# Trust Board Meeting in Public

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| **Schedule** | Thursday 5 March 2026, 13:15 — 16:00 GMT |
| **Venue** | LAS HQ, Boardroom 220 Waterloo Road  London SE1 8SD |
| **Organiser** | Committee Secretary |

## Agenda

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# Agenda

London Ambulance Service NHS Trust

# MEETING IN PUBLIC OF THE BOARD OF DIRECTORS

1.15pm on Thursday 5th March 2026
At HQ Boardroom, 220 Waterloo Road, London SE1 8SD

## 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 4 December 25 | Chair | Approve | Report |
| | 2.2 | Action Log | Chair | Review | Report |
| **3. Staff Story** | | | | | |
| 1.25 | 3.1 | Success of Integrated Care Coordination Hubs<br>Dr Cleaver | FW | Inform | Present |
| 1.45 | 3.2 | Reflections of the Consultant Paramedic & Associate Clinical Director (26 years in Service)<br>Mark Faulkner | MF | Inform | Present |
| **4. Chair and Chief Executive Report** | | | | | |
| 2.05 | 4.1 | Report from the Chair | Chair | Inform | Verbal |
| 2.10 | 4.2 | Report from the Chief Executive | CEO | Inform | Report |
| **5. Director and Board Committee Reports** | | | | | |
| 2.20 | 5.1 | **Performance**<br>5.1 Operational Performance Report: Chief Paramedic | PC | Assure | Report |
| 2.35 | 5.2 | **Quality**<br>5.2.1 Quality Report: CMO and Deputy CEO<br>5.2.2 Quality Assurance Committee Report | FW<br>KB | Assure | Report |
| 2.50 | 5.3 | **People and Culture**<br>5.3.1 Director's Report<br>5.3.2 People and Culture Committee report | SS<br>AR | Assure | Report |
| 3.05 | 5.4 | **Finance**<br>5.4.1 Director's Report<br>5.4.2 Finance and Investment Committee Report | RPa | Assure | Report |

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| | | | BA | | |
| 3.15 | 5.5 | **Audit Committee Report** | RP | Assure | Report |
| 3.20 | 5.6 | **Report from LAS Charity Committee** | BA | Assure | Report |
| 3.25 | 5.7 | **Digital and Data**<br>5.7.1 Directors Report<br>5.7.2 Digital and Data Committee Report | <br>CM<br>CM | Assure | Report |
| 3.40 | 5.8 | **Corporate Director's Report** | JC | Assure | Report |
| **6. Assurance** | | | | | |
| 3.45 | 6.1 | Board Assurance Framework | JC | Approve | Report |
| 3.50 | 6.2 | NHSE Provider Capability Assessment Rating | JK | Note | Report |
| **7. Concluding Matters** | | | | | |
| 3.55 | 7.1 | Any Other Business | All | Note | Verbal |
| 4.00 | 7.2 | Date of Next Meeting – Thursday 14th May 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 4 December 2025

For Approval

Presented by Andy Trotter

London Ambulance Service NHS Trust

**Meeting in Public**
**LONDON AMBULANCE SERVICE NHS TRUST BOARD OF DIRECTORS**
**Held at 1.15pm on Thursday 4th December 2025 at Prospero House, 241 Borough High Street, London SE1 1GA**

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| **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 |
| 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 |
| Pauline Cranmer | PC | Chief Paramedic Officer |
| Simon Stewart | SS | Acting Chief People Officer |
| Roger Davidson | RD | Chief Strategy and Transformation Officer |
| Clare McMillan | CM | Chief Digital Officer |
| Nic Daw | ND | Acting Director of Corporate Affairs |
| **In Attendance** | | |
| Jo Cripps | JC | Incoming Director of Corporate Affairs |
| Nora Hussein | NH | Head of Corporate Governance |
| Kamran Raja | KR | Business Manager to CEO |
| **Apology for Absence** | | |
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| **1.OPENNG ADMINISTRATION** | | |
| 1. | **Welcome and Apologies** | |
| 2. | **Declarations of Interest**<br>There were no new declarations of interest. | |
| **2. GENERAL BUSINESS** | | |
| 2.1 | **Minutes of the Previous Public Board Meeting**<br>The Minutes of the previous public meeting of the Board held on 11 September 2025 were approved as a correct record. | |
| 2.2. | **Action Log**<br>There were no outstanding actions on the action log. | |
| **3. STAFF STORY** | | |
| 3.1 | **Community First Responders (CFR)** | |

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| | FW welcomed Sam, Graham and Caroline (CFR's) who attended to present.<br><br>The Board received a presentation on the scheme following its transition into London Ambulance Service governance arrangements earlier in the year.<br><br>Members noted that the scheme had successfully onboarded volunteers under LAS governance and training standards. Over 80 volunteers had completed training, with several hundred volunteer hours delivered since launch. Deployment through the LAS dispatch system had improved mobilisation, visibility and integration with frontline crews.<br><br>The Board noted that the scheme forms part of the Trust's strategic ambition to improve cardiac arrest survival rates and strengthen community resilience. Recruitment campaigns are planned to expand the scheme, particularly targeting areas of health inequality and communities with lower bystander CPR rates.<br><br>The Board formally acknowledged the contribution of CFR volunteers. | |
| **4. CHIEF EXECUTIVE REPORT** | | |
| 4.1 | **Report from the Chair**<br>The Board noted the Chairman's Report. | |
| 4.2 | **Report from the Acting Chief Executive**<br>The Board received the Chief Executive's report and noted:<br>• Winter preparedness measures commenced earlier than previous years.<br>• Resource Escalation Action Plan (REAP) level had been increased to Level 3 on 13 November 2025 due to rising 999 demand.<br>• Category 2 Auto Dispatch was introduced in August 2025 and is delivering an average three to four minute improvement in Category 2 response times.<br>• Engagement activity with staff continues through roadshows and organisational briefings.<br>• Integrated Urgent Care (IUC) developments include successful award of the North East London contract and preparation for South East London procurement.<br>• A five-year demand and capacity review has been commissioned, with findings expected in 2026.<br>• The NHS England Medium Term Plan requires delivery of Category 2 performance of 25 minutes in 2026/27 and 18 minutes by 2028/29.<br><br>The Board noted the Chief Executive's report. | |
| **5. Director and Board Committee Reports** | | |
| 5.1 | **Performance**<br>PC presented the Operational Performance Report for August - October 2025.<br><br>It was reported that:<br>• Incident volumes were 5.7% above plan year-to-date.<br>• 843,900 incidents had been managed to 31 October 2025.<br>• Category 2 mean performance was 29 minutes 59 seconds year-to-date, remaining below the 30-minute threshold and significantly improved compared to 2024.<br>• Category 1 mean performance was 6 minutes 55 seconds year-to-date.<br>• Hear and Treat performance was 22.3% in October and above plan year-to-date. | |

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| | • Reductions of 60% in 90+ minute waits and 75% in 120+ minute waits had been achieved compared to the previous year.<br>• Job Cycle Time (excluding handovers) was 83 minutes year-to-date, 1 minute 27 seconds above plan.<br>• Hospital handover times averaged 23 minutes 42 seconds year-to-date, above plan.<br><br>The Board discussed the impact of Category 2 Auto Dispatch on operational performance. It was acknowledged that while response times had improved, the system had contributed to an increase in Job Cycle Time. Ongoing work was confirmed to refine dispatch parameters to balance performance gains with operational efficiency.<br><br>Hospital handover delays were recognised as continuing to place pressure on system performance. Engagement with hospital partners was ongoing.<br><br>The Board discussed Priority 2 call-back performance, noting that earlier months had been below target. Consideration was given to whether patients waiting for call-back might subsequently present elsewhere in the system.<br><br>The Board agreed the following **actions**:<br>• Director of Integrated Urgent Care (IUC) to establish whether C2 patients who are not called back within the target time are going elsewhere in the system (e.g., A&E / walk-in), and whether data can be gathered with commissioners to evidence this.<br>• QAC to own the action and report to Board quarterly (assign to QAC)<br>• Integrated performance Report<br>• Director of Performance to refresh the Integrated Performance Report and review SPC methodology to ensure the right headline quality metrics; then take through committees before returning to the Board. | **PC** |
| 5.2<br><br>5.2.1 | **Quality**<br><br>**Quality Report: CMO and Deputy CEO**<br>FW presented the Quality Report.<br><br>Demand from patients presenting with mental health conditions continued to rise. A structured mental health assessment tool had been implemented within the electronic patient record to strengthen documentation and consistency. A significant proportion of mental health patients continued to be managed safely at home.<br><br>Violence, aggression and abuse toward staff remained the highest reported incident categories. The majority of incidents were recorded as low or no harm, with cases involving harm escalated through established patient safety processes.<br><br>During the reporting period, 217 structured judgement reviews were completed following patient deaths, with 83% requiring no further action. Learning identified was progressed through governance routes.<br><br>The Board noted the annual reports on controlled drugs, infection prevention and control, cardiac arrest and STEMI. Cardiac arrest outcomes had improved, with return of spontaneous circulation achieved in 47% of cases during August.<br><br>Members sought assurance regarding continued action on violence and aggression. FW confirmed this remained a priority and was subject to ongoing monitoring. | |

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| 5.2.2 | **Quality Assurance Committee Report**<br>KB presented the Quality Assurance Committee report. He confirmed that the Committee had reviewed quality performance, patient safety themes, digital clinical safety risks, and the emerging data relating to violence and aggression.<br><br>He advised that:<br>• No new matters required formal escalation to Board.<br>• Radar incident reporting transition had not reduced reporting levels.<br>• The Committee had triangulated safety data with performance trends.<br>• Cyber and digital clinical safety risks were now being reviewed in an integrated manner.<br><br>The Committee had discussed externally commissioned audit work and agreed to refine future assurance approaches to ensure timeliness and relevance.<br><br>The Board discussed mental health demand and the sustained high volume of violence-related incidents. It was confirmed that violence remains a persistent theme across reporting. | |
| 5.3 | **People and Culture** | |
| 5.3.1 | **Report from the Acting Chief People Officer**<br>Workforce fill rates remained strong at approximately 98%, with recruitment and forward planning aligned to financial assumptions.<br><br>Employee relations case volumes and tribunal activity had increased. Enhanced digital tracking and bi-monthly Non-Executive oversight were in place to strengthen case management. The Board emphasised the importance of timely resolution.<br><br>Sickness absence remained at approximately 7%. The Wellbeing Team had been refocused on earlier intervention and return-to-work support.<br><br>WRES and WDES metrics showed continued improvement in representation and appointment indicators; however, staff-reported bullying and harassment had not materially improved. AR and SC expressed concern and highlighted the role of middle management behaviours. SS confirmed equality objectives were in place and leadership development for first-line supervisors was being rolled out.<br><br>The Board agreed continued scrutiny through the People and Culture Committee. | |
| 5.3.2 | **People and Culture Committee Report**<br>AR summarised the most recent PCC meetings.<br><br>The Committee had focused on:<br>• 111 turnover (mid-30%) and retention pathways.<br>• Employee relations caseload and tribunal exposure.<br>• Leadership development programmes.<br>• Workforce equality metrics (WRES/WDES).<br>• Violence against staff (new BAF risk).<br><br>During Board discussion, SC and AR raised concern about persistent high levels of staff reporting bullying or harassment by managers. AR emphasised that middle management behaviours are key drivers of culture.<br><br>SS acknowledged the concern and confirmed:<br>• Leadership development programmes are being rolled out. | |

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| | • Equality objectives had been set for senior leaders.<br>• Evaluation of impact would be strengthened.<br>• Executive Leadership Team would undertake deeper accountability review.<br><br>The Board agreed that this issue required deeper analysis at PCC. | |
| 5.4 | **Finance** | |
| 5.4.1 | **Director's Report**<br>RPa presented the Quarter 2 Finance Report.<br><br>The Trust reported a year-to-date surplus of approximately £1.1m at Month 4, with a full-year breakeven forecast maintained. The position reflected continued operational pressures and recognised winter demand risk. Incident volumes were 5.7% above plan year-to-date, with additional growth funding secured to support increased DCA hours.<br><br>Pay expenditure remained aligned to establishment plans and non-pay costs were closely monitored. Financial controls remained in place.<br><br>The 2025/26 capital allocation totalled £77m. Although expenditure was slightly behind phasing, delivery plans were in place to achieve full utilisation. Investment priorities included fleet replacement, electrification infrastructure, estates and digital infrastructure. Substation works were progressing and four electric DCAs were operational.<br><br>The Trust's cash position remained stable. Sensitivity modelling had been undertaken to assess winter risk, with mitigations identified and oversight continuing through the Finance and Investment Committee. | |
| 5.4.2 | **Finance and Investment Committee Report**<br>BA confirmed that FIC had reviewed:<br>• Delivery of the breakeven plan.<br>• Capital programme phasing.<br>• Productivity and efficiency measures.<br>• Cash management.<br>• Fleet electrification investment risks.<br><br>The Committee was satisfied that financial controls were in place and that the Trust remained on trajectory for breakeven, subject to winter pressure risk. | |
| 5.4.3 | **Audit Committee Report**<br>RP reported that Audit Committee had reviewed:<br>• Workforce overpayments (external review commissioned).<br>• Internal audit outcomes (substantial assurance on suicide prevention).<br>• BAF movements (violence risk and commissioned network risk increased).<br>• Cyber security integration and resilience planning.<br><br>The Committee endorsed improved integration of IG, cyber and resilience reporting. | |
| 5.5 | **Digital and Data Report**<br>CM presented the Director of Digital and Data report.<br><br>Progress continued on core infrastructure modernisation, including renewal of legacy systems supporting 999 and IUC. Real-time dashboards had enhanced operational visibility, and AI and automation initiatives were advancing across clinical and operational areas. Work was underway to strengthen benefits realisation frameworks. | |

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| | Following Committee review, BAF risk 2.6 relating to critical infrastructure had been repositioned within tolerance, with the risk score adjusted from 10 to 12 to reflect delivery timing uncertainty rather than system deterioration. CM confirmed this represented prudent recalibration while infrastructure projects progressed.<br><br>The Board emphasised the need for clear KPIs to demonstrate measurable benefit and operational impact as digital initiatives moved into deployment.<br><br>The Board agreed the following **actions**:<br>• A Board development session should be arranged to explore the benefits of technology, including productivity improvements and the digital front door, and invite relevant partners to contribute insights.<br>• Conduct and report on an organisational cyber incident response exercise, providing assurance to the board on preparedness and recovery plans. | **CM** |
| 5.5.1 | **Digital and Data Quality Committee Report**<br>SD reported that the Committee had:<br>• Reviewed the draft AI policy.<br>• Requested cross-committee review (PCC and QAC) before final approval.<br>• Reviewed the Digital Directorate restructure and requested a deeper review at next meeting.<br>• Emphasised need for clearer digital benefits realisation KPIs.<br><br>The Board discussed AI governance risks and assurance mechanisms. | |
| 5.6 | **Corporate Affairs – Director's Report**<br>ND reported that complaints performance within 35 days had fallen to 65% against a 74% target due to capacity pressures within the team. Mitigations were in place to recover trajectory by Q4.<br><br>He also updated on the legal services tender process, with six bids received and moderation scheduled for 8 December.<br><br>Information governance compliance stood at 95% of staff trained, described as a positive position.<br><br>The Board noted the Director and Board Committee Reports. | |
| **6. ASSURANCE** | | |
| 6.1 | **Board Assurance Framework (BAF)**<br>ND presented the updated BAF.<br><br>He confirmed that committees had reviewed relevant risks. One adjustment had been made within Digital and Data, increasing risk 2.6 relating to critical infrastructure replacement from 10 to 12 to reflect delivery uncertainty.<br><br>CM clarified that this was a risk repositioning rather than a deterioration, pending further progress on infrastructure projects.<br><br>The Board approved the Board Assurance Framework. | |
| 6.2 | **Southern Ambulance Services Collaboration (SASC)**<br>JK provided an update on collaborative procurement, digital and AI initiatives across southern ambulance trusts. | |

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| | He acknowledged that progress had been slower than anticipated but confirmed that business cases were now developing, particularly in digital and AI. A CEO letter was being circulated across trusts to reinforce commitment at executive level.<br><br>Board members discussed the challenge of embedding collaboration below senior leadership levels and the importance of tangible delivery.<br><br>The Board noted the update. | |
| **7. FOR INFORMATION** | | |
| 7.1 | **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports**<br>The Board noted the annual WRES and WDES reports. The reports outlined progress in workforce representation, recruitment and disciplinary indicators, alongside areas requiring further improvement, particularly staff experience indicators relating to bullying, harassment and inclusion.<br><br>It was noted that these metrics continued to be scrutinised in detail through the People and Culture Committee. No further discussion was required under this agenda item.<br><br>The Board agreed the following **actions:**<br>• Seek feedback from senior leaders on progress against the equality objectives they set earlier in the year, and report back highlighting learning and examples of best practice to share across the Trust.<br>• Benchmark the Trusts EDI performance against similar Trusts to identify areas for improvement. (assign the action to PCC). | **RD** |
| 7.2 | The Board noted the following reports:<br>1. Cardiac Arrest Annual Report<br>2. STEMI Annual Report<br>3. Quality Dashboard | |
| **8. CONCLUDING MATTERS** | | |
| 8.1 | **Any Other Business**<br>No other business. | |
| 8.2 | Date of Next Meeting 5 March 2026. | |

# 2.2. Action log

For Discussion

Presented by Andy Trotter

NHS London Ambulance Service NHS Trust

# TRUST BOARD IN PUBLIC – ACTION LOG – MARCH 2026

| Meeting | ACTION | LEAD | Due | UPDATE |
|---|---|---|---|---|
| **Dec 25** | **Board Development on Digital and Technology**<br>Arrange a board development session to explore the benefits of technology, including productivity improvements and the digital front door, and invite relevant partners to contribute insights. | CM | | Session to be arranged in Q1. |
| | **111 call-back delays – system impact**<br>• Jackie Niner to establish whether C2 patients who are not called back within the target time are going elsewhere in the system (e.g., A&E / walk-in), and whether data can be gathered with commissioners to evidence this.<br>• QAC to own the action and report to Board quarterly (assign to QAC) | PC | | Closed<br><br>In the CPO report |
| | **Integrated performance Report**<br>ND to refresh the Integrated Performance Report and review SPC methodology to ensure the right headline quality metrics; then take through committees before returning to the Board. | ND | | Closed |
| | **Cyber Incident Response Assurance**<br>Conduct and report on an organisational cyber incident response exercise, providing assurance to the board on preparedness and recovery plans. | CM | | Closed<br>Outcome of the exercise to be presented to Audit Committee in Q1 |
| | **Review of Published Equality Objectives**<br>Seek feedback from senior leaders on progress against the equality objectives they set earlier in the year, and report back highlighting learning and examples of best practice to share across the Trust. | RD | | Closed<br>We have invited leaders across LAS to share their work on inclusion and identified good practice that we plan to share across the organisation. |

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| | **Benchmarking EDI Performance:**<br>Benchmark the Trusts EDI performance against similar Trusts to identify areas for improvement. (assign the action to PCC). | RD | | Closed<br>We have led the production of a maturity matrix for the ambulance sector, assessed ourselves against it and compared ourselves with the broader sector. We will continue to benchmark ourselves on WRES and WDES standards. This work will report People and Culture Committee. |

# 3. Staff Story

For Information

# 3.1. Success of Integrated Care Coordination Hubs

Dr Cleaver

# 3.2. Reflections of the Consultant Paramedic & Associate Clinical Director - 26 Year Service

Mark Faulkner

# 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
# Meeting of the Trust Board on 5 March 2026

## Report from the Chief Executive Officer

### Introduction

1. We have come through a demanding winter with strong performance and real commitment from our people. Our patient waiting times in December were the best they have been for five years, and almost one in four patients received the care they needed over the phone – avoiding unnecessary ambulance dispatches and patient conveyances to busy Emergency Departments. This reflects the impact of our dedicated winter planning, and how focused and resilient our teams continue to be.

2. I have spent time with crews and staff at our new CEO Roadshows, where the executive team travel to ambulance sites across the capital to hear feedback from staff and engage directly with our people on the issues that matter to them). I have also spent time on ride outs with crews, visiting training days and undertaken other site and station visits.

3. On New Year's Eve, I joined our teams deployed in central London where I was able to meet and gain valuable insight from colleagues across the event footprint which included responding to patients. These conversations continue to deepen my insight into the operational and emotional pressures our people face and highlight where further support and investment will have the greatest impact.

4. Our conversations through Team Talk Live, weekly video updates and direct engagement remain vital as we shape our plans for the year ahead. These channels ensure our priorities are grounded in the real experiences our people have in the workplace. The next phase requires us to maintain stability through operational pressure while sustaining and enhancing momentum on longer term objectives including digital transformation, estate improvements and our progress toward Advanced Foundation Trust (AFT) status.

### Inclusion

5. The Inclusion Board has continued to provide helpful insight from across the organisation, particularly around staff experience, career progression and the impact operational pressure can have on our efforts to improve inclusion.

These perspectives have informed our approach to culture and behaviour, including the Anti-Discrimination Charter that is now being finalised. As our wider engagement structures mature – through Roadshows, Team Talk Live, and now strengthened executive sponsorship of staff networks with regular CEO engagement – we will consider how best to evolve the Inclusion Board's role at its next meeting so that our efforts remain focused, streamlined and aligned to where they add the greatest value.

**Operational update**

6. We escalated to REAP 4 on 2 December and subsequently deescalated to REAP 3 and then REAP 2 on 21 January and 18 February respectively. Our teams have shown exceptional focus and professionalism throughout this period, and I want to thank everyone across our organisation for their sustained commitment to delivering safe, high-quality patient care throughout the winter period.

7. Since December, we have managed a small number of declared Significant Incidents and Business Continuity Incidents, reflecting the pressures and operational risks typical of the winter period. These incidents included a large fire in a multi occupancy residential premises, and a road traffic collision involving two double decker busses and were effectively contained through established command structures, timely internal escalation and close coordination with partner agencies. In each case, services were maintained, mitigations were enacted quickly, and learning has been captured to further strengthen our resilience and response arrangements.

8. We continue to refine our approach to production and distribution in our emergency medical service with the phase two results from our Demand and Capacity review due in May 2026. This includes increased clinical input to hear and treat pathways, improved dispatch decisions and further work with teams to balance faster and more appropriate patient responses with the lived experience and safety of frontline crews.

**Strategic priorities**

9. In January we drafted updated Trust priorities for the 2026/27 year and have held discussions with staff about how we can focus our efforts around these key goals. These priorities now guide our 2026/27 business planning and prepare us for the next stage of sustained improvement.

10. Departments are finalising plans over the next six weeks and this work will inform next year's business plan. Our spring roadshows in April will be a critical moment to share the next phase of our strategy with teams across the capital. These discussions will focus on how we best align our demand and capacity, the evolution of our clinical response model and how we prepare for the changes set out in the NHS England Medium and Long Term Plans.

**Digital transformation**

11. Our digital ambitions continue to grow and are increasingly integral to how we improve patient experience and staff efficiency. The IBM workshop on 19 January has helped us shape our next steps and we are developing plans for adopting the latest technology and improving the experience we provide to patients, including further use of ambient voice technology. We are exploring further digital partnership opportunities and are looking at how we design platforms that reduce duplication and optimise clinical and operational time.

12. I joined colleagues who attended the REROUTE event hosted by Apple, which brought together partners from across the system to explore opportunities for innovation, digital collaboration and improved user experience in urgent and emergency care pathways.

**Business Planning**

13. We have now concluded the full set of 2026/27 business planning bilaterals, which highlighted the significant work and progress delivered by teams across the Trust this financial year. These sessions showcased strong performance, alignment with our strategic priorities, and the continued commitment of directorates to improving quality, outcomes and value for our patients.

**Estates**

14. Major estates work is taking place near Canning Town with plans to improve facilities for teams. Once completed, this state-of-the-art campus -with over £22m of capital investment – will lead the way in providing outstanding emergency care to the population we serve, as well as providing the best environment for our people to work from. This includes a new modern ambulance station, a base for specially trained paramedics in our Hazardous Area Response Team (HART) and improved facilities for vehicle preparation, training and staff wellbeing. We will provide further updates on capital investment and our wider estate improvements in the coming months.

**Integrated Urgent Care and 111**

15. We continue to have constructive discussions with NHS England London on the future of the 111 service. South East London has now opened its tender and we will submit our bid in March.

**Advanced Foundation Trust status**

16. We are carrying out a comprehensive gap analysis to map the remaining work necessary as we move towards securing AFT status. This is one of our priorities for 2026/27. Achieving AFT status will give us greater flexibility in how we use our resources, supporting investment in education, university partnerships and long-term workforce sustainability. Support for our application has been secured from NHS England London and we have communicated our intentions to NHS England.

**Workforce and leadership**

17. I am pleased to confirm that our new Director of Corporate Affairs joined us in January and has now formally taken up her role.

18. Recruitment for the Chief Operating Officer and Chief People Officer has now concluded (by the time Trust Board meets in March), with offers being subject to the completion of standard due-diligence processes. Both roles attracted significant interest, including high—calibre candidates from across the United Kingdom and internationally, reflecting the growing profile and reputation of our organisation. These roles will strengthen our executive leadership team and support the delivery of our priorities.

19. Our first Extended Leadership Group of 2026 took place on 11 February and brought together over 150 senior leaders to focus on organisational priorities, including neighbourhood health and our role within the wider London system. Feedback from colleagues was positive and highlighted a strong appetite for continued clarity on priorities and progress. We are currently in the process of identifying tangible actions arising from engagement and will bring these through ELT over the coming weeks.

20. Going forward our new Executive Leadership Team will now take part in structured development sessions every quarter to support stronger long-term thinking and enhanced leadership creating a high performing team.

**Engagement with External Stakeholders**

21. Since our last report we have continued to welcome high profile visitors from London, the UK and overseas. These visits show the growing interest in our service and give us important opportunities to talk about our winter performance, our plans for improvement and the pressures our people face.

22. We were pleased to welcome Wes Streeting MP, Secretary of State for Health and Social Care, who visited Wimbledon on 18 December. This was a valuable opportunity to show how we prepared early for winter and how we continue to deliver safe care under high pressure.

23. On 3 February, I was pleased to be joined by members of the Board as well as colleagues from NHS England London, the Home Office and the Department for Health and Social Care at a demonstration of our Chemical, Biological, Radiological and Nuclear (CBRN) capability. The demonstration was hosted by the NHS Emergency Capability Unit (ECU) at their bespoke facility in Moreton-in-Marsh and provided valuable insight into the specialist equipment, training and joint working that underpin our HART and wider CBRN response.

24. We were also pleased to have been invited to partake in a national learning event held on 12 January which brought together colleagues from across ambulance services nationally to share learning following recent incidents in Manchester and Huntington.

25. We also welcomed James Murray MP, Chief Secretary to the Treasury, to Dockside on 12 February for National Apprenticeships Week. During the visit we shared how we deliver award winning apprenticeship schemes.

26. Alongside these senior visits, the stakeholder communications team and wider LAS teams hosted a number of other important engagements

    a) Dan Tomlinson MP visited Barnet Ambulance Station on 23 January and met crews and station teams.
    b) Howard Dawber OBE, Deputy Mayor of London visited Dockside Education Centre on 12 February to meet colleagues and hear about our award-winning apprenticeship programme and the wider work across the capital.

c) Craig Wylie, Director of EMS for the Western Cape Government, visited our Waterloo Headquarters on 12 February to learn more about our model and our operational approach
d) Keir Mather MP, Minister for Aviation, Maritime and Decarbonisation, visited our Waterloo Headquarters on 26 February to understand more about our work electrifying our fleet and placing electric chargers across London.

27. These visits strengthen our relationships across local, national and international partners and showcase the professionalism of our people and the scale of the work they deliver every day.

**System engagement**

28. A stakeholder perception audit is currently underway with around fifty strategic partners who will take part. This work will inform our upcoming business plan and will be shared with the Board in a development session.

29. We are also seeking to improve the way in which we engage with patients and their families, and capture their first-hand feedback about the services we provide. In addition to our existing survey for 111 service users, we are looking to create a similar tool for those who need 999, and are reviewing the written patient information we provide.

# 5. Director and Board Committee Reports

# 5.1. Performance

# Operational Performance Report

For Assurance

Presented by Pauline Cranmer

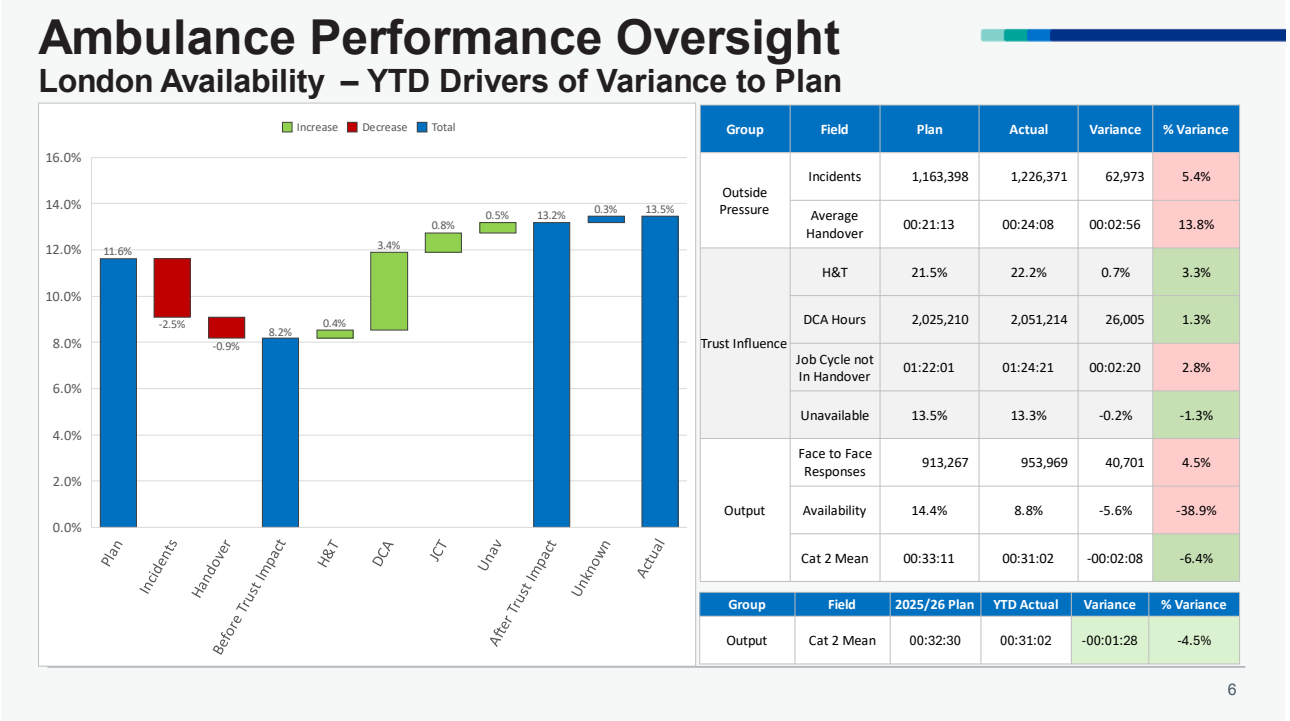
London Ambulance Service NHS Trust

| Report To: | Public Board of Directors | | | |
|---|---|---|---|---|
| Date of meeting: | 5th March 2026 | | | |
| Report title: | Performance Report | | | |
| Agenda item: | 5.1 | | | |
| 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 report provides a summary of performance metrics for the period of 1 November 2025 through to 31 January 2026.

The National NHSE Ambulance team continue to monitor LAS' performance on agreed input metrics as part of the agreed 2025/2026 operating plan. This is summarised in the waterfall chart (figure 1), which shows progress year to date. The LAS is held accountable for those metrics shown as within "Trust Influence".




| Group | Field | Plan | Actual | Variance | % Variance |
|---|---|---|---|---|---|
| Outside Pressure | Incidents | 1,163,398 | 1,226,371 | 62,973 | 5.4% |
| | Average Handover | 00:21:13 | 00:24:08 | 00:02:56 | 13.8% |
| Trust Influence | H&T | 21.5% | 22.2% | 0.7% | 3.3% |
| | DCA Hours | 2,025,210 | 2,051,214 | 26,005 | 1.3% |
| | Job Cycle not In Handover | 01:22:01 | 01:24:21 | 00:02:20 | 2.8% |
| | Unavailable | 13.5% | 13.3% | -0.2% | -1.3% |
| Output | Face to Face Responses | 913,267 | 953,969 | 40,701 | 4.5% |
| | Availability | 14.4% | 8.8% | -5.6% | -38.9% |
| | Cat 2 Mean | 00:33:11 | 00:31:02 | -00:02:08 | -6.4% |

| Group | Field | 2025/26 Plan | YTD Actual | Variance | % Variance |
|---|---|---|---|---|---|
| Output | Cat 2 Mean | 00:32:30 | 00:31:02 | -00:01:28 | -4.5% |

Figure 1: NHSE Operating Plan Monitoring Slide April to January 2026

The LAS dealt with 1,226,371 incidents between 1 April 2025 and to 31 January 2026. This is 5.4% above the operating plan. Of these incidents, 953,686 required a face-to-face response by our frontline staff and was also above plan by 4.5%.

Of those factors within the LAS' control, performance year to date to 31 January 2026 was as follows:

- Hear and Treat - remains at 0.7% above plan at 22.2%. The target for quarter 4 increased to 23% with the LAS delivering 23.5%.
- DCA hours – 2,052,214 hours have been delivered and is 1.3% ahead of plan.
- Job cycle time excluding handovers – was 2 minutes and 20 seconds above plan. This has occurred since the end of August 2025 and coincides with the introduction of the auto-dispatch for category 2 incidents.
- Unavailable time – continues to perform better than plan at 13.3% against a target of 13.5%.

The average hospital handover to 31 January 2026 was 24 minutes 8 seconds and is therefore 2 minutes 56 behind the plan.

LAS continues to be ahead of plan for category 2 performance for the year. As of 31 January 2026, the category 2 mean was 31 minutes 02 seconds. This was 2 minutes 8 seconds ahead of the forecast.

In accordance with the national planning guidance the LAS has now submitted the medium-term operating plan for 2026/27 and following 2 years. Work with the national team and regional ICSs continues and final agreement of plans is expected at some point during March 2026.

**Recommendation/Request to the Board/Committee:**

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

London Ambulance Service NHS Trust

# PUBLIC BOARD OF DIRECTORS MEETING
# **Performance Report – March 2026**

This report provides a summary of performance metrics for the period of 1 November 2025 through to 31 January 2026.

## 1. 2025/2026 Operating Plan

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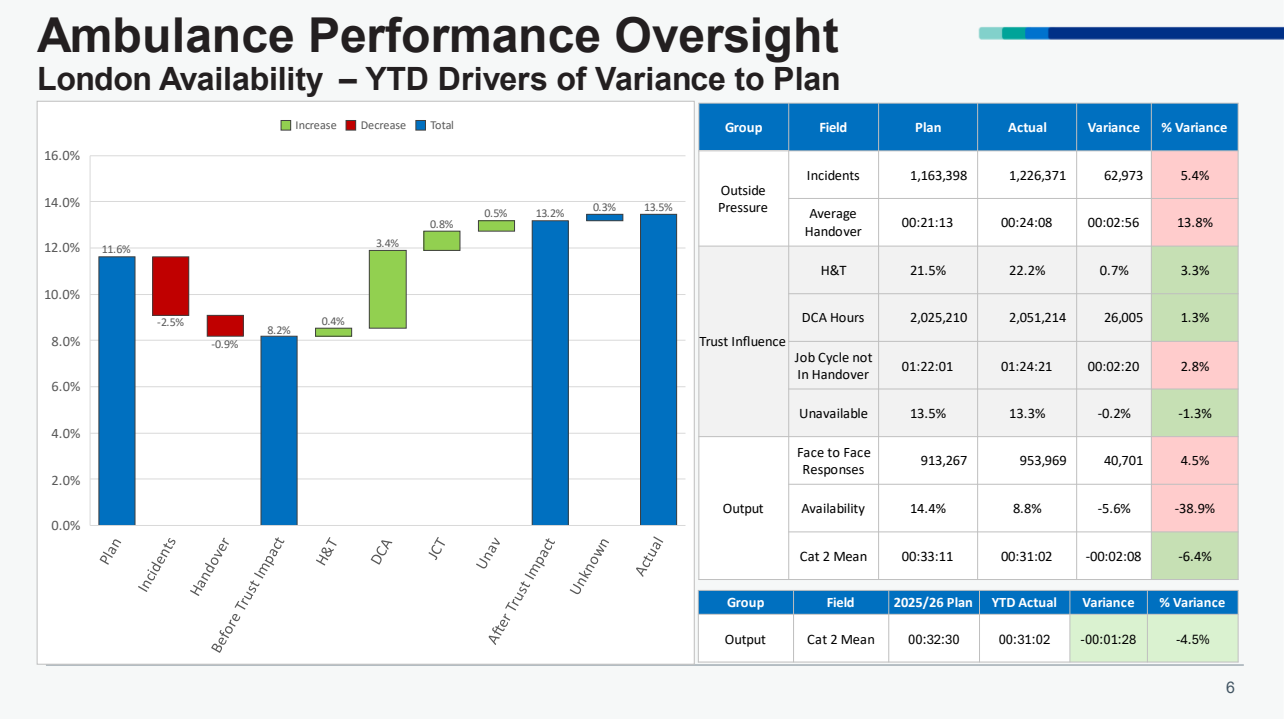


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## 2. Performance Metrics

### 2.1. Call Answering Mean (operating plan metric)

| | | | |
|---|---|---|---|
| November 2025 Target | 10 Seconds | November 2025 Actual | 4 Seconds |
| December 2025 Target | | December 2025 Actual | 3 Seconds |
| January 2026 Target | | January 2026 Actual | 3 Seconds |

The SPC chart shows that the LAS continues to meet the target with common cause variation seen (figure 2).

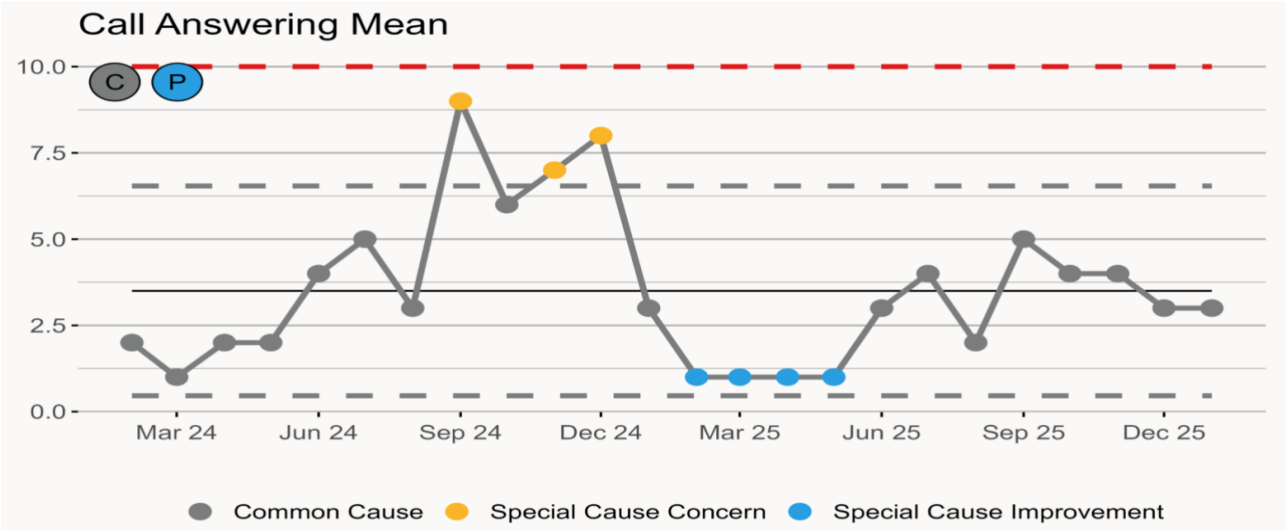



Figure 2: Call answering mean SPC

### 2.2. Category 1 Mean (supporting metric)

| | | | |
|---|---|---|---|
| November 2025 Target | 7 Minutes | November 2025 Actual | 7 Minutes 09 Seconds |
| December 2025 Target | | December 2025 Actual | 7 Minutes 05 Seconds |
| January 2026 Target | | January 2026 Actual | 7 Minutes 02 Seconds |

The LAS has not met the target of 7 minutes in the reporting period. Special cause improvement has continued to be demonstrated since March 2025 and is shown in figure 3 below.

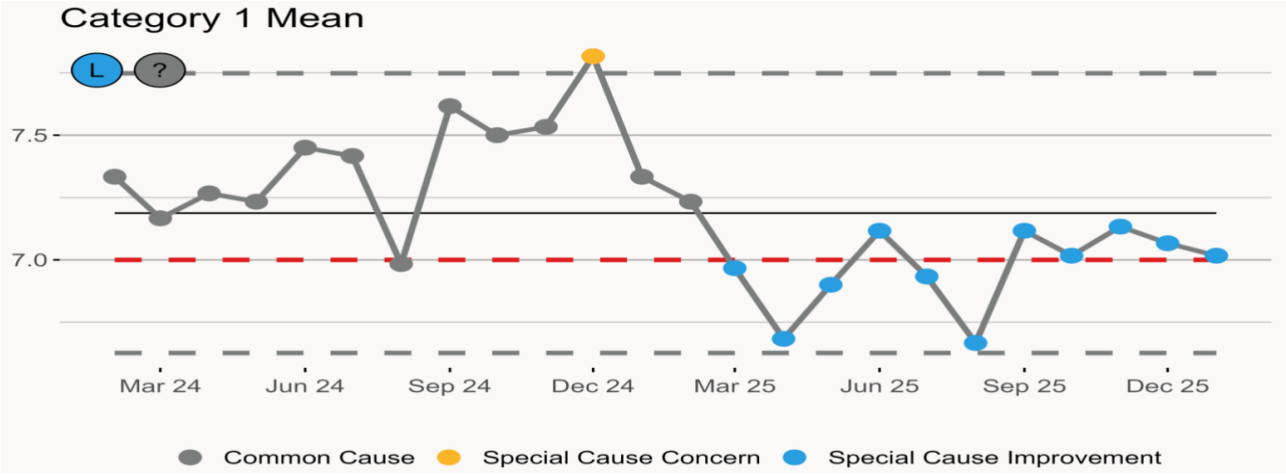



Figure 3: Category 1 Mean SPC

During the winter months there has been a focus to maximise the effectiveness and productivity of the Fast Response Vehicle (FRV) resource. There has been a redistribution of existing resources to ensure better coverage, rather than increase the number of vehicles. Productivity has continued to be a focus of the ambulance operations management team; with time on scene post ambulance arrival, being consistently monitored and reviewed with individuals. Year to date the performance stands at 6mins 58 seconds.

### 2.3. Category 2 Mean (operating plan metric)

| | | | |
|---|---|---|---|
| **November 2025 Target** | 34 Minutes 30 Seconds | **November 2025 Actual** | **35 Minutes 28 Seconds** |
| **December 2025 Target** | 39 Minutes 10 Seconds | **December 2025 Actual** | **32 Minutes 18 Seconds** |
| **January 2026 Target** | 29 Minutes 21 Seconds | **January 2026 Actual** | **32 Minutes 23 Seconds** |

Although the LAS delivered its category 2 performance, ahead of plan, in December by 6 minutes 42 seconds; in both November 2025 and January 2026 the plan was not met by 58 seconds and 3 minutes 2 seconds respectively.

The year to date plan (to 31 January 2026) was 33 minutes 11 seconds. Actual performance was 2 minutes 9 seconds better at 31 minutes 2 seconds.

The statistical process control chart for category 2 (figure 4), has shown common cause variation for the reporting period.

Over the winter period both 999 and ambulance operations have continued to have focused oversight of delivery of services through daily service meetings. This has ensured that we maximise the use of resources by reducing out of service, reviewing job cycle times and appropriate deployment of resources to meet demand. This focus will remain post the winter period.

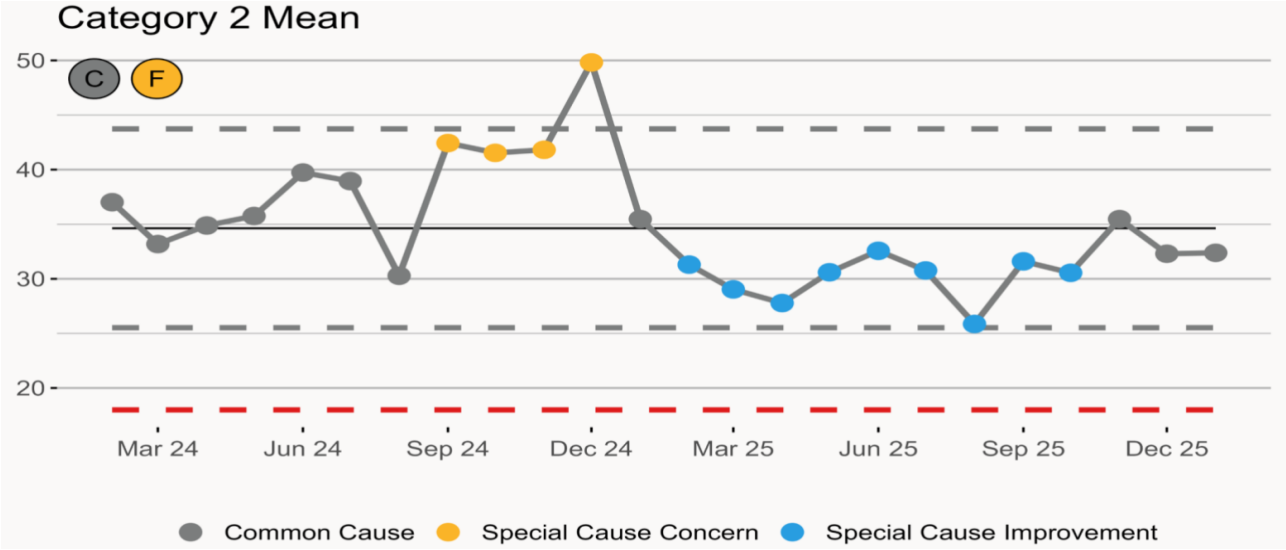



Figure 4: Category 2 mean SPC

## 2.4. Time to dispatch (supporting metric)

| | | | |
|---|---|---|---|
| **November 2025 Target** | 45% or less C2 dispatches greater than 20 minutes | **November 2025 Actual** | **41.4%** |
| **December 2025 Target** | | **December 2025 Actual** | **38%** |
| **January 2026 Target** | | **January 2026 Actual** | **37.9%** |

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 5, compares adherence against this metric for 2024/25 and 2025/26 financial years.

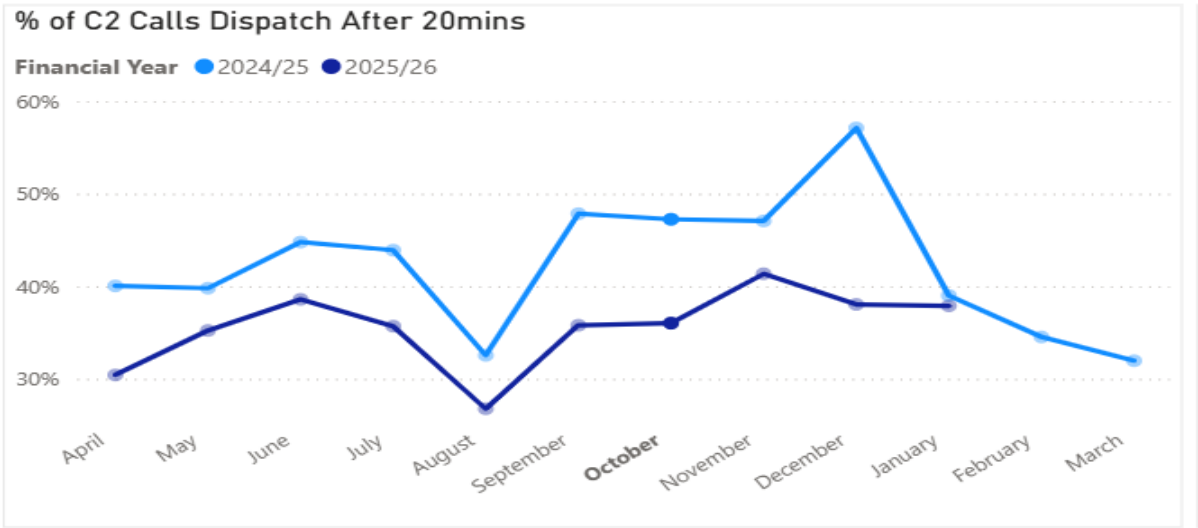



Figure 5: C2 dispatches >20 mins

## 2.5. Cat 2 Distribution (supporting metric)

| | | | |
|---|---|---|---|
| November 2025 Target | Reduction of C2 tail from previous year. | November 2025 Actual | 34.4% reduction |
| December 2025 Target | | December 2025 Actual | 70.3% reduction |
| January 2026 Target | | January 2026 Actual | 30.6% reduction |

There continues to be a reduction in the category 2 tail when comparing the current financial year with the previous. There has been a reduction of 56.8% of incidents taking longer than 90 minutes and a reduction of 71.2% of incidents taking longer than 120 minutes.

