Trust Board Meeting in Public

Schedule	Thursday 4 December 2025, 13:15 — 16:00 GMT
Venue	Prospero House, 241 Borough High Street, SE1 1GA and via MS Teams
Organiser	Committee Secretary

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Agenda

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS

1.15pm on Thursday 4th December 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 11 Sept 25	Chair	Approve	Report
	2.2	Action Log	Chair	Review	Report
3. Patient/Staff Story					
1.25	3.1	Staff Story Community First Responder	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 Verbal
3.05	5.5	**Audit Committee Report**	RP	Assure	Report

3.10	5.7	**Digital and Data** 5.5.1 Directors Report 5.5.2 Digital and Data Committee Report	SD CM	Assure	Report
3.20	5.8	**Corporate Director's Report**	ND	Assure	Report
6. Assurance					
3.25	6.1	Board Assurance Framework	ND	Approve	Report
3.35	6.2	Southern Ambulance Services Collaboration (SASC)	CEO	Note	Report
7. For Information					
3.45	7.1	WRES & WDES 2024-2025	RD	Note	Report
3.50	7.2	1. Cardiac Arrest Annual Report 2. STEMI Annual Report 3. Quality Dashboard	FW	Note	Report
8. Concluding Matters					
3.55	8.1	Any Other Business	All	Note	Verbal
4.00	8.2	Date of Next Meeting – Thursday 5th March 2026	Chair	Note	

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 11 September 2025

For Approval

Presented by Andy Trotter

Meeting in Public
LONDON AMBULANCE SERVICE NHS TRUST BOARD OF DIRECTORS
Held at 1.15pm on Thursday 11th September 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
Martin Machray	MM	Non-Executive Director
Bob Alexander	BA	Non-Executive Director *(MS Teams)*
Shera Chok	SC	Non-Executive Director *(MS Teams)*
Sheila Doyle	SD	Non-Executive Director *(MS Teams)*
Karim Brohi	KB	Non-Executive Director
Anne Rainsberry	AR	Non-Executive Director *(MS Teams)*
Jason Killens	JK	Chief Executive Officer
Rakesh Patel	RPa	Joint Deputy Chief Executive and Chief Finance Officer-
Fenella Wrigley	FW	Joint Deputy Chief Executive and Chief Medical Officer
Simon Stewart	SS	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		
Neil Carson	NC	Urgent Care APP- Patient Story item
Nora Hussein	NH	Head of Corporate Governance
Apology for Absence		

1.OPENNG ADMINISTRATION		
1.	**Welcome and Apologies** AT welcomed all present to the meeting. He noted and welcomed attendees to their first meeting of Trust Board in Public, specifically: • JK, Chief Executive • MM, Non-Executive Director • SS, Acting Chief People Officer. He formally recorded thanks to FW and RPa for providing Acting Chief Executive cover during the interim period prior to JK taking up post. He also formally thanked Mark Spencer, former Non-Executive Director, for his contribution to the Trust and for his leadership as Chair of the Quality and Assurance Committee.	
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 12th June 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	**Patient Story – ICC Single Point of Access- Neil Carson, Urgent Care APP** FW introduced NC and set the context for the Patient Story, describing the development of Integrated Care Coordination (ICC) hubs as part of the UEC and NHS 10-year plan, to provide multidisciplinary decision support, access to alternatives to ED, and a senior clinical decision maker working in real time across 999/111 and community pathways. NC presented two cases from North London ICC: Case 1 – Pre-dispatch ICC decision support: • A care home call was initially made for breathlessness/wheeze. • Following ICC clinical call-back, symptoms were not evident; however, significant hypertension was identified in a patient due dialysis that evening. • ICC clinician contacted the treating renal team; agreement reached for dialysis to proceed at home, with BP re-checks post-procedure and at two hours. • BP normalised within the two-hour review window and the patient remained safely at home overnight under care home observation. • GP was informed of the call outcome and plan. Case 2 – Post-dispatch pathway enabling: • A crew attended a patient found on the floor without injury; assessment indicated suitability for a community alternative pathway. • ICC support was sought due to variability in borough pathway criteria and access times. • ICC arranged Urgent Community Response attendance within two hours, enabling safe discharge at scene and earlier ambulance availability. SC requested assurance that patient feedback data would be incorporated into ICC KPI reporting. It was confirmed KPIs were being formalised with ICBs and patient feedback would be included as ICCs moved from pilot into business-as-usual. SD suggested exploring whether ambient voice AI (Tortus) could capture "pathway failure" or access issues through conversation analytics. CM advised the current structured templates do not retain full call transcription, but this could be explored for future development. FW emphasised the importance of linking ICC impact not only to activity reduction and operational benefit but to patient outcomes and experience, reflecting the improved trajectories shown in the cases. The Board noted the Patient Story, welcomed early ICC impact on safe non-conveyance and system flow, and requested continued KPI reporting including patient feedback and outcomes. The Board thanked NC.	
4. CHIEF EXECUTIVE REPORT		

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4.1	**Report from the Chair** AT provided an update, reflecting on summer operational pressures and expressing thanks to clinical, control and corporate teams. He emphasised winter preparedness and the importance of continued system collaboration and alternative pathway development. The Board noted the Chairman's Report.	
4.2	**Report from the Acting Chief Executive** JK delivered his first public CEO report since commencing in post in July 2025. He highlighted: • Returning to LAS after ten years; early priorities on quality, culture, and partnership leadership. • Commemoration of the 20th anniversary of the 7 July 2005 terrorist attacks, noting the organisation's commitment to learning and preparedness. • Extensive engagement across LAS teams and London system partners. • Continued high summer demand across 999/111, including heatwave impacts, with a positive performance trajectory compared to 2024. • Recognition of staff innovation and external award nominations, and the value of staff wellbeing and charity work in sustaining performance. The Board noted the Chief Executive's report.	
5. Director and Board Committee Reports		
5.1	**Performance**	
5.1.1	PC presented a detailed summary of operational performance for May–July 2025, noting sustained high demand alongside multiple heatwave episodes. PC highlighted that: • Category 1 performance remained ahead of forecast and plan; year to date (to 31 July 2025) was approximately 5 seconds below the 7-minute standard. • Category 2 year-to-date performance was 30m 26s, ahead of plan. PC further advised that, as at the date of the meeting, Category 2 performance had improved to below 30 minutes (29m 34s), providing a strong entry position into autumn. • DCA hours were slightly behind plan early in the reporting period; however, resourcing changes over the summer had returned delivery to plan and strengthened winter readiness. • The organisation had achieved a 58% reduction in responses over 90 minutes and a 74% reduction in responses over 120 minutes. PC acknowledged that, whilst long waits remain above desired levels, this represents focused improvement across control and frontline response. • Overall incidents were approximately 5% above forecast, making the performance improvements particularly notable. • Hear and Treat growth and reduced ambulance unavailability time were key contributors to improved performance. PC emphasised continued attention to safe efficiency, including appropriate time spent with patients. • IUC/111 performance remained strong, with average speed to answer and abandonment rates ahead of targets, and continued robust clinical validation of 111 ambulance requests. • Five significant incidents (including gas leaks/explosions, multiple stabbings and a large fire) and one national 111 telephony outage business continuity incident were declared during the period; each was subject to cold debrief and learning capture.	

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	The Board welcomed the trajectory and sought reassurance on winter sustainability, safe Hear and Treat growth, and continued system action on hospital handover delays. The Board noted the report and accepted it as assurance.	
5.2 5.2.1	**Quality** **Quality Report: CMO and Deputy CEO** FW presented a summary under safe, effective, caring, responsive and well-led domains. She highlighted: • Winter review and forward planning: FW advised the winter plan had run until mid-March 2025, supported patient safety during peak demand, and a full review is complete with learning already embedded into winter 2025/26 planning which commenced in July. • Patient trends: respiratory/viral activity and frailty pressures continued to rise. FW emphasised ongoing high mental health demand and noted that around 80% of mental health patients were managed at home, avoiding ED conveyance, as a sign of effective patient-centred care. • Incident reporting and learning: transition to Radar has been completed without reduction in reporting. Priority incident themes remained violence/aggression, equipment failures, and medicines governance. FW highlighted work to strengthen controlled drugs tracking including a new electronic register. • Learning systems: FW highlighted broader thematic approaches to triangulate and spread learning across sectors. • IPC: the 2024/25 IPC programme was completed and compliance with training and hand hygiene has been sustained into 2025/26. • CFR scheme: FW outlined a new LAS-led CFR scheme launched March 2025 following withdrawal of the previous provider.	
5.2.2	**Quality Assurance Committee Report** KB summarised the QAC discussions, emphasising committee assurance and emerging areas of focus: • KB reported that there were no major new matters requiring escalation, and that QAC provides assurance on quality as reflected in performance and quality reporting. • The committee reviewed cyber and digital clinical safety risks, highlighting the importance of integrating clinical and cyber assurance. • QAC discussed prior externally-commissioned audit work, noting quality/timeliness concerns and agreeing that aspects of patient safety assurance will be refocused via new approaches and skills alignment going forward. • KB thanked Mark Spencer for contributions to quality governance during his tenure, which AT echoed.	
5.3 5.3.1	**People and Culture** **Report from the Acting Chief People Officer** SS presented the People and Culture Report. SS presented key highlights: • Resourcing: Workforce fill rate at 98% with a strong pipeline; around 600 conditional offers in progress. Recruitment plan for remainder of year and initial assumptions for 2026/27 in development.	

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	• Employee relations: Growing ER caseload and tribunal activity. New digital tracking introduced to monitor case duration and improve timely progression. Bi-monthly tribunal assurance sessions with AR and RP continue (next in October). • Sickness absence: At ~7%, described as too high. Wellbeing Team refocused to proactive manager/staff engagement for earlier intervention and recovery support. • Winter/vaccination: Winter workforce resilience and vaccination programme update to PCC next meeting. • Digital enablement: Sickness Digital Assistant handling high query volumes (8,000 to date) with 93% accuracy; 40% of use out-of-hours, showing 24/7 value; scope expansion planned. SC asked about national Guardian changes and leadership development impact. It was confirmed LAS FTSU arrangements remain unchanged and recruitment to vacancies continues; leadership programme outcome measures to be strengthened. BA noted workforce gains must be reflected in financial planning; RPa confirmed modelling and internal workforce group oversight.	
5.3.2	**People and Culture Committee Report** AR summarised PCC assurance focus: • 111 call-handling turnover deep dive (mid-30%): retention levers and career pathways into 999/APP roles. • LCW integration learning reviewed to inform future transitions. • Exploratory AI for recruitment long-listing due to application scale; to return with safeguards before any adoption. • PCC agreed 25/26 BAF risks, including a new risk on rising violence against staff.	
5.4	**Finance**	
5.4.1	**Director's Report** RPa provided a summary of the Trust's financial position He highlighted: • The Trust delivered a c.£1.1m year-to-date surplus against plan at Month 4, with a continued full-year breakeven forecast, recognising winter cost pressures and seasonal demand. • Total 2025/26 capital allocation £77m. Spend to July was slightly behind ideal phasing, but RPa confirmed schemes are mobilised and delivery plans are in place across fleet, estates and equipment to ensure full-year spend and benefits realisation. • RPa confirmed a healthy cash balance and active cash management to maintain resilience through winter and capital drawdown. • Strategic emphasis on enabling fleet electrification. External national funding plus Trust investment is supporting substation upgrades, charging rollout and solar installations at stations. RPa reported 4 electric DCAs already operational and further vehicles due by year-end, contingent on estate readiness.	
5.4.2	**Finance and Investment Committee Report** BA took the FIC report as taken as read and provided assurance that the Committee continues to oversee: • delivery of the breakeven plan, • capital programme progress and affordability, and	

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- productivity/efficiency actions supporting winter resilience.
  BA also noted that a previously outstanding SW London arbitration payment had now been received

5.4.3 **Audit Committee Report**

RP summarised Audit Committee assurances:

- Workforce overpayments: recurring control issue; external specialist review commissioned to identify causes and fix controls.
- Internal audit: substantial assurance received on suicide prevention.
- Risk movements: two BAF risks increased—violence/aggression against staff and dependence on commissioned network service.
- Cyber assurance: committee endorsed integrated reporting combining IG, cyber security and resilience/recovery into a single assurance view.

SD added focus on EPR–cyber linkage and preparedness for virtual incidents.

5.4.4 **LAS Charitable Funds Committee**

BA reported and provided assurance that:

- The Charity has a stretch income target of £607k for 2025/26; income to date was £52k by May, with strong momentum from community fundraising (e.g., London Marathon, Landmarks Half, London–Brighton ride).
- Key upcoming events include Dragon Boat Race (rescheduled due to blue-green algae; two teams withdrew, replacements being sought) and London Life Hike.
- Visibility and individual giving are increasing; a Carol Service is planned for 16 December at St Bride's.
- Work continues with the Bank of England toward a Charity of the Year 2026 nomination.
- Public Access Defibrillators: 11/18 BHF PADs installed (others in train) and 4 LAS Charity PADs installed.
- Main risks: meeting the stretch target amid cost-of-living pressures and sustaining delivery of the London Heart Stoppers campaign.
- Committee supported a future Board seminar deep dive on Heart Stoppers/charity work to strengthen trustee oversight.

5.5 **Digital and Data Report**

CM presented the Digital & Data report and highlighted progress on delivery of the strategy:

- Infrastructure and resilience: renewal of core digital infrastructure, including replacement of legacy telephony/MDT and data-centre improvements supporting both 999 and IUC; focus on reducing outages and improving monitoring.
- Data and operational insight: stabilisation of reporting/warehouse capability enabling more reliable real-time performance dashboards for control and operations.
- AI and automation: continued rollout of ambient voice/AI tools and automation to improve clinical and operational productivity, with benefits tracking becoming more formalised.
- Workforce/digital culture: investment in staff capability (training and role redesign), and a developing customer satisfaction approach for digital services.

5.5.1 **Digital and Data Quality Committee Report**

SD summarised Committee assurance and key focus areas:

- AI policy governance: first draft AI policy reviewed; DDC recommended parallel review by PCC and QAC to cover people, safety and quality impacts before final approval.

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	• Digital operating model restructure: major restructure underway (majority of roles affected). DDC requested a deeper review next meeting on risks, mitigations and capability benefits. • Benefits realisation/KPIs: committee noted increasing number of digital/AI projects moving into implementation and stressed need for robust cross-Trust KPIs to evidence benefits and ROI. • ETOC: ongoing priority to resolve system blockers and track progress, given impact on ED flow and handover.	
5.6	**Corporate Affairs – Director's Report** ME presented highlights from the Corporate Affairs report. ME advised that violence and aggression towards LAS staff remains a significant and worsening risk, both locally and nationally. He summarised recent analysis of LAS assault data showing increasing frequency and severity, and described the Trust's response through an Anti-Violence Charter and a 10-point violence reduction plan. This includes prevention activity, consistent reporting, staff support, and pursuit of prosecution where appropriate. ME reported ongoing engagement with health ministers and system leaders across the UK to strengthen national action on violence, including clearer consequences for assaults on NHS staff and improved system-wide prevention. ME noted that violence reduction and wider corporate risks are being kept under active review through committees and reflected in the Board Assurance Framework, ensuring clear oversight and escalation routes. The Board noted the Director and Board Committee Reports.	
6. ASSURANCE		
6.1	**Board Assurance Framework (BAF)** ME introduced the refreshed Board Assurance Framework, noting it had been reviewed by Audit Committee and updated to align with the priorities and risks within the 2025/26 Business Plan. ME advised that the update reflected significant movement across most risks since the start of the year, and that the BAF now incorporated three emerging risks drawn up from the Corporate Risk Register for Board oversight. The Board discussed a point of wording to ensure accuracy, specifically asking that the narrative for risk 1.8 be clarified to reflect the correct scope and impact of the commissioned medical services network risk. ME confirmed this amendment would be made in the next version. The Board approved the updated Board Assurance Framework.	
7. CONCLUDING MATTERS		
7.1	**Any Other Business** No other business.	
7.2.	Date of Next Meeting 4 December 2025.	

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2.2. Action log

For Discussion

Presented by Andy Trotter

TRUST BOARD IN PUBLIC – ACTION LOG – DECEMBER 2025

Meeting	ACTION	LEAD	Due	UPDATE
	No open actions			

3. Staff Story

Community First Responder

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 December 2025
Report from the Chief Executive Officer

Introduction

1. It is now five months since I commenced my role as CEO of London Ambulance Service (LAS). This has been a busy period of meeting staff and spending time with them in their workplaces and on shifts, as well as understanding recent innovations and how well we are working with the wider NHS. I am keen to keep in contact with our people as much as possible and have introduced weekly video updates, monthly Team Talk Live for all staff and launched an ambitious programme of We Are LAS Roadshows with the aim of engaging with our people to hear directly from them about what matters to them.
2. I recognise that all of our teams are incredibly busy, and demand is set to increase further still as we get into the colder months of winter. The roadshows have been designed so that my executive team and I can get out into the organisation and engage with staff from where they work. From Ilford to Bromley and Edmonton to Fulham, we wanted to hear from teams across the capital. We have had a number of rich conversations, with many valuable suggestions and feedback from staff, all of which will directly inform our business planning for the year ahead. We've tackled some knotty issues and had honest discussions about how staff are feeling - and every piece of feedback has been valuable.
3. I am committed to driving forward improvements that ensure our service is the best it can be for our people and our patients.

Engagement with External Stakeholders

4. On 17 October, we were honoured to host HRH The Prince of Wales at LAS HQ. HRH toured our Control Room and met teams in the site, spoke to staff who had been victims of abuse at work and learnt more about how the Trust supports colleagues, and observed a demonstration of some APP training using state-of-the-art technology. Unfortunately, due to prior commitments, I wasn't able to welcome him personally so my immense gratitude goes to LAS Chief Paramedic Pauline Cranmer, Chair Andy Trotter and the stakeholder communications team for making this historic visit a success.
5. The Royal Visit wasn't the only high-profile visit LAS hosted since my last report. In fact, we had an extraordinarily busy couple of months with high-profile stakeholder visits from across the sector, the UK and even the world. This is testament to the positive reputation and profile LAS has built over the years. Those visiting us included Wes Streeting MP, Secretary of State for Health and Social Care, who came to LAS HQ on 16 September. This was my first engagement with a Secretary of State as LAS CEO and we used this

opportunity to showcase how LAS is preparing for winter earlier than ever while we deliver on the priorities of the Government's 10-Year Health Plan to support our people and patients.

6. Since July, the stakeholder communications and wider LAS teams welcomed over 70 external visitors, including:
   a. Luke Taylor MP (Lib Dem, Sutton and Cheam) visited St Helier Ambulance Station and observed a shift on 11 August
   b. Lord Lieutenant of Devon visited HQ on 10 September to meet the crews who saved his life after he suffered a cardiac arrest
   c. Liam Conlon MP (Labour, Beckenham and Penge) visited our SORT site in Beckenham on 25 September
   d. Annabelle Cleeland (an Australian politician and Shadow Assistant Minister for Health for the Victorian National Party) visited HQ on 29 September
   e. Stuart Andrew MP (Shadow Secretary of State for Health and Social Care) visited HQ on 4 November
   f. We also welcomed colleagues from Thailand, Malaysia, Austria, Norway and Taiwan, and a large number of civil servants and NHS England colleagues.
7. In October, we have also successfully secured a charitable donation of £150,000 from the Mayor of London towards installing 200 defibrillators across communities where they are needed the most. This is a significant boost towards our London Heart Starters campaign and a result of many months of engagement with the Mayor's office.

Recognising LAS people

8. It was a huge honour to present The Sovereign's Long Service and Good Conduct Medals at our Celebration of Service event in November to recognise the extraordinary commitment of 70 LAS people who have dedicated a total of 1,700 years of service to the Trust. It was an undoubtedly inspiring and motivational event and my upmost gratitude goes to all those colleagues who reached these milestones. You can read about some of their heroic stories here. This event was the first where we also presented the newly approved medal clasps for 30- and 40-years' service.
9. As you can see, we work hard to recognise our people's achievements. Much of this recognition also comes from external partners, which is particularly significant. We have celebrated many award wins in recent months, including:
   a. Our Start of Shift project, which made it quicker for our crews to get out on the road at the start of their shifts, has won the HSJ Award for staff wellbeing.
   b. Darren Avery, Strategic Workforce Development Manager, received the Inspirational Professional in Adult Education Award, hosted by the Mayor of London, for his work to develop accessible apprenticeship programmes for Londoners.

c. Rakesh Patel, Chief Financial Officer, was named one of the 50 most influential Black, Asian and minority ethnic people in health by the Health Service Journal (HSJ).
d. Our London Lifesavers team won a special recognition award at the Raising Our Youth as Leaders (ROYaL) Global Awards for their work to train almost 20,000 school pupils in life-saving skills.
e. LAS Paramedic Allan Woodhouse was awarded the Greener AHP Award at the Chief Allied Health Professions Officer Awards 2025

10. As a Trust, we also marked Remembrance Day to commemorate those who gave their lives in war, hosting a service outside LAS HQ. We also came together on 9 September to mark Emergency Services Day.

Winter Update

11. This year, we started our preparations for winter earlier than ever before. Over the summer period, we have had London-wide workshops, working with NHS England and our London system partners to agree approaches to ensure we are providing outstanding care for our patients. As a Trust, we've increased the number of people in our Control Room as well as the number of vehicles on the road. We've also increased the number of clinicians who hear and treat patients which helps reduce the pressure at hospitals as we convey less patients. We are also incorporating technology such as AI to support our clinicians save time and care for more patients.
12. We reviewed and increased the Trust's REAP (Resource Escalation Action Plan) level to Level 3 ('Major Pressure') on 13 November. This followed an increase in the number of calls that we are receiving in the 999 system. With this escalation, we are bringing more clinical colleagues to frontline, focus on improving handover delays and review our dispatch criteria, escalation processes and skill matrices to identify what else we can do to support patient care. We will continue to review the pressure the Service is under with further changes to the REAP level remaining a possibility in the future.
13. To help manage demand for our services and provide the best quality patient care, we introduced Category 2 Auto Dispatch in August which has shown an average 4-minute improvement in response times for C2 calls. The new system allocates ambulances in an 'oldest, highest priority' order within a maximum of 12-minute driving time (revised down from an initial 18-minute cap) distance for our crews. We are continuing to listen to feedback from frontline colleagues to shape the use of this technology going forward as we recognise that it has driven a rise in cancellations that we need to continue to work to refine to ensure we have the right balance between improvements in patient waiting times and the workplace experience for our people.

Ongoing charity work

14. The London Ambulance Charity continues to be busy and successful, raising vital funds to support our teams and the communities we serve across the capital. In September, we held our flagship fundraising event the London Life Hike, welcoming 52 supporters and raising £13,500. We've also held the Dragon Boat Race which raised £16,200. The charity team also supported the LAS Football Tournament, which was a fantastic team-building event for teams.
15. I would like to take this opportunity to invite you to Together in Song. Taking place on 16 December at the iconic St Bride's Church, this Christmas carol service presents a night of carols, candles and community. I encourage you to secure your space via our charity website and extend the invitation to your colleagues and families.

Creating an inclusive LAS

16. Earlier this year, we established a LAS Inclusion Board with a view to strengthen the voices of staff and provide a platform for diverse perspectives to enhance the Trust Board's decision-making processes. I had the privilege to join my first meeting in September, where we discussed tackling violence towards staff, career progression and our latest operational context. I look forward to continuing these conversations and working with the Inclusion Board to turn insight into meaningful action that strengthens inclusion, improves staff experience, and supports better outcomes for our patients and communities.
17. On Friday 28 November I was privileged to both sponsor and welcome colleagues to an event hosted at Dockside in support of Islamophobia Awareness Month. The event was designed to raise awareness of the current issues for colleagues and, I hope, demonstrates a genuine commitment from the Trust, that islamophobia or any type of discrimination will not be tolerated. This links to our core values about respecting and caring for each other and our patients and you will have seen in our Anti-Discrimination Charter. This sets out our clear commitment as an organisation to anti-discrimination and the expectations of our colleagues too.

Integrated Urgent Care (IUC)

18. The Board will be aware of recent announcements that the Trust was successful in its bid to operate the North East London (111/IUC) contract. This good news follows significant work by colleagues across the Trust in the preparation of our bid.

19. South East London will commence a procurement process during Q4 2025/26 for their 111/IUC service, which we will be responding to. Our bid development will shortly commence and will be brought through to Trust Board in due course for approval prior to submission.

System engagement – stakeholder perception audit

20. Further to feedback that was received by the Trust from Integrated Care Board Chief Executives earlier in Q3 in response to our draft Board Capability framework submission, we will undertake a wide-ranging stakeholder perception audit during Q4. With around 50 strategic stakeholders being interviewed, this in-depth and independently conducted work will inform activity in our 2026/27 business plan. We will bring the report and corresponding action plan to a Board development session/seminar during Q1 2026/27.

NHS England Medium Term Plan

21. The recently published Medium Term Plan that supports the delivery of the 10-year plan sets out that ambulance trusts are expected to deliver C2 performance of 25 minutes during 2026/27 and 18 minutes from 2028/29. We have commenced scoping work to identify relevant initiatives to enable delivery of these stretching targets.

Operational Demand and Capacity review

22. Commissioned to report in two phases during 2026, this 5 year forward looking strategic demand and capacity review will both provide evidence-based analysis to inform the type of resources we need by hour of day, day of week and geographical location to meet our performance and quality requirements whilst also benchmarking us against other UK and international Emergency Medical Service (EMS) providers to identify deliverable operational efficiency and effectiveness opportunities. This work will also support the delivery of 21 above.

23. Key findings and recommendations will be reported to Trust Board when available during the first half of 2026 alongside a delivery action plan that will be overseen by the Executive Leadership Team.

Evaluation of Team Based working

24. Consisting of three elements, an externally supported evaluation/review of Team Based working will be undertaken during the next six months. Aiming to identify areas for improvement to ensure we offer the best workplace experience to all our people from the investment made in Team Based working, the work will address:

a. Cultural and workplace experience benefits
b. Value and efficiency of investments made
c. Operational and quality effectiveness

5. Director and Board Committee Reports

5.1. Performance

Operational Performance Report

For Assurance

Presented by Pauline Cranmer

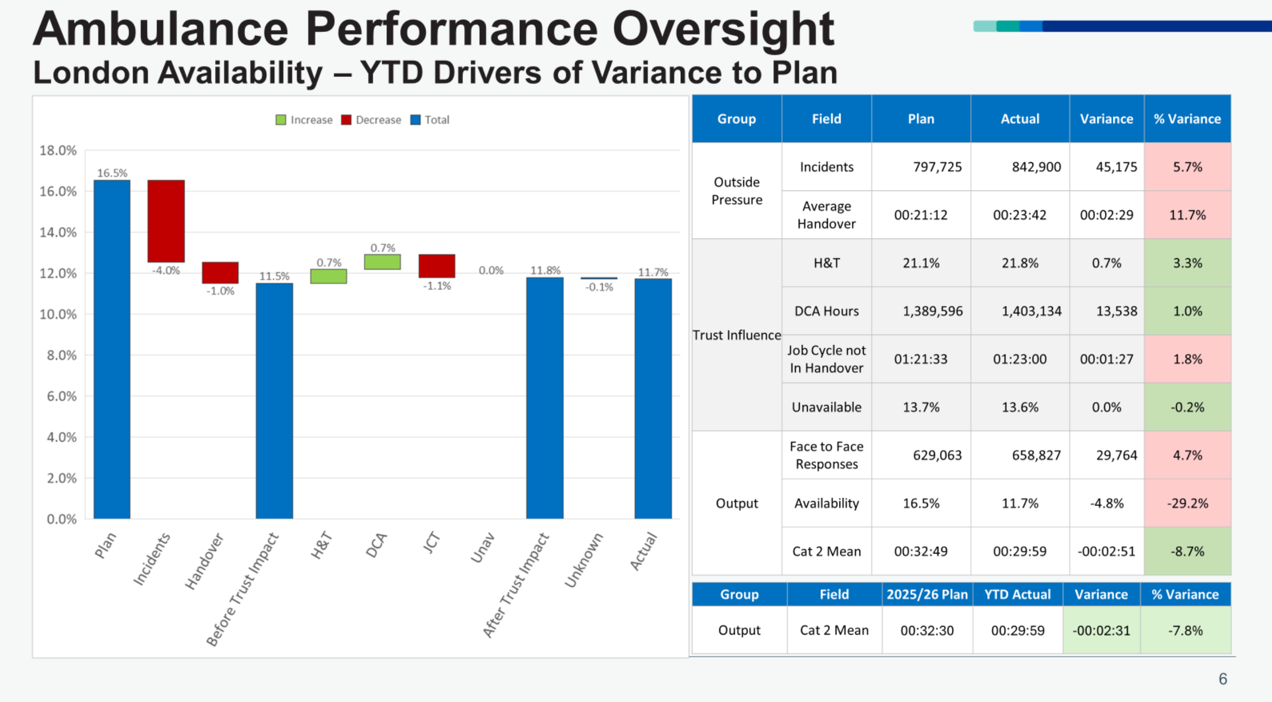
London Ambulance Service **NHS**
NHS Trust

Report To:	**Public Board of Directors**		
Date of meeting:	4th December 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

This Trust Board report covers a summary of performance on key metrics for the period of 1 August 2025 through to 31 October 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 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 October 2025 and any variance therein.



Group	Field	Plan	Actual	Variance	% Variance
Outside Pressure	Incidents	797,725	842,900	45,175	5.7%
	Average Handover	00:21:12	00:23:42	00:02:29	11.7%
Trust Influence	H&T	21.1%	21.8%	0.7%	3.3%
	DCA Hours	1,389,596	1,403,134	13,538	1.0%
	Job Cycle not In Handover	01:21:33	01:23:00	00:01:27	1.8%
	Unavailable	13.7%	13.6%	0.0%	-0.2%
Output	Face to Face Responses	629,063	658,827	29,764	4.7%
	Availability	16.5%	11.7%	-4.8%	-29.2%
	Cat 2 Mean	00:32:49	00:29:59	-00:02:51	-8.7%

Group	Field	2025/26 Plan	YTD Actual	Variance	% Variance
Output	Cat 2 Mean	00:32:30	00:29:59	-00:02:31	-7.8%

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

The number of incidents received continues to be ahead of plan by 5.7% year to date. The LAS dealt with 843,900 incidents to 31 October 2025; 658,749 (4.7% above plan) of which required a face-to-face response by our frontline staff.

Year to date performance of hear and treat was 21.8% and was ahead of plan by 0.7%. The target for hear and treat increased from 21% in quarters 1 and 2 to 22% in quarter 3. In October we delivered 22.3% and therefore remains above target.

The production of DCA hours since the last report has improved since the last report and is now 1% ahead of plan year to date with 1,403,134 hours produced against a plan of 1,389,596 hours.

Unavailable time was on plan, year to date, at 13.6% compared to 13.7%.

The job cycle time (JCT) (excluding hospital handovers), year to date, is now 83 minutes and is 1 minute 27 seconds above plan. This increase in JCT has partially been driven by the introduction by the introduction of auto dispatch for category 2 incidents. However, auto-dispatch on average has delivered a 3 minute improvement in our category 2 mean performance.

The average hospital handover, year to date, is 23 minutes 42 seconds and is above plan by 2 minutes 29 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.

Overall category 2 performance has continued to remain ahead of plan. As of 31 October 2025 the category 2 mean was 29 minutes 59 seconds. This was 2 minutes 31 seconds ahead of year end forecast and remained below the 30 minute national target being sought by NHSE.

Recommendation/Request to the Board/Committee:

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

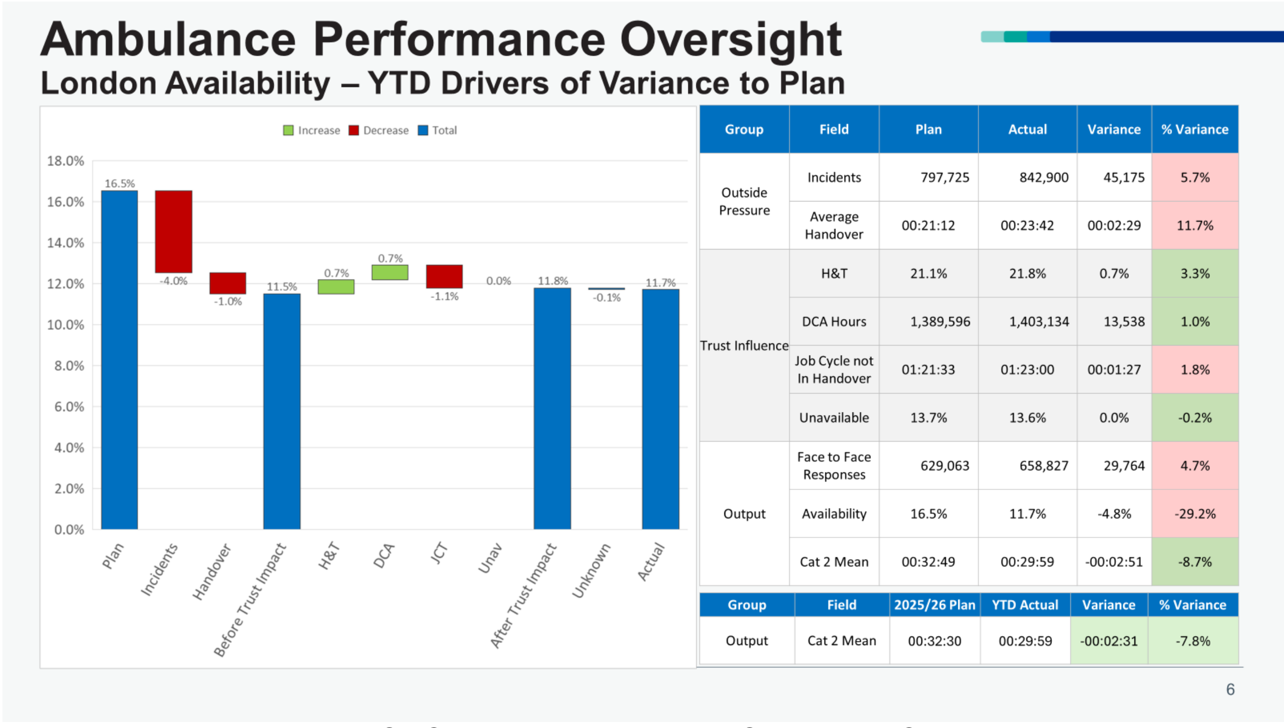
PUBLIC BOARD OF DIRECTORS MEETING
Performance Report – December 2025

This Trust Board report covers a summary of performance on key metrics for the period of 1 August 2025 through to 31 October 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 October 2025 and any variance therein.



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Overall category 2 performance has continued to remain ahead of plan. As of 31 October 2025 the category 2 mean was 29 minutes 59 seconds. This was 2 minutes 31 seconds ahead of year end forecast and remained below the 30 minute national target being sought by NHSE.

2. Performance Metrics

2.1. Call Answering Mean (operating plan metric)

August 2025 Target	10 Seconds	August 2025 Actual	2 Seconds
September 2025 Target		September 2025 Actual	5 Seconds
October 2025 Target		October 2025 Actual	4 Seconds

The LAS continues to exceed the 10 second target contained within the operating plan.

The number of contacts received by the Emergency Operations Centres has continued to be in excess of that seen for the previous year. To 31 October 2025 the LAS had received 1,297,269 compared with 1,208,701 for the same period the previous year, an increase of 7.3%. Figure 2 shows the number of contacts received in each month for August to October 2024 compared to 2025.

Total Contacts	August	September	October
2024	163,091	173,595	182,225
2025	183,012	185,847	195,986
Diff	12.2%	7.1%	7.5%

Figure 2: Number of contacts monthly comparison

The SPC chart shows that the LAS continues to meet the target with common cause variation seen (figure 3).

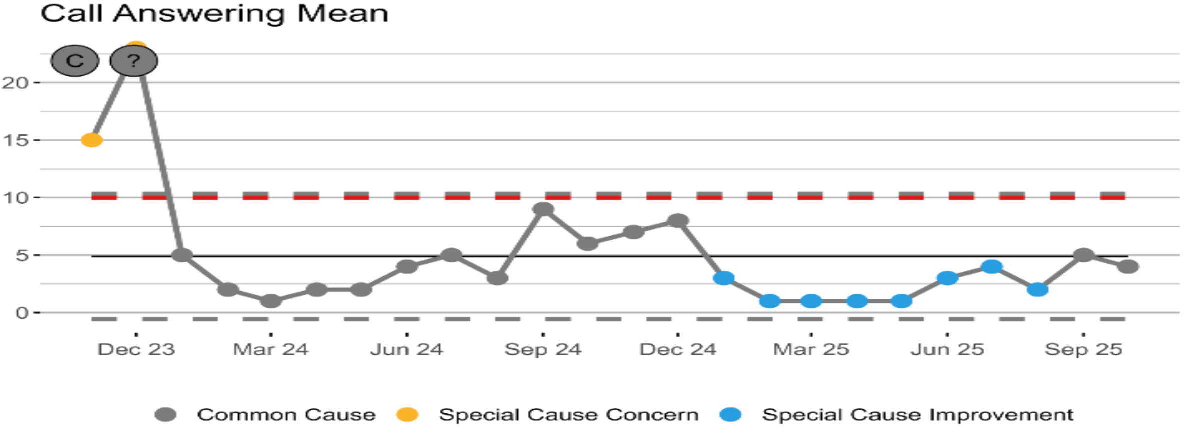


Figure 3: Call answering mean SPC

2.2. Category 1 Mean (supporting metric)

August 2025 Target	7 Minutes	August 2025 Actual	6 Minutes 41 Seconds
September 2025 Target		September 2025 Actual	7 Minutes 08 Seconds
October 2025 Target		October 2025 Actual	7 Minutes 02 Seconds

The LAS, year to 31 October 2025, had a category 1 performance of 6 minutes 55 seconds. This is compared to the national standard of 7 minutes and 7 minutes 21 seconds for the same period the preceding year.

Although the SPC chart shows that the target of 7 minutes has not been consistently met there continues to special cause improvement across the last 2 years, figure 4.

There remains a focus both within Ambulance Operations and 999 Operations to balance the number of fast response vehicles (FRVs) and their effective use to meet the 7 minute national standard. This has continued to look at the job cycle times of FRVs post ambulance arrival and reviews with staff where there has been prolonged time on scene. There continues to be monitoring of dispatch of these resources to ensure that they are targeted to category 1 patients and reducing dispatches to lower acuity patients.

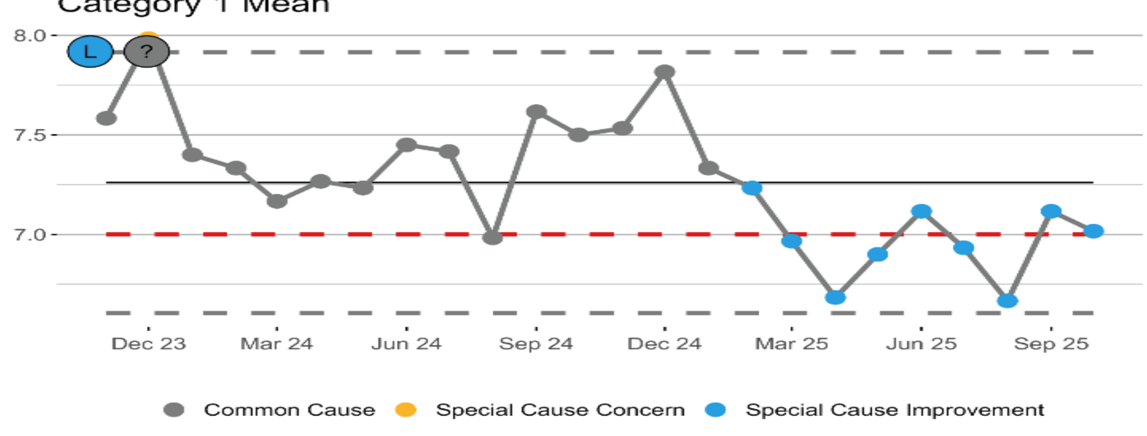


Figure 4: Category 1 Mean SPC

2.3. Category 2 Mean (operating plan metric)

August 2025 Target	27 Minutes 21 Seconds	August 2025 Actual	25 Minutes 53 Seconds
September 2025 Target	33 Minutes 55 Seconds	September 2025 Actual	31 Minutes 36 Seconds
October 2025 Target	33 Minutes 29 Seconds	October 2025 Actual	30 Minutes 33 Seconds

The LAS continues to deliver category 2 performance ahead of the agreed monthly trajectory within the 2025/2026 operating plan. The year to date plan (to 31 October) was set at 32 minutes 49 seconds and actual performance was 2 minutes 51 seconds better at 29 minutes 59 seconds.

In 2024 the category 2 performance for 1 March to 31 October was 37 minutes and 41 seconds. Consequently this year, the LAS has seen an improvement of 7 minutes and 42 seconds.

The statistical process control chart for category 2 (figure 5), continues to show special cause improvement. Although the LAS has not met the national standard of 18 minutes (shown by the red line), it has inconsistently met the national NHSE temporary target of 30 minutes, albeit, the year to date performance is 1 second below this.

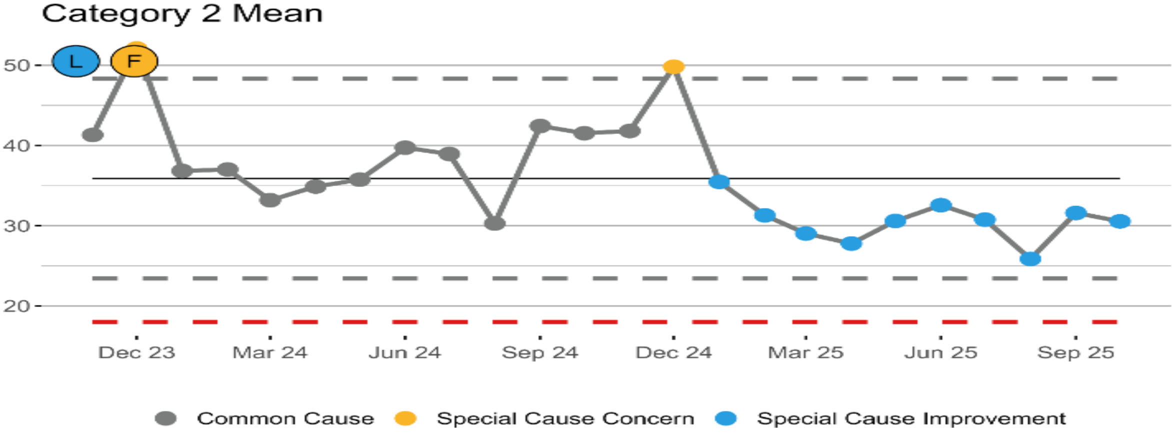


Figure 5: Category 2 mean SPC

2.4. Time to dispatch (supporting metric)

August 2025 Target	45% or less C2 dispatches greater than 20 minutes	August 2025 Actual	26.5%
September 2025 Target		September 2025 Actual	35.8%
October 2025 Target		October 2025 Actual	36%

The LAS has consistently met the target of less than 45% of category 2 dispatches taking more than 20 minutes.

This is a supplementary measure and as running time is normally circa 10 minutes, the more incidents that are dispatched within 20 minutes the greater the opportunity to respond to patients within 30 minutes. Figure 6, demonstrates the improvement in the

dispatch function (compared to the previous year) and this has been driven by the work within 999 Operations as part of its dispatch reset programme.

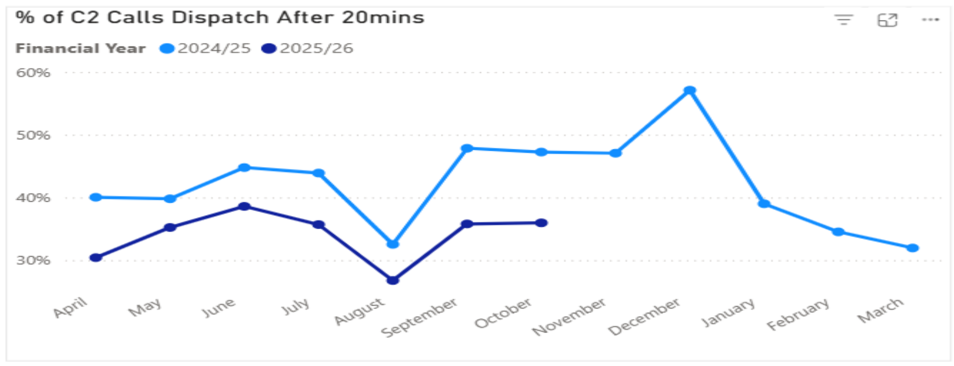


Figure 6: C2 dispatches >20 mins

2.5. Cat 2 Distribution (supporting metric)

August 2025 Target September 2025 Target October 2025 Target	Reduction of C2 tail from previous year.	August 2025 Actual September 2025 Actual October 2025 Actual	53.5% reduction 59.3% reduction 67.8% reduction

The LAS continues to focus on reducing the number of long response times to patients. This ensures better patient outcomes and experience and is directly linked to improving compliance with performance standards.

The work undertaken by 999 Operations to embed dispatch rigour in dealing with longest waiting, highest acuity patients maintains a focus on the category 2 tail and this is reported and monitored within the Quality Assurance Committee.

The following table compares the number of incidents from 1 April to 31 October for both 2024 and 2025, with a breakdown of the months contained within this reporting period. This specifically looks at all incidents which took longer than 90 minutes and 120 minutes.

	April to October 2024	April to October 2025	Diff.	Aug-24	Aug-25	Diff.	Sep-24	Sep-25	Diff.	Oct-24	Oct-25	Diff.
Incidents > 90	31497	12414	60.6%	2327	1083	53.5%	5739	2337	59.3%	5810	1868	67.8%
Incidents >120	12802	3219	74.9%	779	299	61.6%	2553	698	72.7%	2403	466	80.6%

The reduction in the "tail" has continued to improve across the year with a reduction of 60% of incidents taking longer than 90 minutes and 75% longer than 120 minutes. Across the months of this reporting period, the improvement has continued to accelerate with substantial improvements seen in October 2025.

The spread of incidents taking longer than 90 minutes is shown in figure 7, with incidents shown within 5 minute segments.

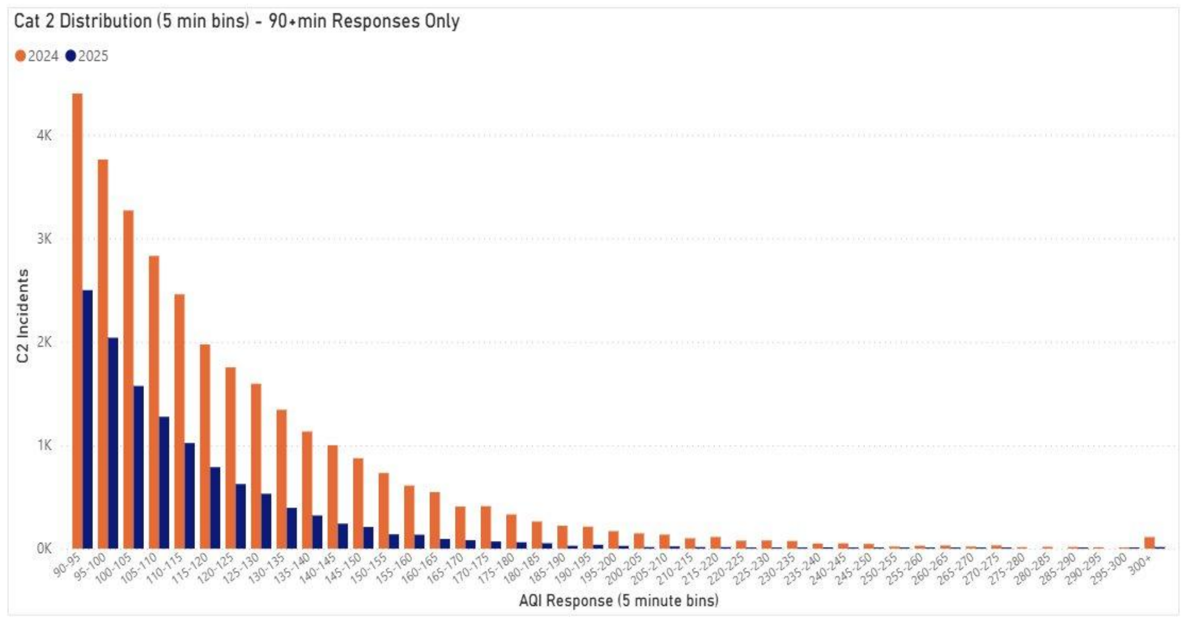


Figure 7: C2 distribution of 90 + minute responses

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

August 2025 Target	1.04	August 2025 Actual	1.05
September 2025 Target		September 2025 Actual	1.08
October 2025 Target		October 2025 Actual	1.08

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 incidents to be as close to 1 resource dispatched as possible.

Figure 8 shows the trend of multiple attendance ratio (MAR) per incident, comparing this year to last. MAR has increased since category 2 auto dispatch was turned on in the last week of August 2025. The auto dispatch system will automatically dispatch resources to a call and may then cancel them if subsequently a more suitable resource becomes available. Each of these dispatches are counted for the purposes of MAR and therefore the increase should be viewed in this context.

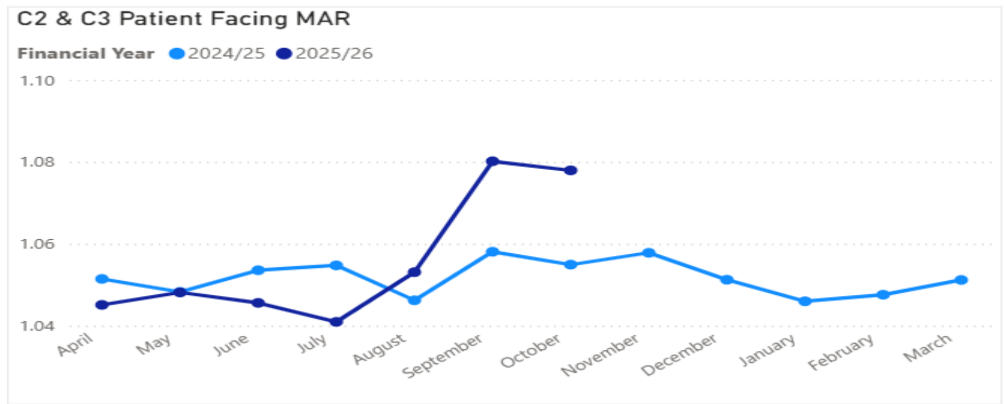


Figure 8: Multiple attendance ratio trend

2.7. Hear and treat (operating plan metric)

August 2025 Target	21%	August 2025 Actual	21.5%
September 2025 Target		September 2025 Actual	22.4%
October 2025 Target	22%	October 2025 Actual	22.3%

LAS continues to be above the operating plan target for hear and treat.

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. This has a positive impact on our response times.

The SPC (figure 9) for hear & treat continues to show special cause improvement. Although no target is specified, performance has remained above the target set out within the operating plan.

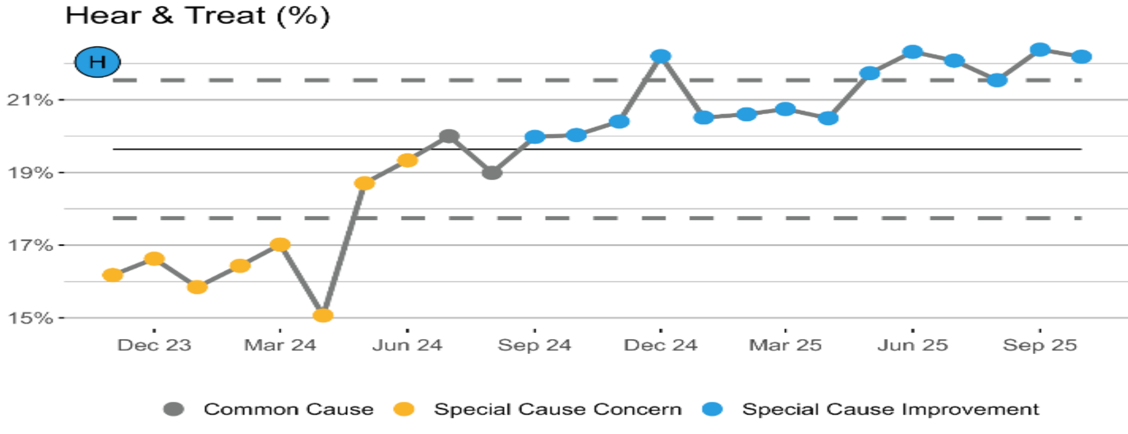


Figure 9: Percentage of hear & treat

2.8. See and treat (operating plan metric)

August 2025 Target	26.2%	August 2025 Actual	26.3%
September 2025 Target	26%	September 2025 Actual	25.2%
October 2025 Target	25.6%	October 2025 Actual	25.1%

As hear and treat has increased to meet the operating plan in September and October, LAS has seen a comparable decrease in the rate of see and treat. Although the target during the period has decreased as well, in line with normal seasonal variation, the target has not been met in the last two months.

The potential for crews to undertake see and treat is reduced as more incidents are dealt with as hear and treat, reducing the need for a face to face response. Overall this is preferential, by meeting patients needs over the telephone, where possible.

The see and treat trend is shown in figure 10 and compares the current financial year with last.

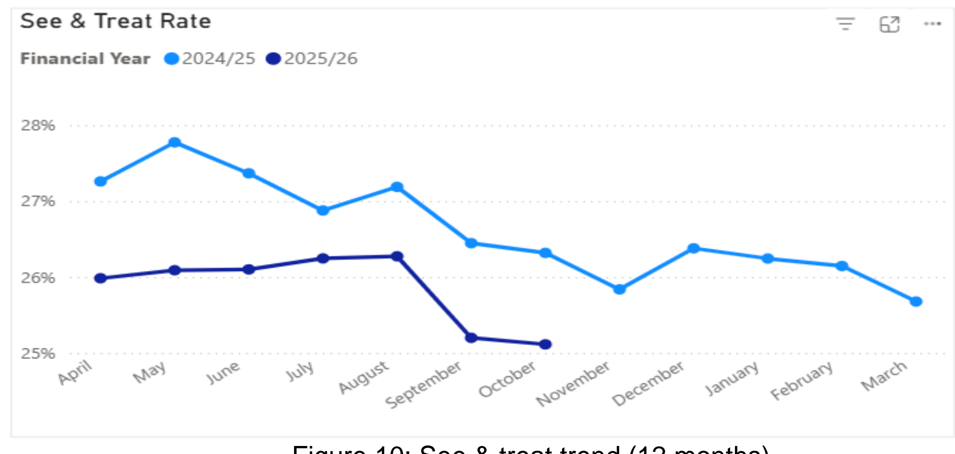


Figure 10: See & treat trend (12 months)

2.9. See and convey (operating plan metric)

August 2025 Target	52.8%	August 2025 Actual	52.2%
September 2025 Target	53.0%	September 2025 Actual	52.4%
October 2025 Target	52.5%	October 2025 Actual	52.6%

As with see and treat, see and convey targets are seasonally adjusted based on patterns seen over the past two years. Although see and convey metrics have been marginally growing, the movement in the target has meant that the target was met in August and September and missed by 0.1% in October.

Comparing see and convey rates with the last financial year shows that the LAS continues to take a smaller percentage of incidents to a healthcare setting. Figure 11 shows the comparative trend for see and convey.

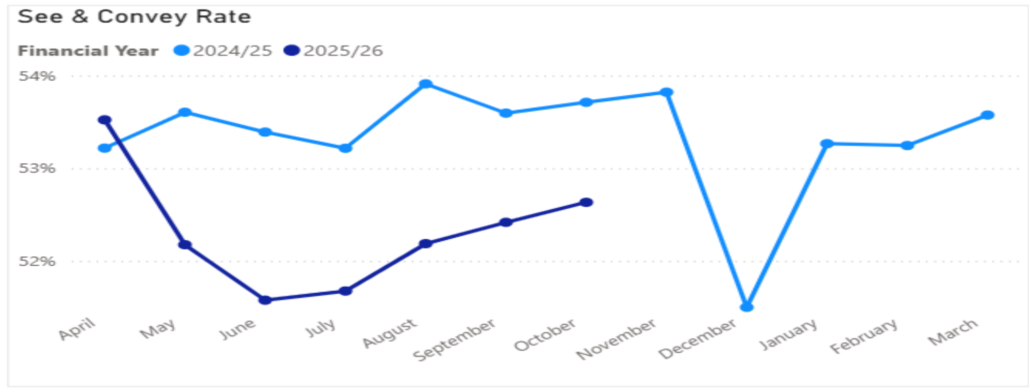


Figure 11: See & convey trend

2.10. Job Cycle Time (operating plan metric)

August 2025 Target	79 Minutes 53 Seconds	August 2025 Actual	82 Minutes 14 Seconds
September 2025 Target	80 Minutes 39 Seconds	September 2025 Actual	86 Minutes 47 Seconds
October 2025 Target	81 Minutes 46 Seconds	October 2025 Actual	86 Minutes 48 Seconds

The target for job cycle time (JCT), excluding hospital handovers, is seasonally adjusted and begins to increase over the autumn and winter periods which is reflective of what is seen each year.

JCT has increased sharply in September and October 2025. This coincides with the introduction of category 2 auto dispatch, which represents the majority of the increases seen. It should be noted, however, that the improvement seen in category 2 response times is, on average, 3 minutes and 18 seconds and outweighs the increase that has been observed in JCT.

999 Operations is continuing to monitor the effect of the auto dispatch function. They are working with Ambulance Operations to find ways in which to mitigate the effect on JCT by refining the rules contained within the auto dispatch function.

As per previous reports, the trend for full JCT is closely monitored and figure 12 shows the continued improvement seen this year compared with last. All aspects of JCT within LAS' control is reviewed at both station and individual level and is a focus of team-based working.

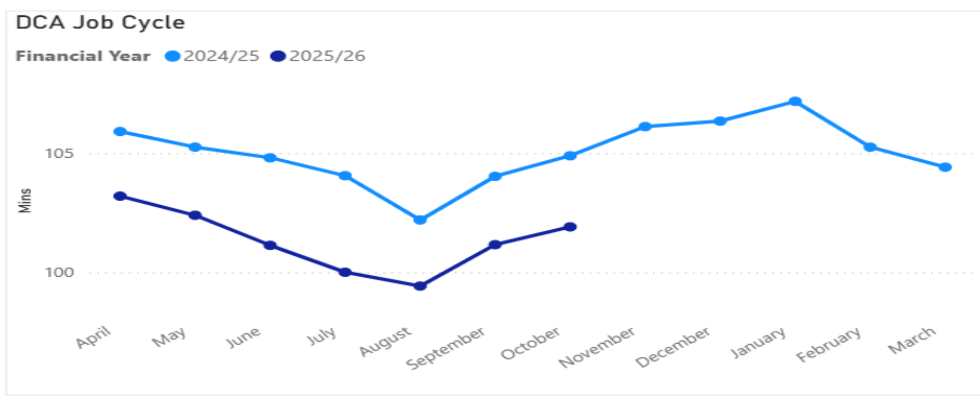


Figure 12: Full Job Cycle Time

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

August 2025 Target	13%	August 2025 Actual	13.1%
September 2025 Target	13%	September 2025 Actual	13.5%
October 2025 Target	13%	October 2025 Actual	13.3%

The unavailable time target has reduced across the year from 15% to 13% where it will remain for the rest of the financial year. The year to date target (to 31 October 2025) in the plan is 13.7% with the LAS delivering 13.6%. However, the target from August to October has been marginally above plan.

The winter delivery cell which commences operation in November 2025 will support focus on out of service across the winter months to help deliver this target.

The out of service trajectory is shown in figure 13 with the split between people and vehicles shown in figures 14 and 15 respectively. In all aspects there has been an improvement in this financial year. The opportunity to deliver further reductions is within people based out of service and this is being driven through team based interventions.

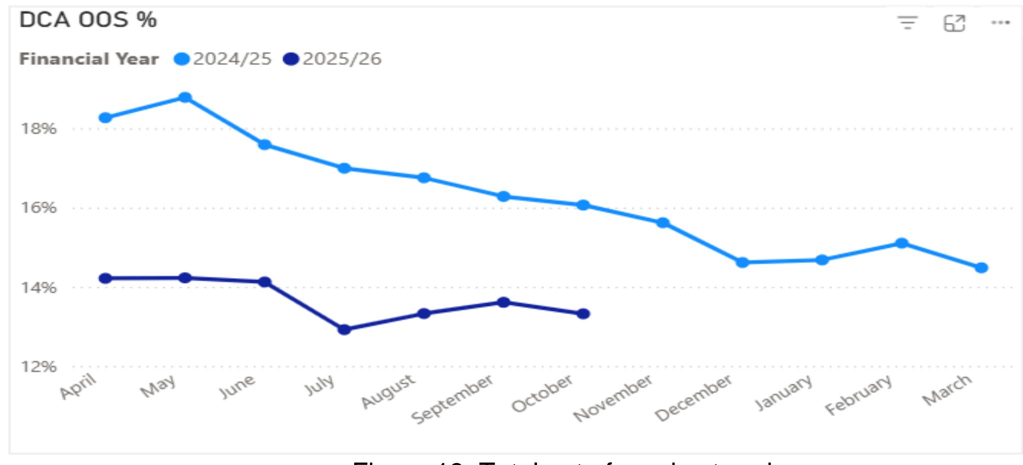


Figure 13: Total out of service trend

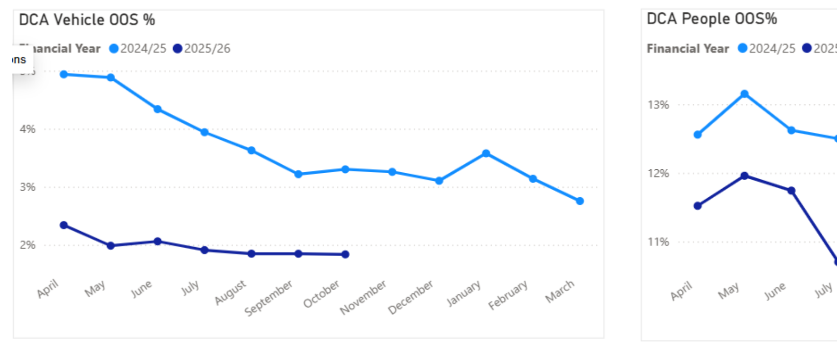


Figure 14: Vehicle out of service trend

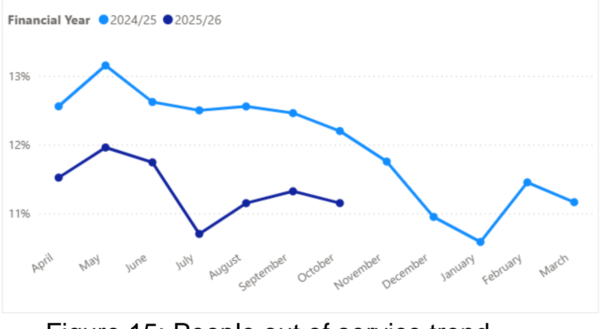


Figure 15: People out of service trend

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

August 2025 Target	20 Minutes 21 Seconds	August 2025 Actual	22 Minutes 55 Seconds
September 2025 Target	20 Minutes 35 Seconds	September 2025 Actual	23 Minutes 32 Seconds
October 2025 Target	20 Minutes 37 Seconds	October 2025 Actual	24 Minutes 33 Seconds

The average hospital handover time remains above the agreed target each month and year to date (to October 2025) is 23 minutes 42 seconds. This 2 minutes 29 seconds above plan. The monthly position has become more divergent from the plan over the last three months and plan versus actual is shown in figure 16 below.

NHSE are holding monthly bi-lateral meetings with ICBs and their providers with regard to actions to bring handovers back within agreed limits. 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.

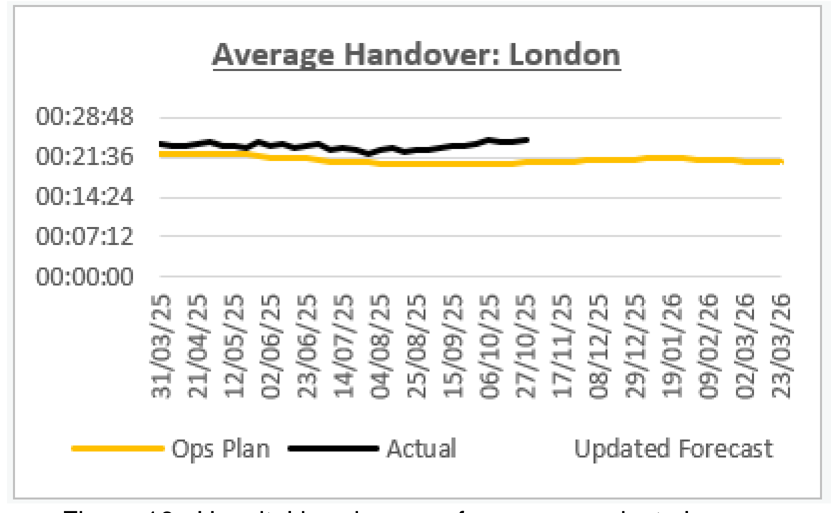


Figure 16: Hospital handover performance against plan

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

August 2025 Target	196,065	August 2025 Actual	203,460
September 2025 Target	194,571	September 2025 Actual	199,346
October 2025 Target	205,563	October 2025 Actual	213,206

Since August 2025 the double crewed ambulance (DCA) hours produced has been above target. The year to 31 October 2025, LAS produced 1,403,134 hours against a plan 1,389,596 hours and was therefore 1% above plan.

The production of Ambulance hours was key to securing the additional growth monies agreed with NHSE and Commissioners.

As part of the deployment of the local delivery model, Ambulance Operations teams are closely monitoring and maintaining delivery of DCA hours to ensure that LAS maintains its current response time performance for all patients.

The trend on the production of hours is shown in figure 17 below.

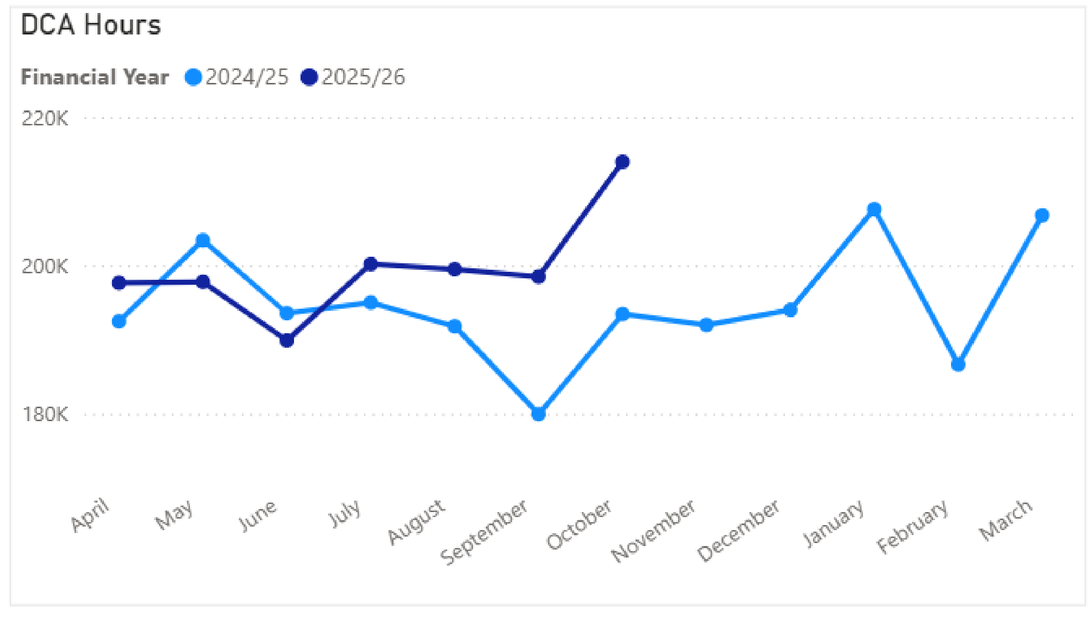


Figure 17: Deployed DCA hours

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

August 2025 Target	42,108	August 2025 Actual	38,302
September 2025 Target	40,293	September 2025 Actual	34,920
October 2025 Target	43,338	October 2025 Actual	37,054

The operating plan numbers for Fast Response Vehicles (FRV) were based on a flat projection taken from the previous years production. Since the start of this financial year the LAS has resized the number of FRVs deployed to ensure that the balance of DCAs have been correct and that category 1 response times can be maintained in line with the national standard.

Throughout this financial year FRV production has been lower than stated in the operating plan although seasonal variability has been maintained.

The improvement in category 1 response times over the last financial year has been achieved through ensuring that FRVs are dispatched appropriately to category 1 patients and ongoing monitoring of their effectiveness. The Ambulance Operations teams continue to review resourcing plans on a weekly basis and ensure that this group is adequately resourced to meet demand.

The trend for the last 2 financial years in FRV produced hours is shown in figure 18.

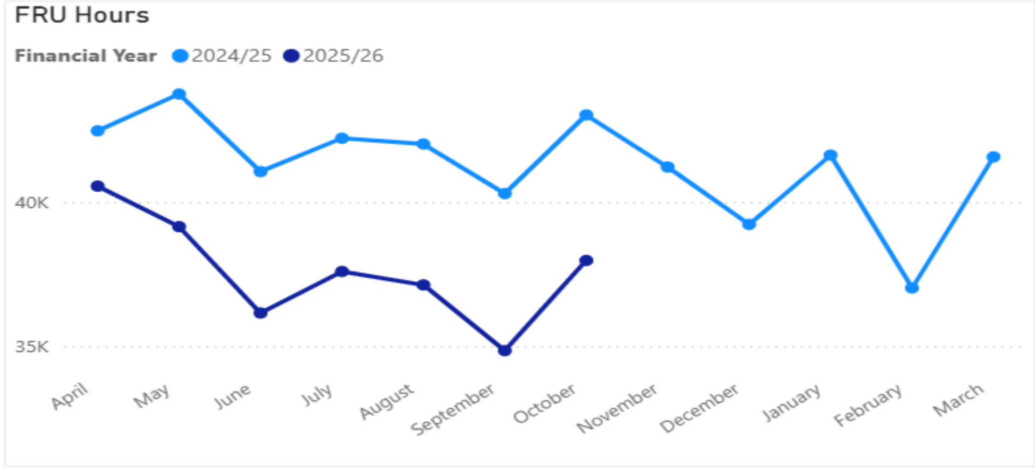


Figure 18: Deployed FRV hours

3. Integrated Urgent Care Balanced Score Card Metrics

3.1. 111 Star 5 utilisation

* 5 volume	No target	August 2025 Actual	2575
		September 2025 Actual	2528
		October 2025 Actual	2952

* 5 ringback time	30 Mins. Crew on scene 60 Mins. Patient call backs	August 2025 Actual	1686 secs (28 mins)
		September 2025 Actual	1513 secs (25 mins)
		October 2025 Actual	1609 secs (27 mins)

In August, 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, 2,361 (August), 2,427 (September) & 2,702 (October) 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 continuing to work 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%	August 2025 Actual	74%
	60%	September 2025 Actual	78%
	60%	October 2025 Actual	80%

Priority 2 % in time	60%	August 2025 Actual	56%
	60%	September 2025 Actual	56%
	60%	October 2025 Actual	62%

Priority 3 % in time	60%	August 2025 Actual	54%
	60%	September 2025 Actual	52%
	60%	October 2025 Actual	56%

In August 2025, LAS handled a total of **56,103** cases within the Clinical Assessment Service (CAS). Of these:

- **9,331** were Priority 1 (P1)
- **34,159** were Priority 2 (P2)
- **6,020** were Priority 3 (P3)

In September 2025, LAS handled a total of **55,635** cases within the Clinical Assessment Service (CAS). Of these:

- **9,092** were Priority 1 (P1)

- **33,826** were Priority 2 (P2)
- **5,806** were Priority 3 (P3)

In October 2025, LAS handled a total of **59,905** cases within the Clinical Assessment Service (CAS). Of these:

- **9,922** were Priority 1 (P1)
- **36,674** were Priority 2 (P2)
- **6,270** 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 ring back 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%	August 2025 Actual	2.04%
		September 2025 Actual	2.38%
		October 2025 Actual	1.97%

Average time to ans.	20 seconds	August 2025 Actual	5.2 secs
		September 2025 Actual	5.2 secs
		October 2025 Actual	5.2 secs

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

In August, 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%	August 2025 Actual	98.6%
		September 2025 Actual	98.9%
		October 2025 Actual	99.6%

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 August 2025 alone, the LAS IUC team **avoided 16,448 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%	August 2025 Actual	75.2%
		September 2025 Actual	73.4%
		October 2025 Actual	75.4%

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.

In August 2025 alone, the LAS IUC were able to divert **75.2%** of all ED Validations away from ED by managing cases through telephone consultation, treatment by senior clinicians, and onward referral where clinically appropriate

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	August 2025 Actual	00:10:08 (608 Seconds)
		September 2025 Actual	00:10:10 (610 Seconds)
		October 2025 Actual	00:10:25 (625 Seconds)

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.

October has seen an increase in AHT. The increase is noted predominantly within the agent "Talk Time", where complexities relating to primary care presentations have increased. These pathways are generally longer in algorithm and lead to increased DoS scrutinisation and selection times in finding the right service for the patient, thereby increasing call length (AHT).

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

During the period of August, September and October 2025 there have been 2 declared Significant incidents.

On 4 September 2025, the Trust responded to a road traffic collision where a double decker bus struck a number of pedestrians. 17 patients were treated in total, of which 15 were conveyed and 2 were discharged at scene.

On 8 September 2025, the Trust responded to a release of pepper spray, which was discarded in a bin, inside Terminal 4 at Heathrow airport. A total of 23 patients were conveyed to hospital.

As with all declared Significant Incidents, a hot debrief was conducted immediately after the conclusion of the incident and a feedback form circulated to all staff involved, including those from Operations, the Tactical and Specialist Operations Centres in EOC and the command team.

During this period there have been 3 business continuity (BC) incidents.

On 18th August 2025, there was a national outage of the LifeX software, which is utilised for the radio positions in our 999 control centres. The failure had started the evening before, resolved and then reoccurred that morning. 9 other Ambulance Trusts affected. The London Ambulance Service declared a BC incident, the BC plan was enacted and after 3 hours the issue was resolved.

