Public Trust Board

Schedule	Thursday 25 May 2023, 11:00 — 14:00 BST
Venue	Prospero House, 241 Borough High Street, London SE1 1GA
Description	Join Zoom Meeting https://us06web.zoom.us/j/84218647375?pwd=VkMwWFhzS2EwamVueWgzNk1ZRzJzZz09 Meeting ID: 842 1864 7375 Passcode: 670566 Dial by your location 0330 088 5830 The United Kingdom 0203 481 5237 The United Kingdom
Organiser	Committee Secretary

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Agenda

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS

11.00am on Thursday 25th May 2023
at Prospero House, 241 Borough High Street, London SE1 1GA and via Zoom

AGENDA

Time	Item	Subject	Lead	Action	Format
1. Opening Administration					
11.00	1.1	Welcome and apologies for absence	Chair	Note	Verbal
	1.2	Declarations of interest	All	Approve	Verbal
2. General Business					
11.00	2.1	Minutes of the Public Meeting held on 28 March 2023	Chair	Approve	Report
	2.2	Action Log	Chair	Review	Report
3. Patient Story					
11.05	3.1	Summary of Patient Story	JM	Inform	Verbal
4. Chair and Chief Executive Report					
11.15	4.1	Report from the Chair	Chair	Inform	Verbal
11.20	4.2	Report from the Chief Executive	CEO	Inform	Report
11.25	4.3	Category 1 Data Quality (to follow)	CEO	Inform	Report
11.35	4.4	Report from the Deputy Chief Executives	Deputy CEOs	Inform	Report
5. Director and Board Committee Reports					
11.45	5.1	Quality and Clinical Care 5.1.1 Director's Report (Quality) 5.1.2 Director's Report (Clinical Care) 5.1.3 Quality Assurance Committee	 JM FW MS	Assure	Report
12.00	5.2	People and Culture 5.2.1 Director's Report 5.2.2 People and Culture Committee 5.2.3 EDI	 DMG AR AR	Assure	Report
Break for Lunch 12.15 to 12.45					
12.45	5.3	Finance 5.3.1 Director's Report 5.3.2 Finance and Investment Committee 5.3.3 Audit Committee 5.3.4 Charitable Funds Committee	 RPa BA RP BA	Assure	Report

1.00	5.4	Corporate 5.4.1 Director's Report	ME	Assure	Report
6.	**Quality**				
1.05	6.1	Quality Report	JL	Assure	Report
1.15	6.2	Quality Account 2022/23	JL	Approve	Report
7.	**Business Plan**				
1.35	7.1	Business Plan – 2023/34	RD	Approve	Report
8.	**Board Assurance Framework**				
1.50	8.1	Board Assurance Framework	ME	Inform	Report
9.	**Concluding Matters**				
2.00	9.1	Any Other Business	All	Note	Verbal
	9.2	Date of Next Meeting – 20th July 2023	Chair	Note	
	9.3	Questions from Members of the Public	Chair	Note	

NB: The full and summary IPR and Quality Report are on the website and in the library in Convene

1. Opening Administration

1.1. Welcome and apologies (verbal)

For Information

Presented by Andy Trotter

1.2. Declarations of Interest (Verbal)

For Approval

2. General Business

2.1. Minutes of the public meeting held on 28 March 2023

For Approval

Presented by Andy Trotter

Public Meeting
LONDON AMBULANCE SERVICE NHS TRUST BOARD OF DIRECTORS
held at 12.30pm. Tuesday, 28 March 2023
Prospero House, 241 Borough High Street, London SE1 1GA and via Zoom

Present		
Andy Trotter	AT	Chairman
Rommel Pereira	RPe	Deputy Chair (in the Chair)
Bob Alexander	BA	Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Karim Brohi	KB	Non-Executive Director
Amit Khutti	AK	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Daniel Elkeles	DE	Chief Executive Officer
John Martin	JM	Joint Deputy Chief Executive and Chief Paramedic & Quality Officer
Fenella Wrigley	FW	Joint Deputy Chief Executive and Chief Medical Officer
Rakesh Patel	RPa	Chief Finance Officer
Damian McGuinness	DMG	Director of People and Culture
In Attendance		
Jaqueline Lindridge	JL	Director of Quality
Mark Easton	ME	Interim Director of Corporate Affairs
Roger Davidson	RD	Director of Strategy and Transformation
Barry Thurston	BT	Director of IT
Victoria Moore	VM	Deputy Head of Corporate Affairs (Minutes)
Apologies		
Anne Rainsberry	AR	Non-Executive Director

1.OPENNG ADMINISTRATION		
1.	**Welcome and Apologies**	
a.	The Chairman welcomed those present to the meeting.	
2.	**Declarations of Interest**	
a.	There were no new declarations of interest.	
2. GENERAL BUSINESS		
2.1	**Minutes of the Previous Public Board Meeting**	
a.	The Minutes of the previous public meeting of the Board held on 31st January 2023 were approved as an accurate record.	

2.2.	**Action Log**	
a.	The action log and updates were noted and accepted as accurate.	
3. STAFF STORY		
3.1	**Sexual Charter**	
a.	The Board had received a presentation relating to a staff story in respect of sexual harassment; the story had been heard in private at the request of the employee.	
b.	The employee, who was a paramedic, shared her story of being subject to sexual harassment in 2022. Whilst the outcome resulted in dismissal, her story highlighted (at the time) that the Trust's processes and practices needed improving. The case was the catalyst for change and the Board heard of how such changes were implemented, noting in particular the launch of the sexual safety charter, the first such charter in the ambulance sector.	
c.	The Board expressed deep regret that a colleague had to go through such experiences and noted the improvements made to date. The Board reinforced their stance on zero tolerance, and thanked the paramedic colleague for sharing her story and her bravery.	
d.	The Board had debated ways in which the Trust could improve further both in terms of education but also processes and practices. A result of this debate had been a number of challenges to be explored and taken to the People and Culture Committee. The outcome of this would be shared at a future Trust Board.	
e.	The Director of People and Culture shared that he had received a message from the member of staff thanking the Board for listening to her story and saying that she felt supported and pleased some good has come out of a terrible situation.	
f.	The board extended their thanks for the bravery in sharing the story and also for the significant role it had played in making our working environment safer for all of our staff.	
4. CHAIR AND CHIEF EXECUTIVE REPORT		
4.1	**Report from the Chair**	
a.	The Chair's report was presented by the Deputy Chair.	
b.	The report recognised the Trust's current challenges, including responding to periods of industrial action, and noted that staff across the Trust had worked hard to provide an adequate service on the strike days and thanked all partners who had helped to ensure the Trust was able to maintain a service.	
c.	Additionally, the Deputy Chair shared that he had visited the LAS offices in Cody Road to visit the Emergency Preparedness, Resilience and Response (EPRR) team. He reported that he had been very impressed with what he saw, particularly the work being undertaken at a national level. The team demonstrated a strong ethos of learning from incidents and the need to continually refresh business continuity planning.	

4.2	**Report from the Chief Executive**	
a.	The CEO presented his report sharing the news that London Ambulance Service was now an accredited Living Wage employer, meaning every member of staff earns more than the Government's recommended minimum wage and will receive a minimum hourly rate of £11.95.	
b.	The CEO reported that since the previous report there had been a further period of industrial action affecting ambulance services across the country, which took place on 11 February 2023. The Board recognised that due to robust planning and a strong working relationship with staff-side colleagues, the Trust was able to respond to our sickest patients in life and limb-threatening emergencies.	
c.	During periods of industrial action the Trust had received support from health and social care partners as well as the military, who volunteered to drive ambulances while our expert clinicians provided care to patients.	
d.	The Chief Executive extended his and the Trust's thanks to everyone who had been part of the response and recognised that these were challenging days and the impact on patients was significant. He noted that unions representing ambulance staff across the country had announced at the end of February that they were pausing further industrial action while they entered into fresh pay talks with the Government. This meant the planned industrial action on 8 March did not take place. The talks had resulted in a potential resolution, with Unison and GMB recommending their members accept the latest pay deal put forward by the Government.	
e.	The Chief Executive also updated on demand and performance recognising that in recent weeks there had been a reduction in the number of 999 calls received, which had led to an improvement in response times to patients. As a result of this, at the start of February 2023 a decision was made to lower the Resource Escalation Action Plan level to 2, indicating 'moderate pressure' on our services. This was a welcome change as it came after a period of sustained and significant pressure on health services across the country.	
4.3	**Report from the Deputy Chief Executives**	
a.	The Deputy Chief Executives presented a summary of their report recognising the revised reporting and assurance structure that had been implemented to ensure continued, safe service delivery throughout the winter.	
b.	Further to the updates provided by both the Chief Executive and the Chair, the Deputy Chief Executives recognised the impact of industrial action and reported that a full operational and clinical plan had been in place to maintain safety for patients and a rapid response to life and limb threatened patients.	
c.	A marked improvement in response times was reported in the period. There was circa 3 minutes improvement in category 1 performance and circa 50 minutes improvement in category 2; compared with December 2022. These performance gains had resulted from a combination of reduction in call volumes, system pressures and continuation of other improvement work.	
d.	Nationally, all Ambulance Trusts had reported improvements in performance during this period, however LAS category 1 performance remained better than the national average and LAS was the second best performing in the country in both months.	

	Category 2 performance improved significantly and was in-line with the England average.	
e.	Hospital handover times improved during January and February 2023. However, 24,151 operational hours had been lost across November and December based on handover times greater than 15 minutes. This equated to a loss of 2,012 ambulance shifts.	
f.	The Trust had continued to support the early release of crews through cohorting arrangements at hospitals and the Board noted that the majority of hospitals had now agreed to LAS cohorting and patient flow initiatives.	
g.	The report also provided an update regarding 111 Call Answering and Clinical Assessment Service (CAS) performance, key issues, events and activities since the last meeting noting that we continue to deliver part or all of 111 call answering and CAS across the five London Integrated Care Board (ICB).	
h.	Finally, the Board noted that the Trust had participated in Exercise Spring Resolve which was a national exercise focusing on the emergency response to a terrorist attack. The Trust's EPRR department spent several months planning for the exercise and on 14th March 2023 LAS was a 'central player' in the London element of the two-day exercise. The exercise included both live play and table top elements, and moved to the North Yorkshire area on the 15th March. Partner agencies included the London Fire Brigade, the Metropolitan Police Service, British Transport Police and Government departments.	
4.4	**Report from the LAS Public and Patient Council**	
a.	The London Ambulance Service Public and Patients Council (LASPPC) was established in 2020 and is one of many ways the Trust engages patients and local communities with its work.	
b.	In line with the LASPPC's terms of reference, the Board received an update from the latest meeting which took place on 15 March 2023.	
c.	At its meeting, the Council had received a short briefing from the Chief Executive on industrial action, performance, hospital handovers, the National Freedom to Speak up Guardians report and achieving accreditation as a London Living Wage employer.	
d.	The Chief Finance Officer had updated members on the emerging estate vision that would be implemented gradually, as the changes would be subject to engagement and funding bids over five years. Members were keen to understand what would happen to plans if funding was not secured and whether LAS was working with other blue light partners	
e.	The Council had also received updates on implementing the Ambulance Data Set from Barbara Pitruzzella, Senior Policy Lead Emergency and Elective Care NHS England. Members had asked questions on data sharing arrangements and data security and had discussed the importance of frontline clinicians having access to feedback on their care.	
f.	The Director of Quality had updated members on the shortlist of Quality Priorities for 23/24, which would be presented to the Trust Board for final approval. The shortlist was produced after engagement with various groups, including the LASPPC.	

g.	The Board recognised the value of the LAS Patient and Public Council and thanked them for their valuable contributions.	
5. STRATEGY UPDATE		
5.1	**Feedback from Patients, Public and Other Stakeholders on the Strategy Development Process**	
a.	Since June 2022, the Trust had been proactively seeking engagement from a variety of stakeholders to inform and shape the development of the next strategy for LAS. The presented paper provided summary of key themes from the engagement process.	
b.	The next step will be to develop the strategy built around the following three missions: • Delivering outstanding emergency and urgent care wherever and whenever needed • Becoming an inclusive, well-led and increasingly skilled organisation people are proud to work for • Using our unique pan-London position to contribute to improving the health of the capital	
c.	The strategy would be finalised and agreed at the June Board meeting.	
d.	The Board recognised the volume and value of information collated and welcomed the proposed approach.	
6. DIRECTOR AND BOARD COMMITTEE REPORTS		
6.1	**Quality and Clinical Care**	
	6.1.1 **Report of the Chief Paramedic and Quality Officer**	
a.	The Chief Paramedic and Quality Officer presented his report noting that the Care Quality Commission (CQC) had launched a new framework for care systems in January 2023. A regulatory action plan had been formulated by the Quality directorate to ensure all key elements of the new framework had been actioned or were in the process of being embedded.	
b.	The Trust continued to be in regular contact with the CQC and had received no further regulatory visits since the system inspection in December 2021.	
c.	Confirmation was provided that the Quality Account for 2022/23 had been drafted and was currently undergoing review. The Report would then come to Board for approval, prior to publication in June 2023. As previously noted, progress on the 2022/23 quality priorities, had been impacted by the implementation of Cleric CAD, the Adastra outage, Industrial Action and high demand. All areas had however made progress.	
d.	A recovery plan for compliance with safeguarding training was shared with commissioners in December and a target compliance with level 2 & level 3 safeguarding training was set at 85%. Following focussed work, level 3 compliance is now above 87% whilst level 2 compliance stands at 79% within 111 (improved from 29%) and 50% in EOC.	

e.	Safeguarding referrals continue at historically high volumes: 6,071 referrals were received in January and February 2023 compared with 4,850 within the same months of 2022 (increase of 25%), showing a rise in reporting from 3.4% of all patient contacts to 5.2%.	
f.	Since the introduction of the Trust's Sexual Safety Charter in February 2022, there had been an increased awareness. A drive to improve education and communications on sexual safety amongst the Trust and within the education team has been implemented along with updated and strengthened guidance relating to professional standards.	
g.	The quarter 3 Freedom to Speak Up report was presented to the People and Culture committee detailing the 93 concerns that were raised to the Guardian. A high volume of concerns raised related to the national announcement of industrial action for ambulance workers as well as the systems and processes utilised during the industrial action period.	
h.	The Guardian is currently supporting the Director of Education with the development of an 'Understanding Bias' programme, due to go live Trust wide during April 2023.	
	6.1.2. **Report of the Chief Medical Officer**	
i.	The Chief Medical Officer presented her report noting that during January 2023 the Trust had experienced a slight decrease in calls per day and face-to-face incidents when compared to December 2022. The Trust, however, continued to experience pressures across the whole Urgent and Emergency Care system.	
j.	As reported in previous updates, pressure was further increased by the periods of industrial action when a different operating model was required to ensure the sickest and most seriously injured patients were receiving a timely response.	
k.	In order to maintain safety during the periods of the Industrial Action, the Trust implemented a clinical safety cell which saw LAS clinicians working alongside senior clinicians from across the NHS. This multi-disciplinary cell provided an expanded clinical skillset and range of specialties which enabled an increased amount of early remote clinical assessment for patients and navigation to alternative care pathways where an emergency ambulance was not required.	
l.	The Chief Medical Officer apologised to those people who waited longer than they should for an ambulance during this very challenging period.	
m.	The Board recognised that the Trust was committed to continuously improving the quality and safety of the care provided to patients. This commitment includes reviewing and learning from deaths that occur in our care.	
	6.1.3. **Report from the Quality Assurance Committee**	
n.	The Chair of the Quality Assurance Committee presented the assurance report noting that the Committee had received a review of the impact of industrial Action on patients and staff that had been developed following a discussion at Board about assurance around the quality of care provided to patients on days of industrial action.	
o.	The review had concluded that whilst Industrial Action had undoubtedly had an impact on the care delivered to patients and their experience, the range of contingency plans, newly developed processes and enhanced levels of senior clinical support and	

	oversight across all operational issues was sufficient to keep patients from serious harm against a backdrop of very challenging circumstances.	
p.	The Quality Committee had approved the proposed quality priorities for 2023/24 for submission to Trust Board for formal approval, noting that they had been developed with the following considerations in mind: progress against the 2022/23 quality priorities, quality intelligence including learning from patient safety incidents, clinical audit and complaints and Trust business plans.	
q.	The Committee also received assurance relating to Right Care Right Place (RCRP) via a presentation on the range of transformation work streams currently underway in the Trust. It was noted that RCRP involved developing different ways of working and would need to be progressed at the right pace. The Quality Assurance Committee had underlined the importance of developing metrics for each of the individual programmes and also of developing an understanding of what success looks like to enable a move from RCRP into standard operations.	
6.2	**People and Culture**	
	6.2.1 **Director's Report**	
a.	The Director of People and Culture noted that the Trust had won the Apprentice Employer of the Year award at the 2023 Annual Apprenticeship Conference, this award celebrates our frontline ambulance apprenticeship pathway. Additionally, the Service had now become accredited with the Living Wage Foundation and LAS is one of few Living Wage Employers amongst London NHS Trusts.	
b.	The results for the 2022 NHS Staff Survey were released on 9 March 2023. The Trust achieved a 62% response rate which was the highest response rate for an ambulance service. The emerging themes would be explored in greater detail at the next People & Culture Committee.	
c.	The work of the Supporting Attendance group continues to focus on two broad areas; firstly, the introduction and embedding of the first day reporting service; secondly, the devising and deployment of directorate focussed improving attendance plans that focus on health promotion, management training and development and employee experience and engagement.	
d.	The first day absence reporting service continues to embed with over 17,000 calls made to the service from September to date. Attendance levels overall have improved since the introduction of the service.	
e.	In March a new management training programme was introduced, Our LAS Our Leaders 100, focussed initially at 100 band 6 and 7 line managers. This leadership development programme will provide the opportunity for managers to learn new skills needed to help progress their career / enhance their leadership portfolios.	
	6.2.2 **Report from the People and Culture Committee**	
f.	The Chair of the People and Culture Committee presented the assurance report recognising that the committee had discussed the significant escalation of industrial action that had been proposed by UNISON. This included notification to take action short of a strike as well as a work to rule over a six-day period commencing on 18th March.	

g.	The initial assessment was that this proposed action, if it occurred as indicated, would have a material impact on LAS ability to provide safe services to its patients. Since the Committee had met industrial action activity had been paused.	
h.	The Committee had received a presentation on recruitment noting that the current projection was that of the 1,387 wte required there would be a gap of 152 wte against plan. The expectation is that the full plan will be delivered in Q2 of 23/24. The shortfall is almost exclusively in paramedic and AAP recruitment and is as a result of lower fill rates in Q1 and Q2 of this year. Fill rates at the current time were much improved and at 94% for paramedics and 99% for AAPs. 111 and 999 call handlers also remain strong with a fill rate of 97%.	
i.	The committee also received an update on employee relations cases. The team had conducted a review to consider how resolution can be more efficient and in particular how to reduce triage times.	
6.3	**Finance** 6.3.1 **Director's Report**	
a.	The Trust had posted year to date surplus of £1.1m as at the end of February 2023 against a deficit plan of £0.4m, a favourable variance of £1.5m.	
b.	The Trust is forecast to invest £31.2m on capital programmes for the year. By the end of February, the Trust had spent £21.2m. This was recognised as £1.8m behind plan, however reassurance was provided that this was concentrated on a few schemes with plans to bring back on track by year end.	
c.	Following fleet update provided to the previous Trust Board members were asked to note that the roll out of new vehicles had continued at pace. The Fleet department had made 152 vehicles available for operational use during 2022/23. A further ten are planned during March. In addition, the Trust had placed orders for 54 Fast Response Vehicles in March. These would be operational in April 23.	
d.	In respect of Estates, the report recognised that work had commenced on the relocation of the 111 call centre from Southern House to Bernard Weatherill House located in the centre of Croydon. The new call centre was due to be operational by August 2023.	
e.	The Board noted that in January, the decision was approved to in-house the Trust's cleaning service and this activity was on track to have a fully in-house service by end of March. Engagement with staff coming to LAS has been positive. 6.3.2 **Report from the Finance and Investment Committee**	
f.	The Chief Finance Officer had presented a paper setting out the financial plan for 2023/24 for submission to NWL ICS on 21st March and to NHSE on 30th March. Members had considered the risks associated with the plan and also the capital and cost improvement programme elements. The Committee recognised the clear coherency of the plan and, notwithstanding its identified risks, supported submission to NWL ICS and recommending that the Board approve submission to NHSE on 30 March 2023	

g	The Committee had received a presentation from the Emergency Operations Centre (EOC) transformation programme recognising the progress against the plan, the recruitment intentions and the importance of ensuring that alongside financial investment, cultural change was embedded to ensure that best practice improvements are implemented effectively.	
6.4	**Corporate Affairs – Director's Report**	
a.	The Director of Corporate Affairs reported that between November 2022 and February 2023, 383 formal complaints were received (compared to 392 in November 2021 – February 2022). In the same period, 564 complaint investigations were completed and assurance was provided that there had continued to be a significant reduction in the number of overdue complaints	
b.	Delay was the theme involving the highest number of complaints in the period (including delay in an ambulance attending and delay in 111 call backs), followed by conduct and behaviour, 111 call handling and non-conveyance (which includes referrals to NHS 111). This is consistent with the previous reporting period.	
c.	Complaint themes are fed through to the Safety Incident and Assurance Learning Group (SIALG). The team continue to follow the guidance from the NHS complaints standards designed by the Parliamentary and Health Service Ombudsman (PHSO) by attempting to provide 'early resolution' on specific complaints that meet the criteria.	
d	In relation to inquests it was reported that 424, Level 1 Inquests and 15, Level 2 Inquests had been Level 1 Inquests had been opened since January 2023.	
e.	In relation to the Data Security and Protection Toolkit (DSPT), the Board noted that of the 113 mandatory assertion evidence items included in the DSPT, 68% have either been completed or are near completion, which is a 23% increase since the previous report.	
f.	The DSPT requires that 95% of all staff are compliant with mandatory Data Security and Awareness Training. It is also required that the Trust only count staff who have been trained within the last twelve months towards the 95% compliance target. The Trust is currently reporting a 60% training compliance level which is an increase of 13% since the previous report. Although the current percentage is below the target trajectory, the IG team are confident this will increase and reach target by the end of the month. This will be facilitated by an increase in reporting supplied by the workforce team and increased reminders to all staff.	
g.	Interest in the work of the Trust remains high and this is reflected in the number of information requests received. During the 2021/22 year, the Trust received 483 requests under the Freedom of Information Act 2000. In the period April 2022 to February 2023, the Trust has received 483 requests, equivalent to a monthly average of 44 requests. January 2023 saw a peak of 67 requests received in month.	
h.	These requests relate to a broad spectrum of questions including response times, hospital handover delays, the impact of industrial action, fleet and Trust spend and procurement. Of the 483 requests received in the period April 2022 to February 2023, 69% have been completed within the statutory deadline.	

7. QUALITY		
7.1	**Quality Report**	
a.	The Director of Quality presented the Quality report which related to January 2023 data. The report continues to demonstrate the impact of prolonged demand on quality of care. This impact remains closely monitored through various quality and safety assurance mechanisms including robust quality visits as well as daily and thematic reviews of patient safety incidents resulting from delayed responses.	
b.	Following a rise in no harm incidents, it was noted that in January there had been a return to normal variation. The top 3 no harm categories in January 2023 remain the same with Medical Equipment, Dispatch & Call (although significantly decreased) and Clinical Treatment.	
c.	Infection Prevention and compliance across the Trust remains positive with high compliance rates (=>95%) across a variety of KPIs. The report highlights that vehicle prep deep clean compliance has fallen below the Trust's expected target of 95% and requires monitoring	
7.2	**Quality Priorities 2023/24**	
a.	The Director of Quality introduced the Quality Priorities for 2023/34, noting that a number of quality priorities had been identified.	
b.	In order to shape the priorities for 2023/24 consideration had been given to the following: • Progress against the 2021/22 quality priorities • Quality intelligence, in particularly learning from patient safety incidents, clinical audit and complaints • Trust business plans and our emerging 5 year strategic intentions	
c.	The proposed priorities arise from a shortlist of eight priorities which were prepared by the Quality Priorities Task and Finish Group, which were then discussed with the Patient and Public Council and the final shortlist of five priorities was recommended approval.	
e.	The Board discussed the priorities as presented, recognising the work undertaken to identify and develop them and approved them for implementation.	
7.3	**Patient Safety Incident Response Plan**	
a.	The LAS became an early adopter of the PSIRF in 2021. The PSIRP presented to Board had been developed around triangulated quality intelligence and a number of changes to the local priorities were proposed. This included increasing the focus on the care of people aged 65 years or older who have fallen as well as other incidents relating to patients at the extremes of age, and a focus on cardiac arrest management to include unrecognised oesophageal intubation and recognition of cardiac arrest, alongside our existing priority of delayed defibrillation.	
b.	The Board recognised that the PSIRP should be considered a 'living document' and it recognised that local priorities may change in response to patient needs. It was proposed that the plan should be formally reviewed after a period of 18 months and	

	confirmation was provided that the document presented used the new template recommended by NHS England.	
c.	The Board noted the PSIRP as presented and supported its adoption.	
7.4	**Risk Management Strategy and Policy**	
a.	The Board received the Risk Management Strategy and Policy for approval.	
b.	The main changes to this version of the policy were summarised for members and included: a Risk Management statement (at the beginning of the document), updates to reflect changes in management structure and the inclusion of a risk management maturity and effectiveness process to be used as indicators for success.	
c.	Following feedback from Audit Committee and Trust Board, the roles and responsibilities have been reviewed and updated and the policy had been approved by the Risk Compliance and Assurance Group and the Executive Committee.	
d.	The Board recognised the changes in the policy and approved it for adoption.	
8. BOARD ASSURANCE FRAMEWORK		
8.1	**Board Assurance Framework**	
a.	The Director of Corporate Affairs presented an updated version of the Board Assurance Framework that incorporated comments and feedback from Board Assurance Committees.	
b.	Changes to current risk ratings since the BAF was last reviewed by the Board were as follows: • Risk 1B – Relating to the development of UEC - risk score has been lowered in light of recent government policy which provides greater assurance that the focus of non-elective care, and investment in ambulance services will continue to be a high priority. • Risk 1C – Relating to industrial action – risk score reduced in light of the new pay offer. • Risk 3A – Relating to a Single Clinical Assessment Model: following feedback from the last Board, the risk description has been re-drafted to make a clearer distinction between issues (the conditions we operate under) and the risks.	
c.	The Board noted that a new risk had been added to the BAF relating to equipping the operational fleet with MDT's.	
d.	The Board was asked to note that the following risks were in development:- • A risk relating to the ability to recruit sufficient staff and acquire assets in time to realise the target improvement in Category 2 and call answering performance required to benefit from the £25m central investment allocation • A risk relating to 'getting the basics right' - staff having access to the full range of equipment that is in full working order to meet the 2023/24 expectation that there would be zero tolerance in terms of crew not having the medical equipment that they need.	

8. CONCLUDING MATTERS		
8.1 a.	**Any Other Business** There were no items of other business raised.	
8.2. a.	**Date of Next Meeting** The next public meeting of the Board would be held on 25 May 2023.	
8.3 a.	**Questions from the Public** There were no questions presented from members of the public.	

2.2. Action log

For Discussion

Presented by Andy Trotter

ACTION LOG – 25th May 2023 PUBLIC BOARD

Meeting	Action	Lead	Due	Update
	No outstanding actions.			

3. Patient Story

3.1. Patient Story

For Information

Presented by John Martin

4. Chair and Chief Executive Reports

4.1. Report from the Chair (verbal)

For Information

Presented by Andy Trotter

4.2. Report from the Chief Executive

For Information

Presented by Daniel Elkeles

London Ambulance Service NHS Trust Board meeting 25 May 2023

Report from the Chief Executive Officer

I would like to begin my report by congratulating King Charles III and Queen Camilla on their Coronation. The Bank Holiday weekend at the start of May was a momentous occasion for our nation. For us at the Service, it was more than just a celebration. The additional visitors and crowds to the capital meant we needed to mobilise extra staff for support at treatment centres, have teams out on foot, on bicycles and working throughout the event footprint to help make sure people could mark the occasion safely. Our fantastic Emergency Preparedness Resilience and Response team once again worked alongside multi-agency partners to ensure the Service was ready for the challenge. We had over 200 additional frontline staff on duty working alongside St John Ambulance to provide medical care within the event footprint, with 65 additional command and event control room staff also giving up their bank holiday weekend to work.

I spent the day shadowing one of our Bronze Commanders stationed in St James' Park, Peter Swan, and it was an absolute honour and a privilege to witness this all first-hand. Every member of Team LAS I met did us all proud, and I would like to say a huge thank you to everyone working over the bank holiday and those who helped to plan our response in the days and weeks ahead of it.

Industrial action update

After months of negotiations, planning, and periods of strike action, I was pleased the NHS Staff Council – which represents more than one million NHS agenda for change staff in England – met in May to make a decision on NHS pay. The majority of NHS staff and their unions, including UNISON and GMB, voted to accept the pay offer.

I know taking part in industrial action was not a decision any of our team members took lightly. The agreement by the NHS Staff Council means our staff will see an uplift in their pay this summer and we as an organisation can move forward in improving working lives, achieving our ambitious strategy and keeping that sharp focus on outstanding patient care.

I am really proud of how we at the Service worked together throughout this challenging period and think we can say with confidence that our values of respect, team work, and caring, really shone through. However, we will not be complacent about levels of staff morale and will continue all of our work to improve our culture and working lives.

Demand and performance update

Improvements in our response times and lower calls volumes meant we were able to remain at REAP (Resource Escalation Action Plan) level 2 between February and the start of May. However, higher than anticipated demand over the first May Bank Holiday weekend and an uplift in demand meant that we have now escalated to REAP 3 to help us bring down our response times. Our latest performance data covering April is available on the NHS England website.

At the time of writing, the report into the findings of the independent review we commissioned in conjunction with NHS England and our commissioners in North West London regarding our data reporting, was being finalised. We will be discussing that report at today's board meeting (Thursday 25 May) and adding it to our Board papers at the same time.

I would like to take this opportunity to thank all of our colleagues who worked over all our bank holiday weekends in April and May. I know many people who were working would have missed out on a special occasion with their loved ones, in particular, because, for the first time in more than 30 years, Easter, Ramadan and Passover all coincided. I am therefore especially grateful for the commitment our teams showed over this period.

Demand for our services over these periods was, as expected, high, with the added challenge of strike action taken by the Royal College of Nursing from 8pm on Sunday 30 April to midnight on Monday 1 May. I would like to thank our teams for their hard work to ensure the delivery of emergency healthcare to the capital.

Following that weekend, we also received thank you letters for our teams from leaders across the system including Chief Nurse of NHS London Jane Clegg, Director of Performance NHS London Martin Machray, the Chief Executive of Guy's and St Thomas' Professor Ian Abbs, and the Executive Medical Director of North Central London ICS Josephine Sauvage.

In April, the capital hosted the 49,500 competitors taking part in the London Marathon, and our teams worked hard to provide care for the runners and spectators. I was pleased to visit the joint control room for the event at our Emergency Operations Centre (EOC) North, where teams oversaw the more than 1,500 people on duty across the Service and St John Ambulance for the event. I also visited teams at the six treatment centres along the 26.2 mile route and was hugely impressed with their work. With over 380 people treated in these centres, thankfully only 39 people across the footprint had to be taken to hospital.

As we moved to the start of a new financial year in April, it was important for us to reflect on all that we have achieved during what was an incredibly busy year in 2022-23. From 1 April 2022 to 31 March 2023, there have been:

- More than two million 111 calls answered across all five London contracts, subcontracts and partners.
- Two million 999 calls, with almost 71,000 of those related to mental health issues.

- More than 970,000 incidents attended face-to-face, with almost 51,000 of those related to mental health issues.
- More than 5,000 incidents attended by our Hazardous Area Response Team.
- More than 3,000 incidents attended by our Joint Mental Health response team.
- More than 2,000 incidents attended by our Community Response Cars, which is all the more impressive as the service only started in October.

These figures show the enormous difference our dedicated teams of staff and volunteers make to our patients, as well as the impact that some of our newly introduced programmes of work are already having for people across London.

I'm delighted we are continuing to make progress on realising the ambitious aims of our five-year estates strategy. Work to fit out the fifth floor at Bernard Weatherill House in Croydon is gathering pace as we look to move our Integrated Urgent and Emergency Care team to this modern facility, which will be much better suited to delivering our service to the capital and to our colleagues who will work there. Alongside this, we have also recently submitted a planning application to expand our Brent ambulance station to accommodate space for five extra ambulances and three fast response cars.

Newly completed improvements to our Tactical Operations Centre at our Waterloo HQ will further support our work to provide the highest quality care for our patients. The site – which has oversight of all our 999 and 111 operations and is the hub where we manage our response to any incident that is declared – has received significant IT and communications upgrades to improve our resilience alongside improvements to working conditions for our members of staff.

In steps that will further support our work, I am also delighted the first of our brand new, state of the art ambulances have now arrived at the Service. These ambulances have been specially designed for us with the input of over 400 frontline team members. The first of their kind in England, these vehicles are lightweight, greener and more efficient to help us meet our sustainability ambitions. 132 of these brand new vehicles will be in operation across the capital by the end of May next year.

We are also shortly receiving 35 new electric Mustang Mach-E cars, which will complement the seven of these iconic vehicles that we already have in operation. I am very pleased that this will mean the Service has the biggest fully electric fleet of fast response cars in the country.

I am also pleased the Service is one of the partners in the new Adult Critical Care Emergency Support Service, which began transporting critically-ill patients between hospitals at the start of April. Working alongside Barts Health, St George's and Imperial NHS hospital trusts, we are making available a fleet of specialist ambulances on standby in the capital so the sickest patients who need expertly-tailored care at a specialist hospital can be safely moved between local hospitals and specialist centres. By working in partnership with our NHS colleagues, we are ensuring that our sickest patients get the best possible care.

It is always important for us to engage with our stakeholders to explain the situation in the capital, promote collaborative working and share learning and best practice. I was therefore very pleased to welcome the new Chief Executive of NHS Providers, Julian Hartley, with his team to our Waterloo HQ in March. This was a great opportunity for us to showcase different areas of the Service, with the group seeing how we're expanding our fleet to include more green vehicles, how we stock those vehicles to make them ready to be deployed, and how our emergency operations centres work.

Julian wrote a blog about his visit, in which he reflected that he had been 'immediately struck by the sense of pride and commitment to serve patients whenever and wherever they need help'.

Supporting our colleagues

In my last report I was very pleased to share the excellent news that the Service is now an accredited Living Wage employer, meaning every member of our staff earns more than the Government's recommended minimum wage and will receive a

minimum hourly rate of £11.95. We achieved this after we bought 90 members of cleaning staff in-house to join the Service family.

Across the last two months, our Chief Finance Officer, Rakesh Patel, and I have been pleased to attend all the induction sessions for our cleaning team. This meant we could personally welcome the cleaners to the LAS Family.

To mark the first anniversary of the Service bringing our Make Ready Teams in house, in March I joined colleagues at the Ilford Make Ready hub where I had the chance to see the team in action, learn what goes into preparing an ambulance and got stuck in to cleaning a vehicle. Our Make Ready teams take great pride in their work and, from the conversations I had with them, it is clear that the move in-house has helped them feel their skills and expertise are valued by the Service.

We are continuing to expand our Teams Based Working initiative, where locally agreed plans see teams and managers work the same shift patterns so they have more meaningful contact and measures such as new rotas introduced to deliver a better work life balance for staff and help colleagues develop as a team. Our Oval Group was the first to go live with the initiative and after two months 99% of staff there say they are pleased with the change, feel part of a team, morale has increased and access to their line manager is much easier. We have now gone live with Team-Based Working in four groups across London, meaning more than 800 staff are now feeling the benefits of this new approach.

To further help our teams shape and improve their working culture, in April I asked our staff and volunteers to let us know the basic issues they thought needed fixing at work and how they would prioritise them in order of importance. The near 400 team members who took part gave us a clear steer for future action and we will be co-creating action plans with our teams around each of the top issues.

We are investing in leaders across the Service through the Our LAS, Our Leaders 100 programme, which officially launched in March. 163 of our band 6 and 7s have come together for the first step in achieving a NVQ level 6 course provided by Middlesex University and I was delighted to attend and open the session.

At the end of April we were pleased to celebrate the end of Ramadan with our Muslim colleagues and wish them Eid Mubarak. More than 1,500 barfi sweets were given out and enjoyed by our teams and I would like to thank our Diversity and Inclusion team for arranging the gesture and the Wellbeing team for handing all the packages out. I was also honoured to join the National NHS Muslim Network's celebration of Eid Al-Fitr in May, after I was invited by Shohail Shaikh, who works in our Organisational Development team and is also one of the co-chairs of our Muslim network.

In March I was pleased to sign a commitment to honour the pledges of our See Me First campaign, where colleagues commit to race equality to support LAS being a fully inclusive organisation. Wearing a badge to show that we have made this commitment is a visible demonstration that we are united against racism and discrimination and will treat all staff with dignity and respect.

In April, I had the pleasure of opening a Trans+ awareness event hosted by the Association of Ambulance Chief Executives, as part of their 'uncomfortable conversations' series. Ahead of the event, I sat down with members of our LGBT+ network, including Trans+ members of staff, and heard about their lived experiences. From broad cultural and societal issues, to practical concerns for our Service, it was clear to me that we have lots to do to build understanding, awareness and visibility of Trans+ and non-binary rights. I am very proud that the Service's LGBT+ Network are developing a new Trans+ Support Group within the network to provide peer-support, discuss Trans+ specific issues and strengthen their voice within the LGBT+ Network.

Remembering those we have lost

As part of the National Day of Reflection in March, we held a ceremony at our Waterloo HQ and a minute's silence to pay tribute to those who lost their lives during the COVID-19 pandemic. This is an important time for people across the UK to remember those who have died and to support those who have been bereaved.

I was very proud that our motorcycle paramedic Richard Webb-Stevens represented the Service at a special event at the Trees of Life Glade at the National Memorial Arboretum to remember those who died during the COVID-19 pandemic. The trees also honour the bravery and dedication of the NHS staff and key workers who served in the COVID-19 pandemic such as Richard.

I also wanted to pay tribute to Steven Tougher, a paramedic in Australia who was killed in April while taking a break during his shift. This was a truly horrific incident. We have formally written to the leaders of New South Wales Ambulance service to express our condolences and make it clear we stand in solidarity with all of them.

Celebrating our colleagues

I am very proud of our staff and volunteers and am always delighted to see how many thank you messages we receive from members of the public for the exemplary care they have received from our teams.

Since my last report, we have received 41 new thank you messages for more than 109 members of staff and volunteers. When information provided by patients makes it possible, we share these messages directly with the colleagues mentioned.

Year	Month	Total number of letters and emails received	Financial YTD	Staff and volunteers recognised	Financial YTD
2023	January	125	1211	344	3152
2023	February	52	1263	179	3331
2023	March	50	1313	136	3467
2023	April	41	41	109	109

In further recognition of the exceptional work being done by our teams, I was delighted that nine MPs from across the capital nominated our Mental Health Joint Response Car and Community Health Joint Response Car teams for awards at the NHS Parliamentary Awards.

The high quality care provided by our staff and volunteers across the Service has again been in evidence over recent months thanks to the huge number of media stories about their outstanding dedication and expertise.

Among these were twins Angie Mills, a 999 call handler, and her brother Steve Mills, an emergency technician, who saved a life of a patient whose heart unexpectedly stopped beating while they were on a shift together. Their remarkable story of teamwork and professionalism was covered in the Evening Standard, BBC One's London News and multiple local news outlets, while both Angie and Steve were also interviewed by Eddie Nestor on BBC Radio London.

I also want to thank our emergency medical technician, James Sweeney, who - as part of World Autism Day in April - shared his story about his difficult childhood before he got an official diagnosis for autism six years ago. I am thrilled that with a few adjustments we were able to support James to do his job to the best of his ability. James' story was featured in the Evening Standard.

I was delighted to hear about five-year-old Zaynab who helped her mum Samina make a full recovery from a debilitating migraine after calling 999 when she collapsed. I was really pleased to see Zaynab reunited with our call handler Natasha, who answered the 999 call, at the Waterloo HQ. Zaynab also met our Chief Medical Officer, Dr Fenella Wrigley, and our Director of 999 Operations, Stuart Crichton, who presented her with a certificate honouring her bravery. I was delighted to meet Natasha and congratulate her on a job well done – the way she handled the call was exemplary. You can listen to a clip of the 999 call to hear just what a remarkable job Zaynab and Natasha did.

I was also very pleased to hear about teenager Joel who was reunited with the Service crew medics at St George's Hospital who saved his life after he suffered a cardiac arrest outside Twickenham Stadium in 2021. LAS team members including Eliza, Josephine and Lee Emmet, a paramedic and training officer who had arrived at the sports venue to train new LAS recruits joining its hazardous area response team, did a remarkable job to help save Joel's life.

In March, I was pleased to see that London Mayor Sadiq Khan wrote to our Paramedic Charlotte Miller to commend her for bravely waiving her anonymity and speak out after she was sexually assaulted on duty. Charlotte did this to encourage colleagues to report if they're subject to such unacceptable behaviour, and to make it clear that any assault on Service staff will not be tolerated.

I am pleased that in April we welcomed Melissa Mead from the Sepsis Trust to our Waterloo HQ as we unveiled a suite of four ambulances decorated with information about the symptoms of sepsis, also known as blood poisoning. The four ambulances travel around 120 miles every day and we hope they will raise awareness of the condition as they respond to emergencies around the capital.

In the same month, brave team members including our Chief Medical Officer, Dr Fenella Wrigley, abseiled from the ArcelorMittal Orbit sculpture in Stratford's Queen Elizabeth Olympic Park to raise money for our very worthy London Ambulance Charity. I was pleased to go along to give some support to the team who raised a total of £8,852, which is an amazing achievement.

We also had had nine runners taking part in the London Marathon in April, raising a fantastic £7,408.13 (including Gift Aid) for the London Ambulance Charity. I am in awe of your determination to complete the 26.2 miles.

This came after a team of us – including myself and our Chief Paramedic and Quality Officer, Dr John Martin, ran the London Landmarks Half Marathon in April. Between

the 18 of us who took part, we raised more than £8,000 for our fantastic London Ambulance Charity.

Finally, I was thrilled that our apprenticeship scheme won another national award in March at the AAC Apprenticeships Awards. We're rightly very proud of our scheme and of all the paramedics who pass through it to join our crews.

4.3. Category 1 Data Quality

Presented by Daniel Elkeles

Report Title	Category 1 Data Reporting		
Meeting:	Trust Board		
Agenda item:	4.3	**Meeting Date:**	25 May 2023
Lead Executive:	Daniel Elkeles, CEO		
Report Author:	Mark Easton, Director of Corporate Affairs		

Purpose:				
	x	Assurance	x	Approval
	x	Discussion		Information

Report Summary

The NHSE/LAS/NWL steering group overseeing the investigation by Verita into the Category 1 misreporting incident has released the report. The irregularity in the data was spotted by the LAS after the implementation of our new computer aided dispatch system.

The report has concluded that a data coding error led to the misreporting of some Category 1 calls from August 2020 until the introduction of a new computer aided dispatch system in September 2022. The error was picked up by an LAS executive and reported to NHSE.

The error meant that for 9 of the 25 months in question the LAS erroneously reported itself as compliant with the C1 target response of 7 minutes, when it was not. During the period LAS survival rates for conditions such as cardiac arrest were comparable to other ambulance services. The investigators have concluded that it is not feasible to review the 225,000 patient records to determine harm and have seen no evidence to suggest patient harm arising from the coding error.

The report identifies weaknesses in LAS governance and culture which led to the error arising and remaining undetected. It was concluded that the error was a technical mistake, not one of integrity.

A series of recommendations have been made to improve data governance and a draft action plan has been devised to address all of the recommendations, many of which are already completed. The Board has agreed to establish an assurance committee covering digital strategy and data quality to oversee the implementation of the improvements required.

Recommendation/Request to the Board:

The Board is asked to consider the report and action plan and agree to the proposed action.

Routing of Paper i.e. previously considered by:

NHSE/LAS steering group and action plan discussed at ExCo.

Corporate Objectives and Risks that this paper addresses:

Data quality is a fundamental building block of good governance. Data quality appears in the BAF as a risk with a score of 15.

Independent review of the circumstances and outcomes surrounding the misreporting of London Ambulance Service performance data

A report for
London Ambulance Service NHS Trust / NHS England

May 2023

Authors
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1. Executive summary

Introduction

1.1 The London Ambulance Service (LAS) implemented a new Computer Aided Dispatch (CAD) system in September 2022.

1.2 LAS observed a significant deterioration in reported performance between the ambulance response times produced by the outgoing system and those produced by the new system. This could not be attributed to any 'bedding in' issues with the new system.

1.3 Systematic analysis by LAS staff identified that the issue first arose in August 2020, and had continued until the implementation of the new system surfaced it.

1.4 The cause of the data discrepancy was identified as a change in the programming code used to extract data from the CAD system and load it into a data warehouse. This change in code was implemented on 19 August 2020. It affected only Category One cases.

1.5 This was of concern to the LAS executive team, as the response times to Category One incidents – life-threatening cases that require that most rapid care – is a key performance metric for ambulance services. LAS had reported incorrect performance data to NHS England and that had in turn, been published in ambulance trust comparative performance reports.

1.6 This report addresses questions in three areas:

- What, specifically, happened in August 2020 to trigger the change of code, the organisational circumstances in which this occurred and what structures and processes were in place at the time to govern and control such activities?
- The effect of the coding error – how great was the magnitude of the misreporting?
- Did any patient harm result from the misreporting?

Part one – Organisational context and the coding error

1.7 In 2015, LAS was placed in special measures – the first ambulance trust to be in this position. A new Chief Executive was appointed in mid-2017 to address the issues that led to the special measures. They were successful in this objective, with steadily improving inspection ratings in 2017-18.

1.8 There was tension between executives and through the wider organisation in this period and into the early 2020's. The environment was widely described as 'siloed', with tension apparent between clinical and operational functions.

1.9 In early 2020, the Covid-19 pandemic placed the organisation under unprecedented strain. The pandemic response became the predominant focus of the organisation.

1.10 In August 2020, the CAD system in place in LAS was ageing, but properly maintained by a pool of substantive staff. The software used to transfer data from the CAD into the data warehouse for reporting purposes had a limited pool of individuals - often contractors – able to maintain it and make any required changes.

1.11 A routine change in the guidance regarding ambulance reporting protocols was received by the trust some time in August 2020. It is not clear by whom or how this was communicated. This change in guidance required a change in the programming of the interface software between the CAD and the trust's data warehouse.

1.12 A single developer wrote and deployed the new code. The revised guidance was meant to increase the time allowed before the 'clock start' of Category One calls from 30 seconds to 240 seconds, but only when these calls came in from healthcare professionals (HCPs).

1.13 Rather than the small number of HCP calls that legitimately fell under the revised guidance, the code applied the 240 second allowance to all Category One calls. This meant that calls received by the trust, triaged as Category One, could have an error of up to 210 seconds (three minutes 30 seconds) - the difference between the standard 30 second allowance for all 999 calls and the 240 seconds that should only have applied to HCPs.

1.14 This reporting error started on August 19 2020 and continued, undetected, until the implementation of the new CAD system in September 2022 triggered a detailed investigation of historical data in November 2022.

1.15 The working practices of the team responsible for the maintenance of the CAD in 2020 lacked basic aspects of good governance, and the absence of checks and balances to document, monitor and quality control system changes such as that made in August 2020.

1.16 Data assurance processes were unclear. Data quality policies and risk management policies were not aligned.

1.17 In March 2020, LAS's internal Data Quality Assessment Team (DQAT) team produced a report that identified the issues that led to the coding error of August 2020. It was not acted on, representing a missed opportunity for the trust to have avoided the misreporting. It is likely that an internal audit report that provided 'significant assurance' on data quality contributed to the lack of follow-up on the DQAT report.

1.18 The 'direction of travel' under the new executive team appears to be a good one, with issues of the past acknowledged and with actions being taken to address these issues.

Part two – Magnitude of the reporting error

1.19 Verita analysis has calculated the monthly reporting error for Category One performance as a range from 42 seconds below actual in November 2020 to a maximum of 77 seconds below actual in July 2022.

1.20 In most of the 25 months for which the incorrect code was applied, the underreporting of actual performance was less than one minute. The analysis showed that, for the majority of cases, the Category One clock start was not the (erroneous) 240 seconds, but rather one of the other triggers applicable under NHS England guidance.

1.21 In nine of the twenty-five months that the incorrect code was active, LAS had incorrectly reported compliance with the 420 second (seven minute) Category One response target. In reality, their underreporting had taken the average response time beyond seven minutes in each of those nine months.

1.22 Our data analysis identified a question as to whether nationally reported Category One ambulance trust data is genuinely comparable as a result of different call triaging approaches in use. This may be compounded by bespoke modifications to 'off the shelf' CAD systems and the use of data warehouses.

Part three – Patient harm

1.23 There is no suggestion that ambulance crews acted inappropriately in the period that LAS misreported its data. The response to calls was as rapid as possible.

1.24 The key issue is that if LAS executives had known that Category One performance was worse than they were reporting, would they have taken steps to improve this and would those steps have been effective given the prevailing effects of the pandemic on the organisation?

1.25 We examined LAS data on out of hospital cardiac arrest (OHCA), a condition with extensive research and credible literature showing a relationship between ambulance response time and patient outcome.

1.26 For the period in which LAS was misreporting, we have records of over 225,000 calls triaged as Category One. It is probable that if LAS performance had been more rapid, the outcomes for some of these patients would have been improved, but establishing a direct relationship is complex and uncertain.

1.27 Survival rates for LAS cardiac arrest patients over the period is in line with other ambulance trusts.

1.28 Any attempt to identify potential harm would require detailed clinical consideration of each of the 225,000 Category One cases. The identification of individual patients that may have been harmed would be speculative.

1.29 We believe that the significant amount of expert clinical time and the associated cost cannot be justified in the pursuit of an uncertain outcome, particularly as we have seen no evidence of patient harm resulting from the coding error.

2. Introduction

2.1 In September 2022, the London Ambulance Service (LAS) implemented a new Computer Aided Dispatch (CAD) system – Cleric – to replace a legacy system – Command Point. Cleric is specifically designed as an ambulance control system. It is used in several UK ambulance trusts, whereas Command Point had been used only by the LAS and was not originally designed as a CAD system.

2.2 As a normal part of the implementation process for Cleric, data was processed through the system as a means to establish that the new solution was operating effectively and accurately.

2.3 With the implementation of any new and complex system, a degree of disruption and some anomalies in the data would be expected, but it was observed that the response times calculated by Cleric were, on a monthly aggregate basis, longer than those reported by LAS over an extended period under the previous system.

2.4 These discrepancies could not be readily explained, and were greater than the 'noise' that is regularly observed in large data sets when they are interrogated by a different system in a slightly different way.

2.5 Further systematic analysis by LAS staff identified that the discrepancy appeared to emerge in August 2020. The issue appeared to be centred on Category One patients (the patients with the greatest need of a rapid response, with an ambulance response time target of seven minutes). LAS has historically reported the fastest Category One response times in the country.

2.6 Given that the key metric of performance for ambulance trusts is their response times, this was of great concern to LAS.

2.7 The current Chief Executive of LAS reported the potential data issues to NHS England and commissioners as soon as they became apparent.

2.8 It was agreed that an independent review of the issue would be appropriate. This was commissioned by LAS in partnership with NHS England and its commissioners.

3. Terms of reference

3.1 The purpose of the review is to determine:

- What occurred?
- What the governance processes were for the change? (The apparent modification of the Command Point code governing the clock start times for Category One patients).
- What the implications were for data reporting?
- Whether any patient harm occurred as a result?
- To establish any further action required to give assurance on data quality and integrity.
- Whether there are any other issues in the ambulance response data other than the one relating to August 2020.

3.2 The aim of the Verita review is to answer questions in three key areas:

- The circumstances surrounding the modification of the Command Point code governing clock start times for Category One patients in August 2020 and the ramifications of this on the integrity of reported data.

- Did these code changes have any material effect on the safety of patients under the care of the LAS in the period August 2020 to September 2022?

- In addition, the Verita team has the remit to investigate and report on any additional areas of concern to the London Ambulance Service that might emerge over the course of the assignment.

3.3 This investigation has no disciplinary or regulatory remit.

4. Approach to the review

4.1 The review was undertaken in private. This consisted of interviews with 21 key individuals, some currently active within the trust and others who had left the trust but were material to the events at hand. Numerous other discussions with those involved were undertaken during the course of the work.

4.2 Formal interviews were conducted with every individual who had been identified as relevant and who agreed and was available to participate. We met most people in the scope of the investigation in person, rather than remotely. A small number of discussions were carried out via Microsoft Teams.

4.3 All of the discussions were recorded, and interviewees were provided with a typed transcript of the conversation. The transcript and recording of the discussions are private to the investigation team other than where we need to include what they have told us in this report. Interviewees were asked not to discuss their interview with others.

4.4 Interviewees were offered the opportunity to comment on the factual accuracy of their interview transcript and to make any amendments they felt necessary or appropriate.

4.5 Multiple sources of other information and evidence were gathered and assessed. This included trust policy and procedural documents, trust board minutes, committee and sub-committee minutes, internal and external audit reports and a range of other documentation set out at Appendix 1.

4.6 In addition to documentary evidence, we collected and analysed a database of all Category One calls received by the trust between January 2018 and December 2022. This contained no patient-identifiable information, but rather operational data on when calls were received and the nature and timings of the response to these contacts.

4.7 In this report we do not name individuals, but rather make reference to broad roles within the organisation. No purpose would be served by naming individuals and, as stated, there is no disciplinary remit within the scope of this work. All of our interviewees participated voluntarily and with the assurance of anonymity wherever possible in order that we received their open, honest opinions.

4.8 We identified no instances of any wilful wrongdoing on the part of any individual connected with this case that would merit any disciplinary action on the part of the trust.

Structure of the report

4.9 The report is divided into three main sections.

4.10 Part one discusses the 'how and why' of the implementation of the incorrect coding to LAS's CAD system in August 2020. It highlights both operational and cultural weaknesses that provided the conditions in which such an event was able to occur.

4.11 Having established how the error was introduced, part two of this report assesses the magnitude of the Category One misreporting between August 2020 and September 2022. A key question for the trust is how, after having been introduced, the error was not identified and rectified for two years. We consider how the reporting of Category One data evolved in the months after August 2020, and discuss how the effect of the Covid pandemic may provide some explanation as to why the trust reported incorrect data for this extended period.

4.12 Part three moves on to the question of whether any identifiable patient harm could have been avoided if the errors had been identified sooner.

4.13 Our findings from interviews and documents are set out in ordinary text. Our comments and opinions are in ***bold italics***. We have included quotes from participants to evidence the points made. Quotes are presented in *italics*.

Part one - The coding error

LAS background, culture, operations and governance

How was the coding error introduced?

5. Context

5.1 LAS is the largest and busiest ambulance trust in the UK, employing 6,500 substantive employees, rising to over 9,500 with the inclusion of contractors, agency, bank and volunteer staff. 2.1 million 999 calls and 2.1 million 111 calls are received annually, resulting in over 1.1 million attendances.

5.2 In November 2015, the trust was placed into special measures – the first ever ambulance trust to be subjected to this – after a highly critical CQC inspection report. The report, that rated the trust as 'inadequate', highlighted numerous issues, in particular:

- Failure to meet response target times
- A high number of frontline vacancies
- Inappropriate staff training, exacerbated by low staffing levels
- Demoralised and stressed staff
- Lack of senior staff supervision

5.3 In response to this situation, from 2015 onwards, the organisation was strengthened by a series of senior appointments including a new Chair, Chief Quality Officer and Chief Information Officer, and by recruitment into specialist roles in procurement, logistics and estates.

5.4 We were told that all these individuals contributed strongly to the progress of the Trust, and so by the time that in May 2017 a new Chief Executive was appointed, actions to address the issues identified by the CQC had been developed and good progress made.

5.5 The remedial actions taken within the trust were recognised by the CQC, with a steady improvement of inspection ratings from 'requires improvement' in a report published in June 2017, to an overall 'good' in May 2018, with the care provided at that time rated as 'outstanding'. Significant improvement was also recognised in quality, responsiveness and leadership.

5.6 In parallel, the trust reshaped its strategy to ensure its services were better tailored to patient needs, expanded its 111 activities, worked more closely with system partners, recruited in order to rebuild its frontline and enhanced the diversity of its workforce.

5.7 This improvement in the performance of the trust was commendable, but was happening against a backdrop of some executive discord within the trust. We heard multiple accounts from long standing senior staff members of significant tensions among the executive team during this period. We were told that the Chair and Non-executive directors were aware of challenges relating to the cohesion and effectiveness of the executive team and the need to tackle these.

5.8 At the heart of these tensions was a significant disconnect between the operational and clinical functions within the trust. The use of the term 'silos' was a recurring theme in our conversations with staff.

5.9 These silos appeared not just between operations and clinical staff, but also between whole directorates. We heard accounts of individual functions communicating poorly, to the point where legitimate questioning or discussion of any issue between them appeared to be received as an attack. This reportedly resulted in separate functions within the trust working in isolation.

5.10 At the same time as these problems were manifesting themselves, the Covid-19 pandemic introduced an unprecedented challenge to the trust. Understandably, the focus of the entire organisation moved on to how best to react to the crisis. 'Business as usual' was overwhelmed by the pandemic response, and with this the capacity to address any underlying issues present in the organisation, even though these were recognised among both the executive and non-executive teams.

5.11 The Covid-19 pandemic, while not providing justification for the weaknesses in process and governance that we will describe below, understandably diverted the focus of the organisation away from these issues, aggravating an already difficult situation.

