Trust Board Meeting in Public

Schedule	Thursday 11 September 2025, 13:15 — 16:00 BST
Venue	Prospero House, 241 Borough High Street, SE1 1GA and via MS Teams
Organiser	Committee Secretary

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Agenda

London Ambulance Service NHS Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS

1.15pm on Thursday 11th September 2025
at Prospero House, 241 Borough High Street, London SE1 1GA

AGENDA

Time	Item	Subject	Lead	Action	Format
1. Opening Administration					
1.15	1.1	Welcome and apologies for absence	Chair	Note	Verbal
	1.2	Declarations of interest	All	Approve	Verbal
2. General Business					
1.20	2.1	Minutes of the Public Meeting held on 12 June 25	Chair	Approve	Report
	2.2	Action Log	Chair	Review	Report
3. Patient/Staff Story					
1.25	3.1	Patient Story ICC Single Point of Access- Neil Carson, Urgent Care APP	FW	Inform	Present
4. Chair and Chief Executive Report					
1.45	4.1	Report from the Chair	Chair	Inform	Verbal
1.55	4.2	Report from the Chief Executive	CEO	Inform	Report
5. Director and Board Committee Reports					
2.05	5.1	**Performance** 5.1 Operational Performance Report: Chief Paramedic	PC	Assure	Report
2.20	5.2	**Quality** 5.2.1 Quality Report: CMO and Deputy CEO 5.2.2 Quality Assurance Committee Report	FW KB	Assure	Report
2.50	5.3	**People and Culture** 5.3.1 Director's Report 5.3.2 People and Culture Committee report	SS AR	Assure	Report
3.00	5.4	**Finance** 5.4.1 Director's Report 5.4.2 Finance and Investment Committee Report	RPa BA	Assure	Report
3.05	5.5	**Audit Committee Report**	RP	Assure	Report

3.10	5.6	**Report from LAS Charity Committee**	BA	Assure	Report
3.20	5.7	**Digital and Data** 5.5.1 Directors Report 5.5.2 Digital and Data Committee Report	SD CM	Assure	Report
3.30	5.8	**Corporate Director's Report**	ME	Assure	Report
6. Assurance					
3.40	6.1	Board Assurance Framework	ME	Approve	Report
7. Concluding Matters					
3.50	7.1	Any Other Business	All	Note	Verbal
3.55	7.2	Date of Next Meeting – Thursday 4th December 2025	Chair	Note	

Annual Meeting in Public **The Board will hold its annual meeting in public as required by statute at 4pm on Thursday 11 September**					
4.00	1.1	Approval of 2024/25 Accountability Statements: • 2024/25 Annual Report and Accounts	FW/RP	Approve	Report
4.15	1.2	• 2024/25 Quality Account	FW	Approve	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 12 June 2025

For Approval

Presented by Andy Trotter

London Ambulance Service NHS Trust

Meeting in Public
LONDON AMBULANCE SERVICE NHS TRUST BOARD OF DIRECTORS
Held at 1.15pm on Thursday 12th June 2025 at Prospero House, 241 Borough High Street, London SE1 1GA

Present		
Andy Trotter	AT	Chairman
Rommel Pereira	RP	Deputy Chair and Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Bob Alexander	BA	Non-Executive Director
Shera Chok	SC	Non-Executive Director
Karim Brohi	KB	Non-Executive Director
Anne Rainsberry	AR	Non-Executive Director
Rakesh Patel	RPa	Joint Deputy Chief Executive and Chief Finance Officer- *Acting CEO*
Fenella Wrigley	FW	Joint Deputy Chief Executive and Chief Medical Officer- *Acting CEO*
Damian McGuinness	DMcG	Chief People Officer
Pauline Cranmer	PC	Chief Paramedic Officer
Mark Easton	ME	Director of Corporate Affairs
Roger Davidson	RD	Chief Strategy and Transformation Officer
Clare McMillan	CM	Chief Digital Officer
In Attendance		
Charlotte Miller	Ms Miller	Paramedic- *Staff Story only*
Nora Hussein	NH	Head of Corporate Governance
Apology for Absence		
Sheila Doyle	SD	Non-Executive Director
Public Attendance: Martin Machary		

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 6th March 2025 were approved as a correct record.	
2.2.	**Action Log** There were no outstanding actions on the action log.	

3. PATIENT STORY		
3.1	**Staff Story – Violence Against Staff** The Board heard from Charlotte Miller, Paramedic, who shared her personal experience of sexual assault by a patient while on duty. She described the traumatic impact and highlighted the value of CCTV evidence in securing a conviction. The value of body-worn cameras was highlighted, both as deterrent and evidential tool, though uptake varies. Misconceptions about privacy and data storage were noted as barriers. The Board discussed the role of peer advocacy and informal support, in addition to management and the Violence Reduction Team. The Board noted rising levels of assaults against staff and debated the need for: • A system-level public campaign with emergency services and the Mayor of London. • Stronger data-sharing between ambulance, police, and hospitals to improve staff protection. • Sustained support for staff beyond the immediate aftermath of incidents. PC confirmed that risk flags exist in the 999 system, though limitations remain for assaults in public spaces. AR highlighted that the People and Culture Committee will retain oversight of staff safety, aligned to survey findings. The Board thanked Ms Miller for her courage in sharing her experience.	
4. CHIEF EXECUTIVE REPORT		
4.1	**Report from the Chair** AT confirmed appointment of Jason Killens as Chief Executive, commencing July 2025. He paid tribute to outgoing CEO Daniel Elkeles, recognising his contributions. He also acknowledged the challenging operational and financial context, including ongoing demand pressures and hospital handover delays. AT welcomed improvements in hear and treat pathways. He reported on planning for the 20th anniversary of the 7 July 2005 London terrorist attacks, stressing the importance of preparedness and commemoration. The Board noted the Chairman's Report.	
4.2	**Report from the Acting Chief Executive** *Report taken as read.* The Board noted the Report from the Acting Chief Executive.	
5. Director and Board Committee Reports		
5.1	**Performance**	

5.1.1	**Operational Performance Report: Chief Paramedic**
	PC presented the Operational Performance Report.
	
	She highlighted:
	• Year-end 2024/25 performance:
	  ○ The Trust closed the year with Category 2 average response time of 37 minutes 22 seconds, an improvement on the previous year.
	  ○ This represented a positive trajectory despite unprecedented demand pressures.
	• Start of 2025/26:
	  ○ Activity levels in April were already 4% higher than the baseline set in planning, continuing the trend of sustained demand.
	  ○ Nevertheless, April performance for Category 2 was 37 minutes 48 seconds – the best performance achieved in nearly two years.
	• Efficiency and productivity:
	  ○ A significant focus has been on reducing ambulance unavailability times, allowing greater resource availability for patient care.
	  ○ The "hear and treat" model continued to perform strongly, with around 11.5% of activity managed without dispatching an ambulance, providing appropriate care through clinical assessment.
	• Contractual framework:
	  ○ The new contract with commissioners places emphasis on resource hours produced, efficiency, and demand management, alongside outcomes such as hospital delays and patient flow.
	• Hospital handover delays:
	  ○ While overall improvements have been seen, pockets of delay over 45 minutes persist in parts of London. Engagement with hospitals is ongoing to address this.
	• Integrated Urgent Care (IUC):
	  ○ LAS remains one of the strongest providers nationally, with robust clinical review ensuring appropriate use of ambulance resources and improved outcomes for patients.
	• Major Incidents and Learning:
	  ○ In April, LAS responded to 10 business continuity incidents, of which two were declared critical incidents.
	  ○ A significant fire incident required treatment of 16 patients; learning from all major events is being captured and embedded.
	
	The Board welcomed the improved Category 2 performance and the demonstration of system resilience despite rising activity.
	
	The Board noted the continuing challenge of hospital handover delays and supported ongoing work with system partners.
	
	Assurance was given that lessons from critical incidents were being addressed and embedded into operational planning.
	
	The Board noted the Operational Performance Report.	

5.2 5.2.1	**Quality** **Quality Report: CMO and Deputy CEO** FW presented the Quality Report, covering the domains of safe, effective, caring, responsive, and well-led.	

She highlighted:

- Winter planning:
  - The Trust's winter plan ran until mid-March and was effective in supporting patient safety during peak demand.
  - A full review has been completed, with learning already being embedded into planning for winter 2025/26 (beginning July).
- Patient trends:
  - Increased cases of respiratory and viral illnesses, particularly amongst frail and elderly patients.
  - Mental health demand remains high: approximately 80% of patients were managed at home, avoiding ED conveyance. This was highlighted as a significant achievement in patient-centred care.
- Incident reporting and learning:
  - Transition to the Radar incident reporting system has been completed, with strong reporting levels maintained.
  - Focus areas include violence and aggression, equipment management, and medicines governance. A new electronic register will strengthen tracking of drug assignment and reduce risk.
  - Greater use of thematic reviews, after-action reviews, Schwartz rounds, and patient safety meetings is ensuring cross-organisational learning from incidents.
- Infection prevention and control:
  - The 2024/25 IPC programme was completed, with actions delivered and compliance with training and hand hygiene sustained into 2025/26.
- Community First Responders:
  - A new LAS-led scheme launched in March 2025 following the withdrawal of the previous provider.
  - 11 responders are now operational, equipped with defibrillators and oxygen, targeting areas with previously lower bystander response.
- Sickle Cell Improvement Plan:
  - Following the Parliamentary report *"No One's Listening"*, LAS has developed and begun delivering a comprehensive action plan.
  - Initiatives include bespoke training, patient engagement, and new direct access pathways at Lewisham and another site for emergency presentations.
  - Early progress was reported as positive.

Board members raised the following points:

Mental Health and Right Care, Right Person model:
Board members discussed the importance of ensuring patients in mental health crisis are seen by the right professional in the right setting. FW noted ongoing partnership work with the London GP group to ensure concerns are addressed through dialogue and shared learning rather than transactional correspondence.

Stroke (SSTEMI) patients and response times:
Concerns about deterioration in ambulance response times for stroke patients, citing the latest Ambulance Quality Indicators (AQI) data showing a 9-minute deterioration. FW clarified:

- The AQI data referenced was from October 2024, a period of exceptional demand and high hospital delays.
- Performance has since improved due to embedding the 45-minute handover process, and updated data will be reported at the next Board and Quality Assurance Committee.

	Integrated Care and Single Point of Access hubs: FW highlighted national work by NHS England on single points of access / integrated care hubs. o LAS is engaged in mobilisation of such hubs across several ICSs. o Early evidence shows good results, with more patients treated at home or in the community through telephone-first models or on-scene crews. o This is reducing unnecessary ED conveyance and improving patient outcomes The Board: • Welcomed the strong focus on mental health patients and community-based models of care. • Commended the introduction of community first responders as a positive step in cardiac arrest response. • The sickle cell improvement plan was endorsed as an important programme addressing equity of care and patient voice.	
5.2.2	**Quality Assurance Committee Report** The Board noted the Quality Assurance Committee Report.	
5.3	**People and Culture**	
5.3.1	**Report from the Chief People Officer** DMcG presented the People and Culture Report. He highlighted: o Core workforce metrics: o 98% fill rate, which was described as very strong. o Pipeline strength and retention/stability rates were reported as moving in the right direction. o External audit work was completed, with the team receiving substantial assurance. o Challenges: o Call handling remains a continuing challenge. KPIs were described as fluctuating and remain a focus of attention. o Organisational development: o A significant number of OD interventions have taken place, supporting organisational consultations and change programmes. o Leadership programmes are being rolled out across the organisation, including bespoke culture-focused programmes for the Hampstead group, with the aim of “getting the best out of our people” and making LAS “a great place to work.” o Freedom to Speak Up: o Recent reporting to the People and Culture Committee highlighted the good work of the team. o There are 50 trained FTSU Ambassadors, of whom 22 are trained in sexual safety, linking to the morning’s staff story on violence and safety. o Digital initiatives: o E-appraisal will go live later this year. o “Bots” are already in use, showing high levels of out-of-hours activity, enabling staff to access HR queries and policy materials at any time. o Work is also underway to explore a virtual GP service, which is at an early stage.	
5.3.2	**People and Culture Committee Report**	

	The Board noted the People and Culture Committee Report.	
5.4	**Finance**	
5.4.1	**Director's Report** RPa provided a summary of the Trust's financial position He highlighted: • Financial position: o The Trust is forecast to break even at year-end. o The financial environment remains very challenging, with tight management required. • Capital programme: o The capital programme continues at pace, with investment across fleet, estates, and facilities. o Specific reference was made to estate development in East London, which will continue into the new financial year. • Workforce changes: o A significant change has taken place for staff in the Make Ready function, with a move to new terms and conditions. o This includes rota alignment and resource group changes to better integrate support staff with frontline requirements. o These changes are being embedded and will continue to bed in over the coming months.	
5.4.2	**Finance and Investment Committee Report** The Board noted the Finance and Investment Committee report.	
5.4.3	**Audit Committee Report** The Board noted the Audit Committee Report.	
5.4.4	**LAS Charitable Funds Committee** The Board noted the LAS Charitable Funds Committee Report.	
5.5	**Digital and Data Report** CM presented the Digital and Data Report. She highlighted • Control room systems: o The new national control room solution service, introduced in November under the Ambulance Radio Programme, continues to experience issues. o NHS England is undertaking a resilience and technical review; findings were discussed at the Digital and Data Quality Committee. • Programme planning: o Digital programmes for 2025/26 are aligned with the Trust's annual plan. • Artificial intelligence (AI) and automation: o A proof of concept is being developed on ambient listening, transcription, and summarisation to: ▪ Reduce post-call time. ▪ Lower administrative burden. ▪ Speed up record completion. o Early pilot results are positive, showing improvements in the hear and treat rate. • Infrastructure programme:	

	○ Major investment is underway to modernise IT infrastructure, align with architectural standards, strengthen cybersecurity posture, and meet growing demand. • Data warehouse: ○ A business case was presented to the Digital and Data Quality Committee and approved by the Executive Committee, recommending incremental improvements to the current platform while exploring future options with NTP.	
5.5.1	**Digital and Data Quality Committee Report** The Board noted the Digital and Data Quality Committee Report.	
5.6	**Corporate Affairs – Director's Report** ME presented the Corporate Affairs – Director's Report. He highlighted: • The Board had received a training session on cyber security earlier in the day. • Information Governance reporting will in future be presented in more detail by the lead executive SIRO. • Areas covered in the assurance process include: ○ Incident reporting. ○ Audit of the Data Security and Protection Toolkit (DSPT). ○ Training – both needs assessment and delivery. ○ Development of asset registers. ○ Progress on Data Protection Impact Assessments (DPIAs). • While reported at high level to the Board, detailed oversight is undertaken by the Audit Committee. Staff assaults • A chart (referenced in the papers) showed the trend of assaults on staff continuing to rise. • In 2024/25 there were 856 assaults, described as "far, far too many." • Many incidents are driven by the condition of patients, particularly mental health presentations. AT noted the earlier Board discussion on mental health provision and stressed the interconnection between service pressures, patient conditions, and violence towards staff. The Board noted the reports.	
6 APPROVAL		
6.1	**Business Plan year review 2024-2025** RD introduced the final review of the 2024/25 Business Plan. He highlighted: • The 2024/25 plan represented Year Two of the Trust's strategy. • Of the 68 commitments, 52 were achieved and 11 remain in progress. • Delivery was monitored throughout the year and will continue to be tracked through to completion. The Board noted the significant progress made against commitments. Assurance was provided that lessons learned will inform delivery of the 2025/26 plan. The Board received and noted the 2024/25 Business Plan Review.	

6.2	**Business Plan 2025/26** RD presented the Business Plan for 2025/26 for approval. He highlighted: • The plan builds on progress from 2024/25 and constitutes the next stage of the Trust's strategy. • New roles, including specialist paramedics in mental health, have been introduced and linked to wider service developments. • Bursary-funded staff are beginning training, and the impact of these roles will depend on how the pathways are embedded in future. • Targeted improvement programmes will focus on specific population needs. • The plan is a live document, with any proposed changes requiring Board approval to ensure accountability. • Committees will be aligned to monitor specific objectives, strengthening governance and oversight. Questions were raised about whether specialist paramedic appointments in mental health linked to earlier discussions on mental health response. RD clarified that bursary-supported roles are in training and pathways will determine future integration. The Board discussed the importance of ensuring committee agendas align with business plan objectives. The Board agreed on the value of requiring formal approval for variations to the plan, to ensure accountability and transparency. The Board approved the 2025/26 Business Plan, noting that Committees will be aligned to oversee delivery of relevant objectives, with quarterly reporting back to the Board.	
7 ASSURANCE		
7.1	**Board Assurance Framework (BAF)** ME introduced the updated version of the BAF, noting that it had been scrutinised by the Audit Committee and was the final iteration for the year. Key points reported: • The BAF had been refreshed to align with the newly approved Business Plan. • Compared to the start of the year, there had been significant changes across almost all risks. • Three new risks in development were highlighted, drawn from the corporate risk register: 1. Increase in health cases closed. 2. Triangulation of learning from different sources. 3. A third emerging risk aligned with wider discussions held earlier in the meeting. • Board members were advised that these risks will be refined further as part of the next cycle. It was suggested clarifying the wording of new risk 1.8 to reflect the risk of not providing medical services network, to ensure accuracy. The Board approved the updated Board Assurance Framework.	
9. CONCLUDING MATTERS		

9.1	**Any Other Business** No other business.	
9.2.	**Date of Next Meeting** The next public meeting of the Board would be held on 11 September 2025.	

2.2. Action log

For Discussion

Presented by Andy Trotter

NHS
London Ambulance Service
NHS Trust

TRUST BOARD IN PUBLIC – ACTION LOG – September 2025

Meeting	ACTION	LEAD	Due	UPDATE
	No open actions			

3. Patient Story

ICC Single Point of Access- Neil Carson, Urgent Care APP

For Information

Presented by Fenella Wrigley

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 Jason Killens

London Ambulance Service NHS Trust
Board meeting September 2025

Report from the Chief Executive Officer

Introduction

1. Having joined London Ambulance Service (LAS) as Chief Executive in July of this year, I am pleased to present my first public report to Trust Board. Going forward the purpose and therefore content of my report to Trust Board will evolve to offer insight into activity across our organisation that would not normally reach Trust Board and to provide an update on the key activities I have engaged with and managed as Chief Executive.
2. July marked my return to our organisation, after ten years away working in other ambulance services having commenced my ambulance sector career at LAS in 1996, as an Emergency Medical Technician in North East London. Since then, I've worked as Chief Executive of the South Australia Ambulance Service from 2015 to 2018 and most recently as Chief Executive of the Welsh Ambulance Services University NHS Trust from 2018 to 2025. I am also the current Chair of the Association of Ambulance Chief Executives (AACE).
3. I am focused on driving forward improvements that ensure our Service is the best it can be for our patients and the nine million people living in London against the backdrop of an ageing population with more complex needs and growing demand on the NHS whilst balancing this with providing the best workplace experience we can for our people. I look forward to working with Trust Board colleagues and those across our organisation to achieve this.
4. In this report, I will also reflect on some important activity that took place before I officially started in my role, when my colleagues Rakesh Patel and Dr Fenella Wrigley were acting CEOs for the Trust.

First month back at LAS as CEO

5. Since starting in my role on 21 July, I have been thoroughly impressed by the teams at LAS and the work they are delivering for Londoners. Although I am not strictly new to LAS, a lot has changed in our organisation in the ten years I have been away as has the backdrop of the city and system we are working with. I am clear that to continue to build in our recent successes we must be a system partner, leader and collaborator seeking to identify opportunities to enhance the

role we have as a regional NHS provider, anchor institution for London and emergency service.

6. I have been meeting a wide range of LAS teams and visiting our sites across the capital. I've joined departmental meetings, team huddles and training days. I've spent time at our Emergency Operations Centres at our Waterloo HQ and Newham sites, as well as our Croydon IUC. It's been incredibly insightful to learn more about our current service delivery offer and hear directly from our people about what matters to them.
7. I have also been pleased to engage with our important external partners, meeting with Trust and ICB leaders and representatives from the Mayor of London's office to discuss our collaboration and shared priorities moving forward.

Remembering 7/7

8. As we reached the 20th anniversary of the London bombings on 7 July, we took time here at LAS to remember the 52 people who died, those who were injured and all those affected by the events of that day.
9. It was a privilege to attend the memorial ceremony at Hyde Park alongside my colleague Chief Paramedic Pauline Cranmer QAM. At the same time, LAS was holding our own event at Waterloo HQ led by Director of Ambulance Operations Darren Farmer KAM.
10. Later in the day, dozens of our clinicians and control room staff who had been involved in the response joined survivors and the bereaved at St Paul's Cathedral for a ceremony of commemoration. Our Emergency Medical Technician Tracy Russell was one of four candle bearers at the service, recognising the lives she saved while working in the tunnel between King's Cross and Russell Square.
11. I shared my memories and reflections of working at LAS on 7 July 2005 as part of our memorial marking the occasion. Then, in 2005 I was an Ambulance Operations Manager at LAS and was part of the team coordinating the Service's response. I can clearly recall now the conversations I had with our people who went into the Underground tunnels: the severity of the injuries, the number of patients, and the challenges of the conditions they were working in. I will never forget the stories of some of the survivors we met in the weeks and months that followed. But I also reflect on the fantastic work with pride that everyone in our organisation at the time did to respond – running towards danger without fear for their own safety to care for and provide the best service possible to those involved.

Engaging with our stakeholders

12. LAS has recently welcomed a range of partners and stakeholders to share our approach on a range of service delivery issues. These include:
    a. Singaporean civil servants from the Ministry of Home Affairs visited HQ on 9 June
    b. Daniel Francis (MP for Bexleyheath and Crayford) visited his local ambulance station in Barnehurst on 27 June
    c. Catherine West (MP for Hornsey and Friern Barnet) visited her local ambulance station in Fiern Barnet on 18 July
    d. Luke Taylor (MP for Sutton and Cheam) visited St Helier Ambulance Station and observed a shift on 11 August
    e. Thai delegates working with the National Institute of Emergency Medicine visited our Dockside Education Centre and Newham EOC, meeting the Clinical Education & Standards team, 999 Operations team and HART on 15 August
    f. Representatives from the Vienna Ambulance Service visited our Waterloo HQ on 21 August.

Hot weather and demand on the service

13. Over recent months, we've seen some extreme demand on our services. During the heatwave in June, the volume of daily 999 calls we received was consistently exceeding 6,000, peaking at 7,200 calls on 1 July. A similar picture was seen across our 111 services, with over 6,000 calls on the busiest day. Despite this pressure, our people reached our Category 2 patients in need of urgent treatment more than eight minutes faster in July than during the same period in 2024. This is testament to the hard work done by our teams to make more clinicians available on shift for our sickest and most seriously injured patients, treat more patients over phone, improve our processes, and work closely with our NHS partners. I want to take this opportunity to thank all those involved who have both delivered operating efficiencies but also worked during some of our busiest and most challenging periods.
14. In recent weeks we have achieved consistent improvement in our patient waiting times, which has enable us to lower the Resource Escalation Action Plan (REAP) level to two – indicating moderate pressure.

External recognition on LAS and our people

15. Despite some challenging days, we have had plenty to celebrate. In particular, I am delighted to share that our projects and people have been recognised in a wide range of external awards. These include:
    a. Work done by our teams to improve recognition of ineffective breathing during 999 calls was shortlisted twice at the HSJ Patient Safety Awards, both in the Urgent and Emergency Care Safety Initiative of the Year and Deteriorating Patients and Rapid Response Initiative of the Year categories
    b. Project 'Pre-hospital Ambulance Support Team (PhAST); a system approach to improving care for frailty patients in Nursing & Care Homes' was shortlisted at the HSJ Patient Safety Awards in the Improving Care for Older People Initiative of the Year, along with Chelsea & Westminster Hospitals NHS Foundation Trust, West London NHS Trust, Borough Based Partnerships and Hounslow Primary Care Network.
    c. Our Start of Shift project to support our ambulance crews get to patients more quickly was shortlisted for the Staff Wellbeing category in the HSJ Awards
    d. Advanced Paramedic Practitioner Kanwal Munir was shortlisted in the Future Leader Award - Next Gen (18-30) category at the 6th Annual B.A.M.E Health & Care Awards 2025
    e. Our Apprenticeship Scheme was ranked third in the country's top 100 apprenticeship employers by The Times.

Charity work to support LAS and our people

16. The work done by our London Ambulance Charity has been going from strength to strength, with the team delivering a range of initiatives over the last couple of months.
17. Our annual Summer Prize Draw in June and July saw our team raising £1,730, which will go towards funding wellbeing support for our teams.
18. On 12 July, our teams participated in the Uniformed Services Day Truck Pull with 24 people from across the Trust coming together to help pull a 13-tonne truck for two miles. There were four trucks in total being pulled by fundraisers for four different charities.
19. I would like to encourage you to consider taking on our London Life Hike on 27 September, which will be raising funds for more public access defibrillators in communities where they are needed most.
20. Finally, it's also not too late to sign up for our Charity's Dragon Boat Race taking place on 18 September.

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:	11 September 2025			
Report title:	Performance Report			
Agenda item:				
Lead Executive:	Pauline Cranmer, Chief Paramedic Officer			
Report Author:	Pauline Cranmer			
Purpose:	X	Assurance		Approval
		Discussion		Information

Key points, issues and risks for the Board

The attached report refers to Trust performance and activity for the period 1 May 2025 to 31 July 2025.

Category 1 and category 2 performance, across the three months, continues to be ahead of forecast and operational plans.

Year to date performance to 31 July 2025, saw category 1 performance at 6 minutes 55 seconds and ahead of the national standard of 7 minutes. This is an improvement of 25 seconds when compared to the same period in 2024.

Category 2 performance, year to date, is 30 minutes 26 seconds and is a 6 minute 54 second improvement on the previous year. This performance is also 3 minutes 10 seconds ahead of the agreed operating plan.

Total incidents continue to be higher than set out in the operating plan by 5.1% with face to face incidents requiring attendance by a frontline resource at 4.2% above expected levels.

As part of the monitoring of the operating plan, hear and treat, job cycle time and unavailable time are all ahead of target. Only DCA hours are below plan by 0.8% for the period to 31 May 2025 and this will be rectified by end 31 August 2025.

The IUC team has continued to see call answering performance with both average time to answer and abandonment rates ahead of target. Compliance of Ambulance and Emergency Department validation remain substantially higher than targets; reducing the number of ambulances dispatched and avoiding Emergency Department attendances.

1 business continuity incident was reported in this reporting period and there were 5 declared significant incidents.

Recommendation/Request to the Board/Committee:

The Trust Board of Directors is asked to accept this report as assurance.

London Ambulance Service NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING
Performance Report – September 2025

This Trust Board report covers a summary of performance on key metrics for the period of 1 May 2025 through to 31 July 2025. In particular it refers to the metrics against which the LAS is monitored by the National NHSE Ambulance team and supporting metrics which are key to delivery of services to patients.

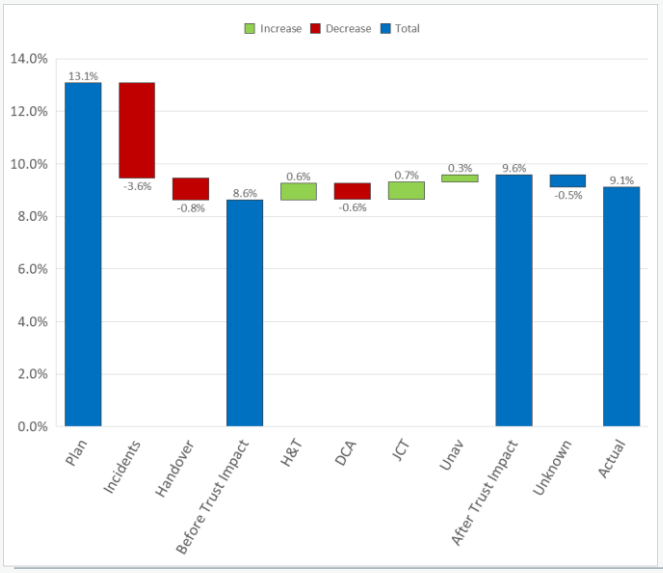
The data used to complete this report is aligned to that provided by the National team as part of the monitoring pack.

1. 2025/2026 Operating Plan

The National NHSE Ambulance team are monitoring the monthly delivery of inputs, as agreed at the start of the financial year, and is set out in the 2025/2026 operating plan. Performance against these inputs are shown in the following waterfall chart for the period to the end of July 2025 and any variance therein.

Ambulance Performance Oversight

London Availability – YTD Drivers of Variance to Plan



Group	Field	Plan	Actual	Variance	% Variance
Outside Pressure	Incidents	455,986	479,400	23,414	5.1%
	Average Handover	00:21:43	00:23:43	00:02:00	9.2%
Trust Influence	H&T	21.0%	21.7%	0.7%	3.2%
	DCA Hours	793,398	786,856	- 6,542	-0.8%
	Job Cycle not In Handover	01:22:08	01:21:18	-00:00:50	-1.0%
	Unavailable	14.2%	13.9%	-0.3%	-2.0%
Output	Face to Face Responses	360,229	375,530	15,301	4.2%
	Availability	13.1%	9.1%	-4.0%	-30.4%
	Cat 2 Mean	00:33:37	00:30:27	-00:03:10	-9.4%

Group	Field	2025/26 Plan	YTD Actual	Variance	% Variance
Output	Cat 2 Mean	00:32:30	00:30:27	-00:02:03	-6.3%

7

Figure 1: NHSE Operating Plan Monitoring Slide April to July 2025

The number of incidents dealt with by the LAS for 1 April to 31 July was 479,400. This is 23,414 (5.1%) above the operating plan. Consequently, the number of face-to-face incidents requiring attendance by the LAS was 375,530 during this period and 4.2% above expected levels.

Year to date performance of hear and treat (21.7%), job cycle time (81 minutes 18 seconds (excluding hospital handovers)) and unavailable time (13.9%) all remain ahead of plan.

The production of double crewed ambulance hours is 0.8%, year to date, below plan. The LAS has instigated recovery actions to be on plan by the end of August 2025. As a consequence, the output measure of availability is off trajectory by -4%.

The average hospital handover continues to remain above the plan that ICBs agreed with NHSE with a variance of 1 minute 54 seconds.

The LAS is responsible for delivery of the four factors labelled as within the Trust's control and not held accountable for outside pressures.

Despite that the service continues to see increased activity and handover times above the expected levels, category 2 delivery continues to be ahead of plan. The forecast for the period for April to July 2025 was 33 minutes 37 seconds with a year-end forecast of 32 minutes 30 seconds. Category 2 performance at the end of July was **30 minutes 27 seconds** and therefore was 3 minutes 10 seconds ahead of the year-to-date forecast and 2 minutes 03 seconds ahead of the year-end forecast.

2. Performance Metrics

2.1. Call Answering Mean (operating plan metric)

May 2025 Target	10 Seconds	**May 2025 Actual**	**1 Second**
June 2025 Target		**June 2025 Actual**	**3 Seconds**
July 2025 Target		**July 2025 Actual**	**4 Seconds**

The call answering mean is set within the operating plan at 10 seconds, the national standard.

The LAS has continued to meet this standard across the period of this report. There has been a continued increase in the number of contacts received and dealt with by the Emergency Operating Centres. The year-on-year comparison showed that there was a 5.6% increase in both May and June 2025 with a 6.8% recorded in July 2025. Figure 2 shows the number of contacts received in each month for May to July 2024 compared to 2025.

Total Contacts	May	June	July
2024	173,932	176,013	179,585
2025	183,711	185,931	191,800
Diff	5.6%	5.6%	6.8%

Figure 2: Number of contacts monthly comparison

The SPC chart continues to show special cause improvement (figure 3)

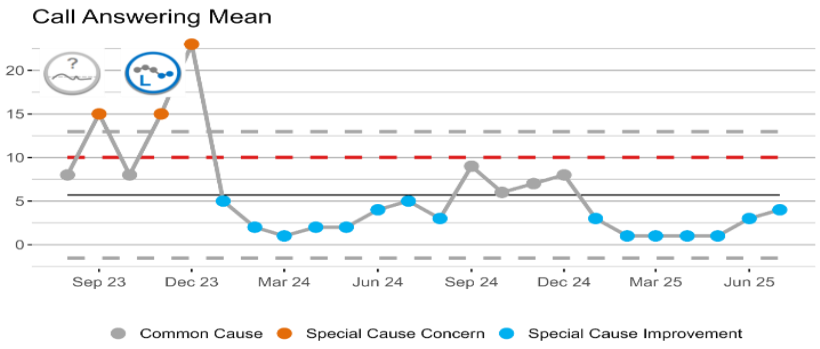


Figure 3: Call answering mean SP

2.2. Category 1 Mean (supporting metric)

May 2025 Target	7 Minutes	May 2025 Actual	6 Minutes 54 Seconds
June 2025 Target		June 2025 Actual	7 Minutes 7 Seconds
July 2025 Target		July 2025 Actual	6 Minutes 56 Seconds

LAS has met the national standard of 7 minutes in both May and July 2025 with June 2025 being 7 seconds above.

Although there has been consistent improvements seen this financial year we continue to see common cause variation shown in the SPC, figure 4.

The year to date position to 31 July 2025 was 6 minutes 55 seconds and was 25 seconds ahead of April to end of July 2024, which was 7 minutes 20 seconds.

LAS continues to review specific elements of the job cycle time related to fast response vehicles. In particular how quickly these vehicles become available post the arrival of a double crewed ambulance to attend the next waiting patient.

The 999 operations team are also concentrating on compliance with standby points to ensure our FRV resources are positioned in the best place to attend patients. In addition, there is a focus on reducing the number of times this resource is dispatched to lower acuity patients to ensure there is optimisation of these vehicles to attend category 1 patients.

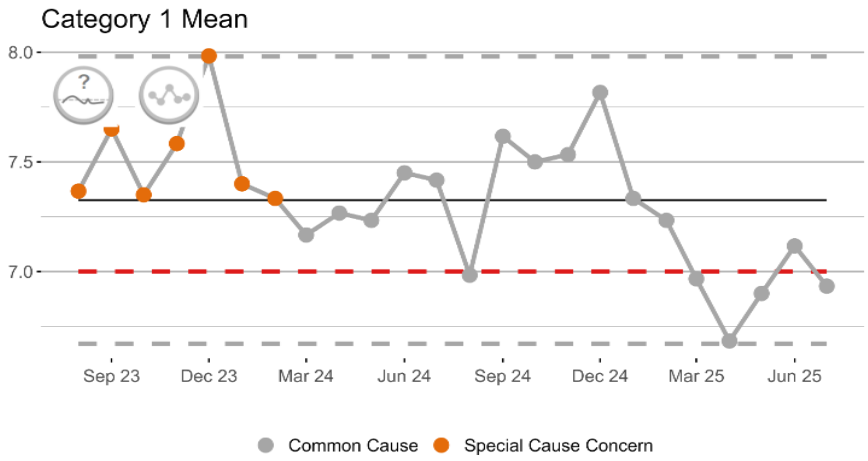


Figure 4: Category 1 Mean SPC

2.3. Category 2 Mean (operating plan metric)

May 2025 Target	33 Minutes 32 Seconds	May 2025 Actual	30 Minutes 38 Seconds
June 2025 Target	37 Minutes 23 Seconds	June 2025 Actual	32 Minutes 34 Seconds
July 2025 Target	34 Minutes 25 Seconds	July 2025 Actual	30 Minutes 46 Seconds

The LAS continues to deliver category 2 performance ahead of the agreed monthly trajectory within the 2025/2026 operating plan. This improved performance is a direct result of improvements seen in relation to double crewed ambulance job cycle time (excluding hospital handovers), out of service and hear and treat rates which are all ahead of the planned trajectory.

The statistical process control chart for category 2 (figure 5), shows special cause improvement. There has been a 6 minute 54 second improvement when comparing the 1 April to 31 July from last year to this; with the C2 mean for the period in 2024 being 37 minutes 20 seconds compared to 30 minutes 26 seconds in 2025.

Productivity using a patients per shift metric continues to focus on reducing episodes where resources are unavailable during their shift to attend patients waiting in the community. This includes both time when resources are "out of service" and elements of the time spent with patients within the control of our staff.

There continues to be work with staff to ensure the consistent compliance of the 45 minute maximum waiting time at hospital policy to minimise any impact of long queues at hospital.

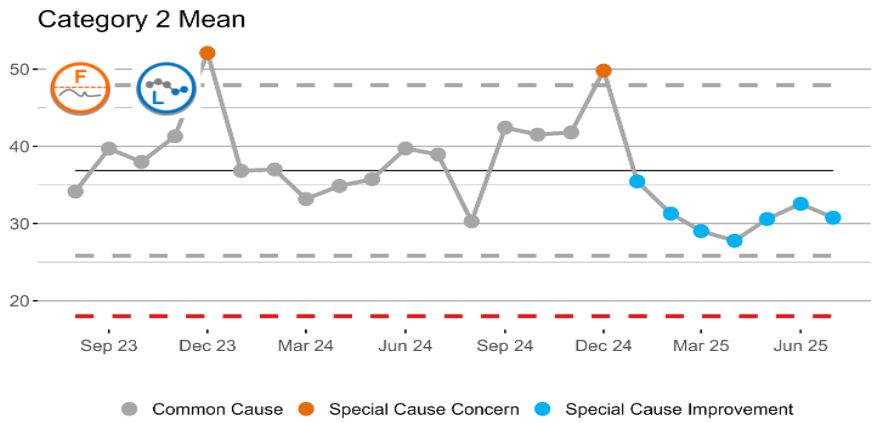


Figure 5: Category 2 mean SPC

2.4. Time to dispatch (supporting metric)

May 2025 Target	45% or less C2 dispatches greater than 20 minutes	**May 2025 Actual**	**35%**
June 2025 Target		**June 2025 Actual**	**39%**
July 2025 Target		**July 2025 Actual**	**36%**

The LAS has consistently met the internal target of less than 45% of C2 dispatches taking more than 20 minutes.

The focus within 999 Operations on ensuring the highest acuity and longest waiting patients within the clinical queue are dealt with expediently, is reducing longer waits for patients and is consistently prioritising out sickest patients. There continues to be a downward trend as demonstrated in figure 6.

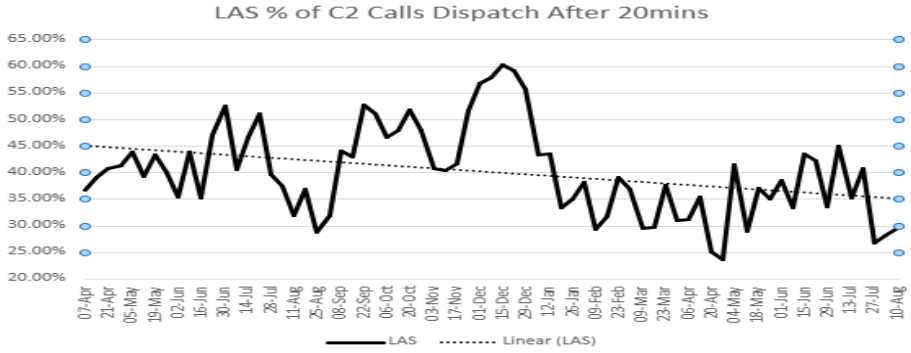


Figure 6: C2 dispatches >20 mins

2.5. Cat 2 Distribution (supporting metric)

May 2025 Target	Reduction of C2 tail from previous year.	May 2025 Actual	57.2% reduction
June 2025 Target		June 2025 Actual	58% reduction
July 2025 Target		July 2025 Actual	59.5% reduction

Linked to the time to dispatch; there is a focus to reduce the "tail" on long dispatches to C2 patients. The distribution of Cat 2 responses is critical both in terms of better patient outcomes and experience. Improvements in reducing the tail also improves compliance with performance standards.

Figure 7 shows the distribution of C2 responses over 90 minutes and shows the comparison for combined incident numbers of May to July 2024 versus 2025. The number of incidents is recorded in five-minute segments above 90 minutes.

A comparison for the period and each month for total number of incidents over 90 and 120 minutes is as follows:

	May to July-24	May to July-25	Diff	May-24	May-25	Diff.	Jun-24	Jun-25	Diff.	Jul-24	Jul-25	Diff.
Incidents > 90 mins	14,117	5,887	58.3%	4135	1768	57.2%	5117	2149	58.0%	4865	1970	59.5%
Incidents > 120 mins	5,752	1,467	74.5%	1615	462	71.4%	2161	553	74.4%	1976	452	77.1%

There has been a substantial reduction in long responses with a 58% reduction in the total number of incidents which took over 90 minutes and an even greater improvement of 74% reduction in incidents taking more than 120 minutes.

Data for months May, June and July only

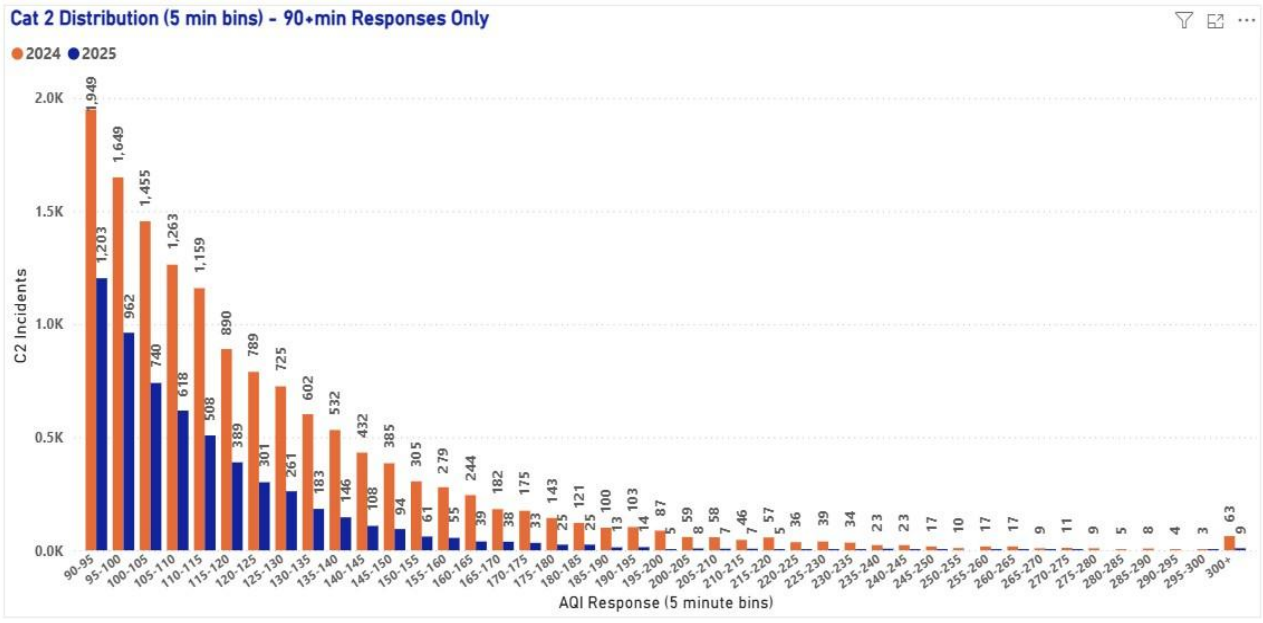


Figure 7: C2 distribution of 90 + minute responses

2.6. Multiple Attendance Ratio for C2 and C3 (supporting metric)

May 2025 Target	1.04	May 2025 Actual	1.05
June 2025 Target		June 2025 Actual	1.05
July 2025 Target		July 2025 Actual	1.04

The number of resources sent to Category 2 and Category 3 calls has an impact on the number of available resources to attend waiting patients. There is a focus to reduce the number of multiple resources sent to be as close to 1 resource dispatched as possible.

The trend for multiple attendance ratio is shown in the trend graph in figure 8. Although there is a slight downward trend, dispatching the right number of resources to each and every face to face incident is a core message being promoted within EOCs. The ability to increase the availability of resource will mean that patients in the community do not have to wait longer than necessary and will improve response standards.

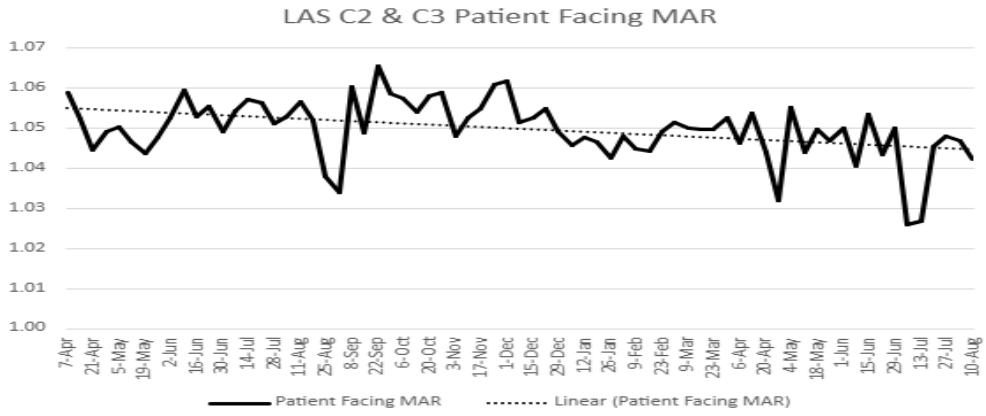


Figure 8: Multiple attendance ratio trend

2.7. Hear and treat (operating plan metric)

May 2025 Target	21%	May 2025 Actual	21.7%
June 2025 Target		June 2025 Actual	22.3%
July 2025 Target		July 2025 Actual	22.1%

Hear and treat continues to be above the target set within the operating plan from May 2025 onwards.

These increases in the hear and treat rate reduce the number of face to face incidents and increases the availability of ambulance resources to attend patients and has a positive impact on our response times.

The live dashboard showing productivity for both teams and individuals has been delivered and embedded within the Clinical HUB. This has supported the deployment of a new clinical supervision model and is being used to support conversations with individuals around their practice.

In addition, use of the Tortus AI product has been extended to all Clinical Hub staff at our 2 sites at Dockside and Waterloo and which is also demonstrating improvements in the number of cases completed each hour by clinicians.

A consequence of these activities is that the LAS has seen an increase in the productivity of clinicians from 2.1 cases being assessed per hour to 2.7 cases per hour.

The SPC (figure 9) for hear & treat continues to show special cause improvement.

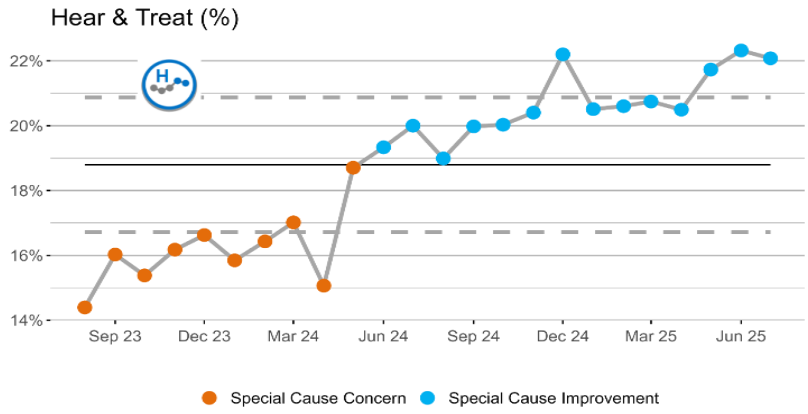


Figure 9: Percentage of hear & treat

2.8. See and treat (operating plan metric)

May 2025 Target	29%	**May 2025 Actual**	**26.1%**
June 2025 Target	28%	**June 2025 Actual**	**26.1%**
July 2025 Target	26%	**July 2025 Actual**	**26.2%**

There continues to be a trade-off between increasing hear and treat and the opportunity for crews to deliver see and treat outcomes. Although we have seen an increase of circa 2% in hear and treat outcomes since the end of the last financial year; see and treat has been maintained at a consistent level of 26% during the period of the report.

The target within the operating plan was set in line with previous years trends and therefore the target in July drops by 2%. This is consistent with the types of illness' which present at different times of the year and consequently the opportunities crews have to deliver significant see and treat outcomes.

The see and treat trend is shown in figure 10.

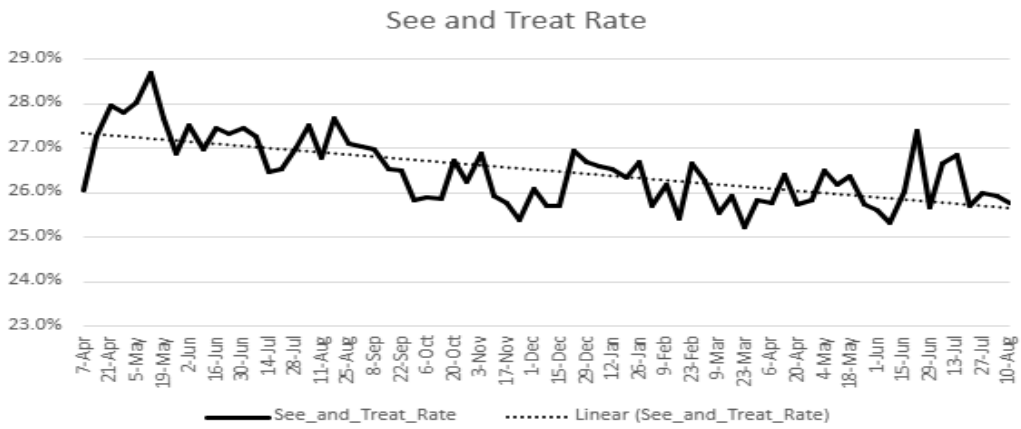


Figure 10: See & treat trend (12 months)

2.9. See and convey (operating plan metric)

May 2025 Target	50%	**May 2025 Actual**	**52.2%**
June 2025 Target	51%	**June 2025 Actual**	**51.6%**
July 2025 Target	53%	**July 2025 Actual**	**51.7%**

See and convey is linked to the increases in hear and treat and see and treat metrics. The expected outcome is that if hear and treat and see and treat increase, then the number of conveyances will be proportionately reduced.

The see and convey targets are seasonally adjusted based on patterns seen over the past two years. As a consequence, the steady rate of see and convey over the past 3 months has meant that the target has been met in July 2025 as it has not increased as expected.

All of these metrics will feed into there being more availability of ambulances to meet the next patient with a representative improvement in patient outcomes, experience and response times. Figure 11 shows the trend for see and convey.

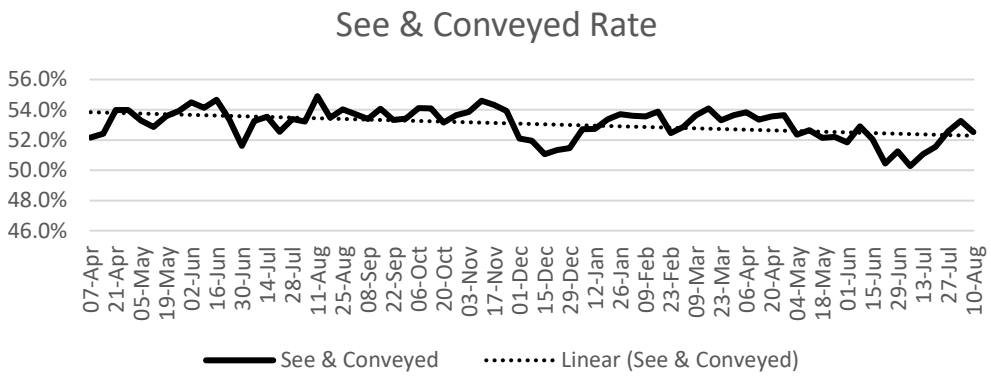


Figure 11: See & convey trend

2.10. Job Cycle Time (operating plan metric)

May 2025 Target	82 Minutes 53 Seconds	**May 2025 Actual**	**83 Minutes 29 Seconds**
June 2025 Target	82 Minutes 9 Seconds	**June 2025 Actual**	**82 Minutes 29 Seconds**
July 2025 Target	80 Minutes 24 Seconds	**July 2025 Actual**	**81 Minutes 53 Seconds**

Job cycle time (JCT), excluding hospital handovers, has continued to reduce in line with the work being undertaken within Ambulance Operations regarding the patients per shift metric. In April the average was 5.2 patients per shift and this has improved to an average of 5.4 by July 2025.

Although the target has not been met so far this financial year, the continued trend is downwards and there is an expectation that current activities around patient per shift will see the monthly targets being met in the autumn.

Full JCT including hospital handovers are shown in figure 12, which is illustrative of the improvement in this metric. The elements of JCT which can be directly impacted on by crews, remains the time spent on scene with the patient and the time taken to become available once a patient has been handed over at hospital. The respective improving trends are shown in figures 13 and 14.

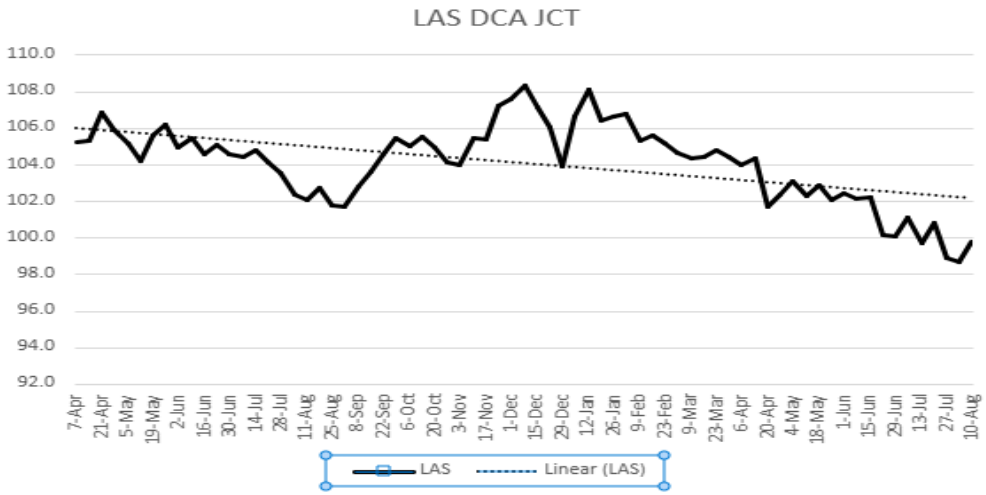


Figure 12: Full Job Cycle Time

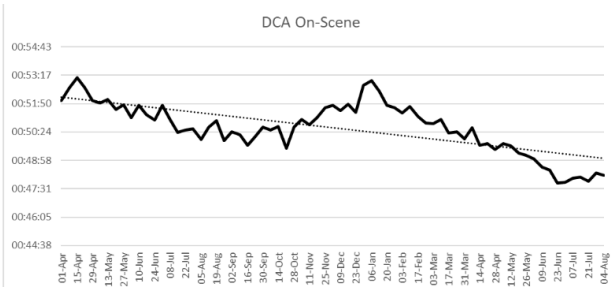


Figure 13: JCT (on-scene time)

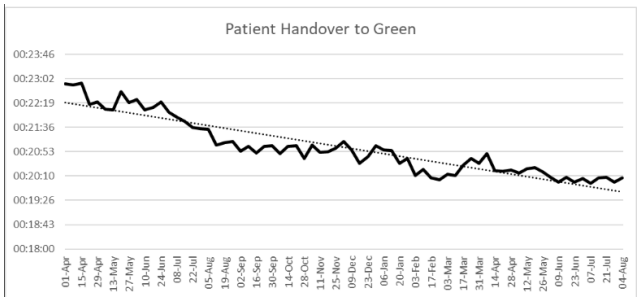


Figure 14: JCT (handover to available)

2.11. Unavailable Time – Out of service (operating plan metric)

May 2025 Target	14.5%	**May 2025 Actual**	**14.2%**
June 2025 Target	14%	**June 2025 Actual**	**14.1%**
July 2025 Target	13.5%	**July 2025 Actual**	**12.9%**

The improvement in reducing out of service has continued across the period May to July 2025 and has been ahead of the target within the operating plan.

The out of service in 2024 for May was 18.7%, June 17.8% and July 16.9%. This therefore represents an improvement of 4.5% in May 2025, 3.7% June 2025 and 4% in July 2025.

The out of service trajectory is shown in figure 15 with the split between people and vehicles shown in figures 16 and 17 respectively. To deliver further improvements the focus remains on how, within local teams, people related out of service can be reduced further through team based interventions.

This is a key measure of success of the transition to the new local delivery model.

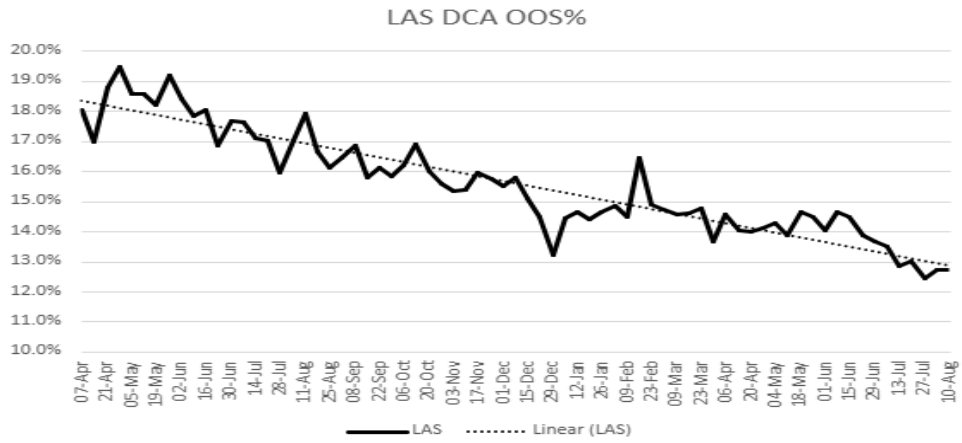


Figure 15: Total out of service trend

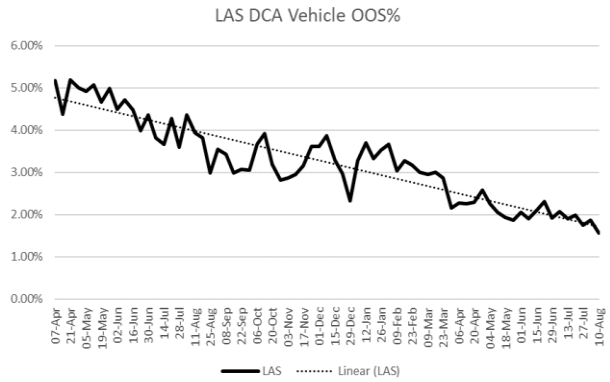


Figure 16: Vehicle out of service trend

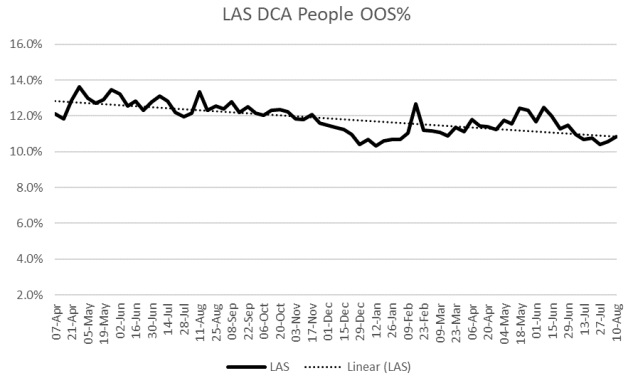


Figure 17: People out of service trend

2.12. Average Hospital handover time (operating plan metric – outside LAS control)

May 2025 Target	22 Minutes 6 Seconds	May 2025 Actual	23 Minutes 52 Seconds
June 2025 Target	21 Minutes 32 Seconds	June 2025 Actual	23 Minutes 47 Seconds
July 2025 Target	20 Minutes 56 Seconds	July 2025 Actual	23 Minutes 13 Seconds

The operating plan includes the plan supplied by ICS areas for improvements in the average handover time. NHSE have confirmed that this element is outside the control of LAS and ICS areas will be asked to account for progress to meeting the trajectory for improvement.

The average hospital handover time remains above the agreed target and year to date is 23 minutes 43 seconds; 2 minutes above plan.

NHSE are holding monthly bi-lateral meetings with ICBs and their providers with regard to actions to bring handovers back within agreed limits. The LAS is not an attendee of these meetings. Meanwhile, the LAS continues to support Trusts with its tiered response in real time and continues to engage at a system and provider level with hospitals that have consistent challenges.

Figure 18 below shows the trend of actual performance against plan.