The following table compares the number of incidents from 1 April to 31 January for both 2024/25 and 2025/26, with a breakdown of the months contained within this reporting period.

| | April to January 2024/25 | April to January 2025/26 | Diff. | Nov-24 | Nov-25 | Diff. | Dec-24 | Dec-25 | Diff. | Jan-25 | Jan-26 | Diff. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incidents >90 | 50549 | 21836 | 56.8% | 5863 | 3844 | 34.4% | 9002 | 2672 | 70.3% | 4187 | 2906 | 30.6% |
| Incidents >120 | 20713 | 5975 | 71.2% | 2463 | 1315 | 46.6% | 3903 | 675 | 82.7% | 1545 | 766 | 50.4% |

The spread of incidents taking longer than 90 minutes is shown in figure 6, with incidents shown within 5 minute segments.

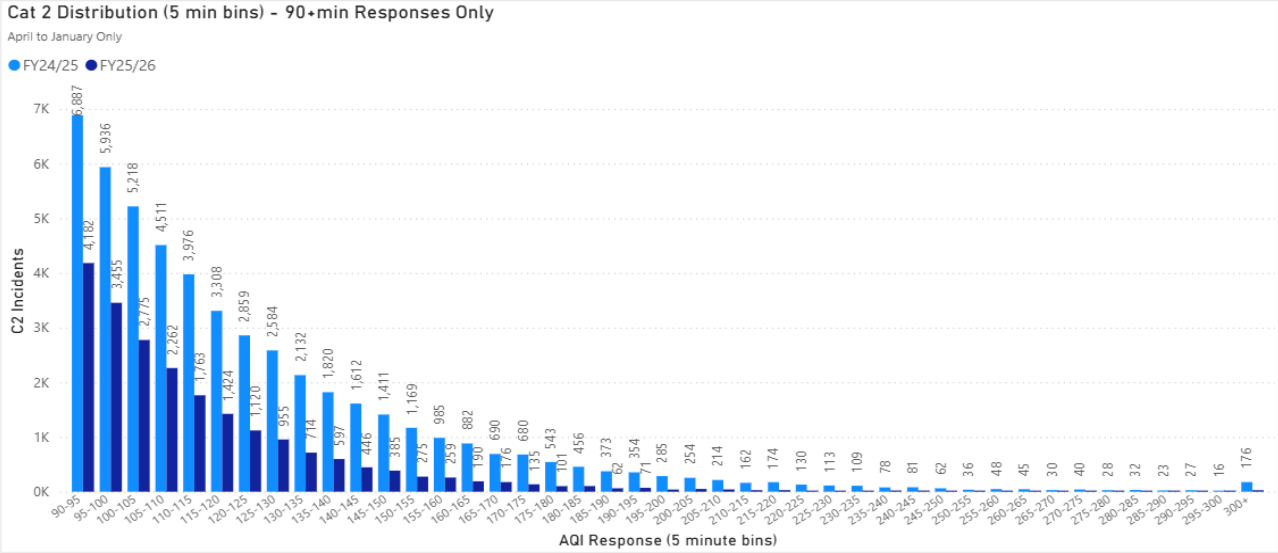



Figure 6: C2 distribution of 90 + minute responses

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

| | | | |
|---|---|---|---|
| August 2025 Target | 1.04 | August 2025 Actual | 1.07 |
| September 2025 Target | | September 2025 Actual | 1.07 |
| October 2025 Target | | October 2025 Actual | 1.07 |

The introduction of category 2 auto dispatch at the end of August 2025 has seen an increase in the multiple attendance ratio. All resources dispatched and then subsequently cancelled in favour of a better resource by the CAD system will count towards MAR. It is believed that the number of cancellations have increased in the same period and a patch to Cleric will be introduced imminently to allow for visualisation of this. As a consequence, this metric will

need to be reviewed in line with the next financial year and appropriate new metric adopted which will show better use of resources.

The pattern is demonstrated in figure 7.

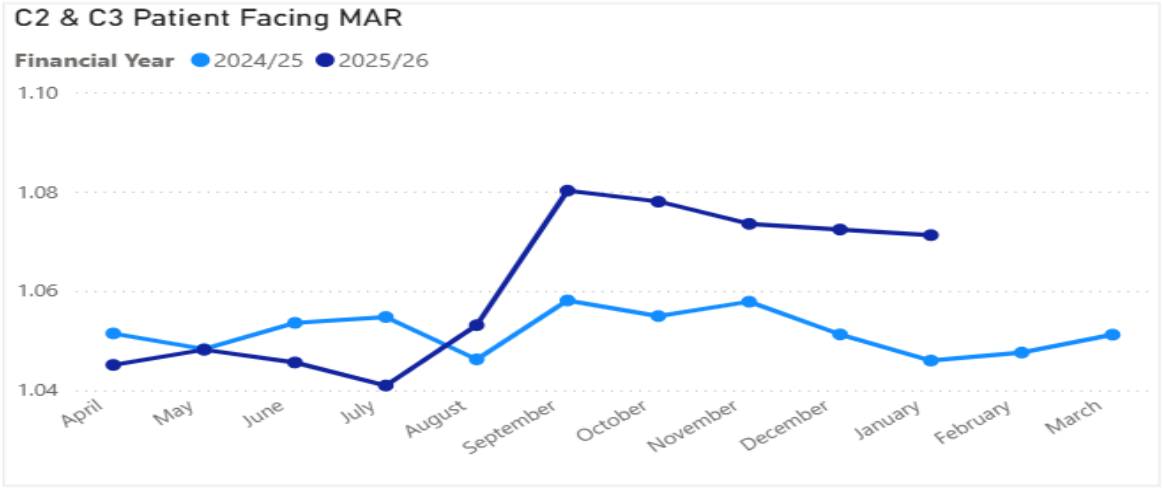



Figure 7: Multiple attendance ratio trend

## 2.7. Hear and treat (operating plan metric)

| | | | |
|---|---|---|---|
| November 2025 Target | 22% | November 2025 Actual | 22.9% |
| December 2025 Target | | December 2025 Actual | 22.9% |
| January 2026 Target | 23% | January 2026 Actual | 23.5% |

Within the 2025/2026 operating plan the target increased each quarter throughout the year. During this reporting period the target has increased to 23%, as from 1 January 2026.

Throughout the year the LAS has met the agreed levels and the SPC in figure 8 shows that there is continued special cause improvement.

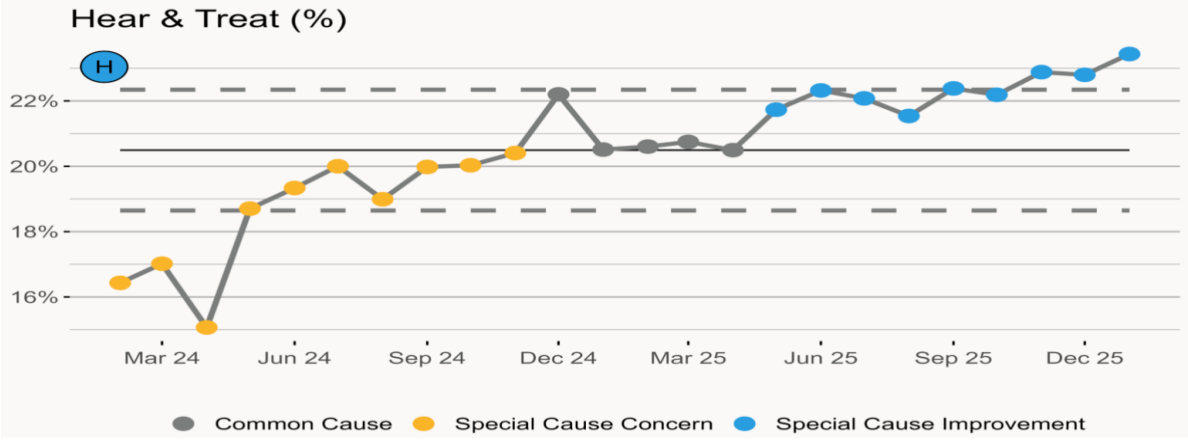



Figure 8: Percentage of hear & treat

## 2.8. See and treat (operating plan metric)

| | | | |
|---|---|---|---|
| November 2025 Target | 25.4% | November 2025 Actual | 25.1% |
| December 2025 Target | 26% | December 2025 Actual | 25.8% |
| January 2026 Target | 26.2% | January 2026 Actual | 24.9% |

See and treat rates have consistently been lower than what was delivered in 2024/2025. During this same period, hear and treat has substantially increased from

circa 16% to 23% and has therefore reduced the opportunity for crews to see and treat patients.

The see and treat trend is shown in figure 9 and compares the current financial year with last.

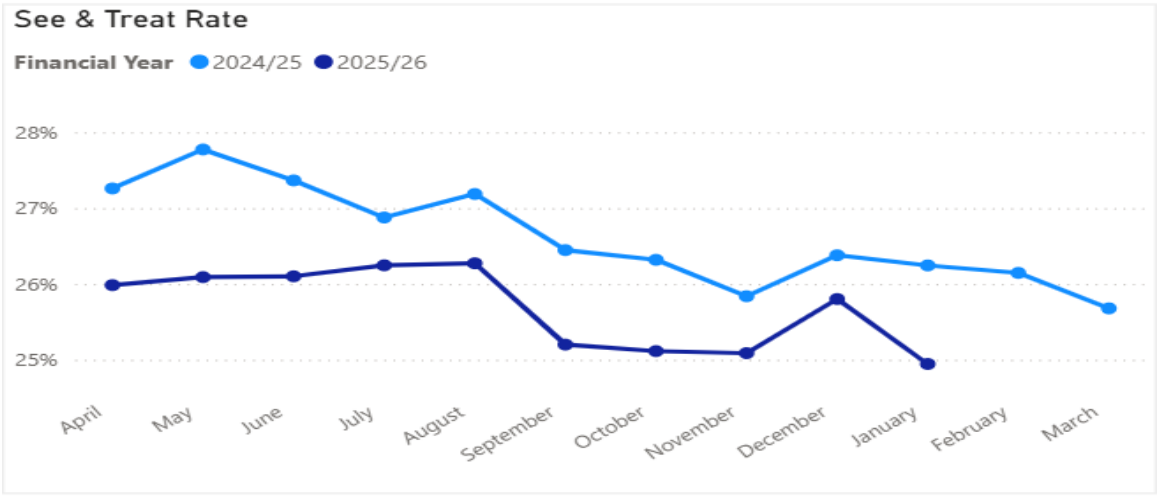



Figure 9: See & treat trend (12 months)

## 2.9. See and convey (operating plan metric)

| | | | |
|---|---|---|---|
| **November 2025 Target** | 52.6% | **November 2025 Actual** | **52.0%** |
| **December 2025 Target** | 52.0% | **December 2025 Actual** | **51.3%** |
| **January 2026 Target** | 50.8% | **January 2026 Actual** | **51.6%** |

The see and convey targets were achieved in November and December, although above target by 0.8% in January 2026.

The target year to date is 51.7% to 31 January 2026, with the LAS 0.4% above target at 52.1%.

As part of team-based working there has been messaging to crews to, where possible and appropriate, use alternative care pathways and find alternatives to conveying patients to hospital. There has been an improvement across this financial year as shown by figure 10.

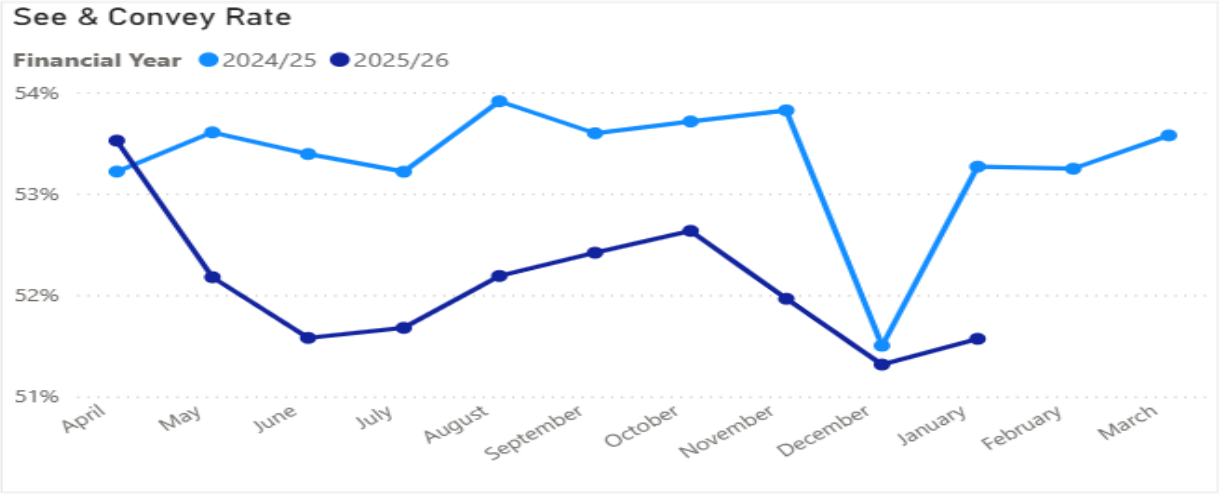



Figure 10: See & convey trend

## 2.10. Job Cycle Time (operating plan metric)

| | | | |
|---|---|---|---|
| **November 2025 Target** | 82 Minutes 39 Seconds | **November 2025 Actual** | **87 Minutes 48 Seconds** |
| **December 2025 Target** | 83 Minutes 14 Seconds | **December 2025 Actual** | **86 Minutes 41 Seconds** |
| **January 2026 Target** | 83 Minutes 25 Seconds | **January 2026 Actual** | **87 Minutes 58 Seconds** |

Job cycle time is expected to rise over the winter period as pressure increases on the system with increased activity. As a consequence, the target increases across this reporting period as shown above.

The LAS met its JCT targets between April and July 2025 and has consistently been above plan from August 2025 onwards. This coincided with the introduction of category 2 auto dispatch and as a consequence there is a need to recalibrate this metric in line with next years operating plan. Although, this metric has not been met for a number of months, overall response times for category 2 patients has improved month on month.

The work being undertaken by the frontline teams to reduce unnecessary JCT has been continuous throughout the year and a consistent reduction achieved in comparison to last years performance as shown in figure 11.

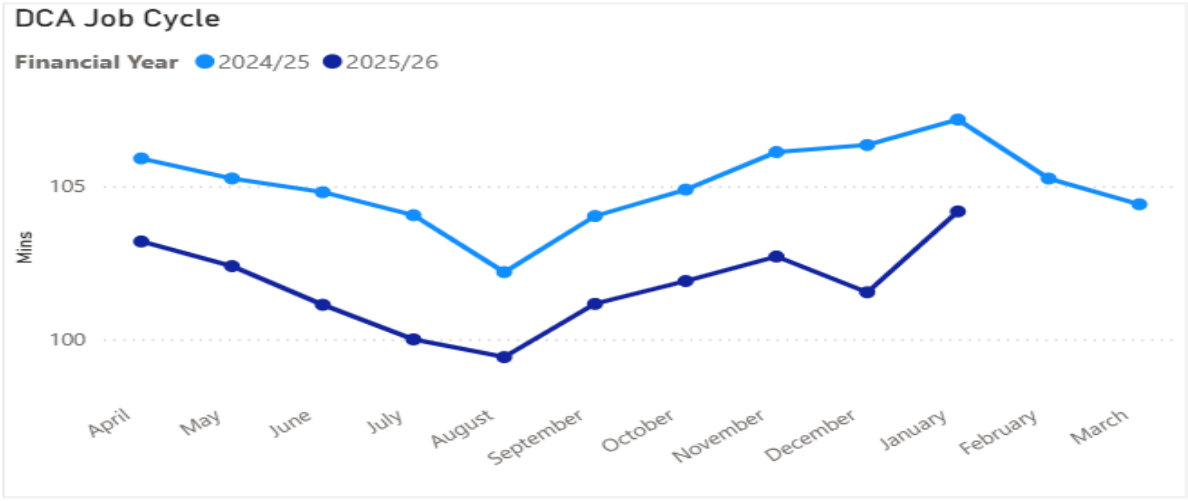



Figure 11: Full Job Cycle Time

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

| | | | |
|---|---|---|---|
| **November 2025 Target** | 13% | **November 2025 Actual** | **12.7%** |
| **December 2025 Target** | 13% | **December 2025 Actual** | **12.3%** |
| **January 2026 Target** | 13% | **January 2026 Actual** | **12.4%** |

There has been a continued reduction in the unavailable time with the oversight of both the winter delivery cell and ambulance operations teams through the local delivery model.

The LAS has consistently met the agreed target during this reporting period. The year to date position to 31 January 2026 is 13.3% which is 0.2% below plan. The

improvement between 2024/25 ad 2025/26 in overall JCT is demonstrated in figure 12.

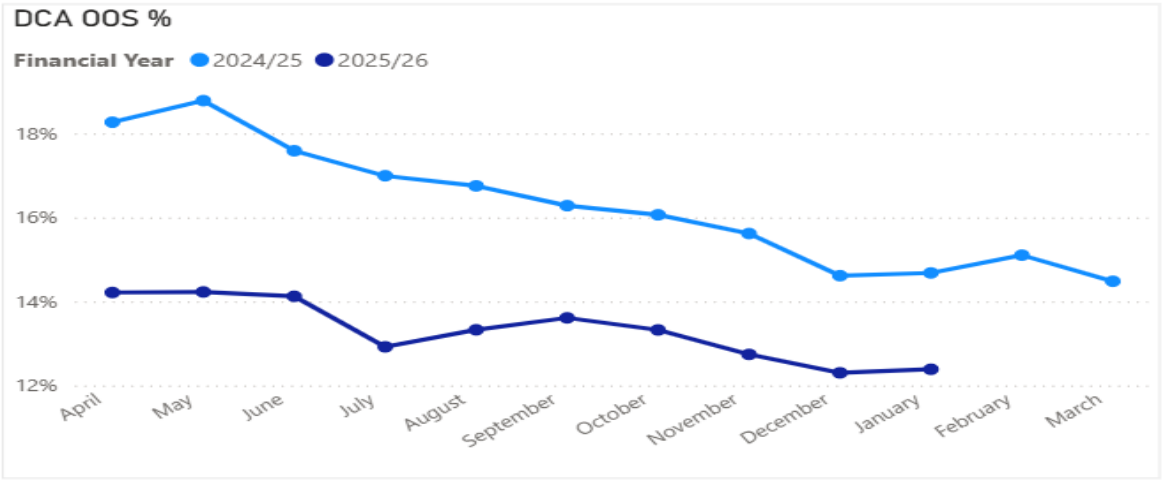



Figure 12: Total out of service trend

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

| | | | |
|---|---|---|---|
| **November 2025 Target** | **21 Minutes** | **November 2025 Actual** | **24 Minutes 47 Seconds** |
| **December 2025 Target** | **21 Minutes 10 Seconds** | **December 2025 Actual** | **24 Minutes 24 Seconds** |
| **January 2026 Target** | **21 Minutes 29 Seconds** | **January 2026 Actual** | **26 Minutes 21 Seconds** |

The average hospital handover time remains above the agreed target each month and year to date, as shown in figure 13. The planned target for the year to January 2026 was 24 minutes 8, which was 2 minutes 56 seconds above plan.

The LAS continues to work with the system to address hospital handover challenges and targets are being reviewed by national and regional teams within NHSE on how this can bring about improvements within the next financial year.

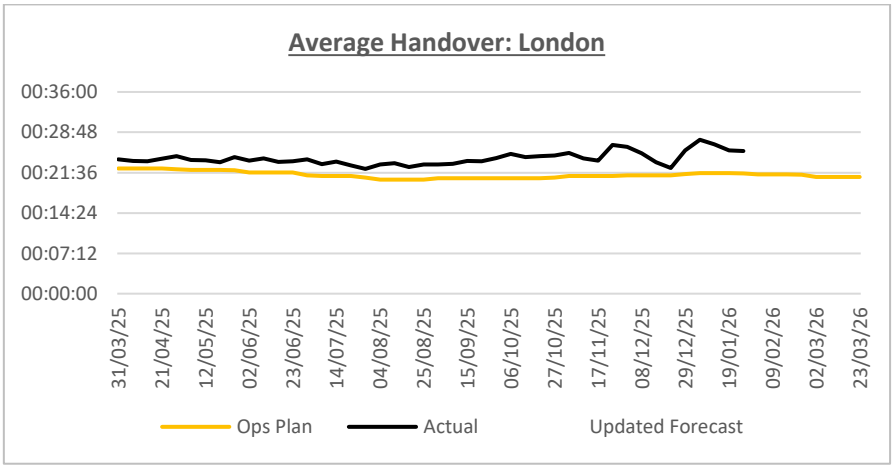



Figure 13: Hospital handover performance against plan

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

| | | | |
|---|---|---|---|
| November 2025 Target | 203,716 | November 2025 Actual | 210,935 |
| December 2025 Target | 218,467 | December 2025 Actual | 215,939 |
| January 2026 Target | 213,431 | January 2026 Actual | 221,206 |

Deployed DCA hours have continued to exceed the operating plan and as of 31 January 2,051,214 hours had been produced year to date. This is 1.3% above plan. DCA hours against plan is shown in figure 14.

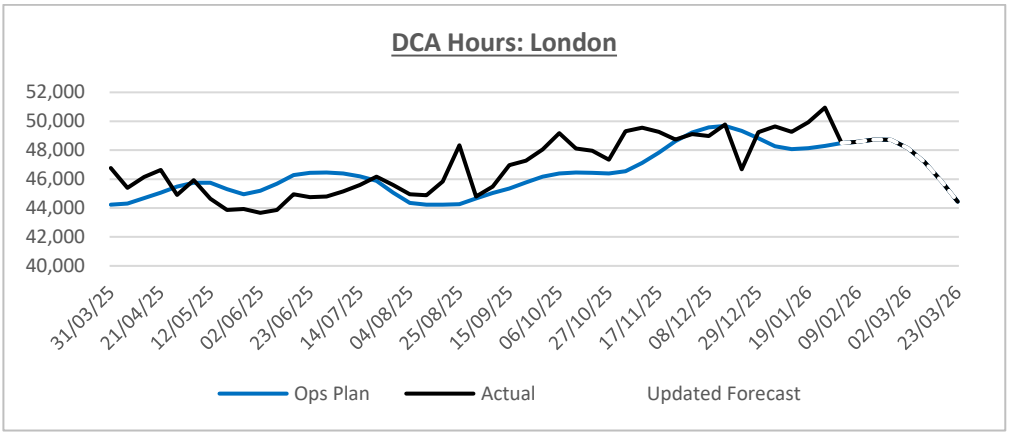



Figure 14: Deployed DCA hours against plan

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

| | | | |
|---|---|---|---|
| November 2025 Target | 40,954 | November 2025 Actual | 37,191 |
| December 2025 Target | 39,419 | December 2025 Actual | 37,346 |
| January 2026 Target | 43,657 | January 2026 Actual | 38,728 |

Figure 15 shows the actual Fast Response Vehicle (FRV) hours deployed against plan. As can be seen the LAS has taken the decision to resize the FRV resource and this has been maintained across this financial year. This has been in preference to resource more double crewed ambulances which has more of an impact on category 2 performance.

Even with this reduced number the performance against category 1 has improved across this financial year which was demonstrated in section 2.1 above, where special cause improvement has been maintained.

As part of the planning exercise for 2026/27 the FRV resource has been reprofiled in line with this years deployment. LAS awaits approval of this plan.

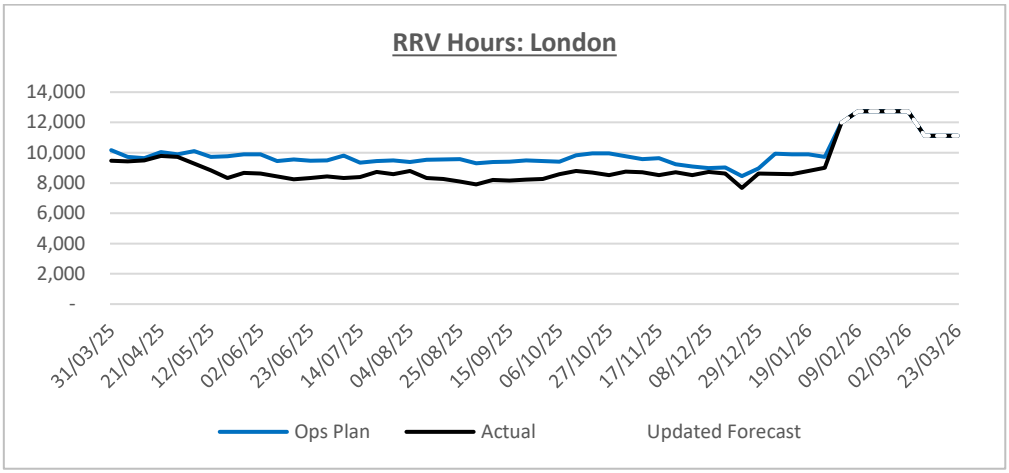



Figure 15: Deployed FRV hours

## 3. Integrated Urgent Care Balanced Score Card Metrics

### 3.1. 111 Star 5 utilisation

| | | | |
|---|---|---|---|
| * 5 volume | No target | November 2025 Actual | 3339 |
| | | December 2025 Actual | 3912 |
| | | January 2026 Actual | 3913 |

| | | | |
|---|---|---|---|
| * 5 ringback time | 30 Mins. Crew on scene | November 2025 Actual | 00:15:02 |
| | | December 2025 Actual | 00:16:45 |
| | | January 2026 Actual | 00:17:28 |

The number of star 5 calls increased over this reporting period (11,164) compared to the previous one (8,055). His demonstrates wider acceptance of frontline crews to seek clinical advice whilst they are with a patient.

Star 5 ringback times have all been within target.

### 3.2. Priority call back times

| | | | |
|---|---|---|---|
| Priority 1 % in time | 60% | November 2025 Actual | 78% |
| | 60% | December 2025 Actual | 74% |
| | 60% | January 2026 Actual | 73% |

| | | | |
|---|---|---|---|
| Priority 2 % in time | 60% | November 2025 Actual | 52% |
| | 60% | December 2025 Actual | 49% |
| | 60% | January 2026 Actual | 49% |

Year on year comparison shows that the CAS performance has seen improvement across the priority groups, with P1 improvement of 75% and particularly seen in the P2 metric has seen a 14% improvement. Although the P1 standard has now been met; P2 remains below 60%.

This performance area has been a key focus, where there were a number of noted contributory factors to a dip in this trajectory. These were:

1) Clinical staffing was increased to match CAS forecasting demand volume and profiles, however case handling times, as a key variable in this planning were increased where clinicians had to navigate referrals where there was less capacity in the system.

2) As call handlers met this same issue, in trying to identify a referral pathway for a patient, where this was problematic, there was a noted increase in "Early Exit" assessments, which were directed to the CAS queue.

3) In addition to this there was a noted increase in support provided to the 999 service with the integrated service support offered through increased warm transferred 999 calls to 111, that required clinical contact increased to average 85 cases per day, with additional direct CHUB to CAS referrals c.50 cases per day. Where this activity increase is often most impacted in evenings and within the higher priority groups of the CAS.

Actions to rectify and resolve this have been:

1) Ensure all non-clinical referrals to CAS have been validated to reduce CAS demand and align to service delivery model. This includes utilisation of the full range of appropriate DOS services when presented to call handlers and avoiding "Early Exit" cases, which increase CAS demand.

2) CAS clinical staffing has been reviewed to increase staffing against demand with revised agent performance metric, generating increased rota fill.

3) Use of network partners has been further increased and optimised with resilience partners, to ensure support requests are filled effectively.

4) Twice daily operational clinical huddles in place to review and amend tactical service delivery plans in optimising CAS ring back performance, with priority on patient safety

5) Revised and ensured the full use of the IUC CSP key actions are being implemented appropriately when required

6) All CAS Clinical ring back priorities are focus areas across IUC, directly linked to commissioner Performance improvement plans and monitored closely by senior operational leads daily with a series of work streams, steps and checkpoints
These measures have already had a significant impact in February where the improvements in all priorities are meeting and exceeding performance improvement plans.

As a result of these actions there has been an improvement seen in February with P1 callbacks at 82.7% and P2 at 70.8%

The P2 distribution tail is shown in figure 16. The graph shows number of cases closed in 30 minute buckets over 60 minutes and covers the period from 1 April to 31 January; comparing the 2024/25 and 2025/26 financial years.

There is a marginal improvement in the current year of 8% reduction in the number of cases waiting over 60 minutes for a ringback. The IUC teams focus on the actions above will look to extend this over the coming period and reduce the tail.

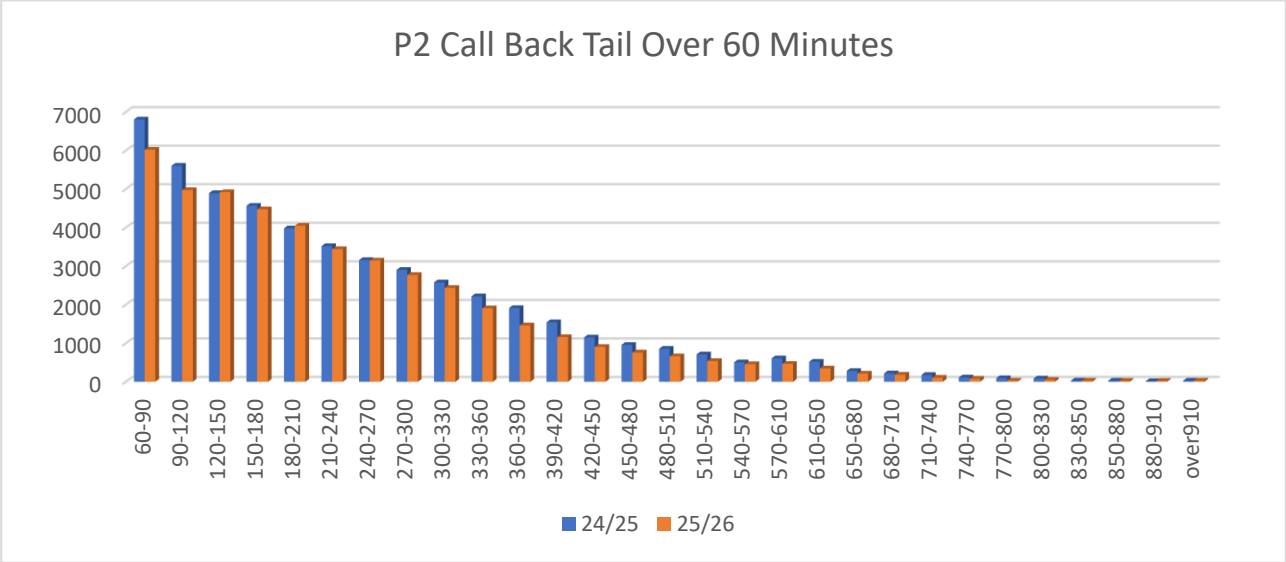



Figure 16: P2 Call Back Tail Over 60 Minutes

### 3.3. Call answering metrics

| | | | |
|---|---|---|---|
| **Abandonment rate** | **Less than 3%** | **November 2025 Actual** | **2.4%** |
| | | **December 2025 Actual** | **2.6%** |
| | | **January 2026 Actual** | **1.5%** |

| | | | |
|---|---|---|---|
| **Average time to ans.** | **20 seconds** | **November 2025 Actual** | **42.8 secs** |
| | | **December 2025 Actual** | **50.1 secs** |
| | | **January 2026 Actual** | **23.2 secs** |

LAS continues to deliver low abandonment rates, with all measures consistently exceeding contractual standards.

Average time to answer was above the target and during November and December 2025 in particular was a result of the demand seen on the service.

### 3.4. Percentage of Ambulance validation

| | | | |
|---|---|---|---|
| **Validation target** | **75%** | **November 2025 Actual** | **93%** |
| | | **December 2025 Actual** | **92%** |
| | | **January 2026 Actual** | **91%** |

The LAS continues to deliver above target performance for ambulance validation.

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%** | **November 2025 Actual** | **57%** |
| | | **December 2025 Actual** | **52%** |
| | | **January 2026 Actual** | **49%** |

The national target of 50% was achieved in both November and December 2025, whilst January 2026 missed it by 1%.

Year to date, with the exception of January, the LAS has met the target, each month, which has ensured that we minimise the number of ED referrals.

### 3.6. Average handling time

| Average Handling time | No target | November 2025 Actual | 00:09:07 |
|---|---|---|---|
| | | December 2025 Actual | 00:09:03 |
| | | January 2026 Actual | 00:08:58 |

The work that has continued to focus on average handling time is taking effect. The average time for the 3 months to October 2025 of 10 minutes 14 seconds reduced to 9 minutes and 3 seconds in this last quarter.

## 4. Resilience & Specialist Assets

During the period of November to January 2026 there have been 3 declared Significant Incidents.

On 25th November 2025, the Trust responded to a fire in a warehouse in Southall. There were no casualties from the fire, however, due to hazardous materials within the warehouse our resources supported the Local Authority with the evacuation and relocation of around 1,000 residents.

On Sunday 7th December 2025, the Trust responded to a hazmat incident at Heathrow Airport, where pepper spray was intentionally discharged onto members of the public. In total 21 patients were assessed and treated, 5 of whom were conveyed to hospital.

On Tuesday 16th December 2025, the Trust responded to a carbon monoxide leak from a heating system in a retail shop in Charlton. In total 30 patients were assessed and treated, 11 of whom were conveyed to hospital.

During the same period there were 4 declared business continuity (BC) incidents.

On Sunday 2nd November 2025 there was loss of water at our Croydon 111 facility, which resulted in a loss of all toilet facilities and drinking water. A BC incident was declared, and plan enacted, relocating the majority of staff to our 111 Barking facility.

Wednesday 12th November there was a fire alarm evacuation at 111 Croydon, which was later identified as a false alarm. All staff were evacuated for 25 minutes, during which service delivery was transferred to Barking 111, with minimal impact.

On Tuesday 18th November 2025 a global Cloudflare outage; which impacted multiple systems including ePCR, CADO, GRS, ID card access, the Trust website and Multi-Factor Authentication. Clinician reverted back to paper patient report forms for 2 hours. No adverse patient safety incidents have been flagged.

On Wednesday 14th January 2026 Cleric Administrator PCs, logged some users out of the system. Internal mitigation was promptly identified, until the issue was resolved, leading to minimal impact on service delivery.

All incidents are currently subject to after action reviews and learning identified will be monitored through the EPRSG group.

# 5.2. Quality

## For Assurance

# 5.2.1. Quality Report

For Assurance

Presented by Fenella Wrigley

London Ambulance Service NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 5 March 2026 | | | |
| **Report title:** | Quality Report | | | |
| **Agenda item:** | 5.2 | | | |
| **Report Author(s):** | Dr Fenella Wrigley | | | |
| **Presented by:** | Dr Fenella Wrigley | | | |
| **History:** | This document summarises the quality of care provided by the London Ambulance Service (LAS) based on data from October and November 2025. It was presented to the Quality Assurance Committee in January 2026. It covers four main domains: Safe, Effective, Caring, and Well-Led/Quality Improvement, providing detailed insights into clinical performance, patient safety, safeguarding, health inequalities, and quality improvement initiatives | | | |
| **Purpose:** | X | Assurance | ☐ | Approval |
| | X | Discussion | X | Noting |

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

**Safe**

1.1 Clinical Demand and Maintaining Safety

The report highlights continued pressures across urgent and emergency care systems during Autumn 2025. Patient safety during high demand is managed through Clinical Safety Plans ensuring prioritisation of the sickest patients and safe referral of lower acuity cases to alternative care pathways.

1.2 Mental Health Care

Mental health demand is continuing to rise. The new electronic Patient Care Record (ePCR) Mental Health Assessment tab has been implemented and supports structured mental state examinations and risk assessments. Mental Health Joint Response Cars (MHJRC) have maintained a safe, productive service with no complaints or safety incidents reported this period. Future operational response to manage the increasing mental health demand is being scoped.

1.4 Safety Incidents – 999

During the reporting period, 2,163 patient safety incidents were reported from 388,590 contacts (0.5%). Most incidents resulted in no or low harm, and we saw reductions in severe harm and deaths. Thirteen learning responses were commissioned during the reporting period.

1.5 Safety Incidents – 999 Clinical Hub

The Clinical Hub reviewed and streamed an average of 74,000 calls per month in November 2025, with 25,000 clinical assessments monthly. Patient safety incidents remained low.

1.6 Safety Incidents – Integrated Urgent Care (IUC)

The majority of the 270 (October) and 212 (November) incidents were no harm, reflecting a positive culture of open reporting. There continues to be an increase in abusive behaviour towards staff during calls - the violence reduction unit are supporting those affected by these calls.

1.7 Overdue Incidents
During October and November, 3,814 incidents were reported with 2,347 closed. The number of overdue local reviews decreased and there is support being offered from the Clinical and Quality Teams to complete reviews where there are delays.

1.8 Learning from Deaths
Structured Judgement Reviews (SJRs) were conducted on 227 cases in Q3 2025-26, with 61 second-stage reviews undertaken. In most cases (82%) no further action was required but local feedback took place with the learning being shared through Clinical Updates, Insight Learning document and integrated into future training.

1.9 Medicines Management
During this reporting period there were no supply issues occurred and 100% of planned deliveries were completed. The Medicines Packing Unit achieved 98% compliance in controlled drug audits. Electronic drug usage form completion was 78% in November- there has been an ePCR system update released to further improve compliance. Two new medications were added to the Advanced Paramedic Practitioner formulary

1.10 Safeguarding
Electronic safeguarding referrals have been embedded for a year, and there are plans to further enhance referral quality using Artificial Intelligence (AI) - supported tools. The Child High Intensity User (CHIU) process was launched in November, focusing on children with frequent contacts, and has already seen good collaboration with multiple partners to address unmet needs and reduce abuse risks.

1.11 Health, Safety and Security
The team have delivered safety courses and supports stress assessment training. From March to November 2025, 78 RIDDOR incidents were reported, mostly manual handling. FFP3 mask fit testing compliance is 76%. A total of 75 physical assaults were reported during November 2025, with the greatest number, 59%, occurring due to the clinical condition of the patient during - the police attended 62%.

1.12 Infection Prevention and Control (IPC)
IPC compliance has been a key focus during the Autumn and environmental and observational audits showed improvements. Hand hygiene compliance was reported at 97%. This exceeds the Trust performance target of 90%. The IPC team actively supported winter preparedness through bulletins, education, and station visits starting October 2025.

**2.0 Effective**

2.1 Clinical Performance Indicators (CPI)
In November 2025, 80% of CPI audits were completed, showing compliance ranging from 90% (Older Fallers) to 97% (Cardiac Arrest).

2.2 Clinical Ambulance Quality Indicators
In July 2025, ROSC sustained to hospital arrival was 33.9%, ranking LAS 1st in the overall group; 30-day survival was 12.1%, ranking 5th. STEMI call to angiography averaged 2:26 hours, with 81% receiving full care bundles. Stroke call to hospital arrival averaged 1:27 hours, faster than the national average.

2.3 LAS Cardiac Arrest Data
In November 2025, 1,120 out-of-hospital cardiac arrests occurred and 400 patients received resuscitation. There was return of spontaneous circulation (ROSC) in 44%, with 32% sustaining it to hospital handover.

2.4 Chain of Survival

LAS continues community engagement to improve cardiac arrest survival through education programs like London Lifesavers and Heart Starters, training over 20,000 schoolchildren and increasing public access defibrillators to 11,000 across London. The Mayor of London donated £150,000 to support defibrillator deployment in underserved areas. Volunteer responder schemes, including Community First Responders and Emergency Responders, play a key role to enhance early intervention.

2.5 ST Elevation Myocardial Infarction

In November 2025, 251 suspected STEMI patients were attended with 97% conveyed directly to a Heart Attack Centre; the average call to hospital arrival was 1 hour 25 minutes.

2.8 Clinical Audit and Research

The 2024-25 Clinical Audit Report, summarising completed projects, national submissions, staff engagement, and public involvement has been approved through Quality Assurance Committee. In the last reporting period clinical audits have been completed on resuscitation termination, low back pain, and midazolam administration. The audit results are shared through Team Huddles and QR codes.

**3.0 Caring**

3.1 Health Inequalities

Reducing health inequalities projects continue to focus on sickle cell, maternal health, learning disability and autism, and cardiovascular disease.

Three Acute Sickle Cell Units across London now accept LAS direct referrals, with over 150 patients conveyed directly.

3.2 Alternative Care Pathways and Care Coordination

The 5 Integrated Care Coordination hubs are operational and supporting ambulance clinicians with joint decision-making to prevent unnecessary hospital conveyances and increase referrals to Alternative Care Pathways including Same Day Emergency Care.

**4.0 Well-Led**

4.1 Quality Regulation

Quality visits have been undertaken to support local teams and provide them with assurance and areas for focus.

4.2 Quality Improvement

The "Back to Base on Time" project for Double Crewed Ambulances has progressed well with good results. Lean for Leaders training is ongoing with a planned Quality Improvement conference in March 2026.

**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 | | |
| Chief Paramedic | **Yes** | X | No | | Via QAC |

| | | | | | |
|---|---|---|---|---|---|
| Medical | **Yes** | X | No | | Via QAC |
| Operations | **Yes** | X | No | | Via QAC |
| Communications & Engagement | **Yes** | X | No | | |
| Strategy | **Yes** | | No | | |
| People & Culture | **Yes** | | No | | |
| Corporate Affairs | **Yes** | X | No | | Via QAC |

London Ambulance Service NHS Trust

**Meeting in Public of The Board of Directors – March 2026**

Trust Quality Report – Reporting on October and November 2025 data

This report focuses on the quality of care provided by the London Ambulance Service (LAS). The Trust's Quality Dashboard report contains the **October and November 2025** data, unless otherwise stated, and provides an overview of the quality performance through relevant key performance indicators (KPIs) and information including the quality improvement agenda across the organisation. This was presented to the Quality Assurance Committee on 13 January 2026.

The report covers four domains: Safe, Effective, Caring and 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.

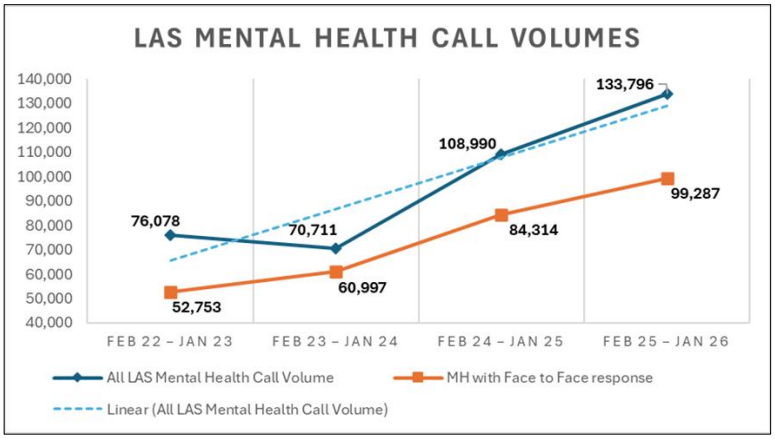
### 1.1 Clinical Demand and Maintaining Safety

As has been reported in the performance report the Autumn period saw continued pressures across the Urgent and Emergency Care and Health and Social Care systems.

Oversight of patient safety, at periods of higher than predicted demand, is managed using the 999 and / or Integrated Urgent Care Clinical Safety Plans (CSP). This provides a governed framework to maintain clinical safety and ensure the sickest and most seriously injured patients receive the fastest possible response whilst patients with lower acuity conditions are safely referred or signposted to appropriate alternative care pathways.

### 1.2 Mental Health Care

Mental health demand continues to rise. The London Ambulance Service continues to work with Mental Health Providers across London.



The new electronic Patient Care Record (ePCR) Mental Health Assessment tab is now live across the Trust, supporting crews to assess and document a structured mental state examination and risk formulation and support 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 | Nov-25 | Dec-25 | Jan-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Shifts Covered | 175 | 161 | 202 | 183 | 199 | 179 | 201 | 200 | 186 | 172 | 185 | 204 | 193 |
| 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 | 6.17 | 6.58 | 6.23 |
| % of shifts covered | 94.09% | 95.83% | 108.60 % | 101.67 % | 106.99 % | 99.44% | 108.06 % | 107.53 % | 103.33 % | 92.47% | 102.78 % | 109.68 % | 103.76 % |
| **Team Activity** | **Jan-25** | **Feb-25** | **Mar-25** | **Apr-25** | **May-25** | **Jun-25** | **Jul-25** | **Aug-25** | **Sep-25** | **Oct-25** | **Nov-25** | **Dec-25** | **Jan-26** |
| Monthly Utilisation | 79.10% | 77.20% | 81.71% | 78.70% | 82.58% | 85.40% | 84.51% | 80.59% | 84.10% | 85.24% | 85.14% | 86.57% | 83.43% |
| Activations | 890 | 934 | 1143 | 1100 | 1132 | 1078 | 1232 | 1204 | 1125 | 1062 | 1112 | 1261 | 1154 |

***MHJRC shift coverage, utilisation and activations***

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

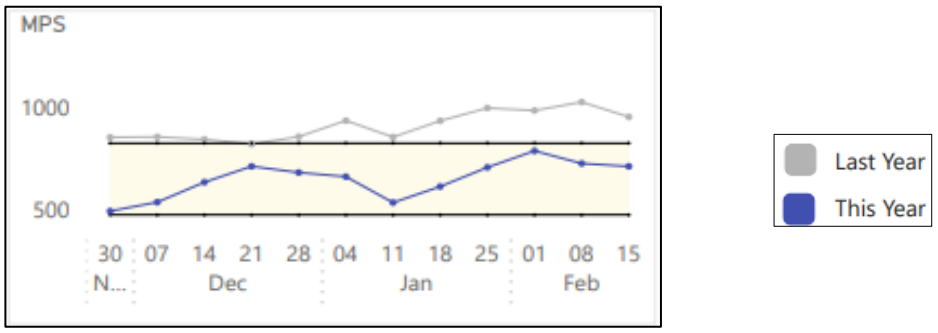
The mental health team have continued to deliver training to ambulance complexes, clinical tutors, 999 emergency operations centre staff, clinical hub clinicians and incident response officers.

Decommissioning notices for the MHJRC have been served to the London Ambulance Service from South West London, North East London and North Central London. Cross directorate work is underway to ensure that patients presenting with a mental health illness continue to receive a timely response or are signposted to the right care provider and not conveyed to the Emergency Department wherever appropriate.

**1.3 Right Care, Right Person (RCRP)**

While RCRP is now business as usual for the police, LAS has retained an escalation process to ensure patient and staff safety. RCRP is sometimes operationally complex. When issues are raised, we aim to capture them consistently so we can improve communication, pathways, guidance, and joint working.

To manage the ongoing volume of calls, the Clinical Hub continues with clinical validation for Category 3 cases, including welfare-related incidents. This improves triage accuracy, safeguards patients and optimises frontline resource use.




***Number of calls received from MPS***

The number of calls being received from the Metropolitan Police is lower than last year suggesting that patients are presenting first time to LAS as a health provider.

**1.4 Safety incidents – 999**

In October and November there were 2,163 patient safety incidents reported against a total of 388,590 patient contacts – this equates to 0.5%. The number of reported incidents has returned to a level consistent with common cause variation.

Of the 2,163 reported incidents, the harm was graded as follows:

- No harm – 1838 (an increase of 147 compared to the previous period)
- Low harm – 258 (an increase of 42 compared to the previous period)
- Moderate harm – 27 (an increase of 7 compared to the previous period)
- Severe harm – 19 (a reduction of 7 compared to the previous period)
- Death – 21 (a reduction of 8 compared to the previous period)

In the severe harm and death groups, 12 incidents took place in October and 28 in November.