5.12 This report, therefore, describes an organisation that in 2020 was emerging from a troubling period in its history, with a new executive team bedding in and necessarily addressing the issues that led to special measures being imposed, but with apparent difficulties in the senior team to gel into a cohesive unit.

5.13 Below, we discuss these issues in more detail as a backdrop to an examination of what happened in August 2020 that resulted in the misreporting of Category One data.

6. Observations on LAS as an organisation leading up to and during the reporting error in August 2020

LAS culture and operating environment 2015 - 2021

6.1 Any organisation in special measures has issues. In such circumstances, there is often a high turnover in the executive team, increased scrutiny on individuals and new ways of working are introduced to address the deficient aspects of the organisation. This often leads to uncertainty, disquiet and tension within and across functions.

6.2 The previous chief executive of the trust believed that the early days of his tenure were positive, and clearly the progress made prior to his recruitment was further built on as the special measures were lifted.

6.3 We were told, however, about issues among the senior leadership team by both executives and non-executives active in the trust at the time.

The non-executive view

6.4 The NEDs that we spoke to were unified in their view that the executive group was inexperienced and '*needed work*'.

6.5 This was mostly clearly manifest in the fact that NEDs were being asked to step in to day to day operations in the trust in a fashion that seemed '*inappropriate*' to those asked to fulfil these requests.

6.6 It was felt by the NEDs that this was a result of a lack of unity in the executive team, resulting in non-execs being called upon to address issues that would be more properly identified and tackled within their own team.

6.7 The lack of unity appears to have been most obviously manifest in tensions between clinical and operational functions within the trust. We were told by multiple individuals that this had been a long-standing difficulty and, although some progress had been made in the period leading up to August 2020, it remained an issue.

6.8 In the period between 2018 and 2020, a number of experienced senior hires were made by LAS. They bought with them extensive experience of a large number of ambulance trusts.

6.9 When asked about their initial impressions of LAS compared to other ambulance trusts, we were told:

"If you'd have asked me a couple of months in, I would definitely describe the organisation as in silos. I think you can see that right up. If you watch the way the Board operated, I've never been on a Board - I've been on four now - where I had to report to the Board as a Director for my functional area, rather than by function."

"Even if you look at our Board papers and look back at Board meetings, you were responsible for your bit rather than all directors [looking at] *all portfolios. Yes, you have areas of expertise, but I would definitely say I walked into an organisation that was quite siloed in function. I think with good intent, people wanted to do their bit, but were quite competitive.* [We needed] *collaboration, as opposed to 'I'm going to get one over on another director'. Not intentionally but more 'I want to make myself good and therefore that competes'. There was some of that, culturally, in there."*

6.10 And specifically relating to the IT functions of the organisation, we were told:

"I've never quite experienced the chaos that was going on in this organisation. I've never seen anything as bad as the IT infrastructure. I used to say that there's nothing in LAS that I haven't seen in any other organisation. I saw nothing in LAS that I hadn't seen somewhere else, but I'd never seen all of it in one place at one time. It was just astonishing."

"There were completely undocumented systems, and even now we have intermittent failures when we try to do something, because we're having to do stuff without really understanding the environment that we're working in because it's just not documented. Most of this goes back maybe 20 years in some cases, or even longer."

6.11 The current CEO on his appointment in August 2021 observed:

"The senior team here was the least cohesive team I have ever joined. It was a bit like coming into an organisation that had two ways of running itself. There was an operational way of running itself and there was the clinical way of running itself."

"This was exacerbated in a culture that has been hierarchical and command-and-control focussed. This makes it hard for people within the organisation to ask the 'top' questions without the fear of getting 'squashed.' The organisation definitely wasn't a psychologically safe one for people to speak up in and it is proving a very big task to change this ingrained set of beliefs across the organisation."

Comment

LAS had clearly been through difficult times in the period after 2015 when it was placed in special measures. Demonstrably, significant progress was made in addressing the issues identified by the CQC, but we have heard compelling evidence that there remained divisions within the executive team and tensions between functions. It is not unusual in Verita's work to observe unrest in circumstances such as these, and LAS is no exception. As we will discuss later in this report, the manifestations of this situation did not provide sufficient management oversight and governance rigour to prevent operational issues arising.

Covid-19 response

6.12 In early 2020, LAS, along with the entire healthcare sector, was confronted by the requirement to respond to the Covid-19 pandemic. Understandably, this became the core focus of the entire organisation. The former Chief Executive told us:

"The pandemic experience, which was the last 18 months or so of my tenure, was something else entirely, and I think it was for everybody. That was very much a genuine emergency situation that required some different ways of working and greater flexibility. I think the Board at LAS were really good in that regard and really supportive, and I think we weathered the initial phases of the pandemic pretty well. We were able to upscale the size of the organisation very rapidly, with

help from colleagues and other private sector partners, to such an extent that we were in a position to respond to the demands placed on us pretty well within a very short space of time."

"My priorities were around identifying the key goals and the key outcomes and ensuring that every part of the organisation was able to respond to those."

"In those early phases everything that I was focused on was ensuring that we had every part of the organisation identifying what we could stop doing, where we could redeploy resources. We had to recruit something like 1,000 people over a six to eight-week period. There was a huge short-term recruitment challenge. There was a huge logistics challenge around vehicles – sourcing enough vehicles, both new and second hand, PPE was a big challenge obviously in those early days, so that was another area. It was tracking back right throughout the organisation, what were all the component parts that would enable us to keep the frontline working?"

6.13 The effect on the front-line teams was profound. We heard from a senior executive:

"That was a very challenging time. It was on top of everything being challenging. Covid was awful, and to put context on the job we do, without being over-emotional about it, it was horrendous, and everyone felt a bit out of control. We don't really know what's happening here, our staff were going into this situation, not knowing if they were going to come to harm, so there was a lot of anxiety."

"It was just the most cruel thing I have ever witnessed in my life, and then behaviours played out that indicated people were becoming more and more stressed and more and more anxious and more and more closed down."

6.14 The NED community were aware (and supportive) of the actions that were taken by the executive. We were told by a NED:

"It was a really awful situation, and what we had to face – I keep coming back to this – is get through Covid, because that was the burning platform that had to be addressed, how do we come out of that in a reasonable way, ensure people are not brought to harm as best we can."

6.15 The organisational response to Covid was entirely understandable, but did not come without cost to business as usual. We were told by a member of the executive team:

"We were in the middle of Covid, and so the rule book, in terms of governance processes, were being shredded. We needed to make rapid decisions, and was difficult for people to keep up with. It was the right thing to do to strip some of the governance out, because we had to deliver stuff we never ever thought we would have to deliver, to be able to get an ambulance to people and pick the phone up. Things were deployed really quickly and that worried people, because we were so used to governance wraparounds and probably lots of people were frustrated that there was sometimes too much governance wraparound and that became a problem."

6.16 A NED told us about the oversight processes introduced during the Covid period:

"When we hit Covid, we started to have much shorter meetings. Obviously, we moved into virtual, because before that it was always face-to-face, and we never had meetings virtually. We started to move into weekly reviews on performance, and what we were doing around addressing and being able to deal with the fast-moving pace that was Covid, and all the pressures associated with that."

"At the sub-committees, we tailored back a little because we wanted to focus on matters that were really pressing and urgent. At one point, we had - perhaps twice-weekly - just a report on how we were doing overall with Covid, and then we would have minuted one-hour meetings once a week, and we would hear from the Chief Executive at the time on how things were tracking – what performance was like, what staff morale was like, what interventions we were making, and so on."

Comment

As we have described, in August 2020 LAS was an organisation that had been through a difficult, unstable period and was experiencing significant tensions between executives. This already challenging situation was exacerbated by the onset of the Covid pandemic, during which already stressed processes were placed under unprecedented strain.

7. August 2020 coding error – how did it occur?

7.1 LAS was alone among all UK ambulance services in using Command Point as its CAD system. It was built by Northropp Grumman, originally for the US military but then modified to provide:

> *"A first responder command and control software for law enforcement, fire, emergency medical agencies and other incident management activities"*.

7.2 LAS first deployed the system in 2011 after initiating the project in 2009. In June 2011, however, the system crashed, forcing LAS to revert to a paper-based system for a period of time while its pre-existing system was re-initiated. Command Point went live in March 2012.

7.3 By August 2020, Command Point was an ageing system, although still properly supported by LAS substantive staff. As LAS was the only UK ambulance service user, there was no opportunity to pool expertise or resources, or to share and learn from the experience of other trusts. On this basis, the decision to migrate to a new solution was prudent.

7.4 A particular issue was the fact that Command Point did not produce any management or business information which could be directly extracted, but rather had to be interrogated by another programme - Extract Transform and Load (ETL) – that then populated a data warehouse. This provided the data for the Business Intelligence (BI) team to both service internal reporting requirements and fulfil LAS's national reporting obligations.

7.5 By August 2020, there was a single developer working at LAS who understood ETL and was responsible for all of its maintenance and development. Not uncommonly in these situations, the developer was not a substantive employee of the trust, but rather a contractor.

Comment

The fact that issues commonly arise with legacy systems that are core to an organisation provides no mitigation for the fact that LAS allowed this vulnerable situation with ETL to occur and to continue. Rather, given its many precedents, it can

only be seen as a failure on the part of LAS. We have seen no evidence of a contingency plan of any sort in the event that this sole remaining developer was to leave the organisation. This clearly left the developer in a position of great strength and LAS vulnerable. It is, however, to the credit of the Cleric implementation team that they recognised and addressed the error in the ETL code. In different circumstances, as ETL was still being used to populate the data warehouse, the error could have been perpetuated after Cleric was implemented.

Notwithstanding that this vulnerability should not have been allowed to arise, we would have expected to see strict processes in place to ensure that any work performed on the ETL was properly documented, tested and with robust quality control and testing procedures in place for any development work undertaken.

Ambulance response times

7.6 A core metric by which ambulance trust performance is measured is speed of response, i.e., how rapidly a suitable crew arrive on the scene of an emergency.

7.7 The measurement of this response time is governed by a set of rules, centrally mandated and applicable to all trusts. A key element of these rules is the time at which the 'clock starts'.

7.8 For Category One calls, this clock start time is determined by the earliest of one of three triggers:

- 30 seconds after a call is received.
- As soon as a vehicle is dispatched to the call (this could be earlier than 30 seconds).
- When the incident is triaged as a Category One call – when the 'determinant' is established.

Recognition of the coding error

7.9 In late 2022, data from the new Cleric CAD system showed a worsening performance on Category One response times in the trust. Cleric was systematically calculating a slower response time than that produced by Command Point. Initially, this was thought to be a result of implementation issues with Cleric – either staff familiarity with the new system or some aspect of the Cleric setup.

7.10 When nothing could be identified with the Cleric set-up that might lead to an incorrect determination of response times, suspicion moved on to the data produced by the ETL programme under Command Point.

7.11 A detailed, systematic examination of the data by LAS staff established that the outputs of Command Point were correct until August 2020. Further analysis showed that the issues arose on August 19, 2020.

7.12 At this point, it became clear to the LAS team that the issue was centred around how Command Point / ETL had treated the data rather than Cleric implementation issues. Having established when the errors started, a search for the cause was undertaken.

7.13 In August 2020, interpretation of a national standard was changed, whereby calls that came in from healthcare professionals (HCPs) would have a 240 second 'allowance' after a call is received, rather than the standard 30 seconds. The rules on vehicle dispatch and establishing the determinant remained unchanged.

7.14 This change in the clock start trigger for calls from HCPs required a change in code for the ETL to reflect the new interpretation and to perform the new calculations in order for the data in LAS's data warehouse to be correct. This data was then used for internal performance reporting and fed into NHS England's 'Ambulance Quality Indicator' (AQI) reports.

7.15 AQI reports are publicly available and are the basis for comparison of the performance of the UK's ten ambulance trusts. As such, their accuracy is of real importance.

7.16 The data showed that, prior to 19 August 2020, the clock start rules for Category One calls had been correctly employed. From this date, however, rather than the (correct) 30 second trigger for clock start, the 240 seconds that should have only been applicable to HCP calls had been used for all Category One calls.

7.17 The result of this was that the response times reported for Category One calls could be reduced by anything up to 210 seconds – the difference between the 30 seconds legitimately available and the 240 seconds that should only have been applied to calls from HCPs.

Modifying the Extract Transform and Load code

7.18 In order to establish the chain of events in August 2020 that led to this significant coding error, we asked for all documentation from the time that would have governed and controlled such activities:

- Who the communication explaining about the change to the treatment of HCPs came from?
- Who in LAS had received and acknowledged this?
- Who produced the system change request form?
- Who it went to in the BI team?
- How this had been communicated to the developer tasked with making the code change?
- What quality control / testing had been in place to ensure that the new rules had been correctly reflected in the system change?

7.19 In short, the change control process that we had expected to see in any properly governed function.

7.20 None of this documentation was available. We explore the reasons for this below.

7.21 While the wider IT function in the trust had a Change Advisory Board in place to govern such activities, none existed within the BI team.

7.22 We asked an executive within BI about their understanding of what occurred in August 2020. We were told:

> *"In making that change, the suspicion is (or what the developer has put his hand up to) is: I've changed the query and it looks like when I did that there was a flag that should identify 01 - is this a Cat 1 call, yes or no, and if yes, fire down this route to apply the 30 second clock start rule; if not, it goes down this filter, to apply the 240 second clock rule. Basically, every Cat 1 call was then being fired down the 240 second filter rather than the 30 second filter rule."*

7.23 When asked about how the change had been initiated, we were told:

> *"It would probably have been through an email or a conversation saying a change is coming down the line, can you make this change. Probably the developer is a single point of failure for the organisation, so is there the professional resource support? Probably not. That element of the function in some organisations may well sit in IM&T and here it is sat in BI, so there is an element where he has quite a lot of professional workings with other members of IM&T who do other stuff around the network and around databases but less around the warehouse. He may well have had some input and support through that route but was anything ever formalised? Probably not and, to be honest, the reflection on what have we got there now? It's not enough."*

7.24 We asked if there was a formal change management process in place for within the BI function in August 2020 and were told:

> *"I don't think so and, to be honest, the reflection for us is what are we doing around that."*

7.25 We discussed whether there was an overarching policy that should govern system changes such as that in August 2020, we were told:

> *"I am unaware, I don't want to say it doesn't exist. My strong expectation is that there is not. Again, it comes back to the reflection around the number of elements of this for me which is around the silo working we have, where you have the sense that the developer has a professional relationship and is working with other*

members - while I am more of an information specialist, I am not a technical specialist. Therefore, as far as some of the professional discussions that [the developer] *would need to have, quite a lot of that is in IM&T. Therefore, my reflection is whether we are structured in the right way to give the right support for individuals."*

"Is the right process in place? Clearly not, so that is something that we need to do."

7.26 Similarly, the quality control activities undertaken on the data in the Data Warehouse were not thought to be robust:

"It has been more about, 'is there a time in there?', not, 'is that time right?', which is probably my reflection. The clock starts is in there and, therefore, the working assumption was that is right, but it feels like we are more about, 'does the system have something we can use rather than is the thing it's using necessarily correct'. It is one of those where you look back and it's the most obvious thing."

"… why didn't we pick up on it? In effect, the AQI rules were written into an ETL, which increases the risk given the complexity and many lines of code that has a person in charge of it, especially if there is a limited resource around doing that and that was a benefit of moving to a new CAD system that generated the timestamps directly."

Comment

Our observation is that the BI Directorate lacked coherence, direction and accountability. The lack of policies and processes to document and control actions taken on systems is a particular weakness.

7.27 We interviewed the developer who changed the ETL code in August 2020. He told us he had had a long-standing relationship with LAS, since 2015, although always as a contractor.

7.28 The Developer explained that during that during the summer of 2020, he had been extremely busy addressing coding issues arising from his predecessors' tenure. At the same time as the code relating to HCPs needed to be updated, he said:

> *"There was a lot to sort out in those few months, and some of it was changes that this guy before had done but not related to this specific issue – but other things where the code probably wasn't quite right. They knew it wasn't right, so I had to try to get it right, and do a bit of a back-date."*

7.29 It is noteworthy that in August 2020 the trust was operating, where possible, on a remote working model.

Comment

Remote working could only serve to amplify any issues of weak management grip. The developer was working largely in isolation, without any checks and balances or, indeed, the ready availability of peers with whom to exchange ideas or discuss issues. We believe that the working arrangements at the time served to make an already bad situation worse.

7.30 We were told about how the developer could have come to know about the system changes that were required to be made to ETL in August 2020:

> *"It might even have just been a conversation. I remember pushing back a little bit because it wasn't quite clear in terms how this should be handled from a response performance perspective. Generally, there is a guy from NHS England, who we've used a few times, who we got to clarify it. Sometimes, there are some people who don't want to take responsibility for anything, and they are really the people who should be."*

7.31 In our conversation, the Developer confirmed that there was no systematic checking or quality assurance of any changes made to the ETL. This was driven both by time constraints and the fact that there was nobody else in the team who had the requisite skills and knowledge to undertake such a process.

7.32 On the subject of having no formal change control process in place for ETL code changes, the developer said:

> *"With reference to the AQIs, in this case because we got someone else to support it, yes, that would be enough, because we are adhering to the AQI guidance, and we* [were acting] *in the spirit of the AQI."*
>
> "[But generally,] *No, and that* [an environment with proper change control governance in place] *would be the ideal environment. I have said this many times, if you don't have things like that, you are running a risk. Eventually, things will happen. Probably about 20 per cent of your time would go into that kind of process, because you need that kind of overhead to make sure that things are done properly."*
>
> *"There is creating the capacity, and it is also about having people who recognise it as important, because what you might get is, 'Well, no, this needs to be the top priority', and then if you say, 'Well, what about this?', and it will be, 'But no, we need to do that.' – and that is your next few weeks and, before that is even finished, there will be something else. You do your best with it."*
>
> *"In terms of managing risk, that is a constant thought, really. It comes down to money and capacity, doesn't it? You have to say that an extreme example would be that you do all these processes and you spend half your time doing that and, sure, it is very well documented and with very controlled change and so on, but you will only get one change every two weeks and you want four changes every week. It is about that balance of knowing what the change is and how well you know the environment – how much risk, if you like."*

7.33 When we discussed what quality assurance checks he performed on his own work, the developer said:

"The intent of the code change was to apply the correct clock start to HCPs. It is likely that the checking of the impact on the data following the clock start change was restricted to identifying that the correct clock start was now being applied to HCPs as the unintended consequence on C1 wasn't expected."

"To be honest, I can't remember if we did that although it is quite likely that we did. In this case, it would be more of a thing that we weren't looking for the bit that went wrong."

Comment

We observe that, within the BI community at the time of the ETL code change, there was a profound lack of governance, engagement and curiosity about data quality and accuracy. It appears that, if data appeared in the field where it was meant to be, in the correct format, this was taken as evidence that it was accurate. There appears to have been little or no questioning of the accuracy of the data.

While we understand that the organisation was (necessarily) diverting its attention to reacting to the pandemic, we do not believe that this provides more than limited mitigation for the coding error. It is a truism that system changes can, and do, result in unintended consequences. To this extent, the situation was unremarkable. What is remarkable, however, is the fact that changes in perhaps the most visible externally reported data for the trust could be subject to such limited controls or checks. It is in times of maximum organisational stress that the need for strong, embedded and meticulously followed policies and processes come to the fore. They provide the framework within which errors such as the one that occurred are avoided.

The fact that the error arose from a set of circumstances well documented in the IT industry, i.e. in an ageing, legacy system with one individual responsible for a key aspect of it only serves to make the matter more inexcusable.

Given all of these facts, it is impossible to typify the events of August 2020 as anything other than an avoidable failure of governance and process. While it would be easy to criticise the individual developer, we do not believe that this is a tenable position. If

adequate checks and controls were in place, the error would likely have been identified and corrected.

8. The governance and assurance of data within LAS

8.1 Having established the context and specific events that led to the introduction of the Category One coding error, this section of the report will examine the policies and processes in place in the trust relating to data quality.

8.2 In it, we discuss how these matters stood in (and leading up to) August 2020, and the changes that have subsequently been implemented. We identify where we believe there are weaknesses and suggest mitigations for them.

The period leading up to and over the change in coding in Extract Transform and Load in August 2020

2018 to 2020

8.3 At a board meeting held on 31 July 2018, the LAS board approved a Data Quality Improvement Strategy, a Data Quality Policy, and a Data Quality Assurance Implementation Plan for the period 2018-2021.

8.4 The meeting was told that a data quality improvement strategy was a *"must do"* from an earlier CQC inspection and internal audit recommendations. The board was also informed that a Data Quality Assurance Team (DQAT) would be in place by October 2018 and assurance on data quality would be overseen by the board's Logistics and Infrastructure subcommittee (LIC).

Comment

The governance structure set out in the policy was complicated, with a confusing set of tiers for reporting and a multitude of separate committees contained within it.

8.5 It is difficult to determine from the documentation what the responsibilities of many of these individual committees were meant to be and how they were meant to relate to each other. We have been told, however, that most of these committees were never in fact

established and that during the period up to mid-2020 the entities with responsibility for data quality governance and assurance were DQAT, which reported into an executive group, the Health Informatics Oversight Group (HIOG), which in turn reported into the LIC.

8.6 Under the Data Quality Policy 2018- 2021 board directors were *"individually accountable for remediation of data quality issues related to KPIs under their ownership"*. However, other than the Chief Information Officer (CIO) and the Performance Director, members of the executive leadership team were not apparently members of, nor did they report into, the HIOG or any of the tiers of responsibility below the LIC board subcommittee.

Comment

This raises questions about how individual executive board members were to be held to account for data quality issues relating to KPIs under their ownership, or whether they were appropriately engaged with the management of data quality issues across the organisation as a whole.

Assurance review framework

8.7 The data quality implementation plan provided for an Assurance Framework made up of what were called a "*KPI Assurance Review Framework"* and a "*Systematic Assurance Framework."*

8.8 The KPI Assurance Review was to *"provide information on the underlying data confidence for the KPIs that measure the trust's performance."* It was to be undertaken in two phases, the first being a spreadsheet based manual review and the second was to involve:

> *"A higher tech tool that will provide a more frequent, up to date view of data quality for any KPI over a much more comprehensive range of potential data quality issues than the manual review does."*

8.9 Responsibility for delivery of this framework lay with the Director of Performance.

8.10 The Systematic Framework was meant to "*give information on the underlying data confidence across all the Trust's information systems and data sources*". It, too, was to be undertaken in two phases, with phase one being a manual spreadsheet-based solution that would be *"transitioned to Phase 2: a real-time assurance measurement system over the period of the strategy."*

8.11 The implementation plan provided that the systematic assurance review framework would be led by the CIO, who would be responsible for its delivery. The plan also provided that the systematic review should be:

> *"Undertaken at least annually but it may be more frequent for particular systems whose underlying data quality may be changing, the systems that require this will be determined by the CIO."*

8.12 The plan anticipated that the second phase technical systems for the KPI and the systematic assurance would be delivered in the second year of the strategy- i.e. 2019.

8.13 The data quality policy adopted in 2018 contains a section on *"Principles of Good Quality Data"*, which sets out 6 characteristics of Data Quality. Under the characteristic *"Validity"*, it states:

> *"Data should be recorded and reported in accordance with its definition and purpose".*

8.14 Under the characteristic *"Reliability"* it states:

> *"Managers and stakeholders should be confident that progress towards targets reflects real changes rather than variations in data collection."*

8.15 An assurance review in respect of the information systems that feed into the trust's KPI reporting was undertaken by the DQAT in late 2019/early 2020. Apart from that review and an audit review undertaken by the trust's internal auditors in mid-2020 (which we discuss below), no further trust-wide reviews or audits of the information and reporting systems have been undertaken in line with the envisaged assurance frameworks. We understand that, at the time of writing, none of the proposed technical solutions for LAS to undertake such reviews of its information and reporting systems have been implemented.

Comment

The descriptions of the characteristics of good quality data could be taken as pointing to the need for controls and checks to ensure that LAS was applying the right coding and, thereby, using the correct measurements and rules to calculate and report on its performance under the Ambulance Quality Indicators.

The implementation plan and assurance frameworks it described made much reference to data quality, including how data was gathered and inputted into the data collection system. They did not, however, explicitly address the need for checks and assurance as to whether the LAS data collection and reporting systems were operating appropriately, whether they were subject to robust change controls and, in particular, whether systems (including the ETL), were applying correct 'rules' and calculating performance appropriately.

Arrangements for the oversight and risk management of data quality

The Quality Assurance Committee and the Information Governance Group

8.16 In July 2020, the LAS board agreed that responsibility for the oversight of data quality would pass from the LIC to the Quality Assurance Committee (QAC) "*as it has direct impact on the quality of care and monitoring.*"

8.17 It is notable that the LIC's terms of reference had stated that it had a duty in respect of data quality to "... *seek assurance with regard to the Trust's Data Quality and information management/governance activities.*"

8.18 Under a subsequent amendment of the terms of reference for the QAC, the committee was given a more limited scope in respect of its oversight of data quality matters. It was only to receive as a standing item:

> *"A report from the Trust's Data Quality and information/governance activities (frequency will be set out in the forward planner accordingly)."*

8.19 This form of words, suggesting a more limited oversight of data quality issues, are repeated in the current version of the QAC terms of reference for the period April 2022 to March 2023.

8.20 At the time that the board oversight of data quality passed to the Quality Assurance Committee, executive responsibility for oversight of data quality passed from the HIOG to the Information Governance Group (IGG). The terms of reference for the IGG state that its purpose is:

> *"To ensure that LAS has clear direction and management support for the activities to comply with data quality principles, Caldicott principles, data protection legislation, the Freedom of Information Act 2000, Data protection legislation and other matters related to information governance."*

8.21 Notwithstanding the fact that the IGG's purpose includes ensuring direction and management support for compliance with data quality principles, there is no further reference in the terms of reference to the subject of fundamental data quality. Section 11 of the terms of reference, which sets out the specific duties of the IGG, is devoted almost exclusively to matters of information governance.

8.22 The list of the core members of the IGG set out in the terms of reference is made up of executives whose roles primarily concern matters of information governance and does not include any executive with responsibility for data quality.

8.23 We have been told that this is a "*housekeeping error*" because the previous Director of Strategy and Transformation, who is included in the membership list, also held the position of CIO. In any event, the current CIO told us that he does not attend the IGG.

8.24 Furthermore, among the listed membership of the IGG there is a notable lack of executives with responsibility for, and understanding of, operational activities. The Chief Medical Officer and Deputy CEO agreed that this is a deficiency that undermines the IGGs capacity to examine and manage matters relating to data quality. We were told:

> *"I would also expect… the Director of Operations and the Director of the two call handling areas, 1s and 9s, to be there because that's where our data assurance*

comes from. Otherwise, we are at risk of further data not being interrogated and constructively questioned."

8.25 Minutes of the meetings of the QAC and the IGG, alongside the evidence of interviewees, show that the emphasis on information governance in their respective terms of reference is played out in the meetings of those committees. A standing member of the IGG when asked about the nature of the meetings told us:

"I don't mean to sound critical, but I wouldn't describe it as a governance meeting. It was more an update meeting from each of the workstreams.

8.26 The same individual questioned how much priority even information governance is given throughout the organisation:

"The other problem with Information Governance, and I suppose links into data, is where it sits in a status priority across the organisation. Information Governance is quite often a group that, if we move to our highest-pressure levels, is deferred or cancelled, whereas it's very unusual for Infection Prevention Control to be cancelled, it's very unusual for Medicines Management to be cancelled or Health and Safety, because they are a regulatory requirement."

"What we saw over the last Covid wave was that it just focused in on the DSPT [Data Security and Protection Toolkit] *return, so it's evidencing doing something because it's a tick box as opposed to doing something to make sure we're doing it. There is a lot of reflection and learning that can come out of this incident that means that we can make things better."*

8.27 When asked about the level of priority given to data quality, information and information governance have in the Quality Assurance Committee, a senior executive said:

"Not very high, or not as high as it should be… and if we are thinking about it, the logical way through it should be that the information governance and data assurance precedes anything to do with quality, because otherwise you are doing quality assurance based on data that you haven't actually assured yourself about."

8.28 The minutes of the QAC meetings show there has been no substantive discussion of data quality by the committee since November 2020 when it considered a report, on eleven key information systems that feed into LAS's Integrated Performance Report. This may in part be explained by the very wide nature of the responsibilities assigned to the QAC, which also includes all aspects of quality, patient safety and patient experience.

8.29 The minutes of the IGG meetings show that these have been held four times a year, and frequently have not had an item on data quality on the agenda. The minutes of the meeting on in July 2021 show that:

> *"Members considered the meeting frequency seeking consideration of a more regular monthly meeting with an agenda that members will find both engaging and that adds value to the trust."*

Comment

It is clear that there are deficiencies in the terms of reference of both the QAC and the IGG, in that they are not adequately explicit about the responsibilities of those committees for ensuring robust and rigorous oversight and assurance of all matters relating to data quality, rather than solely information governance. There is, equally, a deficiency in relation to the membership of the IGG provided for under its terms of reference.

It is, in our view, indicative of the fact that data issues were not seen as a real priority (or a potential problem) in the trust that the meetings of the IGG were not held more frequently than quarterly, and placed little emphasis on basic data quality.

Recommendation

R1 It is imperative that LAS develops the means – in terms of governance processes, systems and personnel – to monitor and address issues with its information, data and reporting systems.

Policies and procedures

Data quality policy 2022-2024

8.30 LAS's current data quality policy (2022-2024) has updated the earlier version to take account of a recommendation by LAS's previous internal auditors of the need for routes by which staff can escalate quality concerns outside formal reviews and audits. It also provides for a significantly simplified governance structure for the management and oversight of data quality.

8.31 However, although the policy states that the Head of IM&T and Security (the Chief Information Officer) has responsibility for overseeing data quality activities and is accountable for ensuring that principles of data quality are upheld in information management systems, the CIO does not feature on the governance structure diagram included in the data quality policy.

8.32 The reporting line set out in that policy shows the Head of Data Quality Assurance reporting through the Director of Business Intelligence and Analytics to the Chief Financial Officer, who in turn reports into the Executive Leadership Team.

8.33 In addition, while the current data quality policy sets out principles for good data quality, including reference to the principles of good data capture, measurement, feedback and correction, the policy is very much concerned with gathering and inputting of data and does not make explicit reference to the need for testing and assurance of any systems by which data is managed or manipulated, including any coding that might be applied to it.

Risk management strategy

8.34 At its meeting in September 2022, the LAS board approved a 'Risk Management Strategy' and 'Policy Statement'. That strategy and policy statement sets out where specific responsibilities for the various risks managed by the trust.

8.35 Although the Chief Financial Officer's responsibilities are stated to include Business Intelligence, it is not specified whether this includes data quality. Under a section covering delegated executive responsibilities, the CIO / IT Programme Director has delegated

responsibility for strategic development and implementation of risk management initiatives relating to information management and technology and data quality.

Comment

It appears, therefore, that there is currently significant incoherence in the documentation providing for the governance and oversight of data quality, in that the accountabilities and lines of reporting under the risk management arrangements differ from those under the data quality policy.

Although we have been told, and the documentation provides, that responsibility for matters of data and data quality ultimately lie with the Chief Financial Officer, there is a question, not addressed in any of the governance documents, including relevant policies and committee terms of reference, about how managers will work together to ensure that there is a (necessary) common approach and understanding on matters of data quality and associated risks between the governance, wider operational, quality and clinical functions of LAS.

We heard from many interviewees that "there is an accountability issue in LAS". A significant contributory factory is likely to be the fact that individual responsibilities are not made explicit in trust documentation such as policies and terms of reference for standing bodies. This must be addressed.

Recommendation

R2 Policy documents and the terms of reference for committees within the trust must be consistent both within themselves and across overlapping areas. Clear lines of accountability must be included in these policies.

9. The data assurance environment within LAS

The work of the Data Quality Assurance Team

9.1 We heard from interviewees about the difficulties experienced by the Data Quality Assurance Team (DQAT) in gaining the support and engagement among other staff and managers for their efforts to promote better data quality management and governance.

9.2 The head of the DQAT told us she did not feel she had the seniority or the interest and support of senior managers necessary to challenge developers and other (more senior) staff about their processes and ways of working, or to design and implement standardised operating procedures across LAS. We were told:

> *Hierarchy matters in this organisation. We have a few heads within the Performance Directorate. I'm the most junior in terms of hierarchy, so you need to have some sort of Directors' push in order for you to engage with some of the work. I would have liked more support."*

9.3 The work of the DQAT has also been hampered by the fact that one of the two analyst positions within the three-person DQAT team has been vacant for some time and the head of the team has only recently been given permission to recruit to it.

9.4 We were told that attempts by the head of the DQAT to set up a data quality forum to bring together developers and systems managers at LAS to share issues, to learn from each other's insights and experience and to offer an element of peer review had not been met with any enthusiasm.

9.5 The head of the DQAT also told us that, although the Data Quality Implementation Plan agreed in 2018 required information systems owners to ensure that staff had appropriate training materials and received appropriate induction and refresher training on the data quality risks for their system, training within teams on data quality was "*extremely patchy*", and there had been no uptake of the e-learning materials devised.

Comment

The work of the DAQT has been of a high quality. In particular the review that it undertook in early 2020 into a CAT 2 clock restart fix, which we discuss in detail below, identified deficiencies and issues which almost exactly mirrored and foreshadowed the issues that were at play in relation to the Cat 1 coding a few months later.

We believe that the idea of a trust-wide data quality forum has merit. The membership and terms of reference for such a forum should be considered by the newly established committee charged with looking at all matters relating to the oversight and assurance of the trust's IT, data and information systems.

We also believe the trust should devise and implement an appropriate trust wide training programme, to include refresher training, for all developers and other staff and contractors managing information and data systems, on standard operating processes and other requirements for maintaining data quality.

Recommendations

R3 The DQAT needs to be fully resourced, and to be given the full support of the executive team.

R4 A data quality forum should be established for developers, data and information system managers and the corporate IM&T team. Its aims should include ensuring the sharing of best practice, the adoption of standard processes and procedures, and peer review in respect of data quality. The chair of the forum should be of sufficient seniority to ensure that it works effectively and that actions identified by it are carried out.

R5 A training programme should be devised and implemented for all staff in any function across the trust managing information, incorporating aspects of proper process and data quality standards.

Risk register and board assurance

9.6 Data quality has not been included in the risks set out in LAS's Business Assurance Framework, nor in the trust wide corporate risk register.

9.7 In respect of data quality, this lack of risk management process appears to have had an effect on the attention given to the subject by the organisation. No board or board committee agenda has included the subject of data quality since November 2020, and there has been no internal audit of data quality matters since mid-2020. The chair of the Audit Committee told us:

> *"… if you go back and look at the BAF – Board Assurance Framework, which obviously is a key document, there is no mention of data as an issue, it's not a risk that is popping up, per se, but it nevertheless pervades a lot of the things we do, it is critical."*

9.8 The Director of Corporate affairs told us:

> *"You'll see our entries on the Board Assurance Framework that relates to cyber security, the robustness of our data systems and so on. I think I would say that the focus of the risks has been more about the risk of cyber-attack and the risk of a systems breakdown than they have any sense that the quality of our data was problematic."*

9.9 We have been told that an amendment to the Business Assurance Framework to add a risk relating to data quality was introduced in March 2023.

9.10 The LAS Chief Executive told us that the organisation now recognises the issue of the lack of clarity and engagement around the governance oversight and assurance of data quality. In response, a subcommittee of the board has been set up, chaired by a Non-Executive Director who is a former CIO.

9.11 We understand that the subcommittee's brief is to consider how the organisation manages and ensures oversight and assurance in respect of Digital and Data Quality, with a specific focus on programs and data that impact the delivery of patient care and board level KPIs.

Comment

We welcome this move and would urge the subcommittee to ensure that whatever committee and oversight arrangements are put in place, they address the issues highlighted in respect of the production of high-quality data and ensure that any committee established to provide board oversight and assurance is able to dedicate adequate time and attention to the issue.

LAS audits and reviews of data quality

March 2020 internal report on a Category Two clock restart fix

9.12 In early 2020, in response to a noticeable year-to-date change in the LAS Category Two response times, the Chief Financial Officer asked the DQAT to undertake an internal review.

9.13 The report of the review, dated March 2020, identifies the fact that in October 2019 there had been a change in the requirements under the AQI regime with regard to the timing points, and allowed clock restarts for in-call upgrades.

9.14 The report notes:

> *"The data correction in the Data Warehouse had a noticeable impact on performance, a previous implementation restricted the clock restart to C1 only regardless of call source. This was inappropriate for Clinical Hub where a clock restart is permissible on any category upgrade."*

9.15 The review found some further discrepancies between the requirements of ETL calculations and what had been actioned, including the fact that:

> *"ETL had been restricted to evaluate triage for the last 24 hours which was unnecessary and had impacted where the recalculating of response was required."*

9.16 The report states that:

"The code has now been amended and data has been back dated. This has added a 25 second improvement to the rolling 12-month (R12) Category Two mean."

9.17 In the section headed *"Recommendations"* the report states:

"To mitigate against any further risks in the short term or another occurrence of such an event, certain actions are required at ***an immediate and urgent level*** **[Verita emphasis]**. *In order to manage risk and mitigate any compromised data, the following recommendations will provide those key assurances once fully implemented:*

1. *Annotated scripts and packages to show what controls it refers to so that any future change can be easily identified.*
2. *Peer review of the codes - a crucial process to allow peers to follow through any amendments and share best [practice].*
3. *Testing phase to ensure the changes work as required.*
4. *Process maps to show the implementation of the update.*
5. *Agreed definitions - agreement with relevant teams as to correct actions and interpretations.*
6. *Process flows - clear process flows and maps needed to illustrate what each part of the ETL process contains.*
7. *Testing environment - this will allow the developer to fully test any changes before they are made live and implemented.*
8. *Periodic reviews - a routine check on all ELT packages and processes to ensure it is fit for purpose.*
9. *Documentation - written documentation to define and clarify each process and function.*
10. *Resource and skill levels - to provide cover and mitigate against single points of failure.*
11. *Validation rules - testing the rules and logic to ensure good data quality practices.*

9.18 Under the heading Conclusion the report states:

"To conclude, the DQA team have not been able to confidently find assurance that such incidents like these are to not occur again. The reason for this is because the same risks are still present, currently this is still a single point of failure as if current BI Developer is to leave or his contract comes to an end there is no adequate cover. This will mean possible knowledge loss without appropriate and clear documentation. The DQA recommendations outline the steps to provide assurance to the trust that the data quality is not compromised, therefore it is vital that the recommendations are considered and implemented. The immediate steps outlined provide guidance and a contingency in the short term."

Comment

The findings and recommendations set out in the March 2020 report on the clock restart fix are in line with, and accurately mirror, our findings about the inadequate arrangements and control processes that were a significant factor in allowing for the inappropriate Category One ETL code change made a few months later in August 2020.

These included the lack of standard operating procedures in respect of any changes made to the ETL code, and the fact that the ETL was developed and managed by a single contractor without cover and without documentation from which the components of the ETL system and any changes made to it could be easily and fully identified by others.

The lack of an immediate internal response to the findings of this report represent a significant missed opportunity for the current situation regarding Category One reporting errors to have been avoided.

While, as stated, we understand that the organisation was coping with the early stages of the pandemic at the start of 2020, we believe that the root causes of this lack of appropriate attention to the recommendations were in essence the issues identified with the culture of the organisation earlier in this report - the fact that the organisation worked in silos that, reportedly, viewed any challenge or questioning as an attack rather than as an opportunity for reasoned discussion and appropriate

action. This, we believe, would have been exacerbated by the fact that the recommendations came from a relatively junior member of the organisation.

Every recommendation from the March 2020 report is in line with the recommendations that we make in relation to the current Category One issues.

Recommendation

R6 The trust should carefully consider the recommendations listed in paragraph 9.17 and seek to implement them in full, with input from the DQAT team.

Internal reviews and internal audit report on data quality assurance 2020

DQAT systems audit review 2020

At the end of 2019 following of an internal audit by LAS's then internal auditors, the DQAT started to carry out reviews of each of the eleven key data systems used by LAS and which feed into the trust's integrated performance reporting.

9.19 In nine out of the eleven data systems, including the CAD system, the DQAT assurance report gave a RAG rating of red (no assurances) or red/amber (partial assurances with significant improvements required) for the confidence level in the data quality processes.

9.20 One of the eleven systems looked at by the DQAT in their review was the CAD system. In their assurance report, based on their review, the DQAT noted as one of their findings in respect of the CAD system:

> *"There are no workflow 'Process Guides' in place to mitigate knowledge loss and standardisation of processes"*

9.21 Among their recommendations were the following:

1. *"Quality Assurance of ETL scripts produced by the Development team to ensure that it works as expected.*

2. *The creation and use of easy to manage workflow "Process Guide" to mitigate knowledge loss and standardise processes."*

9.22 The DQAT recorded the following as the management response to the recommendations in respect of the issues with the ETL scripts and the lack of standardised processes:

> *"These actions have been fed back to the necessary teams as part of the [Data Quality] reviews, with the new Cleric CAD solution these actions will no longer be required as the new CAD will provide an alternative solution."*

9.23 The new CAD system, Cleric has the capability, via a standard SQL query, to produce data for the data warehouse. However, as we understand the current situation, all entries into the warehouse from Cleric are still achieved via an ETL script. This clearly leaves the trust vulnerable to a repeat of the coding error of August 2020.

Comment

The implementation of the new system has currently retained one of the weaknesses of the old. There remains a risk that similar issues regarding ETL coding could happen again. The new CIO is aware of the situation and shares our misgivings and, given the circumstances surrounding this report, we are confident that the organisation will carefully guard against a repeat. Having said this, it seems anomalous that a known vulnerability remains when it could be effectively addressed.

Recommendation

R7 LAS should make every effort to export data, where possible, directly from Cleric to the data warehouse rather than via the ETL.

Internal auditors report 2020

In mid-2020 LAS's then internal auditors undertook an audit, for presentation to the Audit Committee, the objective of which was to "...*provide assurance over the systems in place to ensure compliance with the Trust's Data Quality policies and procedures*."

9.24 The internal auditors report on that audit states that among the risks that were addressed as part of its audit review were:

1. *"The trust's controls and processes in place for securing a high quality of data entry into performance indicators are not fit for purpose.*
2. *Key Performance Indicators submitted to the board as part of the decision-making process is not an accurate reflection of underlying data systems."*

9.25 The report states that the focus of the auditor's work had been on the internal arrangements for the testing, assurance and control of data quality and accurate key performance indicators, which they referred to as the Control Environment. In the concluding section of the report, the internal auditors say that they had reviewed the design and operation of the Data Quality Control Environment and had concluded that the process had provided significant assurance.

9.26 The report makes clear, however, that in carrying out their review the auditors team did not look at or test any of the data systems or the processes for managing those systems. Instead, they relied on the work done by the DQAT in its review and on talking to staff responsible for preparing performance reports for the board.

9.27 The internal auditors made no mention in their report of the lack of standardised processes for ensuring data quality that had been identified by the DQAT in respect of a number of the eleven data systems, including the CAD, nor did they mention the need for assurance of the ETL scripts, nor the fact that the DQAT had only rated the confidence level in the data quality processes for the majority of the data systems as red or red/amber.

Board review

9.28 The DQAT's report on the eleven systems was considered by the IGG and the QAC in November 2020. Minutes of the QAC state that members noted the quality of the report and raised no further questions about it. The Audit Committee considered the internal auditors report at its meeting in November 2020. The chair of the Audit Committee subsequently reported on the internal auditors findings at a meeting of the full board.

9.29 The Chair of the Audit Committee told us:

> *"Behind and supporting* [the internal auditors report]*, as I subsequently found out, is a more detailed report that the Data Quality Assurance Team had undertaken, with a number of actions, and that is the report that the auditors had looked at and gave us assurance that the Executive Team were on the case. They said data quality is being effectively managed. That's what they told us. In terms of, therefore, picking it up as a follow-up report, no, we didn't."*

9.30 He also said:

> *"… this is a significant assurance report, so we have to take some assurance from it, don't we?"*

9.31 Following the discovery of the issues affecting the reporting of Category One performance, LAS's newly appointed internal auditors have been commissioned to undertake an advisory review of the trust's data systems to provide assurance that all the other information systems that supply key data to the Board are accurate.

9.32 The review will identify the data sources and processes that underpin the key KPIs that the Board receive in the Integrated Performance Report.

Comment

The auditor's 'significant assurance' opinion in respect of data quality appears to have given committee and board members a false perception of the robustness of the trust's data quality, and to have played a significant part in the fact that there was no further

engagement by any committee or board and no subsequent internal audit on the subject of data quality until the discovery of the issues with Category One reporting in October 2022.

While the internal auditors report states that their 'Significant Assurance' opinion only covers the trusts arrangements to support effective data quality and should not be read as a wider commentary on the underlying data itself, that limitation is a serious one that appears to have not been fully recognised.

When appointing internal auditors for assignments of this nature, particular care should be taken to understand and agree what is in-scope, and anything that will not be covered. All recipients of the resulting reports should be aware of exactly what is being assured and anything that is not.

Recommendation

R8 The terms of reference for the current advisory review must be carefully considered and precisely drafted, ensuring that the issues regarding data quality raised in this report are included in its scope.

Ongoing management arrangements

9.33 The current Chief Executive told us that he had recently passed overall responsibility for business intelligence and data quality on an interim basis to the newly appointed Chief Information Officer.

Comment

Given our observations regarding the confusion of management responsibilities we welcome this move.

9.34 The Chief Executive also told us that there is significant difficulty in identifying and recruiting anyone with the knowledge, skills and experience of the data requirements of ambulance services. He has suggested that in the light of the scarcity of those with the requisite skills and experience and of the need for ambulance services to work together and to share data and information and learning, it would be appropriate for ambulance services to consider joint board level appointments.

Comment

We would endorse the consideration of appointments with a brief covering multiple ambulance services as a sensible and constructive way to proceed. Not only might this prove attractive to the most capable individuals, the potential for learning across ambulance trusts would be considerably enhanced.

Overarching comment on the governance and assurance of data in LAS

The current governance arrangements and documents providing the framework for the oversight and risk management of data quality are deficient in a number of respects. We would highlight:

- ***Policies are inconsistent and lack clarity about the roles, responsibilities and lines of accountability of those meant to be undertaking the management of data quality.***
- ***There are insufficiently clear and robust terms of reference for the committees charged with oversight and risk management.***
- ***The standing membership of committees meant to consider matters relating to data quality lack representation from relevant operational and clinical functions and activities.***
- ***There is a lack of clarity about the need for collaboration across the functions of LAS to ensure robust data quality and no indications of how that should be achieved.***
- ***There is inadequate priority given, and frequency of the attention paid by relevant committees, to the subject of data quality.***

- ***There is a lack of inclusion of data quality on the BAF or corporate risk register.***
- ***There is a lack of regular internal audit and review of fundamental data quality.***
- ***There is a lack of feedback and follow up on matters of concern.***

These matters have fed into and been borne out in an evident lack of appropriate engagement among senior managers and board members in the subject of information systems and data quality.

10. The current situation

10.1 We are aware that, so far in this report, we have described a difficult situation in LAS in both operational and cultural terms.

10.2 We believe that it is important, however, to emphasise that this related to a particular period in time and not, we believe, the current situation.

10.3 From all layers of the organisation that we have interacted with in the production of this report, the current culture is perceived as positive, and with the right direction of travel.

10.4 The chair has a positive view of the capabilities of the current NED group:

> *"As a team, my observations of them is very positive. I've been impressed with how they work together. The NEDs are very impressive as a group – exceptional, actually. There is also enthusiasm and energy."*

10.5 The NEDs themselves have a positive view of their situation. Typical comments are:

> *"I have to say that the new Chief Executive has really helped to create what appears to me to be a much better working relationship that the Executive now have amongst themselves, and that helps with the way the Board works as well."*

> *"It is far superior to where it was. The way the Exec are also working with the non-Execs is also much better, we're not having to dive into the management arena."*

10.6 This positive view is shared by the current executive team. While all acknowledged that there is still work to do, we heard from a range of individuals:

> *"There really was a step-change in that when the new Chief Executive arrived, and I can say that because I was extremely sceptical of his plan."*

> *"I have to say* [the structure now] *brings people together better. It empowers the Directors to be able to do their own portfolio.*

"Thing are so much better now."

10.7 The particular change in structure that was being referred to was the decision by the new Chief Executive to forego a more traditional Chief Operating Officer role in favour of a more blended structure. To explain the choice, he told us:

"The only way I could see to address the Operations / Clinical divide was to move the Operational responsibilities into the portfolios of the two most senior Clinicians – the Chief Medical Officer and the Chief Paramedic. This is why I have a unique structure in the ambulance sector of not having a Chief Operating Officer but having two deputy Chief Executives who share the Operations brief between them. I don't think anyone would have chosen this as the most logical organisational structure, but it has made a massive difference, because when you vest so clearly in two people both the operational performance and quality briefs you are clearly signalling they are both important and decisions need to take account of both elements. There is no doubt that our operational performance has improved markedly in the last year and that hasn't been at the expense of quality."

10.8 The chief executive explained his decision in light of his views on the ambulance service as compared with his previous acute sector experience:

"At many levels, an Ambulance Trust is very different to other NHS provider organisations. At its simplest form the service has many fewer service lines than most other providers because we only provide a reactive service and there are two primary functions that are either telephone based (call answering and telephone based assessment) or clinicians going to the patient to provide face-to-face assessment and treatment. But the complexity of both these functions are very high, the timescales they need to be delivered in are very quick, the large geography over which services are provided, the relentless 24/7 nature of the service, the capability to respond to major and significant incidents in conjunction with the other emergency services and the reliance on other parts of the Urgent and Emergency Care system to work effectively make the leadership challenge very high".

"Another major difference of the Ambulance sector is how uni-professional it is. Unlike the rest of the NHS where people are used to working in multidisciplinary teams, and you get lots of benefits from different clinical and professional groups bringing their different experiences to decision making, in the ambulance sector you generally don't get that because almost every role is filled by a paramedic. Part of the convening role of a COO is bringing people together from different backgrounds to get to an answer, so you don't need that in the same way in an Ambulance Trust. But you do need to find ways of bringing different perspectives into decision making."

Comment

The current structure, with two Deputy Chief Executives representing the 'two sides' of the organisation is clearly a significant contributory factor in the improving culture of the executive team. At the present time, it offers a solution to the earlier problems of siloed and difficult working relationships.

Ongoing lack of confidence in data

10.9 A number of interviewees highlighted to us that a consequence of the misreporting of the Category One data was that there is now a lack of confidence in the data produced by the BI team. We heard:

"There is much reduced level of confidence in BI data. Would I feel confident saying to you 'Let me give you three examples around three different things' and being able to say to you 'I am 100% assured that this data is right, and it's coming from the right places interpreting it correctly and we are drawing the right conclusions from it… No"

10.10 While unfortunate, this is not unexpected. The issue becomes more significant, however, when there is a culture in which questioning is seen as a hostile act rather than a learning opportunity. We heard:

"Are we mature in accepting criticism as an opportunity to learn. No, we are not."

10.11 And:

> *"I think we have been very channelled into 'It's this way or no way'."*

Comment

We believe that the recent appointment of the new Head of BI / CIO is a positive step, sending a signal of change and, indeed, that questioning of data is a lesser evil than its acceptance without critical appraisal. We believe, however, that a more proactive approach could also pay dividends.

We believe there would be merit in considering the services of a trainer specialising in developing a positive questioning dynamic within teams.

Recommendation

R9 LAS should consider specialist training to teach and promote a positive questioning and learning environment.

Observations on Cleric implementation

10.12 Although not explicit in the terms of reference for this report, we believe that a brief discussion of the Cleric Implementation can provide useful learning for the trust in any future IT implementation.

10.13 Cleric is a mature product used successfully in a number of UK ambulance trusts. Rather than taking it as an 'out of the box' solution and adapting internal processes to fit with the technology, LAS took the opposite approach. We were told that LAS made up to 90 modifications to Cleric in order to make it as similar in operation to Command Point as possible. Highlighted to us were changes to call signs, meal breaks and the MDT systems.

10.14 We were told that many of these modifications were decided on and communicated to the Cleric team from "*quite far down the (LAS) organisation*". This situation was undoubtedly exacerbated by the fact that the majority of senior management capacity was being consumed by the pandemic response, but it is also in keeping with the themes of a lack of management grip and oversight set out in this report.

10.15 A term used in a number of our interviews was *"London exceptionalism"* – the idea that the ambulance service in London is *"different"*, so should do things differently. It is not the place of this report to pass judgement on the veracity of this – we heard arguments both for and against the idea – but it does, in the case of major systems such as Cleric, have negative consequences if it results in in different ways of working to other trusts.

10.16 We understand that a number of the modifications to Cleric have subsequently been rolled back, clearly impacting the cost of the implementation both in the modifications and their reversal.

10.17 The 'go live' of Cleric went well, with few issues and was, undoubtedly, necessary given the age of the Command Point system. Questions should be asked, however, about the process that led to the implementation and what lessons can be learned from it.

10.18 We were told by a NED who is an experienced expert in IT systems:

> *"I think the implementation has gone well. I would say that, with any new system implementation, one has to make sure, as best practice, that one conducts a full review of the system post go-live, a full review of the integrity of the data sources, and a full review of any changes that have been made post go-live. I have already raised this with the Board, and I have already raised it on the BAF, and I have already spoken to the Chair about it – so this will happen, at least while I'm around, because that would be best practice with any new system implementation. Until we do that, we can't declare a victory."*
>
> *"There is a timing for when you would do that. You wouldn't do it immediately after go-live, but you would allow a little time for the system to settle in, but I have said that we should not allow the BAF risk to be closed until we have assurance on these two items. The first is that we have done a full data integrity review external and, No. 2, that we have what I call an 'after action review', so that we*

can really capture all the learnings and lessons from this implementation and make sure that those lessons are fully taken on Board by the Executive."

Comment

One of the great potential benefits of using a common system among peers is that developments can be rolled out seamlessly to all trusts and organisations can learn and benefit from the experience of others. There is a danger that, with too much customisation, these benefits are lost.

We strongly endorse the views of the NED on the benefits of a post-implementation review. Both elements suggested are key. We suggest that core elements of the 'after action review' should be to consider the governance of the project, particularly in relation to the collection and communication of bespoke modifications to the core Cleric system and whether these were / are necessary, or if LAS processes should be brought in line with other trusts.

Recommendations

R10 The trust should conduct a review of the implementation of the Cleric system. The review should incorporate a data integrity review to test the accuracy of the data produced and a review of learnings and lessons which can inform future IT implementation processes.

R11 The trust should use this review to inform and guide any future IT infrastructure purchase.

Part one conclusion

Verita has a long history of working with troubled organisations across healthcare, and so can offer a degree of perspective underpinned by significant experience. In the case of LAS, we think that it is very important to draw a distinct line between the difficult situation described in this report from 2015 and the situation since appointment of the current Chief Executive in mid-2021.

In compiling this report, we have seen a board and executive populated by impressive, dedicated individuals who clearly have a shared vision as to how to improve LAS. We believe that it would not serve the organisation or its users well to disrupt the good work that it now being undertaken, but rather that the senior team should be given space and support to continue with their efforts.

Part two - The effect of the coding error on LAS reporting

11. Reporting effects of the ETL coding error

11.1 In this section of the report, we will estimate the extent to which the coding error in August 2020 compromised the reporting of LAS data, i.e., the difference between the reported and actual Category One (Cat 1) performance.

Methodology

11.2 We received a download of all Category One cases in the period January 2018 to December 2022 in their 'raw form', i.e. with no manipulation by ETL or any other system. This amounted to 591,785 individual records.

11.3 Each record contained 31 fields. These included all of the 'markers' necessary to calculate Cat 1 response times i.e. all of the time stamps for:

- When the call was received
- When the call was answered
- When the triage was completed [the AMPDS determinant established]
- When the first vehicle was despatched to the case
- When the first vehicle arrived on scene

11.4 Also, in the data set were the response times calculated within the ETL and uploaded to the data warehouse. These are the response times that formed the basis for internal and external reporting.

11.5 The balance of the data set comprised information about the case, most notably the AMPDS codes that categorise the nature of the call.

11.6 Not all of the cases in the data were initially categorised as a Cat 1 call, as it is possible for an incident to be upgraded if more information is ascertained or the patient deteriorates prior to the arrival of the ambulance. An additional field was, therefore, provided that highlighted if the call was initially graded a 'Cat 1' or upgraded at a later time. This is significant for the analysis as, in the event of an upgrade, AQI rules allow for a clock start reset from the time that the upgrade occurs.

11.7 Our analysis involved calculating what the correct clock start time should have been for every case, based on the rules described in 7.8, i.e. the earliest of:

- 30 seconds after a call is received.
- As soon as a vehicle is dispatched to the call.
- When the incident is triaged as a Category One call – when the 'determinant' is established.

11.8 We then compared our calculated response time with that determined by the ETL code.

11.9 We are confident that the Verita model is calculating the response times accurately, as we compared our recalculated figures to those submitted by LAS before the coding error happened in Aug 2020 and they were very consistent with the reported figures.