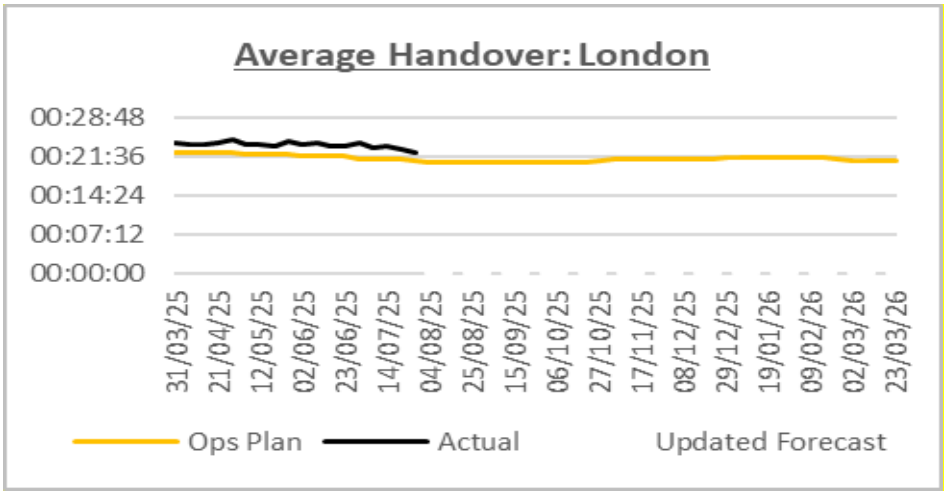


Figure 18: Hospital handover performance against plan

2.13. Resource Hours – Double Crewed Ambulances (operating plan metric)

May 2025 Target	201,211	May 2025 Actual	197,460
June 2025 Target	197,176	June 2025 Actual	190,332
July 2025 Target	203,193	July 2025 Actual	202,040

The number of Double Crewed Ambulance (DCA) hours produced has been under target during the 3 months of this reporting period. Although there was a 2.7% over production in hours in April 2025, the year to date position (April to July 2025) is marginally under plan by 0.8% or 6,542 hours.

The Ambulance Operations team have been focused on the production of hours to reduce the gap in the plan. The intention is to bring the hours back onto plan by the end of August 2025 and will require the team to deliver, on average, 6,550 patient facing ambulance hours per day during August.

The production of Ambulance hours is a key metric to secure the additional growth monies agreed with NHSE and Commissioners.

The trend on the production of hours is shown in figure 19 below.

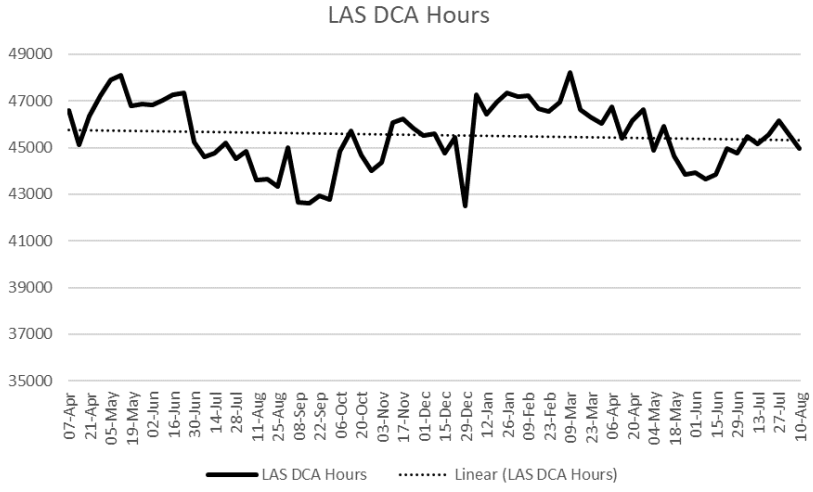


Figure 19: Deployed DCA hours

2.14. Resource Hours – Fast Response Vehicles (operating plan metric)

May 2025 Target	43,701	May 2025 Actual	39,150
June 2025 Target	41,013	June 2025 Actual	36,157
July 2025 Target	42,162	July 2025 Actual	37,597

The number of Fast Response Vehicles (FRV) and their deployment continues to be under review. This is to ensure that this resource is right sized for delivering an appropriate response for Category 1 patients whilst ensuring that there is not an

imbalance of crews who would be better utilised on a double crewed ambulance. In May there was a reduction in the FRV hours to support the rebalancing to DCA hours production.

A review of what incidents FRVs are dispatched to, other than Category 1 patients, is also determining whether this is the most appropriate resource or how these other services could be best serviced.

The trend in FRV produced hours is shown in figure 20.

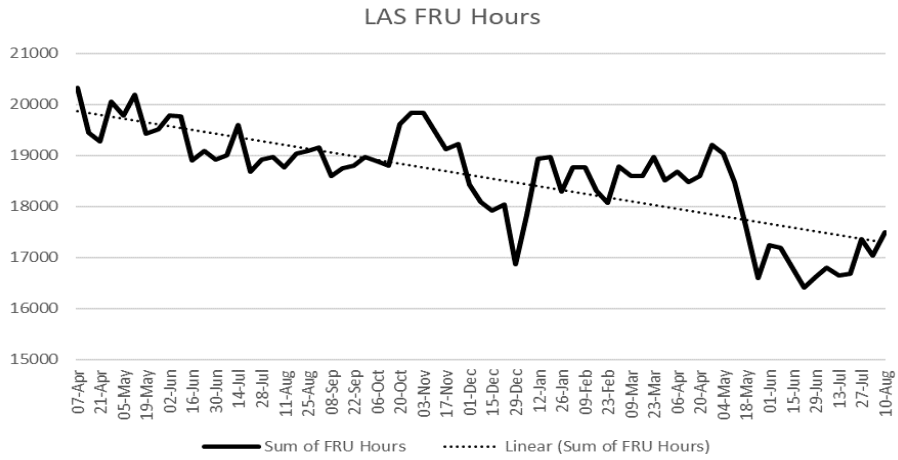


Figure 20: Deployed FRV hours

3. Integrated Urgent Care Balanced Score Card Metrics

3.1. 111 Star 5 utilisation

* 5 volume	No target	May 2025 Actual	3030
		June 2025 Actual	2894
		July 2025 Actual	2884

* 5 ringback time	30 Mins. Crew on scene 60 Mins. Patient call backs	May 2025 Actual	1468 secs (24 mins)
		June 2025 Actual	1815 secs (30 mins)
		July 2025 Actual	1645 secs (27 mins)

In July, our crews continued to benefit from direct access to the IUC 24/7, providing senior clinical decision-making and medical advice to support on-scene decisions across all ICBs. This includes either consultation with the crew or crews requesting a GP to call back directly to the patient, allowing them to leave scene.

Alongside this, 2,399 GP notifications were managed across London practices, strengthening communication between our crews, CAS clinicians, and general practice. This process ensures continuity of care during both in-hours and out-of-hours periods, while avoiding unnecessary phone calls to busy practices or delays for crews waiting for calls to be answered.

Looking ahead, the IUC team is working with the NHSE Regional Team and GP Leads, on refining the London Care Record (LCR) process, to encourage wider use of LCR by primary care ahead of winter.

3.2. Priority call back times

Priority 1 % in time	**60%**	**May 2025 Actual**	**73%**
	60%	**June 2025 Actual**	**67%**
	60%	**July 2025 Actual**	**69%**

Priority 2 % in time	**60%**	**May 2025 Actual**	**55%**
	60%	**June 2025 Actual**	**38%**
	60%	**July 2025 Actual**	**43%**

Priority 3 % in time	**60%**	**May 2025 Actual**	**53%**
	60%	**June 2025 Actual**	**40%**
	60%	**July 2025 Actual**	**45%**

In July 2025, LAS handled a total of 53,473 cases within the Clinical Assessment Service (CAS). Of these:

- 10,167 were Priority 1 (P1)
- 34,829 were Priority 2 (P2)
- 6,377 were Priority 3 (P3)

The Trust has set a business plan target of achieving a minimum of 60% of cases within P1, P2, and P3 priorities receiving a ringback in time. While performance against these metrics continues to improve, it is acknowledged that further improvement is required to consistently achieve target levels.

LAS continues to prioritise decision-making based on clinical need, which can affect reported KPI outcomes where national thresholds are not always aligned with patient safety or best use of resources. The national review of IUC KPIs is expected to address this misalignment, and LAS is actively contributing to the review to request that national metrics:

- are recognised where they provide better outcomes but do not fit current national definitions.
- clinician input overriding NHS Pathways priority is fully reflected in reporting response times.
- Allowing providers to report against commissioned metrics to reflect true performance of the service they are commissioned and funded to provide.

It is important to note that P1 activity often includes cases where crews are on scene. During peak periods, when 999 services are under surge or escalation, LAS manages CAS capacity to release ambulance crews more quickly. This enables patients with lower acuity needs to wait safely, while urgent cases are prioritised — demonstrating an integrated system response that balances patient safety with operational demand.

To support delivery, LAS is increasing the use of monitoring tools to provide the duty management team with real-time performance oversight. This allows early intervention where pressures or variances are identified. Alongside this, quality and productivity expectations set out in clinical role cards are being used to manage individual performance consistently, ensuring staff are supported while maintaining accountability.

Work is also underway to develop the service model in partnership with Primary Care Networks (PCNs) and the wider system, with the aim of reducing non-urgent activity managed within CAS. This will release capacity for more complex and urgent cases, improving performance against priority metrics while strengthening continuity of care for patients.

To strengthen patient communication and support capacity management, LAS has introduced SMS messaging. This provides patients with assurance following contact and enables them to highlight if their condition worsens. It also offers the option to cancel if care is no longer required. This not only improves patient experience; it also helps protect system capacity by reducing unnecessary demand.

In parallel, discussions are underway to develop the use of artificial intelligence (AI), building on learning from the Clinical Hub. The intention is to extend AI capability into clinical audit processes, reducing manual input, improving consistency, and enhancing cost-effectiveness across the Directorate.

These developments demonstrate the commitment to leveraging digital tools to improve patient experience, safeguard capacity, and drive operational efficiency, while maintaining quality and safety as central priorities.

The service is demonstrating progress and resilience, with clear actions underway to strengthen performance, reduce unnecessary activity, and ensure national KPI frameworks evolve to reflect local system working and clinical judgement. Enhanced monitoring and individual accountability measures provide further assurance that productivity and quality will be sustained in real time.

3.3. Call answering metrics

Abandonment rate	**Less than 3%**	**May 2025 Actual**	**1.2%**
		June 2025 Actual	**1.7%**
		July 2025 Actual	**1.4%**

Average time to ans.	**20 seconds**	**May 2025 Actual**	**5.6 secs**
		June 2025 Actual	**5.7 secs**
		July 2025 Actual	**6.4 secs**

LAS continues to deliver high call-answering performance and low abandonment rates, with all measures consistently exceeding contractual standards.

In July, the abandonment rate remained significantly below the 3% threshold, and the average time to answer was maintained well within the 20-second standard, providing strong assurance on accessibility and patient experience.

The service is underpinned by an ongoing focus on productivity and audit, ensuring that call-handling quality remains high and that patients receive safe and effective support.

Regular quality assurance processes and clinical audit are helping to drive improvements.

3.4. Percentage of Ambulance validation

Validation target	**75%**	**May 2025 Actual**	**92%**
		June 2025 Actual	**88%**
		July 2025 Actual	**90%**

There is currently no national performance metric for IUC response times. The previous 1 hour response standard was withdrawn nationally in recognition of the risk posed to Ambulance Services if IUC providers forwarded cases to the 999 clinical queue at one hour, rather than on the basis of clinical need.

In London, LAS has worked with commissioners to introduce a local 1 hour quality metric. This enables enhanced monitoring and assurance, with performance reviewed monthly at ICB Clinical Quality Review Group meetings.

Through its Pan-London ambulance validation service, LAS operates an integrated 111/999 model which ensures patients are managed according to clinical priority, regardless of whether they initially dial 111 or 999. This integrated approach ensures the most appropriate and timely ambulance response, optimising safety and resource use.

In July 2025 alone, the LAS IUC team **avoided 17,000 ambulance dispatches** by managing cases through telephone consultation, treatment by senior clinicians, and onward referral where clinically appropriate. This demonstrates both the scale of impact and the critical role of IUC in reducing avoidable ambulance demand, thereby protecting frontline resources for the sickest patients.

The integrated LAS model is providing clear system benefit by reducing avoidable ambulance conveyances, ensuring patients receive care matched to clinical need, and safeguarding ambulance capacity at times of high demand.

3.5. Percentage of ED validation

Validation target	**50%**	**May 2025 Actual**	**57%**
		June 2025 Actual	**53%**
		July 2025 Actual	**52%**

LAS continues to perform above the national target for reducing unnecessary referrals to Emergency Departments, however higher local metrics have not all been met.

It is recognised that locally agreed pathways exclude injury cases from validation, which impacts reported outcomes. Despite this, LAS has maintained strong performance and is actively identifying further opportunities to strengthen referral avoidance.

The national review of IUC metrics is considering changes to the way ED referrals are reported. Currently, any case referred directly to a non-primary care service is counted as an ED referral. However, this approach does not reflect the use of alternatives such as Same Day Emergency Care (SDEC), Urgent Treatment Centres (UTCs), and other ED-diversion services. LAS will continue to engage in this review to ensure reporting more accurately captures the range of clinically appropriate alternatives being utilised.

LAS is delivering strong performance against national expectations with a continued focus on front line probing and assessment to reduce ED outcomes. We are also influencing the national review to ensure reporting frameworks fairly represent the impact of IUC pathways in reducing avoidable ED attendances.

3.6. Average handling time

Average Handling time	**No target**	**May 2025 Actual**	**00:08:51**
		June 2025 Actual	**00:08:42**
		July 2025 Actual	**00:08:52**

LAS IUC continues to deliver strong performance in call answering and abandonment, however, work is ongoing to address average 111 call handling time (AHT). While AHT remains within acceptable parameters, further reductions would create additional capacity, improving overall service resilience and patient experience.

A key focus is on AUX handling time, where improvements in process efficiency, clearer role expectations, and enhanced use of technology can reduce periods of non-productive time. By refining the way AUX is reported and understood, we are ensuring that performance data more accurately reflects true productivity and operational impact.

Alongside this, the IUC Directorate is prioritising ongoing productivity performance and staff support. Initiatives include targeted audit, coaching, and feedback to ensure calls are handled safely and efficiently, with the right balance between speed and clinical quality. The use of real-time monitoring tools also supports early identification of performance variances, enabling swift intervention.

The programme of work to reduce handling times, refining reporting, and strengthening productivity processes, will further enhance efficiency. This will help to maximise capacity ahead of anticipated winter pressures, while maintaining a strong focus on quality and safe patient care.

4. Resilience & Specialist Assets

Reporting period: 1st May to 31st July 2025.

During this period there have been 5 declared Significant incidents.

During the early hours of Tuesday 17th June the Trust responded to a gas explosion in Hackney, N16. Two patients were treated, one of whom was fatally injured and 1 of whom was conveyed to hospital.

On Thursday 19th June we responded to a fire across 2 residential flats on the third storey of a block in North Kensington, W10. We treated a total of eleven low acuity patients; seven who were discharged at scene and four who were conveyed.

On Wednesday 25th June we responded to a multiple stabbing and tear gas attack in Willesden Green, NW2. Three patients were conveyed, two of whom were seriously injured and a further patient was treated and discharged at scene.

On Monday 21st July we responded to a gas leak in a block of flats, in Kilburn, NW6. In total twelve patients were treated, all for low acuity illness, four of whom were conveyed.

On Monday 28th July we responded to a multiple stabbing outside a hotel in Borough, SE1. We treated four patients in total. One patient was fatally injured and three were conveyed to hospital with serious injuries.

Following all declared Significant Incidents a hot debrief is conducted immediately after the conclusion of the incident, both at scene and with the team from the Specialist Operations Centre (SOC), within our control rooms. A feedback form is then circulated to all staff. For incidents where the hot debrief and feedback identifies potential learning, a follow up cold debrief is conducted within 28 days of the incident date, to further explore the learning and identify the recommendations.

A cold debrief was conducted for the incident of the 28th July, testing a hybrid approach of attendance both in person and via MS Teams.

During this period there has been one declared BC incident.

On Saturday 7th June there was a national 111 telephony outage, that affected our 111 sites. The outage lasted for approximately 2.5 hours and following a review of the incident a number of recommendations were proposed, including updates to our relevant Business Continuity Plans and pre-prepared communications statements.

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:	11 September 2025			
Report title:	Quality Report			
Agenda item:				
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 and Quality Assurance Committee.			
Purpose:	X	Assurance	☐	Approval
	☐	Discussion	☐	Noting

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

The London Ambulance Service (LAS) Quality Report for May to July 2025 highlights ongoing work and monitoring around patient safety, effective clinical care, and system improvements amid rising demand, particularly in mental health.

The report covers key domains including safety, effectiveness, caring, and leadership, detailing performance metrics, quality initiatives, and health inequality projects.

- **Maintaining patient safety under demand:** LAS manages clinical safety during periods of increased demand through 999 and Integrated Urgent Care Clinical Safety Plans. These plans focus on providing a rapid response to critical patients whilst directing less serious cases to community care. Demand for patients with mental health conditions continues to increase. The Mental Health Joint Response Cars achieved an 84.51% community treatment rate in July 2025, reducing emergency department conveyances by 456 patients.

- **Incident reporting and management:** The new risk management system is fully embedded, with patient safety incident reports above the 12-month average but mostly involving no or low harm.
  The key incident categories include medical equipment, security, violence and aggression and medicines management including controlled drugs.
  Moderate and severe harm incidents are reviewed through Patient Sector Incident Groups and Learning from Death processes.

- **Clinical Hub and Integrated Urgent Care safety:** Clinical Hub assessments have increased by 37% compared to the same period last year. Despite this rise in activity, patient safety incidents have remained consistently low with no cases requiring national Patient Safety Investigations.

IUC incident reporting is steady with most incidents reported as no or low harm. Of note however incidents relating to violence and aggression have risen.

- **Learning from deaths:** 175 Structured Judgement Reviews were conducted, with 77% requiring no further action. 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.
- **Medicines Management incidents:** A large number of medicine management incidents are related to controlled drug documentation. There is an ongoing project to implement electronic controlled drug registers.
- **Safeguarding and training compliance:** LAS actively participates in safeguarding boards and has improved training compliance to above 88% for Levels 1 to 3. The electronic referral process is being enhanced to improve quality and compliance.
- **Infection prevention and control:** The annual IPC report highlights governance and progress.
- **Clinical performance and cardiac care:** LAS ranks highly nationally for cardiac arrest outcomes and STEMI care, with ongoing work to reduce call-to-angiography times and improve care bundles. Cardiac arrest care achieved a 44% Return of Spontaneous Circulation (ROSC) rate in May 2025.
- **Community and volunteer engagement:** The London Lifesavers programme has now trained over 40,000 individuals in basic life support including defibrillation to improve cardiac arrest survival. In addition, 17,230 year 8 school children have been trained to date. Public access defibrillator coverage is being expanded in identified “defib deserts.”
- **Integrated Care Coordination (Single Point of Access):** There are now co-designed and collaborative Integrated Care Coordination Hubs in 3 of the 5 Integrated Care Systems (ICS) with plans progressing for the final 2 ICSs. These provide access to a multidisciplinary team who support clinical decision making and referrals reducing ambulance dispatch, emergency department attendances and hospital admissions where care closer to home is available.
- **Health inequalities initiatives:** Very good progress has been made on the projects to address health disparities including care for patients with sickle cell disease, maternal health and social determinants.

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

London Ambulance Service NHS Trust

Meeting in Public of the Board of Directors – September 2025

Trust Quality Report – Reporting on May – July 2025

This report focuses on the quality provided by the London Ambulance Service (LAS). The Trust's Quality Assurance and Improvement Dashboard report contains the May – July 2025 data (unless more up-to-date national or regional data is available).
The report covers four domains:

- Safe
- Effective
- Caring
- Well-Led; Quality Improvement

1.0 Safe

This section reviews the areas which are under the safe domain and how patients are protected from abuse and avoidable harm.

1.1 Clinical Demand and Maintaining Safety

As has been reported in the combined performance report, during the last reporting period, we continued to see pressures across the Urgent and Emergency Care and Health and Social Care systems.

Oversight of patient safety, at periods of high demand, is maintained through the use of the 999 and/or Integrated Urgent Care Clinical Safety Plans (CSP), which provides a framework 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 Mental Health Care

Mental Health demand continues to rise, and 2025 is predicted to be our busiest year ever for Mental Health demand.

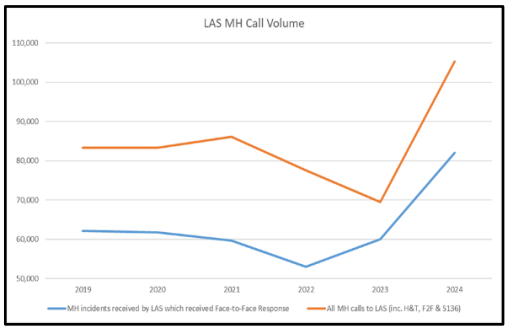


Figure 1: Yearly MH demand

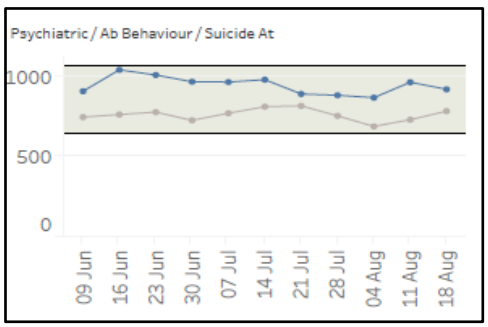


Figure 2: Weekly Mental Health call demand (2024 vs 2025)

The Mental Health Team continue to deliver training across the organisation, and the new electronic patient care record is currently in beta testing.

A new Core Skills Refresher (CSR) on Mental Health Assessment is currently being delivered across the trust.

The Mental Health Joint Response Cars (MHJRC) have continued to deliver a productive and safe service:

Team Output	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25 MTD 18/08
Total Shifts Covered	149	133	130	133	146	143	175	161	202	183	199	179	201	120
Daily Cars (Month average) - Target 6	4.80	4.30	4.33	4.30	4.86	4.60	5.65	5.75	6.52	6.10	6.42	5.97	6.48	6.7
% of commissioned shifts covered	80.11%	71.51%	72.22%	71.51%	81.11%	76.88%	94.09%	95.83%	108.60%	101.67%	106.99%	99.44%	108.06%	Requires full month data

Team Activity	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Monthly Utilisation	81.80%	75.30%	82.30%	82.80%	81.60%	83.90%	79.10%	77.20%	81.71%	78.70%	82.58%	85.40%	84.51%
Activations	804	724	731	739	762	782	890	934	1143	1100	1132	1078	1232

MHJRC shift coverage, utilisation and activations

The MHJRC's decision to treat in the community rate in July 2025 was 84.51%. This translates to a reduction in Emergency Department (ED) conveyances by 456 patients, due to MHJRC attendance, in July 2025.

Quality

There have been no upheld complaints, patient safety incidents or quality alerts for Q1 for the MHJRC. The team have continued to deliver training to ambulance complexes, clinical tutors, emergency operations centre staff, clinical hub staff and incident response officers.

Funding

LAS have been advised by our lead Commissioners that the MHJRC funding is under review. LAS is continuing to work closely with stakeholders and is undertaking a review of options about how to ensure patients continue to receive a patient-centred service.

1.3 Right Care, Right Person (RCRP)

LAS continues to work closely with the Metropolitan Police Service (MPS) to embed the Right Care, Right Person (RCRP) framework. While RCRP is now business as usual for the MPS, LAS has retained a clear escalation process to address any inappropriate application, ensuring patient and staff safety and accountability. To manage the ongoing volume of calls better suited to other agencies, the Clinical Hub continues with clinical validation for Category 3 cases, including welfare-related incidents, improving triage accuracy, safeguarding patients, and optimising frontline resource use.

1.4 Safety incidents – 999

The Trust has now embedded the new risk management system, where all incidents are reported. There has been no reduction in incident reporting observed.

The number of incidents reported has returned to common cause variation but has remained above the 12-month average. A comparison of incident versus reported dates demonstrates a similar trend. The northwest and southeast sectors continue to see the highest number of incidents reported.

The top three categories for the reporting period are as follows:

- Medical equipment – specifically failure of device/equipment.
- Reports of violence/aggression – specifically, direct verbal abuse.
- Medicines management – specifically controlled drug audit errors.

Whilst most incidents reported are within the no or low harm severity grading, the number initially reported as moderate, severe harm and death remained above the mean during this reporting period. All moderate, severe harm and death reported incidents are reviewed via sector Patient Sector Incident Groups (PSIG) and, where applicable, via a Learning from Death (LfD) review.

1.5 Safety Incidents – 999 Clinical Hub

The number of clinical assessments conducted by the Clinical Hub continues to increase. In May and June 2025, the Hub completed an average of 24,000 clinical telephone assessments per month – representing a 37% increase compared to the same period in 2024.

Despite this rise in activity, patient safety incidents have remained consistently low. During May 2025, 14 new patient safety incidents were reviewed. During June 2025, 22 new patient safety incidents were reported and reviewed, totalling 36 for May and June. Of these, 9 were reviewed by the multi-disciplinary Patient Safety Incident Panel team. No incident met the threshold for a Patient Safety Investigation (PSI) under the national framework, and a local investigation and learning was undertaken.

1.6 Safety Incidents – Integrated Urgent Care (IUC)

Incident reporting within the Integrated Urgent Care (IUC) service remained steady in July, with the majority of incidents categorised as *no harm* or *low harm*. This reflects a strong and positive reporting culture, reinforced by the successful transition to the new reporting system RADAR.

A continued emphasis on timely and meaningful feedback has further strengthened staff engagement. Tailored learning sessions, developed in response to reported incidents, have

been well attended across IUC. This proactive approach reinforces the value of incident reporting and demonstrates its direct impact on service improvement and patient care.

Key data and trends identified in May 2025:

- A total of 272 incidents were reported, representing a 12% increase from April (243).
- 270 incidents were graded as *no harm* or *low harm*, underlining the emphasis on early reporting and continuous learning rather than adverse outcomes.
- The three most frequently reported categories were:
  1. 111/IUC Call Handling
  2. Communication around care and consent
  3. Concern Regarding External Provider - continued concerns regarding downstream services, including general practices directing patients to NHS 111 to arrange ambulance transport, and an increase in failed referrals to community teams. These are shared with the relevant services. They are also communicated to Integrated Care Board (ICB) clinical leads, supporting wider system learning and driving improvements across the care pathway.

Of note for IUC colleagues during the months up to July, there was a noticeable increase in incidents involving violence, aggression and abuse. IUC continue to work closely with the Violence Reduction Unit and Frequent Caller Team to support staff and ensure processes are robust when managing these difficult and distressing situations.

1.8 Learning from Deaths

Where incidents require a Learning from Death (LfD) review, if they meet the nationally defined criteria, an enhanced investigation is undertaken using the Patient Safety Incident Response Framework (PSIRF). The harm grading is subject to change following this more in-depth review.

These cases undergo a detailed review working with clinicians, families, 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 opportunities 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.

175 Structured Judgement Reviews (SJR) were undertaken during quarter one (2025/26). 77% of these required either no further action or locally delivered feedback. A learning response was commissioned in 9 cases, including an after-action review (n = 1) and patient safety incident investigations (n = 8).

The themes across SJRs include, but are not limited to, the recognition and management of cardiac arrest, including airway management, ECG interpretation, ambulance response time, recognition of ineffective breathing during 999 call taking and on-scene time management.

Please note the figures within this report are based upon the learning from deaths reviewed within quarter one. Previously, the figures reported were from the cases reported within the time period stated. As the time between the cases being reported and reviewed has decreased to avoid any duplication, only the reviewed data is presented now.

1.9 Medicines Management

A total of 329 medicines incidents were reported in May 2025. 209 related to controlled drugs (CD) documentation errors and 79 to medication administration errors. A project to implement an electronic CD register is ongoing, which will aid in the mitigation of documentation-related CD incidents. There have been no schedule 2 Controlled Drug losses. There continues to be an expansion of independent non-medical prescribing.
Within the IUC, regular prescribing audits are undertaken for antimicrobial, controlled drug, high-risk medicines and repeat prescription prescribing, with feedback to clinicians on themes and areas to reflect on.

1.10 Safeguarding

The Trust continues to actively participate in the Brent Safeguarding Boards for both children and adults, providing assurance regarding the London Ambulance Service (LAS) safeguarding activity through these boards.

An annual Safeguarding Report has been prepared and will be published on the Trust's website, as well as being shared with Commissioners and partner organisations. It will be released alongside the Sexual Safety Annual Report, reflecting our commitment to transparency and continuous improvement. All Safeguarding Policies have been reviewed and are fully up to date, following review at the Safeguarding Assurance Group.

During Q1 and Q2, the primary focus has been on the continued implementation and improvement of the new electronic referrals process. The Trust is now progressing with Phase 2 of this initiative, which aims to further enhance quality and compliance by mandating some fields prior to submission. The new system empowers staff to take ownership of their referrals and the associated details, while significantly reducing the time required to complete a referral. To support this transition, additional guidance on completing referrals, including mandatory fields, is being integrated into the safeguarding refresher training programme and huddles.

There has been a significant improvement in safeguarding training compliance rates during Q1, and as of August 2025, the compliance numbers are as follows:

- **Level 1:** 90.01%
- **Level 2:** 88.37%
- **Level 3:** 88.37%

The compliance standard is set at 90% and must be consistently maintained throughout the financial year to ensure year-end closure at this level. Areas of the Trust where compliance is not at 90% are being overseen by the Clinical Quality Oversight Group (CQOG) to ensure continued improvement and accountability.

1.11 Health, Safety and Security (HS&S)

Current compliance for FFP3 fit testing is 70% due to the 2-year revalidation period. Over 80 staff members have now been trained up as Fit Testers. All porta-count machines are now under a maintenance, servicing and calibration contract, which has been provided by the HS&S team. This is organised directly with the supplier Sunbelt Rentals, who collect and return to the site for ease of use.

Other aspects of the Health, Safety and Security report are covered in more detail in the Corporate Director's report.

1.12 Infection Prevention and Control (IPC)

Quarter 1 of the Infection Prevention and Control (IPC) annual work programme for 2025-26 was completed in June and shared with the Infection Prevention and Control Committee.

- IPC Training compliance was reported at 80% for Level 1 and 64% for Level 2 (target 90%).
- Hand hygiene compliance for July 2025 was reported at 96%. This exceeds the Trust performance target (90%).
- Make Ready six-weekly vehicle deep clean compliance was reported at 65% for July, which is below the Trust's target of 95%. Action recovery plans led by Make Ready services are in place; however, challenges remain with staff vacancies.
- Premises cleaning audit compliance was reported at 95%, which met the Trust's target of 90%.

The Director of Infection Prevention and Control's annual report for 2024-25 has been completed. This report serves as an essential component of demonstrating strong governance procedures, alignment with Trust values and commitment to public accountability. Structured around the ten compliance criteria set out in *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* (Department of Health, 2015), the report offered the opportunity to highlight successes and challenges for 2024-25.

2.0 Effective

This section focuses on the areas under the effective domain, including the provision of appropriate clinical care.

2.1 Clinical Performance Indicators (CPI)

The CPIs are a tool used to continuously audit the care the Service provides to 8 different patient groups, as well as general documentation. Following on from the launch of the new CPI application in January, which enabled efficient auditing and interactive monthly reporting, the Clinical Audit and Research Unit (CARU) has now also developed and implemented new feedback functionality. New features include:

- Audit data is assigned to all attending clinicians to recognise their contribution to patient care
- Data is personalised based on skill level and time spent on the scene
- Clinicians can review compliance before receiving feedback
- Clinicians can save their reflections within the application
- Managers can access compliance overviews and trend insights

In July 2025, 75% of available CPI audits were completed, demonstrating a range of compliance with clinical guidelines, ranging from the Older Fallers CPI with a compliance level of 86% to the Cardiac Arrest CPI at 97%.
The sector clinical quality teams are working within their sectors to ensure that there is ongoing improvement and learning to improve the CPI performance.

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 or a suspected ST elevation myocardial infarction (STEMI). 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, with March 2025 clinical outcomes data being published by NHSE on 14 August 2025. This was released after the preparation of the Quality Dashboard.

There was a good improvement between the January 2025 and March 2025 data. In March 2025, LAS ranked 1st nationally for Return of Spontaneous Circulation (ROSC) at hospital handover in the Utstein comparator group, with a rate of 67.2% (well above the national average of 50.4%). In the overall group, LAS were 3rd with a ROSC rate of 30.4% (national average: 27.7%). For 30-day survival, LAS were placed 2nd in the Utstein group at 36.8% (national average: 29.5%) and 3rd for overall survival with 10.8% (national average: 9.7%).

For STEMI patients, the LAS recorded a Call to Angiography time of 2 hours and 35 minutes*, which was slightly above the national average of 2 hours and 27 minutes. This placed LAS in the 8th nationally. The focus on clinically supported dispatch and reducing on-scene time for patients with time-critical conditions is addressing this.

**This is based on MINAP data, which is subject to change during the revision period*

The Falls Care Bundle was delivered to 52.7% of patients in March 2025 - a slight drop from 54.3% in December 2024.

2.3 Cardiac Arrest data – May 2025

Following a cardiac arrest, 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 May 2025 cardiac arrest data indicate:

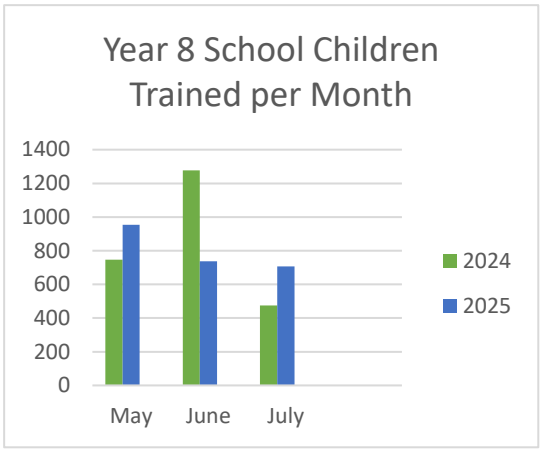
- 996 patients in cardiac arrest were attended by LAS
- 351 patients had resuscitation commenced
- The median time from 999 call to dispatcher-assisted basic life support (chest compressions) was 4 minutes, and the mean response time was 6 minutes
- Mean time from arrival on scene to first LAS defibrillation was 3 minutes
- ROSC was achieved in 44% of patients, with 28% sustaining ROSC to hospital handover

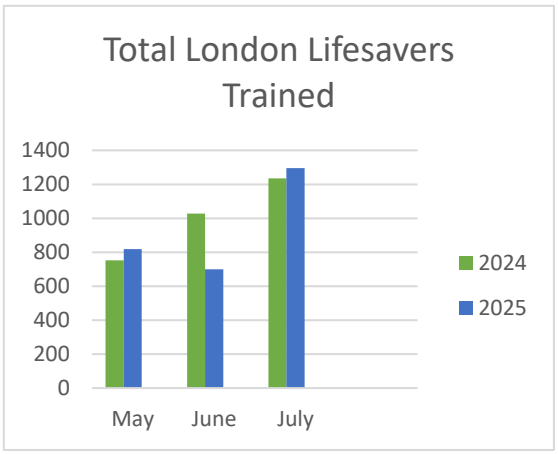
2.4 'Chain of Survival'

Survival from Out of Hospital Cardiac Arrest (OHCA) improves significantly when the "chain of survival" is activated early, through rapid recognition of cardiac arrest, early cardiopulmonary resuscitation (CPR) and prompt defibrillation. High-quality CPR and reduced time to first shock are critical to improving outcomes. These vital interventions are often delivered by our volunteers, including Community First Responders, Emergency Responders, GoodSam responders and London Lifesavers. In many cases, the swift actions of bystanders can mean the difference between life and death.

To strengthen community resilience, we continue to expand our London Lifesavers programme. This initiative equips members of the public with the skills and confidence to recognise cardiac arrest, perform CPR and have the confidence to use a defibrillator. To date, a total of 40,721 London Lifesavers have been trained.

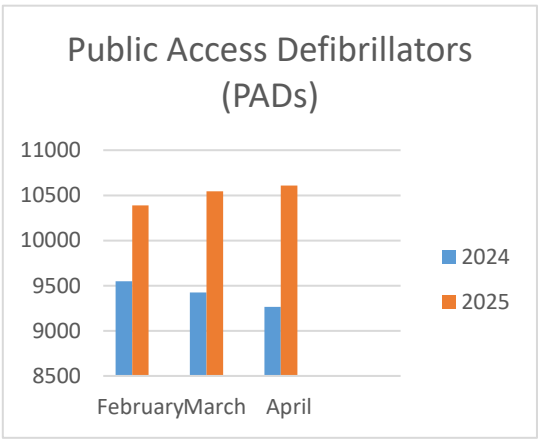
We are continuing the London Lifesavers Schools programme, aimed at providing all year 8 pupils in London with the knowledge and skills to respond to a cardiac arrest. Evidence from countries where CPR is taught in schools shows that survival rates are nearly double compared to those without such education. To date, 17230 school children in London have been trained.

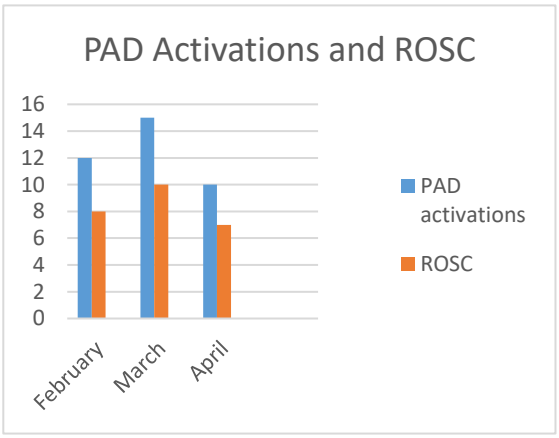




June figures are low compared to last year due to 4 of the 6 schools being Special Education Needs (SEN) with small class sizes. Due to the way the school holidays have fallen this year compared to last year has affected the figures.

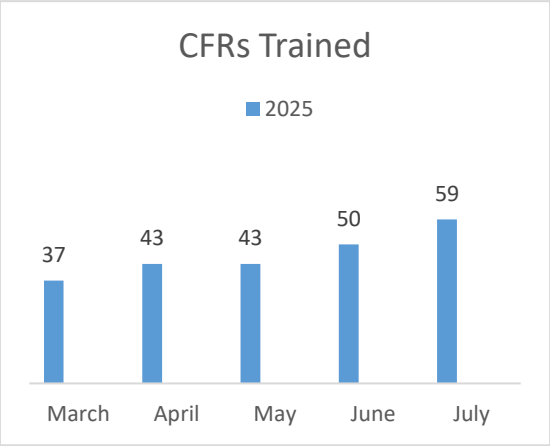
We are also addressing public access defibrillator (PAD) access through our London Heart Starters campaign. We have identified 150 priority areas, known as “defib deserts”, where public access defibrillator coverage is below expected levels. Our focus is on residential areas, as approximately 75% of OHCAs occur in the home. By working with councils, businesses and local communities, we aim to reduce the time to first shock and improve survival outcomes.

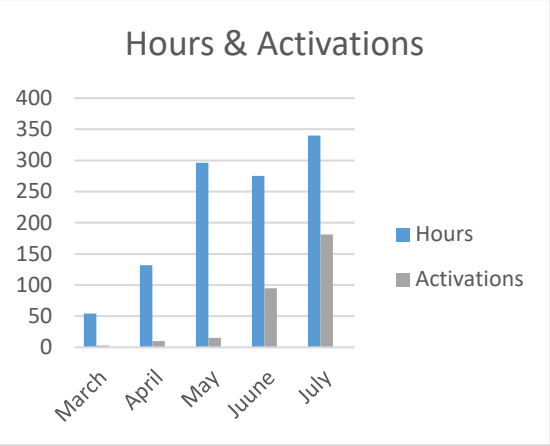




In March 2025, we launched our new Community First Responder (CFR) scheme. This is designed to provide early care from a trained volunteer responder to our most critically ill patients, whilst ambulance resources arrive. Each CFR is equipped with essential life-saving equipment, including a defibrillator, oxygen, airway management tools and basic observation kits. Responders are dispatched via a mobile device using National Mobilisation Application (NMA) technology.

Looking ahead, we aim to train 100 CFRs during 2025/26, focusing recruitment efforts in areas with the greatest need. Beyond emergency response, CFRs will play a key role in enhancing community resilience by providing targeted health advice and support within local communities.





Our volunteers are an integral part of everything we are doing to improve out of hospital cardiac arrest survival.

2.5 STEMI – June 2025

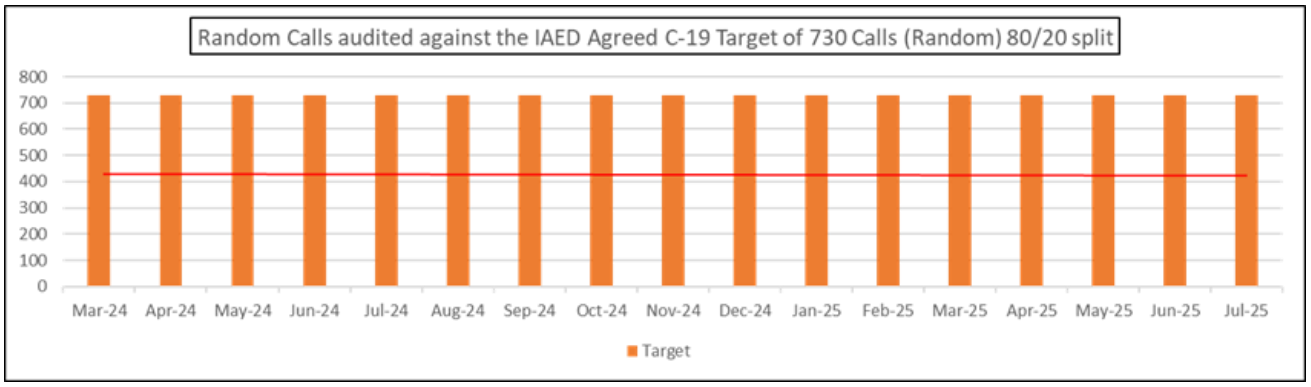
A heart attack, or myocardial infarction (MI), is caused by a sudden blockage of the blood supply to the heart muscle. It is therefore vital that blood flow is quickly restored through clinical interventions such as primary percutaneous coronary angiography and stenting. Our most recent data indicates:

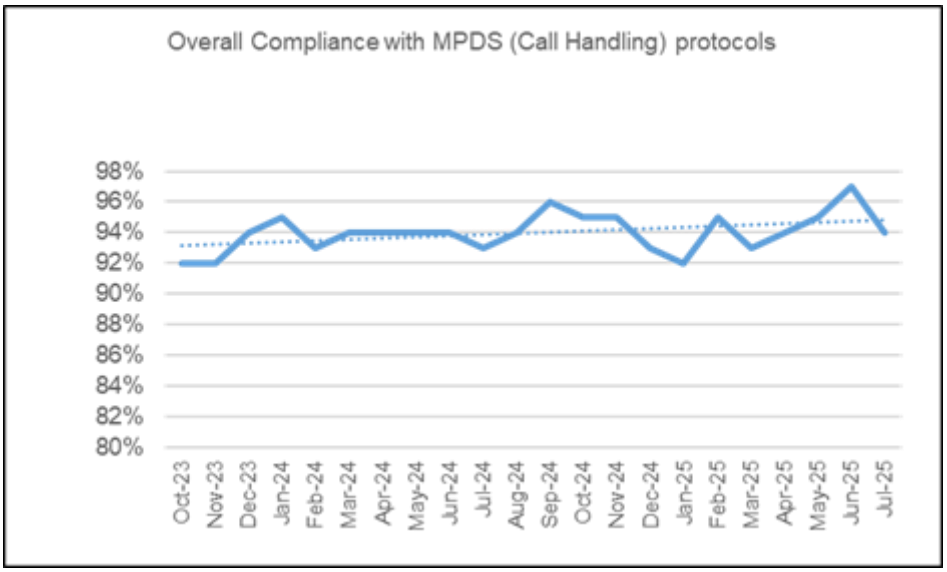
- In June 2025, 272 patients attended by LAS had a STEMI suspected by clinicians
- 99% of these patients had the ECG uploaded onto their clinical record
- 100% of the patients were conveyed to the correct destination, and 99% were conveyed directly to a Heart Attack Centre
- 80% of patients had received the complete care bundle, with 93% receiving analgesia when indicated
- The mean call to arrival at hospital time was 1 hour and 30 minutes.

2.6 Emergency 999 Call Handling

The number of 999 call audits has exceeded the required target, and the Trust has maintained ‘Ace in Good Standing’ for Quarter 2 (April to June 2025). Although 999 call volumes remained high during this reporting period, the required International Academies of Emergency Dispatch (IAED) compliance standards were maintained by EOC call handlers.

The quality assurance team continues to focus on supporting new entrants, and in addition, attends the Emergency Operations Centre (EOC) Team-Based Working huddles and training days to support the learning and development of staff. We continue to work with the Patient Safety team to share areas of best practice and share case scenarios through ‘Learning from Experience' in our Quality Assurance (QA) Journal.





2.7 111 Quality Audits

Mandatory audits across all skillsets achieved 100% completion in July, with an exceptional compliance rate of 92–97%. This demonstrates good clinical governance and sustained commitment to maintaining high standards of practice across the service.

Key themes identified during July included:

- Active listening skills – ensuring patient concerns are fully explored and understood.
- Worsening advice – not all elements of worsening instructions were consistently communicated.
- Breathing difficulties – insufficient probing questions recorded in some cases, highlighting the need for continued focus on comprehensive clinical assessment.

Local sharing of learning has taken place for the internal issues identified.

2.8 Clinical Audit and Research

Clinical audit is a tool to improve clinical quality and patient care and 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. Importantly, it can reduce variability in practice and improve standards of clinical care. It is common practice to find results being used to inform local protocols and national ambulance clinical practice guidelines.

In June, we published a clinical audit report that assessed the administration of midazolam by paramedics. This was presented to the Quality Assurance Committee in July 2025. The audit findings were shared with and informed the national JRCALC group, who were undertaking a piece of work to write a national guideline. The results of the LAS clinical audit demonstrated that, while midazolam was always administered by an appropriately skilled clinician, further education was needed around the indication and dose, which changes for age and underlying health conditions. The recommendations for improvement included:

- Updating the Midazolam PGD to align with the newly released JRCALC midazolam guideline.
- Educating clinicians regarding focal seizures, psychogenic seizures and the importance of giving advice not to drive or operate machinery.
- Considering electronic Patient Care Record (ePCR) fields for seizure start and finish time
- Contributing to the ongoing discussion regarding adding an ePCR prompt for the documentation of patient weight.

The research team continue to be busy, giving the patients we treat the opportunity to be involved in clinical research that is aimed at improving outcomes for themselves and others.

- Across the LAS, there are now a total of 671 clinicians trained in clinical trial delivery.
- The Spinal Immobilisation Study (a randomised controlled trial comparing movement minimisation with triple immobilisation - hard collar, blocks and scoop - for trauma patients with suspected spinal injury) continues to recruit strongly across the LAS. Recruitment surpassed the important milestone of 300 patients and is on track to pass 400 within the coming months.
- The CRASH-4 trial (exploring whether administering intramuscular Tranexamic Acid (TXA) to older patients with mild symptomatic traumatic brain injury can improve outcomes) opened at three new stations in the NE sector, with a further two stations due to open in the coming weeks. We have also surpassed the milestone of enrolling 300 patients into this trial.

3.0 Caring

3.1 Health Inequalities

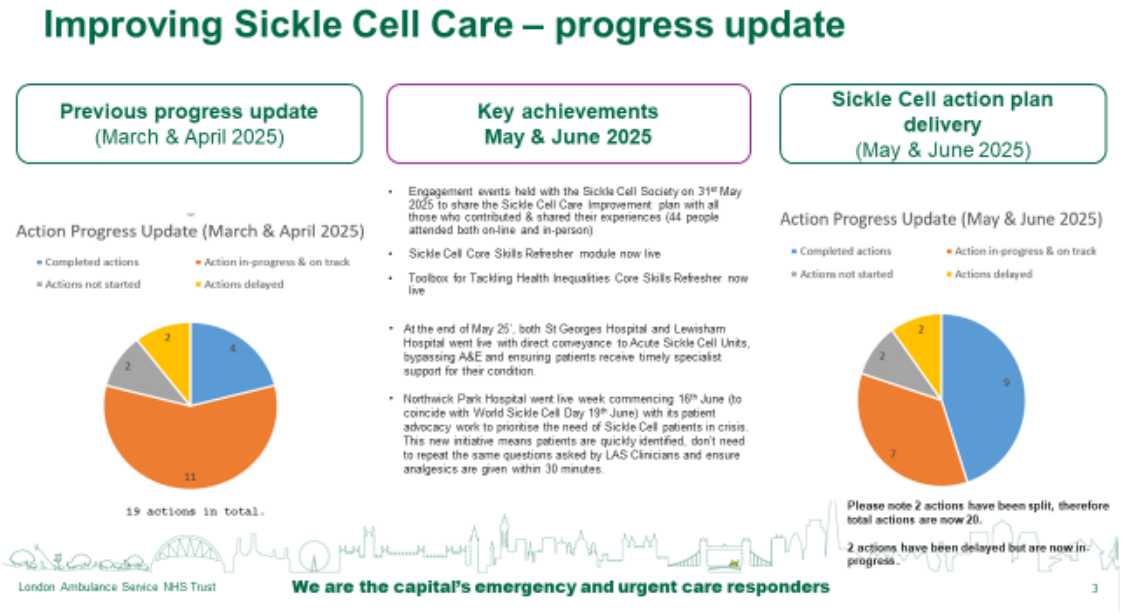
As the only pan-London acute provider, LAS has a unique insight into the Health Inequalities being experienced by Londoners.

The current status of each of the health inequalities work streams can be seen below:

Health inequalities priorities	Project dashboard	Project status
Core 20	London Lifesavers project	On track
	Increasing public access defibrillators project	On track
	Community First Responders (CFR) project	On track
	Response times across London project	Delay
LAS Plus	Cardiovascular disease project	On track
	Mental Health project	Due to start 2026/27
	Maternal health project	On track
	Sickle cell disorder project	On track
	Autism, learning disabilities and neurodiversity project	Due to start Autumn 2025
Wider determinants of health	Smoking cessation project	On track
	Housing & health (damp & mould) project	On track
	Homelessness and health project	On track
	Drug and alcohol project	On track
	Social isolation and health project	On track
Cross-cutting themes	Ethnicity	On track
	English language	On track
	Digital poverty and exclusion	On track
	Children and young people	On track

3.1.1 Sickle Cell Disease

The London Ambulance Service Improving Sickle Cell care action plan contains 20 actions, which were developed following extensive patient engagement, staff engagement and a review of the quality of care LAS provides to patients with sickle cell crisis.



7 of the actions have been completed, including:

- ***Clinical training & education:*** Roll out of a clinical education package on Sickle Cell disease and crisis, including patients sharing their lived experiences and speaking about the elements of care that our clinicians can best support with. Delivery of training continues throughout 2025/26 as part of Core Skills Refresher training.
- ***Clinical training & education****:* Roll out of an e-learning package on Health Inequalities covering racial inequalities, discrimination and the impact of health inequalities, including examples relating to the experiences of those with Sickle Cell Disease. Delivery of training continues throughout 2025/26 as part of Core Skills Refresher training.
- ***Patient-centred care: Go-live with direct ambulance conveyance to two additional acute Sickle cell units in South London –*** St George's University Hospital NHS Foundation Trust and University Hospital Lewisham. Crews can now bypass Emergency Departments at both hospitals and ensure patients with sickle cell disease receive timely specialist support directly from Haemoglobinopathy Teams. We already have direct access to Hammersmith Hospital's Sickle Cell care unit.
- ***Patient engagement & Advocacy****:* To coincide with World Sickle Cell Day (19th June), the LAS worked with Northwick Park Hospital to launch a new patient advocacy initiative to prioritise the care of sickle cell patients in crisis. This means sickle cell patients are quickly identified upon arrival at the emergency department, are prescribed medicines at the point of handover to ensure timely care and given a named clinician to administer the required treatment.

9 actions remain ongoing and on track for delivery which are being progressed with partners:

- Induction materials for new Clinicians have been reviewed and updated to include sickle cell care and will be live in the autumn for new clinical staff.

- Updates to the patient care handbook to include sickle cell universal care plans; providing guidance to staff regarding how to proceed when a patient's universal care plan differs from JRCALC guidance for drug administration.
- Review of Clinical Performance Indicators metric relating to sickle cell to ensure they are up to date and reflect updated NICE recommendations, such as the delivery of analgesia within 30 minutes.

3.1.2 Maternal Health

As part of our work to address health inequalities in maternal health, we continue to work in partnership with two Voluntary, Community and Social Enterprise (VCSE) organisations (Healthwatch Barking and Dagenham and Tower Hamlets *Council for Voluntary Service* - Flourishing Communities*)* to undertake patient engagement activities.

Both VCSE organisations have now concluded their patient engagement activities and shared their final report findings and recommendations. A range of engagement activities were held, including focus groups, 1:1 discussions, online surveys, pop-up events and group discussions with women and birthing people of Global Majority ethnicities, to understand their experiences of accessing urgent and emergency care via 111 and 999 during their pregnancy or within 12 months post-partum.

In addition to the findings of both VCSE reports, our next steps are to review the findings of the 2024 CARU audit into maternity care and conduct a staff online questionnaire. The findings and conclusions from all three key engagement elements with involvement from patients, staff and clinical audit will enable us to develop and implement an improvement plan to help address the specific challenges identified directly by the affected patient groups, and support maternal health improvement in LAS.

English Language proficiency

As part of the LAS five-year action plan to respond to London's Health Inequalities, one of the cross-cutting themes that has been identified is English language proficiency, which contributes to clear disparities in healthcare access, experience and outcomes.

- ***Maternity leaflet:*** In collaboration with Happy Baby Community (a charity that supports women and birthing people and are claiming asylum or seeking refuge in the UK) we have co-designed, and finalised, a maternity health leaflet which contains important information on the services available to support pregnant women. The leaflet has been translated into nine commonly spoken languages. Our next steps are to arrange distribution with charities that promote maternal health, to help improve access to appropriate antenatal care and promote appropriate access to LAS services for women and birthing people with low proficiency in English.
- ***General patient information leaflet:*** We have developed general patient information leaflets to support those with low English language proficiency to navigate health care

services. These have been translated into nine commonly spoken languages, and our next steps are to agree on our distribution routes through charities and organisations.

3.1.3 Social Determinants of Health

We continue to make progress with our Social Determinants of Health, which focuses on the tangible interventions our crews can take to promote improved, longer-term health and prevent ill-health.

Drug and alcohol substance addiction
Crews within North East London have been providing signposting interventions to patients who present with a condition related to alcohol or drug addiction. We are currently working with Turning Point, Hackney, to confirm if any of the patients who were signposted presented to the addiction service to inform future developments in these pathways.

Housing and health
We have agreed digital changes to our safeguarding referral application, to increase awareness, confidence and quality of the reporting of housing concerns, such as the presence of damp and mould. This has been co-designed with external partners to ensure it contains relevant and actionable information for the receiving local authorities. We are currently awaiting the relevant changes to be made on the safeguarding forms and to agree on a go-live date and communication plan.

Homelessness and health
Our crews continue to signpost patients and provide information on roving homelessness support charities who provide a one-stop shop for patients, including oral care, general care, mental health, financial, employment and housing support, such as the Driving for Change initiative by the Change Please Foundation. We have also published details of General Practices that specialise in providing health care for patients experiencing homelessness, as well as advocacy material to support our clinicians to empower patients to register and access primary care services.

Social isolation and health
We have reviewed national recommendations on improving response procedures in prisons, published early this year and are liaising with the Association of Ambulance Chief Executives, seeking a joint collaborative approach to take forward the recommendations.

3.2 Alternative Care Pathways and Care Co-Ordination

3.2.1 Alternative Care Pathways

The central clinical pathways team is focused on the development of Integrated Care Coordination (ICC) Hubs and the Alternative Care Pathways (ACPs) that can support patients to be cared for in the most appropriate place that meets their needs, avoiding unnecessary

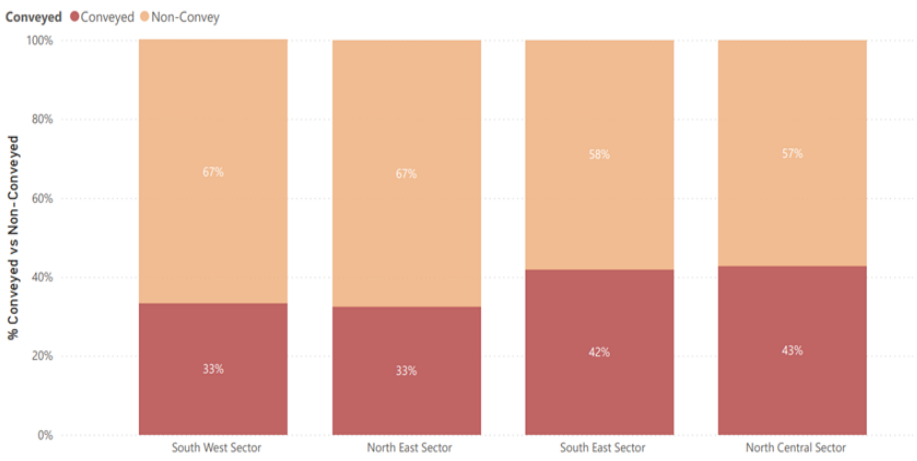
Emergency Department admission. Referrals to Urgent Community Response services remain consistent, despite education and engagement initiatives.

A priority for pathway development within the developing ICC Hubs is with UCR services, and a collaborative action plan has been agreed by the Trust, NHSE Region and ICBs to improve overall access and referrals to services. The Trust has contributed to the development of standardised regional frailty criteria, which are being adopted for the growing number of frailty pathways that LAS clinicians can now access.

3.2.2 LAS Urgent Community Response Cars

A total of 8 Urgent Community Response (UCR) cars are in operation across NC, NE, SW, and SE London. It has reduced from 10 due to providers in the SW and NW London deciding to withdraw from our collaboration. 526 patients were attended to during July 2025, and a total of 154 ambulance conveyances were saved. Collaboration meetings between LAS and external UCR providers continue with weekly/monthly sessions in place. We have continued to work together to maximise the number of patients the LAS UCR team see, as this results in a smaller percentage of patients that require conveyance to an emergency department.

Below shows conveyance/non-conveyance percentage (including Category 1s) and total face-to-face incidents LAS UCR cars attend.



Incidents attended by Urgent Community Response cars result more often in non-conveyance than conveyance.

On 23rd July, a paper was presented to LAS EXCO with a proposal to disestablish the LAS's UCR Cars with a view to expanding and utilising an existing LAS clinician group to attend the same group of patients, but without the need for an external nurse clinician. The proposal was approved, and a separate paper covers this with further information.

LAS will continue to refer to the ICB-based UCR cars to ensure patients receive a response at home wherever possible.

3.2.3 Integrated Care Coordination

The LAS is supporting the five ICS in their development of Integrated Care Coordination (ICC)/ Single Point of Access (SPoA). The aim of these models is to coordinate an urgent and emergency care response, enabling referral to the most appropriate services to meet patients' needs, navigating them to the right place at the earliest point in their journey. Integration is key, working across service and professional boundaries, further embedding the LAS within the wider health system.

In conjunction with ICB and acute partners, the LAS started hosting ICC Hubs at the beginning of 2025; NCL commencing in January, NWL in March and recently SWL in August. Each ICS is at a different stage of development, in NEL tests of change are underway, and the LAS is engaged in conversations with SEL ICB and UEC leads.

Within each ICC Hub, a multidisciplinary team (MDT) provides rapid access to remote clinical consultation for patients, decision-making support to ambulance clinicians and streamlined access to a range of Alternative Care Pathways. The teams include senior clinical decision makers; GPs, ED Consultants, and Advanced Paramedics in Urgent Care, working in conjunction with Paramedic Clinical Advisors. Their role is to review 999 calls and identify patients who are unlikely to require ED attendance, instead providing assessment and advice or referring them directly to an alternative acute or community service.

Early evaluation of models shows a positive service user experience and reduced need for ambulance dispatch and ED attendance. Acute and community service integration is enabling the development of additional pathways, for example, with discharge hubs, virtual wards, high-intensity users and integrated neighbourhood teams.

Initial evaluation of 1,173 cases in the NWL ICC over the first 9 weeks showed the benefit of senior clinical decision makers assessing 999 calls; 48% of cases did not require an ambulance to be dispatched, and only 22% had an ED outcome. During 63 shifts, analysis demonstrated that the ICC Hub avoided 339 ambulance dispatches, 195 ED attendances and an estimated 166 hospital admissions were avoided. These are early results that illustrate the potential for ICC Hub models as they become established, with an expanded MDT and integration with community services.

