London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON THURSDAY 24 MAY 2018 AT 13:00-17:00 15 HATFIELDS, CHADWICK COURT, LONDON SE1 8DJ

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
13.00	**1.**	**TB/18/26** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
13.05	**2.**	**TB/18/27** Oral	**Staff Story** To hear about the experiences of a member of staff.	TB	Information
13.30	**3.**	**TB/18/28** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	Assurance
	4.	**TB/18/29** Attachment	**Minutes of the meeting held in public on 24 April 2018** To approve the minutes of the meeting held on 24 April 2018.	HL	Decision
	5.	**TB/18/30** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
13.45	**6.**	**TB/18/31** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
14.00	**7.**	**TB/18/32** To follow	**Report from Chief Executive** To receive a report from the Chief Executive (CEO).	GE	Information
ANNUAL REPORTING					
14.15	**8.**	**TB/18/33** To follow	**Annual Accountability Statements:** **i) Annual Report** **ii) Annual Governance Statement** **iii) Annual Account** **iv) Annual Quality Account** **v) Patient Experiences Annual Report 2017/18**	JO'H, PH, LB, TB	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
			To receive and approve the key annual accountability statements of the Trust.		
14.30	**9.**	**TB/18/34** To follow	**Board Engagement** To agree the structures for how Executive and Non-Executive Directors will engage with Trust staff and stakeholders	JO'H	Decision
QUALITY, PERFORMANCE AND ASSURANCE					
14.45	**10.**	**TB/18/35** To follow	**People and Culture Committee Assurance Report** To receive the report of the People and Culture Committee meeting on 14 May 2018.	JM	Assurance
15.00	**11.**	**TB/18/36** To follow	**Audit Committee Assurance Report and Annual Report** To receive the report of the Audit Committee meeting on 17 May 2018.	JJ	Assurance
15.15	**12.**	**TB/18/37** To follow	**Quality Assurance Committee Assurance Report** To receive the report of the Quality Assurance Committee meeting on 22 May 2018.	RM	Assurance
15.30	**13.**	**TB/18/38** Attachment	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Discussion
15.45	**14.**	**TB/18/39** Attachment	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and the Corporate Risk Register	PH	Assurance
15.50	**15.**	**TB/18/40** Attachment	**Serious Incident Update** To note declared and closed Serious Incidents.	TB	Discussion
GOVERNANCE					
16.00	**16.**	**TB/18/41** Attachment	**Freedom to Speak Up Quarterly Report** To receive the quarterly update on Freedom to Speak Up Activity.	PH	Discussion
16.15	**17.**	**TB/18/42** To follow	**General Data Protection Regulation (GDPR)** To receive an update on the Trust's progress toward GDPR compliance	PH, RF	Assurance
16.20	**18.**	**TB/18/43** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
16.30	**19.**	**TB/18/44**	**Questions from members of the public**	HL	Information

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
		Oral			
16.45	**20.**	**TB/18/45** Oral	**Any other business**	HL	Information
16.50	**21.**	**TB/18/46** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
17.00	**22.**		**Meeting close** The meeting of the Trust Board in public closes.	HL	
	Date of next meeting: The date of the next Trust Board meeting in public is on Tuesday 31 July 2018 at a venue to be confirmed.				

Additional reports, circulated for information only:

TB/18/47 Quality Report

TB/18/48 Diversity at London Ambulance Service NHS Trust

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Thursday 24 April 2018

DRAFT Minutes of the public meeting of the Board held on 24 April at 12.30pm in London Ambulance Service NHS Trust Headquarters, 220 Waterloo Road, London SE1 8SD

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Director of Finance and Performance
Fergus Cass	FC	Non-Executive Director
Jessica Cecil	JC	Associate Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO) (until item 16)
John Jones	JJ	Non-Executive Director
Amit Khutti	AK	Associate Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director (until item 3)
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
Ross Fullerton	RF	Chief Information Officer
Philippa Harding	PH	Director of Corporate Governance
Patricia Grealish	PG	Director of People and Culture
Jamie O'Hara	JO'H	Director of Strategy and Communications
Apologies		
Sheila Doyle	SD	Non-Executive Director
Benita Mehra	BM	Director of Strategic Assets and Property

1. Welcome and apologies (TB/18/01)

1.1. The Chair welcomed all to the meeting and noted the apologies that had been received.

2. Patient Story (TB/18/02)

2.1. The Board was joined by two members of the Metropolitan Police Service (MPS) who had used a defibrillator and training provided by the London Ambulance Service NHS Trust (LAS) to save the lives of two young children. They related their experience and the outcome of their actions, providing information about the lessons that they had learned and how they had worked with the LAS both before and after the incident.

2.2. The defibrillator and training on how to use it had been provided by the LAS to the MPS as part of a trial; in response to Board members' queries about how the trial was

viewed by the MPS, the officers reported that many who had initially been sceptical about it had become much more positive as a result of their experience. When asked about anything else that might make a similar impact, the question of whether the LAS had power of entry was raised. It was noted that this could have a significant impact on time to treatment in some cases.

2.3. The value of joint working between the MPS and the LAS was emphasised, as were the benefits of joint debriefings when patients had received treatment from both services. This was not only beneficial from the perspective of ensuring a complete knowledge of the events, but also to ensure staff welfare needs were met.

2.4. Board members thanks the members of the MPS for sharing their story.

3. Declarations of interest (TB/18/03)

3.1. There were no declarations of interest.

4. Minutes of the meeting held in public on 27 March 2018 (TB/18/04)

4.1. The minutes of the Trust Board meeting held in public on 27 March 2018 were approved as a true and fair record of that meeting, subject to the following amendments:

4.1.1. The update provided with regard to the results of the training review (paragraph 5.1, ref: TB/17/197) should reflect the fact that the outcome of the Training Review was not due until May 2018. The full results of this review would be available from June 2018.
4.1.2. Paragraph 9.2 (ref: TB/17/202) should reflect the fact that capital would be available in 2018/19, subject to any change in the rules governing this availability.
4.1.3. The first sentence of paragraph 9.3 (ref: TB/17/202) should read "Capital expenditure to the end of February was £13.8 million, against planned expenditure of £25 million."
4.1.4. The second sentence of paragraph 11.3 (ref: TB/17/204) should read "It was noted that the Trust had therefore demonstrated its ability to achieve high performance at this level of demand with the current level of resources, and GE confirmed that a separate discussion about meeting ARP standards had been agreed with commissioners."

5. Matters arising (TB/18/05)

5.1. The action log from previous meetings was reviewed and additional updates noted as follows:

5.1.1. A Board development discussion was due to take place in June 2018.
5.1.2. Sustainability and Transformation Partnership (STP) engagement – the Chair reported that she would be discussing the role of Non-Executive Directors (NEDs) with the Chair of NHS Improvement. Regardless of the outcome of this discussion, it had been agreed that NEDs would be allocated to LAS sectors/STP areas, together with Executive Leadership Team (ELT) members. A paper setting out the Trust's proposed approach to this

engagement would be presented to the next meeting of the Board. The Chair would also discuss the issue further with NEDs in their appraisals.

5.1.3. It was proposed that the outcome of the Corporate Governance Review (ref: TB/17/211) should be re-circulated to Board members in order to confirm that they were content with its proposals. It was agreed that it should be considered approved, subject to there being no substantive issues raised.

6. Report from the Chair (TB/18/06)

6.1. The Chair confirmed that she had nothing of any substance to report that had not been captured in the Chief Executive's report

7. Report from the Chief Executive (TB/18/07)

7.1. GE presented his report on progress and key issues, events and activities since the Board meeting in March.

7.2. Board members referred to the Chief Executive's Roadshows that were due to be launched across the service in the next week. These would reflect on the progress that had been made by the organisation since the last roadshows in November and launch the Trust's new strategy, vision and values. Board members emphasised the value of ensuring that these events were scheduled with as much notice as possible to facilitate maximum attendance.

ACTION: confirm next tranche of Chief Executive's Roadshows as early as possible.

7.3. LB reported the Trust's end of year financial position, which was a surplus of £3.2m, subject to audit. Sustainability and Transformation Fund (STF) allocations and further dividends brought the Trust's final position to £5.7m surplus. However, non-recurrent achievements left the Trust with an underlying deficit of up to £2m, which would require real focus on recurrent efficiency savings to be successfully addressed in 2018/19. Board members also noted that the Trust had been able to deliver 93% of its 2018/19 capital programme.

7.4. The Board noted the report of the Chief Executive.

8. A world class ambulance service for a world class city – strategy 2018/19 – 2022-23 (TB/18/08)

Angela Flaherty (Deputy Director of Strategy) joined the meeting for the consideration of this item.

8.1. GE presented the report which sought approval for the LAS' draft new five year strategy "A world class ambulance service for a world class city". Having been discussed in draft at the private meeting of the Board on 27 March 2018, the document had been amended to reflect Board members' comments, with the principal changes having been made to section 7 ("Estimating the impact of our strategy"). A small working group had been established to specifically focus on this section and the economics of the strategy. Members of this group confirmed that the work they had undertaken could provide the Board with significant assurance with regard to the affordability of the strategy and commended the ELT on the manner in which Board members' comments had been incorporated into the document. It was noted that some minor drafting points remained to be addressed.

8.2. NEDs emphasised the importance of measuring the impact of the strategy's implementation and asked for information about how this would be done. It was reported that evaluation of pioneer programmes was being built into the design of each pilot. Furthermore, the first year of the strategy also translated into the Business Plan for 2018/19, progress against which would be monitored through the corporate scorecard and regular performance reporting to the Board. The Board would also undertake periodic reviews of both the strategy (likely to be annual) and the Business Plan (expected to be at 6 months).

8.3. The Chair reported that she had received a question from the Patients' Forum with regard to the extent to which the Trust had entered into public engagement and co-production in the development of the strategy. GE referred to Appendix B of the strategy ("How we developed our strategy"), which detailed that the Trust had followed established best practice in developing its strategy and had undertaken substantial engagement with its staff, patients and the public, partners and stakeholders throughout. This had ensured that it had been able to benefit from the insight of those who delivered and those who experienced the Trust's services when arriving at a view of how the organisation needed to change. It also meant that these groups had invested in, and own, the strategy.

RESOLVED:

8.4. The Board resolved to approve "A world class ambulance service for a world class city – strategy 2018/19 – 2022-23".

9. Business Plan 2018 – 2019 (TB/18/09)

9.1. LB introduced the report which presented the Trust's Business Plan for approval prior to publication and submission to NHS Improvement as part of the Trust's annual requirement to submit financial, workforce and activity plans and demonstrate their alignment. It was noted that amendments were required to the Trust's outturn in line with the information provided to the Board earlier in the meeting (paragraph 7.3, ref: TB/18/07). The Board meet informally to consider the draft Business Plan on 16 April 2018, since that meeting, it was considered that the most significant change to the Plan was in relation to the use of national Ambulance Quality indicators (AQIs), which were still being finalised. Rather, it was proposed that the "Our Patients" scorecard should incorporate ST-elevation myocardial infarction (STEMI) and stroke care bundles, both of which the Trust was not yet meeting national standards on.

9.2. It was noted that further work was required to ensure that the final Plan provided assurance that the LAS could deliver national performance standards introduced in November 2017 under the Ambulance Response Programme (ARP) by September 2018. As the national AQIs from April 2018 were still being finalised at a national level and were subject to change, delivery would be subject to agreement with commissioners on any additional funding needed to establish the revised operating model. With regard to capital funding; it had been indicated to the Trust that this might be available nationally to bid for. In light of the lead time involved in such bids and the fact that the Trust already had evidence of what its capital requirements would be, the Chair suggested that planning should move forward on this basis. The Chair noted that the outcome of the modelling required to determine the Trust's revised operating model was still awaited and requested an update on this for the next meeting of the Board.

ACTION: provide an update on the modelling work being undertaken to inform the Trust's future operating model at the next meeting of the Board.

9.3. NEDs questioned the role and purpose of the corporate scorecard that had been included within the Business Plan and how this interacted with the integrated quality and performance report received by the Board. GE emphasised that the scorecard was intended to indicate a high level set of outcomes that reflected what the Trust was seeking to achieve. It was not intended to be comprehensive and would be underpinned by many metrics that would still be reported through the integrated quality and performance report and to the Board Assurance Committees, as well as the ELT. It was noted that the Finance and Investment Committee was due to consider the form and content of performance reporting at its next meeting and that this would be an opportunity for further discussion.

9.4. With regard to the question of the appropriateness of using care bundles as an indicator of performance, it was proposed that statistical process controls (SPCs) were a more effective method of measuring quality.

ACTION: Board development session to be arranged on SPCs.

RESOLVED:

9.5. The Board resolved to approve Business Plan for 2018/19, noting that standards incorporated within it were likely to change and that the scorecards and quality and performance reports received by the Board required further clarification.

10. Financial Plan 2018 – 2019 (TB/18/10)

10.1. LB presented the report which provided an update on the development of the Trust Financial Plan for 2018/19, set out the external submission requirements of NHS Improvement and sought approval for the financial, workforce and activity plans for 2018/19. Board members noted the level of work that had been undertaken in the development of this plan in comparison to previous years. ELT members had clear accountabilities with regard to the delivery of specific Cost Improvement Plans (CIPs) and new ways of working had been introduced to facilitate this delivery (specifically the implementation of a Programme Management Office) to increase Board confidence in the deliverability of the plan.

10.2. The Chair referred to the treatment of the apprenticeship levy and requested further information about this.

ACTION: provide further information about the treatment of the apprenticeship levy in the annual financial plan.

10.3. NEDs noted that the plan was demanding with regard to the required level of efficiency of frontline hours and these would require careful tracking. In the past the Finance and Investment Committee had received a schedule of financial risks for consideration and it was confirmed that this would continue into the 2018/19 financial year to provide the necessary assurance that they were being managed appropriately.

RESOLVED:

10.4. The Board resolved to:

10.4.1. approve the Annual Financial Plan and supporting Workforce and Activity plans for 2018/19 as set out in the Trust Business Plan 2018/19 (ref: TB/18/09) for submission to NHS Improvement by 30 April 2018; and
10.4.2. approve the associated revenue and capital budgets for internal delegation.

11. Audit Committee Assurance Report (TB/18/11)

11.1. JJ, as Chair of the Audit Committee, presented the report which provided an overview of the Committee's meeting on 16 April 2018 and indicated the key issues for escalation to the Board, risks and assurances.

11.2. The Committee had receive an update on the progress being made by the organisation against internal audit recommendations and noted that a number of them remained outstanding. Two high priority actions had remained outstanding for some time and required further consideration by the ELT, particularly one which related to the storage and accessibility of records. Whilst it was noted that the independent training review currently being undertaken would provide recommendations on this issue, Board members requested that the ELT take immediate short and long term action to address the recommendation that the Trust should develop its training record storage system to ensure that records could be easily accessed or located using an electronic student management system.

ACTION: take action to address the high priority internal audit recommendation relating to storage and accessibility of records, both in the short and longer term.

11.3. The advisory work undertaken by the Trust's internal auditors to test its readiness for the implementation of the General Data Protection Regulation (GDPR) was noted. Board members were informed that, in addition to the briefing report that had already been circulated in correspondence, a further report would be provided to the Audit Committee's next meeting and then on to the Board at its meeting on 24 May 2018.

12. People and Culture Committee Assurance Report (TB/18/12)
13. Staff Survey 2017 action plans (TB/18/16)

13.1. In light of the fact that one of the key areas of focus of the extraordinary meeting of the People and Culture Committee was the actions being taken in response to the staff survey, the Board agreed that these two items (ref: TB/18/12 and TB/18/16) should be considered together. JM, as Chair of the People and Culture Committee, made an oral report which provided an overview of the Committee's extraordinary meeting on 19 April 2018 and indicated the key issues for escalation to the Board, risks and assurances.

13.2. It was reported that, in addition to the action being taken in response to the 2017 staff survey, the Committee had considered the work that was in progress to improve recruitment and retention within the Emergency Operations Centre. Board members welcomed the Committee's proposal that during the online assessment pilot, a control group should be established to establish the efficacy of methods of assessment that did not involve attendance in person. The Committee had also received detailed

information about the Trust's short, medium and long term planning assumptions. A further iteration of this work was due to be considered by the Committee ahead of its presentation to the Board.

13.3. With regard to the 2017 staff survey, The Committee had considered the report subsequently submitted to the Board, which provided a summary of the headline staff survey 2017 results, analysis of the main published report by key findings and the approach being taken to develop local action plans and address key issues from the survey results. Particular attention had been paid to the work that was being undertaken by the Staff Survey Champions Group and plans to demonstrate that action was being taken as a result of the feedback received through the staff survey. It is proposed that this group be invited to present to the Board as part of a staff story at a future meeting.

ACTION: staff survey champions group be invited to present to the Board as a staff story.

13.4. In response to a question about whether any work had been done to establish whether the staff survey action plans would deliver an improved staff engagement index, it was noted that the questions most closely correlating with this staff engagement score related to workload, feeling unwell due to work-related stress and so on. Many of these issues were already being address through the People and Culture Strategy and, therefore, did not necessarily require inclusion in staff survey action plans.

13.5. Consideration was given to the scores of individual sectors and teams. With regard to parts of the Operations directorate, it was noted that a number of issues raised would be addressed by the current restructuring activity.

13.6. The importance of race equality reporting was noted and Board members were reminded that the Workforce Race Equality Scheme (WRES) was due to be reported to the People and Culture Committee and Board in May.

14. Integrated Quality & Performance Report (TB/18/13)

14.1. Board members noted the report which provided an organisational oversight of all key areas across the LAS. As there had not been a Quality Assurance Committee meeting in April and, therefore no Assurance Report to the Board from that Committee, RM and TB, as Chair of the Quality Assurance Committee and Chief Quality Officer were invited to highlight any issues requiring the Board's attention. It was confirmed that there were none.

14.2. PW provided a further oral update on the Trust's operational performance since the last meeting of the Board. It had been a challenging month as a result of difficult weather and lost hours due to delayed handovers at hospitals; however there Trust had performance strongly over the Easter period. The Trust's 111 service had also performance well, despite an increase in activity in excess of forecast levels, up to an additional 35% on some days. Despite this, the 111 service consistently remained the provider transferring the lowest number of calls to 999.

14.3. Board members noted and condemned the reported levels of violence against Trust staff.

14.4. The Trust's achievement of appropriate reporting against the Reporting of Injuries, Diseases and. Dangerous Occurrences Regulations 2013 (RIDDOR) was welcomed.

15. Board Assurance Framework and Corporate Risk Register (TB/18/14)

15.1. The Board noted the report which provided an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

15.2. In light of the issues raised in relation to the storage and accessibility of training records (paragraph 11.2 TB/18/11), Board members asked for further information about the amalgamation on the CRR of Datix ID 240 (archiving space for training records is insufficient and now decentralised) and Datix ID 302 (there is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system).

ACTION: confirm the rating of the amalgamation of Datix ID 240 and 302.

16. Serious Incident Update (TB/18/15)

16.1. The Board noted the report which summarised the findings from the quarter four thematic review of serious incidents (Sis) and compared these findings with those from the quarter two and three review. The thematic review analysed serious incident activity across the Trust and each STP/sector.

16.2. Board members asked for confirmation of the definition of "human factors" in future reports.

ACTION: confirm the definition of "human factors" in future reports.

16.3. In consideration of the example provided relating to complex medical presentations Board members queried the role of a General Practitioner (GP) who was also on scene conducting a home visit whist LAS paramedics were in attendance. It was confirmed that LAS had primacy of care at this point of handover. This was particularly important when frontline crews treated more acutely sick people more frequently than GPs. The value of both types of practitioner working together was noted, in order to build the understanding of each group.

16.4. Board members asked how reflective practice was conducted and the manner in which this differed from the management of performance issues. It was emphasised that this was a positive engagement and that any recurrent issues were monitored and were very infrequent.

17. Quality Account 2018-19 (TB/18/17)

17.1. The Board noted the final draft of the 2018-19 Quality Account, which outlined the quality priorities that the Trust had consulted on to include in the 2018-20 Quality Strategy and annual account. The priorities had been circulated to commissioners, Patient Forum members and were consulted on via survey monkey with staff during February. Feedback has been collated and included in the report. The report outlined the Trust's quality strategy and its alignment to overarching strategy, quality priorities for 2018-19, progress against 2017-18 quality account priorities and statements of assurance as set out by Department of Health regulations 2018. It was noted that the final Quality Account would be received by the Board at its meeting on 24 May 2018,

as part of the suite of annual accountability documentation that was produced by the Trust.

18. Quality Improvement Plan and current status of Good to Outstanding domains (TB/18/18)

18.1. TB presented the report which incorporated information about how the Trust was currently performing in relation to the Care Quality Commission (CQC) quality domains and key deliverables and approaches it needed to develop over the coming year to move to an "outstanding" rating. This gap analysis had informed the development of the overarching draft Quality Improvement Plan. Board members emphasised the importance of having one overarching plan to drive the improvement of the Trust's performance in order to achieve "outstanding" status. It was noted that next steps were to prioritise the activities, identify timescales and ensure the outcomes were aligned to the performance outcome metrics currently being produced. The plan would then be divided into individual directorate led actions and monitored via governance and performance groups

19. Corporate Governance Framework (TB/18/19)

19.1. This item was withdrawn from the agenda.

20. Trust Board Forward Planner (TB/18/20)

20.1. The Board noted the Forward Planner.

21. Questions from members of the public (TB/18/21)

21.1. The Patients' Forum had asked the following question: "Does the Board agree that effective public engagement and co-production in strategy development should be always events? If so why has there been virtually none in the development of the new LAS Strategy". Board members noted that an answer had been provided earlier in the meeting (paragraph 8.3, ref: TB/18/08). A formal response would also be provided.

ACTION: formal response to be provided the Patients' Forum setting out the extensive level of staff and public engagement that had been undertaken in the development of the strategy.

21.2. Board members considered the role of the Patients' Forum and the best way of ensuring appropriate engagement with as wide a group of patient representatives as possible, giving particular regard to the role of HealthWatch.

22. Any other business (TB/18/22)

22.1. There was no other business.

23. Review of the meeting (TB/18/23)

23.1. Board members confirmed that they considered the quality of the papers presented to the meeting to be good and noted the value of early and regular NED engagement in the development of significant documents such as the strategy and business plan,

although there was a risk that this could reduce the level of challenge given at Board meetings. It was considered useful to have a summary of changes that had been made when such a level of engagement had taken place, in order to ensure that it was clear where documents differed from earlier versions.

23.2. Feedback was provided with regard to the strategy session that had been held before the Board meeting. Board members noted the value of such sessions and the need to ensure that they were followed up appropriately.

24. Meeting close

The meeting closed at 16.00pm. The next Trust Board meeting in public will take place at 13.00pm on Thursday 24 May 2018.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/17/95 para 7.2	A full report on the impact of the new rest break policy to be brought to the Board at its meeting in July 2018, with an interim report to be brought to the Board in March 2018	Paul Woodrow	31/10/17	31/07/18	**On track**	Further report scheduled for Board meeting on 21/07/18
TB/17/125 para 8.10	Recruitment plan, with a focus on the EOC, to be brought to the Board in Spring 2018	Patricia Grealish	28/11/17	31/07/18	**On track**	Proposed to be presented to the Board in July
TB/17/163 para 20.1	Input to be sought for a programme of developmental/strategy sessions for the Board.	Philippa Harding	30/01/18	30/03/18	**CLOSED**	Proposal is with Chair
TB/17/185 para 17.2	Logistics and Infrastructure Committee to consider the controls and mitigations in place with regard to BAF risk 52 and whether it needs to remain on the BAF in light of these	Theo de Pencier, Benita Mehra	27/02/18	21/07/18	**On track**	Next Logistics and Infrastructure Committee meeting scheduled to take place in June.
TB/17/197 para 5.1a	Dates of key STP meetings to be circulated to the Board, setting out those which NEDs are expected to attend.	Jamie O'Hara	27/03/18	24/05/18	**1 month late**	See item on agenda
TB/17/197 para 5.1b	Briefings to be provided to NEDs attending STP meetings.	Jamie O'Hara	27/03/18	24/05/18	**1 month late**	See item on agenda
TB/17/197 para 5.1c	The allocation of executive directors to STP sectors to be reviewed.	Jamie O'Hara	27/03/18	24/05/18	**CLOSED**	See item on agenda
TB/17/207 para 15.4	The terms of reference of the Rest Break sub-group to be circulated.	Paul Woodrow / Patricia Grealish	24/04/18	31/07/18	**CLOSED**	Oral update to be provided at meeting
TB/18/07 para 7.2	Confirm next tranche of Chief Executive's Roadshows as early as possible	Jamie O'Hara	24/04/18			Update requested
TB/18/09 para 9.2	Provide an update on the modelling work being undertaken to inform the Trust's future operating model at the next meeting of the Board	Paul Woodrow / Patricia Grealish	24/04/18	24/05/18	**CLOSED**	Oral update to be provided at meeting
TB/18/09 para 9.4	Board development session to be arranged on Statistical Process Controls (SPCs)	Trisha Bain, Philippa Harding	24/04/18	24/06/18	**On track**	Currently scheduled for June

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/18/10 para 10.2	Provide further information about the treatment of the apprenticeship levy in the annual financial plan.	Lorraine Bewes	24/04/18		**CLOSED**	We have assumed £2m of income from the levy in 2018/19 and £1m as the cost we will have to pay to the levy. The £1m is not identified separately in the plan as it was treated as a FYE of the 2017/18 Apprenticeship Levy.
TB/18/11 para 11.2	Take action to address the high priority internal audit recommendation relating to storage and accessibility of records, both in the sort and longer term	Ross Fullerton	24/04/18	24/05/18	**On track**	A project is being mobilised this month. It will develop the requirements and options analysis during June.
TB/18/13 para 13.3	Staff survey champions group be invited to present to the Board as a staff story	Patricia Grealish/Philippa Harding	24/04/18	28/07/18	**On track**	Date and format to be agreed for July 2018 Board Meeting.
TB/18/14 para 15.2	Confirm the rating of the amalgamation of Datix ID 240 and 302.	Philippa Harding	24/04/18	24/05/18	**CLOSED**	New risk wording: The Trust is unable to access some clinical training records of operational members of staff. Records are kept on separate and remote sites, are kept primarily as paper (not electronic) copies, and are not archived / processed within the framework of a recognised student management system. It is difficult to defend legal claims against the Trust with the paucity of evidence we have available that staff have undertaken their core and statutory / mandatory training. Current rating remains at a major x possible = 12.

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/18/15 para 16.2	Confirm the definition of “human factors” in future reports	Trisha Bain	24/04/18	24/05/18	**CLOSED**	Definition: “Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings”.
TB/18/21 para 21.2	Formal response to be provided the Patients’ Forum setting out the extensive level of staff and public engagement that had been undertaken in the development of the strategy.	Philippa Harding	24/04/18	24/05/17	**CLOSED**	Letter sent with extract from Board minutes

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Report from the Chair			
Agenda item:	06			
Report Author(s):	Heather Lawrence, Chair			
Presented by:	Heather Lawrence, Chair			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Chair's report provides an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒

Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Chair

External

Care Quality Commission (CQC) outcome of inspection

1. The CQC is due to publish its report on 23 May 2018, this is based on the inspection and review of documentation that took place in the Spring.

2. The outcome will be discussed at the Board meeting when we will also expect to know the outcome of the decision by NHS Improvement (NHSI) with regard to Special Measures.

Meeting with Healthwatch England

3. I met with Jane Mordue the Chair of Healthwatch England, it was a productive meeting and I was interested to hear how Healthwatch has developed since its inception and the methods they use for public engagement.

4. I will discuss this further with Garrett Emmerson, Chief Executive Officer (CEO) with a view to visiting one of the London Borough Healthwatch user involvement events.

NHS Roundtable event facilitated by NHS Providers

5. I was invited to take part in a small roundtable discussion on NHS Improvement's (NHSI) organisational development programme with Ian Dalton, CEO of NHSI and McKinsey (Management consultants).

6. The participants were Chairs and CEOs representing all provider sectors and geography. It is known that NHSI and NHS England (NHSE) will be working in a more aligned way without legislative change.

7. Nationally there will be seven Regional Directors (with one for London) whose responsibility will encompass those currently covered separately by NHSE and NHSI. The purpose of the session was to gain our thoughts and insights on the plans and the relationship with Sustainable Transformation Partnerships (STPs) and Integrated Care Systems (ICS) it was a genuine listening exercise where our feedback and concerns were taken on board.

8. I learnt a great deal and also felt valued - a 'lesson to self' on the importance of listening to our stakeholders.

Stephen Barclay MP – Minister of State for the Department of Health and Social Care

9. I was invited to meet with the Minister whose portfolio is to lead on:-

    - Finance, procurement and operational performance
    - Workforce pay and pensions, contracts and whistleblowing
    - Setting the Governments mandate for NHS England
    - Transformation and provider policy

10. I took the opportunity to set out for him our strategic intent relating to our three key aims and in particular how we can act as the 'conductor of the orchestra' for Emergency and Urgent Care, and how this might look organisationally. I also discussed the impact the Service can have on reducing the number of ambulances attending emergency

departments (A&E) through our Advanced Paramedic Practitioners, Urgent Care and Pioneer Services.

11. We talked about the need for Procurement in the ambulance sector to be accelerated.
12. He was also interested in frequent callers and the types of vehicles we will need in the future.

Internal

Visit to Pocock Street

13. I spent an enjoyable morning meeting staff at Pocock street working in the following departments:-

    - Clinical Audit and Research (CARU)
    - Infection Control& Prevention
    - Health and Safety
    - Contracts
    - First Responders

14. The staff were all very positive, knowledgeable in their field and welcoming and open. They really do appreciate meeting Board members and I got the opportunity to learn about their experience of working for the LAS, how it has changed and what their ambitions are both personally and for the organisation.

15. For my part, I learn, gain assurance that we have expert staff working in these important roles, and aim to convey to them the importance we place on their roles, and in their impact on the quality of services we provide to patients in support of front line staff.

16. I do encourage both Executive and Non-Executive Directors to visit these areas for a short period.

Board meetings

17. In light of the progress that the Trust has made in its improvement efforts, I feel that it is now the time to return to holding formal Board meetings every other month. This will give us the time we need to have more wide ranging strategic discussions and developmental sessions. We have been discussing this for some time and I am aware of a number of "bids" for Board time to discuss different strategic issues. I am currently considering the best use of our time and will share a programme for Board strategy, development and briefing sessions in the near future.

18. In Board members are asked to agree that formal Trust Board meetings for the remainder of 2018/19 will take place on:

    - Tuesday 31 July 2018
    - Tuesday 25 September 2018
    - Tuesday 27 November 2018
    - Tuesday 29 January 2018
    - Tuesday 26 March 2018

19. We will also still meet on the following days in 2018/19, but informally and in private:

- Tuesday 26 June 2018
- Tuesday 28 August 2018
- Tuesday 30 October 2018
- Tuesday 18 December 2018
- Tuesday 26 February 2018

Heather Lawrence OBE
Chair

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report Title:	Report from the Chief Executive			
Agenda item	07			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

The Chief Executive's report gives an overview of progress and key events within the Service since the last time the Board convened.

The report is structured in sections, covering key areas of focus of the Trust and Board.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Chief Executive's Report

This report provides the Trust Board with an update regarding key issues, events and activities.

Operational Performance

1. All six key national performance measures were achieved in April 2018. The April Category 1 mean returned 6 minutes 51 seconds while the Category 1 90th centile was 11 minutes 15 seconds, both well within the 7 and 15 minute standards. The Category 1 90th centile has remained within the standard each week since the implementation of the Ambulance Response Programme (ARP) and shows that our most critical patients are being responded to quickly. The latest nationally published data shows that the Trust is ranked 2nd in the Category 1 90th centile measure when compared to all ambulance trusts across England.

2. The Category 3 90th centile demonstrated a major improvement in April, going from just under 3 hours in March to 1 hour 49 seconds in April.

3. In terms of the Emergency Operations Centres (EOC), 91% of all calls were answered within 5 seconds in April 2018 compared to 76% in March 2018. This is a significant improvement when compared to previous months.

4. The Director of Operations published his response to the operational management restructure consultation on Friday 11 May 2018. Copies of the final structures, the new job descriptions and the Equality Impact Assessment were published at the same time. The timeline for implementing the new structure is as follows:

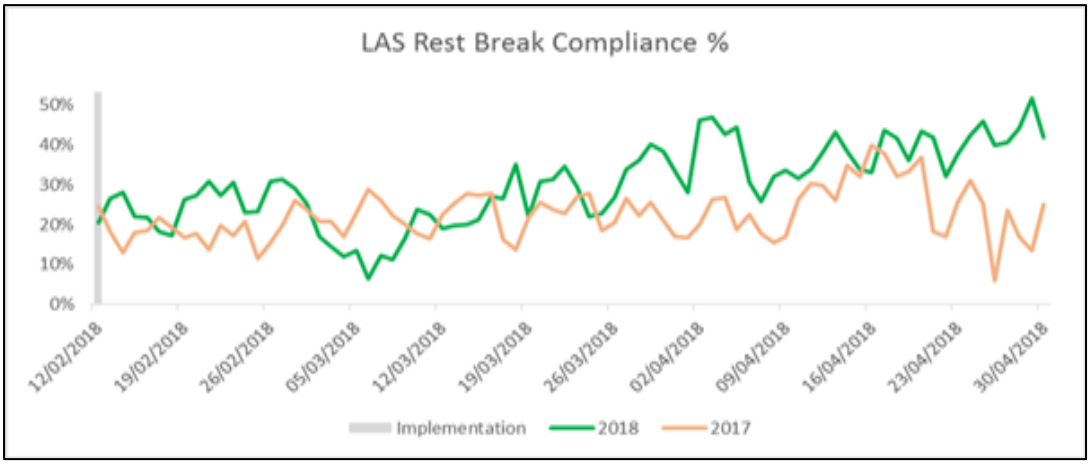
Week	Deliverables
W/C 14/05/18	Remaining job descriptions will complete the job banding evaluation process.
W/C 28/05/18	All staff affected by change will receive letters confirming their individual status; assimilation arrangements if applicable; and requests for expressions of interest where applicable.
W/C 04/06/18	Change of line reporting arrangements will commence for the following groups: QGAMs; CIOs; Incident and Delivery Managers (IDMs)/IROs; Service Improvement Team; First Responders and Community Resuscitation Teams.
11/06/18 – 29/06/18	Assessments and interviews will take place for VSM, 8D, 8C and 8B roles for those affected by change.
July 2018	Remaining appointments to be made for those affected by change.
July 2018	Schedule of development programmes will commence.
September 2018	Full implementation of the new structure will commence.

5. The Key Performance Indicators (KPIs) and deliverables have been agreed and signed for 2018/19 on a directorate-wide and individual 'sub-division' basis at the Operations Challenge and Check meeting held on 17 April 2018. The focus for the coming weeks is to finalise and agree the outstanding targets.

6. Operations has continued to work closely with the PMO to develop its CIPs projects for 2018/19. Over the last month, the projects have been further developed and the first Operational CIPs Board is being held on Wednesday 16 May 2018.

7. The Operations Directorate continue to engage with the Contract Management Team in order to agree a new set of metrics which will combine elements of job cycle time (JCT) which will also include a view of efficiency and productivity. Discussions are also continuing with commissioners to determine the agreed reduction in conveyance to emergency departments during 2018/19.

8. The refreshed approach to rest breaks which was implemented in February 2018 continues to show its impact with rest breaks increasing from an average of 24% in March 2018 to 38.5% in April 2018. Over 40% rest breaks is being reached frequently and over 50% was achieved in late April as shown in the following graph:



9. In order to address the challenges at the end of operational shifts an end of shift pilot which focuses on three station groups in South London (Croydon, New Malden and Deptford) is due to launch on 30 May 2018 and will attempt to protect staff during the last 30 minutes of their shift. Regular safety checkpoint reviews will take place with consideration being given at the same time as to whether the pilot is extended across further station groups/sectors.

10. Progress against EOC recruitment and retention continues to be scrutinised at weekly Operations Resourcing Group meetings. Full establishment is still on track for September 2018.

Finance & Performance

11. As reported elsewhere on the agenda the Trust is £0.2m ahead of plan at the end of April. Income for April was £0.3m lower than planned with activity 0.6% above contracted levels, 1.1% lower than plan. Pay expenditure was £0.46m below plan due to frontline vacancies partially offset by private ambulance and agency usage.

12. The executive team continues to focus on recruitment and retention to reduce reliance on overtime and Private Ambulance Services (PAS) to maintain safe and effective rosters.

13. The Trust delivered its required level of CIP in April (£0.699m) and work is currently underway across the organisation needs to continue to ensure the full £12.3m is delivered in 2018/19. The Trust forecast is to deliver its control total deficit of £1.564m in 2018/19.

14. The Performance Director's team have led on a number of discussions with Commissioners to develop baselines for Hear and Treat and See and Treat for 2018/19. We have jointly agreed a process for devising a baseline figure for both measures, using the LAS minimum data set that is available to Commissioners. This ensures transparency, clear governance, and a validated position for our quarterly flex and freeze activity discussions via the Finance Information Group (FIG).

15. There is still one outstanding issue that remains to be resolved – agreement on the percentage reduction target for patient conveyance to emergency departments in line with the 2018/19 CQUIN. The target needs to be realistic yet challenging from the Trust's perspective, meet our stakeholder expectations and support the wider healthcare

system, and align with the LAS 5-year strategic ambition. These points are somewhat distinct and therefore further work and discussion is planned with key leads to resolve this matter.

16. The Forecasting & Planning team established a new national network in early May, bringing together analytics and forecasting professionals from 10 ambulance Trusts across the UK, with the ambition of helping shape the future of predictive analytics in ambulance services. The successful launch event established a core community, and plans have already been put in place to grow the network and continue to meet regularly to share knowledge, best practice and collaborate to solve common challenges.

IM&T

17. During April IM&T services were successfully delivered with no critical incidents and all services performing within planned service levels.

18. A particular highlight for the team was the submission of London's bid towards becoming a Local Health and Care Records Exemplar (LHCRE) as part of a national scheme led by NHS Digital. If successful the bid will create the ability for London's healthcare providers to share information for use in real-time and for use in population health management across the capital. London Ambulance Service is the primary use case for the bid due to our unique nature as a pan-London provider. The bid was endorsed by the Accountable Officers for each Sustainability Transformation Programme (STP), the Mayor and NHS England.

19. The development of the Outline Business Case for the Electronic Patient Care Record (ePCR) project commenced with a workshop that included 30 operational and clinical members of staff from across the Trust. This project is planned to form part of the CQUIN for 2018/19 which is currently being agreed with commissioners.

20. The IM&T aspects of mobilising the North-East London Integrated Urgent Care service – specifically the delivery of a brand new, resilient and fully functioning contact centre with a full range of clinical systems including Adastra - have completed detailed planning with commissioners and NEL stakeholders. In parallel we have now implemented the Adastra clinical system already used in South East London 111 into the Clinical Hub in the 999 service. Adastra provides better capability for accessing patient care records from within the Clinical Hub and supports efforts to better manage conveyance.

21. A new application for recruitment was successfully implemented on Apple iPads to capture candidate information when at recruitment events such as careers fairs. The new capability provides a much better first impression for the Trust when trying to recruit new employees.

22. We held joint workshops with colleagues from across the GLA to learn how to best manage implementation of cloud-based IT services such as Office 365 and moving to cloud-hosting of IT systems. Working with colleagues from NHS Digital and NHS England we have developed an outline of how LAS IT strategy aligns to national plans to inform future work for both LAS and national colleagues. LAS is hosting workshops in May with IT leads from all of the ambulance trusts and national teams to develop an aligned set of plans.

Strategy

23. At the 24 April Trust Board, our new organisational strategy was signed off. Following that formal approval, the strategy has been launched to our staff through the CEO road shows which took place at the end of April and the start of May. I had the opportunity to share the details of our new strategy at a meeting with commissioners and STP strategy

representatives, focussing largely on the changes to the service that we provide to patients that will happen as a result of full implementation of our strategy. We also had a conversation about the specific benefits for patients and the NHS system as a whole that we believe our strategy can deliver. This stakeholder meeting was the start of an extensive amount of engagement that will be undertaken to build further support for our new strategy.

24. The Medical Directorate and the Strategy team ran a 'Whose Shoes?' maternity workshop on Friday 11 May. It was a high energy and interactive event attended by service users, staff, midwives and stakeholders.

25. 'Whose Shoes?' is a format that has been piloted at hospitals across London using the concept of a board game with scenario based discussions and a graphic facilitator. Participants are encouraged to share experiences and consider different perceptions, i.e. putting yourself into someone else's shoes.

26. In addition, attendees had the opportunity to listen to 999 recordings of maternity calls to highlight the outstanding work of frontline and EOC staff, and a service user shared her emotional story to emphasise the need for service improvements.

27. Attendees identified areas for change, generated ideas and made pledges to say what they would do differently as a result of the workshop. The outputs will be analysed and monitored as part of an action plan to improve maternity care.

28. Feedback from participants was extremely positive. The event was attended by Patients' Forum Chair, Malcolm Alexander, who described the event as "outstanding". Both he and commissioner, Helen Davenport, have pledged to champion improvements for maternity care.

29. The Trust will hold a 'Whose Shoes?' mental health workshop in October and there is the potential to roll it out across the other pioneer services as a method of service user engagement and co-production. This is also the first event of its kind to be held by an Ambulance Trust and there are plans to collaborate with other Trusts to share learnings and best practice.

Quality Improvement

30. The Datix training for induction and managing health and safety course is currently being reviewed and updated to ensure staff are provided with the correct level of information on how to report an incident, as well as the importance of incident reporting. The re-establishment of the Datix user group is planned and will facilitate further systems improvements. An integration plan for NHS 111 is currently being developed and costed.

31. The Health Assure phase one of the systems roll out and training was delivered ahead of the CQC inspection. Phase two is underway and will include a review of lessons learned and improvements to systems and training.

32. The Quality Account is now complete and will be presented to the Board for sign off. This will include an outline of the Trust's quality strategy. The trust are in receipt of complimentary letters of support from both the CCG and the Patients Forum.
33. Quality improvement training is being launched from July, with a 5 day course (one day per month until November). The team has linked up with People and Organisational Development to develop the course and ensure alignment with other education and training initiatives.

34. A quality improvement launch is planned for July at which the directorate will launch the new team structure including the Quality Governance Assurance Managers (QGAMS)

and Chief Information Officers, the quality strategy, the Quality Information training, and a new quality brand.

35. A full review of the Serious Incident management process is underway to ensure the timely turnaround of reports, robust support for Learning from Incidents, and enough time for executive quality assurance approval and sign off.

36. A meeting with 111 and Datix to map the complaints, incident process across both services and ensure alignment with reporting and timeliness has been arranged.

37. The directorate have now recruited to two posts, the Head of Quality Intelligence and Improvement and the Datix Manager, both joined the trust in April.

38. Recruitment is now underway for the vacancies within the quality intelligence and improvement team (3 posts including intelligence administrators and a compliance manager) and the quality, governance and assurance team (4 posts including senior governance managers, a risk manager and a governance lead).

39. The First Youth Ambassadors programme is operating with young people from across London, coming together with staff to provide insight and input into our educational programmes whilst also receiving first aid training and information on careers within the LAS.

40. A meeting with the Chief Executive of Health Force, a charity committed to developing volunteering across health providers, was held to initiate a programme working with the ambulance service to explore a variety of models.

41. An interview with one of the mental health nurses will be shared with staff as part of a mental health awareness week to raise awareness and understanding of the role. In June 2018 there will be additional staff in this important role who will operate a seven day rota and staff a response car.

42. A trial of rotational posts for mental health nurses, working firstly with Barnet, Enfield and Haringey, is progressing well and is supported by the Mental Health Trust Directors of Nursing. A bid has been submitted to Health Education England to support the development of a Mental Health fellowship programme.

43. A tri-borough mental health training programme for police has been developed and is due to be implemented in June 2018. A joint simulation training programme with the police services is to be developed. The aim will be to reflect on case studies from both services which have resulted in serious incident reviews and/or the coroner's office.

Medical Directorate

44. Induction training for the second cohort of eight new Urgent Care Advanced paramedic Practitioners was completed, allowing the opening of two new sites at Friern Barnet and Barnehurst. Planning is underway to recruit and train a third cohort.

45. A Deep Dive on Medicines Management was presented to CQRG and favourably received.

46. The Medical Director and team supported the CEO's roadshows. This is an important opportunity to engage with staff in their workplace, listen to their concerns and suggestions, and share important messages about the Trust's Clinical Strategy.

47. Members of the Medical Directorate provided clinical support to the Trust's coverage of the Commonwealth Heads of Government Meeting and to the London Marathon.

48. Two new project managers have been appointed to support the primary response bag project and the multi-dose medicines project, which will allow more rapid progression of these projects. The second meeting of the Ready-Set-Go programme board has taken place, which will coordinate and ensure Trust-wide support for these projects

49. The Clinical Audit and Research Unit continue to produce reports on time and we are meeting all of our research and audit activity targets. We are currently reviewing all of our processes, datasets and files to ensure compliance with the General Data Protection Regulation (deadline 25th May).

50. The Infection Prevention and Control department collaborated with Public Health England and external partners in the investigation of a death

51. The Clinical Education and Professional Standards team has forged new partnerships with two universities in North West London with a view to innovative educational pathways for LAS staff and importantly will increase the number of graduation time points during the year.

People and Culture

52. My ESR continues to be a success with over 97.5% of Trust staff accessing the new version of the system which became available to Trusts nationally in May 2017. We continue to have the highest % of users using the new ESR Portal in London (out of 71 Trusts) and we are the 2nd highest % of users nationally. Over 56,000 courses have been completed since go-live.

53. Our entry 'ESR Transformation at The London Ambulance Service' has been shortlisted for the Award for 'Best Use of Your ESR' category in this year's Healthcare People Management Association awards which take place on 7 June.

54. The ESR Workforce Dashboard continues to be positively received and we have had over 15,000 views from 515 managers. There is an increased demand from our managers for the ability to export the data and this will be reviewed by the IG Committee to ensure consideration of data protection obligations (6 June).

55. We have gone live with the recording in ESR of the Operational Workplace Reviews (OWR) and Clinical Information Support Overview (CISO) feedback sessions. Managers can now access this data via the ESR Workforce Dashboard, thereby improving the visibility of compliance across the Trust. The LAS308 form has been redesigned to facilitate this for frontline managers.

56. The eForms solution will deliver on-line forms for staff changes and leavers. These forms are interfaced with ESR and have been designed to reduce the administrative burden for managers and their teams and improve the timeliness and accuracy of data in ESR. We have started the pilot in North Central Sector with a Trust wide roll-out to be delivered by 31 October.

57. The ESR team are working with local training teams to roll-out Oracle Learning Management to EOC, 111, NETS, HART, EPRR, Clinical Hub, TRU and Safeguarding Supervision. This is on plan to be completed by the end of June. HART and Safeguarding Supervision are complete and have been handed over to Business As Usual.

58. The last three months has seen considerable activity as we continue to enhance our DBS checking processes. ESR positions have been reviewed and DBS status has been updated to ensure that all staff who undertake 'regulated activity' and any managers of these staff have a requirement for an enhanced check to be completed.

59. The next phase of the rechecking programme has started, covering the current 800 staff who hold a 'standard' DBS check (the correct level check for when they started). This phase is being co-ordinated by Recruitment and supported by local HR teams and station administrators (additional post in recruitment being funded until November 2018). Employees have a choice of three options/locations for their ID checks to be completed. It is expected that this phase will be completed by September 2018. Any Bank staff without a recorded DBS check will not be used until a DBS check has been completed and recorded in ESR. Work has been undertaken to align the bank records between GRS and ESR. This has now been completed and a process is in place to ensure that they remain in alignment. This has also ensured that the bank statutory and mandatory compliance data updated daily via the ESR Workforce Dashboard remains accurate and up to date.

60. A risk was raised by the Trust's Head of Safeguarding at the end of January, highlighting that there are some staff in non-DBS roles but who undertake clinical shifts and therefore should have a DBS check. An assessment of these roles has been completed and 27 staff have been identified and contacted to confirm whether they undertake clinical shifts. 25 of this group have a recorded DBS check and the remaining two will not be able to undertake any overtime until a DBS check has been completed.

61. An action plan has been developed to capture current and future DBS related activities. This covers the LAS Bank, the DBS policy (including arrangements for agency staff and voluntary responders), ESR DBS records, data quality, audits, training, reporting and monitoring. Progress against this plan has been monitored at the weekly DBS meeting (led by Patricia Grealish) and this will move to a monthly meeting, the first of which took place on 11 May.

62. For governance purposes, the People & Culture Committee will monitor and request assurance on all DBS activities and assurance will also be provided via the Trust's Safeguarding Assurance Group.

63. Statutory and Mandatory Training compliance at the end of April 2018 was reported as Trust compliance at 85.8%, Operations compliance at 85.4% and corporate compliance at 89.9%. Operations. This was achieved through a collaborative effort of ongoing reporting, monitoring and support from across the organisation.

64. The reported data for CSR.2017.2 is currently 88.9% and CSR.2017.3 is at 88.8%.

65. Prior to the first meeting of the Learning and Education Group (19 June 2018) a meeting is to be held with Deputy Director of Clinical Education and Quality Standards to identify and split out statutory and mandatory requirements to support plans to meet the needs of pay progression as per the proposed framework agreement as well as alignment to the Core Skills Training Framework to enable Inter Authority Transfer from other NHS organisations so staff are no longer forced to be non-compliant through training not being available.

66. The ESR Central Team has confirmed with our E-Learning team that NHS Digital's Information Governance module has been reconfigured to meet accessibility specifications as well as changes made to ensure that the module is Apple compatible.

67. The new strategy, purpose, vision and values and their associated behaviours have now been launched at the CEO Roadshows. The Leadership and Performance team created posters and leaflets before attending all of the Roadshows to support their launch.

68. In collaboration with Communications, two 'illustrated' engagement events will be held on 30 May 2018 to further support the embedding of the new values and behaviours across the employee journey and with a focus on the People and Culture Strategy. The outputs of these sessions will be in the form of a Z Card in an Oyster card holder using the illustrations of conversations across each of the areas. The morning session will focus on the employee journey and the afternoon will be values and behaviours. The sessions will also be used as an engagement event for the People and Culture Strategy which will be refreshed in light of the finalised organisational strategy.

69. The Trust's new Leadership Development Pathway was also promoted at the CEO Roadshows and plans for the first cohort of the Visible Leader are underway with the Paul Woodrow/Facilitators with a planned start date of 23 July 2018. The other elements of the pathway continue to be developed and new sessions for Management Essentials will launch from June onwards. To ensure staff are equipped as LAS Leaders we are also working in collaboration with Finance and Quality directorates to incorporate sessions on the Carter Review / Best Value and QI.

70. Heidi Maidment (Watch Manager), Bill Kelly (Incident Delivery Manager), Joanna McMahon (Resource and Planning Manager), Chris Milles (Quality, Governance & Assurance Manager) and Nick Bell (now at Welsh Ambulance Service) have recently received the NHS Leadership Academy Mary Seacole's Award in Healthcare Leadership and there success was celebrated on the Pulse. Another presentation for 9 members of staff is also being arranged in June.

71. Also of high interest at the CEO Roadshows was support around development and career pathways. Alongside the Leadership Development Pathway, we have discussed a number of Professional Apprenticeship Pathways and will now be launching quarterly career clinics starting on 13 and 14 September 2018 where we, alongside other directorates, will be available at venues to be determined to discuss career pathways, development and other opportunities open to them.

72. The Re-Think team have completed their Training Review and have met with stakeholders across the organisation observing Induction, training events and CSRs. Meetings have been held around the processes, systems and delivery methods/regularity for all learning and education opportunities across the Trust and the review outcomes presentation and recommendations have been presented to an Executive group on 16 May 2018.

73. Cohort one of Coach to Lead was completed in April 2018. The action learning set to support this will take place in June 2018. The programme is being evaluated and received very positive feedback:

> *"I found the course informative and extremely useful. An insight into Coach to lead would I believe give station managers a grounding of how to approach the not so nice side of management, for example MAP".*
>
> *"Coach to lead made me think about the way I deal with situations. I have had some PDR meetings and have touched on the diamond theory to get staff to open up. Using coaching helped the conversation flow a lot easier and I didn't feel I was 'pulling teeth."*

74. An abridged version of Coach to Lead will become a workshop in the LAS Leadership Development Pathway's Management Essentials in the form of a half day workshop - Coaching Conversations. Work will also be undertaken with NHS Elect to ensure their

Coaching modules within the Engaging Leader and Visible Leader elements align with coaching models used.

75. A Coach to Lead "Train the Trainer" pilot was delivered over two days - 2 and 4 May for EOC. There were eight attendees present on each day. Discussions are currently taking place between Leadership and Performance and EOC on how the learning materials can be incorporated into EOC work based learning modules.

76. A supervision session for EOC has been created to enable employees to reflect on practice with the objective of building resilience. Two sessions have been facilitated on 2 and 15 May respectively with a third one being delivered on 24 May. Feedback included:

> "*Thank you again for your time and support to colleagues of the EOC management team. Feedback has indicated "There were some good discussions had."*
>
> *"Thank you I found the session surprisingly refreshing."*

77. The Sponsorship Mentoring programme has been advertised and has received applications from a wide range of staff. Applications for mentees will be launched in June 2018 once day 1 of the mentor training is complete. The plan for the Reverse Mentoring project is being currently being scoped and will be finalised at the end of May.

78. Appraisal completions were at 88.24% at the end of April and the continued improvements are attributed to the focused collaborative support from across the organisation terms of updating, reporting, monitoring and support.

79. The appraisal audit analysis is now underway and a draft paper outlining the results and any recommendations will be finalised by 25 May 2018.

80. PDR Appraisal training for both managers and staff continues to be delivered supporting them with the current PDR Appraisal system. Due to the changes to values/behaviours, temporary changes have been made to paperwork to ensure continuity whilst we are awaiting a new branding template to update all PDR paperwork.

81. We are progressing the viability of using MyESR's functionality for e-Appraisals with a demonstration delivered by the MyESR team on 17 May followed by a visit to NHS England on 5 June 2018. NHSE implemented e-Appraisals through ESR across their organisation. If MyESR proves unsuitable as a system further systems will be scoped/costed with additional resource requirements outlined to ensure we are still able to capture key information required for reporting/Workforce Dashboard as well as meet the necessary gateways for Pay Progression under the terms of the new Agenda for Change Framework Agreement.

82. The Corporate Induction improvement plan continues with the current weekly format to be replaced by a fortnightly induction at a central location. Learning and Development are collaborating with Recruitment, EOC and Clinical Education to progress this alongside use of better technology with IM&T. Temporary changes to presentations have been made until new branding templates are available to ensure we have the relevant information on vision, purpose, values and behaviours for new starters. Once the logistics has been planned and is working, focus will then turn to content and removal of non-essential sessions to focus on the new starter's on-boarding to the organisation.

83. We have commenced work on the options of enabling pre-employment StatMan training to ensure key subject areas are delivered prior to start dates. It is confirmed that this can be achieved via MyESR but we need to resolve potential issues with our TRAC recruitment system.

84. A full review of staff immunisation was undertaken, this is phase 1 of a three stage audit, review and update and was completed in April.

85. Following the audit process, the vaccination programme commenced across all roadshows, at this stage due to the sheer numbers of staff that were seen and the associated paper work, we still await an update from PAM our OH provider on how many staff have been seen.

86. Additionally, we have carried out a pilot to establish the most successful methods of vaccinating front line staff at Brent, where over 70% of staff now have full immunity and this week we have started a similar project in Bromley. It is felt across both stations the most successful method is ahead of shift starts and at hospitals to capture staff during their patient handovers.

87. The final stage will include a targeted approach focussing on the most proactive stations, whom following roadshows have made contact to get their staff vaccinated, these include Fulham, Greenwich, Hanwell, Hillingdon, Homerton, Islington, Newham, New Malden, Wimbledon

88. There will of course be other sites added to this and a schedule will be prepared by the end of May.

89. The immunisation project is due to be completed by September 2018 and is being delivered within the cost envelope of the PAM OH Contract.

90. The LAS were represented at the Talent BME Inclusion community of practice in April which both the Head of Talent and Diversity Lead attended. This is led by the NHS London Leadership Academy to help NHS organisations in London work together on WRES actions.

91. April saw the LAS represented at a range of recruitment/ engagement events including;
    - Public Services Careers Day at Wembley Fire Station on 7 April 2018
    - London Science Technology Event Wembley on 18 April 2018
    - Kennington Job Centre Plus Employers Event 25 April 2018
    - The London Jobs Show, Westfield Shepherd's Bush 27 & 28 April 2018

92. In preparation for the upcoming Interview Skills Workshop on 24 May, being run for BAME staff, the Diversity Lead has shadowed LAS Paramedic and TEAC interviews. This work is being carried out to ensure that we are able to offer suitably diverse interview panels for all front line and corporate roles.

93. As part of our WRES development work we will be reviewing and revising our WRES Action Plan for 18/19. A stakeholder engagement event is planned for 2nd half of July 2018 (diary planning underway for CEO and Chair attendance).

94. We are delighted to host a visit from Sheffield University who will be facilitating a BME focus group on 18 June 2018 as part of their review of the effectiveness of WRES nationally. We will receive a case study report for us to use in the further development of our own Action Plan.

95. Following appointments to the key 'Heads of' positions in the People and Culture Structure, the senior leadership team is now in place with two interim appointments. Lorna Campbell has joined the team as interim Head of Engagement and already has a busy work programme underway and planned.

96. Recruitment to the new post of People and Culture Business Partner is underway and a development opportunity for an existing member of the team has been finalised to allow an existing HR Manager to step up and immediately give support to the significant number of change programmes underway.

97. An engagement session with current HR managers to explore the move to the Business Partner model is planned for 6 June and broader stakeholder event(s) are planned over 2 dates later in June to include senior functional and Operational managers. Following agreement of priorities through the business planning process, the team are supporting a number of restructures and reorganisations across Operations, EOC, Medical, and Strategy & Communications

98. Discussions are planned with GMB and Unison to agree the principles that will guide the development of the new partnership framework. Agreement form both unions to undertake a membership audit, facilitated by ACAS, is complicated by the GDPR and ACAS will present a protocol for completing this work for agreement by all parties.

99. A considerable amount of work has been carried out to support teams across the organisation to develop and start to take forward their Staff Survey Action Plans. Many Champions attended the recent CEO Roadshows and reporting on progress will now commence with the Executive team supporting the operational teams in their 'buddy' sector to both challenge the effectiveness of identified actions and to deliver those that have been included in the Action Plans. We have an Interim Manager, Delia McMillan, who is funded to 30 June 2018 who is working on the project and who has enabled it achieve its current level of activity.

100. Work has continued with the implementation of the Associate Ambulance Practitioner Apprenticeship Standard programme across the TEAC training with 3 cohorts and a total of 33 candidates to date.

101. We have set up and are now implementing the data return systems to ensure timely repayment of Levy funds and have completed the recruitment of an Apprenticeship Co-Ordinator to facilitate this.

102. Work has started to identify cross Service Apprenticeship opportunities - including IM&T, Procurement, and Vehicle Maintenance. This is in addition to discussions around NETS and Leadership and Management.

103. The Apprenticeship Lead, Anna Byers, is working with the Procurement team to identify training provider partners for the delivery of Functional Skills (English and numeracy at Level 2 for all Apprenticeship candidates who do not or cannot evidence that they already hold these qualifications. This is mandatory for all Apprenticeship Standards at Level 3 or above).

104. An important part of the project for TEACS is a focus, with the Clinical Education Team to ensure the Service is OfSTED 'ready'. An OfSTED visit can be expected at any time now that we have a live programme in place.

Strategic Assets and Property

105. In April the Director of Strategic Assets and Property attended the NHS Improvement Operational Productivity Ambulance review, (Carter) this included the benchmarking of ambulance services around procurement, make ready, fuel and fleet. With this initiative being NHSI lead, input has been received from all ambulance trusts, and provided the trust with an opportunity to understand the synergies and potential opportunities available.

106. Engagement with NHSI regarding the Naylor Review around sustainability and estate metrics, using the opportunity to network and forge relationships through NHSI as the estates team are quite separate from the Carter team.

107. Attendance, in conjunction with Finance, at the NWL STP where capital is being made available for fleet, estates and IMT related projects. This was an opportunity to understand what bids are being put forward from this sector both within primary care and acute trusts. The NWL STP are keen that we are included especially as there is separate funding available for ambulance trusts. As NWL STP are our commissioning lead they have suggested that we make our submissions through them.

108. Together with IMT the navigational system project is being tested in our ambulances to enable better integration between the two teams which will assist the roll out of the new ambulances.

109. The director has undertaken the SRO role for the Ready Set Go programme from the Medical Director, as this project is now in the delivery phase.

110. The landlord of Maritime House has agreed to let an additional floor to house NEL 111. This building currently houses our training provision, by encouraging this approach we are able to support the tight timescales for mobilisation and encourage better utilisation of space through the sharing of facilities.

Communications

111. I held a series of 23 roadshows across the Service at the end of April and beginning of May, which were attended by more than 1,000 members of staff. At each meeting, I gave an update on key developments since the last round of roadshows in the autumn and presented details of both our new strategy and our new vision and refreshed purpose, values and behaviours. There was then a chance for staff to discuss what I had said and ask questions on any subjects. There was a very good level of engagement at all the meetings, with a lot of constructive discussion and debate on a wide range of issues. We have taken away a number of actions to follow up and feedback on, and I will be holding a second round of roadshows this autumn

112. There were high levels of social media engagement during the London Marathon on 22 April as a result of proactive work undertaken by members of the media team:
    - Twitter had a total of 316,834 impressions and 14,793 engagements
    - Facebook secured a total of 33,923 reach and 906 reactions
    - Instagram received a total reach of 28,025 and 3,054 Likes

113. ITV have filmed interviews with three members of staff who were awarded the Emergency Lifesavers Award at the NHS Heroes Awards on 14 May. The Awards will be broadcast on ITV 1, on 21 May.

114. Channel 4 News interviewed Assistant Director of Operational Service Improvement, Stuart Crichton, about our use of the Coordinate My Care app: https://twitter.com/Channel4News/status/991061959566086144

115. Following a conviction for assault on our paramedics, there was an article in the Evening Standard that coincided with the assault on emergency workers' bill reaching report stage in Parliament.

116. Safety and Risk Advisor, Martin Nicholas, represented the Service at the HSJ's latest roundtable discussion on workplace violence in the NHS (to be covered in the HSJ in June).

117. At the request of NHS England, a number of colleagues were involved in the NHS Tea launch event 70 days out from the NHS' 70 year anniversary on 5 July.

118. The communications team participated in a multi-agency exercise on 12 May, liaising with Gold to test our response on communication issues.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Annual Accountability Statements			
Agenda item:	08			
Report Author(s):	Tom Stevenson, Strategy and Communications			
Presented by:	Jamie O'Hara, Director of Strategy and Communications Philippa Harding, Director of Corporate Governance Lorraine Bewes, Director of Finance and Performance			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Board is requested to approve the Annual Accounts, Annual Government Statement and Annual Report. These are being considered in detail by the Audit Committee at its meeting on 24 May 2018. Any amendments following this meeting will be tabled at the Board meeting.

Recommendation(s):

The Board is requested to approve the Annual Accounts, Annual Government Statement and Annual Report.

Links to Board Assurance Framework (BAF) and key risks:

Risk 219 - Failure to maintain an effective financial control environment could lead to poor decision making and the waste of public funds.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☒
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐

Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Amendments to the Annual Governance Statement and Annual Report for 2017/18			
Agenda item:	08			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Previous drafts were presented to the Audit Committee on 16th April 2018 and 17 May 2018			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

The Board is requested to note the following changes to the Annual Report & Annual Governance Statement.

Annual Report
Page 1 – Chair's foreword to be added to in order to reflect the Trust's removal from Special Measures
Page 1 and 2 – Garrett Emmerson, Chief Executive, name spelling to be corrected
Page 9 – Patients' Forum section to be amended to reflect that it is a body that is independent of the London Ambulance Service NHS Trust
Page 12 – Freedom to Speak Up information to be added in, as per Annual Quality Account
Page 24 – Patricia Bain, Chief Quality Officer salary should be in range £120,001-£125,000.
Page 26 – Note added '*** The Trust is waiting for NHS Pension Agency to supply the pension information for Fenella Wrigley'.
Page 29 – Table 2 New Off-Payroll engagements is correct – Removed statement 'Needs to be completed'
Page 30 - 11.3 Staff sickness – figures added 11.7 same as last year.

Annual Governance Statement
Page 1 – Changes to management structure to reflect the fact that it is the Chief Executive's statement
Page 2 – Charlotte Gawne, Director of Communication left the service in June 2017.
Page 2 – Karen Broughton, Director of Transformation, Strategy and Workforce left the service in September 2017.
Page 2 – Sally Herne's name to be included as the Trust's Improvement Director, together with the fact that she left the Trust at the end of March 2018.
Page 7 – Table to be removed and replaced with a summary of the audits undertaken and the assurance ratings received for each.
Page 9 – GDPR section to read "A review of the Trust's compliance with the new General Data

Protection Requirement (GDPR) has been undertaken. Key actions have been taken in line with guidance from the Information Commissioner's Office. Further work and appropriate programme management arrangements are required to ensure full compliance as soon as possible."

Recommendation(s):

The Board is asked to note the changes.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service
Annual report 2017/18

Draft v0.04

Contents

Document version control

Version	Comments	Date
V0.01	First draft by communications	28/03/2018
V0.02	ELT & Board/Audit committee 1st comments	23/04/2018
V0.03	NHSI draft submission	24/04/2018
V0.04	For Board review (May)	24/05/2018
	Final for publication	

1 Chair's foreword

As the demand for health services in London continues to grow the London Ambulance Service (LAS) has a significant and increasing role in working collaboratively with the rest of the health sector as well as the Metropolitan Police Service and London Fire Brigade to meet the needs of the population of London including those who visit and work in the capital. I am pleased to be able to report that over the last year the Trust has made significant progress in the quality of the services it provides, the range of services it provides and in meeting the new Ambulance Response Programme targets. This has been achieved under the leadership of our new Chief Executive, Garrett Emerson and his Executive Team whom I am delighted to introduce to you through this report.

Alongside this, 2017/18 was a challenging year for the NHS and London's emergency services. Our people have had to cope with increased demand and the horrors of terrorism and the Grenfell Tower fire. I am extremely proud of how the Service and all our staff have risen to these challenges and on behalf of the Board offer our heartfelt thanks to them. We continue to work closely with London's other emergency services to make sure we can respond effectively to major incidents; as they occur.

One area of work we want to progress further is our efforts to build a workforce that more accurately reflects the diversity of the patients we serve. We have a detailed action plan to deliver on the Workforce Race Equality Standard and saw some important progress in the last year. I was delighted to welcome Amit Khutti to our non-executive team in November 2017, and through the year we have been running targeted recruitment in Black and Minority Ethnic (BME) publications; holding regular BME network sessions; and in October 2017 we re-established our equality committee. I'm also very excited to see a new sponsorship and mentoring pilot launch in May 2018. We hope it will support BME staff from bands 5-7 to develop their careers further within the Service.

ADDITIONAL SECTION TO ADD FOLLOWING CQC RESULT

Alongside these changes we have also developed new and exciting strategies to enable the Trust to develop our services and staff, and work with other providers to better meet the needs of the population we serve embracing both new technologies and roles for our staff.

Heather Lawrence OBE,
Chair

2 Chief Executive's foreword

I would like to echo Heather's thanks to all our people for their continued commitment. Since joining the Service in May 2017. I have become immensely proud of what we do and the amazing work our people do, day in and day out, for our patients and Londoners in general.

For most people, their only contact with our service is with the 999 and 111 call handlers and the paramedics responding to incidents. However, having been out and about meeting teams, I can assure you it is a huge collective effort. We could not do what we do without the commitment of all our support teams, from fleet and logistics teams who keep our vehicles on the road and equipped with all the kit the crews need, to estates, people, IM&T and many others.

In 2017/18 we again saw increasing numbers of calls to 999 and 111. In addition, the winter pressures have been the toughest the NHS has experienced in many years. Despite these pressures we have performed well and have consistently ranked in the top three or four ambulance trusts across the country for our response times.

Our performance against quality indicators has also been strong as our full Quality Account shows (available on our website). In 2017/18 we have established a strong grip on our quality performance and processes. We have addressed most of issues raised by our previous CQC inspection and have robust plans to continue improving. Alongside good performance in the care we provide we also finished the year in a strong financial position with a small surplus of £5.7m.

We have also established a clear direction for the future. We are clear that we have an essential role in improving the quality of emergency and urgent care services across London. Our strategy for the next five years identifies three themes which will improve patient care and value for money.

We want to develop an integrated clinical assessment and triage service to coordinate the flow of patients through urgent and emergency services; making it as easy as possible for people to get the help they need.

We will continue to provide high quality care to everyone who contacts us, especially those most critically ill and injured. However, we will place a stronger emphasis on assessment and enhanced treatment at scene and in community settings. Pilots have already proven effective and have shaped the commitments we are making in our new strategy.

Equally, as the only pan-London NHS provider, we will work with our partners to identify opportunities to provide more consistent, efficient and equitable services that benefit patients and the healthcare system.

Developing the strategy has been an important piece of work in 2017/18 and one which has involved many of our staff and external stakeholders. I would like to thank everyone who has helped to shape it and the future of our service. You can find out more in section 8 of this report and our full strategy we be available on our website.

Garret Emmerson,
Chief Executive

3 About us

This section provides an overview of who we are and what we do. We summarise the services we provide; our vision, purpose and values; and performance in 2017/18. Some of the key risks and challenges we face are set out later in the report in section 7.6.

We are the largest and busiest ambulance service in the UK and the only London-wide NHS Trust. We have over 5,300 staff and over 1,100 vehicles providing a 24/7 service for Londoners, commuters and visitors to the capital. We cover around 620 square miles and work from 70 bases. Our fleet is being constantly developed and now includes: 446 ambulances, 208 cars, 21 motorbikes and 78 bicycles.

In 2017/18 we answered 1.9 million 999 calls and attended 1.2 million incidents. Our NHS 111 service answered 356,826 calls.

3.1 Our services

Our main role is to respond to emergency 999 calls, getting medical help to patients with serious or life-threatening injuries or illnesses as quickly as possible.

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. We have a range of clinicians and vehicles to respond to less urgent situations and are providing an increasing amount to telephone only support.

To meet the emergency and urgent care needs of all Londoners we provide the following services:

- Taking and prioritising 999 calls
- 999 emergency and urgent care responses (*See and treat* support)
- Clinical telephone advice – (*Hear and treat* support; providing advice to people with less serious illnesses and injuries that don't need a paramedic to be sent to them)
- Dispatching and providing paramedics for London's Air Ambulance
- NHS 111 service for south east London
- Planning for, and responding to, large-scale events and major incidents

We provide a **non-emergency transport service**. This supports our core 999 service in transporting low priority patients to healthcare facilities when there is little or no clinical intervention required en route. The service helps free up paramedic crews to attend life-threatening calls and helps to minimise response times for lower priority patients. The service has continued to grow since being established in 2015 and at the end of 2017/18 was providing approximately 760 journeys a week.

In 2017/18 we also provided **patient transport services**, taking patients to and from their pre-arranged hospital or clinic appointments. We delivered seven contracts across London but have been in the process of handing these over to alternative providers. We stopped providing five of the services during the year and will transfer the final two contracts in April 2018.

3.2 Vision, purpose and values

Our vision, purpose and values for 2017/18 are set out below.

Vision To make the LAS great by delivering safe, high quality care that meets the needs of our patients and commissioners, and that make our staff proud.

Purpose To care for people in London: saving lives; providing care; and making sure they get the help they need.

Values

- **Clinical Excellence:** giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.
- **Care**: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.
- **Commitment**: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

As part of developing a new five-year strategy (see section 8) we have worked with staff and partners to develop new vision and purpose statements. These will be in place from April 2018.

3.3 Performance summary

The table below gives a summary of our performance in key areas. There is more detail in section 7.

	Measure		2017/18	2016/17
Activity	Total 999 calls		1,892,651	1,826,808
	Incidents attended		1,216,914	1,115,945
	Average response time - Category 1 (most life threatening incidents) 1 Nov 17 - 31 Mar 18		7.17 mins	Reporting in this area changed mid-year so is not comparable with 2016/17.
	NHS 111 South East London	Total calls	356,826	319,078
		% answered within 60 seconds	90%	94.4%
		Referrals to 999	8.2	7.6%
Money	Financial performance (year-end position)		£5.7m surplus	£6.0m surplus

Our Trust Board is made up of 14 members — our Chair, six non-executive directors, two associate non-executive directors and five executive directors (including our chief executive). The Board meets in public monthly. Dates, meeting papers and profiles of our board members are on our website: www.londonambulance.nhs.uk/about-us/how-we-are-run/trust-board/

Connect with us and find out more

To keep up-to-date with our work you can follow us on social media. We have accounts on Twitter (@Ldn_Ambulance) Facebook (@LondonAmbulance) Instagram (ldn_ambulance) and YouTube (londonambulance).

You can also find news, publications, details of public board meetings and more about what we do on our website at www.londonambulance.nhs.uk

4 Our patients

4.1 Who we care for

We care for patients with a wide range of critical and urgent conditions:

- Critical care patients are those who are most seriously ill or injured. They include cardiac arrest, heart attack, stroke, and major trauma patients.

- Urgent care covers all other conditions which need our help but are not immediately life-threatening. Examples include maternity, mental health, falls, and minor injuries

4.2 Responding to critical care patients

London has developed specialist centres to care for patients with the most critical illnesses and injuries. We now assess patients' conditions and take people directly to specialist units. Taking people directly to these centres of excellence allows them to get the best care faster; even if the travel time in an ambulance is longer than going to a local hospital.

Critical care patients include people suffering cardiac arrest, heart attacks, stroke and major trauma. They make up approximately 66% of all the incidents we attend. You can find out more about how we support these patients in our Quality Account.

4.3 Responding appropriately to urgent calls

With around 34% of the incidents we attend being urgent, rather than critical, it is essential that we provide an effective response for patients with non-life-threatening conditions. In doing so we must balance the needs of these patients with our need to prioritise ambulances attending critical incidents.

Through 2017/18 we have continued to develop our 'hear and treat' services, where urgent calls are transferred to clinicians to discuss options with the patient.

We also piloted a new service with advanced paramedic practitioners responding to urgent care calls in a car, rather than sending an ambulance with two staff. During 2017/18 the pilot service, based at Croydon, the vast majority of patients were cared for or referred to other services without needing to attend an emergency department. From April 2018 we are extending the service to two more areas of London.

The success of this service, and the growing need to offer an effective response to a wider range of non-critical incidents, has resulted in pilots of four additional pioneer clinical services being developed as part of our new five-year strategy. These will cover maternity, falls, mental health and end-of-life patients.

We have also supported a consultant paramedic to be a guideline committee member contributing to a NICE guideline recommending the establishment of further advanced paramedic practitioner programmes nationally.

4.4 Improving care

Throughout 2017/18 we have been working hard to improve both patient experience and quality of care. Below are a few examples and you can read more in the news section of our website.

Improving hospital handover times

We have worked extensively with hospitals across London to improve handovers between our crews and hospital teams. The work aims to ensure the safety of handovers whilst also reducing the time it takes our crews to be ready to respond to further calls.

The work includes ensuring we are taking patients to the right locations to avoid delays and identifying those patients who are well enough to wait in a chair once they arrive at an emergency department.

For the most seriously ill patients we began piloting a new system of monitoring their condition when handovers are delayed. The system involves a standard set of observations which are repeated at regular intervals until the handover is complete.

Our work on hospital handovers has been recognised as outstanding practice and has played a significant role in reducing waiting times for patients.

Improving our vehicle preparation

The quality of our vehicles and the equipment they carry is essential to providing high quality care to patients. We have made major improvements in this area and have been recognised with a national award in November 2017 for our Vehicle Preparation Gold Service.

The project has now rolled out with 14 hub sites with over 300 people working through the night to keep our fleet on the road. Every night up to 300 ambulances are cleaned inside and out then all 450+ items of medical consumables are checked and restocked as needed. Ambulances are then refuelled and returned to their bases for the start of the next shift.

The work has kept an average of 13 more ambulances on the road each day and has reduced the number of hours ambulances are out of service due to missing equipment by 72%.

Next steps for the programme including extending it to all vehicles including our fast response cars and non-emergency transport vehicles.

Connecting clinicians to essential information

We have now rolled out nearly 4,000 iPads to frontline staff, giving them better access to information whilst with patients. Three applications have been rolled out so far, with more planned for the future:

- **Coordinate my care** – a system that empowers patients to be at the centre of their care, documenting plans and wishes particularly around urgent care.

- **MiDOS** – a digital directory of local services commissioned by the 32 London clinical commissioning groups and tailored to our specific needs.

- **JRCALC** – a clinical guidelines application giving access to an intuitive system supporting clinical decision making with access to up-to-date and relevant clinical guidelines.

Being able to access information from a wide range of clinical systems used by hospitals, GPs, community and mental health services is key to allowing us to provide patients the best care and experience. We are working closely with NHS England, NHS Digital and the pan-London NHS community to develop an electronic patient care record. Our aim is to act as a beacon to promote interoperability across systems for collaboration and sharing of key data.

Cardiac Arrest trials

In January 2018 we began working on a trial supported by the British Heart Foundation. Currently, we transport patients who have had a cardiac arrest caused by a heart attack directly to specialist Heart Attack Centres. Those who suffer a cardiac arrest but who do not have any clear evidence of a heart attack are transported to the nearest Emergency Department. Some experts believe that all patients who have had a cardiac arrest might benefit from being taken directly to a Heart Attack Centre. This randomised trial is looking to answer that question. The trial will run until 2020 and will involve 860 patients.

Positive incident reporting

In early 2017 we launched positive incident reporting as a new way for staff to report good work. During 2017/18 we saw a steady rise in reports with over 50 received during the year. The reports have highlighted good practice in both clinical services and our support teams. We use the reports to identify why and how things go right and explore whether we can replicate it throughout the Service.

Physician Response Unit (PRU)

In 2017 we launched a pilot with London Air Ambulance and Barts Health NHS Trust which has a senior emergency doctor and an ambulance crew member responding to incidents in a car. The PRU carries advanced medication, equipment and treatments usually only found in hospital such as instant result blood tests, urine tests and sutures to stitch serious wounds. This means patients can be treated where they are, avoiding trips to hospital.

Of 652 patients treated by the PRU during its first 111 days of extended service 449 patients were treated in the community. Of these, 312 would otherwise have been taken to the emergency department at hospital. The pilot has shown overwhelmingly positive patient feedback, easing of pressure on busy emergency departments, and significant savings for health services; £411,000 was saved in the first 111 days.

4.5 Patient and public engagement

Insight project

In 2017/18 we continued to develop our Insight project which is working with patient groups to co-design service improvements. We have established and maintained positive relationships with patient groups for sickle cell disease, COPD/respiratory disease and personality disorders. A key success of the project is enabling patients to feel heard, in particular through patient involvement in staff training. All three groups have helped to develop training materials now in use across the Service. We have learnt valuable lessons about how to do this kind of patient engagement well and are now talking to NHS England about how we can share our learning with other parts of the NHS.

Patients' forum

The patient forum plays an important role with representatives from the forum sitting on all of our governance committees and running their own monthly meetings; regularly attended by 20-30 members. Patients' Forum members also meet regularly with senior LAS colleagues, our commissioners and other key stakeholders such as the Care Quality Commission, to highlight areas of good practice and areas where development is required.

The forum has been directly involved in the development of the LAS Academy. Together with staff from the Academy, they have formed a Patient and Public Involvement Panel, and attend steering group meetings. They have developed a teaching programme detailing patient and public involvement in the Academy's syllabus and take part in assessment centres for the recruitment of students.

Community engagement events

We are committed to supporting a wide range of patient engagement and public education events. In 2017/18 we received 654 requested to attend events and were able to join 506 of those. This is thanks to the ongoing support of over 1,200 staff on our volunteers database, with over 300 individuals taking part in multiple events, often in their own time.

We also have four part-time Public Education Officers who continue to focus mostly on activities involving children and young people, such as awareness sessions on the dangers of carrying knives and of using alcohol and other legal highs; careers with us; and multi-agency road safety events such as Safe Drive Stay Alive and Biker Down.

One of the Public Education Officers led a pilot of a scheme which involved all the blue light services attending schools in the London Borough of Haringey. Pupils participated in a range of sessions, rotating between them during a school day. The London Ambulance Service sessions focused on the consequences of carrying knives, and CPR (basic life support) training. The pilot has been evaluated and shown to be highly effective. A bid is now being submitted, with the aim of rolling out the scheme to other London boroughs.

4.6 Friends and Family Test

We collect Friends & Family Test responses from Patient Transport Service and *See & Treat* patients. The total number of responses received in the year 2017/18 was 334. Although the response rate remains low, almost all patients said they would be "extremely likely" or "likely" to recommend our services to their friends and family if they needed similar care or treatment.

5 Our people

We employ over 5,300 staff in a wide range of roles. The majority, 89%, are patient facing including roles treating patients and taking 999 and 111 calls. We have several different emergency clinical roles including consultant paramedics, advanced practitioners, paramedics, trainees, and students. We have also expanded our clinical roles to include mental health nurses, increased numbers of Advanced Paramedics, GPs and pharmacists.

Our workforce is 55% male and 45% female with an average age of 40 for men and 37 for women. Approximately 13% are from Black and Minority Ethnic backgrounds and 1.9% have identified themselves as disabled. The average length of service is 9.4 years, though we have over 700 staff with more than 20 years' service.

5.1 Diversity and equality

At the end of 2017/18 we had 13% of staff from BME backgrounds. This is the same as in 2016/17 and remains significantly below BME representation in the London population (45%) and the wider NHS workforce in London (41%). We are committed to improving this position in the years ahead and have a dedicated action plan linked to the Workforce Race Equality Standard (WRES).

Progress in 2017/18 includes:

- Co-designed a revised WRES action plan with staff in June 2017.
- Regular BME staff engagement events with focus groups and round table events to understand the experiences of our staff and inform our WRES action plan. In December 2017 we also launched a series of lunch and learn sessions looking at our equality challenges.
- Targeted recruitment work to increase the number of BME applications including specific advertising in BME publications and talking to BME communities about career opportunities.
- Recruited our first BME associate non-executive director, Amit Khutti, in November 2017 through the NEXT Director scheme.
- Developed a sponsorship and reverse mentoring programme to support the career development of BME staff at bands 5-7. The pilot begins in May 2018.
- Re-established an equality committee in October 2017.

Performance against WRES indicators:

In 2017/18 we reported against eight of the nine WRES indicators (up from seven the previous year). The position across all indicators remained largely static through 2017/18. The indicator we are not currently able to report on is "relative likelihood of staff accessing non-mandatory training and CPD". We aim to have reporting in place for this during 2018/19.

During our Care Quality Commission (CQC) visit in March 2018 the inspectors spoke with members of the BME network to find out about their experiences working in the Service.

5.2 Recruiting new people

In 2017/18 we recruited over 600 frontline staff covering paramedic, emergency ambulance crew roles and our 999 and 111 call handlers. Our overall vacancy rate at 31 March 2018 was 6%; a slight increase from our year end position in 2016/17 (5.1%).

We have recruited over 100 UK graduate paramedics and continue to work with universities to make our service the employer of choice for students.

We also recruited over 100 emergency medical dispatchers (call handlers), and essential role where we have had significant vacancies in the past. Offering new part-time roles, increasing starting salaries and improving our assessment processes has helped to fill vacancies against an increased establishment for this role.

We have developed a 5-year workforce plan to manage staffing and protect against shortages. The plan includes: ensuring our talent search covers the expanding range of clinical roles we are developing; dynamic workforce modelling and planning across all roles; engaging with students and paramedic graduates across the UK and building stronger relationships with our four partner universities.

5.3 Retaining, developing and supporting our people

We want people to stay with us and develop their skills and careers. Our retention rate has been stable during the year with 10.8% turnover in 2017/18 and we have plans to reduce this further in the years ahead.

We are doing lots to improve our offer to staff with a wider range of non-pay benefits; introducing lease cars and cycle schemes and enhancing our occupational health service to improve the health and wellbeing of our staff. Other important work includes:

Appraisal

To ensure we remain focussed on continuous development for our people we have made sure we achieved out 85% appraisal target this year. Making sure people have an effective appraisal is key to identifying career aspirations and development opportunities. It is also part of ensuring we are a well-led organisation with line managers at all levels committed to supporting their teams to develop. Effective appraisals also help us to provide a training offer that meets the needs of all our people. We are carrying out an appraisal audit and will be identifying further improvement actions during 2018/19.

The LAS Academy

We launched our internal academy in 2016 to help more of our people develop their careers and become registered paramedics, and we have continued to provide access to this program by increasing the placement opportunities on the program and partnering with other providers to support several pathways.

The LAS bursary programme has resulted in 650 staff enrolled into further education programs, supported by Health Education England investing over a million pounds.

Coach to lead

To support our people strategy and encourage a coaching style of management we have piloted Coach to Lead, a two-day programme supported by action learning which gives staff practical coaching skills to develop their leadership style. Evaluation on this programme has been very positive.

Induction

Helping new staff to settle in is vital to ensuring people can succeed in their jobs. We have reviewed our induction programme and have an improvement plan focussed on locations and frequency. An internal stakeholder group has also been set up to review content to make sure everyone gets a timely and effective induction.

Emotional and mental wellbeing

The work our people do can be very stressful and emotionally challenging. We continue to work hard to provide support both to prevent and treat mental ill health. We have a network of peers trained to support colleagues through our LINC Worker scheme and have dedicated counselling available as part of our occupational health services. We also have access to the Mind Blue Light programme which offers confidential, independent and practical support, advice and signposting around mental health and wellbeing, for emergency service staff, volunteers and their families.

Freedom to Speak Up Guardians

Freedom to Speak Up Guardians were introduced in every NHS trust as a result of recommendations in the Francis Report. They are an important part of building a culture of openness and continuous improvement; where we learn from and act on feedback from our people. Feedback continues to be positive about the role and in 2017/18 nine concerns were reported through the Guardian. You can find out more about the work of our Freedom to Speak Up Guardian in our Quality Account.

5.4 Recognising our people

Our annual staff VIP awards continues to recognise the great work of individuals and teams across the service. In 2017/18 there were over 350 nominations across the 11 categories. Throughout the year our staff have also received numerous external awards and praise for the fantastic work they do. Below are a few highlights from across the year.

April – June 2017

- Over 100 letters of thanks from the public, politicians and royalty plus a special mention in the Good Morning Britain Health Star awards; recognising the dedication of staff during the Westminster terrorist attack in March 2017.

- Paul Smith, Sector Delivery Manager, honoured by HM The Queen at Buckingham Palace and presented with the prestigious Queen's Ambulance Service Medal.

- Christina Long, Romford Senior Paramedic, named 'Employee of the Year' at our third VIP Awards ceremony. John Waugh, Homerton Clinical Team Leader, came second in the voting, and David Gordedo, Incident Response Officer, was third.

July – September 2017

- Our safeguarding team were shortlisted in the Education and Training Category at the Patient Safety Awards for their "Dementia Care matters in the Ambulance Service" project.

- We won in the "Best Staff Travel Benefits" category at the Employee Benefits Awards, recognising effective use of benefits for staff travel and car schemes.

- Our mental health nurses team, were shortlisted in the Emergency and Critical Care category of the Nursing Times Awards 2017 and the Innovation in Mental Health category of the HSJ Awards

October - December 2017

- Cycle paramedics recognised by metropolitan police for working with police officers on evening shifts treating revellers in the Christmas party season.

- Emergency Medical Dispatcher Emma Venosi shortlisted for the IAED Dispatcher of the Year award.

- Our Fleet and Logistics Team won the 'Supply Chain Strategy and Design' category of the Logistics and Supply Chain Excellence Awards for their work in our Vehicle Preparation Project

January – March 2018

- We were shortlisted with London South Bank University in the Student Nursing Times Awards for Student Placement of the Year: Community.

- Our Emergency Operations Centre was re-accredited as a Centre of Excellence (ACE), just one of three accredited centres in England, and was shortlisted for Team of the Year at the Control Room Awards 2018.

- We were recognised alongside colleagues from the Metropolitan Police and the London Fire Brigade at the Global Awards.

We also continue to recognise the day-to-day contributions of staff through internally publishing the names of all those who receive a letter or message of thanks and long-service milestones.

5.5 Staff survey results

A total of 2,664 people completed the 2017 staff survey – which is 53.6% and our highest ever response rate. Overall, results are similar to 2016, despite a year full of challenges and significant change. They reflect a consolidation of lots of positive work over the last three years which has seen significant increases in staff satisfaction. Some key results are listed below. Our Quality Account 2017/18 provides a more detailed analysis and the full results are available online.

Significant improvements in 2017 include:

- Error reporting
- Positivity about work
- Mandatory training

Results which are lower than last year include:

- Staff involvement
- Recognition
- Senior manager visibility

Other areas for development include health and wellbeing, staff development and incidents of physical violence. To respond to the 2017 survey results, we have established a network of staff survey champions who are driving forward improvement actions. Champions met twice in February and March 2018 and will work as a group to support ongoing action.

Key commitments that we will follow through with include: improving occupational health support; rostering; rest breaks and our ability to get front-line crews off on time at the end of their shifts; relieving the pressure on staff in our control rooms (particularly in relation to call handling) by continuing to recruit to vacant positions and; making sure all staff in all parts the business feel valued and respected.

5.6 Volunteers

We are grateful to all our volunteer responders who give up their time to support our teams. We have three different types of volunteer responder:

- **Emergency responders** – 131 clinically-trained volunteers responding on blue lights alongside ambulances to 999 calls.
- **Community first responders** – approximately 150 defibrillator-trained St John Ambulance volunteers responding to 999 calls in their own car alongside ambulances.
- **Volunteers at public-access defibrillator sites** – People who work at the 750+ public locations with defibrillators and are trained to respond to emergencies and use the machines while an ambulance is on the way.

Crucially, all these volunteers carry or have access to defibrillators; a machine that can restart the heart when it stops beating. Early use of a defibrillator doubles the chance of survival for cardiac arrest patients. In 2017/18, volunteer responders attended 13,261 emergencies. They were the first on scene in 7,796 of these cases.

6 Our partners

As an integral part of the NHS, we work closely with partners across London. Commissioned by 32 clinical commissioning groups and NHS England for our specialist services, we also work closely with London's hospital, mental health and specialist trusts, as well as the five sustainability and transformation partnerships across the city. In addition, we work in partnership with the other emergency services and London's Air Ambulance.

Working with our partners, we will play a critical part in shaping and delivering the changes required to make the urgent and emergency care system more sustainable in London. Find out more about this work in our Strategy for 2018-2020, available on our website.

6.1 Blue light partners

We continue to maintain a close working relationship with London's other blue light services. The introduction of the Policing and Crime Bill (April 2017) now mandates that all three emergency services have a statutory duty to collaborate and where possible ensure that services operate in the most efficient and effective manner.

We regularly attend incidents with the Metropolitan Police Service (MPS) and London Fire Brigade (LFB). We have a dedicated joint response unit working with the police in 12 London boroughs. This service attends police incidents where clinical support is needed and provides triage, assessment and treatment. It has been very successful and in nearly 80% of cases has avoided the need for a full ambulance crew to be dispatched. There is the potential to expand this further to include the fire brigade and to provide a service to more London boroughs.

We have co-responding systems in place with the police across all London boroughs. This means that for a set of specific issues, most commonly cardiac arrest, both police and ambulance staff are dispatched. Police officers are trained in essential first aid and equipped with defibrillators and can start treatment if they are first to reach the scene. Around 32 per cent of people survive a cardiac arrest in a public place, but, with rapid access to a defibrillator and someone trained to use it, the chance of survival can increase to 80 per

cent. Through this work we have made 700 more defibrillators available across London. With police officers able to provide CPR support co-responding also frees up our crews to carry out more advanced lifesaving.

We also routinely train together and provide training and information for the police and fire brigade on advanced first aid.

During 2017/18 we supported a bid to the Home Office Police Transformation Fund (PTF) to scope the possibility of a single call handling system and centralised control room for London's emergency services. This bid secured £1.9 million for an initial scoping exercise to review the merits of a single control room for London. The scoping work starts in April 2018 and will run for 12 months.

Preparing for and responding to large scale events and major incidents

We plan for and respond to large scale events in the capital, working closely with other emergency services and partner organisations in London to save lives. Planned events include things like the Notting Hill Carnival and the London Marathon. Major incidents during 2017/18 included the terrorist attacks at London Bridge and Parsons Green, and the Grenfell Tower fire. More than 1,000 of our staff were involved in responding to these incidents.

Our responsibilities during major incidents include:

- putting hospitals in London on alert to receive patients
- setting up a system at the scene for prioritising and treating patients based on their medical needs
- treating, stabilising and caring for people who are injured
- taking patients who need further treatment to hospital.

We test our major incident plan on a regular basis both individually and in exercises with our partners.

6.2 Sustainability and Transformation Partnerships

Throughout 2017/18 we have been actively engaged in the work of all five of London's five Sustainability and Transformation Partnerships (STP). Our chief executive and director of strategy have regularly attended core meetings and we worked closely with all areas, particularly on demand management and pressures on emergency departments. We have also worked within individual STPs on a wide range of projects, including:

- Establishing new mental health pathways
- Addressing frequent caller issues in partnership with other agencies
- Attendance at safeguarding boards and child death panels
- Education package to care homes on 'when and why' to call 999 or other options

We are the only NHS trust working across all five STP areas and believe there is an important opportunity to help develop a consistent approach to emergency and urgent care across the capital. At present there is a mixed approach with a wide range of "out-of-hospital" services in place, being piloted or under development. We recognise the need for locally tailored services but also believe increased consistency would provide a better patient experience and support our staff in providing patients with the most appropriate care. We will continue working as part of all five STPs on this in 2018/19 and beyond.