11.10 The tables below show that the Cat 1 response times that LAS reported in seconds (i.e. the Command Point figures) against those recalculated using the Verita model for the period before the coding error occurred. First for 2018:

	Reported	Recalculated	Difference
Jan 2018	427	427	0
Feb 2018	437	438	1
Mar 2018	440	442	1
Apr 2018	409	410	0
May 2018	412	413	0
Jun 2018	430	435	4
Jul 2018	404	404	0
Aug 2018	363	365	2
Sep 2018	376	376	0
Oct 2018	367	367	0
Nov 2018	377	378	2
Dec 2018	378	379	1
2018 Total	**400**	**401**	**1**

Table 1 - Verita calculated vs. reported Category One performance - 2018

11.11 For 2019:

	Reported	Recalculated	Difference
Jan 2019	381	381	0
Feb 2019	397	398	1
Mar 2019	378	379	1
Apr 2019	362	364	1
May 2019	368	369	1
Jun 2019	398	398	0
Jul 2019	395	395	0
Aug 2019	396	396	0
Sep 2019	401	401	0
Oct 2019	411	414	3
Nov 2019	405	405	1
Dec 2019	422	423	1
2019 Total	**392**	**393**	**1**

Table 2 - Verita calculated vs. reported Category One performance - 2019

11.12 Finally, for the period to July 2020:

	Reported	Recalculated	Difference
Jan 2020	391	394	3
Feb 2020	407	408	1
Mar 2020	591	592	0
Apr 2020	431	430	0
May 2020	352	352	0
Jun 2020	346	346	0
Jul 2020	359	359	0

Table 3 - Verita calculated vs. reported Category One performance - 2020

11.13 The data shows that the approach we have deployed produces results closely matched to the (correct) reported figures prior to August 2020. The minor discrepancies in the Command Point and Verita figures can, we believe, be explained by the fact that some retrospective amendments to the data can (legitimately) occur after the AQI figures have been submitted to NHSE. We will discuss these in more detail below, but we do not believe that the divergence in the figures are material to our study and its conclusions.

Comparator data sets

11.14 As part of the background research for this project, Verita received a 'C1 Early Predict Dashboard'. This shows Cat 1 performance across all ten ambulance trusts against a range of different metrics.

11.15 Our intention was to use this data to provide points of comparison for LAS in areas that we concentrate on.

11.16 Examination of this data, however, has demonstrated variation which needs further analysis.

11.17 Below is given a single, but illuminating, example of this – the percentage of all cases that are recorded as Category One calls:

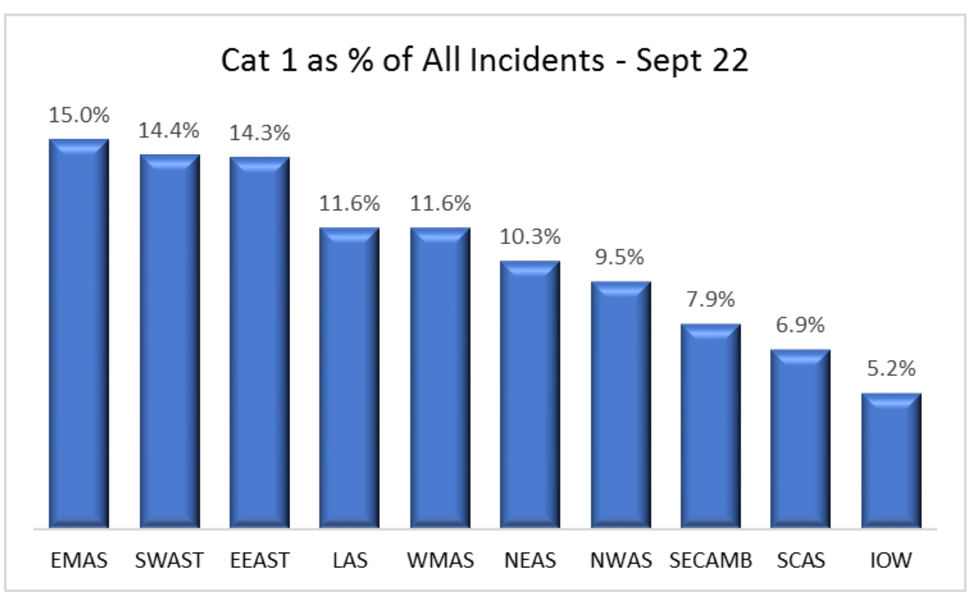

Chart 1 - Percentage of incidents recorded as Category 1 - All trusts, September 2022

11.18 As can be seen, the percentage variability between trusts is very significant, with the highest reported some three times greater than the lowest (albeit that the lowest is the Isle of Wight). September 2022 is not atypical, i.e. this is a representative month. The full data set has many other examples of significantly different reported figures.

11.19 We have been told by a senior executive in NHS England that a likely contributory factor for this discrepancy is the number of calls that are upgraded to Category One from lower categories – in effect, if Category Two performance is poor, the patient deteriorates

to the point when an upgrade to Category One becomes necessary, thereby increasing the percentage of incidents recorded as Category One. We have been told that the data demonstrates a strong correlation between the proportion of Category 1 incidents and Category 2 response times, but Verita has not verified this.

Comment

This interplay between Category Two performance and the number of Category One cases recorded is plausible, but unlikely to explain all of the discrepancy.

11.20 If a 'base metric' – the percentage of calls that are graded as Category One – is not fully comparable across trusts, it will inevitably follow that any metrics that rely on the categorisation (such as response times to Category One calls) will, equally, not be fully comparable.

11.21 We believe that a possible (if not probable) explanation for the remainder of the divergence of reported statistics is the fact that there are two main CAD systems in use across England – Ceric and MIS – and two separate methodologies for triaging calls – AMPDS and NHS Pathways.

11.22 While Cleric and MIS should simply reflect AQI guidance in their treatment of any case, we have seen that LAS has, for example, introduced a number of bespoke attributes to its installation of Cleric. If this has been repeated by other trusts, it is possible that the core systems introduce different interpretations of the same 'rules'.

11.23 The fact that AMPDS and NHS Pathways produce different outcomes has been recognised for some time. In 2017, NHS England in conjunction with the Association of Ambulance Chief Executives and the University of Sheffield published its "*Ambulance Response Programme Review*." In it was stated:

> *"There are differences across all services in terms of the proportion of incidents assigned to each category irrespective of triage system used but overall a larger proportion of calls are assigned to Category 1 and 2 in AMPDS services than in NHS*

Pathways services (range 65-71%) compared to 50-66% in NHS Pathways sites. Overall AMPDS sites have a Cat 1 proportion 2-3% points higher than NHS Pathways sites."

11.24 A further factor that should be considered is if trusts use a data warehouse and, if so, how the data in it is produced. We know from the LAS experience that if the data is manipulated in any way prior to reaching the warehouse, there is the possibility of error being introduced. For the avoidance of doubt, we have not engaged with any other trust to explore this point – it would be significantly beyond our terms of reference – but it is possible that this may be a contributory factor to these observations.

11.25 It is clearly beyond the remit of this report to attempt to determine the nature and genesis of the published statistics, and it is important for us to state that we are, in no way, questioning their central collection and calculation.

11.26 We suspect, however, that, while there is a common set of principles guiding and underpinning how data is calculated and reported, there is in reality an interplay between the CAD system in use (and whether this has had any bespoke reprogramming by individual trusts), the triaging system used and, potentially, the effect of any manipulation to transfer data from the CAD system to a data warehouse.

11.27 If this is correct, there are implications for the reporting and comparison of individual trusts. At present, Ambulance Quality Indicator data – the metrics by which trust performance is compared and national policy is made – publishes data essentially in 'league tables' in which each trust is viewed as equivalent to any other.

Comment

We heard from several individuals with extensive ambulance trust experience that the degree of cooperation, support and mutual benefit from shared learning is limited between ambulance trusts. The environment was described as 'competitive'. Clearly, league tables would promote this competition – by no means a bad thing if they serve to drive up standards and improve patient outcomes – but if tables are to be published, it is of vital importance that they are based on, as far as possible, genuinely equivalent data.

Recommendations

R12 We believe that it would be appropriate for NHS England to engage with ambulance trusts to understand their specific use of their CAD systems – is it an "off the shelf" solution or has it been modified in any way and, if the latter, how and with what effect (if any) on reported data?

R13 NHS England should identify those trusts using a data warehouse and, if possible, gain assurance that each of these trusts – particularly in those areas that are reported nationally – are calculating metrics in an equivalent manner.

R14 It is accepted that AMPDS and NHS Pathways triaging produce different percentages of Category One cases. We believe that NHS England should designate one of these approaches as its 'preferred', and encourage all trusts to adopt it.

Published versus actual data

11.28 In this section of the report, we discuss the degree to which the data submitted to NHSE by LAS in the period August 2020 – September 2022 was incorrect, i.e. the magnitude of the underreporting of Cat 1 response times.

11.29 The methodology used was that described in 11.7, i.e. using our data model to establish what the correct clock start time should have been with a 30 second allowance rather than the 240 seconds provided under the August ETL code.

11.30 As noted in 11.6, if a call is upgraded at any point prior to a unit arriving on scene the clock start time is reset. For the purposes of this analysis, we received a dataset showing the time that an incident was upgraded and used this as the clock start time and used this (as per AQI guidance) as the baseline against which to judge the response time.

11.31 Below, we show the reported (Command Point / ETL calculated) response times vs. those produced by our data model. First for the period August – December 2020:

	Reported	Calculated	Difference
Aug 2020	363	381	17
Sep 2020	346	394	48
Oct 2020	333	380	48
Nov 2020	321	363	42
Dec 2020	394	445	51

Table 4 - Verita calculated vs. reported Category One performance 2020

11.32 As can be seen, in August 2020 when the ETL code was changed, the trust reported an average 363 second (six minutes 3 seconds) Category One response time, whereas in reality this should have been 381 seconds (six minutes 20 seconds).

11.33 This modest difference in August is unsurprising given that the code was not changed until the 19th of the month, but even for the later months of 2020, the error was always under one minute, peaking at 51 seconds in December 2020. In December, though, the additional 51 seconds puts LAS over the seven-minute (420 seconds) Category One target.

11.34 In 2021, although there is a slight upward trend in the magnitude of the misreporting over the course of the year, the maximum difference between the reported and actual figure only climbs above one minute in a single month – July, where the reported was 419 seconds (six minutes 59 seconds) vs. an actual performance of 482 seconds (eight minutes 2 seconds).

	Reported	Calculated	Difference
Jan 2021	382	428	46
Feb 2021	314	358	45
Mar 2021	321	365	44
Apr 2021	339	384	45
May 2021	366	415	49
Jun 2021	393	447	54
Jul 2021	419	482	63
Aug 2021	418	473	55
Sep 2021	446	505	59
Oct 2021	422	476	54
Nov 2021	426	474	49
Dec 2021	429	486	57
2021 Total	**397**	**449**	**52**

Table 5 - Verita calculated vs. reported Category One performance 2021

11.35 It is notable, however, that for the months of January, June, July and August 2021 the trust reported itself as being compliant with the seven-minute Cat 1 target, whereas in reality they had, again, breached it.

11.36 In 2022 prior to the implementation of Cleric, the magnitude of the underreporting error peaked. In August, there was a 77 second discrepancy, taking the reported Cat 1 response time from 483 seconds (eight minutes 3 seconds) to an actual performance of 560 seconds (nine minutes 20 seconds).

	Reported	Calculated	Difference
Jan 2022	397	449	52
Feb 2022	404	453	49
Mar 2022	433	488	55
Apr 2022	400	452	52
May 2022	418	474	56
Jun 2022	454	520	66
Jul 2022	483	560	77
Aug 2022	458	529	71
Cleric Implemented			

Table 6 - Verita calculated vs. reported Category One performance 2022

11.37 Similar to 2021, in the months of January, February, April and May 2022 LAS incorrectly reported itself within the Cat 1 target performance target. In each month, the real performance of the trust was beyond seven minutes.

Comment

Our recalculated figures showing actual response times shows that in nine of the twenty-five months under consideration, the misreporting of responses masked the fact that LAS had breached the seven min (420 second) Category One response target. These are in addition to the seven months that LAS had already reported as beyond the target (though not by the correct amount).

How did we calculate the magnitude of the reporting error - Methodology

11.38 A key question that must be addressed is that if the ETL code was applying the incorrect HCP clock start allowance of 240 seconds to all records, why was this not reflected more closely in the data produced by the ETL, i.e. an error figure closer to 210 seconds.

11.39 Although ETL was allowing a 240 seconds 'delay' to the clock start time on all cases, it was still correctly applying the two other potential clock start triggers: the time of first vehicle despatch and the time when the AMPDS 'determinant' was established.

11.40 We examine the effects of this below.

Data analysis

11.41 As can be seen in chart 2 below, the number of Category One cases incorrectly calculated by ETL is consistently in mid-fifties percent across the period, peaking at 58% in August 2022.

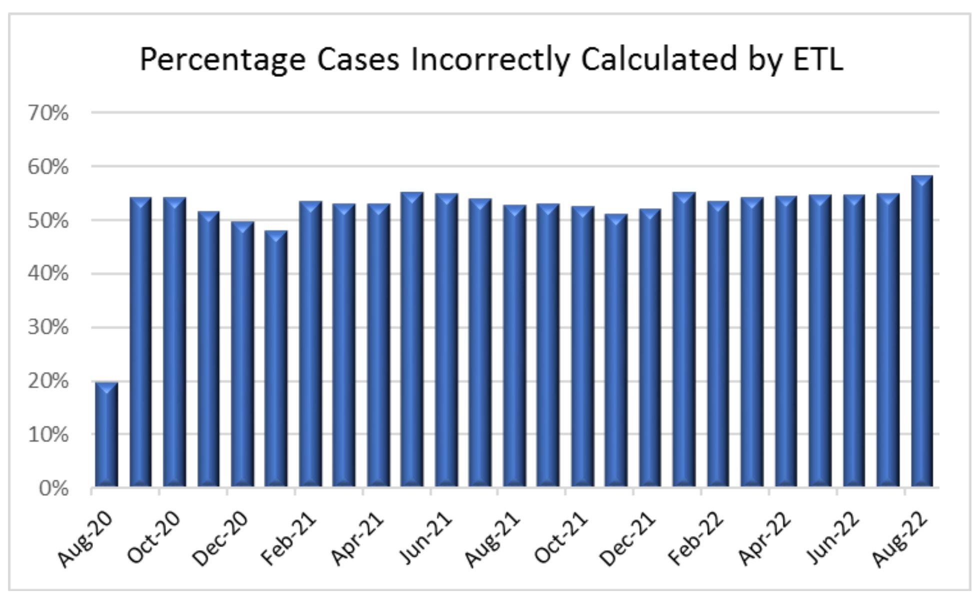

Chart 2 - Cases identified as having been incorrectly calculated by the ETL code

11.42 From 19 August 2020 to end August 2022 – the period in which data was incorrectly reported – there are just in excess of 225,000 records of Category One calls.

11.43 For the purposes of analysis, we segmented these cases into three separate groups, each with distinct characteristics:

1. Those where there was no error in the ETL calculation and so the reported response time was correct, and no upgrade had occurred. 34,911 cases total (15.5%).
2. Those where the reported response time was correct i.e. there was no error in the ETL calculation and an upgrade had occurred. 69,644 cases total (30.9%).
3. Those where the reported response time was incorrect, i.e. there was an error in the ETL calculation, and no upgrade had occurred. 120,893 cases total (53.6%).

11.44 Determining the clock start trigger for each of these groups provides insight as to why the error magnitude comes out as it does. In turn for each of the segments:

1. Reported response time was correct, and no upgrade had occurred

First vehicle despatch starts clock	-	73.9% of the segment
AMPDS Determinant established	-	7.8% of the segment
111 Calls*	-	18.4% of the segment

(Note – calls received from 111 attract an instant clock start. All were handled correctly)*

11.45 In this segment, nearly three quarters of the clock start times were triggered by the despatch of a vehicle. In these cases, the vehicle was despatched in less than 30 seconds, so the “240 second rule” never became active.

11.46 This is true, also, for cases in which the AMPDS code was determined in under 30 seconds.

11.47 In addition to the clock start rules already noted, there is an AQI standard that 111 calls attract a zero second clock start. This rule was applied correctly.

2. Reported response time was correct, and an upgrade had occurred

Upgrade clock start correctly applied - 100% of the segment
(i.e. response times correctly reflect time from clock start to vehicle arrival)

11.48 In this segment, calls were upgraded from an initial, lower category to a Category One incident. As noted, in such instances, AQI standards allow a 'reset' of the clock start time to the point where the upgrade occurred. This rule was applied correctly, and the reported response times were in line with AQI requirements.

3. Reported response time was incorrect, and no upgrade had occurred

First vehicle despatch starts clock - 59.9% of the segment
AMPDS Determinant established starts clock- 23.4% of the segment
240 seconds start clock - 16.8% of the segment

11.49 This segment of applicable records is, in many respects, the most significant for the purposes of this report. It represents those cases where there is no mitigating factor that overrides the application of the 240 second allowance, but rather where this has incorrectly been applied with a material effect on the reported response times.

11.50 The analysis shows us that 20,649 cases had the full 240 seconds allowance applied to them (17.1% of this segments' 120,893 total cases). When put in the context of the more than 225,000 Category One cases over the relevant period, this equates to 9.2% of all Category One incidents in the period when the reporting was incorrect.

11.51 The majority of the cases (59.9%) that did not reach the 240 second limit had their clock start triggered by the despatch of a unit to the incident, with the balance (23%) triggered by the AMPDS determinant being established.

Calculation of the level of misreporting

11.52 This complex interplay of cases and their individual treatments resulted in LAS reporting between 42 and 77 seconds less than their actual monthly performance.

11.53 We started this section of the report by asking how a potential 210 second change could result in a reporting error of the magnitudes described in paragraph 11.38.

11.54 The final element of the explanation lies in an examination of (for those cases that did not reach the 240 second trigger) after how long did either the vehicle despatch or AMPDS determinant being established trigger the clock start?

11.55 We calculated the size of the reporting error for each month the incorrect ETL code was being applied, as shown in tables 4, 5 & 6. Rather than showing repetitive analysis for all of these months, we will instead consider the two extremes – the 42 second error in November 2020 and the 77 second error in July 2022.

November 2020

11.56 Chart 3 below for November 2020 shows that 52% of all Category One cases in the month had a response time incorrectly calculated by the ETL code (red bar). The blue bars show the magnitude of the error – for example 16% of the records had an error of between 1-30 seconds, 7% had an error between 61 and 90 seconds, and 7% fell between 181 and 210 seconds. The individual blue bars sum to the 52% total for the month.

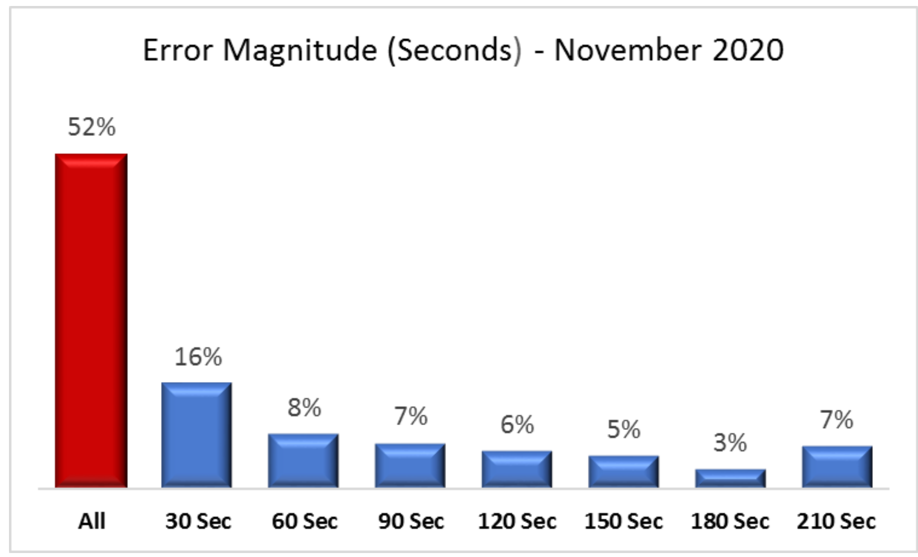

Chart 3 - Calculated Error Magnitude - November 2020

11.57 Each bar represents a 30 second range up to the maximum 210 second error level. Aggregated – each of the time bands shown above coupled with the fact that these cases represent just over half of the monthly total Category One cases (as per paragraph 11.41 above) - equates to the 42 second reporting error.

July 2022

11.58 In July 2022, the shape of the graph is noticeably different, with a greater preponderance of higher magnitude cases, as shown in chart 4 below:

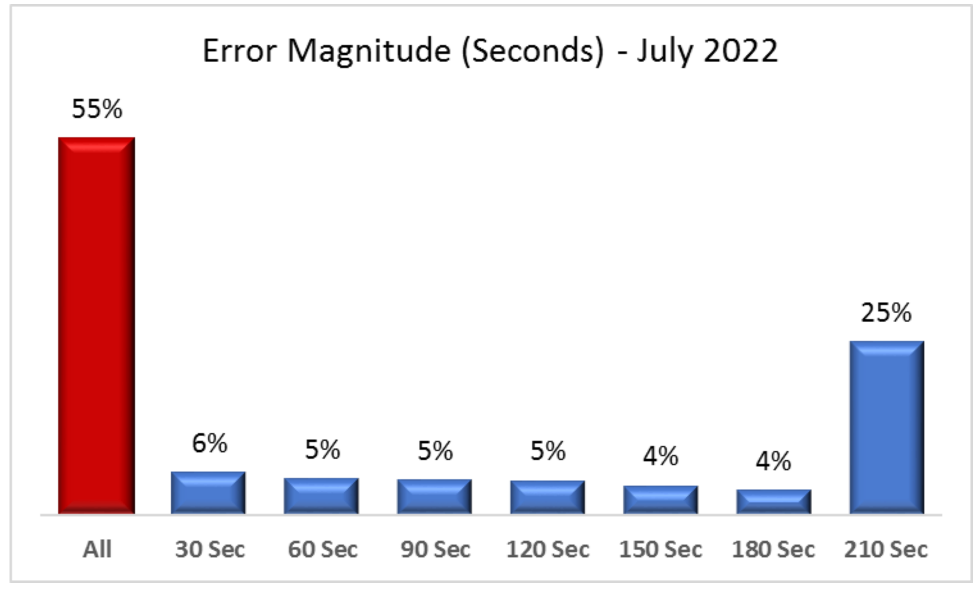

Chart 4 - Calculated error magnitude - July 2022

11.59 In this month, 6% of cases fall into the 1-30 second error band, 5% in the 61-90 second error band and 25% in the 181-210 band. In aggregate these errors equate to an underreporting of actual performance of 77 seconds.

Comment

This data paints a mixed picture for LAS. The worst-case scenario could, theoretically, have meant that all reporting from September 2020 to August 2022 would have been incorrect by 210 seconds. In the worst month (July 2022) the underreporting was only 77 seconds. In essence, the trust was spared from a worse level of misreporting by the fact that the ETL code still correctly applied the other clock start trigger rules.

However, in the 25 months when the coding error was active, the trust incorrectly reported compliance with the seven-minute Category One target in nine separate months.

How was the underreporting allowed to go unrecognised?

11.60 Over the course of our interviews, we witnessed a great deal of self-recrimination as to why, in the period August 2020 up to the implementation of Cleric in September 2022, nobody in the trust recognised that the reported Category One performance was incorrect.

11.61 Explanations – not unreasonably – highlighted the effect that the pandemic response had on the wider organisation in August 2020. We heard:

> *"In August 2020 our demand had dropped significantly. We still had support in the form of mutual aid from the London Fire Brigade, so we had a lot of additional resource. We had Daily Senior Leadership Team meetings that were chaired by the COO or the Chief Executive where it was very much around 'what's not green' as opposed to 'what is green'.*

11.62 This sentiment was echoed by another senior executive:

> *"We didn't spot the Cat 1 issues because the focus was on Cat 2. It is understandable that there would be a lot of bandwidth taken up with actual harm rather than casting around for theoretical harm."*

11.63 A NED told us:

> *"I think where the Board tended to spend its time was on Cat 2. Cat 2 became a big focus because performance was obviously not at the AQI standard and, in some cases, well below. If my memory serves me correctly, yes, there would be a discussion about Cat 1 but were we saying, well okay, should we be challenging that Cat 1 seems to be okay relative to other Trusts? That is the $64,000 question and I don't recall that conversation taking place robustly."*

> *"… I think there was also a rationalisation around why we were maintaining our Cat 1 performance. That would often be things like the volume of work, the period we were in, or the fact that we had extra support – it could be a number of factors that, in hindsight, probably gave us more assurance than we should have taken.*

11.64 There were markedly fewer Category One incidents in August 2020 than had historically been the case. On average in 2019, the trust handled over 11,200 Category One cases per month. In the period April – Dec 2020, during and between the national lockdowns announced in March and November 2020, this number fell to an average of just over 7,200.

11.65 Regarding the change of ETL code in August, we were told by an executive familiar with the data:

> *"Quite often when you put something in, you notice a critical change, something stops working, and the problem with this change they made is, at the time, it's not like on Day 1 they were reporting this, Day 2 someone put the code in and it flooded, and you see a significant shift. What you've got is a drift effect, as far as I can see.*

11.66 LAS reported data supports the view that there was not an immediate step change in the Cat 1 data, but rather 'drift' downwards.

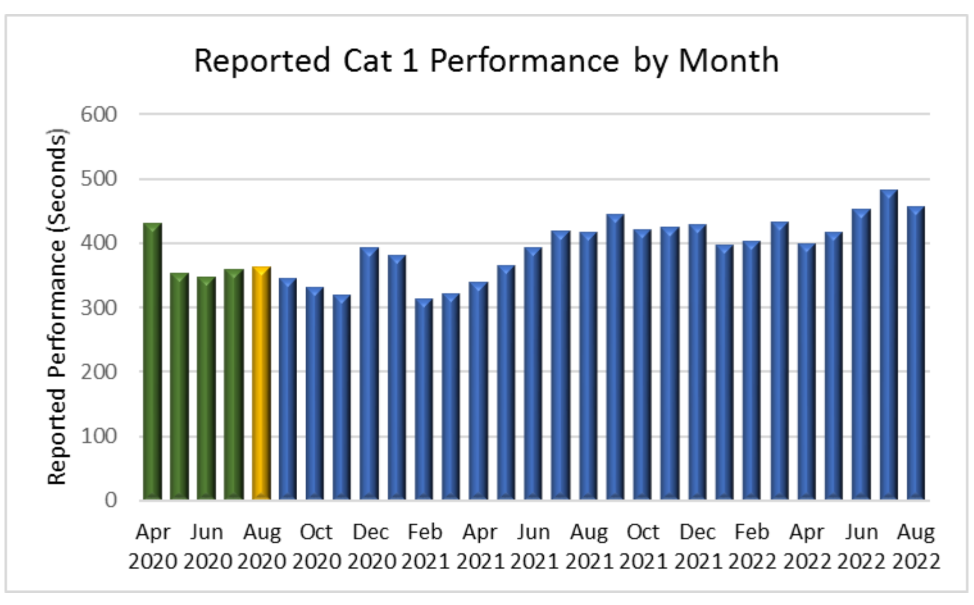

Chart 5 - LAS reported Category One performance - April 2020-August 2022

11.67 Chart 5 shows the four months leading up to August 2020 (green bars), August 2020 in yellow and the months in which the incorrect code was applied in blue.

11.68 There is no 'step change' in reported Category One performance apparent in the months after August 2020. There was a greater fall between April and May 2020 when the correct coding was being applied, and a greater increase between November and December 2020 when the coding error had been in operation for three months.

Comment

For more than two years, LAS failed to recognise that the Category One reporting was incorrect. It is important, however, to recognise the circumstances in which this failure occurred.

The actual incidence of incorrect records was around 50% of the total data set, and most of these showed an error considerably less than the possible 210 seconds.

The pandemic and LAS's response to it was dominating the organisation and metrics that were believed to be 'green' – i.e. compliant with requirements – were receiving little or no attention. Coupled with the fall in Category One case numbers apparent in 2020, it is understandable that performance against Category One targets did not receive management attention.

Further findings of Category One data audit

11.69 During the course of our work, a number of other issues were observed that relate to the quality and veracity of the data reported. For completeness, we outline these below.

11.70 Firstly, we found a number of records in which the first response vehicle 'Arrival time' precedes the 'Call Connect' time, i.e. the first response vehicle has arrived on scene before the call came in.

11.71 Examination of this issue by the LAS BI team suggests that the error arises through poor process by crews, whereby they activate on 'on-scene' alert prematurely.

11.72 We also found some instances of the incorrect ETL calculation being imposed to cases retrospectively – i.e., to cases that did not take place during the period in which the incorrect coding was in use.

11.73 As noted, in the period leading up to August 2020, the Verita analysis was mismatched with LAS reported data by a small number of seconds in some months. We

believe that this retrospective imposition of the incorrect code was instrumental in this. We learned that a small number of patient personal record files were rescanned for a variety of reasons. When the file is rescanned, the record is retrospectively run through the calculations that were in place at that time – in this case the erroneous ETL script. This introduced an error on the record.

Comment

We highlight this point to explain the difference between the reported Category One performance and the Verita calculated figures. At the time of submission – pre-August 2020, the records would have been correct and, therefore, so would LAS reporting. This situation does, however, further highlight the importance of being aware of potential 'unintended consequences' of actions that, in themselves, are legitimate.

11.74 We found instances where the clinical upgrades in Cleric to a higher category were not reflected in the data warehouse. This suggests that the ETL scripts are failing to capture this element of the record from Cleric and transfer them accurately.

11.75 This issue has potential to adversely affect the veracity of reported data, although in this instance to make LAS performance appear worse than it is in reality. When an upgrade occurs, the start clock resets, hence failure to recognise this will add to reported response times for these records.

Comment

In any audit of a large data set, it is unsurprising to identify issues, particularly in a situation such as this where we are interrogating data at the point of a new solution implementation. We would emphasise that the number of records referred to in this section of the report are small, so in a large dataset will have a very limited effect on reported outcomes.

We have reported on and discussed the three issues noted with the relevant individuals in the trust and are confident that they have been understood and corrective actions are being undertaken.

Recommendation

R15 The implementation of Cleric provides the trust with a good opportunity to identify and address any issues in data quality that are identified as part of this implementation. They must be taken.

Part three – Patient harm

12. Did the reporting error cause patient harm?

12.1 The final question we will consider in this report is the patient harm that may have resulted from the underreporting of Category One response times.

12.2 It must be emphasised that there is no suggestion that individual crews acted in any way other than professionally and appropriately for the patients under their care in the period August 2020 – August 2022. In addition, it should be recognised that ambulance crews were working under considerable stress during the misreporting period, as they were very much on the 'front line' of the NHS's pandemic response.

12.3 It should also be noted that the misreporting did not affect the dispatch of any individual ambulance. If triaged as category One, the unit was despatched as a priority.

Comment

No criticism – inferred or explicit – should be directed at LAS crews. We have seen nothing in our interaction with LAS staff that would imply that they acted in anything other than good faith and in the best interests of the patients that they cared for. When calls came into the service, they were responded to as quickly as the prevailing circumstances allowed.

12.4 In assessing what potential harm might have come to LAS patients during the underreporting period, we are considering the possible effects of missed opportunities for action that LAS might have decided to take as a result of more accurate response time reporting. The key question is, therefore, if the executive had been aware of the true Category One performance, would steps have been taken to improve Category One response times, and how effective would these have been?

Assessing potential patient harm

12.5 Patients that require a Category One response are, by definition, in a life-threatening condition. Some, sadly, will not survive.

12.6 It is possible that the LAS executive may have made different decisions had they known that their Category One targets had been missed with greater regularity than they believed, but this would have been subject to the constraints imposed by the pandemic.

12.7 Had the LAS executive been aware of their true Category One response times, and taken action to address these, then it is likely that some patients with a life-threatening emergency would have been attended slightly sooner. This translates into a potential survival benefit, though this benefit is speculative. It relies on the hypothesis that the LAS executive decided to act, and that this had the desired impact on response times and, therefore, outcomes for some patients during the misreporting period.

12.8 We have considered whether the magnitude of avoidable harm or "missed opportunity" can be quantified. It is our view that we cannot say with any certainty what would have happened had the misreporting not occurred.

12.9 Many Category One patients are not found to have a life-threatening problem on ambulance arrival. In those Category One incidents where there is a credible evidence base that response time has a material effect on patient outcomes – essentially cardiac arrest – patient survival is determined by multiple factors.

12.10 It is therefore pertinent to consider patient outcomes during this time. Chart 7 below shows how LAS performed against its ambulance peers for 30-day survival following cardiac arrest in the period August 2020 – June 2022 (the last month for which we have data):

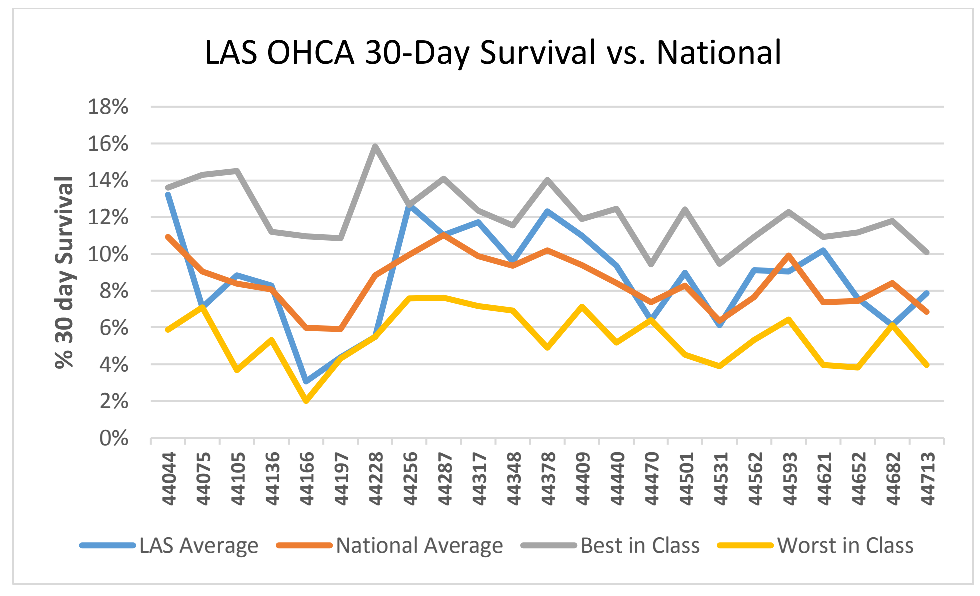

Chart 6 - Cardiac Arrest 30-day survival - August 2020-June 2022

12.11 As can be seen, LAS's performance for the 30-day survival metric is consistently 'in the pack', with an average of 8.7%. Over the 23-month period, its performance represented 'Worst in class' in four separate months and 'Best in class' in one.

12.12 In the time period covered during this review, where LAS received a concern about the quality of care or impact of delays to a Category One patient, the individual investigations and care reviews for these patients used the actual times recorded on the CAD. This data was not taken from the data warehouse, so we can be confident that the data used in reviews of individual patients that had triggered a cause for concerns was correct. These reviews have already been reported and proper duty of candour applied.

12.13 If our analysis was to be meaningfully supplemented, this could only be done through a detailed clinical consideration of all 225,000 Category One patients attended by LAS during the misreporting period.

12.14 This would clearly be a resource intensive, protracted and very costly undertaking. It would also not be able to establish with any certainty whether an individual had suffered avoidable harm as a direct result of the misreporting. We therefore see no compelling reason to draw upon the public purse to pursue this, given the obvious constraints and the uncertain conclusions that would be drawn.

Potential patient harm – conclusions

12.15 Had the LAS executive been aware of the true Category 1 response times and taken effective action to address these, it is likely that some patients would have benefited in terms of improved outcomes and in some cases, such as cardiac arrest, improved survival.

12.16 However, there is no means by which to quantify this, or to identify individual patients who may have been affected. Any potential benefit is speculative. It relies on the assumption that the LAS executive would have decided to act and that this had the desired impact on response times and therefore outcomes for some patients during the misreporting period.

Recommendation

R16 We recommend that no further action be taken with respect to patient harm.

Appendices

Appendix 1

Document List

AQI-Quality-Statement-2015-v1.2

Ambulance Response Programme Review – NHSE – 2017

AC1822 - Audit Cttee mtg 17 May 2018 - Data Quality Framework Review

Draft minutes of Audit Committee meeting 18 June 2020

Agenda - Quality Assurance Cttee 07 July 2020

Draft minutes Quality Assurance Committee 07 July 2020

Agenda - Quality Assurance Committee 20 January 2022 updated

Draft minutes Quality Assurance Committee 20 January 2022

Agenda - Quality Assurance Committee 08 March 2022

Draft minutes Quality Assurance Committee 8 March 2022

Agenda - Quality Assurance Committee 10 May 2022 DRAFT

Draft minutes Quality Assurance Committee 10 May 2022 AP

Agenda - Quality Assurance Committee 05 July 2022 DRAFT v2

Draft minutes Quality Assurance Committee 05 July 2022docx

Agenda - Quality Assurance Committee 06 September 2022

Draft minutes Quality Assurance Committee 06 September 2022

Agenda - Quality Assurance Committee 08 November 2022 v3

Agenda - Quality Assurance Cttee 08 September 2020

Draft minutes Quality Assurance Committee 8 September 2020

Agenda - Quality Assurance Committee 3 November 2020

Draft minutes Quality Assurance Committee 3 November 2020

Agenda - Quality Assurance Committee 14 January 2021

Draft minutes Quality Assurance Committee 14 January 2021

Agenda - Quality Assurance Committee 09 March 2021 FINAL (MS)

Draft minutes Quality Assurance Committee 9 March 2021

Agenda - Quality Assurance Committee 04 May 2021 FINAL

Draft minutes Quality Assurance Committee 4 May 2021 DRAFT

Agenda - Quality Assurance Committee 06 July 2021 DRAFT v3

Draft minutes Quality Assurance Committee 6 July 2021

Agenda - Quality Assurance Committee 07 September 2021 DRAFT v5

Draft minutes Quality Assurance Committee 6 July 2021 v2

Agenda - Quality Assurance Committee 09 November 2021

Draft minutes Quality Assurance Committee 9 November 2021

Agenda IGG 30 July 2020 v3
Draft Minutes of IGG Meeting held on 30 July 2020
IGG Agenda September 2022
Agenda IGG 10 Sept 2020
Draft Minutes of IGG Meeting held on 9 Sept 2020
Agenda IGG 5 November 2020 FINAL
IGG Agenda Feb 2021 FINAL
Draft Minutes of IGG Meeting held on 25 February 2021
IGG Agenda 1 July 2021
Draft Minutes of IGG Meeting held on 1 July 2021 DRAFT
IGG Agenda 13 September 2021
Draft Minutes of IGG Meeting held on 13 September 2021
IGG Agenda November 2021
Draft Minutes of IGG Meeting held on 15 November 2021
IGG Agenda 10 January 2022
Draft Minutes of IGG Meeting held on 10 January 2022v2
IGG Agenda May 2022
Draft Minutes of IGG Meeting held on 23 May 2022
IGG Agenda June DSPT Sign-Off Mtg 2022
Draft Minutes of IGG Meeting held on 16 June 2022
AC1923ii - Audit Cttee Mtg 16 May 2019 - Data Quality IA Report
LAS Review of IUC Service - Draft v3.0
LAS Review of IUC Service Summary Sheet
LIC1973 - LIC Mtg 12 Nov 2019 - Data Quality
Logistics and Infrastructure Committee Terms of Reference 2018-19
Logistics and Infrastructure Committee Terms of Reference 2019-20
Quality Assurance Committee Terms of Reference 2020-21
Quality Assurance Committee Terms of Reference 2021-22
Quality Assurance Committee Terms of Reference 2022-23
Agenda - LIC Mtg 14 January 2020
LIC19103 - LIC Mtg 10 March 2020 - Draft minutes of 14 Jan 2020 Mtg
Audit Committee Agenda 18 June
Draft minutes of Audit Committee meeting 18 June 2020
TB1876 - Public Board 25 Sep 2018 - Draft minutes of 31 July 2018
Strategic Risk summary sheet
Strategic Risk

Strategic Risk COVID-19 BAF 61 - Clinical safety
Strategic Risk COVID-19 BAF 61 - Finance
Strategic Risk COVID-19 BAF 61 - Operations
Strategic Risk COVID-19 BAF 61 - People
Strategic Risk COVID-19 BAF 61 - Quality
For Information - Corporate risk register summary sheet
For Information - Corporate risk register
Committee Organograms and reporting structures v5
LAS Data Quality Policy 2022-24_V1 - Final for ExCo
Governance Review Paper 21 09 2021 September 2021
Draft Terms - LAS Governance Review September 2021
20211215 London Ambulance Service _ GGI report December 2021
Cover GGI Action Plan January 2022
GGI Action Plan January 2022
Cover GGI Action Plan March 2022
GGI Action Plan update March 2022
Cover GGI Report April 2022
GGI_LAS_GovernanceReviewPhase2_April2022
Cover GGI Report May 2022
GGI Action Plan update phase 2 May 2022
ExCo18309 - ExCo Mtg 16 Jan 2019 - IGG Terms of reference
IGG Terms of reference Summary Sheet May 2020
IGG Terms of reference May 2020

Appendix 2

Team Biographies

Peter Killwick

For over 20 years, Peter worked in the consulting industry becoming a partner in an international firm covering a variety of strategic and operational issues in a wide range of sectors including healthcare, automotive, financial services, manufacturing, retail, telecommunications and government. In Verita, he has extensive experience of project managing teams, strategy development, and complex investigation. Within healthcare, he has significant experience of working with both providers and commissioners and their umbrella bodies both in the UK and overseas. Peter has a particular focus on the development and evolution of our diagnostic tools and has very extensive experience in data manipulation and comparative interpretation.

Kate Lampard

Kate is a former practicing barrister. Currently she is the lead non-executive Director in the Department of Health and Social Care and chair of the Charity GambleAware, which tackles gambling harm through research, education and treatment and commissions the National Gambling Treatment Service. Kate undertakes investigations and management consultancy work principally in relation to the provision of public services. She led the NHS investigations into the Jimmy Savile affair and carried out investigations into the culture of the Yarl's Wood Immigration Removal Centre and of the Brook House Immigration Removal Centre. Most recently she has conducted a review of the borders immigration and citizenship service within the Home Office, and has overseen a review of misreporting by a Covid testing laboratory during the pandemic.

Kate is a former chair of a South East Coast Strategic Health Authority and former deputy chair of Financial Ombudsman Service Limited. Kate is a Trustee of the Royal Horticultural Society Limited and of the Esmée Fairbairn Foundation.

Final

Independent review of the circumstances and outcomes surrounding the misreporting of London Ambulance Service performance data

Action Plan*

Recommendation	Rationale	Proposed Action	Lead	Date
R1 It is imperative that LAS develops the means in terms of governance processes, systems and personnel – to monitor and address issues with its information, data and reporting systems.	***It is clear that there are deficiencies in the terms of reference of both the QAC and the IGG, in that they are not adequately explicit about the responsibilities of those committees for ensuring robust and rigorous oversight and assurance of all matters relating to data quality, rather than solely information governance. There is, equally, a deficiency in relation to the membership of the IGG provided for under its terms of reference.***	The Board has agreed a new digital committee whose terms of reference include responsibility for data quality. QAC and IGG have had their terms of reference updated, and a new officer-level data quality group is being established.	Director of Corporate Affairs	Approval of new terms of reference at May Board with DQ group Terms of Reference agreed by ExCo.
R2 Policy documents and the terms of reference for committees within	***It appears, therefore, that there is currently significant incoherence in the documentation providing for the governance and oversight of data quality, in that the accountabilities***	As above plus the data quality policy will be revised to and approved take account of	Director of Corporate Affairs	For approval at ExCo then at June

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the trust must be consistent both within themselves and across overlapping areas. Clear lines of accountability must be included in these policies.	***and lines of reporting under the risk management arrangements differ from those under the data quality policy.*** ***Although we have been told, and the documentation provides, that responsibility for matters of data and data quality ultimately lie with the Chief Financial Officer, there is a question, not addressed in any of the governance documents, including relevant policies and committee terms of reference, about how managers will work together to ensure that there is a (necessary) common approach and understanding on matters of data quality and associated risks between the governance, wider operational, quality and clinical functions of LAS.***	revised accountabilities and structures.		Digital Committee.
R3 The DQAT needs to be fully resourced, and to be given the full support of the executive team.	***We believe that the idea of a trust-wide data quality forum has merit. The membership and ToRs for such a forum should be considered by the newly***	The membership and ToRs for a data quality group have been drafted. It will be chaired by the Chief Paramedic and	Director of Corporate Affairs	For approval at ExCo then agreed by

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R4 A data quality forum should be established for developers, data and information system managers and the corporate IM&T team. Its aims should include ensure the sharing of best practice, the adoption of standard processes and procedures, and peer review in respect of data quality. The chair of the forum should be of sufficient seniority to ensure that it works effectively and that actions identified by it are carried out.	***established committee charged with looking at all matters relating to the oversight and assurance of the trust's IT, data and information systems.*** ***We also believe the trust should devise and implement an appropriate trust wide training programme, to include refresher training, for all developers and other staff and contractors managing information and data systems, on standard operating processes and other requirements for maintaining data quality.***	Deputy CEO as the director lead for data quality. It will have its first meeting in June. The department consists of 3 WTE but currently have 2 vacancies albeit with a new head starting at the end of the May. The remaining vacancy will be filled by the end of June. Further capacity is available in the IT department and work is taking place to integrate further. This will give more senior capacity in the department with immediate effect.	CIO	Digital Committee and reported to Board

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R5 A training programme should be devised and implemented for all IT staff incorporating aspects of proper process and data quality standards.		Departmental training on data quality has been included in the current year for all BI staff with a view of a wider rollout in 24/25. PDRs have been set for completion by the end of May for all BI staff and will include sections on data quality.	CIO	Reported to Digital Committee for assurance
R6 The trust should carefully consider the recommendations listed in paragraph 9.17 and seek to implement them in full, with input from the DQAT team.	9.17 In the section headed *"Recommendations"* the report states: *"To mitigate against any further risks in the short term or another occurrence of such an event, certain actions are required at* ***an immediate and urgent level*** **[Verita emphasis]**. *In order to manage risk and mitigate any compromised data, the following*	A) Several initiatives underway to implement the actions in this recommendation Specialist firm employed to fully document the ETL process in both 111 and 999s. Work underway and will be complete in	CIO	Assurance at Digital Committee

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	recommendations will provide those key assurances once fully implemented: 1. *Annotated scripts and packages to show what controls it refers to so that any future change can be easily identified.* 2. *Peer review of the codes - a crucial process to allow peers to follow through any amendments and share best [practice].* 3. *Testing phase to ensure the changes work as required.* 4. *Process maps to show the implementation of the update.* 5. *Agreed definitions - agreement with relevant teams as to correct actions and interpretations.* 6. *Process flows - clear process flows and maps needed to illustrate what each part of the ETL process contains.*	999s end of May and 111 mid June. B) Following on from above ensure that any unnecessary 'transformations' between CAD and the warehouse are removed and performance data is created in the host system and transferred as is into the data warehouse. Completion in 999s will be for the end of June and in the 111s for the end of July. C) Removal or conversion of contractors to Trust employees. Completed in 999s at the end of March and 111s end of July.		

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	7. *Testing environment - this will allow the developer to fully test any changes before they are made live and implemented.* 8. *Periodic reviews - a routine check on all ELT packages and processes to ensure it is fit for purpose.* 9. *Documentation - written documentation to define and clarify each process and function.* 10. *Resource and skill levels - to provide cover and mitigate against single points of failure.* 11. *Validation rules - testing the rules and logic to ensure good data quality practices.*	D) Closer integration of development teams in IT and BI to remove single points of failure, to create more capacity and introduce professional practice such as peer review underway. E) Creation of a BI test environment overseen by the IT Test team – completion July 23 F) Migration of data warehouse to latest version of SQL by end of May 23 G) Creation of a data dictionary – commencing June 23 and this will be an ongoing action.		

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		H) Migration of all staff to PowerBI as a development platform – commenced in March completion by December 23 I) Adoption of standard tools and practices in the development and analysts areas to allow peer review, staff development and removal of single points of failure. Completion December 23 J) Introduction of a BI Change Advisory Board (BI CAB) to oversee any changes being introduced into the warehouse and ensure that the appropriate		

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		process and policies have been followed.		
R7 LAS should make every effort to export data, where possible, directly from Cleric to the data warehouse rather than via the ETL.	***The new CAD system, Cleric has the capability, via a standard SQL query, to export to the data warehouse directly. However, as we understand the current situation, all entries into the data warehouse from Cleric are still achieved via an ETL script. This clearly leaves the trust vulnerable to a repeat of the coding error of August 2020.***	The ETL process exists in all Trusts and is the method by which data is moved between CAD and the Warehouse, however it is the 'transform' that needs to be removed so that we are extracting and loading performance data direct from the applications that create the data. Actions are (some described earlier but here for context) A) fully documented ETL process and removal of any unnecessary transformational code to make the system extract and load. Completion by June 23	CIO	Assurance at Digital Committee

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		B) Increase developer capacity (merge with IT Development Team) so that code creation is overseen by multiple developers. C) Introduction of a BI CAB to oversee any future changes to and BI process, mirroring IT CAB. D) Senior BI staff to attend IT CAB to ensure they are aware of wider technical and operational changes planned for Trust systems – completion July 23. E) Introduction of Test environment for BI developers by July 23		

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R8 The terms of reference for the current advisory review must be carefully considered and precisely drafted, ensuring that the issues regarding data quality raised in this report are included in its scope.	***When appointing internal auditors for assignments of this nature, particular care should be taken to understand and agree what is in-scope, and anything that will not be covered. All recipients of the resulting reports should be aware of exactly what is being assured and anything that is not.***	Audit Committee to check BDO product against issues identified in the Verita report and commission further reviews to address any gaps in the 23/24 Audit Programme.	CIO/Director of Corporate Affairs	Next Audit Committee
R9 LAS should consider specialist training to teach and promote a positive questioning and learning environment.	***We believe that the recent appointment of the new Head of BI / CIO is a positive step, sending a signal of change and, indeed, questioning of data is a lesser evil than its acceptance without critical appraisal. We believe, however, that a more proactive approach could also pay dividends.*** ***We believe there would be merit in considering the services of a trainer***	ExCo to consider as part of the programme of cultural change at the LAS	HRD/CEO	Assurance at Digital Committee

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	specialising in developing a positive questioning dynamic within teams.			
R10 The trust should conduct a review of the implementation of the Cleric system. The review should incorporate a data integrity review to test the accuracy of the data produced and a review of learnings and lessons which can inform future IT implementation processes. R11 The trust should use this review to inform and guide any future IT infrastructure purchase.	***We strongly endorse the views of the NED on the benefits of a post-implementation review. Both elements suggested are key. We suggest that core elements of the 'after action review' should be to consider the governance of the project, particularly in relation to the collection and communication of bespoke modifications to the core Cleric system and whether these were / are necessary, or if LAS processes should be brought in line with other trusts.***	CIO to conduct post implementation review, including review of bespoke elements and report it to the Digital Committee	CIO	August 23

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R15 The implementation of Cleric provides the trust with a good opportunity to identify and address any issues in data quality that are identified as part of this implementation. They must be taken.	***In any audit of a large data set, it is unsurprising to identify issues, particularly in a situation such as this where we are interrogating data at the point of a new solution implementation. We would emphasise that the number of records referred to in this section of the report are small, so in a large dataset will have a very limited effect on reported outcomes.*** ***We have reported on and discussed the three issues noted with the relevant individuals in the trust and are confident that they have been understood and corrective actions are being undertaken.***	Introduction of a process that will ensure that any changes to data are made at source (CAD) and are fully auditable. Completion by July 23. Desktop build of performance at regular intervals to ensure that reported performance can be repeated through manual processes.	CIO	Assurance at Digital Committee
R16 We recommend that no further action be taken with respect to patient harm.		No further action required.		

*

Action plan relates to actions assigned to LAS

4.4. Report from the Deputy Chief Executives

For Information

Presented by John Martin and Fenella Wrigley

PUBLIC BOARD OF DIRECTORS MEETING

Report of the Deputy Chief Executives – May 2023

This report covers the reporting period of March and April 2023. Although the London Ambulance Service (LAS) has not been subject to industrial action by our staff during this period, we have seen strike action being taken by both junior doctors and nurses across the country.

We have been integral during these periods of action to support the system in the delivery of urgent and emergency treatment for patients. This has included the co-ordination and flow of patients across the capital to ease pressure on local systems; to the provision of clinicians to support delivery at hospital emergency departments.

1. 999 Emergency Operations

The total number of contacts to Emergency Operations Centres (EOC) increased by 16% in March 2023 above the number in February 2023. Although there was a subsequent drop of 9% in April 2023, there is an indication that demand on the service is likely to increase back to pre-industrial action levels. By comparison March and April 2023 contacts were 21% and 19% respectively down on the same months from the previous year.

Month, Year	Contacts	Calls Answered	Call Answer Mean	Max. Call Answer	See & Treat	See & Convey	Hear & Treat
March 23	156,439	123,497	00:00:35	00:08:06	29.1%	55.8%	15.1%
April 23	142,362	112,077	00:00:15	00:07:08	29.6%	56.8%	13.6%

Figure 1. EOC performance for March & April 2023

The improvement in the call answering mean seen since January 2023 has, in comparison to increases in demand over the reporting period, been maintained with April 2023 delivering 15 seconds.

The LAS hear & treat rates continued to be above the national average of 11.4% and 11% for March and April 2023 respectively. This ensures that we continue to find appropriate and safe ways to support patients through alternative pathways rather than sending them an ambulance resource.

There has been a focus on delivering continuous improvements in the way that the EOC operate. We have instigated a Category 1 dispatch desk to ensure that resources are appropriately tasked to ensure that we are getting to the highest acuity patients as a priority.

The transformation programme commenced in December 2022 and a team has now been appointed to support this crucial work, with a programme board now in place.

2. Ambulance Services

	Category 1			Category 2			Category 3		Category 4	
	Mean	90th Centile	Incidents	Mean	90th Centile	Incidents	Mean	Incidents	Mean	Incidents
March 2023	00:08:06	00:13:30	12,185	00:39:12	01:28:23	53,490	01:16:51	14,822	02:25:04	672
England National Average	00:08:49	0015:38		00:39:33	01:26:15		02:13:40		06:54:22	
April 2023	00:07:08	00:11:54	11,542	00:31:20	01:10:26	51,326	00:57:22	15,566	01:56:28	720
England National Average	00:08:07	00:14:27		00:28.35	01:00:32		01:30:55		1:54:16	

Figure 2. March and April 2023 response times measured against Ambulance Quality Indicators

The LAS continues to deliver the 2nd best category 1 performance nationally across both months. Whereas our category 2 sits in the middle when compared to all other Ambulance Trusts.

A trajectory has been agreed for performance improvement across the 2023/24 financial year and is linked to additional funding for increasing operational staffing and resources. In April this trajectory has set a target of 50 seconds for call answering mean and a category 2 mean target of 45 minutes. In both cases we have met the target although it is acknowledged that this was based on 83,000 incidents in the month compared with an expected 89,000.

A major part of meeting increasingly challenging targets will be the reduction of hospital handover delays and the LAS is working closely with partners to ensure the system supports this. Although there has been a slight decrease in hours lost in March and April (23,098) this is against a back drop of industrial action where little or no delays were encountered on strike days. This represents a loss of 1,925 ambulance shifts across the two months. The trajectory looks to remove all delays before the end of the financial year and will be necessary to meet response time targets, especially throughout the latter part of the year.

The percentage of conveyances which took more than 30 minutes for the ambulance crew to handover the patient at hospital in March and April 2023, is set out in the following table.

Hospital site	Percentage of handovers over 30 mins
Barnet	44%
Charing Cross	3%
Chelsea & Westminster	3%
Croydon University Hospital (Mayday)	16%
Ealing	19%
Hillingdon	11%
Homerton	4%
King Georges, Ilford	64%
Kings College	27%

Kingston	16%
Lewisham	32%
Newham	54%
North Middlesex	63%
Northwick Park	38%
Princess Royal, Farnborough	24%
Queen Elizabeth II, Woolwich	12%
Queens, Romford	70%
Royal Free	23%
Royal London (Whitechapel)	30%
St Georges, Tooting	27%
St Helier	28%
St Marys, W2	13%
St Thomas'	21%
University College	14%
West Middlesex	10%
Whipps Cross	45%
Whittington	26%

Figure 3. Proportion of handovers over 30 minutes March/April 2023 (unvalidated data)

Whilst improvement has been made since the peak in December, to achieve the reduction in handover delays is going to require system wide focus.

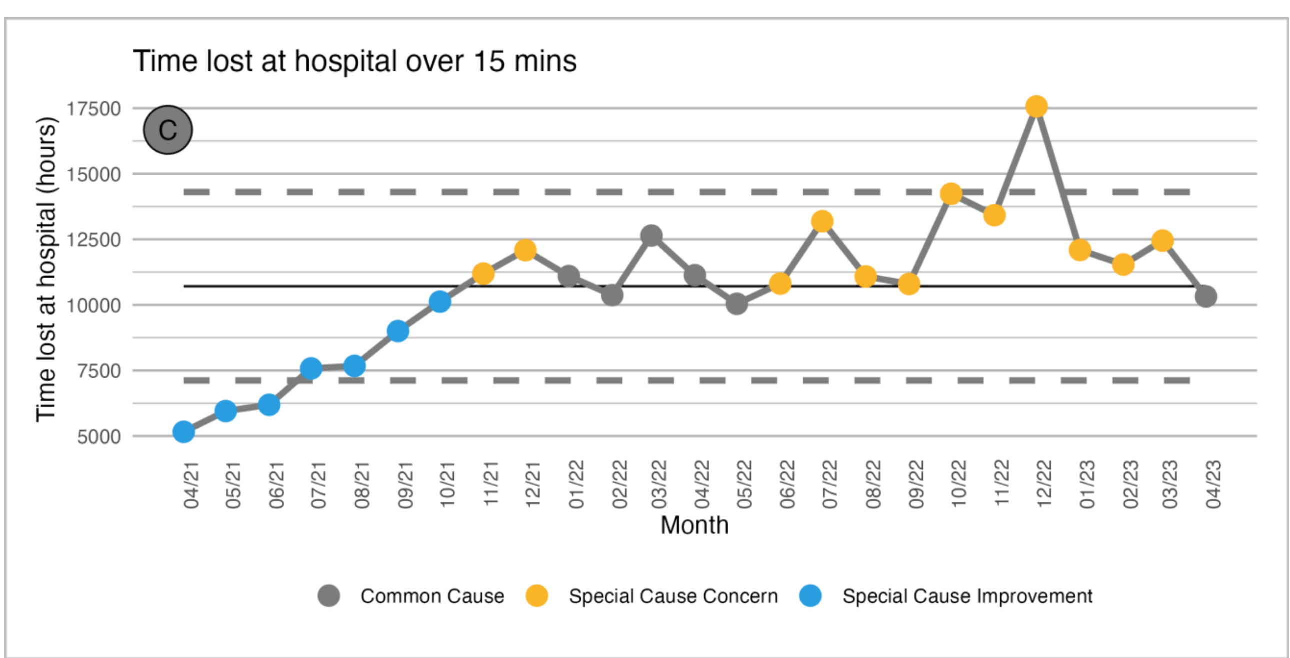


Figure 4. Statistical Process Control of time lost at hospital over 15 minutes

Initiatives around Category 2 improvement that were running over the winter period are being reviewed and developed further to support delivery of the trajectory for the year.