4.0 Well-Led

4.1 Quality Regulation

LAS continues to engage regularly with CQC and respond to queries

Monitoring of internal processes is being carried out by unannounced internal audits completed for Group Stations. The most recent of these audits has highlighted some key areas for focus:

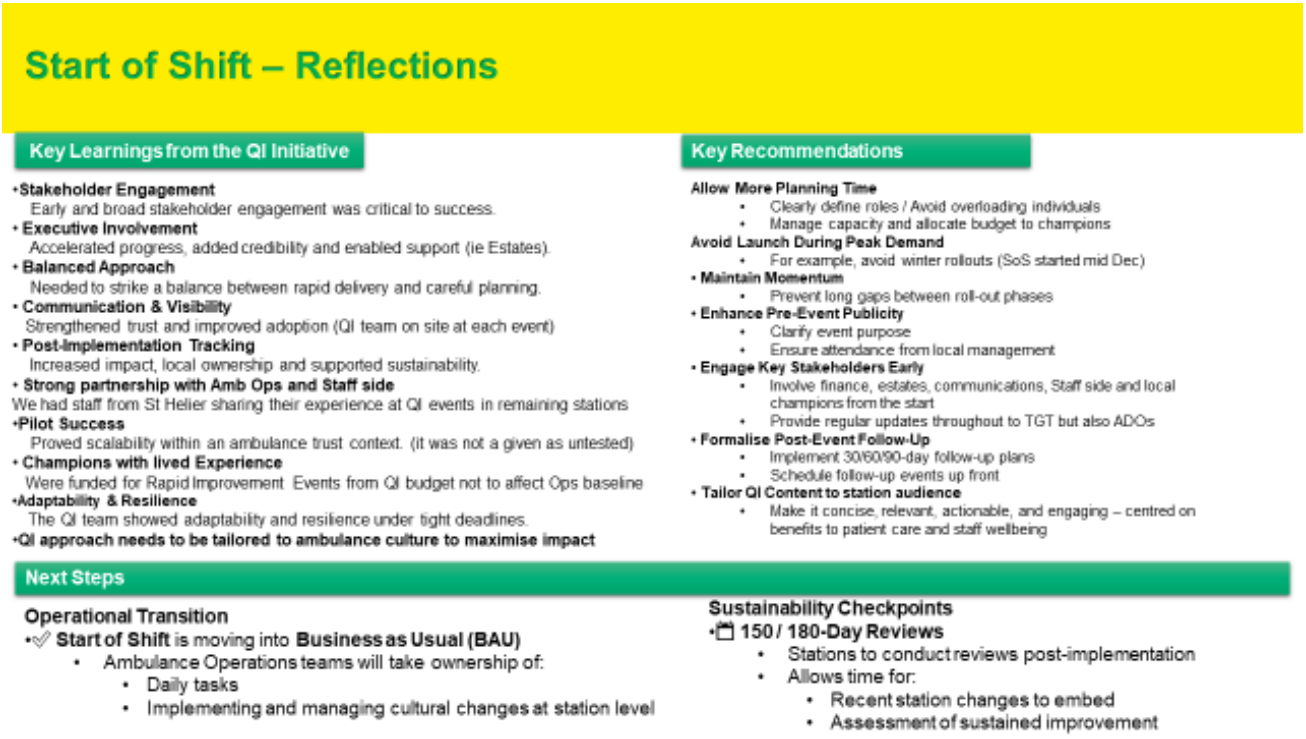
- Not being challenged when entering the site/building
- Internal doors not secured
- Unlocked vehicles outside the site perimeter
- Unlocked vehicles inside the garage
- Green & Red lockers do not match KIT prep
- Dirty Linen was not segregated and was in inappropriate bags
- Non-clinical waste in the clinical waste bin
- Pharmaceutical bins not correctly completed
- Local risks not displayed
- The current version of the IPC advice poster is not displayed

These findings are addressed at the local governance meetings, and support is offered to develop improvement plans where needed.

4.2 Quality Improvement

Start of Shift

The final project report has been completed and presented to the Executive Committee. This has now moved to Business as usual. Lessons learnt and reflections have been captured to ensure we continuously learn from QI projects and their implementation. The Start of Shift project has been shortlisted for the Health Service Journal (HSJ) award in the 'Staff health and wellbeing' category.



Home on Time Rapid Process Improvement Workshop

Following feedback from staff and managers, the focus of the next Rapid Process Improvement Workshop (RPIW) is ensuring staff finish their shifts on time. Working closely with Ambulance Operations and EOC, the 5-day event is scheduled for early September.

QI Training

The next two cohorts of Lean for Leaders are commencing in September. Additionally, the team co-delivered Introduction to Lean with SASH, where 15 participants learned about Waste, Value, and the 5S tool that they can immediately apply in their workplace.

Central Packing Hub

The QI team has been supporting Strategic Assets and Property in optimising operations within the Central Packing Unit. This work included a site visit to Rainham and process mapping covering the journey from packing through to delivery.

Missing Equipment

The QI team has been supporting the Missing Equipment Working Group by facilitating process mapping sessions with key stakeholders from Logistics, Ambulance Operations, and Make Ready teams, among others. The sessions mapped current and future states from warehouse distribution to being scanned onto a vehicle. Identifying priority areas for the project, potential steps for change and feedback to senior management.

New Heathrow Hub

The QI team supported with some of the planned layout design and will continue to provide support and advice as the plans develop.

5.2.2. Quality Assurance Committee Report

For Assurance

Presented by Karim Brohi

London Ambulance Service NHS Trust

Alert – Advise – Assure Committee Board Report

Assurance report:	**Quality Assurance Committee**	**Date:17/07/2025**	
Summary report to:	**Trust Board**	**Date of meeting:**	**11/09/2025**
Presented by:	**Karim Brohi**	**Prepared by:**	**Sarah Whittingham**

Alert

Issues that require Board attention:

- None

Advise

Items where Board input or awareness is needed:

- The committee discussed the need for ongoing evolution of the digital risk report, mapping issues into governance structures, and clarifying which subcommittees oversee which risks (e.g., audit vs. quality). There was agreement to keep a "watching brief" on digital and cyber issues, given their cross-cutting impact on clinical, HR, finance, and operations. The Quality Report identified the top categories for the reporting period are as follows:
  - ➢ Medical equipment – specifically failure of device/equipment.
  - ➢ Reports of violence/aggression – specifically, direct verbal abuse.
  - ➢ Medicines management – specifically controlled drug audit errors.
- It was noted that where an increase in incidents are seen there are cross directorate task and finish groups to identify the issue, agree changes and provide assurance – these have included access permissions for the Abloy Key (drug cupboard access). An audit has confirmed that there were no incorrect access permissions on Abloy keys.
- The Quality report highlighted the issue of a small number of patients being denied access to specific hospitals often due to threatening and aggressive behaviour, and the risk this poses to both patients and staff. It was explained that there is ongoing dialogue with NHS England to understand the risks and work towards a resolution.
- Delays in hospital handover are being overseen at the ICB level, with NHS England national and regional UEC teams now holding ICBs accountable. Over-45-minute handovers are closely monitored to ensure LAS has enacted the plan, and the trust remains in close dialogues with specific hospitals.
- It was reported that there had been seven CQC queries covering a range of subjects. At the time of the meeting 4 were still being

	responded to. The organisation is continuing to do preparatory work for any future visits including working closely with other ambulance services to share learning. PSIRF Internal Audit by BDO -The audit covered data from 2021-2022. Although the actions for the audit had been closed given that PSIRF is now an embedded national process a further review was undertaken against the actions and recommendations and assurance was given which included internal audits and reviews of PSIRF as part of quality reports, sector meetings, and other internal governance processes.
Assure:	**Positive assurances for the Board to note:** • The committee was updated on the Clinical Quality Team Integration noting the quality and clinical teams have been integrated into a single clinical quality team. This integration aims to create shared objectives and improve collaboration within ambulance operations. • It was reported that the Quality team restructure has led to improved morale and more time for important tasks. The team is now able to spend more time on thematic work, including recent projects on skill mix and health inequalities. • The Chief Paramedic Performance Report reflected a positive trend in performance in several areas, with improved response times, increased hear and treat rates, and reduced long waits, all achieved despite rising demand. The committee emphasised the importance of linking these improvements to patient outcomes and staff engagement. • An update on the transition of the "start of shift" quality improvement work into business as usual was provided noting all central QI work is complete, but some implementation issues remain, affecting full realisation of benefits at some stations. • The committee recognised the positive staff engagement and early successes of the QI approach, while acknowledging the need for continued alignment with clinical priorities and robust measurement of impact.
Risks:	**Risks** • The first clinical digital safety report for the trust was presented, aiming to identify and distil the top issues and risks at the intersection of clinical safety, patient safety, and digital systems. This is a new and evolving area for the organisation. • BAF - It was reported that five risks have been rolled over into the 25/26 BAF with two significant new risks being added: • 1.8: Mental health, with a risk score of 16.

	• 1.9: Learning and triangulation, initially scored as 9 but increased to 12 (with a mitigating risk of 16) after review. • Some risks are expected to be reduced soon, and there will be follow-up on progress at the next meeting.
Decisions & Recommendations	• PSIRF Audits - . It was agreed that the committee will continue to monitor PSIRF internally and only consider external audit if it adds value in the future. This assurance was agreed to be taken into the audit committee

5.3. People and Culture

For Assurance

5.3.1. Director's Report

For Assurance

Presented by Simon Steward

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust Board Meeting September 2025 (July 25 data)

Report from the Chief People Officer

Executive Summary

Organisational Development and Talent Management (OD&TM)

The Organisational Development and Talent Management (OD&TM) Team has made significant progress across multiple strategic priorities. Career pathway development is underway across key operational areas, defining roles and learning interventions to support internal mobility. We have secured two NHS Graduate Management Trainees for 2025/26 and successfully hosted a DFN Project SEARCH intern, receiving outstanding feedback. A new organisational change support package has launched to assist colleagues through consultation with targeted development and wellbeing support.

Leadership capability continues to grow through four commissioned programmes, the Centre of Excellence for Leadership and Culture (CELC) pilot, and bespoke interventions. More than 5,000 colleagues have engaged with the Trust's Tackling Discrimination and Promoting Inclusivity (TDPI) programme, and statutory and mandatory training compliance is at 89.16%. The Appraisal Compliance Improvement Project has achieved the 85% target and expectations are for greater compliance with the rollout of the e-Appraisal system.

Additionally, LAS has been ranked third in the UK in the Sunday Times Top 100 Apprenticeship Employers, the only NHS trust in the top 10. The Culture-Led Operational Improvement Programme pilot with the Homerton Group has concluded with a full analysis now informing co-designed interventions in the next phase.

Recruitment & Retention

Recruitment to the Trust Workforce plan continues at a positive rate. The current pipeline is at circa 600 candidates at conditional offer stage. Overall fill rates for Q1 were at 84% with 98% achieved for July. Corporate/Specialist recruitment – there continues to be recruitment activity to support the frontline including recruitment into Advanced Paramedic Practitioners, CRU, TRU, HART, HEMS, PCN Programme, Mental Health and Community Resuscitation roles.

Turnover levels have remained at 9% with stability rates above 90%.

Health and Wellbeing

Wellbeing Activities

The Wellbeing Team has been working to enact the People and Culture Supporting Absence Management Plan, which includes an increased focus on prevention of mental health and musculoskeletal (MSK) illnesses where possible; more focused sickness absence data and supporting managers with complex sickness absences. Working with the other teams within the Organisational Development and Employee Experience Team (OD & EE), the Wellbeing Team is also developing new sickness absence training and a manager's guide to wellbeing, promoting the Association of Ambulance Chief Executive's (AACE) Mental Maintenance Toolkit. In addition, the Resolution Advocacy and Mediation Manager has joined the Wellbeing Team and is undertaking resolution training with team members.

P&C Operations

1. Recruitment

- We ended Q1 continuing with our positive performance with strong pipelines and fill rates. We achieved an 84% fill rate across all available course spaces, improving to 98% in July.

- **Frontline recruitment** – All International courses for this financial year are now completed (one course in April only). The March UK Grad Partner course was fully booked and we ended the year having recruited to all training places for this group. For those Partner University students who graduate in 2025/2026, applications have opened with 217 applications received. The current pipeline for AAP is 115 who are at offer stage and completing their pre-employment checks.

- **Call Handling Recruitment**

  There have been changes in the course requirements within EOC during April, June and July. June saw a reduction in places and July was uplifted, the team have been able to meet the changing requirements. The current pipeline has 12 candidates at conditional offer stage and the team are working with EOC on future pipelines.

  For 111, there were no planned courses during April 25 with May, June and July having full courses on all available spaces. Discussions continue with the area on future requirements for the remainder of the year.

  Corporate/Specialist recruitment – there continues to be recruitment activity to support the frontline including recruitment into Advanced Paramedic Practitioners, CRU, TRU, HART, HEMS, PCN Programme, Mental Health and Community Resuscitation roles.

2. Retention

In July the 12 monthly turnover has returned to below 9% with stability rates at 92%. There are a number of key retention initiatives in progress covering flexible retirement, stay conversations (111 and 999 services), personalised holistic health plans, and improvements to the flexible working process and policy which have helped to streamline the process and improve reporting of activities.

3. Employee Relations

To meet the commitment in the Trust's Business Plan to improve employee experience and engagement for those colleagues requiring resolution, there have been a number of improvements to the Resolution Hub. These have included an increased use of technology to track and submit RfR (Request for Resolution) forms, independent panels and more emphasis on early resolution. Feedback so far has been positive, with all complete RfRs triaged within the same week of submission. This is part of our focus on reducing overall case volumes and length.

To improve the management of ER cases, we have delivered a number of Trust-wide training sessions, which have now been adapted to include reference to the new resolution hub process and what types of cases can be resolved at a local level. To support this a number of new resolution advocates and mediators have been recruited who will be able to assist as appropriate. In addition, managers have been invited to attend mock tribunals. There is also a bi-monthly meeting where all ET cases are reviewed for assurance and learning.

4. Workforce Intelligence, Payroll & Pensions

Workforce Planning

Further development of the 2025/2026 plan has taken place and discussions have started to look at requirements for 2026/2027 and beyond. We will continue our efforts to bring forward the production of the training and recruitment plan to the earliest stage possible as this has proved very beneficial. The collaborative and multi-disciplinary approach across Corporate and Operational teams to both design the plan and to ensure that data systems are aligned across Finance and Workforce has continued. The monthly discussions in place to track performance against plan enables early identification of expected over and under establishment so that any further agile and informed decisions about recruitment can be taken. There is a regular review of leavers and internal movers and subsequent refresh of plan and forecast. There is strong visibility of the planning position at Transformation Boards, Ambulance Workforce Group, Trust Workforce Group, People & Culture Committee and Executive and Board level.

People Scorecard

With a particular focus on triangulation of data, the set of workforce key performance indicators which feature in the Performance Review packs, has been further refreshed to now cover KPIs for vacancy, staff in post, sickness, leavers, statutory and mandatory training, appraisal, turnover, stability, employee relations data and ten equality, diversity & inclusion indicators covering ethnicity, disability and gender. This data provides greater visibility and insights, better explains performance and helps to pinpoint areas for improvement.

Technology

P&C Digital Assistant - the People & Culture team have worked in partnership with East and North Hertfordshire and IBM to deliver a digital assistant for all Trust staff. This new digital technology is providing all LAS staff with the ability to ask P&C related questions and access vital information at a time which suits them. In addition, it is reducing the administrative burden on our HR teams and freeing up their time to focus on more value-added and complex HR activities. It is available for our 8,500 employees and managers, 24 hours a day and 365 days a year and contains a bank of common questions and answers relating to People & Culture and is also able to search People & Culture policies to find answers for specific questions. Since launching in December we have received over 8,000 questions with a 93% recognition rate for responses. 47% of questions have been asked out of hours (1700-0900 Monday to Friday and weekends).

Intelligent Automation - Implementing digital workers in the People & Culture Directorate

With the focus on driving down costs to meet control totals, we have been investigating technological changes to drive new ways of working to improve efficiency. The natural next step is to look at opportunities where high volume low-level processes would benefit from automation ie a digital worker. In P&C the opportunities are considerable and to date 32 processes have been identified which are suitable for automation. From September 2025 we will be mobilising a project to adopt this automation as a 12-month proof of concept to fully test the technology by automating ten priority P&C processes based on time saved across most P&C functions (some of the processes will benefit multiple teams).

DBS checks

As at 31st July 2025, the Trust has a 99.7% 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.

5. Health and Wellbeing

Occupational Health

Both external Occupational Health (OH) providers continue to meet their Key Performance Indicators (KPIs). We continue to offer a comprehensive programme of physiotherapy and tailored support to colleagues with musculoskeletal injuries via our physiotherapy provider, The Psychotherapy Network (TPN). Additional data from both providers has allowed the Wellbeing Team to start work on areas with low usage of occupational health or longer than optimal referral times. Promotion of TPN's Desk Clinic self-help section has also assisted colleagues who have very minor injury or pain with exercises they can do at home that are targeted to their specific issue.

Mental Health Provision

Colleagues are able to access counselling directly, including trauma-focused therapies such as Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) via Optima's 24/7 EAP line or manager referral. Further advanced therapy, for conditions such as complex or historic Post Traumatic Stress Disorder (PTSD) is provided by the LAS' psychotherapist. Peer support and signposting to specialist services is also available to all colleagues via our Wellbeing Hub and LINC peer support network.

Wellbeing Activities

The Wellbeing Team has had a greater focus on sickness absence and prevention, particularly absence related to poor mental health or musculoskeletal (MSK) injury. This has included:

- Capturing and analysing occupational health and sickness data to improve referrals, referral times and identify areas of high and low usage mapped to sickness levels. This has also served to pinpoint variations in sickness types across the Trust and enable the Employee Experience team to produce a more bespoke response.
- Close working between the Wellbeing and HR team on sickness support, particularly what additional specialist help may be available for those on long-term sick or who have repeated absence for the same condition.
- Developing additional absence management training centred on disability and reasonable adjustments to ensure colleagues have all possible support available. The Employee Experience team has also delivered sessions at the inaugural Centre of Excellence for Leadership and Culture (CELC) programme – an internal management development programme.
- Targeted roll-out of psychological surveillance questionnaires that allow colleagues to reflect on their own mental health, with answers analysed by Optima clinicians and supportive measures put in place as appropriate, with focus on areas with high stress-related absence.
- The Wellbeing Team has developed a number of new processes to support the work of the Resolution Advocacy and Mediation Manager and ensure that colleagues receive appropriate early resolution guidance. The team will also be trained in conflict management and resolution advocacy.
- Providing wellbeing support via phone and in person – feedback on the LAS Wellbeing Hub continues to be consistently high with a good or excellent rating of 97%. On average more than 900 colleagues a month contact the Wellbeing Hub.
- Engagement with operational and corporate managers via wellbeing drop-ins, attendance at team meetings and individual support.
- Preparing for the 25/26 flu season, including calibration of all vaccine fridges, creating a manager and vaccinator flu guide and reviewing areas of success from the previous year's programme.
- Introducing additional clinical support options for colleagues who are at risk of absence via a pilot scheme that will be rolled out to the rest of the Trust if successful.
- Overseeing our Wellbeing Support Vehicles (WSVs) and cafes, for which feedback continues to be consistently high. Supported by the LAS Charity, colleagues are able to access the WSVs at hospitals and cafes in our contact centres, where they can have a free drink, snack and chat about their wellbeing with a trained colleague.

6. Freedom to Speak up

The Freedom to Speak Up (FtSU) team provides vital insight and guidance on the culture of our Trust as part of our Employee Experience department. There are 50 FtSU ambassadors across the Trust - colleagues who have volunteered to undertake additional training and

promote speaking up locally. Twenty-two of these colleagues are trained in sexual safety and support colleagues to raise concerns of this nature.

The FtSU Annual Report has now been through the established governance route and a number of priorities agreed for the coming year. As part of this, the team has developed a new reporting framework that will allow them to share monthly data and limited information about concerns on an anonymous basis with relevant Directors or Executives. This should ensure that there is additional visibility of concerns that are taking time to resolve and that themes and the impact of FTSU concerns are better understood. The team has also started to visit areas of the Trust where there are lower numbers of concerns and are preparing a survey for the autumn that will better ascertain colleague's understanding of the process.

7. Organisational Development & Talent Management (OD&TM) Team

Talent Management

Career Pathways

- The team is currently on phase two of developing career pathways across Ambulance Operations, Emergency Operations Centre, 111 and Resilience and Specialist Assets/ Specialist Paramedic roles.
- The team has created the career paths for these areas through engagement with key stakeholders.
- Phase two will see joint working with stakeholders to understand 'core positions' in each of the areas and then creating 'career profiles' that capture the purpose of the role/ key skills and then learning and development interventions to support colleagues in their development journey - getting them ready for their desired role.

NHS Graduate Management Trainee Scheme

- LAS have been successful in securing one HR trainee and one General Management Trainee for 2025/26. These trainees are due to join us on 1 September 2025 to start their 20-day orientation
- The team is currently building a placement structure and orientation working with our current trainees to design and develop this to ensure the best experience for our new starters.

Project SEARCH

- The team was proud to have hosted a DFN Project SEARCH intern in the OD&TM team for a three-month rotation. DFN Project SEARCH is a work programme where young adults with a learning disability/autism are able to ascertain work/employability skills.
- The intern was with the team and took on a range of administrative tasks, and going on ride outs with wellbeing colleagues on the tea trucks.
- This rotation is now completed and LAS have received outstanding feedback for the quality and support given.

Organisational change support package - consultation support

- The team has designed and developed a new support package to provide support to colleagues, who are going through organisational change. This support ranges from:
    - Values-based interview skills sessions

- Personal development sessions - including; boost your confidence, coping with uncertainty, managing stress and building personal resilience, communication skills, presentation skills and more.
- Leadership development sessions - including; understanding yourself as a leader and leading through change.
- 1-2-1 bespoke support - including application and interview skills, mock interviews and career coaching conversations.
- Signposting to 'on the go' learning opportunities and LAS exclusive memberships, such as NHS Elect and London Leadership Academy.
- Signposting to internal wellbeing support services.

Team Support

- The team was commissioned to support the Medicines Packing Unit (MPU) to support them in enhancing their skills to enable them to apply for internal roles at LAS and in the MPU.
- This took the form of application writing, values based interview skills and 1-2-1 support.
- 100% of feedback forms stated attendees would recommend this support to a colleague.

Ad-hoc career conversations

- The team continuously engage and host career conversations with our colleagues across the service.

Learning and Development

Tackling Discrimination and Promoting Inclusivity (TDPI): Phase two

- The Trust is currently running TDPI: Phase two at both Dockside and Brentside until 13 November 2025.
- From Sept 2024 - July 2025 we have delivered sessions to over 5,020 colleagues.
- A further 697 colleagues have booked onto future sessions - we also have 68 sessions remaining.

Statutory and Mandatory (Stat and Mand) Training

- LAS has fulfilled all requests from NHS England to date in relation to the proposed new requirements.
- All Core Skills Training Framework staff groups and roles were reviewed in June alongside tandem the Workforce Intelligence Team and our subject matter experts.
- The next steps are due by 30 September 2025, which is to create an annual Statutory and Mandatory review plan.
- The NHSE Digital Passport – a portable employee record of their statutory and mandatory training - has been de-prioritised. This does not affect LAS colleagues bringing over their existing compliance.
- NHSE is expected to release the new 'Framework' in the autumn
- Statutory and Mandatory training compliance across the Trust stands at 89.16%.

Leadership and Culture Management

Appraisal Compliance Improvement Project

- This has continued to be a focus for the team to drive appraisal compliance across the trust to achieve and sustain the 85% target and ensure that every colleague receives timely feedback and development planning.
- Phase one of the improvement project achieved great success and phase two began in June 2025 with the following actions:
    - Further email reminders sent to all non-compliant colleagues, those with appraisals due (within the next three months), and their line managers.
    - The Head of Organisational Development & Talent Management has contacted directors individually to secure leadership support for compliance in their areas.
    - Monthly compliance data is distributed directly to Senior Leadership Teams to maintain visibility of this area.
- Appraisal compliance Trust wide is 85.04%

E-Appraisal System roll-out

- Following a successful pilot, the e-appraisal system will roll out organisation-wide in 2025/6. We are liaising with the provider and our own internal subject matter experts to ensure there is robust interface between the external system and our own internal systems in readiness.

Team Effectiveness

- The team has continued to enable and inspire team effectiveness through the delivery of bespoke interventions, blending theory with practical applications to effective team working. The team has been supporting colleagues as part of the consultation support package with building resilience, stress management and coping with change.
- The team has designed and launched a three-minute Guide to Effective Team Huddles animation to support the previously published written guide.
- We continue to hold meetings with our CTM/TMs and OD Collaborative, to gain more insight and understanding to the needs of our operational colleagues and to benefit from their feedback to our work streams. These take place on a bi-monthly basis.

Leadership Development Programmes

- In terms of our commissioned leadership programmes the following update is provided:
    - High Performing Leaders, Henley Business School - 23 colleagues completed with a further 2 cohorts to start in Sept 25 and the final cohort in early 2026.
    - PGCert in Healthcare & Medical Leadership, Cumbria University - 39 colleagues currently on the course. The first cohort have completed the programme and await results, with the remaining two cohorts completing in Jan and May 26 respectively.
    - Advanced Diploma in Management Practice, Middlesex University - 67 colleagues currently completing cohort 8-10 with 118 colleagues in cohorts 1-7 having successfully completed the programme. Colleagues from the OD&TM team were proud to represent the service at the graduation ceremony for 17 colleagues held at Middlesex University in June, with further ceremonies for those who have completed to take place in the coming academic year.
    - Aspiring Leaders Programme, NHS Elect - 47 colleagues across 3 cohorts completed the programme with a further of cohort of 24 colleagues to start in September 2025. We will be reaching out to colleagues for expressions of interest in the coming days.

Centre of Excellence for Leadership and Culture (CELC)

- In May 2025, the team officially launched the CELC pilot cohort. Thirteen colleagues from Ambulance Operations attended the inaugural two-day leadership module - 'Management Essentials.'
- Participant feedback has been overwhelmingly positive. Attendees reported a substantial increase in their knowledge of core leadership concepts, scoring 4.82 out of 5 on the question, "How likely are you to recommend this module to a colleague?" This strong endorsement reflects both the relevance of the content and the quality of our facilitators, who are drawn from the OD&TM Team and subject matter experts from the wider People and Culture directorate and organisation as whole.
- A development session took place in June, covering Insights Discovery and an introduction to Action Learning Sets - this also received encouraging feedback, and the 'Building Healthy Teams' module was delivered in July.
- Concurrently, recruitment of Performance Managers into the Emergency Operations Centre (EOC) means that we will launch the first official cohort of CELC apprenticeship in August.

Me and My Leadership Style

- The OD&TM team has released additional short videos in the "Me and My Leadership Style" series. These feature: Stuart Crichton, Director of 999 Operations, and Chris Crawley, CTM, HART.
- Further episodes will roll out throughout our "Year of the Inclusive Team," showcasing a range of leadership experiences and approaches from across the organisation.

Apprenticeships and Employability

- Our LAS Apprenticeships have been ranked third in the country in the Sunday Times Top 100 Apprenticeship Employers listings.
- The prestigious annual rankings celebrates the UK's outstanding apprenticeship employers - recognising their commitment to creating new apprenticeships, the diversity of their apprentices, and the number of apprentices who successfully complete their apprenticeships.
- The LAS was the only NHS Trust to make the top 10. The British Army and The Royal Navy held the top spots. The LAS was also recognised as having one of the highest diversity scores amongst the 100 employers featured in the ranking.

Culture-led Operational Improvement Programme

Homerton Group pilot

- All the team deep dive sessions have now been completed.
- All intelligence gathered (from the Culture climate questionnaire and team deep dives) has been analysed and themed.
- Full management report has been written and going through internal P&C governance process.

- Next steps are to report out to Ambulance Operations management team, move towards co-design of interventions, mobile and evaluate.

8. Clinical Education & Standards

In 2025/2026, Clinical Educations and Standards have delivered the following training:

Newly Qualified Paramedics (NQPs)	18
EMT to NQP (Cumbria)	72
Internal upskill Emergency Medical Technicians (EMTs)	35
Assistant Ambulance Practitioners (AAPs)	28
Experienced Clinicians	3
Non-Emergency Transport Service (NETS)	15
Critical Care Transfer Service	7
Emergency Call Handlers (ECH)	11
111 Call Handlers	47

A further 57 frontline staff, 20 Emergency Call Handlers and 14 Health Advisors have started their training courses.

As of 31st July 2025 the Core Skills Refresher (CSR) 2025/2026 face to face session (Resuscitation Level 3, Moving & Handling Level 2, EPRR , Clinical Decision Making) has been delivered to 2283 frontline staff, with 639 out of 870 spaces booked in the next 2 months.

The 2025/2026 CSR eLearning has been launched with parts one and two live now (Information Governance, Moving & Handling Level 1, JESIP, Initial Operational Response (EPRR), Fire Safety, Resuscitation Updates, Paediatric Assessment - Sepsis & Spotting The Sick Child, IPC Level 2, Mental Health, Older Person Fallers, Sickle Cell, ECGs, Health Inequalities, Capacity. The Medicines Safety and Transgender Awareness sessions will be live very soon.

The LAS continue to invest in quality education, training and development for its workforce in 2025/26, with the enhanced education bursary of up to £5,000 per person which will greatly benefit our growing and diverse workforce. The scheme is so popular that some institutions have depleted their funding source. Funding remains available at other institutions. The 2025/26 Registrant CPD funding is also accessible to our registrant colleagues.

The Clinical Education & Standards (CE&S) team is actively contributing to several key areas of innovation and digital transformation within the Trust:

- AI Integration in Call Handling Training
  CE&S is involved in the development and implementation of artificial intelligence tools to enhance call handling training.

- Digital NQP Portfolio Development
  Work is underway to create a fully digital portfolio for Newly Qualified Paramedics (NQPs). This initiative aims to streamline documentation, improve accessibility, and support continuous professional development through interactive and user-friendly digital platforms.
- Enhanced Simulation and Digital Learning Offerings
  CE&S is expanding its simulation capabilities and digital learning resources. This includes the use of immersive technologies as well as the development of online modules and e-learning tools.

These initiatives reflect CE&S's commitment to modernising education and training, improving learner engagement, and ensuring that clinical staff are equipped with the skills and tools needed to deliver high-quality care in a rapidly evolving healthcare environment.

Simon Steward

Acting Chief People Officer, London Ambulance Service NHS Trust.

5.3.2. People and Culture Committee Report

For Assurance

Presented by Anne Rainsberry (2)

London Ambulance Service NHS Trust

Alert – Advise – Assure Committee Board Report

Assurance report:	**People and Culture Committee**	**Date:**	**6th August**

Summary report to:	**Trust Board**	**Date of meeting:**	**01/08/2025**
Presented by:	**Anne Rainsberry**	**Prepared by:**	**Anne Rainsberry**

Alert

Issues that require Board attention:

- None

Advise

Items where Board input or awareness is needed:

- The Committee undertook a deep dive into 111 call handling turnover and explored plans in place to integrate LCW service
- The Committee explored the current programme of violence reduction against staff and discussed further measures to be explored to enable the safety of staff
- The Committee noted the decision to abolish the National Guardians Office in the NHS ten-year plan and discussed the future implications for the Trusts FTSU function. This will remain in place and will be reviewed once national arrangements to transfer national roles to DHSC are clarified.

Assure:

Positive assurances for the Board to note:

- The Committee received further assurance on the use of AI in recruitment however has asked for further issues to be considered relating to the use of AI in the long listing process in high volume recruitment.
- The Committee approved the annual WRES, WDES and Pay Gap reports all which showed some positive progress but requested that data withing the Pay Gap report be reviewed to ensure consistency of presentation.
- The Committee approved the Annual Equity report
- The Committee received the Internal Audit report and discussed and agreed the action plan.

Risks:

BAF Risks

- The Committee reviewed and discussed the proposed BAF risks for PCC for 25/26. These were agreed
- The Committee agreed the inclusion of a new risk relating to the increase in violence against staff.

Decisions & Recommendations	• The Committee approved the annual WRES, WDES and Pay Gap reports all which showed some positive progress but requested that data withing the Pay Gap report be reviewed to ensure consistency of presentation. • The Committee approved the Annual Equity report

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 2025

Income and Expenditure Plan

The Trust received income of £252.0m and incurred costs of £250.9m for the 4 months to end of July 2025. This position was a year-to-date Income & Expenditure surplus of £1.1m. The Trust has a proportionately higher level of spend across winter and is therefore forecasting to deliver a breakeven position for the full financial year.

Capital Programme

The Trust has a planned Capital Investment Programme of £77.3m during 2025/26 across Fleet, Estates and Medical Equipment. For the 4 months to the end of July 2025, the Trust had spent £8.0m and is forecasting to deliver the overall capital Programme this financial year.

Cash Balance

The Trust had a closing cash balance of £39.0m at the end of July 2025.

Fleet

Fleet have continued to roll out their modernisation plan which has seen them invest £52.9 million over three years. They have brought 523 new vehicles into commission over this time.

The team is working closely with the Greener NHS team to ensure that our fleet is entirely zero emission by 2040 which has seen shift in us procuring Hybrid or fully electric vehicles. Currently three out of four electric Double Crewed Ambulances (DCAs) are out in commission. We have also introduced electric Fast Response Cars (FRU) and have plans to expand the Electric Vehicle (EV) fleet later this year alongside our plans to upgrade our EV charging facilities.

The Fleet department is currently trialing a mobile EV charging unit in Waterloo which is portable and can be moved to the vehicle where it is not always possible to utilise the infrastructure on site.

Fleet is making changes to the workshops in line with plans for estate development the most significant of these being the development of the Fleet Service Hub in East London which will provide fleet services, in-house MOTs and allow us to amalgamate workshops providing improved operational efficiency and provide better support for the workshop technicians.

Estates & Facilities

The Trust is on track to deliver its plans for the East London campus which will house the Resilience and Specialist

Asset team and relocate them from Cody Road. Freeing up space in Cody Road will enable it to be upgraded into a modern ambulance station.

We have also leased and refurbished facilities in East London for a bespoke Make Ready Hub which is now in operational use and has allowed us to amalgamate two of our teams into one and provide them with a base rather than to provide mobile prepping.

Development is also underway in a building adjacent to Cody Road to create a fit for purpose Fleet Service Hub. This will allow for the collocation of a number of fleet workshops to provide a more efficient service and continue to expand our in-house MOT offering for Ambulances.

The Trust has leased a new development close to Heathrow Airport to address the capacity concerns of the local operational teams as they continue to expand their service. The development consolidates a number of local teams and provide a fit for purpose ambulance station in an ideal location.

The Trust is exploring further sites for developments in South East, South West, North Central and East London to create modern and fit for purpose facilities.

We have invested locally at our stations improving facilities in North East London to provide our Driver Training Team with new classroom facilities and provided extra capacity for staff in North West London at our Brent site. We are investing in the security of our stations by addressing replacing gates and fences that are no longer fit for purpose.

Supply & Distribution

The team is continuing to asset tag high value medical devices and are reviewing active RFID tags and the tracking of Medical Gasses. The team have worked closely with the security team around ways of tracking equipment and in the process of reviewing operating procedures to minimise loss of equipment.

The implementation of the Local Delivery Model (LDM) marked a change in ways of working with local ownership of resources, scheduling and out of service. Post implementation the Production Hub remained as a central point of contact and to manage out of service that in the first instance could not be managed locally. In conjunction with Incident Management and Service Delivery (IM&SD) and Operations the team are working through proposals to streamline processes and improve communication between the three groups with the overall aim of localised response.

Centralised Packing has moved under Supply and Distribution and is now housed in our warehouse at Rainham. The team are rolling out across the whole of London with Make Ready still supporting the team during the transition. The Central Packing facility will provide consistency with packing across all the pouches and allow us to monitor the demand and quality all of packs as well as being able to respond quickly to changes agreed by the medical directorate.

Sustainability

The Trust is continuing to work towards a 6% decrease in 25/26 as per the current Green Plan. The Green Plan has been developed in line with the Trusts five year strategy.

The Trust was successful in securing a £4m bid to upgrade our EV infrastructure in the FY 2025/26. This money will allow us to install 2 new sub stations and upgrade 4 existing substations to significantly increase the capacity at those sites. On the back of this we were also successful in receiving a grant of £750k to install 50Kwh chargers at sites across the Trust to support our EV roll out plans.

We have commissioned decarbonation surveys at key sites across the Trust to understand what changes are required to reduce the environmental impact of our buildings and reduce our operating costs.

Make Ready

Since their full move to Agenda for Change in April 2025 the Make Ready team have been embedding their new rotas which better align with operational requirements for prepping and cleaning vehicles as

well as allowing staff more rotation within their shift patterns.

Working alongside their colleagues in other departments the team are rolling out initiaves such as scanning stock on and off vehicles, utilising applications which provide us with better reporting techniques as well allocating and managing their local fleet. The team are also identifying changes in processes around receiving and cataloging kit to ensure better visibility and ownership.

Make Ready are dedicating time and resource to upskilling staff at all levels and to give our supervisor team at stations ownership and autonomy at a local level with their teams to improve quality and performance.

The Make Ready Management and Training Team have moved into their new bespoke facilities in East London alongside some of the East London Make Ready teams.

Make Ready have also bid for Capital which is available through NHSE - if successful this will allow us to modernise our services and invest in technology to improve processes and provide us with better quality assurance.

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

Alert – Advise – Assure Committee Board Report

Assurance report:	**Finance Infrastructure and Productivity Committee**	**Date:**	**28/08/2025**
Summary report to:	**Trust Board**	**Date of meeting:**	**11/09/2025**
Presented by:	**Bob Alexander**	**Prepared by:**	**Sarah Whittingham**

Alert

Issues that require Board attention:

- None to report

Advise

Items where Board input or awareness is needed:

- Arbitration Payment Resolution: It was confirmed that the outstanding payment from SW London for arbitration has now been paid, resolving a previously noted action.
- Decommissioning Compliance: Ongoing work to ensure compliance with national guidance for decommissioning, with escalation of mental health commissioning issues and further discussions planned with the CMO.
- Contract Award and Compensation: It was explained that the financial envelope for a new development (Resilience Hub) had increased compared to the business case, and discussions with advisors are ongoing to finalise detailed costings and compensation, expected to conclude in the next two to three weeks.
- The capital allocation of £77 million, with £20 million earmarked for a new ambulance station dependent on land purchase and cash application approval, and outlined contingency plans to bring forward fleet spend if the land purchase is delayed.
- It was reported that year-to-date capital spend at month 4 is £8 million, with £1.9 million spent in the latest month. The main areas of spend is £2.6 million on fleet (delivery of DCAs ordered last year), ongoing estates work (business cases approved previously), and digital.
- A comprehensive forecast for the year was provided, analysing overspends in ambulance services and strategic assets, the impact of workforce skill mix, and the sustainability of using corporate underspends to offset operational pressures.

Assure:

Positive assurances for the Board to note:

- It was reported the month four financial statements, highlighting a favourable I&E and cash position, £0.4m surplus in month, £1m

	favourable to plan. With the committee discussing the implications for performance metrics, capital spend, and risk management. • The status of the CIP program, confirming that £29.3 million of the £30 million target has been identified, with robust quality impact assessments and plans to integrate CIP discussions with business planning for the next year.
Risks:	**Risks** • The committee agreed to lower the CIP risk score to 12 due to improved delivery confidence, but decided to maintain the I&E risk at 16 until there is certainty regarding performance-related funding for the second half of the year.
Decisions & Recommendations	• The Terms of reference and committee name change action has been completed. • The Committee approved new vehicle service, maintenance, and repair contracts for most lots, except 2A/2B (to remain with local providers due to cost).

Audit

5.5. Audit Report

For Assurance

Presented by Rommel Pereira

London Ambulance Service NHS Trust

Alert – Advise – Assure Committee Board Report

Assurance report:	**Audit Committee**	**Date:**	**21 August 2025**

Summary report to:	**Trust Board**	**Date of meeting:**	**11/09/2025**
Presented by:	**Rommel Pereira**	**Prepared by:**	**Rommel Pereira**

Alert

Issues that require Board attention:

- Our current internal audit services due to expire by 31/3/26. AC approved a competitive tender, noting that scale options via the SASC collaboration and NWL ICS would not be feasible. Recommendations to the Board on a selected provider would be made in January.

Advise

Items where Board input or awareness is needed:

- An Insight session on Strategic Risk benchmarking, reflecting that Ambulance Trust BAF's were more operational with broad programs of work (suggesting Board's needs to maintain a wider span of grip and control). Elsewhere (eg. the Higher Education sector), there are opportunities to learn from and improve the effectiveness of the BAF, with better use of data, risk appetite and drawing out the 2nd line of defence.
- A trust wide cyber business continuity exercise (with the national team) will be developed further with the Board later this year, with an emphasis on recovery and resilience.
- As our AI policy takes shape (overseen by DDC), AC requested an Insight session on AI Strategy & Governance (from KPMG)
- Ambulance Operations commissioning of specialist services from Korn Ferry to assist with Salary Overpayment controls.

Assure:

Positive assurances for the Board to note:

- An internal audit of Suicide Prevention received Substantial Assurance on Design and Effectiveness, with a very good AACE self assessment and also noting LAS as having the most comprehensive Employee Assistance Program across 8 trusts in London.

	• AC noted Internal Audit's 24/25 client benchmarking, which placed LAS well for controls design but improvement still required for implementation and controls effectiveness. • AC noted two new BAF risks - increasing violence & aggression on staff and the impact of decommissioning services for mental health patients - and the ongoing oversight of FIP on future commissioning clarity and securing the second tranche of funding dependent on performance delivery. Looking ahead, LAS will need to prepare for the winter UEC plan and vaccine fatigue and any further industrial action.
Risks:	
Decisions & Recommendations	

Charity

5.6. Report from LAS Charity Committee

For Assurance

Presented by Bob Alexander

London Ambulance Service NHS Trust

Alert – Advise – Assure Committee Board Report

Assurance report:	**Charitable Funds Committee**	**Date:**	**05/08/2025**

Summary report to:	**Trust Board**	**Date of meeting:**	**11/09/2025**
Presented by:	**Bob Alexander**	**Prepared by:**	**Sarah Whittingham**

Alert

Issues that require Board attention:

- None to report

Advise

Items where Board input or awareness is needed:

- Challenges in recruiting participants for the Dragon Boat Race and securing corporate sponsorships for events.
- The committee suggested that board members should actively participate in events like the Dragon Boat Race and the London Life Hike to increase visibility and engagement. This could help attract attention and funds
- It was agreed the need for a strategic approach to support the Heart Stoppers campaign. They emphasised the importance of leveraging local authority relationships and increasing organisational visibility to achieve the campaign's goals. It was agreed to involve the board in the strategic planning process, highlighting the need for targeted discussions and calls to action for board members to support the campaign effectively.

Assure:

Positive assurances for the Board to note:

- It was reported that the charity had a stretch target of £607,000 for the year, with income as of May 2025 at £52,000. There has been strong community fundraising efforts, including the London Marathon, the landmarks Half Marathon, and the London to Brighton cycle ride.
- Upcoming flagship events include the Dragon Boat Race and the London Life Hike. She noted that the Dragon Boat Race had ten teams but was rearranged due to dangerous blue algae, resulting in two withdrawals. Efforts to re-recruit teams were ongoing.

	• The charity's involvement in community events like the Emergency Services Truck Pull and the support for individual giving through the website and monthly contributions. Also the launch of a new event, a Carol service, scheduled for December 16th at Saint Bride's Church. • The committee recognised significant progress in charity activities, with the team being praised for increased visibility, event organisation, and fundraising efforts. There was a sense that the charity is gaining momentum compared to previous years. • Bank of England Charity of the Year Nomination – The team are to continue working with the Bank of England team to progress the charity's nomination for Charity of the Year from 2026. • It was reported that 11 out of 18 British Heart Foundation public access defibrillators had been installed, with two awaiting installation and three pending the process. Four London Ambulance charity public access defibrillators had also been installed.
Risks:	**Risks** • Key risks include the performance against the stretch target and the impact of the cost of living crisis on income. There are also the challenges in delivering the London Heart Stoppers campaign
Decisions & Recommendations	• Shera Chok had joined the committee, completing the action of needing a non-accountant NED to bring a different focus to the committee • The Chair and RoP discussed the completion of the hardship parameter action, agreeing that they were content with running the proposal as constituted and would review it at the beginning of 2026. • ME suggested scheduling a deep dive on the Heart Stoppers campaign and charity activities for the upcoming board seminar. The Chair and CP agreed, emphasising the need for targeted discussions and calls to action for the board.

5.7. Digital and Data

5.7.1. Director's Report

Presented by Clare McMillan

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust Board Meeting

11th September 2025

Report from the Chief Digital Officer

The NHS continues to undergo a significant digital transformation in response to evolving patient needs, workforce pressures, and rapid technological advancement. Against this backdrop, London Ambulance Service Digital & Data directorate has made meaningful progress in aligning with both national priorities and our own internal mission. This report outlines achievements to date, highlights ongoing challenges, and sets out the direction of travel for the year ahead.

Delivery of the Digital & Data Strategy

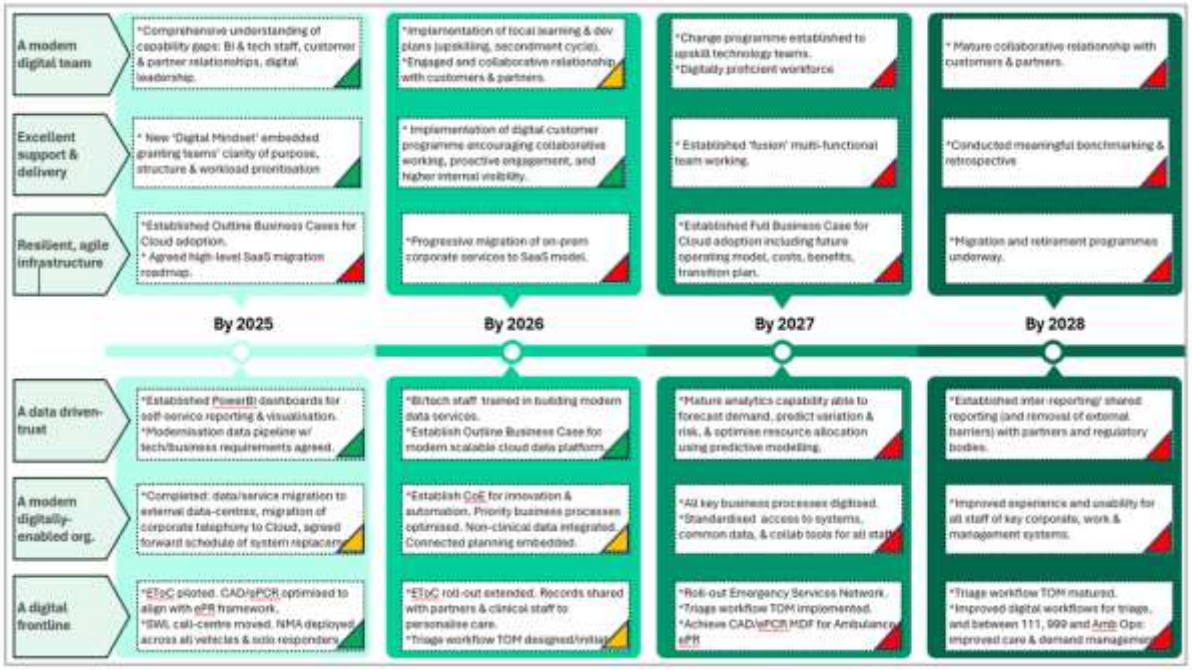
Over the past year, LAS has advanced the implementation of its Digital & Data Strategy. Key infrastructure upgrades have been delivered, including replacement of legacy telephony and MDT systems via the national NMA product, as well as the commissioning of a new data centre at the new IUC centre at Bernard Weatherill House. Data reporting and warehouse stability have improved significantly, enabling real-time insights to support operational and clinical decisions. Staff training in areas such as PowerBI, networking, and workplace tools has strengthened digital capability across the organisation. At the same time, improved monitoring and event management have reduced the frequency and impact of outages, while the launch of an AI and Automation programme—including a pilot of ambient voice technology—has positioned LAS as an early adopter of innovative solutions. A restructure is also underway, with new roles and responsibilities designed to embed a stronger digital culture.

These changes have begun to deliver tangible outcomes. A modernised digital team has been established, supported by an innovation hub that promotes new ways of working. Service support and delivery have improved through the “Brilliant Basics” programme and the adoption of a shift-left model. Our ambition to migrate services to the cloud and SaaS (Software as a Service) platforms has been delayed due to the implementation of a new on-premises architecture but the initial scoping work has now commenced, supported by the development of a cloud strategy. Decision-making is increasingly data-driven, supported by a centralised repository and improved governance, and automation is streamlining key processes—particularly in People and Culter. Digital tools rolled out across 111, 999, and frontline ambulance operations are already enhancing both productivity and patient care.

London Ambulance Service NHS Trust

Performance monitoring is showing early signs of improvement. The volume of service impacting incidents (P1 and P2 incidents) has reduced, and metrics for mean time to restore and incident prevention are under development. To strengthen customer engagement, a structured strategy to measure and improve service satisfaction is being implemented. The 2024 staff survey reported encouraging results, with colleagues citing greater autonomy, respect, and value in their work. Nonetheless, further improvement is required in areas such as line manager engagement and wellbeing support.

Summary of progress



Financial Update

A £2.6 million cost reduction has been achieved for 2025/26, comprising £1 million in pay and £1.6 million in non-pay savings. The introduction of a new Target Operating Model is expected to deliver further efficiencies over time, while exploring collaboration through the Southern Alliance and AACE will help to reduce non-pay expenditure in future years.

The Target Operating Model itself represents a substantial change, affecting approximately 75% of the workforce through 27 new roles and 37 amended positions. Formal consultation is scheduled for September and October 2025. A

central feature of the model will be the launch of a 24/7 IT Operations Centre, which will provide a continuous technical hub for the organisation.

AI Implementation

Nationally, the 10-Year NHS Digital Plan has significant implications for LAS. The Service is well aligned with strategic priorities, including transformation of the NHS App, the adoption of AI tools, integrated urgent care pathways, digital inclusion, and innovation hubs. Current LAS initiatives—such as the use of AI (Ambient Voice Technology) for Hear & Treat, access to the London Care Record, and the rollout of Transfer of Care—are positioning the organisation to contribute meaningfully to these goals. Looking ahead, key focus areas will include AI-assisted triage and the integration of single patient records. However, risks remain, particularly in relation to workforce reductions and the absence of a detailed national delivery plan.

The recent work in the clinical hub has put LAS on the map in leading in this space in the ambulance sector. As part of a wider trial lead by Great Ormand Street Hospital, we were one of the pilot sites identified to trial Ambient Voice Technology with TortusAI. This study has directly influenced the 10-year plan in terms of AI and AVT in all clinical settings. LAS have since commissioned an extension to this trial to implement across both clinical hubs and in ambulance operations. This has attracted media interest, and we have promoted the trial through our comms team as below:

First AI trial sees paramedics at London Ambulance Service treat more patients

Paramedics at London Ambulance Service are using Artificial Intelligence that will allow them to care for hundreds of extra patients a day.

For the first time, an AI tool called Ambient Voice Technology has been trialled by clinicians in the clinical hub of the Service's 999 control room.

Senior paramedics in the clinical hub provide patients with a detailed telephone assessment during which they can give medical advice, guide them to a service in their community – like a GP – or arrange a prescription for them.

The AI technology listens to and digitally transcribes conversations between clinicians and patients and automatically transforms the spoken words into structured medical notes. These notes are then checked and approved by the paramedic.

The time and effort saved on writing notes, means paramedics can treat more people over the phone and better focus on their patients.

Paramedic Genevieve In said: "It's very good – it types up all your notes so you don't have to think about typing things when you are talking to your patient and the notes are concise.

"My favourite thing is when it's listening to calls with an interpreter – often those calls can be really drawn out but this summarises them very nicely.

"I can focus purely on the patient especially when their needs are complex. And if we need to send notes to an ambulance crew we can get them over really quickly – which is much better for the patient."

All patients are asked for consent before AI records the conversation. No patient information is stored within the AI tool to help protect patient data and ensure confidential information is kept secure.

Around 20 per cent of patients calling 999 in London are treated over the phone and the trial has been rolled out so that most of those can benefit from the new technology.

David Davis, Chief Clinical Information Officer and paramedic at London Ambulance Service, said: "With ever increasing demand on our service, we are committed to finding innovative ways to become more efficient while improving patient care.

"Colleagues in our clinical hub have a very busy and demanding role – they can treat as many as 20 patients every shift. That can add up to a lot of paperwork.

"By taking away that stress, this tool is increasing job satisfaction and giving time back to our clinicians to do what they excel at which is delivering patient care.

"We are harnessing exciting technology to improve the lives of our patients and our people."

Paramedics in ambulances also tested the AI tool to record face-to-face conversations with patients. They also found it saved time on paperwork and the Service is further evaluating how the technology can benefit ambulance crews and their patients.

Chief Digital Officer Clare McMillan said: "If every ambulance service adopted this technology, the improvements we are seeing in London would translate into thousands more patients getting faster and better care.

"With the right clinical leadership and oversight, AI can help shape the future of urgent and emergency care delivery, helping us ease the pressures facing the NHS."

The tool – developed by AI company TORTUS – was first tested by clinicians at Great Ormond Street and the trial was then expanded to different clinical settings and sites.

The trial results have informed the Government's 10-year Health Plan for England, with productivity a key focus of the plan.

London Ambulance Service NHS Trust

Project Updates

Related to the ongoing concerns with the national **Control Room Solution**, technical resilience has improved following previous outages, with legacy firewalls replaced and capacity expanded. While stability has been enhanced, residual concerns persists, and Mason Advisory have been commissioned to undertake a full technical assurance review between August and December 2025.

In July 2025, it was confirmed that London Ambulance Service achieved standards met on the **DSPT (Data Security and Protection Toolkit)** for 2024-25. This is a significant achievement for LAS and supports the efforts taken in bolstering our security posture as the assessment now aligns to the NCSC Cyber Assessment Framework.

The **Electronic Transfer of Care** programme has successfully gone live at St Thomas' Hospital and rollout will extend to King's College Hospital and Princess Royal University Hospital. Funding has now been secured through year-end, enabling the team to reset the project plan in collaboration with London Region and acute partners to maximise benefits and ensure shared understanding of data usage.

In summary, LAS Digital & Data has made substantial progress in its first year of strategy implementation, laying the foundations for a more resilient, data-driven, and innovative organisation. At the same time, further work is required to address cost efficiency, workforce engagement, and the risks associated with wider system change. The coming year will be critical in consolidating these gains and positioning LAS at the forefront of NHS digital transformation.

5.7.2. Digital and Data Committee Report

For Assurance

Presented by Sheila Doyle

London Ambulance Service NHS Trust

Alert – Advise – Assure Committee Board Report

Assurance report:	**Digital and Data Quality Committee**	**Date:**	**21/07/2025**
Summary report to:	**Trust Board**	**Date of meeting:**	**11/09/2025**
Presented by:	**Sheila Doyle**	**Prepared by:**	**Sheila Doyle**

Alert

Issues that require Board attention:

- N/A

Advise

DDQ wishes to advise the Board of:

- ***AI Policy***: A draft AI Policy, along with Acceptable Use and Governance Framework was reviewed. Recommendations will be incorporated into the next version. Further input is required from the People & Culture, QAC and Audit Committees.
- ***Target Operating Model:*** Changes within the IM&T organisation *are* expected to impact 75% of current roles. The Committee has requested a deep-dive review at its next meeting to understand potential risks, mitigation strategies, and—critically—how the new structure supports future-proofing the organisation.
- ***Project Portfolio:*** The Committee requested increased emphasis on tracking the realisation of benefits, particularly those enabled through digital or AI-driven change initiatives.
- ***Electronic Transfer of Care*****:** This project, delivered by London Regional Team, has experienced multiple delays and funding challenges. The Committee agreed that a full "reset and replan" is necessary, following a comprehensive review of the project's goals, expected benefits, and governance arrangements.
- ***Rostering & Scheduling tool*****:** DDQ supports the recommendation to extend the current contract and transition to the vendor's cloud-based solution. This decision has been risk-assessed by Exco and is expected to provide sufficient time to standardise processes and ways of working before considering longer-term alternatives.

Assure:

DDQ wishes to provide assurance of:

- ***Digital & Data Strategy Delivery***: Good progress has been made on five of the six year one objectives, with notable improvements in infrastructure, cyber resilience, telephony, data reporting, and data quality. AI and Automation programmes have been launched under a newly established Innovation Hub, supporting the co-delivery of digital solutions aimed at enhancing efficiency and productivity.
- ***Data Quality:*** 2 KPI's – Avg. Patients per DCA and See & Convey to ED – were reviewed and received high assurance with minor improvements. The review focused on the completeness of

	documentation, the robustness of KPI ownership, and the verification of Extract, Transfer, and Load (ETL) processes.
Risks:	**BAF Risks** • ***Risk 2.8:*** The Airways risk has been expanded to include disruption to the Ambulance Radio Program (ARP) following recent national outages. An independent review of the ARP program has been commissioned by NHSE. • ***Risk 2.6*:** Critical IT failure – the committee received an update on 9 projects including the implementation of advanced incident and event monitoring systems. These projects when complete, will facilitate a reduction in the current risk score.
Decisions & Recommendations	**The board is asked to note that:** • The AI Policy will be presented for review and approval in October. • Discussions will be held with P&C Committee to explore the standardisation of Rostering & Scheduling processes and ways of working.

6. Corporate

For Assurance

6.1.1. Director's Report

For Assurance

Presented by Mark Easton

London Ambulance Service NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

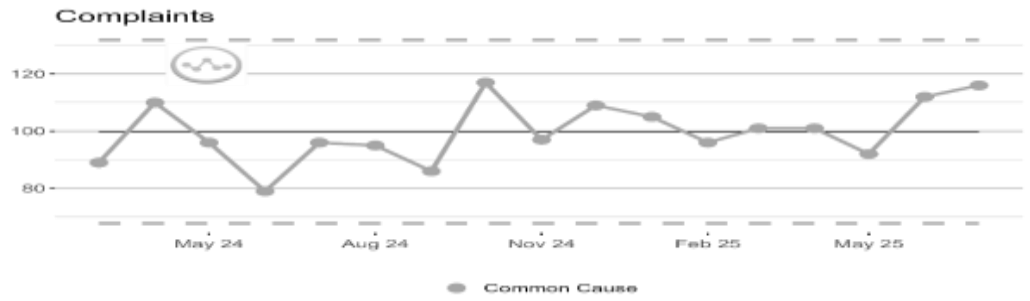
Report of the Director of Corporate Affairs

The Corporate Affairs Directorate currently incorporates Patient Experience, Legal Services, Information Governance, Health, Safety and Security and Corporate Governance.

This report summarises the Directorate activity to July 2025.

PATIENT EXPERIENCE

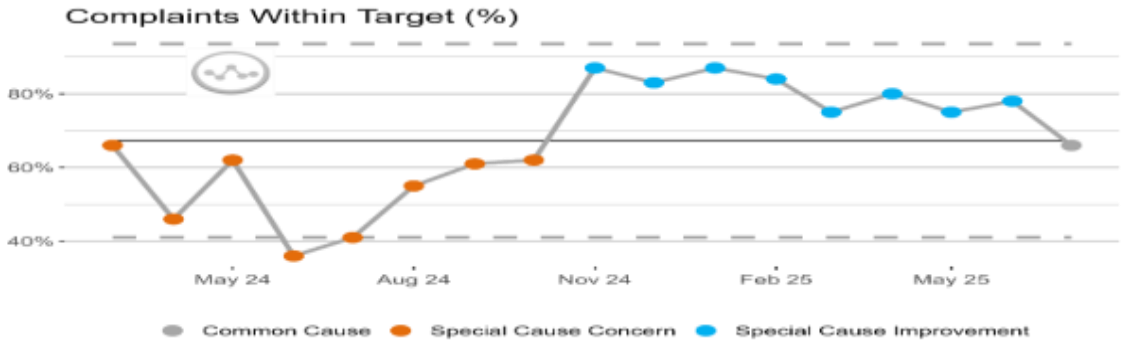
Complaints received



Number of complaints received per month remains in common cause variation. The themes remain consistent with previous reporting periods (complaints relating to conduct and behaviour and delays are consistently the highest theme).

