Trust Board Meeting in Public

Schedule	Thursday 5 September 2024, 12:30 — 16:30 BST
Venue	Prospero House, 241 Borough High Street, SE1 1GA and via MS Teams
Organiser	Committee Secretary

Agenda

12:35	3. Patient Story For Information - Presented by Roger Davidson	26
	3.1. Development of a responsive sickle cell service - to hear from service users For Information - Presented by Roger Davidson	27
	4. Chair and Chief Executive Report For Information	28
13:05	4.1. Report from the Chair For Information - Presented by Andy Trotter	29
13:10	4.2. Report from the Chief Executive For Information - Presented by Daniel Elkeles	30
	4.2 Report from the CEO September 2024.pdf	31
13:15	4.3. 2024/25 Manifesto for the Southern Ambulance Services Collaboration (SASC) For Information - Presented by Daniel Elkeles	41
	4.3 Cover Sheet_SASC_Manifesto_T.Board_September2024.pdf	42
	4.3.1 SASC 2024-25 Manifesto Public Board Paper.pdf	43
	4.3.2 SASC 2024-25 Manifesto poster.pdf	47
	5. Director and Board Committee Reports	49
13:20	5.1. Performance Operational Performance Report For Assurance - Presented by Pauline Cranmer	50
	5.1 Cover Sheet_Perf_Report_T.Board_September2024_draft.pdf	51
	5.1.1 Performance Board Report for September 2024 V3.pdf	53

Agenda

London Ambulance Service NHS Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS

12.30pm on Thursday 5th September 2024
at Prospero House, 241 Borough High Street, London SE1 1GA

AGENDA

Time	Item	Subject	Lead	Action	Format
1. Opening Administration					
12.30pm	1.1	Welcome and apologies for absence	Chair	Note	Verbal
	1.2	Declarations of interest	All	Approve	Verbal
2. General Business					
12.30pm	2.1	Minutes of the Public Meeting held on 6th June 2024	Chair	Approve	Report
	2.2	Action Log	Chair	Review	Report
3. Patient/Staff Story					
12.35pm	3.1	Development of a responsive sickle cell service To hear from service users	RD	Inform	Present
4. Chair and Chief Executive Report					
1.05pm	4.1	Report from the Chair	Chair	Inform	Verbal
1.10pm	4.2	Report from the Chief Executive	CEO	Inform	Report
1.15pm	4.3	2024/25 Manifesto for the Southern Ambulance Services Collaboration (SASC).	CEO	Inform	Report
5. Director and Board Committee Reports					
1.20pm	5.1	**Performance** 5.1 Operational Performance Report: Chief Paramedic	PC	Assure	Report
1.40pm	5.2	**Quality** 5.2.1 Quality Report: CMO and Deputy CEO 5.2.2 Quality Assurance Committee Report	FW MSp	Assure	Report
2.00pm	5.3	**People and Culture** 5.3.1 Director's Report 5.3.2 People and Culture Committee report 5.3.3 EDI Committee Report	DMG AR AR	Assure	Report
2.20pm	5.4	**Finance** 5.4.1 Director's Report 5.4.2 Finance and Investment Committee Report 5.4.3 Audit Committee Report	RPa BA RP	Assure	Report

		5.4.4 Charitable Funds Committee Report	BA		
2.40pm	5.5	**Corporate** 5.5.1 Director's Report	ME	Assure	Report
2.45pm	5.6	**Digital and Data** 5.6.1 Digital and Data Committee Report	SD	Assure	Verbal
6. Strategy- LAS Digital Strategy					
2.55pm	6.1	**LAS Digital Strategy** 6.1 To approve the LAS Digital Strategy	CM	Approve	Report
7. Planning – LAS Business Plan					
3.10pm	7.1	Update on Trust Business Plan for Q1	RD	Approve	Report
8. Assurance					
3.15pm	8.1	Risk Appetite Statement	ME	Approve	Report
3.20pm	8.2	Board Assurance Framework	ME	Approve	Report
3.25pm	8.3	London Ambulance Service Public and Patient Council (LASPPC) update	RD	Note	Report
9. Concluding Matters					
3.30pm	9.1	Any Other Business	All	Note	Verbal
	9.2	Date of Next Meeting – Thursday 5th December 2024	Chair	Note	

Annual Public Meeting				
3.30 to 4.30	2023/24 Accountability Statements: • CEO overview • 2023/24 Annual Report and Accounts • 2023/24 Quality Account • RES and DES Questions from the public	DE RP FW RD	Note	Report

1. Opening Administration

1.1. Welcome and apologies (verbal)

For Noting

Presented by Andy Trotter

1.2. Declarations of Interest (Verbal)

For Approval

2. General Business

2.1. Minutes of the Public Meeting held on 6th June 2024

For Approval

Presented by Andy Trotter

London Ambulance Service NHS Trust

Meeting in Public
LONDON AMBULANCE SERVICE NHS TRUST BOARD OF DIRECTORS
held at 12.30pm on Thursday 6th June 2024 at Prospero House, 241 Borough High Street, London SE1 1GA

Present		
Andy Trotter	AT	Chairman
Rommel Pereira	RP	Deputy Chair and Non-Executive Director
Anne Rainsberry	AB	Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Bob Alexander	BA	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Karim Brohi	KB	Non-Executive Director
Shera Chok	SC	Non-Executive Director
Bob Alexander	BA	Non-Executive Director
Daniel Elkeles	DE	Chief Executive
Rakesh Patel	RP	Joint Deputy Chief Executive and Chief Finance Officer
Fenella Wrigley	FW	Joint Deputy Chief Executive and Chief Medical Officer
Damian McGuinness	DMG	Director of People and Culture
Pauline Cranmer	PC	Chief Paramedic Officer
Mark Easton	ME	Director of Corporate Affairs
Roger Davidson	RD	Director of Strategy and Transformation
Clare McMillan	CM	Chief Digital Officer
In Attendance		
Nora Hussein	NH	Head of Corporate Governance
Apology for Absence		

1.OPENNG ADMINISTRATION		
1.	**Welcome and Apologies** The Chairman welcomed all present to the meeting.	
2.	**Declarations of Interest** There were no new declarations of interest.	
2. GENERAL BUSINESS		
2.1	**Minutes of the Previous Public Board Meeting** The Minutes of the previous public meeting of the Board held on 26th March 2024 were approved as a correct record.	

2.2.	**Action Log** There were no outstanding actions on the action log.	
3. PATIENT AND STAFF STORY		
3.1	Tom Baverstock Clinical Team Manager – Wimbledon Ambulance Station attended and provided a presentation to the Board on Teams Based Working and Debriefs. Tom's Background: Tom introduced himself, highlighting his 14 years of service and his role as the manager of Team 1, Wimbledon. Team-Based Working: Tom provided an overview of team-based working within the London Ambulance Service. He described how this model has been implemented, focusing on its impact on team cohesion and patient outcomes. The team consists of 17 paramedics, including students and apprentices. The team works on a shift system, which allows consistent interaction and support among members. Huddles: Tom detailed the routine of conducting huddles at the start of each shift. These huddles serve as an opportunity to catch up, discuss updates from the medical director, review clinical cases, and share experiences. Case Study: A specific case was discussed where the team managed a cardiac arrest. Tom highlighted the collaborative effort, with more experienced paramedics guiding less experienced ones through the procedure. The patient was successfully resuscitated and transported to Saint George's Hospital. Debriefing: The team held a debriefing session post-incident to review what went well and areas for improvement. Tom emphasised how team-based working facilitated this learning process. When asked how well-being issues are identified and managed during huddles. Tom responded by explaining his approach to monitoring team dynamics and addressing issues early. He emphasised the role of daily interaction in building a supportive environment. The Board discussed the potential benefits and challenges of extending the team-based working model to other teams within the organisation. They recognised the success of the model in fostering team cohesion and improving patient outcomes, but also noted the challenges in implementing it across diverse teams with different dynamics. A discussion ensued on the importance of leadership skills in managing high-stress incidents, such as cardiac arrests. The Board acknowledged the value of the Clinical Leadership Resolution Package and discussed ways to further support the development of these skills across the organisation.	
4. CHIEF EXECUTIVE REPORT		
4.1	**Report from the Chair** The Chairperson provided an overview of key activities and developments since the last Board meeting:	

	The Chair attended several key stakeholder meetings, including interactions with NHS England representatives and local government officials. These meetings focused on enhancing collaboration and securing continued support for the LAS initiatives. Specific mention was made of a meeting with the Integrated Care Systems (ICS) finance leaders, where the Chair emphasised the importance of a clear and consistent budget-setting process that aligns with LAS's operational needs. The Chair conducted site visits to various LAS stations and hospitals to observe the implementation of the "Right Care, Right Person" initiative in action. During these visits, the Chair engaged with frontline staff, gathering feedback on the current challenges and successes of the initiative. A highlight was a visit to a LAS station where the Chair observed a simulation exercise involving chemical, biological, radiological, and nuclear (CBRN) training. The Chair commended the realism and effectiveness of the training, particularly the real-time injects used to enhance learning. The Chair expressed concern about the ongoing uncertainties in the budget-setting process with the ICS, stressing the need for a more transparent and fair approach. The Chair highlighted that this issue could impact LAS's ability to meet performance targets and deliver high-quality care. The Chair committed to advocating for a more structured and predictable financial planning process in future meetings with ICS leaders. The Chair acknowledged the rising incidents of stress and well-being concerns among staff, particularly in light of the increasing demand for LAS services. The Chair praised the efforts of operational managers in recognising and addressing these issues but noted that more needs to be done to support staff on the front lines. The Chair reiterated the importance of the ongoing team-based working initiatives, emphasising that these should be expanded to provide consistent support across all teams. Building on the successes reported by Tom and other managers, the Chair emphasised the need to scale the team-based working model across more teams. This would involve customising the approach to fit different operational contexts within LAS. The Chair encouraged the Board to consider how best to support this initiative, including the potential need for additional resources or training. The Chair highlighted the importance of maintaining strong relationships with key stakeholders, including NHS England, local government, and community organisations. The Chair noted that effective communication and collaboration with these stakeholders would be crucial in navigating the financial and operational challenges ahead. Plans were discussed for hosting a series of stakeholder engagement events to strengthen these relationships and ensure alignment on key issues. The Chair commended the operational teams for their exceptional handling of several high-pressure incidents in recent weeks, including a series of complex emergency responses. The Chair particularly noted the professionalism and dedication shown by staff in these situations.	

	A special mention was made of the teams involved in the recent patient case discussed earlier in the meeting, highlighting their exemplary teamwork and clinical skill. The Chair praised the Clinical Team Managers (CTMs) for their leadership during critical incidents, noting the positive feedback received about the Clinical Leadership Resolution Package. The Chair emphasised the importance of continued leadership development to ensure that all CTMs are equipped to handle the challenges of their roles. In closing, the Chair reiterated the Board's commitment to supporting LAS staff and ensuring that the organisation continues to provide high-quality care to the public. The Chair called for continued focus on strategic priorities and collaboration among all levels of the organisation.	
4.2	**Report from the Chief Executive** The CEO provided a comprehensive update on the operational performance since the last board meeting. The CEO reported that LAS had successfully improved its Category 1 response time to an average of 7 minutes and 29 seconds, which is a 1 minute and 3 second improvement compared to the previous year. The Category 2 response time also saw a significant improvement, closing at 33 minutes and 39 seconds, a 13-minute improvement over the previous year. Despite these improvements, the CEO acknowledged that there is still work to be done to meet national targets consistently, particularly given the rising demand for emergency services. He highlighted the performance of the Emergency Operations Centre (EOC), noting that the call answering time for 999 calls had improved by two seconds, keeping LAS within the national standards. A notable achievement was the stabilisation of the EOC staffing, which has contributed to this improved performance. The EOC is also in the process of restructuring to better align staff rosters with demand patterns, further enhancing efficiency. The CEO reported a significant improvement in the "Hear and Treat" service, with a 19% rate of successfully managing patients through telephone triage and advice. This performance exceeds the national average of 14%, demonstrating LAS's commitment to delivering high-quality care while managing demand on frontline services. The service's success is attributed to the strategic investment in control room staff and technology, which has enhanced the team's ability to safely manage non-critical cases without dispatching an ambulance. The CEO acknowledged ongoing challenges related to staffing, particularly in the recruitment and retention of frontline staff. However, positive strides have been made, with a robust pipeline of new recruits expected to join in the coming months. The CEO emphasised the importance of maintaining a focus on staff welfare, given the pressures of the job. Initiatives such as team-based working and enhanced well-being support are critical to retaining skilled staff and ensuring their ability to provide high-quality care.	

	Building on the earlier discussion, the CEO reiterated the importance of the team-based working model as a cornerstone of LAS's strategy. The model has already shown significant benefits in improving team cohesion, enhancing patient care, and facilitating professional development. Plans are in place to expand this model to more teams across LAS, with the CEO highlighting the need for careful planning and resource allocation to ensure its success. The CEO reported on the recent launch of the South England Ambulance Collaboration, which involves collaboration between LAS and four other ambulance trusts. This initiative aims to improve efficiency, share best practices, and enhance the quality of care provided across the region. A major conference was held to kick-start this initiative, with a focus on translating collaborative efforts into tangible improvements in service delivery. The CEO emphasised the recent launch of the Anti-Discrimination Charter, which clearly outlines LAS's zero-tolerance stance on racism and sexual misconduct. The charter has been well received by staff, and efforts are underway to ensure its principles are embedded in all aspects of the organisation's operations. He also mentioned the formation of a new staff network for women of colour, which has already secured funding for leadership development programs. This is part of a broader strategy to promote diversity and inclusion within LAS. The CEO took a moment to highlight some of the recent achievements and recognitions received by LAS: Digital Communication Award: LAS's communications team won an award for the best use of digital communication, particularly for their efforts in attracting a diverse workforce to the NHS. The CEO praised the team for their innovative approach and the impact it has had on recruitment. Human Resources (HR) Recognition: The HR team has been shortlisted for a prestigious award by the Healthcare People Managers Association, recognising their outstanding work in managing and supporting LAS's workforce during a challenging period. Charity Work: The CEO mentioned the continuing success of the LAS Charity, which has seen significant growth in fundraising activities. An upcoming Dragon Boat Race event was highlighted, with Board members encouraged to participate. The CEO provided an update on patient safety and quality initiatives. Cardiac Arrest Outcomes: LAS's internal data shows that the Return of Spontaneous Circulation (ROSC) rate for cardiac arrest patients reached 32% in March, which is a significant achievement. The CEO attributed this success to the team-based working model and the skills of the Clinical Team Managers. The ongoing London Lifesaver campaign was highlighted as a crucial initiative, encouraging public access defibrillator (PAD) use. Data shows that when PADs are used before the arrival of LAS teams, ROSC rates can increase by 17%. Violence Against Staff:	

	The CEO reported a concerning number of physical attacks on LAS staff, with over 750 incidents recorded in the last year. The Violence Reduction Team has been actively supporting affected staff, leading to 19 successful prosecutions. The CEO emphasised the need for continued vigilance and support, particularly given the increasing frequency of assaults. The deployment of body-worn cameras was noted as a key measure in both preventing and prosecuting assaults. The CEO concluded the report with a look ahead at the key priorities for the coming months: LAS will continue to focus on improving efficiency across its operations, with particular attention on reducing hospital handover delays and enhancing the productivity of frontline teams. Innovation will also be a priority, with ongoing investments in technology and process improvements to support better patient outcomes. Strengthening engagement with key stakeholders will be crucial in navigating the financial and operational challenges ahead. The CEO emphasised the importance of maintaining open lines of communication with NHS England, local authorities, and other partners. Collaboration with other ambulance trusts through the South England Ambulance Collaboration will also be a focus, with the aim of sharing best practices and improving regional service delivery. Continued investment in staff development and well-being will be essential to maintaining a high-performing workforce. The CEO reiterated the commitment to providing comprehensive support to staff, particularly those on the front lines. The CEO expressed gratitude to all LAS staff for their hard work and dedication, particularly during these challenging times. The CEO reaffirmed the commitment to supporting staff, improving patient care, and driving forward key strategic initiatives.	
5. Director and Board Committee Reports		
5.1	**Performance**	
5.1.1	**Operational Performance Report** The Chief Paramedic Officer presented the March and April Performance Report. Category 1-LAS achieved an average response time of 7 minutes and 29 seconds, representing a 1 minute and 3 second improvement from the previous year. This performance is nearing the national target but requires continued efforts to maintain and further improve. The response time for Category 2 calls improved significantly, closing at 33 minutes and 39 seconds. This 13-minute improvement reflects ongoing efforts to optimise resource allocation and reduce delays. The Chief Paramedic Officer reported that the average call answering time for 999 calls improved by 2 seconds, keeping LAS well within national standards. This improvement is attributed to stabilised staffing levels within the EOC.	

	Despite challenges, the 111 service maintained strong performance, particularly during high-demand periods such as bank holidays. The service achieved a call answering rate that exceeded the national average, thanks to targeted staffing adjustments and enhanced support for clinical assessment. Ambulance utilisation remained high, with LAS vehicles in active use for a significant portion of their availability. The Chief Paramedic Officer highlighted the importance of managing this utilisation carefully to avoid overburdening resources. The Chief Paramedic Officer reported the addition of new ambulances to the fleet, which has helped to alleviate pressure on existing resources and improve response times. The Hear and Treat service, which involves managing patient care through telephone triage, achieved a 19% success rate. This is well above the national average of 14%, indicating LAS's effective use of technology and skilled call handlers to manage non-emergency cases. The Chief Paramedic Officer noted that the success of the Hear and Treat service has helped to reduce the number of unnecessary ambulance dispatches, freeing up resources for more critical cases. The Chief Paramedic Officer identified several challenges that have impacted operational performance: LAS has experienced a 5% increase in emergency call volumes compared to the same period last year. This rise in demand has put additional pressure on resources, particularly during peak times. She highlighted the need for ongoing monitoring and adjustment of resource allocation to manage this increased demand effectively. While recruitment efforts have been successful in bolstering frontline staff numbers, the COO acknowledged challenges related to staff retention and well-being. High levels of stress and burnout remain concerns, particularly among those working in high-pressure environments like the EOC. She emphasised the importance of continued support for staff well-being initiatives, including the expansion of team-based working and enhanced access to mental health resources. The Chief Paramedic Officer expressed concern over continued delays in hospital handovers, particularly in North Central London. These delays have had a significant impact on LAS’s ability to respond to new emergencies. LAS has implemented several strategies to address this issue, including the re-routing of some 111 calls to less busy hospitals and enhancing coordination with hospital partners. Despite these efforts, hospital delays remain a critical area for improvement. The Chief Paramedic Officer provided updates on key initiatives aimed at improving operational performance: The recent expansion of the LAS ambulance fleet was highlighted as a critical improvement. The addition of new vehicles, including dual-crewed ambulances and rapid response units, has provided much-needed capacity to meet rising demand. Plans for further fleet expansion and modernisation were discussed, with a focus on incorporating more environmentally friendly vehicles and enhancing the overall resilience of the fleet. The Chief Paramedic Officer reported on the ongoing implementation of advanced dispatch and triage technologies within the EOC. These technologies are designed to improve the accuracy of resource allocation and enhance the ability of call handlers to triage calls effectively. Early results from these implementations have been positive, with improvements in response times and more efficient use of ambulance resources.	

	LAS has launched several quality improvement initiatives aimed at streamlining operations and enhancing patient care. A recent example is the program focused on reducing the time it takes for crews to start their shifts, which has already shown significant results in pilot areas. The Chief Paramedic Officer outlined plans to roll out these quality improvement initiatives across all LAS stations, with a particular focus on those areas experiencing the greatest challenges. The Chief Paramedic Officer thanked the Board for their continued support and collaboration, emphasising that the operational performance improvements seen to date are the result of collective effort across the organisation.	
5.2 5.2.1	**Quality** **Quality Report** The Chief Medical Officer and Chief Paramedic Officer presented the Quality Report. LAS achieved a ROSC rate of 32% for cardiac arrest patients in March 2024. This figure represents a significant improvement over previous periods and is well above the national average. The CQO attributed this success to enhancements in clinical practice, the implementation of team-based working, and the widespread use of PADs. The ongoing London Lifesaver campaign, which encourages the public to use PADs, has been instrumental in improving ROSC rates. Data indicates that early defibrillation before the arrival of LAS crews can increase ROSC by 17%, highlighting the campaign's critical role in saving lives. It was reported that survival to discharge rates for cardiac arrest patients have also shown positive trends. This metric is a key indicator of long-term outcomes and reflects the quality of pre-hospital care provided by LAS crews. The improvements are linked to the integration of advanced life support protocols and timely interventions. LAS's high compliance with national clinical guidelines was highlighted, particularly in the management of time-sensitive conditions such as stroke, myocardial infarction, and sepsis. Regular clinical audits have confirmed that protocols are being consistently followed, ensuring that patients receive the most effective and evidence-based care. LAS maintained strong IPC performance, with no significant outbreaks of healthcare-associated infections during the reporting period. The Board noted that routine audits of IPC practices, including hand hygiene, vehicle and equipment cleanliness, and waste disposal, showed high compliance rates across all operational sites. The Board noted noted increase in the reporting of incidents, particularly near misses and low-harm events. This increase is seen as a positive development, reflecting a growing culture of safety and transparency within LAS. The emphasis has been on encouraging staff to report all incidents, no matter how minor, to facilitate learning and improvement. The implementation of safety huddles and structured debriefs following significant incidents has significantly improved LAS's ability to identify root causes and implement corrective actions. These sessions have become integral to the organization's safety culture, providing a forum for frontline staff to discuss incidents openly and collaboratively.	

	The Board noted that the serious incidents reported during the period, 90% were investigated within the required timeframes, with comprehensive action plans developed to prevent recurrence. LAS has continued its commitment to learning from deaths, particularly those occurring shortly after LAS involvement. The Learning from Deaths process involves a thorough review of such cases to identify any potential areas where care could have been improved. The Board expressed concern over the continued high number of physical assaults on LAS staff, with over 750 incidents reported in the past year. While some incidents were linked to patients' medical conditions, a significant number involved deliberate aggression. The introduction of body-worn cameras has been a significant development in addressing this issue. It was reported that the presence of these cameras has not only helped in reducing the frequency of assaults but has also provided valuable evidence in prosecuting offenders. The Board heard that a pilot project aimed at reducing the time it takes for ambulance crews to start their shifts has been highly successful. The project, which focused on streamlining pre-shift procedures, resulted in a 50% reduction in start-time delays. This has allowed crews to be ready to respond to emergencies more quickly, thereby improving overall response times. Given the success of the pilot, plans are in place to roll out this initiative across all LAS stations. The Board received the latest results from the Friends and Family Test (FFT), which measures patient satisfaction. The results were overwhelmingly positive, with a large majority of patients indicating that they would recommend LAS services to others. The Board received an overview of the complaints received during the reporting period. Although the number of complaints has remained relatively stable, there has been a notable improvement in response times and a reduction in the number of complaints that were upheld.	
5.2.2	**Quality Assurance Committee Report** The Chair of the Quality Assurance Committee (QAC) provided an update on the committee's activities since the last board meeting. A significant portion of the meetings was dedicated to reviewing patient safety metrics, serious incidents, and the effectiveness of corrective actions implemented. The committee closely examined clinical audit results, compliance with clinical guidelines, and the outcomes of quality improvement initiatives. The QAC also monitored LAS's compliance with Care Quality Commission (CQC) standards and other regulatory requirements, ensuring readiness for upcoming inspections.	
5.3	**People and Culture**	
5.3.1	**Report from the Chief People Officer** The Chief People Officer provided an update on the workforce and culture-related activities within the LAS, focusing on key metrics, staff well-being, diversity and inclusion initiatives, and ongoing efforts to enhance the organisational culture.	

LAS continues to maintain stable staffing levels, the Chief People Officer noted that while recruitment efforts have been successful in bringing new talent into the organisation, challenges remain in certain high-demand areas such as frontline paramedics and EOC staff. He discussed plans for upcoming recruitment drives, including partnerships with local colleges and universities to attract younger talent into the healthcare field.

The Board noted a slight decrease in turnover rates, indicating improvements in staff retention. Retention strategies, such as career development opportunities, mentoring programs, and enhanced support for new hires, have contributed to this positive trend.

Utilisation of the Employee Assistance Program (EAP has increased, reflecting heightened awareness and acceptance of mental health support services among staff. The Chief People Officer reported that the program has been particularly beneficial in providing confidential counselling and support during periods of high stress.

A series of stress management workshops were held, focusing on equipping staff with practical tools to manage stress in both their personal and professional lives. Feedback from participants has been positive, with many reporting a significant improvement in their ability to cope with work-related stress.

The Well-being Champions network has been expanded, with additional training provided to these volunteers to better support their colleagues. The Chief People Officer highlighted the important role these champions play in fostering a supportive work environment.

The Occupational Health team has introduced new services, including ergonomic assessments and personalised fitness plans, to support staff in maintaining their physical health.

LAS has launched several campaigns promoting healthy lifestyles, including initiatives focused on nutrition, exercise, and smoking cessation. The Chief People Officer reported that these campaigns have been well-received, with many staff participating in fitness challenges and wellness programs.

The Chief People Officer reported improvements in workforce diversity, with an increase in the representation of women, ethnic minorities, and LGBTQ individuals across all levels of the organisation.

A pay equity analysis was conducted to identify and address any disparities. The Chief People Officer confirmed that LAS remains committed to ensuring pay equity across all roles and that any identified gaps have been addressed through targeted salary adjustments.

The recently launched Anti-Discrimination Charter has been rolled out across the organisation, reinforcing LAS's zero-tolerance stance on racism, sexism, and other forms of discrimination. The Chief People Officer reported that the charter has been well-received, with mandatory training sessions completed.

The expansion of staff networks, including the Women of Colour Network and the LGBTQ Network, has provided platforms for underrepresented groups to share their experiences and influence organizational policies. The Chief People Officer highlighted the role of these networks in promoting inclusion and providing support to their members.

	LAS has introduced leadership development programs specifically targeted at underrepresented groups. The programs aim to equip participants with the skills and confidence needed to advance their careers within the organisation. Continued investment in resilience-building programs, including stress management, mental health support, and physical wellness initiatives, will be a priority. The Chief People Officer highlighted the need to equip staff with the tools to cope with the demands of their roles, particularly in the face of ongoing challenges. The Chief People Officer concluded the report by reaffirming LAS's commitment to supporting its people and fostering a positive, inclusive culture. He thanked all staff for their ongoing dedication and contributions to the organisation's success.	
5.3.2	**People and Culture Committee Report** The Chair of the People and Culture Committee provided a comprehensive update on the committee's recent activities, focusing on key workforce and culture-related initiatives. The meetings focused on reviewing progress against indicators KPIs related to staff recruitment, retention, well-being, and inclusion, as well as discussing strategic initiatives aimed at improving the overall work environment. The Committee noted that while recruitment efforts have successfully filled many critical positions, ongoing challenges remain in attracting and retaining frontline paramedics and call handlers in the EOC. The Committee was briefed on several targeted recruitment campaigns, including initiatives aimed at increasing workforce diversity. These campaigns have shown positive results, with an uptick in applications from underrepresented groups. The Committee reviewed the latest turnover data, which showed a slight decrease in staff turnover rates. The reduction was attributed to enhanced career development opportunities, better on boarding processes, and targeted retention efforts. The committee discussed various retention strategies, including mentoring programs, career progression opportunities, and initiatives to improve work-life balance. The effectiveness of these strategies is being closely monitored, with adjustments made as needed to further reduce turnover. The Committee discussed the importance of fostering a culture of recognition beyond formal awards. A new "Recognition Toolkit" has been developed to help managers regularly acknowledge the efforts of their teams, which has been well-received by both managers and staff. The Committee reviewed the outcomes of recent culture workshops, which provided staff with opportunities to discuss their experiences and contribute to shaping a positive organisational culture. Feedback from these workshops has been incorporated into ongoing cultural initiatives.	
5.3.3	**EDI Committee** The Chair of the EDI Committee provided an update on the Committee's recent activities, emphasising the continued efforts to foster an inclusive and equitable work environment. The Committee identified several priorities for the upcoming period and made recommendations to further enhance EDI efforts:	

	The Committee recommended continued efforts to increase diversity within leadership roles, emphasising the importance of mentorship, sponsorship, and targeted development programs for underrepresented groups. The committee emphasised the need to sustain and expand initiatives that promote an inclusive culture, such as staff networks and inclusive leadership programs. These initiatives should be regularly evaluated and adapted to meet the evolving needs of the workforce. The Committee called for ongoing monitoring of EDI metrics and accountability for progress towards diversity and inclusion goals. Regular updates to the Board on these metrics were recommended to ensure transparency and sustained focus on EDI objectives. To further improve the incident reporting and resolution process, the Committee recommended exploring additional ways to ensure that all staff feel safe and supported in reporting incidents of discrimination or bias.	
5.4	**Finance**	
5.4.1	**Director's Report** The Chief Financial Officer provided a comprehensive overview of the financial performance for the reporting period od end of April 2024. The Trust posted a deficit of £0.9m to the end of April 2024 against a deficit plan of £0.3m, an adverse variance of £0.6m. The Trust is below plan largely due to a shortfall of Cost Improvement Plan schemes compared to target. The Trust is forecasting to recover this position and deliver the breakeven plan by year-end. The Trust will invest £51.3m during 2024/25. By the end of April 2024 the Trust had spent £1.4m across Fleet, Estates and Medical Equipment. The Board noted that the Trust had a closing cash balance of £8.7m at the end of April 2024. The commissioning of the new Double Crew Ambulances (DCAs) continues and has enabled the Trust to decommission older ULEZ non-compliant DCAs and increase the overall numbers from 530 to 580. The new 111 site in South London (Bernard Weatherall House) is now operational. The Trust is now developing detailed plans to implement the 2024/25 Capital Programme. Make Ready continues to see the benefit of the extra preparation hubs that were opened in 2023/24 and the Trust continues to see sustained improvement in prepping rates which has also been benefited by the implementation of fixed fleet and local ownership.	
5.4.2	**Finance and Investment Committee (FIC) Report** The Chair of the Finance and Investment Committee provided a summary of the Committee's activities over the reporting period, focusing on key financial performance indicators, investment decisions, and strategic financial management initiatives. The Committee focused on: Financial Performance Monitoring: Ensuring that LAS's financial performance aligns with budget expectations and strategic goals.	

	Investment Portfolio Management: Reviewing the performance of existing investments and considering new investment opportunities. Strategic Financial Planning: Discussing long-term financial strategies to support the growth and sustainability of LAS.	
5.4.3	**Audit Committee Report** The Chair of the Audit Committee provided an update on the committee's activities The Committee focused on: Financial Reporting: Ensuring accuracy and transparency in financial statements and reports. Internal Controls: Evaluating the effectiveness of internal control systems across the organisation. Risk Management: Reviewing the identification and management of key risks facing LAS. Regulatory Compliance: Monitoring compliance with legal and regulatory requirements.	
5.4.4	**Charitable Funds Committee Report** The Chair of the Charitable Funds Committee provided an update on the Committee's activities. The Committee focused on: Fundraising Performance: Monitoring the effectiveness of fundraising campaigns and events. Fund Allocation: Reviewing and approving applications for the use of charitable funds. Impact Assessment: Evaluating the outcomes and benefits of projects funded by charitable donations.	
5.5 .	**Corporate Affairs – Director's Report** The Director of Corporate Affairs highlighted the focus on managing and addressing complaints, particularly in response times. Efforts are being made to ensure that the largest categories of complaints, especially those related to behaviour, are being scrutinised. The Board noted the importance of compliance with the Data Security and Protection Toolkit (DSPT), which is crucial for maintaining the ability to bid for certain types of work, such as the 111 services. There was a discussion on ensuring that all policies are up to date, with only a few remaining out of date, which are being actively remedied. The Director of Corporate Affairs mentioned ongoing efforts to ensure robust governance, including the need for trustee training to align with the responsibilities of being a trustee, which differ from those of being an executive or non-executive director.	

	The Board noted that the organisation is looking into providing specific training programs to address this need.	
5.6	**Digital and Data Committee Report** The Chair of the Digital and Data Committee provided an update on the Committees activities. The Committee reviewed the final version of the Digital and Data Strategy, which outlines the strategic priorities for the coming years. The strategy is set to be formally presented at the September Board meeting for approval. The Committee noted progress in closing outstanding actions from previous quality reviews.	
6. Planning – LAS Business Plan		
6.1 6.2	**LAS Business Plan 2024/25** **Business Plan Achievements for 2023/24** The Board formally approved two documents: one reviewing the performance against the previous year's business plan and the new business plan for the 2024/25 financial year. The review showed that the organisation met or exceeded many of its objectives, with notable improvements in patient care and operational efficiency. The Board noted the new business plan is closely aligned with the organisation's three strategic missions and ten priorities. It includes specific commitments to improve response times, enhance organisational health, and contribute to the overall health of London. The Board noted the financial challenges, including a discussion on the need to manage these within the constraints of the new business plan. There was also recognition of the importance of continuous monitoring and adjustment to meet financial efficiency goals.	
7.	**ASSURANCE**	
7.1	**7.1 Board Assurance Framework (BAF)** The Director of Corporate Affairs presented the latest iteration of the BAF that had been reviewed by lead executives and assurance committees. There was a review of BAF risks, particularly those related to financial challenges. The Board acknowledged the need to examine these risks more granularly due to ongoing efficiency challenges, budgetary constraints, and service demands. This is especially important in the current financial climate, where funding uncertainties and pressures are significant. It was noted that financial risks and the efficiency plan are areas of continuous monitoring, even during months without formal assurance committee meetings. This reflects an ongoing commitment to financial scrutiny and ensuring that financial management aligns with the Trust's strategic goals.	
7.2	**London Ambulance Service Public and Patient Council (LASPPC) update** The Council received a short briefing from LAS Chief Executive Officer on demand and performance, the launch of the Southern Ambulance Services Collaboration, the opening of the new 111/Integrated Urgent Care (IUC) facility in Croydon at Bernard Weatherill House and the appointment of a permanent Chief Paramedic- Pauline	

	Cranmer, the first female Chief Paramedic in the country. The Chief Executive Officer also updated members on the Service's Workforce Race and Disability Equality Standards Data for 2023/24 and told them about the Trust's new anti-discrimination charter. The LASPPC focused on: Patient Experience: Gathering and analysing feedback from patients to improve service delivery. Community Engagement: Enhancing the relationship between LAS and the diverse communities it serves. Service Improvement: Providing recommendations to LAS on improving the quality and accessibility of services.	
7.3	**Quality Account 2023/24** The Chief Paramedic Officer presented the Quality Account for 2023/24 for approval, subject to the inclusion of further stakeholder statements. It has been prepared and structured in accordance with the National Health Service (Quality Accounts) Regulations 2010. The Quality Account includes a report on progress against the Trusts Quality Account Priorities for 2023/24, presents priorities for 2024/25, reports on key performance metrics and highlights other improvement work for the last financial year. The draft content has been shared with the chairs of the LAS Patient and Public Council, as well other stakeholders, in accordance with statutory requirements. The Quality Account was formally approved by the LAS Board, with the commitment to monitor progress against the identified priorities and report back on achievements in the next annual Quality Account.	
8.	**CONCLUDING MATTERS**	
8.1 a.	**Any Other Business** There was no other business.	
8.2. a.	**Date of Next Meeting** The next public meeting of the Board would be held on 5th September 2024.	

2.2. Action log

For Discussion

Presented by Andy Trotter

London Ambulance Service NHS Trust

ACTION LOG – September 2024 Public Board

Meeting	Action	Lead	Due	Update
	No outstanding actions.			

3. Patient Story

For Information

Presented by Roger Davidson

3.1. Development of a responsive sickle cell service - to hear from service users

For Information

Presented by Roger Davidson

4. Chair and Chief Executive Report

For Information

4.1. Report from the Chair

For Information

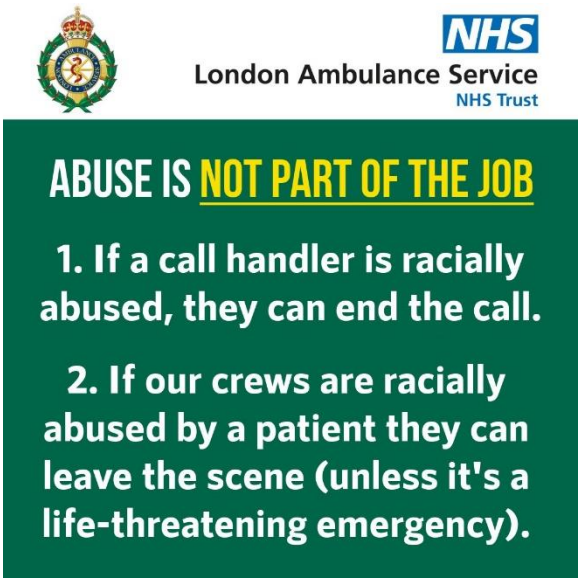
Presented by Andy Trotter

4.2. Report from the Chief Executive

For Information

Presented by Daniel Elkeles

London Ambulance Service NHS Trust Board meeting September 2024



Report from the Chief Executive Officer

I begin my update this month by acknowledging the tragic and horrific events in Southport in July, which claimed three young lives. Our thoughts remain with those affected by these terrible events, including those working in blue light services who attended the incident.

As I'm sure you will be aware, in the days after this tragic event, parts of the country experienced despicable violence and racist behavior, including Islamophobic attacks on Mosques. We worked closely with the Metropolitan Police and our emergency service partners to ensure we were prepared if these hateful acts happened in the capital.

I want to affirm once again how proud I am of the diversity we are creating and nurturing at London Ambulance Service and how important our values of caring, respect and teamwork are. Very sadly, some of our colleagues experienced an increase in overt racism and hostility which was particularly directed to our Muslim team members. It is crucial all of our people are safe at work, no matter their role, and it was important that we stood shoulder to shoulder together during this difficult and troubling time. We therefore took steps to strengthen what our teams can do if they experience abuse from the people they care for, while reminding patients and members of the public that our staff can leave the scene or end a call if they racially abuse our staff. These are concrete actions that show racist and discriminatory behaviour is totally unacceptable to us.

The support we saw from the public was outstanding, with our statement on this approach seen by more than 800,000 people online. The response was overwhelmingly supportive.

But it's not just the general public who have praised our actions. Senior leaders from NHS England have written out to NHS leaders outlining the stance of the NHS on racist and discriminatory behaviour and how to support staff. Within it, the way LAS responded, in particular our public messaging, is highlighted as an example of "empowering individual staff and patients to take action where they encounter racist behaviour, and giving confidence that their organisation will back them when they do".

Our interfaith and B-ME networks also came together to respond to the events, sharing a powerful statement of solidarity with our teams.

Demand and performance update

We have met significant demand for our services over the summer, with our teams working hard to care for patients as temperatures climbed and thousands came to the capital for a number of large-scale events. While we still have more to do in bringing down our response times, I'm pleased to say we have maintained a reduction in where we were at the same time last year.

We have felt the impact of the hot and humid weather – which can exacerbate respiratory issues – in an increase in the number of 111 and 999 calls we have received. To help Londoners stay safe in the heat, our teams have shared advice with the public through the media and via our social media channels. We have also worked hard to make sure we have the staffing levels we need to keep Londoners well cared for.

June saw huge crowds celebrating Pride in London, including our LGBT+ Network who joined the parade with a specially decorated ambulance as our float. Our teams once again worked with emergency service partners to ensure those attending could enjoy the celebrations safely.

On top of the usual demand we would expect for a summer's weekend, on 8 June we were called to an incident in Brockwell Park where a number of people including children were seriously injured on a fairground ride. We declared a significant incident and took four patients to a major trauma centre.

In July, we were exceptionally busy following a global IT outage caused by a faulty software update for Microsoft devices. Although our systems weren't directly affected by the outage, hospitals and GP surgeries experienced significant disruption to services including appointment and patient records systems, which in turn meant more people came to us for medical advice and treatment. During the outage, our 111 health advisors experienced one of their busiest days since the COVID-19 pandemic. I would like to thank our teams for coping so well with this pressure and working hard to get us through this challenge.

July also saw our teams respond to three significant incidents. At a house fire in East Ham on 13 July, tragically, and despite the best efforts of the emergency services, one child died at the scene and two died later in hospital. We also declared a significant incident on 12 July because of a fire in Wandsworth and, in the early hours of 17 July, our teams responded to a significant incident caused by a chemical incident in a block of flats.

While all of this shows just how much our incredible teams are doing to support our patients, I don't think we can deny that there is more we need to be doing across the sector to restore public confidence in the NHS. So in July, I shared my thoughts on how we can redress this in the Urgent and Emergency Care system in an article for the *Health Services Journal.*

Further expanding our work in 111

We have taken on additional responsibility for answering all the 111 calls in North Central London and the majority of the calls in North West London – which equates to around 1,700 additional calls a day – following an agreement with social enterprise London Central West (LCW). LCW continue to provide the 111 Clinical Assessment and GP out-of-hours services. This change is streamlining services to patients needing urgent healthcare advice and services, with no extra cost to the taxpayer. As the change took effect on 1 August, we were pleased to welcome more than 180 LCW colleagues who transferred over to us at LAS.

Kick-starting London Heart Starters

Our London Ambulance Charity has launched the London Heart Starters campaign, which is raising funds to get defibrillators to the 150 neighbourhoods in the capital that need them most.

When someone suffers a cardiac arrest – which is when the heart stops beating – the use of a defibrillator gives the person the best chance of surviving. We have released data showing the 150 neighbourhoods across the capital in greatest need of these life-saving pieces of equipment. Shockingly, 21 of these neighbourhoods have no access to a defibrillator.

There are lots of ways you can support the campaign, including fundraising to have a public-access defibrillator installed where it is needed most or hosting and becoming a guardian of a public-access defibrillator in your area.

On 8 September, we'll be taking part in the London Life Hike – a new fundraising walk that invites Londoners to walk through the beating heart of the capital to raise money for London Heart Starters.

LAS shortlisted for top HSJ Awards

I'm delighted London Ambulance Service has once again been shortlisted in the prestigious HSJ Awards in both the Trust of the Year and Staff Wellbeing Award for our Teams-Based Working initiative. LAS is also a partner in two further shortlisted projects: Wide Way Medical Centre in Merton was shortlisted for the Primary and Community Care Innovation of the Year for the 'GP Support Service' model, while LAS was

shortlisted with King George Hospital in the Provider Collaboration of the Year category for the Rapid Offload Model. **Visits from our stakeholders**

I am always pleased to welcome stakeholders to our sites so they can see first-hand the fantastic work across the Service to deliver outstanding emergency and urgent care.

We were proud to showcase our state-of-the-art facilities in Newham to the Chief Executives of NHS Trusts across London recently, as we hosted the regular meeting with trust leaders at our Dockside Education Centre. We took the opportunity to showcase our Emergency Operations Centre and simulation training room, before offering guests vital trainng in CPR and using a defib London Lifesavers training for our guests.


In the same month we hosted the National Ambulance BME Forum Conference (pictured above), where we were joined by over 120 colleagues from trusts across the country. I was honoured as Chair of the Network to join Kulvinder Hira, our Head of Equality Diversity and Inclusion, in sharing some of the key things we are working on at LAS such as our Anti-Racism Charter and how we'll build resilience and drive systematic change with colleagues across the sector.


During the General Election campaign, we were joined at Wimbledon Ambulance Station by Sir Ed Davey, Liberal Democrat Leader, and Paul Kholer, the party's then-local candidate (pictured above). Ed and Paul worked alongside our Make Ready team at the station to prepare an ambulance for the start of a shift. Our Make Ready Teams

prepare more than 13,000 ambulances for shifts every month, so it was great to see this team get the recognition they deserve.

In July, the Rt Hon Jacqui Smith, Minister of State for Skills, Apprenticeships and Higher Education in the Department for Education, and James Asser, MP for West Ham and Beckton joined us at our Dockside Education Centre to learn more about our award winning apprenticeship scheme and education programme (pictures below). We also gave our guests a tour of Newham EOC, talking them through the career path and development of our teams at the site.

Supporting our teams

Building on the positive impact our Teams-Based Working approach is having for our people in ambulance operations, I'm thrilled to share we have successfully expanded this innovative operating model to include our Emergency Operations Centre and Clinical Hub (CHUB). This means our Emergency Call Handlers, Emergency Resource Dispatchers and CHUB clinicians are now working in close-knit teams of no more than 15, with each team benefitting from a direct line manager, regular team huddles and dedicated team days. I look forward to seeing these colleagues experiencing the same

well-being and welfare benefits this way of working has delivered for our teams in operations.

Providing an inclusive place for everybody to work and thrive in is a very important part of our five year strategy. Our workforce data shows the experiences of staff from ethnic minority backgrounds is not always the same as those of their white colleagues, so we have taken steps to help understand and redress this balance. These have included recruiting and training 30 Independent Panel Members from across LAS to bring additional oversight to interview and selection processes, helping ensure our processes are as free from bias as possible and that everyone gets a fair chance to progress and thrive. We have also delivered a Stepping Up Support Package for managers to use when supporting their team members with development and growth opportunities.

I would like to thank everyone who took part in our London Ambulance Charity's hugely successful first official fundraising dragon boat race on 18 July. The 11 teams taking part – including five from across LAS and six from corporate companies – raised almost £18,000 for a great cause.

Celebrating our teams

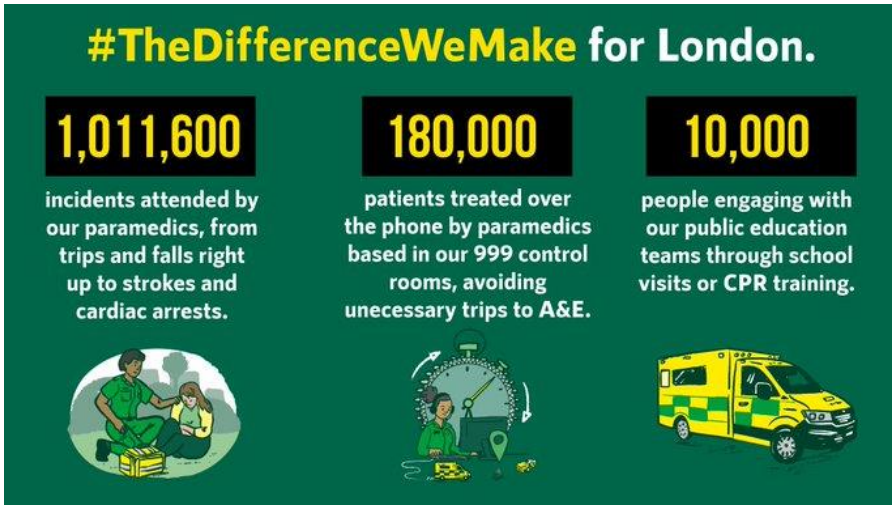
I am very proud of our staff and volunteers and am always delighted to see how many 'thank you' messages we receive from members of the public for the exemplary care they have received from our teams. When information provided by patients makes it possible, we share these messages directly with the colleagues mentioned.

Year	Month	Total number of letters and emails received	Financial YTD	Staff and volunteers recognised	Financial YTD
2024	January	139	1012	366	2627
2024	February	113	1081	299	2809
2024	March	137	1315	159	3265
2024	April	157	157	430	430
2024	May	163	351	410	913
2024	June	167	518	428	1341
2024	July	157	675	430	1771

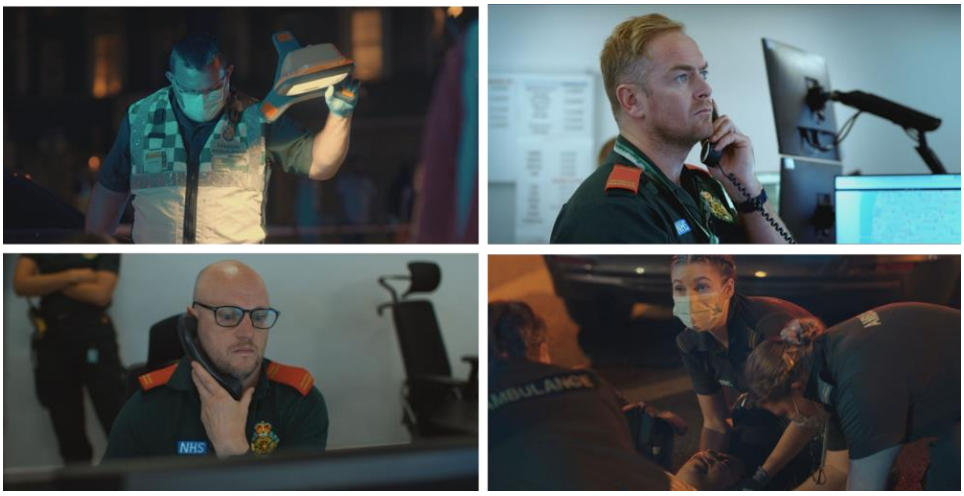
In further recognition of the incredible work done by our teams, I'm thrilled that our award winning apprenticeship scheme has been ranked fifth in the country by the Apprenticeships Top 100 Employers for 2024 – a truly fantastic achievement of which we can all be very proud. The rankings celebrate England's outstanding apprenticeship employers and recognises our commitment to creating new apprenticeships, the diversity of our apprentices and the number of apprentices who successfully achieve their apprenticeships.

Our Fleet team has been also shortlisted for a Motor Transport Award in the Low Carbon Category, recognising the progress we have made in cutting carbon emissions over the past 12 months and moving us to a more sustainable and zero emission fleet.

And if all of these weren't enough, our People and Culture Team have also been shortlisted for two Healthcare People Management Association awards: Team of the Year and People Leader of the Year.



We recognised the work of our frontline teams on International Paramedics Day on 8 July. Since last year's event, our ambulance crews attended 1,011,600 face to face incidents – from trips and falls right up to life-threatening emergencies like strokes and cardiac arrests – and 180,000 patients had been treated over the phone. That's well over one million people whose lives our teams have touched.



You may have been able to see some of these incredible teams in action in August, with the series Emergency airing on Channel 4 from Monday 12 August (and available on demand now). The series showed our ambulance operations colleagues responding to some of the most critically injured patients in London, and putting our values of caring, respect and teamwork on full display. Well done to everyone who took part.

As we celebrate the work of our teams, we are also always looking to those who will be joining the Service in the coming years. In July, colleagues from across LAS were busy inspiring the next generation at our dedicated recruitment event LASFest (pictured above). This was a hugely successful event, with over 600 people from across London coming on the day and more than 1,000 expressions of interest submitted by people wanting to work with us.

We were also delighted to welcome Olympic gold medallist Dame Kelly Holmes to our Waterloo HQ in July for a LGBT+Network event. She talked to our teams about the pressures she has faced – from the intensity of competitive sport to the fear of feeling she had to hide her sexuality while in the army – and how much happier she feels since coming out. She also took time to learn how to effectively deliver CPR in our London Lifesavers training and met teams around our site. Dame Kelly said afterwards, “Honestly, I was humbled by everything that was happening….It was amazing to see how everyone was so passionate about doing their best and doing all they can to help others at the end of the day.”

4.3. 2024/25 Manifesto for the Southern Ambulance Services Collaboration (SASC)

For Information

Presented by Daniel Elkeles

London Ambulance Service NHS Trust

Report to:	**Public Board of Directors**			
Date of meeting:	5 September 2024			
Report title:	Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto			
Agenda item:	4.3			
Report Author(s):	Nic Daw, Director for SASC			
Presented by:	Daniel Elkeles, Chief Executive Officer			
History:				
Purpose:	☐	Assurance	☒	Approval
	☐	Discussion	☐	Noting

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

The attached SASC board paper provides an outline of:

- Membership of the collaboration;
- Goals;
- The process to develop the year 1 manifesto;
- Year 1 priorities
- Governance structure.

In addition a poster summarising the manifesto is also attached.

This manifesto was approved at the SASC Board on the 14th August and is provided to individual Trust boards for approval.

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

The board are asked to approve the SASC manifesto.

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

Directorate	Agreed				Relevant reviewer [name]
Quality	**Yes**		No		
Finance	**Yes**		No		
Deputy Chief Executive / Chief Paramedic	**Yes**		No		
Medical	**Yes**		No		
Communications & Engagement	**Yes**		No		
Strategy	**Yes**		No		
People & Culture	**Yes**		No		
Corporate Affairs	**Yes**		No		

Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto – Board Paper

SASC

Working together for our patients, people and communities

About this document

This document provides the detail an outline for the 2024/25 Manifesto for the Southern Ambulance Services Collaboration (SASC).

Contents

Part A: SASC 2024/25 Manifesto outline

The Southern Ambulance Services Collaboration (SASC) is a Collaboration between East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services.

SASC's foundational goals are to:

- Support the delivery of consistently high quality frontline care
- Enhance the wellbeing of our staff
- Manage financial constraints
- Develop a culture of 'stealing with pride'

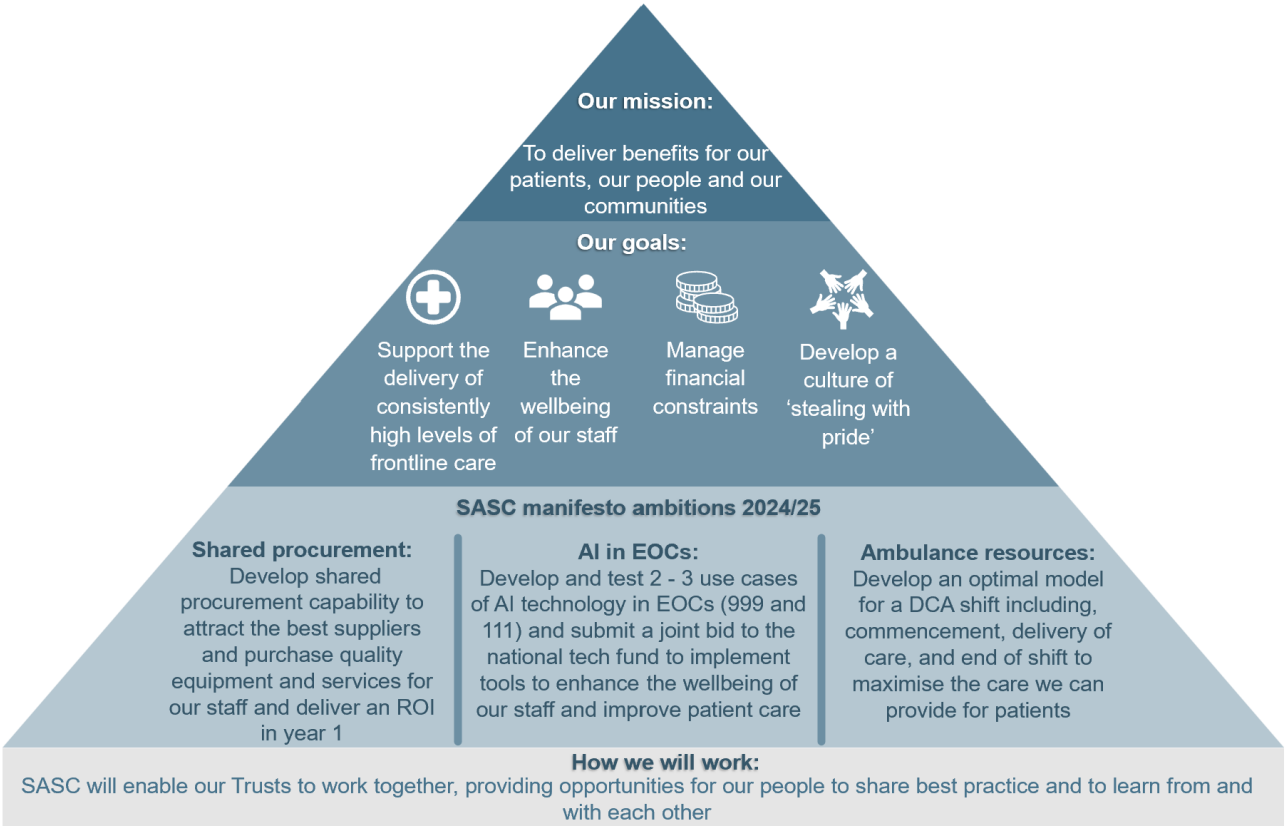
To develop the manifesto, SASC has engaged over 100 people across our five Trusts. The engagement sessions included individual and group CEO and Chair working sessions, problem solving sessions with each Trust executive team, and a workshop with ~100 colleagues across our five Trusts, on the 7th of June 2024. The workshop included five breakout groups, that each generated one to two initiatives. Following the workshop the CEO group selected three immediate priorities for year 1 to deliver improvements for our people, patients, and communities.

SASC's year 1 ambition is to:

- **Develop shared procurement capability to attract the best suppliers, purchase the highest quality products and services at the best price and provide a return on investment (ROI) in year 1.** The overarching principles are (1) the default is shared procurement, and (2) when procuring items, we will first consider how to maximise the net benefits for the collective.
- **Identify and develop two to three use cases of AI technology in EOCs** to improve patient care and support staff wellbeing. Submit a joint bid to the national tech fund. Examples of use cases could include: transcription and summary tools, sentiment analysis, clinical audits, pre-caller ID, etc.
- **Develop an optimal model for a DCA shift.** The focus will be to improve the availability of our ambulance resources by (1) developing best practice processes (e.g., start and end of shift processes, break policies, etc), and (2) optimising how we use and deploy our resources (e.g. what resources and how many we deploy to certain jobs).

The Collaboration will be guided through a governance structure that includes a Collaboration Director, CEO group, and Collaboration board (CEOs & Chairs). Each workstream will be driven forward by a CEO SRO, a director level lead from one of the five Trusts, and a support team where necessary.

Figure 1: Summary of year one Manifesto – programme areas and governance structure



The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

NHS Southern Ambulance Services Collaboration

What is the Collaboration?

The Southern Ambulance Services Collaboration (SASC) is a collaboration between the East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services.