In line with a move to team based working, we have undertaken substantial number of Clinical Team Leader development sessions. This is to ensure that the first line managers are capable of embedding this new way of working as more teams make the transition.

4. Integrated Urgent Care (IUC)

This report provides the Trust Board with an update regarding the 111 Call Answering and Clinical Assessment Service (CAS) performance, key issues, events and activities since the last formal meeting.

LAS continue to run a combined 111 call answering and CAS model across all areas, aimed at improving performance and efficiency. The Single Virtual Contact Centre (SVCC) has been inactive since December as we continue to operate with a variety of separate contract arrangements and performance metrics across areas.

As of the end of March, LAS has confirmed activity for its IUC activity for 23/24, this equates to 2.3m 111 calls and 854k clinical consultations. IUC is currently working to confirm budgets and staffing required for the delivery of this activity and recruitment trajectories are being adjusted to support delivery.

Planned staffing will be through a combination of substantive and sessional / overtime staff. Performance has experienced continued challenge due to pressure:

- Continued surges in demand, particularly at peak times
- High shrinkage due to sickness absence and additional training requirements with LAS at 50% compared to the National Shrinkage of 40%.

The commitment from commissioners to adapt the current CAS service model to reduce the level of primary care within the CAS and redirect to in hours primary care services developed through the Fuller projects will allow a focus on higher priorities and support improved performance compliance.

Commissioners have acknowledged the need for the CAS to focus on patient care and the joint work being undertaken with commissioners will be used to influence future CAS performance and quality metrics.

5. Resilience and Specialist Assets (R&SA)

Since the last report the Trust has responded to two significant incidents. On the 30th March we responded to a fire in the hairdressing salon of a care home in Bexleyheath. Specialist Operations Centre (SOC) North was opened and LAS resources treated 6 casualties, conveying 4 to hospital. We also provided a large amount of support to the Local Authority to relocate 57 residents of the care home to alternative accommodation, for example by utilising one of the Urgent Care Advanced Paramedic Practitioners to assess the needs of some of the residents.

In the early hours of the 30th April we responded to a release of carbon monoxide at a hotel in Kensington. Around 200 guests were evacuated from the building and we treated and conveyed 14 patients to hospital.

The Emergency Planning team have planned and co-ordinated a number of recent large events including:

The London Marathon on Sunday 23rd April. This year saw around 50,000 participants and up to 300,000 spectators' lining the route. For the first time the LAS staffed

treatment centres in sector 3 of the event footprint, alongside the usual additional staffing to respond to calls within the footprint.

The King's Coronation on the weekend of the 6th and 7th May, and preparations leading up to the event, such as the overnight full rehearsal on Tuesday 2nd May, which saw a large number of road closures and the removal of street furniture in Central London. Over the weekend celebrations the LAS provided a considerable number and variety of resources including Commanders and medical response foot teams in the event footprint, as well as Commanders in both the Metropolitan Police control room and the event liaison team control room.

From the Manchester Arena enquiry report volume 2, we have completed an internal review of the 149 ambulance service recommendations and are progressing both nationally and locally by engaging with partners to implement improvements. For example, we are planning for the roll out of the new major incident triage tools across ambulance operations, for completion by June 2024.

5. Director and Board Committee Reports

5.1. Quality and Clinical Care

5.1.1 Director’s Report (Quality)

5.1.2 Director’s Report (Clinical Care)

5.1.3 Quality Assurance Committee

For Assurance

Presented by John Martin, Fenella Wrigley and Mark Spencer

PUBLIC BOARD OF DIRECTORS MEETING

Report of the Chief Paramedic and Quality Officer (CP&QO)

1.0 Regulatory Update

The new framework for the Care Quality Commission (CQC) is currently at the testing stage and we anticipate that the new approach will be ready to be launched towards the end of 2023. Preparatory work is on-going within the Trust, and we are implementing a new system to ensure there is oversight of all domains which will be live in quarter 2. A well led self-assessment began in April which will conclude in June 2023.

The Trust remains in regular contact with the CQC and has received no further regulatory visits since the system inspection in December 2021.

2.0 Clinical Education & Standards (CE&S)

During the year 31 new tutors have been recruited to support delivery of the education requirements across the Trust. The latest recruitment campaign resulted in five additional trainee tutors and two associate tutors. The role of Driving Standards Manager has been recruited to.

Between February and March 2023 a total of 218 learners completed their courses and joined operations.

Newly Qualified Paramedic (international) – 48
Newly Qualified Paramedic (UK) - 21
Associate Ambulance Practitioner - 55
Return to Practice – 17
Emergency Call Co-Ordinator – 35
Emergency Call Handler – 29
Cleric Call Handling – 7
Cleric Dispatch – 6

Educational support in sector roles will be going to advert shortly. With two education Sector Support Manager roles being the first to go out to advert. Followed by Sector Clinical Education Tutor, Sector Associate Clinical Tutor and higher education link tutor.

CE&S will be attending the Twickenham Campus of Harrow, Richmond & Uxbridge Colleges at the end of April as part of their monthly recruitment event to showcase the LAS and the roles available for their students across the Trust.

Following an External Quality Assurance (EQA) visit by the awarding body at the beginning of April for the Associate Ambulance Practitioner (AAP) diploma award no issues were reported, no actions or sanctions received and we will be awarded a green in all areas. It was also noted by the EQA that we have consistent internal quality assurance activity, including good feedback and support for assessors and learners. Evidence of standardisation activity was also good and feedback/communication from assessor to learner was clearly evidenced, along with evidence of reasonable adjustments for learners where appropriate being well managed.

The new AAP to Emergency Medical Technician (EMT) upskill course started on the 5th April and is progressing well. This is the first course of its kind in the LAS and replaces the course previously delivered by an external provider. Adaptations are being made as feedback is received to ensure the programme meets the needs of learners.

There has been a long-standing issue with the marking of learner portfolios. An internal bench mark has now been set for the department of 85% of marking to be completed within 4 weeks of submission. We have adjusted the programmes and workforce plan to ensure there is enough capacity and availability for marking time.

We are in the early stages of exploring flexible roster options, including a nine day fortnight and alternative start/finish times. Staff at both sites are supportive of exploring these options and pilots will be run at both sites once the finer details have come together, this is part of the strategy to support the welfare of both tutors and learners in the education environment.

3.0 Safeguarding

The trust continues to focus on safeguarding training across all areas of the Trust. The target for safeguarding training is 85%, this has been met in the majority of areas of the Trust (91%). Compliance for level 2 training in the EOC is behind target currently (62.5%), with an improvement plan in place.

Back in February 2022 the Trust launched the Sexual Safety Charter signed by the Chief Executive and Chairman. This was in response to the issues seen nationally across ambulance services in relation to sexual abuse of staff. Reporting of sexual safety allegations have increased from 7 in 2020/21 to 18 in 2021/22 and doubled to 41 in 2022/23.

To support care for those with learning disabilities and autism we have introduced the tier 1 Oliver McGowan e-learning which all staff are required to undertake. A proposal

for tier 2 is currently under consideration and we continue to deliver learning disability and autism training to all clinical managers.

4.0 Quality Improvement & Learning

Summary findings from the quarter 4 patient safety thematic include a 7% reduction the number of patient safety incidents reporting when compared to the previous quarter, noting that common cause variation was evident for the entirety of the quarter. The top themes of patient safety incidents remained largely consistent, noting a 42% reduction in the number of reported incidents categorised as 'dispatch and call' which is a reflection of the reduced demand on the Trust during the period.

The report has identified that a number of actions have been undertaken to address the top reporting themes including sending quality alerts externally to other NHS Trusts if concerns had been raised regarding their care. The report has highlighted that further work is needed to understand the challenges with recording demographics correctly within 111 and further to understand the key themes within the 'Clinical Treatment' category.

131 enhanced investigations were commissioned during quarter 4 which comprised of 24 patient safety incident investigations (PSII), 11 met national priorities and 13 met local priorities, 84 incidents for inclusion in the delays thematic, and 23 incidents were investigated utilising alternative methodologies. Incidents commissioned during quarter 4 largely met the trusts plan with exceptions noted regarding cardiac arrest management. Cardiac arrest management has now been included in the 2023/34 plan.

Compliance to investigation deadlines has remained challenged with 62 investigations being open for longer than 6 months. Where applicable, patients, families and staff involved have been engaged with regarding extending deadlines for reports. A weekly task and finish group has been established, chaired by the Director of Quality, to target investigations which are over 6 months old.

The demand on the Trust during the year has led to difficulties in allocating investigations in a timely manner to investigators. The quality improvement and learning team have been focusing on delivering further lead investigator training, upskilling current lead investigators to System Engineering Initiative for Patient Safety (SEIPS) methodology and also increasing the cohort of lead investigators able to undertake patient safety investigations. Further training has also been delivered in relation to Datix incident management which has aided in the reduction in the number of overdue incidents. 58 staff were trained during quarter 4.

Themes from closed investigations included task factors such as compliance and/or adherence to decision support tools or lack of clarity regarding their application and it

is noted that a piece of work is underway reviewing the use of decision support tools by staff. Staff factors were also identified as a theme, specifically cognitive issues such as confirmation bias. Verbal communication factors were identified as being a theme, specifically verbalising clinical impressions with colleagues or patients.

A recent case based discussion event took place where learning from patient safety incidents was shared, specifically airway management, missed safeguarding and a learning from a birth imminent.

A number of improvements have also taken place including the release of updated operational procedures, pre hospital maternity screening and action tool and shared learning regarding recognition of ineffective breathing during call triage.

The falls thematic is near completion with learning being incorporated into the Clinical Team Manager (CTM) conference and further education material. Thematic reviews are ongoing regarding incidents related to the implementation of Cleric and the management of patients in Ventricular Fibrillation (VF). A new thematic was commissioned in April examining ineffective breathing during 999 call handling.

Quality improvement training has relaunched with training planned monthly for the remainder of the year.

5.0 Freedom to Speak Up (FtSU)

47 concerns were raised in quarter 4, with concerns related in particular to systems and processes, management and culture.

We have reviewed the National Guardian Office (NGO) Ambulance Speaking Up Review and begun work on an action plan to address its recommendations, which includes already approving increasing the size of the FtSU team. Jointly with the Safeguarding team we have created a Staff Safety/Sexual Safety Toolkit. The Guardian and FtSU Coordinator are proactively showing visibility and engagement across the sectors and promoting the speaking up culture. The Guardian and Coordinator have visited multiple sites across the organisation having confidential FtSU conversations.

6.0 Health Safety and Security (HS&S)

The HS&S Team have delivered 17 sessions of Managing Safety courses to a total of 310 staff members and 21 sessions of corporate induction during 2022/23 with positive feedback. For the next core skills refresher we are trialling integrating moving and handling training within resuscitation scenarios to better match ‘work as actually done’ and have commenced a train the trainer programme.

A total of 138 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents were reported to the Health and Safety Executive (HSE) during 2022/23, with themes relating to manual handling and slips, trips and falls. A total of 561 physical assaults on staff have been reported during 2022/23, the majority occurring due to the clinical condition of the patient (59%). 27 successful prosecutions for assault have been recorded during 2022/23. We are running drop in sessions on hate crime with the police and are focusing on increasing take-up of body worn video cameras.

7.0 Emergency Bed Service (EBS)

In April the EBS team dealt with 3,378 safeguarding and welfare concerns. This is a an increase of 26% on the same period last year. This is mostly attributable to an increase in child referrals, and work is underway to analyse this. 1,100 falls and diabetes referrals were made, this is a normal seasonal volume.

At the end of the month a new General Practitioner (GP) notification procedure was launched which allows crews to make a simple email notification to a patient's GP informing them of incidental findings of concern in non-conveyed patients (frail patients, fallers, those with hypertension, AF and hyperglycaemia)

8.0 Frequent caller team

585 frequent callers were identified in April. Of these 162 (28%) already have care plans. The national frequent caller group has commenced work on standardising informatics on ambulance frequent callers; work will commence in May on engaging across London to develop a local plan.

Over 60 case meetings with external partners were undertaken, some relating to multiple patients.

Work has commenced on a procedure to support the team in making discretionary disclosures of information to the police.

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS – May 2023

Report of the Chief Medical Officer

Maintaining Patient Safety

As reported in the Deputy CEO report during March 2023 average calls per day and incidents responded to increased compared to January and February 2023. In addition, we continued to be impacted by hospital handover delays which reduced our available resource and impacted on our ability to reach patients within nationally set Ambulance Response Standards. We recognise some patients have continued to wait longer than they should for an ambulance service response for which we apologise.

We are continuing to do everything we can to reduce our response times including:

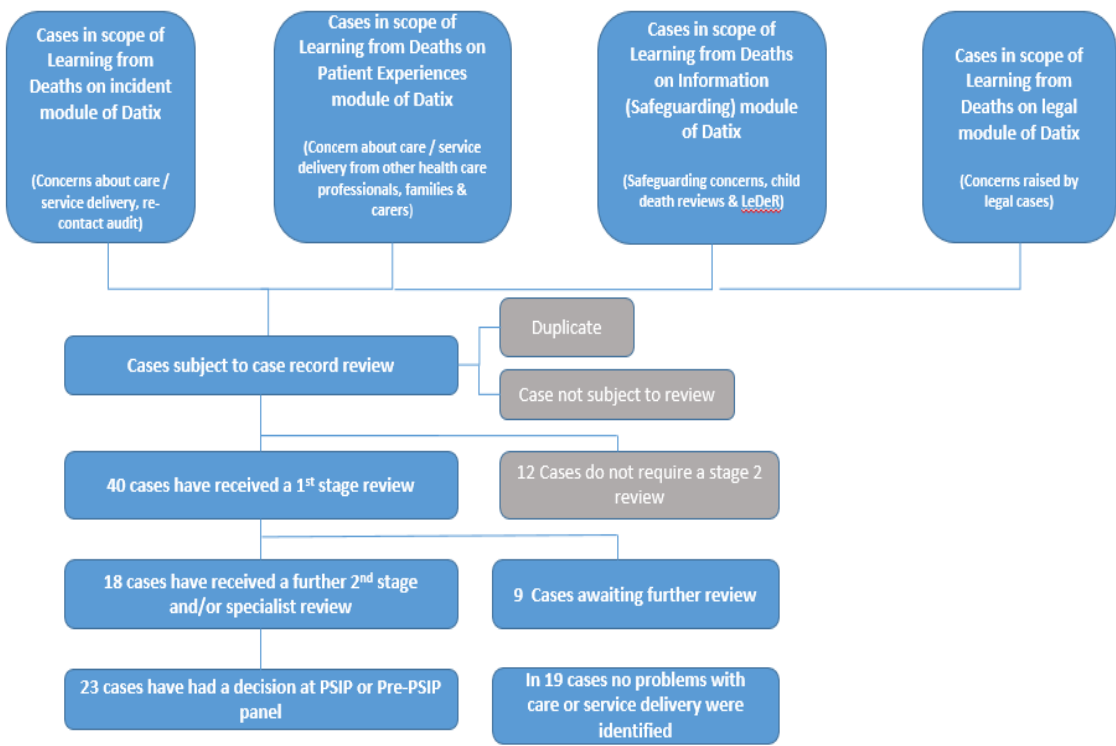
- Supporting the development of additional alternative healthcare pathways to ensure patients are treated nearer home to avoid unnecessary conveyance to emergency departments.
- Working with hospitals and NHS partners to minimise delays as we handover patient care to emergency departments. Pro-active use of cohorting (where one ambulance crew cares for more than one patient awaiting definitive handover to the emergency department, enabling other LAS crews to be released to respond to waiting 999 calls) and dynamic patient flow has continued in order to mitigate the amount of operational time lost due to these delays. The length of time some patients are held in a cohorting area has increased and we are working with the individual hospitals to ensure no harm is coming to these patients.
- Continuing the Category 2 segregation pilot and senior decision maker support

Call volumes into LAS 111 have remained higher than contracted levels although we did see a slight reduction in March 2023. Work is underway, collaboratively with commissioners, to review the Clinical Assessment Service (CAS) model in light of the Hewitt and Fuller reports. This work will be shared to help inform the future model of 111 and CAS services nationally.

The number of reported patient safety incidents continues to indicate a good reporting culture, particularly with the number of no and low harm incidents. All incidents are reviewed to ensure transparent and supportive investigations are undertaken, in line with the Patient Safety Incident Response Framework, to identify and learn from themes. The number of no harm incidents in March 2023 remained at the expected mean– the top 3 ‘no harm’ categories were medical equipment, clinical treatment and dispatch and call although this latter category reduced from 65 in January to 57 in March 2023. The number of moderate and severe harm incidents have slightly reduced reflecting the increased recruitment. A number of incidents continue to be reported as death which can, in part, be attributed to delays occurring at times of high demand.

These incidents undergo a Learning from Deaths (LfD) review and, where they meet the criteria, an enhanced investigation is undertaken using the Patient Safety Incident Framework.

In March 2023 data is as below.



Each case undergoes a detailed review working with clinicians, families and carers and other healthcare providers who have been involved in the care of the patient. A case being reviewed under the learning from deaths process does not necessarily indicate that any errors were made but that there may be internal or cross-organisational opportunity for learning. The process enables us to share learning and understanding and continue to improve the quality of the care we provide to patients and their families.

The Learning from Deaths (LfD) themes form part of the quarterly thematic review. The Q4 report is in development.

Clinical development

National Category 2 Segmentation Pilot

The category 2 segmentation pilot, of which LAS was one of the two early adopter Ambulance Trusts, has now been rolled out nationally. Since the introduction of the new Ambulance Response Programme in 2017, the proportion of Category 1 and Category 2 calls has increased.

In London category 2 calls account for over 60% of 999 calls. The underlying principle of the category 2 segmentation pilot was to address patient safety concerns for the sickest patients (e.g. STEMI, stroke, sepsis) who were, at times, not receiving a timely ambulance response.

In March 2023 we undertook an enhanced clinical assessment on 3,450 C2 patients which was 8% of the total volume of Cat 2 patients. 59% of these patients (n=2053) were validated

as requiring a C2 response after clinical assessment. We were able to provide a response to 39% (n=1,349) patients that was more tailored to their needs rather than sending a standard double crewed ambulance. We received a cancellation before a clinical assessment could be undertaken for 2% (n=48) of calls. This meant we made available 2,561 hours of additional DCA time to get to the patients who most needed an ambulance faster and this contributed to our improved category 2 response times.

There is continuous oversight of the safety and outcomes of the patients referred to alternative pathways using an end-to-end review of cases. None of the patients who had undergone an enhanced assessment required emergency transport to hospital.

During periods of NHS industrial action (IA), the LAS was supported by senior clinicians from across the region in the clinical safety cell. The data we recorded demonstrates a sharp increase in referrals to ACPs following a clinical telephone assessment by an LAS clinician when supported by a doctor. With support from NHS England, we harnessed this learning with our newly enriched partnerships and together with regional Chief Medical Officers, co-designed a 6 week pilot where Integrated Care Board (ICB) clinicians worked alongside LAS clinicians within our emergency clinical assessment service (CAS).

Emergency medicine consultants and general practitioners from NCL and SEL worked alongside LAS paramedics in ICB 'Pods':

- To see if a senior clinician supporting clinical assessment clinicians tethered to a geographical area increases awareness of alternative care pathways,
- To give control room clinicians immediate access to a senior clinician who will be able to empower them to make the most appropriate patient centred clinical decision through shared decision making,
- Ensure patients who require an emergency ambulance receive one without delay,
- To share learning about access to pathways and community teams which supports ICBs to optimise these.

The pilot reinforced the findings from industrial action with an increased number of safe and appropriate referrals to ACPs and associated reduction in ambulance dispatch. We are now developing this across the whole of London with the support of NHSE.

<u>Career progression</u>

Our advanced paramedic critical care clinicians (APP-CC) continue to provide excellent care for our most seriously ill and injured patients and support to our crews on scene and on the telephone. In March 2023 these advanced paramedics attended 335 patients taking additional skills and leadership to the scene. We are further enhancing their skills with the introduction of rocuronium – this is a medication used to paralyse muscles to facilitate adequate ventilation in patients who regain a pulse after cardiac arrest but remain unconscious.

In March 2023 the advanced paramedic urgent care clinicians (APP-UC) attended 748 patients with an average conveyance to ED rate of 29%. There is a pilot ongoing of independent prescribing by appropriately qualified staff in the 999 environment – this allows a prescription to be issued at the scene enabling a greater range of patients to be treated without the requirement for hospital conveyance or referral to another healthcare professional. In

addition, we are developing a referral pathway for APP–UC clinicians to attend and provide support to patients with learning disabilities and autism.

The next recruitment process for both sets of advanced paramedics has commenced which will further enhance the care we can provide our patients as well as provide career progression for our paramedics. A further 12 APP-UC clinicians have just been recruited.

Delivering high quality patient centred care

Continuing to ensure patients receive care in the right place is a key priority – this also helps to reduce the number of patients who are conveyed to the Emergency Department. We are continuing to work with Commissioners to map the available healthcare pathways, clarify and streamline options available for ambulance clinicians and the referral rates to each one.

Urgent Community Response (UCR) cars continue to operate successfully in south west, north east and north central London, with paramedics and external clinicians working together.

ICB / Sector	Start date of project	Number of patients seen	Conveyance rate (latest figure)	On scene time (assessment, treatment and referral)	Approximate number of ambulances saved and available for higher acuity patients
SWL	October 2022	1660	39%	84 minutes	20 - 30
NCL	January 2023	590	22%	78 minutes	20 - 30
NEL	January 2023	964	32%	79 minutes	20 – 30

Infection Prevention and Control

The infection prevention and control team should be congratulated on their successful delivery of all 45 work-plan deliverables over 2022 /23. This has been achieved alongside the ongoing delivery of COVID-19 recovery and leading and shaping response for the UK four nations ambulance services to the emerging threat of MPOX. An IPC masterclass for clinical team managers has focused on auditing and bare below the elbow.

Medicines Management

A two day medicines and patient safety seminar was delivered by our pharmacy and medicine management team. This was the second such event, following the success of the inaugural event in 2020. We are the first ambulance trust to deliver such events and were delighted to welcome colleagues from NHSE, the CQC and the Metropolitan Police.

The Trust medicines management has improved significantly since our CQC Inspection in 2015; this would not have been possible without the engagement and support of colleagues across all directorates in the Trust and wider NHS. The first day was for managers and provided an oversight of the work that has taken place around medicines over the last few years, an insight into the work on-going, provided information about one of the most regulated aspects of our work as a Trust and medicines management in the wider healthcare sector.

The second day was for clinicians and was an opportunity for them to meet the team behind the policies, procedures, clinical guidelines and the decisions relating to medicines in the LAS. It provided an opportunity for clinicians to practice their skills and decision making around drug therapy interventions in a range of patient types that we commonly see in our practice. Clinicians had time to talk to senior clinicians and experts and had a safe space to learn through a mixture of lectures and rotating syndicates in the afternoon. The feedback was excellent and the Chief Pharmacist and Medicines Safety Officer, together with their team, are thanked for their hard work in delivering the seminars.

Patient outcomes:

Through our clinical registries we continue to monitor and report the care provided to patients experiencing either a cardiac arrest, ST elevation myocardial infarction, or a stroke. We submit this data to the NHS England Ambulance Quality Indicators (AQIs) programme, enabling the benchmarking of the quality of care across all ambulance trusts in England.

There is always a time lag in receiving national end-to-end patient data. The most recent national data published is December 2022. The outcomes and performance at this time are reflective of the significant operational pressure being experienced at that time.

LAS Stroke Care data – March 2023

The health outcomes of patients who suffer an acute stroke can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and by early transport of a patient to a stroke centre capable of providing further tests, treatment and care, including an early CT scan of the brain and 'clot-busting' drugs (thrombolysis) for those who are eligible. A time critical patient refers to FAST positive patients whose symptoms were less than 10 hours old when leaving the scene of the incident, where a stroke consultant deemed the patients to be time critical (as part of a video consultation) or where the onset time of symptoms was not recorded.

- LAS attended 1090 suspected stroke patients.
- 1048 were FAST positive and 740 of these were identified as time critical.
- 100% of patients were conveyed to destination Hyperacute Stroke Unit directly after an average on scene time of 35 minutes.

LAS ST-Elevation Myocardial Infarction (STEMI or Heart Attack) data – March 2023

A heart attack, or myocardial infarction (MI), is caused by a sudden blockage of the blood supply to the heart muscle. It is therefore vital that blood flow is quickly restored through clinical interventions such as primary percutaneous coronary angiography and intervention such as stenting. This procedure is time critical and the target time from call to angiography target is 150 minutes. Our most recent data indicates:

- In January 235 patients were attended by LAS and had a confirmed STEMI, a similar number to the last report.
- 86% of patients subsequently confirmed as having an ST elevation myocardial infarction were categorised at the point of 999 call triage as a category 2.
- 99% of the patients were conveyed to the correct destination and 74 % of patients had received the complete care bundle.

- The average clock start to on scene time was 35 minutes.

LAS Cardiac Arrest data – March 2023

Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which includes signs of breathing, coughing or movement or a palpable pulse or measurable blood pressure is the main objective for all out of hospital cardiac arrests, and can, in some cases, be achieved through immediate and effective treatment at the scene. The key to increasing the chances of ROSC are the speed of starting basic life support and defibrillation where the patient is in a shockable rhythm. Our January cardiac arrest data indicates:

- 1060 patients in cardiac arrest were attended by LAS.
- 367 patients had resuscitation commenced.
- 72 patients were in a 'shockable rhythm' on arrival of LAS and defibrillation occurred within 2 minutes of arrival with the patient.
- For all patients in cardiac arrest return of spontaneous circulation was achieved in 26% of patients.

Cardiac arrest survival cases are fed back not only to clinical staff and volunteers but also to EOC call handlers and dispatchers.

Cardiac arrest survival increases the earlier we can start the 'Chain of Survival' with chest compressions and defibrillation – this is very often started by our volunteer community first responders. We need more members of the public to be trained in basic life support and become London Lifesavers. The swift actions of a passers-by can make the difference between life and death.

LAS is supporting a collaboration to boost the number of individuals trained to provide early help and save lives for patients in suffering life-threatening emergencies. Members of the public are invited to learn Cardiopulmonary Resuscitation (CPR), also known as chest compressions, as well as how to use a defibrillator by completing online training from the Resuscitation Council UK. They can then sign up to the app provided by GoodSAM which means they will be alerted to emergencies locally, where they can use their knowledge to help a person in cardiac arrest while an ambulance is on the way.

	December 2022	January 2023	February 2023	March 2023	April 2023
London Lifesaver Numbers	4140	4294	4613	4976	5135
Public access defibrillators (PADs)	7746	7763	7800	7802	7802
PAD activations	15	10	14	16	15
Return of spontaneous circulation	7	3	8	8	8

Clinical audit and research

Research

The Clinical Audit & Research Unit (CARU) continues to attract external funding to support its research activity and enable the delivery of large scale clinical trials, including:

- PARAMEDIC-3: *Pre-hospital randomised trial of medication route in out-of-hospital cardiac arrest.* We have, so far, recruited over 1,000 patients into this national ambulance trial and are the highest recruiting site amongst all ambulance services, being accountable for over a third of all study activity.
- CRASH-4: *Clinical Randomisation of an Anti-fibrinolytic in Symptomatic mild Head injury in older adults.* We contributed to a successful bid for funding, with the London School of Hygiene and Tropical Medicine to support the national roll-out of the CRASH4 trial (amongst both ambulance services and hospital sites). The award, from NIHR, totals £3 million over the next 3 years.
- ARREST – *a randomised controlled trial to determine the best post-resuscitation care pathway for cardiac arrest patients.* We finished recruitment into this trial in December, enrolling 860 patients into this British Heart Foundation funded research project. Data analysis is currently underway.
- RAPID-MIRACLE: *Developing a digital handover application for paramedics to provide a personalized approach to pre-hospital stratification for Out of Hospital Cardiac Arrest.*
- PROTECTeD: *Exploring and Improving Resuscitation Decisions in Out of Hospital Cardiac Arrest.*
- HOTZONE: *Reducing patient deaths during terrorist attacks.*

CARU has trained 1,142 LAS paramedics in trial procedures for the above named studies and these clinicians are currently actively delivering research interventions in the field.

We continue to publish our findings in high impact peer-reviewed scientific journals. Our most recent publication was from our collaborative research with Kings College Hospital titled A machine learning algorithm to predict a culprit lesion after out of hospital cardiac arrest (http://doi.org/10.1002/ccd.30677)

Clinical Audit

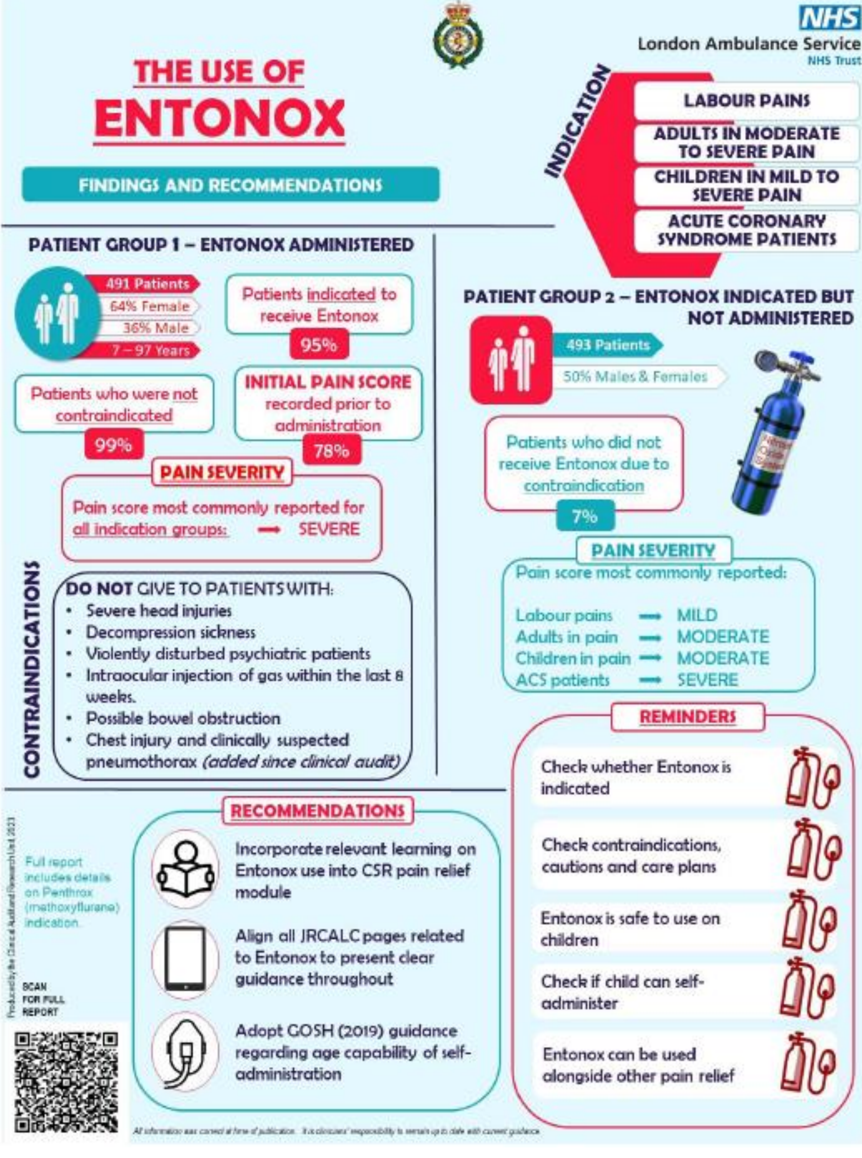
The Trust's clinical audit programme continues to focus on areas of clinical care where there is evidence of a clinical quality issue, areas highlighted through complaints, acknowledged risks, recommendations from previous audits, guideline changes, and areas that are a strategic objective or priority for the LAS.

The Clinical Audit and Research Steering Group (CARSG) approve and prioritise topics for clinical audit projects annually, ensuring that the audit programme remains responsive to the objectives of the LAS, the wider NHS, and pre-hospital care in general. Our clinical audit work programme for 2023-24 was agreed at the spring 2023 CARSG meeting and covers a range of clinical areas including: alteplase, paediatric pyrexia, haemorrhage requiring intervention, overdose, referrals, maternal assessment and obstetric emergencies, allergies and anaphylaxis, morphine as an anticipatory medicine, cardiac arrest drug management, and assessment and management of under 5s not conveyed.

In addition to our clinical audit programme the Clinical Performance Indicator (CPI) programme and the continuous re-contact clinical audit provides assurance and facilitates clinical improvement across a range of different patient groups. These continuous audits also provide an established feedback mechanism for clinical staff to receive individualised feedback on their performance.

The 2022 clinical audit into the administration of Entonox® for pain relief has been published. Entonox® is an inhaled analgesic comprised of a mixture of half oxygen and half nitrous oxide. In the LAS, clinicians administer Entonox® to patients who meet specific criteria as per Joint Royal Colleges Ambulance Liaison Committee Guidelines for use in UK ambulance services (JRCALC). Entonox®, which is self-administered through a mouthpiece or mask, can be given as a stand-alone treatment as well as in conjunction with other drugs as part of a multi-modal approach to pain management. With a rapid onset of action, short half-life and few harmful side effects in short term use, Entonox® is reasonably safe to administer; however, there are some contraindications and cautions as with any drugs.

The results of this clinical audit demonstrate that for the large majority of patients, Entonox® is being administered in line with guidance, with nearly all patients who received it meeting the indications for Entonox® administration and not presenting with any contraindications or cautions.



Assurance report:	Quality Assurance Committee	Date:	09/05/2023
Summary report to:	Trust Board	Date of meeting:	25/05/2023
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 considered:

Quality Report
QAC reviewed the Quality Report, containing March 2023 data, noting in particular that the number of no harm incidents had reduced to within the normal level range over the last three months. The number of IUEC no harm incidents for March 2023 was 247 which was near the upper control limit; this was due to increased incident reporting for demographic errors where patients' telephone numbers or addresses had been recorded incorrectly.

The hand hygiene compliance rate for March 2023 had increased to 98%, exceeding the performance target (90%). The IPC training compliance for level 1 and level 2 was also above the Trust compliance target (91.8% and 93.9% respectively)

There are 736 overdue incidents which have been open on the system longer than 35 days (this excludes SIs, PSIIs & PSRs). During March 2023 the number of incidents reported was higher than average and the number of incidents moved to Quality Check was higher than the average. A Trust wide improvement plan has been agreed to recover this position.

Optimising Our Response to Category 2 Patients
QAC received an update on a pilot relating to clinical navigation and validation by a clinician prior to dispatch for a small group of Category 2 patients. This was based on the identification of a small group of Category 2 patients who may benefit from timely review and clinically informed decision making prior to ambulance dispatch to identify if their care needs are better suited to an alternative care pathway e.g. GP referral, self-care advice etc. Clinical validation is used to establish whether an alternative care pathway is the most appropriate response to the patient's needs and might include escalating an incident to a higher responding priority or identifying that they are suitable for an alternative to a DCA response.

LAS was an early adopter of the pilot in November 2022. The pilot has been under continuous monitoring and oversight by NHSE and AACE. A post go-live safety and efficacy review has been undertaken and remaining Ambulance Services in England have since been invited to develop their own plans to implement Category 2 segmentation teams.

Patient Safety Incident Response Framework
QAC received an update on patient safety investigations and thematic reviews, noting that during the months of February and March 2023, 241 patient safety incidents were reviewed against PSIRF. One incident met the nationally defined priority requiring an external investigation by the Health Safety Investigation Branch and 7 incidents met the nationally defined priority requiring a local investigation by the Trust.

The Patient Safety Thematic Report Q4 2022/23 showed that there was a 7% reduction in the number of patient safety incidents reported during Q4 when compared to Q3. Top themes of patient safety incidents remained largely consistent but there was a 42% reduction in the number of reported incidents categorised as ‘dispatch and call’ which is a reflection of the reduced demand on the Trust during Q4.

Quality Account
QAC received and approved the LAS Quality Account subject to final data checks and the inclusion of stakeholder statements. The Account includes a report on progress against the quality priorities agreed for 2022/23 and presents our priorities for 2023/24. The draft content has been shared with the chairs of the LAS Patient and Public Council, as well as key stakeholders including:

- Commissioners
- Healthwatch
- Overview and Scrutiny Committee

Clinical Audit and Research Update
QAC noted that the Trust’s clinical audit programme focuses on areas of clinical care where there is evidence of a clinical quality issue, areas highlighted through complaints, areas of risk, recommendations from previous audits, guideline changes, and areas that are a strategic objective or priority for the LAS.

The Clinical Audit and Research Steering Group (CARSG) approve and prioritise topics for clinical audit projects annually, ensuring that the audit programme remains responsive to the objectives of the LAS, the wider NHS, and pre-hospital care in general. The clinical audit work programme for 2023-24 was agreed at the Spring 2023 CARSG meeting, and covers a range of clinical areas.

In terms of research, the Clinical Audit & Research Unit (CARU) continues to attract external funding to support its research, activity and enable the delivery of large scale clinical trials.

Infection Prevention and Control
QAC noted that the annual IPC work plan for 2023/24 had been presented and approved at the April meeting of the Infection Prevention and Control Committee.

Clinical Education
QAC received an update on clinical education provision noting that during 2022/23 31 new tutors had been recruited to support delivery of the education requirements across the Trust.

Fix the Basics Programme
QAC received an outline summary of a new scheme being developed within the Trust with the following objectives:
- Continuously improve the safe delivery and quality of care for our patients
- Improve our emergency response
- Support our workforce

QAC received an early outline of the proposed work and considered how it might be related to a Quality improvement process.

Risks:

Risk
QAC received the latest versions of the Corporate Risk Register and Board Assurance Framework.

Changes made to the BAF since last reviewed by QAC on 7 March 2023 were:

- Risk 1A – Relating to the impact of Covid and other infections on demand; reduction of current risk score from 16 to 12 due to the reduced impact on demand with decreasing infection rates.
- Risk 2A – Relating to operational demand exceeding capacity; reduction of current risk score from 20 to 16 due to an overall reduction in demand and an improvement in category 2 performance.

Risks under development were:

- A risk was identified relating to the ability to recruit sufficient staff and acquire assets in time to realise the target improvement of Category 2 and call answering performance, utilising the indicative £25M central investment allocation.

- A risk has been identified relating to ‘getting the basics right’ - staff having access to the full range of equipment that is in full working order

	to meet the 2023/24 expectation that there would be zero tolerance in terms of crew not having the medical equipment that they need. QAC noted that the 2023-24 iteration of the BAF is currently being developed.

Assurance:	

5.2. People and Culture

5.2.1 Director's Report

5.2.2 People and Culture Committee

5.2.3 EDI

For Assurance

Presented by Damian McGuinness and Anne Rainsberry

London Ambulance Service NHS Trust Board meeting 25 May 2023

Report from the Director of People and Culture

1. Executive Summary

Recruitment & Retention

TOTAL FRONTLINE STAFF JOINED THIS YEAR 1,276 FTE	APRIL 2022 - MARCH 2023	RECRUITED
	Paramedics	463
	AAPs	288
	Team Managers	60
	Clinical Team Managers	60
	111	207
	999	167
	NETS	31
	TOTAL	1276

At our People and Culture Committee in May, the department shared the success of the recruitment activity in meeting the plan to increase our front line staff in post by at least an additional 250 WTE in the financial year 2022/23.

To achieve this net increase 1,276 new front line starters were recruited, which included over 350 call handlers, 450 paramedics and 300 AAPs.

The Trusts attraction strategy remains competitive both within the UK (with 524 staff either awaiting interview or completion of pre-employment checks) and internationally, with 285 international employment offers currently in progress.

Our Turnover continues on a downward trend (circa 13%) and the number of frontline leavers has remained positively below plan (-154FTE).

Recruiting Diversity

Whilst the Trust has been successful in both clinical and non-clinical recruitment, we have not had the same success in recruiting staff representative of London. To support the Trust understand this further, in May 2023 the Trust launched a multi-disciplinary project group supported by Sea – Change consultancy (who specialise in EDI recruitment). Updates on this critical project will follow in the coming weeks and months.

Wellbeing

The Wellbeing Team have been heavily focused on a number of new and proactive initiatives that are aimed to assist colleagues with their recovery including

- A number of holistic activities including Yoga classes and Sound Bath sessions. Hosted Trust-wide over an 8 week basis the courses are well underway;
- 90 colleagues have now been nominated for a Wellbeing Award, aiming to recognise those who positively impact on the wellbeing of others.
- Engaging with 111 and 999 Contact Centres to design Wellbeing rooms for each site, the instillation of these fixtures and fittings will be finalised over the coming weeks.

- Continued partnership with the International Liaison Team, recruiting additional Ipara Buddies to the international support scheme. They will share first hand experiences from recent joiners with new recruits, offering additional support throughout this transition period.
- Chair massage has been offered to all contact centres and corporate colleagues. Ten minute sessions can be booked in advance with trained masseurs, with a focus on relieving tension in the neck, shoulders, forearms, wrists and hands in a relaxing environment.

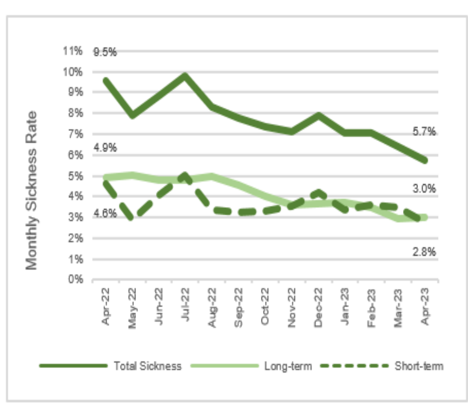
The team have also been developing training sessions for both staff and managers, in conjunction with experts from The Ambulance Staff Charity, Keeping Well NWL and the Centre for Anxiety, Stress and Trauma. These training sessions will support managers to have wellbeing conversations with their teams and provide staff with techniques to help cope with stress, process trauma and support each other.

Along with the current covid vaccination programme, the flu programme has now come to an end. The Trust finished at approximately 50% vaccinated and 5th place in London

Supporting Attendance

Our first day absence reporting service continues to embed with over 24,000 calls made to the service since its launch in August. Supporting our staff back to work has seen significant improved since the introduction of the service – with April recording the lowest absence since 2020.

Supported by various well-being initiatives and our new occupational health provider, we have also seen the crossover of short term and long term absence.



Our LAS Culture Transformation Programme

The key highlight this month has been the launch of our new management training programme - *Our LAS, Leaders 100 programme* specifically designed for Band 6 and 7 line managers.

Initially the programme was capped at 100 places, however as the demand was so high the programme was expanded to 163 places – with every Band 6 and 7 line managers who applied for the programme being successfully enrolled. This programme has been established in partnership with Middlesex University London with our managers being credited with a Diploma in Advanced Management Practice (NQF Level 6 equivalent) upon completion.

*Minimum | Half a day = 4 hours | Total of 3 face to face sessions 6 online sessions

Deep dive – 2022 Staff Survey

At the People and Culture Committee in May a deep dive session was undertaken with respect to our 2022 Staff Survey results.

Our most improved areas were in *supply of materials and equipment, receiving pressure from manager to work when not feeling well enough, received an appraisal and career development opportunities*. The significant improvements we saw from the 2021 staff survey date in *experiences of violence and abuse from patients/the public* were maintained, with our scores seeing a moderate improvement this year.

When compared to our 2021 Staff survey results we improved significantly higher in 3 domains, no significant change in 5 domains, and one significant decline – this was in relation to *satisfaction with pay, standard of care provided by LAS and raising concerns*.

Element/Theme	LAS Score 2021	LAS Score 2022	Difference	Statistically Significant Change?*
We are compassionate and inclusive	6.6	6.6	=	Not significant
We are recognised and rewarded	5.1	5.0	-0.1	**Significantly lower**
We each have a voice that counts	5.8	5.8	=	Not significant
We are safe and healthy	5.1	5.2	+0.1	**Significantly higher**
We are always learning	4.3	4.5	+0.2	**Significantly higher**
We work flexibly	5.2	5.2	=	Not significant
We are a team	6.0	6.0	=	Not significant
Staff Engagement	5.8	5.8	=	Not significant
Morale	5.0	5.1	+0.1	**Significantly higher**

The committee was also taken through local results by sector and departmental level, as well as detailing the associated local action plans that have been developed to address areas of concern.

EDI staff survey results were also analysed as well as initial feedback with respect to associated results regarding the culture programme.

Overall, particularly given that the staff survey was completed in the months of pending industrial action on pay, the committee concluded the results were positive and an indication that the Our LAS culture programme has laid some good foundations for change – the Trust is acutely aware however that there is much more work that can be done to ensure that the London Ambulance Service NHS Trust is the leading employer in the ambulance sector.

P&C Operations

Recruitment

The IUC and 999 call handling pipelines continue to remain strong with over 100 candidates at pre-employment stage. Call handling fill rates remain positive, averaging over 92% for the year to date.

Over 1,250 frontline staff recruited this year including over 350 call handlers, 450 paramedics and 300 AAPs.

- **Paramedic Recruitment** - Year to date we have filled 463 of the 554 training places which is 89 behind plan. The frontline pipelines remain strong with over 300 candidates at conditional offer stage and fill rates have averaged 83% year to date.

  The international recruitment team made 241 offers during their trip to Australia in April and May. The majority of these are due to start from Q4 due to graduation dates and right to work processing. UK graduate recruitment has started with our Partner Universities with a plan to recruit over 200 paramedic graduates.

- **AAP Recruitment** - Year to date we have filled 288 of the 354 training places which is 66 behind plan. 100% fill rate achieved from October has ensured that the gap has not increased, which we expect to close in quarter one of this year.

Retention

Turnover continues on a downward trend and the number of frontline leavers has remained positively below plan (-154fte year to date). We have seen a continued slowdown in the level of International Paramedic leavers with the monthly average reducing from 11 in 2021/2022 to 6 in 2022/2023. The stability rate which measures the % of staff in post for more than one year averages 85% for the year.

The Workforce Retention Group has been established to provide oversight, direction and support regarding all aspects of improving staff retention within the Trust with specific objectives to improve our morale and engagement scores, oversight of all retention development plans and ensuring the right support and resources are in place for managers to improve staff retention. A deep dive is underway for EOC call handling.

The group are using the NHS Employers Staff Retention Guide as a framework, which is aligned to the NHS People Promise and highlights areas where attention may be needed. The group has begun to assess each of these areas and assigned leads from the P&C senior Leadership Team. Once the assessment has been completed, this can be shared more widely with key stakeholders against the Trust.

Supporting Attendance

The work of the supporting attendance group continues to focus on two broad areas; firstly, the introduction and embedding of the first day reporting service; secondly, the devising and deployment of directorate focussed improving attendance plans that focus on health promotion, management training and development and employee experience and engagement.

Attendance details:

In March the monthly Trust wide sickness decreased from 7% to 6.3%. The top 5 reasons for absence are shown in the below table. Focussed efforts to manage long term sickness absence are also shown with one area (SW Sector, Ambulance Operations) reporting 0% long term absentees.

	Reason	%
1	S10 Anxiety/stress/depression/other psychiatric illnesses	22%
2	S99 Unknown causes / Not specified	13%
3	S27 Infectious diseases - Covid	12%
4	S25 Gastrointestinal problems	9%
5	S28 Injury, fracture	8%

The work of the supporting attendance group continues to focus on the embedding of the first day reporting service and the deployment of directorate improvement plans that focus on health promotion, management training and development and employee experience and engagement. Optima are now fully embedded across the Trust, with excellent links into the Wellbeing, Recruitment and Clinical Education teams.

Our first day absence reporting system has received 24,000 calls since its introduction in September 2022. We have seen reductions in the absence rate since that time and whilst the nurse triage system works well, service users still embracing the wider service and management portal.

There have been important wellbeing developments and interventions that will also be impacting on this improvement, evidencing the benefits of our holistic approach. We are also reviewing the Directorate improvement plans, which will be asked to focus on understanding the drivers of stress in the organisation and a local, nuanced response to addressing.

Employee Relations

HR Advisory Teams continue to support our leaders with employee relations activity, particularly with supporting our staff return to work from periods of absence. Those cases that are managed formally, we are pleased to report that our mediation and conflict resolution service reports 100% satisfaction from people who have chosen this route to resolve employment related issues.

4. Health and Wellbeing

Neuro-Inclusion Pathway

The Wellbeing and Equality, Diversity and Inclusion teams are launching a Neuro-Inclusion Pathway, which aims to improve the support the Service offers to colleagues who are neurodiverse. Colleagues will be able to undertake digital cognitive assessments, provided by our external partner, Cognassist, and they and their managers will receive a report advising

on which workplace reasonable adjustments will benefit them. Additionally Cognassist will provide training for all staff to raise awareness of neurodiversity. A launch event for the new pathway will be held on 23 May 2023.

Occupational Health

Seven clinic-standard rooms have been created Trust wide for our on-site occupational vaccination programme which is well underway. Colleagues across the Service are being invited to attend appointments with Optima, our Occupational Health partner. Additionally, our physiotherapy provider has introduced a “Desk Clinic” option for managers to refer staff, allowing them full access to a range of exercise videos that are targeted to their injury as well as face to face physiotherapy treatment.

Mental Health Provision

The Trust has a wide range of mental health resources and options to support colleagues over the summer. The LAS Wellbeing Hub remains the central point of contact, open seven days a week via both phone and email and able to provide signposting to appropriate services. Our peer support network LINC has more than 100 highly trained members and 30 in the senior team who are able to conduct TRiM assessments.

Colleagues are able to directly access counselling, CBT and EMDR via Optima’s 24/7 EAP line. Further advanced therapy, for conditions such as complex or historic PTSD is provided by the LAS Psychotherapist, who is also able to refer into two additional psychotherapists who specialise in trauma. We have also benefitted from the advice of KeepingWell NWL who are able to refer colleagues for fast track IAPT services.

Wellbeing Activities

Workshops for staff and managers that aim to enhance team and individual wellbeing have been developed, additionally, Wellbeing Conversation training provided by the team at Keeping Well NWL is underway, with one face to face training session per week until October 2023. All Ambulance Services and Emergency Operations Centre managers will have the opportunity to attend and gain a greater understanding of how they can sensitively and appropriately support their teams, whilst safeguarding their own boundaries and wellbeing.

Other activities by the Wellbeing Team include:

- A number of holistic activities including Yoga classes and Sound Bath sessions. Hosted Trust-wide over an 8 week basis the courses are well underway;
- 90 colleagues have now been nominated for a Wellbeing Award, aiming to recognise those who positively impact on the wellbeing of others.
- Engaging with 111 and 999 Contact Centres to design Wellbeing rooms for each site, the instillation of these fixtures and fittings will be finalised over the coming weeks.
- Continued partnership with the International Liaison Team, recruiting additional Ipara Buddies to the international support scheme. They will share first hand experiences from recent joiners with new recruits, offering additional support throughout this transition period.
- Chair massage has been offered to all contact centres and corporate colleagues. Ten minute sessions can be booked in advance with trained masseurs, with a focus on relieving tension in the neck, shoulders, forearms, wrists and hands in a relaxing environment. The six week course is now drawing to an end and the service was positively received.

5. Organisational Development and Talent Management (Our LAS Culture Transformation Programme)

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

Leadership and Management Development: Following extensive interest in the Our LAS, Leaders 100 Programme, we have managed to fund places for all 163 applicants this year. This programme has been established in partnership with Middlesex University London, the first two programme cohorts of Band 6 and 7 managers have already completed their induction, working towards a Diploma in Advanced Management Practice (NQF Level 6 equivalent).

The OD and Talent Team is working with the Culture and Leadership Network for Ambulance Services (CALNAS) on the creation of five management skills modules to inform an in-house programme for our Band 4 and 5 colleagues. This programme is expected to start in Autumn 2023. The OD and Talent Team Plus are also providing targeted support for Band 8 and above managers. In recent months, the Team have facilitated a number of Leadership events for Ambulance Operations and Emergency call centre colleagues. These programmes will provide the opportunity for our leaders to learn new skills to help progress their career and enhance their leadership portfolios.

Statutory and Mandatory Training e-learning module – Oliver McGowan Mandatory Training: Overall current statutory and mandatory training compliance is 87.4%. April saw the launch of the 13th module designed to enable healthcare workers to better support people with a learning disability and people with autism. The Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role.

Technology-Enhanced Learning (TEL): At this month's Medicine Management conference, the Chemical, Biological, Radiological and Nuclear (CBRN) and Specialist Operations Response Team (SORT) showcased two e-learning packages developed in partnership with the team. These packages focus on Opioid Exposure and the use of High Dose Naxolone Hydrochoride, as well as Chemical Incidents and Diphotérine®.

The team has been contributing to the Emergency Call Co-ordinators' development programme, supporting our colleagues with values-led learning around communication, coaching and mentoring. We are working with the Wellbeing Hub, the Clinical Audit and Research Unit (CARU) and our Staff Network Chairs, developing interventions to support their teamwork. We have made some successful developments to our Trust Induction, through the inclusion of a greater number of Subject Matter Experts (SMEs), as well as making updates and improvements based on feedback. We have hosted bespoke training sessions for the Clinical Tutors, Clinical Team Managers and Team Managers, as well as IUC Croydon and the First Responders to support with core learning and development skills.

Damian McGuinness

Director People and Culture, London Ambulance Service NHS Trust.

Assurance report:	**People and Culture Committee**	**Date:**	**18/05/2023**
Summary report to:	**Trust Board**	**Date of meeting:**	**25/05/2023**
Presented by:	**Anne Rainsberry, Non-Executive Director, Chair of People and Culture Committee**	**Prepared by:**	**Anne Rainsberry, Non-Executive Director, Chair of People and Culture Committee**

Matters for escalation:	

Other matters considered:

WORKFORCE PLANNING AND RECRUITMENT

The Committee received a presentation on recruitment. It was noted that the paramedic international fill rates are positive with over 300 candidates at offer stage and 200 applications received from UK graduate partner universities. The committee were advised that issues have been identified with EOC recruitment. These related firstly due to changes in the labour market with other employers offering higher salaries and secondly because despite many offers a number of staff did not accept the role. It was noted that several measures were being taken to address this including a review of the end-to-end recruitment processes, implementing a new structure within the recruitment team and embedding an improved governance and escalation processes. In addition, the Director of People and Culture confirmed he was reviewing how competitive pay rates are going forward.

The committee noted that against the projection of 1,481 wte frontline staff required there was a gap of 205 wte against plan. It was noted that there are strong international and local pipelines which were achieving good fill rates. An issue was identified with some recruits being deferred due to not achieving the requirements of the courses, which impacted on the numbers of staff being operationally available. The committee asked for further detail on this and in particular whether recruits went on to pass if at first deferred. The committee were advised that a review of the deferral process and pass criteria is to be undertaken, recognising the need to keep numbers to a minimum and to understand the fall out rates of staff not being operationally available.

The committee received a presentation on the new Workforce Model that had been developed. The model aims to understand the impact of activity and performance planning on the LAS workforce. The model will provide the data for decisions in the coming year on workforce size, skill

mix and deployment. Progress reports on delivery of the plan is being reported through to ExCo and this committee.

ATTENDANCE AT WORK AND WELLBEING

The committee received a presentation on supporting attendance and absence reporting. The Goodshape Service has continued to embed with attendance levels improving since the introduction of the service, and levels of below 6% are now being consistently reported. The committee commended the team on such excellent progress.

The committee was advised of improvements in the management of long term sickness absence with ambulance operations performing strongly with a reduction to 0 – 0.5% across sectors. However 999 and 111 continue to experience higher levels. The committee were given assurance that unions and staff are generally more engaged with the new process and feel supported by it. It was noted that based on this we feel that the Trust can now work towards an overall sickness absence rate of 5%.

EMPLOYEE RELATIONS

The committee received a presentation on progress with employee relations cases. It was noted that the number of employee tribunals remains high and this is being managed in conjunction with engagement with the legal team. There are currently >20 cases however 8 cases have been closed over the last 2 months (settled, won or withdrawn). The committee were informed that as an employer we are not an outlier in terms of numbers. The chair requested that further information on the outcome of cases would be helpful and the Director of People and Culture agreed to arrange a separate meeting.

The committee were advised that there was a 100% satisfaction rate for participants going through the resolution process and that this process would be promoted over the coming year.

RETENTION AND WELLBEING

The committee received a report on retention and wellbeing and noted the improvement in retention figures for March (12%). It was also noted that turnover rates within EOC remain high and that a deep dive for 999 call handling will be presented at the July meeting.