13 learning responses were commissioned in October and November 2025

- 5 nationally defined incidents requiring local PSII (meeting the Learning from Death criteria). Themes include:
  - Management of patients under the influence of drugs and/or alcohol
  - 111 call handling
  - 111 clinical assessment/advice
  - Clinical assessment
  - Response time
- 1 locally defined incident requiring local PSII (meeting local priority). Themes include:
  - Management of patients under the influence of drugs and/or alcohol
- 7 local investigations managed through an After-Action Review. Themes include:
  - Informed consent
  - Management of patients under the influence of drugs and/or alcohol
  - Maternity care

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

- *Violence, aggression and abuse* with 550 cases reported to date, which is an increase of 16 since the last report.
  Actions underway include the violence reduction working group under the Chief Paramedic, trial of different body-worn cameras which fits onto uniform better and additional support for the violence reduction team to support staff.
- *Medicines Management including Controlled Drugs (CD)* with 505 cases reported to date, an increase of 2 since the last report – these incidents largely relate to administrative documentation and a small number of breakages. There have been no reported cases of diversion of Schedule 2 drugs.
  The plans to implement the electronic CD system are progressing with testing about to commence. The system is expected to reduce documentation errors, improve governance, increase operational efficiency, and ease administrative workload across clinical and pharmacy teams.
- *Medical Equipment* (defined as any equipment used with a patient during a care episode, including ambulance equipment bags) has had 491 cases reported to date, an increase of 69 since the last report. General themes of incidents reporting a failure during use include:
  - ETCO2/Capnography ~55
  - ECG/Cardiac monitoring (electrodes) ~40
  - Extrication and handling equipment ~40
  - Consumables (needles and syringes) ~35
  - LifePak device issues (non-specific) ~30

**Learning:**

**Case based discussion** took place in November and was attended by 87 staff from across the Trust. It was also recorded and shared via LASConnect. Themes included:

- A video made by CE&S on the importance of accurate PDS verification
- A presentation from the safeguarding team relating to a case of missed safeguarding opportunities
- A Patient who had fallen and was FAST positive
- Recognition of cardiac arrest
- Non-conveyance decision-making and differential diagnosis for a Patient experiencing PE

**With regards to equipment learning:**

- *ECG Electrode Guidance*: A case study on the new ECG electrodes is being included in the next quarterly learning event / Insight magazine to raise awareness.

- *Powered chair (Venice Ferno):* A Multi-Disciplinary Team meeting took place on 2nd February 2026 to identify learning from patient safety incidents. A task and finish group is being initiated, and actions have been assigned to stakeholders to reduce incidents and share the learning with clinicians.

- Ambulance and FRU *loading lists* to be added to JRCALC+

**Patient safety actions of note:**

- *Patient Care Handbook* revision to cover re Extrication with difficulty in breathing and incorporate a specific action around ensuring Patients' conditions are not exacerbated during extricating by self-mobilising to the ambulance, particularly those presenting with significant dyspnoea.
- *Reminder of the suitability of the patient's travelling to places of care by other means.* Emphasising the importance of targeted worsening advice, administration of attending a hospital or place of care when the patient is not directly conveyed.

**Duty of Candour:**

Overall, duty of candour compliance for November was 93.3%. This is an increase when compared to the last reporting period. Where Duty of Candour is delayed, support is provided to the relevant heads of teams to understand the delay.

| | DoC 2025/26 | | | | Audit of Letters | | | |
|---|---|---|---|---|---|---|---|---|
| | Compliant | Applicable | Performance | Previous | Compliant | Applicable | Performance | Previous |
| PSII 1st Stage DoC | 47 | 49 | 95.9% | 95.7% | 46 | 47 | 97.9% | 97.7% |
| PSII 2nd Stage DoC | 30 | 31 | 96.8% | 88.0% | 30 | 30 | 100.0% | 100.0% |
| PSR 1st Stage DoC | 36 | 37 | 97.3% | 93.8% | 34 | 36 | 94.4% | 93.3% |
| PSR 2nd Stage DoC | 20 | 22 | 90.9% | 94.4% | 19 | 20 | 95.0% | 100.0% |
| Local investigation 1st Stage DoC | 25 | 30 | 83.3% | 73.3% | 25 | 25 | 100.0% | 100.0% |
| Local investigation 2nd Stage DoC (Outcome) | 23 | 25 | 92.0% | 66.7% | 23 | 23 | 100.0% | 100.0% |

**1.5 Safety Incidents – 999 Clinical Hub (data from November to January)**

The number of calls reviewed and streamed by the Clinical Hub has increased significantly across winter, averaging 74,000 per month during November 2025. This represents an additional 12,000 cases per month (75% of all Category 2 to Category 5 activity) receiving clinical oversight by the Clinical Hub. The number of clinical assessments conducted by the Clinical Hub averaged 25,000 per month in November 2025 equating to around 30% of all Category 2 to Category 5 activity.

Patient safety incidents have remained consistently low, with 15 incidents reported and reviewed in November, 13 in December and 14 in January. Of these, the multidisciplinary Patient Safety Incident Group (PSIG) reviewed 15 cases, no case met the threshold for a Patient Safety Incident Investigation (PSII) under the national framework. Of the total number

of patient safety incident reports (41), no concern was identified in 30 cases, feedback was provided to clinicians on 11 occasions.

**1.6 Safety Incidents – Integrated Urgent Care (IUC)**

The majority of the 270 incidents reported in October, and 212 incidents which were reported in November 2025 fell within the *no harm* category, providing assurance that risk to patients has remained minimal. This profile reflects a strong culture of open reporting and continuous learning, rather than incidents resulting in significant adverse outcomes.

The review of the incidents identifies priority themes which have been assigned targeted actions to support improvement as outlined below.

- *Concerns Regarding Other Providers:* It was identified that some Healthcare Professionals were not following the established process when requesting ambulances via 999. This has been raised directly 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. There has also been an increase in recontacts within 111 where patients have been passed to community services and have not received a call back. For a number of OOH providers, their no contact policy does not include leaving a message to advise of attempts to contact patients and as such patients are unaware of the failed contact. LAS 111/IUC have shared their policy to support learning.
- *IUC Call Handling*: Some learning has been identified through routine audit processes – individual staff are receiving direct feedback, enhanced auditing has been introduced, and broader 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 externally provided translation service, 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 learning. Options are being scoped for the 999 and 111 areas around future translation services.
- *Violence and aggression*: The number of abusive calls received by our staff have seen an increase over the last few months. Currently 6.3% of incidents which is a rise of just over 2% on previous month. 111/ IUC are working closely with the violence reduction unit to support staff with the impact of these calls. The abuse our 111 staff are subjected to was used as part of the RESPECT campaign over the Winter.

Continued monitoring, targeted feedback, and proactive engagement with partners will remain central to safeguarding patient outcomes and strengthening service resilience**.** Learning Response Update training took place for IUC designated Learning Response Leads in October.

### 1.7 Overdue incidents

3,814 incidents were reported during October and November, and 2,347 incidents overall were closed. LAS sector (including 111/IUC and 999) teams remain responsible for the oversight of incidents reported on Radar - dashboards have been created on Radar to provide sector teams and clinical quality teams with enhanced oversight. The number of overdue local reviews decreased compared to the previous reporting period but remained higher than we would want at 38.2% trust wide. The local review workflow must remain open until all other workflows and event tasks have been completed which requires all teams to work together to review and close the incidents.

### 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 Q3 of 2025-2026, 227 stage one SJRs were undertaken. If concerns were identified during the first-stage review, a second stage review occurs for validation. Throughout the same review period, 61 stage two SJRs were completed. Of the 227 stage one SJRs, 82% of these required no further action or locally delivered feedback. The themes across SJRs include but are not limited to:

- ECG interpretation
- Early recognition of respiratory compromise during call assessment and on scene
- Prompt escalation following primary survey

In addition to individual feedback, these areas are being covered in local team training and will form part of the Core Skills Refresher (CSR) training of 2026/2027.

### 1.9 Medicines Management

No medicines supply issues have been noted for the reporting period, and 100% of planned medicines deliveries were completed.

- Medicines Packing Unit achieved 98% compliance in CD audit.
- A total of 15,269 medication bags were packed in the LAS Medicines Packing Unit with 15,468 checked and of these 447 near misses recorded (approx. 3%). The robust auditing in place means none of these bags are released to frontline operations.
- Medicines deliveries at last quarter – 100% of planned.
- There was a 78% completion rate of electronic drug usage forms (eDUF) was recorded in November 2025. An update to ePCR is released at the end of November, including a link into Kit Prep Clinician, to link the information together and improve user experience with the aim of improving compliance in this area.

Incident trends and themes reported in medicines align with the work completed during the thematic review into medication errors highlighting themes related to:

- Dosing errors
- Route errors
- Contraindication

Work is ongoing to improve the traceability of medical gases.

The electronic Controlled Drug (e-CD) system project is live and ongoing progressed and user acceptability testing is commencing in March 2026.

Patient Group Directives: The legal definition of a patient group direction (PGD) is ‘a written instruction for the supply and/or administration of a licensed medicine or medicines in an identified clinical situation, signed by a doctor or dentist and a pharmacist’

- 2 new medications have been added to the Advanced Paramedic Practitioner PGD formulary: Levetiracetam (2nd line anticonvulsive agent) and Misoprostol (2nd line / alternative agent for Post Partum Haemorrhage management)
- PGD Training was provided for Maternity team in November.

**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.

Number of statutory meetings information provided for/ attended. (October and November)

- South East: 11 meetings – all attended
- South West: 4 meetings – 3 attended
- North West: 13 meetings – all attended
- North East: 22 meetings – all attended
- North Central: 7 meetings – all attended

Electronic safeguarding referrals have now been successfully embedded for a full year, marking a significant step forward in efficiency and quality.

The number of safeguarding referrals raised within the last quarter. (October and November)

- Adult Safeguarding: 2495
- Adult Welfare: 2523
- Child Safeguarding: 3844
- Child in Need: 648
- London Fire Brigade (fire risk hazards identified): 452
- Prevent: 11

Collaboration with Doc-Works, our platform provider, remains strong as we develop Phase 2 enhancements. These improvements will introduce additional mandatory fields; enhancing the quality of referrals, with implementation in the next few months. The team are working with Clinical Digital teams to implement AI-supported safeguarding information capture, aimed at further improving the quality of safeguarding referrals from frontline crews. This initiative is currently in early implementation.

Safeguarding training compliance continues to improve, with Trust-wide performance now exceeding the commissioned target of 85%. November 2025 Safeguarding Level 1, Level 2 and Level 3 Trust compliance.

- Level 1 = 89.08%
- Level 2 = 87.38%
- Level 3 = 90.28%

**Child High Intensity User (CHIU) Process**

In November, the Trust launched the Child High Intensity User (CHIU) process, and the first two months have been highly successful. 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 collaborates 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. Emerging themes have been identified, and strong partnership working is underway to support those accessing our services

**Learning**:

- *Managing Abusive Callers within the EOC*, work has been undertaken to address abusive callers to 999 services through integrated collaboration across organisational teams, ensuring a coordinated approach. Patient resources have been developed to enhance support and provide clear information. Additionally, engagement with external stakeholders continues, including attendance at multidisciplinary team (MDT) meetings alongside key workers to support individuals involved.

- A working group comprising of ambulance, operations, safeguarding, and clinical education will be established to develop a clear plan for improving the circulation of case studies. This initiative aims to showcase areas of good practice while identifying opportunities to strengthen our safeguarding competencies. By sharing learning effectively, there will be continuous improvement.

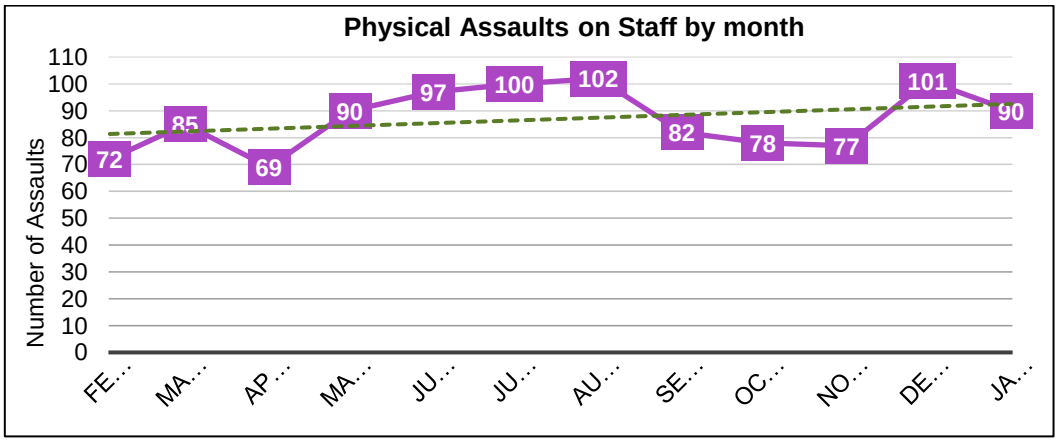
**1.11 Health, Safety and Security**

The Health, Safety and Security (HS&S) team have delivered one Managing Safety course and one Corporate Induction session during November 2025, each with positive feedback. In addition, the HS&S team continue to support the delivery of the Stress Assessment Toolkit training with the sessions running monthly. An online Display Screen Equipment (DSE) package is to be launched and trialled within call-handling and a corporate service before further and full roll-out to the Trust.

A total of 78 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents were reported to the Health and Safety Executive (HSE) from March to November 2025. Manual handling incidents account for the highest number (60%) of RIDDORs reported across the Trust during 2025/26.

Current compliance for FFP3 fit testing is 76% due to the 2-year revalidation period. This will increase with the change to bank staff coming in shortly.

A total of 75 physical assaults were reported during November 2025, with the greatest number, 59%, occurring due to the clinical condition of the patient during. Police have attended 62% of physical assault incidents from March to November 2025. A new Violence Reduction Officer (VRO) will be joining team before the end of the financial year. Trials of body Worn Cameras were taking place in the Autumn.




The HS&S team have supported the Communications team with a Winter campaign highlighting assaults and abuse within the ambulance sector both face-to-face and on the phone.

The National Staff Survey Reduction & Prevention (NSS VRP) task and finished group has now closed and any remaining actions from the 10-Point plan transferred to the Violence Reduction Staff Safety Programme Board (VRSSPB).

**1.12 Infection Prevention and Control (IPC)**

Through our local auditing systems, we continue to monitor, analyse and disseminate infection prevention and control audit data to improve standards and provide safe and effective care for patients.
November data for Infection Prevention and Control (IPC):

- IPC Statutory Mandatory compliance was reported at 79% for level 1 and 56% for Level 2 against a target of 90%.
- Hand hygiene compliance was reported at 97%. This exceeds the Trust performance target of 90%.
- Make Ready six-weekly vehicle deep clean compliance was reported at 68%. Non-Emergency Transport Service (NETS) reported at 27%, this has improved from 15% in the previous months but this is below the Trusts target 90%. Action recovery plans led by Make Ready services are in place, however challenges remain.
- Premises cleaning audit compliance was reported at 95%, which met the Trust's target of 90%.

The IPC team continues to assure local audit data through independent validation audits which provide the opportunity to support compliance improvements.

- 18 environmental audits were performed. Of which 14 achieved the minimum pass criteria of 75%. Significant improvements were noted in relation to cleaning standards of the reaudited sites, this was achieved by 'clutter management' which increased accessibility.
- 6 ride out audits were completed. Of which 5 achieved the minimum pass criteria of 80%.
- 5 A&E observational audits were undertaken.
- Some non-compliance with element 4 of the 5 moments of Hand Hygiene and Bare Below the Elbows were identified in some cases and individual feedback provided

The Flu season commenced earlier than expected this winter season with increased activity and pressures for NHS services noted in November. The IPC team ensured winter preparedness through a triumvirate of internal staff information bulletins, additional educational drop- in sessions and supportive area visits. This commenced in October 2025 and continues until March 2026.

**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 several different patient groups, as well as general documentation.

In November 2025, 80% of available CPI audits were completed, demonstrating a range of compliance with clinical guidelines, ranging from the Older Fallers CPI with a compliance level of 90% to the Cardiac Arrest CPI at 97%.

### 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 July 2025 being published in December 2025.

In July 2025, LAS ranked 1st nationally for ROSC sustained to hospital arrival in the overall group, achieving 33.9% (national average 30.0%). In the Utstein comparator group, LAS ranked joint 6th with 53.7% (national average 55.0%).

The overall 30-day survival rate was 12.1%, placing LAS 5th nationally and above the national average of 11.4%. Within the Utstein comparator group, LAS ranked 3rd with a survival rate of 37.0%, well above the national average of 32.5%.

For STEMI patients, LAS achieved a mean Call to Angiography time of 02:26*, three minutes slower than the national average of 02:23, ranking 7th nationally. A full STEMI care bundle was delivered to 81.0% of suspected STEMI patients. LAS continues to perform below the national average for this measure (84.5%).

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

For stroke patients, LAS recorded an average Call to Hospital arrival time of 01:27. This was faster than the national average of 01:31, placing LAS 4th nationally among ambulance services.

**This is based on SSNAP data which may not be a complete sample and is subject to change during the revision period*

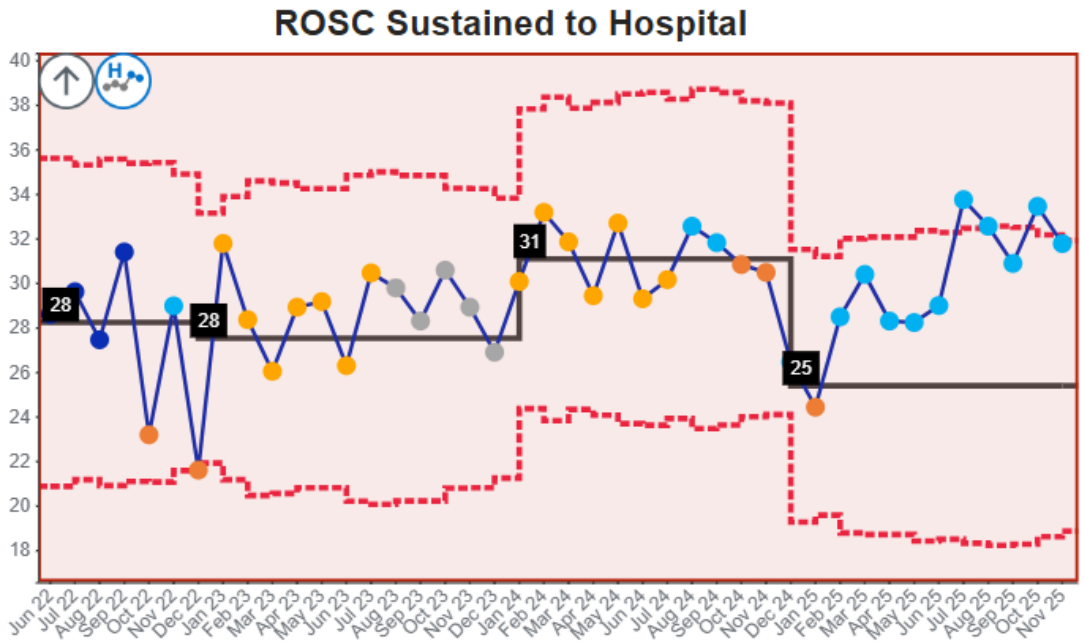
### 2.3 Cardiac Arrest data

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 report from November 2025 demonstrates:

- 1120 patients had an out of hospital cardiac arrest
- 400 patients had resuscitation commenced by LAS clinicians
- The median time from 999 call to dispatcher-assisted basic life support (chest compressions) was just over 4 minutes
- The median response time was 5 minutes 48 seconds
- The average time from LAS arrival on scene to first defibrillation was 4 minutes
- 44% of patients achieved ROSC, 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) improve 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.

The London Ambulance Service continues to be focused on improving survival from OHCA through community engagement, education and targeted intervention. Programmes such as London Lifesavers, London Lifesavers schools programme and London Heart Starters are equipping Londoners with the skills and tools to act confidently in emergencies, particularly

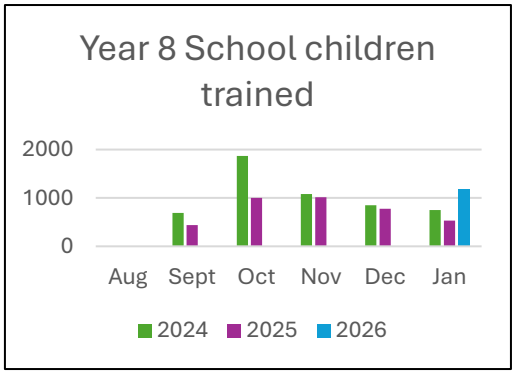
in underserved areas. Our volunteers continue to be an integral part of everything we are doing to improve OHCA survival. The LAS Carol concert at St Bride's Church, Fleet Street was a huge success with all tickets sold and all money raised for the Heart Starters programme.

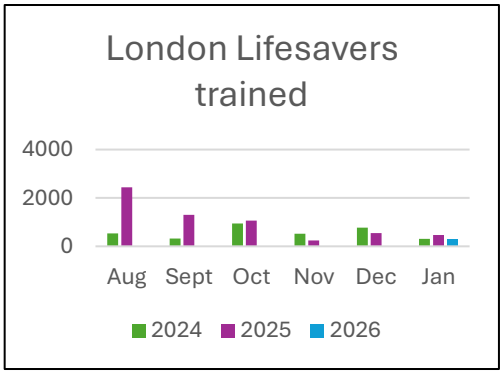
**London Lifesavers**

In October 2023 we launched the London Lifesavers Schools (LLS) programme, aimed at providing all year 8 pupils in London with the knowledge and skills to respond to a cardiac arrest. Evidence from countries where CPR is taught in schools shows that survival rates are nearly double compared to those without such education. In November we surpassed a total of 20,000 school children trained since the scheme began.

London Lifesaver highlights:

- The community resuscitation team continued to strengthen the partnership between LAS and London Zoo by providing training to all their staff and volunteers.
- We collaborated with our charity team and held a pop up at Waterloo alongside volunteers fundraising for the London Ambulance Charity. All money raised going back into the charity for the London Lifesavers campaign.
- We restarted our Palestra House two and half hour LLS free training courses for the public.




**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 this 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.

In October, Mayor of London Sadiq Khan announced a £150,000 donation to the London Heart Starters Campaign, which means we have reached our initial fundraising target and work to install additional defibs in the areas of London that need them most will continue.

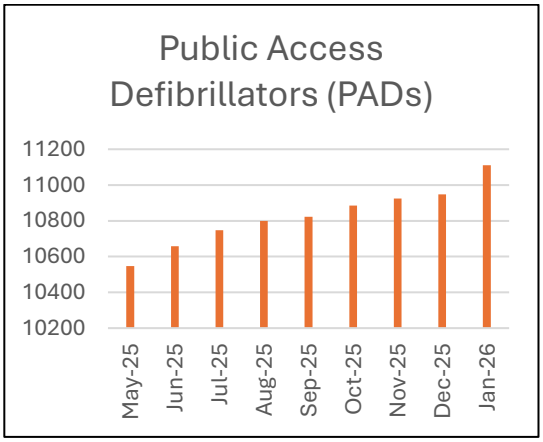
**Defibrillator Deployment**

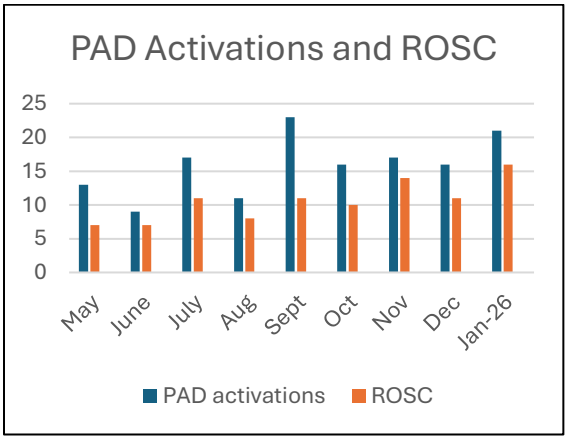
In January we celebrated achieving the milestone of 11,000 defibrillators being publicly accessible across London.

We have undertaken significant work with the British Heart Foundation (BHF) circuit team to increase the availability of school's defibrillators. Including assisting with their registration to include showing availability only when schools are open (a risk was identified that school defib were showing as available 24hrs a day 52 weeks of the year), putting the PAD outside of the school gates where possible to increase availability and in some cases actually getting the PAD out of the box and into service. In May availability was 61% and this has increased to 79%.

**Funding & Support**

The new Charity Defibrillation Co-ordinator started in role in November. This role is funded through the Heart Starters campaign for 2 years.



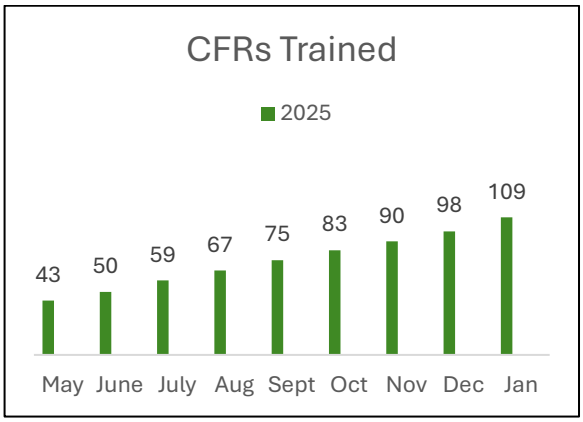

PAD activations increased in January with 16 of 21 uses resulting in the heart starting to beat again. Reporting of bystander basic life support and PAD usage requires LAS clinicians to document it on their electronic patient care record (ePCR). There is work underway to explore changes to the ePCR to make the boxes can be more prominent to prompt crews to complete them.

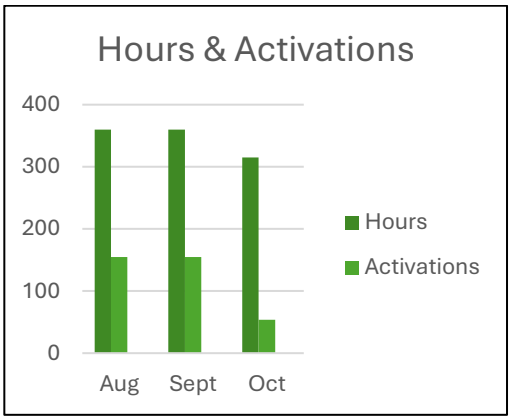
**Volunteers**

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. There are now over 100 trained. 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 App (NMA) technology.




The Emergency Responder (ER) scheme has recently undergone an external review, reflecting ten years of operational activity. ERs are trained by the LAS to respond in pairs using blue lights enabled vehicles (funded through a combination of charitable contributions and LAS resources) to the most critically ill and injured patients. The scheme currently comprises 91 volunteers including both blue light and non-blue light trained responders, operating from eight LAS stations.

**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.

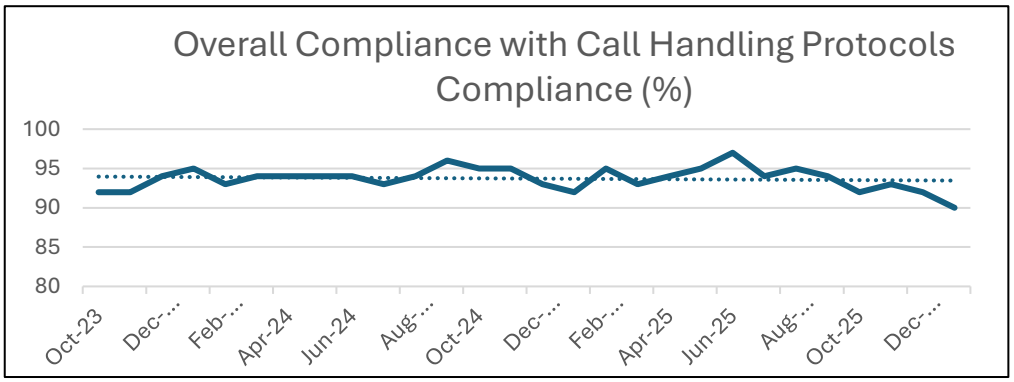
In November 2025:

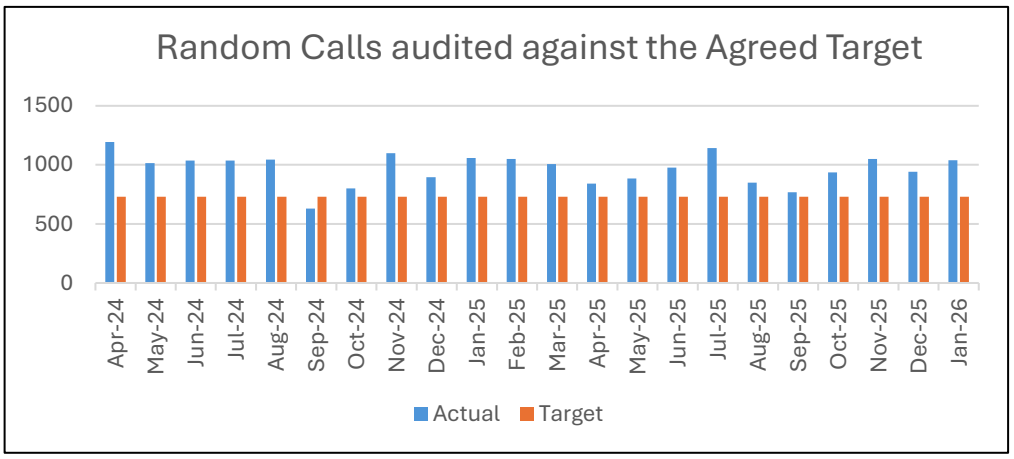
- 251 patients attended by LAS clinicians were suspected of having a STEMI
- An ECG was uploaded to the clinical record for 100% of those patients
- 250 patients were transported to the most appropriate destination, with 97% conveyed directly to a Heart Attack Centre
- 81% of patients received the full STEMI care bundle with 90% receiving analgesia when clinically indicated
- The average time from call to hospital arrival was 1 hour 25 minutes

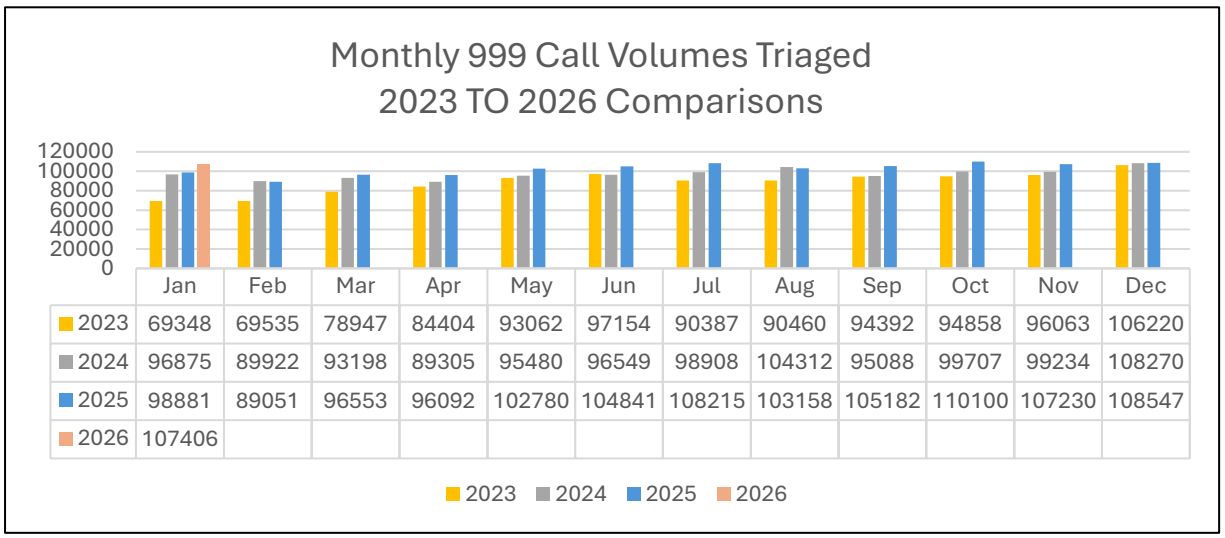
**2.6 Emergency 999 Call Handling**

The number of 999 call audits continues to exceed 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. Quality Assurance (QA) Managers continued to support the EOC Team Based Working huddles and training days to support the learning and development of staff. For 2025

there were 1,062 incidents logged in the Risk management system for QA (Legal, Communications, Patient Experience Department, Governance), an increase of 1,032 when compared to 2024.




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023 | 69348 | 69535 | 78947 | 84404 | 93062 | 97154 | 90387 | 90460 | 94392 | 94858 | 96063 | 106220 |
| 2024 | 96875 | 89922 | 93198 | 89305 | 95480 | 96549 | 98908 | 104312 | 95088 | 99707 | 99234 | 108270 |
| 2025 | 98881 | 89051 | 96553 | 96092 | 102780 | 104841 | 108215 | 103158 | 105182 | 110100 | 107230 | 108547 |
| 2026 | 107406 | | | | | | | | | | | |

## 2.7 111 Quality Audits

All mandatory audits across all skill groups achieved 100% completion in November and December, with overall compliance rates between 91–98%. This reflects strong clinical

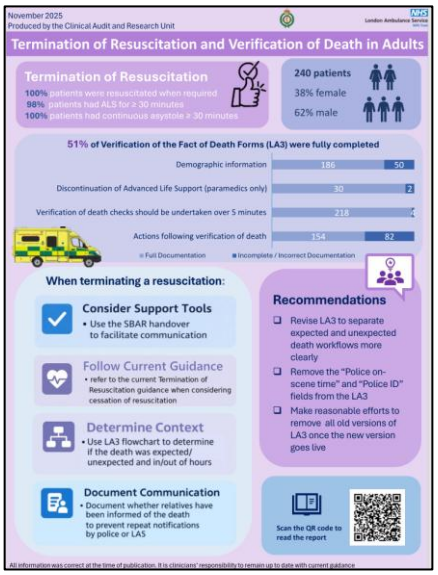
governance arrangements and a sustained organisational focus on maintaining high standards of practice and patient safety across the service.

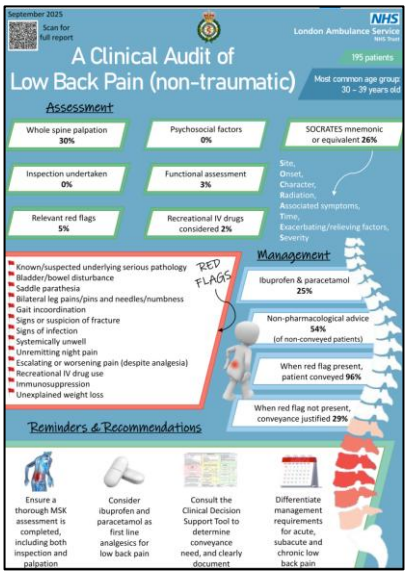
### 2.8 Clinical Audit and Research

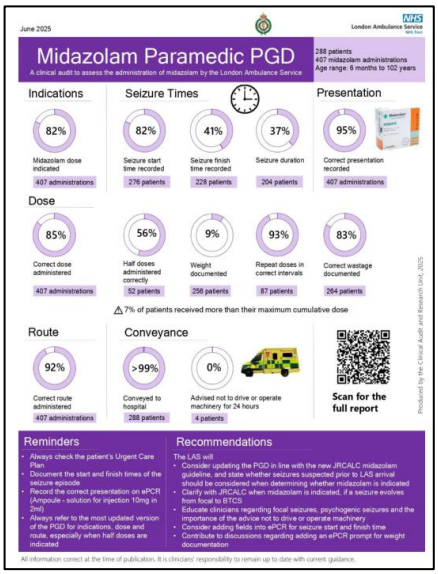
Clinical audit is a tool to improve clinical quality and patient care and plays an important role in ensuring that the highest standard of care is delivered to patients across the National Health Service (NHS). It enables organisations to demonstrate the quality of their services and identify areas for 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.

The 2024-25 Clinical Audit Report, summarising completed projects, national submissions, staff engagement, and public involvement has been approved through Quality Assurance Committee. It also provides evidence of assurance and outlines priorities for clinical audit in 2025-26.

Quality Assurance Committee received clinical audit reports on the Termination of Resuscitation, Low Back Pain and Administration of Midazolam. The audit results are shared through Team Huddles and QR codes. The audits are also shared with JRCALC who frequently amend their guidelines to reflect the findings.




In October, we shared the outcome of a facilitated clinical audit of the administration of medicines by Emergency Responders. The findings show medicines were mostly administered with the correct indication, dose and route. Training sessions have been delivered to all our Emergency Responder volunteers covering the learning which was identified including:

- Correct drug dose documentation
- Post-administration observations
- Ensuring patients are conscious when administering glucose gel
- Having salbutamol doses for patients on beta-blockers.

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 55 patients into clinical trials, bringing us to 443 patients enrolled into the SIS study and 349 into CRASH-4. 34 new clinicians completed trial training, bringing the total number of trained clinicians across both trials to 838.
- Along with a range of academic and clinical partners, we have worked on nine applications for clinical trial funding that have been submitted to various NHIR funding streams.

**3.0 Caring**

This section covers the caring domain and outlines the work being undertaken to ensure optimal care is provided to patients.

**3.1 Health Inequalities**

Reducing health inequalities across London remains a Trust priority.

42 of the 100 actions (across the 5 year plan) have been completed with a further 30 actions 'live' and on track for delivery.

4 of the 5 large improvement clinical priorities projects have been initiated and progressing to plan, including: sickle cell, maternal health, learning disability & autism and cardiovascular disease. Mental Health is due to commence in 2026/27 workplan.

Multiple practical resources to support patients and reduce health inequalities have been launched. Patient information leaflets detailing how to access NHS Services (translated into 9 commonly spoken languages) have been created and distributed, along with specific maternal health leaflets (also translated). A bespoke information leaflet has been co-designed with patients with Sickle Cell and distributed via Sickle Cell organisations, to improve confidence navigating emergency care and identifying how patients can provide feedback on their experience.

For clinicians, a suite of Making Every Contact Count (MECC) initiatives and signposting pathways have been created with London stakeholders, including delivering 'Very Brief Advice' for smoking cessation, signposting patients to drug and alcohol addiction support

services and signposting patients experiencing homelessness to charity organisations, along with advocating for access to primary care services.

A clinical education package 'Toolkit for Tackling Health Inequalities', which highlights what health inequalities are, how they occur and provides clinicians with tools to address these in practice, has now been completed by 76% of clinical staff (n=4,216).

### 3.1.1 Sickle Cell Disease

81% (n=4,518) of clinicians have now completed the Sickle Cell Core Skills Refresher, an education package built directly from the feedback from patients, staff and the findings of clinical audit. The Trust's induction and in-house teaching materials for new starters have also been updated based upon the above findings.

3 of the 4 Acute Sickle Cell Units in London are now open for LAS direct referrals and conveyance (bypassing ED), with over 150 patients conveyed directly to University Hospital Lewisham, St Georges University Hospital and Hammersmith Hospital Acute Sickle Cell Units so far.

Clinical audit shows that these interventions are having an impact with 14% more patients in sickle cell crisis now assisted to the ambulance using a chair or stretcher. Whilst there is further work to do to achieve the target of 95% the training is improving the care and experience for these patients.

### 3.1.2 Maternal Health

The MBRRACE-UK Maternal report 2025 highlighted the persistent inequalities in maternal health outcomes with a significant increase in late maternal deaths. Women from Black ethnic backgrounds are more than twice as likely to die compared with White women and those living in the most deprived areas also continue to have a maternal mortality rate twice that of women living in the least deprived areas. It is well documented that Black and Asian women face disproportionately higher risks during pregnancy, childbirth and the postnatal period.

The maternal health improvement project aims to understand the experiences of women from global majority background regarding using 999 and 111 services during their pregnancy and up to 12 months post-delivery.

The Maternal Health Improvement Plan has been designed following extensive patient engagement with three Voluntary, Community and Social Enterprise Organisations, along with clinical audit and LAS clinician engagement.

### 3.1.4 Learning Disabilities and Autism

People with a learning disability and autistic people are significantly more likely to die prematurely than the general population and have a reduced life expectancy of almost 20 years. 38.8% of deaths of people with a learning disability were avoidable, almost double that of the general population. In this context avoidable means both preventative or treatable and if good quality healthcare had been received in a timely way.

Taking a similar approach to patient engagement as sickle cell and maternal health, the Health Inequalities team have sought expressions of interest from Voluntary, Community and Social Enterprise Organisations to commence key engagement with patients, carers, families and advocates of people with mild, moderate, severe learning disability and people with profound multiple learning disabilities and those with autism.

Three charities who support people with learning disabilities have been commissioned to lead patient engagement activities, and all three are currently scoping different forms of engagement methods from workshops, surveys and focused 1-2-1 sessions. We anticipate engagement with 200 patients, carers and family members.

A similar approach will be taken to engage with Autistic people.

This work will follow our blueprint approach to focused improvement, by applying a triangulated approach of patient engagement, clinician engagement and data / clinical audit to develop a Learning Disability & Autism Improvement Plan.

### 3.1.5 Cardiovascular Disease

Cardiovascular disease is a significant cause of mortality and accounted for 27% of all deaths in the UK in 2022.* The NHS 10-year plan identified cardiovascular disease as a clinical priority and the single biggest condition where lives can be saved. In 2026, the Government will launch the Cardiovascular Disease Modern Service Framework with the ambition to reduce premature deaths from heart disease and strokes.

**National Institute for Health and Care Excellent, What is the impact of CVD? (July 2025)*

The LAS is a ‘pioneer organisation’ for the Office of Health Improvement and Disparities ‘Million Hearts and Minds Programme’ which focuses on promoting health awareness, reducing cardiovascular related adverse outcomes and bridging gaps in heart health equity across London.

LAS already has a notification pathway in place, to inform GPs of patients seen by LAS who have an incidental finding of high blood pressure or high blood sugar. The Health Inequalities team have scoped out further opportunities for cardiovascular health improvement initiatives for emergency and urgent care in 2026/27, working with our system partners, including integrated neighbourhood health teams, expanding the opportunistic identification of patients

presenting with cardiovascular risk factors and supporting our staff with promoting good heart health and awareness of risk factors, along with proactive screening.

### 3.2 Alternative Care Pathways and Care Co-Ordination

#### 3.2.1 Alternative Care Pathways

The clinical pathways team has been focussed on mobilising Integrated Care Coordination Hubs, maximising referrals to Alternative Care Pathways (ACPs) during winter and improving the use of MiDOS, for identifying and accessing pathways as an alternative to Emergency Department (ED) conveyance.

Urgent Community Response (UCR) team referrals have increased over winter and access to UCR capacity visibility is being explored to support referrals to services. There has been a consistent increasing trend in Same Day Emergency Care (SDEC) conveyances over the last 6 months, driven by the successful roll out of the trusted assessor approach.

A care home dashboard has been developed to enable a data informed approach to improvement in our response to people residing in care homes. This will be available to system partners and engagement has commenced to gain their feedback on the design. The Trust is keen to expand access to Acute Frailty Units for ambulance clinicians, reducing conveyance to EDs when hospital admission is required and engagement with our partners continues.

#### 3.2.3 Integrated Care Coordination (Data up to January 2026)

LAS continues to support all five ICSs in the development of Integrated Care Coordination (ICC) or Single Point of Access (SPoA) models. Following extensive collaborative work with system partners, LAS are now hosting five ICC hubs. In Noth West London, South West London, North Central London and North East London these hubs are system wide, with initial South East London delivery focused on the Lewisham and Greenwich footprint in partnership with Lewisham and Greenwich NHS Trust.

These models support ambulance clinicians with joint decision-making led by senior clinicians, preventing avoidable hospital conveyances where appropriate. The ICC hubs are tailored to meet the needs of their local populations and are designed to integrate with local services, as such they are developing at different rates. Work is ongoing with partners to extend ICC hub operating hours and increase the scope of services delivered within them, including closer working with Urgent Community Response and Mental Health clinicians.

To date, the ICC hubs have managed approximately 6,300 cases, enabling 2,756 patients to safely avoid unnecessary emergency department attendance between August 2025 and January 2026. 91% of referrals made by the ICC to the wider system resulted in a successful

outcome demonstrating good access to alternative care pathways. Ambulance clinician satisfaction surveys indicate that paramedics believe the ICC hubs have had a positive impact on patient outcomes and report that the services are easy to access.

The impact of ICC hubs is expected to increase further as their multidisciplinary teams are expanded and integration between community and hospital services continues to develop, creating additional referral options and helping patients' needs to be met in the right place, first time.

**4.0 Well-Led**

This section covers the well-led domain and includes updates on assurance and Trust improvements.

**4.1 Quality Regulation**

Over recent months, the Quality Intelligence and Compliance Team has maintained a strong focus on sustaining regulatory compliance, strengthening assurance maturity, and addressing known areas of risk, with Care Quality Commission (CQC) standards treated as a baseline to be continuously maintained rather than a test to be passed.

Oversight of regulatory compliance has continued through bi-weekly Assurance Packs, supporting Executive visibility of risk, controls and assurance.

There has been a sustained focus on improving incident management, quality checks, training compliance, policy currency and risk control assurance. This has also included a targeted review of overdue incidents, actions, risks and controls to support recovery and prioritisation. Monitoring of workforce, training and operational assurance metrics to inform targeted improvement activity.

Quality visits and assurance activity have highlighted areas for sharing with local managers including vehicle security, equipment management, linen handling and blanket availability. Policy assurance work remains a priority, including review of Standard Operating Procedures and ensuring availability of current versions on LAS Connect.

**4.2 Quality Improvement**

The Quality Improvement (QI) project Back to Base on Time for Ambulance Operations Double Crewed Ambulances (DCA) is now led by a dedicated Task and Finish group led by the Process Owner of the Rapid Process Improvement Workshop (RPIW) held in October. The project is now in the further testing and Plan, Do, Study, Act (PDSA) phase, focusing on Friern Barnet with carefully tracked impact on the out of service, reduction of the incidental

overtime, job cycle time, patients per shift and staff feedback. Once the ideas and new approaches have been thoroughly tested, a plan for the Trust-wide roll out will be developed.

The Back to Base on Time project for non-DCA resources will be started in quarter four with a more bespoke approach rather than one RPIW to encompass them all.

The planning process for the RPIWs in 2026/27, our final year of the Surrey and Sussex Healthcare (SASH) contract, has started and will be aligned with the business planning process for LAS. The process of prioritising QI support for 26/27 will be wrapped around business planning for next year.

Lean for Leaders training is ongoing although Cohort 2 and 3 were paused over winter due to an operational escalation to REAP 4 and will resume in March 2026. Cohort 4 is planned for to start in March 2027 to avoid any pause over winter.

A Quality Improvement conference is planned for March 2026.

London Ambulance Service
NHS Trust

# The Quality Report

Quality Assurance Committee 13th January 2026

Providing Assurance on October and November's data and updates from CQOG (December 2025)

**We are the capital's emergency and urgent care responders**

# Index

# Introduction & Purpose

SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED

The quality report brings together all elements of clinical quality within the London Ambulance Service NHS Trust, meeting our contractual and statutory responsibilities to provide 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.

This report primarily identifies themes and trends across this vast body of data, demonstrating insights into the trust's challenges and the actions taken to mitigate and eliminate risk and harm to patients, staff, and partner organisations.

Data and slides from the preceding two months are 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). This improves efficiency within the organisation by reducing duplication of report writing.

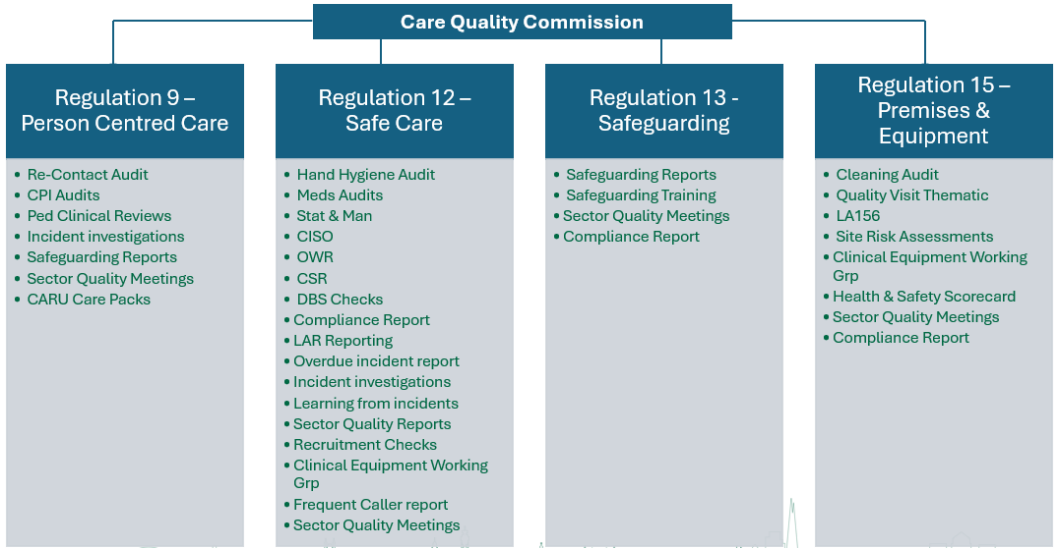
**RADAR**: The Trust's reporting system, RADAR, cross-links modules for Incident reporting (including Patient Safety), Risk, Complaints, Legal, Safeguarding, Freedom to Speak up, producing live dashboards that will eventually replace parts or all of this report.