Complaints closed

The business plan objective is to *Maintain a response rate of 75% to complaints within 35 working days*. There was a dip in performance in July (66%) and it is predicted to be below target in August as a result of annual leave. Performance is closely monitored and escalation measures applied to expedite overdue complaint investigations.



1 new complaint is being investigated by the Parliamentary and Health Service Ombudsman regarding bariatric care (incident from 2022). Explanation and assurances have been provided regarding the *in-house* provision that is now in place.

LEGAL SERVICES

Inquests opened 01 May 2025 – 31 July 2025

Total Inquests - 577

Level 1 Inquests – 560

Level 2 Inquests – 17

Claims opened 01 May 2025 – 31 July 2025

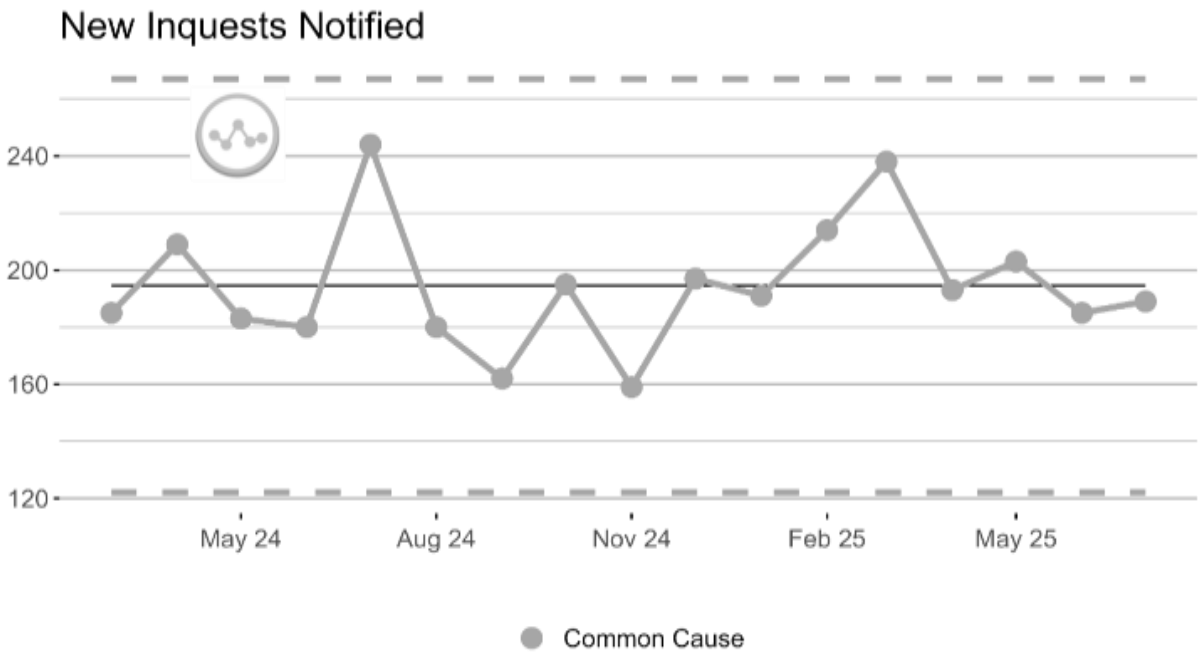
Employment Liability – 8

Public Liability - 1

Clinical Claims - 21

As expected, the number of Inquests notified to the Trust remained relatively high in above period. 7 more inquests were opened in 2025 compared to the same period in 2024. There is an increase of clinical claims notified to the Trust in 2025 compared to 2024 (13 more clinical claims in 2025).

The chart below shows the level of sustained high numbers of notified inquests during 2023-2025 (to date).



Further to an inquest at Croydon Coroner's Court in June we, together with NHSE, have received a Prevention of Future Death (PFD) report. The Trust's response is due on 2nd September 2025 and will be shared with the Quality Assurance Committee.

The Head of Legal and other stakeholders are reviewing and updating 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. TP 015 will be separated into three documents, a concise TP015 policy and two operational guides for criminal and civil enquiries.

The Head of Legal is working with the Procurement Department who are running a tender for the provision of legal services providers. A prospective timeline for this process has been agreed between the two departments.

The Legal Team in collaboration with Bevan Brittan will be delivering a training session about Inquests and witness statement training to the IUC Team – date to be confirmed.

INFORMATION GOVERNANCE

The Trust continues to make robust progress towards compliance with the Data Security and Protection Toolkit (DSPT) requirements.

The Trust has successfully completed the Data Security and Protection Toolkit (DSPT) this year, now aligned to the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

The Trust submitted the DSPT on 25th June 2025, ahead of the deadline, having met all of the 47 outcomes to the required standard. It was just one of four Ambulance Service Trusts to complete the DSPT this year

The Trust is awaiting the release of the 2025 - 2026 DSPT and work has begun to update the Trust training needs analysis and other applicable documentation in preparation for the new release.

As reported to the Audit Committee, asset registers and Record of Processing Activities (ROPA) reports are being updated in line with ICO and NHSE guidance and will be sent to all Trust Information Asset Owners (IAO) when ready, with ongoing support offered IAO's and their Administrators.

The Trust's Privacy Notices are regularly updated and made accessible via LAS Connect and the Trust website.

IG incidents are reported via RADAR, 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 2025, five incidents have been reported to the ICO. Two of these cases are now closed following confirmation from the ICO that appropriate steps had been taken by The Trust to mitigate the impact of the breaches. The Trust is currently awaiting a response from the ICO on the remaining three cases. There are also five open cases dating from 8th December 2023 to the 26th July 2024. All five of these open cases relate to inappropriate access, or poor records management, and are either awaiting an initial response from the ICO, or awaiting a response following updates sent.

Staff compliance with mandatory IG and Cyber Security training stands at over 95%. Targeted efforts are ongoing to improve training uptake, particularly among new starters and those in key roles like Information Asset Owners.

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

FREEDOM OF INFORMATION

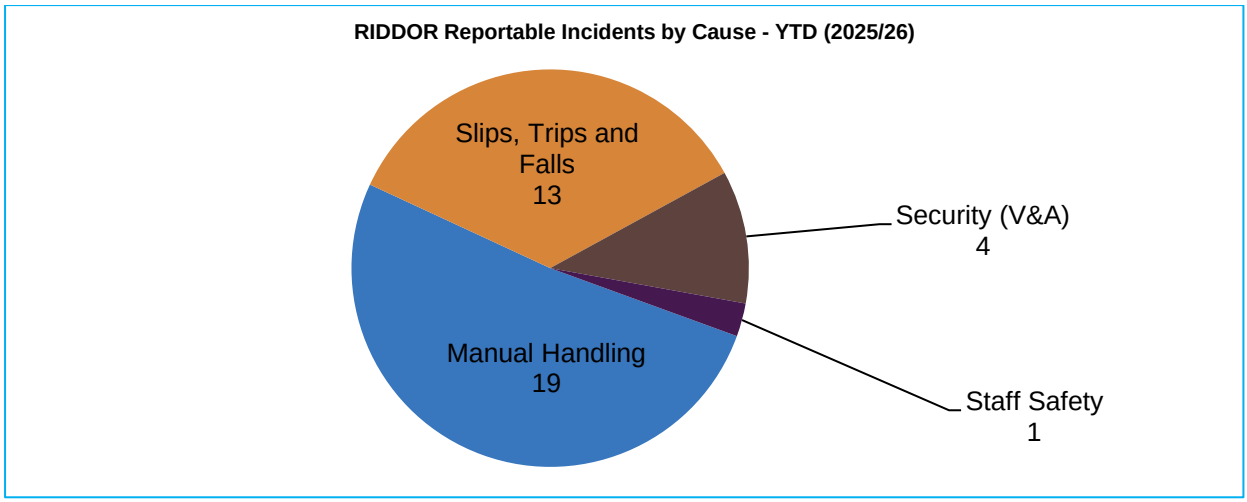
Between May and July 2025, the department received 165 Freedom of Information (FOI) requests. Of these, 156 have been closed, while 9 remain overdue.

HEALTH, SAFETY & SECURITY

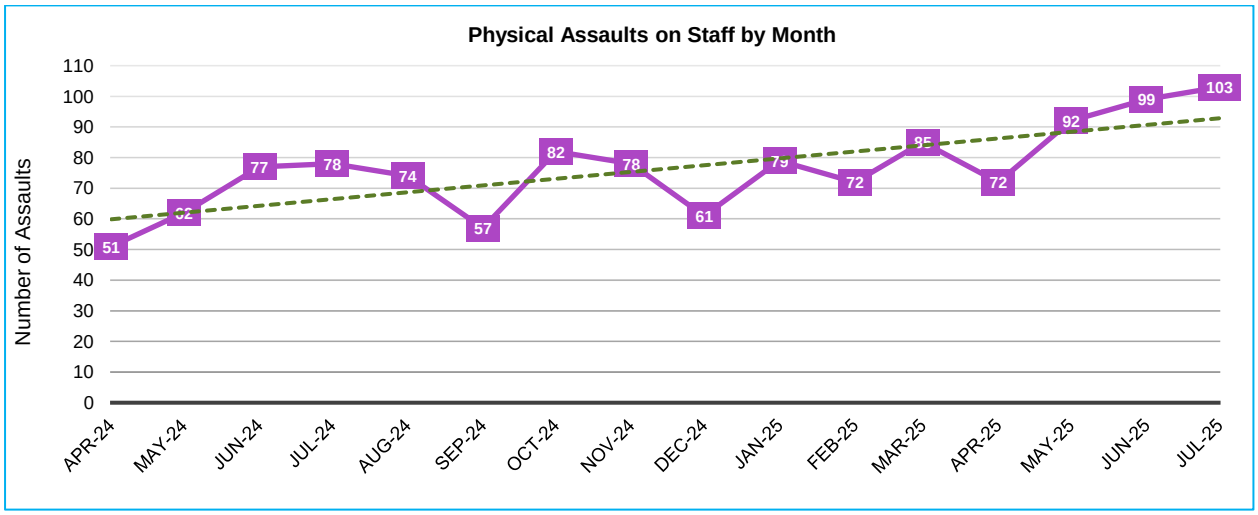
The HS&S Team have delivered 5 sessions of Managing Safety courses to total of 90 staff members and 4 sessions of Corporate Induction during 2025/26 (up to end of July'25), all with positive feedback. A Task & Finish Group has been established to develop a new E-Learning Dynamic Risk Assessment Package for front line / EOC staff; this project is scheduled to be concluded by end of Q3.

A national MSK group meeting in place and collaborative working across all Ambulance Trusts. As part of improving Contractor oversight in relation to legionella risk assessment, a new approach is being developed to implement a system of good practice and assurance of quality control dip sampling of Legionella Risk Assessment including reports/site visits. This collaboration is being led by the Deputy Head of Estates & Facilities, the Quality Compliance Manager and HS&S.

There was a total of 37 RIDDOR incidents reported to HSE during 2025/26 (up to end of July'25). Manual Handling Incidents account for the highest number (51%) of RIDDORs reported across the Trust during 2025/26. Total of 15 RIDDOR incidents were reported to HSE during July 2025. The Trust wide RIDDOR reporting time frame (<15 days) compliance in July'25 was 67%.



A total of 366 physical assaults on staff have been reported for during 2024/25. The greatest number of reported physical assaults (56%) occur due to the clinical condition of the patient during 2025/26 (up to end of July'25). Police have attended 61% of physical assault incidents during 2025/26. The number of successful prosecutions seems to be dropping sharply. We are working with the MPS to understand this and accurately establish the number of open cases/ investigations and CJS backlog and extended time frames for court dates.



Approval for 2 wte Violence Reduction Officers (VROs) has now been given and recruitment has started.

Mark Easton, Director of Corporate Affairs

September 2025

7. Assurance

7.1. Board Assurance Framework

For Approval

Presented by Mark Easton

London Ambulance Service NHS Trust

Report Title	BAF 2025/26			
Meeting:	Trust Board			
Agenda item:		**Meeting Date:**	11 September 2025	
Lead Executives:	Mark Easton, Director of Corporate Affairs			
Report Author:	Frances Field, Corporate Governance Manager			
Purpose:		Assurance	x	Approval
	x	Discussion		Information

Report Summary

2025/2026 BAF

The 2025-26 BAF has been significantly overhauled to align it with the 2025-26 Business Plan, and an updated view of risks facing the organisation. It includes new and amended risks with some risks removed that have been resolved.

Committees have discussed changes to the BAF for 2025-26. The changes below reflect input from the Quality Assurance Committee, Finance and Investment Committee (now called the Finance, Infrastructure and Productivity Committee), People & Culture Committee, Digital & Data Committee and the Audit Committee.

Change in risk scores:

BAF 1.1 We may not achieve the quality standards required in STEMI, cardiac care, and cardiac arrest. Current risk score **increased from 3x4=12 to 4x4=16**. The wording has also been amended to: We may not achieve the quality standards required for the sickest patients.

BAF 2.9 There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year. The current risk score has been increased from **1x4=4 to 3x4=12** to reflect the current position for this financial year.

BAF 2.8 We may not deliver the £30m CIP and productivity programme. The current risk score has been increased from 1x4=4 to 4x4=16 to reflect the current position for this financial year.

Change in wording:

BAF 1.3 **New wording**

We may not achieve at least 60% of patients in each IUC CAS priority being contacted by a clinician within the commissioned timeframe.

BAF 2.1 N**ew wording:**

We may fail to sustain our progress on inclusion or to make further improvements for all staff, including enhancing equity on career progression and pay.

BAF 2.5 **New wording**:

There is a risk of service disruption through a cyber-attack, or information security breach, which could result in unauthorised access to sensitive data, disruption of business operations, financial loss, and reputational damage either through:

- Internal vulnerabilities because the correct system and human safeguards not being in place which may expose us to service disruption and put at risk our DSPT compliance.
- Vulnerabilities on the part of third party systems on which we rely.
- Service disruption due to extended recovery following an attack. [new and additional third bullet point]

BAF 3.1 **New wording**:

We may not meet our commitments set out in the 2025-2029 green plan refresh including a decrease of 4% carbon in 25/26, achieving full ULEZ compliance across our diesel fleet by Q3 and increase the number of EV chargers across LAS estate by 20%.

BAF 3.2 N**ew wording:**

There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London given the differing and fragmented commissioning and tendering of 111 contracts by 5 ICSs. This poses a financial, quality and people risk for the services provided by the LAS.

BAF 3.3 N**ew wording:**

We face a strategic risk as the only London-wide NHS provider around the sustainability of partnerships and funding streams, with evolving ICS roles and regional commissioning shifts causing uncertainty.

C**hange of oversight** from Trust Board to Finance and Investment Committee

Three new risks have been developed and added to the 2025/26 BAF:

BAF 1.6 We are at risk of providing an equitable service to mental health patients because of:

i) Increased demand
ii) Lack of specialised facilities
iii) Lack of alternative pathways accessible to ambulance services

BAF 1.7 There is a risk to patient safety due to gaps in the current oversight of learning stemming from incidents, after action reviews, patient safety incidents and the triangulation of assurance.

- Patient safety incident root causes identify problems with history taking, focused examination, differential diagnosis identification, effective treatment planning and documentation to support and ensure robust clinical records; as well as availability and use of equipment amongst other frequent root causes.
- Whilst education, supervision and core skills exist within the organisation as well as other support mechanisms, these do not always provide the assurance of organisational learning and response or indeed swiftly recognise a concern in an individual's practice or gap in process.

BAF 2.12 Our staff may face escalating levels of violence from patients and the public without an effective strategy to counter it.

Risks removed from the 2025/26 BAF:

(to note the risks in the BAF for 25/26 have been renumbered to be sequential, the risk numbers below were as they appeared on the 2024/25 BAF):

BAF 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. This risk has been removed from the BAF as it has reached its target rating.

BAF 1.7	We may not improve data quality, embed data governance and follow through on the data quality action plan. This risk has been removed from the BAF as it has reached its target rating.
BAF 2.7	Operations may be affected by the shortage of Mobile Data Terminals (MDT's). This risk has been removed from the BAF as it has reached its target rating.
BAF 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. This risk has been removed from the BAF as it has reached its target rating.
BAF 2.12	The Trust may not be able to deliver a balanced income and expenditure plan for 2024/25. This risk has been removed from the BAF as it has reached its target rating. There has now been superseded by BAF risk 2.11 which relates to delivering a balanced income and expenditure plan for 2025/26.

Recommendation/Request to the Board:

The Board is asked to:

- Review and approve the 2025/26 BAF, which includes new and amended risks.

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.

DRAFT Board Assurance Framework – 2025/26 – July 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 for the sickest patients	20	16				16	12	QAC	FW	5
1.2	We may cause harm by not achieving the Ambulance Performance Standards we are commissioned for due to:	25	20				20	12	QAC	PC	8
	• Insufficient funding from commissioners to meet demand	25	25				25	8			
	• Constrained capacity in the UEC system and handover delays at hospitals	25	20				20	12			
	• Underachievement of productivity initiatives	25	12				12	8			
1.3	We may not achieve at least 60% of patients in each IUC CAS priority being contacted by a clinician within the commissioned timeframe.	16	12				12	8	QAC	JN	10
1.4	We may not improve the quality of the care we provide if we do not complete delivery of our quality priorities	20	12				12	8	QAC	FW	12
1.5	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	8	QAC	FW	14
1.6	We are at risk of providing an equitable service to mental health patients because of: i) Increased demand ii) Lack of specialised facilities iii) Lack of alternative pathways accessible to ambulance services	16	16				16	9	QAC	FW	17
1.7	There is a risk to patient safety due to gaps in the current oversight of learning stemming from incidents, after action reviews, patient safety incidents and the triangulation of assurance. • Patient safety incident root causes identify problems with history taking, focused examination, differential diagnosis identification, effective treatment planning and documentation to support and ensure robust clinical records; as well as availability and use of equipment amongst other frequent root causes.	16	12				12	8	QAC	FW	19

	• Whilst education, supervision and core skills exist within the organisation as well as other support mechanisms, these do not always provide the assurance of organisational learning and response or indeed swiftly recognise a concern in an individual's practice or gap in process.										
Mission 2: Becoming an increasingly inclusive, well-led and highly skilled organisation people are proud to work for											
Risks		**Uncon[d]**					**Curr[t]**	**Target**	**Committee**	**Owner**	**Page**
2.1	We may fail to sustain our progress on inclusion or to make further improvements for all staff, including enhancing equity on career progression and pay.	25	16				16	12	P&C	RD	21
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	P&C	DM	23
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	P&C	DM	25
2.4	We may not improve the sexual safety of staff unless we fully implement the action plan we have identified.	20	16				16	12	P&C	PC	26
2.5	There is a risk of service disruption through a cyber-attack, or information security breach, which could result in unauthorised access to sensitive data, disruption of business operations, financial loss, and reputational damage either through:	25	20				20	15	AC	CM/PC	27
	• Internal vulnerabilities because the correct system and human safeguards not being in place which may expose us to service disruption and put at risk our DSPT compliance.	25	20				20	15		CM	
	• Vulnerabilities on the part of third party systems on which we rely.	25	20				20	15		CM	
	• Service disruption due to extended recovery following an attack	25	20				20	15		PC	
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	10				10	10	Digital	CM	29

2.7	There is a risk that the organisation may experience significant disruption due to a failure of national provided services by the Ambulance Radio Programme (ARP). 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 and there have been multiple national outages to the Control Room Solution since its implementation	20	20				20	15	Digital	CM	30
2.8	We may not deliver the £30m CIP and productivity programme.	20	16				16	4	FIC	RP	31
2.9	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	12				12	4	FIC	RP	32
2.10	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.	15	12				12	9	P&C D&D	CM	33
2.11	The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2025/26	20	16				16	4	FIC	RP	34
2.12	Our staff may face escalating levels of violence from patients and the public without an effective strategy to counter it	20	16				16	12	P&C	ME	35
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 meet our commitments set out in the 2025-2029 green plan refresh including a decrease of 4% carbon in 25/26, achieving full ULEZ compliance across our diesel fleet by Q3 and increase the number of EV chargers across LAS estate by 20%	15	8				8	4	FIC	RP	37
3.2	There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London given the differing and fragmented commissioning and tendering of 111 contracts by 5 ICSs. This poses a financial, quality and people risk for the services provided by the LAS.	20	20				20	8	FIC	RP	38
3.3	We face a strategic risk as the only London-wide NHS provider around the sustainability of partnerships and funding streams, with evolving ICS roles and regional commissioning shifts causing uncertainty.	16	12				12	8	FIC	RD	40

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

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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, • 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

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	• Monitoring of Community First Responder outcomes and LifeSaver numbers to reduce time to defibrillation • 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 Sector Heads of Clinical Quality. 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 Head of Clinical Quality 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 Clinical Quality Oversight Group and Clinical Audit and Research Steering Group (CARSG).

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	• 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.
Maintain 999 call answering below a mean of 10 seconds	• Emergency Call Handling Staffing to match rota • Focus on post call wrap up processes • Rest break and sickness monitoring
Ensure Category 2 segmentation is maximised to reduce dispatch of emergency ambulances and ED conveyance where care can be provided in the community	• Increase to 150 clinicians • Embed Clinical Dispatch Support • Roll out of Single Point of Access • Increased access to alternative pathways • Close working with IUC CAS to ensure patients assessed by right clinician • Trusted assessor status • Oversight of MH patients with suicide and OD risk • Oversight of vulnerable patients who have fallen

Further actions

Action	Date by which it will be completed
Cardiac arrest management:	
• Improve return of spontaneous circulation rates to ≥30%	Achieved: December 2024 ROSC was 44% with 30% sustained to hospital
• London lifesaver training being delivered across London	Achieved: recruitment of 7000 Lifesavers planned and we are currently training in 2 schools per week October 1736 – total LLS = 24374 November 1615 – total LLS = 25989 December 1414 – total LLS = 27403
• Deliver resuscitation update training to 85% of staff	Achieved: Resuscitation training and updates being delivered in all CSRs. CTM huddles and case reviews.
Improve care for patients presenting with out of hospital cardiac arrest and/ or ST-Elevation Myocardial Infarction	Achieved: Senior Sector Clinical Leads continue working on care bundles for cardiac arrests and ST –elevation Myocardial infarction. 78% (from 73%) pan London as of January 2024 with pain relief given in 91%.

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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; • The impact of the Right Care Right Person initiative; • 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	5	=	20

Tolerance by Q4 25/26				
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	12	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

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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.
Productivity improvement program within Ambulance Operations.	As demand continues to rise steadily, overall performance has improved throughout Q4. Progress is evident in improved production metrics, including greater ambulance availability and utilisation. As a result, the PPS metric has seen only a slight variation.
Increased recruitment plan within Ambulance Operations.	Regular reviews of the recruitment plan led to a number of courses being revised. Our end-of-year position reflects a fully established directorate.
Ongoing implementation of localised delivery model.	The availability of better metrics (1316 report) and regular reviews of production and productivity.

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
Robust application of Clinical Safety plan	Ongoing

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BAF Risk: *1.3*
We may not achieve at least 60% of patients in each IUC CAS priority being contacted by a clinician within the commissioned timeframe.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by Q4 25/26				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
Introduction of IUC rostering tool and capacity planning.	Workforce planning tool being tested to establish benefits of having a generated rota pattern for more effective rotas. Testing in July 2025, outcome to inform decision for future requirements. The Rotamaster Allocation Wizard is now used to improve fairness and reduce administrative work in clinical rota allocation by enabling direct or sessional assignments before using agencies. It combines data from Clinical Guardian to guide decisions based on performance, productivity, and quality. There are plans to transfer a small number of clinical staff from GRS to Rotamaster, aiming to enhance management across multi-disciplinary and partnership teams.
IUC Clinical Queue Management	Introduction of 24/7 Service Delivery Manager (SDM) with responsibility for overall IUC service to manage demand across call answering, clinical response, workforce and performance. 24/7 clinical queue oversight & management by IUC Clinical Team Navigator (CTN) responsible for reviewing all cases on presentation, using new “NEXT” flagging to identify priority case and allocating resource to undertake Rapid Assessment & Triage (RAT) developed by the SMT to identify, validate and action high priority patients and reduce delay. The system is configured to allow all of our multi-disciplinary workforce located across IUC sites, remote workers and Network Partners to view priority cases and allow named allocation to a clinician option for CTN to manage real time performance to achieve KPI’s. New Clinical Safety Plan has been introduced with learning to increase options for the IUC Duty SDM to action in conjunction with duty supervisor/ CTN. Access to IUC Ops/ Clinical on-call when required. Completed training on new CSP/ NEXT/ RAT process includes focus on KPI compliance in addition to patient safety. Increased clinical floor walker capacity and improved headset response for HA’s accessing clinical advice to manage a call at initial assessment.

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Reporting of CAS Priorities	New national IUC KPIs remain largely unchanged and still using NHS Pathways response time without acknowledgement of clinical review. Placing time over clinical quality, leading to misalignment with local measures and potentially inaccurate national LAS performance data. NHS Pathways is generally risk-averse, but some risks, such as sickle cell and safeguarding, may be missed; CTN clinicians identify these cases and can override standard KPI timeframes when necessary. While commissioners use KPIs for compliance, clinical reviews may alter priorities to ensure patient safety, even if this impacts KPI adherence. The national Expert Group, including LAS and commissioners, is reviewing IUC KPIs to better incorporate clinical input into priority setting.
Individual performance and management, monitoring & review to ensure appropriate standards are met to deliver high quality care and achieve performance	Productivity reports are created for all teams and used in 1:1s and appraisals alongside role cards. Teams use Clinical Guardian/Rota Master data to evaluate workforce quality, productivity, and reliability for rota planning and issue identification. The current manual process will be automated with a new workforce tool. The selection process and skill criteria are being reviewed to enhance clinical workforce capability. Role Card for all clinical roles setting expectations introduced when applying to work for IUC, performance monitored and informs management decisions.

Further actions

Action	Date by which it will be completed
Service Development Workstreams • IUC CAS Clinical Queue Management Guidance • Rapid Assessment & Triage (RAT) Implementation • "NEXT" flagging • **Triangulation Meetings - productivity/ quality / professionalism**	Ongoing - innovation managed through the IUC Work In Progress (WIP)
Digital - A range of actions are captured in the IUC Digital Board including the provision of automated comfort calling, automated patient survey, and call back options. Options for the use of AI across IUC is also being planned through the Trust AI board.	Ongoing, August 2026
Joint LAS/BI Working Group introduced to improve accuracy of reporting for internal dashboards, induvial performance monitoring, forecasting/ rota planning and external reporting to inform financials.	Ongoing – April 2026

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BAF Risk: 1.4
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 Q4 25/26				
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	Continue to safely increase the hear and treat rate to achieve 4% improvement on the 2024/25 year from 19% to 23% across London by the end of the financial year.
Improving outcomes	Deliver 'Improving sickle cell care plan', including providing: • direct access to specialist sickle cell units • An updated educational package for conditions based on the findings from the LAS patient engagement held in 2024/25
Improving efficiency	Reduce incidents relating to the lack of availability of LifePak 15 defibrillators on frontline vehicles

Further actions

Action	Date by which it will be completed
• Working with ICBs to implement the SPoA to ensure that patients are provided with a clinical assessment and then referred to right pathway to meet clinical need	Q3
• Tethering of equipment to local stations • Tracing of equipment • Oversight through equipment working group • Communications to staff to share work and improvements	Q3

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• Health Inequalities Action Plan	
➢ Improving Sickle Cell Care action plan with 19 actions	End of Q4
➢ CORE20 Workstream utilisation of Community First Responders, fundraising for implementation of public access defibrillators and continued recruitment of London Lifesavers.	End of Q4
➢ Cardiovascular notifications in SEL	End of Q4
➢ Maternal Health Programme	End of Q4

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BAF Risk: 1.5

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 25/26				
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

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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
Learning responses	
• Tracking the last 10 closures AND last 10 breeches– identification of time taken in each stage of review and action appropriately	Completed
• Undertake time observation of investigation process to identify waste and non-value adding processes.	In progress
• Implementation of escalation process	Completed
• Horizon scanning and notification of those who are near overdue	Completed
• Defining the role of the supervisor to support standardised approach	Completed
• Produce a quick reference guide for LIs to be shared when allocated learning response	In progress
• Development of LI refresher training	Completed
• Development of LI 'contract'	In progress
• Meeting with supervisors with overdue cases and implement SMART action plans to clear overdue cases	Completed
• Inclusion	Completed
• Review of all overdue learning responses and closing of incidents, which mirror previous incidents for which learning responses have already been commissioned, and reinvestigation will yield no additional learning.	In testing phase
• Introduction of new AAR/SWARM template and family letter template to allow AARs/SWARM to be written up in a much shorter period of time.	Completed
• Directorates now have a nominated individual who will coordinate identifying the most appropriate action owners in their area speeding up the process for Lis	Completed
• Close oversight of timelines by central quality team with early interventions and reminders	End of Q3
• Review of integrated learning across patient safety, clinical and operational areas and clinical education	End of Q3
• Review of processes for sharing of information	End of Q3
• Use of wider range of modalities to share learning decided through engagement with clinicians	End of Q4
Evidence that better sharing of learning reduces similar incidents	

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<u>Overdue incidents</u> • Creation of Dashboards that can be used by all managers to view incidents assigned to their respective areas – associated communications 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. • Maintain low number of incidents unresolved	Completed Completed during transfer to RADAR Completed during transfer to RADAR Completed Completed Ongoing oversight

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BAF Risk: 1.6
We are at risk of providing an equitable service to mental health patients because of: i) Increased demand ii) Lack of specialised facilities iii) Lack of alternative pathways accessible to ambulance services

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by: Q4 25/26				
L	x	C	=	Score
3	x	3	=	9

Controls	Assurances
Clinical Governance and escalation processes	• Regular review of MH incidents through governance forums to identify equity gaps or safety concerns • Clear escalation routes for live time incidents with MH trusts
Workforce Development and Upskilling	• Ongoing training for frontline ambulance staff on mental health assessment and management • Specialist mental health clinicians (e.g. MHSPs and Trainee MH ACPs) embedded in operational role in Clinical Hub and Joint Response Cars
Pathway Mapping and Strategic Engagement	• Regular engagement with Integrated Care Boards (ICBs), Mental Health Trusts and NHS England to develop and/or improve alternative pathways
Data Monitoring and Demand Forecasting	• Use of activity data to monitor MH-related call volumes, outcomes and inequities across different populations • Forecasting tools to identify pressure points and justify service investments. Deployment of MHJRCs where available to provide specialist response
Commissioning Conversations/Influencing	• Continued representation at strategic planning and commissioning boards to advocate for sustained MHJRC funding • EIA to be completed by ICBs – Routine use of Equality Impact Assessments (EQIAs) when changing MH service delivery

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	• Potential inclusion of this risk in the Trust and ICB risk registers for wider system oversight • Formal escalation to commissioners when lack of MH provision results in patient safety concerns

Further actions

Action	Date by which it will be completed
Agree on going funding for MHJRC	End of Q2

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BAF Risk: 1.7

There is a risk to patient safety due to gaps in the current oversight of learning stemming from incidents, after action reviews, patient safety incidents and the triangulation of assurance.

- Patient safety incident root causes identify problems with history taking, focused examination, differential diagnosis identification, effective treatment planning and documentation to support and ensure robust clinical records; as well as availability and use of equipment amongst other frequent root causes.
- Whilst education, supervision and core skills exist within the organisation as well as other support mechanisms, these do not always provide the assurance of organisational learning and response or indeed swiftly recognise

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: Q4 25/26				
L	x	C	=	Score
2	x	4	=	8

Controls	Assurances
A review of CSR / Team Based Working / Huddle content – to ensure the right content is being delivered via the right route to staff and assurance gained on learning being embedded and understood.	CSR and huddles continue across the organisation whilst this work and review is undertaken.
A CSR module starting May 2025 focusing on clinical decision making and differential diagnoses.	This CSR has now started across the organisation and will complete to expected standards by March 2026.
An updated EPCR training programme for all new entrant staff	New entrant education package updated. Current users have access to written materials and clinical leadership team as required.
A review of and development of a new improved supervision model for clinical colleagues across the organisation.	Multiple supervision aspects already in place across the Trust, including huddle time, team training, operational workplace reviews, call debriefs, end to end case reviews. These aspects will continue whilst a number of developments relating to supervision are trialled. This will then be developed into an overarching supervision policy for the organisation.
Involvement of education team within patient safety and assurance and learning meetings to embed learning and ensure triangulation of information.	Education lead now involved in the PSIP weekly meetings, and local learning meetings for each sector.

Further actions

Action	Date by which it will be completed
First multi team meeting 7th July 2025 to discuss potential ways forward regarding CSR / team based working and huddles. The plan will be implemented in Q1 of 2026/27 and developed over the remainder of 2025/26.	Q1 2026/27
Meeting planned for 9th July 2025 to discuss a plan for updated EPCR training and a launch plan, to be led by CCIO team.	TBC following first meeting on 9th
Confirmation of a new supervision policy, informed by current practice and new initiatives following trials.	Q3 2025/26
Confirmation of the embedding of clinical education team into patient safety and learning review meetings, as well as involvement in the agreement of actions following incidents; to ensure that the learning is then embedded into future education and development for staff.	End of Q2 2025/26

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 **Proposed new wording** We may fail to sustain our progress on inclusion or to make further improvements for all staff, including enhancing equity on career progression and pay.

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 25/26				
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 (as part of People & Culture Committee), and Trust Board Use insights from data to inform action planning and FFRs (WRES and WDES) Gender Pay Gap related actions Ethnicity Pay Gap related actions Disability Pay Gap related actions
Continue with scrutiny of changes to policies and practices through EIA process	Ongoing advice as SMEs Effective consultation with stakeholders to ensure inclusive practice
Continue to 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 (as part of People & Culture Committee) and monitored by the EDI Implementation Group. Refresh EDI Implementation plan to reflect progress made and align with ambulance EDI action plan Implement recommendations from EDI audit
Implementation of the recruitment interventions and response to sea change recommendations	Monitored by the Recruitment working group Strategic placement of any roles that become available with ring fences on programmes like OLIR Positive action embedded in Trac and recruitment processes for all targeted recruitment campaigns (IPMs, SuSP, hiring manager to complete a form for all unsuccessful Band 7 candidates)
Conduct staff network review	Review current model of working, use of resource, challenges and support needed to drive better outcomes for staff

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Continue to implement Reasonable Adjustments Policy and Guidance and manage a centralised process and budget through the Reasonable Adjustments Hub	Monitored by Reasonable Adjustments working group and progress reported to EDI Committee Closer scrutiny of complex cases through panel of subject matter experts
Continue to implement of Anti – Racism Charter and Anti-Discrimination Statement	Monitored via the EDI Implementation Group and progress reported to EDI Committee (as part of People & Culture Committee) Integrated into CELC module and wider training, and worked into referral to resolution process Ongoing awareness campaigns through communications and engagement activity Ongoing advice and guidance to staff as SMEs
Continue Sexual Safety oversight group to advise on and monitor changes to Trust process to create a safer environment for all staff	Action plan developed – oversight through Sexual Safety group, EDI Implementation Group and EDI Committee (as part of People & Culture Committee)
Increase accountability for EDI in leaders across LAS through localised action plans and EDI objectives	Develop localised action plans for key directorates – monitoring delivery through EDI Implementation Group EDI objectives for 92% of ELG members – monitoring through ELG and ongoing support provided

Further actions

Action	Date by which it will be completed
Deliver the four business plan objectives: 1. Pilot an Inclusion Board for 12 months to strengthen the voice of all staff in decision making	March 2026
2. Conduct a stocktake and review of the progress on the ambulance Equality Diversity and Inclusion action plan with outcomes and recommendations by Q2.	March 2026
3. Complete 90% of all non-complex reasonable adjustment requests within 6 weeks of submission to the Reasonable Adjustments Hub.	March 2026
4. Increase the representation of under-represented groups in the roles of Assistant Ambulance Practitioner, Incident Response Officer, Emergency Resource Dispatcher, and Clinical Advisors in the Clinical Hub (CHUB).	March 2026

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 25/26				
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
2025/26 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
Wellbeing aligned to LAS People Strategy	

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

Immunisation records to be validated and outstanding vaccinations to be addressed	Staff with gaps in immunisation records offered catch up appointments on three separate occasions
Best practice model in management of absence including fast access to mental health pathway.	New model established
Complete stress risk training (risk:1048)	New stress mgt policy in place and stress risk assessment training being rolled out.

Further actions

Action	Date by which it will be completed
Review of first day absence reporting system	Awaiting embedding of LDM . Pilot now finished. Paper to ExCo 30th July
Review of teams and associated scheduling	Awaiting embedding of LDM . Pilot now finished. Paper to ExCo 30th July

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 25/26				
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
Management and Leadership Support • Launch of Our LAS Centre of Excellence for Leadership and Culture (CELC): • Commissioned Leadership Programmes: • Learning and Education Course Catalogue: • 'Me and My Leadership Style' Series: • Difficult Conversations Training: • Tackling Discrimination and Promoting Inclusivity (TDPI): • Appraisal Support: • Access to Leadership Networks: • Organisational Change Support Packages: • Mentoring and Coaching Access.	Delivered activities throughout 24/25 and 25/26.
Publicise Post Our LAS Culture Change Programme Review.	P&C Director's update to the Board and PCC
Dashboard reporting: • EDI/CDI • OD&TM • 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

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

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	People Scorecard implemented in Feedback Focus Reviews (FFR) covering People and EDI indicators.
Aligned EDI/CDI Strategy and delivery plan / system of measurement	Complete. The EDI Policy has been published.
Comprehensive review of all Policies EIA	Ensure all EIAs are consistent with EIA process and approval with relevant committees and groups and a monitoring process is implemented. Ongoing – December 2025.

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 25/26				
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**
Develop a Creepy, Clumsy, and Criminal session Part 2, focused on Respect, Reintegration, and Responsibility.	To be completed by the end of Q2
Workshop areas of the staff survey results relating to the sexual safety at ExCo/ELG	To be completed by the end of Q2
Comm's video production on the appropriate use of social media	To be completed by the end of Q3
Review the themes from hearings and any gaps in education/learning, ensure consistency on approach and outcome	To be completed by the end of Q4

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 of service disruption through a cyber-attack, or information security breach, which could result in unauthorised access to sensitive data, disruption of business operations, financial loss, and reputational damage either through:

- Internal vulnerabilities because the correct system and human safeguards not being in place which may expose us to service disruption and put at risk our DSPT compliance
- Vulnerabilities on the part of third party systems on which we rely
- Service disruption due to extended recovery following an attack

Uncontrolled				
L	x	C	=	Score
5	x	5	=	25

Current				
L	x	C	=	Score
4	x	5	=	20

Tolerance by Q4 25/26				
L	x	C	=	Score
3	x	5	=	15

• Internal vulnerabilities because the correct system and human safeguards not being in place which may expose us to service disruption and put at risk our DSPT compliance	25	20	15
• Vulnerabilities on the part of third party systems on which we rely	25	20	15
• Service disruption due to extended recovery following an attack	25	20	15

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

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

Implementation of replacement proxy software	Traffic to and from the internet fully monitored and controlled.
Implementation of new asset monitoring software	Full visibility of all LAS owned devices.
Implement Network segregation for back-ups of Critical Systems	Back Ups now hosted on a segregated part of the network
All servers running a support O/S	Remaining 3 x 2012 servers hosted in Azure with Extended Support
CAD end user devices upgraded to Win11 24H2	Complete, with CIS benchmark Level hardening
CAD end user devices patched monthly	Monthly patching implemented from August 2025
Business continuity plans developed to deal with the impact of a cyber-attack to reduce the impact and service disruption.	All plans have been reviewed and mitigations added to manage loss of critical IT systems. BCP plans include actions to continue service delivery during loss of IM&T systems to reduce impact of disruptions and testing of these plans for critical services.

Further actions

Action	Date by which it will be completed
Compliance with DSPT 2025	Complete
Implementation of replacement Zero Trust Security Service Edge software (iBoss)	Complete
Implement MFA for all NHS Shared Services	Complete
Complete deployment of new audit/vulnerability monitoring software on all LAS owned devices	Complete
Infrastructure refresh completion of migration to ARK data centre	Complete
Implementation of Firewall configuration audit software	September 2025
Hardening of internet facing systems	October 2025
Onboarding of 3rd party suppliers to the Privileged Access Management system	September 2025
Publish a paper on our ability to recover critical services, in a timely manner, following a cyber-incident	Complete
Implementation of Trust wide Cyber Awareness Training	September 2025
Document the re-architecture of the CAD environment	Complete
Complete the re-architecture of the CAD environment	Complete
Attainment of Cyber Essentials + accreditation	November 2025
Implement MFA for all legacy systems, where technically possible.	Complete
Reconfigure LAS backup solution	Complete
Complete upgrade of all end user devices to Win11 24H2 (CIS benchmark Level 1 hardened)	October 2025
Complete the RBAC deployment project	February 2026
New Server 2025 CIS Benchmark Level 1 build available and deployed where technically possible	December 2025
Operations and IM&T working jointly on plans to manage prolonged outages	Ongoing – March 2026

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
2	x	5	=	10

Tolerance by Q4 25/26				
L	x	C	=	Score
2	x	5	=	10

Controls	Assurances
Reduction in P1/P2 incidents (aim 30% reduction over year)	Major outage dashboard created as part of our directorate reporting
Rationalise and reduce our data centres to align with best practise architecture	Infrastructure programme board, Digital Delivery Board and regular reporting to ExCo and the Digital & Data Committee
Maintain our core telephony at a supported version	
Work with partners to migrate voice services to a supported infrastructure	
Robust virtual environment infrastructure	
Robust virtual desktop environment	
Maintain our core infrastructure at stations	

Further actions

Action	Date by which it will be completed
Develop a data centre strategy and roadmap with sufficient investment utilising cloud options	July 2025
Revised set of desktop images based on profiles: Admin, CAD user, etc.	June 2025 –aligned to Windows 11
Upgrade core telephony to CM10.2	October 2025
Deploy a supported voice recording solution	March 2026
Upgrade network infrastructure at 10 ambulance stations to support digital connectivity	January 2026
Implementation of a Nutanix-based Server Farm	February 2026
Data Centre consolidation in Waterloo and Corsham	March 2026
Enhanced wireless infrastructure	October 2025
Deployment of a VDI for clinical and corporate users	Novembers 2025
Improve current monitoring solutions through upgrade of Solarwinds	February 2026

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

BAF Risk: 2.7
There is a risk that the organisation may experience significant disruption due to a failure of national provided services by the Ambulance Radio Programme (ARP). 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 and there have been multiple national outages to the Control Room Solution since its implementation

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
5	x	4	=	20

Tolerance by Q4 25/26				
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
NHS England providing oversight and guidance to ARP	
Programme of improvements by Frequentis	Critical Friends group established to review changes and programme of work

Further actions

Action	**Date by which it will be completed**
Upgrade the ICCS to the new Control Room Solution under the national programme	Complete
Regular review of the Airwave Infrastructure	Ongoing
Replacement of the radio handsets	TBC
Review from Masons Advisory into the Control Room Solution infrastructure and application	December 2025
Replacement of legacy CROPS	October 2025

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

BAF Risk: 2.8
We may not deliver the £30m CIP and productivity programme

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 25/26				
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

Further actions

Action	Date by which it will be completed
Develop CIP plan to identify £30m savings	Completed
Implement Vacancy panel	Completed
Introduce targeted Control Total processes	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 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 25/26				
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
Continue negotiations with commissioners and London Regional Office to secure income	Completed
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: 2.10
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 25/26				
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 January 2025, introduction of new product starts in Q1 2025. If new supplier, operational November 2025.	Completed
Rostering Programme Established	August 2025
Review of rostering requirements for 999, 111 and corporate staff	November 2025
Migration of Ambulance Operations to GRS Cloud	TBC
Tender for a workforce management system for 999, 111 and corporate staff	January 2026
Implementation of a new workforce management system	TBC

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

BAF Risk: 2.11
The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2025/26

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by Q4 25/26				
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 to identify CIPS	Ongoing
Liaise with NHSE and commissioners to maximise income	Ongoing
Implement targeted Control Total processes	Ongoing

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

BAF Risk: 2.12
Our staff may face escalating levels of violence from patients and the public without an effective strategy to counter it

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

Tolerance by: Q4 25/26				
L	x	C	=	Score
3	x	4	=	12

Controls	Assurances
Establishment of an Executive led violence and reduction group	Regular reports to ExCo
Quarterly meetings of Violence Reduction Staff Safety Programme Board	Scrutiny at the People and Culture Committee
Corporate Health, Safety and Wellbeing Committee	Scrutiny at the Clinical Quality Oversight Group

Further actions

Action	Date by which it will be completed
Provision of Body Armour • Order received at Rainham for distribution in June to cover the backlog and a further order of 750 has been made due to be delivered in October 2025 for new staff leaving a supply of stock at Rainham.	October 2025
Provision of Body Worn Video Camera • Review BWV equipment and suitability including weight, size, wearability and mounting. • Trial new equipment and evidence management platforms from various providers for future. • Review and relaunch online BWV training and reinstate user creation automation. • Approval to mandate BWV Training for all staff with patient facing roles. • Communication campaigns and opportunities • Paper to ExCo to consider the feasibility to mandate BWV and invest in further equipment.	Paper to ExCo July 2025 report to People & Culture Committee August.
Conflict Resolution Training • Extend existing contract for further year while CRT training is reviewed • Working Group has been established to undertake Review/TNA of CRT training.	Specification development July onwards Tender issued February 2026

• Results will inform specification for new contract and tender for 2026. • Ongoing monitoring of restraint activities across the trust. • Risk to be placed on the risk register.	New contract June 2026
Violence Reduction Policy and Strategy • Violence Prevention Reduction Standard Plan in place and ongoing review	Policy & Strategy to be updated by Q3 2025/26 Review V&A Strategic Risk Assessment Q3

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 **Proposed new wording for 25/26** We may not meet our commitments set out in the 2025-2029 green plan refresh including a decrease of 4% carbon in 25/26, achieving full ULEZ compliance across our diesel fleet by Q3 and increase the number of EV chargers across LAS estate by 20%.

Uncontrolled				
L	x	C	=	Score
5	x	3	=	15

Current				
L	x	C	=	Score
2	x	4	=	8

Tolerance by Q4 25/26				
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	All delivered and in process of being commissioned to go out.

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	Plan approved at Board in July 25
Apply for funding to install EV infrastructure	Ongoing

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.

Proposed new wording for 25/26
There is a risk of fragmentation in IUC and opportunities for integration with emergency services will be lost across London given the differing and fragmented commissioning and tendering of 111 contracts by 5 ICSs. This poses a financial, quality and people risk for the services provided by the LAS.

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
5	x	4	=	20

Tolerance by Q4 25/26				
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.

The LAS IUC team have expanded the provision of services across London to confirm our position as a pan-London provider working to integrate care across the 5 ICSs and other services	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.
The LAS IUC team have also commissioned services which support further integration of patient care across services and across London	The IUC team have launched the General Practice Support Service and 999-111 Warm Transfer pathway to support integration of 111 with other urgent and emergency care services. This further supports the pan-London position of the service and shows the impact of the 111 service on the wider urgent and emergency system.

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

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. **Proposed new wording for 25/26** We face a strategic risk as the only London-wide NHS provider around the sustainability of partnerships and funding streams, with evolving ICS roles and regional commissioning shifts causing uncertainty.

Uncontrolled				
L	x	C	=	Score
4	x	4	=	16

Current				
L	x	C	=	Score
3	x	4	=	12

Tolerance by: Q4 25/26				
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

8. Concluding Matters

For Noting

8.1. Any Other Business

For Noting

Questions from the public

8.2. Date of Next Meeting – Thursday 5 December 2025

For Noting

Presented by Andy Trotter

Public Trust Board- Additional Information

Quality Dashboard

London Ambulance Service
NHS Trust

The Quality Assurance Dashboard

Presented to Quality Assurance Committee 17th July 2025

Providing Assurance on April and May 2025 Data and Updates from CQOG June 2025

We are the capital's emergency and urgent care responders

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Introduction & Purpose

The quality report serves as a single point of truth for all elements of clinical quality within the London Ambulance Service NHS Trust, meeting our contractual and statutory responsibilities for the visibility and reporting of all prescribed metrics to the Executive and Non-Executive Director levels.
Data from the preceding two months is drawn together at the bimonthly Clinical Quality Oversight Group (CQOG), reviewed, and discussed before being formulated into this report for presentation to the Quality Assurance Committee (QAC).

As the report is a work in progress, **there are a number of intentionally blank placeholder slides marking where additional Quality information will be displayed once the baseline committees and reporting structures are introduced** and amended covering areas that are vital to not only fully understanding how safe the organisation is but previously have sat outside of this report.
Other slides are works in progress as we refine reporting templates to aid the efficient flow of information from Ambulance to Board

Patient Story

A 999 call was made for a 38-year-old male by a neighbour who reported they could be heard screaming, and they were concerned for the Patient's welfare. The Patient was allegedly known to take recreational drugs and had a diagnosis of autism. The call was triaged and assigned a category 3 response priority.

A DCA was dispatched, arriving at the Patient around 50 minutes after the call was received. The Patient declined to open his flat door to let the clinicians in, but visual observations were taken, with a RR of 14 and GCS of 15 recorded. The Patient declined to engage and stated he could not trust who they were. A conversation was had over the phone with a remote CTM, who agreed that the best course of action was not to forcibly remove the Patient at that time. Verbal advice was provided to the Patient to call 999 if he changed his mind, experienced any rising frustration or any suicidal thoughts.

The next day, a neighbour called 999 for someone unresponsive and locked in their flat. The call was triaged as a category 2 response priority. The Patient could be visualised pacing inside with agitated behaviour, so LFB were requested for assistance to access. On entering, the Patient was thrashing on the floor with uncoordinated limb movements, was sweaty and flushed, and stated they had taken crystal meth, olanzapine and GHB. Additional resources were requested to manage the Patient, who was administered Haloperidol and Midazolam. The Patient was extricated and conveyed with MPS assistance. After 2 days in the hospital, the Patient was discharged.

Themes:

- The requirement for professional curiosity
- Shared decision making
- Mental capacity and discharge at scene

How have we made patients safer?

- A mental capacity quality improvement project is currently in progress, with multiple actions in progress (such as a review of LAS capacity guidance) that are directly relevant to this case. LAS have launched a new CSR to address challenging mental capacity assessments.

Areas of Focus

Areas of focus:

- ECG interpretation (Risk register, Patient safety incidents with Harm)
- Clinical – The basics done well & clinical decision-making (Quality Alerts, Patient safety incidents with harm, legal)
- Documentation (Audits, Patient safety incidents with harm, Quality alerts)
- Medical Equipment (Patient safety incidents, CQC, staff survey)
- Delays (Patient safety incidents with harm, complaints, performance data, legal)

London Ambulance Service
NHS Trust

Patient Safety & Incidents

We are the capital's emergency and urgent care responders

Clinical Quality Oversight Group

CQOG date : 17 June 2025

Reporting date = April & May 2025

Patient Safety Incident Response Framework

Incidents

Patient Safety Incidents &Themes

A total of 1,956 patient safety incidents were reported on the Trust's Risk Management system, Radar, in April and May 2025. Of note, 2,153 were reported in the same period in 2024.

The top five categories are as follows:

1.Medical Equipment (n.311)
2.Clinical Concern regarding External Provider (n.263)
3.Communication, care & consent (n.198)
4.111/IUC - Call Handling (n.155)
5.Dispatch & Call (n.151)

Learning Responses Commissioned

11 learning responses were commissioned in April and May 2025:

- x6 nationally defined incidents requiring local PSII (meeting the LfD criteria)

Themes include:

  - Informed consent
  - Dispatch and call
  - Management of patients under the influence of drugs and/or alcohol
  - Clinical treatment
  - IUC/111 call handling

- x3 AAR

Themes include:

  - Informed consent
  - Management of patients under the influence of drugs and/or alcohol
  - Incorrect MPDS protocol of fast track selection

- x1 MDT examining missing trolley beds and carry chairs
- x1 clinical opinion concerning informed consent.

Performance

- There are currently 811 overdue local review workflows in the Trust – this equates to 37.4% of all open local review workflows. Overdue workflow by sector breakdown:
  - NC – 105 (34.5%)
  - NW – 128 (32%)
  - NE – 52 (23.7%)
  - SE – 163 (38.6%)
  - SW – 65 (32.5)
  - EOC – 19 (20%)
  - CHUB – 3 (10.7)
  - 111 – 172 (54.7%)
  - RS&A – 65 (61.3%)

- 11 learning responses were closed during April and May 2025 (see appendix)
- Duty of candour compliance for May 2025 was 72.2%. Whilst this is a decrease on the previous reporting period, due to the new financial year, the numbers are lower.
- There are currently 42 open learning responses:
  - PSII – 25
  - PSR (inc. AAR, Swarm and MDT) - 17
- 9 learning responses have breached 6 months (5 PSII and 4 PSR). 3 are pending Exec approval.
- An assurance piece was undertaken concerning the number of cases presented to PSIP each week, noting that there has been a reduction since March 2025, with fewer learning responses being commissioned. Key findings:
  - Slight reduction in reporting of moderate, severe, and death patient safety incidents.
  - Mirrored across other ambulance services
  - Comparable to numbers in Q1 2024
  - Transition to Radar expedited several cases through PSIP, meaning there are fewer backlogged.
  - No specific bottleneck in reviewing cases at PSIGs

CQOG date : 17 June 2025

Reporting date = April & May 2025

Clinical Quality Oversight Group

Patient Safety Incident Response Framework

Learning

Case-based discussion

In May 2025, a case-based discussion was held, and the following cases were presented;

- The Culture of Dying Matters' - discussion around – (DNACPR – verbal, electronic, physical, make time to establish death was expected v unexpected
- Mental Health refusal - Patient assessed within ED and found unresponsive within 2 hours.
- Paediatric trauma - 2-year-old struck by a car
- A carer's concerns. The patient was left at home with advice and no further referral.

Actions of note

Paediatric assessment e-learning was produced and launched as part of CSR.

Signs of shock has been added to the clinical advisor course.

MTS cards have been reviewed by the Clinical Hub with additions being made concerning long term steroid use.

Learning from Midazolam incidents is being incorporated into the next PGD iteration.

Patient safety themes are being included into trust wide review of decision support tools

Current risks and Concerns

Medical Equipment

An increased number of medical equipment incidents occurred in April and May 2025. 311 occurred in 2 months, noting 234 incidents occurred during January and February 2025. Incidents raised concerning issues related to EtCO2 , LP15, broken new-style carry chair. All of these are on the risk register. Incidents are continuing to be raised concerning ECG electrodes.

Radar

- Due to technical challenges, legacy Datix data is not yet available on Radar, and the circa 850,000 documents are not yet on SharePoint. The systems team are therefore managing more daily enquiries, which is preventing progression of the Radar project onto Phase 2, dashboard building.
- Lack of dashboards is impacting teams' efficiency and ability to work effectively from Radar.
- Challenges with understanding when to 'Save and Complete' the Local Review workflow in causing issues with identifying when incidents are ready for 'Quality Check'
- Current use of 'Event Tasks' – often meaningless and contain little information to support in task completion.

Incivility

Seen patient safety incidents involving elements of incivility, either between staff or staff and patients/relatives. These have had fatal consequences for patients.

Ongoing work

Thematics

Following the Patient Safety Forum in March 2025, a review of nationally defined local PSIIs was commissioned. This was due to the numbers doubling from 2021/23 to 2023/25.
The review is considering areas such as:

- Introduction of LFPSE definitions of harm
- Themes and trends of incidents
- LfD implementation
- PSIP attendees
- Coronal process

The Patient Safety Team are considering the ToR for two thematics to commence imminently:

- Skill mix
- Health inequalities

Radar

Delivery of Radar 'drop in' sessions to provide updated training and guidance, and how to access pre-built generic dashboards as well as how to use the 'report builder' which may help with daily functions

Supporting CTMs and managers with effective local investigations, and how to maximise the efficiently of sending an 'event task'

Just Culture

About to launch the 'Being Fair Tool'. Linking in with Professional Standards for Trust education on civility and the impact on patient care.

CQOG date : 17 June 2025

Reporting date = April & May 2025

Clinical Quality Oversight Group

Patient Safety Incident Response Framework

A summary of open and closed thematic/system reviews and their associated improvement plans

NB: Data correct as of 17/06/2025

Theme	Detail	Commissioned date	Report Status	System Improvement Plan Status
Ineffective breathing	Recognition of ineffective breathing during 999 calls	April 2023	Complete – Feb 2024	Complete
Falls	Patients who have fallen and have not been managed within expected standards	March 2023	Complete – Feb 2025	Complete
VF	Incidents where defibrillation was indicated but not delivered for >2 minutes	July 2023	Complete – March 2025	Complete
Medicine administration	Review of incidents involving medication errors	N/A	Complete pending action plan approval	In progress
10D2 & 10D4	Management of high risk determinants	August 2023	Complete – Feb 2024	Complete
Bariatric care	999 and clinical management of bariatric patients	October 2023	Complete – Jan 2024	Complete
Defib pads	Missing or broken defib pads impacting patient care	July 2024	Complete – March 2025	In progress
Shift change over	Patient safety incidents which have occurred during shift change over	August 2024	January 2025	Confirming action owners
HAC	Missed HAC conveyance when presenting with a STEMI	October 2024	Pending approval	In progress
Paediatric care	Assessment and management of paediatric patients	December 2024	Complete - March 2025	In progress
National PSIIs	A review of the past four years of National PSIIs	March 2025	Analysis	TBC
Skill mix	TBC	TBC	Determining ToR	N/A
Health inequalities	TBC	TBC	Determining ToR	N/A

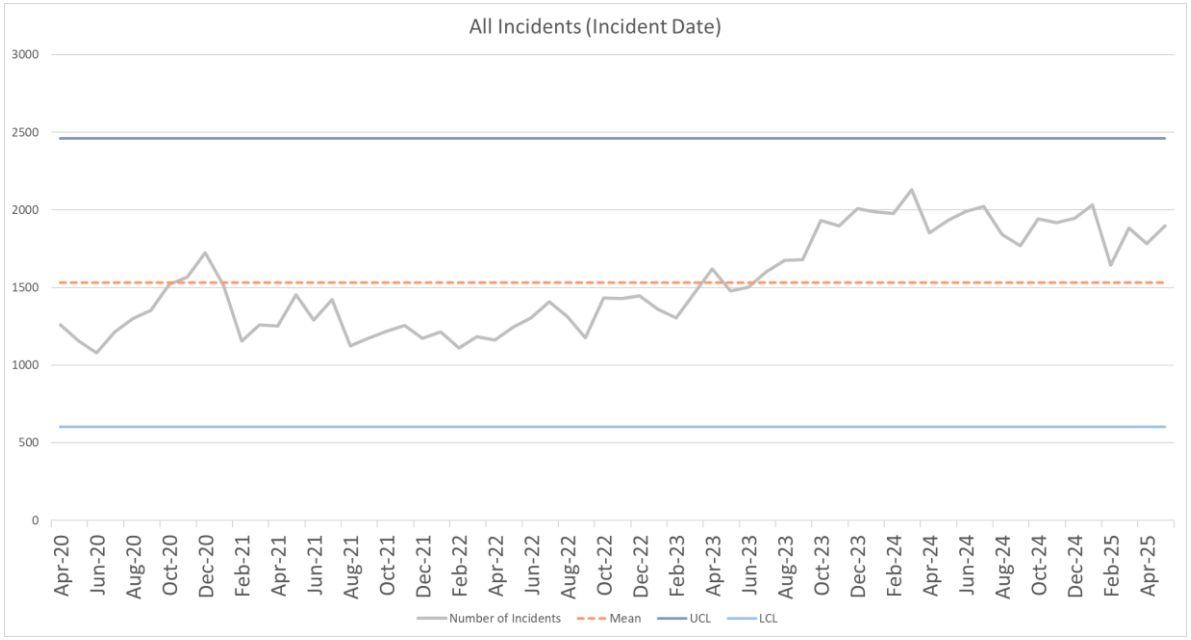
9

Safe | Effective | Caring | Improve

Priority **Owner** AW **Exec Lead** FW

All Incidents

The number of incidents remained constant during the transition to Radar.



The number of incidents reported remained consistent throughout the transition onto Radar.