SASC

Working together for our patients, people and communities

The goals of the Collaboration are to:

- Support the delivery of consistently high-quality frontline care
- Enhance the wellbeing of our staff
- Manage financial constraints by sharing best practice
- Develop a culture of 'stealing with pride'

Our year one manifesto has been co-developed by our people and focuses on three areas of improvement

Our engagement over the past six months

- CEO and Chair working sessions
- Sessions with each Trust's executive team
- Workshop pre-meets for five priority areas involving ~80 staff across the five Trusts
- Workshop with ~100 staff across the five Trusts

From this engagement we identified three priority areas of improvement:

Shared procurement
Develop shared procurement capability

Ambulance resourcing
Implement a best practice model for a DCA shift

AI in EOCs
Implement AI tools in our EOCs to improve patient care and staff wellbeing

The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

Southern Ambulance Services Collaboration

For each area, there are 3-4 priority deliverables…

Shared procurement

Our mission: Develop shared procurement capability, to purchase the best quality products and services at the best price across our five Trusts, and provide an ROI in year 1

Our deliverables:

- **Develop shared procurement approaches** by mapping and aligning our procurement data, systems and processes
- **Identify the items** that will return the highest value and will generate a return on investment in year one
- **Begin joint procurement** in the 2024/25 financial year

AI in EOCs

Our mission: Identify and develop two to three use cases of AI technology in EOCs (999 and 111) and submit a joint bid to the national tech fund to implement tools to enhance the wellbeing of our staff and improve patient care

Our deliverables:

- **Map opportunities** for AI in EOCs to improve patient care and staff wellbeing
- **Develop 2-3 use cases** for AI in EOCs and test across 5 Trusts
- **Place a bid to the National Tech Fund** on behalf of all 5 Trusts
- **Implement at least one AI support mechanism** (e.g., pre caller ID) across all 5 Trusts

Ambulance resourcing

Our mission: Develop an optimal model for a DCA shift including, commencement, delivery of care, and end of shift to maximise the care we can provide for patients

Our deliverables:

- **Map out how time is spent on a DCA shift to** develop a collective understanding of current ways of working
- **Develop a 'common language'** of agreed metrics
- **Identify the priority components** to deliver the greatest collective benefit for patients and staff
- **Develop proposals** to improve these components

5. Director and Board Committee Reports

5.1. Performance

Operational Performance Report

For Assurance

Presented by Pauline Cranmer

London Ambulance Service NHS Trust

Report to:	Public Board of Directors			
Date of meeting:	5 September 2024			
Report title:	Performance report September 2024			
Agenda item:	5.1			
Report Author(s):	Pauline Cranmer, Chief Paramedic Officer			
Presented by:	Pauline Cranmer, Chief Paramedic Officer			
History:				
Purpose:	X	Assurance	☐	Approval
	☐	Discussion	☐	Noting

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

The September 2024 performance report covers the period of May through to July 2024.

The 2024/25 Operating plan has been agreed with NHSE national/regional teams and with Commissioners. The final agreed yearly category 2 target is 35 minutes 57 seconds.

Emergency Operations Centres continue to exceed the national standard of 10 seconds for the call answering mean time standard. Staffing are now at budgeted levels and teams based working has been introduced in July 2024 with implementation of new rosters, team huddles and training days.

Total number of contacts has been higher than forecast across the reported period. Growth was expected to be circa 1% in the financial year 2024/25. Across May to July there has been a circa 10% growth in activity with July 2024 showing circa 15% increase alone.

Category 2 performance for each month being 00:35:45 in May, 00:39:44 in June and 00:38:25 in July 2024. Performance in May and June 2024 were better by 6 minutes 15 seconds and 5 minutes 54 seconds respectively, when comparing to May and June 2023. In July 2024, performance was 6 minutes 55 seconds worse than July 2023 although consistent with the high demand seen.

Ambulance Operations continue to drive efficiencies within their local teams and this has seen a 2 minute 30 second improvement in our job cycle time and an improvement in the number of patients per shift seen by crews from circa 4.7 to 5.1 since April 2024.

The continued focus on hear and treat has seen further improvements in the percentage of calls which we do not send a frontline resource too. This has grown month on month between May and July 2024 which has increased from 18.7% to 20%. This is ahead of the trajectory we agreed within the operating plan which was 16% in May and June 2024 and 17% in July 2024.

Integrated Urgent Care services continue to demonstrate improvements in both the average speed to answer and calls abandoned. For June and July 2024 these were 42.5 seconds and 4.45% respectively. This compares favourably with the 12 month mean of 73.4 seconds and 7.12%. The CAS team managed 88k calls during the two-month period and achieved the KPI in clinical ringbacks for all priorities within target in 53% of cases. This is an improvement on the 12-month mean of 36%.

A significant amount of work has been undertaken in July 2024 to prepare for the LAS to manage all 111 call answering for North Central London taking on the work from LCW. This has required the TUPE transfer of over 250 staff from LCW to the LAS, technical changes to our systems and processes and development of new reporting. In the first 2 weeks of operation, activity has increased by 19% and with abandonment rate dropping to 2%.

The LAS has responded to seven significant incidents which were declared during the reporting period. Six of these incidents related to fires within properties. The final incident was regard to an accident on a fairground ride.

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

The board are asked to approve the report.

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

London Ambulance Service NHS
NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING
Performance Report – September 2024

This performance board report covers all key metrics for main service lines of the London Ambulance Service for the period 1 May 2024 to 31 July 2024.

1. 2024 – 2025 Operating Plan overview

The 2024 to 2025 operating plan was agreed at the end of June 2024 and has been agreed with LAS Commissioners, NHSE (London Region) and the NHSE national ambulance teams. The revised category 2 outturn position for this financial year is now 35 minutes and 57 seconds.

Further funding has been provided for as part of this agreement and includes £1.6 million of non-recurrent funding and £4.8 million recurrent full year funding (equates to £3.2 million in this financial year for part year effect).

The monthly trajectories with actuals through to 31 July 2024 and shown in Figure 1.

Metric	Apr-24	April Actuals	May-24	May Actuals	Jun-24	June Actuals	Jul-24	July Actuals	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
All incidents (AQI A7)	99,094	106,398	101,278	112,369	99,802	110,540	103,028	113,459	102,275	102,969	108,249	100,682	109,578	104,030	98,028	101,395
Incidents with Face-toFace Response (AQI A56)	83,234	85,530	85,064	91,352	83,835	89,168	85,518	90,767	84,883	85,456	88,961	82,556	89,843	84,445	79,409	82,126
C2Mean (Format = hh:mm:ss)	00:34:53	00:34:53	00:35:45	00:35:45	00:35:06	00:39:44	00:32:10	00:38:57	00:32:43	00:35:31	00:36:58	00:39:04	00:47:22	00:36:37	00:32:54	00:31:50
Average Handover Time (Format = hh:mm:ss)	00:24:00	00:24:02	00:24:00	00:23:40	00:24:00	00:23:05	00:24:00	00:22:44	00:24:00	00:24:00	00:24:00	00:24:00	00:24:00	00:24:00	00:24:00	00:24:00
Calls Answered (AQI A1)	110,568	116,678	125,033	126,575	130,141	129,663	122,314	132,025	124,124	129,522	129,003	130,679	143,717	127,967	117,277	128,127
Calls Answer Mean (seconds)	10	2	10	2	10	4	10	5	10	10	10	10	10	10	10	10
Total DCA resource hours	198,519	199,242	193,739	210,220	194,557	199,960	201,974	198,834	193,147	185,010	193,180	194,975	206,116	212,533	200,093	206,946
Total RRV resource hours	42,367	42,473	41,855	43,759	41,526	40,979	44,469	42,215	44,962	41,849	43,269	42,870	42,942	44,001	38,996	44,296
Hear & Treat	16.0%	20%	16.0%	19%	16.0%	19%	17.0%	20%	17.0%	17.0%	18.0%	18.0%	18.0%	19.0%	19.0%	19.0%

Figure 1: 2024/25 Operating plan trajectories with actuals (April to July 2024)

2. 999 Emergency Operations

The total number of contacts into EOC have been on an upwards trajectory for 5 months since February 2024 as can be seen in the SPC chart in figure 2. This continues to show common cause variation albeit activity from May to July 2024 is 10% higher than respective 3 months in 2023.

Total contacts for May, June and July 2024 was 173,893, 175,976 and 179,558 respectively.

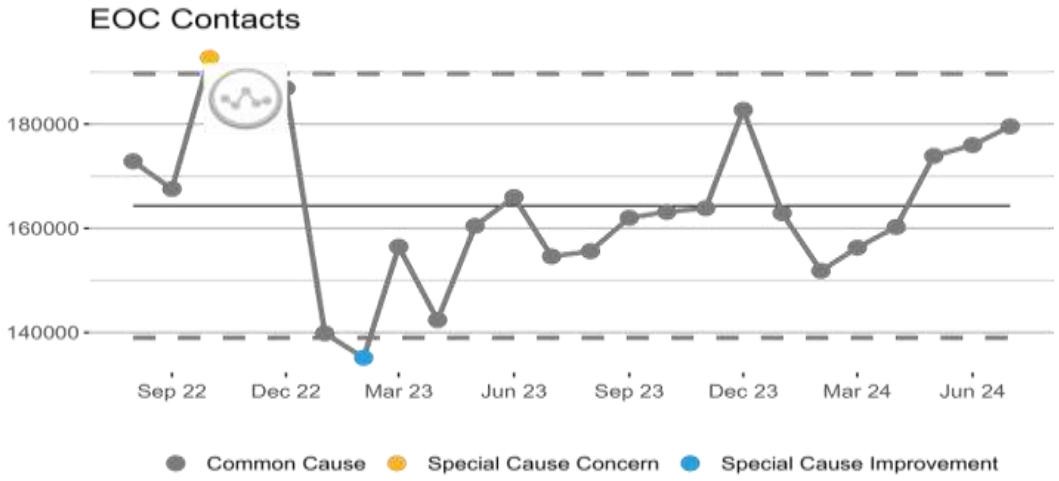


Figure 2: Total Contacts SPC

The call answering mean SPC continues to demonstrate special cause improvement and has exceeded the target of 10 seconds for the last 7 months. Consideration will be given to re-basing the SPC chart from April 2024. The call answering mean was 3 seconds in May and 5 seconds in both June and July 2024. This compares favourably against the national average of 5 seconds in May and 6 seconds for June and July.

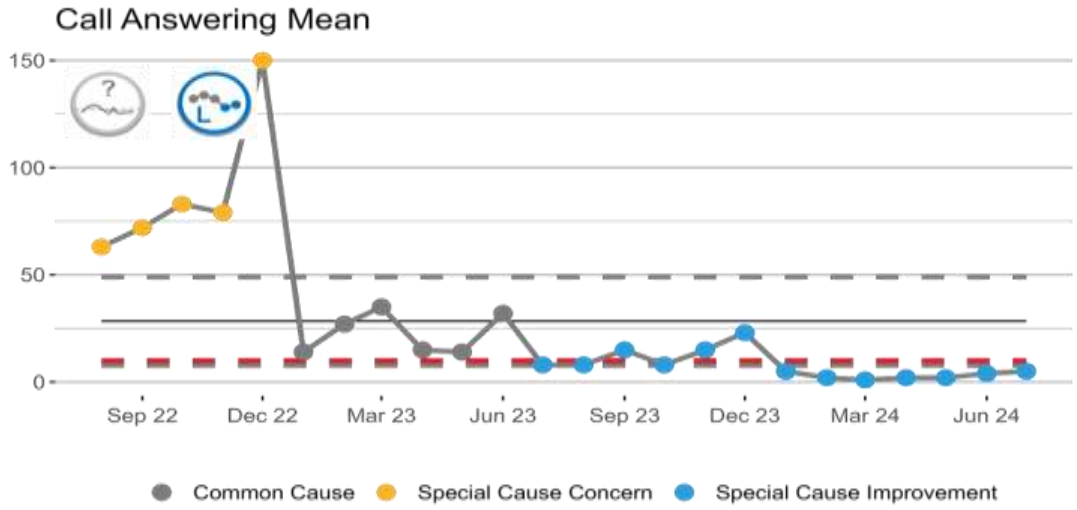


Figure 3: Call answering mean SPC

Teams based working (TBW) was implemented on 1 July 2024 which has introduced team huddles and team days comparable to that introduced across ambulance operations.

New rosters have been implemented to support the roll out of TBW and has been concluded following extensive consultation with staff and union representatives from across EOC. The new roster pattern looks to establish better coverage of staff to meet incoming call volumes. Along with reaching establishment for both call handling and dispatch staff, there is expectation that these new ways of working will further strengthen the performance in EOC.

Key focus for improving performance:

- Development of a category 2 improvement plan which includes:
  - A dispatch reset – looking at re-introducing best practice around dispatch decisions

  - Reducing long dispatch times on cat 2 calls
  - Trailing auto-dispatch on cat2 to assess the effectiveness
- Working with Business Intelligence colleagues to establish CMS data, a set of dispatch key performance indicators and set of metrics to measure category 1 and 2 performance improvement.
- Continue with quality improvement initiative to reduce the category 2 tail and improve responses to our patients.

3. Ambulance Services

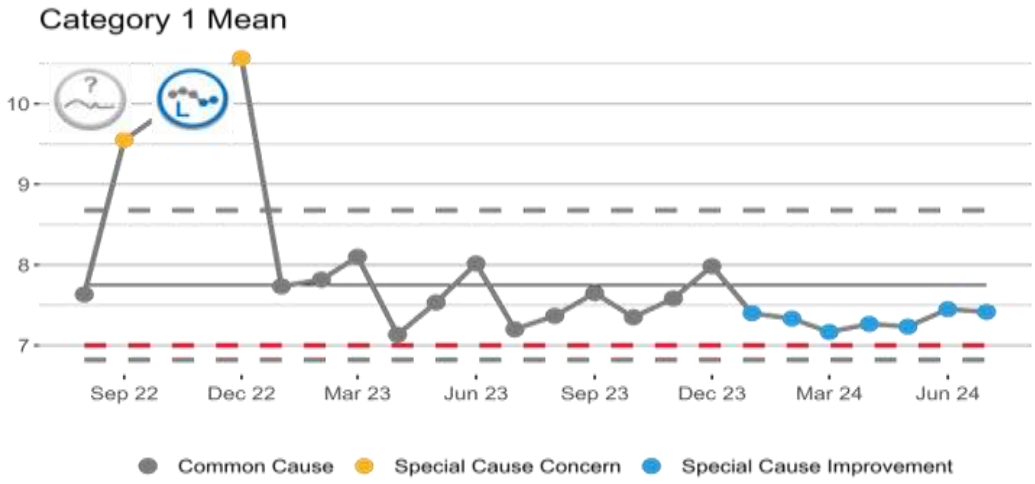


Figure 4: Category 1 mean SPC

The category 1 Mean SPC (figure 4) continues to show special cause improvement although has failed to meet the national standard of 7 minutes. Nationally the LAS continues to be the second best performing Trust in England and delivered a performance of 7 minutes 14 seconds in May, 7 minutes 27 seconds in June and 7 minutes and 25 seconds in July 2024.

The SPC chart for category 2 performance (figure 5) now shows special cause improvement for the period from January 2024 through to July 2024. This is the first time that this has been seen although we continue to not meet the national standard of 18 minutes. Performance for May, June and July 2024 was 35 minutes and 45 seconds, 39 minutes and 44 seconds and 38 minutes and 58 seconds respectively.

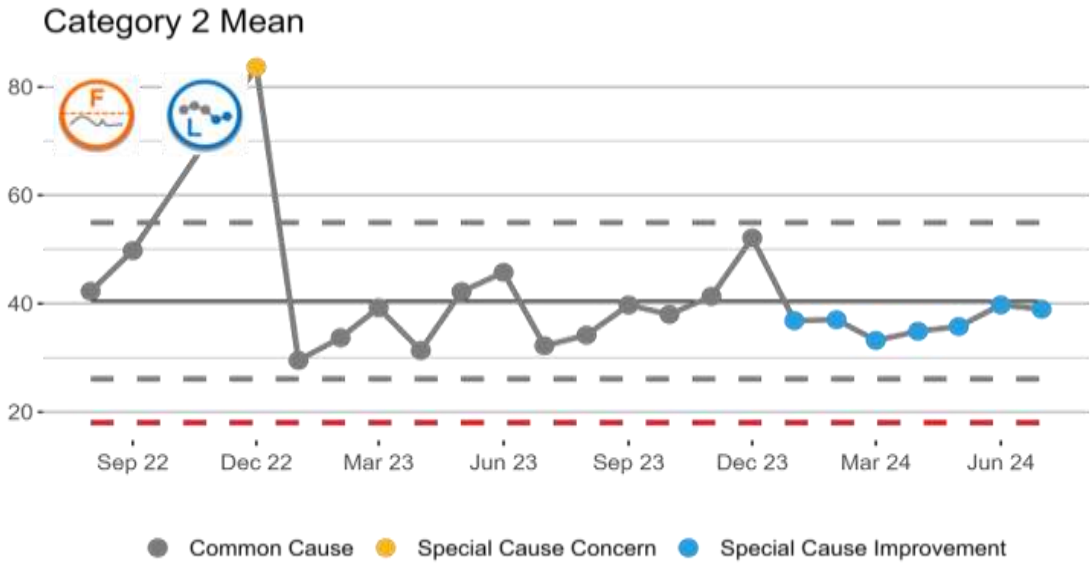


Figure 5: Category 2 SPC chart

The ambulance operations team have a clear focus on which they are working on with their teams through teams based working to maximise productive hours and improve efficiency. This focus is to achieve sustainable improvements in both our Category 1 and 2 performance. This includes:

- Revision of the operational staffing plan to reflect the agreed yearly operating plan down to local level. This is supporting local managers to ensure that they have enough frontline resources to meet commissioned levels.
- As part of our new holistic operating model, managers are looking at reduction of both people and vehicle Out of Service factors; ensuring that we increase the number of productive hours in which to ensure we have resources to provide a safe service. Work in this area is also subject to a quality improvement initiative and will support delivery of this efficiency work.
- Continuation of initiatives set out in previous board reports which are seeing improvements. These included:
    - Reducing aspects of our job cycle time (JCT) that are within crews' control. There has been a reduction in of 2 minutes 30 seconds since April 2024
    - Close management of unauthorised and short notice absence.
    - Review and management of long term sickness
    - Close overtime management delivering resources at specific times of the day and week
    - Focusing on the number of patients per shift completed by crews which has improved from circa 4.7 to 5.1 covering the period of this report.

The category 3 target of 60 minutes has not been consistently hit, however, the SPC chart in the IPR shows (figure 6) common cause variation. Performance for the 3 months of May, June and July 2024 were 1 hour 12 minutes 49 seconds, 1 hour 22 minutes and 35 seconds and 1 hour 28 minutes and 33 seconds respectively.

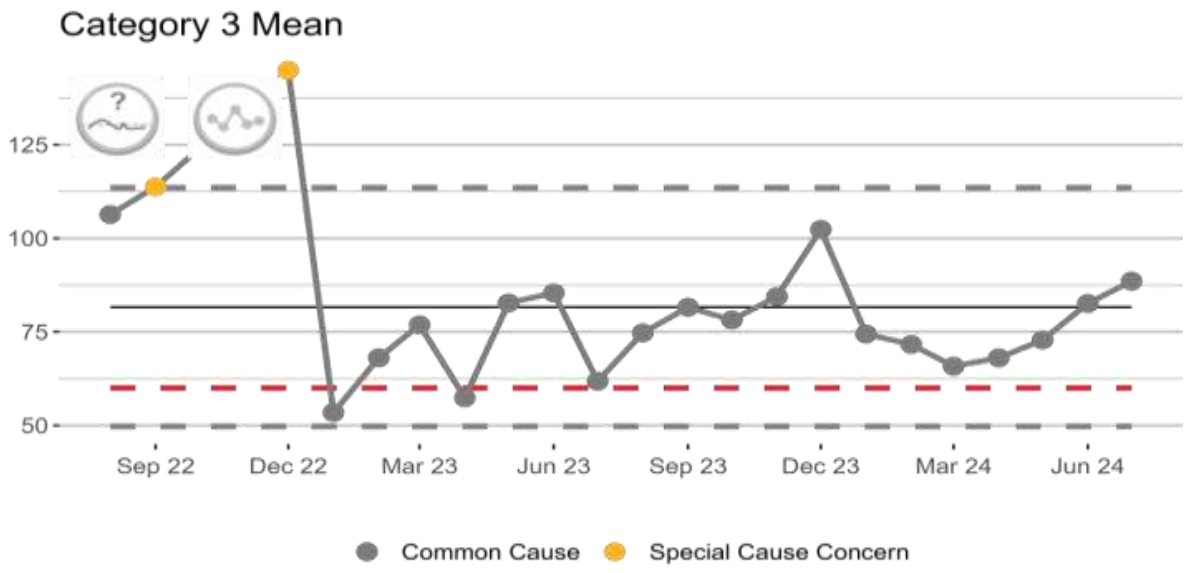


Figure 6: Category 3 SPC

Time lost at hospital is shown in the SPC (figure 7) and continues to demonstrate special cause improvement, although the target has not been met. The target was set as part of the 2023/24 operating plan as 0 hours lost greater than 15 minutes. The average handover time for July was 22 minutes and 44 seconds (figure 1) and this shows a slight improvement across all hospitals. However, there continues to be challenges at specific hospitals where delays are routinely higher than the average.

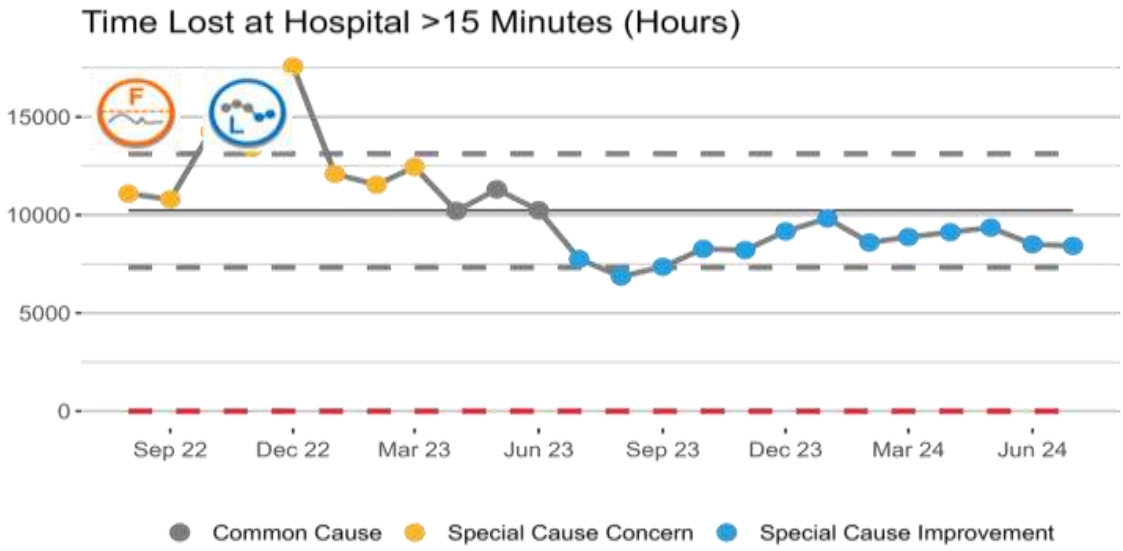


Figure 7: Time lost greater than 15 minutes SPC chart

The percentage of conveyances which took more than 30 minutes for the ambulance crew to handover the patient at hospital across May to July 2024 is shown in figure 8.

Hospital site	Percentage of handovers over 30 mins
Barnet	40%
Charing Cross	3%
Chelsea & Westminster	2%
Croydon University Hospital (Mayday)	11%
Ealing	19%
Hillingdon	17%
Homerton	4%
King Georges, Ilford	31%
Kings College	31%
Kingston	24%
Lewisham	26%
Newham	59%
North Middlesex	48%
Northwick Park	34%
Princess Royal, Farnborough	27%
Queen Elizabeth II, Woolwich	19%
Queens, Romford	55%
Royal Free	31%

Royal London (Whitechapel)	32%
St Georges, Tooting	32%
St Helier	24%
St Marys, W2	6%
St Thomas'	7%
University College	15%
West Middlesex	7%
Whipps Cross	50%
Whittington	25%

Figure 8. Proportion of handovers over 30 minutes March/April 2024 (unvalidated data)

4. National Context

The Ambulance Quality Indicators provide a national context for the ambulance sector and reflect how, comparatively, the LAS is performing. Figure 9 shows our performance against key metrics compared to the national average and to other ambulance services nationally.

Metric/Month	May-24		Jun-24		Jul-24	
	LAS	National	LAS	National	LAS	National
Category 1	00:07:14	00:08:16	00:07:27	00:08:21	00:07:25	00:08:15
Category 2	00:35:45	00:32:44	00:39:44	00:34:38	00:38:25	00:33:25
Category 3	01:12:49	02:00:00	01:22:35	02:02:34	01:28:33	02:01:21
Hear & Treat	18.7%	14.8%	19.3%	15.0%	20.0%	15.4%
See & Treat	28.0%	30.1%	27.3%	29.9%	26.8%	29.7%
Convey to ED	50.9%	50.3%	50.7%	50.4%	50.7%	50.2%
Call ans. mean	00:00:03	00:00:05	00:00:05	00:00:06	00:00:05	00:00:06

Figure 9: LAS performance compared to National performance

5. Clinical HUB / Emergency Clinical Assessment Service (ECAS)

There is no target for hear and treat however the LAS has agreed as part of its operating plan that there will be incremental growth across 2024/25. This will see a 2% growth in hear & treat across the financial year with a target of 1% growth by quarter 2, and moving from 16% (starting point) in quarter 1 to 19% in quarter 4.

The performance by month: May 2024 18.7%, June 2024 19.3% and July 2024 20%.

The SPC chart (figure 10) demonstrates that there is special cause improvement and is reflective of the investment and increase in staff within the clinical hub, along with process change.

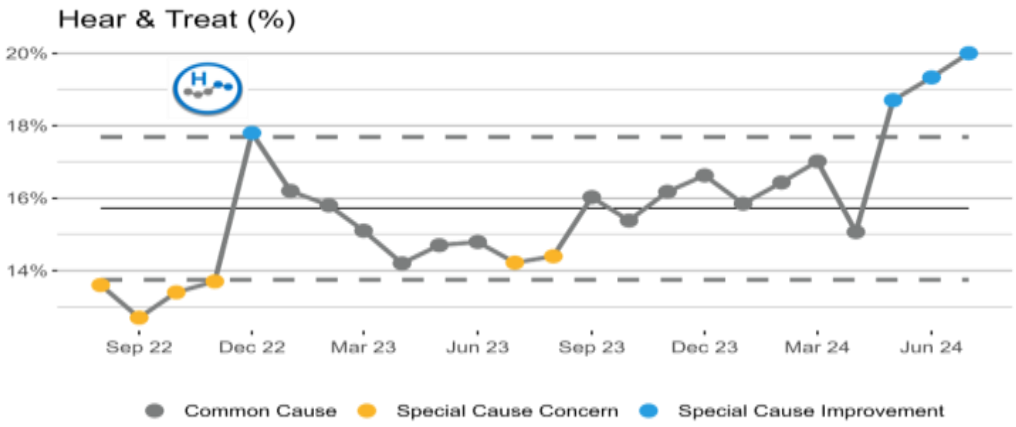


Figure 10: Hear & Treat SPC

The Clinical Dispatch Support (CDS) model continues to be a critical asset in supporting the oversight of patient safety and the delivery of Hear & Treat in the most pressured LAS sectors and ICS areas. From May to July 2024, we have seen increased deployment of CDS sectors as we deliver against our recruitment plan. Notably, sectors that had CDS implemented saw a sustained improvement in Hear and Treat rates, consistently outperforming the Trust's monthly averages. This is expected to continue to improve as we further deliver our recruitment goals to reach our funded establishment of 150 Clinical Advisors.

During the period from May to July 2024, we continued to see improvements in the Clinical Hub's staffing with more staff choosing to join us, and many on secondment expressing a desire to transition to permanent roles. With this, we have made significant progress toward delivery of our recruitment trajectory which was initially forecast to be delivered by November 2024, however with the additional focus is now expected to be completed in September 2024. This has also allowed us to provide a greater number of shifts with full CDS support resulting in improved Hear & Treat as demonstrated by our highest ever reported Hear and Treat performance outside of the pandemic.

To ensure the safety and effectiveness of these improvements, we have further increased our Quality Assurance efforts, conducting an average of over 300 audits each month—up from approximately 250 at the last update. This rigorous auditing process ensures that every clinician is reviewed at least twice per month. The data from our auditing software confirms that the quality of assessments has been maintained, with no increase in patient safety incidents or complaints.

The successful staff-driven rota review was implemented on 1st July 2024. Alongside improved wellbeing for staff, dedicated time for clinical shifts, Quality Assurance and for CTNs to support their teams, this new rota has aligned clinicians more closely with the ambulance operations team, significantly improving how we utilise resource at more challenged periods.

<u>Category 2 Segmentation</u>

The LAS continues to uphold its position as a leading Trust in C2 Segmentation and continue to support other Trusts in refining their delivery models. As key members of the national C2 Segmentation Steering Group, we remain dedicated to fostering collaboration across all ambulance services. To that end, we will be hosting a national learning event in September 2024 where C2 Segmentation leads from all Trusts will come together to share their learning and best practice.

In London, around 45% of the total C2 calls received are eligible for Clinical Navigation. Of these, 10% undergo Clinical Validation (compared to 5.9% nationally), and an average of 44% of these patients are safely managed through alternative care pathways. By maximizing opportunities for Hear & Treat, we have been able to 'release' a significant number of Double Crewed Ambulance (DCA) hours back to Ambulance Services, enabling a more efficient response to higher acuity patients. On average, this equates to approximately 1,200 DCA hours (2,400 staff hours) per week.

Our C2 Segmentation activity has also contributed heavily toward national coding reviews. In July the national Emergency Call Prioritisation Advisory Group (ECPAG) concluded the third coding review and approved a further list of Ambulance Medical Priority Dispatch System (AMPDS) determinants to be prioritised as C3 at call handling. While the volume of calls within this list of determinants is small, it demonstrates the effective delivery against the objectives of C2 segmentation. However, the consequence of three such coding reviews has meant a reduction in the number of calls within scope of segmentation being made available to clinicians as demonstrated in Figure 11.

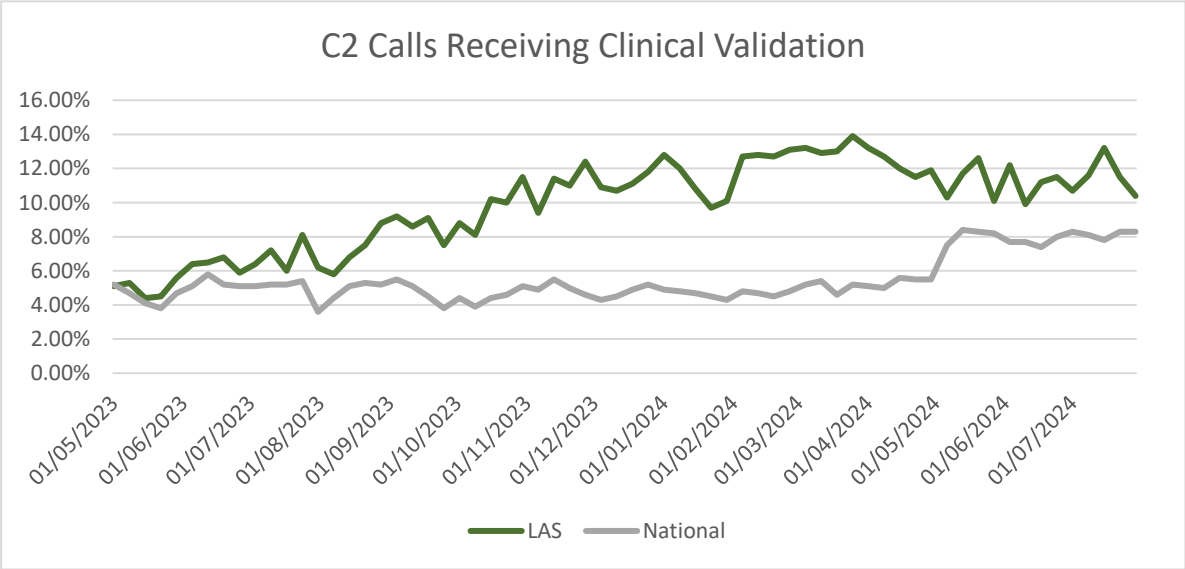


Figure 11: % of calls receiving clinical validation, LAS vs national

On average this equates to around 4.1% of all Category 2 patients being cared for by telephone vs a national average of 2.6% (figure 12).

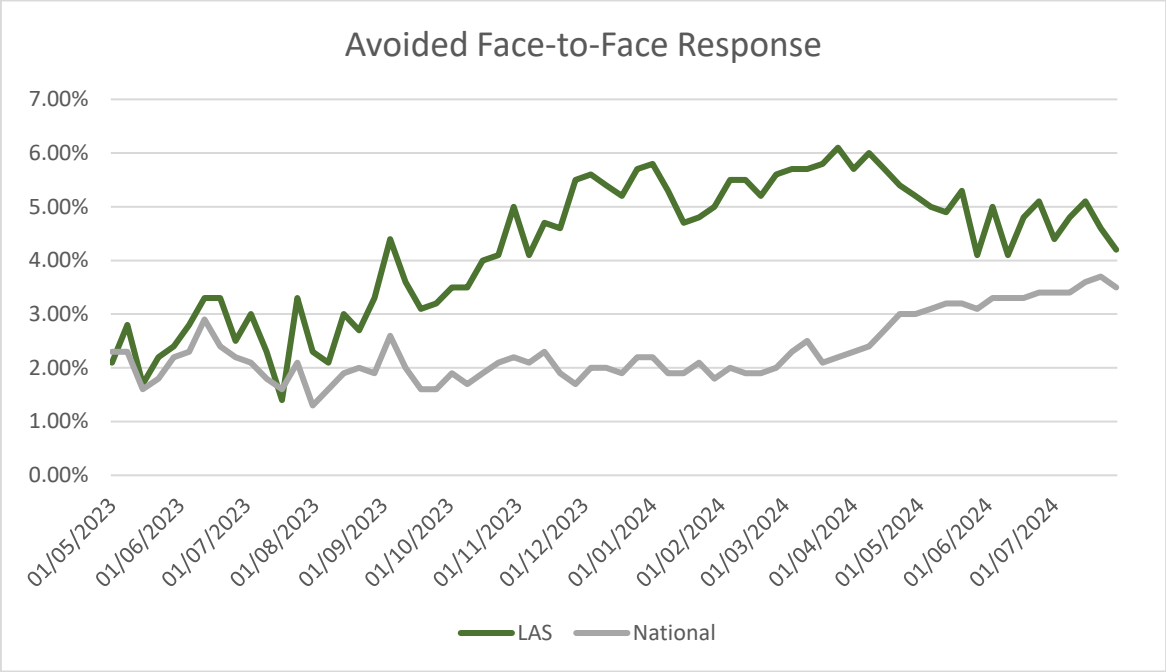


Figure 12: Category 2 segmentation metrics for March & April 2024

Of the calls validated, 45.3% in May, 46.5% in June and 39.9% in July 2024 (figure 13) were safely referred to suitable alternative care pathways and consequently avoided conveyance to hospital.

Metric	May-24	June-24	July-24	Since Last Update
% of eligible calls were dispatched on before Navigation could be undertaken	36%	33%	35%	↓
% of eligible calls underwent Clinical Navigation	49%	47%	48%	↑
% of all Clinically Validated calls were moved out of C2 (Closed, H&T or Other Service/category)	45%	47%	40%	↓
% of calls undergoing clinical validation remained a C2 post assessment	53%	51%	57%	↑
% of all Coded C2 Calls Closed	4%	4%	4%	↔

Figure 13: Category 2 segmentation metrics for May, June & July 2024

The additional Urgent Community Response car for South East London successfully launched as planned in mid-June and is now operating 4 days per week. This expansion means that there are now UCR cars operating across all 5 ICS areas. Teams continue to consist of Paramedics and external clinicians working together to manage patients within the community.

Of note, work continues to start to transition some of the LAS' Specialist Paramedics in Primary Care, across to provide this response – bringing their emergency skillset, as well as their primary care experience and knowledge together, to respond to this same patient group. Their 50% LAS time, will focus on this response as a solo responder, and will ultimately reduce the volume of b6 paramedics required to staff it; and reduce overall cost of external clinicians. Importantly, it will also provide a very clear career pathway from b6 paramedic into primary and urgent care focussed roles within the LAS.

To date:

- 13,666 patients have been attended by a UCR team to the end of July 2024.
- 64% of patients in July 2024 have been treated without conveyance to an emergency department.
- The UCR response continues to provide a faster response than if a double crewed ambulance (DCA) was dispatched to an equivalent patient in Category 2, 3 or 4 as demonstrated in figure 14 below.

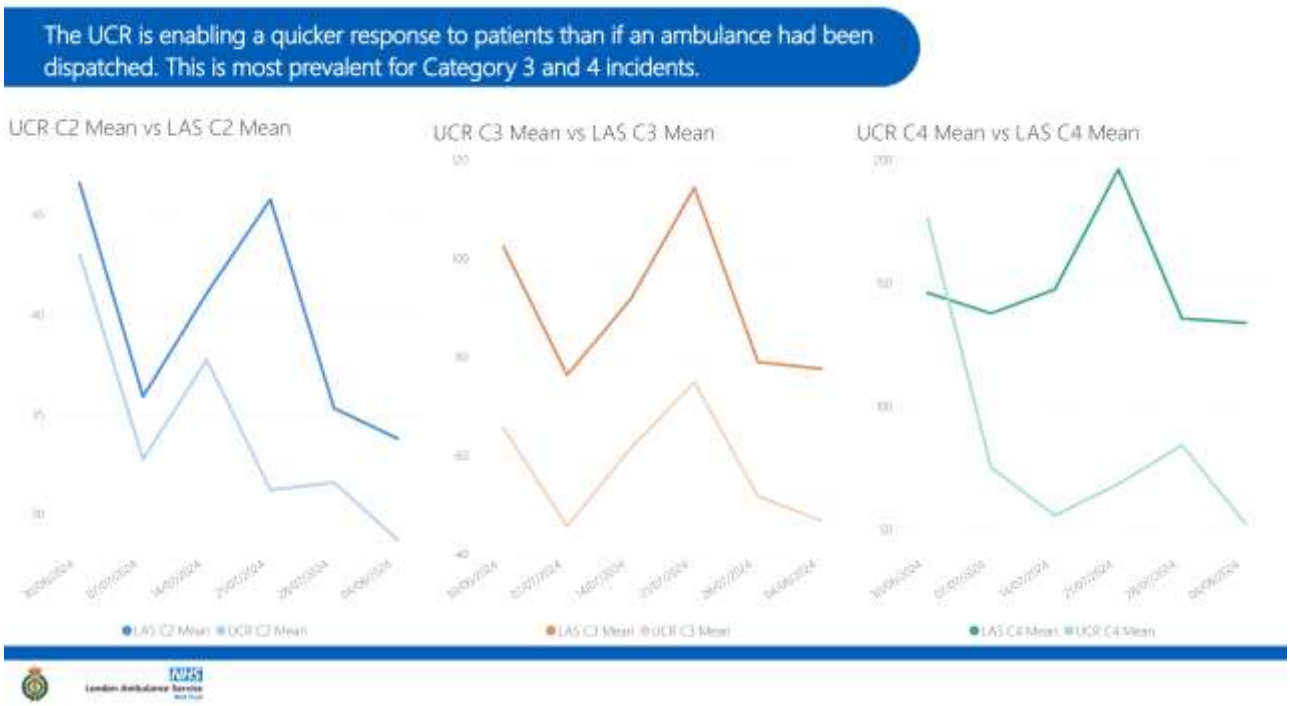


Figure 14: UCR response comparison to double crewed ambulances

6. Integrated Urgent Care (IUC)

In June and July 2024, the IUC team saw improvement across a number of key performance metrics as well as important safety and quality measures. Alongside this, the team continued to deliver a comprehensive Transformation Programme at pace and onboarded around 260 staff from LCW along with their call answering activity. The General Practice Support Service was further expanded and procurements launched for key parts of the delivery model. This has been achieved against a backdrop of high demand especially during the EMIS downtime, the continued transition to the new call centre in Bernard Wetherill House, and the reduction of cost across the service through the CIP and productivity.

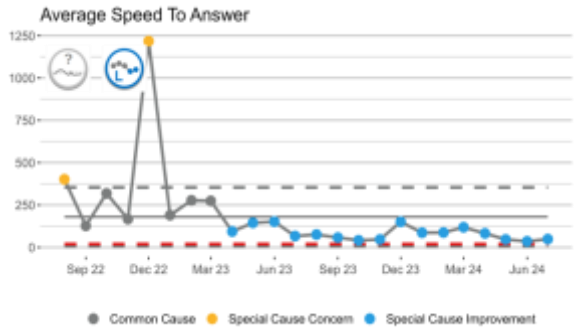
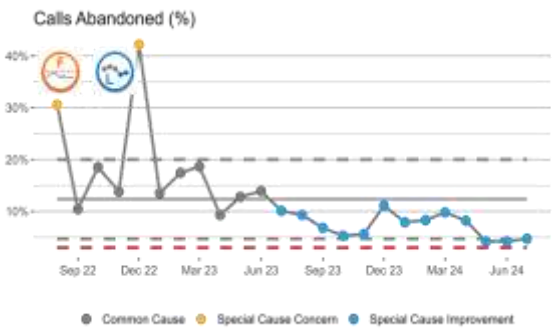


Figure 15: Average speed to answer SPC



SPC Figure 16: Calls abandoned SPC

In June and July, the average speed to answer (figure 15) was 42.5 seconds and the average abandonment rate (figure 16) was 4.45%. This is a vast improvement on the 12-month mean of 73.4 seconds and 7.12% respectively. It is recognised that more work is needed to achieve the 20 seconds speed to answer target and the 3% abandonment rate target however the service is on the correct trajectory to achieve this by the end of the financial year 24/25. Extensive work has been done to improve the productivity of the workforce through the provision of role cards and productivity trackers whilst all managers are having training on having coaching conversations with their teams to improve performance. In addition to this, the data quality in the service has been improved and the creation of new dashboards and wallboards has supported the real-time management of the service. Our performance in these areas was extensively impacted by the unexpected EMIS downtime as part of the global IT outage between 19th and 22nd July however the team managed the incident effectively to recover the position as soon as possible.

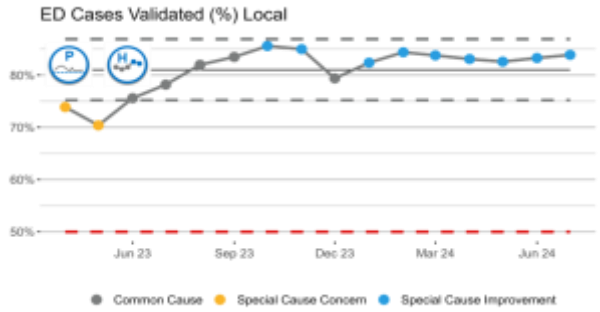
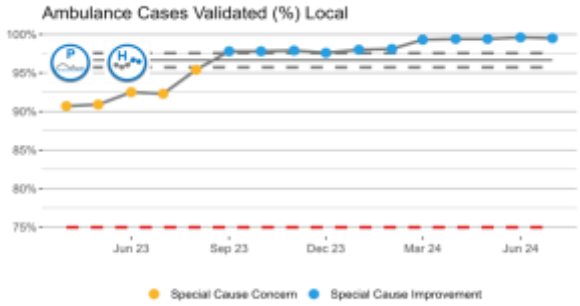


Figure 17: ED cases validated SPC



SPC Figure 18: Ambulance cases validated SPC

During the two months, the team completed 12.4k ED (figure 17) and 38.7k ambulance validation (figure 18) which resulted in 33.9k ambulance dispatches being avoided and 9k fewer emergency department arrivals. The IUC team's performance against these metrics far exceeded the target and shows the role of the IUC team in coordinating access to the wider urgent and emergency sector across London. The team also completed 4.9k Star-5 calls with ambulance crews on scene with an average response time of 20 minutes and 22 seconds. More effective management of the clinical rotas and skill mix has supported the CAS team to deliver this activity alongside changes to the real-time management of the clinical queue to ensure better oversight.

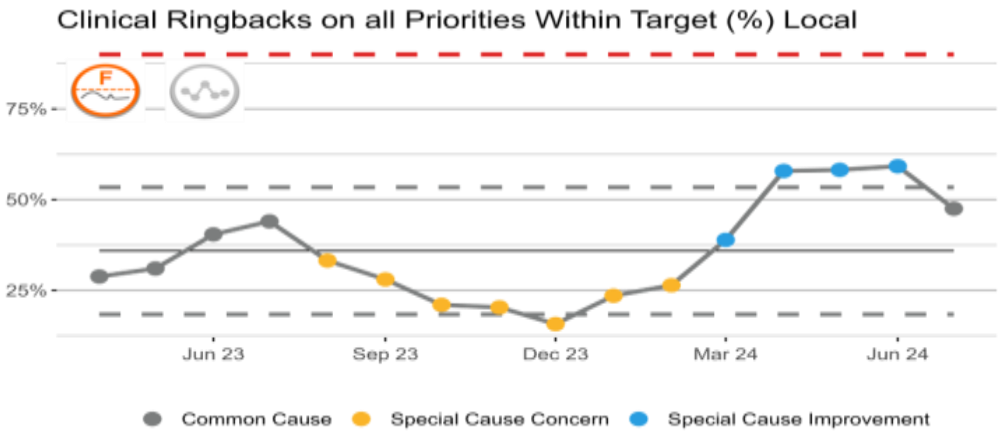


Figure 19: Clinical ringbacks on all priorities within target SPC

The CAS team managed 88k calls during the two-month period and achieved the KPI in clinical ringbacks for all priorities within target (figure 19) in 53% of cases. This is an extensive improvement from the 12-month mean of 36%. There is still a long way to go to achieve the 90% target set out in the IUC contracts and quality priorities however the team are on an improvement trajectory driven by increased productivity, oversight of the queue, and improved clinical queue management. This work has been supported by the Transformation Programme which has recently entered phase 3 whilst continued work to review the sourcing model of the CAS as well as the clinical mix aims to further improve performance and reduce cost.

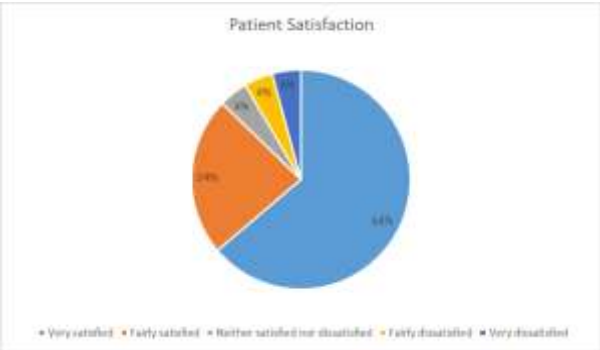


Figure 20: Patient satisfaction results

Figure 21: Time to clinician callback satisfaction

In June, average patient satisfaction was 4.4/5 and that increased to 4.7/5 in July. Furthermore 88% of patients were either satisfied or very satisfied with the service (figure 20). This represents continued strong performance in our provision of safe and effective care; a theme highlighted by the fact that 89% of patients said that they were happy with the time they waited for a clinical call back (figure 21). The team are pleased to see that the improvement made in the overall performance of the service are positively impacting the experience of patients and the level of care they receive.

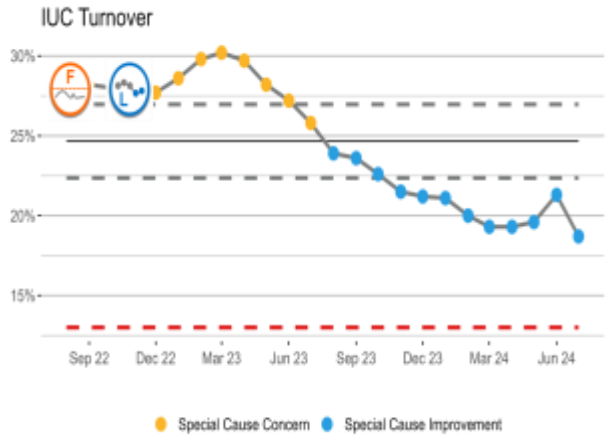


Figure 22: IUC Turnover SPC

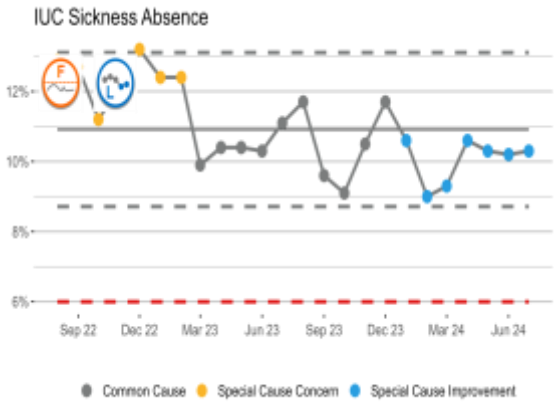


Figure 23: IUC sickness absence SPC

Across both June and July, the IUC team saw a reduction in turnover (figure 22) to 18% which is the lowest recorded level whilst sickness absence (figure 23) has remained consistent at around 10%. This is reflective of the work being done to improve training compliance, provision of 1:1s, and appraisals as measured in the Staff Survey Action Plan. 79.8k hours of HA/SA time was provided across the two months against a plan of 81.9k hours which equates to a rota compliance of 97.6%. This high level of compliance has led to improved performance and staff wellbeing as reflected in the metrics above.

The top 3 incident categories in July 2024 were 111/IUC call handling (82), Communication, Care & Consent (39) and Clinical Concern Regarding External Provider (35). IUC have seen concern regarding external providers enter and remain in the top 3 reported incidents overall. This is mainly due to concerns with downstream providers and general practices asking patients to call 111 to book an ambulance for transport to hospital and we have seen an increase in failed referrals for mental health teams. These incidents are reported to the individual services and raised with the Integrated Care Board leads for review and learning. IUC staff are receiving timely feedback when they are reporting incidents and staff are able to see changes as a results of incidents and are therefore more likely to record incidents. IUC have the lowest number of open and overdue incidents since October 2023.

Overall, the service has seen improvements in some key areas of performance, feedback, and safety which is reflected in the above data. There is still a lot of improvement required to meet the targets set internally and externally however the positive trajectory evidences a wider focus on development in the team. This is alongside the delivery of a Transformation Programme, Cost Improvement Programme, and various Performance Improvement Plans.

The service has also achieved a number of key milestones during this period such as the move to Bernard Wetherill House, TUPE or staff from LCW and transfer of activity, launch of 3 procurements, and development of the General Practice Support Service which has been nominated for a HSJ Award. This work will all be continued over the next reporting period.

Looking forward to the next two months, the IUC directorate will report on the increased activity managed as a result of the LCW TUPE. From 1st August 2024, the LAS team started managing all 111 calls in NCL (an increase from 20%) and 60% of 111 calls in NWL (an increase from 40%).

The team also transferred over 250 staff from LCW to LAS under TUPE and inducted them into the organisation. During July, extensive work was undertaken by the whole team to deliver this programme of work in 6 weeks with changes made to technical configuration,

additional reporting developed, and new staff matched to roles in LAS with all required due diligence completed.

As outlined in the business case, this change was enacted to support the LCW team who were unable to continue providing 111 call answering services in NCL and NWL and ensure continuity of service for our patients. As lead provider in NCL and NWL, the LAS team were well placed to take this activity and team. It further confirms our place as a leading provider of IUC services.

The transition of calls at 1500 on the 31st July went successfully and, since go-live, LAS activity has increased by 19% with abandonment rate dropping in NCL to around 2% (figure 24).

Support from resilience partners (PPG, DHU, Vocare) was utilised to mitigate the risk to performance during the transfer and throughout August this is being returned to normal levels of support.

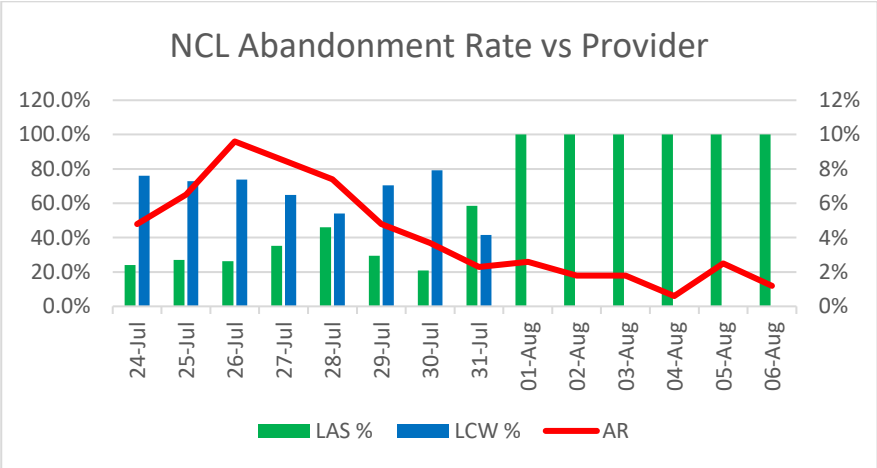


Figure 24: NCL performance following transfer

7. Resilience & Special Assets

Since the last report the Trust has responded to seven declared Significant Incidents, six of which were fires within properties.

On the morning of Tuesday 4th June 2024 we responded to a fire on a high rise building under construction, in Canning Town, E16. The Specialist Operations Centre (SOC) South, at Waterloo managed the incident, which resulted in 10 patients, 7 of whom were conveyed to hospital, all with minor injuries.

The following day, Wednesday 5th June 2024, we responded to a fire in a four storey block of flats in Hackney, E8. The Specialist Operations Centre (SOC) North at Newham managed the incident, which resulted in several patients being assessed and discharged on scene.

On Saturday 8th June 2024 we responded to an accident on a fairground ride in Brockwell Park, SE24, where part of the ride failed. SOC North managed the incident, which resulted in three priority 1 patients and 1 priority 3 patient; all with traumatic injuries and whom were conveyed to hospital.

During the early hours of Friday 12th July 2024 we responded to a fire in a residential property in Streatham, SW16. SOC North managed the incident, which resulted in six patients being assessed, three of whom were conveyed to hospital with smoke inhalation and minor injuries.

The following morning, Saturday 13th July 2024, we responded to a fire in a family's residential property in East Ham, E6. SOC North managed the incident, which tragically resulted in the death of one child and three other children being conveyed to hospital in a critical condition.

In the early hours of Wednesday 17th July 2024 we responded to a fire in a residential property with an illicit drugs laboratory inside, in Fulham, SW6. SOC South managed the incident, which resulted in a number of casualties, four of whom were firefighters from the London Fire Brigade and 1 of whom was a police officer, all overcome with the effects of burning chemicals from the drugs lab.

On Wednesday 31st July 2024 we responded to a fire in a four storey residential building in Northolt, UB5. SOC North managed the incident, which resulted in four patients, one of whom was critically injured.

On the 6th June 2024 the Emergency Planning team conducted the structured debrief for the Hainault machete attack that occurred on the morning 30th April 2024, where tragically a 13 year old child was killed and several other casualties sustained significant traumatic injuries. The debrief was well attended by staff from EOC, operations and the command team. A number of recommendations have been identified following both the debrief and the feedback form circulated to all staff involved in the incident. A summary report is being finalised and recommendations implemented.

The bank holiday weekend at the end of August sees the return of the Notting Hill Carnival. The Trust will deploy approximately 150 staff across the event footprint in command or clinical roles on both Sunday 25th and Monday 26th August. The Specialist Operations Centre at Newham will be managing the event and we will be working with partners from St. John Ambulance, the Metropolitan Police and the event organiser.

The 2024/25 NHS England Emergency Preparedness, Resilience and Response (EPRR) assurance programme launched on the 16th July 2024. The Trust is required to submit our self-assessment by the 6th September 2024, prior to a face to face review with the NHSE EPRR team and Integrated Care Board (ICB) lead on the 25th October 2024. The deep dive topic for this years' assurance is cyber security and the Head of Business Continuity is working closely with colleagues from the Trust's cyber team to gather the required supporting evidence.

8. Advanced Practice

Recruitment for both APP-UC and APP-CC is now complete. APP-UC induction commences in August 2024 and for APP-CC in September 2024.

Since the last report, three APP-UC prescribers have been added to the trust register, with a further six currently undertaking the process. Fourteen staff are due to commence on-boarding this month, having received confirmation of the relevant HCPC register annotations.

Refresher ultrasound training has been procured for APP-CC/UC staff involved in the Fascia Iliaca Compartment Block (FICB) trial alongside “red dot” X-ray interpretation refresher training for APP-UC.

Georgette Eaton returns as Consultant Paramedic (Urgent Care) from late August onwards, having completed a DPhil doctorate at the University of Oxford investigating paramedics in primary care.

Both APP-UC and APP-CC will be deployed as part of the clinical operational arrangements for the Notting Hill Carnival.

APP-UC support to the SP-PC programme continues as this area of enhanced practice develops. The focus towards the end of the year will be on determining recruitment requirements for the forthcoming financial year.

5.2. Quality

For Assurance

5.2.1. Quality Report

For Assurance

Presented by Fenella Wrigley

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	5th September 2024			
Report title:	Quality Report			
Agenda item:	5.2.1			
Report Author(s):	Dr Fenella Wrigley			
Presented by:	Dr Fenella Wrigley			
History:	The quality report has been presented to the Clinical and Quality Oversight Group			
Purpose:	X	Assurance	☐	Approval
	☐	Discussion	☐	Noting

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

This report focuses on the quality of care provided by London Ambulance Service. It should be read in conjunction with the quality performance pack to provide the Trust Board with an overview of quality across the Trust.

The report covers four domains:

- Safe
- Effective
- Caring
- Well Led – Quality Improvement and Regulation

• Reported incidents: The number of incidents reported on Datix has continued to increase throughout the reporting period and has maintained special cause variation. Northwest and Southeast continue to be the highest reporting sectors. Most incidents reported are within the no/low harm severity grading. Tops categories for the reporting period are: Medicines management – specifically errors identified on audit of controlled drugs books; reports of violence/aggression – specifically directly verbal abuse; medical equipment – specifically failure of device / equipment.

• Overdue incidents: The Trust continued to improve on the number of overdue incidents, noting 458 were overdue at the time the quality report was written. This shows continued improvement. Work continues to achieve the reduction as outlined in the trusts business plan.

• Medicines Management: The number of controlled drugs incidents remains high at 217. The majority of incidents are in relation to errors when completing the CD register.

• Safeguarding Level 2 & 3 Training: Compliance on Safeguarding Level 2 & Level 3 has been set at 85% in agreement with commissioners. Plans are in place for those areas where this is not yet being achieved.