The committee asked for a deep dive on this at a subsequent meeting which would include the optimal stability index we want to achieve by staff group – taking into account the inevitable dynamics of the London labour market.

OD / CULTURE PROGRAMMES / EDI

The committee received a presentation on OD / culture programmes which included EDI. The committee noted the progress of the Leaders Programme and the participation of 163 band 6 and 7 managers who will complete the course by Autumn 2024.

The committee also noted the challenge with appraisal compliance rates and that continued engagement with leaders is taking place to

target those outstanding. The committee were advised that work is underway on a new e-appraisal approach which will be available later in 2023. This will provide staff with a platform for continued discussion rather than a once-a-year opportunity to engage with their line managers on feedback and development opportunities.

CLINICAL AND NON-CLINICAL EDUCATION

The committee received an update on clinical and non-clinical education.

The committee noted that all staff will be shortly undertaking the Discrimination, Promoting Inclusivity Conversations training. The chair suggested that the Board should also be included and the CEO agreed to discuss this with the Chair.

The committee noted that C1 driving licences remains an issue and that we are still awaiting the outcome of the consultation exercise completed in January. The committee discussed the impact of this on deploying operational staff and asked for further details on this to be brought back to a subsequent meeting. The committee also noted that university students do not receive blue light training as part of their course. The committee asked if it was possible for this to be commissioned and included as part of the course. The committee asked for this to be put forward as a formal request to HEE.

FREEDOM TO SPEAK UP REPORT

The report was not available to be considered at this meeting. The committee requested that it be circulated and agreed by correspondence in the next week following the committee meeting. The committee were verbally advised that:

- Of the 47 concerns raised in Q4 these mainly from ambulance operations and EOC. Top two themes are process (20 cases), bullying and harassment (11 cases) and management raised 8 concerns.
- The Sexual safety toolkit is being launched and NHS E have commissioned on staff safety in ambulance trusts publication of which is due in Q1. NHS E are also a supporting tackling discrimination and bias programme.

STAFF SURVEY

The committee received a presentation on the results of the 2022 staff survey, and it was noted that the LAS had the largest response in its history of completing the survey. It was noted that the survey was carried out during a period of peak pressure which are reflected in the results.

The committee noted the most improved areas as being, supply of materials and equipment, receiving pressure from manager to work when not feeling well enough, received an appraisal and career development opportunities. The most declined areas were noted as; satisfaction with pay, standard of care provided by LAS and raising concerns. It was noted that work is being done within the culture

	programme to support our staff. The committee were also informed that the introduction of team based working will help staff understand they are doing the right thing by raising concerns and ensure feedback is provided quickly. The committee also received a presentation of results broken down by protected characteristic. It was agreed that this data would be shared with the new EDI committee to develop an action plan It was noted that the results are being broken down into sectors and we will be using the network expertise to resolve some of the results and provide action plans, which will be sector based rather than trust-based plans. The committee noted that there were some encouraging signs in the survey results.
Key decisions made / actions identified:	See other commentary.
Risks:	**Board Assurance Framework** This was reviewed. The committee discussed the staff wellness and sickness absence risk and whether in light of the reducing sickness levels and a stabilisation in turnover rates, the risk score could be reduced. The committee agreed the reduction of the current risk score. The committee also considered whether the rate of the burnout risk could be reviewed in light of the reduced operational demand and the impact this had on staff. Given the wording of the current risk the committee did not consider it was appropriate to decrease the risk score at this time, when 85% of staff had reported staff burnout in the staff survey. However, discussion took place on whether the risk as drafted should be reviewed and the Director of People and Culture agreed to consider this. The level of the staff diversity risk was considered and agreed that the risk rating should remain the same until some material difference could be seen in the overall workforce figures.
Assurance:	Assurance was received on sickness absence, wellbeing of staff and staff retention. Further assurance was a received on resourcing and workforce planning

Assurance report:	**Equality, Diversity and Inclusion Committee**	**Date:**	**22/05/2023**
Summary report to:	**Trust Board**	**Date of meeting:**	**25/05/2023**
Presented by:	Anne Rainsberry, Non-Executive Director, Chair of Equality, Diversity and Inclusion Committee	**Prepared by:**	Roger Davidson- Director of Strategy and Transformation and Kulvinder Hira – Head of Equality, Diversity and Inclusion Reviewed, amended and approved by Anne Rainsberry

Matters considered:

The EDI Committee met for the first time and discussed the following:

Draft terms of reference
The committee discussed the proposed TOR. The question of scope was discussed and in particular whether the committee's remit should cover workforce EDI or include patient experience. It was noted that QAC had a number of existing programmes of work to respond to the needs of specific EDI groups. Therefor it was agreed that this committee would primarily focus on staff but with a view to understand the impact of working with London's diverse population.t In that context the committee agreed to consider a patient rep as a member.
The TORs were approved subject to the above change in membership.

Overview of the current position and work programme

The EDI Committee received a presentation on progress to date and the current proposals for the forward plan including:

1. A review of equality related policies, programmes and projects is currently underway to ensure compliance with the Public Sector Equality Duty.
2. The latest position on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. This provided a snapshot of the latest high-level data.
3. Good practice section provided the committee with forthcoming guidance from NHSE on an EDI Improvement Plan recommending six high impact actions. The high impact actions will enable us to strengthen the implementation of interventions.
4. Reducing health inequalities and improving access for our patient's section provided the national Core20plus5 for adults and children and young people. It was agreed that going forward this would be in scope of QAC
5. Successes, challenges, and draft priorities for 2023-2024 were presented and aimed to provide a strategic direction and governance structure for the EDI agenda.

Gender Pay Gap Report

The committee was presented with the Gender Pay Gap (GPG) Report and its publication is part of the Trusts legal obligations. The Report sought to explain the “gap” in earnings, despite an overall gender-balanced workforce. It identified two key drivers:

1. The lack of women at senior band/over-representation of women at lower bands and
2. An overrepresentation of women within our part-time workforce.

The committee discussed the actions to address the “gap” over the coming year. These are:

1. Improve our engagement and understanding of the Gender Pay Gap and foster a data-informed action culture.
2. Better understand part-time workers’ experiences, the Trust’s attitudes to part-time work and the recruitment practices for such roles
3. Foster an even distribution of gender across the Trust’s roles and bands.
4. Establish clear gender-based targets and structures to enable strategic and systemic change.

The committee discussed the overall work programme and felt it was critical to focus efforts on a smaller number of high impact actions. In particular the work programme should provide a greater focus on retention and the role of line managers in improving the experience of EDI staff.

Proposal for recruiting more Ethnically Diverse Ambulance Workers for LAS

The committee received a presentation on a proposal to conduct a perceptions-based audit and analysis of recruitment (attraction and selection) of ambulance staff. The aim will be to identify those areas that may act as a barrier to recruiting a workforce more representative of the population it serves. The recommendations reports expected in the Summer. The committee requested that a similar audit be undertaken on retention.

Neuro Inclusion Pathway

The committee received a presentation on the new neuro-inclusion pathway. The pathway aims to support colleagues who identify themselves as Neurodiverse or Neurodivergent or who are diagnosed with a Neurodisability. This is a pilot project and is going to run from April 2023 till March 2024.

	The NeuroInclusion platform will enable the staff to get a personalised mapping for their cognitive function supporting them and their managers to create an inclusive workplace for all. The overall objectives are: • Tool for digital cognitive assessment • Reasonable Adjustment and support • High Impact training for leaders and managers • Capturing and Reporting on Data • Compliance under the Equality Act 2010 For those staff requiring it the EDI team will support them with a diagnosis. Managers will also receive ongoing support to put in place any reasonable adjustments. The pathway will be rolled out to 500 employees in a staged approach throughout 2023 and 120 managers will be trained to support colleagues with Neurodiversity and reasonable adjustments.

Key decisions made / actions identified:	• The EDI team to develop action plans that maximises impact in these key areas:
	    ○ Increase inclusive attraction by conducting a deeper dive with diverse communities to understand barriers.
	    ○ Redesign recruitment and selection processes to increase representation to reflect London's population for staff in paramedics and AAPs
	    ○ Improve workplace culture and experience for all staff.
	• It was agreed to publish the Gender Pay Gap report
	• It was agreed that we develop and publish the Ethnicity Pay Gap Report
	• Explore options to recruit a patient representative
	• Align all EDI reporting (GPG, WRES, WDES) to coincide with the Annual General Meeting
	• Provide a benchmark comparison for WRES, WDES and GPG

Risks:	The risks associated with this new work programme and committee are to be scoped. The director of strategy will consider these and bring a draft to the next meeting

Assurance:	The committee received assurance that there is working progress on EDI agenda across the trust and the EDI team are working towards setting objectives for 2023-2024. The committee is yet to receive assurance that this work programme will materially impact the challenges it has identified and has asked for further assurance on this.

5.3. Finance

5.3.1 Director's Report

5.3.2 Finance and Investment Committee

5.3.3 Audit Committee

5.3.4 Charitable Funds Committee

For Assurance

Presented by Bob Alexander, Rakesh Patel and Rommel Pereira

London Ambulance Service NHS Trust Board meeting
25 May 2023

Report from the Chief Finance Officer

Financial Position at the end of April 2023

Income and Expenditure Plan
For the financial year 2022/23, the Trust reported a full year Income and Expenditure (I&E) surplus of £0.1m as at 31 March 2023 against the NHS performance target of a breakeven position, a favourable variance of £0.1m. This position is subject to the year end audit.

The Trust has agreed a breakeven financial plan for 2023/24. The in-month I&E position for April 2023 (month 1) is a £1.8m surplus; £0.3m favourable to plan.

Capital Programme
The Trust invested £33.9m on capital expenditure in 2022/23, and utilised all of its available capital funding.

The capital plan for 2023/24 has been set at £28.8m. Expenditure in April 2023 (month 1) was £0.7m.

Cash Balance
The Trust had a closing cash balance of £32.3m at end of April 23.

Fleet
The roll out of new vehicles has continued at pace since the last report. The Fleet department has made 152 vehicles for operational use during 2022/23. The first 10 lightweight ambulances have been delivered and are either in commissioning or with the Training Department, to be deployed from Oval Station in late May. In addition, the first batch of 17 Fast Response Vehicles ordered in March are being signed off in May for delivery in June.

Estates

The Trust has started construction enabling work and network infrastructure work at Bernard Weatherill House, Croydon. Project design is at RIBA Stage 3 and the second phase of principal contractor selection is nearing completion.

In sourcing of the Trust's premises cleaning service was achieved at the end of March and the Trust is now working with our new colleagues to enhance the service and induct them to the Trust.

The additional education centre facilities at Brentside were also completed in March and these are now being used to support the Trust's ambition of recruiting additional staff and delivering an expanded educational training programme.

Rakesh Patel

Chief Finance Officer, London Ambulance service NHS Trust.

Assurance report:	Finance and Investment Committee	Date:	20/04/2023
Summary report to:	Trust Board	Date of meeting:	25/05/2023
Presented by:	Bob Alexander, Non-Executive Director, Chair of Finance and Investment Committee	Prepared by:	Bob Alexander, Non-Executive Director, Chair of Finance and Investment Committee

Matters for escalation:

There were no matters for escalation.

This was a Finance 'Light' Committee, held in the intervening months between meetings of the full Finance and Investment Committee. Dates of the full Committee have recently been amended to later in the month to enable more timely financial reporting from the Finance team. This means that this report only covers one Finance 'Light' Committee meeting.

FIC

Other matters considered:

Ambulance Radio Programme (ARP) Business Case

The Committee reviewed a business case to roll out replacement control room radio and mobile data systems across the trust. The overall delivery forms part of a national ambulance radio programme. The business case set out the investment needed to roll out new systems and deliver business changes that would release operational and cost benefits.

The Committee noted that this was a complex programme to deliver because LAS was an 'outlier' in that it currently operated a bespoke, in-house system that was different to the rest of the country. However, the national programme was planning the roll out of replacements for all ambulance trusts with the intention of removing legacy risks and promoting improved cross-Trust working on a national scale.

The Committee raised a number of issues in relation to the business case, including the need to avoid a tendency to make the new national system operate like the legacy system. Assurance was given on this point and it was stressed that the national team had been very clear that they would not support any attempts to make the new system look and work like the old, bespoke system.

The Committee agreed the importance of good governance around the programme and that there needs to be a review of the proposed governance and assurance mechanisms for the project, including which Board Committee would have oversight. It was also agreed that benefits realisation would be complex and difficult, and that it would be important to develop a corporate tracker.

FIC approved the ARP business case, subject to clarification and validation of some data in the report.

Month 12 Finance Update

The Committee received a report on the month 12 position which was still subject to audit starting on 4th May.

Key decisions made / actions identified:

Approval of the ARP Business Case.

Risks:

Board Assurance Framework

It was noted that there are two key financial risks on the BAF:-

- 2023/24 financial plan – this risk had been updated to reflect a reduction in risk
- Use of the £25m additional funding both in terms of delivery of the performance targets and the availability of vehicles and assets.

Assurance report:	**Audit Committee**	**Date:**	**18/04/2023**
Summary report to:	**Trust Board**	**Date of meeting:**	**25/05/2023**
Presented by:	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**	**Prepared by:**	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**

Matters for escalation:	**Draft Annual Governance Statement (AGS)** The Committee considered carefully whether the Annual Governance Statement should report any significant breaches of internal control particularly in light of the Verita Report, the draft Head of Internal Audit opinion (which had given moderate assurance) and the internal audit that the Audit Committee had commissioned on Data Quality. It was noted that the criteria for declaring a significant breach of internal control was open to some interpretation. The Committee asked that the disclosures in the AGS on the Verita Report and reporting against the C1 KPI should be expanded and strengthened and would reserve its views following satisfactory responses on points of challenge and clarification on the internal audit of data quality to provide the necessary assurances and further internal audit work that would be programmed into the 23/24 internal audit plan and disclosed in the AGS.
Other matters considered:	**Overview of Control Issues** The 2022/23 financial year had concluded with a break even position. In relation to 2023/24, two significant risks were whether or not LAS would achieve a reasonable financial settlement with commissioners, and how LAS would ensure that it achieves the workforce performance targets that need to be achieved in order to secure the £25m additional funding. There was confidence in the progress of the Data Security and Protection Toolkit which was due for submission at end of June 2023. Operational performance had been significantly better in 2022/23 than in the previous calendar year. However the position in relation to industrial action was very complex and the junior doctor strike had had a significant service impact. The Trust was currently undergoing an in informal well-led review.

SIRO Report
The Committee noted that work on the DSPT was progressing well and that the Trust was in a much stronger position in relation to information governance than the same time in the previous year.

Cyber Security Update
The Committee received a presentation from the Head of IT Risk, Governance and Cyber on cyber assurance and security measures in place to ensure security of systems.

Quality of minutes
The importance of good quality minutes was reinforced as a matter of record and driving action, alignment and accountability,

Key decisions made / actions identified:

Internal Audit Reports

Since the last meeting, four internal audit reports had been completed:

Data Integrity – this broad review of data quality across the Trust had been undertaken by a specialist team. The review had noted a number of positives and had not identified any significant errors in data reporting. The report had, however, noted some limitations in reporting against a number of indicators and the need for ensuring more context when reporting data so that there was absolute clarity about what the data was telling the Board. The Audit Committee raised a number of queries in relation to the level of assurance obtained from the report and it was agreed that an additional piece of work would be scoped that was framed in the context that it would be part of the ongoing programme of audits.

Data Security and Protection Toolkit - A Moderate opinion, highlighting improvements compared to last year and confidence in the submission.

Estates Strategy - A Moderate opinion with 6 medium recommendations. It was noted that there was a high degree of dependency on the support of third parties and that rigorous follow up of the recommendations would be important.

Patient Safety Incident Response Framework - A Moderate opinion overall with 3 medium recommendations. The Committee, noting the timeliness of investigations and overdues, queried if there was sufficient capacity within the team. The CEO assured the Committee that there had been a big focus on reducing the number of overdue incident reviews over the past few months and this work would be ongoing and the Quality Assurance Committee would be kept informed of progress.

The Head of Internal Audit advised his overall end of year opinion as Moderate Assurance, taking account of audit work this year on HFMA, PSIRF, Key Financial controls (Payroll, Recruitment, Procurement), generally positive reviews (2 Substantial Assurance & 4 Moderate Assurance reviews and no significant errors in Data Quality), Follow ups on recommendations and the Trust's financial delivery to plan.

The Chair of the Audit Committee summarised a general theme from all the

internal audit reports that there is good management intent and work in progress on effective systems of control but that there was still some way to go in terms of implementation and execution. Partly this was due to operational pressures but also that this is a new management team with a number of legacy and historical issues to manage.

Draft Internal Audit Plan

The Committee reviewed and commented upon the draft internal audit plan and asked that it be circulated to Board Committees for review.

Local Counter Fraud

The Committee noted the good anti-fraud tone from the top, resulting in an overall Green NHSCFA submission and received an update on the reactive counter fraud work being undertaken by the LCFS.

External Audit Update

KPMG gave a summary of the year end work that was about to start, including an opinion on Value for Money, which would take account of the Verita and Internal Audit reviews.

Financial Reporting

Single tender waivers (STW) – the Committee received a report setting out all the STWs approved since the last meeting. It was noted that the higher number of STWs in the quarter was a function of year end.

Losses and Special Payments – the Committee received a report setting out the level of losses and special payments, which were consistent with notifications and approvals by Remuneration Committee.

Salary overpayments – the Committee welcomed further work undertaken to strengthen controls, actions being taken to recover overpayments and reduce their occurrence. It was noted that a policy on salary overpayments was currently being taken through Staff Council.

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Assurance:

Corporate Risk Register

As part of its annual review, the Committee considered the Corporate Risk Register (CRR) noting that there were currently 29 risks on the register, mostly relating to operational pressures and the impact on services. Members of the Committee raised a number of detailed questions about the CRR which it was agreed would be addressed through the work currently underway on refreshing the CRR.

Board Assurance Framework

The Director of Strategy gave an update on how the risk on the BAF relating to failure to achieve alignment with a range of strategic partners was being managed.

The Committee noted that the BAF was working well as a key assurance document, that it would be reworked to reflect Business Plan 23/24 priorities and asked that consideration be given to developing heat maps tracking risks over time and against target and asked that Anchor Institution risks be brought to the next AC.

Assurance report:	Charitable Funds Committee	Date:	05/05/2023
Summary report to:	Trust Board	Date of meeting:	25/05/2023
Presented by:	Bob Alexander, Non-Executive Director, Chair of Charitable Funds Committee	Prepared by:	Bob Alexander, Non-Executive Director, Chair of Charitable Funds Committee

Matters for escalation:

Nothing to report

Other matters considered:

Charitable Activities Update

The Committee received an overview of charitable activities in two parts. One update focussed on charity development and another on Charity Operations.

Members were provided a summary of charitable developments and operations noting the following:

- The staff lottery is set to start on the 9th June.
- April success included supporting over 4050 fundraisers doing half marathons, full marathons, abseils and continuing without running an ambulance.

A slight delay to the Charity Microsite development, but it is still being worked on and there were changes that they needed to do to align with LAS branding.

In the five year strategy there is a plan to start launching larger campaigns towards the end of year two, three and four and also to launch and achieve an appeal.

London Lifesavers programme, which is funded through charitable funds, also run a community defibrillator. And the aim to build more community resilience by fundraising and to provide more defibrillators in the communities which need them most.

Noted a further idea is to work with the Director of the Head of Historical Collection as LAS have a restricted museum, where the artefacts could have a value and at some point could be open to the public.

	Policy Review It was reported that six charity specific policies are needed within the two categories: • Investment policy • Charitable spending policy • Privacy policy • Ethical gift acceptance policy • Volunteers policy • Fundraising on the Trust Estate policy **Finance Report** The Committee received the Charities Finance report noting the current funds balance and expenditure to date.
Key decisions made / actions identified:	**Charity Staffing Proposal** The committee approved staffing proposal to approve in line with the original strategic plan, hiring an additional band 5 FTE Community and events fundraiser and part time band 4 charity development administrator, with the £209k unrestricted income from 2022-2023. This would represent £56K of the £209k for a year FTC. **Charities Reserved Policy** The committee approved the Charities Reserves Policy **Charity Ethics Policy** The committee approved the Charity Ethics Policy with the view that if it needed any amendments to do so and not wait a year.
Risks:	Risks and mitigations against the Charity strategy were presented and considered.
Assurance:	The Committee received assurance on the Charities activities, financial position and progress against the strategy.

5.4. Corporate

5.4.1 Director’s Report

For Assurance

Presented by Mark Easton

PUBLIC BOARD OF DIRECTORS MEETING

Report of the Director of Corporate Affairs

The Corporate Affairs Directorate incorporates Patient Experience, Legal Services, Information Governance, and Corporate Governance.

This report summarises the Directorate activity from March 2023 to May 2023.

PATIENT EXPERIENCE

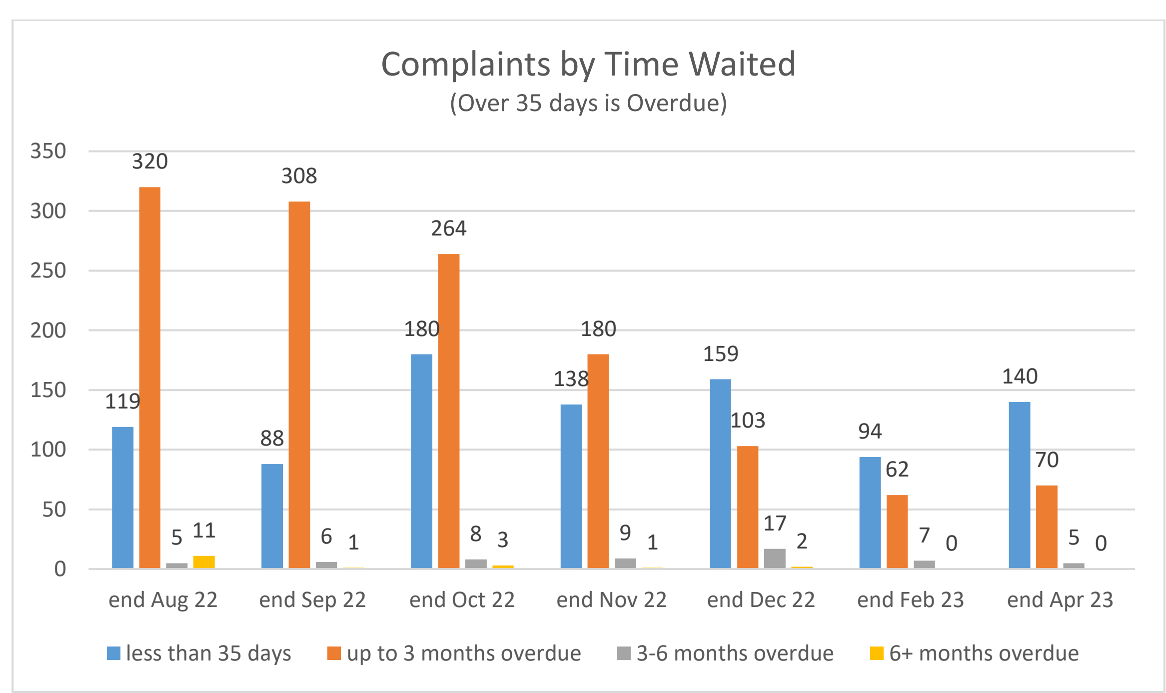
Complaints

Complaints received March – May 2023

194 (216 in same period 2022)

Complaints closed March – May 2023

168 (174 in same period 2022)



At the end of April, there was a total of 215 open complaints. 70 (33%) were overdue the 35 working day target response. The team are still working to reduce this figure through close monitoring and escalation of cases awaiting information from other departments as per the guidance in the Standard Operating Procedure. The team are continuing to prioritise drafting

complaint response letters in date order once the information has been received and also applying the 'early resolution' guidance from the Parliamentary and Health Service Ombudsman (PHSO) for complaints that meet the criteria.

The themes of complaints are almost identical to the previous year data in the same period (with a slight reduction in complaints about delays):

	Conduct and behaviour	Delay	Non-conveyance	111 Call Handling	Treatment
March/April 23	79	31	26	18	7
March/April 22	79	42	26	17	9

The causes of these complaints are investigated with input from local and specialist teams to identify the contributory factors e.g. a system or process issue or human factors and any learning shared with the staff involved.

Version 2 of the team's Standard Operating Procedure for complaints management has been finalised and its application is due to be audited by the team.

The team have one final training session from the PHSO on implementing the Complaints Standards on 19 May with a focus on remedy and writing a good response.

LEGAL SERVICES

Inquests opened since January 2023
Level 1[i] Inquests – 664
Level 2[ii] Inquests – 52

Claims opened since January 2023
Employment Liability - 10
Public Liability - 2
Clinical Claims - 18

The Legal Team continues to see an increase in the number of Inquests received and those being escalated from Level 1 to Level 2. This is due to the increased complexities of cases and Coroners seeking more detailed information.

The Legal Services Manager (LSM) and the Senior Clinical Lead for Mental Health Capacity and Legal Services (SSCL) are triaging all new inquests to enable early escalation, appropriate reviews and early input from the wider Trust, if necessary.

The LSM is also working with the SSCL to make necessary changes to the legal module on Datix to enable improved data collection and analysis and to identify themes and trends.

The Clinical Directorate is currently in the process of recruiting a Sector Clinical Lead who will assist the SSCL with the clinical legal workload.

The legal team now meet regularly with the Head of Quality Improvement and Learning, this has helped identify better ways of working and improved communication with the central team.

A recent training session organised by NHS Resolution (NHSR) and one of our panel firms was a great success. Feedback from the team is that it was invaluable in terms of meeting some of the NHSR team in person and better understanding how each organisation operates. The legal team had good discussions regarding ways of working, improving working practices and working more efficiently with NHSR and our panel firms.

As part of their ongoing commitment to help trusts improve, NHSR are keen to come to LAS to meet senior management to give an overview of their processes and a deep-dive into our claims data.

Following a request from our 111 service. The LSM will also arrange training about Inquests – witness statements and giving evidence at Inquest Hearings for the 111 senior management Team and Clinicians.

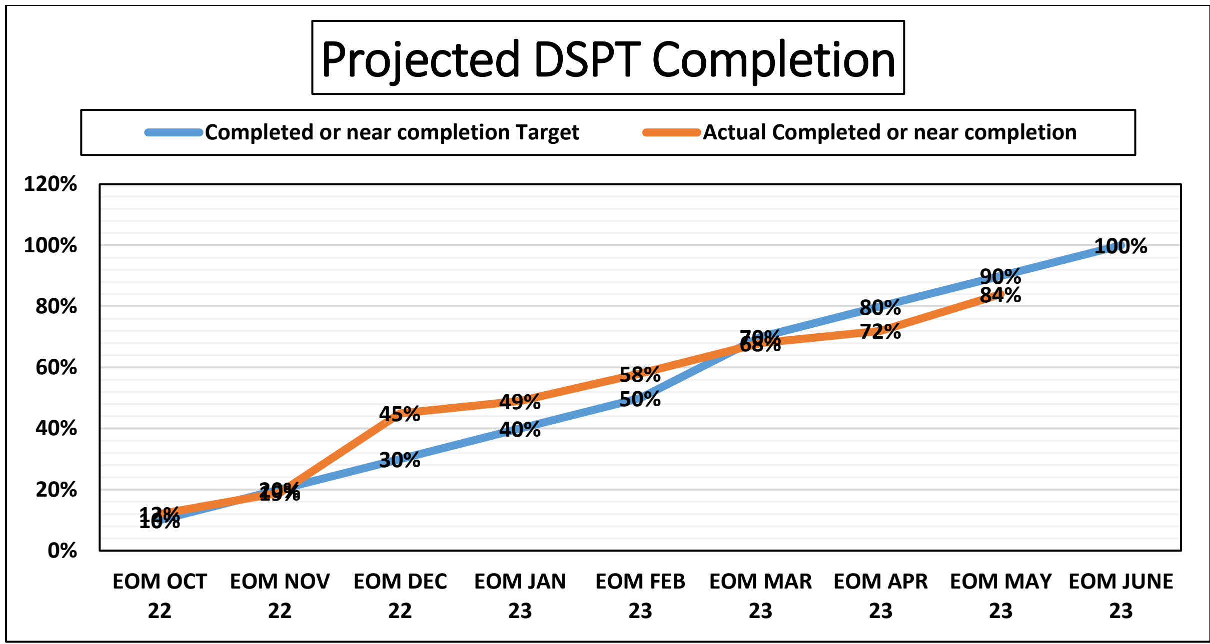
[1] Level 1 Inquests are less complex inquests (with no issues identified for the Trust) which can be dealt as a documentary hearing. Live witnesses not usually required but sometimes LAS witness are called to give live factual evidence.

[1] Level 2 Inquests are more **c**omplex where the Trust is an Interested Party, live witness evidence from attending crew and often senior management is required, and SI report or PSII reports are involved. There may be PFD and reputational risks for the Trusts.

INFORMATION GOVERNANCE

The trust has an annual programme to ensure compliance with the Data Security and Protection Toolkit (DSPT), which is an online self-assessment tool that allows Health Care organisations to measure their performance against the National Data Guardian's 10 data security standards. It is a requirement that any organisation that has access to NHS patient data and systems completes the DSPT to provide assurance that they are practising good data security and that personal information is handled correctly. The deadline for the completion of this year's DSPT sub mission is 30th June 2023.

The below table charts the progress made completing the mandatory assertions evidence items with a realistic projection for full DSPT completion:

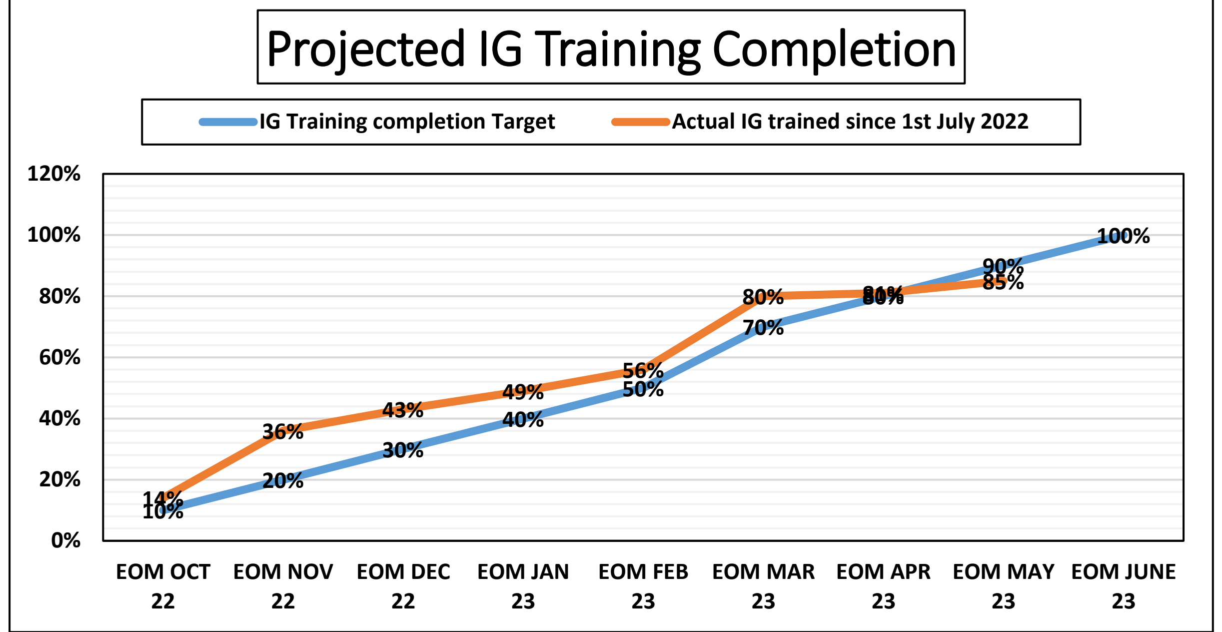


Of the 113 mandatory assertion evidence items included in the DSPT, 84% have either been completed or are near completion, which is a 16% increase since the previous report. Although the completion rate is tracking below target for EOM May 2023, a number of the remaining evidence items relate to the IM&T Team who have provided assurances that the majority of remaining items will be completed by the end of May 2023. This will then leave a small number of evidence items for completion, such as IG training compliance, which have always been predicted for completion in June 2023.

The percentage total for May 2023 was correct at the time this report was written [15th May 2023] and all reporting totals are calculated at the end of each month.

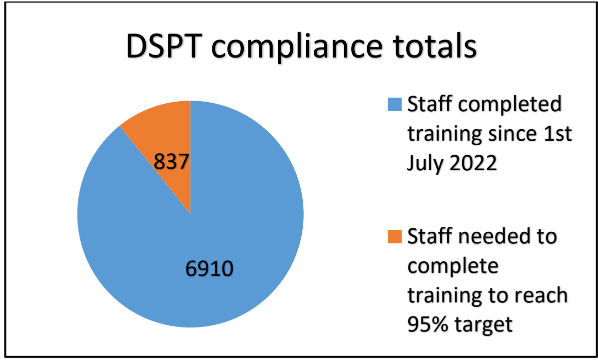
The DSPT requires that 95% of all staff are compliant with mandatory Data Security and Awareness Training. It is also required that the Trust only count staff who have been trained within the last twelve months towards the 95% compliance target.

The below table charts the progress made in reaching the mandatory 95% compliance target with a realistic projection for full compliance:



The IG training completion target projection line has been calculated utilising staff training expiry data. The percentage total for May 2023 was correct at the time this report was written and all reporting totals are calculated at the end of each month.

The Trust is currently reporting an 85% training compliance level which is an increase of 25% since the previous report. This translates into the Trust requiring a further 837 staff members to complete their training before 30th June 2023, as shown in the adjacent pie chart.



Although the current percentage is below the target trajectory and there are still a significant number of staff members to train, the IG team are confident the Trust will reach the 95% target by the deadline of 30th June 2023. This will be facilitated by an increase in reporting supplied by the workforce team. As well as sending reminder emails to all non-compliant staff, the IG Team have also started contacting all Departmental Managers with large numbers of expired or near expiry staff.

Each year the Trust must complete an audit as part of the criteria for completion of the DSPT. The purpose of this audit is to provide an independent high level review of the assertions and evidence items in the DSPT and to identify how compliance could be improved. The audit was conducted by BDO and commenced on 6th March 2023 and the Trust received the final report on 11/04/2023 with the below results:

Overall risk assessment	Overall confidence level in the DSP Toolkit submission
Moderate 0 Critical Risk Recommendations 0 High Risk Recommendations 2 Medium Risk Recommendations 1 Low Risk Recommendation	High

All recommendations are currently in the process of being addressed and will be completed in a timely manner. The DSPT is a high priority project and the Information Governance Team are confident the DSPT will be completed in advance of the deadline of 30th June 2023.

When a data breach occurs within the Trust, dependant on the nature of the breach, it may need to be reported to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and/or the National Cyber Security Centre. There is currently one open case with the Information Commissioners Office. This relates to unauthorised records access by a staff member. The case is being reviewed by an external investigator that the Trust has commissioned, and the ICO has been made aware of the steps taken by the Trust, and asked us for a report when the investigation is complete.

The Trust continues to embed data privacy by design into new projects by undertaking a data protection impact assessment (DPIA), a well-practiced custom that demonstrates how the Trust continues to strengthen its data protection, information governance and security framework.

FREEDOM OF INFORMATION

Interest in the work of the Trust remains high and this continues to reflect in the number of information requests received. As part of the Trust's governance processes, Freedom of Information compliance is reported to the Information Governance Group and Executive Committee and is part of the Quality Report reviewed at QAC; this review and challenge helps to support awareness and to ensure that internal stakeholders are aware of their responsibilities.

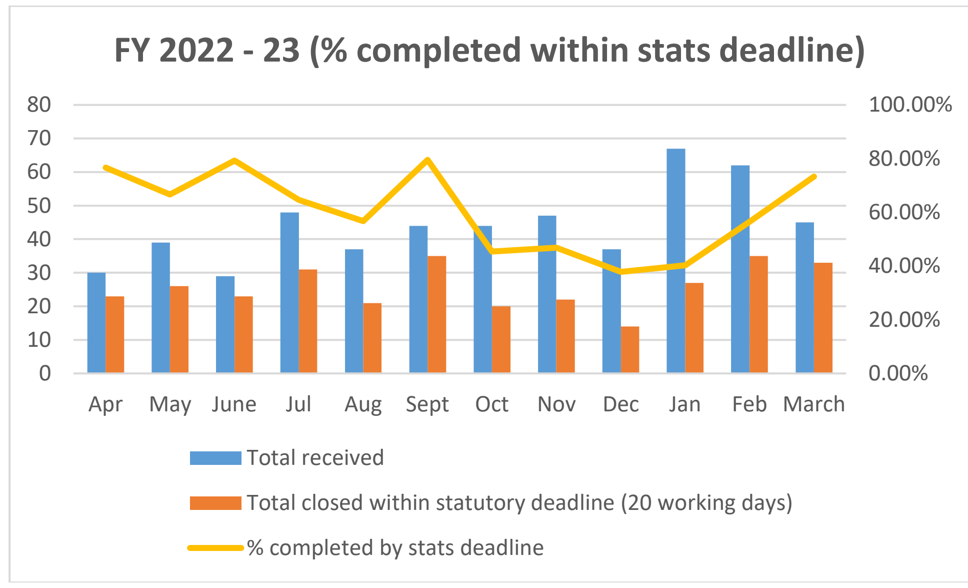
During the 2022/23 year, the Trust received 529 requests submitted under the Freedom of Information Act 2000. In that period, a total of 507 requests (96%) were closed. Of these 310 requests were closed within the statutory deadline (59%).

In the current year FY to-date, we have received a total of 70 requests (52 in April and 18 so far in May). A total of 17 out of 19 requests that are due for completion were completed within the statutory deadline (89% compliance rate).

For the same period in 01 Apr – 30 Apr, a total of 77% requests were completed within the statutory deadline, compared to 89% in the same period 01 Apr – 30 Apr this current year (FY 2023/24).

If the response rate continue on the current trajectory, the Trust should be able to achieve the target rate of 85% compliance. The FOI team continue to meet with the Director of Corporate Affairs fortnightly to monitor the position and to identify process improvements.

The team is currently working to close off any overdue FOIs from last FY, and also to develop a SOP to manage the FOI process better.



6. Quality

6.1. Quality Report

For Assurance

Presented by Jaqualine Lindridge

Report Title	Quality Report			
Meeting:	Trust Board			
Agenda item:	6.1	**Meeting Date:**	25th May 2023	
Lead Executive:	Dr John Martin, Chief Paramedic and Quality Officer			
Report Author:	Various			
Purpose:	X	Assurance	X	Approval
	X	Discussion		Information

Report Summary

The Trust Quality Report, containing March 2023 data, provides an overview of the quality performance through relevant quality Key Performance Indicators (KPIs) and information including the quality improvement agenda across the organisation.

- The number of no harm incidents have reduced within the normal level range over the last 3 months. The top 3 no harm categories in March 2023 remain the same with Medical Equipment (72), Clinical Treatment (58) and Dispatch & Call (57 compared to 179 in Dec 2022)
- The number of IUEC no harm incidents for March 2023 was 247 which is near the upper control limit. This is due to increased incident reporting for demographic errors where patient's telephone numbers or addresses have been recorded incorrectly.
- The Hand Hygiene compliance rate for March 2023 increased to 98% and this score continues to exceed the Trust performance target (90%). Overall submission for January was 188. The IPC training compliance for level 1 and level 2 is above the Trust compliance target (91.8% and 93.9% respectively)
- Overall Trust compliance for Premises cleaning in March dropped from 97% to 95% although continuing to exceed the Trust performance target of 90%. Both IUEC and EOC have been actioned with submission improvements
- There are 736 overdue incidents which have been open on the system longer than 35 days (this excludes SIs, PSIIs & PSRs). During March 2023 the number of incidents reported was higher than average and the number of incidents moved to Quality Check was higher than the average. A Trust wide improvement plan is has been agreed to recover this position, the benefit of which can been seen with the number of overdue incidents being the lowest since pre 2022.
- Stat/ Man training has increased to 87% which is above the 85% target. The Trust achieved an average of 85% for the period of April 2022 to March 2023.

Safeguarding training compliance is 91% for level 3 and 71.45% for level 2, with recovery work underway in EOC to improve this position. MCA training compliance remains good, however it is noted that compliance levels are trending down and this requires action to prevent deterioration below compliant levels.

- CPI compliance remains above the above the target level, with the exception of sickle cell compliance which was at 93%. Completion rates remain below the target level however at 84% and documented staff feedback is not being completed.
- The Trust continues to undertake good levels of 999 call auditing and remain in good standing as an accredited centre of excellence.
- The progress on reducing the backlog of complaints has slowed slightly – 70 out of 187 complaints are currently overdue the 35 working day target (37%).
- The number of overdue policies has increased to 47 (48%) with 49 (52%) in date.

Recommendation/Request to the Board/Committee:

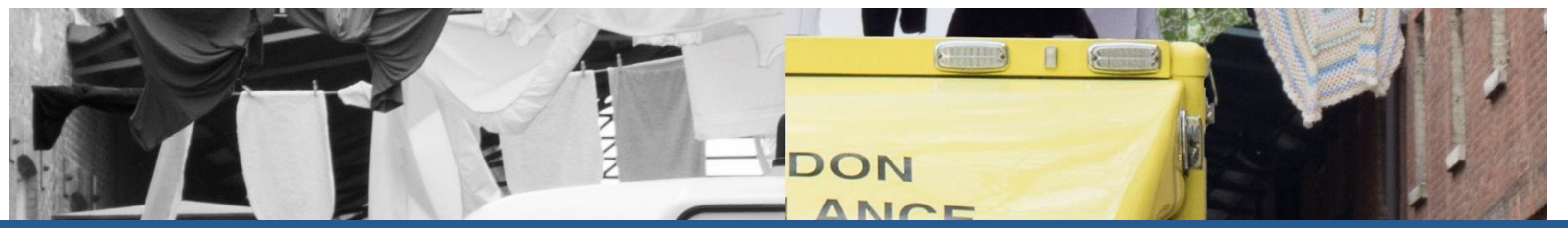
The Board is asked to discuss and approve the Quality Report

Routing of Paper i.e. previously considered by:

QOG (02/05/23)
ExCo (03/05/23)
QAC (09/05/23)

Corporate Objectives and Risks that this paper addresses:

This paper addresses the agreed reporting metrics for quality, in the safe, effective, caring responsive and well led domains.



London Ambulance Service – Quality Report

Report for discussion at the Trust Board

Analysis based on March 2023 data, unless otherwise stated

Quality Report Summary

London Ambulance Service NHS Trust

SAFE

KPI	Latest Month	Measure	Variation	Assurance	Comment
Number of No Harm 999 Incidents	Mar-23	444			**Incidents:** The number of no harm incidents have reduced within the normal level range over the last 3 months. The top 3 no harm categories in March 2023 remain the same with Medical Equipment (72), Clinical Treatment (58) and Dispatch & Call (57 compared to 179 in Dec 2022). The number of moderate & severe harm incidents have reduced, although remain in special cause variation.
Number of No Harm 111 Incidents	Mar-23	247			The number of incidents reported within IUC has been varied the last few months, call volumes remain high. Staff were reminded over the last few weeks on the importance of incident reporting. The number of no harm incidents for March 2023 was 247 which is near the upper control limit with an upward trend. This is due to increased incident reporting for demographic errors where patients telephone numbers or addresses have been recorded incorrectly.
OWR Hand Hygiene Compliance	Mar-23	98%		P	**Hand Hygiene**: The compliance rate for March 2023 increased to 98% and this score continues to exceed the Trust performance target (90%). Five stations did not submit data this reporting period (Romford, Camden, Deptford, New Malden and Wimbledon). Overall submission for January was 188. The IPC training compliance for level 1 and level 2 is above the Trust compliance target (91.8% and 93.9% respectively)
Premises Cleaning Audit	Mar-23	95%		P	**Premises cleaning:** Overall Trust compliance for March dropped from 97% to 95% although continuing to exceed the Trust performance target of 90%. Both IUEC and EOC have been actioned with submission improvements.
Patient Safety - Medical Equipment Incidents	Mar-23	125	L		**Medical equipment incidents:** The top 3 incident categories in March 2023 remain the same- Security, violence, aggression and abuse (165), Medicines Management (141) and Medical Equipment (125). The number of medical equipment incidents has been decreasing the last few months indicating special cause variation Aug'22 onwards
Overdue 999 Incidents	Mar-23	736			**Overdue Incidents:** There are 736 overdue incidents which have been open on the system longer than 35 days (this excludes SIs, PSIIs & PSRs). During March 2023 the number of incidents reported was higher than average and the number of incidents moved to Quality Check was higher than the average. A Trust wide improvement plan is has been agreed to recover this position, the benefit of which can been seen with the number of overdue incidents being the lowest since pre 2022.
Percentage of Safeguarding Training - Level 3	Mar-23	91%			**Safeguarding Level 2 & 3 Training:** A recovery plan for IUEC has been implemented with improvement in the IUEC level 2 compliance. Overall level 2 compliance is now 71.45% across both IEUC and EOC, with further recovery work planned in EOC. Level 3 training Trust wide for March 2023 is at 91.10%.
Statutory & Mandatory Training Compliance	Feb-23	87%	H	?	**Statutory & Mandatory Training:** This has increased from the last reporting period to 87% which is above the 85% target. The Trust achieved an average of 85% for the period of April 2022 to March 2023.

*It is noted that harm levels change following appropriate review including LfD reviews and assessment against PSIRF and the Trust's Incident Management Policy.

Quality Report Summary

EFFECTIVE

KPI	Latest Month	Measure	Variation	Assurance	Comment
ROSC to Hospital (AQI) - Reported 4 Months in Arrears ROSC At Hospital	Nov-22	29%			In November 2022, the LAS ranked 4th for the overall ROSC on arrival at hospital with 29% and above the National average of 27.8%. In the Utstein comparator group the figure was below the national average at 46.4% (average 48.2%) with LAS ranking 8th
Stroke - Call to Arrival at Hospital mean (hh:mm) Reported 4 Months in Arrears	Nov-22	01:46:00			In November 2022, the LAS achieved a time of 01:46, down from 01:53 in October, for the call to arrival at hospital, compared with the national average of 01:47. This is outside the target of 01:10 and the LAS was 5th when ranked against other ambulance services.
MCA Level 1 Training	Mar-23	90%	L	P	**MCA Level 1 & 2 Training:** is 90% with the current eLearning provides both level 1 & 2. Level 3 MCA training is covered within the Trust's safeguarding level 3 training face to face.
Personal Development Review (PDR) Compliance	Mar-23	70.5%	H	F	In March, the PDR compliance is at 70% with an increase of 7% from January. Operational trajectories have been produced and monitored in the compliance report.
CPI - Completion Rate (% of CPI audits undertaken)	Feb-23	84%			**CPI Completion rates:** Completion rates for February 2023 were at 84% and still remain below the target of 95%. All aspects of documented care were above the 95% target except sickle cell compliance which was at 93%. Staff feedback remained at 0%.
Operational Workplace Review (OWR) compliance:	Mar-23	54.76%			OWR: This is currently at 54.76%. This remains below the Trust target of 85% and further action is required.

RESPONSIVE

KPI	Latest Month	Measure	Variation	Assurance	Comment
Number of Complaints	Mar-23	104			**Complaints:** The number of complaints received is similar when compared to the previous year and the overall themes of complaints remain consistent with the previous reporting period. Due to annual leave and sickness absence, the progress on reducing the backlog has slowed slightly – 70 out of 187 complaints are currently overdue the 35 working day target (37%).

WELL - LED

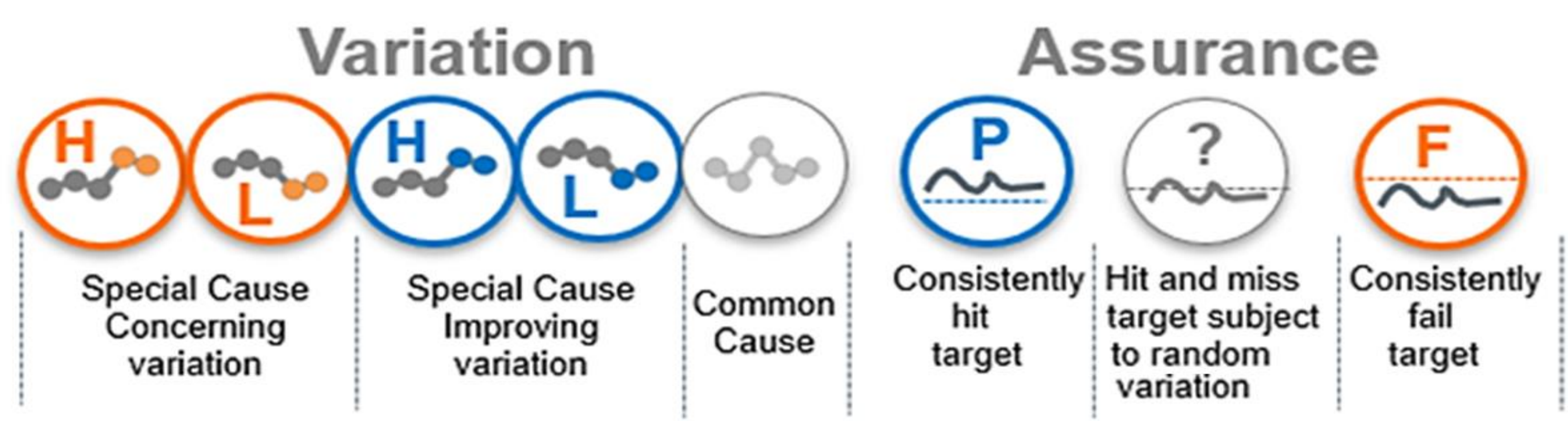
KPI	Latest Month	Measure	Variation	Assurance	Comment
Percentage of all risks reviewed within 3 months	Mar-23	73%			The Trust's compliance in April is 93% for risks reviewed within the last 3 months which is above the 90% target. 100% of risks approved within 1 month (target 90%)
Percentage of policies in date	Mar-23	52%			There are 49 (52%) policies in date across the Trust which is a decrease of 15 since the last reporting period. 47 (48%) of policies remain overdue.

Statistical Process Control (SPC) - Explained

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.

SPC is widely used in the NHS to understand whether change results in improvement. This tool provides an easy way for people to track the impact of improvement projects.



6.2. Quality Account

For Approval

Presented by Jaqualine Lindridge

<table>
<tr><td>Report Title</td><td colspan="4">Quality Account 2022/23</td></tr>
<tr><td>Meeting:</td><td colspan="4">Quality Assurance Committee</td></tr>
<tr><td>Agenda item:</td><td colspan="2">6.2</td><td>Meeting Date:</td><td>25th May 2023</td></tr>
<tr><td>Lead Executive:</td><td colspan="4">Dr John Martin, Chief Paramedic and Quality Officer</td></tr>
<tr><td>Report Author:</td><td colspan="4">Various Authors</td></tr>
<tr><td rowspan="2">Purpose:</td><td></td><td>Assurance</td><td>X</td><td>Approval</td></tr>
<tr><td></td><td>Discussion</td><td></td><td>Information</td></tr>
</table>

Report Summary

Our Quality Account for 2022/22 is presented here for approval, subject to final data checks, formatting for publication and the inclusion of stakeholder statements.

The draft content has been shared with the chairs of the LAS Patient and Public Council, as well the following stakeholders, within the statutory timeframe and in accordance with the National Health Service (Quality Account) Regulations 2010:

- Commissioners
- Healthwatch
- Overview and scrutiny committee

The Account includes a report on our progress against our Quality Account Priorities for 2022/23, presents our priorities for 2023/24 and reports on key performance metrics, and includes the content prescribed by the regulations. Statements from stakeholders have been requested, and will be included in the final account where received. Statements from Commissioners are due by 30th May, in accordance with the statutory timeframe.

The Quality Account has been approved by the Quality Oversight Group (2nd May), the Executive Committee (3rd May) the Quality Assurance Committee (9th May). The report will be published by the 30th June, in accordance with statutory deadlines.

Recommendation/Request to the Board/Committee:

The Committee is asked to approve the quality account content for 2022/23.

Routing of Paper i.e. previously considered by:

N/A

Introduction

This quality account provides a report on the quality of our services and the improvements we are making in relation to patient safety, the effectiveness of care and responding to patient feedback about the care we provide. Part 1 contains a statement on quality and a statement on Directors' responsibilities in relation to quality. Part 2 reports on our progress over the 2022/23 financial year and outlines our priorities for improvement in 2023/24. Part 3 provides statements in relation to our quality infrastructure and statements from our stakeholders, including our Patient and Public and Council and Commissioners.

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Part 1:

Foreword and Statement on Quality
(CEO and CPQO)

Welcome to the London Ambulance Service (LAS) Quality Account for 2022/2023 which provides a review of the quality priorities for the year along with a review of other key services that support the provision of high-quality care and outlines the quality priorities we have set ourselves for 2023/24. Our ambition is to provide patients with the highest quality of care by striving to ensure they receive the right care, in the right place, and at the right time. We provide 999 call handling, hear and treat and ambulance services across London, as well as 111 call handling services in four out of five ICS areas and integrated urgent care clinical assessment services in North East and South East London.

The past year has seen sustained high levels of demand which has resulted in both the 111 and 999 services needing to operate differently in order to maintain safety of care provision to our patients. We worked collaboratively with partner providers to implement several initiatives to make sure we got to people who needed us as quickly as possible, for example introducing ‘cohorting’ at hospitals to free up ambulances to respond to patients waiting in the community, being one of the two sites for the NHS England Category 2 segmentation pilot, which sees our clinicians assessing appropriate calls to ensure those who are in most need receive the fastest response, and designing and implementing a joint Urgent Crisis Response service. However, we recognise that during periods of sustained pressure some of our patients waited longer than the national standards for a response, particularly those with non-life-threatening conditions.

Last year, we set 3 themed quality priorities with 12 supporting objectives and associated Key Performance Indicators (KPIs). These priorities were identified from the feedback from our stakeholders, staff and manager engagement as well as internal sources of quality intelligence. We made good progress on many of the plans that we set out to achieve, but the challenges of sustained high demand meant that we weren’t able to achieve everything we set out to. Our progress against all priorities is detailed in the ‘looking back’ section of this report.

	Patient Care	Status
1.	Improve care for patients presenting with out of hospital cardiac arrest and/ or ST-Elevation Myocardial Infarction	Partial
2.	Improve the identification and referral of unrecognised hypertension responding to the rise in incidents of cardiovascular disease and stroke and linking with CORE20PLUS5	Complete
3.	Develop a Health Inequalities Action Plan	Partial
4.	Improve our compliance with infection prevention and control measures	Complete

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	Patient, Family & Carer Experience	Status
5.	Deliver the Right Care, Right Now Programme	Partial
6.	Improve how the Trust triangulates and shares learning from incidents, complaints, claims and excellence.	Complete
7.	Improve against response and call answering/ call-back indicators, reducing avoidable harm and poor experience due to delays	Partial

	Staff engagement and support	Status
8.	Improve access to clinical supervision for all clinicians to improve access to clinical development and progression	Complete
9.	Improve access to specialist/ advanced practice opportunities and rotational working	Complete
10.	Improve the percentage of staff who feel able to make improvements in their area of work	Partial
11.	QI projects responding to patient's needs by sector	Complete
12.	Back to basics: kit and equipment	Partial

Looking forward to 2023/24 we have developed 5 priorities on which we will focus our improvement efforts: cardiac arrest management, care after a fall, hear and treat consultations, reducing delays and infection, prevention and control.

In recognising the progress we have made during the last financial year, we would like to take this opportunity to publicly thank all our staff, volunteers, partner agencies and system wide partners, who have and continue to work incredibly hard in delivering high quality emergency and urgent care to the people of London during another difficult year.

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. NHSE/I 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 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 Quality Accounts requirements 2023/23 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 2022 to March 2023
- – Papers relating to quality reported to the board over the period April 2022 – March 2023
- – Feedback from commissioners dated X
- – The 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 and Chief Executive Officer

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Part 2: The Look Back: 2022/2023 in Review

Report on the 2022/23 Quality Priorities

Delivering our quality priorities has remained a high priority despite the challenges which have been experienced due to the high demand across the UEC system, on-going COVID recovery and other major events which were unexpected e.g. heat wave, industrial action and the death of HM The Queen. Throughout the year sustained focus was required to deliver safe and effective care and deliver the priorities with a flexible and adaptable approach.

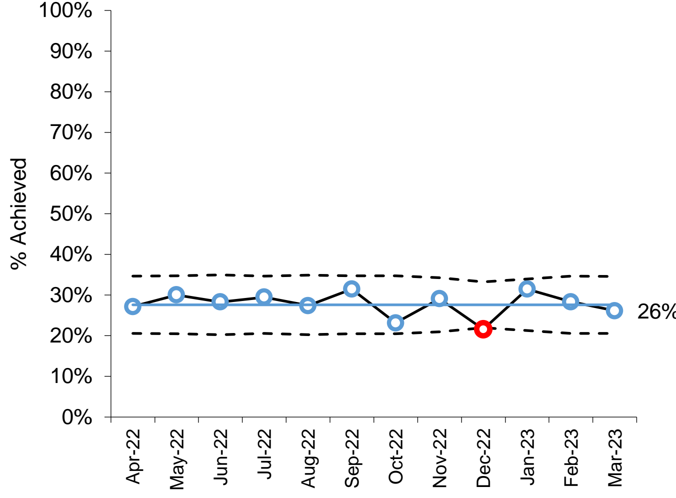
The Trust identified 3 themed quality priorities for the 2022-2023 financial year. These priorities were developed based on our business plan, feedback from our stakeholders and internal sources of quality intelligence. We made significant progress against all elements of the priorities, as outlined in detail in the following sections.