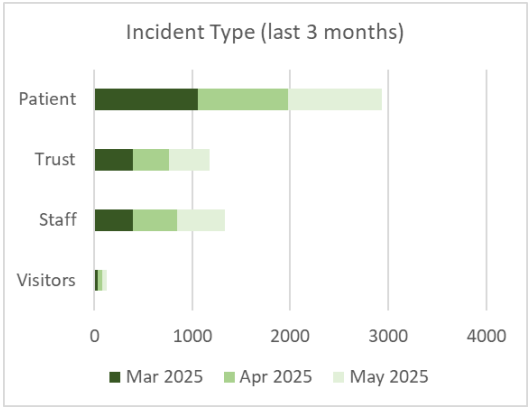
South East sector where the highest reporting area, followed by North West

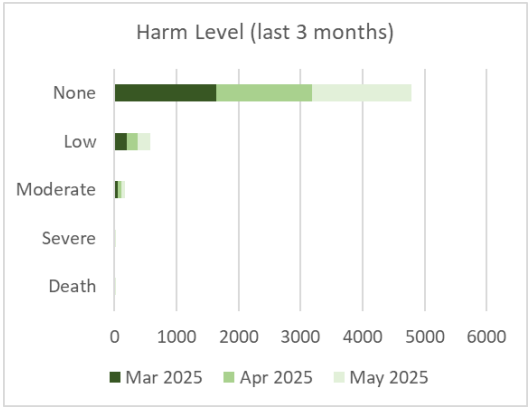
Top categories for this reporting period include:

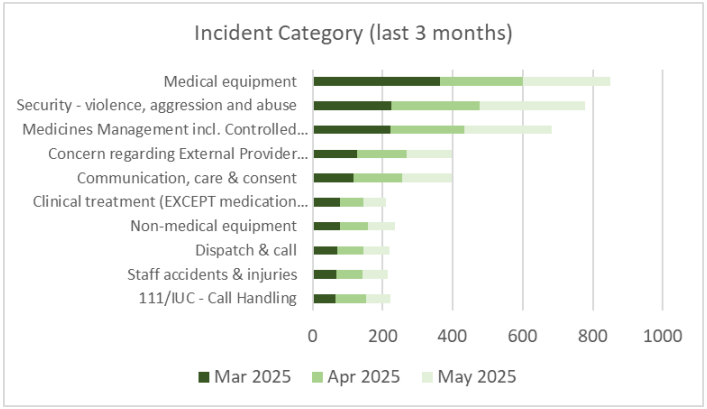
- Medical Equipment
- Security, violence, aggression and abuse
- Medicines management including controlled drugs

Due to the transition to Radar, a number of harm incidents were reported during March 2025, but had occurred prior. This was to ensure a continuation of the investigation.

Reported date will be available for the next report.





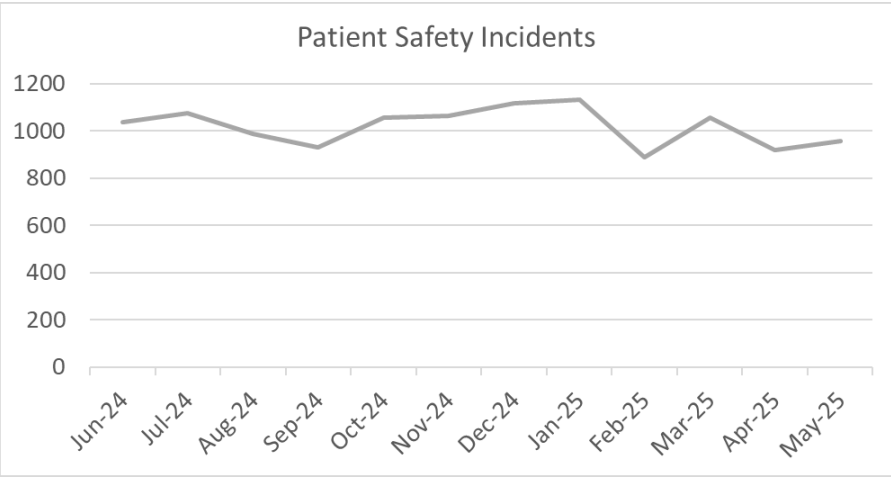


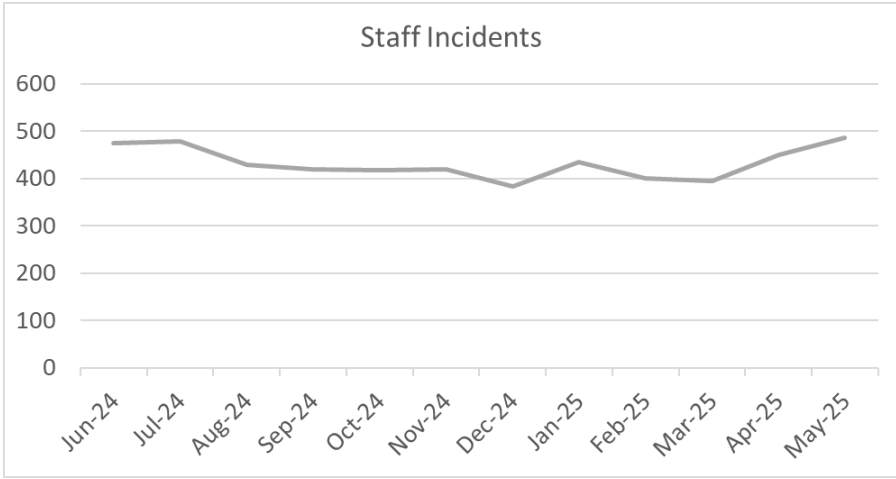
Safe | Effective | Caring | Improve

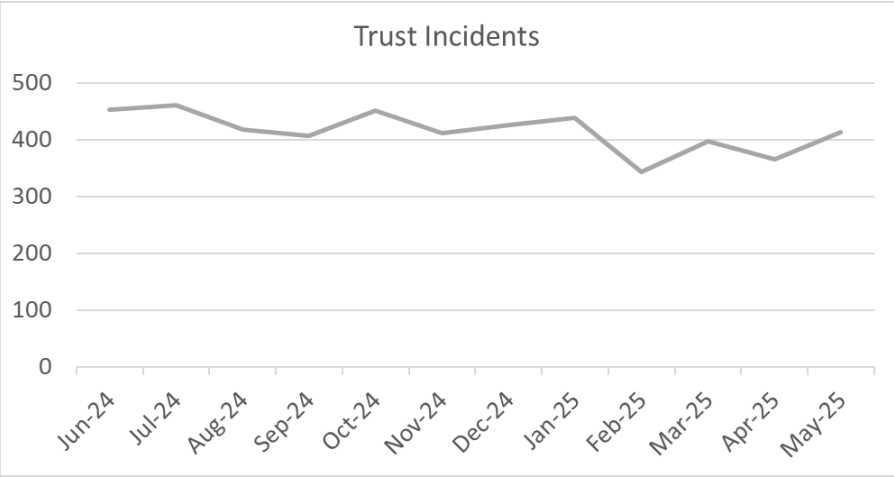
Priority | Owner AW | Exec Lead FW

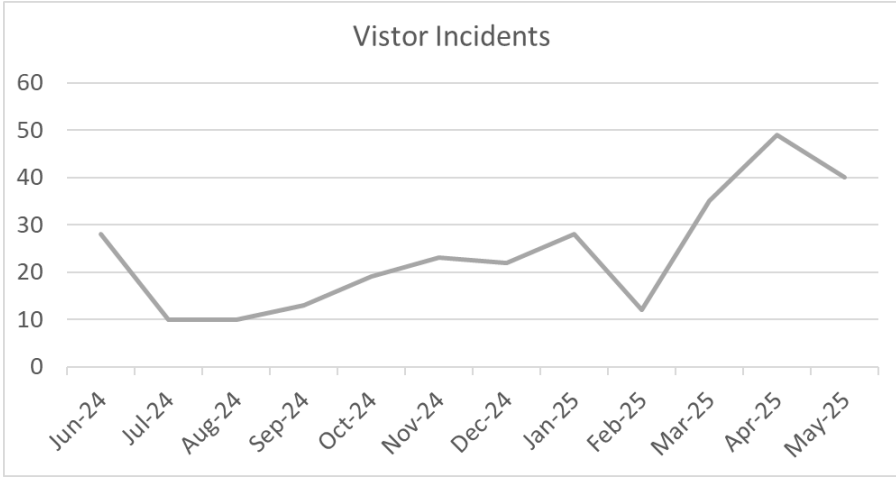
Incidents by Type (incident date)

There has been an increase in 'visitor' reporting since Radar.









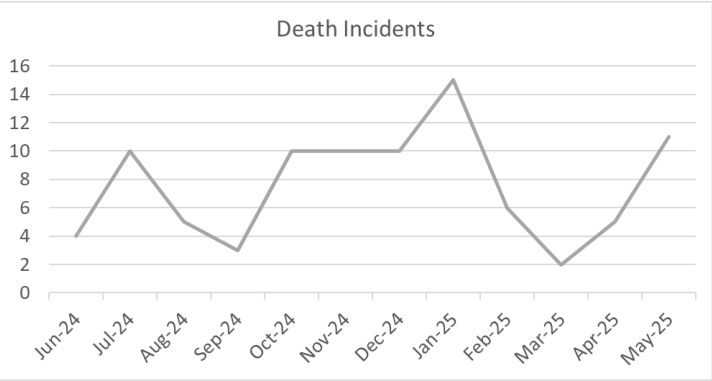
The number of visitor incidents has seen an increase since the transition to Radar. On review, the incidents are seldom referring to visitors and are usually patient safety events.

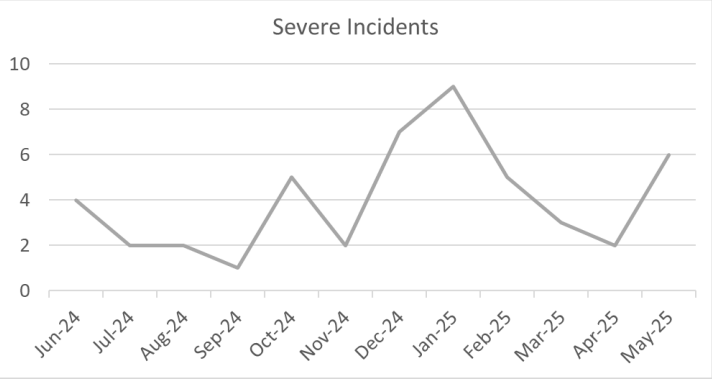
The team are currently working with stakeholders to understand how users are interacting with Radar. A review of all visitor incidents is underway and incidents will be moved to the correct incident type where appropriate.

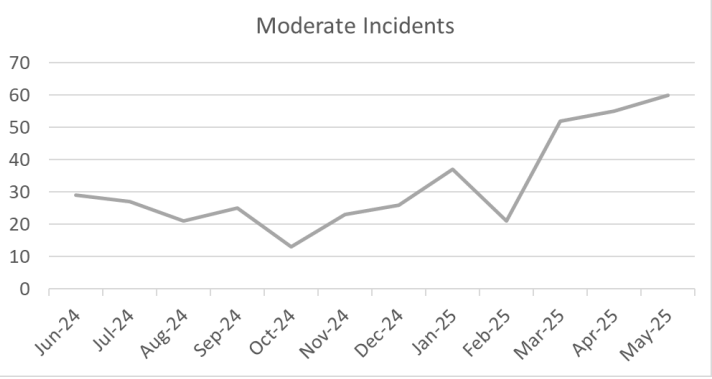
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

Incidents by Harm (incident date)

The number of moderate harm reported incidents remains high.







Learning from deaths

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Apr-25	May-25
C1 calls double 90th cen	0	0	1	0	1	0	1	0	1	0	0	0	1
C2 calls double 90th cen	5	2	2	4	7	2	3	4	4	4	2	3	1
All C3 cases	3	3	4	3	7	3	8	6	6	4	5	9	7
All C4 cases	0	0	0	0	0	1	1	1	0	1	1	0	0
Re-contact within 24 hou	9	11	17	6	7	7	11	7	12	11	14	12	7

PSIP Outcomes - Last 6 months

	Dec24	Jan25	Feb25	Mar25	Apr25	May25
Enhanced Inv. - External		1	2			
Loc-defined - Local PSII						
Nat-defined - Local PSII	4	5	8	2	3	2
Nat-defined - Alt. Team						
Patient Safety Review						
PSR - After Action Review	1	4	4		3	
PSR - Complaint Response	1		2			
PSR - Delays SJR						
PSR - MDT	1			1		1
PSR - SWARM Huddle		1	1			

PSIRF Themes - Last 6 months

	Dec24	Jan25	Feb25	Mar25	Apr25	May25
111 - Clin. Assessment						
Clinical assessment	1	1	1			
Clinical treatment (EXCEPT meds)		1	1		1	
Communication, care & consent						
Dispatch & call	2	3	1			1
Local – Call Handling - 111/IUC		3	2		1	
Local – Call Handling - 999	1		2			
Local – Cardiac Arrest / Airway Mgmt			1			
Local – Cardiac Arrest / Recognition						
Local – F2F - incorrect non conveyance		2	2			
Local – 999/111 clin assess. incorrect advice				2		
Local – F2F - definitive care	1	1	2			
Local – F2F - immobilisation						
Local – F2F - extremes of age	1					
Local – Medicines Management			1			
Local – Emergency Patient Safety Incidents						
Maternal, obstetric and neo-natal		1	2			
Non-medical equipment						1
Patient accidents & injuries			1			
Local priority 1 - Informed Consent					2	
Local priority 2 - Management of patients under influence of alcohol & /drugs					1	1
Local priority 3 - Remote assessment and management of patients at extremes of age.						
Local priority 4 - Incorrect MPDS protocol or fast-track selection					1	

The number of severe and death reported cases reduced during Q4. Increases has been noted during Q1. This is a pattern which has been mirrored on a national level. Moderate harm has remained high throughout this period.

Learning From Deaths

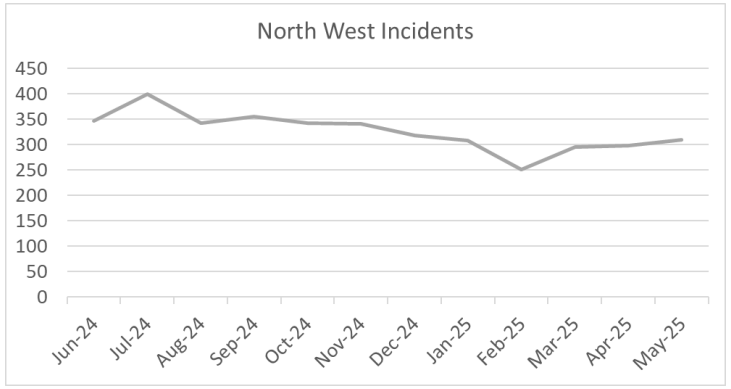
- Within May 43 cases received a learning from death review 17 of which required a further review. There are 11 cases where the stage 1 review is in progress.
- Themes within May include: recognition of cardiac arrest, patient moved before defibrillation, drug administration for hypothermic patients, response time to elderly faller and welfare check. Documentation of capacity assessment in mental health patient and also for a patient under the influence of drugs/alcohol. There have been singular cases recorded for known concerns including 12 lead ECG, expected death protocol.

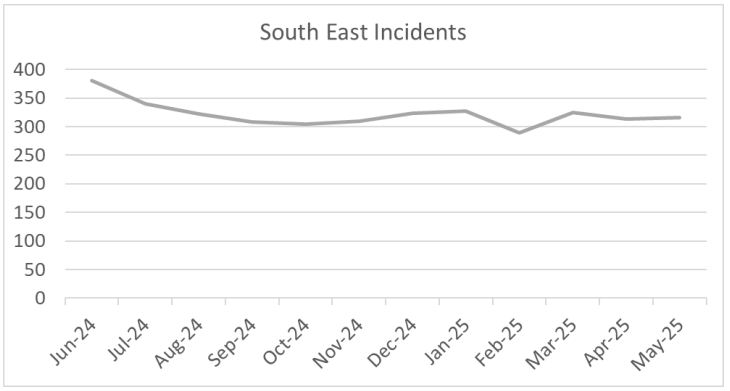
NB. moderate, severe harm and death reported incidents are reviewed via sector Patient Sector Incident Groups where LfD reviews are undertaken. Therefore, the harm grading is subject to change.

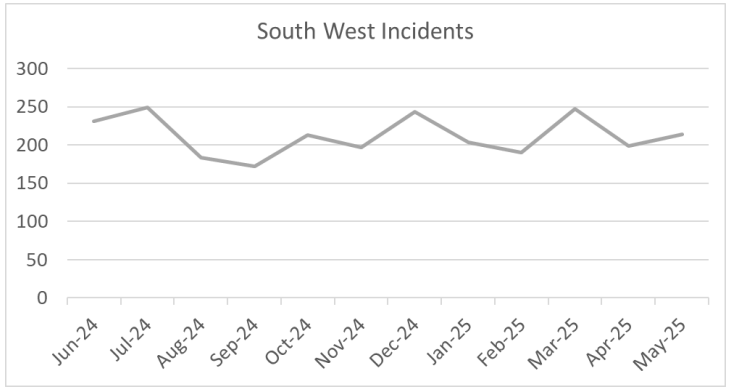
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

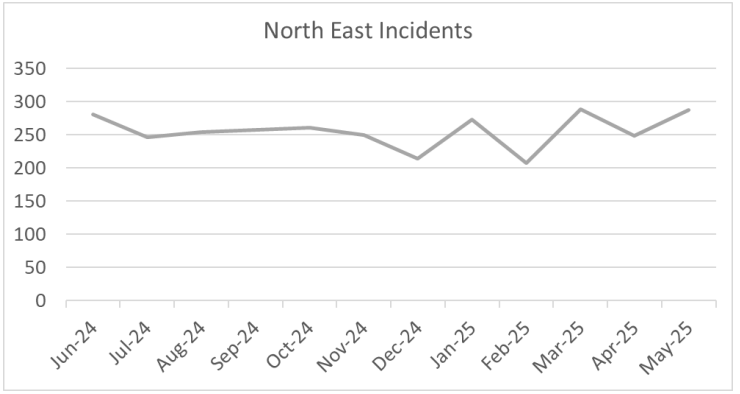
No concerns for escalation

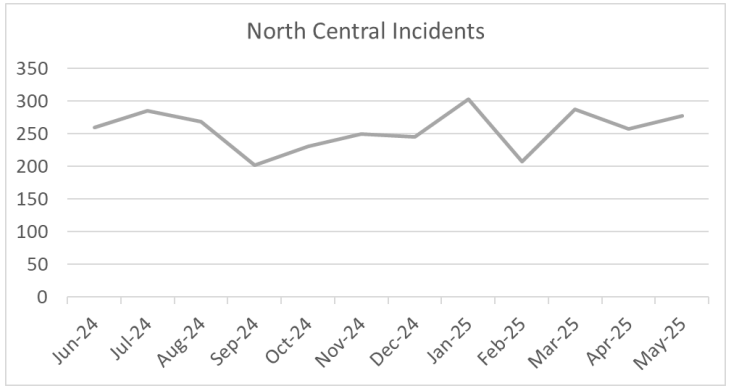
Incidents by Sector (incident date)

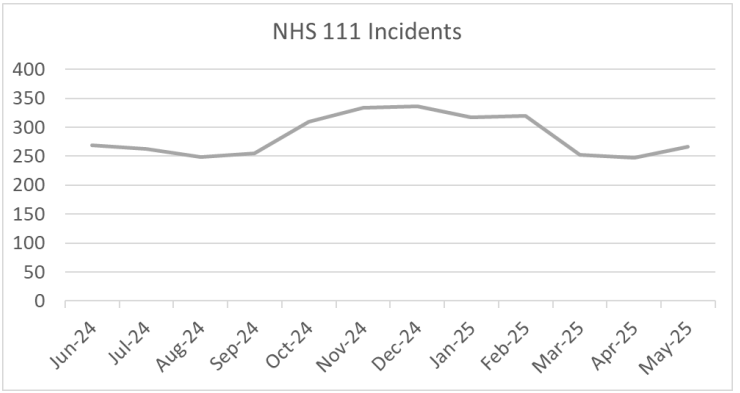












All areas remained in common cause variation based on the date of incident. The highest number of incidents occurred in the South East Sector

NB full data including a breakdown of incidents by sector will be available for the next reporting period.

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

Incidents by Category (incident date)

There has been an increase in medical equipment and security incidents.

Category	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Total
Medicines Management incl. Controlled Drugs	270	290	272	237	269	257	285	309	238	223	210	249	3109
Security - violence, aggression and abuse	260	239	241	232	239	220	194	215	234	226	251	302	2853
Medical equipment	217	194	145	183	173	166	192	183	144	363	237	250	2447
Concern regarding External Provider (Clinical & Non-Clinical)	126	122	123	91	127	121	152	163	131	127	141	129	1553
Communication, care & consent	131	124	111	107	151	157	114	137	93	116	140	140	1521
Dispatch & call	99	120	93	78	104	105	98	141	67	70	75	75	1125
111/IUC - Call Handling	78	87	87	102	101	100	112	90	101	65	87	70	1080
Clinical treatment (EXCEPT medication related)	95	109	95	102	88	81	124	91	84	79	65	66	1079
Moving and Handling of Patients (not including physical restraint)	94	87	74	86	83	91	74	84	71	51	40	43	878
Non-medical equipment	69	66	75	57	68	59	53	67	56	79	79	77	805
Medication Error	66	67	58	54	72	55	62	60	41	48	50	52	685
Staff accidents & injuries	44	48	42	52	43	41	55	64	44	67	76	72	648
Vehicle related	71	49	59	47	44	51	57	53	45	51	57	40	624
Clinical assessment	41	53	50	40	61	51	67	57	34	61	48	53	616
Maternal, obstetric and neo-natal	47	64	53	50	52	44	53	44	48	42	20	44	561
Security - theft, damage to property, loss of property	52	47	39	50	37	51	50	30	36	30	29	33	484
Infection Prevention & Control (incl. Sharps Injury)	40	42	38	40	40	38	31	40	34	24	30	36	433
Access / Transfer / Handover issues	40	33	34	30	45	46	32	26	22	19	23	21	371
111/IUC - Clinical assessment / advice	25	29	27	15	29	39	41	34	39	29	20	22	349
Information governance and breaches of confidentiality	27	41	25	15	38	31	21	26	15	27	25	33	324
Infrastructure, buildings, IT & telephony	29	27	19	26	25	30	21	40	18	22	17	24	298
Patient accidents & injuries	14	29	29	22	14	27	14	20	10	23	20	22	244
Moving and Handling of anything Except Patients	10	13	12	14	8	13	6	14	8	15	9	8	130
Clinical advice	8	5	7	3	9	10	6	8	5	8	6	4	79
111/IUC - Referral to incorrect Out of Hours	10	12	5	2	2	9	9	8	4	1	2	7	71
End of Life / Palliative Care	2	5	7	10	4	4	6	9	4	2	4	8	65
Estates (Incl. Facilities)	8	7	8	11	3	5	1	6	2	4	6	3	64
111/IUC - Confidentiality	7	3	5	7	4	5	6	5	5	4	1	2	54
Transport delays	3	6	5	2	7	4	3	5	7	4	4	3	53
Staff welfare	2	4	3	4	1	3	1	1	2	0	7	3	31
Accidents & Injuries to other members of public	3	0	0	0	1	1	5	2	1	1	4	5	23
Unexpected Child Death	0	1	0	0	0	1	1	1	0	0	0	0	4
CCTV Loss/Failure	2	0	0	0	0	1	0	0	0	0	0	0	3
Moving and Handling of Patients (not including physical restraint), Moving and Handling of Patients (not including physical restraint)	0	0	0	0	0	0	0	0	0	1	0	0	1
Vehicle related, Security - theft, damage to property, loss of property	0	0	0	0	0	0	0	0	0	0	1	0	1

There was an increase of medical equipment incidents since the transition to new ECG electrodes in March 2025.

There was also an increase in Security incidents during the previous reporting period, with May seeing the most number of incidents.

Improvement work is underway in relation to medical equipment incidents. Feedback has been shared with the ECG electrode supplier, highlighting some of the issues seen.

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

The Trust's PSIRP (2025 -2026)

	Incident type Specific risk (or incident subtype) identified through risk assessment process and described with the support of patient safety teams, executive team, patient groups and clinical commissioning groups		Planned response for specific incident type - selected based on risk assessment and particularly on potential for new learning or insight
1	**Informed consent**	Patients not receiving a face-to-face response or non-conveyed, where learning related to informed consent and/or decision-making has been identified.	Inform ongoing improvements linked with safe discharge of patients.
2	**Management of patients under the influence of alcohol and/or drugs**	Patients under the influence of drugs and/or alcohol, where learning related to their assessment and management has been identified	Local safety actions to feed into wider piece to work linked to mental capacity assessment and human factors
3	**Remote assessment and management of patients at extremes of age.**	Patients at the extremes of age where learning has been identified in the assessment and management by the IUC or EOC contact centres, including Clinical Hub	Local safety actions to feed into a wider piece of work
4	**Incorrect MPDS protocol or fast-track selection**	Patients triaged by 999 EOC with incorrect MPDS protocol or fast-track selection, where organisational learning has been identified.	Local safety actions to feed into a wider piece of work.

London Ambulance Service
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Never Events

We are the capital's emergency and urgent care responders

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

Never Event list (2018) NHSE

The majority of the listed Never Events fall outside the day-to-day activities of the majority of staff at LAS; however, to provide assurance and as a result of expanding scopes of practice, the quality team track all of these criteria.

Surgical
- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post-procedure

Medication
- Mis-selection of a strong potassium solution
- Administration of medication by the wrong route
- Overdose of insulin (abbreviations or incorrect device)
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high-strength midazolam during conscious sedation

Mental Health
- Failure to install functional collapsible shower rails/curtains

General
- Falls from poorly restricted windows
- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso or oro-gastric tubes
- Scalding of patients
- Unintentional connection of a patient requiring oxygen to an air flowmeter

Number of Never Events:

0

There have been no never events recorded within the LAS during this period.

London Ambulance Service
NHS Trust

National Patient Safety Alerts, NICE & National Guidance

Compliance & Awareness

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

NICE Guidance
(May 2025)

3 outstanding guidance actions with no further updates:

1. Bronchiolitis in children – no updates since last meeting. Release of standardised worsening care advice is still pending.
2. Vaccine Uptake in the General Population - awaiting publishing in PCH. Will be a closed action once published.
3. Molnupiravir for treating COVID-19 – awaiting further update from 111/IUC if relevant changes affect their formulary.

2 outstanding guidance actions with updates:

1. Falls: assessment and prevention in older adults- is currently being reviewed and amendments to current LAS guidance to be presented at next CAG meeting.
2. Sliding sheets for moving or repositioning – review completed. No action needed by the Trust.
3. NOTE: There currently is a **consultation** review of Sepsis guideline which is planned for November release. This has been reviewed alongside current LAS Sepsis Tool and JRCALC guidelines. From the review, there is no further actions needed from the Trust currently. NICE Sepsis consultation.docx

Trusts are required to review all NICE guidance, respond with applicability, and confirm compliance.

Large numbers of these guidelines are not applicable to ambulance trusts.

A database of these reviews is held centrally.

They are currently discussed in the PSCEG.

Last PSEG (reporting here):19th June 2025.

Concern: Delays in implementing actions.

Whilst we have a robust process for reviewing the NICE guidance as it is published, it is clear that it takes the trust a long time to implement some of the necessary changes.

This has to improve and will be addressed with the review of the new governance meeting and reporting structures which is pending.

Safe | Effective | Caring | Improve

Priority | Owner | Exec Lead

National Patient Safety Updates

None for this reporting period

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NHS Trust

Complaints & Compliments

We are the capital's emergency and urgent care responders

CQOG date : **17/06/25**

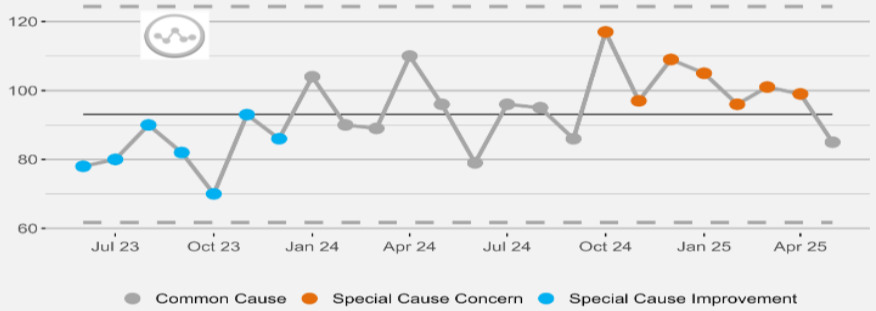
Reporting date = **May 2025**

Clinical Quality Oversight Group

Patient Experience

Complaints

Complaints received:



Number of complaints received per month has reverted to common cause variation after a recent increase.

The themes remain consistent with previous reporting periods (complaints relating to conduct and behaviour and delays are consistently the highest theme). These continue to be monitored for trends and if any meet criteria for an enhanced learning response.

Quality Alerts

Recent theme of GP practices raising concerns about the GP notification process following crew referrals on scene and the lack of information that is provided by 111 when asking them to check the LCR.

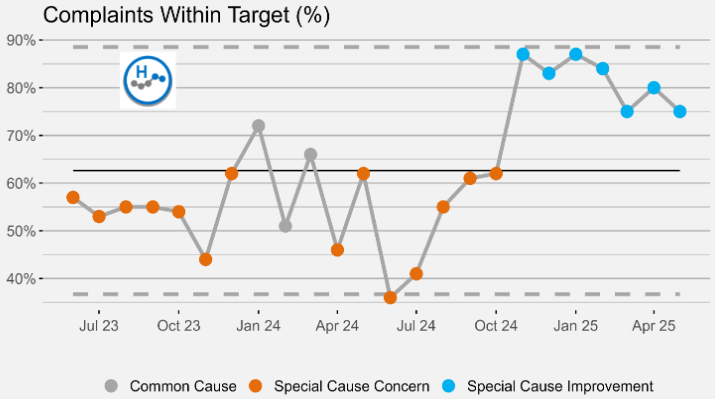
Alerts shared with 111 Governance for review and whether additional guidance needs to be cascaded regarding the process.

Current risks and Concerns

- No current risks
- No concerns or matters for escalation

Performance

Business Plan objective



The target to respond to complaints is 35 working days. The team are maintaining a 75% response rate and this objective is included in the Trust business plan for 2025/26.

The team are currently short-staffed. A Band 7 manager is on long term sick leave and a Band 5 administrator also on long term sick leave. Administrative gaps have been covered temporarily by light duties staff however performance is being impacted until substantive staff return.

Learning

New EOC guidance has been drafted regarding vulnerable patients following complaint previously discussed at CQOG.

Provided details of appreciations received from the public to EOC clinical lead for patients who have had a cardiac arrest so that the callers can be contacted with a view to the 999 call recordings being used for training purposes. Similar project to the previous work on ineffective breathing.

Ongoing collaborative working between the Patient Experience team, our 111 Governance team as well as resilience partners to ensure that key learning points are routinely identified and accurately explained.

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Safe | **Effective** | Caring | Improve | Priority | Owner | Exec Lead

Compliments

Work ongoing to capture themes of the appreciations.

379 appreciations shared with the Patient Experiences Department about LAS colleagues throughout April and May 2025.

Safe | **Effective** | Caring | Improve | Priority | Owner | Exec Lead

Excellence Reporting

147 excellence reports were submitted by LAS staff throughout May 2025. Here are some of the excellence reports received throughout August.

Themes	
Outstanding Patient Care	67
Staff Support/Welfare	20
Thank you	16
Cardiac Arrest Management	13
Mentoring/Teaching	8
Call Handling	6
Working Above and Beyond	4
Maternity Care	4
Scene Management	3
End of Life Care	3
Other	3

'When arriving on scene as the HEMS team, it was evident that the team had performed all the tasks that we would hope to see with a stabbed patient they had achieved external haemorrhage control, applied oxygen & chest seals, removed all the patient's clothing, were gaining big IV access and had extricated him from the property to the ambulance, ready to convey to the MTC. We were on scene quickly and so it was very impressive that they had achieved all of this in a very short time frame, especially as the patient was incredibly unwell and such incidents are always very challenging in the early stages. From 999 to MTC arrival was 44 minutes, which is far quicker than historical averages for London trauma patients. We know from our data that getting bleeding patients into hospital under 60-65 mins from the time of the 999 call has a huge impact on their mortality risk, so the LAS team's speed and accuracy on scene have saved this man's life. They should be very proud.'

'The crews were dispatched to a collapsed patient. They quickly recognised the patient was in cardiac arrest and promptly commenced ALS. When i arrived, I found a calm and well coordinated scene. Renee had assumed the role of clinical lead and delivered a clear and concise handover. The patient received 5 shocks, and ROSC was achieved. The patient stabilised very rapidly and had a GCS 14. The swift actions of the crews, coupled with strong leadership, undoubtedly contributed to this outstanding outcome. This is a textbook example of effective teamwork - well done everyone!'

'Managed a tricky patient in complete DKA with early recognition and attempted appropriate treatment for the patient which concluded with a rapid extrication and emergency conveyance to hospital. Interacted very well with a paediatric patient who was suffering a complicated mental health crisis and acting out violently towards police officers and crew mates.'

'Fantastic palliative care/End of Life recognition despite the situation. Had appropriate referrals and on scene support arranged. Made a patient comfortable and supported their wishes in the face of sudden deterioration. Lovely to arrive and have everything sorted efficiently and effectively.'

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Learning from Deaths

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Learning from Deaths

Quarter 1 2025

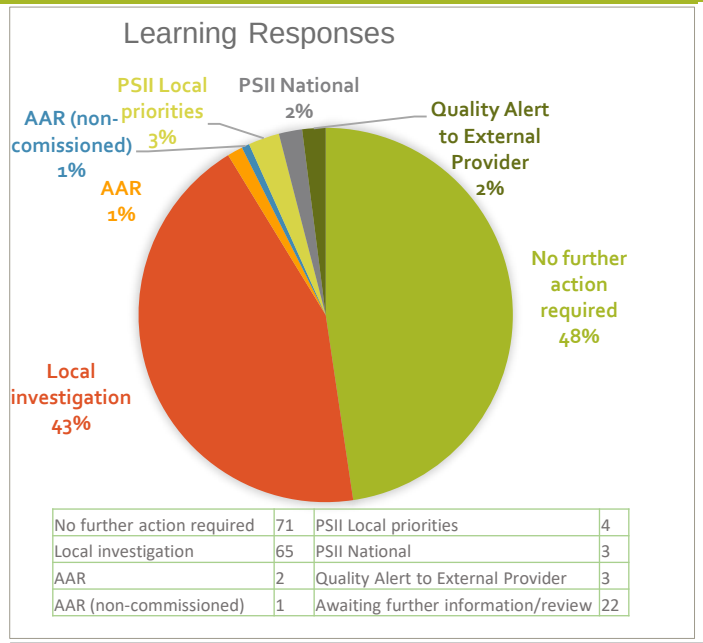
Background: Structured Judgement Reviews (SJR) occur where potential concerns in care and service delivery are identified in cases reported in Radar, learning is extracted and distributed to clinicians

Stage 1 reviewed: 175 | Stage 2 Reviewed: 58 | Stage 1 in progress: 22

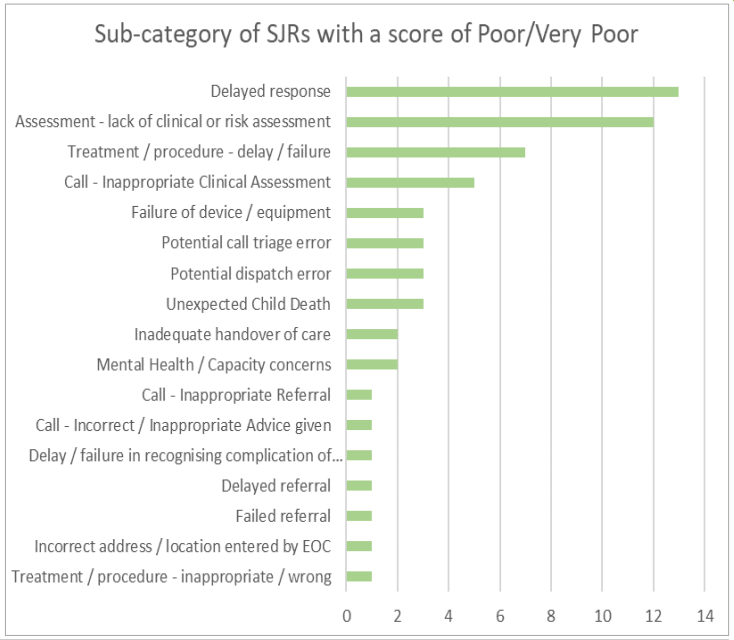
If concerns are identified in the first stage review, a 2nd stage occurs for validation

Q1 Themes Summary

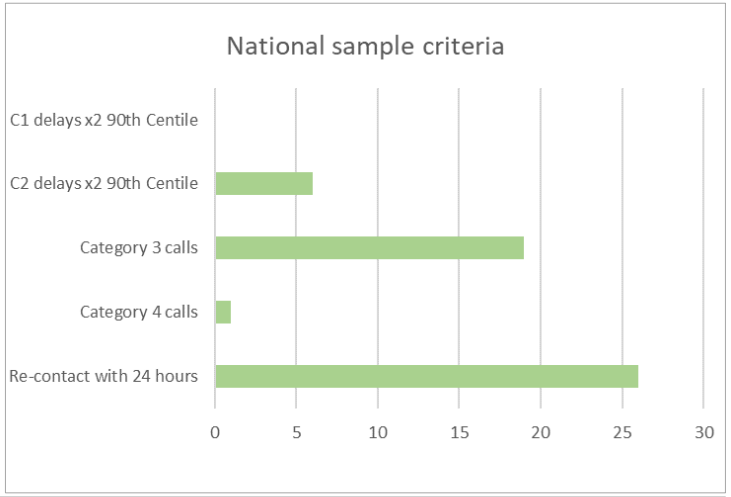
- Referral not considered for end of life care patient
- Appropriateness of care plan for end of life care patient
- Response time
- Recognition of cardiac arrest
- Administration of analgesia
- Patient moved prior to rhythm analysis
- Time taken to request additional resources to scene
- Call handling disposition – ineffective breathing
- Incomplete trauma assessment (intoxicated patient)
- Prolonged on scene time - critically sick patient
- Consideration to pre alert a patient with sepsis
- Long lie – referral tool not considered
- Methodical approach to airway management
- Critical observations during H&T, were not escalated
- Management of patient ingested drugs and alcohol
- Posterior ECG indication
- An ECG was not undertaken post ROSC
- Worsening care advice documentation
- Call handling disposition – timeliness of CPR instructions
- One set of observations in critically sick patient
- Missing older style carry chair
- Verification of Fact of Death completion concerns
- Oxygen administration in critically ill patients
- Missing trolley bed
- Inappropriate advice regarding conveyance of paediatric in cardiac arrest
- Conveyance of baby in car seat



No further action required	71	PSII Local priorities	4
Local investigation	65	PSII National	3
AAR	2	Quality Alert to External Provider	3
AAR (non-commissioned)	1	Awaiting further information/review	22



Of the 4 Local priority PSII cases n=2 relate to informed decision-making and n=2 relate to management of patients under the influence of alcohol and/or drugs. The n=3 national PSII are in relation to: recognition of ineffective breathing at call handling, baby conveyed in car seat with respiratory distress, cardiac arrest management – time to defibrillation.



The themes identified in the reviewed cases with an overall score of poor/very poor are in the Q1 themes summary and plans for the themes with =in the workstreams. Re-contacts within 24 hours has decreased from Q4 (n=44).
Of the re-contact cases n=3 were local priority PSII's , n=1 AAR, n=10 local investigation, n=10 no further action required, and n=2 are awaiting completion of review.

NB: Data compiled by Learning from Deaths Lead using Q1 2025 data.

Learning from Deaths

Learning Themes

Areas for Improvement

- Patient assessment – completion of posterior ECG's when indicated
- Detailing worsening care advice – document the risks explained to the patient
- Completion of trauma assessment in patients under the influence of alcohol and/or drugs
- End of life care plans for patients
- Recognition of critical observations and timeliness conveyance
- Defibrillation of patients is a priority before relocation
- Dispatch of solo resources to chest pain
- Patient assessment – completion of 12 lead ECG's when indicated with interpretation
- Detailing worsening care advice – document the risks explained to the patient
- Perform capacity assessment when capacity in doubt, use available resources including CHUB
- Recognition of potentially critical observations during telephone assessment

Good Practice

- Good airway management demonstrated with missing equipment
- NETS crew management and conveyance of patient with sepsis
- Good involvement of relatives with end of life care and UCP.
- Good management of paediatric cardiac arrest
- Good management of post partum haemorrhage
- Good airway management demonstrated with faulty cuff
- End of life care patient with no referrals in place was made comfortable and GP referral sought for palliative services
- Early recognition of critically ill maternity patient with pre-alert, minimum on scene time

Improvement Workstreams

- Training for make ready staff on sectors with preparing ambulance equipment
- CSR on mental capacity started in July
- CSR content on verification of fact of death
- CSR ALS, BLS & NLS training
- CSR content regarding guidance on hypothermia in cardiac arrest
- Ongoing workstream and training provided by EOC for ineffective breathing for ECH's
- Upcoming 12 lead ECG training
- New PSIRF local priorities embedded
- Back to basics workstream to include training on primary & secondary surveys, and medication administration
- Equipment focus on trolley beds and carry chairs
- Action plan for use of pedi-mate/car seats
- Article in QA Journal regarding use of acronyms
- Clinical Update June 2025 included:
    - Maternal assessment and clinical audit
    - Assessment, treatment and management of fever in under 5's
    - Paracetamol clinical audit
    - Clinical audit of anticipatory medicines
    - Case study in adrenal insufficiency

NB: Data compiled by Learning from Deaths Lead using Q1 2025 data.

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Quality Alerts

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Safe | Effective | Caring | **Improve** | Priority | Owner | Exec Lead

External Quality Alerts

30 Quality Alerts raised by external providers to the LAS throughout **May 2025.**

Themes:

- 4 Concerns raised that incorrect patient details were passed to other IUC providers.
- 3 Concerns regarding a delayed response for hospital transfers.
- 3 Conduct and behaviour towards HCPs.

Quality Alerts raised with external providers

12 Quality Alerts raised by the LAS to external providers, following incident reports completed by LAS staff throughout **May 2025.**

Themes:

- 3 Reports of failed discharge
- 2 Concerns relating to do not resuscitate (DNAR) misinformation/confusion

NB: Data collated from RADAR for May 2025.

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Legal & HM Coroners cases

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

Legal Department (Reporting period – May 2025)

Inquests

Total number of opened (Live cases)– **339**

Number of cases opened in the last two months:

- **April – 193**
- **May – 203**

Themes

- Cat 2 Delay
- NHS 111 Triage
- Capacity assessments/information consent particularly in context of non-conveyance and related to learning difficulty patients.
- Call handling
- Mental health assessments
- Cardiac arrest management

Claims

Total number of live claims:

- **Live EI claims – 58**
- **Live PL claims – 7**
- **Live clinical claims –116**

Employers Liability Claims

Increased number of Employers Liability claims for assault 58 (2024) compared to 3 in 2023, and 1 in 2022.

This is likely due to staff being the victims of more assaults than previous years. Verbal and physical assaults on our frontline staff are on the rise, with around seven physical or verbal attacks on ambulance crews or those taking 999 calls every single day – the highest rate ever recorded.

Employer's Liability Claims – Top 5 themes:

- Defective work equipment
- Trips
- Manual Handling
- Lifting work equipment
- Assault

Concerns

0 PFD issued in past 12 months.

- BT priority line referred to in evidence as well as the LAS approach by call handlers to HCP callers who request to get off the phone and return to the patient, when they are the only clinician on site.

We have been given 7 days to address these in written submissions and the Coroner will then decide on PFD.

Written submission due in court on 13th June 2025.

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Highlight reports from subordinate committees

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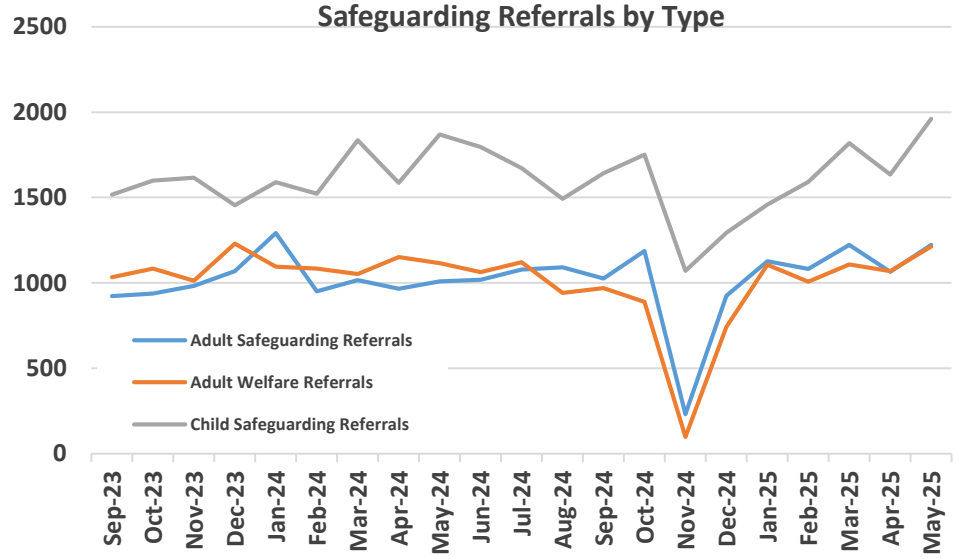
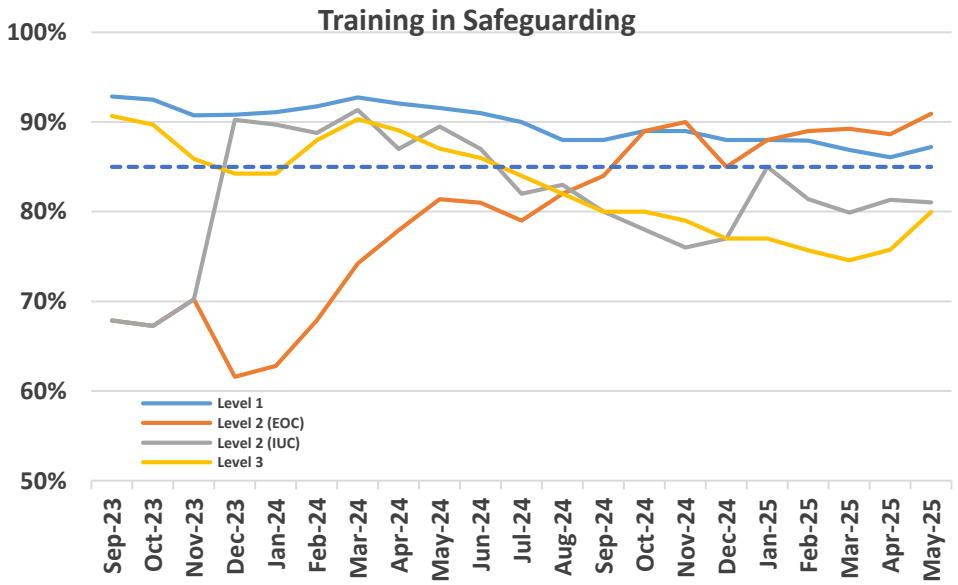
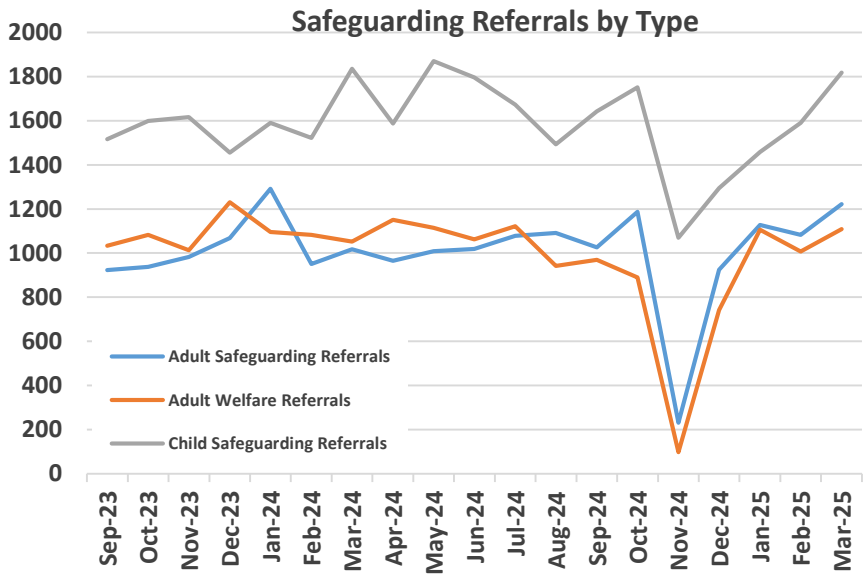
Safe | Effective | Caring | Improve | Priority | Owner AT | Exec Lead PC

Safeguarding

Below compliance for training







Narrative not provided

Safe | Effective | Caring | Improve | Priority | Owner AT | Exec Lead PC

Safeguarding

Training (end of financial year) contractual target 90% for end of financial year (April 2025).

Training	Trust Wide Figures
Safeguarding Level 1	86.57%
Safeguarding Level 2	77.48%
Safeguarding Level 3	74.60%

To support improvement, Level 2 and 3 recovery plans have been requested and were discussed at the most recent Safeguarding Assurance Group (SAG).

The Level 2 safeguarding training target has not been met. This is a concern and highlights the need for renewed focus and accountability.
We are currently conducting a review with individual teams / areas, to identify any staff who have not completed their safeguarding training within the past three years. This will then be risk assessed in terms of follow-on actions, relative to the role of these staff.

NB: Data correct as of CQOG update on 17th June 2025.

CQOG date : 17/06/2025

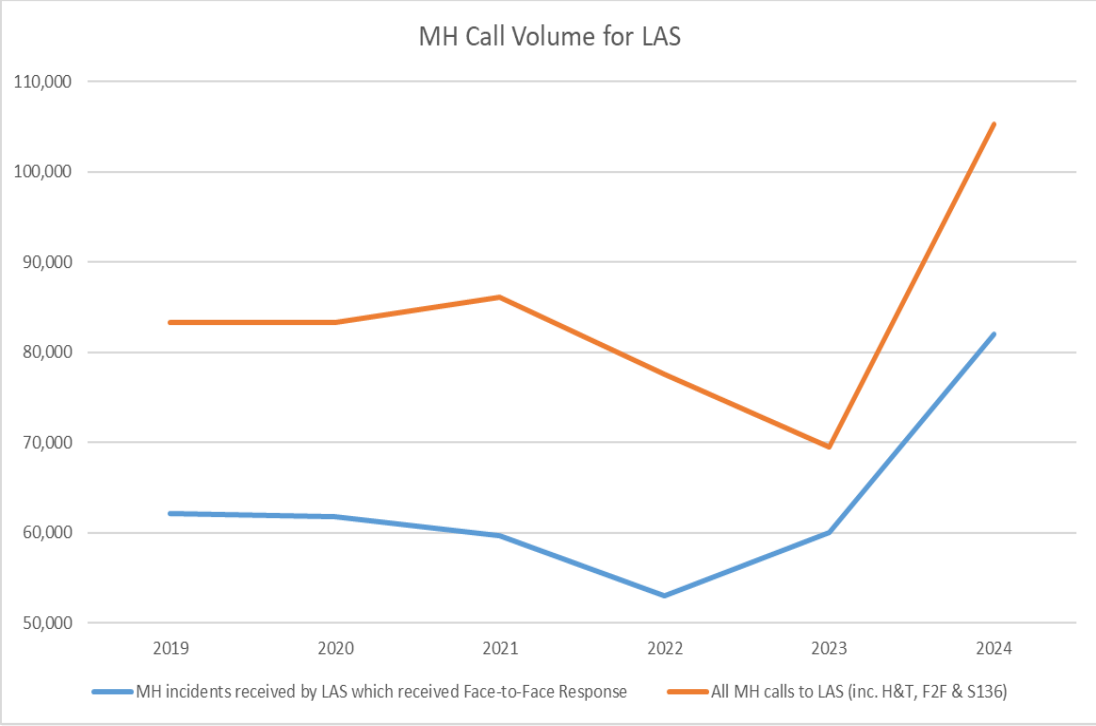
Reporting date = May 2025

Clinical Quality Oversight Group

Mental Health

Incidents

Mental Health Calls to LAS continue to rise as seen in the graph below. Despite the introduction of the 111*2 for Mental Health service there has been no reduction in call volume.



Current risks and Concerns

- **Current risks/Matters for escalation:**

MHJRC Funding

The main risk, at present, is the upcoming funding review for the Mental Health Joint Response Cars. The team are working with the LAS commissioning team on a paper and equality impact assessment around the risks of decommissioning this service. The paper will consider the impact on double crewed ambulances, clinical hub assessments, patient experience and impact on system partners such as Emergency Departments.

S136 Powers

There is a proposed amendment to extend Section 136 powers to some healthcare professionals that us currently under consideration in the House of Lords (Amendment 44 to Mental Health Bill [HL] to Mental Health Bill [HL] - Parliamentary Bills - UK Parliament) If passed this would increase the legal powers of staff under the Mental Health Act and likely have significant operational impact. A joint statement has been released from various organisations including AACE and the College of Paramedics opposing this.

Learning

A re-occurring theme during reviews of incidents is around assessment and documentation of mental state and risk. In order to improve assessment quality the ‘ Mental Health Assessment’ tab within ePCR has been completely re-designed. It will follow a standardised mental state and risk assessment and there will be an associated CSR training package for clinicians.

Two Preventing Future Death Reports have been issued to police forces in the North of England relating to welfare checks and the Right Care, Right Person policing mandate.

CQOG date : 17/06/2025

Reporting date = May 2025

Clinical Quality Oversight Group

Mental Health

Performance

Mental Health Car cover and productivity .

Team Output	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Total Shifts Covered	120	136	131	149	133	130	133	146	143	175	161	202	183
Daily Cars (Month average) - target 6	4.00	4.38	4.36	4.80	4.30	4.33	4.30	4.86	4.60	5.65	5.75	6.52	6.10
% of shifts covered	66.67%	73.12%	72.78%	80.11%	71.51%	72.22%	71.51%	81.11%	76.88%	94.09%	95.83%	108.60%	101.67%

Team Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Monthly Utilisation	72.50%	80.70%	81.70%	81.80%	75.30%	82.30%	82.80%	81.60%	83.90%	79.10%	77.20%	81.71%	78.70%
Activations	569	742	716	804	724	731	739	762	782	890	934	1143	1100

There has been an increasing picture of improving utilisation, shift cover and activations over the past year.

CPD completed within the reporting period.

Month: May 2025

- 01/05 - CHUB Induction MH Session - 20 persons
- 01/05 - EOC Crisis Management - 30 persons
- 15/05 - EOC Crisis Management - 30 persons
- 15/05 - CHUB Induction - 20 persons

CQOG date : 17/06/2025

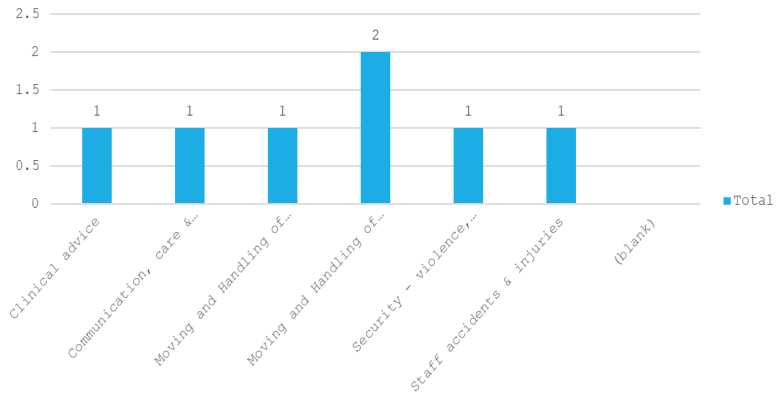
Reporting date = April/May 2025

Clinical Quality Oversight Group

NETS

Incidents

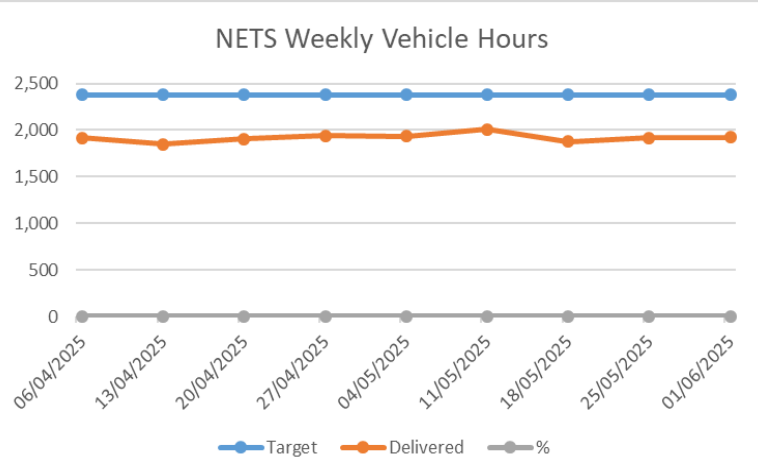
Current Themes	
Clinical advice	1
Communication, care & consent	1
Moving and Handling of anything Except Patients	1
Moving and Handling of Patients (not including physical restraint)	2
Security - violence, aggression and abuse	1
Staff accidents & injuries	1
Grand Total	**7**



Current risks and Concerns

- No Current risks
- No concerns or matters for escalation

Performance



NETS Monthly Sickness Levels			
Month	**WTE**	**Avg Sick**	**%**
April	132	15	11.3
May	132	13	9.8

Learning

- Missing NETS stretcher on NETS vehicle leading to inappropriate management of a bariatric patient - Learning shared with NETs crew encouraging staff to request the bariatric team when required
- Learning for external provider – on arrival of NETS vehicle, patient aggressive, opportunity for a secure vehicle to be sent.
- NETS crews are encouraged to wear BWC when attending patients who display aggression. Recent incidents show attendances to violent and aggressive patients where BWC was not utilised.

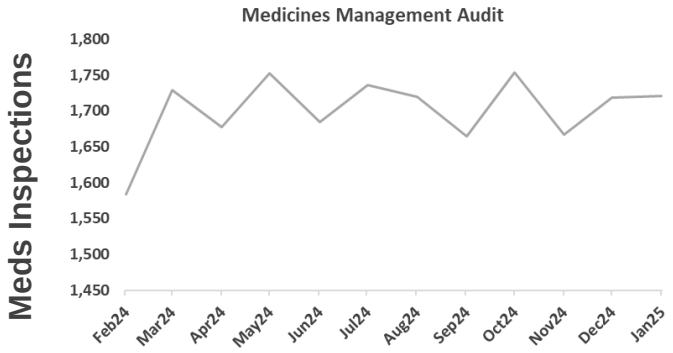
NETS Completed Per day Average					
			Avg Per Day		
	Activated	Completed	Tot Jrys	Tot Veh	Ind Veh
April	2537	2149	101.4	25	4
May	2612	2207	104.4	25	4.1

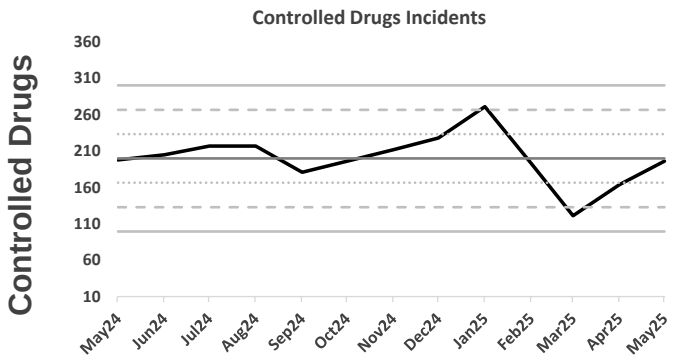
Safe | Effective | Caring | Improve

Priority | Owner TE | Exec Lead FW

Medicines Management

Increase in reported incidents – mainly related to documentation issues. The electronic CD register project is ongoing to mitigate against these incidents.