• Infection control: The overall hand hygiene rate for July 2024 was 90%. This score continues to exceed the Trust performance target (90%). Monthly station cleaning compliance is 96%

• Clinical AQI: The LAS ranked 1st with 32.0% of patients achieving ROSC which was sustained to hospital arrival, well above the national average of 26.9%. In the Utstein comparator group, this value was 52.0%, surpassing the national average of 46.5% and placing the LAS in 2nd position. • Call Handling: Quality Assurance audits exceeded target requirements during this reporting period.
Recommendation(s) / Decisions for the Board / Committee:
For discussion and assurance

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	**Yes**	X	No		Via Clinical Quality oversight Group
Finance	**Yes**	X	No		Via Clinical Quality oversight Group
Chief Paramedic	**Yes**	X	No		Via Clinical Quality oversight Group
Medical	**Yes**	X	No		Via Clinical Quality oversight Group
Operations	**Yes**	X	No		Via Clinical Quality oversight Group
Communications & Engagement	**Yes**	X	No		Via Clinical Quality oversight Group
Strategy	**Yes**	X	No		Via Clinical Quality oversight Group
People & Culture	**Yes**	X	No		Via Clinical Quality oversight Group
Corporate Affairs	**Yes**	X	No		Via Clinical Quality oversight Group

5.2.2. Quality Assurance Committee Report

For Assurance

Presented by Mark Spencer

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**23/07/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**05/09/2024**
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 and Summary

The Committee noted:

- There has continued to be an increase in the reporting of patient safety incidents, specifically no and low harm categories. The top 3 no and low harm categories in May 2024 were Medical Equipment (122), Medication error (77) and Clinical Treatment (75).
- The number of incidents reported within IUC has, like the rest of the service increased the last few months for both No Harm & Low Harm incidents.
- The compliance rate for hand hygiene in May 2024 was 98%. This score continues to exceed the Trust performance target (90%).
- The Trust's overall premises cleaning compliance for May 2024 was 96%, which continues to achieve the Trust performance target of 90% and is an improvement on the last period.
- Medical Equipment incident was the third top reported category in May 2024 with 201 incidents reported.
- There are 508 overdue incidents, which have been open on the system longer than 35 days (this excludes SIs, PSIIs & PSRs).
- Compliance on Safeguarding Level 2 & Level 3 has been set at 85% in agreement with commissioners. Safeguarding training (Level 1 Trust wide) is at 92%, Level 2 Adult and Children for EOC/111 has improved and is 85.5% and Level 3 Trust wide is 87%.
- The total number of complaints overdue (excluding PSI) is 32/169 (18%). 62% of complaints due in May were responded to in time against a target of 75%.
- There are 79 (90%) policies in date across the Trust. 9

Patient Safety Incident Summary
The Committee noted:

- There were 46 Patient Safety Incident Investigations (PSII) and/or Reviews (PSR) completed during these three months. The identified themes and learning points will be taken forward through the various learning channels across the Trust and assurance of this will be included in future thematic reports. 2. Compliance (as of 12/07/2024.
- Cases pending PSIP review are continuing in a position of special cause variation demonstrating improvement. This is due to timely review at sector PSIGs, timely Learning from Death reviews and improvements in the process for considering MPDS quality assurance reports.
- The number of open PSIIs and PSRs has improved since the last reporting period.
- The Trust has set an objective to become zero breach of 6 months by 31 March 2025. In order to achieve this, scoping work has taken place at the Q1 Patient Safety Forum.

Chief Paramedic Performance Report
The Committee noted:

- A summary of key performance metrics and analysis of the improvements in the long delays to some Cat 2, referring to data up to May 2024.
- Call handling means remains strong and below the contracted requirement of 10secs. This is driven by improved resourcing and consistent planning against forecast demand.
- LAS continues to deliver the second best Cat 1 performance nationally for this patient group.
- Actions are being undertaken to improve our underlying performance, including: rapid release of ambulances held at hospitals for C1 patients in the local community.
- Category 2 common cause variation, and efforts are ongoing to further improve response times with actions including reduction in hospital handover time and incentivised overtime targets at key times, specifically night shifts and weekends.
- Category 2 calls with a delayed response of over 90 mins remains high and of significant concern.
- Resource time lost at hospital whilst crews await the handover of patients continues to see an increase.
- Renewed focus is in place on ambulance out of service has seen further improvement in the last two months, thus increasing the hours available to respond.
- Ambulance operations huddle time continues to provide opportunity for group clinical supervision discussion, and peer learning which complement the rollout of direct clinical supervision for Clinical Team Managers.

Quality Improvement Report
The Committee noted:

- There are 3 QSIR associates who are accredited to deliver training across the Trust. To date, 277 staff have been trained in the one-day QI fundamentals course and 67 have now completed the 5-day practitioner course, with another 15 planned on the Practitioner course and 9 booked on the fundamentals for later in the year.
- 1:1 coaching has been successfully provided for various staff across the Trust, including those undertaking projects as part of the 100 Leaders.
- The Trust continues to participate in the IHI Health Improvement Alliance Europe, and the 3 year partnership with Surrey and Sussex Healthcare NHS Trust has now commenced, to further develop the Trusts quality management system and improvement approach. The Trust are active contributors to the growing AmbulanceQ network.

999 Operations Update
The Committee noted:

- Dispatch areas – moved from 17 to 22 , reducing pressure on ERDs.
- Implementation of Clinical Dispatch Support.
- Introduced technical improvements such as an enhanced Suggestions function and new FRU tier points.
- Improved location matching including adding bus stops and developing Top Tips for call handlers.
- Updated rest break agreement.
- Completed 1st major rota change in 20 years- Launched on 1 July with EOC Teams Based Working.

Audit- Controlled Drug Audit
The Committee noted that the Trust currently below 90% compliance compared to the expected performance for controlled drug management, which should sit at 100%.

The Committee noted and were assured about the oversight and actions being taken and future plans with regards to e-CD registers.

Key decisions made / actions identified:

Blue Escalation Plan for Frontline Operations

The Committee approved the actions for frontline clinical operations staff when escalating to Blue, alongside key high-level messaging and proposed interventions, together with identified next steps.

Risks:	The Committee approved the increase score of the following BAF risk: 1.2 We may cause harm by not achieving the Ambulance Performance Standards set out in the NHSE Operating Plan due to: • Insufficient funding from commissioners; • Constrained capacity in the UEC system and handover delays at hospitals • Underachievement of productivity initiatives The risk description has been amended and the risk split into the three key areas, with an increase to the overarching risk score from 4 x 4 (16) to 5 x 4 (20).
Assurance:	The Committee received assurance on the reports presented.

5.3. People and Culture

For Assurance

5.3.1. Director's Report

For Assurance

Presented by Damian McGuinness

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust Board meeting 5th September 2024

Report from the Chief People Officer

Executive Summary

OD & Talent Management

The LAS has once again been recognised by the Department of Education as a Top 100 Apprenticeship Employer, making fifth place, which is our best ever result.

The rankings celebrate England's outstanding apprenticeship employers, recognising their commitment to creating new apprenticeships, the diversity of their apprentices, and the number of apprentices who successfully achieve their apprenticeships. LAS is the only NHS Trust to be featured every year since the rankings were launched in 2020 and the only NHS Trust in the country to make the top 10. Our high ranking puts us ahead of other large employers such as the BBC, BUPA, PWC and Tesco.

The OD and Talent team has amalgamated the 'Our LAS' culture change journey so far and has presented the organisation's collective achievements to date to the People and Culture Committee (PCC). The OD&T team has created visuals to illustrate where we are now in our culture change journey and the actions/successes aligned to our values; as well as how OD&T, which is leading this work, want everyone within our service to feel. These visuals will be shared with #teamLAS as we prepare to launch the next National Staff Survey 2024.

Recruitment & Retention

Recruitment held their first Career and Recruitment event LASFest on 13th July 2024. The main purpose of the event was to:

- Promote a diverse range of roles and support services within the Ambulance Service, marketing the Trust as an employer of choice.
- Attract members of the community reflective of our diverse London.
- Boost pipelines across the majority of our bulk recruitment and hard to fill roles.

The event attracted over 600 visitors.

Recruitment to the Trust Workforce plan continues at a positive rate. The current pipeline is at circa 800 candidates at conditional offer stage (500 plus of these are for frontline roles and call handlers). Course fill rates remain positive across all roles with 89% achieved in Quarter 1 and 100% achieved in July.

Turnover has improved again and is now below 9.5%. The number of frontline and call handling leavers has remained positively below plan.

Workforce Plan 2024/2025

The workforce plans for 2024/2025 have been based finalised on zero growth i.e. recruiting to 1st April 2024 levels throughout 2024/2025 except for specialist and advanced paramedics where there is an objective to increase the total by 60fte.

Health and Wellbeing

The new 2024-26 Health and Wellbeing delivery plan has now been approved by the relevant Trust committees. Based on the NHSE Wellbeing Framework, AACE guidance and specific Trust strategic objectives, the delivery plan sets out the priorities and success measures for the Wellbeing team over the next two years. The plan takes a proactive and holistic approach to the health of all colleagues, with interventions already taking place to reach the goals set for the current year. Highlights include a greater focus on physical health, supporting sickness absence and enhanced engagement with colleagues via opportunities presented by Team based working.

P&C Operations

1. Recruitment

We ended Q4 continuing with our positive performance with strong pipelines and fill rates. We achieved a 94% fill rate across all available course spaces for the financial year 23/24.

- **Paramedic recruitment** – we have had limited courses during Q1, but have been working on our pipelines for courses later in Q2 and Q3. Our UK Grad pipeline current sits at 185 offers made and our International Pipeline is currently at just over 100. We achieved a 100% fill rate in July.

- **AAP Recruitment** – we have filled 25/26 training places in Q1 and continue to have a strong pipeline of candidates offered currently at 140, this includes candidates obtained from the Our LAS Inclusive Response Programme (pre-apprentices), where to date we have had 3 new starters. The Call Handler to AAP programme commenced during April, and we have made 21 conditional offers for candidates to commence during October and January. We achieved a 100% fill rate in July.

- **Call Handling Recruitment**

  Positive fill rates in EOC Call Handling during Q1 filling 38/39 training spaces available, with over 60 candidates currently in our pipeline. 111 call handlers – we achieved a 98% fill rate during Q1 on available training spaces with over 60 candidates at offer stage. We achieved a 100% fill rate in July for call handling recruitment. Both the EOC and 111 call handler pipelines have been boosted by our recent event LAS Fest (see below).

  Corporate/Specialist recruitment – there continues to be significant recruitment activity to support the frontline including recruitment into Advanced Paramedic Practitioners, CRU, TRU, HART, HEMS, PCN Programme, Mental Health and Community Resuscitation roles. We currently have over 150 candidates at conditional offer stage.

Recruitment held their first Career and Recruitment event LASFest on 13th July 2024. The main purpose of the event was to:

- Promote a diverse range of roles and support services within the Ambulance Service, marketing the Trust as an employer of choice.
- Attract members of the community reflective of our diverse London.
- Boost pipelines across the majority of our bulk recruitment and hard to fill roles.

The event attracted over 600 visitors, with initial statistics below. The team are still working through candidates to be assessed and interviewed, for a variety of our roles.

Sign ups (RSVPs)	2,599
Attendees	613
Assessment Registrations (111/999)	341
Expression of Interest NETS	36
Clinical Advisor Nurse Applications	9

Fleet Technician Applications	2
OLIR Sign Ups	22
Princes Trust Sign Ups	28
London Life Savers Trained	230

Call Handler to Frontline Recruitment Program

This program has been designed to create opportunities for call handling colleagues to pursue a clinical career pathway and eventually become a paramedic and beyond. It has a number of key benefits including enabling colleagues to pursue an apprenticeship and earn whilst they complete their training, providing a career pathway where this might not be currently available, improving the attraction of staff, the BME representation on the frontline and retention. Feedback has been very positive to date with over 100 colleagues expressing an interest and a number of offers have already been made. There has been strong senior P&C ownership of this project with regular and consistent communication with candidates. Colleagues are being supported through the application process with AAP information workshops, a guaranteed interview for all candidates who meet the essential criteria, time off and funding for C1 driving courses and signposting, coaching and mentoring for interested colleagues. Positively, BME representation off 60% has been achieved at different stages of the recruitment process.

2. Retention

Turnover has improved to 9.3% in July and the number of frontline leavers and call handlers has remained positively below plan. The stability rate which measures the 'stay' rate for staff over a 12 month period averages 87% for the year.

There are a number of key retention initiatives in progress covering flexible retirement, stay conversations and personalised holistic health plans (initially piloted in 999 and 111 call handling) and a review of the internal exit interview process to improve intelligence on reasons for leaving.

The stay interview pilot has completed and was positively received. This initiative has now moved into BAU and there is a commitment to hold 40 interviews per month (jointly by wellbeing and HR teams). There are plans to roll this out more widely across some sectors in the coming months.

The flexible working policy has been revised to reflect recent changes to legislation. This makes the process easier and more flexible for employees. Employees will not need to explain what effect, if any, the requested change would have/how that might be dealt with, will be entitled to make two requests in any 12 month period (previously one), an employer will not be permitted to refuse a request unless the employee has been consulted and the timing of the employer's decision has been reduced to two months.

3. Employee Relations

In the Trust Business Plan we have committed to improving the employee experience and engagement by reducing the mean length of formal case management to within a timeframe of 12 weeks. To enable us to achieve this we have broken down the key milestones in the process and the following are some indicative KPIs which need to be finalised and these will

then be used to manage our performance. We will be communicating the KPI's over the coming weeks to all staff and staff side and implementing from October 2024.

Stage	Action	Timescale
Resolution Hub	Completion of triage process	5 working days
Mediation/Round Table	Meeting to be arranged	4 working weeks
Formal Investigations	Conduct and employee concern	4 working weeks
Hearing stage	Notification of investigation outcome and hearing date arranged	3 working weeks
Hearing Outcome	Notification of outcome	1 working week

4. Workforce Intelligence, Payroll & Pensions

DBS checks

As at 31st July 2024, the Trust has a 99.9% compliance rate for DBS checks. This represents the total number of recorded DBS checks in the Electronic Staff Record (ESR) as a % of those who are eligible for a check.

Digital Assistant

The People & Culture team at the London Ambulance Service are working in partnership with East and North Hertfordshire NHS Trust and IBM to deliver a digital assistant for their 8,000 staff. We are looking forward to bringing this new digital assistant technology into our People & Culture team which will provide all of our frontline staff with the ability to ask questions and access vital information at a time which suits them. In addition, it will reduce the administrative burden on our HR teams and free up their time to focus on more value-added and complex HR activities. A soft launch is planned for September.

Payroll & Pensions

Significant activity in July supporting the on-boarding of over 250 employees from the London Central & West 111 Service ready for 1st August start date. We have also continued to see increases in the take-up of flexible retirement opportunities (including partial retirement) and have been supporting these staff to ensure they have a smooth process and positive experience.

Workforce Planning 2024/2025

The workforce plans for 2024/2025 have been based on zero growth ie recruiting to 1st April 2024 levels throughout 2024/2025 except for specialist and advanced paramedics where there is an objective to increase the total by 60fte. Recruitment and training plans are in place to deliver the workforce requirements and Ambulance Operations have set up a monthly tracking

meeting to ensure that they maintain staffing levels within budget. This monthly review will enable early identification of expected over/under establishment so that agile and informed decisions about recruitment can be taken. Work is due to start to identify as early as possible staffing requirements for 2025/2026.

5. Scheduling

Since the formation of the Scheduling Transformation Board, there has been positive changes to shape the future operating model of the Scheduling team.

- To achieve the aim of working more closely with Ambulance Operations, there will be a sector based operating model and on the day issues will continue to be addressed by a centralised team. This will allow a closer working relationship between operational managers and their sector Scheduling team, as well as giving local managers more input over their staffing. The new Team Based Working rota for Operational Scheduling has been agreed with a go live date of 2 September 2024.

- There has been positive feedback regarding the delegation of tasks so far (to local management and station administrators) and training will continue to roll out to more group stations. This allows for quicker resolution of minor requests and lets the Scheduling team focus on planning for the days ahead.

- The tender process for our rostering system is in development with a start date of September.

- Work is underway to establish possible routes of system automation, although this is more complex and dependent on the function. For example, we've managed to automate overtime requests, but have challenges automating annual leave. The rostering system tender process seeks to find a product that will have this additional functionality.

- Individual one to one conversations have been held between team members and the Head of Wellbeing and Project Manager to identify the areas of concern. A draft action plan has been formed and we are working closely with the OD & Talent team to plan interventions which will provide leadership development for our Senior Resource Coordinators and improve the sense of teamwork in the department.

- Phase 2 of the Scheduling Transformation Board is underway by reviewing the EOC & 111 Scheduling Teams. The decision was made to combine both areas, and this is now being worked through, while recognising that a separate transformation process is also ongoing within the 111 directorate.

- We have supported with the successful TUPE of our 111 LCW colleagues in August 2024.

6. Health and Wellbeing

Occupational Health

Both of the Trust's Occupational Health providers continue to provide evidence of good performance, with all KPIs being met on a regular basis. Immunisation clinics are in place across London with good attendance rates and capacity to meet any increase in demand due to communicable disease outbreaks. There is additional partnership work to improve the rate of completion for stress risk assessments with expert input from the clinical team at Optima.

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 five 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 has recently recruited an additional psychotherapist to her team. We have also benefitted from the advice of KeepingWell NWL who are able to refer colleagues for fast track IAPT services.

Wellbeing Activities

Over the summer the tea trucks and wellbeing cafes are providing cold drinks and ice pops, with an increased presence on very hot days where possible. Both the trucks and the cafes also distribute wellbeing-related information and encourage discussion with colleagues – topics have included financial and tax support, how to access counselling and participating in the LAS Charity London Life Hike.

Actions from the 2024-26 Wellbeing Delivery Plan are underway, with focus on 8 key priority areas including the introduction of Wellbeing Champions, expanding our Health Coaching programme and promoting Healthy Lifestyles. The Wellbeing Team are also working much more closely with HR and management teams around a more proactive approach to minimising sickness, which includes ensuring that managers and colleagues have the right support to avoid unnecessary absences and minimise periods of sickness.

Another priority area relates to improving physical health and a pilot is underway designed to provide and teach functional movements relevant to individual roles. Working within the teams based working model has allowed capacity to be face to face with teams, building rapport, raising morale, reducing stress through exercise and empowering the workforce to exercise safely, preparing their body for their role.

The pilot groups are Hillingdon, Hayes, Brent, Kenton and Pinner Group Stations as well as EOC south. To date 300 colleagues have enthusiastically engaged in 'huddle' activities and discussions including topics such as: 'Ways to improve movement and manual handling to reduce injury at work' and 'Managing stress and maximising sleep for shift workers'.

Feedback has been extremely positive with comments such as; “I wish I had learnt this when I first started” and “I feel much more confident in my manual handling”. A full evaluation of the pilot will take place towards the end of the year.

7. Organisational Development & Talent Management

In driving forward the Our LAS Culture Change Programme, our latest activities are highlighted here:

Apprenticeships

The LAS has once again been recognised by the Department of Education as a Top 100 Apprenticeship Employer, making fifth place, which is our best ever result. The rankings celebrate England’s outstanding apprenticeship employers, recognising their commitment to creating new apprenticeships, the diversity of their apprentices, and the number of apprentices who successfully achieve their apprenticeships. LAS is the only NHS Trust to be featured every year since the rankings were launched in 2020 and the only NHS Trust in the country to make the top 10. Our high ranking puts us ahead of other large employers such as the BBC, BUPA, PWC and Tesco. Ahead of us in the ranking were the Army, BT, Royal Navy and the Royal Air Force.

Leadership and Culture Management:

The OD and Talent team has amalgamated the ‘Our LAS’ culture change journey so far and has presented the organisation’s collective achievements to date to the People and Culture Committee (PCC). The OD&T team has created visuals to illustrate where we are now in our culture change journey and the actions/successes aligned to our values; as well as how OD&T, which is leading this work, want everyone within our service to feel. These visuals will be shared with #teamLAS as we prepare to launch the next National Staff Survey 2024.

The team is also working with ambulance operations to support CAT 2 response times and how to utilise strategic OD interventions and models to support operational and performance efficiencies.

Appraisal Compliance

The OD&T team has implemented the first phase of a three-stage Appraisal Improvement Plan. Phase one of the plan focusses on increasing appraisal compliance across the organisation between July and September 2024.

The current appraisal compliance rate (as at 7 August) is 78.4%. This represents an increase of 5% since mid-July against a target of 85%. Phases 2 and 3 of the plan will focus more broadly on the organisational approach to, and ethos around appraisals, including evaluation of our e-appraisal pilot.

Team Effectiveness
The team has continued to support team effectiveness and the rollout of teams-based working through delivery of a range of interventions and face-to-face sessions in Ambulance Operations, Emergency Operations Centres (EOC), People and Culture and Health and Safety.

Leadership Development Programmes:
The first modules of the Our Aspiring Leaders (bands 4/5) programme, in partnership with NHS Elect; and the High Performance Leadership programme (Bands 8B-9) in partnership with Henley Business School have been delivered. Planning for the Our LAS, Our Leaders (bands 6/7) programme, in partnership with Middlesex University is progressing prior to courses commencing in September 2024.

Talent Management:

Consultation support for the Emergency Bed Service (EBS) Team
The OD&T team has launched and delivered a consultation support package for colleagues in the EBS team focussed on interview and career development skills.

The support package comprised bespoke sessions on the following topics:

- Values-Based Interview Skills
- Communication Skills
- Presentation Skills
- Coping with Uncertainty
- Managing Stress in the Workplace

The package also included signposting to NHS Elect and other LAS memberships and offering all colleagues bespoke '1-2-1' support from interview skills, mock interviews and a walk through of the Learning and Education Course Catalogue.

Based upon the excellent feedback of this support package, the OD&T team is currently scaling this up with the intention of inspiring and supporting any team which is or may go through consultation/ organisation change in the future.

NHS Graduate Management Training Scheme (GMTS):

The organisation has been successful in the allocation of a HR trainee, who will be based in the People and Culture Directorate from September; and a General Management trainee, who will be allocated to Ambulance Operations. The OD & Talent Team has submitted the associated job descriptions and a well-rounded orientation plan for the trainee's first 20 days at the LAS to give them a solid understanding of how the organisation supports our colleagues, patients and local communities. This includes shadowing opportunities at 111, EOC, ambulance ride-out shifts, meeting local teams and visiting our local ICB.

Learning and Development:

Tackling Discrimination and Promoting Inclusivity Programme Phase 2

This mandatory programme for all colleagues will be launched in September and 240 half-day sessions will run throughout the coming year.

Phase 2 of the programme is under development with a focus on continuing to build a just culture where all colleagues are confident to raise issues and report incidents, demonstrating that we learn when we do not get care right.

In partnership with subject matter experts, we are filming a series of scenarios to support the facilitation of conversations during the sessions, including racial discrimination and sexual safety.

Learning and Education Course Catalogue Offer

We have published version 7.0 of the Learning and Education Course Catalogue, in partnership with Clinical Education & Standards colleagues.

In recent weeks the OD & Talent Team has delivered a series of virtual values-based interview skills sessions for our EOC and EBC colleagues; as well as open courses for all colleagues on Appraise with Values, Communication Through Teamwork, Interview Skills for Interviewers, and the Stress Assessment Toolkit.

In partnership with the Freedom To Speak Up team, we have produced a short video about the service for all colleagues to access online.

8. Clinical Education & Standards

The LAS continues to invest in quality education and training for its workforce in 2024/25, this will continue through an enhanced education bursary of up to £5,000 per person which will greatly benefit our growing and diverse staff. The 2024/2025 Registrant CPD funding has also been agreed by NHSE at £1,000 per registrant.

To support the delivery of the Trust training plan, CE&S are continuing a rolling recruitment campaign with a view to filling all vacant tutor posts.

In Q1 of 2024/2025 CE&S have seen over 150 Paramedics and Call Handlers complete their training and join their respective operational areas and a further 75 frontline staff have started their training courses.

The 2024 CSR modules for ambulance ops have been released and over 2,000 staff have undertaken face to face sessions and these will run until the end of the fiscal year.

The courses for Experienced Clinician Induction (ECI), Bariatric, and the Adult Critical Care Transfer Service (CCTS) have been developed and delivered successfully within the centres.

Damian McGuinness

Chief People Officer, London Ambulance Service NHS Trust.

5.3.2. People and Culture Committee Report

For Assurance

Presented by Anne Rainsberry

London Ambulance Service NHS Trust

Assurance report:	**People and Culture Committee**	**Date:**	**29/07/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**11/07/2024**
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:

DIRECTORATE PERFORMANCE

The committee noted the following:

- The continued excellent progress on recruitment and has received substantial assurance that the plan will be met in full. All recruitment plans remain on track to be met and in some cases exceeded.
- Turnover has further improved in May (circa 10%) and the number of frontline leavers (including international paramedics) has remained positively below plan. The stability or 'stay' rate measures the % of staff who remain in post for more than one year has remained at 87%.
- Work has continued on the workforce plan. In 2024/2025, an additional £4.8m funding has increased the budget from 3,754fte to 3,808fte. To deliver this requirement, there is a plan to recruit 370 paramedics (234 UK and 136 internationally) and 144 AAPs. The current recruitment and training plan is currently forecast to deliver +37fte above this establishment. The gap is expected to close with additional internal movers. The committee discussed and received assurance on the planning assumptions upon which the plan is based including triangulation of productivity assumptions with operation plans.
- The development of the managers dashboard which will provide line managers with workforce metrics and trends for their team. This has been designed to support team-based working and will enable comparison between teams and geographies to support improvement.

- Work continues to develop new scheduling arrangements that supports team based working and closer working with Ambulance Operations. Six potential new rotas shortlisted for staff vote on. The voting period ends on 7 July 2024. The current proposed start date for the chosen new rota is 2 September 2024. Work is underway to establish possible routes of GRS automation, although this is complex and dependent on function. Phase 2 of the scheduling transformation is underway, by reviewing the EOC & 111 Scheduling Teams.
- Sickness reporting arrangements will change from August with the introduction of increased mental health support for those staff who need it. The committee also discussed the risks going forward into winter of a rise in absence noting that currently remains above where we would want it to be at this time of year.
- An analysis of trends in ET cases was discussed and an exploration of how some cases may benefit for earlier resolution. The committee noted the increasing number of claims that are lodged but later withdrawn.

FROM CALL HANDLER TO FRONT LINE

There has been extremely positive progress on the Call handler to Front line programme. At this stage (with some interviews yet to take place) the programme has achieved a 60% BME representation at all stages of the recruitment process. The committee discussed the learning that might be transferable to future similar schemes. This included:

- Senior P&C ownership of this project
- A single point of contact ensuring regular and consistent
- communication with candidates every two weeks.
- Visits to EOC and 111 call centres
- Staff being supported through the application process with:
    - Over 50 staff attending our AAP information workshops.
    - All applicants meeting the essential criteria being guaranteed an
    - Interview.
    - The trust providing time and funding for C1 driving courses.
    - Signposting, coaching, and mentoring for interested staff

CLINICAL EDUCATION DEEP DIVE

The committee received a presentation on the breadth of the Trust's clinical education programme. This covered all aspects from learners, induction, CPD and specialist education. The committee discussed future developments including the future role of simulation and AI in future educational offers.

HEALTH AND WELLBEING

The committee received a presentation on the Health and Wellbeing Plan for the Trust. The plan focuses on eight key areas**:**

- Preventing & Minimising Sickness
- Supporting year of the team
- Trauma Response and Mental Health Support
- Healthy Lifestyle & Education
- Physical Health Promotion
- Health Coaching
- Wellbeing Champions
- Wellbeing Support Vehicles & Cafes

The committee reviewed the action plans for each of these areas and the associated outcome metrics.

CULTURE PROGRAMME – OUR LAS UPDATE

The committee received a presentation on the Trust's culture change programme. The programme now has five key work streams:

- Talent Management
- Leadership and Culture change
- Learning and Development
- Apprenticeships and employability
- Operational response improvement programme

Progress will be measured against a range of metrics some locally determined which can be run frequently and also some from the annual staff survey.

FREEDOM TO SPEAK UP REPORT

The committee noted the progress on FTSU. The meeting discussed the future format of reports, including the need for trend data, and received assurance that this would come to the next meeting.

Key decisions made / actions identified:	See other commentary.
Risks:	**Board Assurance Framework**

	The committee reviewed the refreshed risks aligned to the 2024/25 Business plan. These risks have been reviewed by ExCo and Lead Executives since last reviewed by the committee in May, BAF risk 2.4 relating to sexual safety, is currently being developed and has been included for discussion.
Assurance:	Assurance was received on directorate performance and clinical education programme and the continued implementation of the Our LAS programme.

5.3.3. EDI Committee Report

For Assurance

Presented by Anne Rainsberry

London Ambulance Service NHS Trust

Assurance report:	**Equality, Diversity and Inclusion Committee**	**Date:**	**29/07/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**09/07/2024**
Presented by:	Anne Rainsberry, Non-Executive Director, Chair of Equality, Diversity and Inclusion Committee	**Prepared by:**	Anne Rainsberry, Non-Executive Director, Chair of Equality, Diversity and Inclusion Committee

Matters for escalation:

Other matters considered:

TERMS OF REFERENCE

The committee approved revised terms of reference which updated the membership and the numbers of Non-Executive members that needed to be present to be quorate.

The chair suggested that the committee should consider whether it is getting the full benefit of the voices from the staff networks at the meeting. The agenda is substantial, and time does not always allow for all the networks to help shape the agenda. The chair requested that the Director of Strategy and Transformation consider ways in which the networks contribution could be strengthened.

PART A

EDI PROGRESS REPORT

Following the last meeting ExCo have reviewed the EDI programme to ensure that the proposed objectives and actions will have sufficient impact on the issues the committee has identified.

The committee received a presentation on the agreed programme going forward. The committee noted it had five workstreams:

- **Leadership –** developing leaders and mutual accountability across the organisation.
- **Recruitment** - de-biasing selection and attracting a diverse workforce (Sea Change)
- **Inclusive Culture –** building a just and inclusive organisation, tackling discrimination at all levels.

- **Reasonable Adjustments –** implementing reasonable adjustments policy and manage a centralised process.
- **Compliance –** ensuring we meet legislative requirements and national standards.

To achieve these objectives a number of high impact actions are proposed:

- **HIA1:** Measurable objectives on EDI for Chairs, Chief Executives and Board members
- **HIA2:** Overhaul recruitment processes and embed talent management processes
- **HIA3:** Eliminate total pay gaps with respect to race, disability, and gender
- **HIA4:** Address Health Inequalities within the workforce
- **HIA5:** Comprehensive induction and on-boarding programmes for international recruited staff

The committee discussed agreed these programmes of work.

The committee received an update on progress and noted the following:

- Anti-discrimination statement and anti-racism charters have been published and disseminated.
- 64% of staff have completed the 'Tackling Discrimination and Promoting Inclusivity' training-, with plans for 74% by March 25 and a further follow programme to be launched in April.
- Data collection and analysis continues to improve, and a new scorecard will allow individual managers to see their own teams EDI data and to track progress.
- A deep dive on disciplinary processes in response to WRES indicator 3 has been completed. This has led to a new understanding of what may be driving the difference in EOC and the introduction of new arrangements to ensure consistency of treatment.
- Staff networks have been strengthened with additional dedicated time and resource.
- The call handler to front line programme has resulted in over 50% of applicants for AAP training being from a BME background.
- EDI training has been developed for clinical managers.
- The Trust is on course for regulatory compliance for first time.
- Reasonable adjustments policy and process has been implemented.

The committee also noted that the programme was beginning to have impact:

- One in four staff are from BME background, up to 24%. This is higher in new recruits with 38% coming from a BME background.
- The gender pay gap is narrowing.
- The number of staff saying Trust makes reasonable adjustments has increased from 57% to 64%.
- Over 200 neurodiversity assessments have been completed.
- Staff networks are becoming more engaged and active.
- Very diverse environments parts of our organisation – 111 = 61%, parts of corporate services
- The number of BME staff who believe Trust provides opportunities for progression remains a challenge but has increased from 38.9% to 45.7%
- While there remains a significant challenge to ensure diversity withing the paramedic workforce the number of BME paramedics has doubled in five years

However, the committee also discussed the remaining challenges including:

- BME representation remains well below London population and ELG leadership not diverse.
- Whilst some progress has been made in EOC it remains that there is an increased likelihood of BME staff entering a disciplinary process – two times more likely than white colleagues with issues of consistency.
- BME candidates are two times less likely to be successful than white candidates at job interviews with issues with recruitment process.
- The average BME figures mask disparities – 15 per cent of frontline clinicians with overrepresentation in lower pay bands
- There are real structural barriers to increasing BME representation including the location of university in less diverse areas of the country and the design of career pathways.
- There remains a significant cultural challenge with an embedded narrative of discrimination based on experience coupled some pushback on BME issues from white colleagues.

The committee discussed and reviewed the action plans to address these the business plan objectives of:

- Increase by 10% the proportion of applicants from an ethnic minority background to jobs in ambulance operations and 999, agreeing and implementing an action plan which will include implementation of a new call handler to associate ambulance practitioner recruitment programme.
- Continue strengthening staff networks, agreeing plans so they deliver a proactive agenda and grow their total membership by 20%.
- Improve the likelihood (currently 2x less likely) of Black and ethnic minority candidates being successful at interview stage, by supporting the career advancement of colleagues.

- Improve proportion of disabled colleagues who say in NHS staff survey that reasonable adjustments were made and reduce the number of concerns raised on this topic.
- Develop and deliver an improvement plan against the six Equality, Diversity and Inclusion High Impact Actions with specific focus on all leaders to be held accountable for reducing discrimination and creating an inclusive LAS.

In particular the committee discussed plans to make a step change in recruitment practices. Future action will include:

- Hiring managers will be required to write to the CEO on unsuccessful internal BME candidates, including steps taken to support individual applicants (band 7 and above)
- There are plans to recruit and train more Independent Panel Members commencing with EOC Performance Manager and Emergency Resource Dispatcher roles.
- Developing a fair and transparent processes as part of positive action initiatives in recruitment and performance of all posts in IUC

The committee also discussed the crucial role line managers will play in driving the change. All line managers will have a EDI objective based on their team's data and this will be published to enable staff to see what leaders are seeking to achieve. Managers will also develop locally owned EDI action plans with their staff.

EDI DATA SHARING

The committee received an update on the People Scorecard. This has refreshed workforce metrics and introduced some new ones. This will enable better tracking of progress of EDI objectives including BME representation, promotions, recruitment and conduct cases. The new scorecard will enable line managers to see their data for the first time.

SEXUAL SAFETY

The committee received an update from the sexual safety group.

The group has recently formed to bring together Directorates from across the Trust to work together to tackle unwanted and unacceptable behaviours and to raise the profile of sexual safety in the workplace.

The initial key areas of focus include:

- Advertising of roles, applications on boarding and inductions
- Policy and process development
- Facilitating confidence in managers to tackle difficult conversations.
- Student experience, placement and mentoring

- Investigating incidents and chairing hearings

The committee will receive a further update in due course.

PART B

This was the first meeting where the committee considered its wider scope to address wider health inequalities.

For this first meeting the committee received an update on work to date, the key priorities and proposed work plan.

The committee discussed the health inequalities strategy which sets out key aspirations and outcomes for this area of improvement work:

- Developing a 5-year action plan which will be LAS's contribution to reducing health inequalities experienced by Londoners.
- Strengthening the voice of patients through our Public and Patients Council and patient engagement activities to inform health inequality work,
- Tackle health inequality by using our data and reach to agree with NHS partners on at least two initiatives per year.

To identify priorities the Trust has used the Core20PLUS5 framework for developing evidence-driven approach to health inequalities reduction. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort (the most deprived 20% of the population (as defined by the Index of Multiple Deprivation) and identifies '5' focus clinical areas requiring accelerated improvement. These are:

- Homelessness and Health
- Drug & alcohol addiction
- Housing and Health
- Isolation and Health
- Digital Inclusion
- Patients in detention

LAS has been working with local partners to identify how it can have a positive impact in each of these areas for the most deprived groups.

The framework also allows organisation to add (Plus) locally determined priorities for locally identified populations/groups experiencing poorer-than-average health access, experience, or outcomes.

Through a process of research and extensive engagement the following local priorities are proposed for LAS:

- Cardiovascular Risk Management (inc. Hypertension, Diabetes, Arrhythmias)

	▪ Patients experiencing Mental Health crisis. ▪ Maternal health (including Global Majority ethnicity and absence of ante-natal care) ▪ Patients with Sickle Cell Disorder ▪ Patients with Autism, Learning Disabilities and/or Neurodiversity. The committee reviewed the proposed action plans to deliver this ambitious programme of work and will now begin to receive regular updates on progress. **BOARD ASSURANCE FRAMEWORK** The committee reviewed the draft BAF risks for 24/25. It discussed and agreed the EDI risks and requested that the health inequalities risks be reflected and drafted for consideration by the committee.
Key decisions made / actions identified:	▪ The committee approved new terms of reference ▪ The committee requested that the Director of Strategy and Transformation consider ways in which the networks contribution could be strengthened.
Risks:	
Assurance:	The committee received assurance on the proposed EDI action plan

5.4. Finance

For Assurance

5.4.1. Director's Report

For Assurance

Presented by Rakesh Patel

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust Board meeting

Report from the Chief Finance Officer

Financial Position at the end of July 2024

Income and Expenditure Plan

The Trust posted a deficit of £1.5m to the end of July 2024 against a surplus plan of £0.3m, an adverse variance of £1.8m. The Trust is below plan largely due to a shortfall of Cost Improvement Plan schemes compared to target. The Trust is forecasting to recover this position and deliver the breakeven plan by year-end by introducing further cost control processed.

Capital Programme

The Trust will invest £53.3m during 2024/25. By the end of July 2024 the Trust had spent £8.4m across Fleet, Estates and Medical Equipment.

Cash Balance

The Trust had a closing cash balance of £17.5m at the end of July 24.

Fleet

The Trust continues to commission a number of new vehicles including the remaining 15 Double Crewed Ambulances (DCA) from 24/25 spend and have signed off all elements for an additional 25 DCA builds. We have also commissioned 6 Mental Health Vehicles, 10 Driver Trainers Units to support training for our staff and commissioned 11 new cars for our Resilience and Specialist Asset's teams who provide specialised support during events and incidents.

Estates & Facilities

We are in the process of rolling out our Capital Estates Plan for 24/25 and we are using the opportunity to improve some of our older buildings, expand some existing ambulance stations and improve our facilities for the benefit of our teams and patients.

We have started the first step in our £25 million investment in East London by and are developing a business case for the development of a new state-of-the-art building which will enable us to relocate the Hazardous Area Response Team (HART) from Cody Road into new larger premises and bring together our resilience services including our Tactical Response Unit, Special Operations Response Team, their vehicles and the extensive equipment storage needed for these specialist teams.

The Trust is also continuing with maintenance and upgrade of existing sites, including installing gates and improving security at a number of our sites.

Logistics

We continue to prioritise equipment to ensure that ambulances are fully kitted. In line with the recent work that we have completed around tethering our fleets to local groups we are now looking to expand this into tethering large pieces of kit including the LP15s. This model of tethering the fleet has afforded local groups more responsibility around their vehicles, how they can be rostered and ensuring that workshops have more visibility of fleet assigned to them. By doing the same for equipment we hope to improve visibility via asset scanning and local ownership so that is more readily available to staff and to ensure that faults and missing equipment are recognized and dealt with quickly to minimise disruption.

Sustainability

The Trusts 2024/25 target is to decrease our carbon emissions by a further 6% and Heads of each department are working with our Sustainability Manager to achieve this.

Make Ready

Make Ready are undertaking a transformational piece of work as they approach the end of the TUPE transition meaning they will come under full agenda for change conditions. After our increase of Make Ready sites we are now looking to align their rotas and processes with operations and local management to ensure they are working when needed to clean and prepare vehicles and to improve their relationships with local station groups. This ties in with our ongoing approach to give station groups more autonomy and ownership over their staff, fleet and equipment which in turn will ensure staff have the tools they need to provide patient care.

Rakesh Patel

Chief Finance Officer, London Ambulance service NHS Trust.

5.4.2. Finance and Investment Committee Report

For Assurance

Presented by Bob Alexander

London Ambulance Service NHS Trust

Assurance report:	**Finance & Investment Committee**	**Date:**	**28/08/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**05/09/2024**
Presented by:	**Bob Alexander, Non-Executive Director, Chair of Finance & Investment Committee**	**Prepared by:**	**Bob Alexander, Non-Executive Director, Chair of Finance & Investment Committee**

Matters considered:

Month 4 Finance Report
The Committee noted:

- The in-month Income and Expenditure (I&E) position for month 4 is a £0.1m deficit; £0.3m adverse to plan.
- The Trust has a capital plan of £53.3m for the year. Spend in month 4 was £2.7m.
- The Trust has delivered £7.1m of efficiency reductions to the end July 2024.
- The Trust had a closing cash balance of £17.5m at end of July.
- The Trust is forecasting to achieve its I&E and Capital plan for the year.

Month 4 Capital Report
The Committee noted:

- The Trust has capital resources of £53.3m available for investment in 2024/25.
- The Trust's spent £8.4m on capital investment in the year to Month 4 2024/25.
- The Trust spent £2.7m on capital investment during July (M4) 2024.

Month 4 CIP Report
The Committee noted:

- The Trust's 2024/25 financial plan requires a cost improvement programme (CIP) of £30m to be delivered during the year. As of 9th August, there are PIDs to deliver £20.9m of savings from the target of £30m.
- At the end of July 2024, the risk-assessed forecast is to deliver a total of £26.9m cash releasing savings by the end of the financial year. Of the forecast £26.9m, £17.0m are recurrent savings and £9.9m non-recurrent savings.

- In the month of July, the Trust has delivered £2.0m cash releasing savings against a plan of £2.4m, which is £0.4m behind plan.
- Year-to-date as of the end of July, the Trust planned to deliver CIPs of £9.0m and has achieved £7.1m, which is £1.9m below plan. Year-to-date savings are split £3.3m recurrent and £3.8m no recurrent savings.

Year-End Forecast and Corrective Actions
The Committee received and discussed associated papers regarding a current unadjusted revenue forecast of £4.5m predominantly driven by financial pressures in Ambulance Services and the proposed actions to bring the revenue forecast back to breakeven per the original Plan for 2024/25. These involve the issuing of revised expenditure control totals for all areas of the Service but which predominantly favour Operational areas over those in the Corporate and Central areas and pursuing a site divestment strategy for the remainder of the year that will both support the I&E position and bring in capital receipts to support the overprogramming in the Capital Plan. The Committee supported these actions but recognised the need for careful implementation of the latter and whilst approving Executive Committee authority for implementation stipulated that FIC be kept closely informed of the approach and its progress.

Deep Dive IUC
The Committee discussion revolved around an update on efforts to improve the performance and financial efficiency of a service within the NHS Trust, specifically focusing on a program associated with call handling (likely the 111 service).
The Committee noted key improvements include:

1. Significant reductions in call abandonment rates and response times.
2. Better training and role clarity for staff, including the introduction of role cards for all levels.
3. Early signs of financial improvement with a reduction in the run rate.

The Committee complimented the IUC Leadership working with Finance for the improvements made but reinforced the need for these improvements to be embedded and built on in the coming months to support sustainability of the model. It requested a further session at probably the November FIC for an update.

Consolidation of sites in NE London
The Committee considered a significant and comprehensive business case in respect of estate rationalisation with both capital and revenue investment implications for this and future years that will see services brought together, including HART Resilience, to a purpose-built site in NE London. The Committee commented on positively on both the strength of the case and the clarity of the options appraisal and associated explanations and reasoning. The case is sufficiently significant to require Board approval and though approving it to continue for Board consideration, the Committee recognised two key financial issues:

	1. The capital required to implement the preferred option is both greater than previous options had indicated and it impacts more than one year. So once again, strategic plans require a level of pre-commitment against future capital funding that is as yet unknown. 2. The preferred option indicates and ongoing revenue pressure in future years of approx. £1.5m that will not be obviously covered by a matching source of income/funding and so if pursued becomes a cost pressure in 25/26 and beyond along with pay awards and contracted non pay inflation. Given our current financial position with respect to commissioning conversations and service pressure, this is likely to involve further and enhanced efficiency requirements and it is suggested that thinking begins in parallel to the further consideration of the case.
Key decisions made / actions identified:	The Committee noted the revised unadjusted revenue for the actions forecast for the year and supported the actions proposed to bring the forecast back to a breakeven projection. The Committee supported the onward progress of the business case to consolidate and invest in estate in NE London for Board consideration and approval noting the financial implications of the preferred option (set out earlier). The Committee approved amendments to the BAF for which it has responsibility as set out in the next section.
Risks:	In respect of reviewing the FIC elements of the BAF, the Committee approved the following new risk: 2.12 The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2024/25. The Committee approved the changes to risk scores: 2.11 There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year. Risk score reduced from 4 x 4 (16) to 3 x 4 (12.) 3.1 We may not be able to complete delivery of current green commitments, including decreasing carbon footprint by 6% - and develop four year green plan for 2024-2028. Risk score reduced from 5 x 3 (15) to 3 x 4 (12). 3.2 There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London if the

	current fragmented commissioning and tendering of 111 contracts by 5 ICSs continues. Current risk score increased from 3 x 4 (12) to 4 x 4 (16) and tolerance score from 1 x 4 (4) to 2 x 4 (8).
Assurance:	The Committee was assured of the accuracy and robustness of the current financial position, the unadjusted forecast and the impact of the actions proposed to mitigate that forecast. The Committee were assured of the NE London Estate business case by its comprehensiveness, clarity and underlying assumptions. .

5.4.3. Audit Committee Report

For Assurance

Presented by Rommel Pereira

London Ambulance Service NHS Trust

Assurance report: Audit Committee

Date: 05/09/2024

Summary report to:	**Trust Board**	**Date of meeting:**	**15/08/2024**
Presented by:	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**	**Prepared by:**	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**

Matters considered:

Reflections on Current Risks and Challenges

Audit Committee discussed measures that would be taken on board to keep the Trust on financial track. Performance figures were also looked at and it was noted that August 2024 are better than August 2023.

The Committee felt that the local hospitals had recovered from the cyber-attack, however noted that it continues to be a significant vulnerability and high priority.

The recent race riots were discussed noting an NHSE letter that was sent, and their response cited LAS as an exemplar.

Assurance Map

The committee asked that it also includes governance fora for NARU, SASC, 111, 999 and EPRR, Data Quality feeder groups and ExCo's role as a "filter" (in line with SFI's). The executive are also preparing an Accountability Framework.

Risk Appetite

Audit Committee agreed the new entry which covers racism, sexism and bullying and stressed that the organisation is prepared to take risks in its pursuit of stamping out unacceptable behaviour. The remaining risks were relatively unchanged. The committee reinforced executive's action to withdraw care in the face of racist patient abuse, but thought that Board needs to take a view. London's 111 reconfiguration is another example of Board's appetite to innovate.

SIRO Report

The Committee received the routine report from the SIRO including an update on progress against the Data Security and Protection Toolkit.

Overview of Technology and Cyber Security Issues

Audit Committee received a high level overview of activities undertaken by the IT Risk, Governance and Cyber Team.

The Committee were updated with how the Trust is preparing itself should it have a cyber-attack. This included looking at some forensic investigation training for the team to try and bolster their skills in addition to setting up an area to do small time investigations on individual devices to understand, rather than reimage the machines and to gain further understanding. A report on progress will be submitted to the Audit Committee by year end.

The committee noted NHSE's deployment of KPMG/Deloitte squads if there is an attack and our enhanced supplier cyber posture and increased cyber security rigour. It was asked that a Infrastructure Vulnerabilities (firmware and hardware patching) plan be brought back to AC alongside a plan (by year end) to address the Cybersecurity Resilience Bill.

Internal Audit

Progress Report

The report was shared with the committee informing of progress made against the 2023/24 and 2024/25 internal audit plans. It summarised the work that has been done, together with the assessment of the systems reviewed and the recommendations that have been raised.

Auditors reported a substantial moderate opinion on the data quality audit for STEMI stroke and call handling indicators. A summary on the findings highlighting that there is one medium priority recommendation. Additionally, a low priority recommendation was made to enhance the robustness of the data quality policy. The audit showed strong processes in data collection, validation, reporting, and monitoring.

The committee discussed broadening the scope of the 111 service audit beyond data quality to include governance, cultural aspects, and the effectiveness of transformation work, with a focus on not duplicating existing governance processes.

Internal Audit Follow Up Report

The report was shared with the committee noting that 3 audits are in progress, staff appraisals, fit and proper persons and medical devices, the security and logistics around a loose kit. It was highlighted the fleet management audit will be commencing in October.

The report highlighted 13 recommendations to be followed up, 10 of which are overdue. It was noted that the Trust are implementing a schedule of spot checks and working to having 90% of the higher products of the highest of priority devices reviewed by the end of December.

On overdue audit recommendations, slippage was noted and more realism was asked for in agreeing dates/more specifics in management responses, Business Continuity /Disaster Recovery end to end testing to be followed up by Chief Digital Officer and Chief People Officer.

In consideration of benchmarking with other ambulance trusts – suggestions included an EDI audit in Q1, and CIP's in 25/26. The committee asked the executive and Internal Audit to discuss timing of the cultural maturity advisory audit.

LCF Annual benchmarking report

The report on declarations of interest indicated that the Trust identifies fewer decision-making staff compared to other healthcare organisations.

The committee requested the executive review the current scope to determine if it adequately captures all necessary decision-making personnel. The goal is to ensure that the Trust's declarations of interest policy aligns with best practices and adequately addresses potential conflicts of interest among staff involved in key decision-making processes.

Local Counter Fraud Service

The report provided an overview of the counter fraud work undertaken since the last Audit Committee meeting. The report stated that within the reporting period the LCFS has pursued key work streams including conclusion of the Local Proactive Exercise (LPE) in the area of pre-employment screening; Continuing the LPEs in the area of fuel cards, and procurement, in accordance with NHSCFA guidance; and receipt of five new fraud referrals in the reporting period, with a total of 11 investigations ongoing.

The findings on the Trust's pre-employment screening process were reported, revealing a significant error rate in the documentation of employment history and qualifications. The findings indicated that half of the sampled files contained discrepancies or lacked necessary evidence. The committee recommended that the report be referred to the People and Culture Committee for an in-depth review. The aim to address the identified issues and improve the accuracy and compliance of pre-employment screening documentation, ensuring that all new hires meet the required standards and verifications.

The committee noted the strengthened accountability mechanisms with the ELFS outsourced service provision.

Terms of Reference

The committee reviewed proposed updates to the Audit Committee's terms of reference, focusing on reflecting the name change of NHS Protect to the NHS Counter Fraud Authority. The committee asked for NED clinical representation and membership to be increased to 4 and that AC is sighted annually (for AGS sign off) on status of clinical audits

Self-assessment against provider code of governance

ME referred to the annual report and stated that there is a requirement to either say you are compliant with the provider code of governance or to explain why you are not. It was highlighted that there is one area where we're not compliant, which is the deputy chair chairs the Audit Committee. However a statement has been put in the Annual Report to that effect.

The committee recommended the Board approve this self-assessment (noting that AC would benefit from clinical NED representation), addressing an external audit recommendation.

ELFS Service Auditor Report

It was reported that LAS has several services and financial systems outsourced to ELFS including Accounts Payable, e-Procurement, Accounts Receivable, Cash Receipting and General Ledger. The Trust is in year 2 of the current contract which is due to end in June 2026.

The committee focused on the significance of holding the service organisation accountable, ensuring that the services rendered align with the Trust's expectations and contractual agreements. The conversation revolved around the need for continuous monitoring and evaluation of ELFS's performance to safeguard the Trust's financial integrity and operational efficiency.

Rolling Relief

Teams Based Working has highlighted "roster imbalances" and a rolling relief theoretical calculation of surpluses and deficits (up to £650k and £2.26m), driven from GRS bespoking and data input errors. The committee approved payouts (with the onus on employee to evidence), which has been accrued for and the write off of deficits. The committee asked that the Digital and Data Committees and People & Culture Committees monitor ongoing input controls to prevent recurrence.

Financial Reporting

Single Tender Waivers –
In Q1 there were 12 STWs. Of the 12 waivers, none were above £100k.

Losses and Special Payments

Total payments for the quarter were £0.4m, and for the previous quarter was £0.6m.

Salary Overpayments
It was reported £173k of overpayments occurred in the three months to end June 2024; The total overpayments owed to the Trust at end June 2024 is £1,608k (£187k owed by ex-employees and £1,421k owed by current employees) Total overpayments recovered in the quarter to June through salary deductions is £73k and through debt collection is £8k.
It was noted that process is to be QI'ed with HR oversight

Risks:	**Board Assurance Framework (BAF)** The committee received the BAF, following a review by executive committee and by assurance committees who met in July. In respect of AC's role and attention to organisation-wide risks, it was noted the report provided a good overview of integrated governance. The committee asked that the IUC risk be broadened to cover increased management overhead of the LCW take-on.

5.4.4. Charitable Funds Committee Report

For Assurance

Presented by Bob Alexander

London Ambulance Service NHS Trust

Assurance report:	**Charitable Funds Committee**	**Date:**	**06/08/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**05/09/2024**
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; The following were noted;

- The success for the well-being team and the support vehicles, emphasising their significant impact on staff morale and well-being.
- London lifesavers, detailing the extensive training conducted during school sessions and the additional pop-up trainings aimed at maximising reach and impact on how to use a defibrillator to a multitude of Londoners.
- The launch of the London Heart Starter's campaign was celebrated as a major charitable initiative, with the committee expressing pride in the campaign's potential to significantly benefit Londoners, especially in high-need areas. The campaign's launch was supported by the communications team and gained media attention, including coverage from the BBC, which helped in engaging with local councils and health boards.
- It was noted that the fundraising campaign will fund and maintain additional defibrillators in the 150 communities where they are needed most. It aims to build on the successes of ongoing London Ambulance initiatives to improve cardiac arrest survival rates in London.

- The success of the dragon boat race was highlighted, noting that 11 teams from LAS took on the challenge and raised just over £17,600 of the £18,150 target. JB advised that an event sponsor was secured, KO Cycle, and branding requests which contributed £1,231 towards the event cost.
- The London Life Hike event at the beginning of September has been launched. Currently 80 people have signed up for the walk and extensive recruitment is going on within the team, with the aim of to get as close to 500 people as possible.

Finance Report

The Committee received the Charities Finance report noting the current funds balance and expenditure to date.

Key decisions made / actions identified:

Hardship Applications

The committee reviewed and approved the proposed parameters with minor adjustments, ensuring a clear and fair process for staff seeking financial assistance through the hardship fund. Setting a financial cap of £3000 per application, limiting applications to one per staff member, and requiring a minimum employment duration of one year for eligibility.

Risks:

Risks and mitigations against the Charity were presented and considered.

Assurance:

The Committee received assurance on the Charities activities and financial position.

5.5. Corporate

For Assurance

5.5.1. Director's Report

For Assurance

Presented by Mark Easton

London Ambulance Service NHS Trust

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 to July 2024.

PATIENT EXPERIENCE

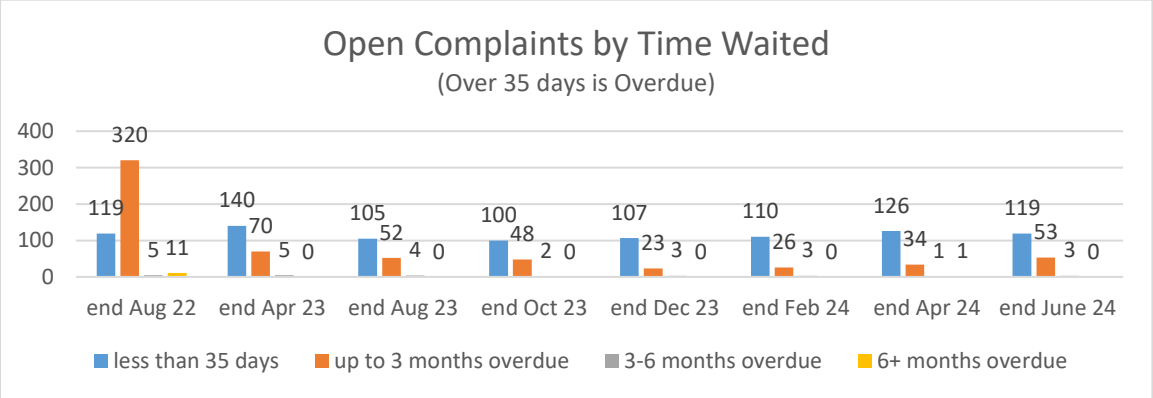
Complaints

Complaints received May – end of June 2024

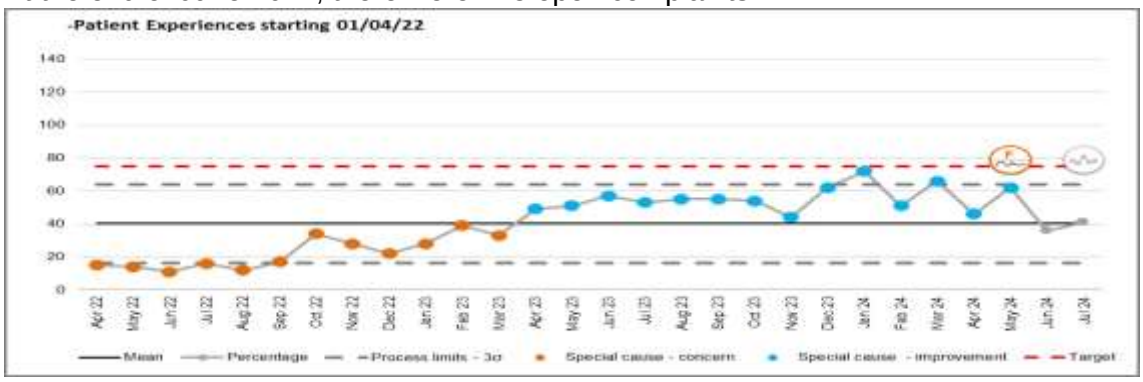
174 (161 in same period 2023)

Complaints closed May – end of June 2024

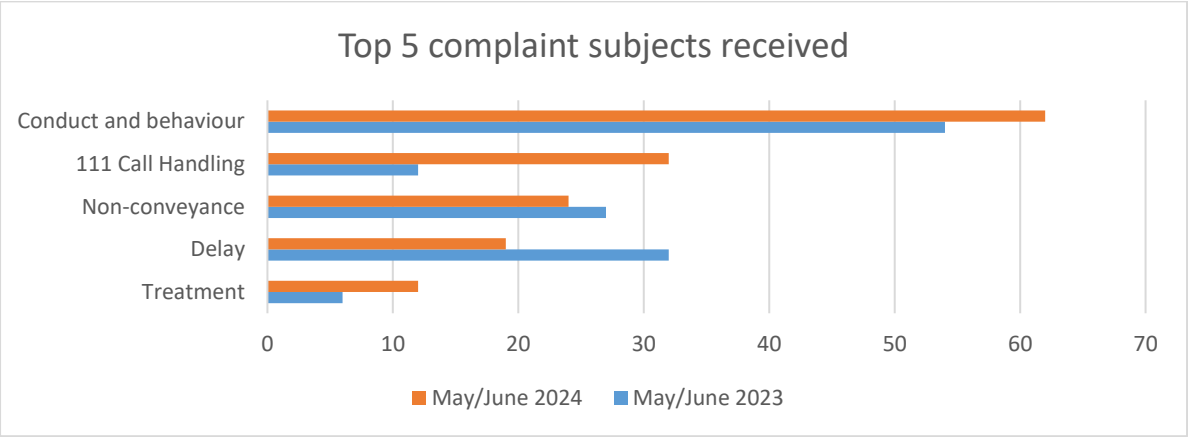
172 (203 in same period 2023)



At the end of June 2024, there were 175 open complaints.