On 28th August 2025, the LAS declared a BC incident due to the evacuation of the Croydon 111 facility, following a fire alarm activation. This was a false alarm and staff returned to duty promptly. The BC plan was enacted, with 111 calls transferred to our Barking facility.

On 6th September 2025, there was a national LifeX outage across multiple Ambulance Trusts and the LAS declared a BC incident. The BC plan was enacted and the issue was resolved one and a half hours later.

On 13th October 2025, there was a national Vodafone outage, during which the LAS declared a BC incident. The outage impacted the electronic patient care record (ePCR) system and Trust mobile phones. The BC plan was enacted with staff utilising the offline mode in the ePCR system.

5.2. Quality

For Assurance

5.2.1. Quality Report

For Assurance

Presented by Fenella Wrigley

Report to:	Trust Board			
Date of meeting:	4 December 2025			
Report title:	Quality Report			
Agenda item:				
Report Author(s):	Dr Fenella Wrigley			
Presented by:	Dr Fenella Wrigley			
History:	Quality Assurance Committee (September and November 2025)			
Purpose:	X	Assurance	☐	Approval
	X	Discussion	X	Noting

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

This document is a comprehensive quality report presented to the Board of Directors in December 2025, focusing on the London Ambulance Service (LAS) performance and quality of care during September and October 2025.

It covers four key domains: Safe, Effective, Caring, and Well-Led, providing detailed insights into clinical demand, safety incidents, clinical performance, health inequalities, integrated care coordination, and quality improvement initiatives.

1.0 Safe

1.2 Mental Health Care

Mental health demand has risen by 97% over two years, exceeding projected call volumes for the financial year. LAS has developed a new electronic Patient Care Record (ePCR) tab to support structured mental state examinations and collaboration with mental health providers.

1.3 Right Care, Right Person (RCRP)

The RCRP framework, now implemented by City of London Police.

1.4 Safety Incidents – 999

In August and September 2025, 1996 patient safety incidents were reported from 368,859 contacts (0.5%). The top incident categories were violence, aggression and abuse, medicines management, and medical equipment issues.

1.5 Safety Incidents – 999 Clinical Hub

Patient safety incidents in this area remained low, with 6 incidents in September and 8 in October, mostly with no harm.

1.6 Safety Incidents – Integrated Urgent Care (IUC)

In September, 235 incidents were reported (2% increase from August), mostly no or low harm. Frequent issues included communication concerns with external providers, call handling

deficiencies such as inconsistent worsening advice and insufficient clinical probing, and security-related incidents.

1.8 Learning from Deaths

In quarter two of 2025-2026, 217 stage one Structured Judgement Reviews (SJRs) were completed, with 83% requiring no further action. Themes inform training and the Clinical Services Review for 2026/2027

1.9 Medicines Management

The 2024-2025 Controlled Drugs Accountable Officer Annual report presented to Quality Assurance Committee showed ongoing commitment to governance and patient safety, with year-on-year audit improvements.

1.10 Safeguarding

Safeguarding training compliance exceeds the 85% target across levels. The Child High Intensity User (CHIU) process was launched in November to support children with frequent contacts through collaboration with system partners.

1.11 Health, Safety and Security

Between March and September 2025, 58 RIDDOR incidents were reported, with manual handling as the leading cause (59%). FFP3 fit testing compliance is 72% and ongoing testing is being supported by over 100 trained fit testers.

1.12 Infection Prevention and Control (IPC)

The 2024-2025 IPC Annual Report presented to Quality Assurance Committee assures compliance and progress.
Winter preparedness guidance was shared in October.

2.0 Effective

2.1 Clinical Performance Indicators (CPI)

CPI audits evaluate care for eight patient groups and documentation. A new feedback function personalises audit data for individual clinicians, allowing for reflection and support where needed.

2.2 Clinical Ambulance Quality Indicators

May 2025 national data showed cardiac arrest Return of Spontaneous Circulation (ROSC) at hospital arrival at 28.2% (national 28.4%), and 48.8% in the Utstein group (national 55.2%). For STEMI patients Call-to-angiography time averaged 2 hours 29 minutes, slightly above the national average.

2.3 LAS Cardiac Arrest Data – August 2025

In August, LAS attended 993 cardiac arrests with 333 resuscitations commenced. ROSC was achieved in 47%, with 32% sustaining ROSC to hospital handover.

2.4 Chain of Survival

Survival improves with early recognition, CPR, and defibrillation, often delivered by volunteers such as Community First Responders and London Lifesavers. The London Lifesavers has delivered a further 93 sessions, including community events and partnerships with organisations like British Islamic Medical Association and London Zoo.

The Heart Starters campaign targets “defib deserts,” focusing on residential areas where 75% of out-of-hospital cardiac arrests occur. The Mayor of London pledged £150,000 to support this initiative.

2.5 Volunteers

The Community First Responder (CFR) is expanding with monthly training courses planned.

2.6 STEMI

In September 2025, 298 patients had suspected ST-elevation myocardial infarction (STEMI) with 98% taken directly to Heart Attack Centres.

2.7 Emergency 999 Call Handling Quality Audits

The Trust exceeded 999 call audit targets, maintaining ‘Ace in Good Standing’ status.

2.8 111 / IUC Quality Audits

Mandatory audits achieved 100% completion in September with compliance rates between 91-98%.

2.9 Clinical Audit and Research

2024-2025 annual cardiac arrest and STEMI reports were shared with the Quality Assurance Committee. Cardiac arrest survival rates have improved to the highest in six years, though bystander CPR rates declined. STEMI care showed faster response times but longer on-scene times.

3.0 Caring

3.1 Health Inequalities

Reducing health inequalities is a priority - resources to support access to NHS services, maternity safety, sickle cell disease, and social issues have been developed.
The ‘Toolkit for Tackling Health Inequalities’ has been completed by 69% of clinical staff.

3.1.1 Sickle Cell Disease

3 of the 4 acute sickle cell units are now open to patients conveyed by LAS.

3.1.2 Maternal Health

Significant ethnic and socioeconomic disparities exist in maternal mortality. A maternal health improvement plan is under development.

3.2 Integrated Care Coordination

Three Integrated Care Coordination (ICC) Hubs are operational, delivering reduced ambulance dispatch and emergency department attendances.

4.0 Well-Led

4.1 Quality Regulation

The Quality Intelligence & Compliance Team has developed a Quality Compliance Framework mapping evidence and risks. Micro-teach sessions and newsletters promote quality standards and share learning.

4.2 Quality Improvement

A Rapid Process Improvement Workshop in October 2025 targeted improving crews' return to base times at the end of shift. A 90-day improvement plan is underway with ongoing measurement and scale-up decisions.

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

For discussion, assurance and noting

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

Meeting in Public of The Board of Directors – December 2025
Reporting on September and October 2025 data

This report focuses on the quality of care provided by the London Ambulance Service (LAS). The Trust's Quality Assurance and Improvement Dashboard report contains the September and October 2025 data provides an overview of the quality performance through relevant key performance indicators (KPIs) and information including the quality improvement agenda across the organisation.

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 using 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 (MH) demand continues to rise and has increased by 97% over the past 2 years. We have already exceeded projected call volume for patients with MH conditions for this financial year.

The Core Skills Refresher on Mental Health Assessment is being delivered.

A bespoke new electronic Patient Care Record (ePCR) Mental Health Assessment tab has been designed and testing completed. This new assessment tab will support crews to assess and document a structured mental state examination and risk formulation and will provide a framework for collaborative conversations with Mental Health Providers.

Mental Health Joint Response Cars (MHJRC)

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

Team Output	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Total Shifts Covered	175	161	202	183	199	179	201	200	186	172
Daily Cars (Month average) - target 6	5.65	5.75	6.52	6.10	6.42	5.97	6.48	6.45	6.20	5.55
% of shifts covered	94.09%	95.83%	108.60%	101.67%	106.99%	99.44%	108.06%	107.53%	103.33%	92.47%

JPS By Resource	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Whole Team	4.18	4.73	4.51	4.74	4.89	5.28	4.96	4.83	5.04	4.76

Team Activity	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Monthly Utilisation	79.10%	77.20%	81.71%	78.70%	82.58%	85.40%	84.51%	80.59%	84.10%	85.24%
Activations	890	934	1143	1100	1132	1078	1232	1204	1125	1062

There have been no upheld complaints, patient safety incidents or quality alerts for this reporting period for the MHJRC.

The team have continued to deliver training to ambulance complexes, emergency operations centre staff and clinical hub staff. Over the past year there have been 75 training sessions delivered to staff across the Trust.

There is work underway to ensure that LAS clinicians providing care to patients suffering a mental health crisis can access and refer into mental health services.

1.3 Right Care, Right Person (RCRP)

RCRP has, since the last report, been implemented by the City of London Police. London Ambulance Service continues to work closely with the Metropolitan Police Service (MPS) to embed the framework. While RCRP is now business as usual for the MPS, LAS has retained an escalation process to ensure patient and staff safety. 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. Learning is shared at joint partnership meetings – the most recent of which was in September 2025.

1.4 Safety incidents – 999

In August and September 1996 patient safety incidents were reported against a total of 368,859 patient contacts – this equates to 0.5%.

This number of reported incidents 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 North West and South East sectors continue to raise the highest number of incidents which reflects the size of the sector and associated call volume.

Most incidents reported are recorded with a no (1691) or low (216) harm severity grading. The number initially reported as moderate (34), severe harm (24) and death (29) remained above the mean during this reporting period.

15 learning responses were commissioned during August and September 2025: 4 are being investigated as nationally defined incidents requiring local patient safety incident investigation, 10 as after-action reviews and one through a Multidisciplinary Team (MDT) review.

The top three categories for the reporting period are as follows and the associated actions taken:

- *Violence, aggression and abuse* (534 cases reported to date which is an increase of 179 since the last report) – actions underway include the set-up of a violence reduction working group under Chief Paramedic, trial of different body worn cameras which fit onto uniform better and additional support into the violence reduction team to support staff.
- *Medicines Management including Controlled Drugs* (508 cases reported to date which is an increase of 6 since the last report) – these incidents relate to administrative documentation and a small number of breakages. There have been no reported cases of diversion of Schedule 2 drugs. Following a formal procurement process, a contract was signed with System C in March 2025 to implement the 'CD Manager' system, developed by Modeus. The system is expected to reduce documentation errors, improve governance, increase operational efficiency, and ease administrative workload across clinical and pharmacy teams.
- *Medical Equipment (any equipment used with a patient during a care episode, including ambulance equipment bags)* (422 cases reported to date which is an increase of 2 since the last report). Specific task and finish groups are addressing commonly reported equipment issues.
    - Concerns around availability and malfunction of the monitors (Life Pak 15) availability was a regularly reported concern. Through the working group the concern around LP15 has dissipated and non-availability is now < 1%. There are a small number of incidents raised around LP15 but this is now more focused on functionality rather than availability. To reduce the risk of technical malfunction the Strategic Assets and Property team continue to undertake a proactive service schedule.
    - The trolley bed task and finish group was established in August 2025 to implement a tested and reliable solution that evidences an increase in trolley bed availability on ambulances across the Trust ahead of Winter pressures and to reduce patient safety incidents caused by delays when crews do not have

trolley beds (if they have had to leave them as part of the handover process). A trial has begun whereby trolley beds in the North East have been given a bar code, which, when scanned and assigned a location on the Central Asset Management System (ProCloud) will allow viewers/users of ProCloud access to live location data.

1.5 Safety Incidents – 999 Clinical Hub

The number of calls reviewed and streamed by the Clinical Hub has remained high, averaging 62,000 per month during August – October 2025. This equates to around 77% of all Category 2 to Category 5 999 calls. The number of clinical assessments conducted by the Clinical Hub has averaged 27,000 per month between August and October which equates to around 30% of all Category 2 to Category 5 999 calls.

Patient Safety Incidents have remained consistently low, with 6 incidents reported and reviewed in September and 8 in October. Of these, 12 were reviewed by the multidisciplinary Patient Safety Incident Panel (PSIP) team, and, post-review, it was agreed that there was no harm. 1 incident met the threshold for a Patient Safety Investigation (PSI) under the national framework, with an After-Action Review undertaken. There is 1 case pending further information to inform a decision from the PSIP team.

1.6 Safety Incidents – Integrated Urgent Care (IUC)

A total of 235 incidents were reported in September, representing a 2% increase from August. 232 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:

- *Communication/Clinical 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 contacts from community teams. These issues are systematically escalated through the quality alert process and 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.
- *111/IUC Call Handling*
  - Worsening advice – not all elements of worsening instructions were consistently communicated.
  - Active listening skills – ensuring patient concerns are fully explored and understood.
  - Breathing difficulties – insufficient probing questions recorded in some cases, highlighting the need for continued focus on comprehensive clinical assessment.
- *Security, Violence, Aggression and Abuse*

There has also been an increase in the number of complements with 3 received in September, showing a recognition of the good work completed by our staff.

1.7 Overdue incidents

The sector teams are responsible for the oversight of incidents reported on Radar. To support sector teams, training is delivered monthly by the patient safety team. Further to this, dashboards have been created on Radar to provide sector teams and clinical quality teams with enhanced oversight.

Currently, there are 723 overdue local review workflows on Radar (34.7%). The local review workflow must remain open until all other workflows and event tasks have been completed. Of those 723 overdue local reviews, 117 have overdue violence reduction unit workflows and 62 are overdue whilst being assessed against the Patient Safety Incident Response Framework (PSIRF).

1.8 Learning from Deaths

Where incidents require a Learning from Death (LfD) review, if they meet the nationally defined criteria, an enhanced investigation, called a Structured Judgement Review (SJR), 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.

Throughout quarter two 2025-2026, 217 stage one SJRs were undertaken. If concerns are identified during the first-stage review, a second stage review occurs for validation. Throughout the same review period, 72 stage two SJRs were completed.
Of the 217 stage one SJRs, 83% of these required no further action or locally delivered feedback.

The themes across SJRs include but are not limited to, the documentation of critical observations and timely escalation, recognition of cardiac abnormalities within ECGs, ambulance response time and documentation of care advice and risks explained. In addition to individual feedback, these areas are being covered in local team training and will form part of the CSR 2026/2027.

1.9 Medicines Management

The Controlled Drugs Accountable Officer Annual report was presented to Quality Assurance Committee – the report provides assurance to the Board of the Trust's continued commitment to Controlled Drugs governance and patient safety, in line with regulatory requirements. The report provides an executive summary of Controlled Drugs audit activity conducted across Quarters 1 and 3 of the 2024 - 2025 financial year within the Trust. The audit programme was intentionally structured with a gap between cycles to allow operational teams and sector quality leads sufficient time to respond to findings and implement improvements. This cyclical approach supports a responsive and sustainable quality assurance process. The audit outcomes from Q1 and Q3 indicate measurable year-on-year improvements in compliance across multiple sectors. These improvements reflect the positive impact of targeted interventions, collaborative working between pharmacy and governance teams, and ongoing staff training.
The Midazolam Patient Group Direction (PGD) has been updated to reflect national guidance.

1.10 Safeguarding

Trust safeguarding assurance is overseen by the Safeguarding Assurance Group (SAG), which reports to the Clinical Quality Oversight Group (CQOG) and then to the Trust Board via the Quality Assurance Committee (QAC). External scrutiny is provided by safeguarding designates from Brent ICB, who attend SAG. The Trust produces a quarterly report through the Safeguarding Health Outcomes Framework (SHOFT), which is submitted to Brent ICB on behalf of all London ICBs.

Electronic safeguarding referrals have now been successfully embedded within the Trust for a full year marking a significant step forward in efficiency and quality. Collaboration with Doc-Works, our platform provider, remains strong as we continue to listen to feedback from users to develop Phase 2 enhancements. These improvements will introduce additional mandatory fields; enhancing the quality of referrals, with implementation planned for early next year.

Safeguarding training compliance has demonstrated good progress. Trust-wide compliance is now above the commissioned target of 85%. This means that for each level the Trust is now above the required target; although work continues with individual departments where they are below the target or are being supported with the development of long-term plans.

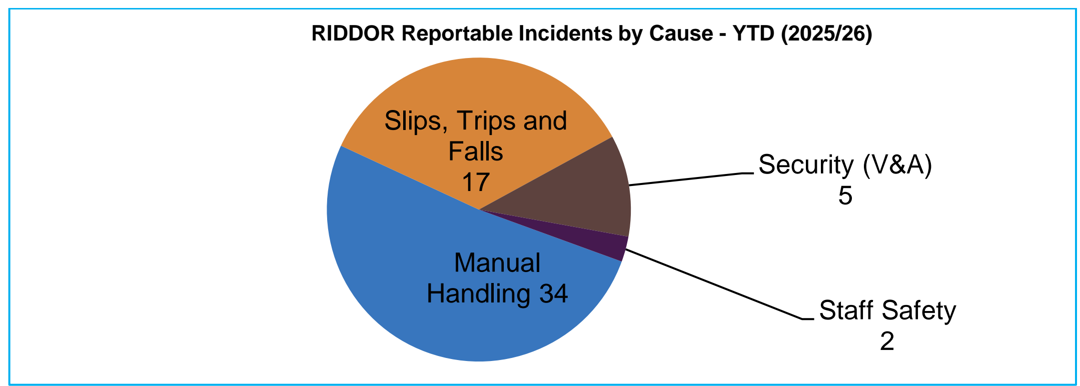
Data correct: November 2025

Safeguarding Level 1	89.24%
Safeguarding Level 2	88.07%
Level 2 EOC	93.23%
Level 2 111	84.04%
Level 3	90.13%

In early November, the Trust launched the Child High Intensity User (CHIU) process. This programme includes a dedicated CHIU Specialist working full-time to review cases where children under 18 have four or more contacts per month. The specialist will collaborate with GPs, primary care services, local authorities, and safeguarding partners to address unmet needs and reduce the risk of abuse and neglect. This development has been received well by LAS staff and importantly by clinicians receiving this additional information. Further updates on this initiative will be provided in future board reports.

1.11 Health, Safety and Security

A total of 58 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents were reported to the Health and Safety Executive (HSE) between March and September 2025. Manual Handling Incidents account for the highest number (59%) of RIDDORs reported across the Trust during this period.



The current compliance for FFP3 fit testing is 72% due to the 2-year revalidation period. Over 100 staff members have now been trained as ‘Fit Testers’. Two weekly reports are sent out to all areas of the Trust, with compliance being monitored centrally and by Location Group Managers (LGM).

1.12 Infection Prevention and Control (IPC)

The Annual Report for Infection Prevention and Control has been shared with Quality Assurance Committee providing assurance about compliance and actions.

The Quarter 2 (July - September) of the 2025/26 Infection Prevention and Control (IPC) annual work programme is complete. The Infection Prevention and Control Committee continues to oversee progress against trajectory for completion.

IPC Training compliance was reported at 78% for level 1 and 57% for Level 2 (Trust target- 90%).

Overall, Trust compliance for hand hygiene was reported at 98% - data is provided by local teams. This exceeds the Trust performance target of 90%.

In October, Make Ready six-weekly vehicle deep clean compliance was reported at 76% DCA and 60% overall service wide. The Trust performance target has been slightly adjusted to 90%, this will bring further alignment to National Cleaning Standards. Action recovery plans led by Make Ready services are in place, however challenges remain with staff vacancies, which continue to impact this compliance.

Premises cleaning compliance was reported at 95%, which met the Trust's target of 90%.

Winter preparedness information and guidance was shared in mid-October to align with Infection Prevention and Control Week.

2.0 Effective

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

2.1 Clinical Performance Indicators (CPI)

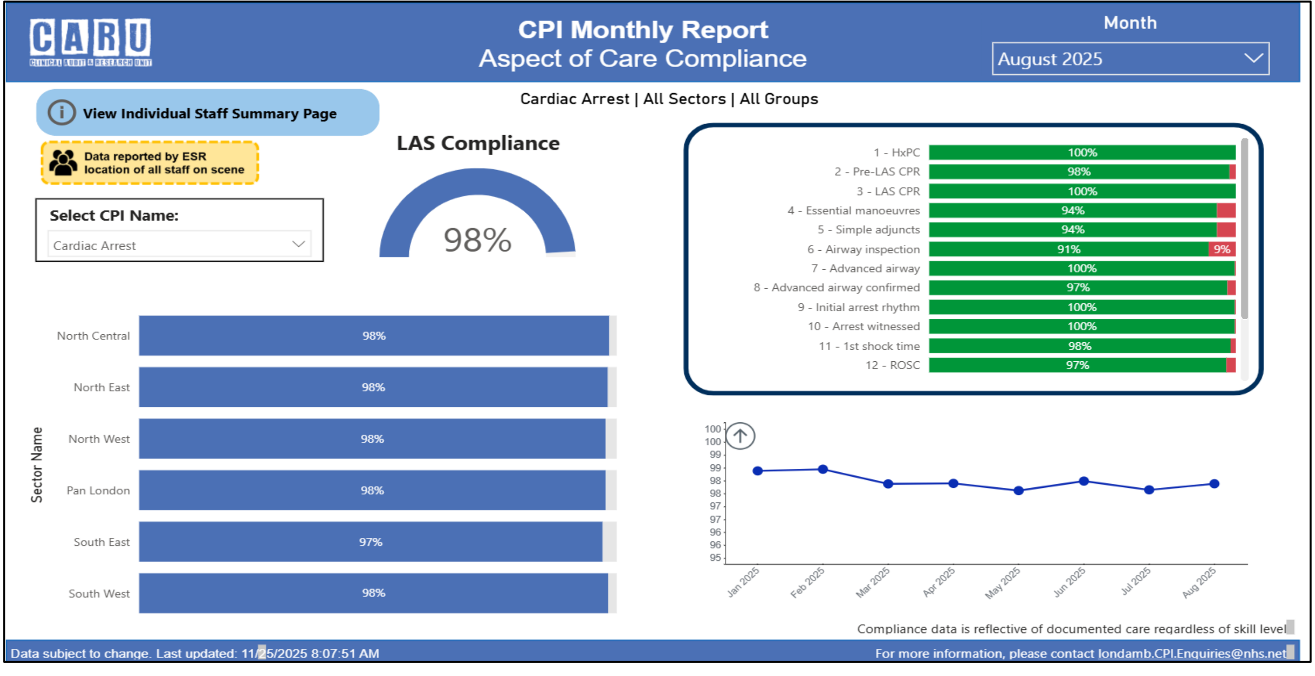
The Clinical Performance Indicators (CPI) are a tool used to continuously audit the care the Service provides to 8 different patient groups, as well as general documentation.

The new CPI feedback function has been launched which:

- Assigns audit data to all attending clinicians to recognise their contribution to patient care
- Is personalised based on skill level and time spent on scene
- Allows clinicians to review compliance before receiving feedback
- Enables clinicians to save reflections,
- Provides managers with compliance overviews and trend insights.

In August 2025, 73% of available CPI audits were completed. Overall compliance ranged from 75% to 100%. The compliance for Older Fallers CPI was 87% and Cardiac Arrest was 98%.

Where compliance is lower the Sector Clinical Quality teams provide feedback and support.



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 a routine delay in receiving complete national patient data, with clinical outcomes for May 2025 being published on 9 October 2025.

In May 2025, 28.2% of patients in cardiac arrest had ROSC on arrival at hospital (compared to the national average of 28.4%). In the Utstein comparator group for ROSC at hospital handover, we achieved 48.8% (compared with a national average of 55.2%).

For 30-day survival, LAS achieved 8.6% (national average 10.1%) and in the Utstein group at 30.2% (just below the national average of 33.7%).

The LAS recorded an average time of 02:29* for the call-to-angiography measure. This is one minute longer than the national average of 02:28.
**Based on MINAP data which may not be a complete sample and subject to change during the revision period*

For stroke patients, LAS recorded an average call-to-hospital arrival time of 01:23**. Although this was quicker than the national average of 01:29. We were ranked in third place for this measure.
***This is based on SSNAP data which is subject to change during the revision period*

2.3 Cardiac Arrest data – August 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 August 2025 cardiac arrest data shows:

- 993 patients in cardiac arrest were attended by LAS and 333 patients had resuscitation commenced
- The median time from 999 call to dispatcher assisted basic life support (chest compressions) was 3 minutes and 54 seconds
- The mean response time was 5 minutes and 43 seconds
- Mean time from LAS arrival on scene to first defibrillation was 4 minutes
- ROSC was achieved in 47% of patients with 32% sustaining ROSC to hospital handover

2.4 'Chain of Survival'

Improving Survival from Out of Hospital Cardiac Arrest (OHCA)

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.

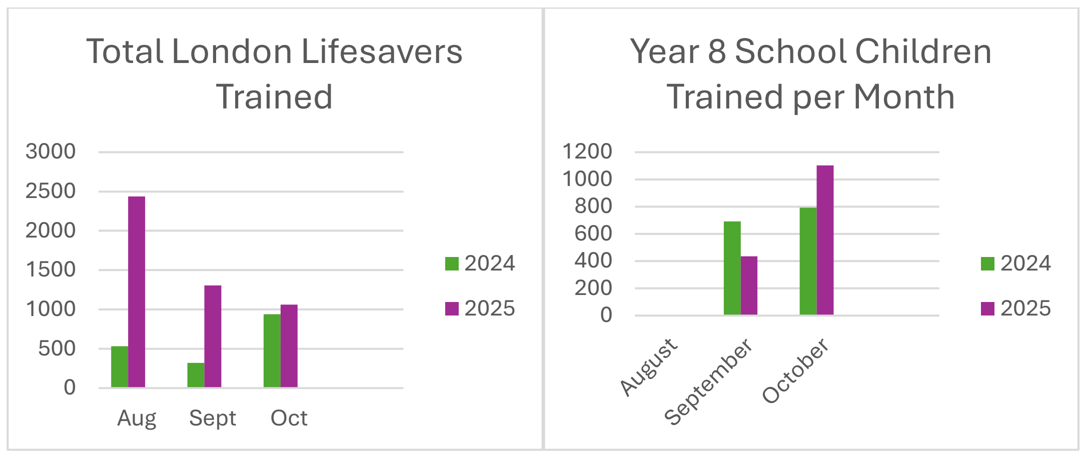
These vital interventions are often delivered by our volunteers including Community First Responders, Emergency Responders, GoodSam responders and London Lifesavers. In many cases the swift actions of bystanders can mean the difference between life and death. To strengthen community resilience, we continue 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.

London Lifesavers

This quarter marked a significant milestone for our public engagement and lifesaving initiatives. We delivered 93 sessions, the highest number since the inception of both campaigns, reaching more Londoners than ever before.
We focused on delivering a coordinated programme during the summer holidays when schools were not open.

- Mass Event at Battersea Park: Celebrated 60 years of LAS, showcasing CPR and early defibrillation benefits, alongside the evolution of our service.
- London Zoo Partnership: Hosted 5 events, training 879 visitors in lifesaving skills.

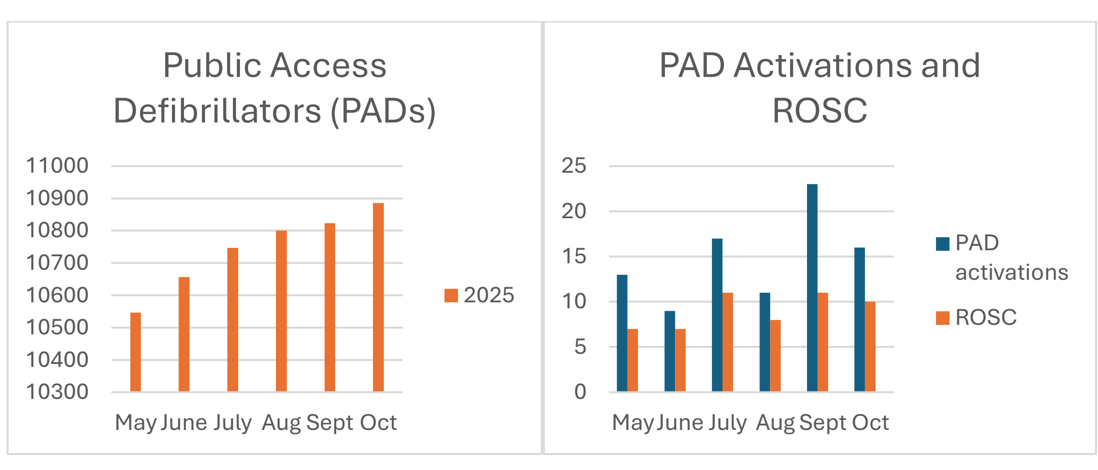
- BIMA Collaboration: Supported the British Islamic Medical Association's annual lifesaver events in mosques nationwide, delivering training to local communities.
- Restart a Heart Week: Conducted multiple events to raise awareness and skills.



Heart Starters
We have identified 150 priority areas, known as "defib deserts" where public access defibrillator (PAD) coverage is below expected levels and are addressing these through our London Heart Starter's campaign. 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.

Defibrillator Deployment
All British Heart Foundation (BHF) donated defibrillators have now been placed. We celebrated partnerships with homeless centres, gifting 38 refurbished PADs to shelters across London supporting some of our most vulnerable citizens.

Funding and Support
The Mayor of London has pledged £150,000 to the Heart Starters campaign, alongside in-kind support to identify suitable PAD locations – reinforcing London's commitment to tackling health inequalities.

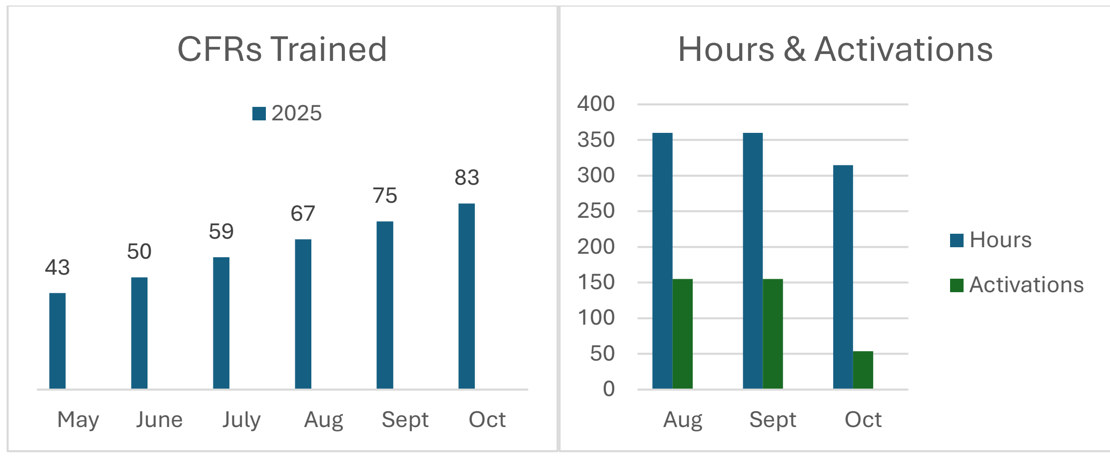


Volunteers
On 28th March 2025 we launched our new Community First Responder (CFR) scheme designed to improve outcomes for our most critically ill patients by ensuring trained volunteer responders arrive ahead of an ambulance when possible.

The scheme began with 11 responders, primarily tasked to attend cardiac arrests. 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 the 2025 -2026 year, focusing recruitment efforts in areas with the greatest need. Beyond the emergency response, CFRs will play a key role in enhancing community resilience by providing targeted health advice and support within local communities.

We are steadily increasing our CFR volunteer numbers by holding monthly training courses.



2.5 STEMI

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.

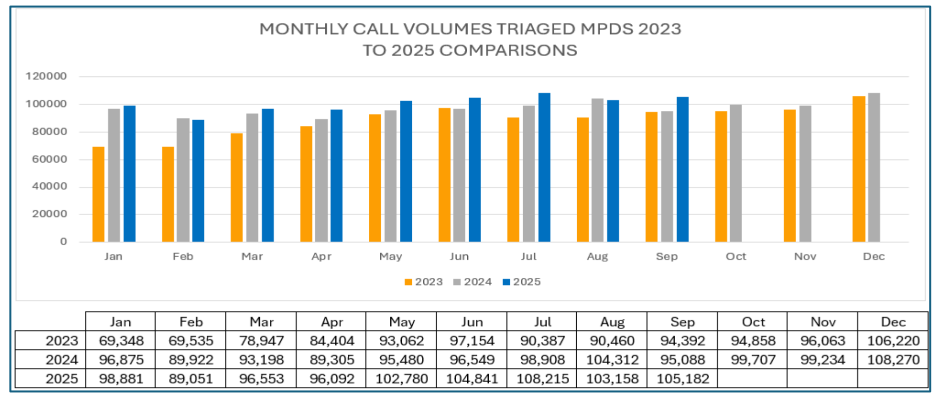
Our most recent data show:

- In September 2025, 298 patients attended by LAS clinicians had a ST-elevation myocardial infarction (STEMI) suspected
- For 99% of these patients, an electrocardiogram (ECG) was uploaded to their clinical record
- 99% of the patients were transported to the appropriate destination, with 98% taken directly to a Heart Attack Centre

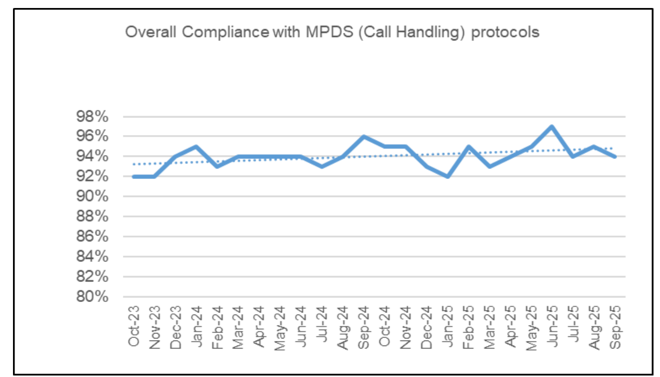
- 84% of patients received the full care bundle, and 94% received analgesia when indicated
- The average time from call to hospital arrival was 1 hour and 25 minutes

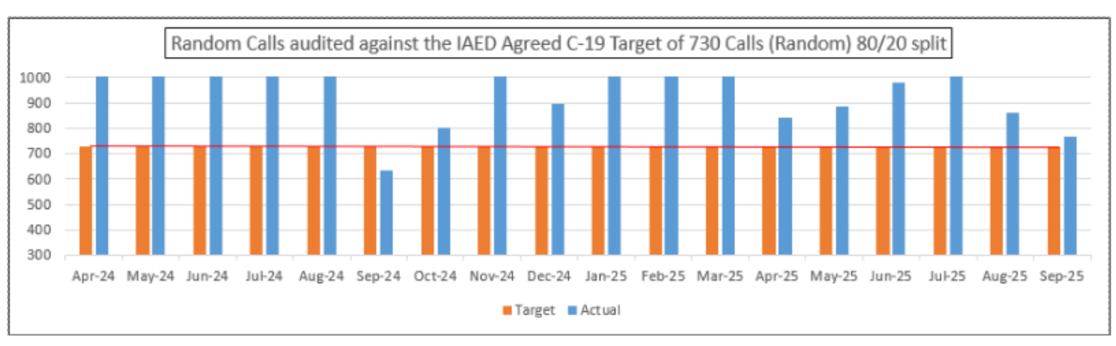
2.6 Emergency 999 Call Handling Quality Audits

The number of 999 call audits has exceeded the required target, and the Trust has remained an ‘Ace in Good Standing’. The quality assurance team achieved the mandatory audit volumes to ensure that the 999 Emergency Operations Centre (EOC) call handling reaches the required International Academies of Emergency Dispatch (IAED) compliance standards. In addition, Quality Assurance (QA) Managers have continued to support the EOC Team Based Working huddles and training days to support the learning and development of staff. There were 105 new incidents logged in September for QA (Legal, Communications, Patient Experience Department, Governance) alongside the routine random and focussed and recontact audit volumes required, a 58% increase of the same period last year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	69,348	69,535	78,947	84,404	93,062	97,154	90,387	90,460	94,392	94,858	96,063	106,220
2024	96,875	89,922	93,198	89,305	95,480	96,549	98,908	104,312	95,088	99,707	99,234	108,270
2025	98,881	89,051	96,553	96,092	102,780	104,841	108,215	103,158	105,182			





2.7 111 / IUC Quality Audits

All mandatory audits across all skillsets achieved 100% completion in September, with an exceptional compliance rate of 91–98%. This demonstrates good clinical governance and sustained commitment to maintaining high standards of practice across the service.

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.

Since the last report we have published two annual reports – cardiac arrest and STEMI and a clinical audit in Midazolam administration. All of these were shared with the Quality Assurance Committee.

The annual cardiac arrest report showed survival rates for out-of-hospital cardiac arrest in London continue to improve, reaching its highest level in six years. This positive trend may be linked to the continued enhancements we have observed in our response across several key areas, including faster call answering and reductions in call-to-arrival times. Of concern are the declining bystander CPR rates which are now at their lowest for 5 years.

The STEMI report also demonstrated good levels of care. While response times are almost 10 minutes faster than they were two years ago, on-scene times have continued the upward trend observed over the preceding five-year period. To support efforts in reducing delays on-scene, CARU identifies incidents where ambulance on-scene times exceed 30 minutes to enable local review and action. There had been a notable improvement in the administration of analgesia, increasing from 83.3% in 2023/24 to 87.9% this year.
As in previous years, most patients were transported directly to specialist HACs to ensure rapid access to advanced interventions such as primary percutaneous coronary intervention (pPCI), commonly referred to as angioplasty.

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.

- We recruited 70 patients into clinical trials, bringing us to 392 patients enrolled into the SIS study and 322 into CRASH-4. Newham group station opened for recruitment to CRASH-4 in September, bringing the total open stations to 32.
- 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 400 patients.

3.0 Caring

3.1 Health Inequalities

Reducing health inequalities across London remains a Trust priority. 30 of the 100 actions (across the 5-year plan) have been completed. 3 of the 5 large improvement projects have been scoped, and a fourth is about to launch for patient engagement (Learning Disabilities and Autistic People).

Multiple practical resources to support patients and clinicians to address health inequalities have been launched, including how to access NHS services info (translated), maternity safety info (translated), Sickle Cell patient information, Making Every contact Count (MECC) services for smoking cessation, drug and alcohol addiction and homelessness.

A clinical education package 'Toolkit for Tackling Health Inequalities' has now been completed by 69% of clinical staff.

3.1.1 Sickle Cell Disease

70% of Clinicians have completed Sickle Cell CSR and 65% of Clinicians have completed Health Inequalities CSR.

3 of the 4 Acute Sickle Cell Units are now open for LAS direct referrals and conveyance.

Clinical audit shows sustained improvement in key areas, including a9% improvement in patients being extricated appropriately.

3.1.2 Maternal Health

There are stark health inequalities experienced by women and birthing people, with significant differences in mortality rates across ethnicities. Black women are four times more likely and Asian women twice as likely, than white women to die during or up to 6 weeks after pregnancy. Severe deprivation will also double the risk of death in comparison to the least deprived population.

The Maternal Health project aims to understand the experiences of women from global majority backgrounds regarding using 999 and 111 services during their pregnancy and up to 12 months post-delivery. Taking a triangulated approach of patient engagement, clinician engagement and clinical audit to develop a maternal health improvement plan aimed at:

- Addressing maternal health service improvement
- Improving patient care

- Enhancing services and reducing disparities in maternal health outcomes.

In December 2024, we commissioned Tower Hamlets Council for Voluntary Services and Healthwatch London Borough of Barking & Dagenham to undertake patient engagement. Alongside this, we have worked with Happy Baby Community to co-design a general maternal health patient information leaflet.

At the LAS, Clinical Audit and Research Unit (CARU) undertook a retrospective maternal clinical assessment audit assessing ePCR data against the clinical audit standards.

Patient engagement has been completed, with 190 patients providing insights into LAS care. 265 clinicians provided feedback regarding confidence with and approaches to maternal clinical care.

Through this patient and clinician engagement, in addition to the clinical audit findings, the below themes have been identified as opportunities to strengthen our care:

- Access to care – ensuring equity of access for women from global majority backgrounds and positive patient experience.
- Effective communication – review our communication methods and tools with recognition of language barriers.
- Education and training – providing specific training drawn from the lived-experiences of women and birthing people from global majority backgrounds
- Partnership working – working with our patients and system partners to improve patient experience

Going forward, the LAS Maternity Team and Health Inequalities Team are reviewing the findings and learning from the engagement activities and clinical audit to inform the development of a maternal health improvement plan.

3.2 Integrated Care Coordination

The LAS continues to work closely with all five ICS partners and the Getting It Right First Time (GIRFT) team at NHS England to advance the development and mobilisation of Integrated Care Coordination (ICC) Hubs. The three existing Hubs in NCL, NWL and SWL are continuing to mature, and demonstrate positive system impact, particularly around reduced ambulance dispatch, reduced ED attendance and improved access to community-based services.

Mobilisation of the final two Hubs is progressing to plan. The North East London (NEL) ICC Hub is scheduled to go live on 24 November, with South East London (SEL) following on 1 December. Engagement with both systems remains positive and operational and clinical workflows are being finalised in partnership with ICB and acute colleagues.

Across all ICCs, the multidisciplinary model continues to provide rapid access to senior clinical decision makers, enabling early clinical consultation, improved decision making for frontline crews and increased use of alternative care pathways. Early evaluation findings from established Hubs continue to indicate improved patient experience and reductions in avoidable ambulance dispatch and ED activity. As NEL and SEL go live, we expect to build on this evidence base and strengthen integration across community and acute services.

4.0 Well-Led

4.1 Quality Regulation

Quality Intelligence & Compliance Team has led a coordinated programme of work designed to embed assurance, improve visibility of data, and ensure sustained compliance at all levels.

Governance and Assurance Framework
A structured Quality Compliance Framework has been developed, mapping key evidence, risks and controls.

A comprehensive Evidence Library has been established, providing central access to inspection-ready documents and supporting assurance materials.

An information pack has been produced to provide a clear overview of governance structures, leadership arrangements, and key achievements.

Quality Assurance and Improvement
Focused and supportive quality checks and deep dives have been undertaken to assess compliance with key standards, particularly within Infection Prevention and Control, Medicines Management and Duty of Candour. Findings have, where needed, been collated into local improvement plans to support action tracking at a sector level.

Engagement and Culture
Delivery of micro-teach sessions across the organisation to refresh understanding of core quality standards, including Governance, Duty of Candour, Infection Prevention and Control, and Safeguarding.

A newsletter has been developed to share good practice, highlight learning, and celebrate achievements from across the Trust.

4.2 Quality Improvement

A 5-day Rapid Process Improvement Workshop (RPIW) was held in October 2025, with a focus on ‘Back to Base on Time’ with the following aims:

- Design interventions that help crews complete their final jobs and return to base within their scheduled shift time — while protecting patient safety and maintaining our response standards
- Develop initiatives that support EOC in making real-time decisions that balance crew welfare with patient need
- Reduce incidental overtime in the last two hours of shifts by eliminating delays, removing non-value-added activities, and improving dispatch decisions—a key outcome measure we have confidence in
- Create sustainable change that improves morale, reduces out-of-service time, and protects our people's time

Ideas for change were formed with support from the Quality Improvement (QI) team with testing occurring in live time which resulted in:

- 75% reduction in incidental overtime (limited sample)
- 13% improvement in Out of Service metrics (limited sample)
- Ideas progressed through Task & Finish groups led by the Process Owners

Going forward, a 90-day improvement plan will occur, with impact of changes measured at 30-day intervals. This implementation is led by process owners, receiving QI support, with updates to be provided to Trust Guidance Team for decisions regarding the scale-up of the project.

5.2.2. Quality Assurance Committee Report

For Assurance

Presented by Karim Brohi

Alert – Advise – Assure Committee Board Report

Assurance report:	**Quality Assurance Committee**	**Date:04/11/2025**	
Summary report to:	**Trust Board**	**Date of meeting:**	**04/12/2025**
Presented by:	**Karim Brohi**	**Prepared by:**	**Sarah Whittingham**

Alert	**Issues that require Board attention:** • None
Advise	**Items where Board input or awareness is needed:** • It was acknowledged that this Quality Assurance Committee is within a 6 weeks of the previous one so some documents were still being refreshed with new data. • Committee members reflected on the volume and type of data being presented and continue to develop QAC's thematic approach, with development of a business cycle schedule and a critical metrics set. • QAC recognised the increasing need for coherent patient feedback and suggested collating and enhancing patient feedback across all services • The BAF will be refreshed ahead of Trust Board. The Board will review the updated BAF in December.
Assure:	**Positive assurances for the Board to note:** • Category 2 performance improved by two minutes against forecast, despite increased activity. • Learning from incidents is now shared more widely through clinical updates, patient safety reviews, and anonymised summaries on internal platforms. The process aims to aggregate individual learnings into actionable themes, with input from clinical teams for training refreshers, for more effective, targeted learning for staff. • It was noted that the cohort of specialist paramedics is growing, with academic provision split across multiple institutions. • New initiatives include AI integration in call handling training and studies on advanced clinical interventions. • The committee received an update on quality improvement (QI) projects and health inequalities action plans, detailing recent

workshops, progress on sickle cell and maternal health projects, and challenges in analysing response times by deprivation.

- The Committee discussed the Morton in the Marsh base and its role in national resilience, with plans for a board visit and a deep dive session on the Emergency Coordination Unit (ECU) scheduled for January to ensure quality and the Trust's values are being delivered at the remote site.

Risks:

Risks

- The BAF was reviewed, with progress noted and it will be updated again ahead of the Trust Board in December.
- The Business Plan was reviewed. At the time of the Committee six were rated amber (slightly off track but expected to recover by year-end), and one is rated red (not expected to recover by year-end). The Business Plan was to be updated further ahead of the Trust Board.
- The red-rated risk concerns the electronic controlled drugs register, delayed due to external technical issues with the supplier. The delay in implementing the electronic controlled drugs register is due to technical challenges with the supplier, who is based in Australia, making communication and progress slower. The pilot is expected to launch soon, after which the risk rating will be reassessed
- The committee discussed the impact of broader system changes (e.g., ICBs merging, London-wide changes, neighbourhood care plans) on funding, performance, and care quality. As these plans develop it was suggested the Trust Board will need to ensure the the BAF reflects this appropriately.

Decisions & Recommendations

5.3. People and Culture

For Assurance

5.3.1. Director's Report

For Assurance

Presented by Simon Steward

London Ambulance Service NHS Trust Board Meeting November 2025 (September 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 achieved national and global recognition by winning two prestigious Chartered Institute of Personnel and Development (CIPD) People Management Awards 2025 for *Best Organisational Development Initiative* and *Best Apprenticeship Scheme* - the highest professional honours in HR and OD. Beyond these awards, the OD&TM portfolio continues to deliver strategic, system-wide impact:

- **Talent Management** - designed career pathways, onboarded NHS Graduate Management Trainee Scheme (NHS GMTS) placements, continued to deliver bespoke organisational change support packages, and Trust-wide career conversations.
- **Leadership and Culture Management** - achieved 86% appraisal compliance, embedded Affina Team Performance Inventory (ATPI)-based team effectiveness, continue to manage the commissioned multiple accredited leadership programmes, established the Centre of Excellence for Leadership and Culture (CELC), and continue to deliver the 'Me and My Leadership Style" Series.
- **Learning and Development** - completed a Trust-wide Learning Needs Analysis, advanced statutory and mandatory alignment with NHSE standards, delivered over 5,800 completions of the Tackling Discrimination and Promoting Inclusivity programme, and launched targeted learning interventions.
- **Apprenticeships and Employability** - continue to deliver their apprenticeship and employability offerings.
- **Culture-Led Operational Improvement Programme** - delivered measurable performance and engagement gains with the Homerton pilot.

Recruitment & Retention

Recruitment to the Trust Workforce plan continues at a positive rate. The current pipeline is at circa 550 candidates at conditional offer stage. Fill rates for September were 100%. 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 and London Ambulance Charity were delighted to win a bid for almost £50,000 from NHSE to develop an innovative new approach to running wellbeing debriefs after potentially traumatic incidents. With the guidance of a psychologist, the team will work with operational managers and colleagues to develop training that works alongside the Trust's current clinical debrief model.

The Wellbeing Team has been working to develop and enact the Winter Wellbeing Plan which has been developed to tackle the specific health and wellbeing challenges for each area of the Trust. This has involved utilising absence and occupational health data to identify trends and hotspot areas and design a unique approach for each. The plan focuses on promoting a proactive approach to reducing mental health illness and musculo-skeletal injury, as well as new training opportunities, self-help and support for managers. A large part of the winter wellbeing plan focusses on the Trust internal flu vaccination programme which has been extensively prepared for by colleagues from all directorates.

An external audit has resulted in a "green" rating for the Trust's Wellbeing and Suicide Prevention support, with one low risk recommendation to bring together all of the relevant work in one guidance document.

The Early Resolution, Mediation and Conflict Support Team continue to support colleagues through early and informal resolution conversations and guidance, roundtables, mediation, conflict coaching and providing welfare support for colleagues going through investigations.

P&C Operations

1. Recruitment

- We ended Q2 continuing with our positive performance with strong pipelines and fill rates. We achieved a 100% fill rate across all available course spaces.

- **Frontline recruitment** – The current UK Partner Graduate pipeline is 184 with 126 spaces left for the remainder of the year. Discussions continue in relation to changes to 25/26 course places to ensure delivery against the financial budget and there is a commitment to ensure all UK Partner Grads are accommodated by Q1 of 26/27. The AAP pipeline is currently at 89 candidates, including 60 external candidates, 19 from the OLIR programme and 10 from the Call Handler to AAP programme.

- **Call Handling Recruitment**

  There were no courses in September. The next course being held in October is fully booked and the two remaining courses for the financial year have a pipeline of 27

candidates. Assessments and interviews are currently being conducted to boost pipeline.

For 111, there were no courses in September. The October course is fully booked for Barking and the remaining courses for this financial year have been stood down as requested by division.

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 September the 12 monthly turnover has remained at 9% with voluntary turnover at 8% and 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, improvements to the flexible working process and policy 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 which remain a challenge.

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. With regard to on-going learning and education, managers have attended mock Employment Tribunal training and in terms of assurance, the bi-monthly review of all ET cases continues, where learning and challenges from key cases are discussed.

4. Workforce Intelligence, Payroll & Pensions

Workforce Planning

Planning discussions are well underway to identify workforce requirements for 2026/2027 and beyond and a high level plan has been drafted and shared. 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 continues. 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.

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 9,000 questions with a 93% recognition rate for responses. 50% 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 November 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 30th September 2025, the Trust has a 99.6% 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). Data from both providers has allowed the Wellbeing Team to develop a winter wellbeing plan that is bespoke for each large area of the Trust, identifying areas with overall low referral rates, low proactive referral rates and where there are higher areas of injury or illness that are related to work.

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.
An external audit, focussing on "Staff Wellbeing and Support (Suicide Prevention)" examined all aspects of the options available within the Trust. After extensive exploratory work, the auditors returned a green rating. Areas of strength included the work of the Wellbeing Team, the range of support available from peer to professional services, the Trust's work on prevention and the high level of governance and oversight. There was one low risk recommendation that recommended bringing together all of our suicide prevention guidance into a single document. This is now being enacted through the Trust's Mental Health Awareness and Suicide prevention group.

Wellbeing Activities

Following a successful bid to NHS Charities Together, the Wellbeing Team has been awarded £50,000 do develop a bespoke training programme, co-designed by LAS colleagues and an external company who specialise in psychologist-led training.
The aim is to create intensive, interactive five-hour training session equipped to provide participants with the psychological insight and practical tools needed to deliver high-quality clinical debriefs following critical incidents. It will enhance the use of the LAS's existing STOP debrief model by embedding trauma-informed, evidence-based approaches to support emotional safety, recognise burnout and distress, and strengthen clinical team resilience. Delivered by a Clinical Psychologist, the training will integrate evidence-based psychological principles with operational realism.

The Wellbeing Team has now developed an extensive "Winter Wellbeing Plan" which includes;

- An increased focus on the Trust internal flu programme, with the wellbeing team centrally supporting all areas to deliver the vaccinations. This has included ensuring all Trust flu fridges and cool boxes are calibrated, that all peer vaccinator guidance documents are up to date and keeping a central training register.
- Redesigning a condenses version of absence management training, that has a focus on the support options available and highlighting specific areas of the supporting absence policy.
- 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.
- Providing Half Day Resolution Framework Training for first time and experienced managers, refreshing interactions with the Resolution Advocates and Mediators and improving resources to support conflict management.

- Launching a new clinical support service Trust wide to ensure colleagues have rapid access to GP services.
- Developing a new "Manager's Guide to Wellbeing" and promoting the AACE Mental Maintenance toolkit to ensure all colleagues have easy access to our support options and self help

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 team have continued to ensure they are visible to all colleagues, both in local areas and at various Trust-wide and regional meetings relating to culture, safety and learning. Work is ongoing to enable colleagues to report concerns as easily as possible, and to promote FTSU as a safe route to do so. The team has been preparing to showcase this through FTSU month in October and have prepared a questionnaire designed to gain additional insight into how FTSU is viewed and utilised. This questionnaire will be rolled out following the closure of the National staff survey at the end of November.

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

Talent Management

Career Pathways

- Initial career pathways have been completed for 999/111/Amb Ops/RSA/Specialist Paramedics. These have been shared and socialised with appointed stakeholders from each area.
- Currently creating the 'core role profiles' (those with frequent recruitment or key roles under the pillars of practice) with the aim of providing more information on the role, skills required and signposting to targeted development to support colleagues in having the right skills and knowledge.

NHS Graduate Management Trainee Scheme

- Two new GMTS Trainees have joined LAS and just completed their orientation, which included an Ambulance ride out, 111 and EOC listening shift, visit to the HART team, shadowing a TRU training, shadowing a mediation, a visit to the ICB, shadowing a surgery at Imperial and meeting with a range of our teams to learn more about them and their roles.
- Both trainees are currently in their first placement with the General Management Trainee working in Ambulance Operations and the HR Trainee working with our P&C teams.

Providing career conversations Trust wide

- The team deliver a range of career conversations that come directly to the OD&TM inbox, signposted by managers or through 'corridor conversations' with colleagues.

- The team also attend ride outs with clinical colleagues to visit different stations and areas to speak about careers at LAS and development. These conversations range from application and interview skills, career coaching, job changing and support colleagues with their personal confidence.

Leadership and Culture Management

Appraisal compliance improvement project

- The team has continued to focus on driving appraisal compliance across the Trust to achieve and sustain the 85% target and ensure that every colleague receives a meaningful appraisal.
- Appraisal compliance Trust wide is at 86.12% (Sept. 2025)
- **ELT has approved the following**:
    - Shift from appraisal linked to increment date to an 'appraisal window' between April and August
    - Introduction of a fully digital e-appraisal platform following a successful pilot
    - Introduction of a performance rating system in line with Agenda for Change (Annex 23)

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 OD&TM team facilitated a successful team development day within the Bromley Group using the Affina Team Performance Inventory (ATPI). This evidence-based diagnostic tool is rooted in research by Professor Michael West and focuses on practical actions the team can take to improve team effectiveness.
- Further ATPI sessions will take place during November and December.

Commissioned Leadership Development Programmes

- In terms of our commissioned leadership programmes the following update is provided:
- High Performing Leaders, Henley Business School - 40 colleagues attending.
- PGCert in Healthcare & Medical Leadership, Cumbria University – 40 colleagues currently on the course. The first cohort have completed the programme and will graduate in November 2025, with the remaining two cohorts completing in Jan and May 2026 respectively.
- Advanced Diploma in Management Practice, Middlesex University – 67 colleagues currently completing cohort 8-10 with 118 colleagues. Cohorts 1-7 having successfully completed the programme.
- Aspiring Leaders Programme, NHS Elect - 47 colleagues across 3 cohorts completed the programme. A further cohort commenced in September with an additional cohort scheduled for October .

Centre of Excellence for Leadership and Culture (CELC)

- The delivery of the pilot programme continues with Modules 1-3 completed. Modules 4 and 5 will be delivered in November and December respectively. On completion participants will commence work on their quality improvement project which will be delivered in March 2026.

- The first action learning set for the above will be delivered in October to promote increased reflexivity and learning.
- The pilot apprenticeship cohort launched in August - the participants being Performance Managers from EOC
- Aggregated feedback from both cohorts is as follows:
  - As a result of this session my knowledge of this topic has increased – 4.56/5
  - How confident do you feel to apply the learning from the session? – 4.12/5
  - The subject matter expert (SME) was engaging and knowledgeable – 4.94/5
  - How likely are you to recommend this module to a colleague – 4.79/5

- **ELT has approved the following:**
  - ELT has approved the scaling up of the CELC apprenticeship programme which will realise significant improvements in leadership and management, targeting bands 5, 6 and 7 in the initial 3 years .

Me and My Leadership Style video series

- The OD&TM team has released a special edition of the "Me and My Leadership Style" series featuring Jason Killens, CEO. Previous editions feature: Stuart Crichton, Director of 999 Operations, and Chris Crawley, CTM, HART, Ranjita Sen, Director of Business Intelligence and Lisa Clancy, CTM at Friern Barnet.
- Further episodes will roll out throughout the year showcasing a range of leadership experiences and approaches from across the organisation.

Learning and Development

Learning Needs Analysis (LNA)

- The team have successfully designed, launched and started an analysis of the findings for our Trust Wide Non-Clinical LNA 2025.
- This LNA aimed to uncover the non-clinical learning and development needs of our people across the Trust. The questionnaire had a total of 1,047 responses (12.2% of the organisation), and spanned from all areas of the organisation.
- The LNA findings will directly influence the way we deliver learning and development within LAS and support the revamping of our Learning and Education Course Catalogue.

Statutory and Mandatory Training

- The team are up-to-date with all actions from NHSE. This includes aligning the 'Gateway 1' and 'Gateway 2' forms to LAS. These forms aim to reduce the hours of mandatory training by assessing if there are other ways for the content to be shared with colleagues.
- The new framework is scheduled for sign-off in December 2025, with the aim of being shared before April 2026. LAS is not required to go live with the new framework in 2026/27, as the packages will not be ready until April 2027. However, we will be devising a clear rollout plan.
- The CQC will approve all CSTF national content, and trusts will be assessed based on the national packages. This is intended to encourage trusts to adopt national content rather than create local versions. However, working with NENAS, we will collaborate with the Ambulance sector to develop shared content if the national content does not meet the needs of LAS.

Tackling Discrimination and Promoting Inclusivity (TDPI)

- So far, 5,816 colleagues have completed phase 2 of TDPI, with a further 655 booked onto future sessions (as of beginning of October 2025).
- TDPI Phase 2 is due to end on 13 November 2025.

L&D delivered sessions

- The team have delivered a range of learning and development sessions, to colleagues across the organisation. This includes a range of specific team interventions to teams such as Friern Barnet, Homerton and Greenwich. The team have also delivered at CELC.
- The team has delivered 'Having Difficult Conversations' and 'Communication Skills' to over 70 colleagues (July – Sept)

Trust Induction

- The team are currently revamping our Virtual Trust Induction. This is being done in collaboration with Subject Matter Expert's and feedback from the sessions.

Apprenticeships and Employability

- Our LAS Apprenticeships have won the award for Best Apprenticeship Scheme at the CIPD People Management Award 2025.
- The CIPD People Management Awards are the benchmark of excellence in HR, L&D and OD.
- The apprenticeship award recognises outstanding apprenticeship programmes that align with business and people strategies and showcase high-quality programmes that are integrated into wider workforce planning strategy, actively promoting inclusion and diversity.
- The judges hailed the LAS scheme, an impressive delivery structure that stood out from the crowd because of the strength of its outreach programme (Our LAS Inclusive Response programme). Judges were also impressed with LAS data on reduced attrition rates and elimination of overseas recruitment, as well as the excellent learner achievement metrics.

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 completed the governance process within P&C and Ambulance Operations.
- Next steps are to report out the findings to the Homerton Group, move towards co-design of interventions, mobilise and evaluate.

8. 2025 NHS Staff Survey

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. It provides the Service with extremely valuable information about how colleagues feel about working here, covering important topics such as staff engagement, development, wellbeing, leadership and teamwork. It allows us to make improvements based on colleague feedback, to make the LAS a great place to work.

The 2025 NHS Staff Survey launched on Monday 22 September, it will run for ten weeks, closing on Friday 28 November. All substantive and fixed-term colleagues, in post on 1 September, have been invited to take part. Colleagues working on bank-only contracts, and those working via external agencies in our 111 contact centres have been invited to participate in the Bank Staff Survey.

As of Thursday 13 November, over two thirds of staff have responded to the survey (5,677 colleagues), and this is currently the highest response rate amongst NHS trusts which contract with Picker to conduct the survey. This is driven by very high participation in 999 Operations (70%) and Ambulance Operations (75%), with the South West Sector reaching 84%.

9. Clinical Education & Standards

In 2025/2026, Clinical Educations and Standards (CE&S) have delivered the following training:

Newly Qualified Paramedics (NQPs)	54
EMT to NQP (Cumbria)	109
Internal upskill Emergency Medical Technicians (EMTs)	62
Assistant Ambulance Practitioners (AAPs)	56
Experienced Clinicians	5
Non-Emergency Transport Service (NETS)	15
Critical Care Transfer Service	0
Bariatric	7
Emergency Call Handlers (ECH)	29
111 Call Handlers	87

A further 89 frontline staff, along with 18 Emergency Call Handlers and 6 Health Advisors, have now commenced their training programmes.

As of 13th November 2025, the Core Skills Refresher (CSR) 2025/2026 face-to-face sessions (covering Resuscitation Level 3, Moving & Handling Level 2, EPRR, and Clinical Decision Making) have been delivered to 3180 frontline staff, with 547 of the remaining 705 spaces already booked up until 31st December 2025.

The 2025/2026 CSR eLearning package is live (including modules on 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, and Capacity). The Medicines Safety and Transgender Awareness modules are due to go live in November. Preparations are also underway for the development of the 2026/2027 CSR programme.

Dedicated CSR sessions have been delivered for Non-Emergency Transport Service (NETS) staff and within EOC for Emergency Call Handlers (ECH) and Emergency Resource Dispatchers (ERD).

Within EOC education, all teaching materials across programmes have undergone a full review and update. A new artificial intelligence (AI) simulation trial is also underway, using AI to simulate caller interactions. This allows new call handlers to practise a diverse range of call types before entering the EOC, significantly improving their preparedness. The trial has been very positively received by both tutors and learners.

The London Ambulance Service continues to invest in the quality education, training, and professional development of its workforce for 2025/26. The enhanced education bursary, offering up to £5,000 per person, continues to support our growing and diverse workforce. Due to its popularity, funding at some partner institutions has been fully utilised, however funding remains available elsewhere. In addition, 2025/26 AHP CPD funding remains open to registrant colleagues.

The digital portfolio for Newly Qualified Paramedics (NQPs) is now in pilot phase and will be reviewed ahead of a planned rollout to all new NQPs in the new financial year. This initiative aims to streamline documentation, improve accessibility, and promote continuous professional development through an interactive and user-friendly digital platform.

CE&S continues to expand its simulation capabilities and digital learning resources. This includes further use of immersive technologies and the creation of new online modules and e-learning tools. CE&S is also collaborating with Apple to explore the integration of the Apple Vision Pro headset into teaching, enhancing learner engagement and supporting a range of learning styles.

These initiatives demonstrate CE&S's ongoing commitment to modernising education and training, strengthening learner engagement, and ensuring that clinical staff have the skills, confidence, and tools required to deliver outstanding patient care in an ever-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)

Alert – Advise – Assure Committee Board Report

Assurance report:	**People and Culture Committee**	**Date:**	**13 November 2025**
Summary report to:	**Trust Board**	**Date of meeting:**	**04/12/2025**
Presented by:	**Anne Rainsberry**	**Prepared by:**	**Anne Rainsberry**

Alert	**Issues that require Board attention:** • There is potential paramedic workforce supply instability, with short-term oversupply creating long-term undersupply if the pipeline is not stabilised. LAS is working with partners across London to identify opportunities to ensure newly qualified paramedics are kept within the system. • The Committee reviewed the likely impact of the Employment Rights Bill. Of particular focus is the strengthening of the duty of employers to protect staff from violence and sexual harassment. LAS has work underway in both these areas.
Advise	**Items where Board input or awareness is needed:** • Workforce Planning – The committee reviewed the work so far and will do so again once allocations are known and commissioners have finalised commissioning intentions. The committee has asked for a deep dive of the future paramedic pipeline at its next meeting. • Sickness and Wellbeing – Longer term absence is a greater proportion of overall sickness absence. The committee discussed the approach to managing this in a way that supports both staff and operational effectiveness. • Equality, Diversity & Inclusion (EDI) – The committee reviewed progress against the key WRES targets. It would like to see further and sustained progress on the proportion of BME staff experiencing disciplinary action. The committee has asked for a focused session on this at its next meeting.
Assure:	**Positive assurances for the Board to note:** • **Staff Survey:** The annual staff survey is underway. The current uptake is 66% and rising. The Trust should be on track for a

	very good response rate. Survey results will be available early in the new year • **Employee Relations:** Resolution Hub volumes are stabilising and strengthened triage and investigation processes are beginning to have a positive impact on earlier resolution of cases and the total case time of those that do proceed to a hearing. • Despite the large number of ETs (in large part to the delays in the Tribunal system post COVID) overall legal spend has reduced. This is due to a strengthened approach to the early resolution of cases including an increasing number resolved without recourse to legal proceedings or financial settlement. • **AI Governance:** The Committee reviewed the policy framework and training plan under development

Risks:	**BAF Risks** Committee discussed two new potential risks. • The paramedic pipeline sustainability and the risk that this years over supply might affect future applications for training • The impact of the Employment Rights Bill on the Trusts obligations and the requirement for it to strengthen its response to this.

Decisions & Recommendations	

Alert – Advise – Assure Committee Board Report

Assurance report:	People and Culture Committee	Date:	18 September 2025
Summary report to:	Trust Board	Date of meeting:	4 December 2025
Presented by:	Anne Rainsberry	Prepared by:	Anne Rainsberry

Alert	**Issues that require Board attention:** • Rising Employment Cases – Internal hearings and ET cases remain above historic levels. The committee requested continued monitoring and assurance of policy alignment with legislative changes. • EDI Team Capacity Risk – There is a temporary reduction in team size to two from October poses delivery risk. Recruitment is underway with interim workload management in place.
Advise	**Items where Board input or awareness is needed:** • Workforce Planning – A draft Ambulance Operations Workforce Plan in development with financial modelling underway. The committee were advised that the inclusion of commissioner funding risks and Market Forces Factor (MFF) adjustments were being reflected. The plan will be reviewed by ELT and presented to the next meeting. • Sickness and Wellbeing – Winter Wellbeing Plan was endorsed and the committee noted the proactive and data-led approach. There are targeted interventions to address mental health and MSK-related absences. The committee advised a continued focus on proactive support, benchmarking best practices, and refining disability-linked data. • Equality, Diversity & Inclusion (EDI) – The committee noted the progress on reasonable adjustments (90% completion) and improved diversity in recruitment. Agreed actions include developing an EDI KPI dashboard, five-year diversity projections, and an action plan to improve BME representation in Incident Response Officer (IRO) recruitment.
Assure:	**Positive assurances for the Board to note:** • Employee Relations – The increase in Employment Tribunal (ET) cases (42 live) is being managed with additional legal support. A deep dive on case trends and Resolution Hub effectiveness is scheduled for next meeting. • Sexual Safety – The implementation of the Sexual Safety Charter is progressing well, with enhanced training, guidance, and peer-led ‘moments to intervene’ development. A forthcoming deep dive will assess compliance with new Workers Protection legislation.

Risks:	**BAF Risks** • Committee agreed to reduce two BAF risk tolerances following improved assurance: BAF 2.2 ('Looking after our people') and BAF 2.3 ('Organisational culture'). Continued monitoring will ensure improvements are sustained.
Decisions & Recommendations	

5.4. Finance

For Assurance

5.4.1. Director's Report

For Assurance

Presented by Rakesh Patel

London Ambulance Service NHS Trust Board meeting

Report from the Chief Finance Officer

Financial Position at the end of October 2025

Income and Expenditure Plan

The Trust received income of £443.4m and incurred costs of £441.1m for the 7 months to end of October 2025. This position was a year-to-date Income & Expenditure surplus of £2.3m. 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 £88.3m during 2025/26 across Fleet, Estates and Medical Equipment. For the 7 months to the end of October 2025, the Trust had spent £20.8m and is forecasting to deliver the overall capital Programme this financial year.

Cash Balance

The Trust had a closing cash balance of £46.0m at the end of October 2025.

Fleet

Fleet continue on with their roll out to modernise the fleet and ensure that we are able to meet the changing needs of the public.

Fleet have commissioned in Q2

- 2 people carriers for our Hazard Area Response Team (HART)
- 7 Double Crewed ambulances (DCAs)
- 2 Electric DCAs
- 1 Ops Commander unit
- 6 Specialist paramedic vehicles
- 2 Bariatric DCAs

Construction work is ongoing on the new workshop site in East London which supports the closure of two smaller sites into one large multipurpose facility. The Fleet Management have been consulting with their teams about the services that can be incorporated into the new Fleet Service Hub and looking at where further efficiencies can be made at workshops across the Trust to bring more services in house rather than have a reliance on outside contractors.

To support this Fleet are developing their current applications to enable crews to record defects, which in turn reports them live to the workshop ensuring they can plan their workload more

proactively instead of waiting for the vehicle to arrive. The system also allows the team to monitor performance and provide key metrics and data.

Estates & Facilities

The Trust continues to develop its plans for East London Campus and remains on track for this. Construction is ongoing on Fleet Service Hub and a new facility for Resilience and Specialist Assets.

Cody Road which currently houses the Resilience and Specialist Asset Team (R&SA) will be upgraded into modern facilities for a new ambulance station. This is currently in procurement phase and construction work will commence next year when the RS&A team move into the new facilities.

Work at Heathrow Airport site continues and is currently in the tender phase with construction work set to start next year. The development consolidates a number of local teams and provides a fit for purpose ambulance station in an ideal location.

The Trust is in the process of upgrading Headquarters which will include a new boardroom, a new meeting room and bespoke facility for IM&T.

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

We are in refurbishing our existing estate and a programme of works has been agreed that will run until the end of the financial year this looks to improve facilities and carry out urgent works at a number of sites this also runs in conjunction with our back log maintenance programme all of which we hope will modernise our estates and make it better place to work for our colleagues.

Supply & Distribution

The team is continuing to asset tag high value medical devices and have tagged c.70,000 devices and are installing active RFID tags on our DCAs which will provide assurances about what is on vehicles. The team continue to work closely with the security team and Met police to explore ways to track missing equipment and have reviewed their processes and operating models. This work is being done alongside the Medical directorate and Operational teams to ensure everyone is using a uniform process around reporting and loss of kit.

Centralised Packing has moved under Supply and Distribution and is now housed in our warehouse at Rainham. The team are have rolled out across three sectors now with Make Ready still supporting the team during the transition. This process will be completed soon and by January 2026 all packs will be packed at a central location and subject to the same audits and quality processes. The team are then going to look into expanding further and supporting other teams such as the Cycle Response Team (CRU) with zebra bags.

The Production Hub team continue to work alongside Operations to support crews with out of service. The team have expanded their remit and are now supporting Make Ready with driver movements utilising their Transport Operatives and supporting operations with the new Trolley Bed initiative. The team have recently utilised the business intelligence team to create automated reports and are exploring further uses of technology so that their Transport Operatives can be tasked with jobs via apps enabling them to plan jobs more easily in priority order.

Sustainability

The Trust is continuing to work towards a 6% carbon emission decrease in 25/26 as per the current Green Plan. The Green Plan has been developed in line with the Trusts five-year strategy. Recently we confirmed that reduction in 24/25 was 4% bringing our total carbon reduction down 12% in the last three years.

The Trust was successful in securing a £4m bid to upgrade our EV infrastructure in the FY 2025/26. This money will has allowed us to scope out 2 new sub stations and upgrade 4 existing substations to significantly increase the capacity at those sites. We have also identified sites and started installation work for solar, LED and battery packs this will be completed by the end of the financial year.

Decarbonisation surveys have taken place at key sites across the Trust the team are currently analysing this data to understand how we can reduce the environmental impact of our entire estate.

Make Ready

Make Ready has been adjusting to their new rotas and recently have undergone recruitment campaigns to align their staffing numbers with current vehicle prepping requirements of the Trust.

The Make Ready preparation app has been rolled out with all colleagues trained and utilising this providing better data of what is on vehicles and what equipment is missing. The next stage is for the team to start using the data and visibility this now provides to streamline processes and look for further efficiencies.

Make Ready have provided a training programme with outside support to their supervisor level staff and engaged in a number of Make Ready led workshops with Operations to improve process and relationships at a local level and look for ways to integrate Make Ready into their groups to provide tailored support whilst adhering to statutory and Trust compliance.

Rakesh Patel

Chief Finance Officer, London Ambulance service NHS Trust.

5.4.2. Finance and Investment Committee Report - Verbal

For Assurance

Presented by Bob Alexander

Audit

5.5. Audit Report

For Assurance

Presented by Rommel Pereira

Alert – Advise – Assure Committee Board Report

Assurance report:	Audit Committee	Date:	30 October 2025
Summary report to:	Trust Board	Date of meeting:	04/12/2025
Presented by:	Rommel Pereira	Prepared by:	Rommel Pereira

Alert	**Issues that require Board attention:** The Committee noted that critical systems fail over testing to be undertaken in line with technology upgrades and/or maintenance windows is a practical and pragmatic approach and agreed to close the outstanding internal audit action. However, the Committee asked that Board be alerted to ongoing business wide operational exposure to resilience and recovery. The Committee advised that the BAF should better reflect system-level uncertainties and how we will work with neighbourhoods, IHO's and potentially converting to a Foundation Trust. In this respect, the Board's oversight and triangulation of the quality of care, performance and funding will continue to be important.
Advise	**Items where Board input or awareness is needed:** The Committee advises the Board that it reinforced a zero-tolerance approach to misappropriation of Trust assets and the need to address related cultural issues, in the context of ongoing fuel-card and LifePak theft investigations. The Committee approved the extension of the External Audit contract by two years to 31st March 2027.
Assure:	**Positive assurances for the Board to note:** The Committee received the final Internal Audit report on the Cost Improvement Programme (CIP). Internal Audit provided a Substantial Assurance opinion, with only one low-priority recommendation relating to how staff feedback is captured post-scheme. The Committee noted the positive assurance for both financial and operational planning and assures the Board on the CIP Substantial Assurance internal audit. The Committee received the final Advisory Internal Audit report on the IUC Service Development programme. The review produced three low-priority recommendations, covering documentation, governance clarity and data quality processes. The Committee accepted management's assurance that commissioner-facing financial/contractual reporting is robust, and confirmed comfort with the low-risk nature of findings. The Committee therefore assures the Board on the IUC Service Development advisory report and the low-risk findings.