Priority 1 – Patient Care

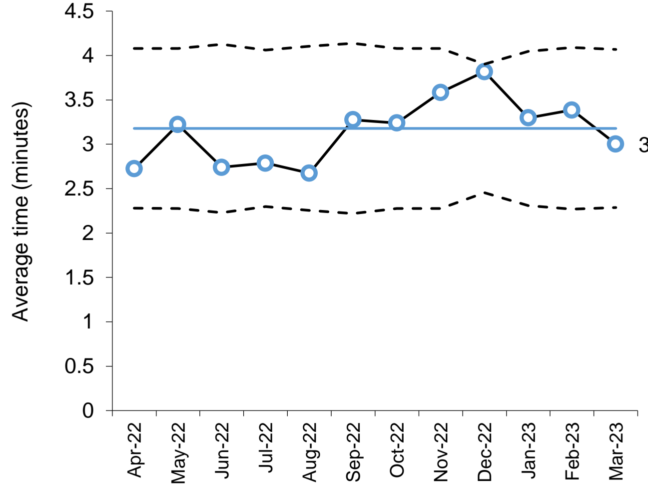
	Patient Care - Overview	Status
1.	Improve care for patients presenting with out of hospital cardiac arrest and/ or ST-Elevation Myocardial Infarction	
2.	Improve the identification and referral of unrecognised hypertension responding to the rise in incidents of cardiovascular disease and stroke and linking with CORE20PLUS5	
3.	Develop a Health Inequalities Action Plan	
4.	Improve our compliance with infection prevention and control measures	

Objective 1: Improve care for patients presenting with out of hospital cardiac arrest and/ or ST-Elevation Myocardial Infarction

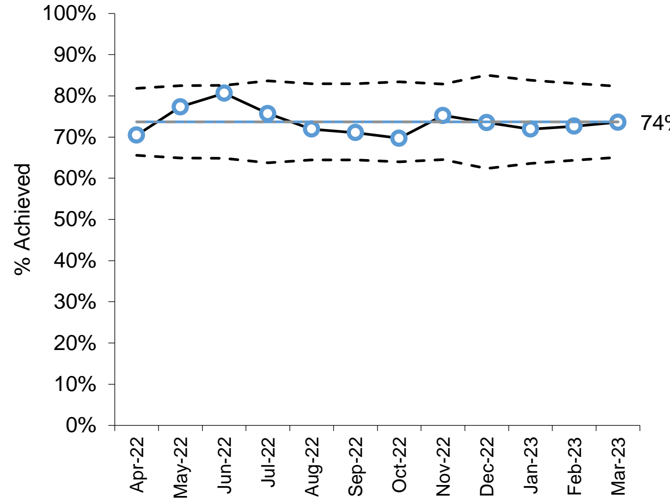
Return of Spontaneous Circulation (ROSC) rates have fluctuated since April 2022 and remain close to 30% target where data is available.



The time measured from arrival on scene to CPR being started has remained below the target of 5 minutes each month and within the SPC control limits.



Delivery of the STEMI care bundle has remained consistently below the target of 80%. Further work in this area this required to improve delivery of the care bundle. Work on improving delivery of the bundle of care will continue throughout 2023/24.



Objective 2: Improve the identification and referral of unrecognised hypertension responding to the rise in incidents of cardiovascular disease and stroke and linking with CORE20PLUS5

We developed a guideline and process for referring patients to primary care with unrecognised hypertension as part of responding to the rise in incidents of cardiovascular disease and stroke and linking with the Core20plus5 approach to reducing health inequalities. We have agreed the referral criteria, analysed historic data to predict the volume of notifications, designed and tested the workflow and are now ready to undertake a pilot in early 2023/24. We expect that approximately 250 patients per day may benefit from referral Trust wide, equating to approximately 1.4 referrals per GP practice per week. These are patients where the finding was incidental and did not require immediate clinical intervention

Objective 3: Develop a Health inequalities Action Plan

We agreed a CQUIN with our commissioners, and focused on three areas: improving the identification of unrecognised hypertension, improving the care of patients with sickle cell disease through early identification, optimising their treatment and conveyance/ referral decisions, and identifying health inequalities within pre-hospital maternity care to improve clinical decision making and improved patient experience.

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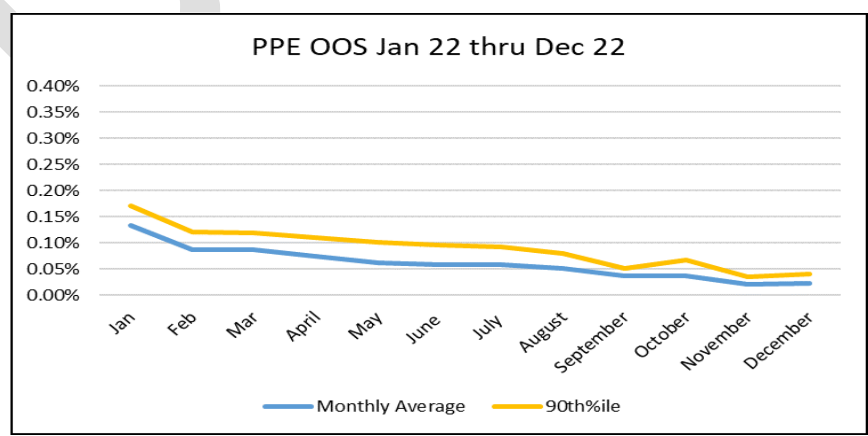
Ethnicity and gender identity is now routinely captured via our electronic patient care record (ePCR), as part of our work to improve use of this data, we intend to analyse 999 contacts, ambulance activity and alternative care referrals in the context of ethnicity, age and gender.

Month	% of EPCR Records with Age Completed	% of EPCR Records with Gender Completed	% of EPCR Records with Ethnicity Completed
Apr-22	95.7%	96.1%	89.4%
May-22	95.4%	95.8%	89.0%
Jun-22	94.9%	95.3%	87.7%
Jul-22	95.0%	95.5%	87.3%
Aug-22	94.9%	95.4%	87.5%
Sep-22	96.5%	96.9%	87.1%
Oct-22	99.5%	99.6%	84.4%
Nov-22	99.6%	99.6%	85.7%
Dec-22	99.7%	99.7%	86.3%
Jan-23	99.7%	99.7%	87.9%
Feb-23	99.4%	99.7%	88.7%
Mar-23	99.7%	99.8%	89.2%

To develop our action plan, we plan to recruit a public health specialist clinician with recruitment to this post commencing from April 2023 Work to develop our health inequalities action plan will continue throughout 2023/24 and forms a key objective in both our Quality priorities, business plan and 5 year strategy.

Objective 4: Improve our compliance with infection prevention and control measures

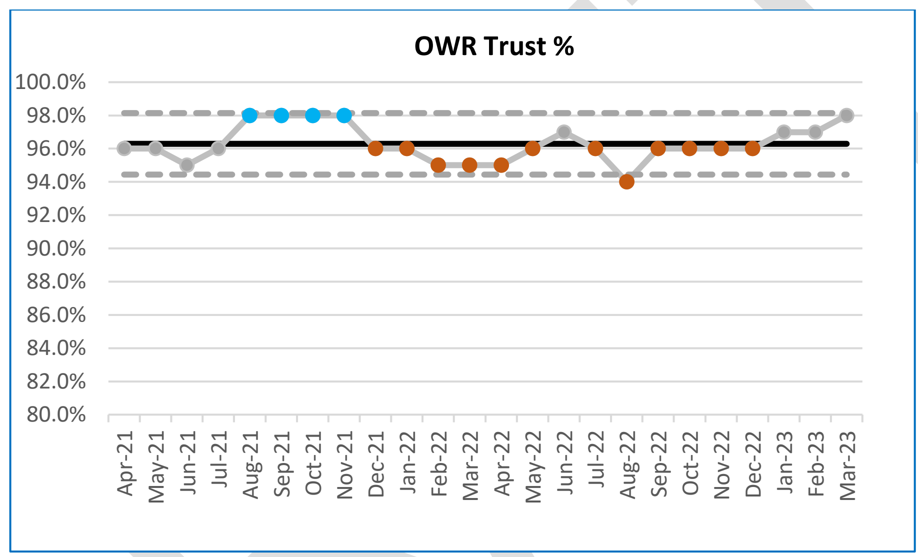
Following the increased use of personal protective equipment (PPE) throughout the pandemic, we set out to ensure we maintained PPE levels. As we have emerged from the national pandemic we have maintained significant focus on infection prevention and control. All of the 2022/23 work-plan actions were completed along with new IPC guidance. A multidisciplinary IPC day was held with national and regional speakers. We have maintained our supply and distribution of PPE, improving availability of PPE at ambulance stations and adjusting guidance in lines with national guidance.

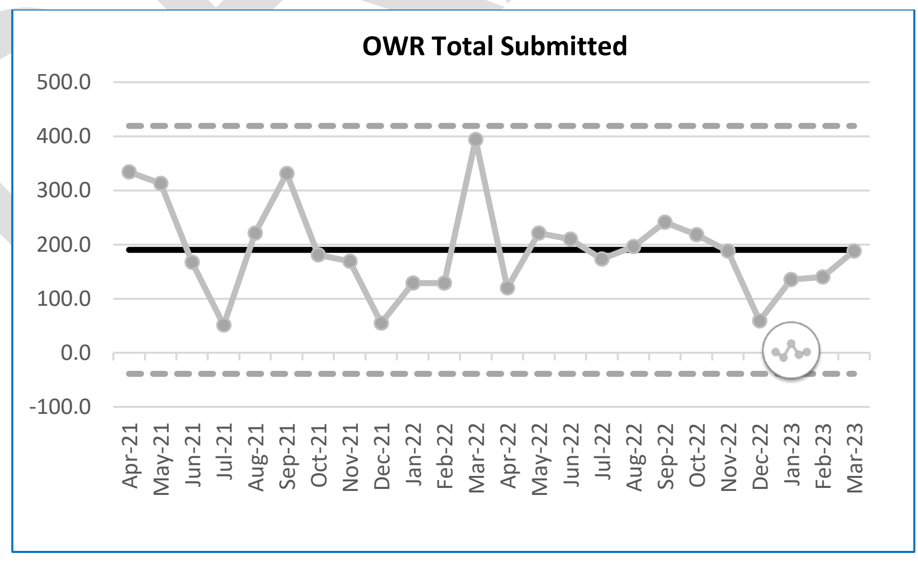


February – December 2022 improvement data by month

The improvements have been achieved by implementation of a Cental Asset Management System and improving auto-replensihment of stock to Make Ready Hubs to ensure stock levels are maintained, supported by Plan, Do, Study, Act (PDSA) cycles to understand root causes.

Reinforcing the importance of exemplary hand hygiene practice continues to be communicated to colleagues as part of the IPC annual work programme. IPC Link Practitioners (IPCLPs) continue to raise hand hygiene standards through leadership and role modelling at stations. A year-to-date review of hand hygiene submissions showed that 9 stations out of 19 met or exceed their annual target. Where audit returns are received, compliance is at a high standard as the following example from February 2022 shows. Further work will be continued into the next year to improve this further, focusing on improving audit returns as part of our priorities for 2023/24.





Priority 2 – Patient, Family & Carer Experience

	Patient, Family & Carer - Overview	Status
5.	Deliver the Right Care, Right Now Programme	🟡
6.	Improve how the Trust triangulates and shares learning from incidents, complaints, claims and excellence.	🟢
7.	Improve against response and call answering/ call-back indicators, reducing avoidable harm and poor experience due to delays	🟡

Objective 5: Deliver the Right Care, Right Place Programme

The 'Right Care, Right Place' programme has been defined and the dedicated board has been re-established following COVID. The following areas will form part of this programme:

- Same Day Emergency Care (SDEC)
- Urgent Treatment Centres (UTC)
- Urgent Community Response (UCR) cars
- Maternity
- Mental Health
- End of Life Care (EoLC)

SDEC Direct or SDEC by exclusion is now live pan-London, with a single information document now available on the mobile directory of services used by ambulance clinicians (MiDoS).

UCR cars are now operating in South West, North East and North Central London. The cars are staffed with paramedics and nurses and operate daily from 08:00-20:00, with solo paramedic staffing overnight.

The UCR teams see patients in lower triage categories and have access to a range of additional skills and diagnostics to enable patients to remain at home where they might have otherwise travelled to hospital.

We are now the lead provider for the Mental Health Joint Response Cars (MHJRC) across London. We now have an MHJRC working in each sector and an additional car responding to patients in central London (6 in total).

All of these initiatives provide the opportunity for LAS to provide bespoke patient centred care particularly to patients from more vulnerable groups. They have been co-designed with partner healthcare providers and also provide development opportunities for clinicians

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Objective 6: Improve how the Trust triangulates and shares learning from incidents, complaints, claims and excellence.

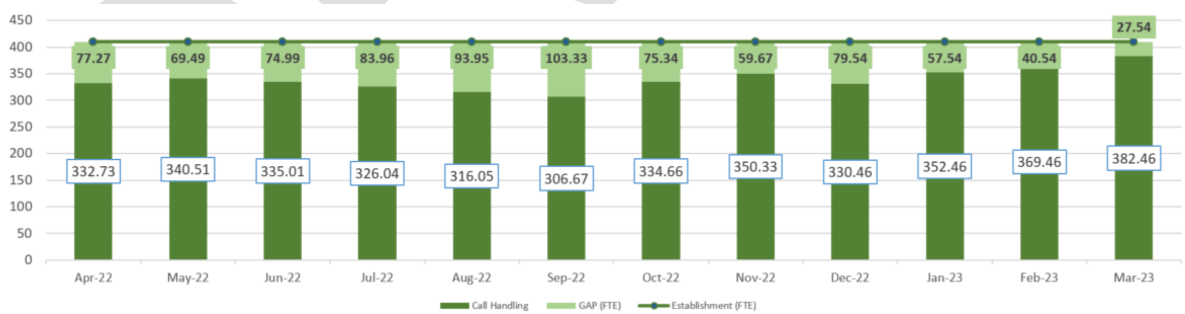
We set out to develop a virtual notice board and digital repository of learning and to develop the Trust Learning from Experience magazine, INSIGHT, to include more interactive and multimedia content.

To achieve this, we established a new intranet page which will become the central 'notice board' to share key communications around learning. A key aspect of this is using the Learning from Experience page to share learning from thematic reviews, INSIGHT Magazine and triangulated data from the Trust's Safety Investigation Assurance Learning Group (SIALG).

We have re-established the Learning from Experience approach, commenced Virtual Learning from Experience Case Events for staff to attend and discuss case reviews following Patient Safety Investigations and the associated learning and discussion points. Further learning is available from 'Learning form Incidents' posters displayed on stations and available on the intranet. We also share information via our weekly 'TV Live' broadcast, at CPD events, and clinical audit infographics.

Objective 7: **Improve against response and call answering/ call-back indicators, reducing avoidable harm and poor experience due to delays**

We set out to improve achievement of 999 call answering indicators. Unfortunately, along with ambulance trusts nationally, the increased call volume meant we saw a significant increase in our call answering mean since April 2022, peaking at 150 seconds (2mins 30 seconds) in December 2022. Following the successful opening of our new 999 control room at Newham in June 2022 and implementation of ClericCAD in September 2022, our focus now is to continue to improve the processes and increase our establishment of emergency call handlers and despatchers. This is being done via the EOC improvement plan.

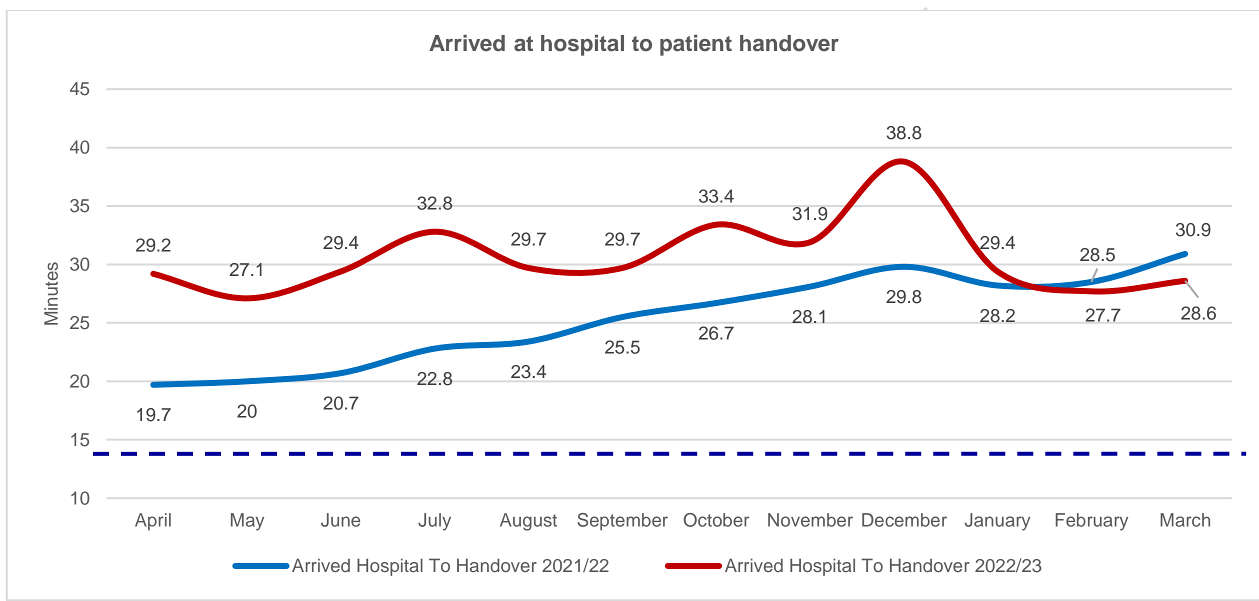


EOC Call Handler Recruitment Plan

We have also introduced Welfare Text Messaging and can now send an SMS message to callers who are awaiting an ambulance dispatch. This provides reassurance that we are working to send them an ambulance along with a request not to use 999 to ask for an expected time of arrival. This has reduced incoming call volumes whilst enabling us to maintain contact with patients awaiting our attendance. We have also now launched an extensive EOC Transformation programme which includes a call handling improvement stream, which will take forward further work into 2023/24.

We have worked closely with the Metropolitan Police to refine the process for them requesting ambulance support to ensure that the sickest patients are passed via the CAD link and others are formally assessed with a validated triage system either via 999 or 111

To maximise the availability of ambulances we have worked with the ICBs and NHSE London to reduce the time lost at hospital awaiting handover. At the beginning of 2022/23 the Trust were averaging arrival at hospital to patient handover at 30.9 minutes. The monthly averages fluctuate between 27.1 and 32.8 minutes, until the winter period where they peak at 38.8 minutes. Currently the average is 28.6 minutes.



Average monthly arrived at hospital to patient handover

The total hours of breaches (> 15 minutes) has increased on the previous year, however cohorting, patient flow and hospital delay escalation interventions have been successfully employed to limit the impact of delays on service delivery. Since September 2022 the total hours returned to Ambulance Operations through LAS led cohorting is over 43,000 hours. Whilst handover delays remain a significant issue, we have developed our 'Patient Flow' team, which coordinates ambulances conveyances to an ED, along with establishing and supporting pre-arranged cohorting, ambulance receiving centres (ARC) or dynamic cohorting arrangements. We have revised default 'catchment areas' for challenged EDs and improved our forecasting of conveyance demand by liaising more closely with ambulance crews at scene. We have also agreed a maximum 45 minute ambulance handover standard with all five of our ICBs, which is monitored via our tactical operations centre.

Our NHS 111 service have been working throughout the year to improve the timeliness of 111 call answering and clinical assessments being commenced. There has been ongoing recruitment of Service Advisors and Health Advisors and broadening of our clinical workforce. We have revised our rosters to ensure they meet the patient need, introduced shorter shifts, and encouraged more cover at weekends and during the evenings. We also established a resilient collaborative with Derbyshire Health United from early November 2022 until 28 February 2023, which saw Derbyshire Health United take 5000 calls weekly.

Hear and treat statistics:

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Apr 22 – Mar 23	32 (0%)	10639 (6.1%)	92957 (53.1%)	530 (0.3%)	70614 (40.3%)

Consult and complete statistics:

	NEL	SEL
Apr 22 – Mar 23	142774 (23.19%)	139827 (25.9%)

Priority 3 - Staff engagement and support

	Staff engagement and support - Overview	Status
8.	Improve access to clinical supervision for all clinicians to improve access to clinical development and progression	
9.	Improve access to specialist/ advanced practice opportunities and rotational working	
10.	Improve the percentage of staff who feel able to make improvements in their area of work	
11.	QI projects responding to patient’s needs by sector	
12.	Back to basics: kit and equipment	

Objective 8: Improve access to clinical supervision for all clinicians to improve access to clinical development and progression

We have transitioned the Emergency Ambulance Crew (EAC) role into the nationally recognised Emergency Medical Technician (EMT) title, a move which was welcomed by staff. We have begun the Implementation of Teams Based Working. An exciting feature of this program is clinical supervisors having dedicated time with their teams to provide clinical support and guidance.

We have recruited a number of Clinical Team Managers, in order to improve managerial and supervisory support as the Trust transitions to Teams Based Working. We have also recruited four new Quality Governance and Assurance Managers, ensuring senior clinical quality support in all operational sectors, and offering progression opportunities to paramedic clinicians. We have also appointed Sector Clinical Leads in all sectors, to support staff alongside the Senior Sector Clinical Leads in

We have also recruited a number of 'first contact' clinicians, a new role which offers the opportunity to obtain further clinical qualifications and develop new clinical skills in primary care under the supervision of general practitioners.

Objective 9: Improve access to specialist/ advanced practice opportunities and rotational working.

We have increased our complement of advanced paramedics and first contact paramedics over the course of the year following successful recruitment events, which include robust clinical selection processes.

During 2022/23 we recruited the following additional staff:

Advanced Paramedic Practitioner-Critical Care= 4 staff (APP-CC)
Advanced Paramedic Practitioner-Urgent Care= 15 staff (APP-UC)
First Contact Paramedic= 3 staff (FCP)

This brings our current totals to:

Advanced Paramedic Practitioner-Critical Care= 40 staff (37.35 WTE) (APP-CC)
Advanced Paramedic Practitioner-Urgent Care= 56 staff (55.5 WTE) (APP-UC)
First Contact Paramedic= 26 staff (26 WTE) (FCP)

Opportunities for secondments and part time/portfolio working have been used as retention strategies and to enhance the knowledge and experience within each team. This is in addition to rotational working practices embedded within APP-UC and FCP

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Objective 10: Improve the percentage of staff who feel able to make improvements in their area of work.

Giving staff the medium and opportunity to share ideas for improvement was fundamental within this objective. We note modest improvements in the autonomy and control reported by our staff via the NHS staff survey.

Autonomy and Control	LAS 2021 Positivity Score	LAS 2022 Positivity Score
Always know what work responsibilities are	83.8%	85.1% ↑
Feel trusted to do my job	79.1%	79.9% ↑
Opportunities to show initiative frequently in my role	57.8%	57.9% ↑
Able to make suggestions to improve the work of my team/department	44.3%	47.0% ↑
Involved in deciding changes that affect work	21.7%	24.8% ↑
Able to make improvements happen in my area of work	26.2%	28.5% ↑

A Quality Improvement engagement mobile app was implemented at the beginning of the year, this has not been utilised as well as intended and our next steps are to focus on specific project, for example in Make Ready, EOC and areas with Team Based Working. This is in addition to local initiatives across stations and groups encouraging staff engagement on improvements, from simple conversations, idea ‘boxes’, specific email addresses, and use of social media. In 2023/24 we will establish a ‘Getting the Basics Right’ quality improvement project, responding to staff feedback on where we should focus our efforts.

We have introduced ‘Quality Bites’, a weekly information and guidance tool included in the Trust Routine Information Bulletin (RIB). This weekly news article promotes quality improvement, quality improvement training and various other aspects of quality governance.

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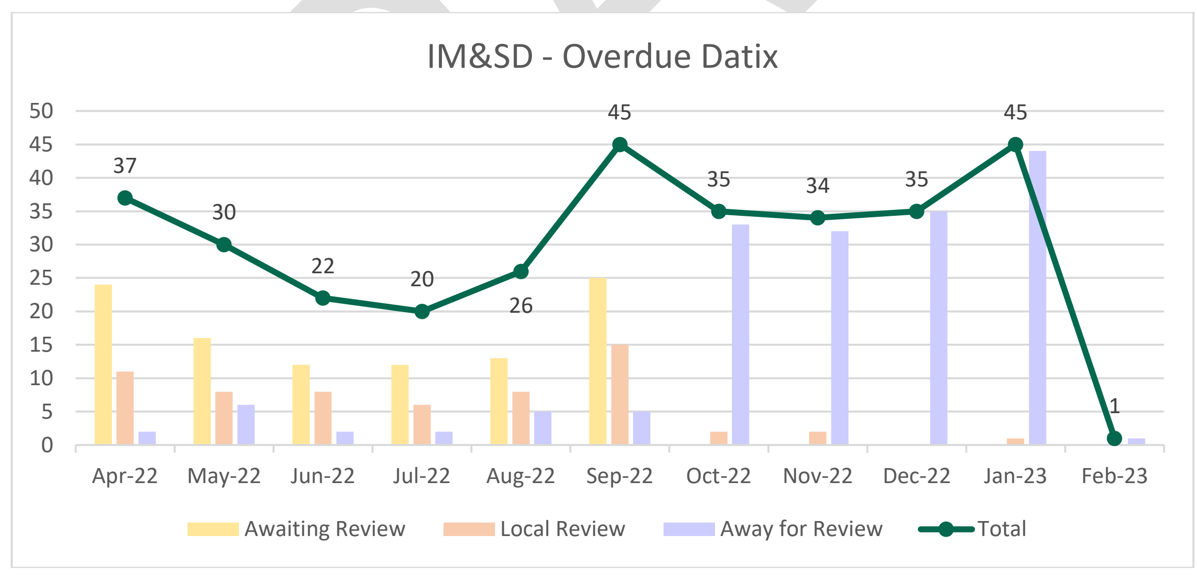
Objective 11: QI projects responding to patients' needs by sector

We sought to implement Quality Advocates in each sector. Unfortunately due to operational pressures this remains a work in progress and the timeline for achieving this has been extended into 2023/24. It is intended that Quality Advocates will engage staff and raise awareness of quality improvement, assurance and learning; acting as a communication link between the Quality Directorate, the Sector Quality Governance & Assurance Manager, Quality Support Officer and local colleagues.

Even when the service is operating under increased demand it is important to continue to improve and learn. We sought to undertake Quality Improvement projects across the Trust during 2022/23 and are pleased to share two examples as part of this Quality Account.

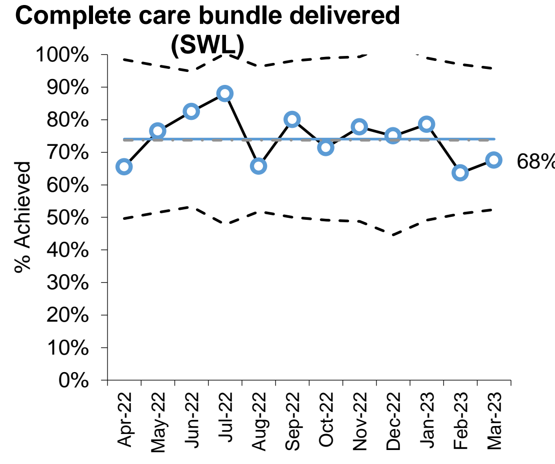
Emergency Operations Centre: Addressing delays in investigating and progressing incident reports.

From a baseline in April 2022 of 222 overdue incidents across all 999 departments (EOC, CHub and IM&SD) there was some initial improvement as a result increased reporting and focus at the 999 Quality Group. Due to competing priorities the rate of reduction was not sustained and following a difficult winter we saw a further spike in overdue incident investigations. Of particular note from the breakdown by department is the success IM&SD have had in reducing their overdue figure to almost zero, as a result of sustained focus with an emphasis on learning and feedback.

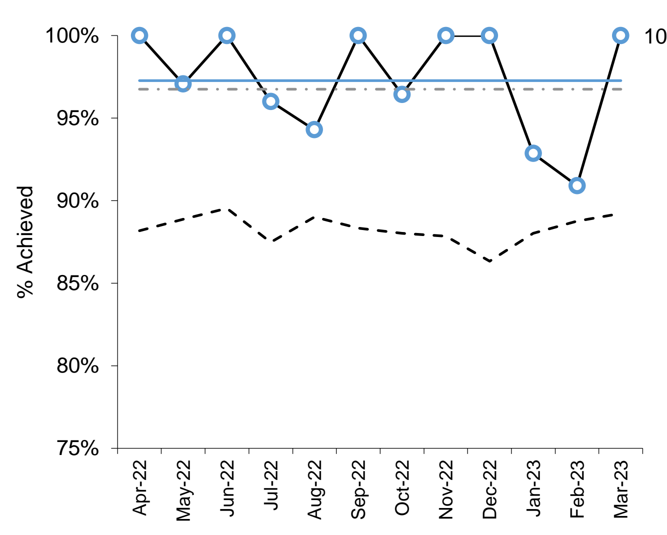


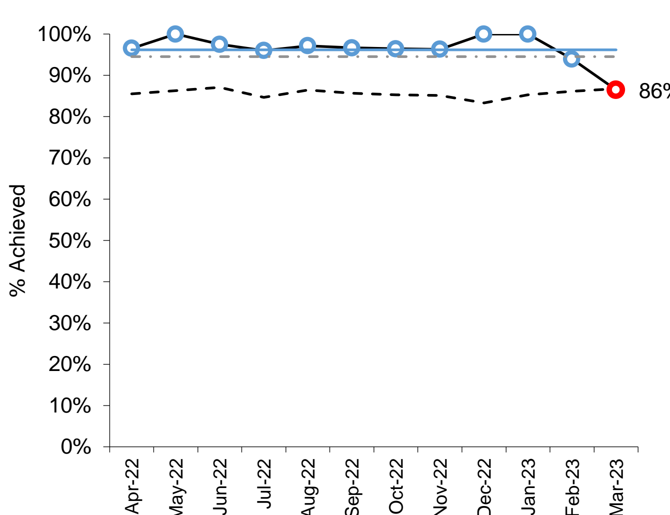
South West London: Improving the STEMI Care Bundle.

The aim of this project was to improve compliance with delivery of full STEMI care bundle which had seen below average compliance historically; and particularly to improve compliance with the provision of analgesia. A range of improvement methods were tested, including feedback to clinicians, written articles highlighting the importance of good STEMI care, virtual CPD sessions, and face to face and virtual delivery of ECG refresher sessions. As a direct result of the improvement initiative, a 28% improvement in delivery of the complete STEMI care bundle, was achieved across the South West sector, between January and July 2022; with the full STEMI care bundle delivered to 83 & 88% of patients in June and July respectively.



Unfortunately, this improvement was not sustained, and compliance varied between 64 and 80% for the remainder of the year. While this was disappointing, improvements in specific elements of care were achieved and sustained for the majority of the year. Specifically the documenting of two pain assessments, and the administration of both aspirin and GTN; both of which saw compliance of 100% by December 2022, being 6% and 5% above LAS average respectively.

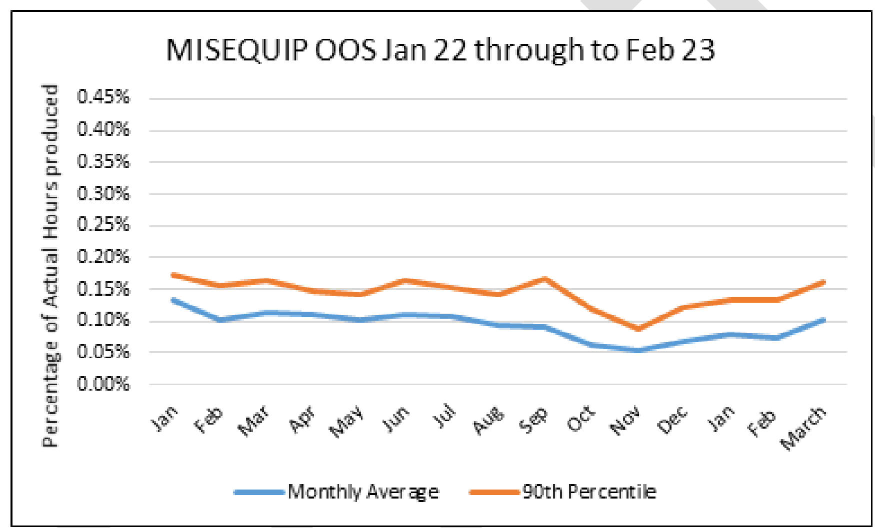




These improvements are being rolled out to the other Sectors through the Senior Sector Clinical leads. During 2023/24 we will be continuing to focus on achieving improvements, maximising the opportunities for sharing learning through teams based working in conjunction with other methods; in order to maintain improvements, and aim of increasing compliance with administration of analgesia.

Objective 12: Back to basics: kit and equipment

We sought to reduce missing equipment incidents and we continue to see a reduction in out of service for this reason. We have now launched auto-replenishment of equipment at hubs, which will increase the availability of equipment when and where it is needed. We have seen a significant improvement in this area, with a reduction from the 2021 average of 0.14% to 0.07% in the last quarter of 2023/24.



We have begun implementation of a Central Asset Management System for equipment which monitors the auto-replenishment of consumables against set minimum levels at our Make Ready hubs ensuring greater availability of stock. Further work includes the implementation of a Make Ready App that will provide better oversight of equipment on each DCA, completion of equipment asset tagging and the stencil marking, which has already begun to reduce losses and encourage returns from other Trusts.

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Core Quality Account Indicators Report

Ambulance Quality Indicator performance - C1-C4 response

During 2022/23 we did not meet our mean or 90th centile response standards and our position was worse overall than the previous financial year.

Metric	Standard	Financial Year	
		2021-22	**2022-23 ***
C1 Mean	7 minutes	00:06:50	00:08:08
C1 90th Centile	15 minutes	00:11:35	00:14:02
C2 Mean	18 minutes	00:38:18	00:47:40
C2 90th Centile	40 minutes	01:27:20	01:48:54
C3_Mean		01:37:12	01:41:03
C3 90th Centile	120 minutes	04:08:09	04:19:24
C4_Mean		03:24:40	03:24:40
C4 90th Centile	180 minutes	07:22:25	07:29:50

* 2022/23 Response Time Performance excludes Oct'22 and Nov'22 data please see page xx of the Annual Governance Statement for further explanation.

The London Ambulance Service considers that this data is as described for the following reasons: this data is captured from a number of sources, such as the computer aided dispatch system, electronic and paper care records, and our vehicles' Mobile Data Terminals. A variety of Data Quality process are then undertaken in order to provide assurances over the data's accuracy. Reducing delays will continue to be a quality priority for 2022/23, with an agreed trajectory to bring C2 response times below 30 minutes by the end of the financial year.

Ambulance Quality Indicator performance – STEMI, Stroke & Cardiac Arrest care bundles

The Trust submitted the following information to NHS England for the reporting period 2022/23 and 2021/22 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.

	2021-22		2022-23*	
	LAS average	**National average** (Range)	**LAS average**	**National average** (Range)
STEMI patients	67.7%	75.5% (60.4-93.6)	70.4%	72.8% (58.4-96.8)
Stroke patients	94.8%	97.3% (94.7-99.3)	96.1%	96.4% (93.2-99.7)
Cardiac Patients**	84.9%	77.2% (62.1 -84.9)	86.5%	77.9% (60.3-97.7)

**At the point of preparation of this Quality Account, NHS England published data for April to November 2022.*
*** Post – resuscitation patients only*

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Patient safety incidents

The number and rate of patient safety incidents reports during 2021/22 and 2022/23 are as follows *(2022/23 data to be added at the end of 2023):*

	2021/22	**2022/23**
Total Patient Safety Incident Reported	5968	6580
Rate of Patient Safety Incidents/1000 EOC contacts (average)	2.68	3.16

	2021/22	2022/23
Total Patient Safety Incident Reported	2303	2368
Rate of Patient Safety Incidents/1000 111 contacts (average)	0.93	1.36

The number and rate of patient safety incidents reports resulting in severe harm or death during 2021/22 and 2022/23 are as follows:

	2021/22	2022/23
Total Patient Safety Incident Reported (EOC contacts)	5968	6580
Total Patient Safety Incidents – Severe or Death	78	176
Rate of Patient Safety Severe or Death Incidents /100 Patient Safety Incidents (average)	1.3	2.68

	2021/22	2022/23
Total Patient Safety Incident Reported (111)	2303	2368
Total Patient Safety Incidents – Severe or Death	3	9
Rate of Patient Safety Severe or Death Incidents /1000 EOC contacts (average)	0.16	0.38

The London Ambulance Service considers that this data is as described for the following reasons: this data is captured on the Trust Risk Management system, Datix, and rates indicate a good reporting culture. The number of patient safety incidents reported per month saw an increase between September and December 2022 with 18 consecutive weeks above the mean. This is attributed to a sustained period of high demand and

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associated REAP4, and further considers the implementation of Cleric CAD. The main theme through incident reporting (over the past 2 years) is delayed response.

All patient safety incidents are reviewed to ensure that a proportionate response is applied, in line with the Patient Safety Incident Response Framework. The London Ambulance Service has taken the following actions to improve this and so the quality of our service by reviewing patient safety incidents relating to delays via a Structured Judgement Review (SJR) process to ensure consistent and robust oversight of delays and identify any system-wide learning. This led to improvement work targeting the dispatch of fast response units to high risk determinants, such as patients presenting with chest pain, and further reviewing the adequacy of the welfare ring back process.

Clinical Audit and Research

The Trust has a robust and diverse clinical audit and research programme that focuses on a range of clinical areas and is responsive to both local and national priorities. During 2022/23, we examined the care provided to a wide range of conditions including cardiac arrest, acute coronary syndromes, stroke and severe sepsis, difficulty in breathing, mental health, sickle cell crisis, pain, transient loss of consciousness, and medicines administration. We also continued to audit the quality of care and appropriateness of decisions made for patients who were discharged of our care.

Our research program continued to perform strongly (see Appendix 1). We collaborated on successful bids for funding and have had seven publications in peer-reviewed scientific journals, and presented at international conferences.

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, and sits on various committees with key partners and stakeholders (including the British Heart Foundation and the UK Resuscitation Council) to continue to champion and develop prehospital research nationally, encourage collaboration and influence changes to national policy and practices.

Research

The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service from 1st April 2022 to 30th January 2023 that were recruited during that period to participate in research approved by a research ethics committee was 997. In addition, 41 staff participated in NIHR portfolio studies as participants.

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Clinical audit

During 2022/23, 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 2022/23 are as follows:

1. **National Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)**

2. **NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:**

    - Outcome from cardiac arrest:
        - Number of patients
        - Return of Spontaneous Circulation (ROSC)
        - Survival
        - 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 2022/23, 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)	5,991	100%
NHS England AQI: Outcome from cardiac arrest a) Total number of cardiac arrests	a) 5,972	100%
NHS England AQI: Outcome from cardiac arrest – ROSC at hospital a) Overall group b) Utstein comparator group	a) 2,102 b) 257	100%
NHS England AQI: Outcome from cardiac arrest – 30-day survival a) Overall group b) Utstein comparator group	a) 2,071 b) 248	100%
NHS England AQI: Outcome from cardiac arrest – Post resuscitation care a) Care bundle delivered to non-	a) 291	100%

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traumatic adult cardiac arrests who achieve ROSC (includes 12 lead ECG assessment, blood glucose and blood pressure measurements, and provision of oxygen and fluids)		
NHS England AQI: Outcome from acute STEMI a) Time from call to angiography for confirmed STEMI patients: Mean and 90th centile b) Care bundle delivered to suspected STEMI patients (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 516 b) 443	100%
NHS England AQI: Outcome from stroke a) Time from call to arrival at hospital for stroke patients confirmed by SSNAP: Mean and 90th centile b) Diagnostic bundle delivered to suspected stroke patients (includes assessment of FAST, blood pressure and blood glucose)	a) 2,037 b) 2,228	100%
NHS England AQI: 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) 1,332	100%

**At the point of preparation of this Quality Account, OHCAO and NHS England reported data were available for April 2022 – September 2022.*

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 2022/23 and the Trust has taken actions to improve the quality of healthcare provided (see Appendix 2).

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Looking Forward: Our Quality Priorities for 2023/2024

For the new financial year, we have identified 5 quality priorities. In order to shape the priorities around the needs of our patients, we developed a task and finish group, and undertook engagement with key stakeholders, including members of the Public and Patients Council (which provides a voice for patients in the design, development and delivery of services).

In identifying these priorities, we have considered:

- Our progress against the 2022/23 quality priorities
- Triangulation of data sources
- The new CQC strategy and framework
- Sources of quality intelligence and performance metrics, business plans and our strategic intentions
- What matters to our staff, patients and the communities we serve.

Our 5 priorities for 2023/24 are:

- **Cardiac arrest management**
- **Care after a fall**
- **Hear & treat consultations**
- **Reducing delays**
- **Infection Prevention and Control**

To deliver improvements in these priority areas, we have identified several specific objectives and will use key performance indicators to measure improvement over the coming year.

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Our progress against these priorities will be monitored and reported on a monthly basis throughout the year to ensure we deliver meaningful improvement on each objective. A full report will be included in the annual Quality Account for 2023/24.

Quality Priority	Source	KPI(s)
Cardiac arrest management	• Patient safety incidents • National Benchmarking	• Improve return of spontaneous circulation rates to ≥30% • Deliver resuscitation update training to 85% of staff
Care after a fall	• Patient safety incidents • Clinical Performance Indicators	• ↑ Urgent Community Response provision to 16 response teams pan-London • Deliver spinal immobilisation training to 85% of staff
Hear & treat consultations	• Trust Risk Register • Licensing requirements	• Implement Clinical Guardian across 999 and 111 • Implement Category 2 Segmentation Programme
Reducing delays	• Patient Safety Incidents • Ambulance Quality Indicators	• Achieve a ≤30 minute C2 mean in line with trajectory • Achieve a ≤10 second call answering mean in line with trajectory
Infection Prevention and Control	• Quality visits • IPC Audit Validation	• Achieve 90% hand hygiene audit compliance • Implement audit software replacement

Part 3

Statements on Quality Infrastructure

Patient Experience

Patient experience and feedback can help us to understand whether our service is safe, caring, responsive, effective and well-led.

We therefore welcome and take all patient and stakeholder feedback very seriously in order to identify any care and service delivery problems and share learning to improve our service.

Trends and emerging themes are regularly reported through the Trust's governance forums. To widen the learning, we publish anonymised case examples on the Trust website and have contributed anonymised case examples to our 'Insight' publication which is disseminated across the Trust. We similarly report cases of significance to the National Ambulance Service Patient Experiences Group, comprising all UK ambulance services. We work closely with advocacy providers, especially POhWER, the largest provider in London.

We have set up weekly meetings to triage new complaints. Specific cases relating where the service provided affected the patient's outcome are routinely shared with the Executive team for review. We also routinely escalate cases to the Quality, Improvement and Learning team where harm has occurred and to ensure that a joined-up approach is taken as part of the Patient Safety Incident Response Framework.

We have successfully negotiated with senior managers from other teams regarding investigation turnaround times and introduced clear monitoring and escalation process for overdue investigations. These have been included in a new Standard Operating Procedure for complaints management.

Learning from complaints is routinely identified and shared via local management teams. We continue to work with local management teams to ensure that learning is shared effectively with affected staff and that staff are engaged with the complaint process. Effective engagement with patients and staff regarding the complaints process is embedded in our revised complaints and feedback policy. The policy is based on the Parliamentary and Health Service Ombudsman's model complaints handling guidance.

We publish information about communicating with us in other languages and in easy read format on our website. An online complaints form is sent to each complainant to inform us of how we have managed their complaint.

We continue to have a strong working relationship with the Parliamentary and Health Service Ombudsman. We have recently been the pilot site representing all UK Ambulance Trusts to design the new NHS Complaint Standards. The standards include early resolution of complaints and embedding a quality improvement culture across the Trust.

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Safeguarding

Safeguarding provides assurance through the Safeguarding Assurance Group to the Quality Oversight Group. We report on our activity for 999 services via the Safeguarding Health Outcomes Framework Template and via quarterly reports for our IUC services. The Trust attends the Brent Safeguarding boards for children and adults and provides further assurance through those boards.

We have a range of policies and procedures in place in respect of safeguarding, and keep these up to date and well communicated to our staff.

Safeguarding referrals and concerns being raised by staff remain within expected range, demonstrating staff awareness of safeguarding issues and the importance of reporting these.

We have continued to see an increase in the reporting of safeguarding allegations against staff, including in relation to sexual assaults and harassment. This was expected following the launch of our Sexual safety Charter and campaign to encourage staff to speak up.
Safeguarding training is part of our statutory and mandatory training programme and in line with the intercollegiate document. Safeguarding training is delivered using a combination of e-learning and face-to-face (including virtual) education. Training is provided to a high standard by Trust Safeguarding Specialists. We achieved by end of calendar year 87.96% for level 1, 54.46% for level 2 and 84.33% for level 3, level 2 & 3 are below our compliance targets, which are 85% by end of financial year and a recovery plan is in place to improve compliance.

The Trust provides information to Multi Agency Risk assessment conferences and participates in Safeguarding Adult Reviews (SAR's), Safeguarding Child Practice Reviews (SCPR) and Domestic Homicide Reviews (DHR) when required.

In November we held a Safeguarding Conference for 200 staff and covered a range of topics with lived experiences, including Trauma informed care and CSA, having difficult conversations, learning from Baby GS, Serious Crime Act and Domestic Abuse Act and duty to report. Substance misuse and safeguarding impact, online gaming & grooming and Learning disabilities. The Deputy Chief Executive Officer also presented a number of Safeguarding Star Badges and Certificates for outstanding safeguarding work.

Full details of safeguarding can be found in the LAS Safeguarding Annual Report.

Information Governance

The Trust continues to strengthen its arrangements for Information Governance (IG). We have a robust programme of IG improvements and awareness and a governance framework to monitor and assure the security of our information. An executive-led Information Governance Group is in place, as well as an Information Governance Policy framework. These ensure the execution of the Trust IG agenda.

IG incidents are reported via the Trust incident reporting system, Datix, which is the Trust risk management system. The Information Governance Manager is notified and reviews the IG incidents and, where necessary by the Quality Governance and Assurance team.

Where there has been an incident resulting in the compromise to patient or staff identifiable data, and depending on the seriousness of such incident, 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 in line with the General Data Protection Regulations (GDPR) requirements.

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/or the National Cyber Security Centre. During 2022/23 four incidents were notified via the data security incident reporting portal. Of these, all four were reported to the ICO and one was also reported to the Department of Health and Social Care and NHS England. This incident specifically related to an external cyber-attack upon a third party software supplier used by the Trust. Of the four incidents reported, two have now been fully investigated and the cases are now closed with the ICO.

On or before 30 June 2023, the Trust will be expected to submit a self-assessment of its Data Security and Protection status via the NHS Digital's Data Security and Protection Toolkit (DSPT). This is a mandatory submission by all organisations that have access to NHS patient data and it provides assurance that they are practising good data security and that personal information is handled correctly. Based on progress so far, the Trust is on course to provide a "Standards Met" DSPT submission.

Care Quality Commission

Throughout 2022/23, we have continued to participate in CQC engagement meetings and responded to routine enquiries. All enquiries have been responded to appropriately with no outstanding queries requiring action.

We retain a rating of 'Good' overall.

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Statements from stakeholders

London Ambulance Service Patient and Public Council

Thank you for sharing the London Ambulance NHS Trust Quality Account for 2022/23.

The London Ambulance Service Public and Patients' Council (LASPPC) recognises that this account has been produced at a time where the London Ambulance Service continued to experience extremely high levels of demand as well as industrial action over December, January, February and March. The Council would like to acknowledge and thank staff and volunteers from across the Service for their outstanding commitment and dedication to patients across London during this very challenging time.

In light of this sustained pressure and demand, the Council has been impressed by the progress made in the quality priorities set last year (2022/23) and are pleased to have worked collaboratively with the Trust on a number of these priorities.

The Council has worked closely with the Trust on developing the priorities for the year, and are proud that council member representatives have provided a voice for patients and the public in a number of the Trust's committees and working groups. We have supported a number of key initiatives across the organisation, as well as providing input on the delivery and implementation of the service through our regular Council meetings.

The Council has also worked collaboratively with the Trust as they continued to make improvements in a number of other quality priorities for 2022/23. For example, including involvement in the development of the Trust's new 5 year strategy and emerging estates 'vision'. Reports from regular council meetings are also presented to the Trust board.

We have been impressed with the level of engagement the Trust has done to involve the Council in the year's quality priorities and we would like to express our appreciation and thanks to your staff who have made progress whilst continuing to manage a huge increase in demand following the pandemic and through periods of industrial action. We also acknowledge their determined commitment to delivering high quality services to patients and we look forward to seeing this relationship becoming stronger throughout the upcoming year.

In looking forward to the quality priorities of 2023/24, the Council can confirm that our members were involved in the development of these priorities, and during these development sessions members welcomed, but also fed into, the five priority areas set out for the year. These priorities demonstrate that patients are truly at the heart of the Service and we are looking forward to another year of working together closely as the Trust sets out to achieve them.

Christine Beasley Co-Chair	Michael Bryan Co-Chair

Commissioners' Statements

Appendix 1: Research Activity

Ongoing research projects from 1st April 2022 to 09th February 2023:

RAPID-MIRACLE is a prospective observational study that validates the MIRACLE2 score in the prehospital setting. The MIRACLE2 tool was designed by researchers at KCH in collaboration with LAS to predict neurological outcomes for patients in out-of-hospital cardiac arrest. The tool aims to stratify patients based on the nature of their cardiac arrest, taking account of variables like age, shockable rhythm and adrenaline administration.

ARREST: a randomised-controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest.

CRASH-4: a placebo controlled, randomised-controlled trial investigating the role of tranexamic acid in the management of older patients with mild, symptomatic, traumatic brain injury.

PARAMEDIC-3: a randomised-controlled trial that aims to identify the best route (intravenous vs. intraosseous) for the administration of adrenaline in out-of-hospital cardiac arrest.

PROTECTeD: this study aims to develop evidence based and ethically grounded guidelines for termination of resuscitation by ambulance service staff in the UK.

HOTZONE: a mixed-methods study examining the causes and timeframes in which casualties to die prior to reaching hospital to establish options for the delivery of interventions that may be beneficial during certain mass casualty incidents.

SEE-IT: a feasibility randomised controlled trial that aims to determine the clinical and cost effectiveness of using GoodSAM video streaming to target emergency medical resources.

CATNAPS: a multi-method study aiming to develop a new approach to fatigue management for UK ambulance services that meets the needs of staff and operations, and is most likely to improve patient and staff safety.

OPTIMAL-CARE: a study involving a survey and qualitative interviews with LAS staff to identify the perceived value and impact of electronic palliative care coordination systems.

STRETCHED: evaluating case management approaches to the care of patients who frequently call the emergency ambulance service.

SUB-30: a feasibility study that aims to assess whether prehospital extra-corporeal membrane oxygenation (ECMO) can be established within 30 minutes of collapse following out of hospital cardiac arrest in London.

PHOTONIC: an observational study aiming to evaluate the use of prehospital video triage services for suspected stroke patients.

PRE-FEED: a mixed-methods diary study examining the predictors and effects of prehospital feedback to emergency ambulance staff on performance and patient outcomes.

CDM TBI: a mixed-methods study examining ambulance clinicians approaches to head injuries in older adults.

Appendix 2: Clinical audit activity and learning outcomes

National clinical audits

The reports of the national clinical audits were reviewed by the provider in 2022/23 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 2022/23 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:

Chronic Obstructive Pulmonary Disease (COPD)

- We requested that the UK COPD ambulance services guidelines are clarified regarding the requirement for 12-lead ECGs, pre-alerts, the indications for salbutamol and concurrent administrations of salbutamol and ipratropium bromide
- Enhancements to the electronic Patient Care Record (ePCR) were advised to improve time data accuracy, documentation of duration of nebulisation and the inspection fields
- We suggested that the Trust considers of air-driven nebulisers
- Teaching materials were updated
- Clinical audit findings were widely shared to clinicians

Paediatric Pain Management

- Reminders to document units and time of medicines administration were included in mandatory clinical training
- A Medical Bulletin was published reminding clinicians of the oral paracetamol dose for 12 year olds
- Clarification was sought on the national guidelines for IV paracetamol for 12 year old patients and they were asked to consider adding weight-based recommendations for oral morphine for paediatric patients
- Potential ePCR related solutions to unit and time documentation errors will be discussed at ePCR Data Quality Meetings
- Provision of an ibuprofen dose suitable for all paediatric patients is being explored

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Transient Loss of Consciousness (TLoC)

- A TLoC section will be added to the ePCR with prompts to encourage documentation of the TLoC event history
- It will be recommended that cardiac auscultation skills be added to mandatory clinical training to ensure clinicians are able to distinguish between normal and abnormal heart sounds
- Additions to Paramedic Pathfinder will be suggested, specifically for patient patients presenting with no red flags and a history of unconsciousness so that care pathways align with JRCALC and NICE Clinical Practice Guidelines

Dexamethasone

- LAS guidance will be updated to reflect the changes in national guidelines regarding age of administration
- Clinical audit findings were shared with clinicians

Cardiac Arrest Complicated by Hyperthermia

- Appropriate cooling methods for out of hospital cardiac arrest will be explored
- Clinical audit findings were shared with critical care advanced paramedic practitioners.

In addition, a further **5 local clinical audits** have been started by the provider in 2022/23, as well as a programme of continuous clinical audit:

The use of Entonox™

Entonox (nitrous oxide) is an inhaled analgesic. The objectives of this clinical audit are to determine if Entonox is being administered in line with guidance and to identify any additional patients that may have benefitted from Entonox use. This clinical audit will also provide an opportunity to gather information on the demographics of patients who receive or are indicated to receive inhaled analgesics. The production, transportation, and wastage of Entonox contributes to the overall carbon footprint of the NHS and the LAS is committed to greener initiatives, so this project will contribute to its exploration of other analgesics in line with relevant product licences.

Haemorrhage of a Traumatic Origin

Uncontrolled haemorrhage is one of the most common preventable causes of death in the trauma population. Patients who are haemorrhaging require prompt and effective treatment to improve the chance of survival and minimise long-term disability. The London Trauma System operates a primary bypass to Major Trauma Centres (MTCs) pathway for severely injured patients. This clinical audit will assess the management of patients with haemorrhage of a traumatic origin in collaboration with the North West London Trauma Network.

Response times, assessment, and management of patients who have taken an overdose

In 2021/22 several potential incidents were reported relating to patients who had taken an overdose. In addition, previous clinical audit cycles have identified the response, assessment and management of this group of patients is an area for improvement. This clinical audit aims to determine whether target response times are met and to evaluate whether patients who have taken an overdose are assessed and managed in accordance

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with JRCALC Clinical Practice Guidelines.

Smoke inhalation injuries
Although rarely attended by most LAS clinicians, patients with smoke inhalation can rapidly deterioration therefore it is important to ensure that the national guidance is adhered to for this patient group. This clinical audit aims to evaluate compliance with JRCALC guidelines in relation to the assessment, treatment and transportation of patients with smoke inhalation injuries.

Prescribing by APP-UC
Urgent care advanced paramedic practitioners (APP_UC) are introducing face-to-face independent non-medical prescribing in to the 999 environment. This clinical audit is an essential part of the clinical governance for non-medical prescribing for the six-month pilot period to ensure compliance with the Procedure for APP Prescribing and Non-Medical Prescribing Policy and to ensure clinical indications are met for individual medicines and any safety incidents are identified.

Continuous quality monitoring
We are continuously auditing the care provided to four patient groups: those who suffer a cardiac arrest, heart attack (ST elevation myocardial infarction), suspected stroke (including FAST positive stroke), or were discharged of our care but re-contacted the 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 the administration of oramorph, antimicrobials, repeat medications, medication of potential misuse, medication safety indicators and high-risk medication prescribing.

Clinical Performance Indicators (CPIs)
London Ambulance Service undertakes a programme of local Clinical Performance Indicators which, during 2022-23, monitored the care provided to 22 patient groups. The Trust audited the records completed by all clinicians for patients in cardiac arrest; with difficulty in breathing; a mental health condition; severe sepsis; elderly fallers and patients discharged on-scene. In 2022/23 we also introduced new CPIs assessing the management of sickle cell crisis and end of life care.

In addition, the Trust has specific audits focusing on the care provided by our Advanced Paramedic Practitioners (APPs). APPs specialising in Critical Care audit the records for adult patients with a (non-traumatic) cardiac arrest, acute behavioural disturbance and major trauma. Our Urgent Care APPs audit their use of naproxen, prednisolone, prochlorperazine and salbutamol inhalers. We also introduced new monitoring of paediatric assessment; abdominal pain; transient loss of consciousness; headache; wound care, and palliative and end of life care for our Urgent Care APPs.

Finally, the CPIs allow for quality assurance of the documentation of 1.7% 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.