In June, 36% of complaints were closed within the 35 working day target. A deep dive has been completed into the causes of delays in responding to complaints in Quarter 1. The process for reviewing response letters has since been streamlined. Delays in drafting responses are being reviewed with individual team members to ensure compliance with the SOP. This fits in with the business plan objective of maintaining a response rate of 75% to complaints within 35 working days. A trajectory has been set for achieving this target by the end of the financial year.



The Patient Experience team have been involved in training for operational staff in learning from experience and investigations including answering complaints and responding to statement requests. This fits in with the ongoing project regarding the continued high proportion of complaints relating to conduct and behaviour and support for staff. Complaints relating to 111 are also being reviewed by the 111 senior management team before approval to ensure that key themes are identified and addressed.

The Parliamentary and Health Service Ombudsman (PHSO) have concluded an investigation into a complaint and advised the complaint was not upheld and no recommendations for the Trust. The complaint related to a delay in attending a patient due to a mapping issue attending a new build property. The PHSO praised the Patient Experience team for their assistance with the investigation in promptly supplying relevant information

LEGAL SERVICES

Inquests opened 01 March 2024 – 31 July 2024

Level 1 Inquests – 905

Level 2 Inquests – 46

Claims opened 01 March 2024 – 31 July 2024

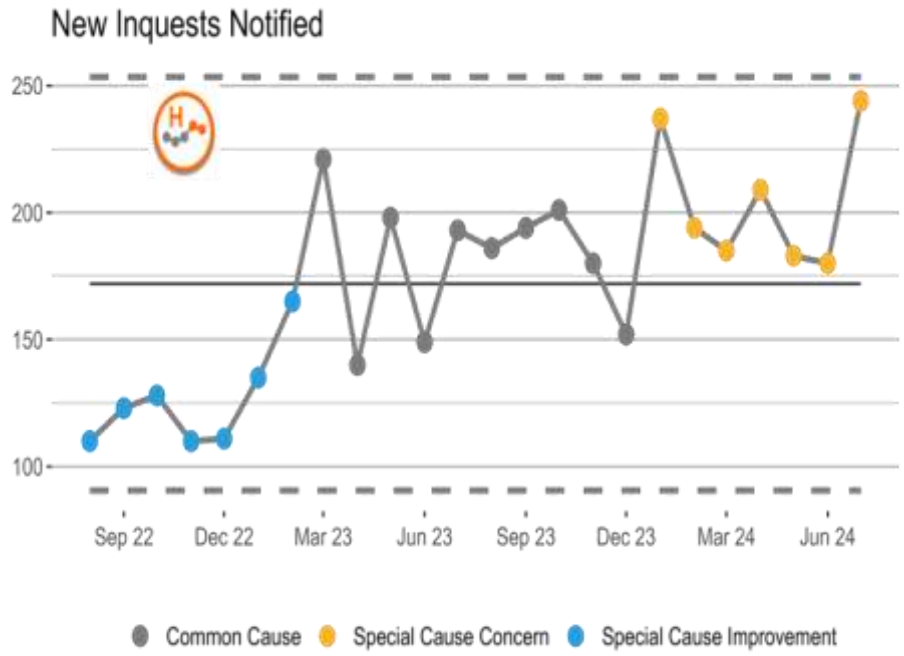
Employment Liability - 16

Public Liability 2

Clinical Claims 7

As expected, the number of Inquests notified to the Trust remained high in July. Total number of Inquests opened in the above period is 3% more compared to the same period in 2023.

The chart below shows the level of sustained high numbers of notified inquests during 2023/2024.



Follow the independent review of our processes and how we link with client departments, a team away day will take place in September to incorporate learning from the resulting action plan.

The Legal Team will be attending a training session organised by Bevan Brittan in October. The focus will be on Disclosure obligations.

The Legal Team will be working with stakeholders to establish an updated process to follow when LAS witnesses are required to provide statements and give evidence in Court and for private prosecution matters.

The Head of Legal will review and update the Legal Handbook and TP015 – Procedure for responding to enquiries from Coroners, Police, the IOPC and others in relation to interviews, the preparation of statements and giving evidence at Inquests and other Court Hearings by end of October 2024.

A ‘witness familiarisation for criminal proceedings’ document has been prepared to assist witnesses attending and giving evidence at Criminal Trials. The finalised version will be circulated. A similar document is being prepared for those attending Court of Protection matters.

INFORMATION GOVERNANCE

Data Security and Protection Toolkit (DSPT) 2023 – 2024

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, for the 2023 – 2024 submission, allowed 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.

The Trust submitted the 2023 – 2024 DSPT on 27th June 2024. Upon submission the Trust received 'Standards Met' accreditation which provides assurances to the public, staff and other organisations that the Trust is practicing good data security and that personal information is handled correctly.

Data Security and Protection Toolkit (DSPT) 2024 – 2025

For the 2024 – 2025 DSPT submission, there will be significant changes to the DSPT. The DSPT will no longer align itself directly with the National Data Guardian's 10 data security standards. As of September 2024 the DSPT will be changing to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. The decision to change the DSPT and align it with the CAF has been made to allow the setting out of broad principles which will provide assurance of Data Security and Protection, instead of the checklist approach of the previous DSPT format.

The CAF has been adopted as the principle cyber standard for healthcare organisations, to facilitate the below:

- Emphasise good decision-making over compliance, with better understanding and ownership of information risks at the local organisation level, where risks can most effectively be managed.
- Support a culture of evaluation and improvement, as organisations need to understand the effectiveness of their practices at meeting the desired outcomes – and expend effort on what works, not what ticks a compliance box.

- Create opportunities for better practice, by prompting and enabling organisations to remain current with new security measures to meet new threats and risks.

The updated DSPT will still require the Trust to continue working on a cultural change to assess Data Security and Awareness Training compliance and to be able to evidence that all staff have an appropriate understanding of Data Security and Awareness/Cyber Security Training instead of relying upon certification proof of training. To facilitate this Information Governance and Cyber Security content is being made available to all staff via multiple channels. Increased resource is being given to the development of face to face training channels for all staff, with staff being given advice and guidance on how to feedback any concerns relating to Data Security they may have. However, the completion of annual Data Security Awareness training by all staff remains fundamental to our approach, with the Trust, as of August 2024, currently reporting a 95% compliance rate.

The process of submitting assessments to NHS England will not change. National assurance will continue to be based on the Trust commissioning independent audits of their self-assessments.

Information Commissioners Office (ICO) and Breach Reporting

IG incidents are reported via Datix, which is the Trust risk management system. 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.

Since 1st April 2024, three incidents have been reported to the ICO and the Trust is currently awaiting a response from the ICO on all three cases. There are also 4 open cases dating from 17th August 2023 to the 6th February 2024. All four of these open cases are either awaiting an initial response from the ICO, or awaiting a response following updates sent.

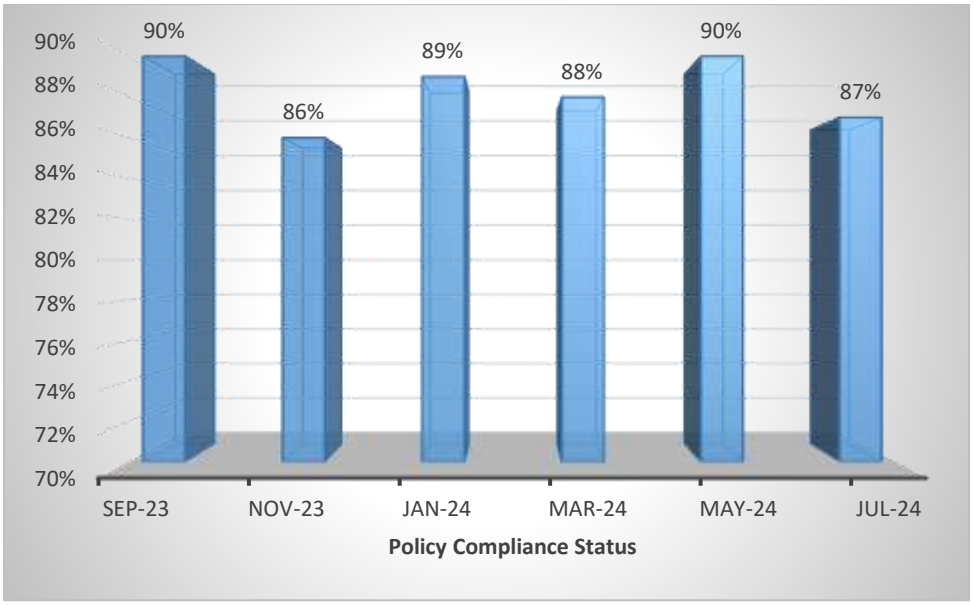
The Trust continues to embed data privacy by design into new projects by undertaking a data protection impact assessment (DPIA), a well-practiced custom that demonstrates how the Trust continues to strengthen its data protection, information governance and security framework.

POLICIES

The Corporate Governance team has continued working with directorates on the review and update of their policies, to keep them in date and reduce the consequences of operating with out of date or inaccurate policies.

Policy owners are being advised in advance when policies are due for review and guided on the review process. As part of the review process policy owners are asked to consider whether policies are still required or can be reclassified to a procedure or guidance documents. The provision of a 6 month extension is also being considered as part of this process, which can be applied to policies requiring a full review with more extensive changes required.

The Trust's policy compliance position is currently at 87% and the Corporate Governance Team are working with policy leads to further improve this, providing reminders for policies that are due for review to avoid policies going out of date.



FREEDOM OF INFORMATION

Introduction

This report provides an analysis of the Freedom of Information (FOI) requests received by the Trust during the period from 1 April 2024 to 31 July 2024. The report also highlights the Trust's performance in handling these requests, comparing it to the same period in the previous year, and outlines ongoing efforts to improve compliance with statutory deadlines.

FOI Request Overview

During the reporting period, the Trust received a total of 192 FOI requests.

Request Handling

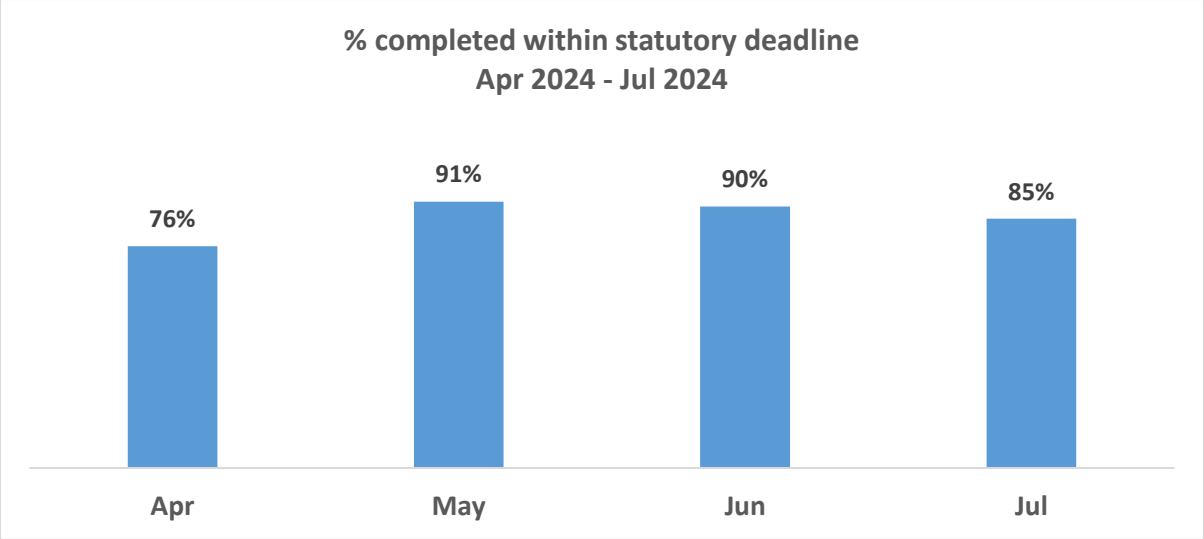
To date, we have successfully completed and closed 184 requests.

Monthly Averages

On average, the Trust received about 48 FOI requests on monthly basis.

Compliance with Statutory Deadlines

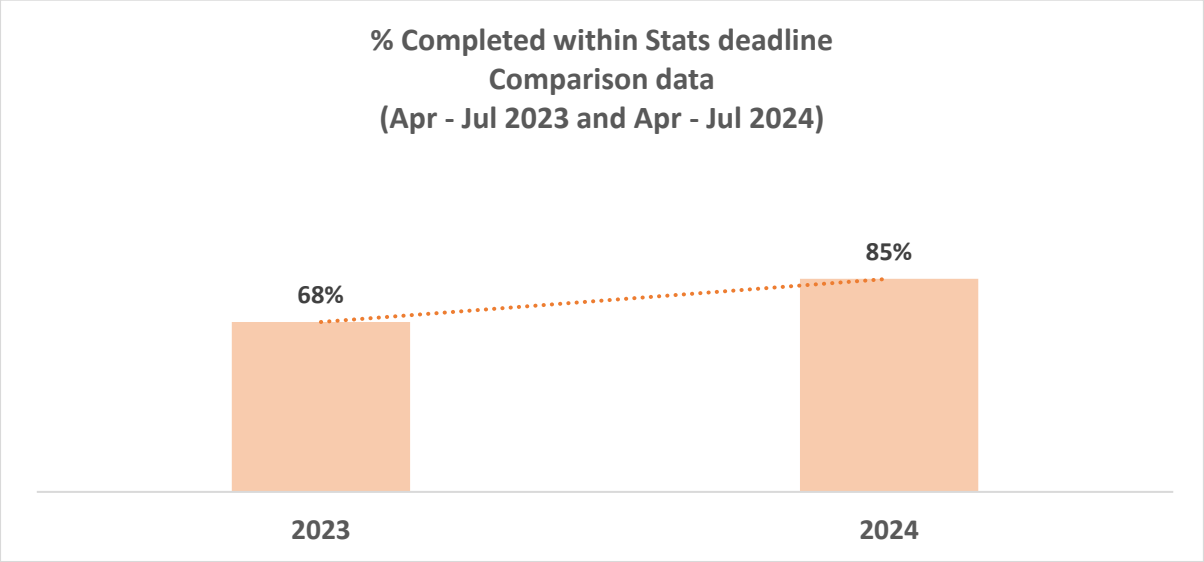
The Trust achieved an overall compliance rate of 85% in responding to FOI requests within the statutory 20-working-day timeframe. This marks a significant improvement compared to the same period in 2023, where the compliance rate was 68%.



The improvement is attributed to some enhancements in the FOI request handling process, including:

- **Collaborative Efforts:** Increased collaboration with stakeholders to ensure timely and accurate responses.
- **Process Improvements:** Implementation of a system for sending deadline reminders to subject matter experts before the deadline for the return of information, which has proven effective in meeting statutory deadlines.

The diagram below illustrates a comparison of the percentage of requests completed within the statutory 20-working-day timeframe for the periods of April – July 2023 and April – July 2024.



Commitment to Improvement
The FOI team is committed to sustaining and further improving the current trajectory of compliance and efficiency, including continuous improvement in communication between the FOI team and subject matter experts to expedite information retrieval.

Source of Information Requests
The below section provides a detailed breakdown of FOI requests based on their origin:

Source	Number of request received Apr-Nov
Media - (Journalists/Media professionals)	22
MPs/ Councilors	0
Individuals	136
Organisations (including campaign groups)	34

Corporate Governance

The following assurance committees have had their terms of reference reviewed and updated as part of the regular cycle:

- Audit Committee
- People & Culture
- Digital and Data
- FIC
- EDI

QAC has had revised terms of reference submitted for agreement at the next meeting. The main change to the terms of reference has been to increase the requirement for being quorate to at least two non-executive directors being present. Other changes have been updating job titles, and in the case of EDI, adding to this committee responsibility for the population aspects of health equality.

The audit committee received a report on our compliance with the Provider Code of Governance on which we have to give an assurance on in the annual report.

Both the updated committee terms of reference, and the report on the Code of Governance are available in the documents library.

Mark Easton
Director of Corporate Affairs

5.6. Digital and Data

For Assurance

5.6.1. Digital and Data Committee Report

For Assurance

Presented by Sheila Doyle

London Ambulance Service NHS Trust

Assurance report:	**Digital & Data Quality Committee**	**Date:**	**05/09/2024**

Summary report to:	**Trust Board**	**Date of meeting:**	**30/07/2024**
Presented by:	**Sheila Doyle, D&DQ Chair**	**Prepared by:**	**Sheila Doyle**

Matters for escalation:

Other matters considered:

Data Quality Update & Review of ePCR

The Committee received an update on the progress of the Data Quality Group, highlighting progress made in closing overdue action. Owners have now been assigned to the recommendations from the CAD review completed in March 2024, and further work is needed to finalize the action plan.

ePCR Data Quality Audit

The ePCR audit was completed in July 2024 with an assessment of significant assurance with minor improvements required. The audit will be repeated in 9-12 months to allow for a period of stability following the recent implementation of the ambulance data set and the application of bug fixes.

The committee discussed ways to improve the system's usability and simplify the user interface, such as reducing manual data entry and enhancing data quality by standardizing hospital names.

The audit identified opportunities for collaboration with the supplier to ensure all documentation is comprehensive and up to date, including clear and concise diagrams of the underlying database. The CCIO advised that he is working with the supplier to establish a national user group to facilitate experience sharing across Ambulance Trusts.

The committee agreed that the scope of the next ePCR audit should be expanded to focus on clinical data and place greater emphasis on the clinical implications of the audit findings. Additionally, the committee requested a review of the 15 recommendations from the audit to ensure they incorporate input from committee members.

Infrastructure Review

The Chief Digital Officer (CDO) presented the findings of an independent review that evaluated the overall health of our core infrastructure, including the data centre and network architecture. The review provided several recommendations, which were categorized into key areas: implementing a more comprehensive cybersecurity patching regime, addressing issues with end-of-life devices, standardising the application of technical standards, and enhancing documentation and technical operating procedures.

The CDO emphasized that developing a Data Centre Strategy, which includes consolidating data centres and adopting a cloud-appropriate approach, will be a crucial next step in addressing these recommendations. This strategy will also support our Green Plan and help identify investment needs for the next three years.

Digital Portfolio Update

The committee received a new report highlighting progress of key programs. The replacement of Mobile Data Terminal continues to make great progress and is expected to complete in late 2024. The update of the EOC 999 Telephony System (CM10) has been moved to mid-September due to critical resource constraint. My clinical feedback program is tracking amber, awaiting final approval of the Data Protection Impact Assessment (DPIA) and further prioritisation of engagement with ICS and Acute Trusts.

Future reports will include updates on Call Sign & Scheduling & Rostering Programs.

CCIO report – Clinical Digital Safety

The Chief Clinical Information Officer (CCIO) provided an update on the work of the CCIO team including the involvement of 4 trained Clinical Safety Officers. The report summarised various measures implemented to ensure digital safety and compliance. An improvement program is currently being developed and will be shared with the committee in due course.

Key decisions made / actions identified:

The Committee Terms of Reference were reviewed and approved.

The results of the annual review of committee effectiveness were discussed, and actions to enhance the committee's performance were agreed.

Risks:

Board Assurance Framework

The Committee reviewed the digital and data related risks on the BAF and agreed to:

- Reduce the score of **risk 2.7** - Operations may be affected by the shortage of mobile data terminals (MDT) to a score of 5, reflecting the substantial progress to date.
- Reword and rescore **risk 2.13** – Scheduling & Rostering vulnerabilities

Assurance:	The inclusion of the new CCIO report will enhance the committee's ability to provide a clinically led assessment of data quality assurance. Additionally, the new Digital Portfolio report will offer greater visibility into critical project activities, further strengthening committee oversight.

6. Strategy - LAS Digital Strategy

For Approval

6.1. To approve the LAS Digital Strategy

For Approval

Presented by Clare McMillan

London Ambulance Service NHS Trust

Report Title					
Meeting:	LAS Public Board				
Agenda item:	Digital & Data Strategy		**Meeting Date:**	5th September 2024	
Lead Executive:	Clare McMillan, Chief Digital Officer				
Report Author:	Clare McMillan, Chief Digital Officer				
Purpose:		Assurance	**X**	Approval	
		Discussion		Information	

Executive Summary

This strategy is not standalone but underpins the wider Trust strategic ambitions by delivering on the digital and data priorities through the core missions of Our Care, Our Organisation and Our London.

As an organisation, and under the previous digital strategy, we have made significant investment in some of our foundations where we were running with some technical debt and legacy services, particularly by modernising our telephony platform, replacing our legacy Computer Aided Dispatch (CAD) system and introducing our patient record system (ePCR). This has delivered huge benefits to the organisation in terms of stability and resilience of services and digitising some of the frontline processes.

This strategy continues with the theme of improvement of the underlying infrastructure and ensuring we are resilient, secure and scalable to meet the ambitions of the Trust, but also to support true digital innovation which enhances the services that LAS delivers to London. This is sometimes a difficult balance to achieve and the strategy lays out 6 digital and data ambitions to ensure we strike the right balance:

- Digital Outcome 1: A Modern Digital Team
- Digital Outcome 2: Excellent Support and Delivery
- Digital Outcome 3: Resilient, Agile Infrastructure
- Digital Outcome 4: A Data-Driven Trust
- Digital Outcome 5: A Modern, Digitally Enabled Organisation
- Digital Outcome 6: A Digital Frontline

This is a critical point in the advancement of digital healthcare with the prominence of digital tools such as AI being at the forefront of innovation, and we need to ensure that we have the right skills and ambitions to maximise the opportunity to improve performance and efficiency across the organisation.

This strategy is ambitious, but rightly so. Our colleagues working on the frontline and in our control rooms deserve the right digital tools and systems to enhance their working practices, not hinder them, and as the only pan-London provider, we have an opportunity to shape the digital landscape for Urgent and Emergency care across London.

The Board is being asked to formally approve this strategy following detailed discussion at the board development session in July 2024.

London Ambulance Service
NHS Trust

DIGITAL & DATA STRATEGY

2024 - 2028

Table of Contents

1. Forward by Clare McMillan, Chief Digital Officer

Since joining LAS, I have been amazed and impressed by the fast-paced nature of the organisation and its staff when responding to incidents and providing first-class care. The scope for digital innovation to support this activity is enormous and we owe it to our operational colleagues to deliver. Whilst we have made some serious headway in the last few years - such as digitising our patient records, upgrading our underpinning infrastructure, and replacing our core clinical systems - we still have a long way to go.

This strategy aims to balance the (sometimes competing) demands of 'keeping the lights on' and supporting true digital innovation which enhances the services that LAS delivers to London. Our strategy underpins the wider trust strategy that aims to 'Deliver outstanding emergency and urgent care whenever and wherever needed'. We will support this ambition by digitising our frontline services, ensuring we have modern infrastructure and data platforms in place, and having great delivery capability in-house and with partners.

There is now a significant opportunity to make use of the latest digital tools & data to ensure we deliver real benefit to our frontline staff and patients - including digital handovers of patients, video calls with other professionals, and making use of future developments in AI to support our frontline decision making. As well as digitising our frontline there is a significant opportunity to join up the vast amount of data held across our organisation, this will help to improve productivity across frontline and support services, as well as supporting population health management across London.

Digital technology moves fast, so rather than design a static five-year plan we are setting out a change roadmap for the next five years, with more certainty over the next two. The course and prioritisation will change, influenced by operational, digital or other factors.

Our ambition is to make digital an area people want to work in and collaborate with. An environment where digital staff learn, innovate and deliver with other colleagues to build the best digital experience for them and for our patients. We will all make sure this strategy is "lived" on the ground. It will guide how we talk about and deliver our services, how we behave and interact with others in the Trust and beyond.

2. What are our ambitions?

2.1 Our vision as an Ambulance Trust

The LAS Five Year Strategy details how **we will deliver outstanding emergency and urgent care whenever and wherever needed for everyone in London, 24/7, 365 days a year while we put care, respect and teamwork at the heart of all we do for Londoners**.

The strategy identifies three core missions to achieve this vision:

- **Mission 1 Our Care:** *Delivering outstanding emergency and urgent care wherever and whenever needed. Specifically, this means the Trust aims to provide care which is rapid and seamless and provide clinical responses centred on individual needs.*

- **Mission 2 Our Organisation:** *Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for. The Trust will look to empower teams to lead and ensure supporting systems are reliable, high quality, and interoperable.*

- **Mission 3 Our London:** *Using our unique pan-London position to contribute to improving the health of the capital. This means the Trust will strategically collaborate with, and lead where appropriate, system partners to reduce service pressures and strengthen understanding of patient needs.*

Maintaining and improving digital and data capabilities are integral to these missions - alongside many of the commitments made within the Trust strategy. **As part of the digital and data strategy we will support**:

- **Mission 1 Our Care** through both (i) ensuring services for staff and patients work well now and are resilient and safe in a changing digital world and (ii) by advancing frontline digitisation, enabling new ways of working, for better and faster care.

- **Mission 2 Our Organisation** through (i) making sure our basics work well and we implement agile, resilient, safe and modern new services, (ii) work to understand and use existing & new data across the Trust better, and (iii) embed a modern digital mindset, so all staff have digital tools at their fingertips to do their jobs efficiently.

- **Mission 3 Our London** by standardising technology and data services with wider national and London systems and working with our partners to capitalise on shared opportunities.

2.2 Our digital & data needs and challenges

From engagement sessions with staff, patients, the public, and colleagues in the health system over the past two years we have heard:

- **Patients want seamless and individualised care** which means that we need to widen access to patient records and resolve broader system communication challenges.

- **Staff want systems that work well everywhere in a joined-up manner**, which are easy to access and use.

- Our **colleagues across London want to ensure we respond to them and operate in a secure, resilient way, minimising delays.** This involves improving our interoperability, pursuing standard rather than bespoke solutions, and integrating urgent care.

- To **support our staff to deliver seamless, individualised care in an efficient manner we need to fix IT basics** update business processes and modernise infrastructure.

We have also held engagement sessions with our digital leads and senior colleagues across the trust and they have highlighted some of the areas where we have historically had challenges:

- **We update our digital and data architecture responding to immediate and short-term demands.** This means we concentrate on fixing technology rather than updating our architecture in line with the longer-term needs of the Trust, our staff, and our patients. We need to be more strategic and plan for the needs of 5+ years.

- **Our digital and data services are not run in an optimal way.** We do not sufficiently prioritise or upgrade how we provide services to ensure higher levels of productivity e.g. automating processes where we can. By not doing so, we leave ourselves little headroom to improve services and embrace new technology, skills, architectures and data needed to accelerate modernisation.

- **Our digital and data infrastructure is not sufficiently scalable and flexible** for us to respond to changing demands in an agile way. Many of our solutions are bespoke and produced in-house, with insufficient use of scaled and standardised alternatives e.g. the Cloud.

- Our **ambitions to improve patient and staff experiences require digital investment** which competes with other funding demands. Unless we work and plan in line with a longer-term strategy, we will struggle to secure sustainable investment funding. This problem will only increase as IT budgets move away from a capital-based model to a revenue-based model.

2.3 Our digital & data ambitions for the future

To ensure we can support the Trust to deliver on its vision over the next five years we have developed our own digital vision based on what our staff have said:

We will provide the appropriate services, whenever and wherever our staff need them to deliver excellent care to our patients, underpinned with modern, secure and reliable technologies and data platforms supporting timely decision making across the organisation.

This vision is in turn supported by six digital outcomes which set out in more detail how we believe we can deliver our digital vision:

Digital outcome 1: A modern digital team

We will develop highly skilled knowledgeable digital teams that demonstrate a digital mindset and work to become a valued transformational partner in support of the Trust missions.

- Adopting a 'digital mindset' requires us to better understand our organisation and the broader digital landscape by embracing input from staff and close working with partners and suppliers to deliver outcomes of value.
- We will review our IT functions and organisation to ensure we have the right shaped teams with the right skills to achieve our ambitions. This includes providing effective management and leadership, clear career pathways from service desk to management, and ensuring appropriate training opportunities for our staff to remain current with latest technologies.
- We will establish a digital innovation hub to deliver digital solutions for business problems, improve healthcare outcomes, and streamline processes. Solutions and improvements will be co-created with clinicians and operational staff. The digital team will work in an agile manner, bringing forward pilots and proof of concepts, allowing projects to 'fail fast' and encourage digital innovation.

Digital outcome 2: Excellent support and delivery

Patients, staff & digital partners will experience brilliant digital and data support through relentless customer service and delivery aligned to Trust priorities.

- We will ensure we have 'Brilliant Basics' and concentrate on removing frustrations felt by staff. Digital teams will be more visible to our operational colleagues and collaborate more closely with non-digital teams and partners.
- We will aim to work better in multi-functional teams that can quickly understand, resource, and resolve problems faced by our colleagues across 999, 111, Ambulance Ops, and Corporate Services.
- We will seek to improve self-service and automation of straightforward support tasks, moving to a 'shift-left' model of support ensuring our technical experts are supporting our most difficult requests.

Digital outcome 3: Resilient, agile, infrastructure

The Trust must be able to depend on a digital infrastructure that is resilient to threats and drives forward LAS flexibility and joined-up working. We will deploy modern standardised infrastructure, data and services that maximise cloud opportunities and reduce overall digital risk.

- We will progressively and appropriately migrate to offsite data processing/storage on the Cloud, utilise SaaS solutions wherever possible to reduce the reliance on our own infrastructure and Data Centre footprint.

- We will modernise critical systems improving/replacing:
    - 999, 111 and Ambulance Station telephony
    - MDTs to use new National Ambulance Mobilisation solution
    - EOC radio Control Room Solutions
    - CAD fallback arrangements
- We will mitigate disruption to digital services and protect our data through the Cyber & Resilience Roadmap.
- This will include working with industry partners and industry best practise to assure our strategic plans. We will use third party specialists where appropriate to deliver our plans and upskill our teams.

Digital outcome 4: A data-driven trust

Our data and data architectures are a central enabling theme for our Trust Strategy. We will create a data-led environment and deliver improvements, so all staff and our partners make more informed and clearer decisions on behalf our patients and staff.

- Data is one of our most strategic assets, given our unique position as a pan-London provider. We are data rich, but we need to develop our maturity in how we exploit that data to make informed strategic decisions and optimise our performance through data-driven insights.
- We will review our current data models, data flows, and data storage to ensure that data is maintained in a central repository establishing a single source of truth for our staff, all supported by updated governance and processes.
- We will modernise our data platforms to support: Automated reporting for internal and external reports, moving from reactive analysis to predictive analysis for decision making, using real-time data to support operational decision making, self-service to data for staff freeing up analysts to focus on value-adding analysis rather than data generation.
- We will drive a data-led approach to decision making across the trust by providing excellent, joined-up, sources of data and promoting data-literacy across all staff to support better decision making.

Digital outcome 5: A modern digitally enabled organisation

We will support the LAS mission to become an inclusive, well-led and highly skilled organisation, by empowering our Trust and staff with new lean digital processes that leverage efficiency, effectiveness and quality improvements, Trust-wide, from our modernised systems.

- We will ensure that core IT applications make best use of our cloud services, co-ordinate system refreshes to minimise duplication, and engage with staff to improve knowledge and use.
- We will ensure that systems are better integrated, enabling more holistic planning, operational cohesion, and further insights. This involves, for example, better linking of front-line systems within workforce, logistics, medicines, and fleet, etc.
- Where possible, we will consolidate specialist systems using core building blocks to reduce complexity and to better integrate overall use and planning.
- We will help drive productivity by digitising and automating key business processes, prioritising workforce intelligence and HR.

Digital outcome 6: A Digital Frontline

We will develop new operational and clinical solutions using our digital infrastructure and linked up data, so frontline staff across 111, 999 and Ambulance Ops have advanced digital tools they need to deliver excellent care to patients, whilst improving our operational Productivity.

- The Trust is planning new delivery models that require digital support to streamline call categorisation, clinical triage, and workflow. This involves expanding the functionality of our systems (e.g. Cleric CAD) and interoperability between systems to improve clinical integration, e-Transfer of Care to EDs, and sharing of patient records and experiences.
- Exploiting new technologies (routine video consultation, process automation backed by AI and NLP) will help our staff save time and better collaborate with our partners.
- Ensuring digital solutions are in place to support Quality Improvement projects around shift start and end times, on-scene times, hospital handovers and out of service.
- We will involve our frontline clinical staff in the co-development, design and testing of digital solutions to ensure they support operational realities and meet the needs of staff.

3. Where are we now?

3.1 What we achieved under our prior digital strategy

The table below sets out key commitments delivered by the last digital & data strategy. These are categorized by reference to digital capability groups that will frame the journey from our current state to our future state as outlined by our vision and digital outcomes. (The digital capability framework underpinning these groups is explained in the next section).

	Complete		In Progress		De-prioritised

Digital Capability Group	Key Commitments	Progress update
Storage & Management of Records: *Improving access to clinical information*	All ambulance crews can access detailed patient records.	All Ambulance Crews can now access the Summary Care Application and Co-ordinate My Care records. Crews can also access all available records within interconnected ICS using OneLondon
	999 & 111 contact centre clinicians can access detailed patient records.	All CHUB and CAS clinicians have access to the same “workbench” of available data across 111 and 999 including those available through OneLondon.
	Electronic patient care records captured for patient attendances.	Roll-out completed March 2021
Business and Clinical Intelligence Functionality: *Building Data & Analytics Capabilities*	Establish analytics platform.	ePCR and CAD data incorporated into the Data Warehouse. Work begun to identify the needs of the Trust and options to deliver the analytics platform of the future.
	Fully integrate analytics platform with all data sources.	Scoping begun, scheduled for full delivery 2026
Asset & Resource Optimisation and Administration: *Standardising infrastructure*	Corporate systems moved to cloud-based services such as Office 365 and NHSMail.	Implementation of a secure mobile solution (ZScaler) has been delivered as an enabler. NHS O365 and NHSMail successfully deployed.
Supporting the provision of Ambulance Services: *Frontline Operations*	Deploy national mobilisation application in vehicles.	Delivery scheduled in 2024
	Automated transfer of care to appropriate providers.	Proof of concept successful – now due to be rolled out in 2024

Supporting the provision of Ambulance Services: *Dispatch Operations*	Implement a replacement computer aided dispatch (CAD) system.	Completed in 2023.
	Implement video capability for 111 and 999 patient.	Implemented in basic form for EOC & IUC during COVID. Awaiting national NHS solution opportunities before deciding on the way forward.
	New control room systems implemented to replace Airwave ICCS.	Delayed due to the lag in the National Programme and the priorities to implement CAD and ePCR. CRS (Control Room Solutions) now scheduled for 2024
	Implement Emergency Service Network in full.	National programme – awaiting revised timescale from DHSC – expected between 2025 and 2028.
	Introduce voice automation in call handling and major incidents.	Delivery in 2024/25 business plan
Storage & Management of Records: *Improving Data Security*	Achieve Cyber Essentials Plus.	Focus is now on Data Protection and security Toolkit. The Trust took the decision to re-prioritise effort and funding.
	Achieve ISO27001 for Information Security Management.	Focus is now on Data Protection and security Toolkit. The Trust took the decision to re-prioritise effort and funding.

3.1 Where we are now in 2024

Our six digital outcomes set out where we are seeking to improve over the next five years. This journey involves maturing key digital capabilities to improve our services, performance, and teams.

We have adapted the 'Digital Capabilities Framework (DCF) for Secondary Care and Ambulance Services', as maintained by NHS England, to enable us to assess our digital maturity. The framework contains eight capability groups which in turn contain multiple capabilities. These capabilities are classified as Core, Transformational or Innovative and naturally align to our digital outcomes (4-6) which are in turn enabled by our digital outcomes (1-3).

We have self-assessed our current state against the DCF (disregarding some capabilities which are not relevant to the ambulatory sector) using the following scale:

0	No examples of this capability yet in place or planned.
1	Only isolated examples of the capabilities have been achieved, either as pilots or within small areas of the organisation.
2	A majority of the capabilities have been implemented or are in progress, however some may not be fully embedded or in wide-spread use across the organisation.
3	Core capabilities have been installed and are widely used. Efforts are underway to test and standup transformational capabilities.
4	All core and transformational capabilities have been installed and are embedded within a modern architecture. Efforts are well-underway to implement innovative capabilities.

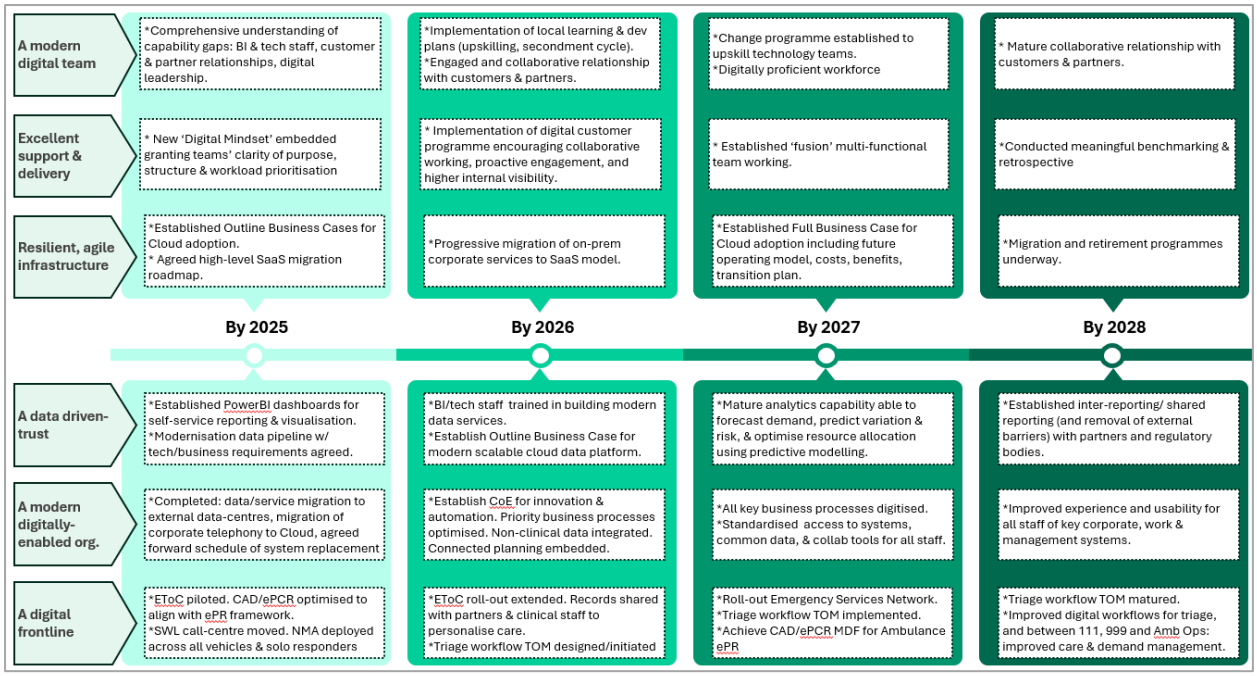
This has allowed us to score our current state against each capability group and set our ambition for the end of the strategy:

NHSE Digital Capability Groups	Relevant Capabilities	2023/24 Current State	2028/29 Ambition
Supporting the provision of ambulance health services: emergency telephony, emergency dispatch, hear & treat, see& treat, hospital conveyance.	10	**50%**	**100%**
Storage and management of records: capture, share, access information at point of care.	15	**50%**	**100%**
Transfers of Care: support digital handovers of care within patient records.	5	**30%**	**100%**
Diagnostics management: supporting tests & orders.	0	**-**	**-**
Ordering optimisation administration and medicines management: order comms, EPMA.	9	**26%**	**100%**
Decision support: providing tools, alerts, notifications, etc.	7	**50%**	**100%**
Remote and assistive care: remote devices, monitoring & consultations	1	**50%**	**100%**
Asset & resource optimisation and administration: scheduling, resource and asset tracking.	8	**38%**	**100%**
Business and clinical intelligence functionality: ops/performance reporting within EPR	6	**42%**	**100%**

4. What will we change?

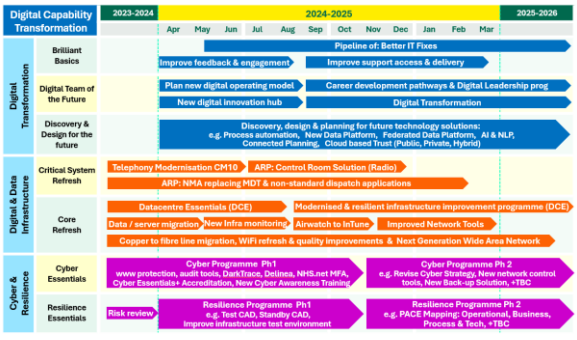
4.1 Five-Year Roadmap

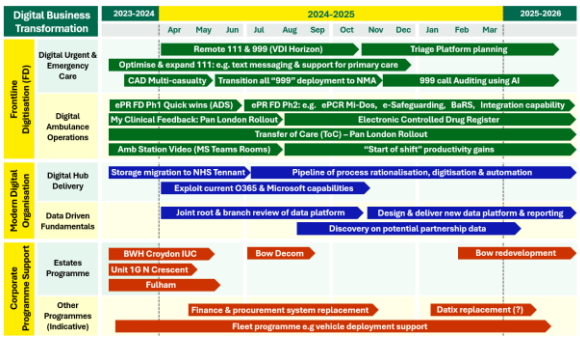
Using our current state assessment and our future ambitions, we have produced a high-level framework set against our six digital outcomes to set out strategic milestones and our intended pace of change.



4.2 Two-Year Plan

To operationalise our ambition we have developed a detailed and costed plan for our key programs and projects of work over the next two-years.





4.3 Principles to guide our actions and balance our portfolio

We will adopt the following principles to help prioritise the portfolio of work, guide key BAU decisions, and direct how our digital and data teams provide services to staff and patients.

1. **Patients and staff at core**

- Patient needs will be at the core of digital and data change and improvements.
- We will use the expertise and experience of staff to co-design easy to use, efficient, and standardised digital and data solutions, which are able to support best practices in clinical safety.

2. **Brilliant service and delivery**

- Our staff will experience brilliant customer service & support and we will proactively communicate how we are fixing and improving services.
- We will ensure what we have works, alongside planning for delivery of new tech and data services.

3. **Maximise trust productivity**

- We will prioritise Trust productivity in digital planning and business change activities.
- Digitally enabled Trust gains will be reinvested into digital to help address affordability constraints and accelerate delivery.

4. **Standardisation throughout**

- We will avoid bespoke and non-standard solutions, reusing building blocks aligned to national, common standards that are easily joined-up for operation and planning.
- We will cultivate fewer, more strategic partnerships with those working across the NHS to produce standardised and nationally-aligned solutions.

5. **Security by Design**

- We will design digital and data solutions that have appropriate resilience, cyber security and data protection; and processes to robustly maintain protection and assure safety.

6. **Decisions aligned to the needs of operational services and Trust strategy**

- All digital choices, resource allocation and skills development will be prioritised and aligned transparently to operational service delivery.
- Investment decisions will be made in good time, in full view of service life, and aligned to the strategic timelines and changing needs of the Trust.

7. **Leadership and accountability at all levels**

- We will embed leadership and accountability at all levels, ensuring staff have the right soft skills and tech skills to succeed.

8. **Promoting learning and digital literacy**

- We will champion continual learning, growing skills in line with evolving technologies and patient & staff needs.
- We will help to improve digital literacy across the Trust, ensuring staff can better use technical devices, overcome technical challenges, and take advantage of digital opportunities.

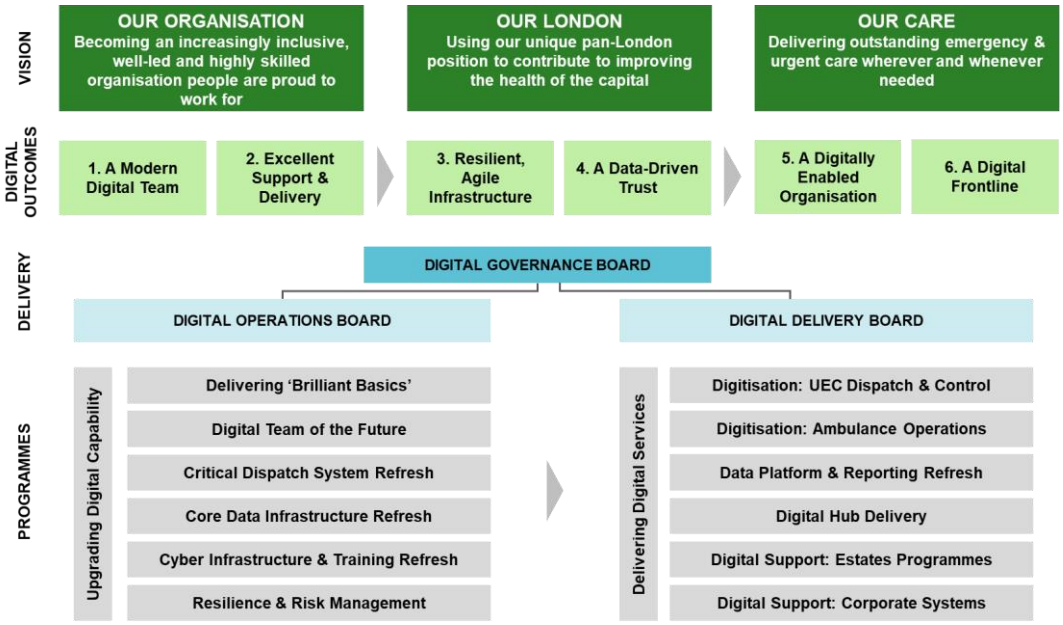
9. **Continuous improvement of our digital services**

- We will adopt a proactive and continuous improvement approach to service management & improvement in line with agreed service improvement roadmaps.
- Digital pipelines of lasting change will streamline effort and ensure investment is not wasted.

5. How will we deliver?

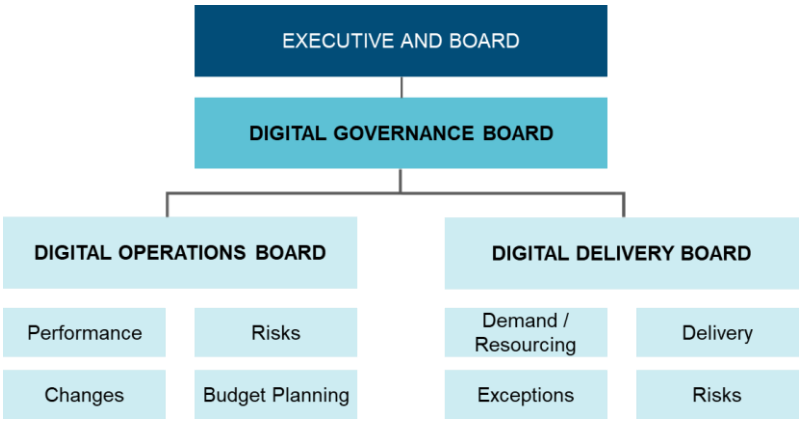
5.1 Portfolio structure

We will deliver our key programmes of work using a portfolio structure overseen by a 'Digital Operations Board' and a 'Digital Delivery Board'. These programmes will be scaled appropriately over the next five years, with 'Upgrading Digital Capability' focussing on upgrading IT infrastructure, maintaining core systems and upskilling our people; whilst 'Delivering Digital Services' will focus on ensuring modern, relevant, digital and data services are in the hands of our frontline staff.



5.2 Governance structure

Our work will be overseen by a 'Digital Governance Board' who will report into the trust Executive, and in turn oversee the 'Digital Operations Board' and the 'Digital Delivery Board'. The Digital Operations Board will manage the ongoing delivery of IT systems and services across the trust, including performance management, risk management, change management (in conjunction with digital delivery board) and annual budget setting. The Digital Delivery Board will manage the delivery of programmes of work including planning, resourcing, exception management, risk management.



5.3 Benefits and KPIs

We will track our progress against completion of core programmes and the delivery of required capabilities. In addition, we will maintain and report a series of KPIs to measure our performance. Below are some example KPIs which we will continue to refine to measure our delivery against customer satisfaction (our trust-wide staff), operational performance (our patients) and employee satisfaction (our digital and data staff).

Benefit	Justification	Proposed KPI(s)
Improved customer satisfaction	We aim to put patients and staff at the core of what we do and provide excellent support to our colleagues across the Trust. Ensuring that our internal customers are highly satisfied is a key objective and benefit, flowing from our 6 digital outcomes.	Customer satisfaction survey (CSAT). Conducted monthly and/or post resolution of service desk enquiries.
Improved operational performance	We aim to ensure our infrastructure is modern, resilient and agile. Superior operational performance is the target benefit and this requires improvements regarding how we mitigate risks and resolves issues.	Risk management as measured by: • risk mitigation time (average time taken from risk identification to risk mitigation) • % of risks resolved before any incident occurs. Incident management as measured by: • Mean time to Respond (MTTR): average time taken from incident reporting to initial response. • Unplanned Downtime of our core systems including CAD, GRS, EPRF, BI
Improved employee satisfaction	We aim to create a modern digital team that works closely with our colleagues across the Trust, leading and holding ourselves accountability at each level. This will be tracked in part through improved customer satisfaction (see above) and higher rates of employee satisfaction.	• Employee net promoter score (eNPS) helps to quickly identify sentiments across the teams and the likelihood they will promote the Trust as a place to work and build a career. (Conducted quarterly). • Record the number of industry recognised qualifications held by staff. (continually updated).

7. Planning - LAS Business Plan

For Approval

7.1. Update on Trust Business Plan for Q1

For Approval

Presented by Roger Davidson

London Ambulance Service NHS Trust

Report Title	Trust Board Coversheet				
Meeting:	Trust Board				
Agenda item:	Q1 update – annual business plan		**Meeting Date:**	05.09.2024	
Lead Executive:	Roger Davidson				
Report Author:	Beata Malinowska				
Purpose:	**x**	Assurance	**x**	Approval	
	x	Discussion	x	Information	

Report Summary

This report presents a summary update for Quarter 1 on the progress of work towards completing LAS annual business plan.

After first three months of the delivery of the annual business plan, the following progress has been achieved:

- One objective completed
- 58 objectives on track for the delivery by the year end
- 12 objectives off track but under control to deliver by the end of the year
- Three objectives off track and significant delay projected for the delivery this year

Next steps

- Internal review process is taking place over the next two weeks that will identify if there are any commitments that may need to be deferred due to availability of funding in this financial year

Recommendation/Request to Trust Board:

Trust Board members are asked to review and approve the Q1 update on the progress on the annual business plan presented in this report.

In addition, Trust Board members are asked to approve the following change requests:

1. Additional objective on developing and signing off LAS uniform policy (objective 37) is proposed to be added.
2. Objective 41 change of SRO from Jonathan Elwood to William Cunliffe.
3. Objective 51 – change from:

   Deliver key performance indicators on the new Heathrow contract (assuming successful tender)

   to:

   Deliver key performance indicators on the new Heathrow contract
4. Two objectives relating to LAS estates plans to be consolidated into one and changed from:
   - *Complete detailed plans and submit planning permission for Bow Ambulance Station for September 2024*
   - *Deliver expansion of 2 ambulance stations*

   to:
   - *Deliver LAS estates strategy for 2024/25* (Objective 60)

Trust Board members are asked to note the next steps and the business plan review process being undertaken.

Routing of Paper i.e. previously considered by:

ExCo on 31.07.2024

Corporate Objectives and Risks that this paper addresses:

Annual Business planning process and strategy implementation.
Aligned with Trust BAF register and Quality objectives.

Business plan for 2024/25 draft commitments

Strategy year 2

London Ambulance Service NHS Trust

Deliverable(s) complete
Deliverable(s) On track
Deliverable(s) Off track - under control
Deliverable(s) Off track - significant delay

Mission	Priority	No.	Commitment 2024-25 - Strategy year two	Board Director	Senior Responsible Officer	RAG rating	Q1 Update
1	Rapid and seamless care	1	**Improve delivery of ST-elevation myocardial infarction (STEMI) care bundle to 80% by the end of financial year**	Fenella Wrigley	Alison Blakely	**Deliverable(s) Off track - under control**	SSCL sector improvement plans refined but unable to fully initiate due to delays in reporting of clinical AQI data (STEMI care pack); data required to inform effectiveness of interventions. Latest data from February, STEMI care bundle pan London 77%, multiple sectors achieving >80% Dec '23-Feb '24. STEMI QI collaborative with Quality Improvement and SSCL teams planned. Continued messaging and education via TBW training days/huddles on adhoc basis, supported by CTM messaging. Planning for pan London STEMI care bundle video commenced. Further guidance on analgesia in STEMI (critical element of care bundle) created and improvement posters approved.
1	Rapid and seamless care	2	**Achieve Return to Spontaneous Circulation mean of 30% by end of financial year**	Fenella Wrigley	Mark Faulkner	**Deliverable(s) On track**	ROSC figures run one quarter behind so only April '24 available with ROSC sustained to hospital at 29%
1	Rapid and seamless care	3	**Achieve consistent mean call-connect to hands-on-chest time of 4mins 15 secs by the end of the financial year to improve Return to Spontaneous Circulation**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) On track**	Introduced regular KPI meetings for all staff; call to arms to Watch Leadership Teams, currently at 35% complete for all call handlers (up from 0%) Introduced method of tracking KPI meeting completion (ESR) Time to Hands on Chest - 4 mins 50 seconds

1	Rapid and seamless care	**4**	**Improve Category 1 performance in comparison to last financial year**	Pauline Cranmer/ Fenella Wrigley	Darren Farmer/ Stuart Crichton	**Deliverable(s) On track**	**EOC Update** Developed and deployed new Power BI cat1/2 tail Business Intelligence report - report 4137 Completed focus group with ERDs to troubleshoot issues leading to extended cat1/cat2 response times. **Update from Darren Farmer** Currently at 7m19s for Q1, second best performance nationally. Focus on provision of FRV hours within Ambulance Operation as well as using the CISO tool to manage FRV on scene time post DCA arrival.
1	Rapid and seamless care	**5**	**Increase activation of public access defibrillators by Emergency Operations Centre by 5%**	Fenella Wrigley	Stuart Crichton/ Mark Faulkner	**Deliverable(s) On track**	In workplan for Q2 start
1	Rapid and seamless care	**6**	**Improve Category 2 performance in comparison to last financial year**	Pauline Cranmer	Darren Farmer	**Deliverable(s) On track**	Currently at 36m52 for Q1, significant challenge in managing down our dependency on incentivised overtime which has been successful. Focus is now on reducing the time that our C2 patients are waiting through management of productivity. This will be achieved through the use of objective setting against the patients per shift metric. A dashboard is under development to assist in these conversations however 75th centile figures are currently available and will be used as stretch objectives to be met by the end of Q3.
1	Rapid and seamless care	**7**	**Improve our performance on 999 call answering to a mean of less than 10 seconds by end of the year**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) On track**	We continue to recruit to our establishment of 500 WTE call handling staff. Currently we are at 480 WTE. We are achieving the 10 second standard, having delivered 3 seconds Call Answer Mean YTD.
1	Rapid and seamless care	**8**	**Ensure 75% of patients in P1, P2 and P3 priorities commence a clinical assessment within the commissioned timeframe**	Fenella Wrigley	Jacqui Niner	**Deliverable(s) On track**	CAS call-back performance has improved from 38.9% at start of financial year to 59.20% by end of Q1. On track for delivery of target. This has been achieved through the actions identified by the transformation programme such as clinical workforce adjustments, improved productivity, better shift/queue management, and improved data oversight and quality

1	Rapid and seamless care	**9**	**Achieve a mean answering time for 111 of less than 3 minutes by the end of the financial year**	Rakesh Patel	Jacqui Niner	**Deliverable(s) On track**	Speed to answer has reduced from 119 seconds at the start of the financial year to 83 seconds by end of Q1. This has been achieved through actions identified through the transformation programme including productivity, scheduling and forecasting, shift management, and data quality and oversight
1	Rapid and seamless care	**10**	**Achieve a hear-and-treat rate of at least 17% each quarter by delivering a Future Dispatch Model across all 5 sectors**	Fenella Wrigley	Alison Blakely	**Deliverable(s) On track**	Delivered >17% H+T for Q1. Actual delivery = 19.2% YTD. Work continues with the move towards all 5 sectors being live with the newly titled 'Clinical Dispatch Support'. Staffing and trajectories on track with all education course for new starters in the clinical hub full until September.
1	Rapid and seamless care	**11**	**Assess the case for change for a triage system and if approved and funding secured begin implementation**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) Off track - under control**	Scoping phase including mapping and clarifying national position and guidance.
1	Rapid and seamless care	**12**	**Deliver first phase of electronic controlled drugs registers to improve clinical safety and efficiency**	Fenella Wrigley	Sumithra Maheswaran	**Deliverable(s) On track**	The substantial amount of preparation work has been completed (including a product spec) and outline business case is now being finalised with finance and will be taken to ExCo by the end of July for approval.
1	Individualised Clinical Response	**13**	**Trial a care co-ordination hub in one Integrated Care System area with co-location of LAS and specialist clinicians enabling 'one-call' referral**	Fenella Wrigley	Alison Blakely	**Deliverable(s) On track**	Learning from national approaches, engagement with system stakeholders and planning of model. Strategic board established, care coordination hub concept presented with approval to proceed with development. Programme management commenced. Mapping of hub design and pathways into hub commenced.
1	Individualised Clinical Response	**14**	**Introduce six mental health ambulances to improve the management of mental health emergencies and support for patients subject to section 136**	Pauline Cranmer	Darren Farmer	**Deliverable(s) On track**	The first of these vehicles has already been deployed operationally with plans to launch the remaining 5 as the fleet becomes available
1	Individualised Clinical Response	**15**	**Maintain 10 urgent community response cars across London**	Fenella Wrigley	Alison Blakely	**Deliverable(s) On track**	10th UCR car to cover SEL launched in June 2024.