5.6. Digital and Data

5.6.1. Director's Report

Presented by Clare McMillan

London Ambulance Service NHS Trust Board Meeting

4th December 2025

Report from the Chief Digital Officer

The NHS digital landscape continues to evolve rapidly, driven by the NHS England Medium Term Planning Framework (MTPF) 2026/27-2028/29 which sets ambitious national requirements for digital transformation. London Ambulance Service has made significant progress in delivering its Digital & Data Strategy while positioning itself as a leader in ambulance service innovation, particularly in AI adoption. This report provides an update on recent achievements, outlines the implications of new national mandates, and sets out our strategic response to ensure LAS remains aligned with national priorities while meeting local operational needs.

National Policy Context: Medium Term Planning Framework

The NHS England MTPF for 2026/27 to 2028/29 establishes a 'digital-by-default' principle across all health services, with mandatory requirements that will shape LAS digital priorities over the coming years. Three areas have particular significance for ambulance services:

Federated Data Platform (FDP)

All NHS providers must onboard to the NHS FDP by 2028/29, adopting its core products and implementing the canonical data model. While LAS is already on the FDP, the platform has been primarily designed for acute trust workflows and data models, creating challenges for ambulance-specific requirements. We are planning a pilot to assess technical compatibility, costs, and functionality gaps to determine the most appropriate implementation approach. This work will inform whether we pursue full adoption as our primary data warehouse, selective use of FDP components, or advocate for ambulance-specific adaptations.

NHS App and Patient-Facing Services

Providers must fully adopt NHS App capabilities, making appointments and patient communications accessible through the app. For LAS, this requires integration with our 111 and 999 services, ensuring patients can access urgent care pathways digitally. We must also review our patient communication channels for migration to NHS Notify, the national standard for patient messaging, replacing legacy systems and improving consistency of patient experience across NHS services.

Implications for LAS Digital Strategy

These national mandates complement our existing digital commitments but require us to re-prioritise our delivery roadmap to ensure compliance alongside local innovation. We are reviewing our two-year delivery plan to sequence national requirements appropriately, identify dependencies between MTPF mandates and local projects, and ensure realistic resource allocation across transformation and 'keeping the lights on' activities. The scale of change required presents resource and capacity pressures, technical complexity in integrating multiple national platforms, and the need for robust change management across the organisation.

AI Implementation and Innovation Leadership

LAS continues to demonstrate sector leadership in AI adoption, building on successful pilots that have attracted national attention and positioned us as an early adopter of transformative technologies.

TortusAI Ambient Voice Technology

Following a successful Proof of Concept funded by the Frontline Digitisation Fund, Tortus AI has progressed to a one-year pilot across both Clinical Hub (CHUB) and Ambulance Operations. The initial trial, supported by a research study led by Great Ormond Street Hospital, demonstrated strong technical performance and measurable improvements in clinical communication and documentation accuracy. The research findings have directly influenced the NHS 10-Year Plan's approach to AI and ambient voice technology in clinical settings.

The technology has now been deployed across all CHUB workstations and is expanding in Ambulance Operations, with pilots at Croydon, Oval, Ilford, and Brent showing improvements in patients per shift and on-scene to handover times. From November 2025, Tortus has also been made available to all neurodiverse staff across the Trust, where it has proven highly popular. The technology saves significant documentation time, allowing clinicians to focus on patient care while automated transcription creates structured medical notes.

AI Governance and Policy Framework

Recognising the importance of responsible AI adoption, we have developed comprehensive governance frameworks through extensive stakeholder engagement across Quality Assurance, People and Culture, Senior Leadership Teams, and Clinical Education committees. The AI & Automation Policy and Acceptable Use Procedure have been presented to the Digital & Data Committee for approval, establishing clear principles for safe, ethical, and effective use of AI technologies across LAS operations. These frameworks will ensure we maintain high standards of clinical safety, data protection, and transparency as we expand AI adoption. Due to the fast-paced nature of the potential use of these technologies, these policy and procedure documents will be reviewed annually instead of the standard three year cycle to ensure we remain responsible and compliant.

Southern Ambulance Services Collaboration (SASC)

LAS is actively pursuing strategic collaboration with four partner ambulance trusts (EEAST, SWAST, SCAS, SECAMB) to deliver shared digital capabilities and infrastructure. This collaboration has progressed significantly, with several initiatives demonstrating substantial benefits.

Collaborative Procurement and Shared Services

The SASC partnership is developing a joint business case for TortusAI procurement across all five trusts, creating a single governance and support structure that reduces costs and increases benefits through economies of scale. This model has potential for sector-wide expansion and is being discussed with the Association of Ambulance Chief Executives (AACE) as a template for national adoption. LAS has already gifted approximately 5,000 pilot hours each to SWAST, SECAMB, and EEAST to support collaborative learning and evaluation.

Infrastructure Collaboration Vision

We have commissioned work with Netcompany to develop a strategic vision for 'smart infrastructure optimisation' across the five-trust partnership. This work evaluates three distinct delivery models:

- **Independent Excellence Model:** Each trust operates independently but coordinates on standards and shares learning while maintaining separate infrastructure
- **Collaborative Framework Model:** A coordinated approach with shared technical standards, common procurement frameworks, and mutual support arrangements while maintaining operational independence
- **Shared Service Model:** A transformative approach creating a multi-trust shared infrastructure delivery capability with consolidated resources, unified management, and pooled expertise

This work will complete in early 2026, providing a strategic vision, detailed model comparison, industry-benchmarked cost estimates, benefits frameworks, and materials for executive discussion. The timing is critical as MTPF requirements represent significant investment and delivery challenges for any single trust. Collaboration offers opportunities to share costs and risks, build stronger negotiating power with national suppliers, create more resilient infrastructure, accelerate innovation, and deliver better value through economies of scale.

Digital Transformation and Business Planning

To accelerate digital transformation and position LAS as a sector leader, we are proposing Digital Innovation Delivery Workshops that will support business planning with a 3-5 year planning horizon. These workshops, facilitated by IBM Consulting, will bring together digital teams, business leaders, frontline staff, and corporate functions across four focused sessions covering call handling (999 and 111), Clinical Assessment Services (999 and 111), Ambulance Operations, and Corporate Services.

The workshops aim to identify short-term innovation priorities with measurable outcomes, agree shared delivery methods and success metrics, focus on usability and user experience for patients and staff, deliver safe and disruptive technologies rapidly, expand partnerships, and maintain clinical competence while embracing digital disruption. Expected outcomes include a shared five-year digital innovation vision aligned with the LAS Digital Strategy, a prioritised innovation roadmap, and a defined model for rapid digital experimentation and sector-wide scaling.

Organisational Transformation

Digital & Data Restructure

The Digital & Data restructure, implementation planned for January 2026, establishes clear operating principles focused on user experience, continuous improvement, and agile delivery. Key elements include enhanced technical leadership through strengthened architecture and engineering functions, operational resilience through a 24/7 IT Operations Centre launching in early 2026, customer-centric service delivery with improved portfolio management, and enabling functions including portfolio delivery, cyber assurance, and digital governance to manage risk and drive project success.

The restructure emphasises culture change, promoting openness, agility, collaboration, and a shared vision to foster a patient-centric, safe, and innovative environment. Ongoing training, upskilling, and

knowledge sharing are prioritised to build a resilient workforce capable of adapting to emerging technologies and future challenges.

Key Projects and Delivery Update

Several major projects have progressed significantly, with particular achievements in completing infrastructure upgrades and expanding AI capabilities:

Windows 11 Upgrades

Both CAD and corporate Windows 11 upgrade projects have been completed successfully. The CAD workstation upgrade addressed critical vulnerabilities and reduced operational risk, while the corporate upgrade delivered approximately 3,400 PCs and laptops upgraded across 70 LAS locations. The upgrades have strengthened system stability, security, and operational resilience, and introduced self-service application access via Software Centre, reducing IM&T support tickets. Key lessons include the importance of early IM&T involvement in equipment replacement decisions to avoid dependencies on outdated software.

Kaiwa AI Training Platform

LAS is conducting a Proof of Concept with Kaiwa, an AI-powered conversational simulation tool developed by PA Consulting to enhance Emergency Call Taker training. The system uses natural language processing and synthetic voice technology to simulate realistic 999 calls, enabling trainees to practise complex scenarios in a controlled environment. Early feedback from tutors and trainees has been highly positive, highlighting realism, engagement, and roughly double the throughput of traditional sessions. South Central Ambulance Service is trialling an alternative product, and a comparison between systems will inform future procurement decisions for the SASC partnership.

Strategic Priorities and Next Steps

Over the coming months, our strategic focus areas include:

- **MTPF Compliance:** Conduct options appraisal on FDP adoption approaches, develop costed implementation plans for national mandates, and update delivery prioritisation
- **AI & Automation:** Finalise AI Policy implementation, expand TortusAI deployment based on evaluation outcomes, and progress SASC collaborative procurement
- **Infrastructure Collaboration:** Complete infrastructure collaboration vision work and present recommendations to SASC leadership for decision on delivery model
- **Digital Innovation:** Deliver Digital Innovation Workshops and develop 3-5 year strategic roadmap aligned with business planning
- **Organisational Development:** Complete Digital & Data restructure implementation and launch 24/7 IT Operations Centre

5.6.2. Digital and Data Committee Report

For Assurance

Presented by Sheila Doyle

Alert – Advise – Assure Committee Board Report

Assurance report:	Digital & Data Quality	Date	18 November 2025
Summary report to:	Trust Board	Date of meeting:	04/12/2025
Presented by:	Sheila Doyle	Prepared by:	Sheila Doyle

Alert

DDQ wishes to alert the board of:

- **Business Plan Delivery:** Of five digital and data objectives for 2025/26, three are on track (green), two are off track but under control (amber). However, several objectives lack clearly defined performance metrics or baselines, making progress difficult to quantify. The Committee has requested that measurable indicators be embedded in future reports**.**
- **National Mandates:** The NHS Medium-Term Planning Framework (2026–2029) introduces a digital-by-default requirement for all providers. The Trust must ensure alignment with national priorities, including the Federated Data Platform (FDP), NHS App integration, and compliance with the Digital Capabilities Framework. Risks include resource constraints, technical complexity, and funding uncertainty**.**

Advise

DDQ wishes to advise the Board of:

- **Strategic Transformation:** The Trust is driving significant digital transformation, within the 111/IUC service, leveraging AI triage, natural language processing, and translation tools. This positions the Trust to effectively support and enable the shift from 'analogue to digital' as set out in the NHS 10-year plan, while ensuring careful management of clinical risks and the responsible deployment of AI.
- **AI and Data Governance:** The Committee has approved an AI and Automation Policy and Acceptable Use Policy, ensuring transparency, risk assessment, and compliance with NHS guidance and data protection. Staff communication and training will accompany rollout, and the policy will be reviewed annually due to the fast pace of change.
- **Data Quality and Assurance:** Ongoing improvements to Electronic Patient Care Record (EPCR) data accuracy and system integration are supported by new technical hires and validation frameworks. The Committee supports aligning LAS data quality measures with national ambulance standards and emphasises cross-committee learning for consistent assurance**.**
- **Workforce and Organisation:** A restructure is proposed to integrate IM&T, BI, and CCIO functions into a single Digital and Data Directorate, supported by a 24/7 IT Operations Centre. The Committee is focused on cultural and workforce impacts, equity, digital literacy, and career progression. Updates on consultation outcomes and risk mitigations are expected in January.

Assure:	**DDQ wishes to provide assurance of:** • **Risk Management**: Nine major infrastructure projects are underway to mitigate critical IT failure risk, with notable reductions in incidents and improved system stability. The Committee has requested a review of risk scoring to reflect these improvements and continues oversight of national dependencies such as the Airwave Replacement Programme. • **Operational Resilience:** The 24/7 IT Operations Centre is on track for completion, enhancing monitoring, incident response, and service continuity. Cybersecurity controls and alignment with NHS England's cyber maturity model are maintained. • **Project Portfolio:** There are 85 active digital projects, with a centralised triage mechanism proposed to ensure alignment with strategic priorities and reduce duplication. The Committee supports prioritisation and benefits realisation tracking.
Risks:	**BAF Risks** • The BAF risk profile remains unchanged.
Decisions & Recommendations	**The board is asked to note:** • Approval of the AI and Automation Policy and Acceptable Use Policy, following extensive stakeholder input.

Corporate

5.6.3. Director's Report

For Assurance

PUBLIC BOARD OF DIRECTORS MEETING

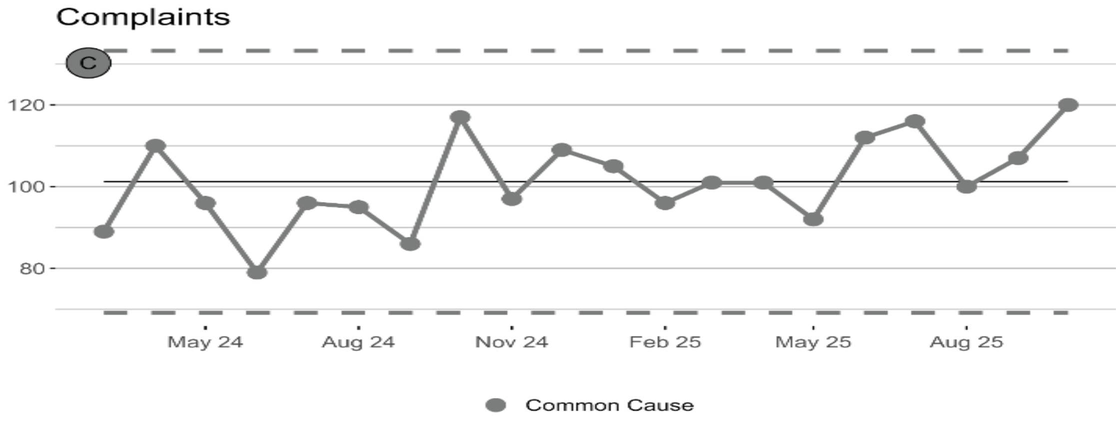
Report of the Director of Corporate Affairs

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 October 2025.

1. PATIENT EXPERIENCE

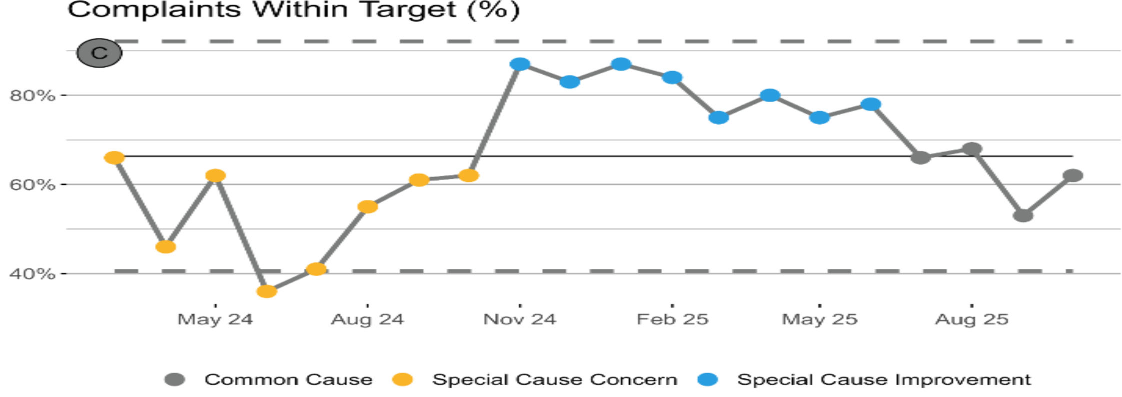
1.1 Complaints received.



The number of complaints received, shown in the above SPC chart, show common cause variation. The monthly average for the calendar year so far is 105 complaints received per month.

The main themes for complaints remain conduct and behaviour or delays and is consistent with previous reports.

1.2 Complaints closed



There are currently 230 open complaints of which 85 are overdue (36%). This is primarily due to capacity within the team due to sickness absence. The team are looking to address current performance and deliver the agreed standard of 75% of complaints responded to within 35 days during quarter 4.

LAS have been collaborating with the Parliamentary and Health Service Ombudsman (PHSO) regarding shaping the new PHSO 5 year strategy. The CEO attended a roundtable meeting with the newly appointed Ombudsman and with the Head of Patient Experience attending a stakeholder feedback session.

The Patient Experience team continue to follow the PHSO complaint standards in the management of complaints.

2. LEGAL SERVICES

Inquests opened 01 May 2025 – 31 October 2025

Total Inquests - 1106

Level 1 Inquests – 1057

Level 2 Inquests – 49

Claims opened 01 May 2025 – 31 October 2025

Employment Liability – 17

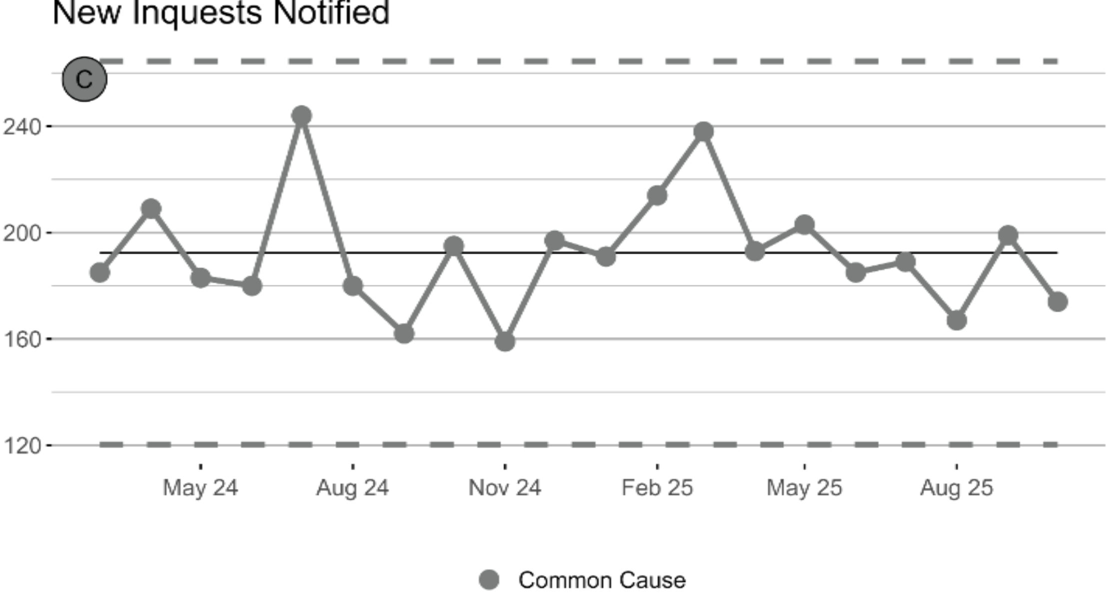
Public Liability - 2

Clinical Claims - 38

As expected, the number of Inquests notified to the Trust remained relatively high in the above period. There is an increase of clinical claims notified to the Trust in 2025 compared to 2024.

The Trust has received a total of 23 Employment Liability claims so far in 2025 which suggests we are on track to see roughly the same number of claims in 2025 as compared to 2024. This will be higher than the years prior.

The SPC chart below shows common cause variation in the numbers of notified inquests during 2023-2025 (to date).



The tender for the provision of legal services was issued and closed on 31st October 2025. The LAS received 6 bids. A moderation meeting is scheduled for 8th December 2025 following completion of the technical evaluation of the bids.

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

The Head of Legal in collaboration with Bevan Brittan will be delivering a training session to the Safeguarding Department and prepare an information pack containing Court attendance and giving evidence at the Family Courts.

3. INFORMATION GOVERNANCE

Information governance (IG) incidents are reported via RADAR, which is the Trust's risk management system.

Where there has been an incident resulting in the compromise to patient or staff identifiable data, a report is made on the Data Security and Protection Toolkit (DSPT) within 72 hours of the notification of the incident reaching the Information Governance 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, ten incidents have been reported to the Information Commissioners Office (ICO). Six of the cases have been closed by the ICO with appropriate steps having been taken by the Trust to mitigate the impact of the breaches.

The Trust is currently awaiting a response from the ICO on the four remaining cases. There are also 5 open cases dating from 8th December 2023 to the 26th July 2024. All five of these open cases are either awaiting an initial response from the ICO or awaiting a response following updates sent.

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

- An independent audit will be conducted by BDO LLP starting from 2nd February 2026 against 12 Outcomes of the 2025-2026 DSPT.
- A training needs analysis for the 2025-2026 DSPT has been approved by the Trust SIRO and will be ratified by the Information Governance Group Committee in November 2025.
- Asset registers and Record of Processing Activities (ROPA) reports have been distributed and are being actively managed by the Information Governance Team.
- The Trust’s Privacy Notices are regularly updated and made accessible via LAS Connect and the Trust website.

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.

4. FREEDOM OF INFORMATION

Between August and October 2025, the department received 159 Freedom of Information (FOI) requests. 189 have been closed during this period, while 3 remain overdue.

5. HEALTH, SAFETY & SECURITY

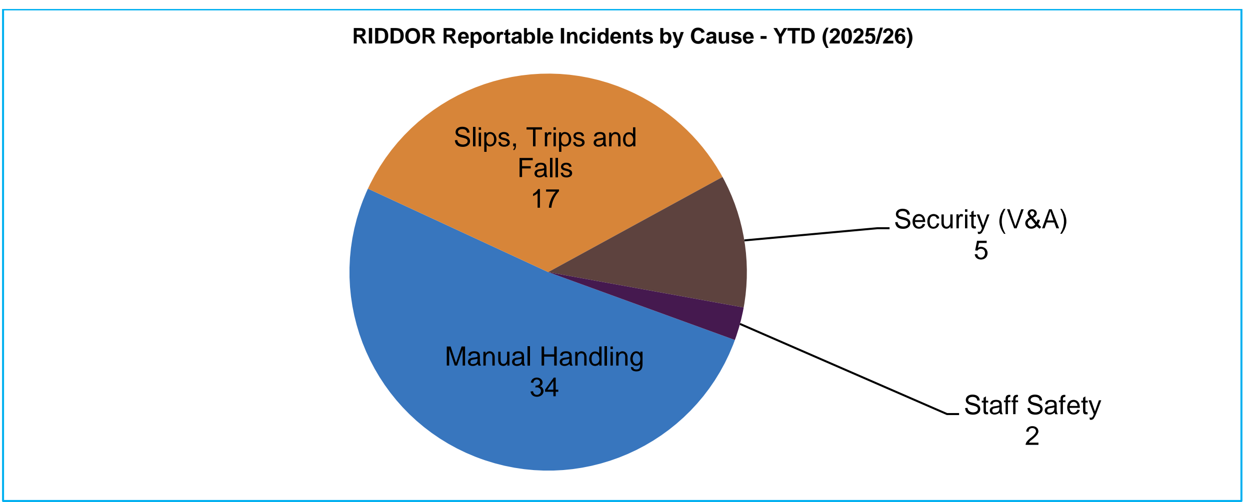
The Health Safety & Security (HS&S) Team have delivered 6 sessions of Managing Safety courses to total of 100 staff members and 5 sessions of Corporate Induction during 2025/26 (up to end of September’25), all with positive feedback.

The HS&S team delivered a session at the Centre of Excellence for Leadership and Culture (CELC) Management Essentials course in August 2025.

The Bariatric specific vehicles are now finished, and the final stage before launching is training and a day has been booked to complete this with the Bariatric Team, Clinical Education and Health & Safety (16th-19th) November 2025.

The Reasonable Adjustments training has been rolled out to all staff with line management responsibility, 10 sessions have been delivered throughout October, with the feedback so far being good.

The total of 58 RIDDOR incidents were reported to HSE during 2025/26 (up to end of September'25). Manual Handling Incidents account for the highest number (59%) of RIDDORs reported across the Trust during 2025/26.

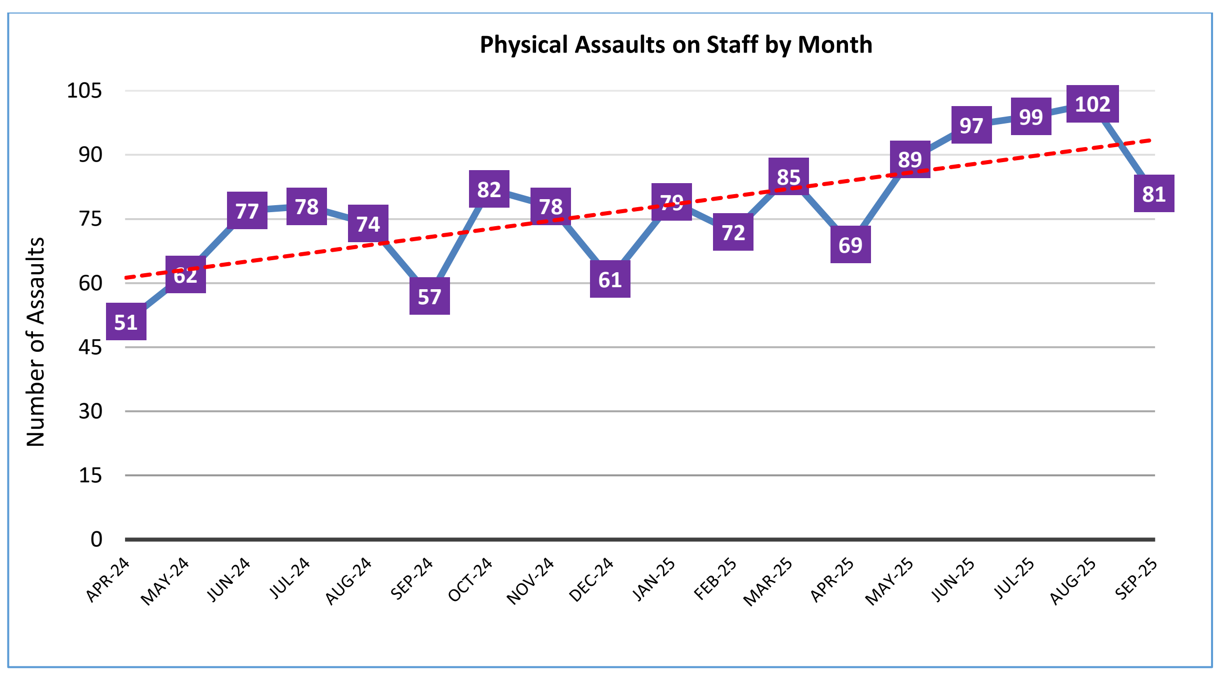


Current compliance for FFP3 fit testing is 72% due to the 2-year revalidation period. Over 100 staff members have now been trained up as Fit Testers. Two weekly reports are sent out to all areas of the Trust, with compliance being monitored centrally and by Local Group Manager's etc.

A total of 534 physical assaults on staff has been reported during the period of March to September 2025. 57% of these have occurred due to the clinical condition of the patient and in 68% of these physical assault cases police have attended the incident. There have been 3 successful prosecutions for assault where incidents have occurred during this time period.

Recruitment for two Violence Reduction Officers (VRO) is now under way. Interim operational support, is being provided through secondments. There is a plan to increase the strategic level engagement with the MPS & Crown Prosecution Service (CPS) to better understand the problems and constraints within the Criminal Justice System. Work continues to swap out the recalled body armour, with the next order now due to arrive in early December, which should bring us to a steady state as we move into the new year.

The Director of Corporate Affairs and Head of Health, Safety & Security delivered a presentation to People and Culture Committee covering the approach to tackle Violence and Aggression and the 10-point plan.



Nic Daw, Interim Director of Corporate Affairs

December 2025

6. Assurance

6.1. Board Assurance Framework

For Approval

Report Title	**BAF 2025/26**			
Meeting:	Trust Board			
Agenda item:			**Meeting Date:**	4 December 2025
Lead Executives:	Nic Daw, Head of 111 & Integrated Emergency Care Service			
Report Author:	Frances Field, Corporate Governance Manager			
Purpose:		Assurance	x	Approval
	x	Discussion		Information

Report Summary

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.

People and Culture Committee (P&C)

Change to risk tolerance scores:

BAF 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. Tolerance score reduced from 3x4=12 to 2x4=8.

BAF 2.3 We may not improve our organisational culture in addressing bullying and / or harassment underpinned by poor underdeveloped management and leadership practices. Tolerance score reduced from 3x4=12 to 2x4=8.

Quality Assurance Committee (QAC)

Change to risk score:

BAF 1.2 Decrease in risk score of third element of risk relating to underachievement of productivity initiatives, from 3x4=12 to 2x4=8.

Digital and Data Committee (D&D)

Change to risk score:

BAF 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. The current and tolerance risk scores have been increased from 2x5=10 to 3x4=12.

Finance, Investment and Productivity Committee (FIPC)

Change to risk score:

BAF 2.8 We may not deliver the £30m CIP and productivity programme. The current risk score has been decreased from 4x4=16 to 3x4=12 by the FIPC.

Recommendation/Request to the Board:
The Board is asked to: • Review and approve the 2025/26 Q2 BAF including the comments of assurance committees with associated scoring of risks.
Routing of Paper i.e. previously considered by:
ELT and assurance committees.
Corporate Objectives and Risks that this paper addresses:
The Board Assurance Framework (BAF) forms a part of the overall risk management and assurance process of the Trust and allows the Board to maintain oversight of the principal risks to the delivery of the Trust's strategic objectives.

Board Assurance Framework – November 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	9
	• 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	8				8	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	11
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	13
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	16
1.6	We are at risk of providing an inequitable 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	19
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	21

	Risks	Uncon[d]	Q1	Q2	Q3	Q4	Curr[t]	Target	Committee	Owner	Page
	• 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]**	**Q1**	**Q2**	**Q3**	**Q4**	**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	25
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	8	P&C	DM	27
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	8	P&C	DM	29
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	31
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	32
	• 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				12	12	Digital	CM	34

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	36
2.8	We may not deliver the £30m CIP and productivity programme.	20	12				12	4	FIPC	RP	37
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	FIPC	RP	38
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	39
2.11	The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2025/26	20	16				16	4	FIPC	RP	40
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	41

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

Risks		Uncond	Q1	Q2	Q3	Q4	Currt	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	FIPC	RP	43
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	FIPC	RP	44
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	FIPC	RD	46

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

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

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

BAF Risk: 1.1
We may not achieve the quality standards required in stroke, cardiac care, and cardiac arrest

Uncontrolled				
L	x	C	=	Score
5	x	4	=	20

Current				
L	x	C	=	Score
4	x	4	=	16

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

Controls	Assurances
Progress with priorities to be monitored on a monthly basis via patient safety incidents and national benchmarking	• Weekly patient safety incident group reviews cases, • PSIRF thematic reports, • 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

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

<table>
<tr><td></td><td>• 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</td></tr>
<tr><td>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)</td><td>• 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.</td></tr>
<tr><td>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.</td><td>• Monitored through Annual Clinical Audit Programme and Research Programme.
• Monitored through Clinical Quality Oversight Group and Clinical Audit and Research Steering Group (CARSG).</td></tr>
</table>

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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: August 2025 ROSC 47% and sustained to hospital 32%
• 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 February 2025 – 946 March 2025 – 207 April 2025 – 1389 May 2025 – 818 June 2025 – 699 July 2025 – 1296

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

	August 2025 – 2439 September 2025 - 1307
• 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. 93% of patients pan London were provided with pain relief in September 2025 (from 90% in April 2025) 84% of patients pan London were provided with the complete care bundle (from 78% in April 2025)

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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;
- 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

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

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

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

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	All 5 ICBs are engaged in the mobilisation of ICC Hubs • The ICC hubs are live in NWL, NCL, SWL and NEL. SEL mobilises on 1st December 2025.
• Tethering of equipment to local stations • Tracing of equipment • Oversight through equipment working group	• Working group has revised Life Pak 15 process for tracing equipment and improve availability through planned servicing cycle.

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• Communications to staff to share work and improvements	• Working group has renewed process for identifying trolley beds left at hospital to enable crews to attend and collect the closest trolley bed – the Out of Service Policy was amended to reflect the new process. 70% of trolley beds are now tagged and traceable. NEL are the early adopters.
• Health Inequalities Action Plan ➢ Improving Sickle Cell Care action plan with 19 actions ➢ CORE20 Workstream utilisation of Community First Responders, fundraising for implementation of public access defibrillators and continued recruitment of London Lifesavers. ➢ Cardiovascular notifications in SEL ➢ Maternal Health Programme	Health Inequalities Action Plan • 30 of the 100 actions (across 5 year plan) completed. 3 of the 5 large improvement projects scoped • Clinical education package 'Toolkit for Tackling Health Inequalities' now completed by 69% clinical staff. • Multiple practical resources to support patients and clinicians to address health inequalities launched, including; how to access NHS services info (translated), maternity safety info (translated), Sickle Cell patient information, MECC services for smoking cessation, drug and alcohol addiction and homelessness. Improving Sickle Cell Care • 20 actions in total; 7 completed, 11 on track, 2 planned for Q4. • 3 of the 4 Acute Sickle Cell Units open for LAS. 4th on track to follow in December 2025. • 76% of frontline clinicians have completed the additional clinical education package. • Clinical audit shows sustained improvement in key areas of clinical audit (9% improvement in patients being extricated appropriately). CORE20 Workstream utilisation of Community First Responders, fundraising for implementation of public access defibrillators and continued recruitment of London Lifesavers. • On going training of LLS and year 8 school children monthly. • New collaboration with the Mayor of London • Increased CFRs hours. Both courses run in September and October have 10 people recruited to them. Extra course planned in the new year as new courses oversubscribed currently. Cardiovascular notifications in SEL

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	• Notifications in place pan London. • 'Know Your Numbers' week (September) publicised through staff networks and internal comms. • Stoptober (October) saw staff welfare and clinically-focused CPD published for staff. Maternal Health Programme • Patient engagement completed, with 190 patients providing insights into LAS care. • 265 clinicians provided feedback regarding confidence with and approaches to maternal clinical care. • Action plan being prepared to commence implementation from January 2026.

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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 Learning Response Lead (LRL) cohort • Provide training in line with PSIRF requirements (12 hours ftf and x2 e-learning packages) • Established monthly LRL drop in sessions to trouble shoot issues • Created LI supervision pool teams group for rapid allocation • Developed SOP for LRL allocation • Created statement of purpose of supervisors • Accurate LRL database for tracking availability and compliance with training • Created sector Radar dashboards to enable monitoring and oversight of learning responses in respective areas. • Moved all reporting to Radar for standardised approach and enable enhanced audit • Monthly 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 LRL	• 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.

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• Adapt AAR template to make an internal document with a view to decrease the team taken to create report post meeting.	
Overdue incidents	
• Established monitoring • Contacted sectors/teams with highest numbers overdue • Escalation via Chief Medical Officer • Bi monthly Radar investigation training • Targeted training to corporate areas without governance leads. • Communication regarding use of 'to do list' function on Radar • Change of metrics to report % overdue which allows for proportionate action • Creating RADAR dashboards for sector oversight • Working with teams workflow responsibilities to support timely investigation and action.	Bi monthly reporting via CQOG and QAC Reporting within quality report Reporting within Performance Reviews and sector based quality reports Staff survey links with outcomes to questions about how responsive the organisation is when a concern is raised. Incident reporting trends – increase would suggest positive reporting culture

Further actions

Action	Date by which it will be completed
<u>Learning responses</u>	
• Tracking the last 10 closures AND last 10 breaches– 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.	• Completed
• 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'	• Completed
• Meeting with supervisors with overdue cases and implement SMART action plans to clear overdue cases	• 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.	• Completed
• 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

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

• Directorates now have a nominated individual who will coordinate identifying the most appropriate action owners in their area speeding up the process for Lis • Close oversight of timelines by central quality team with early interventions and reminders • Review of integrated learning across patient safety, clinical and operational areas and clinical education • Review of processes for sharing of information • Use of wider range of modalities to share learning decided through engagement with clinicians • Evidence that better sharing of learning reduces similar incidents	• Completed • Completed • On going (see 1.7) • On going (see 1.7) • Completed • End of Q4
Overdue incidents • 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 • Completed • Completed • Completed • Ongoing oversight

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BAF Risk: 1.6
We are at risk of providing an inequitable 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 • 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

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

Further actions

Action	Date by which it will be completed
Agree current and future model to meet the increasing MH demand	• Working with ICBs as MH provision is developed as part of the 10-year plan • Developing an agreed internal model for response to MH patients (remote and face to face) • Increasing access to alternatives for MH patients to avoid inappropriate conveyance to ED • Increase number of specialist paramedics MH • Embed MH support into ICC hubs

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

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. The Director of Ambulance Operations has shared a huddle tracker, a Trust wide spreadsheet containing key messaging that is required to be delivered to all operational teams, a confirmation of delivery form and guides on how to deliver a team huddle have also been shared.
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	Education lead now involved in the PSIP weekly meetings, and local learning meetings for each sector.

embed learning and ensure triangulation of information.	
	RADAR automatically shares the incident investigation response and learning derived to the reporter of the incident when the incident is closed.
	Case based discussion events – quarterly MS teams sessions facilitated by the Patient Safety team where incidents and learning are discussed and colleagues have the opportunity to interact.
	Insight Magazine - A comprehensive case book of learning derived from enhanced learning investigations following Patient Safety Incidents are compiled each quarter. The magazine is shared onto the Learning from Experience page onto LAS connect and available for all colleagues to view.
	Enhanced learning responses are summarised, anonymised and uploaded onto the Learning Loft LAS connect page, available for viewing by colleagues Trust wide.
	The Trust wide Quality Report which features learning and key areas of focus from areas across the Trust is saved on the LAS Connect Learning Loft page.
	The enhanced learning responses completed following Patient Safety Incidents are sent to the Deputy Chief Paramedic, Head of Education, Associate Director of Operations of the relevant sector, Medical Director of Clinical Governance, Head of Clinical Quality of the relevant sector, Deputy Director of Clinical Quality Operations to ensure awareness of topics and provide content for education resources.
	Learning bites and bulletins are shared quarterly on LAS Connect Learning loft page accessible to colleagues Trust wide.
	Enhanced learning responses can lead to improvements and clarity of guidance in the centrally stored Patient Care Handbook available on JRCALC and LAS connect. When an amendment is authorised a bulletin is shared on LAS connect highlighting the reason and context for the changes.
	Feedback into national JRCALC guidance
	Monthly CPI audits from CARU – clinicians receive regular feedback
	CARU databases and dashboards – STEMI, cardiac arrest
	The CSR subject approval group, shares the list of CSR topics for the coming year ie. 2026/2027 with attendees of the Patient Safety Incident Response Panel to ensure subject

	areas identified in clinical quality and safety groups (along with topics mandated for Core Skills Training Framework) are covered. Requested topics include but are not limited to : ECGs, spinal assessment and pain management, primary survey, examination and history taking which have been themes of note.
	Learning and Assurance Group – A monthly meeting which seeks assurance from learning across the organisation and discusses emerging themes.
	Enhanced learning responses have led to change in LAS policy. Including the appendices for the 'Out of service' policy following the implementation of the trolley bed task and finish group, a group commissioned to address the missing trolley beds which has a direct impact on patient safety and staff wellbeing.
	Quality improvement initiatives
	Clinical Quality Programme Board and initiatives
	Risk registers and Risk Compliance and Assurance Group
	Quarterly Patient Safety Forum where themes are triangulated and best practice shared.
	Monthly Learning from Death infographics
	Content created and disseminated for team huddles.

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. CSR - a proposal has been made and is being worked through by the various teams who will have an interest or be impacted. It essentially sets out some content to potentially be delivered via huddles (plus a new assurance of that) and then what needs to be delivered in Centre. Nothing set in stone but good progress and on track. The full plan will be implemented in Q1 of 2026/27 and developed over the remainder of 2025/26.	Q1 2026/27
Following the meeting on 9th July: The ePCR training has been rewritten and this new module is delivered during induction for clinicians There are on-going conversations with CESD about updated training for clinicians who are already using ePCR	Q3 2025/26

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

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 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
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

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

	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

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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
2	x	4	=	8

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	

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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 and review of teams and associated scheduling	Awaiting embedding of LDM . Pilot now finished. Paper presented to ExCo on 30th July. Working up proposals for a fully insourced first day reporting system

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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
2	x	4	=	8

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

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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.

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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

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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

Risk	Uncontrolled	Current	Tolerance
• 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

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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
3	x	4	=	12

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

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 Maintain our core telephony at a supported version Work with partners to migrate voice services to a supported infrastructure Robust virtual environment infrastructure	Infrastructure programme board, Digital Delivery Board and regular reporting to Exco and the Digital & Data Committee. Works to migrate services away from Corsham to Waterloo continue with decommissioning and the removal of 22 cabinets from Waterloo DC almost complete A standardised and modern architecture model across all our Datacentres has been implemented. Work is underway within our Infrastructure Programme to patch and upgrade our voice services software to the latest release. The new Nutanix virtual farm environment is currently being built with good progress made which is on track for delivery.
Maintain our core infrastructure at stations	As part of this year's infrastructure programme, we are uplifting the infrastructure of 10 x ambulance stations, improving network connectivity, Wi-Fi and the physical environments that house our infrastructure. This is a continuous project across multiple years as it is not financially viable to deliver these improvements across all locations in one year. .

Further actions

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

Action	Date by which it will be completed
Develop a data centre strategy and roadmap with sufficient investment utilising cloud options	31st January 2026
Revised set of desktop images based on profiles: Admin, CAD user, etc.	Completed – October 2025
Upgrade core telephony to CM10.2	1st March 2026
Deploy a supported voice recording solution	Leadership decision made to continue with current product until 31st March 2027.
Upgrade network infrastructure at 10 ambulance stations to support digital connectivity	31st March 2026
Implementation of a Nutanix-based Servier Farm	31st March 2026
Enhanced wireless infrastructure	31st March 2026
Improve current monitoring solutions through upgrade of Solarwinds	31st March 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	2027
Review from Masons Advisory into the Control Room Solution infrastructure and application	December 2025
Replacement of legacy CROPS	November 2025

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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, FIPC, Trust Board
	Regular oversight of CIP delivery by CIP Programme Board(ExCo) and FIPC

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, FIPC, 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 FIPC

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 FIPC	Completed

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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	Completed
Review of rostering requirements for 999, 111 and corporate staff	January 2026
Migration of Ambulance Operations to GRS Cloud	October 2026
Tender for a workforce management system for 999, 111 and corporate staff	March 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	Completed
Liaise with NHSE and commissioners to maximise income	Completed
Implement targeted Control Total processes	Completed

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.	Action now incorporated into the 10 point plan
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.	Updated via the 10 point plan- further clarity on training requirements being developed with professional leads.

• 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.	
Development of Violence Reduction Charter	Draft reviewed by Inclusion Board in September, it will now go to staff council.
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 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	Completed
Decommission non-compliant fleet	Ongoing
Development of Green plan actions	Completed - 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 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	Ongoing
Continued improvement in performance across LAS IUC services to ensure that we are in the best position ahead of tenders	Ongoing
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	Ongoing

BAF Risk: 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.

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 FIPC
	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	Ongoing as part of approved Infrastructure Strategy
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

6.1.1. Southern Ambulance Services Collaboration (SASC)

For Information

Presented by Jason Killens

Report to:	Trust Board			
Date of meeting:	04 December 2025			
Report title:	Southern Ambulance Service Collaboration Update – October 2025 Update			
Agenda item:				
Report Author(s):	Kamran Raja, Business Manager to the Chief Executive			
Presented by:	Jason Killens, Chief Executive Officer			
History:				
Purpose:		Assurance		Approval
		Discussion	X	Noting

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

Purpose

To provide the Board with an update on the Southern Ambulance Services Collaboration (SASC) key collaborative initiatives discussed at SASC Board (13 October 2025) and CEO (31 October 2025) meetings to include procurement, digital transformation, ambulance optimisation and recruitment.

Actions required:

- **Note** progress on joint initiatives across procurement, digital, operations and recruitment.
- **Endorse** the draft CEO letter for distribution following Board approval

Summary

This cover sheet summarises the work undertaken by SASC in its first year highlighting:

- Procurement Collaboration: A Procurement Board has been established and appointment of an Interim Director for Procurement for SASC has been made – Nick Young (LAS). There are recognised savings of £208K YTD with a further £300-450K identified and next steps identified. Collaborative procurement has been identified as a strategic priority and all CEOs have confirmed support.

- Digital and AI: progress on AI use cases, proof of concepts and opportunity recognised for shared infrastructure with relation to cyber security. Two proof of concepts currently involve (a) training within an EOC environment and (b) streamlining documentation of clinical assessment.

- DCA Optimisation: a focus on identifying variation in data with the aim of moving towards a standard set of data definitions to better inform decision making. Whilst NHS England are aware of this workstream, the Board recommended that a roadmap is to be developed for sharing when there is appropriate rigour and process with understanding of potential implications.

Decisions required
Actions required: • **Note** progress on joint initiatives across procurement, digital, operations and recruitment. • **Endorse** the draft CEO letter for distribution following Board approval

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer**
Quality	Yes		No		
Finance	Yes		No		
Chief Finance Officer Directorates	Yes		No		
Chief Executive Officer	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

A partnership between
the ambulance services of;
East of England
London
South Central
South East Coast
South Western

6th November 2025

A key priority for all our trusts, agreed in June 2024 at the Southern Ambulance Services (SASC) inaugural workshop is collaborative procurement.

Over the last 12 months we have made progress with this initiative, firstly through establishing a joint Procurement Board, chaired by David Eltringham (Chief Executive Officer (CEO) SCAS) comprising all five Chief Financial Officers (CFOs); and in July 2025 we appointed Nick Young as Interim Procurement Director for SASC. Nick, whose permanent role is Head of Procurement Transformation at London Ambulance Service, was appointed following a request for expressions of interest in the role to all SASC trusts Heads of Procurement (HoPs).

During the current financial year over £220K of savings have now been realised through collaborative procurement with up to a further £400K already identified.

In October 2025, the SASC Board comprising Chairs and Chief Executive Officers of all SASC trusts reaffirmed their commitment to collaborative procurement. This recognises the significant financial challenges that the NHS is facing and the benefits of working together for our people and our patients, achieved through shared skills, experience and information as well as strength as a larger customer in the marketplace. Our collective procurement size as a collaboration of five organisations is nearly £1Bn making us, working together, a significant customer and thus able to leverage our market position.

Over the next three months we will run a series of workshops, initially with CEOs, CFOs and HoPs, to determine how we can work together more effectively and the next steps in our collaborative procurement journey. We will then broaden the conversation to stakeholders including procurement teams and users of procurement services. In the meantime, our stated and shared expectation is that where procurement can be done together as a group it should be; thus, our position as members of SASC is 'collaborative procurement first'.

We thank you for your continued support for this important initiative.

Neill Moloney – CEO EEAST

Simon Weldon – CEO SECAmb

Jason Killens – CEO LAS

John Martin – CEO SWAST

David Eltringham – CEO SCAS

Southern Ambulance Services Collaboration (SASC)

Update to Trust Boards following SASC Board Meeting 13th October 2025 and CEO Meeting 31st October 2025

Working together for our patients, people and communities

About this document

This document provides a summary of the SASC Board Meeting on 13th October 2025 and the following SASC CEO meeting on 31st October 2025, focused on Procurement.

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Present at SASC Board Meeting

Attendees:

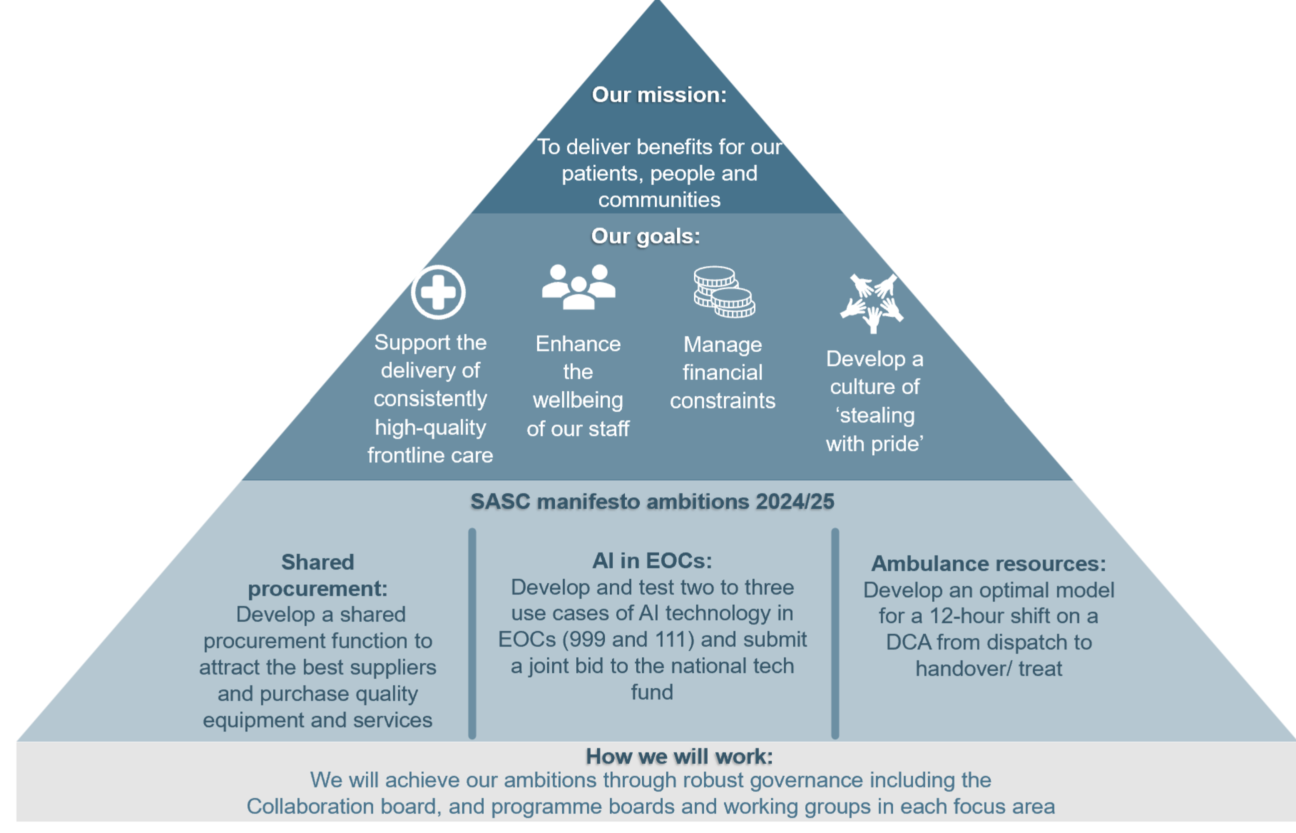
Members:
Mrunal Sisodia - Chair East of England Ambulance Service (in the Chair)
Andy Trotter - Chair London Ambulance Service
Michael Whitehouse - Chair South East Coast Ambulance Service
Raz Akbar - Deputy Chair South Western Ambulance Service
Keith Willett - Chair South Central Ambulance Service
Simon Weldon - CEO South East Coast Ambulance Service
Jason Killens - CEO London Ambulance Service
John Martin - CEO South Western Ambulance Service

In Attendance:
Nic Daw – Managing Director of SASC
Andrew Cratchley – External Support to SASC

Presenting:
Clare McMillan -Chief Digital Officer LAS (Agenda item 4)
Tim Borham - Clinical Product Specialist/Paramedic (Agenda item 4)
Craig Ellis - Chief Digital Officer (Agenda item 4)
Nick Roberts - Chief Digital Information Officer (Agenda item 4, via MS Teams)
Tina Ivanov - SECAmb – (Agenda item 6 via MS Teams)

Apologies
Richard Compton – Chair South Western Ambulance Service
Neill Moloney - CEO East of England Ambulance Service
David Eltringham - CEO South Central Ambulance Service

SASC Year 1 Manifesto



The SASC Board meeting on 31st October provided an opportunity to reflect on progress against ambition over the first year of SASC operations and to explore potential opportunities for Year 2.

This report provides a summary of the SASC Board meeting and the follow up CEO meeting focused on Procurement.

Priority 1 – Procurement

SASC Board 13th October 2025

SASC's year 1 ambition is to:

- **Develop shared SASC procurement to attract the best suppliers, purchase the highest quality products and services at the best price and provide a return on investment (RoI) in Year 1.** The overarching principles are (1) the default is shared procurement, and (2) when procuring items, we will first consider how to maximise the net benefits for the collective.

The SASC Board received an update on progress of collaborative procurement during the financial year 2025/26.

Key notes were:

- The establishment of a Procurement Board – Chaired by David Eltringham CEO SCAS
- Appointment of an Interim Director of Procurement for SASC (Nick Young – Procurement Director LAS)
- Recognised savings in year to date of £208K with a further £300K-£450K identified
- The challenges of operating under the current model were discussed as were opportunities for future collaboration.

The Board agreed that:

- There remains broad support for shared procurement amongst SASC Trusts
- Collaborative Procurement remains the default for all SASC Trusts
- The progress to date was noted and challenges were acknowledged
- To further inform Boards and support the decision to move to Option 4 the following was asked for by Chairs:
    - Gateway criteria
    - Timelines for the move to Option 4
    - To be presented to Boards before the end of FY 2025/26

SASC CEO Meeting 31st October 2025

The meeting of the SASC CEOs on 31st October focused solely on procurement and an in-depth discussion took place around material presented by the Interim Director of Procurement and SASC Central team.

This included a review of "steps to success"

Step 0 – Concept and Case for Change – Complete
Step 1 – Feasibility and Options Appraisal – In place / Underway
Step 2 – Identify and prepare for a move to a preferred option - Gateways
Step 3 – Implementation Readiness
Step 4 – Go Live – Service Launch
Step 5 – Benefits Realisation

Noting that SASC is currently at Step 1 the next step is to identify and prepare for a move to a preferred option. A series of gateways supporting the preparation of a Business Case for presentation to Trust Boards was proposed:

- Gateway 1 – Data and Information Accuracy
- Gateway 2 – Develop Target Operating Model
- Gateway 3 – Understand Implications for Our People
- Gateway 4 – Estimate financial impact – Economic and Finance Cases
- Gateway 5 – Develop Implementation Plan
- Gateway 6 – Present Business Case of above to Trust Boards

The challenges and advantages of both the current operation and moving to a proposed model were discussed and acknowledged

The CEOs reaffirmed the commitment to collaborative procurement as the default and proposed that a workshop is held to work through the gateways with Chief Financial Officers and Heads of Procurement.

This is now being actioned.

Members engaged in activity:

CEO Lead – David Eltringham

CFOs

Steven Course - East of England Ambulance Service
Rakesh Patel - London Ambulance Service
Stuart Rees - South Central Ambulance Service
Simon Bell – South East Coast Ambulance Service
Andrew Rosser – South Western Ambulance Service

Heads of Procurement

Richard Whiteside - East of England Ambulance Service
Nick Young - London Ambulance Service
Julie Robins - South Central Ambulance Service
Geoff Hopper – South East Coast Ambulance Service
Sharon Murphy – South Western Ambulance Service

Priority 2 – Digital and AI

SASC's year 1 ambition is to: **Identify and develop two to three use cases of AI technology in EOCs** to improve patient care and support staff wellbeing. Submit a joint bid to the national tech fund. Examples of use cases could include: transcription and summary tools, sentiment analysis, clinical audits, pre-caller ID, etc.

The SASC Board received updates on progress from the CDIOs of the five SASC Trusts on the following:

Proof of Concept 1 – Staff Training in EOC using AI simulation – PoC Running in SCAS and LAS

Proof of Concept 2 – AI write up of clinical conversations following patient consultations in the Clinical Hub area of the EOC - PoC Running in LAS and SWAST

Opportunities for Shared Digital Infrastructure

Opportunities for Collaboration on Cyber Security

The two proof of concepts had proved to be well received by staff. There were opportunities for increased productivity in both training and in the Clinical Hubs without compromising quality. All CDIOs were involved across the Proof of Concepts with plans to expand the footprints where practical.

The opportunities for shared digital infrastructure were recognised as was the need for enhanced Cyber protection.

- The Board requested that Business Cases be developed for the projects detailed and indicative figures to be prepared for shared digital infrastructure to support planning for FY 2026/27
- The Board noted the progress and close collaborative working of the CDIOs

Members engaged in activity:

CEO Lead – Simon Weldon

CDIOs

Sian Clark - East of England Ambulance Service
Clare McMillan - London Ambulance Service
Craig Ellis - South Central Ambulance Service
Nick Roberts – South East Coast Ambulance Service
Tim Bishop – South Western Ambulance Service

Priority 3 – DCA Optimisation

SASC's year 1 ambition is to**: Develop an optimal model for a 12-hour shift on a DCA.** The focus will be to improve the availability of our ambulance resources by (1) developing best practice processes (e.g., start and end of shift processes, break policies, etc), and (2) optimising how we use and deploy our resources (e.g., what resources and how many we deploy to certain jobs).

Progress was noted on this workstream and in particular the focus has been on identifying variations in data and moving towards a standard set of data definitions to better inform decision making.

A workshop has recently been held with Trust Data and Operational Leads to identify variance and to begin the process of standardising the way in which this could be standardised.

- The SASC Board recognised the challenges that this presents and agreed that the work s should continue with data leads to implement harmonized metrics.
- It was further noted that whilst NHS England were aware of this work, formal sharing would take place once there is rigour in the process and understanding of the potential implications.
- The Board recommended that a roadmap is to be developed for sharing with NHS England

Members engaged in activity:

CEO Lead – Dr. John Martin

Operational Leads

Darren Meads - East of England Ambulance Service
Christopher Reed - London Ambulance Service
Tracy Redman - South Central Ambulance Service
Richard Harker – South East Coast Ambulance Service
Nick Wilson – South Western Ambulance Service
Nick Metcalfe – South Western Ambulance Service

Data Leads

Kyriacos Kyriacou- East of England Ambulance Service
David Bishop - London Ambulance Service
Mark Green - South Central Ambulance Service
Alex Croft – South East Coast Ambulance Service
Paul Quick – South Western Ambulance Service

Additional Project - Recruitment Hub

Colleagues from EEAST and SECAmb provided a presentation on a shared recruitment hub initiative.

This involves the five SASC Trusts collaborating on developing and implementing a system to improve recruitment efficiency from both the Trust and the Recruits points of view.

The SASC Board noting the progress and proposed next steps of:

- Participate in sharing recruitment data and information from all trusts to support baselining and quantification of benefits for the recruitment hub business case.
- To clarify how the proposed recruitment hub aligns with the HR regional model and address concerns about potential imposition of the TOM approach.

Members engaged in activity:

CEO Lead – Neill Moloney

Dr. Hein Scheffer - East of England Ambulance Service
David Ruiz-Celada - South East Coast Ambulance Service
Dr. Tina Ivanov - South East Coast Ambulance Service

Budget

It was noted that SASC was operating within budget with a current surplus of £85K in 2025/26.

Year 2 Priorities

The Board discussed potential Year 2 priorities with the following to be explored further:

- The need for common role descriptions and career pathways to enable portability and harmonisation across organisations was highlighted, referencing previous discussions on transparency and transferability of training.
- The importance of demonstrating cost reduction and improved patient care as strategic outcomes was emphasised suggesting that initiatives should be explicitly linked to these government imperatives.
- The need for a common language and benchmarking across services was identified as critical for measuring and demonstrating success, agreeing that comparability and productivity should be strategic themes.
- It was suggested sharing best clinical practice and learning from variations in wait times and triage processes, adding, supporting the idea of leveraging examples of excellence across services.

Governance Arrangements

The Chair of the SASC Board noted that under the Terms of Reference, their tenure had been completed. For the purposes of continuity, it was agreed that the Chair should continue in this role with a review in FY 2026/27

7. For Information

7.1. WRES & WDES 2024-2025

For Information

Presented by Roger Davidson

Report Title	**Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) Reports**		
Meeting:	Board Meeting		
Agenda item:	WRES & WDES	**Meeting Date:**	04/12/2025
Lead Executive:	Roger Davidson		
Report Author:	EDI team		

Purpose:		Assurance		Approval
		Discussion	X	Information

Report Summary

The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) are requirements for NHS providers to publish as part of the Public Sector Equality Duty, demonstrating progress against various indicators of workforce equality.

The WRES and WDES data were integral to the P&C board report. The final reports were published following approval at the People and Culture Committee in September. Please find attached the final versions of the WRES and WDES reports for the Board's review and completeness.

Request to the Committee

The board is asked to note approval by the People and Culture Committee for completeness.

Routing of Paper i.e. previously considered by:

EDI Implementation Group
People and Culture Committee
Executive Committee

Corporate Objectives and Risks that this paper addresses:

How does the paper address corporate objectives as expressed in the BAF and what are the associated risks and mitigations?

How does the paper contribute to LAS's work to improve and create a more compassionate and positive culture?

How does the paper contribute to work to improve equality and inclusion in the workplace?

The paper is aimed at improving the culture at LAS and creating outstanding, caring and compassionate services through creating an increasingly inclusive well-led organisation and making a measurable improvement in attracting and retaining a workforce that is representative of the communities of London.

Workforce Race Equality Standard

LAS Report and Action Plan – 2024/2025

We are the capital's emergency and urgent care responders

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Overview of the Workforce Race Equality Standard

Purpose

NHS trusts are required to produce and publish their WRES report annually. Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The purpose of the WRES is to ensure that NHS organisations review their data against the nine indicators which are outlined in the WRES, produce an action plan to close any gaps in the workplace experience between white and ethnic minority staff, as well as improving the representation of ethnic minority staff at the Board level of the organisation.

The WRES report is a key component of our workforce EDI work, setting our direction in achieving good practice race equality across all areas of the employee lifecycle and ensuring our staff have access to career opportunities, development and progression and receive inclusive and fair treatment in the workplace.

Methodology

The WRES requires NHS trusts and ICBs to self-assess against 9 workplace experience and opportunity indicators. Four metrics are taken from workforce data and the remaining are based on the NHS staff survey.

Scope

The WRES data included in this report has been obtained from:

- Electronic staff records
- Human resource team records
- Organisational development records
- NHS staff survey

Definitions

The definitions of ethnic minority and white, used in WRES, have followed the national reporting requirements of the ethnic category in the NHS data model and dictionary.

At the time of publication of this report, these definitions were based upon the 2021 ONS Census categories for ethnicity.

Foreword

The capital's emergency and urgent care responders.

We remain absolutely committed to ensuring that our ethnic minority colleagues have a fulfilling experience at work, where they feel safe and are treated fairly. Therefore, it is crucial for us to understand and tackle the disparities between ethnic minority staff and their white counterparts, and why our WRES work is so important.

We are pleased to see the progress LAS has made last year, but recognise there is much more to do to drive further improvements:

- **Improved our representation across the Trust so approximately one in four staff are from an ethnic minority background. This is much higher in some parts of the organisation but there is more to do to drive a better balance across the Trust.**
- **Reduced the difference between white staff and ethnic minority staff being appointed from an interview process. We are delighted to see the changes in this area following the efforts to create fairer interview processes and move this indicator in the right direction.**

Our challenges lie in not only driving further improvements but also sustaining our impactful initiatives and we will continue with putting energy into this. Although we have some way to go, we are confident the work we are putting in will continue to shift the dial in becoming an increasingly diverse and equitable workplace.

Dr Fenella Wrigley

Deputy Chief Executive, Chief Medical Officer, London Ambulance Service NHS Trust

Our strategic equality objectives

To achieve the work set out in the LAS strategy 2023-28, we have developed three EDI objectives which will contribute to the delivery of our vision and goals until 2028 and achieve the mission of "being an increasingly inclusive, well-led and highly skilled organisation people are proud to work for."

The LAS strategy states:

"We aim to build a diverse organisation that values and celebrates difference, promotes equality and prioritises the wellbeing of our people. We will build a workforce that knows and reflects the people we serve. We will build an organisation where everyone can feel they belong, their voice is valued and there are opportunities for a career. Discrimination, bullying, harassment and racism have no place in our organisation and we will take a zero-tolerance approach to tackling this behaviour."

To deliver the missions set out in the LAS strategy, we have developed three EDI objectives which will contribute to the delivery of our vision and goals until 2028:

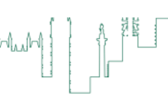
OBJECTIVE 1	**Foster proactively a diverse and open culture with an equitable working environment, including through staff training on discrimination and impactful staff networks.**
OBJECTIVE 2	**Make measurable improvement in attracting and retaining a workforce that represents London, reaching out to relevant communities and helping staff to build great careers.**
OBJECTIVE 3	**Generate clear leadership accountability for action based on good management data and staff feedback, including compliance with legislation and equality standards.**

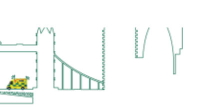
Our progress in 2024/25

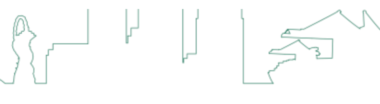
The following report provides an overview of our progress, challenges and aspirations. We remain on a journey and equality, diversity and inclusion is the unifying thread that stems from our core values of care, respect and teamwork and runs through every aspect of our organisation, from leadership to delivery and from workforce to the community we serve. Over the last year we have achieved the following that aligns with our plans and overarching objectives relating to WRES:

- **170 of our most senior leaders have committed to meaningful EDI objectives that drive an inclusive culture, this includes looking at the makeup of their teams, identifying gaps and needs and providing appropriate support and action.**
- **Data led EDI transformation workshops were delivered to create local action plans across key directorates.**
- **Delivered Tackling Discrimination and Promoting Inclusivity training to 75% of the workforce and bespoke training to managers to ensure ongoing learning and setting important foundations.**
- **New 2-step process implemented in to the Referral to Resolution using the Anti-Discrimination and Anti-Racism Charters.**
- **Reduced bias in recruitment and interview processes through Independent Panel Members programme (50+ recruited).**
- **Implemented the new Stepping Up Support Package to support colleagues with development and progression.**
- **2 cohorts of the powerful ‘Women of Colour’ programme delivered to support ethnic minority women with progression into leadership roles.**

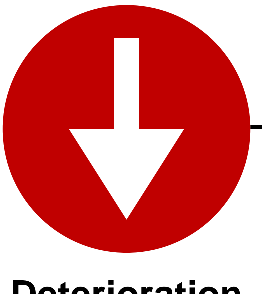
This achievement snapshot demonstrates just part of the journey and the findings in this report show there is much more to do, which will require ongoing dedication, genuine commitment and proactive interventions. Culture change programmes and complex transformation relating to EDI take time. Many of the interventions are in their first year of implementation and whilst we are seeing positive change, some of the benefits will only start to be realised in the coming years and we are committed to embedding what is needed for a fairer future.



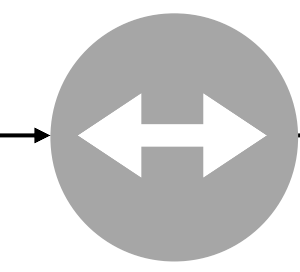




Understanding the findings



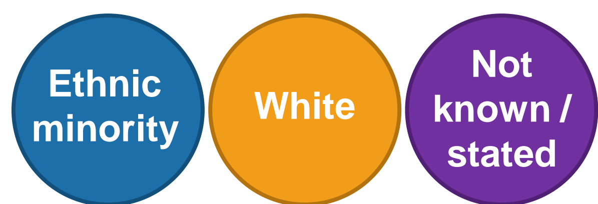
Deterioration



No significant change

Improvement

Key



Metrics 1 - 4 and 9 are a snapshot of our workforce data from 31 March 2025, while Metrics 5-8 are taken from the NHS Staff Survey, conducted in Autumn 2024.

3 key questions explored in this report

What is the data telling us?

How do we compare with previous years?

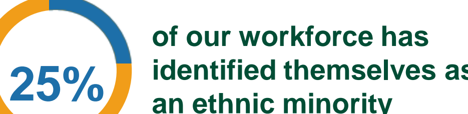
What are we planning to do?

We are the capital's emergency and urgent care responders

Key findings

Metrics 1-4 and 9 are a snapshot of our **workforce data** from 31 March 2025, while Metrics 5-8 are taken from the **NHS Staff Survey**, conducted in Autumn 2024.

1. Staff Representation



of our workforce has identified themselves as an ethnic minority

2. Shortlisting

White applicants are

1.3X

more likely to be appointed from shortlisting

3. Disciplinary

Ethnic minority colleagues are

1.8X

more likely to enter the formal disciplinary process

4. Training

White applicants are

1.2X

more likely to be access non-mandatory training and CPD

5. Bullying from public

43.5%

of ethnic minority colleagues reported experiencing harassment, bullying or abuse from the public

6. Bullying from staff

23.2%

of ethnic minority colleagues reported experiencing harassment, bullying or abuse from colleagues

7. Progression

44.7%

of ethnic minority colleagues believe the Trust provides equal opportunities for career progression and promotion

8. Discrimination

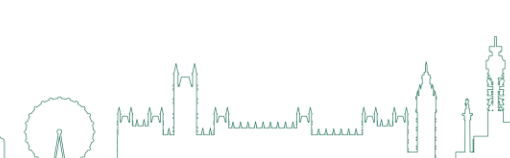
15.3%

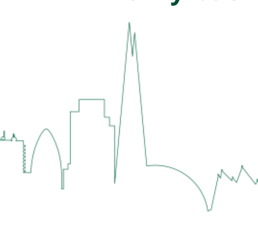
of ethnic minority colleagues experienced discrimination from their manager or colleagues

9. Trust Board

31%

of our Trust Board (voting membership) are from an ethnic minority background





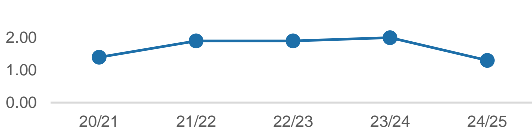
Comparisons

Metrics 1-4 and 9 are a snapshot of our **workforce data** from 31 March 2025, while Metrics 5-8 are taken from the **NHS Staff Survey**, conducted in Autumn 2024.

1. Staff Representation

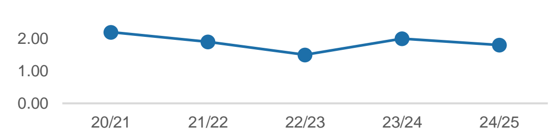
Last year (23/24): 23.9%   This year (24/25): 24.6%

2. Shortlisting



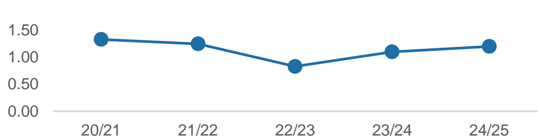
Last year (23/24): 2.0   This year (24/25): 1.3

3. Disciplinary



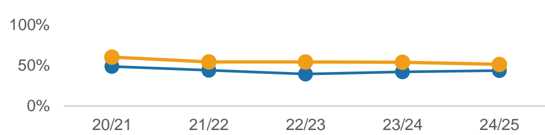
Last year (23/24): 2.0   This year (24/25): 1.8

4. Training



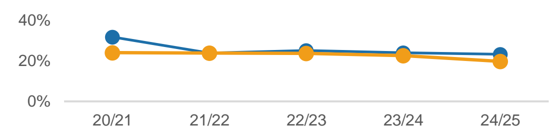
Last year (23/24): 1.1   This year (24/25): 1.2

5. Bullying from public



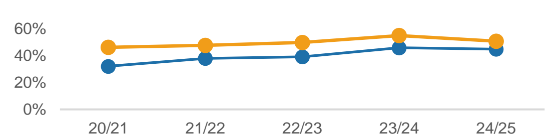
Last year (23/24): 42.0%   This year (24/25): 43.5%

6. Bullying from staff



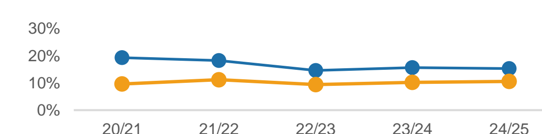
Last year (23/24): 24.0%   This year (24/25): 23.0%

7. Progression



Last year (23/24): 46.0%   This year (24/25): 44.7%

8. Discrimination



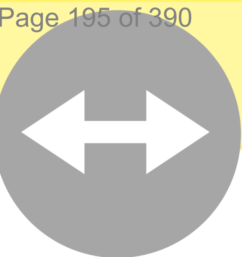
Last year (23/24): 15.6%   This year (24/25): 15.3%

9. Trust Board

Last year (23/24): 31.0%   This year (24/25): 31.0%

Indicator 1

Percentage of staff in each of the AfC (Agenda for Change) bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.



Proportion of workforce identifying as an ethnic minority (%)

Ethnic minority
White

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2021
2022
2023
2024
2025

The data shows that although we are making continued progress in increasing the representation from ethnic minority communities, with **almost 25% of staff members being from an ethnic minority background,** we have **remained consistent in comparison to last year.** However, we have continued to see a **positive trend over the last few years**. Our retention levels are high and the challenging financial operating context has impacted the potential growth in this area.

Our key objective is to increase representation over time and strengthen our values of and mission to provide the highest quality care, in the best way and contributing to Londoners having the best health outcomes in the world.

However it remains important to us to have a workforce that is representative of London, and we are doing more to ensure we are recruiting from diverse communities wherever possible. Our LAS Inclusive Response programme is focused on recruiting and supporting Londoners that are unemployed and often includes the most vulnerable in our communities, and we will continue with such initiatives in the coming year.

Indicator 1

Percentage of staff in each of the AfC (Agenda for Change) bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

Ethnic minority staff across the organisation

The data shows differing representation across all bands. Whilst there remains a large overrepresentation in the lower bands and underrepresentation in the upper bands, we have seen improvements across all bands apart from bands 8d and 9 which is positive. To note, those at VSM level represent a very small number of staff (15 people).

