRUS

This year, London Ambulance Service has been at the heart of the nation's response to the COVID-19 emergency – possibly the greatest peacetime healthcare challenge since the creation of the NHS in 1948. In this section, and in advance of our review of the year generally, we set out how we responded to this challenge.

The first time we were called to a patient suspected of having COVID-19 was 25 January 2021. At that point we were dealing with a new virus about which little was known worldwide. There were no pre-existing guidelines on how to care for patients.

We supported the development of many of the protocols in triage and assessment of this new disease, amending them as more was learned. We continued to be at the forefront in responding to the pandemic as cases peaked for a second time last winter.

The busiest day in the history of London Ambulance Service was 4 January 2021 when we took 8,464 999 calls. On New Year's Day in 2021, ambulance crews treated 3,764 patients – the highest number of patients we have ever seen face-to-face.

The work to rapidly mobilise a pandemic response involved significant changes across our operational teams and required fundamental variations to our ways of working.

First wave

As the crisis first unfolded in early 2020, three immediate operational challenges were identified: ensuring we had the maximum number of ambulances available; having the resilience needed if 999 or 111 call volumes suddenly increased; and being able to mobilise additional blue light drivers for our ambulances to free up clinicians to provide care. We took a number of immediate and substantial actions in order to manage the extreme levels of demand placed on our 999 and 111 services.

They included:

- Building a dedicated COVID-19 999 call-handling centre
- Expanding the NHS 111 facility to accommodate more clinicians to respond to COVID-19 calls
- Enhancing infrastructure to transfer calls to other ambulance services and between 999 and 111
- Redeploying all clinicians to patient facing duties
- Strengthening our leadership team to operate a full seven-day-a-week capability
- Bringing in 900 volunteers, student paramedics and former members of staff
- Training hundreds of London firefighters - and later Metropolitan police officers - to drive ambulances and support our crews
- Rapidly acquiring over 100 extra ambulances and moving crews from other response vehicles onto ambulances
- Developing partnerships with the military and other organisations, like the AA to keep more of our vehicles on the road 24-hours a day, seven days a week
- Working with NHS partners to develop new or improved patient pathways
- Providing additional senior clinical support for 999 and 111 centres and for clinicians on ambulances
- Implementing regular safety and quality reviews for continual oversight of patient safety
- Consolidating operations into larger hub ambulance stations

- Redesigning and increasing the size of our logistics warehouses for storing PPE and other essentials
- Helping design the NHS Nightingale London hospital and creating and delivering a bespoke critical care transfer service
- Coordinating patient transport services across London
- Increasing our engagement with staff and volunteers, including launching LAS TV Live
- Working with the media and other partners to share important information, including how the public could protect themselves

As a result of these actions, by mid-April 2020 we were meeting national performance targets every day.

As we emerged from the first wave of COVID-19, work was done to learn from our response and build resilience for the future, in expectation of a second wave.

Second wave

In December 2020, COVID-19 started spreading far quicker than national forecasting and modelling had predicted due to a new, more transmissible, variant of the virus. Community infection rates quadrupled in a matter of weeks.

Not only did call volumes and face-to-face incidents rise dramatically, but so did infection rates among our own people. At the peak, despite stringent PPE and social distancing measures, the Trust had around 800 staff members absent and nearly 600 isolating - around a fifth of our entire workforce.

Our colleagues at London Fire Brigade, who had been trained to drive ambulances, were also suffering high rates of sickness which meant we could not bring on board these extra blue light drivers as quickly as we had planned and hoped for.

With hospitals dealing with unprecedented numbers of patients, pressure mounted in emergency departments (EDs). When EDs were at their busiest, the delays for patients to be handed over to hospital, added up to 700 hours a day in lost operational time for London Ambulance Service. This meant that, at times, about 25% of ambulances were waiting in queues outside emergency departments and unable to respond to patients who had made a 999 emergency call.

Our response

As a 111 provider for 40% of London, we increased call taking capacity through partnership arrangements with out-of-London providers, where there were fewer COVID infections

Our 999 call handling workforce and infrastructure had already been increased after the first wave. Crucially we had also put in place arrangements with ambulance services across the country to agree a mutual aid framework. These arrangements allowed us to answer more 999 calls than ever before and in turn triage a greater number of patients than ever before.

We trained police officers who, as well as firefighters, boosted our numbers to enable us mobilise up to 500 ambulances per day. We have consistently maintained a fleet of 530 ambulances which can be deployed – with over 90% availability – at all times. This is down to the AA and our own mechanics working 7 days a week to keep vehicles well-maintained.

We increased the number of clinicians in our 999 clinical hub, agreeing a minimum of 35 clinicians rostered on at peak times during any 24-hour period. They were able to undertake enhanced clinical assessments, ensuring the safety of patients waiting for an ambulance. These clinicians were also able to direct patients who did not need an ambulance to alternative care pathways such as direct booking in to primary care and therefore reduce the need for ambulances.

These actions meant that for most of the year we were reaching patients within our target response time. Our average response time for reaching the very sickest patients was 6 minutes and 16 seconds.

Learning

Despite meeting our target times, the pandemic has exposed weaknesses and inefficiencies in the way we previously operated.

We are determined to use this opportunity and build on some of the improvements we have made so that we can continue to maintain and sustain the benefits achieved.

Some of those improvements, like greater integration, were always part of our strategy for delivering against the NHS Long Term Plan.

However new priorities (detailed in a later chapter) have emerged and we will continue to embrace transformation in the months and years to come.

THANK YOU – separate box

Everything we achieved this year was only made possible by the immense effort by many people right across London Ambulance Service, as well as the fantastic help we received from so many other organisations including:

NHS London and NHS England, our partner ambulance services, St John Ambulance, the AA, London Fire Brigade, Metropolitan Police Service, Transport for London, NHS Charities Together, London Air Ambulance, Stagecoach, Wilker ambulance converters, Telent, Bowmans, Wembley Stadium, Virgin Atlantic, British Airways, our partner universities (Anglia Ruskin, University of Herefordshire, St George's University, University of West London, University of Greenwich and University of Cumbria), the armed forces, the Hampton by Hilton Hotel, Waterloo and several other hotels across London, and a multitude of other organisations that have provided welfare support including food and isolation packs and other essential equipment necessary to develop and sustain our response.

4. ABOUT LONDON AMBULANCE SERVICE

Who we are

We are respectful. We are professional. We are innovators. We are collaborators. We are the NHS. We are London. We are life savers.

We answer more 999 and 111 calls than any other ambulance service in the country. We attend more than 3,000 emergencies a day.

Our staff, volunteers, patients and local communities are at the heart of what we do and we involve them in helping to shape our work and the care we provide.

We are the only NHS provider trust to serve the whole of London – one of the world's most dynamic and diverse cities. Demand for our services increases every year as do the challenges and complexities of our mission.

We have more than 8,000 people who work or volunteer for us and together we are striving to be a world-class ambulance service for a world-class city.

We are governed by a Trust Board made up of 14 members: a non-executive chair, seven non-executive directors, five executive directors, including the chief executive, and an associate non-executive director.

Our Executive Committee leads and manages the performance of the Trust within the framework established by the Board. It consists of eight directors, including the five executive directors on the Board.

We are committed to promoting equal opportunities across everything we do, in terms of employment and training, the care we provide and our engagement and decision making.

We have changed our ways of working to respond to COVID-19 and we will build on these improvements.

And as the nation moves towards recovery, we will continue to evolve to meet the changing needs of the nine million people who live and work in London.

History

The first ambulances appeared in London towards the end of the 19th century. These were horse-drawn ambulances operated by six hospitals in the city. The first petrol-powered ambulance was introduced in 1904.

Major change came in 1930 when London County Council took over responsibility for all the hospitals and ambulances.

During WWII, the London Auxiliary Ambulance Service was set up – and most ambulances were driven by women.

In 1948 the National Health Service was established and with that the requirement for ambulances to be available for all those who needed them.

In the 1950s the London County Council's ambulance service moved to headquarters at Waterloo Road – close to the current HQ.

London Ambulance Service was created in 1965 when one single ambulance service replaced the nine existing services working in the city. Back then we had nearly 1,000 vehicles and 2,500 members of staff.

In April 1996 London Ambulance Service became an NHS trust.

Infographic: "By numbers"

999 calls – 1,813,112

111 calls – 1,382,073 (to be updated prior to submission with NWL data)

Incidents attended – 1,100,902

Headcount – 6497

Average response time to most serious calls – 6 mins 16 secs

A 21st century service

The London Ambulance Service of today bears little resemblance to the one created more than 50 years ago.

Back then we only focused on patients with life-threatening conditions and getting them to hospital as quickly as possible. Today, we still respond to life or death emergencies but the scope of our work has expanded to treat many more patients.

We have highly trained clinicians who can treat patients in their own homes or treat and advise over the phone.

Our core work:

- Answer, prioritise and allocate 999 calls across London
- Respond to emergency and urgent 999 calls by sending clinicians to the scene or by treating over the phone
- Provide 111 integrated urgent care services for over 2.5 million people in south east and north east London (to be updated prior to submission with NWL data)
- Take patients referred by a Community Healthcare Professional to hospital for emergency assessment

Other work includes:

- Plan for, and respond to, major and significant incidents with London's other emergency services, NHSE London, the Mayor, local authorities
- Provide paramedics to work for London's Air Ambulance and decide when to dispatch the helicopter
- Educate the public in life-saving skills and use of public access defibrillators as well as raising awareness of issues including knife crime, alcohol abuse and road safety
- Engage with NHS partners, local authorities and the Mayor to encourage a healthier population and a safer London
- Find hospital beds for seriously ill patients and provide transport for the transfer of poorly new-born babies between hospitals in London, Kent, Surrey and Sussex

5. PRIORITIES

Our vision is to become a world-class ambulance service at the heart of urgent and emergency care in London.

Our 5-year strategy was launched in 2018 - before COVID-19 emerged and before the global pandemic disrupted life as we knew it.

The virus has changed the NHS; it has changed London Ambulance Service.

Yet the core elements of our strategy helped enable our response to COVID-19 and remain relevant and appropriate today. And throughout the pandemic we have continued to drive forward progress across each of our three strategic themes.

Strategic Themes

Theme 1: Comprehensive urgent and emergency care, coordination, access, triage and treatment, with multichannel access for patients.

- In addition to our south east and north east London 111 services, we have become the lead provider of Integrated Urgent Care (IUC) services in north west London and

are working with other providers to support the delivery of IUC services in south west London.

- We established dedicated COVID call hubs and have retained increased call-handling functions to improve accessibility of our services.
- We have expanded our video consultation ability in our clinical hub and Clinical Assessment Service to support the remote delivery of assessment and care where appropriate.

Theme 2: A world-class emergency response with enhanced treatment at scene and for critically ill patients, a faster conveyance to hospital

- We have successfully expanded our multiple award-winning Mental Health Pioneer Service across London in collaboration with London's mental health trusts. The service, which sees a registered mental health nurse dispatched alongside a paramedic, continues to deliver improved patient care; reduce hospital conveyance rates; and increase the resilience for providing crisis services across the capital.
- Thanks to our partnership with Macmillan Cancer Support, another award-winning initiative, all 18 ambulance group stations across London now have a clinician with additional training to help support crews attending patients nearing their end of life, and rapid access to Coordinate My Care, an electronic system holding patient care records.
- Through pilots in north east London, we have developed contacts and relationships with system partners to reduce avoidable journeys to hospital and deliver care in the most appropriate setting.
- We have expanded our Advanced Paramedic Practitioner programme from 51 in December 2018 to 82 in March 2021. These experienced paramedics are trained to have extra clinical skills and are authorised to administer a range of additional medicines so they can give patients the very best care for their needs.

Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

- Full details of our partnership working with NHS and emergency services can be found in the Our Partners chapter [LINK](#). This includes paramedics working with GPs in south London; better access to secondary care settings for our patients; and firefighters and police officers responding to 999 calls with our medics.

As we emerge from the pandemic, we need to build on this momentum of positive transformation, and remain resilient to future crises and the long-term impact of COVID-19.

Over the coming months, we will refresh our strategy to ensure we adapt to the changing opportunities and challenges we face.

We already know that areas of focus on will include: (This page will be laid out like a magazine – each of the priorities below in a separate box/bubble rather than continuous text)

Wellbeing

Ensuring our people are both mentally and physically healthy is a top priority for London Ambulance Service. This has been a traumatic year for staff and volunteers: caring for so many patients, while sadly having to deal with the loss of friends, relatives and colleagues.

We remain focused on providing emotional and practical support to our people so they can continue to care for London.

This year we have brought all health and wellbeing initiatives into a central Wellbeing Hub so resources are easily accessible and to focus on the areas which benefit staff the most.

We are working to ensure those services reflect the diverse needs of our people while developing new initiatives to promote physical, emotional and mental wellbeing.

We are creating an environment where people have sufficient breaks from work and are encouraged to take their leave in a managed way.

We want to provide staff and volunteers with a safe rest space to process the physical and psychological demands of work and offer access to a broad range of psychological support, if needed.

Some of the most popular initiatives include:

- Packs of food and drink for staff and volunteers who were having to isolate
- Provision of hot and cold meals and drinks which were distributed across the trust
- Tea trucks which take drinks and snacks to ambulance crews waiting at busy hospitals
- Wellbeing webinars designed in collaboration with the North West London Mental Health lead to help with problems like stress, anxiety and sleep
- Support for staff working from home to encourage a healthy and balanced approach
- 'Welcome back from shielding' packs to ease the return to work for those away for a long period.

Health and safety

Our ambulance crews treat more than 1.1 million patients every year while our 999 and 111 call handlers help more than 3 million. However they are facing an increase in violence and abuse from a minority of the public they work so hard to care for.

Staff and volunteers have reported being punched, kicked, bitten, spat at, assaulted with weapons, threatened and subjected to racist and sexual abuse.

In response we have recruited two Violence Reduction Officers as part of our ongoing work to protect staff. The officers are making sure people have the support they need while also giving practical help for victims who want to take their cases to court.

The team has been working closely with the police to increase the number of successful prosecutions.

In a trial which started in February 2021, crews working in high risk areas have been given body-worn cameras so they can record evidence if a patient or member of the public becomes aggressive or abusive.

We continue to publicise these initiatives and prosecutions through our #notpartofthejob campaign which aims to deter potential offenders by highlighting the serious consequences of abusing staff and volunteers.

Flu and COVID-19 vaccination programmes

We had 200 peer vaccinators involved in our 2020 flu campaign which made the vaccine available to everyone working at London Ambulance Service.

All staff and volunteers were offered the vaccine by 30th November 2020 to make way for the COVID-19 vaccination programme. By this date, we had achieved a 78% vaccination rate for frontline workers and 72% across the organisation.

We secured early access to the COVID vaccine for our staff and volunteers in December 2020. Since then we have worked hard to provide up-to-date information about the vaccine and how staff and volunteers can receive it as well as practical help, like a shuttle bus between 999 and 111 control rooms to the Excel Centre vaccine clinic. By March 2021, 75% of our staff and volunteers had received their first vaccine and that number rose to 82% for patient-facing staff. More than 20% of our people had received both doses by then.

Meanwhile our trust pharmacists and members of our clinical directorate have been available to answer questions and concerns throughout the year.

Black Lives Matter

The murder of George Floyd in the United States on 25 May 2020 had a considerable impact on Black people throughout the world. The Black Lives Matter movement shone a spotlight on all the work we have done in respect of the Workforce Race Equality Standard (WRES), including increasing the diversity of our overall workforce, increasing the number of Black, Asian and minority ethnic (BAME) people on our Board and in senior positions, as well as improving perceptions of career opportunities and reducing discrimination.

However it became clear we had further to go in becoming an anti-racist organisation. This prompted the Chair and the Chief Executive to encourage open and honest 'big conversations' with our staff and volunteers about race and racism. The Trust has since developed an action plan to address equality and diversity as well as the immediate issues faced by Black people in the organisation. Further details of this action plan can be found in the Our People chapter. [LINK](#)

Staff and volunteer engagement and communication

In the early days of the pandemic, with so little known about the disease, it was essential to share information quickly, while also making sure our people had the practical and emotional support to do their job.

Our flagship internal communication tool has been LAS TV Live: a question and answer session with senior executives, which is broadcast live three times a week. This enabled us to keep staff and volunteers up to date with the latest information while being able to address any questions or concerns with transparency and openness.

In January, the sessions attracted up to 700 live viewers and over a thousand downloads after the broadcast.

In addition, we launched an Executive Daily Briefing, which provided a daily update of our operational challenges and achievements through the height of the second wave. We also published 442 bulletins which cover the latest clinical or operational guidance and 335 articles on our intranet.

We had the highest ever engagement for our staff survey and the responses have been analysed to ensure staff experience drives the improvements we are making at London Ambulance Service. You can find our full staff survey analysis here. [LINK](#)

Assistant Ambulance Practitioners

In a year of incredible change and development, the creation of a completely new patient-facing role at London Ambulance Service has been one of our most ambitious achievements.

The first ever cohort of Assistant Ambulance Practitioners (AAPs) celebrated their graduation event in February 2021 and are now working alongside medics on ambulances.

Recruits to the new role undertake a 12-week programme which includes studying for a level 3 diploma in Ambulance Emergency and Urgent Care Support.

Entrants also complete a blue light driving course before they work under the supervision of a mentor in clinical practice for six months.

AAPs develop skills as an entry-level ambulance practitioner which they can ultimately progress to a paramedic role.

Digital 999

We want to embrace the opportunities of data and digital tech to improve the patient experience – and COVID-19 has accelerated much of this.

The Trust implemented electronic patient care records (ePCR) in November 2020, which provides an electronic platform to enter patient data, moving away from paper-based forms. The new system enables the seamless transfer of information to the hospital and produces one contemporaneous set of notes per patient. This innovation will save us from processing and scanning more than 2 million paper records each year.

By the end of March 2021, 4,000 staff and volunteers had been trained on ePCR with more than 125,000 records captured.

Work is continuing to implement a new Computer Aided Dispatch (CAD) to be delivered next year. The new system for our 999 control room will provide the technology needed to improve operational processes when handling emergency calls, and allow us to better collaborate with other ambulance trusts and emergency service partners.

Meanwhile we have replaced our existing CAD hardware and migrated it to two external data centres so there would be no loss of data and the patient experience will be uninterrupted, in the event of CAD failure.

We have migrated our email service of 11,072 accounts to NHS.net to ensure compliance with NHS security standards for the transfer of patient information.

Capital Programme

We have spent more than £43 million as part of an ambitious and exciting programme which aims to improve the quality of care we provide to our patients across London by transforming both our ambulance operations and estate.

With some of our ambulance stations dating back to Victorian times and unfit for a 21st century emergency service, we plan to replace them with a network of state-of-the-art ambulance deployment centres.

After careful review of our estate, we have selected a site in Romford for the development of our first pioneer centre – also known as Hub 1.

This site will include areas and facilities to ‘make ready’ and maintain our ambulances; as well as administrative and training facilities and dedicated wellbeing spaces for our crews at the start and end of their shifts.

Already in 2020/21 – to help us better respond to COVID-19 - we have invested £3.3 million in consolidating our estate, and planned estates work, which resulted in ambulances moving between fewer sites, allowing our vehicle preparation team to save 165 hours a day to restock and clean vehicles. We have also made improvements to a large number of ambulance stations, providing better parking, bathrooms and mess rooms.

Progress is continuing on the design, purchase and construction of a new Medicines Packing Unit which is compliant against regulatory requirements for medicine storage, packing and distribution. We are also working to secure a lease for a suitable warehouse for the Logistics Support Unit which will be fit-for-purpose and allow us to move away from the five separate poor quality units we have been using in Deptford.

Meanwhile we have been making radical changes in our education sites to ensure we can train staff with the necessary skills and expertise to deliver more integrated urgent and emergency care. Instead of classrooms in multiple sites across London, we have built two dedicated fit-for-purpose and digitally enabled training facilities.

6. PATIENTS

Every year in London more than 3 million people call 999 or 111 in need of our help. We aim to provide the best possible care or advice for each and every one of them.

Our patients can include anyone who lives, works or socialises in London: some will have a life-threatening illness or injury; many will be in distress or pain; some may not need an ambulance at all.

Our 999 and NHS 111 services are becoming more integrated, so regardless which number a patient calls, the most appropriate clinical pathways are available.

Whatever a patient’s needs, they can expect to be treated with respect and compassion and for us to deliver excellent care.

Caring for our patients with COVID-19

The challenge of referring patients to the right healthcare facility and managing the flow of the sickest patients into emergency departments (EDs), demanded greater collaboration within the NHS, external stakeholders and regional providers than ever before.

We worked with Integrated Care Systems (ICSs) to establish pathways which were dynamic and responsive to the local area, taking into account capacity, oxygen supply and specialist care options, while reducing the risk of crowding in EDs. We worked together to increase opportunities to care for patients closer to home either by telephone, video or in person. This collaborative work will continue as it means better outcomes for all patients.

By studying the outcomes of our COVID-19 patients, our Clinical Audit and Research Unit (CARU) has been able to participate in projects which should benefit future treatment and care. Two of these research projects have been designated “Urgent Public Health” status by the Government due to their importance to the pandemic. The team also used its research to publish the UK’s first scientific paper to describe the association between out-of-hospital

cardiac arrest (OHCA) and COVID-19 and found an increased rate in OHCA accompanied by a reduction in survival rates. [LINK TO PAPER](#)

Emergency Care: right care, right place

Just under half of all our 999 calls are for patients with potentially life-threatening illnesses or injuries. This includes patients in cardiac arrest, having a heart attack or a stroke or suffering a major traumatic injury or sepsis. Our Clinical Annual Reports for 2019-20 [LINK HERE](#) demonstrate the very high standard of care we provided to these patients.

The north central London video conferencing pathway for patients with stroke symptoms launched in May 2020. Of the 1000 patients seen then, the service has safely triaged 48% of cases as non-stroke and diverted them mainly to local EDs (43%). The other 5% of patients were assessed as non-acute and/or not having had a stroke. We have also expedited the referrals and specialist assessment for patients who have had a high risk transient ischaemic attack (TIA) patients, also known as a 'mini stroke'. Stroke mimics have been identified in 8.5% of cases. The use of the video conferencing pathway has not delayed the definitive care.

In north east London we have co-designed and implemented two innovative pathways. The King George's Hospital Beech Frailty Unit is able to assess and manage older adults from the boroughs of Havering, Redbridge and Barking and Dagenham using comprehensive geriatric assessment (CGA). This diagnostic process is used to determine the medical, psychological, and functional capabilities of an older person in order to develop a coordinated and integrated plan for treatment and long-term follow up. A doctor-led multidisciplinary team delivers this service and enables more elderly patients to be cared for in the community. London Ambulance Service directly conveys around 50 patients a week to this unit.

Changes in medicines legislation mean that paramedics who have undergone appropriate training and mentorship are now able to prescribe medicines, which benefits both our patients and the wider NHS. The first phase of a national pilot has concluded and work is underway into how to progress training for our advanced paramedics to become prescribers. For patients this will mean more timely access to medicines, care closer to home promoting fewer unnecessary trips to hospital, and fewer additional appointments with their GP or other health professionals.

Urgent calls

Urgent care patients make up a significant proportion of our workload and we continue to make progress towards ensuring equity of access for all patients whether they call 999 in an emergency – with chest pain for example - or 111 with an urgent care condition, like a cough. We manage these patients through our integrated urgent care (IUC)/111 services, 999 clinical hub (CHUB) and our specialist paramedics, all of whom provide a detailed clinical assessment and can then get the patient the right care in the right place in the right time-frame.

Our CHUB clinicians assess patients who have called 999 but who do not require an emergency ambulance immediately. Around 11% of 999 calls are handled by the clinical hub team, which is the highest "hear and treat" rate in the country.

Our IUC/111 sites in north east, south east and north west London operate 24-hours-a-day, making it easier for patients to access services when their GP surgery is closed. Patients are assessed by a range of clinicians, including paramedics, nurses, GPs and pharmacists.

Our clinicians, in both 111 and CHUB, can access patient records and care plans to better inform their decisions; they can book appointments directly into local services; and they can prescribe medication over the telephone when required.

The integrated urgent care model we have pioneered has meant more patients are being helped without requiring referrals to other services, which simplifies the experience for the patient and their family, and relieves pressure on the wider NHS. Our IUC services consistently refer the fewest patients into the 999 system across London, which helps to protect our response to those patients with life-threatening conditions.

Special patient groups

1. Bariatric Patients

In January, we published a clinical audit LINK examining the response and clinical assessment provided to bariatric patients, more commonly known as obese patients. While we found a very high standard of assessment, we do need to improve how we identify and dispatch bariatric vehicles. Recommendations have been made and we have committed to a deep dive into the problem to improve the service for these patients.

1. Maternity Patients

Over the past year, the maternity team has worked with teams in our 999 emergency operations centres and NHS 111 sites. We have made it easier to access referrals and improved the experience of women accessing care. We are evaluating the early pregnancy pathway and looking at the potential for a Maternity Triage Line.

Throughout the year, a range of education and training options have been delivered for maternal and newborn care and safety. Our staff and volunteers now receive ongoing support from a maternity team member, to feed into education and training developments.

Our award-winning team also contribute nationally, as part of the Joint Royal Colleges Ambulance Services Liaison and the UK Ambulance Services Maternity Leads group, ensuring that best practice is adopted nationwide.

2. End of Life Care

Our End of Life Care (EoLC) pilot service ended this year but the work is being continued by an established team which means we continue to provide innovative and collaborative care to patients at their end of their life.

We aim to support dying patients and their families and we respect their wishes if they choose to receive care at home or in the community rather than being taken to hospital. EoLC “Champions” are promoting this work at a local level with colleagues, increasing skills and knowledge across the Trust, and improving staff confidence to access appropriate care pathways.

3. Mental Health

Mental Health was identified as a pioneering service in the 2018-23 trust strategy. We currently have six Mental Health Joint Response Cars (MHJRC) running across London. Evaluation of the service found that when a specialist mental health team is sent to a patient, in around 80% of cases, people could be treated at the scene rather than an ambulance trip to hospital, which can add to the patient's distress.

Infection protection and control

This year we welcomed a new substantive Head of Infection Prevention and Control (IPC) to London Ambulance Service. We recognise the work undertaken by the interim Head of Infection and Control during COVID-19 Pandemic early stages.

The IPC team works closely with all directorates and plays an integral role in ensuring the safety of our patients, as well as our staff, contractors and volunteers.

In response to COVID-19, a practical visual resource was developed and published showing patient-facing colleagues how to correctly don and doff PPE. Protective clothing and equipment is not just for COVID-19 patients but for all infectious diseases. We are working hard to ensure we maintain the supply chain for FFP3 disposable respirators and disposable gowns.

As new strains of coronavirus emerge, the team has provided up-to-date guidance and helped staff and volunteers across the organisation to make informed risk assessments. The team will continue to liaise with colleagues to promote early recognition and reporting of potential infection incidents to reduce the risk of transmission.

London Ambulance Service has exceeded national compliance targets for hand hygiene and continues to maintain high-level IPC compliance with cleanliness.

We provide IPC training to all staff and volunteers including mandatory modules, local teaching and scenario-based teaching.

Medicines Modernisation

The COVID-19 pandemic was a powerful reminder of the need for the professionalisation of the medicines packing and distribution function. This plays a vital and important role in ensuring that each frontline clinician has the appropriate drugs to treat their patients.

Projects that sit under the Medicines Modernisation programme are phased across three financial years and ensure that staff are equipped with the correct skills and qualifications in accordance with the Pharmacy Order 2010; the core medicines estate meets the highest quality assurance standards; and that medicines continue to be tracked and temperature is monitored for all storage areas.

The medicines management team will expand next year and we continue to recruit and mentor pharmacy professionals, ensuring a diverse clinical skill set within the service.

The past year seen a lot of change for medicines management - medicines are no longer regulated by the European Medicines Agency (EMA) and now solely regulated by the Medicines and Healthcare Products Regulatory (MHRA).

The pharmacy team has provided clinical and pharmaceutical support to immunisation projects in collaboration with our wellbeing team, which has resulted in the successful partnership work across London for the COVID-19 vaccination programme.

Developing improved models of care for our patients

The Clinical Directorate has been looking towards the future, with how we respond to urgent and emergency calls across London. With the patients we serve in mind, the clinical team is working with the Operational Directorate in partnering with Primary Care Networks (PCN) to pilot paramedics rotating between the ambulance service and primary care.

A scheme in Merton has seen paramedics on e-bikes visit patients in the community, giving flu jabs, treating those suffering with long term conditions, and checking patients following their discharge from hospital. The success of this pilot has led to a similar partnership being set up in the borough of Redbridge, with plans to roll out this service across London.

These opportunities offer career development for paramedics as well as reducing avoidable trips to hospital for patients. With support from Health Education England, advanced paramedics in urgent care are using their skills in clinical and education supervision to develop the PCN paramedic programme.

Additionally, a new model of care is being developed for our patients who experience a fall, and sometimes face long waits for assistance, causing intense distress to both the patient and their family.

If our telephone assessment of these patients identifies them as having no injuries or symptoms that require immediate intervention, we will dispatch volunteer community first responders (CFRs) to the scene, decreasing the time the patient waits for a response, and increasing the positive patient experience. The pilot was due to launch in May 2021.

Patient safety

We are committed to providing high quality and safe care, delivered with compassion, respect and dignity.

Despite the challenges of this year, we doubled our efforts to ensure patient safety while supporting the wellbeing of our staff and volunteers. Significant work has been achieved in relation to quality governance, assurance and improvement.

Below is an outline of some of the highlights from 2020/2021 financial year:

- The Trust is the highest reporting ambulance service for reporting safety incidents reflecting a strong safety culture aiming to provide the highest standards of patient care. We report around 5000 incidents per year compared to the next highest at around 2000.
- We are an early adopter of the national Patient Safety Incident Response Framework and have developed our implementation plan. We have tested the plan through thematic reviews of some of our patient safety incidents during the pandemic which provided significant learning that refined the plan further.
- We have reviewed a number of safeguarding processes and developed safeguarding eLearning and virtual packages.
- Domestic abuse stickers were distributed to ambulance crews to promote conversations, recognition and action in relation to domestic abuse, helping victims access support.
- We have established a Patient and Public Council to ensure patients and local communities are involved in our strategic plans. Members sit on a range of committees including in research and infection prevention and control.
- We continue to monitor the views of patients through complaints and compliments received by our Patient Experience Department.

7. PERFORMANCE

This year London Ambulance Service has experienced the busiest days in our history. During some very difficult weeks of the pandemic, our biggest challenge was maintaining service delivery and safety for our patients.

As explained in the Coronavirus chapter [LINK](#), we quickly implemented new ways of working to deal with the huge spike in 999 calls we were answering and the face-to-face incidents we were attending.

While patients waited longer for an ambulance during the first and second peaks of COVID-19, the full year picture shows the Trust achieved the National Performance Standard for Category 1 patients, which has a target response time of seven minutes.

Ambulance Response Programme

The Ambulance Response Programme (ARP) sets the performance standards for all ambulance trusts in the UK

Category	Response	Target average response time
Category 1	An immediate response to a life threatening condition, such as cardiac or respiratory arrest	7 minutes
Category 2	A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport	18 minutes
Category 3	An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting	2 hours
Category 4	A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic	3 hours

The impact of lockdown on the public, alongside increased awareness and activity for 111 services, meant we had fewer 999 calls and patient-facing incidents in 2020/21 than the previous year.

In 2020/21 we met our Category 1 target, reaching our sickest patients in 6 minutes and 16 seconds, on average.

Category 2 performance

For a significant majority of the year, we reached our Category 2 patients well within the national target times.

However during the first and second waves of COVID-19, when 999 calls, staff sickness and handover times at hospitals were at their highest, some patients had long waits for an ambulance to reach them.

We responded to this dip in performance with several measures including working with hospitals; putting as many crews out on the road as possible; and training firefighters and police to drive ambulances.

With all our efforts focused on recovering performance, we were meeting targets across all categories of incident by the last week of January 2021.

Had it not been for those particularly challenging weeks in April 2020, December 2020 and the first week of January 2021, we would have met the 18 minute target for Category 2 across the year.

PERFORMANCE TABLES ATTACHED – WILL BE ADDED IN DESIGNED VERSION

Progress

One of the most significant new ways of working was reducing the number of solo responders in cars and increasing the number of ambulances available, to ensure patients who need to go to hospital can be conveyed without delay. We continuously review performance but the ambulance-led delivery model has proven to be resilient and flexible and means the sickest patients get the fastest response and that all patients get the right response first time.

Progress has been made in increasing the number of patients we have been able to treat on scene – known as ‘See and Treat’. In 2020/21 our crews were able to treat and discharge or refer 32 per cent of patients. The figure was 27 per cent the previous year.

Access to electronic Patient Care Reports (ePCR) and Summary Care Records has made it easier for clinicians to find appropriate, community-based care for our patients, giving them and their families a better experience and outcome.

The increase in both ‘See and Treat’ and easier access to alternative pathways has meant fewer hospital journeys – down to 51 per cent of all the 999 patients we attend. We are now among the top performing trusts in the country for emergency department (ED) avoidance.

Vehicle availability

We purchased 37 new ambulances to replace the oldest vehicles in our fleet. Newer vehicles are more reliable, reduce emissions and cut running and maintenance costs. Meanwhile our AA partners have been carrying out overnight repairs and fixing some minor repairs.

These improvements had a huge impact on our overall out of service rate which averaged at 1,284 hours in 2020/21 down from 5,730 the previous year.

By March 2021 we had 542 ambulances in service, which is 10% more than the previous year and at the peak of the pandemic, operations were able to deploy over 800 crews a day.

Logistics

The work of our logistics team has transformed beyond recognition as they have ensured ambulances crews have the PPE, medicines and support needed to safely respond to the pandemic. They won a national Supply Chain Excellence award in recognition of their outstanding efforts.

The team, in collaboration with the Trust’s pharmacists, did the necessary planning to ensure we did not run out of oxygen, despite nationwide shortages at hospitals. They also

organised vehicle preparation teams to clean ambulances and equipment at key hospitals which meant crews were able to reach their next patient faster.

999 calls

We received 1,813,112 calls to our 999 operations centre in 2020/21 which is fewer than the year before. Over the same period calls to 111 increased. London Ambulance Service's media and social media activity focused on signposting the public to the appropriate services – especially at times of peak demand and during waves of the COVID-19 pandemic. At the same time a government campaign was launched to increase public awareness of NHS 111 phone and online services.

Once assessed, 46 per cent of 999 calls were given a Category 1 or 2 response, which means nearly half our calls were from patients who were experiencing life threatening or emergency medical events.

Call handling performance has improved compared to last year, and remains strong compared to the national average. However there were several weeks during the two main peaks of COVID when call numbers and sickness rates were so high, we were unable to meet our call handling targets.

As is standard practice during periods of high demand and high levels of staff sickness, ambulance services provide support for each other, which includes answering 999 calls. At the end of 2020, a decision to request aid under the mutual aid framework was made and support was in place within 24 hours.

Our Business Intelligence team were able to produce an entirely new set of forecasts, which displayed predicted call volumes by hour and staff and volunteer numbers, which meant we could request assistance at specific levels and for specific hours. These forecasts became accurate enough to be able to automate the function.

Expansion of the clinical hub

The clinical hub (CHUB) is staffed by clinicians who provide a telephone assessment of patients to determine whether they require an emergency ambulance or can be treated over the phone or referred to another provider.

Increased staffing in 2020/21 allowed us to respond to 133,293 calls this way and treat our patients successfully and safely without the need to dispatch an ambulance. This was essential at times of extraordinary demand and equates to almost 11 per cent of 999 calls, an increase of nearly 3 per cent on the previous year. We have the highest 'Hear and Treat' rates among ambulance trusts in England, including those with a blended 999 and 111 workforce.

In November 2020, CHUB clinicians began reviewing calls from North West London Integrated Care System where the NHS Pathways assessment outcome was a Category 3 or 4 ambulance. Since then, the CHUB has assessed 15,000 calls, of which over 70% did not require an emergency ambulance.

We have been working closely with our NHS partners to provide our clinicians with a greater range of referral options for patients who do not require emergency intervention.

Development and training

Due to the number of large projects ongoing within the division, a number of development roles have been created to support this work and assist the 999 Operations Senior Leadership team.

A bespoke training package in management essentials, coaching and supportive conversations has been designed and is being initiated among watch management teams.

We have built a new training facility that is larger and more flexible enabling three times as many staff to be trained simultaneously. This translates to better patient care as more of our staff and volunteers are trained in the most up-to-date clinical protocols.

A dedicated Incident Response Officer (IRO) Core Skills Refresher (CSR) course has been developed jointly with Resilience and Specialist Assets to incorporate specific learning from incidents and focus on command and control aspects of the role.

We created a new role of Chief Paramedic and Quality Officer to bring together for the first time responsibility for clinical quality and ensuring paramedics and ambulance clinicians have access to world-class training and professional development.

NHS 111 calls

The pandemic has increased awareness of 111 services and led to an 11.5% increase across our north east and south east London Integrated Urgent Care (IUC) services compared to last year. **DATA to be ADDED to PERFORMANCE TABLES**

Despite this we have improved performance for call answering and call abandonment.

NHS 111 services	National target	2019/20		2020-21	
		SEL	NEL	SEL	NEL
Total number of calls	-	544616	677319	625585	756488
Average calls per day	-	1492	1856	1807	2198
Calls answered within 60 seconds	95%	60%	60%	88%	87%
Calls abandoned after 30 seconds	No more than 5%	12%	13%	3%	3%
Calls referred to 999***	<10%	7%	7%	8%	8%

Integration of 999 and 111

Our strategic vision to become primary integrator of urgent and emergency care has accelerated in 2020/21. We now hold contracts for NHS 111 delivery across three of the five London Integrated Care Systems (ICSs) serving around 6 million patients.

A priority for NHS 111 is to expand workforce capacity to ensure we have a sufficient and sustainable number of trained call handlers and clinical advisors to meet demand, and there is infrastructure in place to allow some clinicians to work remotely.

We have a dedicated Integrated Patient Care Directorate with a senior management structure to support our new focus on call answering response and development of the Clinical Assessment Service (CAS) across 111 and 999.

NHS England and Improvement launched the NHS 111 First programme to reduce the number of walk-in ED attendances in 2020. It was designed to protect NHS staff and patients by reducing the risk of infection caused by overcrowded waiting rooms. The scheme encouraged patients to call NHS 111 before attending ED to allow NHS 111 teams to assess their need and, where possible, carry out a clinical assessment using telephone or video consultation to provide appropriate care closer to home.

We have been a key partner in a range of new initiatives and pilots to design, develop and embed improved patient pathways across the urgent and emergency care systems, including community teams. Through collaboration with Barts Health NHS Trust, we have successfully developed a process for call handlers and ambulance crews to refer patients to secondary care clinicians in EDs for telephone consultations.

8. Our People

London Ambulance Service is a growing team of multi-skilled people, in a variety of roles, focused on a single, simple purpose: to save lives. We call ourselves a family: the family in green.

We have more people working for us than ever before. Our substantive employment headcount is 6497 people but when you add all our contractors, agency and bank staff, students and volunteers, we have 9600 people caring for Londoners.

The average length of service with us is **xxx years** but around a third of our staff have worked for London Ambulance Service for more than 10 years.

Behind the scenes

London Ambulance Service is the most visible part of the NHS in the capital. The sirens and flashing blue lights of an ambulance reassure the public that help is on its way.

Most of our workforce has contact with patients – our ambulance crews and call handlers. But it takes a whole team working behind the scenes to ensure all our patients get the right help at the right time.

These include:

- Our People and Culture team looking after welfare, recruitment and making sure we have the right HR policies
- Information Management and Technology (IM&T) specialists delivering innovative technological change to improve the quality of care we provide to patients
- Fleet and logistics teams keeping vehicles maintained and stocked with essential medicine and equipment
- An estates team responsible for creating safe, secure offices or ambulance stations for staff and volunteers to work
- Communications staff engaging with our key NHS and public sector partners, our people and the media to improve understanding of our work
- Teams reviewing our governance, performance and the experience of patients so we are always improving A Clinical Directorate which is responsible for clinical delivery and strategy and clinical innovation

What unites everyone working for London Ambulance Service, is being part of a mission to save lives, improve outcomes and make London a healthier place.

Recruitment

The recruitment team continues to work with Ambulance Services and Clinical Education colleagues to deliver a strong pipeline of registered and non-registered staff.

We have recruited 3,370 new people this year. One of the most remarkable achievements has been to create the new role of Assistant Ambulance Practitioners, advertise, interview and make offers for this new job and give our 102 new recruits training – all in a single year. You can read more about this role on the Our Priorities pages [\(LINK\)](#).

A joint recruitment scheme was developed for call handlers for both the 9s and 1s, allowing the process to be streamlined and beneficial for both departments. For 2020/21 we have recruited and trained 173 Emergency Call Handlers and 81 call handlers have been promoted to Emergency Care Coordinators.

We further increased our clinical advisor staffing by 43%, with 128 staff being recruited and trained to work in the CHUB over the last year.

Apprenticeships

London Ambulance Service has been recognised as **the top NHS trust in the country** for its apprenticeship opportunities, in a national and government-backed league table developed by the National Apprenticeships Service. As well as creating the new Assistant Ambulance Practitioner apprenticeship, this year we have also teamed up with the University of Cumbria to offer paramedic degree apprenticeships. These positions are open to existing staff who will complete classroom and online learning alongside their usual shifts.

We routinely offer apprenticeships to staff to help them develop and gain new knowledge and experiences. This includes leadership and management programmes.

Retention

Our overall vacancy rate on 31 March 2021 was **xxx**. Our staff turnover rate has improved from 9.5% to 8.1%

We are working hard to retain our large number of international paramedics (IPs) which include: funding indefinite leave to remain; supporting staff to use the Government's automatic one-year visa extension; and enhancing our programme of retention interviews.

The number of IP leavers in 2020/2021 is below forecast. **CHECKING FORECAST AND WHAT IS THE NUMBER?**

Volunteers

Volunteers play a vital role at London Ambulance Service and we have always valued their commitment and time. This year, the work of our volunteers throughout the pandemic has been exceptional. They have moved into different roles, changed ambulance stations and learned new skills to help us keep as many ambulances on the road as possible.

The most significant change for our Emergency Responders and Community First Responders was to increase their training to allow them to respond alongside medics on ambulances. This helped us cope with very high demand while many staff were off sick or isolating.

We plan to continue to keep our ERs trained to work on ambulances so they are able to step in at times of high demand in the future.

This will involve increasing the number of ERs with a blue light driving qualification and C1 category training, which means they can treat our sickest patients.

Other roles our volunteers have committed to this year include:

- Providing comfort calls to patients waiting for ambulances
- Call handling on the staff 'swabbing helpline'
- Delivering and collecting self-swab kits to staff who couldn't get themselves to a COVID test centre
- Taking blood samples for antibody testing
- Organising logistics for mass testing requests from NHSE, including asymptomatic PCR testing and lateral flow testing
- Setting up the database of volunteers and helping to run our COVID Personnel Hub
- Providing support to Emergency Preparedness, Resilience and Response (EPRR) particularly in relation to the Nightingale Hospital

Our Emergency Responders and Community First Responders have volunteered 33,723 hours this year. They have worked a further 11,740 hours alongside a paramedic on an ambulance.

Diversity

The murder of George Floyd and the Black Lives Matter movement prompted some honest and sometimes harrowing conversations at London Ambulance Service. It became apparent we needed an immediate action plan to address discrimination and equality.

Key actions include:

- Embedding fair recruitment principles across the Trust
- Training of Black, Asian and minority ethnic (BAME) staff to sit on interview panels to increase diversity in senior roles
- Launch of B-Mentored programme, a mentoring scheme to support BAME staff to progress their careers
- Increase the diversity of the Clinical Team Manager leadership pool
- New Equality Diversity and Inclusion corporate induction including sessions on unconscious bias and cultural awareness
- Weekly BAME drop-in sessions for staff and volunteers to raise concerns or any issues they may have

You can find more on our equality policies in the Annual Governance Statement ([LINK](#))

Workforce Race Equality Standard (WRES)

London Ambulance Service is one of the highest performing trusts for BAME representation at Board level. We have successfully recruited to a new role of Associate Director of Culture, Diversity and Inclusion.

Our percentage of BAME staff has improved to 18%, against our end of year target of 17.5%. We are actively working alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.

However we have work to do to improve opportunities for development while also working to reduce the number of racist attacks on our staff and volunteers by the public and patients.

Staff survey

The annual NHS staff survey took place in autumn 2020 and with 72 per cent of our staff responding, it provides a valuable picture of how people feel about work.

The results show there have been improvements in:

- Relationships with managers
- Staff wellbeing
- Safety culture
- Reducing bullying and abuse from managers and colleagues

However the survey shows, there are three key areas which we need to focus on:

- Building a safer environment and protecting people from abuse and violence
- Stepping-up our approach to equality, diversity and inclusion
- Continuing to strengthen our wellbeing services

There is a fuller analysis of the staff survey results in the Staff Report [\(LINK\)](#)

Health and Wellbeing

We are still working to understand the full impact of COVID-19 on the physical and mental health of our staff and volunteers. We want our people to be happy and feel they can thrive at work. We need staff and volunteers who feel cared for so they, in turn, can care effectively for their patients. London Ambulance Service should be a place that enables our staff to be healthy and prioritise their wellbeing.

Our newly created Wellbeing Hub is our flagship initiative in improving the quality of life for our people. This service has been used extensively by staff and acts as a first point of call for any health and wellbeing related information and issues. Since its inception in July 2020, the Wellbeing Hub has dealt with 2413 enquiries, relating mainly to COVID-19, vaccination advice, mental health and physical health support.

You can read more about our Health and Wellbeing work – including our vaccinations programmes - in the Our Priorities chapter [LINK](#)

Recognising our people

We want our teams to thrive and feel valued and we do that by creating a culture of engagement and loyalty. This year, to recognise the extraordinary work of our teams in responding to COVID-19, every member of staff has been given an extra day of annual leave

We have established schemes to encourage positive feedback and continue to recognise the day-to-day contributions of staff and volunteers through internally publishing the names of all those who receive a letter or message of thanks; or reach long-service milestones. We

use our LAS TV Live broadcasts to encourage staff and volunteers to praise or thank colleagues for exceptional work.

Our annual VIP Awards are one of the highlights of the yearly calendar and the entire workforce is able to vote for the employee of the year. Sadly, this year we had to swap our usual glamorous ceremony for a virtual event. However this did not take away from the honour given to paramedic Keiren Rodwell, who was nominated for the award by his manager for being, “caring and compassionate, as well as clinically brilliant.”

Much of the planning and organising of the VIP awards and our other recognition events, including long service awards, are down to Communications Officer Claire Clarkson. The dedication and hard work she brings to this role were recognised nationally when Claire was named Exceptional Administrator of the Year in the 2020 Ambulance Leadership Forum awards, organised by the Association of Ambulance Chief Executives.

Freedom to Speak Up

The Trust has a full time Freedom To Speak Up (FTSU) guardian and coordinator. We also have 25 advocates, all of whom have received training in how to promote the work of FTSU and support staff and volunteers to raise concerns.

All concerns are investigated and many have led to improvements in processes in a number of different parts of the service. The LAS FTSU team were finalists for the FTSU category at the HSJ Awards. You can read more about our FTSU work in our Annual Governance Statement [LINK](#)

Developing and managing talent

It is essential people feel they can enjoy a meaningful career within London Ambulance Service. We are constantly looking at ways to attract and retain high-quality employees and develop their skills. We want to ensure we have a motivated workforce who are given every opportunity to shine.

Some of the work we have done to achieve this includes:

- All staff discussions on the benefits and considerations of home working which will inform our new Agile Working Police
- Redesign of the Engaging Leader course
- Increasing the provision of blended learning opportunities
- Creating a business administration apprenticeship
- Establishing a Clinical Team Manager recruitment and training plan

9. Partners

Collaboration is key to our success and allows us to provide the best possible care for the people who need us. The pandemic has not only shown what we can do with strong partnerships, but how quickly we can bring about change and improvements for our patients.

We will continue to engage with patient groups, stakeholders, wider system partners and emergency service colleagues to build on our successes and ensure communities are

empowered to help shape the future of their health services. A list of the partners who have supported our response to COVID-19 can be found here. [\(LINK TO CORONAVIRUS CHAPTER\)](#).

Working with our community

The involvement of our patients and communities is crucial in improving all aspects of care including patient safety, patient experience and health outcomes.

In June 2020, we launched the London Ambulance Service Public and Patients Council, which brings together a wide range of patients and public representatives from across London.

The council, which is chaired by Dame Christine Beasley, meets at regular intervals to give feedback on the care we provide and to help shape the way care is delivered. Members provide a voice for patients, the public and carers in the design, development and delivery of Trust services.

We also continue to work closely with local Healthwatch, including keeping them updated about our response to COVID-19.

In September 2020, the Board agreed a new 'patients and communities engagement and involvement strategy' which was developed in partnership with the council and sets out a range of priorities to enhance the way we involve and listen to patients and communities.

This includes co-designing a visits programme – giving patient and public representatives access to our 999,111 and ambulance services so they can provide constructive feedback. The strategy will also see the establishment of a Youth Empowerment Squad, supporting young people to learn more about our work, share their feedback and influence our decision-making.

Ordinarily London Ambulance Service invests in a wide-ranging public education programme, working with community groups and partner agencies to engage with the public. However this year, COVID-19 has meant our public engagements have been cancelled and staff have been re-deployed to support the response to the pandemic.

Working with our NHS partners

As the only NHS trust to cover the whole of London, we work closely with NHS England/Improvement, our 32 commissioners, hospitals and specialist trusts.

We have built on the strong relationships with London's five Sustainability and Transformation Partnerships (STPs). This has included exploring opportunities for further integration of the 999 and 111 systems, as well as longer term policy and strategic plans, most notably the advent of Integrated Care Systems (ICSs). While progress on the development of ICSs was hampered by the pandemic, they are becoming increasingly established in the planning and coordination of care.

In May, London Ambulance Service worked with University College London Hospital to launch video conferencing for the assessment of patients suffering stroke symptoms. Details of this initiative are in [Our Patients LINK](#)

This year also saw the launch of a new pilot in Merton which led to paramedics working in GP surgeries to improve care. Full details of this scheme are also in [Our Patients LINK](#)

Working with our emergency services colleagues

Firefighters and police officers have been driving ambulances and assisting our crews in a ground-breaking blue light collaboration during the pandemic.

The partnership led to us training hundreds of officers from London Fire Brigade and the Metropolitan Police Service to help us respond to the biggest public health challenge in our history.

Both firefighters and police officers are used to driving on blue lights, have basic first aid skills and know the streets of London well, making them ideal partners when demand peaked and the crisis threatened to overwhelm hospitals.

The three emergency services have always worked in partnership responding to routine 999 calls and we have regularly trained and exercised together to ensure we work in a co-ordinated and effective manner at major and critical incidents.

With the roll out of body worn cameras and our commitment to cutting the number of assaults on our staff and volunteers, we have also been working with the police to develop our violence reduction processes. We are sharing learning and best practice to ensure our people get the justice and support they need.

Working with the Mayor of London

The Mayor of London is chair of the London Resilience Forum and re-established a Strategic Coordinating Group in September to bring together emergency services, NHS providers, local authorities and Public Health England in response to the increasing spread of COVID-19.

We have a close relationship with the Mayor and over the year he made several visits to London Ambulance Service, including to our 111 call centre in Barking and opening our new state-of-the-art 999 call handling training centre.

We continue to work with the London Situational Awareness Team, which provides the Mayor's Office and London Assembly Members with accurate and timely information on our performance.

Working with local authorities

Our partnerships with local councils aim to give Londoners the best health, social care and community services – particularly when working in a tough financial environment.

This year we have been engaging with local authorities on their Low Traffic Neighbourhood (LTN) schemes. We support the aim to cut heavy and non-local traffic on residential streets and create healthier neighbourhoods, while making sure ambulance emergency response times are not undermined.

Our Chair and Chief Operating Officer have met London council leaders to ensure our suggestions have been listened to and our concerns taken on board. We will continue to work together to ensure any changes to road layouts or road closures do not delay us reaching critically ill people or getting them to the nearest emergency department.

Working with charities

Our partnership with London's Air Ambulance Charity is a key part of our mission. We provide paramedics to respond – by helicopter or by car – to life-or-death emergencies in London. Every day one of our paramedics works alongside a doctor as part of the London's

Air Ambulance service to treat patients, while a second paramedic is in our 999 control room deciding which calls might need this advanced trauma team.

We further support the charity by providing our clinicians to work alongside an emergency medicine doctor on the Physician Response Unit. The team carries advanced medication, equipment and treatments usually only found in hospital, which means patients can be treated in their homes rather than being taken to an emergency department.

Our partnership work with Macmillan has led to all our ambulance crews being trained in end-of-life care. This specialist training means terminally ill people get the care that meets their needs and respects their wishes. This can help avoid unnecessary trips to the hospital which can be distressing to the patient and their family.

We work closely with St John Ambulance, often to plan and prepare for large public events. This partnership was only strengthened during the pandemic when we gave more than one hundred volunteers from St John enhanced training so they could respond with our paramedics on ambulances.

We are extremely grateful to NHS Charities Together for the support they have given us, including over £1.1 million of funding which we will receive in 2021/22. This money will allow us to support the welfare of our staff and volunteers, including helping to run our popular 'tea trucks'. Much of this money was raised by the late Sir Captain Tom Moore.

As well as our long-established relationships with charities, we are developing new ones, in order to share best practice as we aim to boost our own charity and volunteering programmes. You can read about our LAS Charitable Fund on our Public Value page. [LINK](#)

Working with universities

In partnership with the University of Cumbria, we launched a paramedic apprenticeship programme in March. The nationally accredited programme is designed to make it easier for staff to gain a degree in paramedicine. The course means our Emergency Ambulance Crews (EACs) and Emergency Medical Technicians (EMTs) can continue to work on ambulances while they develop their emergency care skills and progress to becoming a paramedic.

We have continued to work with our partner universities closer to the capital to offer placements to students enrolled in their Paramedic Science degree courses. Second and third year students were a key part of our response to the pandemic and universities are a valuable source for recruitment.

Meanwhile our Clinical Audit and Research Unit (CARU) leads on developing research studies – often in partnership with universities – which contribute to and improve emergency medical care and patient outcomes. These studies are not only used within London Ambulance Service but by practitioners of emergency medicine around the world

London Ambulance Service Public and Patients Council column

Profile Dame Christine Beasley, co-Chair

Dame Christine is a nurse who has worked in a variety of nursing and general management roles in the NHS for over 50 years. She has also been Chair or Trustee for a number of charities.

Profile Michael E Bryan, co-Chair

Michael is a volunteer for, a former patient of and emergency partner to London Ambulance Service. He combines his medical studies with his experience of biotechnology to help

patients. He was also involved in coordinating the Metropolitan Police's response to the pandemic.

Dame Christine and Michael write:

In the year since the council was established we have sought to make it a critical friend to London Ambulance Service.

All our work and our discussions are centred round a focus on improving the service to patients and ensuring patient experience is at the heart of the organisation. We have been looking at both short and medium term issues.

The council has contributed to and influenced the roll out of the Electronic Patient Care Records (ePCR) which is helping to free up more time for staff to spend with patients. Some members of the council have also participated in the Station Accreditation Programme which helps to make sure that patients are cared for safely and effectively.

We have set up a series of sub-groups and some of our most important work is looking at how to improve the patient pathway. In particular, members are working with colleagues from London Ambulance Service to improve the pathways for patients with mental health problems and those nearing the end of their life.

We think the council has got off to a very good start and we are currently developing our programme of work for the next two years.

10. Public Value

The COVID-19 pandemic led to the suspension of contracting and operational planning and the introduction of an interim financial framework for the first half of 2020/21 and revised financial arrangements for the second half of the financial year.

London Ambulance Service spent an additional £85.8 million in response to COVID-19. This included:

- £39.3m on staff costs
- £18.7m on increased 111 capacity
- £7.7m on additional fleet capacity
- £6m on Personal Protective Equipment
- £3.8m on IT and telephony expansion
- £2m in additional decontamination costs.

We received extra COVID funding which allowed us to increase frontline ambulance and call handling hours by over 500,000 hours (21%) despite staff sickness reaching 25%. This allowed the Trust to consistently deliver national performance standards across 47 weeks of 2020/21

Throughout the year we have continued to focus on maximising available resources to provide the best possible value for the public, who ultimately fund the London Ambulance Service. The Trust delivered the control total agreed with North West London Integrated Care System whilst saving £8.3 million through a number of schemes, including working with partners to secure free fuel during both waves of the pandemic.

A summary of our finances are set out in the table below:

Finances	2020/21	2019/20	2018/19
Total Income	£567.6 million	£438.7 million	£389.3 million
Year End Surplus	£1.2 million	£0.2 million	£6.6 million

A number of significant backlog and resilience challenges were exposed by the COVID-19 pandemic in early 2020/21. In order to strengthen service resilience, system partners supported us to deliver urgent infrastructure work to maintain safe patient care. As a result capital investment was nearly doubled in 2020/21 as set out in the table below:

Investment	2020/21	2019/20	2018/19
Capital Expenditure	£43 million	£22.5 million	£21.5 million

This investment has bolstered our resilience, to the benefit of the London-wide healthcare system. Many of the projects embarked on will be completed in 2021/22.

London Ambulance Service spent £16 million on digital programmes including upgrading control room systems and implementing electronic patient records; £9 million increasing and modernising its fleet and improving crew safety systems; and £14.5 million on estates modernisation including consolidating its training estate, expanding control room capacity and improving medicines management.

The current financial framework will remain in place for at least the first half of 2021/22 as the NHS moves from response to recovery and lockdown restrictions ease. The framework for the second half of the year remains uncertain as the impact of vaccinations, increased test and trace and easing lockdown restrictions on the NHS becomes clear. However we will continue to implement our modernisation programme and maintain resilience and have a capital plan of £45.7 million.

We have also identified a savings programme of £9 million for 2021/22 to ensure we continue to deliver value and provides the maximum level of patient care for the resources we receive. This includes ensuring cost reductions through improved supply chain management, increasing productivity and driving down corporate overhead costs.

London Ambulance Service Charitable Fund

The LAS Charitable Fund has grown in strength over the last year, increasing its income from around £40,000 a year to a total of £366,000 in donations and grants in 2020/21.

We are developing a fundraising strategy for our charity so we can invest more meaningfully in the welfare of our people as they deliver the best emergency care for Londoners.

Following significant engagement, we have been awarded various grants to build capacity and capability for our volunteering strand of the charity, as well as to support our frontline workforce.

We are extremely grateful to NHS Charities Together for their support and the £200,000 we have received in 2020/21 with a further £900,000 to follow in 2021/22. This money will support the welfare of our people, and resource our Volunteering Strategy and its aim to recruit 100,000 volunteers.

Sean's story

Call handler Sean Ash, who works in our control room in Waterloo, has raised more than £80,000 for our charity.

Despite being paralysed from the waist down, Sean walked a mile using a Zimmer frame to raise money to support his colleagues.

Sean, who's 39, lost almost all movement in his legs in August 2020, as a result of a rare and severe spinal condition called Cauda Equina Syndrome.

While trying to come to terms with his devastating diagnosis, Sean was inspired by Captain Tom to try to raise money for the LAS Charitable Fund.

He completed his challenge over two days, walking half a mile at a time around the block of his home – an exhausting and gruelling challenge for a man who was previously only able to walk 10 metres and uses a wheelchair most of the time.

11.Risks

The need to respond to COVID-19 has provided both the Trust, and the wider NHS, with one of our biggest ever challenges over the past 12 months. As a Trust we have adapted to a rapidly changing environment with new ways of working to protect the health and safety of patients and our people during the pandemic.

We also adapted our governance practices to react to the fluid nature of managing risks in this unique environment. As we plan for the future in a post-pandemic world, we will continue to review the key risks which may prevent us from achieving our strategic objectives and delivering for the people of London.

As of 31 March 2021, we identified the following strategic risks:

- Continuing to deliver high quality care to patients during COVID-19 whilst maintaining the safety of staff and the public.

We have developed a strategic response to the impact of COVID-19 on the service and the wider community, stepping up resilience to manage surges in demand during the peaks of the pandemic, and integrating them into 'business as usual' going forward.

- The potential for software, hardware or communications failure in IT systems.

We have initiated a number of projects to mitigate the impact of these risks, including unified communications and telephone improvement projects which are overseen by a Programme Management Board.

- System wide threat of cyber-attacks which could disrupt the Trust's ability to operate

We continue to mitigate this threat through technical solutions and utilising support from NHS Digital.

- Challenge of maintaining a sustainable clinical workforce

The Trust is mitigating this risk through a UK graduate recruitment programme, further development of our international recruitment pipeline and working with providers to ensure that the ambulance service remains the employer of choice for paramedics.

- Uncertainty around future funding arrangements

The Trust has continued to work with partners in the North West London Integrated Care System group to ensure that sufficient funding is identified to sustainably deliver against agreed national quality and performance standards in 2021/22 and beyond.

- A lack of contemporaneous immunisation records

We have carried out a review and redesign approach to immunisations to provide assurance around immunity and potentially reduce the need for individuals to isolate following exposure to an infectious disease.

SECTION TWO: ACCOUNTABILITY REPORT

1. Directors' Report

1.1 Board and Executives appointment status – 2020/2021

	Name	From	Until
(Board members) Non-Executive Directors			
Chair	Heather Lawrence	01/04/2016	31/03/2022
Non-Executive Director	Karim Brohi	01/03/2019	28/02/2023
Non-Executive Director	Fergus Cass	01/03/2014	28/02/2021
Non-Executive Director	Sheila Doyle	06/02/2017	05/02/2023
Non-Executive Director	Amit Khutti	01/01/2018	29/02/2024
Non-Executive Director	Jayne Mee	09/01/2017	30/06/2021
Non-Executive Director	Rommel Pereira	01/02/2020	31/01/2024
Non-Executive Director	Mark Spencer	01/03/2019	28/02/2023

Associate Non-Executive Director	Jill Anderson		01/06/2020	31/05/2022
(Board members) Executive Directors				
Chief Executive	Garrett Emmerson		30/05/2017	Present
Chief Operating Officer	Khadir Meer		02/09/2019	Present
Chief Quality Officer	Dr Trisha Bain		01/01/2017	28/02/2021
Chief Paramedic and Quality Officer	Dr John Martin		01/03/2021	Present
Chief Medical Officer	Dr Fenella Wrigley		01/03/2016	Present
Chief Finance Officer	Lorraine Bewes		17/06/2017	Present
Executive Committee members				
Director of Strategy, Technology and Development	Ross Fullerton		15/05/2017	30/03/21
Director of Corporate Affairs	Syma Dawson		01/04/2020	Present
Director of Communication and Engagement	Antony Tiernan		02/09/2019	Present
Director of People and Culture	Ali Layne-Smith		01/09/2019	12/01/2021
Interim Director of People and Culture	Kim Nurse		16/11/2020	Present

1.2 Composition of the Board of Directors – photos will be updated

Our Trust Board is made up of 14 members — our Chair, seven non-executive directors, five executive directors (including our Chief Executive) and an associate non-executive director.

Our Executive Committee consists of nine executive directors and directors, including the five executive directors on the Trust Board.

The chief executive and the other executive directors are appointed through a process of open advertising and formal selection interview. Non-executive directors are appointed by the same method but through NHS Improvement. All executive appointments are permanent and subject to normal terms and conditions of employment.

Our Trust Board

Our Board of Directors comprises a Chair, non-executive directors and our Chief Executive Officer, Chief Operating Officer, Chief Finance Officer, Chief Medical Officer and Chief Quality Officer.

The Board is responsible for setting the strategic direction, culture and organisational performance of our Service and is accountable for ensuring that the Service delivers safe, high-quality care and gives patients the best care.

Non- Executive Directors



Heather Lawrence OBE, Chair – **NEW PHOTO TO BE ADDED**
Heather joined us as Chair in April 2016.

Heather has extensive experience both as an executive, and non-executive director in the healthcare sector, and has chaired and contributed to a number of national health boards.

Heather's experience as a non-executive director began in 2012 when she was appointed by the Secretary of State for Health as non-executive director of Monitor, the NHS Regulator. At the same time she was appointed to a FTSE 250 international health board. In 2017, Heather was appointed as non-executive director on the Royal Marsden Hospital NHS Foundation Trust board, where she now also chairs the quality committee.

Heather also has more than 20 years' experience as a Chief Executive Officer in the hospital and healthcare sector, most recently as Chief Executive Officer of Chelsea and Westminster Hospital NHS Foundation Trust from 2000 to July 2012, taking it to foundation trust status in 2006.

Heather believes that excellence in healthcare is something that everyone should be entitled to and continually strives to deliver this by ensuring that all staff feel valued and enabled to innovate, and transform care for patients.

She was awarded an OBE in the 2010 New Year Honours' List for her services to healthcare.



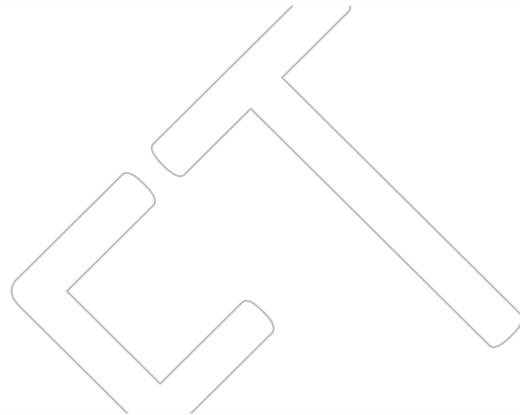
Rommel Pereira, Deputy Chair

Rommel has a track record in finance, business transformation, technology, customer service, procurement and business development.

Until recently, he was an Executive Director at the Bank of England attending its various committees. Prior to this he was an Executive Director of the Financial Services Compensation Scheme after spending five years as Group Chief Operating Officer for the Metropolitan Housing Partnership. His earlier career included senior management roles at JP Morgan Chase.

His recent Non-Executive roles include the One Housing Group, the Shepherds Bush Housing Group and Homerton University Hospital NHS Foundation Trust.

Rommel is the Chair of the Audit Committee.



Fergus Cass (until end of February 2021)

Fergus joined us in March 2014. He was a Non-Executive Director of NHS North West London until the replacement of primary care trusts in 2013 and previously served on the board of NHS Kensington and Chelsea.

He worked for the multinational consumer goods company, Unilever, for 36 years, initially in finance and later as a general manager, heading businesses in Africa and South Eastern Europe. He holds degrees in economics and is a qualified accountant.

Fergus was Chair of the Finance and Investment Committee and Charitable Funds Committee and our Freedom to Speak Up lead until end February 2021.



Sheila Doyle

Sheila joined the Service in February 2017 and has over 30 years' experience at executive and board level in organisations including Norton Rose Fulbright, BP, Royal Mail, IBM and Deutsche Bank.

She specialises in delivering transformational change through the application of innovative technology solutions. She has managed international teams of 400 employees, delivered numerous complex change programmes and integrated diverse technology platforms in support of mergers and acquisitions.

Sheila spent a number of years in Hong Kong, Singapore and Australia providing consulting services to the financial services and manufacturing sectors. She served as a Non-Executive Director on the board of Companies House and was also a member of the Audit Committee.

Sheila is currently the Chief Information Officer at Deloitte and is the Chair of the Logistics and Infrastructure Committee and Digital999 Programme Assurance Committee.



Professor Karim Brohi

Professor Karim Brohi is a consultant Trauma Surgeon at Barts Health NHS Trust, Director of the London Trauma System at NHS England (London), and Director of the Centre for Trauma Sciences at Queen Mary University of London.



Jayne Mee

Jayne joined us in January 2017. She has spent more than 25 years in human resources and organisation development, working in executive roles with Boots, Whitbread, Royal Mail, Punch Taverns and Barratt Developments.

Until June 2015 she was Director of People and Organisation Development at Imperial College Healthcare NHS Trust.

Through her work as an executive coach, Jayne supports executives and organisations in culture change, engagement and transformation.

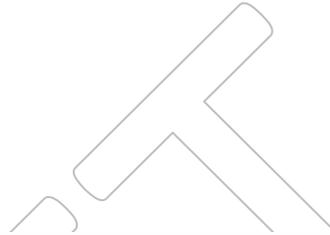
She is also a Non-Executive Director at University Hospitals Bristol and Weston NHS Foundation Trust and a trustee of St John Ambulance, where she chairs the People

Committee and the Remuneration Committee. She is also HR counsel at Prezzo Restaurants.

Jayne is Chair of the People and Culture Committee.



Dr Mark Spencer



Dr Mark Spencer has been a GP for 40 years and continues to enjoy clinical work.

He is also Vice Chair of the London Clinical Senate – the clinical leadership for strategy and assurance for quality of service changes across the capital and has had various roles at NHS England (London), including Deputy Regional Medical Director and Medical Director for Quality and Service Design.

He has also worked in hospital inspection teams for the Care Quality Commission; has advised the National Institute for Health and Care Excellence (NICE) on commissioning guidelines; and has been part of the London Urgent and Emergency Care Clinical and Professional Leaders Group for the past seven years.

As part of his role at London Ambulance Service, Mark chairs the Quality Assurance Committee, which monitors the quality of patient care as well as encouraging new improvements and innovations.



Amit Khutti

Amit is a technology entrepreneur, having co-founded Zava, one of Europe's largest online GP services in 2011.

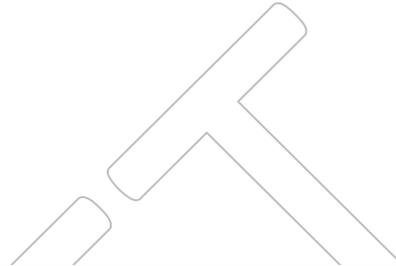
Before becoming an entrepreneur, Amit led on strategy and planning for Chelsea and Westminster NHS Foundation Trust. Prior to joining the NHS, he was a Senior Civil Servant working on delivering key health targets for then Prime Minister Tony Blair.

Amit started his working life as a management consultant for McKinsey & Co, after studying English Literature at Oxford University.

Amit was appointed as Chair of the Finance and Investment Committee and our Freedom to Speak Up lead in March 2021.



Jill Anderson



Jill joined us in June 2020. She brings more than 30 years' experience in the healthcare sector, including executive responsibility in finance, commercial, research and supply chain functions across large multinational organisations.

Jill is currently chief financial officer for ViiV Healthcare, a global subsidiary of the pharmaceutical company GlaxoSmithKline (GSK), which is dedicated to improving the lives of people living with HIV. She is actively engaged in diversity initiatives such as back-to-work programmes for people who are HIV positive.

A graduate in chemistry from the University of Exeter, Jill qualified as an accountant before joining GSK in 1990. She left to launch her own consultancy in 2001 before returning to GSK in 2011.

Executive Directors and Directors



Garrett Emmerson, Chief Executive Officer

Garrett is Chief Executive Officer of London Ambulance Service (LAS). Over the last four years, he has led the service through several major incidents including the 2017 and 2019 London terror attacks, the Grenfell Tower tragedy and, most recently, the Trust's response to the COVID-19 pandemic.

Since his appointment, London Ambulance Service moved from being in 'Special Measures', to achieving a Care Quality Commission (CQC) rating of "Good" overall in May 2018; a

rating that was sustained in 2019. Garrett is leading delivery of the Trust's vision to become London's primary integrator of access to urgent and emergency care.

Garrett was previously Chief Operating Officer for surface transport at Transport for London (TfL), where he led transport operations across London for 8 years, and was responsible for implementing TfL's £4bn road investment programme. Prior to that Garrett was Director of Strategy at TfL and, before that, was a Director at transport consultancy, Steer Davies Gleave.

He is a former Head of Buckinghamshire County Council's transportation service and a former member of the Government Commission for Integrated Transport and Motorists' Forum. He is also an independent advisor on the Office of Rail & Road (ORR) Highways Committee which monitors the performance and efficiency of Highways England, and a Non-Executive Director of Uno Bus Ltd.



Khadir Meer, Chief Operating Officer **NEW PHOTO TO BE ADDED**

Khadir joined us in September 2019 in the newly created role of Chief Operating Officer. He has more than 20 years of experience in public service including 10 years working for the NHS in London. There his roles included, Director of Performance and Improvement and Chief Operating Officer for NHS England (London).

Khadir oversees operations and performance at London Ambulance Service, including both 111 and 999 call answering and clinical triage; ambulance services; projects and programme delivery; technical services; and asset and property management.

Khadir is a member of the Service's Board, and in his role of Chief Operating Officer, leads teams at the forefront of LAS pioneering work in delivering outstanding patient care on scene, on the phone and online – and providing patients with the best care for their needs.



Dr John Martin, Chief Paramedic and Quality Officer

Dr Martin joined us in March 2021 in this newly-created role. He has responsibility for both clinical quality at the Trust and for ensuring paramedics and ambulance clinicians have access to world-class training, education and professional development.

John is a registered and practising paramedic and President of the College of Paramedics.

This is a return to London for Dr Martin who worked for London Ambulance Service while completing his paramedic science degree at the University of Hertfordshire almost 20 years ago.

Following a career as a paramedic with East of England Ambulance Service between 2002 and 2014, Dr Martin was selected for an NHS executive leadership programme.

In the six years since, he has performed a number of director roles at Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust.



Dr Fenella Wrigley, Chief Medical Officer

Fenella was appointed the Chief Medical Officer for London Ambulance Service in March 2016 having been the interim Medical Director since January 2015. She has also been a consultant in emergency medicine since 2006.

She joined us as Assistant Medical Director for control services in 2008 and became Deputy Medical Director in 2010. Fenella has led on our development of urgent care, clinically overseeing the introduction of a clinical hub to provide clinical support and 'hear and treat', and our step-in provision for NHS 111.

She is also the nominated officer responsible to oversee medication error incident reporting and is the Caldicott Guardian.



Lorraine Bewes OBE, Chief Finance Officer



Lorraine has served as Chief Finance Officer since December 2017. Her executive portfolio covers finance, performance, forecasting and business intelligence, procurement and commissioning contracts teams. She has 28 years of NHS senior operational executive experience as well as senior director roles at University College London Hospitals and Hammersmith and Charing Cross Hospitals.

Her last executive role was Chief Financial Officer of Chelsea and Westminster Hospital where she oversaw a portfolio of finance, strategy, business planning, commercial and procurement services, informatics, clinical coding and information governance. She was also part of the management teams who took the trust to foundation trust status and negotiated the acquisition of West Middlesex hospital.

Lorraine has been a national speaker on her special interest in NHS patient-level costing and is a past Chair of the Finance Director network of the Association of UK University Hospitals and the London Procurement Partnership. Lorraine is also an active advocate for the Healthcare Finance Managers Association as Deputy Chair of the Costing for Value Institute and she sits on the London Procurement Partnership steering board. She has also held senior positions in FTSE 100 companies in the media and technology sectors including WH Smith Television Services and BT plc.

Lorraine is a fellow of the ICAEW, a graduate of Trinity College, Oxford University and was awarded the OBE in the 2016 New Year Honours' List for her services to NHS Financial Management.





Ross Fullerton (resigned)

Ross joined us in May 2017 as Chief Information Officer, before becoming our Director of Strategy, Technology and Development in September 2019.

He has had nearly 20 years' experience leading information technology teams and advising IT leaders. Ross held senior IT leadership roles in the defence sector for five years.

Prior to this, Ross spent 10 years as a consultant where he led IT departments through major change at organisations including Centrica, BP, Marks and Spencer and the Student Loans Company.

Ross left the Trust on 31 March 2021.



Syma Dawson, Director of Corporate Affairs

Syma joined us in April 2020 from the Royal Marsden NHS Foundation Trust where she was Associate Director of Corporate Affairs and led the corporate governance team for eight years.

She is responsible for ensuring the right rules, processes and systems are in place so that our organisation performs effectively and lawfully.

Syma has worked in a range of NHS organisations including North East Ambulance Service. She is an Associate of the Chartered Governance Institute and a Chartered Secretary by qualification.



Antony Tiernan, Director of Communications and Engagement.

Antony joined us in August 2019 as Director of Communications and Engagement, managing our external communications, internal communications and partnerships teams as well as leading on volunteering.

He has more than 20 years' experience in health related communications, and most recently worked at NHS England and Improvement where he worked in senior strategic communications roles, including leading the campaign to celebrate 70 years of the NHS.

Antony spent 5 years at Guy's and St Thomas' NHS Foundation Trust and led on the opening of the £60 million Evelina Children's Hospital. He has also worked as Director of Communications at both Epsom and St Helier Hospitals NHS Trust and West Hertfordshire Hospitals NHS Trust.

In 2018, he was named by the CIPR (Chartered Institute of Public Relations) as one of the UK's top PR people.



Kim Nurse, Interim Director of People and Culture

Kim joined us on secondment from West Midlands Ambulance Service where she is the Executive Director of Workforce and Organisational Development.

Kim brings a wealth of experience, with more than 17 years working at director level in a number of ambulance services.