1	Individualised Clinical Response	**16**	**Achieve mean response of less than 120 minutes to fallers still on the ground and make referrals to other services within 60 minutes of 999 call where clinically appropriate**	Fenella Wrigley	Alison Blakely	**Deliverable(s) Off track - under control`**	Defining intended patient demographic cohort on which to report (>65 years, fall, patient still on floor, no time critical illnesses/injuries, receiving a F2F assessment from LAS). Intention to set milestones once reliable base line established.
1	Individualised Clinical Response	**17**	**Gather and take action on patient feedback from people impacted by health inequality, starting with patients with sickle cell disease and new mothers from Black and ethnic minority backgrounds**	Roger Davidson	Beata Malinowska	**Deliverable(s) On track**	1. Sickle cell: Two chosen sickle cell VCSEs finalised their engagement work and shared their reports by the end of June. Recommendations and reports finalised with LAS HI team in July. 2. Scoping of relevant VCSEs to work on patient engagement started (replicating our approach from sickle cell work). Members of the steering group met with some of the VCSEs to test their approach and suitability for the work. 3. Mapping of VCSEs working in this space with other NHS organisation and meeting with NHSE HI and maternal health leads.
1	Outstanding care and leadership of major incidents and events	**18**	**Develop and successfully integrate National Ambulance Resilience Unit (NARU) into LAS - transition the service and develop and launch NARU strategy**	Pauline Cranmer	Natasha Wills	**Deliverable(s) On track**	Transition to LAS BAU completed without operational disruption. The development of the new strategy is ongoing with stakeholder meetings taking place and due to be completed by September.
1	Outstanding care and leadership of major incidents and events	**19**	**Roll out NHSE 10 second triage tool for managing incidents, improving our response and bringing greater clarity to the initial stages of multi-agency or major incidents**	Pauline Cranmer	Natasha Wills	**Deliverable(s) On track**	Training of all frontline staff has been completed. The kit has been rolled out to all Specialist Assets and Incident Response Officers. Currently the kit is being rolled out to frontline ambulances and solo responders.
1	Outstanding care and leadership of major incidents and events	**20**	**Invest in digital tools to support our response to major incidents, including implementing a digital logging solution by end Q3**	Pauline Cranmer	Natasha Wills	**Deliverable(s) On track**	Continue to work with Noggin to finalise the Strategic Commanders element of the logging tool. Will be ready for roll out September.
1	A learning and teaching organisation	**21**	**Invest in career development across organisation, including implementing a band 6 rotation programme by Q2, and increasing number of advanced or specialist paramedic roles by 5%**	Damian McGuinness/ Pauline Cranmer	Darren Farmer (rotations) Tim Edwards (specialist paramedic roles)	**Deliverable(s) On track**	Early conversations have already taken place with all interested parties and a robust implementation plan is currently being worked up ahead of shared with Exco for approval in Q2.

1	A learning and teaching organisation	**22**	**Increase by 10% the proportion of applicants from an ethnic minority background to jobs in ambulance operations and 999, agreeing and implementing an action plan which will include implementation of a new call handler to associate ambulance practitioner recruitment programme**	Damian McGuinness/ Roger Davidson	Jules Potter (call handler to AAP rec programme) / Kulvinder Hira	**Deliverable(s) On track**	**Update from Damian McGuiness** We are undertaking 32 checks on staff, with over 60% BME representation. Another 22 staff are awaiting their C1 provisional license. 64% of these staff are BME. OD&T is running a series of Employability Skills training sessions throughout 2024/5 under the Our Inclusive Response Programme umbrella in support of Londoners who wish to join the LAS either as an AAP or call handler. This is in partnership with the GLA with specific focus on increasing workforce diversity. The OD & Talent Team has launched a Talent Mentoring Programme through a GLA collaboration and portal to encourage mentoring arrangements for colleagues from ethnic minoritised communities. **Update from EDI team:** LAS Fest took place at Newham and attracted wide range of communities and Stepping Up package was in development with OD&T team
1	A learning and teaching organisation	**23**	**Implement a strategic partnership for developing improvement capability and capacity and deliver the Trust's first rapid process improvement workshop using LAS Improve methods**	Pauline Cranmer	Jaqui Lindridge	**Deliverable(s) On track**	The SASH partnership has progressed although starting slightly later than planned. Each of the QI team have been allocated coaches and are booked into the Lean for Leaders Course in July and advanced Leaders in September / December. Exec coaching has been arranged with attendance at EXCO starting 12th July (Trust Guiding team). Intro and taster sessions for lower band staff will be advertised throughout 2024 to engage all areas of the Trust. The L4L course starting in July also has a range of managers attending from B8B to Director level.

1	A learning and teaching organisation	**24**	**Introduce performance metrics for emergency dispatch to ensure greater consistency for patients**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) On track**	During Q1 we have scoped several potential individual-level Dispatch KPIs including "Time to Suggestions pressed", "To stand-by notifications sent" and "Rest breaks allocated". A meeting with Director of Business Intelligence Ranjita Sen occurred on 12/07/24 developing work plan for this being developed. Significant development is needed to make these individual-level KPIs, so a Q3 implementation date should be anticipated. In the meantime, we are also introducing Dispatch audit in the form of a Dispatch Workplace Review, which is anticipated to be introduced in early Q2.
1	A learning and teaching organisation	**25**	**Complete all commissioned learning responses within nationally- defined timeframes, plus reduce overdue open incidents to 25% of total open incidents (excluding those considered for learning response), both by end March 2025.**	Fenella Wrigley	Neal Durge	**Deliverable(s) On track**	Ground work including scoping and establishing reporting metrics completed. Key stakeholders engaged with and exercises took place at Q1 Patient Safety Forum to agree next actions. SOPs into respective areas commenced including escalation process. Metrics monitored throughout reporting period with improvement noted. Data shared via CQOG and Learning and Assurance Group
1	A learning and teaching organisation	**26**	**Deliver via our Clinical Audit and Research Unit one clinical audit per quarter, two annual reports in Q3 and prepare application for one further research study**	Fenella Wrigley	Neal Durge	**Deliverable(s) On track**	A Clinical Audit of the Assessment and Management of Traumatic Haemorrhage by the London Ambulance Service NHS Trust was published in June 2024
1	A learning and teaching organisation	**27**	**Develop a clinical supervision model to support all clinical staff**	Pauline Cranmer	Hannah Curror	**Deliverable(s) Off track - under control**	Fact finding as to areas of good practice already occurring in the LAS.
2	An inclusive and open culture	**28**	**Improve employee experience and engagement by reducing the mean length of formal case management to within a timeframe of 12 weeks**	Damian McGuinness	All ExCo directors	**Deliverable(s) On track**	Employee relations metrics agreed and signed off at EXCO & PCC - People Scorecard. Numerous training sessions for managers and investigation managers taking place in Q1 to support timeframe metrics

2	An inclusive and open culture	**29**	*Focus LAS Culture Programme on improving teamwork (the Year of the Team)* **Achieve c200 managers completing leadership courses**	Damian McGuinness	Simon Steward	**Deliverable(s) On track**	Our Trust-wide Leadership Development Programme is now well underway. Our LAS Aspiring Leaders Programme (Band 4/5) has seen all three cohorts comprising 50 colleagues in total, complete sessions 1 and 2. The High-Performance Leadership Programme (Band 8B-9), delivered in partnership with Henley Business School comprising 27 colleagues, has welcomed cohort 1 with remaining cohorts starting this exciting programme in Sept 2024 and into 2025.
2	An inclusive and open culture	**30**	*Focus LAS Culture Programme on improving teamwork (the Year of the Team)* **Achieve management ratio maximum of 1:15**	Damian McGuinness	Simon Steward	**Deliverable(s) On track**	Both Ambulance Operations and EOC average management ratio is 1:12.
2	An inclusive and open culture	**31**	*Focus LAS Culture Programme on improving teamwork (the Year of the Team)* **Achieve 85% of people with completed appraisals**	Damian McGuinness	Simon Steward	**Deliverable(s) Off track - under control`**	Our compliance appraisal rate stands at 73% (July 2024). An Appraisal Compliance Improvement Project has been devised by OD&T to increase compliance.
2	An inclusive and open culture	**32**	**Continue strengthening staff networks, agreeing plans so they deliver a proactive agenda and grow their total membership by 20%**	Roger Davidson	Kulvinder Hira	**Deliverable(s) Off track - under control`**	Staff networks are responsible for increasing their membership and do this through various including publishing phots of chairs. Staff networks have been much more active over Q1 including Pride, Armed Services Day and Muslim network activities. Baseline for increased membership has been agreed and it's 1,300 so looking to grow to 1,560 by March 2025
2	An inclusive and open culture	**33**	**Improve the likelihood (currently 2x less likely) of Black and ethnic minority candidates being successful at interview stage, by supporting the career advancement of colleagues**	Roger Davidson	Kulvinder Hira	**Deliverable(s) On track**	A total of 30 Independent Panel members have been recrutied and trained from all levels and teams across the Trust. A guidance doscument has been provided for all trainied IPMs. The IPMs are requested to complete a declaration on whether the process was fair and transparent and if they agree with the decision made.
2	An inclusive and open culture	**34**	**Improve the proportion of disabled colleagues who say in the NHS staff survey that reasonable adjustments were made and reduce the number of concerns raised on this topic**	Roger Davidson	Kulvinder Hira	**Deliverable(s) On track**	Reasonable adjustments policy and guidance has been published. A process has been set up with a centralised budget and a dedicated email address monitored by the EDI team. Software licenses have been purchased to support staff.

2	An inclusive and open culture	**35**	**Develop and deliver an improvement plan against the six Equality, Diversity and Inclusion High Impact Actions with specific focus on all leaders to be held accountable for reducing discrimination and creating an inclusive LAS**	Roger Davidson	Kulvinder Hira	**Deliverable(s) On track**	An EDI Programee has been developed and each of the high impact actions have specific actions against them. There will be a particular focus on leadership over Q2 including individual leadership commitments, development workshops and updating our training programmes.
2	An inclusive and open culture	**36**	**Implement a sexual safety action plan leading to significant improvements in response to this question in the staff survey with the aim of reducing incidences**	Pauline Cranmer	Alan Taylor	**Deliverable(s) On track**	Sexual safety working Group now meeting monthly in person. Action plan progressing, is also added to as a live work plan. Chaired by PC Chief Paramedic it reports into the EDI Committee
Bow	An inclusive and open culture	**37**	**Develop and sign off LAS uniform policy by Q4**	Roger Davidson	Roger Davidson	**Deliverable(s) On track**	Scoping work on the basis of previous draft of the policy has commenced.
2	Well-led across the organisation	**38**	**Implement a professional standards group to oversee and ensure registrants are supported through investigations and these are completed in a timely way**	Fenella Wrigley	Mark Faulkner	**Deliverable(s) Off track - under control**	Head of professional standards JD drafted and submitted for re banding with a plan for advert in coming weeks. Tor drafted for professional standards group, Meetings planned to ADO and Ops leads for briefing around HCPC referral guidance. Briefing drafted for HR managers around HCPC process.
2	Well-led across the organisation	**39**	**Take a proactive approach to support the good health of staff, including recognising many have high levels of exposure to trauma, which will be reflected in reducing sickness levels to less than 6%.**	Damian McGuinness	All ExCo directors	**Deliverable(s) Off track - under control**	**Update from 1s/IUC** The IUC team continue to monitor this closely and report at FFR and contract meetings. Sickness levels in Q1 remain stable at 10.2%. An action plan following the staff survey has been developed to support achieving this aim **Update from Damian McGuiness** New reporting system (app) commissioned & managed via working groups. Pilot groups extended.
2	Well-led across the organisation	**40**	**Implement electronic safeguarding referrals**	Pauline Cranmer	Jaqui Lindridge	**Deliverable(s) On track**	Project underway. Currently out to consultation with EBS staff affected. Other workstream progressing well.

2	Well-led across the organisation	**41**	**Maintain a response rate of 75% to complaints within 35 working days**	Mark Easton	William Cunliffe	**Deliverable(s) Off track - under control**	The slightly higher number of complaints due in Q1 2024 compared to Q1 2023 is a factor in the performance. Response rate in Q1 was 49%. Response rate closely monitored through SPC charts. Currently lower than target mainly due to delays in the drafting and review process for complaint response letters. Quality Improvement project in planning stage - Plan stage of PDSA cycle.
2	Well-led across the organisation	**42**	**Complete phase 2 of teams-based working in ambulance operations, including establishing a devolved operations model, a robust plan to provide leadership capacity and capability with a dashboard providing team level detail on all objectives and**	Pauline Cranmer	Darren Farmer	**Deliverable(s) On track**	Dashboard is well under development with a draft version getting feedback at this point. 5 pilot sites for Holistic Operating Model already in place. Recruitment in place for acting CTM with candidates due to be in post for Q3. Recruitment to acting TL planned for Q3
2	Well-led across the organisation	**43**	**Complete implementation of Emergency Operations Centre teams- based working by Q3 including implementation of new rotas, line management structures, and structured team time**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) On track**	TBW went live on 1 July, including a new rota, 1:15 line management structure and structured team time. We continue to recruit to PMCH to fully complete out transition to TBW and to fulfil our 1:15 line reporting.
2	Well-led across the organisation	**44**	**Implement teams-based working within the clinical hub, including new rotas, structured team time and structured clinical time**	Fenella Wrigley	Alison Blakely	**Deliverable(s) completed**	New rosters for TBW and structured operational and team time implemented. This launched 1st July 2024.
2	Well-led across the organisation	**45**	**Deliver 111 transformation programme to improve the productivity in both call answering and clinical assessment**	Rakesh Patel	Jacqui Niner	**Deliverable(s) On track**	The IUC team have worked with TN to deliver an extensive transformation programme which is set to revert to BAU in Q2. This has led to improvements in performance, patients experience, and cost of the service
2	Well-led across the organisation	**46**	**Develop and agree a revised rest break policy for Emergency Operations Centre, 999 and 111 operations**	Pauline Cranmer	Stuart Crichton Darren Farmer Jacqui Niner Damian McGuinness	**Deliverable(s) On track**	The EOC/999 Ops role in this objective is limited in scope; the current version of our Rest Break Agreement has been shared with stakeholders for information.
2	Well-led across the organisation	**47**	**Complete Tactical Operations Unit review and implement recommendations to ensure effectiveness of services provided including incident management desk, patient flow and central support unit**	Fenella Wrigley	Stuart Crichton	**Deliverable(s) On track**	In Q1 we have scoped and valued the associated CIP with this piece of work, and commissioned Transformation Nous to support it Operating model review started

2	Well-led across the organisation	**48**	**Improve productivity in ambulance operations by reducing out-of- service and reducing job cycle time in comparison to last financial year**	Pauline Cranmer	Darren Farmer	**Deliverable(s) On track**	A series of conferences have been delivered to inform all managers within Ambulance Operations of the performance capability process. This will be followed up with detailed training provided by our P&C business partners through Q2 in sector. Focus is now on reducing the time that our C2 patients are waiting through management of productivity. This will be achieved through the use of objective setting against the patients per shift metric. A dashboard is under development to assist in these conversations however 75th centile figures are currently available and will be used as stretch objectives to be met by the end of Q3.
2	Well-led across the organisation	**49**	**Centralise Make Ready packing function to Rainham to deliver improved efficiency and quality**	Rakesh Patel	Rakesh Patel	**Deliverable(s) Off track - under control**	Develop rota
2	Well-led across the organisation	**50**	**Deliver a new internal communications and engagement strategy that aims to increase campaign awareness by 5%, key channel effectiveness by 5% and offers regular opportunities for staff voice to be heard through face-to-face and online events both locally and centrally**	Roger Davidson	Claire Proudlock	**Deliverable(s) Off track - under control**	Strategy drafted and under review; ongoing campaigns/content/events delivered inc ELG x3; IUC move; MFA; Our LAS awards nominations; Pulse survey; Amb ops huddle engagement; London Life Hike; Hybrid-working etc.; Recognition-distribution of coronation medals and ongoing staff milestones recognised
2	Well-led across the organisation	**51**	**Deliver key performance indicators on the new Heathrow contract**	Pauline Cranmer	Darren Farmer	**Deliverable(s) On track**	Contract is yet to be signed but key metrics are already improving. Formal agreement and contract does not come into force until 2025
2	Well-led across the organisation	**52**	**Deliver on the procurement of Integrated Urgent Care contracts pan- London and be successful in securing 111 contracts for North East London and South East London in 2025/26**	Rakesh Patel	Jacqui Niner	**Deliverable(s) On track**	The formal process has not started yet but the IUC team have been engaged in all stakeholder events for the reprocurements and have been a strong advocate for the continued provision of the service. Tender timescales for SEL procurement published.
2	Well-led across the organisation	**53**	**Deliver the 2024/25 Income and Expenditure plan**	Rakesh Patel	All Board directors for their area	**Deliverable(s) Off track - significant delay**	The Trust is behind the I&E plan at the end of Q1
2	Well-led across the organisation	**54**	**Deliver a £30 million cost reduction programme**	Rakesh Patel	All Board directors for their area	**Deliverable(s) Off track - significant delay**	The Trust has not identified the full £30m CIP target.
2	Well-led across the organisation	**55**	**Deliver the 2024/25 capital plan**	Rakesh Patel	All Board directors for their area	**Deliverable(s) On track**	Capital plan approved by FIC and first elements of development of Estate in North East London underway

2	Improved infrastructure	**56**	**Introduce SMS capability to support with customer contact and feedback, where use cases will include text messaging for patient demographics and information (linked to the NHS App) and gathering patient feedback electronically to reduce manual overheads**	Clare McMillan	Clare McMillan	**Deliverable(s) On track**	Business case complete and proof of concept testing with Smart Survey linked to Adastra. Kick off for deployment in July with stakeholders
2	Improved infrastructure	**57**	**Work with London region to connect information gathered at call handling within IUC and publish to the London Care Record for ease of access to information for cross-system use**	Clare McMillan	Clare McMillan	**Deliverable(s) Off track - significant delay**	Waiting on external bid for NHS E London Region
2	Improved infrastructure	**58**	**Commission 185 new vehicles - 92 DCAs, 16 mental health vehicles, 26 HART vehicles, 5 bariatric ambulances, 15 driver training units and 31 cars for frontline staff**	Rakesh Patel	Rakesh Patel	**Deliverable(s) On track**	The Trust is on track to deliver the vehicles. The first batch of DCAs have arrived at the Trust's vehicle commissioning site
2	Improved infrastructure	**59**	**Deliver LAS estates strategy for 2024/25**	Rakesh Patel	Rakesh Patel	**Deliverable(s) On track**	The Trust is updating the Estates plan for NE London with a view to develop new facilities in Cody Road and plans to expand Frien Barnet. All projects progress in line with the plans.
2	Improved infrastructure	**60**	**Develop and implement with Transport for London a programme for electric vehicle charging infrastructure, including identifying sites and early installation**	Rakesh Patel	Rakesh Patel	**Deliverable(s) On track**	The Trust is in early discussions with TfL. Initial site visits at LAS sites have been undertaken
2	Improved infrastructure	**61**	**Improve IT infrastructure, including reducing the use of outdated technologies, reduction in single points of failure, and reduction in major outages. Upgrade of telephony for 111, 999 and corporate services by Q2 and resilience achieved across our data centres by Q3**	Clare McMillan	Clare McMillan	**Deliverable(s) On track**	Telephony upgrade completed for 111 and corporate services. 999 planned go live 25/7/24. External review of infrastructure resilience completed July 2024. Recommendations to move into a programme of workforce delivery in 2024/5
2	Improved infrastructure	**62**	**Evaluate and utilise new emerging technologies, including AI to improve patient care or productivity**	Clare McMillan	Clare McMillan	**Deliverable(s) On track**	A number of proof of concepts are in development including a trial with GOSH Ambient AI programme
2	Improved infrastructure	**63**	**Implement new business intelligence data platform to deliver better productivity and performance reporting – gathering requirements Q1, business case Q2, and delivery Q4**	Clare McMillan	Clare McMillan	**Deliverable(s) On track**	Requirements gathering workshop kick off 10th July 2024

2	Improved infrastructure	**64**	**Deliver the roll out of My Clinical Feedback App across London by the end of March 2025 so all frontline clinicians can learn from outcome information regarding their patients**	Clare McMillan/ Fenella Wrigley	Mark Faulkner	**Deliverable(s) Off track - under control**	**Update from Clare McMillan** IG challenges complete and Implementation starting July 2024 - delivery will be on track **Update from Mark Faulkner** Plan to integrate within FDP has raised a number of challenges to IG process and DPIA re drafted in line with advice from FDP to meet the FDP criteria. Awaiting final approval from FDP IG team provisional approval provided. There is 4-6 weeks' worth of reengineering work to data flows as a result of the FDP IG position and Giles and team have commenced that work. • We have been running engagement webinars with the trusts this week and all has gone fairly well. A few trusts have not engaged so I've requested individual meetings with them w/c 22/7 - realising our top risk around trust resource capacity and availability to deliver our changes.
2	Improved infrastructure	**65**	**Deliver a new call sign structure to align LAS to the rest of UK ambulance trusts. This will support the delivery of a new national control room solution to replace legacy infrastructure and provide a more reliable service, due in Q3**	Clare McMillan	Clare McMillan	**Deliverable(s) On track**	The call sign structure work has been stood down due to risks regarding GRS. CRS on track for delivery for November 2024
3	A system leader and partner	**66**	**Implement a new operating model for managing our contribution to our five integrated care systems with better use of data and coordinated engagement**	Roger Davidson	Beata Malinowska	**Deliverable(s) On track**	1. Monthly internal ICS meetings with ADOs, SSCLs, SPTMs, 1s, BI, Contracting and S&T established and three meetings in each sector completed. 2. Data report for each of the sector developed to reflect most commonly questions asked by ICS partners. 3. ICS stakeholders (top 20 for each sector) identified by each sector.
3	A system leader and partner	**67**	**Develop the General Practice Support Service (GPSS) further, securing agreement and funding to run a pilot of LAS answering phone and navigating patients requiring same day urgent primary care for 100,000 population**	Rakesh Patel	Jacqui Niner	**Deliverable(s) On track**	In Q1, the GPSS service has been provided to two practices with a large consortium (Modality) starting in August24. A further practice (Nelson) is onboarding slightly after. The team have been providing a high quality service and ongoing monitoring and audit is underway.

3	A system leader and partner	**68**	**Work with our system partners to proactively reduce hospital handover delays in comparison to last year by implementing a new patient flow process and by supporting LAS crews with cohorting and accessing alternative care pathways**	Fenella Wrigley / Pauline Cranmer	Stuart Crichton/ Darren Farmer	**Deliverable(s) On track**	**EOC Update** Finalised Patient Flow Framework in consultation with stakeholders **Update from Darren Farmer** Significant focus with operational staff and partners within the acute sector in reducing breaches of the W45 agreement. Particular work being done in support of North Middlesex Hospital
3	A system leader and partner	**69**	**Reduce by 5% face to face interactions with identified cohort of frequent callers by March 2025**	Pauline Cranmer	Jaqui Lindridge	**Deliverable(s) On track**	Some data challenges - changes in the national definition of FC mean there will be a break in the dataset in Q2. However F2F incidents for legacy definition FCs decrease 2.2% April > June, and high vol. callers (50+ calls in 3 months) reduced from 70 to 62.
3	Proactive at making London healthier	**70**	**Improve bystander intervention in cardiac arrest:** **> training 10,000 more London Lifesavers** **> increasing availability of public access defibrillators** **> creating an expanded Community First Responder scheme with first 50 new volunteers recruited this year**	Roger Davidson/ Fenella Wrigley	Mark Faulkner/ Claire Proudlock	**Deliverable(s) On track**	LLS trained in Q1 Year 8 = 2334 Pop Ups = 1662 Everything else = 663 Total trained in Q1 = 4659 We have started the roll out of defibs at all LAS sites with 46 PADs installed and registered on circuit 45 additional PADs registered across London We are working with BHF on a data cleanse to remove all duplicated defibs and those that are no longer active or are orphaned (no guardian assigned). We have started work to engage with all sites who's defibs are not yet registered on the circuit to get them moved off our old database and onto The Circuit. The massive task of getting all the OOS defibs back in service is also taking place. The launch of the defib campaign is scheduled for the 25th July We held 2 induction events so far, which had 20 CFRs on each. We have more CFRs who wish to join the scheme and will be holding another event in August. A paper has been submitted to PSCEG informing that an interim measure to issue those CFRs who have completed
3	Proactive at making London healthier	**71**	**Publish and implement a five-year action plan for reducing health inequalities, including confirming our PLUS5 patient priorities, with plans to listen to and act upon patient views**	Roger Davidson	Beata Malinowska	**Deliverable(s) On track**	Completed the engagement and scoring tool to identifiy LAS PLUS cohorts for NHS CORE20PLUS5 framework. Signed off at ExCo and EDI Committee.

3	Proactive at making London healthier	**72**	**LAS Charity to agree and begin to implement a new mission, focussed on improving cardiac arrest survival, with associated work plan for the charity and a fundraising target of £350,000**	Roger Davidson	Claire Proudlock	**Deliverable(s) On track**	The plan to change the primary mission of our Charity to raising vital funds for public-access defibs was approved at the Charitable Funds Committee and Ex-Co. Since then, we have devised and launched our first ever sponsored walk, the London Life Hike, and have launched the social movement surrounding defib deserts and community fundraising for them.
3	Green and sustainable for the future	**73**	**Complete delivery of current green commitments, including decreasing carbon footprint by 6% - and develop four year green plan for 2024-2028**	Rakesh Patel	Rakesh Patel	**Deliverable(s) On track**	Green Plan being developed
3	Green and sustainable for the future	**74**	**Achieve ULEZ compliance across our diesel fleet by September 2024**	Rakesh Patel	Rakesh Patel	**Deliverable(s) On track**	Fleet replacement programme is on track to comply with ULEZ by middle of financial year

8. Assurance

For Approval

8.1. Risk Appetite Statement

For Approval

Presented by Mark Easton

London Ambulance Service NHS
NHS Trust

Risk Appetite Statement

As part of its work on refreshing the Board Assurance Framework, London Ambulance Service (LAS) has also reviewed its risk appetite statement.

A 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.

London Ambulance Service seeks to minimise risks to its stated purpose of being the capital's emergency and urgent care responder, and achieving its three missions of:

- Delivering outstanding emergency and urgent care whenever and wherever needed;
- Being an increasingly inclusive, well-led and highly skilled organisation people are proud to work for;
- Using our unique pan-London position to contribute to improving the health of the capital.

LAS endeavours to establish a positive risk culture within the organisation, where unsafe practice is not tolerated and where every member of staff and volunteer feels committed and empowered to identify and correct/escalate system weaknesses. However, LAS recognises that risks will inevitably occur in the course of providing care and treatment to patients, employing staff and volunteers, maintaining premises and equipment and managing finances.

LAS is committed to ensuring that a robust infrastructure is in place to manage risks from an operational level to Board level and that where risks crystallise, demonstrable improvements/mitigations can be put in place.

LAS has a **zero risk appetite** for fraud and regulatory breaches. The Trust may, however, take considered risks where the long term benefits outweigh any short term losses. Well managed risk taking will ensure that the skills, ability and knowledge are there to support innovation and maximise opportunities to further improve services.

LAS has an overall **low risk appetite** for risks relating to all safety and compliance objectives, including public and patient harm and employee health and safety

It follows, LAS has a low risk appetite:

- To accept risks that could result in a negative impact on quality including poor quality care or treatment or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice
- To risks relating to all safety and compliance objectives, including public and patient harm to staff health and safety
- To any risk that could result in staff being non-compliant with any frameworks provided by professional bodies

The Trust has a **moderate risk appetite** for the pursuit of its operational objectives including reputational risk and financial risks involving value for money. As such, budgetary constraints may temporarily be exceeded where required to mitigate risks to patient or staff safety or quality of care.

LAS has a **high risk appetite** when seeking opportunities for innovation (clinical and financial) that are within the constraints of the regulatory environment.

LAS will actively utilise the Risk Appetite Statement during any decision making process.

Key Risk Categories and Risk Tolerances

Risk Category	Risk Appetite Level	Risk Appetite Statement	Example
Patient Safety	Low	LAS has a low appetite for risks that may compromise the delivery of safety for patients. LAS will not compromise the safety of staff or patients.	The LAS has recently revised the CSEP plan in order to ensure resources are re-directed to ensure those at most need are prioritised.
Compliance/Regulatory	Low	LAS has a low risk appetite for compliance/regulatory risks which may compromise LAS's compliance with its statutory duties and regulatory environment.	Gaps in the Trust's compliance with medicines management regulations were identified and put on the Trust-wide corporate risk register. Mitigating the risk was a high priority management concern- there was zero appetite for tolerating the risk.
Financial/Value for Money	Low	LAS has a low risk appetite for financial/value for money risks to ensure that statutory requirements are met and the risk of financial loss is minimised.	LAS has restricted spending on overtime as part of our measures to break even.
Business Continuity	Low	LAS has a low risk appetite for business continuity issues, such as cyber security, ERPR, and the NARU service.	LAS aims to assiduously reduce risks in this area, such as addressing cyber security risks as a very high priority.
Performance	Medium	LAS has a medium risk for performance issues, balancing the need for innovative productivity and service initiatives with the need for financial discipline.	Productivity initiatives such as the "start of shift" programme have been balanced with spending restrictions and an ambitious CIP plan.
Reputation	Medium	LAS has a moderate appetite for actions and decisions taken in the interest of enhancing the reputation of the organisation.	Allowing a TV documentary to film our crews had risks, but had upsides for profile and recruitment which justified the risk.
Cultural	High	LAS as a high risk appetite in addressing issues of inappropriate behaviour which may require bold or brave action to challenge unacceptable cultural practices such as racism, sexism and bullying, and for assaults and harassment of our staff.	The Board has agreed to not tolerate discriminatory or abusive behaviour even where this may place the organisation at risk from staff grievances or employment claims, and presses for maximum legal action for all staff assaults.
Innovations (clinical and financial)	High	LAS has a high risk appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities to improve patient outcomes and	Examples include: - our trail blazing C2 segmentation; - increasing the hear and treat rate (including video

		transform services whilst ensuring value for money and that do not compromise the quality of care.	assessment) - initiation Point of Care testing to improve safe management on scene

The Trust commits to review its risk appetite statement on an annual basis and/or following any significant changes or events.

July 2024

8.1.1. Board Assurance Framework

For Approval

Presented by Mark Easton

London Ambulance Service NHS Trust

Report Title	2024/25 Board Assurance Framework Risk and Risk Appetite Statement			
Meeting:	Trust Board			
Agenda item:	8.1.1	**Meeting Date:**	5 September 2024	
Lead Executives:	Mark Easton, Director of Corporate Affairs			
Report Author:	Frances Field, Corporate Governance Manager			
Purpose:		Assurance	**x**	Approval
	x	Discussion		Information

Report Summary

The Trust reviews its risk appetite statement on an annual basis. The latest proposed draft has attached. It has been considered by the Executive Committee and Audit Committee and is recommended to the Board for approval. It has been updated from last year with refreshed examples of risk appetite and a new section reflecting the organisation's commitment to cultural change.

The BAF has been reviewed by the lead executives and by assurance committees since it was last seen by the Board in June. As a result of these reviews some new risks have been identified and updates were made to the controls, assurances and actions, including some changes to risk scores:

Quality Assurance Committee (QAC)

Change to risk score:

1.1 We may not achieve the quality standards required in stroke, cardiac care, and cardiac arrest. Risk score increased from 3 x 4 (12) to 4 x 4 (16).

People and Culture Committee (PCC)

Risk scores agreed:

2.4 We may not improve the sexual safety of staff unless we fully implement the action plan we have identified. Uncontrolled 5 x 4 (20), current 4 x 4 (16), tolerance 3 x 4 (12).

Other points to Note:

- It was highlighted at the People and Culture Committee on 11 July, that for two entries (2.2 and 2.3) the current risk scores were 12, the same as the target or tolerated score for year-end, which suggests no progress will be made during the year. The Lead executive was asked to review this and an update will be given to the P&C Committee in September.

- Risk 2.2 - We may not improve in the NHS People Plan domain regarding Looking after our people - particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically. Current score 3 x 4 (12).

- Risk 2.3 - We may not improve our organisational culture in addressing bullying and / or harassment underpinned by poor underdeveloped management and leadership practices. Current score 3 x 4 (12).

Equality and Diversity Committee (EDI)

Rewording and increase in risk scoring:

2.1 Wording amended to:

We may not achieve the changes required to make the LAS a fully-inclusive and supportive workplace which increases representation and reduces disparities for under-represented groups, especially resolution of the gender pay gap in LAS, how we ensure that people who have a disability are supported, and how do we ensure that people from a BME background are able to progress in LAS.

Uncontrolled risk score increased from 4 x 4 (16) to 5 x 5 (25) and current risk score increased from 4 x 4 (16) to 4 x 5 (20)

Finance and Investment Committee (FIC)

New risk:

2.12 The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2024/25.

Changes to risk scores:

2.11 There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year. Risk score reduced from 4 x 4 (16) to 3 x 4 (12.)

3.1 We may not be able to complete delivery of current green commitments, including decreasing carbon footprint by 6% - and develop four year green plan for 2024-2028. Risk score reduced from 5 x 3 (15) to 3 x 4 (12).

3.2 There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London if the current fragmented commissioning and tendering of 111 contracts by 5 ICSs continues. Current risk score increased from 3 x 4 (12) to 4 x 4 (16) and tolerance score from 1 x 4 (4) to 2 x 4 (8).

Digital and Data Committee (D&DC)

Changes in risk scores:

2.7 Operations may be affected by the shortage of Mobile Data Terminals (MDT's). Risk score reduced from 2 x 5 (10) to 1 x 5 (5) with a view to it being removed at the next Digital Committee meeting.

Risk score agreed:

2.9 There is a risk that performance is impacted if we do not seamlessly deliver the complex programme to replace our legacy dispatch system with the new national Control Room Solution. Uncontrolled 5 x 4 (20), current 3 x 4 (12), tolerance 1 x 4 (4).

New risk Digital and People & Culture:

2.13 We have a legacy staff scheduling system (GRS) which has limited support. Until it can be replaced there is a risk that system failures may cause significant inefficiencies affecting operational performance.

As we did last year, it is intended to track risk scores by quarter so we can monitor progress towards the target risk score by year end.

Recommendation/Request to the Board:

The Board is asked to approve the risk appetite statement.

The Board is asked to review and approve the new BAF risks, and the comments of assurance committees with associated scoring of risks in the attached 2024-25 BAF.

Routing of Paper i.e. previously considered by:

ExCo and 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.

Board Assurance Framework – 2024 - 2025

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed											
Risks		**Uncon[d]**	**Q1**	**Q2**	**Q3**	**Q4**	**Curr[t]**	**Target**	**Committee**	**Owner**	**Page**
1.1	We may not achieve the quality standards required in stroke, cardiac care, and cardiac arrest.	20	12	16			16	12	QAC	FW	4
1.2	We may cause harm by not achieving the Ambulance Performance Standards set out in the NHSE Operating Plan due to:	25	20	20			20	12	QAC	PC	7
	• Insufficient funding from commissioners to meet demand	25	25	25			25	8			
	• Constrained capacity in the UEC system and handover delays at hospitals	25	20	20			20	12			
	• Underachievement of productivity initiatives	25	20	20			20	8			
1.3	We may not be able to achieve the IUC target of 75% of all CAS cases being contacted within the required timeframe and answer 111 in less than 3 minutes by the end of the financial year.	16	12	12			12	8	QAC	JN	9
1.4	The introduction of RCRP poses a risk to our performance and financial model as the LAS has seen an increase in demand, and complexity of the cases received. This places a pressure on the organisation that is currently unfunded, and may compromise care to patients, especially those with mental health conditions.	20	12	12			12	9	QAC	FW	13
1.5	We may not improve the quality of the care we provide if we do not complete delivery of our quality priorities	20	12	12			12	8	QAC	JL	16
1.6	We may not achieve targets for commissioned learning response timeframes and overdue incidents impacting our ability to rapidly adopt any derived learning.	20	16	16			16	8	QAC	FW	18
1.7	We may not improve data quality, embed data governance and follow through on the data quality action plan.	20	12	12			12	8	Digital	CM	20
Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for											
Risks		**Uncon[d]**	**Q1**	**Q2**	**Q3**	**Q4**	**Curr[t]**	**Target**	**Committee**	**Owner**	**Page**
2.1	We may not achieve the changes required to make the LAS a fully-inclusive and supportive workplace which increases representation and reduces disparities for under-represented groups, especially resolution of the gender pay gap in LAS, how we ensure that people	25	16	20			20	12	EDI	RD	22

	who have a disability are supported, and how do we ensure that people from a BME background are able to progress in LAS.										
2.2	We may not improve in the NHS People Plan domain regarding *Looking after our people* - particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically.	20	12	12			12	12	P&C	DM	24
2.3	We may not improve our organisational culture in addressing bullying and / or harassment underpinned by poor underdeveloped management and leadership practices.	20	12	12			12	12	P&C	DM	26
2.4	We may not improve the sexual safety of staff unless we fully implement the action plan we have identified.	20	16	16			16	12	P&C	PC	27
2.5	There is a risk that the organisation may experience a cyber-attack, and struggle to recover service in a timely manner, which could result in unauthorised access to sensitive data, disruption of business operations, financial loss, and reputational damage.	25	15	15			15	10	AC	CM	28
2.6	We may suffer a critical IT failure unless we replace, upgrade and modernise our infrastructure and systems; including network and connectivity, computer and storage services, critical applications and telephony.	20	15	15			15	10	Digital	CM	30
2.7	Operations may be affected by the shortage of Mobile Data Terminals (MDT's)	20	10	5			5	5	Digital	CM	31
2.8	There is a risk that the organisation may experience significant disruption due to a failure of the Airwave service. The Airwave infrastructure is end of life and not due to be fully replaced until the Emergency Services Network programme under the Home Office delivers, which is due in 2029-30.	20	20	20			20	15	Digital	CM	33
2.9	There is a risk that performance is impacted if we do not seamlessly deliver the complex programme to replace our legacy dispatch system with the new national Control Room Solution	20	12	12			12	4	Digital	CM	34
2.10	We may not deliver the £30m CIP and productivity programme.	20	20	20			20	4	FIC	RP	36
2.11	There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year.	20	16	11			12	4	FIC	RP	37
2.12	The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2024/25	20	16	16			16	4	FIC	RP	38
2.13	We have a legacy staff scheduling system (GRS) which has limited support. Until it can be replaced there is a risk that system failures	15	12	12			12	9	P&C D&D	DM	39

	may cause significant inefficiencies affecting operational performance.										
Mission 3: Using our unique pan-London position to contribute to improving the health of the capital											
Risks		**Uncon[d]**					**Curr[t]**	**Target**	**Committee**	**Owner**	**Page**
3.1	We may not be able to complete delivery of current green commitments, including decreasing carbon footprint by 6% - and develop four year green plan for 2024-2028.	15	15	12			12	4	FIC	RP	40
3.2	There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London if the current fragmented commissioning and tendering of 111 contracts by 5 ICSs continues	20	12	16			16	8	FIC	RP	41
3.3	Because of the complexity and scale of our stakeholder partnerships across London, we may struggle to maximise the value and benefits of implementing the new ICS partnership model across LAS which would hinder our ability to spread innovation and solve common challenges.	16	12	12			12	8	Trust Board	RD	43

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1-3	Low risk
	4-6	Moderate risk
	8-12	Significant risk
	15-25	High risk

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.1

We may not achieve the quality standards required in stroke, cardiac care, and cardiac arrest

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	4	=	12

Controls	Assurances
Progress with priorities to be monitored on a monthly basis via patient safety incidents and national benchmarking	• Weekly patient safety incident group reviews cases, • PSIRF thematic reports, • Serious Incident Learning Assurance Group. • Multi-disciplinary forum for incident discussion and identification of learning
Guideline and process developed for referring patients to primary care with unrecognised hypertension as part of responding to the rise in incidents of cardiovascular disease and stroke	• Governance managed through Clinical Advisory Group • Pilot in SE London launched to share incidental findings with GPs, relating to previously undiagnosed hypertension, and also raised blood glucose levels. Information shared via MS form to registered GP. This also addresses one element of the CORE20PLUS5 standards relating to hypertension. Learning will inform further expansion, or improvement followed by expansion.
NHS England AQI: Outcome from cardiac arrest – Post resuscitation care Care bundle delivered to non-traumatic adult cardiac arrests who achieve ROSC (includes 12 lead ECG assessment, blood glucose and blood pressure measurements, and provision of oxygen and fluids	• Monthly Cardiac Arrest Care Pack including infographic. This report contains comprehensive clinical and operational information on the care provided to Cardiac Arrest patients. • Annual Cardiac Arrest report. • Daily and weekly review of Category 1 performance • Monthly monitoring through: ➢ Integrated Performance Report, ➢ Sector Focus ➢ Feedback Reviews (bimonthly) ➢ Quality Report • Feedback to all staff involved in management of cardiac arrest from Clinical Audit Team • Monitoring of Community First Responder outcomes and LifeSaver numbers to reduce time to defibrillation

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

	• Cardiac, stroke and STEMI care bundles now included as part of the core SSCL objectives in terms of learning and improvement, including identifying new ways of implementing change in these areas. • New cardiac arrest checklist includes ROSC care bundle prompts and handover metrics and tools. • CTM training includes post ROSC importance to enable further discussion with their teams during OWR and CPI feedback. • Monitoring of advanced care interventions by APP – Critical Care
NHS England AQI: Outcome from acute STEMI • Time from call to angiography for confirmed STEMI patients: Mean and 90th centile • Care bundle delivered to suspected STEMI patients (includes provision of GTN, aspirin, two pain assessments and analgesia)	• Monthly STEMI Care Pack including infographic. This report contains comprehensive clinical and operational information on the care provided to ST-elevation myocardial infarction (STEMI) patients. • Annual STEMI report. • Monthly monitoring through: ➢ Integrated Performance Report, ➢ Sector Focus ➢ Feedback Reviews (bimonthly) ➢ Quality Report t • Feedback to LAS from Pan London Cardiac networks • Local oversight of STEMI care bundle improvement led by SSCL and QGAM. Individual feedback to clinicians. TBW huddles to share cases. • Clinical update and Insight share cases • Cardiac, stroke and STEMI care bundles now included as part of the core SSCL objectives in terms of learning and improvement, including identifying new ways of implementing change in these areas.
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, including cardiac arrest acute coronary syndrome and stroke.	• Monitored through Annual Clinical Audit Programme and Research Programme. • Monitored through Quality Oversight Group and Clinical Audit and Research Steering Group (CARSG). • Annual Independent Review of clinical audit practices by CARSG's Patient and Public representative. • Monitoring of individual research projects by external Sponsors. National critical friend review of research and governance practices in progress.
Time from call to arrival at hospital for stroke patients confirmed by SSNAP: Mean and 90th centile	• Monthly Stroke Care Pack. This report contains comprehensive clinical and operational information on the care provided to suspected stroke patients, including whether they were conveyed to the most appropriate destination and timescales. • Monthly monitoring through: ➢ Integrated Performance Report,

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

	➢ Sector Focus ➢ Feedback Reviews (bimonthly) ➢ Quality Report

Further actions

Action	Date by which it will be completed
Cardiac arrest management:	
• Improve return of spontaneous circulation rates to ≥30%	December 2023 ROSC was 27%
• London lifesaver training being delivered across London	Achieved: recruitment of 7000 Lifesavers planned for 2023/24 and we are currently training in 2 schools per week
• Reduce by 60 seconds the time it takes from call connect to the start of chest compressions	Achieved: This has been achieved
• Deliver resuscitation update training to 85% of staff	Achieved: Resuscitation training and updates being delivered in all CSRs. CTM huddles and case reviews. March 31st 2024
Improve care for patients presenting with out of hospital cardiac arrest and/ or ST-Elevation Myocardial Infarction - March 31st 2024	Senior Sector Clinical Leads working on care bundles for cardiac arrests and ST –elevation Myocardial infarction. 73% pan London as of November 2023.
Develop a Health Inequalities Action Plan - Delivery of plan by March 31st 2024	Achieved: This has already been completed.

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.2
We may cause harm by not achieving the Ambulance Performance Standards set out in the NHSE Operating Plan due to: • Insufficient funding from commissioners to meet demand; • Constrained capacity in the UEC system and handover delays at hospitals; • Underachievement of productivity initiatives

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
4	x	4	=	20

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	4	=	12

• Insufficient funding from commissioners to meet demand;	25	25	8
• Constrained capacity in the UEC system and handover delays at hospitals	25	20	12
• underachievement of productivity initiatives	25	20	8

Controls	Assurances
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
Weekly NHSE London / Commissioner performance meeting	Executive attendance at meeting
Flexible approach to use of staff including roles and hours/rotas	Review a twice weekly forecasting & Planning meeting to ensure hours match anticipated demand.
Senior (operation) and clinical oversight of delays and incidents to identify risk and harm through pre-set processes	Patient safety incident response framework fully embedded in organisation.
Redeployment scheme for corporate staff utilised in times of high demand	At REAP 4 all clinicians working operationally 50-100% of time.
Twice weekly staffing and resourcing meeting to review operational	Chaired by Directors – review of staffing levels by hour to identify and mitigate risks
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. Additional calls convened to support specific ICB systems challenges.
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
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

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

Real time balancing of patient transport destinations recognising live system pressures at individual ED sites co-ordinated via the Patient Flow 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.	Daily reporting process detailing handover issues – HALO at certain challenged ED's
Cohorting process in place to release crews, handing over patients care to ambulance colleagues.	Tactical operations centre reporting on all cohorting activity – Cohorting process in place
Rapid release procedure to release crews covering a CAT 1 and high Cat 2 call in the community, handing over patient care to hospital staff.	Datix reporting of all rapid release activity
Implementation of pre-planned redirection of patients to protect challenged hospital trusts	Senior oversight from clinical and operational leadership teams and collegiate working with ICB leads.
Work with our system partners to reduce hospital handover delays, working with specific hospitals where needed and supporting LAS crews to utilise W45, cohorting and alternative healthcare pathways through sharing case examples	Senior oversight from clinical and operational leadership teams, working with consultants for REACH, ICB leads to maximise utilisation of appropriate care pathways.
Introduce clinical dispatch support across most challenged sectors, to support safe patient focused dispatch decisions at times of peak pressure.	Twice daily review of clinical support in the EOC

Further actions

Action	Date by which it will be completed
Maintain conveyance to Emergency Department under 50% in all ICSs	Ongoing
Continual Review of dispatch process (999 operations) to assess the safe management of higher acuity patients at times of high demand	Ongoing
Enforce new 45 minute handover protocol with appropriate escalation when required.	Ongoing
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	Ongoing
Productivity improvement program within Ambulance Operations	31/12/24
Increased recruitment plan within Ambulance Operations	31/3/25
Robust application of Clinical Safety plan	Ongoing

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.3
We may not be able to achieve the IUC target of 75% of all CAS cases being contacted within the required timeframe and answer 111 in less than 3 minutes by the end of the financial year

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
IUC Queue Management & CAS Reporting	Operating a combined IUC CAS & Validation queue with variety of "views" for external partners and ability to allocate workload to specific clinicians on duty to drive focus on higher acuity patients in real time. The senior team are exploring new methods used in other IUC areas to create improved streaming of cases, but also consider what actions within the CSEP plan can be deployed for short periods with the need to review/ switch off any actions when agreed levels are reached. GP Leads working on programme of development for duty Navigators, senior management are working with BI as currently reports show response based on initial assessment timeframe and review and change of priority by a clinician is not being recognised
Review of CAS priorities	Joint working group with management and clinical GP Leads for commissioning and LAS have reviewed local mapping, challenge is National reporting does not incorporate local mapping & how services have been commissioned. I.e. local = 1 hr response but reports from national = 20 minutes so shows a breach. Adastra Queues and views for users have been revised to the associated case Priorities aligned to required reporting and to reflect NHS Pathways time coding where applicable and aligned with contractual resilience partnership working
Introduction of IUC rostering tool and improved grip by local management	Phased implementation has reduced over rostering/ spend. Allocation wizard is now in use to improve equitability and reduce admin of rota allocation allowing direct/ sessional allocation prior to agency and using combined with clinical guardian information triangulated performance/ productivity / quality outputs used to influence allocation
Individual performance and management, monitoring & review to ensure appropriate standards are met to deliver high quality care and achieve performance	Progress has been made on producing productivity reports with the BI team but work is ongoing and not yet ready for Ops/Clinical leads to use. Team are now using Clinical Guardian/ Rotamaster information allows monthly review of workforce quality/productivity & reliability to inform rota allocation and identify areas of concern. New configuration on Adastra used to highlight key timings/ events with most recent flagging when a clinician has been on a case for 20 minutes to allow the Navigator to offer support
Real time management and clinical safety & oversight	Adastra has had additional flags/ highlights to draw attention to specific case types to focus on priority cases i.e. Frailty/ EoL or crew on scene call back. Introduction of Senior IUEC Navigator

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

	located next to the IDM within TOC working across 111 and 999 CTN's to support safe management of workload and resource has improved safety (further development ongoing). IUC Navigator and Clinical On Call Teams undertake clinical review of queues and decision to escalate needs to consider level of acuity and timeframes to avoid impacting on higher acuity/ system to manage lower acuity.
Remote & Network/ Partnership Workforce offers greater resilience and opportunity to utilise wider system experienced workforce without generating rate war whilst building relations with system providers	LAS now has technical ability for LAS or partner clinicians to work remotely directly onto our Adastra clinical queue and in July 2023 new VDI telephony was introduced for all to work on LAS telephony/ recording. Although a core site based clinical workforce is required the offer to work remotely improves retention and access to partner workforce increased capacity significantly and reduces use of agency. LAS now have four partners providing clinical assessment service and a framework is being developed to allow greater pool of providers to work with having completed due diligence and governance. Increased staffing from resilience partners to meet validation activity in a timelier response – Request initiated and rota fill expected to increase from Mid-March 2024 to meet demand and release resource to support wider CAS Call back times
Staff rostering to meet expected demand	In order to reduce the mean call answering time in IUC, detailed modelling work has been completed to provide a short, medium, and long term forecast. The IUC scheduling team work to fill the rota based on these forecasts and are measured on variance to forecasted staffing requirement. By improving rota compliance, it will ensure that we have the right number of Heath Advisors and Service Advisors on duty at any one time to meet demand
Reduction in absence and turnover	The IUC management team have been successful in reducing absence rates and turnover through effective management of teams. This ensures that there are fewer last minute cancellations, reduced use of bank, and less training demand on the team therefore improving productivity
Improved calls answered per hour	As part of the wider transformation programme, staff are set a target of calls answered per hour and will be supported to achieve that target with management interventions taken if required. Through answering a standard number of calls per hour in line with the wider team mean, there will be increased capacity within the team to answer calls waiting.
Reduction in average handling time through process improvement and training	Reducing AHT has been achieved through a focus on effective staff training and removal of unnecessary parts of the calls flow. A regular review of the Directory of Services (DoS) and Adastra call flow is conducted and inappropriate steps removed such where possible. In addition, staff are trained how to deal with difficult calls and ensure that calls are managed effectively. The reduction in AHT leads to improved calls answered per hour and a quicker mean answer time.
Provision of more effective and timely in-line clinical support and non-clinical floorwalkers	Work has been completed to measure and manage the timeliness of in line clinical support to ensure that if/when call handlers need to access clinical advice directly during their call, this is

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

	provided sooner. This provision of advice leads to a reduction in average handling time and enables staff to answer calls sooner and reduce the mean answering time. In addition, a non-clinical floorwalker has been introduced to ensure there is senior support for HAs and SAs when taking calls. These roles enable staff to raise concerns and queries to reduce their handling time and improve calls per hour.
Provision of a 'storm trooper' role to manage call split across contracts	In order to ensure that call volume is split between contracts and providers most effectively, a new role has been introduced to manage the diversion of calls. This ensures that if a subcontractor or other provider within the alliance has the ability to manage calls better, more calls are diverted to them to achieve an overall benefit to the system. This ensures that the mean answer time is reduced for patients regardless of location.
Operation of 'golden hour' initiatives	During periods of peak demand, the golden hour initiative has been developed to ensure that all staff able to take calls (including management staff and training staff) cancel other commitments to attend. This has increased capacity at peak times substantially and reduce the mean answer time across all contracts
Improved data quality and oversight	A review of the data quality in the service has been conducted and found a number of duplicates which have now been removed from our reporting. Work is ongoing to establish the cause of the duplicate calls however there is no more certainty that the service is providing the most accurate data possible. In addition, a range of new reporting, forecasting, and workforce data tools and dashboards have been developed to ensure that the operational and management teams all have oversight of the service performance. All management staff have received training on how to use and access the dashboards and all new staff joining the service have an additional module in their training course to introduce the service metrics and targets. This greater grip on the service performance enables teams to focus on where improvements can be made and take actions in real time.

Further actions

Action	Date by which it will be completed
Transformation Program of work initiated with key structure deliverables over the next 6 months (To 31/07/2024). Key work streams will deliver benefits within the earlier and mid phases of the programme. Work streams	July 2024

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

• Case Priorities aligned to required reporting and to reflect NHS Pathways time coding where applicable to support apposite resource management in queue navigation and case prioritisation, as well as in being aligned with contractual commissioner reporting • Introduction of 'Our IUC Team' programme focussing on improving efficiency and teamwork • Adastra Queues and views for users have been revised to the associated case Priorities aligned to required reporting and to reflect NHS Pathways time coding where applicable and aligned with contractual resilience partnership working • Increased staffing from resilience partners to meet validation activity in a timelier response – Request initiated and rota fill expected to increase from Mid-March 2024 to meet demand and release resource to support wider CAS Call back times • Initiated the modelling of Clinical staff requirement by role skillset using historical NHSP Dx coding to establish baseline hourly requirement by role to ensure adequate staffing requirement mapped to demand	Workstreams have been set up and these actions partially completed.
Continuation of above actions as managed through the transformation board: 1. Improved calls per hour through staff management and benchmarking 2. Reduction in AHT through process efficiencies and removal of call flow work 3. Greater roster compliance and golden hour during peak times through better forecasting and rota fill 4. Reduction in staff absence and turnover through additional support and wellbeing across the teams as well as manager intervention when needed 5. Continuation of storm trooper role for call balancing with suggested move to automatic balancing via storm platform 6. Provision of more in-line clinical support and non-clinical floorwalkers to ensure that staff have the support they need to reduce AHT and improve calls per hour. 7. Continuation of golden hour initiative to increase capacity at peak times 8. Introduction of 'Our IUC Team' programme focussing on improving efficiency and teamwork As a result of the actions taken above to mitigate this risk, CAS call back performance improved from 38.9% to 59.2% in Q1 of 2024/2025. Average speed to answer improved from 119 to 83 seconds during the same period. This further mitigates the risk and means the service is on track to meet the control target	Transformation programme due for completion in August 2024

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.4
The introduction of RCRP poses a risk to our performance and financial model as the LAS has seen an increase in demand, and complexity of the cases received. This places a pressure on the organisation that is currently unfunded, and may compromise care to patients, especially those with mental health conditions.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	3	=	9

Controls	Assurances
Discussions with MPS, NHS Partners and Social Care Partners setting out the key risks to patients, the LAS and the health system as a whole and identify solutions. This is via NHSE MPS and Health Partners Board; the RCRP Met Police Board, and a number of subgroups (comms, data, policy and people/training).	Feedback and actions Risks being raised via the formal partnership meetings are followed up with action and learning/improvement noted in formal minutes.
Ability to measure changes in incoming demand to understand impact	Current demand from MPS is now measurable, so a change in this will now also be measurable. A dashboard with live data now exists to monitor in live time the impact.
LAS have worked with MPS and agreed calls will be transferred electronically via existing link between the two systems. This will ensure patients don't have to hang up and redial; but will also ensure we are able to closely identify changes in volumes.	LAS have agreed process to manage CADLINK calls (electronic link) and this will be expanded to manage the additional demand likely to be seen via RCRP. As above, this will also allow measurement of any changes to demand.
Identified calls passed through the electronic CADLINK from MPS to LAS from 1st Nov.	All MPS Calls which need a possible ambulance response have been confirmed will come via CADLINK.
Identified the volume of calls from members of the public and how these will be managed by the police and volume of these calls that will land with the LAS	Retrospective review complete and now ongoing review in place.
New process developed to enable both 111 and 999 call handling / health advisor triage for additional demand.	A process already exists, but this will be refined and enhanced given the extra demand and need for the appropriate triage to be undertaken for these patients
Patient safety oversight in place– to ensure patients remain safe whilst they wait for initial triage after the calls land within LAS CAD, there will be a role in place to oversee the METPOL overall stack.	A business as usual model is being drawn up for a proposal to embed a clinician into MPS, for them to do their 'normal' role but within MPS to also be a point of escalation in both directions using the learning from RCRP launch
Welfare calls received from healthcare partners have increased. This has been manually counted and examples provided by on duty teams for review and escalation.	42 calls audited from a 4/7 period – 24 from acute hospital trusts, the rest from other partners / public. Formally raised to RCRP NHS Partners board. Letter sent by NHS Partners to acute trusts about managing own demand and risk assessments.

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

Internal LAS fortnightly review group meeting – ability to review ongoing challenges with RCRP and to escalate externally should that be required.	Regular review and multi-team approach including Clinical, EOC, Clinical Hub, Operations, MH team, Patient Experiences, 111/CAS.
Newly set up LAS / MPS / NHS weekly touchpoint meeting	Ability to discuss escalation issues in quick time and ensure all partners aligned and sighted on challenges
External escalation process formalised	Escalation process formalised for LAS to raise items of note to the MPS for review in terms of decision making. This is over and above the 'real time' escalation already in place for on duty teams, and allows for learning and improvement to take place with regards to response and collaborative working. A log is kept internally within LAS for collation of themes and to ensure follow up
Regular 'round table' meetings with MPS strategic and operational leads for RCRP	Regular monthly meetings now in place – shared chairing between LAS and MPS leads for RCRP. Shared awareness, shared learning, shared problem solving approach
Case submitted to NHSE for additional funding for the RCRP activity	Using the data now held re: new and increased demand, along with CADLINK data, welfare calls now coming to LAS and the additional staff to oversee this activity; as well as the staffing required to go on the additional MH ambulances to respond to the new s136 demand which the organisation will start to see with the final pillar of RCRP.