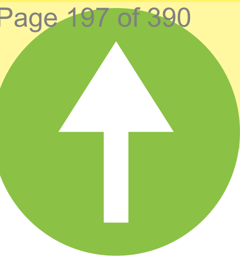
	Ethnic minority	White	Unknown^
Band 2	38.7%	19.7%	41.6%
Band 3	53.1%	30.3%	16.6%
Band 4	34.5%	59.9%	5.6%
Band 5	19.2%	77.8%	3.0%
Band 6	15.1%	82.4%	2.5%
Band 7	15.2%	80.6%	4.2%
Band 8a	21.6%	70.4%	8.0%
Band 8b	17.4%	77.3%	5.3%
Band 8c	22.9%	65.7%	11.4%
Band 8d	12.0%	76.0%	12.0%
Band 9	7.1%	92.9%	0.0%
VSM	15.4%	69.2%	15.4%
Non AfC*	25.0%	40.0%	35.0%

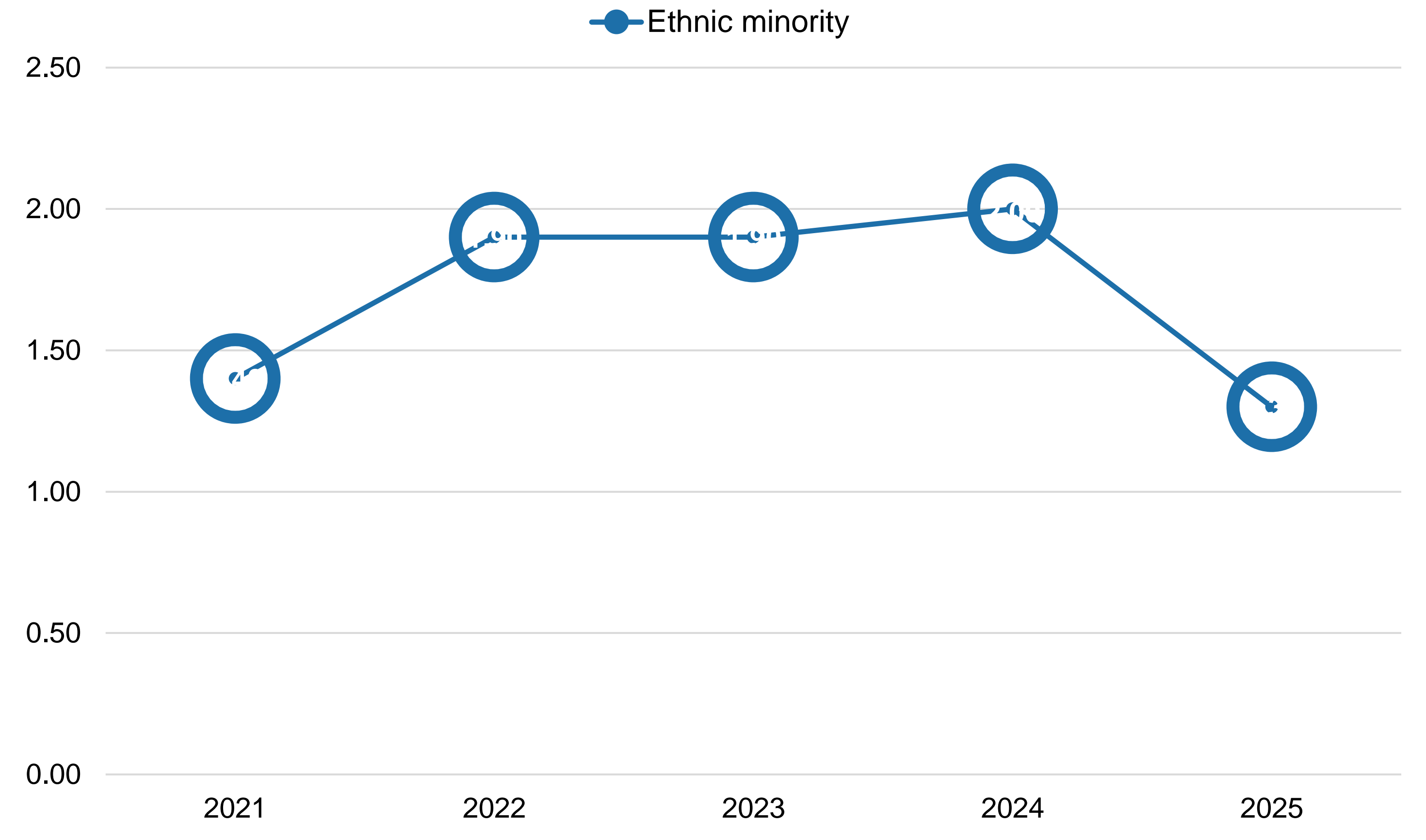
*Our non AfC staff includes over 400 people who prepare frontline vehicles for operational duties and are currently in the process of assimilating following TUPE

^Unknown data is mainly due to data completeness and tends to be lower for TUPE staff

Indicator 2

Relative likelihood of white staff being appointed from shortlisting compared to ethnic minority staff across all posts





A figure below 1:00 indicates that ethnic minority staff are more likely than white staff to be appointed from shortlisting.

The data shows that **white applicants are 1.3 times as likely to be appointed** from an open recruitment process than someone from an ethnic minority community. We are really pleased to see this **significant improvement** compared to last year.

The Trust has invested time and energy to create positive action initiatives to address the results from last year. This has included using Independent Panel Members in recruitment to ensure a fair and unbiased process and supporting senior managers to actively identify staff for talent and development opportunities, offering support through the Stepping Up Support Package and simple confidence boosting conversations.

Our ambition is to drive this difference down further and sustain some of the impactful positive action initiatives that have been implemented this year.

Indicator 3

Relative likelihood of ethnic minority staff entering the formal disciplinary process compared to white staff

A figure above 1:00 indicates that ethnic minority staff are more likely than white staff to enter the formal capability process.

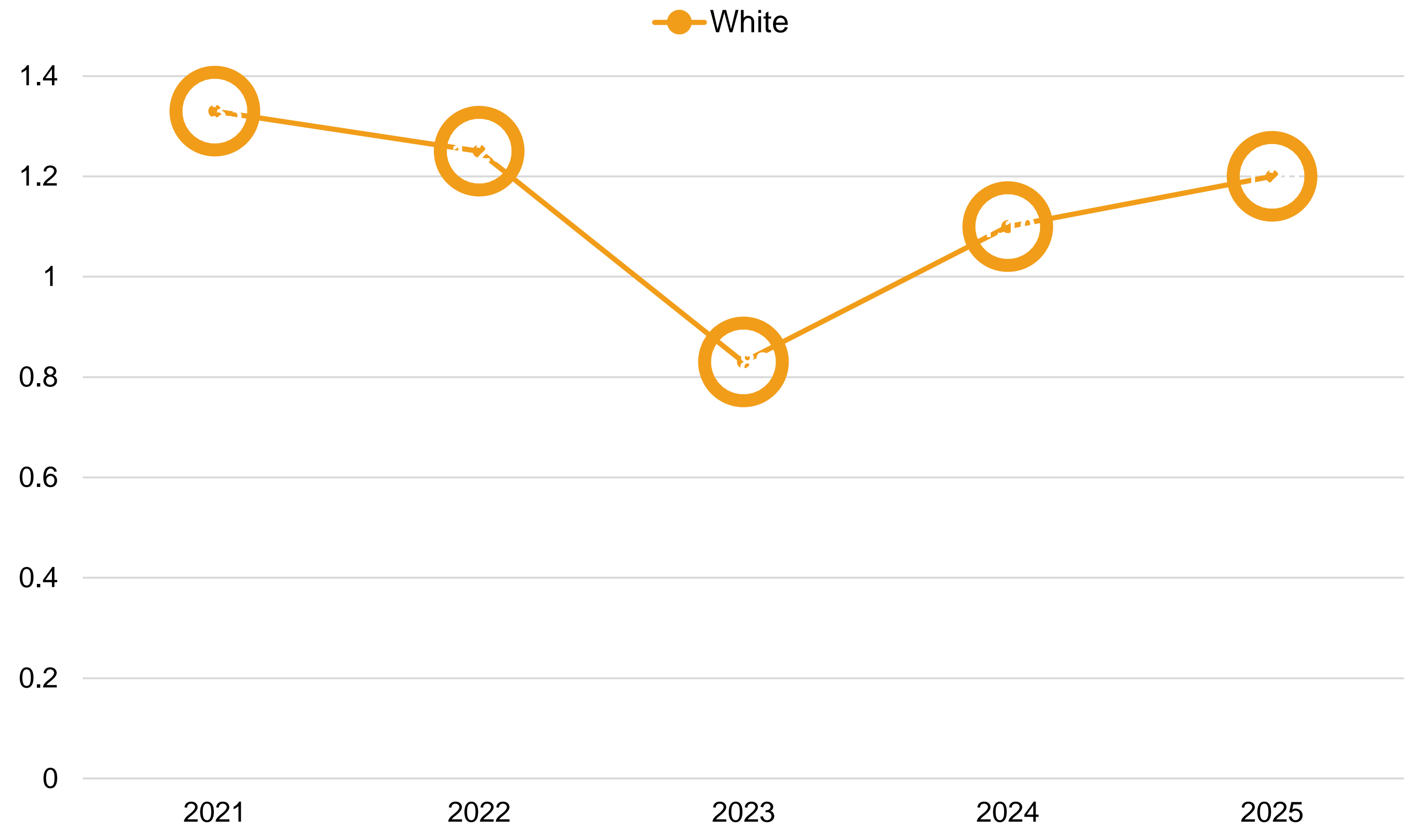
The data shows that **ethnic minority staff are 1.8 times as likely to be put through a disciplinary process** than their white counterparts. There is **an improvement against the previous year** and whilst this is a positive change there is a lot more to be done to ensure this is balanced.

Some of our initiatives, such as the anti-discrimination and anti-racism charters, which sets out our clear expectations and working them in to the 'referral to resolution' process will have contributed to this positive shift.

Over the coming year, we will be sharing more localised data with teams to understand and highlight where there may be issues or patterns and carry out targeted work in those areas.

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD



A figure above 1:00 indicates that white staff are more likely than ethnic minority staff to access non-mandatory training and CPD

The data indicates that **white staff are 1.2 times as likely to access non-mandatory training and Continuing Professional Development (CPD) opportunities** than staff from ethnic minority communities.

This represents a **slight deterioration** on last year, suggesting an ongoing disparity in training and development access or awareness for ethnic minority staff. There has been a **varying trend over the last few years** though the figures have generally remained high.

We will continue to support managers to raise awareness of our Learning and Development course catalogue for more ethnic minority staff to take up learning opportunities. We will also ensure the way the data is captured is improved and comprehensive to include any wider non-mandatory training taking place.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

Ethnic minority White

70%
60%
50%
40%
30%
20%
10%
0%

2021 2022 2023 2024 2025

The data reveals in the last 12 months **43.5% of ethnic minority staff experienced harassment, bullying or abuse from patients, relatives or the public**. This marks a **deterioration on last year's findings** which stood at 42.0%, demonstrating staff face ongoing challenges in this area.

White staff have seen an improvement although are still experiencing a high level of incidents. However, the difference between white staff and ethnic minority staff is closing, moving from 11.9% to 7.7%. The Trust is working hard to put in place measures to ensure we create a safer and more respectful environment for all staff members through zero tolerance policies, where colleagues are supported to step away from such situations and encouraging the increased use of body worn cameras.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Ethnic minority White

35%
30%
25%
20%
15%
10%
5%
0%

25.1%
24.0%
23.6%
22.6%

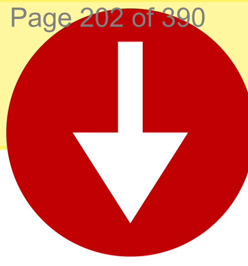
2021 2022 2023 2024 2025

The data reveals in the last 12 months there has been an improvement for both groups in this category. **23% of ethnic minority staff experienced harassment, bullying or abuse from other staff members**. This marks **an improvement on last year's findings** which stood at 24%**.** However the difference between the groups has increased this year with 20% white colleagues reporting such incidents. This demonstrates an ongoing **positive trend over the last few years** however still shows the disparity in experiences between ethnic minority and white staff**.**

The Trust has a zero tolerance approach to bullying and harassment. We have continued with targeted training for all staff and to raise awareness of the behaviour expectations from our colleagues as defined in the anti-discrimination and anti-racism charters. We have provided mechanisms to report freely and offered specialist support for teams and individuals, which will continue in the coming year and we hope to drive this down further.

Indicator 7

Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion



Ethnic minority
White

60%
50%
40%
30%
20%
10%
0%

2021
2022
2023
2024
2025

The data reveals the **percentage of ethnic minority staff who believe the Trust provides equal opportunities for career progression and promotion is 44.7%.** The corresponding figure for white staff is 50.6%. Though both groups have decreased this year, there remains a general **positive trend over the last few years** and the gap between the groups has decreased.

The Trust will be looking at improving the communications about support available for staff, importantly do more to raise awareness of the opportunities available and support all staff to progress.

Indicator 8

In the last 12 months have you personally experienced discrimination at work from any of the following – Manager / Team Leader or other colleagues?

Ethnic minority | White

20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%

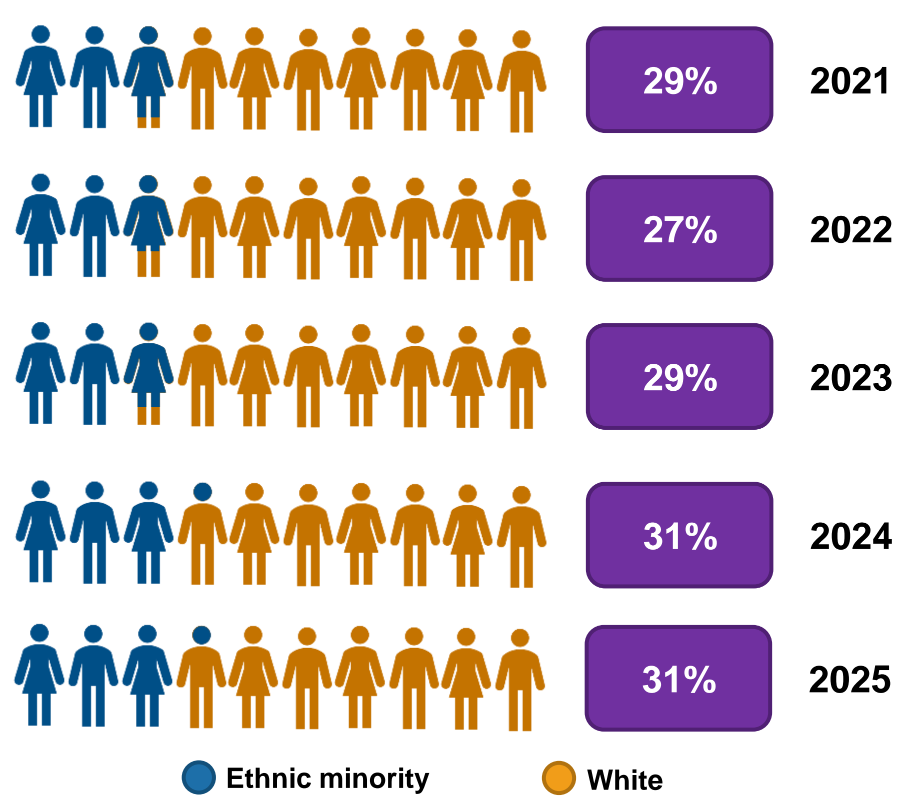
2021 | 2022 | 2023 | 2024 | 2025

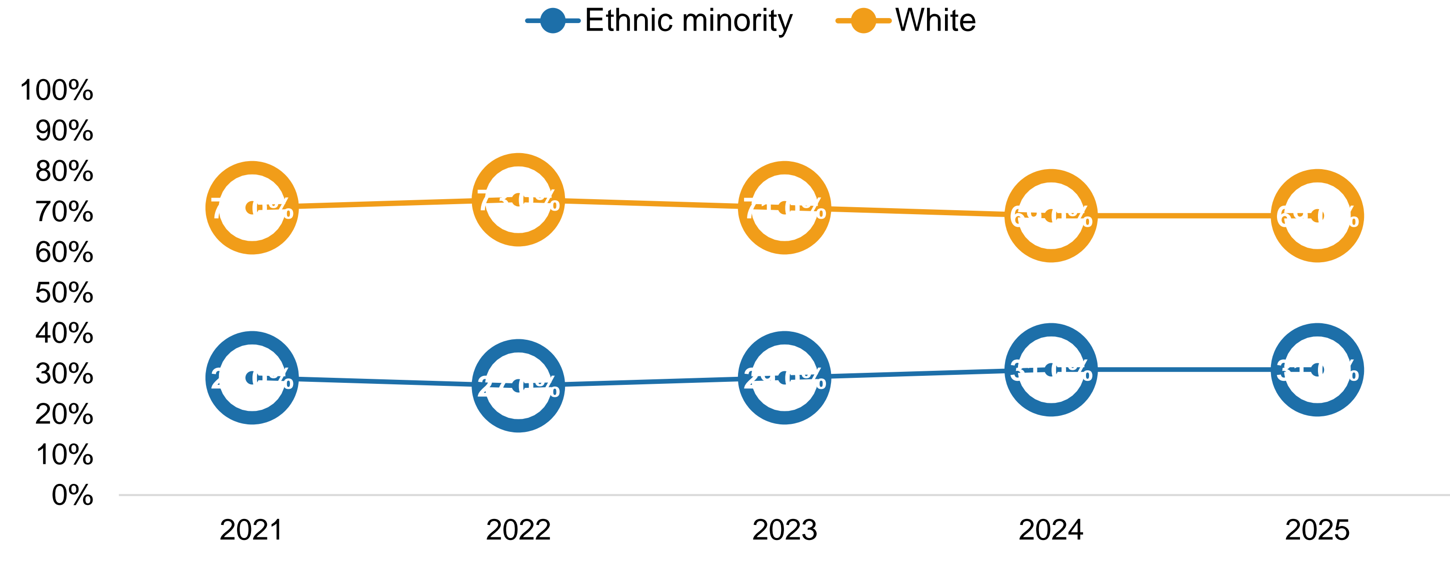
15.3% of ethnic minority staff personally experienced workplace discrimination from managers, team leaders or colleagues in the last year. This is a similar position to the previous year where it was 15.6%. Data relating to white staff showed slight deterioration at 10.6% from 10.2% the previous year and there is a **positive trend for ethnic minority staff over the last few years.**

Having awareness of these unacceptable behaviours is critical and addressing this remains crucial to foster an inclusive and respectful work environment for all. We will continue to support staff to speak up and ensure there is robust training and processes in place to support colleagues. We have also ensured our anti-discrimination and anti-racism charters are an integral part of the 'Referral to Resolution' process and hope to see ongoing improvements in this area.

Indicator 9

Percentage difference between the Organisation's Board voting membership and its overall workforce.





The data indicates that **ethnic minority staff constitutes 31% of the Trust Board's voting membership**, which is 6% higher than the ethnic minority staff makeup of the overall workforce. This is has **remained consistent over the last few years.**

We remain committed to diverse representation at the leadership level and to drive inclusive governance, allowing ethnic minority individuals to be represented and contribute towards decision-making and drive a more inclusive culture.

Summary and next steps

This report shows the progress we are making against the WRES, which focuses on the experiences of people from ethnic minority communities. It highlights where progress has been made, where stronger focus and interventions are needed and how we plan to drive the best outcomes and create a level playing field for ethnic minority staff.

We have made **good improvements against three of the WRES indicators** in 2025, a **deterioration in three indicators** and **no change in three indicators**. Our WRES findings show we need to do more to close the disparities between ethnic minority and white staff, but in some areas we are making good progress. This is particularly significant in Indicator 2 where we are pleased to see a marked improvement and will work hard to sustain this.

There are a range of positive action initiatives that have been put in place already, including targeted training programmes, ensuring our new Anti-Racism Statement and Anti-Discrimination Charters form part of our 'Resolution to Referral' process and the introduction of the Stepping Up Support Package and use of Independent Panel Members. The findings indicate that these interventions are making a difference and we will work to sustain and build on these in 2025/2026.

Whilst we are pleased to see the improvements, we recognise we still have a long way to go to ensure our ethnic minority staff are treated equally and have the same opportunities to progress as their white counterparts. We will continue to drive improvements in the coming year and remain committed to this.

Next Steps

Oversight of WRES will take place through the People & Culture Committee and through the cross-directorate EDI Implementation Group. The EDI Implementation Plan has been updated to focus on areas of importance to WRES:

- **Deliver leadership commitments which support this work via localised EDI action plans and leadership objectives.**
- **Sustain positive action initiatives to close the gap between ethnic minority and white applicants in recruitment**
- **Deliver in house CELC training including a focus on key aspects of WRES.**
- **Continue to reduce the disparity between ethnic minority staff being entered in to disciplinary processes.**

Summary of WRES action plan

The WRES actions are presented below and align to our business plan deliverables for 2025/26:

‘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)’

Desired outcome	Actions	WRES Indicator(s)
Wider organisation inclusion culture shift, driven from leadership	• Track and monitor the impact of all objectives set by ELG • Share data packs relating to WRES routinely with leaders to inform localised action plans • Bring diverse voice/influence to planning and decision making through the Inclusion Board and staff networks	3, 4, 5, 6, 7, 8 and 9
Recruiting fairly and closing the gap between ethnic minority and white applicants	• Sustain and strengthen positive action initiatives to review, identify and change interview processes where barriers are identified, with focus on IRO, ERD, AAP and CHUB • Strengthen awareness and uptake of the ‘Stepping up Support Package’ • Review Band 7 and above unsuccessful internal recruitment and offer targeted support to help the progression from underrepresented colleagues	1, 2, 7, 8 and 9
Anti-discrimination and anti-racism charter widely understood, adopted and creates an inclusive and fair culture	• Develop and deliver EDI as an integral element to Centre for Excellence in Leadership and Culture (CELC) • Strengthen awareness of 2-step Referral to Resolution process relating to charters • Work in collaboration with key functions to strengthen the anti-discrimination work programme, eg: FtSU, Staff Networks and all relevant training programmes • Hear ethnic minority voices through key arenas such as staff networks and the Inclusion Board	1, 2, 6, 7, 8 and 9
Removal of structural barriers for ethnically diverse communities into paramedicine and leadership roles	• Continue targeted programmes to create internal pathways for a diverse talent pipeline • Increase awareness of training and support available, eg; LAS bursary, Women of Colour programme • Trial virtual work experience targeting underrepresented communities to develop pipeline	1, 2, 4 and 7
Ending the disparity between ethnic minority staff being entered into a disciplinary process	• Monitor measures to promote consistency across the disciplinary process • Improve recording of discrimination and disciplinary cases through the Freedom to Speak Up App InPhase’. • Deliver training and raise awareness of use of charters as part of disciplinary process • Monitor data to identify trends/patterns and share with teams	3

Closing remarks from the LAS BME network

The BME Network is committed to supporting colleagues from ethnic minority backgrounds in LAS to have fair access to opportunities, have a good experience working in the Trust and that people are not discriminated because of who they are and where they come from.

By acting as a trusted conduit to ethnic minority communities, bringing insights, lived experiences, raising awareness of issues and bringing expertise, we hope to make a real difference.

We will also continue to celebrate the diversity within the Trust and provide education and cohesion opportunities.

We recognise that even though some progress has been made, we must do better to support our ethnic minority communities in LAS and are pleased to work with the EDI team to support positive actions.

Produced by the LAS Equality, Diversity and Inclusion Team

September 2025

For further information and/or request in an alternative format, please contact: londamb.edimailbox@nhs.net

We are the capital's emergency and urgent care responders

Workforce Disability Equality Standard

LAS Report and Action Plan – 2024/25

We are the capital's emergency and urgent care responders

London Ambulance Service
NHS Trust

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Overview of the Workforce Disability Equality Standard

Purpose

NHS trusts are required to produce and publish their Workforce Disability Equality Standard (WDES) report annually. The purpose of the WDES is to ensure that NHS organisations review their data against the ten indicators outlined in the WDES, produce an action plan to close any gaps in the workplace experience between disabled and non-disabled staff, as well as improving the representation of disabled staff at the Board level of the organisation.

The WDES report is a key component of our workforce EDI work, setting our direction in achieving good practice disability equality across all areas of the employee lifecycle and ensuring our staff have access to career opportunities, development and progression and receive inclusive and fair treatment in the workplace.

Methodology

The WDES requires NHS trusts and ICBs to self-assess against 10 workplace experience and opportunity indicators. Four metrics are taken from workforce data and the remaining are based on the NHS staff survey.

Scope

The report highlights current practice and shows key areas for improvement and progress within the organisation against key indicators of workforce equality for staff with a disability. It enables benchmarking across similar NHS providers and evidence how we meet our duties set out in the Public Sector Equality Duty and the standards required in the Department of Work & Pensions Level 2 Disability Confident scheme.

Definitions

The 2023 WDES technical guidance acknowledges that one of the challenges in monitoring workforce disability within the NHS is that the definitions of disability used within the NHS Electronic Staff Record (ESR), NHS staff survey and NHS jobs are not the same.

These definitions also vary when compared to the legal definition of disability, as set out in the Equality Act 2010. Work is ongoing to align definitions of disability with the Equality Act's definition and set up cross-system, agreed disability questions.

The social model of disability and the concept of 'Disability as an Asset', which are advocated by disabled people and disability rights organisations, underpin the WDES.

Foreword

Creating an organisation where our disabled colleagues feel safe, supported and are able to thrive at work is of huge importance to us, and as a Trust we remain committed to this.

Understanding the experiences of our disabled workforce through the WDES is a crucial tool in our journey to address inequalities and it is encouraging to see the progress we have made:

- **Published Reasonable Adjustments policy and guidance, supported by a centralised hub and budget.**
- **Achieved Level 2 of the Disability Confident scheme to become a Disability Confident Employer.**
- **Fostered an environment where more colleagues feel able to report on incidents of harassment, bullying and abuse.**
- **Continued increase in staff members declaring a disability, though we must do more to ensure there is good representation at all levels of the Trust.**

I recognise that although the Trust has made progress in it's journey to be a more inclusive employer, there is still work to be done, especially where indicators have deteriorated this year. LAS is committed to being a disability inclusive employer and I understand we need to continue to learn and grow to get it right for our disabled staff.

This year we will do more to ensure there are equal opportunities for our colleagues, that their reasonable adjustments are met in a timely and effective manner and our managers are equipped and enabled to make this happen.

The capital's emergency and urgent care responders.

Dr Fenella Wrigley

Deputy Chief Executive, Chief Medical Officer, London Ambulance Service NHS Trust

Our strategic equality objectives

To achieve the work set out in the LAS strategy 2023-28, we have developed three EDI objectives which will contribute to the delivery of our vision and goals until 2028 and achieve the mission of “being an increasingly inclusive, well-led and highly skilled organisation people are proud to work for.”

The LAS strategy states:

“We aim to build a diverse organisation that values and celebrates difference, promotes equality and prioritises the wellbeing of our people. We will build a workforce that knows and reflects the people we serve. We will build an organisation where everyone can feel they belong, their voice is valued and there are opportunities for a career. Discrimination, bullying, harassment and racism have no place in our organisation and we will take a zero-tolerance approach to tackling this behaviour.”

To deliver the missions set out in the LAS strategy, we have developed three EDI objectives which will contribute to the delivery of our vision and goals until 2028:

OBJECTIVE 1	**Foster proactively a diverse and open culture with an equitable working environment, including through staff training on discrimination and impactful staff networks.**
OBJECTIVE 2	**Make measurable improvement in attracting and retaining a workforce that represents London, reaching out to relevant communities and helping staff to build great careers.**
OBJECTIVE 3	**Generate clear leadership accountability for action based on good management data and staff feedback, including compliance with legislation and equality standards.**

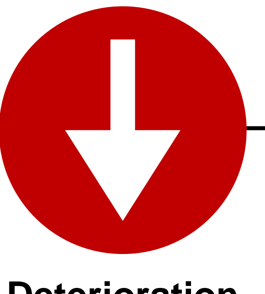
Our progress in 2024/25

The following report provides an overview of our progress, challenges and aspirations to improve the experiences of our disabled staff in LAS. Over the last year we have achieved the following that aligns with our plans and overarching objectives relating to WDES:

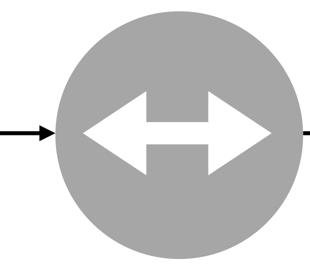
- **Continued implementation of the reasonable adjustments policy and guidance across the Trust, managed by the Reasonable Adjustments Hub and supported by a centralised budget.**
- **Inclusion of reasonable adjustments in mandatory training for 'Tackling Discrimination and Promoting Inclusivity Phase 2'.**
- **Integration of the reasonable adjustments offer in workshops delivered to all staff, including senior and middle management.**
- **Monitoring progress of the reasonable adjustments workstream through a cross-Trust working group.**
- **Established a reasonable adjustments complex case panel, bringing together subject matter experts from the Trust to provide advice, guidance and resolution on complex cases.**
- **Achieved Level 2 of the Disability Confident scheme to become a Disability Confident Employer.**
- **Expanded the Cognassist offer to allow unlimited access to cognitive assessments for staff to better understand their learning style and provide access to training on neurodivergent conditions and how to be neuroinclusive.**
- **Continued close working with our EnAbled staff network colleagues to better understand the needs of our disabled staff and how best to support them**

We recognise that achieving true equality requires ongoing assessment, thoughtful strategies and transparent reporting. In order to improve the experience of people with disabilities, we need to create an environment that encourages more disabled staff to speak up about their experiences and share that they have a long-term condition or disability so we can better understand representation in the Trust and help track our progress against indicators.

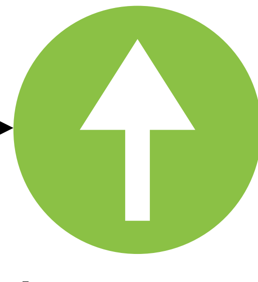
Understanding the findings



Deterioration



No significant change



Improvement

Key

Metrics 1-3 and 10 are a snapshot of our workforce data from 31 March 2025, while Metrics 4-9 are taken from the NHS Staff Survey, conducted in Autumn 2024.

The difference in Metrics 4-7 and 9 is presented in a pie chart. The key for Non-disabled and Disabled staff remains the same.

3 key questions explored in this report

What is the data telling us?

How do we compare with previous years?

What are we planning to do?

Key findings

Metrics 1-3 and 10 are a snapshot of our **workforce data** from 31 March 2025, while Metrics 4-9 are taken from the **NHS Staff Survey**, conducted in Autumn 2024.

1. Staff Representation

11% of our workforce has identified themselves as disabled

2. Shortlisting

Non-disabled applicants are

1.30X

more likely to be appointed from shortlisting

3. Disciplinary

Fewer than 10 disabled

<10

colleagues entered the formal capability process

4a. i) Bullying from public

56.2%

of disabled colleagues experiencing harassment, bullying or abuse from the public

4a. ii) From managers

16.9%

of disabled colleagues experiencing harassment, bullying or abuse from managers

4a. iii) From staff

22.4%

of disabled colleagues experiencing harassment, bullying or abuse from colleagues

4b. Bullying reported

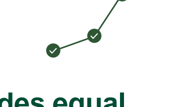
46.4%

of disabled colleagues reported experiencing harassment, bullying or abuse

5. Progression

43.2%

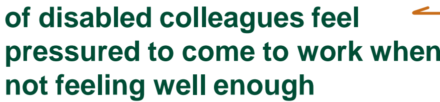
of disabled colleagues believe the Trust provides equal opportunities for promotion



6. Presenteeism

29.2%

of disabled colleagues feel pressured to come to work when not feeling well enough



7. Feeling valued

22.1%

of disabled colleagues feel valued by the organisation

8. Reasonable Adjustments

62.2%

of disabled colleagues say reasonable adjustments were made

9. Staff Engagement

The 0-10 staff engagement score for disabled colleagues is

5.5

10. Trust Board

0%

of our Trust Board (voting membership) are disabled

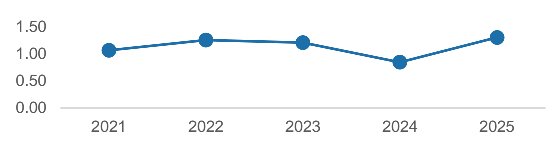
Comparisons

Metrics 1-3 and 10 are a snapshot of our **workforce data** from 31 March 2025, while Metrics 4-9 are taken from the **NHS Staff Survey**, conducted in Autumn 2024.

1. Staff Representation

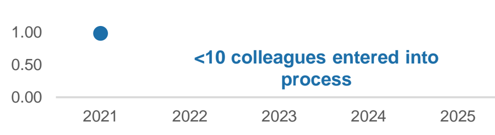
Last year (2023/24): 9.9% This year (2024/25): 10.7%

2. Shortlisting



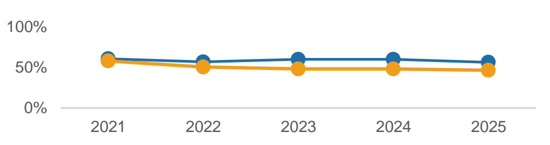
Last year (2023/24): 0.8 This year (2024/25): 1.3

3. Disciplinary



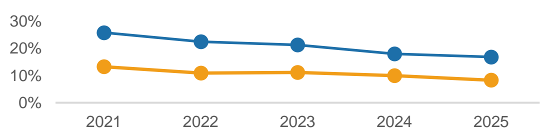
Last year (2023/24): <10 This year (2024/25): <10

4a. i) Bullying from public



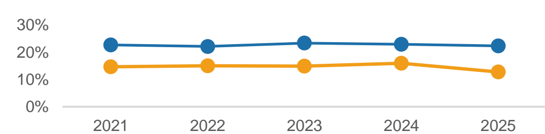
Last year (2023/24): 60.1% This year (2024/25): 56.2%

4a. ii) From managers



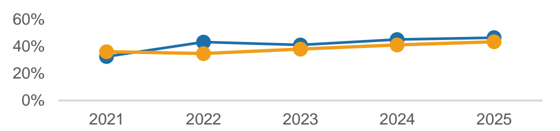
Last year (2023/24): 18.2% This year (2024/25): 16.9%

4a. iii) From staff



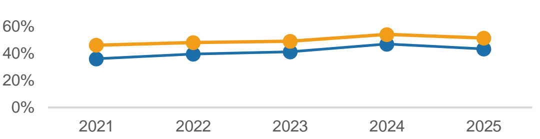
Last year (2023/24): 23.2% This year (2024/25): 22.4%

4b. Bullying reported



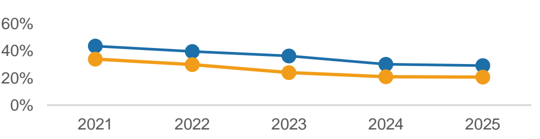
Last year (2023/24): 44.9% This year (2024/25): 46.4%

5. Progression



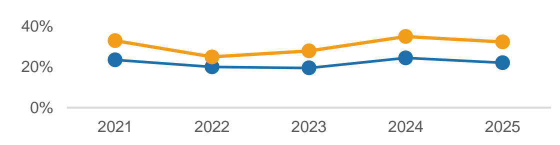
Last year (2023/24): 46.9% This year (2024/25): 43.2%

6. Presenteeism



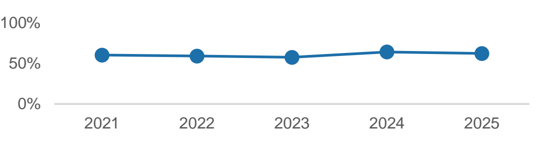
Last year (2023/24): 30.2% This year (2024/25): 29.2%

7. Feeling valued



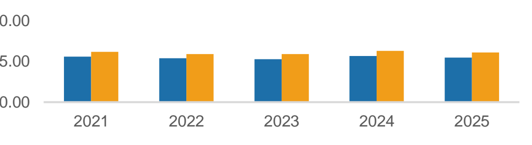
Last year (2023/24): 24.5% This year (2024/25): 22.1%

8. Reasonable Adjustments



Last year (2023/24): 64.0% This year (2024/25): 62.2%

9. Staff Engagement



Last year (2023/24): 5.7 This year (2024/25): 5.5

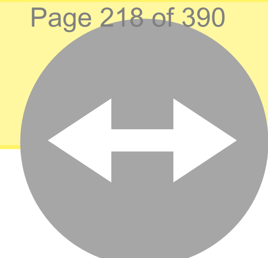
10. Trust Board

Last year (2023/24): 0%

This year (2024/25): 0%

Indicator 1

Percentage of staff in each of the AfC (Agenda for Change) bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.



Proportion of workforce identifying as disabled (%)

Disabled Non-disabled

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2021 2022 2023 2024 2025

This year, the **proportion of disabled staff has remained consistent**, though representation has slightly increased from 9.9% to 10.7%. **In clinical roles, disabled staff make up 10.9%,** compared to 77.8% of non-disabled staff. **In non-clinical roles, disabled staff represent 10.5%,** while non-disabled staff make up 66.9%. We have made **further improvements in completion of disability data fields, increasing to 89%** in comparison to 85% last year. This is a positive trend over the last few years, with increased representation over time.

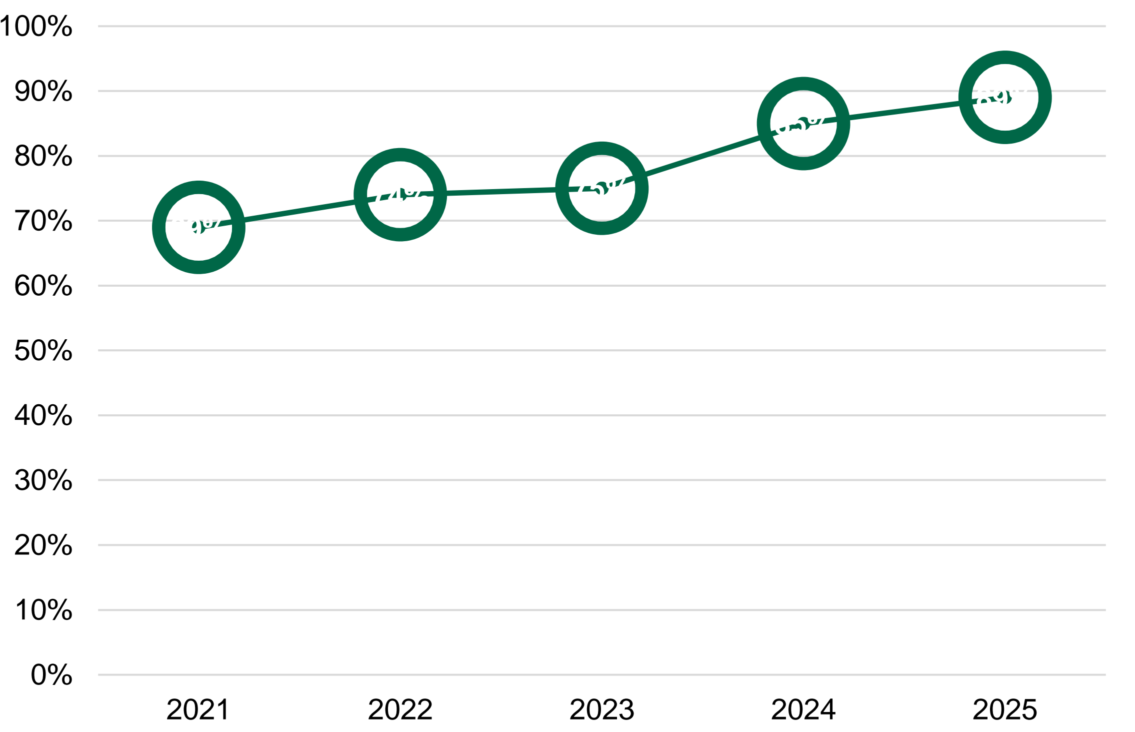
These findings highlight both progress and areas where further efforts can be made to enhance diversity and data completeness within the organisation to create a more inclusive and informed work environment.

Indicator 1

Percentage of staff in each of the AfC (Agenda for Change) bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

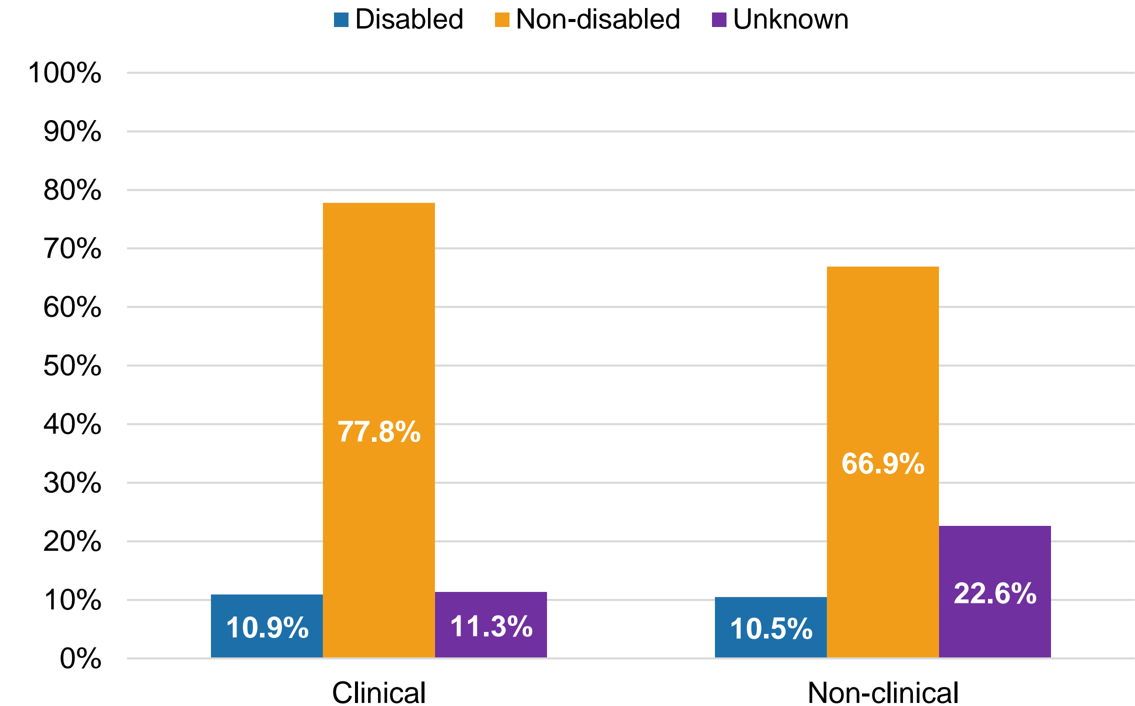
Data completeness – ESR (%)

The data completeness rate has seen a large improvement, increasing from **75**% to **85**%.



Clinical and non-clinical workforce (%)

Disabled colleagues comprise **10.9% of our clinical workforce**, compared to **10.5% of those in non-clinical roles**.



Indicator 1

Percentage of staff in each of the AfC (Agenda for Change) bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

Disabled staff across the organisation

The data shows fairly consistent representation across all bands, however the percentage of disabled staff at Band 4, Band 5, Band 8b, Band 8c and Band 9 is higher than LAS overall. To note, those at VSM level represent a very small number of staff (15 people).

	Non-disabled	Disabled	Unknown^
Band 2	54.9%	6.4%	38.7%
Band 3	70.1%	11.4%	18.5%
Band 4	77.3%	13.5%	9.2%
Band 5	78.6%	10.9%	10.5%
Band 6	74.2%	9.4%	16.4%
Band 7	73.0%	10.4%	16.6%
Band 8a	74.1%	10.5%	15.4%
Band 8b	65.2%	14.4%	20.4%
Band 8c	65.7%	14.3%	20.0%
Band 8d	84.0%	4.0%	12.0%
Band 9	64.3%	21.4%	14.3%
VSM	84.6%	7.7%	7.7%
Non AfC*	50.0%	5.0%	45.0%

*Our non AfC staff includes over 400 people who prepare frontline vehicles for operational duties and are currently in the process of assimilating following TUPE

^Unknown data is mainly due to data completeness and tends to be lower for TUPE staff

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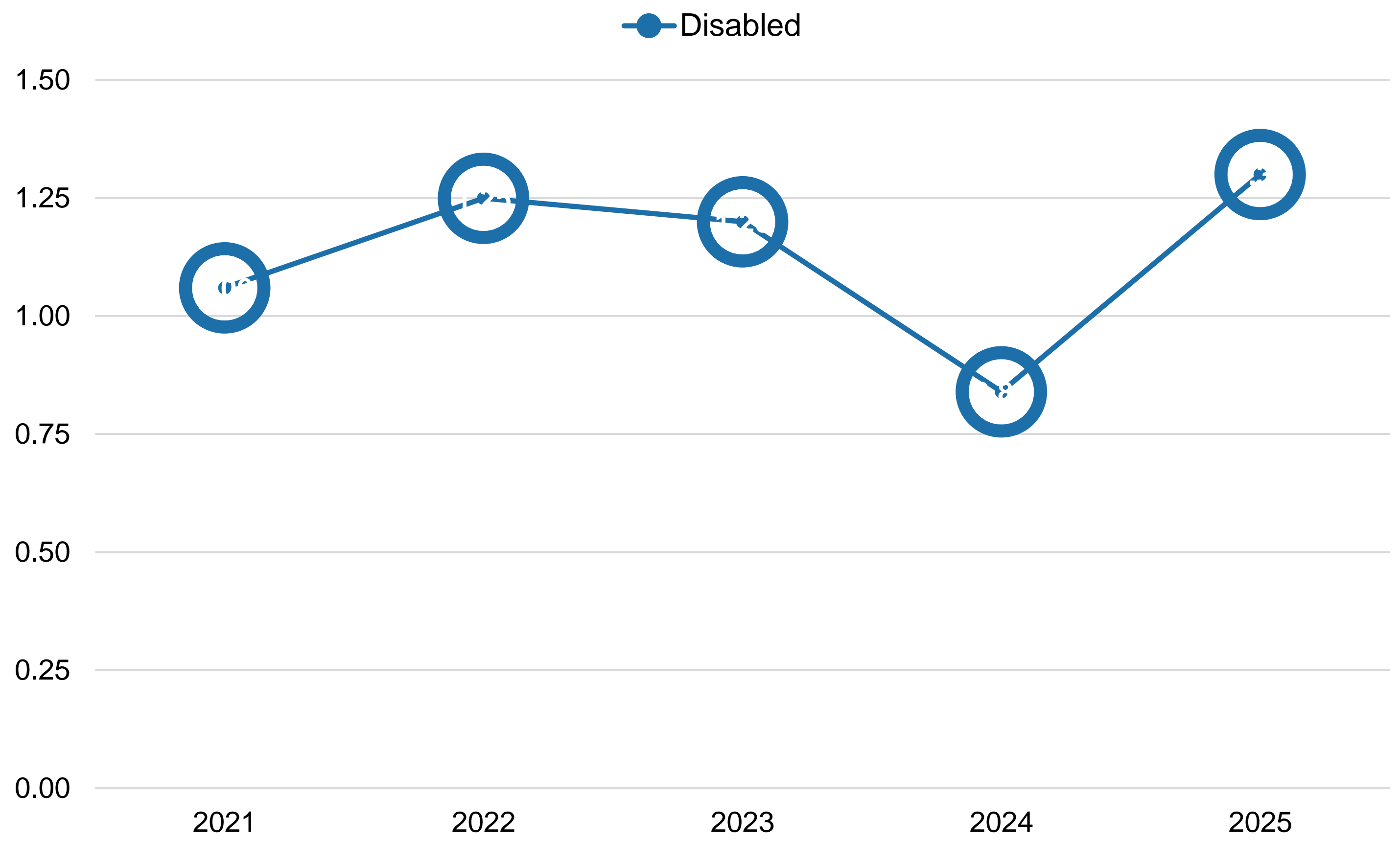
Indicator 2

Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.



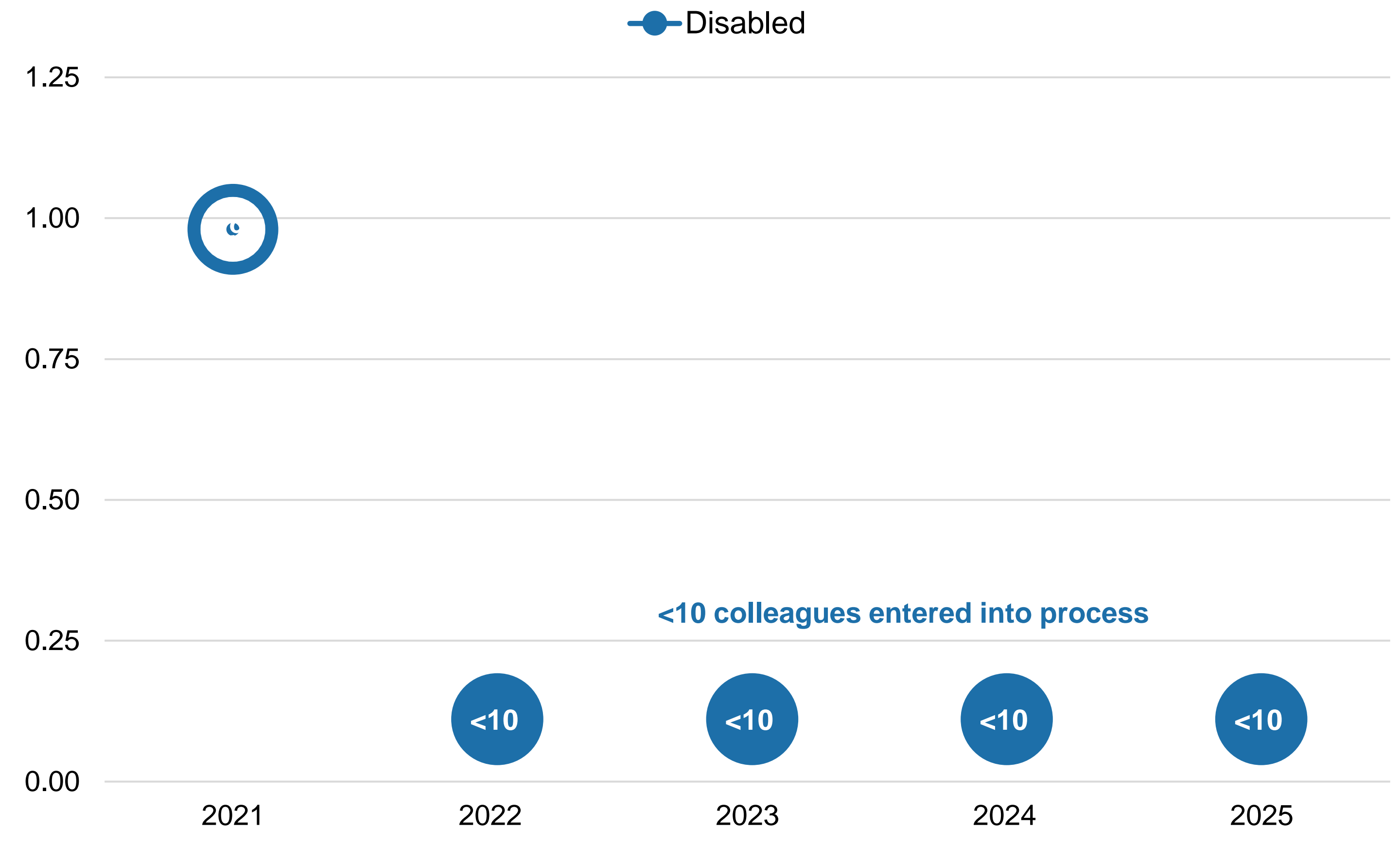
A figure below 1:00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.

This year, the data indicates that the **relative likelihood of non-disabled staff being appointed is 1.30 times more likely than disabled staff**. This shows a deterioration when compared to the previous year when it was 0.84 times and is a **negative change to the previous positive trend,** returning to similar levels seen in 2023 and 2022.

We will be looking further into the reasons as to why we have seen this shift as we have been increasing our efforts to debias our recruitment processes and promote inclusivity, such as ensuring reasonable adjustments at interview are available for candidates. We will continue to drive work that ensures equal opportunities for all, particularly targeting recruitment campaigns where the current workforce is not reflective of our population, and ensure there is fairness throughout our recruitment and selection processes.

Indicator 3

Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff



A figure above 1:00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

In 2021, the relative likelihood of disabled staff entering the formal capability process was 0.98 times more likely than non-disabled staff. However, **fewer than ten colleagues entered this process** in the last four years. This metric has **remained consistent and difficult to ascertain due to the low number of cases**.

This metric only applies to capability on the grounds of performance, not ill health.

Given the limited number of cases in the formal capability process, it is challenging to draw significant conclusions about changes in this metric. It is essential to continue monitoring and assessing this data over time to make more informed assessments about the inclusion and support of disabled staff in the capability process.

Indicator 4a i)

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

	2021	2022	2023	2024	2025
Disabled	60.6%	[illegible]	59.8%	60.1%	56.2%
Non-disabled	57.9%	[illegible]	[illegible]	[illegible]	46.4%

56.2% of disabled staff members have reported experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months. Comparatively, the percentage of non-disabled staff members facing similar issues is 46.4%. This shows that **disabled staff members are more likely to experience such mistreatment than their non-disabled counterparts**. However, the percentage for disabled staff has **improved compared to the previous year** which was 60.1%.

There has been **a varying trend over the last few years,** but has reduced overall over the last 5 years. Continuous efforts are necessary to create a safer and more respectful environment for all staff members, including the continuation of training on being an active bystander and tackling discrimination.

Indicator 4a ii)

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

Disabled / Non-disabled

30%
25%
20%
15%
10%
5%
0%

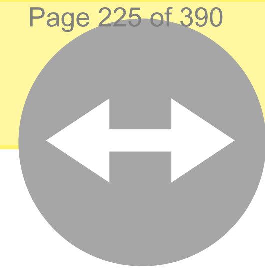
2021 2022 2023 2024 2025

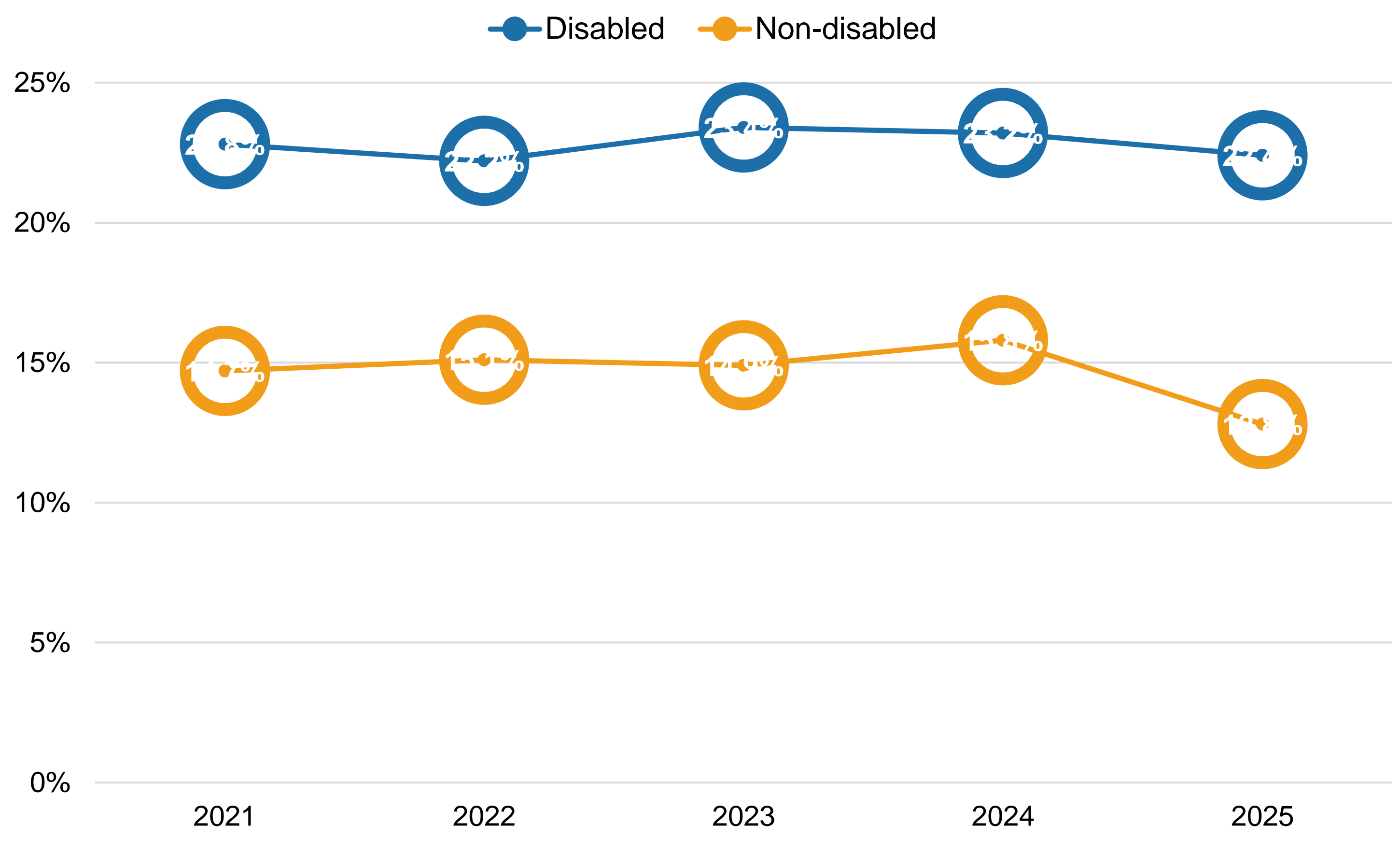
The data indicates that **16.9% of disabled staff members have reported experiencing harassment, bullying, or abuse from their managers** in the last 12 months. Comparatively, the percentage of non-disabled staff members facing similar mistreatment from managers is much lower at 8.3%. It is worth noting that there has been a **slight decrease** compared to the previous year, which was 21.3%. This is a **positive trend over the last few years**, where we have consistently improved our position.

Our priority is to address workplace behaviour to ensure a respectful and inclusive environment for all staff members and reduce the disparities between disabled and non-disabled staff. This includes supporting staff to speak up and call out discrimination, in line with our anti-discrimination statement.

Indicator 4a iii)

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.





This year, the percentage of **disabled staff experiencing harassment, bullying, or abuse from colleagues is 22.4%,** a slight decrease to the previous year of 23.2%. In contrast, non-disabled staff reported a percentage of 12.8%, which is lower than the 15.8% reported in the previous year. **The percentage of disabled staff reporting these incidents has been consistent,** however non-disabled staff have begun to see a decrease.

These findings underscore the importance of maintaining a safe and respectful workplace for all employees to promote a psychologically safe working space for everyone, particularly for our disabled staff. This includes supporting staff to speak up and call out discrimination, in line with our anti-discrimination statement.

Indicator 4b)

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months

Disabled Non-disabled

50%
40%
30%
20%
10%
0%

2021 2022 2023 2024 2025

37.9%
41.3%
43.4%

The data shows an **increase in the reported incidents of harassment, bullying, or abuse at work** by disabled colleagues compared to last year, which was 44.9%. There have also been improvements in non-disabled colleagues reporting these incidents, which is 43.4% compared to 41.3% last year. There has been a general **positive trend over the last few years.**

The trend suggests that **efforts to improve reporting of incidents of harassment, bullying or abuse have improved**. However, work must be done to support colleagues to make them feel comfortable in reporting incidents, ensuring a safe and supportive environment for all employees.

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Indicator 5

Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion.

Disabled   Non-disabled

60%
50%
40%
30%
20%
10%
0%

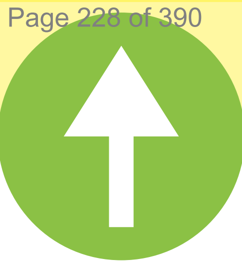
2021 2022 2023 2024 2025

This year, **43.2% of disabled staff believe that the trust provides equal opportunities for career progression and promotion,** which is an decrease from 46.9% in the previous year. Non-disabled staff have a higher percentage, with 51.3% perceiving equal opportunities, down from 54.0% in the previous year.

Although there has been **a deterioration in the perception of equal** opportunities among both disabled and non-disabled staff, there has been a general **positive trend over the last few years.** Additionally, there remains a gap in perception between disabled and non-disabled staff. Addressing this gap is essential for fostering an inclusive and equitable workplace where all employees can thrive.

Indicator 6

Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



Disabled
Non-disabled

50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

2021 2022 2023 2024 2025

This year, **29.2% of disabled staff reported feeling pressured to come to work even when they didn't feel well enough to perform their duties.** This reflects **an improved position to the 30.2% reported in the previous year**. There has been a overall **positive trend** in reducing the perception of feeling pressured to work despite not feeling well among both disabled and non-disabled staff.

These findings suggest that efforts to promote a healthier work-life balance and a more supportive work environment have a positive impact. However, there is still room for further improvement and focusing on employee well-being and support is crucial to sustain and build upon these positive trends.

Indicator 7

Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.

Disabled Non-disabled

40%
35%
30%
25%
20%
15%
10%
5%
0%

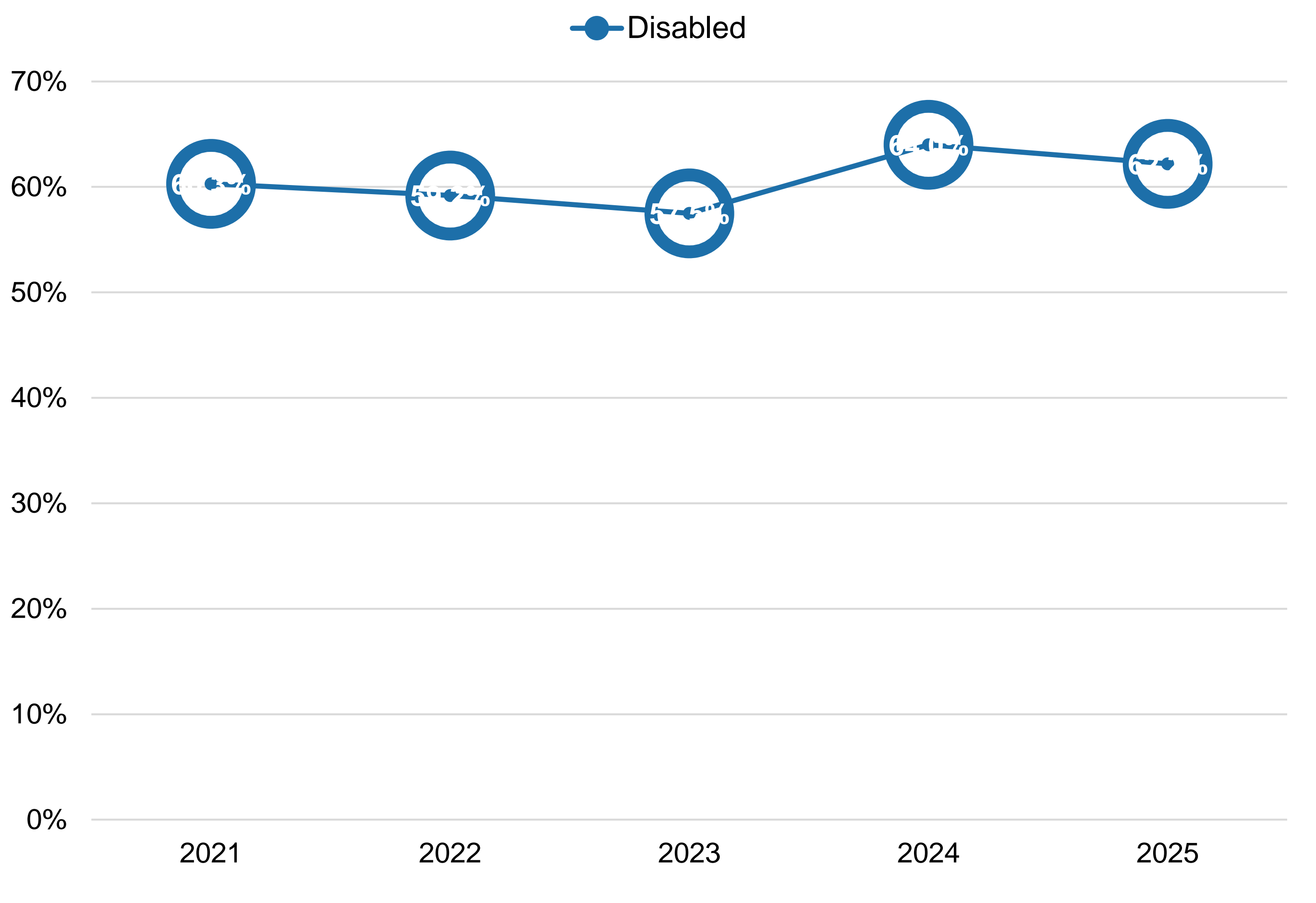
2021 2022 2023 2024 2025

This year, **22.1% of disabled staff reported satisfaction with how LAS values their work, representing a decrease from the 24.5% reported in the previous year.** Non-disabled staff have a higher satisfaction rate with a percentage of 32.4% this year but this has also decreased from 34.9% in the previous year.

This shows a **varying trend towards satisfaction** with how the organisation values work from staff and there remains a disparity between disabled and non-disabled staff. Addressing this difference and working to ensure that all employees feel valued and appreciated for their contributions is crucial to promoting an inclusive and equitable workplace.

Indicator 8

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.



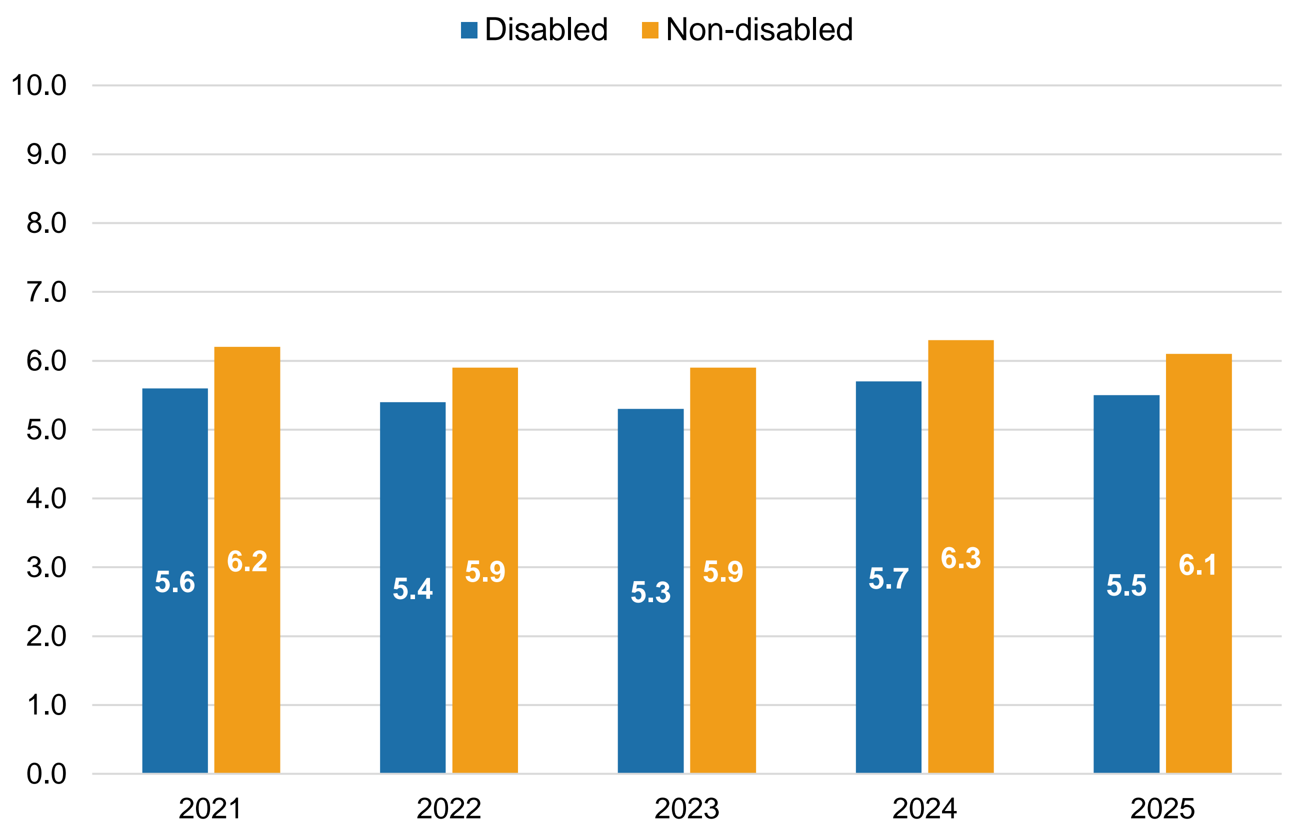
This year, **62.2% of colleagues who declared a disability feel that LAS has made reasonable adjustments to enable them to carry out their work**. This represents a slight decrease from the 64.0% reported in the previous year.

Although there is a decrease when compared to the previous year, this is still an improvement on previous years and suggests there remains **an overall positive trend over time**.

We are committed to the actions being made across the Trust to ensure staff have the necessary accommodations to perform their roles can contribute to a more inclusive and supportive work environment. As we continue to roll out the reasonable adjustments policy and guidance published in 2024, we will continue to actively seek feedback from disabled colleagues to improve adjustments. This will ensure a more inclusive workplace for everyone, as we recognise this data is not a full picture of the experiences of our staff.

Indicator 9

The staff engagement score (out of 10) for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.



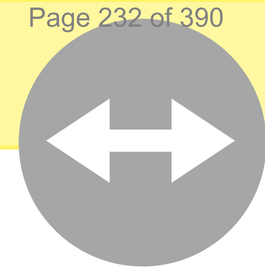
The score for **staff engagement this year for disabled staff is 5.5** which is a slight decrease from 5.7 in the previous year. Non-disabled staff engagement scores have additionally decreased this year to 6.1, compared to 6.3 in the previous year.

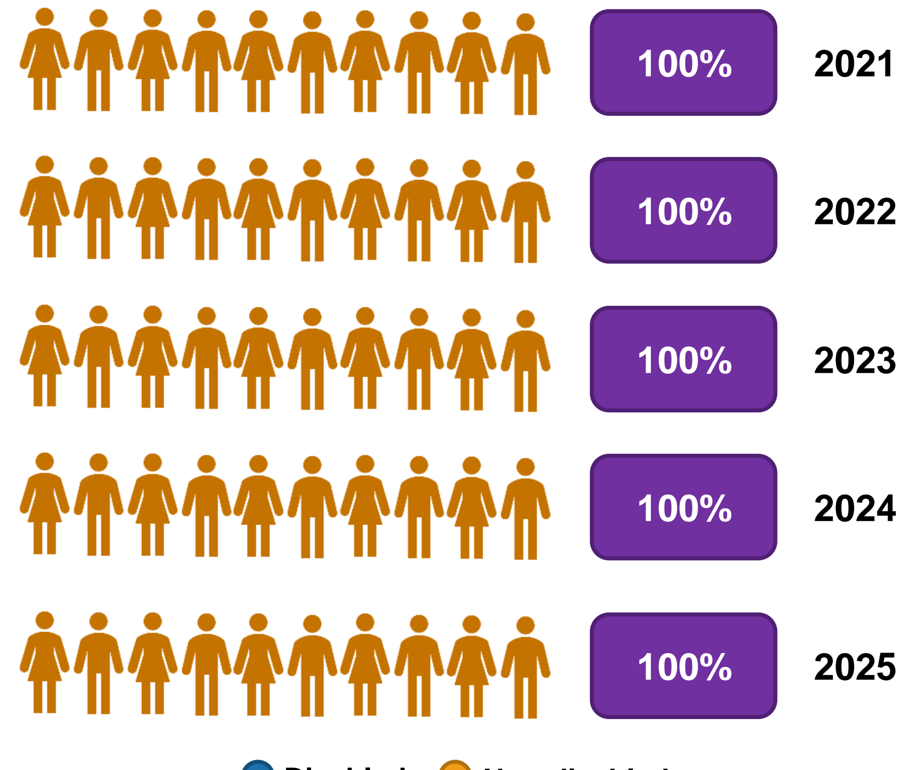
There has been a **varying trend** in the staff engagement score for disabled staff. There also remain differences in engagement scores between disabled and non-disabled staff, though these differences have remained fairly similar over the last 5 years.

This score highlights the importance of addressing and improving the engagement and satisfaction levels of disabled staff within the Trust. We will continue to promote a more equitable and engaged workforce as a priority.

Indicator 10

Percentage difference between the Organisation's Board voting membership and its overall workforce.





The data indicates that there is **no representation of disabled individuals on the organisation's board voting membership**. This percentage has remained unchanged for the past five years. The data shows a **consistent lack of disabled representation on the Trust's board voting membership over the past five years**.

This trend highlights the need for increased efforts to promote diversity and inclusion at the board level of the organisation and additionally ensure staff in leadership positions feel comfortable declaring their disability. Ensuring that disabled individuals are represented in leadership positions can contribute to more informed decision-making and a more inclusive culture.

Summary and next steps

This report shows progress from the past year, highlights current practice, and shows key areas for improvement within the organisation against several key indicators of workforce equality for staff with disabilities.

We have made **good improvements against four of the WDES indicators** in 2024/25, however we have additionally seen a **deterioration in five indicators** and **no change in four indicators**. These results present a varied picture across the Trust and although some of the indicators reflect the efforts put in to improve the experience of disabled staff and eradicate disparities, there is a clear need to continue development and implementation of programmes for positive change.

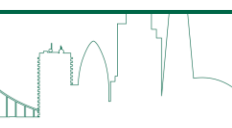
This year, we have supported our staff and managers through training and engagement initiatives to help them better understand the needs of disabled staff and barriers they may face. We have helped staff to be more confident in tackling discrimination and promoting inclusion, whilst also educating on potential biases and how to address these. We additionally published our reasonable adjustments policy and guidance in 2024, making clear our commitment to an inclusive workplace environment to all staff.

In conclusion, we have seen some progress towards disability equality in LAS and ensuring **equal opportunities**, **addressing harassment**, and **promoting diversity and inclusion at all levels** remain our essential goals.