1.3 Register of Interests of Decision-Making Staff 2020/2021

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Heather Lawrence	Chair	Non-Executive Director - Royal Marsden Trust Board	July 2016	Present	
		Trustee NHS Providers - Ambulance Chair Rep	Autumn 2019	Present	
		Trustee British Renal Society	Autumn 2019	Present	
		NHS Improvement Chairman's advisory group member	2017	Present	
Rommel Pereira	Non-Executive Director	Non Executive Director, Homerton University Hospital Foundation Trust	01/06/2019	31/05/2023	
		Non Executive Director / Chair of Audit & Risk Committee, One Housing Group	21/09/2018	20/09/2021	
Sheila Doyle	Non-Executive Director	Deloitte - Employee	01/01/2016	Present	I am a partner and full time employee at Deloitte
		Telstra - Shares	1999	Present	I hold a small number of shares in Telstra - Australian telecommunications company

Jayne Mee	Non-Executive Director	Calabash Limited - Director	01/08/2015	Present	
		St John Ambulance - Trustee	Apr-15	Present	
		University Hospitals Bristol NHS Foundation Trust - Non Executive Director	Jun-19	Present	
Jill Anderson	Associate Non-Executive Director	ViiV Healthcare Ltd, subsidiary of Glaxo SmithKline Chief Financial Officer	01/06/20	Present	
		Ordinary shares in GlaxoSmithKline awarded as part of reward package and long term incentives	01/06/20	Present	
Fergus Cass	Non Executive Director	NIL			
Amit Khutti	Non-Executive Director	NIL			
Karim Brohi	Non-Executive Director	Queen Mary University of London Professor of Trauma Sciences, / Honorary Consultant Trauma Surgeon, Barts Health NHS Trust	01/03/2008	Present	

		Clinical Director, London Major Trauma System NHS England (London)	01/10/2015	Present	
		No clinical private practice. Act as medicolegal expert witness for both personal injury and clinical negligence.	08/06/2020	Present	
Dr Mark Spencer	Non-Executive Director	NIL			I continue as Med Dir NWL and as a GP sub-contracted to CareUK
Garrett Emmerson	CEO	Non-Executive Director University Buses	01/02/2019	Present	
Khadir Meer	Chief Operating Officer	Chair of Minik Kardes (Children's Charity)	2011	Present	
Lorraine Bewes	Chief Finance Officer	NIL			
Fenella Wrigley	Chief Medical Director	Royal London Hospital, Barts Health Emergency Medicine Consultant Financial - Substantive NHS consultant	01/07/2008	Present	
		St John Ambulance London Region Regional Professional lead for Specialist Events	01/08/2012	Present	

		Non-Financial - Voluntary role			
		All England Lawn Tennis Club Chief Medical Officer - Financial	01/09/2018	Present	
		Home Office Immigration Services Clinical Advisor - Financial	01/04/2013	Present	
Patricia Bain	Chief Quality Officer	NIL			
Antony Tiernan	Director of Communications and Engagement	Member, NHS England communications development board (non pecuniary)	01/04/2017	Ongoing	Unpaid - non-financial professional interest
		Member of the HSJ (Health Service Journal) Awards Advisory Board	01/01/2019	Ongoing	Unpaid - non-financial professional interest
Syma Dawson	Director of Corporate Affairs	NIL			
Paul Candler	Procurement Category Manager	NIL			
Paul Gates	Consultant Paramedic	Chairman and Director British Association for Immediate Care	14/11/2019		
		Chairman and Trustee BASICS Essex	12/06/2011		

		Lead Examiner for OSPE for the Diploma in Immediate Medical Care, Royal College of Surgeons of Edinburgh	01/01/2019		
		Regional Professional Lead (Paramedics and AHP's), St John Ambulance, London and South Region	01/01/2015		
Brian Jordan	Assistant Director of Operations (South West)	NIL			
Athar Khan	Director of Integrated Patient Care	Trustee, Leo Academy Trust	01/03/2019	Present	
Agatha Nortley-Meshe	Assistant Medical Director	Membership of NHS Pathways Programme Board (NHS Digital)	08/09/2020	Present	
		Ashinde Ltd	11/11/2020	Present	
		DAPS Global co-director of DAPS global a non-profit organisation aimed at empowering frontline and junior clinicians to undertake quality improvement project	2009	Present	
		The Park Practice, Bromley CCG General Practitioner	2015	Present	

Benjamin Clarke	Assistant Medical Director	Consultant in Emergency Medicine at Royal London Hospital (6 PAs)	2014	Present	This post was in place at the time of my employment with London Ambulance Service and have continued throughout my employment in this Trust.
		Consultant in Pre-Hospital Care with Essex and Herts Air Ambulance. (3 PAs)	2015	Present	This post was in place at the time of my employment with London Ambulance Service and have continued throughout my employment in this Trust.
Michael Cornett	Clinical Operations Manager	Charlton Athletic FC Medical cover at home games	01/08/2018	Present	This commitment does not affect my substantive role within the LAS and does not represent an conflict of interest with LAS
		Essex Medical Training Teaching BLS/ILS courses	01/01/2019	Present	This commitment does not affect my substantive role within the LAS and does not represent an conflict of interest with LAS
Briony Sloper	Deputy Director of Quality and Nursing	Healthy London Partnership/NHS London Region – Secondment to London Region	18/09/2020	18/12/2020	Urgent and emergency care improvement programme / out of hospital Covid-19 response cell lead for ageing well, community services and long length of stay
David Macklin	Deputy Medical Director	Clinical Fellow ED Doctor, Guys and St Thomas	19/09/20	Present	

		Occasional medicolegal expert witness work - none at present	19/09/20	Present	
Jaqualine Lindridge	Covid-19	NHS England and NHS Improvement Emergency Care Improvement Advisor	09/06/2020	Present	I am employed full time by NHSE/I within the Emergency Care Improvement Support Team, and currently seconded to LAS on a part-time basis The nature of my work with NHSE/I is not of a nature which is likely to create a conflict of interest.
Nick Sillett	Advanced Paramedic Practitioner - Critical Care	shareholder and Director of Medical Aide Memoire (MAM) Ltd, an online retailer, selling accessories via a website	01/07/2018	Present	
		I am a volunteer member of BASICS Accident Rescue Service (BEARS).	01/07/2018	Present	
Tim Edwards	Consultant Paramedic	Range of legal firms/organisations and regulatory bodie	02/06/2020	Present	Provision of expert witness or subject matter advice and report writing
		NICE Specialist clinical advisor Royal College of Surgeons Edinburgh	02/06/2020	Present	NICE specialist clinical advisor, examiner for the diploma and fellowship examinations in immediate medical care Royal College of Surgeons Edinburgh and member of the faculty of prehospital care.

Tim Lightfoot	Deputy Medical Director	Doctor Mid & South Essex Hospitals NHS Foundation Trust (Clinical practice in intensive care)	2015	Present	
		Doctor anaesthetics & Intensive Care British Army (reservist – Doctor anaesthetics & Intensive Care)	2015	Present	
Tina Ivanov	Deputy Director Clinical Education & Standards	School Governor The Discovery School Kent	2018	Present	School Governor
Amanda Munroe	Head of Commissioning, Contracting & Costing				NIL
Ashish Vithaldas	Head of Partnerships				NIL
John Downard	Head of IT Integrated Service Delivery				NIL
Lisa Taylor	Chief Staff Officer				NIL

Natasha Wills	Head of Resilience and Specialist Assets	NIL
Nic McCullagh	Director of Programmes and Projects	NIL
Nicholas Daw	Head of 111 & Integrated Emergency Care Service,	NIL
Nick Young	Head of Procurement Transformation	NIL
Nish Dubey	Head of Commercial	NIL
Tracey Watts	Head of Talent	NIL
Pauline Cranmer	Director of Ambulance Services	NIL

Syma Dawson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	83%
Ross Fullerton	x	x	x	✓	✓	✓	x	✓	✓	✓			✓	58%
Ali Layne-Smith ***	x	x	✓	✓	x	x	x	x	x	x				22%
Kim Nurse ****								✓	x	✓			✓	60%
Antony Tiernan	x	x	x	✓	x	✓	x	✓	x	✓			✓	41%

*John Martin joined the Trust 1 March 2021

** Trisha Bain left the Trust 28 February 2021

*** Ali Layne Smith left the Trust December 2020

**** Kim Nurse Joined the Trust November 2020

***** Fergus Cass left the Trust 28 February 2021

Informal Development sessions

Audit Committee

Members	17/04/20	26/05/20	18/06/20	03/09/20	05/11/20	26/02/21	Attendance %
Rommel Pereira	✓	✓	✓	✓	✓	✓	100%
Fergus Cass *	✓	✓	✓	✓	✓	✓	100%
Sheila Doyle	✓	✓	✓	✓	✓	✓	100%
Attendees							
Lorraine Bewes	✓	✓	✓	✓	✓	✓	100%
Syma Dawson	✓	✓	✓	✓	x	x	66%
Garrett Emmerson	x	✓	✓	✓	x	x	50%
Khadir Meer	✓	✓	✓	✓	✓	✓	100%
Mark Spencer	✓	✓	✓	✓	✓	✓	100%

* Fergus Cass left the Trust 28 February 2021

Finance and Investment Committee

Members	21/05/20	21/07/20	22/09/20	17/11/20	15/01/21 - Extra	19/01/21	09/02/21 - Extra	11/02/21 - Extra	23/03/21	Attendance %
Fergus Cass*	✓	✓	✓	✓	✓	✓	✓	✓		100%
Lorraine Bewes	✓	✓	✓	✓	✓	✓	✓	✓	✓	100%
Sheila Doyle	✓	✓	✓	✓	x	✓	✓	x	✓	77%
Garrett Emmerson	✓	✓	✓	✓	x	✓	✓	x	✓	77%
Amit Khutti	✓	✓	✓	✓	x	✓	✓	✓	✓	88%
Rommel Pereira	✓	✓	✓	✓	✓	✓	✓	x	✓	88%
Attendees										
Syma Dawson	✓	✓	x	x	x	x	x	x	x	22%
Heather Lawrence	✓	✓	✓	✓	x	✓	✓	✓	✓	88%
Khadir Meer	✓	✓	✓	✓	✓	✓	✓	✓	✓	100%

* Fergus Cass left the Trust 28 February 2021

Extraordinary meeting

Logistics and Infrastructure Committee

Members	12/05/20	14/07/20	15/09/20	10/11/20	12/01/21	16/03/21	Attendance %
Sheila Doyle	✓	✓	✓	✓	Cancelled	✓	100%
Lorraine Bewes	x	✓	✓	✓		✓	80%
Fergus Cass	✓	✓	✓	✓			100%
Amit Khutti	✓	✓	✓	✓		✓	100%
Khadir Meer	✓	✓	✓	✓		✓	100%
Rommel Pereira	✓	✓	x	✓		✓	80%
Attendees							
Syma Dawson	✓	✓	✓	x		x	60%
Ross Fullerton			✓	✓		✓	100%

* Fergus Cass left the Trust 28 February 2021

People and Culture Committee

Members	14/04/20	16/07/20	17/09/20	12/11/20	14/01/21	18/03/21	Attendance %		
Jayne Mee	Cancelled	✓	Cancelled	✓	✓	✓	100%		
Trisha Bain ***		✓		x	x			33%	
Karim Brohi		✓		✓	✓	x		75%	
Ali Layne-Smith *		✓		x	x			50%	
John Martin ****								✓	100%
Khadir Meer				✓		✓	x	✓	75%
Kim Nurse **						x	✓	✓	66%
Mark Spencer				✓		✓	✓	✓	100%
Attendees									
Garrett Emmerson				x		✓	x	✓	50%
Syma Dawson		✓		✓	✓	x	75%		
Fenella Wrigley		✓		✓	✓	✓	100%		

* Ali Layne Smith left the Trust December 2020

** Kim Nurse Joined the Trust November 2020

*** Trisha Bain left the Trust 28 February 2021

**** John Martin joined the Trust 1 March 2021

Quality Assurance Committee

Members	05/05/19	07/07/20	08/09/20	03/11/20	14/01/21	09/03/21	Attendance %
Mark Spencer	✓	✓	✓	✓	✓	✓	100%
Trisha Bain *	✓	✓	✓	✓	✓		100%
Karim Brohi	✓	x	✓	✓	✓	✓	83%
Heather Lawrence	✓	✓	✓	✓	✓	✓	100%
John Martin **						✓	100%
Jayne Mee	✓	✓	x	✓	✓	✓	83%
Khadir Meer	✓	✓	✓	✓	x	✓	83%
Fenella Wrigley	✓	✓	✓	✓	✓	✓	100%
Attendees							
Syma Dawson	✓	✓	✓	✓	✓	x	83%
Rommel Pereira	✓	✓	✓	✓	x	✓	83%

* Trisha Bain left the Trust 28 February 2021

** John Martin joined the Trust 1 March 2021

Charitable Funds Committee

Members	03/11/20	19/01/21	22/02/21	Attendance %
Fergus Cass*	✓	✓	✓	100%
Lorraine Bewes	✓	✓	✓	100%
Rommel Pereira	x	✓	✓	66%
Antony Tiernan	x	✓	✓	66%
Attendees				
Syma Dawson	x	x	x	0%

* Fergus Cass left the Trust 28 February 2021

2. Annual Governance Statement

Scope of responsibility

1. As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

2. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust (LAS), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

3. Risk management is a key component of enhancing patient and staff care and is an integral part of the Trust's strategic management. It is the process whereby the Trust methodically addresses the risks related to its activities with the goal of achieving sustained benefits to patient care and outcomes through delivery of the LAS Strategy. The focus of risk management at LAS is about being aware of emerging problems, working through what impact they could have and implementing changes and plans to mitigate against the worst case scenario. This is achieved through ensuring clear leadership and accountabilities throughout the Trust and encouraging cross directorate working.
4. The Chief Executive Officer is accountable to the Board for the quality of risk management arrangements within the Trust. Operationally, during 2020 /21 responsibility for the implementation of risk management has been delegated to the Chief Quality Officer and the Director of Corporate Affairs. Since March 2021 the role of the Chief Quality Officer has been replaced by the role of Chief Paramedic and Chief Quality Officer who has now assumed the responsibility for clinical risk management.
5. The Director of Corporate Affairs supports Executive Committee (ExCo) members and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Trust Board, for maintaining the Board Assurance Framework (BAF). The BAF defines the principal risks to achieving the Trust's strategic objectives, together with associated controls, sources of assurance and action plans.

The Chief Paramedic and Quality Officer, and previously the Chief Quality Officer, is the quality governance lead for the Trust. The Chief Paramedic and Quality Officer, and previously the Chief Quality Officer is responsible for the Trust's Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. They are also responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The holders of these posts have continued to drive forward a significant workplan in 2020/21 to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level.

6. Executive Committee (ExCo) members individually, and collectively, have responsibility for providing assurance to the Trust Board on the controls in place to mitigate their associated risks to achieving the Trust's strategic objectives, including compliance with the all the Trust's licences.
7. The Trust Board's Assurance Committees have responsibility for providing assurance in respect of the effectiveness of these controls. A system of "key issues" assurance reports to the Trust Board is in place to highlight any risks to compliance. Board Assurance Committees are well attended by ExCo members and Non-Executive Directors as well as by other key Trust staff.
8. The Quality and Corporate Affairs Directorates also has expanded over the past 12 months to provide further assurance that there are experienced and appropriately qualified staff to lead, support and advise staff at all levels across the organisation with the identification and management of risk.
9. The Risk Management Strategy and Policy sets out clearly defined roles and responsibilities for the senior leadership team and the risk register contains a clear definition of the Corporate (Trust Wide) Risk Register and the process for inclusion. This ensures that the right risks have been identified and prioritised for action. The Trust's Risk Compliance and Assurance Group (RCAG), chaired by the Chief Paramedic and Quality Officer (previously Chief Quality officer)-meets regularly to review risk management and the monitor actions and were appropriate escalates to the Board via executive committee reporting. This ensures appropriate seniority and reflects this Executive Officer's overall responsibility for risk management requirements up to and including the Corporate (Trust Wide) Risk Register. The Trust Risk Manager has continued to improve, strengthen and embed Risk Management systems and processes across the Trust by increased engagement (both operational and corporate) to raise, review and mitigate risk.

Staff - Training

10. The Trust provides a comprehensive mandatory and statutory training programme which includes governance and risk management awareness, ensuring that staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.
11. The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Risk Awareness' is in development and will be available to all staff through ESR in Q1/2.

Currently this course is offered by the Trust Risk Manager face to face in small groups. All managers that are responsible for implementing the risk management procedure locally receive more specialist training to enable them to fulfil their responsibilities. This training is generally offered on a one to one basis and tailored to be relevant to suit the responsibilities and risks associated with their role. All risk management training is recorded centrally in ESR. Staff have access to comprehensive risk guidance and advice via Risk Management Leads in the Quality Directorate, information embedded in the Risk Management page on the Trust intranet and by referring to the Risk Management Procedure. The Trust Risk Manager also supports staff in risk reviews and escalation through monthly quality governance meetings. The recent internal audit of Risk Management indicated that overall key risk management personnel have a good understanding of the risk management process. Risk management training is provided to Executive Committee and Board members every two years, in respect to high level awareness of risk management and to ensure that risks aligned to their remit are reviewed. The Trust Board last received such training in September 2020.

12. The Trust's mandatory and statutory training programme is regularly refreshed to ensure that it remains responsive to the needs of Trust staff and volunteers. There is regular review of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. Despite significant operational pressures due to the impact of COVID-19, the Trust has been able to achieve average target levels of 84% compliance with mandatory and statutory training requirements during 2021/22. Monitoring and escalation arrangements are in place to ensure that the Trust maintains its current good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

The risk and control framework

Risk Management Strategy and Policy

13. The Trust is committed to having a risk management culture that underpins and supports the delivery of the business of the Trust. The Trust will continue to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.
14. The Risk Management Strategy and Policy, which was reviewed and amended in April 2021, provides the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to ongoing operational activities. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. This includes but is not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.
15. The Trust's Risk Management Strategy and Policy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Identifying and reporting risk

16. Risks are identified routinely from a range of reactive/pro-active and internal/external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators etc. These are reviewed to understand the organisational impact and appropriately graded and ranked and included on the Trust's Corporate Risk Register and Board Assurance Framework (BAF). A Risk, Compliance and Assurance Group (RCAG) exists to review and monitor risks added to the Risk Register and regular reports from the Corporate Risk Register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place and remain appropriate. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process.
17. The Trust Board reviewed its approach to strategic risk management in September 2020. A new BAF format was adopted in line with the template recommended by NHS Providers (deemed to be best practice by industry standards). The new BAF format was reviewed by the Trust's internal auditors in February 2021. The Trust Board was provided with a significant level of assurance through this independent assessment of the BAF's operational effectiveness.
18. In accordance with the Trust Board's Scheme of Delegation, responsibility for the management /control and funding of a particular risk rests with the Directorate / Sector / Station concerned. However, where action to control a particular risk falls outside the control / responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment, or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the appropriate corporate committee, the RCAG, the ExCo or the Trust Board for a decision to be made.

Managing risk

19. Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which are reviewed and amended as necessary on an annual basis.
20. Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In addition to standard incident reporting processes, the Trust has had a full time Freedom To Speak Up (FTSU) guardian since 2018/19. Concerns raised through FTSU are all investigated and many have led to improvements in processes in a number of different parts of the service. At Board level, Fergus Cass was the Trust's Non-Executive Director lead for FTSU prior to stepping down from the Board in February 2021, at which point Amit Khutti took on this role. The Audit Committee has also received the thematic reviews and lessons learned and actions noted.

Key events for FTSU:

- At present there are 25 Freedom to Speak Up advocates, all of whom have received training in how to promote the work of FTSU and support staff to raise concerns.

- Erica Green served as the Trust's FTSU guardian between May 2020 and Feb 2021. The role is currently filled by Katy Crichton on an interim basis.
- In August 2020, station administrator Carmen Peters was appointed as a full-time coordinator role to assist with supporting the Guardian, liaising with the advocates and providing an alternative pathway for staff to raise concerns if a conflict of interest occurs with the Guardian.
- The LAS FTSU team were finalists for the FTSU category at the Health Service Journal Awards.
- The Guardian and coordinator are both engaged with the B-ME Black and Minority Ethnic Network, Enabled Disability Network and the LGBT society. The FTSU coordinator is also the Engagement and welfare officer for the B-ME and Enabled Network.
- FTSU and B-ME Network collaborated on events and communications for Black History Month.
- The Guardian gave a presentation at an International Women's Day virtual event where she spoke about the work of Freedom to Speak Up.
- FTSU Month in October 2020, the Guardian and coordinator held a virtual event for the advocates. The Chair and the CEO gave virtual personal speeches virtually and the LEAP team conducted a workshop around stress and boundaries.
- FTSU Month Guardian and coordinator also visited multiple sites across the services offering tea and coffee to staff on a tea truck, including visits to the LSU and 111 both sites.
- The Guardian and Coordinator ran virtual shielding mess rooms, for staff shielding due to the pandemic.
- The Guardian or coordinator were invited to the Resolution Framework meetings to help shape the implementation of this within the Trust.
- The FTSU coordinator attended the White Ribbon campaign meetings.
- The FTSU page on the LAS intranet has been reviewed and refreshed. They are frequently updated with information about the advocates, how to speak up, and a news section and also contains information on the learning that has occurred as a result of FTSU.
- In collaboration with the LEAP team, The Freedom to Speak Up team produced a staff support and wellbeing document for all staff to access in light of the COVID-19 pandemic and from then onwards.
- An Infographic has been developed in order to help colleagues understand the speaking up process.
- The Trust responded to a range of safety concerns from staff in relation to COVID-19 during the early stages of the pandemic. These were raised openly through a variety of channels, including FTSU, and were managed with the provision of optional alternatives for Personal Protective Equipment (PPE) which met the Public Health England (PHE) guidance, development of a wellbeing hub and more management support being available to frontline clinicians.
- Fair treatment issues were raised and responded to in relation to certain areas of the organisation Fleet, Estates and HART.
- Capacity and continuity of FTSU support has been maintained at both an executive and non-executive level of the Trust.
- In 2020/21 155 concerns were raised compared to 278 in the previous financial year. 32% of these came from BAME colleagues, a significant rise on last year, potentially because of focus on the Black Lives Matter movement.

- The focus for the next financial year will be working with managers across the Trust to reduce the number of colleagues who feel they need to raise concerns via FTSU and improve other existing pathways.
21. Business Planning and Service Development proposals do not proceed without an appropriate assessment of, and therefore recognition / acceptance of, the risks involved and the involvement of the relevant expertise. The Trust's ExCo reviewed and agreed the approach to be taken to quality impact assessments (including equality and data protection assessments) in December 2017. This has continued to be used in the Trust's Business Planning activities for 2020/21.
 22. The design of the Trust's BAF was reviewed in September 2020 when a revised format was approved by the Board, incorporating more detailed mapping to strategic risks, tolerance levels and residual to target gap analysis. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Data Protection and Security Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via regular BAF / risk register reports and is supported by a robust Internal Audit Programme.
 23. The Trust last considered its approach to risk management and approved its risk appetite statement in September 2020. The Board is currently considering longer term strategic risks faced by the Trust, including the incorporation of the longer term impact of COVID-19 within the core risks on its BAF. An assurance mapping exercise is being undertaken to create a more formalised, structured assurance reporting mechanism to the Board, which will highlight any anomalies, gaps and duplications of assurance to streamline the information provided to the Board.
 24. The Board has had to focus on a number of emerging risks in 2020/21 including the increased pressure on the service due to the impact of; the COVID-19 Pandemic, the transition arrangements for the UK's departure from the European Union; securing adequate funding arrangements to enable the Trust to deliver commissioned services and to support the Trust's modernisation programme. The Board has been closely monitoring the mitigation of risks relating to COVID-19 via the appropriate assurance committees, Executive Committee and the Audit Committee. The Finance and Investment Committee receive regular reports on progress with commissioning arrangements and the business case to support the modernisation programme.
 25. Throughout 2020/21, the Trust faced unprecedented levels of demand associated with the commencement of first peak of the COVID-19 pandemic in March 2020 and the second in December 2020. Arrangements were put in place at the beginning of the first peak to enable changes to governance and assurance frameworks to ensure a prompt response to the pandemic and reduce burden at a time of significant operational pressure. Use of existing business continuity and Strategic Command structures for decision-making as well as amended executive decision-making and Board Assurance structures enabled the Trust to provide assurance over its decision-making during this period. Actions taken included weekly strategic briefings of Trust Board members, with the ability to quickly escalate and implement issues as they arose whilst maintaining independent assurance and oversight. Peer review of plans was sought from the NHS England Ambulance Strategic Commander to provide further assurance. In order to ensure that all decisions were recorded appropriately, the Trust implemented a formal decision log. These arrangements were flexed to meet the decrease and increases in

pressure throughout this period, some of which have been incorporated into BAU. The Trust requested a review to be carried out of the decision making process during the COVID-19 pandemic.

26. In order to ensure the maintenance of an appropriate control environment, existing controls were adapted to ensure that they maintained appropriate oversight and assurance, whilst recognising the significant operational pressures facing the organisation. These amendments included changes to the Standing Financial Instructions with regard to COVID-19-related expenditure.

27. The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust's Quality Strategy is based on the Care Quality Commission (CQC) fundamental standards. The Trust Board also agrees annual quality priorities.
- The Trust has a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director who is a practising clinician. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives and is supported by the bi-monthly Quality Oversight Group as well as local Sector/Service Quality Governance meetings. The Quality Assurance Committee provides a report of each meeting to the Trust Board.
- The Trust publishes an Annual Quality Account.
- Performance against key quality indicators are reported to the Trust Board in both the Trust's Quality Report and the Integrated Quality and Performance Report.
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Quality Improvement Plan which is monitored at the Organisational Performance Meeting and at local Service/Sector Quality Governance meetings.
- A Station/Service Accreditation programme has been developed which aims to drive quality standards by empowering front line staff to make improvements in line with the Care Quality Commission's (CQC) fundamental standards. During 2020/2021, the Trust ran a pilot which was successful. The programme is planned for roll out this financial year and it is supported by the Patient & Public Council.
- The Trust has identified Non-Executive Directors to lead in respect of specific aspects of governance and risks. These roles are reviewed annually.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient & Public Council (PPC) representatives (e.g. Health Watch).
- Patient and Staff Stories are presented respectively to meetings of the Trust Board and actions and lessons learned are widely shared.
- The Trust has implemented the Patient Safety Incident Response Framework (PSIRF) as an early adopter. This approach allows the Trust to focus on continuously improving by addressing causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- The Trust has implemented the Learning from Death process with an internally developed digital platform to enable reviews and oversight to be undertaken and reported on.
- Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside

effectiveness and patient experience – a patient safety specialist will be appointed during Q1/2 of 2021/22 to lead on Learning from Deaths and external collaboration.

- The Trust has a safeguarding team and a patient experience team to oversee safeguarding matters and patient experience respectively.
- To maintain safety throughout the COVID-19 Pandemic additional senior clinical support was provided to the control rooms (999 and 111) and frontline crews. Additionally close collaboration with the wider London NHS system enabled additional expert support to be accessible for patients who either did not need to be conveyed to an Emergency Department or did not wish to go to hospital.
- Throughout COVID-19 patients who experienced delays in either accessing 999 or 111 or delays to receive a definitive clinical assessment either on the phone or face-to-face as a result of the unprecedented demand were reviewed by an external team and learning was shared.
- As part of the frontline delivery for the NHS in London the Trust were invited to, and engaged in, many COVID-19 surveillance research pilots to help with the understanding of this new disease. This included being early adopters of antibody testing, lateral flow testing and Test to Release (enabling people to end quarantine early via testing).
- The COVID-19 vaccination programme was delivered to LAS staff and volunteers through collaboration with larger Trusts and Regional centres. LAS supported this with providing vaccinators.
- The Trust's COVID-19 expenditure claims in the first Covid surge were audited by Deloitte as part of a national rolling audit programme and the Trust commissioned a further internal audit review of the COVID-19 expenditure during 2020/21. Both reviews provided significant external assurance on the appropriateness and reasonableness of the expenditure incurred in response to the COVID-19 pandemic.

28. In 2020/21 the key performance indicators reported to the Trust Board were rated for data quality as part of the Data Quality Reviews. Further, the following key work was undertaken throughout the year to ensure data quality within the Trust:

- Data Quality Reviews of 11 key systems or reporting arrangements were carried out to assess the quality of data.
- Actions were developed based on the findings and recommendations of these reviews which is regularly monitored by IGG (Information Governance Group) and QAC (Quality Assurance Committee).
- An internal audit by Grant Thornton on Data Quality was carried out in November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a SIGNIFICANT level of assurance (highest possible rating).

29. With regard to complying with the recommendations of “Developing Workforce Safeguards”, the Trust:

- Has formed a Strategic Workforce Planning Group, which is chaired by our Chief Operating Officer / Deputy Chief Executive, and has clear oversight of risk management.
- Employs sufficient numbers of suitably qualified, skilled and experienced staff to meet the care and treatment needs of our patients safely and effectively.

- Has a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and to keep them safe at all times.
- Deploys an approach that reflects current legislation and guidance where it is available.

30. In 2020/21 the Trust retained its focus on the strategic risks associated with workforce, through the BAF and through the People and Culture Committee. The People and Culture Committee has had a specific focus upon the development of a workforce planning model, providing assurance to the Board on this. The ExCo has also met as a Strategic Workforce Planning Group in 2020/21 and regularly received reports on strategic workforce planning activities, to provide additional oversight in this area.

31. During the course of the year, a control issue was identified in respect of the Trust's medicines management and compliance with Medicines & Healthcare products Regulatory Agency (MHRA) regulations. Since 2016, a pharmacist led review of the medicines packing and distribution function (at the Logistics Support Unit) is undertaken every 18 months. In addition, Grant Thornton carry out internal audits on a periodic basis. During a Chief Pharmacist-led review of medicines management at the Logistics Support Unit, it was identified that the Trust should acquire a MHRA Wholesale Dealers License (WDL). This control issue was identified due to a change in the way the MHRA inspects suppliers. In order to achieve a WDL, the Trust must work to Good Distribution Practice (GDP) systems and processes. At the time of the review the estate, staff, systems and processes were sub optimal mostly due to the position of the specialist function in the Trust structure. A comprehensive action plan is now under way and a new medicines management distribution unit is being constructed and management of the function strengthened and led by the Chief Pharmacist.

32. In addition, an internal review of Occupational Health (OH) records highlighted that the transfer of vaccination record information between previous providers did not provide adequate assurance of immunity and due diligence in the contracting processes in relation to providing out of hours (OOH) immunisation service were also identified as sub-optimal. The Trust does not have an internal OH provider and has had the OH service provided by a range of procured providers over the past decade. Each time a new provider has been procured the staff records have needed to be transferred over from the old provider to the new provider. The internal review identified weaknesses in assurance around the transfer and management of these transfer arrangements resulting in the Trust, via the OH provider, lacking assurance around contemporaneous immunisation records for some staff. This lack of assurance around immunity could potentially result in individuals being required to isolate following exposure to an infectious disease. The Trust's Board, advised by its Audit Committee, has recognised that this presented a significant control issue.

33. To address this issue, the Trust commenced an immunisation review programme in 2020/21 including:

- Analysis of immunisation records to identify any gaps.
- Contact tracing processes were followed to identify and protect staff at risk of a lack of immunisation/immunity.
- A task and finish group commenced work to review the systems and processes pre and in early employment to improve the opportunities for immunisations prior to commencement in roles where the risks are the highest.

- Amendment to the recruitment offer letters from Q1/2 to include the immunisation requirements.
- Work to create a reporting framework in ESR so that individual immunisation records are now captured within the system.
- Engagement of an internal OH specialist nurse lead to provide expert advice to the Chief Medical Officer and Head of Wellbeing.

34. In terms of contracting requirements and due diligence an extensive action plan was developed to mitigate any further risks. The Trust will complete delivery of Phase 2 of its immunisation catch up programme and look to embed new processes as part of the retendering of its Occupational Health contract. A validation audit will be carried out with the appointed Occupational Health contract holder to validate records transferred to them with those in ESR. The Trust will also review the clinical evidence for periodic immunity reviews and update its Workforce Immunisation Policy accordingly. This work will take place with a view to establishing significant assurance in the first half of the 2021/22 year.

Quality Strategy

35. The Trust has a Quality Strategy to support quality governance and assurance from station to Trust Board. The Quality Strategy aims to put patients and staff at the centre of everything we do and is underpinned by the Care Quality Commission's definition of quality. Alongside this, is a commitment to a just culture where reporting of both clinical and non-clinical incidents is central to continuous learning and improvement.

36. Quality Governance and assurance is supported by reliable information systems including Datix and Health Assure. These systems are a rich source of data which informs the Trust of its performance against various quality indicators. Each Sector has a dedicated Quality Governance and Assurance Manager (QGAM) and Sector Senior Clinical Lead to oversee Patient safety and the quality of service at Sector level. Their work is overseen by the Central Quality Oversight Group.

37. Every year, the Trust sets specific quality priorities which are reported in the annual Quality Account. These priorities are identified in consultation with both internal and external stakeholder to ensure they are relevant and robust for the coming year. The Trust routinely reviews its performance against its quality priorities and this is reported through the governance structures which include, sector governance meetings, the Quality Oversight Group, the Quality Assurance Committee and the Trust Board. There are processes in place to review performance regularly across the year to ensure that gains are consolidated and any learning is utilised as part of the wider quality improvement plan. These processes include a series of Sector peer reviews and quality performance reviews which are designed to test how well the Trust is doing against the CQC's key lines of enquiry. The outcome of these reviews are reported to relevant teams and meetings to guide decisions and actions.

CQC registration and compliance with the NHS provider licence

38. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

39. During 2020/21, CQC inspection activities at the Trust included regular engagement calls

and virtual monitoring meetings. An infection control assessment post COVID-19 wave 1 was undertaken based on the NHS England framework and CQC reported back they were fully assured.

40. The CQC's overall rating of the Trust remains "Good".
41. The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence at its meeting in May 2020 2021. This assessment was reached following an internal review of the Trust's corporate governance framework.
42. With respect to condition FT4 (NHS Foundation Trust governance arrangements), the Board reviews the terms of reference of its Assurance Committees on an annual basis to ensure their effectiveness and last did so in May 2021. The Trust has an Audit Committee consisting of Non-Executive Directors. The Audit Committee regularly meets with the internal and external auditors without the presence of executive directors or staff. In addition, the Local Counter Fraud specialist presents a report to every meeting of the Audit Committee on measures to tackle Fraud, Bribery and Corruption and also the importance of reporting concerns as appropriate. The Trust also has a Remuneration and Nominations Committee consisting of the Non-Executive Directors, joined when appropriate, by the Chief Executive, the Director of People and Culture and the Director of Corporate Affairs. In addition, the Board has established a number of Assurance Committees which focus on key aspects of the Trust's work. Each Committee is chaired by a Non-Executive Director. All Committees and sub Groups undertake an annual self-assessment of their effectiveness, which is reported to the Board (or the appointing Committee in the case of sub groups). The Audit Committee also submits an Annual Report to the Trust Board and regularly reviews the Standing Financial Instructions and Scheme of Delegation.
43. The terms of reference also serve to define the responsibilities, accountabilities and reporting lines of each Assurance Committee. The Board receives a report following each Assurance Committee meeting, written or approved by the Non-Executive Director Chair, and is therefore able to both receive assurance but also challenge any of the decisions made. Each Assurance Committee also has one identified lead Executive Director. The responsibilities of the Board and its Directors are defined in the Trust's Standing Orders and Standing Financial Instructions, which were reviewed in May 2020.
44. The Board has an annual schedule of business, which is reviewed at each formal meeting of the Board. The schedule defines when reports will be submitted, ensuring that the Board can operate timely and effective scrutiny of its operations. Key performance reports covering corporate, clinical, quality, workforce, finance and operational performance are received at each formal meeting of the Board and an annual report from the Audit Committee, these are made available on the Trust's website.
45. The Remuneration and Nominations Committee reviews, when necessary, the directorate portfolios, and there is a clear organisational structure with staff and managers identified within each directorate, who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. Elsewhere within this report can be found the Trust's duty to operate efficiently, economically and effectively.
46. The reports submitted to each formal meeting of the Board enables timely and effective

scrutiny and oversight by the Board of the Licensee's operations. These are also published on the website. In addition, directors have access to up to date operational information, as well as receiving the details of any serious incidents reported.

47. The Trust is compliant with health care standards that are binding which is demonstrated by the Trust being rated as "Good" overall following the CQC inspection in 2019. As part of gaining assurance Board and ExCo members are encouraged to visit staff in the sectors with each director allocated to a particular sector. In addition, at each meeting of the Board there is an opportunity to hear either a staff or patient story.
48. During the course of the year, a control issue was identified in respect of the Trust's medicines management and compliance with Medicines & Healthcare products Regulatory Agency (MHRA) regulations.
49. Since 2016, a pharmacist led review of the medicines packing and distribution function (at the Logistics Support Unit) is undertaken every 18 months. In addition, Grant Thornton carry out internal audits on a periodic basis. During a Chief Pharmacist-led review of medicines management at the Logistics Support Unit, it was identified that the Trust should acquire a MHRA Wholesale Dealers License. This control issue was identified due to a change in the way the MHRA inspects suppliers. In order to achieve a WDL, the Trust must work to Good Distribution Practice (GDP) systems and processes. At the time of the review the estate, staff, systems and processes were sub optimal mostly due to the position of the specialist function in the Trust structure.
50. As a result, the medicines packing and distribution function will be moving to a newly created pharmacy department, led by the Chief Pharmacist. In order to comply with GDP, the following is underway and due for completion in 2021:
 - A staff restructure has been commissioned and recruitment and induction are underway for General Pharmaceutical Council (GPhC) registered staff for the day-to-day management of the function. All pharmacy assistant staff have been enrolled in training programmes as determined by the Pharmacy Order 2010 and an enhanced internal training programme has been developed which will be delivered by pharmacy technicians. All medicines delivery drivers will be undertaking the medicines management training course for drivers.
 - A new medicines packing and distribution site is being constructed in accordance with that stipulated in the 'Rules and Guidance for Pharmaceutical Manufacturers and Distributors (commonly known as the Orange Guide), 2017'.
 - A new inventory management system has been purchased to provide full information of the traceability, use of medicines, expedited recalls, control of expired medicines at our fingertips.
 - Automated temperature monitoring system has been installed into all static medicines storage areas to provide accurate and timely assurance of the storage of medicines within the conditions stipulated
51. The Quality Assurance Committee receives regular reports from clinical and operational staff and through a number of documents such as the Serious Incident Reports, Quality Oversight Group, and claims and inquests updates and is able to have oversight and challenge the Trust in relation to the quality of patient care. The Trust's Chief Medical Officer, Chief Paramedic and Quality Officer and the Director of Corporate Affairs attend all meetings of the Committee. In addition, the Committee is chaired by a clinician who is

a Non-Executive Director of the Trust.

Roles and Responsibilities

52. The Trust Board holds overall responsibility for the management of risks within the Trust. The Board ensures significant risks to the Trust's ability to provide a quality service are identified and managed. The Board reviews all significant risks at each formal meeting.
53. Non-Executive Directors seek assurance in relation to the performance of the ExCo in meeting agreed goals and objectives. They are required to satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.
54. The Chief Executive is responsible for ensuring that a system is in place for reporting of all incidents.
55. All ExCo members hold responsibility for the identification and management of their risks and ensure they are documented, registered and updated in a timely fashion for the relevant forums to review. They are responsible for the risk management process within the Trust and as such ensure:
- the review of risk and risk registers is maintained in accordance with Trust strategy.
 - all staff have the ability to identify risks and propose they are assessed and entered onto the relevant section of the Trust Risk Register.
 - monitoring and timely review of the Risk Management Strategy and associated policies.
 - provision of expert advice into the incident reporting process.
 - all Managers within their Directorate are familiar and act in accordance with Trust policies.
 - incidents are reported and investigated in accordance with the Trust's Incident Reporting Process.
 - Learning is shared and embedded through a range of modalities including Core Skills Refreshers, Clinical Update and Insight bulletins and podcasts.
56. There were a number of changes to the Trust's senior personnel in 2020/21:
- Kim Nurse joined the Trust in the role of Interim Director of People and Culture in November 2020, replacing Ali Layne-Smith.
 - Trisha Bain left the role of Chief Quality Officer in February 2021 and was replaced by John Martin in March 2021 as the Trust's new Chief Paramedic and Quality Officer.
 - Fergus Cass' term of appointment as Non-Executive Director and Chair of the Trust's Finance and Investment Committee came to an end at the end of February 2021, at which point he left the Trust.
 - Jill Anderson was appointed as an Associate Non-Executive Director with effect from 1 June 2020.
57. The Board Assurance Committees and Executive Committee provide a process for the escalation and assessment of the assurance given in relation to mitigating any identified risks for the organisation.
58. The purpose of the Executive Committee (ExCo) is to lead and manage the performance of the Trust within the strategic framework established by the Trust Board. The ExCo

makes proposals to the Trust Board on key policy and service issues for Trust Board decision. The ExCo meets in a number of different forms throughout each month to focus on different aspects of the Trust's operations. As the Portfolio Management Board, it manages the portfolio of programmes and projects in place to deliver the Trust's Business Plan; as the Strategic Workforce Planning Group, it focuses on the actions required to ensure that the Trust will have the resources it requires to deliver its Strategy; and as the Performance Review Meeting, it retains detailed oversight of every aspect of the Trust's performance.

59. The ExCo has also established the following sub-groups:

- the Risk Compliance and Assurance Group (RCAG) - to oversee the governance of the risk management process and management of risks rated greater than 15.
- the Information Governance Group (IGG) - to ensure that the London Ambulance Service NHS Trust has clear direction of and management support for the activities required to comply with data quality principles; Caldicott principles; Information Security Management (ISO/IEC 17799 / ISO/IEC 27001); data protection legislation; the Freedom of Information Act 2000; the Data Security and Protection Toolkit; records management as defined by the Care Quality Commission (CQC); the Public Records Act; and the Information Governance Alliance Records Management Code of Practice for Health and Social Care.
- The Supply Chain Management Board - monitor compliance with standing orders, standing financial instructions and scheme of delegation regarding procurement and management of the supply chain and oversee development and implementation of third party supply category strategy plans.

60. The Audit Committee monitors risks and reviews the BAF. It critically reviews and reports on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance. The committee also receive internal and external audit report and ensures that all recommendations and actions are followed up.

61. The Finance and Investment Committee has responsibility for monitoring and reviewing the adequacy and utilisation of resources to assure the Board upon the risks relating to the efficient and effective delivery of strategic and operational plans and objectives. It monitors financial risks and reviews the BAF advising the Board of any material risks arising.

62. The Quality Assurance Committee has responsibility for providing the Trust Board with assurance on the achievement of strategic objectives in relation to the provision of a high quality, safe, and effective service. The Trust's definition of quality encompasses three equally important elements:

- Care that is safe – working with patients and their families to reduce avoidable harm and improve outcomes.
- Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients and their families.
- Care that provides a positive experience – to patients and their families.

63. The People and Culture Committee has responsibility for providing the Trust Board with assurance on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

64. Throughout 2020/21 the Logistics and Infrastructure Committee had responsibility for providing the Trust Board with assurance on and overseeing strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate. Cyber security has been assessed via internal audit and the recommendations and actions are being progressed. Consideration is currently being given to incorporating the remit of this Committee into that of the Finance and Investment Committee during 2021/22.
65. The Board has also established a time-limited Digital 999 Programme Assurance Committee, to provide assurance on the delivery of the Trust's Digital 999 Programme (replacement of the Computer Aided Dispatch system and implementation of the Electronic Patient Record Form).

Public Stakeholder involvement

66. The Trust ensures that its Commissioners are provided with regular reports and review meetings to understand the risks which may impact on the Trust.
67. The Trust Board meets at least six times a year in public and its papers are available on the Trust website. During 2020/21, in light of social distancing restrictions associated with COVID-19, the majority of Board meetings took place virtually. From September 2020 these meetings were available to the public for viewing on YouTube. The Board seeks to have as a regular item of business either 'a patient story' or 'a staff story' that enables members of the public or staff to present their experiences to the Board. There is also the opportunity, either through the Trust website or at the meeting on the day, to pose questions to the Trust Board on any matter of concern. This supports the Board's desire to be as open and transparent as possible. All matters are discussed or determined in public unless the matter would not be disclosed under Freedom of Information regulations.
68. In January 2020, the Board finalised plans to launch the London Ambulance Service Public and Patients Council (LASPPC). The aim of the LASPPC is to bring together a wide range of patients and the public representatives from across London at regular intervals to provide feedback on the services we provide and to help shape the way care is delivered. It will also advise the Trust on ways to gain broader engagement, as necessary. Dame Christine Beasley was appointed as an interim Chair of the LASPPC and its first meeting took place in June 2020. The LASPPC has also established eight sub-groups which focus on key areas of our work, including plans to transform our estate.
69. In September 2020, the Board agreed a new 'patients and communities engagement and involvement strategy' which was developed in partnership with the LASPPC and sets out a range of priorities to further enhance the way we involve and listen to patients and communities. This includes working with Healthwatch England, local Healthwatch and the LASPPC to co-design a visits (enter and view) programme – giving patient and public representatives access to our 999,111 and ambulance services so they can provide constructive feedback. The strategy will also see the establishment of a London Ambulance Service Youth Empowerment Squad – supporting young people to learn more about our work, share their feedback and influence our decision-making.

70. In addition to the above the Trust engages with the Greater London Assembly and other appropriate Health Overview and Scrutiny Committees (HOSCs), and also local Healthwatch organisations across London. This has included providing updates throughout the COVID-19 pandemic about our response to the crisis.
71. During consultation of the draft annual Quality Account engagement meetings are set and held around London for various stakeholders to attend for example the public, commissioners and HOSCs.
72. The Trust's comprehensive internet website provides the public with access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest. We also issue a range of bulletins to our partners and key stakeholders.

Corporate Governance Statement

73. The Trust, under Condition FT4 of its Licence, is required to submit to NHS Improvement a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Trust Board and submitted to the Regulator within the prescribed timescales. The Regulator received the statement and did not require a statement from its auditors either:
- confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or;
 - setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.
74. The Trust Board and its Assurance Committees each have an individual schedule of business, which ensures timely performance reporting through the correct governance process.
75. The Board receives regular reports from its Assurance Committees which provide assurance on detailed review and oversight from its own agenda items and reporting groups. The Board also receives a quality and performance report showing operational, financial, quality, clinical and corporate on trends, themes and key performance indicators.
76. The reports often show national benchmarking information from the other nine English ambulance trusts e.g. ambulance response time targets, ambulance quality indicators (AQI), finance and workforce.
77. The Trust has an approved Quality Impact Assessment Framework document. The Board of Directors is responsible for ensuring that transformational programmes designed to provide improved efficiencies do not adversely impact on the quality of the service to patients.

78. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

79. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations

Culture, Diversity and Inclusion

80. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Statutory measures for the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme and the Gender Pay Gap are all shared with the People and Culture Committee and then Trust Board. Trust wide trajectories and progress will be reported on a quarterly cycle.

81. We are committed to actively promoting equality and inclusivity and human rights among our organisation and ensuring equal and fair access to our services for all our patients and their families. We embrace diversity and recognise our responsibility to eliminate discrimination and harassment while supporting and empowering all our people.

82. COVID-19 has given us the opportunity to innovate within the Culture, Diversity and Inclusion work-stream moving forward. Our strategy will focus on hearing the voice of our patients and public.

83. We have learnt and embedded new ways of working from the lessons learnt during COVID-19. We have received positive feedback from corporate services staff working flexibly and remotely. There is still further work to be undertaken to understand the needs of all our staff, some of whom have also shown an interest in a blended approach to working from home and in the office.

84. We have received positive responses from staff and volunteers about our Wellbeing Hub, which has reinforced the necessity to undertake regular wellbeing conversations with staff; conversations which need to be normalised in our PDR and staff welfare discussions. Our response to the challenge of coordinating and vaccinating our staff and volunteers has been significant, and we have worked across the NHS to communicate with key stakeholder groups to address concerns in some cultural groups.

85. The Trust has responded to staff who are vulnerable, shielding or who are suffering from long COVID-19 conditions by making reasonable accommodations such as alternative duties and working from home.

86. We have now appointed an Associate Director of Culture, Diversity and Inclusion who will lead on aspects of Culture, Diversity and Inclusion with staff, patients and volunteers in 2021.

87. We are working towards ensuring our workforce better reflects the diversity of the population it serves in London. We end 2020/21 having recruited more than 200 BME staff, representing over 34% of all our new starters. We now have more than 1,100 BME staff which is 18% representation. There is still more to do to increase these numbers and we will continue to put time effort and attention into this work.
88. We have also worked hard to increase gender diversity and in 2020/21 49% of our senior leadership team (including Trust Board) is female. Overall our female representation Trust wide has increased to 49%.
89. Work has taken place with the College of Paramedics to improve BME admissions onto paramedic science degree courses across the country.
90. We are now in the third year of our Workforce Race Equality Action Plan (WRES) to address our ongoing challenges in this area. The WRES Action Plan Group, which is chaired by the CEO, meets quarterly to focus on driving this work forward.
91. The Trust has started on a journey to ensuring that the right organisational culture is in place to support its patients and staff. During 2020/21, in partnership with the LAS B-ME Network, we undertook activities in response to staff and patient concerns highlighted by the Black Lives Matter movement, including:
- Communication to all staff and volunteers from our Chair and CEO reinforcing that there is no place for racism in our organisation.
 - Drop-in sessions for BAME colleagues to offer a space for sharing, healing and learning.
 - During the summer “Silence is not the Answer” workshops, hosted by our CEO, were held for our managers. The purpose was to educate our managers about colleagues’ lived experience of racism, to provide a safe environment to listen and talk about racism and to enable managers to have conversations about racism with their teams.
 - Staff attended workshops to learn about how to be an ally to BAME colleagues and the importance of allies in encouraging effective dialogue around racism.
 - Work was done to review disciplinary cases to investigate the disparity in likelihood of entering the formal disciplinary process between white and BAME staff.
 - A Black Lives Matter Delivery Plan was formed with the aim of making improvements to the working lives of BAME staff and to improve our performance against the metrics measured as part of the Workforce Race Equality Standard (WRES).
92. The safety of female colleagues was brought to the fore following the murder of Sarah Everard. Actions taken by the Trust included:
- Our Wellbeing Hub offered support and advice.
 - Our Chair and female Executive Directors held drop-in sessions for female staff to share their experiences and concerns about working for the LAS.
 - We are reviewing the general risk assessment processes and are developing a new risk assessment training course.
 - Work is underway to form a Women’s Staff Network.
93. Other key events for 2020/21 included:

- Recognised and celebrated religious events.
- Created a cultural calendar with our Communications Team.
- Started a Cultural Audit of the Trust.
- Work with People and Culture colleagues to introduce our new Resolution Framework.
- Made progress on our WRES and WDES metrics.
- Created a new Recruitment and Selection training programme, including dedicated Recruitment and Selection training for BAME staff to support our aim to increase the diversity of recruitment panels.
- Work with universities to increase the diversity of LAS applicants in their education programmes.
- Analysis of 2020 Staff Survey results.
- Reviewing our Equality, Diversity and Inclusion Policy and enabling policies such as Disability, Recruitment and Menopause policies.
- Started work with AACE and our Communications Team to create an anti-racism campaign due to launch this summer.
- Put together a proposal for a scorecard to report CDI metrics.
- Engaged with Grant Thornton, who undertook an audit to provide assurance over the Trusts' Equality and Diversity control environment and to provide recommendations in line with good practice.

Carbon Reduction

94. The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

95. The Trust secures the economic, efficient and effective use of resources through a variety of means:

- A well-established policy framework (including Standing Financial Instructions).
- An organisational structure which ensures accountability and challenge through the committee structure.
- A clear planning process.
- Effective corporate directorates responsible for workforce, revenue and capital planning and control.
- Detailed monthly financial reporting including progress on achievement of Cost Improvement Programmes and year-end forecasting.

96. The Trust has in place a performance management framework aligned to both the corporate and sector divisional management structure. The framework includes a performance dashboard which includes a series of performance metrics and reflects metrics based on the Carter Report recommendations. The Trust Board reviews the operational, productivity and financial performance, and use of resources both at Trust and Divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the quality and performance report provided to each Board meeting.

97. The Board's business includes comprehensive reviews of performance against clinical, operational, workforce, corporate and financial indicators through the quality and performance report at each formal meeting. Any emerging issues are identified and mitigating action implemented.
98. The Trust's response to the COVID-19 pandemic involved the suspension of some of these measures during COVID-19 parts of 2020/21. The COVID-19 expenditure arrangements were reviewed by internal audit in February 2021 providing a finding of significant assurance with some improvement required. The improvement area identified has now been addressed.
99. The Finance and Investment Committee, which is chaired by a Non-Executive Director with other Non-Executive Directors also members, provides assurance to the Trust Directors as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Board Assurance Committees, in particular the Logistics and Infrastructure Committee, as appropriate. This Committee also has responsibility for providing assurance with regard to the Trust's procurement policies and procedures.
100. The Trust's commitment to value for money is strengthened by the effective and focused use of its Internal Audit service. The Trust engages Internal Auditors to provide an independent and objective assurance to the Board that the Trust's risk management, governance and internal control processes are operating effectively.
101. The Trust has a Local Counter Fraud Specialist (LCFS) supported as required by other qualified LCFS. Any concerns can be directed to the team and, any information is treated in the strictest confidence.
102. External Auditors, Internal Auditors and Counter Fraud report to each meeting of the Audit Committee, and also meet the members of the Audit Committee without Management present.

Information governance

103. The Trust continues to strengthen its arrangements for Information Governance by recruiting two new Managers, including an Information Security Manager. It has a robust programme of information governance improvements and awareness and a governance framework to monitor and assure the security of its information. An executive-led Information Governance Group exists as well as an Information Governance Strategy and Policy, along with a dedicated Information Security Policy.
104. Information governance incidents are reported on DatixWeb and the Information Governance Manager is alerted by email whenever an incident is reported on the system. These incidents are checked by the Information Governance Manager and, where appropriate, by the Quality Governance and Assurance team. Where there has been an incident, such as where we become aware of a loss of information outside the LAS, or there is a risk that personal data has been accessed or disclosed by one or more members of the public, a report is made on the Data Security and Protection Toolkit (DSPT) within 72 hours of the notification of the incident reaching the IG Manager. Each of these reportable incidents is assessed using the 5x5 Breach Assessment Grid in the

Guide to the Notification of Data Security and Protection Incidents. This document provides detailed guidance on the reporting of these incidents and should be read by all staff who have reporting rights in the Toolkit before any report is made.

105. Dependent on the nature of the incident, the information provided on the DSPT is sent to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and the National Cyber Security Centre. In 2020/21, three information governance incidents were notified via the DSPT. One of these was reported to the ICO. No action was taken by the ICO as a result of this.
106. Due to the outbreak of COVID-19, NHS Digital, who have responsibility for the DSPT assessment, have declared its submission deadline as 30th June 2021.

Data quality and governance

107. Data quality and governance within the Trust is headed up by the Data Quality Assurance team. In addition to its regular Integrated Performance Report to its Board, the Trust has in place a Data Quality Strategy which includes a governance structure, policy and implementation plan. Following the development of a rigorous methodology, Data Quality Reviews were carried out on 11 key systems and reporting arrangements used by the Trust during 2020/21. The reviews assessed the quality of data and actions were developed based on the findings and recommendations. Progress on these actions has been regularly monitored by the Trust's Information Governance Group (IGG) and the Quality Assurance Committee (QAC).
108. An internal audit on Data Quality was carried out during November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a significant level of assurance, the highest possible rating.

Review of effectiveness

109. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality assurance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.
110. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of deep dive and internal audit work. The BAF and monthly integrated quality and performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

111. The Trust received the following Head of Internal Audit Opinion for 2020/21:

“Significant assurance with some improvement required”

112. Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust’s BAF and Risk Register including NED review / challenge.
- Regular risk management activity reports to the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit Committee, Finance & Investment Committee and the Quality Assurance Committee.
- The ongoing development of the BAF.
- Consideration of a monthly Quality Improvement Programme report, allowing the Trust Board to monitor improvements in this area.
- The provision and scrutiny of a monthly Integrated Performance Report to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions.

113. The validity of the Corporate Governance Statement has been provided to me by the relevant Board Assurance Committees – most notably the Audit Committee, which have considered and commented on this statement, and by the external auditors.

114. All of the above measures serve to provide ongoing assurance to me, the Executive Committee and the Trust Board of the effectiveness of the system of internal control.

Conclusion

115. Whilst the Trust continues to work to improve its control environment, as set out above, two significant control issues were identified during 2020/21. The first issue was in relation to licence requirements with MHRA, with work continuing to mitigate this risk. The second issue was in relation to due diligence of the management of the transfer arrangements between previous providers under the Occupational Health contract.

116. A comprehensive action plan was developed in relation to contractual monitoring, procurement, recording and management of immunisation records. The work continues to strengthen the control arrangements in place. The Trust will complete delivery of the work programme and look to embed new processes as part of the retendering of its Occupational Health contract.

Signed.....

Chief Executive

Date: xx xx 2021

3. Remuneration and Staff Report

3.1 Remuneration

Our Remuneration and Nominations Committee consists of the Chair and the seven Non-executive Directors. The Chief Executive is usually in attendance but is not present when their own remuneration is discussed.

The Remuneration and Nominations Committee is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits (including pensions and cars), as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirements of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive Directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our Executive and Non-Executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 2 to 14.

Banded remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2020/21 was in the range of £230,001 to £235,000 on an annualised basis. The pay multiplier in 2020/21, based on annualised salary, was 6.0 times the median remuneration of the workforce, which was £38,846. In 2019/20, the banded remuneration of the highest paid director was in the range of £215,001 to £220,000. The pay multiplier in 2019/20, based on annualised salary, was 5.98 times the median remuneration of the workforce, which was £36,399. The increase in the median figure in comparison to 2019/20 is due to an increase in overtime and incentive payments.

In 2020/21, one employee received remuneration in excess of the highest-paid director. Remuneration was in the range of £285,001 to £290,000 (2019/20 £260,001 to £265,000).

The range of staff remuneration is £20,001 to £290,000 (2019/20 £20,001 to £265,000). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The appointment and remuneration of the Chair and the Non-Executive Directors are set nationally. Non-Executive Directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our external auditors.

Salary and pension entitlements of senior managers

A) Remuneration 2020/21

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Rommel Pereira, Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Jill Anderson, Non-Executive Director (from 1 st June 2020)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director (from 1 st April 2020 to 28 February 2021)	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Sheila Doyle, Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Jayne Mee, Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Amit Khutti, Associate Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Karim Brohi, Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Mark Spencer, Non-Executive Director	£10,001-£15,000	£0	£0	£0	£0	£10,001-£15,000
Garrett Emmerson, Chief Executive Officer	£220,001-£225,000	£0	£10,001-£15,000	£0	£0	£230,001-£235,000
Lorraine Bewes, Chief Finance Officer	£155,001-£160,000	£0	£0	£0	£0	£155,001-£160,000
John Martin, Chief Quality Officer (from 1 st March 2021)	£10,001-£15,000	£0	£0	£0	£45,001-£47,500	£55,001-£60,000
Fenella Wrigley, Chief Medical Officer	£115,001-£120,000	£4,700	£5,001-£10,000	£0	£197,501-£200,000	£325,001-£330,000
Patricia Bain, Chief Quality Officer (from 1 st April 2020 to 28 February 2021)	£125,001-£130,000	£0	£5,001-£10,000	£0	£0	£130,001-£135,000

Khadir Meer, Chief Operating Officer	£150,001-£155,000	£0	£0-£5,000	£0	£0	£155,001-£160,000
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The performance pay payments relate to the financial year 2019/20.

Salary and pension entitlements of senior managers (continued)

A) Remuneration 2019/20

Name and Title	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Rommel Pereira, Non-Executive Director (from 1 st February 2020)	£0-£5,000	£0	£0	£0	£0	£0-£5,000
John Jones, Non-Executive Director (from 1 st April 2019 to 31 December 2019)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director (from 1 st April 2019 to 29 th February 2020)	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Associate Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Karim Brohi, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Mark Spencer, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Garrett Emmerson, Chief Executive Officer	£210,001-£215,000	£0	£5,001-£10,000	£0	£0	£215,001-£220,000

Lorraine Bewes, Chief Finance Officer	£130,001-£135,000	£0	£5,001-£10,000	£0	£0	£140,001-£145,000
Paul Woodrow, Director of Operations (from 1 st April to 31 August 2019)	£50,001-£55,000	£2,700	£5,001-£10,000	£0	£65,001-£67,500	£125,001-£130,000
Fenella Wrigley, Chief Medical Officer	£115,001-£120,000	£4,700	£0	£0	£82,501-£85,000	£200,001-£205,000
Patricia Bain, Chief Quality Officer	£125,001-£130,000	£0	£0	£0	£0	£125,001-£130,000
Khadir Meer, Chief Operating Officer (from 2 nd September 2019)	£85,001-£90,000	£0	£0	£0	£40,001-£42,500	£130,001-£135,000

Paul Woodrow received £160,000 redundancy payment and a salary of £25,001 to £30,000 for the period 1st September to 29th November 2019 when he left the Trust. The performance pay payments relate to the financial year 2018/19.

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021
Heather Lawrence, Chairman	**	**	**	**	**	**	**
Jill Anderson, Non-Executive Director (from 1 st June 2020)	**	**	**	**	**	**	**
Fergus Cass, Non-Executive Director (from 1 st April 2020 to 28 February 2021)	**	**	**	**	**	**	**
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**
Amit Khutti, Associate Non-Executive Director	**	**	**	**	**	**	**
Karim Brohi, Non-Executive Director	**	**	**	**	**	**	**
Mark Spencer, Non-Executive Director	**	**	**	**	**	**	**
Rommel Pereira, Non-Executive	**	**	**	**	**	**	**
Garrett Emmerson, Chief Executive Officer	*	*	*	*	*	*	*

Lorraine Bewes, Chief Finance Officer	*	*	*	*	*	*	*
Fenella Wrigley, Chief Medical Officer	£7,501-£10,000	£22,501-£25,000	£55,001-£60,000	£130,001-£135,000	£882,333	£187,482	1,100,860
John Martin, Chief Quality Officer (from 1st March 2021)	£0-£2,500	£0-£2,500	£25,001-£30,000	£115,001-£120,000	£370,611	£743	£404,158
Patricia Bain, Chief Quality Officer (from 1st April 2020 to 28 February 2021)	*	*	*	*	*	*	*
Khadir Meer, Chief Operating Officer	*	*	*	*	*	*	*

*Garrett Emmerson, Lorraine Bewes and Patricia Bain are not members of the NHS Pension Scheme.

**Non-executive directors do not receive pensionable remuneration; there are no disclosures in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (23).

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Table 1: Exit packages

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£000s		£000s		£000s		£000s
£10,000 - £25,000								
£50,001 - £100,000	1	100			1	100		
£150,001 - £200,000								
Totals	1	100			1	100		

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

DRAFT

Reporting of other compensation schemes – Exit packages

	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirements contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	57
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	2	57

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	0
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at the time of reporting.	0
No. that have existed for between three and four years at the time of reporting.	0

No. that have existed for four or more years at the time of reporting.	0
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Table 2: New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll.	0
Number of engagements reassessed for consistency/ assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board member, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	0
Number of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

DRAFT

Staff report

Average Staff Numbers

The average number of staff has increased over last year 6,218 (2019/20 5,797) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	9	5	4
Ambulance Service	2,962	2,913	49
Administration and estates	1,801	1,696	105
Healthcare assistants and other support staff	1,414	1,388	26
Nursing, midwifery and health visiting staff	28	26	2
Scientific, therapeutic and technical	3	3	0
Total	6,218	6,032	186

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The “contracted hours” method of calculating whole time equivalent number should be used, that is, dividing the contracted hours of each employee by the standard working hours.

Staff Composition

At the end of March 2021, we had a workforce of 6,497 staff, made up of 3,234 men and 3,263 women. This was broken down as follows:

	Total	Female	Male
Directors	20	10	10
Senior Managers	283	118	165
Employees	6,194	3,135	3,059
Total	6,497	3,263	3,234

Over the course of the year, a total of 540 people left the service – a turnover rate of 8.1 per cent, compared to 9.5 per cent in 2019/20.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 216 paramedics left during 2020/21.

Staff Sickness

Information on sickness can be found on the NHS Digital site (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>).

Staff Policies

We embrace our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination, and we want to ensure that:

- patients and customers receive fair and equal access to our healthcare service;
- everyone is treated with dignity and respect; and
- staff experience fairness and equality of opportunity and treatment in their workplace.

We want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work;
- promoting and providing training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background; and
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

Staff Survey

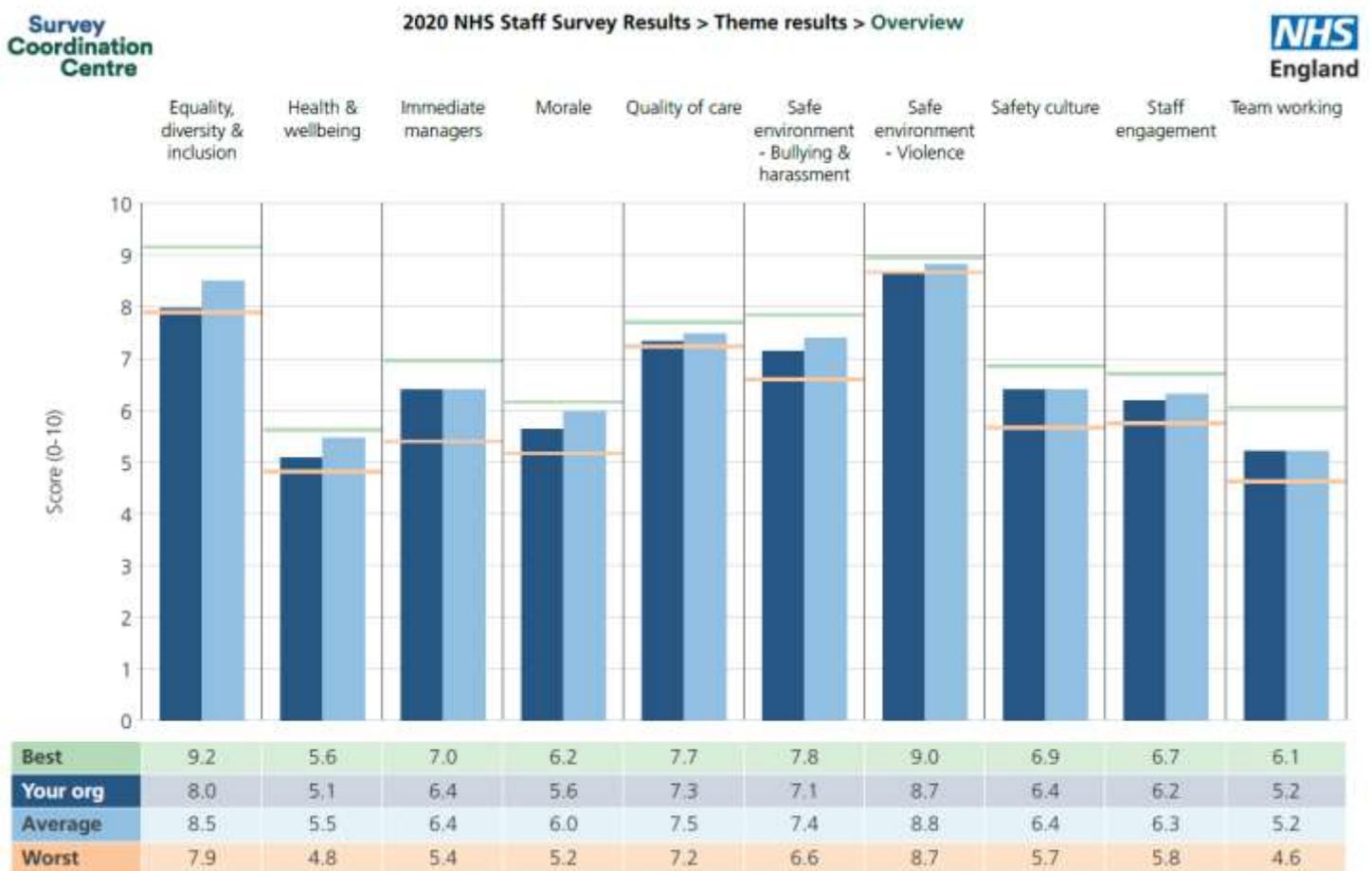
Our 2020 staff survey achieved a response rate of 72%, matching the record set last year. This compares exceptionally well to the average response rate of 56% for other ambulance trusts. Overall, 4,427 staff completed the survey, which is 212 more than last year.

We have seen statistically positive movement in 30 questions, but have gone backwards in 4. In the remaining 41 questions we've stayed about the same. Our overall staff engagement score, which tells us how staff feel about the organisation

generally, has increased slightly from 6.1 last year to 6.2 (on a scale of 1-10), comparing with an average of 6.3 for ambulance trusts. We've made progress in our areas of focus: Your Manager (immediate manager/senior manager); Health & Wellbeing (bullying or abuse from managers & colleagues) and Safety Culture (reporting of and learning from near misses and errors).

55% of staff would recommend the LAS as a place to work, 75% would be happy with the standard of care provided by the LAS if a friend or relative needed treatment and 61% believe care of patients/service users is the organisations top priority.

Analysis shows we are below average in seven of the ten survey themes, when compared with other ambulance trusts. The graph below shows there is still significant work to do if we want to be an employer of choice in the ambulance sector.



Work done since last year's survey

Following the publication of 2019's staff survey results, we focussed on engagement with and development of our core leaders/managers. We also improved the visibility of our senior managers through LAS TV Live and local operational briefings, as well as through the delivery of six sector conferences attended by the CEO, executive team members, and local senior managers (ADO/LGMs/CTMs). As a result, the 'Immediate Manager' and 'Senior Manager' scores (Questions 8a-9d) have all improved, as can be seen below. We shall therefore continue to focus on this area.

Q	Your Managers	2019	2020	Change
Q8a	My immediate manager encourages me at work	62%	64%	+2%
Q8b	Immediate manager can be counted on to help with difficult tasks	68%	70%	+2%
Q8c	Immediate manager gives clear feedback on my work	59%	60%	+1%
Q8d	Immediate manager asks for my opinion before making decisions that affect my work	40%	42%	+2%
Q8e	Immediate manager supportive in personal crisis	70%	75%	+5%
Q8f	Immediate manager takes a positive interest in my health & well-being	61%	65%	+4%
Q8g	Immediate manager values my work	62%	63%	+1%
Q9a	I know who senior managers are	69%	75%	+6%
Q9b	Communication between senior management and staff is effective	30%	35%	+5%
Q9c	Senior managers try to involve staff in important decisions	23%	25%	+2%
Q9d	Senior managers act on staff feedback	26%	28%	+2%

Throughout the last year and a result of COVID-19, we have also put considerable effort into improving the health and wellbeing offering to our staff. We have set up a wellbeing hub providing wayfinding support to staff; provided staff COVID-19 testing and immunisations; introduced tea trucks for operational staff; provided free food and drinks; assisted with accommodation needs.

Improvements

Significant improvements were made in 30 questions when compared to last year's scores. Our most improved questions are:

- In the last three months have you ever come to work despite not feeling well enough to perform your duties? - a fall of 10.3%
- There are enough staff at this organisation for me to do my job properly - score increased by 8.7%
- My organisation treats staff who are involved in an error, near miss or incident fairly - score increased by 4.5%
- I know who my senior managers are – increased by 3.8%
- I am able to meet all the conflicting demands on my time at work – increased by 4.8%

Where more work is required

The following questions received the lowest scores, when compared with the average for ambulance trusts:

- 42% of staff have not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public.
- 76% of staff have not experienced discrimination from patients/service users, their relatives or other members of the public
- 49% of staff have adequate materials, supplies and equipment to do their work
- 57% of staff have not experienced physical violence from patients/service users, their relatives or other members of the public
- 35% of staff reported their last experience of harassment, bullying or abuse.

Next steps

- **Safe environment – violence:** an ongoing public awareness campaign; introduction of body worn cameras and violence reduction officers. However, more needs to be done in this area to ensure staff understand what is not acceptable and report incidents so that action can be taken to secure police action where appropriate.
- **Equality, Diversity & Inclusion:** we have now recruited an Associate Director of Culture, Diversity and Inclusion who will be focussing on all aspects of EDI across the Trust. A cultural audit is underway; gender pay gap analysis is being completed; and a new inclusion policy is being created.
- **Health & Wellbeing:** we have recruited a permanent Head of Wellbeing to continue the progress we made over the last year in this area (moving from a score of 4.7 to 5.1). We are also re-tendering our Occupational Health provision.
- **Safe environment – bullying & harassment:** we will be continuing to focus on the development of our 'core leaders' and introducing a new resolution framework to create a just and learning culture with empowered managers across the organisation.

Expenditure on Consultancy

In 2020/21 the trust spent £0.3m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Garrett Emmerson, Chief Executive Officer

Organisation: London Ambulance Service NHS Trust

Signature:

Date:



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Self-Certification of Compliance with Provider Licence			
Agenda item:	10			
Report Author(s):	Trisha Bain, Interim Director of Corporate Affairs			
Presented by:	Trisha Bain, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting

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

Both NHS trusts and NHS Foundation Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution).

The purpose of self-certification is to ensure that providers carry out assurance on whether or not they can confirm compliance.

Condition G6 of the NHS provider licence requires that providers must have in place processes and systems which:

- a. Identify risks to compliance with the NHS provider licence; and
- b. Take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Condition FT4 of the NHS provider licence requires that providers must:

- a. review whether the governance systems they have in place achieve the objectives set out in the licence condition (i.e. are compliant with “those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS”); and
- b. set out any risks identified to good governance and mitigating actions taken to avoid these risks.

A detailed response to the requirements of Conditions G6 and FT4 of the NHS provider licence is set out in this report.

Recommendation(s) / Decisions for the Board / Committee:

The Trust Board is asked to agree that the Trust is compliant with Conditions G6 and FT4 of the NHS provider licence and endorse presentation and approve for the Chair and Chief Executive to sign this on behalf of the Board.

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

Directorate	Agreed			Relevant reviewer [name]	
Quality	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Finance	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Chief Operating Officer Directorates	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Medical	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Communications & Engagement	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Strategy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
People & Culture	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Corporate Affairs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	



Self-Certification of Compliance with Provider Licence

1.0. Introduction

1. Both NHS trusts and NHS Foundation Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution).

2.0. Self-certification requirement

2. NHS Trusts are required to self-certify after the end of the financial year that they are in compliance with Conditions G6(3) and FT4(8) of the NHS provider licence:
 - *Condition G6(3)* – The Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution; and
 - *Condition FT4(8)* – The provider has compliance with required governance arrangements
3. The purpose of self-certification is to ensure that providers carry out assurance on whether or not they can confirm compliance. How providers undertake this process is for them to decide.
4. Condition G6 of the NHS provider licence requires that providers must have in place processes and systems which:
 - a. Identify risks to compliance with the NHS provider licence; and
 - b. Take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.
5. Providers must annually review whether these processes and systems are effective.
6. Condition FT4 of the NHS provider licence requires that providers must:
 - a. review whether the governance systems they have in place achieve the objectives set out in the licence condition (i.e. are compliant with “those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS”); and
 - b. set out any risks identified to good governance and mitigating actions taken to avoid these risks.
7. A detailed response to the requirements of Conditions G6 and FT4 of the NHS provider licence is set out in Annex A to this report.

3.0. Recommendation

8. The Board is asked to agree that the Trust is compliant with Conditions G6 and FT4 of the NHS provider licence and endorse the Chair and Chief Executive to sign this on behalf of the Board.

Annex A: Self-assessment and certification of compliance with the Provider Licence

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Name

Heather Lawrence

Capacity

Chair

Date

Signature

Name

Garrett Emmerson

Capacity

Chief Executive

Date

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

Corporate Governance Statement

Response Risks and Mitigating actions

1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Confirmed

The Trust is compliant with health care standards that are binding which is demonstrated by the Trust being rated as “Good” overall following its CQC inspection in 2019. The Trust scored at level one for all elements of Use of Resources risk rating by NHS Improvement (NHSI). Under the NHSI Single Oversight Framework the Trust has been placed in segment 2.

The Trust's auditors, as part of its audit of the accounts, review and test systems and procedures for rigour and report any weaknesses to the Audit Committee. The auditors also review the contents of the Annual Report and the Annual Governance Statement and would be obliged to report any concerns. Furthermore, the Trust’s External and Internal Auditors attend the majority of Audit Committee meetings and Audit Committee members meet with Audit representatives on at least an annual basis without management present, which provides an opportunity for the Auditors to raise any concerns. The Chair of the Audit Committee reports to each meeting of the Board following each Audit Committee meeting, as does each of the Chairs of the Board Assurance Committees on a risk and assurance basis. The Chair of the Audit Committee also has private discussions with the Trust auditors outside of the meetings and away from the Executive.

The Director of Corporate Affairs has specific responsibility for maintaining good corporate governance and compliance, in particular complying with the Trust's licence to operate and also the requirements of its CQC registration. This individual is experienced and qualified to ensure that the Trust is aware of and complies with best practice in these areas.

It is essential to have robust systems of control in place for the Chief Executive Officer (and also the Accounting Officer) to sign the Annual Governance Statement. The Audit Committee reviews the content of the Annual Governance Statement and provides assurance to the Board and the Chief Executive, who also draw on a number of sources for assurance but a primary source of assurance is the opinion of the Head of Internal Audit and contained within the Annual Governance Statement.

The Trust has in place Standing Financial Instructions and a Scheme of Delegation that governs decision making within the Trust. The SFIs set out the scheme of delegations and those matters retained for determination by the Trust Board.

At each meeting the Trust Board receives a report on the management of strategic risks as set out in the Board Assurance Framework (BAF) and approves its content. Any risks to delivery of the Trust's strategy incorporated in this document, together with associated mitigations.

The Trust has in place policies and procedures to solicit declarations of interest from directors and senior managers, together with any declarations relating to the receipt of hospitality or external employment. These policies incorporate and raise awareness of Fraud and the content of the Bribery Act. The Board is aware of its obligations under the Bribery Act to have in place and publicise appropriate systems of propriety within the Trust. Directors and those who carry out the duties of a director are aware of the obligations under the fit and proper person test regulations. The Trust has also undertaken appropriate checks to fulfil its obligations under the regulations. The Directors are also aware of the Duty of Candour to which they are subject and encourage staff and patient feedback wherever possible. The Board approved the updated Conflicts of Interest Policy at its meeting in November 2019 which was updated in accordance with national guidance.

2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time

Confirmed

The Board is made aware of any appropriate guidance issued by CQC, NHSI or other bodies who disseminate corporate governance best practice through a number of means, including the Chair's Report, reports of the Director of Corporate Affairs, formal and informal Board briefings and briefings to Board Assurance Committees.

- 3 The Board is satisfied that the Licensee has established and implements:
- (a) Effective board and committee structures;
 - (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
 - (c) Clear reporting lines and accountabilities throughout its organisation.

Confirmed

Each year, the Board and Board Assurance Committees review their own performance and also their Terms of Reference, making appropriate recommendations to the Board. If appropriate, changes are made to the Terms of Reference of the relevant Committee or to the Committee structure. The Board approves any amendments to its corporate governance structure.

The Trust has in place a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate. In addition the Board has established a committee consisting of the chair and the other non-executive directors to consider the remuneration and allowances, and the other terms and conditions of office, of the executive directors including the Chief Executive Officer. The Board also has in place a Quality Assurance Committee, which has primary responsibility for monitoring and reviewing quality and clinical aspects of performance and development plans together with associated risks and controls and quality/clinical assurance to the Board. Other committees in place include the People and Culture Committee, the Finance and Investment Committee and the Logistics and Infrastructure Committee.

Finally the Board receives reports at each meeting from Executive Committee (ExCo) members through the Chief Executive Officers Report. The ExCo is responsible for the management of the Trust and is the senior executive decision making body of the organisation. The Trust's Board Assurance Committee structure includes the relevant executive director that has the lead and responsibility for reporting to each Committee as well as the Non-Executive Chair of the Board Assurance Committee.