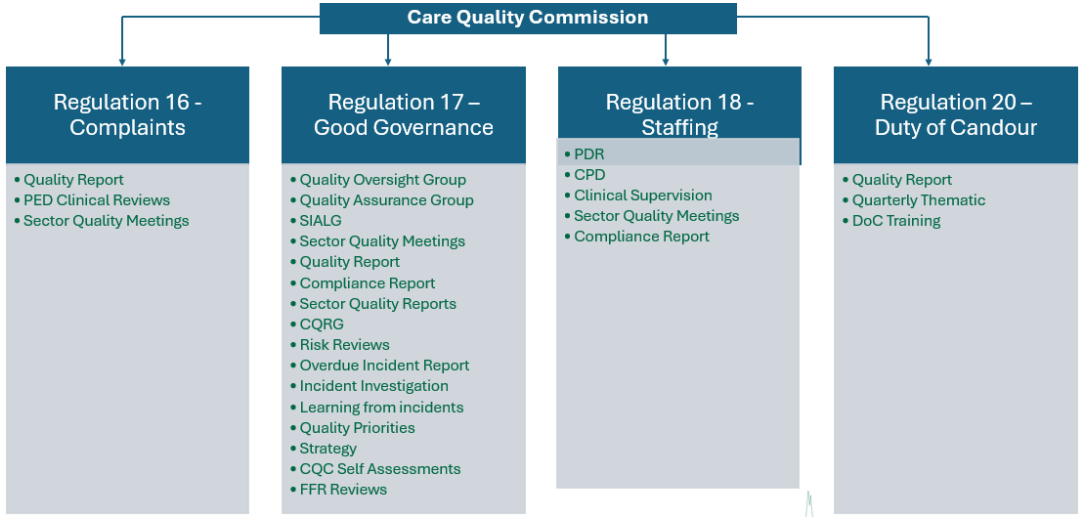
**Important note:**

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.

# Identifying our Obligations – *This report contains data which pertains to the trust's clinical quality governance obligations under the following statutes:*

## Health & Social Care Act 2012:




**Safeguarding**:

- Children Act 1989
- Children and Families Act 2014
- The Children and Social Work Act 2017
- Care Act 2014
- Domestic Abuse Act 2021
- Safeguarding Vulnerable Groups Act 2006
- Sexual Offences Act 2003

**Health & Safety at Work Act 1974**

- Management of Health and Safety at Work Regulations 1999
- Manual Handling Operations 1992 (amended 2002)
- The Health and Safety (Display Screen Equipment) Regulations 1992
- Personal Protective Equipment at Work (Amendment) Regulations 2022
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- RIDDOR. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- Control of Substances Hazardous to Health Regulations (COSHH) 2002
- Personal Protective Equipment at Work Regulations (1992)

- Human Rights Act 1998
- Mental Capacity Act 2005
- Equality Act 2010
- Data Protection Act 2018
- Medicines Act 1968
- The Human Medicines Regulations 2012
- The Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Medicines and Medical Devices Act 2021
- The Misuse of Drugs (Safe Custody) Regulations 1973

# Matters for escalation to QAC

**The following matters are to be escalated from CQOG to QAC:**

- This Quality Report

Items approved at CQOG (December 2025)

- CQOG Terms of reference
- Medical Gases Audit
- LAS Safeguarding Annual Report 2024-2025

London Ambulance Service
NHS Trust

# Triangulating Quality Intelligence & Action Plans

SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED

When all the quality data across directorates is analysed together, what areas stand out, and what are we doing about them as a Trust?

**We are the capital's emergency and urgent care responders**

# Triangulating Quality Intelligence

**The top areas of quality concern:**

- Standard of Clinical Care
  - Initial clinical assessment & management - taking a history, focused examination, forming a differential diagnosis and commencing a treatment plan (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)
  - Assessing Mental Capacity (Patient safety incidents with harm, Learning from Death reviews)
  - Recognition of Cardiac Arrest (Patient safety incidents)
- Medical Equipment – (Patient safety incidents, CQC, staff survey)
- Delays (Patient safety incidents with harm, complaints, performance data, legal)

Action plan to address these concerns:

A system led Quality Improvement Programme to focus on core clinical risk themes is being developed, the first meeting is planned to take place in January 2026.

NB: Nil change with top areas of concern since the previous quarter, however noting actions are in progress to address these.

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NHS Trust

# Quality Regulation & Assurance (incl CQC)

londamb.lascqcevidence@nhs.net

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CQOG date : 23rd December 2025

Reporting date = 15th December 2025

# Quality Regulation and Assurance

Health & Social Care Act 2012

Regulations: 9

WELL LED | SAFE

## Trust Wide Compliance

- 877 overdue incidents
- 24 overdue incident actions
- 438 outstanding quality checks
- 83.09% PDR compliance
- 72.87% OWR compliance
- 59.96% CISO compliance
- 5.09% Vacancy Rate compliance
- 2.46% Sickness compliance
- 89.25% Stat & Man compliance

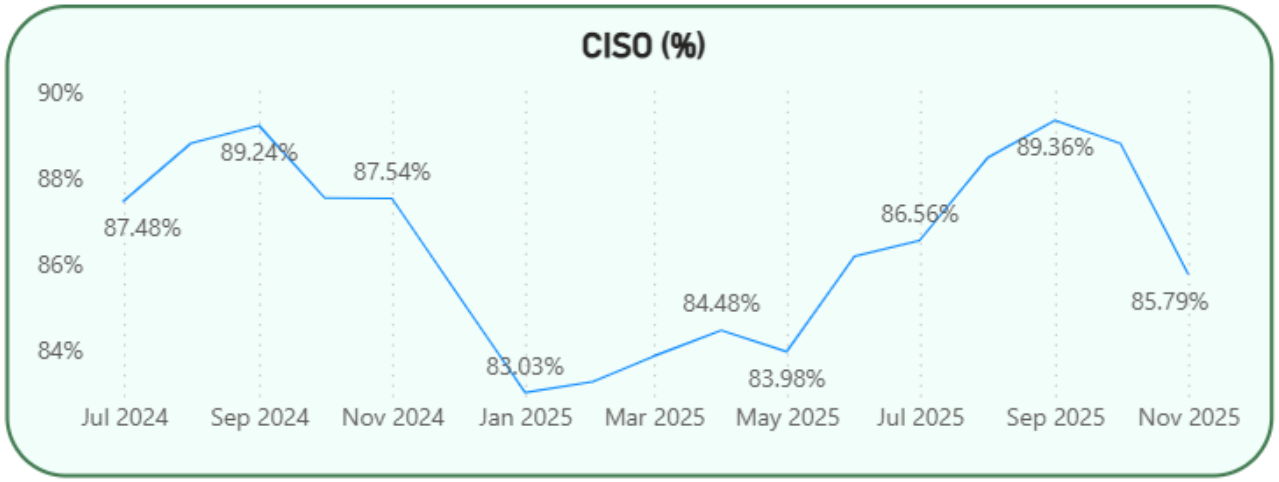
## CQC Preparation

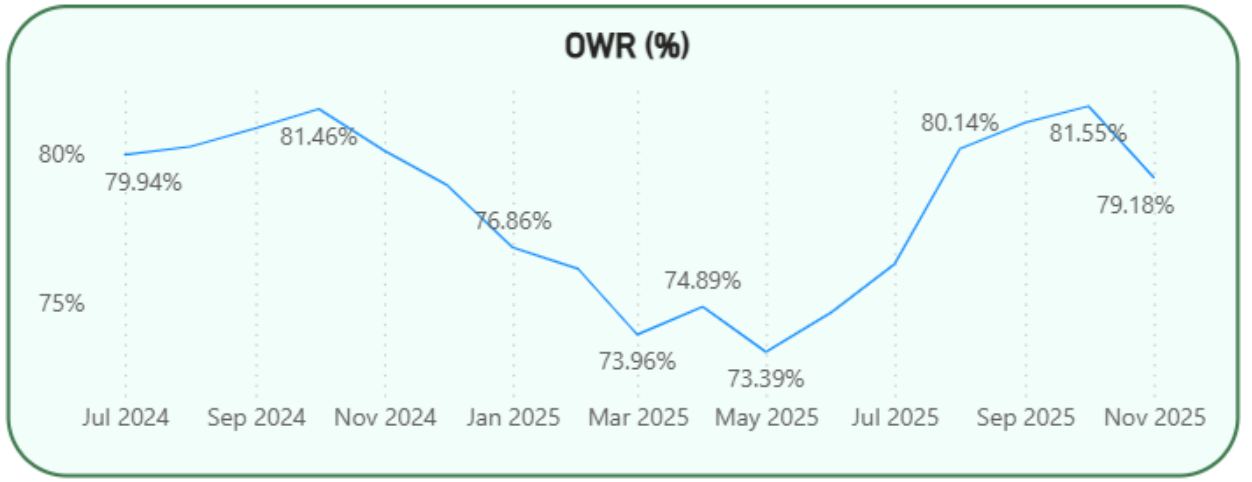
- Focus on CQC as a standard to be maintained rather than a test to be passed.
- Action card and SOP updated – what to do if and when a CQC inspector arrives on any LAS site.
- Review of all risks without controls.
- All station risk posters updated with risks in their areas
- Review of policies and ensure latest versions are available on LAS Connect
- Review of all overdue risks and controls
- Drive on resolving CQC readiness site visits
- Compliance dashboard
- Weekly CQC Prep huddles
- Review of our risk register

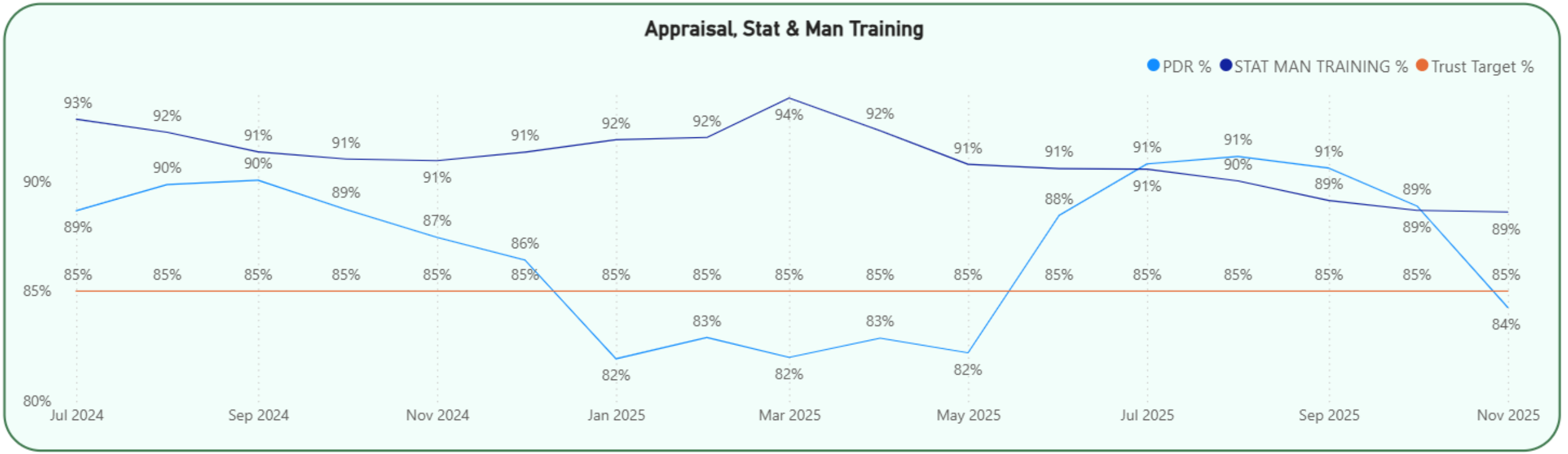
## CQC Update

- Since the last CQOG, LAS has received 2 CQC enquiry. 1 has been closed, 1 remains open.
- South East Coast Ambulance Service had an unannounced inspection focussing on their EOC.
- 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. Consultation closed 15/12/2025.

NB: Data correct on 16/12/2025.




NB: Data exported from the Clinical Quality dashboard. Data correct as of 10/12/2025. The Trust target compliance for Operational Workplace Review (OWR_, Clinical Information & Support Overview (CISO), Appraisal and Statutory and Mandatory Training is 85%

# CQC Enquiries

The CQC have raised **2** since the last Quality Report submission.

All enquiries have been responded to within the deadline, or agreed upon extension.

| No. Received | CQC Reference | Date Received | Response Deadline | Date Responded | Closed/ Open | Description of Enquiry |
|---|---|---|---|---|---|---|
| **13** | CAS-1186870-V2H7T9 CRM:001353000249 | 08/12/2025 | 16/12/2025 | Acknowledgement - 08/12/25 Response 18/12/25 | Closed | Concerns regarding inappropriate sharing of information with another service provider |
| **14** | CAS-1194683-G4Q2B5 CRM:001353000254 | 24/12/2025 | 09/01/2026 | Acknowledgement - 24/12/25 | Open | Anonymous concerns regarding the Freedom to Speak Up process |
| **15** | CAS-1106468-P9J0K0 CRM:001353000255 | 06/01/2026 | 13/01/2026 | Response – 06/01/2026 | Closed | Patient transport concerns – not for LAS |
| **16** | Awaiting ref no. | 06/01/2026 | 13/01/2026 | | Open | Concerns regarding clinical care of a patient |

NB: Data correct on 06/01/2026.

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# Risk

Corporate Risk Register & New Risks of Note

**We are the capital's emergency and urgent care responders**

CQOG date : 23 Dec 2025

Reporting date = Nov 2025

# RCAG - Risk Register Overview – Nov 2025

| Category | 20/10/2025 |
|---|---|
| Total open risks | 142 |
| Risks 15+ | 13 |
| Risks 8 – 12 | 80 |
| Risks <8 | 49 |
| Draft risks | 5 |
| Draft risks overdue | 5 |
| Awaiting approval | 21 |
| Overdue reviews | 8 |
| Missing controls | 16 |
| Missing impact | 53 |

| Overdue Risk Reviews | Last review date |
|---|---|
| RSK-194 | 21/10/25 |
| RSK-210 | 12/11/25 |
| RSK-053 | 09/10/25 |

CQOG date : 23 Dec 2025

Reporting date = Nov 2025

# Risk

Health & Social Care Act 2012

Regulation: 17

RESPONSIVE

## Current risks and Concerns

- There are currently 143 open approved risks in total.
- Currently 12 risks are overdue for review (a decrease of 7 from last report), with 9 overdue by 7 days or more.
- Risk controls provide assurance of action taken or planned to mitigate risk and give assurance of active risk management. There are 12 risks (down from 66) which have no implemented risk controls, and 5 (down from 49) have no risk controls listed at all.
- The current focus is on the 81 risks that have no outstanding controls. Whilst this may accurate for risks that are in the monitoring phase prior to closure, most active risks should have outstanding controls to evidence planned work to mitigate them.
- There are currently 22 draft or awaiting approval risks, the quality of many of these is insufficient to approve them. In addition it is often not clear if these have been approved locally. A new procedure for risk approval is to be produced.

## Performance

•**Corporate Trust Wide Risk Register** (CTWRR) - The CTWRR contains a total of 40 risks that have the potential to affect more than one area of the organisation, or may require input from multiple areas to mitigate.
•The 3 highest rated risks on the register are scored at 16, with a further 4 risks scoring 15 or above.

•**Other Risk Registers** – There are 5 risks rated 15 and above.

•**Longstanding risks** – There are now 7 (down from 10) risks that are 5 years or older. Ongoing work to review these with some already closed.

## 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.
- Policies and procedures being updated to enable clearer understanding of appropriate processes.

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# Patient Safety & Incidents

**We are the capital's emergency and urgent care responders**

# The 2025 – 2026 LAS Patient Safety Incident Response Plan (PSIRP): – For reference

| | Incident type<br><br>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. |

**Patient Safety Incident Response Plan (PSIRP):** Individual to each organisation, but a mandatory requirement (as part of PSIRF), this plan sets out how we will seek to learn from patient safety incidents. To be used in consultation with commissioners to review and develop a prioritisation plan for local Patient Safety Incident Investigations (PSII).

The LAS now changes its PSIRP priorities every 12 months to maximise learning potential from incidents (previously every 24 months).

**Previous LAS PSIRP 2023-2025:**

- Medicines Management
  - Medication Error
  - Errors occurring in the preparation or administration of Medicines
- Call Handling
  - 999 & 111leading to delays and probable harm
- Face-to-Face Clinical Assessment
  - Extremes of age
  - Failure to immobilise
  - Missed the specialist centre pathway
- Discharge of Care
- Cardiac Arrest Management

The central patient safety team continue to monitor these priorities to determine if the actins and recommendations have been effective.

CQOG date: 23 December 2025

Reporting date = October & November 2025

# Patient Safety Incidents & PSIRF

Health & Social Care Act 2012

Regulations: 9, 17, 20

EFFECTIVE RESPONSIVE

## Incidents

**Patient Safety Incidents &Themes**

In October and November 2025, the Trust's risk management system, Radar, reported (n 2,163 ↑167) patient safety incidents.

The top five categories are as follows:
1. Medical Equipment (n. 407 ↑178)
2. Concern regarding external provider (n.374 =)
3. Dispatch & call (n.214 ↑3)
4. Clinical treatment (EXCEPT medication related) (n.202 ↑21)
5. Communication, care & consent (n.142↓8)

The highest reporting sectors are:
1. NHS111 – 40 (↓ 17)
2. North West – 347 (↑28)
3. South East– 313 (↑17)

**Harm**

Of the 2,163 reported incidents, the harm was graded as follows:
No harm – 1838 (↑147)
Low harm – 258 (↑42)
Moderate harm – 27 (↑7)
Severe harm – 19 (↓7)
Death – 21 (↓8)

Across the severe harm and death severities, 12 incidents took place in October and 28 in November. The most common reported category was dispatch and call, with potential triage error and a delayed response accounting for 48% 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 89 moderate, severe harm or death graded incidents reported during the last CQOG, 27 have remained as either death (7), severe (7) and moderate (13)

## PSIRF

**Learning Responses Commissioned**

13 learning responses were commissioned in October and November 2025
- 5 (↑1) nationally defined incidents requiring local PSII (meeting the LfD criteria)

Themes include:
  - Management of patients under the influence of drugs and/or alcohol
  - 111 call handling
  - 111 clinical assessment/advice
  - Clinical assessment
  - Response time
- 1 (↑1) locally defined incidents requiring local PSII (meeting local priority)

Themes include:
  - Management of patients under the influence of drugs and/or alcohol
- 7 (↓3) AARs

Themes include:
  - Informed consent
  - Management of patients under the influence of drugs and/or alcohol
  - Maternity care

**Case examples**

A 78-year-old Patient experiencing lower back pain was transferred to NHS 111. During the transfer, the call went quiet. NHS111 were unable to complete an assessment and transferred the call back to the 9s. When the LAS arrived, the Patient was found deceased.

The Patient, approximately 7 months pregnant, contacted 999 with SOB and upper abdominal pain. She deteriorated rapidly on the way to the hospital and went into cardiac arrest on arrival. Sadly, the Patient died the same day.

A 77–year–old Patient with the problem description given as abnormal blood test had their call held for 18 hours. The Patient sadly died the day after conveyance to the hospital.

CQOG date: 23 December 2025

Reporting date = October & November 2025

# Patient Safety Incident Response Framework

EFFECTIVE RESPONSIVE

## Learning

**Case Based Discussion**
Case based discussion took place in November and was attended by 87 staff from across the Trust. It was also recorded and shared via LASConnect. Themes included:

- Video made by CE&S on the importance of accurate PDS verification
- A presentation from the safeguarding team relating to a case of missed safeguarding opportunities
- A Patient who had fallen and was FAST positive
- Recognition of cardiac arrest
- Non-conveyance decision-making and differential diagnosis for a Patient experiencing PE

**Patient safety actions of note:**

Patient Care Handbook re Extrication with DIB revised to incorporate specific action around ensuring Patients' conditions are not exacerbated during extricating by self-mobilising to the ambulance, particularly those presenting with significant dyspnoea.

Reminder of the suitability of the patient's travelling to places of care by other means. The importance of targeted worsening advice, administration of attending a hospital or place of care when the patient is not directly conveyed.

Ambulance and FRU loading lists to be added to JRCALC+

OOS policy review

## Current risks and Concerns

**Overdue incidents**
The number of overdue local reviews has decreased compared to the previous reporting period, but remained slightly high at 38.2% trust-wide. Concerns regarding specialist teams, which have workflows open and overdue. This is impacting overall operational performance and the ability of local teams to progress incidents.

**Medical Equipment**
The number of medical equipment incidents has risen during the last reporting period. General themes of incidents reporting a failure during use include:
ETCO2/Capnography ~55
ECG/Cardiac monitoring ~40
Extrication and handling equipment ~40
Consumables (needles and syringes) ~35
LifePak device issues (non-specific) ~30

*ECG Electrode Guidance*: A case study on the new ECG electrodes is included in the next quarterly learning event or Inside Insight magazine to raise awareness.

**Overdue Actions**
31 (28%) of open actions are currently showing as overdue on Radar.

## Ongoing work

**Thematics**
The patient safety team is supporting the review of cases concerning the early recognition of unwell patients, specifically undertaking a primary survey.
Initial findings include:
Delayed recognition of critical illness is driven by cognitive bias, reduced psychological bandwidth, variable team challenge, and a less experienced workforce.
Primary surveys are often incomplete or poorly sequenced, with premature focus on documentation, technology, or secondary tasks.
Technology and documentation systems (LifePak, iPad, ePCR) frequently divert attention from hands-on assessment and can encourage checklist behaviour and error.
Organisational systems and culture lack a clear standard for good primary survey practice; training, mentoring, and feedback do not consistently reflect real-world conditions.
Environmental pressures and scene complexity further disrupt structured assessment.

The patient safety team is continuing to support the development of a system-wide improvement plan.

**Radar**
The Patient Safety Team are working with corporate colleagues to support with incident management and oversight on Radar.

CQOG date: 23 December 2025

Reporting date = October & November 2025

# Patient Safety Incident Response Framework

EFFECTIVE RESPONSIVE

## 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 | Write up | 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 |
| Primary Survey | Recognition and assessment of critically unwell patients during the initial 30 seconds of the primary survey or first point of clinical contact | September 2025 | Charis Emmery | Write up | TBC |

CQOG date: 23 December 2025

Reporting date = October & November 2025

# Quality Metric Performance

Health & Social Care Act 2012

Regulations: 9, 12, 17, 20

EFFECTIVE | RESPONSIVE

## Performance and Compliance

### Overdue incidents

- There are currently 877 overdue local review workflows in the Trust – this equates to 38.3% of all open local review workflows. Of note, 3814 incidents were reported during October and November, and 2347 incidents overall were closed. Teams are working hard to clear a backlog of older incidents.
- 75.27% of incidents reported in October had since been closed.

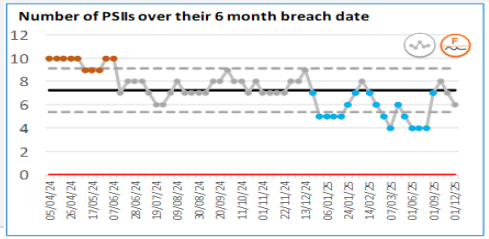
Overdue workflow by sector breakdown:

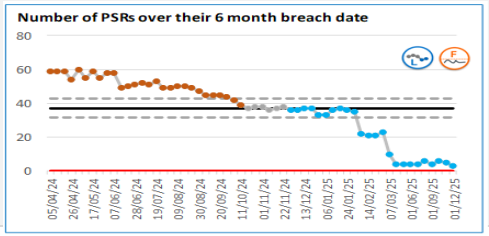
- NC – 91 (30%)
- NW – 147 (36%)
- NE – 64 (28%)
- SE – 154 (40%)
- SW – 89 (36%)
- EOC – 68(35%)
- CHUB – 14 (27%)
- 111 – 49 (33%)
- RS&A – 90 (58%)

### Learning Responses

*No learning response should exceed 6 months from the commissioning date*.

- There are currently 43 open learning responses:
  - PSII – 20
  - PSR (inc. AAR, Swarm and MDT) - 23
- 9 learning responses have breached 6 months (6 PSII and 3 PSR).
  - 4 of these are either awaiting final approval or are in the final QA review stage
  - 1 case CHUB, 1 NE and SW
  - 6 learning responses are concerning IUC/111 processes.




### Duty of Candour

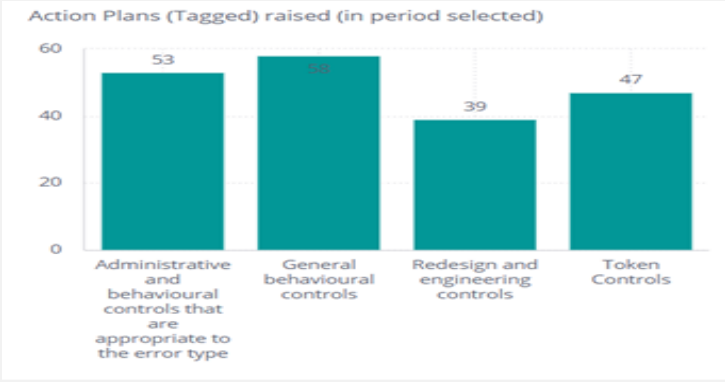
Overall, duty of candour compliance for November was 93.3%. This is an increase when compared to the last reporting period. Where DoC has not been undertaken, escalation has taken place to the relevant heads of teams.

| | DoC 2025/26 | | | | Audit of Letters | | | |
|---|---|---|---|---|---|---|---|---|
| | Compliant | Applicable | Performance | Previous | Compliant | Applicable | Performance | Previous |
| PSII 1st Stage DoC | 47 | 49 | 95.9% | 95.7% | 46 | 47 | 97.9% | 97.7% |
| PSII 2nd Stage DoC | 30 | 31 | 96.8% | 88.0% | 30 | 30 | 100.0% | 100.0% |
| PSR 1st Stage DoC | 36 | 37 | 97.3% | 93.8% | 34 | 36 | 94.4% | 93.3% |
| PSR 2nd Stage DoC | 20 | 22 | 90.9% | 94.4% | 19 | 20 | 95.0% | 100.0% |
| Local investigation 1st Stage DoC | 25 | 30 | 83.3% | 73.3% | 25 | 25 | 100.0% | 100.0% |
| Local investigation 2nd Stage DoC (Outcome) | 23 | 25 | 92.0% | 66.7% | 23 | 23 | 100.0% | 100.0% |

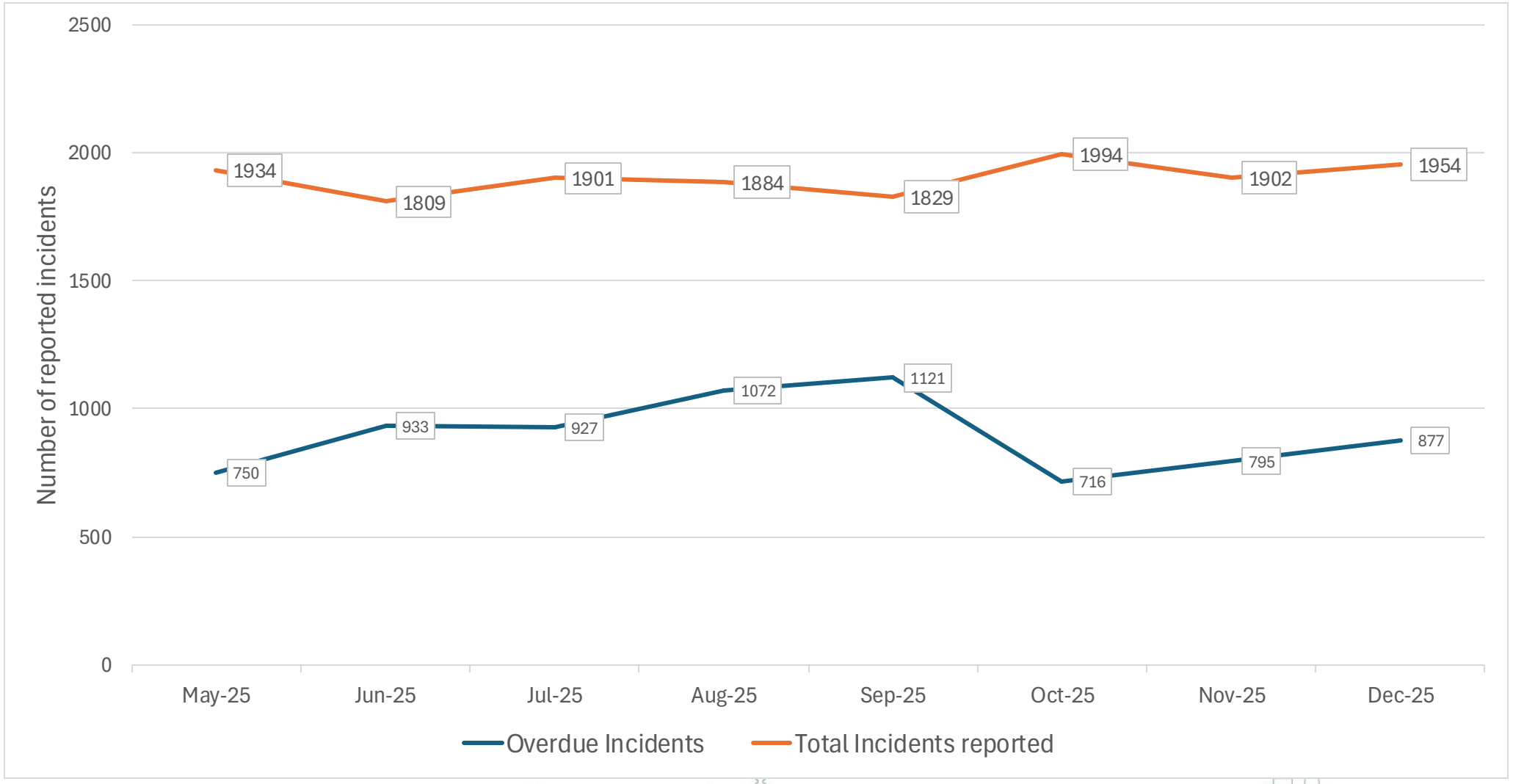
### Actions

There are currently 112 open actions, of which 31 have exceeded their due date (28%).

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.

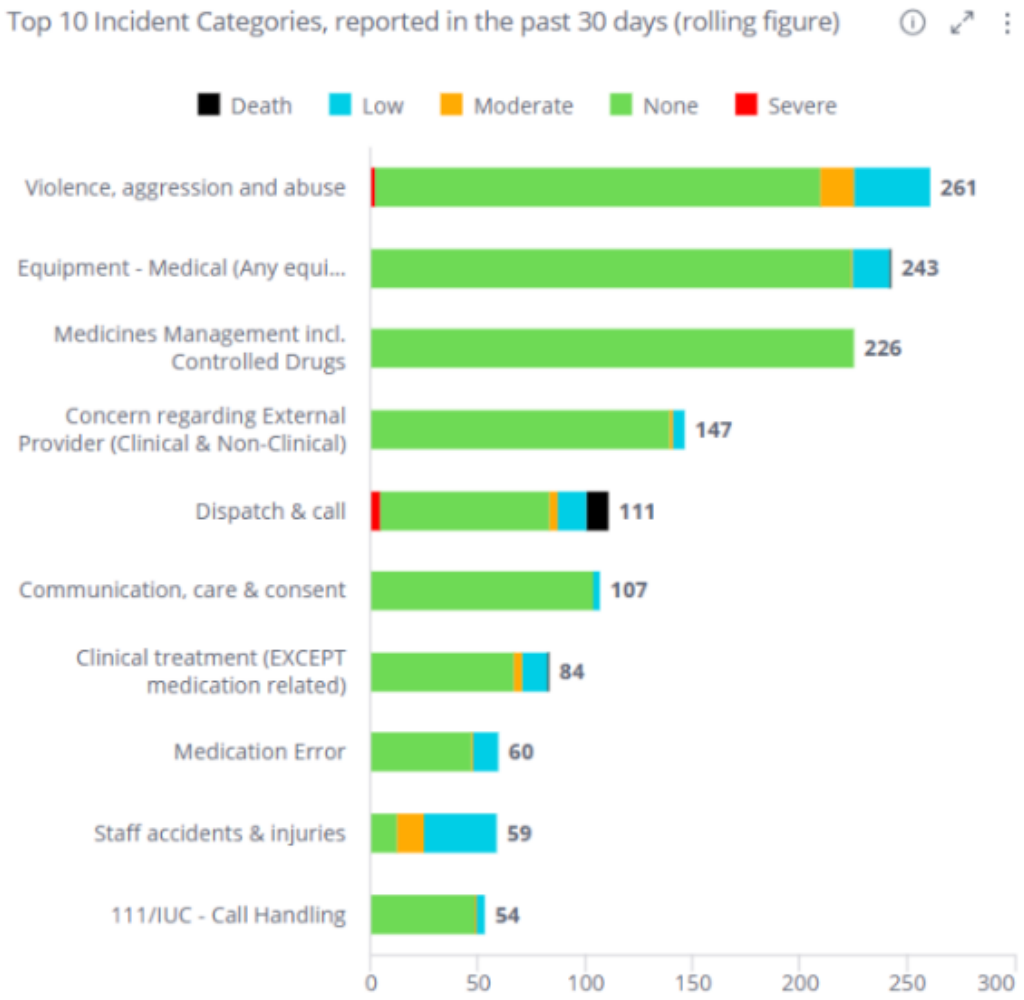


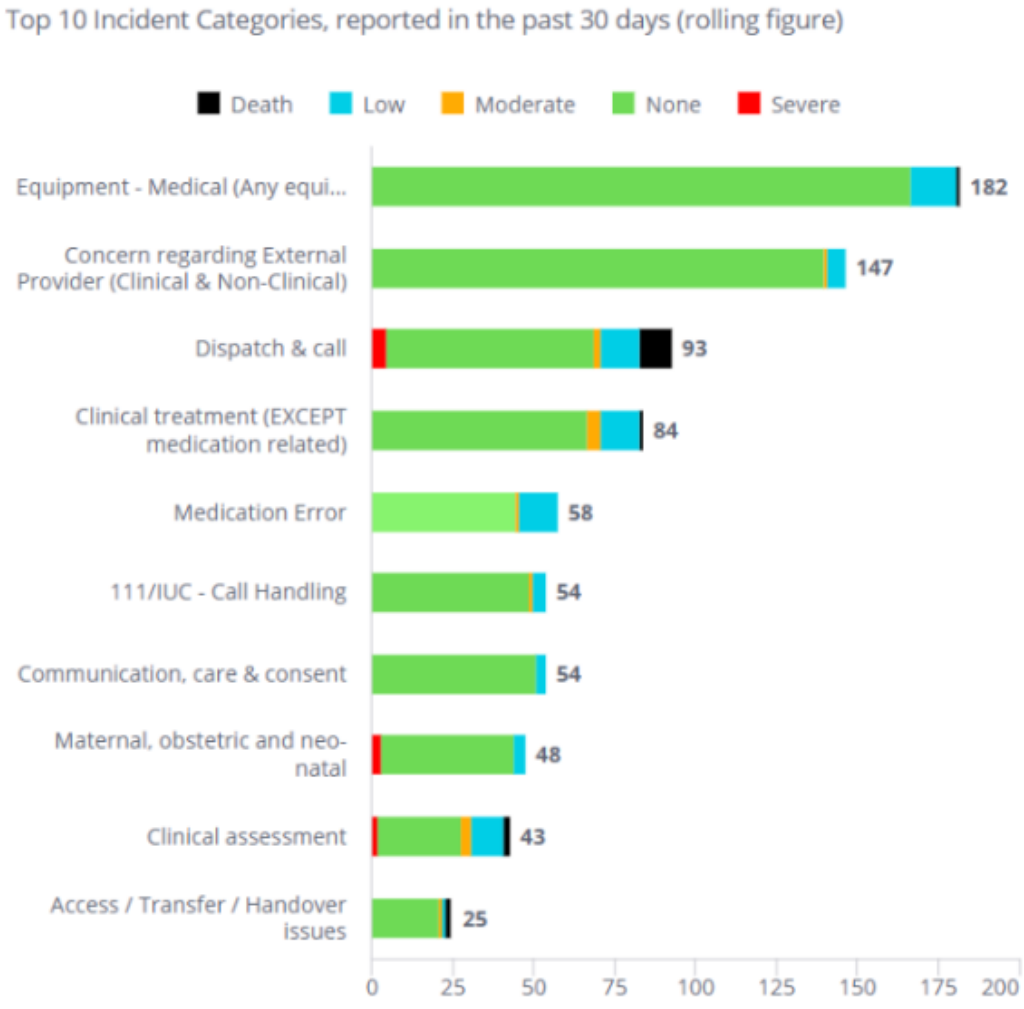
# Total number of incidents reported trust wide vs overdue incidents per month




NB: Data exported from the monthly Trust wide Quality Assurance Reports and RADAR.

# All incident categories vs Patient Safety Incidents




NB: Data exported from RADAR on 25/11/2025.

# Incidents

Year, Month: 2025
Sector / Department: All
Station / Team Location: All

| Year<br>Category | 2025<br>January | February | March | April | May | June | July | August | September | October | November | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicines Management incl. Controlled Drugs | 309 | 238 | 223 | 210 | 249 | 247 | 255 | 238 | 281 | 274 | 231 | 2755 |
| Concern regarding External Provider (Clinical & Non-Clinical) | 163 | 132 | 127 | 141 | 129 | 143 | 195 | 181 | 191 | 212 | 154 | 1768 |
| Medical equipment | 183 | 144 | 363 | 237 | 250 | 199 | 224 | 120 | | | | 1720 |
| Security - violence, aggression and abuse | 215 | 234 | 226 | 251 | 302 | 286 | 182 | | | | | 1696 |
| Communication, care & consent | 137 | 94 | 116 | 140 | 140 | 120 | 112 | 113 | 97 | 110 | 121 | 1300 |
| Violence, aggression and abuse | | | | | | 1 | 82 | 278 | 240 | 292 | 258 | 1151 |
| Dispatch & call | 141 | 67 | 70 | 76 | 78 | 92 | 112 | 103 | 135 | 112 | 120 | 1106 |
| Clinical treatment (EXCEPT medication related) | 91 | 84 | 79 | 65 | 66 | 58 | 86 | 100 | 87 | 105 | 88 | 909 |
| 111/IUC - Call Handling | 90 | 101 | 65 | 87 | 70 | 81 | 72 | 79 | 63 | 72 | 67 | 847 |
| Equipment - Medical (Any equipment used with a patient during a care episode, including ambulance equipment bags) | | | | | | | | 98 | 201 | 239 | 253 | 791 |
| Staff accidents & injuries | 64 | 44 | 67 | 76 | 72 | 65 | 81 | 77 | 75 | 60 | 53 | 734 |
| Medication Error | 60 | 41 | 48 | 50 | 52 | 43 | 54 | 58 | 57 | 63 | 68 | 594 |
| Moving and Handling of Patients (not including physical restraint) | 84 | 71 | 51 | 40 | 43 | 36 | 48 | 42 | 46 | 46 | 50 | 557 |
| Clinical assessment | 57 | 35 | 61 | 49 | 53 | 39 | 53 | 51 | 52 | 59 | 46 | 555 |
| Non-medical equipment | 67 | 56 | 79 | 79 | 77 | 70 | 55 | 44 | | | | 527 |
| Vehicle related | 53 | 45 | 51 | 57 | 40 | 39 | 44 | 49 | 44 | 43 | 36 | 501 |
| Maternal, obstetric and neo-natal | 45 | 48 | 42 | 20 | 45 | 42 | 41 | 31 | 24 | 42 | 50 | 430 |
| Infection Prevention & Control (incl. Sharps Injury) | 40 | 34 | 24 | 30 | 36 | 35 | 32 | 34 | 28 | 31 | 28 | 352 |
| Access / Transfer / Handover issues | 26 | 22 | 19 | 23 | 21 | 28 | 37 | 31 | 32 | 42 | 34 | 315 |
| Information governance and breaches of confidentiality | 26 | 15 | 27 | 25 | 33 | 29 | 21 | 20 | 15 | 29 | 34 | 274 |
| Patient accidents & injuries | 20 | 10 | 23 | 20 | 22 | 31 | 31 | 21 | 34 | 26 | 20 | 258 |
| 111/IUC - Clinical assessment / advice | 34 | 39 | 29 | 20 | 22 | 14 | 20 | 18 | 20 | 17 | 14 | 247 |
| Infrastructure, buildings, IT & telephony | 40 | 18 | 22 | 17 | 24 | 9 | 19 | 18 | 17 | 12 | 20 | 216 |
| Security - theft, damage to property, loss of property | 30 | 36 | 30 | 29 | 33 | 23 | 23 | | | | | 204 |

NB: Data exported from the Clinical Quality dashboard.

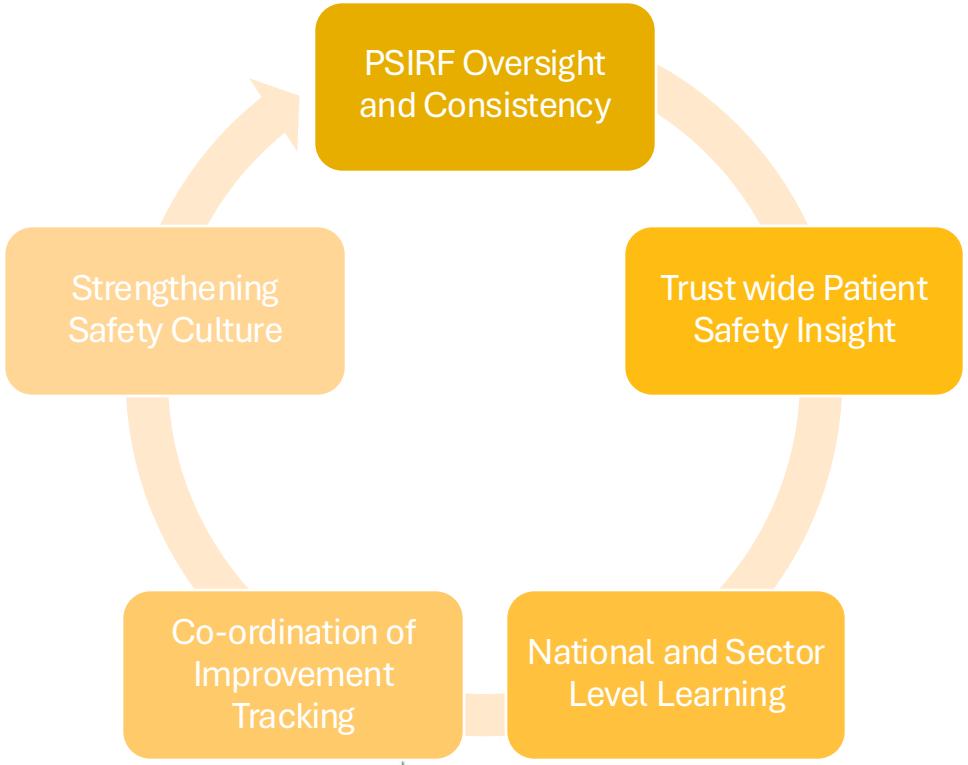
EFFECTIVE RESPONSIVE

# Patient Safety Forum

Patient Safety Forum (a quarterly meeting chaired by the Head of Patient Safety & Patient Safety Specialist) attended by Clinical Quality teams, operational colleagues and representatives from Clinical Education.

**Improvements as a result of learning from incidents reported on RADAR:**

- ✓ Understanding the impact of *missing equipment* on patient care and staff morale:
  - ✓ Evidenced the need for the new trust wide trolley bed scanning process (go live date 15/12/2025)
  - ✓ Creation of a daily equipment check list for FRUs.
  - ✓ Launch of central packing unit for MakeReady.
- ✓ Not normally NETS guidance released
- ✓ ECSR covering PE and differential diagnosis
- ✓ A video providing updates to the Patient Care Handbook



London Ambulance Service
NHS Trust

# Never Events

**We are the capital's emergency and urgent care responders**

# Never Event list (2018) NHSE

SAFE

**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.
- 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.

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# National Patient Safety Alerts, & National Guidance

Compliance & Awareness

**We are the capital's emergency and urgent care responders**

# Guidance

SAFE

## Outstanding guidance actions:

- NG197- Shared decision making (June 2021) – Actions progressing; 2 main workstreams here are the refreshed patient engagement approach and also the CSR Refusal of Care. Patient survey is in draft design, but other elements (eg evaluating and sharing feedback etc will be part of the project group). CSR - Consultant Paramedic working with the Legal team on designing the learning objectives and key content.

- NG9 Bronchiolitis in children (August 2021)–WCA advice sheets have been approved at PSCEG, now waiting for the tech/interface to have further updates. Expected live date shortly after 25th November.

- QS212- Obesity and weight management (August 2025)- Easy read Making Every Contact Count (MECC) advice has been identified and being reviewed for suitability by the Learning Disability and Vulnerabilities Specialist. There is an options paper in progress for how we provide CVD notifications/MECC advice going forward. Consultant Paramedic advises will need to adjust the deadline to meet this, as they are suggesting quite a large overhaul of how we process notifications.

- Trusts are required to review all 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):
- 9th December 2025.

## Guidance released in November 2025

- NG2521 - Suspected sepsis in people aged 16 or over: recognition, assessment and early management
- NG254 - Suspected sepsis in under 16s: recognition, diagnosis and early management
- NG255 - Suspected sepsis in pregnant or recently pregnant people: recognition, diagnosis and early management

# National Patient Safety Updates

SAFE

## National Themes:

- Operational pressures
- Restructuring
- Carry chairs and trolley bed failures that are battery-operated
- FOI requests and administrative burden
- LFPSE data quality

## 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/
- Language/translation service challenges for families – Action – undertaking national thematic on translation services
- Hospital handover delays – some trusts have implemented W45 equivalents as mitigation.

Updates shared in the quarterly internal Patient Safety Forum held in November 2025.

London Ambulance Service
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# Complaints & Compliments

**We are the capital's emergency and urgent care responders**

CQOG date : **23/12/25**

Reporting date = **Oct/Nov 25**

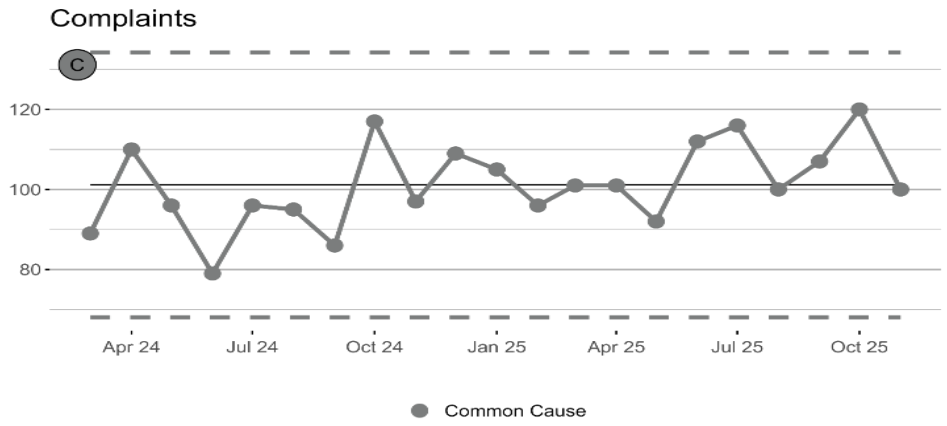
# Patient Experience

Health & Social Care Act 2012

Regulations: 9, 16

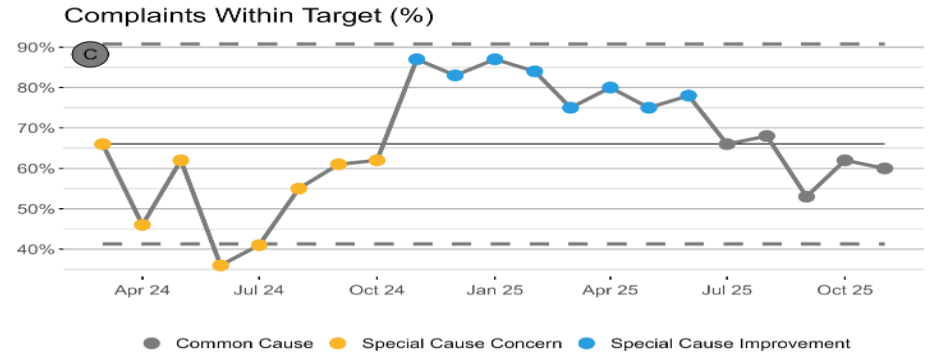
CARING RESPONSIVE

## Complaints




The number of complaints received each month remains within common cause variation, and themes are consistent with previous reporting periods.