Next Steps

Oversight of the WDES will take place through the EDI sub-Board committee and cross-organisational working groups will ensure delivery through these key areas of focus:

- **Inclusive and unbiased recruitment and selection processes**
- **Good quality workforce data**
- **Increased diversity at Trust Board and ELG levels**
- **Managers equipped for meaningful and compassionate conversations**
- **Tackle, prevent and challenge bullying, harassment and abuse against staff**
- **Engagement with disabled staff**
- **Implementing reasonable adjustments and equipping managers to support staff**



Summary of WDES action plan

The WDES actions are presented below and align to our business plan objective for 2025-26: *"Improve the proportion of disabled colleagues who say in the NHS staff survey that reasonable adjustments were made and reduce the number of concerns raised on this topic"*

Desired outcome	Actions	WDES Indicator(s)
Continue focus on ensuring our recruitment and selection processes are inclusive and unbiased	• Ensure Independent Panel Member programme includes challenge for disability bias • Use insights from Disability Pay Gap to understand disparities in representation • Improve disability representation in targeted recruitment campaigns through talent management and development	1, 2 and 5
Improve the quality, collection and analysis of our workforce data on all protected characteristics for staff	• Create time in teams to access ESR to complete equality data in areas where gaps are greatest, for example through huddles or annual appraisals for Band 2 and non-AfC staff where completeness is lowest • Re-run of 'Safe to Say' campaigns on regular basis	1 and 9
Increase the diversity balance, including disability, at Trust Board and ELG levels	• Explore barriers to progression in leadership roles for disabled staff • Ensure completeness of equality monitoring form for Board members	1, 2, 5 and 10
Managers equipped with having meaningful and compassionate conversations	• Monitor data-driven localised action plans to drive improvement and accountability at team, department, directorate and executive levels • Support managers to regularly review disability representation in Feedback and Focus Reviews to identify areas for improvement • Ensure EDI training sessions are integral to leadership learning programmes	3, 6 and 7
Tackle, prevent and challenge bullying, harassment and abuse against staff and create a culture of civility and respect	• Socialise anti-discrimination statement through engagement events and training • Deliver drop-in surgery sessions to give staff increased opportunities to speak up about discrimination • Support the use of body-worn video cameras to de-escalate incidents of violence and aggression towards staff • Conduct a deep dive with the EnAbled network to understand why disabled staff are disproportionately affected by violence and aggression from the public	4a
Disabled staff are engaged in the EDI agenda and empowered to challenge inappropriate behaviours	• Work closely with EnAbled network for lived experience insight, including promoting awareness, supporting positive action initiatives, influence policies and provide input into matters concerning disability • Work closely with Freedom to Speak Up colleagues to support staff in speaking up and challenging inappropriate behaviours	4b and 9
Staff who require reasonable adjustments are supported to be at work and managers are equipped to support them	• Socialise neurodiversity toolkit for managers, alongside continued promotion of reasonable adjustments policy and guidance • Continue implementation of reasonable adjustments process for procuring necessary equipment and software for staff • Develop and deliver reasonable adjustments training to all managers • Reduce health inequalities for staff through health and wellbeing programme	6, 7 and 8

Closing remarks from the LAS EnAbled network

The EnAbled staff network remains committed to amplifying the voices of disabled staff in the London Ambulance Service. Our aim is to remove barriers and foster a culture of genuine understanding of the lived experiences of staff with disabilities. The network aspires to be a dedicated platform for disabled employees to share their experiences, insights and challenges to break down the invisible walls that often isolate individuals with disabilities.

By working in collaboration with the EDI Team and across the Trust, the network raises awareness about the unique needs and abilities of disabled staff, nurturing an environment where their voices are heard and actively sought after. It's not just a support system. It's a catalyst for change that moves the organisation towards a future where inclusivity isn't just a buzzword but a lived reality.

We recognise the progress demonstrated in this year's WDES report and the positive steps being taken to improve equality for our disabled staff. We also understand the work still needed to improve the experiences of our disabled staff and reduce the disparities between them and non-disabled staff.

We are pleased to work in collaboration with the EDI team to support positive actions to ensure disabled staff feel valued and appreciated within the organisation.

Produced by the LAS Equality, Diversity and Inclusion Team

September 2025

For further information and/or request in an alternative format, please contact: londamb.edimailbox@nhs.net

We are the capital's emergency and urgent care responders

7.2. 1. Cardiac Arrest Annual Report

2. STEMI Annual Report

3. Quality Dashboard

For Information

Presented by Fenella Wrigley

Cardiac Arrest Annual Report

April 2024 – March 2025

October 2025

Produced by:

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Cardiac Arrest Summary 2024-25

12,862 Patients Attended

4,631 Resuscitation Attempted

04:21 999 Call to Dispatcher Assisted CPR (Median)

64.2% Bystander CPR performed

08:25 999 Call to Scene (Median)

10:47 999 Call to LAS CPR (Median)

57.5% Resuscitation Terminated On Scene

18.8% Shockable Initial Rhythm

42.5% Conveyed to Hospital

29.5% ROSC Sustained to Hospital

34.4% 30 Day Survival in Utstein Group

10.9% Survived To 30 Days

1. Introduction

From 1 April 2024 to 31 March 2025, London Ambulance Service NHS Trust (LAS) clinicians attended **12,862 patients** who experienced an out-of-hospital cardiac arrest (OHCA) in the Greater London area. This report provides key information on the demographics of these patients, the pre-hospital care they received, and their outcomes.

The information presented in this report was sourced from the LAS Cardiac Arrest Registry maintained by the Clinical Audit and Research Unit (CARU). The registry compiles clinical and operational data derived from patient clinical records, Emergency Operations Centre (EOC) call logs, the GoodSam application, and the national Patient Demographics Service.

Data were collected and are reported in accordance with the internationally recognised Utstein guidelines (1). Average times are reported as means and medians to account for skewed data. All data were correct at the time of the publication.

2. All Cardiac Arrests Attended (n=12,862)

2.1. Demographics

Sex, n (%) *	
Male	7,890 (61.3)
Female	4,917 (38.2)
Unknown	55 (0.4)

Age, mean (median) in years †	
Overall	70 (73)
Male	67 (69)
Female	74 (79)

Location, n (%) ~	
Private location	11,334 (88.1)
Private address	*10,625 (82.6)*
Care home	*709 (5.5)*
Public location	1,522 (11.8)

Ethnic group, n (%)	
White	5,451 (42.4)
Asian	599 (4.7)
Black	580 (4.5)
Other	172 (1.3)
Mixed	117 (0.9)
Unknown	5,943 (46.2)

Chief complaint at call handling, n (%)	
Cardiac arrest	7,858 (61.1)
Breathing problems	621 (4.8)
Unconscious/fainting	565 (4.4)
NHS 111 Transfer	478 (3.7)
Falls	264 (2.1)
Convulsions/fitting	149 (1.2)
Chest pain	120 (0.9)
Other ‡	2,807 (21.8)

Table 1: Profile of patients attended in 2024/25

†Excludes patients with unknown age (n=67). ~ Excludes unknown location (n=6). ‡ Includes healthcare professional admissions (n=95). N.B. Percentages may not total 100% due to rounding

- The mean age of the cardiac arrest patient was **70 years**.
- More patients were **male (61.3%)** who were, on average, 7 years younger than females.
- ‘**White’** was the most frequently documented ethnic group, but nearly half of all ethnicities were unknown or not reported.
- Most OHCAs occurred at a **private location** (**88.1%**, n=11,334).
- **61.1%** of **cardiac arrests** were **identified** as such during call handling.

2.2. Time of cardiac arrest

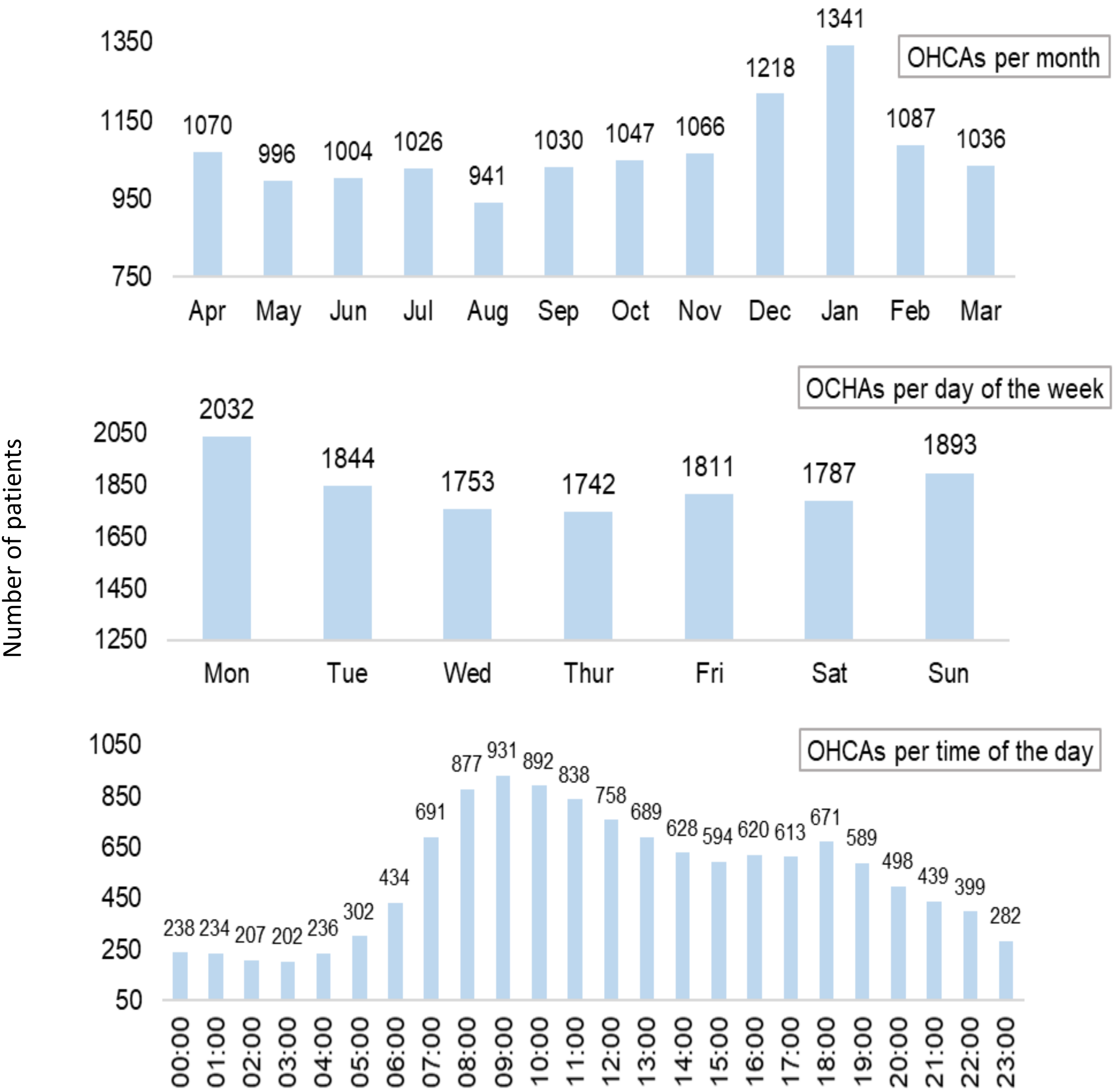


Figure 1: Occurrence of all cardiac arrests

- OHCAs occurred more frequently in **January** (10.4%, n=1,341) and on a **Monday** (15.8%, n=2,032), with the call for help most commonly being received between **9:00 - 09:59** in the morning (7.2%, n=931).

2.3. Resuscitative efforts

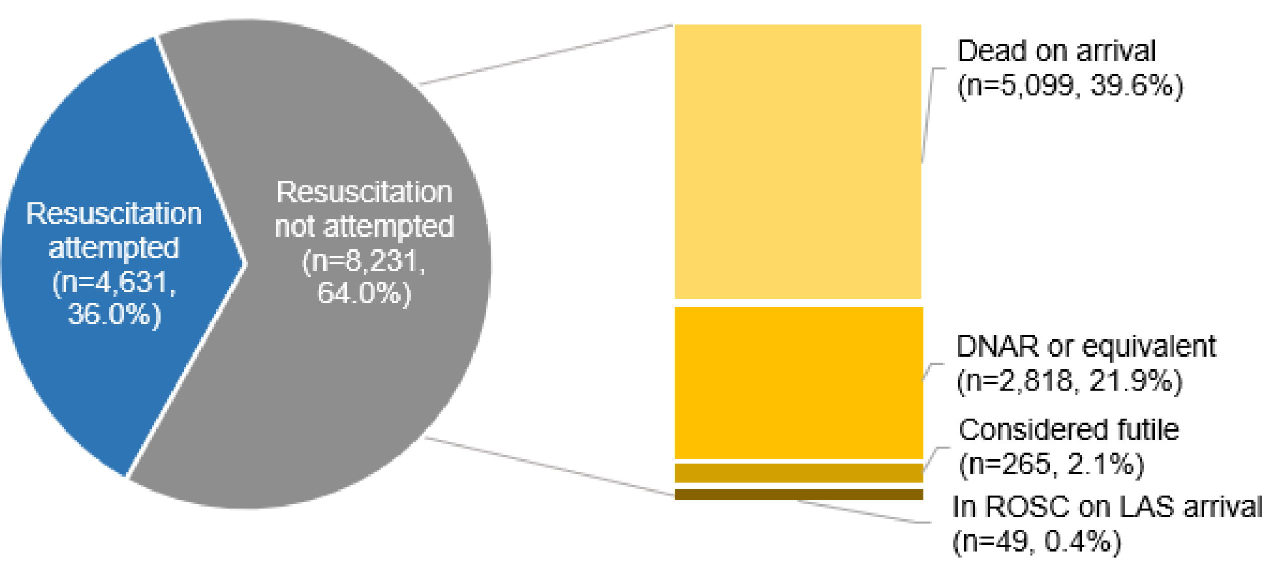


Figure 2: Resuscitative efforts with a breakdown of reasons for non-resuscitation

- **Resuscitation was attempted** by LAS clinicians for **36%** of patients in cardiac arrest (n=4,631).
- The most common reason for resuscitation not being undertaken was that the patient was already dead upon LAS arrival or there was a Do Not Attempt Resuscitation (DNAR) order or equivalent in place.
- 49 patients were reported to have received defibrillator shocks and achieved a return of spontaneous circulation (ROSC) prior to LAS arrival. These patients did not require further resuscitation from LAS clinicians. Further information about this patient group is available in Appendix 1.

2.4. Pre-arrival interventions

2.4.1. Dispatcher assisted CPR

Dispatcher-assisted CPR instructions were provided to the caller in 4,791 cases. It is important to recognise that not all callers will accept CPR guidance. In addition, in some circumstances, such as in cases involving an obvious or expected death, offering CPR instructions may not be appropriate.

The time to delivery of these instructions is presented below.

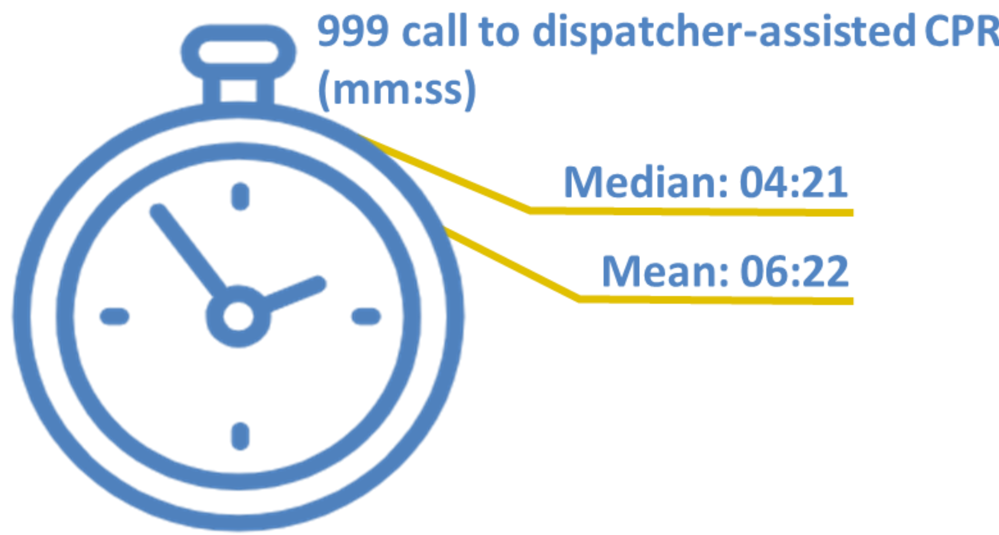


Figure 3: Average time from 999 call to the initiation of dispatcher-assisted CPR

- The **median time** from receiving the 999 call to delivery of dispatcher-assisted CPR instructions was **4 minutes and 21 seconds**, which is consistent with last year's figure (4 minutes and 29 seconds).

2.4.2. GoodSam responders

GoodSam (https://www.goodsamapp.org/) is a mobile application that automatically notifies trained volunteer responders of nearby cardiac arrest incidents.

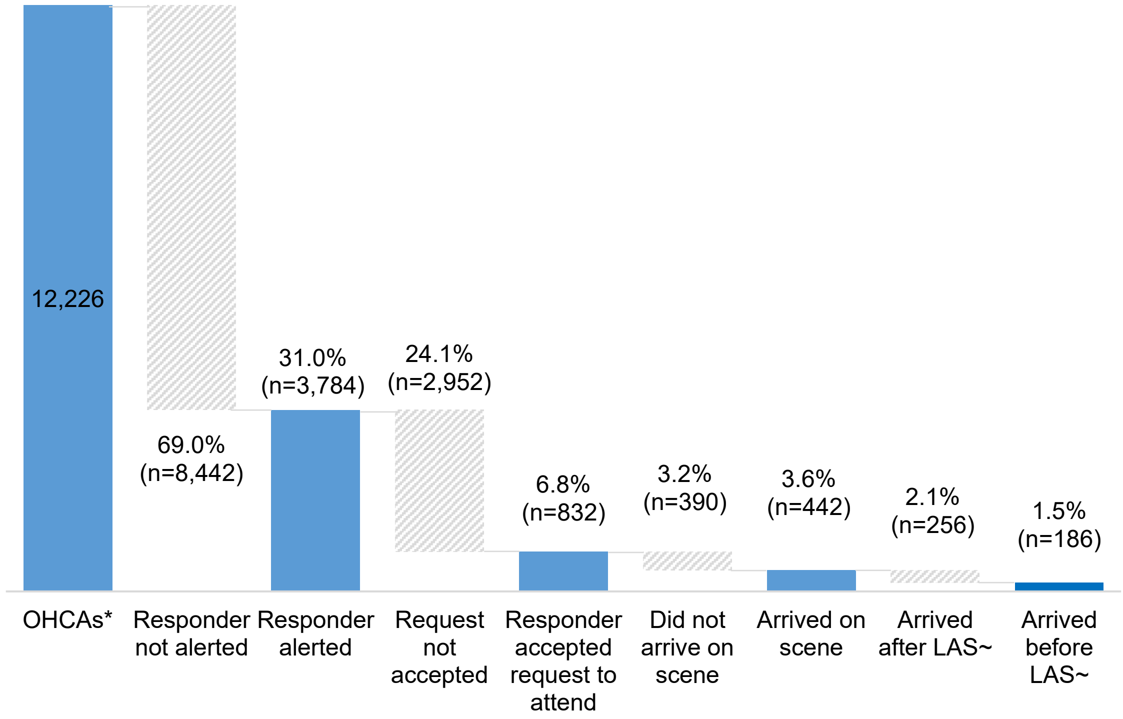


Figure 4: GoodSam responders – from alert to arrival at scene

**Excludes LAS witnessed cardiac arrests. ~ Based 'arrival at scene time' recorded in the GoodSam application*

- GoodSam responders were **alerted** to **31.0%** (n=3,784) of OHCAs in London. This represents a continued upward trend from previous years: 23.7% in 2021/22, 28.4% in 2022/23 and 29.3% in 2023/24.
- **22.0%** of the alerts (n=832/3,784) were **accepted** by volunteers, closely matching last year's response rate of 22.4%.
- When an alert was accepted, more than half (**53.1%**, n=442/832) of responders **arrived** at scene, with **42.1%** (n=186/442) of these arriving **before** the LAS.

3. Where Resuscitation Was Attempted (n=4,631)

This section outlines demographic information and details of the care provided to the 4,631 patients in London who received a resuscitation attempt by LAS clinicians.

3.1. Patient profile

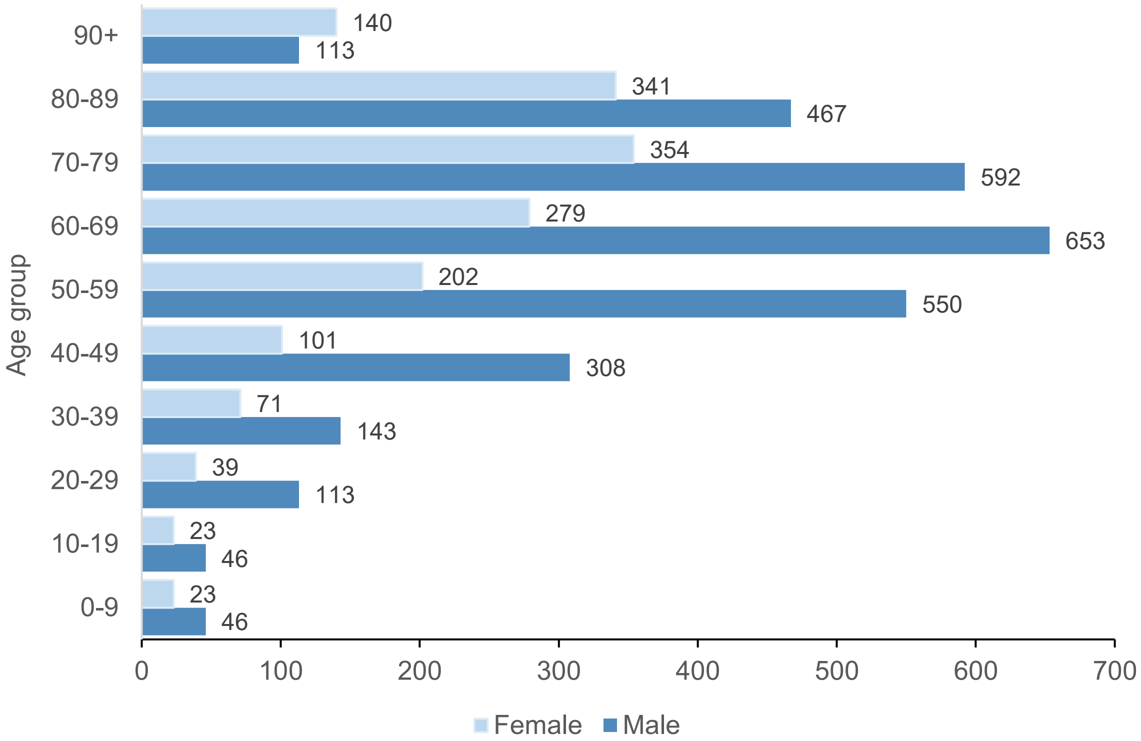


Figure 5: Age distribution by sex for patients who had resuscitation attempted

Excludes patients with missing age and sex information (n=27)

- The average age of patients who received resuscitative efforts from LAS clinicians was **64 years** (median age: 67).
- Where documented, almost two thirds of patients were **male** (**65.9%**, n=3,043).
- The age distribution for **males** was skewed towards **younger** ages compared to females (mean of 64 and 68 years respectively), with a peak between 60-69 for males and 70-79 for females.

3.2. Location of arrest

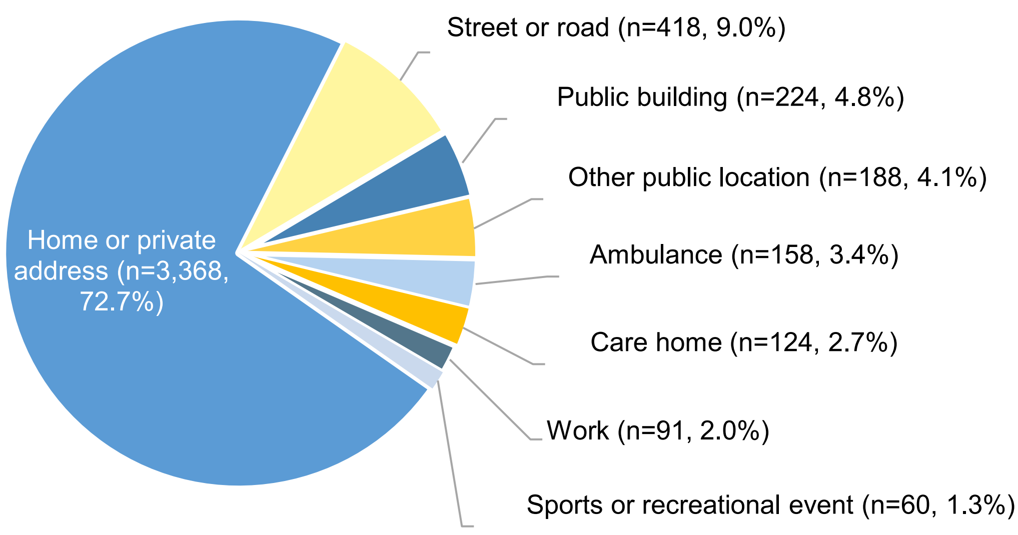


Figure 6: Location of cardiac arrest where resuscitation was attempted

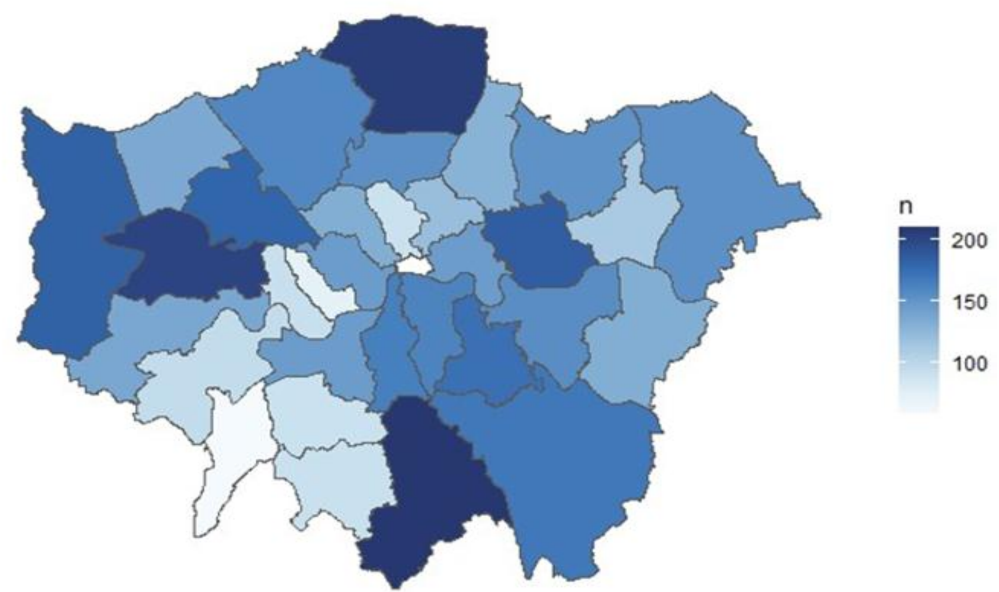


Figure 7: Incidence of cardiac arrest by local authority

Excludes incidents with no location reported (n=94) and City of London due to low numbers (n=13)

- As with all OHCAs across London, the most common location of arrest, for patients who subsequently had resuscitation undertaken by LAS, was a **private** residential location (**72.7%**).
- There was large variation in incidence across London which likely reflects different population demographics and numbers between the areas.

3.3. Time of cardiac arrest

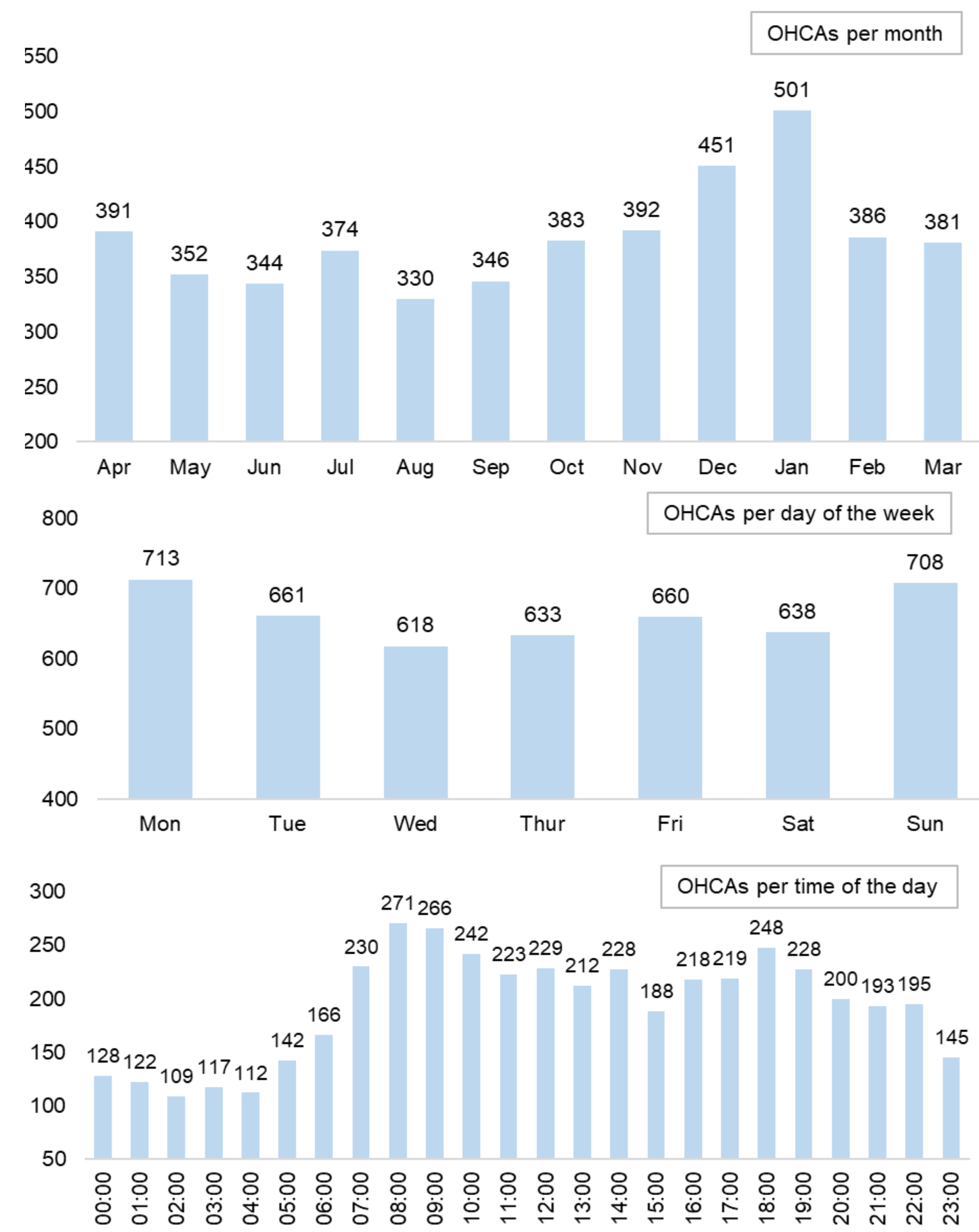


Figure 8: Occurrence of cardiac arrests (resuscitation attempted)

- As with all arrests, OHCAs where resuscitation was attempted occurred more frequently in **January** and on a **Monday**, but the call volume reached its peak **between 08:00 - 08:55** (just slightly higher than 09:00 - 09:59).

3.4. Witness status

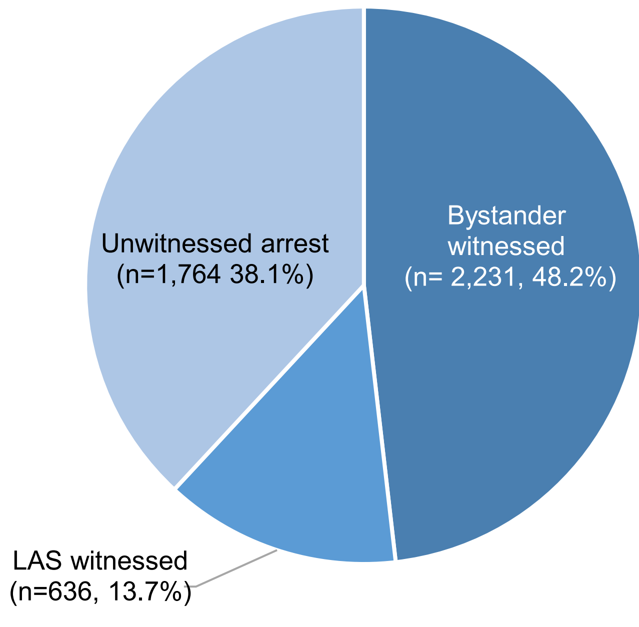


Figure 9: Witness status of cardiac arrest patients

- Almost half of OHCAs, where LAS clinicians attempted resuscitation, were **witnessed by a bystander** (**48.2%**, n=2,231).
- **13.7%** of arrests (n=636) were **witnessed by LAS** clinicians.

3.5. Bystander interventions

This section provides information on the rates of bystander CPR and bystander use of an Automated External Defibrillator (AED). A bystander is a person who is on scene, or alerted to the scene, but is not dispatched as part of an organised emergency response system. LAS witnessed arrests are excluded from all figures. Outcomes associated with these interventions can be found in Appendix 2.

3.5.1. Bystander CPR

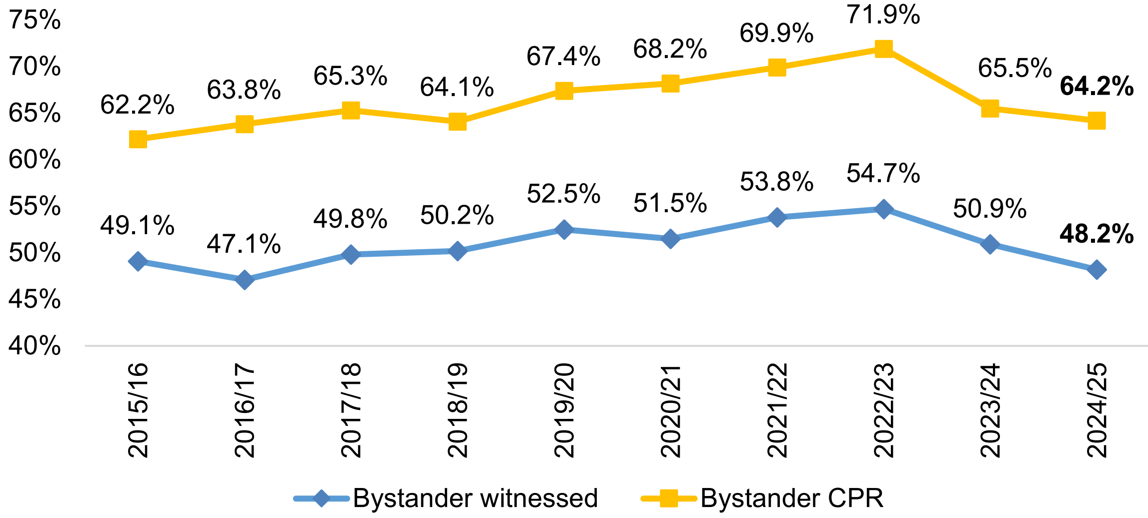


Figure 10: Bystander witnessed* and bystander CPR rates by year

**Includes all cardiac arrests where resuscitation was attempted*

- **64.2%** of patients received **bystander CPR** reflecting a **continued decline** from the peak of 71.9% in 2022/23, mirroring a parallel reduction in the proportion of witnessed cardiac arrests.
- **Bystander CPR provision** was notably **higher** when the arrest was bystander **witnessed** rather than unwitnessed (**68.5%** vs 58.7%).

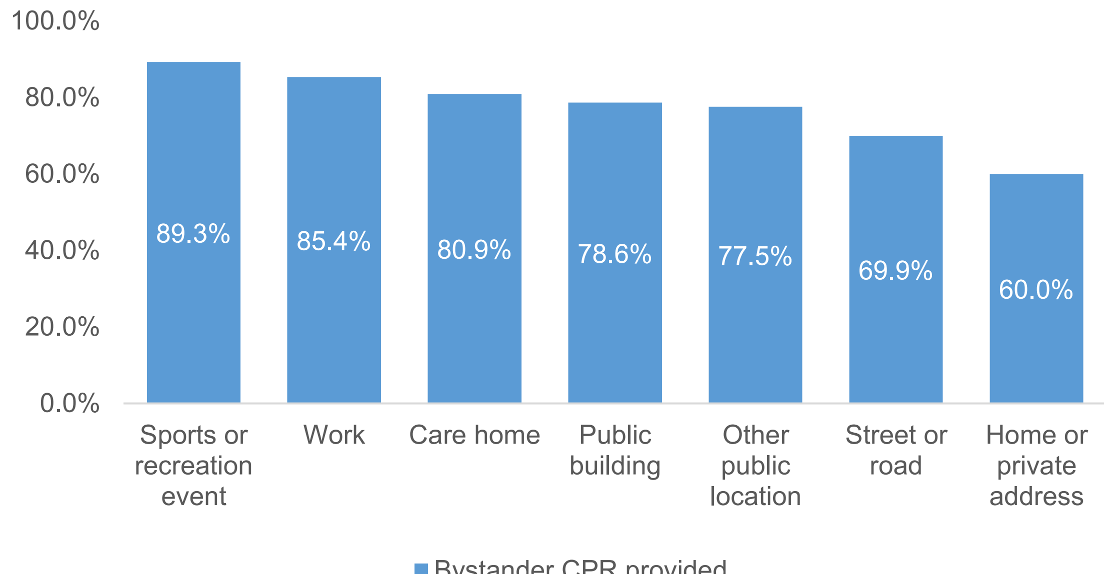


Figure 11: Bystander CPR by location

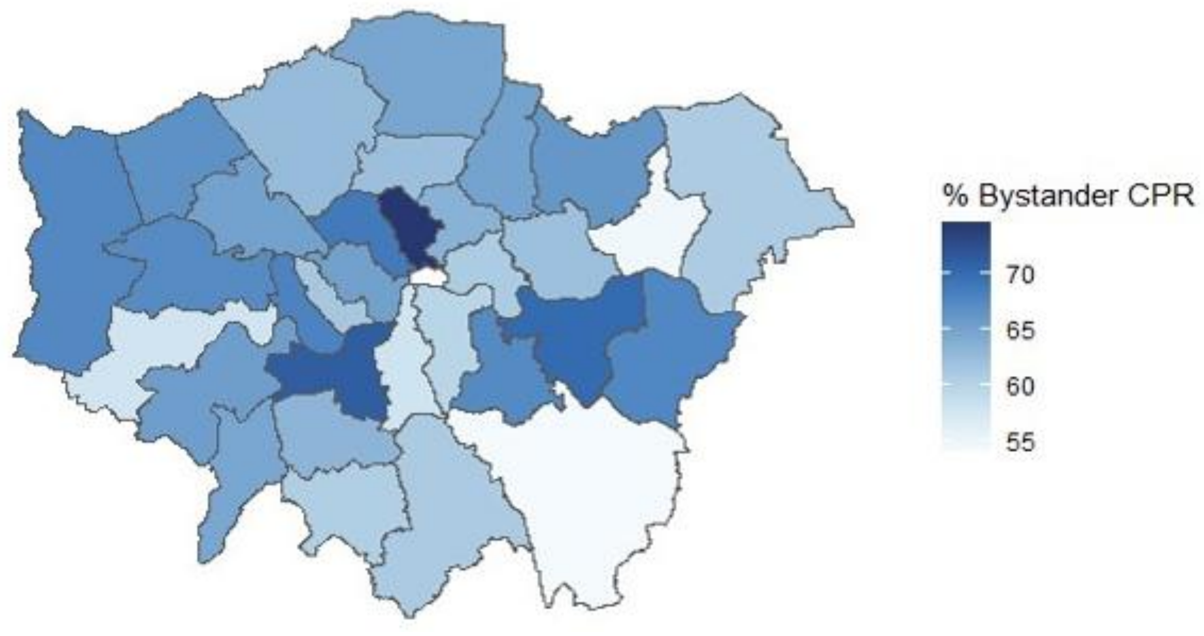


Figure 12: Bystander CPR broken down by local authority

Excludes incidents with no location reported (n=85) and City of London due to low numbers (n=13)

- Bystander CPR was more common at a **sports or recreational event** (89.3%), closely followed by a place of **work** (85.4%).
- There was large variation in bystander CPR rates across the Greater London, with the **highest proportion** in the **Islington** local authority district (74.4%).

3.5.2. Bystander defibrillation

This section reports on defibrillator use by bystanders for patients that had resuscitation continued by LAS. The term 'deployed' refers to when a defibrillator was brought, and attached, to the patient before LAS clinicians arrived on scene.

Figure 13: Bystander defibrillator deployment and use

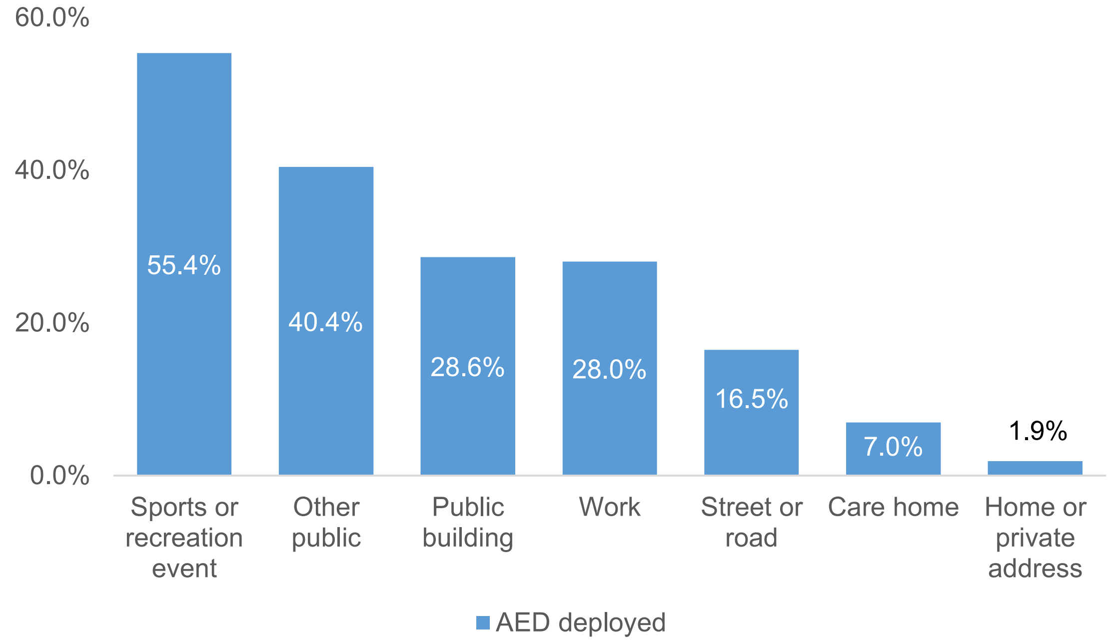


Figure 14: Defibrillator deployment by location

- **7.8%** (n=312) of patients who had resuscitation continued by LAS clinicians, had an **AED brought to them and attached** prior to LAS arrival. This figure is slightly lower than last year's (n=323).
- Just under half had at **least one shock** administered before LAS clinicians arrived on scene (**46.8%**, n=146/312), which is also lower than last year (50.5%).
- Patients were **most likely** to have an AED brought and attached to them when they collapsed at a **sports venue** or **recreational event** (**55.4%**).

3.6. Emergency medical dispatch

3.6.1. Call answering times

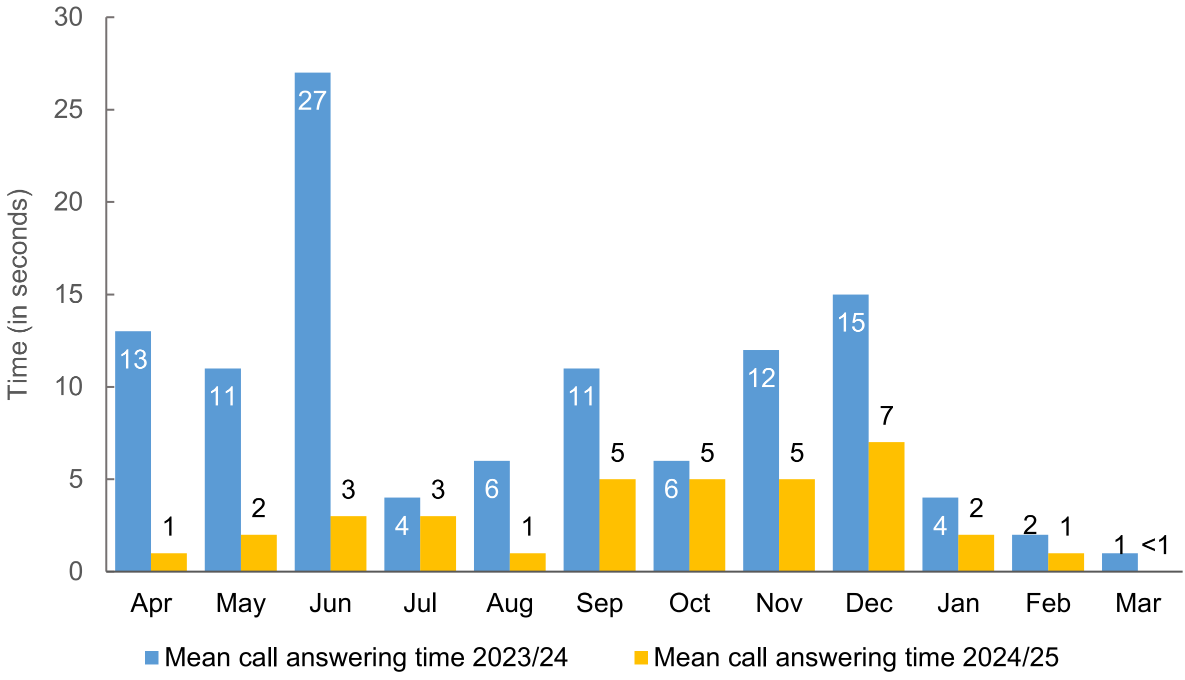


Figure 15: Mean call answering times per month (n=4,335)

Excludes calls transferred directly from another services (e.g. police or NHS 111) and with missing time data

- Average **call answering times** for patients who subsequently received resuscitation attempts by LAS clinicians continued to **improve**, standing at an average of **3 seconds** this year (compared with 42 seconds in 2022/23 and 9 seconds in 2023/24).
- The **longest** average call answering time was in **December 2024** (at 7 seconds) and the **shortest** in **March** 2025 (<1 second).

3.6.2. Chief complaints

The Chief Complaint is allocated during call handling and refers to the primary issue or reason reported by the caller for requesting emergency medical assistance. The table below contains the most frequent Chief Complaints allocated to patients who had resuscitation attempted by LAS.

Chief Complaint at call handling, n (%)	
Cardiac arrest	2,750 (59.4)
Breathing problems	348 (7.5)
Unconscious/fainting	314 (6.8)
Falls	186 (4.0)
NHS 111 Transfer	128 (2.8)
Convulsions/fitting	120 (2.6)
Chest pain	111 (2.4)
Other	674 (14.6)

Table 2: Chief Complaint allocated during call handling

N.B. Percentages may not total 100% due to rounding

3.7. Response times

The following section provides the internationally defined **clinical response intervals**, measured from the time of the '999 call' to 'arrival at scene' (in line with the Utstein definitions). These figures differ from those reported by the NHS England Ambulance System Indicators (AQIs), which use an alternative definition of the response interval[1].

[1] NHS England AQI response intervals are measured using Clock Start to Clock Stop, as per the national AmbSYS specification which is available at: https://www.england.nhs.uk/statistics/statistical%20work-areas/ambulance-quality-indicators/

Year	n	Mean	Median
2021-22	4,366	14:22	09:00
2022-23	4,610	16:06	09:36
2023-24	4,572	12:52	08:31
2024-25	**4,631**	**12:34**	**08:25**

Table 3: '999 call' to 'arrival at scene' clinical response intervals (mm:ss)

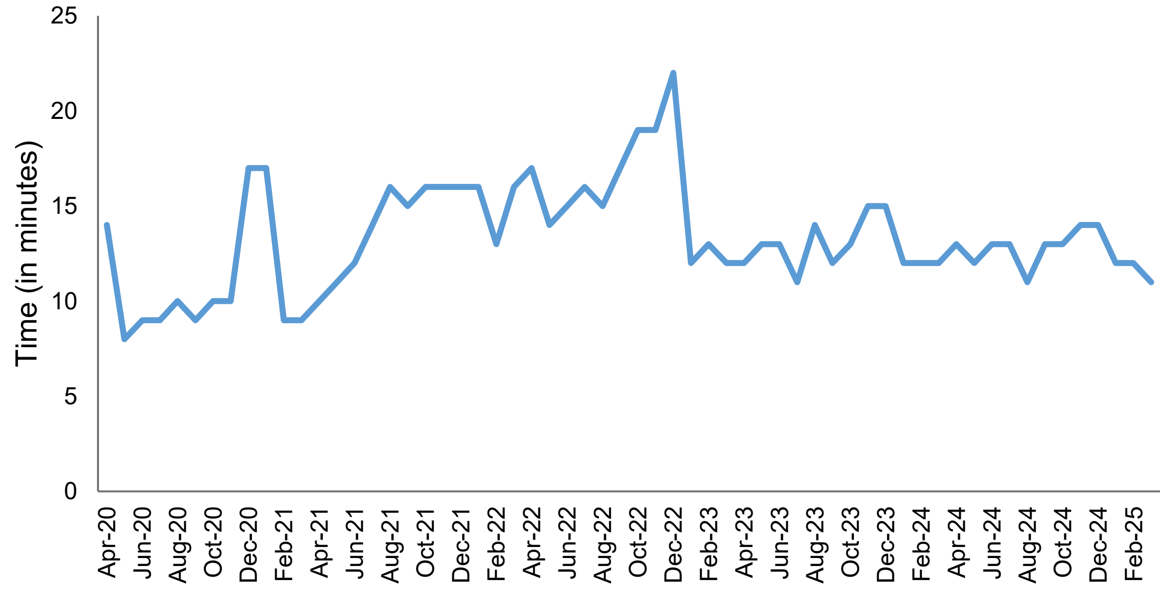


Figure 16: Clinical response interval over 5 years (where LAS attempted resuscitation)

- The clinical response interval **improved slightly** compared to the last year, with a mean of **12:34,** and is the fastest time seen over the past four years.
- Average response times fluctuated over the year. The **longest** average response time was in **December** (14:19), while the shortest occurred in **March** (10:33).

3.8. Key clinical intervention intervals

Year	Interval	n	Mean	Median
2024-25	**999 call^ – LAS CPR***	**2,651**	**14:38**	**10:47**
	999 call^ – LAS defibrillation*~	**646**	**13:36**	**11:04**
2023-24	999 call^ – LAS CPR*	2,560	14:14	10:56
	999 call^ – LAS defibrillation*~	590	12:56	10:55

Table 4: Key time intervals from 999 call (mm:ss) compared with last year

*^ Time the 999 call was connected to the ambulance service. * Excludes LAS witnessed arrests and incidents where times were not documented. ~Based on an initial rhythm of VF/VT*

- The mean time from **999 call to LAS defibrillation** was **longer** this year compared to 2023/24.
- **Missing data** continued to impact the reliability of this metric. CPR times were unavailable for over one third of incidents, and defibrillation times were not recorded for nearly one in ten patients. As such, findings should be treated with caution.

3.9. Clinical presentation

3.9.1. Aetiology

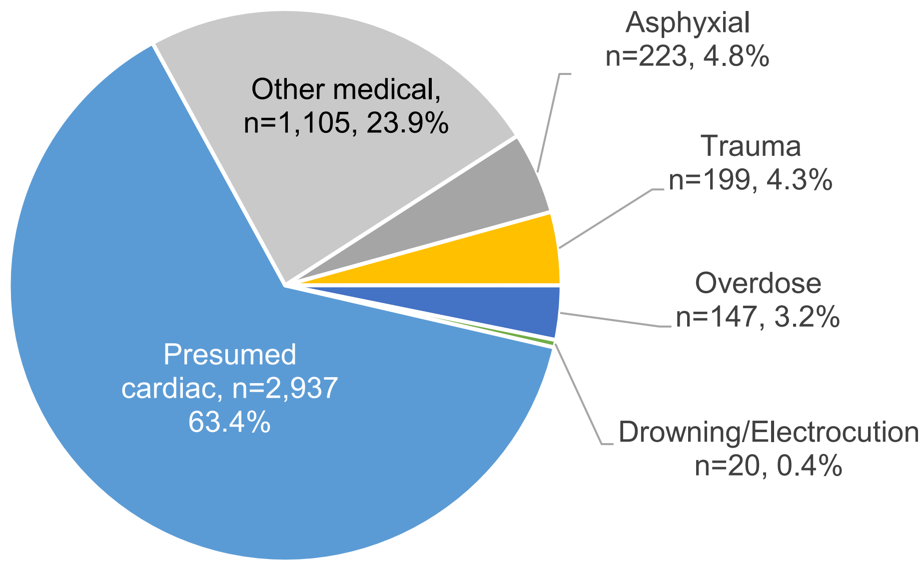


Figure 17: Breakdown of aetiology of cardiac arrests where LAS attempted resuscitation

- The most common cause of cardiac arrest was **presumed cardiac** (**63.4%**).
- Traumatic arrests accounted for 4.3% (n=199) of OHCAs that most frequently affecting younger patient groups, particularly those aged 20-29.

3.9.2. Initial arrest rhythm

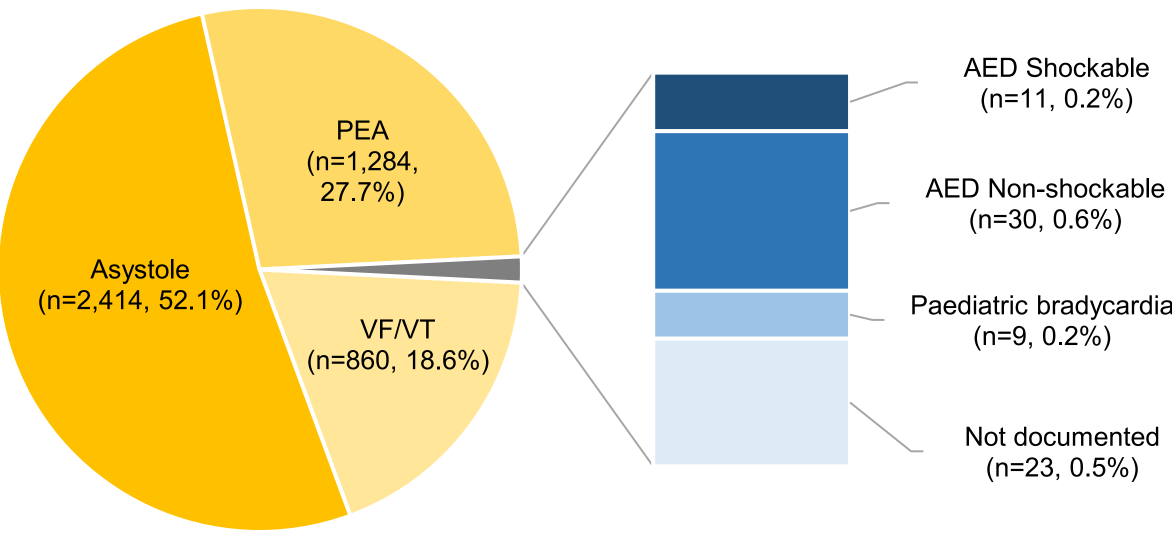


Figure 18: Breakdown of initial recorded cardiac arrest rhythm

Percentages may not total 100% due to rounding

- **More than half of patients** presented in **asystole** (**52.1%**, n=2,414). This is slightly higher than the figure reported last year (50.9%) and in line with the figure reported in 2022/23 (52.0%).
- The proportion of patients presenting with a **shockable rhythm** has seen a modest increase again this year, reaching **18.8%** (n=871), up from 18.5% in 2023/24 and 17.7% in 2022/23.
- There has been a notable improvement in documenting the initial rhythm, with 99.5% (n=4,408) of patients having this recorded, compared to 98.3% last year.

3.10. Conveyance

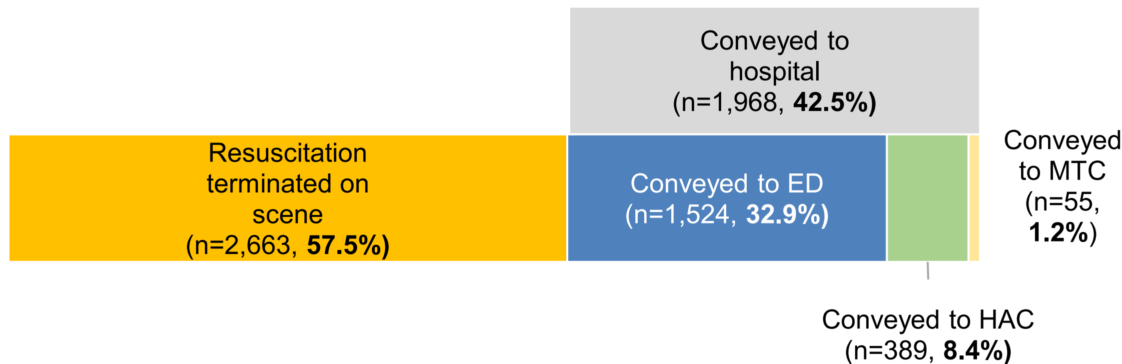


Figure 19: Breakdown of conveyance by destination

- Resuscitation efforts were **terminated on scene** for over half of patients.
- When conveyed, the mast majority were taken to an **Emergency Department** (ED) (**77.4%,** n=1,524/1,968).
- Consistent with last year, a small proportion of patients were taken to specialist facilities: Heart Attack Centres (HACs) (19.8%, n=389) and Major Trauma Centres (MTCs) (2.8%, n=55).

4. Patient outcomes

This section presents outcome data for two groups:

1. **Overall group**: all patients when resuscitation was attempted by the LAS.
2. **Utstein comparator group**: a sub-group of patients who had resuscitation attempted following an OHCA of presumed cardiac aetiology, which was bystander witnessed and initially presented in a shockable rhythm. The completed Utstein Template is presented in Appendix 3.

   N.B., Utstein definitions have been updated expanding the denominator from presumed cardiac to all cardiac arrests with resuscitation attempted (regardless of aetiology). As NHS England's AQIs continue to report the original Utstein comparator group, and for ease of comparison, we continue to use the original

calculation. We will move to the newer, expanded survival calculation when the AQI's are updated and will recalculate our historical figures for comparison.

4.1. ROSC sustained to hospital

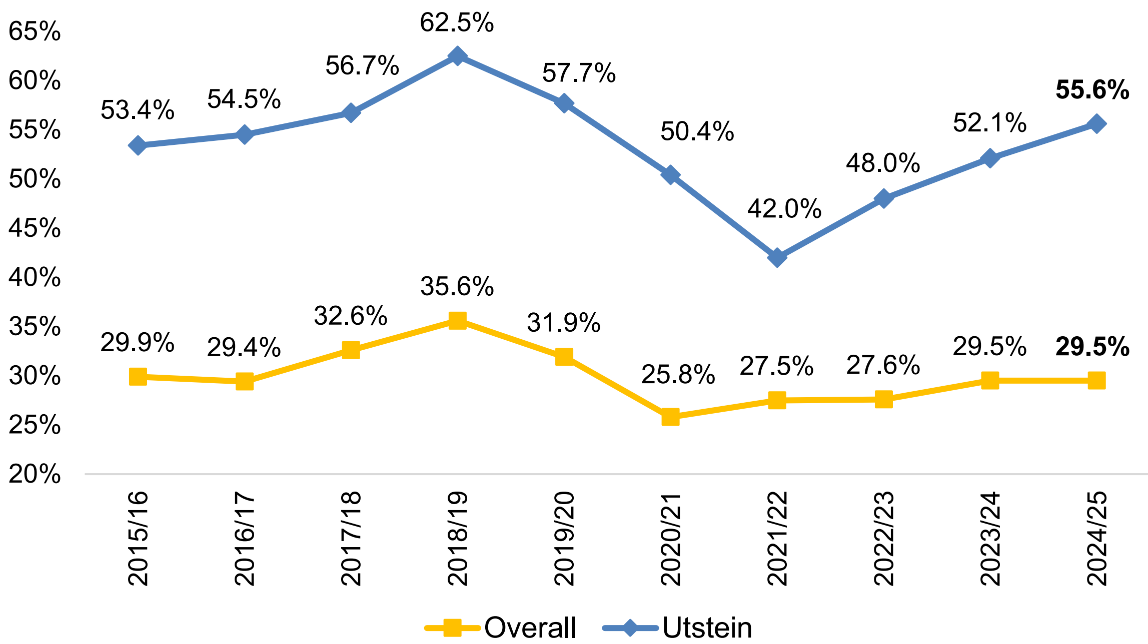


Figure 20: ROSC sustained to hospital over the past 10 years

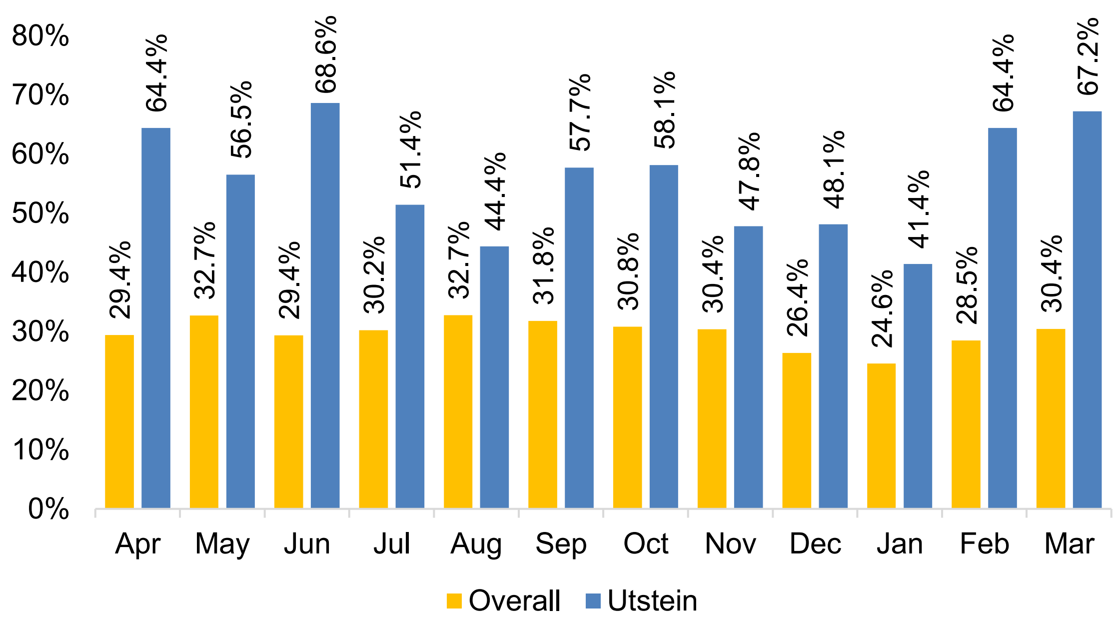


Figure 21: ROSC sustained by month

4.2. Survival to 30 days

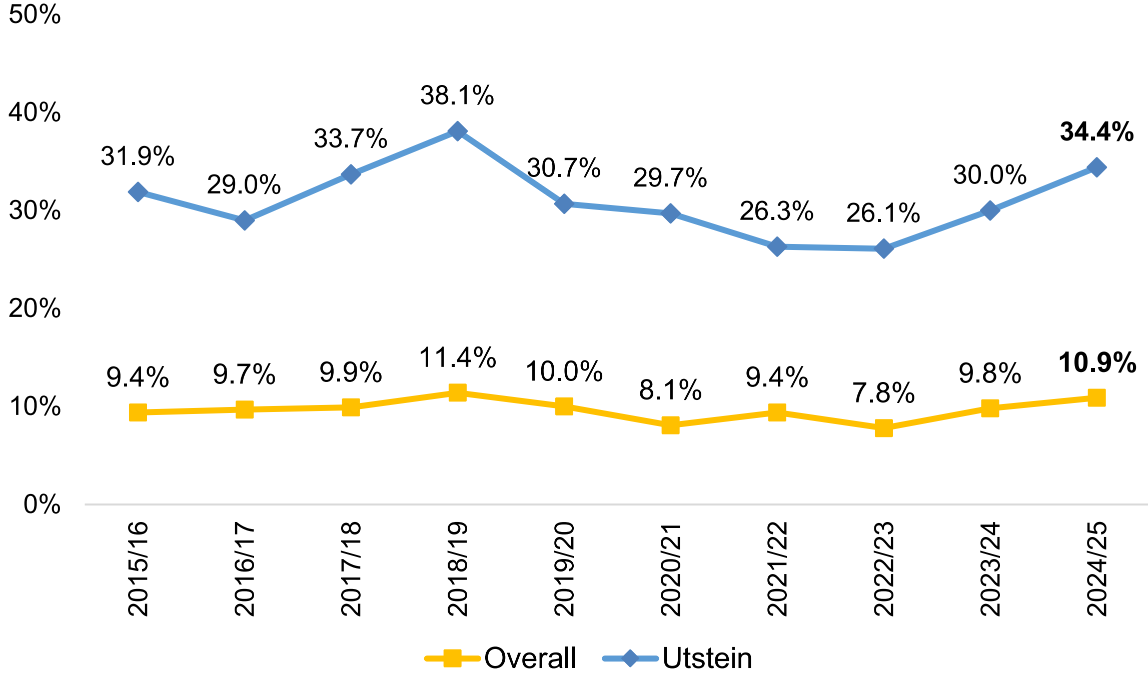


Figure 22: Survival to 30 days over the past 10 years

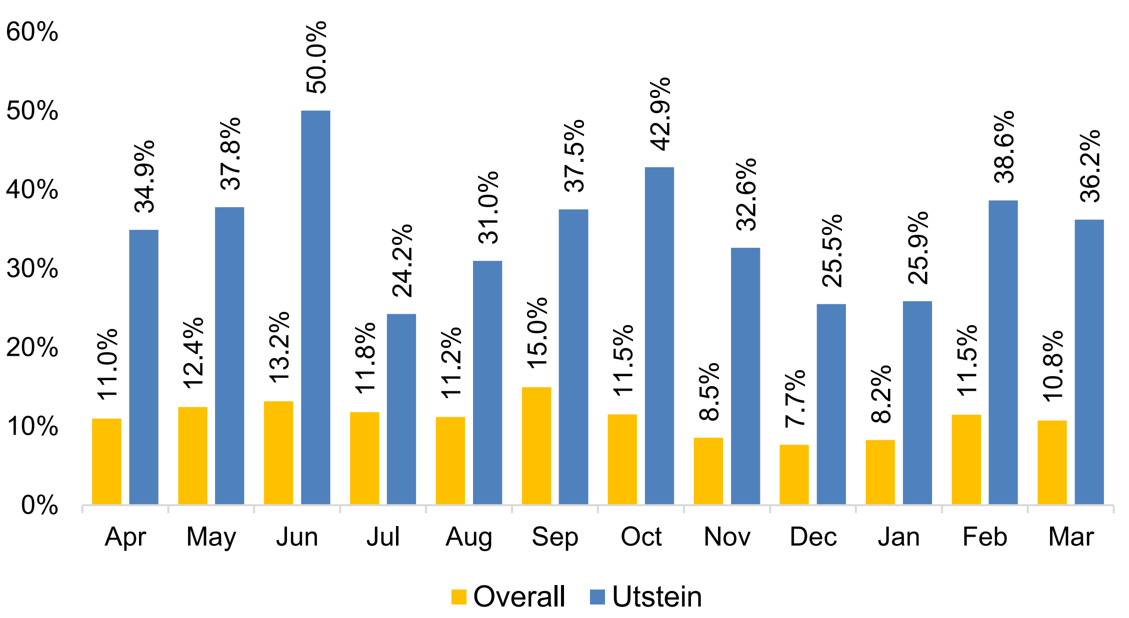


Figure 23: Survival to 30 days per month

- **Overall ROSC** sustained to hospital remained the **same as last year** at 29.5%.
- Amongst the **Utstein** comparator group, the proportion of patients who achieved and sustained **ROSC** until hospital arrival **increased** from last year by 3.5 percentage points, continuing the upward trend since 2021/22.
- **10.9%** of patients (n=494) in the **overall** group were **alive** 30 days after their arrest – this is the **second-highest** survival rate reported within the past 10 years (surpassed by 11.4% in 2018/19). This marks a strong improvement from the low of 7.8% in 2022/23, suggesting a return to pre-pandemic survival levels.
- In the **Utstein** comparator group the survival rate was **34.4%**, also representing the highest figure since 2018/19 (when the survival rate for this group peaked at 37.8%).

Group	**Survival to 30 days**	
	LAS	**National Average**
Overall group	10.9%	9.6%
Utstein comparator group	34.4%	29.9%

Table 5: LAS survival compared with the national average for England (AQIs)

- The LAS's 30-day survival rates continue to **exceed the national average**, with an overall survival rate of 10.9% compared to the national average of 9.6%, and the Utstein comparator group survival rate of 34.4% compared with 29.9%.

4.3. Survival by patient and arrest characteristics

The table below shows the proportion of patients who survived to 30 days within groups of characteristics of interest.

Characteristic	% of each group that survived to 30 days
Sex	12% of males survived to 30 days 8% of females survived to 30 days
Age group	18% of patients aged 0-9 19% of patients aged 10-19 16% of patients aged 20-29 16% of patients aged 30-39 18% of patients aged 40-49 17% of patients aged 50-59 12% of patients aged 60-69 7% of patients aged 70-79 4% of patients aged 80-89 2% of patients aged 90+
Location of OHCA	39% in sports or recreational event 29% in ambulance 24% at work 20% in a public building 17% in street or road 15% in other public location 8% at home or private address 2% at care home
Witness status	25% when LAS witnessed 12% when bystander witnessed 4% when unwitnessed
Bystander CPR	10% of patients who received bystander CPR 6% of patients who did not receive bystander CPR
Bystander defibrillation	33% of those who received bystander defibrillation shocks 8% of those where bystander defibrillation was not given
Aetiology	14% of overdose patients 13% with presumed cardiac aetiology 13% of drowning cases 7% who had an asphyxial cause of arrest 6% who had other medical cause of arrest 5% of patients with traumatic cardiac arrests
Initial rhythm	38% of those with a shockable rhythm 4% of those with non-shockable rhythm
Destination	59% of patients transported to Heart Attack Centre 32% of patients transported Major Trauma Centre 18% of patients transported to Emergency Department

Table 6: Survival to 30 days within each characteristic group

5. Discussion

Survival rates for out-of-hospital cardiac arrest in London continue to improve, reaching the highest level in six years. This positive trend may be linked to the continued enhancements we have observed in our response across a number of key areas, including faster call answering and reductions in call-to-arrival times.

The likely impact of these quicker responses on survival is particularly significant given the potentially negative impact of declining bystander CPR rates that are now at their lowest in six years (mirroring a reduction in bystander witnessed arrests).

The LAS is committed to proactively enhancing bystander intervention rates by equipping members of the public with the necessary skills and confidence to perform lifesaving interventions prior to the arrival of the ambulance service. Over 8,000 members of the public became registered 'London Lifesavers' this year after receiving first aid training from the LAS First Responder Department. Additionally, during 2024/25, 13,000 pupils were trained in lifesaving skills through the London Lifesaver Schools Programme.

In July 2024, along with the London Ambulance Charity, the LAS launched the London Heart Starters Campaign to promote the use of Public Access Defibrillators (PADs). To date, this campaign has facilitated the placement of over 200 PADs across London, with a strategic focus on areas with limited or no access to lifesaving equipment, helping to address health inequalities across the capital. We have also continued our partnership with Transport for London to support training and the provision and maintenance of PADs throughout the London underground network.

Further community engagement has been driven through our partnership with the GoodSam network. The LAS aims to increase the number of accepted alerts by engaging responders through thank-you emails and ongoing communication aimed at identifying and mitigating barriers that may hinder alert acceptance. Additionally, work is underway to improve data accuracy by promoting the correct use of the mobile application by responders when they accept alerts and arrive on scene.

Our commitment to advancing the evidence base for cardiac arrest care through impactful clinical research remained strong through 2024/25. We successfully completed patient enrolment for the PARAMEDIC-3 trial, which investigated the optimal route of adrenaline administration in pre-hospital cardiac arrest. Throughout the study, we enrolled 2,339 patients—contributing over one-third of the total recruitment across the UK. We also finished recruiting to the RAPID-MIRACLE study, which assessed the potential application of a prognostication scoring tool in pre-hospital cardiac arrest. In total we enrolled 292 patients into this study. Additionally, during this reporting year, we co-authored five peer-reviewed scientific publications to inform and improve the care, treatment and outcomes for people experiencing out-of-hospital cardiac arrest, not only in London, but worldwide.

We have continued to actively support national research efforts by contributing data to the UK Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) project, as well playing a key role in the associated project management and steering groups. In parallel, we continue to submit data to the NHS England Ambulance Quality Indicators (AQI) programme, enabling national benchmarking and quality improvement across all English ambulance trusts.

We continue to recognise and celebrate the outstanding efforts of our call handlers, dispatchers and clinicians in delivering exceptional patient care and helping our patients have the best possible outcomes. During 2024/25, CARU sent 3,720 letters to LAS staff who contributed to the care of all patients who survived to 30 days, thanking them for the crucial role they played in each patient's survival.

Finally, in November 2024, CARU launched a new interactive monthly cardiac arrest report that allows clinicians to access detailed information about the quality of care they have personally provided to OHCA patients. As well as highlighting trends and areas of good practice, these reports provide enhanced opportunities for clinical feedback, which is expected to drive further improvements in cardiac arrest management by LAS clinicians.

References

1. Recommended guidelines for uniform reporting of data from out-of-hospital cardiac arrest: the Utstein Style. Task Force of the American Heart Association, the European Resuscitation Council, the Heart and Stroke Foundation of Canada, and the Australian Resuscitation Council. Ann Emerg Med. 1991 Aug;20(8):861-74.

Appendix 1 – Patients found to be ROSC on arrival of LAS (n=49)

49 patients were reported to have received bystander defibrillation and were found in ROSC upon LAS arrival. As a result, further resuscitation efforts were not required. Additional details regarding this patient group are provided in the table below. It should be noted that, due to low availability of defibrillator download data, it is not possible to verify that these patients had been in cardiac arrest and were defibrillated.