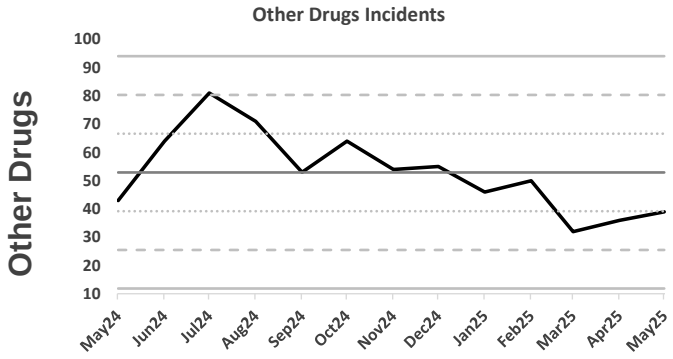




	Dec24	Jan25	Feb25	Mar25	Apr25	May25
CD - Incorrect record	8	2	4	3	1	2
CD - Safe malfunction	1	1	0	0	0	0
CD - Unaccounted for	8	5	3	0	0	2
CD - Wasted	30	44	31	0	0	0
CD - Wrong location	11	7	5	0	0	0
CDA - No documentation	8	9	10	9	4	8
CDA - No information	50	43	23	23	26	42
CDA - No signature	30	46	37	20	28	26
CDA - Not corrected	77	106	77	35	69	72
CDA - Unidentifiable	5	8	3	5	2	5
Total	228	271	193	95	130	157

CD = Controlled Drugs CDA = Controlled Drug Audit

NW	NC	NE	SE	SW	other
1	7	2	7	1	2
0	0	1	1	0	0
2	4	2	9	2	-1
30	16	16	19	12	12
5	4	4	4	1	5
4	22	6	13	2	1
26	72	24	43	32	10
28	61	43	19	28	8
59	154	70	67	68	18
2	7	10	6	2	1
157	347	178	188	148	56



	Dec24	Jan25	Feb25	Mar25	Apr25	May25
Abloy	2	3	4	0	2	0
MS - Damaged cabinet	0	0	0	0	0	0
MS - Loss/Theft	3	4	9	0	0	0
MS - Unsecure	5	1	4	2	1	1
NCD - Damage	14	19	7	10	11	14
NCD - Discrepancy	9	3	10	4	4	3
NCD - Expired	0	1	0	0	0	0
NCD - Missing	7	3	9	3	10	6
NCD - Other	15	10	6	6	2	12
SDP - Contaminated	0	1	1	0	0	0
SDP - Sharps	0	1	0	0	0	0
Total	55	46	50	25	30	36

MS = Medicine Security NCD = Non Controlled Drugs SDP = Secure Drug Packs

NW	NC	NE	SE	SW	other
1	1	1	4	0	4
0	0	0	0	0	0
2	2	1	5	3	3
1	5	2	2	2	2
11	17	14	15	11	7
6	7	6	5	4	5
0	0	0	1	0	0
11	7	4	3	9	4
8	9	7	5	5	17
0	0	0	0	0	2
0	1	0	0	0	0
40	49	35	40	34	44

Medicines Management

- A total of 329 reported medicines incidents in May, of which 209 related to controlled drugs (CD) and 79 to medication administration errors.
- Apparent rise in reported CD incidents, however most relate to documentation errors and this may in part be attributable to renewed reporting via the Radar system after Datix was decommissioned.
- Continued expansion of independent non-medical prescribing

Medicines Audit

- May saw 1,643 inspections (up from April total marginally) with average scores of 98%
- Work underway to review audit profile of medicines pan-Trust.
- Previous number of completed scheduled inspections was approx. 1,720 average. Unclear why numbers have declined.
- All (except one) stations have compliance above 95% this month.

CQOG date : 17th June 2025

Reporting date = Q4 2025

Clinical Quality Oversight Group

Medicines Management

Performance

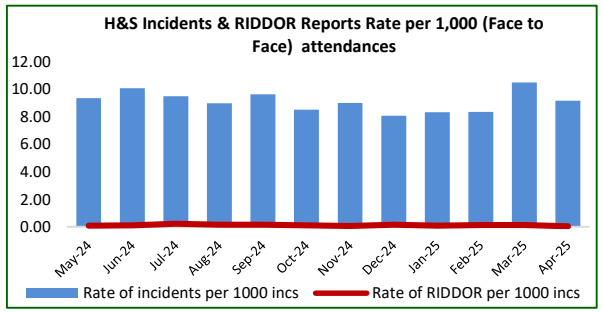
- IUC:
  - In Q4 23/24 a total of 5949 prescriptions were issued by SEL IUC. In Q4 24-25 a total of 5109 prescriptions issued, a reduction in overall prescribing activity of -14%.
  - In Q4 23/24 a total of 8319 prescriptions were issued by NEL IUC. In Q4 24-25 a total of 6751 prescriptions issued, a reduction in overall prescribing activity of -19%.
  - In FY 24/25 a total of 24,005 antimicrobials were prescribed across the North East London (NEL) and South East London (SEL) IUC centres (48% and 46% respectively). This is a decrease compared to the previous year of total 25,745.
  - FY24/25 has demonstrated good evidence of antimicrobial stewardship in integrated urgent care (IUC) prescribing, with consistent levels of broad-spectrum prescribing <10%. With NEL prescribing 6.2% and SEL prescribing 6.61% of broad spectrum antibiotics.
  - Regular prescribing audits take place for antimicrobials, CDs, high risk medicines, repeat medicines with feedback to clinicians.

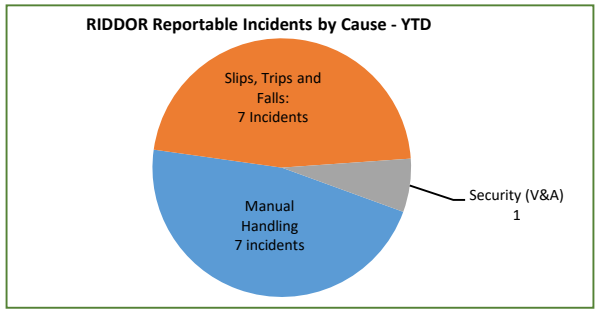
Safe | Effective | Caring | Improve | Priority | Owner EJ | Exec Lead PC

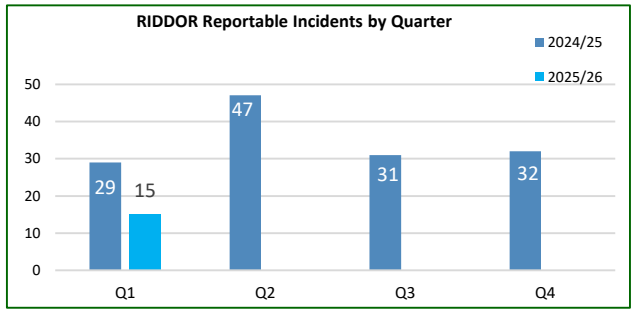
Health & Safety

No concerns for escalation

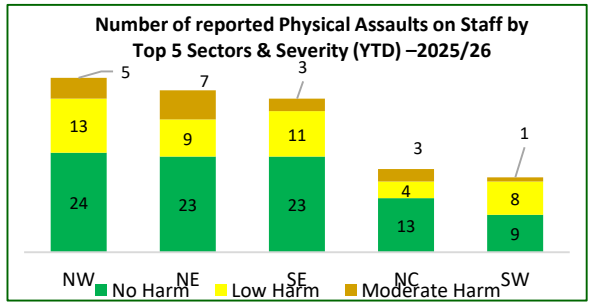
H&S - RIDDOR

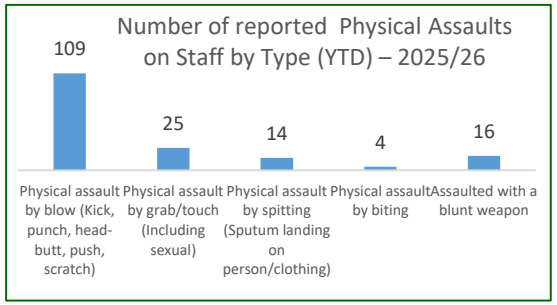


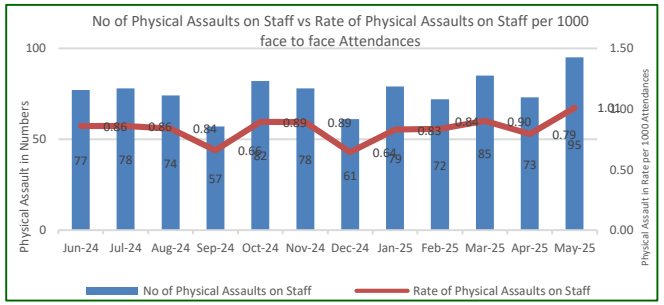




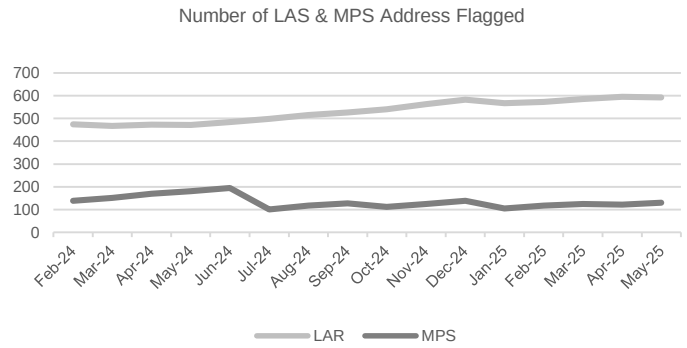
H&S - Assaults







LAR



- During May'25 the total number of H&S incidents reported was 881 resulting in 9.37 events per 1000 (999 face to face) attendances.
- Directed verbal abuse, Physical Assault by blow (kick, punch, push etc.) and Manual Handling (lifting patients) incidents account for the highest numbers reported during May'25.
- Total of 95 Physical assaults reported during May'25.
- Total of 11 RIDDOR incidents were reported to HSE during May'25.
- Staffing resource remains a major challenge, due to the increase in incidents and demand on the VRM. Following the business planning meeting (2) VROs has been approved from the business case and awaiting next steps.
- Continued increase in LAS staff using restraint and physical intervention on patients.
- Ongoing collaboration with Intelligence Systems Manager to address challenges with RADAR implementation. This is presenting risk to the management of Violence aggression and abuse incidents.
- The Health, Safety & Security (HS&S) Team have delivered one session of Corporate Induction, two sessions of Managing Safety course to 22 staff members during May 2025.
- Total of 8 successful prosecution for assault have been recorded during May'25 for incidents reported during 2023/24 (n=6) & 2024/25 (n=2).
- The renewal of BWV camera batteries across operational locations has been completed.

CQOG date : 17/06/2025

Reporting date = May 2025

Clinical Quality Oversight Group

Health, Safety & Security

Performance

- The Trust wide RIDDOR reporting time frame (<15 days) compliance in May'25 was 45% this is due to teething issues with RADAR.
- The Health, Safety & Security (HS&S) Team have delivered one session of Corporate Induction, two sessions of Managing Safety course to 22 staff members during May 2025. The HS&S team delivered a session on the new CELC development programme - Module 1, Management Essentials Day Two (Cohort One).
- Total of 8 successful prosecution for assault have been recorded during May'25 for incidents reported during 2023/24 (n=6) & 2024/25 (n=2).
- Trust wide Site Specific Risk Assessment compliance is currently at 75%.
- Trust wide Fire Drill compliance is currently at 42%.
- Trust wide Fire Risk Assessment compliance is currently at 88%.
- Trust wide Quarterly (1st Quarter) H&S Inspection compliance is currently at 35%.

Learning

- Training was delivered on the latest Bariatric Induction week on all aspects of patient handling, especially bariatric, this included training on all the moving and handling equipment specific to bariatric patients, this was undertaken by the manufacturers of the equipment and external moving and handling experts – the feedback was excellent and staff appreciated the expertise.
- Bariatric Train the Trainer course is being run in June at Brentside Education Centre, members from the Bariatric Teams, Clinical Education and Standards and H & S will be attendance to ensure that going forward we are able to deliver best practice moving and handling training in house.
- An Exec led Violence & Aggression Reduction Project Group has been set up following the results of the National Staff Survey 2024 (V&A one of the 7 key themes and priorities for the Trust) leading to the development of an ELG key action plan for the Project Group to take forward.
- As part of learning from EL claims a collaboration between Legal and HS&S team with invited key stakeholders arranged a Life of an EL Claim – session presented by Capsticks and NHSR in May.

Current risks and Concerns

- Current compliance for FFP3 fit testing is 70% due to the 2 year revalidation period. Over 60 staff members have been trained as Fit Testers and we will continue to offer the training during June to enable more staff to become Certified Testers, in order to further increase the take-up rates. All portacount machines are now under a maintenance, servicing and calibration contract which has been provided by the HS&S team, this is organised directly with the supplier Sunbelt Rentals – who collect and return to site for ease of use.
- Within the VRU staffing resource remains a major challenge, due to the increase in incidents and demand on the Violence Reduction Manager. Following the business planning meeting (2) VROs has been approved from the business case, and awaiting next steps to progress this.
- Continued increase in LAS staff using restraint and physical intervention on patients. A Task & Finish Group in place to extend the CRT contract for a year whilst the training is reviewed.
- Ongoing collaboration with Intelligence Systems Manager to address challenges with RADAR implementation. This is presenting a risk to the management of violence aggression and abuse incidents.

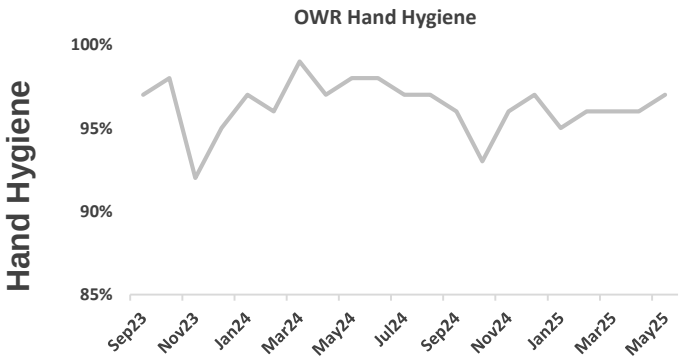
Actions and mitigations

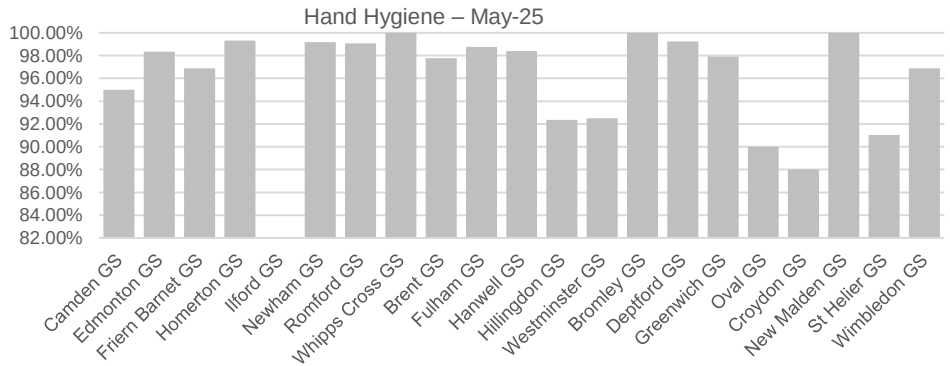
- The Community Resuscitation & Training Department in collaboration with the HS&S Team developed a First Aid course. The course is underway and available throughout the year.
- Work on the latest Ambulance design has started, it will have a different back door configuration with a flip down step being incorporated for ease of access. The latest designs for the Bariatric specific vehicles are now finalised and building is almost completed.
- Body armour risk updated and plan to mitigate the backlog issue, with an order of 715 which has been received at Rainham with an additional 750 ordered to be delivered in October'25.
- The renewal of BWV camera batteries across operational locations has been completed.

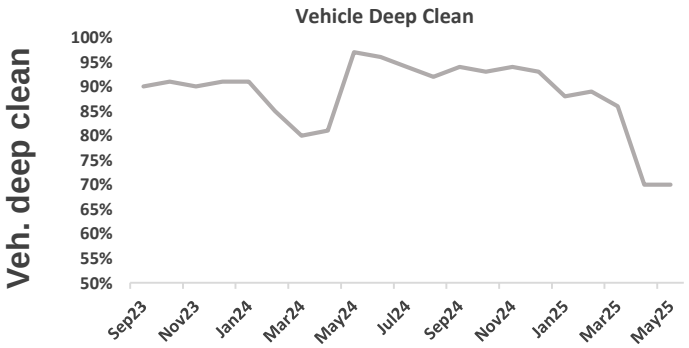
Safe | Effective | Caring | Improve | Priority | Owner IPC | Exec Lead FW

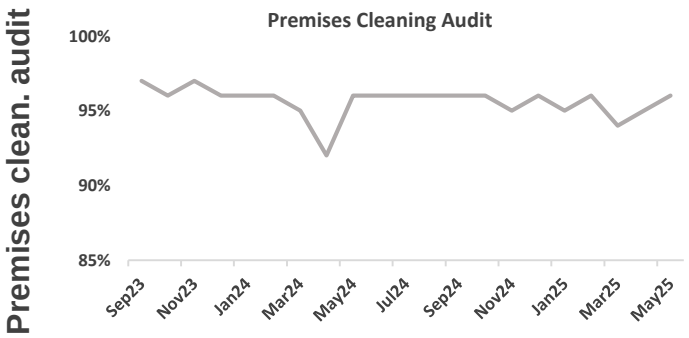
Infection Control

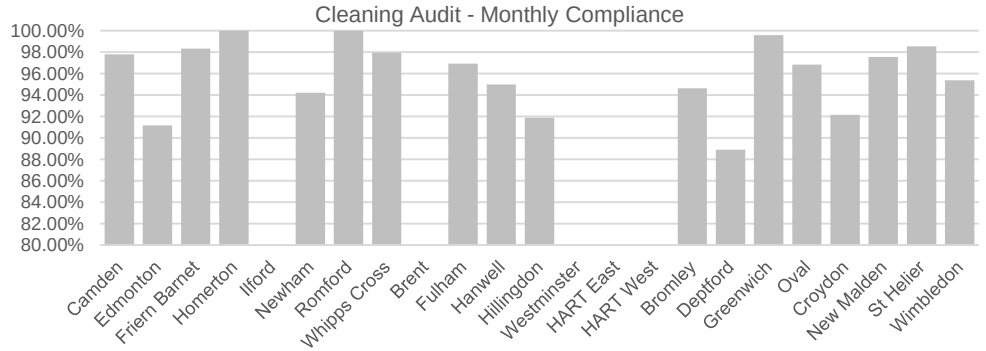
Hand hygiene local data not reflective of non-compliance with BBE practice.











- Hand hygiene local data not reflective of non-compliance with BBE practice.
- Vehicle 6 weekly deep cleans remain below 95% Trust target. National cleanliness standards 2025 highlight gaps in data assurance i.e. numerical number of vehicles cleaned Vs cleanliness of vehicle.
- Sharps incidents increased in May, no consistent themes noted.
- Continued development and publication of LAS IPC manual v. 3.1

CQOG date : 17/06/2025

Reporting date = April and May 2025

Clinical Quality Oversight Group

Infection , Prevention & Control

Incidents

- No local internal outbreaks or incidents reported.

Current risks and Concerns

- Local risks include:

  IPCD/micro hours vacant.

  Hand hygiene compliance –BBE practice

  Local reporting of HH compliance consistently above 95%- disparity observation with validation audit.

- Key updates:

  IPC manual update complete v3.1 published

  Draft DIPC annual report completion –target date June 2025

  Deep clean of vehicles 6 weekly –compliance with Trust target not achieved

  National cleaning standards 2025 – local auditing of vehicle cleanliness requires review to ensure governance and assurance.

Performance

SPC charts completed monthly for onward reporting.

Learning

- BFE exposure themes identified as unintentional and intentional spitting incidents. IPC manual provides guidance for PPE use where blood and body fluid exposure is anticipated, however incidents will occur where this is unexpected.
- Sharps incident themes identified as inappropriate sharps disposal. Reminder to sign/date sharps containers in addition to safe management of waste & sharps previously disseminated to huddles and VP team.

CQOG date : 17/06/2025

Reporting date = April & May 2025

Clinical Quality Oversight Group

Clinical Equipment Working Group

Current risks and Concerns

(*Please see accompanying excel doc. For all clinical equipment risks)*

Highest Priority Risk:

RSK-142: Loss of equipment through diversion

There is a risk of loss of equipment caused by diversion which may lead to reduced ability to respond to patient incidents, and increased financial pressure due to the requirement for replacements if not properly managed.

Several mitigations ongoing, with the RFID system having the biggest impact. They have significantly reduced the window of opportunity for diversion of equipment, and has supported the Met Police with investigations.

Incidents

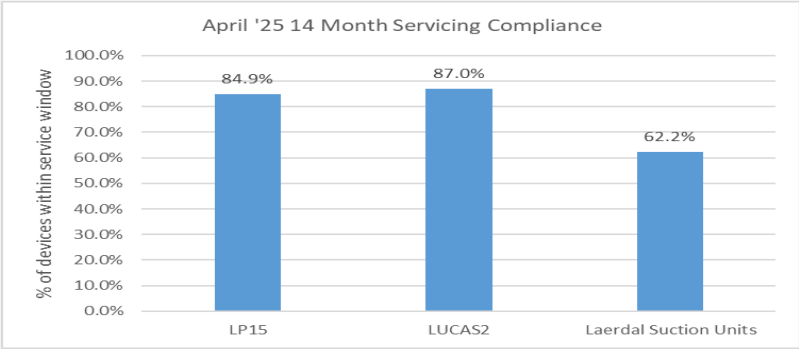
There were 166 radar reports in April 2025 pertaining to an "equipment failure". This is a 45% increase on reports from the previous month.

Introduction of the new ECG dots were responsible for 45 of these 116.

- ECG dots: We have been liaising with the manufacturer to understand the cause, and we are currently trialling new dots within several different teams, and awaiting feedback
- $EtCO_2$ failures: slight downward trend in April with 20 incidents reported
- Retractable syringes: Several reports were submitted following the introduction of the SafeR IM needles as they failed in use during hydrocortisone preparation. Work is ongoing with the supplier to procure a drawing up needle to mitigate this issue. Implementation date TBC.

Performance

Servicing of critical clinical equipment is considered over a rolling 14 month period. Number one priority is LP15's. The target compliance percentage is 95%, however this is unlikely to be met and sustained until Jan 2026 as we embed the new process for tracking assets.



To support locating and returning of items for servicing, we have increased the number of active RFID systems in DCA's, which has resulted in a very tangible increase in asset scans (142'000 in April).

Introduction of weekly vehicle scanning with APP group, with the Urgent Care branch starting scanning of equipment stores to facilitate improved stock management, which has already delivered financial savings.

We are extending this further with a pilot for FRU scanning within North Central.

Future developments

- The Corpuls CPR arm is being trialled as a potential replacement for the LUCAS2 devices as many are nearing the end of their life span and being decommissioned. Roll out expected to be within the 2 months.
- Work is underway to draft a tender for the next generation monitor to replace the LP15
- An evaluation of Diphoterine use within the Trust is also underway

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CQOG date : 17th June 2025

Reporting date = 10th June 2025

Clinical Quality Oversight Group

Digital & Data Report

Digital Incidents 1/4/25 to 10/6/25

Please note these incident do not include all P1/P2 recorded within the log and are curated for those considered to be of relevance to CQOG.

1. 10/4/25: AVLS not being received into CAD 1hr – P2
2. 12/4/25: NMA not receiving incidents or mapping 2.5hrs – P2
3. 23/4/25: Kitprep users unable to access app 22hrs – P2
4. 7/5/25: GRS not working 1hr20mins – P1
5. 20/5/25: Cleric Freezes 1hr30mins – P1
6. 27/5/25: London Care Record Mobile Viewer downtime 14days and still down at 10/6/25 – P2
7. 31/5/25: ARP National Outage of CRS 15mins – P1
8. 6/6/25: OneLondon Transfer of Care Interface Down / failing, intermittent publication of ePCR to LCR and demographics to St Georges – 4 days – P2
9. 7/6/25: NHS 111 national telephone failure ~3.5 hrs – P1

Current risks, Issues & Concerns

- **GoodSAM Video (CVAS)**: Improved reliability of the consultations after codec change from GoodSAM. Further testing required to improve reliability – awaiting IM&T resource to support iPad configuration change.
- **Transfer of Care**: Existing interface is unreliable. Focus to migrate to new direct interface solution by end of year, and re-build new interface on cloud-hosted solution w/ Integrella. ExCo paper supported, but outstanding decision around clinical images.
- **Correct patient identification**: Ongoing risk. Revised ePCR training (eLearning and F2F) produced. Huddle slide pack produced w/ Legal team.
- **Developing this reporting:** This reporting process is in infancy and will need to iterate.

Clinical Safety and Risk Management

- Tortus AI – CSCR + HL approved at PSCEG (15/5)
- Electronic Transfer of Care – CSCR + HL provisionally approved at Exco (28/5) subject to testing

In progress:

- Universal Care Plan – CAD Integration (Dave Macklin – TBC)
- CAD – Clinical Assessment Screen, DoS and PaCCS Integration (Dave Macklin – TBC)

Governance

Recent Guidance

- **Ambient Voice Technology**

National guidelines/rules issued by NHS England 'Ensuring safe and assured adoption of AI Scribe Technology'
Initial appraisal against guidance appears LAS compliant, seeking assurance around:

- Prompt injection
- Tortus position – initial response = compliant

Clinical Impact of Digital Incidents

- Process being put in place to reveal these alongside incident reporting process
- Unaware of significant clinical safety impact of incident, however, will bring back to subsequent meetings as/if arise

Summary of Approvals

- **Tortus AI:**
  - Currently in the process of seeking assurance to meet the requirements set out by NHS E (on 9/6/25).
  - PSCEG approval 15th May
    - User guide(s)
    - Clinical Safety Case Report and HL
  - Templates approved at CAG, but personalisation to be enabled for 'Beta' users to help refine new templates moving forwards

- **Electronic Transfer of Care**:
  - Exco paper for visibility
  - Clinical Safety Case Report and HL provisionally approved at Exco subject to final testing before go-live

CQOG date : 17/06/2025

Reporting date = Apr/May 2025

Clinical Quality Oversight Group

Strategic Assets and Property Management –S&D

Key updates

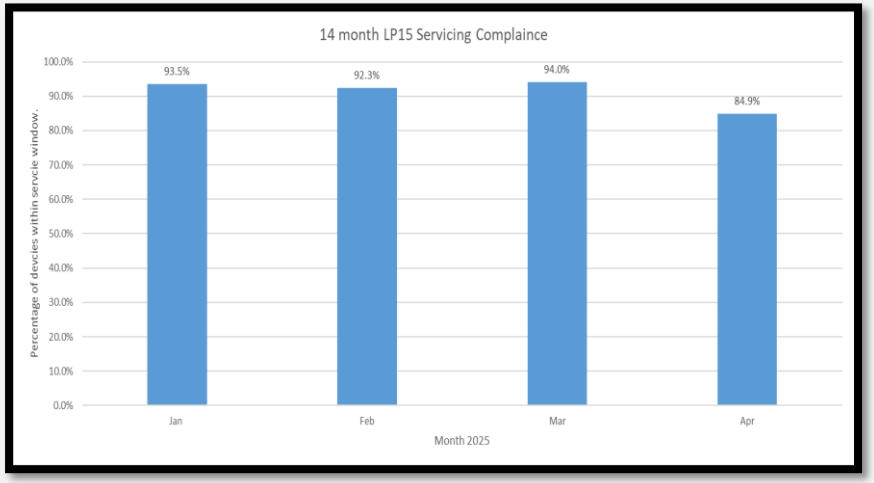
Supply and Distribution
Overall Performance

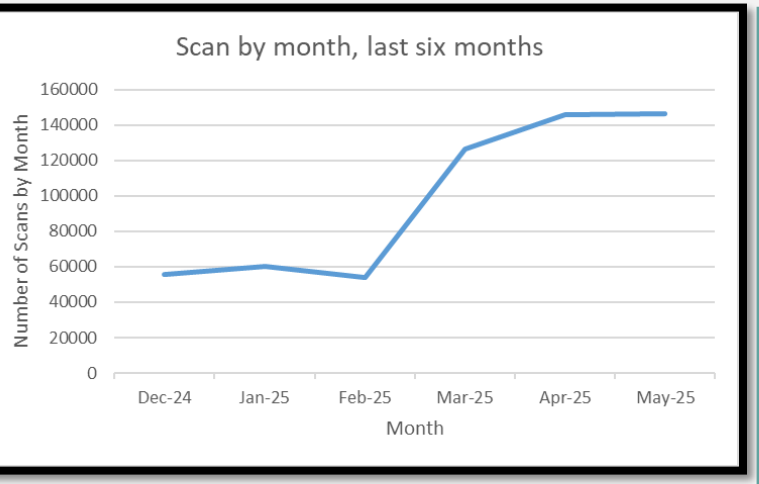
	Target	Apr-25 Monthly Average	May-25 Monthly Average
Warehouse Stock Held (263 lines)	95%	98.94%	98.21%
PPE (18 lines)	100%	100.00%	100.00%
LSU Routes	95%	99.56%	100.00%
MPU Routes	95%	99.94%	99.00%
Oxygen Availability	9.00	9.75	9.63
MR Hub Stock (lines) (263*20=5260)	95%	93.36%	93.04%
MR Hub Overstock (lines)	10%	7.11%	5.13%
Equipment Turnaround	TBC	#DIV/0!	#DIV/0!
Equipment Availability	99%	100.00%	99.00%
Uniform Orders Fulfilled	90%	99.00%	99.00%
MR Orders Fulfilled (consumables)	90%	79.08%	83.35%

Work continues on reviewing the oxygen stock held. Contingency stock has been returned, Work is looking at the demand at each complex versus current holding levels to see where reductions can be made. The aim is to average 9 days resilience across the Trust.

Hub stock availability is averaging 93% across the month, relates to bulk movement of stock rather than little and often, related to Make Ready Hub Coordinator vacancies.

Make Ready Orders. The challenged performance is impacted by delays in carry chair availability, some supply chain issues and linked to the MHHC vacancies receiving stock in, which if not done will trigger the same order again.





Work on scanning assets continues with month on month improves giving far greater visibility on equipment availability. As this improves so the reports to minimise OOS improves.

The upwards improvement shows the on-boarding of 80 Active RFID on board ambulances providing a vehicle scan every time the doors are shut. 15 more on due to be on-boarded in June 25 with IM&T working on an additional 135. All new DCA and cars will come with AFRID installed. The overarching aim is to reduce diversion, support investigations and flag assets left on scene for collecting.

Although report the S&D, as the product owners, this activity is undertaken by all 16 internal user groups.

LP15's are a key part of the Planned and Preventative Maintenance programme and are the Number One priority to ensure that it is serviced.

Historically, LP15 servicing was measured annually, 2022 saw a serviced percentage of 54% of LP15s serviced within the year, 2023 saw 70% and 2024 saw 95%.

Currently the table above shows the number of devices that have been serviced in a rolling 14 month window. Providing an industry standard approach and benchmarking. The target is 95% but that is unlikely to be achieved and sustained prior to Jan 2026 as the new methodology for tracking and recalling the devices is embedded in practice.

CQOG date : 17/06/2025

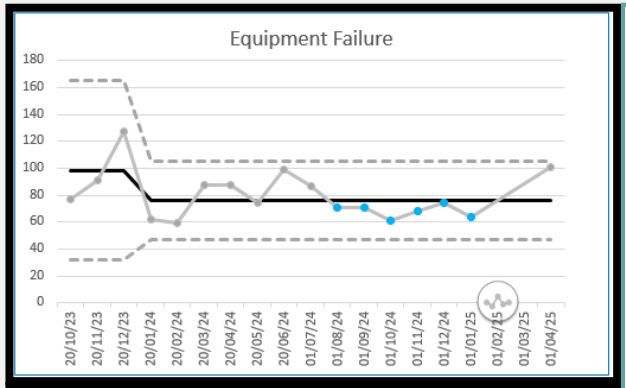
Reporting date = Apr/May 2025

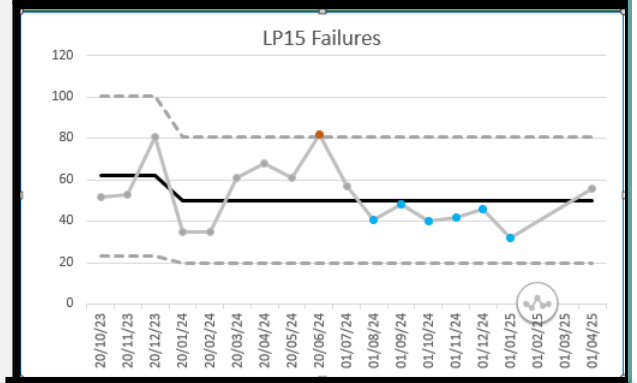
Clinical Quality Oversight Group

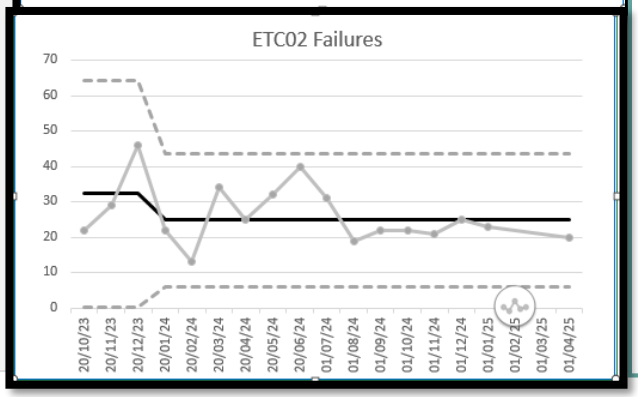
Strategic Assets and Property Management – S&D

Key updates

Medical Device Management







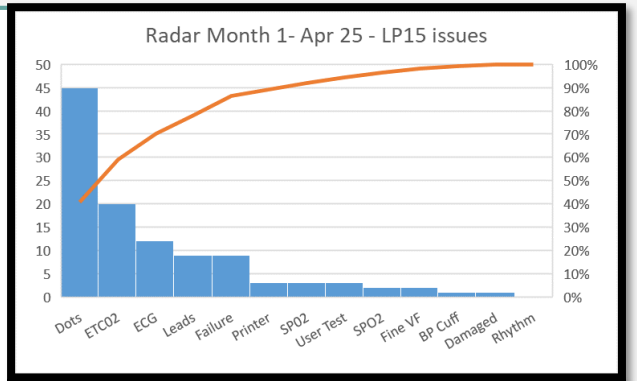
Equipment Failures, types and reasons are monitored on a monthly basis through the Medical Devices Assurance Group with daily review of issues raised by key individuals for immediate action as required.

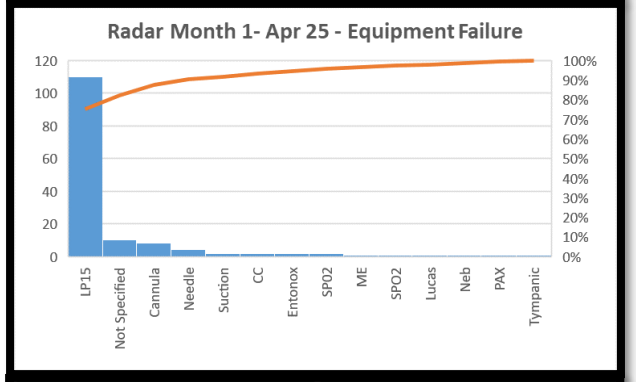
Equipment Failures – for a variety of reasons such age, usage and continued movement devices do fail whilst in use. Prier to to April 20205 this data was recorded through Datix and from April 2025 this data is recorded through RADAR. Monthly results are monitored through SPC charts t identify trends.

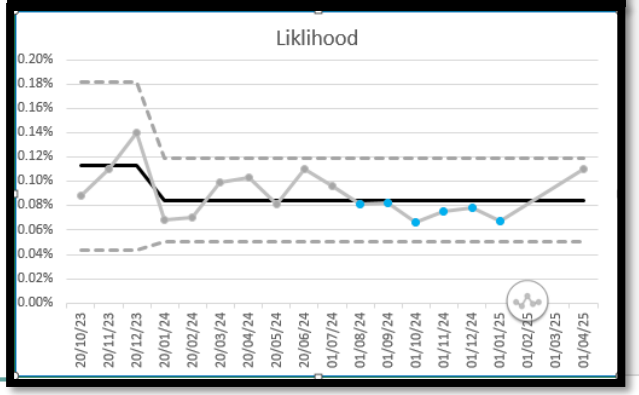
Graph 1 shows that prior to April a reduction in failures was seen and was considered a "special cause improving variation" that was linked to staff training and insourcing of some repairs and maintenance. April 25 has seen an increase in failures. As shown in Graph 2, this trend mirrors an increase in reported LP15 failures but not an increase in ETCO2 failures (graph 3). Graph 4 shows there was a high number of report ECG dots failures (not included in Graph 1 as these are consumables not the device) and also a number of reported ECG failures, and lead failures that are higher than previous month's These could be linked to the ECG dots rather than the actual device.

Overall, other reported failures of medical devices in use are very low, and are also monitored to pick up issues.

As a proxy measure, in lieu of knowing how many times key pieces of kit is used, the number of overall failures is monitored against the number of face-2-face incidents attended in that period. April 25 has seen an increase in the likelihood of a failure from an average of 0.8 incident per thousand F2F calls attended to 0.11 incidents per F2F calls attended.







CQOG date : 17/06/2025

Reporting date = Apr/May 2025

Clinical Quality Oversight Group

Strategic Assets and Property Management – S&D

Current risks and Concerns

Risk should be reviewed along with those related to medical equipment and consumables held with the Medical directorate as the lead in cross-directorate risks

Risk Register

Need Help? Click Here

Create new risk

Show closed | Hide

Reference	Category	Scope	Region / Location	Title	Description	Owner	Last review / Next review	Status / Approval state	Current score
RSK-001	Impact on the safety of patients, staff or public (physical/psychological h...	Region	Supply & Distribution	Lifepak 15 unavailability	There is a risk of reduced operational resource, caused by a lack of availa...	Lee Chacksfield	23-May-2025 21-Aug-2025	Planned Approved	9
RSK-031	Impact on the safety of patients, staff or public (physical/psychological h...	Region	Supply & Distribution	Lack of tracking for medical equipment	There is a risk that the Trust is unable to effectively trace and track def...	Lee Chacksfield	23-May-2025 21-Aug-2025	Planned Approved	12
RSK-065	Impact on the safety of patients, staff or public (physical/psychological h...	Region	Supply & Distribution	Clean linen for patients	There is a risk that the Service may not continue to comply with DH guidanc...	Lee Chacksfield	23-May-2025 21-Aug-2025	Planned Approved	6
RSK-066	Impact on the safety of patients, staff or public (physical/psychological h...	Region	Supply & Distribution	Non-compliance with medical equipment preventative maintenance	There is a risk of non-compliance with preventive maintenance schedules for...	Lee Chacksfield	23-May-2025 21-Aug-2025	Planned Approved	9
RSK-127	Impact on the safety of patients, staff or public (physical/psychological h...	Region	Supply & Distribution	Oversight of internal movements of medical gases	There is a risk of diversion of medical gases such as entonox and regulator...	Lee Chacksfield	23-May-2025 21-Aug-2025	Planned Approved	9

Ongoing work

- Expansion of Medical Equipment Technicians within the workshop
- Move to robust Planned and Preventative Maintenance Schedule for medical devices along with individual device risk assessments
- Expansion of Active RFID on vehicles
- Review of covert and overt security for high value assets
- Focused work with 2x Groups on Diagnostic Pouches (significant outliers)
- Continued support for Groups with regards to tethered kit
- Active work to reduce over stock at hubs – reducing overstock by 3% over the last 2 months (8.6% of lines overstocked to 5% of lines equating to 154 lines reduced)

CQOG date : 17/06/2025

Reporting date = April- May 25

Clinical Quality Oversight Group

Strategic Assets and Property Management – Make Ready

Key updates

•Implementation of planning tool locally saw improvement in vehicle preparation against Peak Vehicle Requirement (PVR) from April 1st – 14th April, exceeding 100% as better planning with preparation windows for Make Ready.

•From April 14th roles and rota consultation increased supervisor headcount to cover to 24hrs, resulted in a number of vacant positions (30). In the absence Supervisors, vehicle preparation continues data/KPI is not always able to be captured in real time.

•Resilience provided by Ambulance Operations is being withdrawn, bolstering resilience within the team to plan, allocate and record KPIs.

•Recruitment underway for x5 Management positions, only x2 of have recently become vacant. Previous hold on x3 for 'staff at risk' from consultations elsewhere.

Current risks and Concerns

- **Lack of C1 drivers.**
  Working with PHub to provide C1 driver cover from the Transport Operative group as capacity for them to assist.
- **Data capture and KPI**
  Recruitment underway for Supervisor position and upskilling staff to provide resilience
- **ProCloud app rollout challenges**
  Ongoing wifi issues across some sites, and data not uploading to Cloud to reflect in dashboard.
- **Management availability & vacancies**
  No Head of Dept/ General Manager. Limited management team size provides North/ South cover 24hrs but across multiple Sectors. Recruitment underway will improve position.

Performance

- Vehicle preparations against PVR is >100% with local planning tool, in sites with full Supervisor establishment, however there are still a number of vacancies across multiple sites.
- StatMan compliance is 88.39%, set to increase with pool shifts and training hours in new rotas
- Sickness has increased recently to 10.4%, long term absences being managed well, increase mainly short term sickness
- Deep clean performance for DCAs in April and May challenged (70% for both months). Recovery plan being drawn up.
- Manual Handling level 2 compliance >95%

Ongoing work

- Training to cover Supervisor planning and KPI recording
- Work ongoing in training of digital applications to better support Make Ready and Logistics processes, to be rolled out once suggested changes implemented
- Group appraisals being booked, with individual appraisals to follow. Plan to stagger due dates as most staff TUPE in on same date all are due within similar timeframes. High staff to managers ratio.
- Recruitment in progress, 13% of vacant supervisor positions offered. Advertised currently.
- Work underway with Apprenticeship and Employability Team & exploring options through agencies as to provide permanent staffing via Procurement as they have been instrumental in providing staffing with a C1 driving licence
- Tailoring asset scanning audits to better review quality and performance and target training

CQOG date : 17/06/2025

Reporting date = June 2025

Clinical Quality Oversight Group

Strategic Assets and Property Management – Fleet

Key updates

- Daily performance meetings to analyse frontline vehicle availability, identify pinch points and take any appropriate actions
- Monitor daily and weekly availability of Fleet Technician resource vs scheduled and planned maintenance vs PVR and frontline vehicle availability
- Daily monitoring of scheduled vehicle servicing. Since introduction of LDM vehicles have been delayed arriving at the workshop

Current risks and Concerns

- Current risks and matters for escalation
    - Fleet – Export from the Trust Risk Register **– this risk has now been removed as mitigating actions have had a positive impact.**

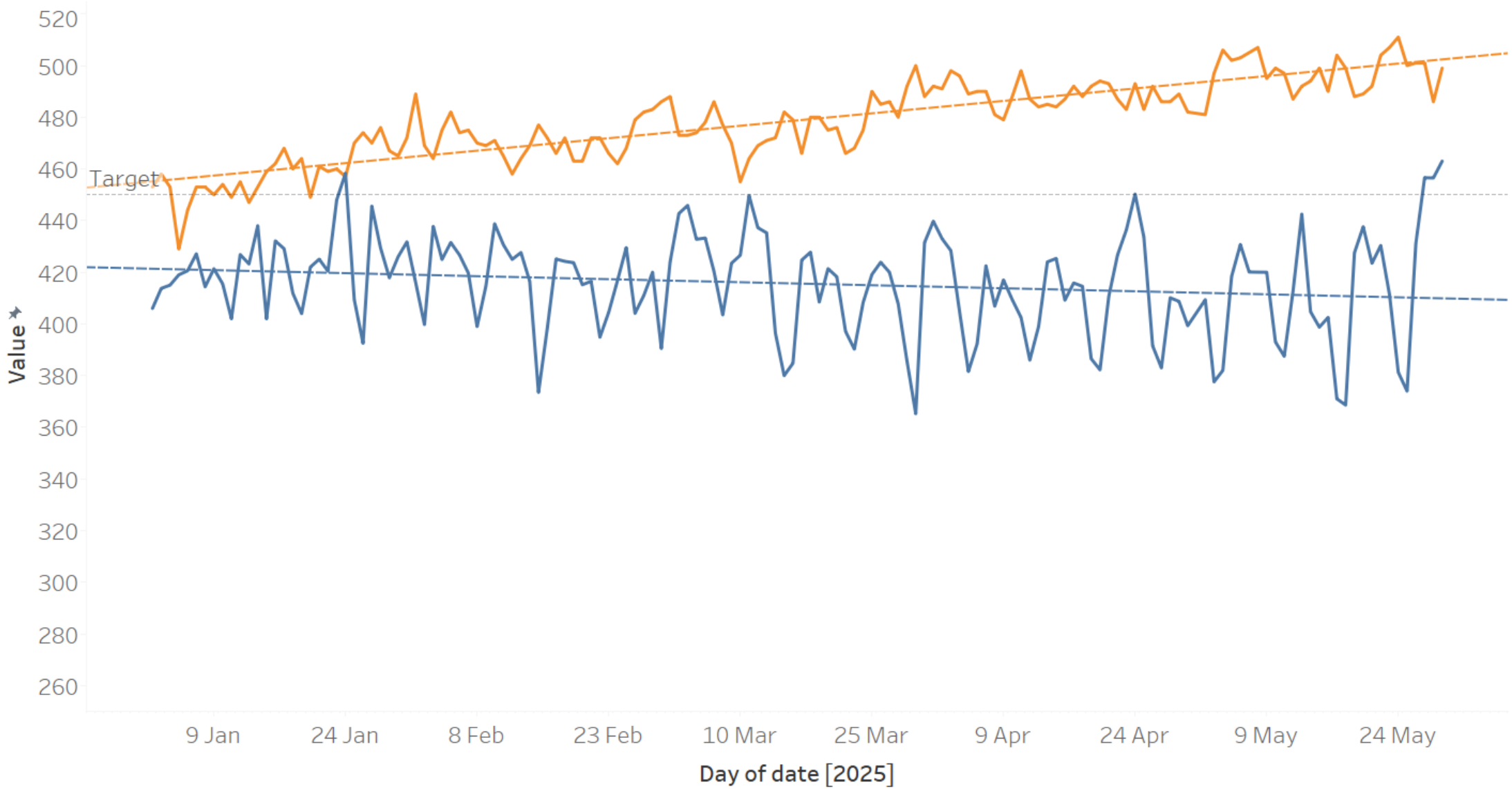
Performance

- DCA availability vs Peak Vehicle Requirement.

Ongoing work

- Weekly LDM meetings with colleagues across the groups/sectors
- Daily Fleet performance meetings

DCA & OPC Vehicle Availability



CQOG date : 17/06/2025

Reporting date = April & May 2025

Clinical Quality Oversight Group

Strategic Assets and Property Management – Estates and Facilities

Key updates

- Key capital projects updates

1. Solar PV Installation: Design and Install contractor approved. Project Manager identified and commences on 9th June. Full designs across 10 sites by end of August.
2. Brent Unit 11 1st Floor Fitout. Design agreed and contractor finalising work costs.
3. Richmond Gate & Railings: Awaiting planning decision. Specification of works to be priced by end of June.
4. Backlog Maintenance: Allocated £485k at end of May.

- Recent repair and maintenance issues that are high or significant risks to the business: Air Conditioning to 5th floor Maritime House awaiting parts, temporary cooler provided on 3rd June.
- ERIC return for 2024/25 completed and submitted.
- Start of Shift: all works completed.

Current risks and Concerns

- No current risks for escalation
- Export from the Trust Risk Register.

Performance

- PDRs and stat man training: All PDRs due to be completed by end of June
- Sickness levels at 3.5%, long term sickness being managed.
- Statutory Compliance – legal requirement for service compliance.

Ongoing work

- Backlog maintenance
- Audits of soft facilities
- Raise awareness of raising repairs tickets
- Recruitment ongoing for Electrical Engineer and Mechanical Engineer.
- Procurement planning to commence from 5th June.

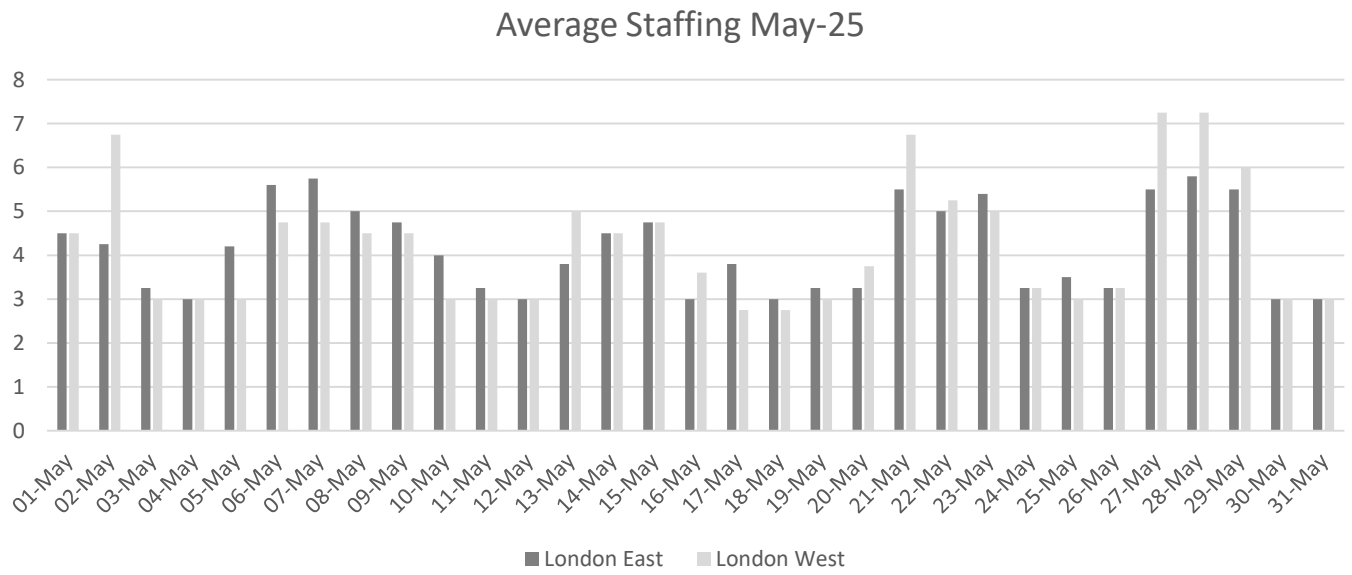
Safe | **Effective** | Caring | Improve

Priority | Owner AW | Exec Lead FW

No concerns for escalation

EPRR

Category	May-25
Hazardous Materials: Fire	104
SWAH: Manmade Structures	96
Operational Support: Clinical Support	73
Water Operations: Inland Water Rescue	40
Hazardous Materials: HAZMAT	31
Operational Support: Manual Handling Support	25
Operational Support: Standby	6
Unstable Terrain: Active Rubble Pile	5
Hazardous Materials: CBRN	4
Support To Security Operations: Security Operations	1
SWAH: Natural Features	1



London Ambulance Service
NHS Trust

Quality Performance Data - 999

We are the capital's emergency and urgent care responders

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

Performance AQI (AMBSYS)

No concerns for escalation

National AQI performance data	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24	Aug24	Sep24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25
C1 mean	8.0	7.4	7.4	7.2	7.3	7.3	7.5	7.4	7.0	7.6	7.5	7.5	7.8	7.3	7.2	7.0	6.7	6.9
C2 mean	52	37	37	33	35	36	40	39	30	42	42	42	50	35	31	29	28	31
C3 mean	102	74	72	66	67	72	82	87	65	102	99	109	130	86	81	69	65	74
C4 mean	166	130	121	121	121	126	139	152	130	179	160	180	202	133	132	113	113	140
999 call answer mean	23	5	3	2	2	3	5	5	4	9	7	7	8	3	1	1	1	1
Clin Validation mean	61	42	40	34	35	38	44	42	35	46	43	50	42	34	27	23	22	25
C5 Clin Assessment mean	42	34	34	31	35	37	37	38	31	36	37	43	50	38	36	32	32	35
H&T / All Incidents	17%	16%	16%	17%	20%	19%	19%	20%	19%	20%	20%	20%	22%	20%	21%	21%	21%	22%
S&T / All F2F	36%	35%	34%	34%	34%	34%	34%	34%	34%	33%	33%	32%	34%	33%	33%	32%	33%	33%
Non ED / Conyeyed	4%	4%	4%	4%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

55

Red = worst month, Green = best month

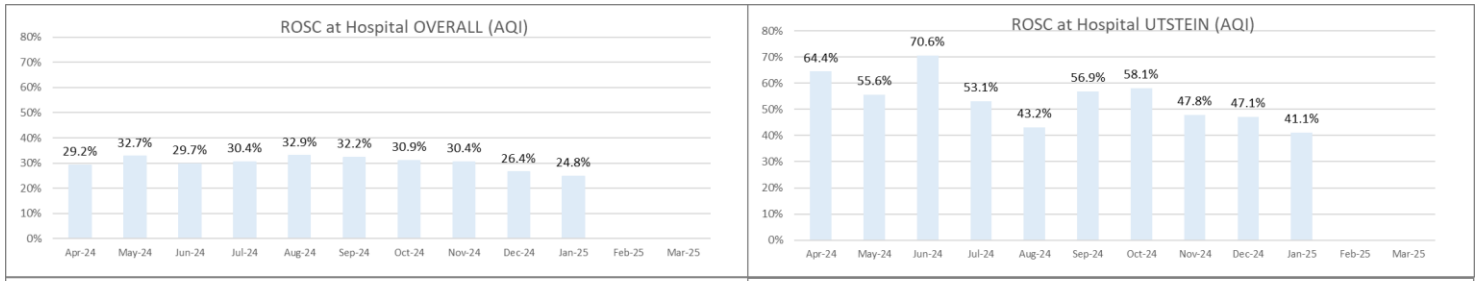
Ranking across Ambulance Trusts (inc IOW)																		
C1 mean	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
C2 mean	10	6	8	7	9	9	9	9	7	10	8	8	8	7	8	8	8	8
C3 mean	2	2	1	1	2	2	2	3	2	3	2	4	3	4	3	3	3	3
C4 mean	5	4	4	3	7	4	7	8	8	10	6	6	7	7	6	5	6	8
999 call answer mean	11	7	3	2	4	4	5	5	4	9	6	7	7	5	4	2	3	2
Clin Validation mean	7	6	6	4	6	4	6	6	7	5	5	7	4	4	3	2	3	3
C5 Clin Assessment mean	4	3	4	3	4	3	5	3	4	3	3	4	3	5	4	4	1	1
H&T / All Incidents	2	3	1	1	1	2	2	2	2	2	2	3	3	2	1	1	1	1
S&T / All F2F	7	7	8	8	8	7	7	8	7	8	7	8	7	8	8	8	8	7
Non ED / Conyeyed	9	9	9	9	9	9	9	9	9	9	9	8	9	9	9	9	9	9

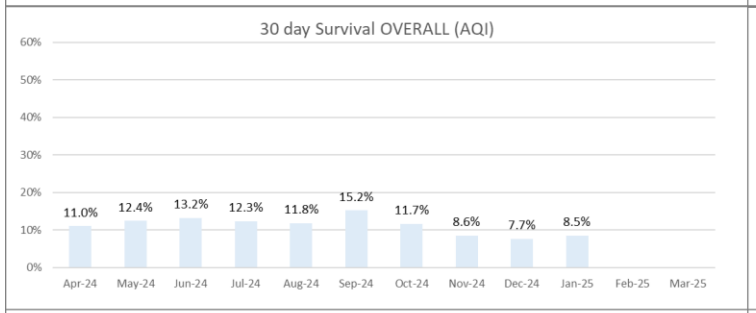
Red = lowest trust, Green = highest trust

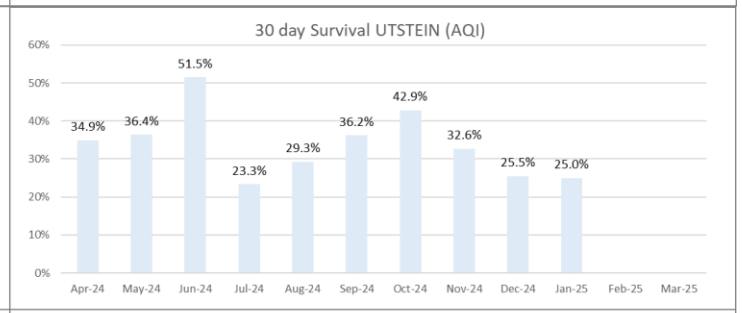
Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

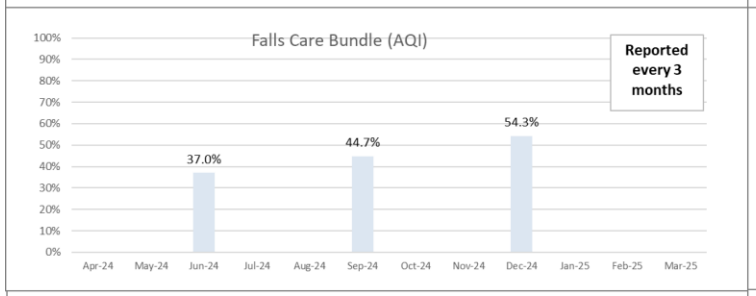
Clinical AQI (AMBCO)

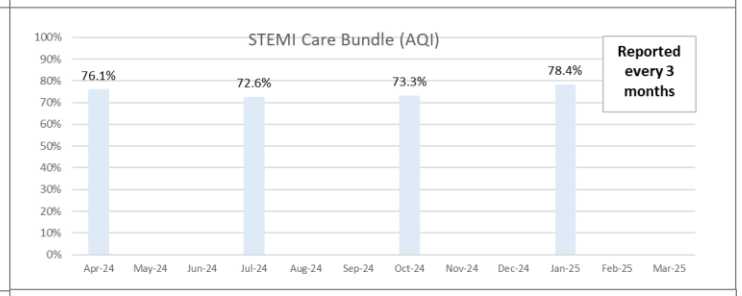
Performing below the national average in ROSC.

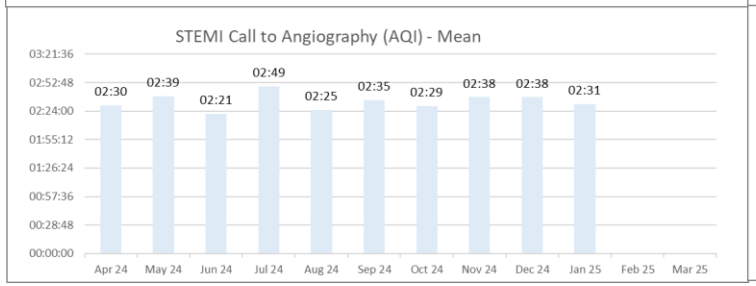


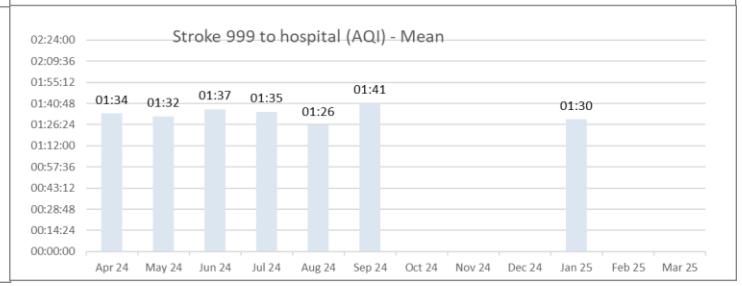












Cardiac Arrest:
ROSC to hospital

In January 2025, the LAS ranked 8th for both the overall ROSC on arrival at hospital group and the Utstein group (24.8% and 41.1% respectively). We are performing below the national average for both measures.

Survival to 30 days

The LAS ranked 5th for the 30-day survival in the overall group with 8.5%, above the national average of 7.9%. In the Utstein group, 25.0% of patients survived to 30 days. We are performing below the national average for this measure and are currently ranked 5th in the country.

STEMI: The LAS achieved a Call to Angiography mean time of 2 hours and 31 minutes*—one minute faster than the national average of 2 hours and 32 minutes. Despite this, the LAS's ranking has slipped from 6th to 7th place nationally.

Care Bundle data was published for January 2025. A full care bundle was provided to 78.4% of suspected STEMI patients. While this is a notable increase of 5.1% from the last reported figures (for October 2024), it is still well below the national average of 82.4%, with the LAS continuing to be ranked in 8th position.

**Based on MINAP data which may not be a complete sample and subject to change during the revision period*

Stroke: The LAS recorded 01:30 for the call to arrival at hospital measure**. While exceeding the national average of 01:37, the LAS ranked in 5th place when compared to other ambulance services.