## Performance




Additional monitoring has been implemented following the recent dip in performance. Target set to return to 75% by end of financial year. Target remains 75% of complaints to be responded to within 35 working days

## Learning

**Overall Learning Summary**

**1. Communication & Professionalism**
•Empathy, reassurance, and professionalism issues identified
•Acknowledge caller requests (e.g., provide CAD number instead of ignoring).
•Demonstrate active listening and compassion during triage and consultations.

**2. Call Handling & Escalation**
•Referring calls back to NHS 111 or 999 incorrectly; arrange appropriate clinical callback.
•Place calls in the clinical queue when required rather than advising patients to self-manage or re-contact services.

**3. Clinical Safety & Documentation**
•Document all relevant symptoms (e.g., slurred speech during stroke protocol) to ensure correct triage outcome.
•Vulnerable patients require correct safeguarding referral (Child in Need vs Safeguarding).
•Apply Mental Capacity Act correctly and inform family members where appropriate.

**4. Operational Conduct**
•Maintain focus during calls;
•Explain protocol changes clearly to avoid confusion.

**5. System & Process Issues**
•NHS 111 delays often linked to service pressure.
•Incorrect advice about pharmacy services and appointment terminology

**Key Learning Hashtags**
**#Communication #ECHmanner #ECHtriage #ECHinstruction #HAmanner #HAinstructions #111clinicianmanner #111clinicianconsult #111delay #Opsclinical #opsmanner #ACPmanner #vulnerablepatient #ForcedEntry**

## Current risks and Concerns

•The CIP outcome took effect in November and is impacting on performance due to workload being to be redistributed. Temporary support is being offered from staff on light duties.

As noted in the previous report:
•Radar dashboards are not fully operational for reports required. This continues to impact performance monitoring.

•Variance in workflow completion by team due to set up of Radar has made reporting challenging. This is being discussed with the team and Radar support.

# Compliments

CARING

**315** appreciations shared with the Patient Experiences Department about LAS colleagues throughout October and November 2025.

NB: Data compiled by Patient Experiences team.

# Excellence Reporting

CARING

**119** excellence reports were submitted by LAS staff throughout October 2025. Here are some of the excellence reports received:

[Redacted]excellent mentoring skills have been noticed by everyone in CHUB, and her positive influence continues to strengthen our culture of mutual respect and development. Amelia consistently demonstrates patience, grace, and professionalism in every interaction, setting a remarkable example for others to follow. Her commitment to guiding and supporting her colleagues has not gone unnoticed. Amelia's ability to listen, provide thoughtful advice, and nurture growth has helped others gain confidence and improve their performance. Her mentoring approach embodies the core values of collaboration, empathy, and continuous learning.

[Redacted] were very quick to recognise and begin to treat a life threatening asthma. They showed great early recognition and aggressive early management. During the call the crew were met with a near miss but both remained focused on ensuring their patients safety and treatment remained paramount. With their efforts, the patient was able to get to hospital safely and appeared to make a good recovery.

[Redacted] handled a call with a suicidal patient excellently. He was incredibly calm, compassionate and empathetic. He stayed on the line to keep her calm and avoid any further injury to the patient.

The staff attended a very complex paediatric cardiac arrest at a residential address. Some of the crews did not know what they were being sent to, but were able to adapt and provide excellent care under a lot of pressure. The team worked well together, ensuring the best possible care was provided.

| Themes | |
|---|---|
| Scene Management | 4 |
| Cardiac Arrest Management | 15 |
| Outstanding Patient Care | 25 |
| Thank you | 1 |
| Working Above and Beyond | 34 |
| End of Life Care | 4 |
| Call Handling | 10 |
| Maternity Care | 5 |
| External | 0 |
| Mentoring/Teaching | 8 |
| Staff Support/Welfare | 8 |
| Other | 5 |
| **Total** | **119** |

London Ambulance Service
NHS Trust

# Learning from Deaths

**We are the capital's emergency and urgent care responders**

# Learning from Deaths

Health & Social Care Act 2012

Regulations: 9, 12, 17, 20

SAFE

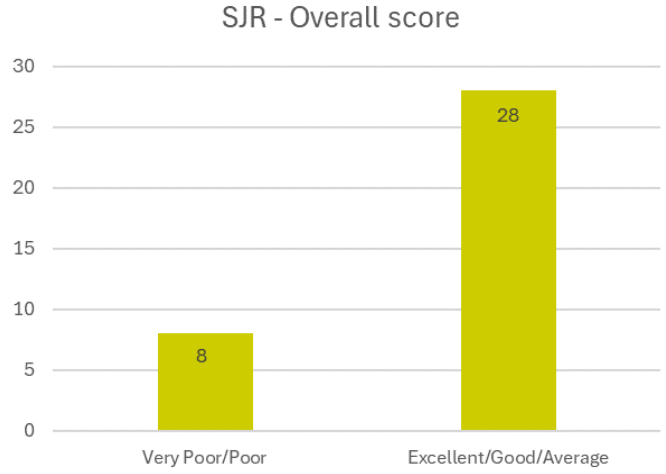
**Background:** Structured Judgement Reviews (SJR) are undertaken to identify opportunities for system-wide learning where care processes and organisational factors may not have supported the best outcomes. The purpose is to understand contributory factors across the work system, and to share insights that strengthen safe and reliable care. Findings are shared with clinicians and teams to support service improvement.

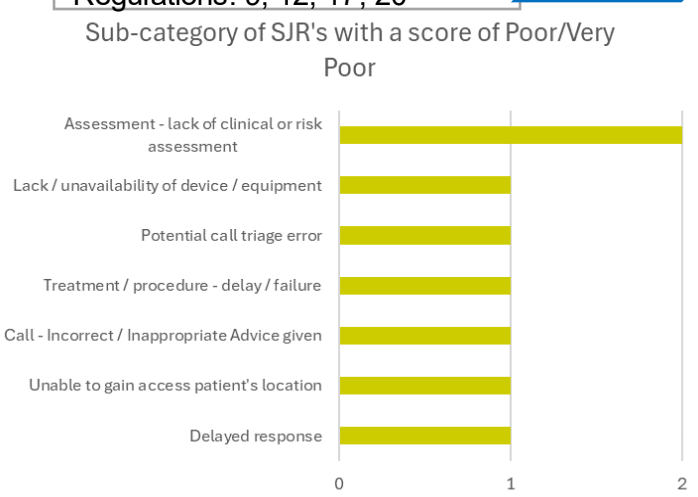
**Month:** November 2025

Stage 1 reviewed: 36

Stage 2 Reviewed: 2

If learning is identified in the first stage review, a 2nd stage occurs for validation




**November Findings**

The following themes highlight **opportunities for improvement across the care system**:

- Pain management opportunity missed; explore barriers to timely analgesia administration.
- Enhancing recognition and management of profound hypothermia in cardiac arrest.
- Reinforcing the 'no trace' policy to promote consistent practice.
- Strengthening recognition of shockable cardiac rhythms and ensuring timely defibrillation.
- Ensuring EtCO2 printout are recorded with ePCR.
- Enhancing early recognition of hypoxia with timely oxygen administration.
- Increasing consistency in ECG interpretation through training and diagnostic support.
- Enhancing clinical hub recognition and escalation of symptom severity.
- Recognition of the problem airway ensuring effective ventilations.
- Enhancing recognition of ineffective breathing in emergency call assessment.
- Strengthening reliability and availability of essential equipment.
- Supporting accurate documentation of clinical assessment.

## SJR Learning Themes

### Learning Identified

- Improve recognition of hypothermia, hypoxia, shockable rhythms, and problem airways
- Strengthen recognition of ineffective breathing in both clinical and call handling contexts.
- Increase consistency in ECG interpretation through training and diagnostic support.
- Support timely analgesia administration by addressing barriers.
- Ensure timely oxygen administration in hypoxia.
- Promote timely defibrillation.
- Improve accurate and complete clinical documentation.
- Strengthen clinical hub processes for recognition and escalation of symptom severity.
- Enhance reliability and availability of essential equipment.
- Reinforce adherence to the no-trace policy.

### Good Practice Identified

- Proactive management of faulty AED equipment during a cardiac arrest.
- Thoughtful recognition of when to question care provided by an external organisation.
- Timely and appropriate escalation when uncertainty arose regarding verification of fact of death.
- Skilled and coordinated management of neonatal life support for a premature patient.
- Effective use of structured troubleshooting approaches during a difficult airway.
- Resilient and collaborative teamwork when essential equipment was unavailable in a trauma scenario.

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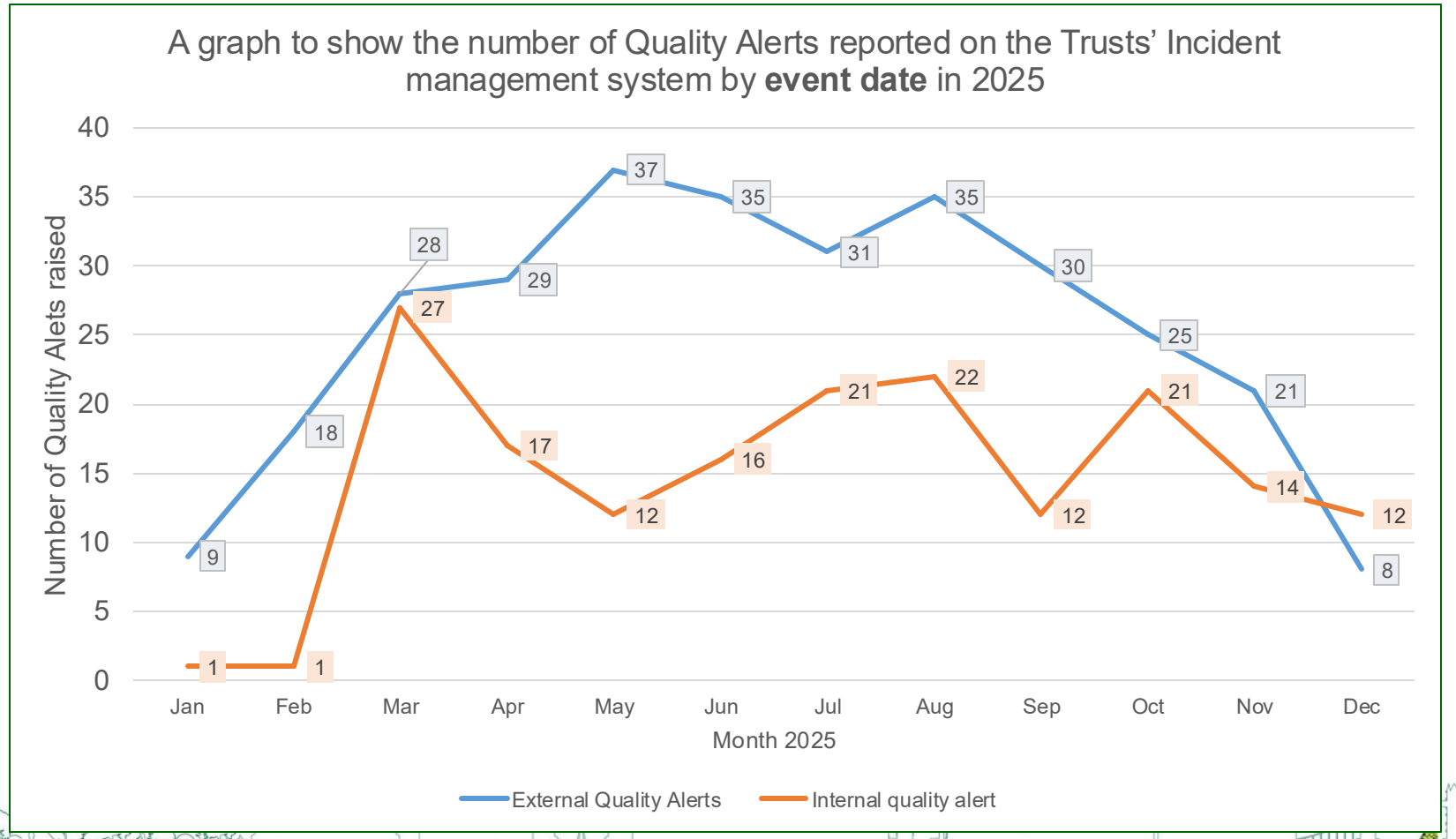
# Quality Alerts

**We are the capital's emergency and urgent care responders**

***A Quality Alert is a structured mechanism for providers to raise concerns about clinical safety, operational performance or service quality. These concerns require investigation and remedial action to address risks to patient safety and enhance the quality of care.***

**Internal Quality Alerts –** Raised by the LAS to other healthcare providers.
**External Quality Alerts - R**aised by external providers to the LAS

NB: Data below exported from the incident management system; this was implemented in March 2025.




**Themes in the past 12 months**:

Internal Quality Alerts:

- Delays in care
- Medication errors
- Issues during handover
- Concerns with safeguarding
- GP/Primary Care concerns (delay/ failed referral)
- Behaviour and unprofessional conduct

External Quality Alerts

- Concerns with clinical assessment/ lack of treatment on route to hospital
  - Including concerns raised with conveyance destination
  - Lack of pre alert

# Themes

RESPONSIVE SAFE

## External Quality Alerts

**20** Quality Alerts raised by external providers to the LAS throughout **December 2025.** (reported date)

**Themes:**

- Delays in patient care/ response (5)
  - Concerns regarding length of time for IFTs.
  - Overcrowding at EDs
- Destination and Conveyance (5)
  - Inappropriate conveyance to ED rather than MTC
  - Conveyance to ED against Urgent Care Plan
  - Non conveyance despite request from HCP
- Communication and handover (5)
  - Concerns pre alert was not placed with receiving hospital
  - Lack of information provided and call categorisation
  - Lack of clinical handover

NB: 5 remaining reports not grouped into a theme.

## Internal Quality Alerts raised with other providers

**11** Quality Alerts raised by the LAS to external providers, following incident reports completed by LAS staff throughout **December 2025.** (reported date)

- Communication and handover (4)
  - Hospital declined handover whilst not on divert

NB: Other reports not grouped into a theme.

NB: Data collated from RADAR reports raised in December 2025.

London Ambulance Service
NHS Trust

# Legal & Coroners

**We are the capital's emergency and urgent care responders**

CQOG date : 23rd December 2025

Reporting date = October & November 25

# Legal

Health & Social Care Act 2012

Regulations: 9, 17, 20

RESPONSIVE

## Inquests & Claims

### 1. Inquests

- Number of opened cases (live cases) - 247
- Number of cases opened per month (last 2 months):
  - October – 174 Inquests
  - November – 175 Inquests
- PFD's and Coroner's concerns
  - No PFD
- 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 - 104
  - Live EL Claims - 62
  - Live PL Claims - 9
- Employers Liability Claims – Staff assault claims ( 5 live claims)
  - Given scale of reported incidents, small proportion of claims (staff assault)

Employers Liability Claims – top 5 themes

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

- Claims are typically low value damages.

CQOG date : 23rd December 2025

Reporting date = October & November 25

# Legal

Health & Social Care Act 2012

Regulations: 9, 17, 20

RESPONSIVE

## Current risks and Concerns

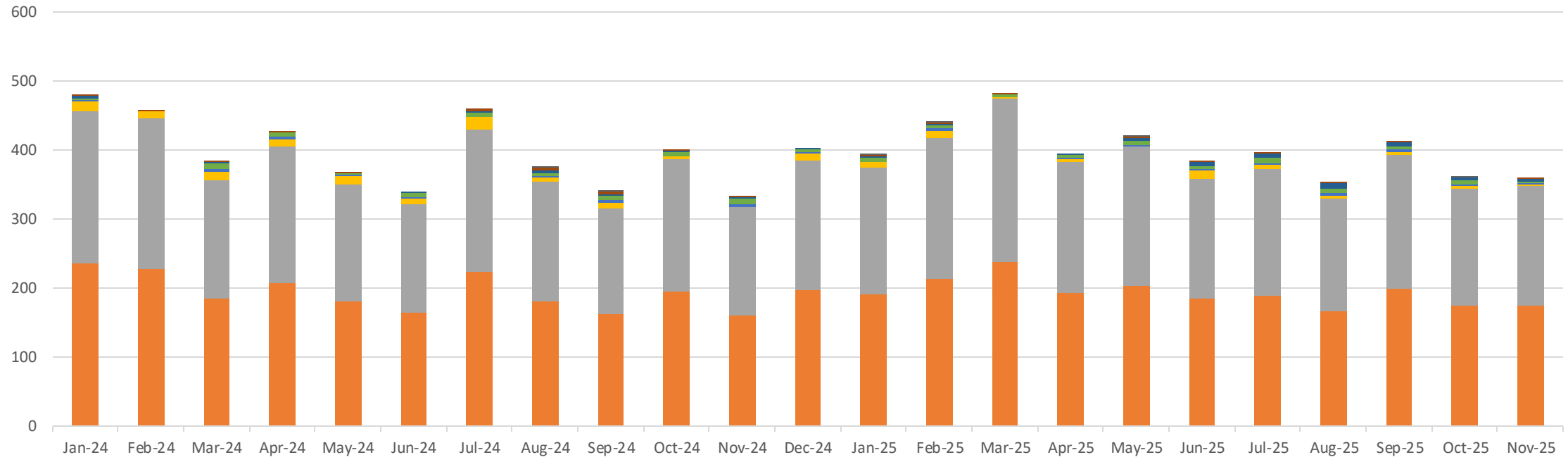
- Any concerns or matters for escalation
- Cases of note
  - On-going case involving assistance dog – sensitive case involving staff member. EDI department have actions to write up a formal procedure around assistance dogs in the Trust – a draft is in progress.
  - Inquest SM – Conclusion suicide
  - No criticism for LAS. Coroner was complimentary of LAS clinicians and the IRO.
  - HMC has asked Ips for PFD submissions as he has a concern about a wider system issue in relation to liaison with family members/ensuring collateral information is available to hospital when patients are conveyed for mental health assessments.
  - Submissions due by 9th January 2026 – HMC may consider writing a PFD at a national level.

## 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
- Still not listed.

# Number of opened inquests and claims by type between January 2024 – November 2025




| | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public Liability Claims | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| Potential Clinical Claims | 1 | 2 | 1 | 1 | 1 | 0 | 3 | 4 | 5 | 1 | 1 | 0 | 2 | 2 | 1 | 0 | 2 | 1 | 2 | 1 | 1 | 0 | 1 |
| Clinical Claims | 4 | 0 | 2 | 1 | 1 | 1 | 2 | 3 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 2 | 3 | 7 | 6 | 8 | 6 | 3 | 3 |
| Enquiries | 2 | 0 | 7 | 5 | 1 | 5 | 6 | 4 | 7 | 7 | 8 | 5 | 7 | 5 | 3 | 4 | 6 | 3 | 8 | 6 | 5 | 8 | 3 |
| Employers Liability | 2 | 1 | 5 | 4 | 3 | 2 | 1 | 3 | 3 | 1 | 4 | 3 | 0 | 3 | 1 | 3 | 2 | 3 | 3 | 4 | 3 | 1 | 2 |
| Level 2 Inquests | 14 | 10 | 11 | 10 | 13 | 8 | 18 | 6 | 8 | 3 | 1 | 9 | 8 | 10 | 1 | 4 | 1 | 11 | 5 | 4 | 6 | 5 | 2 |
| Level 1 Inquests | 221 | 218 | 173 | 198 | 168 | 157 | 206 | 174 | 154 | 192 | 158 | 188 | 183 | 204 | 237 | 189 | 202 | 174 | 184 | 163 | 193 | 169 | 173 |
| Total Inquests | 235 | 228 | 184 | 208 | 181 | 165 | 224 | 180 | 162 | 195 | 159 | 197 | 191 | 214 | 238 | 193 | 203 | 185 | 189 | 167 | 199 | 174 | 175 |



NB: Data provided by the Legal department.

London Ambulance Service
NHS Trust

# Highlight reports from subordinate committees

We are the capital's emergency and urgent care responders

CQOG date : December 2025

Reporting date = October/November 25

# Safeguarding

Health & Social Care Act 2012

Regulations: 13

SAFE

## Key updates

**Number of safeguarding referrals raised within the last quarter. (October and November)**

Adult Safeguarding: 2495
Adult Welfare: 2523
Child Safeguarding: 3844
Child in Need: 648
LFB: 452
Prevent: 11

North West: 2369
South West: 1733
North East: 2013
North Central: 1464
South East: 2029
Out of Area: 580

**Number of statutory meetings information provided for/ attended. (October and November)**

South East: 11/11
South West: 3/4
North West: 13/13
North East: 22/22
North Central: 7/7

## SAG Escalations

- IUEC training compliance has improved significantly, with strong advancement in the training plan
- Child High Intensity User (CHIU) group shows that the first two months have been highly successful. Emerging themes have been identified, and strong partnership working is underway to support those accessing our services. Notably, a positive culture shift has been observed within partner agencies, with many adapting their working practices to better assist with CHIU initiatives
- A working group comprising of ambulance, operations, safeguarding, and clinical education will be established to develop a clear plan for improving the circulation of case studies. This initiative aims to showcase areas of good practice while identifying opportunities to strengthen our safeguarding competencies. By sharing learning effectively, we will drive continuous improvement.
- Managing Abusive Callers within the EOC, work has been undertaken to address abusive callers to 999 services through integrated collaboration across organisational teams, ensuring a coordinated approach. Patient resources have been developed to enhance support and provide clear information. Additionally, engagement with external stakeholders continues, including attendance at multidisciplinary team (MDT) meetings alongside key workers to support individuals involved.
- Safeguarding Annual Report LAS Safeguarding Annual Report 2024-25

## Performance

**Safeguarding Level 1, Level 2 and Level 3 Trust compliance. Compliance target November:**

Level 1 = 89.08
Level 2 = 87.38
Level 3 = 90.28

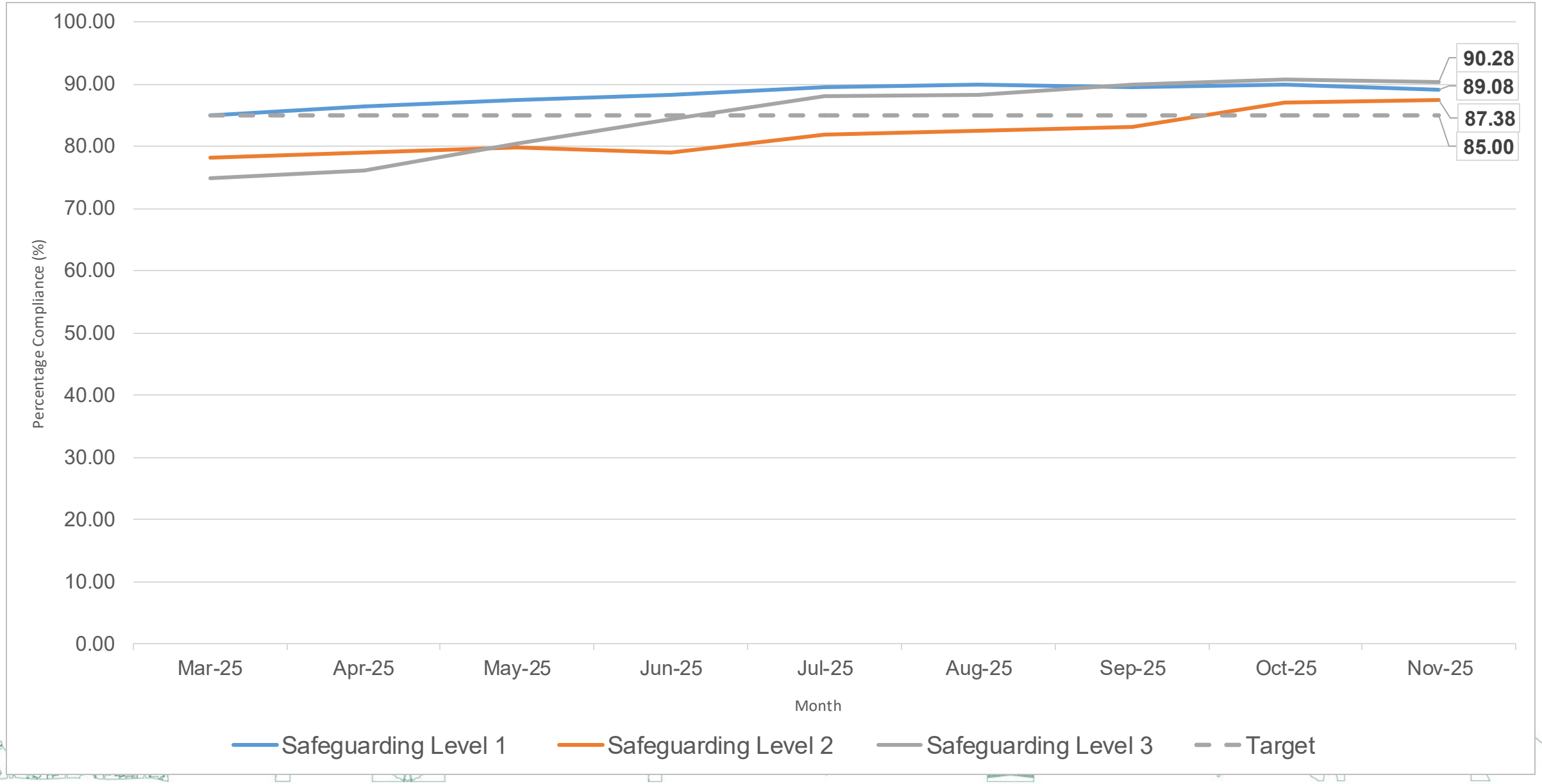
**Safeguarding and sexual safety allegations against staff**

| | |
|---|---|
| **October** | 7 |
| **November** | 3 |
| **Year to Date** | 42 |

**Number of allegations sexual safety or safeguarding reported to external bodies (ie regulator, NHSE, Police):**

Oct/Nov
Police Involvement: 5
LADO: 2

# Safeguarding Compliance




NB: Data exported from the ESR dashboard.

CQOG date : December 2025

Reporting date = October/November 25

# Safeguarding

Health & Social Care Act 2012

Regulations: 13

SAFE

## Learning

**The increase in identified learning is a result of the new process implemented to better capture learning opportunities**

| Learning Incident October | Learning Dissemination |
|---|---|
| Incomplete referral (missing demographics) | Escalation from safeguarding specialist to staff member due to lack of response to safeguarding referrals team. |
| Incorrect process-multiple referrals made could have been combined into one despite very good content. | Email Feedback and excellence award |
| Missed Adult referral- recognising self-neglect as a safeguarding concern (x2) | LA456 & Email feedback |
| Missed Child Safeguarding referral- (LAC) recognising a referral is still required even if a child is already known to social services. (x2) | Email Feedback and retrospective referrals |
| Missed Child Safeguarding referral- Domestic Abuse exposure | Email Feedback including CSM |
| Incomplete referral- not fully submitted causing delayed send | Email Feedback including CTM |

| Learning Incident November | Learning Dissemination |
|---|---|
| Missed unborn safeguarding referral (parental substance misuse) | LA456 |
| Incomplete referral- missing demographics | Discussion CTM |
| Missed Adult Safeguarding Referral- recognising self-neglect as a safeguarding concern x2 | Clinician feedback & Retrospective referral |
| Incomplete referral- X2(welfare + child parental mental ill health) not fully submitted | Email feedback including CTM |
| Missed child safeguarding referral: crew thought the police referral was enough. | Email feedback. safeguarding is everyone's responsibility |
| Missed s.44 of the Care Act 2014- evidence of alcohol dependency self neglect. | LA456 |
| Child death process not followed: Police declared child death a crime scene therefore, crew did not convey but police later requested crew to return to scene to convey. | Escalated to Consultant Paramedic & Associate Clinical Director and Deputy Chief Paramedic. Learning took place with IDM 20.11.25 |

CQOG date : 23rd December 2025

Reporting date = November 2025

# Clinical Equipment Working Group

Health & Social Care Act 2012

Regulations: 15, 17

EFFECTIVE | SAFE

## 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"

Installation of active RFID's within Ambulances have been progressing. Now 100 active, with a further 64 expected to go live in early January.

Previous issues have been with installing brackets to mount the required tablets, new DCA's coming in to the Trust should have brackets pre-installed which should reduce the delays seen over the last 6 months.

## Incidents

- **SafeR IM/SC syringes and non-compatible drawing up needles**
  - A small number of SafeR drawing up needles were distributed to stations in error. These were not compatible with the normal syringes used to administer IV/IO medication. Posing a risk that clinicians may therefore not have access to the correct drawing up needles to draw up medication
  - Stock was recalled back to Rainham, and comms shared to all clinicians. No patient harm incidents reported as a result
- **SafeR IM/SC Syringes and Hydrocortisone**
  - Still seeing incidents reporting failure in use – Local investigation highlighting that the education material had not been viewed
- **Ferno Ve Power Chair**
  - Ongoing incident reporting, mostly in relation to battery failures/faults when in use

## Performance

**Planned Preventive Maintenance (PPM) Report**

Full report has not been produced from MDAG and made available for sharing.

Figures shared at CEWG earlier this month demonstrated improvements from last month in both LP15 and Laerdal suction units. PPM recently reported at 70% and 75% respectively.

**PPM Task & Finish Group**

Has concluded after an 18 month period, and meeting its main objectives. 3 outstanding actions remain which require oversight as detailed in the Cover Report: Cover Report

**Data accuracy within PPM report**

Metrics within the report are calculated manually, introducing variation or error. There is ongoing work with the teams involved to implement automated PPM compliance calculations, which is expected to improve accuracy, and provide more reliable reporting.

## Future developments

- In the absence of a suitable product on the market, guidance to be disseminated to clinicians on safe transportation of paediatrics and newborns in the rear of the ambulance with the Pedi-Mate, and Pedi-Mate Plus.
- Second trial of single use Loxley Splint in 2026 with the view to potentially introduce as standard equipment
- Ongoing work to a list of SOP's including improvements to the SOP for the Return of Medical Devices (All SOP's found here)

CQOG date : 23/12/2025

Reporting date = November 2025

# Health, Safety & Security

Health & Social Care Act 2012, Regulation: 12
Health & Safety at Work etc Act 1974

SAFE

## Incidents

- During November'25 the total number of H&S incidents reported was 790 resulting in 8.26 events per 1000 (999 face to face) attendances. 597 (76%) of the H&S related incidents reported during November'25 resulted in No Harm/Adverse/Near Miss. 136 (17%) of the H&S related incidents reported during November'25 resulted in Low Harm. 54 (7%) of the H&S related incidents reported during November'25 resulted in Moderate Harm. 3 Severe Harm H&S related incidents (2-V&A related and 1 Patient related incidents) were reported during November'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 November'25).
- Total of 75 Physical assaults reported during November'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 (59%) occur due to the clinical condition of the patient during 2025/26 (up to end of November'25); Police attended 62% of physical assault incidents during 2025/26 (up to end of November'25).
- Total of 8 RIDDOR incidents were reported to HSE during November'25.
- Total of 5 MSK related RIDDOR incidents were reported during November'25. The highest number (n=4) of MSK related RIDDOR incidents for November'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

- Collaborative working with Wellbeing Team to look at MSK injury data and outcomes.
- Updating of Moving and Handling training delivered on all Clinical Induction programmes to be undertaken in collaboration with CESD.
- New vehicles designs being finalised, DCA's FRU's and IRO vehicles in consultation.
- 3rd Design of Ford DCA's being launched with Feedback mechanisms in place.
- National MSK group meeting and collaborative working across all Ambulance Trusts, the last meeting was held on the 6th November, next meeting to be held in December.
- BWVC- 9 incidents were share with staff members for self-reflection / review. 1 incident was shared with a resolution investigator (BWV Review Panel was held) during November'25.

## Current risks and Concerns

- Current compliance for FFP3 fit testing is 76% 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. All areas with low compliance rates have been following up with action plans being put in place to address this.
- 6 to 8 week backlog of reviewing Radar reports and contacting victims.
- Ongoing backlog in Criminal Justice Systems resulting in case timeframes being extended. Average timeline is 18-24 months at present with some being longer.
- 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

- Total of 78 RIDDOR incidents were reported to HSE during 2025/26 (up to end of November'25).
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in November'25 was 88% this is due teething issues with RADAR, such as late reporting or misreporting staff injuries under patient incident headings.
- Trust wide Site Specific Risk Assessment compliance is currently at 92%.
- Trust wide Fire Drill compliance is currently at 86%.
- Trust wide Fire Risk Assessment compliance is currently at 100%.
- The Axon Trial at Hillingdon is progressing well, so far, we have seen 1,406 camera assignments, 160 uses of translation, 6 incidents, 1 live stream.
- Total of 268 safety alerts have been received and processed during 2025/26 (up to end of November'25). Total of 3 alerts have been accessed as applicable to LAS and they have been actioned and closed.

## Actions and mitigations

- The Health, Safety & Security (HS&S) Team have delivered one session of Corporate Induction and one session of Managing Safety Course to 21 staff members during November 2025.
- The Health, Safety & Security (HS&S) Team continue to support the delivery of the Stress Assessment Toolkit Training with the sessions running monthly and working collaboratively with OD&Talent and Wellbeing Manager.
- Agreement has been reached to progress the retender/ award of the conflict resolution contract and continued ongoing discussion on how to address restraint and physical intervention in the service.
- CEO Organisational Impact statement now agreed and signed by the CEO and is being attached to cases to support staff and their cases.
- Christmas Comms Campaign launching "All we want for Christmas is respect".
- A Task and Finish Group has been set up to address the ongoing issues in relation to trolley bed availability, this is due to complete in December with actions for all areas of the Trust being put in place.
- Train the trainer to be organised for the Bariatric team for them to deliver training in house on an ongoing basis.
- Dynamic Risk Assessment training package being developed and draft planned end of December'25.

CQOG date : 23rd December '25

Reporting date = Oct-Nov 2025

# Medicines Safety and Governance

Health & Social Care Act 2012

Regulations: 12, 17

SAFE

## Performance

**EDUF compliance**

- Current compliance score: 78% (target = 100%)
- Kit Prep Clinician deep-link in ePCR released with end of November ePCR updates by CCIO team – end user experience driven for improving compliance

**Patient Group Directions**

- In this reporting period:
  - 10 PGDs have been reviewed and released
  - 3 applications received for new PGDs – (IV Antibiotics for APP-UC).
  - 4 PGDs currently under scheduled review
  - 2 New medications added to APP PGD formulary:
    - Levetiracetam (2nd line anticonvulsive agent)
    - Misoprostol (2nd line / alternative agent for PPH management)

- Overall compliance with PGD acknowledgements is good. Compliance is <95% on the following PGDs due to very recent updates being released
  - Midazolam (Paramedic)
  - Penthrox
  - Haloperidol
  - Misoprostol
  - Nitrofurantoin
  - Pivmecillinam
  - Lansoperazole
- PGD Training provided for Maternity team in November.

**Prescribing**

- Review of Trust prescribing policy completed
- Scheduled review of APP-UC prescribing formulary underway.
- Work underway for establishment of overarching Non-Medical Prescribing Committee with sub groups for each area of prescribing practice within the Trust (APP and IUC-111). TOR drafted and awaiting approval by MMG.

## Learning

- Incident trends and themes are aligning with work completed during the thematic review into medication errors highlighting themes relating to
  - Dosing errors
  - Route errors
  - Contraindication
- Noting some errors occurring secondary to delays in updating of JRCALC+ app at the point of care

## Ongoing work

- Leading on Pan London approach to Time Critical Medicines / Patients own drugs (see HSSIB report on time critical medicines)
- E-CD register
- Engagement with local authority and OHID teams on assisting with responses to spikes in contaminated illicit drug deaths
- JRCALC Medicines governance committee work – currently working as 2nd checker/validator on drug monograph updates.
- Ambulance Services MSO Group – no

CQOG date : 23.12.2025

Reporting date = October and November 2025

# Medicines Management Group (MMG)

Health & Social Care Act 2012

Regulations: 12, 17

SAFE

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

- OCTOBER Meeting:
  - No medicines supply issues
  - Medicines Packing Unit update reports 98% compliance in CD audit.
  - Medicines deliveries at last quarter – 100% of planned.
  - **For escalation:** Lack of assurance in traceability of medical gases which requires addressing. Linked to disputed significant cost with BOC. Summarised report to be collated of actions being implemented to address traceability and accountability of medical gases.
  - CARU report missing trial pack from CRASH4 identified at Westminster Group. Investigations underway to determine location of drug trial pack.
- NOVEMBER Meeting:
  - Medicines Packing Unit update reports total of 15,269 bags packed, 15,468 checked, 447 near misses recorded which equals approximately 3% (slight increase from last month of 2%).
  - **For escalation:** Entonox cylinders have been returned to BOC from film production companies in which these cylinders were originally sent to LAS. Currently, there isn't full traceability on cylinders which will make it difficult to investigate but planned to highlight the fraud team.
  - Confirmed loss of trial pack from Westminster Group – CARU awaiting to be informed of implications from research school.

**For Noting:**

- OCTOBER Meeting: IUC Prescribing Policy latest version of minor changes reviewed and approved.
- NOVEMBER Meeting:
  - Lidocaine monograph amendments made to allow for increased volume administration to facilitate FICB procedures for APP skill set following FICB service evaluation report recommendations.
  - CRASH4 trial expanded to include Edmonton station.

**Recommendations(s)/ Decisions for the Board/Committee**

- OCTOBER Meeting: **For escalation:** Lack of assurance in traceability of medical gases which requires addressing.
- NOVEMBER Meeting: none

**AOB**

- OCTOBER Meeting: none
- NOVEMBER Meeting: Attached for medicines assurance and traceability perspective: Medical Gases Committee Report - Quantitative Analysis of Medical Gas Cylinder Movements: Seven-Month Review from Delivery to Return.

Reporting date = Dec 2025

# Infection, Prevention & Control

Health & Social Care Act 2012, Regulation: 12
Code of Practice on the Prevention of Infections & Related Guidance
Health & Safety at Work etc Act 1974

SAFE

## Incidents

- A Flu season started early this winter, increased activity across many regions are occurring. The H3N2 subtle genetic shift is potentially driving increased transmission in addition to less than optimal vaccine uptake – Reported on 15/12 NHSE are seeing a plateau of flu cases.
- As at 16th Dec- ICBs, UKHSA, NHSE, have not and are not planning any mask mandates – Local A&Es are undertaking local RAs and advising based on HoC and patient populations.
- MPU was reviewed by the IPCLT on 21/11/2025, following an escalation that increase sickness was reported amongst colleagues that were off duty with an influenza-like illness. On in-person review the following was noted and recommended: Use of PPE, colleagues reminded that whilst wearing gloves is appropriate with used packs, these must be doffed and hand hygiene performed before entering other working areas of the unit to reduce cross-contamination risks. Increased cleaning of high touch points and work surfaces. Outbreak review tool had not been completed and therefore challenging to assess. Existing IPC resources promoted and provided as reminders.

## Current risks and Update

Local risks remaining: IPCC has not met since Aug CQOG

IPCD/micro hours vacant –closed

Gap in assurance for MR vehicle cleanliness audit - reporting and escalation. Action plan composed by MR underway.

New - HoC RA Seasonal Respiratory Infections, local NHSE universal mask wearing tool.

Key updates:

IPC minutes included within these papers/submissions.

Specialised Asset –fit testing reported as low, H&S reviewing

Deep cleaning compliance remains a concern inc NETs - New head of service in place and new managers recruited

Winter comms and IPC advice/guidance published including updates for lowering threshold for mask wearing.

Acknowledgement of updated of cleaning schedule document and workstream to update validation audits

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

Noted continual Absence of Logistic and EPRR group and subsequent reports from IPCC

## Performance

Nov Data:

- IPC Training compliance was 79% for level 1 and 56% for Level 2 (target 90%)
- Hand hygiene compliance was reported at 97%. This exceeds the Trust performance target (90%).
- Make Ready six-weekly vehicle deep clean compliance was reported at 68%. NETs reported at 27%, this has improved from 15% in the previous months but this is below the Trusts target 90% . Action recovery plans led by Make Ready services are in place, however challenges remain
- Premises cleaning audit compliance was reported at 95%, which met the Trust's target of 90%.
- 2 sharps incidents and 5 body fluid exposures reported

IPC Validation audit October and November:

18 environmental audits were performed. Of which 14 achieved the minimum pass criteria of 75%. Significant improvements were noted in relation to cleaning standards of the reaudited sites, this was achieved by clutter management which increased accessibility.

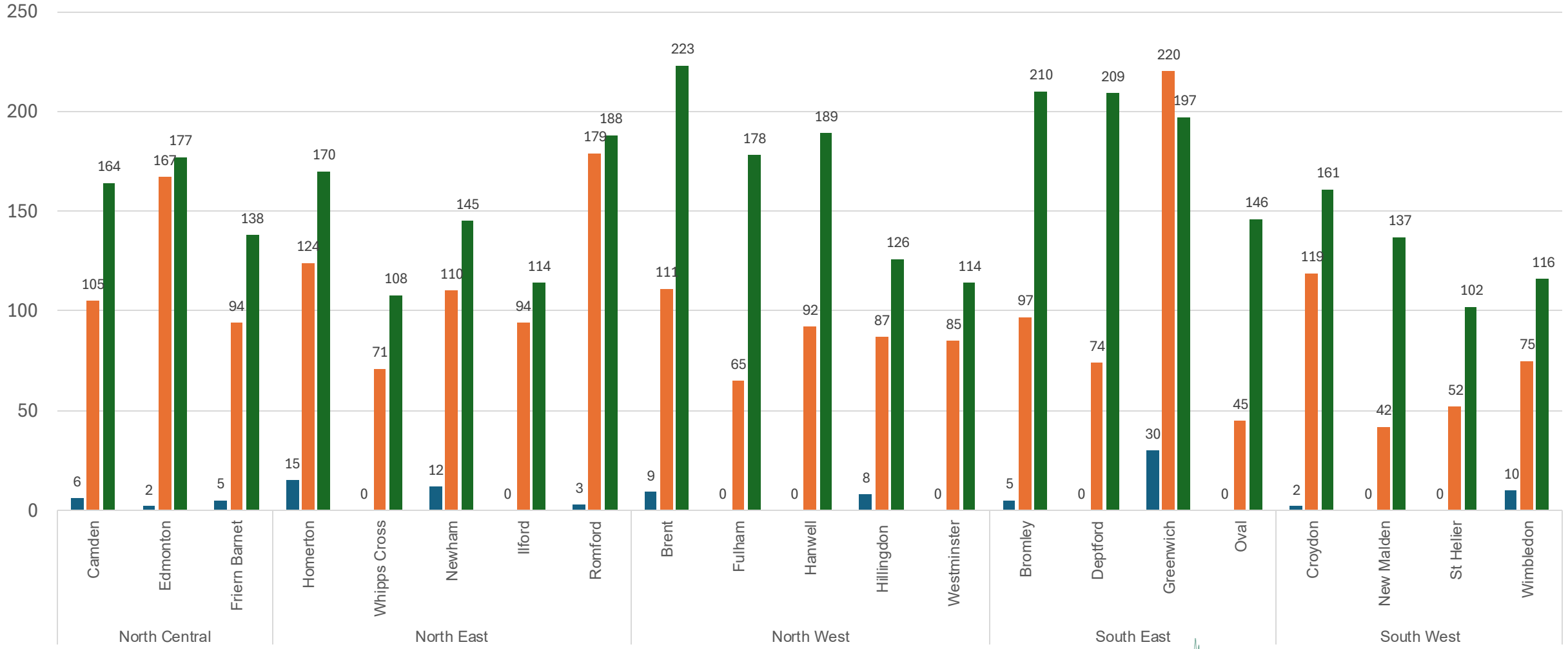
6 ride out audits were completed. Of which 5 achieved the minimum pass criteria of 80%. Non-compliance with element 4 of the 5 moments of HH and BBE- gel nails was reported as a theme.

5 A&E observational audits were undertaken. Of which 1 achieved the pass criteria of 80%. Hand hygiene – a combination of all 5 moments were not carried out. BBEs was a significant problem – false/painted nails.

## Continual assurance

NB see IPC board assurance framework for further information.

# YTD OWR Hand Hygiene Audit December 2025



CQOG date : December 2025

Reporting date = October/November 25

# Professional Standards

Health & Social Care Act 2012

Regulations: 17, 18

RESPONSIVE

## Cases

•There were **4** cases referred to the Professional Standards Review Panel for the reporting period.

•All **4** 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.

## 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

## Performance

- All **4** cases were triaged within the target of **24 hours** of receipt.
- All **4** cases were referred to the HCPC within **48 hours** of receiving the required information
- **5** Professional Standards teaching sessions have been delivered by the HoPS. These include sessions to NQPs/IROs/TMs and team training days.

## Themes and Trends

- **Three** 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.

CQOG date : 23/12/2025

Reporting date = 09/10/2025 - 11/10/2025 (next CAG 08/01/2026)

# Clinical Advisory Group (CAG)

Health & Social Care Act 2012

Regulations: 9, 12, 13, 17

WELL LED

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

09/10/2025

- Stroke video triage expansion to South London – Approved
- ACP: Integrated Neighbourhood Teams NWL ICC – Approved

22/10/2025

- Chest Infection Worsening Care Advice – Approved
- COPD Exacerbation Advice – Approved
- Acute on Chronic Heart Failure Advice – Approved
- Falls in Older Adults – Approved
- Hypoglycaemia (Resolved) – Approved
- Lower Urinary Tract Infection (UTI) in Adults – Approved
- Seizures– Approved
- Head Injury Worsening Care Advice – Approved
- Faints – Approved
- Diarrhoea and Vomiting (Adults and Children) – Approved
- Back Pain – Approved
- Asthma– Approved
- Abdominal Pain – Approved
- Generic Worsening Care Advice Document – Approved

13/11/2025

- FCIB expansion for APP – Approved
- NWL ICC, medical SDEC direct booking for Senior Clinical Decision Makers (SCDM) pilot - Not approved in the meeting. Follow up and approval on 28/11/2025

11/12/2025

- ACP NCL Acute Sickle Cell Unit North Middlesex Hospital

**For noting – admin changes**

- Hammersmith Sickle Cell pathway – Accepting patients who previously would have been conveyed to Northwick Park Hospital
- ACP SEL Acute Sickle Cell Unit Lewisham - Admin changes
- Barking and Dagenham EOLC LAS ACP - Nov 2025 V2 signed.docx
- Havering EOLC LAS ACP - Nov 2025 V2 signed.docx
- Redbridge EOLC LAS ACP - Nov 2025 V2 signed.docx
- South Camden (including north east Westminster) and Islington community palliative care services - draft.docx
- ACP SEL ICC (LGT).docx

## Recommendations(s)/ Decisions for the Board/Committee

- None

CQOG date: 23 December 2025

Reporting date = October and November 2025

# Learning and Assurance Group

Health & Social Care Act 2012

Regulations: 9, 12, 13, 15, 16, 17, 18, 20

WELL LED

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

Key points/issues

- Equipment safety remains a dominant theme, including ECG electrodes, IM needles/syringes, LifePack 15, trolley beds, and carry chairs. Central packing is reducing missing equipment, but failures and availability issues persist.
- Carry chair risks continue to receive significant focus, with ongoing mitigations (retrofits, harness changes) and clear emphasis that reduced reporting does not mean risk resolution.
- Violence, aggression, and musculoskeletal injuries remain high, with violence incidents consistently reported and MSK injuries a major cause of sickness absence. Recruitment of violence reduction officers is progressing but delayed.
- Clinical quality concerns include missed injuries, missed STEMIs, delayed cardiac arrest recognition, ECG artefact, $ETCO_2$ issues, and informed consent problems, with education and thematic reviews underway.
- Safeguarding continues to show missed and incomplete referrals and suboptimal training compliance (particularly Level 2 in NHS 111), despite ongoing system and training improvements.
- Learning from Deaths highlights recurring issues with breathing, defibrillation, ECG interpretation, and medication use, supported by thematic reviews and improved dissemination via infographics.
- Patient safety governance shows improving duty of candour compliance and learning response closures, but ongoing breaches and data quality issues (LFPSE harm discrepancies) remain under review.

## Key Risks for the Board/Committee's attention

- Patient harm risk from equipment failures (ECG artefact, syringe failures, chair/trolley issues).
- Staff injury and sickness risk linked to carry chairs, manual handling, violence, and musculoskeletal injury.
- Regulatory and reputational risk from safeguarding issues, violence incidents, and learning response breaches.
- Assurance risk where reduced reporting may mask unresolved system problems.
- Data quality and oversight risk relating to LFPSE harm discrepancies and overdue actions.