AED use	Defibrillator shock delivery reported by bystanders (100.0%) Defibrillator shock delivery confirmed by a download (14.3%)
Witnessed status	Arrest witnessed by bystander (93.9%)
Dispatcher assisted CPR	CPR instructions provided (42.9%)
Bystander CPR	Bystander CPR provided (100.0%)
GoodSam responders	Responder on scene (6.1%) Responder arrived before LAS (2.0%)
Location	Sports or recreational event (38.8%) Street or road (20.4%) Public building (16.3%) Other public location (14.3%) Work (8.2%) Home or private address (2.0%)
Sex	Male (85.7%) Female (14.3%)
Age	Mean (56) Median (61)
Destination	ED (67.3%) HAC (30.6%) MTC (2.0%)
Survival	Survived to 30 days (93.9%) Unknown (6.1%)

Table 7: Patients found in ROSC on LAS arrival

Appendix 2 – Outcomes by bystander intervention (where LAS continued resuscitation)

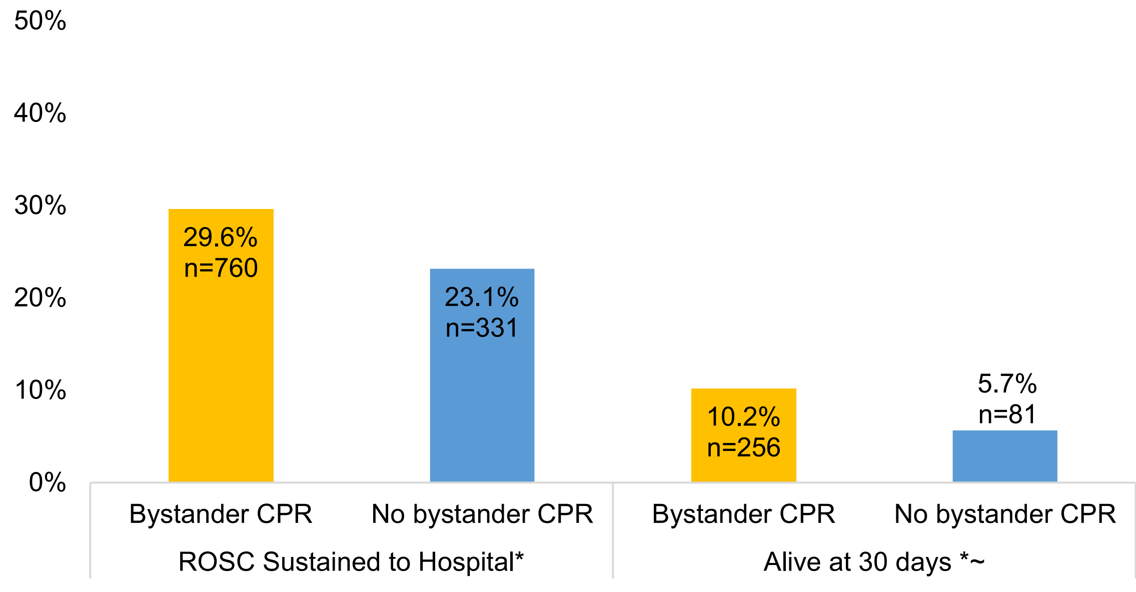


Figure 24: Outcomes for patients by bystander CPR

**Excludes LAS clinician witnessed cardiac arrests. ~Excludes 70 patients where outcome data were unavailable.*

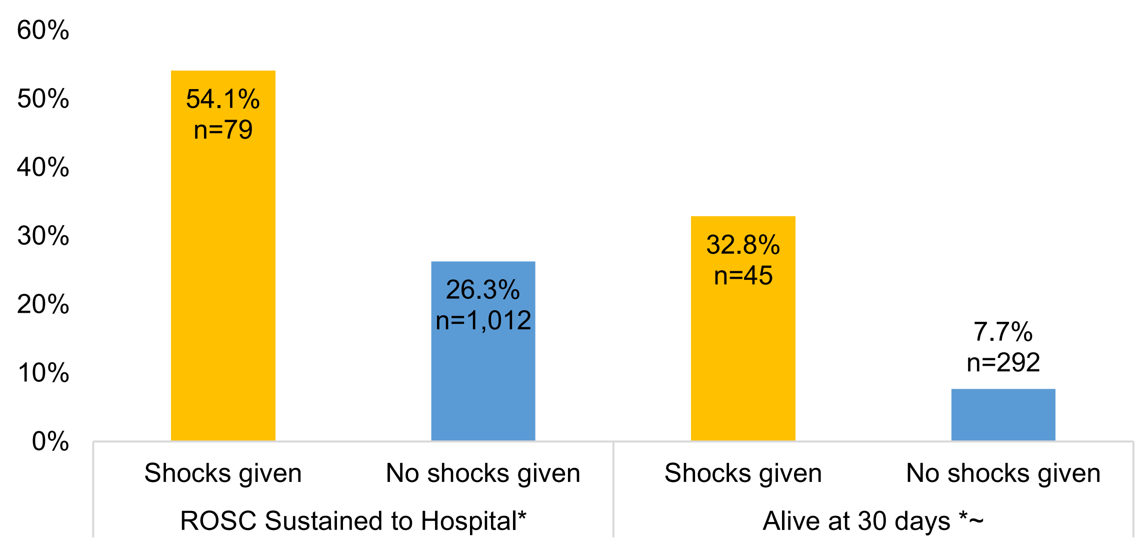
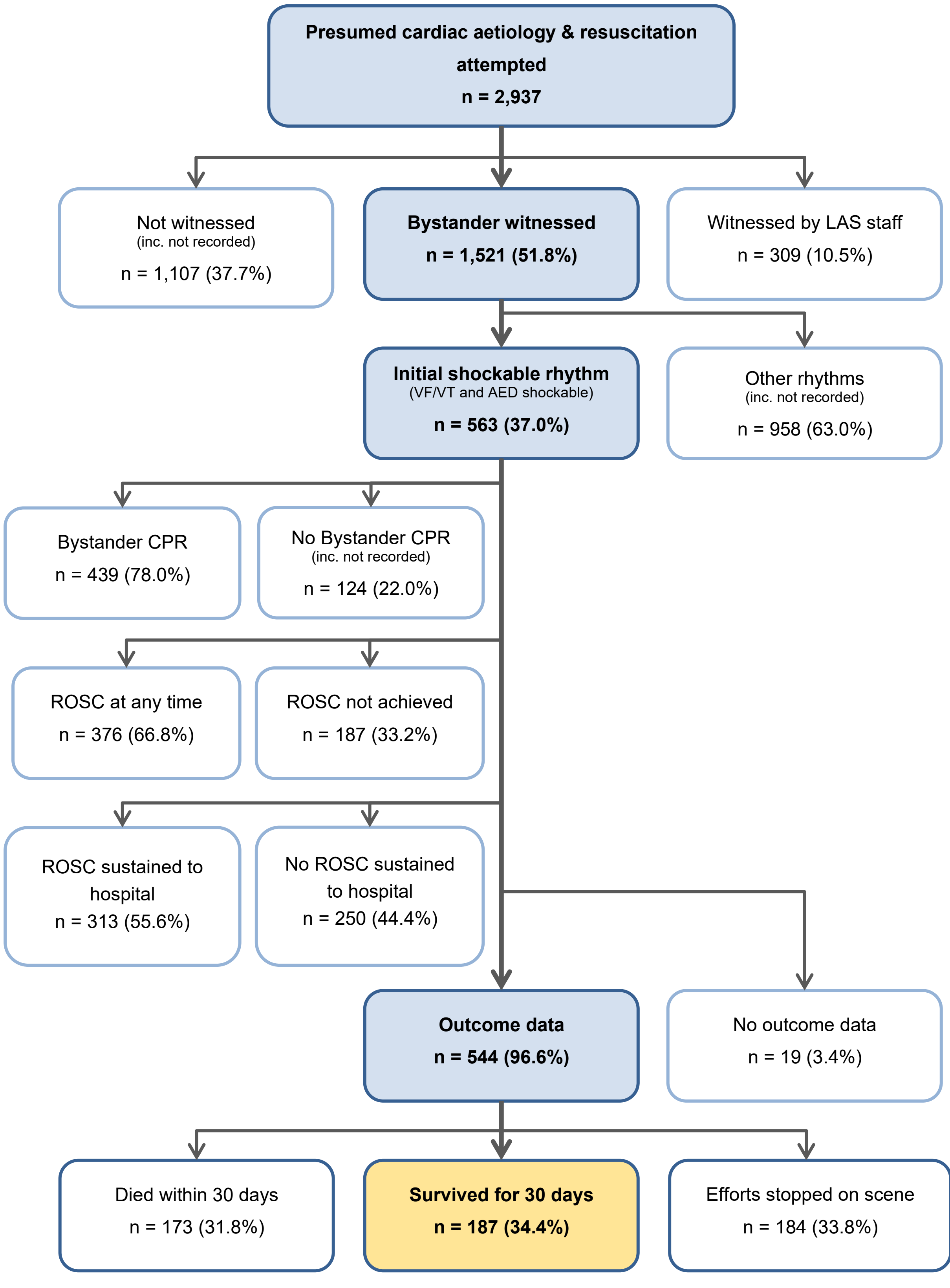


Figure 25: Outcomes for patients by bystander defibrillation

**Excludes LAS clinician witnessed cardiac arrests. ~ Excludes 70 patients when outcome data were unavailable.*

- **ROSC** sustained to hospital arrival was achieved for **29.6%** of patients, who **received bystander CPR** and then had LAS continue the resuscitative efforts**,** compared to **23.1%** of patients who did not receive CPR prior to the arrival of LAS clinicians.
- **30-day survival** was **10.2%** among patients who received **bystander CPR**, compared to 5.7% in those who did not.
- Among patients who received a **defibrillation by bystanders** and then had resuscitation continued by LAS clinicians, **54.1%** achieved and **maintained ROSC** until hospital arrival, compared to 26.3% of those who did not receive bystander defibrillation.
- The proportion of patients, who **received bystander defibrillation** and **survived** their cardiac arrest to at least 30 days, **was 32.8%**. In contrast, among the patients who did not receive pre-LAS defibrillation, survival to 30 days was 7.7%.

Appendix 3 – Utstein Survival Template



ST Elevation Myocardial Infarction (STEMI) Annual Report

April 2024 – March 2025

October 2025

Produced by:

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STEMI Care Summary 2024-25

3,653 Suspected STEMI patients

75.0% — 60 years (mean)

25.0% — 72 years (mean)

35 mins — Response

45 mins — On scene

Aspirin 97.1%

GTN 95.9%

Full Care Bundle 74.5%

Pain assessments 89.2%

Analgesia 87.9%

99.3% — Conveyed according to guidelines

94.1%* — Discharged alive

* MINAP discharge data available (n=887)

1. Introduction

Between 1st April 2024 and 31st March 2025, a total of **3,653 patients** were managed by London Ambulance Service NHS Trust (LAS) clinicians for a suspected ST Elevation Myocardial Infarction (STEMI). This report presents information on the demographics and the care we provided to those patients.

Data were sourced from the LAS's STEMI Registry which is maintained by the Clinical Audit and Research Unit (CARU). This registry compiles information from Emergency Operations Centre (EOC) call logs and electronic Patient Clinical Records (ePCRs). Additional information about hospital treatment and patient outcomes were obtained from the Myocardial Ischaemia National Audit Project (MINAP) database. All data presented reflect the most accurate information available at the time of publication.

Patients who experienced a cardiac arrest prior to hospital handover are not included in this report as their care is covered in the Cardiac Arrest Annual Report.

2. Findings

2.1 Patient profile (n=3,653)

Sex, n (%)	
Male	2,740 (75.0)
Female	913 (25.0)

Age in years, mean (median)	
Overall	63 (63)
Male	60 (60)
Female	72 (74)

Ethnic group, n (%)	
White	1,355 (37.1)
Asian	456 (12.5)
Black	393 (10.8)
Other	115 (3.1)
Mixed	72 (2.0)
Unknown	1,262 (34.5)

Chief complaint at call handling, n (%) ^			
Chest pain	1,576 (43.1)	Unconscious/fainting	209 (5.7)
NHS 111 transfer	701 (19.2)	Healthcare professional admission	146 (4.0)
Breathing problems	472 (12.9)	All other complaints	549 (15.0)

Table 1: Overall demographics of suspected STEMI patients

^ *Percentages may not total 100% due to rounding*

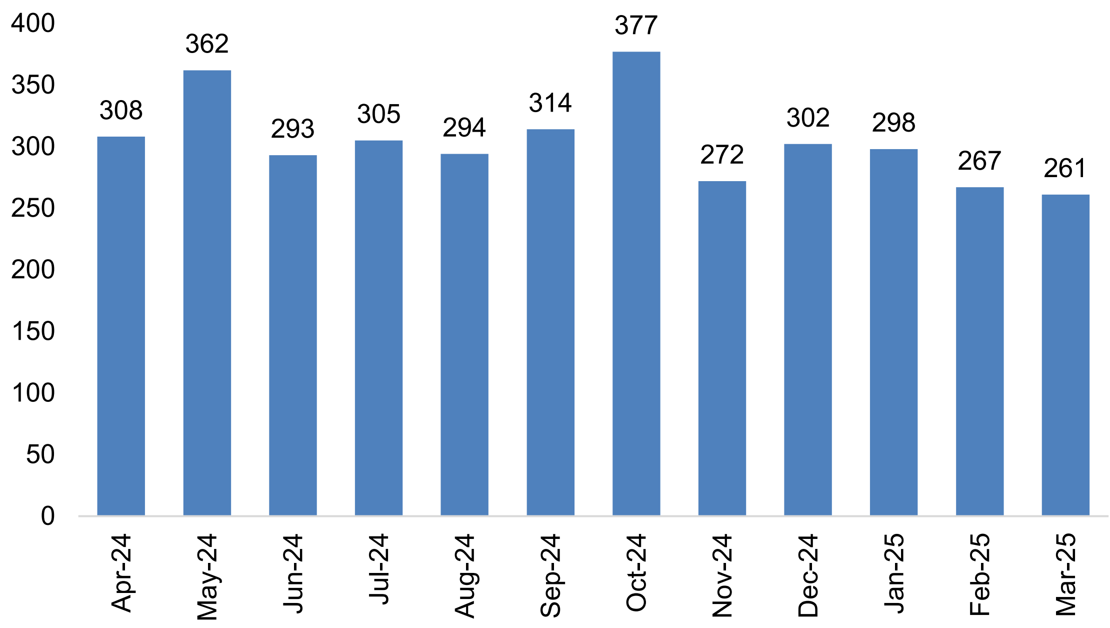

Figure 1: Number of suspected STEMI patients attended per month

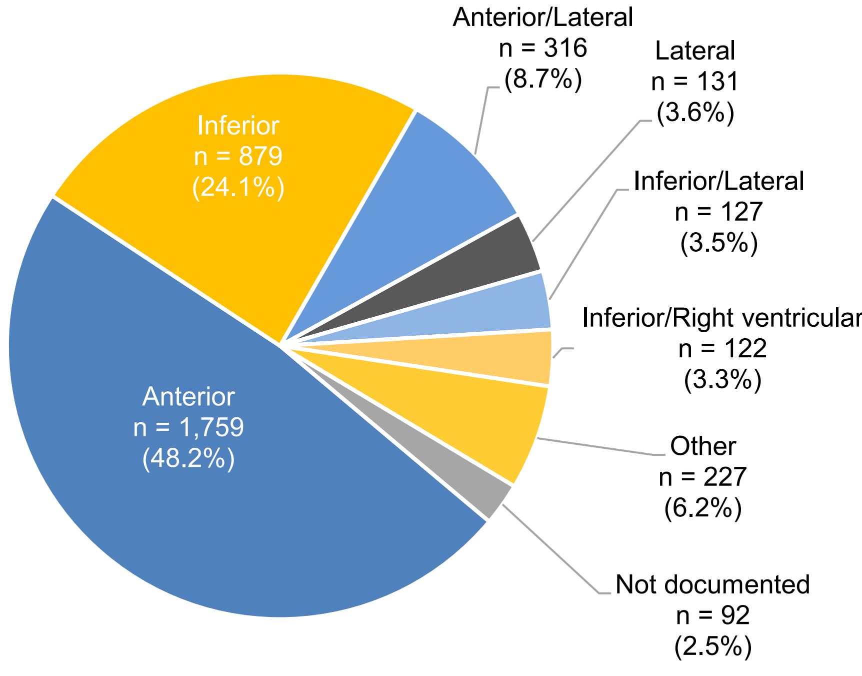

Figure 2: Documented region of ST elevation

Percentages may not total 100% due to rounding

- We saw a 14% increase in the number of patients presenting with a suspected STEMI compared to last year (3,653 vs 3,196).
- Similarly to previous years, the overall mean age was **63 years**, with the majority being **male** (75.0%, n=2,740).
- On average, males were 12 years younger than female patients (60 vs. 72 years).
- **October** 2024 saw the highest number of suspected STEMI patients (n=377), closely followed by May 2024 (n=362).
- **Anterior ST elevation** was the most frequently seen infarct location, appearing as the sole location in 1,759 patients (48.2%) and in combination with other regions for a further 429 patients (11.7%).

2.2 Response times

The times presented in this section are based on the internationally reported **clinical response interval** (https://www.ahajournals.org/doi/pdf/10.1161/01.CIR.84.2.960), which starts when a 999 call is connected to the ambulance service and finishes the moment the wheels of the first arriving vehicle come to a complete stop on scene.

Clinical response times are different from those published in NHS England's Ambulance System Indicators[1], which are measured using an alternative definition of the response interval.

n	Mean	Median
3,653	**0:34:35**	**0:22:48**

Table 2: '999 call to arrival at scene' clinical response interval (h:mm:ss)

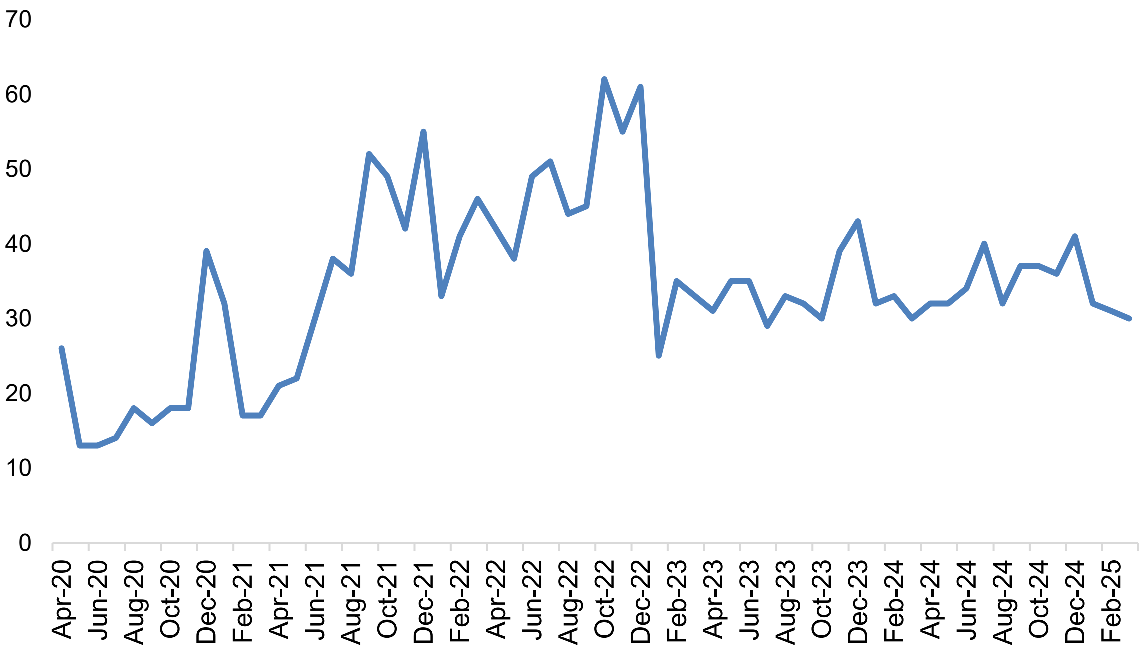

Figure 3: Monthly mean clinical response intervals (mins) over the last 5 years.

[1] NHS England AQI response intervals are measured using Clock Start to Clock Stop, as per the national AmbSYS specification which is available at: https://www.england.nhs.uk/statistics/statistical%20work-areas/ambulance-quality-indicators/

- The mean response time increased by one minute compared to last year, (34:35 vs 33:33 minutes). The median increase was lower at 37 seconds.
- The mean response time has been **notably shorter** over the past two years compared with the peak of 44:18 minutes in 2022/23.
- For this reporting year, the shortest average monthly response time was seen in **March** 2025 (29:52 minutes). The longest was observed in **December** 2024 (41:39 minutes).

2.3 On-scene times

The reported overall on-scene time is measured from the moment the first LAS vehicle arrives at the scene to departure of the conveying vehicle. In situations where an ambulance is not immediately available, a solo responder can be dispatched to initiate patient assessment and provide early care, particularly for high-risk patients.

Since solo responders are unable to convey patients to hospital, their on-scene times are typically longer than for incidents attended by a double-crewed ambulance only.

First vehicle on scene	n (%)	Mean	Median
Solo responder	991 (27.3)	0:54:10	0:50:18
Double-crewed ambulance (DCA)	2,643 (72.7)	0:42:11	0:39:59
Overall (regardless of first resource to arrive)	**3,634**	**0:45:27**	**0:42:41**

Table 3: On-scene times by first arriving vehicle (h:mm:ss)

Excludes 18 patients not transported to hospital and one conveyed by a third-party ambulance (accompanied by an LAS solo responder)

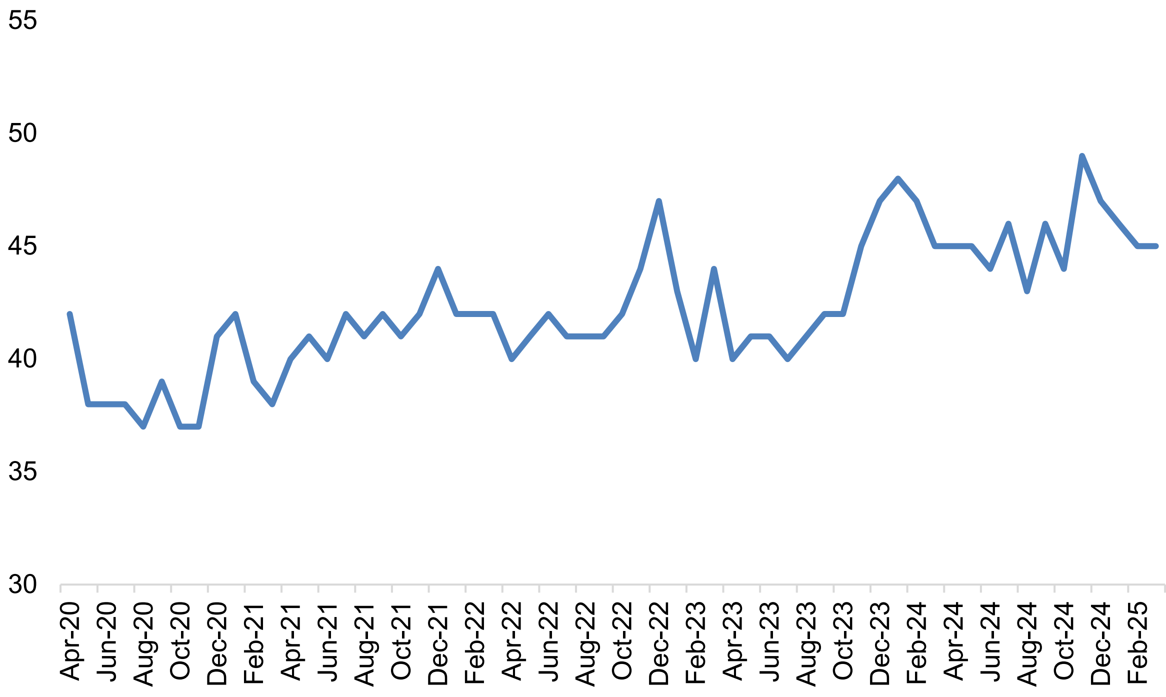

Figure 4: Monthly mean on-scene times (mins) over the last 5 years

- The proportion of incidents where a **solo responder was the first resource** on scene has continued to rise, standing at **27.3%** (n=991), up from 23.2% the previous year. This increase continues from the introduction of targeted dispatch *.
- The overall **mean** on-scene time has steadily increased over the last 5 years, rising from 38:45 in 2020/21 to **45:27** this year.

**Targeted dispatch aims to minimise treatment delays for calls with the high-risk Category 2 determinants 10D2 and 10D4. When these calls have been held for more than eight minutes, a solo responder will be dispatched. A 10D2 code indicates chest pain with difficulty speaking between breaths, while 10D4 indicates chest pain with clamminess or cold sweats.*

2.4 STEMI care bundle

Compliance calculations relating to undertaking two pain assessments changed in April 2024. Prior to this date, the second pain assessment was considered compliant if undertaken following 'treatment' which included aspirin/GTN administration. Under the revised approach, a second pain assessment is only complaint when recorded after *analgesia* administration. If no analgesia is given, then any two pain assessments are counted as compliant. Due to this change, we are unable to make comparisons with previous years for both the pain assessment element and overall care bundle delivery.

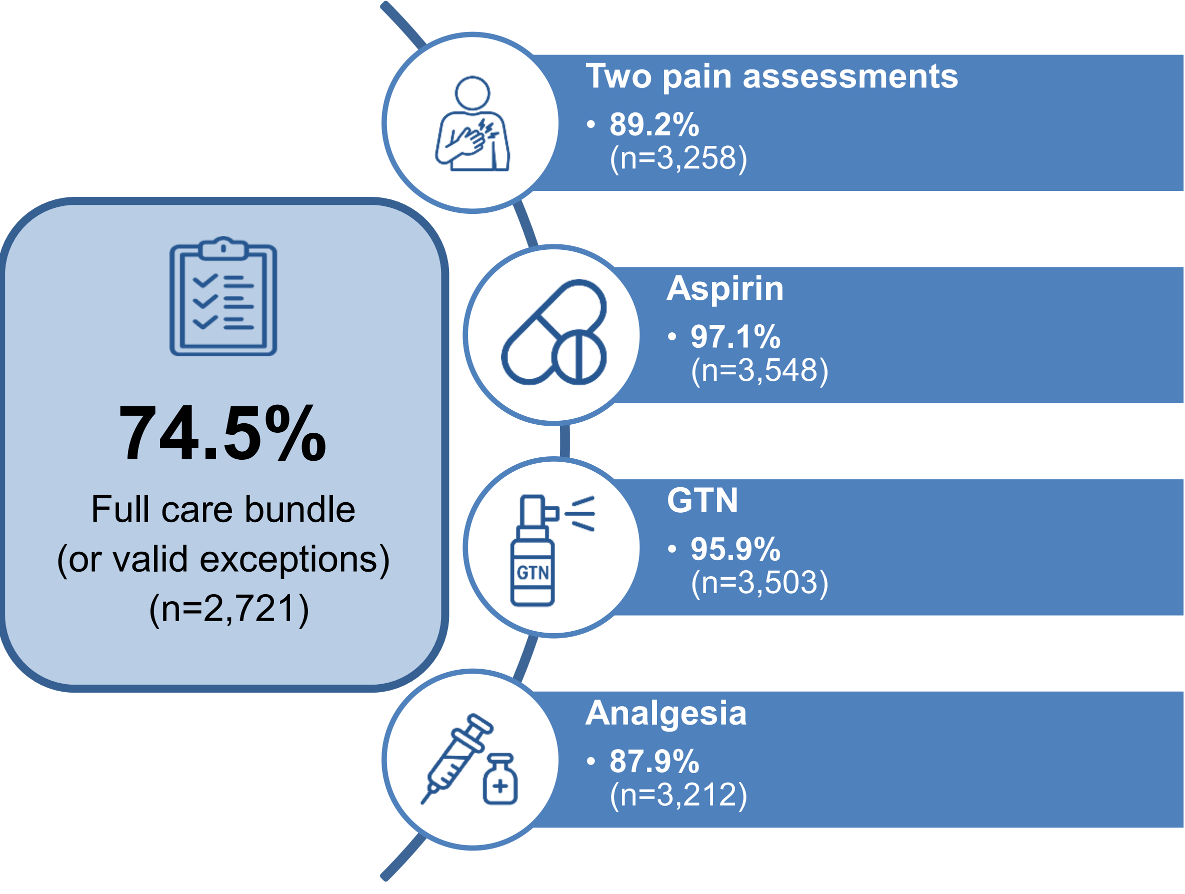

Figure 5: Compliance with the STEMI care bundle by individual component

- A complete **STEMI care bundle** was provided to **74.5%** (n=2,721) of patients.
- **Analgesia** administration remains the lowest scoring element (87.9%, n=3,212) but has improved, **rising more than 12.5 percentage points** over the last 5 years (see Appendix 1).

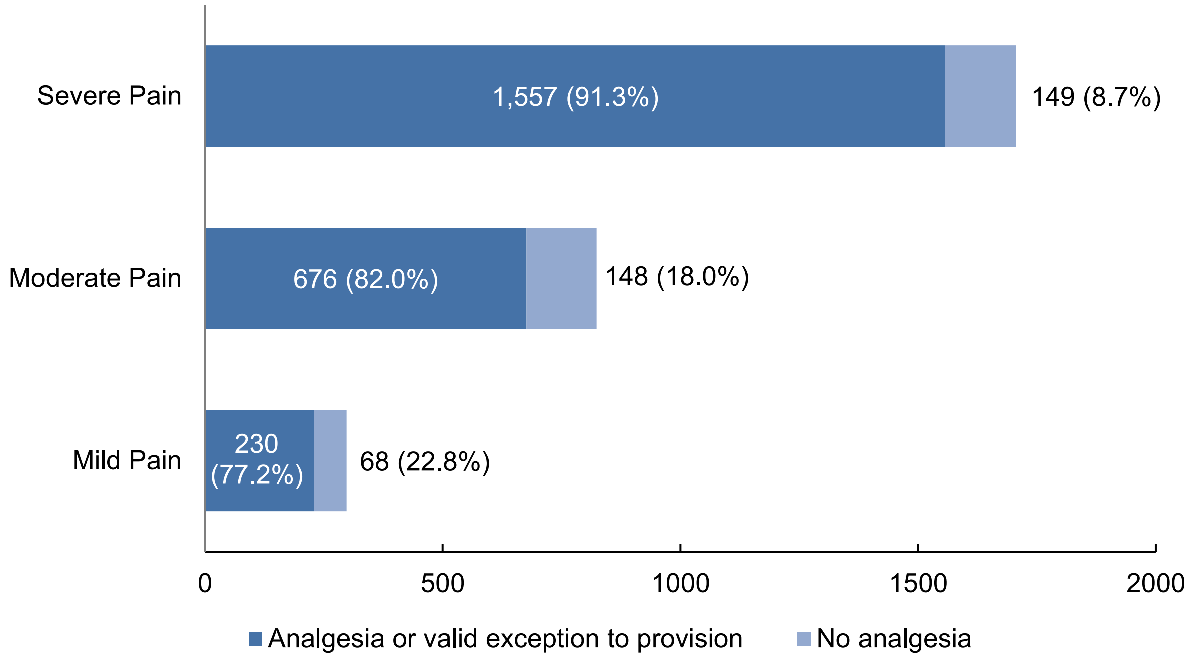

Figure 6: Analgesia administration by initial pain severity*

** Qualitative or numerical severity. Excludes pain-free at initial pain assessment (n=640) and pain severity not recorded (n=185)*

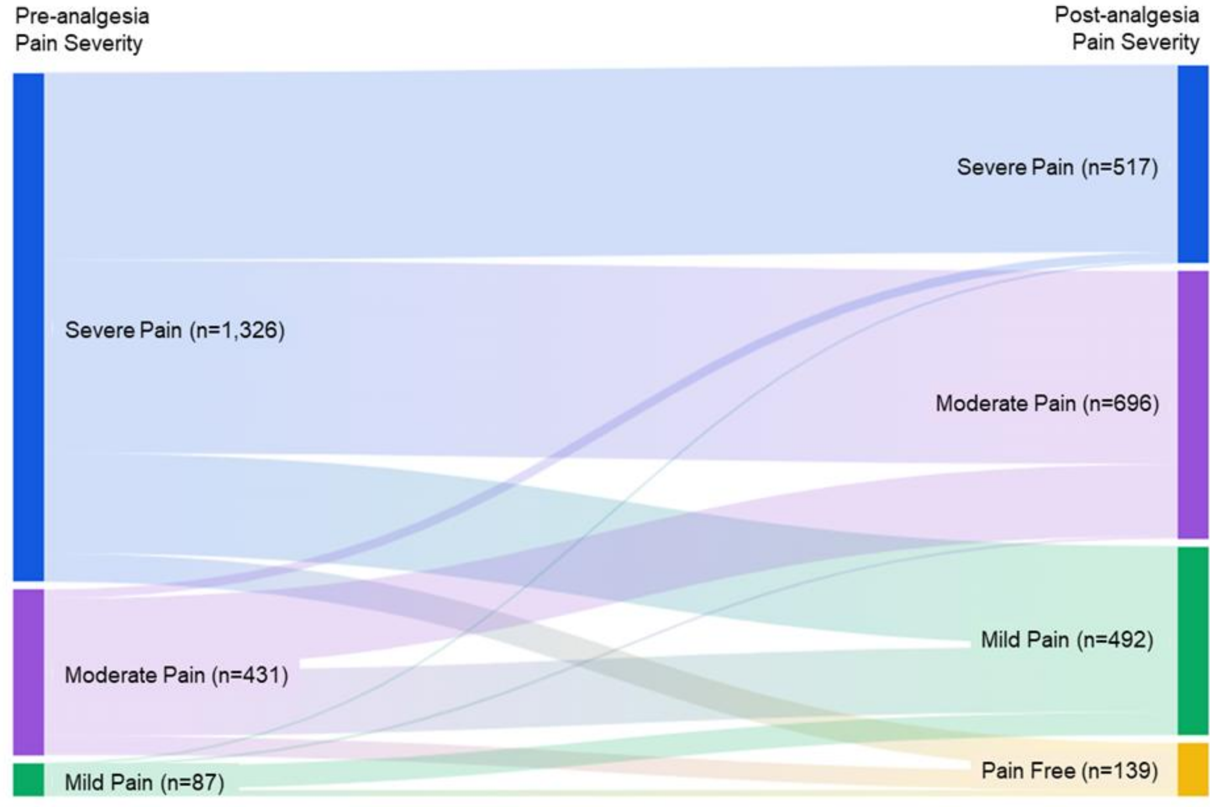

Figure 7: Changes of pain severity when analgesia was administered (n=1844)

Excludes patients not in pain at initial assessment/did not receive analgesia/did not have pain assessed or reassessed (n=1,809)

- An initial pain severity or an exception to pain assessment was documented for **97.7%** of patients (n= 3,569).
- 46.7% of patients (n=1,706) reported **severe pain,** but 149 of those (8.7%) **did not receive analgesia** and no valid exceptions were recorded.
- 84 patients received analgesia but did not have an initial pain severity recorded.
- 20 patients were given morphine despite being pain-free throughout LAS attendance. These instances were reported as potential patient safety incidents.
- Of the 1,326 patients who were initially in severe pain and had their pain reassessed, 488 (36.8%) still reported severe pain after receiving analgesia.

Analgesia provision to patients who initially reported severe pain	**n (%)**
Intravenous (IV) morphine	664 (39.0)
Entonox and IV morphine	168 (9.9)
IV morphine and IV paracetamol	129 (7.6)
Entonox	106 (6.2)
IV paracetamol	67 (3.9)
Oral morphine	49 (2.9)
Oral paracetamol	41 (2.4)
Entonox, IV morphine and IV paracetamol	40 (2.3)
Entonox and oral morphine	38 (2.2)
Entonox and oral paracetamol	32 (1.9)
IV morphine and oral paracetamol	28 (1.6)
Intramuscular (IM) morphine	27 (1.6)
Entonox and IV paracetamol	22 (1.3)
Entonox and IM morphine	11 (0.6)
Oral morphine and oral paracetamol	10 (0.6)
Entonox, IV morphine and oral paracetamol	6 (0.4)
Entonox, oral morphine and oral paracetamol	4 (0.2)
IM morphine and oral paracetamol	3 (0.2)
IV morphine and oral morphine	3 (0.2)
Entonox, IV morphine and oral morphine	2 (0.1)
Entonox, IM morphine and oral paracetamol	2 (0.1)
Subcutaneous (SC) morphine and IV paracetamol	1 (<0.1)
Valid exceptions to all 3 analgesia (including patient refusal)	102 (6.0)
Analgesia not provided	**149 (8.7)**
Total	**1,704**

Table 4: Patients with initial severe pain by type of analgesic administered

Excludes 2 patients in severe pain given analgesia due to potential drug documentation errors

- **69.5%** (n=1,185/1,704) of patients who initially reported severe pain received **morphine**, either alone or in combination with other analgesia.
- 41 patients in severe pain received only **oral paracetamol**. For 3 of these patients, oral paracetamol was the only option due to unsuccessful IV cannulation and exceptions to both Entonox and morphine.
- 5 patients received both oral and intravenous (IV) morphine. In all instances morphine was initially administered orally due to unsuccessful IV cannulation but was provided IV once access was established.

2.5 Conveyance

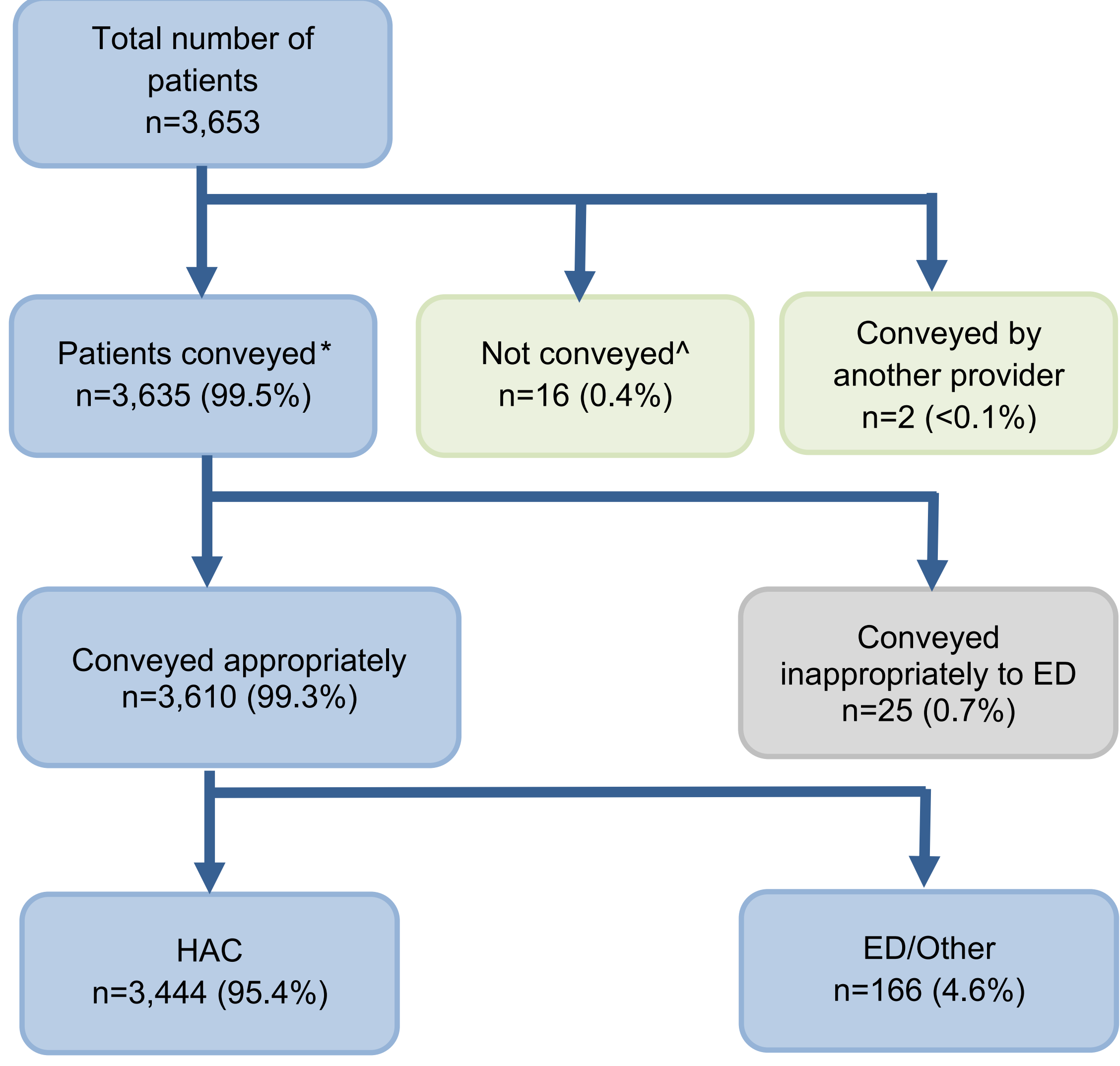

Figure 8: Conveyance

^All 16 patients refused hospital against advice

- Consistent with previous years, **99.3%** of suspected STEMI patients who were conveyed, were transported to an appropriate destination. **95.4%** of those were taken directly to a specialist **Heart Attack Centre** (HAC).
- 191 (5.3%) patients were conveyed to an Emergency Department (ED) or another non-HAC specialist unit. 25 (0.7%) of these patients met the criteria for HAC conveyance. All instances where the pathway decision was not in line with clinical guidelines were reported as potential patient safety incidents.

2.6 Call to arrival and journey to HAC times

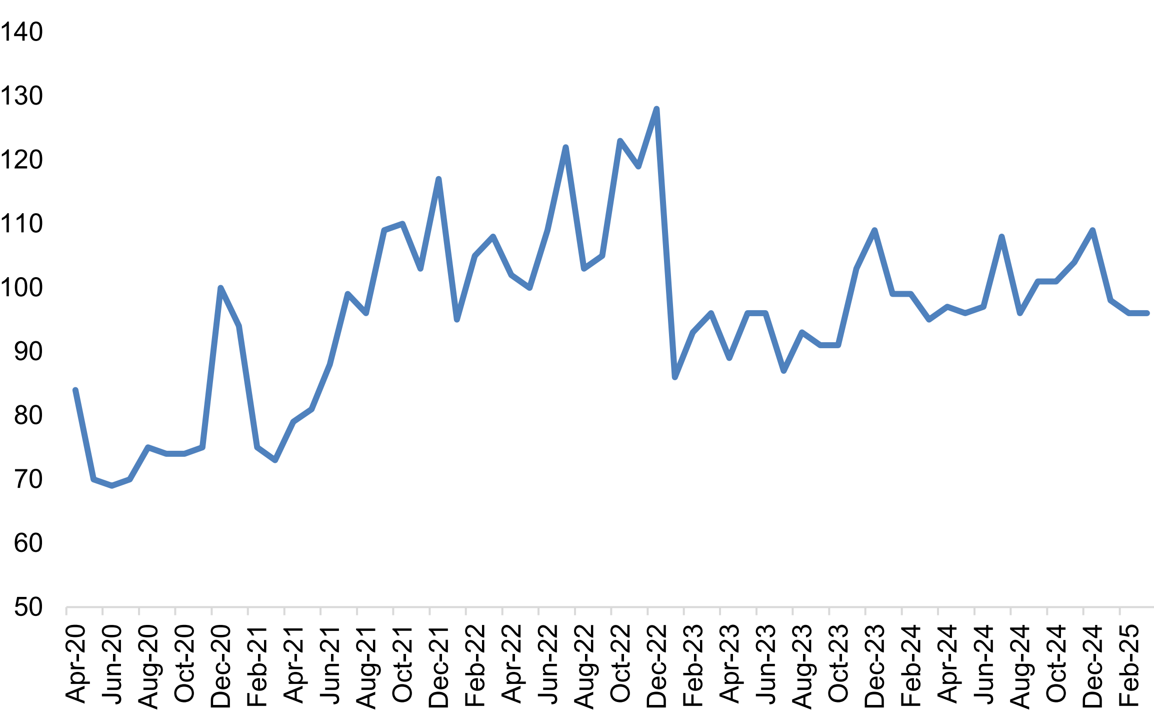

Figure 9: Monthly mean 999 call to arrival at HAC times (mins) over 5 years

999 call* to arrival at HAC:

Mean: 1:39:56
(Median: 1:31:06)

Leave scene to arrival at HAC (journey time):

Mean: 0:20:07
(Median: 0:19:04)

Figure 10: Mean call* to hospital and journey times when conveyed to a HAC^ (h:mm:ss)

**Time 999 call was connected to the ambulance service, ^Excludes one patient who was conveyed by a third-party ambulance and accompanied by an LAS solo responder*

- The average time from **999 call to arrival at a HAC** increased from 1:35:40 last year to **1:39:56**, making it the **second longest** annual average time in the past five years.
- The mean **journey time** for patients conveyed directly to a HAC remained stable, with a slight increase from 19:42 in 2023/24 to **20:07** minutes this year.

2.7 Patient outcomes

On arrival at a HAC, hospital staff assess the patient and, if a STEMI is confirmed, determine the patient's suitability for Percutaneous Coronary Intervention (pPCI).

Hospital staff subsequently create a record within the Myocardial Ischaemia National Audit Project (MINAP) database, which includes the patient's details, hospital treatment and discharge information. Ambulance services are able to access a specific subset of this data, which is used to source patient outcome information.

There is considerable variation in the quality and quantity of data submitted to MINAP. This year, outcome data were available for **less than one-third** of our conveyed suspected STEMI patients.

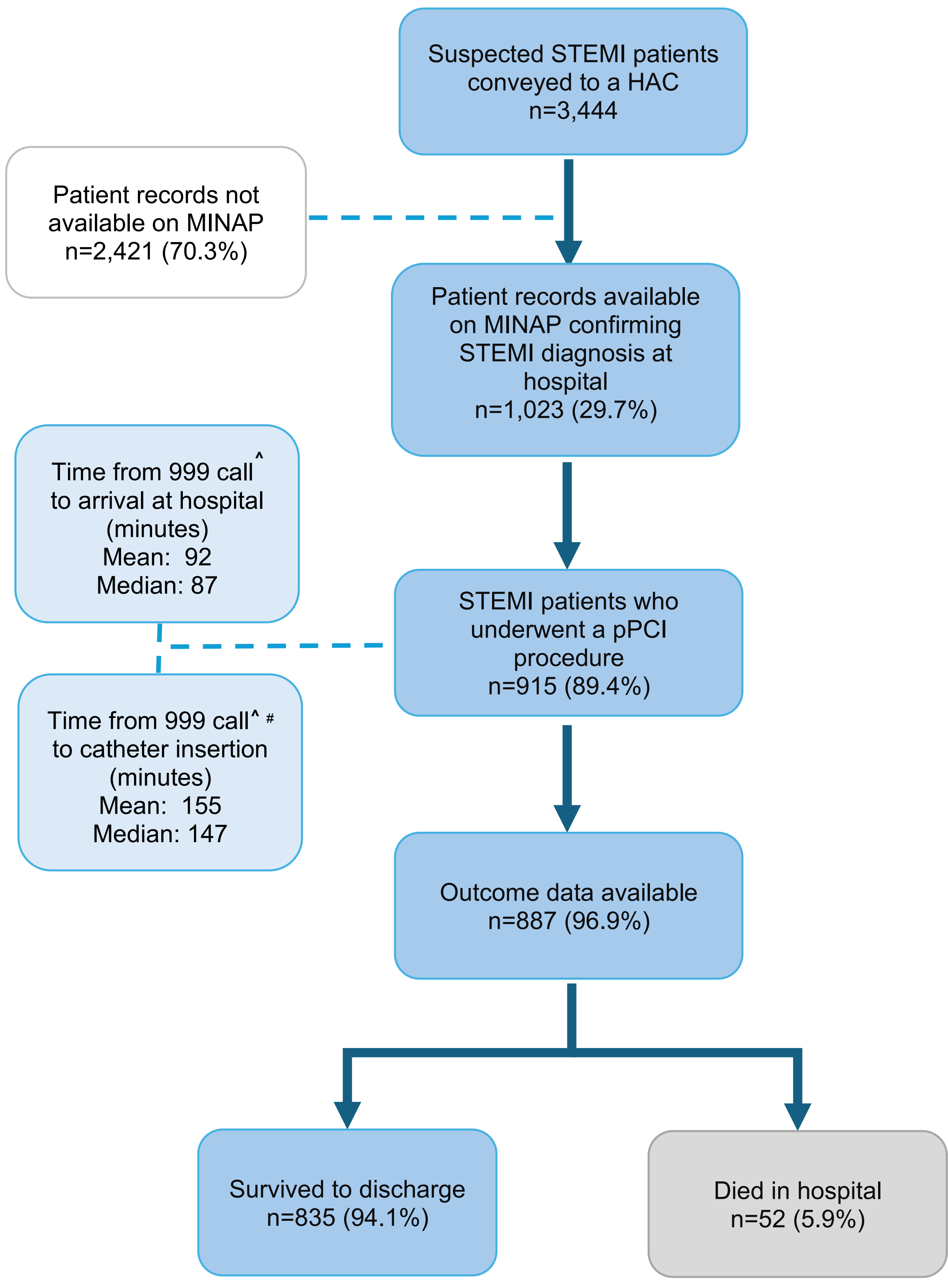

Figure 11: Outcomes for suspected STEMI patients

^ Calculated from the time that the 999 call was connected to the ambulance service
 # Excludes 44 patients with unavailable/implausible reperfusion times

- The majority of confirmed STEMI patients (**89.4%,** n=915) received pPCI.
- The mean average **call to arrival at HAC** for those receiving pPCI was **92 minutes** (one minute longer than last year).
- The mean average time from the **999 call to catheter insertion** in the HAC increased to **155 minutes** this year (vs 143 minutes last year).
- Notably, the time from hospital arrival to the start of the procedure **increased by 11 minutes**, rising from 52 minutes in 2023/24 to 63 minutes this year.
- **94.1%** (n=835) **survived** to discharge, which is a slight decrease of 1.3 percentage points from last year, but broadly consistent with previous years.

3. Discussion

LAS clinicians treated 3,653 patients with suspected STEMI during 2024/25, representing a considerable 14.3% increase compared to the previous year. While the reasons behind this increase are unclear, this pattern reflects emerging evidence of increased deaths involving cardiovascular disease since the COVID pandemic[1]. One possible contributory factor worth considering in relation to the increased reported incidence in London is that our clinicians are more readily using the suspected STEMI clinical code as a result of a number of local quality improvement initiatives and a heightened organisational focus on STEMI care across LAS during the past year.

While response times are almost 10 minutes faster than they were two years ago, on-scene times have continued the upward trend observed over the preceding five-year period. Going forward, the LAS will focus on reducing on-scene times. Supporting this effort, CARU will continue to highlight (via monthly reports) all incidents where ambulance on-scene times exceed 30 minutes to enable local review, feedback and action.

Care bundle provision, at 74.5%, remains below the internal target of 80%. However, there has been a notable improvement in the administration of analgesia, increasing from 83.3% in 2023/24 to 87.9% this year. Further work is needed to ensure that the choice of analgesia is appropriate to the severity of the patient’s pain.

As in previous years, the vast majority of patients were transported directly to specialist HACs to ensure rapid access to advanced interventions such as primary percutaneous coronary intervention (pPCI), commonly referred to as angioplasty.

Through the Ambulance Clinical Quality Indicators (AQIs), NHS England benchmarks ambulance services against each other on ‘Call to Angioplasty’ times. Hospital data, submitted via MINAP, demonstrated a 12-minute increase in the average time from 999 call to angioplasty. Importantly though, the ‘999 call to hospital arrival’ part of this pathway increased by only one minute, highlighting that the majority of the delay occurred after patients reached hospital and was outside of the ambulance service control. We will report these findings to the National Ambulance Clinical Quality Steering Group and recommend that ambulance services should not continue to be benchmarked against the ‘Call to Angioplasty’ AQI metric, and this should be replaced with the more appropriate measure of ‘Call to Hospital Arrival’ instead. In the meantime, we will work with the Pan-London Cardiac Group to improve the time to treatment.

Unfortunately, hospital outcome data was unavailable for a significantly large proportion of patients (>70%). Where data was available, it showed an impressively high survival to hospital discharge rate of 94.1%.

During this reporting year, CARU implemented several developments and enhancements to strengthen the review and oversight of the care provided to patients with suspected STEMI. These developments included a new Suspected STEMI Registry Application and an interactive Power BI STEMI monthly report. The Power BI report provides individual clinicians with access to comprehensive information on all suspected STEMI patients they personally attend, including compliance with the care bundle, on-scene times and pathway decisions. Enhanced reporting capabilities also enable clinical and operational managers to access detailed information and respond proactively to patterns in care provision. As well as supporting managerial oversight, this function facilitates structured clinical conversations and feedback, helping to drive continuous improvements in STEMI care across the service.

Just after this reporting period, in May 2025, the LAS introduced the STEMI Care Checklist which is located in the Multi-Dose Drug Packs. This initiative was

introduced as part of the ongoing commitment to improving care bundle provision and is intended to reinforce the importance of delivering the full STEMI care bundle.

Looking ahead, CARU will undertake a clinical audit project focusing on STEMI care, providing detailed analysis of the clinical care provided and identify incidents (and themes) where STEMI may have been unrecognised during assessment. It will explore practices related to analgesia administration, pain management and care bundle delivery, as well as examining potential disparities in care provision across different demographic groups.

The newly introduced clinical quality teams plan to implement further initiatives at a sector-level and work to improve the feedback loops. One such initiative includes sending feedback communications to clinicians to highlight outstanding clinical practice, congratulating them when they have provided excellent care bundle delivery and highlighting any areas for potential improvement.

The newly implemented and planned improvement measures will help ensure that we provide the highest standard care and achieve the best possible experience and outcomes for our patients with a suspected STEMI.

[1] excess-deaths-involving-cvd-in-england_an-anlysis-and-explainer.pdf

Appendix 1 – STEMI care over the last 5 years

		2020/21	2021/22	2022/23	2023/24	2024/25
Total number of patients		2,826	2,818	2,480	3,196	3,653
Response times (h:mm:ss)	mean	0:21:14	0:38:22	0:44:18	0:33:33	0:34:35
	median	0:13:39	0:23:59	0:26:14	0:22:11	0:22:48
On-scene time (conveyed patients only) (h:mm:ss)	mean	0:38:45	0:41:42	0:42:03	0:43:22	0:45:47
	median	0:36:23	0:39:09	0:38:56	0:40:27	0:42:41
Aspirin administered		96.6%	97.6%	97.1%	96.9%	97.1%
GTN administered		96.7%	95.4%	97.3%	96.5%	95.9%
Analgesia administered		75.4%	77.6%	78.5%	83.3%	87.9%
Conveyed appropriately		98.9%	99.1%	98.9%	99.1%	99.3%
Journey to HAC time (h:mm:ss)	mean	0:18:29	0:19:14	0:19:26	0:19:42	0:20:07
	median	0:18:02	0:18:31	0:18:44	0:18:45	0:19:04
999 call to arrival at HAC (h:mm:ss)	mean	1:17:55	1:38:40	1:45:29	1:35:40	1:39:56
	median	1:11:36	1:27:36	1:30:19	1:26:28	1:31:06
999 call to catheter insertion time* (min)	mean	129	151	160	143	155
	median	122	139	145	134	147

**Based on data obtained from MINAP*

The Quality Report

Quality Assurance Committee 4th November 2025

Providing Assurance on September and October data and updates from CQOG (October 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 to aid the efficient flow of information from Ambulance to Board.

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).

Important note:

The purpose of this report is to consider areas of learning, irrespective of whether they would have made a clinical difference to individual patients or not. It is based on the information available to the author at the time of writing. The information within and any judgments on the level of harm have not been subject to specific legal tests or burden of proof. The report and supporting papers are designed to identify learning and best practice and should not be seen as an admission in respect of any legal proceedings.

Patient Story - example

There were three attendances to the Patient, a 40-year-old female, within 24 hours.

A 999 call was received from a HCP for the Patient who had taken an overdose. The call was triaged as a category 2 response priority, and an ambulance attended. On arrival, the Patient stated they did not want help. The Patient was assessed to have capacity, and a conversation was held with the HCP. The Patient was discharged on scene.

Several hours later, a further call was received with the description given as: 'Patient wanting to end their life'. On arrival, the Patient was found to have self-harmed with two 10-inch, full-thickness lacerations to their thigh and continued to cut herself in the presence of the ambulance clinicians. MPS attended, and the Patient was conveyed to ED under the Mental Capacity Act. Whilst waiting to hand over, the police left, and the Patient absconded.

5 hours later, a call was received from MPS for the Patient, described as: 'high risk missing person – cuts to leg'. On arrival of the ambulance, the police advised that they had found the Patient walking along the road and had taken them home. The Patient declined being suicidal, refused observations and conveyance. A discussion was held with CHUB, who advised the Patient lacked capacity and required conveyance, but this was not agreed by clinicians on scene. The Patient was discharged at the scene.

Over the next two days, the Patient was placed on section 2 of the Mental Health Act and required treatment for their wounds due to necrosis.

Themes and Key findings:

First attendance:
Informed decision: there were no observations other than visual ones gained at the first attendance. The Patient was declining. The review considers that the Patient had consumed an unknown quantity of medications and that encouraging the Patient to allow observations would allow them to be fully informed of the risks.

Third attendance:
Communication: Show professional curiosity about why the Patient had been deemed a high-risk missing person, which would aid in decision-making.
Clinical assessment: The clinicians could have encouraged the Patient to have a full physical assessment, including observations and examination of the wounds.
Clinical advice: the review learned that advice was sought from the CHUB but not followed due to a difference of opinion in relation to capacity.

How have we made patients safer?
1. The Trust are undertaking a comprehensive review of existing guidance on mental capacity.
2. Since this incident, a clinical safety bulletin was shared on the importance of the use of Toxbase and how this can be accessed by clinicians or with the support of the CHUB.

Matters for Escalation to QAC

The following matters are to be escalated from CQOG to QAC:

- This Quality Report
- CQC Executive Briefing and CQC Inspectors Briefing
- Cardiac Arrest Annual Report 2024 – 25
- STEMI Annual Report 2024-25
- Q2 Mystery Shopper Audit

Triangulating Quality Intelligence

Triangulating themes – The top areas of quality concern:

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

NB: Nil change with top areas of concern since the previous quarter, however noting actions are in progress to address these.

Patient Safety & Incidents

We are the capital's emergency and urgent care responders

Incident Reporting

Incidents

Number of Incidents

Incident Reporting

Incident Type

Incidents by Type by Year

Type ● Member of LAS staff (including Bank Staff) ● Patient(s) ● The Trust ● Visitors, contractors, other organisation staff or the public

2025: 3.9K, 8.9K, 3.5K
2024: 5.2K, 12.4K, 5.3K
2023: 4.7K, 10.4K, 4.1K
2022: 3.8K, 8.5K, 3.1K
2021: 4.3K, 8.5K, 2.4K
2020: 3.6K, 6.0K, 2.4K

0K 5K 10K 15K 20K

Incidents by Type 2025 YTD

Type ● Member of LAS staff (including Bank Staff) ● Patient(s) ● The Trust ● Visitors, contractors, other organisation staff or the public

2025 January: 435, 1132, 438
2025 February: 400, 888, 343
2025 March: 395, 1055, 397
2025 April: 450, 920, 365, 49
2025 May: 486, 957, 413, 40
2025 June: 445, 929, 374
2025 July: 438, 1050, 396
2025 August: 456, 996, 394
2025 September: 394, 953, 406

0 500 1,000 1,500 2,000

Incidents by Type Top 10 Sector 2025 YTD

Type ● Member of LAS staff (including Bank Staff) ● Patient(s) ● The Trust ● Visitors, contractors, other organisation staff or the public

North West Sector: 794, 1370, 568
South East Sector: 758, 1358, 553
North Central Sector: 504, 1010, 884
NHS111: 245, 2063
North East Sector: 701, 948, 648
South West Sector: 470, 909, 432
Emergency Operations Centre: 175, 552
Resilience and Specialist Assets: 99, 286, 168
Clinical Hub (CHUB): 108
Clinical Hub (CHUB) & ICC: 89

0 500 1,000 1,500 2,000 2,500 3,000

Incidents by Type & Severity 2025 YTD

Type ● Member of LAS staff (including Bank Staff) ● Patient(s) ● The Trust ● Visitors, contractors, other organisation staff or the public

Death
January: 15
March: 2
April: 5
May: 11
June: 8
July: 14
August: 12
September: 15
0 10
Number of Incidents

Low
January: 160, 97
February: 129, 61
March: 97, 86
April: 97, 69
May: 116, 86
June: 98, 86
July: 110, 109
August: 120, 108
September: 105, 105
0 200
Number of Incidents

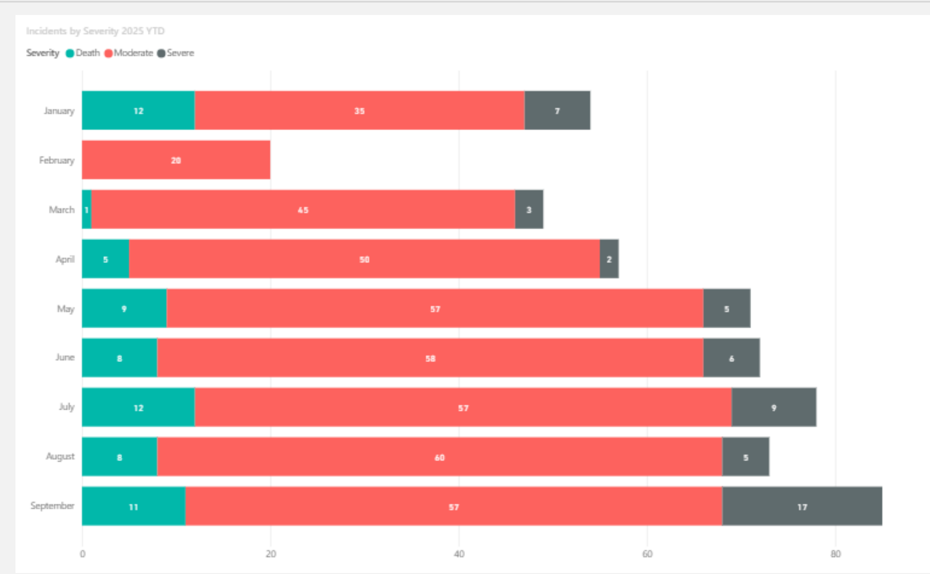
Moderate
January: 26, 11
February: 20
March: 39, 9
April: 50
May: 46, 13
June: 51, 6
July: 51, 9
August: 52, 12
September: 48, 19
0 50
Number of Incidents

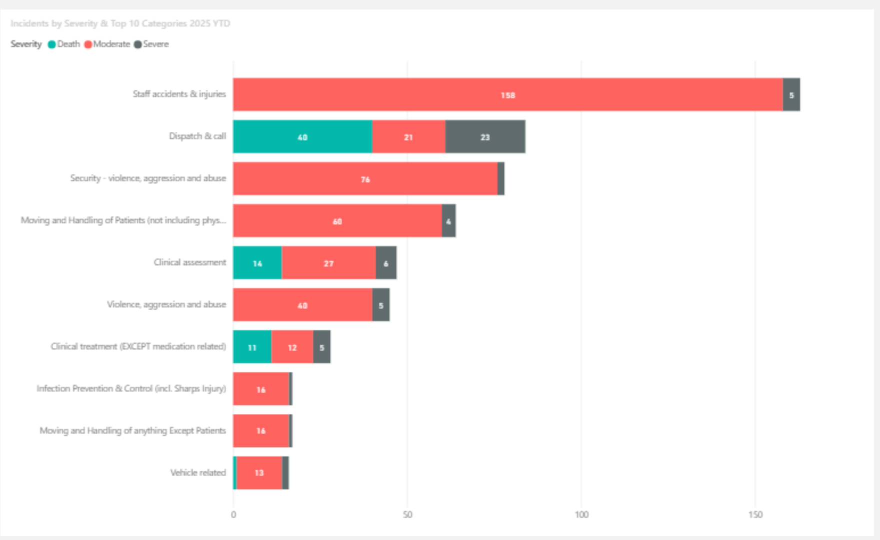
None
January: 1.0K, 0.6K
February: 0.8K, 0.3K
March: 1.0K, 0.4K
April: 0.3K, 0.8K, 0.4K
May: 0.3K, 0.8K, 0.4K
June: 0.8K, 0.4K
July: 0.9K, 0.4K
August: 0.9K, 0.4K
September: 0.8K, 0.4K
0K 1K 2K
Number of Incidents

Severe
January: 9
March: 2
May: 3, 3
June: 6
July: 5, 5
August: 8
September: 4, 17
0 20
Number of Incidents

Incident Reporting

Incident Harm





PSIP Outcomes - Last 6 months						
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Enhanced Inv. - External						
Loc-defined - Local PSII						
Nat-defined - Local PSII	3	2	3	4	1	3
Nat-defined - Alt. Team						
Patient Safety Review						
PSR - After Action Review	3		3	4	3	7
PSR - Complaint Response				1		
PSR - Delays SJR						
PSR - MDT		1			1	
PSR - SWARM Huddle						

PSIRF Themes - Last 6 months						
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
111 - Clin. Assessment						
111/IUC - Call Handling			1			
Clinical assessment			1	4	1	2
Clinical treatment (EXCEPT meds)	1					
Communication, care & consent						
Dispatch & call		1		1		1
Local – Call Handling - 111/IUC	1					
Local – Call Handling - 999						
Local – Cardiac Arrest / Airway Mgmt						
Local – Cardiac Arrest / Recognition						
Local – F2F - incorrect non conveyance						
Local – 999/111 clin assess. incorrect advice						
Local – F2F - definitive care						
Local – F2F - immobilisation						
Local – F2F - extremes of age						
Local – Medicines Management						
Local – Emergency Patient Safety Incidents						
Maternal, obstetric and neo-natal						
Non-medical equipment		1				
Patient accidents & injuries						
Local priority 1	2		3		1	4
Local priority 2	1	1	1	2	2	
Local priority 3						2
Local priority 4	1			2	1	1

Incident Reporting

Incident Sectors

Incidents by Sector & Severity 2025 YTD

Severity: Death, Low, Moderate, None, Severe

Sector	Low	None
North West Sector	0.4K	2.2K
South East Sector	0.4K	2.2K
North Central Sector	0.2K	2.1K
NHS111		2.3K
North East Sector	0.3K	1.9K
South West Sector	0.3K	1.5K

0K 1K 2K 3K

Incidents by Sector & Type 2025 YTD

Type: Member of LAS staff (including Bank Staff), Patient(s), The Trust, Visitors, contractors, other organi...

Sector	Member of LAS staff (including Bank Staff)	Patient(s)	The Trust
North West Sector	0.8K	1.4K	0.6K
South East Sector	0.8K	1.4K	0.6K
North Central Sector	0.5K	1.0K	0.9K
NHS111	0.2K	2.1K	
North East Sector	0.7K	0.9K	0.6K
South West Sector	0.5K	0.9K	0.4K

0K 1K 2K 3K

Incidents by Sector & Top Categories 2025 YTD

Sector / Department: NHS111, North Central Sector, North East Sector, North West Sector, South East Sector, South West Sector

Category	NHS111	North Central Sector	North East Sector	North West Sector	South East Sector	South West Sector
Medicines Management incl. Controlled Drugs		656	395	362	356	277
Medical equipment		307	351	307	405	279
Security - violence, aggression and abuse	130	217	289	353	359	185
Concern regarding External Provider (Clinical & Non-Cl...	701	94	100	168	121	90
Communication, care & consent	414	93	92	116	124	61
111/IUC - Call Handling	642					
Clinical treatment (EXCEPT medication related)		83	103	152	142	81
Staff accidents & injuries		87	143	122	122	72
Violence, aggression and abuse		86	107	131	104	83
Non-medical equipment		82	84	97	109	106

0 500 1,000 1,500 2,000

Incident Reporting

Top 30 Incident Category

Category	January	February	March	April	May	June	July	August	September	Total
Medicines Management incl. Controlled Drugs	309	238	223	210	249	247	254	238	266	2234
Medical equipment	183	144	363	237	250	199	224	120		1720
Security - violence, aggression and abuse	215	234	226	251	302	286	182			1696
Concern regarding External Provider (Clinical & Non-Clinical)	163	131	127	141	129	143	194	181	188	1397
Communication, care & consent	137	93	116	140	140	120	112	113	93	1064
Dispatch & call	141	67	70	75	75	91	112	103	132	866
Clinical treatment (EXCEPT medication related)	91	84	79	65	66	58	85	98	80	706
111/IUC - Call Handling	90	101	65	87	70	80	71	78	62	704
Staff accidents & injuries	64	44	67	76	72	65	81	77	72	618
Violence, aggression and abuse						1	81	278	239	599
Non-medical equipment	67	56	79	79	77	70	55	44		527
Medication Error	60	41	48	50	52	43	53	58	54	459
Moving and Handling of Patients (not including physical restraint)	84	71	51	40	43	36	47	42	42	456
Clinical assessment	57	34	61	48	53	38	51	50	44	436
Vehicle related	53	45	51	57	40	39	43	49	44	421
Maternal, obstetric and neo-natal	44	48	42	20	44	42	41	31	20	332
Equipment - Medical (Any equipment used with a patient during a care episode, including ambulance equipment bags)								98	200	298
Infection Prevention & Control (incl. Sharps Injury)	40	34	24	30	36	35	32	34	26	291
Access / Transfer / Handover issues	26	22	19	23	21	28	37	31	31	238
111/IUC - Clinical assessment / advice	34	39	29	20	22	14	20	18	19	215
Patient accidents & injuries	20	10	23	20	22	31	31	21	34	212
Information governance and breaches of confidentiality	26	15	27	25	33	29	21	20	14	210
Security - theft, damage to property, loss of property	30	36	30	29	33	23	23			204
Infrastructure, buildings, IT & telephony	40	18	22	17	24	9	19	18	17	184
Security and Crime (Except Violence, Aggression and abuse)							8	32	41	81
Moving and Handling of anything Except Patients	14	8	15	9	8	5	3	1	3	66
Clinical advice	8	5	8	6	4	5	5	3	5	49
Estates (Incl. Facilities)	6	2	4	6	3	6	5	12	4	48
Staff welfare	1	2		7	3	4	1	9	10	37
End of Life / Palliative Care	9	4	2	4	8	4	2	2		35
Transport delays	5	7	4	4	3	4	2	4	2	35
Total	2017	1633	1875	1776	1882	1755	1895	1863	1742	16438

CQOG date: 07 October 2025

Reporting date = August & September 2025

Patient Safety Incidents & PSIRF

Incidents

Patient Safety Incidents &Themes

In August and September 2025, the Trust's risk management system, Radar, reported 1,996 patient safety incidents.

The top five categories are as follows:

1.Concern regarding external provider (n.374 ↑39)
2.Medical Equipment (n. 224 ↓98)
3.Dispatch & call (n.211 ↑ 31)
4. Clinical treatment (EXCEPT medication related) (n.181 –↓43)
5. Communication, care & consent (n.151↓49)

The highest reporting sectors are:

1. NHS111 – 426 (↓30)
2. North West – 319 (↓29)
3. South East – 296 (↓5)

Harm

Of the 1,996 reported incidents the harm was graded as follows:

No harm – 1691 (↓97)
Low harm – 216 (↑21)
Moderate harm – 34 (↑8)
Severe harm – 26 (↑16)
Death – 29 (↓2)

Across the severe harm and death severities, 21 incidents took place in August and 32 in September. The most common reported category was dispatch and call, with potential triage error and a delayed response accounting for 42% of cases.

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. Of the 67 moderate, severe harm or death graded incidents reported during the last CQOG, 22 have remained as either death (11), severe (3) and moderate (8).

PSIRF

Learning Responses Commissioned

15 learning responses were commissioned in August and September 2025:

- x4(↓4) nationally defined incidents requiring local PSII (meeting the LfD criteria)

Themes include:

  - Clinical assessment
  - Recognition and management of cardiac arrest
  - 999 call handling

- X10 (↑3) AAR

Themes include:

  - Informed consent
  - Management of patients under the influence of drugs and/or alcohol
  - Telephone management of a paediatric patient

- X1 MDT

Themes include:

  - Informed consent

Case examples

An 80-year-old patient had fallen and had experienced a long lie. There were discharged on scene, re contacted the service and died unexpectedly.

A 26-year-old male, who was fitting, was found inside a church, lying in the recovery position, unresponsive and snoring, and was being attended to by non-LAS clinicians. Cardiac arrest was not immediately recognised, and the patient did not receive timely defibrillation for VF.

A patient, who was under the influence of alcohol, reported being hit by a bus. They were conveyed to a local emergency department, where they were found to have sustained multiple injuries and required a transfer to a major trauma centre.

CQOG date: 07 October 2025

Reporting date = August & September 2025

Patient Safety Incident Response Framework

Learning

Case Based Discussion
Case based discussion took place in August and was attended by 80 staff from across the Trust. It was also recorded and shared via LASConnect. Themes included:

- Identifying patients on scene post RTC
- Retained placenta and PPH
- Assessment and management of a time critical patient
- Learning from excellence

Patient safety actions of note

Targeted improvements to Health Advisor training are being introduced to strengthen the application of probing within NHS Pathways.

Development of huddle and team day materials covering the assessment and management of patients with learning disabilities or autistic people.

Review and update the OOS policy regarding the management of vehicles without trolley beds

Creation of bite size videos to share via team huddles highlighting the importance of clear communication between EOC and clinical operations.

Current risks and Concerns

Overdue incidents
The number of overdue local reviews has decreased compared to the previous reporting period, but remained high at 46.19% trust wide. Concerns regarding specialists teams, which have workflows open and overdue. This is impacting overall operational performance and the ability for local teams progress incidents.