Further actions

Action	Date by which it will be completed
Identify if changes can be made to CAD via Cleric so that only critically unwell patients would be accepted through this link, and other patients (not critically unwell) would be required to call 999 for formal triage.	Closed: No longer being scoped – CAD changes at the MPS system are not currently possible. This will be reviewed again in the coming months with a potential MPS CAD change.
Set up report to capture MPS CADLINK calls, as well as calls relating to RCRP from other NHS/Social care stakeholders to measure increased demand and trends	Achieved: Report relating to calls from MPS is now set up and reporting successfully. Reporting on calls from other partners, especially social care is proving more problematic as they often come from individuals as opposed to via the 'agency' and as such are difficult to measure or locate within our system.
Understand the next phases of RCRP and timeframes associated with them and their launch	Achieved: Phase 2 is planned for implementation at the beginning of 2024-25
CAD / cleric changes to enable these calls to present into their own queue within the CAD system are being scoped by the IM+T team. The management of them once they land within LAS CAD is a separate work stream and will work regardless of where the calls sit within the system.	Achieved: This was not possible, but the process for these calls to be managed as its own work stream is complete with individual staff assigned to it, within the EOC and clinical team each day.
Additional staff will be put in place in the initial weeks whilst the extra demand is understood.	Achieved: and will continue

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

RCRP Pod in Met Police Control Room will be staffed with an LAS clinician for the first 4 weeks post launch. This will enable safety oversight, trend analysis and better understanding of impact	Achieved: and will continue
Welfare call increase from acute trusts - LAS have proposed some interim steps to manage this demand. LAS have also requested formal communication from NHSE to acute trusts to manage own demand and risk assessments and not pass directly to LAS.	Achieved: – will be monitored and a longer term solution identified should it be required if demand continues to increase for these calls.
LAS to present case studies at the next MPS RCRP Strategic Board – to define cases where people are currently falling through potential gaps in process, identified through the joint working described above. For example, cases where the caller is not describing a health emergency but where the MPS are also not attending such as a concern for welfare or a person missing from an acute trust ward.	July 2024 Partners Board

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.5

We may not improve the quality of the care we provide if we do not complete delivery of our quality priorities

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by June 25				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
Quality priorities are monitored via a monthly report to the monthly Quality Improvement Programme Board. This report is standardised and includes key achievements, milestones, key risks and issues as well as key concerns and potential barriers.	Assurance is provided to the Clinical Quality Oversight Group and Quality Assurance Committee.
Improving efficiency	• Cat 3 & 4 validation is above plan and continues to sit around 98%. Improvements have been implemented to maintain this position. • Clinical Dispatch Support is live in all Sectors. A rota review for increased staffing has been agreed and will go live in July. • The reducing OOS improvement project has begun with engagement sessions and idea generation events. 8 test of change objectives have been identified.
Feedback and learning	• KPIs are being developed to address outstanding actions for learning from AARs and Inquiries • The first Rapid Process Improvement Workshop is planned for January 2025. Preparatory training and coaching from SASH has commenced. Planning for the RPIW will start around early December based on improvement priorities agreed by the Trust Guiding Team.
Improving outcomes	• 29 new performance managers have been appointed with KPI meetings arranged. Call to 'got address' data shows the Location matching <80 seconds KPI is being met. • An improvement collaborative for STEMI bundle compliance has been arranged to start on 29th July. Work has begun in relation to SSCL KPIs and a supporting video is planned for July 2024 also. • Timeline for health inequalities reduction plan has been created and stakeholder engagement sessions have been undertaken

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

Reducing delays	• BI have been commissioned to develop a Cat/Cat 2 portal report and heat map to support data driven improvements. An accelerated design day using QI methodology is being planned for July. • Activities have been planned to deliver the P1-3 call back KPI including a Queue Management Process, review of clinical staffing, performance management and review clinical rotas

Further actions

Action	Date by which it will be completed
• Progress C1 and C2 improvement plans	Carried into 2024/25
• Complete delivery of spinal immobilisation training	End of June 25

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.6
We may not achieve targets for commissioned learning response timeframes and overdue incidents impacting our ability to rapidly adopt any derived learning

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 24/25				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
Learning responses	
Increased Lead Investigator (LI) cohort Provide training in line with PSIRF requirements (12 hours ftf and x2 e-learning packages) Established monthly LI drop in sessions to trouble shoot issues Created LI supervision pool teams group for rapid allocation Developed SOP for LI allocation Accurate LI database for tracking availability and compliance with training Created sector Datix dashboards to enable monitoring and oversight of learning responses in respective areas. Moved all reporting to Datix for standardised approach and enable enhanced audit Weekly data sent of open and overdue learning responses sent to key stakeholders Enhanced DoC monitoring and audit Weekly meetings with PED and Legal regarding learning responses and associated complaint/inquest for early escalation Development of an escalation process for overdue learning responses. Standing agenda item on 1:1s with supervisors Implementation of sign off process. Agreement with Ops in relation to abstractions and stand downs for LIs	Weekly monitoring and tracking via SPC Bi monthly reporting via CQOG and QAC Feedback from external sources including CQC, ICB, Coroner, patients/families/local authority. Staff survey links with outcomes to questions about how responsive the organisation is when a concern is raised.
Overdue incidents	
Established monitoring Contacted sectors/teams with highest numbers overdue Escalation via Chief Paramedic Officer Monthly Datix investigation training	Bi monthly reporting via CQOG and QAC Reporting within quality report Reporting within FFR and sector based quality reports

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

Targeted training to corporate areas without governance leads. Communication regarding use of 'to do list' function on Datix Change of metrics to report % overdue which allows for proportionate action	Staff survey links with outcomes to questions about how responsive the organisation is when a concern is raised. Incident reporting trends – increase would suggest positive reporting culture

Further actions

Action	Date by which it will be completed
<u>Learning responses</u> Tracking the last 10 closures AND last 10 breeches– identification of time taken in each stage of review and action appropriately Undertake time observation of investigation process to identify waste and non-value adding processes. Implementation of escalation process Horizon scanning and notification of those who are near overdue Defining the role of the supervisor to support standardised approach Produce a quick reference guide for LIs to be shared when allocated learning response Development of LI refresher training Development of LI 'contract' Meeting with supervisors with overdue cases and implement SMART action plans to clear overdue cases Inclusion	End of Q2 2024/25
<u>Overdue incidents</u> Creation of Dashboards that can be used by all managers to view incidents assigned to their respective areas – associated comms piece. Bi-weekly meetings with team leads with those with most % overdue Understand barriers for corporate teams with high % overdue Development of an aid-memoire to be distributed to all managers with hints/tips and FAQ on incident investigation Communication about 'standard work' and the move to make incident reviewing form part of daily/weekly standard actions.	End of Q2 2024/25

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

BAF Risk: 1.7
We may not improve data quality, embed data governance and follow through on the data quality action plan

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
A data quality group was established in July 2023 which undertakes an over view of data quality issues.	The Digital and DQ Committee receives reports from various sources on Data Quality
Actions from the BDO audit review on Data Integrity are being monitored and reported by the Data Quality Assurance Team	Being monitored by internal auditors BDO for implementation
Departmental training on data quality to be rolled out to new BI team staff members	Training completion of new staff to be monitored by BI Business Manager
Data quality issues picked up through daily performance reviews and referred back to BI/F&P/CAD teams for investigation.	Performance discussed routinely at 8.30 and 5pm meetings. Gold Dashboard is monitored throughout the day

Further actions

Action	Date by which it will be completed
Produce internal system assurance review: EPCR	Completed
Reviewing draft Digital & Data Strategy –strengthening the Data related outcome to stress that data quality becomes part of everyone's responsibility.	Draft DD Strategy has been updated
Reinstate Data Quality ESR training module to all staff with responsibility for data entry/validation (induction, mandatory training)	Q4 2024/25
Review content of ESR training module to make specific and relevant to LAS data	Q1 2025/26
Annual External Audit on data quality is completed for 2024/25	TBC : Scope yet to be identified from Audit committee/BDO
Analyst vacancy to be filled within Data Quality Assurance Team	Oct-24
Develop the DQA work plan for 2024/25	Completed & shared with the digital committee

Mission 1: Delivering outstanding urgent and emergency care wherever and whenever needed

Supporting leads to implement 8 remaining actions from previous reviews (internal & external)	*41 actions have closed since June 2023. Remaining actions will be completed by Q2 2024/25.*
• Verita Cat 1 Misreporting – Monitoring of BAU actions from the recommendations	• Ongoing to Sep-24
• BDO Data Integrity Review – Monitoring of BAU actions from the recommendations	• Ongoing to Sep-24
• IUEC internal review – 3 recommendations	• Q2 2024/25
• Fleet internal review - 2 recommendations	• Revised Q2 2024/25
• Workforce internal review	• Closed
• Datix internal review- 2 recommendations	• Revised Q2 2024/25
• BI-999 -2 outstanding actions	• Kick off project meeting on Data Warehouse replacement on 10th July
• CARU internal review	• Closed
Project to investigate the re-architecture of the CAD environment	December 2024
Attainment of Cyber Essentials + accreditation	January 2025
Implement MFA for all legacy systems, where technically possible.	March 2025

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.1
We may not achieve the changes required to make the LAS a fully-inclusive and supportive workplace which increases representation and reduces disparities for under-represented groups, especially resolution of the gender pay gap in LAS, how we ensure that people who have a disability are supported, and how do we ensure that people from a BME background are able to progress in LAS

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
4	x	5	=	20

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	4	=	12

Controls	Assurances
Established process and reporting for WRES, WDES, GPG, EPG, EDS and Annual Equality Report	Reports and one action plan reported to EXCO, EDI Committee, and Trust Board
Develop and implement the EDI Programme aligned with business plan deliverables and high impact actions	Meeting national requirements and success measures – Reported to ExCo and EDI Committee and monitored by the EDI Implementation Group
Implementation of the recruitment interventions and response to sea change recommendations	Monitored by the Recruitment working group
Implementation of Reasonable Adjustments Policy and Guidance and manage a centralised process and budget (approved May 2024)	Monitored by Reasonable Adjustments working group and progress reported to EDI Committee
Implementation of Anti – Racism Charter and Anti-Discrimination Statement (Launched May 2024)	Monitored via the Just Culture working group and progress reported to EDI Committee
Establish a Sexual Safety oversight group to advise on and monitor changes to Trust process to create a safer environment for all staff	Action plan developed in May 2024

Further actions

Action	Date by which it will be completed
Deliver the five business plan objectives: 1. Increase by 10% the proportion of applicants from an ethnic minority background to jobs in ambulance operations and 999, agreeing and implementing an action plan which will include implementation of a new call handler to associate ambulance practitioner recruitment programme.	March 2025
2. Continue strengthening staff networks, agreeing plans so they deliver a proactive agenda and grow their total membership by 20 per cent.	March 2025

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

3. Improve the likelihood (currently 2x less likely) of Black and ethnic minority candidates being successful at interview stage, by supporting the career advancement of colleagues.	March 2025
4. Improve the proportion of disabled colleagues who say in the NHS staff survey that reasonable adjustments were made and reduce the number of concerns raised on this topic.	March 2025
5. Develop and deliver an improvement plan against the six Equality, Diversity and Inclusion high impact actions with specific focus on all leaders to be held accountable for reducing discrimination and creating an inclusive LAS.	March 2025

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.2
We may not improve in the NHS People Plan domain regarding *Looking after our people* - particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	4	=	12

Controls	**Assurances**
Attendance Workstream established as part of PCC and meets bi-monthly.	Exception Reporting to PCC
Wellbeing Strategy and Inputs	Monitoring of progress via PCC
On-going operational management and robust Sickness absence policy management	Highlights reported to PCC and Board via directors' report and in month assurance through FFR's
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	Reports to PCC.
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
The Trust Board will have direct oversight in relation to managing this risk with Assurance provided by PCC / QAC.	Daily performance reviews / meetings / reports
2023/24 workforce plan agreed	Trust Workforce Group
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
Promotion of the Flu programme with Trust wide flu clinics	Progress of programme reported to Board in PCC Directors report
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**
Refresh Wellbeing strategy that aligns to LAS People Strategy	Q4 23/24

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

Review of first day absence reporting system	Q4 23/24
Review of teams and associated scheduling	Proposed structure of review by Q4 23/24
Immunisation records to be validated and outstanding vaccinations to be addressed	Completed - Staff with gaps in immunisation records offered catch up appointments. Review position end of 2024.
Actions from reviewing wellbeing offerings Pilot project underway to identify best practice model in management of absence including fast access to mental health pathway.	Completed New model established by Aug 2024
Complete stress risk training (risk:1048) New stress mgt policy in place and stress risk assessment training being rolled out.	Completed Review 12/24.

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.3
We may not improve our organisational culture in addressing bullying and / or harassment underpinned by poor underdeveloped management and leadership practices

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
4	x	3	=	12

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
Training sessions available for all leadership delivered by the EDI team	

Further actions

Action	**Date by which it will be completed**
Develop 2023-2028 People and Culture Strategy as assigned metrics	By Q4 23/24 (in conjunction with EDI Team)
Aligned EDI/CDI Strategy and delivery plan / system of measurement	Complete. EDI Policy and Workforce Strategy Delivery plan approved by PCC. Review progress 12/24.
Comprehensive review of all Policies EQIA	Ongoing – December 2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.4
We may not improve the sexual safety of staff unless we fully implement the action plan we have identified

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	4	=	12

Controls	**Assurances**
Working group established with representation from across the Trust chaired by the Chair Paramedic.	Providing a report on progress to the Equality Diversity & Inclusion (EDI) Committee
The Trust Board will have direct oversight in relation to managing this risk with	Assurance provided by People & Culture Committee (PCC). Quality Assurance Committee (QAC).
Monthly review meetings of all cases involving sexual misconduct to ensure progress to conclusion	Progress report to Safeguarding Assurance group / PCC
Freedom to Speak up Guardian	Reports via PCC
Sexual Safety Ambassadors in all areas of the Trust	Reports via PCC
Update and republish Sexual Safety Charter	Trust wide expectations of behaviour.

Further actions

Action	**Date by which it will be completed**
Deliver investigation and Hearing training to managers with a focus on managing concerns of sexual misconduct.	End of Q3 2024/5
Deliver Clumsy, Creepy Criminal discussion training to all team manager (cascaded through Directorate leads).	End of Q3 2024/5
Sexual safety e-learning	End of Q4 2024/5
Tackling Discrimination part 2, with a focus on sexual misconduct and active bystander training	End of Q4 2024/5
Development of Professional Standards approach for the Trust	End of Q2 2024/5

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.5
There is a risk that the organisation may experience a cyber-attack, and struggle to recover service in a timely manner, which could result in unauthorised access to sensitive data, disruption of business operations, financial loss, and reputational damage.

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
3	x	5	=	15

Tolerance by Q4 24/25				
L	x	C	=	Score
2	x	5	=	10

Controls	Assurances
Technical cyber protection & detection tools deployed/monitored daily	Cyber Committee checks assurances and reports to the board
Implementation of Artificial Intelligence threat detection software	Devices deployed to Corsham & Bow.
Cyber security team in place to identify/mitigate cyber threats or incidents	Cyber Committee checks assurances and reports to the board
Achievement of at least 'Met Standards' in DSPT	Reported annually by NHSe
Legacy systems being replaced	DSPT assurance level reported in annual report
Unsupported software being replaced	Annual Pen Test carried out and reported to the Board
All issues related to Cyber logged on Trust Content Management System	Demonstrable response to cyber threats
Process in place to address all CareCerts issued by NHSe	DSPT assurance level reported in annual report
Cyber security monitoring and assurance	Integrated into BAU daily checks
Monitoring of additional external resources, including BitSight & NCSC	Cyber Committee checks assurances and reports to the board
Regular Table Top Cyber exercises undertaken within IM&T	Documented and reported to the Head of Business Continuity

Further actions

Action	Date by which it will be completed
Compliance with DSPT 2024	June 2024
Implementation of replacement Zero Trust Security Service Edge software (iBoss)	June 2024
Implement MFA for all NHS Shared Services	June 2024
Complete deployment of new audit/vulnerability monitoring software on all LAS owned devices	June 2024
Infrastructure refresh completion of migration to ARK data centre	July 2024
Implementation of Firewall configuration audit software	July 2024
Hardening of internet facing systems	August 2024
Onboarding of 3rd party suppliers to the Privileged Access Management system	September 2024
Publish a paper on our ability to recover critical services, in a timely manner, following a cyber-incident	September 2024
Implementation of Trustwide Cyber Awareness Training	October 2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

Project to investigate the re-architecture of the CAD environment	December 2024
Attainment of Cyber Essentials + accreditation	January 2025
Implement MFA for all legacy systems, where technically possible.	March 2025

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.6
We may suffer a critical IT failure unless we replace, upgrade and modernise our infrastructure and systems; including network and connectivity, computer and storage services, critical applications and telephony.

Uncontrolled				
L	x	C	=	Score
4	x	5	=	20

Current				
L	x	C	=	Score
3	x	5	=	15

Tolerance by Q2 24/25				
L	x	C	=	Score
2	x	5	=	10

Controls	Assurances
Migration of infrastructure to Tier three data centres	IMT Delivery Board in place which oversees the work and reports to the Board via the Chief Digital Officer's report
Upgrade of data network to include resilience and failover at Corsham and Farnborough	Demonstrated CAD resilience and recovery
Dependencies mapped and managed between core infrastructure programmes: CM10, Network Readiness Assessment and Data Centre Essentials	No downtime upgrade successfully completed for CAD
Upgrade programmes in delivery: CM10 (Telephony), MDTs	Agreed strategic direction for data centres and infrastructure
Upgrade or decommission plan for all out of support servers (Windows 2012 R2 and below)	Upgrade and maintenance plan for all critical systems
Network Readiness Assessment for Voice and Data	Network Readiness Assessment for voice and data ahead of CM10
Application lifecycle plans for out of support critical applications	

Further actions

Action	Date by which it will be completed
999 and 111 on supported CM10 telephony platform	July 2024
Commission external review of the current infrastructure and map the "as is"	June 2024 Complete
Topology of architecture (spine and leaf) to be used as a baseline for changes and future plans	June 2024 Complete
Develop a data centre strategy and roadmap with sufficient investment utilising cloud options	September 2024
Revised set of desktop images based on profiles: Admin, CAD user, etc.	August 2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.7
Operations may be affected by the shortage of Mobile Data Terminals (MDT's) 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. 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.

Uncontrolled				
L	x	C	=	Score
4	x	5	=	20

Current				
L	x	C	=	Score
1	x	5	=	5

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	5	=	5

Controls	Assurances
Purchased all available MDT stocks from incumbent supplier	Completed.
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. Stock of legacy MDTs currently tracking very high to the point where we need to start looking at disposal of old stock
The national Mobile Data Vehicle Solution (MDVS), which will replace MDTs is currently due to start 01/09/2023	Weekly meeting established alongside Project Board and Working Group
Pilot National Mobile Application Lite to identify interim MDT solution	Completed
Deployment of NMA in 20 double crewed ambulances by end of September	Completed
Rollout of 80-90 DCA's with NMA by Christmas 2023	Completed
Rollout of NMA to the entire LAS fleet	Started, running at 4 vehicle conversions per day and on-track to complete late 2024
Gap in controls	
Legacy system architecture	Whilst the back-end system is old, it is running on new hardware and has a support contract in place

Further actions

Action	Date by which it will be completed

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

Enabling works for NMA Lite Pilot	Completed
Pilot replacement interim solution (NMA Lite) on 30 Android Devices	Completed
Equip up to 80 new vehicles with the new NMA equipment	Completed
Over 50% of both new and legacy fleet upgraded with NMA equipment	Completed
Rollout NMA to remainder of LAS Fleet	31/12/2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.8
There is a risk that the organisation may experience significant disruption due to a failure of the Airwave service. The Airwave infrastructure is end of life and not due to be fully replaced until the Emergency Services Network programme under the Home Office delivers, which is due in 2029-30

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
5	x	4	=	20

Tolerance by Q4 24/25				
L	x	C	=	Score
5	x	3	=	15

Controls	Assurances
Contract with ARP and subcontractors for the component parts of the Airwave network covering 24/7/365	ARP are regularly reviewing and replacing component parts of the infrastructure

Further actions

Action	Date by which it will be completed
Upgrade the ICCS to the new Control Room Solution under the national programme	November 2024
Regular review of the Airwave Infrastructure	Ongoing

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.9

There is a risk that performance is impacted if we do not seamlessly deliver the complex programme to replace our legacy dispatch system with the new national Control Room Solution

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	4	=	4

Controls	Assurances
	Extensive functional, non-functional and User Assurance Testing has either already been successfully carried out, or planned to be carried out, prior to go-live
All other ambulance trusts will have gone live on CRS ahead of LAS go live in November 2024	CRS Implementation Lead has been appointed within EOC to manage operational impact and mitigation
ARP assurances that each migration has been more seamless than the last, and that they are now taking place with no significant issues	Migration Planning Workshops are to be setup jointly with ARP to design our granular, detailed Migration Plan. This will ensure a very high level of assurance is adhered to on the go-live day(s), in terms of checks, regular go/no-go calls, and a 'war room' with all senior stakeholders present that are deemed necessary
CRS go-live day(s) itself is a very heavily supported exercise resource-wise, with ARP supplying tens of dedicated resources across both sites to ensure the implementation, lifting and shifting, and investigation of any issues is as expedient as possible	The Migration Planning Workshops will also produce a Fallback Plan, to be enacted in the event that something major goes wrong when moving CROP positions from the current system to the new one
	All 600+ staff will have been trained on the new system prior to go-live. This means they will be able to switch, mid-shift, from using the current system to using the new system, with minimal (if any) impact on their ability to carry out their duties. Alternatively, Ops may decide upon a rollout approach whereby members of staff do not start using the new system until their next shift post-go live (TBC from Migration Planning Workshops

Further actions

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

Action	Date by which it will be completed
Extensive functional and non-functional testing	Completed
Development work complete and smoke testing between LAS and Terafix	July 2024
Staff Training to commence	1st August 2024
All staff training complete	18th October 2024
Installation of Redbox LifeX software	August 2024
Connectivity testing complete	30th August 2024
Building of CROPs	September 2024
UAT	October 2024
Go Live	4th November 2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.10
We may not deliver the £30m CIP and productivity programme

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
5	x	4	=	20

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	4	=	4

Controls	Assurances
Work with Budget managers to develop CIP Programme building on the transformation programmes	Delivery against the CIP plan is scrutinised through: ExCo, FIC, Trust Board
	Regular oversight of CIP delivery by CIP Programme Board(ExCo) and FIC
Management of Capital Plan	Regular reporting to Capital Steering Group (ExCo) and FIC

Further actions

Action	Date by which it will be completed
Develop CIP plan to identify £30m savings	July 2024
Implement Vacancy panel	May 2024

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.11
There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	4	=	4

Controls	Assurances
Submit 2024/2025 financial plan for submission to NHSE as per national timetable	Delivery against the financial plan is scrutinised through: ExCo, FIC, Trust Board
Continual liaison with commissioners and the London Regional Office to secure additional funding	Regular oversight of CIP delivery by CIP Programme Board(ExCo) and FIC

Further actions

Action	Date by which it will be completed
Develop financial plan (including I&E, Cost Improvement and efficiency plan, capital and cash)	Completed
Continue negotiations with commissioners and London Regional Office to secure income	Q2 2024/25
Chief Financial Officer to provide update on Capital Plan to FIC	Completed

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.12
The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2024/25

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	4	=	4

Controls	Assurances
Monthly financial performance review sessions between senior operational managers and CFO	Delivery against the I&E is scrutinised through: ExCo, FIC, Trust Board
Where appropriate, development of mitigation schemes and financial recovery plans	Regular oversight of CIP delivery by CIP Programme Board(ExCo) and FIC
Work with NHSE and ICSs to maximise income	Delivery against the I&E is scrutinised through: ExCo, FIC, Trust Board

Further actions

Action	Date by which it will be completed
Work with operational managers	Ongoing
Liaise with NHSE and commissioners to maximise income	Ongoing

Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for

BAF Risk: 2.13
We have a legacy staff scheduling system (GRS) which has limited support. Until it can be replaced there is a risk that system failures may cause significant inefficiencies affecting operational performance.

Uncontrolled				
L	x	C	=	Score
5	x	3	=	15

Current				
L	x	C	=	Score
4	x	3	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
3	x	3	=	9

Controls	Assurances
Daily Meetings with current supplier/LAS Scheduling Team/IM&T during periods of interruption.	Reports provided to Gold on a daily basis.
Internal GRS Support Group established to immediately convene when there are any outages and provide a route of escalation for internal stakeholders.	Reported to Trust Gold/Exec team as required
Rolled back SQL database to previous version	Decision made in collaboration with LAS IM&T department, which has resulted in a reduction in GRS reporting issues.
Daily Review of system by Scheduling Team	Escalated to Head of Scheduling
Agreed plan of proactive maintenance	

Further actions

Action	Date by which it will be completed
New rostering system tender due to begin 1st August 2024, development of new product starts in April 2025. If new supplier, operational November 2025.	Q4 2024

Mission 3: Using our unique pan-London position to contribute to improving the health of the capital

BAF Risk: 3.1
We may not be able to complete delivery of current green commitments, including decreasing carbon footprint by 6% - and develop four year green plan for 2024-2028

Uncontrolled				
L	x	C	=	Score
5	x	3	=	15

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 24/25				
L	x	C	=	Score
1	x	4	=	4

Controls	Assurances
Memorandum of understanding in place with the Mayor's office to provide a dispensation from ULEZ standards until October 2025. This is staggered by vehicle type	Signed MOU
Delivery of 83 DCAs	Delivery by mid 2024

Further actions

Action	Date by which it will be completed
Exploring additional funding streams for replacement ambulances	Ongoing
Decommission non-compliant fleet	Ongoing
Development of Green plan actions	July 2024

Mission 3: Using our unique pan-London position to contribute to improving the health of the capital

BAF Risk: 3.2
There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London if the current fragmented commissioning and tendering of 111 contracts by 5 ICSs continues

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 24/25				
L	x	C	=	Score
2	x	4	=	8

Controls	**Assurances**
The LAS IUC team is part of alliance arrangements in NCL and NWL with a single contract shared between providers including PPG and LCW. This means that the LAS IUC team is the only provider in NEL/SEL and the lead provider in NCL and NWL. The service has influence and leadership roles across all ICB areas and a role in coordinating shared learning and innovation which reduces the risk of fragmentation	The LAS IUC service and wider organisation has a strong relationship with commissioners in each London ICB as well as in the London Region team. This ensures that the LAS team is a stakeholder in conversations about the future direction and strategy of IUC services across London. Where there are opportunities to further integrate the service and align contracts, LAS is in a strong position to influence these conversations.
The IUC LAS team have seen extensive improvements across all contract areas which has led to LAS being seen as a leading provider of 111 and CAS services across London. Where commissioners look to procure a single service, LAS would be in a favourable position to bid for that contract.	There are many models in use across the UK where 999 and 111 services are integrated across ICBs and Regions. This helps to support the case for change in London and offers examples of innovative ways of working whether fragmentation is reduced
The LAS IUC team already have extensive experience of reporting both independent performance and London-wide activity and performance which provides assurance that the service is in a position to be able to manage a pan-London contract. It also reduces the impacts of the fragmented commissioning landscape given our oversight of the data from the whole region. The availability of the STORM and PRM platforms also enables load sharing and balancing across the region to reduce the impact of fragmented services	The LAS IUC team have taken extensive steps to further integration across multiple pathways such as 999-111 warm transfer, General Practice Support Service, Ambulance Validation, and HCP calls. This highlights LAS as a key innovator and driver of integration to make the chase for change.
	A number of pan-London services are in place such as 111Online, and systems such as the London Care Record integrate services further. The LAS IUC CAS operates a pan-London model with DoS and direct referrals managed by two CTNs. This ensures there is greater

Mission 3: Using our unique pan-London position to contribute to improving the health of the capital

Further actions

Action	Date by which it will be completed
Continued engagement with commissioners to move towards pan-London commissioning of IUC services	Apr25
Continued improvement in performance across LAS IUC services to ensure that we are in the best position ahead of tenders	Apr25
Continued development of innovations to integrate services, data, and patient pathways across London to reduce risk of fragmentation and ensure LAS are leading innovations in pan-London IUC provision	Apr25

Mission 3: Using our unique pan-London position to contribute to improving the health of the capital

BAF Risk: 3.3
Because of the complexity and scale of our stakeholder partnerships across London, we may struggle to maximise the value and benefits of implementing the new ICS partnership model across LAS which would hinder our ability to spread innovation and solve common challenges

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: Q4 24/25				
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 and FIC
	Approach to be reviewed at planned Board Development days

Further actions

Action	Date by which it will be completed
Reviewing our maturity on health inequalities using a national tool	Completed and submitted to AACE in March
Plan pilot for supporting primary care in line with fuller stock take	Completed as per business plan achievements for 202/24 (in submission papers for 6th June Board)
Begin to implement estates modernisation strategy	End March 2024 - estates modernisation has started
Agree an operating model with how the LAS interacts with the 5 ICS	Completed
Build on Strategy engagement to further strengthen links with partners	Ongoing

9. London Ambulance Service Public and Patient Council (LASPPC) update

Presented by Roger Davidson

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	5 September 2024			
Report title:	London Ambulance Service Public and Patient Council (LASPPC) update			
Agenda item:				
Report Author(s):	Jai Patel, Head of Stakeholder Engagement			
Presented by:	Roger Davidson, Chief Strategy and Transformation Officer			
History:	N/A			
Purpose:	☐	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

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.

In line with the LASPPC's terms of reference, this paper provides an update from the latest meeting (28 August 2024).

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

The Board is asked to note the contents of this paper.

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

Directorate	Agreed				Relevant reviewer [name]
Quality			No		N/A
Finance			No		N/A
Chief Operating Officer Directorates			No		N/A
Medical			No		N/A
Communications & Engagement	-		-		-
Strategy			No		N/A
People & Culture			No		N/A

LONDON AMBULANCE SERVICE PUBLIC AND PATIENTS COUNCIL UPDATE FOR THE TRUST BOARD

1. The London Ambulance Service Public and Patients Council (LASPPC) meeting took place on 28 August 2024 (agenda attached, Appendix 1).

2. The Council received a short briefing from Consultant Paramedic Mary Emery on the progress of the London Ambulance Service's initiatives to reduce health inequalities. Mary outlined the development of a five-year action plan focused on key patient groups, including those with sickle cell disease and new mothers from global majority ethnicities. She highlighted the use of the Core20Plus5 framework to target the most deprived 20% of the population and locally identified groups. Mary emphasised the importance of co-designing improvement projects with patients and staff to ensure these initiatives are effective and impactful. She thanked the Council for their ongoing support and contributions in advising on these critical issues.

3. Members raised questions about the clarity and consistency of terminology for sickle cell conditions and whether maternal health initiatives included miscarriage, both of which were addressed. Concerns were also discussed regarding care transitions from paediatric to adult services for sickle cell patients and the need for tools like a "medical passport" to aid communication with healthcare providers. Additionally, there was interest in the selection process for focus group locations. Overall, the discussion centred on ensuring clear communication and inclusive strategies to reduce health inequalities.

4. Jai Patel, Head of Stakeholder Engagement, updated the group on the paper reviewing the membership of the LASPPC. The review aims to align the Council's role with the Trust's broader strategy for gathering feedback from patients and the public, particularly those impacted by health inequalities, and to ensure the membership reflects the demographic and geographic diversity of London.

5. The conversation focused on the discussion paper, which was amended based on member feedback and presented at a special meeting in July 2024 for further review. Members discussed proposed changes to the LASPPC membership model, including revising the recruitment process to appoint co-chairs first for better alignment, setting a flexible membership cap of up to 20 members, and ensuring diverse representation. Concerns were raised about term lengths and turnover, and the nomination and selection process for Healthwatch representatives was also discussed, with a balanced approach proposed to ensure fairness and oversight. The Council supported the direction of the paper but called for further clarifications. The plan is to incorporate the latest comments and submit a revised paper to the Trust Board for approval, detailing the new membership model and amended Terms of Reference.

6. The Council received a short briefing from Chief Medical Officer Fenella Wrigley on the increased demand for services over July and August due to high temperatures, LAS's response to the recent Notting Hill Carnival, and updates on Mpox awareness and staff safety protocols. Fenella also discussed the expansion of the 111 contract in North London, the London

Heart Starters campaign to increase access to defibrillators, and the Trust's shortlisting in four categories for the HSJ Awards. She also thanked the co-chairs and council members for their contributions and their role in advising on decisions, particularly on achieving successful engagement with patients, the public, and carers, as well as providing feedback on the care provided to ensure the services reflect the needs of patients across London.

10. Concluding Matters

For Noting

10.1. Any Other Business

For Noting

10.2. Date of Next Meeting – Thursday 5th Decembers 2024

For Noting

Presented by Andy Trotter

Questions from the public

Library: Additional Information

London Ambulance Service
NHS Trust

Quality Assurance & Improvement Report

Report for discussion at the Trust Board

Analysis based on July 2024 data, unless otherwise stated

To be read in conjunction with the Integrated Performance Report

Summary

		May-24	Jun-24	Jul-24	Comment
SAFE	Reported Incident Volumes	No data	No data		Increase in meds management and violence/agression incidents
	Level of Incident Harm	No data	No data		Increase in death and moderate harm reported incidents during the reporting period
	Sector variation in Incidents	No data	No data		
	Medicines Management	No data	No data		High number of incidents reported in relation to CD audit findings
	Health & Safety	No data	No data		
	Safeguarding	No data	No data		Not meeting required target for level 2 safeguarding
	Infection Control	No data	No data		
EEFECTIVE	Clinical AQI	No data	No data		
	Performance AQI	No data	No data		
	CPI Audits	No data	No data		
	Call Handling	No data	No data		
	111 - NEL	No data	No data		
	111 - SEL	No data	No data		

	Recent quality issues which QAC should be aware of/don't have a QI plan
	Areas where quality is not of the level required and which are being reviewed
	No serious areas of concern with quality of Care

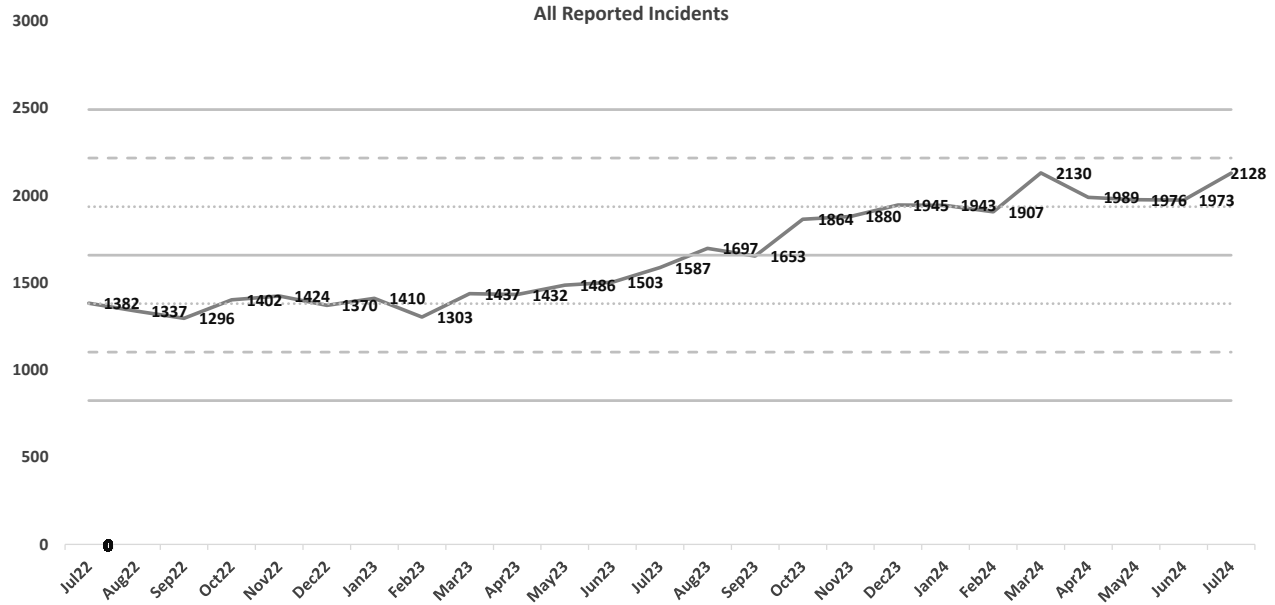
Clinical AQI (AMB-CO)	Dec23	Jan24	Feb24
Stroke (median)	7	3	6
Stroke (90th centile)	8	6	7
Stroke (mean)	7	5	5
STEMI (90th centile)	5	3	5
STEMI (mean)	5	7	6
Cardiac Arr ROSC	7	1	3
Cardiac Arr ROSC (Ulstein)	7	5	2
Cardiac Arr 30day surv	7	1	4
diac Arr 30day surv (Ulstein)	5	1	7
STEMI care bundle		6	
Cardiac Arr care bundle		4	
(Trust Ranking)			

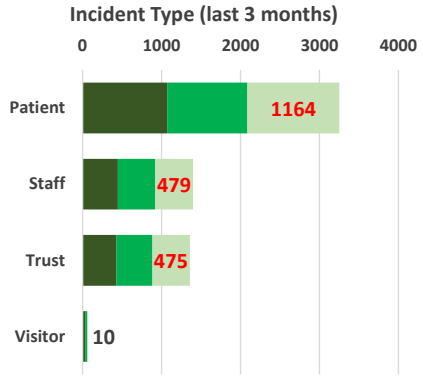
Performance AQI (AMB-SYS)	May24	Jun24	Jul24
C1 mean	2	2	2
C2 mean	9	9	9
C3 mean	2	2	3
C4 mean	4	7	8
999 call answer mean	4	5	5
Clin Validation mean	5	7	7
C5 Clin Assessment mean	4	6	4
H&T / All Incidents	2	2	1
S&T / All F2F	7	7	8
Non ED / Conyeyed	9	9	9
(Trust Ranking)			

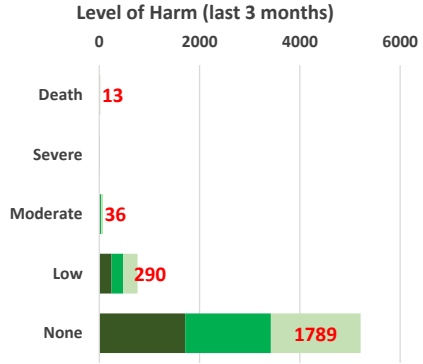
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

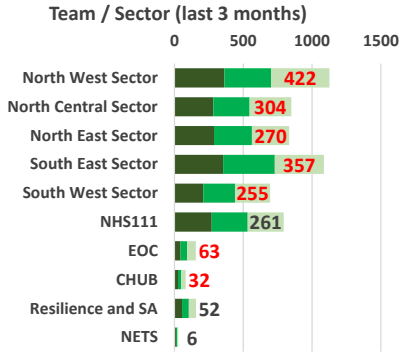
All Reported Incidents

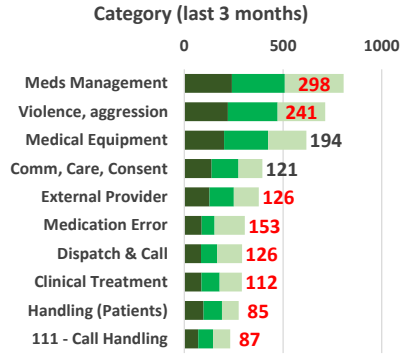
Number of reported incidents have continued to increase during this period. Meds management and Violence/aggression incidents numbers are above the 12 month average.











May-24 | Jun-24 | Jul-24 | above 12 month avg

The number of incidents reported on Datix have continued to increase throughout the reporting period and have maintained special cause variation.

North West and South East continue to be the highest reporting sectors.

The majority of incidents reported are within the no/low harm severity grading.

An increase in these metrics is a sign of a positive reporting culture within the Trust.

Tops categories for the reporting period are:

- **medicines management – specifically errors identified on audit of controlled drugs books,**
- **reports of violence/aggression – specifically directly verbal abuse**
- **medical equipment – specifically failure of device / equipment**

Work is in progress to support the trusts business plan objective of reducing the number of overdue incidents. Responding to incidents in a timely manner will further increase the positive reporting culture within the Trust.

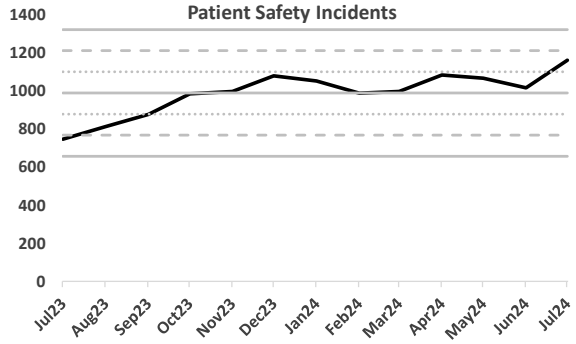
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

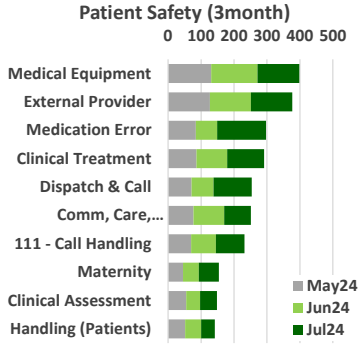
Incidents by Type

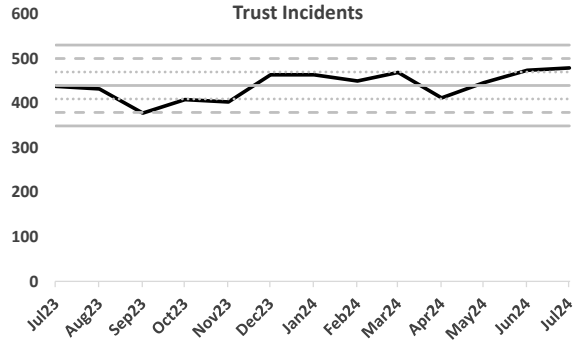
No concerns for escalation

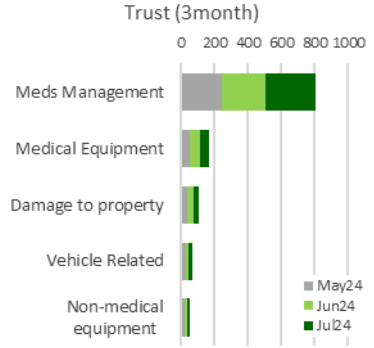
Common cause variation is evident across all four reporting types.

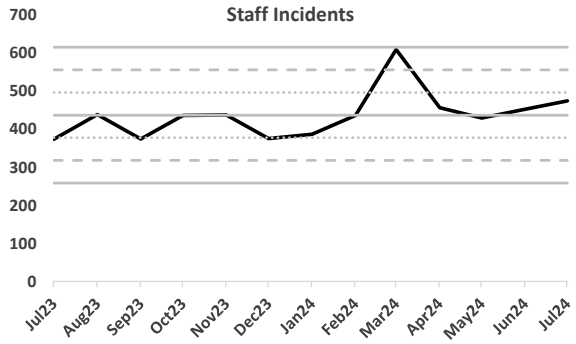
The central patient safety team review new incidents reported on daily basis. This is with a view to flag those of immediate concern but also to ensure that they are reported under the correct category/type.

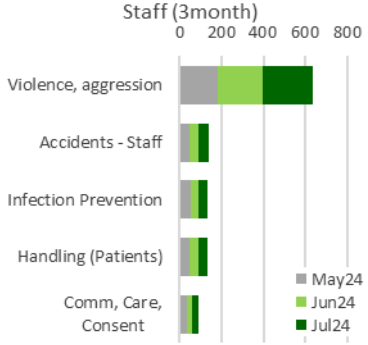


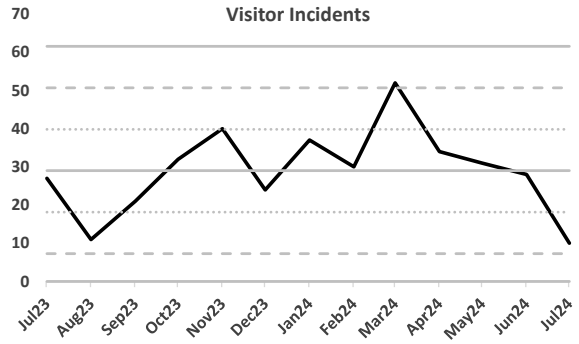


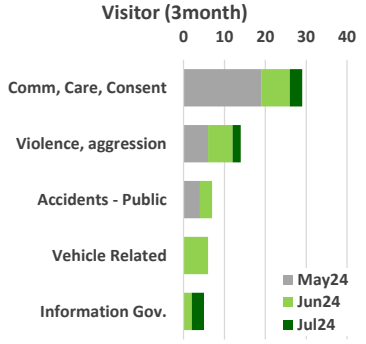








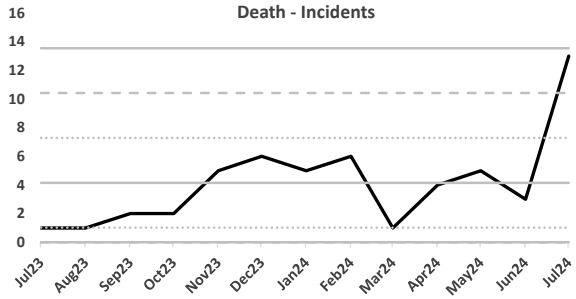


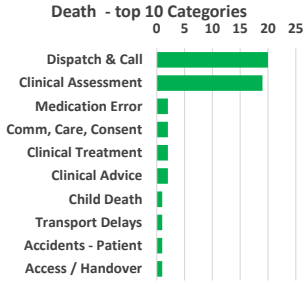


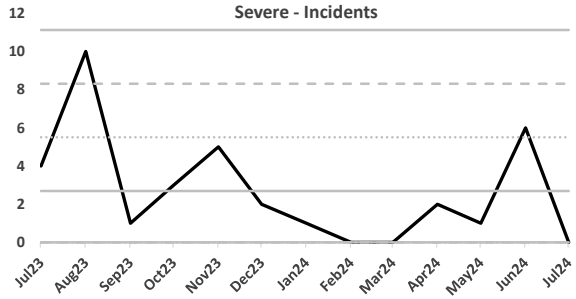
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

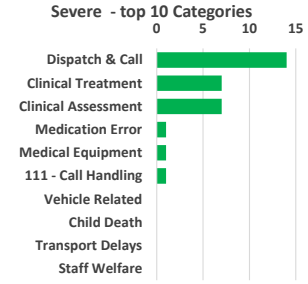
Incidents by Harm

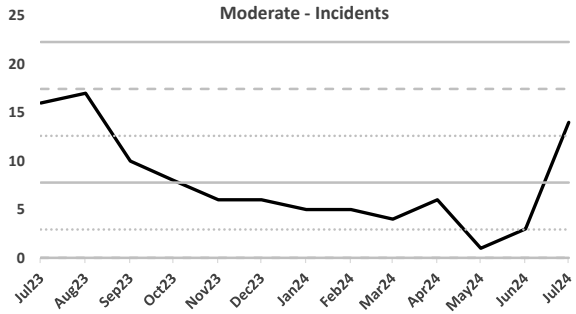
There was an increase in death and moderate harm reported incidents during the reporting period. Of the 14, 12 were reported in relation to incidents that took place during the month of July.

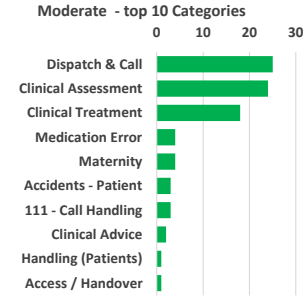












Learning From Deaths

	Feb24	Mar24	Apr24	May24	Jun24	Jul24
LFD - Reason 1						
LFD - Reason 2						
LFD - Reason 3						
LFD - Reason 4						
LFD - Reason 5						
LFD - Other						

PSIP Outcomes - Last 6 months

	Feb24	Mar24	Apr24	May24	Jun24	Jul24
Enhanced Inv. - External		3	1	1		
Loc-defined - Local PSII	2					
Nat-defined - Local PSII	3	11	3	6	3	5
Nat-defined - Alt. Team						
Patient Safety Review				1		
PSR - After Action Review	4	9	4	6	3	9
PSR - Complaint Response						1
PSR - Delays SJR	1	1				
PSR - MDT	2					2
PSR - SWARM Huddle			1	1		1
	12	24	9	15	6	18

PSIRF Themes - Last 6 months

	Feb24	Mar24	Apr24	May24	Jun24	Jul24
111 - Clin. Assessment		1				
Clinical assessment				1		
Clinical treatment (EXCEPT meds)						
Communication, care & consent			1			
Dispatch & call	1	4		4	1	3
Local – Call Handling - 111/IUC		3				
Local – Call Handling - 999	2	2	2	3		2
Local – Cardiac Arrest / Airway Mgmt				1		1
Local – Cardiac Arrest / Recognition	1					1
Local – F2F - incorrect non conveyance	6	7	2	2	2	2
Local – 999/111 clin assess. incorrect advice			1	2		2
Local – F2F - definitive care	2	1	2	1	1	1
Local – F2F - immobilisation			1			
Local – F2F - extremes of age					1	
Local – Medicines Management		1				2
Local – Emergency Patient Safety Incidents						
Maternal, obstetric and neo-natal		4		1		
Non-medical equipment						
Patient accidents & injuries		1			1	
	12	24	9	15	6	14

The number of reported moderate harm and death incidents saw an increase in the month of July.

In relation to the death reported incidents:

- **Two cases relate to incidents identified from Inquest and therefore are pre July 2024.**
- **Seven cases were in relation to non-conveyance decision making.**
- **Two cases were identified by a central patient safety team harm review of the weekend of the national IT failure (19 July)**

The remaining cases relate to potential call handling concerns and/or response time.

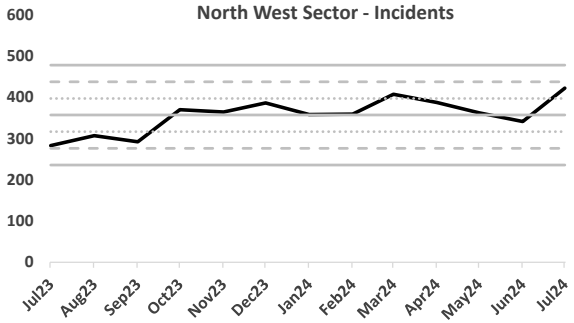
NB. moderate, severe harm and death reported incidents are reviewed via sector Patient Sector Incident Groups where LfD reviews are undertaken. Therefore the harm grading is subject to change

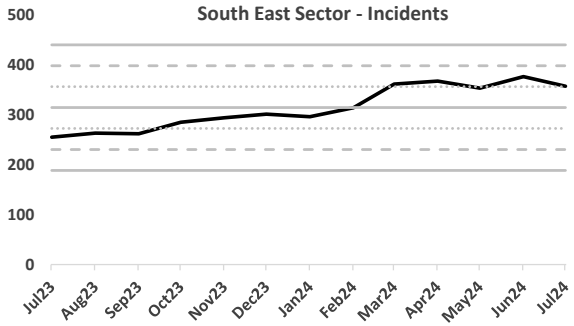
LfD figures to be available for the next reporting period.

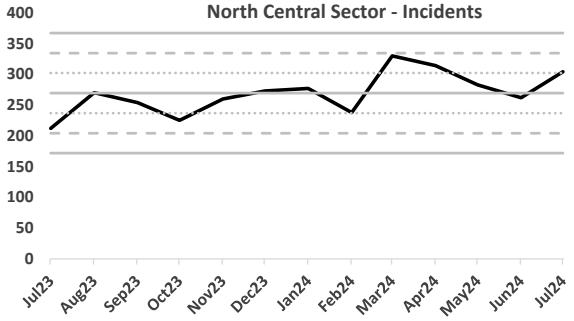
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

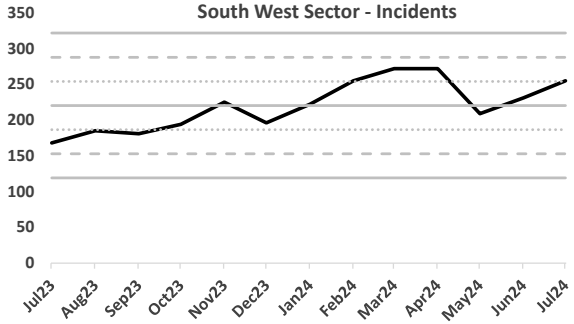
Incidents by Sector

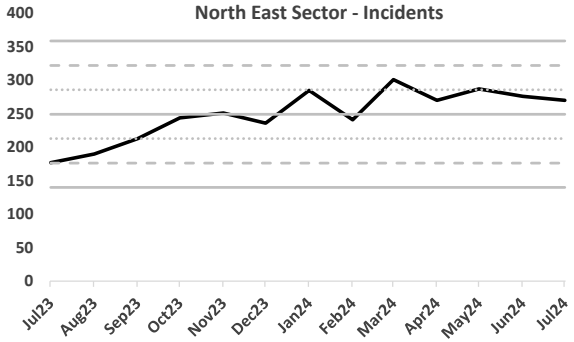
No concerns for escalation

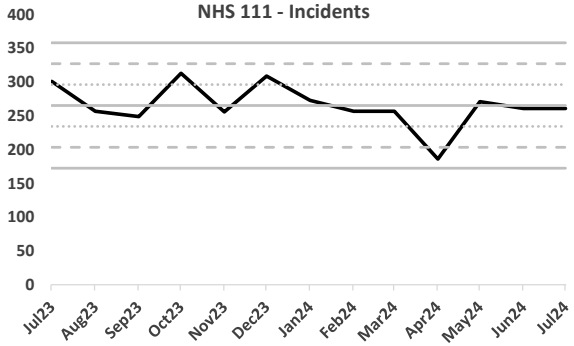












Breakdown of data by Team for last 3 months

	NW	NC	NE	SE	SW	111
Patient	553	353	389	539	339	638
Staff	255	167	223	292	190	121
Trust	293	305	191	233	143	11
Visitor	7	12	13	12	12	9
Patient %	50%	42%	48%	50%	50%	82%
Staff %	23%	20%	27%	27%	28%	16%
Trust %	26%	36%	23%	22%	21%	1%
Visitor %	1%	1%	2%	1%	2%	1%
Death	7	2	2	1	1	1
Severe	2	2	2	0	1	0
Moderate	3	6	3	0	1	1
Low	64	42	48	68	47	9
None	477	301	334	470	289	627
Death/Sev/Mod %	2.2%	2.8%	1.8%	0.2%	0.9%	0.3%
Patient Contacts Incidents	67,269	37,886	54,478	57,613	35,855	
Death (per 100k)	10	5	4	2	3	
Severe (per 100k)	3	5	4	0	3	
Moderate (per 100k)	4	16	6	0	3	
Death/Sev/Mod (per 100k)	18	26	13	2	8	

Incident Categories (per 100k)

Meds Management	294	552	171	233	262	
Violence, aggression	211	219	195	264	301	
Medical Equipment	184	272	207	248	245	
Comm, Care, Consent	36	77	79	90	78	
External Provider	100	95	59	97	81	
Medication Error	110	135	92	94	73	
Dispatch & Call	49	45	53	68	61	
Clinical Treatment	83	95	77	109	92	
Handling (Patients)	83	121	68	111	162	
111 - Call Handling	4	0	0	7	0	
Non-medical equipment	64	92	83	75	114	
Vehicle Related	67	61	64	68	84	
Maternity	59	40	44	73	70	
Damage to property	40	32	53	62	31	
Clinical Assessment	42	55	39	31	50	
Infection Prevention	43	74	46	61	36	
Accidents - Staff	37	37	46	59	56	
Access / Handover	51	113	33	38	8	
Information Gov.	12	13	11	26	11	
111 - Clin. Assessment	1	3	2	0	6	

The North West and South East continue to be the highest reporting sectors.

The South East has the lowest reported percentage of incidents in death/seve/mod category and the lowest death/seve/mod incidents per 100K patient contacts.

The highest proportion of death/seve/mod incidents are within North Central which also has the highest number of these incidents per 100k patient contacts.

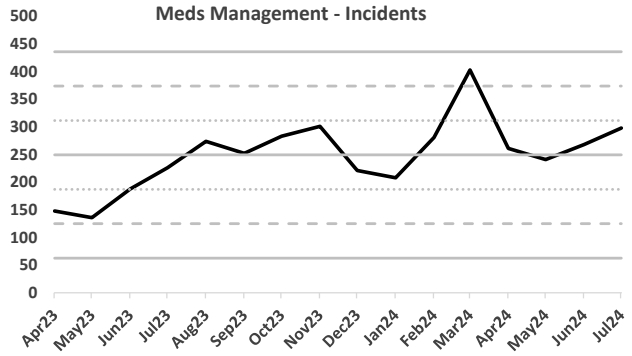
In relation to the top three categories per 100k patient contacts:

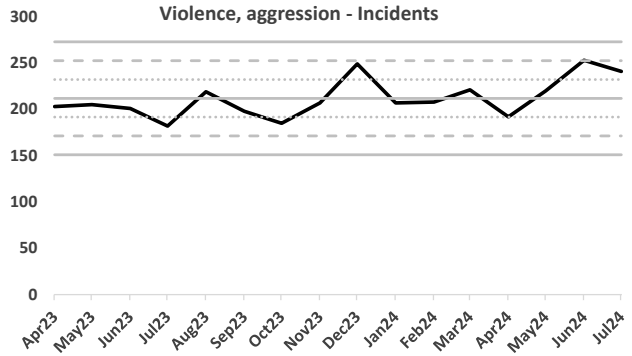
- **North Central has the highest rates of med management incidents**
- **South West has the highest rates of violence/aggression incidents**
- **North Central has the highest rates of medical equipment incidents**

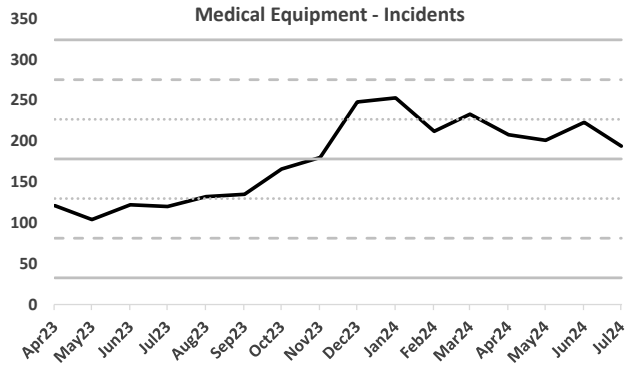
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

Incidents by Category

No concerns for escalation







Categories	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24	Total
Meds Management	274	252	283	301	221	208	281	403	261	241	268	298	3291
Violence, aggression	219	198	185	207	249	207	208	221	192	220	253	241	2600
Medical Equipment	132	135	166	180	248	253	212	233	208	201	223	194	2385
Comm, Care, Consent	135	132	185	176	162	154	150	148	121	138	136	121	1758
External Provider	14	67	86	92	101	121	107	129	97	127	124	126	1191
Clinical Treatment	106	74	81	61	88	93	85	85	96	86	93	112	1060
Dispatch & Call	75	82	76	118	96	84	74	63	64	84	82	126	1024
Handling (Patients)	71	55	65	73	84	96	89	85	106	97	93	85	999
Medication Error	47	43	44	44	59	56	52	92	213	87	66	153	956
111 - Call Handling	89	72	118	71	83	81	78	63	51	70	75	87	938
Vehicle Related	60	67	66	80	62	77	87	74	84	68	74	49	848
Access / Handover	41	108	94	83	81	56	50	40	48	58	40	35	734
Non-medical equipment	39	26	47	41	54	60	61	74	82	88	68	69	709
Damage to property	67	40	48	44	52	45	43	68	49	52	53	45	606
Clinical Assessment	59	44	48	43	54	45	59	51	53	55	42	51	604
Accidents - Staff	58	40	61	38	39	53	50	46	44	48	44	50	571
Maternity	33	48	37	39	38	46	47	48	51	45	48	61	541
Infection Prevention	31	27	35	33	29	56	36	55	41	57	40	46	486
Information Gov.	29	28	20	32	24	27	27	24	27	16	31	38	323
111 - Clin. Assessment	26	17	27	18	38	27	19	28	17	28	22	30	297
Buildings, IT	19	12	12	18	19	17	24	23	16	21	30	26	237
Accidents - Patient	15	21	14	21	15	10	12	13	20	34	15	28	218
111 - Confidentiality	17	19	16	13	8	15	9	7	6	14	7	3	134
Handling (not Patients)	3	5	10	13	9	16	18	10	11	14	9	13	131
Clinical Advice	8	6	7	9	7	13	8	11	8	5	7	6	95
Estates (Incl. Facilities)	10	10	9	6	7	4	5	10	4	6	8	7	86
111 - Incorrect Referral	7	11	6	11	5	7	3	4	5	4	10	12	85
Transport Delays	3	6	2	1	6	5	8	8	5	0	3	7	54
Palliative Care	3	3	6	5	2	4	1	7	3	5	2	5	46
Staff Welfare	0	4	4	4	4	3	2	4	3	3	2	4	37
Accidents - Public	5	1	5	5	1	2	1	3	2	4	3	0	32
Child Death	1	0	1	0	0	1	1	0	1	0	0	0	5
CCTV Loss/Failure	1	0	0	0	0	1	0	0	0	0	2	0	4

Red = Highest count per month, Green = Lowest count per month

Medicines management incidents continue to be the highest reported incident category.