7 Quality and performance

Our overall performance is measured using a range of key performance indicators (KPIs) across quality of care, response times and finances. Progress is monitored continuously by our Board, sub-committees and the management team. We report progress against these as part of our integrated performance report at monthly public board meetings and the papers are available on our website.

7.1 Quality matters

We are focused on improving the quality of our services and have come a long way in the two years since the Care Quality Commission (CQC) rating of 'requires improvement' in 2016. During 2017/18 we have delivered a comprehensive action plan and we welcomed the CQC back in March 2018 to review our progress. Their final assessment will be published on our website later in the year.

We know we have come a long way. But we also know there is more to do. Our new quality strategy, published in 2018, sets the direction for the years ahead. Through it we will focus on quality of clinical care, continuous improvement and putting patients at the centre of everything we do. Our objective is 'outstanding' CQC ratings across all our sites and services by 2020.

Quality improvements

Our full quality account for 2017/18 is published as part of our quality strategy. Some highlights from the year are listed below. You can find out more about each of these in our quality account, available on our website.

Patient Safety

- Established a new integrated quality and governance directorate, increasing capacity and capability for our quality agenda.
- Improved processes for identifying safety and quality risks.
- Improved services for mental health and end-of-life patients with specialist nurses and training for our wider clinical staff.
- Implemented a new learning and quality improvement framework with training for staff in quality improvement methodology.
- Independent review of processes for serious incident investigation and learning confirmed "significant assurance".

Patient experience

- Improved risk assessment tool for mental health patients.
- Investment in new equipment to ensure obese patients get effective dignified care.
- Improved infection control processes monitored through regular assurance visits.
- Multi-agency working to support frequent callers resulting in reduction in calls.

Clinical effectiveness

- Consistent performance against new response time targets (routinely within top 3 ambulance trusts on monthly results)
- Working with emergency departments to reduce patient handover times; significantly reducing waiting times for patients.
- Implemented a new standardised approach to ambulance-led patient cohorting across London.
- Introduced a mortality review group to identify and share learning; with information also shared with other ambulance trusts.

Our quality account also includes information on incidents and how we learn from them; the audits and research we are involved in, and our performance against Duty of Candour requirements.

Our progress during 2017/18 has been significant and has brought about much improved outcomes for our patients. We will strive to maintain this through our quality improvement plans for 2018/19 and beyond.

7.2 999 performance

The main 999 performance indicators are how quickly we reach patients following a call. The way all ambulance trusts are measured for response times changed at the end of October 2017. Below is a summary of our performance in the two periods (April 2017 – October 2017 and November 2017 – March 2018).

999 performance April 2017 – October 2017

Total 999 calls

All 999 calls are given a category. Up to October 2017 category A was the high priority incident and was sub-divided into Red 1 and Red 2. Red 1 were the most time critical including cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 were serious but less immediately time critical including conditions like stroke and fits. Category C incidents were lower priority and sub-divided into four types; C1 incidents had a target response time of 45 minutes and C2, C3 and C4 had a 60 minute target response time.

The table below shows how many calls we received in each category:

Category	**04/17 – 10/17**	**2016/17** (full year)
Red 1	13,146	19,854
Red 2	348,424	590,857
C1	37,486	66,106
C2	400,367	692,775
C3	107,608	185,346
C4	150,898	271,868
Other	48	36
Total calls	**1,057,977**	**1,826,842**
Hear and Treat response	71,068	127,532
Incidents attended	655,028	1,115,981

Response times by call category

Category	National target	04/17 – 10/17	2016/17
Red 1 (within 8 minutes)	75%	73.94%	69.19%
Red 2 (within 8 minutes)	75%	70.39%	66.31%
Red 19 (within 19 minutes)	95%	94.64%	93.48%
Category C (C1 - C4)			74.5%

999 performance November 2017 – March 2018

From 1 November 2017 new national indicators for ambulance trusts were introduced. There are now four categories of incidents that we respond to. Category 1 is the highest priority and category 4 the lowest. The new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response.
- Ensure national response targets to apply to every patient for the first time – so ending 'hidden waits' for patients in lower categories.
- Ensure more equitable response for patients across the call categories.
- Improve care for stroke and heart attack patients through sending the right resource first time.

Category	Targets	11/17 – 03/18	No. of incidents
1	**7 minutes** mean response time	7.17 mins	41,107
	9 out of 10 people reached in less than **15 minutes**	11.50 mins	
2	**18 minutes** mean response time	21.56 mins	267,780
	9 out of 10 people reached in less than **40 minutes**	45.55 mins	
3	9 out of 10 people reached in less than **2 hours**	2h 39.5 mins	106,795
4	9 out of 10 people reached in less than **3 hours**	2h 34.15 mins	55,467
	Face to face incidents all categories		471,149
	Hear and treat incidents		19,806
	Total incidents		**490,955**

Comparison with other Ambulance trusts

Our performance in 2017/18 has been consistently amongst the best in the country, across both the old and new indicators. Although we have yet to fully alter our operating model to meet the requirements of the new ambulance response standards, since their introduction we have consistently been in the top three for category 1 incidents.

Winter planning and performance

Our preparations for winter pressures in 2017/18 were some of the most detailed we have ever done and helped to ensure that our performance remained strong despite very heavy pressure on our services and the wider NHS. Throughout the winter period we worked closely with NHS England, NHS Improvement, hospitals, Clinical Commissioning Groups and other providers. We ran daily safety reviews to look at and learn from all incidents and for three weeks through the Christmas period our winter planning team was working 16 hours a day. We worked with hospitals to minimise hand over times and had a representative in NHS England's "winter room" to support planning across the whole of London's NHS.

7.3 NHS 111 South East London performance

We run the NHS 111 service in South East London covering a population of 1.8 million people across Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark. NHS 111 is a telephone assessment service for people who need urgent medical help and advice but are not in a life-threatening situation. Calls are answered by highly trained advisors, who are supported by healthcare professionals, 24 hours a day, 365 days a year.

The key performance measures are percentage of calls answered within 60 seconds, calls abandoned after 30 seconds and calls which had to be referred to 999 (with fewer referrals showing better performance). The table below summarises 111 performance in 2017/18 and the previous year for comparison. We have seen a significant increase in calls with nearly 38,000 more calls in 2017/18 than the previous year (over 100 more calls each day on average and nearly 200 more on weekends). This has led to a reduction in our call answering performance but we are continuing to work to improve this.

Measure	National target	2017/18		2016/17	
Total number of calls	-	364,024		319,078	
Average calls per day	-	Weekday	868	Weekday	739
		Weekend	1313	Weekend	1,134
		Bank Holiday	1568	Bank Holiday	1,460
Calls answered within 60 seconds	95%	322,279 (90%)		297057 (94.4%)	
Calls abandoned after 30 seconds	No more than 5%	3564 (1%)		2001 (0.6%)	
Calls referred to 999	<10%	8.2%		9.7%	

Comparison with other NHS 111 providers in London

There are 5 providers of 111 services across 8 areas in London. We are consistently amongst the best performers for percentage of calls answered within 60 seconds and the lowest level of abandoned calls. We also consistently deal with more 111 calls without needing to dispatch and ambulance or recommend A&E.

The services is rated 'good' by the Care Quality Commission. However, we continue to work to make improvements in specific areas. Since April 2017, we have more than halved our vacancy rate (from 13.8% to 5.6%). We have improved team meeting processes and are improving the stability of the telephone systems.

From August 2018, we will be providing the NHS 111 and Integrated Urgent Care service for seven clinical commissioning groups in North East London.

7.4 Financial performance

Our financial performance in 2017/18 is detailed in the financial statements (section 12 of this report). Overall, we finished the year in a positive financial position with a small surplus of 1.5% of our total budget. During the year we invested £23.4m on capital to modernise our Fleet, IM&T systems and Estate.

	2017/18	2016/17
Total budget	£364.6 million	£355.5 million
Year-end surplus/deficit	£5.7 million surplus	£6 million surplus

7.5 Sustainability

We are committed to making improvements in all aspects of environmental performance, recognising that reducing our carbon impact on the environment is critical for the communities we serve, for patients, our finances, our environment, and the planet.

By introducing our new fleet preparation system (see section 4.4) we have also reduced the environmental impact of cleaning our vehicles. Water consumption has come down from 872 litres a day to 207 litres. Saving nearly a quarter of a million litres a year. The use of cleaning chemicals has also reduced from 40 litres per day down to just 7 litres.

Our fleet management team have been looking at opportunities to introduce electric and hybrid vehicles and we are exploring opportunities for joint development in this area with our other blue light partners. We currently use around 4million litres of diesel per year; so this is an important area we want to develop. We have started trials of an electric response vehicle. We are exploring electric/zero emission options for new vehicles (including motorbikes) and retro fitting electric systems into existing vehicles. We are also looking at options to move our operational managers onto more environmentally friendly vehicles.

Our vehicle replacement programme for 2017/18 has included 140 new vehicles and allowed us to introduce Euro 6 (emission standard) compliant vehicles to better meet the environmental requirements set out by the London Mayor. Our estates team have also been introducing environmental improvements and we have upgraded lighting in a number of our bases to switch to more energy efficient systems.

7.6 Risks and continuing challenges

We manage risk through our corporate risk registers, board assurance framework and risk management policy. The board assurance framework and corporate risk register are presented at Trust Board meetings, and further scrutiny is applied at Quality Governance and Audit Committees. The risk register is reviewed in detail by our Executive Leadership Team each month. Risk Management is an integral part of our approach to continuous quality improvement and supports delivery against key performance indicators. Full details can be found in our annual governance statement in section 9 of this document.

Our new five-year strategy sets out the continuing challenges we face and is summarised below.

8 Developing our five-year strategy

London's NHS continues to face substantial and sustained growth in demand for urgent and emergency care. The pressures include:

- a growing and aging population
- an increasing prevalence of acute and complex conditions
- demand from our most critically ill patients increasing at the highest rate
- a high vacancy rate for frontline staff and increased competition for staff between providers.

The rise in demand puts significant pressure on our staff and affects our ability to deliver a high-quality service. To address these challenges London needs an ambulance service with a clear emphasis on assessment and treatment at scene and able to take clinically appropriate patients to a range of services.

To deliver this we have developed a new five-year strategy, being published in April 2018. Our ambition is to be a world class ambulance service providing access to integrated urgent and emergency care 'on scene', 'on phone' and 'on line'.

A core part of our strategy is developing a wider range of services to respond more effectively to different situations. In 2017/18 we piloted an urgent care advanced paramedic practitioner service with excellent result. The strategy identifies four more *pioneer services* which we will develop for falls, mental health, maternity and end of life care.

We believe developing these services to offer a tailored see and treat response for different patients could mean over a quarter of all patients receive a specialist service that treats and discharges them on scene. Together with improved hear and treat services provided over the phone we believe this could reduce ambulance conveyances to hospital emergency departments by up to 122,000 a year. This work would reduce the burden on emergency departments and reduce the number of patients unnecessarily admitted into hospital overnight. As well as improving patient experience this could save the health system in London between £12.1m and £36.5m per year; allowing this money to be spent elsewhere.

During November and December 2017, we spent six-weeks engaging with staff, partners and patient representatives to make sure the strategy fully addresses their needs. This included over 1,600 interactions with staff, engaging with 23 stakeholder organisations including all five London Sustainability and Transformation Partnerships and face to face meetings with our Patients' Forum.

The new five-year strategy will be published on our website later in 2018
www.londonambulance.nhs.uk

9 Annual governance statement

provided separately prior to final layout for publication

10 Remuneration report

Our Remuneration and Nominations Committee consists of the Chair and the six non-executive directors. The Chief Executive is usually in attendance but is not present when their own remuneration is discussed.

The Remuneration and Nominations Committee is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits (including pensions and cars), as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirements of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 25 to 28.

10.1 Banded remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2017/18 was in the range of £200,001 to £205,000 on an annualised basis. The pay multiplier in 2017/18, based on annualised salary, was 5.61 times the median remuneration of the workforce, which was £36,504. In 2016/17, the banded remuneration of the highest paid director was £195,001 to £200,000. The pay multiplier in 2016/17, based on annualised salary, was 5.64 times the median remuneration of the workforce, which was £35,218.

In 2017/18, one (2016/17, Nil) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £245,001 to £250,000 (2016/17 £Nil).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The appointment and remuneration of the Chair and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below on the salary and pension entitlement of senior managers has been audited by our external auditors.

10.2 Salary and pension entitlements of senior managers

A) Remuneration 2017/18

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Heather Lawrence, Chair	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Jayne Mee, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Amit Khutti, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Garrett Emmerson, Chief Executive (from 30 May 2017 to 31 March 2018	£170,001-£175,000	£0	£0	£0	£0	£170,001-£175,000
Andrew Grimshaw, Acting Chief Executive (from 1 April 2017 to 29 May 2017) and Finance Director (from 30 May 2017 to 16 June 2017)	£30,001-£35,000	£0	£0	£0	£37,501-£40,000	£70,001-£75,000
Lorraine Bewes, Director of Finance (from 17 June 2017 to 31 March 2018)	£100,001-£105,000	£0	£0	£0	£0	£100,001-£105,000
Andy Bell, Acting Director of Finance (from 1 April 2017 to 31 May 2017)	£20,001-£25,000	£0	£0	£0	£12,501-£15,000	£30,001-£35,000
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£10,001-£12,500	£135,001-£140,000
Fenella Wrigley, Medical Director	£105,001-£110,000	£4,700	£0	£0	Waiting for information from the NHS Pension Authority	Waiting for information from the NHS Pension Authority
Patricia Bain, Chief Quality Officer	£120,001-£125,000	£0	£0	£0	£0	£120,001-£125,000

A) Remuneration 2016/17

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000
Heather Lawrence, Chair	£35,001-£40,000	£0	£0	£0	£0
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0
Sheila Doyle, Non-Executive Director	£0-£5,000	£0	£0	£0	£0
Jayne Mee, Non-Executive Director	£0-£5,000	£0	£0	£0	£0
Fionna Moore, Chief Executive (up to 31 December 2016)	£145,001-£150,000	£3,600	£0	£0	£0
Andrew Grimshaw, Director of Finance (up to 31 December 2016), Acting Chief Executive (from 1 January 2017)	£130,001-£135,000	£0	£0	£0	£40,001-£42,500
Andy Bell, Acting Director of Finance (from 1 January 2017)	£20,001-£25,000	£0	£0	£0	£40,001-£42,500
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£207,501-£210,000
Fenella Wrigley, Medical Director	£110,001-£115,000	£4,800	£0	£0	£202,501-£205,000
Zoe Packman, Director of Nursing and Quality (up to 25 May 2016)	£15,001-£20,000	£0	£0	£0	£17,501-£20,000
Briony Sloper, Acting Director of Nursing (from 6 June 2016 to 31 December 2016)	£45,001-£50,000	£0	£0	£0	£50,001-£52,250
Patricia Bain, Chief Quality Officer (from 3 January 2017)	£30,001-£35,000	£0	£0	£0	£0

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018
Heather Lawrence, Chair	**	**	**	**	**	**	**
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**
John Jones, Non-Executive Director	**	**	**	**	**	**	**
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**
Amit Khutti, Non-Executive Director	**	**	**	**	**	**	**
Garrett Emmerson, Chief Executive (from 30 May 2017 to 31 March 2018)	*	*	*	*	*	*	*
Andrew Grimshaw, Acting Chief Executive (from 1 April 2017 to 29 May 2017)	£0-£2,500	£0-£2,500	£40,001-£45,000	£100,001-£105,000	£630,233	£14,336	£702,771
Lorraine Bewes, Director of Finance (from 17 June 2017 to 31 March 2018)	*	*	*	*	*	*	*
Andy Bell, Acting Director of Finance (from 1 April 2017 to 31 May 2017)	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£177,933	£3,352	£199,771
Fenella Wrigley, Acting Medical Director (acting to February 2016)	***	***	***	***	***	***	***
Paul Woodrow, Director of Operations	£0-£2,500	£0-£2,500	£40,001-£45,000	£110,001-£115,000	£728,704	£31,598	£767,590
Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*

***** Garrett Emmerson, Lorraine Bewes and Patricia Bain are not members of the NHS Pension Scheme.

** Non-executive directors do not receive pensionable remuneration, there are no disclosures in respect of pensions for non-executive directors.

*** The Trust is waiting for NHS Pension Agency to supply the pension information for Fenella Wrigley.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (23).

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Table 1: Exit packages

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000								
£10,000 - £25,000	1	10,534			1	10,534		
Totals	1	10,534	Nil	Nil	1	10,534	Nil	Nil

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.3 Reporting of other compensation schemes – exit packages

	Agreements	Total value of agreements
	Number	**£000s**
Voluntary redundancies including early retirements contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring MHT approval	0	0
Total	**0**	**0**

The remuneration report includes disclosure of exit payments payable to individuals named in that report.

10.4 Off-Payroll engagements

Table 1: Off-Payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at the time of reporting.	0
No. that have existed for between three and four years at the time of reporting.	0
No. that have existed for four or more years at the time of reporting.	0

Table 2: New Off-Payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll.	0
Number of engagements reassessed for consistency/ assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

Needs to be completed.

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board member, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	11

11 Staff report

11.1 Average staff numbers

The average number of staff has increased over last year 5,138 (2016/17 5,054) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	2	2	0
Ambulance Service	2,654	2,609	45
Administration and estates	1,377	1,288	89
Healthcare assistants and other support staff	1,075	1,075	0
Nursing, midwifery and heath visiting staff	30	19	11
Total	**5,138**	**4,993**	**145**

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The “contracted hours” method is used to calculate whole time equivalent numbers, that is, dividing the contracted hours of each employee by the standard working hours.

11.2 Staff composition

At the end of March 2018, we had a workforce of 5,359 staff, made up of 2,925 men and 2,434 women. This was broken down as follows:

	Total	Female	Male
Directors	15	10	5
Senior Managers	171	64	107
Employees	5,173	2,360	2,813
Total	**5,359**	**2,434**	**2,925**

Over the course of the year, a total of 578 people left the service – a turnover rate of 10.8 per cent, compared to 9.8 per cent in 2016/17.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 206 paramedics left during 2017/18.

11.3 Staff sickness

The average working days lost in 2017/18 was 11.7 (2016/17 11.7). The data is based on calendar years January 2017 (2016) to December 2017 (2016).

11.4 Staff policies

We embrace our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve. We aim to provide

innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination, and we want to ensure that:

- patients and customers receive fair and equal access to our healthcare service;
- everyone is treated with dignity and respect; and
- staff experience fairness and equality of opportunity and treatment in their workplace.

We want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work;
- promoting and providing training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background; and
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

11.5 Expenditure on consultancy

In 2017/18 the trust spent £1.6m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Garrett Emmerson, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature:

Date:

12 Financial statements

provided separately prior to final layout for publication

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of London Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in London Ambulance Service NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

A number of changes have been made to the Trust's management structure in 2017/18, including the appointment of a Chief Executive and a number of changes to director portfolios.

Garrett Emmerson was appointed as Chief Executive with effect from 30 May 2017, at which point Andrew Grimshaw (Director of Finance) who had been Acting Chief Executive left the organisation. Andy Bell (Deputy Director of Finance) who had been Acting Director of Finance whilst Andrew was Acting Chief Executive, also left the organisation in June 2017. Lorraine Bewes took on the role of Director of Finance and Performance in July 2017. Other Executive Board members, Dr Trisha Bain (Chief Quality Officer), Dr Fenella Wrigley (Medical Director) and Paul Woodrow (Director of Operations) continued in their roles in 2017/18.

Ross Fullerton (Chief Information Officer) joined the Trust in May 2017, as did Patricia Grealish (Director of People and Organisational Development). Ross

replaced Steve Bass, who had taken on the role of interim Chief Information Officer in March 2017. Mark Hirst, interim Director of HR provided support to the Board and Executive Leadership Team (ELT) until Patricia's appointment. Sandra Adams, Director of Corporate Governance/Trust Secretary, left the Trust in April 2017 and an interim arrangement was put in place until Philippa Harding was appointed to the post in November 2017. Karen Broughton (Director of Transformation, Strategy and Workforce) and Charlotte Gawne (Director of Communications) left the Trust in xxx and Jamie O'Hara joined the Trust as Director of Strategy and Communications in November 2017. During 2017 a new post of Director of Strategic Assets and Property was created, to which Benita Mehra was appointed in January 2018. In addition, as a result of being in Special Measures, the Trust has had continued support from NHS Improvement through the role of the Improvement Director.

The Director of Corporate Governance supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the Board of Directors, for maintaining the Board Assurance Framework (BAF) that defines the principal risks to achieving the Trust's strategic objectives together with associated controls, sources of assurance and action plans. The Chief Quality Officer is the quality governance lead for the Trust. She is responsible for the Trust Risk Management Strategy and Policy and Incident Management Policy, including Serious Incidents. She is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to clinical governance and risk, up to and including the Trust's Corporate Risk Register. The holders of these two positions have driven forward a significant workplan to strengthen the Trust's risk management processes, at all levels of the organisation, from Board to station-level. This has included an increased focus on strategic risk and the BAF by the Board, ELT and Board Assurance Committees, to the establishment of appropriate Quality Assurance structures and a clearly articulated Quality Assurance Framework. The Trust's focus has been on learning from good practice in this area, both internally and externally.

In 2017 the Chief Executive launched a new approach to performance management, which ensured that Directorates and Operational sectors were held to account for delivery of objectives and improvements, including those relating to governance and quality governance. Work on the extension of the performance management framework continues into 2018/19.

Training

The Trust provides comprehensive mandatory and statutory training programme which includes governance and risk management awareness, ensuring that staff are

trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The Trust's Risk Management Strategy and Policy sets out the approach that it takes to the provision of training in relation to risk management. An e-learning package 'Introduction to Risk Management' has been developed and will be available to all staff through the Trust intranet. Staff have access to comprehensive risk guidance and advice via the Quality Governance Directorate; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities have this provided internally. Training compliance is reported to the Trust Board and Executive Leadership Team via the People and Culture Committee. The Trust Board receives training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

The Trust's mandatory and statutory training programme is regularly reviewed to ensure that it remains responsive to the needs of Trust staff. There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. A review of the Training Needs Analysis was undertaken during 2017/18 to ensure that mandatory training remains targeted and appropriate as well as manageable for staff. Despite significant operational pressures, the Trust has been able to achieve target levels of compliance with mandatory and statutory training requirements and this focus continues into 2018/19. Monitoring and escalation arrangements are in place to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

Leadership development programmes are also being developed for all staff, which will address the importance of managing risk.

The risk and control framework

Risk Management Strategy and Policy

The Trust Board approved an updated Risk Management Strategy and Policy at its meeting on 27 February 2018. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

The Risk Management Strategy and Policy provides the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the LAS is able to deliver its objectives by identifying and managing risks, enhancing opportunities and creating an environment that adds

value to on-going operational activities. The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical risks. Including but not limited to; strategic, financial, operational, regulatory, environmental and reputational risks.

The Trust's Risk Management Strategy and Policy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Risks are identified routinely from a range of reactive & pro-active and internal & external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators etc. These are appropriately graded and ranked and included on the Trust's Corporate Risk Register and Board Assurance Framework (BAF). A Risk, Compliance and Assurance Group exists to review and monitor risks added to the Risk Register and regular reports from the Corporate Risk Register and the BAF are submitted to the relevant Board Assurance Committees and Trust Board. The Audit Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process. The BAF and Risk Register has undergone significant review and amendment during 2017/18 and more closely aligned with the agenda of the Trust Board and Board Assurance Committees.

In accordance with the Trust Board's Scheme of Delegation, responsibility for the management / control and funding of a particular risk rests with the Directorate / Sector / Station concerned. However, where action to control a particular risk falls outside the control / responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the appropriate Corporate Committee, the Risk, Compliance and Assurance Group, the Executive Leadership Team or the Trust Board for a decision to be made.

Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which were reviewed and strengthened during 2017/18.

Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a culture where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. In 2017/18 the Trust appointed a full time interim Freedom to Speak Up Guardian (FTSUG) and it is in the process of appointing a substantive FTSUG,

supported by a 'hub and spoke' model of Freedom to Speak Up Advocates. The Trust's 2017 staff survey results indicate that there have been improvements with regard to the development of a reporting culture across the organisation.

Business Planning and Service Development proposals do not proceed without an appropriate assessment of and therefore recognition / acceptance of the risks involved and the involvement of the relevant expertise. The Trust's ELT reviewed and agreed the approach to be taken to quality impact assessments (including equality assessments) in December 2017. This is being adopted in the Trust's Business Planning activities for 2018/19.

The Trust's BAF is designed to assist the Trust in the control of risk. The BAF incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Information Governance Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via quarterly BAF / risk register reports and is supported by a robust Internal Audit Programme. The BAF was significantly reviewed during 2017/18 in response to the findings of the Care Quality Commission following its inspection of the Trust at the end of 2016/17.

In respect of the control of risk, ELT members individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to identify, manage and mitigate risks to compliance with the Trust's licence. The Assurance Committees of the Trust Board in turn have responsibility for providing assurance in respect of the effectiveness of those controls. A system of 'highlight' reports to the Trust Board is in place to highlight any risks to compliance. Board Assurance Committees are well attended by Executive and Non-Executive Directors as well as by other key Trust staff. A review and strengthening of the Board sub-committees was undertaken during 2017/18 to ensure that the Trust's meeting structure is able to meet the challenges to be faced by the organisation during 2018/19 and beyond.

The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust has in place a Quality Strategy which has been approved by the Trust Board. The Trust Board also agrees annual quality objectives.
- The Trust has in place a Quality Assurance Committee (a committee of the Board) which meets bi-monthly and is chaired by a Non-Executive Director. The Quality Assurance Committee is responsible for monitoring performance against the agreed annual quality objectives. The Committee provides a report of each meeting to the Trust Board.
- The Trust publishes an Annual Quality Account.

- Performance against key quality indicators are reported the Integrated Performance Report.
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Quality Improvement Programme
- As part of its Quality Assurance Framework, a programme of announced and unannounced (Executive and Non-Executive) Director Visits is also in place in order to ensure that there is 'Board to Station oversight and ownership of quality & safety issues.
- The Trust has identified Non-Executive Directors to lead in respect of specific aspects of governance and risks. These roles are reviewed annually.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient & Public Involvement (PPI) representatives (e.g. Health Watch).
- Patient and Staff Stories are presented respectively to alternate meetings of the Trust Board monthly and actions and lessons learned are widely shared.

The effectiveness of the Trust's governance structures also continued to be tested during 2017/18 via internal and external testing including internally via the Deep Dive and Annual Internal Audit Programme and externally via relevant external reviews and visits including during 2017/18 a Well Led Review by the CQC.

As a result of the CQC's inspection, the Trust's rating improved and moved to "good". The CQC was able to report that local governance arrangements had improved and that there was a higher level of awareness and understanding of the value and importance of reporting, reviewing and learning from incidents, for managing risks and performance outcomes. There are still areas that need to be improved, but this finding represents a significant improvement for the Trust.

The Trust's Head of Internal Audit Opinion was one of: 'Significant assurance with minor improvements required'. Our internal audit service's work has confirmed that, whilst some weaknesses were identified in the design of controls in the areas under review during the year, there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in the majority of key areas reviewed.

The following reviews were undertaken in 2017/18 and awarded the following levels of assurance:

#	Review	Assurance	Recommendations Accepted			
			H	M	L	Total
1	Fleet preparation	Partial assurance with improvements required	0	7	1	8
2	Procurement maturity	Partial assurance with improvements required	0	5	5	10
3	Contract management	Partial assurance with improvements required	1	3	0	4
4	Clinical education	Partial assurance with improvements required	2	2	3	7
5	Financial controls*	Significant assurance with minor improvement opportunities	0	0	3	3
6	Serious incidents	Significant assurance	0	0	5	5
7	Fit & proper person policy compliance	Significant assurance	0	0	2	2
8	Information governance toolkit	Partial assurance with improvements required	0	1	2	3
9	Non-standard payments	Partial assurance with improvements required	3	1	1	5
10	Data quality framework	Partial assurance with improvements required	0	5	3	8
11	GDPR	N/A	2	4	2	8
Total			8	28	27	63

Recommendations	Recommendations Accepted			
	H	M	L	Total
Total carried forward from previous prior year	7	20	11	38
Add: new recommendations raised during the period	8	28	27	63
Remove: recommendations implemented by 31 March 2018	(8)	(24)	(23)	(55)
Total current outstanding internal audit recommendations	**7**	**24**	**15**	**46**
Of which are considered overdue:	2	12	7	21

The internal auditors were asked mainly to review areas that members of the management team had identified as areas where internal control was possible weaker. Having confirmed this through the findings of the internal auditors, work has been undertaken throughout 2017/18 and continues into 2018/19 to improve these areas of control.

CQC registration and compliance with the NHS provider licence

During 2017/18, the Trust received announced and unannounced visits by the CQC relating to its core services as well as a Well-Led Review. No significant issues were raised in respect of these visits.

The Trust Board has assessed itself in compliance with the relevant aspects of the NHS provider licence.

The trust is fully compliant with the registration requirements of the Care Quality Commission.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board has agreed Standing Orders and Standing Financial Instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

The Trust implemented a new performance management framework in 2017/18 aligned to both the corporate and sector divisional management structure. The framework included adopting a performance dashboard including metrics based on the Carter Report recommendations and includes a series of performance metrics. The Trust Board reviews the operational, productivity and financial performance, and use of resources both at Trust and Divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the integrated quality and performance report provided to each Board meeting.

The Trust's external auditors are required to consider whether the NHS Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee. Their report is on page xx

Information governance

The Trust continues to strengthen its arrangements for Information Governance and

has the following arrangements in place:

- an Information Governance Steering Group
- an Information Governance Strategy and Policy along with a dedicated Information Security Policy;
- the Trust's was compliant with the requirements of the IG Toolkit at Level 2 by the deadline of 31 March 2018.

A review of the Trust's compliance with the new General Data Protection Requirement (GDPR) has been undertaken. Whilst the Trust will not achieve full compliance with the GDPR by the deadline of 25 May 2018, key elements are in place in line with guidance from the Information Commissioner's Office. Further work and appropriate programme management arrangements are required to ensure full compliance as soon as possible.

During 207/18, the Trust reported no serious incidents relating to information governance, including data loss or confidentiality breach.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

In addition to the monthly review of quality data undertaken through the Commissioners' Quality Review Group, the following arrangements are in place to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

Governance & Leadership:

- A Board member, the Chief Quality Officer, leads on quality and advises the Trust Board on all matters relating to the preparation of the Trust's annual Quality Account.
- The Trust's Director of Performance is responsible for providing the information and performance data which informs the Annual Quality Account.
- The Trust's Director of Performance is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate.

Policies & Plans in ensuring quality of care provided:

- Policies and procedures are in place in relation to the capture and recording

of patient data.

- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.

Systems & Processes:

- Systems and processes are in place for the audit and validation of performance data both centrally and at operational level.
- The Trust's Datix reporting system has been reviewed in 2017 and restructured, ensuring regular (weekly) validation, weekly, prior to submission to national datasets.

Data Use & Reporting:

- A monthly Integrated Performance Report which outlines the Trust's performance against key quality and other objectives including benchmarking and comparative data, and are the subject of discussion and challenge at every monthly Trust Board meeting and also informs the annual Quality Account.

The Trust has consulted with its commissioners, patients' forum, healthwatch, CCG and STP leads and Trust staff during 2017/18 in relation to the progress made on the Trust's 2017/18 Quality Strategy and to agree its 2018/19 priorities.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of deep dive and internal audit work. The BAF and monthly integrated quality and performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust's BAF and Risk Register including NED review / challenge.
- Regular risk management activity reports to the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit Committee, Finance & Investment Committee and the Quality Assurance Committee.
- The ongoing development of the BAF
- Consideration of a monthly Quality Improvement Programme report, allowing the Trust Board to monitor improvements in this area.
- The provision and scrutiny of a monthly Integrated Quality and Performance to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions. The Trust's performance management arrangements were strengthened during 2017/18 including through the introduction and embedding of Executive Performance Reviews and some changes to Director portfolios.

The validity of the Corporate Governance Statement has been provided to me by the relevant Board Assurance Committees – most notably the Audit Committee, which have considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of internal control.

Conclusion

Whilst the Trust continues to work to improve its control environment, as set out above, no significant control issues have been identified.

Signed……..

Chief Executive Date: xx May 20xx

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director

London Ambulance Service NHS Trust

DRAFT
Annual accounts for the year ended 31 March 2018

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Improvements, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officers Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST

Opinion

We have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

• give a true and fair view of the financial position of London Ambulance Service NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
• have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

• the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
• the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST CONT'D

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006
In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception
We are required to report to you if:

• in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
• we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
• we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
• we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
• we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in these respects.

Responsibilities of the Directors and Accountable Officer
As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 3, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF LONDON AMBULANCE SERVICE NHS TRUST CONT'D

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of London Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
Date

The maintenance and integrity of the London Ambulance Service NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	355,557	343,299
Other operating income	4	9,041	12,208
Operating expenses	5, 7	(355,193)	(345,525)
Operating surplus/(deficit) from continuing operations		**9,405**	**9,982**
Finance income	10	114	84
Finance expenses	11	(27)	(142)
PDC dividends payable		(3,780)	(4,079)
Net finance costs		**(3,693)**	**(4,137)**
Other gains / (losses)	12	17	118
Surplus / (deficit) for the year		**5,729**	**5,963**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	1,309	(2,474)
Revaluations	15	6,333	667
Other recognised gains and losses		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	12	-	-
Recycling gains / (losses) on available-for-sale financial investments	12	-	-
Foreign exchange gains / (losses) recognised directly in OCI	12	-	-
Total comprehensive income / (expense) for the period		**13,371**	**4,156**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	4,770	6,577
Property, plant and equipment	14	162,111	142,368
Total non-current assets		**166,881**	**148,945**
Current assets			
Inventories	16	2,746	3,115
Trade and other receivables	17	24,098	35,518
Non-current assets held for sale / assets in disposal groups	18	-	44
Cash and cash equivalents	19	30,300	18,637
Total current assets		**57,144**	**57,314**
Current liabilities			
Trade and other payables	20	(44,918)	(41,457)
Provisions	23	(8,259)	(8,064)
Other liabilities	21	(90)	(57)
Total current liabilities		**(53,267)**	**(49,578)**
Total assets less current liabilities		**170,758**	**156,681**
Non-current liabilities			
Borrowings	22	(107)	(107)
Provisions	23	(9,576)	(10,548)
Total non-current liabilities		**(9,683)**	**(10,655)**
Total assets employed		**161,075**	**146,026**
Financed by			
Public dividend capital		59,694	58,016
Revaluation reserve		58,081	52,217
Other reserves		(419)	(419)
Income and expenditure reserve		43,719	36,212
Total taxpayers' equity		**161,075**	**146,026**

The notes on pages 21 to 61 form part of these accounts.

Name	Garrett Emmerson
Position	Chief Executive
Date	24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**58,016**	**52,217**	**(419)**	**36,212**	**146,026**
Surplus/(deficit) for the year	-	-	-	5,729	**5,729**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,770)	-	1,770	**-**
Other transfers between reserves	-	(8)	-	8	**-**
Impairments	-	1,309	-	-	**1,309**
Revaluations	-	6,333	-	-	**6,333**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Public dividend capital received	1,678	-	-	-	**1,678**
Public dividend capital repaid	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**59,694**	**58,081**	**(419)**	**43,719**	**161,075**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**58,016**	**56,153**	**(419)**	**28,120**	**141,870**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**58,016**	**56,153**	**(419)**	**28,120**	**141,870**
Surplus/(deficit) for the year	-	-	-	5,963	**5,963**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	(2,129)	-	2,129	**-**
Impairments	-	(2,474)	-	-	**(2,474)**
Revaluations	-	667	-	-	**667**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**58,016**	**52,217**	**(419)**	**36,212**	**146,026**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
This reserve was created when London Ambulance Service became a NHS Trust. The negative reserve balance was caused by the legal title of a property not being properly transferred from NHS Estates when the Trust was created. Once the error had been identified, the London Ambulance Service NHS Trust purchased the property from the NHS Estates and this led to a negative reserve being created.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		9,405	9,982
Non-cash income and expense:			
Depreciation and amortisation	5.1	13,054	13,784
Net impairments	6	(9)	308
Income recognised in respect of capital donations	4	-	(159)
(Increase) / decrease in receivables and other assets		11,798	(21,062)
(Increase) / decrease in inventories		369	(116)
Increase / (decrease) in payables and other liabilties		865	1,548
Increase / (decrease) in provisions		(804)	4,207
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**34,678**	**8,492**
Cash flows from investing activities			
Interest received		103	93
Purchase of intangible assets		(960)	(308)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(19,817)	(5,949)
Sales of property, plant, equipment and investment property		130	329
Receipt of cash donations to purchase capital assets		-	-
Net cash generated from / (used in) investing activities		**(20,544)**	**(5,835)**
Cash flows from financing activities			
Public dividend capital received		1,678	-
Public dividend capital repaid		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		(4,149)	(4,229)
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**(2,471)**	**(4,229)**
Increase / (decrease) in cash and cash equivalents		**11,663**	**(1,572)**
Cash and cash equivalents at 1 April - brought forward		**18,637**	**20,209**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**18,637**	**20,209**
Cash and cash equivalents at 31 March	19	**30,300**	**18,637**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis. This is based on the expectation the the Trust will be able to maintain a positive cash flow across 2018/19, not require any external financial support to achieve a positive cash flow and be able to pay its creditors across 2018/19 as they fall due. Trust management expect these conditions to be met in and continue beyond 2018/19.

Note 1.2 Critical judgements in applying accounting policies
There were no critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset Valuations
All land and buildings are restated to fair value by way of professional valuations. Full revaluation will be provided every five years. In the intervening years the fair values are updated by way of annual desktop revaluations. For the desktop revaluation the specialised operational values are updated in line with the current Tender Price Index published by the Building Cost Information Service (BCIS). The value of the land, non specialised assets and market values are reviewed by the valuer in line with analysis of market movements during the period.

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.6.5 and the carrying values of property, plant and equipment and intangible assets in notes 14.1 and 13.1 respectively.

Provisions
Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in note 23.

Annual Leave Accrual
The accrual is based on management's estimation of untaken leave as at 31 March 2018. The carrying value of the accrual is £4.58m within note 20 under accruals and deferred income.

Injury Cost Recovery Scheme Accrual
The Trust receives income from the NHS injury cost recovery scheme for the recovery of ambulance journey costs relating to road traffic accidents. Accruals are made for receivables that are uncertain in amount. The receivables are based on "management estimates supported by the number of cases" supplied by hospitals. The carrying value of the receivables is £3.25m within note 17 under prepayments and accrued income.

Note 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably; and either
• the item has cost of at least £5,000; or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the *GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	3	99
Plant & machinery	5	10
Transport equipment	2	10
Information technology	3	7
Furniture & fittings	3	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains, and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	3	7
Software licences	3	7

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables.

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at “fair value through income and expenditure” are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 23 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.17 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpreatations to be applied in 2017-18. The application of the Standards as revised would not have a material impact on the financial statements for 2017-18, were they applied in the year.

IAS 7 Statement of cash flows
IFRS 12 Disclosure of interest in other entities

Accounting Standards issued but not applicable in this financial year

IFRS 9 Financial instruments
IFRS 15 Revenue from contracts with customers
IFRS 16 Leases
IFRS 17 Insurance contracts

The Trust does not expect material changes to arise when IFRS9, IFRS 15 and IFRS 17 are implemented. However for IFRS 16 we are expecting material changes due to operating leases coming on to the balance sheet. The Trust is currently assessing the impact these changes will have on the financial statements.

Note 2 Operating Segments

The Trust Board considers that the Trust has only one segment which is the provision of accident and emergency services.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
A & E income	352,358	339,077
Patient transport services income	2,001	2,987
Other income	1,198	1,235
Total income from activities	**355,557**	**343,299**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	7,166	6,227
Clinical commissioning groups	342,183	328,709
Department of Health and Social Care	-	508
Other NHS providers	1,472	2,133
NHS other	653	2,074
Local authorities	27	(5)
NHS injury scheme	1,198	1,235
Non NHS: other	2,858	2,418
Total income from activities	**355,557**	**343,299**
Of which:		
Related to continuing operations	355,557	343,299

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	237	294
Education and training	1,080	1,785
Receipt of capital grants and donations	-	159
Non-patient care services to other bodies	66	-
Sustainability and transformation fund income	7,514	9,636
Income in respect of staff costs where accounted on gross basis	144	243
Other income	-	91
Total other operating income	**9,041**	**12,208**
Of which:		
Related to continuing operations	9,041	12,208

Note 5 Expenses

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Staff and executive directors costs	253,754	239,674
Remuneration of non-executive directors	89	83
Supplies and services - clinical (excluding drugs costs)	7,719	6,531
Supplies and services - general	11,215	10,610
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	802	951
Inventories written down	-	75
Consultancy costs	1,605	1,546
Establishment	9,285	8,417
Premises	9,199	9,481
Transport (including patient travel)	30,065	30,331
Depreciation on property, plant and equipment	10,465	11,095
Amortisation on intangible assets	2,589	2,689
Net impairments	(9)	308
Increase/(decrease) in provision for impairment of receivables	2	72
Increase/(decrease) in other provisions	149	-
Change in provisions discount rate(s)	131	1,243
Audit fees payable to the external auditor:		
audit services- statutory audit	84	68
other auditor remuneration (external auditor only)	-	19
Internal audit costs	156	123
Clinical negligence	2,785	1,989
Legal fees	1,012	385
Insurance	1,303	1,250
Research and development	823	802
Education and training	6,651	5,991
Rentals under operating leases	5,211	5,082
Redundancy	535	-
Car parking & security	223	206
Hospitality	-	10
Other	(650)	6,494
Total	**355,193**	**345,525**
Of which:		
Related to continuing operations	355,193	345,525

Note 5.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	19
Total	**-**	**19**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(9)	308
Total net impairments charged to operating surplus / deficit	**(9)**	**308**
Impairments charged to the revaluation reserve	(1,309)	2,474
Total net impairments	**(1,318)**	**2,782**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	205,507	193,346
Social security costs	23,130	21,994
Apprenticeship levy	1,025	-
Employer's contributions to NHS pensions	22,947	22,479
Termination benefits	535	-
Temporary staff (including agency)	6,698	7,182
Total gross staff costs	**259,842**	**245,001**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**259,842**	**245,001**
Of which		
Costs capitalised as part of assets	427	208

Note 7.1 Retirements due to ill-health

During 2017/18 there were 5 early retirements from the trust agreed on the grounds of ill-health (10 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £262k (£750k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2018 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 London Ambulance Service NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where London Ambulance Service NHS Trust is the lessee.

The Trust leases ambulances, fast response cars and other vehicles for periods of 3 to 6 years. The Trust leases buildings to provide facilities for ambulance stations, vehicle workshops and other accommodation. The lease term varies between 1 and 15 years.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	5,211	5,082
Total	**5,211**	**5,082**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	3,744	4,755
- later than one year and not later than five years;	9,521	10,319
- later than five years.	5,281	6,680
Total	**18,546**	**21,754**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	96	65
Interest on other investments / financial assets	18	19
Total	**114**	**84**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Unwinding of discount on provisions	27	142
Total finance costs	**27**	**142**

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	29	181
Losses on disposal of assets	(12)	(63)
Total gains / (losses) on disposal of assets	17	118

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**2,643**	**-**	**-**	**16,593**	**-**	**990**	**-**	**20,226**
Additions	24	-	-	-	-	758	-	**782**
Reclassifications	14	-	-	64	-	(50)	-	**28**
Disposals / derecognition	(273)	-	-	(121)	-	-	-	**(394)**
Gross cost at 31 March 2018	**2,408**	**-**	**-**	**16,536**	**-**	**1,698**	**-**	**20,642**
Amortisation at 1 April 2017 - brought forward	**2,379**	**-**	**-**	**11,270**	**-**	**-**	**-**	**13,649**
Provided during the year	178	-	-	2,411	-	-	-	**2,589**
Reclassifications	**14**	**-**	**-**	**14**	**-**	**-**	**-**	**28**
Disposals / derecognition	**(273)**	**-**	**-**	**(121)**	**-**	**-**	**-**	**(394)**
Amortisation at 31 March 2018	**2,298**	**-**	**-**	**13,574**	**-**	**-**	**-**	**15,872**
Net book value at 31 March 2018	**110**	**-**	**-**	**2,962**	**-**	**1,698**	**-**	**4,770**
Net book value at 1 April 2017	**264**	**-**	**-**	**5,323**	**-**	**990**	**-**	**6,577**

Note 13.2 Intangible assets - 2016/17

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,511**	**-**	**-**	**16,510**	**-**	**705**	**-**	**19,726**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**2,511**	**-**	**-**	**16,510**	**-**	**705**	**-**	**19,726**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	-	11	-	556	-	**567**
Reclassifications	138	-	-	131	-	(271)	-	**(2)**
Disposals / derecognition	(6)	-	-	(59)	-	-	-	**(65)**
Valuation / gross cost at 31 March 2017	**2,643**	**-**	**-**	**16,593**	**-**	**990**	**-**	**20,226**
Amortisation at 1 April 2016 - as previously stated	**2,125**	**-**	**-**	**8,897**	**-**	**-**	**-**	**11,022**
Provided during the year	**257**	**-**	**-**	**2,432**	**-**	**-**	**-**	**2,689**
Disposals / derecognition	(3)	-	-	(59)	-	-	-	**(62)**
Amortisation at 31 March 2017	**2,379**	**-**	**-**	**11,270**	**-**	**-**	**-**	**13,649**
Net book value at 31 March 2017	**264**	**-**	**-**	**5,323**	**-**	**990**	**-**	**6,577**
Net book value at 1 April 2016	**386**	**-**	**-**	**7,613**	**-**	**705**	**-**	**8,704**

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**51,220**	**59,175**	**-**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,677**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	945	-	15,565	163	3,889	2,056	6	**22,624**
Impairments	-	(149)	-	-	-	-	-	-	**(149)**
Reversals of impairments	34	694	-	-	-	-	-	-	**728**
Revaluations	823	3,529	-	-	-	-	-	-	**4,352**
Reclassifications	-	33	-	(6,171)	605	4,782	723	-	**(28)**
Disposals / derecognition	-	(23)	-	-	(45)	(1,313)	(2,114)	-	**(3,495)**
Valuation/gross cost at 31 March 2018	**52,077**	**64,203**	**-**	**18,708**	**17,539**	**49,897**	**14,204**	**80**	**216,708**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**12,025**	**27,030**	**11,193**	**61**	**50,309**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**2,724**	**-**	**-**	**1,401**	**4,942**	**1,396**	**2**	**10,465**
Impairments	-	(37)	-	-	-	-	-	-	**(37)**
Reversals of impairments	-	(703)	-	-	-	-	-	-	**(703)**
Revaluations	-	(1,981)	-	-	-	-	-	-	**(1,981)**
Reclassifications	-	-	-	-	-	-	(28)	-	**(28)**
Disposals / derecognition	-	-	-	-	(45)	(1,277)	(2,106)	-	**(3,428)**
Accumulated depreciation at 31 March 2018	**-**	**3**	**-**	**-**	**13,381**	**30,695**	**10,455**	**63**	**54,597**
Net book value at 31 March 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**
Net book value at 1 April 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**51,758**	**62,039**	**-**	**2,096**	**16,026**	**45,189**	**12,773**	**74**	**189,955**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**51,758**	**62,039**	**-**	**2,096**	**16,026**	**45,189**	**12,773**	**74**	**189,955**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	1,545	-	8,909	101	1,048	717	-	**12,320**
Impairments	(886)	(4,418)	-	-	-	-	-	-	**(5,304)**
Revaluations	348	114	-	-	-	-	-	-	**462**
Reclassifications	-	2	-	(1,691)	756	292	643	-	**2**
Disposals / derecognition	-	(107)	-	-	(67)	(3,990)	(594)	-	**(4,758)**
Valuation/gross cost at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**16,816**	**42,539**	**13,539**	**74**	**192,677**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**4**	**-**	**-**	**10,080**	**26,051**	**10,358**	**59**	**46,552**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**4**	**-**	**-**	**10,080**	**26,051**	**10,358**	**59**	**46,552**
Provided during the year	**-**	**2,723**	**-**	**-**	**1,987**	**4,954**	**1,429**	**2**	**11,095**
Impairments	-	(2,522)	-	-	-	-	-	-	**(2,522)**
Revaluations	-	(205)	-	-	-	-	-	-	**(205)**
Disposals/ derecognition	-	-	-	-	(42)	(3,975)	(594)	-	**(4,611)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**12,025**	**27,030**	**11,193**	**61**	**50,309**
Net book value at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**
Net book value at 1 April 2016	**51,758**	**62,035**	**-**	**2,096**	**5,946**	**19,138**	**2,415**	**15**	**143,403**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	52,077	64,200	-	18,708	4,158	19,089	3,749	17	**161,998**
Owned - donated	-	-	-	-	-	113	-	-	**113**
NBV total at 31 March 2018	**52,077**	**64,200**	**-**	**18,708**	**4,158**	**19,202**	**3,749**	**17**	**162,111**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	51,220	59,175	-	9,314	4,791	15,358	2,346	13	**142,217**
Owned - donated	-	-	-	-	-	151	-	-	**151**
NBV total at 31 March 2017	**51,220**	**59,175**	**-**	**9,314**	**4,791**	**15,509**	**2,346**	**13**	**142,368**

Note 15 Revaluations of property, plant and equipment

A professional revaluation was undertaken on all land and buildings at 31 March 2018.

The valuation was carried out by the District Valuers of the Revenue and Customs Government Department. The valuation was carried out in accordance with the terms of the Royal Institution of Chartered Surveyors (RICS), insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health.

The market value was used in arriving at fair value for the operational assets subject to the additional special assumptions that:

a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;

b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest; and

c) regard has been had to appropriate lotting to achieve the best price.

The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.

GROSS CARRYING VALUE OF ASSETS IN USE	**2017/18**
	£000
Furniture & fittings	56
Transport equipment	8,395
Plant & machinery	7,694
Information technology	15,630
Total	**31,775**

Note 16 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	60	41
Consumables	2,686	3,074
Total inventories	**2,746**	**3,115**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £10,757k (2016/17: £10,147k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £75k).

Note 17 Receivables

Note 17.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	3,747	6,916
Capital receivables (including accrued capital related income)	-	2
Accrued income	14,765	23,898
Provision for impaired receivables	(853)	(851)
Prepayments (non-PFI)	5,547	4,420
Interest receivable	12	1
PDC dividend receivable	420	51
VAT receivable	84	692
Other receivables	376	389
Total current trade and other receivables	**24,098**	**35,518**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	14,785	27,238
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**851**	**782**
Prior period adjustments	-	-
At 1 April - restated	**851**	**782**
Increase in provision	77	47
Amounts utilised	-	(3)
Unused amounts reversed	(75)	25
At 31 March	**853**	**851**

The Trust makes provisions for all non-NHS debts over 180 days past their due date and any organisation that has been put into receivership or liquidation.

Note 17.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	7	-	-	-
Over 180 days	103	-	65	-
Total	**110**	**-**	**65**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,878	-	2,000	-
30-60 Days	326	-	13	-
60-90 days	54	-	41	-
90- 180 days	101	-	117	-
Over 180 days	409	-	146	-
Total	**2,768**	**-**	**2,317**	**-**

The majority of the Trust's debt is owed by Clinical Commissioning Groups, Foundation Trusts and NHS Trusts whose parent entity is also the Department of Health and Social Care, and therefore risk of default is low.

Note 18 Non-current assets held for sale and assets in disposal groups

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**44**	**101**
Prior period adjustment		**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**44**	**101**
Assets sold in year	(44)	**(57)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**44**

Note 19 Cash and cash equivalents movements

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**18,637**	**20,209**
Prior period adjustments	-	-
At 1 April (restated)	**18,637**	**20,209**
Net change in year	11,663	(1,572)
At 31 March	**30,300**	**18,637**
Broken down into:		
Cash at commercial banks and in hand	7	12
Cash with the Government Banking Service	30,293	2,625
Deposits with the National Loan Fund	-	16,000
Total cash and cash equivalents as in SoFP	**30,300**	**18,637**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**30,300**	**18,637**

Note 20 Payables

Note 20.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	7,445	6,014
Capital payables	10,715	8,086
Accruals	17,719	18,035
Social security costs	3,268	3,342
Other taxes payable	2,428	2,622
Other payables	3,343	3,358
Total current trade and other payables	**44,918**	**41,457**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
VAT payables	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,839	1,286
Non-current	-	-

Note 20.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2017 £000
- outstanding pension contributions	3,234	3,229

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	90	57
Total other current liabilities	**90**	**57**
Non-current		
Deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Other loans	-	-
Total current borrowings	**-**	**-**
Non-current		
Other loans	107	107
Total non-current borrowings	**107**	**107**

Note 23 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**9,713**	**444**	**-**	**-**	**-**	**-**	**8,455**	**18,612**
Change in the discount rate	121	-	-	-	-	-	10	**131**
Arising during the year	179	490	-	-	-	525	5,076	**6,270**
Utilised during the year	(405)	(291)	-	-	-	-	(1,453)	**(2,149)**
Reversed unused	(815)	(385)	-	-	-	-	(3,856)	**(5,056)**
Unwinding of discount	23	-	-	-	-	-	4	**27**
At 31 March 2018	**8,816**	**258**	**-**	**-**	**-**	**525**	**8,236**	**17,835**
Expected timing of cash flows:								
- not later than one year;	463	258	-	-	-	525	7,013	**8,259**
- later than one year and not later than five years;	1,840	-	-	-	-	-	612	**2,452**
- later than five years.	6,513	-	-	-	-	-	611	**7,124**
Total	**8,816**	**258**	**-**	**-**	**-**	**525**	**8,236**	**17,835**

The Early Departure Costs provision of £8,816k (2016/17 £9,713k) comprises pensions relating to claims for Personal Injury Benefits. The amounts are calculated by the NHS Pensions Agency following assessment of the individuals' claims. The sum provided is recalculated annually based on changes in annual rates and life expectancy; it is adjusted for inflation and a discounting factor of 0.10% is applied.

The Legal Claims provision of £258k (2016/17 £444k) relates to Employers Liability Claims based on estimates of costs and settlements provided by the NHS Litigation Authority.

The Redundancy provision of £525k (2016/17 nil) relates to ongoing management restructures within the Trust.

The other provision of £8,236k (2016/17 £8,455k) includes £2,619k relocation costs for recruitment of overseas paramedics, £2,291k in relation to pending legal cases affecting calculation of holiday pay, £876k for pending employment tribunals, £809k for service penalties, £264k for changes in VAT rules, and £1,370k in respect of pension payments due to employees made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees.

Note 23.1 Clinical negligence liabilities

At 31 March 2018, £59,070k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of London Ambulance Service NHS Trust (31 March 2017: £55,349k).

Note 24 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(106)	(182)
Gross value of contingent liabilities	**(106)**	**(182)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(106)**	**(182)**
Net value of contingent assets	-	-

Note 25 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	3,265	4,459
Intangible assets	14	141
Total	**3,279**	**4,600**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	18,936	-	-	-	**18,936**
Cash and cash equivalents at bank and in hand	30,300	-	-	-	**30,300**
Total at 31 March 2018	**49,236**	**-**	**-**	**-**	**49,236**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	28,706	-	-	-	**28,706**
Cash and cash equivalents at bank and in hand	18,637	-	-	-	**18,637**
Total at 31 March 2017	**47,343**	**-**	**-**	**-**	**47,343**

Note 26.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	107	-	**107**
Trade and other payables excluding non financial liabilities	39,318	-	**39,318**
Total at 31 March 2018	**39,425**	**-**	**39,425**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	107	-	**107**
Trade and other payables excluding non financial liabilities	39,789	-	**39,789**
Total at 31 March 2017	**39,896**	**-**	**39,896**

Note 26.4 Fair values of financial assets and liabilities

The book value (carrying value) of financial assest and liabilities is considered to be a reasonable approximation of fair value.

Note 26.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	39,318	39,789
In more than one year but not more than two years	-	-
In more than two years but not more than five years	107	107
In more than five years	-	-
Total	**39,425**	**39,896**

Note 27 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	1,506	1,532	1,432	1,637
Total losses	**1,506**	**1,532**	**1,432**	**1,637**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	41	1,002	58	306
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**41**	**1,002**	**58**	**306**
Total losses and special payments	**1,547**	**2,534**	**1,490**	**1,944**

Note 28 Related parties

The Department of Health and Social Care, as the London Ambulance Service NHS Trust's parent department, is considered to be a related party.

During the year none of the Department of Health and Social Care Ministers, London Ambulance Service NHS Trust board members or members of key management staff, or parties related to any of them, has undertaken any material transactions with the London Ambulance Service NHS Trust.

The London Ambulance Service NHS Trust has had a significant number of material transactions during the year with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where receipts exceed £10m.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
NHS Barnet CCG	-	13,146	-	229
NHS Brent CCG	-	16,024	-	298
NHS Bromley CCG	-	12,821	61	302
NHS Camden CCG	-	10,759	-	74
NHS Central London (Westminster) CCG	-	11,733	-	1,115
NHS City and Hackney CCG	-	11,273	-	155
NHS Croydon CCG	-	15,102	-	405
NHS Ealing CCG	-	13,181	-	409
NHS Enfield CCG	-	11,976	-	191
NHS England	-	13,818	-	5,802
NHS Greenwich CCG	-	11,450	-	128
NHS Havering CCG	-	10,365	-	203
NHS Hillingdon CCG	-	13,667	-	209
NHS Hounslow CCG	-	10,041	-	-
NHS Lambeth CCG	-	13,856	296	161
NHS Lewisham CCG	-	11,862	-	253
NHS Newham CCG	-	12,304	-	15
NHS Redbridge CCG	-	10,428	-	172
NHS Southwark CCG	-	13,702	-	29
NHS Tower Hamlets CCG	-	10,252	-	28
NHS Wandsworth CCG	-	10,483	-	170

The Trust has a number of staff who also work for St John Ambulance Service. The transactions with St John Ambulance Service during the year comprised expenditure of £1,234k (2016/17 £1,445k) and the amount payable by the Trust as at 31 March 2018 was £193k (31 March 2017 £29k).

The London Ambulance Service NHS Trust acts as corporate trustee for the London Ambulance Service Charity. There were no financial transactions with the Charity in 2017/18.

Note 29 Events after the reporting date

There have been no events after the reporting period that need to be disclosed in the financial statements.

Note 30 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	55,980	96,013	55,286	86,195
Total non-NHS trade invoices paid within target	47,695	69,177	46,377	69,717
Percentage of non-NHS trade invoices paid within target	85.20%	72.05%	83.89%	80.88%
NHS Payables				
Total NHS trade invoices paid in the year	304	2,488	351	1,859
Total NHS trade invoices paid within target	242	1,073	294	1,218
Percentage of NHS trade invoices paid within target	79.61%	43.13%	83.76%	65.52%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 31 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	(9,985)	1,572
External financing requirement	(9,985)	1,572
External financing limit (EFL)	8,696	1,572
Under / (over) spend against EFL	18,681	-

Note 32 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	23,406	12,887
Less: Disposals	(111)	(207)
Less: Donated and granted capital additions	-	(159)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	23,295	12,521
Capital Resource Limit	24,964	19,168
Under / (over) spend against CRL	1,669	6,647

Note 33 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	5,339
Add back income for impact of 2016/17 post-accounts STF reallocation	419
Breakeven duty financial performance surplus / (deficit)	5,758
Reconciliation to I&E Surplus	
Add back all I&E impairments/(reversal)	9
Add back depreciation on capital donations	-38
Suplus /(deficit) for the year	5,729

Note 34 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,425	1,002	2,751	262	262	6,048	(4,405)	6,143	5,758
Breakeven duty cumulative position	2,569	3,994	4,996	7,747	8,009	8,271	14,319	9,914	16,057	21,815
Operating income		279,864	283,617	281,731	303,109	303,827	324,052	319,992	355,507	364,598
Cumulative breakeven position as a percentage of operating income		1.43%	1.76%	2.75%	2.64%	2.72%	4.42%	3.10%	4.52%	5.98%

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Quality Account and Strategy			
Agenda item:	08(iv)			
Report Author(s):	Dr Patricia Bain, Chief Quality Officer			
Presented by:	Dr Patricia Bain, Chief Quality Officer			
History:	QIP Programme Board			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report presents the Board with the final Quality Account and Strategy.

Recommendation(s):

The Board is asked to approve the final Quality Account and Strategy.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐

Efficiency and sustainability will drive us	☒

NHS
London Ambulance Service
NHS Trust

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019

70 YEARS OF THE NHS 1948 - 2018

Contents

Foreword

The London Ambulance Service is the only pan London Trust and is the busiest ambulance service in the country responding year on year to increasing demands. Our Trust was inspected February 2016 by the CQC, who gave us an overall rating of 'requires improvement' in their final report. The care we give to patients was rated as outstanding, a number of services were rated as 'good' but the standards observed were not consistent nor of the quality the Trust aspires to deliver. During the year we have delivered a comprehensive action plan and external assessment confirms what we know, that our services have improved over the last two years. However we also know there is further improvement to make to achieve our vision of providing a world class service. Through this strategy, we want to strive for 'outstanding' Care Quality Commission (CQC) rating across our sites and services by 2020.

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing and growing population. However, with these challenges, we have an exciting opportunity when it comes to improving healthcare quality.

We hope our commitment to improvement and our determination to get things right for our patients, people and stakeholders is clear in this strategy. We are working to harness opportunities to continuously improve in order to provide safe, high quality, patient-centred care for all our patients. In addition we need to ensure that our staff are provided with the skill and support to deliver the right care and feel motivated and able to do so.

To achieve this, we are rolling out a programme of quality improvement and human factors training and developing our systems and processes to build an organisation-wide culture of continuous improvement. At the same time, patients will have a stronger voice than ever before, and we have begun and will continue to work more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

This strategy is the plan by which we will continue our journey to achieve our ambitions and a positive outcome in subsequent CQC inspections as continuous quality improvement becomes our business as usual.

Dr Patricia Bain
Chief Quality Officer

Statement of Directors responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHSI has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporates the above legal requirements) and the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account. The London Ambulance Service, whilst not a Foundation Trust has prepared the annual quality account in line with this guidance ensuring directors have taken steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to March 2018
  - papers relating to quality reported to the board over the period April 2017 – March 2018
  - feedback from commissioners dated April 2018
  - feedback from Overview and Scrutiny Committee dated March 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
  - the 2017 national staff survey
- The quality report presents a balanced picture of the NHS trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Chair Date

Chief Executive Date

Section 1:

Introduction to our Quality Strategy and Accounts 2018/19

The quality strategy for the Trust, aims to bring together our plans in line with over overarching strategy, business planning process and the CQC quality assessment framework. The purpose of the strategy is to set out the goals and targets for London Ambulance Service (LAS) in providing high-quality services over the next year and, therefore, delivering our vision and objectives.

Developing our Trust-wide strategy

We recently published a document entitled 'Our strategic intent 2018/19 – 2022/23', it sets out our ambition and describes how we plan to evolve in order to achieve improved outcomes and a better experience for patients.

It formed the basis for a six-week period of consultation that took place with internal and external stakeholders during November and December 2017, the main purpose of which has been to ensure that we fully address the needs of patients, our staff, partner NHS organisations and other business partners across London.

We are working with many of our stakeholders and business partners, including the CQC, to co-design our final strategy, which is due for release early 2018.

Our trust strategy focuses on improvement, and therefore supports delivery of our vision and objectives. It sets out a number of the key enablers and examples of the projects required to improve performance to illustrate the breadth of our work programme.

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.

The Trust's vision

The London Ambulance Service is uniquely placed to play a wider role within the London health economy.

Our ambition is to become a world-class ambulance service for a world-class city: London's primary integrator of access to urgent and emergency care on scene, on phone and online.

This vision will be delivered through the achievement of the Trust's strategic objectives, which are:

- Acting as a multi-channel single point of access and triage to the urgent and emergency care system across London.
- Providing a high quality and efficient differentiated clinical service that better matches care to patient urgent and emergency needs.
- Using our influence and working with partners to ensure a consistent approach to urgent and emergency care.

Our Purpose

We exist to:

- Provide outstanding care for all of our PATIENTS
- Be a first class employer, valuing and developing the skills, diversity and quality of life of our PEOPLE
- Provide the best possible value for the tax paying PUBLIC, who pay for what we do
- PARTNER with the wider NHS and public sector to optimise healthcare and emergency services provision across London

What is the Quality Strategy?

Our quality strategy is the plan through which we focus on the quality of clinical care and to ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of everything that we do.

This strategy sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number one priority. It sets out our five domain quality goals and associated targets and a number of projects which we must focus on to ensure we can evidence that our services are safe, effective, caring, well led and responsive. It also describes the governance arrangements to ensure delivery and sustainability from 2018/19. The strategy also outlines our current position, showing the improvements we have made in our 2017-18 Quality Account priorities and what we are building on going forward.

It is ambitious, setting out our commitment to make quality central to all that we do. It also reinforces that wherever possible, our focus will be on embracing new ways of working to improve care for patients and integrating healthcare across the wider integrated urgent and emergency care system.

It provides a modern approach to continuous improvement and acknowledges that our people are central to delivering our strategy.

We will use the implementation of the Quality Strategy to strengthen confidence and pride in the services we provide. We want patients to be confident that the Trust is among the best in the world.

We want people working in and with the Trust to be confident that they are providing the best service they can, are valued and are important. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so. We want a shared pride in the Trust and assurance that it is the very best it can be.

How we developed the strategy

The strategy has been informed by the reports and recommendations from key stakeholders, staff and patient representatives and the CQC framework. We also assessed our progress against priorities in our last quality account.

Comparison was also undertaken of trends and variation from a range of intelligence including:

- Patient surveys
- Staff surveys
- Governance data, e.g. incidents, complaints, claims and audit

This was then merged with feedback from key stakeholders, including our people and our commissioners.

We have therefore been careful to develop goals and targets that are measurable whilst trying to encapsulate our commitment to the qualitative elements of our work. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and reportable goals to aim for. These targets will be redefined each year in our annual quality account, with progress monitored through the Trust's governance system. We believe that if we can meet our targets under each quality domain, we will see significantly improved outcomes for our patients and a better working environment for our people. Our goals and targets have been selected to have the highest impact across the Trust and are purposely challenging.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. A series of Trust-wide improvement projects, informed by our CQC inspection action plan and a review of the key lines of enquiry that the CQC use, have been established to deliver specific time bound programmes of work.

What is our definition of quality?

We have based our definition of quality on the CQC's framework, which draws on the Francis, Keogh and Berwick reviews and recommendations.

Our approach aligns Berwick's improvement principles which are embodied within safe, effective, caring, responsive and well led domain. The combination of performance in each of the five domains determines the overall quality of the healthcare we provide. We believe that we can improve services only by supporting continuous improvement in all areas hence our commitment to this driver.

The previous quality account and improvement programme for the Trust focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our CQC inspection, this strategy and our priorities for 2018-19 and beyond will strive to bring the trust to an 'outstanding' rating.

The quality domains

The quality domains are outlined below, together with the descriptor of what these mean. The domains match those used by the CQC to ensure we are focused on making improvements which are aligned with our regulatory body's expectations.

Safe

People are protected from abuse and avoidable harm

Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Responsive

Services are organised so that they meet people's needs

Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Delivering the Strategy:

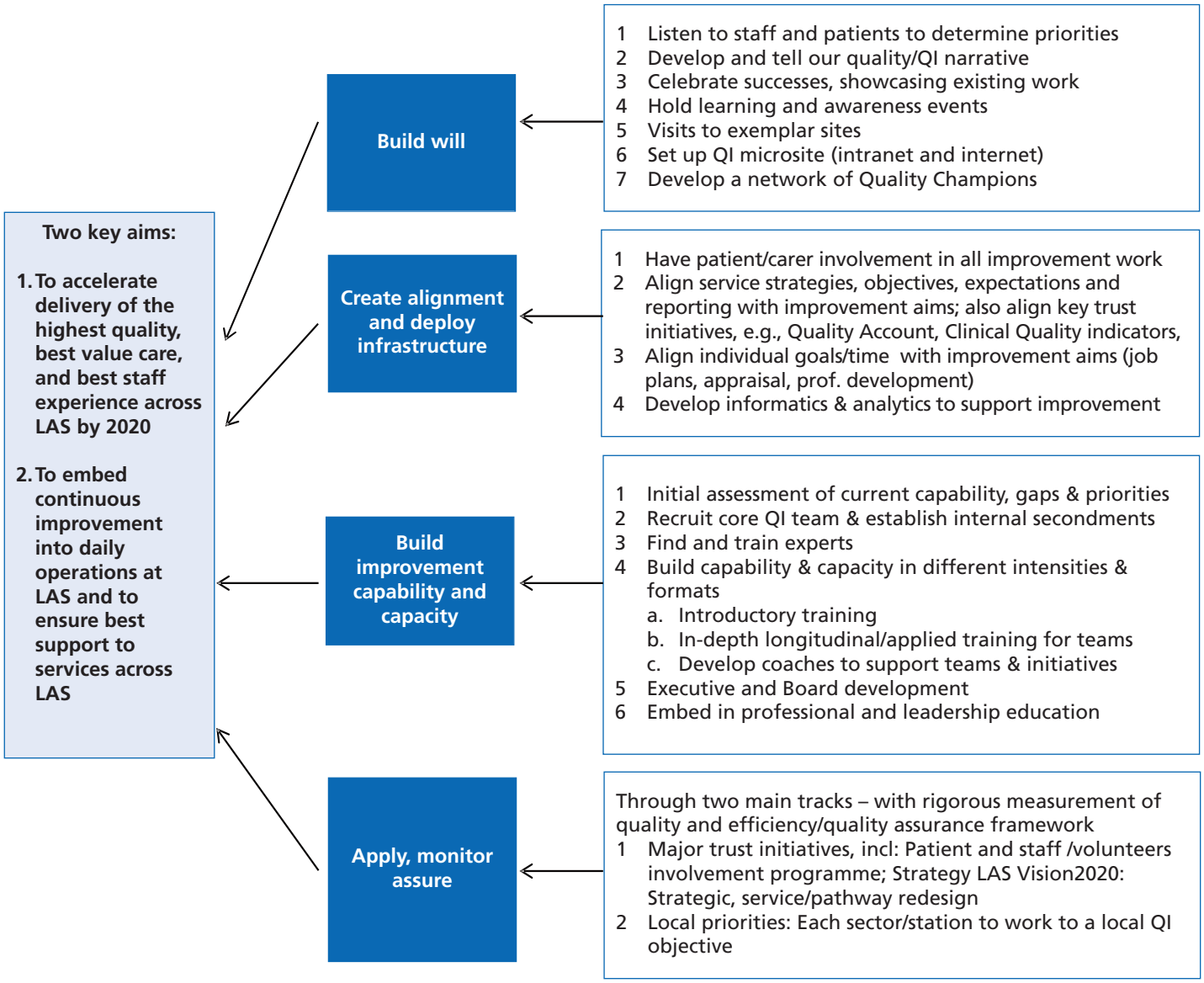
How will the strategy be delivered and progress monitored?

Quality Goals and Targets

The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. These are outlined under each quality domain and have been chosen to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our goals and targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff. The goals and targets under each domain will be incorporated into the quality report and performance scorecards, ensuring they can be tracked from station to board. This will provide clarity on the Trust's priorities and will show the impact of the improvements we have made.

Building Delivery Capacity and capability

Delivering the strategy will be predicated on ensuring we have the right skills and capacity across the organisation. The outline plan below sets out the key activities to achieve this aim, are detailed in our implementation plan.



Building the Will

Integral to all programmes must be the aim of robust patient and staff involvement so they support the development of what represents a high quality and efficient service. It is important that we continue to explore further ways of getting feedback from staff via Quality Champions, patient and carers and community groups, in addition to our continued engagement with the Patients Forum. The patient involvement teams will develop a framework to ensure these aims and the successes they have already achieved are embedded.

The importance of ensuring that we take every opportunity to engage with examplar sites partners in the redesign of services and pathways in order to secure the right outcomes is articulated in our organisational strategy. Supporting this programme will be a communication strategy that includes intranet and internet development.

Creating alignment

Alongside the quality goals and targets, we have developed measurable and structured improvement projects aligned to our strategic and business objectives. These projects have been informed by analysis of a number of measures of our performance including:

- Our strategic intent
- current performance against national and local targets
- our quality account
- areas of known risk
- our CQC inspection and report during 2018
- review of the key lines of enquiry that the CQC publish.

Each project has been assessed for their potential to positively impact on the Trusts strategic goals and targets and we are confident that we have the necessary work in progress to deliver the required improvements. Progress with these improvement projects will be reported via the Trust's governance and performance management structures. This will allow us to measure and monitor the milestones, outcomes and timeframes of the projects, with clear lines of accountability and responsibility to the project owners. Executive oversight of quality of care in the Trust is through the Quality Oversight Group, which will report quarterly progress and exception to the Quality Assurance Committee. Trust board reporting will occur on a quarterly basis. Our annual Quality Account will report on progress against the strategy and confirm the targets for the following year.

Building Capability to deliver the strategy

We recognise that our staff are the key to delivering the strategy and we need to train and support people to make continuous improvement and improve systems and processes. We have therefore agreed to adopt a standardised approach to improvement Plan, Do,Study, Act (NHSI QSIR model) to ensure staff have the tools they need to sustain improvement. The capabilities needed to drive this system of wide improvement and which staff will be trained in includes:

- An understanding of Human Factors
- Concept of safety systems
- Driver diagram development
- Improvement methodologies, including Plan Do Study Act (PDSA), Lean, Patient flow studies
- Change management principles
- Measurement skills and knowledge
- Flow and service re-design management

Evidence internationally (IHI) suggest for an organisation the size of LAS that a commitment to training at a minimum, 1-3% of the workforce in improvement methods is required for continuous improvement (Table 2 below) A programme to identify and priorities the appropriate staff at all levels and utilisation of 'train the trainer' techniques will build the capacity required. A small team of staff trained in providing QI methodology and Human Factors approaches will provide the staff with the skills and tools to empower them to lead their own QI projects. QI improvement plans will be developed by staff at every level, with the focus to build capacity across, the workforce.

QI capability model for LAS – by staff group and role

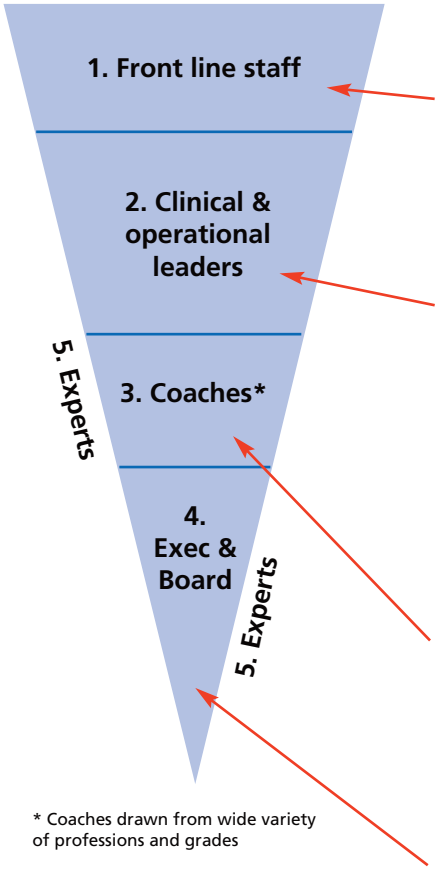


Table 2 QI Capability Model

Total potential needed	Eventual coverage needed	Knowledge/skills needed	What's involved
5,000	100%	• Introduction to improvement & model for improvement • Identifying issues, developing & testing ideas • Measurement & variation	• Introductory e-learning sessions (incl. at induction) • Online/self-accessed • Over 3 year period
400	100	• Deeper understanding of improvement methods, variation and measurement • Goal-setting, leading and managing for improvement	• Applied learning in teams over time linked to opportunities in real work • Access to coaching • Embedding into existing programmes
Experts	10	• As above, plus sophisticated enabling and coaching skills for individuals and teams	• Applied learning and reflection in coaching teams supported by classroom programme
250	250	• Direction-setting, "mood" & leading for improvement • Link to strategy and overall priorities; appreciation of systems; making variation and trends visible	• Self-determined but typically includes: mix of individual/group; sessions with external experts; peer visits/"Board-to-Station"; quality assurance visits"
n/a	All Board members	• Deep Dive methodology including of QI theory and science • Spread and implementation • Coaching/mentoring, teaching • Knowledge-generation and research • Measures for decision makers	• Careful objective-setting, review and planned (career) development • Applied learning through doing/coaching • Reflection and peer support • "Masterclasses" • Individually-tailored • Board Development Session June

High Impact Innovations (DH 2012) requires NHS Trusts to prove to commissioners that they are implementing technological and innovative solutions to improve quality. As a Trust we are already exploring the use of technology via the roll-out of hand held devices to frontline staff, e-PCR development, tele-medicine/skype. Opportunities to explore technology further are outlined in our IM&T strategy.

Applying continuous assessment and improvement

Major trust initiatives, with rigorous measurement of quality and efficiency programmes and local sector and station QI objectives will be designed. Monitoring and reporting on our programmes and ensuring we respond to any emerging risks will be achieved via our quality assurance framework. The main response to the outcomes from these various reporting mechanisms will be:

- Immediate risk mitigation if necessary) and review/update of risk registers
- Identification of a quality improvement activity: station, sector and trust wide using an agreed criteria and methodology
- Consideration of 'intensive support programme' in areas that are not consistently meeting standards – using the approach that is currently in place for the North East sector.
- Consideration of a Deep Dive review

The streamlining of governance and **'floor to Board' assurance structures** will support the delivery of high quality and efficient care with early identification of risks, monitoring performance issues quickly to ensure we continuously improve. The further development and embedding of these frameworks will continue through to 2018-2019 and will support the development of a continuous improvement and learning culture.

Section 2:

Looking Forward: Our Quality goals and targets 2018-19

Our goals are set out under each of the quality domains. The targets which support the delivery of these goals have been developed for our year one of the strategy. Each year we will review progress and ensure our targets are focused on areas where improvement is most needed and will be defined within our annual quality account.

Safe

People are protected from abuse and avoidable harm

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable.

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal will be to be below the national average for the number of incidents causing severe and extreme harm in year one and continue to reduce the number throughout the years of the strategy. Throughout year one of our Quality Strategy, we will be focusing on achieving sustainable improvements in the target areas outlined below; these targets aim to reduce avoidable harm in specific priority areas and set the trajectory to ensure that we can achieve our goal of eliminating avoidable harm by the end of year three.

Target 1

We will implement Health Assure reporting and Monitoring system to ensure that we have real-time monitoring of our compliance against the CQC key lines of enquiry, clinical audits, NICE guidance, national alerts, at every level in the organisation.

This system will provide assurance to the Board and our regulators and patients that we are meeting the high standards of care and safety consistently across the whole organisation. Scorecards will be available from station to Board and will be used to monitor progress via our governance and assurance processes. We will be able to identify areas for improvement more quickly and focus our effort in these areas. Our regulators will be able see, assess and access evidence with regard to our improvement status at the 'touch of a button'.

90% implementation of Health Assure functionality by December 2018

Target 2

Improving Hospital Handover Delays
National emergency care performance metrics set a standard for emergency patients arriving at hospital by ambulance to be handed over to, and the ambulance trolley cleared by, the receiving acute Trust within 15 minutes of arrival to enable the ambulances to respond to the next 999 patient.

Ambulance handover performance across London remained challenging throughout 2015/16 and 2016/17; this continued into 2017/18 with patient's frequently experiencing handover delays in excess of 15 minutes following their arrival at emergency departments (EDs). Between January and September 2017, 62% of the patients conveyed by the London Ambulance Service (LAS) to an ED experienced a delay, waiting beyond the target of fifteen minutes for handover to on-going care. In the context of productive ambulance cover hours beyond that fifteen minute target, 49,494 hours were lost while delayed at an ED and this equates to 4,125 lost twelve hour ambulance shifts in the same period.

It is recognised that hospital handover delays is a multi-factorial system problem and we need to work together to identify issues at each stage and resolve them. The LAS will continue to work with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London during 2018-19.

Handovers over the 15, 30 and 60 minute target and total time lost, to reduce quarter on quarter against the same period in 2017/18

Target 3

During 2016-17 the Trust made significant improvements in medicines management in terms of ensuring the tracking and monitoring of drugs at station level. The next phase is to ensure that we have the most secure environments to store and monitor drug usage. The second phase of the secure drug room programme, that entails re-designing the station environment, fitting CCTV cameras and more secure locking systems will be rolled out across 2018-19. In addition we have re-designed the vehicle based bags that paramedics and other staff use when attending patients. This provides the teams with more secure storage and an ability to store all equipment that is required on scene in one holdall.

100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations

Target 4

During the latter half of 2016 it became apparent that there were a number of cases where defibrillation was being delayed during the management of cardiac arrest. This trend continued into early 2017 and triggered a thematic analysis. Whilst it was believed that the apparent increase in incidents might be related to the increased number of defibrillator data downloads by Advanced Paramedic Practitioners (APPs) coupled with a significant drive to increase reporting of potential incidents through the online incident reporting system (Datix). It was identified that further work was needed to understand the root causes and ensure that learning to prevent recurrence was embedded across the Trust.

It is clearly recognised that the challenges of managing a pre-hospital cardiac arrest are very different to in-hospital where the cardiac arrest team is made up of different clinicians with per-determined and specific roles and who will have worked as a team together. The crew resource management challenges of pre-hospital cardiac arrest cannot be underestimated – the crews may never have met each other, there will be public and family to support and manage and the equipment will initially be remote form the patient. The LAS has been accepted on human factors train the trainer programme supported by UCLH. During 2018-19, in conjunction with all other aspects of risk reduction and pathway development, we will deliver training to relevant staff to improve the management of these difficult scenarios with the aim of reducing these incidents further.

Increase the number of defibrillator downloads year-on-year to 20% by end of 2019.

Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Goal: To provide our patients with the best possible experience. Improving the care we give to vulnerable groups.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience, we need to listen to our patients, their families and carers, and respond to their feedback.

We will aim to improve our position, with our goal being to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently. The indicators outlined below will support this goal and help us determine whether our services are caring and patient centred in all aspects.

Target 1

Our work supporting patients with mental health and in sometimes complex medical conditions has been acknowledged as exemplary. As part of our Strategic Intent, we are aiming to improve and develop services that be recognised as 'pioneering' in relation to this patient group. Our aim is to ensure we have system wide collaboration with all healthcare services to provide 'seamless', timely and the most appropriate care for these patients.

We will continue to work with key stakeholders to provide the best possible outcome for these patients. This work will include supporting patients who frequently call the service during crisis or to request help that is not necessarily provided by the emergency services. We will be increasing our resource internally to enable our expert staff to work closely with providers for example, social services, to put key interventions in place more rapidly and consistently across the pan-London service provision.

Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline

Target 2

Our strategy to become London's primary integrator of access to urgent and emergency care on scene, on phone, on line, requires significant changes to the way in which we deliver services to our patients. As part of this strategy is the recognised need to widen and increase our patient involvement in both the development of these new services and the monitoring of their success. The Trust will therefore develop a Patient Involvement Framework (PIF), with the support of patients, public, specific patient voluntary groups to ensure we have genuine involvement and participation and that the view of these groups are considered in any wide scale changes that we make. The new framework will also enable us to capture feedback from a more diverse patient population through the introduction of data collection methods, use of information technology, that will enable the trust to directly compare how different groups respond to and identify specific issues and the interventions to improve these.

Evidence of patient involvement in all QI and service re-design programmes.

Target 3

The LAS currently provides care to up to 9000 women a year at different stages in pregnancy, the service covers 26 maternity units and three standalone birth centres.

The services is recruiting the first Practice Leads for Pre Hospital Maternity Education across the LAS, and in the UK. They will form the Maternity team, alongside the Consultant Midwife, to lead the development of the Pan London Maternity Pioneer Service.

Maternity Pioneer Service:
The pan London maternity model will aim to:

1. a) Provide midwifery expertise within the control room environment allowing the ability to reduce the number of ambulance conveyances (up to 20% reduction)

   b) Provide a midwife advice line to provide a resource to staff both in the control room and on scene at a maternity episode of care (increasing expert advice capacity to 50% of calls fitting criteria).

2. Provide midwifery expertise within a response vehicle alongside ambulance clinicians to be dispatched to imminent birth calls Develop a commissioning model for pre-hospital birth, when provided by midwives within the emergency services.

The pan London model will pilot the response model in a sector across London (aligned to the Local Maternity System/STP footprint).

Alongside the Pioneer Model, a co-designed and co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model.

Reduce the number of ambulance conveyance (20%). Employ two whole time equivalent practice developments midwives and deliver a training programme 2018-19.

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Goal: Ensure staff complaints in providing 'best practice' care and to be in the top quartile for all national clinical audit outcomes.

Clinical audit is a key improvement tool through which we continually monitor and improve the quality of care that we provide. By fully taking part in national clinical audit programmes, we are able to benchmark our performance against our peers, ensure the care we provide is evidence-based and measure improvements on a year-by-year basis.

We aim to be in the top quartile for outcomes for all those national clinical audits in which we are eligible to participate and where data is analysed this way. This enables us to have evidence that each of our services is effective and promotes a good quality of life for our patients. Further assurance of this will be provided by compliance and training that meets the changing nature of service delivery.

Target 1

We have chosen this target to ensure that we get the best clinical outcomes for our patients. Changing the way in which we deliver care and increasing the delivery of care using a multi-disciplinary approach requires a fundamental review of the type and quality of training that we proved to our staff. In addition it is important that we ensure staff have the time to attend training, a constant pressure with the increasing demand on delivering the service we provide. We will carry out a root and branch review during the early part of 2018 to inform an improvement programme to ensure that : systems and processes are robust with strong governance frameworks; the training is appropriate and easily accessible; a revised training programme to include any further training requirements highlighted to meet the changing nature of delivery, the programmes of training align to operational delivery, and to ensure that staff are released to attend training and meet statutory requirements. We will also identify potential income generation, potential opportunities and have an identified 'training brand'. Ultimately the aim is to ensure our staff continue to provide clinically effective care based on best practice guidance.

Root and branch independent training review completed.

Implementation plan developed by September 2018

Target 2

During 2017-18 the LAS, as with all other ambulance services, implemented the Ambulance Response Pilot (ARP). The new response targets set out different response categories and set out an approach that requires Trusts to report on new quality indicators. During 2018-19 the LAS will work with the business intelligence team to ensure that we develop methods to collate and report on these new indicators. In doing so we will have clear evidence of areas were we have improved patient outcomes and also have the ability to highlight areas were we may not be meeting the standards of care that we strive to deliver.

New quality Indicators developed and being reported via performance scorecards by December 2018

Target 3

We recognise that people are the key to delivering our quality strategy. We therefore must make sure that we are supporting and training our people to make improvement continuously as well as carrying out their roles. We want to implement new ways of working to improve our processes, systems and services with transparent measurement and track progress. We have therefore decided to adopt a standardised approach to quality improvement to make this possible. The NHSI methodology is designed to support and encourage our staff by providing them with the tools they need to make sustained improvements. We want this to stimulate a culture of learning and development in improvement and ensure that change becomes the way of doing things in the Trust. As part of this process, the Trust has gained financial support during 2017-18 to increase the capability in relation to both Quality Improvement and Human Factors training programmes. We will set out an implementation plan that enables a critical mass of staff to be trained and also ensure this is aligned to our quality assurance processes to provide continual feedback, reporting and learning (see outline plan in section 1).

QI training plan agreed and 100% of identified key cohorts trained by September 2018

Target 4

The changing nature of our operating model, requires us to review the way in which our staff are allocated to their shifts. The Director of Operations will continue to work with colleagues to roll out this significant piece of work supported by our new Forecasting & Planning Team. A Trust-wide review of rosters will be completed by March 2018 with implementation due in summer 2018.

At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019

Responsive

Services are organised so that they meet people's needs

Goal: To consistently meet all relevant national performance targets standards through responsive patient pathways in year one, and exceed them by year three.

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events have shown that our patients agree.

To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

As well as the national targets above, we will focus on the following targets to improve our responsiveness as a Trust to patients who complain.

Target 1

Over the last 12 months the Trust has consistently been one of the strongest performing ambulance services. It is currently the third highest national performer in implementing the new ARP standards.

Additional recurrent funding has been secured over the last six months for additional frontline and Emergency Control Services staff, and we have also introduced an additional Incident Response Team to further strengthen our resilience capability.

We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP.

Target 2

The Patient Experience Team is working with the sector teams to provide feedback and actions to enable learning from complaints. We continue to respond within timelines for complaints, meeting the majority of patient response within 35 days.

Throughout 2018-19 we will focus on improving further our processes in dealing with complaints from the patients and public we serve. We will undertake a review of our complaints responses, supported by our patients, to ensure that our complaints responses include the appropriate information and express our apologies in a genuine way. We will aim to further improve the turnaround time for our letters and include more information in relation to the lessons we have learned. In addition we will continue with our patient and staff stories at the Board, which have been instrumental in making sure the executive team understand better the experiences of our patients and staff.

Over 75% of complaints letter being responded to within the 35 day timescale

Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Goal: To increase the percentage of our people who have been trained and provided with leadership development.

Evidence shows that people who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their patients. Our goal is to increase the percentage of people who would recommend our Trust as a place of work. By supporting our people to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a patient. This goal will be supported by the targets outlined below.

Well led

During 2017-18 we have strengthened our leadership team, our governance systems and processes and set out key strategies e.g. People and Organisational Development, IM&T, which will act as key enablers going forward to the delivery of our strategic objectives.

Target 1

Our statutory and mandatory training programmes ensure the safety and well being of staff and patients. During 2017-18 we moved the majority of our training to on-line e-learning and also implemented a new reporting tool on ESR to improve the ability to monitor and report compliance. We have chosen a target of 85% compliance to demonstrate that our staff comply with statutory and mandatory requirements which have a direct impact on patient safety.

85% compliance with statutory and Mandatory training 2018-19

Target 2

Fully implement our leadership development programmes at all levels and develop a culture of professionalism, with all staff clear about their roles and responsibilities.

Leadership programme developed and implementation plan in place

Equality and Diversity

At LAS we are committed to promoting equality of opportunity and diversity to enhance our inclusion work. LAS has committed to ensure that equality, diversity and human rights are embedded in all areas of our employment, planning and service delivery. We strive to provide excellence in all we do and recognise the value that Inclusion brings. We are committed to ensuring that all our employees are treated with dignity and respect and given equal opportunity and encouragement to progress and develop within the organisation.

We strongly believe that diversity and inclusivity in all its forms delivers greater impact in the work we do and enhances the services we deliver to Londoners. Our commitment to the principles of Diversity and Inclusion informs all of our work with our people.

Will continue to implement the P&OD strategy through 2018-19 and progress the addition of activity outlined below:

- Implement our Trust strategy and refresh supporting strategies. Working with STPs in developing and implementing system-wide improvements .
- Complete re-structures.
- Develop and implement staff communications and engagement model.
- Continue to strengthen Risk Management systems and processes.
- Continued implementation of the Quality Improvement Plan and Quality Improvement capability across the organisation.
- Maintain the focus on culture and holding people to account.
- Developing a culture of professionalism, with all staff clear about their roles and responsibilities.
- Complete re-negotiation in terms and conditions of annual leave and flexible working.
- Continue to strengthen IM&T resilience.
- Continue to develop and implement WRES improvement programme
- Continue to develop and implement Equality and Diversity Action Plans

Section 3:

Looking Back: Quality performance 2017-18

The progress against our targets and goals we set out in our Quality Account 2017-18 are outlined here, under the quality domain headings.

Quality Priorities 2017-18

The priorities for 2017-18 as set out in our previous Quality Account (2016) are highlighted below against the 3 domains for quality, Patient Safety, Experience and Effective care. Progress against each of the domains is provided, where relevant impact key performance indicators are included

Patient Safety

During 2017-18 we introduced and established a new integrated Quality & Assurance directorate which aligns quality functions into one directorate. Recruitment to new posts has now concluded and the structure brings both an increase in capacity and capability to the quality agenda across the trust. Quality governance frameworks have been reviewed and rationalised with clear lines of reporting via new Terms of Reference, minutes and key issue reports to provide assurance and allow escalation of issues from 'floor to Board'. A risk management improvement programme has also been developed and continues to be implemented to identify key safety and quality risks more accurately and to ensure staff are trained in identifying risks and regularly review and assess risks to patient safety and quality of care.

Target 1: Development of pathways for patients who fall, have mental health issues, are at the end of life and bariatric.

Our strategic intent document, developed during 2017-18 , sets out the further system wide pioneering services we aim to develop and deliver during 2018-19 and onwards. This year work has progressed in relation to mental health support, with increased training, alternative care pathway development, data sharing alongside the recruitment of an additional 3 mental health professionals to provide advice in the clinical hub and support the initiation a mental health response car. This is a pilot to enable mental health clinicians to work alongside paramedics to respond to patients undergoing a mental health crisis, and commenced in December 2017. This will be evaluated and, if successful, rolled out to other sectors.

In addition the Trust has been successful in gaining funding for three full time staff to provide dedicated support to End of Life care providing advice and training for staff in giving support to families and patients at end of life. In addition clinical audit, alternative care pathway utilisation and service development will also be part of this remit.

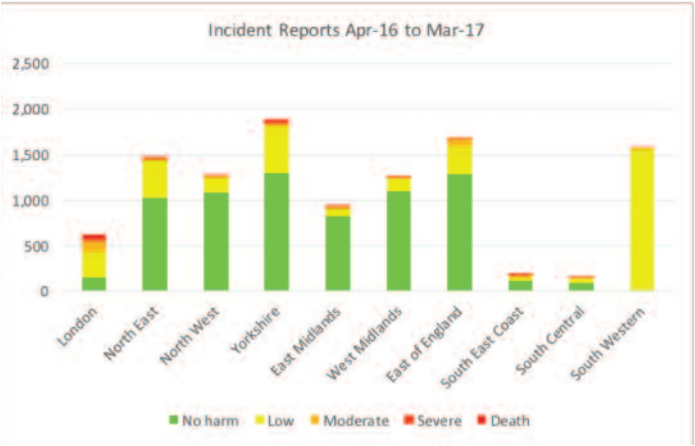
A Bariatric equipment business case is being presented to ELT at the end of February 2018, this outlines a significant investment, this will need to align to the current logistics work programmes and consider the impact of the ARP future operating models. In addition considering the type of equipment and support we require to ensure these patients have effective and dignified care.