The Trust's Standing Financial Instructions include a scheme of delegated authorities which was reviewed and approved by the Executive Committee and Audit Committee in April 2020. The Trust refers to and is compliant with its Standing Orders.

- 4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:
- (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
 - (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
 - (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to

Confirmed

The Trust secures the economic, efficient and effective use of resources through a variety of means:

- A well-established policy framework (including Standing Financial Instructions)
- An organisational structure which ensures accountability and challenge through the committee structure
- An clear planning process
- Effective corporate directorates responsible for workforce, revenue and capital planning and control
- Detailed monthly financial reporting including progress on achievement of Cost

standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

Improvement Programmes and year-end forecasting.

The Trust has in place a performance management framework aligned to both the corporate and sector divisional management structure. The framework includes a performance dashboard including metrics based on the Carter Report recommendations and includes a series of performance metrics. The Trust Board reviews the operational, productivity and financial performance, and use of resources both at Trust and Divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the quality and performance report provided to each Board meeting.

The Board's business includes comprehensive reviews of performance against clinical, operational, workforce, corporate and financial indicators through the quality and performance report at each formal meeting. Any emerging issues are identified and mitigating action implemented.

The Finance and Investment Committee which is Chaired by a Non-Executive Director with other Non-Executive Directors also members, provides assurance to the Trust Directors as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Board Assurance Committees, in particular the Logistics and Infrastructure Committee, as appropriate.

The Trust's commitment to value for money is strengthened by the effective and focused use of its Internal Audit service. The Trust engages Internal Auditors to provide an independent and objective assurance to the Board that the Trust's risk management, governance and internal control processes are operating effectively.

The Trust has a Local Counter Fraud Specialist (LCFS) supported as required by other qualified LCFS Local Counter Fraud Specialist (LCFS). Any concerns can be directed to the team and, any information is treated in the strictest confidence.

External Auditors, Internal Auditors and Counter Fraud report to each meeting of the Audit Committee, and also meet the members of the Audit Committee without management present.

The Chief Paramedic and Quality Officer and Medical Director submit regular reports to the Quality Assurance Committee, which escalates issues as appropriate to the Board, this includes information about patient experience and any reports of the CQC. The Board receives a report of current Serious Incidents at each meeting, and quarterly receives a report on themes and the learning that is taking place. The Serious Incident Group and the Quality Oversight Group regularly

consider the identification of high risk incidents and responses to these.

The Trust publishes with the agenda for each ordinary meeting of the Board and Information Pack, this contains and is available to view on the Trust's website:

- Operational Key Performance Indicators
- Corporate & Clinical Quality Indicators
- Financial Performance
- Workforce Indicators

The Board at each meeting receives a report from the Chair of the relevant committees on any matters of risk to the Trust.. The Board and Board Assurance Committee meetings are scheduled for the year ahead for agenda planning and the preparation of reports. Each director has responsibility for the preparation of reports. As stated previously the Board and Board Assurance Committee receive reports on the Board Assurance Framework, which has also been the subject of audit by the Trust's Internal Auditors.

During the course of the year, a control issue was identified in respect of the Trust's medicines management and compliance with Medicines & Healthcare products Regulatory Agency (MHRA) regulations. Since 2016, a pharmacist led review of the medicines packing and distribution function (at the Logistics Support Unit) is undertaken every 18 months. In addition, Grant Thornton carry out internal audits on a periodic basis. During a Chief Pharmacist-led review of medicines management at the Logistics Support Unit, it was identified that the Trust should acquire a MHRA Wholesale Dealers License. This control issue was identified due to a change in the way the MHRA inspects suppliers. In order to achieve a WDL, the Trust must work to Good Distribution Practice (GDP) systems and processes. At the time of the review the estate, staff, systems and processes were sub optimal mostly due to the position of the specialist function in the Trust structure

An additional control was identified via internal processes in relation to contract management of the Out of Hours immunisation service. A comprehensive action plan was produced to ensure risks were mitigated.

The above enables effective scrutiny and oversight by the Board of the Trust's operations. The Board has resolved that there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a "going concern". The statements on a 'Going Concern' basis means that management has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future with no necessity or plans either to liquidate or cease operations. If this were not the case it would be necessary to prepare the statements with the assumption that the business would not continue

beyond a further 12 months after the end of the accounting period. The Audit Committee recommended to the Board that there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern.

5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

- (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
- (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
- (c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
- (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
- (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
- (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Confirmed

The Remuneration and Nominations Committee of the Board considers the skills mix of the Executive Board members and Executive Committee members, which are triangulated against the capabilities required to provide organisational leadership in the current climate. The Board is compliant with appropriate statutory and good practice guidance in terms membership of the Board and senior management of the organisation.

The Chief Executive is the Accounting Officer of the Trust.

In addition to the Chief Executive and the Chief Finance Officer, the Chief Paramedic and Quality Officer, Chief Operating Officer and Chief Medical Officer are Executive Directors of the Trust. The Board also has two Non-Executive Directors with clinical backgrounds who are members of the Board's Quality Assurance Committee. The Board and the Quality Assurance Committee receive timely and up to date information on quality care that has been reviewed by clinicians prior to submission to the Board. The Quality Assurance Committee meets every other month and the Chair of the Committee reports to each meeting of the Board to provide assurance on matters of patient quality and safety, including learning and analysis of any incidents and near misses as part of influencing the Trust's clinical and operational procedures and policies.

The Board at every ordinary meeting receives a report of current Serious Incidents. The Trust uses Datix system for incident reporting and is implementing an Electronic Patient Care Record System which will further assist in electronic incident reporting.

The Board actively engages with members of the Local Health Economy on matters relating to patient care and quality; this includes Healthwatch and Health Overview and Scrutiny Committees and the Health and Well Being Boards.

6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and

Confirmed

The Board receives a report to each meeting on matters relating to the issues considered by the People and Culture Committee, in particular workforce and has in place a five year People and Culture Strategy. The Board regularly receives updates on mandatory training for both clinical and non-clinical staff. The Remuneration and

appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Nominations Committee regularly discusses the skills mix of the executive members of the Board.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name

Heather
Lawrence

Name

Garrett
Emmerson



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Annual Accounts 2020/21			
Agenda item:	11.1			
Report Author(s):	James Corrigan, Financial Controller			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	Audit Committee 23 April 2021			
Status:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Discussion
	<input checked="" type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Key Points, Issues and Risks for the Committee's attention:				
<p>Planning completed with NW London partners halfway through the year targeted a surplus of £2.394m (adjusted financial performance surplus of £2.326m) on the basis that all outstanding COVID-19 retrospective top up income claims were paid and the pandemic remained under control, however the new wave of COVID-19 put the Trust under increased pressure at the start of 2021. During March the Trust agreed with the NWL system a revised outturn of breakeven after funding increased annual leave costs.</p> <p>The Trust has delivered a surplus of £1.119m (adjusted financial performance surplus of £257k) which is £257k higher than the revised breakeven outturn agreed with NW London Health Care Partners. Operating costs increased by £115.9m and income increased by £116m compared to 2019/20 primarily due to COVID-19 impacts and funding.</p> <p>The Trust has met all of its key statutory financial duties (subject to audit) for 2020/21.</p>				
Recommendations for the Committee:				
The Trust Board is asked to note that the 23 April 2021 reviewed the draft annual accounts and approved the submission of the draft accounts to NHSI by the 27 th April 2021				

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	Agreed			Relevant reviewer [name]
Quality	Yes		No	
Finance	Yes		No	
Chief Operating Officer Directorates	Yes	X	No	Lorraine Bewes, CFO
Medical	Yes		No	
Communications & Engagement	Yes		No	
Strategy	Yes		No	

People & Culture	Yes		No	
Corporate Affairs	Yes		No	

London Ambulance Service NHS Trust

Annual accounts for the year ended 31 March 2021

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

Risk management is a key component of enhancing patient and staff care and is an integral part of the Trust's strategic management. It is the process whereby the Trust methodically addresses the risks related to its activities with the goal of achieving sustained benefits to patient care and to the LAS Strategy. The focus of risk management at the LAS is about being aware of potential problems, working through what effect they could have and planning to prevent the worst case scenario. This is achieved through ensuring clear leadership and accountabilities throughout the Trust.

The Chief Executive is accountable to the Board for the quality of risk management arrangements within the Trust. Operationally, responsibility for the implementation of risk management has been delegated to the Chief Paramedic and Quality Officer and the Director of Corporate Affairs.

The Director of Corporate Affairs supports Executive Committee (ExCo) members and Non-Executive Directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Trust Board, for maintaining the Board Assurance Framework (BAF). The BAF defines the principal risks to achieving the Trust's strategic objectives, together with associated controls, sources of assurance and action plans. The Chief Paramedic and Quality Officer is the quality governance lead for the Trust. She He is responsible for the Trust's Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. The Chief Paramedic and Quality Officer is also responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The holders of these two positions have continued to drive forward a significant workplan in 2020/21 to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level.

ExCo members individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to mitigate their associated risks to achieving the Trust's strategic objectives, including compliance with the Trust's licence.

The Trust Board's Assurance Committees have responsibility for providing assurance in respect of the effectiveness of these controls. A system of "key issues" assurance reports to the Trust Board is in place to highlight any risks to compliance. Board Assurance Committees are well attended by ExCo members and Non-Executive Directors as well as by other key Trust staff.

The Quality and Corporate Affairs Directorates also have a number of experienced and appropriately qualified staff to lead, support and advise staff at all levels across the organisation with the identification and management of risk.

The Risk Management Strategy and Policy sets out clearly defined roles and responsibilities for the senior leadership team and the risk register contains a clear definition of the Corporate (Trust Wide) Risk Register and the process for inclusion. This ensures that the right risks have been identified and prioritised for action. The Trust's Risk Compliance and Assurance Group (RCAG) meets regularly to review risk management and the Chief Paramedic and Quality Officer serves as Chair of the meeting. This ensures appropriate seniority and reflects this Officer's overall responsibility for risk management requirements up to and including the Corporate (Trust Wide) Risk Register. The Trust Risk Manager has continued to improve, strengthen and embed Risk Management systems and processes across the Trust by increased engagement (both operational and corporate) to raise, review and mitigate risk.

Staff - Training

The Trust provides a comprehensive mandatory and statutory training programme which includes governance and risk management awareness, ensuring that staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Risk Awareness' is in development and will be available to all staff through ESR in Q1/2. Currently this course is offered by the Trust Risk Manager face to face in small groups. All managers that are responsible for implementing the risk management procedure locally receive more specialist training to enable them to fulfil their responsibilities. This training is generally offered on a one to one basis and tailored to be relevant to suit the responsibilities and risks associated with their role. All risk management training is recorded centrally in ESR. Staff have access to comprehensive risk guidance and advice via Risk Management Leads in the Quality Directorate, information embedded in the Risk Management page on the Trust intranet and by referring to the Risk Management Procedure. The Trust Risk Manager also supports staff in risk reviews and escalation through monthly quality governance meetings. The recent internal audit of Risk Management indicated that overall key risk management personnel have a good understanding of the risk management process. Risk management training is provided to Executive Committee and Board members every two years, in respect to high level awareness of risk management and to ensure that risks aligned to their remit are reviewed. The Trust Board last received such training in September 2020.

The Trust's mandatory and statutory training programme is regularly reviewed to ensure that it remains responsive to the needs of Trust staff. There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. Despite significant operational pressures due to the impact of COVID-19, the Trust has been able to achieve average target levels of 84% compliance with mandatory and statutory training requirements during 2021/22. Monitoring and escalation arrangements are in place to ensure that the Trust maintains its current good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

The risk and control framework

Risk Management Strategy and Policy

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

The Risk Management Strategy and Policy, which was reviewed and amended in March 2020, provides the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds value to ongoing operational activities. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. Including but not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

The Trust's Risk Management Strategy and Policy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Identifying and Reporting Risk

Risks are identified routinely from a range of reactive/pro-active and internal/external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators etc. These are appropriately graded and ranked and included on the Trust's Corporate Risk Register and Board Assurance Framework (BAF). A Risk, Compliance and Assurance Group (RCAG) exists to review and monitor risks added to the Risk Register and regular reports from the Corporate Risk Register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place and remain appropriate. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process.

The Trust Board reviewed its approach to strategic risk management in September 2020. A new BAF format was adopted in line with the template recommended by NHS Providers (deemed to be best practice by industry standards). The new BAF format was reviewed by the Trust's internal auditors in February 2021. The Trust Board was provided with a significant level of assurance through this independent assessment of the BAF's operational effectiveness.

In accordance with the Trust Board's Scheme of Delegation, responsibility for the management /control and funding of a particular risk rests with the Directorate / Sector / Station concerned. However, where action to control a particular risk falls outside the control / responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment, or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the appropriate corporate committee, the RCAG, the ExCo or the Trust Board for a decision to be made.

Managing Risk

Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which are reviewed and amended as necessary on an annual basis.

Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In addition to standard incident reporting processes, the Trust has had a substantive full time Freedom To Speak Up (FTSU) guardian since 2018/19. Concerns raised through FTSU are all investigated and many have led to improvements in processes in a number of different parts of the service. At Board level, Fergus Cass was the Trust's Non-Executive Director lead for FTSU prior to stepping down from the Board in February 2021, at which point Amit Khutti took on this role.

Key events for FTSU:

- At present there are 25 Freedom to Speak Up advocates, all of whom have received training in how to promote the work of FTSU and support staff to raise concerns.
- Erica Green served as the Trust's FTSU guardian between May 2020 and Feb 2021. The role is currently filled by Katy Crichton on an interim basis.
- In August 2020, station administrator Carmen Peters was appointed as a full-time coordinator role to assist with supporting the Guardian, liaising with the advocates and providing an alternative pathway for staff to raise concerns if a conflict of interest occurs with the Guardian.
- The LAS FTSU team were finalists for the FTSU category at the HSJ Awards.
- The Guardian and coordinator are both allies of the B-ME Black and Minority Ethnic Network, Enabled Disability Network and the LGBT society. The FTSU coordinator is also the Engagement and welfare officer for the B-ME and Enabled Network.
- FTSU and B-ME Network collaborated on events and communications for Black History Month
- The Guardian gave a presentation at an International Women's day virtual event where she spoke about the work of Freedom to Speak Up.
- FTSU Month in October 2020, the Guardian and coordinator held a virtual event for the advocates. The Chair and the CEO gave virtual personal speeches virtually and the Leap team conducted a workshop around stress and boundaries.
- FTSU Month Guardian and coordinator also visited multiple sites across the services offering tea and coffee to staff on a tea truck, including visits to the LSU and 111 both sites.
- The Guardian and Coordinator ran virtual shielding mess rooms, for staff shielding due to the pandemic.
- The Guardian or coordinator were invited to the Resolution Framework meetings to help shape the implementation of this within the Trust.
- The FTSU coordinator attended in the White Ribbon campaign meetings.
- The FTSU page on the LAS intranet has been reviewed and refreshed. They are frequently updated with information about the advocates, how to speak up, and a news section and also contains information on the learning that has occurred as a result of FTSU.

- In collaboration with the LEAP team, The Freedom to Speak Up team produced a staff support and wellbeing document for all staff to access in light of the COVID-19 pandemic and from then onwards.
- An Infographic has been developed in order to help colleagues understand the speaking up process.

Business Planning and Service Development proposals do not proceed without an appropriate assessment of and therefore recognition / acceptance of the risks involved and the involvement of the relevant expertise. The Trust's ExCo reviewed and agreed the approach to be taken to quality impact assessments (including equality and data protection assessments) in December 2017. This has continued to be used in the Trust's Business Planning activities for 2020/21.

The design of the Trust's BAF was reviewed in September 2020 when a revised format was approved by the Board, incorporating more detailed mapping to strategic risks, tolerance levels and residual to target gap analysis. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Data Protection and Security Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via regular BAF / risk register reports and is supported by a robust Internal Audit Programme.

The Trust last considered its approach to risk management and approved its risk appetite statement in September 2020. The Board is currently considering longer term strategic risks faced by the Trust, including the incorporation of the longer term impact of COVID-19 within the core risks on its BAF. An assurance mapping exercise is being undertaken to create a more formalised, structured assurance reporting mechanism to the Board, which will highlight any anomalies, gaps and duplications of assurance to streamline the information provided to the Board.

The Board has had to focus on a number of emerging risks in 2020/21 including the increased pressure on the service due to the impact of; the COVID-19 pandemic, the transition arrangements for the UK's departure from the European Union; securing adequate funding arrangements to enable the Trust to deliver commissioned services and to support the Trust's modernisation programme. The Board has been closely monitoring the mitigation of risks relating to COVID-19 via the appropriate assurance committees, Executive Committee and the Audit Committee. The Finance and Investment Committee receive regular reports on progress with commissioning arrangements and the business case to support the modernisation programme.

Throughout 2020/21, the Trust continued to face unprecedented levels of demand associated with the commencement of first peak of the COVID-19 pandemic in March 2020 and the second in December 2020. Arrangements were put in place at the beginning of the first peak to enable changes to governance and assurance frameworks to ensure a prompt response to the pandemic and reduce burden at a time of significant operational pressure. Use of existing business continuity and GOLD structures for decision-making as well as amended executive decision-making and Board Assurance structures enabled the Trust to maintain control over its decision-making during this period. In order to ensure that all decisions were recorded appropriately, the Trust implemented a formal decision log. These arrangements were flexed to meet the decrease and increases in pressure throughout this period, some of which have been incorporated into BAU. The Trust requested a review to be carried out of the decision making process during the COVID-19 pandemic.

In order to ensure the maintenance of an appropriate control environment, existing controls were adapted to ensure that they maintained appropriate rigor, whilst recognising the significant operational pressures facing the organisation. These amendments included changes to the Standing Financial Instructions with regard to COVID-19-related expenditure.

The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust's Quality Strategy is based on the CQC fundamental standards. The Trust Board also agrees annual quality priorities.
- The Trust has a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director who is a clinician. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives and is supported by the bi-monthly Quality Oversight Group as well as local Sector/Service Quality Governance meetings. The Quality Assurance Committee provides a report of each meeting to the Trust Board.
- The Trust publishes an Annual Quality Account.
- Performance against key quality indicators are reported to the Trust Board in both the Trust's Quality Report and the Integrated Quality and Performance Report.
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Quality Improvement Plan which is monitored at the Organisational Performance Meeting and at local Service/Sector Quality Governance meetings

- A Station/Service Accreditation programme has been developed which aims to drive quality standards by empowering front line staff to make improvements in line with the Care Quality Commission's (CQC) fundamental standards. During 2020/2021, the trust run a pilot which was successful. The programme is planned for roll out this financial year and it is supported by the Patient & Public Council.
- The Trust has identified Non-Executive Directors to lead in respect of specific aspects of governance and risks. These roles are reviewed annually.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient & Public Council (PPC) representatives (e.g. Health Watch).
- Patient and Staff Stories are presented respectively to meetings of the Trust Board and actions and lessons learned are widely shared.
- The Trust has implemented the Patient Safety Incident Response Framework (PSIRF) as an early adopter. This approach allows the Trust to focus on driving improvement by addressing causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- The Trust has a safeguarding team and a patient experience team to oversee safeguarding matters and patient experience respectively.

In 2020/21 the key performance indicators reported to the Trust Board are being were rated for data quality as part of the Data Quality Reviews (further information available below). The following key work was undertaken throughout the year to ensure data quality with the Trust:

- Data Quality Reviews of 11 key systems or reporting arrangements were carried out to assess the quality of data.
- Actions were developed based on the findings and recommendations of these reviews which is regularly monitored by IGG (Information Governance Group) and QAC (Quality Assurance Committee).
- An internal audit by Grant Thornton on Data Quality was carried out in November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a SIGNIFICANT level of assurance (highest possible rating).

With regard to complying with the recommendations of "Developing Workforce Safeguards", the Trust:

- Has formed a Strategic Workforce Planning Group, which is chaired by our Chief Operating Officer / Deputy Chief Executive, and has clear oversight of risk management.
- Employs sufficient numbers of suitably qualified, skilled and experienced staff to meet the care and treatment needs of our patients safely and effectively.

In 2020/21 the Trust retained its focus on the strategic risks associated with workforce, through the BAF and through the People and Culture Committee. The People and Culture Committee has had a specific focus upon the development of a workforce planning model, providing assurance to the Board on this. The ExCo has also met as a Strategic Workforce Planning Group in 2020/21 and regularly received reports on strategic workforce planning activities, to provide additional oversight in this area.

Quality Strategy

The Trust has a clear quality strategy to direct quality governance and assurance from station to Trust Board. The Quality strategy aims to put patients and staff at the centre of everything we do and is underpinned by the Care Quality Commission's definition of quality. Alongside this, is a commitment to a just culture where reporting of both clinical and non-clinical incidents is central to continuous learning and improvement.

Quality Governance and assurance is supported by reliable information systems including Datix and Health Assure. These systems are a rich source of data which informs the Trust of its performance against various quality indicators. Each Sector has a dedicated Quality Governance and Assurance Manager (QGAM) to oversee Patient safety and the quality of service at Sector level. Their work is overseen by the Central Quality Oversight Group.

Every year, the Trust sets specific quality priorities which are reported in the annual Quality Account. These priorities are identified in consultation with both internal and external stakeholder to ensure they are relevant and robust for the coming year. The Trust routinely reviews its performance against its quality priorities and this is reported through the governance structures which include, sector governance meetings, the Quality Oversight Group, the Quality Assurance Committee and the Trust Board. There are processes in place to review performance regularly across the year to ensure that gains are consolidated and any learning is utilised as part of the wider quality improvement plan. These processes include a series of Sector peer reviews and quality performance reviews which are designed to test how well the Trust is doing against the CQC's key lines of enquiry. The outcome of these reviews are reported to relevant teams and meetings to guide decisions and actions.

CQC registration and compliance with the NHS provider licence

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

During 2020/21, CQC inspection activities at the Trust included regular engagement calls and virtual monitoring meetings.

The CQC's overall rating of the Trust remains "Good".

The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence at its meeting in May 2021. This assessment was reached following an internal review of the Trust's corporate governance framework.

With respect to condition FT4 (NHS Foundation Trust governance arrangements), the Board reviews the terms of reference of its Assurance Committees on an annual basis to ensure their effectiveness and last did so in May 2021. The Trust has an Audit Committee consisting of Non-Executive Directors. The Audit Committee regularly meets with the internal and external auditors without the presence of executive directors or staff. In addition, the Local Counter Fraud specialist presents a report to every meeting of the Audit Committee on measures to tackle Fraud, Bribery and Corruption and also the importance of reporting concerns as appropriate. The Trust also has a Remuneration and Nominations Committee consisting of the Non-Executive Directors, joined when appropriate, by the Chief Executive, the Director of People and Culture and the Director of Corporate Affairs. In addition, the Board has established a number of Assurance Committees which focus on key aspects of the Trust's work. Each Committee is chaired by a Non-Executive Director. All Committees and sub Groups undertake an annual self-assessment of their effectiveness, which is reported to the Board (or the appointing Committee in the case of sub groups). The Audit Committee also submits an Annual Report to the Trust Board and regularly reviews the Standing Financial Instructions and Scheme of Delegation.

The terms of reference also serve to define the responsibilities, accountabilities and reporting lines of each Assurance Committee. The Board receives a report following each Assurance Committee meeting, written or approved by the Non-Executive Director Chair, and is therefore able to both receive assurance but also challenge any of the decisions made. Each Assurance Committee also has one identified lead Executive Director. The responsibilities of the Board and its Directors are defined in the Trust's Standing Orders and Standing Financial Instructions, which were reviewed in May 2020.

The Board has an annual schedule of business, which is reviewed at each formal meeting of the Board. The schedule defines when reports will be submitted, ensuring that the Board can operate timely and effective scrutiny of its operations. Key performance reports covering corporate, clinical, quality, workforce, finance and operational performance are received at each formal meeting of the Board and are made available on the Trust's website.

The Remuneration and Nominations Committee reviews, when necessary, the directorate portfolios, and there is a clear organisational structure with staff and managers identified within each directorate, who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. Elsewhere within this report can be found the Trust's duty to operate efficiently, economically and effectively.

The reports submitted to each formal meeting of the Board enables timely and effective scrutiny and oversight by the Board of the Licensee's operations. These are also published on the website. In addition, directors have access to up to date operational information, as well as receiving the details of any serious incidents reported.

The Trust is compliant with health care standards that are binding which is demonstrated by the Trust being rated as "Good" overall following the CQC inspection in 2019. As part of gaining assurance Board and ExCo members are encouraged to visit staff in the sectors with each director allocated to a particular sector. In addition, at each meeting of the Board there is an opportunity to hear either a staff or patient story.

The Quality Assurance Committee receives regular reports from clinical and operational staff and through a number of documents such as the Serious Incident Reports, Quality Oversight Group, and claims and inquests update are able to have oversight and challenge the Trust in relation to the quality of patient care. The Trust's Chief Medical Officer, Chief Paramedic and Quality Officer and the Director of Corporate Affairs attend all meetings of the Committee. In addition, the Committee is chaired by a clinician who is a Non-Executive Director of the Trust.

Roles and Responsibilities

The Trust Board holds overall responsibility for the management of risks within the Trust. The Board ensures significant risks to the Trust's ability to provide a quality service are identified and managed. They review all significant risks at each formal meeting.

Non-Executive Directors seek assurance in relation to the performance of the ExCo in meeting agreed goals and objectives. They are required to satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

The Chief Executive is responsible for ensuring that a system is in place for reporting of all incidents.

All ExCo members hold responsibility for the identification and management of their risks and ensure they are documented, registered and updated in a timely fashion for the relevant forums to review. They are responsible for the risk management process within the Trust and as such ensure:

- the review of risk and risk registers is maintained in accordance with Trust strategy
- all staff have the ability to identify risks and propose they are assessed and entered onto the relevant section of the Trust Risk Register
- monitoring and timely review of the Risk Management Strategy and associated policies
- provision of expert advice into the incident reporting process
- all Managers within their Directorate are familiar and act in accordance with Trust policies
- incidents are reported and investigated in accordance with the Trust's Incident Reporting Process.

There were a number of changes to the Trust's senior personnel in 2019/20 2020/21:

- Kim Nurse joined the Trust in the role of Interim Director of People and Culture in November 2020, replacing Ali Layne-Smith.
- Trisha Bain left the role of Chief Quality Officer in February 2021 and was replaced by John Martin in March 2021 as the Trust's new Chief Paramedic and Quality Officer.
- Fergus Cass' term of appointment as Non-Executive Director and Chair of the Trust's Finance and Investment Committee came to an end at the end of February 2021, at which point he left the Trust.
- Jill Anderson was appointed as an Associate Non-Executive Director with effect from 1 June 2020.

The Board Assurance Committees and Executive Committee sub-groups provide a process for the escalation and delegation of assurance and risk throughout the Trust.

The purpose of the Executive Committee (ExCo) is to lead and manage the performance of the Trust within the strategic framework established by the Trust Board. The ExCo makes proposals to the Trust Board on key policy and service issues for Trust Board decision. The ExCo meets in a number of different forms throughout each month to focus on different aspects of the Trust's operations. As the Portfolio Management Board, it manages the portfolio of programmes and projects in place to deliver the Trust's Business Plan; as the Strategic Workforce Planning Group, it focuses on the actions required to ensure that the Trust will have the resources it requires to deliver its Strategy; and as the Performance Review Meeting, it retains detailed oversight of every aspect of the Trust's performance.

The ExCo has also established the following sub-groups:

- the Risk Compliance and Assurance Group (RCAG) - to oversee the governance of the risk management process and management of risks rated greater than 15;
- the Information Governance Group (IGG) - to ensure that the London Ambulance Service NHS Trust has clear direction of and management support for the activities required to comply with data quality principles; Caldicott principles; Information Security Management (ISO/IEC 17799 / ISO/IEC 27001); data protection legislation; the Freedom of Information Act 2000; the Data Security and Protection Toolkit; records management as defined by the Care Quality Commission (CQC); the Public Records Act; and the Information Governance Alliance Records Management Code of Practice for Health and Social Care.

The Audit Committee monitors financial risks and reviews the BAF. It critically reviews and reports on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

The Finance and Investment Committee has responsibility for monitoring and reviewing the adequacy and utilisation of resources to assure the Board upon the risks relating to the efficient and effective delivery of strategic and operational plans and objectives. It monitors financial risks and reviews the BAF advising the Board of any material risks arising.

The Quality Assurance Committee has responsibility for providing the Trust Board with assurance on the achievement of strategic objectives in relation to the provision of a high quality, safe, and effective service. The Trust's definition of quality encompasses three equally important elements:

- Care that is safe – working with patients and their families to reduce avoidable harm and improve outcomes.
- Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients and their families.
- Care that provides a positive experience – to patients and their families.

The People and Culture Committee has responsibility for providing the Trust Board with assurance on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

Throughout 2020/21 the Logistics and Infrastructure Committee has had responsibility for providing the Trust Board with assurance on and overseeing strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate. Consideration is currently being given to incorporating the remit of this Committee into that of the Finance and Investment Committee during 2021/22.

The Board has also established a time-limited Digital 999 Programme Assurance Committee, to provide assurance on the delivery of the Trust's Digital 999 Programme (replacement of the Computer Aided Dispatch system and implementation of the Electronic Patient Record Form).

Public Stakeholder Involvement

The Trust ensures that its Commissioners are provided with regular reports and review meetings to understand the risks which may impact on the Trust.

The Trust Board meets at least six times a year in public and its papers are available on the Trust website. During 2020/21, in light of social distancing restrictions associated with COVID-19, the majority of Board meetings took place virtually. From September 2020 these meetings were available to the public for viewing on YouTube. The Board seeks to have as a regular item of business either 'a patient story' or 'a staff story' that enables members of the public or staff to present their experiences to the Board. There is also the opportunity, either through the Trust website or at the meeting on the day, to pose questions to the Trust Board on any matter of concern. This is all part of the Board's desire to be as open and transparent as possible. All matters are discussed or determined in public unless the matter would not be disclosed under Freedom of Information regulations.

In January 2020, the Board finalised plans to launch the London Ambulance Service Public and Patients Council (LASPPC). The aim of the LASPPC is to bring together a wide range of patients and the public representatives from across London at regular intervals to provide feedback on the services we provide and to help shape the way care is delivered. It will also advise the Trust on ways to gain broader engagement, as necessary. Dame Christine Beasley was appointed as an interim Chair of the LASPPC and its first meeting took place in June 2020. The LASPPC has also established eight sub-groups which focus on key areas of our work, including plans to transform our estate.

In September 2020, the Board agreed a new 'patients and communities engagement and involvement strategy' which was developed in partnership with the LASPPC and sets out a range of priorities to further enhance the way we involve and listen to patients and communities. This includes working with Healthwatch England, local Healthwatch and the LASPPC to co-design a visits (enter and view) programme – giving patient and public representatives access to our 999,111 and ambulance services so they can provide constructive feedback. The strategy will also see the establishment of a London Ambulance Service Youth Empowerment Squad – supporting young people to learn more about our work, share their feedback and influence our decision-making.

In addition to the above the Trust engages with the Greater London Assembly and other appropriate Health Overview and Scrutiny Committees (HOSCs), and also local Healthwatch organisations across London. This has included providing updates throughout the COVID-19 pandemic about our response to the crisis.

During consultation of the draft annual Quality Account engagement meetings are set and held around London for various stakeholders to attend for example the public, Commissioners and HOSCs.

The Trust's comprehensive internet website provides the public with access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest. We also issue a range of bulletins to our partners and key stakeholders.

Corporate Governance Statement

The Trust, under Condition FT4 of its Licence, is required to submit to NHS Improvement a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Trust Board and submitted to the Regulator within the prescribed timescales. The Regulator received the statement and did not require a statement from its auditors either:

- confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or;
- setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

The Trust Board and its Assurance Committees each have an individual schedule of business, which ensures timely performance reporting through the correct governance process.

The Board receives regular reports from its Assurance Committees which provide assurance on detailed review and oversight from its own agenda items and reporting groups. The Board also receives a quality and performance report showing operational, financial, quality, clinical and corporate on trends, themes and key performance indicators.

The reports often show national benchmarking information from the other nine English ambulance trusts e.g. ambulance response targets (ARP), ambulance quality indicators (AQI), finance and workforce.

The Trust has an approved Quality Impact Assessment Framework document. The Board of Directors is responsible for ensuring that transformational programmes designed to provide improved efficiencies do not adversely impact on the quality of the service to patients.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Statutory measures for the Workforce Race Equality Scheme (WRES), the Workforce Disability Equality Scheme and the Gender Pay Gap are all shared with the People and Culture Committee and then Trust Board. Trust wide trajectories and progress will be reported on a quarterly cycle.

We are committed to actively promoting equality and inclusivity and human rights among our organisation and ensuring equal and fair access to our services for all our patients and their families. We embrace diversity and recognise our responsibility to eliminate discrimination and harassment while supporting and empowering all our people.

COVID-19 has given us the opportunity to innovate within the Equality, Diversity and Inclusion work-stream moving forward. Our strategy will focus on hearing the voice of our patients and public.

We will learn and embed new ways of working from the lessons learnt during COVID. We have received positive feedback from Corporate Services staff working flexibly and remotely. There is still further work to be undertaken to understand the needs of all our staff, some of whom have also shown an interest in a blended approach to working from home and in the office.

We have received positive responses from staff and volunteers about our Wellbeing Hub, which has reinforced the necessity to undertake regular wellbeing conversations with staff; conversations which need to be normalised in our PDR and staff welfare discussions. Our response to the challenge of coordinating and vaccinating our staff and volunteers has been significant, and we have worked across the NHS to communicate with key stakeholder groups to address concerns in some cultural groups.

The Trust has responded to staff who are vulnerable, shielding or who are suffering from long COVID conditions by making reasonable accommodations such as alternative duties and working from home.

We have now appointed an Associate Director of Culture, Diversity and Inclusion who will lead on aspects of Equality, Diversity and Inclusion with staff, patients and volunteers in 2021.

We are working towards ensuring our workforce reflects the diversity of the population it serves in London. We end 2020/21 having recruited more than 200 BME staff, representing over 34% of all our new starters. We now have more than 1,100 BME staff which is 18% representation. There is still more to do to increase these numbers and we will continue to put time effort and attention into this work.

We have also worked hard to increase gender diversity and 49% of our senior leadership team (including Trust Board) is female. Overall our female representation Trust wide has increased to 49%.

Work has taken place with the College of Paramedics to improve BME admissions onto paramedic science degree courses across the country.

We are now in the third year of our Workforce Race Equality Action Plan to address our ongoing challenges in this area. The WRES Action Plan Group, which is chaired by the CEO, meets quarterly to focus on driving this work forward.

Other key events for 2020/21 include:

- Recognise and celebrate religious events
- Create a cultural calendar with our Communications Team
- Undertake a Cultural Audit of the Trust
- Work with People and Culture to introduce our new Resolution Framework
- Make progress on our WRES and WDES metrics
- Introduce a Women's Forum within the Trust
- Introduce a new interview and recruitment training programme
- Work with universities to increase the diversity of LAS applicants in their education programmes
- Implement our Equality, Diversity and Inclusion Policy and enabling policies such as, Disability, Recruitment and Menopause this year
- Create a Carers Network, for staff with caring responsibilities

Carbon Reduction

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust secures the economic, efficient and effective use of resources through a variety of means:

- A well-established policy framework (including Standing Financial Instructions)
- An organisational structure which ensures accountability and challenge through the committee structure
- A clear planning process
- Effective corporate directorates responsible for workforce, revenue and capital planning and control
- Detailed monthly financial reporting including progress on achievement of Cost Improvement Programmes and year-end forecasting.

The Trust has in place a performance management framework aligned to both the corporate and sector divisional management structure. The framework includes a performance dashboard which includes a series of performance metrics and reflects metrics based on the Carter Report recommendations. The Trust Board reviews the operational, productivity and financial performance, and use of resources both at Trust and Divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the quality and performance report provided to each Board meeting.

The Board's business includes comprehensive reviews of performance against clinical, operational, workforce, corporate and financial indicators through the quality and performance report at each formal meeting. Any emerging issues are identified and mitigating action implemented.

The Trust's response to the COVID-19 pandemic involved the suspension of some of these measures during parts of 2020/21. The COVID-19 expenditure arrangements were reviewed by internal audit in February 2021 providing a finding of significant assurance with some improvement required. The improvement area identified has now been addressed.

The Finance and Investment Committee, which is Chaired by a Non-Executive Director with other Non-Executive Directors also members, provides assurance to the Trust Directors as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Board Assurance Committees, in particular the Logistics and Infrastructure Committee, as appropriate. This Committee also has responsibility for providing assurance with regard to the Trust's procurement policies and procedures.

The Trust's commitment to value for money is strengthened by the effective and focused use of its Internal Audit service. The Trust engages Internal Auditors to provide an independent and objective assurance to the Board that the Trust's risk management, governance and internal control processes are operating effectively.

The Trust has a Local Counter Fraud Specialist (LCFS) supported as required by other qualified LCFS. Any concerns can be directed to the team and, any information is treated in the strictest confidence.

External Auditors, Internal Auditors and Counter Fraud report to each meeting of the Audit Committee, and also meet the members of the Audit Committee without Management present.

Information Governance

The Trust continues to strengthen its arrangements for Information Governance by recruiting two new Managers, including an Information Security Manager. It has a robust programme of information governance improvements and awareness and a governance framework to monitor and assure the security of its information. An executive-led Information Governance Group exists as well as an Information Governance Strategy and Policy, along with a dedicated Information Security Policy.

Information governance incidents are reported on DatixWeb and the Information Governance Manager is alerted by email whenever an incident is reported on the system. These incidents are checked by the Information Governance Manager and, where appropriate, by the Quality Governance and Assurance team. Where there has been an incident, such as where we become aware of a loss of information outside the LAS, or there is a risk that personal data has been accessed or disclosed by one or more members of the public, a report is made on the Data Security and Protection Toolkit (DSPT) within 72 hours of the notification of the incident reaching the IG Manager. Each of these reportable incidents is assessed using the 5x5 Breach Assessment Grid in the Guide to the Notification of Data Security and Protection Incidents. This document provides detailed guidance on the reporting of these incidents and should be read by all staff who have reporting rights in the Toolkit before any report is made.

Dependent on the nature of the incident, the information provided on the DSPT is sent to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and the National Cyber Security Centre. In 2020/21, three information governance incidents were notified via the DSPT. One of these was reported to the ICO. No action was taken by the ICO as a result of this.

Due to the outbreak of COVID-19, NHS Digital, who have responsibility for the DSPT assessment, have declared its submission deadline as 30th June 2021.

Data Quality and Governance

Data quality and governance within the Trust is headed up by the Data Quality Assurance team. In addition to its regular Integrated Performance Report to its Board, the Trust has in place a Data Quality Strategy which includes a governance structure, policy and implementation plan. Following the development of a rigorous methodology, Data Quality Reviews were carried out on 11 key systems and reporting arrangements used by the Trust during 2020/21. The reviews assessed the quality of data and actions were developed based on the findings and recommendations. Progress on these actions has been regularly monitored by the Trust's Information Governance Group (IGG) and the Quality Assurance Committee (QAC).

An internal audit on Data Quality was carried out during November 2020. The audit reviewed the design and operation of the Data Quality control environment and concluded that the process has provided a significant level of assurance, the highest possible rating.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality assurance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of deep dive and internal audit work. The BAF and monthly integrated quality and performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

The Trust received the following Head of Internal Audit Opinion for 2020/21:

“Significant assurance with some improvements”

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust’s BAF and Risk Register including NED review / challenge.
- Regular risk management activity reports to the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit Committee, Finance & Investment Committee and the Quality Assurance Committee.
- The ongoing development of the BAF
- Consideration of a monthly Quality Improvement Programme report, allowing the Trust Board to monitor improvements in this area.
- The provision and scrutiny of a monthly Integrated Performance Report to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions.

The validity of the Corporate Governance Statement has been provided to me by the relevant Board Assurance Committees – most notably the Audit Committee, which have considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Committee and the Trust Board of the effectiveness of the system of internal control.

Conclusion

Whilst the Trust continues to work to improve its control environment, as set out above, no significant control issues have been identified.

Signed.....Chief Executive

Date.....

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum* . These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

.....Date.....Chief Executive

.....Date.....Chief Finance Officer

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST

Opinion

We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2020 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2019/20 HM Treasury's Financial Reporting Manual (the 201820 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2019/20 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGNO1 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter — Property Plant and Equipment valuation

We draw attention to Note 1.23 Sources of estimation uncertainty and Note 15 Revaluations of property, plant and equipment of the financial statements, which describes the valuation uncertainty the Trust is facing as a result of COVID-19 in relation to property valuations. Our opinion is not modified in respect of this matter.

Emphasis of matter — Disclosures in relation to the effects of COVID-19

We draw attention to Note 1.2 of the financial statements, which describes the Financial and operational consequences the Trust is facing as a result of COVID-19 which is impacting patient demand, personnel available for work and being able to access offices. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report on pages 1 to XX, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST CONT'D

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2008 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014: or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in these respects.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 15, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST CONT'D

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of London Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to State to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

*Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
23 June 2020*

The maintenance and integrity of the London Ambulance Service NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters, and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income

		2020/21	2019/20
	Note	£000	£000
Operating income from patient care activities	3	496,419	428,408
Other operating income	4	71,204	10,151
Operating expenses	5, 7	(562,683)	(433,604)
Operating surplus/(deficit) from continuing operations		4,940	4,955
Finance income	10	9	189
Finance expenses	11	36	(45)
PDC dividends payable		(3,432)	(4,846)
Net finance costs		(3,387)	(4,702)
Other gains / (losses)	12	(393)	(59)
Surplus / (deficit) for the year		1,160	194
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(6,043)	297
Revaluations	15	322	3,112
Total comprehensive income / (expense) for the period		(4,561)	3,603
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		1,160	194
Remove net impairments not scoring to the Departmental expenditure limit		1,473	(55)
Remove I&E impact of capital grants and donations		(480)	35
Remove 2018/19 post audit PSF reallocation (2019/20 only)			(125)
Remove net impact of inventories received from DHSC group bodies for COVID response		(1,896)	
Adjusted financial performance surplus / (deficit)		257	49

Statement of Financial Position

		31 March 2021	31 March 2020
	Note	£000	£000
Non-current assets			
Intangible assets	13	13,089	8,183
Property, plant and equipment	14	194,053	177,183
Total non-current assets		207,142	185,366
Current assets			
Inventories	16	6,440	4,508
Receivables	17	26,606	22,270
Cash and cash equivalents	18	39,787	25,964
Total current assets		72,833	52,742
Current liabilities			
Trade and other payables	19	(80,605)	(46,815)
Provisions	22	(7,557)	(6,584)
Other liabilities	20	(251)	(193)
Total current liabilities		(88,413)	(53,592)
Total assets less current liabilities		191,562	184,515
Non-current liabilities			
Borrowings	21	(107)	(107)
Provisions	22	(8,381)	(8,436)
Total non-current liabilities		(8,488)	(8,543)
Total assets employed		183,074	175,972
Financed by			
Public dividend capital		77,840	66,178
Revaluation reserve		47,907	55,620
Other reserves		(419)	(419)
Income and expenditure reserve		57,745	54,593
Total taxpayers' equity		183,074	175,972

The notes on pages 25 to 64 form part of these accounts.

Name
Position
Date

10 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	66,178	55,620	-	(419)	-	54,593	175,972
At start of period for new FTs	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	1,160	1,160
Other transfers between reserves	-	(1,992)	-	-	-	1,992	-
Revaluations	-	322	-	-	-	-	322
Public dividend capital received	11,662	-	-	-	-	-	11,662
Taxpayers' and others' equity at 31 March 2021	77,840	47,907	-	(419)	-	57,745	183,074

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	64,356	54,070	-	(419)	-	52,540	170,547
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2019 - restated	64,356	54,070	-	(419)	-	52,540	170,547
At start of period for new FTs	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	194	194
Other transfers between reserves	-	(1,859)	-	-	-	1,859	-
Impairments	-	297	-	-	-	-	297
Revaluations	-	3,112	-	-	-	-	3,112
Public dividend capital received	1,822	-	-	-	-	-	1,822
Taxpayers' and others' equity at 31 March 2020	66,178	55,620	-	(419)	-	54,593	175,972

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

This reserve was created when London Ambulance Service became a NHS Trust. The negative reserve balance was caused by the legal title of a property not being properly transferred from NHS Estates when the Trust was created. Once the error had been identified, the London Ambulance Service NHS Trust purchased the property from the NHS Estates and this led to a negative reserve being created.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	2020/21	2019/20
Note	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit)	4,940	4,955
Non-cash income and expense:		
Depreciation and amortisation	5.1 14,548	11,535
Net impairments	6 1,473	(55)
Income recognised in respect of capital donations	4 (539)	-
(Increase) / decrease in receivables and other assets	(3,593)	4,643
(Increase) / decrease in inventories	(1,932)	(1,871)
Increase / (decrease) in payables and other liabilities	29,407	4,054
Increase / (decrease) in provisions	963	1,352
Other movements in operating cash flows	-	-
Net cash flows from / (used in) operating activities	45,267	24,613
Cash flows from investing activities		
Interest received	19	199
Purchase of intangible assets	(9,178)	(1,755)
Purchase of PPE and investment property	(30,258)	(16,039)
Sales of PPE and investment property	25	46
Receipt of cash donations to purchase assets	488	-
Net cash flows from / (used in) investing activities	(38,904)	(17,550)
Cash flows from financing activities		
Public dividend capital received	11,662	1,822
Other interest	(10)	(20)
PDC dividend (paid) / refunded	(4,192)	(4,620)
Net cash flows from / (used in) financing activities	7,460	(2,818)
Increase / (decrease) in cash and cash equivalents	13,823	4,246
Cash and cash equivalents at 1 April - brought forward	25,964	21,718
Cash and cash equivalents at 31 March	39,787	25,964

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

[Going concern accounting policy to be provided separately for providers to paste in at a later date]

These accounts have been prepared on a going concern basis. The key factors supporting this assumption are set out below.

In line with NHS specific considerations for going concern, all the operations of the Trust are considered to be continuing operations with no plans made or directions received for the provisions of service derived from operational activities of the Trust to either cease or be transferred to another organisation.

At the time of preparation of the financial statements the COVID-19 pandemic is ongoing and has resulted in the temporary suspension of contracting arrangements for 2020/21 between CCGs and the Trust, with funding for the Trust's services being settled by a block contract paid monthly and in advance at a sustainable value determined by NHS England. As a key provider of front line emergency health care services significant additional expenditure is being incurred by the Trust on resources in staffing, temporary staffing, patient transport and consumable supplies, such as personal protective equipment. In the financial year 20/21 where these levels of expenditure exceed the block contract values, further funding has been received by NHS England under a "top-up" regime to ensure Trusts break even. As such assurance is taken that national NHS arrangements are in place to ensure expenditure incurred in the financial year ended 31 March 2021 and beyond in relation to the COVID-19 response will be funded and not result in financial distress or risks to going concern. In addition the Trust has commenced discussions with funders on concluding the post COVID-19 revenue settlement via the NWL HCP accountable officers.

The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 setting out that NHS Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. While there is uncertainty on the duration of the COVID-19 pandemic, arrangements in place across the NHS and as described here are believed to ensure the Trust remains both sustainably funded and a going concern for the foreseeable future.

Financial Governance arrangements in place within the Trust support the appropriate planning, forecasting and management of finances, as established through the Standing Orders, the Standing Financial Instructions and Scheme of Delegation, all of which have been reviewed and approved by the Trust board in March 2020. These along with the financial and operating policies of the Trust such as the Treasury Management Policy, provide the framework for financial decision making and support the preparedness and flexibility for overcoming financial challenge.

Detailed cashflow forecasting has been performed reflecting scenarios for the expected duration and values of the block contract arrangements during 2020/21 with a return to NHS Provider and CCG contracting at values in draft plans. The key assumptions in these scenarios are that the existing arrangements of block contract with central top up (excluding retrospective top up) continue for the remainder of the financial year and next year. Inflationary cost factors after March 2021 on pay and non-pay costs are anticipated to be matched by inflatory increases to funding in the 2021/22 financial year. The Trust will be able to maintain a positive cashflow until at least September 2021, not require any long term financial support to achieve a positive cashflow and be able to pay its creditors as they fall due during

DHSC has made available Public Dividend Capital funding streams for support in the short-term and long-term for NHS Providers with exceptional needs or who are in financial distress. While the Trust is not forecast to require this support, assurance is to be taken from its availability that adverse financial challenges could be endured.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

[Revenue accounting policy to be provided separately for providers to paste in at a later date]

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Note 1.7 Property, plant and equipment cont'd

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.7 Property, plant and equipment cont'd**Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	3	99
Plant & machinery	5	10
Transport equipment	2	10
Information technology	3	7
Furniture & fittings	3	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets**Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	Max life
	Years	Years
Information technology	3	7
Software licences	3	7

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Note 1.11 Financial assets and financial liabilities cont'd

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee*Finance leases*

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Note 1.13 Provisions cont'd

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 22 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.18 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust is working with Real Asset Management to develop an electronic lease register that will automate the accounting entries for leasing under the new standard. Financial procedures and controls are being modified to incorporate the changes arising from the new standard.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

The following list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2020-21.

- IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of iFRS after 1 January 2016. Therefore not applicable to DHSC group bodies. Not EU-endorsed.

- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. It is likely to be adopted in 2023/24.

Note 1.21 Critical judgements in applying accounting policies

There were no critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies.

Note 1.22 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next

Asset Valuations

All land and buildings are restated to fair value by way of professional valuations. Full revaluation will be provided every five years. In the intervening years the fair values are updated by way of annual desktop revaluations. For the desktop revaluation the specialised operational values are updated in line with the current Tender Price Index published by the Building Cost Information Service (BCIS). The value of the land, non specialised assets and market values are reviewed by the valuer in line with analysis of market movements during the period.

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.7 and the carrying values of property, plant and equipment and intangible assets in notes 14.1 and 13.1 respectively.

The Trust have considered the 31 March 2021 valuation for material uncertainty arising from the developing economic impact of the COVID-19 pandemic as relevant to property valuation inputs. While we note this as a factor that reduces certainty in property valuations, we do not consider this to be a material uncertainty at 31 March 2021. An explanation of this assessment is provided in note 15.

Provisions

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 22.

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2021. The carrying value of the accrual is £10.52m within note 19 under accruals.

Injury Cost Recovery Scheme Accrual

The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on management estimates supported by the number of cases supplied by hospitals. The carrying value of the receivable is £3.45m within note 17 under prepayments and accrued income.

Note 2 Operating Segments

The Trust Board considers that the Trust has only one segment which is the provision of accident and emergency services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
A & E income*	471,940	415,053
Patient transport services income	-	(11)
Other income	1,022	1,203
Additional pension contribution central funding**	13,105	12,163
Other clinical income ***	10,352	-
Total income from activities	496,419	428,408

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***Other clinical income comprises income from NHSE to cover expenditure in relation to increased annual leave accruals due to the impacts of COVID-19 on resourcing (£4.8m) and the settlement for certain sections of the Flowers case (£5.6m).

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	£000	£000
NHS England	28,291	26,296
Clinical commissioning groups	465,639	397,514
Department of Health and Social Care	20	39
Other NHS providers	576	113
NHS other	6	194
Local authorities	-	(11)
Injury cost recovery scheme	1,022	1,203
Non NHS: other	865	3,060
Total income from activities	496,419	428,408
Of which:		
Related to continuing operations	496,419	428,408
Related to discontinued operations	-	-

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	275	-	275	213	-	213
Education and training	4,624	-	4,624	4,671	-	4,671
Provider sustainability fund (2019/20 only)			-	3,143		3,143
Financial recovery fund (2019/20 only)			-	1,591		1,591
Reimbursement and top up funding*	60,850		60,850			-
Income in respect of employee benefits accounted on a gross basis	523		523	533		533
Receipt of capital grants and donations		539	539		-	-
Charitable and other contributions to expenditure**		4,393	4,393		-	-
Total other operating income	66,272	4,932	71,204	10,151	-	10,151
Of which:						
Related to continuing operations			71,204			10,151
Related to discontinued operations			-			-

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. Standard and retrospective top up payments received in the first half of the year to support Trust costs (including COVID-19 response costs) are reflected here.

**In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective and medical equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,191k of PPE and £146k of medical equipment purchased by DHSC along with £56k of charitable contributions to expenditure. Income to reflect these contributions is included here.

Note 5 Expenses**Note 5.1 Operating expenses**

	2020/21	2019/20
	£000	£000
Staff and executive directors costs	381,790	312,595
Remuneration of non-executive directors	138	109
Supplies and services - clinical (excluding drugs costs)	34,886	17,580
Supplies and services - general	38,970	16,707
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	519	708
Inventories written down	182	(25)
Consultancy costs	293	385
Establishment	10,898	11,153
Premises	14,549	9,485
Transport (including patient travel)	35,727	28,723
Depreciation on property, plant and equipment	12,975	10,411
Amortisation on intangible assets	1,573	1,124
Net impairments	1,473	(55)
Movement in credit loss allowance: contract receivables / contract assets	165	18
Increase/(decrease) in other provisions	(1)	377
Change in provisions discount rate(s)	400	671
Audit fees payable to the external auditor		
audit services- statutory audit	151	86
other auditor remuneration (external auditor only)	-	-
Internal audit costs	142	109
Clinical negligence	4,703	3,711
Legal fees	161	1,302
Insurance	920	564
Research and development	831	941
Education and training	8,535	7,733
Rentals under operating leases	6,693	4,724
Redundancy	929	13
Car parking & security	520	1,190
Hospitality	-	2
Other	4,561	3,263
Total	<u>562,683</u>	<u>433,604</u>
Of which:		
Related to continuing operations	562,683	433,604
Related to discontinued operations	-	-

Significant additional expenditure has been incurred in relation to the Trust's response to COVID-19 in 2020/21 with £85.8m of related expenditure reported across the full year (2019-20 figures were only impacted for a short period). Notable items include £48.2m incorporated in Staff and executive directors costs (2019/20: £4.36m), £11.6m incorporated in Supplies and services - clinical (excluding drugs costs) (2019/20: £2.33m), £10.9m incorporated in Supplies and Services - general (2019/20: £0.2m) and £9.3m incorporated in Transport (including patient travel) (2019/20: £0.85m) above.

Note 5.3 Other auditor remuneration

There was no other auditor remuneration in 2019/20 (2018/19 nil).

Note 5.4 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 6 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	1,473	(55)
Other	-	-
Total net impairments charged to operating surplus / deficit	1,473	(55)
Impairments charged to the revaluation reserve	6,043	(297)
Total net impairments	7,516	(352)

Note 7 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	306,591	243,662
Social security costs	32,186	27,216
Apprenticeship levy	1,415	1,216
Employer's contributions to NHS pensions *	43,194	39,998
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	929	13
Temporary staff (including agency)	6,817	8,521
Total gross staff costs	391,132	320,626
Recoveries in respect of seconded staff	-	-
Total staff costs	391,132	320,626
Of which		
Costs capitalised as part of assets	1,161	1,314

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. From 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have however been recognised in these accounts.

Note 7.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £57k (£202k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 9 Operating leases**Note 9.1 London Ambulance Service NHS Trust as a lessee**

This note discloses costs and commitments incurred in operating lease arrangements where London Ambulance Service NHS Trust is the lessee.

The Trust leases ambulances, fast response cars and other vehicles for periods of 3 to 6 years. The Trust leases buildings to provide facilities for ambulance stations, vehicle workshops and other accommodation. These lease terms vary between 1 and 15 years.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	6,693	4,724
Total	6,693	4,724
	31 March	31 March
	2021	2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	3,735	3,808
- later than one year and not later than five years;	7,084	7,370
- later than five years.	1,889	2,356
Total	12,708	13,534
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	(4)	186
Other finance income	13	3
Total finance income	9	189

Note 11 Finance expenditure**Note 11.1 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	9	20
Total interest expense	9	20
Unwinding of discount on provisions	(45)	25
Total finance costs	(36)	45

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	9	20
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	17	-
Losses on disposal of assets	(410)	(59)
Total gains / (losses) on disposal of assets	(393)	(59)

Note 13 Intangible Assets**Note 13.1 Intangible assets - 2020/21**

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	3,361	-	-	18,699	-	-	-	5,615	-	27,675
Additions	2,400	-	-	611	-	-	-	3,723	-	6,734
Reclassifications	2,718	-	-	1,335	-	-	-	(3,951)	-	102
Disposals / derecognition	-	-	-	(503)	-	-	-	-	-	(503)
Valuation / gross cost at 31 March 2021	8,479	-	-	20,142	-	-	-	5,387	-	34,008
Amortisation at 1 April 2020 - brought forward	2,569	-	-	16,923	-	-	-	-	-	19,492
Provided during the year	613	-	-	960	-	-	-	-	-	1,573
Reclassifications	-	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(146)	-	-	-	-	-	(146)
Amortisation at 31 March 2021	3,182	-	-	17,737	-	-	-	-	-	20,919
Net book value at 31 March 2021	5,297	-	-	2,405	-	-	-	5,387	-	13,089
Net book value at 1 April 2020	792	-	-	1,776	-	-	-	5,615	-	8,183

Note 13.2 Intangible assets - 2019/20

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	2,984	-	-	17,794	-	-	-	3,336	-	24,114
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2019 - restated	2,984	-	-	17,794	-	-	-	3,336	-	24,114
Additions	16	-	-	21	-	-	-	3,538	-	3,575
Reclassifications	361	-	-	884	-	-	-	(1,259)	-	(14)
Disposals / derecognition	-	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2020	3,361	-	-	18,699	-	-	-	5,615	-	27,675
Amortisation at 1 April 2019 - as previously stated	2,337	-	-	16,031	-	-	-	-	-	18,368
Prior period adjustments	-	-	-	-	-	-	-	-	-	-
Amortisation at 1 April 2019 - restated	2,337	-	-	16,031	-	-	-	-	-	18,368
Provided during the year	232	-	-	892	-	-	-	-	-	1,124
Reclassifications	-	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-	-
Amortisation at 31 March 2020	2,569	-	-	16,923	-	-	-	-	-	19,492
Net book value at 31 March 2020	792	-	-	1,776	-	-	-	5,615	-	8,183
Net book value at 1 April 2019	647	-	-	1,763	-	-	-	3,336	-	5,746

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	52,232	64,362	-	21,883	20,429	56,920	20,064	1,165	237,055
Additions	-	5,408	-	24,048	1,760	2,187	3,436	407	37,246
Impairments	-	(10,769)	-	-	-	-	-	-	(10,769)
Reversals of impairments	-	(34)	-	-	-	-	-	-	(34)
Revaluations	275	(80)	-	-	-	-	-	-	195
Reclassifications	-	1,306	-	(17,760)	1,363	12,218	2,584	187	(102)
Disposals / derecognition	-	(98)	-	-	(118)	(91)	(676)	-	(983)
Valuation/gross cost at 31 March 2021	52,507	60,095	-	28,170	23,434	71,234	25,408	1,759	262,608
Accumulated depreciation at 1 April 2020 - brought forward	-	7	-	-	15,880	30,320	13,523	142	59,872
Provided during the year	-	3,453	-	-	1,252	5,644	2,457	169	12,975
Impairments	-	(3,250)	-	-	-	-	-	-	(3,250)
Reversals of impairments	-	(37)	-	-	-	-	-	-	(37)
Revaluations	-	(127)	-	-	-	-	-	-	(127)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(5)	-	-	(118)	(87)	(668)	-	(878)
Accumulated depreciation at 31 March 2021	-	41	-	-	17,014	35,877	15,312	311	68,555
Net book value at 31 March 2021	52,507	60,054	-	28,170	6,420	35,357	10,096	1,448	194,053
Net book value at 1 April 2020	52,232	64,355	-	21,883	4,549	26,600	6,541	1,023	177,183

Note 14.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	52,154	61,613	-	15,921	18,833	54,387	16,716	319	219,943
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2019 - restated	52,154	61,613	-	15,921	18,833	54,387	16,716	319	219,943
Additions	-	2,182	-	13,099	668	1,687	478	842	18,956
Impairments	-	(1,942)	-	-	-	-	-	-	(1,942)
Reversals of impairments	-	702	-	-	-	-	-	-	702
Revaluations	78	1,679	-	-	-	-	-	-	1,757
Reclassifications	-	265	-	(7,138)	928	2,829	3,126	4	14
Disposals / derecognition	-	(137)	-	-	-	(1,983)	(256)	-	(2,376)
Valuation/gross cost at 31 March 2020	52,232	64,362	-	21,883	20,429	56,920	20,064	1,165	237,055
Accumulated depreciation at 1 April 2019 - as previously stated	-	7	-	-	14,847	27,602	12,100	83	54,639
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2019 - restated	-	7	-	-	14,847	27,602	12,100	83	54,639
Provided during the year	-	3,049	-	-	1,033	4,594	1,676	59	10,411
Impairments	-	(533)	-	-	-	-	-	-	(533)
Reversals of impairments	-	(1,059)	-	-	-	-	-	-	(1,059)
Revaluations	-	(1,355)	-	-	-	-	-	-	(1,355)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(102)	-	-	-	(1,876)	(253)	-	(2,231)
Accumulated depreciation at 31 March 2020	-	7	-	-	15,880	30,320	13,523	142	59,872
Net book value at 31 March 2020	52,232	64,355	-	21,883	4,549	26,600	6,541	1,023	177,183
Net book value at 1 April 2019	52,154	61,606	-	15,921	3,986	26,785	4,616	236	165,304

Note 14.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	52,507	60,054	-	28,170	6,372	35,249	10,096	1,448	193,897
Owned - donated/granted	-	-	-	-	48	108	-	-	156
NBV total at 31 March 2021	52,507	60,054	-	28,170	6,420	35,357	10,096	1,448	194,053

Note 14.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	52,232	64,355	-	21,883	4,549	26,561	6,541	1,023	177,144
Owned - donated/granted	-	-	-	-	-	39	-	-	39
NBV total at 31 March 2020	52,232	64,355	-	21,883	4,549	26,600	6,541	1,023	177,183

Note 15 Revaluations of property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2021.

The valuation was carried out by District Valuer Services of the Valuation Office Agency, an executive arm of HMRC, out in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS), insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health.

The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021.

This year the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

a) Specialised In Use (Operational) assets - buildings valued using depreciated replacement cost methodology
 The majority of the trust buildings are valued using the depreciated replacement cost basis. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19.

b) Non - Specialised In Use (Operational) assets including the land element of the depreciated replacement cost valuation of specialised assets
 The trust has a few non-specialised in use buildings. There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

The market value was used in arriving at fair value for the operational assets subject to the additional special assumptions that:

- a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;
- b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest; and
- c) regard has been had to appropriate lotting to achieve the best price.

The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.

The following table summarises the gross carrying value of fully depreciated assets that are still in use.

GROSS CARRYING VALUE OF ASSETS IN USE

	2020/21
	£000
Furniture & fittings	56
Transport equipment	11,330
Plant & machinery	12,070
Information technology	9,264
Total	<u><u>32,720</u></u>

Note 16 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	333	150
Consumables	6,107	4,358
Total inventories	6,440	4,508
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £12,355k (2019/20: £9,834k). Write-down of inventories recognised as expenses for the year were £182k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,191k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 17 Receivables**Note 17.1 Receivables**

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	18,411	17,419
Capital receivables	96	51
Allowance for impaired contract receivables / assets	(1,085)	(920)
Prepayments (non-PFI)	7,069	4,805
Interest receivable	-	10
PDC dividend receivable	708	-
VAT receivable	617	468
Other receivables	790	437
Total current receivables	26,606	22,270
Non-current		
Contract receivables	-	-
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current receivables	-	-
Of which receivable from NHS and DHSC group bodies:		
Current	14,128	12,614
Non-current	-	-

Note 17.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	920	-	5,668	-
Prior period adjustments			-	-
Allowances as at 1 April - restated	920	-	5,668	-
New allowances arising	179	-	58	-
Reversals of allowances	(14)	-	(40)	-
Utilisation of allowances (write offs)	-	-	(4,766)	-
Allowances as at 31 Mar 2021	1,085	-	920	-

Note 18 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	25,964	21,718
Prior period adjustments		-
At 1 April (restated)	25,964	21,718
Net change in year	13,823	4,246
At 31 March	39,787	25,964
Broken down into:		
Cash at commercial banks and in hand	9	8
Cash with the Government Banking Service	39,778	25,956
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	39,787	25,964
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	39,787	25,964

Note 19 Payables**Note 19.1 Trade and other payables**

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	5,011	6,807
Capital payables	13,279	8,786
Accruals	49,599	20,125
Social security costs	4,465	3,998
Other taxes payable	3,541	2,939
PDC dividend payable	-	52
Other payables	4,710	4,108
Total current trade and other payables	<u>80,605</u>	<u>46,815</u>
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	<u>-</u>	<u>-</u>
Of which payables from NHS and DHSC group bodies:		
Current	1,108	969
Non-current	-	-

Note 20 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	251	193
Total other current liabilities	<u>251</u>	<u>193</u>
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	<u>-</u>	<u>-</u>

Note 21 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Bank overdrafts	-	-
Other loans	-	-
Total current borrowings	<u>-</u>	<u>-</u>
Non-current		
Other loans	107	107
Total non-current borrowings	<u>107</u>	<u>107</u>

Note 21.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	-	107	-	-	107
Cash movements:					
Financing cash flows - payments and receipts of principal	-	-	-	-	-
Financing cash flows - payments of interest	-	-	-	-	-
Non-cash movements:					
Additions	-	-	-	-	-
Application of effective interest rate	-	-	-	-	-
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Early terminations	-	-	-	-	-
Other changes	-	-	-	-	-
Carrying value at 31 March 2021	-	107	-	-	107

Note 21.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	-	107	-	-	107
Prior period adjustment	-	-	-	-	-
Carrying value at 1 April 2018 - restated	-	107	-	-	107
Cash movements:					
Financing cash flows - payments and receipts of principal	-	-	-	-	-
Financing cash flows - payments of interest	-	-	-	-	-
Non-cash movements:					
Additions	-	-	-	-	-
Application of effective interest rate	-	-	-	-	-
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Early terminations	-	-	-	-	-
Other changes	-	-	-	-	-
Carrying value at 31 March 2020	-	107	-	-	107

Note 22 Provisions**Note 22.1 Provisions for liabilities and charges analysis**

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re- structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020	1,234	7,771	320	-	-	-	5,695	15,020
Change in the discount rate	22	378	-	-	-	-	-	400
Arising during the year	12	148	256	-	-	829	3,323	4,568
Utilised during the year	(154)	(417)	(216)	-	-	-	(722)	(1,509)
Reversed unused	-	-	(107)	-	-	-	(2,389)	(2,496)
Unwinding of discount	(6)	(39)	-	-	-	-	-	(45)
At 31 March 2021	1,108	7,841	253	-	-	829	5,907	15,938
Expected timing of cash flows:								
- not later than one year;	151	417	253	-	-	829	5,907	7,557
- later than one year and not later than five years;	603	1,710	-	-	-	-	-	2,313
- later than five years.	354	5,714	-	-	-	-	-	6,068
Total	1,108	7,841	253	-	-	829	5,907	15,938

Injury Benefits provision of £7,841k (2019/20 £7,771k) relates to staff injured at work, whilst the Early Departure Costs provision of £1,108k (2019/20 £1,234k) relates to staff who have taken early retirement. Both amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of -0.95% is applied.

The Legal Claims provision of £253k (2019/20 £320k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

There Redundancy provision of £829k (2019/20 nil) relates to management restructures within the Trust.

Other provisions of £5,907k (2019/20 £5,695k) includes £4,306k in relation to pending legal cases affecting calculation of holiday pay, £604k for pending employment tribunals, £306k in relation to whether team leader allowances are pensionable, £317k for potential service level penalty provisions and £374k in relation to relocation costs for recruitment of overseas paramedics.

Note 22.2 Clinical negligence liabilities

At 31 March 2021, £74,378k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2020: £64,277k).

Note 23 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(119)	(170)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(119)	(170)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(119)	(170)
Net value of contingent assets	-	-

Note 24 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	5,735	3,765
Intangible assets	3	279
Total	5,738	4,044

Note 25 Financial instruments

Note 25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 25.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	18,212	-	-	18,212
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	39,787	-	-	39,787
Total at 31 March 2021	57,999	-	-	57,999

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	16,992	-	-	16,992
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	25,964	-	-	25,964
Total at 31 March 2020	42,956	-	-	42,956

Note 25.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Other borrowings	107	-	107
Trade and other payables excluding non financial liabilities	68,308	-	68,308
Total at 31 March 2021	68,415	-	68,415

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Other borrowings	107	-	107
Trade and other payables excluding non financial liabilities	39,826	-	39,826
Total at 31 March 2020	39,933	-	39,933

Note 25.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	68,308	39,826
In more than one year but not more than five years	107	107
In more than five years	-	-
Total	68,415	39,933

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 25.5 Fair values of financial assets and liabilities

The book value (carrying value) of the financial assets and liabilities is considered to be a reasonable approximation of fair value.

Note 26 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	5
Bad debts and claims abandoned	-	-	12	12
Stores losses and damage to property	2,076	1,083	2,320	927
Total losses	2,076	1,083	2,333	944
Special payments				
Ex-gratia payments	25	802	19	584
Total special payments	25	802	19	584
Total losses and special payments	2,101	1,885	2,352	1,528
Compensation payments received		-		-

Note 27 Related parties

The Department of Health and Social Care, as the London Ambulance Service NHS Trust's parent department, is considered to be a related party.

During the year none of the Department of Health and Social Care Ministers, London Ambulance Service NHS Trust board members or members of key management staff, or parties related to any of them, has undertaken any material transactions with the London Ambulance Service NHS Trust.

The London Ambulance Service NHS Trust has had a significant number of material transactions during the year with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where receipts exceed £10m.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
NHS Barking and Dagenham CCG	-	11,307	8	-
NHS Brent CCG	-	16,453	-	730
NHS Central London (Westminster) CCG	-	64,285	-	2,500
NHS City and Hackney CCG	-	14,240	9	-
NHS Ealing CCG	-	15,030	-	-
NHS England	116	73,665	27	7,878
NHS Havering CCG	-	13,763	7	-
NHS Hillingdon CCG	-	14,539	-	-
NHS Hounslow CCG	317	17,673	-	-
NHS Newham CCG	-	15,743	9	-
NHS North Central London CCG	(2)	63,862	-	2
NHS Redbridge CCG	-	13,639	9	43
NHS South East London CCG	48	90,904	-	741
NHS South West London CCG	-	59,422	-	-
NHS Tower Hamlets CCG	-	16,201	8	-
NHS Waltham Forest CCG	-	12,756	10	674
NHS West London (K&C & QPP) CCG	-	10,512	-	-

The Trust has a number of staff who or volunteer for St John Ambulance Service. Transactions with St John Ambulance Service during the year comprised expenditure of £1,788k (2019/20 £1,858k), income of £Nil (2019/20 £Nil) and the amount payable by the Trust as at 31 March 2021 was £Nil (31 March 2020 £115k).

Fenella Wrigley has worked for the following organisations that have had transactions with the Trust during 2020/21. Receipts from related parties Home Office £1k (2019/20 £128k) and Barts Hospital £488k (2019/20 £60k). Payments to Barts Hospital was £120k (2019/20 £120k). Amounts due from Barts Hospital is £79k (2019/20 £45k) and Home Office is £Nil (2019/20 £35k).

The London Ambulance Service NHS Trust acts as corporate trustee for the London Ambulance Service Charity. During the financial year ending 31 March 2021 the Trust received grants of £174k (2019/20 £Nil).

Note 28 Events after the reporting date

There have been no events after the reporting period that need to be disclosed in the financial statements.

Note 29 Better Payment Practice code

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	57,095	284,756	53,149	191,362
Total non-NHS trade invoices paid within target	53,746	267,506	47,325	176,414
Percentage of non-NHS trade invoices paid within target	94.1%	93.9%	89.0%	92.2%
NHS Payables				
Total NHS trade invoices paid in the year	448	3,390	380	2,506
Total NHS trade invoices paid within target	372	2,905	333	1,998
Percentage of NHS trade invoices paid within target	83.0%	85.7%	87.6%	79.7%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 30 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000	2019/20 £000
Cash flow financing	(2,161)	(2,511)
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	(2,161)	(2,511)
External financing limit (EFL)	30,585	8,395
Under / (over) spend against EFL	32,746	10,906

Note 31 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	43,980	22,532
Less: Disposals	(462)	(145)
Less: Donated and granted capital additions	(539)	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	42,979	22,387
Capital Resource Limit	42,980	22,675
Under / (over) spend against CRL	1	288

Note 32 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	257
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	257

Note 33 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,425	1,002	2,751	262	262	6,048
Breakeven duty cumulative position	2,569	3,994	4,996	7,747	8,009	8,271	14,319
Operating income		279,864	283,617	281,731	303,109	303,827	324,052
Cumulative breakeven position as a percentage of operating income		1.4%	1.8%	2.7%	2.6%	2.7%	4.4%
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
		£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(4,405)	6,143	5,758	6,958	174	257
Breakeven duty cumulative position		9,914	16,057	21,815	28,773	28,947	29,204
Operating income		319,992	355,507	364,598	388,978	438,559	567,623
Cumulative breakeven position as a percentage of operating income		3.1%	4.5%	6.0%	7.4%	6.6%	5.1%

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty assessment should be 2009/10. Periods prior to 2009/10 have been consolidated to provide the cumulative breakeven position. The Trust is subject to a three year period for recovery of any deficit incurred. The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the subsequent two financial years.



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Month 12 Finance Report			
Agenda item:	11.2			
Report Author(s):	James Corrigan, Financial Controller			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	This paper provides an update on the Trust month 12 financial position.			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<p>The purpose of this paper is to set out the financial position for the Trust as at 31 March 2021 (month 12), subject to audit.</p> <p>Key points to note are that the Trust:</p> <ul style="list-style-type: none"> • The Trust ended the year with a surplus of £1.2m (£1.2m lower than planned) • Had a closing cash balance of £39.8m at the end of March 2021 • The Trust incurred an additional £88.4m in responding to COVID 19 during the year • The Trust delivered its full capital plan for 2020/21, with closing capital expenditure of £43.8m. <p>The Trust has met all its statutory financial duties for 2020/21 (subject to audit)</p>				
Recommendation(s) / Decisions for the Board / Committee:				
<p>The Trust Board is asked to note the financial position and outturn for the Trust for the year ending 31 March 2021.</p>				

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

Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		



Finance Report

Month 12: March 2021



Key Headlines

Duty	Target	Outcome	
External Financing Limit (EFL)	£30.6m	(£2.1m)	Achieved. The Trust has an £32.7m under spend against its EFL which is permitted. The movement on the EFL is due to the higher than planned year-end cash balance £21.0m and expected £11.7m EFL adjustment for PDC received. The main reasons for the favourable position are that the low levels of outstanding debts, capital slippage; lower than planned provision payments, high level of accruals and a high level of outstanding supplier invoices due to increased level of expenditure and management authorisation timeliness which is being picked up through the finance improvement plan.
Capital Resource Limit (CRL)	£42.98m	£42.96m	Achieved. The Trust fully utilised all the capital resource available.
Break-Even duty – Surplus/Deficit and Adjusted Financial Performance (statutory)	Surplus/Deficit: £2.394m surplus Adjusted Financial Performance: £2.326m surplus	Surplus/Deficit: £1.119m surplus Adjusted Financial Performance: £0.257m surplus	Planning completed with NW London partners halfway through the year targeted a surplus of £2.394m (adjusted financial performance surplus of £2.326m) on the basis that all outstanding COVID-19 retrospective top up income claims were paid and the pandemic remained under control, however the new wave of COVID-19 put the Trust under increased pressure at the start of 2021 and some outstanding retrospective top up income was withheld relating to the write back of existing CAD capital and write off of prior year income from CCGs relating to the Flowers case
Better Payment Practice Code (non-NHS) – volume	95%	94.1%	5.1% improvement in performance on Volume and 1.7% increase on Value compared to 2019/20 performance.
Better Payment Practice Code (non-NHS) – value	95%	92.2%	

Summary

This paper updates on the financial position as at the end of March 2021 (month 12, financial year 2020-21).

The Trust was operating under an adjusted financial framework up to M6 which involved pausing business planning (including Cost Improvement Programmes) and contracting and commissioning processes (including CQUIN). The framework involved the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions. This has allowed expenditure on the Trust's response to the COVID-19 pandemic to be funded.

From month 7 onward, this framework was replaced with fixed income envelopes which are being managed at STP or ICS level, and required the achievement of financial efficiencies by the Trust of £2.4m based on that plan, with additional efficiency required to match new approved spend (currently expected to be around £4.5m bringing the total to £6.9m).

The Trust is reporting a full year surplus of £1.160m (£0.257m surplus on an adjusted financial performance basis) which is consistent with the target position agreed with NW London partners due to the reversal of accrued COVID retrospective top up income (£5.35m relating to the write back of existing CAD costs from capital and Flowers income from prior year written off), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£7.3m). The position incorporates costs of additional resourcing to meet COVID surge requirements of £12.7m. The amount of retrospective top up income recognised decreased by £5.35m in M11 (full year £44.564m). Total COVID costs YTD (excluding centrally provided consumables and equipment) are £85.8m, with £7.6m recognised in M12 primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, and operational support services.

Items of note include:

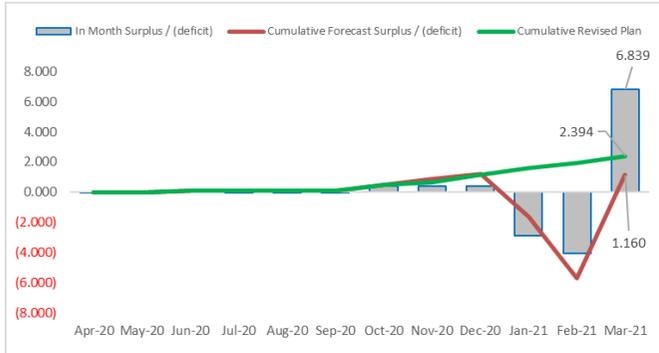
1. Income finished the year £43.4m higher than NHSI plan due to £13.1m of notional income for central NHSE pension contributions on behalf of LAS staff, additional COVID related income from NW London Commissioners (£7.3m), Flowers case income (£5.6m) and annual leave accrual movement funding (£4.8m) from NHSE, £2.9m to support 111 First resourcing (reflected in budgets), £5.7m in relation to NW London IUC Service provision (reflected in budgets), notional income for consumables and equipment provided by DHSC during the pandemic (£4.4m) and the notification of an additional £1.9m of Health Education England income for education and training, offset by a £5.35m reduction in COVID retrospective top up income in relation to M1-6.
2. Pay expenditure was £390m which is £28.2m higher than budget due to the recognition of £13.1m of notional cost for central NHSE pension contributions on behalf of LAS staff, £5.6m of accrued cost in relation to settlements in relation to the Flowers case for 2019-20 and 2020-21 overtime and additional COVID surge resourcing (£9.3m).
3. Non pay expenditure (including depreciation and finance costs) finished the year £7.4m higher than budget due to additional COVID support to respond to the impact of the new COVID-19 variants (£3.3m), dilapidation provisions (£2.1m), centrally provided stock and equipment costs (£2.4m), higher general supplies and services spend (£2m) largely in relation to professional service support and projects and property impairment costs (£1.5m), offset by lower depreciation and PDC costs due to project slippage (£3.7m).