Carry chairs
Whilst significant work is underway to tackle ambulances without trolley beds, the issue of missing or broken carry chairs remains problematic. There are now multiple ambulance configurations and a lack of standardisation regarding the type of carry chair available. Issues have also been seen with newer models of chair or brackets housing chairs braking. This has an operational impact as multiple resources are needed to attend a single patient, impacting Cat 2 performance, a patient safety impact with patients experiencing prolonged time on scene and a staff wellbeing/welfare impact with concerns raised about MSK injuries or needing to make difficult extrication decisions. The following has taken place:

- Escalation
- A single risk covering multiple pieces of equipment has been split with carry chairs being a separate risk for ongoing mitigation and management
- Relevant teams are aware of the concerns.

Overdue Actions
72% of open actions are currently showing as overdue on Radar.

Ongoing work

Thematics
The skill mix thematic has completed the initial stage of review and identified no correlation between the skill mix and the likelihood of a patient safety event. Further work is underway to ascertain the skill grade of the attending clinician.

Data collection is underway for thematics exploring

- Health inequalities and non-convergence
- The patient safety team is collaborating to support a thematic review of discharge decision-making from decision support tools.

The patient safety team is supporting the review of cases concerning the early recognition of unwell patients, specifically undertaking a primary survey. Key cases of note include the recognition and early management of patients who present in cardiac arrest.

Radar
The Patient Safety Team are working with corporate colleagues to support with incident management and oversight on Radar.

Patient ID Issues
The Patient Safety Team are supporting a systems thinking approach to the risk regarding matching a patient to incorrect details via the PDS trace. This has had some significant implications for individuals and presents as a patient safety concern.

CQOG date: 07 October 2025

Reporting date = August & September 2025

Patient Safety Incident Response Framework

Thematic reviews

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

Theme	Detail	Commissioned date	Lead(s)	Report Status	System Improvement Plan Status
Ineffective breathing	Recognition of ineffective breathing during 999 calls	April 2023	Hannah Robinson	Complete – Feb 2024	Complete
Falls	Patients who have fallen and have not been managed within expected standards	March 2023	April Wrangles	Complete – Feb 2025	Complete
VF	Incidents where defibrillation was indicated but not delivered for >2 minutes	July 2023	Charis Emmery	Complete – March 2025	Complete
Medicine administration	Review of incidents involving medication errors	N/A	Gavin Mooney	Complete pending action plan approval	In progress
10D2 & 10D4	Management of high risk determinants	August 2023	Cathy Sheridan & Dan Saunders	Complete – Feb 2024	Complete
Bariatric care	999 and clinical management of bariatric patients	October 2023	Dan Saunders	Complete – Jan 2024	Complete
Defib pads	Missing or broken defib pads impacting patient care	July 2024	Cathy Sheridan	Complete – March 2025	In progress
Shift change over	Patient safety incidents which have occurred during shift change over	August 2024	Dan Saunders	Complete - January 2025	Confirming action owners
HAC	Missed HAC conveyance when presenting with a STEMI	October 2024	Ken Crossley	Complete – June 2025	In progress
Paediatric care	Assessment and management of paediatric patients	December 2024	Cathy Sheridan	Complete - March 2025	In progress
National PSIIs	A review of the past four years of National PSIIs	March 2025	Dan Saunders	Complete – August 2025	N/A
Skill mix	Review of patient safety incidents association with skill mix	June 2025	Jos Miles	Further analysis	TBC
Non-conveyance health inequalities	Health inequalities associated with non conveyance decision making	June 2025	Cathy Sheridan	Data collection	TBC
Non-conveyance clinical decision making	Use of decision support tools (Pathfinder and Clinical Decision Support Tool) in non conveyance decision making	July 2025	Grace Harman/Cathy Sheridan	Data analysis	TBC

CQOG date: 07 October 2025

Reporting date = August & September 2025

Quality Metric Performance

Performance and Compliance

Overdue incidents

- There are currently 1121 overdue local review workflows in the Trust – this equates to 46.19% of all open local review workflows. Of note 3726 incidents were reported during August and September, and 3894 incidents overall were closed. This acknowledges that the teams are working hard to clear a backlog of older incidents.
- 50.5% of incidents reported in August had since been closed.

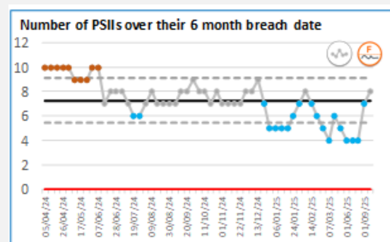
Overdue workflow by sector breakdown:

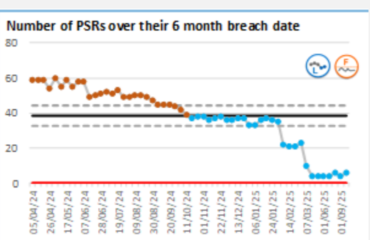
- NC – 66 (26.94%)
- NW – 141 (37.5%)
- NE – 94 (36.15%)
- SE – 315 (58.23%)
- SW – 57 (32.57%)
- EOC – 55 (33.33%)
- CHUB – 14 (33.33%)
- 111 – 171 (57.77%)
- RS&A – 124 (62.63%)

Learning Responses

No learning response should exceed 6 months from the commissioning date.

- There are currently 49 open learning responses:
  - PSII – 23
  - PSR (inc. AAR, Swarm and MDT) - 26
- 14 learning responses have breached 6 months (8 PSII and 6 PSR).
  - 5 of these are either awaiting final approval or are in the final QA review stage
  - 1 has been approved in principle pending amendments
  - 7 learning responses are concerning IUC/111 processes.





Duty of Candour

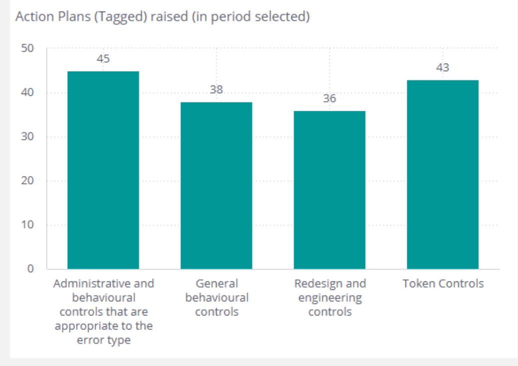
Overall, duty of candour compliance for September was 89.3%. This is a decrease when compared to the last reporting period. Where DoC has not been undertaken, escalation has taken place to the relevant heads of teams.

	DoC 2025/2026				Audit of Letters			
	Compliant	Applicable	Performance	Previous	Compliant	Applicable	Performance	Previous
PSII 1st Stage DoC	41	43	95.3%	97.5%	40	41	97.6%	97.4%
PSII 2nd Stage DoC	18	19	94.7%	100.0%	18	18	100.0%	100.0%
PSR 1st Stage DoC	26	29	89.7%	96.2%	25	26	96.2%	96.0%
PSR 2nd Stage DoC	15	15	100.0%	100.0%	15	15	100.0%	100.0%
Local investigation 1st Stage DoC	18	22	81.8%	83.3%	18	18	100.0%	100.0%
Local investigation 2nd Stage DoC (Outcome)	16	22	72.7%	77.8%	16	16	100.0%	100.0%

Actions

There are currently 119 open actions, of which 86 have exceeded their due date (72%).

The majority of actions are considered 'weak' in terms of their potential to prevent the incident from re-occurring. The Patient Safety Team are currently working to support the notion that all actions should be SMART, and have developed templates to support Learning Response Leads.



CQOG date: 7th October 2025

Reporting date: Aug 25 – Sep 25

CARU

Key Findings

National AQIs (April 2025 data, published September 2025):

ROSC: LAS ranked 5th nationally for ROSC sustained to hospital in the overall patient group, with 28.3% (vs. 26.2% national average). In the Utstein comparator group, LAS ranked 2nd in England with 57.8% (vs. 42.1% nationally).

Survival: In the overall patient group, 11.5% of patients survived to 30 days, above the national average of 10.0%. In the Utstein comparator group, LAS ranked 1st nationally with a 30-day survival of 37.8%—over 10 percentage points higher than the national average of 27.1%.

STEMI: The LAS recorded a Call to Angiography time of 02:26, ranking 7th nationally (3 minutes slower than the national average).

STEMI Care Bundle was provided to 77.1% of patients, down from 78.4% in January and below national average of 80.0%. LAS remains in the 8th place for the third consecutive reporting cycle.

Stroke: Our average call-to-hospital arrival time was 01:18, a notable improvement from 01:27 reported last month. LAS achieved joint 1st position nationally for this measure (10 min faster the national average of 01:28).

Falls: Our care bundle compliance dropped slightly from 54.3% in December to 52.7% in March. We are currently ranked 5th nationally.

Note: STEMI and Stroke figures are based on MINAP and SSNAP data respectively which may not be complete samples and are subject to change following revisions.

Low Back Pain (non-traumatic) Clinical Audit:

Patient history: The majority of patients had the history and duration of pain, and previous advice recorded.

Clinical observations: Most patients had NEWS2 recorded; for 54% it was calculated correctly every time. A quarter of patients who had a blood glucose recorded had documentation suggesting this was necessary.

Pain assessment: 94% of patients had at least one pain score recorded; with SOCRATES (or equivalent) detailed for 26%.

Red flags: 5% of patients had all relevant red flags recorded.

Physical assessment: A full abdominal assessment was documented for 17%. 30% full spinal palpation, 6% spinal muscle palpation, and 4% had SI joint palpation recorded. No patients had all individual aspects of inspection; 3% had evidence of the full functional assessment.

Psychological and social factors: No patients had consideration of all social and psychological factors recorded.

Pain management: Ibuprofen was administered to 19% and 25% received combined therapy of ibuprofen and paracetamol.

Advice and non-conveyance: 29% were not conveyed to hospital; 54% of whom received non-pharmacological advice. Simple exercises were advised for 36%.

Conveyance: 95% who required hospital were conveyed. Clinical review determined non-conveyance may have been more suitable for some patients.

Recommendations from Clinical Audit

- Share the findings of this clinical audit through a Clinical Update article and Huddle video.
- Propose a CSR module on MSK assessment including palpation, inspection and functional assessment.
- Suggest further clarity in the JRCALC LBP Guideline specifically regarding the need for blood glucose assessment, use of equivalent pain assessment mnemonics, red flag symptoms, assessments outside the paramedic practice, and differentiating requirements for acute, subacute and chronic LBP.
- Consider ways the Service can make codeine more accessible to patients.
- Support the proposal for advice slips or emails with relevant information to be given to patients when discharged at scene.
- Propose a checklist to promote consistent documentation.

Highlights

Clinical Annual Reports (2024/25):

The Cardiac Arrest and STEMI annual reports have been written and will be shared with CQOG for approval. They will be released once they have been to QAC and Trust Board.

Clinical Performance Indicators (CPIs):

The new CPI feedback function was launched which:

- assigns audit data to all attending clinicians to recognise their contribution to patient care
- is personalised based on skill level and time spent on scene
- allows clinicians to review compliance before receiving feedback
- enables clinicians to save reflections,
- provides managers with compliance overviews and trend insights.

Research:

- We recruited 70 patients into clinical trials, bringing us to 392 patients enrolled into the SIS study and 322 into CRASH-4.
- Newham station group opened for recruitment to CRASH-4 in September, bringing the total open stations to 32.
- This period there was one journal publication by LAS authors, with two further publications in press.
- We are working with a number of partners on several research funding applications for potential future clinical trials.

CQOG date : 7th October 2025

Reporting date = September 2025

Clinical Equipment Working Group

Current risks and Concerns

For all current medical equipment Risks: Risk Register

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"

Active RFID's within Ambulances have been incorrectly reported up until September, with only 60 reported as active at September's CEWG. Work is commenced to look at alternative devices.
There have been significant delays with tablet installation in WAS vehicles, and IM&T updates being required.

Incidents

Medico ECG dots

Reporting of incidents has deceased; this needs to be balanced between improved use as clinicians have become more use to the new devices, and reporting fatigue. Awaiting results of the latest batch trialled by clinicians but is looking positive.

SafeR IM/SC Needles

Ongoing reporting of failures when being used. Becoming evident that training material to mitigate this issue has not been shared at a local level, resulting in repeated incidents.

Ferno Venice Power chair

Some reports of failing in use & battery failures continue

Local level investigations:

Varying standards of local investigation following reported equipment failures. Procedure for 'Investigating Medical Device Adverse Incidents' is being written to support this. Currently in draft.

Performance

- **LP15 PPM Compliance**
- Below target. Compliance is currently 65%
- Barriers: Excess held on stations, reduced availability of warehouse delivery team supporting collections, staffing constraints within the Equipment Workshop

- **Laerdal Suction Unit (LSU) PPM Compliance**
- Below Target. Compliance is currently 58%
- Barriers: Sites not releasing devices due for service, infrequent visits from external service provider, devices not being present on site for external provider visits.

- **Action Plans:**
  - Increase in communications to Make Ready to reiterate the need to return due/overdue devices
  - Replacement LP15 units to be made available for exchange with overdue devices
  - Procurement of additional LSU's to facilitate exchange with overdue devices
  - Training for Make Ready Technicians on the returns process to reduce the reliance on MR Hub Coordinators.
  - LSU to review minimum stocks levels at hubs, and additional equipment to be redistributed as needed

LSU PPM Recovery Proposal
LP15 PPM Recovery Proposal

Future developments

- Updated CEWG Terms of Reference and CEWG Distribution list
- Live Tracker for SOPs underpinning Policy TP111created for monitoring progress of new SOP's following the introduction of the Policy for Management of Medical Devices (TP111).

Compiled by: Emily Reeson

Presented by: Mark Faulkner

Information for : Assurance/approval

CQOG date : 07/10/2025

Reporting date = August 2025

Health, Safety & Security

Incidents

- During August'25 the total number of H&S incidents reported was 821 resulting in 8.72 events per 1000 (999 face to face) attendances. 600 (73%) of the H&S related incidents reported during August'25 resulted in No Harm/Adverse/Near Miss. 168 (20%) of the H&S related incidents reported during August'25 resulted in Low Harm. 53 (7%) of the H&S related incidents reported during August'25 resulted in Moderate Harm. No Severe Harm H&S related incidents were reported during August'25.
- Directed verbal abuse, Physical Assault by blow (kick, punch, push etc.) and Manual Handling (lifting patients) incidents account for the highest numbers reported during 2025/26 (up to end of August'25).
- Total of 96 Physical assaults reported during August'25. The most common underlying causes remain intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication. The greatest number of reported physical assaults (56%) occur due to the clinical condition of the patient during 2025/26 (up to end of August'25); Police attended 59% of physical assault incidents during 2025/26 (up to end of August'25).
- Total of 14 RIDDOR incidents were reported to HSE during August'25.
- Total of 9 MSK related RIDDOR incidents were reported during August'25. The highest number (n=4) of MSK related RIDDOR incidents for August'25 occurred in Patient's Home. There is an average of 1 reported moving and handling incident for every 2000 face to face attendances and an average of 3 working days lost per 1000 face to face attendances.

Learning

- We continue to see some incidents related to the powered chairs being reported from all sectors, these have been added to the agenda for the Vehicle Working Group, as there are new themes emerging around availability of chairs along with the connection faults identified below where the bottom batteries are showing as full but the chair not working at all or where the chair is working on its own - this is due to the top handset battery running out and the Bluetooth connectivity being interrupted thus causing the chair to either stop working completely or intermittently. To resolve this the connecting wire should be installed between the top and bottom battery compartments.
- Collaboration with Head of Estates & Facilities and the Quality Compliance Manager to develop governance on Contractor oversight relating to legionella risk assessment.

Current risks and Concerns

- Current compliance for FFP3 fit testing is 72% due to the 2-year revalidation period. Over 80 staff members have now been trained up as Fit Testers. Two weekly reports are sent out to all areas of the Trust, with compliance being monitored centrally and by LGM's etc.
- 6 to 8 week backlog of reviewing Radar reports and contacting victims.
- Increased demand, impacting on victims contact and support, outstanding cases, data tracking and providing awareness and training.
- 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.

Performance

- The Trust wide RIDDOR reporting time frame (<15 days) compliance in August'25 was 71% this is due teething issues with RADAR, such as late reporting or misreporting staff injuries under patient incident headings.
- The Health, Safety & Security (HS&S) Team have delivered one session of Corporate Induction during August 2025.
- Trust wide Site Specific Risk Assessment compliance is currently at 75%.
- Trust wide Fire Drill compliance is currently at 39%.
- Trust wide Fire Risk Assessment compliance is currently at 74%.

Actions and mitigations

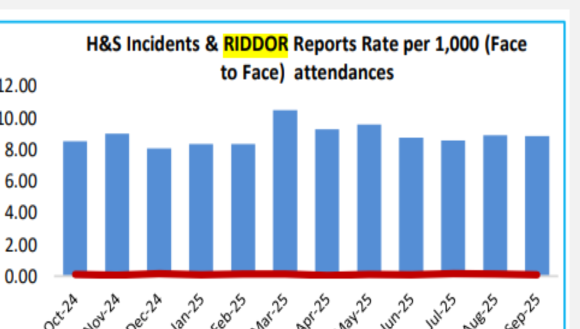
- The Bariatric ambulance is now in the UK for final sign off, the bariatric teams have been involved throughout the design and build process – there has been a delay in these coming out for operational use due to tail lift issues, but we are chasing this and hopefully they will be released in September.
- There is a retrofit being undertaken to strengthen and protect the Stryker bracket from further damage, more changes will also be made to ensure that the chair can only be loaded the correct way around thus ensuring the top bracket does not take all the weight of the chair.
- Chairs to be discussed and actions identified at the Vehicle Working Group to include harness swap out procedures.
- ExCo have given approval for the VR0 x2 roles (band 5) to be recruited to. 2x Violence Reduction Officers secondments agreed with EOC and Op's.
- The Health, Safety & Security (HS&S) Team supported the delivery of the Stress Assessment Toolkit Training during July 2025 with the next session taking place on 03/10/25 (10:00-12:30).
- A Task & Finish Group has been established to develop a new E-Learning Dynamic Risk Assessment Package for front line / EOC staff. The project is scheduled to be concluded by end of Q3.

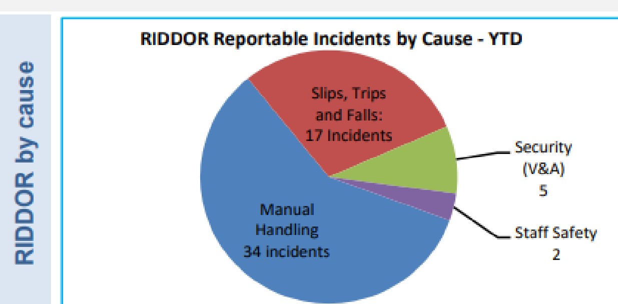
Compiled by: Amar Nachimuthu | Presented by: Edmund Jacobs | Information for : Assurance/approval

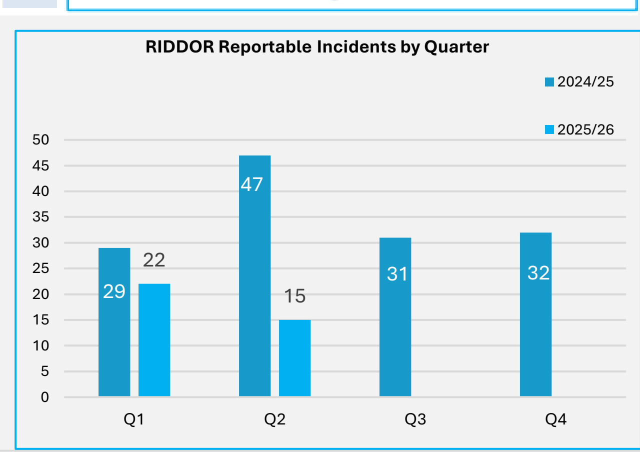
An overview of the Trust's health and safety performance for 2025/26 (up to end of August'25) is provided in the Health, Safety & Security Scorecard at Appendix-1.

Health, Safety and Security

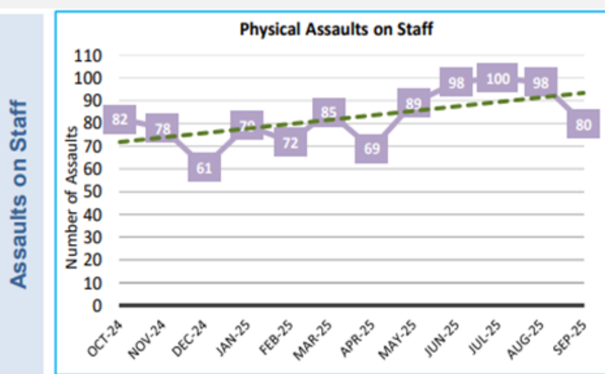
RIDDOR

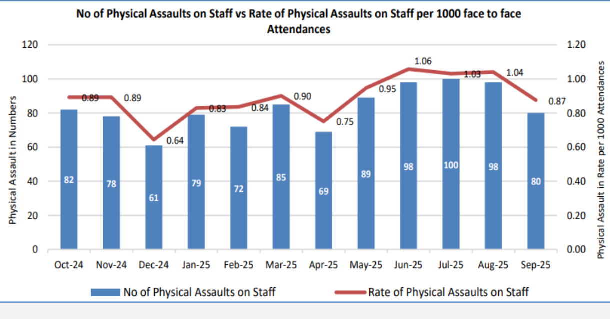


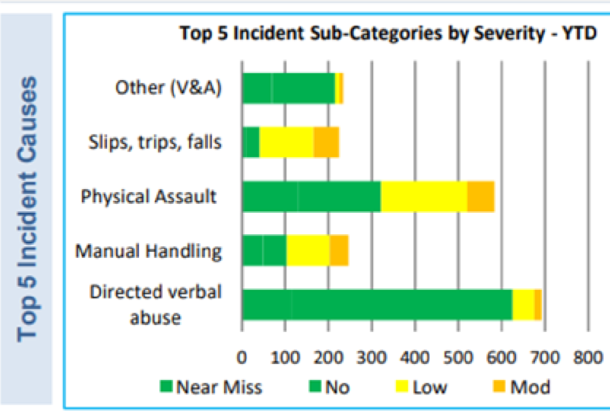




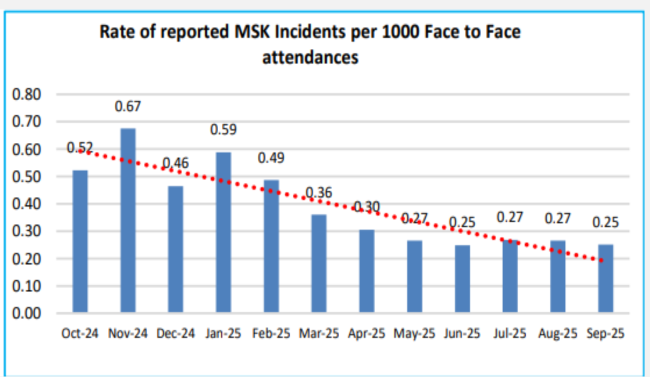
Physical Assaults

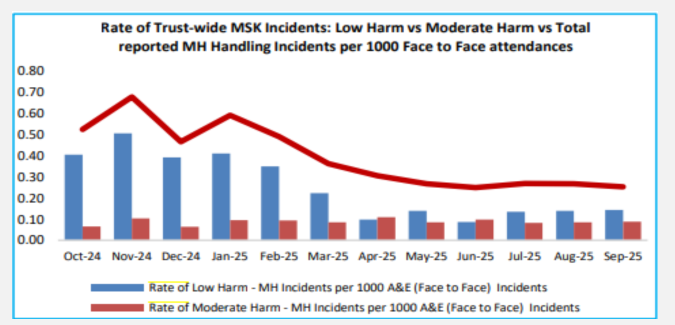


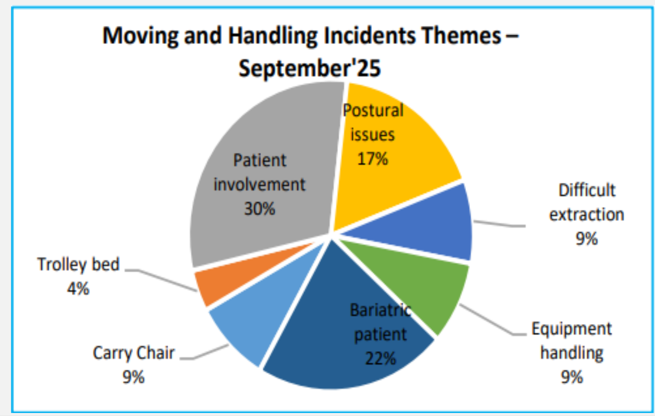




MSK







During Sep'25 the total number of H&S incidents reported was 808 resulting in 8.83 events per 1000 (999 face to face) attendances.

Directed verbal abuse, Physical Assault and Manual Handling (lifting patients) incidents account for the highest numbers reported during Sep'25.

Total of 80 Physical assaults reported during Sep'25.

Total of 58 RIDDOR incidents were reported to HSE during Sep'25.

Rollout of Reasonable Adjustments training to Ops Directorate to include 999 call handling during September and October.

Axon body worn camera trial is imminently about to begin at Hillingdon.

Continued resourcing challenges in Violence Reduction and Crew Safety Systems resulting in back logs and risk.

Ongoing backlog in Criminal Justice Systems resulting in case time frames being extended. Average timeline is 18-24 months at present with some being longer.

The timeframe compliance of reporting RIDDOR incidents (<15 days) to the HSE across the Trust during Sep'25 was 86%, this is due teething issues with RADAR, such as late reporting or misreporting staff injuries under patient incident headings.

The Health, Safety & Security Team have delivered one session on Managing Safety course to 10 staff members during Sep'25.

Total of 3 successful prosecutions for assault have been recorded for incidents reported during 2025/26 (up to end of September'25).

The Bariatric specific vehicles are now finished, and the final stage before launching is training, a day has been booked to complete this with the Bariatric Team, Clinical Educaiton and Health & Safety.

CQOG date : 07/10/2025

Reporting date September 2025

Strategic Assets and Property Management – Make Ready and Supply & Distribution

Team	Key Updates	Performance	Concerns and matters for escalation	Ongoing work
Make Ready	• NC Sector and Assistant Manager in place & have attended training • NW Sector Manager position been offered > awaiting recruitment checks. • NW Assistant Manager interviews w/c 13th October 2025 • ODM 1 year secondment interviews w/c 13th October 2025 • MRHC vacancies currently at 10 > positions NE & NW Sectors, working along side Employability Team, funded by GLA with interviews being undertaken w/c 6th October 2025 • SW Make Ready Specialist interview also being undertaken w/c 6th October 2025 • Authority to recruit MRT vacancies was for 13 posts. 7 agency staff successful and undergoing pre employment checks. Need to readvertise as vacancies increased due to staff retention	• Stat & Mand training > 90.46% • Specialist training > 77.87% • Sickness > 8.43% LTS > 6.41% • Staff trained on Make Ready App > 62.14% • Deep Clean performance for DCA's continues to be challenging circa 79% > NETS cleans > 14% • Make Ready resourced to PVR 430 with current DCA fleet being 587 .It also does not include packing of bags and pouches which is still being undertaken by Make Ready in 3 Sectors albeit that NW starting to be rolled out 10th October by LSU • Appraisals > 73%	• Lack of C1 drivers still to be addressed > not much uptake on C1 scheme with only 13 staff expressed interest since May 25 • TO support in place, however, weekend cover is limited due to their staffing levels •RSK- 167 audit assurance for Make Ready > updated audits and frequency now aligned with National Standards of Healthcare Cleanliness, and have been shared and agreed with IPC > Dep Clean KPI also aligned to 90% •RSK – 141 > refer to Data	• Continue to do group appraisals with 73 outstanding • Make Ready App starting to show progress > with number of preps recorded in Procloud to the number of preps recorded on the planning sheet is 49.3% • Development days for band 4 MRHC are planned throughout October • Make Ready Management and Ops development sessions being held in North & South > 24th & 25th October 2025

Compiled by: Mandy Green

Presented by: Emily Ross

Information for : Assurance

CQOG date : 0710/2025

Reporting date September 25

Strategic Assets and Property Management – Make Ready and Supply & Distribution

Team	Key Updates	Performance	Concerns and matters for escalation	Ongoing work
Supply and Distribution	•Failure of LP15s and ETCO2 continue to reduce in number • •PPM continues to be embedded. Action plans developed and implemented for improving servicing compliance for Manger Elks and Suction units. Targets and progressed monitored through Medical Devices Assurance Group.	(see performance tables below)	• Register - Radar Healthcare	Continue rollout of CPU into NC and move to NW following completion of NC. Staffing key challenge to roll out WDO/CPU recruitment continues but faces challenges around visas CAMs roll out to ECU ongoing and continue roll out of Vehicle Preparation App across Make Ready. Work with fleet on CAMs for managing maintenance of Trolley Beds, Carry Chairs and Scoops in line with other medical devices

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
	Target	Monthly Average	Monthly Average	Monthly Average	Monthly Average	Monthly Average	Monthly Average
Warehouse Stock Held (263 lines)	95%	98.94%	98.21%	98.66%	98.42%	99.49%	98.91%
PPE (18 lines)	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
LSU Routes	95%	99.56%	100.00%	100.00%	100.00%	100.00%	100.00%
MPU Routes	95%	99.94%	99.30%	100.00%	100.00%	100.00%	100.00%
Oxygen Availability	9.00	9.75	9.63	9.73	10.25	10.79	9.99
MR Hub Stock (lines) (263*20=5260)	95%	93.36%	93.04%	93.56%	93.97%	94.58%	94.57%
MR Hub Overstock (lines)	10%	7.11%	5.13%	4.56%	3.82%	4.66%	5.62%
Equipment Turnaround (LP15)	TBC	#DIV/0!	#DIV/0!	2.70	2.40	#DIV/0!	#DIV/0!
Equipment Availability	99%	100.00%	99.00%	99.00%	99.00%	99.00%	99.00%
Uniform Orders Fulfilled	90%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
MR Orders Fulfilled (consumables)	90%	79.08%	83.35%	83.63%	86.73%	92.02%	87.39%

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Missing Equipment (hours lost for missing Equipment/Actual Hours)		0.08%	0.07%	0.05%	0.03%	0.03%	0.06%%

Compiled by: Andy Heward

Presented by: Emily Ross

Information for : Assurance

CQOG date : 07/10/2025

Reporting date = September 25

Strategic Assets and Property Management – Fleet and Estates & Facilities

Team	Key Updates	Performance	Concerns and matters for escalation	Ongoing work
Fleet	• New DCAS have entered frontline service and will continue to roll out for coming months • Works have commenced on the new fleet workshop site in North Crescent Cody	• There is continued positive DCA availability against PVR • The NC sector has suffered with high DCA VOR. The Fleet Management Team are working with the workshop to resolve this. • 2 x new DCA been placed at Edmonton • Reduction in DCA OOS hours VWORKS- July 748hrs, August 671 hours and Sept 604 hours	• Qbe insurance costs have risen to the high rate of RTCS	• Daily fleet programmes meeting to identify issues or trends with VOR • Tyre Pressure monitoring system are being fitted the DCA Mercedes Fleet • Commencement of FEX Strap replacement programmes of C42 FCVA • Continued workshop/fleet night mobile recruitment campaign
Estates and Facilities	• Backlog Maintenance, allocated £873,216 on target to spend £1,527,000 before end of financial year. • Estate Improvement Works • Richmond Gate & Fencing, contractor pricing up specification, expect to be onsite end of August. Brent Unit 11 1st Floor completed in August 2025 • Estates Safety Fund - Fulham Fire Alarm, works commence 8th August. Greenwich rewire, survey undertaken and design in progress. HQ heating, design in progress. Chase Farm Roof replacement, design consultants to be appointed. • Solar PV, structural assessments underway.	• Statutory compliance – legal requirement for service compliance. At or near 100% apart from Deisel Tank servicing, working with Contractor and Procurement to improve current figure of 25%	• Current risks and matters for escalation. • Solar PV. Edmonton electrical supply has to be brought upto current standards before installation. • Bromley, Camdon & Newham flat roofs may require structural support.	Backlog Maintenance – 66 current projects. Estates Improvements – 2 projects Estates Safety Fund – 4 projects Solar PV – 10 sites.

Compiled by: Anne Fulcher/ Mark Chandler Bird

Presented by: Emily Ross

Information for : Assurance

CQOG date : 07/10/2025

Reporting date = Oct 2025

Infection, Prevention & Control

Incidents

- Community and acute services are preparing for winter illnesses, season commences mid October where there is predicted increases of respiratory and viral illnesses that result in pressure for services.
- Increased activity noted for Rhinovirus, COVID and Influenza. Stratus and Nimbus noted as circulating, however not VOC.

Current risks and Update

Local risks remaining: IPCC has not met since Aug CQOG

IPCD/micro hours vacant.

Hand hygiene compliance –BBE practice for review at next IPCC

Gap in assurance for MR vehicle cleanliness audit - reporting and escalation. Action plan composed by MR underway.

Key updates:

IPC Board assurance summary enclosed within submission papers.

Preparedness for winter comms and IPC advice/guidance updates.

DIPC annual report minor amendment to summary section.

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

National cleaning standards 2025 – MR head of service and team are moving quickly on development of audit programme for vehicle cleanliness.

New IPC practitioner in post . This has been rectified with new IPC practitioner commencing mid September.

Performance

Sept Data:

- IPC Training compliance was 79% for level 1 and 59% for Level 2 (target 90%)
- Hand hygiene compliance was reported at 98%. This exceeds the Trust performance target (90%).
- Make Ready six-weekly vehicle deep clean compliance was reported at 65% for Aug- Sept data not currently available, this is below the Trusts target. Action recovery plans led by Make Ready services are in place, however challenges remain with staff vacancies.
- Premises cleaning audit compliance was reported at 97%, which met the Trust's target of 90%.

IPC Validation audit Q2:

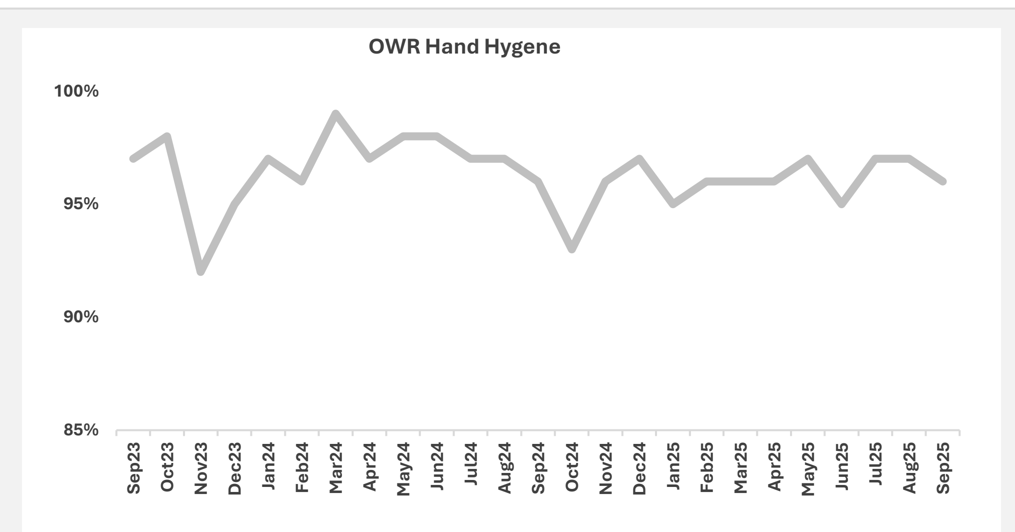
- 22 environmental station audits were undertaken and 3 non-station premises. This includes reaudits of areas that did not achieve 75% and were re-audited within a 3 month time frame. Of the 25 premises, 11 scored 75% or above.
- 8 IPC Observational ride outs were undertaken. 6/8 achieved 80% or above.
- 8 A&E observational audits were undertaken. 1/5 achieved 80% or above.

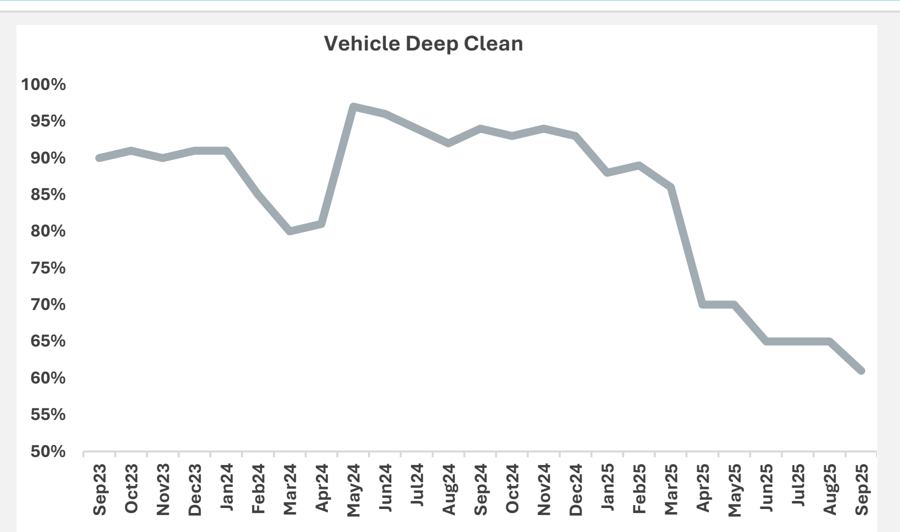
Continual assurance

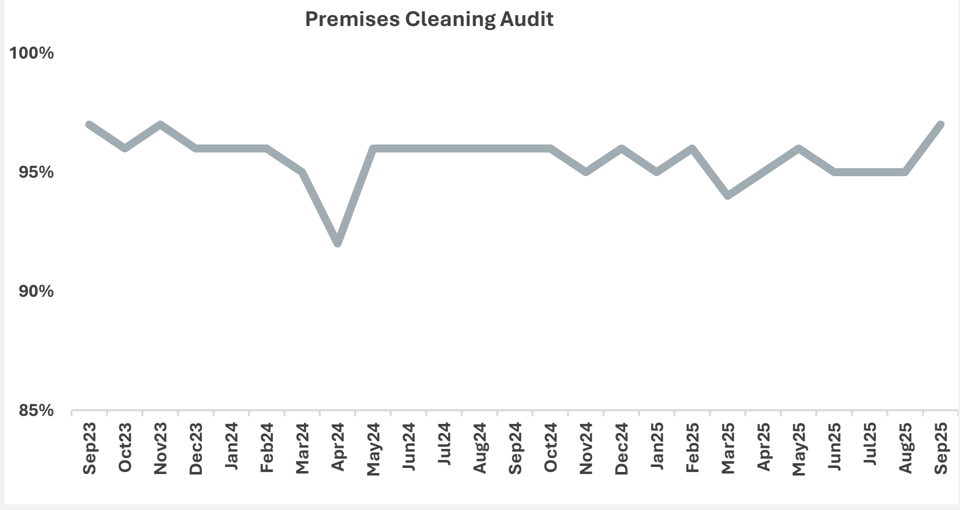
IPC board assurance framework and summary- updated and completed Sept 2025 shared with this committee

Infection, Prevention & Control

IPC







Local hand hygiene compliance reported by local groups is 96% overall. Premises cleaning compliance is reported at 97%

6 weekly vehicle cleaning reported at 61% compliant overall and 14% for NETs

7 body fluid exposures incidents were reported with no underlying themes 1 sharps incident was report.

Vehicle cleaning remains consistently low. MR team is working on recovery plan

IPC extended support visits to all group stations completed over 3 months July-Sep.

IPC practitioner commenced in September.

Extended training provided to CSO cohort.

Clinical Hub

Quality Overview

Cases Awaiting Review

Cases in Progress

Date Range (Received)

01/07/2025 — 08/09/2025

Case Type Per Month by Incident Date

Outcomes Per Month by Incident Date

Themes Per Month by by Incident Date

Month	Assessments	Incident Review	INC/1000	Recontacts	REC/1000	CG Review Group	CG/1000
December 2024	297786	1	0.00	31	0.10	37	0.12
January 2025	301225			20	0.07	12	0.04
February 2025	298493	1	0.00	31	0.10	28	0.09
March 2025	315356	1	0.00	27	0.09	39	0.12
April 2025	298877	2	0.01	36	0.12	24	0.08
May 2025	312916	4	0.01	52	0.17	12	0.04
June 2025	305940	7	0.02	37	0.12	15	0.05
July 2025	294587	9	0.03	40	0.14	27	0.09
August 2025	257615	8	0.03	47	0.18	2	0.01
Total	**396457**	**33**	**0.08**	**321**	**0.81**	**196**	**0.49**

Quality Report - Last 3 Months

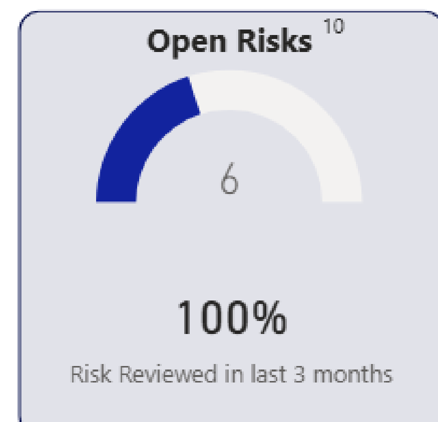
Case Reviews Received [1]

Month	Complaint	Incident	Legal	Total
August	2	6		8
July	5	13	5	23
June	10	9	3	22
May	5	7	2	14
Total	22	35	10	67

Appraisal, Stat & Man Training [8]

Month	Appraisal Compliance (%)	Change	Stat & Man Compliance (%)	Change
May 2025	86.32%	2%	90.93%	2%
June 2025	93.30%	7%	91.38%	7%
July 2025	96.89%	4%	92.17%	4%
August 2025	99.54%	3%	92.29%	3%

Open Risks [10]



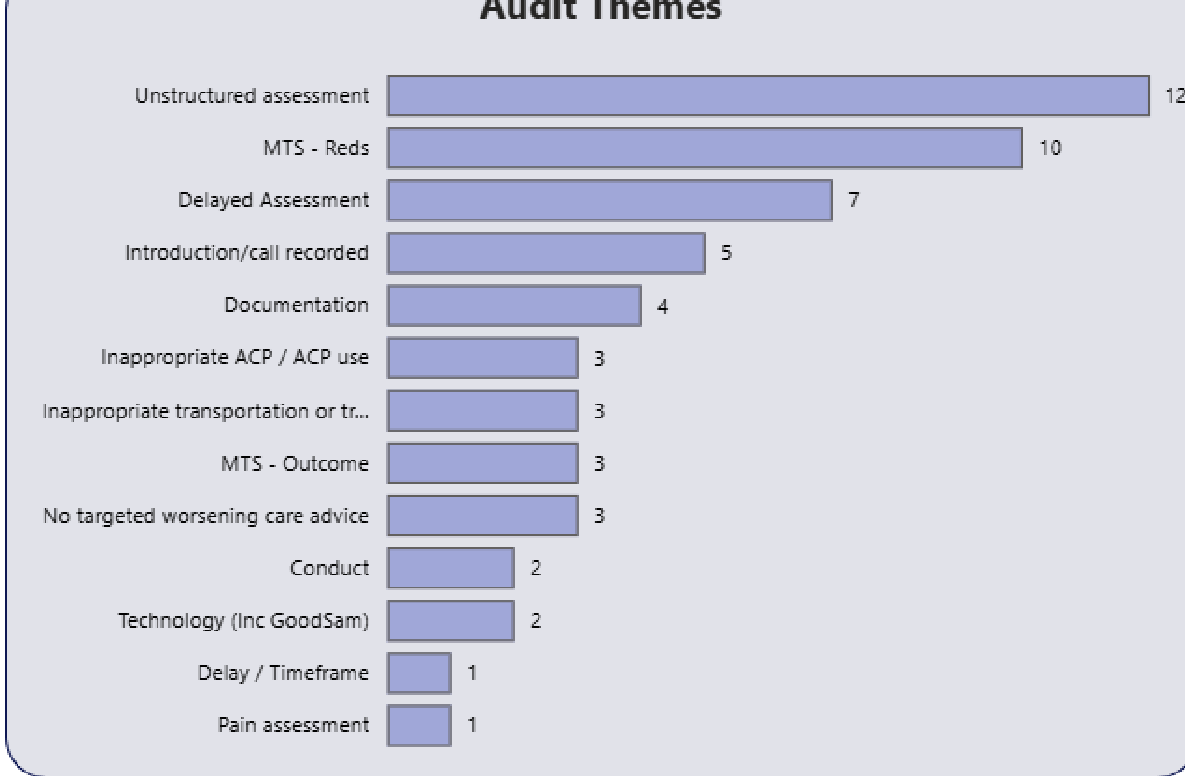
Hear & Treat [5]

Month	NCL	NEL	NWL	SEL	SWL	All
May	22.5%	22.9%	21.9%	21.0%	19.8%	21.6%
June	22.9%	23.8%	22.6%	21.0%	20.4%	22.2%
July	22.4%	23.8%	22.5%	20.7%	19.8%	21.9%
August	21.8%	22.2%	21.8%	20.2%	21.5%	21.5%
Total	22.4%	23.2%	22.2%	20.7%	20.4%	21.8%

Clinical Audits & Recontacts [6]

Month	Clinical Support	Score (%)	MTS	Score (%)	Recontacts
May 2025	80	99	598	99	52
June 2025	84	99	494	98	37
July 2025					40
August 2025					47

Audit Themes [7]



Clinical

Clinical Quality

Clinical Hub - Clinical Quality

Month	Assessments	Incident Review	Incident Review / 1000	Recontacts	Recontacts / 1000	Clinical Hub Audits	CA Audit % Score	Clinical Hub Audits / 1000	CG Review Group	CG/1000	Clinical Support Audits	CSD Audit % Score
August	21675	10	0.46	47	2.17							
July	24514	10	0.41	40	1.63							
June	22672	19	0.84	37	1.63	494	98	21.79	5	0.22	84	99
May	22938	16	0.70	52	2.27	598	99	26.07	12	0.52	80	99
April	21508	13	0.60	36	1.67	571	98	26.55	24	1.12	85	99
March	22703	16	0.70	27	1.19	552	97	24.31	39	1.72	77	99
Total	**136010**	**84**	**0.62**	**239**	**1.76**	**554**	**98**	**4.07**	**80**	**0.59**	**82**	**99**

Outcome	Number
No Error	69
Feedback	58
Action Plan	4
PSIG Referral	2
Department Learning	1
Total	**134**

Assessments - Number of assessments undertaken by Clinical Hub (not including UCAS/CSREF)
Incident Review - Number of cases reported as an Incident (Complaints, Radar, Legal) that undergo an enhanced clinical hub review. Linked to the date of the call
Recontacts- Includes all recontacts (Post assessment or post UCAS)
Clinical Hub Audits - Number of audits undertaken on assessments in that month + average % score
CG Review Group - Number of audits, from the total amount that went to the Clinical Review Group for learning
Clinical Support Audits - Number of audits undertaken on assessments in that month + average % score
/1000- The number of the data point in review per 1000 assessments. i.e. for every 1000 assessments undertaken 20 undergo random audit

The data for audits, incident reviews are reported int he month that the assessment took place. For this reason there will be a delay in some data being uploaded, i.e. audits completed in the following month

- Across 136,010 assessments over six months, the Clinical Hub consistently delivered strong audit outcomes, with an average CA Audit Score of 98% and CSD Audit Score of 99%.
- Only 0.62 incident reviews per 1,000 assessments were required, with the majority resulting in *no error* (69 cases, 51%) or *feedback only* (58 cases, 43%)
- Recontact rates averaged 1.76 per 1,000 assessments, with no significant upward trend despite increasing demand.
- 68,861 assessments over the last quarter — averaging ~22,954 per month.

Performance Review – September 2025

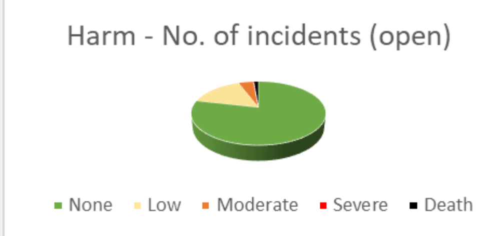
Reporting date – 01/04/2025 - 30/09/2025

South East Sector Clinical Quality – Performance Review

Incidents

Incidents

Group	Total incidents	Total closed	Total Open
Deptford	490	345	145
Greenwich	374	336	38
Bromley	355	228	127
Oval	316	244	72



Incidences: INC_2098 Maternity input – awaiting feedback at local level.

Incidents narrative: 1) Medical equipment, 2) violence, aggression and abuse 3) Communication, care and consent

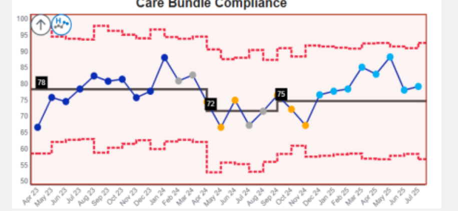
PSIG: 94 Incidences though PSIG. Themes are delay response and access to care, equipment and resource complications, recognition of cardiac arrest and STEMI

DOC: Stage one and two = 100%

Learning responses: 6 open (4 PSII and 2 AAR) Informed consent and management of patients under the influence of alcohol and/or drugs

Clinical

STEMI care & plan:



Currently 79%

Positive reinforcement letters, Rosie's STEMI presentation and Jo's ECG presentation

ROSC: 29% ROSC to hospital, 46% Achieved on scene

Trusted assessor Y/N by site: 3/5 Acutes SDEC awaiting PRUH and KCH.

QEH only site without Midos ACP to AFU.

Clinical supervision sector staff OWR (Aug):

Bromley: 81.56% Deptford 71.43%

Oval 83.68% Greenwich 83.82%

Clinical supervision CTMs: 4 shift undertaken 3 sign offs

CPI feedback and themes: No clinical aspect of care below 92% - 92 % Older falls and Sickle cell care

Quality & compliance

- **Complaints number:** 52 Complaints and 35 External Quality Alerts
- **Themes:** Conduct and behaviour(28), Damage to property(2), LAR (2)
- **Excellence reports:** 118 (highest month June 31)
- **Quality alerts & themes:** 34 Themes: inadequate handover, ?should have been a pre-alert and LAS calling GPs not within guidance.
- **Medicines management compliance:** 2,0498 medicine management checks across 11 sites averaging 97.62%
- **IPC compliance:** Deptford missed their cleaning compliance for the second month running. August saw a decline in hand hygiene audits.
- **Quality visits:** Laminated signs for segregation of waste, spot checks by management for unlocked vehicles. Pac testing for Bromley's new management area. 85% compliance, plus new CSQO in post.

Matters for escalation

- Increasing amount of LAR RADARs. SE highest sector in August, especially in patient with LD and ND.
- ICB collaboration in SEL - in favour of borough model care systems
- 50% of MAN Ambulance have no powered chairs (ferno Venice chairs). 90% of MAN Ambulance have a broken charger.

Performance Review: September 26th 2025

Reporting date = 1st April – 31st August 2025

South West Sector – Clinical Quality – Performance Review

Incidents

Total open/ closed
Croydon- 42/ 384
New Malden – 66/396
St Helier – 45/266
Wimbledon – 27/203

Patient Harm			
None	416	Severe	1
Low	57	Death	1
Moderate	2		

Longest open incident – INC 4010 – CD audit error reported 01/05/25, awaiting local investigation
Overdue incidents Q1 – SW lowest sector = 20%

Top 3 incident categories
1. Failure of device/ equipment (221)
2. Physical abuse (94)
3. CD audit errors (59)

Learning –Role criteria, safe discharge at scene including informed decision making
- Learning bites shared monthly
- Huddle content shared: Frailty line, "You said, We did", HCP details for QAs

PSIG: 125 cases reviewed
Themes:
1.Concerns RE external providers (30)
2. Midazolam administration (23)
3. Re-contacts (8)

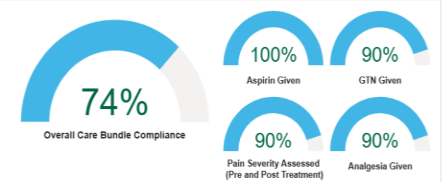
DOC
One outstanding – IUC related

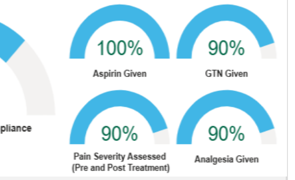
Learning responses.
- Missed VF and delayed shock – PSII
- Overdose, minimal observations whilst awaiting MPS

Clinical

- **STEMI care & plan (Jul 25)**:

Plan: Key priority for the SW SCL following recruitment.





- **ROSC (May 25)**

43% ROSC Achieved

28% ROSC Sustained to Hospital

- **Trusted assessor: I**n place at all SDECS in SW.
- **CTM clinical supervision:**
- SW sector = 91% for previous cycle ending in Aug'25.
- Plan to move to new yearly cycle
- Training dates agreed for CQ team as required
- **CPI**

Group	Completion (July)
Croydon	39%
New Malden	93%
St Helier	97%
Wimbledon	63%

- Good compliance across all aspects of care, including Older Fallers – SW = 89% (LAS = 87%)

Matters for escalation

Potential areas of concern:

- MPS attendance at calls
- New vehicle (Ford) rear door closure

Quality & compliance

Complaints number: 31 received
1. Conduct and behaviour (20)
2. See & Treat (4)
3. Safeguarding Referral (2)

Quality alerts & themes: 12 received
1. See & Treat/ Convey (5)
2. Conduct and behaviour (2)

Medicines management compliance (Aug)
- Croydon – 31 (99%)
- New Malden – 29 (97%)
- St Helier – 30 (99%)
- Wimbledon – 30 (99%)

IPC compliance – Hand hygiene Completed YTD/ Annual Target
- Croydon – 63/161
- New Malden – 35/ 137
- St Helier – 47/ 102
- Wimbledon – 52/ 116

Quality visits: Overall compliance – 89.77%
Overall positive findings: Clean and tidy working spaces, relevant posters on display

Common recurring issues such as dirty linen segregation/ bagging non compliance, PRF boxes found unlocked.

Clinical Quality Sector Dashboards

Our Senior Quality Business Analyst is currently producing Clinical Quality Sector Dashboards.
NB: The report currently contains test data for the purpose of this display.

Sector Dashboard Examples | No label

File

Pages

- Staff Training
- Workforce
- Incidents
- IPC

Incidents

Year, Month: All | Sector / Department: All | Station / Team Location: All

Total Incidents By Severity

Severity: Death, Low, Moderate, None, Severe

Month	January	February	March	April	May	June	July	August	September	October	November	December
Number of Incidents	6.8K	6.2K	6.8K	7.7K	7.8K	7.5K	8.1K	6.1K	6.0K	6.9K	6.8K	7.0K

Overdue Incidents

Year	North Central	North East	North West	South East
2025				
March	14	37	25	18
April	12	26	26	15
May	24	37	30	21
June	11	30	25	20

Top 10 Categories

Category: Security - violenc..., Medical equipment, Medicines Man..., Communicatio..., Dispatch & call, 111/IUC - Call ..., Clinical treat..., Moving and ..., Infection Pr..., Vehicle related

- Security - violence, aggression and abuse 16.9%
- Medical equipment 15.66%
- Medicines Management incl. Controlled Drugs 15.56%
- Communication, care & consent 12.15%
- Dispatch & call 9.11%
- 111/IUC - Call Handling 7.72%
- Clinical treatment (EXCEPT medication related) 6.98%
- Moving and Handling of Patients (not including physical restraint) 5.94%
- Infection Prevention & Control (incl. Sharps Injury) 5.1%

CQOG date : 7th October 2025

Reporting date = Aug'25 – Sep'25

Digital & Data Report

Digital Incidents 28/07/2025 to 29/09/2025

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

1. 30/07/25: PDS Trace high rates of failure for 2hrs 45mins - P2
2. 17/08/25: All LifeX Radios unavailable 4hrs - P1
3. 18/08/25: Crews are unable to hear EOC via radio 3hrs - P1
4. 27/08/25: PDS Trace errors for some users 2hrs - P2
5. 06/09/25: National ARP dropping out 2hrs - P1*
6. 23/09/25: Delay using dial out via Cleric 1hr 15min - P2

*2 further ARP issues on the same date, both P2, 4.5hr than 5hrs in duration

Current risks, Issues & Concerns

- **Electronic Transfer of Care (eToC)**: Go-live with Princess Royal University Hospital completed. Transition to the new Cloud solution for publication of ePCR Case Summaries to the London Care Record also complete. This included new functionality to allow for ePCR Case Removal and Republication from a new user interface.
- **Correct patient identification**: CE&S video has been produced and incorporated into the Legal Case Review huddle presentation which will be re-distributed via huddles. Agreement to complete a ePCR development to highlight differences in patient details during PDS trace. 3rd in the development backlog.
- **Adastra – Publication to the London Care Record:** Engagement to progress has been slow. There is also uncertainty over future funding beyond Year 1. Discussion to be held with CDO, CCIO Team and Clinical IT Services on options to best progress.

Governance

Recent Guidance
- None

Clinical Impact of Digital Incidents
- Process being put in place to reveal these alongside incident reporting process. This remains a work in progress.
- It is noted that during the period of PDS Trace unavailable (22/07/25) none of these records could be published to the London Care Record.
- Unaware of significant clinical safety impact of incident, however, will bring back to subsequent meetings as/if arise.

Product Testing
- **ePCR**: ePCR Beta has been released (31/7). General ePCR release planned for mid-November.
- **London Care Record Mobile Viewer:** A new fix to mitigate against potential upstream errors has been tested and implemented. This was affecting loading circa 4% of patient records (primarily in NWL). There is an outstanding upstream provider fix still being investigated, affecting 9% of patient records.

Summary of Approvals
- None of note.

Clinical Safety and Risk Management

- Work is progressing with ETHOS to complete ePCR and Adastra Clinical Risk Safety Cases. First draft of the ePCR Hazard Log and Adastra has now been completed. Work pressing on the Clinical Risk Management Plan for ePCR.

In progress:
- Universal Care Plan – CAD Integration (System update with LAS CAD Support team for deployment ASAP)
- CAD – Clinical Assessment Screen, DoS and PaCCS Integration (CAD System development with supplier – delivery due Nov2025).
- CAD Hazard Log – Review being undertaken by David Macklin

Risk

CQOG date : 07 Oct 2025

Reporting date = Sept 2025

Risk

Current risks and Concerns

- There are currently 45 out of 124 risks overdue for review (an increase of 19 from last report), with 5 overdue by 40 days or more.
- Risk controls provide assurance of action taken or planned to mitigate risk and give assurance of active risk management. There are 124 open risks, 66 of there have no implemented risk controls, and 49 have no risk controls listed at all.
- There are currently 21 draft or awaiting approval risks, these are going to be reviewed by the risk team and owners approached to determine if they are they require making live. Some have already been updated following RCAG.

Performance

•**Corporate Trust Wide Risk Register** (CTWRR) - The CTWRR contains a total of 38 risks that have the potential to affect more than one area of the organisation, or may require input from multiple areas to mitigate.
•The highest rated risk on the register is scored at 20, with a further 8 risks scoring 15 or above.

•**Other Risk Registers** – There is 1 risk rated 15 and above.

•**Longstanding risks** – There are now 10 risks that are 5 years or older. 2 of these are due to be closed shortly.

Learning

- Risk training and workshops continue to be provided to those teams that would like them. This includes a presentation on risk management in the LAS with a chance to ask any questions, followed by a short workshop to help identify risks.
- During this reporting period this was provided to the North West Sector and People and Culture.

Compiled by: Stuart Fitch

Presented by: Stuart Fitch

Information for : Assurance

CQOG date : October 2025

Reporting date: August/September (part)

Clinical Education & EGC Reports

Training

- **Completed Training YTD figures:** 104 frontline registrants; 78 non registrants; call handling: 29 in 9's and 60 in 1's
- **CSR 2025.2 YTD:** attendance 2519
- **Section 19 YTD:** 123
- **FRU driving YTD:** 259 (these are S19 compliant too)
- **Driving courses numbers YTD**: 156

EGC Reports

The next EGC not planned to sit until 07/10/2025, details will be included in next CQOG report

Assurance

- Fitness Assessment proposal (to replace lifting assessment) ready for review and presentation to operational colleagues
- Driving Investigations: 4 x Police, 17 x East, 17 x West
- Safe2Drive drivers: 65 x outstanding staff not yet signed up, 41 of which are in Operations and being managed locally between Driving Standards & Operational Management. This also includes some staff currently away from work. Safe2Drive has been confirmed for next year.
- Open Athens registrations now at 1266
- YTD allocation AHP CPD funding 25/26: £173,599
- YTD LAS Bursary 25/26: £421,758

Future Plans

Clinical Refresher Training Days for Non-Frontline Clinical Managers.
Course to refresh non- frontline clinicians for operational duties. 6 dates planned in October 2025.
Planned attendance to date:

Centre	Date	No. attendees
Dockside	07/10/25	3
Dockside	15/10/25	9
Dockside	24/10/25	5
Brentside	17/10/25	0
Brentside	22/10/25	1
Brentside	27/10/25	5

Current risks and Concerns

LD&A 1 day session 2026/2027

Compiled by: Hannah Curror

Presented by: Alison Blakely

Information for : Assurance

CQOG date : October 2025

Reporting date = August/September 2025

Professional Standards

Cases

•There were **9** cases referred to the Professional Standards Review Panel for the reporting period.

• **8** cases met the threshold on triage for an immediate referral based on the severity of the cases, and therefore, there was no need to bring the cases to the professional standards review panel.

• Since the Panel has gone live (Feb 25), **27** cases have been triaged. From this, 7 were taken to the panel. Of the **7** cases taken to the panel, **four** were found to need a referral to the HCPC. The remaining **three** were sent back for local management.

Current risks and Concerns

•External delays with investigations by regulators – There are significant delays with the HCPC and NMC processing referrals and moving to final hearing stages with our cases. The HoPS is meeting with the senior case manager at the HCPC to ensure there is oversight of all open cases and to remove any blockers that are identified.

•The oldest open HCPC case is from **June 2023** with a final hearing scheduled in **September 2025**.

•The oldest open NMC case is from **April 2023** with no final hearing date scheduled as of yet.

Performance

•All 9 cases were triaged within the target of **24 hours** of receipt.

•The **7** cases that required referral to the HCPC were referred within **48 hours** of receiving the required information.

•**5** Professional Standards teaching sessions have been delivered by the HoPS/DCPO. These include sessions to NQPs/IROs/TMs and team training days.

Themes and Trends

- **Six** of the cases related to misconduct.

- Misconduct is classed as behaviour that falls short of what can reasonably be expected of a professional.

- **One** of the cases were related to clinical competence concerns.

- Clinical competence is classed as lack of knowledge, skill and judgement, usually repeated and over a period of time.

- **Two** of the cases related to a caution or a conviction

Compiled by: Lee Busher

Presented by: Alison Blakely

Information for : Assurance

CQOG date : October 2025

Reporting date = August/September 2025

Safeguarding

Key updates

Number of safeguarding referrals raised within the last quarter. (To end of August)

Adult Safeguarding	1258
Adult Welfare	1220
Child Safeguarding	1767
Child in Need	291
LFB	221
Prevent	1

Number of statutory meetings information provided for/ attended.

South East	2
South West	3
North West	1
North East	7
North Central	2

100% attended

Any safeguarding audits and findings.

- None since last report

Current risks and Concerns

Safeguarding training compliance below 90% compliance at all levels.

Executive working with exec colleagues to gain improvements.

Each area has been asked to provide recovery plans

Performance

•Safeguarding Level 1, Level 2 and Level 3 Trust compliance. Compliance target 90% (Figures correct 22/09/25)

Level 1 89.75% All ↑ since last reporting period
Level 2 83.08%
Level 3 89.49%

Since the last report to CQOG, commissioners have confirmed that their 90% compliance requirement was incorrect in our contract and have returned this to 85% which means LAS' compliance is now above the required standard for l1 and l3, but below the required standard for l2.

- Safeguarding and sexual safety allegations against staff (Since April 2025) 28 (Figures correct 22/09/25)
- Number of allegations sexual safety or safeguarding reported to external bodies (ie regulator, NHSE, Police): 8 (Figures correct 22/09/25)

Learning

Learning from incidents:) (Feedback provided for all incidents through LA456)

- 4 missed child referrals: parental mental ill health (x2) LAC & MH (x1) Need to safeguard children even if known to LA (x1)
- 4 Incomplete referrals- missing demographics (x2), lack of detail due to thinking EPCR being sent (x2)
- Inappropriate Adult referral- DVA but no care and support needs (x1)
- Missed adult referral: neglect & acts of omission in a care setting (x1)

Learning dissemination

- Newsletter Learning Bites (covers parental mental ill health and LAC & Mental Health, inappropriate referrals)
- LA456 Formal feedback process
- Email- for more general feedback e.g. Incomplete referrals
- Case Study and Case based learning.

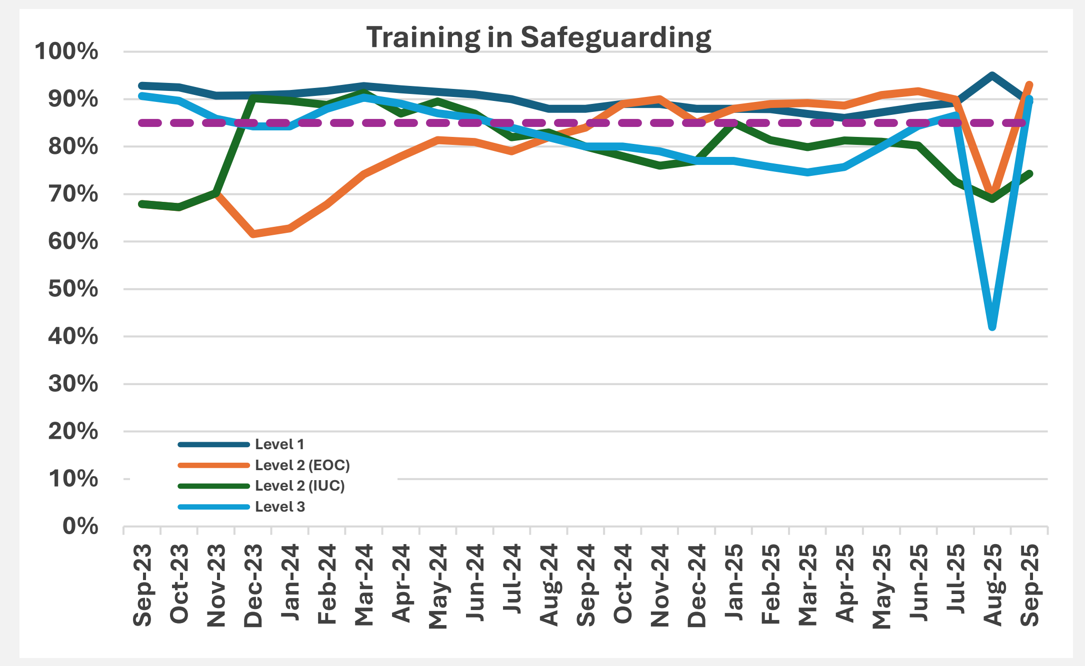
Compiled by: Alan Taylor/ Safeguarding Team

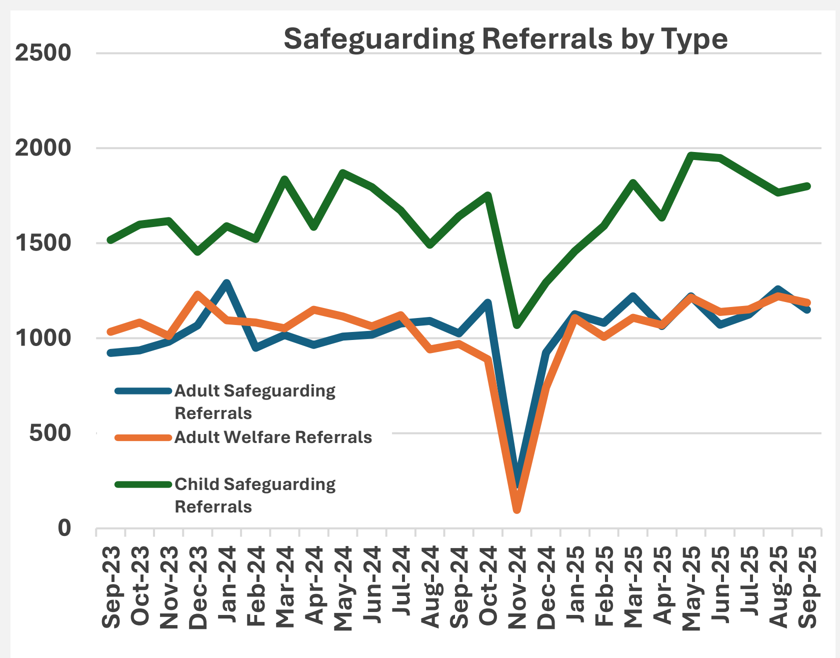
Presented by: Alison Blakely

Information for : Assurance

Safeguarding

Training & Referrals





Training at level 2 is still non-compliant this has been for 3 years now. Action plans have been requested.

111 still non-compliant and no long-term plans for future compliance.

EOC have made good progress and compliance is good.

CQOG date : October 2025

Reporting date = July/August/September

R&SA (including NHS Emergency Capabilities Unit)

Incidents

Patient Safety Incidents Q2

- 92 patient related incidents reported Q2
- Severity breakdown: Death 3, Moderate 1, Low 9, None 79. Deaths were re-categorised to no harm post PSIG.

Top Incident Categories

1. Clinical treatment (Except medication): 37 incidents
2. Medical equipment: 14 incidents
3. Medication Error: 9 incidents
4. Concern regarding External Provider (Clinical & Non-Clinical): 7 incidents
5. Clinical Assessment: 5

Current risks and Concerns

Concern around:

- Equipment – Concern around risk of delays in loading and transporting patients from major incident scenes, due to non compatibility of trolley beds between different makes and models of DCA.
- Equipment Reliability: 13 incidents clustered around equipment reliability/availability. Items included capno lines, retractable needle failures, Transwarmer, CO_2 monitor failures, missing airway kit, ventilator default settings.
- Concern around FIT testing compliance ahead of winter. This is to be highlighted to R&SA teams for action.
- Concern around management of penetrating trauma. Learning arising from multiple stabbing, where it took circa 1hr to transport pts to hospital. (Not R&SA Specific)

Performance

- SORT trained staff
  Dual trained 213 - CBRN/PCA only 51
  MTA/PCA only 18 - Total 282
- HART staffing – the onboarding of 7 staff in September means HART are fully established for paramedics.
- The relocation of the Emergency Capabilities Unit (NHS ECU) is complete and work continues on sorting training areas, classrooms, etc. at the new site at Fire Service College, in Moreton in Marsh, ahead of the ECU delivered courses which recommence in mid-October.

Learning

Stroke pathway delay (Severe): Stroke symptoms misattributed to medication overdose. Patient missed HASU window due to delayed triage; later found to meet criteria during APP assessment.

End of Life Care – Clinical Decision Making (Severe) Concerns raised during audit over glucose gel, oxygen, and glucagon use in a patient actively dying. Review found no harm but identified multiple learning points around end-of-life decision-making and documentation.

Clinical Assessment – Missed Stroke (Moderate) Patient with hyperglycaemia and reported fall was not assessed for stroke symptoms. FAST+ signs identified 48 hours later, outside thrombolysis window. Review found missed opportunity for earlier stroke recognition and escalation.

Compliance

July 2025 CPI % (↑ or ↓ compared to June 2025)	LAS	HART	TRU
Cardiac Arrest	97% ↔	99% ↑ (4%)	96% ↓ (1%)
Difficulty in Breathing	No data	No data	No data
Older Fallers	87% ↔	N/A	95% ↑ (5%)
General Documentation	96% ↔	97% ↓ (3%)	96% ↓ (2%)
Sepsis	95% ↓ (1%)	98% ↓ (2%)	96% ↔
Mental Health	92% ↓ (1%)	93% ↓ (3%)	92% ↓ (4%)
Sickle Cell Crisis	92% ↑ (1%)	N/A	96% ↓ (1%)
Discharged at Scene	95% ↔	94% ↓ (3%)	95% ↓ (1%)

R&SA	July	Aug	Sept
Information Governance	98%	98%	99%
Safeguarding level 3 Adult	93%	94%	95%
Safeguarding level 3 Children	93%	94%	95%
CSR 2025.1a e-learning	65%	67%	71%
CSR 2025.1b e-learning	22%	36%	41%
CSR 2025.2	65%	70%	74%
FFP3 Fit Testing	59%	58%	58%

Compiled by: Papadopoulos/Marchese
Presented by:
Information for : Assurance

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.

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.

National Patient Safety Alerts, NICE & National Guidance

Compliance & Awareness

We are the capital's emergency and urgent care responders

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

NICE Guidance

Updates to the existing actions are as follows (as of 20/10/2025)

- **NG9 Bronchiolitis in children** (Published: June 2015) – As part of an ongoing piece of work the Clinical Advisory Group have approved list of 10 specific worsening care advice documents, pending Exec approval of the content of each draft, before these are shared Trust wide. An EPCR update will be shared in late October 2025 which includes functionality of a worsening care advice button for clinicians to select and electronically send the advice to the patient.
- **NG197- Shared decision making (**Published 17th June 2021) – Assigned a new owner in June 2025 (Consultant Paramedic for Health Inequalities) who is currently reviewing the guidance and formulating recommendations.
- **NG249 - Falls: assessment and prevention in older adults** (Published 29th April 2025) – Changes to pathway have been through Clinical Advisory Group and approved. A bulletin was released Trust wide on 20/10/2025 sharing the new falls referral criteria.
- **QS212: Overweight and obesity management. (Published: 05 August 2025)** - Currently under review Consultant Paramedic for Health Inequalities.

PDF
MDB490 - New Falls Referral Criteria 20-10-25.pdf

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 Patient Safety Clinical Effectiveness Group (PSCEG)

Last PSEG (reporting here):

18th September 2025

Guidance actions closed within the reporting period:

- **HTE2- Intermittent urethral catheters for chronic incomplete bladder emptying -** Has been reviewed by Specialist Paramedic Primary Care (SPPC) clinical leadership team and no further action is needed by the trust. Action now closed following specialist review.

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

National Patient Safety Updates

Updates shared by the LAS Head of Patient Safety & Patient Safety Specialist in the quarterly Internal Patient Safety Forum held in September 2025

National Themes:

- Staffing and recruitment
- Operational pressures
- Right Care Right Person (RCRP) – increase in police to ambulance referrals (PFDs have been issued)
- Coroner engagement
- Duty Of Candor (DoC) – preparing for new legislation.
- Learning responses and families
- Medical devices – Zoll – increased reliance on battery powered medical devices with limited life span.