Clinical concern about an external provide incidents have continued to increase since the category was introduced in September 2023.

Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

Overdue Incidents

The number of overdue incidents has improved but remains outside the Trusts target of 25%

Severity	<1	1-2	2-3	3-6	6-12	12+	All
Death							0
Severe							0
Moderate	5			2	1		8
Low	29	9	4	2	8	4	56
None	201	47	28	42	34	42	394
Total	235	56	32	46	43	46	458

Incident Type	<1	1-2	2-3	3-6	6-12	12+	All
Patient	112	42	14	19	21	21	229
Trust	56	8	7	18	11	14	114
Staff	65	6	10	8	10	11	110
Visitor	2		1	1	1		5
Total	235	56	32	46	43	46	458

Top 15 Teams	<1	1-2	2-3	3-6	6-12	12+	All
North West Sector	30	7	4	3	1		45
North East Sector	38	4		1	1	1	45
Emergency Operations Centre	26	11	1	1			39
South East Sector	34	2	1	1	1		39
Pharmacy	16	2	2	9	1	2	32
South West Sector	17	5	5		1		28
Clinical Hub (CHUB)	13	1	4	3	2		23
North Central Sector	13	3	4	1			21
Information Management & Technology (IM&T)				7	4	6	17
Supply & Distribution		1		3	5	6	15
Frequent Caller Team	4	2		1	2	6	15
Clinical Education & Standards	4	6	1	1	3		15
Resilience and Specialist Assets	8	3	1	2	1		15
NHS111	8	1	1	2		2	14
Non Emergency Transport (NETS)	5	3			2		10

The number of overdue incidents has continued to improve since April 2024 when there were over 900 overdue incidents.

Metrics to consider are also proportion of open incidents which are overdue. This will be included in the dataset for next reporting period.

SE and NW sectors are the largest reporting sector. Proportionately they have some of the lowest numbers of overdue incidents when compared to those that are open.

Tracking of the numbers of overdue incidents will be available in the next quality report

Improvement work is underway, meeting with corporate areas of the Trust whom own overdue incidents.

Support documents/aid memoirs are being developed to assist with managers completing investigations.

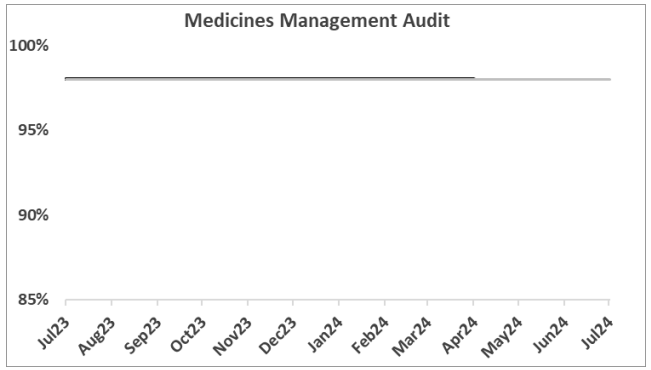
Regular reporting and feedback is being provided to those areas with overdue incidents.

Safe | Effective | Caring | Improve | Priority | Owner TE | Exec Lead FW

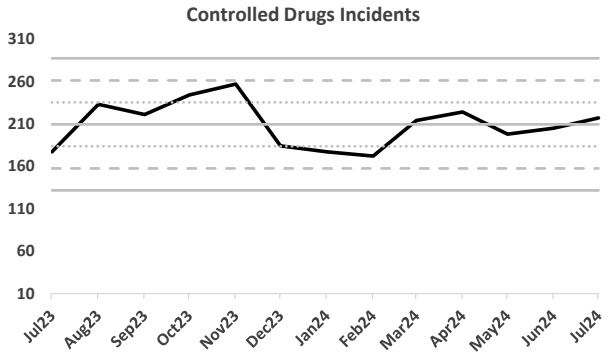
Medicines Management

Continue to see a high number of controlled drug reported incidents

Meds Inspections



Controlled Drugs



	Feb24	Mar24	Apr24	May24	Jun24	Jul24
Audit - Not corrected	51	53	65	61	80	76
Audit - No Documentation	5	14	19	14	14	13
Audit - No Signature	27	36	27	22	29	33
Audit - No Information	27	43	49	36	28	23
Audit - Unidentifiable	6	2	9	2	1	10
Incorrect record	3	5	3	8	6	6
Wrong Location	9	8	11	9	8	11
Safe Malfunction	0	0	1	0	0	1
Unaccounted for	12	10	7	10	7	7
Wasted	32	43	33	36	32	37
Total	172	214	224	198	205	217

Audit

- The PW inspection results are based on the numbers of inspections which take place only. Current work stream in situ to update the account holders for this audit tool.
- R&SA undertaking work relating to number of APP audits undertaken. The APP operational capacity to undertake these audits differs to regular Group Management Teams.
- Action plans for lowest scoring stations / areas sit with respective SMT / QGAMs
- Data unavailable May 2024 onwards, a ticket has been raised.

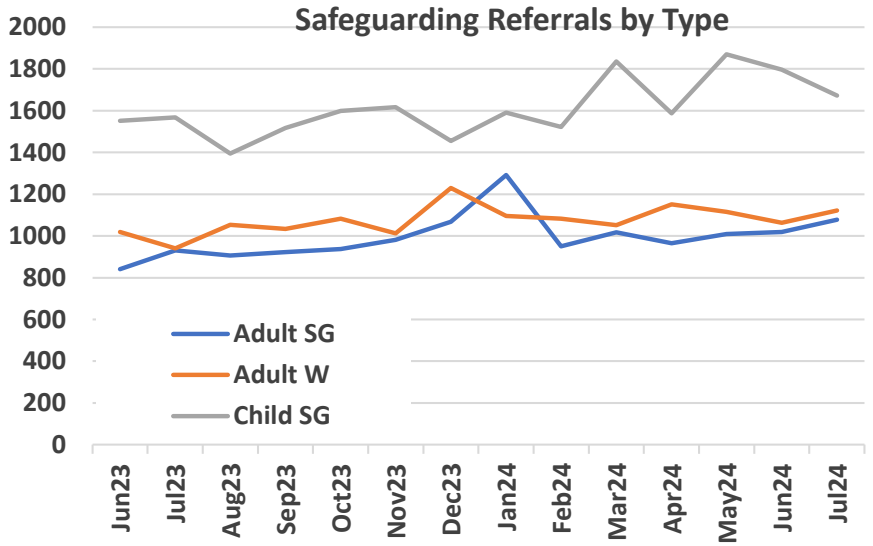
Controlled Drugs

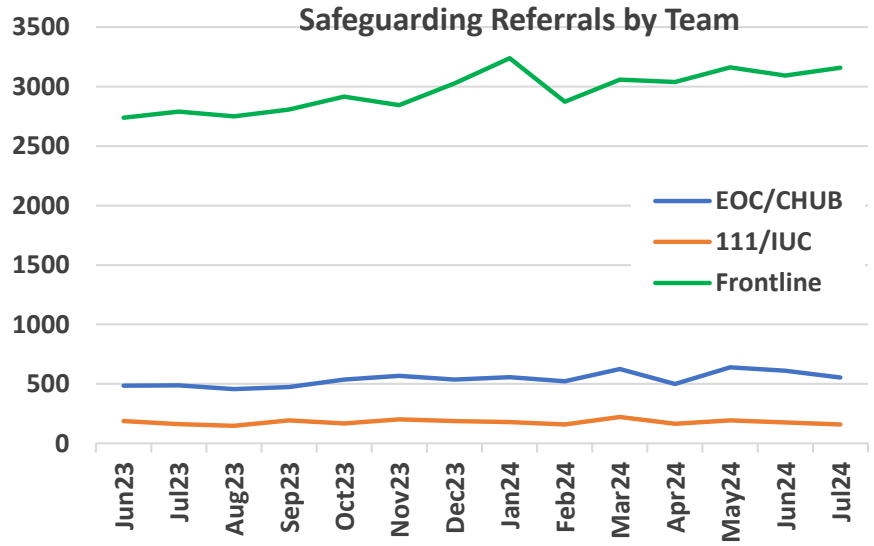
- No loss of schedule 2 controlled drugs
- Other controlled drug (CD) incidents
  - Documentation errors (n=173) and Recording errors (n=4)
  - Abloy key loss/misuse (n=3) and CD safe malfunction (n=1)
  - Breakages (n=28) or wastage (n=9)
  - Morphine retained off duty (n=8) or CDs left unsecured (n=3)
- Other incidents
  - Kitprep malfunction (n=1), Drugs Usage Form discrepancy (n=4)
  - Damage (n=3), breakages (n=4), loss (n=8) and missing (n=10)
  - Drugs unsecure (n=6) and seal broken (n=28)
  - Sharps left in drugs pack (n=2)
  - Non-LAS drug errors (n=6)
  - Inappropriate administration of adrenaline (n=3), aspirin (n=1), benzylpenicillin (n=1), dexamethasone (n=1), glucose (n=1), hydrocortisone (n=1), ipratropium (n=1), midazolam (n=22), morphine (n=12), entonox (n=1), ondansetron (n=2), oxycodone (n=1), paracetamol (101), methoxyflurane (n=1), salbutamol (n=1), TXA (n=2).

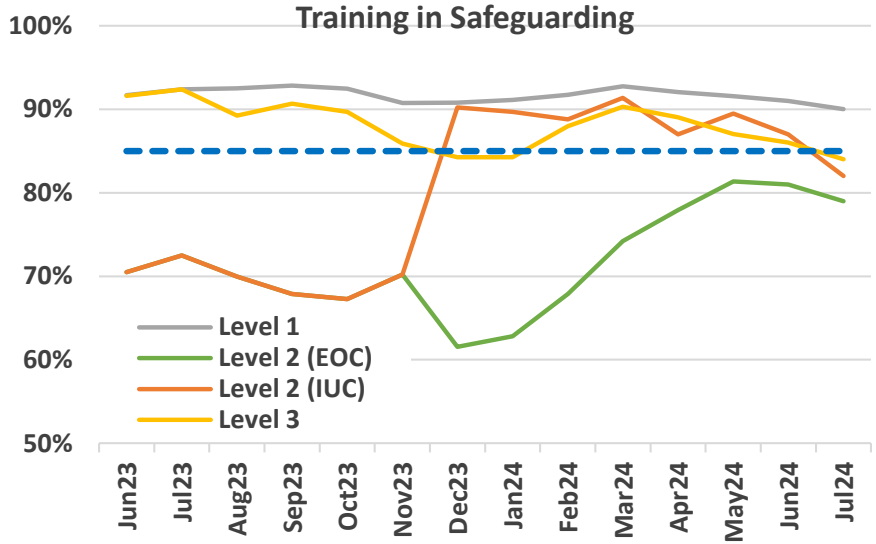
Safe | Effective | Caring | Improve | Priority | Owner AT | Exec Lead PC

Safeguarding

Not meeting required target for level 2 safeguarding although noted improvements made compared to position a the beginning of the calendar year.







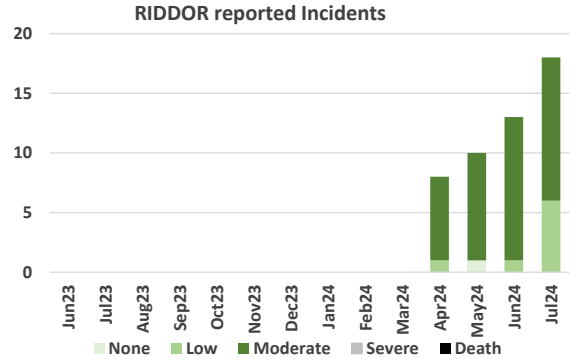
- **Compliance on Safeguarding Level 2 & Level 3 has been set at 85% by end of year. For the third year we have failed to reach the 85% target for level 2. A risk has been raised as insufficient progress has been made. Discussions are ongoing with EOC.**
- **Safeguarding referrals have continue to be historically high, particularly for children; this is system-wide. Also a high volume of referrals from EOC**
- **Significant focus for this period and the remainder of the year is a large and complex workforce change process associated with the move to electronic referral project. The consultation process ended in July, but the timeline runs through until Q3.**

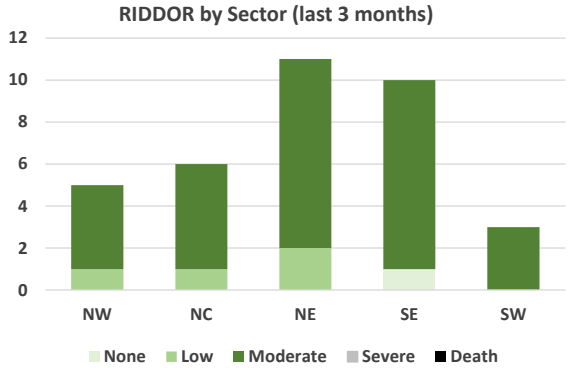
Safe | Effective | Caring | Improve | Priority | Owner EJ | Exec Lead PC

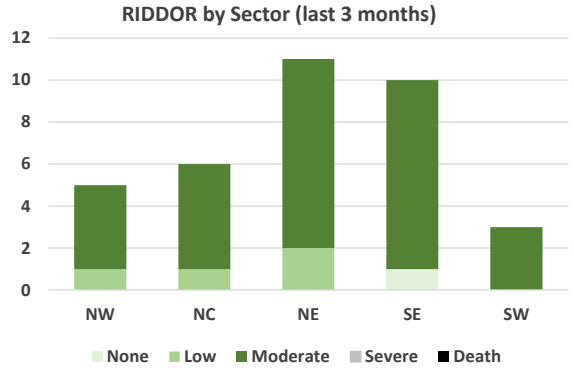
Health & Safety

No concerns for escalation

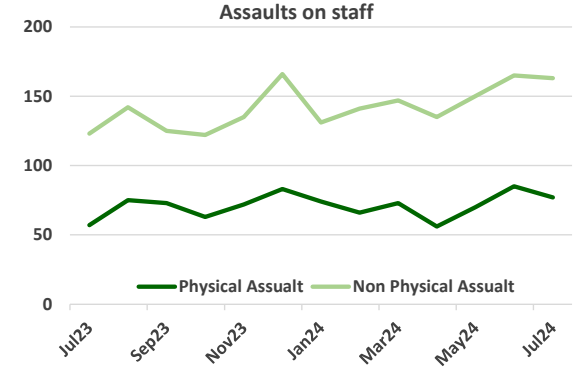
H&S - RIDDOR

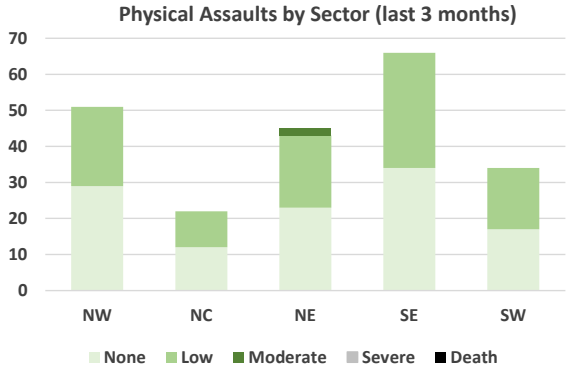


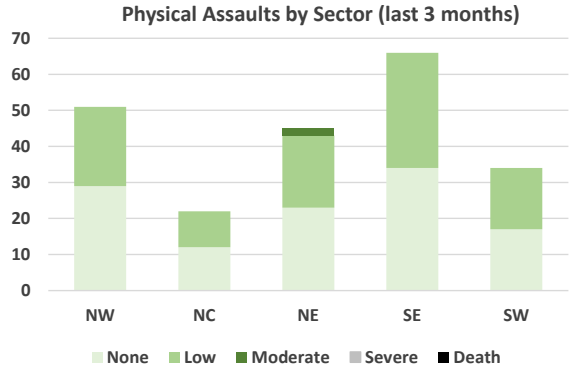




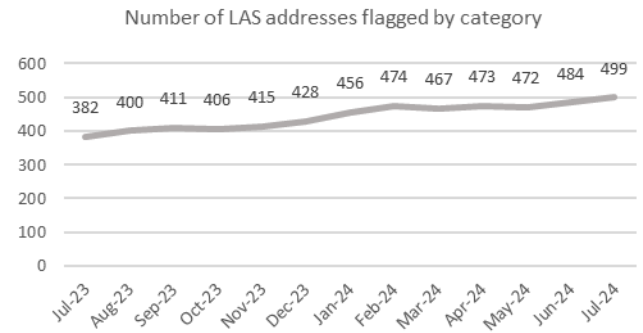
H&S - Assaults

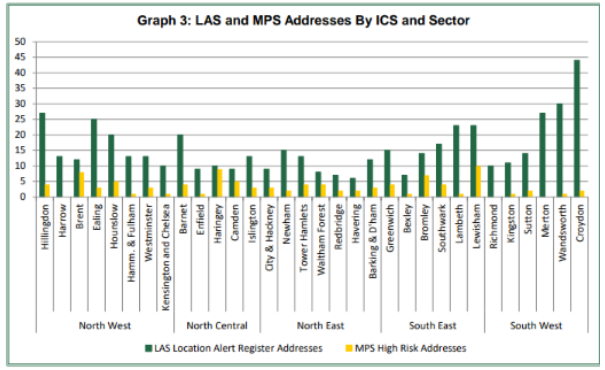


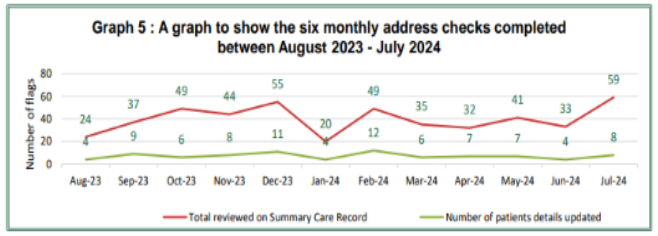




Location Alert Register







RIDDOR

- **5 reported RIDDOR incidents occurred in Patients' Home (n=5), 3 incident occurred in Ambulance Station (n=3), 1 incident occurred in Hostel (n=1), 1 incident occurred in Public Place (n=1) and 1 incident occurred in Training Centre (n=1).**
- **2 reported RIDDOR incidents involved Kit Bag (n=2), 2 incident involved Track Chair (n=2), 1 incident involved Carry Sheet (n=1), 1 incident involved Carry Chair (n=1), 1 incident involved LP 15 (n=1), 1 incident involved Scoop (n=1) and 3 incidents involved no equipment (n=3).**
- **3 reported RIDDOR incidents resulted in Back injury (n=3), 3 incidents resulted in Shoulder injury (n=3), 3 incidents resulted in Upper Limb injury (n=3), 1 incident resulted in Hip injury (n=1) and 1 incident resulted in Knee injury (n=1).**
- **9 reported RIDDOR incidents were occurred during Lifting & Carrying (n=9), 1 incident occurred during Pushing & Pulling (n=1) and 1 incident occurred during Training (n=1).**

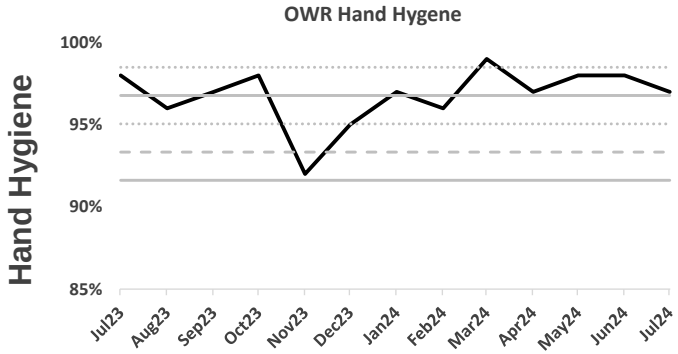
Physical Assault

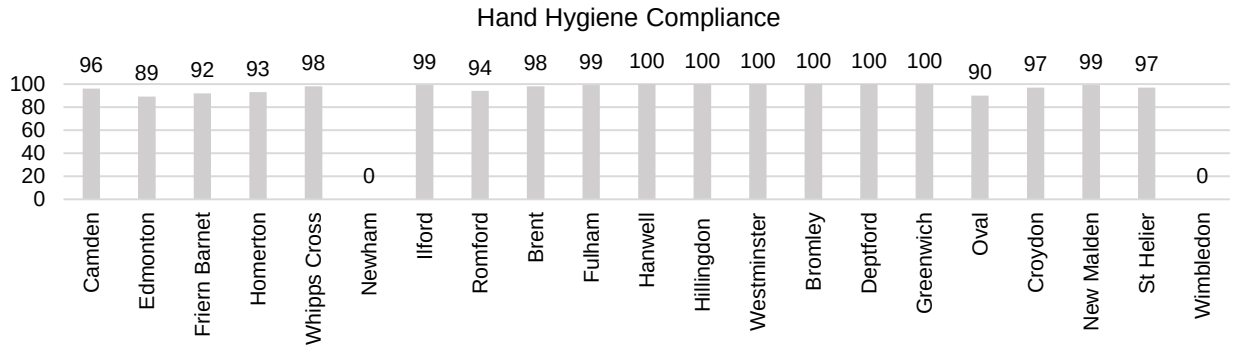
- **A total of 266 Physical Assaults on Staff were reported during 2024/25 (up to end July'24).**
- **143 (54%) of the incidents were reported as 'No Harm/Near Miss incidents, 120 (45%) incidents were resulted in 'Low Harm' and 3 (1%) incidents were resulted in 'Moderate Harm'.**
- **6 out of the 189 Physical Assault on Staff were caused by other (ex: family member of the patient / by standers etc).**

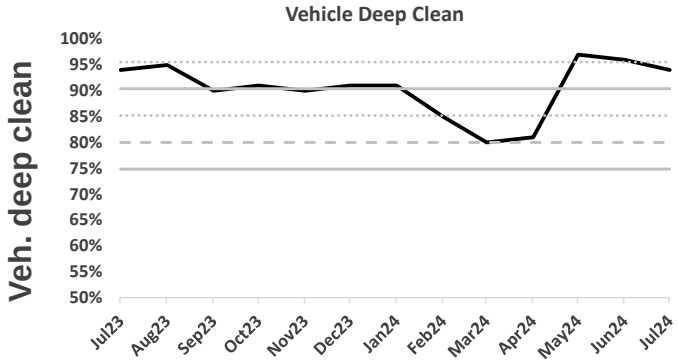
Safe | Effective | Caring | Improve | Priority | Owner IPC | Exec Lead FW

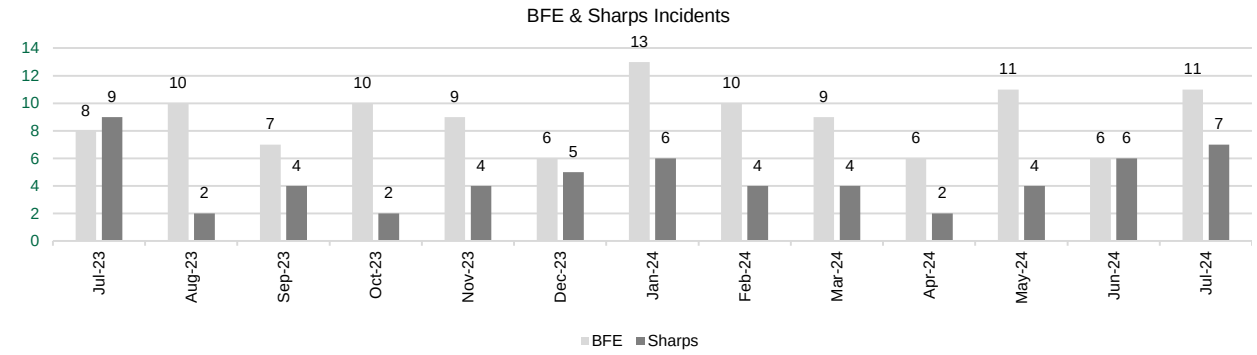
Infection Control

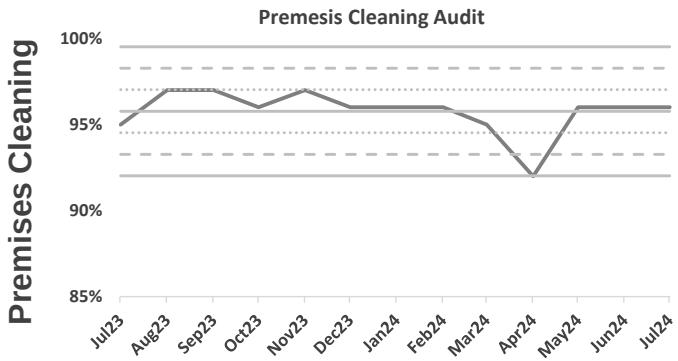
No concerns for escalation











- The overall Trust OWR hand hygiene compliance is reported at 97% exceeding the Trust target of 90%. 19/21 group stations submitted data
- The DCA Trust compliance is reported at 94%, just under the Trust target of 95%. North East and North West Sectors did not meet the compliance target.
- The Monthly Station Cleaning compliance is reported at 96% against the Trust target of 90%. There no data submissions for 5 group stations
- Sharps Incidents - 2 related to disposal of blood sugar monitoring sharps. 4/7 had linkage to IV cannula inducer needles (2 post procedural due to disposal and 2 occurred during the cannulation process). An additional subtheme emerged across these themes in relation to injuries occurring due to abandoned sharps within the vehicle applying to 2 of the total incidents.
- BFE Incidents - 4 resulted from post insertion cannula flushing, 2 resulted from unintentional spitting to eyes/mouth & 3 were airway related

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

Clincial AQI (AMBCO)

No concerns for escalation

National AQI Clinical Outcomes	Feb23	Mar23	Apr23	May23	Jun23	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24
Stroke median time call to hosp arrival (mins)	75	84	73	80	80	77	81	83	80	85	91	79	81					
Stroke 90-centile time call to hosp arrival (mins)	128	147	135	138	147	140	140	139	137	149	181	148	140					
Stroke mean time call to hosp arrival (mins)	83	94	84	88	93	87	91	92	89	94	107	93	90					
STEMI 90th centile time from call to PPCI (mins)	178	219	196	216	186	182	191	201	195	188	220	196	203					
STEMI mean time from 999 call to PPCI (mins)	136	180	154	154	144	129	132	138	135	139	151	154	150					
Cardiac arrest ROSC by hosp arrival	28%	26%	29%	29%	26%	31%	30%	28%	31%	29%	27%	30%	33%					
Cardiac arrest (Utstein) ROSC by hosp arrival	57%	54%	50%	45%	61%	61%	58%	47%	49%	49%	50%	52%	59%					
Cardiac arrest survival at 30 days	9%	9%	11%	10%	8%	9%	13%	8%	8%	10%	7%	11%	11%					
Cardiac arrest (Utstein) survival at 30 days	37%	36%	36%	26%	36%	28%	33%	23%	31%	28%	26%	34%	26%					
STEMI received care bundle			72%			71%			77%			80%						
Cardiac arrest post-ROSC care bundle			84%			82%			76%			89%						

Red = worst month, **Green** = best month

Ranking across Ambulance Trusts (inc IOW)																		
Stroke median time call to hosp arrival	4	8	2	6	4	3	9	5	5	7	7	3	6					
Stroke 90-centile time call to hosp arrival	3	5	6	5	5	7	8	3	4	5	8	6	7					
Stroke mean time call to hosp arrival	3	5	3	6	4	4	6	3	4	5	7	5	5					
STEMI 90th centile time from call to PPCI	2	9	6	10	2	1	3	3	6	3	5	3	5					
STEMI mean time from 999 call to PPCI	3	11	9	8	4	1	1	1	3	2	5	7	6					
Cardiac arrest ROSC by hosp arrival	6	8	6	6	8	3	4	6	5	4	7	1	3					
Cardiac arrest (Utstein) ROSC by hosp arrival	3	5	5	9	2	2	4	7	8	6	7	5	2					
Cardiac arrest survival at 30 days	6	2	4	6	9	4	4	4	9	3	7	1	4					
Cardiac arrest (Utstein) survival at 30 days	3	3	3	7	3	6	4	6	6	6	5	1	7					
STEMI received care bundle			7			7			7			6						
Cardiac arrest post-ROSC care bundle			3			4			8			4						

Red = lowest trust, **Green** = highest trust

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

Performance AQI (AMBSYS)

No concerns for escalation

National AQI performance data	Feb23	Mar23	Apr23	May23	Jun23	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24
C1 mean	7.8	8.1	7.2	7.6	8.0	7.2	7.4	7.7	7.4	7.6	8.0	7.4	7.4	7.2	7.3	7.2	7.5	7.4
C2 mean	34	39	31	42	46	32	34	40	38	41	52	37	37	33	35	36	40	39
C3 mean	68	77	57	83	85	62	75	82	78	82	102	74	72	66	68	73	83	89
C4 mean	136	145	116	142	160	120	130	158	131	145	166	130	121	121	121	127	139	152
999 call answer mean	27	35	15	14	33	9	8	15	9	15	23	5	3	2	2	3	5	5
Clin Validation mean	0	0	62	90	82	57	60	61	55	56	61	42	40	34	35	38	44	42
C5 Clin Assessment mean	0	0	34	42	39	73	53	44	44	42	42	34	34	31	35	37	37	38
H&T / All Incidents	16%	15%	14%	14%	15%	14%	14%	16%	15%	16%	17%	16%	16%	17%	20%	19%	19%	20%
S&T / All F2F	34%	34%	34%	35%	35%	34%	35%	35%	34%	34%	36%	35%	34%	34%	34%	34%	34%	34%
Non ED / Conyeyed	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	5%	5%

Red = worst month, Green = best month

Ranking across Ambulance Trusts (inc IOW)	Feb23	Mar23	Apr23	May23	Jun23	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24
C1 mean	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
C2 mean	8	8	7	11	11	6	8	8	6	9	10	6	8	7	9	9	9	9
C3 mean	3	3	2	2	2	2	2	2	1	2	2	2	1	1	3	2	2	3
C4 mean	7	4	7	6	7	6	8	7	3	6	5	4	4	3	7	4	7	8
999 call answer mean	9	9	10	9	9	7	6	10	5	10	11	7	3	2	4	4	5	5
Clin Validation mean	1	1	9	11	11	8	8	7	7	8	8	7	7	5	7	5	7	7
C5 Clin Assessment mean	1	1	6	8	5	9	6	6	6	6	4	3	4	3	5	4	6	4
H&T / All Incidents	1	2	2	2	2	2	2	2	2	2	2	3	1	1	1	2	2	1
S&T / All F2F	8	7	8	6	6	7	6	8	8	6	7	7	8	8	7	7	7	8
Non ED / Conyeyed	10	10	10	10	10	10	10	10	10	10	9	9	9	9	9	9	9	9

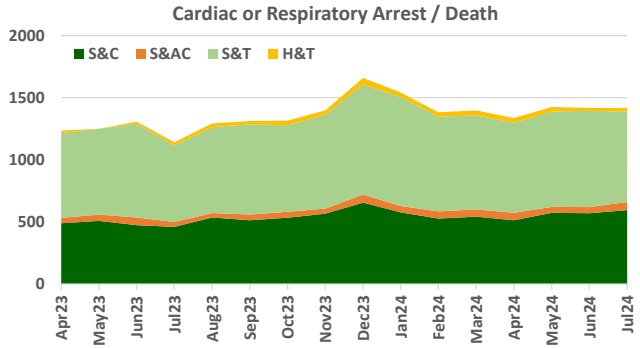
Red = lowest trust, Green = highest trust

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

AQI Performance

No concerns for escalation

Cardiac



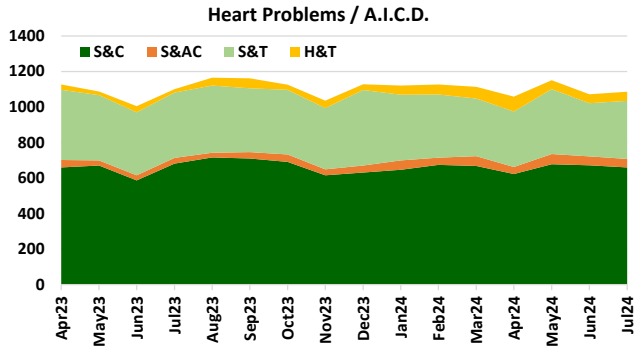
Operational Performance - last 3 months

	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	3,786	46%	4%	50%	6.0	40	45	92
Cat 2	4	0%	0%	100%	16.2	-	-	108
Cat 3	273	1%	0%	99%	9.8	45	-	91
Cat 4	0	-	-	-	-	-	-	-
Cat 5	108	1%	0%	99%	16.9	1	-	78

Quality Performance - last 3 months

	ROSC by hospital arrival		
	ROSC	count	%
NW	111	307	36%
NC	46	159	29%
NE	54	214	25%
SE	62	247	25%
SW	62	190	33%
OTHER	34	122	28%
LAS	369	1239	30%

Heart



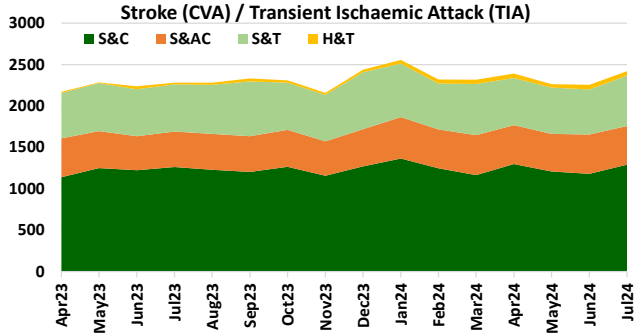
Operational Performance - last 3 months

	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	48	73%	13%	15%	6.8	33	34	103
Cat 2	2,706	65%	5%	31%	35.1	38	38	75
Cat 3	394	57%	5%	38%	70.3	40	39	68
Cat 4	1	100%	0%	0%	252.8	38	-	-
Cat 5	6	17%	0%	83%	25.9	41	-	81

Quality Performance - last 3 months

	ROSC by hospital arrival		
	ROSC	count	%
NW	334	346	97%
NC	153	155	99%
NE	236	244	97%
SE	284	303	94%
SW	216	221	98%
OTHER	45	47	96%
LAS	1268	1316	96%

Stroke



Operational Performance - last 3 months

	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	5	80%	20%	0%	5.3	82	97	-
Cat 2	6,141	54%	22%	24%	36.9	43	34	81
Cat 3	614	52%	9%	39%	57.5	43	37	76
Cat 4	1	100%	0%	0%	258.6	28	-	-
Cat 5	27	44%	4%	52%	38.7	32	38	72

Quality Performance - last 3 months

	ROSC by hospital arrival		
	ROSC	count	%
NW	54	68	79%
NC	36	40	90%
NE	32	43	74%
SE	44	53	83%
SW	32	39	82%
OTHER	4	9	44%
LAS	202	252	80%

Cardiac Arrest:

The LAS ranked 1st with 32.0% of patients achieving ROSC which was sustained to hospital arrival, well above the national average of 26.9%. In the Utstein comparator group, this value was 52.0%, surpassing the national average of 46.5% and placing the LAS in 2nd position.

LAS was the second-best performing Trust for both overall and Utstein survival. 12.3% of patients in the overall group survived for 30 days against a national average of 9.1% and in the Utstein comparator group, 34.7% survived against a national average of 27.6%.

The post-resuscitation care bundle compliance was not published by NHS England this month.

STEMI:

In March 2024, the LAS achieved an average time of 02:22 for the Call to Angiography measure*. This was 7 minutes shorter than in February, and 8 minutes shorter than the national average of 02:30, ranking the LAS in 3rd place against all other ambulance services.

STEMI Care Bundle data was not published for March 2024. The next data will be released in September 2024 (for April 2024 patients).

Stroke:

The LAS achieved a call to arrival at hospital time of 01:27 **. While exceeding the national average of 01:34, the LAS is ranked 4th among other ambulance services, dropping from the 3rd place in February.

***Based on MINAP data which may not be a complete sample and could change during the revision period.*

***Based on SSNAP data which may not be a complete sample and could change during the revision period.*

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

No concerns for escalation

CPI Audits

Audited rate of compliance to care	Jan23	Feb23	Mar23	Apr23	May23	Jun23	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24
Completion rate	80%	84%	77%	82%	83%	72%	78%	78%	77%	80%	82%	84%	93%	80%	83%	86%	93%	
Cardiac arrest	96%	97%	97%	97%	97%	96%	97%	97%	97%	97%	98%	97%	97%	98%	98%	97%	98%	
Discharged at scene	97%	97%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	97%	97%	97%	96%	
Mental health (Diagnosed)		96%		95%		96%		95%		96%		95%		95%		96%		
Mental health (Undiagnosed)	95%		95%		96%		95%		95%		94%		96%		96%		95%	
Sepsis	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	
DIB		96%		96%		96%		96%		96%		95%		96%		95%		
Elderly falls	94%	95%	95%	94%	95%	95%	95%	94%	94%	95%	95%	95%	95%	96%	96%	95%	95%	
End of life care	95%		95%		94%		95%		95%		95%		95%		96%		95%	

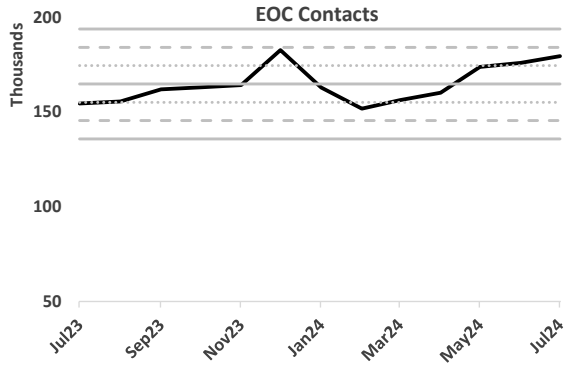
Red = worst month, Green = best month

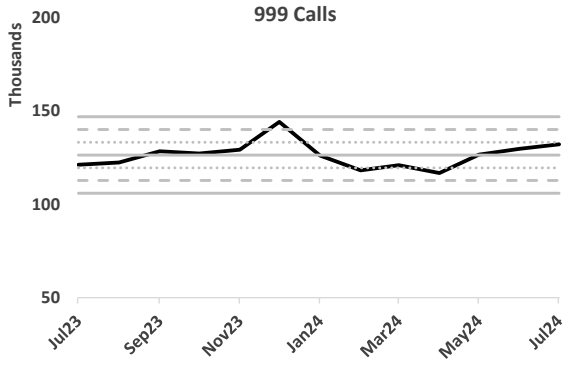
Safe | **Effective** | Caring | Improve | Priority | Owner SW | Exec Lead FW

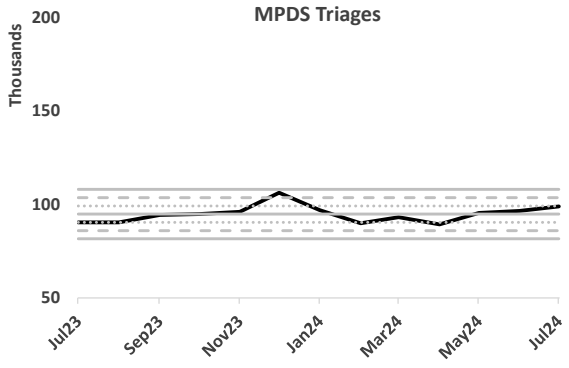
Call Handling

No concern for escalation

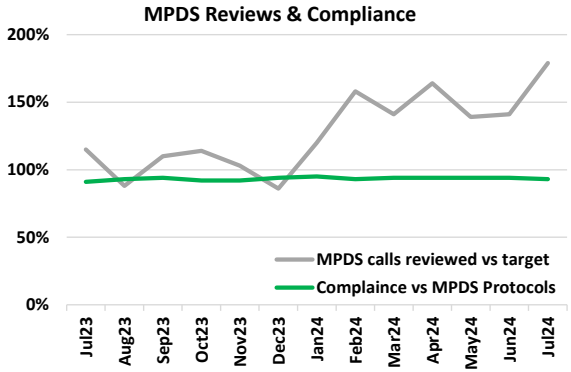
Call Volumes

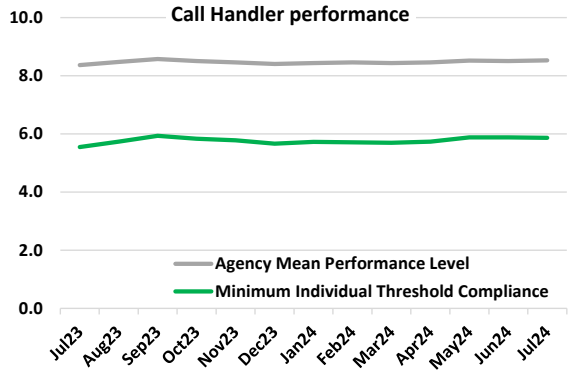


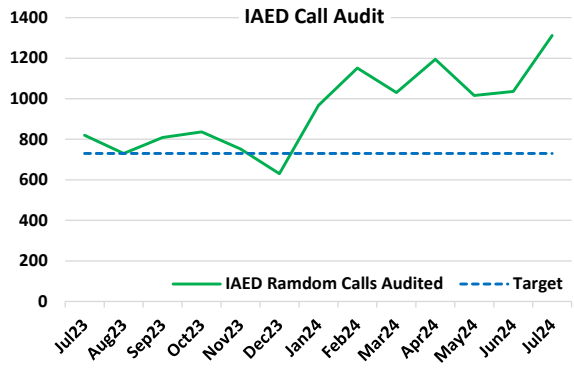




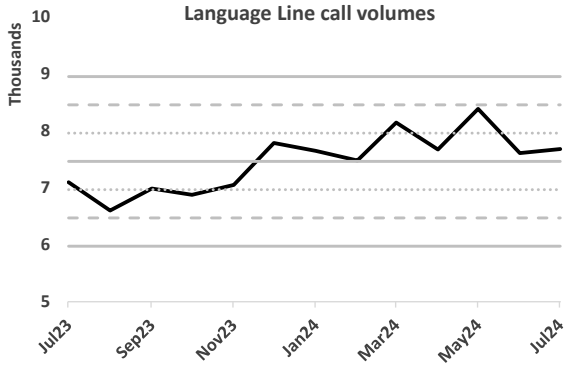
CH Performance

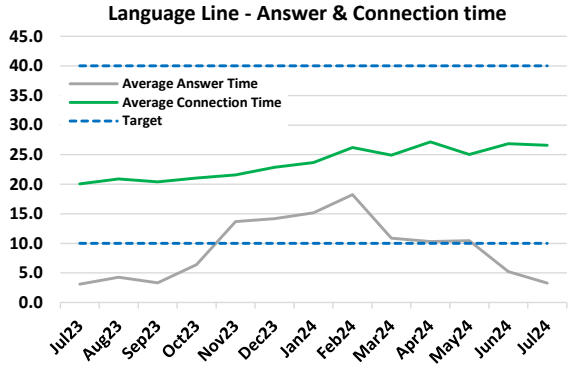


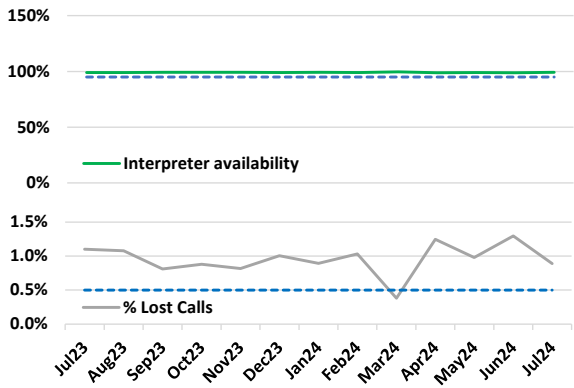




Language Line





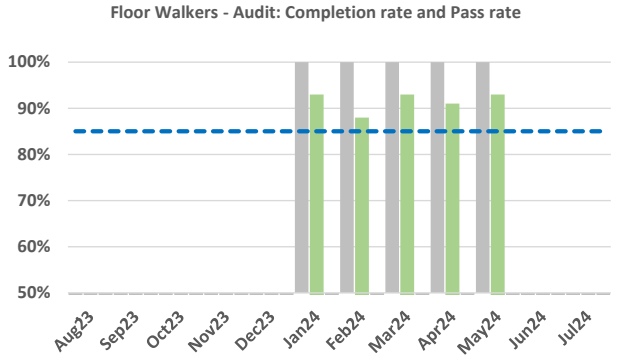


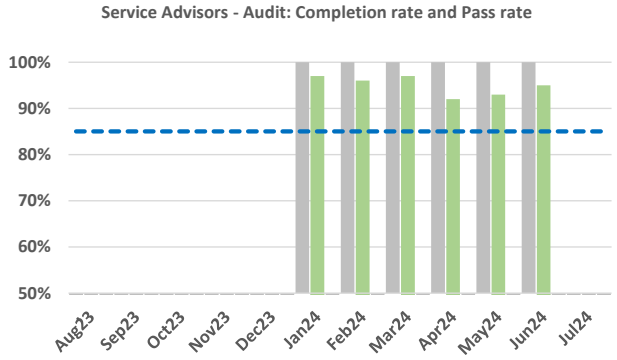
- We achieved ACE in good standing for Q2 (Apr-Jun 24), and huge congratulations to the QA department for all their hard work on this achievement. Supporting EOC staff to improve and maintain high compliance levels is testament to the hard work of the team. The QA Team were nominated for Team of the year in their respective category.
- Data is still being gathered into staff demographics within EOC, the call handler new entrant recruitment and turnover rates in order to identify trends and variation affecting the Quality Assurance department. The review will continue to look at the impact of increased volumes of QA requests from Governance, Legal and Safeguarding, and the increasing requirement for additional support to EOC staff.

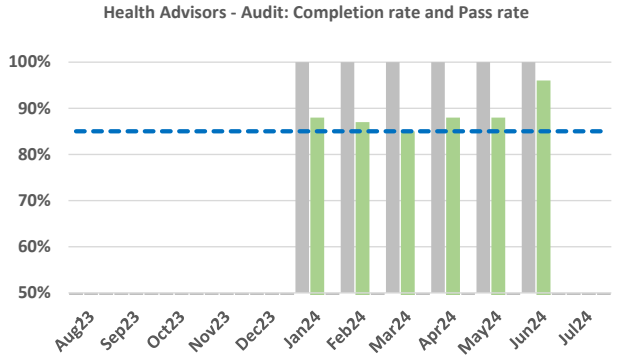
Safe | **Effective** | Caring | Improve | Priority | Owner JN | Exec Lead FW&RP

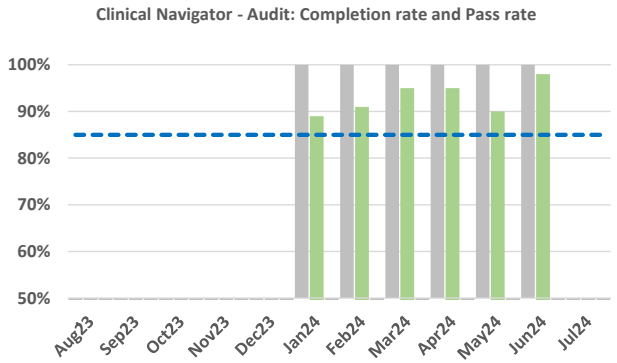
111 Quality Audit - SEL

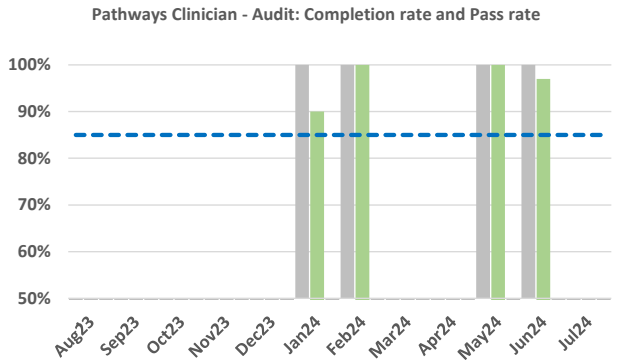
No concerns for escalation

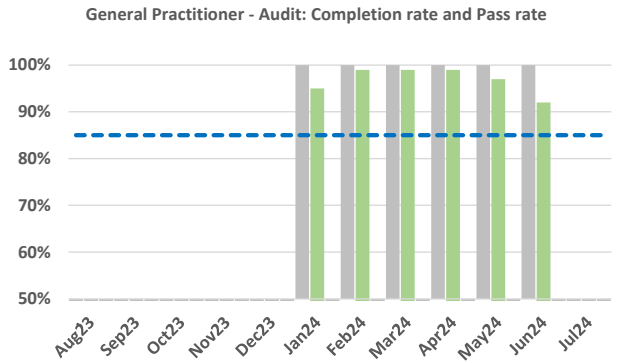












Pass rate (above target) | Pass rate (below target) | Completion rate

Service/Health Advisors

- Themes identified from the failed audits were; failing to provide worsening and failing to operate within the boundary of their role

Clinical Navigator/Pathway Clinician

- Improvement seen with appropriateness of clinical advice calls coming though to headset
- Where there are issues, same issues of trust in NHSP & processes
- Improvement seen with compliance of a SBAR handover

GP/ACP

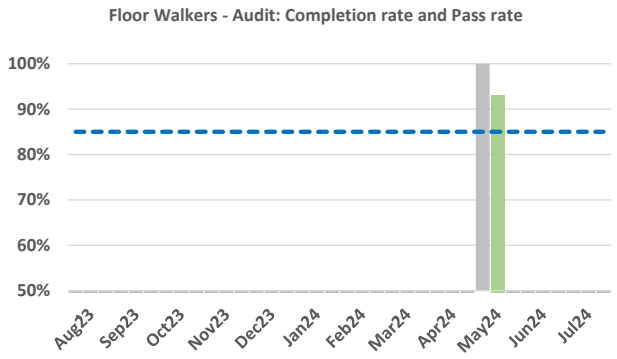
- Not given targeted worsening care advice
- Unstructured assessment
- Documentation improvement required

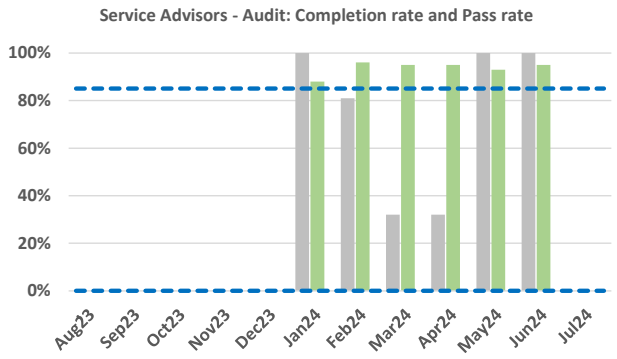
*data not available for July 2024

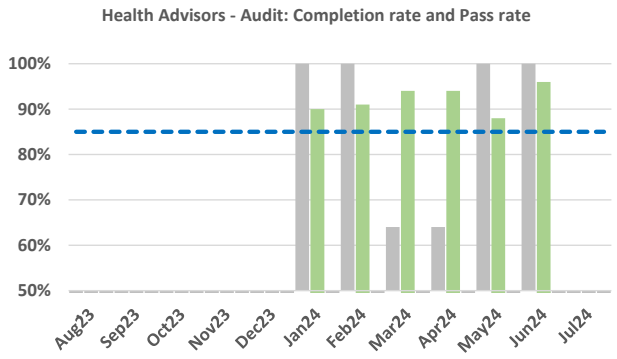
Safe | **Effective** | Caring | Improve | Priority | Owner JN | Exec Lead FW/RP

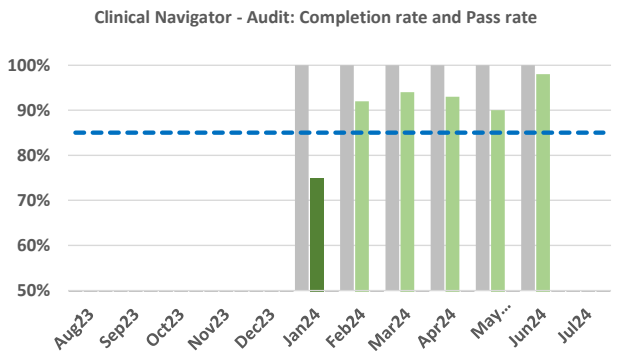
111 Quality Audit - NEL

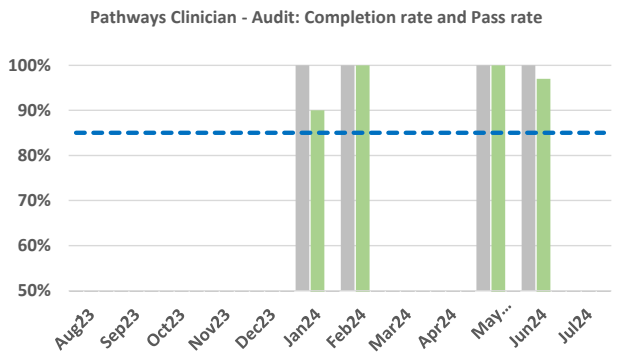
No concerns for escalation

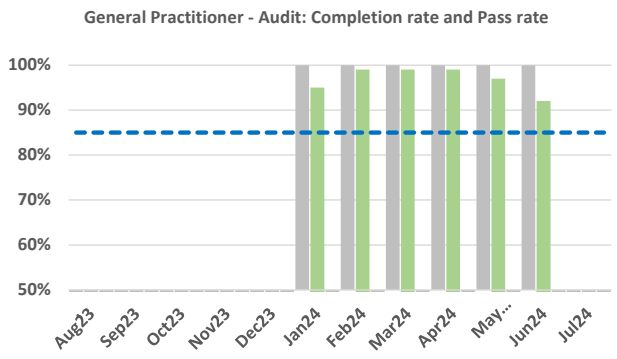












Pass rate (above target) | Pass rate (below target) | Completion rate

Service/Health Advisors

- Themes identified from the failed audits were; failing to provide worsening and failing to operate within the boundary of their role

Clinical Navigator/Pathway Clinician

- Improvement seen with appropriateness of clinical advice calls coming though to headset
- Where there are issues, same issues of trust in NHSP & processes
- Improvement seen with compliance of a SBAR handover

GP/ACP

- Not given targeted worsening care advice
- Unstructured assessment
- Documentation improvement required

*data not available for July 2024

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

No concerns for escalation

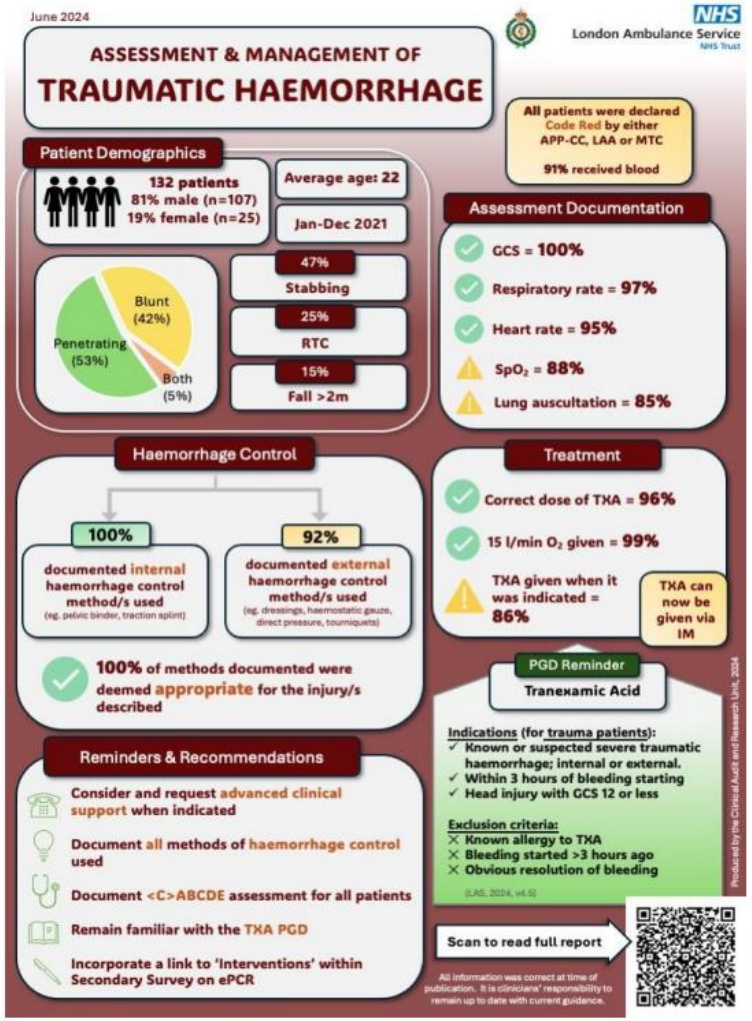
CARU

Research

- The Spinal Immobilisation study (SIS) is recruiting strongly, with 35 patients enrolled into the trial in June and 38 enrolled in July.
- CRASH-4 recruitment at LAS has surpassed 200 patients.
- PARAMEDIC-3 has closed to recruitment, with LAS the highest performing Ambulance Service for recruitment. The first results will be available in the early Autumn.
- 16 patients were recruited to RAPID-MIRACLE across June and July, bringing total recruitment to nearly 300.
- The LAS are currently supporting two external qualitative projects looking at falls (AMBOFALL) and clinician experience of attending stabbings.

Clinical Audit

- In June we published our latest clinical audit report which focuses on the assessment and management of traumatic haemorrhage by the LAS. The results of this clinical audit demonstrates some excellent areas of practice, particularly around appropriate choice of haemorrhage control methods and conveyance decisions. However, documentation of some aspects of assessment, such as lung auscultation and oxygen saturation readings, the use of external haemorrhage control methods and the administration of TXA, where indicated, require improvement. The recommendations for improvement include:
  - Encouraging the documentation of all methods of haemorrhage control used including any internal haemorrhage control methods, as well as external methods such as bandages, haemostatic agents and tourniquets.
  - Reminding clinicians to record all vital signs and aspects of a patient assessment on the ePCR.
  - Reminding clinicians of the inclusion and exclusion criteria of TXA administration according to the PGD.
  - Enhancing awareness of the need to request advanced clinical support when indicated.
- In July we approved two new facilitated clinical audit projects, one to complement the sickle cell improvement plan and the other looking at the Emergency Responder Group's medication administration.