The Trust finished the month with a cash position of £39.8m, and capital spend (excl donated assets) was £43.8m YTD (£43.3m YTD net of disposals) which includes the reversal of £2.3m of CAD upgrade work in progress costs in prior months and COVID-19 phase 1 and 2 response related capital spend which amounted to £19.3m YTD.



Key Financial Indicators

Surplus / (Deficit)



Use of Resources Rating

	YTD		Full year	
	Plan	Actual	Plan	Actual
Capital service cover rating				
Liquidity rating				
I&E margin rating				
Variance from control total				
Agency rating				
Overall rating				

M12 YTD Forecast

GREEN	GREEN	GREEN
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- The full year position at month 12 is a £1.160m surplus (£0.257m surplus on an adjusted financial performance basis) which is consistent with the target position agreed with NW London partners due to the reversal of accrued COVID retrospective top up income (£5.35m), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£7.3m).
- The position incorporated £85.8m of costs in relation to the Trust's response to COVID-19 and the M1-6 retrospective income top up in the position decreased by £5.35m to £44.6m in M11.
- The Trust has been operating under an adjusted financial framework for April to September 2020 which involved the Trust receiving block and top up income in advance as determined by NHSE/I, from month 7 onward, this was replaced with fixed income envelopes managed at STP or ICS level.

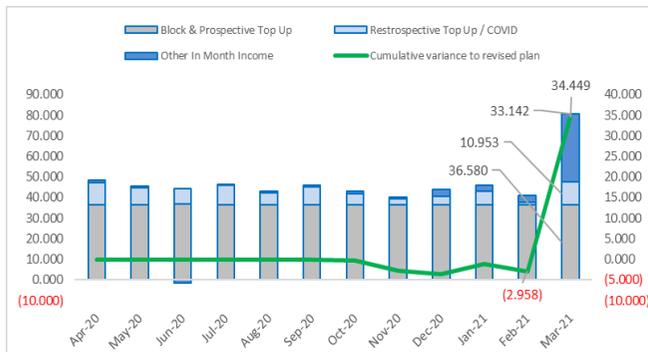
M12 YTD Forecast

N/A	N/A	N/A
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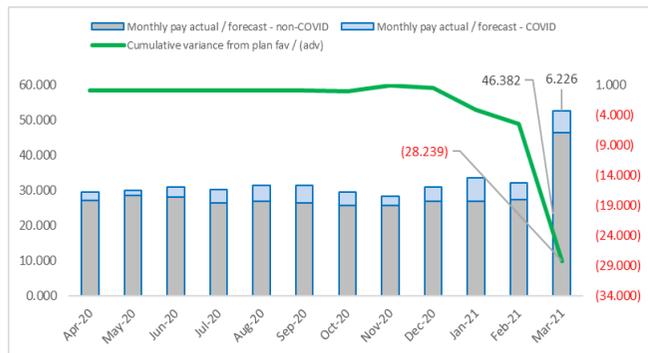
- NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). The table left shows the Trust's current Use of Resources rating for YTD and full year position.
- The overall rating is a weighted risk rating across five financial metrics. The overall rating includes an override where if any one metric is a 4, the highest overall rating that can be achieved is a 3
- No use of resources scores are currently available under the interim financial framework arrangements.**

Key Financial Indicators

Income



Pay Expenditure



M12 YTD Forecast

GREEN GREEN GREEN

- The total income position finished the year £34.4m higher than budget due to notional centrally paid pension income (£13.1m), additional NWL COVID support income (£7.3m), NHSE Flowers case (£5.6m) and annual leave income (£4.8m).
- This was £43.4m higher than NHSI plan with the difference predominantly due to additional income for IUC Services (£9m).
- In M1-6 the Trust received block contract income in advance (£34.084m per month) as determined by NHSE/I, along with a standard monthly top-up amount (£2.657m per month) and retrospective top ups to breakeven financial performance, though this has now been reduced by £5.3m to £44.6m.
- In M7-12 block contract income in advance (£34.084m per month) remained, and was supplemented by standard top up income of £15.313m (£2.552m per month) and increased COVID support income of £33.3m.
- Other Operating Income is £71.2m full year comprising mainly of top up and retrospective top up income for M1-6 (£60.9m), notional PPE and equipment income (£4.4m) and Education & Training income (£4.6m).

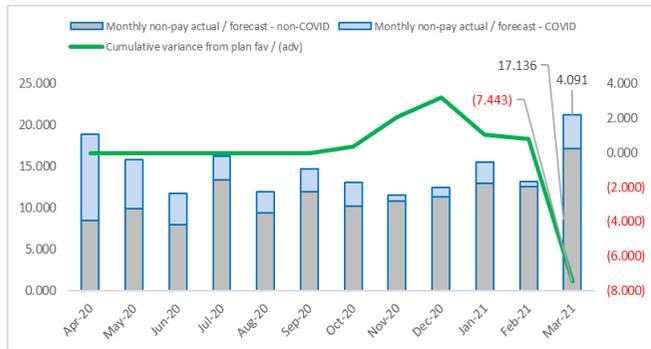
M12 YTD Forecast

GREEN GREEN GREEN

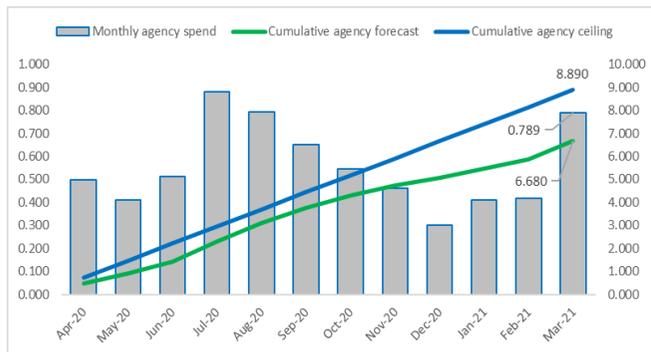
- Pay expenditure was £28.2m over budget full year at £390m due to notional pension contribution costs paid on the Trust's behalf by NHS England (£13.1m), increased annual leave accrual costs (£4.8m), additional Flowers case settlement costs £5.6m and additional COVID support resourcing from internal, LFB and Met Police sources (£9.2m).
- This was £35m higher than the NHSI plan with the additional variance predominantly due to post plan budget expanded service provision in IUC.
- Total COVID pay costs are £48.2m full year primarily in relation to additional resourcing across Ambulance Services, IUC Services, 999 Operations and Critical Care Transfer Services, and including costs associated with responding to the new COVID variant.
- £9.5m has been recognised full year for seconded LFB and Met Police resources covering COVID support provided during the May to March period, and including support in relation to the impact of the new COVID-19 variant.

Key Financial Indicators

Non-Pay Expenditure



Agency Ceiling



M12 YTD Forecast

GREEN GREEN GREEN

- Non pay expenditure including financial charges finished the year at £176.5m which was £7.4m unfavourable to revised budgets due to overspends in IUC (£2.3m) for external resourcing, Programmes and Projects (£1.8m) in relation to project costs and resources, IM&T (£0.9m) for external resources and technology costs, higher central costs (£1.8m) driven by impairments and Fleet and Logistics (£1.8m) driven by PPE provided by DHSC offset by lower ambulance services costs (£2.1m).
- Non pay COVID-19 costs are £40.2m full year in relation to increased 111 IUC external resourcing, increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning, personal protective equipment, medical equipment and operational consumables, and in relation to IT equipment and IT services to enable home working and expand the capacity and capability of systems and telephony.
- £1.9m of previously capitalised non pay costs (hardware, software and professional fees) related to the CAD replacement project were written back as expenditure in prior month positions and £0.4m of assets were impaired.

M12 YTD Forecast

GREEN GREEN GREEN

- Full year agency spend was £6.7m, which was £2.2 lower than the full year agency ceiling of £8.9m.
- The Trusts limited agency forecast reflects the implementation of alternative resourcing models within the IUC Clinical Triage service.

Key Financial Indicators

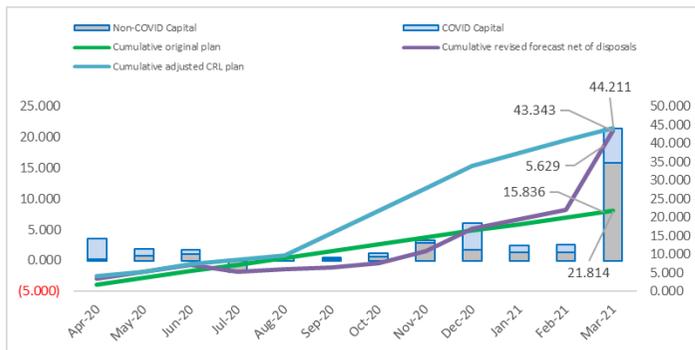
Cost Improvement Programme

M12 YTD Forecast

GREEN GREEN GREEN

- 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 across this period.
- Under the new financial framework 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 were developed to meet this need.
- Additional efficiencies were identified to match any new approved spend with a further £4.5m bringing the total to £6.9m.
- The Trust has delivered £8.3m of run rate reductions in the financial year exceeding the £6.9m requirement.

Capital Expenditure



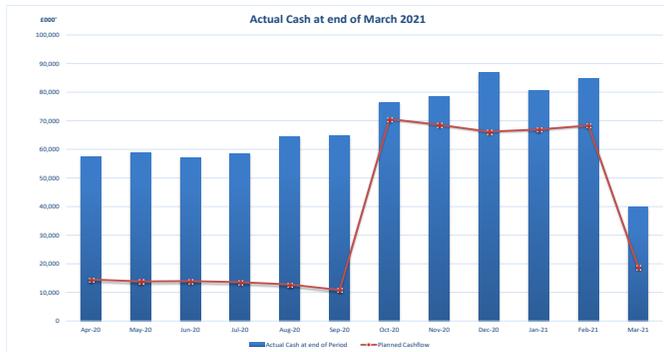
M12 YTD Forecast

GREEN GREEN GREEN

- Full year capital expenditure net of disposals and donated assets was £43.3m (£44m before disposals), fully utilising the CRL available to the Trust
- Very significant capital project spend was able to be recognised in M12 enabling forecast spend to be met.
- Capital spend on the Trust's phase 1 and 2 COVID-19 responses was £19.3m (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 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.

Key Financial Indicators

Cash

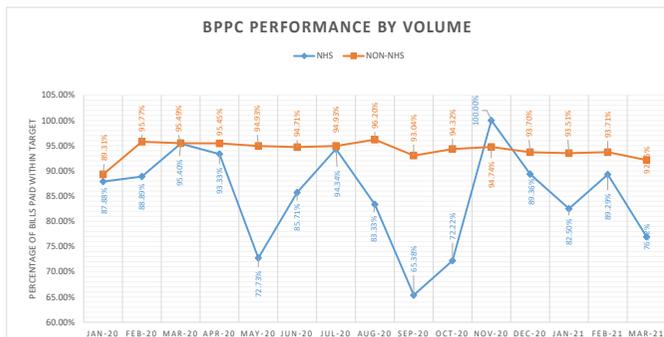


M12 YTD Forecast

GREEN GREEN GREEN

- Cash was £39.8m as at 31 March 2021, £21m above the revised plan.
- The cash balance fell in March 2021 due to the ending of the block contract income being paid one month in advance during the period April 2020 to February 2021.

Better Payment Practice Code



M12 YTD Forecast

AMBER GREEN GREEN

- The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days.
- The Trust achieved
- The NHS and Non-NHS performance by volume for March 2021 was 76.9% and 92.1% respectively.
- The Trust has a high volume of overdue invoices waiting to be approved
- Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.

Key Financial Indicators

Cash

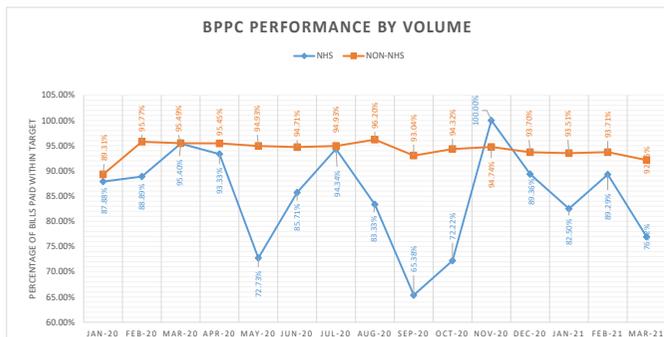


M12 YTD Forecast

GREEN GREEN GREEN

- Cash was £39.8m as at 31 March 2021, £21m above the revised plan.
- The main reason for the favourable position was the high level of accrued expenditure at year end.
- Cash balances have decreased in March compared to February due to the cessation of payment of block contract income in advance.

Better Payment Practice Code



M12 YTD Forecast

AMBER AMBER AMBER

- 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 March 2021 was 76.9% and 92.2% respectively. The YTD NHS and Non-NHS performance by value was 83.0% and 94.1% respectively.
- The Trust has a high volume of overdue invoices waiting to be approved
- Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.

COVID-19 Response Expenditure (YTD)

Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000
YTD													
Month 12 2020-21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Additional Staff Costs (EOC and Ambulance Services)	39,324	1,677	801	1,894	2,347	3,955	4,263	2,782	2,367	3,461	6,146	4,321	5,311
NHS 111 Additional Capacity - Staff	7,064	297	527	890	1,239	270	603	903	434	385	397	326	793
NHS 111 Additional Capacity - External Contracts	11,771	979	1,849	1,330	726	936	814	1,522	251	573	1,052	406	1,319
Decontamination Services - Premises	1,993	116	206	16	236	148	237	261	123	173	202	97	210
Defibrillators, Medical and Ambulance Equipment	809	1,229	191	681	59	16	86	26	11	4	172	64	15
IT Support	1,411	370	496	43	303	60	81	34	39	0	10	1	4
Private Ambulance and Managed Operations Services	1,213	558	638	593	95	476	346	89	4	527	69	386	374
Vehicle Leasing	191	26	29	38	14	18	36	38	25	7	19	8	15
Telephony, Radio and IT Systems Expansion	2,402	906	112	848	173	117	41	48	146	146	42	80	14
Accommodation	1,560	400	344	241	33	91	319	11	113	0	6	10	284
Personal Protective Equipment	6,461	3,639	905	1,165	5	51	354	0	237	112	369	8	2,120
Fleet Maintenance and Preparation	7,714	1,531	621	1,535	1,001	377	20	832	416	492	647	246	35
Critical Care Transfer Service	1,426	524	242	167	50	78	73	23	8	7	13	61	180
Property Adjustments and Expansions	786	148	48	123	62	24	34	41	29	31	128	42	77
COVID Asset Depreciation	649	-	-	-	-	-	301	64	90	7	102	90	10
Other	3,905	516	336	965	530	330	191	93	17	317	194	107	342
Total COVID-19 Expenditure	88,379	12,915	7,346	6,807	6,617	6,915	7,758	6,588	3,526	5,166	9,119	5,305	10,318

The Trust has incurred £88.4m of COVID 19 costs for the year including notionally recognised costs for centrally provided consumables and equipment (M1 £12.9m, M2: £7.3m, M3: £6.8m, M4: £6.6m, M5: £6.9m, M6: £7.8m, M7: £6.6m, M8: £3.5m, M9: £5.2m, M10: £9.1m, M11: £5.3m, M12: £7.6m, Centrally provided notional costs: £2.4m) in order to provide significantly expanded resourcing, vehicle, vehicle and technical capacity.

The new variant of the COVID virus and the impact this is having on staffing, NHS demand and thus resourcing requirements means that costs in these areas have increased significantly, though the shorter than expected surge period has allowed the February to March 2021 forecast to be reduced.

PPE requirement for the Trust has increased significantly compared to BAU and the Trust has supported the wider health system through mutual aid for single use PPE (in excess of 0.6m items provided).

Vehicle deep cleans have continued to be required at a significantly increased level and Critical Care Transfer support was being

provided for hospital transfers after being mobilised for the Nightingale Hospital.

Estate consolidation has been undertaken to consolidate operations and enable a flexible deployment model and improve efficiency across supply chain management. The Trust currently has 43 stations in use.

The Trust is actively reviewing its COVID-19 response in conjunction with partners to minimise cost whilst maintaining resilience and resource capacity throughout this challenging period.

Significant items of spend are summarised in the table at top left and are detailed below and to the right.

- Additional Staff Costs Ambulance Services and EOC (£39.3m YTD) reflecting the cost of additional resourcing to cover increased abstractions, longer job cycle times, higher time off the road and increased resource capacity in control rooms. Includes LFB and Met Police support charges of £9.5m YTD.

- Personal Protective Equipment (£6.2m YTD) for items such as gowns, coveralls, protective face visors, glasses, masks and filters and including £2.1m worth of stock provided by DHSC free of charge the usage of which has been recognised notionally in the M12 accounts along with matching income.
- Accommodation (£1.6m YTD) for accommodation for staff to support isolation requirements and related PSAs to prevent staff being unduly impacted financially. Limited new provision has commenced in line with the current surge and additional PSA costs have been recognised.
- NHS 111 Additional Capacity Staff (£7.1m YTD) for additional resourcing through internal sources.
- NHS 111 Additional Capacity External Contracts (£11.8m YTD) predominantly for additional clinician resources such as GPs, nurses and advanced practitioners (£6m) and additional non-clinical call handling resource support (£5.1m).
- Fleet Maintenance and Preparation (£7.7m YTD) additional external fleet maintenance support and preparation resources for cleaning higher numbers of vehicles more frequently.
- Defibrillators, Medical and Ambulance Equipment (£0.8m YTD) for additional defibrillators, ambulance and medical equipment for the expanded fleet.
- Private Ambulance Services (£1.2m) for additional private ambulance resources.
- Telephony & IT Systems Expansions (£2.4m YTD) expanding the capacity of telephony and technical systems and equipment.
- IT Support (£1.4m YTD) for additional IT support resources
- Critical Care Transfer Service (£1.4m YTD) which was stood up in conjunction with London Nightingale Hospital and now supports hospital transfers and includes £0.15m of equipment provided free of charge by DHSC which has been recognised notionally in the accounts as of M12 along with matching income.
- Decontamination Services - Premises (£2m YTD) for increased frequency of premises cleaning.

Movement in Forecast Outturn

Directorate / Division	Full Year 2020-21 £000				
	Annual Budget	M11 Forecast	M12 Position	M11 to M12 Movement fav/(adv)	COVID-19 Total Cost in Positions
Chief Executive	(2,490)	(2,482)	(2,536)	(54)	0
Chairman & Non-Executives	(118)	(135)	(144)	(9)	0
People & Culture	(6,392)	(6,602)	(6,570)	32	(37)
Communication & Engagement	(2,475)	(2,469)	(2,587)	(118)	0
Ambulance Services	(259,764)	(264,677)	(273,769)	(9,092)	(38,577)
999 Operations	(39,772)	(40,221)	(40,537)	(316)	(2,767)
IUC Services	(43,634)	(44,473)	(45,165)	(692)	(19,525)
Performance	(1,272)	(1,167)	(1,143)	23	0
Programmes & Projects	(8,541)	(7,820)	(7,630)	191	0
COO Management	(1,444)	(1,485)	(1,402)	83	0
Corporate Services	(8,172)	(8,309)	(8,441)	(132)	0
Finance	(4,271)	(4,210)	(4,326)	(115)	0
Strategy & Transformation	(2,126)	(2,703)	(3,044)	(341)	0
IM&T	(17,900)	(18,634)	(18,518)	116	(3,451)
Medical	(19,608)	(16,063)	(14,995)	1,068	(1,426)
Quality & Assurance	(5,616)	(5,436)	(5,379)	57	0
Strategic A&P Management	(378)	(494)	(573)	(79)	0
Property	(12,947)	(13,097)	(13,410)	(313)	(2,029)
Fleet & Logistics	(54,283)	(53,749)	(52,073)	1,676	(12,529)
Directorate Sub-Total	(491,203)	(494,228)	(502,242)	(8,015)	(80,341)
Central Income	516,772	516,966	529,831	12,866	0
Central Depreciation & Fin Charges	(19,528)	(16,393)	(17,457)	(1,064)	0
Apprenticeship levy	(1,414)	(1,429)	(1,415)	14	0
Legal Provisions	(945)	(588)	(699)	(111)	0
Other central costs & income	181	153	(564)	(717)	0
Net Reserves incl Unallocated CIP	2,283	(4,265)	(2,174)	2,090	0
COVID-19 Income and Central Costs	(3,752)	(3,909)	(4,120)	(211)	(3,846)
Central Sub-Total	493,597	490,535	503,402	12,867	(3,846)
Total surplus / (deficit)	2,394	(3,693)	1,160	4,852	(84,187)

Commentary on key forecast movements

1. Ambulance Services

- Increase between M11 forecast and M12 position due to recognition of Flowers case accrued settlement costs (£5.6m) recognised in overtime), higher seconded resource costs from LFB and Met Police (£1m) and annual leave accrual impacts.

2. Central Corporate

- Central Income movement due to the inclusion of £5.6m of Flowers case income and £4.8m NHSE Annual Leave income, along with £2.5m of additional income from NW London Commissioners in relation to COVID costs.
- Other Central Costs and Income movement due to increased redundancy costs (£0.5m) and year end bad debt provision recognition (£0.2m). Also includes notional income and expenditure in relation to central NHSE pension contributions paid on behalf of the Trust (£13.1m).
- Net Reserves incl Unallocated CIP movement driven by the movement of £3.4m of reserves (predominantly related to forecast annual leave accrual cost increases previously forecast centrally which have been recognised in other areas of the Trust based on year end information, partially offset by higher lease property related dilapidation (£1.3m) recognition compared to forecast based on updated information.
- Central Depreciation & Financial Charges movement due to the recognition of property valuation impairment charges (£1.5m) offset by lower PDC Dividend charges (£0.3m) and lower depreciation (£0.1m).

3. Medical

- Reduction in cost between periods due to additional Health Education England income (£0.7m) and lower numbers of recruits in training compared to forecast and thus lower trainee pay, course costs and facilities costs (£0.3m).

4. Fleet & Logistics

- Reduction in cost between periods due to the recognition of notional income in relation to centrally provided DHSC PPE (£4.2m) and lower operational supplies and services costs (£0.9m) primarily due to lower required levels of vehicle preparation support partially offset by higher PPE costs recognising DHSC provided PPE used (£1.9m) and higher equipment costs (£1.1m) largely in relation to year end stock movements and projects.

5. IUC Service

- Increase in cost between periods due to higher than forecast additional COVID contingency resource usage (£0.5m) and higher depreciation costs (£0.1m).

Supporting Information



	Month 12 2020-21 £000			YTD Month 12 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	43,109	74,846	31,737	463,886	496,419	32,533	463,886	496,419	32,533
Other Operating Income	159	5,829	5,670	69,289	71,204	1,915	69,289	71,204	1,915
Total Income	43,268	80,675	37,407	533,175	567,623	34,449	533,175	567,623	34,449
Operating Expense									
Pay	(29,853)	(52,609)	(22,756)	(361,732)	(389,971)	(28,239)	(361,732)	(389,971)	(28,239)
Non Pay	(10,939)	(18,759)	(7,821)	(147,039)	(156,689)	(9,650)	(147,039)	(156,689)	(9,650)
Total Operating Expenditure	(40,792)	(71,368)	(30,576)	(508,771)	(546,660)	(37,889)	(508,771)	(546,660)	(37,889)
EBITDA	2,476	9,307	6,831	24,404	20,963	(3,441)	24,404	20,963	(3,441)
EBITDA margin	5.7%	11.5%	5.8%	4.6%	3.7%	(0.9%)	4.6%	3.7%	(0.9%)
Depreciation & Financing									
Depreciation & Amortisation	(1,596)	(2,804)	(1,208)	(16,293)	(16,023)	270	(16,293)	(16,023)	270
PDC Dividend	(445)	323	768	(5,340)	(3,432)	1,908	(5,340)	(3,432)	1,908
Finance Income	0	0	0	(4)	9	13	(4)	9	13
Finance Costs	(2)	68	70	(34)	36	70	(34)	36	70
Gains & Losses on Disposals	0	(55)	(55)	(340)	(394)	(54)	(340)	(394)	(54)
Total Depreciation & Finance Costs	(2,043)	(2,468)	(425)	(22,010)	(19,803)	2,207	(22,010)	(19,803)	2,207
Net Surplus/(Deficit)	433	6,839	6,406	2,394	1,160	(1,234)	2,394	1,160	(1,234)
NHSI Adjustments to Fin Perf									
Remove Asset Donations I&E Impact	5	(407)	(412)	(68)	(480)	(412)	(68)	(480)	(412)
Remove AME Impairments	0	1,473	1,473	0	1,473	1,473	0	1,473	1,473
Remove Donations from DHSC Bodies	0	(1,896)	(1,896)	0	(1,896)	(1,896)	0	(1,896)	(1,896)
Adjusted Financial Performance	438	6,009	5,571	2,326	257	(2,069)	2,326	257	(2,069)
Net margin	1.0%	8.5%	7.5%	0.4%	0.2%	(0.2%)	0.4%	0.2%	(3.6%)

Full Year Position

The full year position is a £1.160m surplus (£0.257m surplus on an adjusted financial performance basis) which is £1.123m behind plan due to the reversal of accrued COVID retrospective top up income (£5.35m), the impact the new COVID variant surge has had on resourcing requirements and asset valuation impairment (£1.5m), offset by additional income in M12 from NHSE to cover annual leave movements (£4.8m) and additional income from NWL Commissioners (£2.5m).

Key items to note in the positions are:

- 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 was £32.5m favourable to budget full year due to £13.1m of notional income for central NHSE pension contributions on behalf of LAS staff, additional COVID related income from NW London Commissioners (£7.3m), Flowers case income (£5.6m) and annual leave accrual movement funding (£4.8m) from NHSE, Critical Care Transfer Service income (£0.5m) and IUC income (£0.5m).
- Other operating income was £1.9m favourable full year due to notional income for consumables and equipment provided by DHSC during the pandemic (£4.4m), the notification of an additional £1.9m of education and training income from Health Education England and £0.6m of additional charity, recharge and capital asset grant income offset by the reversal of £5.35m of accrued COVID retrospective top up income that the Trust was notified will not be received.
- Pay expenditure was £28.2m over budget full year due to the recognition of £13.1m of notional cost for central NHSE pension contributions on behalf of LAS staff, £5.6m of accrued cost in relation to settlements in relation to the Flowers case for 2019-20 and 2020-21 overtime and additional COVID surge resourcing (£9.3m).
- Non pay expenditure (excl depreciation and finance costs) was £9.7m adverse full year due to additional COVID support to respond to the impact of the new COVID-19 variants (£3.3m), dilapidation provisions (£2.1m), centrally provided stock and equipment costs (£2.4m) and higher general supplies and services spend (£2m) largely in relation to professional service support and projects.
- Depreciation and finance costs are £2.2m favourable to budget full year due to slippage on the Trust capital programme and subsequent PDC cost adjustments, offset by property impairment costs (£1.5m).

Financial Position by Directorate

Directorate	Month 12 2020-21 £000					YTD Month 12 2020-21 £000					Full Year 2020-21 £000				
	Budget	Actual	Budget Variance fav/(adv)	COVID	Actual excl COVID	Budget	Actual	Budget Variance fav/(adv)	COVID	Actual excl COVID	Budget	Forecast	Budget Variance fav/(adv)	COVID	Actual excl COVID
Chief Executive	(213)	(251)	(38)		(251)	(2,490)	(2,536)	(45)		(2,536)	(2,490)	(2,536)	(45)		(2,536)
Chairman & Non-Executives	(12)	(21)	(9)		(21)	(118)	(144)	(25)		(144)	(118)	(144)	(25)		(144)
People & Culture	(569)	(804)	(235)	(22)	(782)	(6,392)	(6,570)	(177)	(37)	(6,533)	(6,392)	(6,570)	(177)	(37)	(6,533)
Communication & Engagement	(206)	(341)	(136)		(341)	(2,475)	(2,587)	(112)		(2,587)	(2,475)	(2,587)	(112)		(2,587)
Ambulance Services	(20,871)	(29,942)	(9,071)	(4,902)	(25,040)	(259,764)	(273,769)	(14,006)	(38,527)	(235,242)	(259,764)	(273,769)	(14,006)	(38,527)	(235,242)
999 Operations	(3,120)	(3,544)	(425)	(209)	(3,335)	(39,772)	(40,537)	(766)	(2,767)	(37,771)	(39,772)	(40,537)	(766)	(2,767)	(37,771)
IUC Services	(2,581)	(3,478)	(897)	(2,139)	(1,339)	(43,634)	(45,165)	(1,532)	(19,056)	(26,110)	(43,634)	(45,165)	(1,532)	(19,056)	(26,110)
Performance	(96)	(74)	23		(74)	(1,272)	(1,143)	129		(1,143)	(1,272)	(1,143)	129		(1,143)
Programmes & Projects	(488)	371	859		371	(8,541)	(7,630)	911		(7,630)	(8,541)	(7,630)	911		(7,630)
COO Management	(71)	(52)	20		(52)	(1,444)	(1,402)	41		(1,402)	(1,444)	(1,402)	41		(1,402)
Corporate Services	(709)	(855)	(146)		(855)	(8,172)	(8,441)	(270)		(8,441)	(8,172)	(8,441)	(270)		(8,441)
Finance	(352)	(425)	(73)		(425)	(4,271)	(4,326)	(54)		(4,326)	(4,271)	(4,326)	(54)		(4,326)
Strategy & Transformation	(244)	(638)	(394)		(638)	(2,126)	(3,044)	(917)		(3,044)	(2,126)	(3,044)	(917)		(3,044)
IM&T	(1,246)	(1,319)	(72)	(34)	(1,284)	(17,900)	(18,518)	(618)	(3,451)	(15,066)	(17,900)	(18,518)	(618)	(3,451)	(15,066)
Medical	(2,165)	(992)	1,173	17	(1,009)	(19,608)	(14,995)	4,613	(1,229)	(13,766)	(19,608)	(14,995)	4,613	(1,229)	(13,766)
Quality & Assurance	(487)	(410)	77		(410)	(5,616)	(5,379)	237		(5,379)	(5,616)	(5,379)	237		(5,379)
Strategic A&P Management	(81)	(160)	(80)		(160)	(378)	(573)	(195)		(573)	(378)	(573)	(195)		(573)
Property	(1,053)	(1,544)	(491)	(136)	(1,408)	(12,947)	(13,410)	(463)	(2,029)	(11,380)	(12,947)	(13,410)	(463)	(2,029)	(11,380)
Fleet & Logistics	(4,160)	(2,916)	1,244	1,789	(4,705)	(54,283)	(52,073)	2,210	(12,529)	(39,544)	(54,283)	(52,073)	2,210	(12,529)	(39,544)
Directorate Sub-Total	(38,723)	(47,393)	(8,670)	(5,637)	(41,756)	(491,203)	(502,242)	(11,039)	(79,625)	(422,617)	(491,203)	(502,242)	(11,039)	(79,625)	(422,617)
Central Income	40,870	57,963	17,093	5,899	52,064	516,772	529,831	13,060	83,772	446,060	516,772	529,831	13,060	83,772	446,060
Central Corporate	(1,714)	(3,731)	(2,017)	(262)	(3,469)	(23,175)	(26,430)	(3,255)	(4,146)	(22,283)	(23,175)	(26,430)	(3,255)	(4,146)	(22,283)
Total	433	6,839	6,406	0	6,839	2,394	1,160	(1,234)	0	1,160	2,394	1,160	(1,234)	0	1,160

Ambulance Services

- Overspend of £14m primarily due to recognition of Flowers settlement costs (£5.6m) and increased COVID resourcing costs to respond to the new variant surge (£8.5m full year).
- COVID-19 costs are £38.5m full year primarily in relation to increased resourcing levels in preparation for higher absence rates and longer out of service, and LFB and Met Police support costs (£9.5m full year).

999 Operations

- Full year position is £0.8m over budget primarily due to increased resourcing costs to respond to the new variant of COVID-19.
- COVID-19 costs are £2.8m full year primarily in relation to increased resourcing levels.

IUC Services

- Full year position is £1.5m over budget due primarily to the

increased resourcing costs to respond to the new variant of COVID-19, partially offset by additional income (£0.6m).

- COVID-19 111 IUC costs net of income are £19.1m full year primarily in relation to increased call handling and clinical resourcing compared to pre-COVID planning.

Programmes & Projects

- Full year position £0.9m underspent due to Digital 999 project cost phasing differences due to COVID related slippage (£1.5m), Medicine Packing Unit project slippage (£0.5m) and additional income for Body Worn Camera and electric vehicle projects (£1m combined), partially offset by capitalisation differences and overspends on IT Infrastructure and secure email (£1.3m), Control Centres (£0.5m) and DCAs (£0.5m).

Strategy & Transformation

- Full year overspend of £0.9m driven by Ambulance Operations Modernisation project overspends.

Fleet & Logistics

- £2.2m favourable to budget full year due primarily to notional DHSC PPE income (£4.2m) offset by notional costs (£1.9m).
- Net COVID-19 costs of £12.5m full year relate primarily to increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle cleaning, and increased purchases of personal protective equipment, medical equipment and operational consumables partially offset by notional income noted above.

IM&T

- £0.6m unfavourable to budget for the year due to higher net resourcing costs (£0.4m) and higher technology and comms costs (£0.3m).
- COVID-19 costs of £3.5m relate primarily to IT equipment and IT services to enable home working, and systems and telephony expansions.

Medical

- Favourable variance of £4.6m driven by increased HEE income notified less associated costs not already forecast, and re-phased and reduced trainee costs due to current COVID pressures.
- COVID-19 costs relate to Critical Care Transfer Service (£1.2m).

Property

- £0.5m unfavourable to budget for the year due to driven by increased rent, rates and service charges.
- COVID-19 costs of £2m full year relate primarily to increased premises cleaning and facilities adjustments to facilitate new operating models.

Income

Income by Type	Month 12 2020-21 £000			YTD Month 12 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Patient Care Income									
Commercial Service Income	117	74	(43)	1,210	1,075	(135)	1,210	1,075	(135)
Emergency & Urgent Care Income	40,743	47,330	6,588	449,400	457,244	7,844	449,400	457,244	7,844
Emergency Bed Service Income	0	8	8	0	47	47	0	47	47
Injury Cost Recovery Income	81	51	(30)	970	1,022	52	970	1,022	52
Neonatal Service Income	12	12	0	130	130	0	130	130	0
Non-Contract E&UC Income	16	(4)	(20)	174	135	(39)	174	135	(39)
Other Patient Care Income	101	11,074	10,973	773	12,451	11,678	773	12,451	11,678
Patient Transport Service Income	0	0	0	0	0	0	0	0	0
Specialist Service Income	203	913	710	2,533	2,504	(29)	2,533	2,504	(29)
Telephone Advice Service Income	1,837	2,283	446	8,695	8,706	11	8,695	8,706	11
Centrally Paid Pension Income	0	13,105	13,105	0	13,105	13,105	0	13,105	13,105
Total Patient Care Income	43,109	74,846	31,737	463,886	496,419	32,533	463,886	496,419	32,533
Other Operating Income	159	5,829	5,670	69,289	71,204	1,915	69,289	71,204	1,915
Total Income	43,268	80,675	37,407	533,175	567,623	34,449	533,175	567,623	34,449

The Trust was operating under an adjusted financial framework for the period April to September 2020 which involved pausing contracting and commissioning processes (including CQUIN), the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions. In M8-12, fixed Top up and COVID supplement income was received, and an additional £7.3m has been received from NWL STP in relation to COVID related costs.

Patient Care Income

Emergency & Urgent Care Income

- E&UC income is £7.8m favourable full year due to additional NWL STP and other specific COVID related support income.

- Block contract income is reported under the emergency and urgent care heading with £34m being received each month.
- M7-12 top up, fixed COVID and additional COVID surge support income totalling £48.7m is also included here.
- This has been offset in the position by the crediting of invoices issued in relation to the Flowers case (£2.5m) in M3.

Telephone Advice Service Income

- This limited to 111 First programme and NW London 111 IUC Service income due to the adjusted financial framework in place, and is in line with budget.

Centrally Paid Pension Income

- £13.1 of notional income has been recognised in relation to increased pension costs paid by NHE on the Trust's behalf.

Other Patient Care Income

- This includes £5.6m Flowers case income and £4.8m NHSE Annual Leave income

Commercial Service Income

- Due to the COVID-19 pandemic, very limited stadia income was received and Heathrow contract income was reduced and was adverse to budget by £0.1m.

Specialist Service Income

- The full year Specialist Service income position finished the year broadly on budget with adjusted BARTS PRU service income (£0.7m adverse variance) offset by additional bodyworn camera project income (£0.7m).

Other Operating Income

M1-6 Top Up Income

- Standard monthly top up income of £2.657m was received in M1-6, along with retrospective top up income to breakeven (on an adjusted financial performance basis) of £44.6m YTD. This decreased by £5.35m in month 11 due to notifications this amount will not be paid.

Other Non Patient Care Income

- Notional income of £4.4m has been recognised in relation to PPE and equipment provided centrally by DHSC.

Education & Training

- Education and Training funding is £1.9m favourable to revised budgets full year due to higher training & development funding from Health Education England for the Nov – Mar period.

Pay Expenditure

Pay Expenditure by Type	Month 12 2020-21 £000			YTD Month 12 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Substantive									
Corporate & Support Staff	(2,951)	(3,248)	(298)	(33,589)	(32,807)	782	(33,589)	(32,807)	782
Directors And Senior Managers	(1,500)	(1,609)	(109)	(16,196)	(15,249)	946	(16,196)	(15,249)	946
Frontline Control Staff	(2,681)	(3,040)	(359)	(27,821)	(27,696)	126	(27,821)	(27,696)	126
Frontline Ops Staff	(15,321)	(17,965)	(2,644)	(179,055)	(182,187)	(3,132)	(179,055)	(182,187)	(3,132)
Med. Nursing & Clin Adv Staff	(710)	(826)	(116)	(8,158)	(8,015)	143	(8,158)	(8,015)	143
Non-Emergency Control Staff	(15)	(21)	(6)	(179)	(184)	(4)	(179)	(184)	(4)
Non Emergency Ops Staff	(442)	(318)	124	(5,330)	(4,849)	481	(5,330)	(4,849)	481
Ops Management & Team Leaders	(2,769)	(3,267)	(497)	(32,223)	(33,043)	(820)	(32,223)	(33,043)	(820)
Other Pay Costs	29	(10,429)	(10,457)	(945)	(15,449)	(14,504)	(945)	(15,449)	(14,504)
Overtime & Incentives	(2,527)	(8,985)	(6,458)	(39,983)	(47,977)	(7,995)	(39,983)	(47,977)	(7,995)
Total Substantive	(28,886)	(49,707)	(20,821)	(343,478)	(367,456)	(23,978)	(343,478)	(367,456)	(23,978)
Agency	(111)	(789)	(678)	(4,980)	(6,680)	(1,700)	(4,980)	(6,680)	(1,700)
Bank	(362)	(324)	39	(6,230)	(6,038)	192	(6,230)	(6,038)	192
Seconded	(494)	(1,789)	(1,295)	(7,044)	(9,797)	(2,753)	(7,044)	(9,797)	(2,753)
Total Pay Expenditure	(29,853)	(52,609)	(22,756)	(361,732)	(389,971)	(28,239)	(361,732)	(389,971)	(28,239)

Full Year Position

Pay expenditure was £390m for the year which was £28.2m adverse to revised budgets. Key items include:

- Notional pension contribution costs paid on the Trust's behalf by NHS England (£13.1m)
- COVID-19 response costs of £48.2m (£9.2m higher than budget excluding annual leave costs) primarily in relation to additional resourcing across Ambulance Services, IUC Services, 999 Operations and Critical Care Transfer Services, and including costs associated with responding to the new COVID variant.
- Flowers case accrued settlement costs (£5.6m recognised in overtime)
- The COVID position includes £9.5m of costs in relation to seconded support from the LFB and Met Police.
- Increased annual leave accrual costs (£4.8m)
- Overspend in Ambulance Services (£15.6m) is primarily due to anticipated costs associated with responding to the new COVID variant, Flowers case settlement costs and annual leave costs, whilst the overspend in Central Corporate (£14.5m) is primarily in relation to the notional pension costs paid on the Trust's behalf by NHE noted above (£13.1m).
- These are partially offset by favourable variances in Programmes and Projects (£1m) due to capitalisations and delays in projects due to COVID, and Medical (£1.9m) due to capitalisations and delayed recruitment to vacancies.
- Pay spend in relation to the 111 First programme and NW London IUC services are included in budgets and forecasts (both funded through additional income).

Pay Expenditure by Directorate	Budget			Actual			Budget Variance fav/(adv)		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	26	(11,683)	(11,709)	(1,276)	(15,791)	(14,515)	(1,276)	(15,791)	(14,515)
Chief Executive	(170)	(204)	(33)	(2,037)	(2,136)	(99)	(2,037)	(2,136)	(99)
People & Culture	(336)	(453)	(117)	(4,567)	(4,974)	(407)	(4,567)	(4,974)	(407)
Communication & Engagement	(185)	(234)	(49)	(2,370)	(2,433)	(63)	(2,370)	(2,433)	(63)
Ambulance Services	(20,118)	(30,007)	(9,889)	(246,988)	(262,541)	(15,552)	(246,988)	(262,541)	(15,552)
999 Operations	(3,018)	(3,443)	(425)	(38,511)	(39,121)	(610)	(38,511)	(39,121)	(610)
IUC Services	(1,770)	(2,058)	(288)	(20,527)	(20,348)	179	(20,527)	(20,348)	179
Projects & Programmes	(166)	(193)	(27)	(2,079)	(1,091)	988	(2,079)	(1,091)	988
COO Management	(51)	(5)	46	(1,198)	(1,072)	125	(1,198)	(1,072)	125
Corporate Services	(210)	(266)	(57)	(2,224)	(2,188)	35	(2,224)	(2,188)	35
Finance	(269)	(314)	(45)	(3,274)	(3,417)	(144)	(3,274)	(3,417)	(144)
Performance	(86)	(85)	1	(959)	(933)	26	(959)	(933)	26
Strategy & Transformation	(65)	(251)	(186)	(771)	(1,018)	(247)	(771)	(1,018)	(247)
IM&T	(393)	(390)	3	(4,390)	(4,134)	257	(4,390)	(4,134)	257
Medical	(1,829)	(1,593)	236	(16,300)	(14,450)	1,850	(16,300)	(14,450)	1,850
Quality & Assurance	(488)	(483)	5	(5,712)	(5,584)	128	(5,712)	(5,584)	128
Strategic A&P Management	(80)	(48)	32	(345)	(239)	106	(345)	(239)	106
Property	(40)	(47)	(7)	(649)	(754)	(105)	(649)	(754)	(105)
Fleet & logistics	(606)	(852)	(246)	(7,551)	(7,742)	(191)	(7,551)	(7,742)	(191)
Total Pay Expenditure	(29,853)	(52,609)	(22,756)	(361,732)	(389,971)	(28,239)	(361,732)	(389,971)	(28,239)

Non Pay and Financial Charges

Non Pay by Type	Month 12 2020-21 £000			YTD Month 12 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Non Pay Expenditure									
Establishment Expenses	(669)	(1,391)	(722)	(10,023)	(10,901)	(878)	(10,023)	(10,901)	(878)
General Supplies & Services	(1,460)	(3,001)	(1,541)	(20,134)	(23,923)	(3,789)	(20,134)	(23,923)	(3,789)
Technology & Communications	(1,076)	(1,762)	(686)	(17,131)	(19,290)	(2,159)	(17,131)	(19,290)	(2,159)
Operations Supplies & Services	(4,251)	(7,178)	(2,928)	(55,137)	(57,897)	(2,759)	(55,137)	(57,897)	(2,759)
Premises & Fixed Plant	(1,525)	(4,133)	(2,608)	(18,226)	(21,173)	(2,947)	(18,226)	(21,173)	(2,947)
Transport	(1,959)	(1,295)	664	(26,387)	(23,505)	2,882	(26,387)	(23,505)	2,882
Total Non Pay Expenditure	(10,939)	(18,759)	(7,821)	(147,039)	(156,689)	(9,650)	(147,039)	(156,689)	(9,650)
Financial Charges									
Depreciation & Amortisation	(1,596)	(2,804)	(1,208)	(16,293)	(16,023)	270	(16,293)	(16,023)	270
Other Financial Charges	(447)	335	783	(5,717)	(3,781)	1,937	(5,717)	(3,781)	1,937
Total Financial Charges	(2,043)	(2,468)	(425)	(22,010)	(19,803)	2,207	(22,010)	(19,803)	2,207
Total Non Pay & Financial Charges	(12,982)	(21,228)	(8,246)	(169,050)	(176,493)	(7,443)	(169,050)	(176,493)	(7,443)

Full Year Forecast Position

Non pay expenditure including financial charges finished the year at £176.5m which was £7.4m unfavourable to revised budgets. Key items include:

- £3.8m negative variance on General Supplies and Services due predominantly to increased project costs (£1.5m), forecast achievement of CIP in transport previously budgeted in general supplies and services (£1.2m), managed service resourcing in IM&T (£0.7m) and training costs (£0.3m).
- £2.8m negative variance on Operational Supplies and Services primarily in relation to notional costs recognised for PPE and equipment provided by DHSC without charge (£2.4m) and other COVID response costs.
- £2.9m negative variance on Premises expenses primarily in relation to dilapidation provisions (£2.2m) and estates projects (£0.5m).
- £2.2m negative variance on Technology and Comms due to additional system and technology service costs, project costs and GoodSam app costs.
- Partially offset by lower depreciation and PDC (£2.2m favourable variance due to capital project slippage partially offset by property valuation impairment), and reduced transport costs (£2.9m favourable variance driven by lower private ambulance costs).
- COVID-19 response costs of £40.2m in relation to increased 111 IUC external resourcing, increased external vehicle maintenance and prep services, increased vehicle and premises cleaning, PPE, medical equipment, operational consumables, IT equipment and services to enable home working and expand systems and telephony capacity and capability, and depreciation impacts in respect of assets purchased.
- Write back and impairment in prior months of £2.3m of previously capitalised technology and general supplies and services costs in relation to the CAD project.

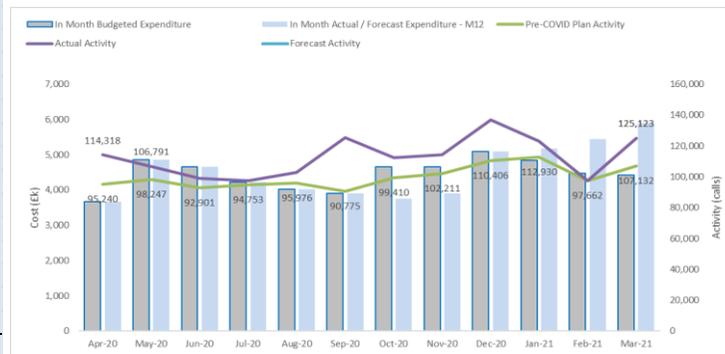
Non Pay by Directorate	Budget Variance fav/(adv)			Budget Variance fav/(adv)			Budget Variance fav/(adv)		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	(1,740)	(5,154)	(3,413)	(22,147)	(23,961)	(1,814)	(22,147)	(23,961)	(1,814)
Chief Executive	(43)	(48)	(5)	(458)	(410)	48	(458)	(410)	48
Chairman & Non-Executives	(12)	(21)	(9)	(114)	(139)	(25)	(114)	(139)	(25)
People & Culture	(354)	(458)	(104)	(3,957)	(3,709)	247	(3,957)	(3,709)	247
Communication & Engagement	(25)	(50)	(25)	(315)	(332)	(17)	(315)	(332)	(17)
Ambulance Services	(1,042)	(224)	818	(16,144)	(14,034)	2,110	(16,144)	(14,034)	2,110
999 Operations	(101)	(101)	0	(1,281)	(1,437)	(155)	(1,281)	(1,437)	(155)
IUC Services	(2,660)	(3,843)	(1,183)	(31,979)	(34,286)	(2,307)	(31,979)	(34,286)	(2,307)
Projects & Programmes	(389)	(1,080)	(691)	(7,104)	(8,923)	(1,819)	(7,104)	(8,923)	(1,819)
COO Management	(20)	(46)	(26)	(246)	(330)	(84)	(246)	(330)	(84)
Central Income	0	0	0	0	0	0	0	0	0
Corporate Services	(499)	(589)	(89)	(5,960)	(6,264)	(305)	(5,960)	(6,264)	(305)
Finance	(83)	(111)	(28)	(998)	(917)	81	(998)	(917)	81
Performance	(10)	11	22	(313)	(210)	103	(313)	(210)	103
Strategy & Transformation	(179)	(394)	(215)	(1,355)	(2,043)	(688)	(1,355)	(2,043)	(688)
IM&T	(853)	(929)	(76)	(13,509)	(14,419)	(909)	(13,509)	(14,419)	(909)
Medical	(390)	(356)	34	(3,959)	(3,428)	530	(3,959)	(3,428)	530
Quality & Assurance	(12)	28	40	(146)	(136)	10	(146)	(136)	10
Strategic A&P Management	(1)	(112)	(111)	(34)	(335)	(301)	(34)	(335)	(301)
Property	(1,013)	(1,497)	(484)	(12,301)	(12,659)	(358)	(12,301)	(12,659)	(358)
Fleet & logistics	(3,554)	(6,256)	(2,702)	(46,731)	(48,522)	(1,791)	(46,731)	(48,522)	(1,791)
Total Non Pay & Financial Charges	(12,982)	(21,228)	(8,246)	(169,050)	(176,493)	(7,443)	(169,050)	(176,493)	(7,443)

IUC / 111 Services

	111 IUC Total YTD M12 2020-21 £000			111 IUC Total FY Forecast M12 2020-21 £000		
	Budget	YTD	Variance fav/(adv)	Budget	Full Year Forecast	Variance fav/(adv)
Income						
Income from Activities	8,872	9,468	597	8,872	9,468	597
Other Income	0	0	0	0	0	0
Total Income	8,872	9,468	597	8,872	9,468	597
Pay						
Substantive Staff	(16,852)	(15,749)	1,102	(16,852)	(15,749)	1,102
Agency	(2,551)	(3,405)	(854)	(2,551)	(3,405)	(854)
Bank	(1,124)	(1,193)	(69)	(1,124)	(1,193)	(69)
Total Pay Expenditure	(20,527)	(20,348)	179	(20,527)	(20,348)	179
Non Pay						
Establishment Expenses	(39)	(28)	10	(39)	(28)	10
General Supplies & Services	(1,224)	(1,576)	(352)	(1,224)	(1,576)	(352)
Technology & Communications	(1,565)	(1,715)	(151)	(1,565)	(1,715)	(151)
Operations Supplies & Services	(27,407)	(28,823)	(1,416)	(27,407)	(28,823)	(1,416)
Premises & Fixed Plant	(1,437)	(1,713)	(276)	(1,437)	(1,713)	(276)
Transport	(8)	(6)	1	(8)	(6)	1
Depreciation & Amortisation	(300)	(424)	(125)	(300)	(424)	(125)
Total Non Pay	(31,979)	(34,286)	(2,308)	(31,979)	(34,286)	(2,308)
Net Surplus/(Deficit)	(43,634)	(45,166)	(1,532)	(43,634)	(45,166)	(1,532)

Key points to note:

- The current financial arrangements mean that funding for NE and SE London contracts are predominantly covered by block contract arrangements, however specific income was received for 111 First (£2.9m) and NW London IUC (£5.7m).
- Full year activity was around 13% higher than the pre-COVID plan due to COVID related demand changes. Compounding this, calls requiring transfer to a clinician have increased by 22% and 26% YTD for SE and NE London respectively, along with an increase in clinician call time of 27% and 29% in SE and NE London respectively.
- Significant quantities of additional resource have been engaged to manage activity - COVID-19 response costs have been £19.5m for the year.
- The overall IUC position includes £28.5m of managed services and GP costs to deliver stable clinical services and respond to COVID-19 demand levels, the 111 First programme and to provide the NW London 111 service.



Capital Investment

	Actual (£m) Apr-20	Actual (£m) May-20	Actual (£m) Jun-20	Actual (£m) Jul-20	Actual (£m) Aug-20	Actual (£m) Sep-20	Actual (£m) Oct-20	Actual (£m) Nov-20	Actual (£m) Dec-20	Actual (£m) Jan-21	Actual (£m) Feb-21	Actual (£m) Mar-21	Total
Monthly capital spend	3.554	1.842	1.770	(1.603)	0.761	0.512	1.164	3.278	6.058	2.447	2.557	21.465	43.805
Original plan	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	21.814
Adjusted CRL Plan	4.226	1.080	2.197	1.145	1.145	6.038	6.038	6.038	6.038	3.428	3.428	3.410	44.211
Revised forecast	3.554	1.842	1.770	(1.603)	0.761	0.512	1.164	3.278	6.058	2.447	2.557	21.465	43.805
Disposals				(0.356)		(0.005)						(0.101)	(0.462)
Revised forecast net of disposals	3.554	1.842	1.770	(1.960)	0.761	0.507	1.164	3.278	6.058	2.447	2.557	21.364	43.343
Cumulative actual	3.554	5.396	7.166	5.562	6.323	6.836	8.000	11.278	17.336	19.783	22.340	43.805	
Cumulative original plan	1.818	3.636	5.454	7.271	9.089	10.907	12.725	14.543	16.361	18.178	19.996	21.814	
Cumulative revised forecast net of disposals	3.554	5.396	7.166	5.206	5.967	6.474	7.638	10.917	16.975	19.422	21.979	43.343	
Cumulative adjusted CRL plan	4.226	5.306	7.503	8.648	9.793	15.831	21.869	27.907	33.945	37.373	40.801	44.211	

Programme	(£m) YTD (excl Disposals)
CAD Essentials	(2.492)
Digital 999	5.736
COVID-19 Response - Phase 1	5.822
COVID-19 Response - Phase 2	7.377
Fleet	9.119
IM&T Essentials	8.449
IM&T Cyber	0.094
OneLondon	0.003
Medicines Modernisation	0.936
Spatial Development	4.750
Estates	3.109
Logistics	0.441
Ambulance Operations Modernisation	0.401
Other	0.058
Total	43.805

The Trust's capital plan was revised in mid-late June 2020 (following review in late May) to reflect additional capital investment in relation to COVID-19 from the initial £21.8m to a revised £44.2m. A further £6.1m had been identified to increase the CRL limit to £50.3m, however in conjunction with NW London partners, this was scaled back to £39.9m due to reduced availability of funding and other changes. This has now increased to £43.8m due to additional PDC for technology investments and is expected to be funded from:

- Internally generated capital (£20.2m);
- HSLI, Provider Digitisation, Cyber Security and other Technology Programme PDC (£5.9m);
- Grants (£0.4m); and
- COVID Phase 1 PDC (£5.6m).

YTD and Full Year Position

- Full year capital expenditure net of disposals and donated assets was £43.3m (£44m before disposals) compared to previously planned capital expenditure of £44.2m (£0.9m behind plan net of disposals).
- Very significant capital project spend was able to be recognised in M12 enabling forecast spend to be met.
- Capital spend on the Trust's phase 1 and 2 COVID-19 responses was £19.3m (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 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 Flow Statement

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Mar-20	Mar-20	Mar-20
	Actual	Actual	Actual	Actual	Actual	Actual	YTD	YTD	YTD
	£000	£000	£000	£000	£000	£000	Move	Plan	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	64,610	76,394	78,620	86,719	80,572	84,806	25,964	25,964	0
Operating Surplus	1,849	2,117	1,677	(1,519)	(2,694)	7,298	18,951	24,242	(5,291)
(Increase)/decrease in current assets	8,512	2,247	7,024	(3,985)	7,279	(13,363)	(6,268)	9,380	(15,648)
Increase/(decrease) in current liabilities	2,397	4,700	1,807	1,836	4,547	(38,141)	31,680	711	30,969
Increase/(decrease) in provisions	(86)	(240)	(1,265)	(104)	402	959	963	(3,903)	4,866
Net cash inflow/(outflow) from operating activities	12,672	8,824	9,243	(3,772)	9,534	(43,247)	45,326	30,430	14,896
Cashflow inflow/(outflow) from operating activities	12,672	8,824	9,243	(3,772)	9,534	(43,247)	45,326	30,430	14,896
Returns on investments and servicing finance	0	0	0	12	0	1	1	(12)	13
Capital Expenditure	(888)	(3,880)	(1,144)	(2,387)	(5,300)	(11,853)	(38,973)	(45,665)	6,692
Dividend paid	0	(2,718)	0	0	0	(1,474)	(4,192)	(5,392)	1,200
Financing obtained	0	0	0	0	0	11,555	11,662	13,480	(1,818)
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	(888)	(6,598)	(1,144)	(2,375)	(5,300)	(1,771)	(31,502)	(37,589)	6,087
Movement	11,784	2,226	8,099	(6,147)	4,234	(45,018)	13,824	(7,159)	20,983
Closing Cash Balance	76,394	78,620	86,719	80,572	84,806	39,788	39,788	18,805	20,983

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.

Summary

There has been a net inflow of cash to the Trust of £13.8m, this is £21.0m higher than the planned outflow of (£7.2m)

Cash funds at 31 March stand at £39.8m

Operating Surplus

- The operating surplus at £19.0m is £5.3m below plan

Current Assets

- The movement on current assets is (£6.3m), (£15.7m) lower than the planned movement
- Current assets movement was due to receivables (£0.4m), accrued income (£12.1m), prepayments (£1.3m) and inventories (£1.9m)

Current Liabilities

- The movement on current liabilities is £31.7m, a £31.0m higher than planned movement.
- Current liabilities movement was lower than planned due to trade and other payables £3.8m, accruals £26.0m and deferred income at £1.2m. The accruals increase is due to an increase in activity and delays in suppliers sending their invoices for payment.

Dividends

- The movement on dividends paid is (£1.2m), the lower payment is due to higher daily cash balances during the year

Provisions

- The movement on provisions is £1.0m, which is £4.9m higher than the planned movement. This is due to the payment for the Flowers case being deferred until next year.

Capital Expenditure

- Capital cash movement was a net outflow of £39.0m which is £7.0m below plan due to capital slippage

Statement of Financial Position

	Mar-20 Act £000	Oct-20 Act £000	Nov-20 Act £000	Dec-20 Act £000	Jan-21 Act £000	Feb-21 Act £000	Mar-21 Act £000	Plan £000	Mar-21 Var £000	%
Non Current Assets										
Property, Plant & Equip	177,186	175,818	178,122	182,659	184,050	185,029	194,033	204,281	(10,248)	(5.0%)
Intangible Assets	8,183	9,202	9,601	9,253	8,990	9,223	13,109	9,167	3,942	43.0%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	
Total Non Current Assets	185,369	185,020	187,723	191,912	193,040	194,252	207,142	213,448	(6,306)	(3.0%)
Current Assets										
Inventories	4,508	4,555	4,641	4,761	4,755	4,943	6,440	4,492	1,948	43.4%
Trade & Other Receivables	22,270	27,693	25,360	18,216	22,207	14,740	26,780	12,906	13,874	107.5%
Cash & cash equivalents	25,964	76,394	78,620	86,719	80,572	84,807	39,788	18,805	20,983	111.6%
Non-Current Assets Held for Sale	0	0	0	0	0	0	0	0	0	
Total Current Assets	52,742	108,642	108,621	109,696	107,534	104,490	73,008	36,203	36,805	101.7%
Total Assets	238,111	293,662	296,344	301,608	300,574	298,742	280,150	249,651	30,499	12.22%
Current Liabilities										
Trade and Other Payables	(47,012)	(100,753)	(103,289)	(109,433)	(111,359)	(113,189)	(81,037)	(46,557)	(34,480)	74.1%
Provisions	(6,584)	(8,489)	(8,226)	(6,974)	(6,419)	(6,798)	(7,557)	(3,255)	(4,302)	132.2%
Borrowings	0	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	0	
Total Current Liabilities	(53,596)	(109,242)	(111,515)	(116,407)	(117,778)	(119,987)	(88,594)	(49,812)	(38,782)	77.9%
Total Assets Less Current Liabilities	184,515	184,420	184,829	185,201	182,796	178,755	191,556	199,839	(8,283)	(4.1%)
Non Current Liabilities										
Trade and Other Payables	0	0	0	0	0	0	0	0	0	
Provisions	(8,436)	(7,756)	(7,781)	(7,770)	(8,223)	(8,248)	(8,381)	(7,887)	(494)	6.3%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.0%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	0	0	0	
Total Non Current Liabilities	(8,543)	(7,863)	(7,888)	(7,877)	(8,330)	(8,355)	(8,488)	(7,994)	(494)	6.2%
Total Assets Employed	175,972	176,557	176,941	177,324	174,466	170,400	183,068	191,845	(8,777)	(4.6%)
Financed by Taxpayers Equity										
Public Dividend Capital	66,178	66,285	66,285	66,285	66,285	66,285	77,840	79,658	(1,818)	(2.3%)
Retained Earnings	54,593	55,071	55,455	55,838	52,980	48,914	57,741	56,986	755	1.3%
Revaluation Reserve	55,620	55,620	55,620	55,620	55,620	55,620	47,906	55,620	(7,714)	(13.9%)
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.0%
Total Taxpayers Equity	175,972	176,557	176,941	177,324	174,466	170,400	183,068	191,845	(8,777)	(4.6%)

Non Current Assets

- Non current assets stand at £207.1m, £6.3m below plan. This is due to our planned capital being reduced in year by DHSC.

Current Assets

- Current assets stand at £73.0m, £36.8m above plan
- Cash position as at 31 March is £39.8m, £21.0 above plan
- Trade & Other Receivables, Receivables (debtors) at £26.8m are £13.8m above plan, accrued income at £17.0m is £12.0m above plan, receivables at £2.5m is £0.4m above plan and prepayments at £7.1m are £1.3m above plan

Current Liabilities

- Current liabilities stand at £88.6m, £38.8m above plan
- Trade and Other Payables, Payables and accruals at £88.6m are £34.2m above plan
- Deferred Income at £0.3m is 0.2m above plan.
- Current provisions at £7.6m is £4.3m above plan. Payment of the provision for the flowers case has deferred until the next financial year

Non Current Liabilities

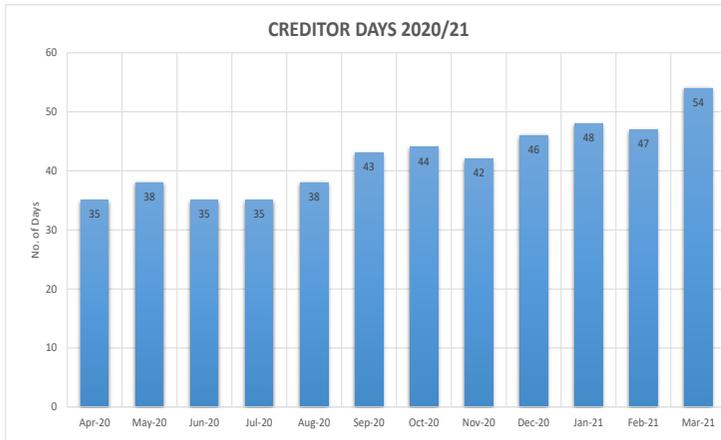
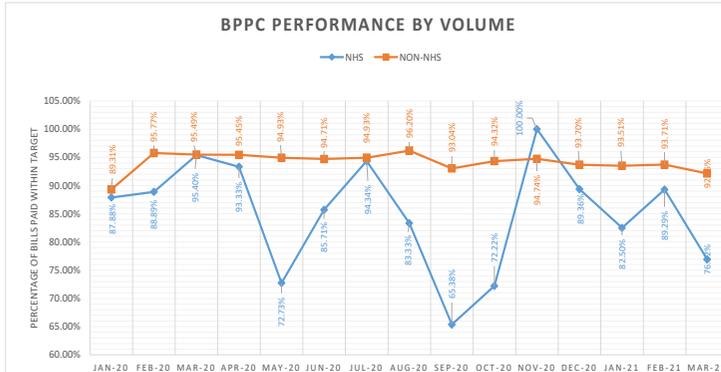
- Non current provisions at £8.5m, £0.5m above plan. Borrowings are on plan

Taxpayers Equity

- Public Dividend Capital stands at £77.8m is (£1.8m) below plan
- Retained Earnings stands at £57.7m, is £0.8m above plan
- Revaluation Reserve stands at £47.9m, is (£7.7m) below target. This due to the fall in the value of buildings as at 31 March 2021.
- Taxpayers Equity stands at £183.1m, is (£8.8m) 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.

Better Payment Practice Code (BPPC)



BPPC

- The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days.
- The Trust has a high volume of overdue invoices waiting to be approved. ELFS and finance team are chasing managers and staff to approve their invoices.
- ELFS and finance are working to fine tune the process of invoice approval to reduce the delays.
- The volume of invoices paid for the 12 months to the end of March 2021 is 57,095 and 448 for Non-NHS and NHS respectively.
- During the COVID period there has been a focus on paying invoices within 7 days wherever possible. At present whilst only 17.6% of invoices were paid within 7 days based on their invoice date (24.0% based on date received), invoices are put on the next payment run regardless of due dates as soon as they are authorised for payment. The Trust currently makes two payment runs to suppliers each week.

Creditor Days

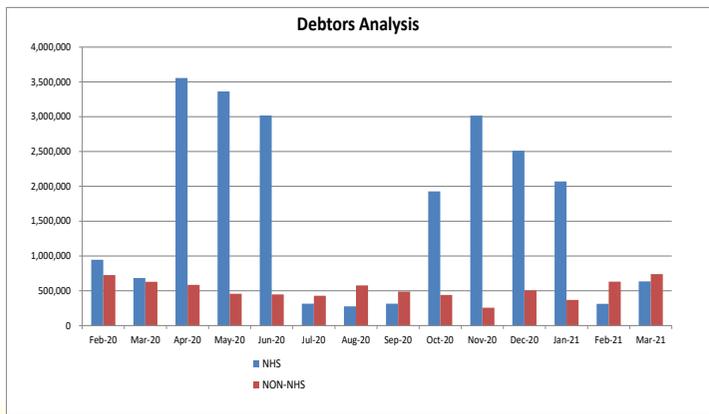
- The increase in creditor days in September 20, October 20 and March 20 was due to an increase in capital creditors and COVID spend.
- There has been a steady increase in creditor days over the winter and summer months.

Debtors Analysis

Aged Debtors Summary 31st March 2021

	Note	Total £'000	Days Overdue			
			0 - 30 £'000	31 - 60 £'000	61 - 90 £'000	Over 91 days £'000
NHS Debtors						
Nhs Brent Ccg	1	249	224	25	-	-
Nhs South East London Ccg	1	106	24	32	2	48
Barts Health Nhs Trust	1	84	49	21	2	12
West Midlands Ambulance Service Univ. Nhs Ft	1	78	78	-	-	-
North East London Csu	1	24	21	-	-	3
Guy'S & St Thomas' Nhs Foundation Trust	1	21	17	-	1	2
<£5,000	1	72	17	9	5	41
NHS Debtors		634	431	86	10	106
Non-NHS Debtors						
Merton Health Ltd	2	159	-	159	-	-
Heathrow Airport Ltd	3	223	111	111	-	-
Twickenham Rfu	4	37	24	13	-	-
Tottenham Hotspur Fc	5	31	-	31	-	-
Association Of Ambulance Chief Executives	6	25	25	-	-	-
<£15,000	7	264	25	27	12	200
Total Non NHS Debtors		738	185	341	12	200
TOTAL DEBTORS 28th February 2021		1,372	617	427	22	306

Source: Debtors Ledger 31st March 2021



Debtors Position: 31st of March 2021

Total outstanding NHS and Non-NHS debtors as at 31st March 2021 amounted to £1.4m. The NHS over 60 day's debt stands at £116k.

1. NHS Debtors:

- 3 x NHS Brent Ccg invoice for £224k. South East London CCG have requested backing to support that SEL commissioned the service, an update will be provided in due course. 7 x small balance and Extra Contractual Journey (ECJ) fees which the Trust is actively pursuing, we expect much of this remainder to be resolved during April.
- 18 x Barts Health NHS Trust Invoices (£12k). The invoices relate to ongoing issues the Trust have had in respect of Barts raising the required purchase orders. We have now managed to locate the correct senior finance managers for each case and are now liaising directly with finance, so expect resolution for all these invoices in the coming weeks.
- North East London NHS Trust The Trust are in the process of resolving these individually with the respective budget holders and expect payments to continue to come in during April.

2. Merton Health Ltd- £159k (1 invoice) – The invoice is due for payment, payment expected anytime from now.

3. Heathrow Airport Ltd- £223K (2 invoices) – Invoices paid on the 12th April 2021.

4. Twickenham Rfu - £37k (10 invoices) - The Trust has received £14.6k in April 2021.

5. Tottenham Hotspur Fc - £31k (4 invoice) - The invoices were not received, Invoices have now been sent again, waiting for payment.

6. Association Of Ambulance Chief Executives - £25k (2 invoice) - Invoices paid on the 16th April 2021.

7. Non-NHS Debtors <£15k - £264k consists of; £199k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £15 of stadia events, the stadiums are being chased for payment on a regular basis. The remaining 50k is due from local Government bodies and other miscellaneous organisations.

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



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Quality Report			
Agenda item:	12			
Report Author(s):	John Martin, Chief Paramedic and Quality Officer			
Presented by:	John Martin, Chief Paramedic and Quality Officer			
History:	Quality Assurance committee – May 2021			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting

Key Points, Issues and Risks for the Board / Committee’s attention:

This paper presents the annual quality account 2020/2021 which is presented in two parts.

Part 1:
 This section looks forward to this financial year (2021-22) and presents 10 quality priorities to be implemented during the year. These priorities were identified following a review of internal quality intelligence, consultation with the Quality Governance Managers across all sectors and services, the Medical Directorate team & members of the Quality Oversight Group.

This year’s 10 quality priorities are;

1. Implementation of the Patient Safety Incident Response Framework (PSIRF)
2. Improving staffing levels, productivity and efficiency across Integrated Patient Care service
3. Improving the management of clinical equipment
4. Improving Medicines management & storage
5. Further engagement and involvement of Patients & Communities
6. Delivery of the Clinical Strategy
7. Integrating the 999 and 111/ IUC CAS systems
8. Implementation of the station/service quality accreditation programme
9. Development of the Trust’s Culture Diversity and Inclusion (CDI) Strategy
10. Continued focus on Staff health & wellbeing

Part 2:
 This section looks back at progress made against the 18 quality priorities of the last financial year (2020-2021). Despite the pandemic, considerable progress was made on 17 of the 18 priorities as detailed in the report. The one exception was the quality priority relating to the roll out of tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients. This was suspended as a priority as both services had to be taken off the road due to COVID.

Recommendation(s) / Decisions for the Board / Committee:

The Trust Board is asked to approve the Annual Quality Account for publication

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

Directorate	Agreed			Relevant reviewer [name]	
Quality	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Finance	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Chief Operating Officer Directorates	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Medical	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Communications & Engagement	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Strategy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
People & Culture	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Corporate Affairs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	

THE ANNUAL QUALITY ACCOUNT 2020/2021

FOREWORD

This is our Quality Account 2020/2021; it details progress against the quality priorities set last year and outlines the quality priorities for this year.

As an organisation, we are committed to providing high quality & safe care, delivered with compassion, respect and dignity. We strive to provide outstanding care to all our patients and to be a first-class employer. The underlying ambition is to improve patient care, patient experience and the experience of our staff.

Throughout the pandemic our priority remained on delivering safe and good quality care to the population of London. We worked with national teams and system wide partners to ensure our service was responsive to changes and updates to national guidance in relation to the pandemic and we continued to work collaboratively to ensure the people of London received the best care possible.

We want to take this opportunity to thank all our staff, volunteers, colleagues from other emergency services and system wide partners, who worked incredibly hard and supported delivering good quality emergency and urgent care to the people of London during the pandemic. We are very proud of all our people (staff, volunteers and partners) for their hard work and collaboration during a very difficult year. As an organisation, we reaffirm our commitments to continue working very closely with all our partners and volunteers while maintaining focus on improving staff health and wellbeing; to ensure they continue to find fulfilment in work through the pandemic and post the pandemic.

Across the year, we delivered on a number of quality initiatives and priorities despite the pandemic and associated different ways of working. In Quarter 3 for example, we ran a successful pilot of the station/service quality accreditation scheme. The scheme assessed services in line with the Care Quality Commission's (CQC) fundamental standards. Five stations (one in each sector) took part and following a period of focused quality improvement actions, four out of the five stations were accredited as "GOLD" stations and one achieved a "Silver" award. Throughout the pilot, there was positive engagement from staff, members of the Patient and Public Council and our Commissioners and this has helped in refining the programme and roll out this coming year.

The Trust continues to be the highest reporting Ambulance service for reporting safety incidents which reflects its strong safety culture. We are also proud of what we have achieved in relation to the 2020 staff survey. The Trust is the second highest scoring Ambulance Trust in terms of staff survey response rate. 72% (4427) of staff completed the survey in 2020, compared to 71% in 2019 - an increase of c30% since 2016. From the 75 questions that allow a year on year comparison, we have seen significant improvement in 30 questions, no change in 41 questions and a slight decline in 4 questions. The results also showed a reduction in staff reporting that they experience peer to peer bullying in the last 12 months. This is notable progress and we continue to focus on responding to feedback from our staff.

Last year, we identified eighteen quality priorities for focus. These priorities were a composite of the feedback from the CQC inspection report of January 2020, feedback from our stakeholders and our priorities derived from internal sources of quality intelligence. We recognised right from the beginning, that last year would be different due to the pandemic and we focussed our efforts and committed to delivering on these priorities; because we believed they remained fundamental to delivering good quality care.

By the end of the year, we have made significant progress against 17 out of the 18 priorities. This is detailed in the look back section of the quality account. The one exception was the quality priority relating to the roll out of tempus monitors for the Motorcycle Response Unit and Cycle Response Unit. This was suspended as a priority as both services were refocussed as part of the pandemic response.

Whilst the pandemic presented challenges, a number of opportunities emerged and these are now shaping how we work and how we plan our future services. Looking ahead, we have worked with various stakeholders to identify 10 quality priorities for 2021/22.

In identifying these priorities, we have considered the following:

- Progress against the current quality priorities
- Learning from the pandemic
- The emerging CQC strategy
- Priorities informed by various sources of quality intelligence, trust business plan as well as clinical and quality strategy
- What matters to our staff, patients & the communities we serve; for example staff wellbeing & patient involvement.

The ten priorities for this year are:

1. Implementation of the Patient Safety Incident Response Framework (PSIRF)
2. Improving staffing levels, productivity and efficiency across Integrated Patient Care service
3. Improving the management of clinical equipment
4. Improving Medicines management & storage
5. Further engagement and involvement of Patients & Communities
6. Delivery of the Clinical Strategy
7. Integrating the 999 and 111/ IUC CAS systems
8. Implementation of the station/service quality accreditation programme
9. Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy
10. Continued focus on Staff health & wellbeing

Overall, we are very proud of what we have achieved across the year during a pandemic and we will continue in our commitment to continuously improve our quality of care.

Dr John Martin
Chief Paramedic & Quality Officer

Part 1: Proposed Quality Priorities 2021-2022

This financial year has been dominated by efforts to respond to the pandemic. While this has been challenging, new opportunities have emerged as well as significant learning in many areas which will shape the way we maintain good quality of care. Additionally, triangulation of internal quality intelligence and the emerging CQC strategy provide further opportunities to identify new areas of focus in relation to quality. To this end, it is proposed that the 2021-22 quality priorities take into account the following;

- a) Progress against the current quality priorities
- b) Learning from the pandemic
- c) The emerging CQC strategy
- d) Priorities informed by various sources of quality intelligence, trust business plan as well as clinical and quality strategy
- e) What matters to our staff, patients & the communities we serve; for example staff wellbeing & patient involvement

Guided by the above principle, below are the 10 proposed quality priorities for 2021/2022.