National risks:

- New Duty of Candour Bill (widely referred to as the Hillsborough Law) and its implications (individual accountability and criminal sanctions) Due to have its second reading in the House of Commons on Monday 3rd November 2025. https://commonslibrary.parliament.uk/research-briefings/cbp-10359/
- Coroner expectations clashing with PSII methodology.
- Language/translation service challenges for families – Action – undertaking national thematic on translation services
- Implications of the Dr Penny Dash report 01/07/2025 (de-prioritisation of patient safety in wider NHS planning) Review of patient safety across the health and care landscape

Complaints & Compliments

We are the capital's emergency and urgent care responders

CQOG date : **07/10/25**

Reporting date = **Aug/Sept 25**

Patient Experience

Complaints

Complaints

120 – 100 – 80

May 24 · Aug 24 · Nov 24 · Feb 25 · May 25 · Aug 25

● Common Cause

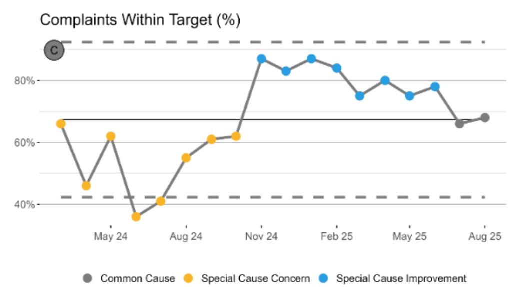
The number of complaints received each month remains within common cause variation, and themes are consistent with previous reporting periods.

- One complaint was **not upheld** by the PHSO.
- Two new complaints are under investigation:

C46960 – Patient diagnosed with stroke and taken to HASU; however, the patient had been involved in an RTC 24 hours earlier and should have been taken to an MTC. Scope includes: call prioritisation, dispatch delay (3 hrs 17 mins for C2), ETA information, and the decision not to convey to MTC. *Awaiting PHSO findings.*

C39211 – Conveyance decision for a 103-year-old patient who later deteriorated and died in hospital. An additional clinical review supported the original investigation, confirming that conveyance was appropriate. *Awaiting PHSO findings*

Performance



Additional monitoring has been implemented following a recent dip in performance after the summer period and due to individual performance issues. The target remains for 75% of complaints to be responded to within 35 working days

Quality Alerts

Following EOC's collaboration with YAS, there has been an increase in Quality Alerts related to address issues. A joint approach has been agreed with the Patient Safety Team, PED, and the Quality Assurance Department. YAS has been provided with additional information and a contact sheet to support this work

The transfer of Quality Alerts from PED to the Quality Directorate is progressing:

- Job description and banding have been approved
- The affected staff member has been informed
- Final arrangements are being completed prior to transfer

Current risks and Concerns

As noted in the previous report:

- Radar dashboards have not yet been implemented, which continues to impact performance monitoring.

- The CIP outcome will take effect in November and may affect performance. Duties are planned to be redistributed, and additional support is being sought from staff on light duties to assist.

The revised clinical rota has led to some issues, as staff from the Clinical Hub were added without receiving the necessary training

Learning

- **#ECHtriage** (8 mentions) recurring issues with call triage accuracy and process

- **Operational themes** #opsmanner (6) and #opsclinical (5) highlight staff behaviour and clinical decision-making

- **Call handling** (#999callhandling) and **staff manner** (#HAmanner) also feature prominently.

The ongoing theme of communication/conduct and behaviour is due to be discussed at the National Ambulance Service Patient Experience Group (NASPEG) to support collaborative work.

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

Compliments

Work ongoing to capture themes of the appreciations.

227 appreciations shared with the Patient Experiences Department about LAS colleagues throughout August and September 2025.

NB: Data compiled by Patient Experiences team.

Excellence Reporting

127 excellence reports were submitted by LAS staff throughout September 2025. Here are some of the excellence reports received:

A really excellent display of teamwork from the 4 members of staff on scene for a young gentleman found in cardiac arrest. The level of respect and professionalism seen from those involved on our arrival was outstanding, and the patient and his family received the best care and support possible despite the circumstances. Really great work - thank you.

I would like to recognise REDACTED for her exceptional dedication in supporting a paramedic student with extensive learning needs. Throughout the placement, she created a supportive and inclusive learning environment, demonstrating patience, adaptability, and unwavering encouragement to help the student reach their full potential. She was highly engaging and tailored her teaching approach to the student's needs while maintaining clear and consistent expectations. Despite her best efforts, when it became evident that the student was unable to meet the required standards, she approached the situation with professionalism and integrity, not shying away from making the difficult but necessary decision to fail the student. This demonstrated her commitment to both patient safety and the professional standards of the role, whilst ensuring the student received fair and transparent feedback throughout the process.

I've been in the service for about a year and half now. I just want to say how impressed by just how much REDACTED seems to live and breathe our trust values. I don't even work with REDACTED, however, almost every time I'm on LAS connect, I see REDACTED leading from the front. She has such a presence, from merely seeing photos of her out and about engaging her teams or being the first person to answer someone's question on LAS connect. We should feel proud and lucky to have REDACTED. What's super funny, is that I was searching LAS connect for the link to this excellence report form - and guess who had answered someone's request for the link previously - none other than REDACTED.

Themes	
Scene Management	3
Cardiac Arrest Management	8
Outstanding Patient Care	40
Thank you	5
Working Above and Beyond	33
End of Life Care	2
Call Handling	3
Maternity Care	4
External	0
Mentoring/Teaching	7
Staff Support/Welfare	14
Other	8
TOTAL	**127**

REDACTED conducted a rapid and systematic assessment on a fitting patient. He utilised members of public on scene and maintained control of the scene despite a chaotic environment

Learning from Deaths

We are the capital's emergency and urgent care responders

51

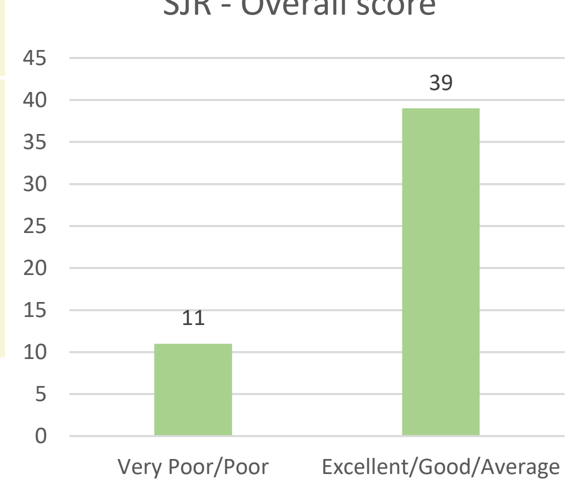
Learning from Deaths

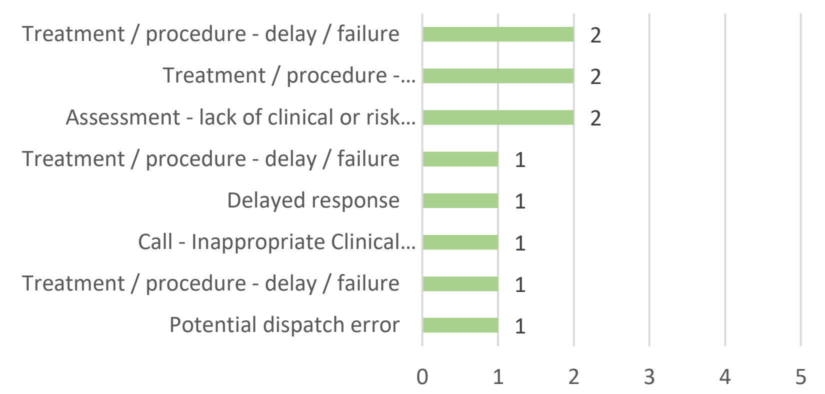
Background: Structured Judgement Reviews (SJR) are undertaken to identify opportunities for system-wide learning where care processes and organisational factors may not have supported the best outcomes. The purpose is to understand contributory factors across the work system, and to share insights that strengthen safe and reliable care. Findings are shared with clinicians and teams to support service improvement.
Month: August 2025

Stage 1 reviewed: 50

Stage 2 Reviewed: 10

If learning is identified in the first stage review, a 2nd stage occurs for validation





August Findings

The following themes highlight **opportunities for improvement across the care system**:

- Strengthening recognition processes for hypostasis and rigor mortis, supported by decision-making guidance.
- Improving timeliness and appropriateness of drug administration through process and resource review.
- Embedding primary survey completion as a consistent safety step.
- Enhancing recognition and escalation pathways for cardiac arrest.
- Supporting safe administration of drugs with reliable tools and guidance.
- Standardising approaches for end-of-life care patients.
- Increasing familiarity and access to the Adult Life Support (ALS).
- Improving airway management processes, including equipment availability and technique reinforcement.
- Optimising use of clinical decision-making tools in trauma care.
- Strengthening the utilisation of interpretation services.
- Enhancing systems for early recognition and escalation of patient deterioration.
- Promoting accurate completion of the verification of fact of death document
- Increasing consistency in ECG interpretation through training and diagnostic support.

SJR Learning Themes

Learning Identified

- Work system support needed to enable consistent recognition of cardiac abnormalities within ECGs.
- Improved systems for documenting care advice and risks explained to patients.
- Reinforcement of processes for escalation to ALS when indicated.
- Clearer recognition and documentation of critical observations and timely escalation.
- Optimised familiarity with defibrillation pads and AED use.
- Reliable processes to ensure drug checks and preparation before administration.
- Strengthening adherence systems for long-term drug administration.

Good Practice Identified

- Effective use of structured troubleshooting processes in managing a difficult airway.
- Excellent multidisciplinary teamwork in pediatric cardiac arrest.
- Proactive safety-netting for patients with capacity concerns.
- Demonstrated resilience and teamwork in managing care when equipment was unavailable.
- Efficient system response to a running call.

NB: Data compiled by the Learning from Deaths Lead – August 2025 data.

Quality Alerts

We are the capital's emergency and urgent care responders

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

External Quality Alerts

54 Quality Alerts raised by external providers to the LAS throughout **August and September 2025.**

Themes:

- Inappropriate Conveyance (6 cases)
  - Patients sent to the wrong facility or not conveyed to the appropriate care unit.
- Incorrect Information (6 cases)
  - Issues with wrong addresses, postcodes, or patient details passed between services.
- Ambulance Denial or Delay (5 cases)
  - Patients denied ambulance services or experienced delays in dispatch.
- Improper Handover (4 cases)
  - Concerns about patients not being properly handed over or booked in at hospital.
- Other themes of note, Paramedic conduct, missed or delayed stroke recognition/action leading to poor outcomes, poor communication between teams, safeguarding concerns (elderly/vulnerable patients left at risk).

Internal Quality Alerts raised with other providers

175 Quality Alerts raised by the LAS to external providers, following incident reports completed by LAS staff throughout **August and September 2025**

60 of these reports were raised by 111 to highlight delayed patient care, including GPs encouraging patients to call for an ambulance rather than utilising HCP – HCP. This follows a similar theme from the previous reporting period.

Other themes of note:

- Medication errors – incorrect dosage or medication dispensed.
- Hospitals refusing handovers or turning patients away.
- District nursing and community care failures, delays in home visits and refusals to attend.
- Communication breakdowns – failed callbacks, lack of contact or follow up.
- Incorrect or failed referrals and poor handover between services.

NB: Data collated from RADAR reports raised in August and September 2025.

Legal & Coroners

We are the capital's emergency and urgent care responders

55

CQOG date : 7th October 2025

Reporting date = August & September 2025

Legal

Inquests & Claims

1. Inquests

- Number of opened cases (live cases) - 262
- Number of cases opened per month (last 2 months):
  - August – 167 Inquests
  - September – 199 Inquests
- PFD's and Coroner's concerns
  - 1PFD received (Inquest MR) –
    - Response provided on 2 September 2025.
- Themes
- Cat 2 delay
- NHS111 Triage
- Capacity assessment/information consent particularly in context of non-conveyance and related to learning difficulties.
- Call handling
- Mental Health assessments
- Cardiac arrest management
- ABD cases

2. Claims

- Number of opened claims:
  - Live Clinical Claims - 133
  - Live EL Claims - 65
  - Live PL Claims -7
- EL Claims – Staff assault claims (5 live claims)
  - Given scale of reported incidents, small proportion of claims (staff assault)
- Themes
- EL Claims – top 5 themes
- Defective work equipment
- Trips
- Manual Handling
- Lifting work equipment
- Assault
  - Claims are typically low value damages.

CQOG date : 7th October 2025

Reporting date = August & September 2025

Legal

Current risks and Concerns

- **Cases of note**
  - On-going case – sensitive case involving staff member. EDI department have actions to write up a formal procedure around the theme in the Trust – no further update
  - Clinical Claim – linked to an Inquest (Hearing date not yet listed).
  - Case relates to a missed opportunity to consult the immobilisation algorithm reference card to immobilise the patient pre-hospital admission
  - Learning – clinicians involved in this case have refreshed themselves with the immobilisation algorithm and learning slides have been shared to team huddles to remind staff to use the algorithm.
  - The algorithm has also been updated since the incident to assist clinicians in decision making.

Performance

- **Targets**
  - No targets as cannot predict number and types of claims and inquests received.
  - Performance – adhered to Court deadlines and directions – no Schedule 5 notices received.

Coroners cases where CQC are an IP

- J Brett – Oxycodone overdose case
- Expert report received.
- Still not listed.

Highlight reports from subordinate committees

We are the capital's emergency and urgent care responders

CQOG date : 07/10/2025

Reporting date = August and September 2025

Compiled by: Tim Edwards & Rebecca Paleka

Presented by:

Information for : Assurance

Medicines Management Group (MMG)

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

- AUGUST Meeting:
  - Medicines Packing Unit update reports 98% compliance in CD audit.
  - Medicines deliveries at last quarter – 100% of planned.
  - 10% reduction in oxygen holding but still at 10 days resilience.
  - Compliance levels of PGD trackers is well maintained.
  - CARU presented results of Midazolam clinical audit report with recommendations being to include changes to the PGD and educational needs identified for bilateral tonic-clonic seizures and focal seizures.
- SEPTEMBER Meeting:
  - Medicines Packing Unit update reports total of 14,340 bags packed, 14,685 checked, 313 near misses recorded which equals approximately 2% (near misses largely related to multi-dose drug packs being inaccurately reported by clinicians).
  - Current Midazolam PGD to be extended until new release of Midazolam PGD.
  - CRASH4 trial expanded into Newham and likely to further expand into NC sector.

For noting

- AUGUST Meeting: No changes to Trust Medicines Risk Register after recent review.
- SEPTEMBER Meeting: CD prescribing options paper being considered, no formal decisions on expanding APPUC prescribing to include CD medicines.

Recommendations(s)/ Decisions for the Board/Committee

- AUGUST Meeting: none
- SEPTEMBER Meeting: none

AOB

- AUGUST Meeting: none
- SEPTEMBER Meeting: none

CQOG date : 07/10/2025

Reporting date = 11/09/2025 (next CAG 09/10/2025)

Compiled by: G.Harman

Presented by: N/A

Clinical Advisory Group (CAG)

Agenda items approved through CAG

Items approved

- APPCC: ACOP EOC
- ACP: SEL Early Pregnancy Assessment Unit
- SPPC: Urinary Catheter Management and Troubleshooting
- ICC Clinical Letters

Items seen for noting

- OP023 updated
- ACP SEL End of Life Care (Greenwich & Bexley) (no clinical changes)
- ACP SWL Crisis Café 'Hestia' (same clinical criteria as 'sutton crisis café' approved at Aug CAG 25
- ACP SEL SDEC (administrative changes)

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

- None

Recommendations(s)/ Decisions for the Board/Committee

- None

AOB

- None

CQOG date: 07 October 2025

Reporting date = August and September 2025

Compiled by: April Wrangles

Presented by: April Wrangles

Information for : Assurance

Learning and Assurance Group

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

Key points/issues

- Equipment: Ongoing issues with ECG electrodes, syringes, Life Pack devices, and carry chairs; trials of improved electrodes show progress.
- Violence & Safety: Continued high levels of violence, aggression, and musculoskeletal injuries; resource pressures and backlog in report reviews.
- Carry Chairs: Failures causing staff injuries and patient risk; to be added as a Trust-wide risk.
- Maternity: Ongoing interface issues and incivility; destination guidance nearing completion; new practice development midwife appointed.
- Training: Updates to simulation training, introduction of AI callers, new videos, and CSR updates; staffing shortages affecting delivery.
- Learning from Deaths: Themes include delayed cardiac arrest recognition, ECG interpretation, and morphine use; thematic review due November.
- End-of-Life Care: Incidents linked to poor advance care planning; new education package and medication CSR launching.
- Safeguarding: Missed child referrals and inappropriate adult referrals continue; audit and training refresh underway.
- Complaints: 79 in August; main themes communication and staff manner.
- Patient Safety: Duty of Candour compliance 90.3%; 42% of actions overdue but improvement work ongoing.

Key Risks for the Board/Committee's attention

- Equipment reliability – ECG electrodes, IM syringes, Life Pack devices, trolley beds, and carry chairs.
- Carry chair failures – Staff injury and patient safety risk; to be added as Trust-wide risk.
- Violence & aggression – High incident levels and backlog in reviews.
- Overdue actions (42%) – Weakens assurance and learning impact.
- Safeguarding – Ongoing missed and inappropriate referrals.
- Training and resource pressures – May affect the delivery of education and simulation courses.

AOB

None applicable

CQOG date : 07.10.25

Reporting date August/September 2025

Compiled by: Maxine Finch

Presented by: April Wrangles

Patient Safety and Clinical Effectiveness Group

Key points, Issues and approved items Board/Committee's attention:

Items for Approval

21st August 2025: SP-PC COP007 Urine Catheter Management Troubleshooting – approved

18th September 2025: No items for approval

Items for Discussion

21st August 2025: Pan London Guideline for In Utero Transfer

Matters for Escalation

- No matters for escalation

Risks and assurance

Risk identification is included as a standing agenda item for all PSCEG meetings.

No new risks have been identified since the last update. Members are supported to review and update risks as appropriate. .

AOB

Quality Performance Data - 999

We are the capital's emergency and urgent care responders

999 Ambulance Clinical Quality – 999 Ops Board Report

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)

- **Open learning responses:** 4 (Clinical Hub), 5 (EOC)
- **6 month breach**: 0 (EOC), 2 (Clinical Hub). Both awaiting exec approval.
- **Cases reviewed at PSIG:** 22 (August 2025)
- **Outstanding LFDs:** 16 (stage 1 – 11 have been allocated pending completion), 0 (stage 2)

RADAR support

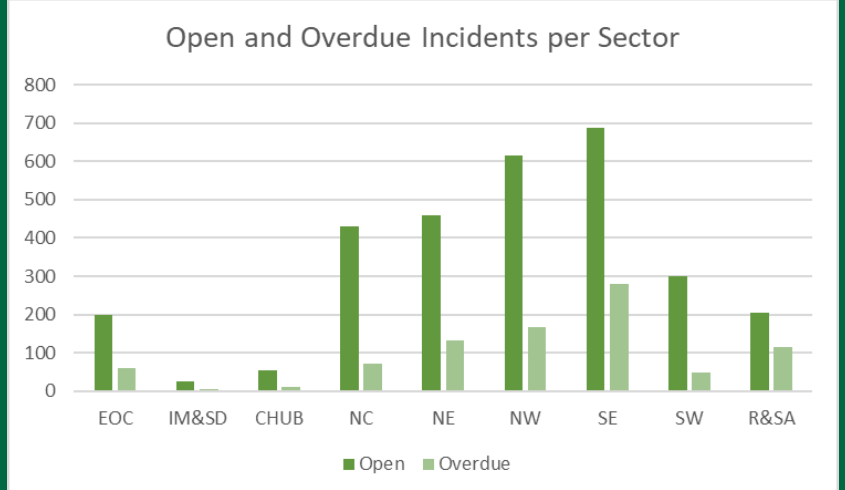
- Drop-in support sessions ongoing with EOC, IM&SD and CHUB leadership teams.
- Weekly 999 incident review and overdue incident review to support responsible managers with recommended actions and provide oversight.

Training

- Local investigation and Radar training provided to new PMs and CSOs by the 999 clinical and quality team.
- Lead investigator training for learning responses scheduled for Sept & Oct. To be delivered by Patient Safety specialists.
- New CSOs have now undertaken complaint response and LFD training and now have allocated office time to support.

Overdue Incidents (as of 11/09/2025)

- **Open incidents:** 199 (EOC), 25 (IM&SD), 55 (CHUB), 1 (QA), 0 (NETS EOC)
- **Overdue incidents: 59** (EOC), 6 (IM&SD), 11 (CHUB)



Incident reporting themes:

- **Incorrect addresses**
- **Ineffective breathing**
- **Incorrect duplication**

Investigation quality

- Audit of local investigations is currently being undertaken to understand areas of support required.
- Incident Investigation guide being finalised to support managers with completing thorough and effective local incident investigations.
- Updated Just Culture guide being finalised to support with appropriate actions following a reported incident.

Quality Visits

- Next visits to be undertaken between October – December 2025.
- On a recent visit to Newham, marked improvements have been seen regarding poster compliance.

Abusive Callers

- Continue to work closely with the Violence Reduction Unit for ongoing management of cases.
- Finalising a poster for EOC staff to understand what happens once they report an abusive call on Radar, to increase level of reporting.

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:** Potential recent increase in incidents. Provisionally included in next CSR. Potential to repeat e-learning in interim.
- **Dispatch to high risk Category 2 incidents (10D2, 10D4):** Sustained reduction in incidents.
- **Management of duplicate calls:** CAD development due to be implemented in November.
- **Ensure clinical input is obtained when there isn't a bariatric vehicle available:** Sustained reduction in incidents. Assurance and feedback sent to dispatch and IM&SD GM monthly.

Completed actions:

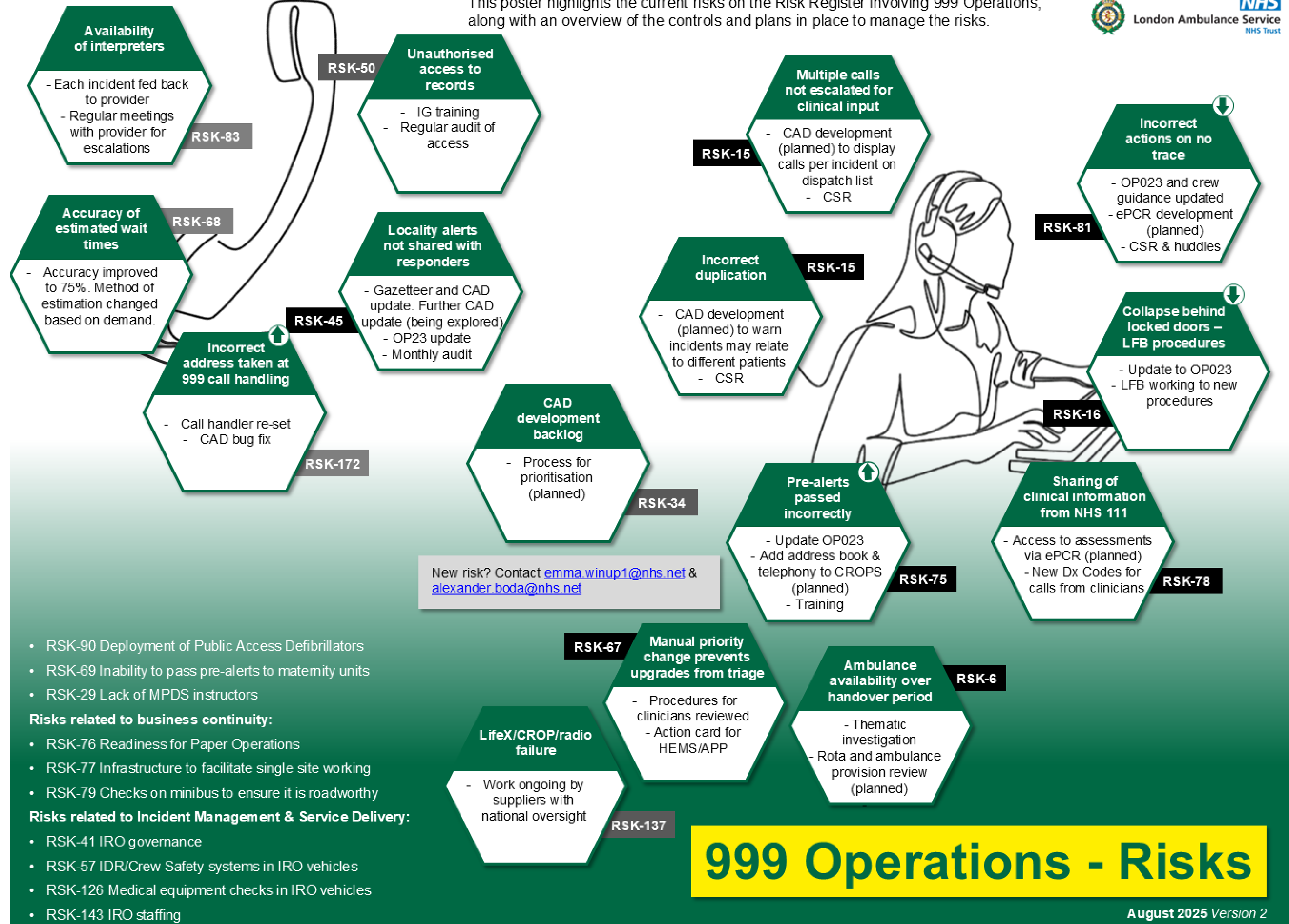
- **Management of HCP/IFT update:** Implemented 2 September
- **Review of OP023:** Live 12 August
- **C1 auto-dispatch on Default Desk:** Live 12 August
- **Updated codes for CAD to search for a PAD:** Scheduled for 17 September

In the pipeline:

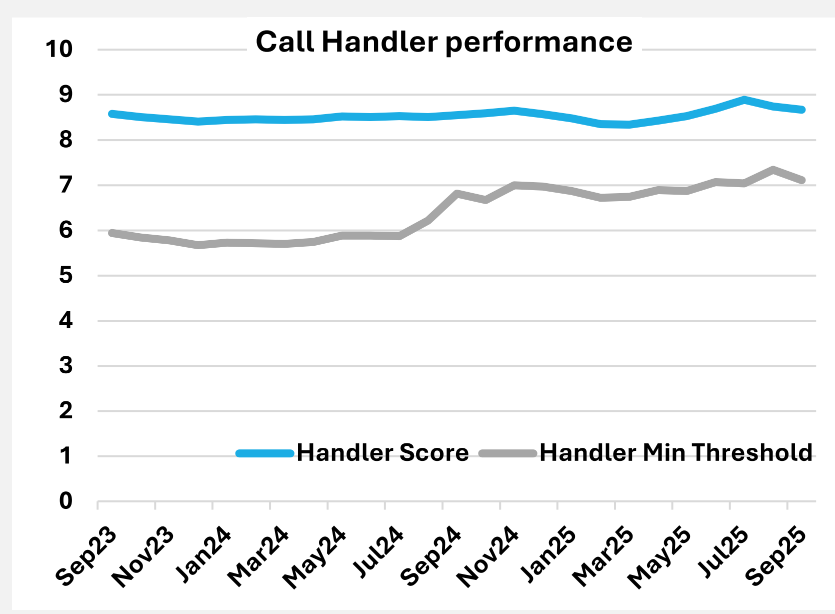
- **Review of CQC recommendations to other services:** Review to be completed for potential gaps
- **CQC mock inspection**

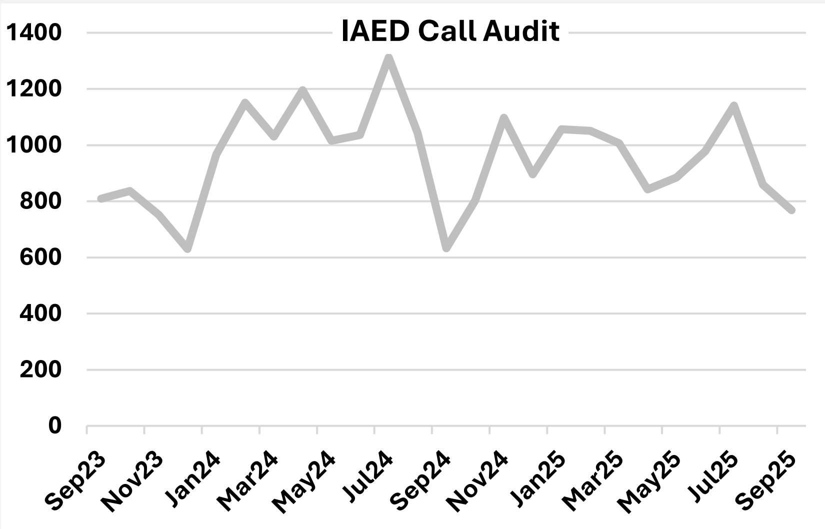
National work streams

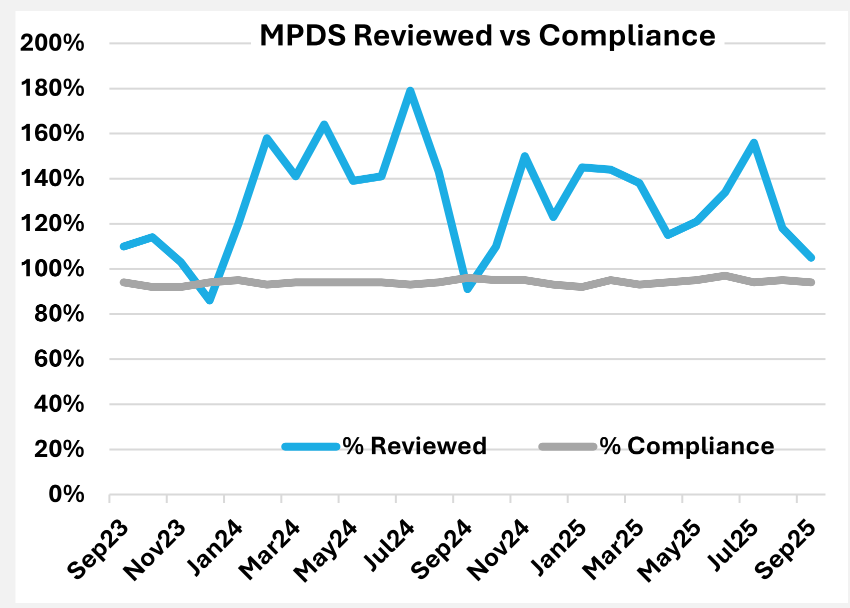
- MPDS & ProQA update implemented on **9 September.**
- Recommendations from national Category 2 review implemented.
- Awaiting research approval from CARU to progress work with IAED to develop triage of chest pain with support from Sector Senior Clinical Lead (Clinical Data).


Clinical & Quality
This poster highlights the current risks on the Risk Register involving 999 Operations, along with an overview of the controls and plans in place to manage the risks.
NHS
London Ambulance Service
NHS Trust
Availability of interpreters
- Each incident fed back to provider
- Regular meetings with provider for escalations
RSK-83
RSK-50
Unauthorised access to records
- IG training
- Regular audit of access
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
- OP023 and crew guidance updated
- ePCR development (planned)
- CSR & huddles
RSK-81
Accuracy of estimated wait times
- Accuracy improved to 75%. Method of estimation changed based on demand.
RSK-68
Locality alerts not shared with responders
- Gazetteer and CAD update. Further CAD update (being explored)
- OP23 update
- Monthly audit
RSK-45
Incorrect duplication
- CAD development (planned) to warn incidents may relate to different patients
- CSR
RSK-15
Collapse behind locked doors – LFB procedures
- Update to OP023
- LFB working to new procedures
RSK-16
Incorrect address taken at 999 call handling
- Call handler re-set
- CAD bug fix
RSK-172
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
New risk? Contact emma.winup1@nhs.net & alexander.boda@nhs.net
RSK-90 Deployment of Public Access Defibrillators
RSK-69 Inability to pass pre-alerts to maternity units
RSK-29 Lack of MPDS instructors
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-41 IRO governance
RSK-57 IDR/Crew Safety systems in IRO vehicles
RSK-126 Medical equipment checks in IRO vehicles
RSK-143 IRO staffing
RSK-67
Manual priority change prevents upgrades from triage
- Procedures for clinicians reviewed
- Action card for HEMS/APP
Ambulance availability over handover period
- Thematic investigation
- Rota and ambulance provision review (planned)
RSK-6
LifeX/CROP/radio failure
- Work ongoing by suppliers with national oversight
RSK-137
999 Operations - Risks
August 2025 Version 2

EOC Call Handling







EOC met the required standards of audit and compliance for ACE

Working towards the creation of an Action Card to support EOC over the winter pressure period

105 new incidents logged for QA (Legal, Comms, PED, Governance) alongside the routine random and focussed and recontact audit volumes required

The department has high levels of absence, which has affected the volumes of audit conducted.

Working with the team to try to spread the audits across both EOC sites, and teams to support absences

Quality Performance Data - 111

We are the capital's emergency and urgent care responders

CQOG date : 07/10/ 2025

Reporting date = August 2025

111 & IUC

Incidents

The majority of the 303 incidents reported in August fell within the *no harm* category. Of those reviewed, five were classified as low harm, two as moderate, and one as severe. Following PSIG ratification, all but the severe incident were downgraded to low or no harm, providing assurance that risk to patients has remained minimal.
This review has also surfaced four priority themes that require senior oversight, alongside targeted actions already underway to support improvement.

•**Concerns Regarding Other Providers:** A growing trend has been identified where GPs are not following the established process when requesting ambulances via 999. This has been raised directly with practices and shared with ICBs for oversight. To support improvement, the correct process has been re-circulated to providers, with ongoing feedback and engagement in place.

•**IUC Call Handling:** Concerns persist around adherence to process, with some instances of staff working outside their remit. In response, staff are receiving direct feedback, enhanced auditing has been introduced, and teaching sessions with case-based discussions are being delivered to strengthen consistency and confidence in practice.

•**Communication, Care and Consent:** Reports have risen regarding the reliability of Language Line, with concerns about both availability and professionalism. This has been escalated for awareness and further review, while staff are being encouraged to share real-time feedback to support monitoring and provider accountability.

•**Capacity and Resourcing:** Staff sickness and annual leave during August reduced team capacity, creating delays in managing incident reviews. Additional support has now been put in place to address the backlog and ensure incidents are completed in a timely manner.
Collectively, these findings underline the importance of sharper system-wide assurance, but also demonstrate that corrective actions are already in motion. Continued monitoring, targeted feedback, and proactive engagement with partners will remain central to safeguarding patient outcomes and strengthening service resilience.

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 August 2025, LAS Integrated Urgent Care Service were offered 194,611 calls and answered 187,352 calls. This resulted in an abandonment rate of 1.6% (against a 3% target) and an average speed to answer of 5 seconds (against 20 second target).

Rota fill within LAS reached was 113% in Aug with turnover at 19.39% and sickness absence at 12.48%. The turnover has decreased compared to June due to the decreased 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 Aug is at 90.75%.
19,298 Category 3 and 4 ambulance validation cases were validated by 111 clinicians, with 16,448 cases (85%) being re-triaged to a lower acuity level.
The number of ETC/ED dispositions validated by the Clinical Assessment Service (CAS) was 6312 and of these 68% were directed to a more appropriate, lower acuity outcome.
Priority 1 CAS call back performance improved to 73.6%

Learning

Learning from Incidents

- We can provide strong assurance this month, with excellent audit compliance and constructive engagement with system partners. Audit completion rates for Health Advisors, NHS Pathways Clinicians, GPs, and Advanced Clinical Practitioners (ACPs) were exemplary at 100%, with overall compliance ranging between 92% and 97%. This marks a slight improvement post-feedback in the CDSS Pathways clinician cohort.

- Two end-to-end reviews were also presented to ICB colleagues. The first explored themes around abusive callers and staff welfare, while the second examined Category 3 ambulance requests in patients aged 18–55 — specifically focusing on which elements of the Pathways algorithm trigger an ambulance response, and how these decisions are subsequently validated by a clinician. These reviews reinforce the robustness of clinical decision-making and reflect our commitment to collaboration and transparency with system partners.

Patient Feedback

- Survey responses this month remain broadly positive. **92% of patients** reported feeling treated with dignity and respect. **70.2%** indicated they were overall satisfied with the level of care received. While this represents a decrease, further scrutiny suggests that the satisfaction scores reflect the *entire patient journey* rather than specifically the 111 service. Work is underway to refine the survey question set to better capture satisfaction levels attributable to 111, alongside deeper analysis of the current data.

Quality Performance Ambulance Operations

We are the capital's emergency and urgent care responders

Performance Review – September 2025

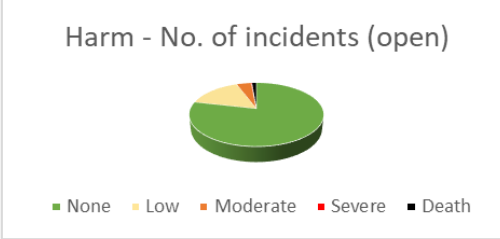
Reporting date – 01/04/2025 - 30/09/2025

South East Sector Clinical Quality – Performance Review

Incidents

Incidents

Group	Total incidents	Total closed	Total Open
Deptford	490	345	145
Greenwich	374	336	38
Bromley	355	228	127
Oval	316	244	72



Incidences: INC_2098 Maternity input – awaiting feedback at local level.

Incidents narrative: 1) Medical equipment, 2) violence, aggression and abuse 3) Communication, care and consent

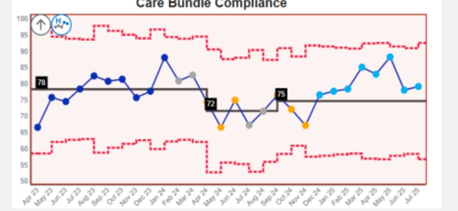
PSIG: 94 Incidences though PSIG. Themes are delay response and access to care, equipment and resource complications, recognition of cardiac arrest and STEMI

DOC: Stage one and two = 100%

Learning responses: 6 open (4 PSII and 2 AAR) Informed consent and management of patients under the influence of alcohol and/or drugs

Clinical

STEMI care & plan:



Currently 79%

Positive reinforcement letters, Rosie's STEMI presentation and Jo's ECG presentation

ROSC: 29% ROSC to hospital, 46% Achieved on scene

Trusted assessor Y/N by site: 3/5 Acutes SDEC awaiting PRUH and KCH.

QEH only site without Midos ACP to AFU.

Clinical supervision sector staff OWR (Aug):

Bromley: 81.56% Deptford 71.43%

Oval 83.68% Greenwich 83.82%

Clinical supervision CTMs: 4 shift undertaken 3 sign offs

CPI feedback and themes: No clinical aspect of care below 92% - 92 % Older falls and Sickle cell care

Quality & compliance

- **Complaints number:** 52 Complaints and 35 External Quality Alerts
- **Themes:** Conduct and behaviour(28), Damage to property(2), LAR (2)
- **Excellence reports:** 118 (highest month June 31)
- **Quality alerts & themes:** 34 Themes: inadequate handover, ?should have been a pre-alert and LAS calling GPs not within guidance.
- **Medicines management compliance:** 2,0498 medicine management checks across 11 sites averaging 97.62%
- **IPC compliance:** Deptford missed their cleaning compliance for the second month running. August saw a decline in hand hygiene audits.
- **Quality visits:** Laminated signs for segregation of waste, spot checks by management for unlocked vehicles. Pac testing for Bromley's new management area. 85% compliance, plus new CSQO in post.

Matters for escalation

- Increasing amount of LAR RADARs. SE highest sector in August, especially in patient with LD and ND.
- ICB collaboration in SEL - in favour of borough model care systems
- 50% of MAN Ambulance have no powered chairs (ferno Venice chairs). 90% of MAN Ambulance have a broken charger.

Performance Review: September 26th 2025

Reporting date = 1st April – 31st August 2025

South West Sector – Clinical Quality – Performance Review

Incidents

Total open/ closed
Croydon- 42/ 384
New Malden – 66/396
St Helier – 45/266
Wimbledon – 27/203

Patient Harm			
None	416	Severe	1
Low	57	Death	1
Moderate	2		

Longest open incident – INC 4010 – CD audit error reported 01/05/25, awaiting local investigation
Overdue incidents Q1 – SW lowest sector = 20%

Top 3 incident categories
1. Failure of device/ equipment (221)
2. Physical abuse (94)
3. CD audit errors (59)

Learning –Role criteria, safe discharge at scene including informed decision making
- Learning bites shared monthly
- Huddle content shared: Frailty line, "You said, We did", HCP details for QAs

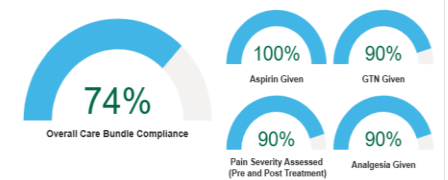
PSIG: 125 cases reviewed
Themes:
1.Concerns RE external providers (30)
2. Midazolam administration (23)
3. Re-contacts (8)

DOC
One outstanding – IUC related

Learning responses.
- Missed VF and delayed shock – PSII
- Overdose, minimal observations whilst awaiting MPS

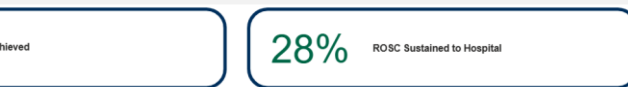
Clinical

- **STEMI care & plan (Jul 25)**:



Plan: Key priority for the SW SCL following recruitment.

- **ROSC (May 25)**



- **Trusted assessor: I**n place at all SDECS in SW.
- **CTM clinical supervision:**
- SW sector = 91% for previous cycle ending in Aug'25.
- Plan to move to new yearly cycle
- Training dates agreed for CQ team as required
- **CPI**

Group	Completion (July)
Croydon	39%
New Malden	93%
St Helier	97%
Wimbledon	63%

- Good compliance across all aspects of care, including Older Fallers – SW = 89% (LAS = 87%)

Matters for escalation

Potential areas of concern:

- MPS attendance at calls
- New vehicle (Ford) rear door closure

Quality & compliance

Complaints number: 31 received
1. Conduct and behaviour (20)
2. See & Treat (4)
3. Safeguarding Referral (2)

Quality alerts & themes: 12 received
1. See & Treat/ Convey (5)
2. Conduct and behaviour (2)

Medicines management compliance (Aug)
- Croydon – 31 (99%)
- New Malden – 29 (97%)
- St Helier – 30 (99%)
- Wimbledon – 30 (99%)

IPC compliance – Hand hygiene Completed YTD/ Annual Target
- Croydon – 63/161
- New Malden – 35/ 137
- St Helier – 47/ 102
- Wimbledon – 52/ 116

Quality visits: Overall compliance – 89.77%
Overall positive findings: Clean and tidy working spaces, relevant posters on display

Common recurring issues such as dirty linen segregation/ bagging non compliance, PRF boxes found unlocked.

Clinical Quality Sector Dashboards

Our Senior Quality Business Analyst is currently producing Clinical Quality Sector Dashboards.

Sector Dashboard Examples | No label

Pages

- Staff Training
- Workforce
- Incidents
- IPC

File

Incidents

Year, Month: All | Sector / Department: All | Station / Team Location: All

Total Incidents By Severity

Severity: Death, Low, Moderate, None, Severe

Number of Incidents: 10K, 5K, 0K

January	February	March	April	May	June	July	August	September	October	November	December
6.8K	6.2K	6.8K	7.7K	7.8K	7.5K	8.1K	6.1K	6.0K	6.9K	6.8K	7.0K

Overdue Incidents

Year	North Central	North East	North West	South East
2025				
March	14	37	25	18
April	12	26	26	15
May	24	37	30	21
June	11	30	25	20

Top 10 Categories

Category: Security - violenc..., Medical equipment, Medicines Man..., Communicatio..., Dispatch & call, 111/IUC - Call ..., Clinical treat..., Moving and ..., Infection Pr..., Vehicle related

- Security - violence, aggression and abuse 16.9%
- Medical equipment 15.66%
- Medicines Management incl. Controlled Drugs 15.56%
- Communication, care & consent 12.15%
- Dispatch & call 9.11%
- 111/IUC - Call Handling 7.72%
- Clinical treatment (EXCEPT medication related) 6.98%
- Moving and Handling of Patients (not including physical restraint) 5.94%
- Infection Prevention & Control (incl. Sharps Injury) 5.1%

NB: The report currently contains test data for the purpose of this display.

Research & Clinical Audit

Link to CARU live CPI dashboard (requires VPN)

We are the capital's emergency and urgent care responders

CQOG date: 7th October 2025

Reporting date: Aug 25 – Sep 25

CARU

Key Findings

National AQIs (April 2025 data, published September 2025):

ROSC: LAS ranked 5th nationally for ROSC sustained to hospital in the overall patient group, with 28.3% (vs. 26.2% national average). In the Utstein comparator group, LAS ranked 2nd in England with 57.8% (vs. 42.1% nationally).

Survival: In the overall patient group, 11.5% of patients survived to 30 days, above the national average of 10.0%. In the Utstein comparator group, LAS ranked 1st nationally with a 30-day survival of 37.8%—over 10 percentage points higher than the national average of 27.1%.

STEMI: The LAS recorded a Call to Angiography time of 02:26, ranking 7th nationally (3 minutes slower than the national average).

STEMI Care Bundle was provided to 77.1% of patients, down from 78.4% in January and below national average of 80.0%. LAS remains in the 8th place for the third consecutive reporting cycle.

Stroke: Our average call-to-hospital arrival time was 01:18, a notable improvement from 01:27 reported last month. LAS achieved joint 1st position nationally for this measure (10 min faster the national average of 01:28).

Falls: Our care bundle compliance dropped slightly from 54.3% in December to 52.7% in March. We are currently ranked 5th nationally.

Note: STEMI and Stroke figures are based on MINAP and SSNAP data respectively which may not be complete samples and are subject to change following revisions.

Low Back Pain (non-traumatic) Clinical Audit:

Patient history: The majority of patients had the history and duration of pain, and previous advice recorded.

Clinical observations: Most patients had NEWS2 recorded; for 54% it was calculated correctly every time. A quarter of patients who had a blood glucose recorded had documentation suggesting this was necessary.

Pain assessment: 94% of patients had at least one pain score recorded; with SOCRATES (or equivalent) detailed for 26%.

Red flags: 5% of patients had all relevant red flags recorded.

Physical assessment: A full abdominal assessment was documented for 17%. 30% full spinal palpation, 6% spinal muscle palpation, and 4% had SI joint palpation recorded. No patients had all individual aspects of inspection; 3% had evidence of the full functional assessment.

Psychological and social factors: No patients had consideration of all social and psychological factors recorded.

Pain management: Ibuprofen was administered to 19% and 25% received combined therapy of ibuprofen and paracetamol.

Advice and non-conveyance: 29% were not conveyed to hospital; 54% of whom received non-pharmacological advice. Simple exercises were advised for 36%.

Conveyance: 95% who required hospital were conveyed. Clinical review determined non-conveyance may have been more suitable for some patients.

Recommendations from Clinical Audit

- Share the findings of this clinical audit through a Clinical Update article and Huddle video.
- Propose a CSR module on MSK assessment including palpation, inspection and functional assessment.
- Suggest further clarity in the JRCALC LBP Guideline specifically regarding the need for blood glucose assessment, use of equivalent pain assessment mnemonics, red flag symptoms, assessments outside the paramedic practice, and differentiating requirements for acute, subacute and chronic LBP.
- Consider ways the Service can make codeine more accessible to patients.
- Support the proposal for advice slips or emails with relevant information to be given to patients when discharged at scene.
- Propose a checklist to promote consistent documentation.

Highlights

Clinical Annual Reports (2024/25):

The Cardiac Arrest and STEMI annual reports have been written and will be shared with CQOG for approval. They will be released once they have been to QAC and Trust Board.

Clinical Performance Indicators (CPIs):

The new CPI feedback function was launched which:

- assigns audit data to all attending clinicians to recognise their contribution to patient care
- is personalised based on skill level and time spent on scene
- allows clinicians to review compliance before receiving feedback
- enables clinicians to save reflections,
- provides managers with compliance overviews and trend insights.

Research:

- We recruited 70 patients into clinical trials, bringing us to 392 patients enrolled into the SIS study and 322 into CRASH-4.
- Newham station group opened for recruitment to CRASH-4 in September, bringing the total open stations to 32.
- This period there was one journal publication by LAS authors, with two further publications in press.
- We are working with a number of partners on several research funding applications for potential future clinical trials.

CARU

Measures	Target / Range	RAG	YTD 25/26	04/2025	05/2025	06/2025	07/2025	08/2025	09/2025	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)			28%	28%	28%					↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)			53%	58%	49%					↓			LQ1b		
STEMI Care Bundle (AQI) (Reported every 4 months)	80%	R	77%	77%	-					↑			LQ2c		
Stroke - Call to Arrival at Hospital - Mean (hh:mm)			01:19	01:18	01:21					↑			LQ3a		
Survival to 30 days (AQI)			10%	12%	9%					↓					
Survival to 30 days UTSTEIN (AQI)			34%	38%	30%					↓					
STEMI On scene duration (measured from first DCA)			39	40	38	39	37	39		↑					
STEMI Call to Angiography - Mean (hh:mm) (AQI)			02:27	02:26	02:29					↑					
Falls (aged 65+, discharged at scene) (AQI) (Reported every 4 months)			-	-	-										
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	72%	73%	70%	71%	76%			↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			Data not currently available							↔			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	97%	97%	97%	98%	97%	97%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	R	95%	95%	95%	95%	95%	94%		↓		✓	LQ12		
Documented Care - Mental Health (diagnosed and undiagnosed) Compliance (CPI audit)	95%	R	93%	94%	93%	93%	92%	92%				✓	LQ12		
Documented Care - Sepsis Compliance (CPI audit)	95%	R	96%	96%	96%	96%	95%	95%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	R	93%	94%	-	94%	-	92%				✓	LQ12		
Documented Care - End of Life Care Compliance (CPI audit)	95%	G	95%	-	95%	-	95%	-		↑					
Documented Care - Older Fallers Compliance (CPI audit)	95%	R	87%	88%	88%	88%	86%	86%							
Documented Care - Sickle Cell Crisis Compliance (CPI audit)	95%	R	92%	93%	92%	92%	92%	92%		↑					

Cardiac Arrest:

ROSC to hospital

In May 2025, LAS ranked 5th nationally for ROSC to hospital in the overall group with 28.2%, against a national average of 28.4%. For the Utstein comparator group, we ranked 8th with 48.8% versus the national average of 55.2%.

Survival to 30 days

We ranked 9th overall with 8.6% of patients surviving to 30 days, which is below the national average of 10.1%. For the Utstein comparator group, we ranked 7th, achieving 30.2%, also below the national average of 33.7%.

STEMI: The LAS recorded an average time of 02:29* for the call-to-angiography measure. This is one minute longer than the national average of 02:28, and ranks the LAS in 8th place nationally

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

Stroke: We achieved an average call-to-hospital arrival time of 01:23**, faster than the national average of 01:29. We are currently ranked in the 3rd place nationally for this measure.

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

Falls: no care bundle data was published this month. The next figures will be released in November (for June 2025 data).

CARU

Clinical Audit & Research

Clinical audit

•In September, we published our most recent clinical audit report which focuses on the assessment and management of low back pain (non-traumatic). The results of this clinical audit demonstrate some areas of good practice, particularly documentation of patient history. However, several key areas for improvement are identified such as inconsistent documentation, limited use of red flags and MSK assessment components, psychosocial factors and high conveyance rates for patients potentially more suitable for alternative pathways. The recommendations for improvement include:
•Reminding clinicians to perform a thorough MSK assessment.
•Sharing findings with JRCALC to recommend: the removal of blood glucose section, including the use of alternative pain assessments to SOCRATES, removal of assessments outside paramedic scope of practice and to differentiate requirements for acute, subacute and chronic low back pain.
•Recommending the symptoms on the JRCALC low back pain red flag list is reviewed and refined.
•Considering ways the Service could make codeine more accessible to patients.
•Providing further evidence supporting the proposal for advice slips for patients discharged at scene with LBP.
•Proposing JRCALC collate all relevant LBP assessments in an easy to access format to promote consistent documentation.
•We have had an abstract accepted for the Faculty of Pre-Hospital

Research

•The CRASH-4 trial opened at Newham and West Ham stations in September, bringing the total number of ambulance stations participating in the trial to 32.
•North Middlesex hospital has indicated that they are willing to receive CRASH-4 patients, opening up participation to another 3 stations.
•The Spinal Immobilisation Study (SIS) approached 400 patients in September, an important milestone for this busy study.

Advanced Practice & Specialist

We are the capital's emergency and urgent care responders

CQOG date : October 2025

Reporting date = August/ September 2025

Advanced Practice – Critical Care

Incidents

Number of incidents	Themes
14 – Aug 9 - Sept	Chemical restraint Obstetric emergency
	Total 23

Restraint: 14 cases

Prescriptions: NIL

Intubation: 191 (Q1). Overall success 97%; 1st pass 85%

Current risks and Concerns

Number & Description of open risks reported on the risk register (RADAR) .

Nil

There continues to be a gap in provision for advanced practice within the clinical quality oversight team. This is because the teams have moved out from RSA and their new location does not have a direct link. This is being worked through with the clinical quality team.

Performance

CPI Compliance: 98%

Performance:

August	On Scene Time	83.1
August	Job Cycle Time	108.3
August	Utilisation	36.5
Sept	On Scene Time	88.7
Sept	Job Cycle Time	115.9
Sept	Utilisation	32.5%

Statutory/Mandatory Compliance: 85.54%

Attendance at Case Review: 64 past 4/52

Supervision Shifts: 7

Cover:

August: No days below minimum cover
September: No days below minimum cover to date, all remaining days to plan.

Learning

Learning From Incidents – Weekly case based review discussions

Practice Development – Corpuls CPR Arm, kit check system, Ultrasound database, Intelligent data dashboard, Misoprostol PGD, Levetiracetam PGD, Prescribing pilot continues, Arterial line scoping, 2x studies – rocuronium and ketamine, CPI revision.

Compiled by: Nick Brown, Dave Biginton

Presented by: Alison Blakely

Information for : Assurance

CQOG date : September 2025

Reporting date = August/September 2025

Advanced Practice – Critical Care

Training

Mandatory Training Compliance
StatMan: 85.54%
Specialist Training: 78.92%

Training/Educational achievement

- Corpuls CPR Arm-automated chest compression device
- Revised Advanced clinical operating procedures/ PGDs

Attendance at clinical governance days

20

Assurance over revalidation/qualification/ recertification

All re-registered with HCPC

Assurance

PGD Breaches:

None

Audit/Research:

Rocuonium Study: APPCC use of paralysis over a one year period

Ketamine Study: APPCC use of Ketamine over a one year period

VF Study: Currently being discussed with CARU

Chemsex Study: Led by an APPCC-study looking at attendance at Chemsex incidents by LAS

Further updates/ Ongoing work

CQOG date : October 2025

Reporting date = August/September 2025

Advanced Practice – Urgent Care

Incidents

Number of incidents	Themes
7 Aug/4 Sep	Cold chain broken
	Total 11

Restraint: Nil

Prescriptions:

July

Total medications marked as prescribed = 95

Medication given from LAS drug packs = 70
Prescribed and supplied over-labelled pre pack = 18
Electronic Prescription Service (EPS) = 6

August

Total medications marked as prescribed = 85
Medication given from LAS drug packs = 51
Prescribed and supplied over-labelled pre pack = 29
Electronic Prescription Service (EPS) = 4

Current risks and Concerns

Number and description of open risks reported on the risk register (RADAR) :

Nil

There continues to be a gap in provision for advanced practice within the clinical quality oversight team. This is because the teams have moved out from RSA and their new location does not have a direct link. This is being worked through with the clinical quality team.

Performance

CPI Compliance (July 2025 latest data)

- Abdo Pain – 89%
- Discharge – 95%
- Document – 95%
- MH – 100%
- Paed – 71%
- TLOC – 86%
- Cardiac Arrest – 97%
- P/EoLC 97%
- Headache – 88%
- Fallers – 82%
- Sepsis – 96%
- Wound – 96%

Performance:

August	Conveyance to ED	35.28%
August	Utilisation	57.2%
Sept	Conveyance to ED	35.74%
Sept	Utilisation	54.5%

Supervision Shifts:
August: 5 (low due to induction)
September: 2 planned (low due to induction)
Year to Date: 56
Target: x3 a year (74 staff with latest cohort)

Cover:
August: 3 early, 5 lates below minimum (1xCGD, short term sick)
September 3 early, 3 late below minimum to date.

Learning

Learning From Incidents: Awaiting outcomes. Themes, Heathrow airport working practice, palliative/EOLC
Practice Development: Awaiting outcome.

Compiled by: Tim Edwards, Dave Biginton

Presented by: Alison Blakely

Information for : Assurance

CQOG date : August 2025

Reporting date = August/September 2025

Advanced Practice – Urgent Care

Training

Mandatory Training Compliance:
StatMan 86.9%
Specialist Training 77.57%

Training/Educational Achievement:

- Clinical Governance Days (CGD) (1 per month)
- Non Medical Prescribing (NMP CGDs (1 per month)
- PGD Education for cohort 8
- Red Dot XR course (Xray interpretation) for cohort 8
- Induction for cohort 9
- NMP Course (Cohort 7, 7 clinicians)
- Finished MSc (Cohort 6, 13 waiting final results)
- Clinical supervision completed postgraduate certificate in medical education (PGCME) and PGCert Paediatrics (both progressing to PGDip)

Attendance at Training Days:
CGDs (required to attend 1 per quarter):

- Q1 Intimate Exams (72 attended)
- Q2 EPRR (36 attended – cycle ongoing)

NMP CGDs (required to attend min 4 per year)

- 51 attended

Assurance over revalidation/qualification/ recertification

- All re-registered with HCPC
- Working through NMP revalidation for LAS requirements

Assurance

PGD Breaches:

None

Audit/Research

Research to evaluate the programme (ongoing CoP small grant)

Data work with data scientist (led by Tim) Comparative analysis looking at BAU versus APP – UC response to examine, incremental benefit (if present)

Research evaluation of dementia education (ongoing)

Further updates/ Ongoing work

Pilot of 1 APP rotating within SGUL has started Post completion of MSc ongoing development towards 4 pillars of advanced practice. Development role as a lecturer, whilst completing a PGCert in Education. On completion of pilot year APPUC will deliver education at SGUL in line with the required 4 pillars and provide revenue to the LAS.

CQOG date : October 2025

Reporting date = August/September 2025

Specialist Practice

Incidents

Number of incidents	Themes
3	CD recording errors, equipment faults, body fluid exposure

Current risks and Concerns

- Uncertainty with national ARRS funding long term with changes to NHSE. No impact currently.
- Recent addition of newly qualified GP's to ARRS funding list for PCNs to access which could result in replacement of LAS paramedics
- Challenges to expansion of programme – very dependent on PCN funding streams

There continues to be a gap in provision for advanced practice within the clinical quality oversight team. This is because the teams have moved out from RSA and their new location does not have a direct link. This is being worked through with the clinical quality team.

Performance

CPI Compliance:
Due to go live in October

Performance:

Utilisation	50.23%
On Scene Time	87.86 minutes
Job Cycle Time	104.18 minutes
Discharge on Scene	41.19%
Recontact Rate	2.26% - nil blue calls or deaths

Supervision Shifts:
August: 7 (low due to annual leave of team and CS)
September: 5 (low due to recruitment for tSPPC >qSPPC)
Year to Date: 77
Target: 3x a year current staff = 48

Cover: no minimum cover standardised due to small number within the band 7 team. For review after next recruitment.

Learning

Learning from incidents - None

Compiled by: Hannah Russell

Presented by: Alison Blakely

Information for : Assurance

CQOG date : October 2025

Reporting date = August/September 2025

Specialist Practice

Training

Mandatory Training Compliance:
- Stat/Man = 73.77% - highlighting the need to complete with clinicians on supervision, appraisals, monthly forum and email.

Academic Progress:
Cumbria course
- Recent pass of PGCert for 8 clinicians
- 1 pending resit result

SGUL course
- First cohort progressing well all passed module 1
- Second cohort started September'25

Prescribing courses
-Staggered starts at Hertfordshire and SGUL for Oct'25, Jan'26, March'26 to avoid overloading through winter pressures

Attendance at Training Days:
CGDs (required to attend 2 per annum):
- September; *Paediatrics - Emergency presentations + ALS refresher* = 20

Current Training Requirements:
-All qSPPC to be trained in catheter trouble shooting approval granted at all relevant governance groups. Awaiting video creation from comms and equipment delivery.

Assurance over revalidation, qualification, recertification:
- All re-registered with HCPC

Assurance

- tSPPC training group, audited via sector/group audit/CPI
- qSPPC group, CPIs creation in progress and update to go live 1st October. Interim solution, spot checks of ePCRs and individual feedback provided

Further updates/ ongoing work

Clinical Updates:

- Catheter care: Clinical Operating procedure approved at CAG and PSCEG. Training package for qSPPC group being created.
- Pilot for 5 qSPPC to undertake independent & supplementary prescribing module from September 2025. Skill to only be used within the primary care setting. Currently working with local PCN teams to create formulary and ensure auditing process available

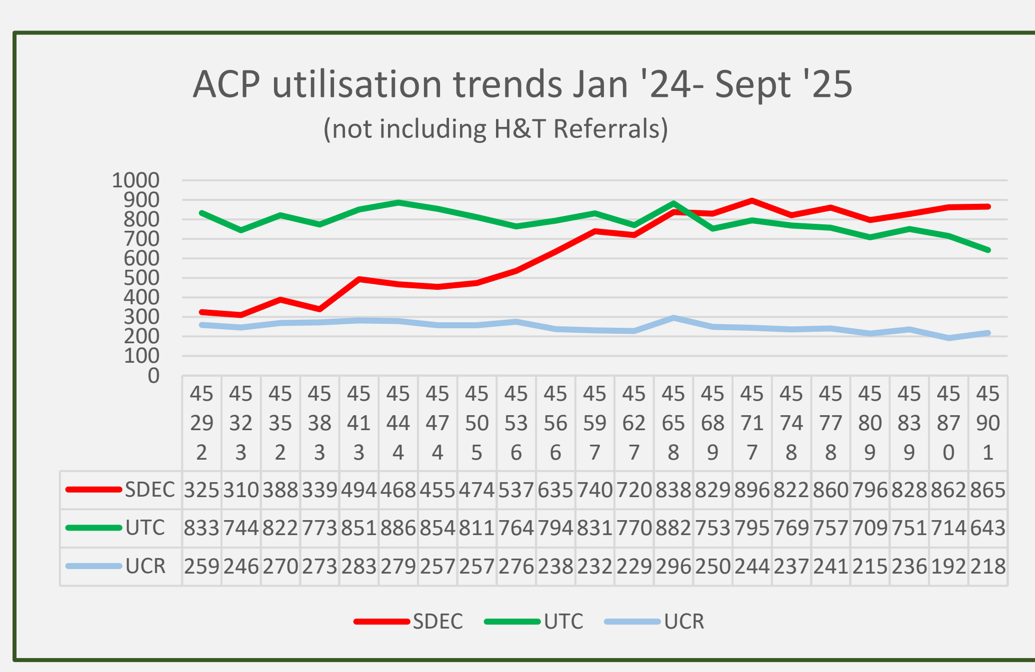
Operational Updates:

- SPPC vehicles transitioning to new liveried vehicles taking place beginning OCT. Risk: Current vehicles have no visible rear warning lights when boot open at scene.

3rd Party Oversight & Alternative Pathways

We are the capital's emergency and urgent care responders

Alternate Pathways



	45292	45323	45352	45383	45413	45444	45474	45505	45536	45566	45597	45627	45658	45689	45717	45748	45778	45809	45839	45870	45901
SDEC	325	310	388	339	494	468	455	474	537	635	740	720	838	829	896	822	860	796	828	862	865
UTC	833	744	822	773	851	886	854	811	764	794	831	770	882	753	795	769	757	709	751	714	643
UCR	259	246	270	273	283	279	257	257	276	238	232	229	296	250	244	237	241	215	236	192	218

Variation in trends for face to face referrals to alternative care pathways

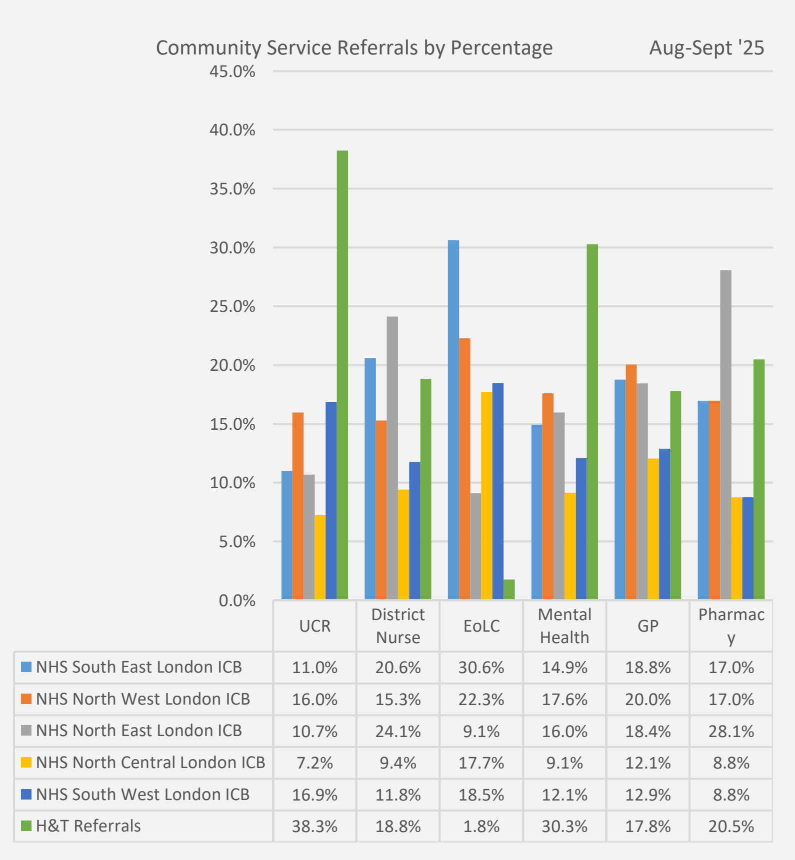
SDEC Same Day Emergency Care

Increase in SDEC referrals due to the adoption of a Trusted Assessor approach, utilising exclusion criteria.

All sites now Trusted Assessor within SWL, NWL, NCL.

UTC Urgent Treatment Centre, recent decrease in referrals.

UCR Urgent Community Response, referrals constant despite initiatives. Collaborative action plan agreed by LAS, NHSE region and ICBs on track.



	UCR	District Nurse	EoLC	Mental Health	GP	Pharmacy
NHS South East London ICB	11.0%	20.6%	30.6%	14.9%	18.8%	17.0%
NHS North West London ICB	16.0%	15.3%	22.3%	17.6%	20.0%	17.0%
NHS North East London ICB	10.7%	24.1%	9.1%	16.0%	18.4%	28.1%
NHS North Central London ICB	7.2%	9.4%	17.7%	9.1%	12.1%	8.8%
NHS South West London ICB	16.9%	11.8%	18.5%	12.1%	12.9%	8.8%
H&T Referrals	38.3%	18.8%	1.8%	30.3%	17.8%	20.5%

Digital innovations to improve ACP utilisation under development, anticipated release November ’25

MiDOS integration with ePCR, will auto populate postcode and streamline searching for services.

‘Virtual referral button’ in ePCR, will enable clinicians to notify Integrated Care Coordination Hubs, Clinical Hub and specific pathways of their case, enable access to live ePCR and provide contact details for call back, supporting clinical decision making.

- **Winter planning**
- Posters to summarise sector based ACPs and education videos being produced.
- Focus on Integrated Care Coordination Hub development

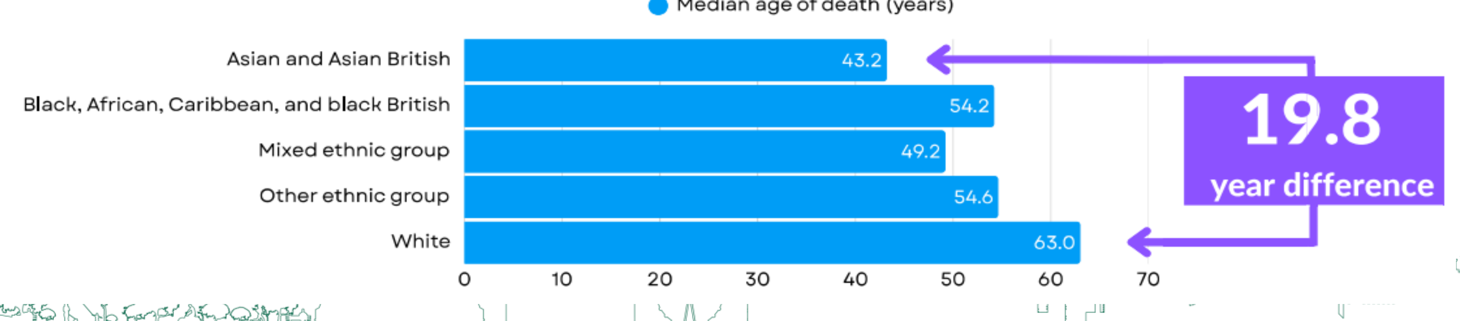
LEDER report 2023 - Overall demographic and data highlights

Learning Disabilities

Adults with a learning disability die **19.5 years younger** than the general population

38.8% of deaths were **avoidable**

Key contributors to avoidable deaths were:
-Delays in care and treatment
-Issues with organisational systems
-Gaps in care provision
-Diagnosis and treatment guidelines were not met.



Autism

The **top 5 comorbid physical health conditions** are:

1. Cardiovascular conditions
2. Constipation
3. Respiratory conditions
4. Impaired mobility
5. Diabetes

Suicide, misadventure or accidental death is the most common cause of death for autistic adults that had a LEDER review

54.5% had a diagnosis of depression

42.5% had a diagnosis of anxiety disorder

Key contributors to avoidable deaths were:
-Inadequate training for staff around autistic adults needs
-Lack of awareness around autistic adults needs
-Insufficient referrals to specialist services

Compiled by: Jessica Howe

Presented by: N/A

Information for noting

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

London's Air Ambulance

NO DATA PROVIDED

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

Safe | Effective | Caring | Improve

Priority | Owner | Exec Lead: FW

Physicians Response Unit

NO DATA PROVIDED

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

Risk

Corporate Risk Register & New Risks of Note

We are the capital's emergency and urgent care responders

CQOG date : 07 Oct 2025

Reporting date = Sept 2025

Risk

Current risks and Concerns

- There are currently 45 out of 124 risks overdue for review (an increase of 19 from last report), with 5 overdue by 40 days or more.
- Risk controls provide assurance of action taken or planned to mitigate risk and give assurance of active risk management. There are 124 open risks, 66 of there have no implemented risk controls, and 49 have no risk controls listed at all.
- There are currently 21 draft or awaiting approval risks, these are going to be reviewed by the risk team and owners approached to determine if they are they require making live. Some have already been updated following RCAG.

Performance

•**Corporate Trust Wide Risk Register** (CTWRR) - The CTWRR contains a total of 38 risks that have the potential to affect more than one area of the organisation, or may require input from multiple areas to mitigate.
•The highest rated risk on the register is scored at 20, with a further 8 risks scoring 15 or above.

•**Other Risk Registers** – There is 1 risk rated 15 and above.

•**Longstanding risks** – There are now 10 risks that are 5 years or older. 2 of these are due to be closed shortly.

Learning

- Risk training and workshops continue to be provided to those teams that would like them. This includes a presentation on risk management in the LAS with a chance to ask any questions, followed by a short workshop to help identify risks.
- During this reporting period this was provided to the North West Sector and People and Culture.

Compiled by: Stuart Fitch

Presented by: Stuart Fitch

Information for : Assurance

CQC & Assurance

londamb.lascqcevidence@nhs.net

We are the capital's emergency and urgent care responders

CQOG date : 7th October 2025

Reporting date = September 2025

Quality Regulation and Assurance

Trust Wide Compliance

- 1098 overdue incidents (as at 1st October 2025)
- 85.80% PDR compliance
- 74% OWR compliance
- 84.80% CISO compliance
- 5.54% Vacancy Rate compliance
- 7.10% Sickness compliance
- 88.84% Stat & Man compliance
- 89.48% Safeguarding L2 compliance
- 89.97% Safeguarding L3 compliance
- 76.92% Safeguarding Trust Board
- 79.16% IPC L1 compliance
- 58.69% IPC L2 compliance
- DoC data unavailable at time of report

CQC Preparation

- Working with Sarah Rodenhurst-Banks & Sarah Brooks to draft a table top exercise for ExCo.
- Table Top exercise planned for 10th August with 999 Ops SLT.
- "You Said, We Did" posters developed and distributed across sectors.
- Clinical Quality Programme Board developed to include further projects and to monitor progress of these including sector improvement plans.

CQC Update

- Since the last CQOG, LAS has received 1 CQC enquiry. 1 has been closed, 1 remains open.
- South East Coast Ambulance Service had an unannounced inspection focussing on meds.
- South Central Ambulance Service & East of England still waiting for their inspection reports.
- CQC are continuing to review the number of Quality Statements with the aim of reducing them further, due to duplication.

CQC Enquiries

The CQC have raised **2** since the last Quality Report submission.

All enquiries have been responded to within the deadline.

No. Received	CQC Reference	Date Received	Response Deadline	Date Responded	Managed By	Closed/ Open	Description of Enquiry
11	CAS-1058520-Q0P8S8 CRM:001353000226	13/09/2025	19/09/2025	Response - 16/09/25		APitcher	Closed
12	CAS-1086472-J7B5C8 CRM:001353000233	07/10/2025	14/10/2025	Acknowledgement - 07/10/2025 Initial response - 15/10/25		CClubley	Open

NB: Data correct on 20/10/2025.

8. Concluding Matters

For Noting

8.1. Any Other Business

For Noting

Questions from the public

8.2. Date of Next Meeting – Thursday 5 March 2026

For Noting

Presented by Andy Trotter