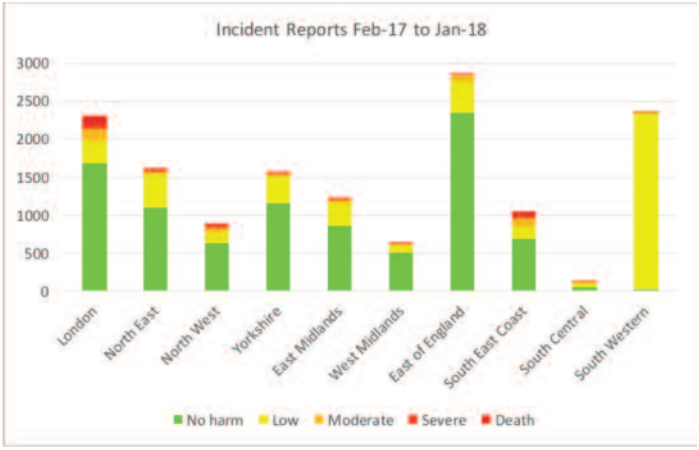
Target 2: Improve and embed learning from incidents

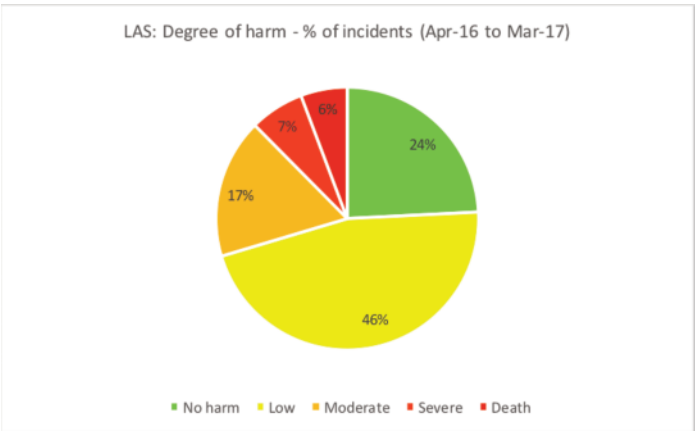
A learning and quality improvement framework was agreed by the Board in November 2017 and is now being implemented, supported by a communication strategy. Implementation will be complete by March 2018 and continuous embedding of the framework will continue, supported by the revised quality assurance framework. In addition monies to train a cohort of staff in quality improvement methodology and human factors was also provided by NHSI. This programme of work will start in July 2018 and continue throughout 2018.

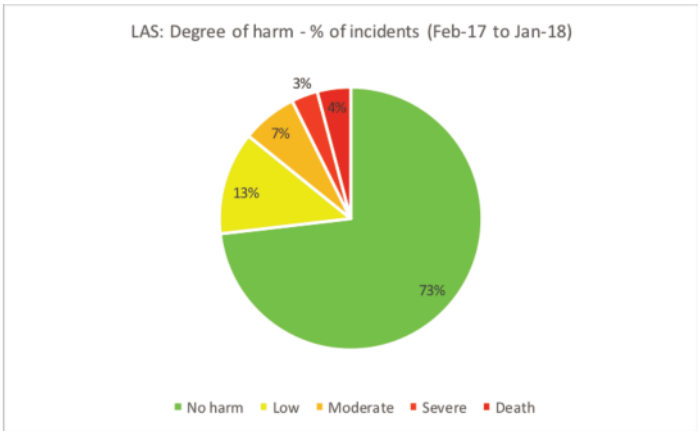
We have evidence of learning from incidents from the inclusion of feedback in core skills refresher courses, various changes to working practices, i.e. ventricular fibrillation, managing patients with spinal injuries. During 2017-18 we had an independent review by our internal auditors (KPMG) who gave the Trust Significant Assurance rating with regard to the serious incident investigation and learning process.

In addition our no/low harm reporting rates have improved to a currently in the higher quartile compared to national benchmarked levels during 2017-18. LAS are now reporting over 90% of incidents within the no/low harm category (see charts opposite).









Learning from experience

Below show some examples of where the Trust have made improvements as a result of serious incident investigations:

1 Change in practice regarding the management of cardiac arrests as a result of a significant number cases concerning delayed defibrillation

2 Changes within the Gazetteer system to improve the accuracy of locations across London

3 Policies that have been identified to be unfit for purpose have been reviewed and updated

4 Improved training, compliance audits and the development of a new policy for the management of breached Patient Group Directions

5 Guidance issued to staff on the management of paediatric patients with particular focus on the measurement of oxygen saturations

6 Development of a feedback mechanism of all maternity related incidents to the maternity training programme

7 Process for investigating and managing thematic reviews of similar incidents. For example; delayed defibrillation and the Non-emergency Transport Service

8 Equipment concerns highlighted to the equipment replacement programme which assisted in the development of business cases to replace specific pieces of equipment

9 Learning from incidents training delivered to all EOC staff and included on the paramedic academy courses

10 Incorporation of case studies to the internal leaning from incidents Insight magazine

11 Changes to practice included in core skills refresher courses for both EOC and frontline operations

12 Case studies included in the internal Clinical Update magazine

Patient Experience

Target 1: Effective and consistent risk assessment completed for patients presenting with a mental health crisis

Revision to the risk assessment tool and training have been introduced during the year, we have seen an improvement in the quality of mental health assessments, with a current average of 91% of core criteria being recorded as demonstrated through the monitoring of monthly clinical performance indicators. In addition bespoke training has been delivered by our mental health nurses to staff within our emergency operation centres, call handling staff and clinicians; to specialist response teams such as the joint response unit; to specific cohorts of staff such as incident response officers and clinical team leaders (with over 200 staff trained in specific areas such as mental capacity). We anticipate the introduction of mobile devices will further improve our ability to carry out and record assessments real-time with guidance immediately available from various 'apps' that staff can access quickly on-scene.

Target 2: Improved compliance with Infection Control standards

Infection control issues identified internally and through CQC, have improved significantly, we are seeing the majority of sectors showing over 90% compliance against their monthly performance on hand hygiene. Infection control practices at A&E have also improved, vehicle cleaning remains an area of focus as does hygiene standards in some identified stations. These are being closely monitored through regular quality assurance visits. We will utilise more fully the Perfect Ward app to allow digital uploads of data from station visits during 2018-19

Target 3: Ensure patients have timely and appropriate access to services

System wide demand management projects to improve care and experience of patients have seen improved response times, with the Trust meeting the majority of targets consistently.

Work undertaken with specific frequent callers has shown considerable reductions utilising a multi-agency approach to case management to our highest volume callers. However we are reviewing the resources required to support the delivery of a programme to increase the potential of reducing the significant impact this patient group have on demand in 2018-19. The aim will be to enable case management to be undertaken for a larger number of cases through increasing capacity within the current dedicated frequent caller team, allowing increased involvement in system wide initiatives, evaluation of interventions on patient outcomes, patient experience, operational and system wide performance.

Trust-wide performance:
Consistently meets response targets under the new operational model as outlined on page 38, Table 12.

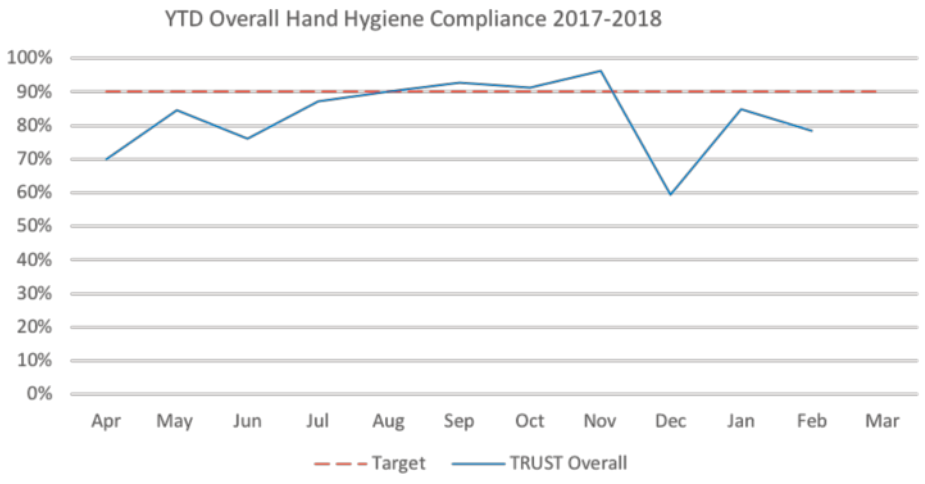


Table 3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Trust Overall	97.0%	97.0%	94.8%	94.3%	96.8%	95.7%	93.0%	95.0%	95.0%	93.0%	91.0%
North East	95.0%	95.0%	97.8%	96.2%	96.0%	97.0%	98.0%	98.0%	98.0%	98.0%	97.0%
North Central	99.0%	99.0%	82.5%	91.2%	97.0%	97.0%	97.0%	90.0%	97.0%	91.0%	97.0%
North West	99.0%	99.0%	98.3%	98.0%	98.0%	96.0%	96.0%	93.0%	96.0%	98.0%	98.0%
South East	99.0%	98.0%	98.3%	95.5%	97.0%	98.0%	99.0%	97.0%	95.0%	95.0%	99.0%
South West	97.0%	97.0%	94.0%	94.0%	96.0%	98.0%	99.0%	97.0%	95.0%	95.0%	96.0%
Others							95.0%	95.0%		100.0%	91.0%
HART							65.0%	81.0%	89.0%	80.0%	65.0%
NETS	93.0%	93.0%	9.3%	91.0%		88.3%	96.0%	95.0%	83.0%	87.0%	85.0%

Clinical Effectiveness

Target 1: Improve outcome as reported Ambulance Quality Indicators

We have implemented and constantly measure best practice models of care following the introduction of the Ambulance Response Programme (ARP) in October 2017. Currently we are 3rd best performing ambulance trust nationally against these response time indicators.

We have maintained our programme against the Stroke Care bundles at 96%. However, in relation to STEMI patients we are below the national average. We will continue to focus on this.

Target 2: Standardise hospital handovers including the use of NEWs for the sickest patients

We recognised that hospital handover delays is a multi-factorial system problem and we needed to work together to identify issues at each stage and resolve them. The LAS has worked with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London.

ED Site visits up to October 2017

The Emergency Care Improvement Programme (ECIP) were tasked to complete a series of site visits and assessments leading to improvement recommendations at various acute hospitals. Follow up visits commenced in October/ November to measure progress against the individual recommendations made by ECIP. This work has also included widespread sharing of Patient Flow guidance with operational leads at each acute site and the identification of LAS contacts for trusts.

LAS engagement managers have worked with their local EDs to support ECIP led initiatives designed at reducing the potential for handover delays to occur. By identifying patients who could either wait or be seen in a hospital chair (#fit2sit). Or through reviewing the conveyance choices made by LAS clinicians (Front Door Challenge); for example could their patient of been seen in another area of the department, or have been conveyed/referred to an alternative pathway.

Sharing of LAS predicted data
Predictions of LAS activity for conveyance numbers by day of week/hour to each ED were shared to support stakeholders in their winter planning. LAS predicted activity is shared weekly with the NHS E Winter Room for inclusion in its daily update report

Cohorting process

Patient cohorting is a process whereby ambulance clinicians handover the care of their patient to an ED clinician immediately after triage regardless of bed availability. This can allow ambulances to become available for dispatch to another incident more quickly; it is the responsibility of Acute Trusts to implement and staff this. Ambulance-led cohorting is the same process, but is implemented and staffed by the LAS because it is felt that the risk of not doing so would be to the significant detriment of the Trust and patient safety. A standard process for Cohorting across London including the triggers and reporting process for when it can be used has been designed and implemented with the agreement of NHS E.

NEWS is based on a simple scoring system which allocates a score to physiological measurements in adult patients. The aggregate NEWS score provides an indication of how unwell the patient is. Patients are assessed and attributed a score and category (Red ≥7, Amber 5-6 and Green <5) the categories are regarded as high, medium and low risk respectively. The trial started on 21.12.17, a NEWS card is attached to the patient whilst waiting where handover is delayed and/or cohorting is implemented. The card is contained within a plastic wallet, an elastic band is used to attach the card to the patient's wrist. The card is folded to ensure that the appropriate red, amber or green

Table 4

	2017-18*		2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)

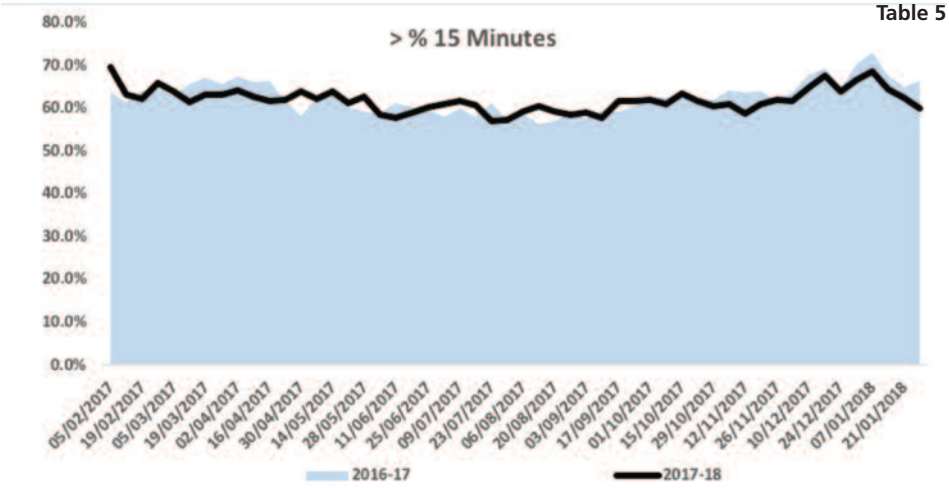
**At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.*

page is visible before being placed into the plastic wallet which is then attached to the wrist of the patient. It is intended that staff would commence use of NEWS cards where the anticipated wait is likely to exceed 30 minutes and in all cases where Cohorting is commenced. The NEWS is reassessed every 30 minutes until the patient is handed over to ED staff. The trial aims to assess the impact of handover delays on patients, assisting in the identification of unwell or deteriorating patients.

Performance update Jan 2018
As the following charts highlight hospital performance in 2017/18 when measured by handovers over the 15, 30 and 60 min target and total time lost has improved against the same period in 2016/17

Our work on hospital handovers has been recognised as outstanding practice and has played a significant role in reducing waiting times for patients, we will continue this work through 2018-19.

Table 5



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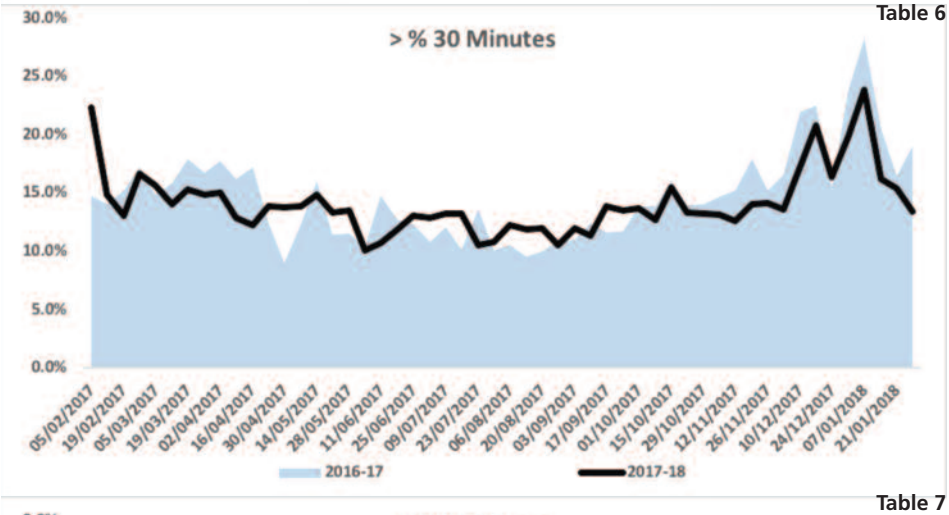


Table 7

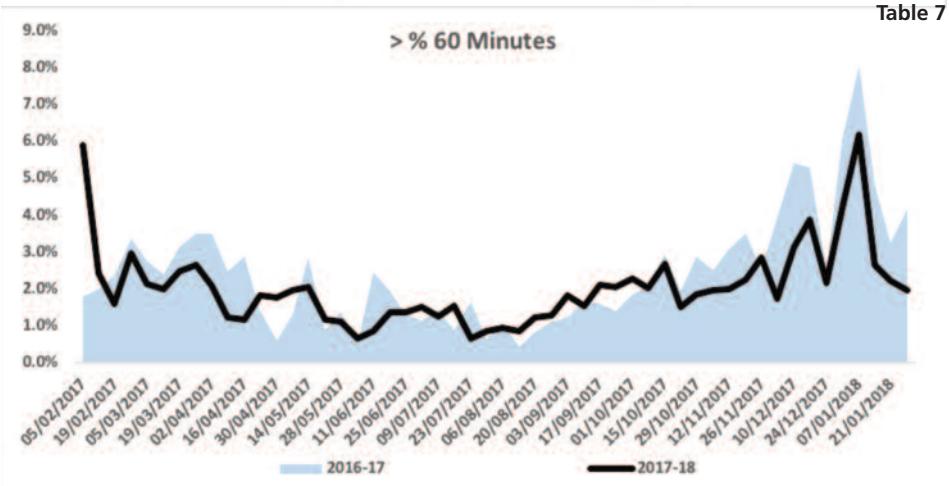
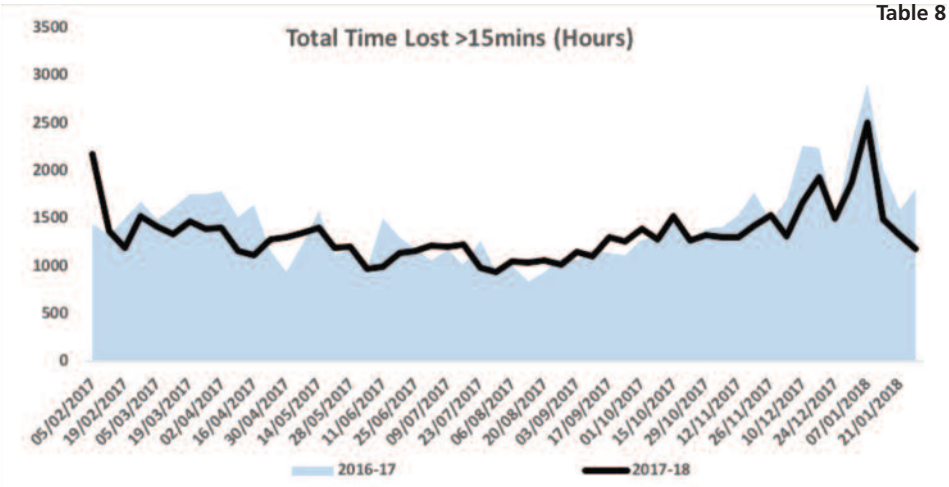


Table 8



Target 2: Develop a mortality and morbidity review process

We have introduced a mortality review group to ensure information is available in relation to specific groups/themes to target learning and improvement. We are also working with other ambulance trust to ensure we have a standardised approach to share learning across different organisations. The outcome of the analysis is aggregated with information from SIs, incidents, complaints, claims to provide identification of themes and focus improvement efforts. Preventing Future Deaths notices are now reported into this group and also discussed at Quality Oversight Group to enable thematic analysis of trends across all incidents.

We are also working with other ambulance services to agree a standardised approach to mortality reviews and to share learning across different services.

Conclusion

Our progress during 2017-18 has been significant and has brought about much improved outcomes for our patients, as demonstrated in this section of the report. We will strive to continually improve and sustain that improvement through our quality improvement plans for 2018-19 and beyond.

Section 4:
Statements of assurance from the Board

Statements mandated by NHS England

Each year we are required to report a number of mandatory statements, which you will find reported in this section:

Data Quality Assurance

The London Ambulance Service manages data quality for Accident & Emergency information, using a bespoke application developed internally. All information received from the 999 CAD system, Command Point, Mobile Data Terminals (MDT) and Patient Report Forms (PRFs) is processed through this application. Within the application, records that satisfy any of the pre-defined validation rules are presented for reviewing, and can be amended where necessary, if there is adequate evidence available to do so.

Records are reviewed for:

- Illogical time sequences between timestamps
- Unlikely gaps between timestamps
- Incorrect hospital codes
- Missing timestamps where one would be expected
- Conveyances by non-conveying vehicles
- Patient Handover breaches at hospital
- Mismatched Patient Report Forms (PRFs)
- Discrepancies between Command Point, MDT, and PRF data

A facility is available to allow staff outside of Management Information to request a review of any data items. These data quality queries are submitted via the Business Intelligence (BI) Portal for consideration by the Data Quality team to ensure that they meet agreed rules. No-one outside of the Data Quality team within MI can make amendments to any records. There is an audit history for any record flagged for reviewing, and all changes and actions taken (or not taken as the case may be) are logged with the username/change made/date/time.

All reports produced by the Business Intelligence team follow a pre-determined check list to ensure accuracy and compliance with Ambulance Quality Indicator guidance. Every report is peer reviewed and approved by a senior member of the team prior to publication

A report demonstrating compliance against the Ambulance Quality Indicators (AQI) guidelines is submitted annually to Executive Leadership Team (ELT) for approval. A data quality strategy is under development to be approved by the Trust Board in 2018.

Income

The income generated by the NHS services reviewed in 2017 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2017/18.

Clinical Effectiveness and Audit

The London Ambulance Service NHS Trust has a robust clinical audit and research programme that focuses on both local and national areas of priority. In 2017/18 the LAS examined the care provided to a wide range of patients including those that had a heart attack, cardiac arrest, stroke, trauma, mental health related conditions and paediatric care. Our research programme continued to grow and alongside our existing cardiovascular studies (including the world's largest randomised controlled trial of adrenaline in cardiac arrest), we launched a new randomised control trial examining whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest.

In addition to continuously assessing the care provided to cardiac, stroke and trauma patients, during 2018-19 we will focus on sepsis care with the introduction of a new continuous registry. We will also continue to audit the appropriateness of decisions made for patients who are discharged at scene and then re-contact the Service within 24 hours having severely deteriorated or died unexpectedly.

Clinical audit

During 2017/18, only one national clinical audit and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audit and national confidential enquiries that the London Ambulance Service NHS Trust was eligible to participate in during 2017/18 are as follows:-

NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:

- Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
- Outcome from cardiac arrest – Survival to discharge
- Outcome from acute ST-elevation myocardial infarction (STEMI)
- Outcome from stroke

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

The London Ambulance Service NHS Trust submitted the following

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
NHS England AQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 1,962 b) 263	a) 1,962 b) 263	100%
NHS England AQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 1,881 b) 235	a) 1,881 b) 235	100%
NHS England AQI: Outcome from acute STEMI a) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. b) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 658 b) 1,531	a) 658 b) 1,531	100%
NHS England AQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 3,737 b) 6,411	a) 3,737 b) 6,411	100%

Table 9

Table 10

	2017-18*		2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)

**At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.*

information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2017/18 and 2016/17.

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: data are captured by the LAS from clinical records completed by ambulance staff attending patients as part of on-going clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The reports of the above national clinical audits were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust has taken actions to improve the quality of healthcare provided as set out in Appendix 1.

CQUINS

A proportion of London Ambulance Service NHS Trusts income in 2017/18 was conditional on achieving quality improvement goals within the contract. The 2017/18 CQUIN schemes were set according to the Commissioning for Quality and Innovation payment framework and either set nationally, or agreed with the lead Commissioner, Brent CCG, acting on behalf of the pan-London CCGs. Further details of the agreed goals for 2017/18 are detailed in Appendix 2. Achievement will be confirmed following the final Q4 submission, due in April 2018.

Serious Incidents (SIs)

A total of 459 cases were reviewed by the Serious Incident Group in 2017/18. Of these, 92 incidents were deemed to meet the criteria to be declared as serious to NHSE.

In July 2017 the SI investigation process was reviewed and significant changes made. The process was launched in August 2017. Improvements were made to the DatixWeb system to enable clearer monitoring and enhance compliance with internal and external deadlines. Current Lead Investigators across the Trust attended an update/refresher training day and the Quality, Governance and Assurance Team provide serious incident investigation training each month for new investigators. As of March 2018 a total of 57 managers have been trained to investigate serious incidents. To assist in times of high operational demand, significant efforts have been made to utilise managers from other areas of the Trust. Of the 57 trained investigators 38 are operational managers and 19 are from non-operational backgrounds.

Currently the Trust does not have any serious incident investigations that have breached the 60 working day deadline to the CCG. During January 2018, the Trust instructed KMPG to undertake an independent audit of the revised serious incident process. The outcome of this provided significant assurance that the Trust was investigating incidents effectively, actions were taken in a timely manner, patients and relatives were informed and staff were supported.

Quarterly thematic reviews have shown issues concerning call handling and dispatch and clinical treatment. Themes from the reviews have been shared across the Trust and actions to address the concerns have been incorporated into an intensive actions plan for the Emergency Operations Centre (EOC). Additional actions have been taken in relation to the clinical treatment concerns and are detailed below.

Learning from experience

Below show some examples of where the Trust have made improvements as a result of serious incident investigations:

13 Change in practice regarding the management of cardiac arrests as a result of a significant number cases concerning delayed defibrillation

14 Changes within the Gazetteer system to improve the accuracy of locations across London

15 Policies that have been identified to be unfit for purpose have been reviewed and updated

16 Improved training, compliance audits and the development of a new policy for the management of breached Patient Group Directions

17 Guidance issued to staff on the management of paediatric patients with particular focus on

the measurement of oxygen saturations

18 Development of a feedback mechanism of all maternity related incidents to the maternity training programme

19 Process for investigating and managing thematic reviews of similar incidents. For example; delayed defibrillation and the Non-emergency Transport Service

20 Equipment concerns highlighted to the equipment replacement programme which assisted in the development of business cases to replace specific pieces of equipment

21 Learning from incidents training delivered to all EOC staff and included on the paramedic academy courses

22 Incorporation of case studies to the internal leaning from incidents Insight magazine

23 Changes to practice included in core skills refresher courses for both EOC and frontline operations

24 Case studies included in the internal Clinical Update magazine

Future developments
During 2016/17 the Chief Quality Officer led an in-depth review of the serious incident process with the objectives to review the time taken to investigate incidents and improve the sharing of learning from investigations. The reviewed process amended and three nominated Executive Directors now form a panel for reviewing and signing off reports.

The focus for 2018/19 will be centred on the development of the Quality Governance and Assurance Team. To date the team has a newly appointed Head of Quality Governance and Assurance, current roles have been reviewed, job descriptions developed or updated and clear lines of responsibility have been assigned. Work will continue to appoint a dedicated risk manager and a team of business partners to provide an additional level of support to the serious incident process and lead investigators.

Duty of Candour

Duty of Candour training is part of the mandatory training for all relevant members of staff and is valid for three years. Currently 4,446 (87%) members of staff have completed the training. Additionally all Lead Investigators are provided with the regulation 20 compliance requirements, its place within the serious incident process and the history of the regulation.

The role of the lead investigator will include the requirement to have a robust working knowledge of the Duty of Candour process and these individuals will be responsible for ensuring compliance will all investigations assigned to them. Further support regarding the Duty of Candour is found in both the revised Duty of Candour Policy and Serious Incident Policy. To improve the monitoring of Duty of Candour compliance in relation to serious incidents and those graded as moderate harm, the Datix Web system was developed to include a section dedicated to the individual stages and allows for compliance reports to be reviewed.

CQC

Following the June 2016 Care Quality Commission (CQC) inspection of the service, the LAS developed a Quality Improvement Programme (QIP) which was a single overarching plan to address quality improvement in the Trust. A clear programme of delivery, accountability and governance was established, led by the Chief Quality Officer and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our QIP via Executive Leadership Team meetings and via Quality Oversight group, Quality Assurance Committee and Board.

This Quality Improvement plan has been delivered the majority of actions completed, with a number of actions being incorporated into business as usual for Directorates; projects of a more complex nature, which are yet to be completed, are being incorporated into the 2018/19Business Plan.

The CQC has conducted a Well-Led inspections of The London Ambulance Service NHS Trust on March 21st and 22nd 2017 . Two unannounced visits were also carried out in:

- Emergency Operations Centres
- Urgent and Emergency Care sites

The final report will not be available prior to the publication of the annual Quality Account, however initial feedback is positive and the report will be available in May 2018.

Safeguarding

The London Ambulance Service NHS Trust are continuing to ensure the safeguarding of children and "adults at risk" this remains a focal point within the Trust, which is committed to ensuring all persons within London are protected at all times.

The Trust has seen an increase of incidents and safeguarding concerns raised by our staff to 1.95% reporting around 1800 concerns a month to the local authorities. The Trust has recruited a full time administrator to assist with the increased workload.

During the year we have introduced two new policies:

- Safeguarding supervision policy
- Chaperone policy

We have also improved our governance arrangements and introduced several quality assurance practice review groups that scrutinize concerns raised by staff and ensure best practice to protect those at risk.

- Child Death Review Group
- Safeguarding Incident Review Group
- Care Home Review Group
- Prevent Review Group

The Trust continually seeks to learn from practice and detailed below is some of the learning from safeguarding cases in 2017-18:

- A Safeguarding Adult Review (SAR) Found that the LAS and other agencies failed to notify the police of severe neglect, we are now working in partnership with the police and have produced materials on the importance of involving the police in safeguarding cases and provided training to over 90% of clinical staff.
  We have also written an article tor the Trust "Clinical News"
- Following a Serious Case Review (SCR) it was felt staff did not gain enough information about a situation and missed vital facts. We have since improved our safeguarding training and included a section on professional curiosity.

- The Trust has also introduced an escalation policy for repeat safeguarding concerns raised by staff, this is a result of several case reviews which identified we made multiple referrals for patents, but these were unsighted and no additional action was taken.

The Trust continues to improve its safeguarding practice and during 2017-18 has:

- Established pathway for young violence referrals to "Red Thread"
- Increased partnership working and engagement
- Introduced safeguarding supervision
- Fully integrated 111 safeguarding into Trust processes
- Improved response for safeguarding information to partners through recruitment of a full time administrator.

The Trust has a good working relationship with a wide range of partners. Working in Partnership is vital to protect people from abuse and neglect. The Safeguarding Team continues to support and educate staff to recognize the signs of abuse and neglect, report concerns and monitor and assure safeguarding practices through on going audit review groups.

Staff Survey

For 2017 the survey was sent to all Trust staff electronically for the first time. Of 4970 eligible employees 2664 questionnaires were completed, giving an overall response rate of 54%. This is the highest ever response rate for the Trust and supports the determination of the Executive Team to gain extensive feedback on the employee experience to inform developments and focus for 2018/19.

The average response rate across all Ambulance Trusts was 46%. LAS' response rate is therefore significantly higher than other Ambulance Trusts.

The main published report sees the findings of the questionnaires summarised by the national survey centre Picker Europe, on behalf of the Department of Health, presented in the form of 32 Key Findings (KF). This year the Key Findings are presented under nine themes listed below:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

Overall indicator of staff engagement

The staff engagement score ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their Trust) and 5 indicating that staff are highly engaged.

The Trust score was 3.36 compared with 3.39 in 2016.

The overall indicator for staff engagement is calculated using three key findings:

- Staff recommendation for the Trust as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute towards improvements at work

Summary of Key Improvements and Developments

The categories where the Trust has performed better are:

- Working patterns
- Patient care and experience
- Reporting incidents

The categories where the Trust performed less well are:

- Violence, harassment and bullying
- Equality and Diversity

The key findings which benchmarked higher than other Ambulance Trusts were:

- % satisfied with the opportunities for flexible working
- Effective team working

By key finding, the areas where the Trust needs to focus improvement is:

- % staff appraised in last 12 months
- % believing the organisation provides equal opportunities to career progression/promotion
- % reporting good communication between senior management and staff
- % agreeing that their role makes a difference to patient/service users
- % experiencing harassment, bullying or abuse from staff in last 12 months
- % reporting most recent experience of harassment, bullying or abuse

Key staff groups

Gender

Women had more positive scores overall than men (26 out of the 32 key findings). Women had a staff engagement of 3.43 compared with 3.34 for men. Slightly less women had appraisals (73% v 75%) and also scored higher in levels of work related stress and attending work despite feeling unwell. None of these scores were statistically significant differences.

Black and Ethnic Minority staff

In 21/32 key findings BME staff had a more positive response than white staff. An additional 2 key findings had the same score. BME staff had a staff engagement score of 3.43

compared with 3.36 for white staff. BME staff had higher levels of job satisfaction except for their perceived ability to contribute towards improvements at work. BME staff reported higher rates of experiencing bullying and harassment from white staff (38% v 31%) and a slightly lower rate of reporting (30% v 31%). Levels of appraisal were 5% less for BME staff and they also rated the quality of training lower.

The scores with the most significant difference were in relation to Equality and Diversity. 37% reported experiencing discrimination at work compared with 26% of white staff and 47% felt that the organisation provides equal opportunities for career progression and promotion compared with 62% of white staff.

Taking Action

All actions will be later found by a network of Staff Survey Champions, these have been identified to create and deliver action plans locally across all areas of the Trust. Champions have been encouraged to work with their local union reps in taking forward this work. Each Champion has been provided with a survey report for their area and will engage with their colleagues to identify the areas for improvement and potential actions. It was recommended that each action plan focused on 3 actions.

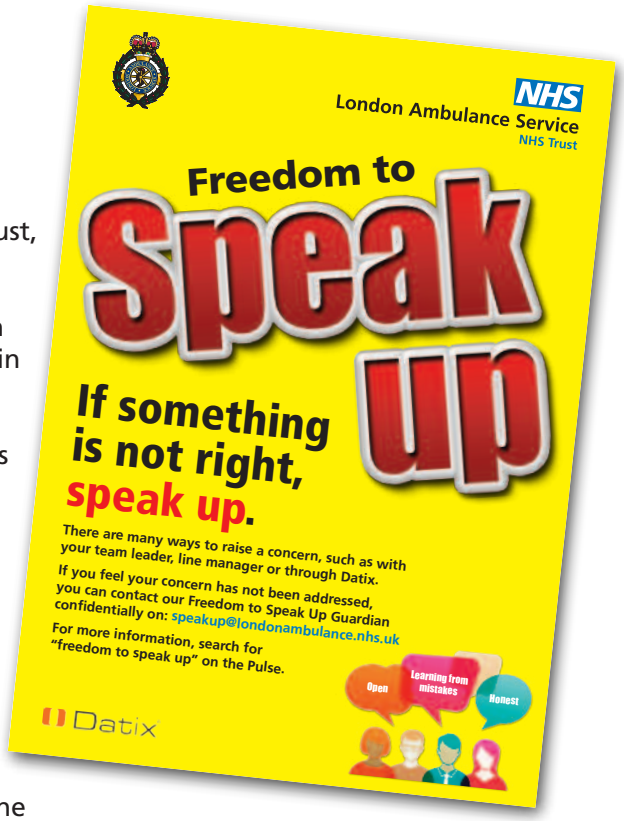
Champions came together to provide them with an overview of the staff survey outcomes and a toolkit to support the development of action plans. Follow up events will be planned during the year to provide an opportunity to update on progress, share ideas and provide support in the development and delivery of action plans. Basecamp (an online sharing platform) has been set up as a document repository and as an area to share information and provide peer support.

As each local area has been asked to identify 3 actions, the Trust decided upon a Corporate action plan to supplement this with 3 Service wide actions based on the 3 key findings which had a statistical decrease in 2017.

These are:

- % believing the organisation provides equal opportunities for career progression (by 14%)
- % able to contribute towards improvement at work (by 4%)
- % reporting good communication between senior management and staff (by 3%)

Freedom to speak up



Freedom to Speak Up Guardians have been introduced in each NHS Trust, as a result of the recommendations in the Francis Report. A Guardian was appointed at the LAS in October 2016, and undertook this role in addition to her core role as Head of Patient & Public Involvement and Public Education. She stepped down at the end of December 2018, to be replaced by a full-time interim Freedom to Speak Up Guardian, who was tasked with promoting the role in the Trust and facilitating the recruitment of a permanent Guardian.

Since the role was introduced the Trust has:

- Announced the role in the internal Routine Information Bulletin and produced a leaflet to be attached to staff payslips.
- Established a Freedom to Speak Up LAS group, with dates to meet quarterly.
- Agreed reporting arrangements to the Trust Board.
- Designed a secure recording and reporting module on Datix, which is only visible to the Freedom to Speak Up Guardian.
- Hosted a successful visit by colleagues from the National Guardian's Office.
- Had its Freedom to Speak Up arrangements audited by KPMG. The LAS was the first NHS organisation to have taken this action.

The LAS Guardian has attended the national launch and undertaken the Freedom to Speak Up training. He is a member of the London regional network and national ambulance network for Freedom to Speak Up Guardians.

Since the role has been introduced, a total of 9 concerns have been reported. The majority of these have related to a bullying culture across a team or part of the organisation, two have related to trust processes, two to patient safety concerns, and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements. Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.

Information Governance

London Ambulance Service NHS Trust Information Governance Assessment Report overall score for 2017/18 reached 83% satisfactory, Level 2 for all requirements.

National Reporting

London Ambulance Service NHS Trust did not submit records during 2016/17 to the secondary users service for inclusion in the Hospital Episode Statistics.

London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Section 5:
Reporting on core indicators

In October 2017/18 the ambulance response categories changed following the national implementation of Ambulance Response Programme. The figures below will therefore represent the category achievements to October and the changed categories from October to March 2018.

April to October categories

Cat A These are calls or incidents categorised as immediately life threatening, Cat A subdivides into Red 1 and Red 2. The categories are based on AMPDS codes provided by the Department of Health.

Category A % reached in 19 mins: The percentage of Cat A incidents where any responder capable of conveying a patient arrived at the scene of an incident within 19 minutes. This is measured from clock start to when the first conveying vehicle (MRU/CRU – if only vehicle) arrives on scene. The target is 95% within 19 minutes.

Red 1
This is a subcategory of Cat A, these are the category of calls that are deemed the most time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from call connect to when the first responder arrives on scene.

Red 2
This is a subcategory of Cat A, these are the category of calls that are deemed serious but less immediately time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from either first dispatch, determinant or 240 seconds and the clock stops when the first responder arrives on scene.

Table 11

	A8			A19		
	R1	R2	A	R1	R2	A
Apr-17	79.38%	73.63%	73.83%	98.98%	95.44%	95.56%
May-17	73.71%	71.90%	71.96%	98.60%	94.94%	95.06%
Jun-17	73.61%	69.75%	69.88%	98.38%	94.26%	94.39%
Jul-17	72.51%	68.55%	68.69%	98.64%	94.01%	94.17%
Aug-17	74.47%	72.05%	72.14%	98.54%	94.32%	94.47%
Sep-17	70.70%	68.47%	68.54%	98.23%	93.75%	93.90%
Oct-17	73.28%	68.65%	68.82%	98.90%	94.79%	94.94%
2017/18	**73.90%**	**70.40%**	**70.52%**	**98.61%**	**94.50%**	**94.64%**

Table 11 demonstrates our achievement of these category calls during 2017-18 from April to October.

The month on month performance for A8, A19 and the year end position.As the Ambulance Response Programme was implemented on the 1st November 2017, year end position is calculated from April to 31st October 2017.By way of comparison, the 2017/18 year end position shows a considerable improvement at the same point for 2016/17. (from April to October 2016).This improvement is more noticeable for the A8, Red 1 (R1) and Red 2 (R2) measures. The overall A8 measure increased by 4.51% from 66.01% in 2016/17 to 70.5% in 2017/18. Red 1 performance increased by 5.27%, from 68.64% in 2016/17 to 73.9% in 2017/18.Red 2 performance improved by 4.47% from 65.93% to 70.40%.

Table 12

System Indicators Post ARP implementation	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
November 2017	00:07:03	00:11:28	00:18:25	00:36:28	02:13:10	02:28:48
December 2017	00:07:23	00:12:04	00:24:07	00:51:08	02:58:23	02:51:44
January 2018	00:07:08	00:11:43	00:20:23	00:42:05	02:24:59	02:19:05
Current YTD (2017/18)*_ * From 1st November 2017 – 11th February 2018	00:07:13	00:11:46	00:21:14	00:44:13	02:32:34	02:31:55

System Indicators – Post ARP Implementation

The above table shows the six key indicators and our performance since the Ambulance Response Programme was implemented (November 2017).Performance in all 6 measures improved in January 2018, seeing a reduction of the time taken to respond to patients compared to December. The most significant improvement was seen in categories 3 and 4 where there was a reduction of over 30 minutes for C3 and C4 90th centiles. The C1 mean performance has been stable week on week since November 2017, which is reflected in the monthly performance. Januarys 2018 shows a reduction by 15 seconds to 7 minutes and 8 seconds. This is marginally above the national standard of 7 minutes. C1 90th centile shows each monthly performance successfully within the national standard of 15 minutes, this is also reflected in the year to date position at 11 minutes and 46 seconds. C2 mean is above the 18 minutes by a few minutes each month. The year to date position shows 3 minutes and 14 seconds above the national standard. C4 90th centile has remained within the national standard of 3 hours every month since the implementation of ARP. The year to date performance is within the national standard by a substantial 28 minutes and 5 seconds.

Complaints and Patient Advice & Liaison (PALS)

Introduction

Patient experience and feedback is a rich source of information that allows us to understand whether our services are meeting the standards we set ourselves and meeting patients' expectations. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously and do our best to offer a comprehensive response, clearly identifying any lessons and using these to improve our service, where appropriate.

It is important to ensure that patients' voices can be heard. To this end, and to compliment the information we already have available, this year we introduced two new leaflets under the banner of '*Talking With Us*'. The first is available on all ambulances, providing information about how to make a complaint or to thank our staff; the second is sent out with every complaint response, inviting complainants to feedback on their experience of making a complaint.

Activity

Year ending March 2018, the volume of complaints dropped slightly, totalling 938 against 1016 in 2016/17. Enquiries continue to increase 4277 against 4215 being received in 2016/17. The PTS service has reduced dramatically, now operating as NETS. NHS 111 complaints (via LAS) are also hosted by the team.

The Resource Escalation Action Plan (REAP) was used during persistent periods of high 999 call demand meant that the REAP level for this year was mostly implemented at moderate or severe. The daily average for 999 calls is currently 5185. The average percentage of complaints received against calls **attended** is [0.08%].

Complaint risk score – to 21/02/18

During 2017/18, 26 complaints and one PALS enquiry were referred to the Serious Incident Group. Of these, eight were declared as a Serious Incident.

Risk grade 2017/18	Data
Low	807
Moderate	125
Significant	5
High	1
Total	**938**

Complaint outcomes details

If a complaint is upheld, learning will be noted and actioned accordingly. This can involve a range of measures including feedback, reflective practice and bespoke training held locally, with emerging themes reported to the relevant department/Governance Committee to consider action. The Patient Experience Annual Report, published later this year, will provide a comprehensive analysis.

Table showing complaint outcomes of **closed** complaints 2017/18

2017/18	Data
Not upheld	483
Partially upheld	117
Referred to other Agency	102
Upheld	83
Actioned	29
Under investigation	124
Total	**938**

Table 13

Complaints by subject 2017/18	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	21	255
Conduct	16	19	24	19	19	16	17	25	20	22	23	20	240
Road handling	12	11	13	14	10	7	14	9	7	6	10	6	119
Treatment	1	2	5	1	7	5	16	8	9	8	14	4	80
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	4	47
Totals (above)	53	49	62	60	62	38	75	76	62	59	90	55	741
Annual totals	**66**	**70**	**77**	**73**	**86**	**51**	**94**	**85**	**84**	**74**	**102**	**76**	**938**

Themes

These continue to be dominated by delay and staff conduct. However, many complaints increasingly involve multiple issues, for example, call management + a delayed response + attitude of crew staff + care provided.

The top five key subjects were as show in table above:

Performance

We have been able to achieve a significant improvement in throughput performance targets. Year to date performance is 82% responses within 35 working days.

To achieve this the following measures have been actioned

- Improved resourcing to Quality Assurance team
- Closer relationship with QGAMs
- Changes in some of the methodological processes the team use
- Changes in administrative practice at the Executive Office.
- Weekly review of complaints against target response times

We do however continue to experience external factors that can influence performance, for example telephony and IT problems.

Examples of learning
Complaints continue to be a powerful tool to describe patients' experiences and the learning that has resulted are presented to the Patient Feedback and Learning Group.

Staff attitude

Our practice when we receive a complaint about staff attitude and behaviour is to additionally review the care provided, which has often demonstrated a correlation.

Example one - delay/call management

Complaint from patient's mother that there was a delay in attending her daughter when she experienced a seizure.

On assessment questioning, it was confirmed that the patient was had experienced a grand mal seizure, which was still in progress. This presentation amounts to a high priority emergency with a Fast Responder and an ambulance being sent whilst the call was in progress. The call handler stayed on the line and the patient stopped fitting and recovered. At this point, her symptoms were determined at a lower priority. The Fast Responder was duly stood down (as they are maintained to be sent to patients determined at a high priority. The ambulance crew were similarly diverted in favour of a patient assessed as a higher priority emergency. Satisfied that the patient was not at any immediate risk, the call handler concluded by explaining that an ambulance would be arranged but it could take up to 45 minutes for help to arrive, so a further 999 call should be made if the patient's condition changed in the interim.

The Quality Assurance evaluation found that the initial highest priority should have been maintained as the event should be assessed as a continuous fit in view of the duration. Given the complexity of the patient's care arrangements, we agreed to arrange a specific emergency care component of the patient's care plan.

Example two - staff attitude call handler

Complaint from relative about the way she was spoken to when she made the 999 call about a patient who had collapsed
The call hander had difficulties in establishing whether the patient was breathing and was very assertive in trying to calm the caller down so that she could clarify this. However, they did not manage the situation very well, deviating from the prescribed questioning, omitting to use the breathing detector tool, failing to verify the location or to apply appropriate customer service skills. As well as feedback being given to the call hander concerned, we recommended the case be used as a training example in managing challenging calls.

Example three - attending staff attitude

Complaint from the patient about the aggressive manner towards her
The patient was a familiar caller to 999 and made multiple complaints about ambulance staff We had worked with the health and social care professionals responsible for her care to establish an emergency care component of her plan but we continued to look at each case on its merits. On this occasion, although we found that the overarching care provided was reasonable and that the paramedic needed to be assertive, his use of pain stimulus was unnecessary.

Example four – treatment

Complaint from patient that a nebuliser was not administered after she suffered an asthma attack
It would seem that the paramedic felt the patient had a chest infection. However, the information detailed in the assessment record was minimal, which made it problematic to conclude a nebuliser should have been used. This is because a chest infection of itself does not mandate a nebuliser, chest infections can precipitate asthma. We concluded that if there was any suggestion of a wheeze or exacerbation of asthma, then a nebuliser probably should have been given. Extensive feedback was given to the Paramedic with an emphasis on the importance of recording the assessment record to an optimum level. They were also asked to jointly review the treatment protocols in relation to patients with symptoms similar to this presentation.

Example five – treatment – Ombudsman/EOC

Notes on methodology:
For recording purposes, complaints about a delay in an ambulance response are attributed to EOC although we recognise that local operational resourcing may have played a contributory role.

As far as the outcome category, we take the view, accepted by the Health Service Ombudsman that a delay in an ambulance response does not of itself indicate a failure in service delivery.

The criteria we use in upholding a complaint is where a significant shortcoming is identified, for example that the EMD applied the wrong clinical triage protocol which in turn gave a lower priority determinant than should have been the case. This is applied in accordance with our holistic approach, which has been cited as best practice by the Ombudsman. This means that we look into related issues irrespective of what the complaint is about, or where we identify issues not complained about. Thus where a complaint is nominally about the call handler's manner, we will arrange a Quality Assurance (QA) evaluation review to ensure the call was triaged at the apposite level of priority. We also apply the Ombudsman's principles for remedy, including making financial recompense where appropriate.

In terms of performance, we concur with the Francis report in that complaints management is an organisational, not a departmental, responsibility. As such, throughput is a largely determined by the contribution of other departments, which can be compromised by significant demand to the Trust. We have now devised a means by which we can provide evidence of performance across the departments concerned.

Those cases where there has been a protracted delay reflect where the matter under investigation was declared as a Serious Incident (SI), the ensuing report being used to as the substantive response to the complaint. The delays were therefore once again completely outwith the control of the PED team although the Trust are now making strides in achieving improved SI completion.

Themes

- Delay caused by demand exceeding resourcing. On some recent occasions, less than adequate resourcing to EOC has been identified.
- Triage errors, including technical and procedural errors
- Poor staff attitude
- The practice of applying 'workarounds'
- Confusion in the application of the health professional protocol, both internally and externally, post ARP.

Learning from these themes

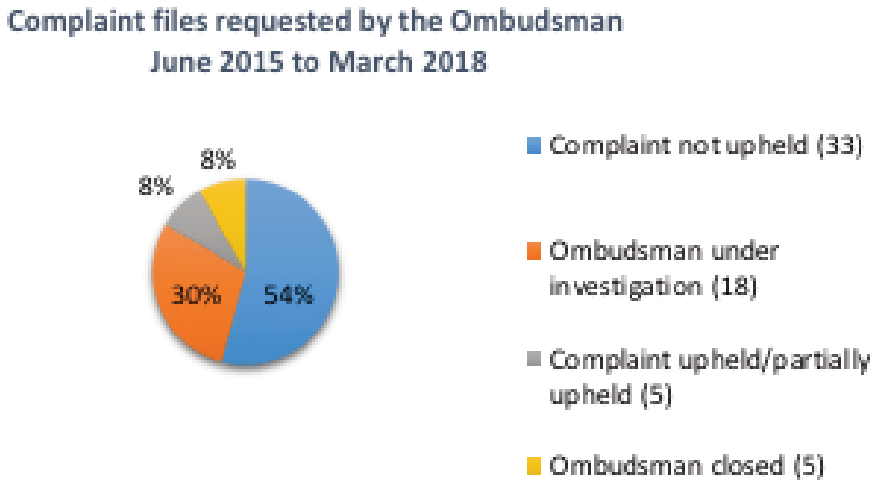
1. Complaint from family who were unhappy with the Serious Incident report, the key issues being the delay in an ambulance being sent and the care provided to the patient, who later died. Although the Ombudsman did not uphold the complaint in relation to the matters complained about, the report found that the practice in applying 'workarounds' to enable a higher priority response to particular patient symptoms amounted to maladministration.

The 'workarounds' the Ombudsman referred to were limited to very specific circumstances and put in place having been determined locally and based on other drivers (for example a Preventing Future Deaths notice, issued by the Coroner in an unrelated case) to ensure a more commensurate level of priority could be achieved, in the interests of patient care. We explained that some of these would no longer be needed when the Trust moved to use a newer version of MPDS. Solutions for the remaining issues, including the workaround that was at issue in this case, have been resolved following liaison with the International Academies of Emergency Dispatch and the Association of Ambulance Chief Executives, in the light of new Ambulance Response Programme (ARP) standards. Finally, we agreed to share the learning from this case with all UK ambulance services

Ombudsman cases

The Ombudsman continues to investigate a high proportion of complaints across all NHS Trusts, especially where a death has occurred.

Pie chart showing requests by the Ombudsman and outcomes:



Patient Engagement

The LAS Patients' Forum

The Trust continues to work closely with its Patients' Forum, an independent lay organisation that takes an overview of the Trust from the point of view of service users, carers and the public. The Forum provides representatives for all the Trust's governance committees and its own monthly meetings are hosted at LAS Headquarters, supported by the Patient & Public Involvement Team.

In the year 2017-18, Patients' Forum meetings included the following topics and speakers:

- Delivering safe and effective emergency and urgent care in London, presented by the Director of Operations
- Developing higher quality care, presented by the Deputy Director of Nursing & Quality
- Demand management, presented by the Deputy Director of Operations (Emergency Operations Centre)
- The CQC report findings, presented by the Chief Quality Officer
- Race equality in the LAS, presented by the Director of People and Organisational Development
- The Ambulance Response Programme, presented by the Assistant Director of Operations for Service Improvement
- Patient & Public Involvement in the LAS, presented by the Head of Patient & Public Involvement
- The flu epidemic and vaccination campaign, presented by Dr Sam Perkins from Public Health England

Patients' Forum members meet regularly with senior LAS colleagues, LAS commissioners and other key organisations such as the CQC, to highlight areas of good practice and areas where development is required.

Patients' Forum members have been directly involved throughout the year in the development of the LAS Academy. Together with staff from the Academy, they have formed a Patient and Public Involvement Panel, and attend steering group meetings. They have developed a teaching programme detailing patient and public involvement in the Academy's syllabus, and take part in assessment centres for the recruitment of students.

Friends and Family Test (FFT)

The Trust continues to record Friends & Family Test (FFT) responses from Patient Transport Service and See & Treat patients, although the response rate remains low. The total number of FFT responses received in the year 2017-18 was334. Almost all patients who responded to the question said they would either be "extremely likely" or "likely" to recommend their friends and family to the LAS if they needed similar care or treatment.

The National Ambulance Service Patient Experience Group is in discussions with NHS England and NHS Improvement, to highlight the limitations of this methodology for ambulance service patients and discuss alternative methods of patient engagement.

Community Engagement Events

The LAS remains committed to supporting a wide range of patient engagement and public education events with LAS presence requested at654 events in the year 2017-18. Of these, we were able to attend 506, 77% of all requests made. This is due to the ongoing support of over 1,200 staff on our database, with over 300 individuals taking part in multiple events, often in their own time.

We have created a closed Facebook group for staff involved in public engagement, as another method of communication. Through this group we provide information about the team and about forthcoming events, and staff can post their own ideas and questions for members of the team to answer. This has been extremely successful and the group has over 600 members.

The four part-time Public Education Officers continue to focus mostly on activities involving children and young people, such as awareness sessions on the dangers of carrying knives and of using alcohol and other legal highs, careers in the LAS, and multi-agency road safety events

such as Safe Drive Stay Alive and Biker Down. Many of these are carried out with partner organisations.

Blue Light Collaboration

We are working closely with our partners on the "prevention" sub-group of the Blue Light Collaboration project, to ensure we make the best use of the resources available and share good practice. The Head of Patient & Public Involvement and Public Education is an active member of the steering group and has now also facilitated the inclusion of the LAS Head of First Responders in the group.

One of the Public Education Officers has led on a key project as part of this work, piloting a scheme which involved all the blue light services attending schools in the London Borough of Haringey. Pupils participated in a range of sessions, rotating between them during a school day. The London Ambulance Service sessions focused on the consequences of carrying knives, and CPR (basic life support) training. The pilot has been evaluated and has been shown to be highly effective. A bid is now being submitted, with the aim of rolling out the scheme to other London boroughs.

Co-production and co-design activities

Co-production and co-design are powerful ways to maximise the benefit of patient involvement, both for patients and for staff.

Following the Insight Project, funded in 2016-17 by the NHS England Insight Team, a range of co-production activities have continued to gather momentum. These have focused on three specific patient groups: those with sickle cell disease, COPD (chronic obstructive pulmonary disease) and personality disorder. Some patients from those groups (sickle cell and personality disorder) have taken part in developing and delivering training packages for LAS staff, whilst others have taken forward ideas such as carrying health information "passports" or crisis cards (COPD and sickle cell) and how to get information across in a 999 call. Members of the personality disorder group delivered a presentation at the Safeguarding Conference this year, and have made a film for use in staff training. We are talking to the Sickle Cell Society about children and young people making a film about pain, for use in the LAS Academy's module on pain management.

Discussions have commenced with Healthwatch London, with a view to commissioning a local Healthwatch group to carry out co-production and co-design activities to support the new LAS Strategy. This work is likely to focus on the four 'pioneer' services: mental health, maternity, falls and end of life care.

The Trust also hosted an event for its Partnership Reference Group (PRG), which is made up of Healthwatch and voluntary sector organisations, to get the group's feedback on its strategic intent. Earlier in the year we held a PRG event focusing on volunteering, to share information about different schemes and learn from PRG members' experiences.

Staff development and training

The Patient & Public Involvement Team ran a four-day course in October for staff who volunteer to undertake patient engagement work for the Trust. The course has been running for a number of years now and is well-established, being updated and adapted each year according to the feedback received and the Trust's changing public education priorities. The course includes skills training (e.g. presentation skills), knowledge (e.g. disability awareness) and self-awareness activities such as an introduction to the Myers-Briggs Type Indicator (personality types). This year, because of the links made through the Blue Light Collaboration work, we were able to use the London Fire Brigade's training facilities, free of charge.

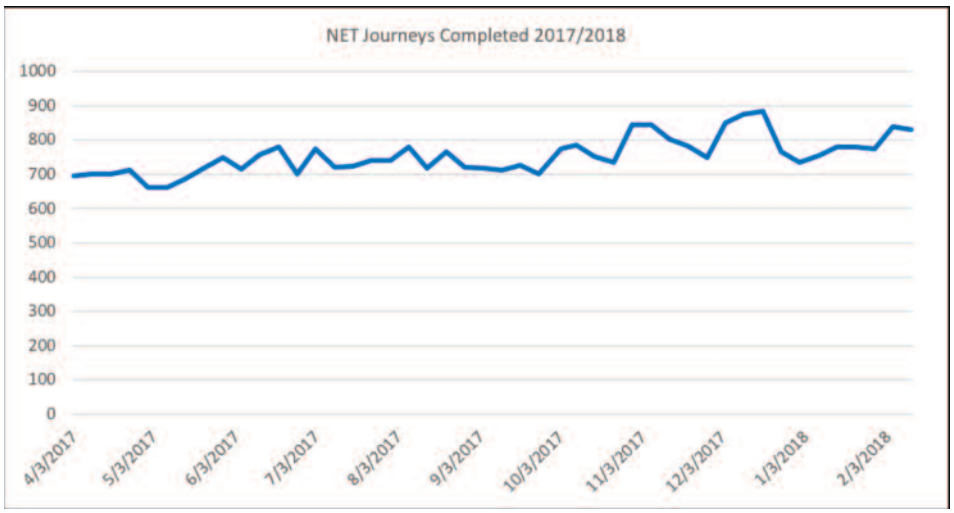
The Patient & Public Involvement Team has purchased an online disability awareness training programme, which any member of LAS staff can use at no extra cost. The course includes modules on a range of disabilities and gives practical tips and information about how best to communicate with people affected by those disabilities, and how to provide and adapt services for them.

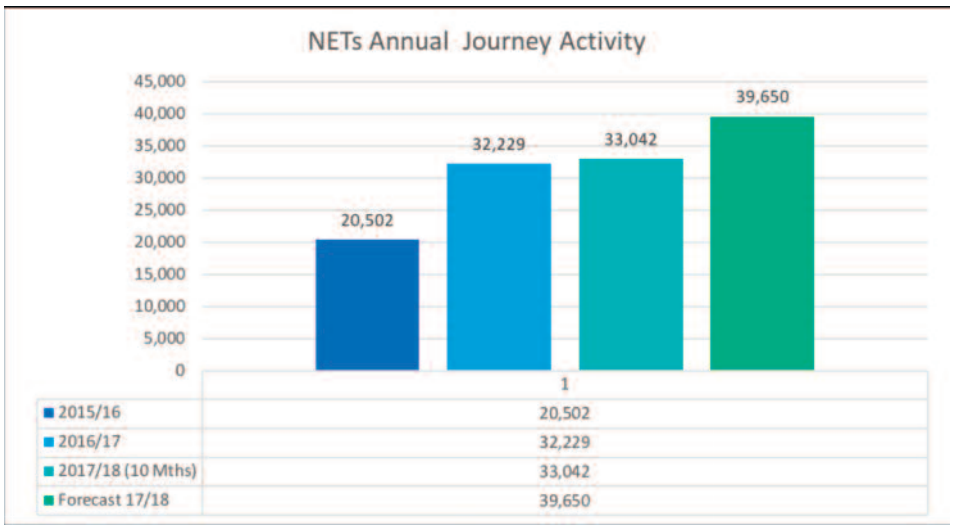
Every other month the Trust Board hears a patient story, usually told directly by the patient involved. This helps to ensure patients feel heard by the organisation, and provides an opportunity for Board members to hear about patients' experiences first-hand.

Section 6:
Other services

5a : Non-Emergency Transport Services

The **Non-Emergency Transport service (NETs)** which commenced in June 2015 has continued to grow. This service supports our core A&E service in transporting the lowest acuity patients to healthcare facilities where there is little or no clinical intervention required en route. As a result we are able to increase the availability of frontline crews to attend life threatening calls made to the service and ensure lower acuity patients receive transport within an agreed timeframe providing for a better patient experience.
The number of journeys completed by NETs has continued to grow in line with the development of the service with delivery rising from approximately 100 journeys a week at commencement to approximately 800 journeys a week by the end of the financial year. We are implementing plans to reach a target of 900 journeys per week. The increase in delivery of journeys is shown in the following graph:





The NETs pre-plan mental health community assessment journey requests via our e-booking system and use have now been rolled out to all the Mental Health Trusts in London. This project has been highly successful with the majority of this cohort of mental health service users now seeing transport arriving at the commencement of their assessment or within 30 minutes. Following on from the Mental Health Transport project the Service has also seen the pre-booking of journeys for end of life care patients where journeys are time critical rolled out and this service is now operating from three hospices. The service is currently engaged in the roll out of this service to all other Hospices operating within the London area.

In line with the growth of NETs, there has been an increase in the number of NETs operational staff from 90 to 120. The introduction of 13 apprentices last year under the national apprentice scheme have now completed their first year with us and have been employed by the Service with some working on NETs and some have been successful in applications to further progress and are now currently training to become TEACs.

All existing staff (PTS and NETs) have completed Core Skills Refresher training during the year which has included Infection, prevention & control, Safeguarding, Prevent, Sepsis, Dementia, Patient report forms and End of life care. In addition other statutory and mandatory training was delivered by e-learning.

Both of these services are an important part of our core business and they are fully integrated into our quality governance processes.

5b: South East London 111 - 2017/18

This report has been prepared to review the activity within LAS 111 South East London (SEL) for 2017/18 and has been broken down into nine key areas.

- Care Quality Commission Update
- Workforce Transformation
- Procurement of future services
- Incidents, complaints and feedback
- Call Quality and monitoring
- Safeguarding
- Patient Experience
- Training
- Pilots and Innovation

Care Quality Commission Update

Following CQC recommendations from the inspection in September 2016 (rated "Good" overall) SEL111 has continued to improve substantive staffing, more than halving the percentage WTE vacancy rate since April 2017. A gap analysis has been undertaken and there is an IM+T Project Plan in place to address the remaining issues. Finally open forums have commenced whereby Staff have an opportunity to meet with the HR Manager and 111 Operations Manager.

Workforce Transformation

By 31st March 2019 all NHS111

services are required to have evolved into an Integrated Urgent Care service, providing a "consult and complete" service, reducing referrals to other areas of the NHS. SEL are undertaking Phase 1 of the work required, having employed an Integrated Urgent Care Workforce Transformation Manager to oversee the process.

Procurement of Future Services

In January 2018, LAS was awarded the NHS 111 Integrated Urgent Care and clinical assessment service in North East London.

Mobilisation of the new service is in progress and LAS are due to commence Service delivery from August 2018. Future Annual Quality Account reports will include NEL Service performance.

Procurement has commenced for the future service for South East London and a bid will be submitted by 13 March 2018 for the service which is currently due to go live in October this year.

Incidents, complaints and feedback

Incident details

Two Serious Incidents were declared this year, both related to clinical advice and have been investigated, with all actions completed to ensure mitigation of future incidents. Incidents reported relate to a range of issues at LAS 111. A key trend identified over the last year has been errors in the referral of patients into an Out Of Hours (OOHs) service. The process for reporting and feeding back these incidents has changed and an action plan put in place to decrease the amount of incorrect referrals.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the LAS crews and the GP Out of Hours (OOH) providers. The majority relate to the perceived inappropriateness of the referral and whilst several have been upheld, some are due to a lack of understanding of the 111 system. Considerable effort has been put into improving understanding and communication channels between the 111 and 999 services; and also improving understanding between the 111 service and OOHs services, e.g. including them in End to End reviews and engaging in workshops to promote collaboration between services.

Type	Mar 18	Feb18	Jan 18	Dec 17	Nov 17	Oct17	Sep17	Aug17	July 17	Jun17	May 17	Apr 17
Serious incidents			0	0	0	0	0	0	0	0	1	1
Incidents			120	184	112	150	133	180	88	80	87	82
Complaints (formal)			8	19	3	5	7	7	5	4	2	8
HCP feedback			2	3	2	2	4	0	3	2	2	5
Compliments			4	6	1	1	3	2	3	2	0	6
Authorised confidentiality breaches			18	11	8	8	15	12	11	7	18	18
Wrong OOHs GP referrals			39	68	39	39	39	32	36	32	25	18

Table 14

Feedback to Health Care Professionals

12 feedback forms have been sent to other providers of care. Staff are encouraged to raise issues where the actions of other healthcare providers have resulted in a delay in patient care, or where a procedure appears to be unsafe or inappropriate. The most common issues are with regard to communication issues and handover of patients between services such as GP OOH Providers failures to accept patient referrals due to patient location, or disputes causing delay to patient care.

Authorised confidentiality breaches

Authorised confidentiality breaches are logged when a patient has been referred to a service without their consent and/or knowledge. The breaches are used for patients where it is deemed not safe to leave them without further assistance or in the case of safeguarding, not safe to notify them i.e. domestic abuse where the assailant is still on the premises. The breaches are authorised at the time of the incident by a senior clinician within the call centre.

Compliments

Twenty-eight (28) compliments have been received relating to both the service and individuals undertaking patient contact duties. Recognition for staff has increased, as compliments continue to be published in the Trust's weekly bulletin in addition to being displayed on site noticeboards.

Call quality and monitoring

We have continued to exceed the required standard for 1% of call audits every month including the winter months where demands on the service increased. Each staff member has a minimum of 3 calls audited each month. Where performance issues are identified the level of audit is increased. Since October 2017 compliance percentage (target 86%) has not been achieved. An action plan is in place to improve compliance with a focus on key themes identified during audits.

End to End call audits

Monthly end to end call reviews are undertaken at LAS111. This year a total of 50 calls were audited by the senior management team, including the Trust's Assistant Medical Director and South East London Clinical Lead. The audits are attended by healthcare professionals from the areas of focus which ensures their input and to improve partnership working, communication and practice. The end to end audits have all highlighted areas of good practice but also areas that require some improvement and action plans have been put in place to address concerns.

Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 415 people in total to Social Services which equates to circa 0.15% of all calls taken. Referrals for adults were predominantly for welfare concerns and for children for safeguarding issues.

As a large proportion of referrals stem from information provided in a patient's Special Patient Notes (SPN), a deep dive into the timeliness and validity of these SPNs is underway. Early data has been presented at the South East London Clinical Governance meeting. It suggests more can be done by external agencies to increase the reliability of this information.

Patient Experience

The 111 patient surveys are sent each month to around 300 patients, an increase from 250. The average response has increased from last year to 38 a month (from 29 a month). Work is ongoing to examine new ways to enable patient feedback, including the possible use of email or text messaging. This includes engagement with the SE London patient representative to design a survey which will encourage a higher response level.

Language line

Spanish continues to be the most requested language, followed by Arabic and Portuguese. The average calls per month has increased from 106 in 2016/17 to 137 in 2017/18.

Training

All staff have undertaken mandatory training relating to changes made to the 111 call

Call Audit Data	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
Calls answered at 111			34,941	35,721	22,361	22,346	25,361	20,242	28,321	26,015	28,656	28,381
% Call audits (target >1%)			1.2%	1.1%	1.7%	1.6%	1.4%	1.5%	1.2%	1.5%	1.4%	1.4%
No. Call audits			423	376	378	427	356	308	341	379	406	398
No. Call Handler audits			246	218	224	254	210	191	177	211	225	223
No. Clinical Advisor audits			177	158	154	173	146	117	164	168	181	175
% Compliance (target >86%)			80%	85%	83%	84%	88%	90%	89%	90%	88%	88%

Table 15

management system "Pathways" with two version updates (13 and 14) being completed, the latter in November 2017. Following the response to a Serious Incident, a TOXBASE calculation and overdose management training refresher was introduced to all clinicians. A pilot demonstrating the success of critical thinking and probing skills work shop led to the mandatory introduction of this training. This training is in addition to the full compliance to statutory and mandatory training as required by the London Ambulance Service NHS Trust. Agency staff are given all mandatory training including safeguarding and also offered places on all workshops that are appropriate.

Pilots and Innovation

- LAS 111 has been actively involved in a number of pilots throughout the year including
- Direct booking patients under 5 years old into OOHs appointments
- Direct bookings in to GP hubs across additional boroughs
- Implementation of *567 access lines into BAU
- Expanding direct referral pathway for patients presenting with Mental Health difficulties to cover all 6 boroughs.
- Introduction of 111 online for SEL
- Enhanced clinical assessment for ED dispositions
- Working groups to introduce the ability to access additional patient records to inform clinical decision making and allow staff access to electronic prescription tracker.

Section 7:
Feedback from our partners and stakeholders

We are obligated to give stakeholders the opportunity to comment on our Quality Account and to then publish their comments in full. This year we invited the following organisations/groups to respond.

- The London Ambulance Service Commissioners 27 April 2018
- Patients' Forum response dated 14 May 2018
- Healthwatch were provided with the draft Quality Accounts in March 2018 for comment

We would like to thank those organisations/groups for taking the time to read and respond. Their comments are published in this section. To be inserted once received

NHS
Brent, Harrow and Hillingdon
Federation of
Clinical Commissioning Groups

27 April 2018

Diane Jones
Executive Office
BHH Clinical Commissioning Groups
3rd Floor, The Heights
59-65 Lowlands Road
Harrow
HA1 3AW
Tel: 020 8422 6644
E:diane.jones11@nhs.net

Mr Garrett Emmerson
Chief Executive
London Ambulance Service NHS
Trust
220 Waterloo Road
London
SE1 8SD

Re: London Ambulance Service NHS Trust Quality Strategy: Vision 2020 and Quality Account 2018 – 2019

The North West Collaboration of CCGs has welcomed the opportunity to review your Quality Strategy and Account for 2018–2019. We have reviewed the content of the Quality Report and are able to confirm that this complies with the requirements for NHS Trusts as set out by the Department of Health and NHS Improvement. The Quality Report provides an open and transparent declaration of the status of the quality of the services the Trust provides which is generally easy to read, and seems very comprehensive and particularly ambitious considering your goal of striving for an 'outstanding' Care Quality Commission (CQC) rating by 2020.

The Trust had previously set 8 targets against the domains of Patient Safety, Patient Experience and Clinical Effectiveness for 2017/18, and we are pleased to see the progress the Trust has made against these. There is clear evidence in the report demonstrating how the Trust has embedded their quality work to improve care provided to its patients. We note that the focus on mental health crisis continues as reported in the LAS Strategic Intent 2018/19 – 2022/23 under the 'pioneer differentiated services'. It is also encouraging to see how well LAS are performing against the new Ambulance Response Programme (ARP) response standards, as benchmarked nationally.

The 2018/19 Report includes 14 targets divided between the five CQC quality domains, ensuring that services are safe, caring, effective, responsive and well-led, which will assist in supporting the Trusts endeavours to strive for an 'outstanding' CQC rating by 2020. It is encouraging to see that the Trust has responded positively to previous CQC findings demonstrating good progress made against infection prevention and control (IPC) standards, as well as evidence of organisational learning from incidents. We take note of previous CQC comments surrounding vehicle checks, equipment and skill mix issues, and are encouraged by the inclusion of roster reviews under the 'Clinical Effectiveness' (Target 4), as well as the Target 1: review of the operational model under the 'Responsive' domain in line with ARP and the new ambulance quality indicators (AQIs), and assume that these will be sufficient to address issues identified.

Harrow CCG Chair: Dr Amol Kelshiker
Brent CCG Chair: Dr Ethie Kong
Hillingdon CCG Chair: Dr Ian Goodman
Chief Officer: Rob Larkman

NHS
Brent, Harrow and Hillingdon
Federation of
Clinical Commissioning Groups

We recognised significant improvements made in the processing of Serious Incident (SI) investigations, and it is pleasing to see how responsive the Trust has been towards improving standards of care, for example: delayed defibrillation. The incidence of SIs involving the Emergency Operations Centres (EOCs) remains high, and we look forward to working with you towards improving the quality of services in this area, also to include the prioritisation and timely response to inter-facility transfers and urgent Heath Care Professional (HCP) requests for transport. Furthermore, the CCGs recognise the significant impact staff training can have on quality improvement, and are pleased to note that the Quality Report includes comprehensive focus on staff training under the effective and well-led domains, including a root and branch independent training review, a quality improvement (QI) training plan, compliance with statutory and mandatory training, and leadership development.

As per feedback from Commissioners and Sustainability and Transformation Partnership (STP) leads, it is pleasing to hear that LAS have taken note of the Workforce Race Equality Standard (WRES) requirement and that this will now be included under the 'Well-Led' section of the WRES plan. It is also very pleasing to see that the Trust is exploring the use of technology for improving services, including the roll-out of hand-held devices to frontline staff, future electronic patient record form (e-PRF) technology, and the use of tele-medicine/skype. The impact on quality improvement from the use of e-PRF technology cannot be underestimated, and may prove to be the single most significant influence on standards of care yet.

We would concur with the Trust that the five priority focus areas and 14 associated targets you have set for 2018/19 are appropriate considering previous CQC feedback, recognising pressures on the Trust in these areas during 2017/18 across London, and considering the LAS strategic intent leading up to 2023. We would like to thank all the LAS staff for their continued commitment to the delivery of a high quality service to the local residents of London. We look forward to continuing to work with the Trust to monitor progress against set priorities for 2018/19 through the Clinical Quality Review Group (CQRG), in order to gain assurance of continuous improvement of the quality of ambulance services provided across London.

Yours sincerely

Diane Jones
Director of Quality & Safety
NHS Brent, Harrow & Hillingdon
Clinical Commissioning Groups

Cc: Dr Trisha Bain, Chief Quality Officer, LAS
Dr Kuldhir Johal, Chair, LAS Clinical Quality Review
Dr Ethie Kong, Chair, NHS Brent Clinical Commissioning Group
Philip De Bruyn, Assistant Director for Quality & Safety (LAS Lead)
Jennifer Roye, Deputy Director for Quality & Safety, BHH CCGs

PATIENTS' FORUM
FOR THE LONDON AMBULANCE SERVICE

Trisha Bain
Chief Quality Officer
London Ambulance Service

May 14th 2018

QUALITY ACCOUNT (QA) 2018 – PATIENT FORUM RESPONSE

Dear Trisha, we are delighted to present the Forum's response to your 2018 Quality Account. We have valued working with Briony Sloper and yourself over the past year and appreciate your tireless work to implement critical changes to the operation of the LAS and enhance the quality of care for patients. This has included the development of the Quality Oversight Group that brings together all of the major players responsible for the safety and quality of services. The continuing development of end of life care, mental health care and midwifery services are major areas that we commend in terms of enhanced patient care.

Our assessment of the Quality Account and our Recommendations to the Board are as follows:

1) **We welcome the following statements of LAS commitment to patient and public involvement contained within the QA:**

- Patients will have a stronger voice that every before (page 1)
- The patient is at the centre of everything that we do (page 5)
- Listen to staff and patients to determine priorities (page 9)
- Have patient/carer involvement in all our improvement work (page 9)
- Integral to all programmes must be the aim of robust patient and staff involvement (10)
- We need to listen to our patients, their families and carers, and respond to their feedback (15)
- Our goal being to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently (page 15)
- We need to widen and increase our public involvement in both the development of these new services and monitoring of their success. (15)
- A co-designed an co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model (16)
- Services are organised so that they meet people's needs (19)

RECOMMENDATION-1: THE LAS SHOULD CONTINUOUSLY DEMONSTRATE THAT ACTION IS BEING TAKEN BY THE TRUST AS A RESULT OF RECOMMENDATIONS MADE TO THE LAS BY THE PATIENTS' FORUM AND HEALTHWATCH IN THE ANNUAL QUALITY ACCOUNT.

The LAS accepts this recommendation

2) **Integration of PPI work-streams in the LAS**

PPI work-streams in the LAS are not yet integrated. The PPI team led by Margaret Luce carries out excellent work, e.g. the Insight project and continuous work with communities across London. This team has a well developed PPI Action plan and Patient Engagement Strategy (2016-2020) (see also PPI Annual Report). This work is not integrated with other major PPI work-streams, e.g. the engagement exercise which preceded publication of the LAS strategy and the streams of work that are being progressed following adoption of the LAS overall strategy. We would strongly recommend integration of all PPI streams of work to ensure effectiveness, consistent quality and evidence-based practice, e.g. to ensure that the public voice influences LAS practice, policy and strategy.

RECOMMENDATION-2: THE LAS SHOULD INTEGRATE ALL PATIENT AND PUBLIC INVOLVEMENT WORK-STREAMS IN ORDER TO ENSURE THAT THE SHARED EXPERTISE OF THE PPI TEAM AND OTHER DEPARTMENTS INFORMS ALL PPI WORK IN THE LAS INCLUDING THE PIONEER PROJECTS

3) **Ethnic Diversity within the LAS**

Images of LAS staff in the QA and other document show virtually no diversity, which is recognised as a major issue by the communications team. This happens repeatedly in LAS publications, suggesting that the Communications Department needs to ensure that they produce more relevant material. The LAS public website has been positively modified in its presentation in this respect.

We commend the proactive and continuous work that is now taking place across London to recruit staff that reflect the city's population. Patient

care will improve when the workforce better understands and mirrors the population treated and cared for by the LAS.

RECOMMENDATION- 3: ALL LAS PUBLICATIONS SHOULD ENSURE THE VISIBILITY OF ETHNIC DIVERSITY IN ITS WORKFORCE

4) **"Quality is our number one priority".** (page 6)
We would suggest that "Safety and Quality" should be the first priority for the LAS.

5) **"Goals and targets that are measurable**" (page 6)
We would expect this to include recommendations arising from the public and patients' voices.

6) **Safe – (page 13)**
We suggest that this section should refer to 'moderate harm, severe harm and death' in compliance with the statutory Duty of Candour.

Target 2 – Hospital Handover Delays – We fully support the LAS goal (to reduce handovers in excess of 15 minutes by a quarter), although we believe that there should be no handovers at all in excess of 15 minutes. There are no 30 or 60 targets as suggested in the QA. A 30 and 60 minute handover is a breach of the national agreement on handovers.

We suggest that the QA states what the LAS expects of STPs, CCGs and hospital trusts to deal with this appalling problem. Patient safety is at the heart of everything the LAS does, and in our view more assertive action is required to protect patients from unacceptable delays.

RECOMMENDATION- 4: THE LAS SHOULD PUBLISH ITS STRATEGY TO OBTAIN GREATER SUPPORT FROM STPs, CCGs AND HOSPITAL TRUSTS TO SUBSTANTIALLY REDUCE HANDOVER WAITS IN EXCESS OF 15 MINUTES.

7) **Caring – (page 15)**

Target One – Mental Health Care

a) The publication which described the LAS mental health work as exemplary should be referenced in the QA.

b) We strongly support the employment of mental health nurses in the clinical hub, the enlargement of the team and the development of Advanced Mental Health paramedics. We also support the trial of a paramedic and mental health nurse working together to enhance mental health care. We see this as an important step in the direction of developing LAS Advanced MH paramedics.

RECOMMENDATION-5: THE LAS SHOULD DEVELOP IN LIAISON WITH THE FORUM A PROPOSAL FOR ADVANCED MENTAL HEALTH PARAMEDICS

c) We would like to see effective methodologies developed to obtain information from patients who have been sectioned under s135 or s136, and cared for by LAS staff. Similarly, patients who use the NET service should be able to comment on the service when NETS is used to provide transport for them, in connection with assessment or sectioning under the Mental Health Act. Methodologies need to be specifically designed for this purpose (see for example the Insight methodology).

RECOMMENDATION- 6: THE LAS SHOULD DEVELOP IN LIAISON WITH THE FORUM, METHODOLOGIES TO GATHER QUALITATIVE DATA FROM PATIENTS RECEIVING MENTAL HEALTH CARE AND THOSE RECEIVING BARIATRIC CARE, TO ASSESS THE QUALITY OF CARE THEY HAVE RECEIVED.

Target Two – PPI – PIF

a) We strongly support the LAS goal of having patient involvement in all service redesign programmes and a patient involvement framework (PIF) developed to apply this goal consistently (page 15). However, we note that **there is already an LAS PPI strategy and LAS Action Plan,** which should be integrated.

b) The Patient' Forum is a centre of excellence for PPI work and many of our members have considerable expertise in the field. We hope that the learning from the recent LAS strategy engagement exercise, will provide valuable reflection for the next steps in the development of PPI in the LAS.

c) We would suggest considerable care is needed in agreeing a methodology to a collect data from patients, as there are no effective generic systems for collecting data from patients who use emergency ambulance services. A great deal of money could be wasted on ineffective systems. The Friends and Family test demonstrates this point well and led to the development of the Insight projects.

d) We strongly support the Target 2 recommendation regarding evidence of PPI in all QI and service design programmes.

RECOMMENDATION-7: THE PROPOSED PIF SHOULD BE DEVELOPED IN LIAISON WITH THE TEAM THAT HAS DEVELOPED THE LAS PPI STRATEGY AND ACTION PLAN

Target Three – Development of a team of practice leads for pre-hospital maternity education
We strongly support Target Three and have been involved in the selection of the two midwives to carry out this role.

8) Effective –

Target Two – ARP – We are pleased that more work is being carried out on the presentation of data. Compared with previous data sets (pre-ARP) we find the current data sets unhelpful in determining the how well the LAS is performing. Handover data is now of good quality.

RECOMMENDATION-8: ARP DATA SHOULD BE PRODUCED THAT IS ACCESSIBLE TO THE PUBLIC AND BASED ON PERFORMANCE IN EACH LONDON BOROUGH.

9) Responsive – Target 2– Complaints investigations – This section is excellent. We would like to see the investigation time for complaints reduced to 30 working days in 2018, and to have access to systematic data on the findings and recommendations from complaints. We have been attempting to review complaints for the past year without success, despite the support of the Chief Quality Officer and Patient Experiences Department for this audit activity. We believe the 75%, 35 days target is much too low and compares unfavourably with most other NHS and Foundation Trusts.

RECOMMENDATION- 9: THE LAS SHOULD REDUCE THE TARGET TIME FOR INVESTIGATION OF COMPLAINTS DOWN TO 30 DAYS

RECOMMENDATION-10: THE LAS SHOULD DESIGN A SYSTEM TO ALLOW ACCESS, WITH THE CONSENT OF THE COMPLAINANT, FOR THE FORUM TO EXAMINE COMPLAINTS DATA FOR THE PURPOSES OF AUDIT

Quality Account – we believe it is essential that the LAS works with the Forum to implement recommendations made to the LAS in the Forum's submission to the QA. This would be a good test of responsiveness and would demonstrate that the LAS values public involvement in the development of its services.

RECOMMENDATION-11: ISSUES RAISED BY THE FORUM IN THE QUALITY ACCOUNT SHOULD BE SUBJECT TO ONGOING DISCUSSION WITH THE LAS REGARDING IMPLEMENTATION.

10) Well Led – Target 2 – LAS Strategy
a) The LAS did not carry out a reasonable consultation exercise on the overall LAS strategy during the engagement period. Only one small short meeting was held with public participants. The Forum's detailed submission received no response despite several requests, until May 2018. We strongly **Recommend** the LAS carries out a detailed public involvement exercise on the content and implementation of their strategy and follows the lead of the Quality team which is inclusive and works closely with the Forum. We commend Whose Shoes PPI event of May 12th

RECOMMENDATION-12: ALL LAS STRATEGIES SHOULD BE SUBJECT TO AN AGREED PUBLIC ENGAGEMENT AND INVOLVEMENT PROTOCOL AND METHODOLOGY BEFORE PUBLICATION.

Yours sincerely
Malcolm Alexander
M. Alexander
Chair
Patients' Forum for the LAS
07817505193

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EXECUTIVE COMMITTEE	Adrian Dodd	WALTHAM FOREST HEALTHWATCH

Appendix 1: Clinical Audit : Learning outcomes

Below are the actions taken following audits during 2017-18:

- Continued clinical education provided to staff through face-to-face training and publication of updates in bulletins and newsletters
- Release of infographics promoting the key monthly findings
- Feedback regarding inappropriate triage decisions and extended times provided to clinical staff by Quality, Governance and Assurance Managers
- Continued use of the "Clinical Information and Support Overview" tool to facilitate discussions with clinicians and Clinical Team Leaders regarding clinical audit findings, illness coding and time spent on scene

The reports of **10 local clinical audits** were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided against each as detailed below.

Documentation of EZ-IO® Intra-osseous System use

- Distribute an infographic reporting improvements made and reiterating the importance of documenting needle size and a named anatomical site and side when gaining intra-osseous (IO) access
- Publish an article in the Trust-wide clinical newsletter to share keys findings and actions
- Create a prompt card documentation reminder to be inserted in EZ-IO kit bags
- Amend the Patient Report Form (PRF) User Guide to specify that IO needle size should be documented in millimetres
- Share report with the LAS Clinical Education and Standards Department

Assessment and transport decisions of patients with major head injuries

- Define the illness codes for major and minor head injuries in the PRF User Guide
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Make the 'Management of Minor Head Injuries' assessment tool more available for all clinicians
- Share report with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guideline Developers and Contributors and seek further clarity regarding the assessment and management of head injuries
- Re-audit whether there has been an improvement in the recognition and management of clinically significant head injuries

Patients who severely deteriorated or died unexpectedly within 24 hours of being discharged at scene

- Declare seven serious incidents identified by this continuous audit
- Flag one case to another organisation for them to declare as a serious incident
- Provide constructive and positive feedback to individual crews, where necessary
- Share the findings of this audit with NHS England and suggest the Ambulance Quality Indicator re-contact data guidance is amended to exclude public places
- Continue with the Continuous Re-Contact Clinical Audit in 2017-2018, with the inclusion of NHS 111 referrals and Hear & Treat assessments
- Write an article for the Trust-wide clinical newsletter focussing on the importance of consistent discharge documentation
- Create a short animation focussing on consistent discharge documentation for the LAS intranet and Facebook group
- Write a case study for the LAS Insight Magazine demonstrating good patient assessment and discharge documentation and evidencing full patient assessment on the PRF
- Continue to monitor the decisions made for 50% of patients not conveyed to hospital and facilitate the provision of individualised feedback to clinicians

Administration of dexamethasone

- Share report with the JRCALC Guideline Developers and Contributors and seek further clarity regarding whether mild croup is an indication for dexamethasone
- Distribute the key findings in a Trust-wide newsletter, together with an infographic displayed in all ambulance stations
- Share the findings with the LAS Business Intelligence Team, specifically the number of times dexamethasone was miscoded in the sample
- Undertake a re-audit to assess whether there has been an improvement in documentation of indication for dexamethasone administration

Administration of ondansetron

- Share keys findings and necessary actions with clinicians through the publication of an article in a Trust-wide clinical newsletter and a corresponding infographic to be displayed at all ambulance stations
- Distribute an infographic highlighting how ondansetron and other drugs should be given
- Share report with the LAS Medicines Management Group and Clinical Tutors
- Care provided to the patients with a genuine illness or injury at Exercise Unified Response
- Explore the feasibility of including event call signs in the Clinical Performance Indicator audit programme
- Consider the suitability and training needs of clinicians not normally deployed on frontline duties at events
- At events, share the LAS PRF User Guide with clinicians not normally deployed on frontline duties
- Share report with the LAS Department for Emergency Preparedness, Resilience and Response, the Medical Directorate, Cycle Response Unit and Community First Responders
- Analgesia given to adult patients
- Distribute to all ambulance stations the key findings in an infographic
- Share report with the LAS Medicines Management Group, the Medical Directorate and Clinical Tutors
- Include whether or not adequate analgesia was given in future clinical audits

Care given to patients with a suspected mental health disorder

- Consider continuously auditing the care provided to patients with an undiagnosed psychiatric problem, or carry out a re-audit once all actions have had sufficient time to take effect
- Record a Q&A session with the Service's Mental Nurses outlining the importance of undertaking a thorough patient assessment
- Share findings with clinicians in a Trust-wide clinical newsletter, together with physical conditions which may mimic a mental health condition
- Share keys findings in an infographic to be displayed at all ambulance stations
- Promote the LA383 (Adult Mental Health Assessment Form) at Sector Quality Meetings
- Review the wording of the 'psychiatric problem – undiagnosed' illness code

Use of adrenaline (1:1,000) re-audit

- Produce an allergic reactions and asthma tool for the LAS Digital Pocket Guide application
- Create a short video presentation of the stages of allergic reaction and asthma, and when adrenaline (1:1,000) is indicated for publication on the Service's intranet and Facebook page
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review all training materials related to adrenaline (1:1,000)
- Share report with the LAS Medicines Management Group
- Undertake a re-audit once all actions have had sufficient time to take effect to determine whether there has been an improvement in adrenaline (1:1,000) administration

Documentation of mental capacity assessments

- Produce a guidance animation of the key principles of the Mental Capacity Act and what constitutes a thorough mental capacity assessment
- Write a case study for the LAS Insight magazine which promotes positive learning from experience
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review the current LA5 (Capacity tool documentation for the treatment of patients who are unable to consent)
- Update the downloadable LA5 on the LAS intranet and arrange removal of the old LA5s in circulation
- Share report with the LAS clinicians and Mental Health Nurses in the Clinical Hub

In addition, a further **5 local clinical audits** were started by the provider in 2017/18 as detailed below.

Management of paediatric pyrexia re-audit

The LAS 2012 Paediatric Pyrexia Clinical Audit found that patients aged 2-8 years with pyrexia of unascertained origin were often not appropriately re-assessed before a decision was made to discharge them at scene, and the patient's medical history was not always considered. Following training and raising awareness of the guidance and protocols, this re-audit assess the appropriateness of discharge decisions for paediatric patients with pyrexia.

Decision making surrounding paediatric conveyance

Following national concerns from the Royal College of Paediatrics and Child Health regarding the amount of

infants left at home following ambulance attendance, a baseline clinical audit was undertaken on patients aged under 1 year old who were discharged at scene. As a result, the LAS issued a paediatric conveyance policy stating that: all patients under 2 years should be conveyed to a hospital; patients aged 2-5 years who are not conveyed must be referred to their GP or suitable Health Care Professional (HCP), and patients aged 6-12 years who are not conveyed should be strongly considered for referral to their GP or a suitable HCP. This clinical audit aims to assess whether conveyance decisions for patients aged 0-12 years are in line with this LAS protocol.

Administration of hydrocortisone re-audit

In 2013 the LAS Hydrocortisone Clinical Audit identified an underuse of hydrocortisone in the treatment of acute severe and life-threatening asthma. A number of actions were taken as a result. This re-audit will assess whether the actions implemented following the previous clinical audit have led to increased use of hydrocortisone for patients with acute severe and life-threatening asthma.

Transient loss of consciousness (TLoC) re-audit

The LAS 2013 TLoC Clinical Audit found that whilst some elements of history taking and assessment were well completed; aspects more specific to TLoC required improvement. A voluntary study day was run to highlight the importance of history taking and a prompt card was produced and issued to assist clinicians with the management of TLoC. Despite the initiatives to improve care, in 2016 a review of the National Institute for Health and Care Excellence (NICE) quality standard for TLoC showed improvements were still needed. In addition, in 2016/17, two incidents were reported relating to the care of TLoC patients. This clinical audit aims to determine whether patients presenting with TLoC are being assessed, treated and managed in line with the LAS, NICE and UK Ambulance Service Clinical Practice guidelines.

Management of intentional overdose

This clinical audit aims to address concerns raised by the LAS 2013 Overdose Clinical Audit which found patients triaged as having no life-threatening symptoms often received a response outside of the commissioned target, when some of them required a pre-alert to hospital. In addition, five incidents have been reported on the Trust's incident reporting system where there was a delay responding to a patient who had overdosed, two of which were declared as serious incidents. This clinical audit aims to: assess if patients who have taken an intentional overdose are being triaged appropriately; examine any reasons for longer than average on scene times, and determine if patients who have taken an intentional overdose who are not conveyed are being appropriately assessed and referred.

The London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to six patient groups (cardiac arrest, difficulty in breathing, glycaemic emergencies, mental health, severe sepsis and patients that were discharged on scene) and quality assures the documentation on 2.5% of all clinical records completed. We also undertake five continuous audits that monitor the care provided to every patient who falls within the following groups: cardiac arrest, STEMI, stroke, major trauma, discharged at scene but re-contacted the Service within 24 hours having severely deteriorated or died unexpectedly.

The Trust also submit data to the National Out-of-Hospital Cardiac Arrest Outcomes project, a registry of out of hospital cardiac arrests in England. This registry is being used to look at the national variations in outcomes of cardiac arrest and provide evidence to help inform treatment and improve survival amongst this patient group. During 2017/18 we provided 4,432 cases to the registry.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and contributing to wider healthcare improvement. Clinical research ensures our clinical staff keep up to date with the latest possible treatment options and their active participation leads to improved patient outcomes. The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service NHS Trust in the first 3 quarters of 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 683. These patients were recruited into a range of interventional and observational studies. These studies were:

ARREST: A randomised controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest

RIGHT-2: A randomised trial that aims is to determine whether glyceryl trinitrate (GTN) improves outcome in patients with ultra-acute stroke when administered as soon as possible after onset.