Quality Domain	Proposed Quality Priorities 2021/22	Source	Rationale	KPI
Safe	Implementation of the Patient Safety Incident Response Framework (PSIRF) as a pioneer in the new process for other Ambulance Trusts.	Carried forward from 20/21.	Implementation of the PSIRF will provide an integrated approach to patient and staff safety, with focus on learning and continuous improvement.	Development & delivery of effective QI projects to address findings from PSIRF thematic reviews
	Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services – (front end, CAS and management – including CHUB/ECAS).	Carried forward from 20/21.	Whilst important progress was made in IUC in 2020/21, further work is still required to reduce variation in both the front end and CAS staffing and outcomes. The priority has been amended to include senior clinical support based on learning from the pandemic. Senior clinical cover provides greater assurance that the safety of patients awaiting an emergency response can be managed. The CHUB/ECAS is included in recognition of the	Standardisation of both the front end and CAS staffing and outcomes. Appropriate rota fill for the expected establishment as per contract or local plans

Quality Domain	Proposed Quality Priorities 2021/22	Source	Rationale	KPI
			increasing integration between 999 and 111 services.	
	Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment which is enshrined in policy.	Internal quality intelligence.	The Trust currently does not have robust tracking mechanisms and has agreed a business case to introduce mechanisms for this process including development of a new policy for clinical equipment. This will improve the quality and governance of equipment use and provision across the service.	Medical devices policy and appropriate governance in place by end of Q2, 2021/22. Reduction in incidents relating to clinical equipment from baseline Q2 of 2021.
	The trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation.	Business plan deliverable.	To improve the quality of Medicines Management by adhering to legal and regulatory requirements as well as accepted best practice. To ensure our staff work in an environment that enables them to carry out their work safely and securely, and to ultimately improve clinical quality and patient care.	100% roll out of the inventory management system in phase 1 (April 2021) 70% automated temperature monitoring system roll out in phase 2 (2021/22) 100% medicines packing unit complete by December 2021 Recruitment of pharmacy technicians & integration of the relevant logistics staff into the pharmacy team by the end of 2021
Caring	Patient & Communities engagement & involvement.	Emerging CQC strategy.	We want to shape our services based on what matters to people and communities who use our services by developing various ways of receiving and acting on feedback.	Implementation of the patient and communities engagement and involvement strategy plan
Effective		Business	It is the trust's intention to	Reduced number

Quality Domain	Proposed Quality Priorities 2021/22	Source	Rationale	KPI
	Continued delivery of the Clinical Strategy (2016/17-2022/23 2019 Refresh)	plan	<p>deliver the highest possible quality of care and to improve the safety, outcomes and experiences of our patients, whilst ensuring equity of access. Our Clinical Strategy outlines the roadmap of how we will achieve this across all of our clinical services, focusing on innovation, service development and learning opportunities which reflect our population and their needs.</p> <p>Much of the Clinical Strategy has now been delivered, however continued focus is required to complete delivery in the context of a post-COVID healthcare system. The pandemic has produced much innovation, and enabled accelerated delivery in some areas. We now intend to embed and further integrate our functions via the Right Care, Right Place programme.</p>	of outstanding strategy deliverables from April 2021 baseline.
Responsive	Integrating the 999 and 111/ IUC CAS systems to provide seamless care for patients regardless of access point.	Carried forward from 20/21.	While this priority is on track, work is needed to further embed the integration. Integration of these two services means that we are able to utilise our resources to provide equitable care for patients regardless of the number they dial to access the service. Patients contacting us via 111 or 999 will receive a timely clinical assessment and access to the care and advice they need.	Increased consult and complete episodes in 111 from April 2021 baseline & meeting Hear & Treat KPIs
Well Led	Implementing the station/service quality accreditation programme	Internal quality Assurance	Quality accreditation is a concept grounded in frontline leadership and is focused on not only	Supporting 100% of stations/service who volunteer to take part in the

Quality Domain	Proposed Quality Priorities 2021/22	Source	Rationale	KPI
			meeting the expected quality standards but also, in encouraging innovation and transformation. There is strong evidence to suggest that quality accreditation schemes, promote safer care, sharing of good practice and motivate staff to continuously improve the quality of care.	programme
	Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy.	Internal quality intelligence.	Embedding our trust values and behaviours is key to our success as an organisation and part of that is investment and focus on Culture Diversity and Inclusion.	CDI Strategy developed and implementation plan deployed.
	Continue to invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.	Carried forward from last year.	The aim of the health & wellbeing strategy is to make sure that all of our people can achieve a healthy balance between work and home life, are well equipped to deal with stress, have safe and effective physical environments – both vehicles and buildings - to work in and access to appropriate and relevant services when they need them.	Completion of various actions in the implementation plan. Improvement in score for the 2021 national staff survey questions relating to staff wellbeing

PART 2. THE LOOK BACK; 2020/2021 QUALITY PRIORITIES

London Ambulance Service (LAS) is committed to providing high quality & safe care, delivered with compassion, respect and dignity. We strive to provide outstanding care to all our patients and to be a first-class employer. Our commitment is underpinned by a focus on quality of care and staff wellbeing. Due to the pandemic, the 2020-2021 financial year was like no other. While it has been challenging, new opportunities have emerged and this is shaping how we plan our services for the future. Our staff worked very hard to ensure high quality standards of care were maintained and the Trust was still able to deliver on a number of quality initiatives and priorities despite the pandemic and associated different ways of working.

In Quarter 3, the Trust ran a successful pilot of the station/service quality accreditation scheme. The scheme assessed services in line with the Care Quality Commission's (CQC) fundamental standards. Five stations (one in each sector) took part and following a period of focused quality improvement actions, four out of the five stations were accredited as "GOLD" stations and one achieved a "Silver" award. There was positive engagement with staff and members of the Patient and Public Council during the accreditation process which has helped in refining the programme to make it fit for roll out from April 2021. Furthermore, the Trust continued to be the highest reporting ambulance service for reporting safety incidents (circa 5,000 per year compared to the next highest circa 2000) which reflects a strong safety culture.

The Trust identified eighteen quality priorities at the start of 2020-2021 financial year. These priorities were a composite of the feedback from the CQC inspection report of January 2020, feedback from our stakeholders and our priorities derived from internal sources of quality intelligence. We recognised right from the beginning, that this year would be different due to the pandemic. Despite this, we doubled our efforts and committed to our quality strategy because we know that it is at times like these that we need to remain steadfast in delivering good quality care while supporting the wellbeing of our staff. In the following section, we outline the actions we took in relation to 20/21 quality priorities in all the five CQC domain.

CQC Domain: Safe

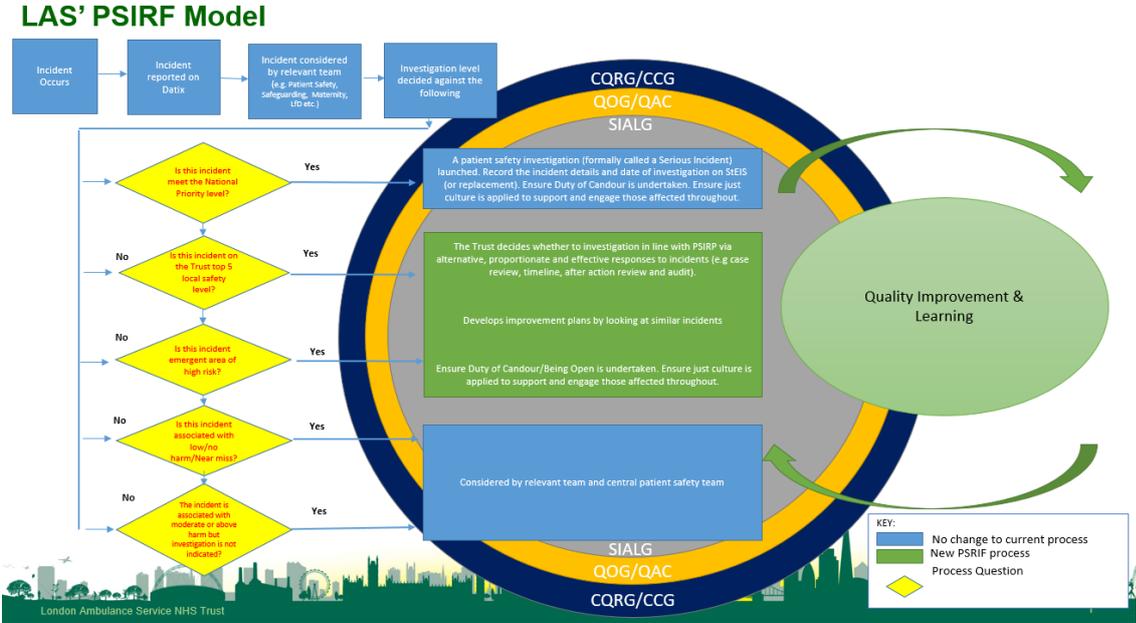
1. Implement the Patient Safety Incident Response Framework (PSIRF) and be a pioneer in the new process for other Ambulance Trusts.

The PSIRF is a key part of the NHS patient safety strategy which was published in July 2019. The Framework proposes a new approach to investigating patient safety incidents in a way that focuses decisions and actions to assisting learning and improvement by allowing organisations to examine incidents thematically, openly and without fear of inappropriate sanction. As part of the national implementation plan, LAS was one of the few organisations who were identified by NHS England & Improvement (NHSE&I) as an early adopter, to test the introductory version of the framework.

Working with a variety of stakeholders both internally and externally, LAS started to develop a PSIRF implementation plan with a target of achieving 100% implantation of this plan by the end of the financial year. A task and finish group was created which consisted of a cross directorate multidisciplinary team and started to develop the risk profile that would underpin the implementation of the framework. The risk profile of patient safety incident risks for the Trust was arrived at by analysing data from recent patient safety incident reports, complaints, freedom to speak up reports, mortality reviews, case note reviews, staff survey results, claims, staff suspensions, and a variety of risk assessments. The plan was submitted both to NHSE&I and commissioners and continuously refreshed over a period of time to include feedback from all the stakeholders. LAS was able to test this approach by conducting

thematic reviews of some of the top patient safety incidents during the pandemic which provided significant learning that refined the plan further. The Trust's experienced an increase in demand during December and January for which the Trust went into Resource Escalation Action Plan 4 (REAP 4). This saw the PSIRF implementation plan put on hold. The PSIRP plan was approved by the Trust Board in January 2021. The aim is to go live on the new framework in early April 2021.

The LAS PSIRF model is illustrated below.



2. The administration of thrombolysis by Advance Paramedic Practitioner – Critical Care (APP-CC) for patients in cardiac arrest with pulmonary embolus

London Ambulance Service has skilled Advanced Paramedic Practitioners in critical care (APP-CC) with extensive skill, knowledge and experience in helping critically ill patients including those in cardiac arrest. The Trust committed to providing further training to 32 Critical Care Advance Paramedic Practitioners, to enable them to administer thrombolysis to patients who need it. By offering training in the administration of thrombolysis, LAS would further extend the treatment options on offer for patients requiring thrombolysis which would in turn improve survival rates for that group of patients. This year all APP-CC have received training to enable them to administer thrombolysis when it is indicated. A recent audit has shown that in all cases thrombolysis was administered appropriately and this is attributed to this training.

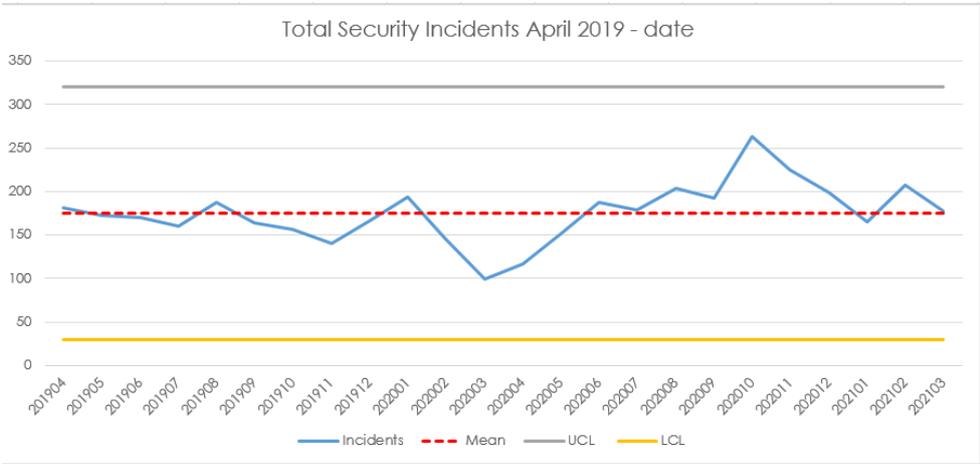
3. Pilot of non-medical prescribing for paramedics in conjunction with HEE.

The Trust aimed to develop paramedic prescribing to allow medicines to be prescribed rather than supplied or administered under the Patient Group Directions (PGD) which facilitate administration and supply of additional medicines carried by Advanced Paramedic Practitioners (APP). The intention was to increase the number of cases that can be managed autonomously by this group of staff which in turn would enable more patients to be cared for in the community setting without the requirement for onward referral or transfer to hospital.

The pilot aimed to train 10-12 paramedics and by quarter 4 (2020/2021), four paramedics had completed the independent prescribing training, a further three had completed the taught element of the course, and another three had just commenced training. The pilot trajectory has been disrupted by COVID and at the time of writing this report, it is anticipated that the pilot will conclude in June 2021 with operationalisation of non-medical prescribing within the 999 environment commencing once the options appraisal has been conducted.

**4. Ongoing testing of Trust security measures to ensure continuous improvement
Trust arrangements to secure vehicles stations and equipment.**

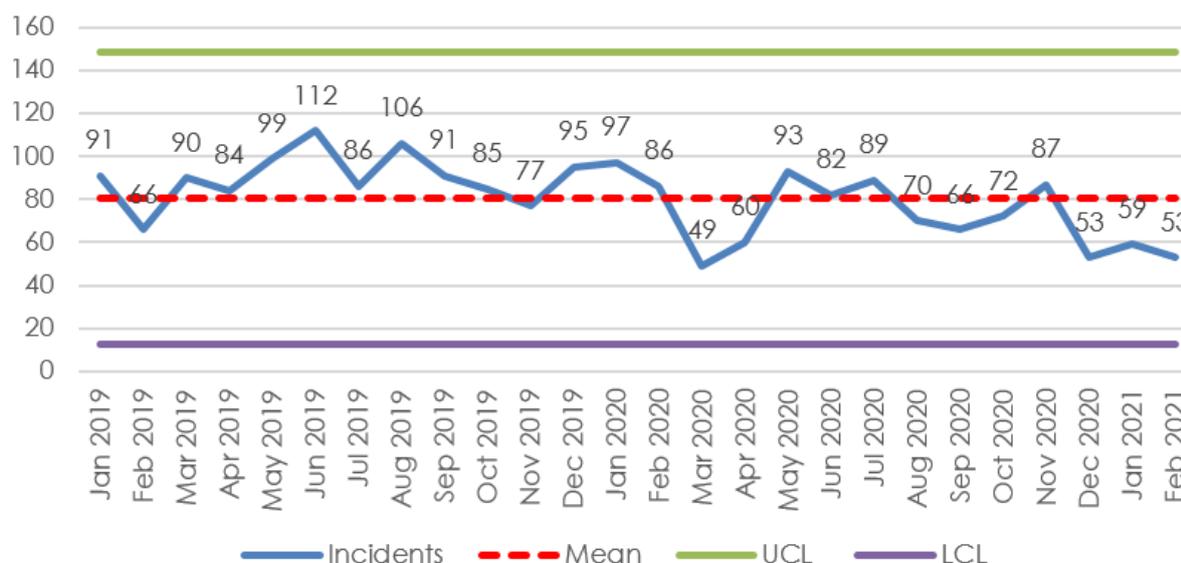
LAS continues to focus on security measures to ensure timely actions are taken proactively to maximise security across the trust estate and facilities. A number of random audits/checks have taken place across the year including mystery shopper audits designed to test the effectiveness of the security actions being taken. We wanted to see a reduction in security related incidents from April 2020 baseline. Such incidents includes, premises burglary, vandalism, theft of personal & Trust property and Vehicle related security incidents. Security incidents remained around the mean across the year as illustrated in the table below and this remains an area of focus.



5. Completion of the medicine management room project to ensure medicines are correctly stored.

Medicines management including storage is very important for patient care. The Trust had seen a reduction in the number of storage/security medicines' related incidents since the secure drug room project started and wanted to complete the project to further reduce these incidents. It is pleasing to report that the construction of all 15 new rooms is complete and all rooms in open stations are in use. This has contributed to a reduction in controlled drug related incidents as illustrated below;

Controlled Drugs Incidents



CQC Domain: Effective

6. Assess the use of the IUC service's escalation plan triggers to ensure key factors are being considered.

The Clinical Assessment Service consists of all patients awaiting a clinical call back in IUC. This queue is managed by the Clinical Navigator, a senior healthcare professional who is responsible for overseeing the safety of patients within the queue and taking action to ensure timely and appropriate re-contact of patients. The CAS is underpinned by the Demand Management Policy (DMP) which details levels of demand/capacity surge and appropriate mitigating actions to take to safeguard the welfare of all patients awaiting call back.

Work was undertaken to design and build an audit tool that would be fit for purpose in relation to this policy. This work consisted of identifying principally whether a) the escalation level enacted at any given audit time was consistent with the triggers for that escalation level, as set out in the IUC Demand Management Plan and b) whether the escalation actions detailed within the aforementioned plan were enacted appropriately. Where there was deviation from agreed processes, the option was to detail if this was a decision made by the Clinical Navigator or whether Senior Clinical on Call advice had been sought.

The audit tool was launched in June 2020, however neither NEL nor SEL IUC CAS services required escalation out of business as usual (BAU) during June or July. The CAS queue had remained well managed throughout and therefore audit of escalation triggers and actions was not applicable for this time period. The decision was then made that audits would now occur even if no escalation out of BAU, in order to ensure CAS level 1 (BAU) is managed appropriately.

This new process took place from October and six audits were completed for this period, which showed that on five occasions the escalation activity matched the Demand Management Policy. On the 6th occasion, appropriate deviation from policy had occurred as advised by Senior Clinical on Call. Compliance was 100% and no issues identified.

A further six Audits were completed for November across IUC sites. Three audits passed with 100% - the correct level of escalation was calculated and the actions implemented were reflective of the actions required as detailed in the DMP. Three audits failed and on further inspection the following issues were identified; on two of the occasions, escalation actions

had been put in place despite service not meeting escalation triggers and on one occasion escalation triggers were met but key actions within the plan were not implemented.

To ensure the learning loop was completed, feedback of audits was provided to Site Senior Clinical Leads, who manage the Clinical Navigators and could provide feedback and guidance to ensure future escalations were met with appropriate actions. Due to the escalation to REAP4 in December and January, escalation audit were suspended in response to increased demand. A programme of audits remain in place to continue to provide assurance on how the DMP is being utilised.

7. Continue with efforts to achieve the IUC service's staff rota to ensure comprehensive covers at all times.

Last year, we focused on ensuring that we had adequate staff across all skill sets in order to respond to call demands and provide timely care to our patients. This was particularly important during the pandemic which created significant demand for the Integrated Urgent Care services. Staffing rosters were reviewed and increased in line with LAS forecasting and planning projections, recognising the continued fluctuation call demand and changing patient behaviour, in line with London regional and national demand forecasts and 111First policy. Contingency was provided within revised rosters to cope with call demand surge. The performance challenges faced due to COVID were managed, monitored and reported daily to Daily Senior Leadership Team meetings with actions to provide assurance and oversight.

Additionally, the service has continued to build on the integration pathways which were implemented to support the Trust's response to the COVID pandemic and the ability to flex workforce across 111/999 based on demand is a key action for future service sustainability. Integrating 111/999CAS systems has been identified as a London requirement as part of the wider system U&EC Restoration Board and Think NHS 111 First programme (London-wide system response to COVID). LAS has committed to 3 key priorities as part of this programme:

- Optimise 111CAS outcomes,
- Increase 999 Hear & Treat rate
- Optimize See, Treat & Refer outcomes.

The Trust engaged in multi-provider discussions with NWL ICS to design and deliver an enhanced IUC model which will provide the foundation for future 111/999CAS integration.

8. Roll out of tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients

This quality priority was intended to equip the Cycle & Motor Cycle Response units with ECGs to enable timely assessments of patients they deem as requiring an ECG. This in turn was to ensure that fleet can attend other calls, reducing delays for patients. Unfortunately, this quality priority had to be suspended due to COVID as it became necessary to take both Cycle & Motor Cycle Response units off the road.

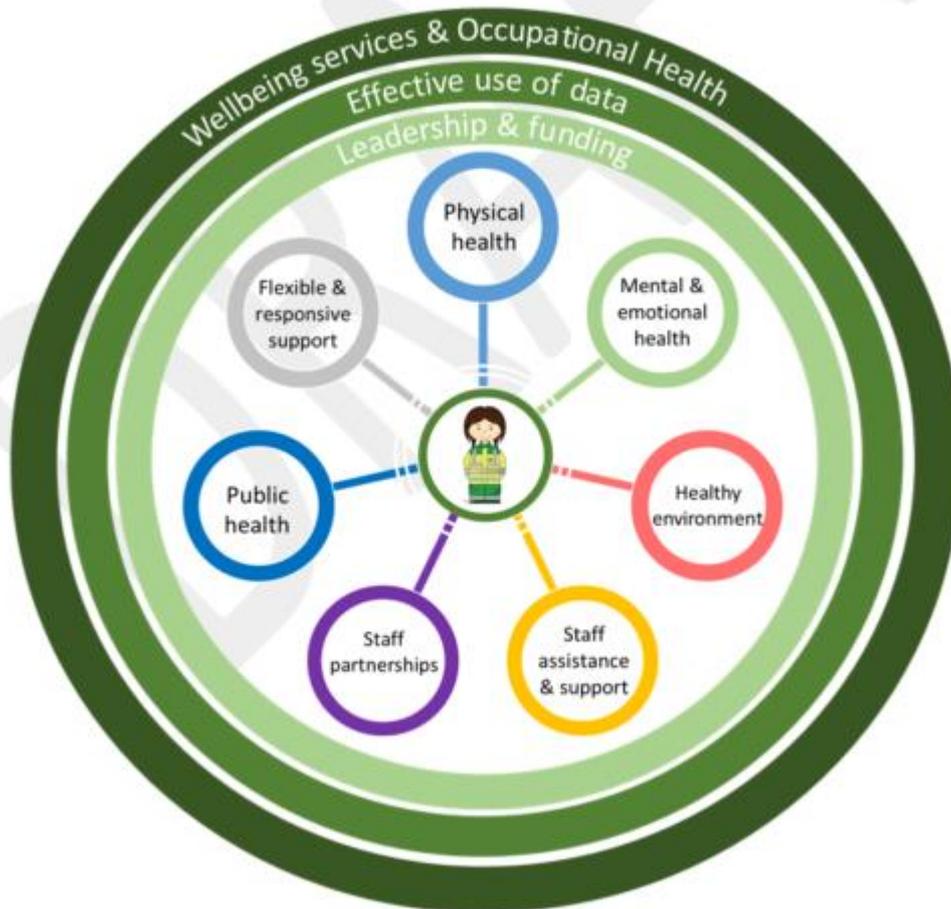
CQC domain Caring

9. Invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.

As the busiest ambulance service in the country our staff and volunteers provide care and support to millions of people each year who live, work and travel in London. LAS continually strive to deliver evidence based welfare and wellbeing support back to our staff and volunteers as an integral part of our core business. This is underpinned by our ambition to be a first class employer, who value and develop the skills, diversity and quality of life of staff. In recognition of the challenges that the pandemic has presented, the Trust developed a Health & Wellbeing strategy which sets out its approach for transforming how staff and volunteers

can access health and wellbeing support. This is a live strategy to ensure it is flexible and able to respond to emerging need as the organisation continues to fight the pandemic.

The aim of the health & wellbeing strategy is to make sure that all of our people can achieve a healthy balance between work and home life, are well equipped to deal with stress, have safe and effective physical environments – both vehicles and buildings - to work in and access to appropriate and relevant services when they need them. LAS' health & wellbeing strategy details seven core themes as illustrated in the diagram below.

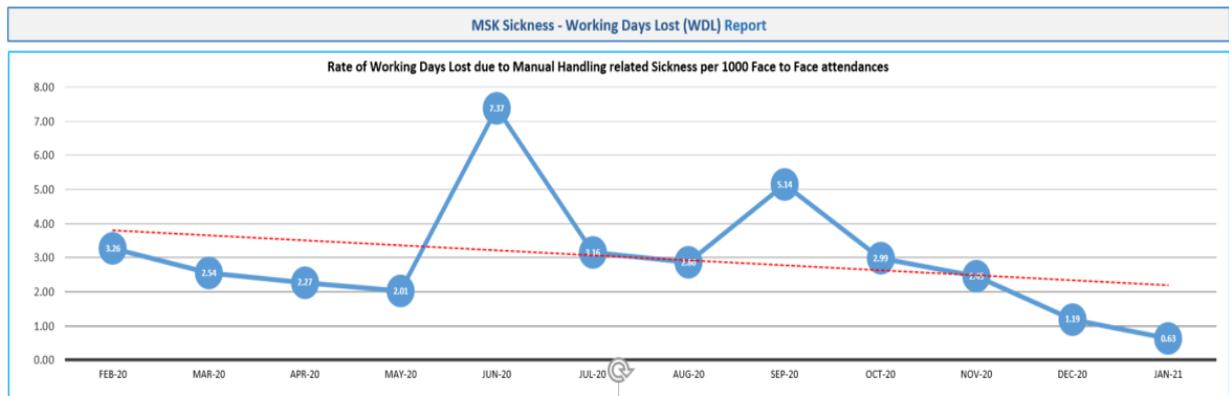


Below is an outline of some of the examples of work that sits under each theme.

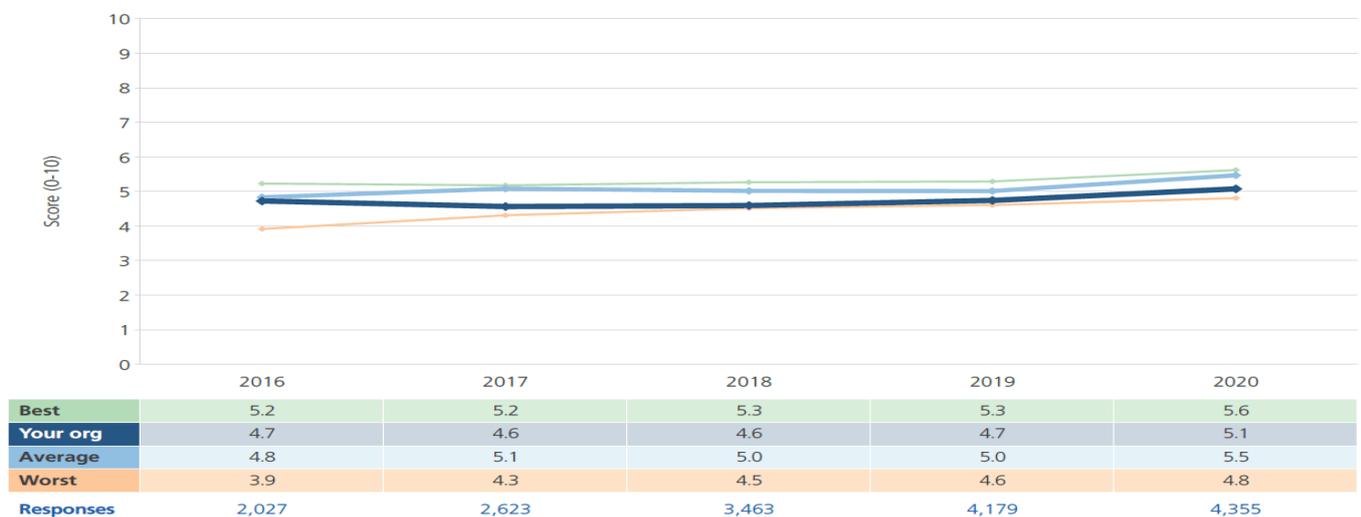
- **Physical health:** For example Occupational Health provision that is more accessible and targeted to the needs of our staff with better communication and understanding of the Trust
- **Mental & emotional health :** For example, better access to a wider range of professional mental health services with specialist experience and training that reflect the diversity of our staff and the range of jobs within the Trust
- **Healthy Environment:** For example, ensuring that our workplaces include dedicated healthy spaces and an environment designed to suit the needs of our staff including suitable equipment and furniture
- **Staff Assistance and Support:** Establishment of the Wellbeing Hub as a single point of access to wellbeing services provided and endorsed by the Trust, supported by use of 87% app
- **Staff Partnerships and Peer Support:** Increased collaborative Wellbeing work at a senior, executive and non-executive level across the trust

- **Public Health:** Improved immunisation processes from new starters onwards including greater flexibility and the use of technology for more agile record keeping.
- **Top-Up/Flexible Response :** Equip our staff and managers with tools and training that promote personal resilience and how to identify staff in need

The target was a reduction in the number of days sick from manual handling injuries per 1000 incidents (face to face) <3.5 and the graph below shows a clear reduction which is positive for staff wellbeing.



The second target was improvements in the 2020 staff survey results in relation to the wellbeing matrix compared to the 2019 staff survey results. This has been achieved as illustrated in the table below. Work will continue to further improve this matrix.



10. Develop the stress policy in relation to wellbeing of staff. Ensure this is implemented effectively.

Throughout the year, the Trust continues its efforts to address stress amongst staff which leads to increased absence from work. This work was part of the wider work to improve staff wellbeing as described above. A Stress Management Policy was developed last year and will provide a framework for further work in the coming year.

11. Reduction in Violence & Aggression

As an organisation we recognise that our staff experience unacceptable levels of violence and abuse while delivering care to the public. The impact of being assaulted is sometimes more damaging than the actual injury and LAS is committed to changing the culture with robust support to staff. The rate of reportable violence/assault incidents per 1000 face to face incidents is currently at 0.54.

A Violence Reduction and Staff Safety Programme Board was formed last year to better support staff who experience violence and abuse by providing specialist advice and a standardised approach. The Trust is currently undertaking a trial of the Body Worn cameras to further safeguard staff from violence and aggression and the outcome of this trial will inform future plans.

Responsive

12. Undertake a deep dive review into delays (2x90th centile) to patients due to recent high demand and COVID19

The trust aims to provide a responsive service by working hard to prevent delays to treatment, which can cause harm to our patients. A deep dive was undertaken of the delays related to the first wave of COVID and resulting action plan was reviewed monthly at the Trust's Safety Investigations Assurance and Learning Group (SIALG) by the second wave in December 2020 all actions were completed. A further review is underway to look at learning from the second and a new report will be published with further learning for the next financial year.

13. Integrating the 999 and 111/IUC CAS systems to provide seamless care for patients regardless of access point

LAS strives to provide an equitable service to all patients who use our service regardless of whether the call us on 999 or 111. To this end, there has been significant effort and investment applied to the continued delivery of this strategic priority: for example

- Applying 111First initiatives consistently to the 111/IUC CAS and 999 ECAS in order to provide patients with parity of access to downstream ICS services, including the launch of the BEACH electronic referral to Emergency Department to 111CAS and ECAS staff
- Enabled ECAS clinicians to refer to UCAS clinicians for onward consult and complete following initial clinical assessment, starting in NEL
- Although not selected to participate in the national C3/C4 validation pilot, LAS continues to engage other ambulance trusts to incorporate learning and has engaged London colleagues to support the referral of suitable 111 C3/C4 ambulance outcomes to the ECAS for clinical validation
- Working with the London Directory of Service (DOS) team to review current access to downstream services for UCAS and ECAS, and identifying quick win opportunities to enable access for UCAS & ECAS via 'LAS CAS Approved'
- Development of NWL multi-provider 111/999 integrated care model from initial concept to development of service model, patient pathways and mobilization process – target Go Live for phased implementation from 10/11/2020. This is the first step in developing the foundations for LAS to become London's primary integrator of urgent & emergency care services.

14. Clinical development of ePCR and a new CAD system to capture clinical care of patients

The Trust continues to improve its information technology infrastructure and this year we have focused on replacing our Computer Aided Dispatch (CAD) system and the introduction of the electronic patient clinical record (ePCR). The new systems are to support the clinical decision-making process there by improving the patient prioritisation functionality which will in turn support delivery of time care. While the roll out has been impacted by the pandemic,

there is steady and notable progress on uptake across all services. From February to March 2020 there was a 10% increase in usage across the Trust and this continues to increase.

Well led

15. Develop Quality Improvement Hubs for sharing best practice through a formalised operations & management structure

The Trust is committed to continuous quality improvement and utilises the QSIR methodology and a number of staff are trained in this. A QI pilot was launched in our Integrated Urgent Care services in September with a dedicated resource to undertake a project and this was completed at the end of November. The aim of the pilot was to ascertain whether having dedicated resource at a local level provides the resource needed to develop QI initiatives into projects as well as increase the chance of these projects being implemented and sustained. The QI pilot has been evaluated and confirms having dedicated resource at a local level did allow a QI project to be taken forward and implemented. The development of the quality improvement plans in each sector is linked to the Patient safety Incident Response Framework which comes into effect April 2021.

16. A continuous focus on improving the Staff Survey results particularly around Bullying & Harassment (B&H) culture.

Following the publication of 2019's staff survey results, the Trust focussed on engagement with and development of our core leaders/managers. There was a particular focus on improving the visibility of leaders across the trust. This was supported by the increased use of technology such as Microsoft teams, Zoom, LAS TV Live to update staff on the Trust priorities and direction. This was complimented by local operational briefings and sector conferences attended by the CEO, Executive Team Members, and Local Senior Managers (ADO/LGMs/CTMs). Throughout the year the trust put considerable effort into improving the health and wellbeing offering to our staff as described in the sections above.

72% (4427) of staff completed the survey in 2020, compared to 71% in 2019 - an increase of c30% since 2016. This places the Trust in the second highest scoring Ambulance Trust in terms of response rate. From the 75 questions that allow a year on year comparison, the Trust has seen significant improvement in 30 questions, No change in 41 questions and deterioration in 4 questions. The results also showed a reduction in staff reporting that they experience peer to peer bullying in the last 12 months.

The questions in which there has been a significant improvement (green) or deterioration (red) year on year are grouped in four themes, as follows:

AREA		
YOUR JOB	9	1
YOUR MANAGER	7	0
HEALTH & WELL-BEING	11	3
YOUR ORGANISATION	3	0
TOTAL	30	4

17. Explore and develop the paramedics in Primary Care Network (PCN) proposal to provide a broader training opportunity for paramedics

Last year the Trust identified an opportunity in taking part in the Primary Care Networks initiative. The PCN are a national initiative which build on the core of current primary care services within the NHS and enable greater provision of proactive, personalised, coordinated

and more integrated health and social care. This presented further opportunities for our staff to develop, helping our recruitment and retention. This could be achieved by working closely with partners and key stakeholders to develop the PCN proposal to include the London Ambulance Service.

During the year the trust undertook trials of the proposal. The Merton trial commenced in October 2020 and the Redbridge trial started in November 2020. Focus group sessions have been arranged and feedback was sought providing an overview of the trials; early indications suggest global benefits with positive feedback from multiple stakeholders. There is continued engagement with NHSE & HEE and the national criteria for the PCN paramedic role is still subject to approval. In the interim, the trust continues to plan and prepare to provide paramedics in preparation for April 2021, when the PCN paramedic role is expected to be included in the national primary care contract.

18. Ensuring that the Trust adopts and maintains the optimal health and wellbeing strategies and culture for both existing LAS staff and the expanded workforce during and after the COVID-19 pandemic.

During COVID19, LAS began a process of recruiting a large number of external personnel to ensure peak demand was met in a safe and efficient manner. These personnel were either contracted from external organisations such as the London Fire Brigade or the AA, or were external personnel to the LAS who underwent rapid training and deployment. Our aim was to embed our distinct LAS set of values and behaviours for both existing LAS staff and the expanded workforce who were on boarded during times of increased demand. We wanted to extend our culture and values, nurturing a culture of inclusion and collaboration.

The Trust Well Being Hub have been pivotal in ensuring staff are signposted to the relevant agencies for support and in the roll out of the vaccination programme. The Hub organised and ensured staff on the road had refreshments by implementing the “Tea Trucks”. The Trust also recruited a Head of Wellbeing to cover wellbeing support for staff across the Trust. They are responsible for the Wellbeing hub, welfare resources as well as vaccination programmes. The position has had a clear positive impact on staff and is now in the process of permanent recruitment. A review of the skill matrix was undertaken, agreed and implemented during the second wave of COVID, continuously evaluating its impact on patients and staff. The Trust also recruited an Associate Director of Culture, Diversity and Inclusion to drive the Trust plans on equality and diversity, as well as lead on the delivery of Staff Survey plans for LAS. Part of their portfolio is the development of agreed metrics to understand and measure engagement, equality and culture.

STATEMENTS OF ASSURANCE

1. SAFEGURDING

LAS has a suite of policies and procedures in relation to safeguarding practices and these are well communicated. Safeguarding training is provided at all levels of the organization and is above contractual target.

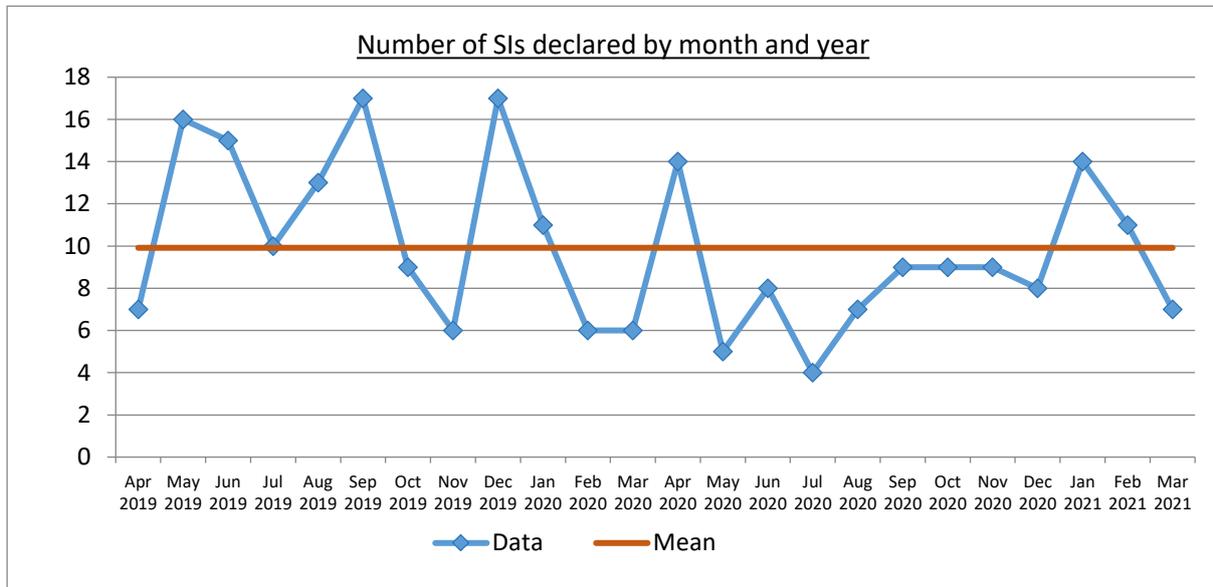
2. PATIENT EXPERIENCE

LAS continues to monitor & respond to feedback from patients, carers, families and the public. This feedback is received in a variety of forms such as compliments, complaints, feedback to local surveys and through our Patient & Public Council. This feedback is collated, analysed and action plans are developed to address themes. With the implementation of PSIRF, themes from patient feedback will contribute to our quality improvement plans.

3. PATIENT SAFETY INCIDENT REPORTING

The Trust is the highest reporting ambulance service for reporting patient safety incidents which reflect a strong safety culture.

4. SERIOUS INCIDENTS: The below graph illustrates number of SI's declared by month and year



5. CARE QUALITY COMMISSION

During 2020/21, the CQC inspection activities at the Trust included routine engagement calls & virtual meetings. The trust was last inspected in September 2019 and a report was published in January 2020. The trust retained its rating of Good overall. Two "Must Do" actions were issued in relation to medicines & security of vehicles and premises. The Trust developed an action plan to not only address these two areas but to also address the recommendations made by the CQC ("Should Do" actions). Significant progress has been made in all areas and the trust continues to focus on all areas under the five CQC domain.



Last rated
3 January 2020

London Ambulance Service NHS Trust



6. DATA QUALITY ASSURANCE

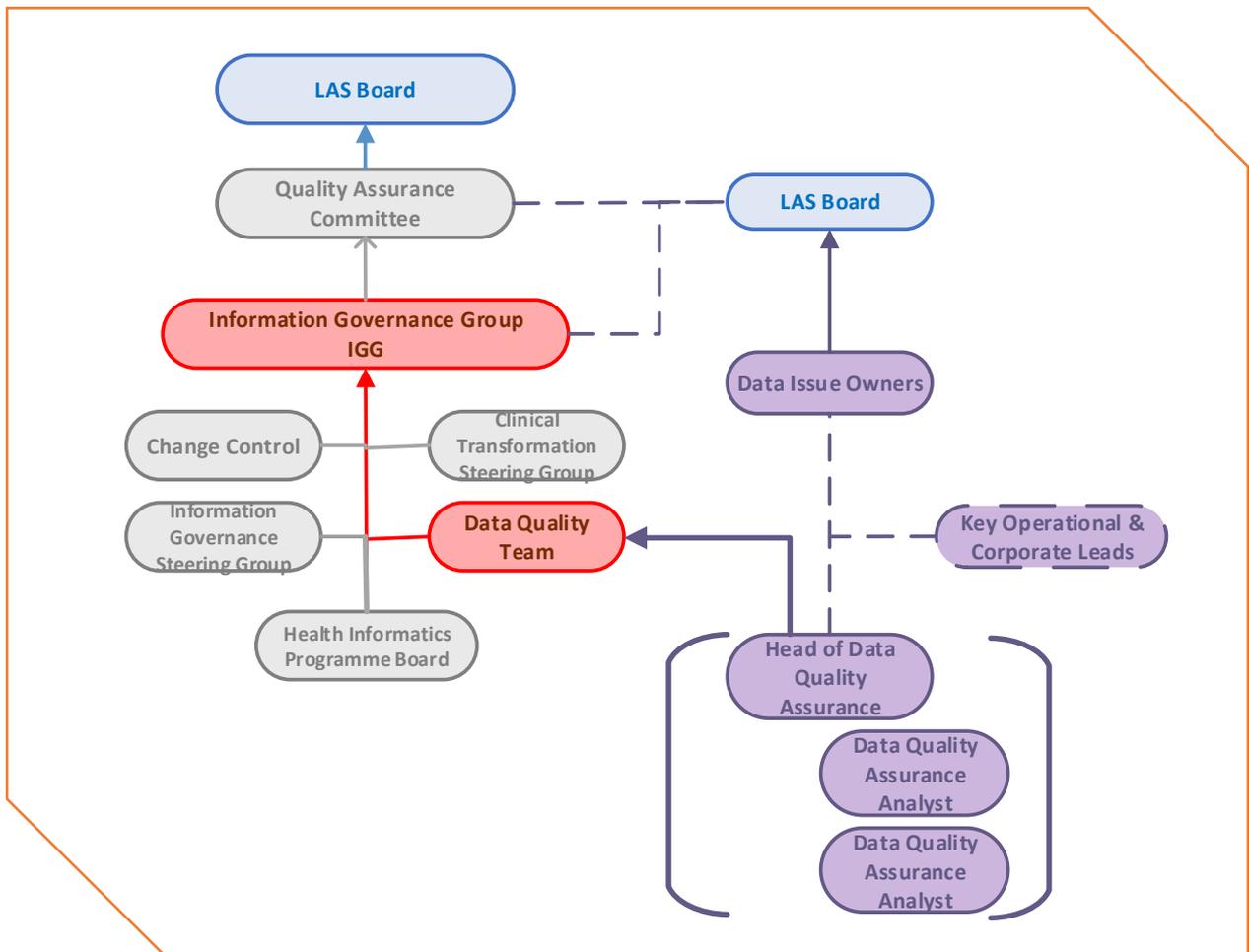
Data Quality Assurance for Annual Quality Account Statement

The Trust has an independent Data Quality Assurance (DQA) team who provides Trust wide oversight of Data Quality. This is to ensuring Data and Information used by the Trust to inform Performance, Operations and Strategic Decisions are of Good Quality.

The DQA Team Objectives and Aims

- The DQA team carries out Data Quality Reviews to assess all the Trust's Data Sources and Reporting Arrangements.
- The team drives improvement by reporting any issues, monitoring any actions, as well as providing guidance and training
- The team acts as a key contact for receiving escalation from other staff and teams for Data Quality issues identified outside of the formal review process
- The team is also responsible for raising profile of Data Quality with everyone understanding the importance for day to day activities as well as future strategies

Governance Structure



Work completed during 2020/21

- Data Quality review of 11 key systems used across LAS, have been completed

- Data Quality Assurance ratings for associated KPIs in Integrated Performance Report (IPR) have been developed
- Actions were developed based on the recommendations of the Reviews which are being reviewed regularly.
- A methodology has been developed based on academic research – journals and NHS standards to derive a robust Data Quality strategy for the LAS
- Work has been carried out to promote and raise the awareness of DQA via different channels (Induction Video, RIB coms, E-Learning)
- Data Quality Impact Assessment for the new ePCR and CAD has been completed.
- Further Data Quality Reviews based on escalation received / additional requirement have been carried out.

Internal Data Quality Audit

The Trusts Internal Audit Plan sets out regular assessment of effectiveness of the Trust's Data Quality systems and processes. The Public Sector Internal Audit Standards (PSIAS) and NHS Internal Audit Standards require Internal Audit to undertake mandated annual reviews covering Data Quality.

London Ambulance Service NHS Trust ('the Trust') reports data to a variety of internal meetings, including its Board and sub-committees and divisional meetings, and to external organisations, such as commissioners and regulators.

Some of these will be made available to the public and inform perceptions of the quality of care delivered by the Trust. Others will be used internally for decision making about quality and efficiency. As such it is vital that the information used is reliable and accurately reflects the performance of the Trust.

An internal audit by Grant Thornton was completed in November 2020. This audit reviewed the design and operation of the Data Quality control environment as set out in the scope and concluded that the process has provided a SIGNIFICANT level of assurance (highest possible rating). This shows improvement from "Partial assurance with improvement required" in 2019. This puts LAS in a strong position to continue to drive actual improvement in underlying datasets.

Please note that the Significant Assurance opinion reflects the work performed over the areas specifically under the scope of this review, which concern the arrangements the Trust has in place to support effective data quality. It should not be read as a wider commentary on the underlying data itself. As noted in Appendix 3 of the Audit Report, the assurance process undertaken by the Data Quality Assurance team has already identified that the underlying data systems require improvement if the Trust's 98% confidence level is to be met, and the monitoring of implementation of recommendations arising from these forms part of the Trust's ongoing assurance arrangements.

7. INCOME

The income generated by the NHS services reviewed IN 2020/2021 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2019/2020.

8. INFORMATION GOVERNANCE:

In February 2021, the London Ambulance Service submitted a baseline position for the NHS Data Security and Protection Toolkit standards. The Trust continues to progress the information governance work programme against the data security and protection standards ahead of the final submission in June 2021.

9. CLINICAL AUDIT

Ambulance Quality Indicator performance – STEMI, Stroke & Cardiac Arrest care bundles

The Trust submitted the following information to NHS England for the reporting period 2020/21 and 2019/20 regarding the provision of an appropriate care bundle to STEMI patients and those resuscitated after cardiac arrest, as well as a diagnostic bundle for stroke patients.

	2020-21*		2019-20	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	68.2%	77.3% (76.2 – 78.3)	76.4%	78.3% (76.3 – 79.8)
Stroke patients	96.9%	98.1% (98.0 – 98.3)	98.0%	98.0% (97.2 – 98.5)
Cardiac Patients**	83.4%	73.3% (72.8 – 73.8)	94.5%	70.9% (69.0 -72.2)

*At the point of preparation of this Quality Account, NHS England reported data for April to September 2020 was submitted during 2020/21.

** Post – resuscitation patients only

Clinical effectiveness and audit

The Trust has a robust and diverse clinical audit and research programme focusing on a range of clinical areas of both local and national importance. During 2020/21, we examined the care provided to a wide range of conditions including cardiac arrest, acute coronary syndromes, stroke and severe sepsis, as well as respiratory and bariatric care. We also continued to audit the quality of care and appropriateness of decisions made for patients who were discharged of our care.

Despite many research projects being suspended across the NHS due to the COVID-19 pandemic, our research activity continued to perform strongly, with multiple collaborations to design novel research projects, successful applications for external research funding, and nine publications in peer-reviewed scientific journals, including the first paper in the UK to describe the association between out-of-hospital cardiac arrest and COVID-19. We also participated in research projects designated 'Urgent Public Health' status by the Government due to their importance to the COVID-19 pandemic (see Appendix 1).

We continued to support the development of the NHS England Ambulance Quality Indicators, working with NHS England on behalf of the National Ambulance Service Clinical Quality Group. Our Head of Clinical Audit & Research continues to Chair the National Ambulance

Research Steering Group, helping to develop prehospital research nationally, encourage collaboration across ambulance services and influence changes to national policy and practices.

Clinical audit

During 2020/21, two national clinical audits and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the Trust participated in 100% of national clinical audits in which it was eligible to participate. The national clinical audit and national confidential enquiries that the Trust was eligible to participate in during 2020/21 are as follows:-

- **National Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)**

- **NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:**
 - Outcome from cardiac arrest:
 - Number of patients
 - Return of Spontaneous Circulation (ROSC)
 - Survival to discharge
 - Post-resuscitation care bundle
 - Outcome from acute ST-elevation myocardial infarction (STEMI)
 - Outcome from stroke
 - Outcome from sepsis

The national clinical audits that the Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	Number of cases submitted *	Percentage of cases submitted as eligible for inclusion
National Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	3,678	100%
NHS England AQI: Outcome from cardiac arrest a) Total number of cardiac arrests	a) 10,692	100%
NHS England AQI: Outcome from cardiac arrest – ROSC at hospital a) Overall group b) Utstein comparator group	a) 3,884 b) 504	100%
NHS England AQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 3,678 b) 431	100%
NHS England AQI: Outcome from cardiac arrest – Post resuscitation care a) Care bundle delivered to non-traumatic adult cardiac arrests who achieve ROSC (includes 12 lead	a) 502	100%

ECG assessment, blood glucose and blood pressure measurements, and provision of oxygen and fluids)		
NHS England AQL: Outcome from acute STEMI a) Time from call to angiography for confirmed STEMI patients: Mean and 90 th centile b) Care bundle delivered to suspected STEMI patients (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 953 b) 687	100%
NHS England AQL: Outcome from stroke a) Time from call to arrival at hospital for suspected stroke patients: Mean and 90 th centile b) Diagnostic bundle delivered to suspected stroke patients (includes assessment of FAST, blood pressure and blood glucose)	a) 2,788 b) 3,285	100%
NHS England AQL: Outcome from sepsis – Sepsis care bundle a) Care bundle delivered to adult suspected sepsis patients with a National Early Warning score of 7 and above (includes a set of clinical observations, provision of oxygen, fluids and pre-alert)	a) 7,494	100%

** At the point of preparation of this Quality Account, NHS England reported data was available for December 2019 to September 2020. And for the OHCAO submission from April 2020 – September 2020*

The Trust considers that the data in the table above is as described for the following reasons: this data is captured by the LAS from clinical records completed by ambulance clinicians attending patients as part of on-going clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported to NHS England.

The reports of the above national clinical audits were reviewed by the provider in 2020/21 and the Trust has taken actions to improve the quality of healthcare provided (see Appendix 2).

Research

The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service from 1st April 2020 to 30th January 2021 that were recruited during that period to participate in research approved by a research ethics committee was 26. This is a marked decrease in comparison to previous years due to the suspension of many research projects during the COVID-19 period. Nonetheless, we recruited a total of 660 staff as study participants to national wellbeing COVID studies.

Appendix 1: Research Activity

Ongoing research projects from 1st April 2020 to 28th February 2021:

PRINCIPLE: is a designated Urgent Public Health study that is testing interventions suitable for use in the community, to treat older people with suspected or confirmed SARS-CoV-2 infection.

UK-REACH: is another Urgent Public Health study, aiming to investigate COVID-19 outcomes in people of different ethnicities working in health and social care, and how these relate to working conditions, job types, and general health and living circumstances. The findings of this study will be used to make rapid recommendations to the Government to protect health and social care workers.

CARA: a national survey evaluating the effects of the COVID-19 pandemic on the wellbeing of ambulance personnel.

SWAP: a national observational study aiming to identify characteristics of effective employee mental well-being strategies, approaches or interventions within UK ambulance Trusts and to understand how to improve current staff well-being services generally and with specific reference to the COVID-19 pandemic.

TRIM: a linked outcome study looking at which triage model is the safest and most effective for the management of 999 callers with suspected COVID-19.

STRETCHED: is evaluating the case management approaches to the care of patients who frequently call the emergency ambulance service.

ARREST: a randomised-controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest. Due to the COVID-19 pandemic, the trial was suspended for most of this year.

AIR CGM: this prospective study assesses the impact of using a continuous glucose monitor within 72 hours of a severe hypoglycaemic episode in patients with Type 1 diabetes who are treated by ambulance clinicians for severe hypoglycemia and discharged at scene. Active recruitment into this trial was also suspended due to the COVID-19 pandemic.

MATTS: aims to develop an accurate national pre-hospital triage tool to identify patients with major trauma who could benefit from specialist care at a major trauma centre. This year we completed the data collection for Phase 2 of the trial, but the trial has been suspended due to the COVID-19 pandemic.

Appendix 2: Clinical audit activity and learning outcomes

National clinical audits

The reports of the national clinical audits were reviewed by the provider in 2020/21 and the Trust has taken actions to improve the quality of healthcare provided:

- Released monthly and annual reports and infographics promoting the key findings of the review of cardiac arrest, STEMI and stroke care
- Provided both constructive and positive feedback to staff regarding inappropriate triage decisions, incomplete care bundles, and extended response times

Clinical audit projects

The reports of **5 local clinical audits** were reviewed by the provider in 2020/21 and the Trust plans to take/has already undertaken the following actions to improve the quality of healthcare provided against each audit as detailed below:

Use of Emergency Arrhythmia Centre pathways:

- Clarify with the Pan London Arrhythmia Group/ Cardiac Leadership Group whether high grade AV block and symptomatic sinus node disease could be added to the criteria suitable for conveyance to an Emergency Arrhythmia Centre
- Emphasise the importance of recording use of a specialist pathway on the patient's clinical record

Patients who severely deteriorated or died unexpectedly within 24 hours of being discharged of LAS care:

- Cases identified via this clinical audit contributed to the LAS pilot submission for the national framework on Learning from Deaths
- Ten serious incidents, identified through this audit, were declared
- Constructive and positive feedback was provided to individual clinicians and Emergency Call Handlers
- Case studies were shared for ad hoc staff educational purposes
- Findings have informed development of the electronic Patient Care Record
- Details of all expected deaths have been provided to the LAS End of Life Care Team to promote shared learning
- Retrospective safeguarding referrals were made for three patients
- A variety of relevant clinical audits will be proposed to be undertaken next year
- We will suggest a review of the training on documentation of clinical records

Assessment and management of patients receiving end of life care

- The findings have been used to inform development of the electronic patient care record
- The key findings will be communicated to staff and we will write a Clinical Update article to educate staff on pharmacological and non-pharmacological symptom management and assessment (including pain)
- We will continue to promote the use of Coordinate My Care
- Consider whether a regular clinical audit of end of life care should be introduced

Triage, dispatch and assessments for patients identified as bariatric

- Dispatchers were reminded of the need to 'ring fence' bariatric vehicles so they are only used for non-bariatric patients at times of high demand
- The illness code 'bariatric' will be removed and staff will be encouraged to complete estimated weight, where relevant

Newly Qualified Paramedic and non-registrants' use of clinical decision making tools for patients who are referred to alternative healthcare pathway (including self-care) rather than conveyed to an emergency department

- The key findings were distributed via a Trust-wide clinical newsletter, together with an infographic shared on the staff Facebook group
- Use of NEWS2 was encouraged during ePCR training
- The Capacity Assessment Tool has been incorporated into the ePCR
- We will archive the guidance notes associated with the Patient Referral Tool and ensure the electronic version of the Tool contains all of the relevant information and is available on clinicians' iPads
- We will ensure it is clear on the electronic guidance available for clinicians that the NEWS2 tool should not be used for women who are pregnant
- We will consider whether the requirement for non-registrants to record two full sets of observations is still relevant
- Non-conveyance codes will be reviewed and clarity provided as to when certain codes should be used

In addition, a further **18 local clinical audits** have been started by the provider in 2020/21, as well as a programme of continuous clinical audit:

Mental Health Joint Response Car

The Mental Health Joint Response Car (MHJRC), staffed by a Paramedic and Mental Health Nurse, was implemented to provide specialist face to face assessment and management of patients in mental health crisis. The MHJRC also attends high priority calls and may be called by a crew on scene to provide advice with a patient who has a mental health complaint. This clinical audit aims to demonstrate the safety of this initiative.

Advanced airway management re-audit

A clinical audit of advanced airway management was last undertaken in 2010. Since then airway management policy and procedures have been amended and the iGel was introduced. Several incidents have also been highlighted including: issues with poor utilisation of basic airway manoeuvres and adjuncts, lack of proper laryngoscopy to identify and clear foreign body airway obstructions, poor technique in advanced airway management and issues around the management of patients with a tracheostomy or laryngectomy. Therefore this clinical audit will assess current airway management by LAS staff.

Hip fracture re-audit

Suspected hip fractures in patients aged 65 and older represent a large volume of calls attended by the LAS. Clinical assessment and management of this patient group can be complex due to co-morbidities, polypharmacy and complex social situations. To ensure best practice, we conducted a clinical audit of hip fractures in 2012. This re-audit will assess for improvements in care and to determine if current care delivered by LAS clinicians is congruent with local and national standards.

Code Red

The “Code Red” priority call for massive transfusion pathway was introduced in 2016 and approved by the leads in the four London Major Trauma Centres (MTCs) for use by Advanced Paramedic Practitioners in Critical Care (APP-CC). Careful monitoring of the activation of the pathway was recommended as part of the Advanced Clinical Operating Procedure (ACOP), as calling a “Code Red” has a significant impact on a MTC including: pausing routine and urgent surgery; clearing radiology and theatre space, and loss of precious blood products in priming rapid transfusion devices. This clinical audit aims to determine compliance to the current “Code Red” ACOP principles.

Urgent Care treatment of: Headache, wounds, end of life care, paediatrics, abdominal pain, and transient loss of consciousness

Advanced Paramedic Practitioners in Urgent Care (APP-UC) aim to assess, treat and safely discharge patients, or utilise appropriate care pathways to reduce unnecessary hospital admissions. APP-UC take a detailed history and use targeted advanced assessment and skills such as a detailed neurological assessment, otoscopy and ophthalmology, pregnancy tests and urinalysis, and point of care blood testing, as well as other interventions such as wound closure. These clinical audit projects will inform the development of Clinical Performance Indicators (CPIs) for the APP-UC team.

Alteplase

Early administration of fibrinolytics (drugs that break up or dissolve blood clots) in cardiac arrest caused by pulmonary embolism has been shown to improve survival. Thrombolysis in cardiac arrest from other causes (e.g. haemorrhage) may worsen outcome, and evidence has shown that administration in undifferentiated cardiac arrest does not improve survival. The LAS is the first ambulance service to introduce alteplase, a fibrinolytic, for use by the Advanced Paramedic Practitioners in Critical Care (APP-CC) under a Patient Group Direction (PGD). Therefore this clinical audit will assess whether alteplase is being used in the LAS appropriately according to the PGD and Advanced Clinical Operating Procedure (ACOP).

Partnership working during COVID-19

As the call rate increased and the operational workforce pressure increased dramatically during the Coronavirus pandemic (COVID-19), new systems were developed to provide the

safest clinical response to the greatest number of patients. The new structures included utilising personnel from other agencies such as the London Fire Brigade (LFB), as well as emergency responders (ERs), Non-Emergency Transport crews (NETs) and third year paramedic university students to staff front line resources. This retrospective clinical audit will determine the types of patients attended by and care delivered by crews made up of COVID-19 Support Non-Paramedic Staff (CSNPS), and provide assurance that patients received a high level of care.

Notting Hill Carnival

The Notting Hill Carnival is a large, high-profile public event attended by more than a million people every year. A large number of dedicated resources are deployed to the area. These resources support the St. John Ambulance in providing medical cover for people attending the event and ensuring that other people in the area receive a response consistent with our usual day-to-day work over the course of the event. This clinical audit project looks to provide some reassurance that the things that need to happen for every patient are still happening in this context, particularly focusing on basic observations and essential documentation.

Protocol 36

Protocol 36 is an MPDS card used to triage infected patients in the event of an official disease outbreak, epidemic or pandemic. Protocol 36 was activated for the first time as part of the Trust's response to the Coronavirus pandemic. At its peak, calls related to COVID-19 accounted for nearly 50% of demand on the service. As such, this clinical audit will assess call handler compliance with the MPDS Protocol 36 card.

Sickle cell crisis re-audit

The care we provide to patients in sickle cell crisis has been audited three times previously, and while each re-audit identified improvements, further progress is needed around pain relief and medicines management. Therefore this clinical audit aims to determine whether any improvement has been made since the last clinical audit.

Cardiac arrest complicated by hyperthermia

Ambulance clinicians routinely measure temperature when managing patients in cardiac arrest as abnormally low (hypothermia) or high (hyperthermia) temperatures may represent treatable causes. This clinical audit aims to measure care provided to and clinical outcomes of patients presenting in cardiac arrest complicated by hyperthermia.

Emergency Responder medicine administration

The Trust is currently reviewing its management of station based medicines and how Emergency Responders are able to access three of the medicines within their skillset: salbutamol, glucose gel and aspirin. To help inform the review this clinical audit will measure Emergency Responder compliance to medicine administration.

Cardiac Arrest – Post-resuscitation care

APP-CCs have an advanced clinical operating procedure for how to manage patients in non-traumatic out of hospital cardiac arrest where a pulse has been achieved. This includes supporting cardiac output through the use of cardioversion, pacing and inotropic (or vasopressor) administration and sedation. Following the introduction of the ACOP an associated CPI was developed. This clinical audit project will inform the development of a CPI for the APP-CC team.

Continuous quality monitoring

We also continuously audit the care provided to patients who suffer either a cardiac arrest, acute coronary syndromes (including STEMI, new onset Left Bundle Branch Block and high risk ACS), suspected stroke (including FAST positive stroke), or were discharged of our care but re-contacted the Service within 24 hours having severely deteriorated or died unexpectedly. Findings from these four continuous audits are shared internally and staff

receive feedback to support learning where indicated.

In addition, the Trust also regularly monitors compliance with clinical guidelines in relation to oramorph, antimicrobials, repeat medication, medication of potential misuse, and high risk medication prescribing.

Clinical Performance Indicators (CPIs)

London Ambulance Service undertakes a programme of local Clinical Performance Indicators which, during 2020-21, monitored the care provided to 10 patient groups (cardiac arrest, difficulty in breathing, mental health - both diagnosed and undiagnosed, severe sepsis, elderly fallers, patients discharged on-scene and adult (non-traumatic) cardiac arrest, acute behavioural disturbance and major trauma attended by an APP-CC). We also quality assured the documentation of 2.5% of all clinical records completed by ambulance clinicians. Staff receive individual clinical feedback from these audits, highlighting areas of good practice and those in need of improvement.

Statement from the Patient & Public Council

The LAS Patient and Public Council was established in 2020 and has sought to be a critical friend to the LAS as it provides day to day care as well as implementing its future strategy. The Council has been impressed with how the organisation has faced the last year of extraordinary challenges. Council members have recognised how the service quickly adapted to rapid changing circumstances to provide the best possible care to their patients. Of particular note is how they have and are continuing to support their staff. At the same time Council members have been involved in working with staff as they continue to develop improvements in patient pathways and the safety of the services they provide.

STATEMENTS FROM COMMISSIONERS

NORTH EAST LONDON CLINICAL COMMISSIONING GROUP



North East London
Clinical Commissioning Group

Commissioners Statement for London Ambulance Trust 2020/21 Quality Account

Thank you for asking us to provide a statement on the Trust's 2020/21 Quality Account and priorities for 2021/22.

North East London Clinical Commissioning Group is responsible for commissioning the 111 Integrated Urgent Care Clinical Assessment Service for the population of east London. The comments on this statement therefore only relate to that service.

Over the last year the 111 IUC CAS service in London has had to respond to the global pandemic caused by SARS-CoV-2. Words seem inadequate to convey our gratitude to staff who selflessly provided the highest possible standards of care to our residents in such difficult and distressing circumstances. We support initiatives that enable staff to reflect, recover and

receive the support they need going forward and recognise that this will be essential for some years to come.

The Pandemic highlighted the need to enable staff quickly to work successfully from home. Whilst this has been facilitated for some clinicians, we would like to see the opportunity for home working to be extended to experienced Health Advisors.

In the light of this we congratulate the Trust in meeting its target to improve national staff survey results and we strongly commend the continued focus on staff wellbeing and support in 2021/22.

The Quality Account outlines a wide range of quality improvement projects and programmes and we applaud the development of the Quality Improvement Hubs and would like to suggest a QI approach as a guiding principle for 111 /999 integration and development.

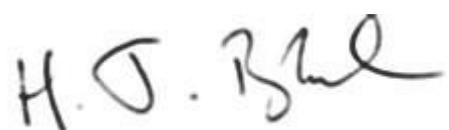
Last year the Trust became an early adopter for implementation of the Patient Safety Incident Response Framework (PSIRF). As commissioners we have a role to play in supporting the Trust with a smooth transition to this new system and are working with the Trust in the pilot phase to implement the PSIRF as part of the new NHS Patient Safety Strategy.

In 2020/21 the Trust undertook further work to assess the use of the 111 IUC CAS service's escalation plan and triggers to ensure key factors were being considered. The Trust also launched an audit tool in June 2020 which was used during 2020/21 despite workload demands. We congratulate the Trust on this programme of work and support the Trust to continue to use audits to test the model and ensure it is safe and effective.

We very much welcome the Trust's focus on reviewing productivity and outcomes for those working in IUC, ECAS and CHUB services. Understanding and addressing variation that exists between clinical staff and improving hear and treat rates safely is so important for improving our patients' experience as well as reducing the demand on our urgent and emergency care face-to-face services. We would like to suggest that frontline 999 crews should also be included in this review.

We support integrating pathways, strengthened to respond to the COVID pandemic and also the ability to flex workforce across 111/999 based on demand. This will be key to support the delivery of 111 First policy and to support 111/999 CAS integration. As such we support the continued focus on integrating the 999 and 111 systems to provide seamless care for patients regardless of access point and would like to suggest further work to measure the patient journey and patient defined outcomes for this programme of work. We suggest there is more work to do for the 111 First policy and 111/999 integration in terms of measuring what matters to patients and carers.

We confirm that we have reviewed the information contained within the Account only where these relate to 111 CAS for east London we have no concerns about accuracy or completeness. Overall we welcome the 2020/21 quality account and are again looking forward to another year working together to improve the quality of services for the population we serve.



Henry Black , Acting Accountable Officer, NHS North East London CCG



**South East London
Clinical Commissioning Group**

South East London CCG – Head Office
160 Tooley Street
London SE1 2TZ
www.selondonccg.nhs.uk Tel: 020 7525 7888

Dr John Martin, Chief Quality Officer,
London Ambulance Service NHS Trust,
220 Waterloo Road,
London SE1 8SD Sent electronically

Thursday 13th May 2021

Dear John,

Re: South East London Commissioning Group Statement on the London Ambulance Service NHS Trusts Quality Account 2020/2021

Thank you for submitting the London Ambulance Service Quality Account 2020/2021 with the South East London (SEL) Clinical Commissioning Group (CCG) as the commissioner of the SEL 111 Integrated Urgent Care (IUC) service. The Quality Account (QA) has been produced in unprecedented circumstances and the CCG wishes to acknowledge the continuing fortitude, compassion and commitment shown by all the staff at the London Ambulance Service NHS Trust during this time.

Throughout 2020/2021 the local CCGs worked closely with the Trust to seek assurance of the quality of the services it provided and appreciated the open and frank discussions that we had, including at the peak of the pandemic. We believe that the QA demonstrates the progress made on achievement of last year's 18 priorities and the plans for future development. The proposed quality priorities identified by the Trust for 2021-22 are fully supported by SEL CCG.

We recognise the following achievements.

During a challenging year, the Trust was one of the few early adopter organisations, for the implementation of the Patient Safety Incident Response Framework, thus demonstrating genuine commitment to learning with the inclusion of quality improvement patient safety initiatives. The Trust continued to be the highest reporting ambulance service for reporting safety incidents which reflects a strong positive reporting safety culture.

We are pleased to see the achievement in the downward trend in a reduction in

controlled drug related incidents and the continued emphasis on improvements in medicines management in line with the CQC recommendations.

The Trust's determined efforts to achieve the IUC service's staff rota to always ensure comprehensive and flexible cover was tested. The need to regularly review, scale up and respond to changing patient behaviour and call demand surge as required during the pandemic was trialled, and the Trust is to be commended on its ability to respond to this.

We welcome the Trust's continuous commitment to the health and wellbeing of staff, to ensure they feel safe and supported to do their job and deliver a quality service. It is good to see the positive impact on sickness absence and staff feedback given the challenges and pressured situations staff have operated within during Covid-19 unprecedented times.

Whilst the Trust retains its rating of Good overall and has had some focussed inspections, the CCG will continue to work with the Trust on those areas that continue to be a challenge to improve the quality of the 111 service to the SEL population which it delivers.

Although we recognise that important progress was made in IUC in 2020/21, it is evident that further work is still required to reduce variation in both the front end and CAS staffing and outcomes.

The need to further embed the integration of the 999 and 111 IUC CAS systems and build upon the learning and innovation of the past year to provide seamless care and an equitable service.

The Trust focus on engagement and involvement plans to gather the views of patients and communities through a variety of methods to help shape responsive and sustainable services.

We would like to express our appreciation for the way your staff have managed to huge increase in demand during this pandemic and for their professionalism, expertise, and ongoing determined commitment to delivering quality safe services.

In the Quality Account the Trust is clear that there is still much to be done to consistently deliver the outstanding services that local people deserve. We endorse the new quality priorities for 2020/2021 and very much look forward to continuing our collaborative approach to quality improvement in the year ahead.

Yours sincerely



Kate Moriarty-Baker Chief
Nurse Caldicott Guardian
NHS South East London CCG

14th May 2021

Private & Confidential

Dr John Martin Chief Quality Officer
London Ambulance Service
NHS Trust 220 Waterloo
Road

Re: London Ambulance NHS Trust Quality account 20/21

Thank you for sharing the London Ambulance NHS Trust Quality Account for 2020/21 which we received on 05/05/2021.

We would normally share the account within our CCGs and associates for their review and comment. However, as you will appreciate, the work of the CCGs is focussed on supporting the restoration of services following the pandemic. As such, we are not in a position to comment fully on the account with our stakeholders as we normally would. However, my direct team has reviewed the account and made the following comments, which I support:

- Where we can check, the data in the account appears to be accurate.
- We wish to congratulate the Trust and the staff for working tirelessly to support patients and the wider community against the unprecedented challenge of COVID-19. We note the significant improvements achieved in 20/21 by developing innovative quality initiatives and piloting locally owned concepts that strengthen continuous quality improvement and patient safety.
- The Trust successfully piloted the Station/service Quality Accreditation programme that robustly assessed local ambulance stations in line with the Care Quality Commission's (CQC) fundamental standards. We commend the Trust for its commitment to wider engagement with numerous stakeholders via coproduction as this programme has been rolled out Trust wide now. Prospectively commissioners look forward to seeing the overall impact of such initiatives and share the wider learning with other system partners.

- We acknowledge the significant accomplishment of successfully implementing the Patient Safety Incident Response Framework (PSIRF) and rolling out the new framework on schedule despite the significant challenges and uncertainties posed the pandemic. Most importantly, there was exemplary collaborative working with numerous stakeholders – a real testament to commitment, dedication and resilience.
- The Trust astutely upskilled its workforce with extended skills and competencies aimed at maximising the potential for paramedics to manage critically ill patients. We welcome the additional cohort of Advanced Paramedic Practitioners trained to administer thrombolysis in acute presentations and the pilot training programme for non-medical prescribing for paramedics that will undoubtedly improve patient outcomes and overall alleviate pressure on the healthcare system.
- We are pleased with the Trust’s commitment with regards to ongoing testing of Trust security measures to ensure continuous improvement Trust arrangements to secure vehicles stations and equipment. Commissioners look forward to seeing a reduction in the number of security related incidents across the Trust’s estate and facilities.
- The safe and secure handling of medicines is a key area of focus for commissioners and the timely completion of the medicine management rooms is well received. There has been a steady reduction in medicines’ related incidents since the secure drug room project commenced. To this end, we look forward to seeing the overall impact this will have on controlled drug related incidents.
- The Trust’s CQC rating of “Good” has been maintained and we commend the Trust for promptly addressing the two “Must Do” actions issued by the CQC in relation to medicines & security of vehicles and premises. The Trust went a step further and developed an action plan that addressed the recommendations made by the CQC "Should Do" actions. Overall commissioners are pleased to note the significant progress made against all areas.
- Progress on the Trust’s quality priorities has been reviewed for 20/21. Considerable progress has been made against the 17 of the 18 quality priorities, which is exceptional considering the impact of Covid. We support the Trust’s to decision to curtail the roll out of tempus monitors for Motor Cycle Response Units (MRU) was curtailed as a priority due to COVID.
- Significant pressure has been placed on the mental and physical wellbeing of staff throughout the pandemic with extraordinary determination, creativity and care. Commissioners recognise that the mental and physical health for all Trust employees is an absolute priority and we applaud the Health & Wellbeing strategy and other associated initiatives.
- Body Cameras are a vital tool for frontline staff as their use may deter the public from behaving antisocially, abusively or aggressively against staff. Commissioners look forward to the output of the body worn camera trial and anticipate a

reduction in violence against staff, fewer complaints, increased conviction rates of offenders and a reduction in time spent on investigations.

- There has been an improvement in staff survey results and most importantly there are sustained efforts in improving key themes such as bullying and harassment. Commissioners are pleased to learn of the Trusts ambition to strengthen diversity and inclusion by recruiting a Director of Culture to drive forward the Trusts plans on equality and diversity.
- The Trust has been proactively exploring and developing the paramedics in Primary Care Network (PCN) proposals to provide a broader training opportunity for paramedics. This approach will undoubtedly contribute to supporting the Trust to focus on attracting and retaining skilled and motivated staff.

We look forward to working closely with the Trust in the coming year and ensure that we continue to champion the quality, safety and safeguarding agendas together, for the benefit of the commissioned services for patients.

Yours Sincerely



Diane Jones
Chief Nurse and Director of Quality

Statement of Directors responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHSI has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporates the above legal requirements) and the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account. The London Ambulance Service, whilst not a Foundation Trust has prepared the annual quality account in line with this guidance ensuring directors have taken steps to satisfy themselves that:

- ❖ The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual **2020/21** and supporting guidance
- ❖ The content of the Quality Account is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2020 to March 2021
 - Papers relating to quality reported to the board over the period April 2020 – March 2021
 - Feedback from commissioners dated 14 May 2021

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2021
 - The 2020 national staff survey
- ❖ The quality report presents a balanced picture of the NHS trust's performance over the period covered
 - ❖ The performance information reported in the quality report is reliable and accurate
 - ❖ There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
 - ❖ The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Chair

Date

Chief Executive

Date



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	LAS response to the NHSE System Oversight Framework consultation			
Agenda item:	13			
Report Author(s):	Angela Flaherty, Associate Director of Strategy and Transformation			
Presented by:	Angela Flaherty, Associate Director of Strategy and Transformation			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<ul style="list-style-type: none"> NHS England and NHS Improvement have prepared proposals for a new approach to NHS system oversight that reinforces system-led delivery of integrated care. The framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan. A sixth theme includes local priorities that are set by individual ICSs. The framework does not describe how it would be applied to the oversight of regional providers LAS have developed a response that highlights the complexity of applying the framework to regional providers, and which suggests that oversight of regional providers should be conducted at a regional level based on the 5 national oversight themes, with a sixth set of metrics that reflect regional priorities. 				
Recommendation(s) / Decisions for the Board / Committee:				
<ul style="list-style-type: none"> The Trust Board is asked to note the consultation response which was submitted on 14 May 2021 				

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	Agreed			Relevant reviewer
Quality	Yes		No	
Finance	Yes	X	No	Chief Finance Officer
Chief Operating Officer Directorates	Yes		No	
Medical	Yes		No	
Communications & Engagement	Yes		No	
Strategy	Yes	X	No	Angela Flaherty
People & Culture	Yes		No	

Corporate Affairs	Yes		No		
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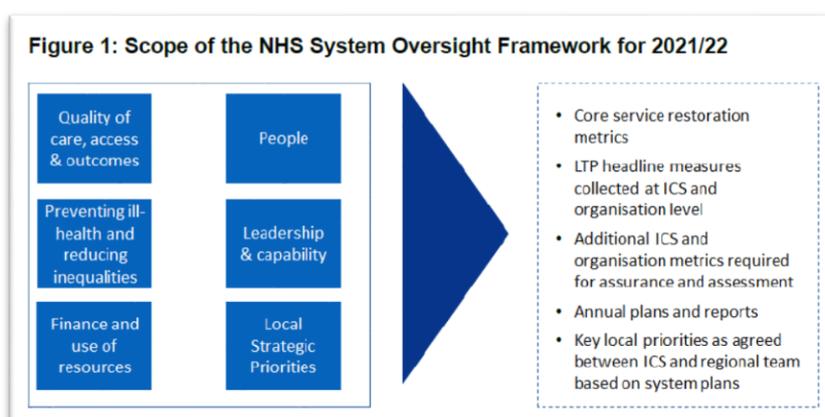


NHSE System Oversight Framework Consultation Summary and Response

NHS England and NHS Improvement have prepared proposals for a new approach to NHS system oversight that reinforces system-led delivery of integrated care.

The proposed framework has different oversight arrangements that depend upon both the maturity and performance of the ICS, and those organisations within it.

The framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across providers, commissioners and ICSs: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. A sixth theme includes local priorities that are set by individual ICSs.



ICS, provider and commissioner performance will be measured against core metrics aligned to each of the six themes. Organisations will then be segmented into one of four groups, depending upon their performance (as outlined below).

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	This is the 'default' segment unless an ICS, trust or CCG triggers the criteria for moving into another segment. While ICSs in this segment will still be on a development journey, they will demonstrate many of the characteristics of an effective, self-standing ICS. Where performance is challenged at system, place or organisation level, plans that have the support of system partners will be in place to address this.			Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Organisations in segment 1 will be high performing and expected to be in the top quartile across the relevant subset of oversight metrics, with an agreed financial plan and forecast delivery against the full-year envelope, and with a CQC rating of 'good' or 'Outstanding' overall and for well-led. For Trusts to score in Segment 1, they also need to play a strong, active leadership role in supporting and driving key local place-based priorities, provider collaboration arrangements and overall ICS priorities.

Trusts in segment 1 will be able to request access to funding to provide peer support to other organisations, be exempt from consultancy controls / relevant running cost limits, and benefit from a more streamlined business case approvals process.

Where Trusts have significant support needs that may require formal intervention and mandated support, they will be placed in segment 3 or 4. They will be subject to enhanced direct oversight by NHSE/I and may be subject to additional reporting requirements and financial controls.

The Framework describes proposals for an updated Recovery Support Programme (RSP) to replace the Special Measures Programme, which seeks to provide system-oriented support to focus on the underlying drivers of organisation problems and work with the parts of the system that hold the key to improvement. The RSP will be time limited with clear exit criteria.

The Consultation on the System Oversight Framework concluded on 14th May 2021, and our LAS response to the consultation is included below.