## AOB

Clinical education innovation: Use of AI in simulation, pursuit of external accreditation, and production of high-quality in-house educational videos

Learning from Deaths: Improved dissemination through monthly infographics; thematic work progressing on cardiac arrest recognition, breathing, and defibrillation issues

CQOG date : 23 December 2025

Reporting date October and November 2025

Health & Social Care Act 2012

Regulations: 9, 12, 17

WELL LED

# Patient Safety and Clinical Effectiveness Group

## Key points, Issues and approved items Board/Committee's attention:

Items for Approval

A number of amalgamated clinical operating procedures for primary and urgent care were approved. These included:

- Ketone Testing
- Discharge and referral JSOP
- Wound care procedure
- Dispatch guidance to deliberate self harm

North East London Drug and Alcohol Pilot Evaluation: ME presented the evaluation of the North East London drug and alcohol signposting pilot, highlighting the outcomes, challenges with data sharing and consent, and proposed exploring a new phase involving electronic notifications to services

Items for Discussion

BBA SOP for London Review confirmed no operational changes.

## 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. .

CQOG date : 23rd December 2025

Reporting date = Oct'25 – Dec'25 at 10/12/25

# Digital & Data Report

Health & Social Care Act 2012

Regulations: 12, 17

EFFECTIVE

## Digital Incidents 01/10/2025 to 25/11/2025

*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. 10/10/25: Internet downtime at multiple stations 4hr- P1
2. 14/10/25: Vodafone Nationwide outage 2hr – P1
3. 01/11/25: Kit prep failure 5hr – P1
4. 17/11/25: Adastra has gone down for both Croydon & Barking 15 mins – P2
5. 18/11/25: External EPCR & CADO unavailable Global Cloudflare outage 4hr (ePCR move to paper for 2 hrs BCI) - P1

## Current risks, Issues & Concerns

- **Electronic Transfer of Care (eToC)**: Go-live with King's College Hospital on 3rd of December. Currently tracking for demographics-only implementation for both St Marys' and Charing X for mid-Jan. A 'Send Patient Data' button has now been enabled on ePCR to allow clinicians to send updates manually. ETOC temporarily suspended following KCH go-live due to data quality issue – now resolved.
- **Correct patient identification**: The CE&S video has been produced and incorporated into the Legal Case Review huddle presentation and has been redistributed to clinicians via huddles. The latest ePCR release changes the behaviour of the 'PDS Trace' flag – this is now reset if the NHS Number/DOB is modified manually. ISBAR has been promoted for identification of patients for ambulance handovers with ETOC and as standard process for MiDoS referrals.
- **NPSA Alert – Penicillamine v Penicillin allergy:** Engagement with Chief Pharmacist and medicines team to explore reordering and other mitigations in ePCR. Adastra update TBC.

## Governance

**Recent Guidance**

- Recent bulletins issue on: Timely incident closure, ePCR release, eTOC. Huddle pack ePCR, AVT and eTOC. Management updates for Kit Prep Station Audit

***Clinical Impact of Digital Incidents***

- *Process being put in place to reveal these alongside incident reporting process. This remains a work in progress.*
- On the 18th of November, Cloudflare suffered a global outage which affected ePCR and a number of other internal systems (e.g. internal authentication for GRS). A BCI was declared, and clinicians reverted back to ePCR once it was determined the system had stabilised. There are no known patient-related incidents reported due to this event. Debrief to be held January 2026 to consider process change for ePCR product team to move to paper and advice Gold & SCOC to protect patient data.

***Product Testing***

- ***ePCR****:* V1.232.0 was released on 25th of November after successful testing. A number of minor bugs are being resolved with Cleric.
- There were two high priority fixes implemented:
  - The destination settings contained a bug which caused PRU ED to be removed. A fix is being developed planned to allow for further configuration changes without unintended consequences.
  - The '+ Patient' button fix has regressed since it was implemented in Beta. The button has now been hidden until a further fix is implemented.
- **Electronic Transfer of Care:** Testing is progressing with NWL Trusts.
- **Tortus AVT Pilot extension:** Gone live in clinical hub in SWAST and planned for SECAmb.

***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, Adastra and CAD.

*In progress:*

- Tortus AI – The hazard log is being updated to account for the new telephony integration being developed. Hazard log updated following revision to Mental Capacity section removal in advance of revision.
- *CAD Hazard Log – Review being undertaken by David Macklin*

London Ambulance Service
NHS Trust

# Quality Oversight
# 999 (EOC & CHUB)

We are the capital's emergency and urgent care responders

Clinical & Quality

Reporting date = October 2025

Health & Social Care Act 2012

Regulations: 9, 12,15, 17, 18, 20

SAFE

**Purpose and Objectives**

**Continuously improve the safe delivery and quality of care for patients**

- Deliver our annual quality objectives
- Deliver the quality objectives relating to patient care, and patient and family experience

## 999 Patient Safety (EOC, IM&SD, Clinical Hub)

(as of 13/11/2025)

- **Open learning responses:** 4 (Clinical Hub), 5 (EOC)
- **6 month breach**: 0 (EOC), 2 (Clinical Hub) -- patient safety team and CHUB SLT managing
- **Cases reviewed at PSIG:** 36 (Oct 2025)
- **Outstanding LFDs:** 13 (stage 1 – 10 allocated pending completion), 2 (stage 2)

### Risks

- All EOC and IM&SD risks have been reviewed at the monthly risk review meetings and have documented controls.
- Updated risk poster has been shared with all EOC managers via email and LAS Connect.
- Closed risks this month:

  **RSK-079** - transport for single-site working
- New risks approved this month:

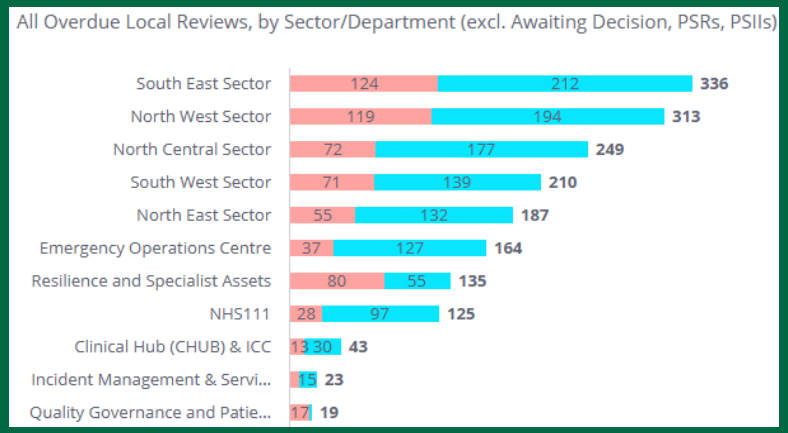
  **RSK-228** - Lack of testing prior to CAD Database upgrade and truncation

  **RSK-229** – recognition of ineffective breathing

  **RSK-230** - Messages from the MPS not presenting when in the CSD stack

## Overdue Incidents (as of 13/11/2025)

- **Open incidents: 127** (EOC), 15 (IM&SD), 30 (CHUB), 0 (QA), 0 (NETS EOC)
- **Overdue incidents: 37** (EOC), 8 (IM&SD), 13 (CHUB)




### Learning Responses completed in October 2025:

- INC-9519 PSII - learning identified around cancellations for vulnerable patients
- INC-878 non-commissioned AAR – learning identified around triaging third party prior to attempting first/second party contact

### Training

- 12 CHUB & 9 999ops managers have completed updated Learning Response Lead training. Further sessions scheduled in November. This has increased resilience of number of managers able to undertake learning responses.

## Quality Visits (QV)

- Q3 Quality visits were undertaken in October.
- Both EOC sites showed significant improvements with poster compliance and logger sheets being filled out regularly for vehicle checks.
- Waterloo 100%, Newham 93%
- Areas of improvement required for Newham:
  - PAT testing to be completed
  - Fridge checks are not currently being completed regularly
  - Out of date posters on display and risk poster requires updating

## Abusive Callers

- Continue to work closely with the Violence Reduction Unit, and in collaboration with the Frequent Caller Team, for ongoing management of cases.
- There is early evidence of a successful intervention with one of the top frequent abusive callers.
- Significant increase in abusive caller incident reports on Radars: August – 11 reports, September – 19 reports, October – 44 reports, November (until 13/11/2025) - 24 reports so far.
- Risk assessments are being completed for consideration of IDP flags for specific frequent abusive callers to empower staff to terminate a call without providing further warnings if abuse is displayed.

Clinical & Quality

RESPONSIVE

**Abusive caller case management – a case study**

"An individual made 221 calls in 3 months. The calls contained threats of violence and abuse, which also included some racially motivated hate incidents.

The incidents were reviewed by the EOC quality team for an LAR decision and there was also specialist input provided by both the frequent caller and learning disability teams. Police reports were submitted by staff with the help of EOC managers and subsequently followed up by the violence reduction unit (VRU), with the staff member's consent.

Taking into account the individual's mild learning disability, the police spoke with the staff members who were in agreement regarding a proactive alternative method in order to act quickly to avert further abuse to call handlers. This involved issuing a community resolution order which would be an out of court decision, meaning that there would not be a prolonged police investigation but that the case would be closed following a meeting with the individual.

There was a multi department collaboration with the LAS, MET and Social Services to try and engage with the individual face to face. Representatives from all the agencies attended the home address to emphasise the effect their actions and words were having on staff, and also hindered our ability to assist those who needed genuine emergency help. Subsequent criminal consequences were also discussed if the behaviour continued.

They engaged well in the meeting supported by their family. They acknowledged they understood and agreed to accept the Community Resolution that the police were issuing. This agreement was signed on the same day and they further agreed to stop calling and being abusive.
To our knowledge, the individual has not called since this meeting took place, and it has now been 7 days.

This approach or out of court decision is not available or appropriate in every case involving abusive callers. This is due to multiple reasons, including the severity of the incident, the possible charges under consideration, and the wishes of the victim.

We just want to thank staff for continuing to report via radar and to the police where appropriate to do so. We want to reassure you that we are working collectively to try and make improvements and support staff."

Clinical & Quality

SAFE

**Purpose and Objectives**

Support the 999 Operations Directorate to deliver the clinical objectives in the business plan

**Top incident reporting themes:**

- **Incorrect addresses**
- **Ineffective breathing**
- **Incorrect duplication**
- **Multiple calls for same patient not being escalated to the Clinical Hub**

**System Improvement Plans for top incident reporting themes:**
**Improve recognition of ineffective breathing:**

- E-learning has been reviewed and updated. Delay with updating ESR, EOC Education managing.
- To be included in next CSR cycle

**Location matching (RSK-172):**

- Gazetteer superusers on each watch to run through scenarios with each member of the team. Scenarios have been finalised. RW leading on roll out.
- Location matching SOP and associated resources to be re-shared
- 3 steps for location matching to be displayed on each desk

**Management of duplicate calls:**

- CAD development implemented and functionality due for testing.

**Completed actions:**

- **LFB Fire Survival Guidance portal now available -** for use when managing a fire for significant, major or high-rise building incidents.
- **UCP and Cleric CAD integration –** implemented 12 November.

**In the pipeline:**

- **Streamlining dispatch review process –** updating dispatch review form, additional ownership on sector teams to review radio recordings locally for investigations and investigate demand via BI portal.
- **Quality of local investigations –** an audit is in process to understand gaps in quality to feed into a system improvement plan.

**National work streams**

- Provisional date for next MPDS update in Feb 26. Update includes changes requested by LAS
- Research approval completed for work with IAED to develop triage of chest pain. Awaiting meeting with CARU to unblock governance.
- Work ongoing to review data from Category 2 Segmentation with NHSE

**CQC preparation**

- CQC inspections - "what you need to know" briefings delivered to 999ops managers by SCL AB.
- CQC virtual grab pack & checklist saved to EOC, IM&SD and Clinical Hub SharePoint
- Observation SOP draft complete. Awaiting sign off by PJ/FW

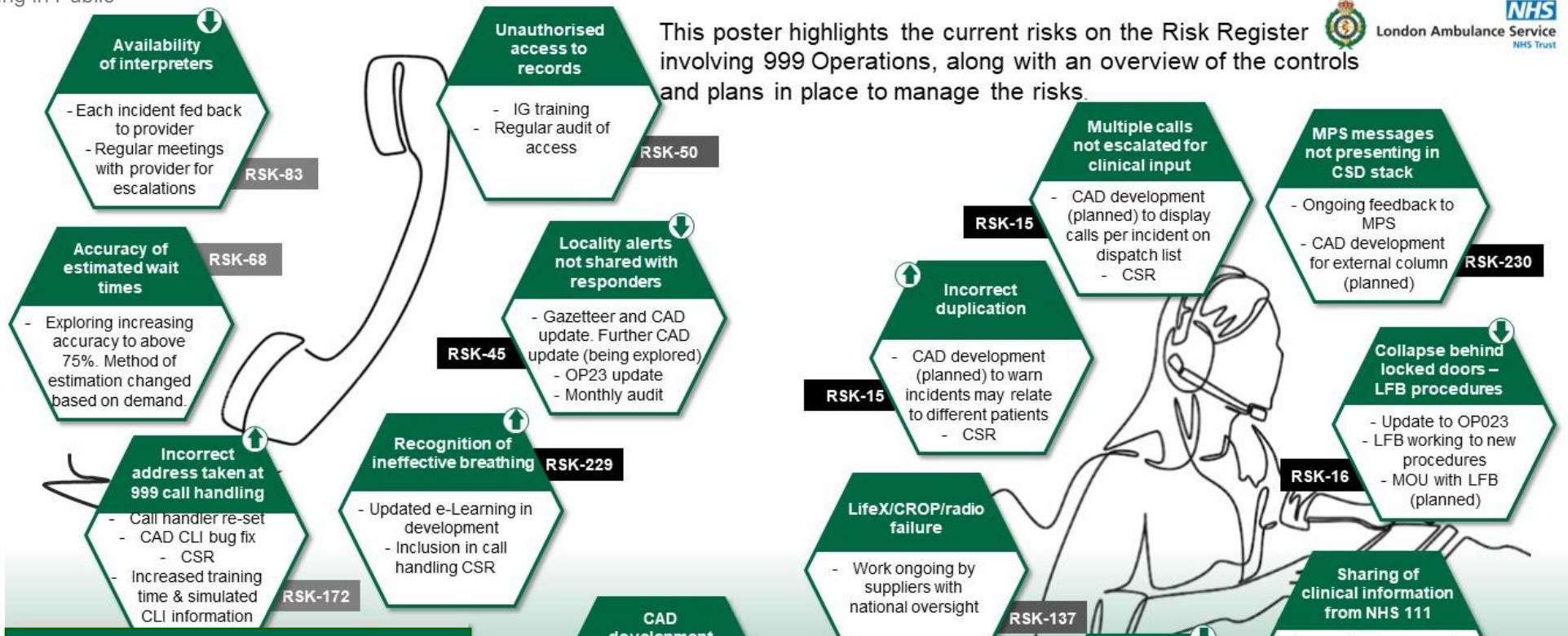
Clinical & Quality

RESPONSIVE

SAFE

London Ambulance Service NHS Trust

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.



**Availability of interpreters** RSK-83
- Each incident fed back to provider
- Regular meetings with provider for escalations

**Unauthorised access to records** RSK-50
- IG training
- Regular audit of access

**Accuracy of estimated wait times** RSK-68
- Exploring increasing accuracy to above 75%. Method of estimation changed based on demand.

**Locality alerts not shared with responders** RSK-45
- Gazetteer and CAD update. Further CAD update (being explored)
- OP23 update
- Monthly audit

**Incorrect address taken at 999 call handling** RSK-172
- Call handler re-set
- CAD CLI bug fix
- CSR
- Increased training time & simulated CLI information

**Recognition of ineffective breathing** RSK-229
- Updated e-Learning in development
- Inclusion in call handling CSR

**Multiple calls not escalated for clinical input** RSK-15
- CAD development (planned) to display calls per incident on dispatch list
- CSR

**MPS messages not presenting in CSD stack** RSK-230
- Ongoing feedback to MPS
- CAD development for external column (planned)

**Incorrect duplication** RSK-15
- CAD development (planned) to warn incidents may relate to different patients
- CSR

**Collapse behind locked doors – LFB procedures** RSK-16
- Update to OP023
- LFB working to new procedures
- MOU with LFB (planned)

**LifeX/CROP/radio failure** RSK-137
- Work ongoing by suppliers with national oversight

**Sharing of clinical information from NHS 111** RSK-78
- Access to assessments via ePCR (planned)
- New Dx Codes for calls from clinicians

**Pre-alerts passed incorrectly** RSK-75
- Update to OP023
- Add address book & telephony to CROPS (planned)
- Training

**CAD development backlog** RSK-34
- Prioritisation exercise undertaken
- Documentation process (planned)

**Ambulance availability over handover period** RSK-6
- Thematic investigation
- Rota and ambulance provision review (planned)

**Manual priority change prevents upgrades from triage** RSK-67
- Procedures for clinicians reviewed
- Action card for HEMS/APP

- RSK-90 Deployment of Public Access Defibrillators
- RSK-69 Inability to pass pre-alerts to maternity units
- RSK-29 Lack of MPDS instructors
- RSK-189 Safeguarding training compliance
- RSK-180 Heathrow Airside Driving

**Risks related to business continuity:**
- RSK-76 Readiness for Paper Operations
- RSK-77 Infrastructure to facilitate single site working
- RSK-228 Lack of testing prior to CAD upgrade & truncation

**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

# 999 Operations - Risks

**November 2025** *Version 1*

CQOG date : 23/12/2025

Reporting date = October and November 2025

# Clinical Hub

Health & Social Care Act 2012

Regulations: 9, 12, 17, 18

SAFE

## Incidents

- 63 incidents open in RADAR across CHUB and ICC. Themes around incorrect triage, delays in ambulance response and possible missed triage.
- 5 incidents were referred into sector PSIG all were deemed to need local departmental level learning. One SWARM huddle undertaken outside of PSIRF.
- Across 23,767 assessments in October and 23,145 assessments in November we had 50 recontacts in October and 64 in November. This equates to 2.1 recontacts per 1000 assessments in October and 2.8 for November.

## Current risks and Concerns

- Risks have been reviewed in CHUB quality meeting and new risks mainly to do with Integrated Care co-ordination centres there are now 11 open risks for the Clinical Hub and ICC. All have been reviewed and controls are in place.

## Performance

- Hear and treat for October 22.2%, November 22.9%
- 80% of C2B calls were streamed with 37% being deemed suitable for assessment. Of the 37% calls sent for assessment 27% were resolved with H&T this equates to 5% of all Hear and Treat activity.
- Clinical Advisors 145 WTE against an establishment of 150
- CSM 46 WTE against an establishment of 50. Recruitment for the remaining CSMs has been undertaken and they will join the team in January 2026
- Clinical advisor away days have now been completed. We are continuing to train senior clinical decision makers.
- September 529 audits October 215 audits with a compliance of 98%. For CSD audits 78 audits undertaken in September and 64 in October with a compliance score of 99%

## Learning

- Clinical Advisor away days focusing on improving hear and treat.
- SCDM training days

# Clinical Hub SLT Report

## Staffing

CA FTE (Paid)


CSM FTE


152.2
Total CA FTE

Leavers v Planned in next 3 months

35.9
CA Leavers

37.9
CAs Planned FTE

## Quality & Risks

Cases Awaiting Review


Cases in Progress


Clinical Hub Risks

11
Open Risks

100%
Reviewed in last 3/12

| Month | Cases | Recontacts | Audits |
|---|---|---|---|
| November 2025 | 14 | 64 | |
| October 2025 | 21 | 50 | 315 |
| September 2025 | 19 | 45 | 529 |

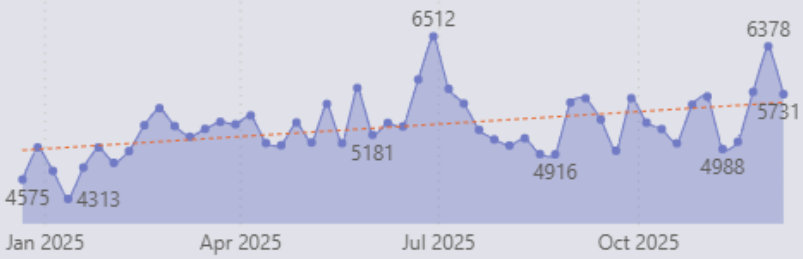
## Overview each month

| Year | Month | Assessments | Streaming | All Incidents | All Excluding C1 | % with an assessment* | % streamed* | % H&T |
|---|---|---|---|---|---|---|---|---|
| 2025 | November | 23,145 | 72,177 | 95,485 | 80,618 | 29% | 74% | 22.9% |
| | October | 23,767 | 66,391 | 97,652 | 83,214 | 29% | 67% | 22.2% |
| | September | 23,412 | 4,624 | 91,341 | 77,813 | 30% | 5% | 22.3% |
| | August | 22,079 | | 94,092 | 81,011 | 27% | | 21.5% |
| | July | 25,143 | | 96,981 | 82,696 | 30% | | 21.9% |
| | June | 23,543 | | 92,625 | 78,534 | 30% | | 22.2% |
| | **Total** | **141,089** | **143,192** | **568,176** | **483,886** | **29%** | **25%** | **22.1%** |
| **Total** | | **141,089** | **143,192** | **568,176** | **483,886** | **29%** | **25%** | **22.1%** |

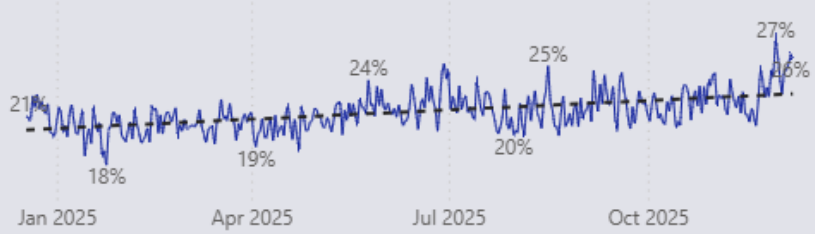
* % with an assessment excludes C1s

% streamed excludes C1s, and only includes Incidents ie H&T/F2F

## Assessments in Rolling 12 months




## Hear & Treat by Rolling 12 months




## Page Links

- Quality
- Quality Report
- Open Cases
- Risks
- Audit
- Timeline
- CA Forecast
- CA FTE
- CSM FTE
- Staff & Sick
- EDI & RFR
- Flags
- Hear & Treat
- C2
- Budget
- Information

Clinical Hub SLT Report Version 2 | User: james.lafferty1@nhs.net | Last Refresh: 16/12/2025 11:16

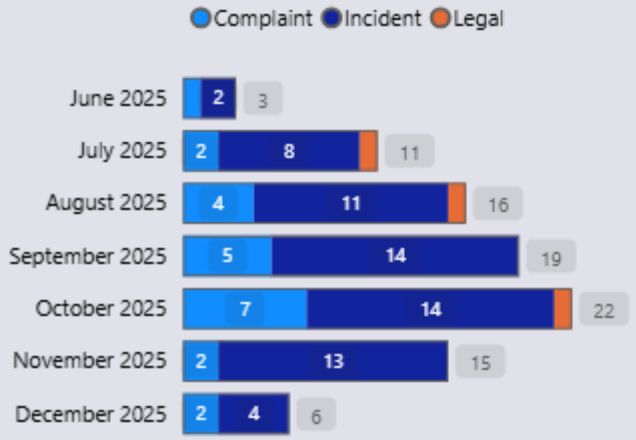
# Quality Overview

Cases Awaiting Review: 1

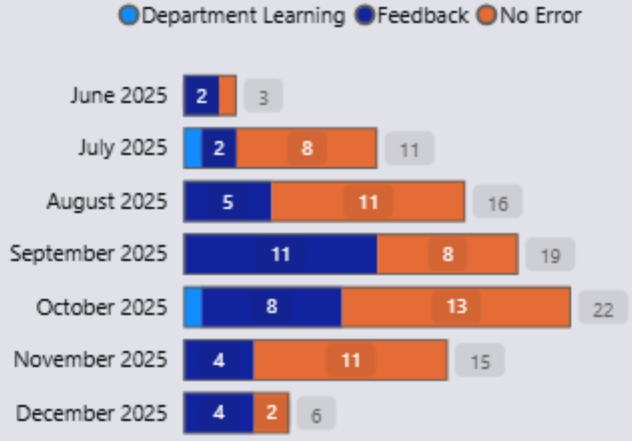
Cases in Progress: 4

Date Range (Received): 01/04/2025 – 22/12/2025

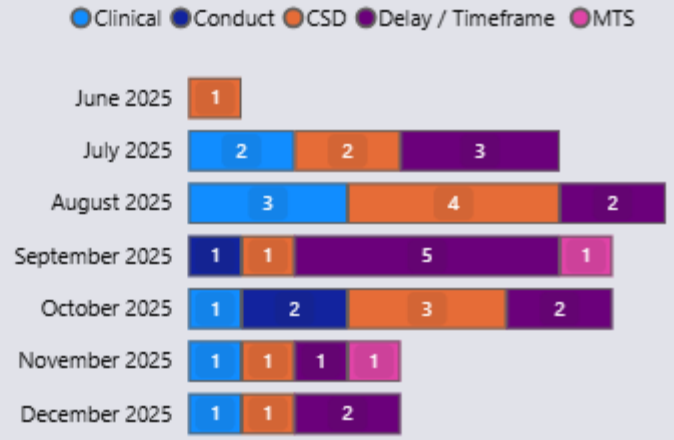
## Case Type Per Month by Incident Date




## Outcomes Per Month by Incider




## Themes Per Month by by Incider




| Month | Assessments | Incident Review | Incident Review per 1000 assessments | Recontacts | Recontacts per 1000 assessments | CA Audits | CA Audits Score % | CA Audits per 1000 assessments | CSD Audits | CSD Audits Score % | CG Review Group | CG per 1000 assessments | Excellence Reports |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2025 | 23,145 | 15 | 0.6 | 64 | 2.8 | 339 | 98 | 14.6 | 22 | 99 | | | 23 |
| October 2025 | 23,767 | 22 | 0.9 | 50 | 2.1 | 429 | 98 | 18.1 | 97 | 99 | 3 | 0.1 | 2 |
| September 2025 | 23,412 | 19 | 0.8 | 45 | 1.9 | 529 | 98 | 22.6 | 78 | 99 | 9 | 0.4 | 1 |
| August 2025 | 22,079 | 16 | 0.7 | 47 | 2.1 | 462 | 98 | 20.9 | 80 | 99 | 6 | 0.3 | 2 |
| July 2025 | 25,143 | 11 | 0.4 | 40 | 1.6 | 593 | 98 | 23.6 | 77 | 100 | 27 | 1.1 | 1 |
| June 2025 | 23,543 | 20 | 0.8 | 37 | 1.6 | 594 | 98 | 25.2 | 84 | 99 | 15 | 0.6 | 2 |
| May 2025 | 23,839 | 18 | 0.8 | 52 | 2.2 | 598 | 99 | 25.1 | 80 | 99 | 12 | 0.5 | |
| April 2025 | 22,292 | 16 | 0.7 | 36 | 1.6 | 571 | 98 | 25.6 | 85 | 99 | 24 | 1.1 | |
| March 2025 | 23,479 | 9 | 0.4 | 27 | 1.1 | 552 | 97 | 23.5 | 77 | 99 | 39 | 1.7 | |
| February 2025 | 20,503 | 3 | 0.1 | 31 | 1.5 | 596 | 98 | 29.1 | 62 | 99 | 28 | 1.4 | |
| January 2025 | 21,043 | 1 | 0.0 | 20 | 1.0 | 518 | 98 | 24.6 | 62 | 99 | 12 | 0.6 | |
| December 2024 | 21,275 | 1 | 0.0 | 31 | 1.5 | 598 | 98 | 28.1 | 72 | 99 | 37 | 1.7 | |
| **Total** | **273,520** | **151** | **0.6** | **480** | **1.8** | **6379** | **98** | **23.3** | **876** | **99** | **212** | **0.8** | **31** |

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# Quality Report - Last 6 Months

## Case Reviews Received

| Month | Complaint | Incident | Legal | Total |
|---|---|---|---|---|
| November | 8 | 15 | 1 | **24** |
| October | 4 | 9 | 6 | **19** |
| September | 8 | 19 | 4 | **31** |
| August | 2 | 6 | | **8** |
| July | 5 | 13 | 5 | **23** |
| June | 10 | 9 | 3 | **22** |
| **Total** | **37** | **71** | **19** | **127** |

## Outcomes Per Month by Incident Date

| Month | Department Learning | Feedback | No Error | Total |
|---|---|---|---|---|
| November 2025 | | 4 | 10 | **14** |
| October 2025 | 1 | 8 | 12 | **21** |
| September 2025 | | 11 | 8 | **19** |
| August 2025 | | 5 | 11 | **16** |
| July 2025 | 1 | 2 | 8 | **11** |
| June 2025 | | 9 | 11 | **20** |
| **Total** | **2** | **39** | **60** | **101** |

## Quality & Risks

Open Risks


100%

Risk Reviewed in last 3 months

| ID | Title | Status | Last Review |
|---|---|---|---|
| 158 | Signs of Shock | Open | 21/10/2025 |
| 232 | Lack of Uninterruptable Power Supply at Clinical Hub remote sites. | Open | 27/10/2025 |
| 233 | Lack of available space for full operational delivery of North Central Integrated Care Coordination Organisation | Open | 27/10/2025 |
| 234 | Clinician assessed NHS 111 DX codes sent back to 111 for assessment. | Open | 27/10/2025 |
| 242 | Human resources/ organisational development/staffing/ competence - Funding uncertainty for ICC | Open | 20/11/2025 |
| 243 | Risk of Clinical Hub resources/management being diverted to ICC | Open | |
| 244 | Quality/complaints/audit - ICC reporting - lack of availability of automatically generated reports | Open | 20/11/2025 |
| 33 | Clinical Hub Managers - Decision making and documentation of EPRR decision | Open | 21/10/2025 |
| 37 | Clinical Hub Assurance of Data | Open | 21/10/2025 |
| 60 | Clinical Hub Improvements | Open | 21/10/2025 |

## Clinical Audits & Recontacts

| Month | Clinical Support | Score (%) | MTS | Score (%) | Recontacts |
|---|---|---|---|---|---|
| June 2025 | 84 | 99 | 594 | 98 | 37 |
| July 2025 | 77 | 100 | 593 | 98 | 40 |
| August 2025 | 80 | 99 | 462 | 98 | 47 |
| September 2025 | 78 | 99 | 529 | 98 | 45 |
| October 2025 | 64 | 99 | 315 | 98 | 50 |
| November 2025 | | | | | 64 |
| **Total** | **383** | **496** | **2493** | **490** | **283** |

## Appraisal, Stat & Man Training

| Month | Appraisal Compliance (%) | Change | Stat & Man Compliance (%) | Change |
|---|---|---|---|---|
| June 2025 | 93.30% | 7% | 91.38% | 7% |
| July 2025 | 96.89% | 4% | 92.17% | 4% |
| August 2025 | 99.54% | 3% | 92.29% | 3% |
| September 2025 | 94.32% | -5% | 92.20% | -5% |
| October 2025 | 94.51% | 0% | 91.83% | 0% |
| November 2025 | 92.41% | -2% | 91.78% | -2% |

## Audit Themes - Top 5

| Theme | Count |
|---|---|
| Delayed Assessment | 5 |
| Unstructured assessment | 4 |
| Introduction/call recorded | 3 |
| MTS - Reds | 2 |
| No targeted worsening care advice | 2 |
| **Total** | **16** |

## Excellence Reports

| Month | Excellence Reports |
|---|---|
| November 2025 | 23 |
| October 2025 | 2 |
| September 2025 | 1 |
| August 2025 | 2 |
| July 2025 | 1 |
| June 2025 | 2 |
| **Total** | **31** |

## Hear & Treat

| Month | NCL | NEL | NWL | SEL | SWL | All |
|---|---|---|---|---|---|---|
| June 2025 | 22.9% | 23.8% | 22.6% | 21.0% | 20.4% | 22.2% |
| July 2025 | 22.4% | 23.8% | 22.5% | 20.7% | 19.8% | 21.9% |
| August 2025 | 21.8% | 22.2% | 21.8% | 20.2% | 21.5% | 21.5% |
| September 2025 | 23.0% | 23.5% | 22.1% | 21.7% | 21.2% | 22.3% |
| October 2025 | 23.5% | 23.2% | 22.2% | 21.4% | 20.6% | 22.2% |
| November 2025 | 24.1% | 23.9% | 23.1% | 21.6% | 21.5% | 22.9% |
| **Total** | **23.0%** | **23.4%** | **22.4%** | **21.1%** | **20.8%** | **22.1%** |

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London Ambulance Service
NHS Trust

# Quality Oversight
# 111

**We are the capital's emergency and urgent care responders**

CQOG date : 23/12/2025

Reporting date = October 2025

# 111 & IUC

Health & Social Care Act 2012

Regulations: 12, 16, 17, 18

SAFE

## Incidents

The majority of the 270 incidents reported in October fell within the *no harm* category. 3 Incidents were reviewed as initially moderate or severe. Of those reviewed, 2 were classified as low harm, and one as severe following PSIG ratification, providing assurance that risk to patients has remained minimal.

This review has also addressed priority themes that require senior oversight, alongside a increase in one particular area with 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.
- **Violence and aggression:** The number of abusive calls received by our staff have seen an increase over the last few months. Currently 6.3% of incidents which is a rise of just over 2% on previous month. We are working closely with the violence reduction unit to support staff with the impact of these calls.

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 October 2025, LAS Integrated Urgent Care Service were offered 197,898 calls and answered 189,449 calls. This resulted in an abandonment rate of 1.58% (against a 3% target) and an average speed to answer of 6.87 seconds (against 20 second target).

Rota fill within LAS reached was 110% with turnover at 21.96% and sickness absence at 12.80%. The turnover has increased due to an increase in the 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 is at 92.77%.

38250 Category 3 and 4 ambulance validation cases were validated by 111 clinicians, with 3396 cases (86%) being re-triaged to a lower acuity level.

The number of ETC/ED dispositions validated by the Clinical Assessment Service (CAS) was 13300 and of these 74% were directed to a more appropriate, lower acuity outcome.

Priority 1 CAS call back performance improved to 78.5%.

## 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 91% and 98%. This marks a slight improvement post-feedback in the ACP clinician cohort.
- Learning Response Update training took place for all our designated Learning Response Leads in October

**Patient Feedback**

- Survey responses this month remain broadly positive. **91% of patients** reported feeling treated with dignity and respect. **72.6%** indicated they were overall satisfied with the level of care received. Work is underway to refine the survey question set to better capture satisfaction levels attributable to 111, alongside deeper analysis of the current data.

London Ambulance Service
NHS Trust

# Quality Oversight
# Ambulance Operations

**We are the capital's emergency and urgent care responders**

# R&SA (including NHS Emergency Capabilities Unit)

**Reporting Date = October / November 2025**

Health & Social Care Act 2012
Regulations: 12, 13, 17, 18

SAFE

## Current risks and Concerns

### Risks

**Command & Control:** Risk of ineffective joint agency command and control / delays in critical decision-making and reduced operational effectiveness, when LAS staff deployed to the Met Police control centre at Hendon; due to inadequate communications infrastructure and systems access.

**Command & Control:** Risk that LAS staff will be unable to provide consistent support to high-threat and joint agency operations at Met Police buildings due to new police ID card protocols and vetting processes, which will lead to delays in communication, compromised information sharing, and failure to meet JESIP requirements during critical incidents.

**Mass Causality Response:** Risk that patient safety may be compromised due to a lack of equipment compatibility for mass casualty vehicles since UKHSA ended their commitment to undertake the maintenance functions, which will lead to delays in treatment, and reduced operational effectiveness during major incidents.

### Concerns:

**Trolley Beds** – 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.

**FIT testing compliance** ahead of winter. Currently 69% in last two years.

## 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) to Fire Service College in Moreton in Marsh is completed and ECU delivered courses recommenced in mid-October.

## Compliance

| October 2025 CPI % | LAS | HART | TRU | APP-CC | APP-UC | SP-PC |
|---|---|---|---|---|---|---|
| Cardiac Arrest | 97% | 96% | 97% | 98% | 96% | 96% |
| Difficulty Breathing | 92% | N/D | 91% | 94% | 93% | 94% |
| Older Fallers | 88% | N/A | 88% | 62% | 88% | 88% |
| General Documentation | 95% | 100% | 95% | 99% | 91% | 92% |
| Sepsis | 95% | 94% | 95% | 96% | 97% | 96% |
| Mental Health | 93% | 90% | 90% | 88% | 100% | 83% |
| Sickle Cell Crisis | 92% | N/A | 85% | N/D | N/D | 94% |
| Discharged at Scene | 95% | 98% | 94% | 94% | 97% | 95% |

| R&SA | Sept | Oct | Nov |
|---|---|---|---|
| Information Governance | 99% | 99% | 99% |
| Safeguarding level 3 Adult | 95% | 94% | 90% |
| Safeguarding level 3 Children | 95% | 94% | 90% |
| CSR 2025.1a e-learning | 71% | 76% | 79% |
| CSR 2025.1b e-learning | 41% | 51% | 57% |
| CSR 2025.2 | 74% | 76% | 79% |
| FFP3 Fit Testing | 58% | 64% | 69% |

# R&SA (including NHS Emergency Capabilities Unit)

SAFE

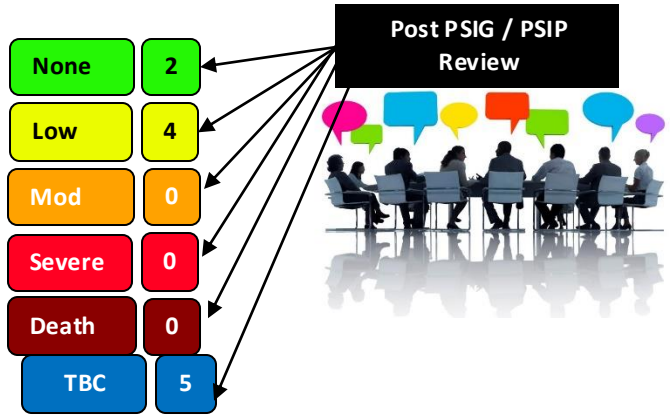
## Incidents

**Patient Safety Incidents Q3**

- 75 patient related incidents reported Q3 to date
- Harm Reports: Death 3, Severe 2, Moderate 1, Low 9, None 66. Deaths were re-categorised to no harm post PSIG.

**Top Incident Categories**

1. Clinical treatment (Except medication): 29 incidents
2. Maternal / Obstetrics x13
3. Medical Equipment x 11
4. Medication Error x 8
5. Clinical Assessment x




## Learning

**Important Learning Themes**
Restraint & Sedation Governance: Multiple ABD cases required chemical sedation under PGD. Some breaches occurred (e.g., incorrect dosing, second dose outside PGD).
**Learning**: Around need to reinforce PGD compliance, and risks of decision-making under pressure, especially in custody or high-risk environments.

**Medication Safety Errors** included duplicate paracetamol dosing, incorrect midazolam doses during seizures, and PGD breaches.
**Learning:** Emphasise double-checking doses, awareness of recent / cumulative doses, and contingency planning for IT failures (e.g., JRCALC access).

**Equipment Reliability & Availability**
Failures of LifePak monitors, ultrasound probes, and drawing-up needles delayed care. Missing paediatric probes and MedSleds impacted patient management.
**Learning:** Strengthen pre-shift equipment checks and review pathways for replacements.

**Maternal & Neonatal Emergencies**
Incidents included breech births, cord prolapse, postpartum haemorrhage, and a home birth requiring NLS.
**Learning**: Reinforce rapid pre-alerts, adherence to local maternity pathways, and readiness for obstetric emergencies.

**Clinical Assessment**
Cases of inadequate falls assessment and mismanagement of hypothermic patients highlighted gaps in risk evaluation.
**Learning:** Promote thorough documentation and use of alternative pathways when hospital conveyance is declined.

# Sector Clinical Quality

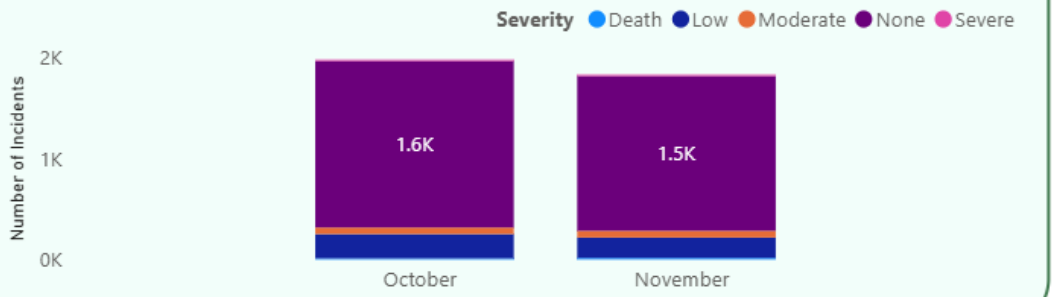
Health & Social Care Act 2012
Regulations: 12, 17

EFFECTIVE SAFE

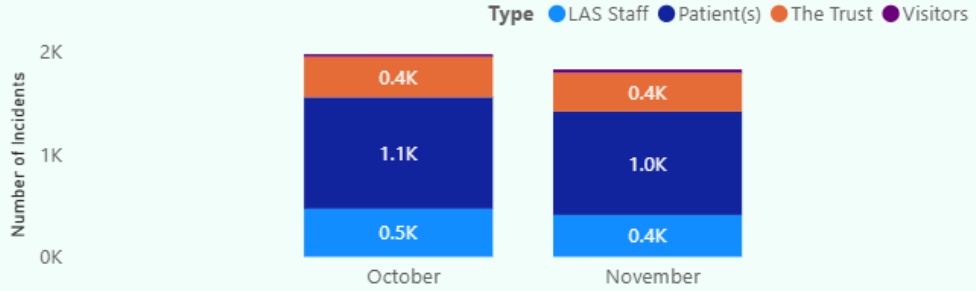
## Incidents

Year, Month: Multiple selections
Sector / Department: All
Station / Team Location: All

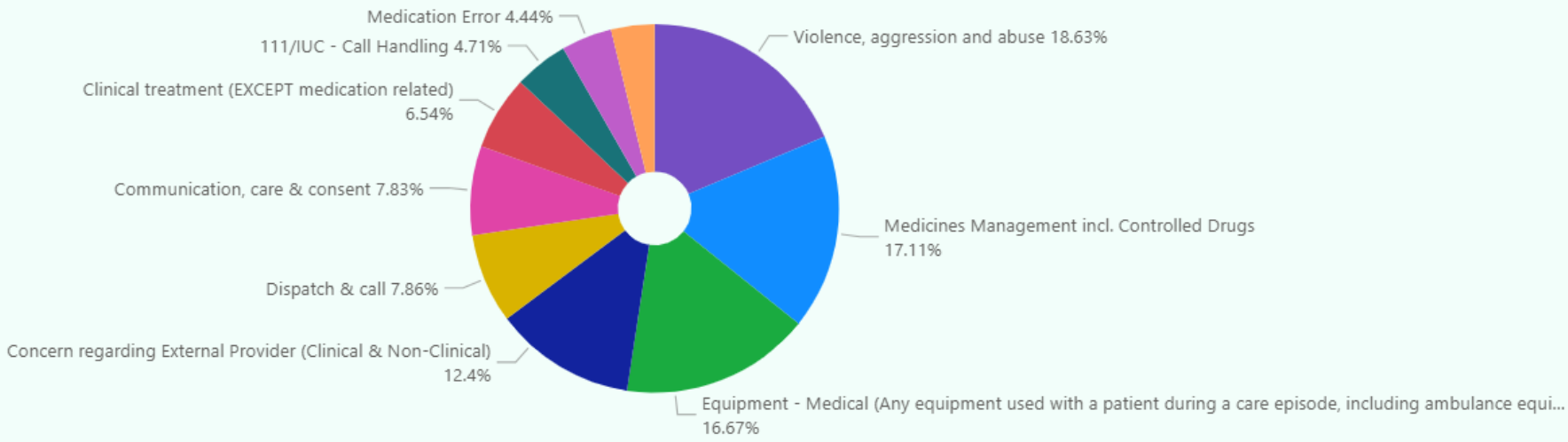
### Incidents By Severity




### Incidents By Type




### Top 10 Categories




NB: Data exported from the Clinical Quality dashboard – October and November 2025

# Sector Clinical Quality

Health & Social Care Act 2012

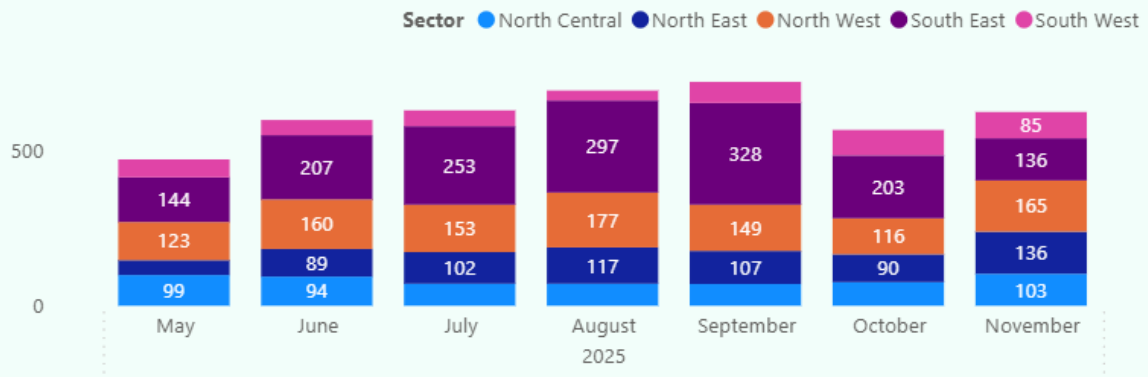
Regulations: 12, 17, 20

EFFECTIVE SAFE

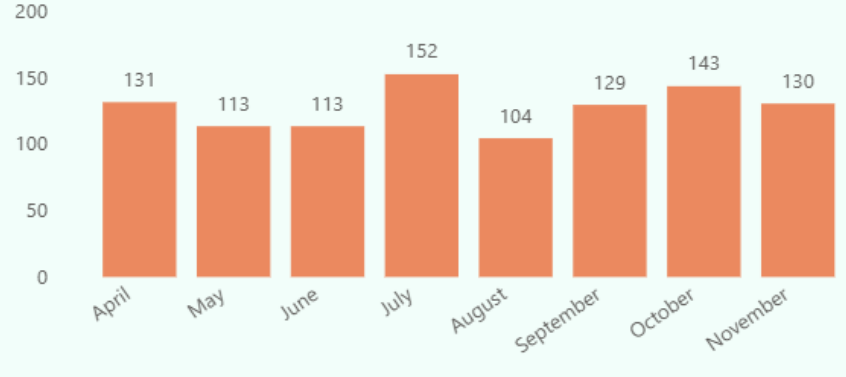
## Quality Summary

Sector: All

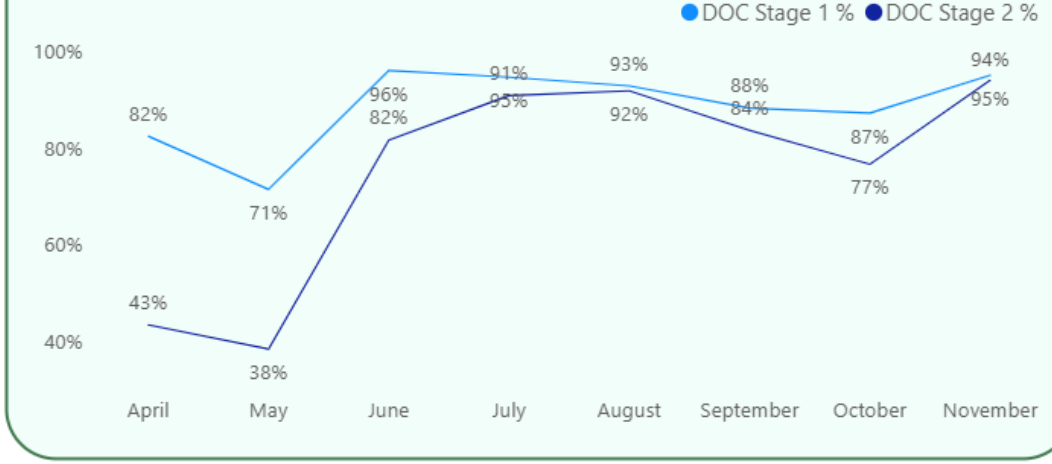
### Overdue Incidents



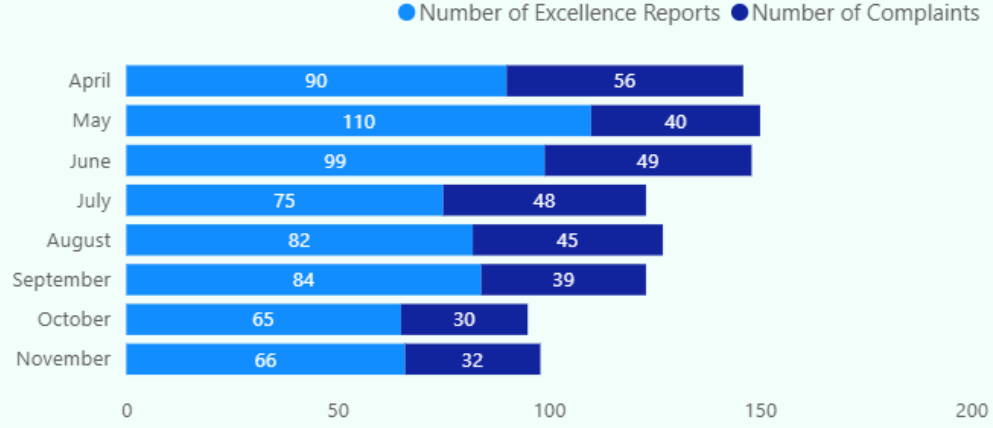

### PSIG




### DOC Compliance




### Feedback




NB: Data exported from the Clinical Quality dashboard – October and November 2025

London Ambulance Service
NHS Trust

# Research & Clinical Audit

Link to CARU live CPI dashboard (requires VPN)

We are the capital's emergency and urgent care responders

CQOG date: 23rd December 2025

Reporting date: Oct 25 – Nov 25

# CARU

Health & Social Care Act 2012

Regulations: 9, 17

EFFECTIVE

## Key Findings

**National AQIs (July 2025 data, published December 2025):**

**ROSC:** LAS ranked in the first place nationally for ROSC sustained to hospital arrival in the overall group at 33.9% (national average: 30.0%). In the Utstein group, LAS ranked joint 6th with 53.7% (national average: 55.0%).