In 2017/18 145 members of clinical staff received protocol training to enable them to participate in interventional and observational research at the London Ambulance Service NHS Trust.

Appendix 2: CQUINS 2017-18 and 2018-19 : UPDATE

Table 16

Goal No.	Goal Name	Description of goal
1A	National: Introduction of Health and Wellbeing Initiatives – Improving Staff Health and Wellbeing	Percentage point improvements to staff survey results on 3 questions against a 2015/16 baseline.
1B	National: Introduction of Health and Wellbeing Initiatives – Healthy food for NHS staff, visitors and patients	Continuing improvements to healthy food provision delivered in 16/17 and extending requirements for 17/18, 18/19.
1C	National: Introduction of Health and Wellbeing Initiatives – Improving the uptake of flu vaccinations for front line staff within Providers.	Achieving an uptake of flu vaccinations by frontline clinical staff of 70% for 2017/18
12	National:Ambulance Conveyance	A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department.
STP1	National:Supporting Local Areas	Support engagement with local STP initiatives
STP2	National:STF Control Total	Delivery of financial controls – Risk Reserve
L1	Local:Implementing the Digitalisation Enablers	Providing the frontline, clinical staff at London Ambulance with personal issue mobile devices.

Table 17

CQUIN Description		Total Available	Estimated Achieved	Estimated Percentage Achieved
National Health and Wellbeing	Improvement of health and wellbeing of NHS staff	£260,562.00	£65,140.50	25%
	Healthy food for NHS staff, visitors and patients	£260,562.00	£260,562.00	100%
	Improving the uptake of flu vaccinations for front line staff	£263,701.00	£65,925.25	25%
Ambulance Conveyance		£784,825.00	£549,377.50	70%
Mobile Devices for Frontline Staff		£3,139,299.00	£3,021,575.29	96%
STP Engagement		£1,569,650.00	£1,506,864.00	96%
STF Delivery (Control Total)		£1,569,650.00	£1,569,650.00	100%
Total CQUIN		**£7,848,249.00**	**£7,039,094.54**	**90%**

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019

70 YEARS OF THE NHS 1948 - 2018

NHS
London Ambulance Service
NHS Trust

Headquarters, 220 Waterloo Road, London SE1 8SD

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Patient Experiences Annual Report 2017/18			
Agenda item:	08(v)			
Report Author(s):	Gary Bassett, Head of Patient Experiences			
Presented by:	Gary Bassett, Head of Patient Experiences			
History:	Quality Report, Patient Experiences and Feedback Group			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The final 2017/18 Patient Experiences Annual Report provides an overview and analysis of activity including cases investigated by the Health Service Ombudsman, examples of lessons learned and action taken by the Trust arising from service-user feedback and complaints.

The report outlines;

- Complaint performance during 2017/18
- Patient Advice & Liaison Service demand and analysis 2017/18
- Our compliance with Governance arrangements

Recommendation(s):

The Board is asked to approve the annual report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☒

Reputation	☒
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Patient Experiences

Annual Report

2017/18

Table of Contents **Page**

1. Introduction

Listening to the patient and service-use experience enables the Trust to improve and develop our service. One of the major ways we do this is via our Patient Experiences team, who manage the following portfolios.

- Complaints
- Patient Advice and Liaison Service (PALS)
- Solicitor and other requests for medical records and witness statements.

This report provides an overview and analysis of activity including cases investigated by the Health Service Ombudsman; examples of lessons learned and the action taken by the Trust arising from service-user feedback and complaints.

2. Context

This year, the Trust received 1,892,659 calls to our Emergency Operations Centre, just under 4% higher than the previous year (1,826,840). This constitutes a daily average of 5185 x 999 calls. We attended 1,122,444 of these calls with a 0.08% ratio of complaints being made.

Managing demand

One of the most significant changes to service delivery this year has been the introduction of the National Ambulance Response Programme (ARP).
https://www.england.nhs.uk/urgent-emergency-care/arp/

Complaints handling features

- We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, *Principles of Remedy*
- Each complainant received a response that was personally reviewed and signed by the Chief Executive (or a deputising Director).
- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.
- Our website offers information about how to make a complaint about the service we provided.
- Activity and themes arising from complaints are regularly reported to the Trust Board
- Our Learning from Experience Group reviews the themes and issues emerging from complaints and the action taken to improve services and the experience of patients

Overview

3. Summary of complaints, PALS, Quality Alerts

The total number of enquiries to PALS and complaints received in 2017/18 was 5278. This comprised of 4278 PALS specific enquiries and 938 complaints; the latter represents an approximate 8% dip over the previous year (1016).

44 cases involved treating the referring professional as acting on behalf of the patient[1]. This enables the patient a recourse opportunity and advocacy assistance. The department also managed 44 Quality Alerts from Health Care Professionals.

From April 2018 we will assume full responsibility for external Quality Alerts and expect workload to increase substantially.

Table 1 'HCP referral' cases

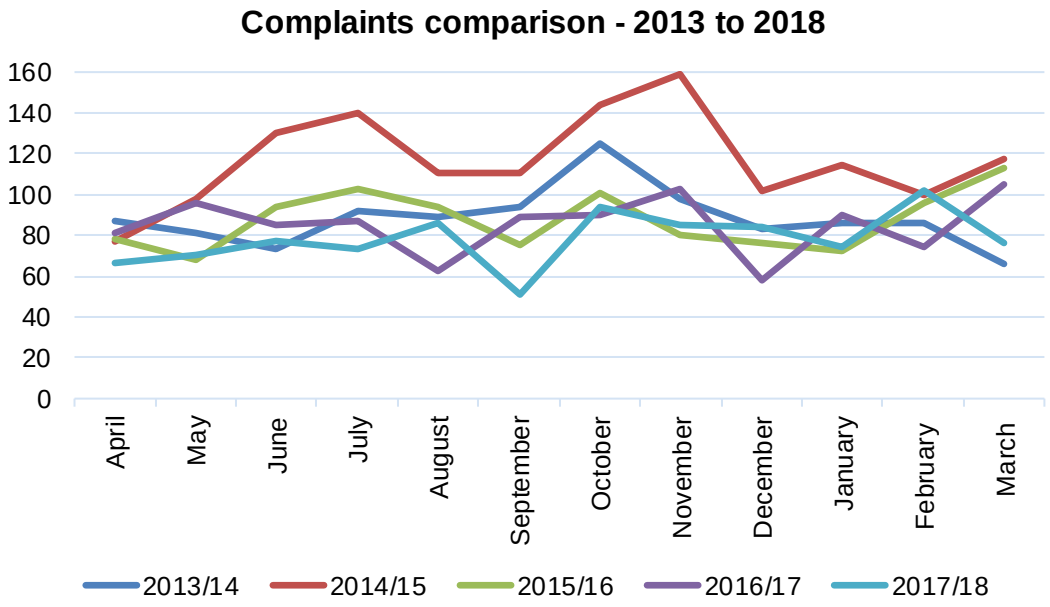
		Recorded under PALS				*Recorded as complaints on behalf of the patient*				
Title	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
HCPR	2	79	51	78	21	50	82	71	64	44

[1] *This is considered best practice in the light of Section 8 of The Local Authority Social Services and NHS Complaints (England) Regulations (2009) as one responsible body (health and social care providers) cannot use the complaints procedure to 'complain' about another.*

Historical benchmarking

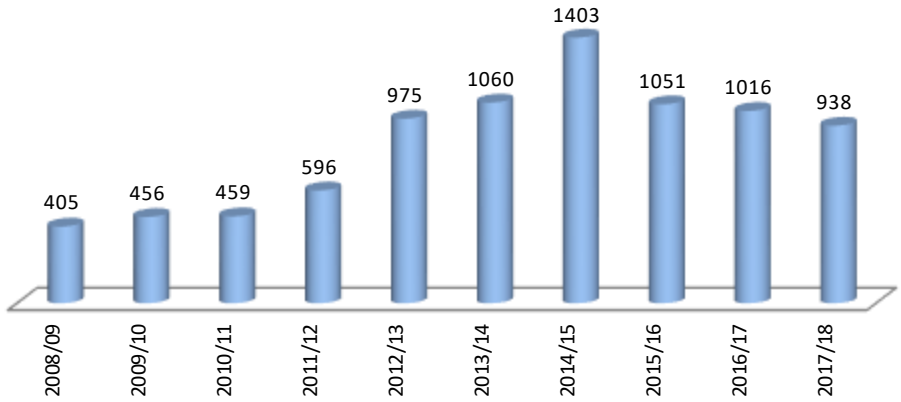
Complaint volumes have continued to level out since the exceptional demand in 2014/15. We therefore use the data for 2015/16 (1051) as our benchmark. The following graph demonstrates complaint numbers received from April 2014 to March 2018.

Graph 1 The following graph demonstrates complaint comparisons - April – March 2013 to 2018



Graph 2 shows complaints received by year indicating the fluctuation in volumes since 2008. 2017/18 is more comparative to 2012/13.

Graph 2 Complaints comparison 2008/09 to 2017/18



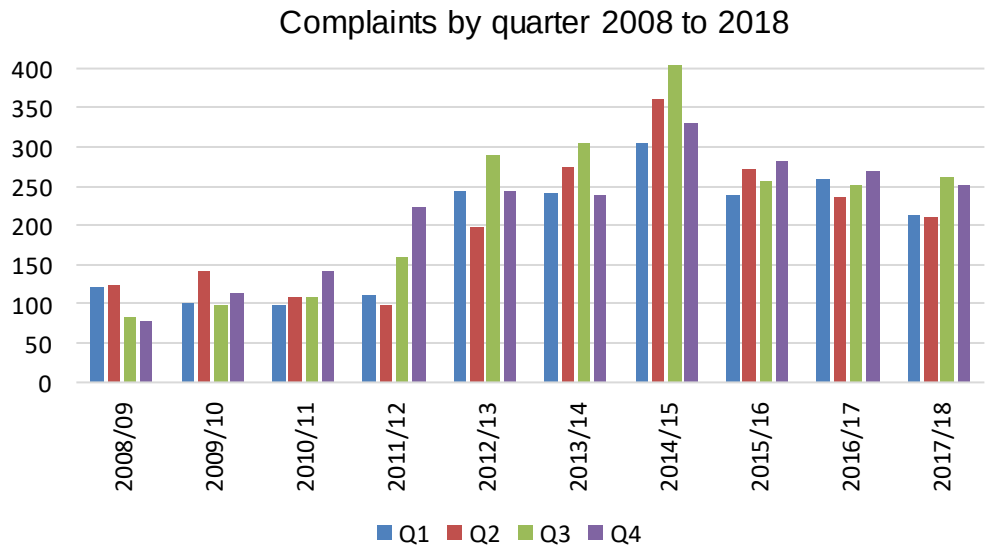
When the complaint volume is matched with the rise in demand, this indicates a fairly constant rate at 0.08%. This is illustrated in Table 2 below:

Table 2: Complaints 999 incident ratio against demand

Month	Face to face incidents	Complaints received	Percentage of complaints against calls attended (rounded)
Apr-17	89420	66	0.07
May-17	96581	70	0.07
Jun-17	92661	77	0.08
Jul-17	94855	73	0.08
Aug-17	91828	86	0.09
Sep-17	90327	51	0.06
Oct-17	96364	94	0.10
Nov-17	93535	85	0.09
Dec-17	97780	84	0.09
Jan-18	97258	74	0.07
Feb-18	86261	102	0.12
Mar-18	95574	76	0.08
Totals	**1122444**	**938**	**0.08%**
		Average	0.08%

Graph 3 Complaints by quarter 2008 to 2018.

NHS Digital now request complaints data on a quarterly basis:



4. Performance and response timeframes 2017/18

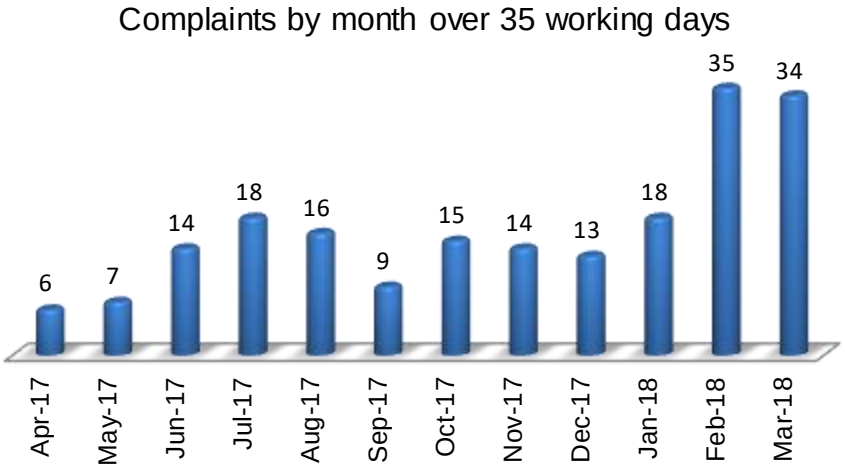
We achieved 100% acknowledgement of complaints within 3 days, in accordance with Reg 13(3) of the NHS complaints regulations.

The NHS works to a locally determined set of targets; in our case, the base line target is 35 working days (an extension is agreed with the complainant if appropriate, see below).

In those cases where the 35 day target was assigned, we have achieved a turnaround of approximately 75%.

The following graph illustrates compliance with our target trajectory, this data is compiled for the Quality Report each month, this is a dynamic figure. The drop in performance throughput towards the end of the year was prompted by winter pressures to the Trust which meant that staff were not available to offer statements, evaluate 999 call management and provide clinical appraisals.

Graph 4 The following graph illustrates compliance within 35 day target



In accordance with accepted practice and agreement with the complainant, in a number of cases the target response time was increased (see below). As indicated, this was usually because of complexities arising as more information became available or times of significant pressure to the Trust. A further consideration is where a the matter that is the subject of a complaint is also declared as a Serious incident, a governance mechanism used across the NHS which attracts a target completion within 60 days, with a further 20 days period for approval and sign off by Clinical Commissioning Groups.

Table 3 Complaint response times – 2017/18

Complaint response times 2017/18 – including where the target date was increased		Number achieved
35 working days	807	608 (75%)
40 working days	26	17 (65%)
45 working days	47	24 (51%)
60 working days	28	12 (41%) includes 8 serious incidents
Concerns (no time frame)	30	30
Total	**938**	**691 (75%)**

Table 4 Complaints by Department Area

Area	Numbers of complaints
Sector Services	456
Control Services[2]	336
Not LAS / Other organisation	92
Central Operations	29
Patient Transport Service (PTS)	11
HR & Workforce	5
Finance and Performance	4
Clinical Education and Standards	2
Quality and Nursing	2
Strategy and Transformation	1
Total	**938**

Table 5 Complaints by the top 5 subjects 2017/18

Complaints by subject 2017/18	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	21	255
Conduct	16	19	24	19	19	16	17	25	20	22	23	20	240
Road handling	12	11	13	14	10	7	14	9	7	6	10	6	119
Treatment	1	2	5	1	7	5	16	8	9	8	14	4	80
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	4	47

[2] *All complaints regarding a delay are attributed to Control Services. However, the cause is not due to processes within control they are mainly due to resourcing across all areas.*

Totals (above)	53	49	62	60	62	38	75	76	62	59	90	55	741
Annual totals	**66**	**70**	**77**	**73**	**86**	**51**	**94**	**85**	**84**	**74**	**102**	**76**	**938**

Other common themes include:

- Call management errors
- The patient being referred to an Alternative Care Pathway rather than being taken to hospital
- NHS 111 call management

5. Analysis/Themes

Current volumes involve relatively new areas of service delivery, for example calls managed by our NHS 111 team who provide this service in the South East London area; our use of community responders; and the effects on response times to lower priority emergencies when the Surge Plan (the Trust's escalating demand management plan) is implemented.

The highest volume of complaints were about delays in an ambulance response; these are administratively attributed to the Emergency Operations Centre under the existing case management practice although clearly much depends on the available resourcing, an operational responsibility.

5. Governance and Learning mechanisms

We provided regular monthly summary activity reports to the Quality Oversight Group and the Control Services Governance Group. The Patient Experiences & Feedback Group receives bi-monthly updates. This is an important part of our work. The Group reviews and brings together lessons learned from external sources, adverse incidents, litigation, comments, concerns, complaints, audits, major incidents, safeguarding and information governance issues.

Patient stories also continue to be a powerful tool to describe patients' experiences and these and the learning that has resulted are presented to the Trust Board.

From a national perspective, we also report on quarterly basis to NHS Digital.

We continue to monitor public websites such as *Patient Opinion* and *NHS Choices.*

Our *'Talking with Us'* Complaints and '*Thanking our staff*' leaflets have been made available on all our vehicles and each complainant receives a '*Feedback on Complaints'* form with every complaint response.
http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

We include examples of learning on the Trust website and disseminate these across the Trust via in our *Insight* magazine, *Clinical Update Bulletins and Control Services Bulletins.* To widen the learning in appropriate cases, we also share these with the National Ambulance Patient Experiences Group.

6. Examples of learning 2017/18

Staff attitude

Example 1

Complaint that the attending staff did not appear to understand how the patient's mental health problems affected her and she heard them inform the hospital she had threatened them with scissors, which she denied; they also used abusive language.

We concluded that the crew felt threatened, even if this had not been intended. Whilst we do not condone derogatory language, especially as this risk can cause an unpredictable situation to escalate, this was a reaction to a potentially volatile situation and the need to immediately be assertive in order to disarm the patient. The member of staff concerned was quite clear that she did not mean to seem unkind and had the

welfare of the patient in mind, even though the sudden incident with the scissors understandably scared her.

Example 2

Complaint that the attending staff were dismissive of the patient's sickle cell crisis symptoms.

We explained that the patient should have been offered a carry chair and/or trolley bed to the ambulance and taken to their usual treatment centre. It was also unclear whether the extent of the patient's symptoms had been explored. The staff undertook a reflective practice exercise on the treatment of sickle cell patients.

Example 3

Complaint that an ambulance was declined despite the gravity of the patient's symptoms.

The Quality Assurance evaluation identified that the call handler made a technical error when applying the triage protocol which would have otherwise achieved a higher priority from the outset. Priority would still have been given to patients determined at a higher categorisation but in keeping with our learning approach, feedback was given to the call handler concerned.

Example 4

Complaint hosted by Acute Trust that the attending ambulance staff appeared to question why an ambulance had been called

The paramedic acknowledged that he came to a view based on the fact the patient was not in acute distress and accepted that although he did not mean to be derogatory, this was inappropriate.

Example 5

Complaint that the attending ambulance staff did not help the patient into her property despite her being hardly able to walk.

We concluded that it would have been more compassionate and safer practice to have ensured the patient was able to safely get into her home. In addition, the assessment record did not make any reference to any assessment of the patient's hip, which should have been completed. Feedback was offered accordingly.

Example 6

Complaint at the aggressive attitude of the call handler.

The call handler did not adhere to protocols which may have prevented the conflicting answers provided and the triage assessment to be conducted more quickly. She also deviated from the prescribed questioning, omitted to use the breathing detector tool and failed to verify the location. She did not display appropriate customer service skills and should not have given precise details of the responding ambulance resource, as

it is possible they could have been re-directed to another 999 call so this was misleading. An apology was offered and reflective practice arranged.

Delay/ambulance dispatch

Example 7

Complaint that there was a delay in an ambulance attending a patient after she had a seizure on a bus - resulting in the bus driver taking her to hospital

There were some technical shortcomings in the management of the initial 999 call, the call handler was rude at times, omitted to give the correct post-dispatch instructions and to explain that it may take up to 45 minutes for an ambulance to be dispatched. Extensive feedback was offered to the call handler concerned and their performance monitored for a period decided by their line manager.

Example 8

Complaint that despite his injuries post RTC, the patient was referred to NHS111.

The Quality Assurance evaluation identified that the call handler omitted to check whether the patient was still on the floor and that the information provided by the patient that there was an arm deformity should have prompted a higher priority outcome. The call handler will was given extensive feedback and their performance monitored for a period decided by their line manager

Example 9

Complaint that despite her symptoms, the caller's daughter was declined an ambulance.

The Quality Assurance evaluation identified that the call handler gave the incorrect referral information to the caller. The patient should have been referred to the CHUB as opposed to NHS 111.

Example 10

Complaint from patient to LAS 111 regarding the length of time awaited for a clinical call back.

We identified that the call was managed and assessed properly with a correct determinant of a call back within 6 hours being achieved. However, this was not communicated to the patient who was advised that she would receive a call within 2 hours

Example 11

Complaint from child's mother that she was declined an ambulance for her daughter despite her symptoms

The Quality Assurance evaluation concluded that the call handler made an error of judgement when applying the initial clinical triage protocol. Although call handlers do not have any clinical expertise, they are trained to ask a series of structured questions

to progress through the triage process in order to assess the patient's condition and to determine the appropriate level of priority response. In this case, the 'Heart problems/AICD' protocol should have been applied which would have indicated a Category 2 priority, although priority would still have been given to patients determined at a higher categorisation.

Example 12:
Complaint from patient's husband at the delay in providing a critical transfer ambulance for his wife, who was experiencing a placental abruption

The Quality Assurance evaluation confirmed that from the information provided all 999 calls were largely managed in accordance with our protocols, although some shortcomings have were identified and the Clinical Hub should have applied an upgrade after 60 minutes, as the operative misunderstood the new guidance in line the ARP. An exceptional bulletin was issued at all staff.

Patient Specific Protocol (psp)

Example 13
Complaint from parent about the delay in attending a child with a Patient Specific Protocol logged on the address.

Although the system highlighted the psp for the patient, the supervisor in EOC should have comprehensively reviewed that so that an upgrade could be made accordingly.

Example 14:
Complaint that the attending medic did not administer a nebuliser after she suffered an asthma attack

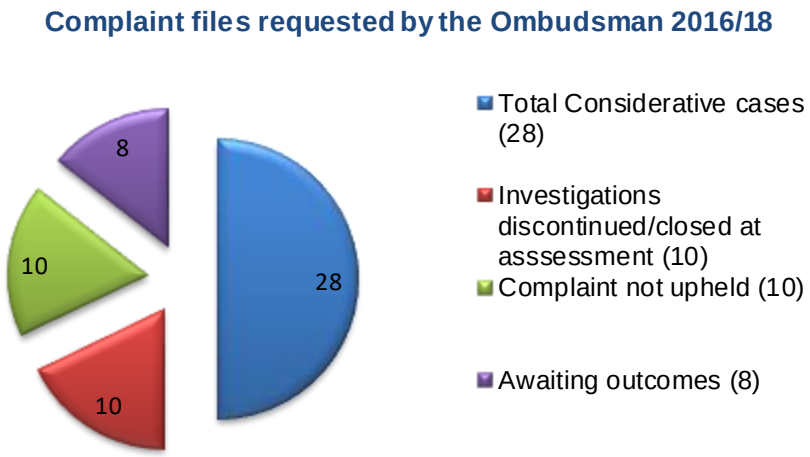
Extensive feedback was given to the Paramedic by the local management team, with an emphasis on the importance of recording the assessment record to an optimum level. They also jointly reviewed the treatment protocols in relation to patients with symptoms similar to the patient's presenting symptoms

7. Ombudsman case review

28 cases were considered by the Health Service Ombudsman. This includes complaints where the incidents in question occurred earlier but were considered by the Ombudsman during 2016/17.

We await notification on 8 cases, the remainder were closed following considerative assessment or the case not upheld following formal investigation.

Pie chart 1 Cases Requested by the Ombudsman2016/18



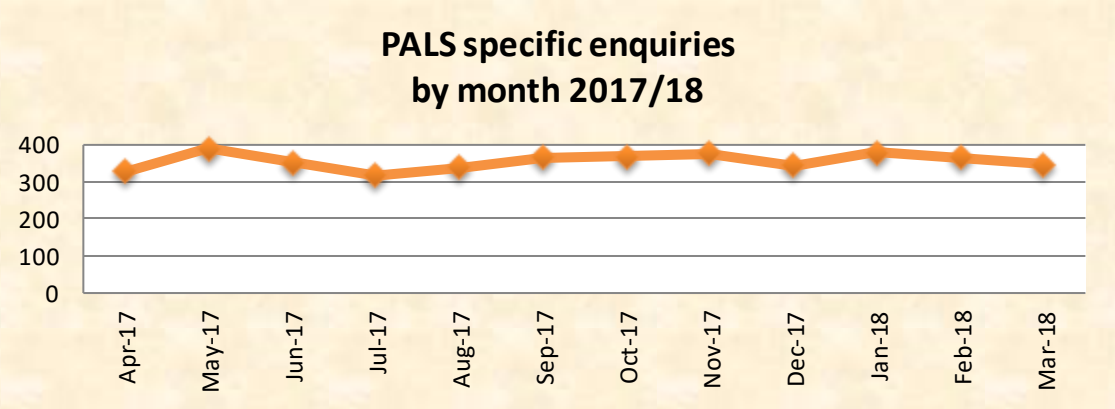
8. PALS

PALS offer immediate assistance including liaising with other departments and agencies. During 2016/17 there were 4302 contacts from patients, carers, relatives and the public. This contrasts to the decrease in the numbers of complaints in the same period and highlights the importance of maintaining our PALS service in order to provide advice, support and information to patients, families and their carers.

The most common subjects of enquiry are hospital destination, lost property and requests for medical records; policy and practice enquiries are also common from academics, students, other health and social care agencies and members of the public. Bereavement related enquiries are a further consistent theme.

The following graph demonstrates a consistency in the monthly total of PALS enquiries.

Graph 5 PALS cases recorded by month 2017/18



9. Solicitor enquiries

The team includes a specialist who process all requests for medical records, including those made by a solicitor acting on behalf of the patient or relatives, where legal action is not intended against the Trust. Additionally, we facilitate requests for witness statements, which are obtained via a face-to-face interview with staff.

This service attracts a fee. In 2017/18, 1568 requests were made by solicitors for medical records and requests to interview operational staff, generating a total of £65,641. However, this fee will no longer be applicable after the introduction of new legislation in May 2018.

Table 6 Solicitor summary

Solicitors request for medical records						
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
April	69	118	122	110	100	93
May	78	121	100	103	90	113
June	98	96	109	100	107	114
July	94	107	123	114	120	125
August	79	135	94	90	77	103
September	117	100	108	124	83	109
October	80	138	149	119	101	111
November	109	124	141	96	86	103
December	66	87	83	88	98	84
January	84	94	125	104	89	106
February	104	120	128	92	104	124
March	109	116	96	126	111	137
TOTAL	**1087**	**1356**	**1378**	**1266**	**1166**	**1322**

The following sums have been received since April 2013:

Table 7 Fees received in respect of Solicitors enquiries 2013/2018

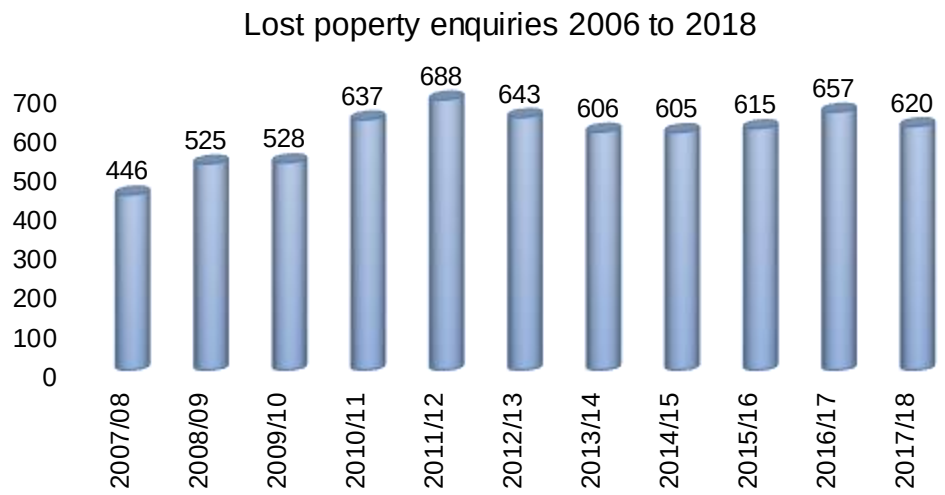
2013/14	£60,645
2014/15	£52,541
2015/16	£50,566
2016/17	£56,690
2017/18	£65,641

10. Lost Property

We continue to engage with the SMARTbags™ team and design improvements have been made to the property bags.

Graph [6] evidences the total lost property item enquiries received by year.

Graph 6 Lost Property.



Commonly reported items include mobile phones, spectacles, false teeth, keys, walking sticks and jewellery.


LONDON
AMBULANCE
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London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Board Engagement			
Agenda item:	09			
Report Author(s):	Jamie O'Hara, Director of Strategy and Communications			
Presented by:	Jamie O'Hara, Director of Strategy and Communications			
History:	N/A			
Status:	☐	Assurance	☒	Discussion
	☒	Decision	☐	Information

Background / Purpose:

We operate in a very complex stakeholder world, with many partners with who we engage with on a day-to-day basis, but many more who we have yet to start a relationship with. We also have a Board with a rich, and diverse, expertise in a number of areas that we do not fully utilise.

We have also done a lot to improve the visibility of the Executive with frontline staff, following the CQC inspection in June 2017, which reported that we needed to focus on this area.

This paper has the following objectives:

- Introduce a 'Board to Ward' style approach to raise the visibility of the Board within each of the five STP sectors – both internally and externally.
- Provide the 'frontline' with a direct link to the senior management of the trust.
- Provide opportunities for executives and Board members to increase their engagement with staff and stakeholders, acting as 'ambassadors' to broker relationships with key partners for the purposes of the strategy and embed the organisation's new purpose and values.

Recommendation(s):

The Board is asked to agree the approach set out in the report.

Links to Board Assurance Framework (BAF) and key risks:

In 2017, the CQC identified a disconnect between the leadership team and frontline staff as an area for improvement.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐

Financial	☐
Workforce	☒
Governance and Well-led	☒
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Board engagement

Background

1. Sustainability and Transformation Partnerships (STP) were formally established in 2016. They were established to strategically plan and fund all health and care activities within the geographical areas that they cover. The area covered by the London Ambulance Service has five STPs covering North East, North West, North Central, South East and South West London.

2. Since the establishment of STPs, we have attempted to ensure that we proactively and regularly engage with each of the STPs to help develop the five London STP plans. In early 2017, we re-organised our operational sectors to match the STP areas and aligned our local areas stakeholder engagement activity, through sector based Stakeholder Engagement Managers (SEMs) and Community Involvement Officers (CIOs), to match.

3. We also appointed both Executive and Non-Executive leads at Trust Board level to oversee strategic engagement with each STP. Following the departure of a number of executive directors in 2017, the then new Chief Executive took personal responsibility for strategic executive engagement across all five areas, supported latterly by the Director of Strategy and Communications.

4. The Non-Executive Director leads in each area have been as follows:

    - North West London – Fergus Cass
    - North East London – Theo de Pencier
    - North Central London – Jones Jones
    - South West London – Bob McFarland
    - South East London – Heather Lawrence

5. Whilst these arrangements have enabled us to bring an increased focus to our area based strategic external engagement. Through work the Board has done on internal engagement and leadership, coupled with Staff Survey information, evidence from the recent Chief Executive Staff Roadshows and Care Quality Commission (CQC) inspection report, it has become clear that there are still issues that we need to address in terms of internal visibility of 'senior management' in the operational sector areas.

6. Whilst some of this challenge is undoubtedly about improving the capability, competence and support for senior management within the sectors themselves, an element of this needs to be about achieving further improvements in the visibility and approachability of the Trust Board level leadership of the organisation, at both executive and non-executive level, to achieve genuine 'boardroom to mess room' front line engagement. This will be essential going forwards if we are to achieve our ambition to move the trust further forward in the CQC well-led domain to become an overall 'Outstanding' trust.

7. As a result, earlier this year, the Chief Executive asked the Trust Board to approval the principle of both Executive Leadership Team members and Non-Executive Directors taking on an enhanced sector based engagement role. This was agreed in principle, subject to some concerns, particularly on behalf of Non-Executive Directors, about their ability to take on further work due to existing time commitments.

8. As a result further work has been undertaken to understand how this might be achieved, taking account of the constraints identified above. This report sets out a proposed way forward for the Trust Board to consider.

Objectives

9. This paper therefore has the following objectives:

   - Raise the visibility of the Executive Leadership Team and Board within each sector – both internally and externally.
   - Improve organisation 'frontline' connectivity with the Trust Board.
   - Provide opportunities for Board members to increase their engagement with staff to help embed the organisation's new vision, purpose, values and behaviours.
   - Develop strategic relationships with key local stakeholders (eg. STP leadership and CCGs, local acute hospital management and alternative care pathway providers), support local LAS management and acting as strategic 'ambassadors' to broker relationships and help implement our new strategy.

Proposed Way Forward

10. It is proposed that Executive Management Team (ELT) members are 'buddied up' to individual sectors to support the local area management teams led by the sector-based Assistant Directors of Operations and the new station Group Managers and Clinical Team Managers (when appointed following the current Operations Directorate restructure. They will also work closely with the sector based Stakeholder Engagement Managers (SEMs) and Quality Governance & Assurance Managers (QGAMs) to support local engagement and quality management. A similar approach will also be applied to the 999 & 111 operations centres

11. ELT members have agreed the following area-based responsibilities:

Function	**Executive Leadership Team Member**
North West	Jamie O'Hara Benita Mehra
North East	Trisha Bain Jill McGregor
North Central	Lorraine Bewes Ross Fullerton
South East	Philippa Harding
South West	Patricia Grealish Angela Flaherty
999 & 111 operations centres	Paul Woodrow Fenella Wrigley

12. Members of the ELT have committed to making one visit per month to their area to meet local staff, for example through station based 'drop in' sessions/surgeries etc, and will also book regular 'work days' based at a location in their sector, to work alongside local area management teams. They will also attend their sector's monthly performance meeting with the Chief Executive and aim to undertake any ambulance 'ride outs' they do in their local sector area.

13. This engagement will in turn support the increased focus the Chief Executive himself is placing on area based staff engagement with the new 'twice a year' format of the staff roadshows, to ensure that the senior management team of the Trust has regular visibility and engagement with front line staff members throughout the year.

Proposed Role of Non-Executives Going Forward

14. It is proposed that we continue to have at least one, and ideally two, Non-Executive Directors allied to each sector area, taking a strategic interest in both the workings and development of the local area STP. The aim would be to coordinate this activity through the stakeholder engagement team to tie in with the role played by the Chief Executive and Director of Strategy and Communications in high level external stakeholder engagement, and the role of SEMs and CIO's at a more operational level.

15. Internally focused local area activities undertaken by non-executives will necessarily be constrained by other time commitments, however it is hoped that non-executives might be able to join executive colleagues in some of the engagement activities outlined above and, where undertaking 'ride-outs' or other engagement activities, focus them on their relevant sector area. This will facilitate a joined-up approach to leadership, enable the Board to consider local issues from both a non-executive and executive perspective and create a small 'team' of Board members with specific knowledge of and interest in each of the sector areas.

16. Consideration has also been given to expressed work commitments that some non-executive members currently have, and it is proposed that this is reflected in the following proposed sector areas:

Function	**Non-Executive Director**
North West	Jessica Cecil Fergus Cass
North East	Theo de Pencier
North Central	John Jones Jayne Mee
South East	Amit Kuti Sheila Doyle
South West	Robert McFarland
999 & 111 operations centres	Heather Lawrence

Other Potential Activities

17. Other activities that could potentially be undertaken by either executive of non-executive Board members include:

Internal opportunities	**External opportunities**
Attending local management meetings eg sector meetings, EOC, 111	We produce a newsletter for each sector, which each board member for that sector could contribute an article once a year.
Attending local meetings eg team leader meetings (to hear about clinical issues)	Supporting the ADOs at meetings in the sector – this could be: • STP meetings, such as workstream meetings and A&E delivery boards

	• CCG meetings, to support the ADO and observe • Attendance at other sector meetings to support the team and observe
Shadowing staff eg team leader, resilience call sign	Proactively identify opportunities for the Board to attend events or speak at events in their sector
Rideouts – managers, crew or single responder	Meetings with Chair's for other sector based stakeholders, such as CCG Chairs, relevant VCS Chairs etc
CPD events	Involvement in public engagement activities via the PPI team

18. Non-Executive directors and ELT members also already participate in a programme of Quality Assurance visits when they will carry out specific quality checks in local areas. To avoid duplication, they will not carry out quality checks as part of this engagement approach.

How will the Board be supported?

19. A briefing note covering each sector will be provided every month by the Director of Strategy & Communications and his team. This will provide the Board and ELT with information about key issues in each sector, as well as details about forthcoming meetings internally at an STP and CCG level. Each sector has its own Stakeholder Engagement Manager and will be the point of contact for any further information, or detail, the Board may have. The Director of Strategy and Communications, with the Stakeholder Engagement Managers, will facilitate and prepare non-executive directors members and ELT members for their engagements.

20. For internal visits, non-executive board members and ELT members should capture the main observations from their visits, via email to the relevant assistant director of operations for their sector, with a copy to the Director of Operations. This will capture their main observations from their visit.

21. For external visits, non-executive board members and ELT members should capture the main observations from their meetings either verbally to the Director of Strategy and Communications or via email.

Recommendations

22. The Board is asked to approve the proposed approach set out in this paper.

Jamie O'Hara
Director of Strategy and Communications

London Ambulance Service NHS Trust

Assurance report:	**People and Culture Committee**	**Date:**	**14/05/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**24/05/2018**
Presented by:	**Jayne Mee, Non-Executive Director, People and Culture Committee Chair**	**Prepared by:**	**Jayne Mee, Non-Executive Director, People and Culture Committee Chair**

Matters for escalation:

The Board is aware that the Committee has been focussing upon the organisation's development of a workforce planning tool. This is continuing to be developed and a further iteration is due to be considered by the Committee ahead of its presentation to the Board at its meeting in July.

Agency – the Committee received a tabled paper setting out the Trust's agency usage. A plan is required to reduce the overall usage of agency staff, in order to ensure that the organisation remains within national caps. The Committee required further assurance on progress with this activity and the presentation of a clear plan for further action, as well as what has already been achieved to be presented at its meeting in July.

Workforce Race Equality Scheme (WRES) – the Committee was informed of the progress that has been made in this area. Much has been done, but there is much still to do. The report received by the Committee has been presented to the Board for information and there will be an opportunity to discuss this at the Board meeting in July.

Other matters considered:

EMD recruitment - online assessments pilot and control group – the Committee was informed that these are being run concurrently. Both started at the beginning of May. A report on progress is to be circulated to the Committee in correspondence, in advance of the Committee's meeting in July.

The Emergency Operations Centre (EOC) restructure consultation proposals will be presented to the Committee in July, with the restructure due to be completed by the time that the Committee is due to meet in September.

	Staff survey action plans are clearly developed and have been referenced at the Chief Executive's Roadshows. The Committee emphasised the importance of not just tracking the process for responding to key themes of the staff survey, but also what is changing as a result of the actions that are being taken. The Committee noted the improvement of the information presented to it through people and culture dashboard; however more needs to be done to provide a detailed analysis of the implications of the information provided.
Key decisions made / actions identified:	Recruitment activity – the Committee noted the difficulies associated with the Healthcare Professions Council registration process and the implications of this for paramedics joining the organisation from abroad. Whilst this issue seems to have been resolved for now, it is something that should be kept under review. Band 6 paramedic funding – the Committee noted the need for confirmation of training resource requirements. Also confirmation that there is budget for the additional training resources that have been identified. The Committee was informed that the outcome of the training review was due to be fed back to the Quality Assurance Committee meeting later in the month and reported in more detail to the next meeting of the People and Culture Committee.
Risks:	Band 6 funding and training resource requirements Action required to reduce agency usage. Recruitment activity continues to require focus.
Assurance:	The Committee has taken assurance from the ever improving quality of reporting and flagging of issues to the Committee. Progress is being made against significant aspects of the People and Culture Strategy .

London Ambulance Service NHS Trust

Assurance report:	**Audit Committee**	**Date:**	**17/05/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**24/05/2018**
Presented by:	**John Jones, Non-Executive Director, Audit Committee Chair**	**Prepared by:**	**John Jones, Non-Executive Director, Audit Committee Chair**

Matters for escalation:

General Data Protection Regulation (GDPR)

The General Data Protection Regulation (GDPR) becomes enforceable from 25 May 2018. An update on implementation confirms we expect to achieve an appropriate level of compliance by 25 May but full compliance will not be possible until the end of 2018. An update report will be provided at the Board meeting.

Data Quality Strategy

An updated Data Quality Strategy for the Trust is in final draft and is to be considered at an upcoming Executive Team meeting. Comments will be sought from Audit Committee members and it is planned for the Strategy to be presented to the July Trust Board for approval

Other matters considered:

The Annual report from the Internal Audit service (KPMG) was received and includes the Head of Internal Audit Opinion – see assurance section.

The Committee considered the final Internal Audit report from KPMG for 2017/18 on Data Quality Framework. This highlighted the need for agreement of the data quality strategy and implementation of its aims – see assurance section.

A progress report on the external audit of the annual accounts for 2017/18 was presented by Ernst and Young. Work is progressing satisfactorily and they are on track to complete their audit by the due date.

The updated Board Assurance Framework (BAF), which shows five red risks, was reviewed. These are also subject to monitoring by respective

	Board Assurance Committees .Future BAF reports will be updated to include risks relating to the 2018/19 plan objectives. Use of single tender waivers to April 2018 were reviewed. The Gifts and Hospitality Register and the Register of Interests were reviewed by the Committee. The Committees forward plan was reviewed.
Key decisions made / actions identified:	The final draft of the Annual Governance Statement was approved. The Annual Report of the Audit Committee was approved and this is on the Trust Board agenda today.
Risks:	No new risks were highlighted.
Assurance:	The Head of Internal Audit Opinion for 2017/18 takes into account positive assurance on major control systems (e.g. finance controls and governance) but partial assurance from a number of studies (e.g. contract management, fleet and procurement). The resulting overall opinion for the Trust for 2017/18 was: 'Significant assurance with minor improvements required' can be given on the overall effectiveness of the organisation's framework of governance, risk management and control. The assurance rating for the Data Quality Framework audit was Partial Assurance with improvements required. Eight recommendations were made, all being accepted. Both representatives of the internal (KPMG) and external auditors were present at the meeting.

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**22/05/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**24/05/2018**
Presented by:	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**	**Prepared by:**	**Robert McFarland, Non-Executive Director, Quality Assurance Committee Chair**

Matters for escalation:

- Serious Incidents (SIs) Reports: Anonymised synopses of individual SIs have previously been included alongside information concerning investigation times and actions completed. These should be available for the Board, or for this Committee confidentially, on behalf of the Board, to be properly assured.

Other matters considered:

Report from North West Sector: Chris Myles and Martin McTigue QGAM, Catherine Wilson SEM and Ian Johns ADO

- NW Sector is a busy sector with five Group Stations, a large visiting population (Westminster and Heathrow) and has had staff shortages particularly among Clinical Team Leaders. Despite this we were given several examples of quality improvements including Health and Safety reporting, complaints, and a focus on stroke and cardiac times which was showing improvement. An MSK Project, focused on life changes, as well as musculoskeletal injuries is about to commence.
- Health Assure: introduction will be complete across all group stations this month and is starting to inform management meetings.
- Hospital Handover: Despite having two of the most challenged A&E departments in this regard, NW sector has managed, by working with all involved, to reduce by 3% time lost in hospital waiting despite an increase in conveyance of 4%. Cohorting guidelines are established with escalation using the NEWS system to flag clinical deterioration. Work across the sector includes developing STP wide Acute Care Pathways (ACPs) available on MiDOS; Rapid response teams are available locally to avoid conveyance to hospital, and a Primary Care Liaison Officer has made a difference to frequent caller demand. Referrals had increased following an opportunity for Paramedics to shadow the Rapid Response Teams.

Quality Report

- The improvement in quality indicators on the dashboard was noted
- Following a review of the use of the Datix system, some discrepancies in recording incidents have been noted (particularly with regard to medicines management incidents). These are being analysed and proposed changes will be put in a report to the Board in June.
- There is still no improvement in the proportion of stroke patients conveyed to HASU within 60 minutes. The Committee is not yet assured that there is an effective action plan across the Trust to address this issue. Although ARP has changed to overall target times a LAS time target is still needed to be sure our part of the patient journey is good. The action plan is due to be considered at the Committee's next meeting.
- Complaints – numbers have increased and Quality Alerts from other providers have been added to the workload. There is again a holdup waiting for QA review of the taped calls. The Quality and Assurance Team is reviewing in depth the complaints process and will bring the result of this review to the July meeting.

Serious Incidents

- The improvements in timely investigation and reporting were again noted.
- We were assured that we had changed the response to patients with chest pain to avoid delay (some of these patients were categorised by ARP as a C2) and notified the need for change to the national review.
- Previously synopses of the individual SI had been included alongside data concerning investigation times and actions completed. NEDs felt that the committee should have sight of these confidentially, on behalf of the Board, to be properly assured. (Similarly significant complaints, particularly those which are being considered by the Ombudsman).

Health and Safety

- All actions are either complete (47) or underway (22) and none overdue.
- Bariatric support will be provided by St Johns Ambulance for another year then the service brought in house the following year with four new vehicles. This service also includes training in specialised techniques to move patients with abnormal weight, size and shape safely out and into the vehicle.

Towards Outstanding

- Trisha Bain presented the actions which would be necessary to move our rating by CQC to "outstanding". It was emphasised this was part of the Trust's overall improvement strategy.

Clinical Council

- The first meeting of the Clinical Council was on 13th March. This had been a successful and worthwhile meeting as evidenced by the circulated resultant action plan.

Training Review

- This report, commissioned as there were concerns, is now just complete and was not available for this meeting. We were told that there were many areas of good practice, but the report has also identified areas of concern which are a potential risk for the Trust. The outcome of the report is due to be considered by the Executive ahead of its submission to the People and Culture Committee and Quality Assurance Committee, together with proposed responses to the recommendations contained within it.

Key decisions made / actions identified:

Quality Strategy and Annual Quality Account
Patient Experience Annual Report
Safeguarding Annual Report

- The Committee was pleased to recommend final versions of these reports.

Risks:

There are no BAF risks currently allocated.

- BAF risk 47 (staffing in EOC) remains a concern and we await the conclusions of the restructuring review before the next meeting.
- Internal Audit recommendations: There is still concern about storage and accessibility of training records, which had been escalated to the Board at its meeting on 24 April 2018.

Assurance:

- Internal reconfiguration of staffing to manage frequent callers has been agreed and so this can move forward.
- All Health and Safety Actions are either complete (47) or underway (22) and none overdue.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Integrated Quality and Performance Report			
Agenda item:	13			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Key Leads from Quality, Finance, Workforce, Operations and Governance			
History:	N/A			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendation(s):

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

Links to Board Assurance Framework (BAF) and key risks:

This report contains an overview of Trust Risks directly linked to the BAF but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

May 2018

* All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout April 2018 unless otherwise stated.

Delivery of care continues to be safe, but the ongoing demand pressures on the system remains challenging. Cat 1 Mean was 7 minutes 26 seconds. LAS ranked 2nd in Cat 1 90th centile compared to other Trusts. Trust vacancy rates have remained at 6%. Appraisal rates have improved from 69% to 87%. Year to date the position is £0.2m ahead of plan. Year to date CIPs are on plan.

OUR PATIENTS

- Hand hygiene reporting improved from 95% in March 2018 to 98.38% in April against the set target of 90%
- The Trust is continuing to meet national reporting standards for RIDDOR reporting which is now at 13 days. (National reporting standards <15 days)
- Complaints responses >35 days has increased from 8 cases to 40 in April. Additional clinical support has been provided in order to reduce delays.
- There were 6 Serious Incidents declared in April, returning to the level expected in comparison to the previous year.

OUR PERFORMANCE

- Category 1 Mean for April was 6 minutes 51 seconds. This is 9 seconds below the national standard.
- 95,619 Incidents were provided with a face-to-face response. Category 1 incidents reached 8,194 incidents.
- In April, total hours lost to Patient Handovers at hospital reached 5,028. April saw the average time lost from patient handover to green remain at 6 minutes and time lost in hospital to patient handover reduce from 14 minutes to 10 minutes.
- In April 91% of all calls received into the EOC were answered within five seconds. This has increased from 76% in March.

OUR MONEY

Year to date the position is £0.2m ahead of plan.

Year to date demand is currently running at 0.6% above contract baseline. This is below the budgeted level of activity included in the Trust's plan of 1.7%, and as such main contract variable income is £0.3m below budget.

Year to date CIPs are on plan. There is a risk that the Trust will not deliver its £12.3m CIP target.

Capital spend for M1 was £0.8m which is £1m behind plan. The Trust CRL will be confirmed by the end of June 2018. The Trust is currently preparing a bid for submission to NHSE to fund the capital costs of the transition to the new performance standards.

The new annual agency spend cap is £5.9m. M1 agency spend is above the cap and an action plan for recovery is being overseen by the People & Culture Committee.

OUR PEOPLE

- Vacancy rates have remained at 6%.
- Overall turnover has increased from 10.7% to 11.2%.
- The monthly sickness position for April remains at 5.2%.

↑	Increasing concern	↓	Decreasing concern
↑	Increasing negatively	↓	Decreasing negatively
↑	Increasing positively	↓	Decreasing positively
↔	Remains steady	↔	Information only

Demand for 111 was exceptionally high during March however service delivery remains safe with no Serious Incidents declared. Patient Transport Service delivery was maintained against a background of continued recovery from current winter pressures and adverse weather conditions.

LAS 111 (SOUTH EAST LONDON)

- ↓ 111 failed to achieve 95% or more of calls answered in 60 seconds on 21 days.
- ⇔ Call demand was 1.7% lower than predicted in April, but saw an 11.5% increase from April 2017.
- ⇔ Referrals to 999 remain consistently low and lower than both the London and national average.
- ⇔ LAS SEL ranked 1st across London for Percentage of calls abandoned after 30 seconds.

PATIENT TRANSPORT SERVICE

- ⇔ Delivery was maintained against a background of continued recovery from current winter pressures and adverse weather conditions.
- ⇔ April was our last month of delivering PTS journeys on our last remaining contract St Georges Community in South West London which finished on the 30th April 2018 We delivered a final total of 1,047 journeys as compared to the March total of 1,465 journeys.

LAS IMPROVEMENT

Single Oversight Framework

The purpose of the Single Oversight Framework (SOF) is to identify where providers may benefit from, or require, improvement support across a range of areas. The five themes are: Quality of care, Finance and Use of Resources, Operational Performance, Strategic Change, and Leadership and Improvement Capability.

NHSI segment the provider according to the scale of issues faced.
It does not give a performance assessment in its own right.

1 - Providers with maximum autonomy
2 - Providers offered targeted support
3 - Providers receiving mandated support for significant concerns
4 - Special measures

LAS Current Status	
LAS Shadow Segmentation	4
LAS Breach Status	Breach & Special measures

CQC Overall Rating	Caring	Effective	Responsive	Safe	Well-led
Inadequate	Good	Requires improvement	Requires improvement	Inadequate	Inadequate

OUR RISKS

BAF Risk 49
The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

BAF Risk 47
The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

BAF Risk 45
There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

↑	Increasing concern	↓	Decreasing concern
↑	Increasing negatively	↓	Decreasing negatively
↑	Increasing positively	↓	Decreasing positively
⇔	Remains steady	⇔	Information only

Key Performance Indicator Report Summary

	Key Performance Indicator	Apr-18	Mar-18	Feb-18	Chart
QUALITY	Adverse Incidents (Patient)	↓	↑	↑	
	Adverse Incidents (Staff)	↑	↑	↓	
	Potential Serious Incidents referred to SI Group	↓	↑	↓	
	Serious Incidents (LAS Declared)	↓	↑	↓	
	Serious Incidents (LAS Declared) Overdue	↔	↔	↔	
	Regular Reporting of Incidents - Shared Learning	↔	↔	↔	
	Total Complaints	↑	↓	↑	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↑	↓	↑	
	Controlled Drug Incidents - Not reportable to LIN	↓	↑	↓	
	All LIN Reportable Incidents	↔	↔	↔	
	Overall Medication Errors	↓	↑	↓	
	Missing Equipment Incidents	↑	↑	↑	
	Failure of Device/Equipment/Vehicle Incidents	↔	↑	↑	
	CPI - Completion Rate*		↓	↔	

	Key Performance Indicator	Apr-18	Mar-18	Feb-18	Chart
111	Calls answered within 60s	↑	↑	↓	
	Calls abandoned after 30s	↓	↓	↑	
	Percentage of calls referred to 999	↑	↓	↑	

	Key Performance Indicator	Apr-18	Mar-18	Feb-18	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↑	↓	
	Vacancy Rate (Frontline)	↑	↓	↓	
	Vacancy Rate (Trust)	↑	↔	↓	
	Turnover Rate (Frontline Paramedic)	↑	↑	↑	
	Turnover Rate (Frontline)	↑	↑	↑	
	Turnover Rate (Trust)	↑	↑	↑	
	Sickness (Trust)	↑	↓	↑	
	Sickness (Frontline)	↑	↓	↑	

*These KPIs are reported one month in arrears

	Key Performance Indicator	Apr-18	Mar-18	Feb-18	Chart
PERFORMANCE	A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. The six key performance measures are listed below, which will be monitored in this document. The arrows show the movement in the measures when compared to the performance from the previous month.				
	Cat 1 Mean	↓	↓	↑	
	Cat 1 90th Centile	↓	↑	↑	
	Cat 2 Mean	↓	↔	↑	
	Cat 2 90th Centile	↓	↔	↑	
	Cat 3 90th Centile	↓	↓	↑	
	Cat 4 90th Centile	↓	↑	↑	

	Key Performance Indicator	Q1	Q2	Q3	Q4
FINANCE	Financial Stability Risk Rating (FSRR)				
	Capital Service Capacity				
	Liquidity Days				

	Key Performance Indicator	Apr-18	Mar-18	Feb-18
	Cash Balance - Monthly Profile - £000s	↔	↓	↓
	Income and Expenditure Deficit by Month - £000s	↓	↑	↓
	Income and Expenditure Deficit Cumulative - £000s	↓	↑	↓
	Income Variance from re-phased budget - £000s	↓	↑	↓
	CIP Delivery Against Plan - £000s	↓	↑	↓
	CIP Forecast Against Plan - £000s	↓	↑	↓
	Forecast Capital Spend Against the CRL - £000s	↓	↑	↑
	Debtor Days	↑	↑	↔
	Creditor Days	↓	↑	↔
	Agency spend against plan - £000s	↓	↑	↑

The RAG status is calculated against targets/trajectories/thresholds where available. The Chart column shows the trend over the previous 3 months | The arrows indicate the direction of KPI compared to previous month

A new series of standards, indicators and measures were introduced through the Ambulance Response Programme (ARP) in November 2017. These Key PERFORMANCE measures will be included from January onwards and, continued to be monitored in this document.

Our Patients

Safety

- Hand Hygiene reporting improved from 95% in March 2018 to 98.38% in April against the set target of 90%
- National IPC Group from 4 countries met in LAS premises in April 2018 to undertake national benchmarking work streams. LAS is ahead in quality assurance of cleanliness standards using ATP swabs, workforce immunisation, IPC training, and is leading on the national work stream to define standards for ambulance station environment
- No unaccounted for morphine losses
- 8 Serious Incident investigations were closed in April.
- We have received feedback from the CCG advising of the significant assurance the Trust provides regarding the management and learning from SI's
- One joint training event with Northwick Park Hospital as part of strengthening communication and joint MDT (May 2018)
- The Trust Intelligence Systems Manager has identified a number of improvements within the incident reporting system (Datix).

Actions & Assurance

- Maintain medicines management audit programme
- Further station based maternity "skills drills" training offered
- Successful appointment of 2 Practice Leads for Pre Hospital Maternity Care – Commencement in July/August 2019
- The improvements made in Datix ensures greater accuracy when generating reports. For example; some CD incidents were not extracted from Datix when using certain search criteria.

Effectiveness

- 97% of stroke patients received the complete care bundle in March (in line with the 2017-18 average)
- 'Mean from call to arrival at hospital' for stroke patients was 1 hour and 15 minutes in November 2017 (in line with the national average)
- Cardiac arrest response time for C1 patients in March remained at 7 minutes (11 minutes 90th centile)
- A high of 63.8% ROSC was achieved for the Utstein comparator group in March

Actions & Assurance

- Recommended changes to the CPIs to help reduce job cycle time went live on 1st April
- The Elderly Falls CPI was launched
- Retrospective safeguarding referral and Datix incident prompts were incorporated into the CPIs with a flag for further discussion
- Findings to be shared upon completion of report
- Existing incidents reviewed and staff provided with feedback

Caring

- First trust "Whose Shoes" listening event to take place on 11th May 2018

Actions & Assurance

- Outcome from engagement event to be incorporated into trust wide Quality Improvement Projects.

Our Patients

Safety

- Six-weekly deep clean compliance of A&E vehicles was 94.4% against the Trust target of 95%
- FFP3 solution delayed
- Sharps/BFE data and communicable diseases for staff is not yet available for May Report
- By the end of 2017/18 only 35% of clinicians received two face-to-face CPI feedback sessions (28% received no feedback at all) against a target of >95%.
- 8 Health Partner Alerts were received by maternity units in relation to delays when midwives have requested transfers. The Trust Consultant Midwife is reviewing each case and is in the process of updating aide memoire card issued to Midwives who require ambulance transport for mothers in labour.

Actions & Assurance

- Reissue promotional posters relating to correct administration of adrenaline
- Quality alerts not currently raised as a Datix incident – recommendation to implement
- Meeting with Quality Assurance Managers for the EOC 3/5/2018 to find workaround and request for change

Effectiveness

- Contract for KitPrep and Perfect Ward apps due for renewal in November 2018 – this process will need to go tender due to the costs involved. Potential risk to disruption of audit and medicines tracking processes
- In March, 74% of STEMI patients received the complete care bundle against a target of 100% (excluding exemptions i.e. when an element of the care bundle is not indicated)
- 'Mean time from call to angiography' for STEMI patients for November 2017 was 2 hours and 8 minutes. This is below the national average of 2 hours and 18 minutes (NHS England AQI Statistical Note – 10th May 2018)
- 52% of patients arrived at a HASU within 60minutes of stroke onset against a target of 66%

Actions & Assurance

- Medicines management group input into the renegotiations
- CARU have produced an infographic detailing the four care bundle elements with hints and tips for each element and a handy list of valid exceptions

Caring

- During April we received a 23% increase in complaints of which 40 related to delays in an ambulance attending (39%).
- The outcome of this increase is that the number of complaints over 35 working days at the time of this report exceeded 40.

Actions & Assurance

Delays are attributed to operational pressure in the respective teams (EOC QA, Chub and Operations). Staffing levels due to unplanned absence within the Patient Experience Department have also impacted throughput. The Chief Quality Officer has arranged for additional clinical support to be provided to the team in order to reduce delays.

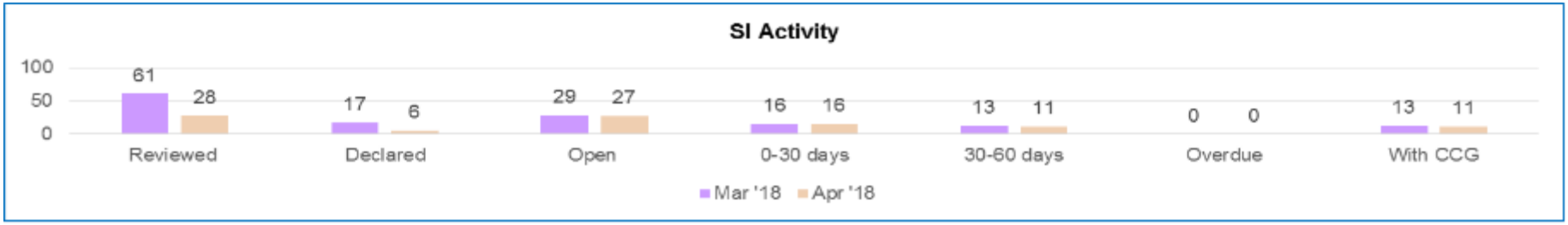
Patient Safety

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

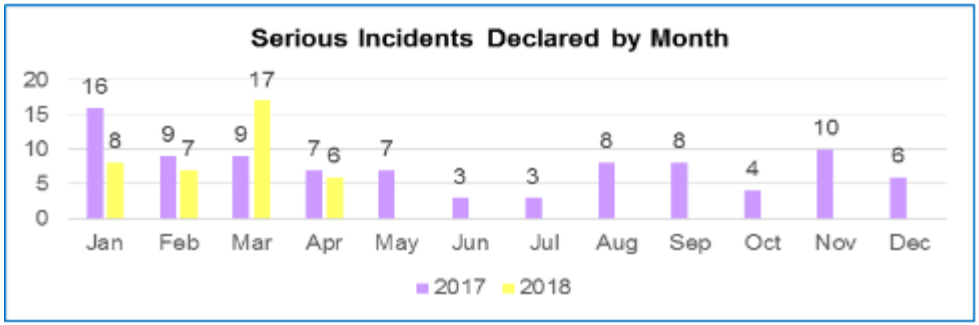
Measures	Target / Range	RAG	YTD 18/19	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	G	98%	78.4%	71.7%	98.0%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	R	2.4	2.7	2.7	2.4	↓					
Patient related Adverse Events - NO HARM	100	G	172	168	176	172	↓					
Patient related Adverse Events - LOW	40	R	24	28	34	24	↓					
Patient related Adverse Events - MODERATE	25	R	14	14	18	14	↓					
Patient related Adverse Events - SEVERE			5	2	12	5	↓					
Patient related Adverse Events - DEATH			5	18	19	5	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.7	2.9	2.7	3.7	↑					
Staff related Adverse Events - **NONE**			184	135	140	184	↑					
Staff related Adverse Events - **LOW**			146	108	110	146	↑					
Staff related Adverse Events - **MODERATE**			4	7	9	4	↓					
Staff related Adverse Events - **SEVERE**			0	2	0	0	↔					
Controlled Drugs - Other Reportable Incidents			46	46	56	46	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	96%	91%	93%	96%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month			6	7	17	6	↓					
Serious Incidents breaching 60 days	0	G	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	G	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			4%	6.5%	6.2%	4.1%	↓					
Needle Stick Injuries as % of Staff Adverse Events			1%	2.0%	1.5%	0.6%	↓					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Missing Equipment Incidents as % of all reported incidents			3%	3%	3%	3%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	11%	10%	10%	↓					
Staff Immunisation Status - FROM NEXT MONTH							↔					
Number of NRLS uploads In-Month	1	G	1	1	1	1	↔			LQ21		

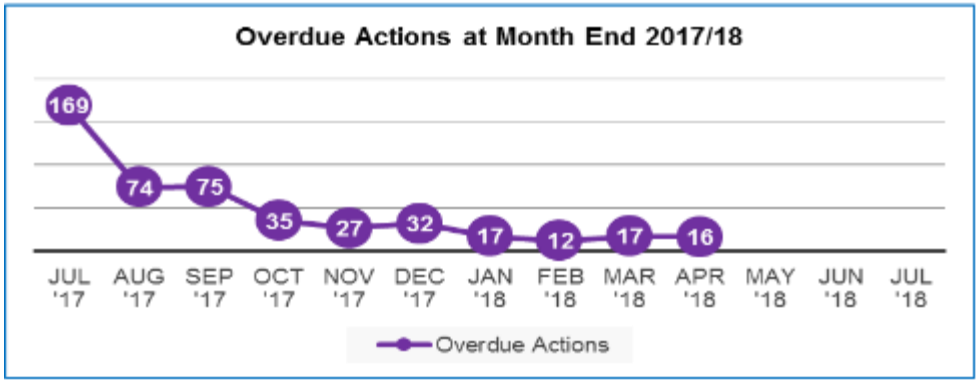
Patient Safety

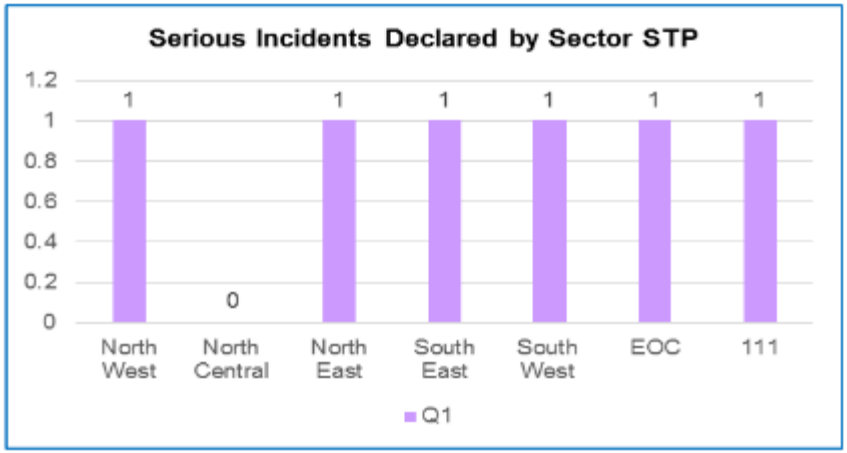
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



A total of 28 incidents were **reviewed** by SIG in April of which 6 were declared as SIs. 11 completed investigations have been submitted to the CCG and are awaiting closure or comments. The Trust is maintaining its contractual obligations with the CCG and currently there are 0 investigations that have breached the 60 working day deadline.



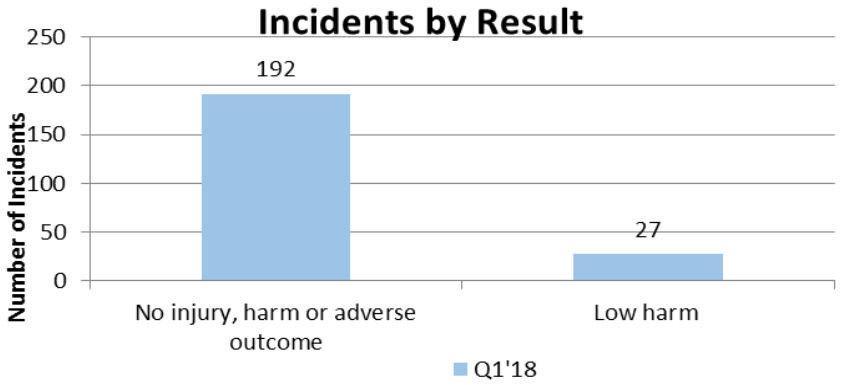




- The number of SIs declared in April 2018 has returned to the level expected in comparison to the previous year.
- There are currently 16 SI actions that are overdue (against an internal target of <10). The Quality, Governance and Assurance Team maintain contact with the accountable manager on a weekly basis.
- The majority of actions that are overdue are part of larger service improvement programmes or are affected by rota patterns and staff absence.

Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



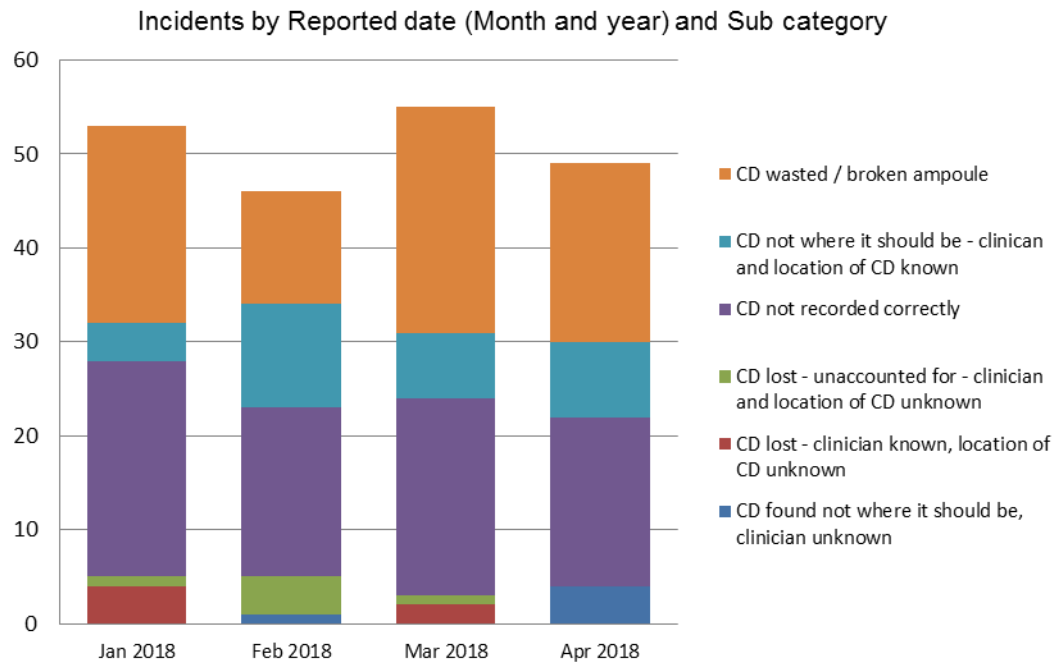
- In April, the new Head of Quality Intelligence & Improvement joined the Trust along with a new Datix Systems Manager. Collectively they have worked to validate how data is collected and shared by the Trust incident reporting system, including uploads to the National Reporting & Learning System (NRLS). This included ensuring the level of harm is extracted from the post investigation element of the incident report resulting in improved accuracy and assurance.
- The Trust incident reporting system is being reviewed and the way data is being collected has now been validated. KPI's for 2018/19 are currently in the process of being finalised.

The Trust set annual Key Performance Indicators (KPI's) for the reporting of incidents that have been graded as either no harm or low harm. The target of 1200 no harm incident reports was exceed in 2017/18 whilst the target number of incident reports for Low harm has not been achieved.

Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q3		Q4			
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Nov	Dec	Jan	Feb		
21	Operational Risk	There is a risk that the Trust does not learn from previous serious incidents and therefore does not prevent or mitigate against similar incidents from occurring in the future.	Mike Ward	Trisha Bain	12	12	9	9	9	6	Approval required for additional work flows to cover key findings and recommendations from thematic reviews. Recent KMPG audit demonstrated significant assurance of learning from SIs.
673	Operational Risk	There is a risk that there will be a delay in identifying incidents that meet the SI criteria and therefore a delay in immediate risk mitigations as a result of incorrect grading or internal audit delays.	Mike Ward	Trisha Bain	9	6	6	6	6	3	There is a delay in local management reviewing incidents and ensuring the grading is correct. This is currently being mitigated by the Quality, Governance and Assurance Team undertaking daily incidents reviews whilst further training is provided to local managers.

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- No unaccounted for losses of injectable morphine
- Total of 44 other controlled drug incidents including
  - Wastage or breakages (n=18)
  - Documentation errors (n=17)
  - Morphine retained off duty or found in wrong location (n=6)
  - CD safe left open (n=2) or unable to access safe (n=1)
- Non-controlled drugs incidents
  - Ampoule breakages (n=4)
  - KitPrep app malfunction or discrepancy (n=4)
  - Out-of-date stock (n=4) and insufficient or missing stock (n=2)
  - Lost or missing drugs packs (n=2) or inadequate stock (n=1)
  - Incorrect or inappropriate administration of adrenaline (n=2), paracetamol (n=1), 10% dextrose (n=2), salbutamol (n=1) and glucagon (n=1).
  - Overdose of oral morphine by care home staff (n=1)

Actions

- Ampoule trays procured to reduce incidence of morphine ampoule breakages
- Review of Perfect Ward contract with recommendation to extend to support future medicines management initiatives
- Increased frequency of medicines management group meetings

Assurance

- No unaccounted for losses of injectable morphine
- Rapid identification and return of morphine retained off duty
- Reduction in incidence of controlled drug breakages and documentation errors compared with previous month.
- The Trust Intelligence Systems Manager has identified a number of improvements within the incident reporting system (Datix). These improvements ensure greater accuracy when generating reports. For example; some CD incidents were not extracted from Datix when using certain search criteria in previous months.

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	39%	31%		↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	63%	64%		↑			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%				↔			LQ2b		
STEMI care bundle (AQI)	74%	G	70%	71%	74%		↑			LQ2c		
Stroke to HASU within 60 minutes (AQI)	66%	R	67%	54%	52%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	00:32		↔					
Survival to Discharge (AQI)			10%				↑					
Survival to Discharge UTSTEIN (AQI)			38%				↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:41		↔					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	90%	87%		↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%	29.1%	35.0%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98.0%	98.0%		↔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	94.0%	94.0%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96.0%			↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		↓			LQ12		

Actions

CPI Guidance Notes v8.0 was published on 1 April 2018 and incorporated some major changes in order to help reduce job cycle time and to ensure the CPI process continues to serve our most vulnerable patient groups. Major changes included:

- The introduction of a new Elderly Falls CPI, which looks at the care received by all patients over the age of 65 with incident code 03 (Falls)
- A safeguarding process that prompts auditors to make a retrospective safeguarding referral through EBS if they feel one was required but not carried out at the time of the incident
- A tick box allowing auditors to log on Datix any additional clinical or safety concerns seen during the CPI audit and to flag this for further discussion during CPI feedback
- The ability to flag a specific PRFs identified through CPI audit for discussion during face to face CPI feedback (positive as well as constructive)

Assurance

- To address the reduction in LAS CPI completion (for the first time in three months). In March, five paramedics on restricted duties, two APPs, one student paramedic, one OPC Mentor and one Team Coordinator received CPI training
- The LAS finished 2017/2018 by continuing to deliver a high standard of care to patients discharged at scene, in cardiac arrest, with glycaemic emergencies or presenting with severe sepsis, along with the general standard of documentation.
- At 94% in March, the LAS maintained the high standard of care for patients with a diagnosed psychiatric problem achieved in February.

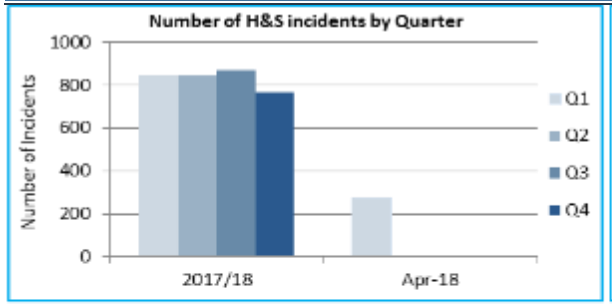
Responsive

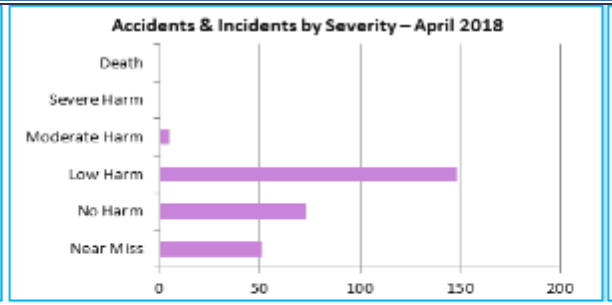
Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

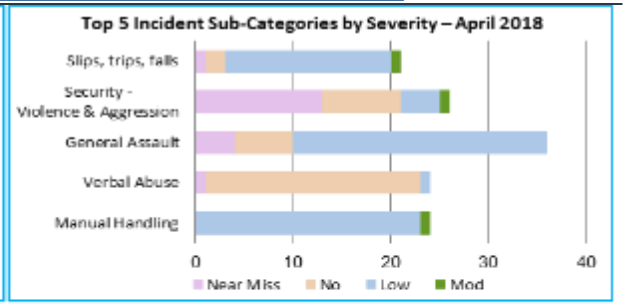
Measures	Target / Range	RAG	YTD 18/19	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.84	3.8	4.0	3.8	↓				
Complaints Acknowledged within 3 working days	100%	G		100%	100%	100%	⇔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R		21	8	40	↑			LQ29b	
Rate of Complaints per 1,000 Incidents				1.2	0.8	0.9	↑			LQ29c	
Positive Feedback Compliments				125	120	146	↑			LQ29e	
CMC records viewed			393.00	303	441	393	↓			LQ30	
Friends and Family Test Recommending LAS as % of total responses	94%	R	66%	0%	100%	66%	↓			LQ27	
Friends and Family Test Response Rate			0.01	0.0	0.0	0.0	⇔			LQ28	
Mental Health related calls as percentage of all calls			8%	7.0%	8.3%	7.5%	↓				
Mental Health related MPS calls as percentage of all calls			2%	1.7%	2.1%	2.1%	↓				
Mental Health related Incidents as percentage of all calls			5%	4.3%	5.0%	4.7%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.4%	0.4%	↓				

Health & Safety Scorecard

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain



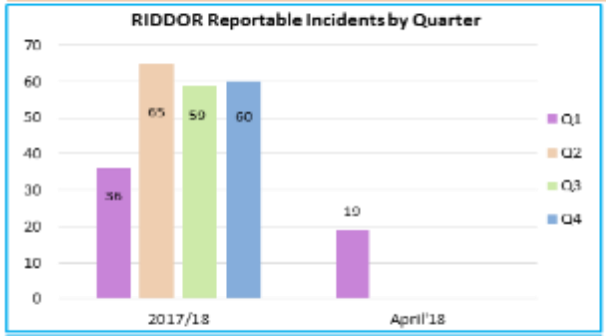


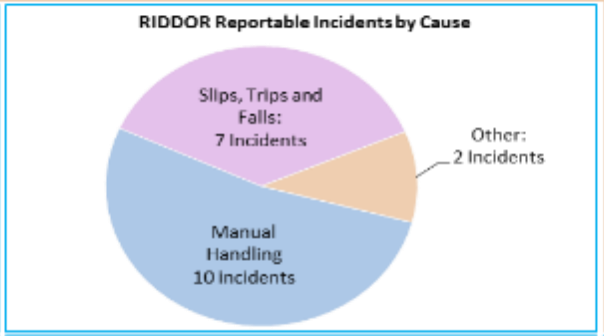


3330 health and safety related incidents were reported during 2017/18. 277 incidents have been reported in April 2018. These H&S related incidents account for 39% of all the incidents reported across the Trust in April 2018.

148 (53.4%) of the H&S related incidents reported during April 2018 resulted in low harm. 5 (1.8%) incidents resulted in Moderate. 124 (44.8%) of the incidents were reported as 'No Harm/Near misses'.

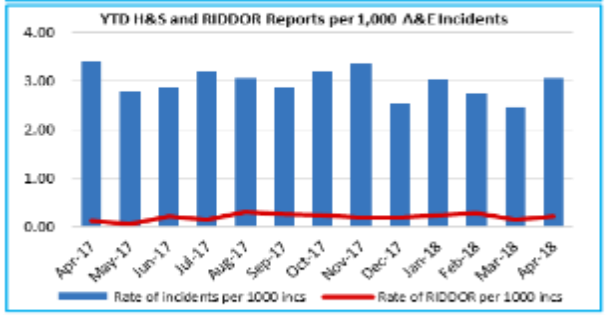
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported durine April 2018.

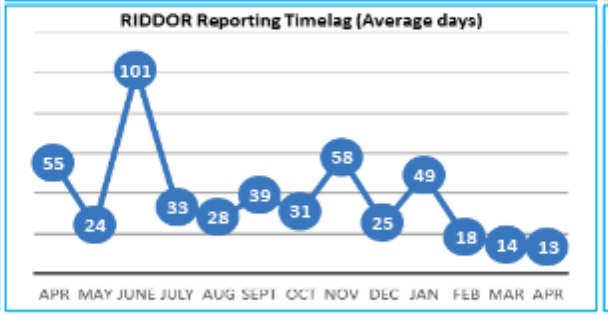


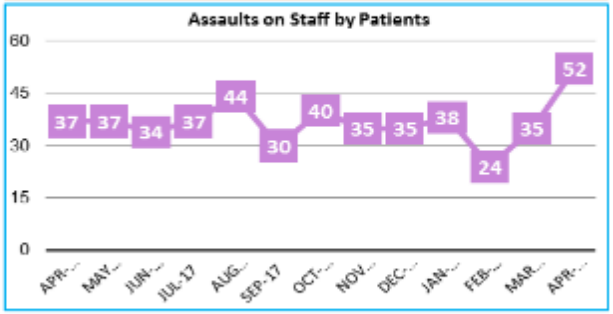


Key Updates:

1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. The provision of practical MH Training to relevant frontline and support services staff has commenced. This training will now form part of the Mandatory Training Programme.
3. Fire Marshal training has been undertaken and completed for nominated representatives across the Trust. The H&S Department will commence the roll-out of fire drills in conjunction with fire marshals from May 2018.
4. Work is on-going to progress the actions identified on the Health and Safety Action Plan following the Independent audits completed in June 2017 and March 2018. 45 out of the 69 identified actions have now been completed.
5. The Trust-wide Site Specific Risk Assessment procedure has been approved by the Corporate Health and Safety Committee. The H&S department have commenced the roll out of the risk assessments across the Trust.







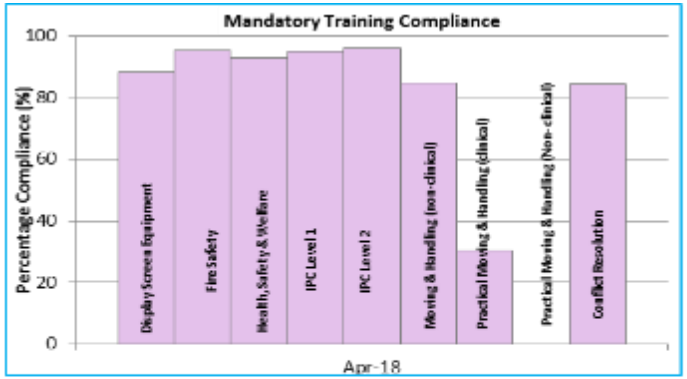
6. The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to April 2018.
NB: No benchmark/comparable data was received from any of the other ambulance Trusts during April 2018.

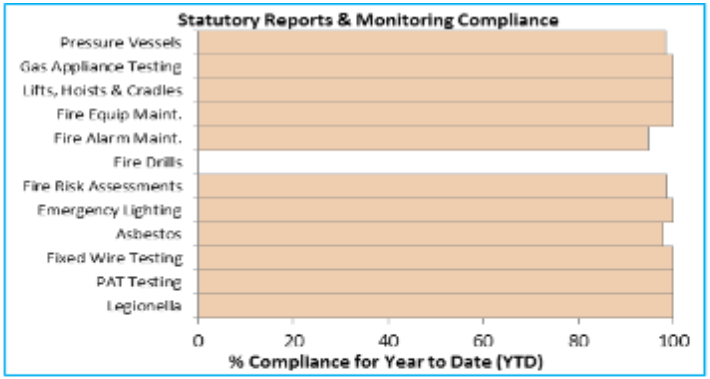
7. 220 RIDDOR incidents were reported to the HSE in 2017/18.
8. 19 RIDDOR incidents were reported in April 2018 with an average time lag of **13 days. 4 out of the 19 RIDDOR incidents were reported out of time in April 2018.**

9. There was an increase in assault on staff by patient related incidents in April 2018. The most common underlying causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Health & Safety Scorecard

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain





10. The practical MH (non-clinical) training is a new course put in place since April 2018 for non-operational (support services) staff who undertake MH activities. 147 members of staff have been identified as requiring this training and training dates have been circulated through the Learning and Development Team.
11. Trust-wide compliance for the Manual Handling Training (Clinical) in April 2018 was at 30.39%. The practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.
12. Fire Compliance: Fire marshal training has been completed across the Trust. The H&S Dept. will coordinate the roll-out of the 6 monthly fire drills per site commencing from May 2018.
13. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q4 Jan	Q4 Feb	Q4 Mar	Q1 Apr	Target Risk Rating	Key changes/updates since last review
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	16	16	16	16	16	9	The provision of practical manual handling training commenced in April 2018. This training now forms part of the mandatory/statutory training for frontline/operational staff. The version 3 replacement of the older version 1 Mangar Elks have been purchased and are currently being rolled out across the Trust. As at 30/04/2018, 142 (61%)of the new version 3 Elks have been installed. The remaining equipment will be installed over the next 4 weeks.
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	12	12	4	No key changes since last review. Agreement around the Terms of reference for Corporate H&S Committee deferred until the July Corporate H&S Committee meeting and following the ACAS review of Trade Union numbers.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing as part of CSR 1, 2018. Lone worker policy approved, risk assessments incorporated into the site specific risk assessment programme which is being rolled out by the H&S Department.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	9	3	The average RIDDOR reporting time lag reduced to 13 days in April 2018. It is recommended that this risk is **downgraded to L=3 x C=3 with RR of 9.**
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Site specific risk assessments programme has commenced and will continue throughout 2018/19. Managing H&S training in place to help support Managers with understanding their H&S responsibilities.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is being rolled out by the H&S Department during 2018/19. LSMS in regular liaison with staff and sites where security related incidents have been reported.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	6	6	6	6	3	Additional resources have been recruited into the H&S Team on an interim basis. Approval required from the Workforce Panel to recruit substantively.

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 themes 2017/18

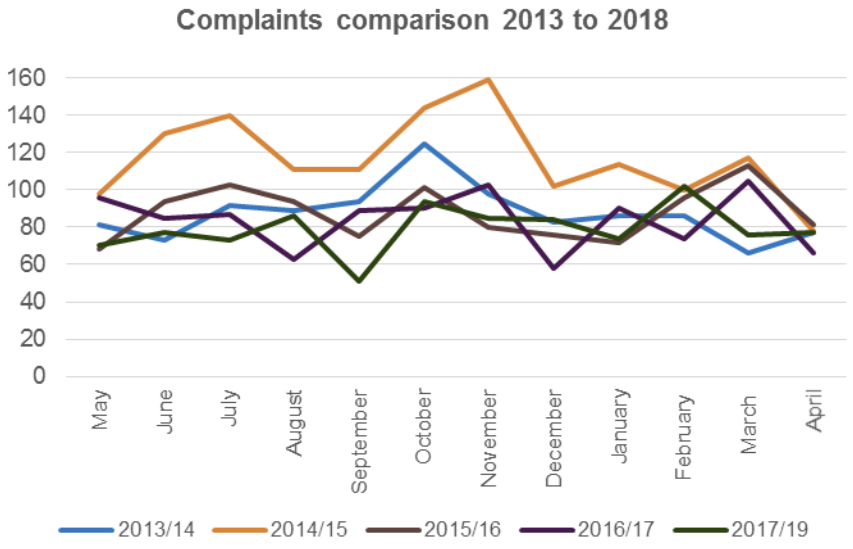
Complaints by subject 2017/18	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	Total
Delay	17	16	14	26	9	22	33	19	17	40	21	21	255
Conduct	19	24	19	19	16	17	25	20	22	23	20	18	242
Road handling	11	13	14	10	7	14	9	7	6	10	6	5	112
Treatment	2	5	1	7	5	16	8	9	8	14	4	9	88
Non-conveyance	0	4	12	0	1	6	1	7	6	3	4	6	50
Totals (above)	49	62	60	62	38	75	76	62	59	90	55	59	747
Annual totals	70	77	73	86	51	94	85	84	74	102	76	77	949

Review of April 2018

- Complaints where 'delay' was the primary concern were back in line against the annual average (21)
- The annual percentage of complaints against calls attended by the Trust remains at approximately 0.08%
- During April there were 21 Quality Alert referrals of which 13 remain under investigation. A total of 66 have been received since PED assumed responsibility for this area of work.
- There were 77 complaints this month which includes one from a HCP on behalf of the patient and 5 complaints relating to NHS111
- Since ARP was introduced, complaints relating to each category have been as follows: ARP x Cat 1 = 21, ARP x Cat 2 = 135, ARP x Cat 3 = 76 and ARP x Cat 4 = 62. (see April table on next page)
- There were 9 complaints attributed to clinical treatment. These include treatment of a sickle cell patient who felt that the crew did not understand the impact on him of his condition, a patient with symptoms of food poisoning who was not conveyed, where no stretcher was provided for a patient and a patient upset about the crew obtaining a blood test from a pinprick test.

Assurance and learning

- A comprehensive review of unresolved Ombudsman cases has been undertaken in conjunction with the Ombudsman's office. Currently there are 8 cases where the files have been requested by the Ombudsman with a view to undertaking a full investigation.
- 366 PALS enquiries were managed by our duty team last month. Due to the continued high number and complexity, we intend to improve the function and management of this facility with improved shared responsibility amongst the team.
- We are supporting the Medical Directorate with the 'Learning from deaths' project and will be reviewing the demographic data within Datix to support that.
- Some members of the team will attend the 'Whose Shoes' maternity workshop to improve understanding of such complaints



Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Complaint response times – April 2018

Month	Total complaints remaining open/re-opened as at time of report each month	Closed during the month	opened complaints by month
Jan-18	106	98	74
Feb-18	109	91	102
Mar-18	131	70	76
Apr-18	108	93	77
Totals	454	352	329

- During April we received a 23% increase in complaints of which 40 related to delays in an ambulance attending (39%). (see snapshot above).
- The outcome of this increase is that the number of complaints over 35 working days at the time of this report exceeded 40.
- This backlog can be attributed to delays in obtaining Quality Assurance reports whilst QA staff were redeployed to the Control Room. Currently we are awaiting 35 such reports.
- The management of Quality Alerts (concerns raised by other healthcare providers) has also impacted on case officers workload. There are currently 26 of these under investigation by the Patient Experience Department.

Categories of complaint calls

April 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	5
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	23
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	6
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	8
Category A Red 2 - 8 min response	1
Not CAD related or information awaited	34
Total	77

Assurance & Learning

- Staff have been invited to undertake a full days training with regards to the management of Serious Incidents
- In the last two years there have been 17 complaints where an SI has been declared . 9 of these related to a patient who has died.
- Similarly, team members will attend a Mental Health training session later this month.
- Access as Editors to the new LAS website has been delayed so we have been unable to improve the lost property reporting process and the feedback leaflet online form. It is anticipated that this will be available shortly . We aim to have an update for the next Quality Report
- We are arranging team workshops to discuss complaint management and the way in which we can improve the use of Datix to assist with that.
- We will then arrange a meeting with the Datix support team to discuss the outcomes of this workshop and if they can assist.
- The Ombudsman has re-arranged his visit to the Trust to 28 June 2018

Case example

Example one – smoking outside an ambulance station:

We received a complaint from a member of the public that staff at one of our ambulance stations have been littering the street with cigarette stubs.
Arrangements were made in collaboration with our Estates department and cleaning contractors to remove cigarette stubs weekly. The complainant was advised that we also promote non smoking with support for staff who wish to give up. We will also remind them of their responsibility to dispose of cigarette stubs appropriately.

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No	Supplementary information	
North West	7	Public engagement: no. of hours (April 2018)	41
North Central	0	Approximate audience numbers (April 2018)	1,091
North East	5	No. of public engagement events: year to date (April 2018)	28
South East	8		
South West	3	No. of staff on LAS Public Education Facebook group	706
Outer London/PPI	5	No. of staff on contact list	1,333
Total	**28**		

Public Engagement activities

Topics and objectives:

- **School and college visits**

Information on the LAS, including possible careers. Also a chance to teach some BLS and knife crime awareness.

- **Cubs, Brownies and Scouts**

Teaching of first aid including BLS.

- **Knife Crime events**

Awareness of the consequences of carrying a knife.

- **Older people's groups e.g. Seniors Forum**

Information about the LAS and dealing with medical emergencies.

- **Careers/recruitment events**

Information about careers in the Service and how to apply.

- **Road safety e.g. Biker Down / Driven by Consequences**

Awareness of the consequences of dangerous driving, including speeding and not wearing a seatbelt.

Staff Awards

- The Service has been shortlisted for the "Best use of ESR" at the Health and People Management Excellence Awards 2018. The awards recognise and reward outstanding work in healthcare human resource management.

Staff Recognition

- On Sunday 22nd April, 15 members of staff ran the London Marathon in aid of the Chief Executive's Charity The Charlie Chaplain playground. This charity provides a play area and play equipment to children and young people with a range of special educational needs and disabilities.

- Staff from the Brent group picked up their rolling pins this week to raise money for Stand Up To Cancer. The collective baking effort raised an amazing £335.46 for the cause with cakes being sold at Kenton Ambulance Station and outside Northwick Park Hospital Harrow.

Our Performance

Since February 2015, three other ambulance services - South West, Yorkshire and West Midlands - have been involved in trials led by NHS England of the new standards. They focused on four main areas:

- Identifying the most seriously ill patients as early as possible through processes known as Pre-Triage Sieve and Nature of Call.
- Giving control room staff more time (up to 240 seconds) to assess incidents through a process known as Dispatch on Disposition.
- Developing new clinical code sets and response categories using the best available clinical evidence.
- Developing new targets, indicators and measures.

The trials have also been independently reviewed by the University of Sheffield.

Category	Percentage of calls per Category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	• 7 minutes mean response time • 15 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being dispatched • 30 seconds from the call being connected	The first emergency vehicle that arrives on scene stops the clock.(There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	• 18 minutes mean response time • 40 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 3	34%	• 120 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 4	10%	• 180 minutes 90th centile response time	The earliest of: • The problem being identified • An ambulance response being • dispatched • 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

The new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response
- Ensure national response targets to apply to every patient for the first time – so ending 'hidden waits' for patients in lower categories
- Ensure more equitable response for patients across the call categories
- Improve care for stroke and heart attack patients through sending the right resource first time.

Due to the nature and impact of these changes, the previous performance measures are not comparable. However, NHS England have published National Standard for a number of the key measures which are included here.

Ambulance Response Programme
Performance Summary

	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
Previous month (Mar 18)	00:07:24	00:11:58	00:23:21	00:49:21	02:51:25	02:36:36
Last month (Apr 18)	00:06:51	00:11:15	00:16:54	00:33:16	01:49:37	02:05:08
Current YTD (2018/19) * From 1st – 30th April 2018	00:06:51	00:11:15	00:16:54	00:33:16	01:49:37	02:05:08

Demand

- A total of **90,372** incidents were provided with a face to face response.
- **Category 2** incidents reached a total of **50,041**. This accounts for 55% of face-to-face responses.
- **8,193** incidents were categorised as **Category 1** and provided with a face-to-face response.