LAS Response to the NHSE System Oversight Framework Consultation

#	Consultation Question	LAS Response
1	(a) Do you agree that the proposed approach to oversight set out in this document meets the purposes and principles set out above? (b) If not, how could the proposed approach be improved?	Yes, the proposed approach to oversight is consistent with the purposes and principles set out in the framework.
2	(a) Do you agree that oversight arrangements for place-based systems and individual organisations within the ICS should reflect both the performance and relative development of the ICS? (b) If not, please give your reasons.	<p>No – the proposed approach works for single locality organisations, but it does not take account of regional providers that work across multiple ICSs, such as ambulance services. For regional providers, it is unclear how the performance and relative development of the multiple ICSs that they cover will affect their oversight arrangements.</p> <p>Our view is that there must be workable exceptions to the proposed framework, and that oversight of regional providers should be conducted at a regional level.</p>
3	(a) Do you agree that the framework's six themes support a balanced approach to oversight, including recognition of the importance of working with partners to deliver priorities for local populations? (b) If not, how could the proposed approach be improved?	<p>Yes, partly agree - we agree that the first five national themes support a balanced approach, but it is not yet clear how the sixth oversight theme which focusses on local ICS priorities would be applied to the oversight of regional providers, like ambulance services, who work across multiple ICSs.</p> <p>It would be neither practical nor equitable for regional providers to be monitored against 5 different sets of local priorities from 5 different ICSs, alongside the 5 other metric sets that are collected across the other national themes. Instead, our preference would be for oversight of regional providers to be conducted at a regional level based on the first five national themes within the framework, with an agreed set of regional metrics which would form the sixth oversight area.</p> <p>We would also welcome further guidance around how the role and performance of local authorities is included in the system oversight framework, particularly in relation to system performance against the '<i>preventing ill health and reducing inequalities</i>' metrics.</p>
4	(a) Do you agree that the proposed approach will support NHS England and NHS Improvement regional teams to work together to develop locally appropriate approaches to oversight? (b) If not, how could the proposed approach be improved?	<p>No - the proposed approach to oversight does not yet fit the complexity of regional providers who cover multiple ICSs.</p> <p>The approach to oversight of regional providers needs to be consistent with the approach for the commissioning and funding of regional providers to ensure that there is alignment across performance monitoring, and commissioning and investment decisions across the region.</p>

<p>5 (a) Do you support the proposed approach to segmentation across ICSs, trusts and CCGs? (b) How could the proposed approach be improved to better inform oversight arrangements and effectively target support capacity?</p>	<p>Yes, partly agree - there need to be workable exceptions to the segmentation of ICSs, Trusts and CCGs based on top- or bottom-quartile performance.</p> <p>For instance, bottom-quartile performance may not be the most appropriate criteria for segmentation when the overall sector is a high-performing sector.</p> <p>Similarly, in sectors like the ambulance sector, where there are a small number of individual providers with similar levels of performance, a focus on bottom- or top-quartile performance might create volatility, as small changes in the performance of individual providers could radically re-order the cohort from year-to-year. There need to be workable exceptions to the segmentation of ambulance service Trusts to ensure that support is effectively targeted in the right places.</p>
<p>6 (a) Do you have any additional suggestions that could improve the proposed approach to oversight, support and intervention?</p>	<p>Consistent with our response to the previous questions, the framework needs to be adjusted to take account of the complexity of regional providers which span across multiple ICSs. Our view is that the oversight of regional providers should happen at a regional level.</p> <p>Beyond this, we would also welcome a greater role for peer review from Trusts in Segment 1 to support Trusts in Segments 3 or 4. This will support the spread of good practice, and reduce reliance on external support.</p> <p>We also welcome the additional benefits available to NHS organisations in Segment 1, but would want a cap on consultancy spend to remain for organisations within this segment, albeit at a higher threshold, to ensure that there are still some controls in place to assure value for money.</p>
<p>7 (a) Do you agree that the current model of special measures for individual organisations should be replaced by a more system-focused support programme? (b) If not, please give your reasons.</p>	<p>Yes – we agree that a more system-focused support programme is an improvement on the current model of special measures.</p>
<p>8 (a) Do you support the proposed approach to the Recovery Support Programme? (b) How could the proposed approach be improved to better support systems, trusts and/or CCGs to address complex and/or longstanding challenges?</p>	<p>Yes, mostly agree – we support the proposed approach to the Recovery Support Programme, and in particular its system focus which ensures that the underlying drivers of problems are addressed by the parts of the system that hold the keys for improvement.</p> <p>We would welcome a greater role for peer support and learning to feature in the RSP to maximise the sharing of good practice from within the NHS, rather than relying solely on external consultancy support. In practice, peer to peer support would work best across similar providers (e.g. acute to acute) located across different ICSs.</p>

9 (a) Do you support the proposed approach to CCG assessment? (b) If not, how could the proposed approach be improved? *Not applicable*



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Board Assurance Framework			
Agenda item:	14			
Report Author:	Frances Field, Risk and Audit Manager			
Presented by:	James Stanton, Head of Corporate Governance			
History:	N/A			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting

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

The Trust Board is asked to:

- Note the current position of BAF risks as summarised below and the detail set out in the accompanying BAF document:
 - BAF risk 61 COVID-19 Impact:** The risk has been reviewed by the responsible directors following the approval by the Trust Board on 30 March 2021 to decrease the residual risk score from 20 (4 x 5) to 12 (4 x 3) with no further changes to the residual risk score.
 - Finance** sub-category risk: The risk was reviewed by the Chief Finance Officer on 7 May 2021, residual risk score remains at 5 (5 x 1).
 - Operational** sub-category risk: The risk was reviewed by the Chief Operating Officer on 5 May 2021 with amendments to mitigations and the residual risk score remains at 12 (4 x 3).
 - Clinical safety** sub-category risk: The risk was reviewed by the Chief Medical Officer on 27 March 2021 with no change to the residual risk score which remains at 12 (4 x 3).
 - Quality** sub-category risk: The risk was reviewed by the Chief Paramedic and Quality Officer on 6 May 2021 with amendments made to mitigations and the residual risk score remains at 12 (4 x 3).
 - People and Culture** sub-category risk: The risk was reviewed by the Director of People and Culture on 27 April 2021 with an amendment to mitigations and the residual risk score remains at 12 (4 x 3).
 - BAF risk 56** -The Trust’s ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets. The risk was reviewed on 6 May by the Director of People and Culture Committee who considered a

proposal to decrease the residual risk score from 16 (4 x 4) to 12 (4 x 3) in light of the controls in place, however members considered that there is still uncertainty around securing our required establishment of paramedics as set out in our workforce plans and agreed that the residual risk score should remain at 16 (4 x 4).

- **BAF risk 58** – There is a risk of catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients. **This risk has been reviewed and updated by the Chief Information Officer, residual risk score remains at 16 (4 x 4).**
- **BAF risk 45** - A cyber-attack could materially disrupt the Trust’s ability to operate for a prolonged period. **This risk has been reviewed and updated by the Chief Information Officer, residual risk score remains at 15 (5 x 3).**
- **BAF risk 63** – Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a minimum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards. **The risk was reviewed by the Chief Finance Officer on 7 May 2021 with amendments to controls and actions, residual risk score remains at 15 (5 x 3).**
- **BAF Risk 65** - There is a risk that the health and wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease. **This risk is has been reviewed with the Interim Director of People and Culture and the Chief Medical Officer, the residual risk score remains at 12 (4 x 3).**

2. Note two further BAF level risks were discussed at the Finance and Investment Committee and Logistics and Infrastructure Committee meetings in May. Members of FIC proposed the consideration of a risk in respect of Capital and members of LIC a further risk in respect of the Hub 1 project. These will be reviewed and articulated by the responsible directors, for consideration by the Board in July 2021.

Recommendations for the Trust Board:

The Board is asked to Approve the Board Assurance Framework

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

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		John Martin, Chief Paramedic and Quality Officer
Finance	Yes		No		Lorraine Bewes, Chief Finance Officer
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer, Chief Operating Officer
Medical	Yes	X	No		Fenella Wrigley, Chief Medical Officer
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		Kim Nurse, Director of People & Culture
Corporate Affairs	Yes	X	No		James Stanton, Head of Corporate Governance

Board Assurance Framework: April 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.

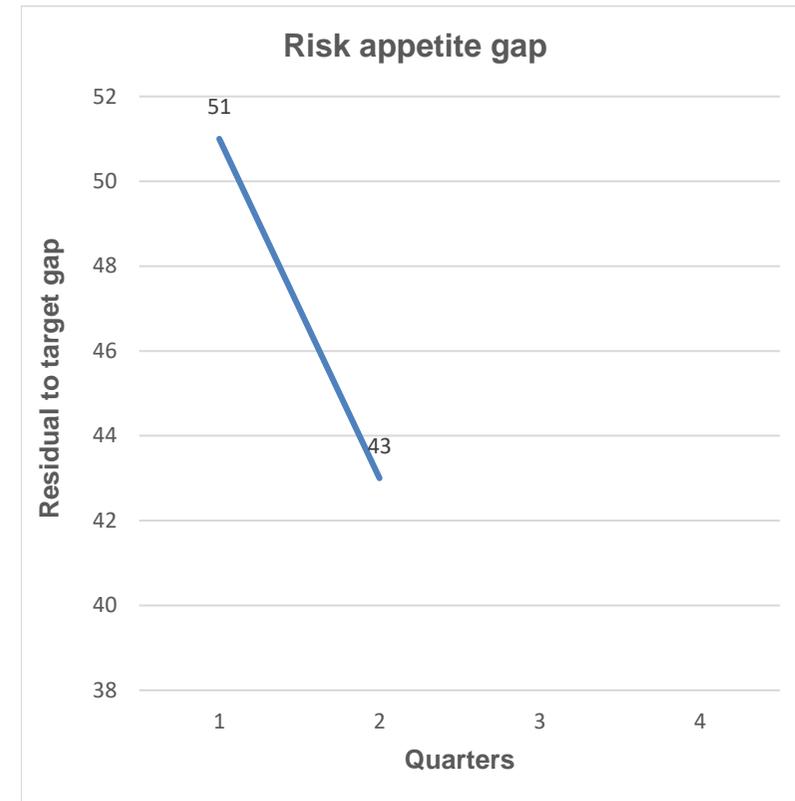
The Board is asked to note the changes highlighted in red and in particular the risks exceeding the Board tolerance scores as shown in the table below.

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	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	↔
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 – 2021/2022

	Target	Jan '21	Apr '21
BAF 61 COVID 19	8	20	12
BAF 58 IT failure	4	16	16
BAF 45 Cyber Security	10	15	15
BAF 56 Recruitment/Retention	8	16	16
BAF 63 Future Funding	5	15	15
BAF 65 Immunisation	8	12	12
Total risk score	43	94	86
Residual to target gap		51	43



BAF 61 COVID 19: A proposal to reduce the residual rating from 20 (4 x 5) to 12 (4 x 3) 12 due to decreased pressure on the organisation was approved by the Trust Board on 30 March 2021

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. We are now procuring a third party supplier to support our international paramedic recruitment.

8. **Substantive 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
9. 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.
10. 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.
11. **PSIP** monitoring and reporting all **patient safety** incidents – COVID19 and non-COVID19 related – monthly end to end review of patient pathway incidents (IUC and Emergency pathways
12. Worked with CQC and NHSI and agreed SI process whilst recognising the scale of investigations required to meet LfD regulatory requirements
13. 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.
14. 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
 15. 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.
 16. The Trust has secured the forecast outturn as at month 10 including £4.8m for COVID surge which was set aside within the NWL STP contingency fund. The Trust is now required to deliver an allowable deficit of £1.2m (after the impact of increasing the annual leave accrual by £3.6m. The Trust has also delivered £7.0m efficiency savings.
 17. 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.

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| | | <ol style="list-style-type: none">6. 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. 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. The paramedics currently working within the PCNs are benefiting from new experiences and gaining new skills to bring back to the Trust.7. To improve our internal pipeline of registered clinicians, we are partnering with Medipro to provide additional training capacity for our TEAC programme.8. The Strategic Workforce Planning Group is meeting fortnightly to review performance against workforce plans.9. Under the Ambulance Operations Programme there is a retention workstream which is focusing on the design and implementation of initiatives to reduce the number of planned leavers. This includes working with the LAS International Support team to put in place 121 retention interviews with our international paramedic staff, addressing the feedback from the iPara survey and supporting this group with applications for visa extensions and indefinite leave to remain and promoting opportunities for staff who are considering retirement. | | | | |
|--|--|---|--|--|--|--|

10. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation
11. The Trust has developed a paramedic apprenticeship programme to attract and retain non clinical employees.
12. The Trust is developing accessible career pathways for non-registered clinical roles. Introduced new Band 4 role (Assistant Ambulance Practitioner). Two cohorts totalling 130 have joined in 2020/21, one will be operational in Feb 21 and the second cohort in July 21.
13. The LAS academy is coming to an end and we will move to the partnership with Cumbria for an apprenticeship programme.
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 2021/22 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 fortnightly

			<p>monthly basis supported by a number of workstreams including IUC and Ambulance Operations.</p> <p>4. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo.</p> <p>5. Monthly tracking of actual leavers against forecast, pension estimate enquiries, visa expiry data.</p>					
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			<p>11.Regular reporting to committees, sub committees and groups.</p> <p>12.IT Delivery Board established with Terms of Reference</p> <p>13.Draft roadmap developed and is being socialised with operations</p> <p>14.Commissioned independent reports.</p> <p>15.Routine planned maintenance.</p> <p>16.Outline business cases.</p> <p>17.Project boards established for replacement of critical systems</p> <p>18.Capital allocation of funds for corrective actions.</p> <p>19.D999 Programme Board established and overseeing key projects</p> <p>20.Issues with systems discussed at all levels of the Trust</p>		<p>6. Review CISCO telephony platform and create a plan for transitioning from the current system.</p> <p>7. CAD Essentials Board has been superseded by the IMT Delivery Board</p> <p>8. CAD dashboard to be implemented and reviewed at IMT Delivery Board</p> <p>9. Cyber to be moved to ICT and a clear roadmap developed to resolve outstanding issues including patch management</p> <p>10. Completion of build of new hardware platform for existing CommandPoint to be completed at Crown Hosting Centres</p> <p>11. IT Priorities reassessed and focused on key areas</p> <p>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 Replacement Strategies in progress to address</p> <p>13. Network configuration to be reviewed and upgraded to include resilience.</p> <p>14. Primary network site of Bow to be relocated to Waterloo.</p> <p>15. Relocate all hardware platforms out of Bow data centres and into</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>01/04/21</p> <p>30/05/21</p> <p>01/11/21</p>		
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					<p>Crown Hosted Data Centres 16. Relocation of all Trust services from systems in Bow to new hardware platforms in Crown Hosted Data Centres</p>	01/11/21		
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STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do

Executive Lead		Chief Information Officer		Assuring Committee	Logistics and Infrastructure Committee			
No. and Risk description	Initial risk score	Key controls and assurances		Residual risk score	Action plan	Timescale	Risk tolerance	Board update
45	A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	20	<p>Controls</p> <ol style="list-style-type: none"> 1. Technical cyber protection, detection and remediation solutions are deployed but require review. 2. The continuation of a professional cyber security team as a managed service to deal with incidents and cyber response e.g. Royal Surrey ransomware notification. Information Security Management support in Corporate Affairs. 3. Auditable set of documents covering people, processes, procedures and technical controls; reviewed by NHSD and third parties at least twice a year 4. Broad set of real-time security reporting and alerting with ability to take immediate action 5. NHS specific intelligence feed from NHS Digital implemented in technical controls and cyber responses <p>Assurances</p> <ol style="list-style-type: none"> 1. Compliance-based cyber security KRIs/KPIs (reported to IM&T SMT and monthly CEO performance review) 2. Performance reporting to L&IC through IM&T 3. Internal Audit and independent audit against DSPT 4. Additional NHSD assurance support through CORS programme 5. CareCert notifications performance measured and reported as part of the IM&T's KPIs, reported to IM&T SMT & ExCo monthly 	15	<ol style="list-style-type: none"> 1. Deliver technical control/assurance projects: <ol style="list-style-type: none"> a. Network segregation and access control (Cisco ISE and TrustSec) b. Hardening of internet-facing systems (configuration and improved access control) c. N365 – Underpinned by the IG Compliance monitoring and data loss prevention - Investigating existing M365 access to Information Protection technology d. SolarWinds Logging solution and Security Information & Event Management (SIEM) 2. Leverage NHSD funded opportunities: <ol style="list-style-type: none"> a. Cyber Risk Framework workshops to enable enterprise integrated cyber risk management b. CORS Support – Supplier cyber management process, training needs analysis, baseline security architecture patterns, cyber cultural vision statement c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised qualifications. 3. Recruitment of substantive IG and Information Security resource at 2nd line of defence. 	<p>CIO</p> <p>Aug 2020 June 21</p> <p>June 21</p> <p>June 21</p> <p>Complete</p> <p>CIO</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p>	6-10	

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
<p>63 Due to the national uncertainty over future funding arrangements, from 21/22 including uncertainty of future commissioning arrangements, 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 for the second half of 2021/22.</p> <p>This risk relates to all commissioned services including 999 and IUC /111 services covering NEL / SEL and NWL</p>	<p>5x4=20 11.11.20</p>	<p>Controls</p> <ol style="list-style-type: none"> 1. Case made to regulator and ICS system leaders for investment in ambulance operations modernisation programme to realise Carter identified efficiency opportunity over 3-5 years. The Trust needs to get further commitment from commissioners that they will support the transformation programme, including the ambulance operations modernisation business case. 2. Comprehensive resource model developed which links workforce, frontline fleet capacity, finance, and demand to forecast ability to deliver national response performance standards. 3. Income for H1 of 2021/22 agreed with ICS with agreement of receipt of non NHS income and additional surge costs excluded. 4. 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. 5. CFO linking with national tariff setting, National Ambulance Implementation and Improvement Board and commissioner 	<p>5x3=15 11. 11.20</p> 	<ol style="list-style-type: none"> 1. Identify components of the strategic efficiency plan to PID level. 2. Monthly reporting of downside or worst case scenarios included in the Finance Report. 3. Implement financial control transformation plan. 4. Implement service line reporting. 5. Work with pan-London ICS CFOs lead to achieve buy in to modernisation Programme. 6. Work with pan-London ICS CFO's and London region to secure required CDEL and supporting cash. 7. Agree H2 income plan by the end of End of September 21. 8. Prioritise of capital and revenue service development for H2 is outstanding. 9. Complete lean process review of IUC/111 services to support commissioning discussions. 	<p>Complete</p> <p>Complete</p> <p>30 Sep 21</p> <p>30 Sep 21</p> <p>Ongoing</p> <p>30 Sep 21</p> <p>30 Sep 21</p> <p>30 Jun 21</p> <p>30 Sep 21</p>	<p>12-16</p>	

CFO group to ensure transparency and ongoing awareness of cost to deliver expectations set through NHSE & Regional directives.

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.
3. Bi-weekly meetings to agree short and medium term forecasts and resourcing required to deliver performance.
4. Asset disposal plan aimed at closing £14.5M of the Trust's capital cash requirement.
5. Benefits realisation including efficiency delivery is on the internal audit review plan to report by Q1.
6. End to end process review for IUC services to be completed by the end of September 2021 to optimise efficiency and support commissioner discussions.

Gap in Control

1. Capital Plan of £45.7M developed for 21/22 with a capital remaining CDEL and cash gap of £24.3M.
2. H2 income plan to be agreed by end of September 2021 for both 999 and IUC/111 services.
3. Prioritisation of capital and revenue service development for H2 is outstanding.

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

Executive Lead Director of People and Culture Assuring Committee People and Culture Committee / Quality Committee

No. and Risk description	Initial risk score	Key controls and assurances	Residual risk score	Action plan	Timescale	Risk tolerance	Board update
<p>65 There is a risk that the Health and Wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease</p> <p>Source Recent review of OH records indicate transfer of vaccination record information between previous providers does not provide assurance of immunity.</p> <p>Lack of evidence of immunity may result in recommendation for restricted attendance or isolation following exposure.</p>	<p>16 3.11.20</p>	<p>Immunisation catch up programme commenced.</p> <p>Records are now captured in ESR</p> <p>Analysis of immunisation records to identify any gaps</p> <p>Contract tracing processes in place to identify and protect staff at risk of lack of immunisation /immunity</p> <p>Initiation of work through the ESR Account Manager and local/regional user groups to create a reporting framework in ESR.</p> <p>A task and finish group commenced work to review the systems and processes pre & in early employment to improve the opportunities for immunisations prior to commencement in roles where the risks are the highest.</p> <p>Gaps in controls Some staff have no results from historic immunity testing.</p> <p>There have been periodic Occupational Health provider changes, where the transfer of records from one third party provider to the next was incomplete, missing or corrupted.</p> <p>No systems in place for periodic immunity reviews.</p>	<p>12 3. 11.20</p> <p>↔</p>	<p>Data analysis using OHIO/ESR to understand the full scope of the issue.</p> <p>Design and deliver clear concise factual communications to staff about:</p> <ul style="list-style-type: none"> • The issues • The risks • The solutions <p>Delivery of the Phase 1 immunisation catch up programme will be completed in December 2020</p> <p style="color: red;">Verbal Update from CMO to board recommending next steps for immunisations programme, with paper presented to ExCo on 17.3.21.</p> <p style="color: red;">Appointment of OH specialist as LAS advisor</p> <p>Design and implement immunisation assurance reports from OHIO.</p> <p>Task and finish group- Review & redesign the approach to immunisations, timings of checks and processes starting at the pre employment. Currently being worked into retender spec. timeline will be in line with contract renewal.</p> <p>Review the clinical evidence for</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>31/12/21</p> <p>Ongoing</p>	<p>6-10</p>	

			<p>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.</p> <p>An OH specialist advisor has been interviewed and offered the post. There was an initial start date of June 2021 but indications are we will be able to have support from May initial 3 days per week and then increasing to fulltime from June. The focus will be on the immunisation programme and providing the CMO and Director of P+C / Head of Wellbeing with the necessary expert advice around the OH tender and specialist OH advice and support. This appointment, which will initially be fixed term to ensure there is organisational benefit, was a recommendation from the FAOW investigation supported by the Audit committee but has been challenging to secure due to COVID and OH providers supporting the national vaccine programme.</p>		<p>periodic immunity reviews.</p> <p>Complete delivery of Phase 2 of the immunisation catch up programme.</p> <p>Review and revise the Workforce Immunisation Policy in line with the evidence for or against periodic immunity reviews.</p> <p>Launch new processes enabling staff to take personal responsibility to attend appointments , keep up to date and maintain personal immunisation records.</p> <p>Scope and tender process underway for a proactive and flexible OH service which strives for continuous quality improvement and uses the " Making Every Contact Count" principles to assess health and lifestyle choices, including immunisation status awareness and checks through every staff interaction. This has commenced and is noted for completion by 30 June 2021.</p> <p>Ensure the OH contract award includes the requirement for a live bi-directional OH interface with ESR.</p> <p>Complete a validation audit with the appointed OH contract holder to validate records transferred to them with those in ESR prior to switching on the bi-directional interface for vaccination data. No other OH data will be shared.</p>	<p>30/06/21</p> <p>Ongoing</p> <p>30/06/21</p> <p>Ongoing</p> <p>Jan 2022</p> <p>Jan 2022</p> <p>Jan 2022</p>		
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					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		
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Appendix 1

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: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	8
<p style="color: red;">Risk reviewed on 28 April 2021 by Chief Operating Officer – residual risk score remains a 12 (4 x 3).</p> <p>Operational Risk Description:</p> <p>As a result of the Covid-19 pandemic, all operational areas in LAS suffered from reduced ability to deliver timely responses to the 999 / 111 / IUC demand. In addition to failing to deliver service, there are risks of gaps in IM&T response to the changing situation, supply chain gaps, business continuity, and emergency preparedness. The three main strategic risk components are: risk of reduced infrastructure availability to support demand; reduced staffing capacity to respond to demand and reduced responsiveness in with a view of circumstances change. The current concern is focused on the need to respond to the additional peak combined with the usual winter pressures.</p> <p>The three main strategic aims that the activities listed below cover:</p> <ul style="list-style-type: none"> • Increased capacity and capabilities in terms of infrastructure; including in times where the Trust is undergoing development and transformation. • Responsive staffing across different LAS services and impact on staffing availability from transformation work as well as BAU. • Increased process responsiveness to changes in situation (both internally and through collaboration with system partners). This includes operational focus to recover activities during times of reduced Covid-19 impact and then returning to a full capacity operation as well as a pattern of recurring peaks in demand that is forecasted. <p>Key activities and actions to mitigate risk:</p> <ul style="list-style-type: none"> • COLT was set up to support information sharing, enable a resilient response to the situation and robust decision making. This has been converted into a BAU daily Exec-led group, and following the increasing pressure over December the Daily Performance Group was stood up. Following a reduction in pressure, the daily performance meeting was stood down and the regular executive led meeting took its place. • Regular meetings taking place to ensure a timely response in case the Covid pressures increase and pose a risk to performance delivery. In that case a plan is in place to stand up a daily response meeting looking at specific pressure points to allow a daily exec oversight of trust position and decision making such as: 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 which is progressing well to date. • Medium term forecast and planning is undertaken by the trust to cover the response to demand expected during the government proposed roadmap. • Additional planning is being started up to ensure the Trust is resilient ahead of a potential third wave. • 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 12 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. 			

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	8
<ul style="list-style-type: none"> • Wrote a Covid-19 response plan of operational and clinical response based on different levels of expected impact on the service. • Operational recovery planning is ongoing to shape the response for decreasing pressure, in view of the forecast. Some of the actions are to be implemented at the end of the incident and some after LAS is after the peak. • Close review of performance and the impact of the various actions undertaken through a response for Covid-19. This will be used to inform the plans for operational response to additional peaks of Covid-19 demand. • Ongoing review of specifically Covid-19 related risks and response to those. • Oversight of CAD stability: <ul style="list-style-type: none"> ✓ CAD Essentials board to be restarted and control room risks will be an agenda item ✓ Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place ✓ Audits of telephony system ✓ CAD dashboard to be implemented and reviewed at CAD essentials board • IM&T to respond to Trust requirements where a change in practice is requiring a technological change, as part of this increasing the availability of remote working via TEAMS. • IM&T to provide assurance that bandwidth capacity is available to enable higher numbers of staff to work remotely. • The Trust has rolled out a staffing plan to deploy non-standard ambulance to simplify scheduling and increase oversight of delivery levels. • The Trust conducted its assessment of the risks faced by the Trust in the event of a <u>worst case</u> sickness levels across LAS and the wider system, in line with the framework mandated by the Department of Health and Social Care. This risk assessment has now been published, available for the public. • Expansion of the DCA fleet to maximise the vehicle availability to respond to increasing demand. • Incorporated a wide range of volunteers into the 999 and 111 services to support continued service delivery, retained the capability and systems to increase the number of volunteers if required by demand. • Expansion of 999 control room capabilities and capacity to respond to calls. • Separated out the Covid-19 calls from 999 and 111 to allow a specialised response. • Fuel stocks confirmed which address the civil contingency act requirement to supply 24 days' supply. And a fuel monitoring system is installed and working to protect fuel stocks. New Fuel policy and procedure to support business continuity to be rolled out. • The trust rolled out a plan for distribution and testing of FFP3 masks as well as plans for acquiring further supply, with systems in place to source additional PPE as required to respond to changing demand • Engagement with CCG's NHSE&I, PHE and all system partners throughout the planning, preparedness, response and recovery to maintain confidence across the system of robust arrangements within the London Ambulance Service. • Continue adapting the plan clinically and operationally as the situation develops. • To seek assurance from third party suppliers to the Trust that they have a robust Business Continuity Plan to provide supplies to the Trust. 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. 			

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	8
<ul style="list-style-type: none">Review of the impact on staff capacity and availability as a result of transformation projects and development of services by the Trust.			

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	8

The risk was reviewed by the Director of People and Culture on 27 April 2021 and the residual risk score remains at 12 (4 x 3).

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 151 AAPs in 2020/21 with a further 240 planned for 2021/22.**
- 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.
- Partnership arrangements have been put in place with the Met Police to support us at peak times.
- 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.

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	8
<ul style="list-style-type: none"> • 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. • There is a national programme of lateral flow testing which has been in place since December 2020, designed to help prevent the spread of COVID-19. Tests will help to identify staff and volunteers who should be isolating. • There is a national COVID-19 vaccination programme which has been in place since December 2020 to protect staff and patients. • Completed individual risk assessments Trust wide. 			
<p>3. Possible safety and reputational risk through the rapid recruitment of significant additional staff and volunteers to be deployed to frontline and support areas.</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Utilise national "fast track" arrangements put in place for the NHS with agencies such as DBS, UK Visa, • Utilise existing services such as NHS Passport to verify employment history, statutory and mandatory training, qualifications and registration or existing and returning NHS staff members • Expand existing Bank arrangements to hire staff and reduced risk of co-employment exposure • Require individual/departmental risk assessments that confirm supervisory requirements, limited access to restricted areas • Establish and accelerated Occupational Health declaration process for new staff and volunteers • Incorporate requirements for 3rd party resource providers to verify and guarantee staff have the correct authorisation to work, qualifications, registrations, DBS etc. 			
<p>4. Impact on BAU Recruitment especially the Australian Paramedic programme</p> <p>Key activities and actions to mitigate risks: (reflected in BAF risk 56)</p> <ul style="list-style-type: none"> • Departments encouraged to review all current and planned recruitment at the beginning of the COVID period and decisions made to pause, delay or stop recruitment • BAU recruitment resource redirected to focus on priority recruitment areas such as call handlers, blue-light drivers, C1 licence holders through the dedicated "Personnel hub". • Australian recruitment programme regularly reviewed and approach updated as necessary. Current status – planning to continue on a Skype basis as international travel to conduct interviews is not possible. This will require training of non-operational staff to conduct interviews. We are now procuring a third party supplier to support our international paramedic recruitment. • 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. 			

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	8
<p>5. Ensure new and redeployed staff receive the training and equipment they require to fulfil new and existing roles safely</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Bespoke training programmes created to equip staff to carry out new roles safely e.g. EOC support call handler • Buddying and supervisory shifts implemented before new starters work in “live” environment • 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 			
<p>6. Governance risk</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Utilise Joint Decision Making (JDM) / Decision Log protocols to capture decisions made / authorisation levels etc. during the COVID period • Regular contact with EPRR teams to seek advice on the above • Membership of regional and national network bodies (e.g. Ambulance HRD forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working • Extraordinary staffside / management consultation arrangements in place • People & Culture Committee short form process established and utilised as required. • Membership of COVID, Daily Senior Leadership Team (DSLTL) represented at GOLD meetings and calls, daily submission of metrics and reports with regards to P&C elements e.g. sickness absence, accommodation required, and staffing 			
<p>7. Future impact on our culture of actions taken and behaviours adopted through COVID period.</p> <p>Key activities and actions to mitigate risks:</p> <ul style="list-style-type: none"> • Continuing FTSU arrangements in place • Regular contact between P&C HR Managers, HR BPs, line managers and staff side to ensure issues captured and addressed quickly and fairly as most hearings and investigations are paused (now back to BAU Staff Council held every other month, weekly OPF, hearings now taking place) • Resolution framework 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: Lorraine Bewes		Financial	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	15 5	5
<p style="color: red;">Risk reviewed on 7 May 2021 by the Chief Finance Officer, residual risk score remains at to (5 x 1) = 5 due.</p> <p><u>Strategic Risk Description:</u></p> <p>There is a risk that the Trust is unable to deliver its key performance metrics due to insufficient Covid funds being secured for the second half of 20/21.</p> <p><u>Underlying Cause</u></p> <p>The financial arrangements for the remainder of 20/21 have now been finalised with NWL STP. The Trust has secured the forecast outturn as at month 10 including £4.8m for COVID surge which was set aside within the NWL STP contingency fund. The Trust is now required to deliver an allowable deficit of £1.2m (after the impact of increasing the annual leave accrual by £3.6m. The Trust has also delivered £7.0m efficiency savings.</p> <ol style="list-style-type: none"> 1. Fails to capture the material financial impacts of COVID 19. Cannot recover the full income required for COVID 19 from NHS England/Improvement. <p>Actions taken:</p> <ul style="list-style-type: none"> • The Trust has established a COVID 19 Resource Tracking template to be completed for all COVID 19 related resource requests, these are all approved by Trust Gold and reported to ExCo and FIC on a regular basis. • The Trust continues to fully document all COVID 19 related expenditure to ensure it will 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. • The Trust has secured the forecast outturn as at month 10 including £4.8m for COVID surge which was set aside within the NWL STP contingency fund. 2. Is unable to identify and sustain cost efficiencies from opportunities post Covid-19 <p>Actions taken:</p> <ul style="list-style-type: none"> • The Trust is developing an efficiency programme, building in benefits realisation principles from PWC audit of D999 programme to deliver savings to meet the 1% CIP requirement expected of all organisations plus cost pressures that have arisen in the 2nd half. A total opportunity of £11m was been identified of which £7.0m is now delivered. 3. Is unable to identify and sustain innovation and improvements during and post Covid-19 i.e. CAD replacement/EPCR implementation. <p>Actions taken:</p> <ul style="list-style-type: none"> • 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) <p>Actions taken:</p> 			

COVID-19 - Sub-category Strategic Risk Assessments

Responsible Director: Lorraine Bewes	Financial
<ul style="list-style-type: none">• Case for urgent Covid funding includes investment in asset tracking of key equipment and kit required for ambulances to be functional across the whole organisation and deployment points to track and manage inventory and reduce the risk of fraud.• The Trust is maintaining its existing control environment across segregation of duties, adherence to SFIs, Scheme of Delegation and procurement controls. <p>Additional action against mitigation of risks 1-5</p> <ol style="list-style-type: none">1. 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.2. Revenue bridge for STP CFO has been agreed across NWL STP.3. Review of monthly Covid spend by Directorate4. Development of downside mitigation plan5. Development of a BAU and transformation efficiencies plan <p>Assurance of controls</p> <ol style="list-style-type: none">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 Board3. Daily Senior Leadership Team priority theme for July is Budget resilience	

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: John Martin		Quality	
Risk assessment using NHS risk matrix	Initial Rating	Current Rating	Target Rating
	20	12	2x3= 6

Risk reviewed 6/05/21 with amendments to key activities and controls, residual risk score remains at 12 (4 x 3).

Key activities:

- 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.
- All compliance and standards audits continue. Quality reviews have recommenced.
- COVID19 Review for patient harm has following wave 2 has been completed and learning will be taken forward.
- Demand has decreased significantly to normal level and number of incidents have also returned to normal levels.
- Deteriorating patient process trialled in 2020 re-introduced to provide information to prioritise patients waiting at ED departments. Five case studies submitted to QGARD for national review of harm.
- QOG and associated sub committees have re-commenced.
- CQRG has re-commenced for external review of quality.
- Planning taking place for post lock down changes.

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
- Regular Senior Leadership Development to escalate any issues
- PSIP monitoring and reporting all patient safety 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)
- Working with national leads for safeguarding, coroners to maintain oversight whilst reducing operational pressures.
- 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
- 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	12	8

Risk reviewed 27/04/21, residual risk score remains at 12 (4 x 3).

As the Trust emerges from the consequences of the second COVID wave the priority is the continued response to our patients and the rapid assimilation of learning from wave 2 into actions that may mitigate the consequences of a 3rd wave.

The new Clinical Safety Plan has been launched and has had its first review stage with excellent feedback. This will allow a more dynamic targeted approach undertaking specific actions to mitigate specific challenges

Staffing levels in the ECAS/CHUB and IUC are being reviewed with the experience gained from wave 1 and 2

We are continuing to work with partners to embed pathways which were beneficial for patients during COVID waves in recognition of the fact that acute hospital providers will continue to see bed pressures as they manage the consequences of COVID

We have worked collaboratively with London providers to introduce remote oximetry

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.

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	12	8
<ul style="list-style-type: none"> • 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. • 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 (i.e. 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 <p><i>CAVEAT: The Board recognises that due to the overwhelming nature of the pandemic on London healthcare, suboptimal outcomes must be considered in the context of the whole response and the provision of high quality care to the largest number of patients possible.</i></p>			



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Corporate (Trust Wide) Risk Register			
Agenda item:	For information			
Report Author(s):	Helen Woolford, Head of Quality Improvement and Learning			
Presented by:	Helen Woolford, Head of Quality Improvement and Learning			
History:	Assurance report from Risk Compliance and Assurance Group (RCAG)			
Purpose:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input checked="" type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting

Key Points, Issues and Risks for the Committee’s attention:

Corporate (Trust Wide) Risks rated 15 and above were considered by the Risk Compliance and Assurance Group (RCAG) on 11th March 2021.

New Risk

- There were no new risks for inclusion in the Corporate (Trust wide) Risk Register.

Current Risk

- Risk ID 775 - There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers to prevent neutral from being lost during a network power outage. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services independently at Bow and HQ.

Update: The Group were advised that a project manager had been assigned to review the UPS upgrade and what actions were required as next steps.

- Risk ID 973 - There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.

Update: The Group were updated on the ongoing discussions regarding the mystery shopper audit to ensure the correct information was captured to inform further work needed. The group agreed that this risk remained and would be ultimately addressed through the Ambulance

Modernisation Programme. The risk and score has remained unchanged during the last year with the current score rating having been in place since January 2020.

- Risk ID 1112 - There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.

Update: The Group were informed that there was no new update. This risk was added to the Corporate (TW) Risk Register in June 2020 and the risk and score has remained unchanged.

Risk De-escalation

- Risk ID 1050 – There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the new response bags due to packing errors by VP or being diverted by staff which could lead to failure or delay in patient care.

Update: The Group were informed that robust auditing was in place on bags and individual packs. There were systems being implemented to enable clinicians to be informed of any equipment's missing due to supply issues. The Group agreed, in light of these mitigating controls, the risk be de-escalated to a risk score of 8.

- Risk ID 1106 – There is a risk that the LAS, Hazardous Area Response Team, Special Operations Response Team and Tactical Response Unit will be out of license to perform their core competencies because of the impacts of COVID-19. Training was suspended for all of the R&SA specialist response staff (HART, SORT, and TRU) and prevented training/ refresher in PPE. The consequence of this is that the LAS will not be compliant with audit and staff will not be as conversant with equipment and PPE not used regularly which could impact on patient and staff safety.

Update: The Group were advised the risk had been reviewed locally by the team and relevant training had re-started. The group agreed the risk be de-escalated to a risk score of 10.

Closed Risk

- There were no risks considered for closure.

Tolerated Risks

- There are two tolerated risks:

Risk ID 1081 - There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed. Review date: 30/04/2021.

Risk ID 1133 - There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers. Review date: 11/08/2021.

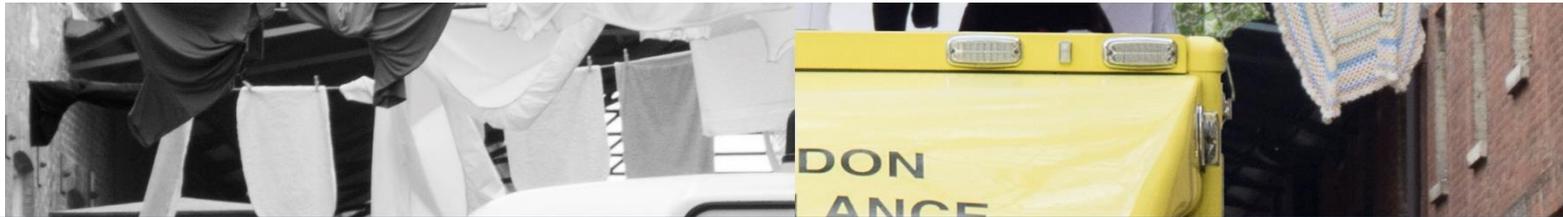
Recommendation for the Committee:

The Trust Board is asked to note the Corporate (Trust Wide) Risk Register.

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

Directorate	Agreed				Relevant reviewer
Quality	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Finance	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Chief Operating Officer Directorates	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Medical	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Communications & Engagement	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Strategy	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
People & Culture	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative
Corporate Affairs	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	RCAG Representative

ID	Sector / Department	Description	Risk level (current)	Controls in place	Risk Owner	Last review date	Assurance	Risk level (Target)	Progress Notes
775	Estates	There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers to prevent neutral from being lost during a network power outage. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services independently at Bow and HQ.	15	Business resilience fall back accommodation in is place for all operations currently working out of Bow and this has been tested with fall back at Waterloo and other locations across the LAS estate. The business recovery plan was enacted and LAS was able to continue to deliver services across London.	Andrew Goodman	11/03/2021	1. Ops, Strategic Assets and Property and IMT project team have been reinstated 2. A risks and options paper was developed by the team on the 22/3. And this included the set of tests that would be undertaken on the equipment	5	11/03/2021 Risk Reviewed at RCAG: The Group were advised that the projects and programme department had placed the transformer work on hold with a view to the longer term plan. A project manager had been assigned to review the UPS upgrade and what was required as next steps.
973	Estates	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.	15	1. Security management Policy implemented. 2. Organisational procedure on station duties in place and communicated to staff. 3. Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4. Security surveys being carried out on vulnerable sites. 5. Support available from the Metropolitan Police where acts of theft, damage, vandalism are reported. 6. Security awareness training incorporated into H&S training delivered across the Trust. 7. Engagement of security guards at sites where delay is common	Andrew Goodman	23/03/2021	1. Incidents reported on Datix. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Regular review of incidents by Trust LSMS.	4	11/03/2021 Reviewed at RCAG: The Group were updated that there were ongoing discussions regarding the mystery shopper audit. The group agreed that this risk remained and would be ultimately addressed through the Ambulance Modernisation Programme.
1112	NHS111	There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.	16	On a daily basis all unmanned phones are checked once per shift to ensure they are logged off. Incidents are raised if an unmanned phone is left logged in and staff member notified. All patients whose calls have been missed and not noted to have recontacted the service will be called back	Jacqui Niner	11/03/2021	Incidents are raised on Datix to document when phones are left unmanned but logged in. All patients whose calls have been missed and not noted to have recontacted the service will be called back	4	11/03/2021 Reviewed at RCAG: TThe Group were informed that there was no new update.
1081	Fleet and Logistics	TOLERATED RISK There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed.	16	A review is underway, which was commissioned by the COO. Chief Pharmacist has carried out a detailed review of the medicines packing function in line with Good Distribution Practice criteria.	Andrew Goodman	09/11/2021	Chief Pharmacist has carried out an initial assessment.	2	30/12/2020 Reviewed at Medicines Risk Review. Risk tolerated until the end of the financial year (30/04/2021). Monthly review to continue.
1133	South East Sector	TOLERATED RISK There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes and also the introduction of Low traffic Neighbourhood Schemes LTNs. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers.	15	Bulletin circulated to crews Return CRU to certain areas of London Emergency Services Group established and meeting monthly with LAS, LFB, MPS, sub director of streets and TfL head of traffic flow. LAS COO has formally written to TfL and Local Authorities to express concern (LFB has also formally written) and PFD notice from Leeds City Council shared LAS consistently objecting to calming measure that put physical barrier in place (planters or lockable bollards)	Khadir Meer	11/02/2021	Review of performance and impact on job cycle times Monitor incidents via Datix	5	11/02/21 Reviewed at RCAG: This is a tolerated risk and will be reviewed again in 6 months (11/08/2021)



London Ambulance Service – Quality Report



Report for discussion at the Trust Board
Analysis based on March 2021 data, unless otherwise stated



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2. Effective	• NICE Guidance	21
	• AQI and Clinical Audit	22-25
	• Handover to green performance	26
	• PDR & MCA Training	27
	• EOC Call Handling Quality Assurance	28
	• Language Line	29

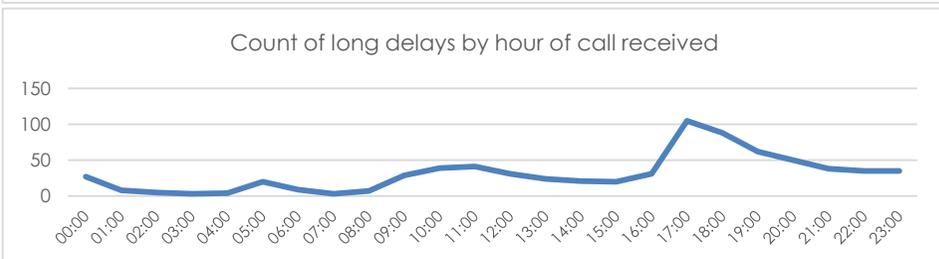
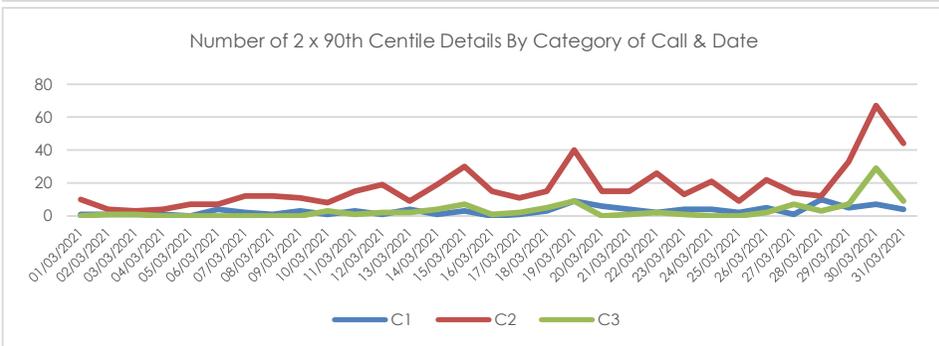
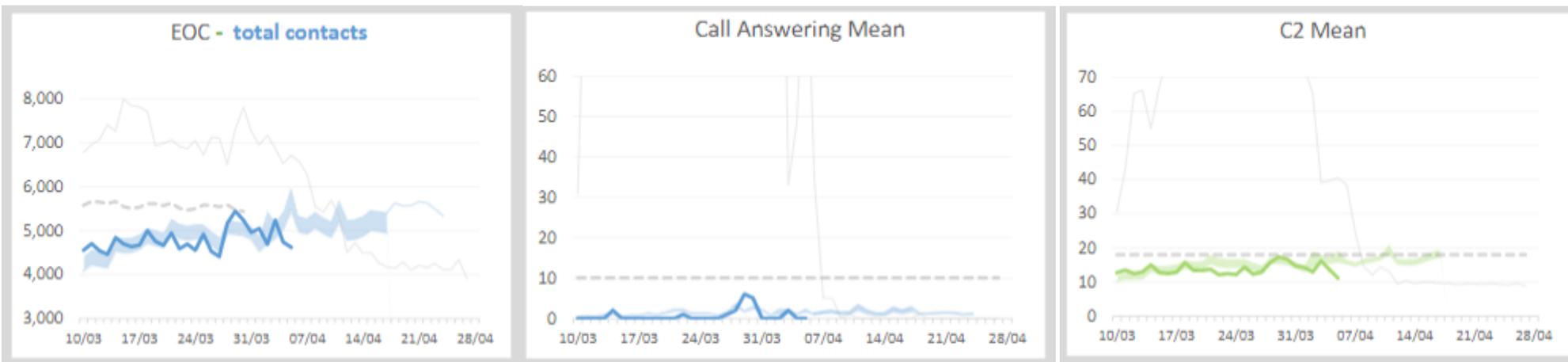
Section	Content	Pages
3. Caring	• Caring Scorecards	31-32
4. Responsive	• Frequent Callers	34
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5. Well Led	• Learning from Excellence	37-38
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Quality Domain	Metric	Mar-21	Highlights from this report by quality domain	Metric	Mar-21	Potential concerns and actions being taken
Safe	Rate of Low/No Harm Incidents per 1000 Contacts - 999	3.4%	<p>Incidents: The trust continues to see consistent incident reporting which indicates a good reporting culture as well as a culture of openness. In the previous report (January 2021), an increase in incidents graded as moderate harm and above was reported which was attributed to increase in demand due to COVID19 wave 2. This has since returned to normal reporting figures.</p> <p>Medicines management: There is assurance that there is an effective systems for identifying drugs retained off duty and resolving issues promptly.</p> <p>Safeguarding: Level 1 training is at 95.5% achieving the overall annual target.</p> <p>Infection Prevention & Control: Hand Hygiene compliance for March 2021 is 94%. Compliance exceeds the expected Trust target of 90% for the group station that submitted data. Vehicle prep deep clean compliance is reported at 99%, exceeding the Trust target of 95%. Premises cleaning for 18 Group Stations/Services who submitted data for analysis provides a Trust compliance of 96%.</p> <p>Health & Safety: The Wellbeing Strategy & the delivery plan has been presented for approval, there are many aspects of the MSK Action Plan embedded within this strand of work.</p>	Medical Equipment Incidents Report	167	<p>Medical Equipment continues to be the highest reported category of incident. The majority of these are required failure of devices rather than missing devices which had previously been seen over the course of the year.</p> <p>Actions being taken: An education and training piece of work is being undertaken between operations and logistics. A deep dive review into these incidents to ensure any further actions are identified and taken. This will be presented to SIALG in May and QOG in June 2020. The Trust is purchasing an asset tracking system and new make ready contract to support and monitor this issue going forwards.</p> <p>Safeguarding level 2 & 3 training: The number of trained staff is below the Trust target of 90%. Action being taken: Sufficient places on training course throughout the coming year (2021/22) have been made available to ensure the required % of staff receive this training. Trajectory: To achieve 90% compliance for both training by December 2021.</p> <p>Meds Management: There has been a few incidents relating to medicines packing and out of date drugs remaining in circulation. To date, 1 incident has been declared an Serious Incident Investigation. Actions being taken: Immediate audit and investigation of out of date drugs encompassing medicines packing and operational management of drugs packs. The development of the new medicines packing unit is ongoing and medicines training for packing unit staff is in place to improve drug handling and supply management.</p> <p>Statutory & mandatory training: As at 31st March the trust was tracking below the 85% target at 82%. Action being taken: Regular reports are sent to managers and individual to remind them of when training is due.</p>
	Rate of Low/No Harm Incidents per 1000 Contacts - IUC	0.9%		Percentage of Level 2 Safeguarding Training	70.9%	
	Perfect Wards Inspection - Average Score	98%		Percentage of Level 3 Safeguarding Training	73.8%	
	Percentage of Level 1 Safeguarding Training	95.5%		Incidents regarding out of date drugs	3	
	Percentage OWR Hand Hygiene Compliance	94%				
	Percentage of VP Deep Clean A&E Vehicles	99%		Statutory & Mandatory Training Compliance	82%	
	Percentage of Premises Cleaning Audit	96%				
Effective	MCA level 1 training	93.3%	<p>MCA level 1 training: is above the trust target of 85%</p> <p>Language Line: There is assurance that the language line is used effectively in EOC</p> <p>Clinical AQIs: The LAS achieved the highest ROSC on arrival at hospital for the overall group in November 2020 at 30.1% ranking 1st place amongst other ambulances services in England, above the national average of 25.5%. We also achieved a higher than average ROSC on arrival at hospital for the Utstein group (53.7% vs 47.5%), ranking 3rd place.</p> <p>Stroke: Our Stroke team received the NHS England AQI figures relative to November 2020. For the 4th month in a row and 6th time in the financial year (2020/2021), the LAS continues leading the rest of the country in terms of mean Call to Arrival at Hospital Time for suspected stroke patients (1.07), well above the national average of 1.24.</p>			<p>MCA Level 2 Training: is currently not offered. Action being taken: Plans to include this in 2021-22 CSR programme are being developed.</p> <p>PDR Compliance: is at 77%, an improvement on the 73% compliance in February. Action being taken: People and culture are working closely with Corporate teams (who have lower compliance levels than frontline teams) to improve their compliance levels. This includes weekly PDR reports to highlight team members who have an expired PDR date and those who are due to expire in the coming three month period. Compliance is being reviewed by the P&C team with a paper due to P&C committee shortly. Operations are piloting a new combined CISO/OWR/CPI/PDR process which may improve the compliance further.</p> <p>OWR compliance: is currently at 47%; the target is 85%. This is a 3% improvements when compared to the position in January but further work is needed. Action being taken: Sectors have station specific trajectories in place with various timescales. Performance against the trajectory is monitored at local Sector/Service Quality Governance Meetings. It is important to note that OWRs had to be suspended for a considerable period of time due to risks associated with COVID and as such that there is now significant work required to recover performance.</p>
	Total calls of language line calls in EOC	6,030 (4.2%)		Personal Development Review (PDR) Compliance	77%	
	ROSC At Hospital (AQI) - Reported 4 Months in Arrears ROSC At Hospital UTSTEIN (AQI) - Reported 4 Months in Arrears	30.1%				
	ROSC At Hospital (AQI) - Reported 4 Months in Arrears ROSC At Hospital UTSTEIN (AQI) - Reported 4 Months in Arrears	53.7%		Operational Workplace Review (OWR) compliance:	47%	
	Stroke - Call to Arrival at Hospital mean (hh:mm)	01:07				

Quality Domain	Metric	Mar-21	Highlights from this report by quality domain	Metric	Mar-21	Potential concerns and action
Caring	Percentage of views of CMC care plans by LAS	5743 (70%)	<p>End of Life care: The number of patients that received an appropriate onward review has increased by 3% compared to the 2017 clinical audit, with 90% of clinicians practising sharing decision with other health care professionals and/or the patient and their family in the care episode.</p> <p>In the majority of cases (84%) the management of this patient group was deemed appropriate.</p>			
	Percentage of conveyances of EoLC patients to ED	14.6%				
Responsive	Total complaints for 2020/21	1052	<p>Complaints: Total complaints for 2020/21 was 6% less than the previous year (1125). This is in line with our expected trajectory due to the COVID19 pause period during March to June 2020 when complaint numbers dipped.</p>			
	Rate of Complaints	0.11				
Well led	Number of PFDS	0	<p>Preventing Future Deaths: No PFDS since the last report (January 2021).</p> <p>Excellence Reports: 144 reports were submitted which is the largest number ever received in one month. All Excellence reports are shared with individuals, teams and sectors as well as used in learning events such as the monthly SI learning meeting and the quarterly learning from experience group.</p> <p>The latest INSIGHT magazine which was developed by the Quality Improvement and Learning Team and released in February 2021 included 11 key topic areas which were supported by case studies from SIs, incidents and also Excellence Reports.</p>	Risks Reviewed Within the last 3 Months	75.9%	<p>Risk management : 75.9% of risks have been reviewed within the last 3 months, the target is 90%.</p> <p>Actions being taken: The risk team are working with key areas of outstanding risks to ensure these are undertaken in April 21. The team are also working with the performance team to ensure that risks are monitored via the bi-monthly performance meetings to encourage local ownership and accountability.</p> <p>Trajectory: To achieve the 90% KPI target by May 2021.</p> <p>Policies: There are 10 overdue for review & 72 currently under review.</p> <p>Action being taken: The team are committed to continuing to work with stakeholders to ensure that the position is resolved quickly to reduce the consequences of operating with out of date or inaccurate policies. The trust wide review of policies is being monitored at the Senior Leadership Development Meeting (SLDM), particularly progress against the list of out of date documents.</p> <p>Trajectory: To achieve 90% of policies in date by June 2021</p>
	Number of Excellence Reports submitted	144				
					% of policies in date	

The service is meeting operational delivery KPIs, with call answering and mean response within national set timeframes.

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



In March 2021 there were 735 long delays, 8% of these resulted in a blue call. There was an increase in long delays experienced at the end of March. This was multifactorial in nature and included call handling pressures due to higher than predicted call volumes (300+ for several hours) and hospital pressures. Performance was particularly challenged in the NE Sector of which a number of specific actions were taken to address this.

	C1	C2	C3	Grand Total
Total	94	542	99	735
Blue Call	20	41	1	62

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

- DX012 - Emergency Ambulance Response (Category 3) (16% n = 115) – 5 required a blue call
- Unknown (10% n = 77) – 5 required a blue call
- DX0121 - Emergency Ambulance Response (Category 3) (3% n = 22) – 4 required a blue call

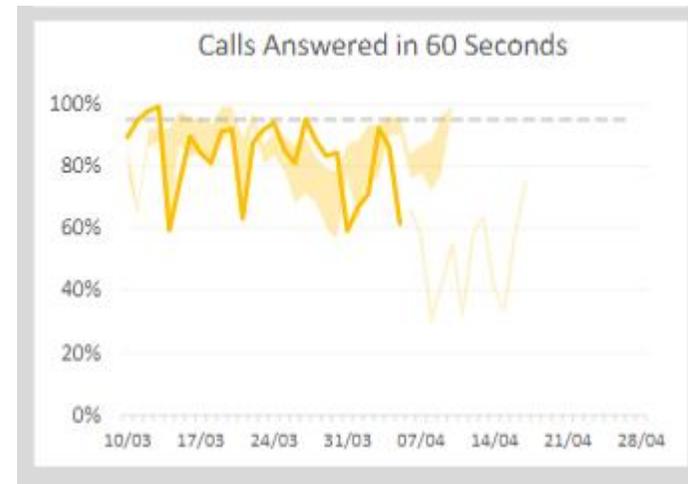
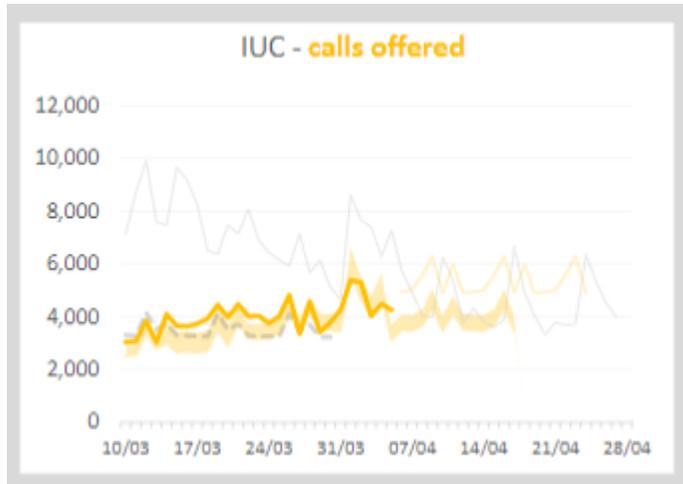
55% (n=402) patient whom experienced a long delay were not conveyed and 45% were conveyed. It was also found that 35% (n 255) of all long delays occurred between the hours of 17:00 and 19:00.

Action being taken include:

- Forecasting and planning weekly focus
- Overtime incentives to ensure cover at predicted busy periods.
- Daily operational performance review and actions

The performance of 111 call handling against strategic objectives is being monitored closely to ensure performance is being managed within set performance targets/thresholds for IUC in SEL/NEL/NWL.

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



Indicator (KPI Name)	Status	W/C 01/03/2021	W/C 08/03/2021	W/C 15/03/2021	W/C 22/03/2021	Sparkline
SEL IUC Priority 1 - %LAS 35 minutes safety threshold	●	94.7%	93.9%	87.8%	83.9%	
SEL IUC Priority 2 - %las 75 minutes safety threshold	●	98.6%	94.6%	85.8%	88.0%	
SEL IUC Priority 3 - %LAS 150 minutes safety threshold	●	98.1%	87.6%	65.2%	70.2%	
SEL IUC Priority 4 - %las 260 minutes safety threshold	●	98.0%	96.2%	77.9%	88.6%	
SEL IUC Priority 6 - %LAS 420 minutes safety threshold	●	100.0%	100.0%	86.2%	91.9%	
SEL IUC Priority 7 - %LAS 540 minutes safety threshold	●	100.0%	98.6%	95.8%	96.6%	

Indicator (KPI Name)	Status	W/C 01/03/2021	W/C 08/03/2021	W/C 15/03/2021	W/C 22/03/2021	Sparkline
NEL IUC Priority 1 - % LAS 35 minutes safety threshold	●	94.5%	90.0%	83.6%	84.0%	
NEL IUC Priority 2- %LAS 75 minutes safety threshold	●	95.6%	91.3%	68.8%	63.7%	
NEL IUC Priority 3 - %LAS 150 minutes safety threshold	●	96.7%	97.9%	86.8%	80.7%	
NEL IUC Priority 4- %LAS 260 minutes safety threshold	●	100.0%	99.7%	89.5%	84.6%	
NEL IUC Priority 5 -%LAS 360minutes safety threshold	●	99.2%	99.5%	94.3%	95.1%	
NEL IUC Priority 6 - %LAS 420 minutes safety threshold	●	97.5%	100.0%	96.7%	95.0%	

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

1. Safe

We must ensure we protect our patients and staff from abuse and avoidable harm. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

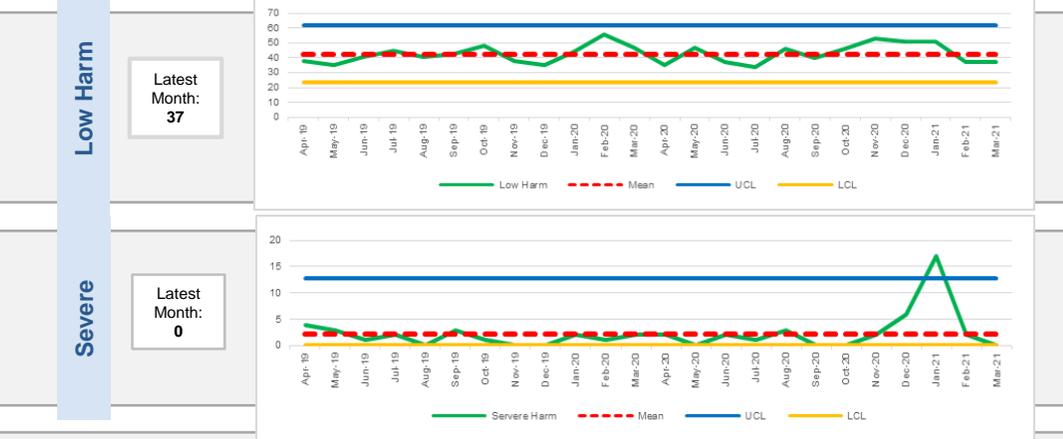
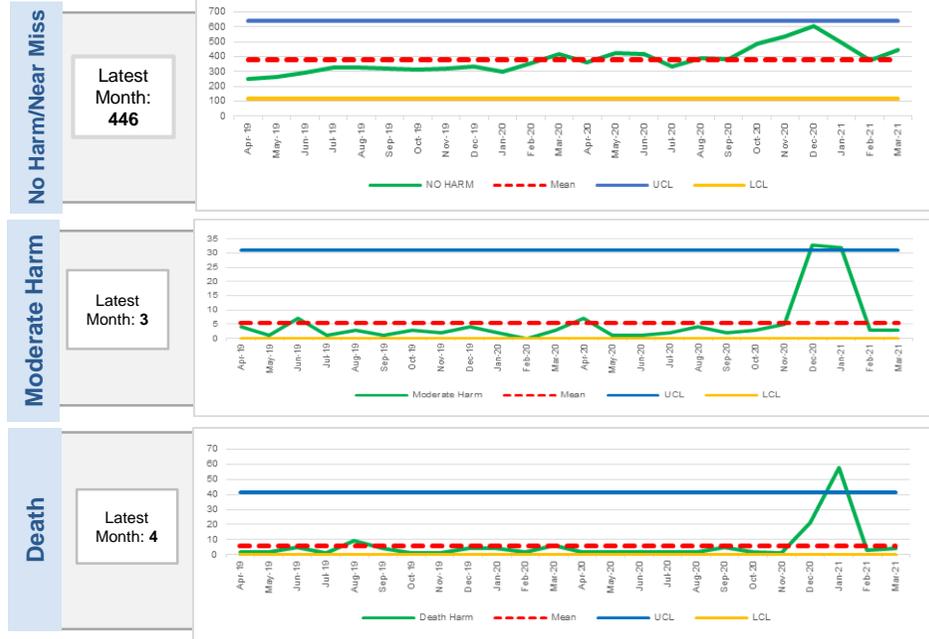
For further assurance we then provide additional data and analysis on:

- Patient Safety
- Infection Control
- Medicine Management
- Safeguarding
- Health and Safety
- Clinical & Non Clinical Claims and Legal Inquests
- Outcome of Quality Visits (Environmental & Equipment)
- Statutory and Mandatory Training

Outstanding Characteristic: People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

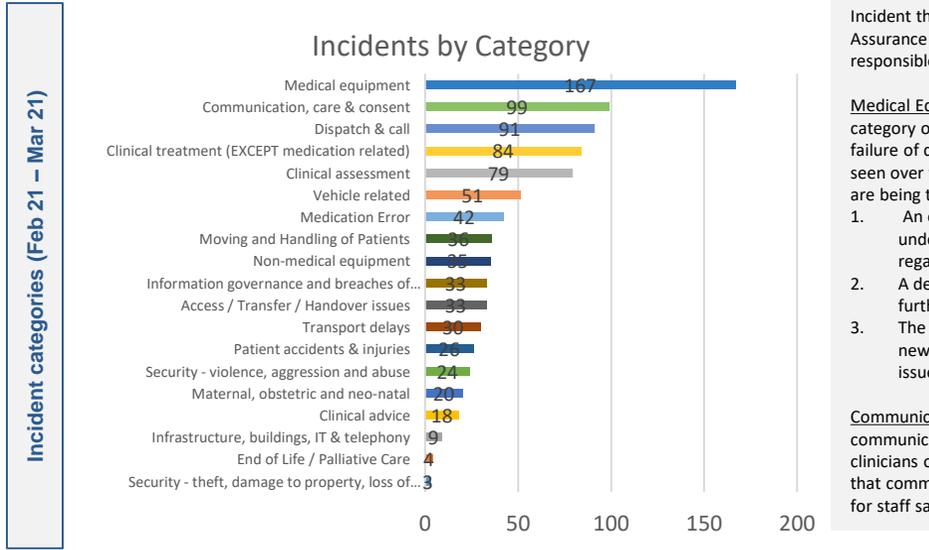
1. Safe - 999 Incident Management

Owner: Helen Woolford | Exec Lead: Dr. John Martin



Analysis of SPC graphs:
The number of reported no and low harm incidents (3.4) continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust Safety Investigations Assurance and Learning Group (SIALG). There continues to be a yearly increase in the reporting of these incidents with an 35% increase in 2020/21.

The number of moderate, severe and death patient safety incidents decreased in February and has returned within normal reporting numbers following the received COVID19 wave which saw demand on the service increase.



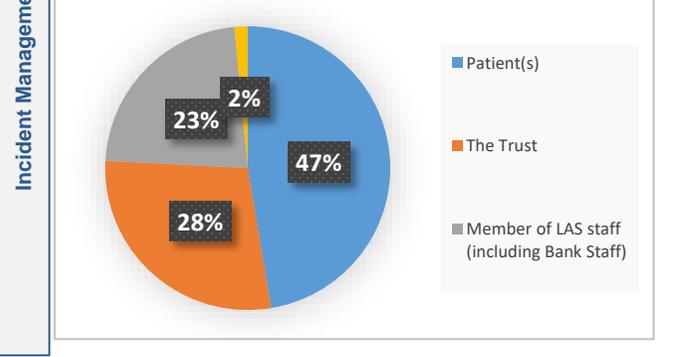
Incident themes are monitored at the Safety Investigation Assurance and Learning Group (SIALG) with escalations to responsible departments where required.

- Medical Equipment** continues to be the highest reported category of incident. The majority of these are regarding failure of devices rather than missing devices which was seen over the first quarter of the year. A number of actions are being taken including:
1. An education and training piece of work is being undertaken between operations and logistics regarding returning/replacing broken equipment.
 2. A deep dive review into these incidents to ensure any further actions are identified and actioned.
 3. The Trust is purchasing an assess tracking system and new make ready contract to support and monitor this issue going forwards.

Communication: There has been a recent theme of communication channels not being monitored between clinicians on scene and EOC. Work is underway to ensure that communications are monitored correctly within EOC for staff safety purposes.

There are 935 incidents (as of 01/04/2021) which have been opened on the system longer than 35 working days (this excludes Sis and COVID 19 reviews). This breaks down to 443 patient incidents, 212 staff incidents 14 visitor incidents and 266 Trust related incidents.

This remains a focus of QGAMs to support operational colleagues investigate and close down incidents accordingly.



1. Safe - IUC Incident Management

Owner: Helen Woolford | Exec Lead: Dr. John Martin

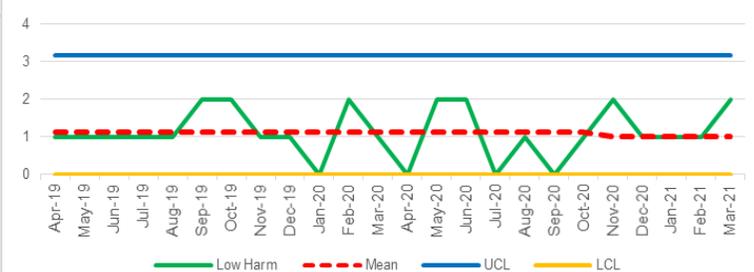
No Harm/Near Miss

Latest Month: 163



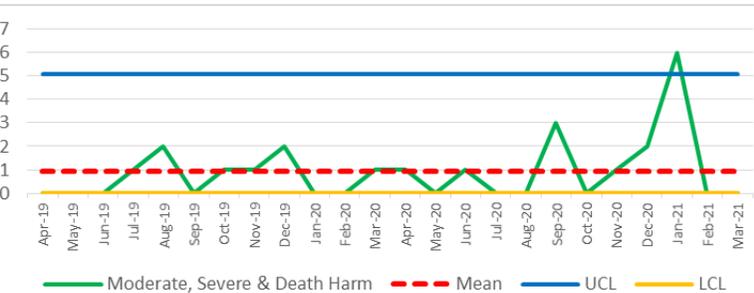
Low Harm

Latest Mo2th: 1



Moderate, Severe & Death Harm

Latest Month: 6

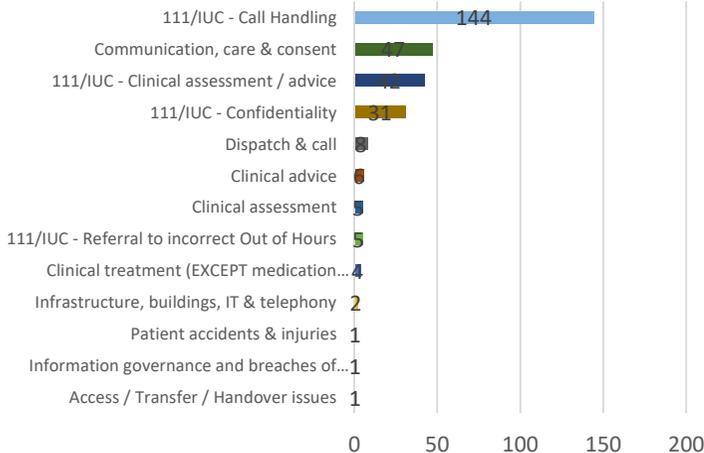


Analysis of SPC graphs:
The number of reported no and low harm incidents (0.9) continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust Safety Investigations Assurance and Learning Group (SIALG). There continues to be a yearly increase in the reporting of these incidents with an 75% increase in 2020/21.

The number of moderate, severe and death patient safety incidents decreased in February returning to normal reporting numbers following the received COVID19 wave which saw demand on the service increase.

Incident categories (Feb 21 – Mar 21)

Incidents by Category



Incident themes are monitored at the Safety Investigation Assurance and Learning Group (SIALG) with escalations to responsible departments where required.

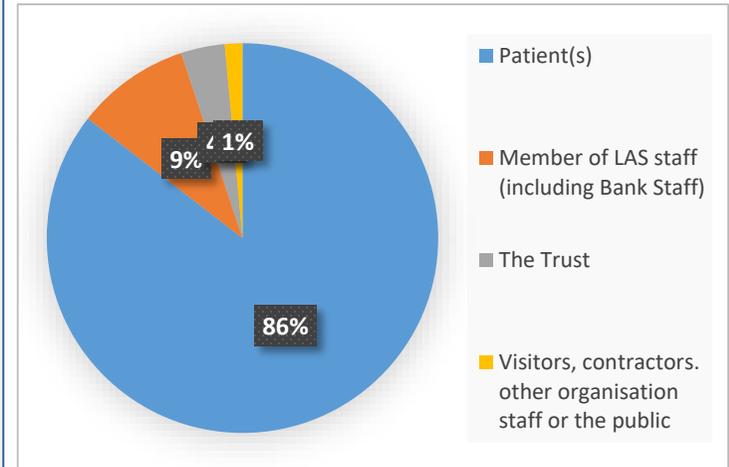
Call Handling: Regular Clinical CPD sessions have recommenced, individual feedback is provided and deep dives into practice occur to ensure any trends are addressed.

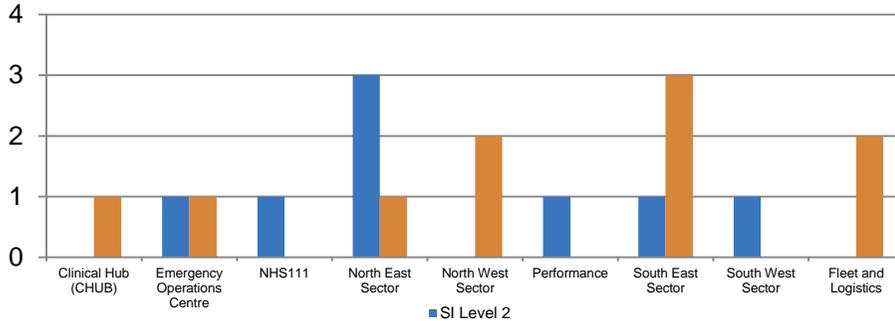
Consent is routinely monitored to ensure principles of consent and capacity are adhered to. There is good use of these Acts within IUC

The vast majority of the incidents fit into the call handling category. The service actively promote all staff in the reporting of incidents, once investigated all cases are fed back for learning and if any trends are identified, further retraining is provided. In comparison of incidents vs call volumes the % is low.

Incident Management

There are 138 incidents (as of 01/04/2021) which have been opened on the system longer than 35 working days (this excludes SIs & COVID 19 reviews). This breaks down to 118 patient incidents, 13 staff incidents 2 visitor incidents and 5 Trust related incidents.





During February and March 2021, 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.

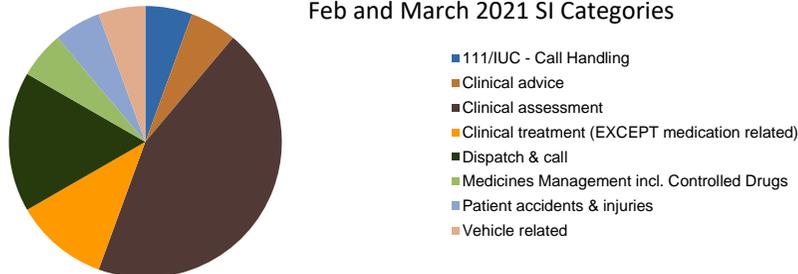
Of note,

- 8 incidents were declared based on the face to face clinical assessment undertaken. Specifically 3 incidents related to the management of patients who had sustained traumatic injuries.
- 1 incidents involved the management of a patients airway, specifically endotracheal intubation.
- 1 incident involved a 999 call which was not triaged where MPDS triage was indicated.
- 1 incident involved a delay in obtaining a Category 1 response priority, and subsequently delivering CPR instructions.
- 1 incident involved a vehicular issue where the boot of an FRU was not able to be opened and a defibrillator not able to be retrieved.
- 1 incident regarding an out of date drug in a drug pack being available for potential use by identified before being administered.

Mitigating actions that have taken place:

- Communications have been sent out to FRU staff notifying them of the quick boot release button in the rear of the vehicle.
- The Clinical Update to contain education on Silver Trauma.
- The Education and Standards Team reviewed all teachings in relation to silver trauma to ensure that they are up to date and delivered to all clinical staff.
- 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.

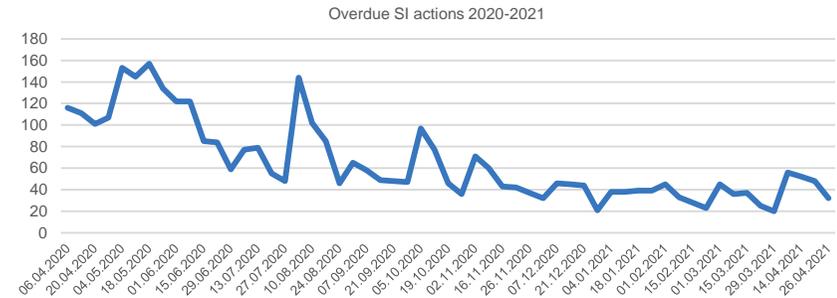
Feb and March 2021 SI Categories



There continues to be a focus on SI actions and at the end of March there were 149 open actions, of these 20 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 (SIALG) where escalations to departments are communication, if required.

These actions are having an impact on reducing the number of overdue SIs:



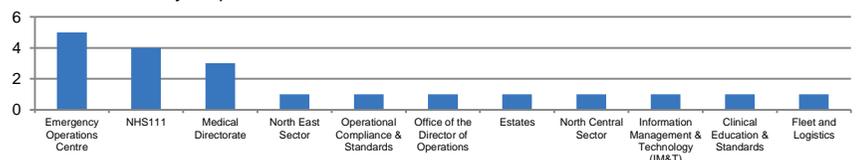
There are 2 incidents which are oldest and highest in priority:

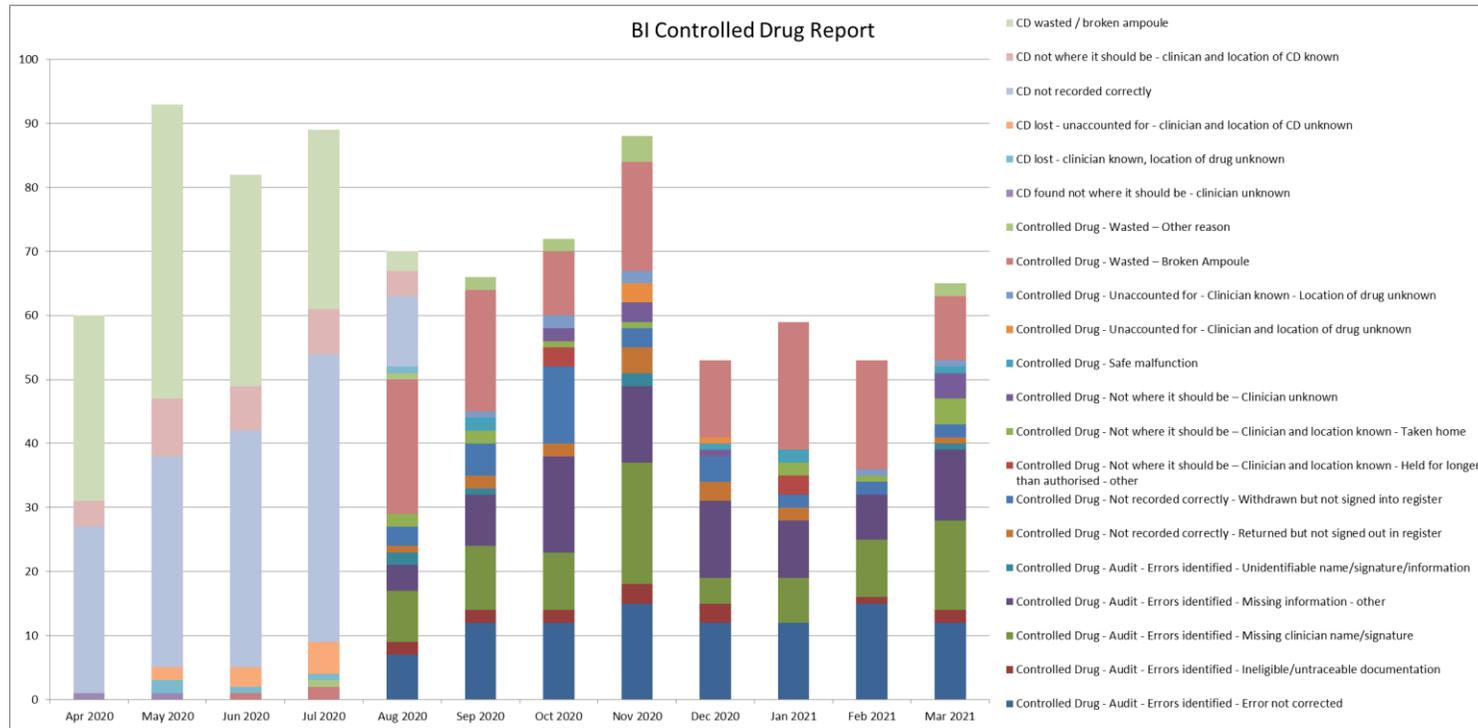
1. The Trust to increase internal logging of usage of/access to data which should provide a further deterrent against inappropriate access to data; and allow the Trust to monitor usage of data. Update: It had been identified that the Trust should have improved logging on the Windows Server infrastructure. As part of Cyber Essentials project 'Security Information and Event Management' (SIEM) had been budgeted. This is now encompassed as part of the Solarwinds project incorporating SIEM which is in progress.