***Based on SSNAP data which may not be a complete sample. Also, data was not available for NWAS.*

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Safe | **Effective** | Caring | Improve

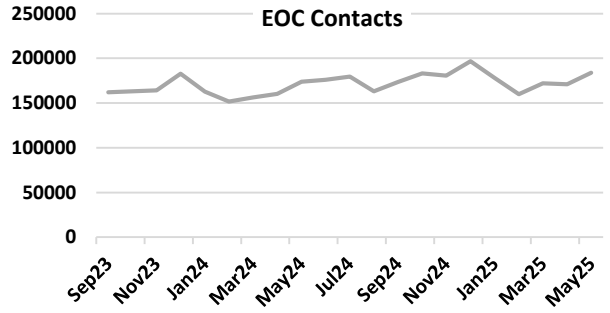
Priority | Owner SW | Exec Lead FW

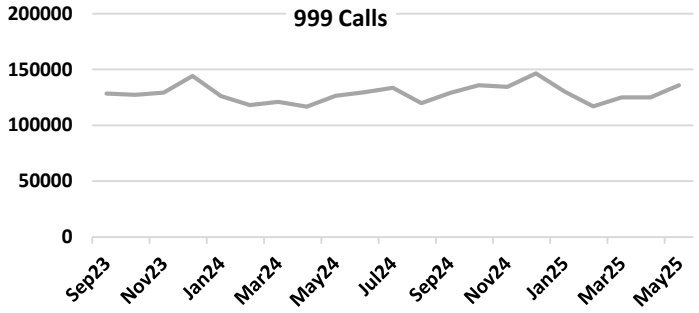
Call Handling

No concerns for escalation

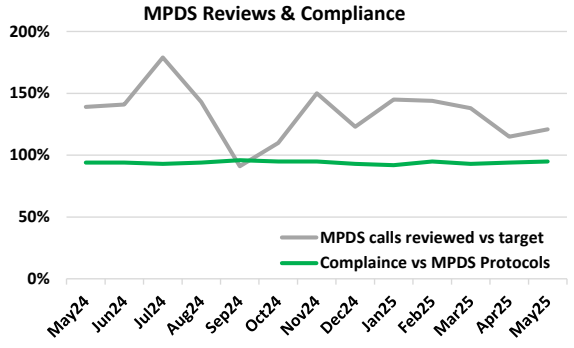
EOC QA narrative not provided

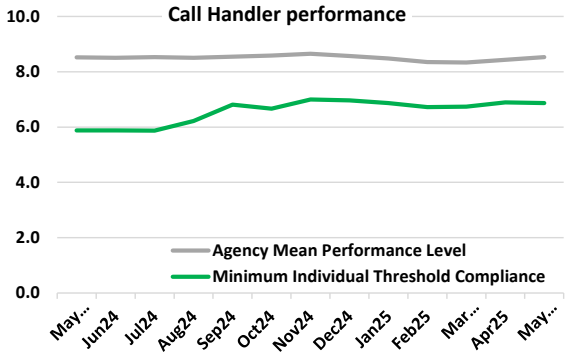
Call Volumes

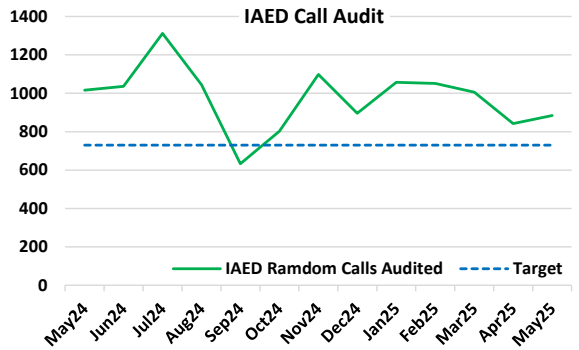




CH Performance







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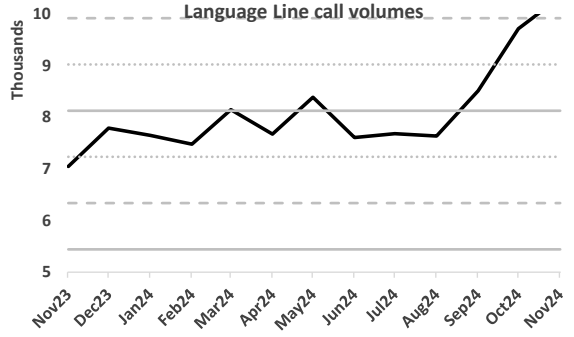
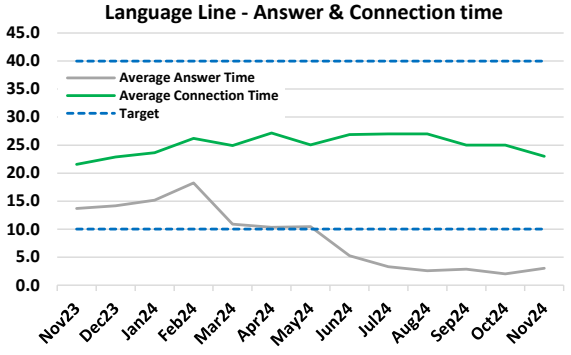
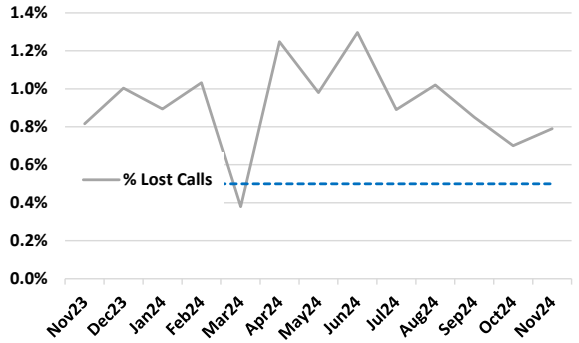






Senior Clinical Lead: Alexander Boda
Clinical Quality Support Manager: Emma Winup

Clinical & Quality

Purpose and Objectives

Continuously improve the safe delivery and quality of care for patients
- Deliver our annual quality objectives
- Deliver the quality objectives relating to patient care, and patient and family experience

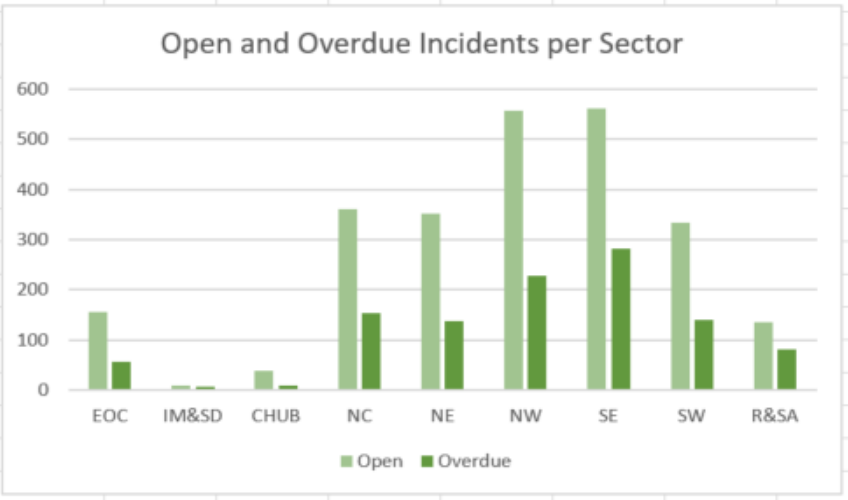
999 Patient Safety (EOC, IM&SD, Clinical Hub)
as of 12/06/2025

- **Open learning responses:** 1 (EOC), 5 (Clinical Hub)
- 6 month breach: 0 (EOC), 1 (Clinical Hub). Breach being managed by patient safety team.
- **Risks:** All risks reviewed at EOC and IM&SD risk review meetings May and June.
- **Cases reviewed at PSIG:** 21 (May 2025)
- **Outstanding LFDs:** 6 (stage 1), 1 (stage 2)
- **Excellence reports received:** 11
- **Excellence letters sent following PSIG review:** 3

Abusive callers
- The vast majority of these RADAR reports relate to a very small number of individuals. We are supporting VRU with active case management and are seeing tangible results from this approach. It is a resource intensive activity and we have offered support to VRU to try and streamline how we work together.

Overdue Incidents

- **Open incidents:** 155 (EOC), 9 (IM&SD), 38 (CHUB), 0 (QA), 0 (NETS EOC)
- **Overdue incidents:** 56 (EOC), 6 (IM&SD), 9 (CHUB)



Completed actions:

- **Definition of vulnerable fallers on the floor:** Bulletin released to address concerns via PED
- **Oversight of education courses:** Link to education SharePoint now shared
- **Return to Practice framework:** Shared with leadership teams

RADAR

Ongoing drop-in support sessions hosted in May with EOC leadership teams, in addition to daily training sessions held by the Intelligence Systems Manager.

- Weekly 999 incident review and overdue incident review to support responsible managers with recommended actions and provide oversight.
- Working with RADAR team to address access issues and exploring options to streamline dispatch review process.

Compliance

- **Met with compliance team:** To understand areas where additional focus may be required. General feedback was 999 Operations is in a good place.
- **Well led audit and mock CQC inspection:** Provisionally planned for July
- **Board pack key piece of evidence for our team. To further improve, we need to look at how we evidence and share our actions and improvement plans.**

Senior Clinical Lead: Alexander Boda
Clinical Quality Support Manager: Emma Winup

Clinical & Quality

Purpose and Objectives

Support the 999 Operations Directorate to deliver the clinical objectives in the business plan

System Improvement Plans:

- **Improve recognition of ineffective breathing:** Shortlisted for HSJ Patient Safety Award in two categories
- **Dispatch to high risk Category 2 incidents (10D2, 10D4):** Sustained reduction in incidents.
- **Management of duplicate calls:** Awaiting CAD development.
- **Ensure clinical input is obtained when there isn't a bariatric vehicle available:** Sustained reduction in incidents.

In the pipeline:

- **Quality assurance of CAD lookup table and Response Matrix:** Paper approved at Change Board and awaiting LAS CAG which was moved back to after Board
- **Management of HCP and IFT:** CAD changes remain in test and require final amendments. Bulletin in draft pending screenshots from CAD
- **PSIRF Local Priority – Chief Protocol selection** Initial meeting planned with patient safety team to progress

Question for Board - Do we think the call handling reset has been effective?

National work streams

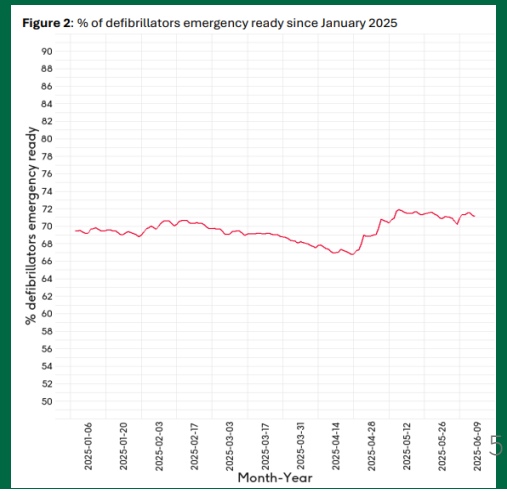
- MPDS update now available. Provisional date for implementation **9 September** (subject to NHSE approval).
- National Category 2 review ongoing. Initial finding that 50% of MPDS C2 activity from just 10 determinants, and recommendation to focus on pulling out low risk groups to reduce volume.
- Work ongoing with IAED to develop triage of chest pain with support from Sector Senior Clinical Lead (Clinical Data). Currently seeking internal research approvals.
- AACE contacted to offer support to progress recommendations in HSSIB report looking at healthcare in prisons, however no response as yet.

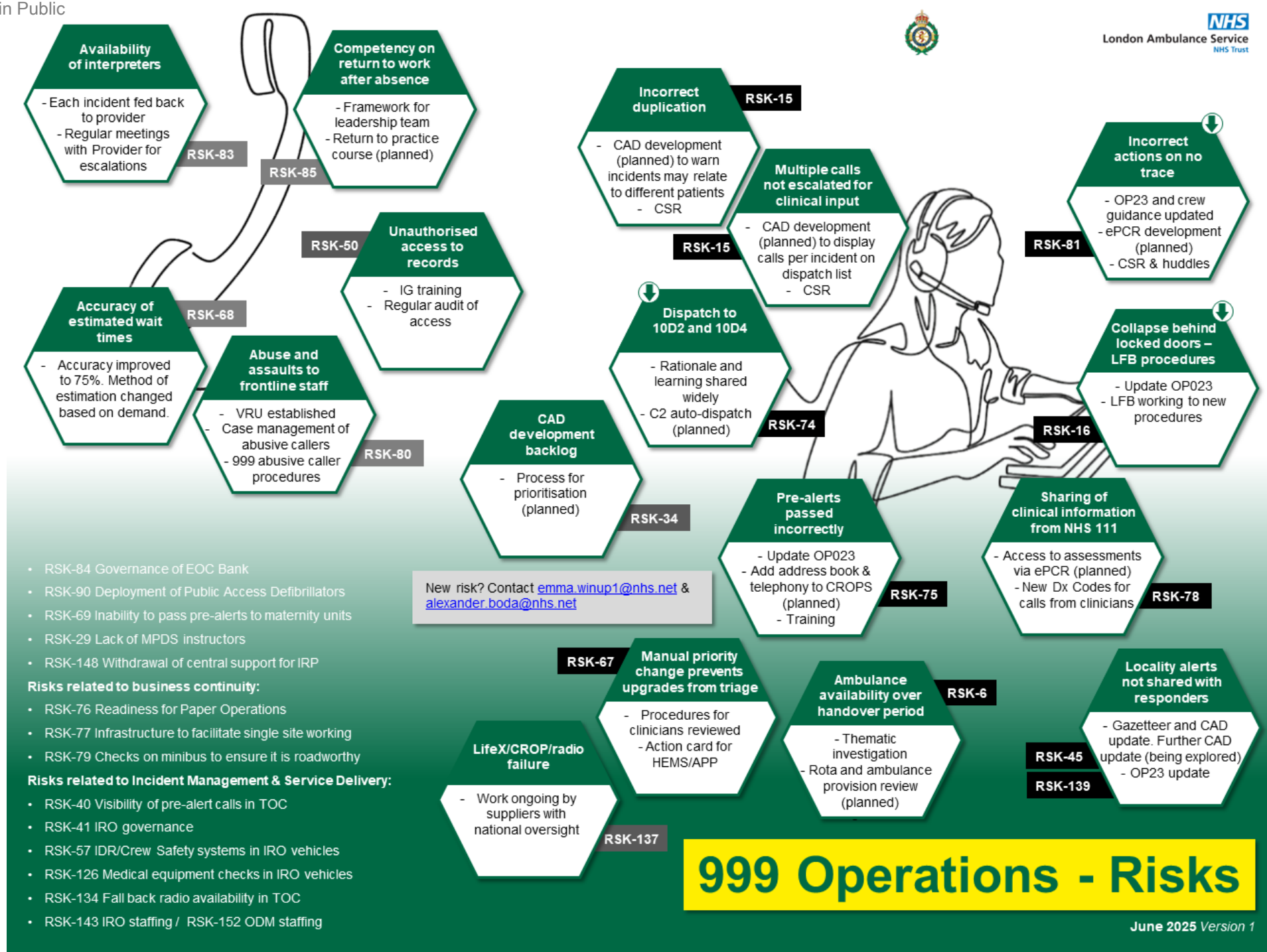
Increase activation of public access defibrillators – deep dive

There are 7010 registered on The Circuit. Of these, 4985 are emergency ready with the remaining 2025 not available. This means that 71% of defibrillators registered on The Circuit are emergency ready in London (9 June 2025)

The 'defib taskforce' has contacted over 700 guardians since 6 May, with 86 (12%) now emergency ready, and a large number of PAD sites decommissioned or a new guardian assigned.

There has been a recent increase in activation (from around 160 a week to 210 a week), however this is typical of the time of year (school holidays).




Availability of interpreters
- Each incident fed back to provider
- Regular meetings with Provider for escalations
RSK-83
Competency on return to work after absence
- Framework for leadership team
- Return to practice course (planned)
RSK-85
Incorrect duplication
RSK-15
- CAD development (planned) to warn incidents may relate to different patients
- CSR
Multiple calls not escalated for clinical input
- CAD development (planned) to display calls per incident on dispatch list
- CSR
RSK-15
Incorrect actions on no trace
- OP23 and crew guidance updated
- ePCR development (planned)
- CSR & huddles
RSK-81
RSK-50
Unauthorised access to records
- IG training
- Regular audit of access
Accuracy of estimated wait times
RSK-68
- Accuracy improved to 75%. Method of estimation changed based on demand.
Abuse and assaults to frontline staff
- VRU established
- Case management of abusive callers
- 999 abusive caller procedures
RSK-80
Dispatch to 10D2 and 10D4
- Rationale and learning shared widely
- C2 auto-dispatch (planned)
RSK-74
Collapse behind locked doors – LFB procedures
- Update OP023
- LFB working to new procedures
RSK-16
CAD development backlog
- Process for prioritisation (planned)
RSK-34
Pre-alerts passed incorrectly
- Update OP023
- Add address book & telephony to CROPS (planned)
- Training
RSK-75
Sharing of clinical information from NHS 111
- Access to assessments via ePCR (planned)
- New Dx Codes for calls from clinicians
RSK-78
RSK-67
Manual priority change prevents upgrades from triage
- Procedures for clinicians reviewed
- Action card for HEMS/APP
Ambulance availability over handover period
RSK-6
- Thematic investigation
- Rota and ambulance provision review (planned)
Locality alerts not shared with responders
- Gazetteer and CAD update. Further CAD update (being explored)
- OP23 update
RSK-45
RSK-139
LifeX/CROP/radio failure
- Work ongoing by suppliers with national oversight
RSK-137
• RSK-84 Governance of EOC Bank
• RSK-90 Deployment of Public Access Defibrillators
• RSK-69 Inability to pass pre-alerts to maternity units
• RSK-29 Lack of MPDS instructors
• RSK-148 Withdrawal of central support for IRP
Risks related to business continuity:
• RSK-76 Readiness for Paper Operations
• RSK-77 Infrastructure to facilitate single site working
• RSK-79 Checks on minibus to ensure it is roadworthy
Risks related to Incident Management & Service Delivery:
• RSK-40 Visibility of pre-alert calls in TOC
• RSK-41 IRO governance
• RSK-57 IDR/Crew Safety systems in IRO vehicles
• RSK-126 Medical equipment checks in IRO vehicles
• RSK-134 Fall back radio availability in TOC
• RSK-143 IRO staffing / RSK-152 ODM staffing
New risk? Contact emma.winup1@nhs.net & alexander.boda@nhs.net
999 Operations - Risks
June 2025 Version 1

CQOG date : 06/06/2025

Reporting date = April/May 2025

Clinical Quality Oversight Group

Clinical HUB

Incidents

- **Number of open incidents**
  - 36 open
- Number of incidents reviewed under PSIRF resulting in an enhanced learning investigation
- **APRIL**
  - 19 incidents reported in April
    - 5 reviewed at PSIG
      - 3 near miss
      - 1 low harm
      - 1 moderate harm
    - All reviewed at PSIG/PSIP – no harm
- **MAY**
  - 26 incidents reported in April
    - 6 reviewed at PSIG
      - 5 near miss
      - 1 moderate harm
    - All reviewed at PSIG/PSIP – 4 no harm / 1 for further review
- **Recontacts**
  - Total - 86
  - None reportable to PSI

Current risks and Concerns

Open Risks

33 - Clinical Hub Managers - Decision making and documentation of EPRR decision – Last review 12/02/2025

37 – Clinical Hub Assurance of Data – Last review 12/02/2025

62 – Mental Health and Overdose Clinical Reviews – Last review 12/02/2025

60 – Clinical Hub Improvements – Last review 12/02/2025

61 – Clinical Advice to EOC – Last review 12/02/2025

158 – Signs of Shock – Last review 01/04/2025

Performance

- Hear and treat compliance
  - C2 segmentation
- Recruitment and staffing levels
  - 45.5/50 WTE CSM
  - 143.9150 WTE CA
- Training courses

4 CA Courses

  - 08/04 / 22/04 / 29/04 / 13/05
- Number of audits for Clinical Advisors (B6) 981
- Audit compliance 97%
  - Themes

Summary of Identified Themes

Please refer to the below chart which highlights the distribution of themes identified. Notably, **'MTS outcome'** was the most frequently occurring theme this month.

•Incorrect MTS card selection
•Missed or skipped MTS red flags
•Unstructured clinical assessments
•Inappropriate transport decisions – for example, attempting to arrange taxi transport for patients when not clinically appropriate
•Delayed assessments – red flag clearance should be conducted within **3–5 minutes**
•Failure to record an MTS number – if an assessment is not completed, please document as (00:00)
•Third-party audits – some cases involved assessments conducted without the patient present, which is not appropriate

- Number of audits for Clinical Support Managers for Clinical Support Desk 96
- Audit compliance 99%
- Themes
  - None of note.

Learning

- Learning from incidents and experience sessions.
- Plans in place for Signs of Shock – learning / Para pass module / emphasis on CA course / Mouse mats

London Ambulance Service
NHS Trust

Quality Performance Data - 111

We are the capital's emergency and urgent care responders

CQOG date : 17/06/2025

Reporting date = May 2025

Clinical Quality Oversight Group

111 & IUC

Incidents

- The top three recurring incident themes remain: call handling, concerns related to other providers, and communication around care and consent. However, over the past three months, there has been a noticeable increase in incidents involving violence, aggression, and abuse.
- We continue to work closely with both the Violence Reduction Unit and the Frequent Caller Team to support staff and ensure our processes are robust when managing this specific cohort of patients.
- Ongoing collaboration with team managers is focused on providing real-time feedback to staff to help reduce call handling errors.
- In 10 incidents were reported at the level of moderate harm or above. All incidents underwent review, with only one identified as requiring an enhanced investigation.
- A dedicated work stream is in place to support staff in the accurate categorisation of incidents and the effective use of RADAR reporting tools.
- C300 incidents currently open – a plan to reduce this number is currently in place.
- A significant increase in complaints was observed from one particular provider. Following a comprehensive end-to-end review and a meeting with the provider, it was acknowledged that all concerns had been managed appropriately. The provider also confirmed a better understanding of the NHS 111 mechanism and triage process.

Current risks and Concerns

Matters for escalation

- Current safeguarding mandatory training has decreased. GMs have implemented an action plan across both sites to support increasing compliance within the next 3 months.
- Active risks on the risk register –
- RSK 019 - IUC sites staff safety
- RSK 022 – Adastra playback
- RSK 035 – Information sharing 111> 999
- RSK 110 - Call answering delays
- RSK 111- Clinical staffing
- RSK 112 – Mental Health Pathways

Microsoft Excel Worksheet

Performance

- In May 2025, LAS Integrated Urgent Care Service were offered 188,310 calls and answered 180,023 calls. This resulted in an abandonment rate of 1.4% (against a 3% target) and an average speed to answer of 5.9 seconds (against 20 second target).
- The proportion of calls assessed by a clinician or clinical advisor increased to 43.1%. The proportion of callers advised to pursue self-care following clinical input was 21.4%.
- Rota fill within LAS reached was 93.3% in May with turnover at 23.93% and sickness absence at 13.43%. The turnover has increased due to the increased number of director-level hearings which have resulted in dismissals.
- Absence had impacted rota fill but was managed internally through sickness management protocols, enhanced infection prevention and control (IPC) measures, and rota backfill arrangements.
- Training compliance in May is at 93.97%.
- In May, the team saw a decrease in the average speed to answer times for clinical and non-clinical support lines and managed aux usage within the telephony system.
- In May 20,766 Category 3 and 4 ambulance validation cases were validated by 111 clinicians, with 17,925 cases (86%) being re-triaged to a lower acuity level.
- The number of ETC/ED dispositions passed to the Clinical Assessment Service (CAS) for clinical validation was 6951 and of these 68% were directed to a more appropriate, lower acuity outcome.
- Priority 1 CAS call back performance improved, increasing to 72%

Learning

Learning from Incidents

- Audit completion rates for Health Advisors, NHS Pathways Clinicians, GPs, and Advanced Clinical Practitioners (ACPs) were exemplary at **100%**, with overall compliance rates ranging between **90% and 94%**.
- The latest Quality Bulletin included a case-based discussion focused on the atypical presentation of stroke, aimed at enhancing clinical recognition and response.
- A separate bulletin was issued to clarify staff roles and responsibilities in managing cases of alleged sexual assault. The guidance covered different age groups and outlined appropriate support pathways for both patients and staff.

Quality Improvement Initiatives

- The Pharmacy First Quality Improvement Project has been initiated. Staff feedback has been collected and a Task and Finish Group established to address key themes and recommendations.
- Clinical guidance for queue management has been completed. This includes updates for Clinical Team Navigators and the introduction of a “next flag” system to better highlight cases of clinical concern for prioritisation by the clinical workforce.

Patient Feedback

- **87.7%** of patients responding to this month’s survey reported feeling treated with dignity and respect.
- **67.2%** indicated they were overall satisfied with the level of care received.

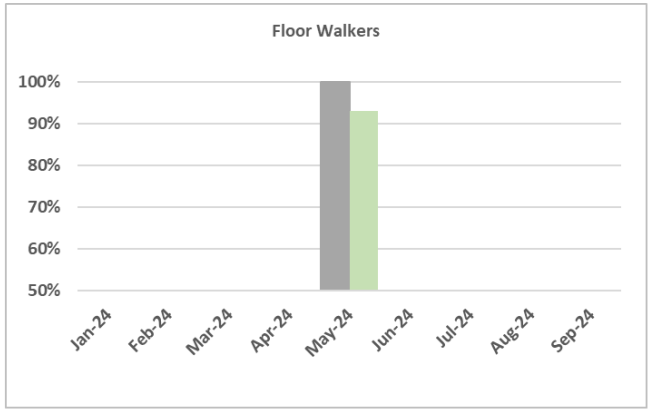
Safe | **Effective** | Caring | Improve

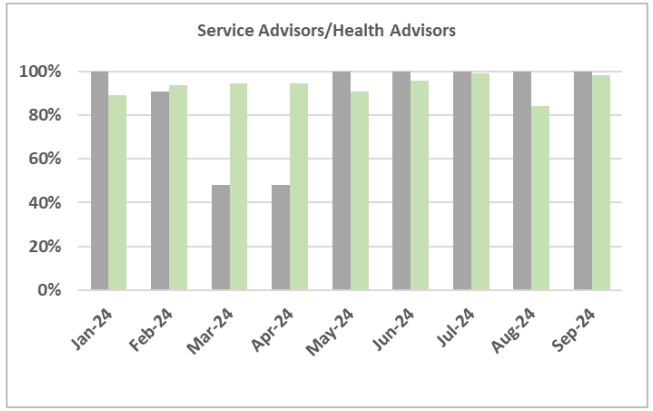
Priority | Owner JN | Exec Lead FW/RP

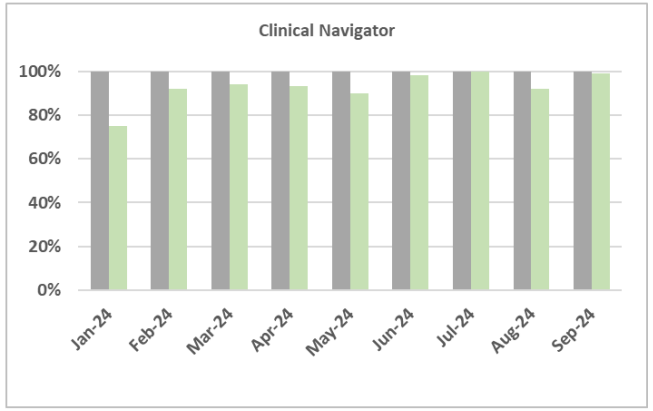
111 Quality Audit - SEL

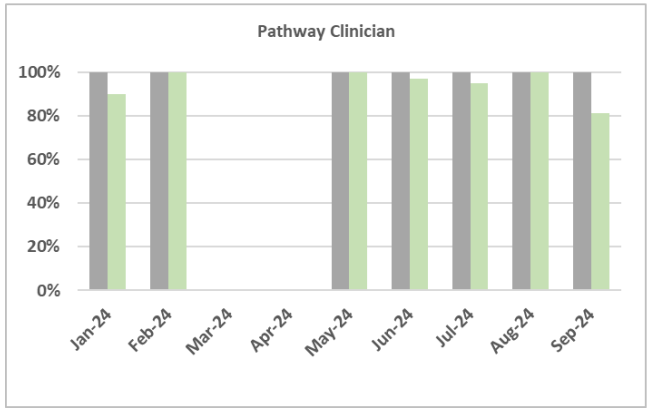
No concerns for escalation

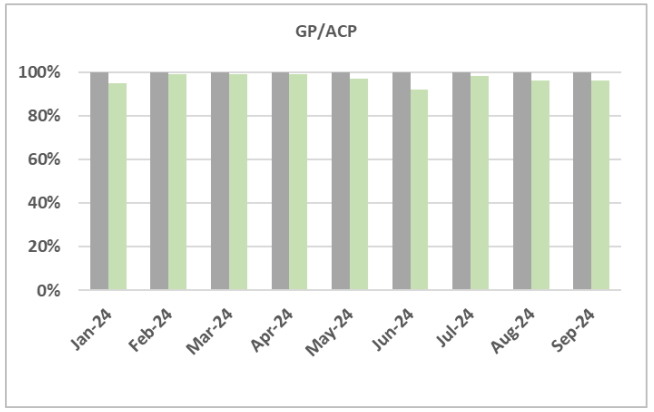
No update provided by IUC











Completion rate Pass rate

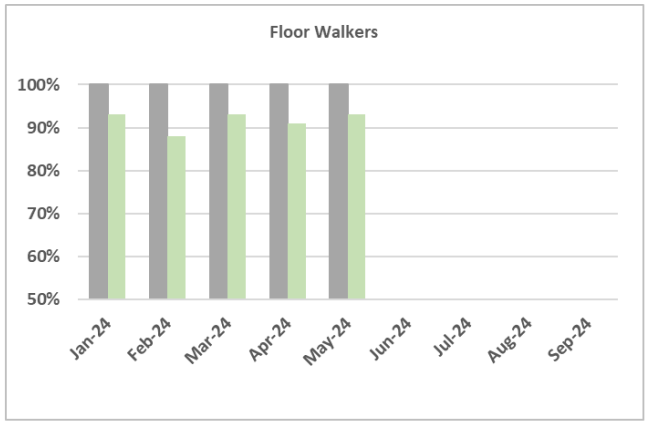
Safe | **Effective** | Caring | Improve

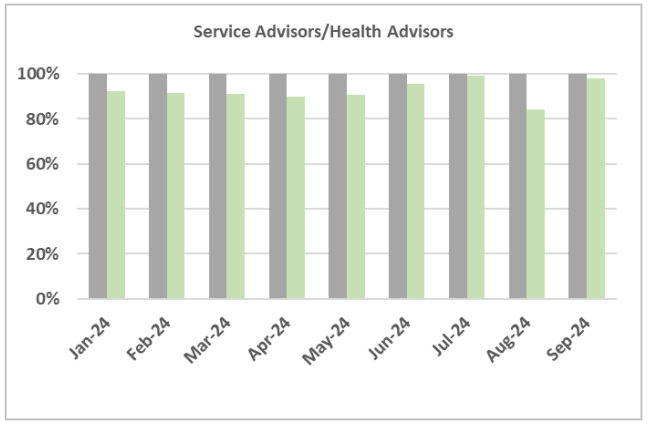
Priority | Owner JN | Exec Lead FW/RP

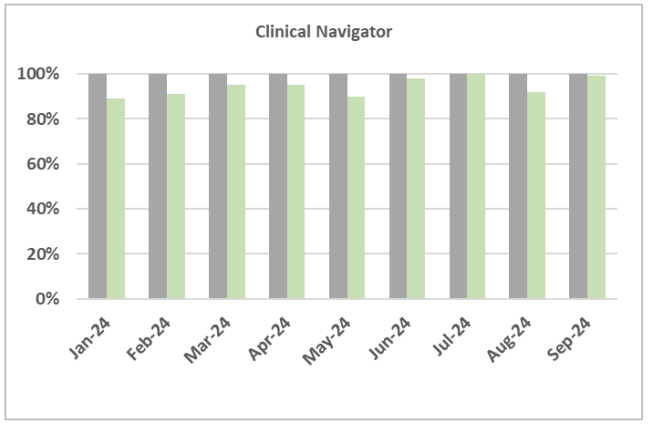
111 Quality Audit - NEL

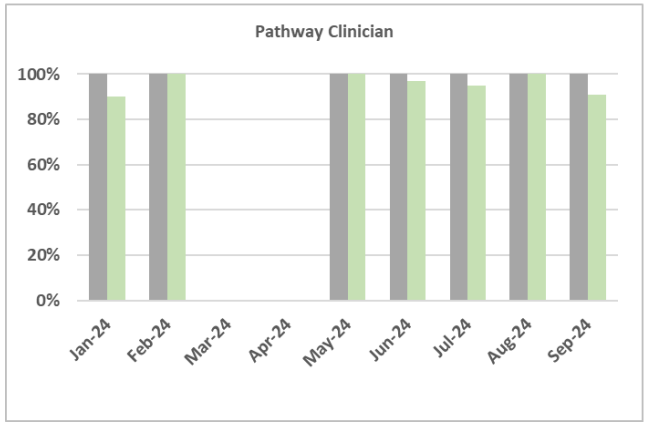
No concerns for escalation

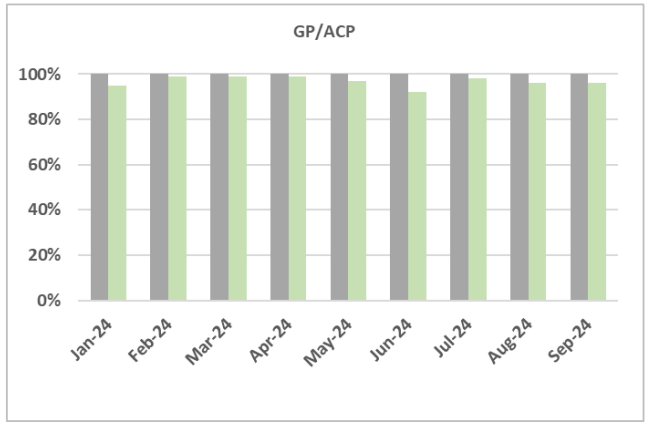
No update provided by IUC











Completion rate Pass rate

London Ambulance Service
NHS Trust

Research & Clinical Audit

Link to CARU live CPI dashboard (requires VPN)

We are the capital's emergency and urgent care responders

CQOG date: 17th June 2025

Reporting date: Dec 24–May 25

Clinical Quality Oversight Group

CARU

Key Findings

National AQIs (December 2024 data, published May 2025):

ROSC at hospital handover: LAS ranked 5th nationally in the overall group, with a rate of 26.4% (national average: 25.4%). For Utstein ROSC, we ranked 8th, performing below the national average (LAS: 47.1%, national: 51.7%)

30-day survival: LAS ranked 6th, performing slightly above the national average in the overall group (LAS: 7.7%, national: 7.4%). In the Utstein group, we were again below the national average (LAS: 25.5%, national: 27.8%) and ranked joint 6th.

Falls Care Bundle: We ranked 3rd nationally, providing this bundle to 54.3% of older fallers - almost a 10% increase from September 2024.

STEMI: LAS 'call – angiography' time was 02:38 (consistent with November data).

Clinical Audit reports:

Anticipatory Medicines: Overall, the results were positive, particularly regarding the administration of anticipatory medicines when indicated, via the correct dose and route.

Areas identified for improvement include: pain assessment, medication documentation in the drug section of ePCR, drug wastage documentation, and ensuring 'As Required' (PRN) and Stock Balance chart photos are attached to the ePCR.

Paracetamol (patients aged 12-15 years): Paracetamol administration was indicated in most cases, but documentation of dose, route, patient weight, and pain severity requires improvement to ensure accurate and safe treatment.

Paediatric Pyrexia: Clinician decisions to discharge patients at the scene were consistently safe, supported by thorough documentation of medical histories and clear decision making. Areas for improvement include a lack of referrals to an appropriate healthcare professional and documentation of capillary refill.

Allergies: While there was good practice in the identification and treatment of allergic reactions, improvement is needed for patients experiencing anaphylaxis.

Recommendations from Clinical Audit

ePCR suggestions: prompt weight documentation when paracetamol is selected; add medication validation, and make the capillary refill section and "at patient" field more accessible
CSR proposals: anaphylaxis recognition and treatment, and paracetamol administration
JRCALC clarifications: whether blood pressure should be measured for paediatric patients having an allergic reaction and if adrenaline should be given in 5-minute intervals or at least 5 minutes
CPI addition: assessing whether a referral to an appropriate healthcare professional has been completed within the Discharged at Scene CPI
Further investigation: paracetamol dosing errors in children
Reminders: assess pain for all patients (including facial expressions or body movements if patients are non-verbal); start anticipatory medicines from the lowest dose of a range (or in line with the previous dose administered); administer Trust-issued medications in the absence of anticipatory medications when symptoms are present; document anticipatory medicines in the drug section of ePCR, drug wastage for controlled drugs (including zero wastage), contact name of referral, and photo of the MAAR chart (both PRN and Stock Balance charts)

Performance & Highlights

Clinical Performance Indicators (CPIs):
In January, we launched a new CPI application that pre-populates data where possible, allowing auditors to focus on clinical judgement. Audit data is now attributed to all attending clinicians (rather than the submitting clinician), acknowledging their collective contribution. A new query function enables auditors to pause audits and consult CARU or specialists, while built-in quality assurance supports feedback on audit accuracy. Further developments are planned for rollout over the coming year.

Clinical Audit Work Programme for 2025-26:
The Programme was approved by the Clinical Audit & Research Steering Group (CARSG) and includes:

- Acute Behavioural Disturbance
- Hear & Treat Worsening Advice
- Hyperventilation and Panic Attack
- Management of Hypothermic Cardiac Arrest
- Major Head Injury
- Non-Conveyance of Abdominal Pain
- Non-Conveyance of Headache
- Overdose and Poisoning in Children

We also approved two new facilitated clinical audit projects looking at bariatric care and IPC cannulation.

Research:
Over the last few months, we have recruited 133 patients into clinical trials.

CRASH-4 has opened at Homerton Group and is due to open in Ilford & Romford Groups imminently, adding a total of 5 more ambulance stations to the trial.

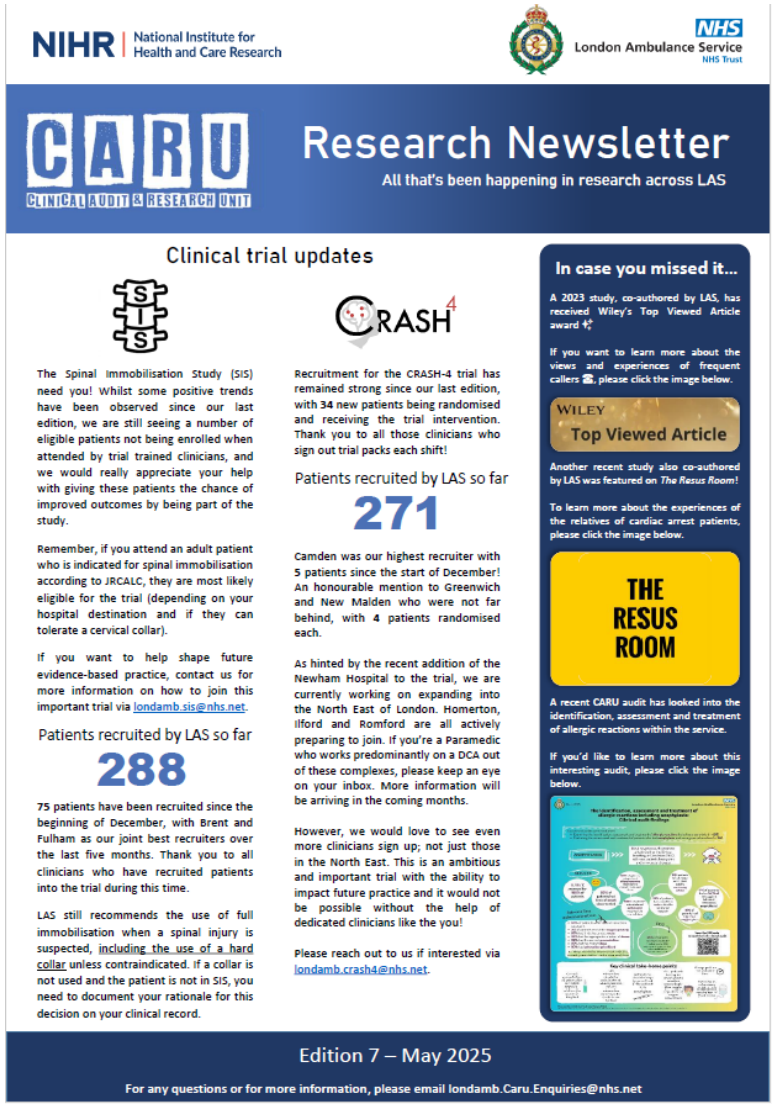
There have been 6 peer-reviewed journal publications and 8 presentations by LAS authors since December 2024.

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

CARU

May 2025 Newsletter

Adobe Acrobat Document



NIHR | National Institute for Health and Care Research

London Ambulance Service NHS Trust

CARU Clinical Audit & Research Unit

Research Newsletter

All that's been happening in research across LAS

Clinical trial updates

The Spinal Immobilisation Study (SIS) need you! Whilst some positive trends have been observed since our last edition, we are still seeing a number of eligible patients not being enrolled when attended by trial trained clinicians, and we would really appreciate your help with giving these patients the chance of improved outcomes by being part of the study.

Remember, if you attend an adult patient who is indicated for spinal immobilisation according to JRCALC, they are most likely eligible for the trial (depending on your hospital destination and if they can tolerate a cervical collar).

If you want to help shape future evidence-based practice, contact us for more information on how to join this important trial via londamb.sis@nhs.net.

Patients recruited by LAS so far

288

75 patients have been recruited since the beginning of December, with Brent and Fulham as our joint best recruiters over the last five months. Thank you to all clinicians who have recruited patients into the trial during this time.

LAS still recommends the use of full immobilisation when a spinal injury is suspected, including the use of a hard collar unless contraindicated. If a collar is not used and the patient is not in SIS, you need to document your rationale for this decision on your clinical record.

Recruitment for the CRASH-4 trial has remained strong since our last edition, with 34 new patients being randomised and receiving the trial intervention. Thank you to all those clinicians who sign out trial packs each shift!

Patients recruited by LAS so far

271

Camden was our highest recruiter with 5 patients since the start of December! An honourable mention to Greenwich and New Malden who were not far behind, with 4 patients randomised each.

As hinted by the recent addition of the Newham Hospital to the trial, we are currently working on expanding into the North East of London. Homerton, Ilford and Romford are all actively preparing to join. If you're a Paramedic who works predominantly on a DCA out of these complexes, please keep an eye on your inbox. More information will be arriving in the coming months.

However, we would love to see even more clinicians sign up; not just those in the North East. This is an ambitious and important trial with the ability to impact future practice and it would not be possible without the help of dedicated clinicians like the you!

Please reach out to us if interested via londamb.crash4@nhs.net.

In case you missed it...

A 2023 study, co-authored by LAS, has received Wiley's Top Viewed Article award

If you want to learn more about the views and experiences of frequent callers, please click the image below.

WILEY Top Viewed Article

Another recent study also co-authored by LAS was featured on *The Resus Room*!

To learn more about the experiences of the relatives of cardiac arrest patients, please click the image below.

THE RESUS ROOM

A recent CARU audit has looked into the identification, assessment and treatment of allergic reactions within the service.

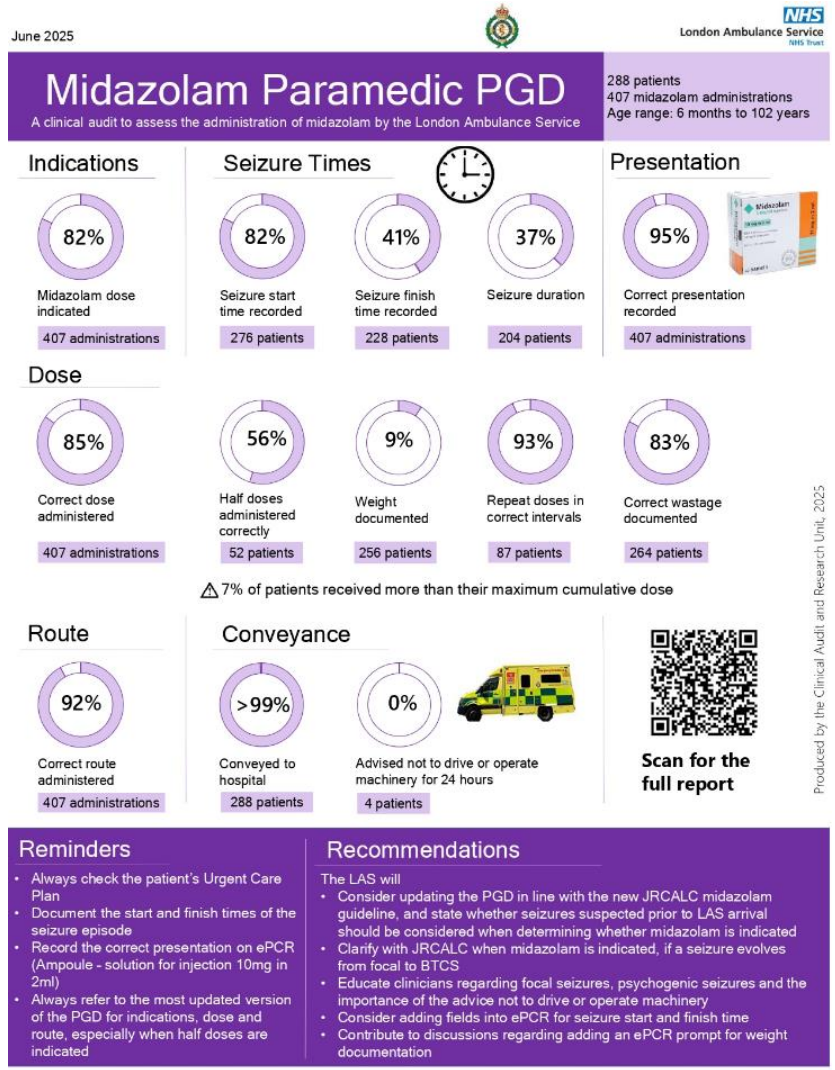
If you'd like to learn more about this interesting audit, please click the image below.

Edition 7 – May 2025

For any questions or for more information, please email londamb.Caru.Enquiries@nhs.net

Midazolam Paramedic PGD Audit

JPG File



June 2025

London Ambulance Service NHS Trust

Midazolam Paramedic PGD

A clinical audit to assess the administration of midazolam by the London Ambulance Service

288 patients
407 midazolam administrations
Age range: 6 months to 102 years

Indications

82% Midazolam dose indicated — 407 administrations

Seizure Times

82% Seizure start time recorded — 276 patients

41% Seizure finish time recorded — 228 patients

37% Seizure duration — 204 patients

Presentation

95% Correct presentation recorded — 407 administrations

Dose

85% Correct dose administered — 407 administrations

56% Half doses administered correctly — 52 patients

9% Weight documented — 256 patients

93% Repeat doses in correct intervals — 87 patients

83% Correct wastage documented — 264 patients

⚠ 7% of patients received more than their maximum cumulative dose

Route

92% Correct route administered — 407 administrations

Conveyance

>99% Conveyed to hospital — 288 patients

0% Advised not to drive or operate machinery for 24 hours — 4 patients

Scan for the full report

Produced by the Clinical Audit and Research Unit, 2025

Reminders

- Always check the patient's Urgent Care Plan
- Document the start and finish times of the seizure episode
- Record the correct presentation on ePCR (Ampoule - solution for injection 10mg in 2ml)
- Always refer to the most updated version of the PGD for indications, dose and route, especially when half doses are indicated

Recommendations

The LAS will

- Consider updating the PGD in line with the new JRCALC midazolam guideline, and state whether seizures suspected prior to LAS arrival should be considered when determining whether midazolam is indicated
- Clarify with JRCALC when midazolam is indicated, if a seizure evolves from focal to BTCS
- Educate clinicians regarding focal seizures, psychogenic seizures and the importance of the advice not to drive or operate machinery
- Consider adding fields into ePCR for seizure start and finish time
- Contribute to discussions regarding adding an ePCR prompt for weight documentation

All information correct at the time of publication. It is clinicians' responsibility to remain up to date with current guidance.

Safe | **Effective** | Caring | Improve | Priority | Owner RF | Exec Lead FW

No concerns for escalation

CPI Audits

Audited rate of compliance to care	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24	Aug24	Sep24	Oct24	Nov24	Dec24	Jan25
Completion rate	78%	77%	80%	82%	84%	93%	80%	83%	86%	93%	83%	90%	82%	84%	87%	88%	77%	78%
Cardiac arrest	97%	97%	97%	98%	97%	97%	98%	98%	97%	98%	97%	98%	97%	98%	98%	98%	98%	98%
Discharged at scene	96%	96%	96%	96%	96%	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%	97%	97%	96%
Mental health (Diagnosed)	95%		96%		95%		95%		96%		95%		95%		96%		97%	
Mental health (Undiagnosed)		95%		94%		96%		96%		95%		95%		97%		97%		94%
Sepsis	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	94%
DIB	96%		96%		95%		96%		95%		95%		95%		96%		94%	
Elderly falls	94%	94%	95%	95%	95%	95%	96%	96%	95%	95%	95%	95%	95%	95%	96%	88%	88%	89%
End of life care		95%		95%		95%		96%		95%		96%		96%		96%		96%

Red = below median, **Green** = above median

Completion rate by sector	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24	Jul24	Aug24	Sep24	Oct24	Nov24	Dec24	Jan25
North West	82%	83%	98%	87%	81%	83%	85%	92%	90%	98%	90%	82%	92%	85%	83%	78%	72%	0.57
North Central	79%	97%	76%	75%	79%	90%	77%	89%	98%	95%	95%	99%	86%	88%	89%	93%	98%	0.86
North East	94%	91%	95%	89%	83%	98%	95%	91%	84%	89%	85%	90%	82%	83%	84%	87%	69%	0.8
South East	50%	59%	54%	64%	81%	98%	66%	68%	73%	88%	68%	91%	90%	96%	95%	98%	81%	0.96
South West	97%	81%	94%	100%	96%	99%	85%	79%	92%	100%	97%	99%	59%	73%	90%	83%	80%	0.95

Red = below median, **Green** = above median

London Ambulance Service
NHS Trust

Advanced Practice & Specialist Services

We are the capital's emergency and urgent care responders

CQOG date : 17/06/2025

Reporting date = May 2025

Clinical Quality Oversight Group

Advanced Practice

Incidents

Number of incidents	Themes
11	Restraint
4	Medical equipment
1	Medicines management
1	Staff accident/injury
1	Information governance
1	Medication error
1	Non-medical equipment

- Restraint – 10 (CC) & 1 (UC)
- UC APP - prescriptions (March)
  - 65 prescriptions
  - Most common – amoxicillin, ondansetron, paracetamol, salbutamol inhaler
  - No adverse incidents
- APP-CC - intubation success 98.4% (Q4)

Current risks and Concerns

- RADAR reports currently 27 open (excludes ops risks).
- Expansion of APP-UC and SP-PC resource now means that capacity to dispatch and provide clinical advice and support is exceeded.

Performance

- APP CPI results
  - APP-UC no report in May due to implementation of new system
  - APP-CC – completion rate 97%
    - Cardiac arrest 99%
    - Major trauma 99%
    - General documentation 100%
- Performance metrics / targets - APP Ops manager on leave
- Stat man compliance - APP Ops manager on leave
- Attendance at clinical governance days
  - APP-UC Q1 67/71 staff
  - APP-CC 22 in May
- Supervision shifts
- APP-UC 55/66 in Q1 and 10 in May 2025
- APP-CC 7 in May 2025
- Cover – APP Ops manager on leave

Learning

- Learning from incidents – none live at present with learning
- Practice development – consideration of levitaracetam for APP-CC and IV Abx for APP-UC

CQOG date : 17/06/2025

Reporting date = May 2025

Clinical Quality Oversight Group

Advanced Practice

Training

- Mandatory training compliance – APP CC Ops Manager on leave
- Educational achievement
    - APP-UC 3 staff with extenuating circumstances – requirement to repeat one module Attendance at training days
    - APP-CC 3 staff have not completed an MSc due to legacy requirements for the role differing – plans in place for these. Nil other concerns.
- Assurance over revalidation/qualification/ recertification – no issues identified

Assurance

- PGD breaches - none
- Audit& Research
    - Dihpoterine work being presented at Stockholm EMS conference
    - Planned evaluation for APP-CC use of ketamine

Further updates

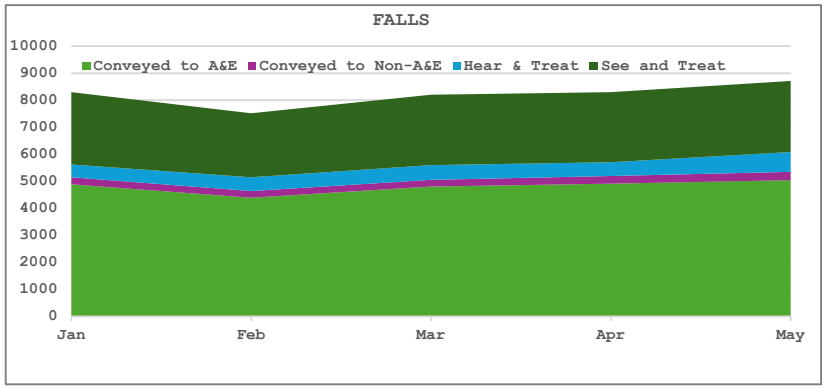
- APP-UC exploration of IV antibiotic sin the community
- Clarification of APP-UC and SP-PC remits

Safe | Effective | **Caring** | Improve | Priority | Owner | Exec Lead: FW

No concerns for escalation

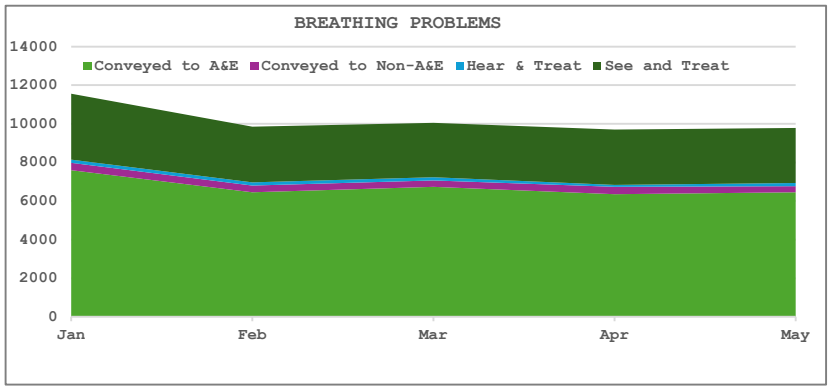
Summary 1 of 2

Fallers



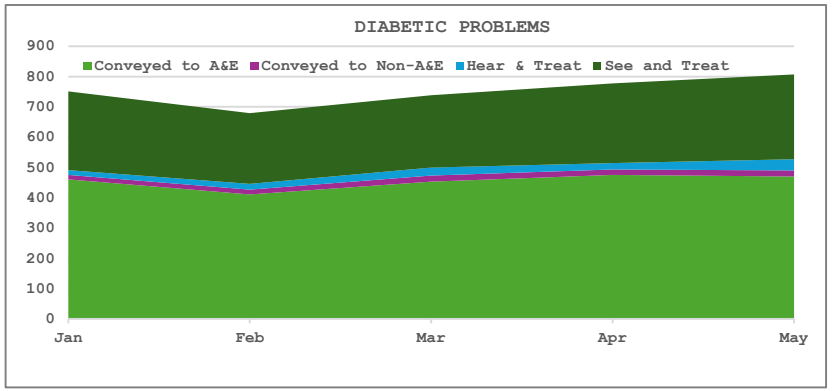
	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	1798	3%	1%	0%	1%
Cat 2	27014	44%	2%	1%	18%
Cat 3	10395	10%	0%	5%	10%
Cat 4	235	0%	0%	0%	0%
Cat 5	1591	1%	0%	1%	2%
ALL	**41,033**	**59%**	**3%**	**7%**	**31%**

Breathing



	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	18570	26%	1%	0%	9%
Cat 2	31491	40%	2%	1%	19%
Cat 3	599	0%	0%	1%	0%
Cat 4	69	0%	0%	0%	0%
Cat 5	230	0%	0%	0%	0%
ALL	**50,959**	**66%**	**3%**	**1%**	**29%**

Diabetes



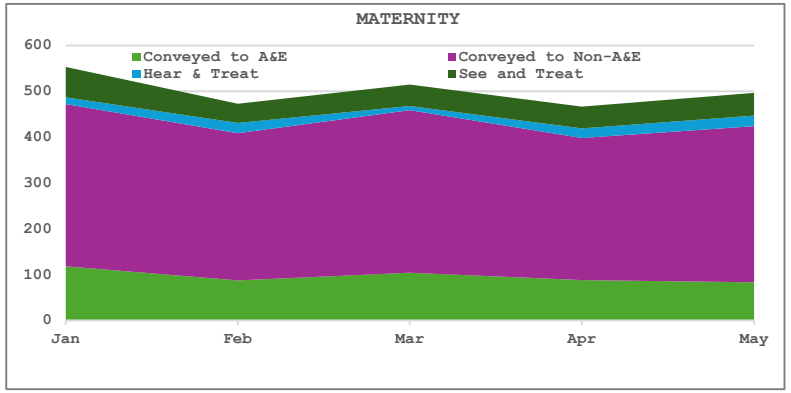
	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	546	8%	0%	0%	6%
Cat 2	3029	50%	2%	1%	27%
Cat 3	72	1%	0%	1%	0%
Cat 4	12	0%	0%	0%	0%
Cat 5	94	1%	0%	1%	1%
ALL	**3,753**	**60%**	**2%**	**3%**	**34%**

Safe | Effective | **Caring** | Improve | Priority | Owner | Exec Lead: FW

Summary 2 or 2

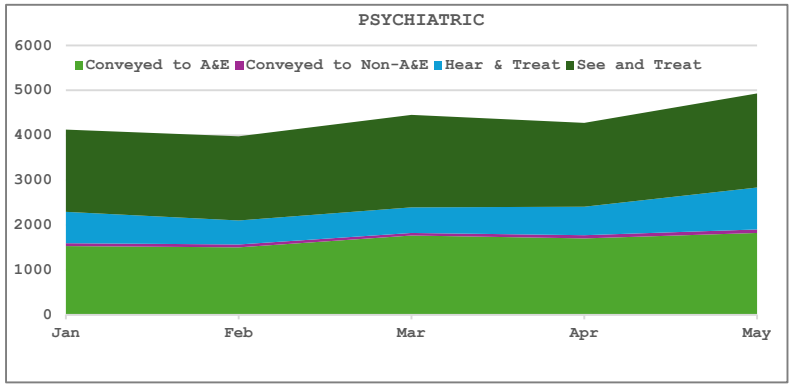
No concerns for escalation

Maternity



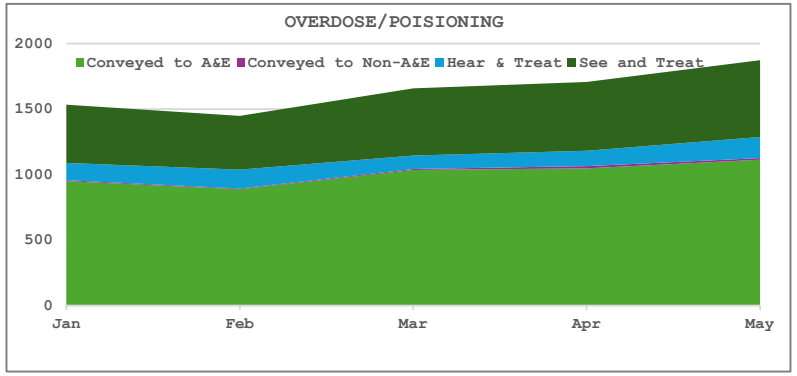
	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	1731	12%	51%	0%	6%
Cat 2	535	4%	15%	0%	2%
Cat 3	167	3%	0%	3%	1%
Cat 4	1	0%	0%	0%	0%
Cat 5	71	0%	1%	1%	1%
ALL	**2,505**	**19%**	**67%**	**4%**	**10%**

Psychiatric



	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	529	2%	0%	0%	1%
Cat 2	5153	13%	0%	0%	10%
Cat 3	10184	17%	1%	4%	26%
Cat 4	61	0%	0%	0%	0%
Cat 5	5838	7%	0%	11%	9%
ALL	**21,765**	**38%**	**2%**	**15%**	**45%**

Poisoning



	F2F Incidents (Jan-May)				
	Total	C TO A&E	C TO Non-A&E	H&T	S&T
Cat 1	357	3%	0%	0%	1%
Cat 2	5029	43%	0%	1%	17%
Cat 3	2400	14%	0%	4%	11%
Cat 4	20	0%	0%	0%	0%
Cat 5	412	1%	0%	4%	1%
ALL	**8,218**	**61%**	**1%**	**8%**	**30%**

Maternity

- 44 maternity incidents reported in May, all no harm.
- Interface work - Walk through/sim at RLH to improve interface. Team effort with local CTM/crew and RLH representatives including simulation fellow. Route identified from ED which doesn't require swipe card access - temporary signage installed. Route has been shared with NEL, NCL and SEL quality leads for huddles. Ongoing QI/data collection to measure impact (arrival at hospital and clinical handover). Review in Sept.
- Neonatal Operational Delivery Network Conference accepted LAS maternity team poster presentation on prehospital newborn thermoregulation strategies. The maternity team attended the day and met with neonatal teams from across London.