Performance

- April shows **all 6 key** performance measures **achieving** response times **within** the various National Standards.
- April shows **91%** of calls received into EOC were **answered within 5 seconds**.
- C3 90th centile measure saw the most significant improvement in performance. This was from just under 3 hours in March to 2 hours 49 seconds in April.

Performance Overview
Response Times by Category

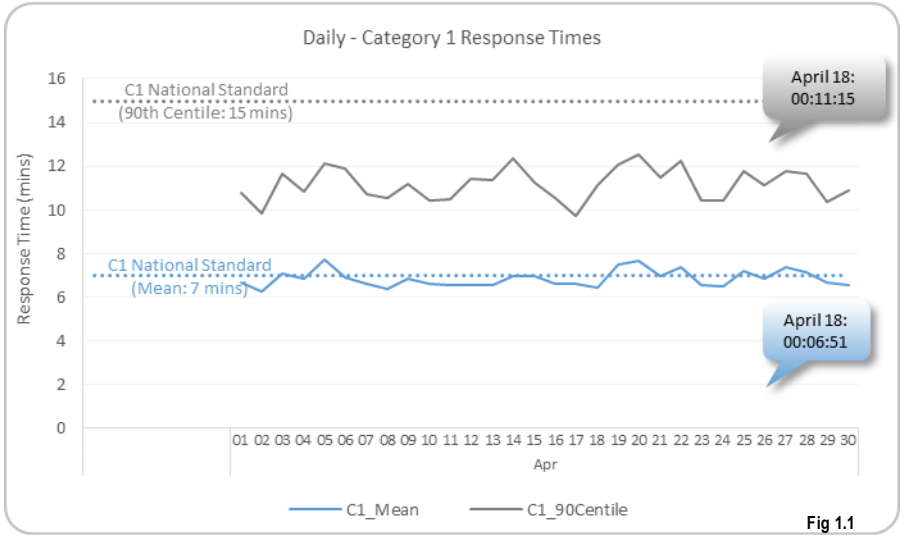


Fig 1.1

Category 1

The NEW Category 1 (C1) measure is expected to comprise of approximately 8% of all incidents and covers a wider range of conditions than the former Red 1 category. These will be responded to within an average time of seven minutes.

Fig 1.1 shows the time taken to respond to patients triaged as Category 1 (C1)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 15 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
  - The dotted blue line shows the National Standard of 7 minutes average (mean) response time.

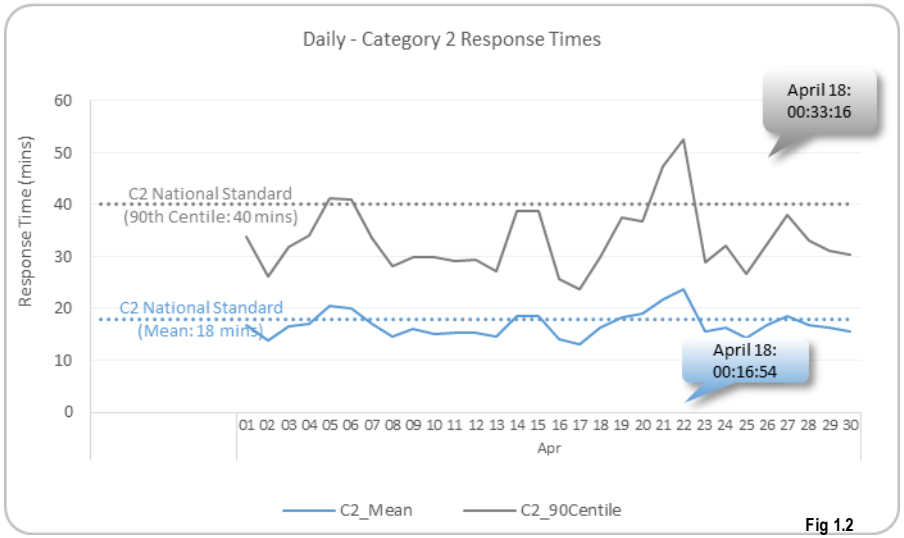


Fig 1.2

Category 2

The NEW Category 2 (C2) measure is expected to comprise of approximately 48% of all incidents. These will be responded to within an average time of 18 minutes.

Fig 1.2 shows the response time for patients triaged as Category 2 (C2)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 40 minutes 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time
  - The dotted blue line shows the National Standard of 18 minutes average (mean) response time.

Performance Overview
Response Times by Category

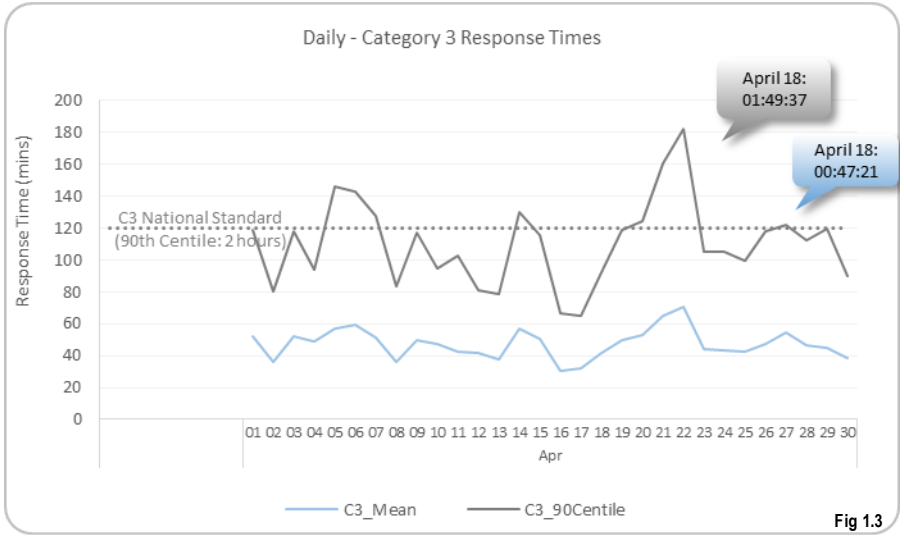


Fig 1.3

Category 3

The NEW Category 3 (C3) measure is expected to comprise of approximately 34% of all incidents.

Fig 1.3 shows the time taken to respond to patients triaged as Category 3 (C3)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 120 minutes (2 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
  - There is no National Standard for the mean response time.

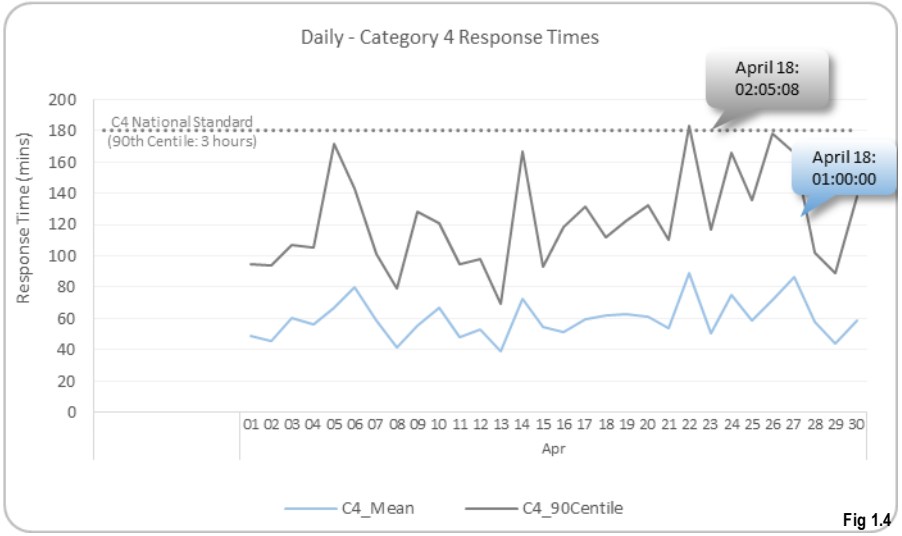


Fig 1.4

Category 4

The NEW Category 4 (C4) measure is expected to comprise of approximately 10% of all incidents.

Fig 1.4 shows the response time for patients triaged as Category 4 (C4)

- The grey line shows the LAS 90th centile response time.
  - The dotted grey line shows the National Standard of 180 minutes (3 hours) 90th centile response time.
- The blue line shows the LAS **daily** average (mean) response time.
  - There is no National Standard the mean response time.

Performance Overview
Demand by Category

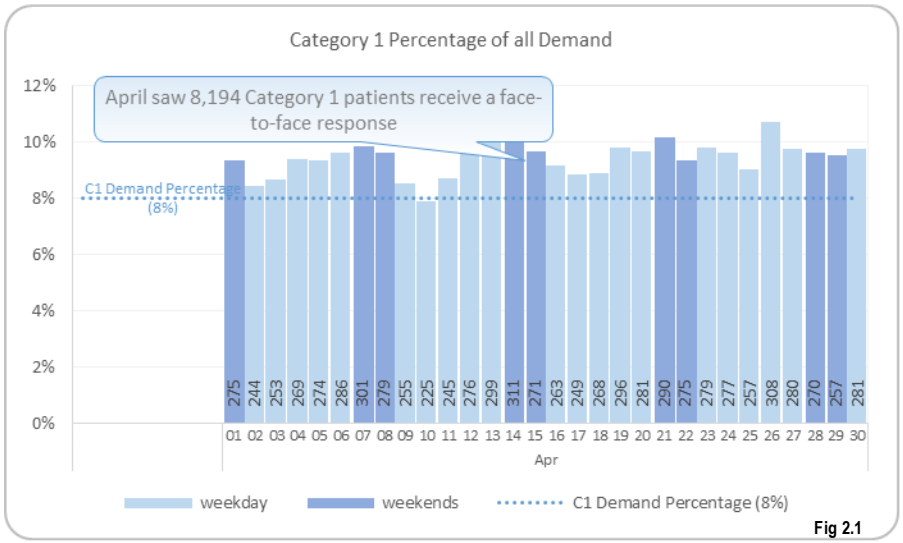


Fig 2.1

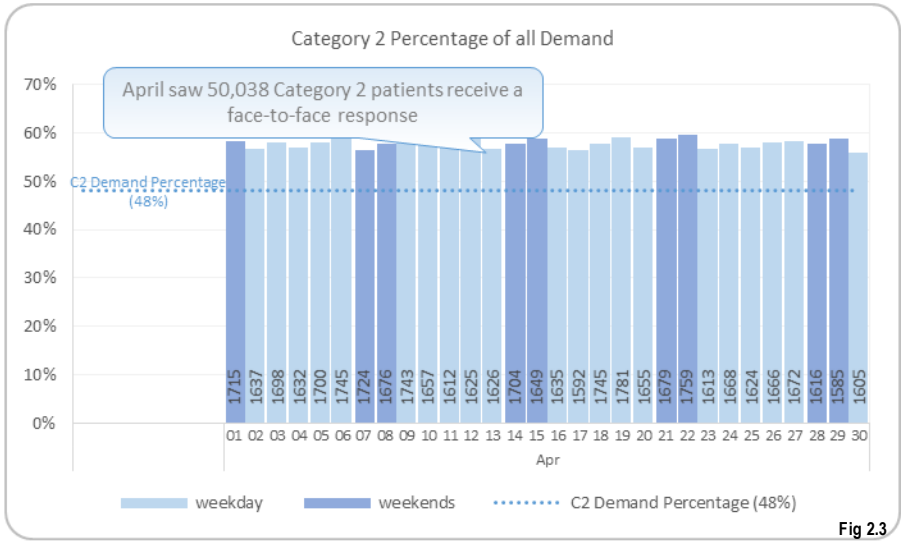


Fig 2.3

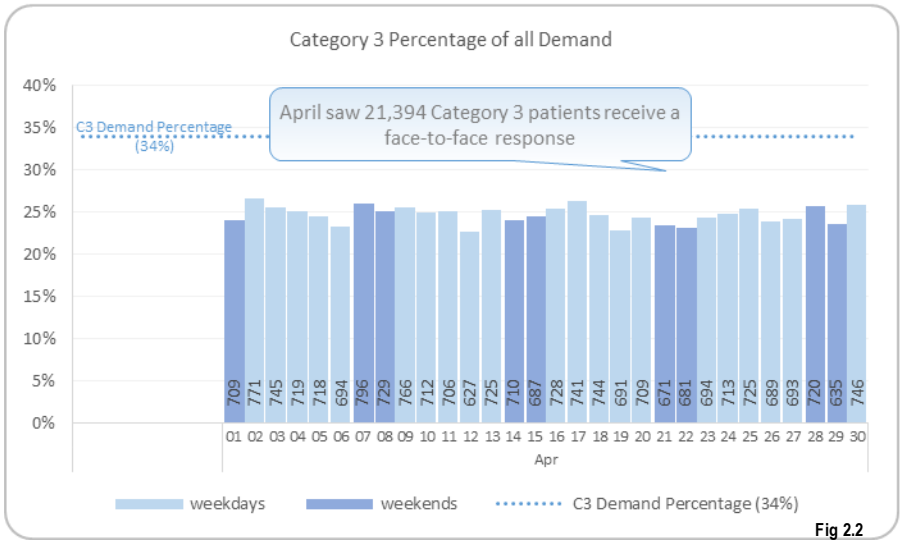


Fig 2.2

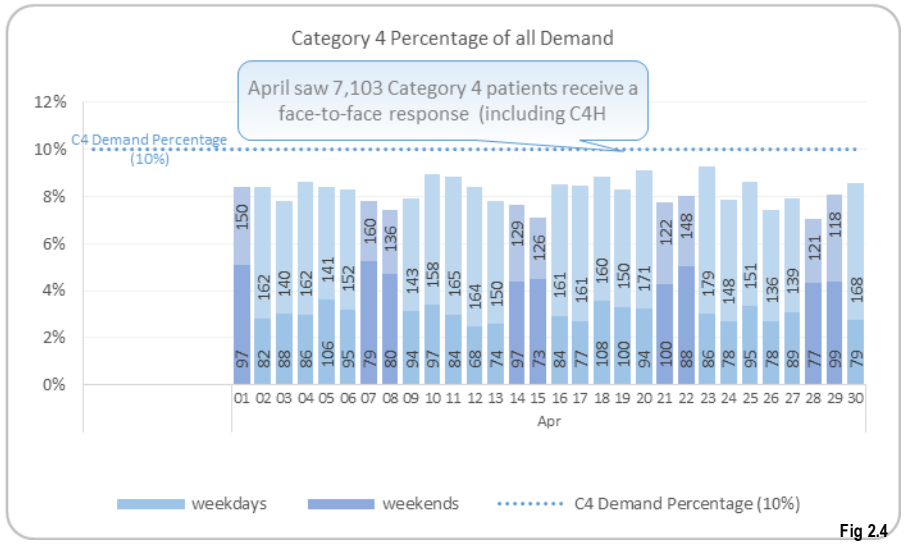


Fig 2.4

Performance Overview
90th Centile Performance

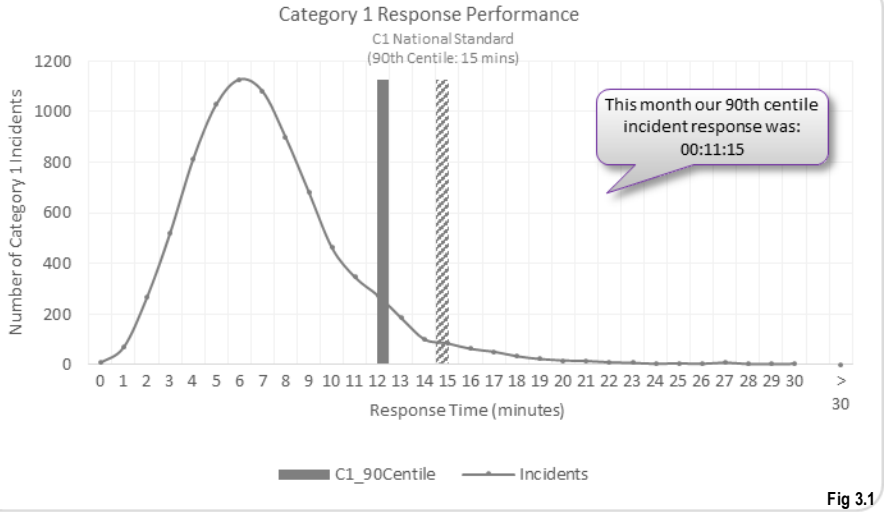


Fig 3.1

■ Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The 90th centile response time in **April** was **00:11:15** minutes, **within** the 15 minutes National Standard as set out in the guidelines by NHSI.

Of the 8,194 incidents requiring a Category 1 response, 7,374 incidents received a face to face response within 00:11:15 minutes.

The LAS 90th centile has been **consistently within the 15 minutes** standard **each week** since ARP was implemented.

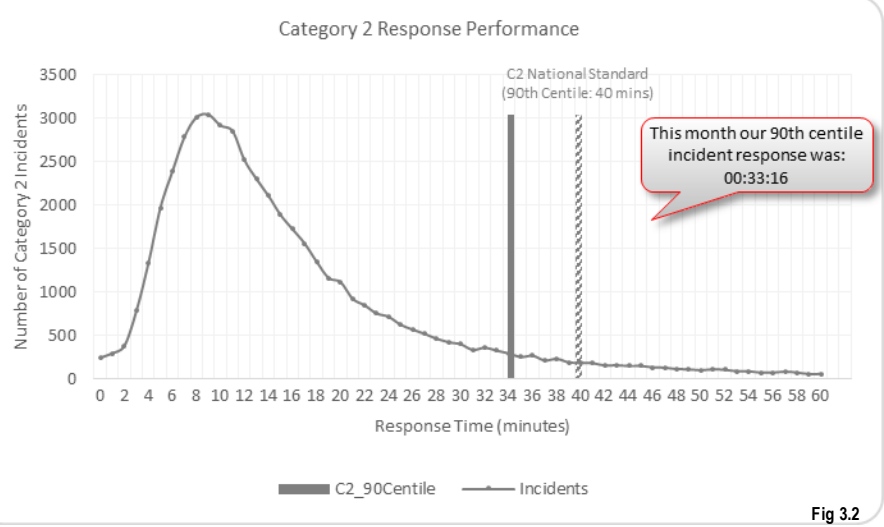


Fig 3.2

■ Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The 90th centile response time in **April** was **00:33:16** minutes, **within** the 40 minutes National Standard as set out in the guidelines by NHSI.

Of the 50,038 incidents requiring a Category 2 response, 45,031 incidents received a face to face response within 00:33:16 minutes.

April 2018 is the second time this measure has performed **within** the national standard, **since ARP** began in November 2017 (00:36:28)

Performance Overview
90th Centile Performance

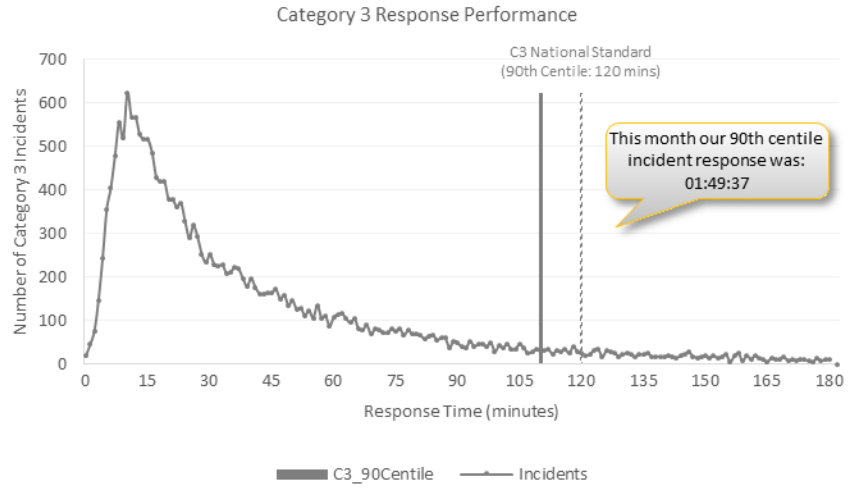


Fig 3.3

- Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The LAS 90th centile response time in **April** was **01:49:37**
This is **within** the 120 minutes (2 hours) National Standard as set out in the guidelines by NHSI.

Of the 21,394 incidents requiring a Category 3 response, 19,329 incidents received a face to face response within 01:49:37 minutes.

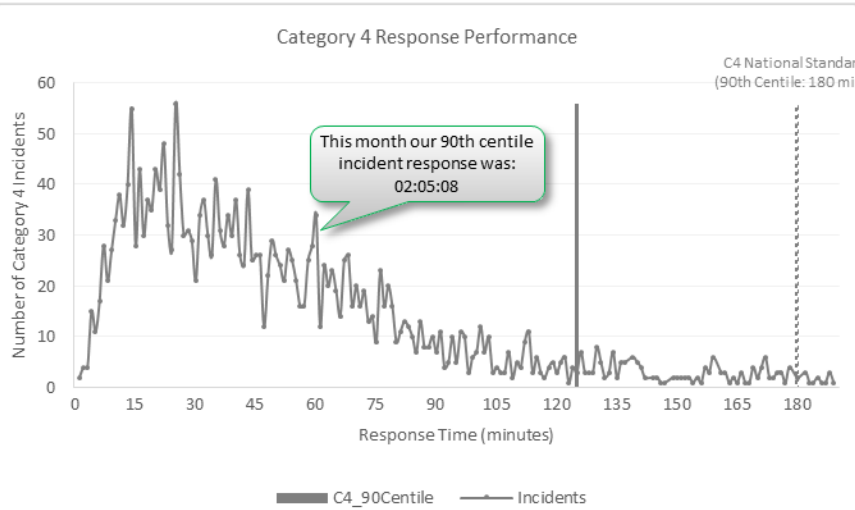


Fig 3.4

- Fig 3.2 Demonstrates the response distribution for Category 4 incidents.

The 90th centile response time in **April** was **02:05:08** minutes, **within** the 3 hours National Standard as set out in the guidelines by NHSI.

Of the 2,632 incidents requiring a Category 4 response, 2,368 incidents received a face to face response within 02:05:08 minutes.

The LAS 90th centile has been well **within** the 3 hour standard for the 6 **months** since ARP was implemented.

Performance Overview
Key Metric Variance

Category	Measure	LAS Monthly Performance	National Standard	Variance
Category 1	Mean Response Time	**00:06:51**	7 minutes	**00:00:09**
	90th centile	**00:11:15**	15 minutes	**00:03:45**
Category 2	Mean Response Time	**00:16:54**	18 minutes	**00:01:06**
	90th centile	**00:33:16**	40 minutes	**00:06:44**
Category 3	90th centile	**01:49:37**	120 minutes	**00:10:23**
Category 4	90th centile	**02:05:08**	180 minutes	**00:54:52**

Performance Overview

National Picture

April 2018

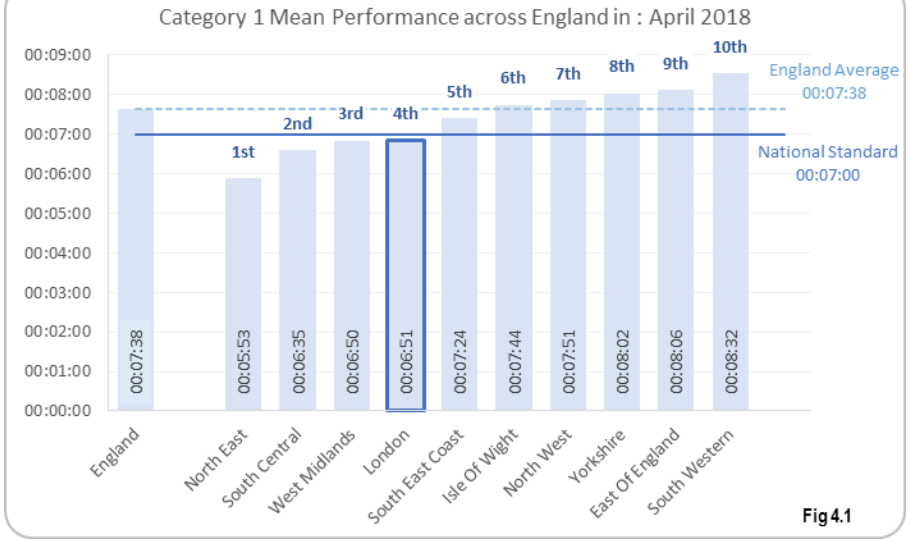


Fig 4.1

- Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England during April 2018.

Additional information also displayed :
The National Standard (00:07:00)
The average for England (00:07:38)
The ranking position for each Trust

- LAS achieved **6 minutes and 51 seconds** for the **mean** response time for **Category 1** patients. This is **within** the 7 minute national standard.
- LAS ranked **fourth** when compared to 9 other Ambulance Trusts across England.
- LAS also performed **within** the England average by **46 seconds**.

Fig. 4.2 Displays the six key ARP performance measures for each Ambulance Trust across England during April 2018.

- **LAS ranked 2nd** in the **Category 1 90th centile** performance measure, compared to the other Trusts.
- For the **Category 2 mean**, **LAS remained stable ranked at 5th** compared to the other Trusts.

April 2018	Mean Category 1	90th Centile Category 1	Mean Category 2	90th Centile Category 2	90th Centile Category 3	90th Centile Category 4
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00
England	00:07:38	00:13:26	00:20:15	00:41:42	01:55:52	02:43:12
East Midlands	00:08:36	00:15:39	00:31:57	01:08:06	02:41:18	02:01:50
East of England	00:08:06	00:14:44	00:22:43	00:47:23	02:17:03	02:47:28
London	00:06:51	00:11:15	00:16:54	00:33:16	01:49:47	02:05:08
North East	00:05:53	00:10:05	00:17:09	00:34:56	02:01:38	01:52:32
North West	00:07:51	00:13:24	00:23:38	00:51:59	02:21:50	02:56:37
South Central	00:06:35	00:11:50	00:14:13	00:27:46	01:40:08	02:33:04
South East Coast	00:07:24	00:13:45	00:16:08	00:30:17	02:32:34	04:10:57
South Western	00:08:32	00:15:50	00:23:25	00:48:24	01:58:50	04:15:42
West Midlands	00:06:50	00:12:04	00:11:23	00:20:24	00:55:17	01:32:40
Yorkshire	00:08:02	00:13:44	00:21:39	00:45:53	02:05:16	02:44:53
Isle of Wight	00:07:44	00:16:37	00:12:21	00:30:52	01:17:58	03:01:4

Fig 4.2

Performance Overview

Performance by STP

These tables show 6 key performance measures for March and April 2018 profiled by STP.

April performance shows the improved performance compared to March. This improvement could be attributed to the warmer weather experiences and the school holidays over the Easter period. This also follows a similar pattern from previous years

All STP areas remained **within** the national standard for almost **all key measures**.

- The **C3 90th centile** performance in the **North Central** STP, although **just above** the national standard, shows the **highest improvement** of over 1 hour 25 minutes.
- **C4 90th centile** in the **South West** STP was the only measure to increase. (by just over 2 minutes) Despite this increase this measure remains **within** the **national standard** of **3 hours**.

April 2018 STP Position	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:06:47	00:10:46	00:17:54	00:35:27	02:05:50	02:02:31
North East	00:07:00	00:11:18	00:17:05	00:33:05	01:57:16	02:13:36
North West	00:06:44	00:11:16	00:17:10	00:34:14	01:56:23	01:58:06
South East	00:06:54	00:11:27	00:15:31	00:30:13	01:32:42	02:01:11
South West	00:06:50	00:11:27	00:16:56	00:33:12	01:39:23	02:03:17

March 2018 STP Position	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:07:36	00:12:16	00:25:53	00:55:47	03:31:08	02:42:54
North East	00:07:31	00:12:21	00:25:31	00:54:05	03:04:53	03:09:28
North West	00:07:09	00:11:44	00:22:40	00:47:51	03:02:15	02:47:14
South East	00:07:15	00:11:48	00:20:45	00:43:51	02:19:51	02:16:36
South West	00:07:37	00:12:03	00:21:46	00:45:06	02:33:49	02:01:03

Performance Overview
Call Answering Performance

April 2018

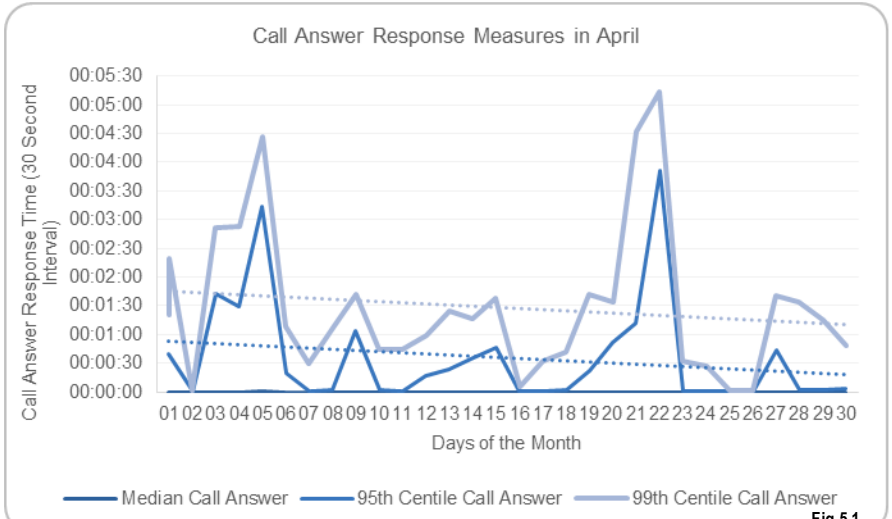


Fig 5.1

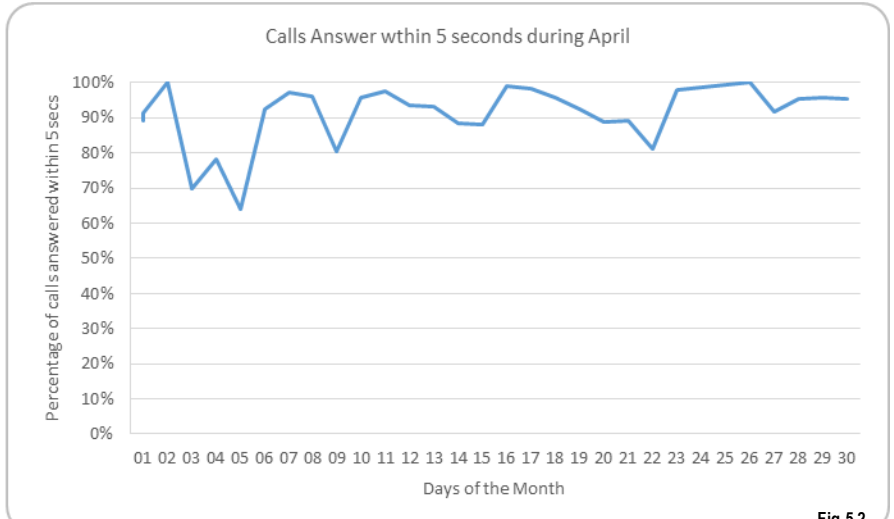


Fig 5.2

- Figure 5.1 demonstrates **three key measures** for call answering under the Ambulance Response Programme (ARP).
- During April 2018 the median call answering was **zero seconds**.
  - This means **50%** or **half** of all calls received into the Emergency Operations Centre (EOC) were answered **immediately**.
- The **95th centile** was 0 minutes and 39 seconds.
  - In other words 95 out of every 100 calls were answered in less than 39 seconds.
- To demonstrate the reduction of call answering response times the dotted lines show a linear downward trend throughout the month. This is for both the 95th and 99th centile measures.

- Figure 5.2 shows the percentage of calls answered within five seconds.

The new ARP standards no longer use this performance measure and for that reason there is longer a requirement to report it.

However, to illustrate the graph shows the daily call taking performance in the month.

- In April **91%** of all **calls** received into the EOC were answered **within five seconds**.
- The graph shows the continued improvement of this measure throughout the month and achieving 91% towards the end of April.

Hospital Handover Summary
Hospital Conveyance Lost Hours

April 2018

In April a total of **5,028 hours were lost** at hospital.

- The most hours were lost at **Queens Romford** with **542** hours lost.
- Ranking second highest was **Hillingdon** with **403** hours lost.
- **Northwick Park** ranked third highest in hours lost at hospital with **389** hours lost.
- The above three hospitals are responsible for **27%** (**1,334**) of hours lost at hospital, across London in April.
- Over **6** of the previous 12 **weeks** Queens Romford have **ranked highest** in **lost hours** at hospital.

Non-blue calls. Arrival at hospital to patient handover, April 2018

	Arrived to Handover						
	Total Conveyances	Total Handovers	Handovers exceeding 15 mins	% over 15 mins	Overrun per breach (mins)	Total time lost over 15 mins (hrs)	12 Week Trend
Barnet	1595	1483	678	46%	12	137	
North Middlesex	2433	2193	1351	62%	11	239	
Royal Free	1516	1374	970	71%	13	208	
University College	1686	1533	1132	74%	14	268	
Whittington	1571	1442	744	52%	8	98	
Homerton	1356	1265	327	26%	5	25	
King Georges	1350	1223	1101	90%	13	244	
Newham	2003	1533	1332	87%	12	270	
Queens Romford	2836	2629	2091	80%	16	542	
Royal London	2149	1894	1106	58%	7	133	
Whipps Cross	1793	1578	1095	69%	10	189	
Charing Cross	1255	1160	668	58%	6	71	
Chelsea & West	1284	1186	471	40%	6	45	
Ealing	1256	1171	522	45%	10	86	
Hillingdon	1798	1674	1303	78%	19	403	
Northwick Park	2828	2613	1274	49%	18	389	
St Marys	1903	1770	1089	62%	9	158	
St Thomas'	2106	1927	1213	63%	7	149	
West Middlesex	1896	1808	736	41%	6	75	
Kings College	2293	2106	1680	80%	10	279	
Lewisham	1445	1298	793	61%	7	95	
Princess Royal	1692	1529	654	43%	19	203	
Queen Elizabeth II	2326	2255	531	24%	10	90	
Croydon	2082	1933	1356	70%	11	240	
Kingston	1615	1523	1011	66%	6	102	
St Georges	1983	1844	1193	65%	9	179	
St Helier	1240	1172	758	65%	9	111	
LAS TOTAL					10	5028	

Non-blue calls. Patient Handover to Green, April 2018

	Handover to Green						
	Total Conveyances	Total Handovers To Green	Handovers exceeding 14 mins	% Over 14min	Overrun Per Breach (Mins)	Total Time Lost Over 14 Minutes (Hrs)	12 Week Trend
Barnet	387	371	202	54%	6	21	
North Middlesex	558	519	255	49%	7	31	
Royal Free	368	349	157	45%	7	18	
University College	456	434	256	59%	8	33	
Whittington	389	368	170	46%	6	17	
Homerton	353	337	192	57%	7	23	
King Georges	294	281	130	46%	6	12	
Newham	468	445	206	46%	13	45	
Queens Romford	662	636	362	57%	7	43	
Royal London	507	487	277	57%	8	37	
Whipps Cross	476	445	190	43%	7	22	
Charing Cross	301	286	117	41%	6	11	
Chelsea & West	298	288	163	57%	6	17	
Ealing	310	298	123	41%	6	12	
Hillingdon	404	389	177	46%	5	15	
Northwick Park	724	691	346	50%	6	34	
St Marys	448	427	215	50%	7	24	
St Thomas'	529	487	261	54%	7	30	
West Middlesex	461	451	198	44%	5	16	
Kings College	527	512	235	46%	6	22	
Lewisham	374	354	145	41%	5	12	
Princess Royal	380	365	173	47%	6	16	
Queen Elizabeth II	610	589	240	41%	4	14	
Croydon	478	456	246	54%	5	20	
Kingston	402	389	182	47%	5	15	
St Georges	494	465	232	50%	4	15	
St Helier	319	315	151	48%	3	9	
					6	585	

Hospital Handover Summary
Hospital Conveyance by Location

April 2018

This map shows the location of each ED hospital across London.

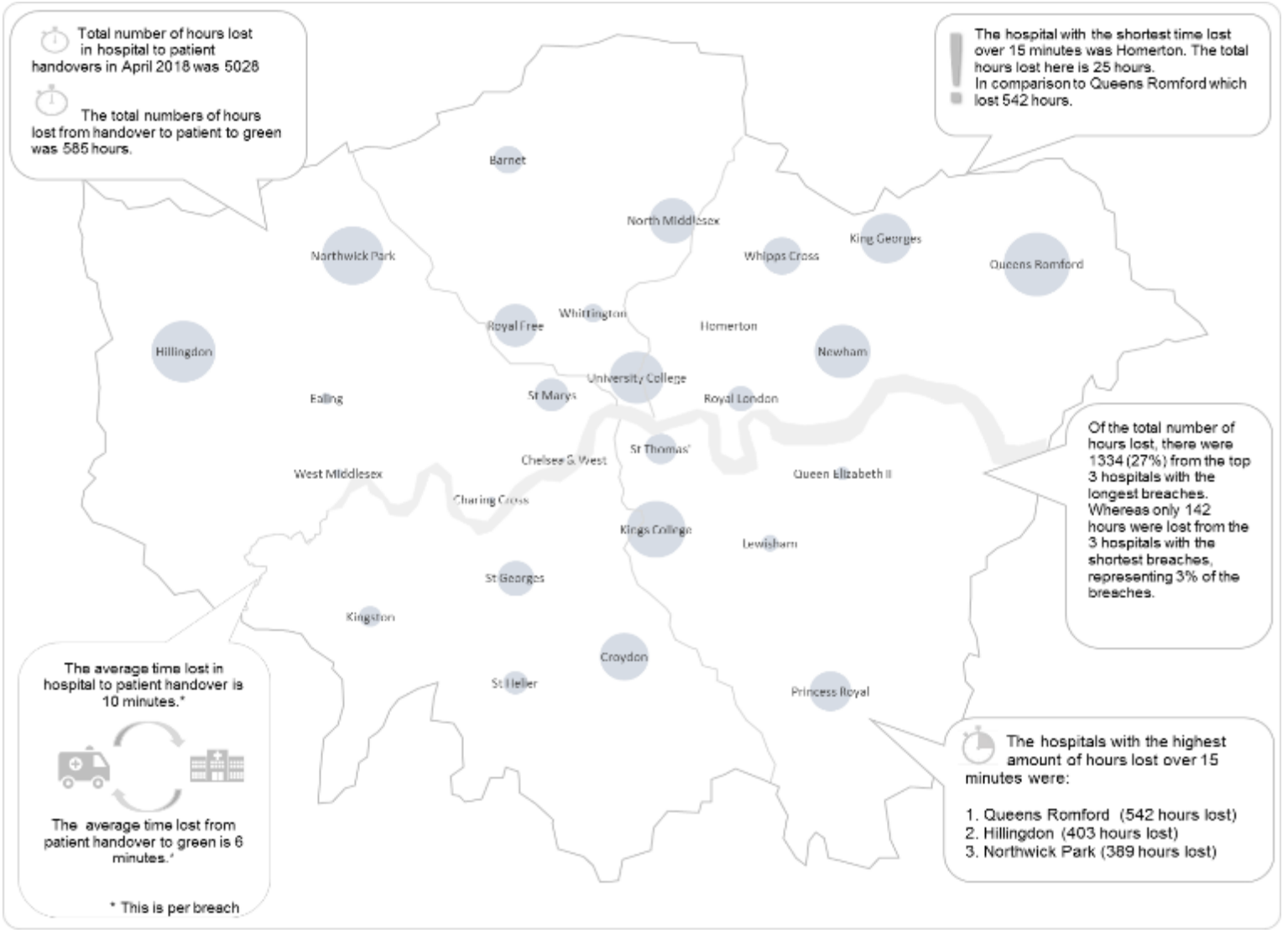
The size of the bubble relates to the comparative hours lost* at that hospital.

The larger the bubble, the more hours lost at hospital.

For example, during the reporting week, the highest hours lost were at Queens Romford.

The fewest hours were lost at Homerton, as the bubble can barely be seen

* Total time accrued after 15 minutes, for arrival at hospital to patient handover.



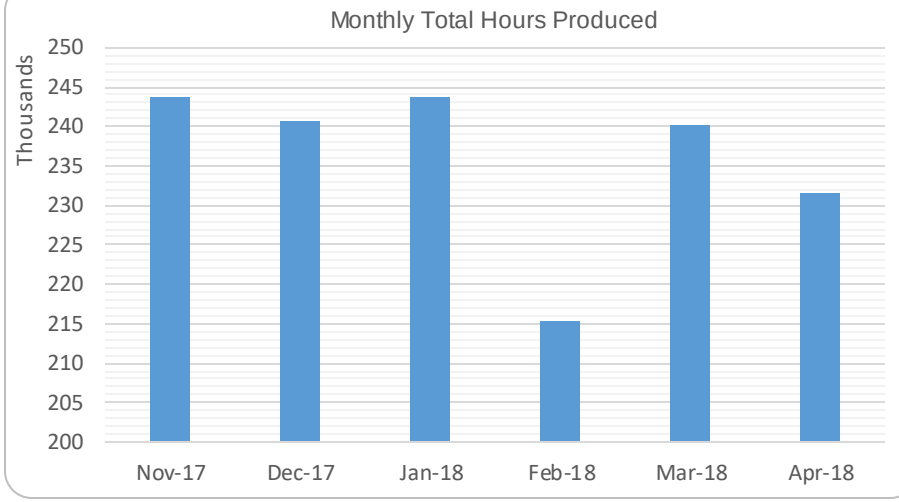
Highest number of hours lost.

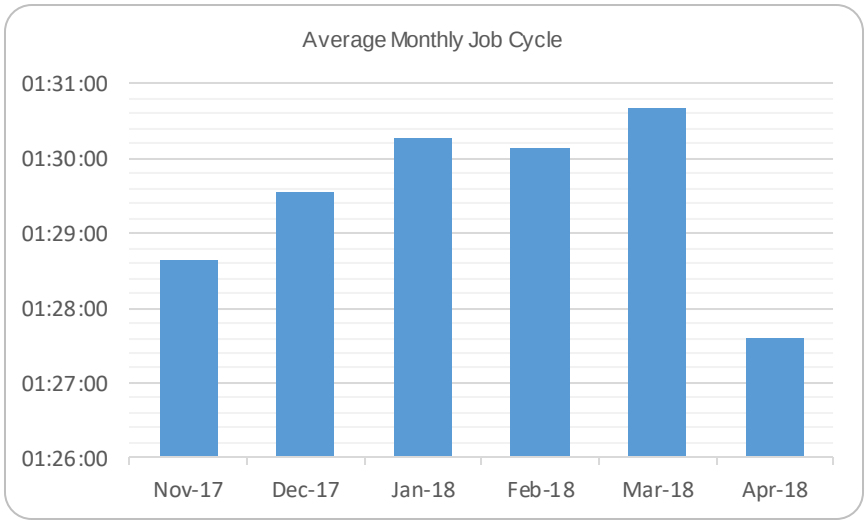
Lowest number of hours lost.

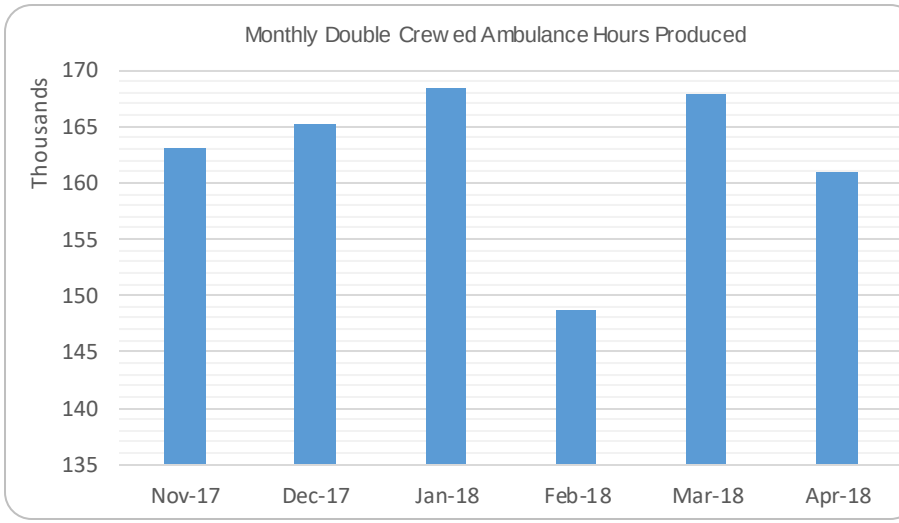
Job Cycle & Capacity
Ambulance Response Programme

April 2018

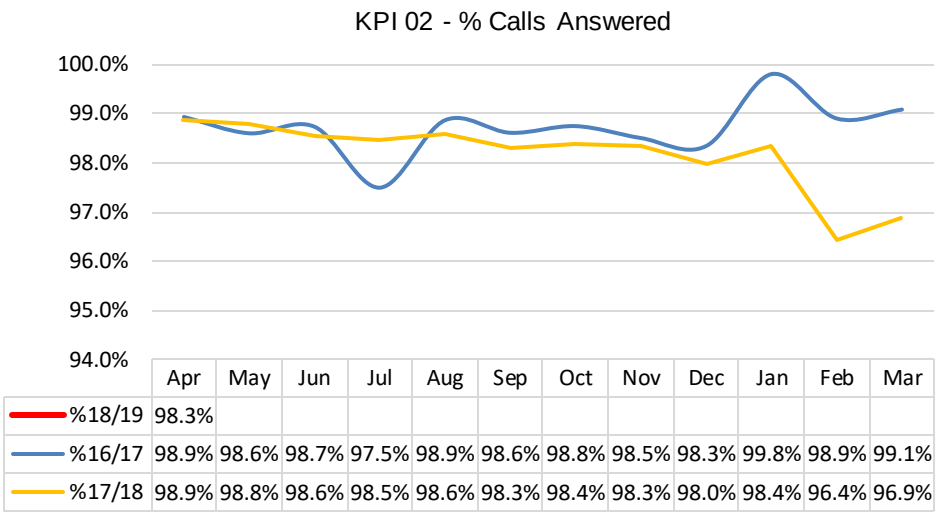
- The graphs below shows the Job Cycle Time on average per month since the implementation of the Ambulance Response Programme.
  - It demonstrates a slight drop of just over 3 minutes from March 2018
- The graphs opposite show the number of hours produced on average per month since the implementation of the Ambulance Response Programme.
  - April shows a slight drop in March of 4%.







LAS 111 (South East London)
Demand and Capacity



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
%18/19	98.3%											
%16/17	98.9%	98.6%	98.7%	97.5%	98.9%	98.6%	98.8%	98.5%	98.3%	99.8%	98.9%	99.1%
%17/18	98.9%	98.8%	98.6%	98.5%	98.6%	98.3%	98.4%	98.3%	98.0%	98.4%	96.4%	96.9%

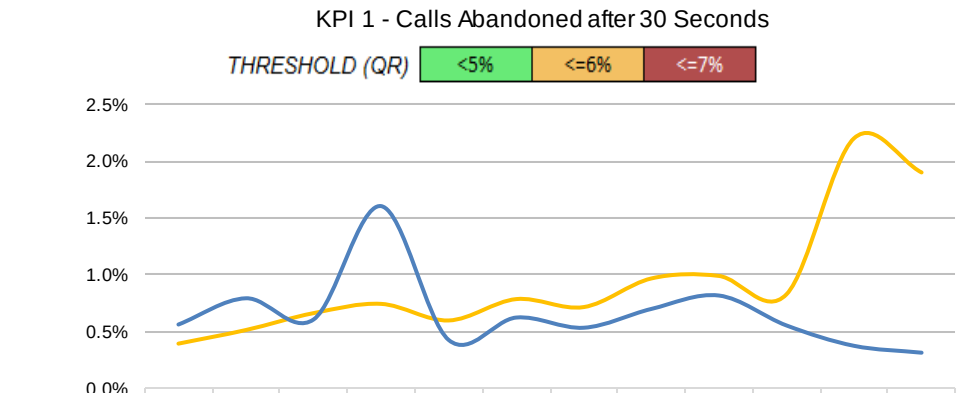
Demand: Call volume was slightly less than March 2018 but 11.5% higher than in April 2017.

Capacity: Demand exceeded capacity throughout April. Agency clinician and call handler inductions took place throughout April in addition to a recruitment drive for substantive staff.

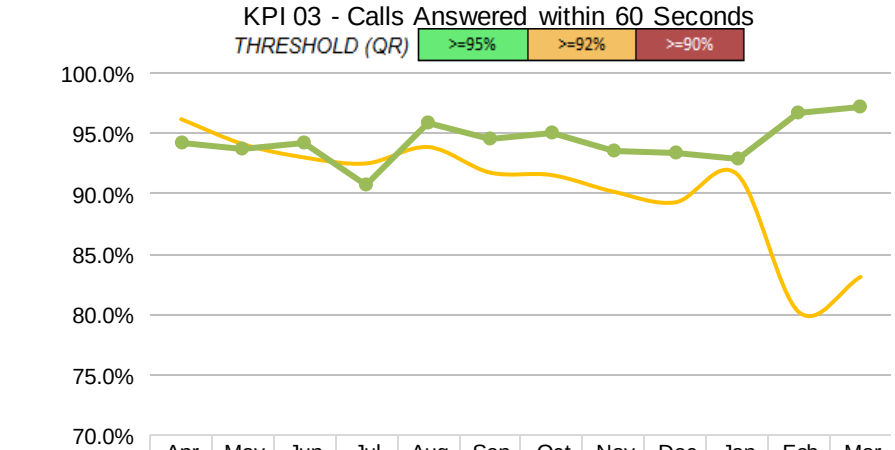
Efficiency: The percentage of calls answered in 60 seconds was 90.5% in April, with the target (95%) achieved on only 9 days. The operational focus has been on balancing access to the service and minimizing time to clinical call back.

Service Projects: The service focus throughout April has been on identifying variable factors which reduce appropriateness of enhanced clinical triage of Emergency Department and Ambulance dispositions.

April had a significant focus on preparation for, and participation in, the OSCE assessment for the bid for the South East London 111 and Integrated Urgent Care Service.



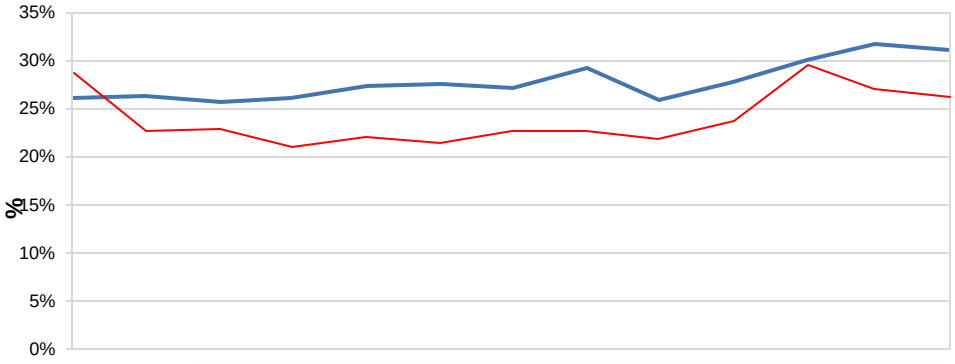
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.9%											
16/17	0.4%	0.5%	0.7%	0.7%	0.6%	0.8%	0.7%	1.0%	1.0%	0.8%	2.2%	1.9%
15/16	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	90.5%											
17/18	96.2%	94.1%	93.0%	92.5%	93.9%	91.8%	91.6%	90.2%	89.3%	91.6%	80.2%	83.1%
16/17	94.2%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%

LAS 111 (South East London)
Call Destinations

QR12a: % of calls referred to a clinical advisor



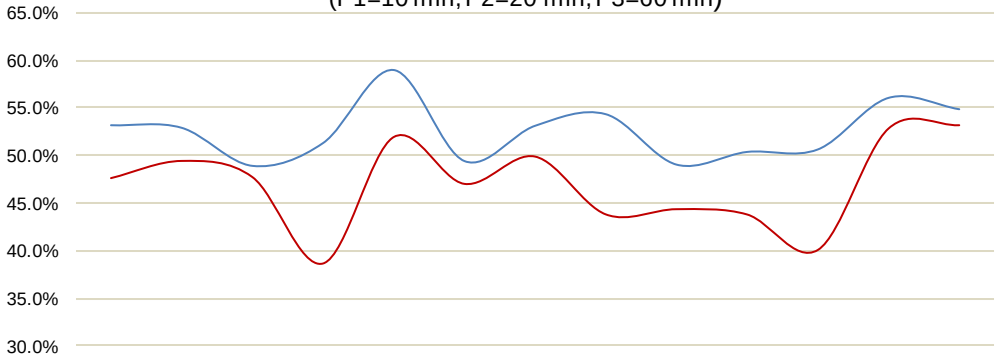
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
current year	26.2%	26.3%	25.7%	26.2%	27.3%	27.5%	27.1%	29.1%	25.8%	27.7%	29.9%	31.7%	31.0%
Prev Year	28.8%	22.7%	22.9%	21.0%	22.1%	21.5%	22.6%	22.7%	21.7%	23.8%	29.5%	26.9%	26.2%

Quality Indicators: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include complexity of calls, enhanced clinical assessment for Low Acuity Ambulance outcomes and availability of Clinical Advisors to accept a warm transfer. A prioritization system is in place to inform those decisions.

Safety: There were 72 Incidents in Datix with completed investigations in April. Of these 14% (n=10) related to authorized breaches in confidentiality including safeguarding referrals made without patient consent, 17% (n=12) to failure to follow procedure, 58% (n=42) to delay in care. The remaining 11% (n=8) were closed with no further action required. Incidents are under investigation and feedback given to staff where appropriate.

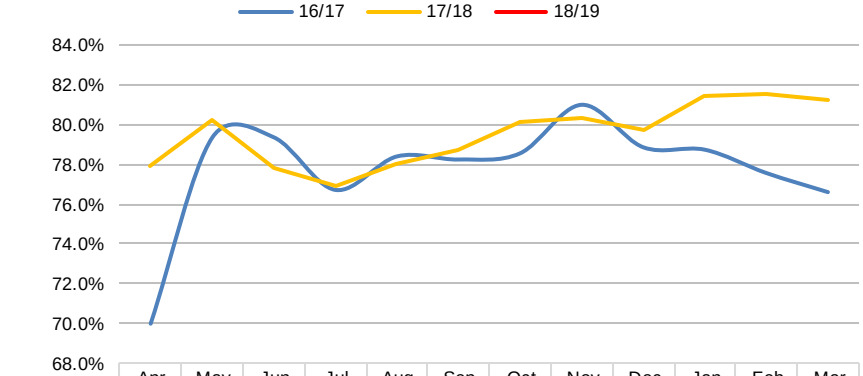
One Serious Incident (SI) was identified, relating to the clinical assessment of a patient. This is under investigation. The service received four complaints, three HCP feedback, six compliments and two complaints relating to other organizations.

KPI 05
calls % warm transferred
(P1=10 min, P2=20 min, P3=60 min)



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
current year	53.2%	52.9%	48.9%	51.3%	59.0%	49.4%	53.1%	54.3%	49.0%	50.4%	50.6%	56.0%	54.9%
prev year	47.6%	49.4%	47.7%	38.7%	51.9%	47.0%	49.9%	43.8%	44.4%	43.8%	40.1%	52.8%	53.2%

KPI 04 - Percentage (%) of answered calls Triaged

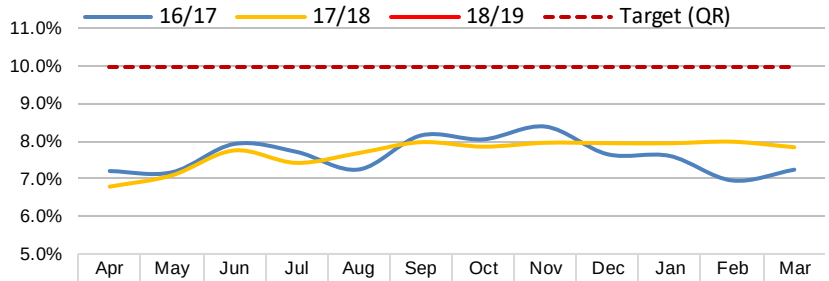


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	70.0%	79.3%	79.3%	76.7%	78.4%	78.2%	78.5%	81.0%	78.8%	78.7%	77.6%	76.6%
17/18	77.9%	80.2%	77.8%	76.9%	78.0%	78.7%	80.1%	80.4%	79.8%	81.4%	81.5%	81.2%
18/19	81.2%											

LAS 111 (South East London)

Triage Destinations

KPI 10 - Percentage of answered calls transferred to 999



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%
17/18	6.8%	7.1%	7.8%	7.4%	7.7%	8.0%	7.9%	8.0%	8.0%	7.9%	8.0%	7.8%
18/19	8.4%											
Target (QR)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

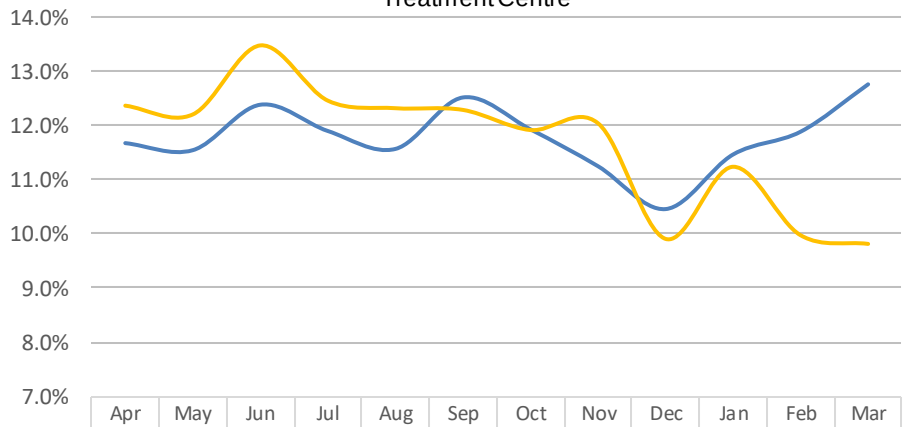
LAS 111 consistently has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for Low Acuity Ambulance outcomes.

Enhanced reassessment of Emergency Treatment Centre dispositions has resulted in a reduction in onward referrals and a focussed audit aims to introduce evidence based re-triage criteria.

When the above are combined ,this gives an indication of the impact on Emergency and Urgent Care. Of the London providers, LAS 111 refers the lowest number of combined cases into Emergency and Urgent Care..

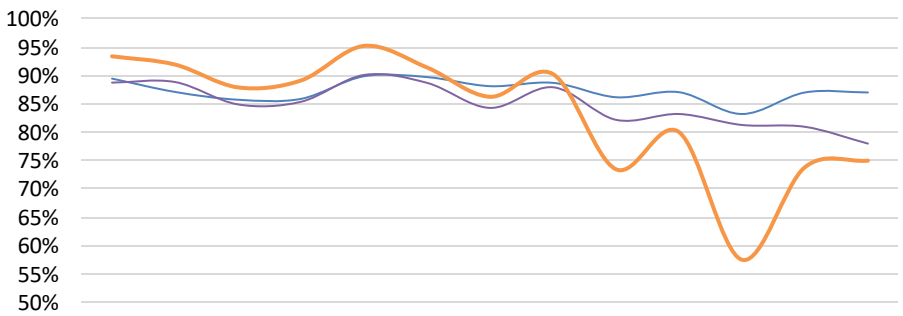
Call back performance remained the same as March due to using clinicians to field front end calls to balance prioritisation of patient care.

KPI 11 - Percentage of patients advised to attend Emergency Treatment Centre



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%
17/18	12.4%	12.2%	13.5%	12.5%	12.3%	12.3%	11.9%	12.1%	9.9%	11.2%	10.0%	9.8%
18/19	9.9%											

KPI 7,8,9 Call Backs and warm transfers (P1=10 min, P2=20 min, P3=60 min)



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
P1 <10m)	89%	87%	86%	86%	90%	90%	88%	89%	86%	87%	83%	87%	87%
P2 <20m)	89%	89%	85%	85%	90%	89%	84%	88%	82%	83%	81%	81%	78%
P3 <60m)	93%	92%	88%	89%	95%	91%	86%	90%	73%	80%	58%	74%	75%

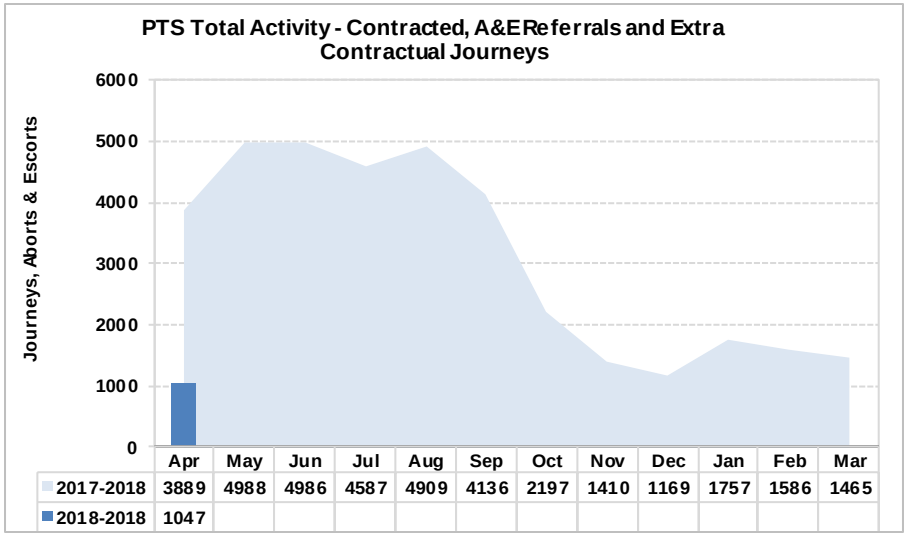
LAS 111 (South East London)
London and National Comparison – April 2018

The table below shows LAS' performance on key Quality Requirements (QRs) agreed in Schedule 12 contract of the SEL CCGs contract for providing 111 services. It shows a comparison to that of the other four London providers and the regional and national totals. ***Our ranking is out of five London providers***.
Data is taken from the weekly NHS England 111 Situation Report, and is collated for April 2018.

Description	Target	LAS	Care UK	LCW	PELC	Vocare	London	LAS ranking (pan-London)	England
Total calls answered	N/A	30,884	24,008	32,159	34,447	26,810	156,655		1,189,016
% of Calls answered within 60 seconds	95%	89.40%	87.81%	86.03%	80.06%	79.77%	84.50%	1	82.65%
% of Calls abandoned after 30 seconds	5%	1.08%	1.89%	2.51%	5.11%	4.51%	3.09%	1	3.59%
% of Calls transferred to, or answered by a clinical advisor	N/A	32.31%	23.80%	29.21%	26.55%	31.24%	28.73%		24.72%
Of calls transferred, percentage transferred warm	N/A	56.13%	21.49%	83.14%	51.06%	35.57%	52.31%		32.93%
Of call backs, percentage within 10 minutes	100%	55.32%	45.11%	47.73%	47.30%	60.58%	52.10%	2	41.31%
% of Calls referred to 999	10%	8.52%	9.45%	10.91%	8.61%	9.55%	9.40%	1	10.73%
% of Calls referred to Emergency Department	N/A	9.97%	9.93%	11.02%	10.49%	9.91%	10.33%	3	8.73%

*Modified clinical call back model agreed with commissioners. Contract QR target does not reflect this
*Ranking is from 1-5 with 1 representing the best performance in that area. **Data is provided up till 29th April 2018**

Patient Transport Service
Activity Update and Profitability Update



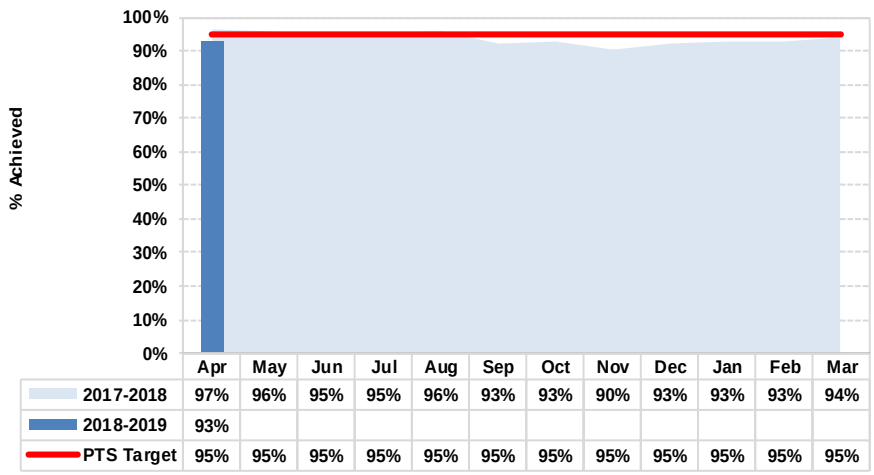
April was our last month of delivering PTS journeys on our last remaining contract St Georges Community in South West London which finished on the 30th April 2018 We delivered a final total of 1,047 journeys as compared to the March total of 1,465 journeys.

Delivery was maintained against a background of continued recovery from current winter pressures and adverse weather conditions.

None of the PTS staff on this contract TUPEd to the new provider on the 01/05/18 with most taking up positions within NETS. Those that did not, either retired or took up new opportunities outside of Service.

Month	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2018
Apr	15044	13227	8495	5478	3889	1047
May	15987	13164	7943	5602	4988	
Jun	14852	10129	8967	5797	4986	
Jul	16481	10508	8923	5631	4587	
Aug	14401	9028	5457	5705	4909	
Sep	15002	9602	6097	5565	4136	
Oct	16739	10957	5841	5723	2197	
Nov	15981	10063	5989	6433	1410	
Dec	13986	9250	4943	4980	1169	
Jan	16409	9753	5103	5266	1757	
Feb	15232	9787	5306	4913	1586	
Mar	13978	10520	5264	5387	1465	
Total	184092	125988	78328	66480	37079	1047

Patient Transport Service
KPI Update

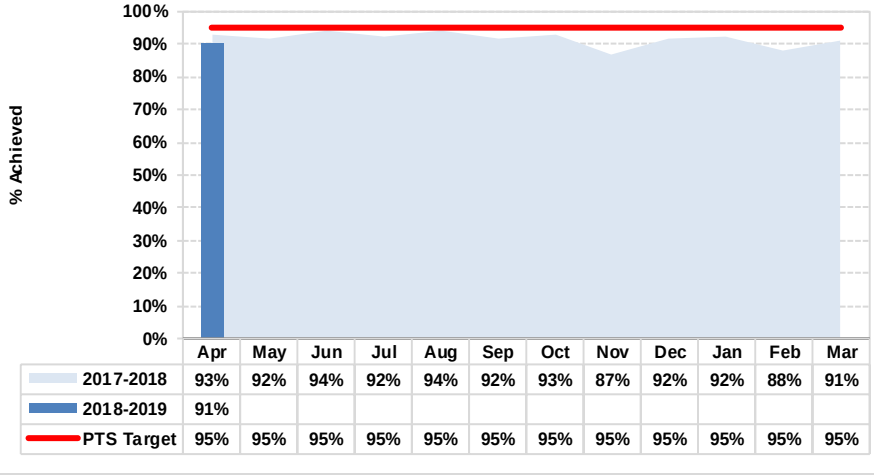


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-2018	97%	96%	95%	95%	96%	93%	93%	90%	93%	93%	93%	94%
2018-2019	93%											
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

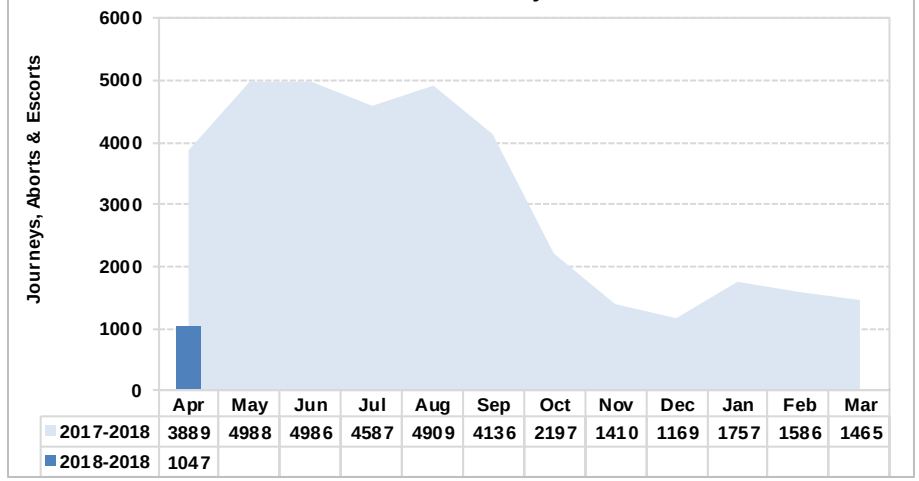
The arrival at hospital against the appointment time saw a decrease to 93% in April, and is below the 95% target.

Our activity profile is linked to the remaining contract where we are providing transport in the community settings with longer distances and spread of care centres where patients are being taken to.

Departure against patient ready time saw no change remaining at 91% for April against the background of activity as given above. This was below the target of 95%.

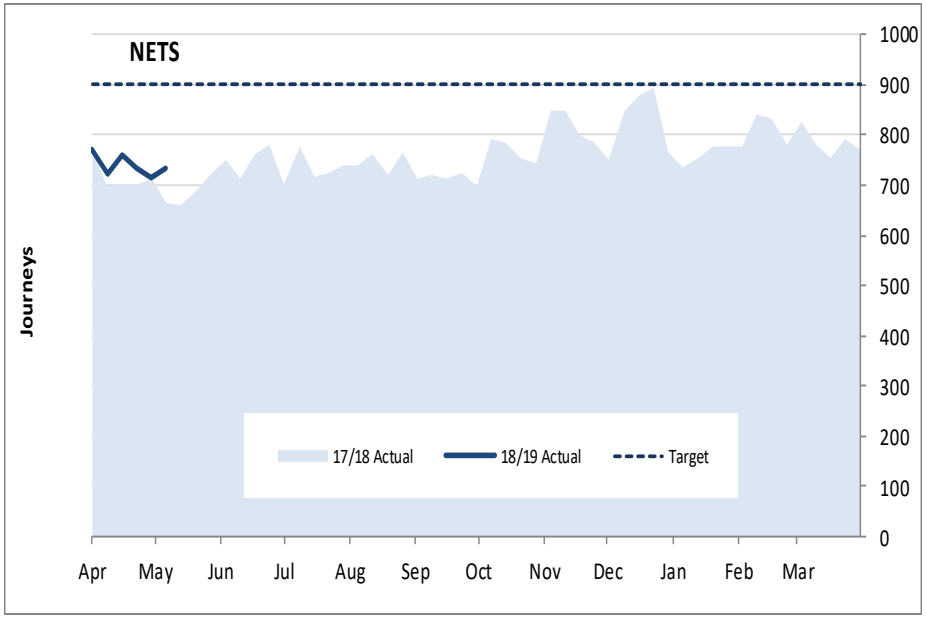


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-2018	93%	92%	94%	92%	94%	92%	93%	87%	92%	92%	88%	91%
2018-2019	91%											
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-2018	3889	4988	4986	4587	4909	4136	2197	1410	1169	1757	1586	1465
2018-2018	1047											

Non-Emergency Transport Service



Non-Emergency Transport Update

- NETs saw a decrease in the month and delivered an average of 737 journeys per week for the month, down from the previous month average of 772
- During April we saw the NETs overall weekly performance being maintain at a level in line with the impacts of resources, activity levels and waiting times.
- The team maintained its continued focus in ensuring the quality and number of calls to the NETS dispatch group was maintained.. The average number of calls passed to NETS also decreased from last months 1,094 per week to 997 calls per week for the month.
- NETS staffing/resourcing was also impacted by high rates of short term sickness over the month averaging at 5.4% up from last months 4.1%.
- Performance continued to suffer due to increasingly lengthy handover times at hospitals with specific issues with Queens, PRU and Hillingdon hospitals.
- From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETs and completed

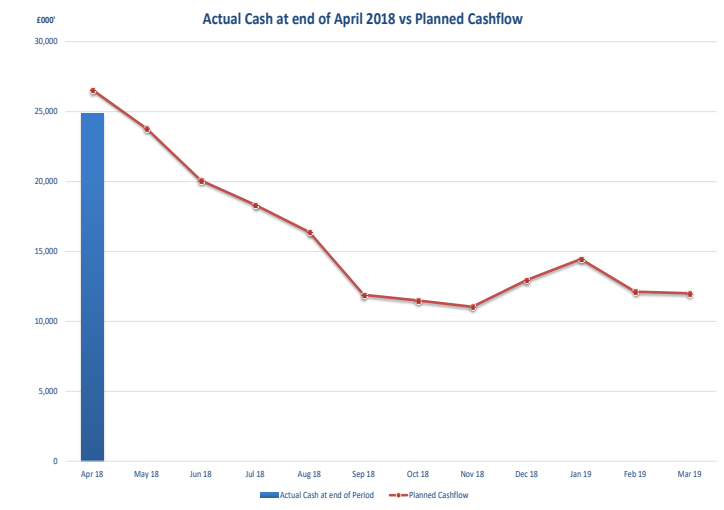
Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
05/03/2018	1194	12	400	782
12/03/2018	1071	8	309	754
19/03/2018	1078	12	281	785
26/03/2018	1036	2	264	770
02/04/2018	1014	5	265	744
09/04/2018	1005	7	239	759
16/04/2016	1021	22	266	733
23/04/2018	949	8	226	715

Our Money

Financial Indicator	Summary Performance	Forecast Outturn	Current Month	Previous month
Surplus / Deficit (Year to date and Forecast)	Year to date the position is £0.2m ahead of plan. The Trust is forecasting achieving its control total of £1.564m deficit. Key issues in the position are: • Income is £0.3m behind budget due to demand activity in month is only 0.6% above contract versus the 1.7% assumed in the plan. • On-going vacancies in core frontline staff groups are offset by Overtime, Incentive and PAS support for Frontline Capacity to support continued demand pressure	GREEN	GREEN	GREEN
Income	Income is £0.3m adverse in month due to: • Income is £0.3m behind budget due to demand activity in month is 0.6% above contract versus the 1.7% assumed in the plan. • No budget has been included for PTS as contract ceased last year but activity has continued and £0.1m income received.	AMBER	AMBER	GREEN
Expenditure (incl. Financial Charges)	In month expenditure is £0.5m behind plan due to: • Agency over spend £431k.. The Trust has a ceiling of £5.9m and strategies are being out in place to stay under this. • Vacancies in frontline covered by overtime £0.3m.	GREEN	GREEN	GREEN
CIPs	In month CIP was £0.7m and YTD on plan. The full year target of £12.3m is a risk and will continue to be closely monitored for the remainder of the year.	AMBER	AMBER	AMBER
Balance Sheet	Capital spend is ££0.8m in M1 which is £1m behind plan. Full year capital plan is £17m.	GREEN	GREEN	AMBER
Cashflow	Cash is £24.9m, £1.7m below plan. CCG income received was lower than planned.	GREEN	GREEN	GREEN
BPPC	Non-NHS 87%, NHS 93% performance (volume) for this month, performance is still below 95% target.	AMBER	AMBER	AMBER

Executive Summary – Key Financial Metrics

Owner: James Corrigan | Executive Lead: Lorraine Bewes



	Month 1 2018-19 £000			YTD Month 1 2018-19 £000			Full Year 2018-19 £000
	Budget	Actual	Variance fav / (adv)	Budget	Actual	Variance fav / (adv)	Budget
Surplus / (Deficits)	(1,454)	(1,284)	170	(1,454)	(1,284)	170	(1,564)
EFL				3,738	5,424	(1,686)	18,288
CRL				1,775	761	1,014	17,126
Suppliers paid within 30 days - NHS	95%	93%	(2.0%)	95%	93%	(2.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	87%	(8.0%)	95%	87%	(8.0%)	95%
EBITDA %	0.5%	0.8%	0.3%	0.5%	0.8%	0.3%	4.9%
EBITDA	137	225	88	137	225	88	18,112
NRAF (net return after financing)				0.00%	0.00%	0.0%	0.0%
Liquidity Days				(0.96)	(0.34)	0.62	(2.21)
Use of Resources Rating				3.0	3.0	0.0	2.0

- Year to date the position is £0.2m ahead of plan. The Trust has a full year outturn plan of £1.564m deficit.
- Income is £0.3m behind plan due to the budget including over activity at 1.7% and only 0.6% being achieved.
- The Trust is £1m behind a capital plan of £17m. The CRL will be confirmed at the end of June 2018.
- Cash is £24.9m, £1.7m below plan. CCG income received was lower than planned.
- Non-NHS 87%, NHS 93% performance (volume) for this month, performance is still below 95% target.

Statement of Comprehensive Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Month 1 2018-19 £000			YTD Month 1 2018-19 £000			Full Year 2018-19 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance fav/(adv)
Income									
Income from Activities	28,988	28,693	(295)	28,988	28,693	(295)	364,702	364,407	(295)
Other Operating Income	191	184	(8)	191	184	(8)	3,438	3,430	(8)
Total Income	**29,180**	**28,877**	**(303)**	**29,180**	**28,877**	**(303)**	**368,140**	**367,837**	**(303)**
Operating Expense									
Pay	(22,373)	(21,915)	458	(22,373)	(21,915)	458	(268,853)	(268,564)	289
Non Pay	(6,669)	(6,737)	(68)	(6,669)	(6,737)	(68)	(81,175)	(81,244)	(69)
Total Operating Expenditure	**(29,042)**	**(28,652)**	**391**	**(29,042)**	**(28,652)**	**391**	**(350,028)**	**(349,807)**	**220**
EBITDA	**137**	**225**	**88**	**137**	**225**	**88**	**18,112**	**18,030**	**(82)**
EBITDA margin	0.5%	0.8%	0.3%	0.5%	0.8%	0.3%	4.9%	4.9%	(0.1%)
Depreciation & Financing									
Depreciation & Amortisation	(1,241)	(1,158)	83	(1,241)	(1,158)	83	(15,516)	(15,433)	83
PDC Dividend	(350)	(350)	0	(350)	(350)	0	(4,200)	(4,200)	0
Finance Income	2	1	(2)	2	1	(2)	67	65	(2)
Finance Costs	(2)	(1)	1	(2)	(1)	1	(27)	(26)	1
Gains & Losses on Disposals	0	0	0	0	0	0	0	0	0
Total Depreciation & Finance Costs	**(1,591)**	**(1,509)**	**83**	**(1,591)**	**(1,509)**	**83**	**(19,676)**	**(19,594)**	**83**
Net Surplus/(Deficit)	**(1,454)**	**(1,284)**	**170**	**(1,454)**	**(1,284)**	**170**	**(1,564)**	**(1,564)**	**0**
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	(0)	3	3	(0)	38	38	(0)
Remove STP funding 2016/17	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance	**(1,451)**	**(1,281)**	**170**	**(1,451)**	**(1,281)**	**170**	**(1,526)**	**(1,526)**	**0**
Net margin	(5.0%)	(4.4%)	0.5%	(5.0%)	(4.4%)	0.5%	(0.4%)	(0.4%)	0.3%

Income

- Year to date the Trust is £0.3m behind plan.
- Year to date demand is currently running at 0.6% above contract baseline. This is below the budgeted level of activity included in the Trust's plan of 1.7%, and as such main contract variable income is £0.3m below budget.

Operating Expenditure (excl. Depreciation and Financing)

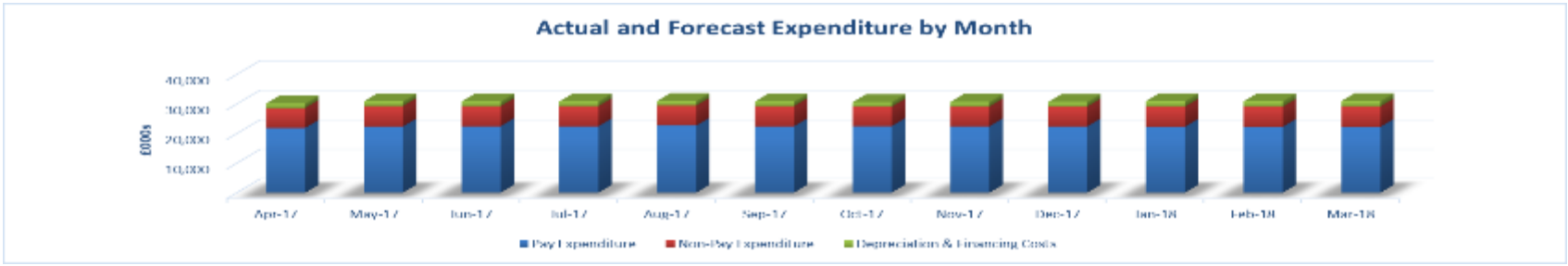
- Pay expenditure is £0.5m lower than plan , due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure £90k and agency spend £430k.

EBITDA

- The Trust delivered an EBITDA of £225k in April which represents 0.8%.

Depreciation and Financing

- Overall Financial Charges are £0.1m favourable at the end of April due to slippage in the Capital programme.



Main Contract Variable Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Month:	Apr-19	2018-19 Monthly Contract Base	2018-19 Actual Activity	2018-19 Actual Activity Increase / (Decrease) vs Contract Base	Total Incidents Difference to Contract Base (%)	Chargeable Activity over Contract Base	£ 239.37	CCG Split Based on Incident Difference
Area	CCG Names	Total Incidents	Total Incidents	Total Incidents			Total Additional Charge or (Credit) at 75% Marginal Rate	
NEL	NHS City and Hackney CCG	3,000	3,019	19	0.63%			£ 4,548.03
NEL	NHS Newham CCG	3,302	3,335	33	1.00%			£ 7,899.21
NEL	NHS Tower Hamlets CCG	2,782	2,936	154	5.54%			£ 36,862.98
NEL	NHS Waltham Forest CCG	2,491	2,592	101	4.05%			£ 24,176.37
NEL	NHS Barking and Dagenham CCG	2,327	2,372	45	1.93%			£ 10,771.65
NEL	NHS Havering CCG	2,802	2,897	95	3.39%			£ 22,740.15
NEL	NHS Redbridge CCG	2,793	2,959	166	5.94%			£ 39,735.42
NEL	**NEL Total**	**19,497**	**20,110**	**613**	**3.14%**	**613**	**£ 146,733.81**	**£ 146,733.81**
NCL	NHS Barnet CCG	3,551	3,574	23	0.65%			£ 5,505.51
NCL	NHS Camden CCG	2,949	2,788	-161	-5.46%			-£ 38,538.57
NCL	NHS Enfield CCG	3,182	3,270	88	2.77%			£ 21,064.56
NCL	NHS Haringey CCG	2,627	2,745	118	4.49%			£ 28,245.66
NCL	NHS Islington CCG	2,540	2,587	47	1.85%			£ 11,250.39
NCL	**NCL Total**	**14,849**	**14,964**	**115**	**0.77%**	**115**	**£ 27,527.55**	**£ 27,527.55**
NWL	NHS Brent CCG	3,463	3,400	-63	-1.82%			-£ 15,080.31
NWL	NHS Harrow CCG	2,151	2,175	24	1.12%			£ 5,744.88
NWL	NHS Hillingdon CCG	3,716	3,650	-66	-1.78%			-£ 15,798.42
NWL	NHS Central London (Westminster) CCG	3,186	3,052	-134	-4.21%			-£ 32,075.58
NWL	NHS Ealing CCG	3,578	3,488	-90	-2.52%			-£ 21,543.30
NWL	NHS Hammersmith and Fulham CCG	2,042	2,001	-41	-2.01%			-£ 9,814.17
NWL	NHS Hounslow CCG	2,714	2,688	-26	-0.96%			-£ 6,223.62
NWL	NHS West London CCG	2,485	2,413	-72	-2.90%			-£ 17,234.64
NWL	**NWL Total**	**23,335**	**22,867**	**-468**	**-2.01%**	**-468**	**-£ 112,025.16**	**-£ 112,025.16**
SEL	NHS Bexley CCG	2,472	2,468	-4	-0.16%			-£ 957.48
SEL	NHS Bromley CCG	3,088	3,114	26	0.84%			£ 6,223.62
SEL	NHS Greenwich CCG	2,775	2,938	163	5.87%			£ 39,017.31
SEL	NHS Lambeth CCG	3,519	3,540	21	0.60%			£ 5,026.77
SEL	NHS Lewisham CCG	2,933	2,969	36	1.23%			£ 8,617.32
SEL	NHS Southwark CCG	3,517	3,613	96	2.73%			£ 22,979.52
SEL	**SEL Total**	**18,304**	**18,642**	**338**	**1.85%**	**338**	**£ 80,907.06**	**£ 80,907.06**
SWL	NHS Croydon CCG	4,133	4,164	31	0.75%			£ 7,420.47
SWL	NHS Kingston CCG	1,569	1,566	-3	-0.19%			-£ 718.11
SWL	NHS Merton CCG	1,881	1,856	-25	-1.33%			-£ 5,984.25
SWL	NHS Richmond CCG	1,575	1,594	19	1.21%			£ 4,548.03
SWL	NHS Sutton CCG	2,020	2,000	-20	-0.99%			-£ 4,787.40
SWL	NHS Wandsworth CCG	2,734	2,665	-69	-2.52%			-£ 16,516.53
SWL	**SWL Total**	**13,912**	**13,845**	**-67**	**-0.48%**	**-67**	**-£ 16,037.79**	**-£ 16,037.79**
London Total		**89,897**	**90,428**	**531**	**0.59%**	**531**	**£ 127,105.47**	**£ 127,105.47**

Initial reported activity for April 2018 is 0.6% above the contract baseline. This is 1.1% lower than the planned level of activity
In the Budget (1.7%).

On this basis the LAS would be able to invoice £127k of additional variable income.
This has been recognised in the accounts
at month 1.

The April activity is based on April flex figures.

Cash flow Statement Full Year

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Apr-18 Actual	Apr-18 YTD Move	Apr-18 YTD Plan	Apr-18 Var
	£000	£000	£000	£000
Opening Balance	**30,300**	**30,300**	**30,300**	**0**
Operating Surplus	226	226	137	89
(Increase)/decrease in current assets	716	716	(334)	1,050
Increase/(decrease) in current liabilities	(2,805)	(2,805)	1,041	(3,846)
Increase/(decrease) in provisions	402	402	(584)	986
Net cash inflow/(outflow) from operating activities	(1,461)	(1,461)	260	(1,721)
Cashflow inflow/outflow from operating activities	**(1,461)**	**(1,461)**	**260**	**(1,721)**
Returns on investments and servicing finance	0	0	2	(2)
Capital Expenditure	(3,963)	(3,963)	(4,000)	37
Dividend paid	0	0	0	0
Financing obtained	0	0	0	0
Financing repaid	0	0	0	0
Cashflow inflow/outflow from financing	**(3,963)**	**(3,963)**	**(3,998)**	**35**
Movement	(5,424)	(5,424)	(3,738)	(1,686)
Closing Cash Balance	**24,876**	**24,876**	**26,562**	**(1,686)**

There has been a net outflow of cash to the Trust of £5.4m.

Cash funds at 31 April stand at £24.9m.

Operating Surplus

- The operating surplus at £0.2m is higher than planned.

Current Assets

- The movement on current assets is £0.7m, £1.1m higher than planned movement.
- Current assets movement was higher than planned due to receivables (£2.3m), accrued income £3.7m and prepayments (£0.3m).

Current Liabilities

- The movement on current liabilities is (£2.8m), a £3.8m higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£4.7m), accruals £0.6m and Deferred income £0.3m.

Provisions

- The full year movement on provisions is £0.4m, is a £1.0m increase on plan.

Capital Expenditure

- Capital cash outflow is £4.0m, this is on target.

CQUINs

Owner: James Corrigan | Executive Lead: Lorraine Bewes

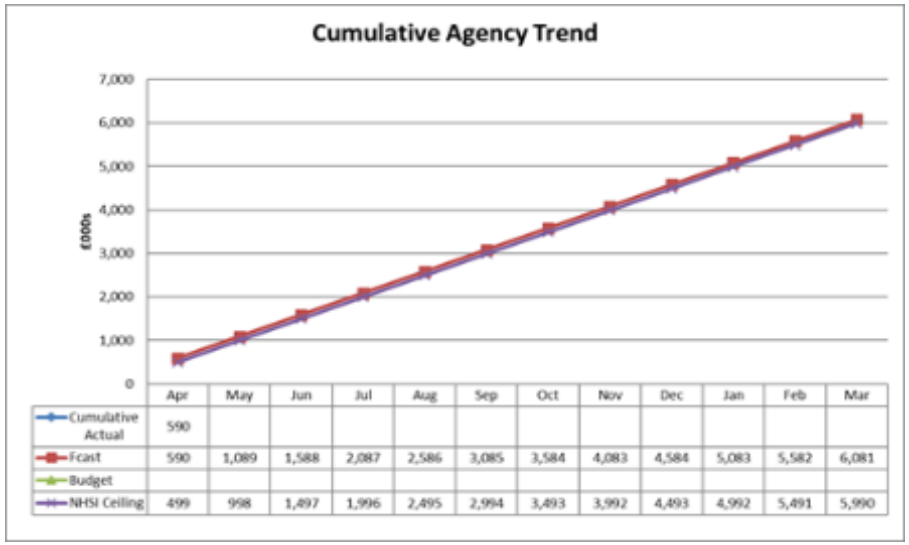
FIC - LAS 2018/19 ES & UC Contract – Commissioning for Quality & Innovation (CQUIN) SCHEDULE & UPDATE – as at 11th May 2018

#	CQUIN Indicator title	CQUIN leads	Final indicator period	Annual value	Qtr 1 Available	Q1 Predicted Achieveme	Achieved Q1	Qtr 2 Available	Q2 Predicte d	Achieved Q2	Qtr 3 Available	Q3 Predicted Achieve	Achieved Q3	Qtr 4 Available	Q4 Predicted Achieve	Achieved Q4	Total Estimat ed	Annual Actual Achieve	Differen ce	Risk/ Issue/Notes
	Note all CQUINs follow a two year contract period and so apply across 2017/18 – 2018/19. The below outlines commitments and funding related to 2018/19 financial year only.																			
1a	**National CQUIN 1a:** Improvement of health and wellbeing of NHS staff	Patricia Grealish Nicola Bullen	Final Period – Q4 18-19	£ 267,079.54										100% £267,080	0% £0	TBC 28.05.2019	0% £0	£-	N/A	N/A
1b	**National CQUIN 1b: Healthy food** for NHS staff, visitors and patients	Benita Mehra Steve Dawson	Final Period – Q4 18-19	£ 267,079.54										100% £267,080	0% £0	TBC 28.05.2019	0% £0	£-	N/A	N/A
1c	**National CQUIN 1c:** Improving the uptake of **flu vaccinations** for front line staff within Providers	Fenella Wrigley Neil Thomson	Final Period – Q4 18-19	£ 267,079.54										100% £267,080	0% £0	TBC 28.05.2019	0% £0	£-	N/A	N/A
12	**National CQUIN 12: Ambulance Conveyance**	Paul Woodrow Craig Harman	Final Period – Q4 18-19	£ 801,238.63										100% £801,239	0% £0	TBC 28.05.2019	0% £0	£-	N/A	On-going dicussions with commissioners in relation to reduction in conveyance targets for 2018.19. Payment is currently expected in Q4, however on-going work with commissioners means some payment made be available in Q1.
STP 1	**National CQUIN: STP Engagement**	Jamie O'Hara Fiona Claridge	Final Period – Q4 18-19	£ 3,204,954.52	25% £801,239	25% £801,239	TBC 28.08.2018	25% £801,239	0% £0	TBC 27.11.2018	25% £801,239	0% £0	TBC 26.02.2019	25% £801,239	0% £0	TBC 28.05.2019	25% £801,239	£0	N/A	Specific deliverables and weightings to be agreed in Q1 (Q1 to be measured on existing basis) with equal weighting across the year assumed.
L1	**Digitalisation**	Ross Fullerton Ian Golding	Final Period – Q4 18-19	£ 3,204,954.52	25% £801,239	25% £801,239	TBC 28.08.2018	25% £801,239	0% £0	TBC 27.11.2018	25% £801,239	0% £0	TBC 26.02.2019	25% £801,239	0% £0	TBC 28.05.2019	25% £801,239	£-	N/A	Specific deliverables and weightings to be agreed in Q1 with equal weighting across the year assumed.
	Total Value Available (2.5% of contract value)			£ 8,012,386	£ 1,602,477			£ 1,602,477			£ 1,602,477			£ 3,204,955						
	Total Value Predicted					£ 1,602,477			£ -			£ -			£ -					
	Total Value Achieved						£-			£-			£-							

Key - RAG status
INTERNAL RAG (for ELT / monitoring)
Red denotes: CQUIN not achieved
Amber denotes: partial achievement
Green denotes: CQUIN expected full achievement
Blue denotes: Achieved in full

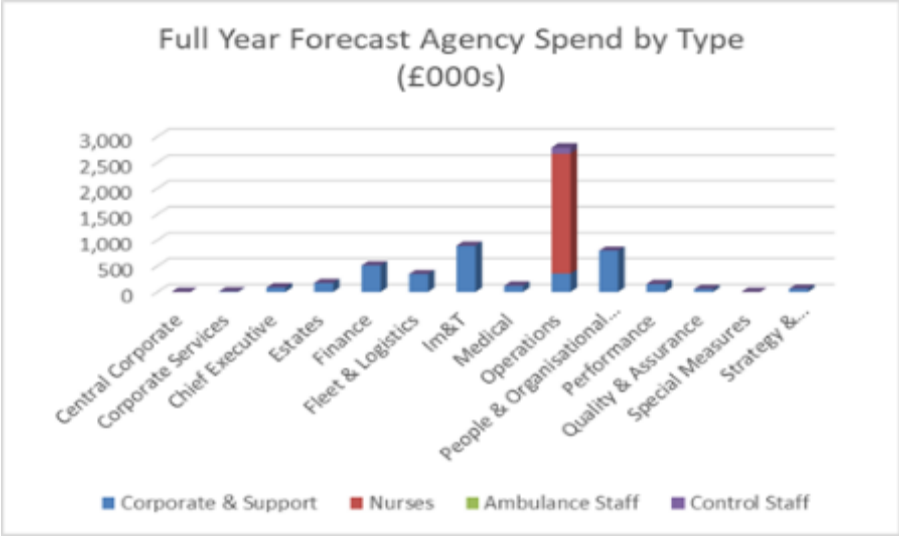
Agency Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Actual	590											
Fcast	590	1,089	1,588	2,087	2,586	3,085	3,584	4,083	4,584	5,083	5,582	6,081
Budget												
NHSI Ceiling	499	998	1,497	1,996	2,495	2,994	3,493	3,992	4,493	4,992	5,491	5,990

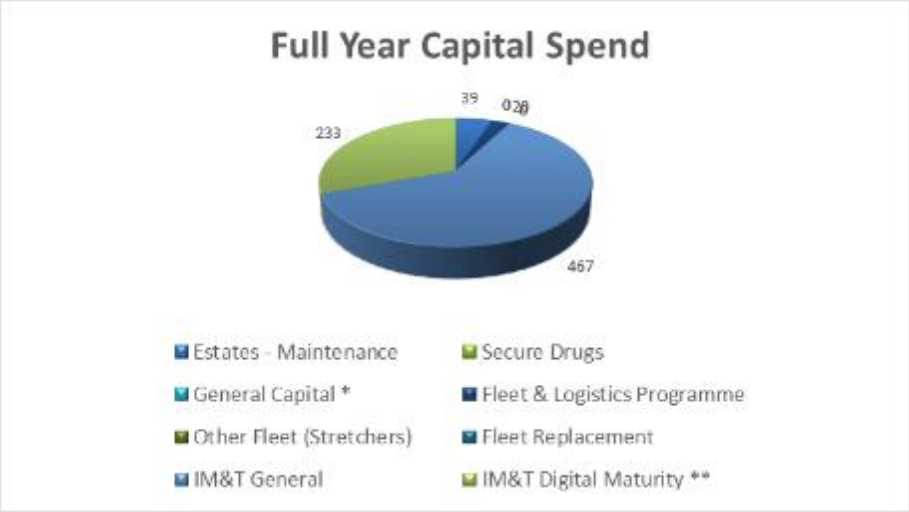
Agency Summary by Division & Type	Full Year Forecast (£000s)			
	Corporate & Support	Nurses	Ambulance Staff	Control Staff
Central Corporate	0	0	0	0
Corporate Services	10	0	0	0
Chief Executive	88	0	0	0
Estates	172	0	0	0
Finance	512	0	0	0
Fleet & Logistics	344	0	0	0
Im&T	892	0	0	0
Medical	120	0	0	0
Operations	353	2,317	0	118
People & Organisational Dev	796	0	0	0
Performance	151	0	0	0
Quality & Assurance	56	0	0	0
Special Measures	0	0	0	0
Strategy & Communications	61	0	0	0
Total	**3,555**	**2,317**	**0**	**118**



The Trust's NHSI agency spend ceiling is £5.99m. Agency spend in excess of this level would result in the loss of planned STF income, and ineligibility for further STF funding announced.