**Survival:** Our overall 30-day survival rate was 12.1%, placing us 5th nationally, above the national average of 11.4%. Within the Utstein comparator group, we ranked 3rd with a survival rate of 37.0%, well above the national average of 32.5%.

**STEMI:** LAS recorded a mean Call to Angiography time of 02:26 - three minutes slower than the national average of 02:23 - ranking 7th nationally.

We provided a full STEMI care bundle to 81.0% of suspected STEMI patients. The LAS continues to perform below the national average for this measure (84.5%), currently ranked 9th in the country.

**Stroke:** We recorded an average Call to Hospital arrival time of 01:27. This was faster than the national average of 01:31, placing LAS in the 4th place among all ambulance services.

**Falls:** No falls care bundle data was published for July. September's data will be submitted in January and published in February 2026.

Note: STEMI and Stroke figures are based on MINAP and SSNAP datasets respectively which may not be complete samples and are subject to change following revisions.

**Facilitated Clinical Audit: Emergency Responders' Medicines Administration**

**Overall:** Medicines were mostly administered with correct indication, dose, and route.

**Aspirin:** Mostly administered appropriately (1 incorrect and 1 contraindicated use). 25% had incorrect dose (likely documentation errors) and 86% had post-administration observations.

**Oxygen:** Correct administration and post-administration observations recorded for nearly all patients (1 dose error).

**Nitrous Oxide:** Correct administration, and post-administration observations for all but one patient.

**Glucose 40% Oral Gel:** Most patients appropriately indicated for glucose, however 3 with reduced GCS received it inappropriately. Dosage was not recorded for 2 patients. Many had the amount documented (rather than the composition) and 2 did not have post-administration observations.

**Salbutamol:** All but one patient had indication documented; 1 did not have route recorded. Dose was missing or incorrect for one-fifth of patients (including 3 needing half doses), and 83% had post-administration observations.

## Recommendations

CPD sessions have been delivered to all volunteers covering:

- correct drug dose documentation
- post-administration observations
- ensuring patients are conscious when administering glucose gel
- halving salbutamol doses for patients on beta-blockers

## Highlights

**Clinical Audit Report (2024/25)**

The 2024-25 Clinical Audit Report was published, summarising completed projects, national submissions, staff engagement, and public involvement. It also provides evidence of assurance and outlines priorities for clinical audit in 2025-26.

**Clinical Annual Reports (2024/25):**

The Cardiac Arrest and STEMI annual reports were published in December 2025.

**External publication**

A conference poster on how patients with allergic reactions present to the ambulance service was well received at the Faculty of Pre-hospital Care Conference in Edinburgh

**Research:**

- We recruited 55 patients into clinical trials, bringing us to 443 patients enrolled into the SIS study and 349 into CRASH-4.
- 34 new clinicians completed trial training, bringing the total number of trained clinicians across both trials to 838.
- CRASH-4 has gained agreement in principle to open 4 more stations, which will bring the total station count to 36.
- This period there were 4 journal publications by LAS authors.

London Ambulance Service
NHS Trust

# Clinical Education

**We are the capital's emergency and urgent care responders**

CQOG date : December 2025

Reporting date: October/November 25

# Clinical Education & EGC Reports

Health & Social Care Act 2012

Regulations: 12, 18

SAFE

## Training

**Completed Training YTD figures:**

- 215 frontline registrants; 196 non registrants; call handling: 47 in 9's and 92 in 1's
- CSR 2025.2 YTD: 3524 attendance
- Section 19 YTD: 178
- FRU driving YTD: 251
- Driving courses numbers YTD: 273

**EGC Reports**

- Apprenticeship numbers (YTD) 176 AAP, 208 EMT, 292 Paramedic (Cumbria), 5 CELC
- Ongoing ESR challenges with assuring all clinical staff are assigned to CSR 2025.1C packages
- 2026/2027 CSR content has been agreed (attached) and work is underway to develop the session material
- Restructured Clinical Advisor course implemented and progressing successfully
- Clinical Leadership & Resuscitation Programme part 2 awaiting ELT sign off

## Assurance

- Driving Investigations: 1 police investigation, 17 in the East, 1 in the West. 12 Trust investigations post RfR triage
- Safe2Drive drivers: 6117 out of 6147 licences have been checked and completed. 23 Ops & 7 non ops licences outstanding, ongoing manual checks being reviewed and reported
- Current rise in driving licence expiry dates which is being monitored and-managed
- Open Athens registrations now at 1376
- YTD allocation AHP CPD funding 25/26: £367,860.76, 611 applications
- YTD LAS Bursary 25/26: £678,708.51, 554 applications
- 5,600 (61.6%) colleagues completed Tackling discrimination and promoting inclusivity (TDPI) Phase 1. 6158 (67.7%) colleagues completed TDPI Phase 2
- Trust wide Stat/Man compliance is at 88.56%, Appraisal compliance is at 83.72%
- Trust Training Plan numbers agreed, awaiting 111 figures

## Future Plans

- Exploring AI tools and applications, including an AI simulation for 999 call handling, successful trial ran in November
- Reviewing accreditation options to support internal delivery of simulation-based training
- National podcast recorded and webinars planned with AACE for early 2026 to promote updated EoLC JRCALC & new pediatric guidelines
- Section 19 enactment date remains TBC, will demand changes to FRU training and evidence of BLD responding within a 3-month period
- Funding stream identified which will support bringing all aspects of the Bariatric course in house for training

## Current risks and Concerns

LD&A 1 day session 2026/2027

Section 19 enactment and subsequent necessary changes.

CQOG date : December 2025

Reporting date: October/November 25

# Clinical Education & EGC Reports

SAFE

## Future Plans

| Title | Subject | Time |
|---|---|---|
| **2026.1 e-Learning** | Information Governance *(Statutory)* | 30 mins |
| | IPC Level 2 *(Statutory)* | 30 mins |
| | Equality, Diversity & Human Rights (Statutory) | 30 mins |
| | Health, Safety & Welfare (Statutory) | 30 mins |
| | Medicines Safety (Essential) | 1 hr |
| | Initial Operational Response (EPRR) (Essential) | 45 mins |
| | JESIP (Essential) | 30 mins |
| | ECGs (Request) | 45 mins |
| | Refusal of Care (Request) | 45 mins |
| | Spinal Assessment & Pain Management (Request) | 30 mins |
| | Vascular Emergencies (Request) | 30 mins |
| | **Total** | **6 hrs 45 mins** |
| **2026.2 Face to Face** | Resuscitation (L3) - Including VoD/ToR updates *(Statutory)* | 5 hrs |
| | Primary Survey & Recognising Unwell Patients (Request) | 2 hrs |
| **2026.3 Face to Face** | LD&A Tier 2 *(Statutory)* | 7 hr 30 mins |
| | **Total** | **14 hrs 30 mins** |
| | **Grand total** | **21 hrs 15 mins** |

**Core Skills Refresher (CSR) topics and hours for 2026/27 for all clinical staff.**

Subject areas identified by various clinical, quality, and safety groups, as well as topics mandated for coverage under the Trust's compliance with the Core Skills Training Framework (CSTF).

Adrenaline for anaphylaxis was a requested subject. This will be covered in the medicines safety package.

London Ambulance Service
NHS Trust

# Quality Oversight
# Advanced & Specialist Practice

**We are the capital's emergency and urgent care responders**

CQOG date : December 2025

Reporting date =October/November 25

# Advanced Practice – Critical Care

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Incidents

| Number of incidents | Themes |
|---|---|
| **(Oct) 22** | ABD/Restraint x 13, Equipment failure (needles and US probe) |
| **(NOV) 23** | ABD/Restraint x8, Maternal emergencies x 6 |

**Restraint:** 18 (10 Oct to 10 Nov)

**Intubation**:76 Oct, 97.37% success within 2 attempts

Children no ETI (100%, n=2)

## Current risks and Concerns

**Number & Description of open risks reported on the risk register (RADAR) .**

There is a risk of insufficient operational and clinical management capacity, caused by the potential of further expansion of the APP programme, which may lead to sub optimal levels of day to day management and governance.

## Learning

**Learning From Incidents:** Ongoing issues with Lumify HUD connectivity (attempting resolution with Phillips). Ongoing issue with USS storage and IM&T ability to resolve

**Practice development** - Arterial lines, new video laryngoscope, Corpuls CPR arm, Misoprostol PGD, Levetiracetam PGD new Ketamine PGD, Magnesium in pre-eclampsia

## Performance

**CPI Compliance:**
Completion: 96% (August-latest)
ABD: 98%
OHCA: 98%
Major Trauma: 98%

**Performance:**

| | October | November |
|---|---|---|
| **On Scene Time** | 84.1 | 84.7 |
| **Job Cycle Time** | 111.7 | 112.3 |
| **Utilisation** | 38.3% | 35.8% |

**Statutory/Mandatory Compliance:** 83.14%

**Case Based Review Attendance**
746 this year (13.8/APPCC)

**Supervision Shifts:**
October: 5
November: 6

**Cover:** No understaffed shifts Oct or Nov

CQOG date : December 2025

Reporting date = October/November 25

# Advanced Practice – Critical Care

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Training

**Mandatory training compliance**

- ESR Modules focus for stat/mand
- Corpuls CPR arm complete end of November

**Training achievement / pipeline**

- 15 undertaking MSc
- Corpuls CPR arm training ongoing

**Attendance at training days**

- 277 attendances for 2025

**Assurance over revalidation/qualification/ recertification**

- All registrants remain on register, No concerns.

## Assurance

**PGD breaches**

1 Ketamine. No harm. Reported as required.

**Audit & Research**

Rocuonium Study: APPCC use of paralysis over a one year period

Ketamine Study: APPCC use of Ketamine over a one year period

Chemsex Study: Led by an APPCC-study looking at attendance at Chemsex incidents by LAS

## Further updates/ Ongoing work

- Daily review go live December (planned)
- New CPIs go-live 1 December
- Temporary changes within the APP leadership team from December 8th for a fixed period of time

CQOG date : December 2025

Reporting date = October/November 25

# Advanced Practice – Urgent Care

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Incidents

| Number of incidents | Themes |
|---|---|
| **(Oct) 13** | Overdue equipment service (raizer chair), Needle failure |
| **(Nov) 9** | No themes |

**Restraint:** None reported

**Prescriptions:**

| | September | October |
|---|---|---|
| Total Prescriptions | 67 | 102 |
| From LAS Drug Pack | 40 | 64 |
| Prescribed/Supplied | 19 | 15 |
| Electronic Prescription Service (EPS) | 7 | 19 |
| On Formulary Prescribing | 97% | 98% |
| Off formulary Medications | co-amoxiclav, cyclizine lansoprazole (30mg rather than 15mg) | |

## Current risks and Concerns

**Number and description of open risks reported on the risk register (RADAR)** :

New risk added in relation to potential challenges related to expansion of APP-UC numbers without committed increase in managers.

There is a risk of insufficient operational and clinical management capacity, caused by the potential of further expansion of the APP programme, which may lead to sub optimal levels of day to day management and governance.

## Learning

**Learning From Incidents:** None this report
**Practice Development:** Ultrasound devices purchased to expand FICB provision. Education package being developed for delivery in 2026. Rotational working in hospice setting with Marie Curie

## Performance

**CPI Compliance** (Sep/Oct)

- Abdo Pain – 86%/86%
- Cardiac Arrest – 98%/100%
- Discharge – 96%/94%
- P/EoLC - 94%/98%
- Document – 94%/91%
- Headache – na/71%
- MH – 100%/100%
- Fallers – 95%/88%
- Paed – 100%/92%
- Sepsis – 93%/97%
- TLOC – 81%/44%
- Wound – 90%/95%

**Performance:**

| | October | November |
|---|---|---|
| **Conveyance to ED** | 34.59% | 34.64% |
| **Utilisation** | 56.9% | 48.9% |

**Supervision Shifts:**
October: 14
November: 19

Year to Date: 90
Target: 3 per year (186 total)

**Cover:**
October: 5 earlies, and 5 lates below min
November: 7 earlies and 0 lates below min

CQOG date : December 2025

Reporting date = October/November 25

# Advanced Practice – Urgent Care

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Training

**Mandatory Training Compliance**:
- Stat/Man 82.86%
- Specialist Training 78.83%

**Training/Educational Achievement:**
- Cohort 6 (12 APPs) completed MSc
- Cohort 7 (8 APPs) completed NMP
- Cohort 9 induction completed – mentoring ongoing

**Attendance at Training Days:**
- Q2 CGDs (EPRR focus) – 59/69* (1 CGD cancelled but replanned for Q4 for remaining numbers)
- Q3 CGDs (paediatric focus) - 51/80** (1 CGD to be held in December)

* Pre cohort 9 (69 APPs/CLT)
** Post cohort 9 (80 APPs/CLT)

**Assurance over revalidation/qualification/ recertification**
- HCPC re-registration checks completed
- Ongoing clinical governance days
- Ongoing Non medical prescribing (NMP) governance days
- NMP re-authorisation to prescribing register ongoing

## Assurance

**PGD Breaches:**

None

**Audit/Research:**

- Right Care, Right Place, Right Care: 12-month longitudinal analysis of activity and impact of Advanced Paramedic Practitioners Urgent Care in London' which is a 12-month study evaluating the APP-UC team.
- Cohort 6 QI's being considered for publication

CQOG date : December 2025

Reporting date = October/November 25

# Specialist Practice

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Incidents

| Number of incidents | Themes |
|---|---|
| 0 | |

**Trainee SPPC - (tSPPC)**

**Qualified SPPC - (qSPPC)**

## Learning

**Learning from incidents:** None of note for this reporting period

**Practice development:** Catheter Care, Pilot for 5 qSPPC to undertake independent& supplementary prescribing module

## Current risks and Concerns

**Ongoing themes**

Uncertainty with national ARRS funding long term with changes to NHSE. No impact currently. Monitoring position.

- 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

DCPO met with NHSE regarding the enhanced practice apprenticeship scheme which could if required, potentially be an education route for specialist practice for the organisation. Awaiting further information from NHSE and university partners.

## Performance

**CPI Compliance:**
Portal confirmed to go live 01/12/25

**Performance metrics / targets**

| | October | November |
|---|---|---|
| Utilisation | 58.31% | 50.50% |
| On Scene Time | 90.89 minutes | 88.34 minutes |
| Job Cycle Time | 109.82 minutes | 104.61 minutes |
| Discharge on Scene | 41.60% | 42.83% |
| Recontact Rate * | August data; 1.25% | September data; 1.76% |

*Data for reporting period not synced due to data availability provided in arrears)

**Supervision shifts - numbers / target**

Oct = 7 (low due to 1 CS currently LTS)
Nov = 11 (Low due to 1 CS currently LTS)
Year to date = 93
Target; x3 a year (48 total clinicians)

CQOG date : December 2025

Reporting date = October/November 25

# Specialist Practice

Health & Social Care Act 2012

Regulations: 9, 12, 17 & 18

SAFE

## Training

**Mandatory training compliance**

- Appraisal reviews = 75%
- Professional registration = 100%
- Statutory & Mandatory Compliance = 84%
- Appraisals for all staff booked.

**Academic progress**

- All PGCert students now at City St Georges
- Prescribing pilot split between Hertfordshire and City St Georges
- Support for individual CPD via the bursary being provided as required

**Training**

- All qSPPC to be trained in catheter trouble shooting approval granted at all relevant governance groups. Training video complete from comms and equipment delivered, appropriate training records being created.

**Attendance at training days**

- Clinical Governance day 11/11/25, 16 in attendance, clinical theme elderly fallers, external speaker (expert witness/GP) discussing medio-legal aspects of clinical care.

## Assurance

**Audit**

- tSPPC training group, audited via sector/group audit/CPI
- qSPPC group, CPIs creation in progress and delayed to 1st December for go live – no proceeding data held. Interim solution, spot checks of ePCRs and individual feedback provided on supervision.

## Approval

For approval:

SP-PC Clinical Governance Policy

SPPC Clinical Governance Policy v1.3 Dec25.docx

## Further updates/ ongoing work

**Clinical Updates:**

- Catheter care: Training package for qSPPC group being created, predicated to go live early 2026.
- Pilot for 5 qSPPC to undertake independent & supplementary prescribing module ongoing. Skill to only be used within the primary care setting. Currently working with local PCN teams to create formulary and ensure auditing process available. No implications to contracting, supported by Chief Pharmacist.

**Operational Updates:**

- SPPC vehicles now transitioned to new liveried vehicles. Previous risk: of no visible rear warning lights when boot open at scene now resolved.
- Work underway to reduce likelihood of clinicians accumulating hours owed to the trust as part of self-rostering.
- Overpayments reclaim work ongoing.
- Substantive appointment of Team Managers x 2 and Specialist Paramedic in Primary Care Administration and one seconded Team Manager.

London Ambulance Service
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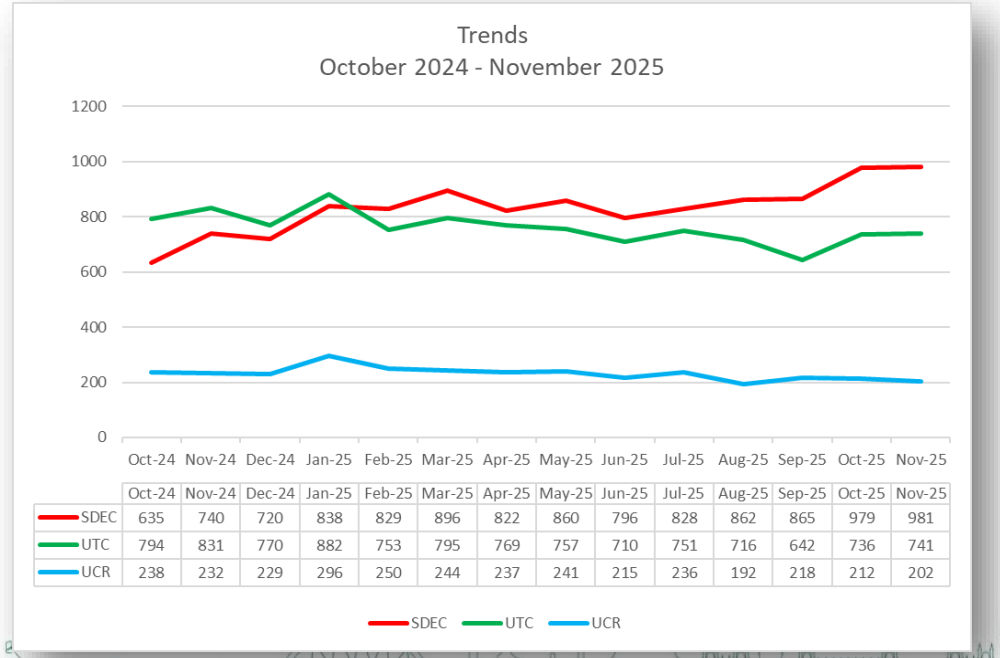
# Quality Oversight
# 3rd Parties & Alternative Pathways

**We are the capital's emergency and urgent care responders**

# Use of Alternative Care Pathways (ACPs)

## Education to support use of alternatives to ED conveyance for winter

- **UCR education video** produced by Clinical Quality lead for UCR with Clinical pathways and NHSE support, shared in Huddles.
- **SDEC video and campaign in NCL** raising awareness of Trusted Assessor, resulting in increased referrals. Strategy and Transformation team producing analysis of SDEC Trusted Assessor referrals, to inform pan London improvement in access.
- **Posters and interactive maps** to highlight options available and services offered.




| | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SDEC | 635 | 740 | 720 | 838 | 829 | 896 | 822 | 860 | 796 | 828 | 862 | 865 | 979 | 981 |
| UTC | 794 | 831 | 770 | 882 | 753 | 795 | 769 | 757 | 710 | 751 | 716 | 642 | 736 | 741 |
| UCR | 238 | 232 | 229 | 296 | 250 | 244 | 237 | 241 | 215 | 236 | 192 | 218 | 212 | 202 |

**Oct –Nov '25 ACP data**

Increasing trend in hospital pathway utilisation:
SDEC (blue line)
UTC (green line)

## MiDOS

**Change in categorisation** and labelling of ACPs in MiDOS to enable **easier access** to main pathways, also highlighting ICC Hub.

**Real time access to ACP issue reporting** (previously 2-3 month delay). MiDOS feedback from LAS clinicians now accessible via portal, enabling clinical quality teams to take rapid actions with service providers.

# Integrated Care Coordination (ICC)

ICC Hubs operate across the system, **co-ordinating Urgent & Emergency Care response,** driven by the patient's condition.

- Each hub is staffed by a Senior Clinical Decision Maker (SCDM) to support ambulance clinicians with joint decision-making, pre-dispatch decisions and streamlined access to ACPs, identifying and coordinating the most appropriate service to meet the patient's need.
- **From December 2025, the LAS has operated ICC hubs across all 5 sectors. SEL (Lewisham and Greenwich Trust footprint) and NEL ICC hubs have only recently opened. This update covers activity between October and November 2025 for the three ICB wide hubs in NCL, NWL and SWL.**

## NCL

- **421** cases handled, supporting 1.03% of LAS demand across the sector
- 100% SCDM staffing (service open)
- 79% CSM staffing

- 91 avoided ED attendances
- Excellent acceptance rates for onward referrals
  - 100% UCR
  - 100% SDEC
- Good satisfaction from ambulance clinicians
  - 87% felt ICC positively impacted patient outcome
  - 95% would use the service again

### Challenges and Developments

- Low utilisation and productivity being addressed, targeted engagement with LAS clinicians/SCDMs
- Operational lead appointed Dec '25 (CTM secondment) to support improvement activity
- 7 Day working agreed to support winter from Dec

Pan London report being developed in Jan '26

## NWL

- **1,106** cases handled, supporting 1.69% of LAS demand across the sector
- 71% SCDM staffing (service open)
- 40% CSM staffing

- 553 avoided ED attendances
- Good acceptance rates for onward referrals
  - 80% UCR
  - 82% SDEC
- Good satisfaction from ambulance clinicians
  - 82% felt ICC positively impacted patient outcome
  - 93% would use the service again

### Challenges and Developments

- Significant SCDM staffing challenge, moving to substantive staffing model provided by acute Trusts
- Onboarding delays for SCDM and UCR clinicians, also postponing the co-location of UCR SPA
- Low update of APPUC to staff ICC Hub role (ICB funded)
- Operational lead appointed (ICB funded) with focus on rota fill and service development

## SWL

- 238 cases handled, supporting 0.62% of LAS demand across the sector
- 91% SCDM staffing (service open)
- 56% CSM staffing
- 34 avoided ED attendances
- Excellence acceptance rates for onward referrals
  - 100% UCR
  - 100% SDEC
- Good satisfaction from ambulance clinicians
  - 97% felt ICC positively impacted patient outcome
  - 100% would use the service again

### Challenges and Developments

- Soft launched August as staffing model stabilised, now SCDM cover until end March
- Sustained increase in calls to ICC Hub
- ICB appointed operational lead to develop Hub and integrate pathways, current focus on mental health *2 and frailty services

# 5.2.2. Quality Assurance Committee Report

For Assurance

Presented by Karim Brohi

London Ambulance Service NHS Trust

# Alert – Advise – Assure Committee Board Report

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|---|---|---|---|
| **Assurance report:** | **Quality and Assurance Committee** | **Date:** | **13 January 2026** |

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|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Karim Brohi** | **Prepared by:** | **Fenella Wrigley** |

**Alert**

**Issues that require Board attention:**

**Persistent Clinical Risk Themes**
The Committee noted that the clinical risk themes remain consistent with previous reporting periods. These include:

- Standards of clinical assessment and documentation
- Recognition and management of cardiac arrest
- Reliability and availability of medical equipment
- Delays in service delivery impacting patient safety

**Medical Equipment and Traceability**
Risks relating to equipment reliability, including trolley beds and medical gas traceability, remain under active management. The Board is asked to note the continued oversight of these risks.

**Mental Health System Pressures**
Increasing demand and system-wide constraints within mental health pathways continue to present operational and clinical risk.

**Funding Risk (Board Assurance Framework)**
The corporate funding risk remains high-rated. A review of its wording and scoring will be undertaken in light of the updated financial plan, with recommendations to be brought forward.

**Advise**

**Items where Board input or awareness is needed:**

**Strengthened Quality Intelligence Framework**
Progress continues in the triangulation of incidents, complaints, legal cases, patient feedback and audit findings through the RADAR reporting system. The development of live dashboards is expected to enhance predictive oversight and thematic risk identification.

**Learning from Deaths and Patient Safety Incident Response Framework (PSIRF)**
The Committee reviewed thematic learning relating to:

- Recognition of ineffective breathing
- Timely defibrillation
- ECG interpretation

- Documentation standards

Improvement actions are embedded within education and governance processes.

**Operational Performance**

- Improvements in Category 2 response performance were noted.
- Hear and Treat rates continue to improve following targeted investment.
- Utilisation of advanced and specialist practitioners remains below optimal levels and is under review to ensure alignment between control room processes and clinical deployment.

**Health Inequalities Programme**

The Trust's approach remains aligned to the NHS Core20PLUS5 framework. A Maternal Health Action Plan has been developed following patient and staff engagement. A detailed discussion will be scheduled at a future meeting.

**Committee Effectiveness and Reporting**

The Committee is refining its reporting approach to ensure a stronger focus on assurance, clarity of risk, and reduction in paper volume. Deep dives will be aligned to principal risk themes.

**Assure:**

**Positive assurances for the Board to note:**

The Committee is able to provide the following assurances:

- No Never Events were reported during the period.
- Duty of Candour compliance has improved.
- Sixteen longstanding risks have been closed following mitigation.
- A structured and robust clinical audit programme is in place, with evidence of impact on local and national practice.
- Learning from incidents is disseminated through formal governance routes, including case-based discussion forums and electronic publications.
- Safeguarding processes remain robust, with appropriate referral and oversight mechanisms in place.

**Risks:**

**BAF Risks**

The Committee reviewed relevant strategic risks and notes:

- Funding from commissioners (under review)
- Mental health system capacity pressures
- Equipment traceability and reliability
- Workforce training compliance gaps
- Incident review timeliness (improving trajectory)

| Decisions & Recommendations | **Decisions Made by the Committee**<br>• Approval of clinical audit reports.<br>• Endorsement of updated clinical procedures.<br>• Agreement to refine the structure and frequency of assurance reporting.<br>• Agreement to alternate Quality Improvement and Health Inequalities deep dives.<br><br>**Recommendations to the Board**<br>The Board is asked to:<br>1. Note the continued focus on core clinical risk themes.<br>2. Support the review of funding risk scoring.<br>3. Endorse the ongoing quality improvement programme targeting clinical standards, equipment reliability and service delays. |
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# 5.3. People and Culture

## For Assurance

# 5.3.1. Director's Report

For Assurance

Presented by Simon Steward

London Ambulance Service NHS Trust

# London Ambulance Service NHS Trust Board Meeting March 2026 (January 26 data)

# Report from the Chief People Officer

## P&C Operations

### 1. Recruitment

We have maintained our strong performance with a 100% fill rate in January and February, and 97% for Quarter 3. Our pipelines remain robust with approximately 250 candidates holding conditional offers for paramedic, non-registrant, and call handling roles. Recruitment activity to support the frontline continues, including roles such as Advanced Paramedic Practitioners, CRU, TRU, HART, HEMS, PCN Programme, Mental Health, and Community Resuscitation.

### 2. Retention

In January 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

Work is continuing to strengthen the Trust's approach to managing Employee Relations matters, with a focus on improving the experience of colleagues involved in resolution processes. Developments within the Resolution Hub have included enhanced digital oversight of Request for Resolution (RfR) submissions, the use of independent panels, and a continued emphasis on resolving concerns at the earliest possible stage.

The Resolution Framework is being further developed to build upon early resolution processes and provide ongoing support for managers in addressing issues promptly, consistently, and fairly within their teams.

Targeted learning and development initiatives have been delivered across the organisation to support managers in handling ER matters, aligned with the updated processes and offering practical guidance on local resolution pathways. Capacity has also been strengthened through the appointment of additional Resolution Advocates and Mediators.

Managers have further participated in practical Employment Tribunal Mock sessions to enhance preparedness and confidence in handling tribunal related matters.

Assurance mechanisms remain in place, with regular Employment Tribunal case reviews providing Board level oversight, highlighting key themes, and supporting organisational learning.

## 4. Workforce Intelligence, Payroll & Pensions

### Workforce Planning

Through our internal business planning process we have identified our workforce requirements for 2026/2027-2028/2029 and we have recently submitted our workforce plan to NHS England. The collaborative and multi-disciplinary approach across Corporate and Operational teams has supported the design of the plan and ensured that the data systems are aligned across Finance and Workforce. 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 IBM to deliver a digital assistant for all Trust staff. This 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 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. Working closely with our colleagues in the Digital and Data directorate, we have mobilised a project to adopt this automation as a 12-month proof of concept to fully test the technology by automating ten priority P&C processes based on time saved across most P&C functions (some of the processes will benefit multiple teams).

### DBS checks

As at 31st January 2026, 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

The Health and Wellbeing team has been working on a sickness transformation programme with P&C colleagues and operations managers, which over winter has seen sickness fall by 1.2% over the two months from the beginning of December 2025 to the end of January. Actions of the team have included supporting managers with long-term sickness; the establishment of an alternative duties hub; and the development of an absence management platform. The team has worked closely with the advisory team and OD&TM to update the supporting attendance and occupational health training for managers.

The team has also focussed on key priorities over winter with an aim to prevent absence and improve health and wellbeing across the Trust. These have included;

- The implementation of the Winter Wellbeing Plan, with bespoke actions for each area determined by absence data
- The roll out of the internal flu programme, with the Trust 3rd in London by the end of January 2026 and with a 10% higher uptake than 24/25
- The introduction of “Beyond Stop”, a brand new psychological debrief training session for managers, funded by a £50,000 winning bid to NHSE
- Realigning the team to properly support early resolution and mediation for the management of conflict.

## 6. Freedom to Speak up

The Freedom to Speak Up (FtSU) team continues to provide vital insight into the culture of the Trust and from January 2026 now sits within Corporate Affairs. The team continues to plays a key role in supporting psychological safety and enabling colleagues to raise concerns confidently, safely and appropriately across the organisation.

There are currently 49 trained FtSU Ambassadors across the Trust. These colleagues have volunteered to undertake additional training and act as local champions for speaking up Arrangements are being made to further train them on Bystander training to further strengthen psychological safety when speaking up in the LAS. Of these, 22 Ambassadors are trained in sexual safety, providing specialist support to colleagues who wish to raise concerns of this nature. To further strengthen capacity and resilience, a new Deputy Guardian has been appointed to support the management of concerns across the organisation.

The FtSU team has maintained a strong focus on visibility and engagement. This includes presentations at staff SLT meetings and local huddles, helping colleagues to understand who FtSU is, what it does, and how to access support. The team also attends Culture and Retention groups, holds a regular slot on the CELC programme, and undertakes regular feedback and evaluation of FtSU activity to inform continuous improvement. Detailed planning is underway to support collaborative working across teams and functions.

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

Building upon our CIPD Award win for Best OD Initiative, the OD&TM Team is now scaling high-impact programmes to drive measurable organisational benefit across the Trust.

### 7.1 Talent Management

***Career pathways***

- Draft pathways completed for 999/111/Amb Ops/RSA/Specialist Paramedics; final Trust-wide launch pack to be issued by end of March 2026.

***NHS Graduate Management Training Scheme***

- Five trainees (two HR, two General Management, one Policy & Strategy from NHSE) progressing well with excellent feedback.
- Expression of Interest (EOI) submitted for 2026 cohort (Amb Ops, HR, EOC).

***Organisational change support package***

- New bespoke consultation support package launched in partnership with services and HR Advisory team.

***Trust-wide career conversations***

- Direct career coaching via inbox referrals, manager signposting and ride-outs across stations. Support includes application and interview skills, career coaching, transitions and professional confidence building.
- Coaching programme (recognised by the European Mentoring and Coaching Council) launched with 18 colleagues. Preparation underway to launch our career clinics and internal coaching hub.

## 7.2 Leadership and Culture Management

***Appraisal compliance***

- Sustained focus on 85% target; Trust currently at 84.09% (Jan 2026).

***New Talent Performance Cycle and e-Appraisal rollout***

- Executive Leadership Team (ELT)-approved talent performance cycle aligning appraisal to business planning (April–August window).
- New appraisal policy (including Agenda for Change (AfC) Annex 23 performance ratings) in development.
- Full digital e-Appraisal launch in April 2026.

***Team effectiveness***

- Facilitated several successful team development days using the Affina Team Performance Inventory (ATPI) delivering practical team improvements.
- Targeted interventions planned following 2025 Staff Survey analysis.

***Commissioned leadership programmes***

- Henley High Performing Leaders – 40 participants.
- PGCert Healthcare & Medical Leadership (Cumbria) – final cohorts complete Jan/May 2026.
- No further cohorts for Middlesex Advanced Diploma or NHS Elect Aspiring Leaders.

***Centre of Excellence for Leadership and Culture (CELC)***

- ELT-approved scale-up for organisation-wide rollout, targeting Bands 5-7 over three years.
- Communications to be released end of February 2026; first cohort March 2026.

***Me and My Leadership Style video series***

- Ongoing video series showcasing diverse leadership approaches.

***Sexual safety training***

- Proposal ratified; delivery planning underway with subject experts.

## 7.3 Learning and Development

***Learning Needs Analysis***

- 1,047 responses (12.2% of workforce); governance underway.
- New non-clinical L&D offer being designed in response.

***Statutory and Mandatory Training***

- All NHSE actions complete; Gateway 1 & 2 aligned to LAS.

- New framework sign-off in December 2025; rollout plan in development with full implementation from April 2027.

***Tackling Discrimination & Promoting Inclusivity (TDPI)***

- Phase 2 completed November 2025; 6,158 completions (67.7%).

***L&D delivery***

- Continued broad L&D delivery across the Trust.

***Trust induction***

- Virtual induction redesign underway in collaboration with SMEs and focus groups.

### 7.4 Apprenticeships and Employability

- New HR, L&D, OD and Payroll apprenticeships launched.
- Fourteen P&C colleagues enrolled; further cohorts planned - programmes lead to CIPD and CIPP professional accreditation.

### 7.5 Culture-Led Operational Improvement

**Homerton group pilot**

- Deep dives complete, culture data analysed and themed.
- Governance concluded - report issued to Homerton Group.
- Implementation groups being established, aligned with 2025 Staff Survey findings.

**Simon Steward**

**Acting Chief People Officer, London Ambulance Service NHS Trust.**

# 5.3.2. People  and Culture Committee Report

For Assurance

Presented by Anne Rainsberry (2)

London Ambulance Service NHS
NHS Trust

# Alert – Advise – Assure Committee Board Report

| | | | |
|---|---|---|---|
| **Assurance report:** | **People and Culture Committee** | **Date:** | **9th February 2026** |

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|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Anne Rainsberry** | **Prepared by:** | **Anne Rainsberry** |

## Alert

**Issues that require Board attention:**

**Culture and Staff Experience**

- Staff survey results remain broadly stable, but cultural indicators have not shown the desired progress despite sustained interventions. The Committee discussed the need to refocus the programme with a particular emphasis on front line leadership capability and accountability.

**Employee Relations Case Volumes**

- There continue to be high case volumes with longer than planned times for resolution. A review of the Resolution Hub model is underway, and this will report back to the Committee in due course.

**Sickness Absence and Workforce Wellbeing**

- Although performance has improved year-on-year, sickness absence remains a key focus. The Sickness Transformation Team continues work on both long and short-term absence. Future decisions regarding the Viv-up service require clearer evidence of impact and cost clarity.

## 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 when compared to white peers.
- 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**

**Workforce Risks in the BAF**

- Current Board Assurance Framework risks do not fully reflect the workforce planning risks.
- An additional workforce-related BAF risk is being developed.

**Decisions & Recommendations**

# 5.4. Finance

## For Assurance

# 5.4.1. Director's Report

For Assurance

Presented by Rakesh Patel

London Ambulance Service NHS Trust

## London Ambulance Service NHS Trust Board meeting

## Report from the Chief Finance Officer

**Financial Position at the end of January 2026**

### Income and Expenditure Plan

The Trust received income of £633.2m and incurred costs of £631.5m for the 10 months to end of January 2026. This position was a year-to-date Income & Expenditure surplus of £1.7m. 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 £102.2m during 2025/26 across Fleet, Estates and Medical Equipment. For the 10 months to the end of January 2026, the Trust had spent £43.6m and is forecasting to deliver the overall capital Programme this financial year.

### Cash Balance

The Trust had a closing cash balance of £82.0m at the end of January 2026.

**Strategic Assets and Property**

### *Capital Estates and Programmes*

Resilience Hub East the new home for our Hazardous Response Team (HART), and Fleet Service Hub are only a few weeks from opening with the teams starting to enact their migrations plans from their current facilities. The facilities are bespoke, modern and are fit for purpose for our HART and workshop teams. The works form part of the East Campus programme which will continue to develop with a new ambulance station which work will start on later in 2026.

The Trust has made improvements in our Headquarters building in Waterloo, building a new boardroom with state-of-the-art meeting facilities. We have also made changes in the rest of the building resulting in more space for staff to meet, improved facilities enabling teams to be collocated together and work is ongoing for a new facilities for the IM&T team so they can provide better live support for our teams.

The Trust has successfully secured a site in Southeast London and design work has already started on this. This facility will collocate several stations within the Oval group proving brand new facilities in a building that has been designed to be fit for purpose as well as offering opportunity for future growth of the teams.

The Trust is in the process of procuring further land in Southwest London for brand new ambulance station which will collocate operations, workshops and Make Ready with some of our specialist teams.

### EV

Significant progress has been made with the installation of EV charging infrastructure across the trust. The programme will see the installation of substations and EV chargers at 20 key sites where we plan to deploy our electric ambulances as they start to arrive early in 2026/27. All 20 sites will be completed by the end of March 2026.

### Solar

The Trust are installing solar panels at 13 sites across the estate along with battery storage at 4 of these sites. These align with the EV charging programme to support the infrastructure at these key sites and offset the cost of electricity.

### Estates

We are working through an ambitious refurbishment programme to refresh and update the facilities at our ambulance stations. This includes the installation of new kitchens and changing facilities. We are working through our backlog maintenance programme and incorporating this with the essential estate's safety works that are needed.

### *Fleet*

The latest batches of Double Crewed Ambulances (DCA) were all live by the end of Jan 2026 alongside our new bariatric fleet.

By the end of the financial year fleet will have received 40 new Fast Response Vehicles and will have commissioned circa 45 vehicles to support our Team leaders, Make ready and Premises cleaners' team and provided numerous types of fit for purpose vehicles to support our Emergency Preparedness Resilience and Response teams (EPRR) to support our crews at major incidents and events.

Fleet have rolled out a new application that will replace the current paper LA1 forms, not only will this provide a more sustainable way of securing information about vehicle checks it allows any information regarding potential defects or damage to be sent directly to the workshops and allows the teams to monitor and plan their workload better and allows us to plan for vehicles to be taken off the road without affecting availability for crews.

### Sustainability

We are working through our actions within the refreshed Green Plan and have made significant progress against these. Our calculations have shown a 12% overall reduction in our carbon footprint over the last 3 years.

### Supply & Distribution

The team is continuing to asset tag high value medical devices and have tagged c.80,000 devices and are installing active RFID tags on our DCAs which will provide assurances about what is on vehicles. This is currently live in 112 DCAs. 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.

Centralised Packing is now live across all ambulance operations site in London and the qualitative checks that are done on audit are showing positive results. The team continue to work alongside Make Ready on stations to ensure that packs and bags are being scanned in so that there is visibility in the end-to-end delivery and collection process of our assets.

The Production Hub team work alongside Operations highlighted opportunities for better working practices because of this the out of service element will be moving into Operations in April 2026. This supports the local working model better and allows the teams to liaise with Make Ready and the Warehouse teams to identify where there are resource challenges at specific groups.

**Rakesh Patel**

**Chief Finance Officer, London Ambulance service NHS Trust.**

# 5.4.2. Finance and Investment Committee Report

For Assurance

Presented by Bob Alexander

London Ambulance Service NHS Trust

# Alert – Advise – Assure Committee Board Report

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|---|---|---|---|
| **Assurance report:** | **Finance, Infrastructure & Productivity Committee (FIPC)** | **Date:** | **26 February 2026** |

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|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Bob Alexander** | **Prepared by:** | **Bob Alexander** |

**Alert**

**Issues that require Board attention:**
The Trust's capital programme for 2025/26 totals £102.2m.

At Month 10, year-to-date expenditure is £43.6m. A significant proportion of the remaining programme is scheduled for delivery in the final two months of the financial year.

The Committee has reviewed:

- Funding approvals and drawdown arrangements,
- Delivery schedules for fleet and estates schemes,
- Governance and oversight arrangements.

The Committee is satisfied that delivery plans are in place and continues to maintain enhanced oversight given the scale and phasing of the programme.

An update was received regarding discussions with the local authority in relation to land requirements associated with wider redevelopment proposals.

The Trust is engaged in ongoing dialogue to ensure operational requirements are protected. A further update will be provided to the Committee and Board as appropriate.

**Advise**

**Items where Board input or awareness is needed:**
**Month 10 Financial Position**
The Committee reviewed the Month 10 Finance Report.

Key points:

- In-month deficit: £0.3m (better than plan)
- Year-to-date surplus: £1.7m
- Favourable variance to plan: £1.5m
- Efficiency savings delivered: £24.7m year to date
- Cash balance at end January: £82.0m

The Trust remains on track to deliver a break-even position for 2025/26.

**2026/27 Productivity & Efficiency Programme**
The 2026/27 efficiency target is £19.2m.

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| | A Productivity & Efficiency Board is overseeing scheme development. Schemes have been identified and are progressing through governance gateways.<br><br>The Committee will receive a further update at its March meeting.<br><br>**South East London IUC Procurement**<br>The Committee reviewed the financial analysis underpinning the Trust's proposed submission to the South East London IUC procurement.<br><br>The model includes multiple service components (call handling and clinical assessment services).<br><br>The Committee was satisfied that:<br>• Financial modelling has been undertaken,<br>• Risks and delivery considerations have been reviewed,<br>• Governance arrangements are in place.<br><br>The financial position supporting the bid was approved. |
| **Assure:** | **Positive assurances for the Board to note:**<br>The Committee provides assurance that:<br>• Financial reporting is consistent with prior months and reflects appropriate oversight.<br>• The Trust remains forecast to achieve its planned year-end position.<br>• Recurrent efficiency delivery remains above 85% and in line with plan.<br>• Cash balances and working capital performance remain favourable to plan.<br>• Capital funding streams are confirmed and enhanced oversight arrangements are in place given the scale of the programme. |
| **Risks:** | **BAF Risks**<br>The Committee reviewed financial delivery, capital programme delivery, and productivity risks. The risk rating for the following risks were reduced in light of delivery in the first ten months of 2025/26:<br>1. Reduce risk rating on delivery of Income and Expenditure<br>2. Reduce risk of delivering the cost improvement programme in full recognizing that an element will be delivered non-recurrently<br>3. Reduce risk of delivering the capital programme in full based on the assurance received on plans in the last two months of the financial year<br>4. Reduce risk on delivering actions identified for 2025/26 in the Green Plan. |
| **Decisions & Recommendations** | The Board is asked to:<br>1. Note the Month 10 financial position.<br>2. Note the capital programme update.<br>3. Note progress on 2026/27 productivity planning. |

4. Note the approval of the financial position underpinning the SEL procurement submission.

# Audit

# 5.5. Audit Report

For Assurance

Presented by Rommel Pereira

London Ambulance Service NHS Trust

# Alert – Advise – Assure Committee Board Report

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|---|---|---|---|
| **Assurance report:** | **Audit Committee** | **Date:** | **21/1/2026** |

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|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Rommel Pereira** | **Prepared by:** | **Rommel Pereira** |

**Alert**

**Issues that require Board attention:**
There is nothing to ALERT the Board about.

**Advise**

**Items where Board input or awareness is needed:**

- Board's rigorous focus on critical service risks should be maintained, with the forthcoming BAF refresh presenting an opportunity to more broadly strengthen how risks, controls and mitigating actions are described.
- AC would maintain its oversight of Cyber risks (and requested regular reporting of 3rd party suppliers), alongside operational resilience and recovery assurance including business ownership for managing the impact of a prolonged incident that extends beyond IT. The Director of Resilience & Specialist Assets would be invited to regularly attend.
- In its regular review of Losses & Special Payments and Salary Overpayments, AC requested a report on learnings from losses and results of the 3rd party review in Ambulance Operations, respectively; the latter being supplemented as necessary with Counter Fraud's review.