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Glossary (To be updated)

APP-CC	Advanced Paramedic Practitioner (Critical Care)
AQI	Ambulance Quality Indicator
CAS	Clinical Assessment Service
CDI	Culture, Diversity and Inclusion
CHUB	Clinical HUB
COPD	Chronic Obstructive Pulmonary Disorder
CORE20PLUS5	Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
COVID-19	Coronavirus disease caused by the SARS-CoV-2 virus
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
DOS	Directory of Services
DQA	Data Quality Assurance
DSPT	Data security and protection toolkit
ECAS	Emergency Clinical Advisory Service
ECG	Electrocardiogram
ECMO	extracorporeal membrane oxygenation
ED	Emergency Department
ePCR	Electronic Patient Care Record
GDPR	General Data Protection Regulation
GP	General Practitioner
GSTT	Guy's and St Thomas' NHS Foundation Trust
GTN	Glyceryl trinitrate
ICO	Information Commissioners Office
ICS	Integrated Care System
IG	Information Governance
IUC	Integrated Urgent Care
KPI	Key Performance Indicator
LAS	London Ambulance Service
LASPPC	London Ambulance Service Patient and Public Council
MHJRC	Mental Health Joint Response Car
MHRA	Medicines and Healthcare products Regulatory Agency
MPU	Medicines Packing Unit
MTC	Major Trauma Centre
NHS	National Health Service
OHCAO	Out-of-Hospital Cardiac Arrest Outcomes

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PGD	Patient Group Direction
PPE	Personal Protective Equipment
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QI	Quality Improvement
REACH	Remote Access Emergency Coordination Hub
ROSC	Return of spontaneous circulation
SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST Segment elevation myocardial infarction
TLOC	Transient loss of consciousness
TOC	Tactical operations centre
UCAS	Urgent Clinical Advisory Service

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7. Business Plan

Presented by Roger Davidson

Report to:	Trust Board			
Date of meeting:	25/05/2023			
Report title:	Business Plan 2023/24			
Agenda item:	7.1			
Report Author(s):	Roger Davidson			
Presented by:	Roger Davidson			
History:	ExCo			
Purpose:	☐	Assurance	☒	Approval
	☒	Discussion	☐	Noting

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

Attached is the Trust's proposed business plan for 2023 – 2024. This sets out key deliverables for the year and constitutes the first year of delivery of the Trust's new five year strategy. Deliverables are therefore aligned to strategic objectives, and have been developed in conjunction with the feedback from the 25/04/2023 Trust Board Meeting.

An appendix has been included that provides a review of the delivery against our 2022/23 business plan, and created in conjunction with the annual report and quality report for the 2022/23 year.

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

The board is asked to approve the Trust's 2023/24 business plan.

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

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance & Procurement	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes	x	No		Roger Davidson
Strategy	Yes	x	No		Roger Davidson
People & Culture	Yes		No		
Quality	Yes		No		
Corporate Affairs	Yes		No		

London Ambulance Service
NHS Trust

LAS business plan for 2023/24 and delivery highlights from business plan 2022/23

LAS Business plan 2023/24 for approval

Business plan for 2023/24

There were a number of areas from our 2022/23 Business Plan on which we will continue working on, so have included these in our 2023/24 Business Plan.

The delivery of the 2023/24 Business Plan will be the first year of implementation of our forthcoming five-year strategy and therefore organised according to our three proposed missions for 2023/28.

Delivering outstanding urgent and emergency care wherever and whenever needed		
Quality	Clinical outcomes	Heart attack and stroke national performance measures to improve: • Heart attack care bundle and achieve 80% consistently • Convey stroke patients to HASU and achieve mean of 110 minutes.
	Cardiac arrest	Reduce by 60 seconds the time taken between call connect and start of chest compressions for patients in potential cardiac arrest bringing the mean below 5 minutes from call connect
	Quality accounts	Deliver the five quality indicators standards set by our Trust Board for 2023 / 24
	Paramedic CPD data	Link LAS clinical data and hospital data together for one whole ICS area and produce clinical feedback app
	Patient feedback	Define and implement new processes for gathering user feedback (user feedback is already being undertaken by LAS 111), in particular hearing from people impacted by health inequality
	Incident reporting	Scope and implement a more user-friendly incident reporting system
Performance	Call answering	Call answering – deliver 10 second mean
	Category 1	Delivery performance less than 7-8 minutes throughout the year
	Category 2	Deliver Cat 2 mean of 30 minutes

Business plan for 2023/24

Delivering outstanding urgent and emergency care wherever and whenever needed (continued)		
999 EOC	Hear and Treat	All clinically suitable patients in Cat 2,3,4 are assessed and navigated by a Clinician to the most appropriate response
	Triage system	Make decision on which 999 triage system (Pathways / AMPDS) to use in the future
	Transformation	Deliver EOC transformation programmes including scope implementation of AI system to enhance call auditing
999 Ambulance Operations	Mental Health	Have Mental Health Clinicians available 18/24 and 6 Mental Health Joint Response cars operating 7 days a week.
	Older People	Have 16 joint response cars in operation pan-London so all clinically-appropriate non-injured elderly fallers get tailored response 12 hours per day
	Advance practice	Increase the number of Urgent Care Advanced Paramedic Practitioners in operation by 2 per day (an additional 2 x12hr shifts)
	Critical care transport	Mobilise new pan-London critical care transport service with Barts Trust.
111	Call answering	90% of patients requiring urgent clinical assessment (Priority 1,2,3) will receive a call back within 1 hour
	Hear and Treat	Deliver KPIs for timeliness and outcomes for clinical assessment function
Resilience	Compliance	Implement learning from our after-action reviews and other key inquiries including Manchester Arena
	EPRR	Develop a specialist cadre of Commanders at a strategic and tactical level.

Business plan for 2023/24

Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for		
Culture	WRES and WDES	Improve compliance with the NHS workforce race equality standards and workforce disability equality standards
		Increase the proportion of new recruits from ethnically diverse backgrounds by at least 8%
	Retention	Devise and implement action plan for staff retention
	Staff survey	Continue overall improvement for LAS and aim to be in top 1/3 across all people promise areas
	Discrimination	Launch mandatory 'Tackling discrimination and promoting inclusivity' training workshops with circa 50% of staff undertaking it by year end
	Team Based working	Roll out team-based working across all 20 ambulance operational groups
	EOC culture	Launch a team based working programme in EOC
	Line management	Devise a plan, to demonstrate progress towards 80% of managers having line reporting responsibility for fewer that 15 WTE staff.
	Review scheduling practices	Tender scheduling system and engage staff and embed new system
	Violence aggression	Ensure roll out of body worn cameras to all stations by end of year
	Leadership	Deliver an NVQ Leadership framework for all more senior leadership roles
	Freedom to Speak Up	Strengthen LAS service in response to national recommendations

Business plan for 2023/24

Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for (continued)		
Finance	Control total	Deliver 2023 / 24 control total including £25m CIP programme
	Capital	Deliver 2023 / 24 capital plan
	Medium term financial strategy	Develop medium term financial strategy to underpin the five year strategy 2023 / 28
	111	Move into new 111 EOC at Bernard Weatherill House, Croydon
	Ambulance Stations	Work up design and achieve planning permission for new ambulance station in Bow
		Increase footprint of at least 2 further ambulance stations to increase capacity
IT	Mobile data terminals	Agree, pilot and implement a replacement for the mobile data terminals
	Control room	Agree a programme for replacement of the radio system and complete implementation of the new telephone system
	Transfer of Care	Develop further, our new clinical and operational systems, link them using the NHS number internally, with partners and with the London Care Record.
	AI and new technology	Develop and scope for investment and building of LAS capabilities in automation and AI driven automation
Well Led	Well led	Participate in well-led self assessment and implement actions coming from this
	Leadership review	Review leadership structure and implement resulting changes
	Professionalisation	Set up a pan LAS professional standards group
	Data quality	Improve data quality, responding to current audits and independent reports

Business plan for 2023/24

Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for (continued)		
Education	Student pathways	Review governance and improve student experience – 85% of theory–based portfolio marking to be completed and returned to the learner within 4 weeks of submission
Staffing	Rotational model	Increase number of paramedics enrolled on band 7 development programme by 10% with First Contact Practitioners (FCPs) increasing by 30+WTE
	Ambulance Staff	Increase number of WTE available for frontline ambulance operations by 300 WTE by year end
	EOC staff	Increase number of WTE call handler / dispatch staff by 150 WTE by year end
	Clinical staffing (EOC)	Increase number of WTE clinicians in EOC doing clinical assessments by 72 WTE by year end
	Sickness absence	Achieve sickness absence rate of 6% or less on average during the year
	Career pathways	Map out clear career pathways across all areas of LAS and develop a staff retention plan
Fix the basics	Programme	Engage staff in identifying their priorities from fixing the basics and act upon this information, including reducing Out of Service time by 5%
	Rest Breaks	Agree and implement a revised rest break policy.
Productivity	Time	Reduce lost time across the Organisation (e.g. start of shift, on-scene time)

Business plan for 2023/24

Using our unique pan-London position to contribute to improving the health of the capital		
Environment	ULEZ compliance	Ensure we have achieved compliance by March 2024 in line with Mayor's commitments
	Carbon reduction	Reduce annual carbon emissions by 5% (about 5,000 tonnes CO2e) through interventions in estates, fleet, clinical, digital, logistics and staff engagement
	EV infrastructure	Install EV charging point across 40 sites
Public Education	London Lifesavers	Agree and implement new London Lifesavers campaign, recruiting 7,000 new life savers and launching a new schools programme.
		Improve accessibility to the Public Access Defibrillators to make a total of 10,000 in the capital.
	Public Education	Use data to create targeted prevention programme for children and young people (violence reduction, substance misuse, what to do in an emergency) as well as promoting careers in the LAS
	Using 999	Review our communications to public on using 999 and 111 services and devise a new campaign
Primary Care	Fuller Stocktake	Work up and implement at least one pilot supporting primary care in London to deliver Fuller Stocktake
Partnerships	ICS	Agree and implement an operating model on how the LAS interacts effectively at the right levels in the 5 ICS.
	Digital	Link our ECR to move hospital emergency department systems where there is demand
Health Inequalities	maturity	Review our maturity across other ambulance Trusts using national tool

Appendix: Delivery highlights from LAS business plan 2022/23, and how learning will inform the LAS business plan 2023/24

Context

This pack has included the proposed 2023/24 LAS business plan for approval and the following slides outline our year-end achievements of 2022/23 business plan for consideration.

In May 2022, the LAS Trust Board agreed our organisational Business Plan for 2022/23, setting out 10 priorities for the year and signalling a new strategy for the future. The Trust has made significant progress on these organisational priorities while also managing very significant operational pressures including:

- Increased demand - answering more that 4 million calls, providing care to 995,755 people on scene and helping more than 175,000 people over the phone.
- The most severe level of pressure on our service at the start of the 2022/23 Business Plan at REAP 4 (Resource Escalation Action Plan) and coping with the on-going effects of Covid 19 pandemic.
- Large-scale planed events that brought millions of additional people into our capital (incl the Platinum Jubilee and HRH Queen State funeral).
- Key Incidents – in Summer 2022 we experienced extreme warm weather causing a heatwave and wild fires, increasing demand on our service.
- Four periods of industrial action with 90% of our ambulance staff going on strike during a busy winter including increased sickness in the community with a surge in flu cases and an outbreak of Streptococcus A in children.
- Pressures on the London healthcare system - during November and December 22', the LAS lost over 31,000 operational hours and 2,012 ambulance shifts while delayed at hospital.

Look back at 2022/23 LAS business plan priorities

We said we would improve our services, strengthen our organisation and build our strategy for the future

Our patients

Continuously improve the **safe delivery and quality of care** for our patients

- Deliver our annual quality objectives.
- Develop and use clinical outcome data more effectively.

Improve our **emergency response**

- Improve the resilience and performance of our call handing and clinical assessment functions.
- Work with partners to ensure the best care for our patients, including hospital handovers and utilisation of alternative pathways.
- Reduce dispatch and conveyance rates by developing appropriate local alternatives.

Create more integrated and resilient **111/999 services**

- Create a single clinical assessment function for 111 and 999.
- Develop a workforce that can manage patients effectively at first point of contact.

Strengthen our specialist teams' response to incidents, risks and threats

- Update the facilities and improve the locations of our teams.
- Ensure ongoing readiness for future incidents and events

Our organisation

Support **our workforce**

- Increase the size of our permanent workforce.
- Expand our educational capacity.
- Encourage and promote diversity across our teams.
- Reduce violence and aggression experienced by staff
- Offer enhanced wellbeing provision.

Develop a **positive working culture**

- Strengthen local team working.
- Co-create a new values and behaviours framework.
- Design and launch a new appraisal process to ensure greater support to people.

Strengthen & optimise our **digital and data assets**

- Replace CAD, telephony and datacentres.
- Join up data internally & externally
- Develop an agile and data-driven ambulance service.

Use resources more **efficiently** and **productively**

- Define and deliver a cost improvement plan for 2022/23 and beyond, getting maximum value for the LAS pound invested.

Our future

Build our role as an "**anchor institution**" that contributes to life in London

- Strengthen the in-house make-ready function.
- Support local recruitment and create rewarding careers for Londoners.
- Achieve our 22/23 carbon neutral plans.
- Deliver the London Lifesavers project, increasing volunteer and defibrillator availability.
- Work collaboratively to deliver public health messaging.

Develop a new **five-year strategy** to improve services for the communities we serve

- Confirm priorities for the next five years, including estates modernisation
- Take a collaborative approach with partners to tackle health inequalities
- Build partnerships with others to design new and innovative models of care, including in primary care.

2022 / 2023 Business Plan Year End Progress summary

2022 / 23 Business Plan Priority areas	Total number of commitments	Total number of Commitments DELIVERED	Total number of commitments PARTIALLY DELIVERED
1. Continuously improve the safe delivery and quality of care for our patients.	3	1	2
2. Improve our emergency response	5	2	3
3. Create more integrated and resilient 111/999 services	2	2	0
4. Strengthen our specialist teams' response to incidents, risks and threats	3 (changed to 2)	0	2
5. Support our workforce	7	3	4
6. Develop a more positive working culture	4	4	0
7. Strengthen and optimize our digital and data assets	3	3	0
8. Use resources more efficiently and effectively	3	3	0
9. Build our role as an "anchor institution" that contributes to life in London	6 (changed to 5)	4	1
10. Develop a new five-year strategy to improve services for the communities we serve	4	3	1
TOTAL	**38**	**25**	**13**

***Carried over –** A revision of the commitment or particular measures will be carried over into 2023 / 24, not necessarily exactly the same commitment.

Priority 1 - Deliverables 2022/23

Priority 1: Continuously improve the safe delivery and quality of care for our patients, by:

Delivering our annual quality objectives	How did we do?	Rating	Are we carrying it forward?
In 2022/23 we looked to continue the work to improve our patient outcomes in three main areas. 1) Following an out-of-hospital cardiac arrest, the **Return of Spontaneous Circulation** (ROSC) (e.g. signs of breathing) is the main objective and can be achieved through immediate and effective treatment at the scene (e.g. Advanced or Basic Life Support). The national average for patients who receive this care by the ambulance service and sustain ROSC to the hospital is 30%. 2) ST-segment elevation myocardial infarction (STEMI) is a type of heart attack caused by a sudden blockage of the blood supply to the heart muscle. It is vital that blood flow is quickly restored. In addition, patients with STEMI need to be managed correctly, including the administration of a care bundle (e.g. pain relief). During 21/22, we maintained but did not improve our **STEMI bundle compliance**. 3) A reconfiguration of **stroke services** saw patients in London conveyed directly to a stroke unit (HASU) rather than the nearest Emergency Department; 97.6% of our stroke patients now go directly to HASUs. The health outcomes of patients who suffer an acute stroke can be improved by recognising the symptoms of a stroke, making a diagnosis quickly, and early transport.	1) Return of Spontaneous Circulation (ROSC) rates have fluctuated since April 2022 but remain close to the 30% national target where data is available. We met or exceeded the national target for nine months of the 22/23 year. All variations are within normal control limits, suggesting the fluctuations are within normal range. 2) The 22/23 year has seen a slight reduction in the STEMI care bundle (-0.4%) compliance. It has remained below the target of 80% for 8 months of the year, giving an average of 70.4%, just below the national average of 72.8%. 3) We have reduced the stroke on scene time by 1 minute, from an average of 36 minutes in 21/22. The '999 call to arrival at HASU' has been increasing slightly since 2018/19, owing to increased response times. Clarifying averages for the year was challenged by a discrepancy in how we reported Cat 1 calls, affecting November's data. Therefore averages do need to be taken as approximate.	Partially delivered	We aim to improve patient outcomes for cardiac arrests by reducing the time taken between call connect and chest compressions by 60 seconds, increasing the chances of ROSC. We will continue to work towards delivering the STEMI care bundle to achieve 80% consistently. Although we completed our deliverable for stroke patient, we will work towards improving outcomes by ensuring a mean 'call to arrival at HASU' time to be below 110 minutes.

Priority 1 - Deliverables 2022/23

Priority 1: Continuously improve the safe delivery and quality of care for our patients, by:

Delivering our annual quality objectives (continued)	How did we do?	Rating	Are we carrying it forward?
The **quality account** provides a report on the quality of our services and the improvements we are making in relation to patient safety, the effectiveness of care and responding to patient feedback about the care we provide, including progress over the 2022/23 financial year and outlines the priorities for improvement in 2023/24. We aspired to deliver all objectives relating to patient care, patient and family experience and staff engagement.	Progress has been made in all areas of our quality objectives relating to patient care, patient and family experience and staff engagement, with 6 of the 12 areas fully completed. Some of the deliverables including; 1) A new intranet page and a digital magazine were established to **share learning,** data and case reviews to aid in reflective practice and service developments. 2) The development of a number of new roles, expanding the number of Clinical Team Managers and the introduction of teams-based working means that we have improved the provision of **clinical supervision** from 21/22. 3) Improvements have been made by the implementation of a Central Asset Management System to allow for greater control of **PPE levels** in line with national guidance. 4) We have worked towards the improvement of the identification and referral of unrecognised **hypertension** as a response to the rise in incidents of cardiovascular disease and stroke.	Partially delivered	We look to deliver the five quality indicators standards set by our Trust Board for 2023/24 Scope and implement a more user-friendly incident reporting system Increase number of paramedics enrolled on band 7 development programme by 10% with First Contact Practitioners (FCPs) increasing by 30+WTE.

Develop and use clinical outcome data more effectively	How did we do?	Rating	Are we carrying it forward?
In 22/23, we said that we would pilot a **clinical feedback app**. This led to the development of the 'My Clinical Feedback app', designed to link ambulance (LAS) and Lewisham and Greenwich NHS Trust (LGT) datasets to enable an end-to-end analysis of patient care, help facilitate service design and provide feedback to our clinicians in order to aid learning and lead to system-wide improvements in sharing data.	We collaborated with McKinsey and LGT on the pilot. Our pilot clinicians were able to access patient reports, learn from experience and share positive feedback. We are working with acute trusts to roll this out more widely.	Delivered	We will work towards linking the LAS clinical data and hospital data together across a whole ICS area, having completed a tender process for the app.

Priority 2 - Deliverables 2022/23

Priority 2: Improving our emergency response, by:

Improving the resilience and performance of our call handling and dispatch functions	How did we do?	Rating	Are we carrying it forward?
In 22/23 we aimed **to improve our Category 2 response time** (for serious conditions, such as stroke or chest pain, which may require rapid assessment and/or urgent transport), to become one of the top 5 performing ambulance trusts in the country. For Cat 2 the national response average in 21/22 was 41:18. For London, the average was 38:17, sitting in 7th place of the 11 ambulance trusts.	We are currently 8th in the UK with a mean time of 40 minutes and an average of 33 minutes against an average UK position of 32 minutes. In October and November, response times were not available, and this has been taken into account for the national figures. We have since stabilised our Category 2 performance and seen a slight improvement in quarter 4 to 34m 16s. This year has seen a number of challenges in the service and across the NHS throughout the year. On average, we did not meet our response targets, but performance has stabilised, and slightly improved with a reduction in overall demand.	Partially delivered	The 22/23 ambition will roll forward; to deliver CAT2 recovery response time (<30 minutes) as a priority. This will be further supported by increases in the number of front line staff by 300 WTE and in the Clinical Assessment units (CAS) by 72 WTE by year end to increase capacity and a priority to ensure that the CAS assess CAT 2,3,4 patients to reduce demand
In addition to the above, 22/23 also saw the ambition to deliver **sustainable improvement on call handling**, to become one of the top performing ambulance trusts in the country. We aimed to do this through increasing the number of call handlers, and investing in dispatch with the aim of achieving a call answering mean of 10 seconds.	The mean call answering time for 21/22 was 25 seconds and increased to 62 seconds in 22/23. This in part, can be attributed to the implementation of a new call-answering dispatch system in October, that together with Winter pressures across the NHS, saw call answering peaking at a mean of 150 seconds. Call answering time has now stabilsed, with the last quarter of 2022/23 having an average of 25 seconds.	Partially delivered	The 22/23 ambition will roll forward. This will be further supported by priorities to increase the number of call handlers by 150 WTE, and reduce the call answering time to <10 seconds. The launching of team based working to help improve sickness levels and clinical support for our frontline, as well as scoping a AI system to enhance call auditing to identify areas of learning will aid this.

Priority 2 - Deliverables 2022/23

Priority 2: Improving our emergency response, by:

Work with partners to ensure the best care for our patients, including hospital handovers	How did we do?	Rating	Are we carrying it forward?
Our 22/23 business plan outlined how we would work with our partners to **increase the proportion of 999 patients that access alternative care pathways**, particularly frail patients and those with mental health conditions. Vulnerable patients (i.e. elderly fallers and mental health concerns) must receive better access to care, including through better use of alternative care pathways.	We said we would investing in specific patient cohorts, implementing multi-disciplinary teams to ensure we will provide the most personalised care possible for our patients. We did this by appointing a Director of Clinical Pathways to oversee this work, and increased the number of specialist resources, such as urgent care response cars, mental health cars, and advance paramedics. Additionally, we said we would collaboratively develop and expand appropriate same day emergency care (SDEC) pathways for these patients, ensuring that their patient journey is as effective as possible, and increasing them to 146 by January 2023.	Partially delivered	Although we have delivered the actions set out in the 22/23 business plan, we aim to further strengthen this by again increasing the number of APPs in urgent care, increasing the availability of the mental health team, and increasing joint response cars for fallers.
We aimed to work with partners to **reduce hospital handover delays** to achieve standards and improve quality and safety for patients, through co-developing action plans with our integrated care system (ICSs) to address hospital handover delays across London, for example, the Fit to Sit process enabling a progressive approach to patient mobility using wheelchairs, or by allowing the patient to walk on arrival to the emergency department if clinically appropriate.	The actions were delivered throughout 22/23, and the benefits are expected to be seen in 23/24 as processes such as 'Fit to Sit' are embedded and become business as usual. Pressures over the last year including a growth in Emergency Department (ED) waits over the last 12 months, (compared to the preceding 12 months) at 0.2% for type 1 A&Es, as well as the number of patient being seen under four hours decreasing at one point to below to 60% in London, have meant that hospitals have seen significant pressure in the EDs	Delivered	The actions for hospital handovers have been implemented, and the results will be evaluated throughout 23/24.
Reduce dispatch and conveyance rates by developing appropriate local alternatives	**How did we do?**	**Rating**	**Are we carrying it forward?**
A review of the dispatch model will be undertaken to enable a more targeted and clinically supported dispatch process to patients in need. Longer-term, emerging technologies will provide greater options for dispatching resources to patients. We therefore agreed we would review and update the **clinical model for ambulance dispatch** to ensure patients get the right response at the right time.	The Category 2 Auto Dispatch Trial in the North West Sector took place in January 2023 and the Category 2 Validation Pilot Live in March 2023,	Delivered	A review of the 999 triage system will help to underpin any improvements to a new dispatch model. AI systems are able to enhance call auditing and triaging, and will be scoped in 2023/24.

Priority 3 - Deliverables 2022/23

Priority 3: Create more integrated and resilient 111/999 services, by:

Create a single clinical assessment function for 111 and 999	How did we do?	Rating	Are we carrying it forward?
Our aim is for every patient requiring urgent healthcare support or advice to undergo **an initial telephone clinical assessment** and where appropriate, a full clinical consultation. This is to ensure they receive the right care, at the right time, in the right place regardless of whether they dial 999 or 111. To do this, we looked to establish a resilient multi-disciplinary emergency and urgent care assessment service that would enable improved hear and treat and consult and complete rates for patients.	To enable this, we are working towards interoperability between Cleric, the new computer aided dispatch system, and Adastra, the urgent care clinical system; which already has interoperability with other GP systems. We have also developed a Regional Cat 3&4 Ambulance outcome validation model, now being considered by other Ambulance Trusts across the country, which aims to assist CAT 3&4 calls based on the patients clinical need, irrelevant of whether the caller has dialled, 111 or 999.	Delivered	Although completed, we continue with our aspirations in the clinical assessment units, including delivery of the KPIs for timeliness and outcomes. We also aspire in 23/24 to see 90% of patient requiring an urgent clinical assessment (Cat 1,2,3) receiving a call back within an hour.
Develop a resilient workforce so that we can help patients more effectively at first point of contact	**How did we do?**	**Rating**	**Are we carrying it forward?**
In 22/23 we looked to expand the **resilience of the workforce**, including our incident management and service delivery team (who ensure we are on track operationally on a day-to-day basis), 111/999 control centres and clinical assessment services. We will also look to strengthen our leadership structures to improve efficiency, productivity and staff welfare.	During the year, we implemented a 50:50 job share in the eCAS, allowing for more flexible working to create an attractive recruitment offer. In addition we increased the multi-disciplinary CAS clinicians by recruiting General Practitioners and Advanced Clinical Practitioners to our Newham and Waterloo sites. Our teams can now work across all sites and be allocated to work in any clinical queue (whether the 999 or 111 que) due to upgraded IT and telephony. Introduction of a dedicated management team to support and manage the workforce, productivity, performance and real time service delivery has also strengthened our leadership.	Delivered	For the 23/24 business plan there are no further aspirations directly related to the workforce, however there will be a move into a new 111 EOC location based at Croydon.

Priority 4 - Deliverables 2022/23

Priority 4: Strengthen our specialist teams' response to incidents, risks and threats, by:

Update the facilities and improve the locations of our teams	How did we do?	Rating	Are we carrying it forward?
The beginning of 2022 found that staffing numbers had nearly doubled for some of our specialist teams in recent years, as a result of changing and developing requirements. The Resilience & Specialist Assets directorate is required to meet NHS England and NARU standards for specialist equipment and vehicles, which together with the increase in staff, put additional strain on the current estate and infrastructure. We therefore committed to Identify an alternative site and agree the relocation of the HART team	A clear specification of requirements was identified for a suitable site however repeated searches have not identified any suitable locations. NARU guidelines state that new vehicles will require a larger area than is currently available.	Partially delivered	To roll forward to 23/24, to establish a plan for the HART base to be relocated by 24/25, and provide eSort functions as detailed below
We looked to establish a new venue for eSORT (Special Operations Response Teams) training which meets the service criteria, including the increased capacity requirements mentioned above. Part of this specialist training includes responding to marauding terrorist attacks and incidents involving CBRN (chemical, biological, radiological, and nuclear risks).	A temporary measure was established in Beckenham, where training was successfully delivered. Location and size limitations necessitate consideration for a new permanent site (or shared facilities with enlarged HART sites) going forward.		This objective has been merged with the above.
Ensure ongoing readiness for future incidents and events			
We are nationally recognised for planning events, and the team's high-quality delivery and responsiveness is evidenced by compliance with national standards and specific feedback from previous inspections. We looked in 22/23 to continue to meet the Interoperable Capabilities outlined by the Department of Health and Social Care (DHSC) and NHS England, as they evolved throughout the year, including delivering public order training, enhanced SORT (mentioned above), and JESIP (Joint Emergency Services Interoperability Programme) and Commander training	After successful on-going recruitment and training for staff within our HART (Hazardous Area Response Team), TRU (Tactical Response Unit) and SORT teams (Special Operations Response Team), we have positively increased the gender diversity of the directorate, as well as ensuring we are well resourced to respond to future incidents and events.	Partially delivered	Ensuring continued high performance remains ongoing, with a priority to implement learning from our after-action reviews and other key inquiries including the Manchester arena. We also look to develop a specialist cadre of strategic commanders.

Priority 5 - Deliverables 2022/23

Priority 5: Support our workforce:

Increase the size of our permanent workforce	**How did we do?**	**Rating**	**Are we carrying it forward?**
To keep pace with the increasing demand for our services, we launched an ambitious recruitment programme in May 2022 and recruited over 1,600 new employees by the end of March 2023. We committed to recruiting 477 paramedics, 45 members of staff to our non-emergency transport, 300 call centre staff and 200 paramedics internationally.	We are proud to have been able to recruit over 900 frontline ambulance staff and almost 400 call handling staff across our 999 and 111 services this year, as well as insourcing two key services, Make Ready – the team of staff who work around to clock to restock, re-fuel and deep clean ambulances at the end of a busy shift, and our Cleaning Services. Although not all targets have been met, substantial improvements have been made.	Partially delivered	The 23/24 plan for staff will include looking at an action plan for retention of staff. Our strategic goals include trebling the number of advanced and specialist clinicians, which will further support the targets not made in 22/23.
We committed to reviewing all our structures so that every member of staff has a line manager who has sufficient time and skills to be an effective leader, through ensuring station managers had no more than 15 line reports, a non-registrant leadership role and a greater variety of operational roles to aid efficient management models.	The launch of the Our LAS, Our Leaders programme has seen more than 163 of our Band 6 and 7 members of staff beginning further training to develop their leadership skills. Those taking part will complete eight modules covering managing staff, building high-performing teams and overseeing budgets. We have also worked hard to increase gender diversity, with 50% of our workforce and 40% of our senior leadership team being female. The work to ensure a reduction in the number of line reports will be rolled forward to next year.	Partially delivered	The 23/24 plan for staff will include delivering an NVQ leadership framework for all more senior leadership roles, as well as devising plan towards 80% of managers having line reporting for less than 15 WTE staff.
Expand our educational capacity	How did we do?	Rating	Are we carrying it forward?
With a focus on staff development and a commitment to upskilling our staff and volunteers, our clinical education team looked to accommodate the full training requirements of the new staff cohorts by expanding the educational capacity in 22/23. As a result, we looked to invest in digital capabilities to ensure training can successfully be provided, to on-board the new staff we need.	The expansion of Brentside and Newham Dockside Education Centre was completed, allowing for 10 new classrooms, 8 new skills rooms and a media room. However, given the given the above expansion, we need to assess if a 3rd centre is necessarily in light of capital available and priorities.	Delivered	With the expansion, an assessment needs to take place as to whether a 3rd educational site is necessary. Therefore on hold.

Priority 5 - Deliverables 2022/23

Priority 5: Support our workforce:

Encourage and promote diversity across teams	How did we do?	Rating	Are we carrying it forward?
We understand that actively promoting equality and inclusivity among our organisation is an important part of making the Trust a great place to work. We strive to ensure equal and fair access to our services for all our patients and their families. We recognise our responsibility to eliminate discrimination and harassment while supporting and empowering all our people. The 22/23 business plan looked to further improve our compliance with the NHS's workforce race equality standards (WRES) and workforce disability equality standards (WDES).	We end 2022/23 having recruited more than 400 members of staff from ethnic minority groups, representing over 32% of all our new starters. We now have more than 1,580 staff from ethnic minority backgrounds, which is 21% of our total workforce. There is still more to do to increase these numbers and we will continue to put time effort and attention into this work. We launched our See ME First campaign in October 2022, giving our staff and volunteers the opportunity to pledge to visibly show a commitment to race equity and speak up if they see or experience discrimination of any kind. We have worked with our partners at the Business Disability Forum to host Disability Confidence workshops, with some aimed at People and Culture colleagues, and some for a more general audience	Delivered	We roll forward this objective looking to increase further our WRES and WDES compliance. We also aim to increase the proportion of new starters from ethnically diverse backgrounds by a further 8%.
Reduce violence and aggression experienced by staff	**How did we do?**	**Rating**	**Are we carrying it forward?**
Keeping our people safe will always be a priority for London Ambulance Service. Our members of staff and volunteers should never have to experience violence or aggression, but sadly – due to the behaviours of a small minority of patients and members of the public – these incidents remain unacceptably high. We agreed to publish and implement an action plan to reduce violence and aggression towards our staff and support them more effectively in 22/23 to help reduce this,	In September 2022, we invested more than £3 million to fit 510 of our ambulances and 55 of our fast response cars with upgraded and comprehensive crew safety systems. These measures are further supported by our continuing work to roll-out body work cameras for our teams. We have also recruited a dedicated Violence Reduction Manager.	Partially Delivered	The roll out of body worn cameras to all stations will continue into 2023/24.

Priority 5 - Deliverables 2022/23

Priority 5: Support our workforce:

Offer enhanced wellbeing provisions	How did we do?	Rating	Are we carrying it forward?
Using an evidence-based approach that maximised our internal expertise, we looked to shape the provision of our occupational health service and utilises the offers from external partners to increase wellbeing support.	Our award winning Wellbeing team has expanded this year and developed a strategy in line with current government recommendations and guidance to raise the Health and Wellbeing of our staff and, as a result, our organisation and our patients. Our Wellbeing Team deliver a range of training for managers across the Trust, meet staff at inductions, run support groups. As part of the improved occupational health provisions, GoodShape (occupational health provider) was implemented in September 2022 and now business as usual.	Delivered	Make significant reductions in unplanned and sickness absence, achieving the lowest unplanned absence rates compared to other ambulance services.
We wanted to make significant reductions in unplanned and sickness absence, achieving lowest unplanned absence rates compared to other ambulance services.	The sickness absence rate for 21/22 was 8.25%, above the national average for ambulance trusts by .19%. Our sickness absence has greatly improved from 12 months ago, and is currently at 6.11%. This is positive news for staff and patients, however we do not have the lowest rate of sickness absence amongst all Ambulance Trusts. Work through some functionality issues within the GoodShape system to assit in reducing the sickness rate further, and making it easier for managers to support employees during unplanned absences.	Partially delivered	Our goal for the 23/34 business plan is to see sickness levels fall below 6% during the year, partly through increased IPC practices which may indirectly affect sickness levels.

Priority 6 - Deliverables 2022/23

Priority 6: Develop a positive working culture:

Strengthen local working	How did we do?	Rating	Are we carrying it forward?
It is essential people feel they can enjoy a meaningful career within London Ambulance Service. Creating career pathways in every part of the organisation, allows LAS to expand and offer diverse and exciting roles for future and current member of staff.	The Service has now finalised our frontline ambulance apprenticeship career pathway, enabling trainees to join LAS without clinical experience or qualifications. We also introduced an NHS Master Technician position to make sure our technicians have an opportunity to develop their career. Clinical career pathways have been developed, although are not widely published.	Delivered	This work will continue to map out clear staff progression pathways across LAS
Co-create a new values and behaviours framework	**How did we do?**	**Rating**	**Are we carrying it forward?**
Our staff and volunteers are our greatest asset. To help make LAS a great place to work, this year, we began a new programme of work to transform our culture and improve the working lives of our teams. Last years we aimed to produce a new set of values – designed by our staff and volunteers, which are now at the heart of all we do.	Over 1300 staff attended our LAS values programme, by developing and agreeing our Trust Values and Behaviours. Leadership 'master classes' were held, focusing on our values. We also introduced recruitment with values based training and published our values and commitments booklet. From recruitment, induction, appraisal, learning & development we ensure the interaction & conversation is based on our values	Delivered	
In making the LAS a great place to work, we also want to be somewhere staff recommend to others as a good workplace. We looked to do this through improving our performance in the NHS staff survey, including the percentage of staff who recommend our Trust as a place to work	Although improvements were made in– being a learning organisation, health and wellbeing and morale, 45% of staff recommending LAS as a place to work, the same result as last year. Therefore we have developed this target for 23/24 to include all 6 people promises, so give a greater understanding of what our staff expect from working at LAS.	Delivered	In 23/24 we will look to continue overall improvement for LAS and aim to be in the top 1/3 across all people promise areas.

Priority 6 - Deliverables 2022/23

Priority 6: Develop a positive working culture:

Design and launch a new appraisal process to ensure greater support to people	How did we do?	Rating	Are we carrying it forward?
The business plan focused in improving the quality and effectiveness of our appraisals, recruitment process, and managing inappropriate behaviors in colleagues. We aimed to deliver this through a new appraisal system that will support staff development, include a new behavioural framework that can guide appraisers, and allow team leaders to get to know their teams, enabling us to ensure eligible colleagues are appraised.	A new and simplified appraisal process has been implemented with associated training to encourage regular and effective conversations throughout the year between line managers and their team members. We have increased slightly in the 'Appraisals' score from last years NHS Staff Survey (from 2.7 to 2.8), and expect further improvements for next year.	Delivered	

Priority 7 - Deliverables 2022/23

Priority 7: Strengthen and optimise our digital and data assets:

Replace CAD, telephony and datacentres.	How did we do?	Rating	Are we carrying it forward?
A computer-aided dispatch (CAD) system enables our service to run, from call taking to dispatch, and service quality monitoring and reporting. With 22/23 we aimed to replace the CAD and begin replacing legacy radio and mobile data systems.	The new Cleric CAD system went into live operational use from September 2022, which has resulted in the Trust utilising a CAD system that aligns with a number of other Ambulance Trusts, and is compatible with other NHS systems used in primary and secondary care. We have a programme to replace the existing Mobile Data Terminals (MDTs) in trust emergency vehicles, so they provide information between CAD and Ambulances, and to follow the national rollout of radio and mobile data systems to all Trusts.	Delivered	We will be carrying forward the work to agree, pilot and implement a replacement for the MDTs. We are also agreeing a programme for replacement of the radio system and complete implementation of a telephone system.
Join up data internally and externally	**How did we do?**	**Rating**	**Are we carrying it forward?**
Information sharing is an important issue for integrated teams, like those in Urgent and Emergency Care, to get right. We wanted to improve care by enhancing the sharing of our patients' electronic records as well as joining up data and linking it with our partners' records.	The adoption of the Cleric CAD system and ePCR (electronic patient care record) both enable patient records to be shared more easily, by allowing the relevant clinicians to have quick access to vital information, for example the Transfer of Care process in October 2022 utilised Cleric, One London and ePCR to allow for patients attending certain hospitals to be registered prior to arrival, allowing for a reduced waiting time in the Emergency Department,	Delivered	We are looking to further develop this objective by linking systems by NHS number and with the London Care Record
Develop an agile and data-driven ambulance service	**How did we do?**	**Rating**	**Are we carrying it forward?**
Upgrade emergency operations and integrated care telephony to allow flexible working across sites and lay ground for further modernisation.	The telephony system used by our call handlers in 999 and health advisors in 111 has been upgraded, to allow for flexible working across sites. However there are wider dependencies, for example, on the correct software being used, that need further attention.	Delivered	Autumn of 23/24 will see some of the hardware go live.

Priority 8 - Deliverables 2022/23

Priority 8: Use resources more efficiently and productively

Define and deliver a cost improvement plan for 2022/23 and beyond, getting maximum value for the LAS pound invested	How did we do?	Rating	Are we carrying it forward?
We aimed to deliver our agreed control total for 2022/23, including the successful delivery of our cost improvement programme (CIP); saving money for the trust through recurrent and non-recurrent means. In order to deliver the income and expenditure plan, the Trust planned an ambitious efficiency programme of £24m.	During 2022/23 the Trust continued to focus on improving value for money to the public and saved £24.8m through a number of schemes including improving our productivity through decrease of sickness levels, improved supply chain management and reducing overhead costs, allowing us to meet our target.	Delivered	Our target for next year will be to deliver the control total, including a CIP of £25m
In order to return to pre-pandemic levels of operational productivity, a number of metrics were used in our efficiency programme, including workforce efficiencies in reducing sickness levels, reducing infrastructure costs through as estates strategy, modernizing the fleet with hybrid and electric vehicles, and investing in IT Infrastructure.	Improvements have been made in a reduction in sickness levels, the successful implementation of IT infrastructure and modernizing the fleet. However, further work is required in order to improve a number of indicators, for example, job cycle times.	Delivered	In 2023/24, we are looking to reduce time lost across the organisation, for example at the start of shift. This will work alongside our priority to ensure that out of service time is reduced by 5%, and a rest break policy is implemented, providing further metrics.
The Trust's aim is to continue to improve its enabling infrastructure to provide an environment that supports working in the most optimal way in modern facilities. This included a £31m Capital Programme that included investing in estates infrastructure, IT investments and our fleet.	During 2022/23 London Ambulance Service spent £31.0m on capital expenditure in the following areas: £16.6m increasing and modernising its fleet to replace ageing vehicle, and meet low emission targets and improving crew safety systems; £10.0m on estates modernisation including consolidating its training estate, improving its logistics support capability, improving medicines management and; £4.6m on digital programmes including implementing a new Computer Aided Dispatch system.	Delivered	A capital plan of £27.6m has been finalised for next year. A high proportion of this programme is committed to updating the Trust's ambulance fleet with a planned investment of £15m during next financial year.

Priority 9 - Deliverables 2022/23

Priority 9: Build our role as an "anchor institution" that contributes to life in London

Strengthen the in-house make ready function	How did we do?	Rating	Are we carrying it forward?
Starting on the 1 April 2022, the Make Ready teams who work across the capital to get the ambulance fleet ready and stationed in the right places for the next shift became NHS employees within the LAS, as the existing contracts (which were held by providers MITIE and Churchill Group) come to a planned end.	By bringing the Make Ready team into LAS, we can now ensure their pay matches the London Living Wage following two separate pay increases totaling 8%. After the 2022/23 year we have maintained and stablised services, and improved the retention rate by decreasing it by 1%. We have also recruited 65 new colleagues and reduce wastage, implemented a senior management team and increased staff engagement. We will continue with a scoping a potential service increase i.e. NETS, and make incremental change to the Agenda for Change terms to their contracts.	Delivered	Phase 2 in 2023/24 will focus on the business case delivery plan, the implementation of a full LAS management model and delivering benefits.
Support local recruitment and create rewarding careers for London	**How did we do?**	**Rating**	**Are we carrying it forward?**
As part of the NHS People Plan, the LAS aims to support local recruitment and create rewarding careers for Londoners, including recruiting additional clinical staff in 2022/23. This included ensuring entry level recruitment is representative of the communities and populations we serve across London.	Despite successful recruitment campaigns, the diversity of our staffing profile is not representative of London and our ability to deliver a more inclusive service and therefore improve patient care is diminished. Recruitment campaigns are not attracting diverse applicants in sufficient numbers, caused in the main by the fact the paramedic profession lacks diversity. The Board has agreed an action plan and a committee charged with overseeing its implementation.	Delivered	Increase the proportion of our staff from ethnically diverse backgrounds by 3% (22% to 25%)
We actively sought to promote paramedicine as a career pathway to diverse student communities in London, in part by creating a rewarding career paths, ensuring that our managers are as diverse as our population.	The LAS has a presence at recruitment fairs across London, including in areas with a high proportion of ethnically diverse students, additionally, we actively sought publicity materials which are reflective of London's diverse populations. However, on-going active promotion of paramedicine needs to continue, to ensure it is a career choice to diverse student communities.		Amalgamated into: Increase the proportion of our staff from ethnically diverse backgrounds by 3% (22% to 25%)

Priority 9 - Deliverables 2022/23

Priority 9: Build our role as an "anchor institution" that contributes to life in London

Achieve our 22/23 carbon neutral plans	How did we do?	Rating	Are we carrying it forward?
All NHS organisations, including the LAS, have environmental responsibilities. The London Ambulance Service (LAS) published its Green Plan in December 2021 outlining its carbon reduction ambitions to reduce emissions it directly controls by 2040. As part of this, we wished to ensure at least 10 per cent of our 1,000-plus vehicles are electric or plug-in hybrid electric.	In 2022/23 we began rolling out new electric vehicles following the announcement of £16.6 million initial investment to purchase 225 new vehicles, including 40 new ambulances that are lighter and produce lower emissions than our current vehicles, as well as 42 electric fast response cars and three electric motorcycles. The first of our 225 new greener vehicles are already in use, including all-electric motorbikes and fast response cars and lighter emergency ambulances. The trust is the first service to use electric motorbikes to respond to emergency calls.	Delivered	We are adapting this priority to ensure it remains relevant, to; ensure we have achieved compliance on ULEZ emissions by March 2024 in line with mayor's commitments, reducing carbon emissions by 5%, as well as installing electrical vehicle charging points across 40 sites.
Deliver the London Lifesavers project, increasing volunteer and defibrillator availability	**How did we do?**	**Rating**	**Are we carrying it forward?**
The London Lifesavers campaign aims to recruit and train life savers who are able to perform chest compressions and use a defibrillator – the device that uses an electric shock to help revive someone should their heart suddenly stop. Our target was revised to recruit 7000 London Lifesavers and deliver 8000 public access defibrillators across London.	During 2022/23 we recruited and trained 4,765 London Lifesavers (LLS), and recorded 7802 Public Access Defibrillators. The continuation of London Lifesavers will focus on training the public and secondary school aged children, and a further 198 extra Public Access Defibrillators are required	Partially delivered	In 2023/224 we aim to recruit 7,000 London lifesavers during a schools programme, and deliver 8000 public access defibrillators across London
Work collaboratively to delivery public health messaging	**How did we do?**	**Rating**	**Are we carrying it forward?**
We already work with many schools and patient groups to educate on the impact of different life choices and regularly use these platforms to discuss how interventions can significantly impact different and healthier lifestyles. We aimed in 2022/23 to deliver sessions on health and prevention of harm for children and young people across the capital	Our education resources have been updated to include accessible materials for individuals with learning disabilities, and since January, the Public Education team have delivered 149 days of engagement, reaching 19,873 children and young people.	Delivered	We will use data to create a targeted prevention programme for children and young people across the capital.

Priority 10 - Deliverables 2022/23

Priority 10: Develop a five-year strategy to improve services for the communities we serve

Confirm priorities for the next five years, including estates modernisation	How did we do?	Rating	Are we carrying it forward?
London LAS has more than 80 properties for use by operational teams and our support services. There is significant variation in the size, location, age and use of these properties. Not all the buildings we work from provide the working environment we aspire for our staff, and they have been shown to promote inefficiencies in how we work. We are committed to undertaking a full review of our estate in 2022/23 to inform longer term decisions about how we use our assets and where we make investments in the future. We aimed to co-produce an estates strategy with incremental implementation from 2022/23 onwards.	In 2022/2023 we began work to re-locate our 111 call centre based in Croydon into a modern facility in the town centre which will have space for a third education centre, enabling us to have a training facility in south London to complement our existing centres in west London and east London. We also expanded the Brentisde Education centre, and refurbishments of ambulance stations has commenced. We also looked at plans to convert our former emergency operations centre in Bow into a new ambulance station for the Tower Hamlets area. In addition, we opened a rebuilt ambulance station in Ponders End. Ann Estates Strategy has been issued, and supports this work.	Delivered	The work to modernize our estates continues, and in 2023/2 we will work up a design and achieve planning permission for new ambulance station in Bow. We will also increase footprint of at least two further ambulance stations to increase capacity

Take a collaborative approach with partners to tackle health inequalities	How did we do?	Rating	Are we carrying it forward?
As regional providers, ambulance services have wide access to patients, as well as a wealth of knowledge and information to help systems understand their populations and gain insight and a broader understanding of inequalities in the context of access, experience and outcomes. We aimed to take a joined-up approach across all of urgent and emergency care, to deliver a whole systems approach to tackling health inequalities.	We have linked in with the national NHS England approach to reducing health inequalities, and working this year to better understand and identify the health and social inequalities that exist in London. To develop our Health Inequalities action plan, we plan to recruit a public health specialist clinician with from April 2023 and delivering the action plan throughout 2023/24 and forms a key objective in both our Quality priorities, business plan and 5 year strategy.	Partially delivered	As well as delivering the Health Inequalities action plan, we will review our maturity across other ambulance Trusts using the national tool.

Priority 10 - Deliverables 2022/23

Priority 10: Develop a five-year strategy to improve services for the communities we serve

Build partnerships with others to design new and innovative models of care, including primary care	How did we do?	Rating	Are we carrying it forward?
As part of our work to increase collaboration with primary care and work with primary care networks, we looked to contribute to the implementation of the Fuller Stocktake recommendations; a series of recommendations for local and national leaders, and articulates important ideas about the future shape of urgent care and about the further development of neighbourhood teams.	The Urgent Community Response cars which allow for patients to be treated at home, are good examples of partnership working that could support primary care in line with the Fuller Stocktake recommendations. We have also developed a close working relationships with ICSs through our engagement work on the next five year strategy, to ensure we are aligned in our future goals.	Delivered	We will continue to work with the wider NHS in London to explore opportunities to support Primary Care, and work up and implement at least one pilot.
The COVID pandemic increased collaborative working across regional partnerships, through locality based clinical networks. The learning from these networks has continued, and the alternative care pathways that were established now form business as usual. The 2022/23 business plan supported this working, by looking to develop new and innovative ways of working with our partner organisations and across the Trust.	We worked with partners to pilot and expand the Community Response Cars to other parts of London, and use the learning to develop and evaluate the REACH project, which aims to reduce unnecessary hospital visits by facilitating other appropriate care pathways. Additionally, as a result of Industrial Action, we have used the learning from this to involve Senior Clinicians in reviewing telephone clinical assessments that do require a physical response.	Delivered	We will agree and implement an operating model on how LAS interacts effectively at the right levels in the 5 ICSs, and work with rest of NHS in London on how to communicate to the public and healthcare providers on using 999 and 111 services

8. Board Assurance Framework

8.1. Board Assurance Framework

For Information

Presented by Mark Easton

Report Title	Board Assurance Framework		
Meeting:	Trust Board		
Agenda item:	8.1	Meeting Date:	25 May 2023
Lead Executive:	Mark Easton, Director of Corporate Affairs		
Report Author:	Frances Field, Corporate Governance Manager		

Purpose:				
	x	Assurance	x	Approval
	x	Discussion		Information

Report Summary

2022-2023 Year-end BAF

The 2022-2023 Q4 BAF position has been presented to the lead scrutiny committees for review and consideration of the controls and actions in place to mitigate the risks linked to objectives. The committees reviewed the objectives assigned to them and considered the evidence provided by the lead executives on the status of the risks.

Proposed changes to risk scores since the 2022-2023 BAF was reviewed by the Board are as follows:

- Risk 1A – Relating to the impact of Covid and other infections on demand; reduction of current risk score from 4 x 4 (16) to 3 x 4 (12) due the reduced impact on demand with decreasing infection rates.
- Risk 2A – Relating to operational demand exceeding capacity; reduction of current risk score from 5 x 5 (20) to 4 x 4 (16) due to an overall reduction in demand and an improvement in category 2 performance.
- 5C – Relating to staff wellness / sickness absence. Reduction of risk score due to levels of absence reducing from peak of 11% to 6%, supported by c300 WTE net increase in workforce and turnover rate that has stabilised.

2023-2024 BAF

A draft 2023-24 BAF summary table based on the 2023-2024 Business Plan objectives / mission statements will be considered at the next ExCo. Executives will be asked to review their BAF risks in light of the revised business objectives / mission statements and amend them or develop new risks as required for the next round of assurance committees.

Included in the new risks are:

- A risk relating to the ability to recruit sufficient staff and acquire assets in time to realise the target improvement of Category 2 and call answering performance, utilising the indicative £25M central investment allocation.

- A risk relating to 'getting the basics right' - staff having access to the full range of equipment that is in full working order.

Recommendation/Request to the Board:

The Trust Board is asked to:

- Consider the current assessment of risks, controls, assurances and actions set out in the year-end BAF document, and approve the risk scores.

Routing of Paper i.e. previously considered by:

Executive Committee and Board Assurance Committees.

Corporate Objectives and Risks that this paper addresses:

The Board Assurance Framework (BAF) forms a part of the overall risk management and assurance process of the Trust and allows the Board to maintain oversight of the principal risks to the delivery of the Trust's strategic objectives.

London Ambulance Service NHS Trust
Board Assurance Framework
March 2023

Introduction

The Board Assurance Framework (BAF) for 2022/23 has been designed so that it is aligned with the three strategic themes and the 10 objectives in the Trust business plan. These objectives feed into objectives for the Executive and thereafter to staff.

The Trust's risk appetite statement is a written articulation of the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives. The full risk management statement is included within the Trust's Risk Management and Strategy which is available on The Pulse and should be used to inform the tolerance of risk areas. In summary:

The London Ambulance Service seeks to minimise risks to its stated purpose to:

- Provide outstanding care for all 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

Strategic Goal	Objective		Risks		Risk scores uncond	Q1	Q2	Q3	Q4	Committee	Owner	Pge
Provide Outstanding Care for our Patients	1	Continuously improve the safe delivery and quality of care for our patients	1A	Impact of Covid and other infections on demand	20	12	16	16	**12**	QAC	FW	5
			1B	Development of UEC	12	12	12	6	6	QAC	FW	6
			1C	Industrial action	20	N/A	20	15	15	QAC/P&C	FW	7
	2	Improve our emergency response	2A	Operational demand exceeding capacity	25	20	20	20	16	QAC	JM	10
			2B	Hospital handover delays	20	N/A	N/A	16	16	QAC	JM	11
	3	Create more integrated and resilient 111 services	3A	Single clinical assessment model	16	12	12	12	12	QAC	JN	13
			3B	Multidisciplinary workforce integration	16	12	12	12	12	QAC	JN	14
	4	Strengthen our specialists' teams response to incidents, threats and risks	4A	Major incident capacity	15	12	12	12	12	AC	JM	17
Build our Organisation	5	Support our workforce	5A	Recruitment and retention	20	12	12	12	12	P&C	DM	20
			5B	Diversity of staffing profile	16	16	16	16	16	P&C	DM	21
			5C	Staff wellness	20	16	16	16	12	P&C	DM	22
			5D	Staff burnout	16	16	16	16	16	P&C	DM	23
	6	Develop a positive working culture	6A	Culture	16	12	12	12	12	P&C	DM	26
	7	Strengthen our digital and telephony capability	7A	Cyber attack	25	15	15	15	15	AC	BT	29
			7B	Critical systems failure	20	15	15	15	15	FIC	BT	31
			7C	CAD/Newham implementation	16	12	4	4	4	FIC	BT	32
			7D	Data reporting	20	N/A	N/A	15	15	QAC	BT	33
			7E	Mobile Data Terminals (MDT's)	N/A	N/A	N/A	20	20	FIC	BT	34
Develop Our Future	8	Use of resources more efficiently and productively	8A	Deliverable financial plan 22/23	16	12	12	8	8	FIC	RP	37
			8B	ULEZ Compliance	16	12	8	8	8	FIC	RP	38
			8C	Deliverable financial plan 23/24	16	N/A	N/A	16	12	FIC	RP	39
	9	Build our role as an anchor institution		*(No BAF level risks identified)*						AC	RD	
	10	Build a new five-year strategy	10A	Alignment with strategic partners	16	12	12	12	12	FIC	RD	44

Strategic Goal 1 – Provide Outstanding Care for our Patients

Objective 1	Continuously improve the safe delivery and quality of care for our patients
Lead Executive	Fenella Wrigley, Chief Medical Officer
Lead Assurance Scrutiny	Quality Assurance Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
There has been a reduction in overall demand associated with a continued increased deployment of double crewed ambulances saw an improvement in category 2 performance. We continue to monitor and review any delays. The EOC Transformation programme has appointed to the key improvement roles with the successful candidates about to commence in post. The Category 1 dispatch desk has gone live During Q3, following the implementation of the new Cleric CAD our Category 1 response has begun to stabilise towards the nationally agreed ambulance response standards. The Category 2 Performance Improvement Plan including the national Category 2 segmentation pilot continues to ensure patients are receiving the right care in the right place and supports dispatch to our sickest and most seriously injured patients as quickly as possible. An increase in clinical advisors has improved the number of patients that are receiving a remote assessment from a validation clinician. Learning from industrial action has been used to implement a pilot of senior clinical decision making within ICBs utilising senior decision makers from within each ICB We continue to implement an improved hospital handover process that compliments other measures to ensure the timely release of ambulance crews awaiting handover at Emergency Departments. Deploying rapid release for Cat 1 and a number of Category 2 incidents when a DCA is not available to respond.	In view of current performance, and current pressures on the service, the committee can only be partially assured until there is evidence of further delivery against the improvement plan.		

Indicators/milestones

Priorities	Oversight	Q1	Q2	Q3	Q4
Continue to improve clinical outcomes across the organisation, including for patients who have had a stroke and heart attacks	Chief Medical Officer	**ROSC** to hospital 27% Individual **STEMI** bundle components 75% **Stroke** on scene time for patients conveyed direct to a HASU (crew decision) 43 mins	**ROSC** to hospital 28% Individual **STEMI** bundle components 78% **Stroke** on scene time for patients conveyed direct to a HASU (crew decision) 38 mins	**ROSC** to hospital 28% Individual **STEMI** bundle components 79% **Stroke** on scene time for patients conveyed direct to a HASU (crew decision) 36 mins	**ROSC** to hospital aim 30% / actual 31% Individual **STEMI** bundle components aim 80% / actual 27% **Stroke** on scene time for patients conveyed direct to a HASU (crew decision) 35 mins

Strategic Goal 1 – Provide Outstanding Care for our Patients

				RAG		RAG		RAG	
Deliver the quality objectives relating to patient care, patient and family experience and staff engagement, published in the annual report	Director of Quality	Develop the delivery plan for the quality account		Deliver the commitments for the action plan		Deliver the commitments for the action plan		Deliver the commitments for the action plan	
		RAG		RAG		RAG		RAG	?Q4 delivered / 2022/2023 BP commitment not delivered
Pilot the production of clinical outcome data for a range of conditions linking 111/999/ambulance data with hospital data sets	Director of Strategy	Refine the project to clinical outcome data		Deliver the proposed action plan to share outcome data between providers		Start using the data for improving patient care		Link with the ADS Process	
		RAG		RAG		RAG		RAG	

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 1A Objective 1
IF cases of Covid, or other infection e.g. influenza, increase THEN there will be a significant increase in demand and a reduced availability of staff due to isolation and staffing vacancies LEADING TO longer response times and poorer outcomes for patients.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by 31/3/23				
L	x	C	=	Score
3	x	4	=	12

Controls	**Assurances**
Personal Protective Equipment issued to staff	FIT testing programme for disposable masks
Infection Control measures in place – infection control audits and support from IPC champions	Infection numbers reported monthly and included in Board reports.
Vaccination to help protect staff from Covid and influenza	See Staff wellbeing entry and indicators
Demand controls set out in objective 1.	Adequate spacing in call taking areas and screens between desks where this is challenging
Update to IPC and working safely guidance	Updated each time new national guidance produced and shared widely across LAS using all channels of communication

Further actions

Action	**Date by which it will be completed**
We will continue to monitor the situation and impact of living with COVID, or other infection e.g. influenza, and through attendance at national and regional meetings	Ongoing
Ensure workforce plan is delivered to provide resilience	31/3/23
Ensure lessons from each COVID wave are reviewed and embedded into future planning and actions taken	Completed 31/12/22
Internal influenza vaccination programme to encourage uptake	Completed
Regular briefings through bulletins and TV live reminding on IPC procedures	Completed
IPC study day	Completed

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 1B	**Objective 1**
There is a risk that the increasing backlog of elective care may result in the national focus on elective care leading to de-prioritisation of focus to transform emergency care at a time when UEC demand is increasing.	