2018/19 Capital Plan/Spend Full Year – Month 1 Summary

Owner: James Corrigan | Executive Lead: Lorraine Bewes



Capital Programme	Exec Lead	Operational Lead	Month 1 Plan £'000	Month 1 Actual £'000	Month 1 Variance £'000	Full year Plan £'000	Forecast Outturn £'000
Expenditure Plan:							
Estates	B Mehra	S Dawson	101	39	62	2,177	2,177
IM&T	B Mehra	S Dawson	738	700	38	7,900	7,900
Fleet	B Mehra	J Wand	460	20	440	1,820	1,820
Fleet Replacement	B Mehra	J Wand	476	0	476	5,229	5,229
IM&T Digital Maturity	R Fullerton	R Fullerton	0	0	0	0	0
							0
Capital Expenditure Plan			**1,775**	**759**	**1,016**	**17,126**	**17,126**

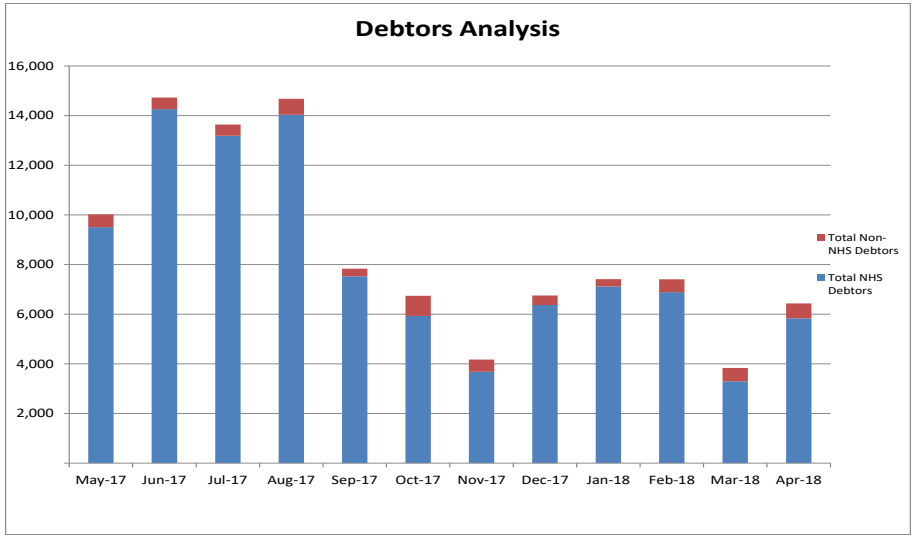
- Capital spend is ££0.8m against a budget of £1.8m, £1m behind plan.
- The Trust CRL has not been confirmed yet.

Debtors Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Aged debtors Summary 30th April 2018

	Note	Total	Days Overdue 0 - 30	31 - 60	61 - 90	Over 91 days
		£'000	£'000	£'000	£'000	£'000
NHS Debtors						
Nhs Central London (Westminster) Ccg	2	1,111	192	901	17	1
Nhs West London (Kandc And Qpp) Ccg	3	905	189	704	12	
Nhs Bromley Ccg	4	772	772			
Nhs Wandsworth Ccg	5	633	631	1	1	
Nhs Ealing Ccg	6	409	404	2	1	2
St Georges University Hospitals Nhs Ft	7	377	93	143		141
<£377,000	1	3,749	3,177	200	58	315
Total NHS Debtors		**7,956**	**5,457**	**1,951**	**89**	**459**
Advanced Payments	8	-2,123	-2,123			
Total NHS Debtors		**5,833**	**3,334**	**1,951**	**89**	**459**
Non-NHS Debtors						
Heathrow Airport Ltd	9	109	109			
Arsenal Football Club	10	94	35	25	33	
International Academies Of Emergency Dispatc	11	65	65			
Unison	12	37	5	9	23	
Kings College London	13	37	25	11		
<£37,000	14	260	81	58	14	109
Total Non NHS Debtors		**602**	**320**	**104**	**70**	**109**
TOTAL DEBTORS 30th April 2018		**6,435**	**3,654**	**2,055**	**159**	**568**



Debtors Position: 30th April 2018

Total outstanding NHS and Non-NHS debtors as at 30TH April 2018 amounted to £6.4 million.

The NHS over 60 day's figure of £0.7M includes amounts due from both CCGs £0.3m and NHS Trusts £0.1m.

1. NHS Debtors over 60 days.
   - PTS Non-Contract Activity - £173k – The PTS ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues.
   - Out of London (A&E ECJ) Journeys - £99k – The A&E ECJ invoices have been queried by various CCG's who are disputing the charges. The LAS contracts and EOC team are liaising with the CCG's to resolve the issues. £4k has been paid in May by various CCGs
   - PTS Contract Activity - £540k – £180k has been paid in May 2018 by various organisations. We are continuously liaising with the organisations to clear the outstanding invoices.
   - Neonatal Transfer Service - £160k – The NTS invoices have been queried by various CCG's who are disputing the charges. The LAS contracts team is liaising with the CCG's to resolve the issues.

The Trust is actively pursuing the outstanding debts.

2. NHS Central London CCG - £1.1m - £0.9m paid on 1st of May (March 18 SLA & CQUIN). The CCG has confirmed that we can expect payment for the £0.2m on the 11th of May 2018.
3. NHS West London CCG - £0.9m - Paid £0.1m on 1st of May. Payment for £0.7m received on the 9th of May (March 17/18 SLA & CQUIN). For the remaining £0.1m payment is expected on the 15th of May.
4. NHS Bromley CCG - £0.7m - (6 invoices) £0.6m paid on 1st of May (3 invoices) Remaining £0.1m awaiting approval, expected payment date 15th of May.
5. NHS Wandsworth CCG - £0.6m - (11 invoices) paid £5k on the 1st of May. Remaining invoices awaiting approval.
6. NHS Ealing CCG - £0.4m - awaiting validation, expected payment date is the 15th of May.
7. St Georges University Hospitals NHS FT - £377k (19 PTS Invoices). We are liaising with the Trust to obtain a payment date of the invoices.
8. Payments in advance were made by the following CCG's: Southwark £1m, Lambeth £1m.
9. Heathrow Airport Ltd - £109k (1 invoice) has been approved and will be paid on the 29th of May 2018.
10. Arsenal Football Club - £94k (4 invoices) 1 invoice (£34k) has been queried by the organisation, we have issued a part credit. Payment is expected on the 31st of May.
11. International Academies Of Emergency Dispatch - £65k (1 invoice) isn't due until the end of May.
12. Unison - £37k (7 invoices) payment is being withheld as Unison are querying the secondment recharges and the amount the employee has been paid, Human Resources & Payroll at LAS are dealing with this query.
13. Kings College London - £37k (2 invoices) will be paid on the 31st of May.
14. Non-NHS Debtors - £260k consists of; £96k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £62k of stadia events, the stadiums have been chased for payment on a regular basis. The remaining £102k is due from local Government bodies and other miscellaneous organisations.

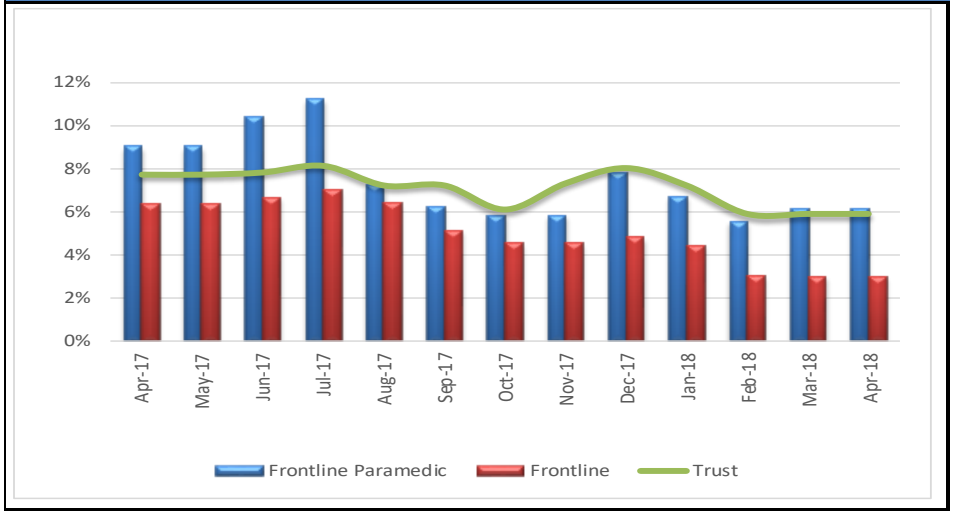
The graph to the left shows the debtors trend for the last 12 months.

Our People

Section	Key Headlines From Each Section.	April 2018	March 2018	February 2018
Vacancy and Recruitment	• The overall vacancy rate has remained at 6% against a 5% target. • We have identified additional core front line posts to deliver the 18/19 increased demand. Work is in progress with colleagues in Operations to determine how these posts should be allocated across the Sectors.	6%	6%	6%
Turnover	• Total Trust turnover has increased to 11.2% against a threshold of 10%. • Frontline turnover has increased from 9.9% to 10.3% Please note this does not include Control Room or NHS 111 leavers. • Frontline paramedic turnover has increased from 10.9% to 11.5%.	11.2%	10.7%	10.6%
Sickness	• Sickness for April remains at 5.2% against a target of 5%. • Sector Ops sickness has remained at 5.7%.	5.2%	5.2%	5.2%

Trust wide
Vacancy

TRUST VACANCY RATE



	Establishment	In post (as at 30th April)	Vacancy wte	Vacancy %
Trust Total	5,411.00	5,108.28	302.72	5.6%
Total Frontline (Sector)	3,380.00	3,019.25	360.75	10.7%
Frontline (Sector) Paramedics	1,859.00	1,753.68	105.32	5.7%
Frontline (Sector) Non-Paras	1,521.00	1,283.50	237.50	15.6%
EOC	502	468	34	6.8%
Other staff (including Corporate)	1,529.00	1,621.03	-92.03	-6.0%

EOC recruitment (Emergency Medical Dispatchers)

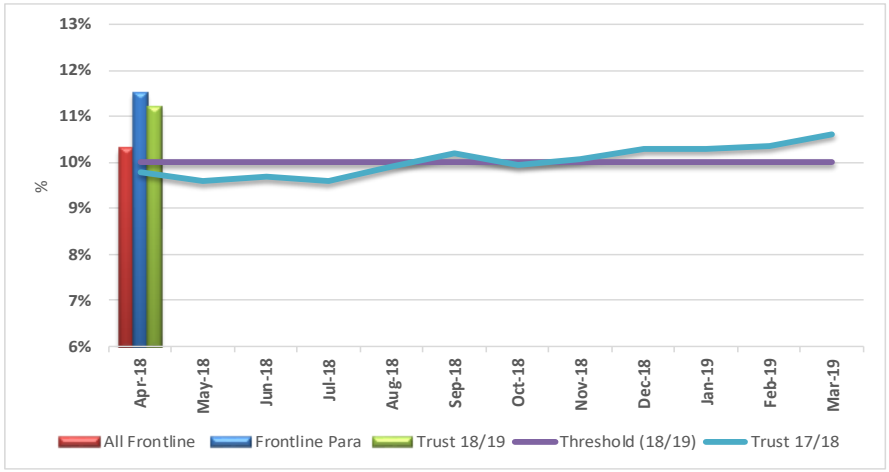
- The EOC Recruitment Board continues to consider continuous improvement and has identified a number of initiatives to improve recruitment and retention. Those identified so far include:
- Streamlining of selection process, including re-assessing pass rates and introduction of online assessments.
- Overfilling our training places to allow for any candidate drop outs.
- EMD on-line assessment – we have started the pilot which will run from 1st May 2018 to 31st July 2018, assessing up to 500 candidates. There are currently 42 candidates who are undergoing pre-employment checks, 4 of who have been sent a contract. We anticipate a further 18 to be cleared by 1st June 2018.
- Streamlining and improvement of pre-employment checking.
- Introduction of incentives for newly employed EMDs.
- Introduction of a part time roster.

Trainee Emergency Ambulance Crew recruitment - In order to to unblock our pipeline, we have agreed to fund C1 licence costs for our TEAC recruits (approximately £1,200 per person), starting April to Jul 2018 at an estimated cost of £100,000. This will be paid as an RRP and will have a 2 year post employment start claw back. From the group of all eligible candidates who are interested in the C1 incentive, 49 have already started their C1 Practical training. There are currently 93 candidates in the pipeline, awaiting allocation to a course, 20% of who have full C1 Licence and/or C1 in progress.

Paramedic recruitment – to date 74 Partner UK Graduates have been offered and allocated to a course. There are a number of assessments/ interviews planned for UK Paramedics (Partner, Non-Partner and Qualified) between 26th May 2018 to 7th July 2018 and 104 Paramedics are expected to be assessed/ interviewed. We have a confidence level of 100% for the iParas starting on 14th May 2018. Of the original cohort of iParas recruited Oct 2017, 64 have withdrawn (39% attrition rate).Between 15th January 2018 and 30th April 2018, 135 iParas have joined the organisation of which 120 (89%) are now HCPC registered.

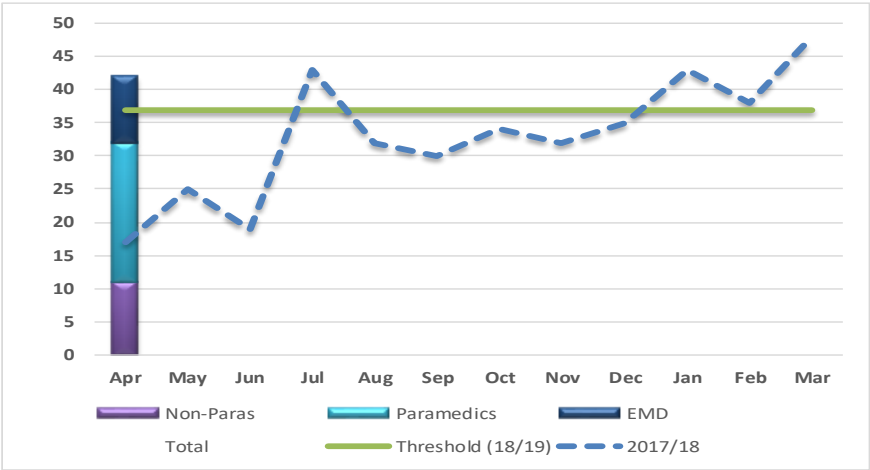
Trust wide
Turnover/Leavers

TURNOVER



- The total Trust turnover has increased from 10.7% to 11.2% (12 month rolling figure).
- Frontline turnover (Sector Ops) has increased from 9.9% to 10.3%.
- Frontline paramedic turnover has increased from 10.9% to 11.5%.
- EOC turnover has increased from 17.6% to 18.9%.
- NHS 111 turnover has decreased from 17.8% to 16.9%.
- Corporate Directorates turnover has decreased from 14% to 13%.

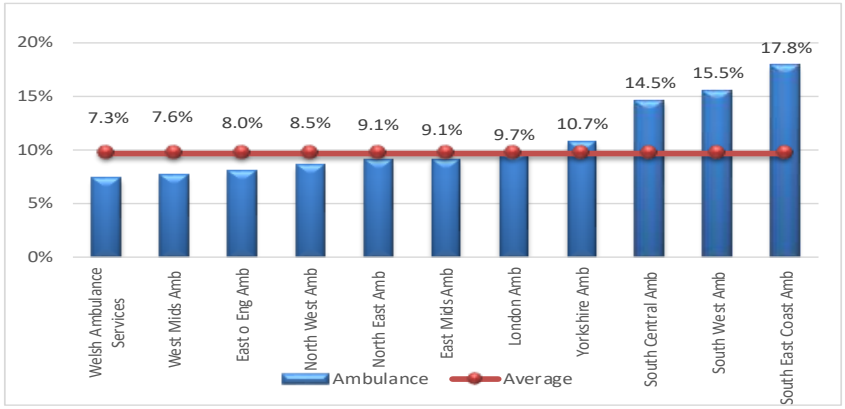
FRONTLINE LEAVERS



- There were 42 frontline leavers in April (see table opposite).
- 79% of the frontline leavers (33 staff) were resignations ie. unplanned. There were 8 dismissals and one retirement.
- 52% (11) of paramedics left for reasons of relocation
- 42% of paramedics had two year's or less service.

Trust wide
Benchmarking Turnover/Sickness

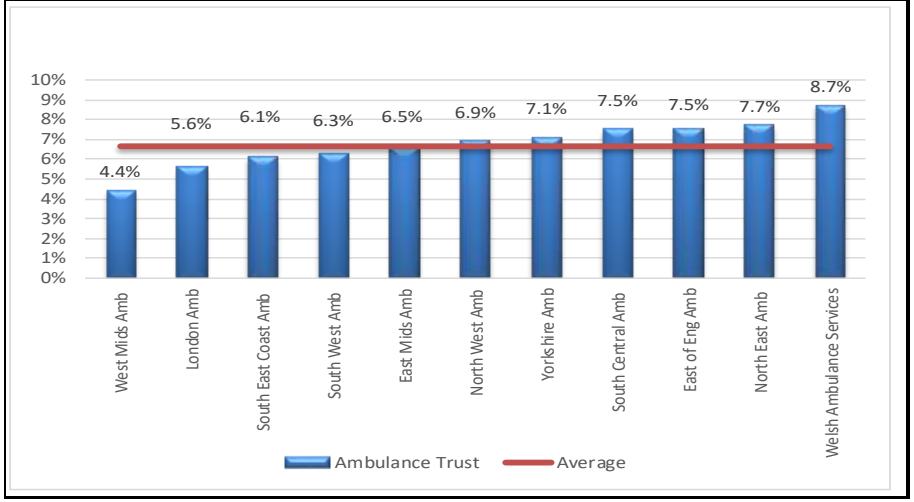
BENCHMARK TURNOVER RATE - FEBRUARY 2018



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has remained in 7th place.
- The LAS is at the national average of 9.7%.

Source of data: NHS Health and Social Care Information Centre – data as at 28th February 2018. Data is available two months in arrears.

BENCHMARK SICKNESS RATE - JANUARY 2018

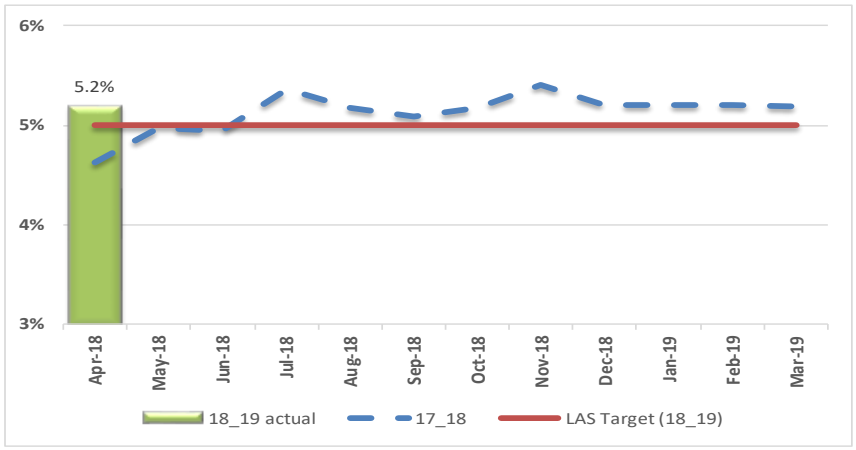


- This graph shows the sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has remained in 2nd place.
- The LAS is below the national average of 6.6%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st January. Data is available three months in arrears.

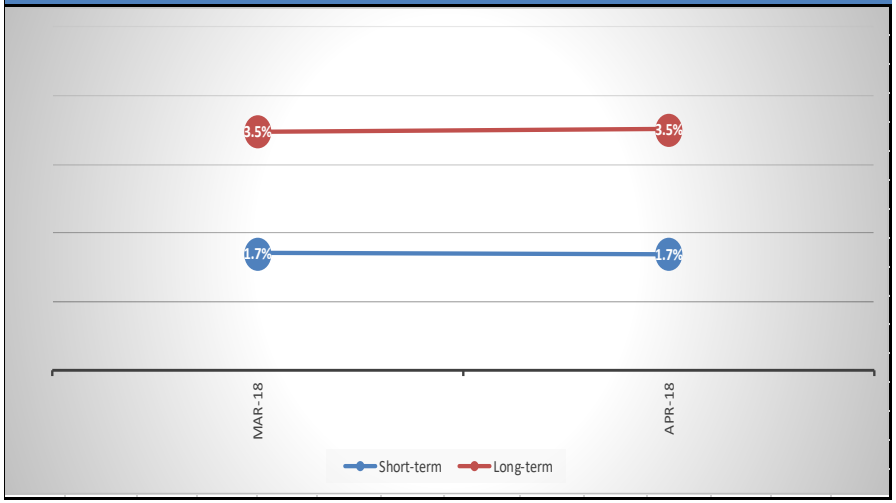
Trust/Sector level
Sickness Absence

SICKNESS



- Trust wide sickness for April remains at 5.2%
- Frontline sickness (non-corporate) has remained at 5.7%.
- Corporate sickness has remained at 3%.

SICKNESS - LONG-TERM V SHORT-TERM

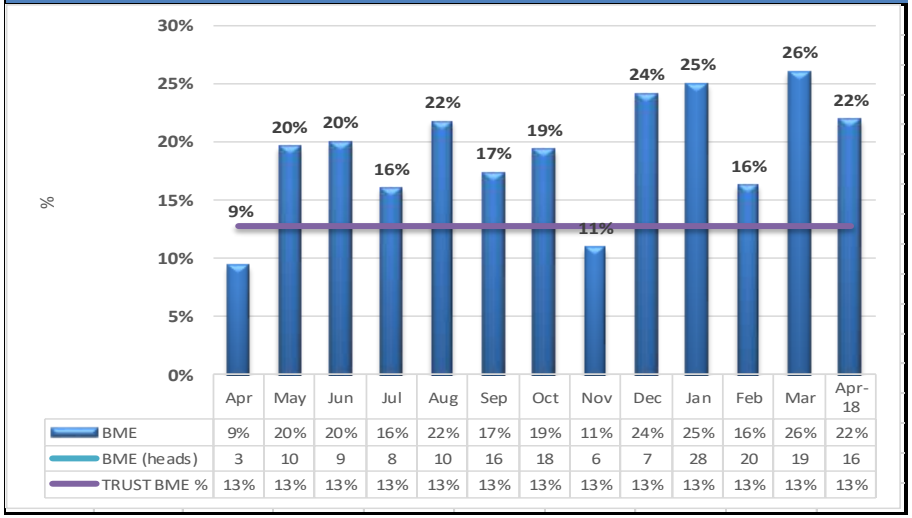


- This graph shows the sickness rate for all staff split by short-term and long-term sickness.
- The LAS 18/19 target for sickness is 5% - 2% short-term, 3% long-term.
- In April, the short-term sickness has remained at 1.7% and the long-term sickness has remained at 3.5%.
- Long-term sickness accounts for 67% of all sickness.

NB. Long-term sickness is any continuous episode of sickness lasting for 28 days or longer.

Workforce Race Equality Standard (WRES)

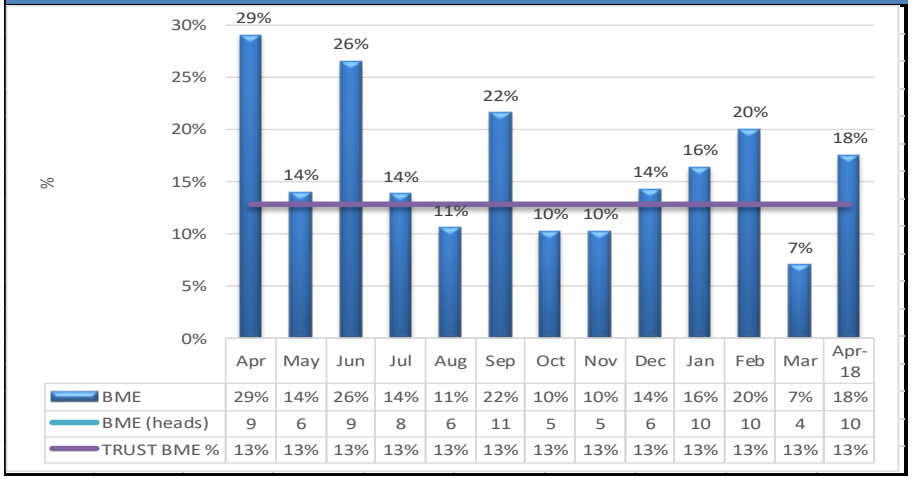
BME STARTERS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-18
BME	9%	20%	20%	16%	22%	17%	19%	11%	24%	25%	16%	26%	22%
BME (heads)	3	10	9	8	10	16	18	6	7	28	20	19	16
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

- As part of the WRES action plan and the People & Culture Strategy we are required to report on our monthly starters and leavers and quarterly on our recruitment and disciplinary data. These show the numbers of BME starters and leavers from April 2017 to March 2018 compared to the current Trust BME profile.
- In April 2018 we had 16 BME starters including 9 paramedics.
- In April we had 10 BME leavers including 4 paramedics.

BME LEAVERS

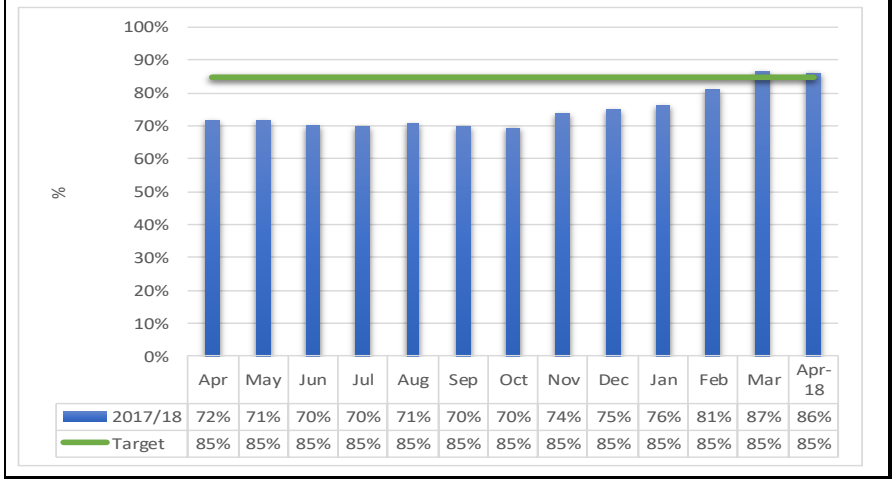


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-18
BME	29%	14%	26%	14%	11%	22%	10%	10%	14%	16%	20%	7%	18%
BME (heads)	9	6	9	8	6	11	5	5	6	10	10	4	10
TRUST BME %	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

- LAS were represented at the Talent BME Inclusion community of practice on the 16th April 2018, both the Head of Talent and Diversity consultant attended. This is led by the NHS London Leadership Academy to help NHS organisations in London to work together on WRES actions.
- The LAS WRES was presented to the Brent CCG Commissioner on the 24th April 2018.
- April saw the LAS represented at a range of recruitment/engagement events including;
- Public Services Careers Day at Wembley Fire Station on 7th April 2018
- London Science Technology Event Wembley on 18th April 2018
- Kennington Job Centre Plus Employers Event 25th April 2018
- The London Jobs Show, Westfield Shepherd's Bush 27th & 28th April 2018
- In preparation for upcoming Interview Skills Workshop being run for BAME staff, the Diversity Consultant has shadowed LAS Paramedic and TEAC interviews

Statutory and Mandatory Training & Appraisals

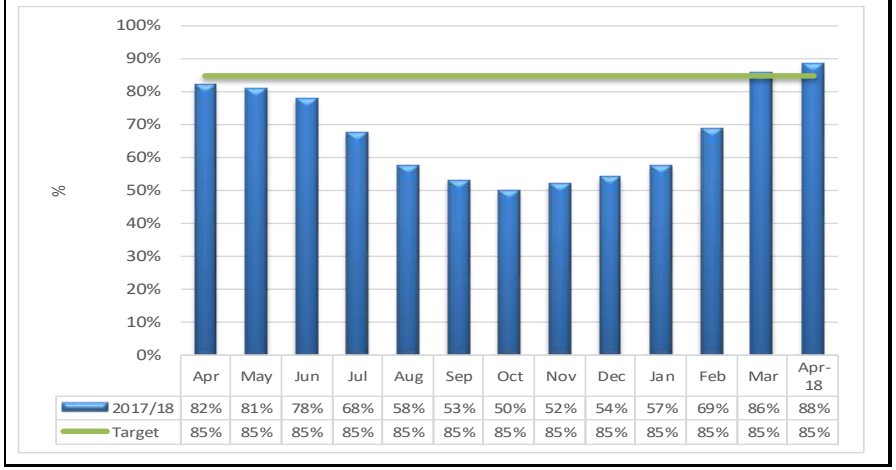
STAT AND MAND TRAINING COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-18
2017/18	72%	71%	70%	70%	71%	70%	70%	74%	75%	76%	81%	87%	86%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- My ESR continues to be a success with over 97.5% of Trust staff accessing the new version of the system which became available to Trusts nationally in May 2017. We continue to have the highest % of users using the new ESR Portal in London (out of 71 Trusts) and we are the 2nd highest % of users nationally. Over 56,000 courses have been completed since go-live.
- Our entry 'ESR Transformation at The London Ambulance Service' has been shortlisted for the Award for 'Best Use of Your ESR' category in this year's Healthcare People Management Association awards which take place on 7th June.
- Trust compliance is 86%, Corporate compliance 90% and Operations is at 85.4%.
- CSR.2017.2 stands at 89% and CSR.2017.3 is at 89%.
- The ESR Project Team are continuing their optimisation phase of ESR Oracle Learning Management with teams across the organisation.

APPRAISAL COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-18
2017/18	82%	81%	78%	68%	58%	53%	50%	52%	54%	57%	69%	86%	88%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

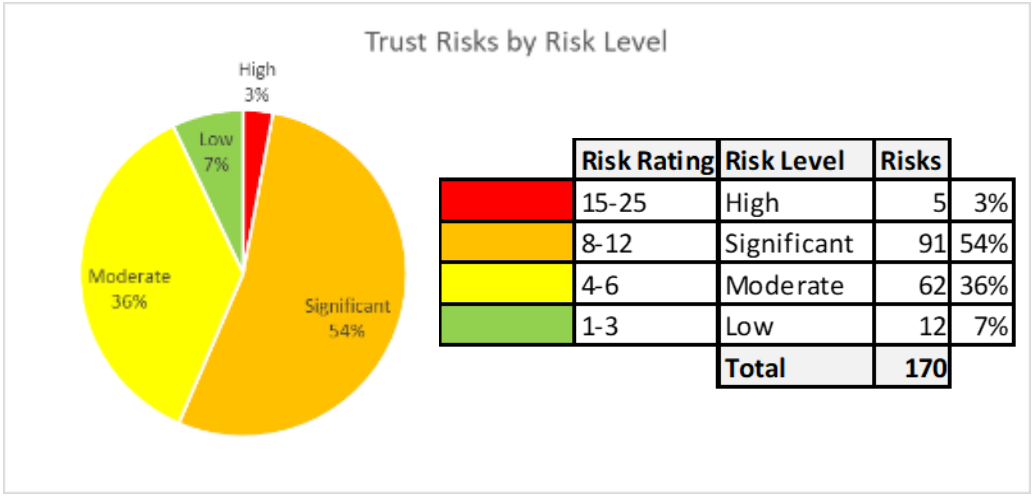
- Appraisal completions were at 88.24% at the end of April and the continued improvements are attributed to the focused collaborative support from across the organisation terms of updating, reporting, monitoring and support.
- The appraisal audit analysis is now underway and a paper outlining the results and any recommendations will be presented by 18th May 2018. PDR Appraisal training for both managers and staff continues to be delivered supporting them with the current PDR Appraisal system. Due to the changes to values/behaviours, temporary changes have been made to paperwork to ensure continuity whilst we are awaiting a new branding template to update all PDR paperwork.
- We are progressing the viability of using MyESR's functionality for eAppraisals with a demo from the MyESR team on 17th May followed by a visit to NHS England on 5th June 2018 who have implemented eAppraisals through ESR across the organisation.

OUR RISKS

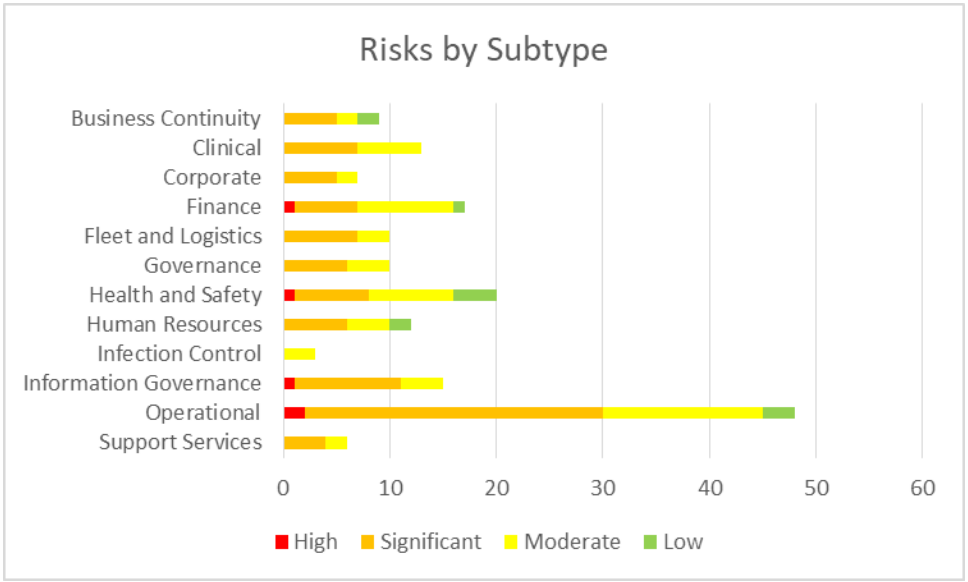
There are 5 risks on the Board Assurance Framework (BAF) and 2 other highly rated risk which are included on the Corporate Risk Register (CRR); Finance and Performance (1), People and Organisational Development (1) IM&T (1), Operational (1), Logistics & Infrastructure (2) and Quality Directorate (1) . The highest risk scores at 16, with the others at 15, 12 and 10. These risks are:

Section	Risks
Finance	BAF 49 – CRR 713 -The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19 – current rating 15.
People and Organisation Development	BAF 47 – CRR 704 - The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo – current rating 16.
IM&T	BAF 45 – CRR 734 - A cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period – current rating 15.
Logistics & Infrastructure	BAF 51 – CRR 767 – Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready, could be vulnerable to market volatility leaving the Trust without a service provider at short notice – current rating 12. BAF 51 – CRR 768 - Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.– current rating 10.
Quality	CRR 677 – Risk of musculo-skeletal injuries to front line staff – current rating 15.
Operations	CRR 706 – Lack of capacity to deliver training through reliability, space and insufficient facilities – current rating 16.

Our Risks



	Risk Rating	Risk Level	Risks	
	15-25	High	5	3%
	8-12	Significant	91	54%
	4-6	Moderate	62	36%
	1-3	Low	12	7%
		Total	**170**	



The register of risks approved showed the following at the 8th May 2018:

- 57% of the Trusts risk register has a risk level of High or Significant.
- 27% of the Trust's risks are operational, Health and Safety risks accounting for 11%, Information Governance risks accounting for 8%, Finance risks accounting for 10%, Clinical risks accounting for 7% and Human Resources risks accounting for 7%.

Top 3 Risks:

BAF Risk 49

The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

BAF Risk 47

The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

BAF Risk 45

There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description
ADO	Assistant Directors of Operations
ARP	Ambulance Response Program
APP	Advanced Paramedic Practitioners
AQI	Ambulance Quality Indicator
BME	Black and Minority Ethnic
CARU	Clinical Audit and Research Unit
MHRA / CAS	Medicines & Healthcare products Regulatory Agency / Central Alerting System
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDLO	Controlled Drugs Liaison Officers
CISO	Clinical Information & Support Overview
CPI	Clinical Performance Indicator
CPD	Continuing Professional Development
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRU	Cycle Response Unit
CSR	Core Skills Refresher (Training)
DBS	Disclosure & Barring Scheme
DOC	Duty of Candour
EAC	Emergency Ambulance Crew
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Dispatcher
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ESR	Employee Service Record
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)
FFT	Friends and Family Test
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale
FRU	Fast Response Unit
GCS	Glasgow Coma Scale
GTN	Glyceryl Trinitrate

Acronym	Meaning / Description
HAC	Heart Attack Centres
HART	Hazardous Area Response Teams
HASU	Hyper Acute Stroke Unit
HCP	Health Care Professional
iPara	International Paramedic
JCT	Job Cycle Time
KPI	Key Performance Indicator
LIN	Local Intelligence Network
LINC	Listening Informal Non-Judgemental Confidential
MAR	Multiple Attendance Ratio
MRU	Motorcycle Response Unit
MTC	Major Trauma Centre
NETs	Non-Emergency Transport
NRLS	National Reporting and Learning System
OOH	Out Of Hours
OWR	Operation Workplace Review
PAS / VAS	Private / Voluntary Ambulance Services
PED	Patient Experiences Department
PGD	Patient Group Directions
PFVH	Patient Facing Vehicle Hours
PRF	Patient Record Form
PSP	Patient Specific Protocol
PTS	Patient Transport Service
QGAM	Quality, Governance and Assurance Manager
QR	Quality Requirement
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
SI	Serious Incident
SIG	Serious Incident Group
STEMI	ST-Segment Elevation Myocardial Infarction
TEAC	Trainee Emergency Ambulance Crew
TRU	Tactical Response Unit
YTD	Year to Date
WTE	Whole Time Equivalent

Integrated Performance Report – Glossary

Other Terminology	Meaning
Green ambulance outcomes	Lower acuity ambulance outcomes

LAS 111 (South East London)			
QR	**Measure**	**Target**	**Description**
	Total calls answered		Number of calls made to 111 and answered by an LAS call handler.
05	Calls answered within 60 seconds	95%	Of the total answered calls, how many were answered within 60 seconds of being queued for an advisor?
04	Calls abandoned after 30 seconds	1%	Of the total calls offered and reaching 30 seconds following being queued for an advisor, how many did the caller hang up before they were answered?
	Calls referred to a clinical advisor		Of the total answered calls, what percentage were directly triaged by a clinician during their 111 episode?
	Of calls transferred, percentage transferred warm		Of the total answered calls that were transferred to a trained 111 clinical advisor, how many were transferred while the caller was on hold?
13	Of call backs, percentage within 10 minutes	100%	Of the total calls where person was offered a call back by a 111 clinician, for how many was the person actually called back within 10 minutes of the end of their first call?
10	Calls referred to 999	10%	Of the total number of calls answered, what were the number of final dispositions that result in an ambulance being dispatched?
11	Calls referred to Emergency Department	5%	Of the total calls received and triaged by a 111 call handler or clinician, how many were referred to a type 1 or 2 A&E department?

Other London 111 service provider	Areas Covered
London Ambulance Service (LAS)	1. South East London
Care UK	1. Hillingdon, 2. North West London
Partnership of East London Co-operatives (PELC)	1. East London & City. 2. Outer North East London
London Central & West (LCW)	1. Inner North West London, 2. North Central London
Vocare	1. Croydon, 2. Wandsworth, 3. Sutton & Merton, 4. Kingston & Richmond

London Ambulance Service NHS Trust

Assurance report:	**Finance and Investment Committee**	**Date:**	**23/05/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**24/05/2018**
Presented by:	**Fergus Cass, Non-Executive Director, Finance and Investment Committee Chair**	**Prepared by:**	**Fergus Cass, Non-Executive Director, Finance and Investment Committee Chair**

Matters for escalation:

- The framework for developing, monitoring and reporting of the Cost Improvement Programme (CIP) is in place. Only £2.9m out of £12.3m is now regarded as "high risk". Certain projects will deliver less than expected and alternative schemes are being developed. There is some slippage in project initiation. Using the monitoring system, future meetings of the Committee will focus in depth on projects that are off track and will hear reports from the managers responsible. Recruitment and procurement are seen as the most critical enablers.
- Work is progressing on the Five Year Financial Plan. In the next stage, known efficiency opportunities from 2019 onwards will be confirmed so that gaps can be identified and a response developed.

Other matters considered:

- Finance, Cash Flow and Capital Expenditure reports for April were reviewed. The financial position is £0.2m ahead of plan, cash balances are £1.7m below plan due to the timing of receipts and payments, and capital expenditure is £1.0m behind plan.
- It was noted that a bid for £8.5m has been submitted to obtain funding for fleet investment that will support delivery of the ARP targets.
- Technical releases were noted: there are no new significant matters.

Key decisions made / actions identified:

- Modeling assumptions and milestones for the Five Year Financial Plan were reviewed; these are in line with national guidance.
- The process and programme of work relating to business cases was noted. It was confirmed that investment proposals will come to the Committee in line with Standing Financial instructions.

	• The forward plan for the Committee was agreed. • Discussion of the form and content of the integrated performance report was postponed pending further review by ELT.
Risks:	• It is proposed that Risk 49, relating to delivery of the 2018/19 CIP of £12.3m, should remain on the BAF. • As part of the risk management process, assumptions will be finalised relating to how the ARP performance targets will be met and what resources, both human and financial, will be required to deliver them. • The Committee reviewed other financial risks and will continue to monitor them. They mainly comprise: reduced income due to lower activity than planned; delivery of CQUINs totaling £8m; and the agency spending limit of £5.9m which, if breached, would cost £2.7m of STF funding. • Mitigations are being developed and include reserves of approx £4m.
Assurance:	As noted, the Committee reviewed financial performance, cash flow and capital expenditure to the end of April. It discussed the reasons for variances from plan. It noted that there was a significant deficit in the month (£1.3m), due to seasonal factors affecting the timing of income and expenditure but that this was £0.2m better than plan. On the basis of the financial reports and the explanations provided it concluded that the financial targets for the year remain achievable. The risks, mitigations and reserves will be kept under close review.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	14			
Report Author(s):	Frances Field, Risk and Audit Manager			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Leadership Team and Board Assurance Committees			
Status:	☐	Assurance	☐	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This paper provides the ELT with an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

Recommendation:

The ELT members are asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

This paper sets out the content of the BAF and the CRR.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒

Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Board Assurance Framework (BAF)

Current BAF Risks

1. There are currently five risks on the BAF, three of which have a net rating of 15 or above, they are set out below in descending order of severity.

Severity	Risk	Risk Owner	Scrutinising Committee	Comments
1	**BAF Risk 49** The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 2018/19.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	
3	**BAF Risk 47** The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre (EOC).	Patricia Grealish, Director of People and Organisational Development	People and Organisational Development Committee	
4	**BAF Risk 45** A cyber-attack could materially disrupt the trust's ability to operate for a prolonged period.	Ross Fullerton, Chief Information Officer	Logistics and Infrastructure Committee	
5.	**BAF Risk 51** Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	Benita Mehra, Director of Assets and Property	Logistics and Infrastructure Committee	
6.	**BAF Risk 50** The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	Benita Mehra, Director of Assets and Property	Logistics and Infrastructure Committee	

Risk discussions in May

Board Assurance Committees

2. The Executive Leadership Team (ELT) last reviewed the BAF and CRR at its meeting on 16 May 2018. At this meeting it was agreed that no further changes to the BAF should be proposed at the current time.

3. As reported to the Board at its meeting on 24 April 2018, it is anticipated that BAF Risk 50 (The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room) will soon be de-escalated as a result of business continuity planning activity that has taken place, it is proposed that this should be discussed by the Logistics and Infrastructure Committee at its meeting on 05 June 2018 before any such recommendation is made to the Board.

4. In a risk horizon scanning discussion, the ELT noted that a further possible risk to be considered by the Logistics and Infrastructure Committee at its next meeting:

    - Delivery of the Secure Drugs Rooms project.

Corporate Risk Register

Highly-rated CRR risks not included on the BAF

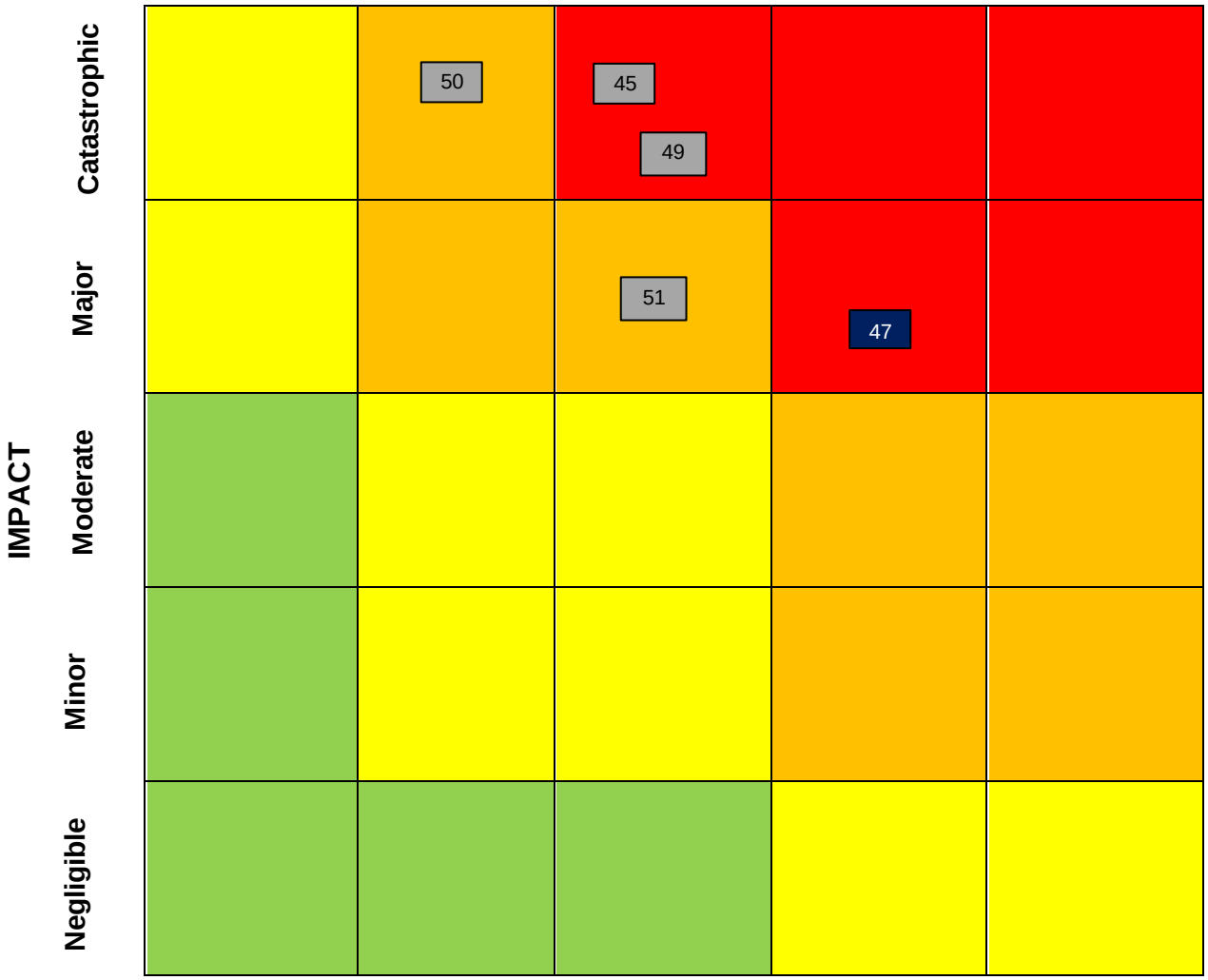
5. The following two risks currently have a rating of 15 or greater and are not included on the BAF:

    - Datix ID 706 – Lack of capacity to deliver training through reliability, space and insufficient facilities.

    - Datix ID 677 – Risk of musculoskeletal injuries to frontline staff due to:
        - 1) the frequency of lifting and handling activities involved during the care and treatment of patients
        - 2) The need to undertake manual handling activities in uncontrolled and difficult environments.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – May 2018



In order of severity:

BAF Risk 49
The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

BAF Risk 47
The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo.

BAF Risk 45
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

BAF Risk 50
Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.

Proposed for removal from the BAF

BAF Risk 51
Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice

Risk Severity

- High Risk (15-25)
- Significant Risk (8-12)
- Moderate Risk (4-6)
- Low Risk (1-3)

Key

- Net risk rating
- Gross risk rating = net risk rating

GOAL 1	**Provide outstanding care for our patients**

DELIVERABLE	1. We will deliver the key deliverables in our Quality Plan for 2018/19 to improve patients' experience and quality of care for patients using our service. 2. We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards. 3. We will continue the roll-out of our urgent care Advanced Paramedic Practitioner service across all five STP areas to improve patient care and reduce the need for patients to go to hospital and develop a new paramedic practitioner role. 4. We will complete our new five-year strategy document and publish new or revised 'daughter documents' containing detailed plans on how we will deliver it. 5. We will pilot the new 'Pioneer Services' set out in our new strategy. 6. We will implement a 'frequent caller plan' to improve the care we provide those patients to better meet their needs and reduce the impact of their calls on our wider patient response times. 7. We will continue to improve the quality and security of our drug management through the roll-out of our Secure Drugs Room project, primary response bags, vehicle based drugs pack, internal order drug system and enabling applications. 8. We will improve the quality of care we deliver to patients and our work with partners across the system by introducing new capability that builds on the roll out of iPads to our front-line clinicians.

Links to Deliverables	BAF Risk	**Further mitigation required**

GOAL 2	**Be a first class employer, valuing and developing the skills, diversity and quality of life or our people**
DELIVERABLE	9. We will complete our recruitment plan to fully establish our front-line and newly enlarged Emergency Operations Centre structures. 10. We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate,. 11. We will embed our new Vision, Purpose, Values and Behaviours (set out in our new strategy document) across the organisation and fully align our competencies to the employee journey at LAS in: recruitment, promotion, training and development and appraisals. 12. We will complete action plans across all functional and operational areas of the business to respond to the key issues identified in the 2017 Staff Survey and implement the planned actions in time for the 2018 Staff Survey. 13. We will continue to deliver our Workforce Race Equality Standard (WRES) Action Plan, together with other measures, to improve diversity, inclusivity and equality across all areas of the organisation. 14. **We will continue to implement our Clinical Education Strategy.** 15. **We will develop and roll-out training and development for all our people across functional and operational teams.**

Links to Deliverables	BAF Risk	**Further mitigation required**
9, 10	47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo.	• Consideration to be given to an additional recruitment campaign. • Continuation of the project meetings to maintain the level of scrutiny required by the service. • Continuation of the support offered to recruitment for shortlisting, assessment space and

GOAL 3	Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London	**DELIVERABLE**	16. We will continue to work with our commissioners and STP partners to lower demand, improve access to, and use of, Appropriate Care Pathways (ACPs) and lower overall conveyance to Emergency Departments, developing the use of technology to provide faster access to patient care through digital means where appropriate. 17. We will mobilise the North East London Integrated Urgent Care (111) contract and continue to seek a greater role in the London-wide integration of access to emergency and urgent care, including retaining the South East London 111 service. 18. We will work closely with London acute hospital trusts, NHSI and NHSE to further reduce delays to patients and our crews at hospitals, especially during times of peak pressure on the wider system (e.g. during periods of high demand such as adverse weather). **19. We will work closely with other emergency services and partners (e.g. the Greater London Authority family and London's boroughs), fulfilling our statutory obligations to collaborate, innovate and maximise the efficiency of our combined public service provision.**

Links to Deliverables	BAF Risk	**Further mitigation required**

GOAL 4	**Provide the best possible value for the tax paying public, who pay for what we do**

DELIVERABLE	20. We will deliver our control total and maintain our use of resources rating with NHSI. 21. We will deliver Cost Improvement Programme (CIP) efficiency savings of £12.3m in 2018/19 and develop a programme of further efficiencies to inform our business planning for 2019/20 and 2020/21. 22. We will complete the review of business resilience across the organisation and implement measures to effectively manage risk and ensure the continuity of our services during times of disruption, including GDPR compliance and Cyber risk assurance. 23. We will manage and deliver our proposed capital programme of £15.5m to support the delivery of our overall strategic objectives. **24.** We will ensure the delivery of our agreed CQUIN's (as agreed with our core contract commissioners) to improve the quality and value of the services we provide on their behalf.

Links to Deliverables	BAF Risk	Further mitigation required
20, 21, 23, 24	49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19	• Review Finance structure and prepare case to Trust Board to enable business partnering support • Establish a process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme
22	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• NHS Digital led review of LAS cyber security (November 2017) • Implementation of recommendations from PA Consulting report • Implementation of HMG good practice in cyber controls • Introduce scenario planning and rehearsals for response to a major cyber- attack on LAS
22	50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room	• A project has been set up to manage the replacement of the UPS. End point to be defined for the project which will result in the replacement of the UPS.

PROPOSED TO BE REMOVED FROM THE BAF

22	51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	• We are developing a tender for services which we will be taking to market in the next four months.

BAF Risk no. 49 The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee
Date risk opened: 17/011/2017	**Date risk expected to be removed from the BAF:** September 2018	

Underlying Cause/Source of Risk:

1. Unknown Target Operating Model.
2. Size of and pace of delivery of recurrent CIPs will need to increase - need to be driven by evidence-based, relevant benchmarking metrics in order to achieve full efficiency opportunity.
3. Need for appropriate programme approach/resource to deliver efficiency projects.
4. Up until 2017/18, the LAS operated within a block contract and fixed income financial envelope and has been in special measures over the last year, with the result that priority could not be given to developing financial and commercial awareness of budget holders to develop a devolved service level management model in line with the norm in other NHS organisations, which will accelerate delivery of value improvement. 5. Instead, budget control has largely been achieved through central management and contingency accounting so need to develop more mature financial framework and capability for budget delivery. 6. The Trust has delivered only £6m of the £17.8m CIP recurrently in 17/18 due to insufficiently robust governance and project management capability.

Gross Rating	Current/Net Rating	Target Rating
25	15	10

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process.	1. Trust Board and FIC finance reports 2. Capital Programme action plans 3. Detailed review of budget by CEO and CFO has reduced headline CIP from £18.6m (5.3%) to £12.3m (3.2%) 4. Contract has now been agreed within the financial plan envelope but needs to be signed	1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency). 3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impact assessment on Quality and Performance as part of Business Planning 5. Design and confirm programme resource budget to deliver strategic intent Yr 1 enablement, service development, business process improvement and efficiency programme. 6. Establish programme management office 7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy.	31/07/18 Completed Completed Completed Completed Completed Completed 31/08/18 31/05/18

		9. Complete initial QIA and risk rating on CIP performance and keep under review monthly.	
Signed: Lorraine Bewes			

BAF Risk no. 47 The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre at Bow and Waterloo

Risk Classification: People & OD	**Risk Owner:** Patricia Grealish	**Scrutinising Committee:** People & OD Committee
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF 31/10/2018**	

Underlying Cause/Source of Risk:
Recruitment: Competition for similar roles is strong and offer higher salaries (in the vicinity of HQ and Bow). Retention: The working environment in control rooms is frequently pressurised and staff turnover is high compared to other roles in the Trust

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. A monthly EOC Board tackles underlying causes of recruitment and retention, with a weekly call update to ensure progress is being made. This meeting is chaired by the Deputy Director of Operations (Control Services). 3. The existing recruitment process has been discussed and reviewed to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment function to ensure specialist knowledge in the recruitment team to allow good decisions on passing candidates through the shortlisting process. 7. A range of recruitment activities throughout Q1 will specifically target recruitment to EOC. 8. EMDs have been released to support job fairs to promote the role. 9. EMDs support EOC Training team delivering Open Evenings for potential candidates interested in joining 10. EOC are participating in the ongoing Talent Review which will look at the end to end process and identify improvements / gaps. 11. The team are currently looking at an alternative online assessment (NWAS currently use this approach) and will look to pilot a scheme should it prove affordable and of value 12. ELT task and finish group to bring focus and decision-making to challenges. 13. EOC restructure to commence May 2018, full completion September 2018. **Gaps in controls** None identified.	1. Monthly recruitment meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support from PLM, Control Services 4. Recruitment activity added to weekly tracker reported to Operational Resourcing Group (Chaired by Director of Operations, deputy chair Director of People and OD). 5. Online assessment project now live.	1. The END Role will be included as part of planned recruitment campaign. 2. Meet relevant people at Met Police to share and establish best practice and mutual ways of working. 3. Review feasibility of online assessment for EOC recruitment and run pilot. 4. EOC Recruitment Project Meetings are taking place. 5. Allocate appropriate resource to interview and assessment activities. 6. To plan and roll out the EOC restructure, including incentives to address retention.	Completed Completed Completed 31/10/2018 Completed 30/10/2018

Signed:	Patricia Grealish

BAF Risk no. 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period

Risk Classification: IM&T	**Risk Owner:** Ross Fullerton	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 01/06/2017	**Date risk expected to be removed from the BAF:** ongoing	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
The changing sophistication and nature of cyber threats has accelerated rapidly in recent years; cyber-attacks are regularly successful at disrupting many organisations in ways that weren't considered possible only a short time ago. This is compounded by an under-investment in IT security at LAS over the same time frame. As a consequence there is a deficiency in the overall awareness of cyber risk inside and outside of IM&T and we lack the skillsets, processes, governance and tools to mitigate the evolving threat profile effectively.	20	15	10

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
In mid-2017 the LAS identified that insufficient attention had been paid to information security. This risk was created at that time which has since been re-baselined (May 18) to reflect improvements delivered and the current state. **Existing Controls** • A managed cyber service from Cognita • Remediation of specific gaps in controls and overly restrictive security services. • Programme of audit and remediation to obtain the Cyber Essentials accreditation • Procurement of improved network technologies for implementation in 2017-18 **Gaps in Controls** • Flat internal network structure – with little segregation and overly-permissive access. • No modern defence to a DDoS attack • An Intrusion detection system which is end of life. • Lack of real-time intelligence on vulnerabilities and threats. • Outdated security approaches to support mobile working, information access and cloud adoption. • Inadequate management of user accounts.	**Assurance of Controls** 1. Reports to quarterly Information Governance Group and monthly M&T Performance review of cyber-related KPI performance and incidents. 2. Reports of work carried out as part of the Cyber Programme reported to the IGG and RCAG and LIA. 3. Ongoing monitoring and reporting of our compliance to NCSC Cyber Essentials framework. 4. Annual NHS IG Toolkit review **Gaps in Assurance** • Lack of real-time intelligence on vulnerabilities and threats to support decisions and reporting. • Cyber programme activity is not governed and reported as part of the Trust Programme framework. • NCSC Cyber Essentials accreditation is insufficient moving forward.	1. Obtain financial approval for Phase 2 of the Cyber programme into 2018/19. to mitigate gaps in controls and enable secure mobile working. 2. Incorporate the CyberProgramme in the Trust Programme farmework (IM&T essentials) 3. Implement Phase 2 of the Programme 4. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS 5. Initiate an IM&T Project to improve management of user accounts 6. Deliver the IM&T Project to improve management of user accounts 7. Deliver a solution to provide improved intelligence on vulnerabilities & threats to support decisions and reporting. 8. Agree the scope and level of future accreditation appropriate for the Trust. 9. Produce a plan to achieve the proposed accreditation.	16/05/18 16/05/18 17/05/19 31/05/18 04/06/18 16/12/18 17/05/19 31/08/18 31/10/18

Signed: Ross Fullerton

BAF Risk no. 50 The main power supply to Bow is lost as a result of UK Power Networks having a failure on their system impacting on our ability to provide a continuous service to our control room

Risk Classification: Strategic Assets and Property	**Risk Owner:** Benita Mehra	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 20/02/2018	**Date risk expected to be removed from the BAF:** June 2018	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
Existing UPS is undersized for the demand requirement in the building	**15**	**10**	**5**

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Reduction in UPS dependence by transfer of demand to non-essential supply (where possible). 2. Maintenance of existing UPS equipment. 3. Design of new provision and purchase of upgrade equipment. 4. Engagement with UKPN to mitigate risks associated with essential network repairs or known service interruptions. 5. Schedule of OP66 events (2018) - 17/04, 19/06, 07/08, 24/10.	1. Ongoing monitoring of UPS demand. 2. No degradation of service experienced during unplanned network power outage (18/02/18). 3. UPS maintenance contract in place. 4. Generator maintenance and test schedule in place. 5. Regular Project Group meetings.	1. Project team in place to investigate/manage upgrade project and identify window for upgrade works. 2. Ongoing investigations to consider interim repairs. 3. IM&T migration programme to Cloud based services. 4. Development of EOC Business Continuity Plan.	In place May 2018 Sept 2018 In progress

Signed: Benita Mehra

Proposed to be removed from the BAF

BAF Risk no. 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice		
Risk Classification: Strategic Assets and Property	**Risk Owner:** Benita Mehra	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 20/02/2018	**Date risk expected to be removed from the BAF**: June 2018	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
1. External influences to the market volatility affective service provider's ability to function.	**16**	**12**	**4**

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Business continuity plan is in place which includes Legal and People and OD feedback.	1. The business approach is being discussed with NHSI and the Cabinet Office bi weekly.	1. We are developing a tender for services which we will be taking to market in the next four months.	June 2018

Signed: Benita Mehra

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
706	Lack of capacity to deliver training through reliability, space and insufficient facilities This has been through age, fair wear and tear.	27/10/2017		20	High	Future space requirements are being considered as part of the Estates strategy. The current lease is being extended until December 2019 due to being unable to identify an appropriate alternative location and, also, due to the pressures on IM&T to support the move. IM&T also operate within the site and, again, would have required alternative space provision. A formal specification of EOC training requirements is to be created and alternative locations to be identified. To accommodate lead times for a relocation to new premises, a new location will need to be identified and agreed by August 2019.	Bewes, Lorraine	06/04/2018	16	High	An agreement to draw up and present a business case. Support in the location of a future proof and appropriate venue that suits both training and supports meeting room and CAD team support	DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downard aware and supportive of the urgent review of premises and continued co-located situation.	4	Moderate
704	The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centres at Bow and Waterloo.	17/11/2017	47	16	High	1. Weekly EOC Recruitment Group meets to discuss and tackle all matters of recruitment and retention. 2. A monthly EOC Board tackles underlying causes of recruitment and retention, with a weekly call update to ensure progress is being made. This meeting is chaired by the Deputy Director of Operations (Control Services). 3. The existing recruitment process has been discussed and reviewed to ensure that re-entry of candidates is not unreasonably blocked. This will be kept under ongoing review. 3. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 4. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 5. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 6. Shortlisting training and delivery being provided to support the recruitment function to ensure specialist knowledge in the recruitment team to allow good decisions on passing candidates through the shortlisting process. 7. A range of recruitment activities throughout Q1 will specifically target recruitment to EOC. 8. EMDs have been released to support job fairs to promote the role. 9. EMDs support EOC Training team delivering Open Evenings for potential candidates interested in joining. 10. EOC are participating in the ongoing Talent Review which will look at the end to end process and identify improvements / gaps. 11. The team are currently looking at an alternative online assessment (NWAS currently use this approach) and will look to pilot a scheme should it prove affordable and of value 12. ELT task and finish group to bring focus and decision-making to challenges. 13. EOC restructure to commence May 2018, full completion September 2018.	Grealish, Patricia	11/05/2018	16	High	1. The END Role will be included as part of planned recruitment campaign. 2. Meet relevant people at Met Police to share and establish best practice and mutual ways of working. 3. Review feasibility of online assessment for EOC recruitment and run pilot. 4. EOC Recruitment Project Meetings are taking place. 5. Allocate appropriate resource to interview and assessment activities. 6. To plan and roll out the EOC restructure, including incentives to address retention.	1. Monthly recruitment meetings to review the ongoing status - Headed up by DDO, Control Services 2. Weekly reports sent through to PLM, Control Services. 3. Daily contact with Recruitment EMD lead during first weeks for support from PLM, Control Services 4. Recruitment activity added to weekly tracker reported to Operational Resourcing Group (Chaired by Director of Operations, deputy chair Director of People and OD). 5. Online assessment project now live.	8	Significant
713	There is a risk that... The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19.	17/11/2017	49	25	High	Robust CIP governance process being implemented for 17/18, including quality impact assessment process using performance management cycle framework and dedicated CIP support from PMO (benefits manager) and Finance; Robust Capital Programme governance process being implemented for 17/18 including benefits realisation process.	Bewes, Lorraine	11/05/2018	15	High	8. Develop budget and business case training programme as part of Trust Management Development programme to support financial strategy. 5. Design and confirm programme resource budget to deliver strategic intent Yr 1 enablement, service development, business process improvement and efficiency programme. 6. Establish programme management office 7. Review Finance structure and prepare case to Trust Board to enable business partnering support. 2. Confirm priority Trust improvement plan for 18/19 for patient outcomes, people capability and use of resources (business process efficiency). 3. Complete benchmarking process for identifying additional opportunities for efficiency improvement and development of an evidence-based strategic multi-year savings programme. 1. Confirm target operating model, demand & capacity plan, workforce plan and budgets for next 3 years. 4. Set Cash Limited Budget for 18/19 with appropriate triangulation of delivery risk and impect assessment on Quality and Performance as part of Business Planning	1. Trust Board and FIC finance reports 2. Capital Programme action plans 3. Detailed review of budget by CEO and CFO has reduced headline CIP from £18.6m (5.3%) to £12.9m (3.64%)	10	Significant
734	There is a risk that a cyber-attack will materially disrupt the Trust's ability to operate for a prolonged period.	14/12/2017	45	20	High	In mid-2017 the LAS identified that insufficient attention had been paid to information security. This risk was created at that time which has since been re-baselined (May 18) to reflect improvements delivered and the current state. Existing Controls • A managed cyber service from Cognita • Remediation of specific gaps in controls and overly restrictive security services. • Programme of audit and remediation to obtain the Cyber Essentials accreditation • Procurement of improved network technologies for implementation in 2017-18 Gaps in Controls • Flat internal network structure – with little segregation and overly-permissive access. • No modern defence to a DDoS attack • An Intrusion detection system which is end of life. • Lack of real-time intelligence on vulnerabilities and threats. • Outdated security approaches to support mobile working, information access and cloud adoption. • Inadequate management of user accounts.	Fullerton, Ross	11/05/2018	15	High	1. Obtain financial approval for Phase 2 of the Cyber programme into 2018/19. to mitigate gaps in controls and enable secure mobile working. 2. Incorporate the CyberProgramme in the Trust Programme farmework (IM&T essentials) 3. Implement Phase 2 of the Programme 4. Introduce scenario planning and rehearsals for response to a major cyber attack on LAS 5. Initiate an IM&T Project to improve management of user accounts 6. Deliver the IM&T Project to improve management of user accounts 7. Deliver a solution to provide improved intelligence on vulnerabilities & threats to support decisions and reporting. 8. Agree the scope and level of future accreditation appropriate for the Trust. 9. Produce a plan to achieve the proposed accreditation.	Assurance of Controls 1. Reports to quarterly Information Governance Group and monthly M&T Performance review of cyber-related KPI performance and incidents. 2. Reports of work carried out as part of the Cyber Programme reported to the IGG and RCAG and LIA. 3. Ongoing monitoring and reporting of our compliance to NCSC Cyber Essentials framework. 4. Annual NHS IG Toolkit review Gaps in Assurance • Lack of real-time intelligence on vulnerabilities and threats to support decisions and reporting. • Cyber programme activity is not governed and reported as part of the Trust Programme framework. • NCSC Cyber Essentials accreditation is insufficient moving forward.	10	Significant

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
677	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments. In 2017/18, 558 out of the 3327 health and safety incidents reported on Datix related to manual handling incidents. 523 of the incidents reported resulted in low/moderate harm. 127 of the 220 incidents reported as RIDDOR were due to manual handling injuries. The impact of this risk includes: 1. Moderate/severe harm to staff. 2. Staff injury claims. 3. Impact on patient care and the delivery of services due to staff absences/shortage of resources. 4. Damage to organisational reputation. 5. Potential breach of statutory duty. 6. Litigation and increased financial costs from claims and compensation.	20/09/2017	47	15	High	1. Manual Handling Group in place – Chaired by a DDO. 2. Manual handling policy implemented across the Trust. 3. Awareness training provided to all front line staff during their Corporate Induction to the Trust. 4. Monitoring of incidents, trends and compliance undertaken by the Corporate Health and Safety Committee. 5. Small handling kits available on all vehicles to aid the easy handling of patients. 6. Specialist MH equipment e.g. Manger Elk, trolley beds, Ferno Tracked Carry Chairs e.t.c are available to all front line staff. 7. Trust-wide incident reporting and management system in place through Datix. 8. Additional support available for staff where they are unable to safely lift a patient or equipment. 9. Risk assessments has been completed for high risk manual handling activities. 10. TOR for Manual Handling Group has been finalised and agreed. The group does not currently report to any of the Trust's high level committees. 11.Manual Handling policy has been updated and agreed. 12. Business case to replace all version 1 Mangar Elk lifting equipment has been approved and orders been placed. 13. The provision of practical manual handling training commenced in April 2018. This training now forms part of the mandatory/statutory training for frontline/operational staff.	Bain, Trisha	04/05/2018	15	High	4. H&S Department to monitor the effectiveness of arrangements implemented to reduce the number of incidents relating to failure of medical equipment such as track chairs/mangar elks/tail lifts. 2. Audit the availability and use of small handling aids kit by frontline/operational staff. 3. Review of current Datix incident categories to ensure these accurately capture/reflect incidents reported. 4. Deliver practical manual handling refresher training to all frontline operational staff during CSR 1 of 2018/19. 6. Send Manual Handling policy to PMAG for approval. 5. Ensure arrangements are in place to deliver practical manual handling training to staff in support services such as IM&T, Fleet, Logistics e.t.c. 6. Fleet & Logistics to commence the process for purchasing/replaceing all version 1 Mangar Elk equipment. 1. Review of Trust TNA and clinical education training plan to reflect practical MH training frequencies for all staff involved in undertaking MH tasks (including Estates, Fleet & Logistics).	1. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group. 2. Review and oversight by Manual Handling steering group.	9	Significant
430	There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.	08/12/2006	7	20	High	1. Daily focus to place MRU/CRU/TRU/HART and APPs on rest break during rest break window 2. Current target in place for 25 DCAs per hour of rest break window to be placed on rest breaks per 12 hour shift 3. Management and escalation of staff who actively avoid having a rest break 4. Parallel work in progress to protect end of shift times to avoid late jobs (as reasonably possible) 5. Robust implementation of the existing rest break policy 6. On-going rigorous management of out of service.	Woodrow, Paul	09/04/2018	12	Significant	757 - Out of Service (OOS) Hub implemented. Central Support Unit (CSU)on PD33 deals with all OOS requests. Recruit additional frontline staff. Review management and EMD capacity within EOC. Agree the new rest break policy with Trade Unions. Current rest breaks arrangements to be reviewed. Update skill mix model. An end of shift working group which includes trade union representatives commenced in early January and will publish its plan in April 2018. The Rest Break Compliance Group is aiming to develop an automated function through NG (the CAD provider) so that rest breaks (on and off station) can be recorded at the touch of a button and mitigate any under recording. Implement new rest break policy Current rest break arrangements to be robustly applied. Out of service HUB implemented Agree the process for the rest break arrangements to be implemented. Recruiting frontline staff to 3169 by March 2016. Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015. Increase rest break window to allow more time for the allocation of breaks Move 5 identified DCAs per hour and per sector onto an 'out of service' code so that it is only possible for them to be interrupted for a Category 1 call. Identify 15 - 30 ambulances to provide extra DCA shifts between 11:00 and 23:00 hours (bridging shifts) so that additional cover is in place over the rest break window to protect the allocation of breaks Launch a robust communications strategy for internal and external parties which will explain the rationale for changes being implemented from 1 February 2018 Development of a clear clinical safety process to support dispatch staff at times of reduced DCA availability. Formal review of the number of rest breaks/flexible breaks taken with the Director of Operations, Director of People and Organisational Development and trade unions. Commence operational roster review. Implement new rest break policy. On-going rigorous management of out of service.	1. Re-focused DDS desk within EOC to allocate rest breaks 2. Rest break dashboard developed to give oversight of compliance and performance 3. KPIs in place to monitor rest break allocation as part of the Quality Improvement Plan KPI report 4. Monthly updates provided to the Operations Board on progress and compliance 5. Rest break allocation rates are reviewed at Chief Executive performance reviews 6. A task and finish group which includes executive directors, control services managers and medical directorate representatives are monitoring rest break allocation rates and have agreed the actions which are due to be delivered by 1 February 2018. 7. An operational roster review has commenced with ten stations due to go live with new rosters in September 2018 with the following 8 group stations going live in March 2019.	8	Significant
630	We do not have enough qualified Driving Instructors to train the amount of new entrant staff that we employ in emergency response ambulance driving. This has a significant impact on the Trust's Cost Improvement Programme, by having to fund the provision of external Driving Instructors at a representative monthly cost [December 2017] of £57,118, exclusive of VAT. The Trust can also not be assured that driving standards can be maintained, as we do not have enough capacity to provide a regular review programme.	11/05/2017		20	High	Depending on budgetry constraints, we are able to fund the provision of external driving instructors. We are currently developing six clinical Tutors. We have some previous departmental DI trained staff working for us on an occasional basis.	Ivanov, Tina	03/05/2018	12	Significant	Source DI / tutor job description Advertise additional DI tutor posts Recruit to six driving instructor positions. Complete JD banding for Driving Instructor Role	The risk and controls relating to it will be reviewed at the monthly Risk Review meeting. External providers are regualrly communicated with to ascertain the ability to cover current and future requirements. The long-term strategy will be discussed at the senior mangement team meetings.	1	Low
676	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust. The independent review of Trust-wide health and safety compliance conducted in June 2017 highlighted areas of non-compliance some of which are listed below: 1. Lack of arrangements to clearly identify, assess and manage significant risks associated with manual handling, lone working and driving. 2. Outstanding actions from the HSE Improvement Notice issued to the Trust in 2010. 3. Lack of arrangements to effectively manage human factors associated with alcohol, drugs, fatigue or night work and their impact on HS&S performance. 4. Lack of clearly defined management systems. 5. Limited verification that controls or training are effective. 6. Limited performance reporting, monitoring or clear governance arrangements.	20/09/2017	46	20	High	1. Corporate Health and Safety Committee meeting structure in place. 2. Dedicated Health and Safety Department to support the Trust, and to ensure compliance with Health and Safety requirements. 3. Health and safety policies and procedures are in place to support staff and provide guidance on Trust-wide arrangements to maintain safety. 4. Health and safety related training provided to all staff during induction to the Trust and on an ongoing basis. 5. Medical equipment and PPE are available and provided to all staff. 6. Trust-wide incident reporting and management system in place through Datix. 7. ELT/Board oversight for H&S compliance through the Trust's committee reporting structure. 8. Regular update reports are provided for Trust-wide committees. 9. Responsible Director for Health and Safety in place for the Trust. 10. Regular reporting of H&S action updates through the monthly Quality Report, Quarterly Health and Safety Committee and the Quality Oversight Group. 11. Senior Management Level H&S Training completed by ELT/Board Members. 12. Health & Safety Strategy agreed by the Board. 13. Non Executive Director appointed for Health & Safety. 14. H&S compliance review undertaken in March 2018 and it highlighted significant improvements in compliance. 15. H&S Training provided across the Trust reviewed and re-written to ensure the training provided is relevant and reflects current legislative requirements.	Bain, Trisha	04/05/2018	12	Significant	Ensure the robust implementation of all actions and recommendations identified by the independent review (NB: Independent review action plan contains 59 actions managed seperately). Conduct review of H&S compliance during Q4, 2017/18 in order to assess progress with Trust-wide H&S Performance. Agree Terms of Reference for the Corporate Health and Safety Committee ensuring appropriate representation. Implement a system of annual health and safety audits to identify and address areas of gaps in Trust-wide H&S performance.	1. Monthly reporting to the ELT & Board through the Quality Report. This commenced in June 2017. 2. Monthly update and assurance reports to the ELT about the Health and Safety Action Plan from October 2017. 3. Review and oversight by the Corporate Health and Safety Committee and the Quality Oversight Group and monthly CEO Performance Meetings. 4. Non Executive Director appointed for Health & Safety.	4	Moderate

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands	10/06/2016		16	High	1, Forward view of fleet requirement for next 3 years 2, Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that unplanned maintenance levels do not adversely affect fleet capacity and the provision of safe environment to operational staff 3, Ensure capital investment is committed to support fleet volume and replacement 4,External/stakeholder support in place as required 5, Maintain a capacity plan based on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan 6, Have an agreed vehicle specifications 7, Agree and maintain deployment headroom in fleet numbers to manage variation	Benita Mehra	19/04/2018	12	Significant	Retain up to 50 ambulances following introduction of 140 new vehicles Manage roll out of 60 new FRU cars Progress Business Case for further FRU cars Review case to retain ambulances following introduction of 140 new vehicles Retain 20 FRU cars to increase size of fleet to 180 Review additional ambulance capacity to support roll out of new Vehicle Preperation Scheme Delivery of 140 new vehicles throughout 2017 Draft and implement action plan to ensure all potential capacity can be realised from the exisitng fleet	1, Forward view of fleet requirements 2, Plan in place to move current fleet to under 7 years 3, Capital investment requirement understood and reflected in LTFM 4, vehicle specification in place.	9	Significant
117	There is a risk that the equipment for front line vehicles may not be properly maintained. This may result in clinical failure due to faulty equipment	21/05/2015		16	High	1,Replacement equipment budgets in place, process agreed and adhered to. 2, Maintenance/Replacement of kit undertaken when required 3, Process for maintenance of equipment reviewed 4, asset database showing maintenance records	Benita Mehra	05/04/2018	12	Significant	introduce improved asset tracking to improve location tracking of equipment Clarify the risk and totally review Roll out of vehicle preperation project	Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet Reports and OOS reports	6	Moderate
120	There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care	21/05/2015		16	High	1. Serial numbers on all re-usable equipment that can be accurately tracked. 2. Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs. 3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays. 4. Vehicle Preparation HUB scheme in place - vehicles checked nightly for missing equipment. 5.Audit system in place for missing equipment. 4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles 5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles. 6, Electronic VDI pilot completed, all equipment has bar code or serial number 7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role 8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports. 9, Current VP contract reviewed and any immediate changes are agreed. 10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed. 11, Pilot project in NE area to provide and resupply equipment store implemented. 12, Business case for the roll out of VP pan London has been agreed. 13, Project board and working groups established. 14, Review of delivery standards completed. 15, New KPIs reported through to QIP. 16, Deep dive by QIP panel completed. 17, Preparation of tender documents and standard commencing DEC2016. 18, Contract variations being developed to increase scope of works to include FRU and NETS vehicles. 19, Proposal developed for the implementation of a depot based make Ready managers and 2 Make Ready Operations Managers to oversee the delivery of the contractor, coordinate more effectively with Fleet Workshop managers and local operational management teams on a daily basis. 20, Additional equipment is being sourced to facilitate the roll out where needed. 21, Vehicle equipment being recovered pan Trust. To date £350K (Nov2016). 22, Implementation of 'managed stock' project across the Trust in line with VP roll out. 23, Approval of BC for new vehicles for delivery during 2017. 24.VP hub project fully rolled out with nightly audit of equipment and replacement	Benita Mehra	05/03/2018	12	Significant	Email Justin Wand to see if thinks this risk should be merged with 121 Enhanced daily vehicle check Roll out Vehicle Preparation to rest of service Ensure adequate stocks of consumables and equipment are available to VP staff Fully develop equipment database reports to indicate where any equipment is missing	1, Clinical Equipment Group; 2, Asset tracking report; 3, VP reports; 4, VP Contract; 5, Equipment Process; 6, Project completion 7, Board reports and meeting minutes.	8	Significant
121	There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care	21/05/2015		16	High	1. Agreed 'standard load list' of vehicle equipment including re-usable v disposable in place. 2. Equipment stock levels agreed and maintained 3. Responsibility for each item of equipment clearly defined 4. Budget responsibilities for replacement equipment clear 5. Review of personal issue kit 6, A "core" equipment list for DCA & FRU has been defined and agreed 7, Funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed. 8, An equipment amnesty and physical review all stations and complexes for "retained" equipment has been undertaken. 9, A new paper based VP VDI form has been introduced. 10, Pilot to assess benefits of VP proposal carried out and documents describing benefit drafted. 11, BC for roll out of VP system pan London developed. 12, Board approval gained for BC 13, Project board and working group developed 14, Project plan defined and agreed 15, Additional equipment purchased to support roll out 16, project reclaiming, decontaminating and resupplying medical equipment established. 17, 'Managed stores' system established to support VP and daily supply of medical consumables 18, 'Blanket' trial and evaluation established and recommendations developed. 19, KPIs developed and monitored for the completion of wash and stocking of vehicles 20, Medicines management programme defined encapsulating all aspects of prep, supply and delivery, collection and disposal. 21, Development of Bag Review Group in April 2017 working schedule to review and replace modular bags as required and for personal issue equipment to be phased out	Benita Mehra	09/04/2018	12	Significant	Embed follow up process for reports on missng equipment to be entered on datix Implement enhanced asset tracking system Roll out VP hubs to 14 sites Trust Wide Implement working group to review personal issue kit – check status of any existing work with CEG Email Justin Wand to see if thinks this risk should be merged with 120	1, Progress made in agreement of core equipment and further equipment amnesty. 2, Decontamination of equipment commenced and robust. 3, Analysis of asset tracking systems being undertaken. 4, VP VDI improved 5, Ops VDI process changed and LA1 updated 6, required committees and working groups have been established to review	8	Significant
302	The Trust is unable to access some clinical training records of operational members of staff. Records are kept on separate and remote sites, are kept primarily as paper (not electronic) copies, and are not archived / processed within the framework of a recognised student management system. It is difficult to defend legal claims against the Trust with the paucity of evidence we have available that staff have undertaken their core and statutory / mandatory training.	01/06/2005		16	High	An archiving system was in place to organise historic records at the Fulham administration archive site, but does not have the capacity to incorporate new documents Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system. However, these do not integrate with a student management system to identify whether the stored training records are located.	Ivanov, Tina	03/05/2018	12	Significant	Management of student records Transfer risk to the corporate risk register. Construct gating template Compose an options paper Comprehensive user specifications Undertake meeting with external scanning providers Investigate funding stream for external scanning Host meeting Gain formal project management support for this risk	Reviewed at monthly departmental Risk review meeting	8	Significant
380	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	11/06/2014		16	High	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies. 3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available.	Fullerton, Ross	20/04/2018	12	Significant	1. The current MDT software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 & 3. 2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above. 3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process. 5. Obtain 2nd hand SatNavs from other Trusts.	IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweigh the volume of units required. In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles.	4	Moderate

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
762	There is a risk that uniforms are not being supplied to some new entrant students in time for their operational placements and / or driving courses. This is due to a very limited timeframe between uniform being ordered and the 1st placements, and limitations on the provision of available stock from the two providers. This can prevent students going out on placement, and can therefore delay students from moving to operational duties at the end of their course, if placements are rearranged. This will ultimately delay the provision of new operational staff to Operations.	20/02/2018		16	High	Education Managers contact other sites to see if there is any spare uniform unissued from current course students or retained from previous course students Operations are contacted to see if there is any spare uniform available.	Ivanov, Tina	03/05/2018	12	Significant	E-mail for information Host meeting with Procurement, finace, and support services	A meeting has been undertaken to review the ordering of uniform, including departmental responsibility and timing. If the learner is measured for their uniform earlier in their induction process, and the order is placed earlier, this may prevent some of the supply issues specifically related to timing from occurring. A sizing kit will be procured for all education sites, to ensure that learners can try on actual garments and check the required size. The proposal of a uniform store is being investigated currently by CE&S managers.	8	Significant
767	Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice	26/02/2018	51	16	High	Business continuity plan is in place which includes Legal, people, and OD feedback.	Wand, Justin	08/05/2018	12	Significant	We are developing a tender for services which we will be taking to market in the next four months	The business approach is being discussed with NHSI and the Cabinet Office bi weekly	4	Moderate
771	International paramedics are finishing training and are not able to work as paramedics which impacts on providing operational hours as under the terms of their visa they cannot work in any role except as patient facing paramedic or in a training role.	05/03/2018		16	High	1. International paramedics are required to apply for HCPC registration as part of the pre-employment process. 2. The request to apply to HCPC is sent to a least 8 weeks before the date of their course start date by the recruitment team. 3. A recent change to the process requires the Paramedic to notify the Recruitment Team when the Scrutiny Fee has been submitted to HCPC in order for them to be allocated to a course. 4. As part of the new process Paramedics are sent guidance on the HCPC application process with regular follow ups. 5. A meeting with the HCPC resulted in a temporary agreement for limited support to provide a weekly check/update of an LAS generated tracker spreadsheet showing progress of submitted applications 6. The Clinical Education team and operational colleagues have worked out a programme to continue the 'training status' of the paramedics until they are registered	Grealish, Patricia	11/04/2018	12	Significant	Decision on course intake 30 April	• LAS have continuous contact with international paramedics (2-3 times per week) to encourage speedy completion of the HCPC application process. • LAS provide clear guidance to the international paramedics on the importance of making an accurate application and of paying their scrutiny fee as soon as possible • HCPC are providing support to check status of application (weekly) processing for all international paramedics against a schedule provided by LAS (weekly) • Education and operational teams have devised a solution to deploy the paramedics that have completed their training and are not registered to ensure they do not breach the terms of their visa Matter is discussed weekly at ORG and A&E Resourcing and mitigating actions agreed upon by all relevant stakeholders	4	Moderate
753	There is a risk that ongoing delays in ambulance crews handing over their patients at Hospital EDs across London will reduce operational cover in the surrounding area and compromise patient care.	06/02/2018		15	High	1. Delays at hospitals monitored 24/7 by LAS Incident & Delivery Managers (IDM). 2. IDMs dispatch Incident & Response Officers (IRO) to EDs that are under pressure. 3. LAS have seconded senior manager to work in NHS E Winter Room to focus on link between LAS and wider Healthcare system with regards to hospital delays over winter 2018. 4. Operational manager has been seconded to lead on work to address hospital issues over winter 2018. 5. Regular Hospital Handover meetings held between LAS/ECIP and NHS I Improvement and Relationship managers focusing on handover delays. 6. Intelligent Conveyance (IC)desk in EOC runs to smooth out spikes in ED conveyance monitoring arrivals over a rolling 60 minute window. 7. LAS SEMs work with local EDs to review handover processes, flow and address issues	Wrigley, Fenella	05/04/2018	12	Significant	Finalise the cohorting standard operating procedure Meeting with Director of Ops NHSI Hosptial Handover Programme 2018/19 Review SOP	1. IDMs report on hospital issues in their daily shift reports. 2. IROs report to IDM on hospital issues in real time during their site visits. 3. ECIP and NHS I relationship managers feedback to Hospital Handover meetings held by LAS/NHS I. 4. IC monthly report on activity 5. Daily winter sit rep sent out by NHS E Winter Room	6	Moderate
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement	27/05/2016		12	Significant	Risk management training sessions for managers was rolled out across the Trust from November 2015 and monthly sessions are still on-going. Risk registers are reviewed quarterly by the Governance and Assurance Team and areas of non compliance are reported to the Risk Compliance and Assurance Group. The Governance and Assurance Team provide support to areas and directorates through the attendance at meetings and 1:1 support where required.	Harding, Philippa	09/05/2018	12	Significant	Review compliance with the update of Corporate Risks and report compliance to the RCAG Review progress with risk management of higher level risks within directorates. Audit of local risk registers to be presented to RCAG each month for escalation of non compliance.	Compliance with the process is reviewed by the Risk Compliance and Assurance Group and areas of non compliance are escalated to the appropriate Directors.	4	Moderate
28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule. The impact of this may be: * adverse publicity / reputation * court order for specific disclosure which has financial implications; * adverse finding by HM Coroner / trial judge; * financial implication of settling claim as a result of not having any evidence to rebut allegations which could be disproved with the benefit of accessing voice recordings.	10/02/2016		12	Significant	Whilst the call log provides a summary of information noted this is not deemed to be an adequate control. Work is being undertaken by IM&T to source parts to keep the system running as and when required	Harding, Philippa	19/04/2018	12	Significant	Speak with IM&T re 111 risk Speak with Pauline Cramer re risk of over-recording Procurement and installation of new equipment Investigate conversion of DAT tapes to a modern media	IM&T are working on two projects to convert existing tapes and to procure and install new equipment and to investigate conversion of DAT tapes into a modern media	8	Significant
411	There is a risk that the lack of ownership of and responsibility for information assets will increase the likelihood of a security breach or data loss incident occurring.	08/10/2014		12	Significant	None	Fullerton, Ross	26/04/2018	12	Significant	Create and launch IA management framework Identify all information assets and owners IAO to take control of assets supported by a data breach process Identify the IT information assets and owners Introduce a policy to assign an Information Asset owner (individual) to every new and existing IT information asset	Risk discussed and monitored by IM&T SMT	3	Low

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
439	There is a risk that tail lift failures on operational ambulances will impact on patient care. Due to various causes ranging from the age of the operational vehicles, user error electrical, mechanical etc. There has been an increase in the failure rate of tail lifts.	07/10/2013		12	Significant	1. All A&E operational vehicles with tail lifts are inspected on an 8 week basis. PTS vehicles on a 26 week basis (Updated 11/15 – S.Westrope amended maintenance schedule for A&E – every 12 weeks). 2. Crew staff undertake vehicle daily inspections. 3. All tail lifts are inspected in line with Loler compliance. Additionally independent inspections by the Freight Transport Association are undertaken. These are on a 10% inspection basis. 4. Reduce age of vehicles as the tail-lift is being used past the "designed life". 5, Ambulance design reviewed to include tail lift (from further actions) 6,Alternative tail lift has been fitted to a small percentage of vehicles (from further actions) 7, Training programme for workshops on fault finding organised (from further actions) 8, Signage placed in Ambulances to indicate the type and correct operation of the tail lift in question. (from further actions) 9, Instructional video demonstrating the procedure to operate the tail-lift in an emergency – placed on the "Pulse" June 2015 plus notes in "RIB" (from further actions) 10, 104 new A&E Ambulances to replace 67 x 12yr old units.(from further actions) 11, new tail lift design being implemented as part of New DCA specification (140 vehicles) Contract management in place Contract let to specialist contractor supporting maintenance	Benita Mehra	09/04/2018	12	Significant	Fit new parts and springs to tail lifts at LOLER safety checks 6 week saety check on tail lift Fit new springs and covers to vehicles at next service and then at MOT Change tail lift springs annually and place protective cap on mechanism. 140 new ambulances with new external tail lift l	1. Motor risk management group review identified incident related to operational vehicles. 2. Corporate Health and Safety Group review all incident statistic trends. 3. Fleet management meet on a weekly basis and also review vehicle incident rate trends.	8	Significant
448	There is a risk that... not all EOC functions are able to continue in the event of planned or unplanned CAD outage, as there is insufficient space within the EOC estate. Therefore, some non-critical (but BAU) functions will cease during this time.	11/06/2016		12	Significant	Current actions identified are: 1. Priority list of NON Critical functions to be stopped is circulated. 2. Watch Managers tasked to dynamically assess requirements 3. Non-critical EOC functions are now included in the revised OP66 which is pending sign off. (AJE)	Cranmer, Pauline	19/04/2018	12	Significant	Review of CRITCAL and NON CRITICAL functions of EOC Review of the Trust/EOC Business Continuity Plan Review of EOC estate capacity issues Identify potential suitable sites for expansion, both internally and externally Review relevancy of current dispatch model Review numbers of staff required for each function	Plan for paper operations (OP66) is up to date and is available on The Pulse Dates are planned to test the Control Services plan for paper operations Control Services representation is included in the BC / DR steering group	8	Significant
468	Risk that the communications team is unable to obtain accurate, timely information about casualties from Gold during a major incident, which leads to inaccurate information being put into the public domain, risking a drop in public and stakeholder confidence in our ability to manage major incidents.	14/09/2016		12	Significant	1. Communications team attend Gold meetings during a major incident. 2. It has been agreed that Gold will be the link for the communications team in terms of providing casualty numbers and details. e. Communications team policy is not to work with the lowest figure provided regarding casualties and provide a round number, for example, over xx casualties.	Patton, Angela	17/01/2018	12	Significant	Meet with Ops to clarify risk and identify mitigation - post RCAG 12 May 2017 Request that process re provision of casualty figures is added to major incident plan	This issue has been discussed with former Director of Operations and EPRR lead.	6	Moderate
475	There will be a detrimental impact on service delivery targets at times of high demand. Unexpected and unplanned increase in call volume which outstrips staffing capacity may have a detrimental effect on the service delivery.	23/09/2016		12	Significant	1. Demand management plan in place to manage acute changes in demand 2. Operational managers on duty 24/7 to monitor performance, changes in demand and escalation to relevant parties when required 3. On call access to LAS111 senior management, EOC Incident Delivery Managers, Gold on call Directors and NHSE representatives 4. Business continuity plan in place with escalation procedure documented	Daw, Nicholas	05/04/2018	12	Significant	1. Review of business continuity plan Review of staffing forecasting against predicted demand Ongoing recruit to fill vacancies Roster review Build break relief into rosters Review of business continuity plan Review of staffing forecasting against predicted demand Review Recruitment Plan for 111 Roster review	1. Current staffing matched against forecast planning 2. Continual use of agency staff to cover gaps 3. Roster review commenced to include training and relief addition to forecast.	8	Significant
580	There is a risk that the Attobus MPC-2 Mobile Data Terminals (MDT), currently installed in fleet vehicles will become unserviceable. This is due to the age of the units and the withdrawal from the market place. This would result in delayed response times, impacting on operational efficiency, and the potential for vehicles to remain Out of Service (OOS) if the existing unit cannot be repair and no other spare unit is available.	16/01/2017	45	12	Significant	The current spares holding is at an acceptable 10% of the active fleet. Approx. 70 units. This is actively monitored by the third party supplier Telent. However, if fleet planned to grow the number of frontline vehicles and require additional units, the likelihood score will increase.	Fullerton, Ross	20/04/2018	12	Significant	Confirm that APC2 is fit for LAS purpose Review MDVS solution Confirm Telent spares stock	Telent are under contractual obligation to manages the MDT assets.	3	Low
675	There is a risk that the management of the student journey is reduced due to the reliance on local databases for recording activities, leading to decreased accuracy in, and restricted accessibility to, progress details.	19/09/2017		12	Significant	Recording of all activities on a student database, held centrally. Utilising other electronic systems where possible such as OLM, ESR, GRS and Moodle Scanning and electronic storing files and copies of documents in common drives	Ivanov, Tina	03/05/2018	12	Significant	Complete procurement Set up a meeting for a demonstration of the Intrepid database	Standardisation committee Credentialing committee	6	Moderate
678	Risk of physical and non-physical assault to frontline staff who come into contact with patients and members of the public during the course of their work. The impact of these incidents include: 1. Emotional, psychological distress to staff members. 2. Physical harm/injury to staff members where they are physically assaulted.. 2. Loss/decline of staff morale. 3. Increase in staff absences thereby impacting on service delivery. 4. Negative reputational damage to the LAS as an employer. 5. Increase in claims and litigation to the Trust.	20/09/2017		12	Significant	1. Security Management Policy implemented. 2. Violence Avoidance and Reduction Procedure in place. 3. Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4. Local management support, LINC and counseling services are available to staff. 5. Monitoring of incidents via the Trust's Health & Safety Committee where incident trends are reviewed and actions agreed to mitigate risks to staff. 6. Specialist advice available across the Trust via the LSMS and Health, Safety & Security Team. 7. High risk address flagging procedure in place and communicated to all relevant staff. 8. Air Wave radios and panic alarm systems implemented for all front-line staff. 9. Where appropriate, IRO and Police support available for staff. 10. Operational monitoring of incidents at Sector Level through the QGAMs and GSMs. 11. Conflict resolution training is provided to all frontline staff at induction and refreshed every 3 years. 12. Obstructing Emergency Worker legislation in place. 13. Post Violence Support Procedure in place to support staff. 14. Stab vest and relevant PPE are provided to A&E staff. 15. H,S & S Team pro-actively monitors all incidents reported to ensure appropriate follow up, investigation, and share lessons/alerts across the Trust. 16.LSMS ensures regular communication and follow up of incident trends with Sector QGAMs, GSMs and staff. 17.H,S&S Department to provide extra training to Team Leaders who will support staff affected by incidents where requested. 18. Trust-wide lone working arrangements and risk assessments reviewed and implemented. 19. Security training incorporated into the Trust's H&S Induction Training Sessions.	Bain, Trisha	04/05/2018	12	Significant	H&S Team to liaise with Wellbeing Team regarding the implementation of stress audits. Stress work group being formed. LSMS to work with Training/Operations regarding the timely issue of stab vests to new starters. H&S Team to support Ops with implementing lone working arrangements across the Trust with the view of implementing robust risk assessments that addresses the risks associated with lone working. H&S Team to incorporate security training into the Trust H&S Induction Training Sessions.	1. Incidents reported on the Datix System. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Periodic review of High Risk addresses by the Operations Team.	6	Moderate
699	The Supplier of the Redbox recording system for 999 and 111 calls, does not proactively, manage O/S and security updates from Microsoft. Therefore if Microsoft release a security update for its servers or an O/S patch. Redbox do not test these patches or updates first to ensure that they will work with a customers configuration. Therefore the customer takes the risk of applying these patches/ OS upgrades and if they cause an issue only at that time will Redbox work with us to produce a solution. We do not have a test environment currently in place to test any new patches or O/S updates	11/10/2017		12	Significant	A test environment will need to be put in place to ensure that any updates from Microsoft for their servers can be tested before being released to the Redbox servers	Downard, John	20/04/2018	12	Significant	Investigate viability of providing a test environment Review & update patch deployment procedure	A test environment will ensure that we can control and test and patches in a safe environment.	4	Moderate

Corporate Risk Register as at 9th May 2018

ID	Description	Opened	BAF Reference:	Gross Rating	Gross Level	Controls in place	Manager	Last review date	Rating (current)	Risk level (current)	Further Actions	Assurance	Rating (Target)	Risk level (Target)
701	There is a risk that the GRS Service may not be recovered within business expected timeframes as a result of the current support model. Specifically: - There is a reliance on business senior users for support of the service which is not documented or formally agreed. - Due to single points of knowledge, IM&T may not be able to support/maintain system at required service level (Critical system with 24x7 support)	17/10/2017		12	Significant	Cross training/skilling GRS is supported 24x7 by IM&T, and any loss or degradation of service is supported by the IM&T incident/on-call management processes.	Fullerton, Ross	20/04/2018	12	Significant	Documented GRS SLA / Service Definitions Documented GRS Technical Application & Infrastructure Support Process	Incident management and on-call processes well documented and known. Recently reviewed and updated by IM&T service delivery (completed September 2017)	4	Moderate
246	There is a risk that... the Trust will not be able to maintain a full patient record (and manage quality and standards), should the 999 recording system fail into and out of the EOCs.	15/03/2012		15	High	1. Review by IM&T of all lines to be recorded and provision of extended service to EBS 2. Testing of recording at Bow to ensure consistency of service	Fullerton, Ross	19/04/2018	10	Significant	Provide links for Access to Airwaves recordings via Redbox Ongoing monitoring of the system, particularly at Bow, where problems have been experienced. IM&T to work to ensure all critical lines recorded at both sites.	1. On-going monitoring of the system, particularly at Bow, where problems have been experienced. 2. IM&T to work to ensure all critical lines recorded at both sites	5	Moderate
775	Current UPS capacity is insufficient to meet building supply demand and equipment condition is deteriorating; requiring upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services at Bow until repairs are undertaken.	16/03/2018	50	15	High	Reduction in UPS dependence by transfer of demand to non-essential supply (where possible) Maintenance of existing UPS equipment Design of new provision and purchase of upgrade equipment Engagement with UKPN to mitigate risks associated with essential network repairs or known service interruptions - Schedule of OP66 events (2018) - 17/04, 19/06, 07/08, 24/10	Benita Mehra	08/05/2018	10	Significant	Project team in place to investigate/manage upgrade project and identify window for upgrade works IM&T migration programme to Cloud based services - Development of EOC Business Continuity Plan	- Ongoing monitoring of UPS demand - No degradation of service experienced during unplanned network power outage (18/02/18) - UPS maintenance contract in place - Generator maintenance and test schedule in place - Regular Project Group meetings	5	Moderate
481	Limited live reporting tools are available to 111 operational management (wallboard, Individual Monitoring etc.) The performance wall board used to monitor the number of calls waiting to get through to LAS111, the abandonment rate, SLA and staff activity by skill set has not been available since the 31st March 2016. This impacts the Operations Supervisors ability to proactively manage service demand. There is a risk that calls waiting to get through to LAS111 will be delayed.	23/09/2016		10	Significant	Operations Supervisors use 'calls waiting' metric to monitor real service access, this is present on the current iteration of the wallboard. Also in use is the additional functionality within Cisco Supervisor Desktop (CSD)- this allows ops supervisors to measure staff 'not ready' status.	Fullerton, Ross	05/04/2018	10	Significant	To install new visual managent tools within the SEL 111 contact centre NWAS Visit Add evidence from NWAS visit to risk record Delivery of IPM capability Mitigate lack of IPM tools Further development of 111 reporting requirements Review CISCO reporting tools	There is a known problem whereby the reports that are available are not updating in a timely way. This is with principle suppliers for further investigation under problem ref: 40010105 **This has been resolved - JW 11/04/2017**	2	Low

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Serious Incident Update (April Data)			
Agenda item:	15			
Report Author(s):	Michael Ward – Head of Quality, Governance & Assurance			
Presented by:	Trisha Bain – Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The purpose of this document is to summarise Serious Incident activity within the Trust for the month of April.