Mental Health

- Mental Health Joint Response Cars (MHJRC) - In the month of May the MHJRC covered 101% of commissioned shifts, had 1110 activations and a utilisation of 78.7% Mental Health call volume across the trust continues to rise month on month.
- There is an upcoming funding review for the Mental Health Joint Response Cars. The team are working with the LAS commissioning team on a paper and equality impact assessment around the risks of decommissioning this service. The paper will consider the impact on double crewed ambulances, clinical hub assessments, patient experience and impact on system partners such as Emergency Departments.

London Ambulance Service
NHS Trust

3rd Party Oversight & Alternative Pathways

We are the capital's emergency and urgent care responders

Safe | Effective | **Caring** | Improve

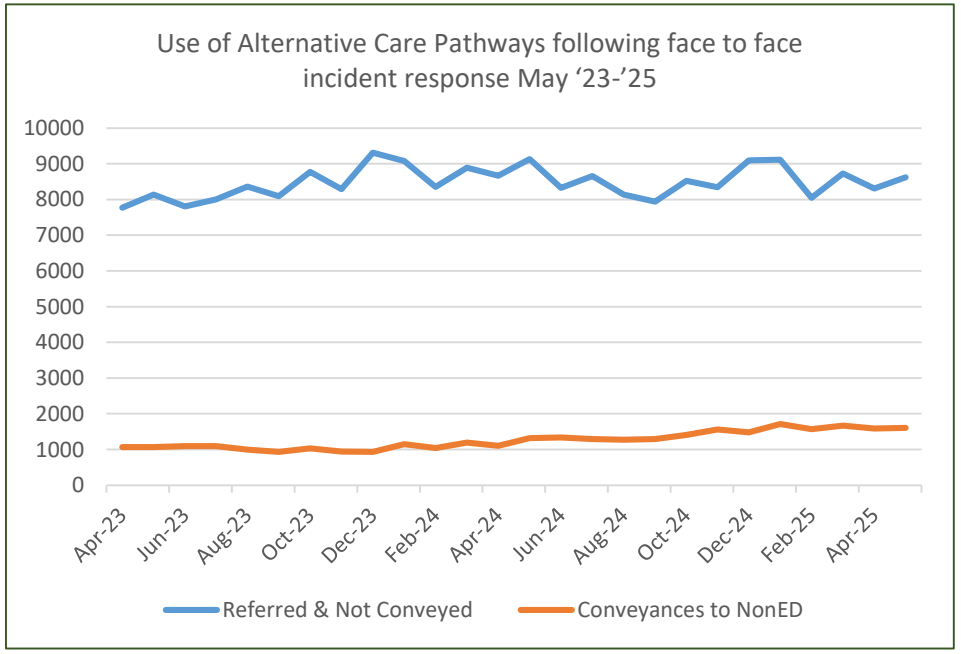
Priority | Owner: GMJ | Exec Lead: FW

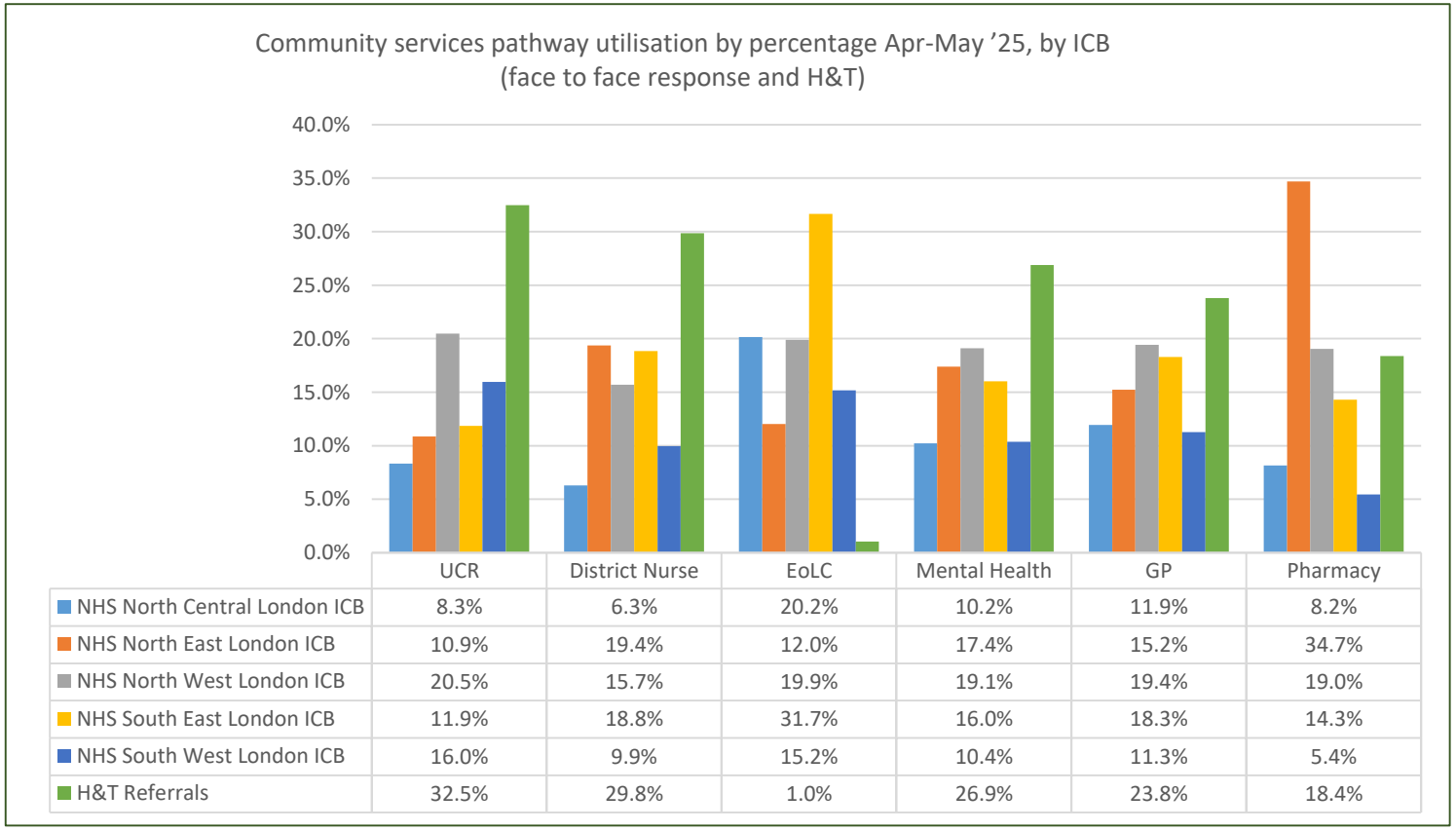
No concerns for escalation

Alternate Pathways

Face to face incident response, conveyance to Non ED outcome: overall conveyance to Non ED services (UTC/SDEC) has remained relatively stable, with a slight upward trend in the last year (percentage of all incidents increased from 1.4% to 1.7%). Increase driven by SDEC 'Trusted Assessor' model.

Face to face incident response, referred and not conveyed outcome: overall onward referral of patients to other services has remained stable. Increasing number of incidents that result in onward community referral are managed by hear and treat (shown in green) and current face to face outcome coding limits full understanding of community referrals undertaken.





	UCR	District Nurse	EoLC	Mental Health	GP	Pharmacy
NHS North Central London ICB	8.3%	6.3%	20.2%	10.2%	11.9%	8.2%
NHS North East London ICB	10.9%	19.4%	12.0%	17.4%	15.2%	34.7%
NHS North West London ICB	20.5%	15.7%	19.9%	19.1%	19.4%	19.0%
NHS South East London ICB	11.9%	18.8%	31.7%	16.0%	18.3%	14.3%
NHS South West London ICB	16.0%	9.9%	15.2%	10.4%	11.3%	5.4%
H&T Referrals	32.5%	29.8%	1.0%	26.9%	23.8%	18.4%

Safe | Effective | **Caring** | Improve

Priority | Owner GMJ | Exec Lead FW

No concerns for escalation

Alternate Pathways

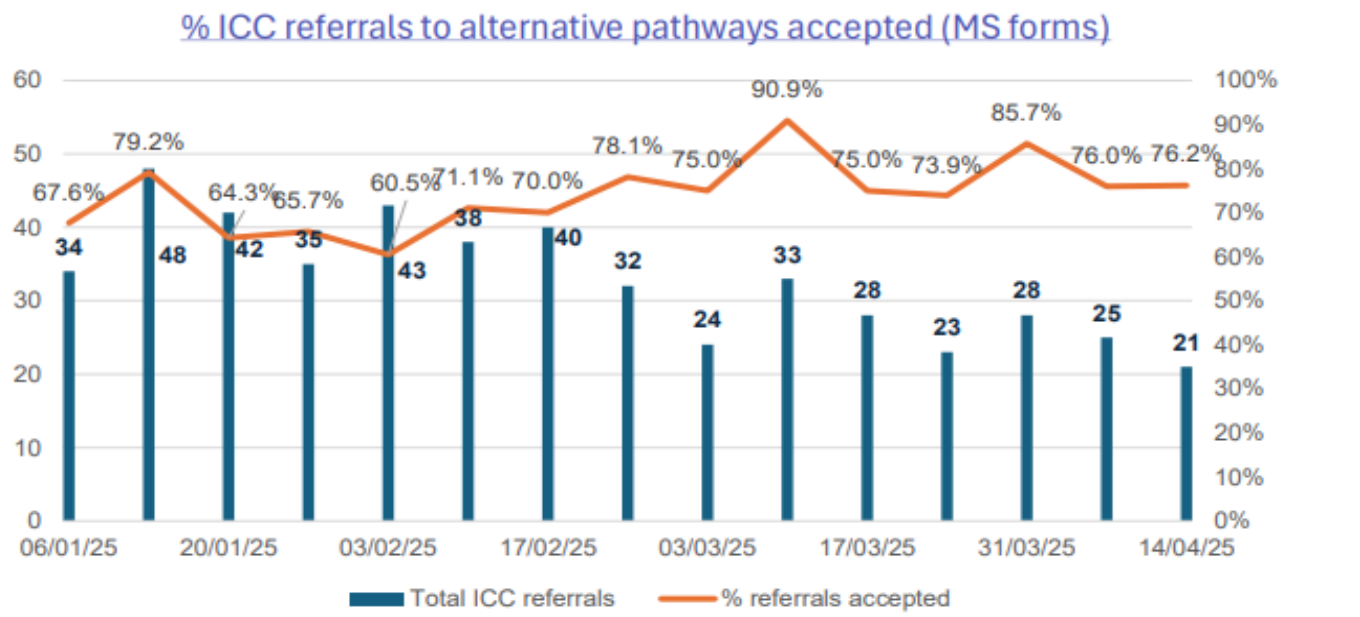
Integrated Care Coordination (ICC)/SPoA (terminology interchangeable)

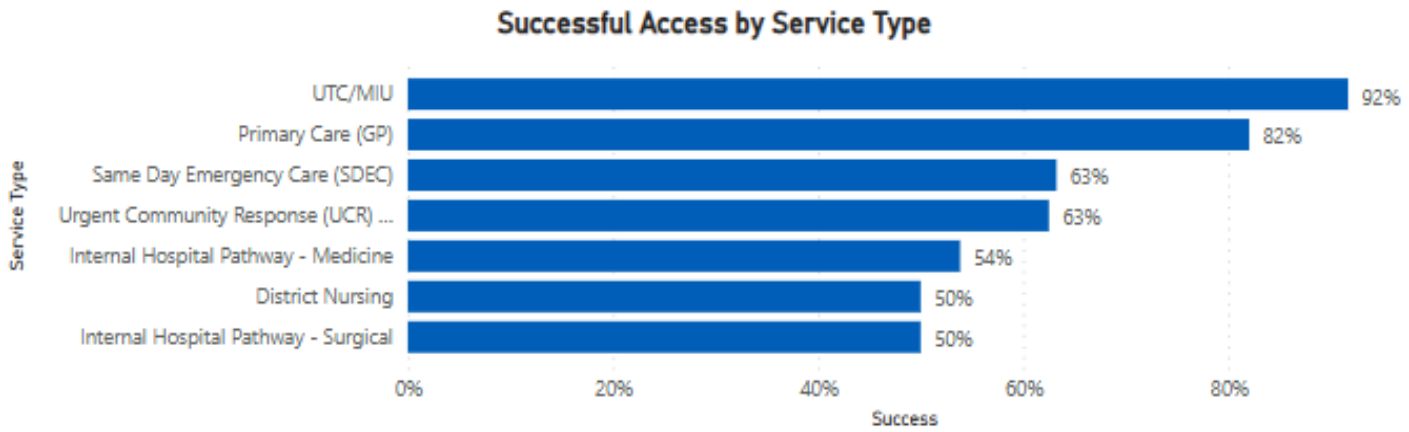
- ICC Hubs operate across the system, **co-ordinating Urgent & Emergency Care response**, driven by the patient's condition.
- An MDT of senior clinical decision makers provides rapid access to **remote clinical consultation for patients, support to ambulance clinicians** and **streamlined access** to ACPs, identifying and coordinating the most appropriate service to meet the patient's need.
- The LAS currently has two ICC Hubs in NCL and NWL and is engaging with partners in other ICS, with the ambition to have ICC Hubs operating London wide for winter '25. ICC Hubs reduce DCA dispatch and ED conveyance, while increasing ACP utilisation.

NCL The majority of referral outcomes are captured, by MS form. The volume of referrals includes those undertaken by Clinical Hub H&T as BAU. There has been an increase in acceptance rate since opening of the ICC Hub in Jan '25.

NWL All referral outcomes are captured, via MIDOS or ICC Hub data portal. The volume of referrals does not include Clinical Hub H&T BAU.

- ICC Hub open during Mar-May '25. Over 63 days: 1,433 attempted referrals, 88% of attempts were successful, access varied by service type.
- Integration with acute Trusts enabled new pathways for patients, acceptance was higher when the pathway was integrated with the ICC Hub.





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

London's Air Ambulance

PLACE HOLDER

New section

No data available this report

Following the development of the 3rd Party oversight group which will report into CQOG. This section of the report will be used to highlight key metrics and any issues in regards to London's Air Ambulance to provide assurance that as a trust we are aware of the activity and have adequate oversight of our 3rd party partners

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WORK IN PROGRESS

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

Physicians Response Unit

New section

No data available this report

Following the development of the 3rd Party oversight group which will report into CQOG. This section of the report will be used to highlight key metrics and any issues in regards to the Physicians Response Unit to provide assurance that as a trust we are aware of the activity and have adequate oversight of our 3rd party partners

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WORK IN PROGRESS

Safe | Effective | Caring | Improve | Priority | Owner | Exec Lead PC

National Ambulance Resilience Unit

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WORK IN PROGRESS

New section

No data available this report

Following the development of the 3rd Party oversight group which will report into CQOG. This section of the report will be used to highlight key metrics and any issues in regards to NARU to provide assurance that as a trust we are aware of the activity and have adequate oversight of our 3rd party partners

Safe | Effective | Caring | Improve

Priority | Owner | Exec Lead FW

IUC Cars

New section

No data available this report

Following the development of the 3rd Party oversight group which will report into CQOG. This section of the report will be used to highlight key metrics and any issues in regards to IUC cars to provide assurance that as a trust we are aware of the activity and have adequate oversight of our 3rd party partners

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WORK IN PROGRESS

London Ambulance Service
NHS Trust

Quality Team Performance

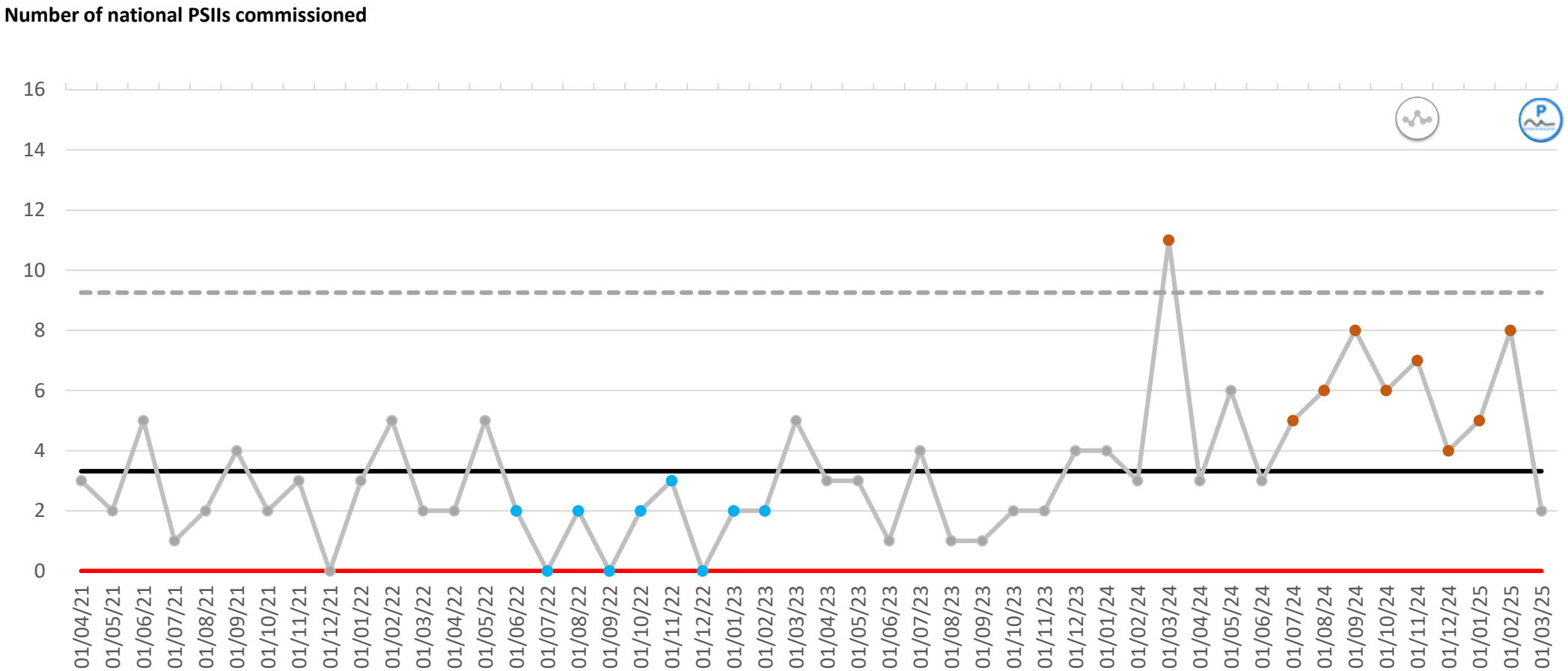
We are the capital's emergency and urgent care responders

PSIP outcomes

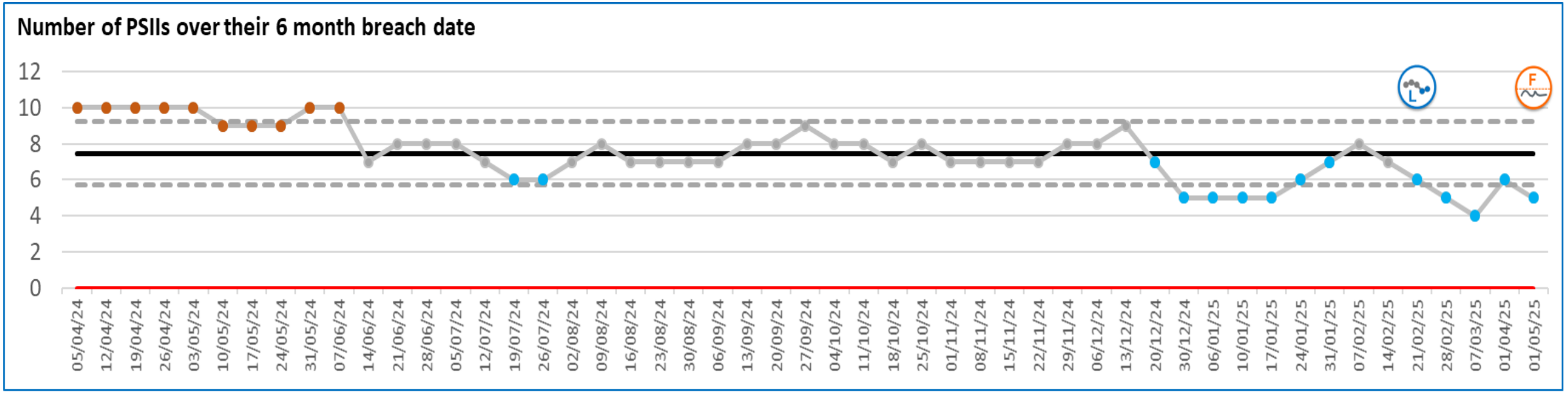
- Overall number of learning responses has reduced by 15%
- If remove delay SJR cases (42% of all responses in 2021-23 and just 3.4% in 2023-25) – overall commissioning rate increased by 25%
- In 2021/23 National PSIIs made up 22% of PSIP incidents.
- In 2023/25 National PSIIs made up 32% of PSIP incidents.

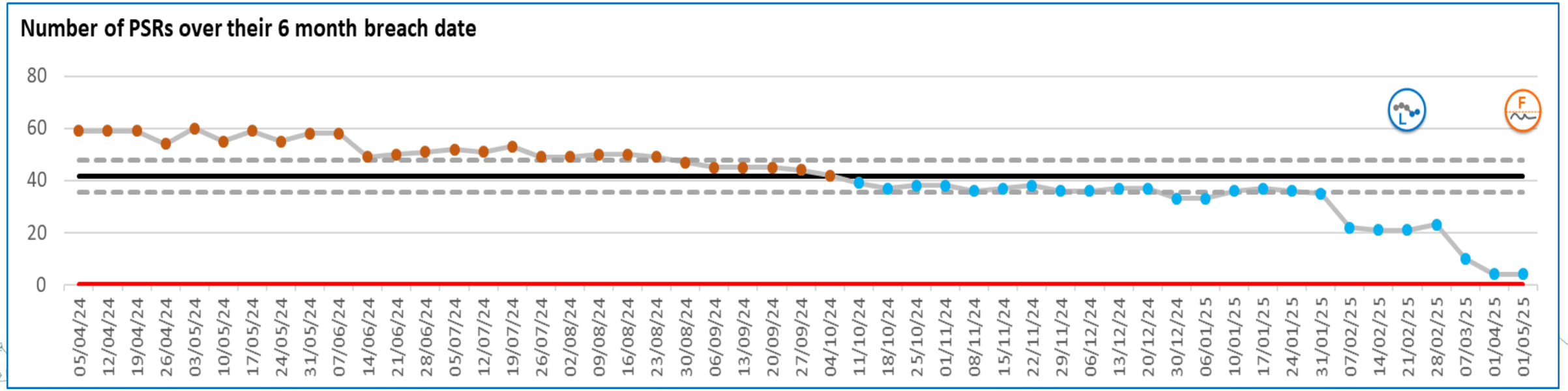
	2021-2023	2023-2025	% change
Learning Response total	257	321	+25%
National PSII's	57	102	+79%
Local PSII's	39	21	-46%
PSR – Case Review	156	0	N/A
PSR - AAR	0	157	N/A
PSR – Swarm	0	16	N/A
PSR – MDT	0	18	N/A
Thematics	5	7	+40%
Non-Learning Response total	1738	1383	-20%
Delays SJR	833	58	-93%
Local Investigations	905	1317	+46%
Complaint responses	0	8	N/A
Total of all outcomes	1995	1704	-15%

National PSIIs commissioned between 01/04/2021 – 01/03/2025



Enhanced Learning Response Performance April 24 – May 25

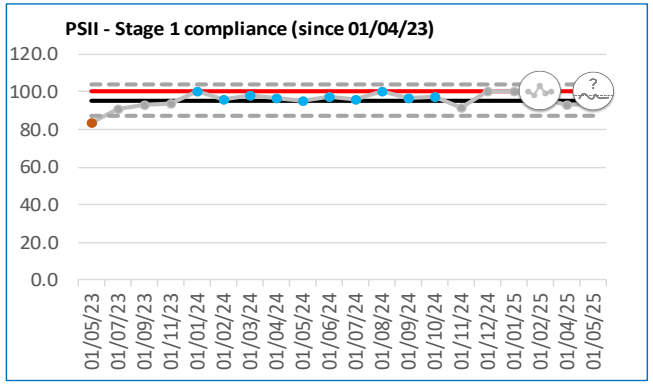


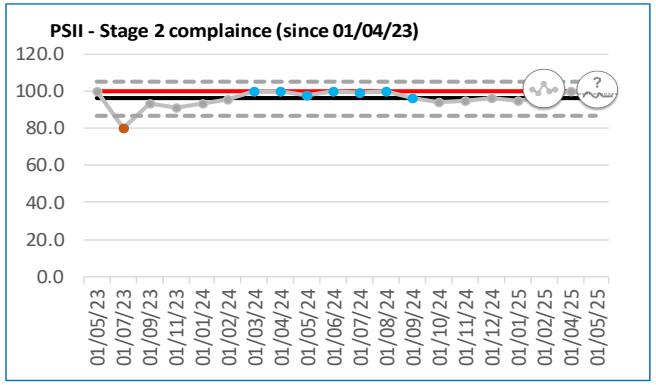


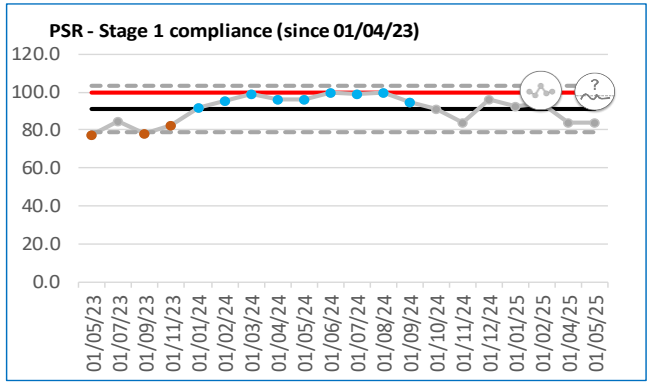
Performance – (May-23 to May-25)

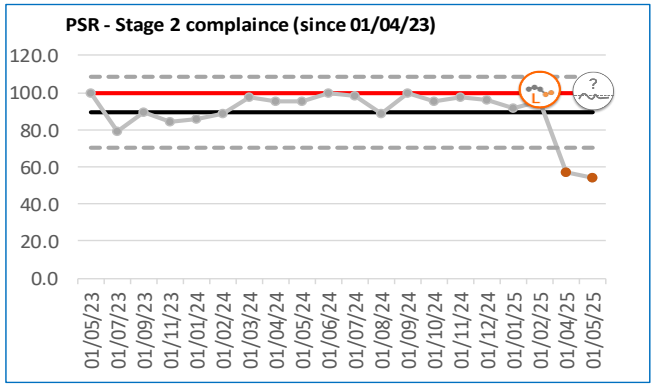
Overall Duty of Candour compliance for month, compared to target and previous

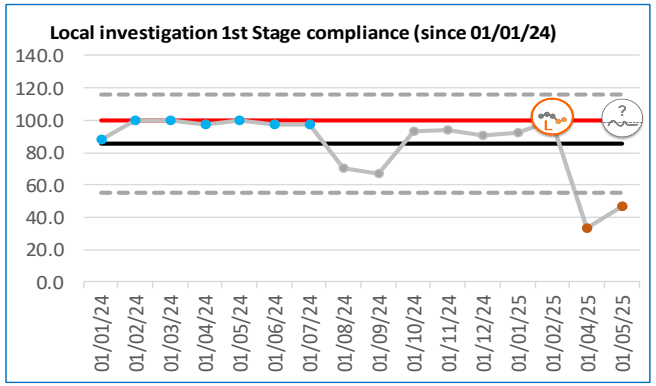
	DoC 2025/2026				Audit of Letters			
	Compliant	Applicable	Performance	Previous	Compliant	Applicable	Performance	Previous
PSII 1st Stage DoC	29	31	**93.5%**	**93.1%**	28	29	**96.6%**	**92.6%**
PSII 2nd Stage DoC	6	6	**100.0%**	**100.0%**	6	6	**100.0%**	**100.0%**
PSR 1st Stage DoC	16	19	**84.2%**	**84.2%**	14	16	**87.5%**	**87.5%**
PSR 2nd Stage DoC	6	11	**54.5%**	**57.1%**	6	6	**100.0%**	**100.0%**
Local investigation 1st Stage DoC	7	15	**46.7%**	**33.3%**	7	7	**100.0%**	**100.0%**
Local investigation 2nd Stage DoC (Outcome)	6	15	**40.0%**	**33.3%**	6	6	**100.0%**	**100.0%**

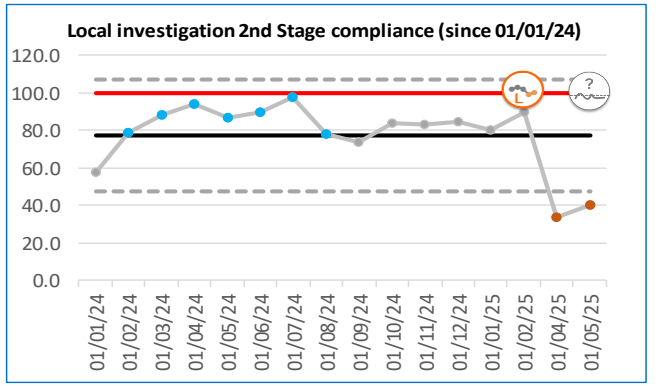












Overall Compliance

- Overall Duty of Candour compliance – 72.2% (last month 73.7%)
- Audit compliance (DOC letters) - 95.7% (97.1% last month)

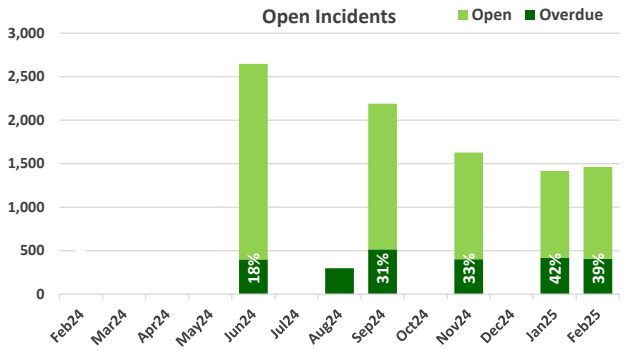
Actions planned

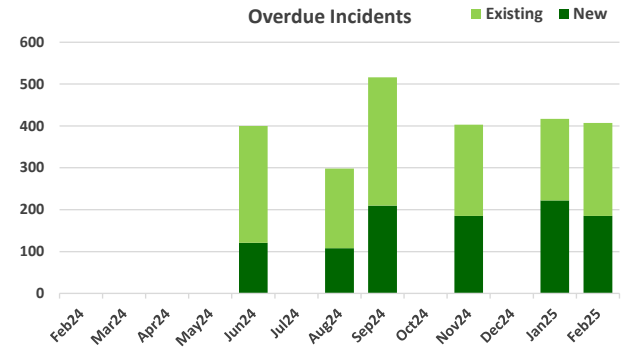
- Develop set of easy read DoC templates
- List of all outstanding DoC and Being Open shared with sectors monthly, highlighting action required
- Sectors to contact supervisors to action.
- Seek feedback on DoC process from staff, patients and families

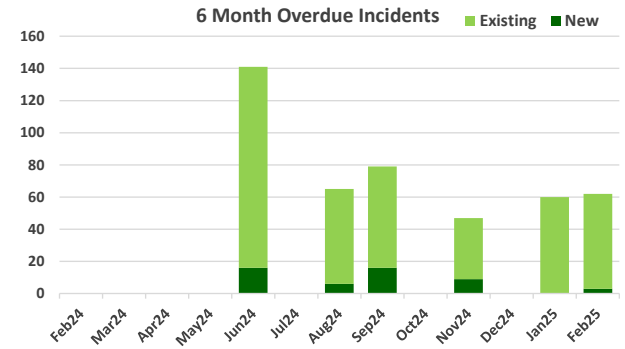
Safe | Effective | Caring | Improve | Priority | Owner AW | Exec Lead FW

Overdue Incidents (reported date)

The number of overdue incidents has increased since the end of Q4.







Severity	<1	1-2	2-3	3-6	6-12	12+	All
Death							0
Severe	1			1			2
Moderate	3				1		4
Low	17	9	1	1	26	14	68
None	168	79	33	39	10	12	341
Total	189	88	34	41	37	26	415

Incident Type	<1	1-2	2-3	3-6	6-12	12+	All
Patient	110	62	22	30	34	20	278
Trust	31	12	6	7	1	6	63
Staff	45	13	5	3	2		68
Visitor	3	1	1	1			6
Total	189	88	34	41	37	26	415

Top 15 Teams	<1	1-2	2-3	3-6	6-12	12+	All
NHS111	22	24	15	12	3	2	78
North West Sector	36	15	5	8	2	1	67
CARU					25	21	46
South East Sector	26	7		1	1		35
EOC	21	9	1				31
South West Sector	12	7	2	2			23
North East Sector	17	3			1	1	22
North Central Sector	15	3		2			20
NETS	5	4	2	7			18
CHUB	7	6	1	1			15
Resilience and SA	5	3	1	1			10
MRU		2	5				7
IM & SD	5			1			6
IM&T				4	1		5
Frequent Caller Team	3	1					4

There are currently 811 overdue local review workflows in the Trust – this equates to 37.4% of all open local review workflows. Overdue workflow by sector breakdown:

- NC – 105 (34.5%)
- NW – 128 (32%)
- NE – 52 (23.7%)
- SE – 163 (38.6%)
- SW – 65 (32.5)
- EOC – 19 (20%)
- CHUB – 3 (10.7)
- 111 – 172 (54.7%)
- RS&A – 65 (61.3%)

Work is underway creating dashboards on Radar to provide enhanced oversight to sector teams. Adjustments have also been made to the Radar system to support timely incident review,

London Ambulance Service
NHS Trust

Sector Clinical Quality Compliance

We are the capital's emergency and urgent care responders

Date: 10/06/2025

Reporting date = May 2025

Clinical Quality Compliance

Sector: South East

Compliance

Only those figures below target compliance are listed below *(data taken from Quality Assurance Report June 2025)*

- Open learning responses older than 6 months – 20%
- Duty of Candour Stage 1 compliance – 88%
- Duty of Candour Stage 2 compliance – 33%
- 1 risk overdue a review
- 144 overdue incidents
- PDR:
  - Bromley – 79.70%
- OWR:
  - Bromley – 68.53%
  - Deptford – 72.40%
  - Greenwich – 78.97%
  - Oval – 83.68%
- CISO:
  - Bromley – 76.39%
- Safeguarding Training:
  - L1 – 80.00%
  - L3 – 82.47%
- Sickness – 8.15%

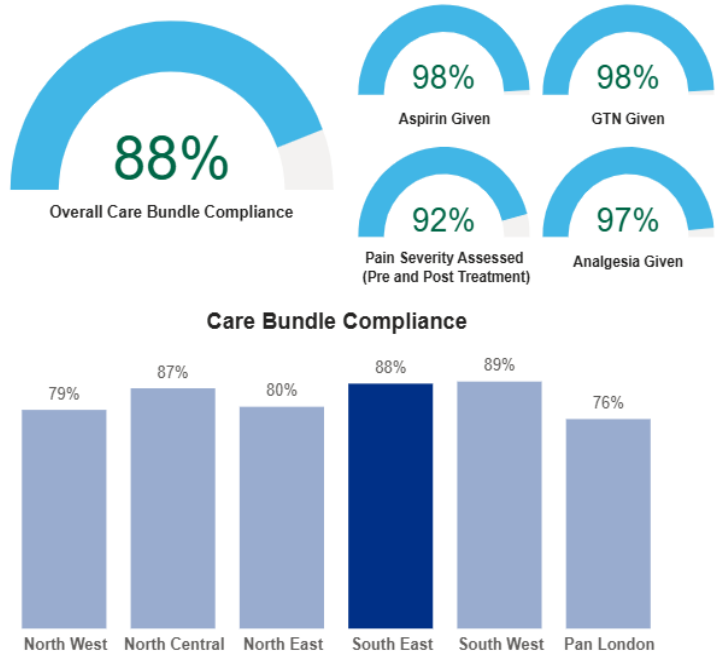
Key Concerns

- Level of overdue incidents
- Level of open learning responses older than 6 months
- Duty of Candour compliance
- Risk register – no local risks
- Safeguarding Level 1 & 3 - compliance
- Hand Hygiene audits not completed consistently at all stations
- Quality Visit:
  - Dirty Linen Not Segregated
  - Blanket Availability
  - Security

Recommendations

- Realistic trajectory in place for PDR / OWR / CISO rates
- Review daily drugs audit submissions to ensure submission rates are 95%+
- Review & update overdue risks
- Update risk register to reflect current situation
- Update improvement plan to reflect key concern areas

Stemi Care Bundle Compliance - May 2025



Date: 10/06/2025

Reporting date = May 2025

Clinical Quality Compliance

Sector: South West

Compliance

Only those figures below target compliance are listed below *(data taken from Quality Assurance Report June 2025)*

- Open learning responses older than 6 months – 100%
- Duty of Candour Stage 1 compliance – 29%
- Duty of Candour Stage 2 compliance – 17%
- 1 risk overdue a review
- 58 overdue incidents
- PDR:
  - New Malden – 84.38%
  - Wimbledon – 80.39%
- OWR:
  - Croydon – 71.15%
  - New Malden – 63.35%
  - St Helier – 81.48%
  - Wimbledon – 75.33%
- CISO:
  - New Malden – 71.33%
  - Wimbledon – 78.99%
- Safeguarding Training L3 – 82.84%

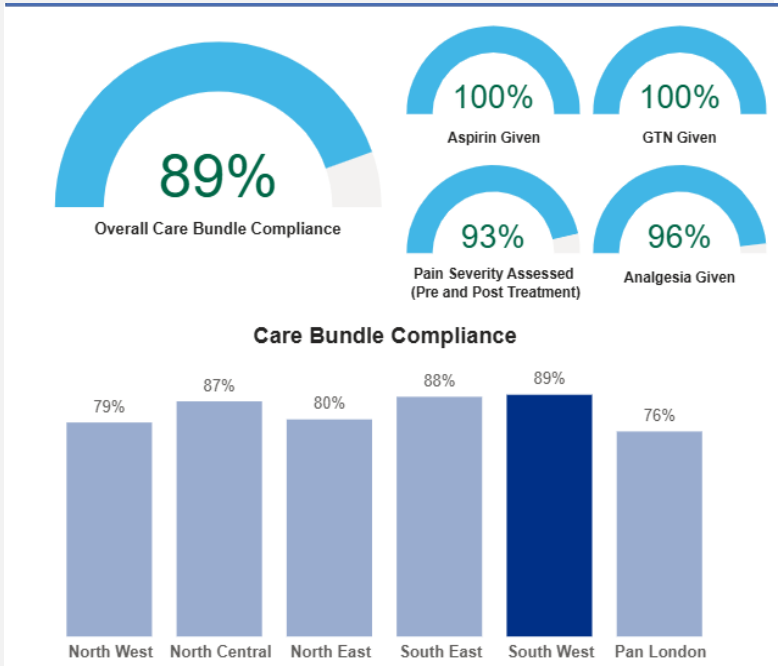
Key Concerns

- Level of overdue incidents
- Level of open learning responses older than 6 months
- Duty of Candour compliance
- Risk register – no local risks
- Safeguarding Level 3 - compliance
- Cleaning audit & Hand Hygiene audits not completed consistently at all stations
- Quality Visit:
  - Dirty Linen Not Segregated
  - Pharmaceutical Bins Not Labelled
  - Blanket Availability
  - Security

Recommendations

- Realistic trajectory in place for PDR / OWR / CISO rates
- Review daily drugs audit submissions to ensure submission rates are 95%+
- Review & update overdue risks
- Update risk register to reflect current situation
- Update improvement plan to reflect key concern areas

Stemi Care Bundle Compliance - May 2025



Date: 10/06/2025

Reporting date = May 2025

Clinical Quality Compliance

Sector: North West

Compliance

Only those figures below target compliance are listed below *(data taken from Quality Assurance Report June 2025)*

- Open learning responses older than 6 months – 33%
- Duty of Candour Stage 1 compliance – 75%
- Duty of Candour Stage 2 compliance – 67%
- 1 risk overdue a review
- 123 overdue incidents
- PDR:
  - Brent – 63.18%
  - Fulham – 81.90%
  - Hilingdon – 83.33%
  - Westminster – 76.74%
- OWR:
  - Brent – 66.55%
  - Fulham – 77.13%
  - Hanwell – 81.63%
  - Hilingdon – 79.53%
  - Westminster – 65,77%
- CISO:
  - Brent – 64.89%
  - Hilingdon – 81.76%
  - Westminster – 68.84%
- Safeguarding Training L1 - 83.33%
- Staff Turnover – 6.37%
- Sickness – 6.48%

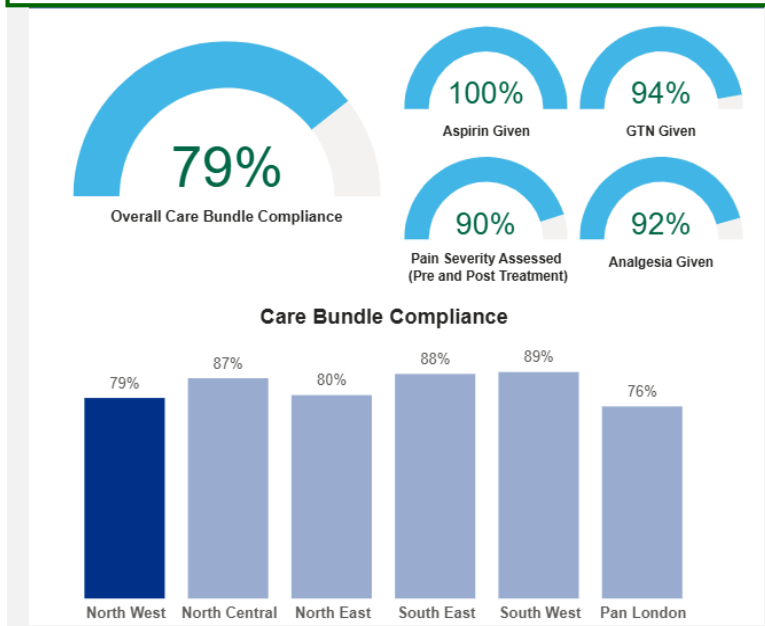
Key Concerns

- Level of overdue incidents
- Level of open learning responses older than 6 months
- Duty of Candour compliance
- Safeguarding Level 1 compliance
- Cleaning audit & Hand Hygiene audits not completed consistently at all stations
- Quality Visit:
  - Dirty Linen Not Segregated

Recommendations

- Realistic trajectory in place for PDR / OWR / CISO rates
- Review daily drugs audit submissions to ensure submission rates are 95%+
- Review & update overdue risks
- Update risk register to reflect current situation
- Update improvement plan to reflect key concern areas

Stemi Care Bundle Compliance - May 2025



Date: 10/06/2025

Reporting date = May 2025

Clinical Quality Compliance

Sector: North East

Compliance

Only those figures below target compliance are listed below *(data taken from Quality Assurance Report June 2025)*

- Open learning responses older than 6 months – 33%
- Duty of Candour Stage 1 compliance – 75%
- Duty of Candour Stage 2 compliance – 67%
- 2 risks overdue a review
- 48 overdue incidents
- PDR:
  - Homerton – 74.07%
  - Ilford – 80.42%
  - Newham – 83.43%
  - Romford – 83.97%
  - Whipps Cross – 69.29%
- OWR:
  - Homerton – 60.42%
  - Ilford – 83.22%
  - Newham – 75.00%
  - Romford – 78.67%
  - Whipps Cross – 72.79%
- CISO:
  - Ilford – 80.58%
  - Whipps Cross – 80.95%
- Safeguarding Training:
  - Level 1 – 83.33%
  - Level 3 – 75.08%

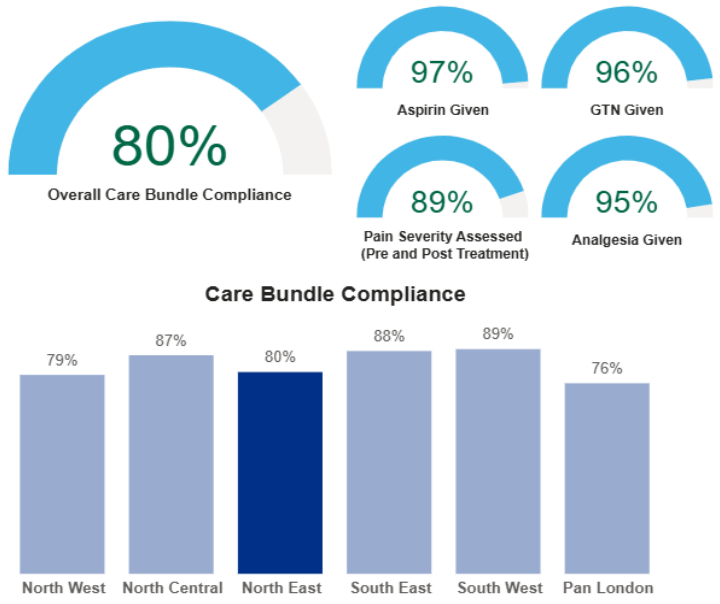
Key Concerns

- Level of overdue incidents
- Level of open learning responses older than 6 months
- Duty of Candour compliance
- Risk register – no local risks
- Safeguarding Level 3 compliance
- Cleaning audit not completed consistently at all stations
- Hand Hygiene audits below monthly target.
- Quality Visit:
  - Dirty Linen Not Segregated
  - Pharmaceutical Bins not labelled
  - Security

Recommendations

- Realistic trajectory in place for PDR / OWR / CISO rates
- Review daily drugs audit submissions to ensure submission rates are 95%+
- Review & update overdue risks
- Update risk register to reflect current situation
- Update improvement plan to reflect key concern areas

Stemi Care Bundle Compliance - May 2025



Date: 04/06/2025

Reporting date = May 2025

Clinical Quality Compliance

Sector: North Central

Compliance

Only those figures below target compliance are listed below *(data taken from Quality Assurance Report June 2025)*

- Open learning responses older than 6 months – 50%
- Duty of Candour Stage 2 compliance – 50%
- 5 risks overdue a review
- 99 overdue incidents
- PDR:
  - Camden – 80.31%
  - Edmonton – 71.70%
- OWR:
  - Camden – 73.37%
  - Edmonton – 54.46%
  - Friern Barnet – 77.35%
- CISO:
  - Edmonton – 76.08%
  - Friern Barnet – 84.02%
- Safeguarding Training:
  - Level 1 – 63.64%
  - Level 3 – 80.87%

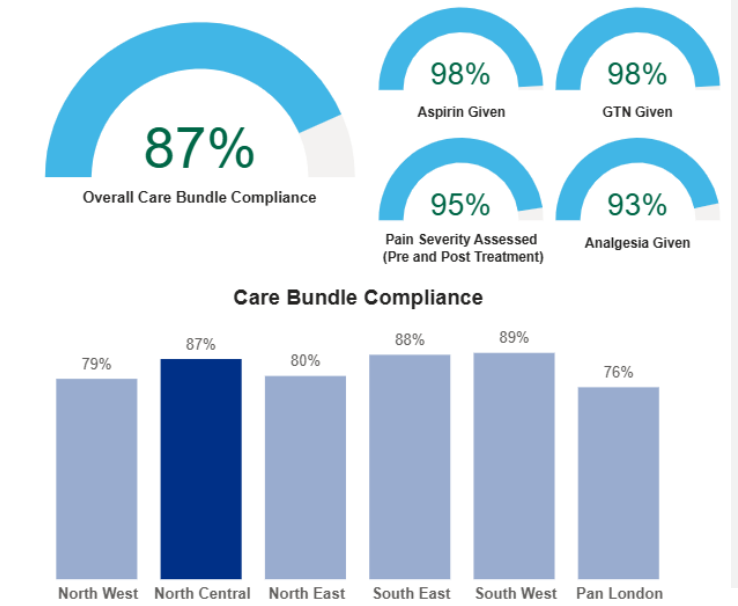
Key Concerns

- Level of overdue incidents
- Level of open learning responses older than 6 months
- Increase in controlled drug incidents in May 2025 and remained high since 2023.
- Cleaning audit not submitted consistently (Mar/Apr)

Recommendations

- Realistic trajectory in place for PDR / OWR / CISO rates
- Review daily drugs audit submissions to ensure submission rates are 95%+
- Review & update overdue risks
- Update risk register to reflect current situation
- Update improvement plan to reflect key concern areas

Stemi Care Bundle Compliance - May 2025



London Ambulance Service
NHS Trust

Risk

Corporate Risk Register & New Risks of Note

We are the capital's emergency and urgent care responders

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

Risks with a total score >15

Data exported from RADAR on 07/07/2025

Reference	Created on	Title	Description	Category	Impact of risk	Status	Current score	Target score
RSK-006	19-Mar-2025	Delayed response at shift changeover	There is a risk of delayed provision of appropriate patient care caused by reduced availability of resources at shift handover, which may lead to patient harm and/or reputational damage if not properly managed.	Impact on the safety of patients, staff or public (physical/psychological harm)	Risk of poor patient outcome or experience as a result of delayed response	Overdue	16	8
RSK-142	10-Apr-2025	Loss of equipment through diversion	There is a risk of loss of equipment caused by diversion which may lead to reduced ability to respond to patient incidents and increased financial pressure due to the requirement for replacements if not properly managed.	Finance including claims		Overdue	20	4
RSK-013	20-Mar-2025	Body armour for operational staff	There is a risk to the safety of operational staff in situations requiring body armour, caused by multiple issues relating to it's quality and availability to the workforce, which may lead to staff harm if not properly managed.	Impact on the safety of patients, staff or public (physical/psychological harm)	Harm to staff who do not have the PPE	Planned	15	5
RSK-014	20-Mar-2025	ECG interpretation	There is a risk of sub-standard quality of care for patients suffering a STEMI, caused by ECGs not being correctly interpreted, which may lead to delayed or non-conveyance to a HAC leading to patient harm and reputational damage if not properly managed.	Impact on the safety of patients, staff or public (physical/psychological harm)		Planned	15	5
RSK-015	20-Mar-2025	Duplicate emergency calls	There is a risk of reputational damage and patient harm caused by the management of duplicate emergency calls process because calls can be duplicated to an already closed call and there is no automatic clinical oversight of multiple 999 calls which may lead to patient harm, delayed responses and reputational damage if not properly managed.	Impact on the safety of patients, staff or public (physical/psychological harm)		Planned	15	3

London Ambulance Service
NHS Trust

CQC & Assurance

londamb.lascqcevidence@nhs.net

We are the capital's emergency and urgent care responders

CQOG date : 17th June 2025

Reporting date = May 2025

Clinical Quality Oversight Group

Quality Regulation and Assurance

Trust Wide Compliance

- 750 overdue incidents (as at 4th June 2025)
- 80% compliance with DoC Stage 1
- 53% compliance with DoC Stage 2
- 21% open learning responses older than 6 months
- 75,64% PDR compliance
- 68,46% OWR compliance
- 81.06% CISO compliance
- 76.72% Stat & Man compliance
- 79.85% Safeguarding L2 compliance
- 79.49% Safeguarding L3 compliance
- 33 risks overdue a review

CQC Preparation

- CQC Briefing to Clinical Quality directorate took place on 4th June.
- Further specific briefings planned for week commencing 16th June and are open to all staff. These sessions will cover requirements/expectations of:
  - Risk
  - IPC
  - Medicines
  - Patient Safety
  - Health, Safety & Security
- Key Concerns & Compliance Packs sent to Heads of Clinical Quality & ADO's on 10th June 2025. Each sector will be required to complete an Improvement Plan by 18th June 2025. This will then be monitored and reported via Sector CQOG updates.
- Concerns log created for the Quality Intelligence & Compliance Team to log soft intelligence that has been gathered. This will then be triangulated against risk registers / incidents etc.
- Framework under development for Strategic Assets & Property and a meeting arranged for 9th July to further develop this.
- Mystery Shopper audit launched focussing on key concern areas. Stations will be visited throughout June.

CQC Update

- Since the last CQOG, LAS has received 7 CQC enquiries. 3 are closed, 4 remain open.
- CQC enquiry themes include:
  - Lack of equipment
  - Maintenance of equipment
  - Learning from complaints
- South Central Ambulance Service received an unannounced 4 day CQC inspection between 6th & 9th May 2025. This is the first known inspection under the new single assessment framework.
- Key areas of focus for SCAS inspection:
  - Medicines
  - Equipment
  - EOC
- East of England Ambulance Service are still waiting for their CQC report from their November 2024 inspection. The CQC identified a backlog of reports that were 'stuck' in their system for technical or process reasons. In January 2025, there was a backlog of 500 – as at 11 May, they had reduced the backlog down to 38 reports.

Compliance

London Ambulance Service NHS Trust

Trust - The reporting period is 01/06/25 – 30/06/25

	Quality Statement	KPI	Target	Last month	Current month	Variation	Improvement
SAFE	Learning Culture	Overdue Incidents	0	750	933	+183	-
		Reported Patient Incidents	-	984	887	-97	
		Reporting Staff Incidents	-	475	447	-28	
		Controlled Drugs Incidents	-	250	241	-9	
		Medication Errors	-	79	44	-35	

	Quality Statement	KPI	Target	Open Incidents	Overdue Incidents	Overdue %
SAFE	Learning Culture	Open/Overdue Incidents	-	2265	183	41.2%

Safe | **Effective** | Caring | Improve | Priority | Owner: RF | Exec Lead: FW

Mandatory Training Compliance

Training Type	Required	Completed	Outstanding	%
Total	166,992	149,679	17,313	89.63%
Display Screen Equipment (3 Years)	3,650	3,300	350	90.41%
Duty of Candour (3 Years)	8,391	8,168	223	97.34%
EPRR Incident Response (Clinical) (1 Year)	5,313	4,678	635	88.05%
EPRR Incident Response (EOC) (1 Year)	789	651	138	82.51%
EPRR JESIP Awareness E-Learning (1 Year)	471	398	73	84.50%
EPRR JESIP Commander Classroom (3 Years)	293	238	55	81.23%
EPRR LAS Operational Commander Foundation (3 Years)	318	246	72	77.36%
EPRR LAS Tactical Commander Foundation Course (3 Years)	30	18	12	60.00%
Equality, Diversity and Human Rights - 3 Years	8,391	8,056	335	96.01%
Fire Safety (2 Years)	8,391	7,915	476	94.33%
Fraud Awareness (No Renewal)	8,391	7,664	727	91.34%
Health, Safety and Welfare - 3 Years	8,391	8,041	350	95.83%
Infection Prevention and Control - Level 1 - 3 Years	8,391	6,866	1,525	81.83%
Infection Prevention and Control - Level 2 - 1 Year	5,439	3,689	1,750	67.82%
Information Governance and Data Security - 1 Year	8,391	8,015	376	95.52%
Medicines Management (1 Year)	5,151	4,641	510	90.10%
Medicines Management (NETS) (1 Year)	146	135	11	92.47%

Training Type	Required	Completed	Outstanding	%
Mental Capacity Act Level 1 (3 Years)	5,280	4,989	291	94.49%
Moving & Handling Level 2 (Load Handling) (3 Years)	481	287	194	59.67%
Moving and Handling - Level 1 - 3 Years	8,391	8,077	314	96.26%
Moving and Handling - Level 2 - 2 Years	5,326	4,875	451	91.53%
NHS Conflict Resolution (England) - 3 Years	5,333	4,834	499	90.64%
Oliver McGowan Training on Learning Disability and Autism Tier 1 (3 Years)	8,391	7,848	543	93.53%
Preventing Radicalisation - Basic Prevent Awareness - 3 Years	8,391	8,061	330	96.07%
Preventing Radicalisation - Prevent Awareness - 3 Years	5,444	5,326	118	97.83%
Resuscitation - Level 1 - 1 Year	8,391	7,066	1,325	84.21%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	169	109	60	64.50%
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	169	109	60	64.50%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	5,189	4,131	1,058	79.61%
Resuscitation - Level 3 - Newborn Immediate Life Support - 1 Year	5,190	4,132	1,058	79.61%
Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	5,190	4,132	1,058	79.61%
Safeguarding Adults & Children Level 2 (EOC/111) (3 Years)	1,473	1,181	292	80.18%
Safeguarding Adults (Version 2) - Level 1 - 3 Years	1,428	1,260	168	88.24%
Safeguarding Adults (Version 2) - Level 3 - 3 Years	5,489	4,636	853	84.46%
Safeguarding Children (Version 3) - Level 1 - 3 Years	1,428	1,260	168	88.24%
Safeguarding Children (Version 3) - Level 3 - 3 Years	5,490	4,636	854	84.44%
Safeguarding Trust Board (3 Years)	12	11	1	91.67%

NB: Data exported from ESR Workforce Dashboard - StatMan Training on 01/07/2025

Training - ESR Workforce Dashboard (requires VPN)

Compliance

NHS London Ambulance Service NHS Trust

Trust - The reporting period is 01/06/25 – 30/06/25

	Quality Statement	KPI	Target	Last month	Current month	Variation	Improvement
SAFE	Safe & Effective Staffing	PDR	85%	75.64%	82.98%	+7.34%	
		OWR	85%	68.46%	69.93%	+1.47%	
		CISO	85%	81.06%	83.75%	+2.69%	
		Vacancy Rate	<5%	5.64%	4.91%	-0.73%	
		Staff Turnover	<10%	8.79%	9.08%	+0.29%	
		Sickness	<5%	6.29%	7.13%	+0.84%	
		Stat & Man Training	85%	76.72%	89.63%	+12.91%	

Safe | Effective | Caring | **Improve** | Priority | Owner | Exec Lead

CQC Enquiries

7 enquiries were raised throughout April 2025 – June 2025, all enquiries have been responded to within the deadline.

No. Received	CQC Reference	Date Received	Response Deadline	Date Responded	Closed/Open	Description of Enquiry
1	CAS-869662-B2D3V7 CRM:001353000179	29/04/2025	N/A	Acknowledgement - 29/04/25 Response - 20/05/25	Closed	Historical allegation of sexual abuse from LAS staff
2	CAS-880470-G7S3M6 CRM:001353000180	20/05/2025	N/A	Acknowledgement - 20/05/25 No response required	Closed	Anonymous concern re creation of senior managerial posts allocated without proper evaluation
3	CAS-881080-P3B4C5 CRM:001353000181	20/05/2025	28/05/2025	Acknowledgement - 21/05/25 Response - 28/05/25	Closed	Anonymous concern re lack of equipment, specifically trolley beds
4	CAS-921787-J6M6T4 CRM:001353000184	03/06/2025	10/06/2025	Acknowledgement - 03/06/25 Response - 10/06/25 Follow up response - 16/06/25	Closed	Anonymous concern re unsafe repair of medical devices
5	CAS-888289-W4F2B1 CRM:001353000186	04/06/2025	11/06/2025	Acknowledgement - 04/06/25 Response - 16/06/25	Closed	Anonymous complaint regarding non-conveyance to Watford General Hospital
6	CAS-728928-R0B6F5 CRM:001353000188	10/06/2025	17/06/2025	Acknowledgement - 11/06/2025 Response - 17/06/25	Closed	Concern regarding investigation and response to previous complaint
7	CAS-926455-X8K1G6 CRM:001353000191	11/06/2025	18/06/2025	Acknowledgement - 11/06/2025 Response - 17/06/25	Closed	Contact post complaint to LAS regarding EOC management of suicidal thoughts.

Annual Meeting in Public

Approval of 2024/25 Accountability Statements:

- 2024/25 Annual Report and Accounts

For Approval

Presented by Fenella Wrigley and Rakesh Patel

• 2024/25 Quality Account

Presented by Fenella Wrigley