**Assure:**

**Positive assurances for the Board to note:**

- Internal Audit provided Substantial Assurance on Key Financial Systems. And an overall assurance on IT Change Management, with recommendations to strengthen governance, process consistency and assurance over change implementation. AC requested that follow up's on IA recommendation deadlines be strengthened.
- The External Audit plan for 25/26 was approved, noting increased materiality, additional focus on the capital programme and increased requirements on climate related exposures. Looking ahead, with emerging regulatory interest in AI, AC noted the Trust's AI Policy progressing through internal governance and requested an Insight session on AI (and Organisational Resilience - see note above)

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| | • AC received Counter Fraud auditors report on proactive and reactive investigations and reinforced a zero-tolerance approach to fraud. |
| **Risks:** | |
| **Decisions & Recommendations** | |

# 5.6. Report from LAS Charity Committee

For Assurance

Presented by Bob Alexander

London Ambulance Service NHS Trust

# Alert – Advise – Assure Committee Board Report

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|---|---|---|---|
| **Assurance report:** | **Charitable Funds Committee** | **Date:** | **13/02/2026** |

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|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Bob Alexander** | **Prepared by:** | **Bob Alexander** |

**Alert**

**Issues that require Board attention:**

- None to report

**Advise**

**Items where Board input or awareness is needed:**

- A bid for approximately £2.5 million was submitted to a potential sponsor to support cardiac arrest survival initiatives, with positive initial feedback but awaiting formal approval from the company's governance structures.
- Efforts to engage London football clubs and their associated charities in defibrillator initiatives and fundraising were reported to the Committee, noting limited responses except for Brentford, which has been particularly active and supportive
- The committee discussed the complexities of working with football club foundations, which often seek funding for their own programmes, and suggested exploring partnerships with supporters' clubs and the London United network
- A total expenditure of £320,000 and income of £218,000, with a net asset base of approximately £1.2 million was reported.
- The Committee discussed the draft 2026-2027 plan, including campaign priorities, income targets, and the need for a phased budget approach pending the outcomes of the strategy review and major funding opportunities.
- The Committee discussed the commissioning of an external strategy review by the Charities Aid Foundation (CAF), outlining its scope, rationale, timeline, and integration with the charity's future planning.
- It was noted that CAF would consult with key LAS stakeholders, including heads of wellbeing, historic collection, and first responders, to ensure the strategy reflects the needs of those supported by the charity.
- The expected timeline was outlined with initial phases completed by mid-March, strategy drafting in late March and April, and final outputs

| | |
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| | ready for review ahead of the May committee meeting and subsequent board consideration |
| **Assure:** | **Positive assurances for the Board to note:**<br>• It was reported that the London Life Hike had fewer attendees than expected but secured its first corporate sponsor, thanks to collaboration with the IT team, resulting in all fundraising proceeds going directly to charitable objectives.<br>• The Success of the Carol service was highlighted, noting positive feedback and the involvement of the ceremonial unit, with Tortus AI agreeing to sponsor the event again in 2026, ensuring no cost to the charity.<br>• Teams for the marathon and half marathon are in place and actively fundraising, with jerseys to be distributed soon, and these events are expected to contribute to the charity's income.<br>• It was confirmed ongoing work with the Greater London Authority and the mayor's office to finalise the grant agreement, with the first instalment expected in the current fiscal year. |
| **Risks:** | **Risks**<br>• The committee agreed the need to refresh the risk register, particularly in light of potential significant donations and strategic changes, and agreed to collaborate on updating the document before the next board review. |
| **Decisions & Recommendations** | • The committee agreed to set a six-month budget for the next financial year, to be revised once the outcomes of the strategy review and potential major donations are known, ensuring governance and financial oversight. |

# 5.7. Digital and Data

# 5.7.1. Director's Report

Presented by Clare McMillan

London Ambulance Service NHS Trust

# London Ambulance Service NHS Trust Board Meeting

## 5th March 2026

## Report from the Chief Digital Officer

### Introduction

This report provides an overview of digital and data activity across the Trust, with a focus on operational resilience, priority portfolio delivery, and national alignment. Core technology services have remained stable, with improved incident performance and continued management of capacity and legacy risks.

A key strategic highlight is the transition of My Clinical Feedback into a national NHS England Federated Data Platform product, delivering financial savings and national impact. The report also outlines progress and challenges across the digital portfolio, data quality, clinical digital safety, and emerging opportunities linked to national funding and mandates.

### My Clinical Feedback

My Clinical Feedback (MCF) is a clinically-led digital product co-designed by the Trust to address a long-standing gap in ambulance clinical practice: the inability for paramedics to receive structured feedback on patient outcomes following conveyance. The product supports individual learning, strengthens clinical governance, and enables system-wide analysis of patient pathways and outcomes. The Trust has led the successful implementation of MCF across London, positioning LAS at the forefront of national ambulance digital innovation.

Following close collaboration with the national NHS England Federated Data Platform (FDP) team, an agreed route has been established to transition MCF from a locally developed solution into a core national FDP product. LAS will act as the originating trust and national reference site, retaining the clinical Senior Responsible Owner role and supporting national rollout during 2026/27.

This transition delivers clear financial and strategic benefits for the Trust. LAS will no longer incur the annual £250k licence and support costs, contributing directly to Cost Improvement Programme targets, while securing a sustainable national home for the product with long-term support and development capacity. Planned enhancements include expanded functionality, availability to CHUB clinicians, and integration with the London Care Record.

From a system perspective, MCF establishes a national standard for structured clinical feedback across ambulance services, reducing local variation and duplicated

development, strengthening interoperability across ambulance–acute interfaces, and ensuring ambulance-specific requirements are embedded within the national FDP roadmap.

The Trust's leadership has been recognised through shortlisting in two categories at the HSJ Digital Awards.

## Operational stability and technology services

Technology Services have continued to provide stable support to frontline operations, with service performance largely within agreed thresholds. Notably, there has been a reduction in technology-related incidents during the period, reflecting improvements in change control, system monitoring, and underlying infrastructure resilience.

Key areas of focus included cyber security assurance, core infrastructure stability, and strengthening service management capability. Workforce capacity within specialist technical roles remains a constraint, but targeted recruitment and use of interim support have mitigated immediate risk. Residual risks associated with legacy infrastructure components and reliance on a limited supplier market continue to be actively managed through clear mitigation plans and established escalation routes.

## Digital portfolio delivery

The Digital Portfolio remains aligned to Trust priorities, national direction, and emerging clinical and safety feedback. Specific work has progressed to address issues raised through clinical feedback, with targeted improvements prioritised where digital systems directly impact frontline usability, safety, and workflow efficiency.

While several programmes have made steady progress, a small number continue to experience delivery challenges. The ECDR programme remains the most significant area of concern, with ongoing issues related to supplier delivery, dependency on external partners, and the complexity of integrating with existing systems. These challenges have resulted in slippage against planned milestones. The programme has been subject to detailed review through the Digital & Data Committee, with strengthened governance, revised delivery plans, and clearer escalation routes now in place. Recent developments have resulted in a delivered product which is now being tested by the pharmacy team which has increased the confidence in delivery.

The AppAbility (PowerApps) programme is progressing well and is establishing a managed, governed Power Apps capability aligned to the Digital Strategy. Governance, assurance, and training arrangements are nearing completion, early training feedback is positive, and a pipeline of applications has been identified. Confidence in delivery remains high.

## Data Quality & Analytics

Work continues to strengthen data quality, assurance, and analytical capability. Data Quality assessments highlight gradual improvement, alongside persistent challenges in a small number of operational datasets where process and system constraints

remain. Actions are in place to address these issues through targeted data quality improvement plans and closer integration with operational leads.

## Medium-term planning and national requirements

Initial medium-term planning work reflects the increasing scale and pace of national digital mandates, including platform adoption, interoperability requirements, and data standards. While these align with the Trust's strategic direction, they place additional pressure on capacity, funding, and change bandwidth. Further work is underway to refine sequencing options and clarify the trade-offs between national compliance, local transformation, and 'keeping the lights on' activity. This will be brought back to the Board as part of the 2026/27 planning cycle.

The Frontline Productivity Programme, launched by NHS England, provides a significant national funding opportunity to support digital and infrastructure investment across provider organisations, with a clear focus on productivity improvement, legacy modernisation, and risk reduction. Funding is available across four priority areas: cyber security, electronic patient record (EPR) optimisation, EPR systems, and core digital infrastructure including networks, cloud and hosting. An accompanying national Investment Product Catalogue sets out the scope, expected outcomes, and assurance requirements for all proposed investments.

The programme aligns strongly with the Trust's Digital & Data Strategy 2024–2028, presenting a material opportunity for LAS to accelerate delivery of priority initiatives, subject to matched internal funding and appropriate assurance. Key immediate opportunities include cyber security enhancements aligned to the Trust's Cyber & Resilience Roadmap, expansion of Ambient Voice Technology building on the TortusAI pilot, improvements to network resilience across the operational estate, and support for the Trust's cloud-first infrastructure strategy. Medium-term opportunities include EPR optimisation, data platform development, and progression of the Digital Capabilities Framework.

## Digital Clinical Safety

The Trust continues to strengthen its approach to clinical digital safety, with positive external assurance and demonstrable compliance with national standards. An independent review by ETHOS has provided assurance on the robustness of the Trust's clinical safety risk management arrangements and has informed the development of a draft Clinical Safety Risk Management (CSRM) system for incorporation into Trust governance. The review was overall positive, recognising the maturity and consistency of the Trust's approach to managing digital clinical risk.

As part of this work, the Trust has completed DCB0160 Clinical Safety Case Reports for two key systems implemented during the COVID-19 period. These retrospective safety cases included a comprehensive identification and assessment of hazards and established a structured approach to aggregating and monitoring risks across the system lifecycle. This provides a sustainable mechanism for ongoing assurance, risk visibility, and continuous improvement in clinical safety.

# 5.7.2. Digital and Data Committee Report

For Assurance

Presented by Clare McMillan

London Ambulance Service NHS Trust

# Alert – Advise – Assure Committee Board Report

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|---|---|---|---|
| **Assurance report:** | **Digital & Data Quality Assurance** | **Date:** | **27th January 2026** |

| | | | |
|---|---|---|---|
| **Summary report to:** | **Trust Board** | **Date of meeting:** | **05/03/2026** |
| **Presented by:** | **Clare McMillan on behalf of Sheila Doyle** | **Prepared by:** | **Clare McMillan** |

**Alert**

**Issues that require Board attention:**

- **Electronic Controlled Drugs Register:**
  The Committee discussed progress with the implementation of the electronic Controlled Drug Register, which is intended to strengthen medicines management, auditability, and clinical safety. The Committee discussed the issues relating to delayed delivery and took assurance on the management actions that are being undertaken and the progress made.
- **My Clinical Feedback:**
  The Committee noted the continued strong performance of the *My Clinical Feedback* product, which is now being transitioned to NHS England and hosted on the Federated Data Platform as the only Ambulance specific application.

**Advise**

**Items where Board input or awareness is needed:**

- **Funding, Business Cases and National Alignment:**
  The Committee received an update on work underway to secure further funding to support delivery of the Trust's digital and data priorities, particularly in the context of increasing national requirements under the NHS Medium-Term Planning Framework. While progress is positive, the Committee highlighted the importance of accelerating associated business cases and options appraisals where required, to ensure timely approvals and avoid delivery slippage.
- **Clinical Safety:**
  The Committee received a report from Ethos, which provides insight into the organisation approach to clinical safety and digital tools. This is being used to inform broader work on clinical digital capability, workforce engagement, and leadership development, particularly in relation to clinical safety and the CCIO function.
- **Clinical Safety and Digital Literacy:**
  A review is underway, led jointly with the Chief Paramedic and the CCIO to consider the Trust's overarching approach to building sustainable capability in clinical safety and clinical digital leadership. This includes the role of the CCIO team, the virtual clinical safety model, and the need for a more formal and consistent approach to clinical digital literacy across the organisation. Outcomes from this review will be reported once concluded.

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| | |
| **Assure:** | **Positive assurances for the Board to note:**<br>• **Strategic and Structured Approach to Digital Clinical Safety:** The Committee is assured that the Trust is taking a coherent and forward-looking approach to strengthening clinical safety, learning, and digital capability. This includes alignment with national platforms such as the Federated Data Platform, use of digital tools to support feedback and learning, and active consideration of how best to build leadership and workforce capability to support safe digital transformation. |
| **Risks:** | **BAF Risks**<br>• No new or escalated Board Assurance Framework risks were identified through this discussion. Existing risks relating to digital delivery, clinical safety, and workforce capability remain under active review through established governance arrangements. |
| **Decisions & Recommendations** | • Progress with the electronic Controlled Drug Room and its importance for medicines governance and clinical safety<br>• The positive impact and national relevance of the *My Clinical Feedback* solution<br>• Ongoing work to secure funding and accelerate digital business cases in response to national requirements |

# Corporate

# 5.7.3. Director's Report

## For Assurance

London Ambulance Service NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

**Report of the Director of Corporate Affairs**

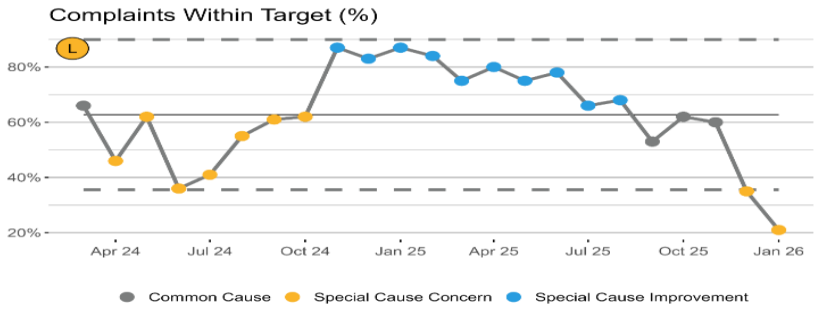
The Corporate Affairs Directorate currently incorporates Patient Experience, Legal Services, and Corporate Governance.

## Patient Experience Department

### Complaints

The monthly average for the financial year to date is 107 complaints received per month.

There are currently 307 open complaints, of which 178 are overdue (58%). Performance within the Patient Experience team continues to be significantly affected by capacity within the team and the distribution of work on complaints, medical records and subject access requests across the team. In addition, improvements in quality assurance processes for complaint responses have elongated the complaint sign-off process.




A recovery action plan is in place and it is expected that the team will deliver the necessary improvements to sustainably recover performance to the required standard (75% of complaints responded to within 35 working days) by the end of May 2026.

One complaint held with the Parliamentary Health Service Ombudsman (PHSO) since 2024 has now been closed, with no further action for the Trust. No new PHSO referrals were received.

The main themes arising from complaints continue to be related to conduct and behaviour and delayed ambulance responses.

### Compliments

Since the last Board report, 329 compliments have been received about LAS staff and services.

### Patient Liaison

Since the last Board report, the team has managed 196 patient advice contacts, providing patients, their families and carers with support including help to resolve concerns informally,

navigating the health system and obtaining support for health-related questions. Since 1 April 2025, the team has managed over 800 patient advice contacts in this way.

Subject Access Requests

The Patient Experience team also manages subject access requests (SAR) from patients and solicitors. The team handles in excess of 200 requests per month; these can be complex involving call recordings, electronic patient care records (ePCR), as well as audio-visual materials including footage from CCTV and body worn cameras requiring careful redaction. The team met the standard of fulfilling 99% of subject access requests within the required timeframe of 1 month.

**Freedom of Information**

For the period November 2025 - January 2026, the department received 160 Freedom of Information (FOI) requests. 140 have been closed during this period, and 2 are overdue. There are 23 open FOI requests, these are all within the statutory time frame. Current performance year to date is 65.3% against an internally agreed target of 73% of FOIs responded to within 20 days.

Work is underway to review FOI processes within the department to improve internal arrangements and response times.

**Legal Services**

Inquests opened 1 December 2025 – 31 January 2026

| | |
|---|---|
| Total Inquests | 371 |
| Level 1 Inquests | 358 |
| Level 2 Inquests | 13 |

Claims opened 1 December 2025 – 31 January 2026

| | |
|---|---|
| Employment Liability | 3 |
| Public Liability | 4 |
| Clinical Claims | 6 |

No Prevention of Future Deaths (PFD) reports have been issued directly to the Trust. However, PFDs have been issued to the Department of Health and Social Care and NHSE/NHS Pathways in relation to cases involving the Trust.

**Jo Cripps, Director of Corporate Affairs**
**March 2026**

# 6. Assurance

# 6.1. Board Assurance Framework

For Approval

London Ambulance Service NHS Trust

| Report Title | BAF 2025/26 | | | |
|---|---|---|---|---|
| **Meeting:** | Trust Board | | | |
| **Agenda item:** | 6.1 | **Meeting Date:** | 5 March 2026 | |
| **Lead Executives:** | Jo Cripps, Director of Corporate Affairs | | | |
| **Report Author:** | Frances Field, Corporate Governance Manager | | | |
| **Purpose:** | | Assurance | **x** | Approval |
| | **x** | Discussion | | Information |

**Report Summary**

Committees discussed the BAF in January 2026 and the changes below reflect input from the Quality Assurance Committee, the Finance, Infrastructure and Productivity Committee, People & Culture Committee, Digital & Data Committee and the Audit Committee.

The BAF is currently being reviewed in line with the Medium Term Business Plan priorities and a refreshed BAF for 2026/27 will be brought to the Trust Board in May for approval.

**Finance, Investment and Productivity Committee (FIPC)**

**Change to risk scores**:

**BAF 2.8** We may not deliver the £30m CIP and productivity programme. Decrease in current risk score from 2x4=8 to 1x4=4, due to progress made with delivering the CIP and productivity programme.

**BAF 2.9** There is a risk that we may not implement the capital programme to optimise the opportunity afforded by the funding in this financial year. Decrease in current risk score from 3x4=12 to 1x4=4, due to progress made with implementing the programme.

**BAF 2.11** The Trust may not be able to deliver a balanced Income and Expenditure Plan for 2025/26. Decrease in the current risk proposed by FIPC, from 3x4=12 to 1x4=4, to reflect the current position with delivering the plan.

**BAF 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%. Decrease in current risk score from 2x4=8 to 1x4=4, due to achieving the commitments set out for 2025/26.

**New risk**:

**BAF 2.13** The Trust may not deliver sufficient productivity and efficiency improvements and deliver the required cost reductions to deliver the ambulance response times within

the financial envelope for 2026/27. New risk proposed with uncontrolled risk score of 4x5=20, current score of 4x5=20 and tolerance score of 1x4=4.

**Next Steps**

The BAF is currently being reviewed in line with the Medium Term Business Plan and agreement of the seven strategic priorities for 2026/27. A refreshed BAF for 2026/27 will be brought to the Trust Board in May for discussion and approval.

## Recommendation/Request to the Board:

The Board is asked to:

- Review and approve the 2025/26 Q3 BAF including the addition of a new risk and 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 – February 2026

| 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 | | 12 | 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 | 15 | | 15 | 12 | QAC | PC | 8 |
| | • Insufficient funding from commissioners to meet demand | 25 | 25 | 25 | 25 | | 25 | 8 | | | |
| | • Constrained capacity in the UEC system and handover delays at hospitals | 25 | 20 | 20 | 20 | | 20 | 12 | | | |
| | • Underachievement of productivity initiatives | 25 | 12 | 12 | 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 | 12 | | 12 | 8 | QAC | JN | 10 |
| 1.4 | We may not improve the quality of the care we provide if we do not complete delivery of our quality priorities | 20 | 12 | 12 | 12 | | 12 | 8 | QAC | FW | 12 |
| 1.5 | We may not achieve targets for commissioned learning response timeframes and overdue incidents impacting our ability to rapidly adopt any derived learning. | 20 | 16 | 16 | 12 | | 12 | 8 | QAC | FW | 15 |
| 1.6 | We are at risk of providing an inequitable service to mental health patients because of:<br>i) Increased demand<br>ii) Lack of specialised facilities<br>iii) Lack of alternative pathways accessible to ambulance services | 16 | 16 | 16 | 16 | | 16 | 9 | QAC | FW | 18 |
| 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.<br>• Patient safety incident contributory factors 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 | 12 | | 12 | 8 | QAC | FW | 20 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | • 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 | 16 | | 16 | 12 | P&C | RD | 24 |
| 2.2 | We may not improve in the NHS People Plan domain regarding *Looking after our people* - particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically. | 20 | 12 | 12 | 12 | | 12 | 8 | P&C | SS | 26 |
| 2.3 | We may not improve our organisational culture in addressing bullying and / or harassment underpinned by poor underdeveloped management and leadership practices. | 20 | 12 | 12 | 12 | | 12 | 8 | P&C | SS | 28 |
| 2.4 | We may not improve the sexual safety of staff unless we fully implement the action plan we have identified. | 20 | 16 | 16 | 16 | | 16 | 12 | P&C | PC | 30 |
| 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 | 20 | | 20 | 15 | AC | CM/PC | 31 |
| | • 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 | 20 | | 20 | 15 | | CM | |
| | • Vulnerabilities on the part of third party systems on which we rely. | 25 | 20 | 20 | 20 | | 20 | 15 | | CM | |
| | • Service disruption due to extended recovery following an attack | 25 | 20 | 20 | 20 | | 20 | 15 | | PC | |
| 2.6 | We may suffer a critical IT failure unless we replace, upgrade and modernise our infrastructure and systems; including network and connectivity, computer and storage services, critical applications and telephony. | 20 | 10 | 10 | 15 | | 15 | 10 | 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 | 20 | | 20 | 15 | Digital | CM | 36 |
| 2.8 | We may not deliver the £30m CIP and productivity programme. | 20 | 16 | 12 | 12 | | 4 | 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 | 8 | | 4 | 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 | 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 | 8 | | 4 | 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 | 16 | | 16 | 12 | P&C | PC | 41 |
| 2.13 | The Trust may not deliver sufficient productivity and efficiency improvements and deliver the required cost reductions to deliver the ambulance response times within the financial envelope for 2026/27 | 20 | | | | | 20 | 4 | FIPC | RP | 43 |
| **Mission 3:** | **Using our unique pan-London position to contribute to improving the health of the capital** | | | | | | | | | | |
| **Risks** | | **Uncon[d]** | **Q1** | **Q2** | **Q3** | **Q4** | **Curr[t]** | **Target** | **Committee** | **Owner** | **Page** |
| 3.1 | We may not meet our commitments set out in the 2025-2029 green plan refresh including a decrease of 4% carbon in 25/26, achieving full ULEZ compliance across our diesel fleet by Q3 and increase the number of EV chargers across LAS estate by 20% | 15 | 8 | 8 | 8 | | 4 | 4 | FIPC | RP | 44 |
| 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 | 20 | | 20 | 8 | FIPC | RP | 45 |
| 3.3 | We face a strategic risk as the only London-wide NHS provider around the sustainability of partnerships and funding streams, with | 16 | 12 | 12 | 12 | | 12 | 8 | FIPC | RD | 47 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | evolving ICS roles and regional commissioning shifts causing uncertainty. | | | | | | | | | |

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 |
| 3 | x | 4 | = | 12 |

| 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,<br>• PSIRF thematic reports,<br>• Learning Assurance Group.<br>• 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<br>• 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<br>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.<br>• Annual Cardiac Arrest report.<br>• Daily and weekly review of Category 1 performance<br>• Monthly monitoring through:<br>➢ Integrated Performance Report,<br>➢ Sector Focus<br>➢ Feedback Reviews (bimonthly)<br>➢ Quality Report<br>• Feedback to all staff involved in management of cardiac arrest from Clinical Audit Team<br>• Monitoring of Community First Responder outcomes and LifeSaver numbers to reduce time to defibrillation |

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

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|---|---|
| | • 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.<br>• New cardiac arrest checklist includes ROSC care bundle prompts and handover metrics and tools.<br>• CTM training includes post ROSC importance to enable further discussion with their teams during OWR and CPI feedback.<br>• Monitoring of advanced care interventions by APP – Critical Care |
| NHS England AQI: Outcome from acute STEMI<br>• Time from call to angiography for confirmed STEMI patients: Mean and 90th centile<br>• Care bundle delivered to suspected STEMI patients (includes provision of GTN, aspirin, two pain assessments and analgesia) | • Monthly STEMI Care Pack including infographic. This report contains comprehensive clinical and operational information on the care provided to ST-elevation myocardial infarction (STEMI) patients.<br>• Annual STEMI report.<br>• Monthly monitoring through:<br>➢ Integrated Performance Report,<br>➢ Sector Focus<br>➢ Feedback Reviews (bimonthly)<br>➢ Quality Report t<br>• Feedback to LAS from Pan London Cardiac networks<br>• Local oversight of STEMI care bundle improvement led by Sector Heads of Clinical Quality. Individual feedback to clinicians. TBW huddles to share cases.<br>• Clinical update and Insight share cases<br>• Cardiac, stroke and STEMI care bundles now included as part of the core Head of Clinical Quality objectives in terms of learning and improvement, including identifying new ways of implementing change in these areas. |
| Robust and diverse clinical audit and research programme that focuses on a range of clinical areas and is responsive to both local and national priorities, including cardiac arrest acute coronary syndrome and stroke. | • Monitored through Annual Clinical Audit Programme and Research Programme.<br>• Monitored through Clinical Quality Oversight Group and Clinical Audit and Research Steering Group (CARSG).<br>• Annual Independent Review of clinical audit practices by CARSG's Patient and Public representative.<br>• 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<br>• Focus on post call wrap up processes |

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

| | |
|---|---|
| | • 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<br>• Embed Clinical Dispatch Support<br>• Roll out of Single Point of Access<br>• Increased access to alternative pathways<br>• Close working with IUC CAS to ensure patients assessed by right clinician<br>• Trusted assessor status<br>• Oversight of MH patients with suicide and OD risk<br>• 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: November 2025 ROSC 44% and sustained to hospital 32% |
| • London lifesaver training being delivered across London | Achieved: In November 2025 we surpassed a total of 20,000 year 8 school children trained since October 2023.<br>In addition over 1200 lifesavers were trained. |
| • 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 | :On-Going:<br>Senior Sector Clinical Leads continue working on care bundles for cardiac arrests and ST –elevation Myocardial infarction.<br><br>In October 2025 the Care Bundle was provided to 83% of patients and in November 2025 the Care Bundle was provided to 81%<br>93% of patients pan London were provided with pain relief in October 2025 and 90% in November 2025 |

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

**BAF Risk: 1.2**

We may cause harm by not achieving the Ambulance Performance Standards set out in the NHSE Operating Plan due to:

- Insufficient funding from commissioners to meet demand;
- Constrained capacity in the UEC system and handover delays at hospitals;
- Underachievement of productivity initiatives

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 5 | = | 25 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 3 | x | 5 | = | 15 |

| 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 | 8 | 8 |

| Controls | Assurances |
|---|---|
| Ongoing development of alternative pathways for patients to receive care either remotely or closer to home | Programme lead reporting to CEO and Deputy CEO to develop and embed pathways including urgent care response |
| Weekly NHSE London / Commissioner performance meeting | Executive attendance at meeting |
| Flexible approach to use of staff including roles and hours/rotas | Review a twice weekly forecasting & Planning meeting to ensure hours match anticipated demand. |
| Senior (operation) and clinical oversight of delays and incidents to identify risk and harm through pre-set processes | Patient safety incident response framework fully embedded in organisation. |
| Redeployment scheme for corporate staff utilised in times of high demand | At REAP 4 all clinicians working operationally 50-100% of time. |
| Twice weekly staffing and resourcing meeting to review operational | Chaired by Directors – review of staffing levels by hour to identify and mitigate risks |
| Ongoing communication with acute hospitals on handovers understanding current system pressures and instigating timely divert processes. | Monitored at weekly North West London Gold System call. Additional calls convened to support specific ICB systems challenges. |
| Senior and clinical oversight of delays and incidents identify risk and harm through pre-set processes | Twice weekly regional hand over meeting with ICS handover improvement plans designed collaboratively with LAS |
| LAS input to national solutions to reduce handover delays | Development of Delays Thematic Reports for each quarter produced using Patient Safety Incident Response Framework |
| Ongoing development of alternative pathways for patients to receive care either remotely or closer to home | Appointment of Pathways Programme lead reporting to CEO and Deputy CEO to develop and embed pathways including urgent care response |

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

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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: ICC hubs are supporting the referral of patients to alternative pathways to reduce avoidable conveyance |
| Continual Review of dispatch process (999 operations) to assess the safe management of higher acuity patients at times of high demand | Ongoing: Category 2 streaming is continuing to navigate patients to more appropriate pathways where an emergency ambulance |
| Enforce new 45 minute handover protocol with appropriate escalation when required. | Achieved: W45 embedded pan London |
| Continual review of triage and dispatch processes to identify high acuity calls requiring immediate ambulance response | Ongoing: Category 2 streaming is continuing to navigate patients to more appropriate pathways where an |

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

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| | emergency ambulance which releases capacity for higher acuity patients. |
| Continuous engagement with local acute trusts to identify improvements in the hospital handover procedures | Achieved: Good collaboration and engagement through local operational and clinical quality teams with support from Executives as needed. |
| Maximise use of same day emergency care (SDEC) to reduce unnecessary conveyance of patients to ED's | Ongoing: All Trusts have direct access to SDEC except for 2 which remains a focus to resolve. |
| Robust application of Clinical Safety plan | Achieved: Clinical Safety Plan is fully implemented |
| Implementation of recommendation from ORH to reduce ambulance job cycle time through management of outliers | Ongoing; Phase 1 diagnostic completed and phase 2 diagnostic work continues |

## 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.<br><br>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.<br><br>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.<br><br>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. |

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

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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**<br>• IUC CAS Clinical Queue Management Guidance<br>• Rapid Assessment & Triage (RAT) Implementation<br>• "NEXT" flagging<br>• **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:<br>• direct access to specialist sickle cell units<br>• 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 | Achieved: All 5 ICBs are engaged in the mobilisation of ICC Hubs<br>• The ICC hubs are live in all sectors<br>• Work continues to support the ICBs preparing business plans for the continuation |
| • Tethering of equipment to local stations<br>• Tracing of equipment<br>• Oversight through equipment working group | • Working group has revised Life Pak 15 process for tracing equipment and improve availability through planned servicing cycle. |

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

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| • Communications to staff to share work and improvements | • Business case being developed for procurement of replacement device for LifePak 15, allowing for replacement of decommissioned devices.<br>• 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<br>➢ Improving Sickle Cell Care action plan with 19 actions<br>➢ CORE20 Workstream utilisation of Community First Responders, fundraising for implementation of public access defibrillators and continued recruitment of London Lifesavers.<br>➢ Cardiovascular notifications in SEL<br>➢ Maternal Health Programme | <u>Health Inequalities Action Plan</u><br>• 42 of the 100 actions (across 5 year plan) completed. 4 of the 5 large improvement projects scoped<br>• Clinical education package 'Toolkit for Tackling Health Inequalities' now completed by 69% clinical staff.<br>• 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.<br><br><u>Improving Sickle Cell Care</u><br>• 20 actions in total; 7 completed, 11 on track, 2 planned for Q4.<br>• 3 of the 4 Acute Sickle Cell Units open for LAS with over 150 patients conveyed.<br>• 86% of frontline clinicians have completed the additional clinical education package.<br>• Clinical audit shows sustained improvement in key areas of clinical audit (9% improvement in patients being extricated appropriately).<br><br><u>CORE20 Workstream utilisation of Community First Responders, fundraising for implementation of public access defibrillators and continued recruitment of London Lifesavers.</u><br>• On going training of LLS and year 8 school children monthly.<br>• New collaboration with the Mayor of London<br>• 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.<br><br><u>Cardiovascular notifications in SEL</u> |

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

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

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

**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 |
| 3 | x | 4 | = | 12 |

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

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

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

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

### Further actions

| Action | Date by which it will be completed |
|---|---|
| <u>Learning responses</u><br>• Tracking the last 10 closures AND last 10 breaches– identification of time taken in each stage of review and action appropriately<br>• Undertake time observation of investigation process to identify waste and non-value adding processes.<br>• Implementation of escalation process<br>• Horizon scanning and notification of those who are near overdue<br>• Defining the role of the supervisor to support standardised approach<br>• Produce a quick reference guide for LIs to be shared when allocated learning response<br>• Development of LI refresher training<br>• Development of LI 'contract'<br>• Meeting with supervisors with overdue cases and implement SMART action plans to clear overdue cases<br>• 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.<br>• 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<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed |

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

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| • Directorates now have a nominated individual who will coordinate identifying the most appropriate action owners in their area speeding up the process for Lis<br>• Close oversight of timelines by central quality team with early interventions and reminders<br>• Review of integrated learning across patient safety, clinical and operational areas and clinical education<br>• Review of processes for sharing of information<br>• Use of wider range of modalities to share learning decided through engagement with clinicians<br>• Evidence that better sharing of learning reduces similar incidents | • Completed<br>• Completed<br>• Completed<br>• On going (see 1.7)<br>• On going (see 1.7)<br>• Completed<br>• End of Q4 |
| <u>Overdue incidents</u><br>• Creation of Dashboards that can be used by all managers to view incidents assigned to their respective areas – associated communications piece.<br>• Bi-weekly meetings with team leads with those with most % overdue<br>• Understand barriers for corporate teams with high % overdue<br>• Development of an aid-memoire to be distributed to all managers with hints/tips and FAQ on incident investigation<br>• Communication about 'standard work' and the move to make incident reviewing form part of daily/weekly standard actions.<br>• Maintain low number of incidents unresolved | <br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Completed<br>• Ongoing oversight |

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

| BAF Risk: 1.6 |
|---|
| We are at risk of providing an inequitable service to mental health patients because of:<br>i) Increased demand<br>ii) Lack of specialised facilities<br>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<br>• 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<br>• 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<br>• 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<br>• EIA to be completed by ICBs – Routine use of Equality Impact Assessments (EQIAs) when changing MH service delivery<br>• Potential inclusion of this risk in the Trust and ICB risk registers for wider system oversight<br>• 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<br>• Implement the agreed internal model for response to MH patients (remote and face to face)<br>• Increasing access to alternatives for MH patients to avoid inappropriate conveyance to ED<br>• Increase number of specialist paramedics MH<br>• 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.<br>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.<br>The full plan will be implemented in Q1 of 2026/27 and developed over the remainder of 2025/26. | Q1 2026/27 |
| The ePCR training has been rewritten and this new module is delivered during induction for clinicians<br>The CCIO is leading a piece of work, in conjunction with CESD, about updated training for clinicians who are already using ePCR | Q2 2026/27 |
| Confirmation of a new supervision policy, informed by current practice and new initiatives following trials. | Achieved |

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

| | |
|---|---|
| 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. | Achieved |

## 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<br>Use insights from data to inform action planning and FFRs (WRES and WDES)<br>Gender Pay Gap related actions<br>Ethnicity Pay Gap related actions<br>Disability Pay Gap related actions |
| Continue with scrutiny of changes to policies and practices through EIA process | Ongoing advice as SMEs<br>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.<br>Refresh EDI Implementation plan to reflect progress made and align with ambulance EDI action plan<br>Implement recommendations from EDI audit |
| Implementation of the recruitment interventions and response to sea change recommendations | Monitored by the Recruitment working group<br>Strategic placement of any roles that become available with ring fences on programmes like OLIR<br>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<br>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)<br>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<br>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<br>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:<br>1. Pilot an Inclusion Board for 12 months to strengthen the voice of all staff in decision making | March 2026 |
| 2. Conduct a stocktake and review of the progress on the ambulance Equality Diversity and Inclusion action plan with outcomes and recommendations by Q2. | March 2026 |
| 3. Complete 90% of all non-complex reasonable adjustment requests within 6 weeks of submission to the Reasonable Adjustments Hub. | March 2026 |
| 4. Increase the representation of under-represented groups in the roles of Assistant Ambulance Practitioner, Incident Response Officer, Emergency Resource Dispatcher, and Clinical Advisors in the Clinical Hub (CHUB). | March 2026 |

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

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

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 4 | = | 20 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 3 | x | 4 | = | 12 |

| Tolerance by Q4 25/26 | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 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 | |

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

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

## Further actions

| Action | Date by which it will be completed |
|---|---|
| Review of first day absence reporting system 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 |

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

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

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 4 | = | 20 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 3 | x | 4 | = | 12 |

| Tolerance by Q4 25/26 | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 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<br>• Launch of Our LAS Centre of Excellence for Leadership and Culture (CELC):<br>• Commissioned Leadership Programmes:<br>• Learning and Education Course Catalogue:<br>• 'Me and My Leadership Style' Series:<br>• Difficult Conversations Training:<br>• Tackling Discrimination and Promoting Inclusivity (TDPI):<br>• Appraisal Support:<br>• Access to Leadership Networks:<br>• Organisational Change Support Packages:<br>• 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:<br>• EDI/CDI<br>• OD&TM<br>• WRES and WDES data<br>• Retention<br>• Staff survey engagement scores | P&C Director's update at OPMS / PCC / Trust Board |
| Statutory mandatory and PDR compliance (reporting) | P&C Director's update at OPMS / PCC / Trust Board |

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

| | |
|---|---|
| Chief Executive's blog / Staff Communication bulletin and leadership development days | References in various Director reports that go to the Board / Board sub committees |
| Training sessions available for all leadership delivered by the EDI team | |

**Further actions**

| Action | Date by which it will be completed |
|---|---|
| Develop 2023-2028 People and Culture Strategy as assigned metrics | People Scorecard implemented in Feedback Focus Reviews (FFR) covering People and EDI indicators. |
| Aligned EDI/CDI Strategy and delivery plan / system of measurement | Complete. The EDI Policy has been published. |
| Comprehensive review of all Policies EIA | Ensure all EIAs are consistent with EIA process and approval with relevant committees and groups and a monitoring process is implemented. Ongoing – December 2025. |

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

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

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 4 | = | 20 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 4 | x | 4 | = | 16 |

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

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

**Further actions**

| **Action** | **Date by which it will be completed** |
|---|---|
| Develop a Creepy, Clumsy, and Criminal session Part 2, focused on Respect, Reintegration, and Responsibility. This work is in train. | To be completed by the end of Q2. The content has been agreed; work is now underway developing the training and agreeing the delivery method. Planned role out from Q1. |
| Comm's video production on the appropriate use of social media | To be completed by the end of Q3. This has been delayed due to competing comms priorities and should be ready by the end of Q4 |
| Review the themes from hearings and any gaps in education/learning, ensure consistency on approach and outcome | To be completed by the end of Q4 |

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

**BAF Risk: 2.5**

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

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

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 5 | = | 25 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 4 | x | 5 | = | 20 |

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

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

| Controls | Assurances |
|---|---|
| Technical cyber protection & detection tools deployed/monitored daily | Cyber Committee checks assurances and reports to the board |
| Implementation of Artificial Intelligence threat detection software | Devices deployed to Corsham & Bow. |
| Cyber security team in place to identify/mitigate cyber threats or incidents | Cyber Committee checks assurances and reports to the board |
| Achievement of at least ‘Met Standards’ in DSPT | Reported annually by NHSe |
| Legacy systems being replaced | DSPT assurance level reported in annual report |
| Unsupported software being replaced | Annual Pen Test carried out and reported to the Board |
| All issues related to Cyber logged on Trust Content Management System | Demonstrable response to cyber threats |
| Process in place to address all CareCerts issued by NHSe | DSPT assurance level reported in annual report |

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

| | |
|---|---|
| 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 |
| 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. |
| All Lond-Amb workstations upgraded to Win11 24H2 | Complete, with CIS benchmark Level hardening |
| Cyber Essentials accreditation gained | This is the first stage to obtaining Cyber Essentials + |

### 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 | April 2026 |
| Hardening of internet facing systems | April 2026 |
| Onboarding of 3rd party suppliers to the Privileged Access Management system | June 2026 |
| 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 | March 2026 |

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

| | |
|---|---|
| Document the re-architecture of the CAD environment | Complete |
| Complete the re-architecture of the CAD environment | Complete |
| Attainment of Cyber Essentials + accreditation | November 2026 |
| 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) | Complete |
| Complete the RBAC deployment project | Complete |
| New Server 2025 CIS Benchmark Level 1 build available and deployed where technically possible | April 2026 |
| Operations and IM&T working jointly on plans to manage prolonged outages | Ongoing |
| Implement new device vulnerability monitoring software (IT Health) | April 2026 |
| Implement new 3rd Party Supplier Assurance software (Panorays) | April 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 | 5 | = | 15 |

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

| Controls | Assurances |
|---|---|
| Reduction in P1/P2 incidents (aim 30% reduction over year) | Major outage dashboard created as part of our directorate reporting |
| Rationalise and reduce our data centres to align with best practise architecture<br>Maintain our core telephony at a supported version<br>Work with partners to migrate voice services to a supported infrastructure<br>Robust virtual environment infrastructure | Infrastructure programme board, Digital Delivery Board and regular reporting to Exco and the Digital & Data Committee.<br><br>Works to migrate services away from Corsham to Waterloo continue with decommissioning and the removal of 22 cabinets from Waterloo DC almost complete<br><br>A standardised and modern architecture model across all our Datacentres has been implemented.<br><br>Work is underway within our Infrastructure Programme to patch and upgrade our voice services software to the latest release.<br><br>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. . |

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

### Further actions

| Action | Date by which it will be completed |
|---|---|
| Develop a data centre strategy and roadmap with sufficient investment utilising cloud options | Completed |
| Revised set of desktop images based on profiles: Admin, CAD user, etc. | Completed |
| Upgrade core telephony to CM10.2 | April 2026 |
| Deploy a supported voice recording solution | Leadership decision made to continue with current product until April 2027. |
| Upgrade network infrastructure at 10 ambulance stations to support digital connectivity | March 2026 |
| Implementation of a Nutanix-based Server Farm | March 2026 |
| Enhanced wireless infrastructure | March 2026 |
| Improve current monitoring solutions through upgrade of Solarwinds | 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 | Complete |
| Replacement of legacy CROPS | Complete |

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

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

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 4 | = | 20 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 1 | x | 4 | = | 4 |

| 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 |
| 1 | x | 4 | = | 4 |

| 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 |

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

| BAF Risk: 2.10 |
|---|
| We have a legacy staff scheduling system (GRS) which has limited support. Until it can be replaced there is a risk that system failures may cause significant inefficiencies affecting operational performance. |

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 3 | = | 15 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 4 | x | 3 | = | 12 |

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

| Controls | Assurances |
|---|---|
| Daily Meetings with current supplier/LAS Scheduling Team/IM&T during periods of interruption. | Reports provided to Gold on a daily basis. |
| Internal GRS Support Group established to immediately convene when there are any outages and provide a route of escalation for internal stakeholders. | Reported to Trust Gold/Exec team as required |
| Rolled back SQL database to previous version | Decision made in collaboration with LAS IM&T department, which has resulted in a reduction in GRS reporting issues. |
| Daily Review of system by Scheduling Team | Escalated to Head of Scheduling |
| Agreed plan of proactive maintenance | There is proactive maintenance in place 24/7 |
| Third Party Cross Supplier communications | Effective communications with all relevant third parties implemented |

**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 |
| Review of rostering requirements for 999, 111 and corporate staff | March 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 |
| 1 | x | 4 | = | 4 |

| 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**<br>• 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. | The order has now been received, and confirmation received that all eligible staff have a stab vest. Action closed |
| **Provision of Body Worn Video Camera**<br>• Review BWV equipment and suitability including weight, size, wearability and mounting.<br>• Trial new equipment and evidence management platforms from various providers for future.<br>• Review and relaunch online BWV training and reinstate user creation automation.<br>• Communication campaigns and opportunities<br>• Paper to ExCo to consider the feasibility to mandate BWV and invest in further equipment. | Action now incorporated into the 10 point plan<br>Plan to be delivered by end of Q4. |
| **Conflict Resolution Training**<br>• Extend existing contract for further year while CRT training is reviewed<br>• Working Group has been established to undertake Review/TNA of CRT training.<br>• Results will inform specification for new contract and tender for 2026. | Updated via the 10 point plan- further clarity on training requirements being developed with professional leads. |

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

| | |
|---|---|
| • Ongoing monitoring of restraint activities across the trust.<br>• Risk to be placed on the risk register. | |
| **Development of Violence Reduction Charter** | This will go to the Inclusion Board in Q4 |
| **Violence Reduction Policy and Strategy**<br>• Violence Prevention Reduction Standard Plan in place and ongoing review | Policy & Strategy to be updated by Q3 2025/26<br>Review V&A Strategic Risk Assessment Q3<br>On track for sign off in Q4 |

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

| **BAF Risk: 2.13** |
|---|
| The Trust may not deliver sufficient productivity and efficiency improvements and deliver the required cost reductions to deliver the ambulance response times within the financial envelope for 2026/27 |

| Uncontrolled | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 5 | x | 4 | = | 20 |

| Current | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 4 | x | 5 | = | 20 |

| Tolerance by: Q4 25/26 | | | | |
|---|---|---|---|---|
| L | x | C | = | Score |
| 1 | x | 4 | = | 4 |

| **Controls** | **Assurances** |
|---|---|
| Additional resource appointed to support identification and delivery of cost reduction | Report to Productivity and Efficiency Programme Board |
| Updated governance for delivery of productivity, efficiencies and cost reduction | Report progress to Executive Leadership Team (ELT) and FIPC |
| Focus on delivery of performance and financial targets during business planning | Monthly reporting to FIPC |

**Further actions**

| **Action** | **Date by which it will be completed** |
|---|---|
| Develop mitigations for cost reduction if CIP target not met | June 2026 |
| | |
| | |

## 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 |
| 1 | x | 4 | = | 4 |

| 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 |

# 6.2. NHSE Provider Capability Assessment Rating

For Noting

Presented by Jason Killens

London Ambulance Service NHS Trust

| Report Title | Outcome of Provider Capability Assessment Process | | | |
|---|---|---|---|---|
| **Meeting:** | Trust Board | | | |
| **Agenda item:** | 6.2 | **Meeting Date:** | 5 March 2026 | |
| **Lead Executive:** | Jason Killens, Chief Executive | | | |
| **Report Author:** | Jo Cripps, Director of Corporate Affairs | | | |
| **Purpose:** | **x** | Assurance | | Approval |
| | | Discussion | **x** | Information |

## Report Summary

As part of the NHS Oversight Framework (NOF), NHS England asked all Trusts to undertake a self-assessment against a range of expectations on provider capability, derived from the Insightful Provider Board framework. The LAS Board submitted its self-assessment in November 2025 against the following areas:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

NHS England wrote to the Trust to confirm that it has rated us as 'Green' on the provider capability framework.

This rating will form an important aspect in our ambition to become an Advanced Foundation Trust.

The letter confirming this is attached at Appendix 1.

## Recommendation/Request to

The Board is asked to note this update.

## Routing of Paper i.e. previously considered by:

N/A

## Corporate Objectives and Risks that this paper addresses:

All

By email to:

London Region
10 South Colonnade
Canary Wharf
London E14 4PU

Jason Killens
Chief Executive Officer
Andy Trotter
Chair
London Ambulance Service NHS Trust

9th February 2026

Dear Colleagues

**LONDON AMBULANCE SERVICE NHS TRUST - CAPABILITY RATING**

You will be aware that the NHS Oversight Framework 2025/26[1] (NOF), published on the 26 June 2025 and updated 24 October 2025, outlines a consistent and transparent approach to assessing integrated care boards (ICBs), NHS trusts and foundation trusts. This seeks to ensure public accountability for performance and provides a foundation for how NHS England works with systems and providers to support improvement.

As part of the NOF, NHS England will assess NHS trust boards' capability, using this alongside their NOF segment to determine what actions and/or support may be needed. As a key element of this, NHS trust boards were asked to self-assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

We wrote to you at the end of August confirming the commencement of the first Provider Capability self-assessment process[2] and requested that you complete and submit the national self-assessment template by the end of October for NHS England regional assessment. Thank you and your team for having completed your self-assessment and submitted in accordance with the ask.

[1] NHS England » NHS Oversight Framework 2025/26
[2] NHS England » Assessing provider capability: guidance for NHS trust boards

During October – November 2025 the regional team reviewed your submission statements and evidence, which we triangulated with our own views, your historical track record of delivery, any recent regulatory history, and relevant third-party information (including ICB and CQC) to support us in reaching a holistic view across the six domains and to assign a single overall capability rating.

These ratings were subject to review and final ratification by NHS England's Executive Board.

Following this process we have allocated LONDON AMBULANCE SERVICE NHS TRUST an overall capability rating of Green for 2025/26.

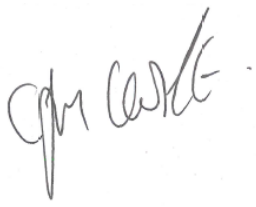
As part of our oversight responsibilities, we will continue to monitor trust performance, which may lead to in year changes in the overall assessment rating if concerns arise across any of the assessment areas or, alternatively, there is evidence of improvement.

We will publish provider capability ratings in Q1 26/27 taking account of the implications of Q4 25/26 segmentation and planning outcomes in an updated view of organisations' capability.

If you wish to discuss the rating in more detail, please contact Edmund King, in the first instance, email: edmund.king@nhs.net

Finally, I would like to take this opportunity to thank you and your teams for your continued hard work towards delivering improvements to ensure the population of London has timely access to high quality care.

Yours sincerely



**Dame Caroline Clarke**
**Regional Director**
**NHS England London**

Cc: Edmund King, Chief Operating Officer and Patch Lead

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Implications of ratings are as follows:
**Green:** no concerns have arisen from the assessment. Boards should continue to strengthen their capability.
**Amber-Green/Amber-red**: some concerns of varying seriousness across one or more areas to be addressed. We will work with providers to ensure that appropriate support is in place.
**Red:** material and/or long-running concerns. Providers with a delivery segment of 4 will move to NOF segment 5, indicating the provider is among the most challenged in the country. NHS England will subsequently:

- Withhold pay awards from those VSMs in post at the provider for over two years;

- Review whether to enrol the provider in the National Provider Improvement Programme (NPIP), designed to ensure the most challenged providers have the conditions in place to deliver sustainable improvement and a credible plan to do so; and
- Review existing regulatory action at the provider.

Note: A small number of organisations are continuing to receive RSP support. This will continue until end of March 2026, regardless of confirmed NOF segment, to support sustainable improvement. For these providers now in NOF5, support will transition to NPIP. NHS England will contact providers separately to confirm the arrangements above.

# 7. Concluding Matters

For Noting

# 7.1. Any Other Business

For Noting

# Questions from the public

# 7.2. Date of Next Meeting – Thursday 5 March 2026

For Noting

Presented by Andy Trotter