The document will provide an overview of the main contributory factors that influence serious incidents and the actions taken by the Trust to address recurring themes.

Recommendation(s):

The Board is asked to note the report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Serious Incidents Update: April 2018

Introduction and Background

1. This paper provides assurance to the Board regarding the effectiveness of the Trust's serious incident management process. The report provides an overview of the current status in relation to serious incidents (SIs), including action completion status.

2. An analysis of SI activity will be provided in the following formats:
    a. SI activity by month
    a. Number of SIs by sector and STP
    b. Clinical Commissioning Group (CCG) feedback
    c. Category type (theme)
    d. Number of outstanding (overdue) actions by sector

3. Additionally, this paper includes a monthly summary of the SI investigations that were submitted as final to the Clinical Commissioning Group (CCG), and the executive summaries from these reports (appendix 1).

4. An overview of the Trust Duty of Candour compliance will be provided.

Context

5. During April 2018, six SI reports were submitted to the CCG.

6. The Trust's current position on meeting the 60 working day target for submitting SI reports remains at 100%.

Investigation Update

Summary of SI investigations submitted to the CCG during April 2018

7. Of the 33 actions detailed below 48% have been completed and closed (n=16). 15 are currently in progress and are within the assigned deadline (45%), and two have breached the assigned deadline due to staffing availability and shift patterns but will be completed by the end of May 2018.

StEIS Number	Incident type	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within timescales (60 days)
2018-2120	Dispatch & Call	24.01.2018	Meeting between EMD and line manager	Completed	20.04.2018	Yes
			Review and update of SOP	30.05.2018		
			Consultant Paramedic to meet crew to discuss management of patient, assessing and recording of a patients capacity	30.05.2018		
			LAS to write to LFB to recognise LFB officers undertaking effective CPR	Completed		
2018-2883	Dispatch & Call	31.01.2018	Assigned SIG Action	Completed	30.04.2018	Yes
			Implement human resources processes	Completed		
			QA department to identify any similar issues or trends with regards to calls involving breathing and to raise these through the Trust QA Improvement process	15.05.2018		
			Obtain NOK contact details from GP and make contact with them to share findings of investigation and to offer apologies	30.05.2018		
2018-990	Dispatch & Call	10.01.2018	Assigned SIG Action	Completed	09.04.2018	Yes
			DoC contact	Completed		
			DoC letter and upload to Datix	Completed		
			Actions around risk 337 to be implemented	Completed		
			LAS to continue with the operational model to ensure they	30.04.2020		

			continue to match capacity with demand			
2018-353	Dispatch & Call	03.01.2018	Continue with the Trust recruitment programme	Completed	09.04.2018	Yes
			Continue with the oversight and review of capacity and demand	Completed		
			Briefing to be disseminated via The Pulse and RIB	Completed		
			Clinical Lead to devise reminder for Clinical Staff	31.05.2018		
2018-1605	Dispatch & Call	17.01.2018	EMD A to be supported to gain greater understanding of their role	Completed	17.04.2018	Yes
			EMD A to be placed with a Work Based Trainer	Completed		
2018-2124	Treatment/Procedure – Delay / Failure	24.01.2018	CTL to meet with crew for ECG recognition training	Completed	16.04.2018	Yes
			Meeting with crew to review report and discuss confirmation bias	Completed		
			ECG interpretation support for crew	Completed		
			Medical Directorate to highlight importance of conveying atraumatic chest pain to EDs	Completed		

SI Activity by Month

8. During April, six SI's were declared. Fig. 1 illustrates the number of declared SI's in April is comparable to the same month in 2017.

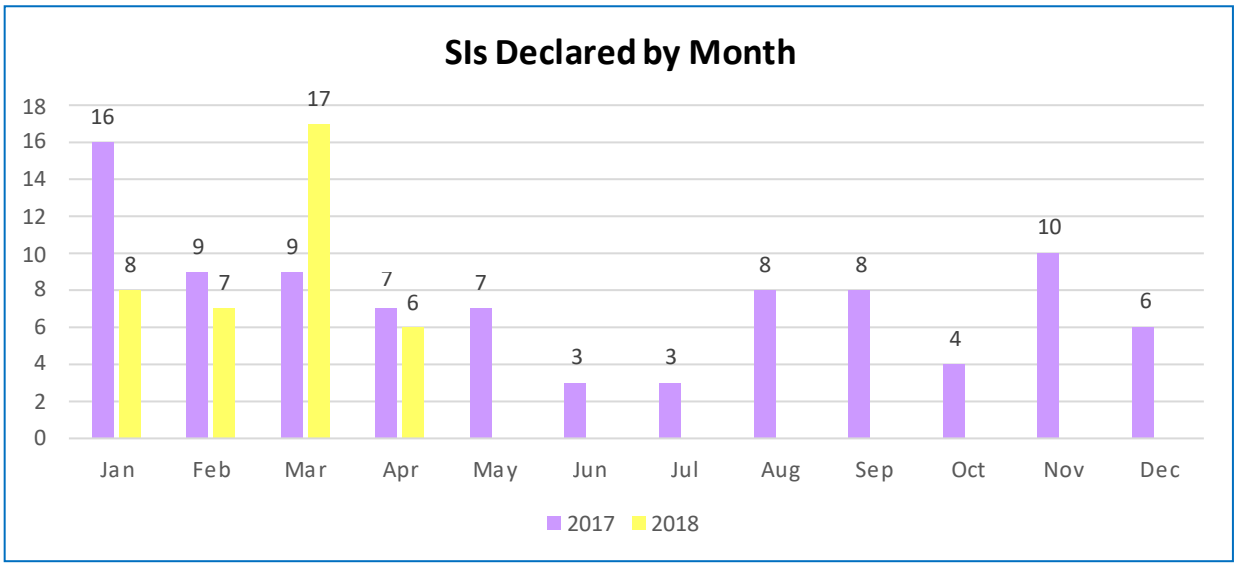


Figure 1 - SI's Declared by Month

9. Fig.2 demonstrates the SI activity across April compared to the previous month.

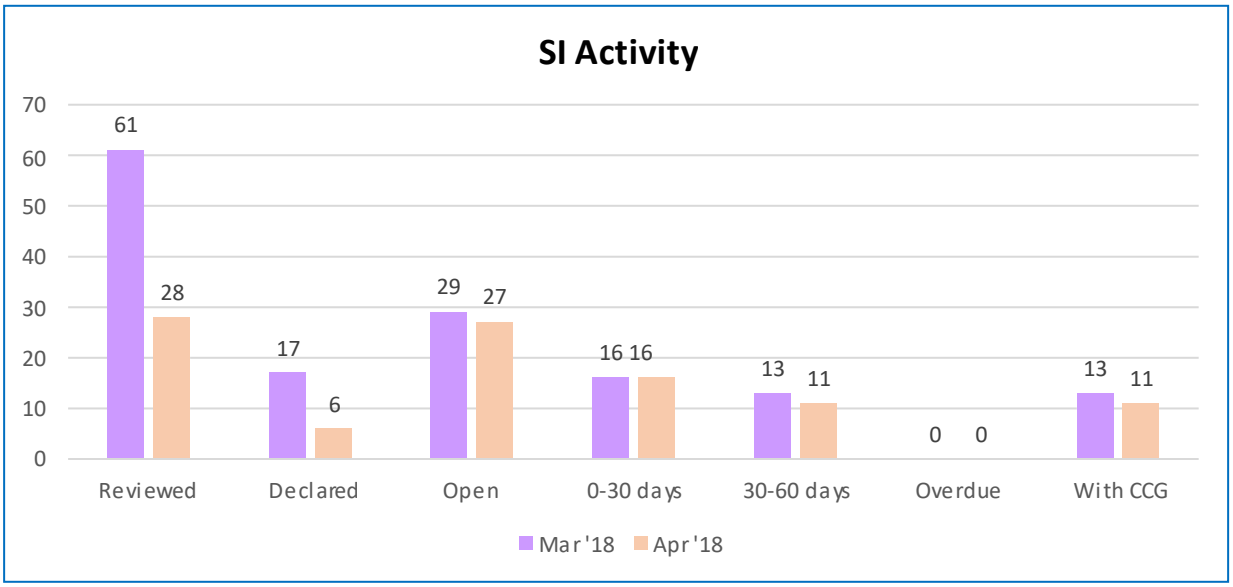


Figure 2 - SI Activity

SI's by Sector/STP

10. Fig. 3 demonstrates the distribution of SIs across the sectors/STPs.

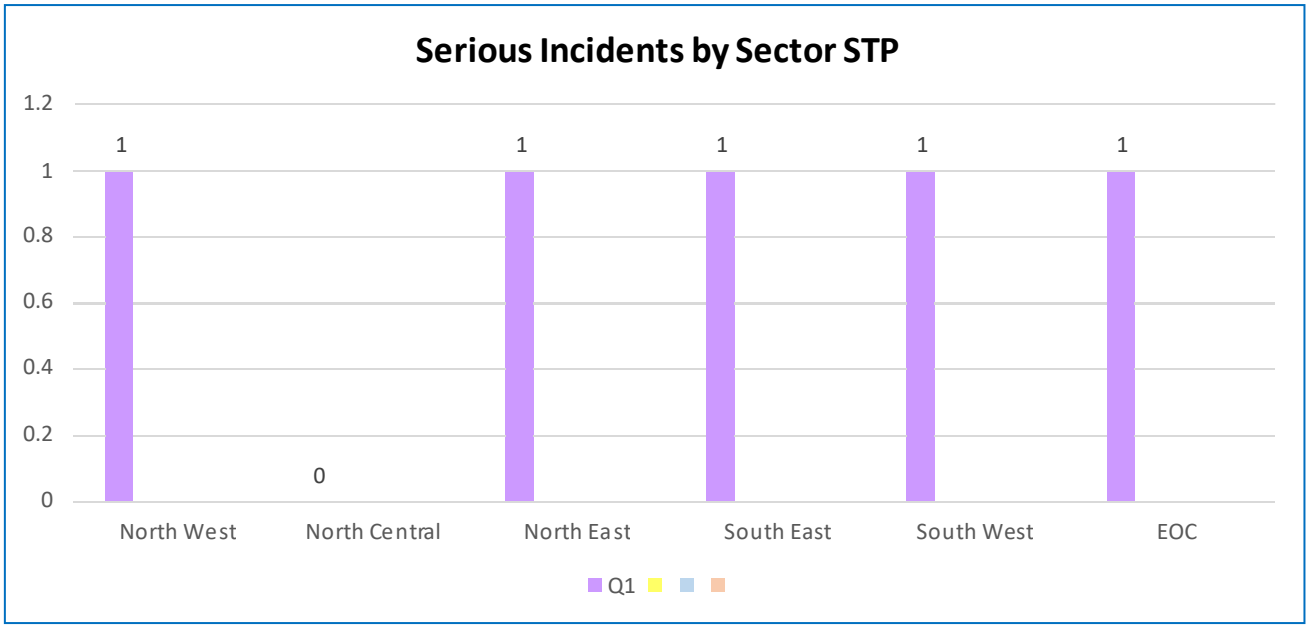


Figure 3 - SI's by Sector STP

CCG Feedback

11. Fig.4 provides themes of comments received from the CCG following the submission of a completed SI report.

12. It is considered that by capturing themes in the comments the Trust receives from the CCG prior to the closure of a report may assist in the identification of gaps in our investigations, or a lack of clarity, that can be used to improve the quality of the investigations, reports and actions.

13. During April 2018 the CCG raised a further information request comments on one SI. This was for a patient who had suffered a post-operative bleed, and was left at home with the decision to not convey the patient being made in conjunction with a GP. The comments requested clarity relating to primacy of care in circumstances where a more senior clinician is on scene. The attending staff were directed to undertake reflective learning regarding the suspicion and identification of haemorrhage. The CCG requested an action be added to the investigation that ensures organisational learning in relation to patients with a history of surgery who are presenting with low blood pressure.

14. All questions referred to the Trust by the CCG were responded to before the provided deadline.

15. The Quality, Governance and Assurance Team will continue to monitor the comments for recurrent themes and trends. Anticipated actions for the Team include inviting the Commissioners into the Trust to enhance their understanding of the protocols and processes within EOC, providing a high level report on identified gaps in our policies and procedures to the Executive Team and incorporating any gaps identified in our action plans and/or investigations into the current Lead Investigator training programme.

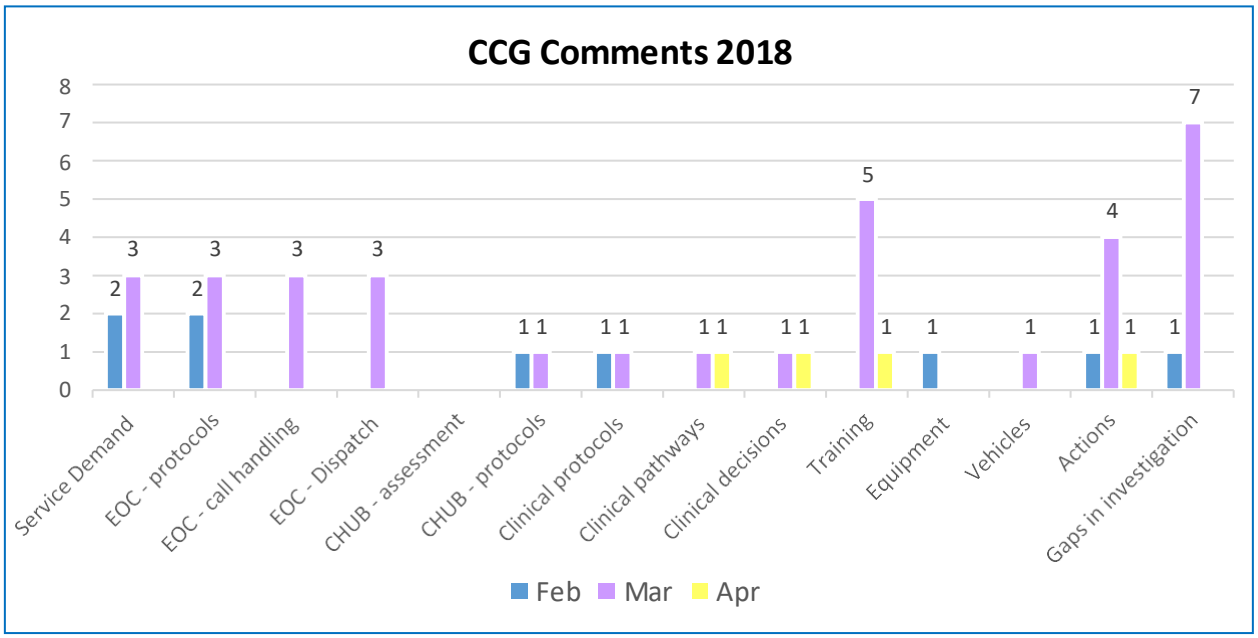


Figure 4 - CCG Comment Themes

SI Category Themes

16. Dispatch and Call Handling and Clinical Treatment and Assessment continue to be the recurrent themes of SI investigations across the Trust.

17. To date the Quality, Governance and Assurance Team have provided information to support an intensive EOC action plan. In addition, an identified theme from incident reports was shared with the Serious Incident Group relating to 999 calls for patients presenting with chest pain. As a result, the Trust has modified its response to these patients.

18. By way of an update from the previous month:

19. Feedback received from Control Services management indicates a need to include an additional descriptor in Datix to differentiate between Dispatch & Call error vs Vehicle Availability. Control Services feel they are being misrepresented on occasion when the delay to dispatch is outside of the control of EOC.

20. A 'Learning from SI's' training session has been developed and delivered during all core skills refresher (CSR) days for all members of staff working within EOC. The training is being delivered by the Head of Quality, Governance and Assurance and the Clinical Advisor for Legal and Governance. The aim of the training is to ensure that all members of staff are familiar and aware of the SI investigation process within the Trust, including how incidents are identified and declared. Specifically, learning from incidents that concern EOC is presented and discussed. To date this learning has been shared at 5 EOC CSR days.

21. The focus of the Quality, Governance and Assurance Team over the coming months will be on the clinical treatment and assessment issues identified.

22. To date the team have provided learning from SI investigations and contributory factors training to the Paramedic Academy students and will continue to provide this training for future courses.

23. High level reports are presented to individual meetings on a monthly and bi-monthly basis to ensure learning from incidents is considered when proposed changes across the Trust are discussed. Examples include the Patient Safety Group, Clinical Standards Working Group and Infection Prevention and Control Committee. More recently the team have been asked to provide a similar report for the Clinical Education and Standards Group and Learning From Incidents Group.

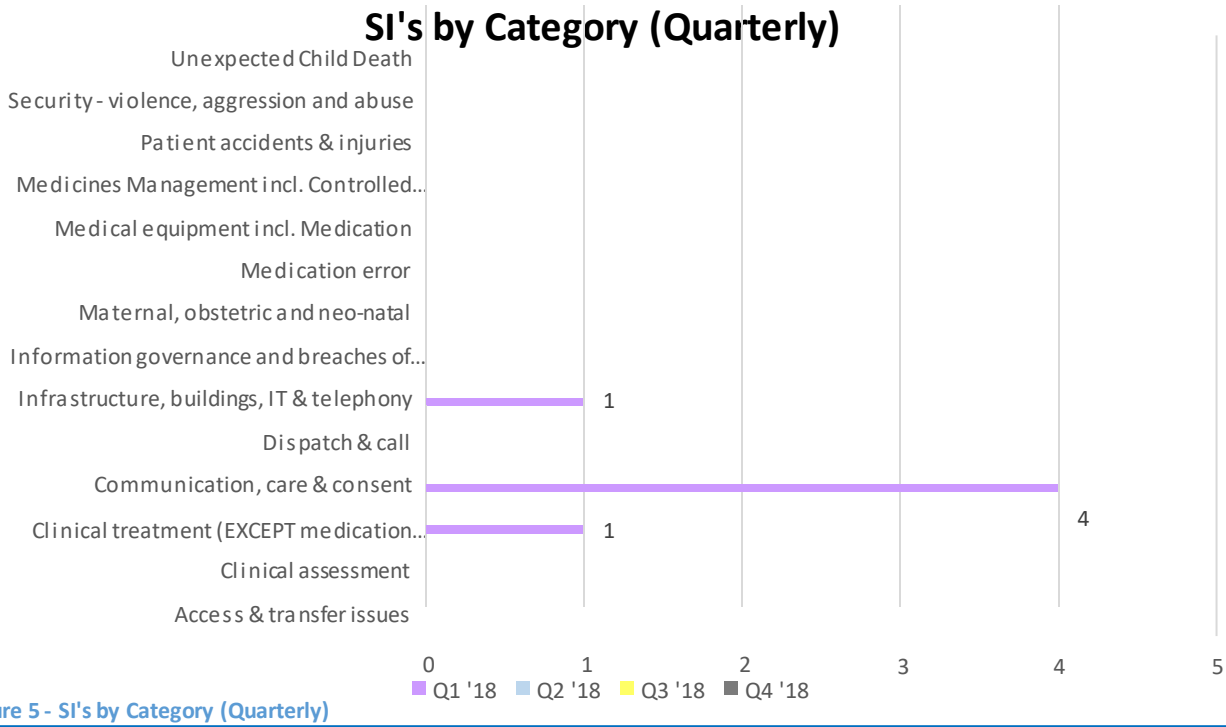


Figure 5 - SI's by Category (Quarterly)

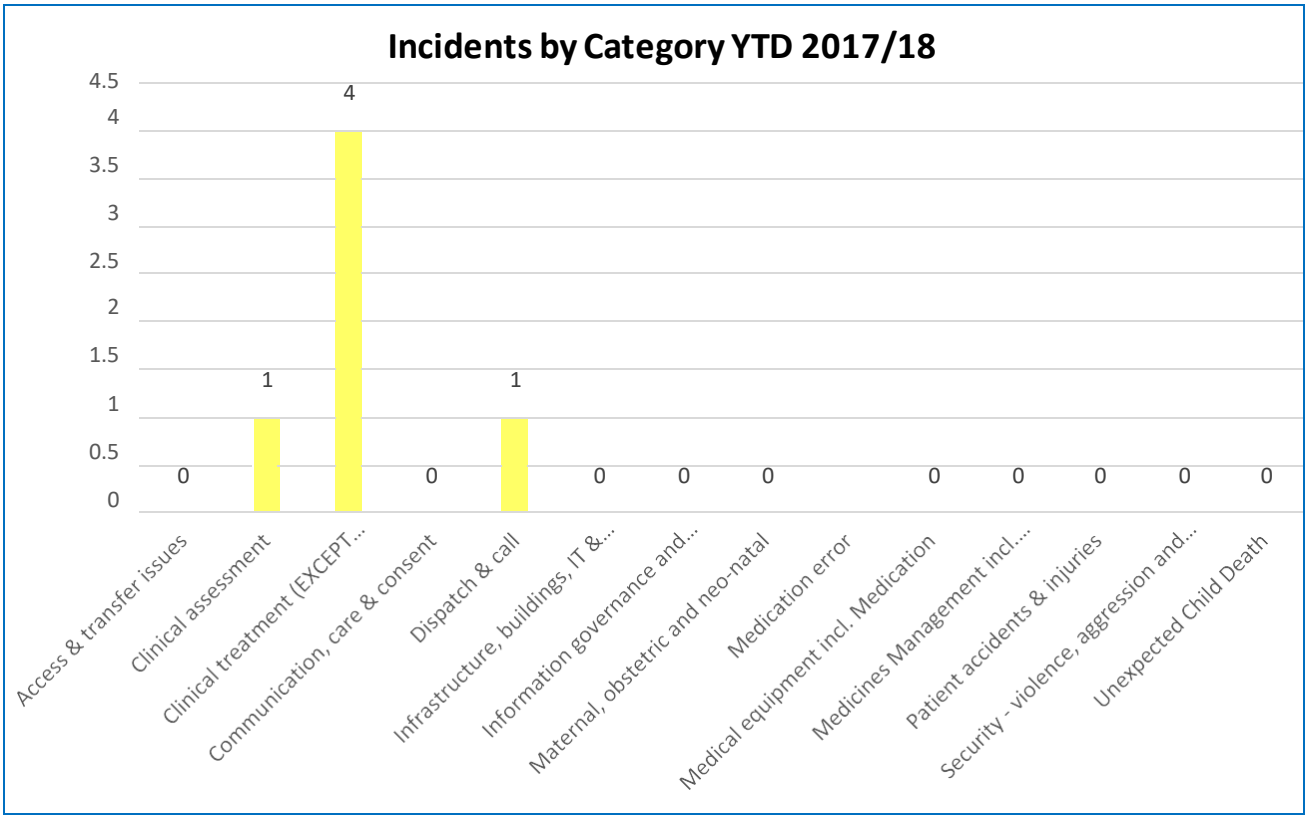


Figure 6 – SI's by Category (YTD)

SI Action Compliance

24. Following the identification of a significant number of outstanding actions from closed SI investigations in July 2017, there has been a noteworthy decrease in the number of actions that have currently breached the assigned deadline (see figure 7 below).

25. Whilst 16 actions are yet to be completed, the Quality, Governance and Assurance Team have been communicating on a weekly basis with the accountable managers and providing support where required.

26. The majority of actions that are currently overdue are in progress and delayed due to factors out of the control of the accountable manager. Examples include operational demand, staff absence and shift patterns which are delaying the manager in arranging training and/or feedback.

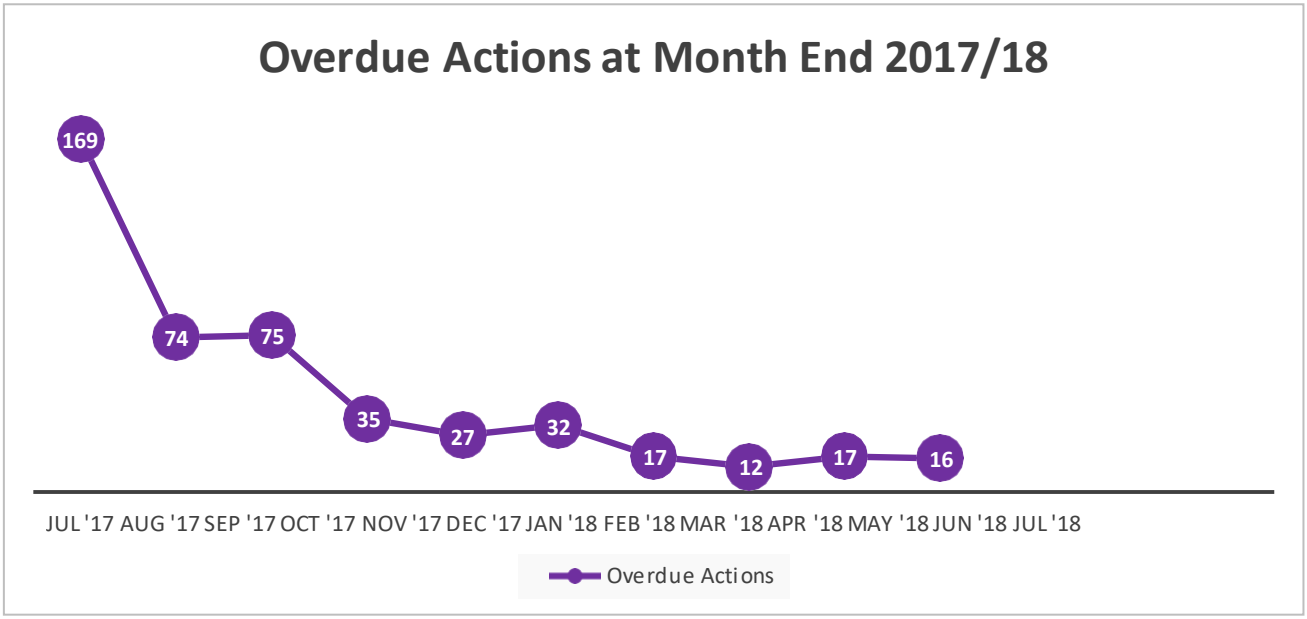


Figure 7 - Outstanding Actions by Month

Duty of Candour Compliance

27. The Duty of Candour is a statutory requirement applicable to all declared SIs within the Trust.

28. Fig. 8 demonstrates the Trust's current Duty of Candour compliance for SIs declared during April 2018.

29. Of note, the initial apology was not provided for 5 incidents as the Quality, Governance and Assurance Team were unable to make contact with the patient's next of kin despite significant efforts. Method used to ensure compliance included telephoning the patients documented next of kin, voice mail messages, communications with the hospital and/or the patients last known location (care home, nursing home, hostel etc.) and cross checking the provided next of kin details with the patients GP or utilising the NHS Spine.

30. A formal letter has been sent for the remaining SI that is currently being investigated. Where this was not achieved, the Trust had not been provided with, or managed to obtain a forwarding address for the patient's next of kin.

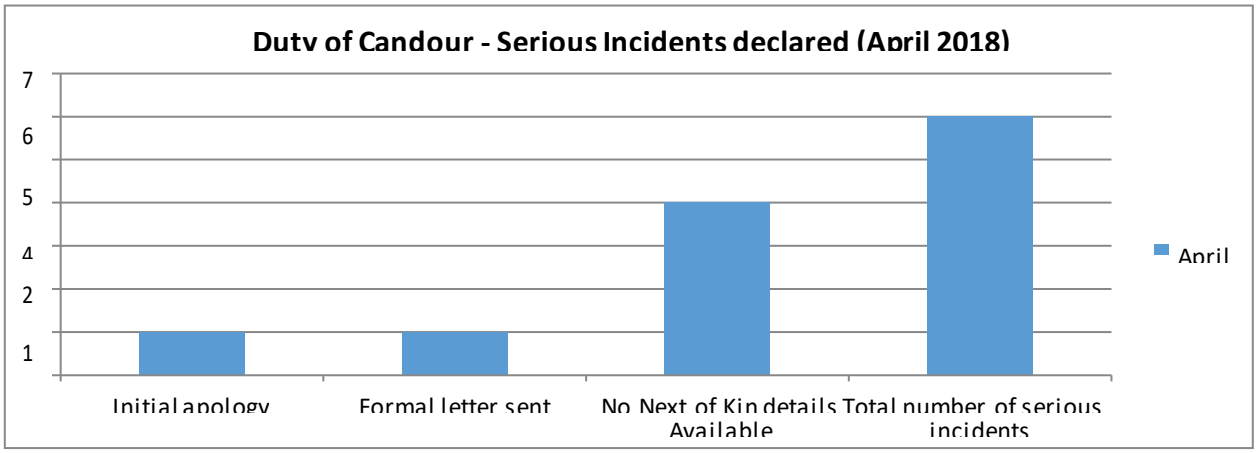


Figure 8 - Duty of Candour Compliance

Incidents

31. The 2018/19 Key Performance Indicators (KPI's) have been set by the Chief Quality Officer.

32. Fig. 9 provides a summary of the incidents reported by quarter and Fig. 10 demonstrates the year to date reporting figures for no and low harm incidents.

33. The target for no harm incident reports for 2018/19 has been set at 2,800.

34. Low harm incident reports for 2018/19 should exceed 500.

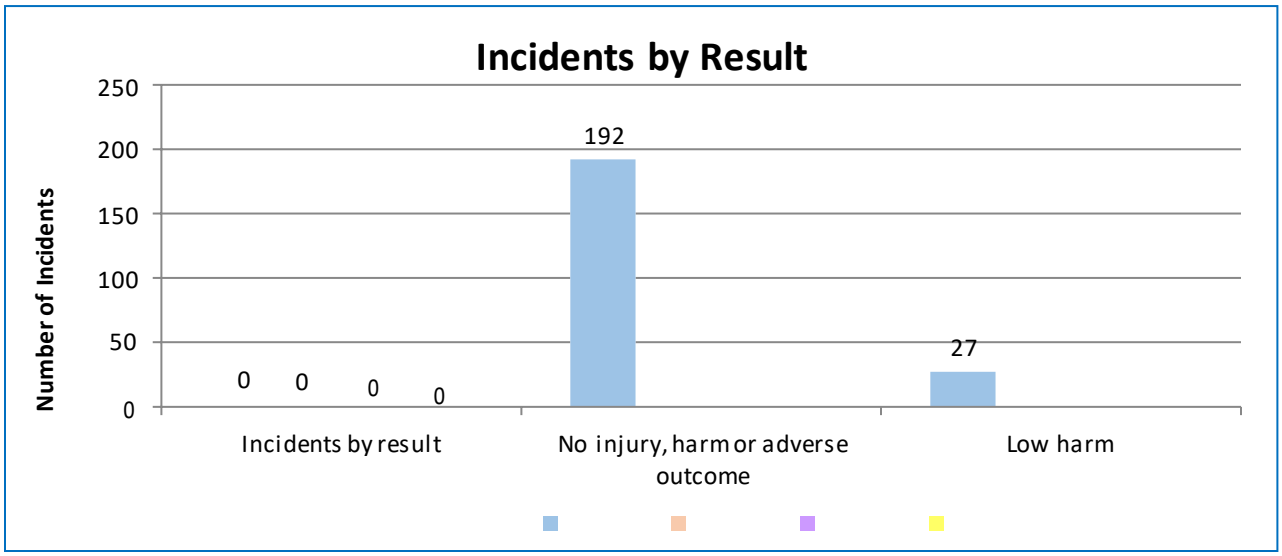


Figure 9 - No harm, low harm and NRLS incident reporting

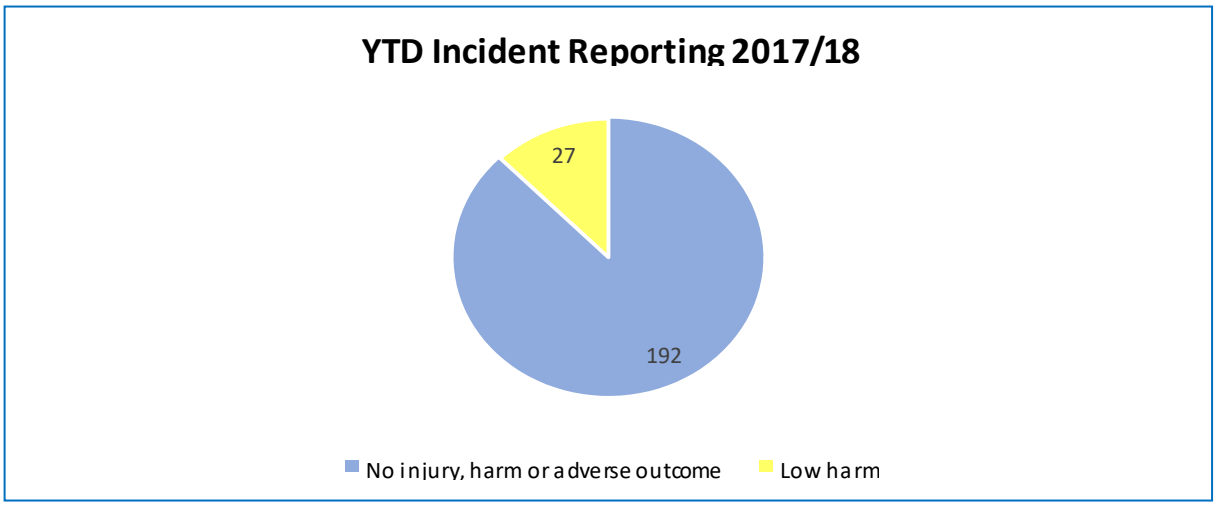


Figure 10 - Year to Date incident reporting figure

Conclusion

35. We are maintaining our targets of 60 working days in relation to submitting completed SI investigations.

36. SI action compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required.

37. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the serious incident group and assurance processes.

38. Additionally, by monitoring comments received from the CCG it is thought that the Trust can learn from identified themes to improve our investigations and reports.

Dr Patricia Bain
Chief Quality Officer

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Freedom to Speak Up Quarterly Report			
Agenda item:	16			
Report Author(s):	Conal Percy, Interim Freedom to Speak Up Guardian			
Presented by:	Conal Percy, Interim Freedom to Speak Up Guardian			
History:	N/A			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This report provides the Board with an update on Freedom to Speak Up activities since January 2018 and the 'Guidance for boards on Freedom to Speak Up'.

Recommendation(s):

The Board is asked to note the update provided in this report and collectively contribute to an LAS Freedom to Speak Up strategy.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Freedom to Speak Up Quarterly report

Background

1. As Board members are aware, it is a requirement in the standard NHS contract that NHS Trusts appoint a Freedom to Speak Up Guardian. Guardians can be approached by any worker in confidence, at any time, to discuss concerns about any risk, malpractice or wrongdoing which they believe is harming the service.

2. In January 2018 a full time interim Freedom to Speak Up Guardian was appointed to raise the profile of Freedom to Speak Up across the organisation; take the necessary steps to ensure an open and transparent recruitment process; continue to deliver a Freedom to Speak Up service across the Trust; and to represent the LAS at national and regional speaking up events.

3. This report provides information about Freedom to Speak Up activities that have taken place within the London Ambulance Service NHS Trust (LAS) and nationally since the last Board update in January 2018.

4. Important guidance for Boards on Freedom to Speak Up and the individual responsibilities of each Board members is included at the end of this report.

LAS activities:

5. In line with the standard NHS contract, the LAS is required to report quarterly details of Freedom To Speak Up cases to the National Guardian's Office. In quarter four 2017-18, five cases have been raised and two cases have been closed. By way of comparison there were two cases raised during Q1 – Q3 2017-18.

6. The format of the quarterly reporting of LAS cases was set out in January's report to the Board and is as follows.

    - **How many new speaking up cases were raised?** Five.
    - **Are there any areas of the service that have featured more than others?** Concerns were raised from across the Trust and not in any one area.
    - **Any actions taken as a result of investigation into these cases?** The Guardian focuses on the outcomes workers seek when they raise concerns. Following discussions between the worker and the Guardian two cases were investigated and the following recommendations fed back:

        1. The first was a request from a paramedic in the Cycle Response Unit who had concerns that CRUs were being 'missed or overlooked for incidents' as they were not integrated into the Ambulance Response Programme. The issue had been raised through multiple channels and senior management in the Emergency Operations Centre were aware. A six monthly review of Ambulance Response Programme (ARP) will take place in July 2018 which will include a review of the dispatch of cycle response units.

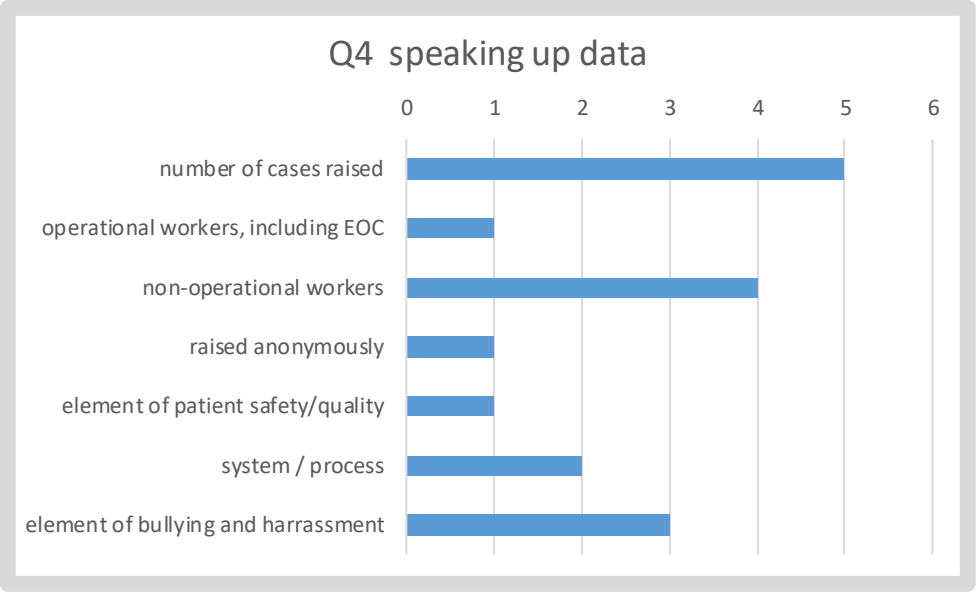
        2. The second was an anonymous concern raised about the 'fairness' of granting annual leave to individuals joining a team and the impact on the allocation of Christmas leave for existing staff. HR have agreed to review the arrangements for

annual leave and assess the 'fairness' of allocating leave over holiday periods to balance the needs of the organisation, existing staff and new staff.

- **Any themes arising?** Bullying and harassment continues to be a concern for staff. In each of the three bullying and harassment cases recorded with the Guardian, the workers either wished to address their concerns through other channels or decided against taking action for fear of suffering detriment.

7. From the Guardian's point of view the wishes of the worker is paramount and their confidentiality should be maintained to ensure they do not suffer detriment from speaking up. In each of the three cases workers reported that they valued the opportunity to talk through their actions with a confidential third party.

8. As a priority action the Board may wish to evaluate the effectiveness and range of current initiatives to address persistent concerns being raised (and not being raised) of bullying and harassment. As an organisation aspiring to be a first class employer, all workers should be valued for speaking up and have confidence in the processes to address bullying and harassment allegations.



[NB – a single case may include several categories and ALL the categories that apply to it are reported]

9. Conal Percy, interim Guardian and Philippa Harding, the executive lead for Speaking Up, were interviewed by the CQC during the re-inspection in March. The CQC also met the Guardian separately as is now customary during CQC inspections. The CQC were positive about the recent promotion of speaking up activities and the plans to create a network of local speaking up champions across the Service on appointment of the part-time Guardian.

10. Other activities during the quarter:

- A Trust wide Freedom to Speak Up survey received 200 responses on how best to foster a speaking up culture, identifying current areas of good practice and barriers to speaking up. The results have yet to be published while recruitment to the part-time post is underway.

- Speaking up pages on the Pulse were updated.
- In January the interim Guardian was introduced to the Board and at a CEO managers' briefing.
- Speaking up was promoted on news items on the Pulse, Facebook / LIA and a newly designed speak up poster was distributed to approximately 80 LAS sites, including stations, NETS and 111.
- Speaking up has been incorporated into the induction programme for all new staff.
- The permanent part-time Guardian post has been created, banded and advertised.
- The interim Guardian carried out station visits with the NHS Improvement Director and attended a number of CEO Roadshows.
- The interim Guardian attended regional and national speaking up events.
- Completion of FTSU self-review tool. The Board needs to articulate a clear LAS FTSU vision with a realistic strategy, linking speaking up with patient safety, staff experience and continuous improvement.

National Guardian's Office (NGO):

11. The NGO has published Guidance for Boards on Freedom to Speak Up in NHS trusts (May 2018). The guidance has been produced jointly by the NGO and NHS Improvement and is attached as an Annex to this report.

    - It sets out expectations of Boards and Board members in relation to Freedom to Speak Up.
    - A self-review tool is provided with guidance and the Board are asked to discuss the contents of this document.
    - It includes important guidance for Freedom to Speak Up Guardians on their relationship with Board members, and reporting to their Boards.

12. In April the NGO published a Guardian Education and Training Guide produced in partnership with Health Education England and the NHS Leadership Academy

    - the guide will help guardians improve their skills and knowledge
    - includes a competency framework and self-assessment toolkit to support training and development needs.

13. The NGO published a universal job description for guardians which was incorporated into the LAS Guardian job description.

14. A data analysis of the NHS Workforce Race Equality standard was published in March[1]. It made reference to the critical role of Freedom to Speak Up Guardians to support a more open culture within the NHS and of the disproportionate bullying experienced by BME staff that raised concerns.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/wres-data-analysis-report-albs.pdf

- Some organisations are funding and supporting broader action to establish **safe spaces** for workers to speak up and provide better support for workers health and wellbeing.

15. NHS Improvement has published a Just Culture guide[2] that encourages managers to treat workers involved in a patient safety incident in a consistent, constructive and fair way.

    - The fair treatment of workers supports a culture of fairness, openness and learning in the NHS by making workers feel confident to speak up when things go wrong, rather than fearing blame.

    - This guide supports a conversation between managers about whether a worker involved in a patient safety incident requires specific individual support or intervention to work safely.

    - There is a distinction between inadvertent human error which may require support and coaching, versus gross negligence, or deliberate harm which may require sanction.

16. In February 2018 the NGO published its second Freedom to Speak Up case review about the speaking up culture, processes and policies at Northern Lincolnshire and Goole NHS Foundation Trust. The report included 23 recommendations for the Trust designed to support improvement. Key findings included:

    - Evidence of a poor speaking up culture in the trust where issues raised by workers were not always responded to according to good practice, including where staff had raised serious safety issues

    - Evidence of bullying in the trust, including the existence of a bullying culture within specific teams, that made workers fear the consequences of speaking up

    - The trust's bullying and harassment policy needed improvement to ensure it met the standards set out in guidance by NHS Employers.

    - The review also found evidence of good practice that was supportive of trust workers speaking up. This included:

    - A robust recruitment process to select staff to undertake the role of Freedom to Speak Up Guardian and Associate Guardians to support speaking up

    - The launch of a series of listening events in autumn 2017, to listen and learn from the views of staff

    - The improvement of human resources processes to ensure they are more supportive of workers who speak up

    - The commencement of work to assess the personal professional values and behaviours of senior managers

17. In January 2018 he CQC published new guidelines in relation to the fit and proper person's requirement (FPPR) for directors[3]. The first NGO case review (November 2017) made a recommendation for the CQC around FPPR for directors in relation to workers who had

[2] https://improvement.nhs.uk/documents/2490/NHSi_just_culture_guide_A3.pdf

[3] https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf

spoken up about alleged discriminatory and racial discriminatory behaviour of one of the directors. Its recommendation for the CQC was that information from people who speak up is considered when assessing whether a satisfactory fit and proper person review has taken place.

18. The NGO is to undertake three new case reviews following the raising of speaking up issues at the following trusts:

- Derbyshire Community Health Services NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trusts
- Nottinghamshire Healthcare NHS Foundation Trust

19. The NGO held its annual conference in London. There were presentations from:

- Michael West, Head of Thought Leadership the Kings Fund on compassionate collective leadership

- Martin Bromiley, commercial airline pilot and Chair of the Clinical Human Factors Group, talked about the importance of non-technical skills, including inquiry and assertiveness. Inquiry included not being afraid to express a lack of knowledge. Assertiveness included team members speaking up without hesitation and how to deal with conflict and with aggressive behaviour. Leaders were expected to be decisive, but concentrate on what was right, rather than who was right.

- Sir David Behan, Chief Executive of the CQC, spoke on creating an open and honest reporting culture.

- Sir Simon Stephens, CEO of NHS England, reported on the results of the NHS staff survey and the 5 questions relating to speaking up. Specifically the percentage of staff who:
    1. know how to report
    2. are secure in reporting
    3. did actually report
    4. are encouraged by their organisation to report
    5. are treated fairly

- Dr Henrietta Hughes, the National Guardian spoke on the themes raised to Guardians, the majority of which concern bullying and harassment.

20. Organisations are required to provide quarterly data to the National Guardian's Office. Key headlines from Q4 national data (January – March 2018) are:

- 2,114 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- 642 of these cases included an element of patient safety / quality of care
- 1,027 included elements of bullying and harassment.
- 93 related to incidents where the person speaking up may have suffered some form of detriment.
- 366 anonymous cases were received
- 16 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 222 of the 232 NHS trusts sent returns. Over 95% sent returns, up from 62% for Q1 (April – June)

National Ambulance Network of Guardians (NAN):

21. The National Ambulance Network of Guardians meets quarterly to share good practice and provide mutual support. The meetings are held in different regions and include an element of CPD as well as an opportunity to network and share information.

22. The most recent meeting (March 2018) was held at West Midlands Ambulance Service. The Non-Executive Director responsible for speaking up attended for part of the meeting to have an informal conversation with members of the group.

Conclusion

23. The LAS continues to have a high level of engagement with the NGO, the National Ambulance Network and the London Region Network of Guardians.

24. The NGO's recent case reviews and guidance to the Board are beginning to demonstrate the value of the Guardian role.

25. Once the LAS appoints a part-time Guardian there will be an opportunity to develop and increase capacity within the role. The Board needs to demonstrate its commitment to the speaking up culture and actively support the creation of Freedom to Speak Up advocates.

26. The Board is asked to note the contents of this report.

Conal Percy
Interim Freedom to Speak Up Guardian

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	General Data Protection Regulation (GDPR)			
Agenda item:	17			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Board briefing previously circulated in correspondence			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This paper provides the Audit Committee with an update on the organisation's progress with preparations for the implementation of the General Data Protection Regulation (GDPR).

Recommendation:

The Committee is asked to note and comment on the progress being made.

Links to Board Assurance Framework (BAF) and key risks:

Compliance with GDPR has not been identified as a BAF risk, but it is risk that the Audit Committee and the Board has identified requires mitigation.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

General Data Protection Regulation (GDPR)

Background and introduction

1. As the Board is aware, a GDPR project has been established, which has made great strides towards identifying the key issues the London Ambulance Service NHS Trust (LAS) faces with regard to GDPR and which has completed some significant milestones.

2. Further to a briefing that was circulated to the Board in correspondence earlier this year, the Board is aware of the impact of GDPR, the results of a self-assessment undertaken by the Chief Information Officer and the Director of Corporate Governance and the actions proposed to address the gaps identified as a result of this. The Audit Committee has also received the outcome of a GDPR preparedness review undertaken by the Trust's internal auditors (KPMG) and an update on progress against these actions.

Information Commissioner's Office (ICO) 12 Steps

3. The ICO issued 12 steps to prepare for GDPR, these fundamental steps give clear guidance on how organisations should prepare to address the requirements. The 12 steps and the impact on LAS are detailed below:

    i) **Awareness** – Ensure decision makers are aware of the new legislation and the likely impact this will have on the LAS.

    ii) **Information you hold** – We must understand what personal data we hold – where we got it from and who we share it with.

    iii) **Communicating Privacy Notices** – Notices tell individuals what data we are collecting and what we will do with it. These must be reviewed and updated.

    iv) **Individual rights** – While rights given to individuals under DPA are preserved, the GDPR adds further rights. We must ensure we have processes in place to support their being exercised.

    v) **Subject access requests** – The GDPR requires these to be handled slightly differently, and reduces the time available for responses. Processes will need to be reviewed and updated.

    vi) **Legal justification for processing** – The GDPR requires us to have a clear legal basis for the processing of personal information. This will need to be documented.

    vii) **Consent** – The GDPR is more explicit over how we may gain consent for processing and allows individuals to withdraw it. Where the justification for processing is consent, they will need to meet the new rules.

    viii) **Children** – New rules will apply to the processing of the personal information of children.

    ix) **Data breaches** – Breaches will now need to be reported to the ICO in certain circumstances. We will need to review our breach handling process and bring it into line with the GDPR.

x) **Data protection by design** – All business changes and projects around the processing of personal information must complete privacy impact assessments as part of the planning of the work.

xi) **Data protection officer** – We must appoint a DPO who will take responsibility for data protection. We will need to decide where the role sits within LAS and its governance arrangements.

xii) **International** – Where we have international operations, we will need to determine which supervisory authority we come under.

Actions taken in light of the 12 Steps

4. The Trust has taken the right approach, but needs to finalise this work, in order to ensure that it completely complies with GDPR and the subsequent changes to the Data Protection Act (DPA). Since the GDPR has built on the fundamentals of the DPA, the Trust has numerous policies, processes and safeguards in place, these have been augmented to support GDPR:

i) **Awareness** – All Information Asset Owners (IAO), senior management and Board members are aware of the changes – furthermore the staff have been made aware of the changes through Information Asset Register (IAR) Workshops and a formal training programme is being drawn up. Training used for all staff is the nationally approved online training package and it is our understanding that this will be updated to reflect the new DP legislation.

ii) **Information you hold** – We have identified the data types and sources allowing us to work with the IAOs to ensure that their data is processed and handled with the appropriate controls, using Data Privacy Impact Assessments (DPIA). We continue to work with the IAOs to maintain a good level of control over the data.

iii) **Communicating Privacy Notices** – Our privacy notices have been changed in accordance with the requirements and they tell individuals what data we are collecting and what we will do with it. These notices will continue to be reviewed and updated.

iv) **Individual rights** – We have updated our internal processes to support individuals' rights of rectification, erasure (the right to be forgotten), restriction, data portability and objection to processing.

v) **Subject access requests** – The LAS has made changes to its processes to provide individuals with access to their personal information normally within one month and at no charge. These changes are an augmentation of our existing processes.

vi) **Legal justification for processing** – The Trust has a clear legal basis for the processing of personal information. This justification has been documented and will be reviewed on an on-going basis.

vii) **Consent** – Where the justification for processing is consent; the Trust, where applicable, has changed its processes to support the obtaining of verifiable consent that is freely given, specific, informed and unambiguous and allows individuals to withdraw it.

viii) **Children** – The Trust has reviewed the changes and these have minimal impact on the processing of the personal information of children, where they do, the Trust has ensured that the transparency and lawfulness are maintained.

ix) **Data breaches** – The Trust has updated its policies and processes to comply with the requirement to report specific breaches to the ICO within 72 hours of becoming aware of such a breach. These changes are slight changes to our current operational practises.

x) **Data protection by design** – All business changes and projects around the processing of personal information must complete privacy impact assessments as part of the planning of the work. Our Architectural Review Board has GDPR requirements as part of the Information Artefacts; these include, but are not limited to, DPIA, Data maps, etc.

xi) **Data protection officer** – The Trust has appointed a DPO who will take responsibility for data protection.

xii) **International** – We understand our obligation and whilst we do not currently share data with overseas parties, we will continue to review the situation.

Organisational Commitment

5. The Trust is now in the second tranche of work to ensure that complete compliance to the GDPR is met. There is a dedicated team to ensure that our GDPR maturity and posture are increased as the programme continues to make definite and concise changes to the practises at the Trust. Our team have management support and good reporting channels to the executive, LAS continue to meet their legal obligations and safeguard our data.

GDPR project deadlines and dependencies

6. The Trust has a key set of objectives and milestones for the rest of the year to ensure full compliance with GDPR, having the fundamentals in place, LAS realises that the minimum standard would not suffice in the healthcare sector and we strive to be the best we can in safeguarding our staff and patients data.

Conclusion

7. LAS has taken their obligations under GDPR and reviewed current operations to ensure that the new security principle are complied with. We have taken a holistic approach and incorporated the processes, policies, awareness and technical controls to protect our data. The concepts are not new to LAS and we continue to improve our practises to ensure that the confidentiality and integrity is maintained whilst in our domain. Our technical teams are safeguarding systems, architecture and solutions to provide secure processing of personal data. Accountability for the data sits at the highest level in LAS and our Board are cognisant of our responsibilities under GDPR. Data protection is at the heart of all we do.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	18			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	Assurance	☒	Discussion
	☐	Decision	☒	Information

Background / Purpose:

This report provides the Board with an updated forward plan for Board meetings until the end of the 2018/19 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas.

This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.

Recommendation(s):

The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2018/19 financial year.

This report relates to the following Board Assurance Framework (BAF) or other risk:

Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Trust Board forward planner: 2018/19

Area	Lead	July - Tuesday 31 July 2018	August
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Staff Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	
	JJ		
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP		
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW	Rest Break Policy implementation review	
	PW	EPRR/NARU Action Plan	
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE	Quarterly Strategy Update	
	LB		
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH		
	JO, PH		
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		
		Patitent Experience Annual Report	
		Patient & Public Involvement Annual Report	
		Public Education Annual Report	

Trust Board forward planner: 2018/19

Area	Lead	September - Tuesday 25 September 2018	October
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Patient Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	
	JJ	Audit Committee Assurance Report	
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP		
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW		
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE	Quarterly Strategy Update	
	LB		
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH	FTSUP Quarterly Report	
	JO, PH		
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		

Trust Board forward planner: 2018/19

Area	Lead	November - Tuesday 27 November 2018	December
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Staff Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	
	JJ	Audit Committee Assurance Report	
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP	Logisitics & Infrastructure Cttee Assurance Report	
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW		
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE		
	LB	Business Plan progress review	
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH		
	JO, PH		
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		

Trust Board forward planner: 2018/19

Area	Lead	January - Tuesday 24 January 2019	February
Standing items	HL	Welcome and apologies	
	All	Declarations of Interest	
	HL	Minutes of previous meeting	
	HL	Matters arising & action log	
	TB	Patient Story	
	HL	Report from the Chair	
	GE	Report from the CEO	
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	
	JJ		
	RM	Quality Assurance Committee Assurance Report	
	JM	People & OD Committee Assurance Report	
	FC	Finance & Investment Committee Assurance Report	
	TdP		
	PH	BAF & Corporate Risk Register	
	TB	Serious Incident Management	
	PW		
	PW		
Annual Reporting	LB, PH		
	PH		
	JJ		
	TB		
Strategy & Planning	GE	Quarterly Strategy Update	
	LB		
	TB		
	PG		
Governance	TB		
	PH	Report from the Trust Secretary	
	PH	Trust Board forward planner	
	PH		
	PH		
	PH	FTSUP Quarterly Report	
	JO, PH		
Concluding matters	HL	Questions from members of the public	
	HL	Any other business	
	All	Review of the meeting	
Additional reports	TB	Quality Report	
	TB		
	RF		
	PG		

Trust Board forward planner: 2018/19

Area	Lead	March - Tuesday 26 March 2019
Standing items	HL	Welcome and apologies
	All	Declarations of Interest
	HL	Minutes of previous meeting
	HL	Matters arising & action log
	TB	Staff Story
	HL	Report from the Chair
	GE	Report from the CEO
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report
	JJ	
	RM	Quality Assurance Committee Assurance Report
	JM	People & OD Committee Assurance Report
	FC	Finance & Investment Committee Assurance Report
	TdP	
	PH	BAF & Corporate Risk Register
	TB	Serious Incident Management
	PW	
	PW	
Annual Reporting	LB, PH	
	PH	
	JJ	
	TB	
Strategy & Planning	GE	Quarterly Strategy Update
	LB	
	TB	
	PG	
Governance	TB	
	PH	Report from the Trust Secretary
	PH	Trust Board forward planner
	PH	
	PH	
	PH	
	JO, PH	
Concluding matters	HL	Questions from members of the public
	HL	Any other business
	All	Review of the meeting
Additional reports	TB	Quality Report
	TB	
	RF	
	PG	

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	24 May 2018			
Report title:	Quality Report			
Agenda item:	Additional Report (for information only)			
Report Author(s):	Dr Trisha Bain Chief Quality Officer			
Presented by:	Dr Trisha Bain Chief Quality Officer			
History:	Quality Assurance Committee meeting on 22 May 2018			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report outlines April's position in relation to quality performance

Recommendation(s):

The Board is asked to note and consider the content of this report.

Links to Board Assurance Framework (BAF) and key risks:

All Board Assurance Framework risks relating to quality governance and risk frameworks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Ambulance Service NHS Trust

Quality Report

May 2018

All data pertains to April 2018 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

Legend
- Above Target
- Within 5% of Target
- Over 5% from Target

Executive Summary: Exception Report (Positive)

Safety

- Hand Hygiene reporting improved from 95% in March 2018 to 98.38% in April against the set target of 90%
- National IPC Group from 4 countries met in LAS premises in April 2018 to undertake national benchmarking work streams. LAS is ahead in quality assurance of cleanliness standards using ATP swabs, workforce immunisation, IPC training, and is leading on the national work stream to define standards for ambulance station environment
- No unaccounted for morphine losses
- 8 Serious Incident investigations were closed in April.
- We have received feedback from the CCG advising of the significant assurance the Trust provides regarding the management and learning from SI's
- One joint training event with Northwick Park Hospital as part of strengthening communication and joint MDT (May 2018)
- The Trust Intelligence Systems Manager has identified a number of improvements within the incident reporting system (Datix).

Actions & Assurance

- Maintain medicines management audit programme
- Further station based maternity "skills drills" training offered
- Successful appointment of 2 Practice Leads for Pre Hospital Maternity Care – Commencement in July/August 2019
- The improvements made in Datix ensures greater accuracy when generating reports. For example; some CD incidents were not extracted from Datix when using certain search criteria.

Effectiveness

- 97% of stroke patients received the complete care bundle in March (in line with the 2017-18 average)
- 'Mean from call to arrival at hospital' for stroke patients was 1 hour and 15 minutes in November 2017 (in line with the national average)
- Cardiac arrest response time for C1 patients in March remained at 7 minutes (11 minutes 90th centile)
- A high of 63.8% ROSC was achieved for the Utstein comparator group in March

Actions & Assurance

- Recommended changes to the CPIs to help reduce job cycle time went live on 1st April
- The Elderly Falls CPI was launched
- Retrospective safeguarding referral and Datix incident prompts were incorporated into the CPIs with a flag for further discussion
- Findings to be shared upon completion of report
- Existing incidents reviewed and staff provided with feedback

Caring

- First trust "Whose Shoes" listening event to take place on 11th May 2018

Actions & Assurance

- Outcome from engagement event to be incorporated into trust wide Quality Improvement Projects.

Executive Summary: Exception Report (Improvement Required)

Safety

- Six-weekly deep clean compliance of A&E vehicles was 94.4% against the Trust target of 95%
- FFP3 solution delayed
- Sharps/BFE data and communicable diseases for staff is not yet available for May Report
- By the end of 2017/18 only 35% of clinicians received two face-to-face CPI feedback sessions (28% received no feedback at all) against a target of >95%.
- 8 Health Partner Alerts were received by maternity units in relation to delays when midwives have requested transfers. The Trust Consultant Midwife is reviewing each case and is in the process of updating aide memoire card issued to Midwives who require ambulance transport for mothers in labour.

Actions & Assurance

- Reissue promotional posters relating to correct administration of adrenaline
- Quality alerts not currently raised as a Datix incident – recommendation to implement
- Meeting with Quality Assurance Managers for the EOC 3/5/2018 to find workaround and request for change

Effectiveness

- Contract for KitPrep and Perfect Ward apps due for renewal in November 2018 – this process will need to go tender due to the costs involved. Potential risk to disruption of audit and medicines tracking processes
- In March, 74% of STEMI patients received the complete care bundle against a target of 100% (excluding exemptions i.e. when an element of the care bundle is not indicated)
- 'Mean time from call to angiography' for STEMI patients for November 2017 was 2 hours and 8 minutes. This is below the national average of 2 hours and 18 minutes (NHS England AQI Statistical Note – 10th May 2018)
- 52% of patients arrived at a HASU within 60minutes of stroke onset against a target of 66%

Actions & Assurance

- Medicines management group input into the renegotiations
- CARU have produced an infographic detailing the four care bundle elements with hints and tips for each element and a handy list of valid exceptions

Caring

- During April we received a 23% increase in complaints of which 40 related to delays in an ambulance attending (39%).
- The outcome of this increase is that the number of complaints over 35 working days at the time of this report exceeded 40.

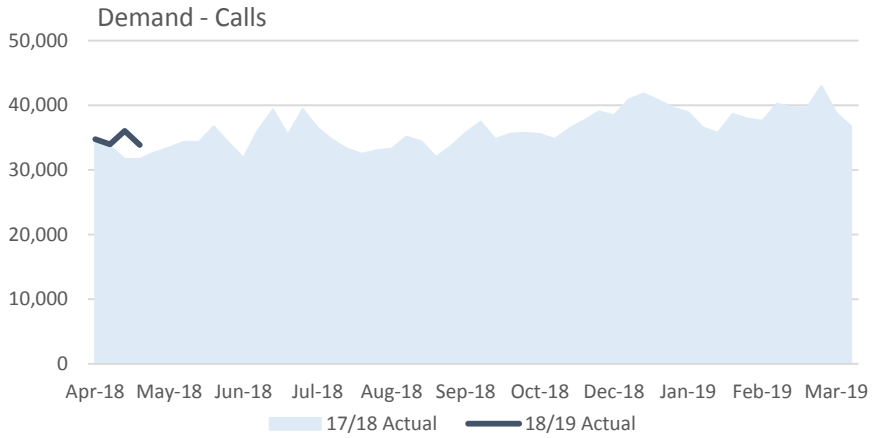
Actions & Assurance

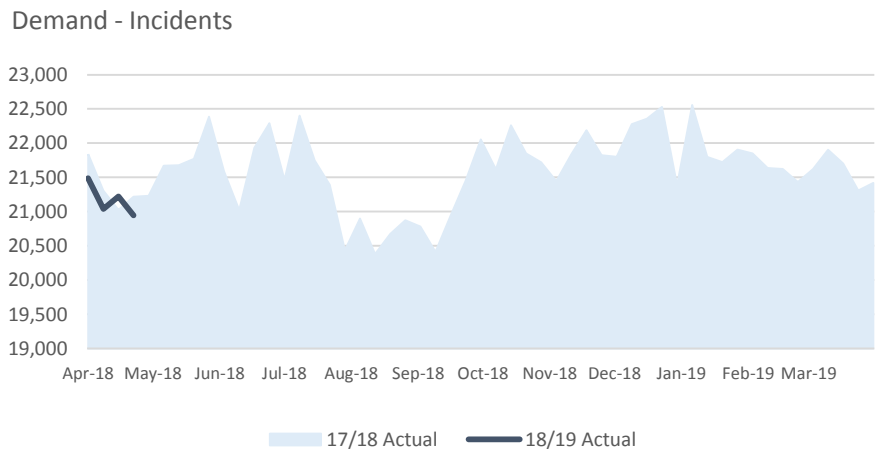
Delays are attributed to operational pressure in the respective teams (EOC QA, Chub and Operations). Staffing levels due to unplanned absence within the Patient Experience Department have also impacted throughput. The Chief Quality Officer has arranged for additional clinical support to be provided to the team in order to reduce delays.

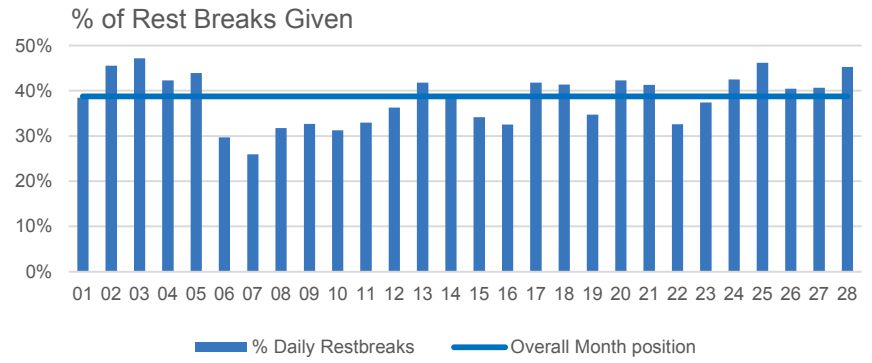
Performance Pressure

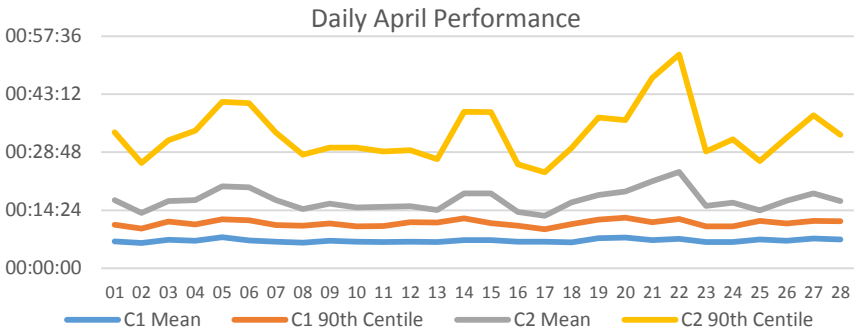
Pressures

Performance









- In April the Trust lowered the Resource Escalation Action Plan (REAP) level to Level 1 – Steady. This means the number of manned resources is meeting the demand of our 999 and Urgent Care activity and that this activity is within or below the forecast expectation. Our YTD performance indicates we are meeting key performance targets and delivering a safe, quality service.

- REAP 1 allows for certain abstractions for clinical development, training and essential meetings with Clinical Team Leaders in order to provide feedback to staff on the quality of the care they are providing to patients.

SAFE – Dashboard

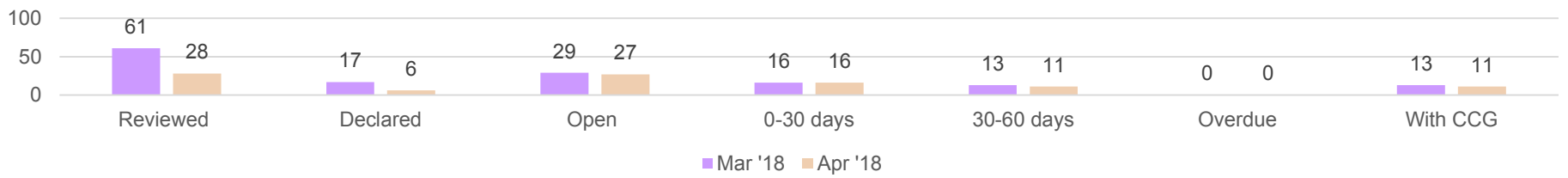
Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	G	98%	78.4%	71.7%	98.0%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	R	2.4	2.7	2.7	2.4	↓					
Patient related Adverse Events - NO HARM	100	G	172	168	176	172	↓					
Patient related Adverse Events - LOW	40	R	24	28	34	24	↓					
Patient related Adverse Events - MODERATE	25	R	14	14	18	14	↓					
Patient related Adverse Events - SEVERE			5	2	12	5	↓					
Patient related Adverse Events - DEATH			5	18	19	5	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	G	3.7	2.9	2.7	3.7	↑					
Staff related Adverse Events - **NONE**			184	135	140	184	↑					
Staff related Adverse Events - **LOW**			146	108	110	146	↑					
Staff related Adverse Events - **MODERATE**			4	7	9	4	↓					
Staff related Adverse Events - **SEVERE**			0	2	0	0	↔					
Controlled Drugs - Other Reportable Incidents			46	46	56	46	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	G	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	G	96%	91%	93%	96%	↑					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	G	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month			6	7	17	6	↓					
Serious Incidents breaching 60 days	0	G	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	G	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	G	100%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events			4%	6.5%	6.2%	4.1%	↓					
Needle Stick Injuries as % of Staff Adverse Events			1%	2.0%	1.5%	0.6%	↓					
Never Events	0	G	0	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	G	0%	0%	0%	0%	↔					
Missing Equipment Incidents as % of all reported incidents			3%	3%	3%	3%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents			10%	11%	10%	10%	↓					
Staff Immunisation Status - FROM NEXT MONTH							↔					
Number of NRLS uploads In-Month	1	G	1	1	1	1	↔			LQ21		

SAFE - Patient Safety

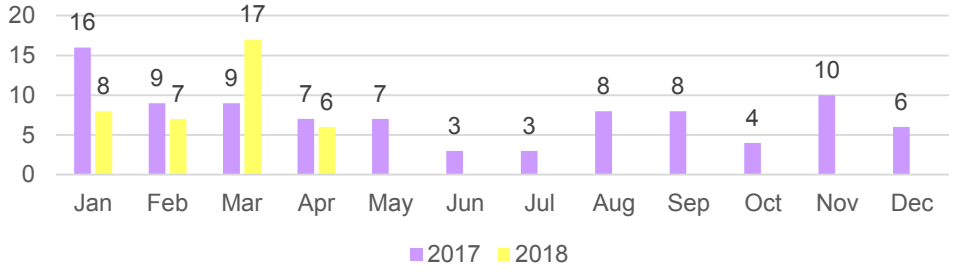
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

SI Activity

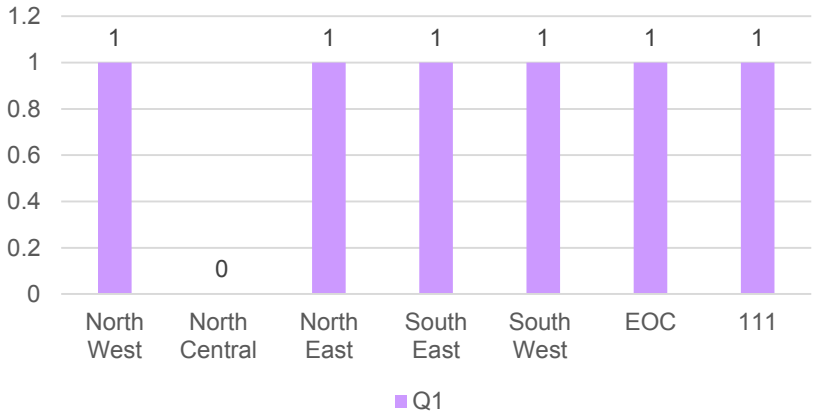


A total of 28 incidents were reviewed by SIG in April of which 6 were declared as SIs. 11 completed investigations have been submitted to the CCG and are awaiting closure or comments. The Trust is maintaining its contractual obligations with the CCG and currently there are 0 investigations that have breached the 60 working day deadline.

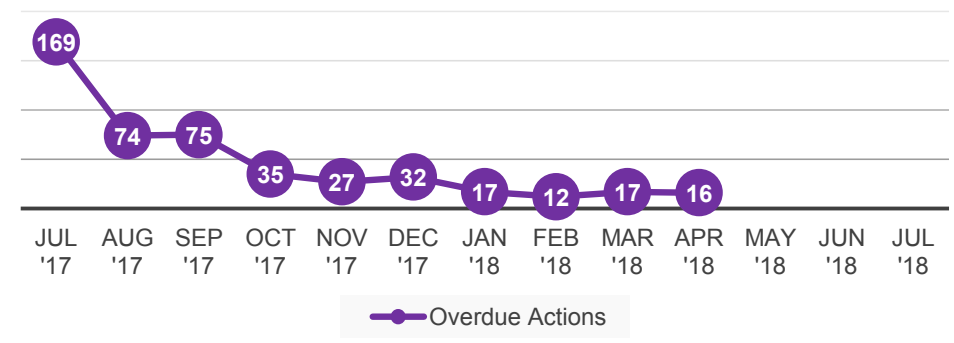
Serious Incidents Declared by Month



Serious Incidents Declared by Sector STP



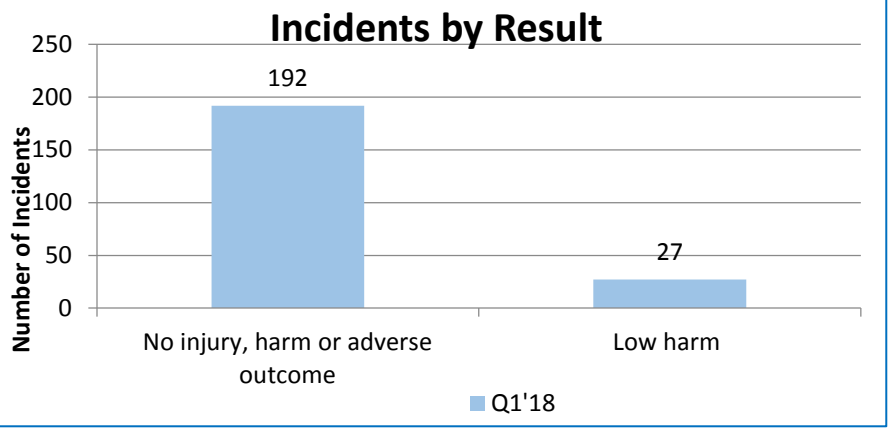
Overdue Actions at Month End 2017/18



- The number of SIs declared in April 2018 has returned to the level expected in comparison to the previous year.
- There are currently 16 SI actions that are overdue (against an internal target of <10). The Quality, Governance and Assurance Team maintain contact with the accountable manager on a weekly basis.
- The majority of actions that are overdue are part of larger service improvement programmes or are affected by rota patterns and staff absence.

SAFE - Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



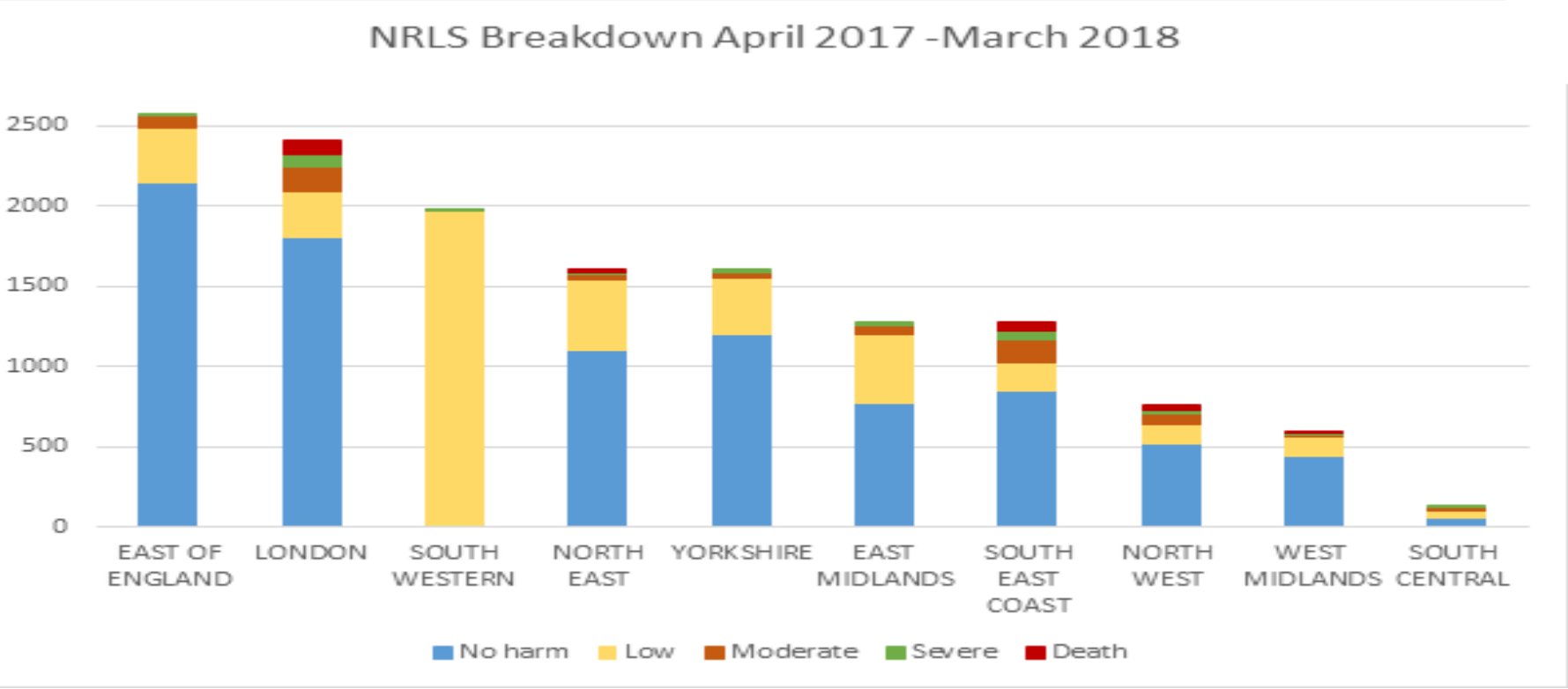
- In April, the new Head of Quality Intelligence & Improvement joined the Trust along with a new Datix Systems Manager. Collectively they have worked to validate how data is collected and shared by the Trust incident reporting system, including uploads to the National Reporting & Learning System (NRLS). This included ensuring the level of harm is extracted from the post investigation element of the incident report resulting in improved accuracy and assurance.
- The Trust incident reporting system is being reviewed and the way data is being collected has now been validated. KPI's for 2018/19 are currently in the process of being finalised.

The Trust set annual Key Performance Indicators (KPI's) for the reporting of incidents that have been graded as either no harm or low harm. The target of 1200 no harm incident reports was exceed in 2017/18 whilst the target number of incident reports for Low harm has not been achieved.

Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q3		Q4			
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Nov	Dec	Jan	Feb		
21	Operational Risk	There is a risk that the Trust does not learn from previous serious incidents and therefore does not prevent or mitigate against similar incidents from occurring in the future.	Mike Ward	Trisha Bain	12	12	9	9	9	6	Approval required for additional work flows to cover key findings and recommendations from thematic reviews. Recent KMPG audit demonstrated significant assurance of learning from SIs.
673	Operational Risk	There is a risk that there will be a delay in identifying incidents that meet the SI criteria and therefore a delay in immediate risk mitigations as a result of incorrect grading or internal audit delays.	Mike Ward	Trisha Bain	9	6	6	6	6	3	There is a delay in local management reviewing incidents and ensuring the grading is correct. This is currently being mitigated by the Quality, Governance and Assurance Team undertaking daily incidents reviews whilst further training is provided to local managers.

SAFE – NRLS Uploads

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



The Trust is the second highest reporter to the National Reporting & Learning System (NRLS). The data is comparable in Trusts with a similar demographic (i.e. SECAMB).

This data represents those Patient safety incidents which the Trust (and other ambulance Trusts) has selected to report to the NRLS, this does not reflect all Patient related incidents reported in the same period (April 17-Mrach18).

Only those incidents that have been selected and have been closed and given Final Approval are reported to the NRLS.

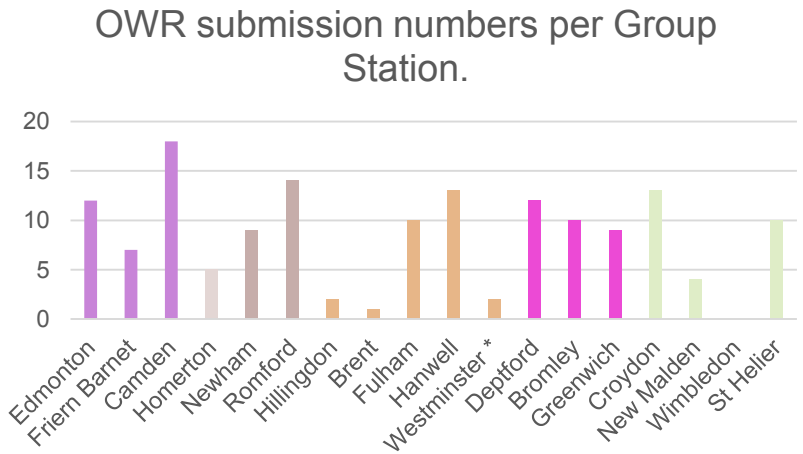
We are currently reviewing our processes for the reporting of incidents to the NRLS so trends may change in the future.

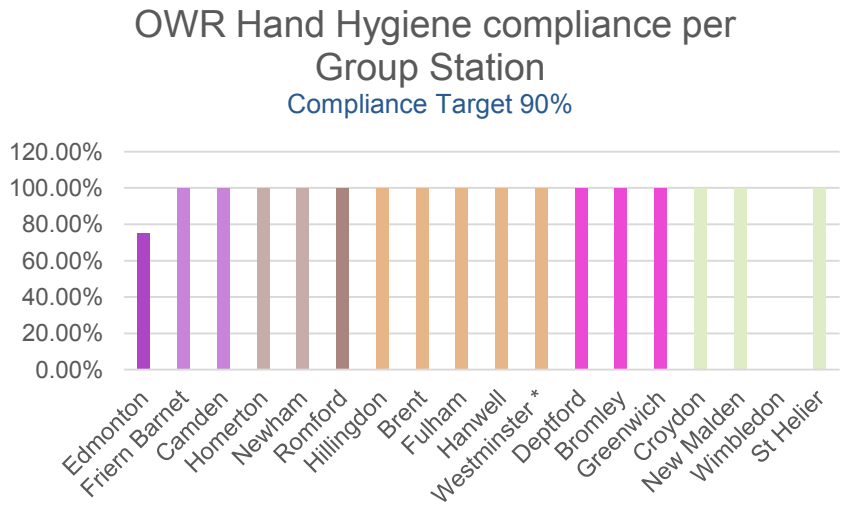
The next reporting cut off to the NRLS is the 31/05/2018, for all incidents occurring 01/10/2017 to 31/03/2018.