2. The Trust should consider moving towards electronic access system for all LAS buildings. There are some stations where this facility in place which has been enabled however not all operational stations have this facility in place. This will ensure that local managers have oversight of individuals who have accessed their stations, reduce workload on the resource co-ordinators and local management when changing door codes. Additionally access to LAS buildings can be restricted should a member of staff leave the Trust.

Update: This action will be addressed via the long term strategy aims regarding estates which includes the ambulance modernisation programme. The action deadline will be extended to reflect this ongoing programme of work.

Overdue actions by Department





- Single loss of syringe of morphine (8mg) in hospital ward.
- Total of 74 other controlled drug (CD) incidents including
 - Medicines left unsecured (n=8)
 - Documentation error (n=43)
 - CD damage, breakages or losses (n=12)
 - CD retained off duty (n=9)
 - Abloy key loss (n=1)
- Non-controlled drugs incidents
 - KitPrep discrepancy (n=7)
 - Breakage (n=9), damage (n=2), loss (n=1) or out of date (n=3) drugs
 - Drugs usage form discrepancies (n=5)
 - Drug pack unsealed (n=1) or drugs unsecured (n=1)
 - Inappropriate administration of dexamethasone (n=2), aspirin (n=1), diazepam (n=3), glucagon (n=1), midazolam (n=1), naloxone (n=1), ondansetron (n=1), paracetamol (n=5), salbutamol (n=1).

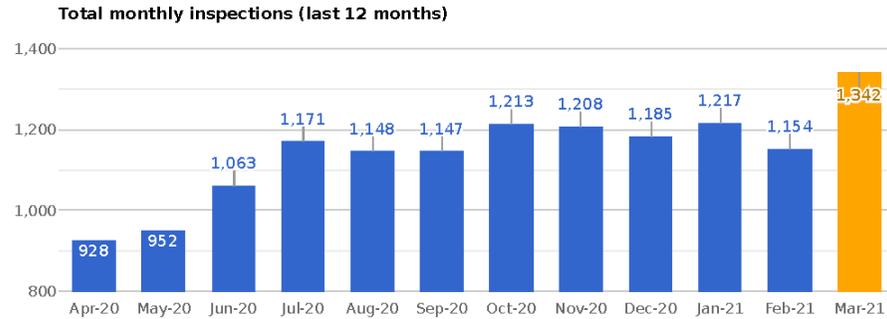
Assurance

- Incidents where morphine retained off duty identified and resolved promptly. This means that controlled drugs remain secure and accounted for.
- Single unaccounted for loss of morphine in hospital environment – likely disposal.

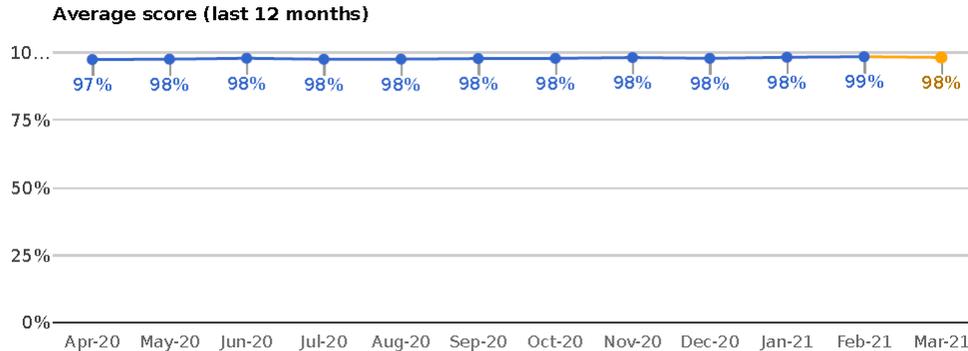
Actions

- Audit of medicines packing unit underway given recent reports of drug pack and form discrepancies
- Ongoing development of new medicines packing unit – will enhance medicines management.
- Procurement of Buttercups medicines training for medicines packing unit staff to improve drug handling and supply management.

This month we have carried out 1342 inspections across 52 areas - an average of 25.81 inspections per area.



The average score across the organisation this month was 98%.



The PW inspection results are based on the numbers of inspections which take place only. Year on year comparison shows .notable difference since station consolidation; inspection trends on the rise since reduction of REAP and reinstating daily management tasks for CTM/IROs/APPs

Action plans for lowest scoring stations / areas sit with respective SMT / QGAMs

Highest Scoring Clinical Areas

Rank	Area	Score this month	Score last 12
1	Twickenham	100% (1)	96% (14)
2	APP Westminster	100% (2)	100% (42)
3	APP Friern Barnet	100% (1)	100% (20)
4	APP Ilford	100% (4)	100% (32)
5	APP Brent	100% (1)	100% (5)

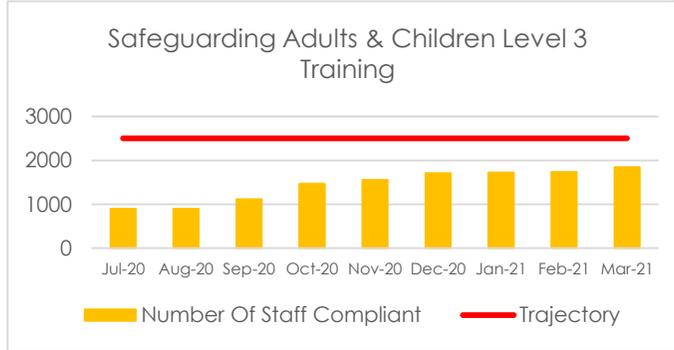
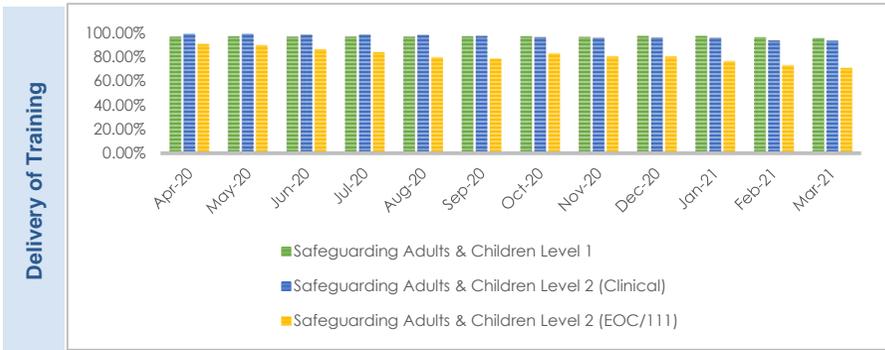
Lowest Scoring Clinical Areas

Rank	Area	Score this month	Score last 12
48	Brent	97% (30)	97% (311)
49	Kenton	96% (28)	97% (331)
50	Ilford	96% (29)	97% (344)
51	St Johns Wood	95% (21)	98% (234)
52	Deptford	91% (33)	95% (292)

Numbers in brackets show number of inspections score is calculated from.

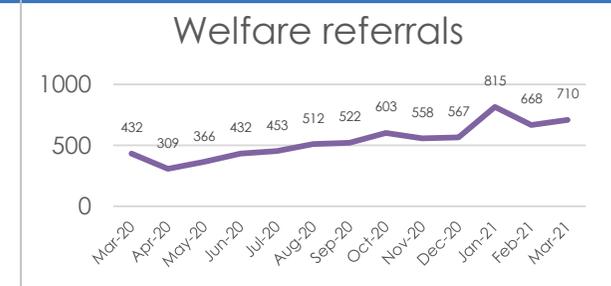
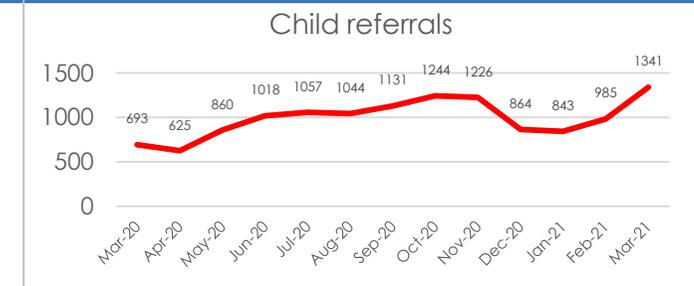
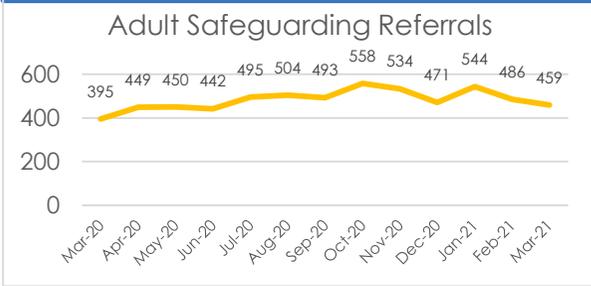
1. Safe -Safeguarding

Owner: Alan Taylor | Exec Lead: Dr. John Martin

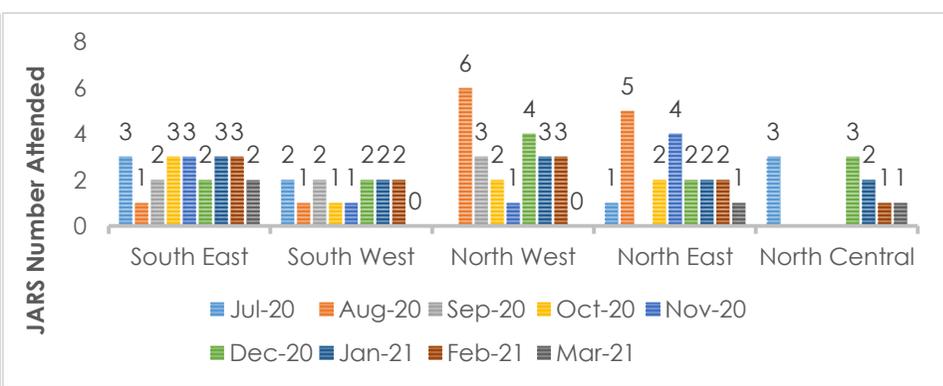
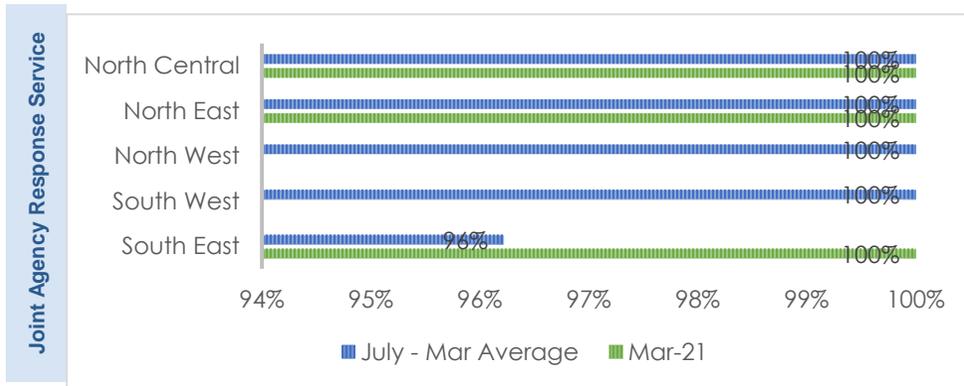


Month	L3 %
Jul-20	35.88%
Aug-20	35.84%
Sep-20	44.72%
Oct-20	58.80%
Nov-20	62.24%
Dec-20	68.36%
Jan-21	68.88%
Feb-21	69.52%
Mar-21	73.80%

Level 3 training trajectory is at 73.80% for March 2021 (1845/2500 of staff). This had been adjusted from 3000 due to coronavirus outbreak but due to the second recent COVID19 wave the target of 2500 staff trained was also missed.



Adult safeguarding referral remain within normal range Child referrals are within normal range Welfare concerns are beginning to rise and return to normal reporting.

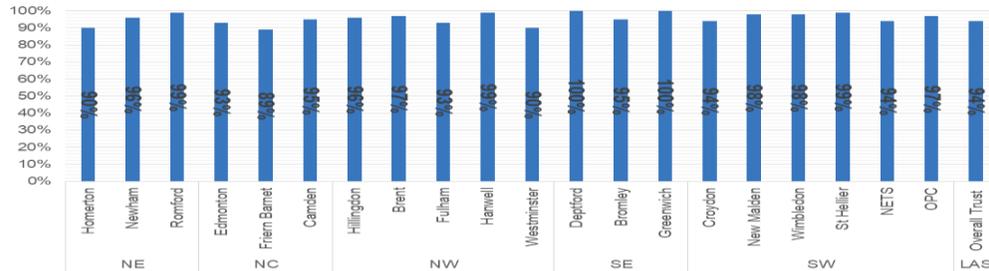


The Joint Agency response meetings are now managed directly by the Safeguarding Team. These are now held virtual and as a result the Trust has been able to attend 100% of these Multi agency meetings.

1. Safe - Infection Prevention and Control

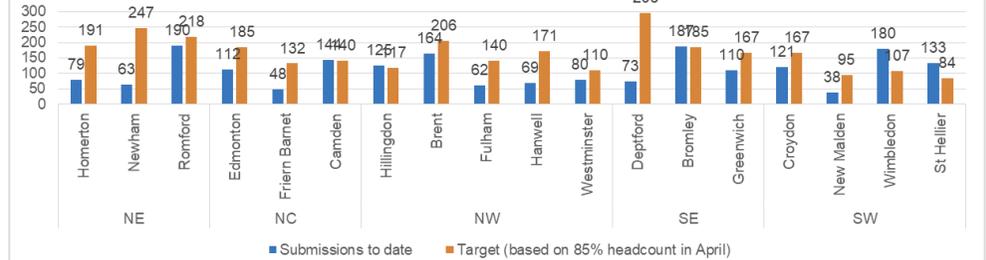
Owner: Claire Brown | Exec Lead: Dr. Fenella Wrigley

OWR Hand Hygiene Compliance - March 2021
Target 90%



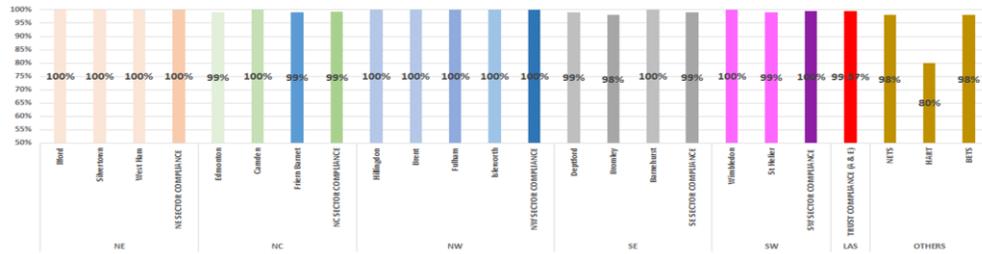
Overall the Trust OWR hand hygiene compliance for March 2021 is 94% remaining the same as February. Compliance exceeds the expected Trust target of 90% for the group station that submitted data. **Actions:** Reinforcing the importance of compliant Hand Hygiene practice has been communicated as part of the IPC programme of work. Hand Hygiene audits at A&E departments, were suspended following the Government lockdown on March 23rd, 2020, as accessibility to A&E departments was restricted to reduce transmission. Audits have been undertaken by link practitioners since mid June and the importance of undertaking these re-emphasised at the IPCLP meeting in November. Daily Quality huddles facilitated by the Quality Team throughout the month of January emphasised the need to continue these audits through the REAP 4 pressures to QGAMS to provide assurance and benchmark compliance.

OWR Hand Hygiene Submissions - YTD



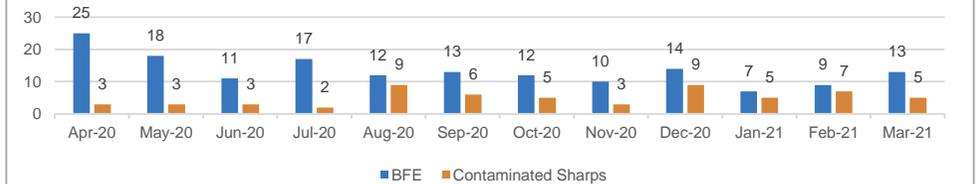
All group stations submitted OWR data for March 2021 compared to 16/18 in February 2021. Overall submissions have increased to 741 in the month of March, an exceptional amount compared to 160 submissions in February. As this month brings us to year-end, it confirms that 67% (66.9) of the annual submission target has been achieved. This month, the IPC Team continued to support sectors by completing IPC OWR audits whilst conducting the A&E observational audits. Group stations manage their respective annual trajectory for OWR submissions and it is acknowledged by the IPC Committee that this may have resulted in some monthly zero submissions throughout the year. **Actions:** Highlighted at IPCC and QOG the importance of continued audit for preparedness and prevention. Review of auditing targets and future proposal for presenting at QOG

VP DEEP CLEAN A&E VEHICLES MARCH 2021 (Target 95%)



Trust compliance for March is reported at 99%, exceeding the Trust target of 95%. In response to COVID-19, 6 vehicle decontamination hubs were organised at: Brent – NW Sector, Isleworth – NW Sector, Bromley – SE Sector, St Helier – SW Sector, Ilford – NE Sector & Silvertown – NE Sector - was the hub where the Nightingale vehicles were cleaned.

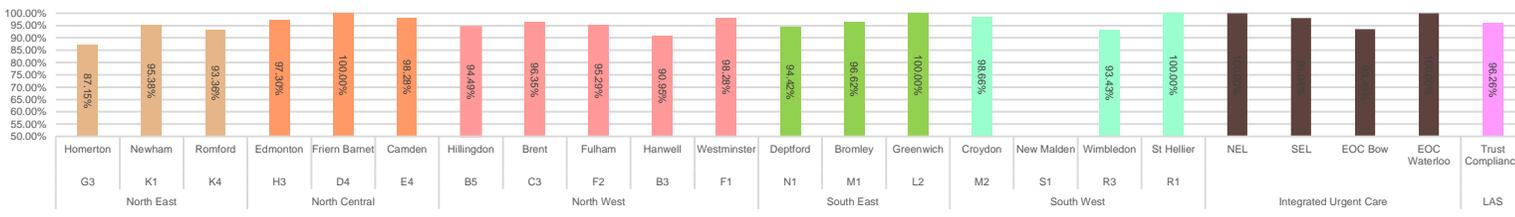
DATIX reported Bodily Fluid Exposure (BFE) and Contaminated Sharps Incidents APR-20 to MAR-21



A total of 18 incidents were reported via Datix for contaminated sharps injuries and exposure to BFE in March 2021.

- 11/13 BFE incidents reported this month were as a result of true exposure to body fluids (BFE)
- All 5 incidents reported this month were as a result of true contaminated sharps injuries

Premises Cleaning Audit - March 2021 (Target 90%)

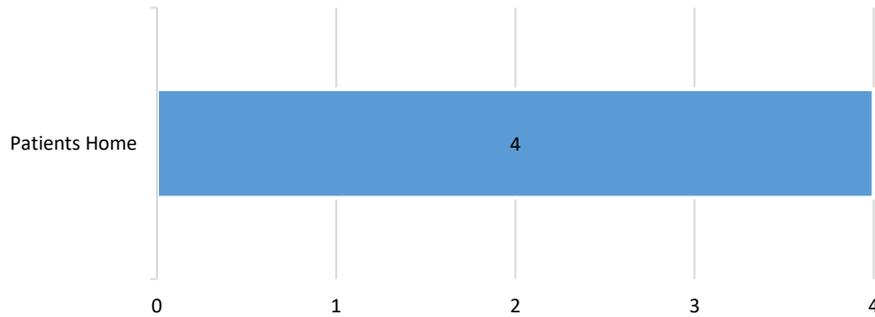


18 Group Stations/Services submitted data for analysis in March 2021. Overall Trust compliance for March is 96%. This score continues to exceed the Trust performance target of 90%. In response to the COVID-19 situation, some Ambulance station premises have been temporarily closed to consolidate resources and therefore not all group stations were occupied. In those instances cleaning audits were not carried out. Stations that failed to achieve the required performance target of 90% have been escalated to the facilities manager, who has been asked to establish why this has happened and what remedial actions have been put in place by the contractor, Lakethorne. **Actions:** Scores below 90% -escalated to facilities manager



Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) by Sector –March 2021

MSK RIDDOR Incidents - Location



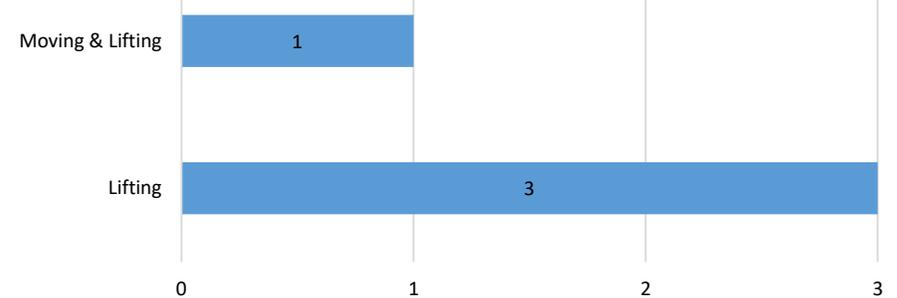
MSK RIDDOR Incidents – Equipment Involved



MSK RIDDOR Incidents – Body Part



MSK RIDDOR Incidents – Action Involved



Findings

- Riddor related incidents have remained fairly static since April'2020 with an average of 13 per month. The highest number of Riddor incidents for March'21 occurred in the patients home.
- The peak of Riddor related incidents reporting varies by month from sector to sector with the highest reporting during June'2020.
- There is an average of 1 reported moving and handling incident for every 2000 face to face attendances and an average of 3 working days lost per 1000 attendances.

Actions

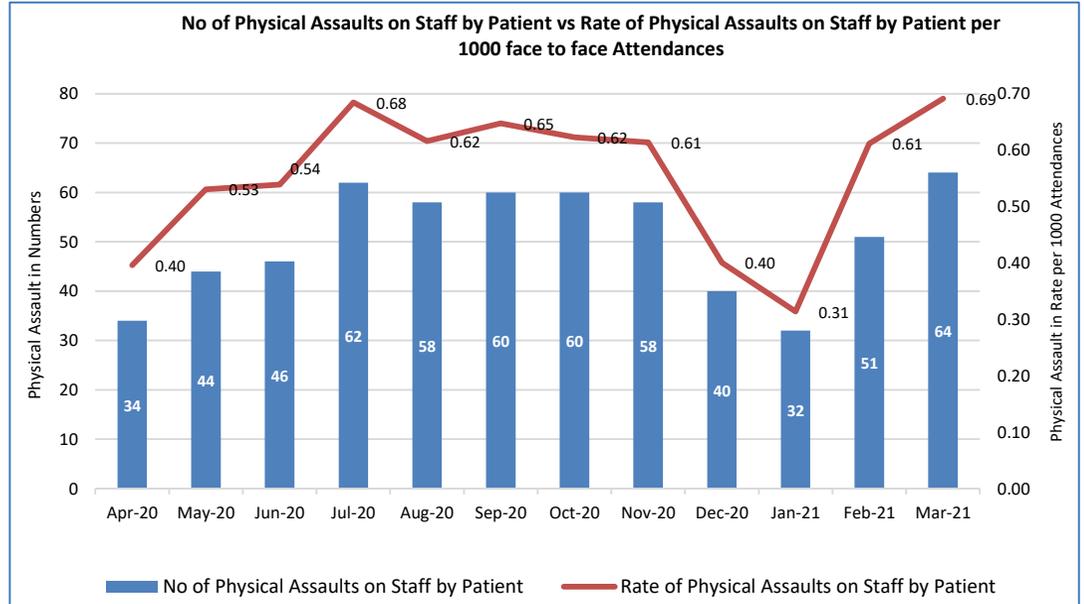
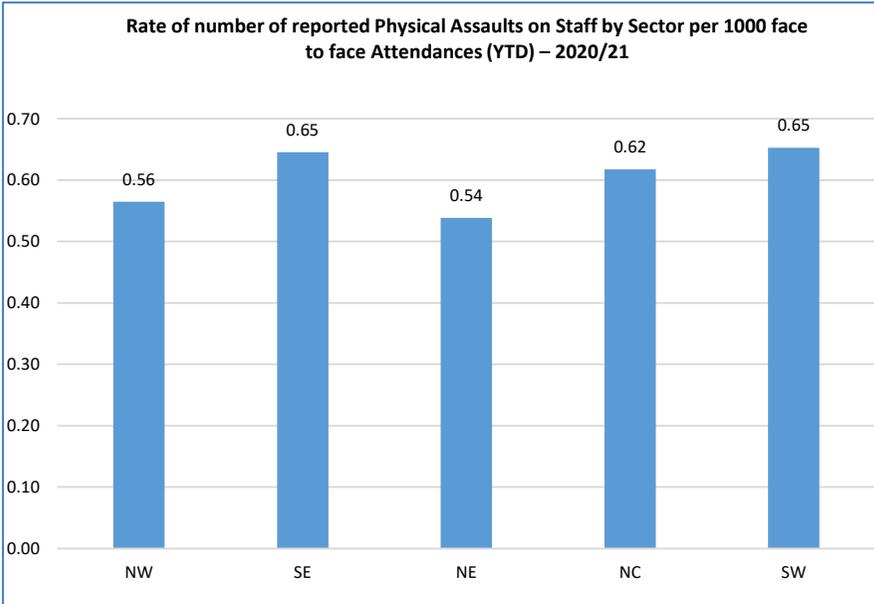
- The Wellbeing Strategy has been presented for approval, there are many aspects of the MSK Action Plan embedded within this strand of work.
- We are currently working on a video based electronic learning platform for CSR due to the pandemic face to face training is not practical, the videos include best practice in regards to moving and handling of persons. Along with some tips and tricks for using the small handling aids.
- Representation and feedback into the new Occupational Health re-tender is taking place and Physiotherapy and MSK requirements are being incorporated.
- Meetings with the current OH provider and the Physio Network have been taking place with requests for data being made, so that we can understand where the MSK damage is occurring and what remedial/proactive solutions can be undertaken going forward.
- MSK action plan has been updated and will be the focus of the steering group, along with the MSK workshop.

Assurances

- Under the Manual Handling Steering Group we are feeding into the OH re-tender. OH re-tender project board including MSK KPIs into the OH performance reporting. Currently all work is being addressed through Manual Handling Steering Group.



Owner: Edmund Jacobs | Exec Lead: Syma Dawson



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.

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 (April'2020 to March'2021).

Findings

- 65 assaults reported during March'21.
- The greatest number of reported physical assaults (54%) occur due to the clinical condition of the patient;
- Police attended 69% of physical assault incidents;
- 27 successful prosecutions for assault have been recorded (year to date); and further 23 cases are awaiting trial.

Actions

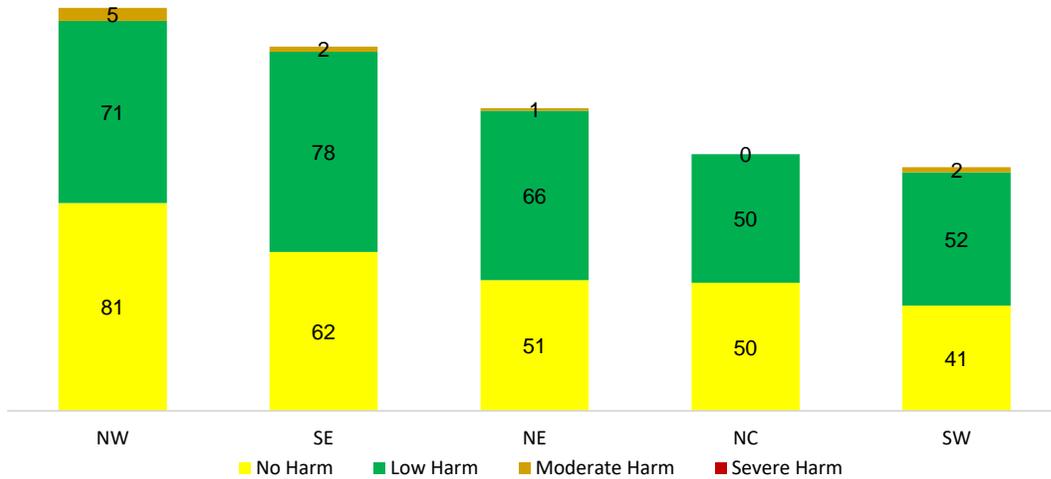
- Close liaison with MPS Operation Hampshire continues to support victims through the criminal justice process.
- LAS and MPS information sharing agreement being produced to help facilitate VROs in liaising with MPS to support and update victims.
- A VPRS Plan has been developed and has been presented to the P&C Committee, and will be presented to the CHSWBC for agreement.

Assurances

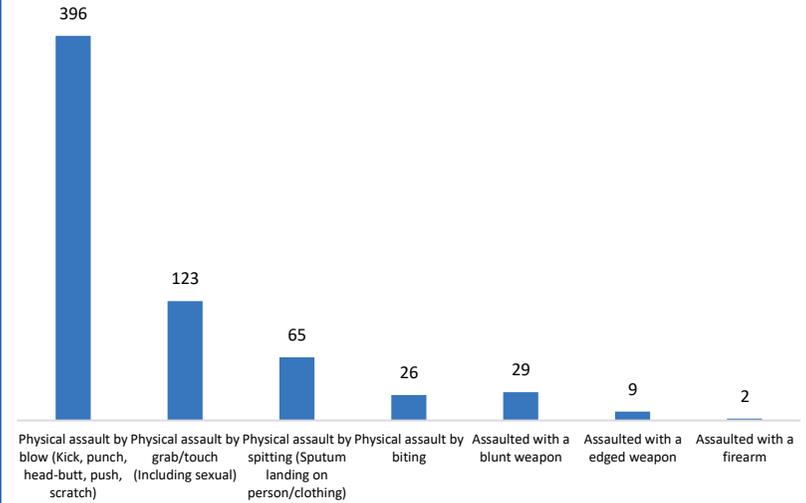
- Violence Reduction – Violence Reduction Officers (VROs) continue to provide support and guidance to both victim and management, following incidents of violence and aggression.
- BWVC trial continues
- Further funding from NHSE/I provided at short notice for BWVC trial.
- BWVC further funding enabling uplift in camera quantity from 219 to 1060.
- BWVC monitoring and governance group being established initial usage of cameras.
- LAS Violence Prevention and Reduction Standards work plan.



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



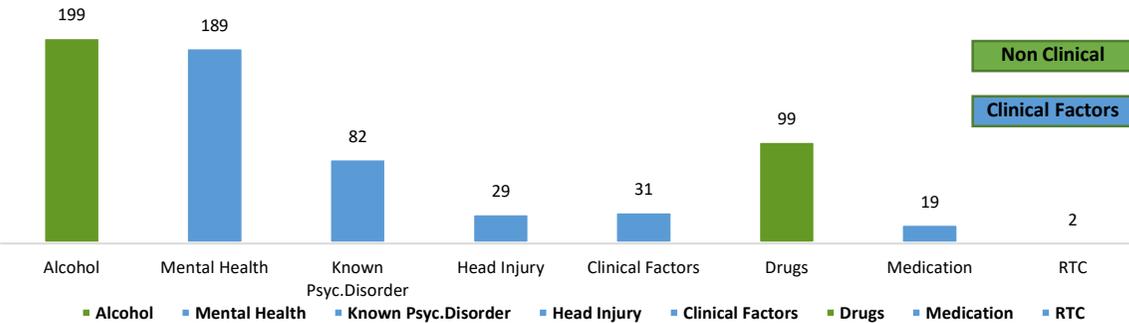
Number of reported Physical Assaults on Staff by Type (YTD) – 2020/21



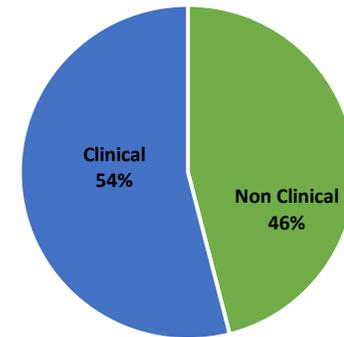
- Notes:**
- A total of 650 Physical Assaults on Staff were reported during 2020/21 (up to end March'21).
 - 304 (47%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 346 incidents resulted in Harm. 334 (51%) of the harm related incidents were reported as 'Low Harm and 12 (2%) incidents were reported as Moderate Harm.
 - 41 out of the 650 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 (61% , n=396) accounted for the highest number of incidents reported during 2020/21 (up to end March'21).

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



Percentage Breakdown of Factors (YTD) – 2020/21

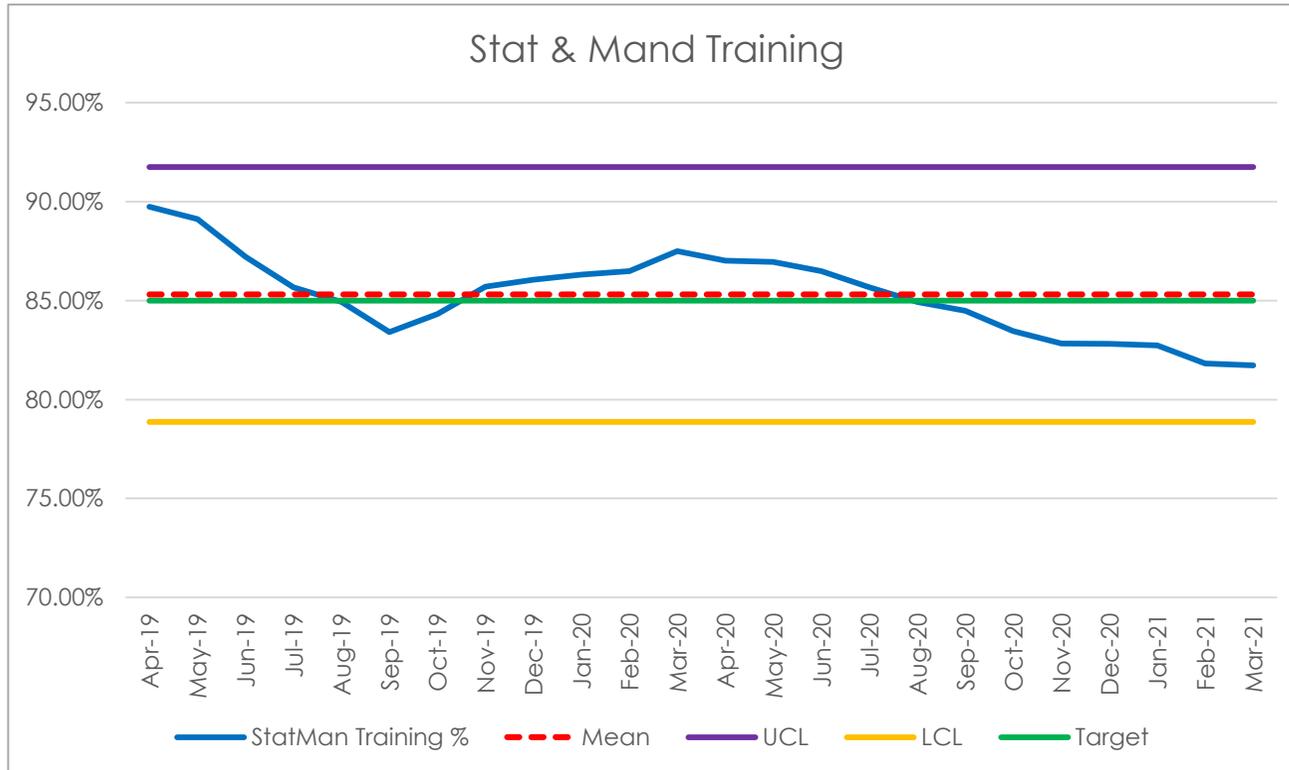


- Notes:**
- Clinical Factor: 350 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=189), Known Psyc.Disorder (n=82), Head Injury (n=29), Clinical Factors (n=31), Medication (n=19).
 - Non Clinical Factor: 300 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=199), and Drug (n=99) and, RTC (n=2).

1. Safe - Statutory & Mandatory Training

Owner: Chris Randall | Exec Lead: Kim Nurse

Stat & Man Training



Stat and mand training – as at 31st March we are currently tracking below our 85% target at 82%.

Actions:

Regular reports are sent to managers and individuals highlighting those who have any expired training as well as those who are due to expire in the coming three month period.

Course	Feb-21	Mar-21
Display Screen Equipment (3 Years)	80.50%	80.64%
Duty of Candour (3 Years)	94.16%	94.02%
EPRR Incident Response (Clinical) (1 Year)	80.18%	76.92%
EPRR Incident Response (EOC) (1 Year)	76.54%	77.31%
EPRR JESIP Awareness E-Learning (1 Year)	43.04%	55.70%
EPRR JESIP Commander Classroom (3 Years)	79.73%	75.32%
EPRR LAS Operational Commander Foundation (3 Years)	46.93%	41.05%
EPRR LAS Tactical Commander Foundation Course (3 Years)	79.17%	79.17%
EPRR Tactical Commanders (Old Course) (3 Years)	0.00%	0.00%
Equality, Diversity & Human Rights (3 Years)	80.71%	81.94%
Fire Safety (2 Years)	93.85%	93.61%
Fraud Awareness (No Renewal)	83.24%	83.39%
Health & Safety Trust Board (1 Year)	0.00%	0.00%
Health, Safety & Welfare (3 Years)	95.46%	93.89%
Infection Prevention & Control Level 1 (3 Years)	95.13%	94.91%
Infection Prevention & Control Level 2 (1 Year)	93.38%	92.01%
Information Governance (1 Year)	92.22%	92.82%
Medicines Management (1 Year)	92.78%	91.59%
Medicines Management (NETS) (1 Year)	6.84%	5.36%
Mental Capacity Act Level 1 (3 Years)	93.46%	93.33%
Moving & Handling Level 1 (3 Years)	93.27%	93.11%
Moving & Handling Level 2 (Load Handling) (3 Years)	70.48%	70.75%
Moving & Handling Level 2 (People Handling) (1 Year)	11.10%	14.94%
NHS Conflict Resolution (3 Years)	91.71%	91.37%
Prevent Level 1 (3 Years)	94.30%	93.95%
Prevent Level 2 (3 Years)	90.02%	88.04%
Resuscitation Level 1 (1 Year)	72.58%	72.65%
Resuscitation Level 2 Adults (1 Year)	42.37%	46.90%
Resuscitation Level 2 Paediatrics (1 Year)	42.37%	46.90%
Resuscitation Level 3 Adults (1 Year)	60.62%	60.84%
Resuscitation Level 3 Newborn (1 Year)	60.62%	60.84%
Resuscitation Level 3 Paediatrics (1 Year)	60.62%	60.84%
Safeguarding Adults & Children Level 1 (3 Years)	96.21%	95.50%
Safeguarding Adults & Children Level 2 (Clinical) (3 Years)	93.49%	93.29%
Safeguarding Adults & Children Level 2 (EOC/111) (3 Years)	72.79%	70.53%
Safeguarding Adults & Children Level 3 (3 Years)	36.43%	37.99%
Safeguarding Trust Board (3 Years)	36.84%	36.84%

2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Clinical Ambulance Quality Indicators
- NICE and JRCALC Guidance Updates
- Clinical Audit Performance
- Handover to Green
- PDR & MCA Training

Outstanding Characteristic: *Outcomes for people who use services are consistently better than expected when compared with other similar services.*

The summaries of NICE guidance released by NHS Sheffield Clinical Commissioning Group have been reviewed for months November 2020 to March 2021. Nine articles of guidance relevant to the Trust were reviewed in detail, with subsequent actions in progress. Two articles of guidance relevant to the Trust remain in review.

The Trust has liaised with the Association of Ambulance Chief Executives (AACE) in regards to recommendations which affect intravenous fluid management in the context of diabetic ketoacidosis in children and young adults, and actions to bring medicines guidelines in-line with those recommendations will be made nationally via the Joint Royal College Ambulance Liaison Committee (JRCALC).

Following the release of a guideline relating to encouraging the uptake of Vitamin D supplements in specific groups, a Making Every Contact Count (MECC) brief intervention is being developed.

A gap analysis of a new guideline relating to the management of the long term effects of COVID-19 has identified an opportunity to improve Trust clinical guidance in this area. These actions will be taken forward in conjunction with a review of further guidance on the treatment and management of COVID-19 which was released on 1st April 2021.

2. Effective - Clinical Ambulance Quality Indicators

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

Measures	Target / Range	RAG	YTD 20/21	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	31%	R	27%	28%	30%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	52%	55%	54%					↔			LQ1b		
STEMI Care Bundle (AQI) (Reported every 4 months)	74%		77%	-	-					↔			LQ2c		
Stroke Care Bundle (AQI) (Reported every 4 months)	98%		98%	0%	-					↔			LQ3b		
Stroke on scene duration (CARU continual audit)	00:30	G	33	31	33					↔					
Survival to Discharge (AQI)			4%	6%	0%					↔					
Survival to Discharge UTSTEIN (AQI)			17%	26%	0%					↔					
STEMI On scene duration (CARU continual audit)			38	37	39					↓					
Call to Angiography - Mean (hh:mm)	02:10		02:09	02:13	02:20										
Stroke - Call to Arrival at Hospital - Mean (hh:mm)	01:10		01:10	01:14	01:07										
CPI - Completion Rate (% of CPI audits undertaken)	95%	G	-	94%	97%	92%	96%	96%		↔		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			-	6%	11%	12%	14%	17%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	-	96%	96%	98%	97%	98%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	R	-	94%	95%	95%	95%	94%		↓		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	-	94%	-	94%	-	94%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	-	96%	96%	96%	96%	95%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	-	-	97%	-	97%	-		↔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)	95%	R	-	93%	93%	94%	93%	93%		↔					



AQI: Narrative

Cardiac Arrest: The LAS achieved the highest ROSC on arrival at hospital for the overall group in November 2020 at 30.1% ranking 1st place amongst other ambulances services in England, above the national average of 25.5%. We also achieved a higher than average ROSC on arrival at hospital for the Utstein group (53.7% vs 47.5%), ranking 3rd place.

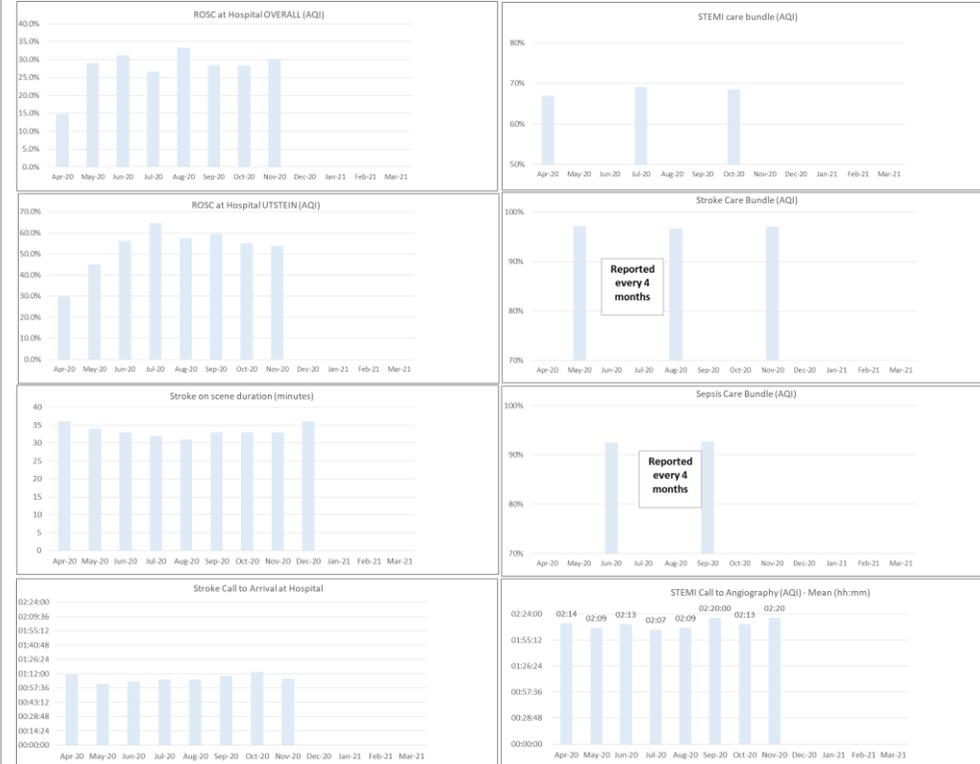
Stroke: Our Stroke team received the NHS England AQI figures relative to November 2020. For the 4th month in a row and 6th time in the financial year (2020/2021), the LAS continues leading the rest of the country in terms of mean Call to Arrival at Hospital Time for suspected stroke patients (1.07), well above the national average of 1.24. In terms of our Stroke Diagnostic Bundle data, the LAS has improved from a ranking of 9th place in August 2020 to 8th in November 2020. In the same month, the Stroke Diagnostic Bundle was performed on 97% of suspected stroke patients, slightly below the national average of 97.8%.

STEMI: The LAS' time for the Call to Balloon measure for November 2020 was 02:20, which ranked 7th in England overall. However, this figure is only 6 minutes longer than the best performing service in England, and is still within the national target of 02:30. STEMI Care Bundle data was not required by NHS England this month; the next data due to be published will be for January 2021 (due in June).

Our Cardiac Arrest team are currently processing cases from December/January where we have seen another significant rise in cases associated with the COVID-19 pandemic peak. This will slow data processing and cause further delays to monthly care packs. It is also unlikely that we will be able to submit a full month of data for the January 2021 AQI, due to be submitted in May 2021.

Due to pressures associated with the pandemic, we did not receive any outcome data from hospitals for November 2020 cases and we are therefore unable to report a survival figure in the national AQIs.

NHS England have now approved a change to using 30 day survival, rather than survival to hospital discharge, which will come into effect from January 2021 cases. This will reduce our reliance on individual hospitals and allow us to report more accurate survival data in a timelier manner.





Clinical Audit Update

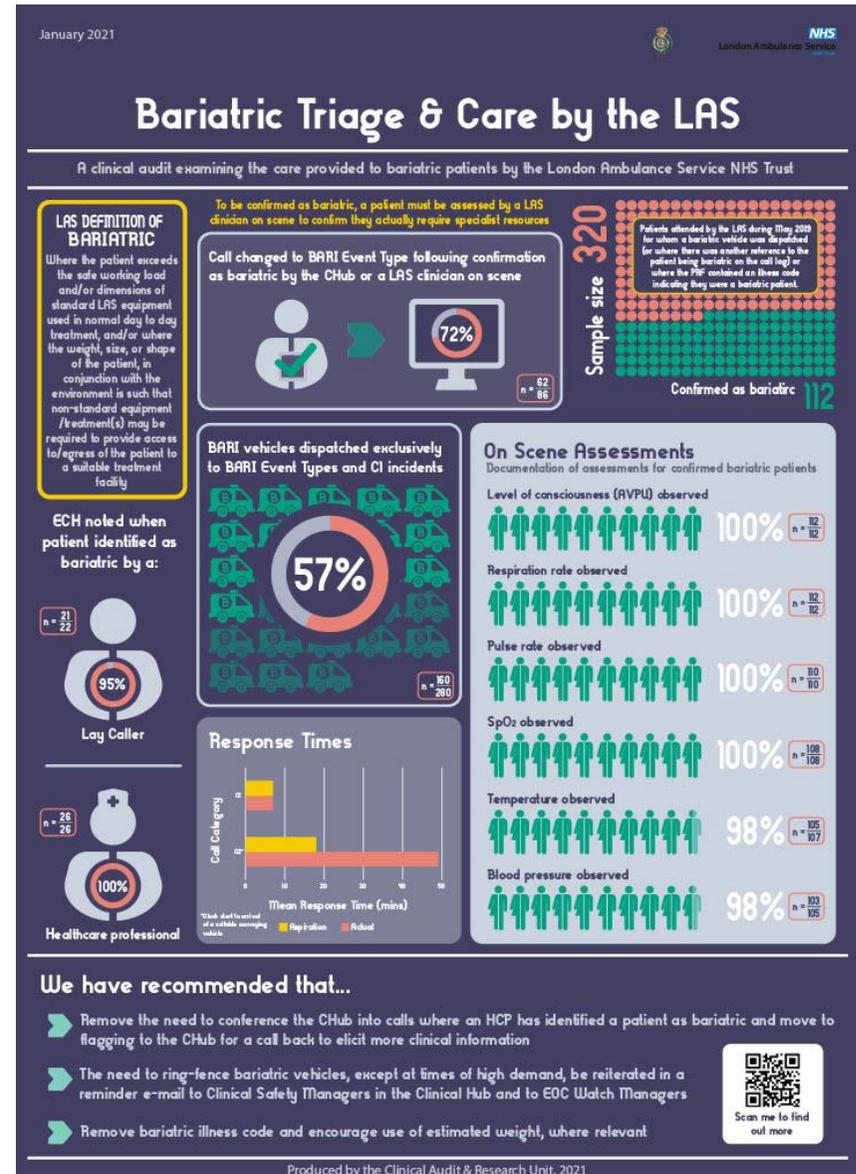
On the 11th February we published our latest clinical audit report which focuses on triage, dispatch and assessment for patients who are identified as bariatric. This clinical audit identified that the clinical assessment undertaken for this group of patients is of a very high standard, especially given the variation in clinical presentation and their potential for deterioration. However, there are some areas for improvement specifically around identifying and dispatching bariatric vehicles. Recommendations for improvement include: reminding dispatchers of the need to 'ring fence' bariatric vehicles and only so they are only used for non-bariatric patients at times of high demand; removing the need to conference the Clinical Hub (CHUB) into calls where a healthcare professional (HCP) has identified a patient as bariatric with a move to flagging the call to the CHUB for a call back to elicit more clinical information, and removal of the illness code 'bariatric' and instead encouraging clinicians to complete estimated weight on the electronic patient care record (ePCR), where relevant.

Two facilitated clinical audit reports were published in March, one by the Macmillan End of Life Care Team and the other by the Advanced Paramedic Practitioners in Urgent Care (APP-UC) Group in order to pilots five potential Clinical Performance Indicators (CPIs): Paediatric Assessment; Abdominal Pain; Transient Loss of Consciousness; Headache; Wound Care, and Palliative and End of Life Care.

We have approved another facilitated clinical audit for Integrated Urgent Care (IUC) Clinical Assessment Service (CAS) focussing on the NHS Business Authority Medication Safety Indicators Prescribing Practice.

In addition to the clinical audit projects already underway, the Clinical Audit & Research Steering Group (CARSG) agreed a further six clinical audit projects for 2021-22 and an additional three in the event that further resources become available: Mental Capacity Act; Sepsis; Haemorrhage requiring intervention; Allergic reactions and anaphylaxis; Missed stroke, and Referrals. Reserve projects: Newborn care; Headache, and Silver Trauma.

In February and March, CPI training was delivered to 12 paramedics on restricted duties, 7 Operational Placement Centre (OPC) mentors, 4 paramedics in a Team Coordinator roles and 1 Senior Sector Clinical Lead (SSCL). CPI auditors reported 13 potential patient safety incidents via Datix and suggested 2 retrospective safeguarding referrals through the Emergency Bed Service (EBS).





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

Research Update

UK-REACH:

In February we opened the United Kingdom Research Study into Ethnicity and COVID-19 Outcomes in Healthcare Workers (UK-REACH) at LAS. UK-REACH is an Urgent Public Health study which has received funding from the UK Government to help understand why people from certain ethnic backgrounds are more likely to develop severe COVID-19. The UK-REACH staff survey closed on 28th February and in March we received confirmation that 11 LAS staff had been recruited into the Study.

COMPARE:

In March we opened a study developed by South Western Ambulance Service NHS Foundation Trust which aims to assess the impact of COVID-19 on Emergency Medical Service led out of hospital cardiac arrest resuscitation (COMPARE). The study is open to all grades of clinical staff who have performed resuscitation during the pandemic and this month two members of staff were recruited into the study and undertook a virtual interview with the study team.

Research Capability Funding (RCF):

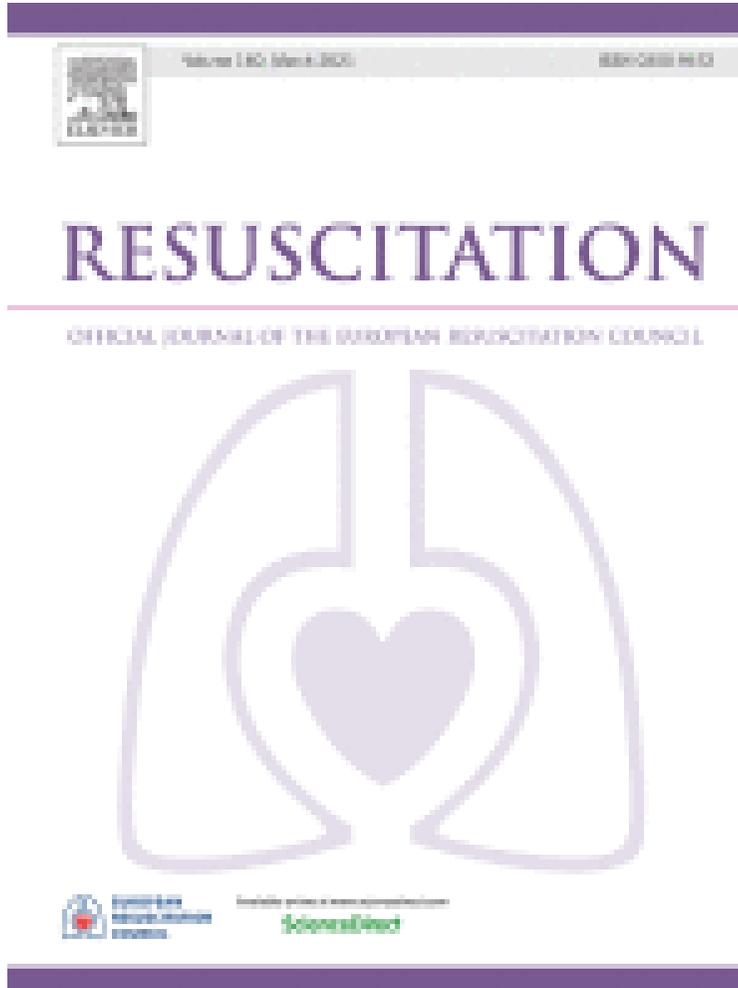
This month we received confirmation that due to a high volume of research recruitment (at least 500 study participants to non-commercial clinical studies conducted through the Clinical Research Network during the previous reporting period of 1 October 2019 – 30 September 2020) we would be awarded RCF to support research activity next financial year.

Publication:

This month a paper co-authored by the Head of Clinical Audit & Research ('Long term outcomes of participants in the PARAMEDIC2 randomised trial of adrenaline in out-of-hospital cardiac arrest') was published in Resuscitation.

Future Research:

CARU continued to work towards opening the CRASH4 study, and began preparations to open the HTA funded PARAMEDIC3 study later in 2021. The ARREST trial remains suspended whilst a decision is taken on the feasibility of reopening the study during the COVID-19 pandemic and the HRA confirmed that they will not be accepting applications for regulatory approval for student research until September 2021, and will then not accept applications for undergraduate students.



2. Effective – Maximising safe non-conveyance to ED

Please note: 999 performance data is correct as at 22/03/21 and is subject to change due to data validation processes

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 significant drop in the number of delays in February, with the overall number of hours lost at 1,016 hours lost from our arrival to patient handover over 30 mins. Queens Romford, Whipps Cross, North Middlesex and Newham had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the highest number of lost hours over 30 minutes, at 180 hours for the month.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,350	1,295	196	15%	37.7	22.4
	North Middlesex	2,262	2,183	674	31%	156.5	26.9
	Royal Free	1,284	1,196	214	18%	39.0	23.7
	University College	998	964	35	4%	4.7	15.1
	Whittington	1,300	1,227	176	14%	31.9	21.2
North East	Homerton	1,094	1,014	45	4%	3.6	16.5
	King Georges	1,011	956	243	25%	40.3	26.1
	Newham	1,388	1,287	399	31%	40.7	25.6
	Queens Romford	2,303	2,182	990	45%	180.4	30.6
	Royal London	1,551	1,404	150	11%	10.7	20.9
	Whipps Cross	1,328	1,239	450	36%	134.4	30.0
	Charing Cross	1,123	1,087	7	1%	1.0	12.3
North West	Chelsea & West	1,166	1,085	14	1%	2.7	15.8
	Ealing	1,088	1,051	9	1%	1.3	11.5
	Hillingdon	1,625	1,551	146	9%	31.4	16.9
	Northwick Park	2,881	2,793	143	5%	33.1	15.3
South East	St Marys	1,437	1,376	108	8%	16.4	18.2
	West Middlesex	1,753	1,692	81	5%	15.2	17.1
	Kings college	1,703	1,635	301	18%	31.8	23.3
	Lewisham	1,262	1,147	88	8%	16.3	19.3
	Princess Royal	1,622	1,507	212	14%	87.2	21.8
	Queen Elizabeth II	2,004	1,865	44	2%	7.9	14.3
	St Thomas'	1,630	1,557	48	3%	3.8	17.6
South West	Croydon	1,861	1,805	103	6%	41.4	19.1
	Kingston	1,333	1,256	42	3%	3.1	19.1
	St Georges	1,599	1,476	255	17%	24.0	21.4
	St Helier	1,087	1,033	84	8%	19.0	20.1
TOTAL	41,043	38,863	5,257	14%	1,016	20.3	

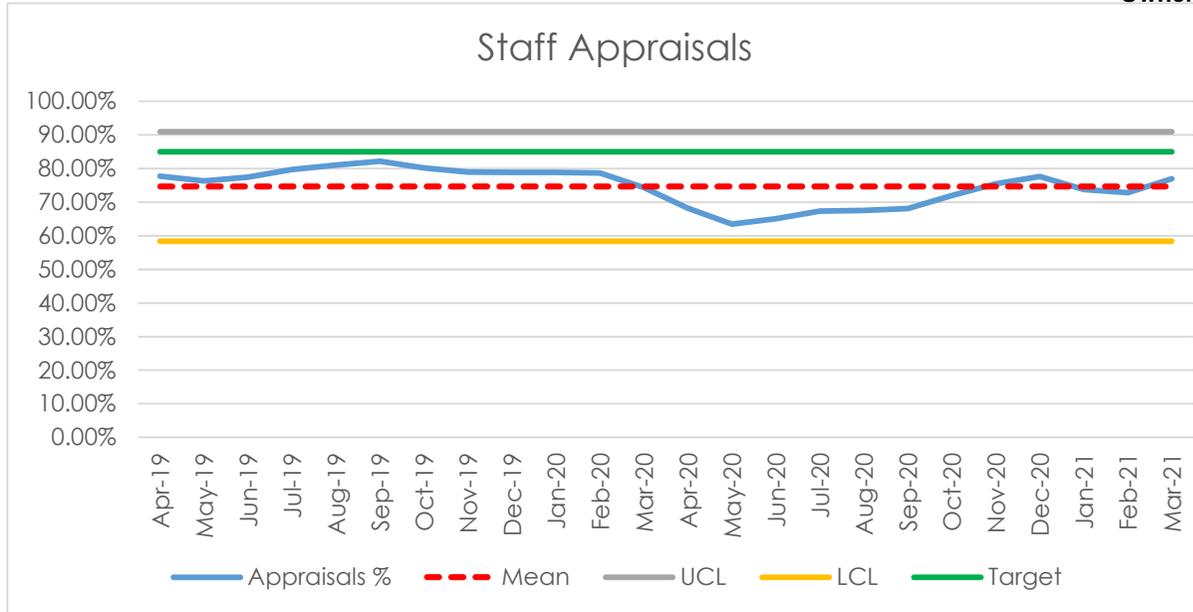
Patient Handover to Green

In February, we saw handover to green performance return to within the target, with 15.4. However, close to 2,900 hours were lost due to patient handover to green exceeding the 14 minute threshold. Handover to Green received organizational focus through the COVID19 response team and will receive renewed focus as part of planning and recovery.

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	1,873	1,048	56%	165.1	15.7	29.9	9.5
	Edmonton	2,749	1,704	62%	283.4	17.4	31.3	10.0
	Friem Barnet	1,610	946	59%	131.7	15.9	28.8	8.4
North East	Homerton	1,952	1,104	57%	179.5	15.3	30.0	9.8
	Newham	2,565	1,514	59%	254.3	16.4	31.1	10.1
	Romford	2,796	1,581	57%	170.8	14.6	25.5	6.5
North West	Brent	3,384	1,953	58%	246.7	15.7	26.6	7.6
	Fulham	2,068	1,183	57%	159.9	15.9	27.1	8.1
	Harwell	2,463	1,389	56%	133.6	14.5	23.6	5.8
	Hillingdon	1,493	773	52%	77.6	14.2	23.1	6.0
	Westminster	1,282	757	59%	104.2	15.9	28.4	8.3
South East	Bromley	2,347	1,338	57%	147.7	14.7	25.6	6.6
	Deptford	3,388	1,872	55%	217.3	14.7	25.5	7.0
	Greenwich	1,662	1,007	61%	104.6	15.0	25.4	6.2
South West	Croydon	1,739	1,063	61%	113.8	15.5	25.5	6.4
	New Malden	1,137	731	64%	85.1	16.1	26.8	7.0
	St Helier	1,256	701	56%	73.5	14.9	24.6	6.3
	Wimbledon	1,043	602	58%	74.9	14.1	26.1	7.5
Other	NULL	742	592	80%	62.7	14.3	25.7	6.4
	IRO	2	1	50%	0.3	17.6	28.7	18.0
	Other	395	223	56%	35.3	13.7	26.4	9.5
	Training	917	513	56%	73.5	15.6	27.4	8.6
TOTAL		38,863	22,595	58%	2895.5	15.4	27.1	7.7

Appraisals

Latest Month:
77%

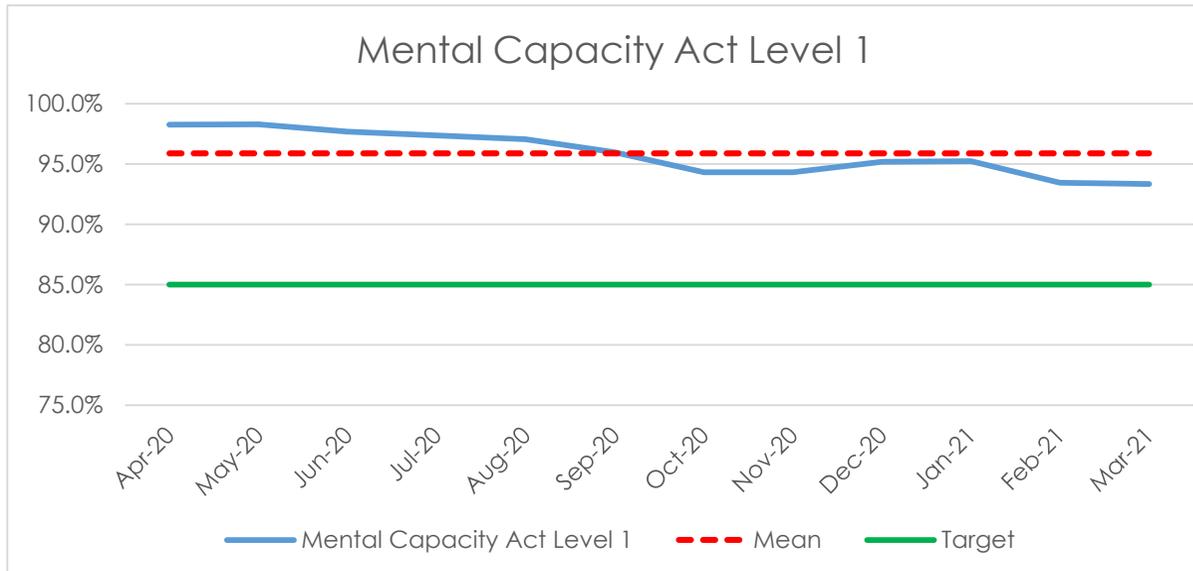


PDRs – our current compliance is at 77%, an improvement on the 73% compliance in February.

Actions: 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.

MCA Training

Latest Month:
93.33%



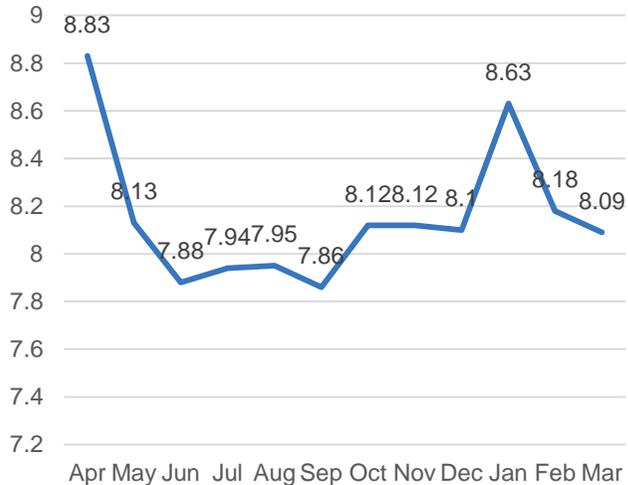
We are currently not delivering Level 2. There is a tolerated risk (ID 1044) on the Corporate (TW) Risk Register.

Action: The safeguarding team are working with Clinical Education and plans are underway to include in 2021-22 CSR programme.

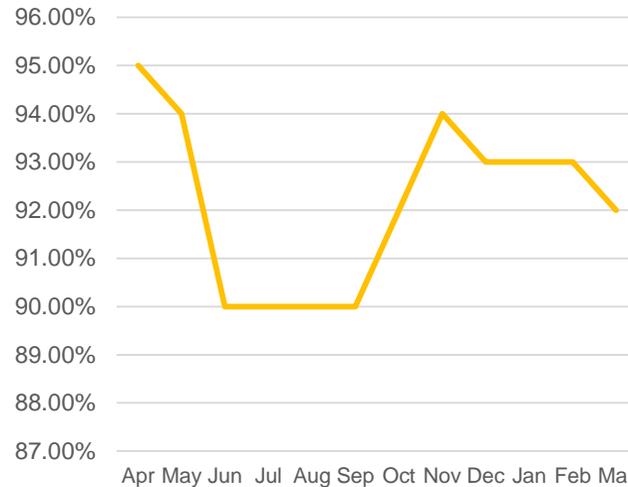
2. Effective – EOC Call Handling Quality Assurance

Owner: Sue Watkins | Exec Lead: Dr. John Martin

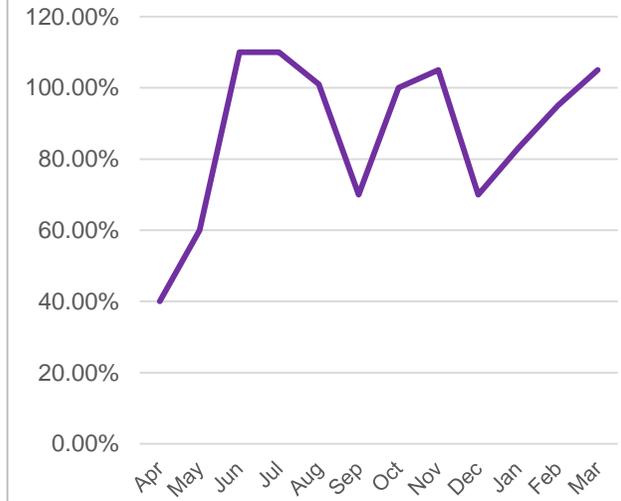
The Average Call Handler (scored from 0 (poor) to 10 (excellent))



Overall Compliance with MPDS (Call Handling) protocols



The Percentage of Emergency (MPDS) calls reviewed against requirements



Highlights

Recruitment process ongoing owing to the successful authority to recruit process.

QA staff continue to explore the opportunities for WFH. QA are successfully providing feedback in a more timely manner with the aid of MS Teams. Feedback can be give at any time of the day, without either unnecessary travel to the site, making it a much more efficient and effective service.

Lowlights

Challenges continue to exist in delivering the non-funded aspects of the QA role to support other departments work.

Staffing in QA remains a challenge.

Team have been saddened with the very sad loss of a colleague and LAS staff member in March 2021.

Current Focus

Currently embedding revised MPDS Audit process. This allows a more supportive, preventative approach rather than the previous corrective approach to resolving call handling issues.

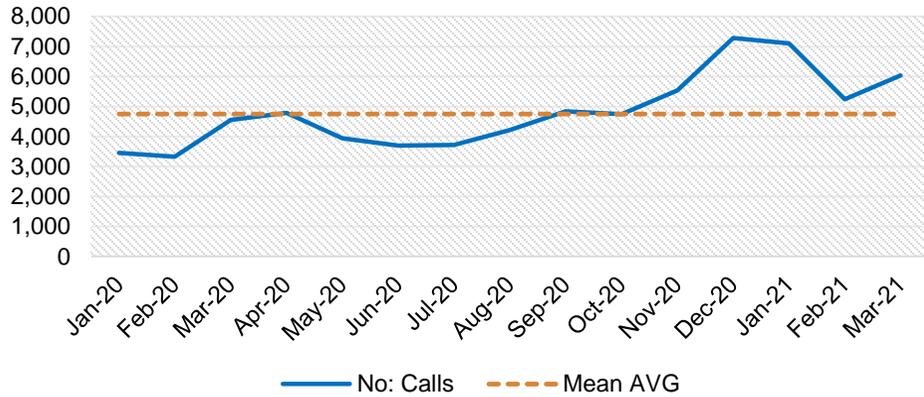
Working with the Academy to streamline AQUA reporting to enable QA Managers to feedback to EOC Watch teams consistently.

QA continue to undertake to weekly diarised meetings with the EOC Watch teams. The feedback has been excellent, staff feel they have an opportunity to speak with the QA team, and have open and honest discussions. A FAQ sheet is being prepared, and will be added to the newly planned QA page on the intranet.

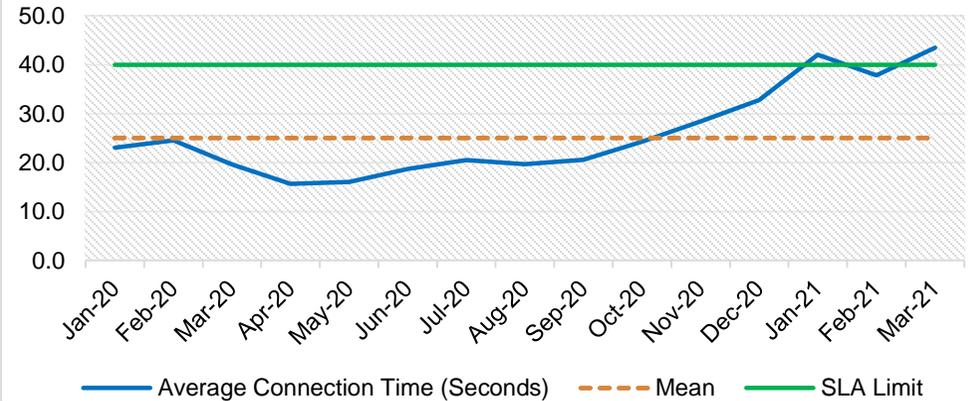
2. Effective – EOC Language Line

Owner: Sue Watkins | Exec Lead: Dr. John Martin

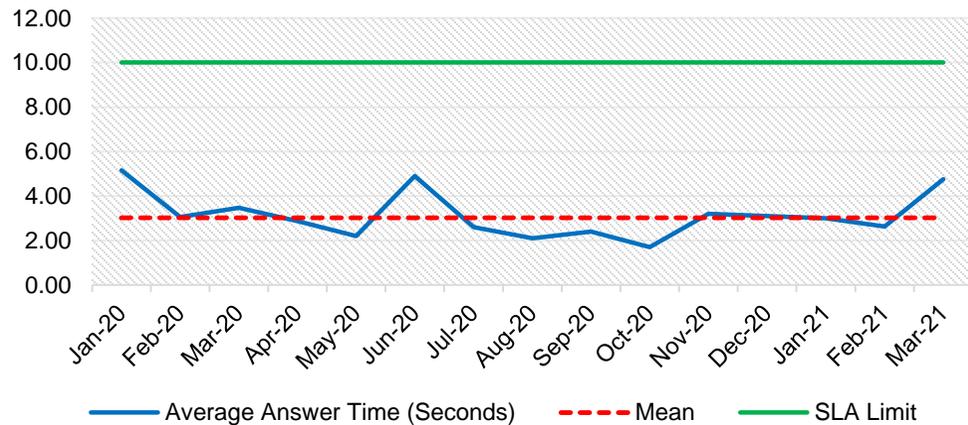
Total Number of Calls



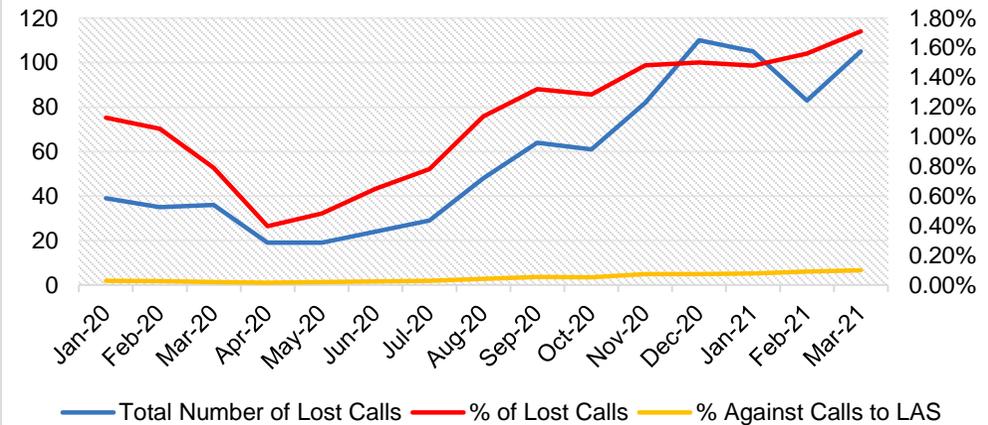
Average Connection Time



Average Answer Time



% Lost Calls Against Calls To LAS



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Number of Lost Calls	39	35	36	19	19	24	29	48	64	61	82	110	105	83	105
% of Lost Calls	1.13%	1.05%	0.79%	0.40%	0.48%	0.65%	0.78%	1.14%	1.32%	1.29%	1.48%	1.50%	1.48%	1.56%	1.71%

3. Caring

We must ensure that the service involves and treats people with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

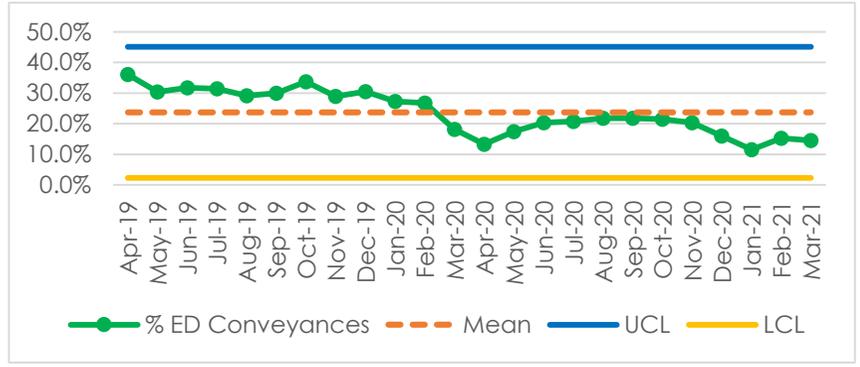
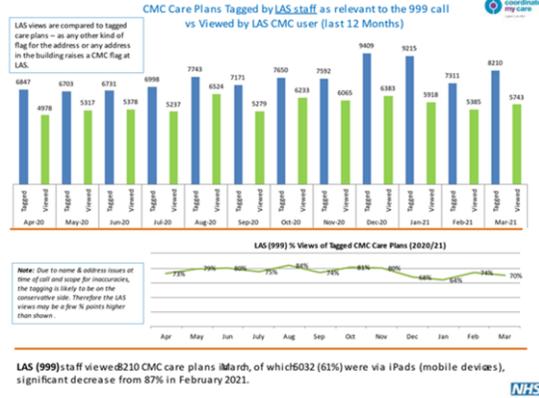
For further assurance we then provide additional data and analysis on:

- Mental Health
- Maternity
- End of Life

Outstanding Characteristic: *People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.*

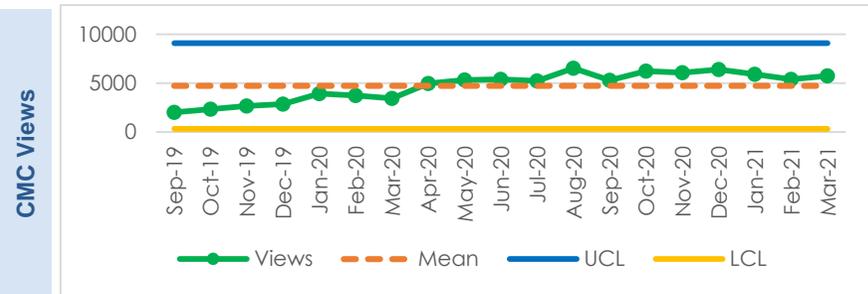
3. Caring - End of Life Care/Mental Health

Owner: Various | Exec Lead: Dr. Fenella Wrigley



Clinical audit presented to CARSG with EoLC CPI approved

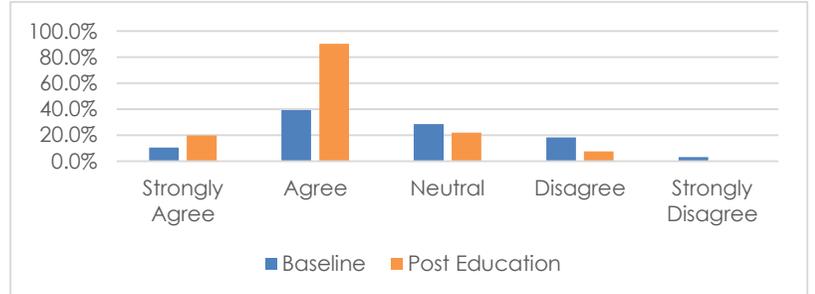
Evaluation dissemination at sector meetings



Staff Confidence

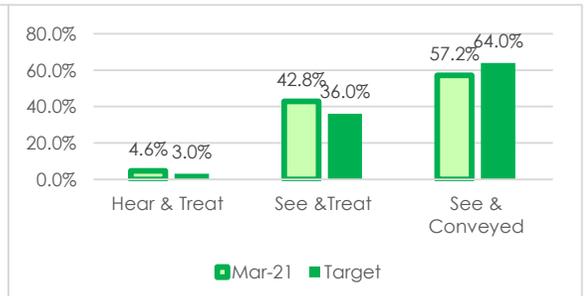
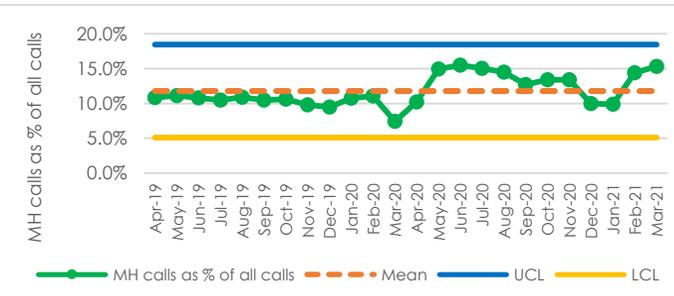
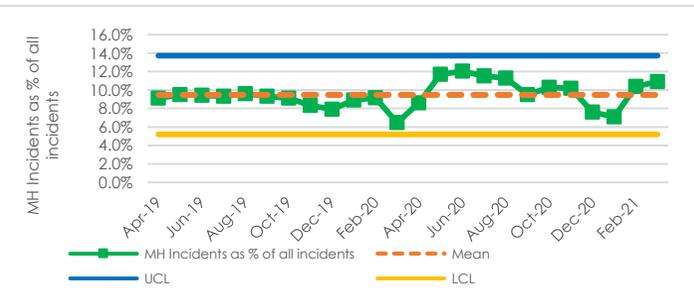
78% staff post education felt confident

28% increase from baseline



Substantive team recruited, due in post May 2021
New EoLC coordinators in post April 2021

E-learning package for 111/EOC call handlers completed
Updated Advance Care Planning guidance for additional clarity.