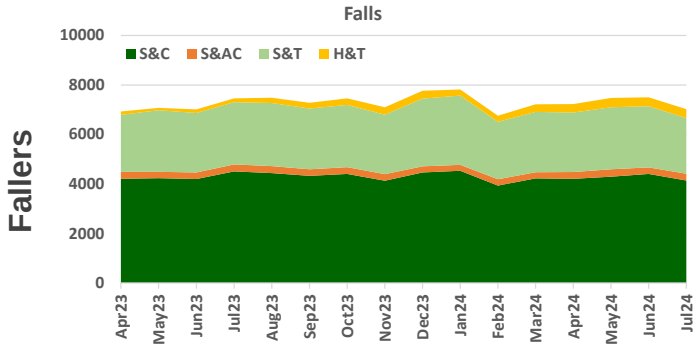


Safe | Effective | **Caring** | Improve | Priority | Owner | Exec Lead FW

Summary 1 of 2

No concerns for escalation

Falls



Operational Performance - last 3 months

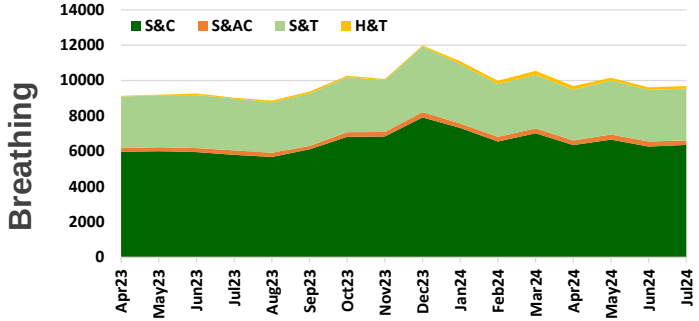
	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	1,008	73%	11%	16%	7.4	41	43	72
Cat 2	11,880	68%	4%	27%	34.9	50	48	84
Cat 3	7,288	51%	3%	46%	53.0	54	50	82
Cat 4	15	40%	7%	53%	158.3	42	73	74
Cat 5	718	38%	1%	61%	56.3	62	34	84
ALL	20,909	61%	4%	35%	40.7	51	48	83

Quality Performance May24

Compliance to care - CPI - Elderly falls

	%
NW	96%
NC	95%
NE	95%
SE	95%
SW	94%

Breathing Problems



Operational Performance - last 3 months

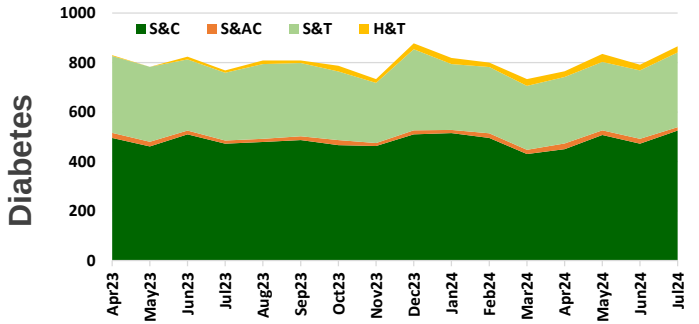
	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	9,561	72%	3%	25%	7.3	37	36	70
Cat 2	19,098	64%	3%	33%	35.9	42	40	81
Cat 3	256	54%	2%	45%	92.9	42	34	77
Cat 4	2	100%	0%	0%	154.9	30	-	-
Cat 5	101	46%	1%	53%	43.8	38	60	59
ALL	29,018	66%	3%	31%	27.0	40	39	78

Quality Performance Apr24

Compliance to care - CPI - DIB

	%
NW	95%
NC	93%
NE	97%
SE	96%
SW	96%

Diabetic Problems



Operational Performance - last 3 months

	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	404	61%	1%	37%	7.3	47	33	82
Cat 2	1,931	63%	2%	35%	33.4	42	45	83
Cat 3	43	63%	0%	37%	135.7	48	-	70
Cat 4	1	0%	0%	100%	48.9	-	-	49
Cat 5	32	41%	0%	59%	48.9	36	-	63
ALL	2,411	62%	2%	35%	31.0	43	44	83

Quality Performance -

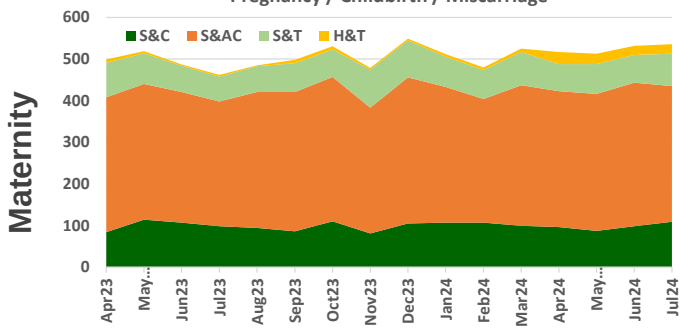
	%
NW	
NC	
NE	
SE	
SW	

Safe | Effective | **Caring** | Improve | Priority | Owner: CL/LS | Exec Lead: FW

Summary 2 or 2

No concerns for escalation

Pregnancy / Childbirth / Miscarriage



Operational Performance - last 3 months

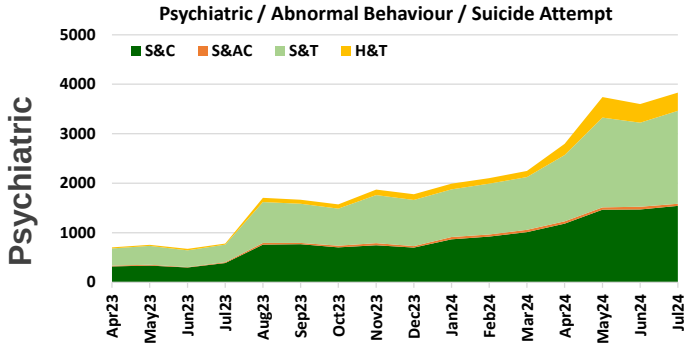
	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	1,042	17%	72%	11%	9.0	32	27	63
Cat 2	333	11%	73%	16%	22.7	37	30	57
Cat 3	113	60%	4%	35%	37.7	35	22	57
Cat 4	0	-	-	-	-	-	-	-
Cat 5	23	30%	26%	43%	33.4	25	26	44
ALL	1,511	19%	66%	14%	14.5	33	28	60

Quality Performanc May24

Compliance to care - CPI - Discharged at Scene

	%
NW	96%
NC	97%
NE	97%
SE	95%
SW	97%

Psychiatric / Abnormal Behaviour / Suicide Attempt



Operational Performance - last 3 months

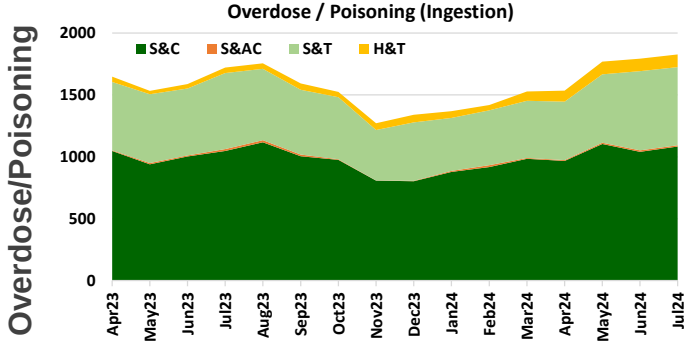
	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	266	66%	9%	26%	9.2	44	51	75
Cat 2	2,412	56%	1%	42%	41.9	50	46	88
Cat 3	5,382	39%	1%	60%	88.2	50	61	79
Cat 4	8	25%	0%	75%	265.3	26	-	66
Cat 5	1,944	43%	2%	55%	83.8	50	76	75
ALL	10,012	45%	1%	54%	74.2	50	59	80

Quality Performanc Apr24

Compliance to care - CPI - Mental Health (diagnosed)

	%
NW	96%
NC	94%
NE	97%
SE	96%
SW	98%

Overdose / Poisoning (Ingestion)



Operational Performance - last 3 months

	F2F Incidents				Perf	On Scene Time		
	Total	S&C	S&AC	S&T		S&C	S&AC	S&T
Cat 1	398	68%	1%	31%	6.9	37	56	60
Cat 2	3,786	65%	1%	35%	41.6	41	49	67
Cat 3	842	58%	1%	41%	71.5	41	34	65
Cat 4	0	-	-	-	-	-	-	-
Cat 5	57	42%	0%	58%	82.9	39	-	55
ALL	5,083	63%	1%	36%	44.3	41	47	66

Quality Performanc May24

Compliance to care - CPI - Mental Health (undiagnosed)

	%
NW	96%
NC	94%
NE	96%
SE	95%
SW	96%

Mental Health

- NWL ICB hosted a mental health workshop with LAS, mental health providers and commissioners. It has been agreed that the quarterly mental health LAS mental health provision meetings will be stood down and the agenda will be absorbed through other existing forums.
- The Mental Health Joint Response Cars (MHJRCs) continue to operate across the city apart from North East London. Due to the different operating model the MHJRC in NEL is currently not being provided as the provider is not supplying staff. This has been escalated to the CEO.
- To date the team have seen over 24,650 patients with an Emergency Department Conveyance of 18%.
- The LAS Mental Health team continue to provide subject matter expertise to ambulance operations colleagues whilst they launch their mental health transport ambulances.
- The team continue to engage with the Met Police Central Mental Health team.
- The team continue to deliver training sessions to various teams across the organisation as part of their teams.

Maternity

- Training – Teams Based Working model continues to be an efficient way for the maternity team to deliver face to face training. Obstetric emergency training delivered to 211 clinicians over 13 sessions/70.5 hours.
- National JRCALC updates in progress: cord prolapse, birth imminent, shoulder dystocia, eclampsia.
- New national maternity decision tool – launching later in the year. Incorporates new national maternity obstetric early warning score criteria.
- National Pre-hospital Maternity and Newborn Care conference 3rd September in Birmingham

London Ambulance Service NHS Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS – September 2024

Trust Quality Report – reporting on July 2024 data

This report focuses on the quality of care provided by London Ambulance Service (LAS). It should be read in conjunction with the quality performance pack to provide the Trust Board with an overview of quality across the Trust.

The report covers four domains:

- Safe
- Effective
- Caring
- Well Led – Quality Improvement

1. Safe

In this section we will review the areas which are under the safe domain and how we protect our patients from abuse and avoidable harm. This is covered in the quality report pages 3 – 12.

1.1 Maintaining Patient Safety

As has been reported in the combined performance report, during last the reporting period, we continued to see pressures across the Urgent and Emergency Care and Health and Social Care systems, with July seeing very high demand.

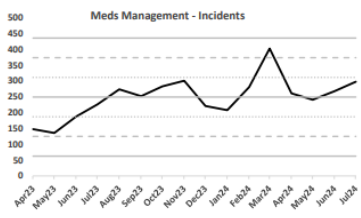
Oversight of patient safety, at periods of high demand, is maintained through use of the 999 and / or Integrated Urgent Care Clinical Safety Plans (CSP). CSP provides a framework for LAS to maintain clinical safety and deliver the fastest response to our sickest and most seriously injured patients whilst navigating patients with less serious conditions to care closer to home.

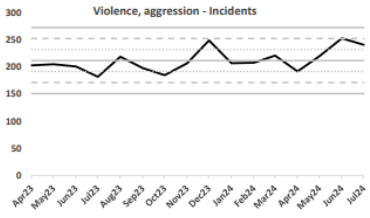
1.2 Safety incidents – 999

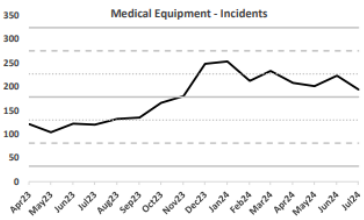
There has continued to be an increase in the reporting of patient safety incidents reflecting a positive reporting culture. The majority of incidents reported are within the no/low harm severity grading.

Tops categories for the reporting period are:

- Medicines management – specifically errors identified on audit of controlled drugs books
- Reports of violence/aggression – specifically direct verbal abuse
- Medical equipment – specifically failure of device / equipment







Moderate, severe harm and death reported incidents are reviewed via sector Patient Sector Incident Groups. Where incidents require a Learning from Death review, if they meet the nationally defined criteria, an enhanced investigation is undertaken using the Patient Safety Incident Framework. The harm grading is subject to change following this more in depth review. The number of reported incidents initially reported as moderate harm and death increased in July. The themes for July 2024 included 999 call handling, clinical assessment and treatment. These cases undergo 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.

1.3 Safety incidents – 999 Clinical Hub

During the month of July there were 32 incidents reported on the Trust Incident Management and Learning system (Datix), an increase of 6 reports on the previous month.

Out of the 32 incident reports, 31 were found to be no or low harm. Incident reports are not always indicative of issues or errors within the Clinical Hub but where the Clinical Hub has had involvement in the episode of care and this number is in line with a continued increase in the number of clinical assessments and safety reviews being undertaken. There was 1 moderate or above incident report which is an example of this and where a Clinical Hub CTN identified a call management error and took action to expedite a response to the patient.

8 cases were heard in multi-disciplinary PSIG and whilst learning was identified, none met the threshold for a Patient Safety Investigation under the national framework.

1.4 Safety incidents – 111 / integrated urgent care (IUC)

The number of incidents reported within IUC has, like the rest of the service, increased in the last few months for both no harm and low harm incidents. This is again due to the positive reporting culture within IUC and that staff are receiving timely feedback when they are reporting incidents. Staff working within 111 / IUC are able to see changes as a results of incidents and are therefore more likely to record incidents.

The top 3 incident categories in July 2024 were 111/IUC call handling (82), Communication, Care & Consent (39) and Clinical Concern Regarding External Provider (35).

IUC have seen concern regarding external providers enter and remain in the top 3 reported incidents overall. This is mainly due to concerns with downstream providers and general practices asking patients to call 111 to book an ambulance for transport to hospital and we have seen an increase in failed referrals to mental health teams. These incidents are reported to the individual services and raised with the Integrated Care Board leads for review and learning. IUC staff are receiving timely feedback when they are reporting incidents and staff are able to see changes as a results of incidents and are therefore more likely to record incidents.

1.5 Overdue incidents

The Trust continued to improve on the number of overdue incidents, noting 458 were overdue at the time this report was generated. This is an improvement when considering the Trust position of circa 900 overdue in April 2024 and 508 which were reported in the last quality report. Work continues to achieve the aim as outlined in the Trusts business plan.

IUC have the lowest number of open and overdue incidents since October 2023.

Improvement work is underway, meeting with corporate areas of the Trust whom own overdue incidents. Support documents/aide memoirs are being developed to assist with managers completing investigations. There is regular reporting and feedback is being provided to those areas with overdue incidents.

1.6 Infection Prevention and Control (IPC)

The overall hand hygiene rate for July 2024 was 97%. This score continues to exceed the Trust performance target (90%).

Deep cleaning compliance for ambulance is at 94% against a Trust target of 90%.

Monthly station cleaning compliance is 96% against a Trust target of 90%.

The Infection Prevention and Control Team are working closely with the Emergency Preparedness, Resilience and Response' (EPRR) and NHS England to ensure LAS guidance for Mpox remains in line with national guidance.

1.7 Medicines Management

The number of controlled drugs (CD) incidents remains high at 217. The majority of incidents (n=173) are in relation to errors when completing the CD register. Further training is being provided about the completion of the CD books. There have been no losses of schedule 2 controlled drugs.

1.8 Safeguarding

Safeguarding provides assurance through the Safeguarding Assurance Group to Clinical Quality Oversight Group internally and the Brent Safeguarding boards for children and adults externally.

Safeguarding referrals and concerns being raised by staff have increased but remain within expected range, demonstrating staff awareness of safeguarding issues and the importance of reporting these. Work is ongoing to operationalise a new electronic safeguarding referrals system from Autumn this year which will further improve governance and provide assurance of safeguarding referrals as well as reducing the time taken to make a referral.

Safeguarding allegations against staff remain in line with last year's figures. The Sexual Safety Charter, posters, and newsletters have been distributed across the Trust. This is also an area of focus for all new staff joining the Trust with clear emphasis on the Trusts expectations. Mandatory sexual safety e-learning is now live to all staff. The Trust has established a Sexual Safety Working Group to aid improvements in this area. The Trusts Disclosure and Barring rechecks are continuing and progress is reported via the Safeguarding Assurance Group.

The Trust's level 2 training compliance is improving, with focussed work being undertaken to bring compliance to the required level. The Trust remains fully compliant with level 1 and level 3 safeguarding training.

1.9 Health Safety and Security

The HS&S Team have delivered 4 sessions of Managing Safety courses to a total of 77 staff members, 4 sessions of Corporate Induction and 1 session of Fire Marshal training to 26 staff members during 2024/25 (up to end of July '24). All these sessions have received positive feedback. The Stress Assessment Toolkit Training continues to be a helpful tool to support managers undertaking stress risk assessment for staff that they manage, and continues to be available on a monthly basis (except in August).

A total of 50 RIDDOR incidents have been reported to the Health and Safety Executive (HSE) up to the end of July 2024. Manual handling incidents account for the highest number of RIDDOR reports. A total of 21 RIDDOR incidents were reported to HSE during July 2024. The Trust wide RIDDOR reporting time frame (<15 days) compliance in July 2024 was 71%.

Current compliance for FFP3 fit testing is 68% (there is a 2-year revalidation period). The ongoing plan is to bring Fit Testing in house to be delivered through group station teams, and arrangements are progressing to purchase more fit testing machines ahead of the delivery of a comprehensive training program.

A total of 266 physical assaults on staff have been reported since April 2024 up to end of July 2024. The greatest number of reported physical assaults (57%) occur due to the clinical condition of the patient. Police attended 54% of physical assault incidents. There have been 2 successful prosecutions for assault so far in 2024/25.

2. Effective

This section considers whether LAS is providing an effective service by which we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. This is covered in the Quality Report pages 12 - 19.

2.1 Clinical Performance Indicators (CPI)

Every month the Clinical Audit & Research Unit produce CPI reports and progress charts. CPIs are a tool used to continuously audit the care the Service provides to 9 different patient groups. The embedding of team based working in sectors has maintained the improvement in the completion of CPIs with over Trust-wide 93% being completed in May 2024. Areas for learning from the CPI audits are shared with the Sector Senior Clinical Leads to incorporate into local training sessions and team huddles.

2.2 Clinical Ambulance Quality Indicators

Through our clinical registries we continue to monitor and report the care provided to patients experiencing either a cardiac arrest, ST elevation myocardial infarction (STEMI), 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 however this is now being produced monthly. The Quality report for July 2024 includes the March 2024 clinical outcomes data which were published on 8 August 2024.

In March 2024 the LAS ranked 1st with 32.0% of patients achieving ROSC which was sustained to hospital arrival, well above the national average of 26.9%. In the Utstein comparator group (patients with cardiac arrest of presumed cardiac origin where the arrest was bystander witnesses and the initial rhythm was Ventricular Fibrillation or Ventricular Tachycardia), this value was 52.0%, surpassing the national average of 46.5% and placing the LAS in 2nd position.

LAS was the second-best performing Trust for both overall and Utstein survival rates. 12.3% of patients in the overall group survived for 30 days against a national average of 9.1% and in the Utstein comparator group, 34.7% survived against a national average of 27.6%. The post-resuscitation care bundle compliance was not published by NHS England this month.

For our STEMI patients, in March 2024, the LAS achieved an average time of 02 hours and 22 minutes for the Call to Angiography measure*. This was 7 minutes shorter than in February, and 8 minutes shorter than the national average of 2 hours and 30 minutes, ranking the LAS in 3rd place against all other ambulance services. STEMI Care Bundle data was not published for March 2024. The next data will be released in September 2024 (for April 2024 patients)

**This is based on MINAP data which is subject to change during the revision period*

For our stroke patients the March SSNAP data showed LAS achieved a call to arrival at hospital time of 1 hour and 27 minutes against a national average of 1 hour and 34 minutes.

We are maintaining our focus through the 999 Emergency Operations Centre and Ambulance Operations teams to ensure ambulances are available and dispatched to patients as quickly as possible for all time critical patients. This is an area of focus for the new EOC team huddles.

For front-line clinicians' guidance around time critical patient management on scene has been reviewed and shared and the sector senior clinical leads and clinical team managers are focused on briefing clinicians during Team Huddles and local teaching using case based

discussions to share best practice.

2.3 Cardiac Arrest data – June 2024

Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) which includes signs of breathing, coughing, movement, 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 achieving return of spontaneous circulation (ROSC) are the speed of starting basic life support and defibrillation when the patient's heart is in a shockable rhythm. Our June 2024 cardiac arrest data indicates:

- 1001 patients in cardiac arrest were attended by LAS
- 344 patients had resuscitation commenced
- The median time from 999 call to dispatcher assisted basic life support (chest compressions) was 3:56
- Mean time from arrival on scene to first LAS defibrillation was 3 minutes
- For all patients in cardiac arrest return of spontaneous circulation was achieved in 44% of patients

2.4 'Chain of Survival'

Cardiac arrest survival increases the earlier we can start the 'Chain of Survival' with chest compressions and defibrillation – this is often started by our volunteer community first responders. The swift actions of passers-by can also make the difference between life and death. We are working hard to encourage members of the public to be trained in basic life support and become London Lifesavers (find out more and register for training here: https://www.londonambulance.nhs.uk/getting-involved/become-a-london-lifesaver/).

2024	April	May	June	July
Year 8 school children trained	15, 803	17, 821	19, 032	21,128
Total London Lifesaver Numbers	715	1,304	315	902
Public access defibrillators (PADs)**	9264	9438	9551	9627
PAD activations	13	14	9	15
Return of spontaneous circulation	9	9	7	11

** The variation in numbers is due to PADs on the Circuit being automatically removed when a consumable needs replacing and then the guardian of the PAD having to re-upload it once the consumable has been replaced.

2.5 Call handling quality assurance

The EOC Quality Assurance (QA) department continue to exceed the audit requirements for incoming 999 call demand. In the last reporting period, 180% of required audits were undertaken. We have maintained our last reported position of 89% audited calls being highly

compliant or compliant. The team are consistently achieving the volume of audits and required feedback to staff also in particular where there is support and learning required. This also ensures we maintain our position as an Accredited Centre of Excellence with the International Academy of Emergency Dispatch.

The EOC QA department are working closely with EOC in the implementation of Teams Based Working and sharing learning from incidents and best practice. This will include delivery of materials on Teams Huddles along with supporting the curriculum for EOC Core Skills Refresher courses as well as training for Emergency Call Handlers in preparation for the deployment of AMPDS Version 14.

2.6 Clinical Audit and Research

Clinical audit is a tool to improve clinical quality and patient care which plays an important role in ensuring that the highest standard of care is delivered to patients across the National Health Service (NHS). It enables organisations to demonstrate the quality of their services, and identify areas for improvement or where further education may be needed. Clinical audit can also highlight where new investment and resources are needed to support clinical practice. Most importantly, it can reduce variability in practice and improve standards of clinical care. Clinical audit can also provide a valuable contribution to the existing evidence base. It is now common practice to find results being used to inform local protocols and national ambulance clinical practice guidelines.

Clinical audit can also bring benefits to participating clinicians demonstrating how evidence can be used to inform practice, enabling them to be a direct part of that change. It also demonstrates their commitment to continued professional development. In addition, by providing insight into how information from clinical records is used, it can enhance clinicians' own documentation.

In June we published our latest clinical audit report which focuses on the assessment and management of traumatic haemorrhage by the LAS. The results of this clinical audit demonstrates some excellent areas of practice, particularly around appropriate choice of haemorrhage control methods and conveyance decisions. However, documentation of some aspects of assessment, such as lung auscultation and oxygen saturation readings, the use of external haemorrhage control methods and the administration of TXA, where indicated, require improvement. The recommendations for improvement include:

- Encouraging the documentation of all methods of haemorrhage control used including any internal haemorrhage control methods, as well as external methods such as bandages, haemostatic agents and tourniquets.
- Reminding clinicians to record all vital signs and aspects of a patient assessment on the ePCR.
- Reminding clinicians of the inclusion and exclusion criteria of TXA administration according to the PGD.
- Enhancing awareness of the need to request advanced clinical support when indicated.

The research team continue to be busy;

- The LAS is participating in the Spinal Immobilisation Study (SIS), a randomised controlled trial which aims to determine whether movement minimisation is non-inferior to triple immobilisation (hard collar, blocks and scoop) for trauma patients with suspected cervical spine injury. This study is recruiting strongly, with 35 patients enrolled into the trial in June and 38 enrolled in July.
- CRASH-4 is exploring the role of intramuscular Tranexamic Acid (TXA) in older patients with mild symptomatic traumatic brain injury. Trial-trained paramedics administer the trial drug, containing either TXA or a placebo, to these patients on scene CRASH-4 recruitment at LAS has surpassed 200 patients.
- PARAMEDIC-3 is a randomised-controlled trial investigating the best way to deliver drugs to patients in cardiac arrest. Ambulance services across England and Wales are taking part, and the study aims to recruit 15,000 patients. Eligible patients will be randomised to an intravenous-first (IV) or intraosseous-first (IO) vascular access strategy. PARAMEDIC-3 has now closed to recruitment, with LAS the highest performing Ambulance Service for recruitment. The first results will be available in the Autumn.
- RAPID-MIRACLE is a prospective observational study aiming to validate the $MIRACLE_2$ score in the prehospital setting. The $MIRACLE_2$ 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. 16 patients were recruited to RAPID-MIRACLE across June and July, bringing total recruitment to nearly 300.

3.0 Caring

This section considers whether the service we provide involves and treats people with compassion, kindness, dignity and respect. It is covered in the quality report pages 21-22.

3.1 Health Inequalities

As the only pan-London acute provider, LAS has a unique insight into the Health Inequalities being experienced by Londoners.

The Health Inequalities work is progressing in line with the agreed timescales and key highlights since the last reporting period include:

Governance

The Equality, Diversity and Inclusion (EDI) committee have been consulted in the identification of the key areas of focus for quality improvement as part of the Reducing Health Inequalities action plan.

The Health Inequalities team will report bi-monthly into the EDI committee, with a focused Health Inequality agenda, in order that assurance and oversight occurs at the appropriate forum.

Patient deep dives

The engagement work conducted by two third sector partners: Sickle Cell Society and Croydon Sickle Cell and Thalassaemia support group has concluded, with both Organisations submitting reports of their findings to LAS. These are being analysed and triangulated with clinical audit findings, to form an 'Improving Sickle Cell Care' action plan, due to be launched in Q3 2024/25. A patient story at the Trust Board in September will focus on living with sickle cell.

Work has also begun to scope patient engagement for our Maternal Health focus, including patients with a global majority ethnicity and those without ante-natal care. A number of discussions and visits to charitable Organisations have occurred and the expression of interest tender invitation is being finalised by the Health Inequalities team, ready for publication in September. We expect the Health Inequalities panel to score the submissions in October 2024 and start the work with the selected Voluntary, Community and Social Enterprise organisations from November 2024.

Creating the 5 year 'Reducing Health Inequalities Action Plan'

The 'LAS PLUS' cohort, which are five priority areas based on local population inequalities and interventions within the scope of LAS, has now been agreed and the overarching 5 year Action Plan is in development.

The action plan is based on the Core20PLUS5 NHS framework and specific projects have now been agreed under all 3 elements (Core 20%, LAS PLUS, 5 nation priorities). Additionally, wider (social) Determinants of Health, where LAS can contribute to the improvement of population health, have been identified.

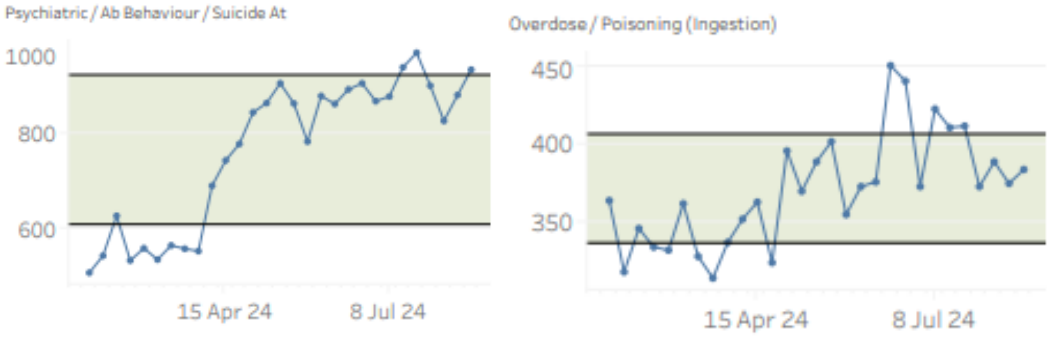
The following projects have also commenced;

- Smoking Cessation signposting
- Alcohol and Drug Addiction signposting
- Damp and Mould identification
- Patients experiencing Homelessness - supporting individualised care through UCP
- Inclusivity of Worsening Care advice (language proficiency and reasonable adjustments

LAS continues in discussion with NHSE to obtain access to patients' ethnicity details, which are held within the system but not available to ambulance services. Discussions are progressing positively, with the need for this information to be shared as necessary to reduce health inequalities. Information Governance and technical facilitation of data receipt is currently being collaboratively explored.

3.2 Mental Health Care

Mental health presentations have continued to increase since April 2024 as demonstrated in the weekly graph below showing the number of 999 calls being received where mental health was the primary complaint



Ensuring that patients suffering a mental health crisis receive easy access to the right care is a priority at both a Trust and regional / national level. The Trust continues to operate five Mental Health Joint Response Cars (MHJRCs) daily across four of the Integrated Care Systems (ICS) areas, with North East London as the exception. The team continues to maintain a see and treat rate of around 80%. Overall, there has been an improvement in productivity and performance, with the team averaging 4.68 calls per shift and a utilisation rate of 81%.

Recruitment to the expanded team, coupled with a rota review, provide further resilience to the team.

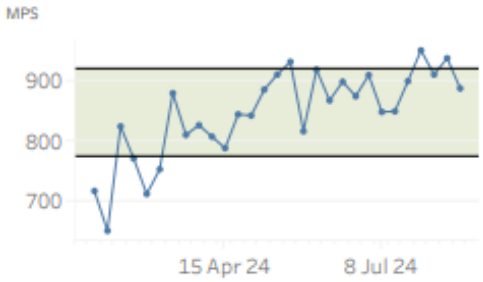
There is also a current focus on training and education across the wider Trust. In conjunction with the Clinical Education team and South London and Maudsley NHS Foundation Trust, the team is launching a bespoke pre-hospital mental health care training package

Data June/July 2024

	June- 24	July - 24
Monthly Utilisation	81%	81.8%
Activations	716	804
ED conveyance rate	80.8%	80.76%

RCRP

The Trust has embedded all of the RCRP activity into business as usual processes now. Close monitoring continues of activity relating to RCRP; and on average the Trust now sees between 350-400 calls received electronically from the Metropolitan Police Service (MPS) each day. This does not include patients who have called 999 directly and have already contacted the police. The weekly demand chart shows the increasing numbers of patients referred to LAS from the MPS.



A challenge which the Trust is currently working through is the volume of calls relating to 'welfare' checks. These 999 calls present a triage and clinical challenge as they are frequently not medical presentations but presentations relating to social problems or missing patients from acute Trusts who do not have the means by which to respond. This is something the LAS continues to work through with NHS partners via the NHS RCRP / MPS partners board.

3.3 Pathways and Care Co-Ordination

As per both the Trust's strategy and business plan; as well as the UEC recovery plan initially released in 2023 and updated in May 2024; the Trust continues to work towards an integrated care coordination approach. This concept is well developed in North West London (NWL) and will be the basis for other conversations across London. LAS has an integral role in the development of these coordination hubs given the oversight LAS has on the wider London NHS system and that the infrastructure exists to enable a joined up, cohesive approach. For patients this would result in more streamlined opportunities for LAS clinicians to make referrals and seek advice about alternative care pathways.

3.4 LAS Urgent Community Response Cars

Urgent Community Response (UCR) cars are continuing to operate with paramedics and external clinicians working together with continual review and learning to maximise the best staffing model. 13,666 patients have been attended by a UCR team to the end of July 2024.

The South East London (SEL) UCR car has now successfully been launched in collaboration with Oxleas running from Greenwich station. There is close working with external UCR providers to ensure that all capacity available is used in order to maximise the number of patients who would benefit from this response and not require an emergency ambulance or conveyance to an emergency department.

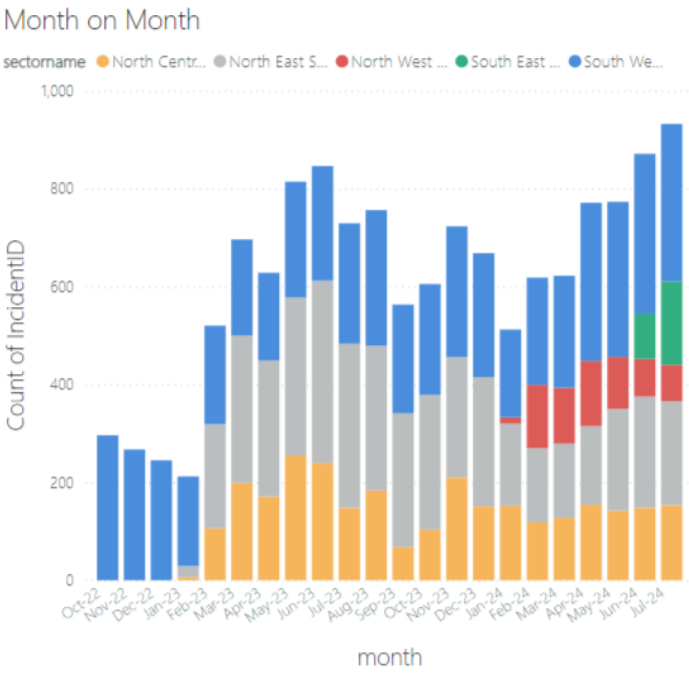
A plan continues to be developed, regarding the transition of specialist paramedics onto the UCR cars to increase the development opportunities for LAS clinicians and cover for the UCR cars.

LAS UCR Car – Data June/July 2024

	June	July
Total patients seen	779	932
Conveyed rate to ED (excluding Category 1s):	34%	36%
Total ambulances saved	223	270

London Ambulance Service NHS Trust

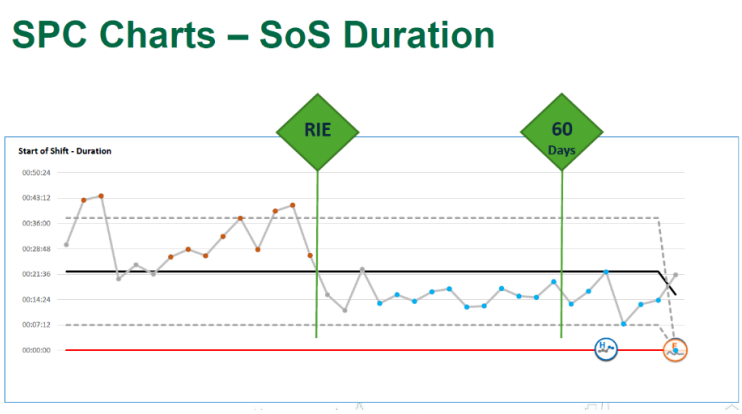
Patients seen per month



4.0 Quality Improvement and Regulation

Our three-year partnership with Surrey and Sussex Healthcare NHS Trust (SASH) commenced in June 2024. As part of this partnership, we have begun adopting lean methodology, and have commenced training with the first cohort of the five-day Lean for Leaders course delivered by SASH kaizen practitioners in June. Further half-day and full-day lean training for a variety of staff groups is planned for September and November. Also as part of the SASH partnership, the Trust Guiding Team (TGT) has formed, and is now meeting monthly as part of the Executive Committee. The TGT work to guide improvement activity across the Trust and champion the development of LAS Improve as our improvement approach. A development day for the executive committee has been planned to take place in September, at East Surrey Hospital.

The early success produced by the St Helier Start of Shift rapid improvement event was seen to be sustained at the 60-day improvement review, with the 15-minute mean maintained and an improvement on the process median time from 15 minutes 35 seconds to 14 minutes 14 seconds.



A programme of work is now commencing to scale the improvements across the Trust, using a market place approach to enable teams to share their improvements with others whilst enabling and empowering local ownership.

4.1 Quality Regulation

The Trust remains in regular contact with the Care Quality Commission (CQC), we have received no further regulatory visits since the system inspection in December 2021 and are not subject to any enforcement action.

The Head of Quality Regulation and Improvement and Senior Compliance Manager are now co-chairing the Association of Ambulance Chief Executives (AACE) National CQC Learning Group, and have commenced a piece of work to develop materials to assist ambulance Trusts interpret the new inspection frameworks and understand ‘what good looks like’.

London Ambulance Service NHS Trust

Audit Committee

Terms of Reference (effective August 2024-September 2025)

1. Purpose

1.1 The Audit Committee (the Committee) has been established to focus on the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

2. Constitution

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

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members, all of whom shall be non-executive directors of the Trust and have voting rights. The Trust Chair shall not be a member of the Committee.

5.2 At least one member of the Committee must have recent and relevant financial experience.

6. Chair

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

7. Attendance

7.1 The Chief Finance Officer and the Director of Corporate Affairs should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

7.2 The Non-Executive Chair of the Quality Assurance Committee should be invited to attend all Audit Committee meetings.

7.3 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

7.4 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

8. Quorum

8.1 The meeting will be quorate provided that two NED Committee members are in attendance, including the Chair of the Committee, or their nominated deputy (who must also be a Non-Executive Director). In the absence of the Chair, Committee members may nominate a deputy chair for the purposes of that meeting from their midst.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

11.1 The Committee shall meet a minimum of four time per annum. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

11.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12. Duties

Purpose

12.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

12.2 The Committee shall review the Board Assurance Framework and the corporate risk register annually and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.

12.3 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

12.4 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

12.5 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

12.6 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

12.7 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Assurance Committees of the Board and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

Internal Audit

12.8 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

12.8.1 approval of the appointment of internal auditors and any question of resignation and dismissal.

12.8.2 Review and approval of the Internal Audit strategy, operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

12.8.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

12.8.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

12.8.5 an annual review of the effectiveness of Internal Audit.

External Audit

12.9 The external auditor is appointed by the Trust Board on recommendation from a Panel established through the Audit Committee.

12.10 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

12.11 The auditor panel's functions are to:

12.11.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules

- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

12.11.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed external auditor;

12.11.3 Advise (if asked) the Trust Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

12.11.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

12.11.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor

12.12 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

12.12.1 consideration of the performance of the External Auditor;

12.12.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

12.12.3 discussion with the External Auditors of their local evaluation of audit risks;

12.12.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

12.12.5 discussion and agreement on the Trust's Annual Governance Statement.

Risk and Assurance Functions

12.13 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

12.13.1 review of the work of the Quality Assurance Committee in the management of clinical risk including assurance gained from the clinical audit function;

12.13.2 review of the work of the Finance and Investment Committee in the management of financial risk and the management of risk relating to IM&T, Estates, and Fleet & Logistics;

12.13.3 review of the work of the People and Culture Committee in the management of workforce risk;

12.13.4 Digital and EDI committees?

12.13.5 review of the Executive Leadership Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Risk Compliance and Assurance Group;

12.13.6 review the Board Assurance Framework to ensure that it is focussed on the key strategic risks to the business and clearly identifies

controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;

12.13.7 review of the findings of any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);

12.13.8 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

Counter Fraud

12.14 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Cyber and Information Governance

12.15 The Committee shall satisfy itself that the organisation has adequate arrangements in place for cyber security and information governance.

Management

12.16 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

12.17 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

12.18 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, the Committee shall ensure that arrangements are in place to enable the Trust to effectively respond to major, critical and business continuity incidents whilst maintaining services to patients

Financial Reporting

12.19 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

12.20 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

Other

12.21 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

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

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

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

London Ambulance Service NHS Trust

KPMG Audit Recommendation: Code of Governance review

There is a KPMG 2023/24 audit recommendation that requires action by the September Audit Committee:

Issue, Impact and Recommendation

From discussions with senior management, we established that the Trust had not evaluated itself against the Provider Code of Governance, which came into force from 1 April 2023. We also noted that the Trust had not prepared the disclosures regarding compliance with that Code within the annual report.[1]

Self-evaluation is important as it allows the Trust to identify areas where it is not acting in line with public expectations as to how it is governed and run, meaning that the Trust will be unable to take prompt action to bring itself in line.

We recommend that the Trust performs a formal annual self-evaluation, and presents findings and actions to the Audit Committee for further assessment.

Management Response/Officer/Due Date

The Trust will undertake a self-evaluation against the Provider Code of Governance and present the findings to the Audit Committee.

Director of Corporate Affairs

30 September 2024

For the purposes of transparency I have reproduced the Code of Governance Provisions below, along with a brief statement following each paragraph in red, setting out the LAS position. It should be noted that trusts are not required to give positive assurance on every statement, they are obliged to set out where they do not comply.

I have included the provisions for Foundation Trusts, but struck through the text for clarity.

[1] For the record, I told the auditors that I had reviewed the code of governance and satisfied myself that were compliant except for one area, which I noted in the annual report. I also inserted the following statement in the annual report "The Trust can confirm that is has complied with the NHS England Code of Governance with the exception of requirement 25, which states 'the chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director'. The Trust's chair of the audit committee is its senior independent director. The Trust is satisfied that the benefits of this arrangement outweigh any risks to the effective operation of the Audit Committee."

Code of Governance

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Section A, 2.2

The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.

The LAS Board has published its vision and values within its strategy, which sets out its role within London. It is used as described above.

[There is no 2.3]

Section A, 2.4

The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its

contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

Systems and processes to measure the Trust's effectiveness and efficiency are embodied in its quality and performance reports, and through the accountability and governance systems of the trust. The Trust board and its sub-committees regularly reviews the trust's performance, including those plans agreed through partnerships and collaborations.

Section A, 2.5

The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

The board has a full set of agreed metrics which it regularly reviews. It regularly commissions external advice e.g. the McKinsey review, Verita etc.

Section A, 2.6

The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

The Quality Assurance Committee leads on clinical governance and quality management and regularly reports to the Board.

Section A, 2.7

The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that

the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

The chair regularly engages with stakeholders. Committee chairs engage with stakeholders on matters within their responsibility. Stakeholder views are reported to the Board and discussed e.g. recent visit of regional director to Board.

Section A, 2.9

The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.

Achieved through Freedom to Speak Arrangements which are reported at People & Culture Committee and reported to Board.

Section A, 2.10

The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.

Achieved through Conflicts of Interest policy and monitored at Audit Committee.

Section A, 2.11

Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

No concerns have been raised but NEDs know this is open to them.

Section B, 2.1

The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring

that adequate time is available for discussion of all agenda items, in particular strategic issues.

The chair sets the agenda ensures time is available for discussion

Section B, 2.2

The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

The chair complies with this.

Section B, 2.3

The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

The chair facilitates this as evidenced by appraisal feedback.

Section B, 2.4 (NHS foundation trusts only)

~~A foundation trust chair is responsible for ensuring that the board and council work together effectively.~~

Section B, 2.5

The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

Not compliant as explained in annual report.

Section B, 2.7

At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

We have 8 NEDs and 5 EDs

Section B, 2.8

~~No individual should hold the positions of director and governor of any NHS foundation trust at the same time.~~

Section B, 2.9

The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. ~~For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.~~

Committee membership and chairing is reviewed as new NEDs are appointed.

Section B, 2.10

Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

We comply with this.

Section B, 2.11

~~In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.~~ For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.

Section B, 2.12

Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

The chair holds NED-only meetings as required.

Section B, 2.14

When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

Compliance demonstrated in the register of interests.

Section B, 2.15

All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

Everyone has access to the Director of Corporate Affairs.

Section B, 2.16

The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

This is a statement of law and policy.

Section B, 2.17

All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

This is a statement of law and policy and understood.

Section B, 2.16

All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

The LAS Board does this and reviews its effectiveness in doing so.

Section B, 2.17

The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.

The Board meets every month, alternately formally and in development mode. It has a scheme of delegation and reservation.

Section C, 2.1 (NHS foundation trusts only)

~~The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.~~

Section C, 2.2 (NHS foundation trusts only)

~~There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.~~

Section C, 2.3 (NHS foundation trusts only)

~~The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.~~

Section C, 2.4 (NHS foundation trusts only)

~~The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.~~

Section C, 2.5 (NHS foundation trusts only)

~~Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.~~

Section C, 2.6 (NHS foundation trusts only)

~~Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.~~

Section C, 2.7 (NHS foundation trusts only)

~~When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.~~

Section C, 3.1 (NHS trusts only)

NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

This is a statement of policy which the LAS complies with.

Section C, 4.1

Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.

The LAS is compliant with this and its FFP arrangements are currently being audited.

Section C, 4.3

The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need

for extension should be clearly explained and should have been agreed with NHS England.

The chair has been in post 2 years.

Section C, 4.4 (NHS foundation trusts only)

~~Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.~~

Section C, 4.5

There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. ~~For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair.~~ NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.

The LAS has annual appraisal of its directors and committees.

Section C, 4.6

The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

The chair and CEO act on review findings.

Section C, 4.8 (NHS foundation trusts only)

~~Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:~~

- ~~holding the non-executive directors individually and collectively to account for the performance of the board of directors~~
- ~~communicating with their member constituencies and the public and transmitting their views to the board of directors~~
- ~~contributing to the development of the foundation trust's forward plans.~~

~~The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.~~

Section C, 4.10 (NHS foundation trusts only)

~~In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.~~

Section C, 4.11

The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

This is part of the appraisal process.

Section C, 4.12

The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

This is the approach of our remuneration committee.

Section C, 5.1

All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

Our directors receive an induction and training.

Section C, 5.2

The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.

Achieved through appraisal and FFP processes.

Section C, 5.3

To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also

need to be appropriately briefed on values and all policies and procedures adopted by the trust.

Directors have the appropriate knowledge of the trust.

Section C, 5.4

The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

Our directors receive an induction and training.

Section C, 5.5

The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

Part of appraisal.

Section C, 5.6 (NHS foundation trusts only)

~~A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.~~

Section C, 5.8

The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

Information is freely available and subject to scrutiny and validation.

Section C, 5.9

The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as

facilitating appropriate induction and assisting with professional development as required.

Information is shared across the board.

Section C, 5.10

The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

Information is freely available and subject to scrutiny and validation. It is periodically reviewed for completeness and appropriateness.

Section C, 5.11

The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

This is the way the LAS board operates.

Section C, 5.12

The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The

availability of independent external sources of advice should be made clear at the time of appointment.

Independent advice is available where required.

Section C, 5.13

Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

Committees have the resources necessary to discharge their duties.

Section C, 5.14

Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

This is a statement of advice to NEDs.

Section C, 5.16 (NHS foundation trusts only)

~~Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.~~

Section C, 5.17

The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on

the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Directors are indemnified for acts made in good faith.

Section D, 2.1

The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

The deputy chair chairs the audit committee, but has the relevant skills and experience and there are other independent members with expertise.

Section D, 2.2

The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy
- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements

- reporting to the board of directors on how it has discharged its responsibilities.

Agreed

Section D, 2.3

A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.

Our external auditors were appointed less than 5 years ago.

Section D, 2.5

Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.

A policy is in development which will reflect current practice. Essentially we shall guard against threats to audit independence and identify the types of non-audit work that should not be commissioned from external auditors.

Section E, 2.1

Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.

- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary.
- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement

Any performance related additions comply with the conditions above, although most directors do not have a performance related element to their pay.

Section E, 2.2

Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

The LAS complies with this.

Section E, 2.4

The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.

The remuneration committee is reminded of this as appropriate.

Section E, 2.5

Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.

LAS complies with this.

Section E, 2.7

The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior

management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

LAS complies with this.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Section C, 4.9 (NHS foundation trusts only)

~~The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.~~

Section C, 5.7 (NHS foundation trusts only)

~~The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.~~

~~The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.~~

Section C, 2.9 (NHS foundation trusts only)

~~Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.~~

~~The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.~~

Section B, 2.13

The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.

All are agreed by the Board and available.

Section C, 4.2

Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

See https://www.londonambulance.nhs.uk/about-us/how-we-are-run/trust-board/trust-board-members/

Section E, 2.6

The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

The LAS remuneration committee complies with this.

Conclusion

As stated in the annual report, the Trust is compliant with the code, except for one area where we have stated our reasons for non-compliance.

Mark Easton

Director of Corporate Affairs

July 2024

London Ambulance Service NHS Trust

Digital and Data Quality Committee

Terms of Reference (effective July 2024-August 2025)

1. Purpose

1.1 The Digital and Data Quality Assurance Committee has been established in order to provide the Trust Board with assurance on the achievement of the London Ambulance Service NHS Trust's strategic objective in relation to the development and delivery of its digital strategy and assurance on non-financial data quality.

1.2 Scope of Committee:

- Digital & Data infrastructure supporting the service.
- Digital & Data Strategy, Transformation & Innovation to enable patient care
- Receiving assurance on the integrity and quality of all data apart from financial data.

2. Constitution

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

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust and shall consist of not less than five members (of whom three should be Non-Executive Directors), all of whom shall have voting rights. The Chief Digital Officer is the lead Executive committee member.

The executive members are:

- The Chief Digital Officer
- The Chief Clinical Information Officer,
- The Chief Paramedic

The committee shall have the ability to co-opt external (non-voting) advisory members who bring an independent, expert perspective.

6. Chair

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

7. Attendance

The following executives should normally attend Digital and Data Quality Assurance Committee meetings;

7.1 The Medical Director (Caldicott Guardian) and the Director of Corporate Affairs (SIRO)
7.2 The Caldicott Guardian if not the Medical Director.
7.3 The Director of Business Intelligence

The following should attend as required:
7.4 The Director of Finance when resources are being discussed
7.5 The Director of Strategy and Transformation when required
7.6 The Chief Executive can attend any meeting but must attend at least annually.

7.7 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance.

8.1.1 The Chair or nominated Chair of the Committee; and one other NED
8.1.2 At least two Executive Committee members, one must be the CDO or CCIO Officer.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

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

12. Duties

12.1 To gain assurance that:

i. The Trust Digital & Data Transformation Strategy aligns with the 2023-2028 Trust Strategy.

ii. Governance and Management of Digital & Data Transformation programmes are effective.

iii. Data quality Governance and management structure is operating effectively.

iv. Data Collection, validation, manipulation and reporting processes adhere to the Trusts Data Quality Policies and Standards.

v. The Trust's BAF risks, delegated to the committee, are being tracked and mitigated.

To aid its work the Committee will receive regular assurance from the Trust Data Quality Group and any audit reports on data quality and other digital matters within its remit.

12.2 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

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

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

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

London Ambulance Service NHS Trust

Finance and Investment Committee Terms of Reference (effective May 2024-June 2025)

1. Purpose

1.1 The Finance and Investment Committee has been established in order to provide assurance and make recommendations to the Trust Board on the finance and investment plans of the Executive Committee and to be assured of their consistency through discussion with other Board committees.

1.2 The Finance and Investment Committee also oversees and provides assurance on strategic development and investment whilst ensuring compliance with all regulatory and statutory duties and Trust strategy.

1.3 The Finance and Investment Committee shall conduct independent and objective review(s) of financial and investment policy and Investment.

2. Constitution

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

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

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

6. Chair

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

7. Attendance

7.1 The Trust Chair should be invited to all Finance and Investment Committee meetings.

7.2 The Director of Corporate Affairs and the Chief Financial Officer should normally attend all Finance and Investment Committee meetings.

7.3 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee Chair.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance:

8.1.1 The Chair or nominated Chair of the Committee plus one other non-executive director; and at least one of the two Executive Committee members, one of whom must be the Chief Executive or Chief Finance Officer or a Deputy Chief Executive.

9. Meeting administration

9.1 A member of the Committee Secretariat will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

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

12. Duties

Financial Policy, Management and Reporting

12.1 To consider the Trust's 2 – 5 year financial strategy, in relation to both revenue and capital prior to its submission to the Board.

12.2 To consider the Trust's annual financial targets and cash flow and to monitor progress against these.

12.3 To review the annual financial plan before submission to the Board.

12.4 The Committee will oversee the development of and progress against Trust efficiency and cost improvement programmes having due regard to the view of the Quality & Performance Committee in respect of the associated Quality Impact Assessments.

12.5 To review proposals and make recommendations to the Board for major business cases and their respective funding sources.

12.6 To monitor progress with the capital programme making any recommendations for changes or re-allocation of capital.

12.7 To commission and receive the results of in-depth reviews of key commercial issues affecting the Trust on behalf of the Board.

12.8 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and related contractual risk.

12.9 To consider the Trust's tax policy and compliance.

12.10 To annually review the financial policies of the Trust and make appropriate recommendations to the Board.

12.11 To review the Trust's Board Assurance Framework and Corporate Risk Register sections relating to financial risk. To review the impact of any risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion or updating onto the Board Assurance Framework.

Investment Policy, Management and Reporting

12.12 To approve and keep under review, on behalf of the Board, the Trust's investment strategy and policy.

12.13 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHS Improvement's requirements.

Procurement

12.14 To receive assurance regarding procurement development and the alignment of this with the Trust's overall commercial strategy development.

Capital Investment

12.15 To consider the capital and investment plans for the Trust and to scrutinise business cases for capital investment, to ensure they are consistent with Trust strategy and within the overall trust financial plan. To inform/advise the Trust Board of recommendations from the Committee as appropriate.

13. Review and reporting responsibilities

13.1 The minutes of all meetings of the Committee shall be formally recorded.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its Investment according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

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

London Ambulance Service NHS Trust

People and Culture Committee

Terms of Reference (effective July 2024-August 2025)

1. Purpose

1.1 The People and Culture Committee has been established in order to assure the Board on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

2. Constitution

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

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff will cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain whatever internal information as is required to fulfil its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Director of People and Culture, Chief Paramedic and the Director of Education) and shall consist of no less than eight members, all of whom shall have voting rights.

6. Chair

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

7. Attendance

7.1 The Director of Corporate Affairs, Chief Finance Officer, Freedom to Speak up Representative and Assistant Director of Equality and Inclusion should normally attend all People and Culture Committee meetings.

7.2 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance;

8.1.1 The Chair or nominated Chair of the Committee plus one other non-executive director; and

8.1.2 At least one of the two Executive Committee members, one of whom must be the Director of People and Culture or Chief Paramedic.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the chair of the Committee.

11. Frequency of meetings

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

12. Duties

12.1 To enable the Trust Board to obtain assurance that the Trust achieves the following in a spirit of inclusion and diversity:

Leadership and Culture

12.1.1 Culture – oversees the development of organisation culture to ensure the organisation performs to the right values and delivers patient-focussed outputs

12.1.2 Leadership Development – is taking appropriate steps to develop its current and future leaders

12.1.3 Training – has the systems and processes in place to ensure that its people are well equipped to undertake the tasks that are expected of them and that it can fulfil its workforce planning

12.1.4 Training – ensures the appropriate training is available to develop the organisation.

12.1.5 Statutory and Mandatory training – ensures that its people have timely access to relevant statutory mandatory training and that they are compliant at all times

Healthy Workplace

12.1.6 Staff support – has appropriate systems and process in place to ensure the health and wellbeing of its people, occupational health offered and supporting them following their involvement in major incidents

12.1.7 Bullying and Harassment & Freedom to Speak up – is taking appropriate steps to prevent inappropriate behaviours in the workplace

Engagement

12.1.8 Recognition – has recognition schemes in place which recognise excellent contributions that reflect the Trust's values contributes to the accomplishment of its goals

12.1.9 Employee relations – has an effective strategy for dealing with employee relations and effective partnership arrangements with recognised Trade Unions

12.1.10 Employee voice –has effective methods of staff engagement that promote the concept of 'you said we did' in support of an inclusive approach to working with its people

Talent

12.1.11 Values based recruitment – has the systems and processes in place to ensure that it has the workforce it requires to deliver its goals

12.1.12 Succession planning – is able to replace people in key roles should they no longer be able (short term) or wish (longer term) to fulfil them

12.1.13 Equality, Diversity and Human Rights - has a dynamic workforce that reflects the diversity of its patients

Workforce

12.1.14 Strategic workforce planning – has appropriate people-related plans and strategies in place to enable delivery of the Trust's strategy and business plans

12.1.15 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

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

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will receive each year the Responsible Officer Report.

13.4 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.5 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

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

London Ambulance Service NHS Trust

Quality Assurance Committee

Terms of Reference (effective July 2024-August 2025)

1. Purpose

1.1 The Quality Assurance Committee has been established in order to provide the Trust Board with assurance on the achievement of the London Ambulance Service NHS Trust's strategic objectives in relation to the provision of a high quality, safe, and effective service.

1.2 The Trust's definition of quality encompasses three equally important elements:

- **Care that is safe –** working with patients and their families to reduce avoidable harm and improve outcomes.
- **Care that is clinically effective –** not just in the eyes of clinicians but in the eyes of patients and their families.
- **Care that provides a positive experience –** to patients and their families.

2. Constitution

2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are reviewed periodically at meetings of the Trust Board.

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Chief Medical Officer and the Chief Paramedic) and shall consist of not less than five members (of whom three should be Non-Executive Directors), all of whom shall have voting rights.

6. Chair

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

7. Attendance

7.1 The Director of Corporate Affairs should normally attend all Quality Assurance Committee meetings, with the Chief Executive invited to attend at least annually.

7.2 The Non-Executive Chair of the Audit Committee should be invited to attend all Quality Assurance Committee meetings.

7.3 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

7.4 At least twice a year the appropriate Internal Auditor representative should attend Quality Assurance Committee meetings.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance.

8.1.1 The Chair or nominated Chair of the Committee and one other NED; and

8.1.2 At least two Executive Committee members, one of whom must be the Chief Paramedic and Quality Officer or Chief Medical Officer, or their delegated representative.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be uploaded at the discretion of the Chair of the Committee.

11. Frequency of meetings

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

12. Duties

12.1 To enable the Trust Board to obtain assurance that:

- People are protected from abuse and avoidable harm *(Safe)*
- People's care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible *(Effective)*
- Staff involve and treat people with compassion, kindness, dignity and respect *(Caring)*
- Services are organised so that they meet patient needs *(Responsive)*
- The leadership, management and governance of the organisation ensures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture *(Well-Led).*

12.2 To receive the following standing items:

- A summary of actions report relating to the appropriate Care Quality Commission (CQC) domain/s to include an update report from the appropriate Executive Led Group/s including exceptions, notifiable events and relevant performance metrics.
- The Trust's corporate risk register – section relating to the appropriate domain in relation to quality and safety. To review the impact of any corporate risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion onto the Board Assurance Framework.

- The Trust's Board Assurance Framework – section relating to the strategic objectives and associated risks delegated to the Committee or that may impact on the quality and safety of services to patients and their families (at least quarterly).

12.3 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

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

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

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