Uncontrolled				
L	x	C	=	Score
4	x	3	=	12

Current				
L	x	C	=	Score
2	x	3	=	6

Tolerance by 31/3/23				
L	x	C	=	Score
3	x	3	=	9

Controls	**Assurances**
Recent government policy has given greater assurance that the focus on non-elective care, and investment in ambulance services, will continue to be a high priority.	The LAS continues to work with executives at regional and national meetings to ensure urgent and emergency care is prioritised and our development plans are approved.

Further actions

Action	**Date by which it will be completed**
Influence regional and national bodies to maintain focus on the delivery of UEC	This has been achieved – a significant focus on UEC pan London. Work continues on delivery of plans
Agree and implement influencing plan for all five ICSs that strengthens partnerships with new ICB leadership teams and ICS members (trusts, local authorities, PCNs)	This has been achieved – a significant focus on UEC pan London. Work continues on delivery of plans
Support the co-design of new pathways to enable patients to be managed closer to home and reduce avoidable conveyance to ED	This has been achieved – a significant focus on UEC pan London. Work continues on delivery of plans
Continue conversations at a national level tariff and funding streams for 2022/23 through active participation on national bodies	ongoing
Ambulance performance is a key focus for winter delivery across the wider healthcare system to address hospital handover challenges	Pan London agreement achieved for cohorting and maximum 45 minute handover

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 1C Objective 1
Following the ballots on industrial action a series of strikes are planned which will affect the LAS with a widened scope to include all staff including 111, EOC and front line vehicles. We expect significant staff participation in the strike leading to a reduction in workforce availability to respond to calls, provide health advice, dispatch ambulances and crew ambulances including specialist responders; resulting in a reduction in our ability to provide services resulting in prolonged and/or substantial failure to meet operational performance targets, which will lead to worse patient outcomes, including patient harm up to loss of life. Causes: National pay dispute – with all unions taking industrial action

Uncontrolled				
L	x	C	=	Score
4	x	5	=	25

Current				
L	x	C	=	Score
3	x	5	=	15

Target				
L	x	C	=	Score
4	x	4	=	16

Controls	**Assurances**
Local engagement with the Trade Unions to mitigate risk	NHS Employers
Partnership Agreement - Engagement with the Trade Unions to mitigate risk	Staff Council
Business Continuity Plans and operational management arrangements	EPRSG
Sector level NASPF for sector wide engagement	NASPF
Legislation governing conduct of industrial action	NHS Employers
Command structure on the day of the strike	NHS Employers

Further actions

Action	**Date by which it will be completed**
Continue with action planning to mitigate strike effects including derogation negotiation with unions, deployment of military and other external resources, deployment of clinical volunteers sourced from across London, re-deployment of corporate and other staff, command arrangements on strike days.	ongoing
Support to wider NHS for the Junior Doctors IA	Completed

Strategic Goal 1 – Provide Outstanding Care for our Patients

Objective 2	Improve our emergency response
Lead Executive	John Martin, Chief Paramedic and Quality Officer
Lead Assurance Scrutiny	Quality Assurance Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
Continuous patient safety review processes in place Implement the Clinical Safety Cell to monitor and prioritise held calls Category 2 recovery work stream developed Workforce plan established and recruitment underway Embed an integrated clinical operational governance structure, including revised performance management (Feedback, Focus, Review meetings) External support to identify areas for improvement	In view of current performance, and current pressures on the service, the committee can only be partially assured until there is evidence of further delivery against the improvement plan.		

Indicators/milestones

Description	Oversight	Q1	Q2	Q3	Q4
Deliver sustainable improvement on national performance indicators compared with 2021/22, particularly for call handling and category two ambulance response times, so we are one of the top five in England	Director of EOC/Director of Ambulance Services	Confirm the workforce plans to increase the resource available including call handling and ambulance crews Confirm plan from the 'improving our response to patients' Q1 project Undertake Waste walks and interviews with best practice	Implement the workforce plan actions including recruitment. Deliver learnings, recommendations and action plan from Q1 projects and waste walks.	Achieve a call answering mean of 20s RAG	Achieve a call answering mean of 10s RAG
		RAG	RAG	Achieve an improving C2 mean performance RAG RAG	Improved C2 mean performance to be one of the top 5 performing ambulance trusts. RAG
Review and update clinical model for ambulance dispatch to ensure patients get the right response at the right time.	Chief Medical Officer	Scope clinical safety metrics to ensure that no patient is left without a clinical assessment and plan for longer than 2 times the 90th centile	Reduction in clinical incidents based on levels of harm (death, severe, moderate, low, no) Reduction of complaints relating to longest waits linked with	Implementation of revised clinical model and dispatch	Reduction in longest held call no longer than 1 times the 90th centile.

Strategic Goal 1 – Provide Outstanding Care for our Patients

			scoped trajectory calculated against baseline and best in class.		
		RAG	RAG	RAG Unknown	RAG
Work with our partners to reduce hospital handover delays to achieve standards and improve quality and safety for patients	Director of Ambulance Services	Agree stakeholder forums in each ICS area with representation from Acute trusts and incident delivery function	Agree action plan and improvement trajectory in each ICS	Implement action plans - on track, outcomes are not.	Implement action plans
		RAG	RAG	RAG	RAG
Work with our partners to increase the proportion of 999 patients that access alternative care pathways, particularly frail patients and those with mental health conditions.	Chief Medical Officer	**UCR** – Scope and develop the role out of the ICS paramedic/UCR clinician collaborative **SDEC** – Implement exclusion criteria for crews to take patients directly to SDEC	**UCR** – implemented at SWL ICS **SDEC** – 3 patients to each SDEC/ICS from both 111/999	**UCR** – NEL and NCL go live end Jan 23 **SDEC** – pan London exclusion criteria agreed. MHJRC agreed for all 5 ICS	**SDEC** – 5 patients to each SDEC/ICS from both 111/999.
		RAG	RAG	RAG	RAG

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 2 A **Objective 2**
IF operational demand increases above capacity due to more patients accessing urgent and emergency care, THEN resources will be over-stretched LEADING TO poorer clinical outcomes and inequitable access to services.

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
4	x	5	=	20

Tolerance by 31/3/23				
L	x	C	=	Score
2	x	5	=	10

Controls	**Assurances**
Workforce plan in place	Monitored at People and Culture Committee
The use of volunteers is maximised	
Flexible approach to use of staff including roles and hours/rotas.	Quality directorate have established risk and incident hub to interrogate and learn.
Ongoing communication with acute hospitals on handovers	Twice weekly regional hand over meeting with ICS handover improvement plans designed collaboratively with LAS
Senior and clinical oversight of delays and incidents identify risk and harm through pre-set processes	Early adopter of Patient Safety Incident Response Framework (April 2021) Development of Delays Thematic Reports for each quarter.
Redeployment scheme for corporate staff utilised in times of high demand	At REAP 4 all clinicians working operationally 50-100% of time.
LAS input to national solutions to reduce handover delays	Senior attendance at NASMED and QiGARD and Ambulance Capacity Meeting
Twice weekly staffing and resourcing meeting to review operational	Chaired by Directors – review of staffing levels by hour to identify and mitigate risks
Weekly NHSE London / Commissioner performance meeting	Executive attendance at meeting
Ongoing development of alternative pathways for patients to receive care either remotely or closer to home	Programme lead reporting to CEO and Deputy CEO to develop and embed pathways including urgent care response

Further actions

Action	**Date by which it will be completed**
Recruit to 1650 wte (UK and overseas) as per workforce plan	31/3/2023
Reduce conveyance to Emergency Department to under 50% in all ICSs	31/3/2023
Increase education directorate capacity to meet workforce plan	31/3/2023
Continual Review of dispatch process to assess the safe management of higher acuity patients at times of high demand	Ongoing
Launch Category 2 recovery programme	Established
Establish a clinical safety hub within EOC separate from ECAS	Established

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 2 B **Objective 2**
If hospital handover delays continue at their current levels there is a potential that we will be unable to provide an emergency ambulance response to critically unwell patients within the community which may affect clinical outcomes.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by 31/3/23				
L	x	C	=	Score
3	x	4	=	12

Controls	**Assurances**
Ongoing communication with acute hospitals on handovers understanding current system pressures and instigating timely divert processes.	Monitored at weekly North West London Gold System call
Senior and clinical oversight of delays and incidents identify risk and harm through pre-set processes	Twice weekly regional hand over meeting with ICS handover improvement plans designed collaboratively with LAS
LAS input to national solutions to reduce handover delays	Development of Delays Thematic Reports for each quarter produced using Patient Safety Incident Response Framework
Weekly NHSE London / Commissioner performance meeting	Senior attendance at NASMED and QiGARD and Ambulance Capacity Meeting
Ongoing development of alternative pathways for patients to receive care either remotely or closer to home	Appointment of Pathways Programme lead reporting to CEO and Deputy CEO to develop and embed pathways including urgent care response
Real time balancing of patient transport destinations recognising live system pressures at individual ED sites co-ordinated via the Intelligent Conveyance Desk.	Tactical Operations Centre grip report produced bi-daily
Placing of hospital ambulance liaison officers (HALO) at certain challenged ED sites to improve the handover process between triage nurses and ambulance staff.	
Cohorting process in place to release crews, handing over patients care to ambulance colleagues.	
Rapid release procedure to release crews covering a CAT 1 call in the community, handing over patient care to hospital staff.	
Utilisation of alternative means of conveyance using St John Ambulance volunteers to convey patients not requiring ambulance transportation	

Further actions

Action	**Date by which it will be completed**
Enforce new 45 minute handover protocol with appropriate escalation when required.	End January
Reduce ambulance conveyance to Emergency Department to under 50% in all ICSs	31/03/2023
Continual review of triage and dispatch processes to identify high acuity calls requiring immediate ambulance response	Ongoing
Continuous engagement with local acute trusts to identify improvements in the hospital handover procedures	Ongoing
Maximise use of same day emergency care (SDEC) to reduce unnecessary conveyance of patients to ED's	31/03/2023

Strategic Goal 1 – Provide Outstanding Care for our Patients

Objective 3	Create more integrated and resilient 111 services
Lead Executive	Jacqui Niner, Director of IUEC
Lead Assurance Scrutiny	Quality Assurance Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
We have rolled out our LAS values and Leadership and we have introduced 50/50 roles. Initial introduction of Rotamaster and Clinical Guardian have been introduced and this will be ongoing development as we configure the systems to meet our needs and roll it out across the directorate. Workforce expansion being developed through cross directorate working, i.e. 50/50 role, and introduction of new skillsets and flexible working arrangements across IUEC.	In view of current performance, and current pressures on the service, the committee can only be partially assured until there is evidence of further delivery against the improvement plan.		

Indicators/milestones

Description	Oversight	Q1		Q2		Q3		Q4	
Continue to be one of the top three national 111 providers, as measured by call-answering performance, patient outcomes and the number of referrals to alternative pathways	Director of IUEC	Launch recruitment campaign for new frontline staff to respond to increased demand.		Provide the structured support for Managers (Our LAS, Values and Leadership)		Implement RotaMaster and Clinical Guardian software to improve rostering and clinical Audit - in progress			
		RAG	Green	RAG	Green	RAG	Green		
Establish full digital and a resilient workforce integration of our multi-disciplinary emergency care and urgent care assessment services to enable improved hear-and-treat and consult-and-complete rates for patients	Director of IUEC	Agree the 50:50 Role (Clinical assessment / Ambulance crew) with HR and Finance		Agree the 50:50 roles (CAS / Road). Commence Recruitment		Expand recruitment – targeting joint, part-time and flexible clinical assessment roles		Agree and implement job share / rotational roles with partner providers	
		RAG	Green	RAG	Green	RAG	Green	RAG	Green

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 3A **Objective 3**
Our 111 service operates under five different contracts which are governed by different regulators, contracts, funding, performance, and quality metrics. Calls are distributed across contract boundaries depending on response times leading to a potential mismatch between contacts and activity leading to a risk of reputational damage, quality issues and financial loss.

LAS will continue to work with commissioner's contract negotiation to influence future 111CAS commissioning and use learning/ data to influence change and improvement to allow best management of patients based on their presentation not the number they chose to call.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Ongoing collaborative working with regions and commissioners to design contracts for IUC, to include new quality metrics, KPIs and patient flow pathway.	Weekly regional meetings with regional IUC leads and commissioners
Ongoing internal review of performance and finance to ensure contracts remain viable.	Formal confirmation on how funding will be applied during development
	Fortnightly meetings with CFO and FFR

Further Actions

Action	**Date by which it will be completed**
Work with commissioners to move to Pan London 111 Contract held by LAS	March 2023
Representation as National/ Regional/ ICB 111 and 999 forums to contribute & drive case for change.	Ongoing
Escalation of areas of risk/ improvement required to influence case for change	Ongoing
Work with Region/ Commissioners for local change/ improvement for London patients	Ongoing
Work with wider system Primary Care/ Community Teams to improve integration	Ongoing

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 3B **Objective 3**
There is a risk that if we don't deliver a programme of change within LAS to support delivery of a fully integrated system due to capacity causing delay to completing key deliverables caused by IUC expertise and management capacity within LAS being limited

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Continual review of work stream being introduced	Work with ExCo to highlight any challenges and gain support as required

Further actions

Action	**Date by which it will be completed**
Operational/ training/ clinical/ workforce/ finance/ BI and each area will require a work stream with project support.	February 2023
Project Resource to be identified to support specific work streams	February 2023
Organisational commitment to resourcing and funding service development including backfill key roles to release expertise to needed to deliver objectives	February 2023

Strategic Goal 1 – Provide Outstanding Care for our Patients

Objective 4	Strengthen our specialists' teams response to incidents, threats and risks		
Lead Executive	John Martin, Chief Paramedic & Quality Officer		
Lead Assurance Scrutiny	Audit Committee		
Lead Executive's Assurance statement	Assured ☒	Partially Assured ☐	Not Assured ☐
Positive results from 2 external reviews, discussed at audit committee Full recruitment to teams following a recent recruitment campaign New eSORT training centre established at Beckenham	In view of recent positive external reviews the committee is reasonably assured.		

Indicators/milestones

Description	Oversight	Q1	Q2	Q3	Q4
Identify an alternative site and agree re-location of the hazardous area response team serving the east of the city	Chief Paramedic & Quality Officer		Develop a business case with options for a new location for HART (East) RAG: Green	Find site that meets the criteria of the preferred option Update business case with known financial information	Confirm new location Develop detailed plan for moving to new site including service continuity through transition RAG: Amber
Confirm a new venue for eSORT training which meets the service criteria, including the increased capacity requirements.	Chief Paramedic & Quality Officer	Develop a detailed specification for the alternative training location required by the SORT team RAG: Green	Identify options for the training location Develop detailed plans to move Moved to Beckenham (temporary solution) RAG: Green	Beckenham has been identified and repurposed for SORT training. Move has been completed RAG: Green	Location and size limitations identified. RAG: Amber
Maintain the team's high quality delivery and responsiveness, evidenced by compliance with national standards and specific	Chief Paramedic & Quality Officer	Receive the final formal feedback from NARU on compliance with National Standards	Develop a comprehensive action plan to address the issues and recommendation made in the feedback	Deliver the commitments made in the action plan including staff training	Deliver the commitments in the action plan Prepare and oversee the next annual inspection

Strategic Goal 1 – Provide Outstanding Care for our Patients

feedback from previous inspections							
		RAG		RAG			

Strategic Goal 1 – Provide Outstanding Care for our Patients

BAF Risk 4A Objective 4
IF we do not have sufficient capacity to enact the Business Continuity Plan in the event of a protracted Major Incident (i.e. over 12 hours in duration) THEN we will not be able to respond to routine calls LEADING TO poorer patient outcomes.

Uncontrolled				
L	x	C	=	Score
3	x	5	=	15

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by 31/3/23				
L	x	C	=	Score
2	x	3	=	6

Controls	**Assurances**
Major Incident Plan and Business Continuity Plans in place	Externally assured by NHSE and March 2022 by NARU
Pager and cascade systems in place to call in extra staff	Regular testing undertaken
Pro-active planning for known increases in demands	Staffing levels increased to ensure impact on BAU minimised
Mutual aid and volunteer support	Development of collaborative working practices at large scale events such as the funeral of HM Queen Elizabeth.
Management of non-major incident patients	Use of CSEP and REAP to manage incoming demand Working with other providers to maximise access to alternative pathways
AAR and debriefs to learn lessons	Actions and learning are fed into EPRSG

Further actions

Action	**Date by which it will be completed**
As set out in milestone table above	

Strategic Goal 2 – Build our Organisation

Objective 5	Support our workforce
Lead Executive	Damian McGuinness, Director of People and Culture
Lead Assurance Scrutiny	People and Culture Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
• Establishment has increased by over 400 WTE year to date • We have managed to increase existing workforce availability through various work streams (retention / absence / etc.) • Improving our employment offer to existing and new staff through education, learning and development and diversity	Given current and persistent pressures on the workforce the committee can only be partially assured until there is evidence of further delivery against the workforce plan		

Indicators/milestones

Description	Oversight	Q1	Q2	Q3	Q4
Deliver an ambitious recruitment programme, leading to a net increase of frontline staff of more than 400 whole-time equivalents.	Director of People & Culture	2022/23 recruitment plans to be agreed by ExCo and budgeted accordingly. Recruitment drive in Australia to be commissioned	Review success of Australian recruitment drive & national NHSP advert for call handling strategy	Review of all recruitment campaigns and agree revised methodologies for remaining posts	Review of all recruitment campaigns and agree revised methodologies for remaining posts
		RAG	RAG	RAG	RAG
Improve further our compliance with the NHS's workforce race equality standards and workforce disability equality standards.	Director of People & Culture	Renewed CEO commitment to delivery of the WRES Action Plan via annual objectives. Formal re-launch and funding of staff networks. B-ME Network Executive Lead is our CEO.	Embed new recruitment practice following Our LAS masterclasses training	Review implementation of Resolution Framework and impact on BAME staff; Demographic data of those involved in cases to be reported by the Resolution Hub on a quarterly basis.	Launch anti-racism campaign/pledge and See Me Campaign.
		RAG	RAG	RAG	RAG
Review all our structures so that every member of staff has a line manager who has sufficient time and skills to be an effective leader	Chief Executive / Director of People & Culture	Exploration of current team model, desired outcome and funding available	Socialise desired team model	Embed new team model with associated Our LAS leadership behaviour framework	Review current team model and address any shortfalls
		RAG	RAG	RAG	RAG

Strategic Goal 2 – Build our Organisation

Expand our educational capacity, both estate and courses.	Director of Education	Secure lease for expansion at Brentside Clinical Education Centre. RAG (green) **Develop the operational plan** for the blended learning / digital education plans. **Develop workforce plan** for establishing Driving Education Academy. **RAG** (amber)	ExCo paper scoping paper for third Clinical Education Centre in South London RAG (green)	Complete the move into new capacity at Brentside Education Centre RAG (amber)	Complete the business case for a Third Clinical Education Centre. RAG (amber)
Publish and implement an action plan to reduce violence and aggression towards our staff and support them more effectively.	Director of Quality	Publish the Reduce violence and aggression action plan RAG (green)	Implement the commitments of the Reduce Violence and Aggression action plan RAG (green)	Implement the commitments of the Reduce Violence and Aggression action plan RAG (green)	Implement the commitments of the Reduce Violence and Aggression action plan RAG (green)
Make significant reductions in unplanned and sickness absence, achieving lowest unplanned absence rates compared to other ambulance services.	Director of People & Culture	Initial meeting of the improving sickness absence group following May PCC Signing of contract and implementation period of first day absence reporting service run by Goodshape; Transition to new OH provider. Agree recovery plan and revised 6% KPI RAG (green)	Management of 6% trajectory OPMs to review progress in each service. OPMs to review progress in each service Contact monitoring Review feedback of service RAG (green)	Embedding of first day reporting and performance management of contract; On-going performance review RAG (green)	Review of actions taken in previous quarters - with aim of maintaining 6% KPI RAG (green)
Offer improved occupational health provision, increasing staff health and wellbeing support.	Director of People & Culture	Re-tender and appointment of Occupational Health provider RAG (green)	Start to implement Royal Foundation Mental Health Commitment at work. Prepare for 2022/23 Flu season, review. Improve mobile wellbeing provision RAG (green)	Contract management RAG (green)	

Strategic Goal 2 – Build our Organisation

BAF Risk 5A: Objective 5
If our recruitment and retention strategy fails to account for the needs of the modern workforce across London THEN we will not be able to maintain a sufficiently skilled workforce LEADING TO a reduction in the quality of care.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
18-month recruitment and retention plan in place	P&C report performance to the Trust Board and PCC demonstrating we are making some progress but slightly below plan on recruitment
International Recruitment Partner in Place	P&C Director's update to the Trust Board and PCC showing positive impact seen from Nov 2021
Agreed retention programmes in place	P&C Report to the Trust Board and PCC detailing retention
Vacancy management and recruitment systems and processes	P&C OPM reporting
Working with NHS England and Ambulance Sector on joint campaigns	Recruitment workforce group bi weekly meeting

Further actions

Action	**Date by which it will be completed**
Review team structures and operational roles to improve support for staff and provide progression opportunities for a more diverse workforce	March 2023
Recruit 477 additional paramedics	March 2023
Recruit 500+ Assistant Ambulance Practitioners (AAP) from our local population	March 2023
Develop the operational plan for the blended learning / digital education plans.	Ongoing
Develop workforce plan for establishing Driving Education Academy	Ongoing
Identify sites for expanding our education provision both short and long term	Ongoing
Develop guidance for use across the Trust for inclusion objectives, reasonable adjustments and a commitment to anti-racism	March 2023
Outreach Programmes to support with Recruitment and address EDI objectives e.g. Princes Trust, Job Centres, Local community centres, Football Academies	Ongoing
Submission for Silver accreditation of the Armed Forces Covenant which will support further recruitment of Ex-military staff into roles within LAS	Jan 2023
Create a recruitment workforce steering group – to review and ensure that recruitment activity is on target	Complete

Strategic Goal 2 – Build our Organisation

BAF Risk 5B Objectives 5 and 9
If the diversity of our staffing profile is not representative of London, our ability to deliver a more inclusive service and therefore improve patient care will be compromised.
Cause: Recruitment campaigns not attracting diverse applicants, caused in the main by the fact the paramedic profession lacks diversity

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
Established process and reporting for WRES	BME recruitment and retention metrics reported to EXCO, PCC and Trust Board
Recent demographic reporting of recruitment of CTM and CTN	Improvement on Staff Survey Results with BME indicators reported Trust wide.
Our Trust Anti-Racism document is to be agreed at ExCo	Introduction of de-bias recruitment tool kit and interview panel training for all staff.
Re-design and facilitation of new EDI training package for Engaging Leader Programme	BME recruitment and retention metrics reported to EXCO, PCC and Trust Board
Development of a new Cultural Intelligence programme.	BME recruitment and retention metrics reported to EXCO, PCC and Trust Board
Recruitment campaigns that attract diversity	Recruitment KPIS

Further actions

Action	Date by which it will be completed
Proactive approach to encourage all staff to improve and record their protected characteristics, on ESR thereby reducing the difference seen in staff survey.	Ongoing
Alignment of the outputs from our cultural transformation programme, e.g. policies, EQIa and training programmes.	Complete
Introduction of Inclusion Ambassadors to sit on Trust wide interview panels	31/03/2023
Our LAS - behavioural framework	Complete
Our LAS – recruitment toolkit	Complete
Recruitment EDI KPIs	31/03/2023
Commissioning of specialist recruitment campaign	31/03/2023

Strategic Goal 2 – Build our Organisation

BAF Risk 5C Objective 5
IF we do not increase staff wellness THEN sickness absence will remain high and retention will be problematic LEADING TO overreliance on temporary staff, stretching the goodwill of staff at work, increasing costs on recruitment and, ultimately, poorer patient outcomes. Causes: The prolonged time that staff have been working under pressure from COVID 19 and remaining on REAP 4 for long periods at a time – reflected across the ambulance sector

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by 31/03/23				
L	x	C	=	Score
3	x	4	=	12

Controls	**Assurances**
Promotion of the Flu programme with Trust wide flu clinics	Progress of programme reported to Board in PCC Directors report
Wellbeing Strategy	Monitoring of progress via PCC
Robust Sickness absence policy management	Audited sickness numbers, highlights reported to board via directors' report
Risk assessments for at risk staff groups	Reported via Health and Safety Directorate
Staff wellbeing clinics / Staff counselling / OH support	Feedback reported to Board in PCC Directors report
Freedom to Speak Up Guardian and champion networks	Feedback from Q4 will be in PCC Directors report

Further actions

Action	**Date by which it will be completed**
Develop a wellbeing strategy that aligns to P&C Strategy	March 2023
Procurement and implementation of first day absence reporting system	Sept 2023
Review of teams and associated scheduling	March 2023
Embed OH contract	Complete
Immunisation records to be validated and outstanding vaccinations to be addressed	Ongoing – March 2023 desired end point

Strategic Goal 2 – Build our Organisation

BAF Risk 5D	**Objective 5**
If staff report high levels of burnout and / or experience moral distress our ability to maintain a healthy skilled workforce to provide care will be compromised. **Cause**: Longevity of high service demand and increase in operational pressures exceeding available capacity. Moral distress is defined as the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action.	

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe staffing guidance.	Daily performance reviews / meetings / reports
Paramedic agenda embedded both acute and primary care setting to allow more efficient resource utilisation	Daily performance reviews / meetings / reports
The Trust Board will have direct oversight in relation to managing this risk with Assurance provided by PCC / QAC.	Daily performance reviews / meetings / reports
2022/23 workforce plan – establishment growth	Recruitment and Retention Steering Groups
Continuing to regularly review and increase the staff wellbeing offerings	Wellbeing team working to NHSE wellbeing framework – regular meetings with NHSE
Continuing to use temporary staff and offer staff overtime to ensure no disruption to delivery of services	Continuous monitoring of staff sickness/absence - GRS
Absence management recovery plan	Daily monitoring of sickness levels with particular focus on frontline staff
Wellbeing team working to NHSE People plan and suicide prevention rules	Well-being Steering Group
Established Health and Wellbeing hub for all staff to call for general advice and signposting of services.	Wellbeing team working to AACE suicide prevention rules – Regular meetings with NHSE

Further actions

Action	**Date by which it will be completed**
Introduction of a first day sickness management service Trust wide	Complete
Actions from reviewing wellbeing offerings	Ongoing
Complete stress risk training (risk:1048)	Ongoing
OH new provider	Complete

Strategic Goal 2 – Build our Organisation

Objective 6	Develop a positive working culture
Lead Executive	Damian McGuinness, Director of People and Culture
Lead Assurance Scrutiny	People and Culture Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
• Maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development • Ensuring a workforce that is engaged with what the Trust is seeking to achieve – embedded within our revised Trust values • Ensure staff are being supported in their career development and to maintain competencies and training ensuring a positive "well-led" CQC domain & staff engagement score.	Given current and persistent pressures on the workforce the committee can only be partially assured until there is evidence of further delivery against the workforce plan		

Indicators/milestones

Description	Oversight	Q1		Q2		Q3		Q4	
Co-design, launch and embed a new set of Trust values and behaviours	Director of People and Culture	Trust Values and Behaviours will be socialised at the Leadership Masterclasses in May and Launched across the Trust in June 22		Embed new Values and Behaviours in the Trust documents, emails, promotional materials and Trust inductions.		Monitor changes in behaviour as a result of new values.		Use staff survey, questionnaires and focus groups to measure effectiveness of new values and behaviours.	
		RAG	Green	RAG	Green	RAG	Green	RAG	Green
Improve our performance in the NHS staff survey, including the percentage of staff who recommend our Trust as a place to work.	Director of People and Culture	Key themes from 2021/22 Staff Survey have been captured in our Cultural Transformation Programme. 600 line managers to undergo training to reset Trust values and model expected behaviours.		Re-engage with Staff Survey Champions and work with LGMS to agree top three priorities. EDI/OD tea to provide local support and training.		Introduction of local staff survey engagement tool – monitor and address and shortfalls		Review 2022 staff survey results. Remains same as last year – 45% of staff recommending LAS as a place to work.	
		RAG	Green	RAG	Green	RAG	Amber	RAG	Amber

Strategic Goal 2 – Build our Organisation

<table>
<tr><td rowspan="2">Improve the quality and effectiveness of our appraisals, recruitment process and managing inappropriate behaviours in colleagues</td><td rowspan="2">Director of People and Culture</td><td colspan="2">Revised process for appraisals, recruitment and expected behaviour will be socialised at the Leadership Masterclasses in May and launched across the Trust in June 22.</td><td colspan="2">Embed new tools in Trust policies and training materials.</td><td colspan="2">Monitor changes in behaviour as a result of new processes / behaviours.</td><td colspan="2" rowspan="2">Use staff survey, resolution hub and questionnaires with focus groups to measure effectiveness.</td></tr>
<tr><td>RAG</td><td></td><td>RAG</td><td></td><td>RAG</td><td></td></tr>
<tr><td rowspan="2">Create pathways to enable career progression for staff in every part of the organisation</td><td rowspan="2">Director of People and Culture</td><td colspan="2">Engage with key stakeholders including Networks and Unions to Scope Career Pathways.</td><td colspan="2">The new Culture working group will oversee a Talent programme, which will include Career Pathways.</td><td colspan="2">Launch Pilot Career Pathway Programme.</td><td colspan="2">Roll our Career Pathways more widely across LAS. Use staff survey, questionnaire and focus groups to measures effectiveness of the career pathways.</td></tr>
<tr><td>RAG</td><td></td><td>RAG</td><td></td><td>RAG</td><td></td><td>RAG</td><td></td></tr>
</table>

Strategic Goal 2 – Build our Organisation

BAF Risk 6A	**Objective 6**
Current Risk 6A: IF we do not improve our staff culture and survey engagement scores THEN staff will be arguably feel less engaged, potentially LEADING TO poorer patient care. Caused in the main by operational pressures & associated burnout	

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by 31/03/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Protected time to support Leadership Development (24 hours a month)	ESR tracking – and local reporting
Post Our LAS Programme Review.	P&C Director's update to the Board and PCC
Dashboard reporting: • EDI/CDI • LEAP • WRES and WDES data • Retention • Staff survey engagement scores	P&C Director's update at OPMS / PCC / Trust Board
Statutory mandatory and PDR compliance (reporting)	P&C Director's update at OPMS / PCC / Trust Board
Chief Executive's blog / Staff Communication bulletin and leadership development days	References in various Director reports that go to the Board / Board sub committees

Further actions

Action	**Date by which it will be completed**
Develop 2023-2026 People and Culture Strategy	31 March 2023
Aligned EDI/CDI Strategy	31 March 2023
Our LAS Leadership Framework	Complete
Our Behavioural and Competencies Frameworks	Complete
Suite of EDI Training tools	31 March 2023
Comprehensive review of all Policies EQIA	31 March 2023

Strategic Goal 2 – Build our Organisation

<table>
<tr><td>Objective 7</td><td colspan="3">Strengthen & Optimise our Digital and Data Assets</td></tr>
<tr><td>Lead Executive</td><td colspan="3">Barry Thurston, Chief Information Officer</td></tr>
<tr><td>Lead Assurance Scrutiny</td><td colspan="3">Finance and Investment Committee – Critical Systems / Audit Committee – Cyber Security</td></tr>
<tr><td>Lead Executive's Assurance statement</td><td>Assured ☐</td><td>Partially Assured ☒</td><td>Not Assured ☐</td></tr>
<tr><td>The 999 and 111 control rooms are on a manufacture supported telephony platform (CM8) with a move to CM10 due for completion in June 2023
Cleric is now the Trusts computer-aided dispatch system and with successful fail-over tested, we are now about to begin replacing legacy radio and mobile data systems.
Business processes are now being reviewed with a view to increasing the governance and oversight on data collection and data storage.</td><td colspan="3">The recent cyber-attacks on the 111 and 999 systems and the finance systems shows the continuing vulnerability of our key digital systems. Therefore notwithstanding the excellent work on recovery, the committee looks forward to the reports coming to the Board on lessons learnt, so that further strengthen measures can be considered.</td></tr>
</table>

<table>
<tr><td colspan="8">Indicators/milestones</td></tr>
<tr><td>Priorities</td><td>Oversight</td><td colspan="2">Q1</td><td colspan="2">Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td rowspan="5">Deliver a new integrated and standardised computer-aided ambulance dispatch system</td><td rowspan="5">Chief Information Officer</td><td colspan="2">UAT, TTT, Security Testing Farnborough and Corsham Build Server Testing.
Infrastructure modernisation</td><td colspan="2">Staff Training
MDT Development and Deployment Go Live
Infrastructure modernisation</td><td rowspan="5">Action complete
Cleric CAD in operational use 23/09</td><td rowspan="5"></td></tr>
<tr><td>RAG</td><td>Green</td><td>RAG</td><td>Amber</td></tr>
<tr><td colspan="2">Cleric CAD:</td><td colspan="2">Cleric CAD</td></tr>
<tr><td>RAG</td><td>Amber</td><td>RAG</td><td>Green</td></tr>
<tr></tr>
<tr><td>Upgrade emergency operations and integrated care telephony to allow flexible working across sites and lay ground for further modernisation.</td><td>Director of 999 EOC
Chief Information Officer</td><td colspan="2">Complete software update to allow Newham to connect to LAS Telephony network CM8 Go Live</td><td colspan="2">Infrastructure Build and configuration for CM10</td><td>CM10 Go Live</td><td>Commence the removal of the legacy IT / telephony. Further upgrade from Aura CM8 to CM10 required.</td></tr>
</table>

Strategic Goal 2 – Build our Organisation

		RAG		RAG		RAG		RAG	
Migrate the emergency operation centre in Bow to Newham.	Brian Jordan Dir of 999 EOC Barry Thurston - Chief Info Officer			Migration Completed		N/A delivered			
				RAG					
Improve care by enhancing the sharing of our patients' electronic records, joining up data and linking it with our partners' records	Chief Clinical Information Officer	Complete a comprehensive plan for piloting the practical sharing of patient care records		Completion of the mobile (iPad) access to 'OneLondon' Clinical records. Publication of the ePCR photography policy LAA onboarded to LAS ePCR Publication of the recommendations to link up London's maternity data.		Completion of the Transfer of Care (ToC) to see data flow from ePCR into the native Cerner EPR. Publication of ePCR records (St Georges patients only) to the London Care Record		Publication of ePCR records for all ePCR submissions to the London Care Record. Outstanding - Adoption of the Ambulance Data Set into the Trust	
		RAG		RAG				RAG	

Strategic Goal 2 – Build our Organisation

BAF Risk 7A	**Objective 7**
New risk description: There is a risk that the current infrastructure within the Trusts technical architecture is not robust enough to withstand a cyber attack	

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
3	x	5	=	15

Tolerance by 31/3/23				
L	x	C	=	Score
2	x	5	=	10

Controls	**Assurances**
Technical cyber protection, detection and remediation deployed to identify any threats	Included in the Cyber Committee's report to the Board. Functional and need review.
Implementation of Artificial Intelligence threat detection software – single device in Bow. Another device is due to be delivered to Corsham, as a resilient service.	
Cyber security team in place to identify and mitigate cyber threats or incidents	Cyber Committee checks assurances and reports to the board
Procedure checked twice a year by NHSD	Cyber Committee checks assurances and reports to the board
Legacy systems being replaced	DSPT assurance level reported in annual report
Unsupported software being replaced	Annual Penetration test carried out and reported to the Board via the Cyber Committee
All issues related to Cyber logged on Trust CMS (Content Management System)	Demonstrable response to three cyber threats out of hours in the current year
Process in place to address all CareCerts issued by NHS Digital	No current assurances to the Board
	Enterprise Architecture Council (EAC) now in place
	Technical Design Authority (TDA) now in place

Further actions

Action	**Date by which it will be completed**
Cyber security monitoring and assurance - Tenable vulnerability monitoring - weekly scanning of all active windows devices and actioning alerts - Lansweeper – daily check of windows domain and high priority device alerts	Ongoing

Strategic Goal 2 – Build our Organisation

- Windows Defender – automated alerting in place for virus protection on windows devices and actioning where necessary - Zscaler – daily checks of browsing activity - Robust procedure for the acknowledgment and mitigation of NHSD Cyber alerts	
Hardening of internet facing systems	March 2023
Infrastructure refresh completion	June 2023
Compliance with DSPT 2023	June 2023
Recruitment process for cyber SME in place – interviews on 24 February 2023	February 2023
Recruitment process and change of job description for cyber gatekeeper	Complete

Strategic Goal 2 – Build our Organisation

BAF Risk 7B	**Objective 7**
New risk description: There is a risk that our critical systems could fail resulting in the Trusts inability to either answer calls from patients or to be able to dispatch resources to patients	

Uncontrolled				
L	x	C	=	Score
4	x	5	=	20

Current				
L	x	C	=	Score
3	x	5	=	15

Tolerance by 31/3/23				
L	x	C	=	Score
2	x	5	=	10

Controls	**Assurances**
Review of CAD infrastructure and report on telephony system.	Reports provided to COLT and FIC and accepted. Reported to the Board via the Finance and Investment Committee.
CAD performance monitoring	tbc
Annual winter maintenance by CAD vendor on existing database	Telephony resilience tested and proven to work. Data centre network resilience to HQ and BOW tested and works.
Replacement of legacy infrastructure and operating systems	Regular reporting on progress reports to the Board via the Finance and Investment Committee
Migration of infrastructure to Tier three data centres	IMT Delivery Board in place which oversees the work and reports to the Board via the Director of IT's updates.
EOC controls upgraded to CM8 telephone system	No high priority events outstanding for the telephone system
Upgrade of data network to include resilience and failover at Corsham and Farnborough	Demonstrated CAD resilience and recovery
Go live testing for 4 four period the week before go live date	

Further actions

Action	**Date by which it will be completed**
CAD replacement strategy	Complete
Relocate Bow hardware	Complete
Completion of Corsham migration	End of March 2023
Completion of Farnborough migration	June 2023
Relocation of radio systems	Complete
Relocation of North Control function to Newham	Complete
Move IP Office (Fall-back telephony) on to new MPLS network	February 2023 – on track
999 and 111 on supported CM10 telephony platform	August 2023

Strategic Goal 2 – Build our Organisation

BAF Risk 7C **Objective 7**
We previously showed two risks associated to the delivery of the new Cleric CAD system: **Risk 1** - The Trust fails to implement the new CAD system by September 2022 **or** **Risk 2** - The CAD system is implemented on time but system functionality or stability problems result in an unsuccessful implementation. Cleric was successfully implemented in September with only minor issues arising. The risk score has therefore significantly reduced. Two actions need to be completed before the risk can be closed: 1) Conduct an after action review of the project and; 2) Conduct an assessment of the quality and integrity of the system data and business rules including any changes made to the system post go live. These actions will be overseen by the Audit Committee, following which the risk will be removed from the BAF and become business as usual.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
1	x	4	=	4

Tolerance by 30/9/22				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
ExCo continues to receive a fortnightly assurance report from the Programme Team	Lessons learnt report to Audit Committee
QAC clinical review	

Further Actions

Action	**Date by which it will be completed**
Conduct an after action review of the project with stakeholders	TBD
Internal audit and Verita review of data quality to be submitted to Audit Committee and any lessons learnt to be identified.	May 2023

Strategic Goal 2 – Build our Organisation

BAF Risk 7D	**Objective 7**
There is a risk which has been highlighted following the go live of Cleric CAD that systems, practice and processes in place may have led to the incorrect reporting of response times leading to organisational disruption, threats to service delivery and reputational damage. **Cause**: Incorrect processes and use of functionality to meet the Operational needs of the Trust, that do not support correct categorisation of patients both resulting in inaccurate reporting of response times and potential patient risk	

Uncontrolled				
L	x	C	=	Score
4	x	5	=	20

Current				
L	x	C	=	Score
3	x	5	=	15

Tolerance by 30 May 2023				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Cleric CAD cell meeting established to log and resolve issues	Cleric CAD cell team established to remediate the situation
Process in place to highlight and review Category 1 CADs where response times may be incorrectly recorded and reported	Directors meeting daily to review progress
Engagement with AACE subject matter experts to support understanding and implementation of correct processes	External review to assess any incorrect reporting
CAD transformation team established under Stuart Crichton's leadership	Received BDO Audit report on selected key performance indicators

Further Actions

Action	**Date by which it will be completed**
Internal audit of data quality to be submitted to Audit Committee	April 2023
Lessons learnt identified from Verita report to be delivered	TBD
Lessons learnt from BDO Audit to be delivered	End September 2023
Establishment of Digital Strategy and Data Quality Committee	Q1 23/24
Commissioned an audit of documentation for ETL process	End April 2023

Strategic Goal 2 – Build our Organisation

BAF Risk 7E Objective 7
The Trust are looking to establish a new solution to replace the existing Mobile Data Terminals (MDTs) in trust emergency vehicles (to provide information between CAD and Ambulances) to follow the national rollout of radio and mobile data systems to all Trusts. However, that programme of work has been considerably delayed and the Trust finds itself with legacy system still in operation that is no longer available to purchase, and devices are rapidly reaching the end of their economic life. **It is unlikely that the full national system will be available in time for this situation not to become a major issue for the Trust and therefore an interim system to bridge the period is a necessity.** **Without an appropriate solution LAS will not be able to fit new vehicles with MDTs or replace those that break in service, potentially resulting in vehicles being withdrawn from service.** **The national Mobile Data Vehicle Solution (MDVS), which will replace MDTs is currently due to start 01/12/2023**

Uncontrolled				
L	x	C	=	Score
4	x	5	=	20

Current				
L	x	C	=	Score
4	x	5	=	20

Target				
L	x	C	=	Score
1	x	5	=	5

Controls	**Assurances**
Purchased all available MDT stocks from incumbent supplier (for delivery 20/01/2022)	Completed. All 14 devices delivered to Telent (22/02/2023)
Manage and monitor the existing MDT spares stock with our installer (Telent), and assist in expediting repairs with incumbent supplier (Attobus)	Active engagement with Telent and Attobus Current stock numbers being provided on an ongoing weekly basis. Telent have confirmed they over counted allocated stock which has reduced the available stock

Strategic Goal 3 – Develop our Future

	Stock figures currently tracking above initial predictions and being monitored weekly
Lobby national ARP Project Team to bring forward MDVS rollout in LAS	Weekly meeting established alongside Project Board and Working Group
Pilot Cleric MDT and NMA Lite to identify interim MDT solution	Cleric and ARP actively engaged and pilots are moving forwards. Cleric MDT Testing conducted 6th and 11th April. Cleric progressing fixed. Pilot due to start second half of April NMA Lite available; meetings underway with National Programme to agree config updates prior to pilot. YAS site visit cancelled by YAS due to go-live. Awaiting new date from YAS.
ePCR system in place that will receive patient demographics with some interface adjustments	Alternative means of receiving data in the cab

Further actions

Action	**Date by which it will be completed**
Options paper submitted to ExCo with recommended solution	Complete
Purchase Android Tablets	Complete
Enabling works for Cleric MDT Pilot	Complete
Implement agreed recommendation from ExCo Paper	Complete
Enabling works for NMA Lite Pilot	31/05/2023 – Delayed due to Cleric MDT work progressing.
Pilot replacement interim solution (Cleric MDT) on 2 Apple Devices at Oval	05/05/2023 – Delayed by 5 weeks
Pilot replacement interim solution (NMA Lite) on 2 Android Devices at Oval	31/06/2023
Review plans for vehicles with no MDT capability (using Cleric MDT)	31/06/2023

Strategic Goal 3 – Develop our Future

Review LAS vehicles with MDTs that haven't been used for 1+ months	14/05/2023

Strategic Goal 3 – Develop our Future

Objective 8	Use of resources more efficiently and productively
Lead Executive	Rakesh Patel, Chief Financial Officer
Lead Assurance Scrutiny	Finance and Investment Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
• The Trust posted a year to date surplus of £1.1m as at the end of February 2023 against a deficit plan of £0.4m, a favourable variance of £1.5m. • The Trust is on track to deliver the year end plan to breakeven. • The Trust is forecast to invest £31.2m on capital programmes for the year. By the end of February the Trust had spent £21.2m. This £1.8m behind plan, however this is concentrated in a few schemes with plans to bring back on track by year end. • The Trust had a closing cash balance of £60.6m at end of February.	The committee can only be partially assured until the CIP programme recovers to plan and wishes to undertake a deep dive in under-performing areas at its next meeting.		

Indicators/milestones

Priorities	Oversight	Q1		Q2		Q3		Q4	
Deliver our agreed control total for 2022/23 including the successful delivery of our cost improvement programme.	Chief Financial Officer	Resolve outstanding income issues with ICSs. Develop detailed CIP plans and governance framework		Monitor delivery of CIP plan through Governance framework. Monitor I&E delivery and identify mitigations if required.		Monitor delivery of CIP plan through Governance framework. Monitor I&E delivery and identify mitigations if required.		Monitor I&E delivery and identify mitigations if required. Prepare for year end close down	
		RAG		RAG		RAG		RAG	
Return to pre-pandemic levels of operational productivity.	Chief Financial Officer	Develop efficiency metrics as part of CIP Programme		Monitor delivery as part of CIP programme		Monitor delivery as part of CIP programme		Monitor delivery as part of CIP programme	
		RAG		RAG		RAG		RAG	
Deliver the capital programme for 2022/23 and secure any available additional funding.	Chief Financial Officer	Develop detailed plans for the "core" programme		Monitor capital plan. Develop plan for schemes within "over-programme" pot Access any in-year allocation		Monitor capital plan. Develop plan for schemes within "over-programme" pot Access any in-year allocation		Monitor capital plan Prepare for year-end If appropriate deliver schemes from "over-programme" budget Develop capital plan for 23/24	
		RAG		RAG		RAG		RAG	

Strategic Goal 3 – Develop our Future

BAF Risk 8A **Objective 8**
IF the Trust does not deliver the financial plan for 2022/2023, there is a risk that expenditure might exceed agreed income levels leading to regulator/commissioner intervention.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
2	x	4	=	8

Tolerance by End of Q4				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
2022/2023 financial plan submitted to NHS England on 20 June 2022	Delivery against the financial plan is scrutinised through: ExCo, FIC, Trust Board
CIP governance framework in place.	FIC assured at January meeting, that on review of finance report the risk had reduced and the score could be brought down
CIP Programme Management Office also established	Regularly oversight by CIP Programme Board and assurance reports to FIC
	Gaps in assurances A small number of CIP schemes require further development

Further actions

Action	**Date by which it will be completed**
QIAs to be completed. PIDs have been developed	End of Q3

Strategic Goal 3 – Develop our Future

BAF Risk 8 B Objective 8
There is a risk that the Trust will not have the required number of ULEZ compliant vehicles to achieve compliance with ULEZ regulations by October 2023, resulting in possible daily fines for each non-compliant vehicle entering the ULEZ zone. **Cause: Commissioning contract stipulates the Trust needs to draw from the national procurement of vehicles which is a single supplier who have currently closed their order books.** **Update: The November FIC approved a plan to procure compliant vehicles and the risk has now significantly reduced**

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
2	x	4	=	8

Tolerance by End of Q4				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Memorandum of understanding in place with the Mayor's office to provide a dispensation from any ULEZ fines until October 2023.	Signed MOU
Approval by NHS England for a procurement contract for 19 ambulances with another provider (currently being fulfilled)	Derogation approval letter from Director for Community Care, Mental Health and Ambulance Improvement Support (NHSE) Inspection of first vehicle on 2nd August
	Gaps in assurance 130 vehicles are currently non-compliant Delay on delivery of the 19 ambulances on order Sufficient funding to replace remaining non-compliant vehicles

Further actions

Action	**Date by which it will be completed**
Applying for further derogation for 39 diesel ambulances and 4 electric ambulances	Completed
Exploring additional funding streams for replacement ambulances (Green Bonds)	31 March 2023
FIC approval for purchase of complaint vehicles	completed

Strategic Goal 3: Develop our Future

BAF Risk 8 C Objective 8
IF the Trust does not receive approval of a deliverable financial plan for 2023/2024, there is a risk that expenditure might exceed agreed income levels leading to regulator/commissioner intervention.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Draft 2023/20224 financial plan for submission to NHSE as per national timetable (yet to be published)	Delivery against the financial plan is scrutinised through: ExCo, FIC, Trust Board
	Regularly oversight by ExCo during development of plan and assurance reports to FIC

Further actions

Action	**Date by which it will be completed**
Issue business and financial planning guidance and timescale for 22/23.	Complete
Develop financial plan (including I&E, Cost Improvement and efficiency plan, capital and cash)	Planning to be completed by March 2023
Continue working with NWL ISC (as host commissioner) and London regional office during contracting process. discussions with commissioners and regulators over 22/23 budget	Planning to be completed by March 2023

Strategic Goal 3 – Develop our Future

Objective 9	Build our role as an anchor institution that contributes to life in London
Lead Executive	Roger Davidson, Director of Strategy and Transformation
Lead Assurance Scrutiny	Audit Committee

Lead Executive's Assurance statement	Assured ☐	Partially Assured ☒	Not Assured ☐
We have made good progress across the various projects under this heading which encompass many parts of the organisations. Some have been affected by changing priorities in response to operational pressures in particular the research on diversity. We have however made good progress on defining our role as an anchor institution which will be a key feature of our strategy. This will focus on delivering our green strategy, being a good employer, spending our money to benefit communities where possible and expanding and targeting our public education.	The committee notes the variable state of development of the various actions under this domain, and mixed RAG rating of the milestones. It looks forward to the identification of key risks by the time it next meets and an understanding of the drivers of the RAG ratings and how they might be put back on track.		

Indicators/milestones

Priorities	Oversight	Q1	Q2	Q3	Q4
Ensure the transition in house of the Make Ready service delivers the benefits to the staff and our service set out in the business case	Chief Financial Officer	Embed insourced team to feel part of LAS RAG	Continual review of business case to identify and deliver efficiencies RAG	Review the options to expand the scope of the Make Ready service to include more LAS vehicle cohort	Deliver the benefits expressed in the Business Case RAG
Ensure entry level recruitment is representative of the communities and populations we serve across London	Director of People & culture, Director of Strategy and Transformation, Chief Paramedic & Quality Officer	Recruit to newly established EDI team - particular focus on EDI specialist recruitment knowledge. Collaborate with NHE/I on anchor network RAG	Recruitment strategies to be commissioned. Recruit public education lead to support – through educational activity – the recruitment of staff and volunteers from diverse communities RAG	Develop and implement Public Education Strategy that encourages diverse local communities to work at LAS, including children and young people RAG	Delivery of Public Education Strategy (on-going) Review of all recruitment campaigns and agree revised methodologies for failed campaigns.

Strategic Goal 3 – Develop our Future

Actively promote paramedicine as a career pathway to diverse student communities in London	Director of People & culture, Director of Strategy and Transformati on, Chief Paramedic & Quality Officer	Initiate research to define the specific issues and challenges with respect to diversity in para medicine. Join with other partners including AACE support collective view	Discuss findings of research with HEE and LAS education partners including universities Agree action plan with partners and Health education team	Implement action plan to support more diverse recruitment including working more closely with targeted London Communities Postponed until 23/24	Implement action plan to support more diverse recruitment including working more closely with targeted London Communities Postponed until 23/24
		RAG	RAG	RAG	RAG
Ensure at least 10 per cent of our 1,000-plus vehicles are electric or plug-in hybrid electric	Rakesh Patel – Chief Financial Officer	38 new hybrid vehicles brought into use.	Start on developing charging infrastructure Start receiving electric FRUs and mental health cars	Receive the remainder of the 220 vehicles	Start developing plans for 23/24 fleet procurement.
		RAG	RAG	RAG	RAG
Recruit 7000 London Lifesavers and deliver 8000 public access defibrillators across London.	Dir of Comms & Engagement	Host London Lifesavers Awards - raises awareness and recognition.	Launch a dedicated comms & engagement plan to raise awareness and increase recruits.	Hosting a number 'restart a heart event' (where high numbers of people are trained at high profile)	
		RAG	RAG	RAG	
Deliver sessions on health and prevention of harm for children and young people across the capital.	Dir of Comms & Engagement	Visual planner to measure each staff member / volunteer activities and the topics covered (to monitor progress)	Promotion of team commenced to raise profile & key messages. Recruit Public Education Lead	Expanding volunteer database – objective is to have 100 additional volunteers by December. Develop and Launch Public and Education Strategy.	Updating our Education / PPI resources – including enhancing the accessibility of our resources. Delivery of Education Strategy (on-going)
		RAG	RAG		RAG

Strategic Goal 3 – Develop our Future

Objective 10	Develop a new five-year strategy to improve services for the communities we serve
Lead Executive	Roger Davidson, Director of Strategy and Transformation
Lead Assurance Scrutiny	Finance and Investment Committee

Lead Executive's Assurance statement	Assured ☒ Partially Assured ☐ Not Assured ☐
We have made good progress on engagement; engaged 350 more leaders in events across LAS, completed a major crowdsourcing project in which some 500 participated, completed 375 interviews with front line staff, on track to achieve our target of 600, commissioned 23 Health watches to carry out public engagement, reached out to key stakeholders ICSs, health/wellbeing boards, social care leaders and GPs, developed plans for engagement with acute hospitals, primary care, the GLA and London UEC board, engaged with ICBS and London Estates Board on estates strategy and we are preparing socialise this more widely. On content, our workstreams have produced a first cut of their strategic priorities. The key task for the LAS leadership in January is refine this content, ensuring alignment with 23/24 business planning. To support operational pressures, the target for completion of the strategy project has been put back to the end of Q1 23/34.	The committee is pleased with the progress at this early stage is assured that the development of the strategy is on track.

Indicators/milestones

Priorities	Oversight	Q1	Q2	Q3	Q4
Co-produce, with our partners and patients, a five-year strategy focused on health inequality, to commence in April 2023.	Director of Strategy and Transformation	Scoping strategic with our internal and external leaders including all ICS's. Board development session with major focus on health inequality.	Engage with partners of the challenges priorities and ambition for LAS	Continuing engagement and policy development Final publication moved back to June 2023 to free management time to address service pressures	The strategy will be ready to begin formal governance processes, ahead of Trust Board agreement in June 2023. Moved back to July / September 2023.
		RAG (Green)	RAG (Green)	RAG (Green)	RAG (Amber)
Co-produce an estates strategy with incremental implementation from 2022/23 onwards.	Chief Financial Officer	Set up programme	Publish Estates options paper following agreement with Trust Board	Formally engage with stakeholders to obtain feedback on the options	Publish an agreed strategy Start implementation of agreed strategy
		RAG (Green)	RAG (Amber)		

Strategic Goal 3 – Develop our Future

Increase collaboration with primary care, working with primary care networks and contributing to implementation of the Fuller Stocktake recommendations.	Chief Medical Officer / IUC Medical Director	Agree contracts of support with next cohort of PCNs Scope LAS response to the Fuller Stocktake	Start rotational placements with three new PCNs Identify the priorities and developed an action plan from the Fuller Stocktake RAG	Agree additional PCNs looking for support from LAS paramedics Plan and deliver Fuller Stocktake action plan with partners	Plan and deliver Fuller Stocktake action plan with partners RAG
Continue to develop new and innovative ways of working with our partner organisations and across the Trust.	Director of Strategy and Transformation	Collect and analyse data to guide opportunities for new ways of working RAG	Complete review on the feasibility of joint response community cars RAG	Agree priorities areas where new models / innovation is required. RAG	Scoped, defined and agreed new models with partners, ready for implementation. RAG

Strategic Goal 3 – Develop our Future

BAF Risk 10 A **Objective 10**
Risk description: There is a risk that if we fail to achieve alignment with a complex range of external partners we may not subsequently achieve our strategic objectives

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: 31/3/23				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
Internal and external engagement plan in progress and being developed to build the consensus for the strategy	Reviewed by Executive Committee (ExCo)
	Specific topics reviewed by Board sub committees as appropriate e.g. P&C, FIC
	Approach to be reviewed at planned Board Development days

Further actions

Action	**Date by which it will be completed**
Develop a health inequalities action plan alongside commissioners	31 March 2023
Develop a shared, rotational PCN model with the primary care networks in London	31 March 2023
Develop an updated estates modernisation strategy in collaboration with staff and partners	31 March 2023
Define and agree new models (for ways of working) with partners	31 March 2023
Developing links to external partners	Ongoing

9. Concluding Matters

For Assurance

9.1. Any other business (Verbal)

For Noting

9.2. Date of Next Meeting – Thursday 20 July 2023

For Noting

Presented by Andy Trotter

9.3. Questions from Members of the Public
(Verbal)

For Noting

Presented by Andy Trotter

NB: The full and summary IPR is on the website and in the library in Convene