The team were shortlisted for the HSJ Value Award .
We continue to engage with stakeholders regarding ongoing funding for the Mental Health Joint response Cars.
We have new staff starting with us in April which will help build resilience.

3. Caring - Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Maternity Performance Review Dataset:
 Agree organisational operating model for maternity care across ambulance and integrated urgent care

Highlights and Our Service Values:

Respectful
 Maternity team support staff wellbeing through debriefing maternity events and Case review
 Total staff supported by year end 87 staff

Innovative
 COVID19 –BBA Pathway NEL scoped to look for system improvement
 Pan London engagement to develop maternity specific COVID19 screening tool

Professional
 Maternity webinars: Year end 362 attendees

Collaborative
 NEL & LAS working on Single Operating Process for the Local Maternity System

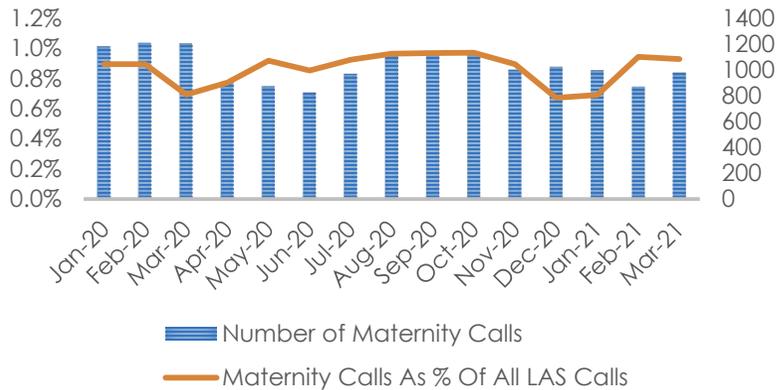
Exceptions (Improvement required):

Outstanding
 ➤ Maternity dataset

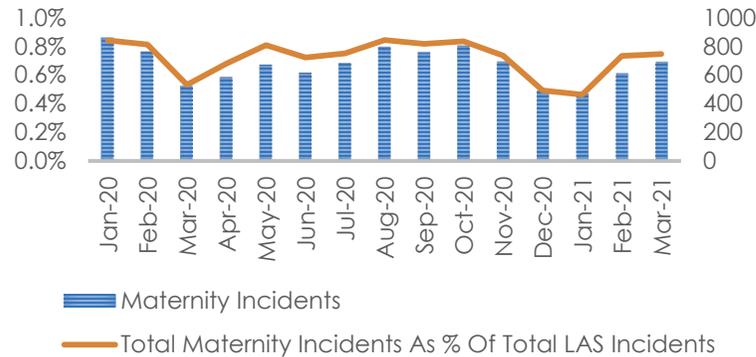
Maternity 3 Top Priorities:

- 1) Test new PPH Screening and Action Tool
- 2) Launch of maternity Datix incident trigger list
- 3) BBA Pathway NE London

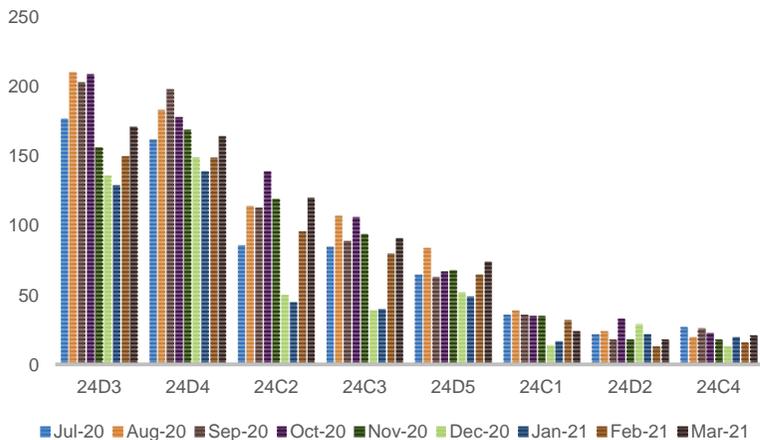
MATERNITY CALLS AS % OF ALL CALLS



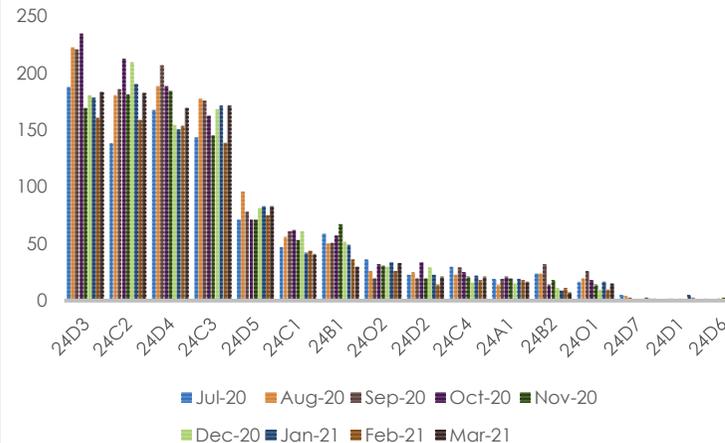
TOTAL MATERNITY INCIDENTS AS % OF TOTAL LAS INCIDENTS



NUMBER OF MATERNITY INCIDENTS BY MOST FREQUENT CATEGORIES



NUMBER OF MATERNITY CALLS BY MOST FREQUENT CATEGORIES



4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Frequent Callers
- Complaints

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*



Owner: Alan Hay/John O'Keefe/Juliette Smyth | Exec Lead: Dr John Martin

National definition of a **frequent caller** is anyone aged 18+ years who:

- Calls 5+ times in one month from a private dwelling; or
- Calls 12+ times over a three month period from a private dwelling

New & existing callers 648

NHS numbers matched 100%

Stakeholder meetings online 75

March 2021

The Frequent Caller Team (FCT) continue to attend multi-disciplinary meetings (MDTs) and High Intensity User (HIU) forums to review individual callers and their needs, formulate multi-agency strategies to reduce calls, and better manage demand.

Highlights

- Working with the new IG Manager has allowed the team to progress longstanding IG queries
- Working with the new LAS solicitor has helped support the escalation of complex patients where specialist legal advice is required
- The Team met with Berlin Ambulance & Fire service's HIU practitioner to share best practice
- Increasing numbers of external stakeholders are starting to use Coordinate My Care (CMC)

Lowlights

- Ongoing issues with IM&T and interoperability of systems used

Plans for April

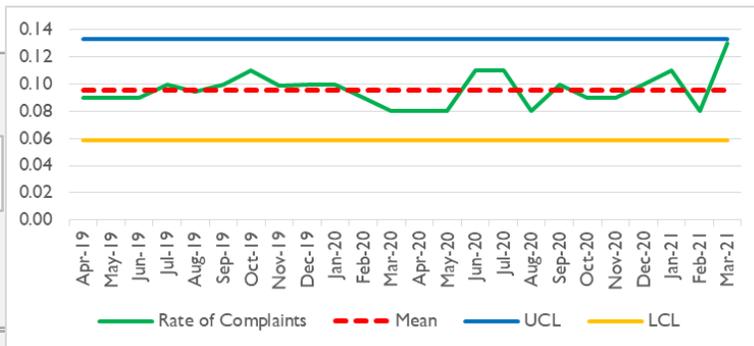
- Review and improve Frequent Caller Management Database
- Commence work to devise and implement FC process for 111IUC
- Work with MH / Med Dir colleagues to establish a position in respect of SIM project
- Review IDP process
- Continue to work to influence discussions around CMC, esp. around consent
- Restart conversation about restricted send
- Pilot integration of the National Record Locator (NRL) / Summary Care Record (SCR) into FC process

Sector	CCG	Patients	Mar-21	Calls last quarter	Calls last 12 months	12 month cost	Patients with care plan
SE	LEWISHAM CCG	20	684	1665	3448	£411,380	7
NE	CITY AND HACKNEY CCG	45	429	1573	3951	£529,034	22
NE	WALTHAM FOREST CCG	17	391	796	1768	£189,976	5
SE	SOUTHWARK CCG	27	345	923	2432	£331,700	3
NC	BARNET CCG	27	344	711	1742	£252,958	8
SW	CROYDON CCG	32	289	876	2053	£340,958	6
NC	ENFIELD CCG	26	271	1281	4749	£520,499	4
NW	HILLINGDON CCG	23	265	709	1792	£228,301	5
NW	HARROW CCG	15	258	726	1483	£226,465	4
NC	HARINGEY CCG	23	255	957	2808	£300,881	9
NW	EALING CCG	25	253	727	2174	£286,404	2
SE	LAMBETH CCG	27	225	867	3538	£392,483	6
NW	HOUNSLOW CCG	16	218	635	1788	£182,718	4
SW	WANDSWORTH CCG	23	200	663	1734	£209,650	3
NW	WEST LONDON CCG	25	200	602	1948	£290,486	3
SE	BEXLEY CCG	23	198	734	1881	£234,126	4
SE	GREENWICH CCG	22	197	635	2430	£315,084	9
NC	CAMDEN CCG	21	194	647	1777	£218,591	5
NE	HAVERING CCG	12	193	560	2095	£230,529	2
NW	BRENT CCG	23	184	539	1506	£201,569	2
NE	NEWHAM CCG	23	182	601	1729	£234,776	4
NE	BARKING AND DAGENHAM CCG	17	171	504	1567	£185,248	1
NE	TOWER HAMLETS CCG	19	165	807	1923	£248,511	7
SW	RICHMOND CCG	14	153	451	955	£114,034	2
NC	ISLINGTON CCG	22	151	394	1033	£148,966	11
SW	SUTTON CCG	19	136	526	1231	£195,533	4
NE	REDBRIDGE CCG	18	123	537	2523	£215,378	2
NW	CENTRAL LONDON (WESTMINSTER) CCG	11	116	289	1087	£138,810	1
SE	BROMLEY CCG	12	93	298	968	£148,335	3
SW	MERTON CCG	9	71	231	533	£80,348	1
NW	HAMMERSMITH AND FULHAM CCG	10	67	200	667	£113,806	2
SW	KINGSTON CCG	2	15	43	136	£24,890	1

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: **0.13**



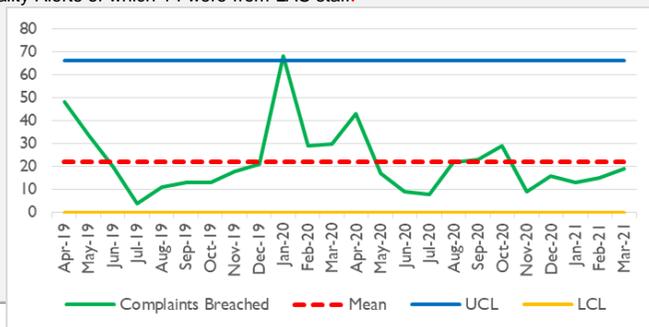
Complaints (including those recorded as concerns) was at the highest level for March since 2014. (120/117).

There were 390 x PALS enquiries which includes 158 added to the duty spreadsheet that did not require any further actions other than referring the enquirer to the correct team.

We managed 41 Quality Alerts of which 14 were from LAS staff.

Responding to complaints

Latest Month: **19**



Patient Experience – March 2021

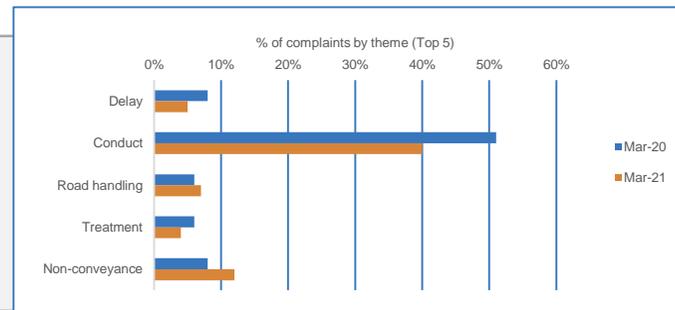
The Ombudsman’s Complaints Standards Framework was published at the end of March 2021. This model complaint handling procedure sets out how organisations providing NHS services should approach complaint handling. They apply to all NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

The guidance is being tested in pilot sites during 2021 and will be refined and introduced across the NHS in 2022. LAS has been selected as one of the early adopters and we are liaising with NASPEG to feed back on the recommendations.

We continue to abide by the guidance from NHS EI that during the Covid pandemic all healthcare organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The guidelines are effective from 01 February to 30 April and every effort should be made to avoid developing a backlog of complaints where it is possible to investigate and respond to the issues raised.

A number of Trusts have been impacted by this due to staff redeployment and increased absences due to Covid which in turn has affected our responses in some instances where complaints are hosted elsewhere.

Categorisation



Total complaints for 2020/21 were 1052 – 6% less than the previous year (1125) but in line with our expected trajectory due to the Covid pause period during March to June 2020 when complaint numbers dipped.

Patient Experiences Department (PED) team will manage any complaint involving the service provided by HUC 111 where the call has been generated via LAS with effect from 14 April 2020.

We will be working alongside the P&C Business Support Manager to provide input into the new agile working policy for the LAS. Service mobile phones have been provided for the team so that personal phones are no longer used to manage calls from the public. This is especially important whilst the team continue to work remotely.

We are in liaison with the End of Life team preparing a feasibility report for the recruitment of a Bereavement Counsellor in the Trust to support operational staff and other colleagues who have been affected by death. Our team have managed a significant number of such complaints and enquiries during 2020/21 with a high percentage linked to the impacts of Covid-19.

Actions and Learning

5. Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

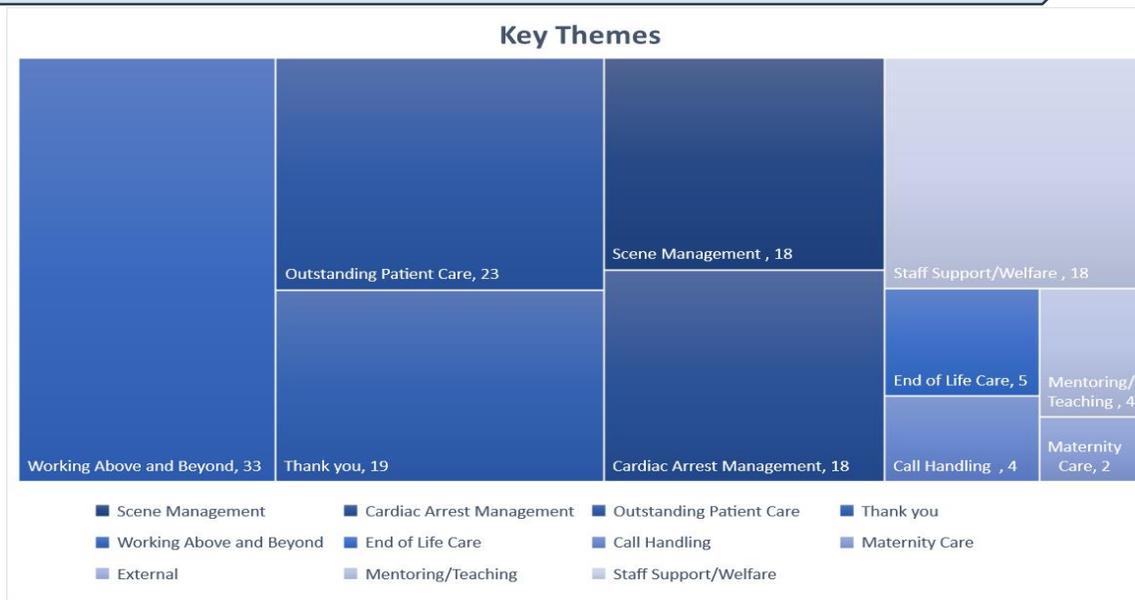
Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*



In March 2021 144 **Excellence Reports** submitted were submitted which is the largest number ever received in one month.

Key themes identified from March reports include:

- Working Above and Beyond
- Outstanding Patient Care
- Thank you



Martin

Working Above and Beyond

This crew attend a fire in the roof of a 5 storey block of flats. A female was reported by the LFB to be bed bound in her flat on the fourth floor requiring to be evacuated on an orthopaedic stretcher. The LFB reported that they would not be able to fight the fire until the female was removed as the water damage would cause her bedroom ceiling to collapse on her. The crew were aware that they only had a short window of opportunity before the fire became out of control act **swiftly, professionally, and as a team**. they effected a rapid evacuation of the female and her husband without incident. They then **cared** for them both whilst exploring suitable accommodation. eventually conveying the patient to hospital as a final option as this was the only place of safety left available to them. The LFB later reported as predicted the bedroom ceiling had collapsed.

Whilst on scene of sudden infant cot death, this IRO arrived on scene showing **true leadership** that is a credit to himself and the LAS. Not only did the IRO have the challenging job of organising scene management of family members, Police, and pets in an emotionally charged area, he was also comforting LAS staff making sure we were his number one priority. They went **above and beyond the call of duty** in his welfare after the incident had been handed to the hospital. Words can not thank the IRO enough for the words of encouragement, his comfort and help offered. **A true NHS hero.**

Outstanding Patient Care

On this CAD, the call was triaged as Cat 5. The Clinician picked up the call in CHUB and conducted a ring back. Following her telephone assessment the call was upgraded appropriately to a Cat 2. The Clinicians **excellent** clinical assessment meant that a critically ill patient, who was rapidly deteriorating, received medical intervention in a timely manner. Patient given BenPen by crew and blue to ED with meningitis. ED consultant also **commended** all involved for rapid assessment and treatment of a critically unwell 30 year old female.

They attended a Patient who had been stabbed, they treated the patient in a very **efficient, timely** and **professional** manner. The patient at the time was not exhibiting any signs or symptoms of being acutely unwell but unbeknown to us was bleeding internally. Their **rapid assessment** skills coupled with the recognition of a possible life threatened condition (unknown at the time, but possible) dictated a prompt response of conveyance to hospital continuing treatment of life saving drugs on route, which I believed **saved the patient's life.**

Thank You

I called West Ham Workshop regarding a Critical Care Transfer Service ambulance needing repair, **very soon** I received a call back from the workshop informing me the parts were available for the vehicle.

The ambulance was moved to West Ham. In a short time, the workshop informed me the repair had been completed. This **efficient rapid** repair minimised out of service time and enabled us to maintain our Critical Care Transfer capability.

Thank you to the crew for their assistance on a call.

We were called to a young girl with breathing difficulties and we handed over this patient to you on your arrival. Both of you showed **true compassion, dedication** and **competence** when dealing with the patient and when **collaborating** with us in the treatment. **Thank you** for your positivity and making it this a good experience for us and the patient.

They have worked hard and shown a **passion** to set up the well being room at Greenwich giving us all a relaxing space to have fun and boost morale. For her **infectious happiness** and recreational sports (table tennis, & darts) she has worked hard to provide, I feel she deserves high praise and this excellence report. **Thank you!**



Exec Lead: Dr. John Martin



The LAS has a tiered system for incident learning, which encompasses individual learning via specific support and feedback, sector level monitoring and action on incidents to higher level thematic/ strategic learning within sectors, and across the Trust.

Excellence reporting and themes are monitored at the Safety Investigation Assurance and Learning Group (SIALG). The Group examines excellence reports alongside themes from serious incidents, complaints, legal cases, patient experiences, and audits to see where learning can be extracted and shared throughout the organisation.

Excellence reports are shared via the following local and Trust wide routes:

- All Excellence reports are shared with individuals, teams and sectors within 48 hour of being reported.
- Used in the Learning events such as the monthly SI learning meeting and the quarterly learning from experience group.
- INSIGHT magazine edition 8 was developed by the Quality Improvement and Learning Team and was released in February 2021. This included 11 key topic areas which were supported by case studies from SIs, incidents and also *Excellence Reports*.

Some examples of excellence reports from March:

Cardiac Arrest Management:

This crew attended a 14 year old paediatric cardiac arrest.

They were first on scene and within literally seconds of arrival, had identified cardiac arrest, had placed pads on, and **delivered a shock**. This one shock resulted in a ROSC, which later on led to respiratory effort.

The **outstanding** speed of defibrillation was confirmed on APP download, and the continued quality of CPR till next pulse check was impressive.

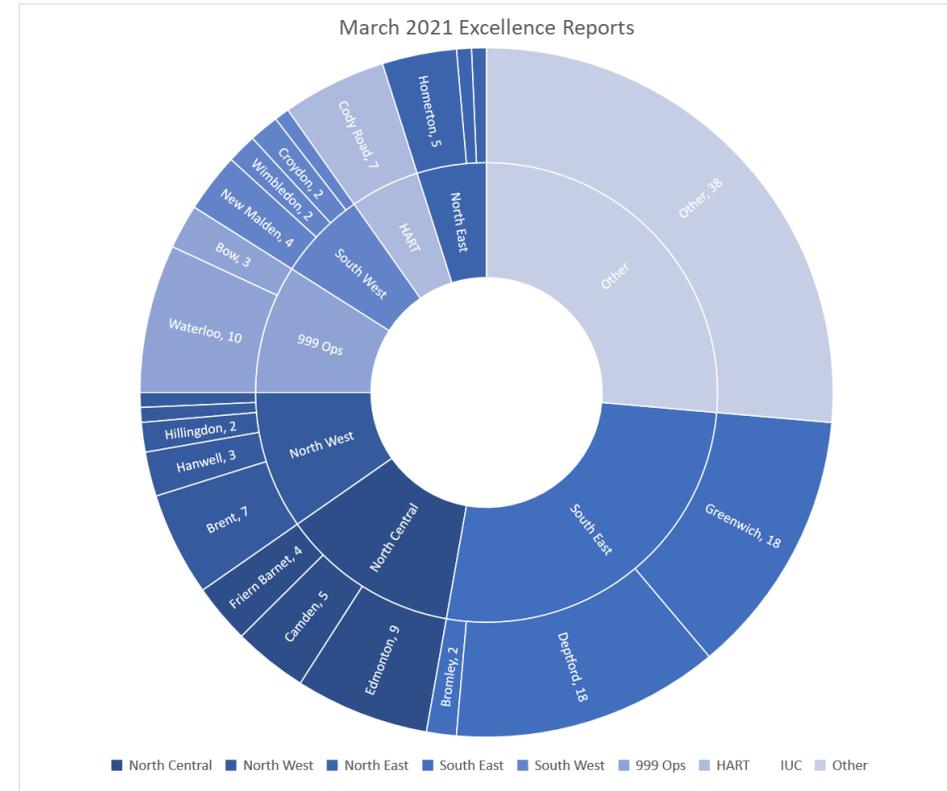
Call Handling:

They did an **excellent handover** to a clinician on a warm transfer using the SBAR process. What she had found during her pathways assessment and the recommendation from the clinical navigator was **very clear**, giving the clinician a good background into the reason for the call and her concerns. **Well done!**

Bystander CPR observed by the first crews on scene was clearly effective. Staff on scene at the care home informed crews that call handler had kept them calm and made them feel supported. Staff also felt that they were doing the right thing and were grateful of the call handlers **support** and **competence**.

Scene Management:

They were the team leader on scene when we arrived (3rd resource) to a multi patient assault with four patients all with stab wounds. I felt she had **excellent management skills**. In such a chaotic environment she managed the scene well and ensured we all felt **supported** in our **patient care**. As a result of her great management the job went well and was well **coordinated**.



5. Well led - Risk Management

Owner: Helen Woolford | Exec Lead: Dr. John Martin

Risk Management

Against the Trust KPIs:

- 75.9% of risks have been reviewed within the last 3 months – target 90%
- 83.3.7% of all risks approved within 1 month in March– target 90%

The risk team, including the new risk manager, are liaising with all teams where there are overdue risk reviews. The two main departments where this is needed as a priority are:

- The strategy department who have 16 risks reviews overdue. The risk team have scheduled a review meeting with the department which will take place in the coming week.
- The IUC Services who have 11 overdue risk reviews, this has been escalated to the QGAM for action.

Trajectory: The team are working to achieve the KPI targets by May 2021.

Corporate (Trust wide) Risk Register

	Negligible	Minor	Moderate	Major	Catastrophic	Total
Almost certain	0	0	0	0	0	0
Likely	0	2	2	2	1	7
Possible	0	0	6	6	2	14
Unlikely	0	0	0	2	2	4
Rare	0	0	0	0	0	0
Total	0	2	8	10	5	25

Risk Assurance and Compliance Group (RCAG)

The RCAG review all red (15 and above) scored risks on a monthly basis, including those held in the Corporate Trust wide Risk Register as well as those held on other risk registers across the Trust.

The group review the risks monthly in terms of movement to ensure that risks are, where relevant, moving as required, tolerated or escalated for actions through the Trust.

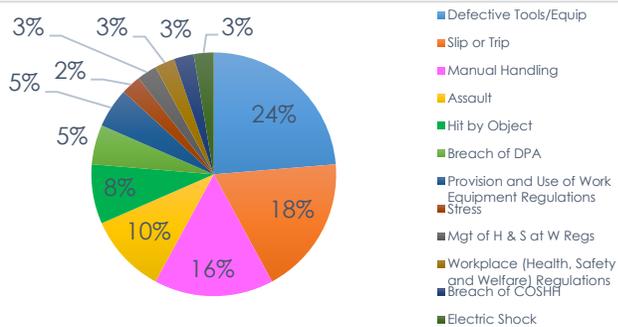
In the last month, there were 5 red risks on the Corporate risk register. This is demonstrated in the movement table to the right of this text. There were 2 risks which have been reduced in the last 2 months, this is demonstrated by the movement table on the right.

ID	Sector / Department	Description	Opened	Initial Risk Score	October Risk Score	November Risk Score	December Risk Score	January Risk Score	February Risk Score	March Risk Score	Change in Risk Score:	Progress Notes:
973	Estates	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.	02/09/2019	15	15	15	15	15	15	15	↔	Ambulance modernisation programme to address risk.
1050	Fleet and Logistics	There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the vehicle or primary response bags due to errors by Vehicle Preparation Team or being misplaced by staff during the treatment of patients which could lead to failure or delays in patient care.	12/03/2020	16	16	16	16	16	16	8	↓	Enhanced VDI check conducted everyday on each vehicle with regularly auditing on both bags and packs to make sure everything is in them.
1081	Fleet and Logistics	There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence, which may lead to the inability for LAS staff to treat patients if not properly managed.	25/04/2020	16	16	16	16	16	16	16	↔	Tolerated risk
1112	NHS111	There is a risk that a patient will be connected to an unattended telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.	05/06/2020	16	16	16	16	16	16	16	↔	Management issue. IM&T to investigate the option with Avaya for phones to be upgraded
1133	South East Sector	There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers.	04/08/2020	15	15	15	15	15	15	15	↔	Tolerated risk
775	Estates	There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers to prevent neutral from being lost during a network power outage. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services independently at Bow and HQ.	16/03/2018	15	10	15	15	15	15	15	↔	UPS at Bow and Waterloo require a transformer to protect against failure.
1106	Resilience and Specialist Operations	There is a risk that the LAS, Hazardous Area Response Team, Special Operations Response Team and Tactical Response Unit will be out of license to perform their core competencies. Because of the impacts of COVID-19, training was suspended for all of the R&SA specialist response staff (HART, SORT, TRU). The core competencies of: HART - Safe Working at Height, Swift Water Rescue, Urban Search and Rescue, Confined Space Working, High Consequence Infectious Disease Transfer and CBRN, SORT - Decontamination, TRU - MTA. This has also prevented training/refresher in all PPE. The consequence of this is the LAS will not be compliant with audit. Staff will not be as conversant with equipment and PPE not used regularly. This could all impact on patient and staff safety.	27/05/2020	20	10	10	15	15	15	10	↓	Risk de-escalated due to a number of staff being non-compliant in accordance with license requirements due to missing training during COVID.

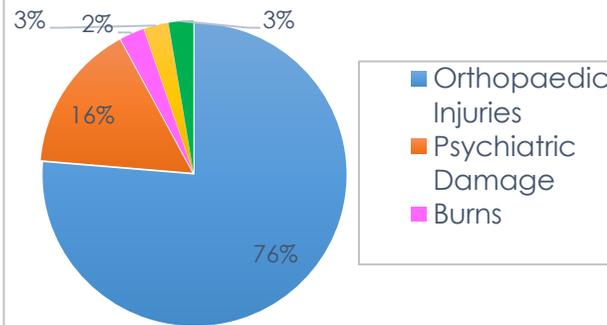
5. Well led - Legal Clinical & Non Clinical Claims

Exec Lead: Syma Dawson

Current Non-Clinical Open Cases by Cause



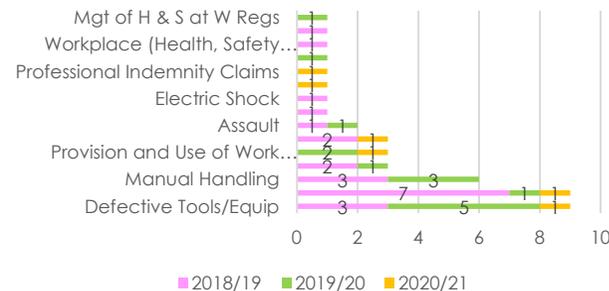
Current Non-Clinical Open Cases by Injury



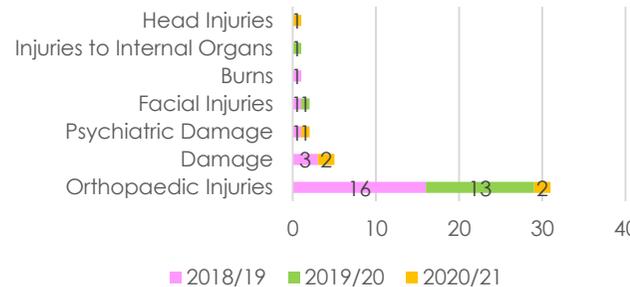
Closed Non-Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	2019/20	Grand Total
Assault	£0.00	£0.00	£0.00
Defective Tools/Equip	£15,036.00	£0.00	£15,036.00
Hit by Object		£0.00	£0.00
Manual Handling	£11,184.90		£11,184.90
Mgt of H & S at W Regs	£0.00		£0.00
Professional Indemnity Claims		£1,064.00	£1,064.00
Prov & Use of Personal Prot Equip Regs	£0.00		£0.00
Provision and Use of Work Equipment Regulations	£2,822.00	£0.00	£2,822.00
Sharps Injury	£8,298.80		£8,298.80
Slip or Trip	£0.00	£0.00	£0.00
Theft/Criminal Damage		£0.00	£0.00
Grand Total	£37,341.70	£1,064.00	£38,405.70

Closed Non-Clinical Claims by Cause



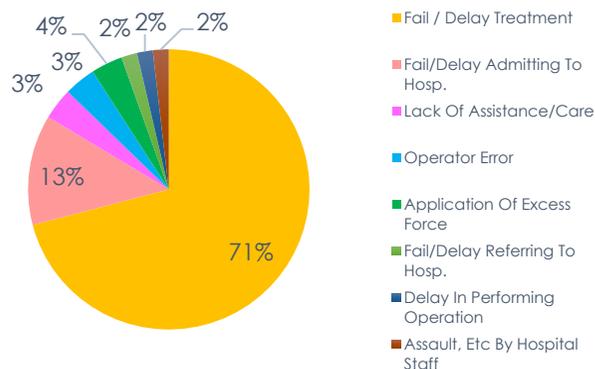
Closed Non-Clinical Claims by Injury



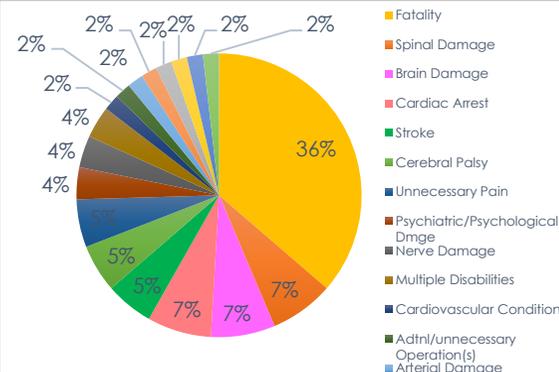
Closed Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	Number of Cases
Fail / Delay Treatment	£31,280.44	3
Fail/Delay Admitting To Hosp.	£3,724.65	1
Grand Total	£25,278.74	3

Current Clinical Open Cases by Cause



Current Clinical Open Cases by Injury



Highlights

- No PFDs since January 2021.
- Inquest of Fishmongers Hall starting 14/04 – all witnesses well prepared and supported.
- Pre-Inquest Review hearing for Streatham held – Trust is not an Interested Party to the proceedings.
- 2 Legal Secondee working very well in the department – one as an Inquest and Claims assistant and one acting as a Trust advocate.
- LSM updating witness statement templates and Legal Services Handbook.

Lowlights

- Coroners courts still facing a backlog, high volumes of coroners notification still being received per week.
- 1 additional Legal Secondee required to assist with large volume of work.
- Manager to start recruitment process for substantive posts.

5. Well Led - Trust Policies

Owner: Victoria Moore | Exec Lead: Syma Dawson

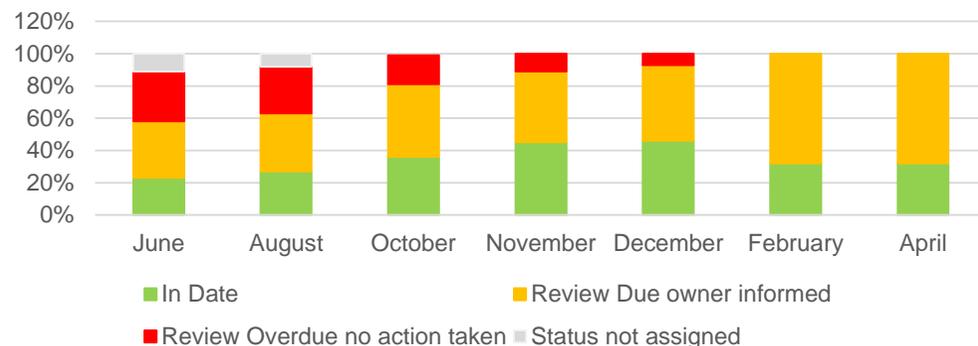
A review of those policies held within Health Assure and on the Pulse has identified 108 Policies, the current status is reported below.

A full review of the position has now been completed and a structured approach is being taken to address the position and to establish a process for recovery.

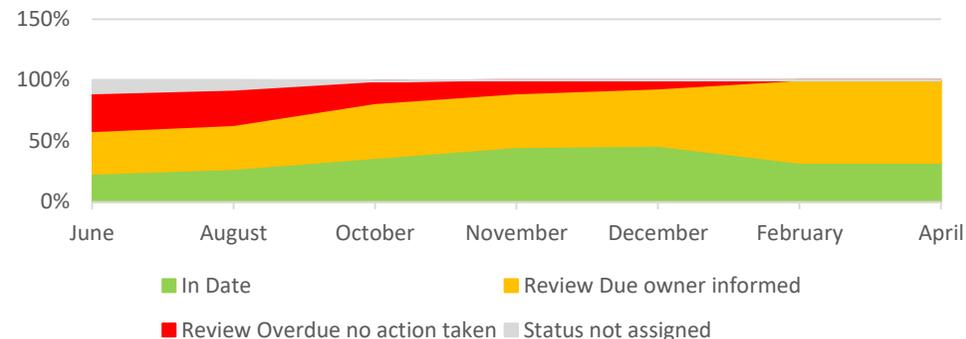
Progress has been impacted by the recent increased operational activities resulting in responsible owners and stakeholders being required to focus on other tasks.

Trajectory: The team are working to have 90% of policies reviewed and updated by June 2021

Policy Update June 2020 to April 2021



Policy Progress Update June 2020 to April 2021



Actions

Following the reinvigoration of a strong governance approach the team have reviewed the historic and taken the following actions:

A shared Policy inbox has been established to provide a single point of contact and reference for policy resolution or queries. It will then be possible to utilise the outlook calendar to programme reminders for the team to take or follow up any planned action. Which will complement the management through Health Assure.

All policy records have been reviewed, and a clear base line for action has been achieved.

Policy owners have previously been contacted and prompted to action with little success this process has been reviewed and refined to include additional accountability. There is now clear open dialogue and confidence action is being taken.

Health Assure will be updated with relevant information and approved policies as appropriate.

The team have been made aware that there is likely to be further movement with the policies. 8 have been identified which may be appropriate for closure. The Policies will remain on the log until appropriate confirmation has been received.

Work in progress

Acknowledging that the position is not fully resolved the team are committed to continuing to work with stakeholders recognising the requirements and daily pressures and ensuring that deadlines are not unreasonable and continue to ensure that the position is resolved quickly to reduce the consequences of operating with out of date or inaccurate policies.

Next Steps and Improvements

To complement the actions taken and to ensure that Trust staff remain engaged in the process the team have recognised that there is further work that can be done to ensure that the user 'experience' is improved.

It is anticipated that these measures will reduce frustration with the process and action and deter individuals from keeping local unpublished copies, as well as ensuring that all Trust staff are able to find and access the information required.

This work will include:

A review of the Policies page on the Pulse to ensure that policies are easily referenced

A monthly update email to be sent to managers to inform them of those policies that have been updated and published

These next steps are not limited to those listed and will be subject to regular review to ensure that the outcomes are as expected and delivered appropriately.



Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	FTSU 2020/21 Annual Report			
Agenda item:	For Information			
Report Author(s):	Katy Crichton, Head of Wellbeing			
Presented by:	Trisha Bain, Interim Head of Corporate Affairs			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Noting
Key Points, Issues and Risks for the Committee's attention:				
<p>This paper is provided to present an overview of the activities and outputs of the Freedom to Speak Up Team and concerns raised in 2020/2021.</p>				
Recommendation for the Committee:				
<p>The Trust Board is asked to note the content of the report</p>				

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



Freedom to Speak Up Annual Report 2020/21

Katy Crichton and Carmen Peters





Freedom to Speak Up and the Values of the LAS

Respectful – FTSU supports a culture where everyone has a voice and deserves to be heard, whatever their role in the LAS. FTSU encourages staff to challenge behaviours appropriately, but provides an alternative route to stop conflict at the earliest stage.

Professional – Patient and Staff safety is the professional responsibility of all colleagues, and FTSU allows the reporting of these issues in a confidential, impartial way.

Innovative – FTSU concerns often involve working with staff to find resolutions to unique, diverse or previously undiscovered issues that may require high levels of sensitivity or input from multiple directorates or colleagues

Collaborative – By working together with all levels, departments and directorates, FTSU aims to bring staff together to solve the issues that are raised and improve patient care and the experience of working for the LAS for everyone.

Foreword

In 2019/20 The London Ambulance Service was recognised as the most improved NHS trust in England for fostering a positive speaking up culture by the National Guardians Office. The Covid-19 pandemic has transformed many aspects of our ways of working but the need to listen to colleagues who speak up remains paramount. The number of FTSU concerns raised within the LAS this year is still significant at 155, although a large decrease on the previous year and it remains to be seen if this is due to improved processes and relationships with managers within the Trust or because of the pandemic. The FTSU team would like to thank outgoing FTSU Non-Executive Director Fergus Cass for his support over the last few years and to extend a warm welcome to Amit Khutti, who will be taking over the role. Thank you also to Erica Greene who stepped down from her role as Interim FTSU Guardian at the end of February 2021.





2020/21 in summary

- At the end of May 2020 substantive FTSU Guardian, Katy Crichton, began a secondment as LAS Head of Wellbeing. Erica Greene stepped up as Interim FTSU Guardian, supported by new full time FTSU coordinator Carmen Peters.
- There are currently 25 Freedom to Speak Up advocates within the Trust, all of whom have received training in how to promote the work of FTSU and support staff to raise concerns. All advocates are offered monthly 1:1s with Carmen.
- Interim FTSU Deputy Guardian Erica Green continued to have a strong relationship with senior managers and had regular one-to-ones with the CEO, the COO and the Director of People and Culture.
- Erica and Carmen are both allies of the B-ME Network, Enabled Disability Network and the LGBT society. Carmen is also the Engagement and welfare officer for the B-ME and Enabled Network and worked with the B-ME network on a joint event for black history month, as well as creating articles celebrating BAME people who have spoken up throughout history.
- Carmen met bi weekly with the Diversity & Inclusion consultants and Dignity at work lead to discuss the themes across the trust i.e. Racism, discrimination and Bullying & Harassment.
- For FTSU Month in October 2020 Erica and Carmen held a virtual event for the advocates at which the Chair, the CEO and other senior managers gave speeches about the importance of the speaking up culture within the trust. The LEAP team also kindly conducted a workshop about stress and boundaries
- Also during October, Erica and Carmen visited multiple sites across the services offering tea and coffee to staff on a tea truck, ensuring to visit sites that had previously raised high number of concerns.
- Erica and Carmen ran virtual shielding mess rooms for staff shielding due to the pandemic in order to support colleagues who may be feeling isolated or disconnected from work.
- Erica and Carmen attended the Resolution Framework and new Patient safety framework meetings and were able to provide input based on FTSU concerns.
- The FTSU page on the LAS intranet was reviewed and refreshed.
- Katy was part of the CEO's staff survey review group and led a 'speaking up' session at the sector leadership conferences in order to promote positive cultural change and empower local management teams.
- There were continued quarterly Freedom to Speak Up steering group meetings, alongside quarterly Dignity at Work meetings.

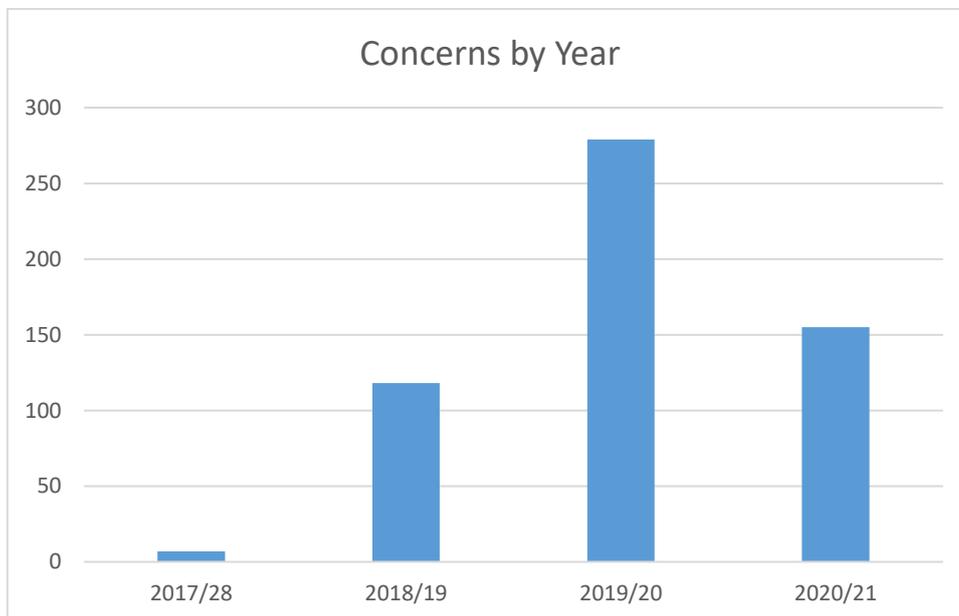




- In collaboration with the LEAP team, The Freedom to Speak Up team produced a staff support and wellbeing document for all staff to access in light of the COVID-19 pandemic and from then onwards.
- The LAS FTSU team was shortlisted for the HSJ FTSU award



The Data



The number of concerns decreased from last year by over 100. There may be positive reasons for this, such as virtual FTSU promotion and staff feeling more comfortable in making initial contact with their line manager, or initiatives such as LAS TV live – where staff and volunteers have a chance to ask questions of the senior team directly.





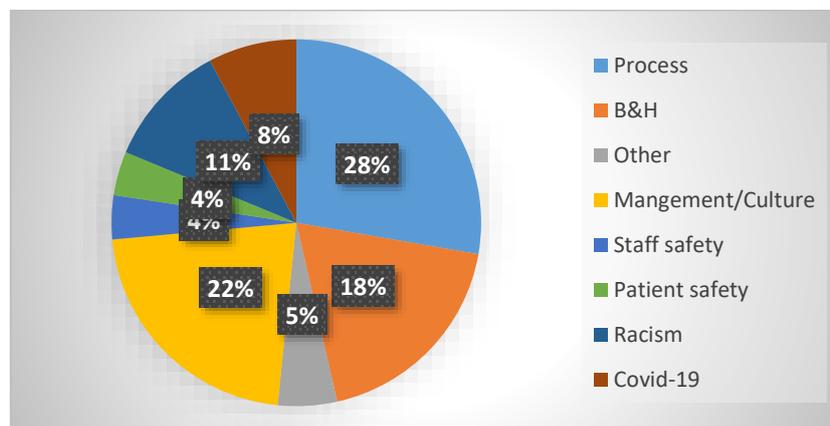
It may also be the case that the decrease in concerns is due to the lack of face to face opportunities for the FTSU team to meet with colleagues or hold FTSU events. There is also anecdotal evidence to show that colleagues may have felt their issues “trivial” in the midst of the pandemic and therefore did not raise them when they may have previously done so.

Themes

Themes	Q1	Q2	Q3	Q4	total
Process	10	21	3	9	43
B&H	7	8	9	5	29
Other	0	3	2	3	8
Management/Culture	7	7	9	11	34
Staff Safety	1	2	2	1	6
Patient Safety	0	2	3	1	6
Racism	8	2	1	6	17
Covid – 19	2	1	3	6	12
total	35	46	32	42	155

As in 2019/20 ‘Process’ at 28% has continued to be the most common reason for staff raising concerns, followed by Management/Culture at 22%. Both of these issues continue to link back to poor communication, lengthy processes and lack of emotional support or perceived understanding.

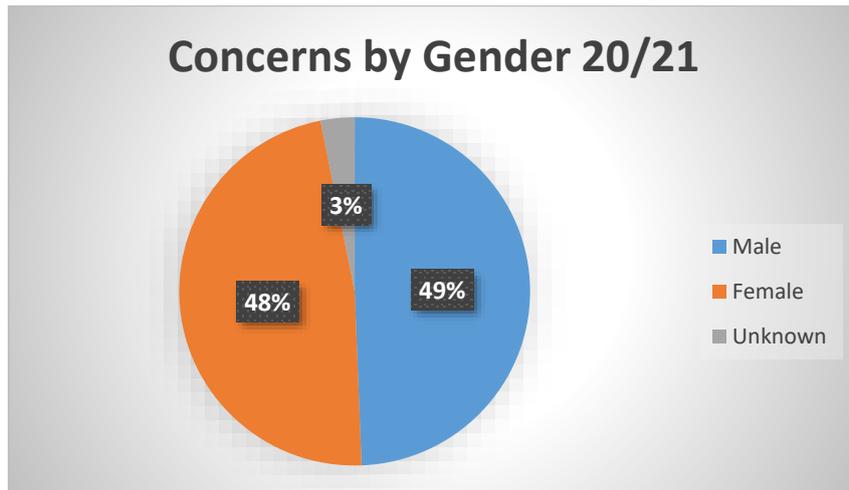
It is also possible to link world events timing of some of the issues above – for example, the number of concerns raised about racist behaviours in Q1 was linked to the tragic death of George Floyd and the high profile of the Black Lives Matter movement. As well as this, half of the concerns raised about Covid-19 occurred in Q4, as London went through the worse of the second wave





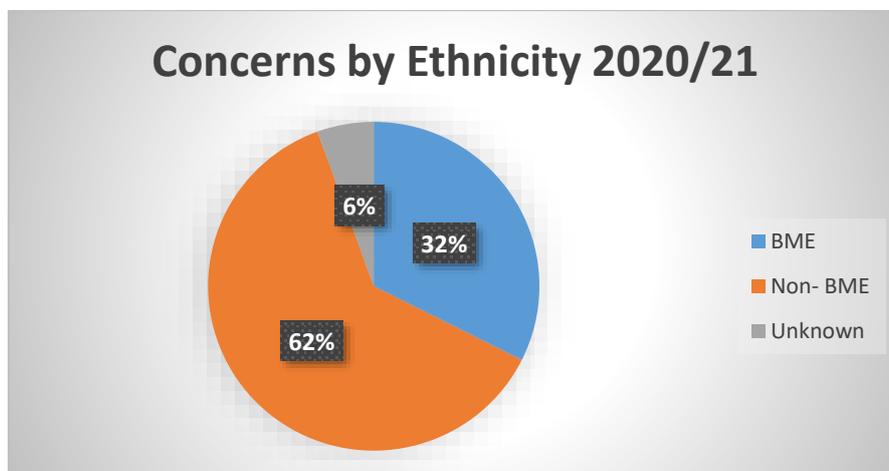
Gender

The proportion of concerns raised according to gender remains largely unchanged from previous years and largely representative of the workforce.



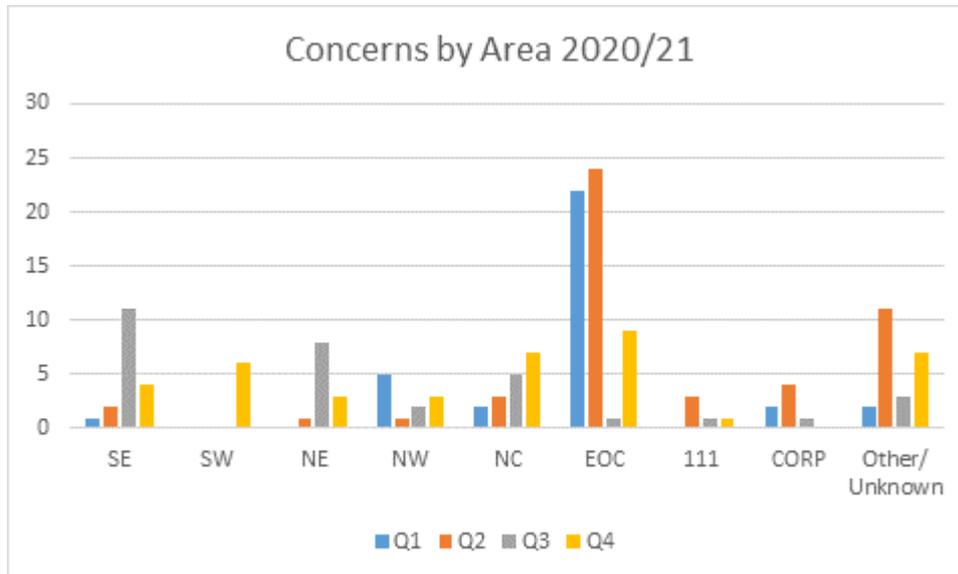
Ethnicity

There continues to be a rise year-on-year of concerns raised by BME colleagues, with 17% in 2018/19 to 32% in 2020/21. This may have been due to the work the Trust has undertaken to promote a firmly anti-racist environment, as well as the work done by the FTSU team to collaborate with the B-Me network.





Concerns by Area



The most concerns in both volume and by proportion of workforce have come from EOC. This may be due to the accessibility to face to face FTSU support in Q1 and 2 particularly, as the team spent a lot of time in both EOC North and South.

There has been a decrease in the number of concerns raised by colleagues in the corporate areas of the Trust from 22% to just 4% - again most likely to be due to the pandemic, with many colleagues working from home.

By sector the least concerns were raised in the SW (6) and the most in the SE (18). There is no obvious pattern to the concerns raised in themselves, although the numbers could be linked to the presence of FTSU advocates.

Actions Taken

As has been the case in previous years, the majority of concerns that were raised helped the member of staff to access information or to find closure on issues that related to them personally, with some contributing to bigger changes. The FTSU team were pleased to work with the wider Trust in sharing the concerns raised about racism, and have an opportunity to help shape the action plan that was drawn up in response to the Black Lives Matter movement, including getting racism added as a reporting category on Datix.

Concerns raised about Covid-19 included issues with risk assessments and appropriate redeployment –these were resolved by with assistance from H&S and management teams. There were also concerns relating to communications and regular updates – these were passed on to operations and communications teams and resolved via platforms such as LAS TV live.





There continue to be issues relating to formal processes within the Trust – mostly that they are lengthy or feel unsupportive. These concerns, along with those relating to behaviours, were fed into the development of the new resolution and patient safety frameworks and it is hoped that many of these issues will be resolved with the launch of these processes.

Additional Information

- Only 29 members of staff provided feedback relating to over 100 concerns raised **and** closed in 2020/21. All said they did not suffer at a detriment to speaking up.
- We have had one negative feedback from staff, who did not feel the Dignity at work process was supportive. Otherwise all feedback given was positive.
- 8 out of the 155 raised concerns were anonymous, citing repercussions, isolation and fear as the main reasons to remain anonymous.
- 22 concerns remain open from 2019/20

What LAS colleagues have said about FTSU

- “Freedom to Speak Up is a good service, I never thought or saw the need for it until I needed the service myself, every time I get emails I never took time to read up but as from today I will be taking time to read up emails”
- “I am happy with the care and support I received”
- “Thank you for the support given/offered”.
- “One can never underestimate the importance of talking to someone who understands”.
- “At least my voice was heard! Thank you again for all your support”.
- “I would use FTSU again and no I haven’t experienced any detriment because of raising my concerns”.
- “FTSU have been fantastic. Thank you so much”.

Recommendations

Ultimately, the aim of FTSU is to create an environment in which colleagues feel safe and supported to raise their concerns with their management teams or through existing P&C processes. In order to make this a reality, the following recommendations have been identified

- All managers to undertake FTSU e-learning on ESR and to encourage their teams to do so also.





- Further training based on the concerns raised through FTSU and the reason colleagues chose to take this route instead of contacting a manager/HR should be provided for managers in conjunction with EDI/Civility and Behaviours work
- FTSU to work with EDI/Wellbeing/DAW to create a “Positive Workforce Culture” training package for all colleagues
- In order to ensure colleagues in harder to reach departments are targeted FTSU will need to have a physical presence across the Trust as social distancing rules relax.
- FTSU will be recruit more advocates with particular focus on areas or roles in the Trust that are not represented
- The feedback rate has dropped considerably for this year, so work should be done within the team to look at how this can be improved and, importantly, hear from colleagues who had a negative experience with FTSU.



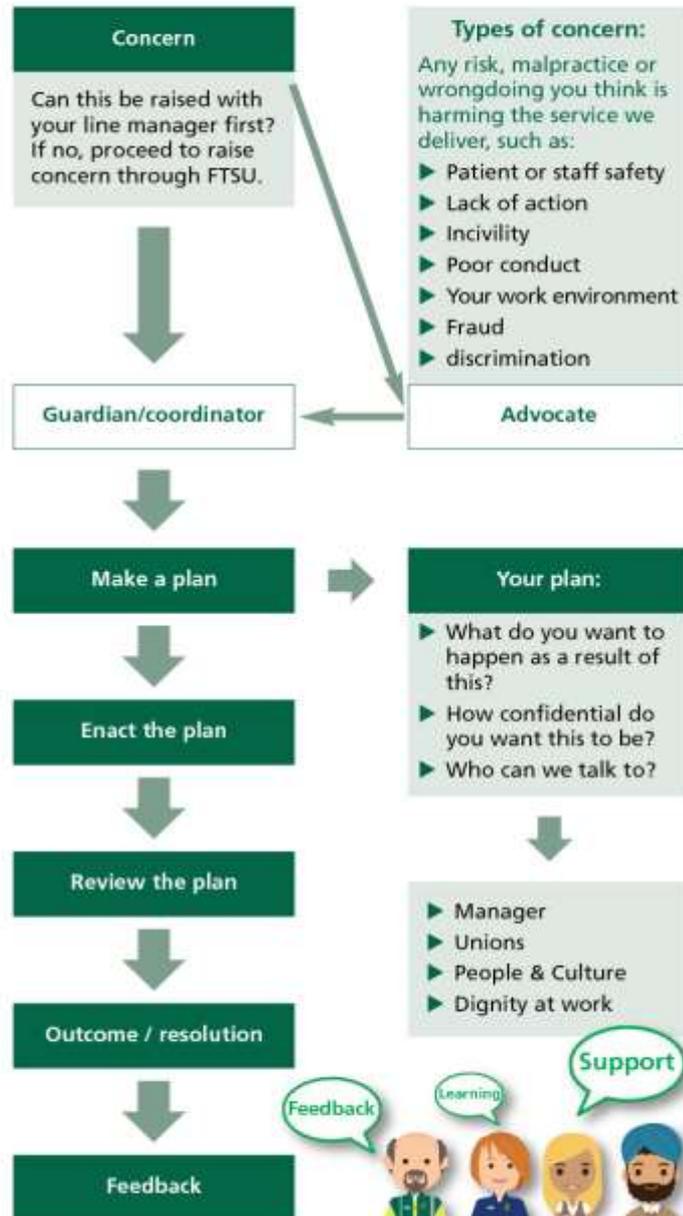


What happens when you raise a Freedom to Speak Up concern.

* Confidentiality will have to be broken if a member of staff or patient are at immediate risk of danger.

Who enacts the plan?
The person who raised the concern or FTSU?

For more information please see the FTSU pulse pages and the FTSU policy.





Report to:	Trust Board			
Date of meeting:	25 May 2021			
Report title:	Patient Experiences Annual Report			
Agenda item:	For Information			
Report Author(s):	Jacqueline Dawson, Deputy Head of Patient Experience Gary Bassett, Head of Patient Experience			
Presented by:	Trisha Bain, Interim Head of Corporate Affairs			
History:	N/A			
Purpose:	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Approval
	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Noting
Key Points, Issues and Risks for the Board / Committee's attention:				
<p>The Patient Experiences Annual report included detail of activity, complaint outcomes, analysis, performance and ombudsman reviews during 2020/21.</p> <p>The report acknowledges the challenges presented by the Pandemic and measures put in place and recognises the focus of 2021/22.</p> <p>It is believed that the report meets Quality Account/Regulatory Requirements.</p>				
Recommendation(s) / Decisions for the Board / Committee:				
The Trust board is asked to approve the Patient Experiences Annual Report				

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

PATIENT EXPERIENCES

ANNUAL REPORT

2020/21

Author: Jacqueline Dawson, Deputy Head of Patient Experience, Gary Bassett, Head of Patient Experience.

MAY 2021



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Annual Report Patient Experiences Department

2020/21

Introduction

Patient experience and feedback allows us to understand whether our services are meeting the standards we set ourselves and addressing patients' expectations. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously and do our best to offer a comprehensive response to any issues brought to our attention, clearly identifying any lessons and using these to improve our service, where appropriate.

We report trends and emerging themes through the Trust's governance processes and to widen the learning, publish anonymised case examples on the Trust website and contributing to our 'Insight' publication which is disseminated across the Trust. We also contribute to the national ambulance forum (National Ambulance Service Patient Experiences Group (NASPEG), comprising all UK ambulance services.) where the issues raised are common to the sector as a whole.

2020/21 has been a challenging year for all NHS Trusts. On 25 March 2020, amidst growing concerns about the pandemic and the immediate impact on service provision, we adopted the guidance from the Health Service Ombudsman and NHS England to 'pause' the NHS complaints process to allow us to release staff to focus on front-line duties and responding to COVID-19.

This initial 'pause' period was for three months with effect from 26 March 2020. However, any complaints made after 26 March 2020 still needed to be investigated, we simply had more time to respond. We were also obliged to adhere to the guidance from NHSE, which indicated that *"consideration should be given to complainants who, at the time of the 'pause', have already waited excessively long for their response"*.

We advised complainants of the process we were adopting so they could understand that there may be a delayed response but most feedback was supportive. We also identified a number of issues in addressing outstanding complaints that involved other Trusts who had suspended their complaint management process under the 'pause' umbrella.

The team did as much as possible to lessen the need for staff to be stood down, including developing the as yet unadopted 'early resolution' process that is expected to be a key feature of the



Ombudsman's new draft universal guidance, by calling complainants/advocates back and limiting as much as possible the questions we needed to ask staff.

We updated the Trust website, reduced the opening hours on the duty function to 10:00 – 15:00, Monday - Friday and agreed a process with Bart's about the management of any complaints and enquiries relating to the Nightingale Hospital. Independent monitoring was set up with POhWER, with a representative from the Ombudsman's office acting as observer, as a governance facility.

NHSE and the Ombudsman advised at the end of the 'pause' period on 30 June 2020 that the arrangements were to cease but a second national lockdown was imposed in January 2021 and we were obliged to inform the agencies referred to that we needed to impose our own 'pause' in the light of the pressure to the 999 and 111 services. This was effective from 01 February to 03 March 2021.

Activity

For the year ending 2020/21, complaint volumes were impacted by the pandemic although the overarching total was slightly lower. However the complexity of those and the exponential increase in complaints where the patient died and Covid-19 was recorded as a contributory factor meant that the team were more than ever before being asked to cope with the continued emotional distress of complainants.

A review of the Duty Officer function highlighted the vulnerability of staff answering distressing, agitated or aggressive calls whilst working from home. Due to the unprecedented volume of enquiries, especially at the peak of the pandemic, a dedicated spreadsheet to capture unrelated enquiries as categories without needing case management was designed by the team to function alongside the case management system.

Following the cessation of the Ombudsman 'pause' arrangements, we saw the numbers of complaints and enquiries increase in the ensuing months. We reviewed the 'Talking with us' section of the LAS website in collaboration with our Communications team to make it more user-friendly for stakeholders and improve signposting mechanisms to other departments.

Totals for 2020/21 were 1050 complaints, 6641 PALS enquiries and 434 Quality Alert notifications (internal and external).

The top 5 subjects of complaints were:

Conduct and communication issues	529
Non-conveyance	98
Road handling	88
Delay	74
Treatment	56

An on-line complaints form was added to the website together with improved signposting to locate that. Since the form was added in November 2020, complainants have increasingly been using this method of contact



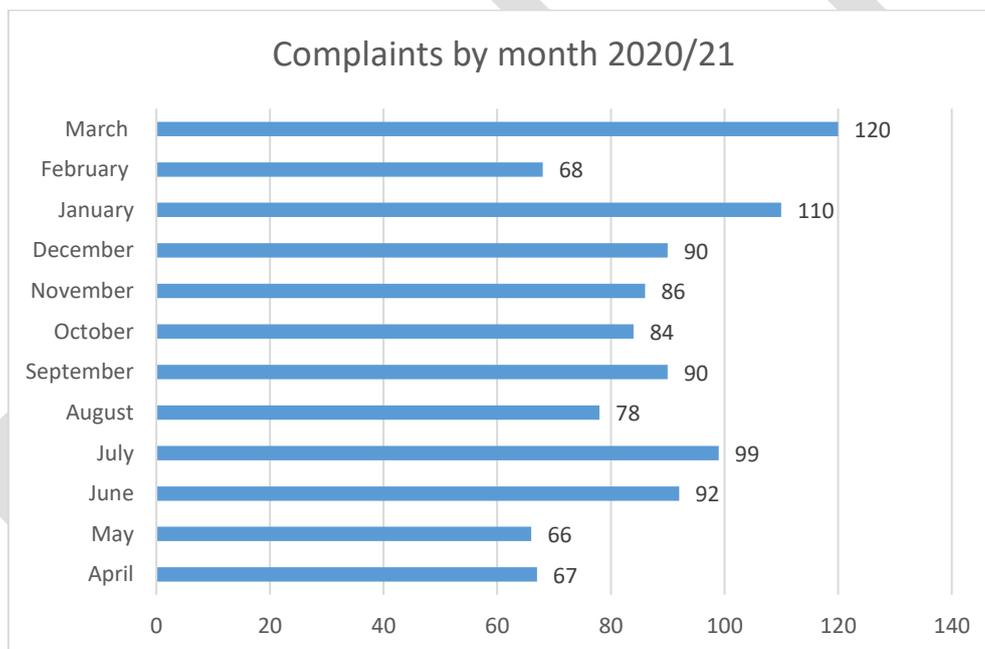
Complaints about our NHS 111 teams totalled 150, 89 about NELIUC and 53 about SELIUC, 6 were not LAS and 2 related to NWLIUC. We have assumed responsibility for the management of a designated cohort of complaints as part of the LAS management of the NWLIUC 111 function. In liaison with the strategic lead we have made changes to Datix and anticipate an overall rise in the number of NHS111 complaints.

The number of external Quality Alerts raised by other Healthcare Professionals increased from 364 in 2019/20 to 434. We also now take responsibility for the management of internal Quality Alerts about other providers raised by LAS staff. A total of 99 such requests have been received in 2020/21 but we anticipate this will rise in the future as staff become more aware of the process.

The average percentage of complaints received against calls attended is 0.10%.

Graph 1.

Complaints by month 2020/21:



Complaint outcomes

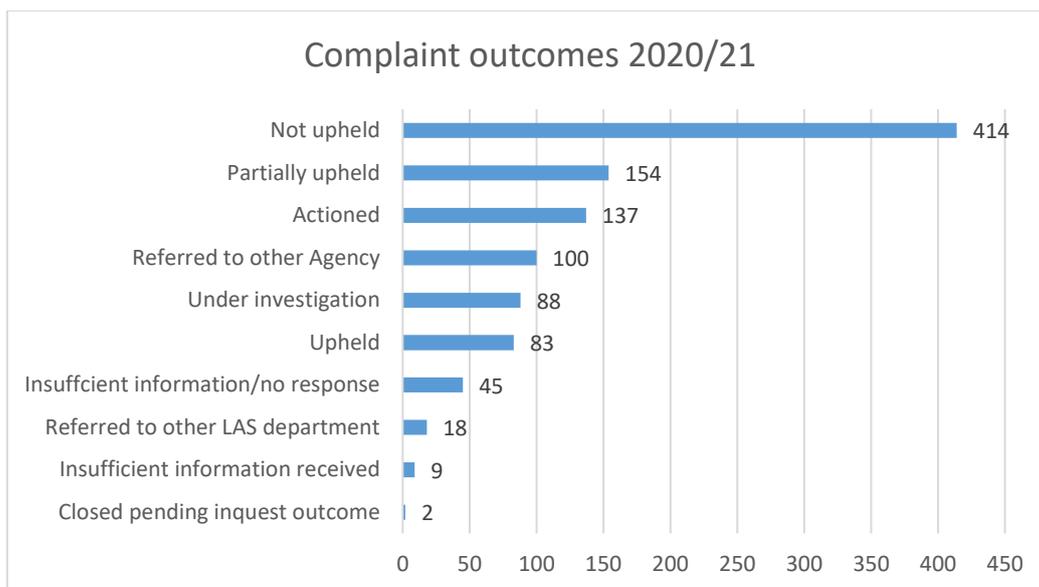
Where a complaint is *upheld* or *partially upheld*, the learning identified is actioned accordingly. This can involve a range of measures including feedback, reflective practice and bespoke training held locally, with emerging themes reported through the governance structure.

We monitor any agreed learning that has been identified to ensure that actions have been undertaken.

Graph 2.

Complaint outcomes 2020/21





Themes

In 2020/21, complaints about staff communication and conduct increased to 529. This has now substantially overtaken complaints that in the main relate to the delay in an ambulance being assigned.

Complaints about NHS 111 mostly relate to an incorrect referral pathway or a delay in clinical call backs.

Many complaints increasingly involve multiple issues, for example, call management + a delayed response + attitude of crew staff + care provided.

Currently driving issues remain the responsibility of the department, in the light of the Driving Standards Unit being discontinued.

Common themes:

- Delay caused by demand exceeding resourcing and the implementation of CSEP
- Triage errors, including technical and procedural errors
- Poor staff interaction with patients,, exacerbated by the demands of Covid-19
- The process of referrals to NHS111 not always being understood by 999 callers

March 2020 saw the advent of Covid-19 which substantially impacted on complaint volumes.



Table 1.

The top five key subjects were as follows:

Complaints by month and subject 2020/21	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Conduct/communication	40	42	49	54	40	44	45	48	37	46	36	48	529
Delay	4	0	2	4	8	10	11	1	8	17	3	6	74
Road handling	2	3	7	14	10	11	3	11	6	6	7	8	88
Treatment	1	5	7	5	3	5	5	3	6	8	3	5	56
Non-conveyance	8	7	10	9	5	6	4	8	9	9	8	15	98
Totals	55	57	75	86	66	76	68	71	66	86	57	82	845

Performance

Our current target for complaint responses is 75% within 35 working days.

Throughput during 2020 was hindered by a number of factors aside from the pandemic. The Service merged the email system to that used by NHS.net, this resulted in a number of issues as we endeavoured to maintain our Business as Usual. The most severe impact was on the ability of the team to pick up voice messages on the duty phone system. Whilst this issue was eventually resolved, it led to a review of the duty function whilst staff worked predominantly from home.

Despite all of the unprecedented issues faced by the team during 2020/21, the 75% response target was achieved.

Some of the improvements we have achieved this year:

- We have approached the End of Life team regarding the increasingly high numbers of complaints and enquiries that involve a deceased patient. It is hoped that the Trust will consider access to a specialist (bereavement) Counsellor to support both patients and our staff. A section supporting this will be included in our Business Plan.
- We will be reviewing our Quality Assurance process for Datix and use the workshops and KPIs to ensure that we capture optimum information about all the work streams for which we have responsibility. This will also be a driver to examine whether some of the issues we manage could be better achieved by other departments.
- Improvements to the case weighting mechanism in Datix have been implemented to monitor performance and the complexity of some complaints. This is part of an ongoing project regarding staff development and links to the Training Workshops we have delivered via



Teams. Good progress has been made with the Training Programme primarily for new staff but this also acts as a refresher and monitoring mechanism for existing team members.

- Following the outcome audit of Subject Access Requests by Grant Thornton, further changes were made to Datix to improve recording of time frames in line with statutory requirements. We have also improved the SAR information on the website to clarify the process for those who request copies of the records we hold.
- We collaborated with the other internal stakeholders as an Early Adopter with the implementation of the Patient Safety Incident Response Framework. To assist with this process we arranged for a number of improvements in Datix in the way we capture outcomes and learning from the work we undertake. We also submitted a number of case examples.
- We were invited to collaborate with the trial of the Sector Business Partner model and two staff were identified to lead on the PED aspects of this project working alongside the QGAMs in the trial areas. A number of improvements were identified and fed into the project which is currently being evaluated prior to consideration for wider roll-out.
- Working with the Business Partner model is seen as an excellent opportunity to adhere to the proposals from the Ombudsman in 2021 and match those requirements.
- We were specially invited to contribute to the Ombudsman's review towards the unification of guidance across the NHS
- Our Head of Department was elected as Chair of the National Ambulance Service Patient Experiences Group (NASPEG)

We have also worked very closely with Quality Assurance team who manage evaluations of 999 call management.

Ombudsman cases

The Ombudsman is working on the Complaints Standards Framework which sets out a single sets of standards for staff to follow and will provide standards for leaders to help them to capture and act on the learning from complaints. We have been selected as an Early Adopter site the new guidance aims to provide a clear vision of how to approach feedback and complaints effectively and will set out the best practice regarding learning from complaints to improve services. It is anticipated that this will establish the basis of a new regulatory framework.

The 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.

The Ombudsman considered 23 complaints during 2020/21 (8 of which were carried forward from 2019/20 of which 2 remain under investigation). Currently there are 7 cases with the Ombudsman.



Financial Remedy

The Ombudsman introduced specific guidance that all Trusts were expected to apply, in cases where the patient had experienced a poor service or injustice, including distress or unnecessary pain. We are currently following these guidelines.

Patient Experiences Learning Examples

Examples of learning/outcome

Complaints continue to be a powerful tool to describe patients' experiences and the learning that has resulted is presented through the governance process.

Case examples – demonstrating learning from complaints

1. Complaint from patient's family following receipt of the records about the call management

It was identified that owing to a system error, the patient should have been determined at a higher level of priority from the outset and the call handler's manner fell below the customer services standards we expect. Extensive feedback was given to the call handler concerned with request that they are supported for a period to be decided by their line manager.

2. Complaint from patient's wife about the management of her 999 calls and the confusion that arose when the ambulance staff arrived at the scene

It was identified that when updating the system, the first frontline ambulance crew used a relatively new disposition code which caused some confusion. In view of this, we brought this incident to the attention of Control Services governance team to consider what might be done to prevent situations of this nature from reoccurring.

3. Complaint from a member of the public who was concerned that his employer was contacted by a staff member after his brother was taken to hospital with suspected Covid -19

We explained we would not expect ambulance staff to specifically contact relatives or employers but that they encourage patients to self-inform any necessary party y. As remedial action, feedback was offered to the crew about their obligations in sharing information.

4. Complaint from patient's grandson that the attending staff advised the family to arrange a taxi to take the patient to hospital

We explained that whilst we encourage patients to travel independently where it is safe to do so, given the patient's age, frailty and clinical presentation and that she was already on board the ambulance, it would have been appropriate and more compassionate for the crew to take her. We asked the crew to meet with a Clinical Team Manager to reflect on these considerations.

5. Complaint from patient's wife that the attending staff did not appear to be adhering to Covid-19 compliance measures and the unhelpful comments made by the crew



Our guidelines at the time indicated that the ambulance staff did not wear adequate PPE. We asked that the crew were offered clarification about this and to be mindful of the language they use in engaging with patients and relatives.

6. Complaint from the patient that an ambulance was arranged via NHS 111 without his being informed following a possible overdose and that one of the attending ambulance crew was aggressive in manner

We explained the obligation on NHS 111 to arrange a 999 response in these circumstances but it was clear that the relationship between the patient and the crew broke down almost from the outset. We found that the ACP at NHS 111 should have consulted Toxbase and passed more details to the crew. When the crew arrived, they might also perhaps have better explained that they only had a very limited knowledge of events. Once again, we arranged for feedback to be offered to all those involved and an anonymised account will be published in 'Insight' to widen the learning

7. Quality Alert. Allegations of inappropriate use of the Emergency Department for an aggressive, homeless patient

The patient had been homeless for over 6 months and had been advised to seek a place of safety at the local Emergency Department by NHS 111 and the Police due to pain in his feet. The ambulance staff explored all the options available to them including contacting Streetlink and our Clinical Hub for further advice.

In the best interest of the patient, the crew took him to the ED. The *Homelessness Reduction Act (2017)* places a duty on public authorities (which includes Emergency Departments) to refer service-users who they think may be homeless or threatened with homelessness to the local authority homelessness unit /housing options teams. For more information, please see: <https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer>

8. Complaint from the family regarding the reluctance to convey and End of Life care patient to hospital

A 999 call was received for an elderly female with dementia who had fallen the previous day but had since experienced reduced mobility and a period of unresponsiveness.

Following their assessment, the crew suspected sepsis. Although the patient did not have an existing Coordinate My Care (CMC) entry, the ambulance crew learned that the patient had a Do Not Attempt Resus (DNAR) in place and was being referred to the palliative care team. The crew discussed the possibilities for the care of the patient with the family who preferred the patient to be taken to hospital.

A complaint was subsequently received from the family who were concerned about the apparent reluctance to convey the patient to hospital. Ambulance staff are expected to consider treatment/management options for the patient, and in particular to consider the least disruptive and potentially distressing option for palliative care patients, especially those with cognitive impairment, this is not always the wish of the patient or their family.

This case serves as a reminder about the sensitivities surrounding End Of Life Care (EOLC) and that ambulance staff should be sensitive to the wishes of the patient and their family at all times, always being clear in their decision making so the patient and their carer/family are left feeling they have done all they can in the best interests of the patient and according to their wishes.



Conclusion and focus:

The next year will focus on ensuring that improvement activity, based on the thematic reviews, will continue. We will also be piloting the Ombudsman new guidance and will be sharing the learning and our experience with all other ambulance services through our key stakeholder groups.

Our work with other directorates on behavioral and cultural aspects of patient care will be one of the key projects of the team in 2021/22.

We will of course strive to meet all regulatory standards, as we have during the year, and provide support guidance and advice to our patients and staff to ensure that the organization continues to deliver high quality care for all.

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