SAFE - Infection Control

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly Hand Hygiene Compliance April 2018 (Trust Compliance target: 90%)





Performance

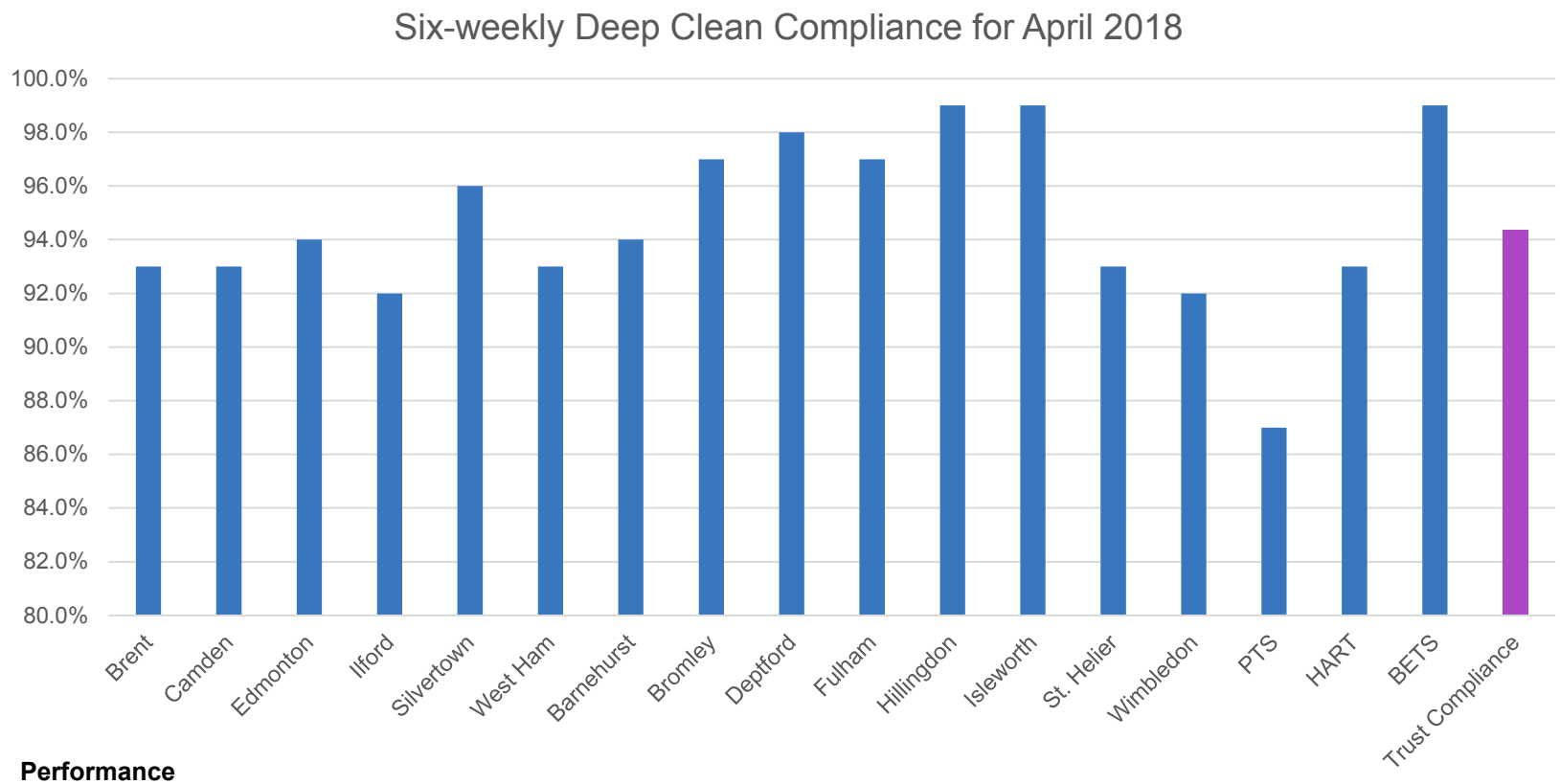
- Hand Hygiene reporting agreed for 2018/19: Submitted with non-submissions highlighted so they can be taken forward to operations performance reviews
- Compliance % for those submitted are analysed - **Overall Trust compliance 98.38% for April**
- Variable submissions from Station Groups in April
- Wimbledon was the only Group Station that did not submit in April

Actions and Assurance

- QGAM of stations not submitting are made aware in order to continue to have oversight of their area
- IPC reports regularly at Sector Quality Meetings
- Monthly CEO Performance Reviews
- Monthly oversight by IPC Team
- Quarterly Oversight by ICDG and IPCC
- IPC Champions who attended training in April provided UV light and disclosing cream to demonstrate practical hand hygiene and provide training
- Positive conversations at A&Es across London in march and April by IPC team members
- Visibility and support for Wellbeing team at CEO Roadshows

SAFE - Infection Control

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Performance

- Logistics agreed report was ready for sharing
- Analysis of the data submitted for each Group Station submitted by the VP Contract Manager was analysed by the IPC team
- Six-weekly deep clean compliance for the trust 94.4% against a target of 95%
- PTS scoring 87%

Actions and assurance

- Logistics managers have regular contract meeting with contractors; regular stakeholder meetings established
- Oversight by quarterly ICDG and IPCC

Monthly IPC Training Compliance April 2018 (Trust Compliance target: 90%)

Training compliance for Level 1 and Level 2 remains good:

- Level 1 – 95.05%
- Level 2 – 96.38%

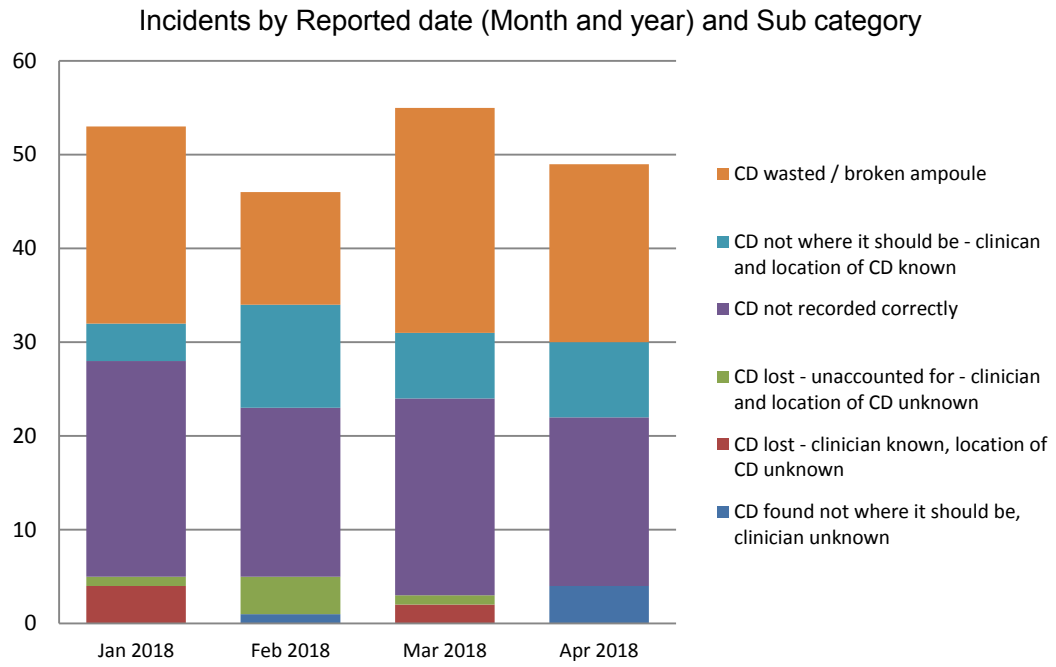
Premises cleaning April 2018 (Compliance Target 90%)

North East	96%
North Central	99%
North West	89%
South East	98%
South West	94%

The Trust compliance score is 95%, well above the agreed target.

SAFE - Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- No unaccounted for losses of injectable morphine
- Total of 44 other controlled drug incidents including
  - Wastage or breakages (n=18)
  - Documentation errors (n=17)
  - Morphine retained off duty or found in wrong location (n=6)
  - CD safe left open (n=2) or unable to access safe (n=1)
- Non-controlled drugs incidents
  - Ampoule breakages (n=4)
  - KitPrep app malfunction or discrepancy (n=4)
  - Out-of-date stock (n=4) and insufficient or missing stock (n=2)
  - Lost or missing drugs packs (n=2) or inadequate stock (n=1)
  - Incorrect or inappropriate administration of adrenaline (n=2), paracetamol (n=1), 10% dextrose (n=2), salbutamol (n=1) and glucagon (n=1) .
  - Overdose of oral morphine by care home staff (n=1)

Actions

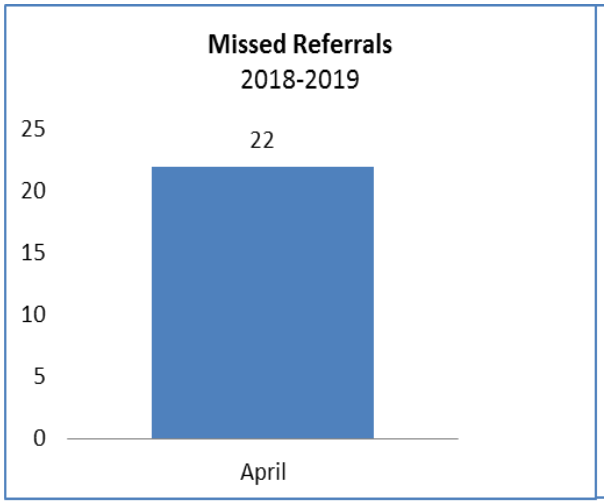
- Ampoule trays procured to reduce incidence of morphine ampoule breakages
- Review of Perfect Ward contract with recommendation to extend to support future medicines management initiatives
- Increased frequency of medicines management group meetings

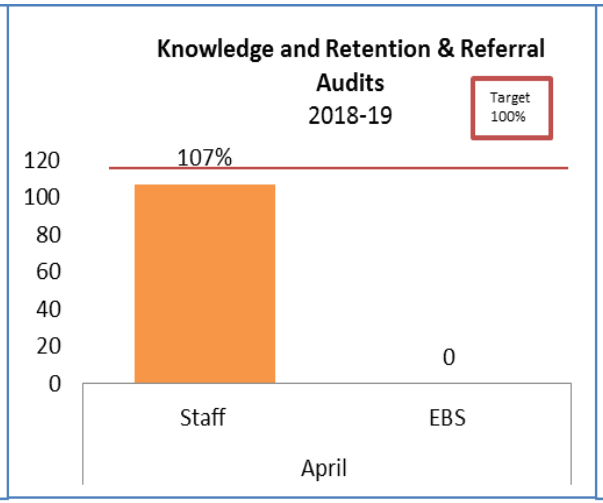
Assurance

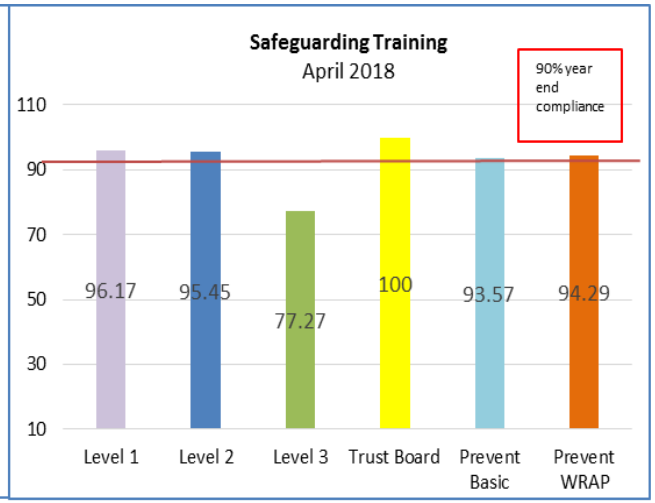
- No unaccounted for losses of injectable morphine
- Rapid identification and return of morphine retained off duty
- Reduction in incidence of controlled drug breakages and documentation errors compared with previous month.
- The Trust Intelligence Systems Manager has identified a number of improvements within the incident reporting system (Datix). These improvements ensure greater accuracy when generating reports. For example; some CD incidents were not extracted from Datix when using certain search criteria in previous months.

SAFE - Safeguarding

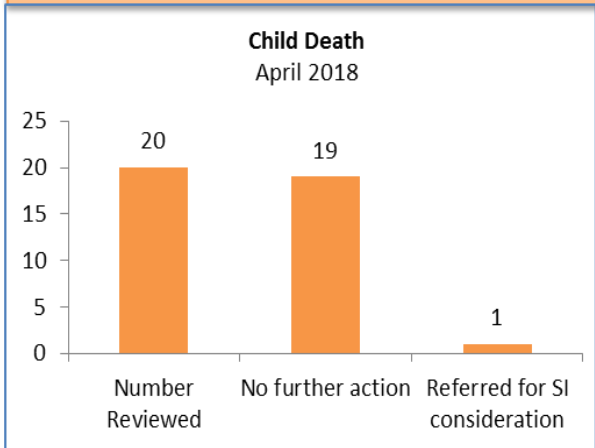
Owner: Alan Taylor | Executive Lead: Trisha Bain

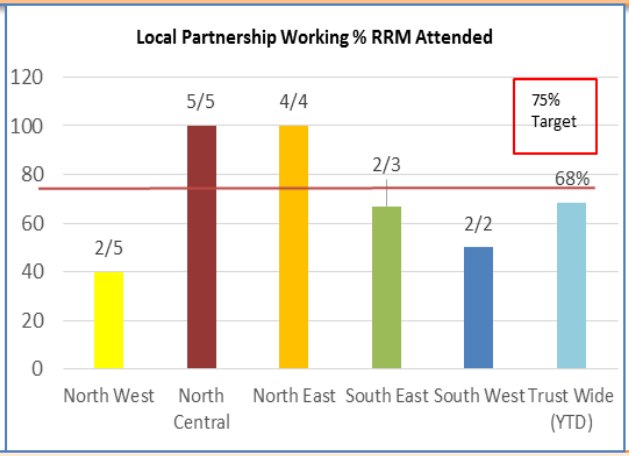






Missed Referrals (Shadow KPI) 122 missed referrals identified in 2017/18 identified from Audits, CARU, SARs and SCR. **Knowledge and Retention Audits** review staff learning across the Trust have a target of 13 per month = 100%. EBS Quality of referral audit currently being established and will report from next month. **Safeguarding Training** on Track for 95% compliance by end of financial year, 111 & EOC have recovery plan to improve compliance.



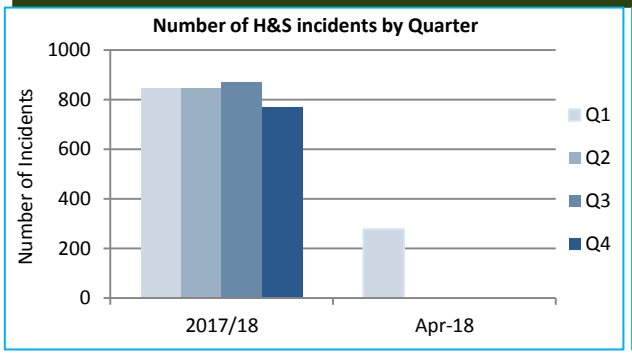


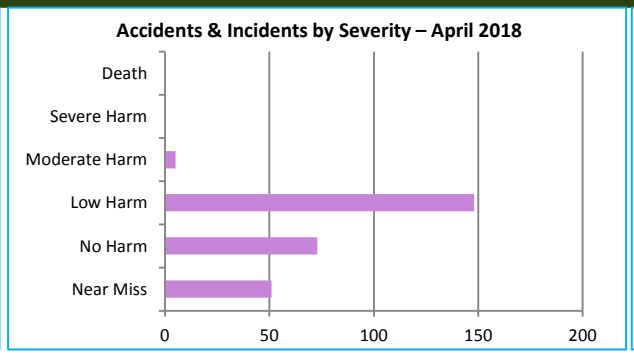
Trust safeguarding referrals and concerns raised

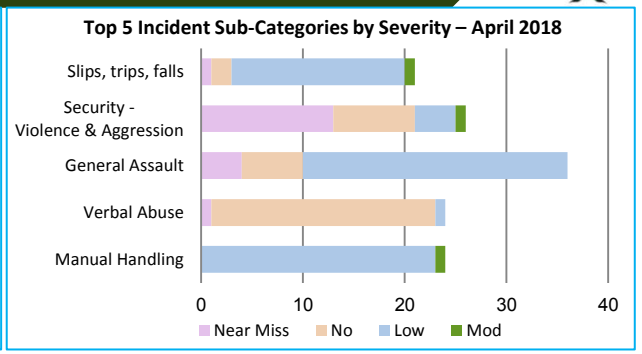
Month	Adults Safeguarding	Adults Welfare	Children	Total Referrals	% incidents
Apr-18	393	650	637	1650	1.8%
May-18					
Jun-18					
Jul-18					
Aug-18					
Sep-18					
Oct-18					
Nov-18					
Dec-18					
Jan-19					
Feb-19					
Mar-19					

Child Death: 100% were processed within 3 weeks of receiving 1 referred to SIG. : **Local Partnership Working** Discussed with Operations work ongoing to improve compliance operations managers aware of importance of these meeting. With operational restructure compliance is proving difficult. Have begun to ask for dial in details so we can attend remotely. **Trust Safeguarding Referrals & Concerns Raised:** Referrals remain within expected levels .

SAFE - Health & Safety Scorecard – (April 2018)



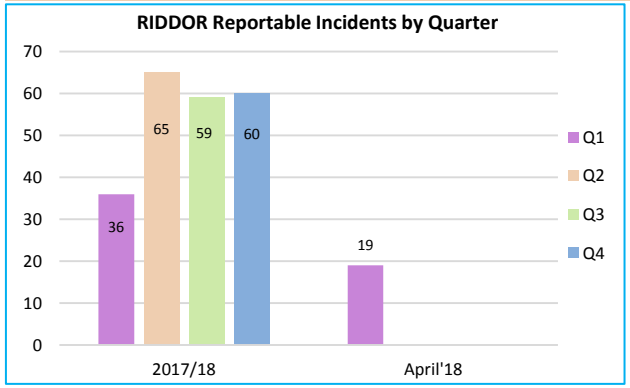


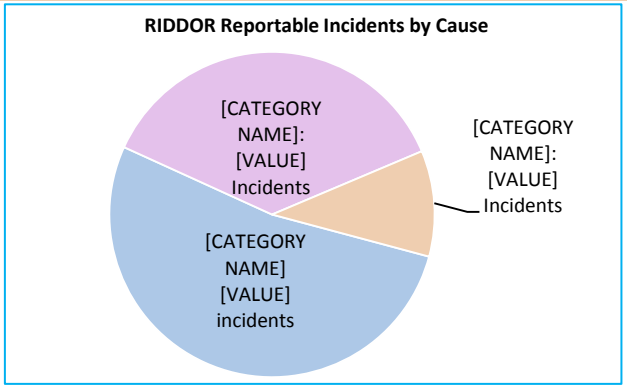


3330 health and safety related incidents were reported during 2017/18. 277 incidents have been reported in April 2018. These H&S related incidents account for 39% of all the incidents reported across the Trust in April 2018.

148 (53.4%) of the H&S related incidents reported during April 2018 resulted in low harm. 5 (1.8%) incidents resulted in Moderate. 124 (44.8%) of the incidents were reported as 'No Harm/Near misses'.

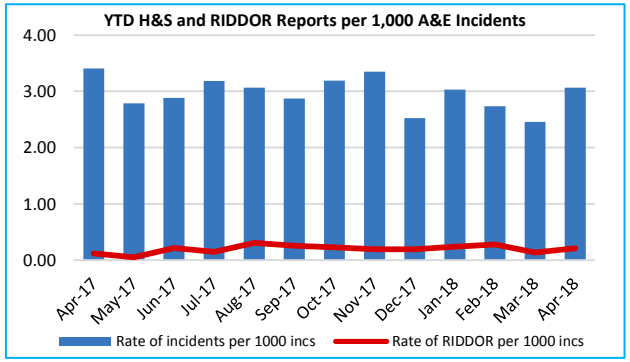
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported during April 2018.

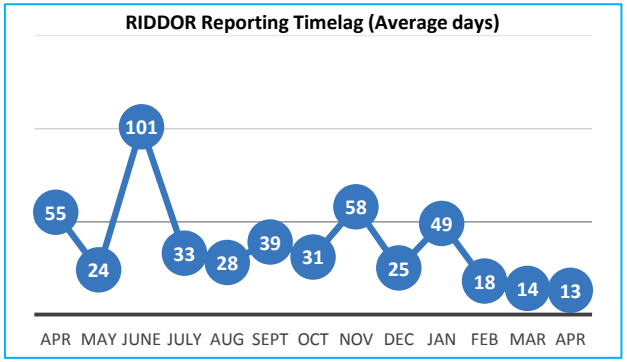


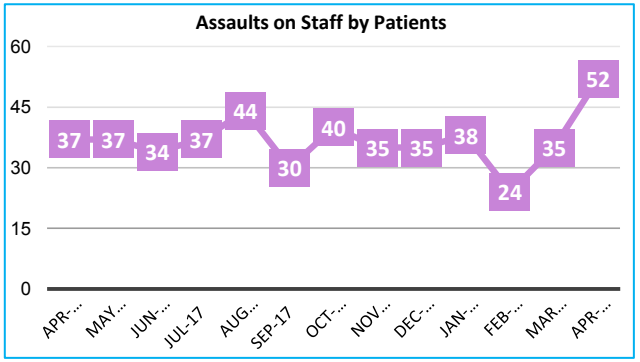


Key Updates:

1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. The provision of practical MH Training to relevant frontline and support services staff has commenced. This training will now form part of the Mandatory Training Programme.
3. Fire Marshal training has been undertaken and completed for nominated representatives across the Trust. The H&S Department will commence the roll-out of fire drills in conjunction with fire marshals from May 2018.
4. Work is on-going to progress the actions identified on the Health and Safety Action Plan following the independent audits completed in June 2017 and March 2018. 45 out of the 69 identified actions have now been completed.
5. The Trust-wide Site Specific Risk Assessment procedure has been approved by the Corporate Health and Safety Committee. The H&S department have commenced the roll out of the risk assessments across the Trust.







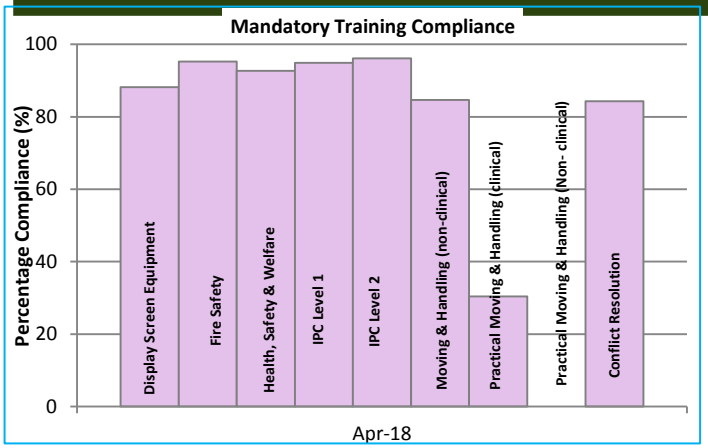
6. The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to April 2018.

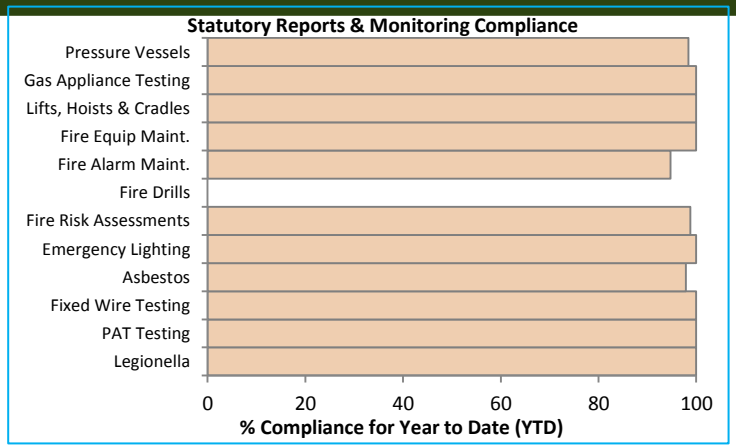
NB: No benchmark/comparable data was received from any of the other ambulance Trusts during April 2018.

7. 220 RIDDOR incidents were reported to the HSE in 2017/18.
8. 19 RIDDOR incidents were reported in April 2018 with an average time lag of **13 days**. **4 out of the 19 RIDDOR incidents were reported out of time in April 2018.**

9. There was an increase in assault on staff by patient related incidents in April 2018. The most common underlying causes include: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

SAFE - Health & Safety Scorecard – (April 2018)





10. The practical MH (non-clinical) training is a new course put in place since April 2018 for non-operational (support services) staff who undertake MH activities. 147 members of staff have been identified as requiring this training and training dates have been circulated through the Learning and Development Team.
11. Trust-wide compliance for the Manual Handling Training (Clinical) in April 2018 was at 30.39%. The practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.
12. Fire Compliance: Fire marshal training has been completed across the Trust. The H&S Dept. will coordinate the roll-out of the 6 monthly fire drills per site commencing from May 2018.
13. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating Q4 Jan	Q4 Feb	Q4 Mar	Q1 Apr	Target Risk Rating	Key changes/updates since last review
677	Manual Handling	Risk of musculo-skeletal injuries to frontline staff due to: 1. The frequency of lifting and handling activities involved during the care and treatment of patients. 2. The need to undertake manual handling activities in uncontrolled and difficult environments.	Ayodeji Adeyemi	Trisha Bain	15	15	15	15	15	9	The provision of practical manual handling training commenced in April 2018. This training now forms part of the mandatory/statutory training for frontline/operational staff. The version 3 replacement of the older version 1 Mangar Elks have been purchased and are currently being rolled out across the Trust. As at 30/04/2018, 142 (61%)of the new version 3 Elks have been installed. The remaining equipment will be installed over the next 4 weeks.
676	Health & Safety	Lack of compliance with statutory health and safety requirements due to limited evidence and assurance that required health and safety management systems have been implemented to ensure the health, safety and welfare of staff and others who are affected by the activities of the Trust.	Ayodeji Adeyemi	Trisha Bain	20	20	20	12	12	4	No key changes since last review. Agreement around the Terms of reference for Corporate H&S Committee deferred until the July Corporate H&S Committee meeting and following the ACAS review of Trade Union numbers.
678	Violence & Aggression	Risk of physical and non-physical assault to frontline staff that come into contact with patients and members of the public during the course of their work.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	12	6	Provision of Conflict Resolution training – ongoing as part of CSR 1, 2018. Lone worker policy approved, risk assessments incorporated into the site specific risk assessment programme which is being rolled out by the H&S Department.
681	Health & Safety	There is a risk that the Trust will be unable to meet its statutory RIDDOR reporting requirements due to: 1. Lack of a timely and consistent process for escalating/reporting incidents from stations to the Health, Safety & Security Team. 2. Delayed reporting of incidents received or reported retrospectively.	Ayodeji Adeyemi	Trisha Bain	12	12	12	12	9	3	The average RIDDOR reporting time lag reduced to 13 days in April 2018. It is recommended that this risk is **downgraded to L=3 x C=3 with RR of 9**.
682	Health & Safety	Lack of clearly identified process (inspection/risk assessment programme) for highlighting health and safety related risks from site level to the Health & Safety Team to enable the team provide the required assurance to the Trust Board regarding compliance with statutory Health and Safety Legislation.	Ayodeji Adeyemi	Trisha Bain	9	9	9	9	9	3	Risk register reviewed on a monthly basis. Site specific risk assessments programme has commenced and will continue throughout 2018/19. Managing H&S training in place to help support Managers with understanding their H&S responsibilities.
679	Security	Risk of theft, criminal damage and vandalism due to the lack of robust and inadequate security arrangements at LAS properties/sites.	Ayodeji Adeyemi	Trisha Bain	8	8	8	8	8	4	Programme of site inspections and risk assessments which will enable the prompt escalation of gaps in site security to Estates /Trust Management is being rolled out by the H&S Department during 2018/19. LSMS in regular liaison with staff and sites where security related incidents have been reported.
680	Staffing	Lack of capacity within the Health, Safety and Security Department to effectively provide the required H&S Support (including the provision of statutory/mandatory training) to all staff and directorates across the Trust.	Ayodeji Adeyemi	Trisha Bain	9	6	6	6	6	3	Additional resources have been recruited into the H&S Team on an interim basis. Approval required from the Workforce Panel to recruit substantively.

EFFECTIVE – Dashboard

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	29%	G	31%	39%	31%		↓			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	53%	63%	64%		↑			LQ1b		
STEMI to PPCI w ithin 150 minutes (AQI)	93%		93%				↔			LQ2b		
STEMI care bundle (AQI)	74%	G	70%	71%	74%		↑			LQ2c		
Stroke to HASU w ithin 60 minutes (AQI)	66%	R	67%	54%	52%		↓			LQ3a		
Stroke Care Bundle (AQI)	98%	R	97%	96%	97%		↑			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	00:32		↔					
Survival to Discharge (AQI)			10%				↑					
Survival to Discharge UTSTEIN (AQI)			38%				↑					
STEMI- On scene duration (CARU continual audit)				00:42	00:41		↔					
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	90%	87%		↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving tw o feedback sessions YTD			2%	29.1%	35.0%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98.0%	98.0%		↔		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	94.0%	94.0%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96.0%			↔		✓	LQ12		
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		↓			LQ12		

Actions

CPI Guidance Notes v8.0 was published on 1 April 2018 and incorporated some major changes in order to help reduce job cycle time and to ensure the CPI process continues to serve our most vulnerable patient groups. Major changes included:

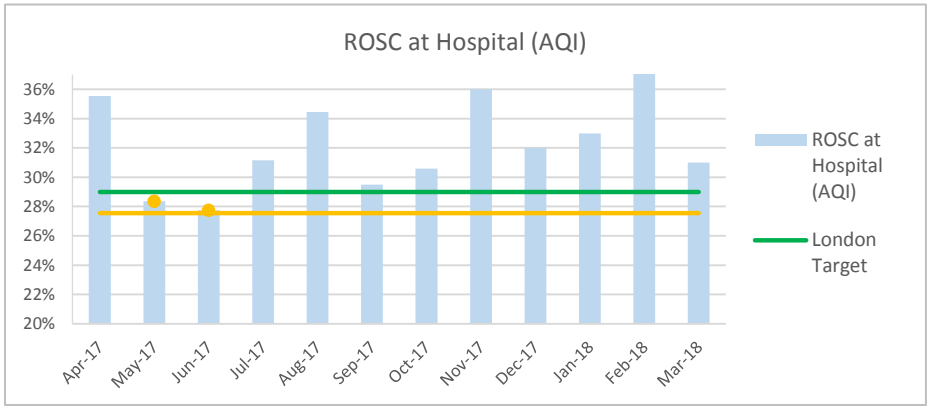
- The introduction of a new Elderly Falls CPI, which looks at the care received by all patients over the age of 65 with incident code 03 (Falls)
- A safeguarding process that prompts auditors to make a retrospective safeguarding referral through EBS if they feel one was required but not carried out at the time of the incident
- A tick box allowing auditors to log on Datix any additional clinical or safety concerns seen during the CPI audit and to flag this for further discussion during CPI feedback
- The ability to flag a specific PRFs identified through CPI audit for discussion during face to face CPI feedback (positive as well as constructive)

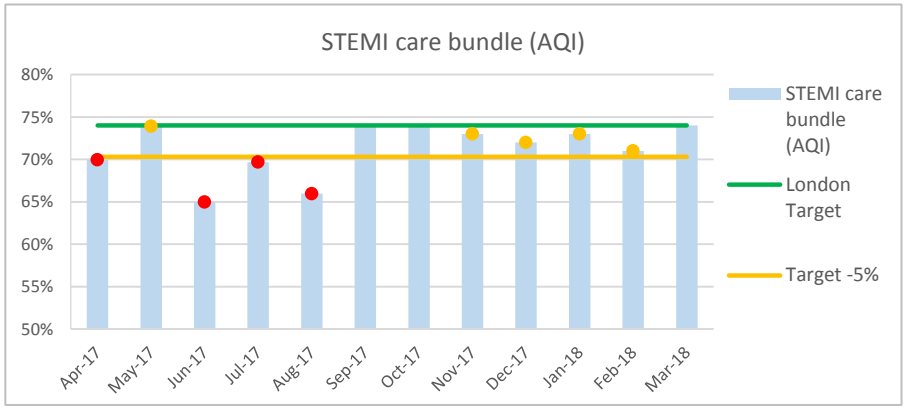
Assurance

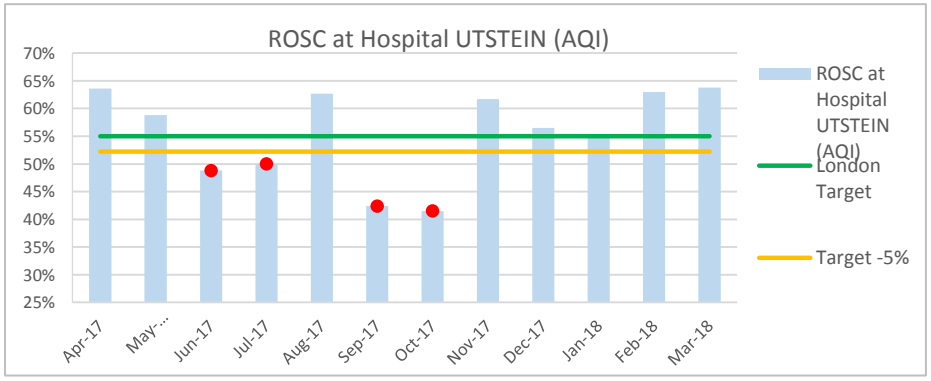
- To address the reduction in LAS CPI completion (for the first time in three months). In March, five paramedics on restricted duties, two APPs, one student paramedic, one OPC Mentor and one Team Coordinator received CPI training
- The LAS finished 2017/2018 by continuing to deliver a high standard of care to patients discharged at scene, in cardiac arrest, with glycaemic emergencies or presenting with severe sepsis, along with the general standard of documentation.
- At 94% in March, the LAS maintained the high standard of care for patients with a diagnosed psychiatric problem achieved in February.

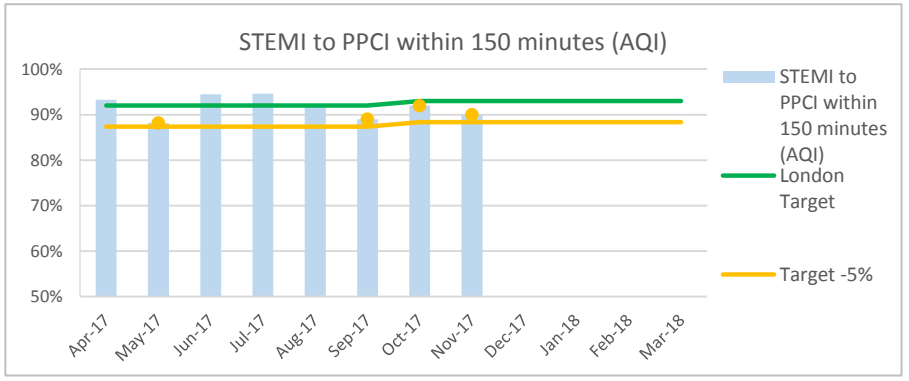
EFFECTIVE - Clinical AQIs

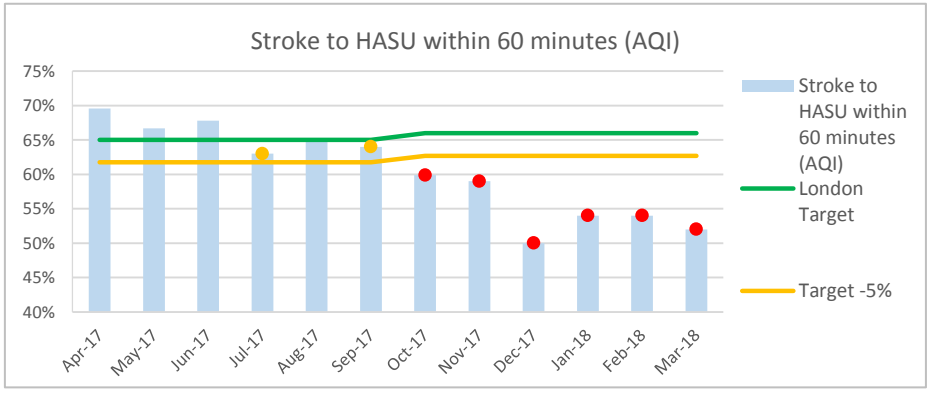
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

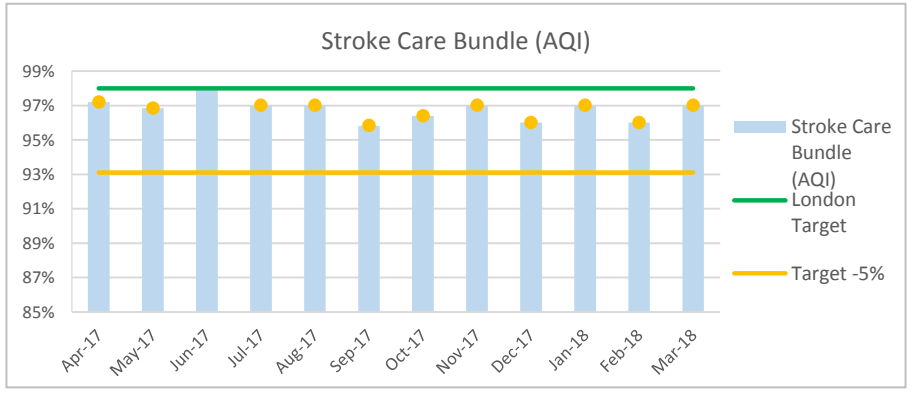








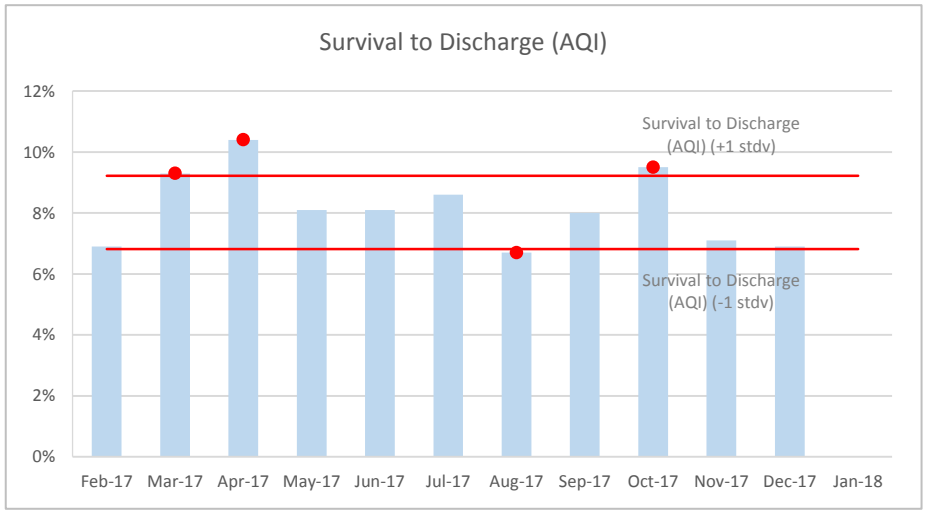


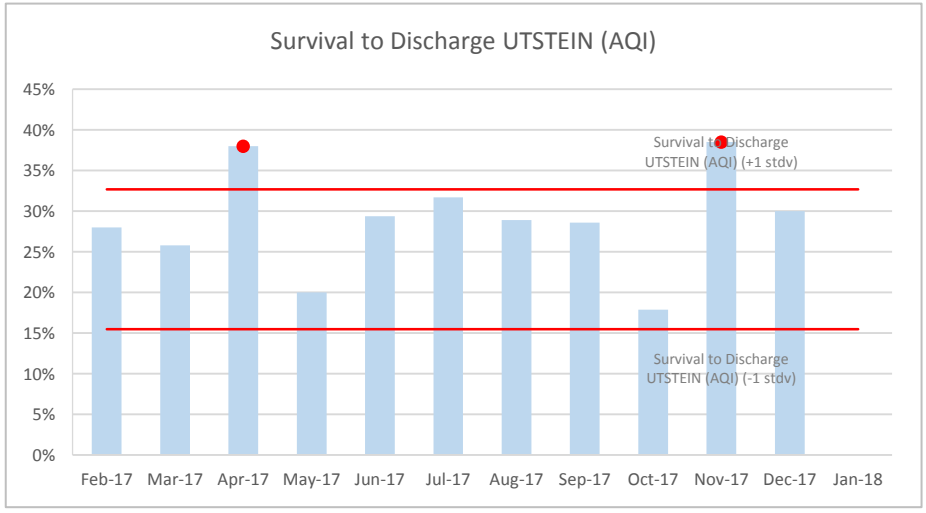


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

EFFECTIVE - Clinical AQIs

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





AQI: Narrative

- In March, 74% of STEMI patients received the complete care bundle (equalling the highs of May, September and October). This continues to require improvement
- NHS England have replaced the 'STEMI to PPCI within 150 minute' measure with 'mean time from call to angiography'. The data for November 2017 shows this as 2 hours and 8 minutes (below the national average)
- 97% of stroke patients received the complete care bundle in March (in line with the 2017-18 average)
- For stroke, 'call to HASU within 60 minutes' has been replaced with 'mean from call to arrival at hospital'. In November 2017 this was 1 hour and 15 minutes (in line with the national average)
- Cardiac arrest response time for C1 patients in March remained at 7 minutes (11 minutes 90th centile)
- Overall ROSC declined in March to 31%; however a high of 63.8% was achieved for the Utstein comparator group
- Survival to hospital discharge was 6.9% in December 2017 for the overall group and 30.0% for the Utstein comparator group.

Note: The most up to date time measures published by NHS England are for November 2017 and survival data from Acute Trusts is from December 2017

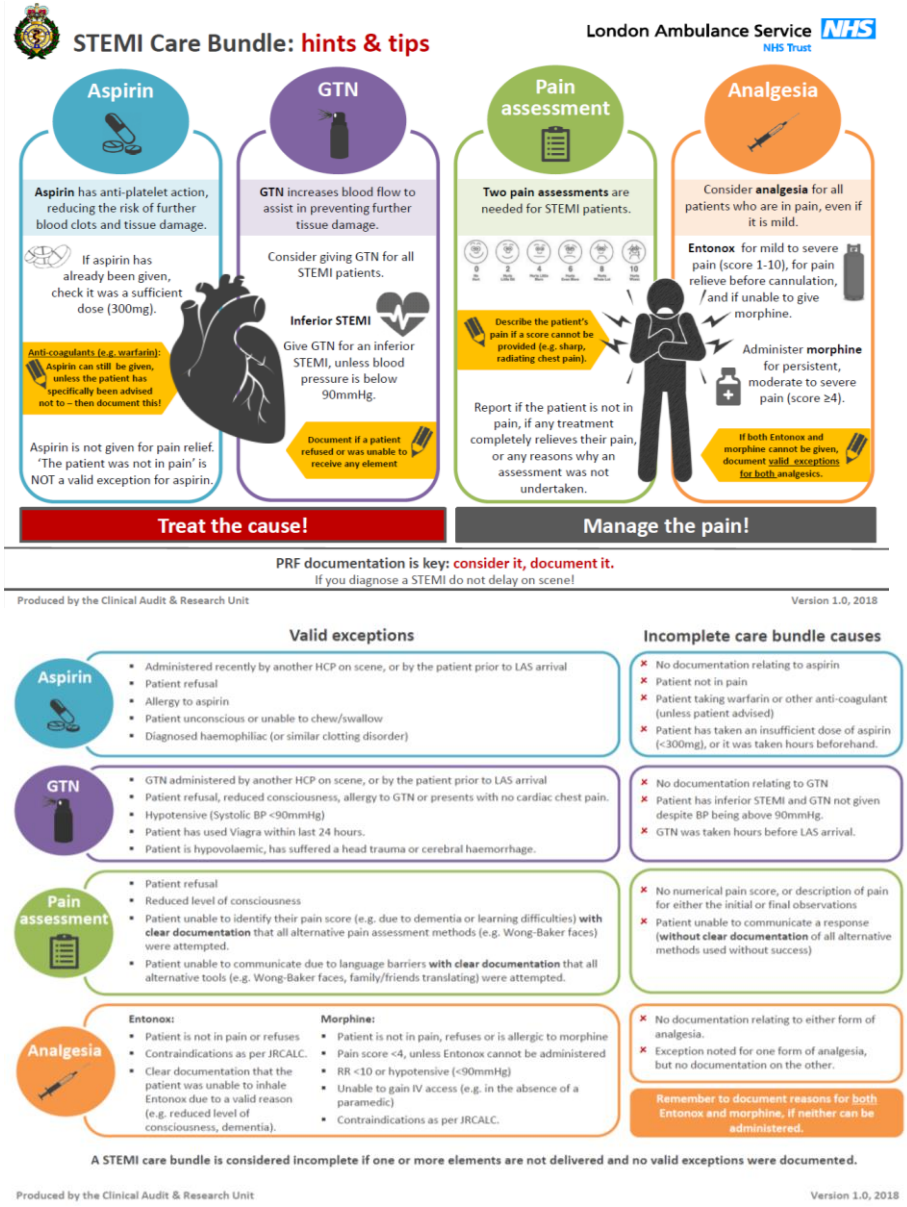
AQI: Actions

As the STEMI care bundle continues to be recorded for around 75% of patients service-wide, CARU have produced an infographic detailing the four care bundle elements we review monthly. The infographic includes a reminder of the guidance with hints and tips for each element and a handy list of valid exceptions we use for our monthly reporting. We hope this will provide clarity as to how we determine a 'complete' care bundle and ultimately improve our compliance. The infographic has now been distributed via the Digital Pocket Guide, on LiA and in the RIB adverts. A3 printed copies have been sent to ambulance stations and the infographic will also be added to the pulse (see next slide for the infographic)

* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

EFFECTIVE - Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley



Research Actions & Outcomes

We have £153,922.00 worth of new projects starting in Quarter 1. These projects are in the areas of Diabetes, Major Trauma and Maternity.

We have recruited a Research Facilitator for 12 months to help run projects and design new ones.

We have now recruited 25 patients to the ARREST research trial (which is double the expected target).

We have recruited 196 patients to the RIGHT-2 trial, exceeding contractual targets. The project will close on 25th May 2018, one month ahead of schedule.

Clinical Audit: Progress

We continue to work on eight clinical audit projects and facilitate five members of staff to undertake their own clinical audit projects.

The Clinical Audit & Research Steering Group will be meeting on the 8th of May to approve the clinical audit work plan for 2018/2019.

Actions & Assurance

As a result of our Continuous Re-contact Clinical Audit, in April:

- 36 crews were recommended for feedback (13 positive & 23 constructive)
- 3 Clinical Advisors on the Chub were recommended for constructive feedback
- 3 unexpected deaths were flagged on Datix (SIG did not declare any as SIs)

CARING - End of Life Care

Owner: Briony Sloper| Exec Lead: Trisha Bain

Recruitment

We have successfully recruited an exceptional end life care nurse consultant to lead the Macmillan partnership programme with us. We had patient representation on the panel and will be making a formal announcement shortly.
The lead paramedic interviews are scheduled for the 22nd May and we have 6 internal candidates shortlisted. The newly appointed nurse consultant will be joining us on the panel.

We unfortunately received no applications for the programme manager post but will re-advertise once the paramedic lead has been appointed potentially opening up to external applicants.

Partnership Working

We are standing members of the EOLC Clinical Leadership Group and attended the quarterly forum where LAS feedback and input is invited to inform a wide range of service developments and policy developments
The LAS presentation at the Pan London end of life care conference on the 17th April with extremely positive feedback from key partners and subsequent invitations to present at additional forums to share ther ole of the LAS and the challenges faced.

We are presenting at a range of external events for dying matters week including speaking to a number of patient representative groups and commissioning forums.

We are currently working with NEL to review end of life care pathways across the STP footprint to identify variances and gaps in provision.

Care Homes

We are currently working closely with the MPS to review the guidance issued to officers to support decision making re: expected vs. unexpected deaths which has been highlighted as an issue now that more MPS teams are being deployed as first responders to cardiac arrest calls and reported incidents whereby attending officers have approached palliative care deaths as unexpected.

Pathways/Coordinate My Care

Staff have accessed 393 patient records in April 2018 compared to 441 in March 2018.

There has been an increase in quality alerts passed to LAS via CMC from providers to review the care provided by our teams where it was identified to be contrary to the CMC plan. Themes include ambulance staff understanding of DNAR documentation, poor history provided by care home s and crews not accessing the CMC plan to assist with decision making.
2 positive experiences of care were reported through the same pathway with providers praising the care provided and the length and one compliment received from a family. Feedback has been provided to the staff involved.

CARING - Patient & Public Engagement

Lead: Trisha Bain

Owner: Margaret Luce | Exec

Public Engagement events

Area	No	Supplementary information	
North West	7	Public engagement: no. of hours (April 2018)	41
North Central	0	Approximate audience numbers (April 2018)	1,091
North East	5	No. of public engagement events: year to date (April 2018)	28
South East	8		
South West	3	No. of staff on LAS Public Education Facebook group	706
Outer London/PPI	5	No. of staff on contact list	1,333
Total	**28**		

Public Engagement activities

Topics and objectives:

- **School and college visits**

Information on the LAS, including possible careers. Also a chance to teach some BLS and knife crime awareness.

- **Cubs, Brownies and Scouts**

Teaching of first aid including BLS.

- **Knife Crime events**

Awareness of the consequences of carrying a knife.

- **Older people's groups e.g. Seniors Forum**

Information about the LAS and dealing with medical emergencies.

- **Careers/recruitment events**

Information about careers in the Service and how to apply.

- **Road safety e.g. Biker Down / Driven by Consequences**

Awareness of the consequences of dangerous driving, including speeding and not wearing a seatbelt.

Staff Awards

- The Service has been shortlisted for the "Best use of ESR" at the Health and People Management Excellence Awards 2018. The awards recognise and reward outstanding work in healthcare human resource management.

Staff Recognition

- On Sunday 22nd April, 15 members of staff ran the London Marathon in aid of the Chief Executive's Charity The Charlie Chaplain playground. This charity provides a play area and play equipment to children and young people with a range of special educational needs and disabilities.

- Staff from the Brent group picked up their rolling pins this week to raise money for Stand Up To Cancer. The collective baking effort raised an amazing £335.46 for the cause with cakes being sold at Kenton Ambulance Station and outside Northwick Park Hospital Harrow.

CARING - Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

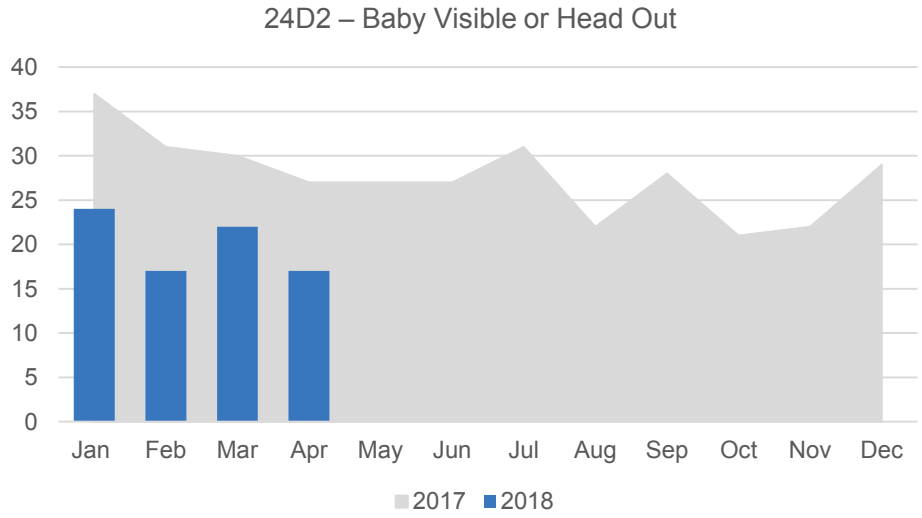
Maternity Good News

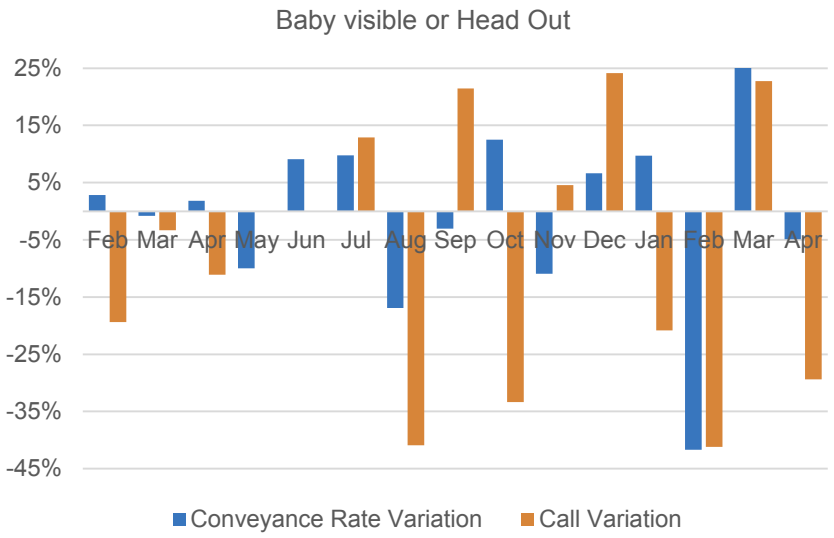
Appointment of 1.5 WTE Practice Lead for Pre Hospital Maternity Care – Commencing in July 2018
Advertisement of 0.5 WTE Practice Lead currently out to advert

Five sessions of maternity training across the LAS –

- Fulham Education Centre x 2
- Homerton Ambulance Station x 2
- Northwick Park Hospital Maternity team and LAS Clinicians to celebrate international day of midwifery 2018
- Quality Assurance Managers – Maternity Update

- "Whose Shoes" event – May 11th 2018 – Joint User and Staff Engagement event for Maternity care.





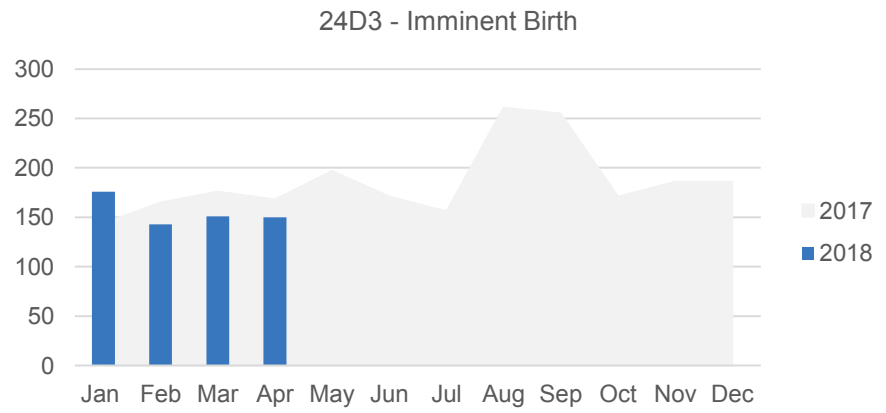
Average – 20 calls per month (range 17-24)
Average conveyance rate for call type – 95%

Opportunities
Thematic analysis of call types to establish opportunity to reduce conveyance rates for appropriate women and babies.

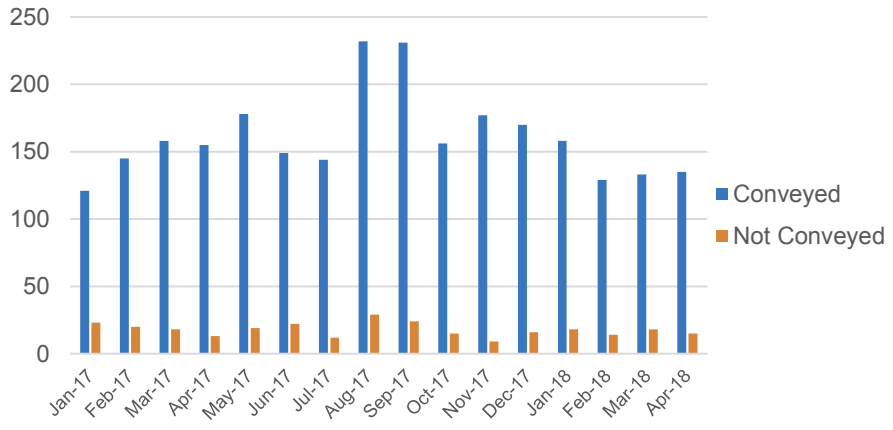
CARING - Maternity

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

24D3 - Birth Imminent Call

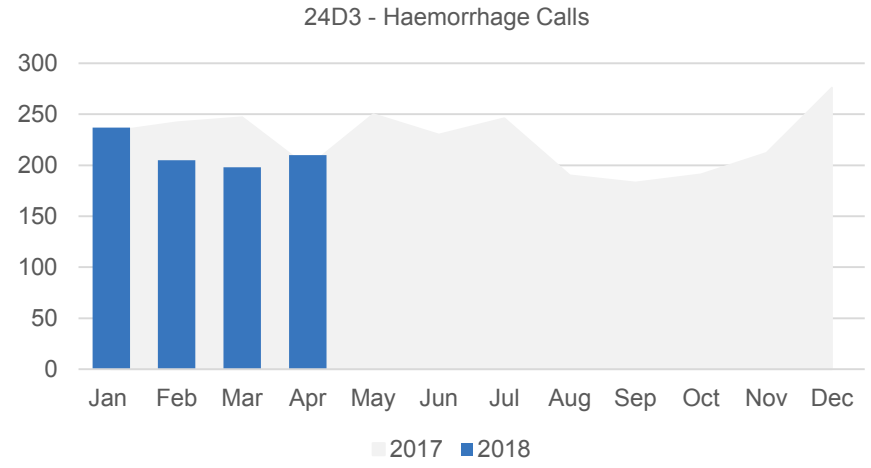


24D3 - Birth Imminent Call

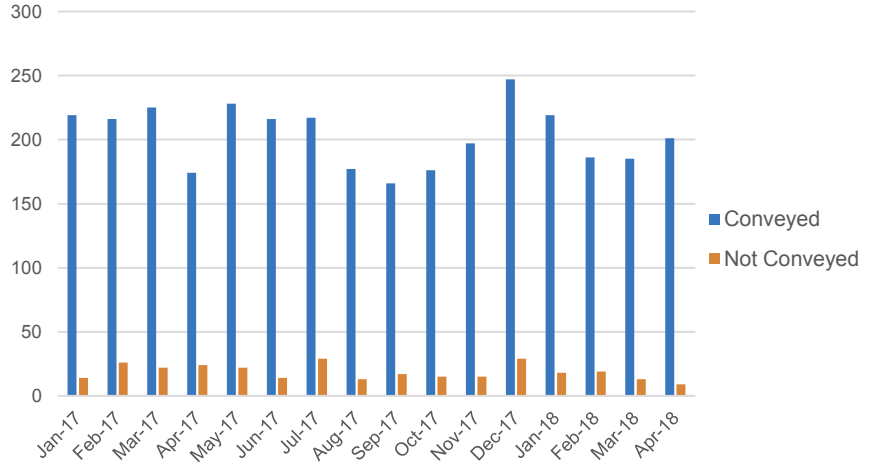


Birth Imminent Calls require further detail to establish the proportion of calls that result in a birth.

24d4 – Haemorrhage after 24 weeks of pregnancy



24d4 – Haemorrhage after 24 weeks of pregnancy



Haemorrahge calls account for a significant proportion of calls. Thematic analysis of this group of callers will require further work to elucidate whether there is an opportunity for midwife led video assessment could improve pathway management.

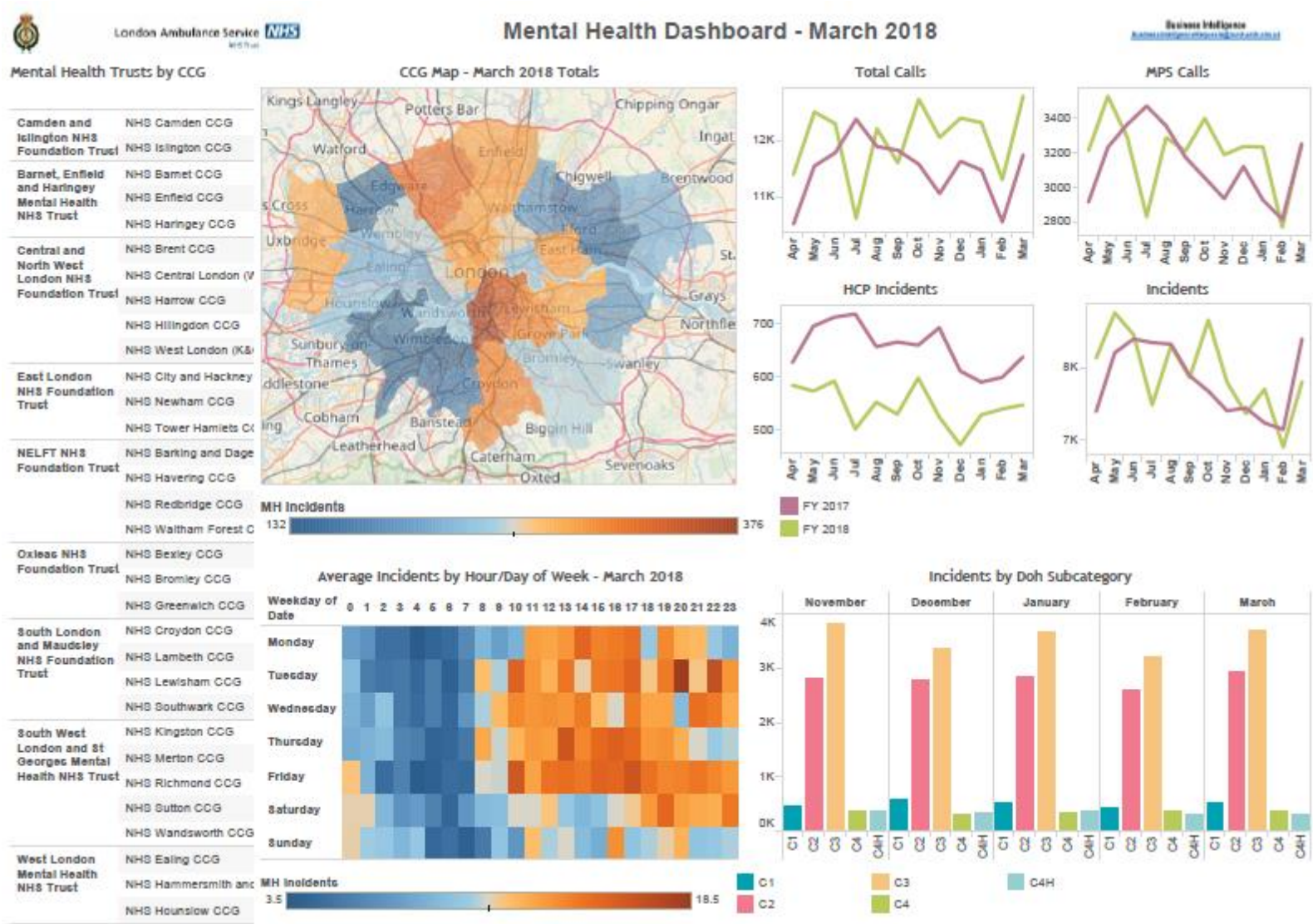
RESPONSIVE - Dashboard

Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Feb-18	Mar-18	Apr-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.84	3.8	4.0	3.8	↓				
Complaints Acknowledged within 3 working days	100%	G		100%	100%	100%	↔			LQ29a	
Complaints Response (35 working day breach) YTD	0	R		21	8	40	↑			LQ29b	
Rate of Complaints per 1,000 Incidents				1.2	0.8	0.9	↑			LQ29c	
Positive Feedback Compliments				125	120	146	↑			LQ29e	
CMC records viewed			393.00	303	441	393	↓			LQ30	
Friends and Family Test Recommending LAS as % of total responses	94%	R	66%	0%	100%	66%	↓			LQ27	
Friends and Family Test Response Rate			0.01	0.0	0.0	0.0	↔			LQ28	
Mental Health related calls as percentage of all calls			8%	7.0%	8.3%	7.5%	↓				
Mental Health related MPS calls as percentage of all calls			2%	1.7%	2.1%	2.1%	↓				
Mental Health related Incidents as percentage of all calls			5%	4.3%	5.0%	4.7%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.4%	0.4%	↓				

RESPONSIVE - Mental Health

Owner: Briony Sloper| Exec Lead: Trisha Bain



RESPONSIVE - Mental Health

Owner: Briony Sloper| Exec Lead: Trisha Bain

Staffing

Recruitment – 3 additional WTE staff commence in post on 02/07/2018

Bespoke mental health training has been delivered to Clinical Hub Staff, Advanced Paramedics (Urgent Care) and 111 staff.

The e-learning module for the next CSR is being finalised focussing on mental capacity and utilising real case studies to allow staff to apply the legislation to realistic scenarios and follow their decision making process through to conclusion with guidance and explanatory notes.

Pocket cards for staff providing a decision making aid when assessing a patient experiencing a mental health crisis have been disseminated to staff across the organisation – these compliment the recent CSR delivered but act a s physical aide memoir.

Partnership Working

We have secured funding to support 120 places for our staff to attend Mental health Simulation Training at Lambeth Hospital. The training days will be in conjunction with Metropolitan Police officers to improve joint working and mental health knowledge. This follows a successful pilot and evaluation in south London.

We have mapped out all of the Mental Health Appropriate Care Pathway Provision pan London. We are liaising directly with the mental health trusts whose areas have a service gap.
We are visiting an exemplar site in Cambridge with police services to identify opportunities for wider collaboration and joint working.

We are progressing a specific programme of work with the police and fire services to improve the quality of care provided to dementia sufferers with a launch event planned at City Hall this summer.

Innovation

In conjunction with a Clinical team leader a mental health tool for the Clinical Hub has been produced. The tool aims to provide guidance for staffing providing advise to crews calling the Clinical Support Desk in EOC. Initial feedback has been positive and there are plans to potentially develop the tool further and make it available on the LAS app.

A rotational programme for mental health nurses is being progressed in the first instance with Barking Enfield and Haringey Mental Health Trust as a trial to explore the challenges and opportunities this approach could afford to both services.

Patients

We continue to work closely with the users by experience patient group from Oxleas MH Trust to support service redesign and training delivery meeting them on a monthly basis to progress programmes of work.

We are currently planning a ‘Whose Shoe’s’ event – key stakeholders, patients and staff will attend to help shape the future of Mental Health Care within LAS.

RESPONSIVE - Frequent Callers

Owner: Briony Sloper| Exec Lead: Trisha Bain

The national definition of a frequent caller is anyone aged 18+ years who:

- *Calls 5+ times in one month from a private dwelling; or*
- *Calls 12+ times over a three month period from a private dwelling*

Frequent Caller Team (FCaT) updates (April 18):

- Last month the Frequent Caller Management Database (FCMD) identified **569** new & existing frequent callers meeting the national definition. 100 % of patients were matched with their NHS number.
- The Frequent Caller Team (FCaT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behaviour, call rates, and formulate multi-agency strategies to reduce calls to LAS.
- FCaT attended the SIM launch at New Scotland Yard. SIM is a joint Metropolitan Police & Mental Health initiative to better manage frequent callers who are regularly detained under s.136 of the Mental Health Act. Four London Trusts have now begun pilots.

Frequent Caller Team (FCaT) challenges:

- Insufficient staffing within FCaT to manage the caseload. In light of LAS' operational restructure, Stakeholder Engagement Managers (SEMs) are no longer able to support Frequent Caller work at the same level. FCaT support may reduce further if Community Involvement Officers (CIOs) are asked to focus on other priorities.
- A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and Emergency Department plans. FCaT staff continue to discuss plans with external agencies regarding the use of Coordinate My Care (CMC).
- It has been identified that frequent callers feature in a number of recent serious incidents where they have unfortunately died. This serves to highlight the increased vulnerability of this cohort of patients and with the current capacity restraints pro-active management of anyone expect the most prolific callers is not possible which leaves patients at risk who may not be triggering to other services. This will be added to the local risk register .

Case study:

64 yr old male patient, living alone. Difficulties with chronic anxiety. Calls 999, 111 or GP when feeling frightened, unwell, or anxious. In the past 6 months had become the 2nd highest caller in London (301 calls/month at peak).
LAS made contact with GP, explained concerns re. call rate and emphasised crew's concerns around patient's safety at home.
Initial temporary plan made by GP surgery - GP receptionist called patient each morning to clarify any anxieties he had and would book him a same-day GP appointment as required; assist with pharmacy/prescription queries, accompany to blood tests, etc. This had a noticeable impact on patient's calls to LAS and GP, e.g. calls to LAS down to 175/month, 72/month, then 13/month, across a 3 month period.
LAS requested multi-disciplinary team (MDT) meeting with GP, mental health social worker, psychiatrist, psychology and care agency. All professionals keen to work together to manage the patient's calls to LAS and to GP surgery. Patient's next of kin living overseas was involved with the MDT discussions via the social worker. MDT meeting agreed further investigations and assessments required to clarify cognitive functioning and safety at home.
Patient then admitted to hospital with infection and delirium.
Whilst an inpatient, patient was reassessed in relation to his cognitive functioning and his ability to undertake physical tasks to care for himself. Diagnosed with Frontal Temporal Dementia, and required assistance to mobilise safely. Patient found not to have capacity in relation to him making a decision to return home. A Best Interests Decision was made, recommending that patient moves into an extra care sheltered placement with 24-hour support. Patient remains an inpatient whilst awaiting an appropriate placement.

RESPONSIVE - Frequent Callers

Owner: Briony Sloper| Exec Lead: Trisha Bain

Cluster	CCG	Patients	Calls last month	Calls last quarter	Calls last 12 months	% of patients with NHS no.
NE	BARKING AND DAGENHAM CCG	11	79	316	827	100%
NC	BARNET CCG	30	273	720	2092	97%
SE	BEXLEY CCG	16	187	406	1177	100%
NW	BRENT CCG	26	171	611	1542	100%
SE	BROMLEY CCG	17	93	228	580	100%
NC	CAMDEN CCG	14	104	448	1177	100%
NW	CENTRAL LONDON (WESTMINSTER) CCG	14	135	538	1506	100%
NE	CITY AND HACKNEY CCG	35	279	996	2949	100%
SW	CROYDON CCG	24	233	583	1798	100%
NW	EALING CCG	24	194	685	3004	100%
NC	ENFIELD CCG	21	189	648	1535	100%
SE	GREENWICH CCG	21	205	558	1841	100%
NW	HAMMERSMITH AND FULHAM CCG	15	109	369	1290	100%
NC	HARINGEY CCG	26	622	1612	3548	100%
NW	HARROW CCG	10	99	245	880	100%
NE	HAVERING CCG	16	272	776	2224	100%
NW	HILLINGDON CCG	21	117	573	1689	100%
NW	HOUNSLOW CCG	14	606	1812	3409	100%
NC	ISLINGTON CCG	16	266	537	1869	100%
SW	KINGSTON CCG	9	43	166	489	100%
SE	LAMBETH CCG	24	199	850	2022	100%
SE	LEWISHAM CCG	12	202	504	1251	100%
SW	MERTON CCG	5	28	92	472	100%
NE	NEWHAM CCG	21	183	505	1420	100%
NE	REDBRIDGE CCG	13	107	419	1042	100%
SW	RICHMOND CCG	7	81	313	899	100%
SE	SOUTHWARK CCG	24	346	832	2396	100%
SW	SUTTON CCG	16	110	340	842	100%
NE	TOWER HAMLETS CCG	14	98	360	1205	100%
NE	WALTHAM FOREST CCG	19	209	617	1396	100%
SW	WANDSWORTH CCG	12	158	493	1044	100%
NW	WEST LONDON CCG	22	238	813	1993	100%
	Top 5	569				
NW	HOUNSLOW CCG	F	496	1379	2377	
NC	HARINGEY CCG	F	333	815	837	
NE	HAVERING CCG	F	134	299	655	
NW	WEST LONDON CCG	M	79	267	445	
SE	LAMBETH CCG	M	57	214	393	

RESPONSIVE- Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 themes 2017/18

Complaints by subject 2017/18	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	Total
Delay	17	16	14	26	9	22	33	19	17	40	21	21	255
Conduct	19	24	19	19	16	17	25	20	22	23	20	18	242
Road handling	11	13	14	10	7	14	9	7	6	10	6	5	112
Treatment	2	5	1	7	5	16	8	9	8	14	4	9	88
Non-conveyance	0	4	12	0	1	6	1	7	6	3	4	6	50
Totals (above)	49	62	60	62	38	75	76	62	59	90	55	59	747
Annual totals	70	77	73	86	51	94	85	84	74	102	76	77	949

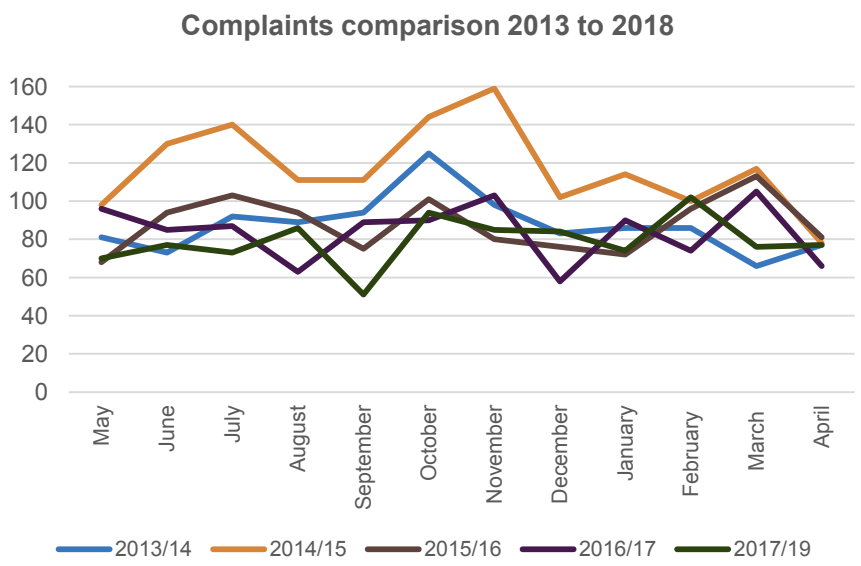
Review of April 2018

- Complaints where 'delay' was the primary concern were back in line against the annual average (21)
- The annual percentage of complaints against calls attended by the Trust remains at approximately 0.08%
- During April there were 21 Quality Alert referrals of which 13 remain under investigation. A total of 66 have been received since PED assumed responsibility for this area of work.
- There were 77 complaints this month which includes one from a HCP on behalf of the patient and 5 complaints relating to NHS111
- Since ARP was introduced, complaints relating to each category have been as follows: ARP x Cat 1 = 21, ARP x Cat 2 = 135, ARP x Cat 3 = 76 and ARP x Cat 4 = 62. (see April table on next page)
- There were 9 complaints attributed to clinical treatment. These include treatment of a sickle cell patient who felt that the crew did not understand the impact on him of his condition, a patient with symptoms of food poisoning who was not conveyed, where no stretcher was provided for a patient and a patient upset about the crew obtaining a blood test from a pinprick test.

Assurance and learning

- A comprehensive review of unresolved Ombudsman cases has been undertaken in conjunction with the Ombudsman's office. Currently there are 8 cases where the files have been requested by the Ombudsman with a view to undertaking a full investigation.
- 366 PALS enquiries were managed by our duty team last month. Due to the continued high number and complexity, we intend to improve the function and management of this facility with improved shared responsibility amongst the team.
- We are supporting the Medical Directorate with the 'Learning from deaths' project and will be reviewing the demographic data within Datix to support that.
- Some members of the team will attend the 'Whose Shoes' maternity workshop to improve understanding of such complaints

Complaint numbers April 2013 to April 2018



RESPONSIVE - Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Complaint response times –April 2018

Month	Total complaints remaining open/re-opened as at time of report each month	Closed during the month	opened complaints by month
Jan-18	106	98	74
Feb-18	109	91	102
Mar-18	131	70	76
Apr-18	108	93	77
Totals	454	352	329

- During April we received a 23% increase in complaints of which 40 related to delays in an ambulance attending (39%). (see snapshot above).
- The outcome of this increase is that the number of complaints over 35 working days at the time of this report exceeded 40.
- This backlog can be attributed to delays in obtaining Quality Assurance reports whilst QA staff were redeployed to the Control Room. Currently we are awaiting 35 such reports.
- The management of Quality Alerts (concerns raised by other healthcare providers) has also impacted on case officers workload. There are currently 26 of these under investigation by the Patient Experience Department.

Categories of complaint calls

April 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	5
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	23
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	6
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	8
Category A Red 2 - 8 min response	1
Not CAD related or information awaited	34
Total	77

Assurance & Learning

- Staff have been invited to undertake a full days training with regards to the management of Serious Incidents
- In the last two years there have been 17 complaints where an SI has been declared . 9 of these related to a patient who has died.
- Similarly, team members will attend a Mental Health training session later this month.
- Access as Editors to the new LAS website has been delayed so we have been unable to improve the lost property reporting process and the feedback leaflet online form. It is anticipated that this will be available shortly . We aim to have an update for the next Quality Report
- We are arranging team workshops to discuss complaint management and the way in which we can improve the use of Datix to assist with that.
- We will then arrange a meeting with the Datix support team to discuss the outcomes of this workshop and if they can assist.
- The Ombudsman has re-arranged his visit to the Trust to 28 June 2018

Case example

Example one – smoking outside an ambulance station:

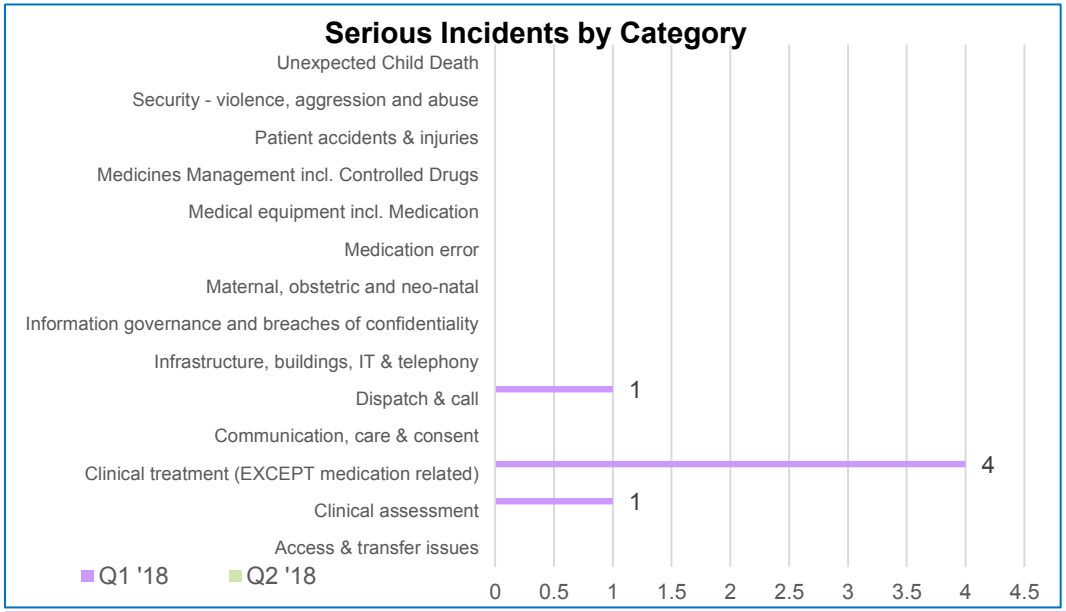
We received a complaint from a member of the public that staff at one of our ambulance stations have been littering the street with cigarette stubs.

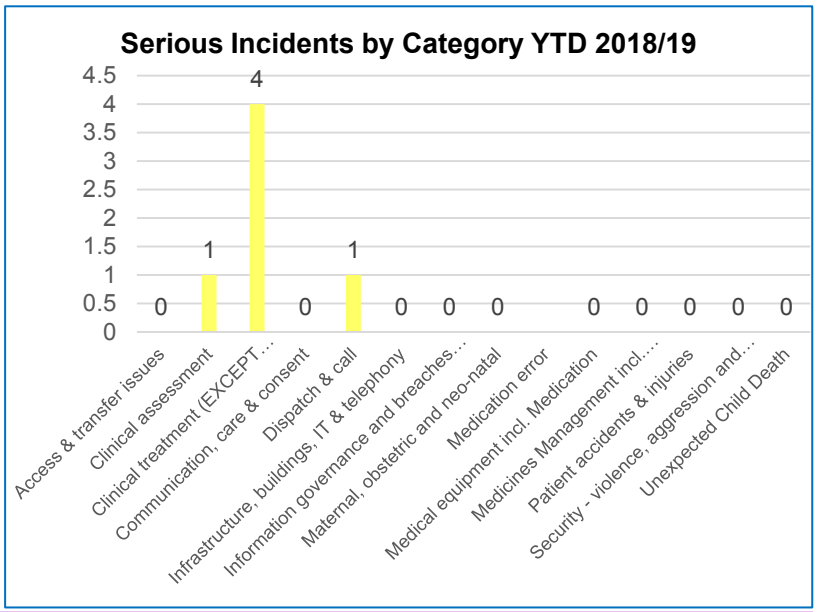
Arrangements were made in collaboration with our Estates department and cleaning contractors to remove cigarette stubs weekly.

The complainant was advised that we also promote non smoking with support for staff who wish to give up. We will also remind them of their responsibility to dispose of cigarette stubs appropriately.

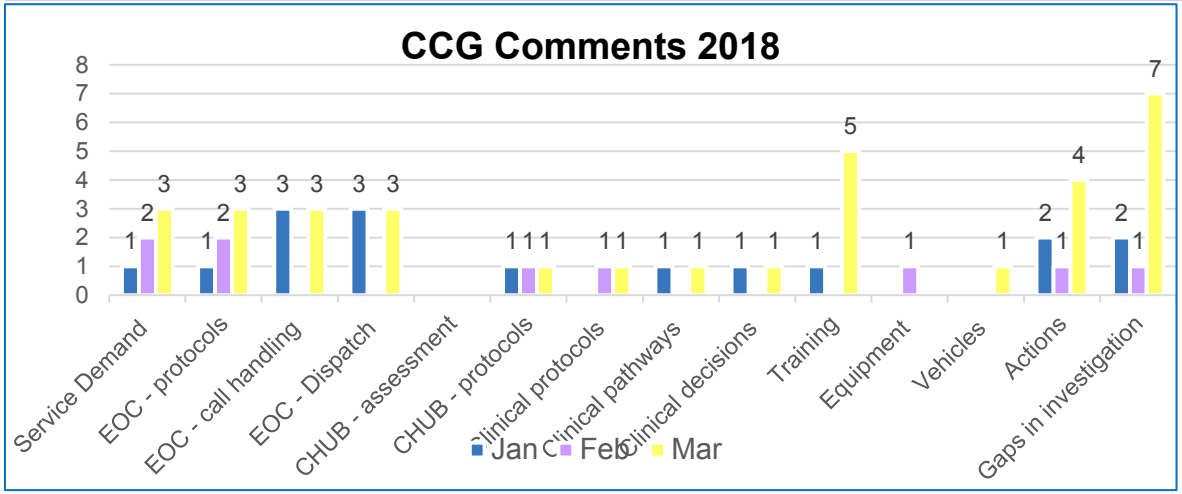
WELL-LED - Learning from Incidents

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain





Dispatch and call and error in the clinical management of a patient remain the recurrent themes in the majority of SI investigations. In response to the dispatch and call management errors the Trust has commissioned an intensive EOC actions plan which has incorporated learning from SI investigations. Additionally a recent safety review of the management to HCP calls has provided a number of organisational learning points to improve the process within EOC.



Clarification around clinical protocols and equipment concerned the management of cardiac arrests and the LifePak 15 monitors, the oversight of held calls and management of Inter-hospital Transfers and HCP admissions.

All questions put to the Trust were answered before the provided deadline.

The Quality, Governance and Assurance Team will continue to monitor the comments received from the CCG for themes and trends.

At a recent meeting with the CCG they advised they have been provided with significant assurance of investigations undertaken by the Trust in relation to incidents involving defibrillation of VF and Chest Pain patients.

Anticipated actions for the team include inviting the Commissioners into the Trust to enhance the understanding of the protocols and processes in place within EOC, providing high level reports on identified gaps in our policies to the Executive Team and incorporating any gaps in the actions plans or investigations into the Lead Investigator training.

WELL-LED - Learning From Deaths, Inquests and Claims

Owner: Nicola Foad | Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

Inquests – figures and learning

- In the month of April, LAS were requested to attend Inquests to give oral evidence on 5 occasions, 1 less than for the month of March.
- No Prevention of Future Death (PFD) reports were received in April.
- There are 14 open Inquests which are linked to a Serious Incident Investigation or Root Cause Analysis.

Inquests – figures and learning

- No learning from Inquests has been highlighted this month.

Claims – figures and learning

- The number of open Claims / Incidents with NHS Resolution at end of each quarter for the financial year 2016/17 and 2017/18 are shown below. The number of clinical negligence claims open under the Clinical Negligence Scheme for Trusts (CNST) has risen whilst the number of employer and public liability claims open under the Liabilities to Third Parties Scheme (LTPS) has fallen.

Financial Year	Scheme	Q1	Q2	Q3	Q4
2016/17	CNST	32	34	35	37
	LTPS	83	72	78	76
2017/18	CNST	40	47	45	45
	LTPS	75	69	70	54

Claims – learning and actions

- In the month of April, 2 Employer Liability claims were opened where the reported cause of injury was the alleged result of a defective track carry chair. The Deputy Director of Fleet and Logistics reported at the Corporate Health and Safety Committee meeting on 24th April 2018 that new gas struts were being fitted on all the track carry chairs.
- In addition to the above the Deputy Director of Fleet and Logistics has further commented that “the current position is that manual handling equipment is maintained in line with the vehicle but details by serial number are scant. The intent is to develop item specific maintenance records that enable separate recording of key items and their maintenance. The current Tranman system does not enable this but we are working with the developer to enable this requirement.” The timescale has not been confirmed but is to be as soon as possible.

Sector Heat Map: Quality Data

CQC		Key Performance Indicator	NW	NC	NE	SW	SE	LAS Target	LAS Ranges
SAFE		Hand Hygiene OWR compliance	93%	96%	100%	100%	100%	90%	
		Rate of Patient related Adverse Events per 1,000 Incidents	2.2	1.2	2.3	2.7	2.3	5	
		Rate of Staff related Adverse Events per 1,000 Incidents	2.8	3.4	4.7	4.0	4.1	3	
		Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	0	
		Percentage of Incidents reported within 4 days of incident occurring	96%	98%	99%	92%	96%	85%	
		Potential Serious Incidents referred to SI Group	4	1	0	0	2		
		Serious Incidents declared in-month	0	0	0	0	0	0	
		Serious Incidents breaching 60 days YTD	0	0	0	0	0	0	
		Serious Incidents breaching 40 days YTD	0	0	0	0	0	0	
		Medication Errors as % of Patient Adverse Events	4.5%	6.7%	2.5%	6.3%	4.8%	0%	
		Needle Stick Injuries as % of Staff Adverse Events	0%	0%	0%	0%	3%	0%	
		Missing Equipment Incidents as % of all reported incidents	9%	1%	3%	2%	4%		
		Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents	11%	7%	14%	16%	9%		
		Safeguarding Adults & Children Level 1	98%	99%	99%	98%	99%	90%	
		Safeguarding Adults & Children Level 2 - Clinical	96%	97%	97%	97%	98%	90%	
		Percentage of staff completing Core Skills Refresher 2017.2 (cumulative)	90%	88%	87%	80%	93%	90%	
		Percentage of staff completing Core Skills Refresher 2017.3 (cumulative)	91%	89%	79%	92%	91%	90%	
EFFECTIVE	*	ROSC at Hospital (AQI)	34.3%	32.9%	28.0%	33.3%	29.3%		
	*	STEMI care bundle (AQI)	74.1%	67.3%	82.7%	66.0%	84.2%		
	*	Stroke to HASU within 60 minutes (AQI)	61.0%	43.4%	50.0%	52.5%	52.5%	65%	
	*	Stroke Care Bundle (AQI)	97.2%	96.2%	96.9%	96.1%	97.7%	98%	
	**	Survival to Discharge (AQI)	-	-	-	-	-		
	*	CPI - Completion Rate (% of CPI audits undertaken)	83%	77%	82%	100%	100%		
	*	Documented Care - Cardiac Arrest Compliance (CPI audit)	98%	99%	97%	97%	98%	95%	
	*	Documented Care - Discharged at Scene Compliance (CPI audit)	97%	97%	97%	97%	97%	95%	
	*	Documented Care - Mental Health Compliance (CPI audit)	95%	92%	91%	94%	97%	95%	
	*	Documented Care - Severe Sepsis Compliance (CPI audit)	97%	98%	97%	97%	98%	95%	
	*	Documented Care - Difficulty In Breathing Compliance (CPI audit)	-	-	-	-	-	95%	
	*	Documented Care - Glycaemic Emergencies Compliance (CPI audit)	98%	96%	98%	98%	97%	95%	
RESPONSIVE		Rate of Complaints per 1,000 Incidents	0.3	0.3	0.4	0.5	0.4		
		Mental Health Related Incidents	8%	9%	7%	8%	8%		
		Mental Health Related HCP Incidents	0.5%	0.6%	0.4%	0.7%	0.5%		
		Rate of Frequent Callers per 1,000 Calls	7.3	8.4	7.7	6.2	6.2		

* data shown refers to Apr-18 ** data shown refers to Dec-17

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	24 May 2018			
Report title:	Diversity at London Ambulance Service NHS Trust			
Agenda item:	Additional Report (for information only)			
Report Author(s):	Melissa Berry			
Presented by:	Patricia Grealish, Director of People and Culture			
History:	At LAS we are committed to promoting equality of opportunity and diversity to enhance our inclusion work. LAS are committed to ensuring that equality, diversity and human rights are embedded in all areas of our employment, planning and service delivery. This paper sets out the base line of the LAS current position in relation to Equality & Inclusion. The paper also sets out the Trust approach to strengthening the Equality & Inclusion work in line with the People and Culture Strategy.			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report is presented to set out the Trust's progress report for 2017/18 and its proposed work programme for 2018/19.

Recommendation(s):

The Board is asked to note the content of the report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☒
Governance and Well-led	☒

Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☐

Purpose of the report:

1. This report provides an update on all the strands of work and the development which has taken place across the London Ambulance Service (LAS) to progress the equality and inclusion agenda in the last 12 months from April 2017 to March 2018. It outlines the Trust's:

    - Fresh approach to the Equality Delivery System and our Equality Objectives
    - Progress against the individual equality strands
    - Next steps and priority areas for equality and diversity

Background:

2. The London Ambulance Service is one of the largest and busiest in the world. Serving a growing population of over 8.6 million people in one of the most diverse cities in the world. The Service employs over 5,000 staff, with currently just over 13% of its workforce from a black and minority ethnic background and with a 45% female workforce.

3. The Public Sector Equality Duty (PSED), part of the Equality Act (2010) requires all public sector organisations to:

    - Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
    - Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
    - Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

4. The LAS has a legal responsibility to promote equality as required by the Equality Act 2010, and to address health inequalities, as required by the Health and Social Care Act 2012.

Our commitment to Equality and Diversity:

5. As an integral part of the National Health Service (NHS) the LAS is committed to delivering the very highest standards of care to patients from diverse cultures, different age groups and a range of abilities and needs. We aim to lead in the field of equality, diversity and human rights within the Ambulance Sector.

6. The Service is committed to being an employer of choice providing an inclusive and thriving workplace for existing and potential employees in all roles; including volunteers, apprentices and student paramedics.

7. The Service will provide a working environment free from discrimination, harassment or victimisation, where everyone receives fair and equitable treatment, regardless of sex, pregnancy or maternity status, race, disability, religion or belief, sexual orientation, gender reassignment, marital or civil partnership status or age.

8. The Service has an established Equality and Inclusion Committee, which meets every 8 weeks and which provides a forum to discuss and challenge the Trust's work programme for equality and diversity. The committee is chaired by the Director of People and Culture and includes representation from the Patients Forum and Trade Unions, other community groups.

NHS Equality delivery system grading and objectives:

9. The Equality Delivery System (EDS2) is a system which helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice (See Appendix 1).

10. In January 2018 the Equality and Inclusion Committee undertook an assessment of the Service using the EDS2 grading system to ascertain the Trust's preparedness against a baseline. The overall score was "developing".

11. Using this score and, in conjunction with patient groups and subject leads, the Equality and Inclusion Committee agreed Equality Objectives, to include:

Objective Number	Objective	How
Objective 1:	To capture and analyse patient equality data to understand trends and use this information to inform business and Service planning to provide an inclusive service. Including the use of the sexual orientation standard	The implementation of the Electronic Patient Care Record project (ePCR) will develop a digital version of our current paper Patient Record Form (PRF) for use on our clinician issued iPads.
Objective 2:	To implement the actions of the Workforce Race Equality Standard (WRES) for 2018 / 19 to increase the Black and Minority Ethnic (BME) representation across the Trust.	The WRES is a high priority delivery plan for the Service and has actions set out to progress the equality and inclusion agenda across the Service.
Objective 3:	To embed and strengthen the Equality agenda for patients and engage with local populations.	Through the Equality committee, building contacts with local community organisation
Objective 4:	The Disability Equality Scheme (DES), will form part of the commissioning contract and will follow on from the (WRES) work. We will establish an action plan to address each of the areas identified in the DES. *(Note: the DES has not yet been finalised)*	The work will initially be led by the Equality & Inclusion lead to benchmark the data and carry out consultation with disabled employees. We have a starting point of 1.9% of staff declaring a disability

12. The achievement of the Equality Objectives will lead to benefits in the short, medium and longer term for our employees, patients and service users. These benefits include:

    - Better patient / service user experience

- Improved patient / service user access
- Improved / informed business planning for Service development
- Improved engagement with London healthcare providers of business intelligence information.

Progress against the individual equality strands

13. The table below provides an overview of progress of the 9 individual equality stands over the last 12 months.

9 Individual equality strands (protective characteristics)	Progress overview:
Sexual Orientation:	The LAS has an active and thriving Lesbian, Gay, Transsexual (LGBT) network. Jules Locket (Practice Learning Manager, EOC) opened the London Pride event in 2017 with Mayor of London, Sadiq Khan The Stonewall diversity champions programme is a framework for creating a workplace that enables LGBT staff to reach their full potential. The LAS aims to work towards being in the Stonewall list of top 100 employers index.
Gender reassignment	Stonewall are delivering gender identity training in May 2018 in our Emergency Operations Centre (EOC) and to People and Culture business partnering team to help raise awareness of transgender equality. There are now gender-neutral toilets at t HQ and BOW.
Race	The LAS has been on a journey to progress the nine Workforce Race Equality Standard (WRES) indicators over the last 18 months; the indicators are reviewed every month at the performance meeting chaired by the CEO. We have introduced "The Diversity Award" as part of our internal LAS VIP staff recognition scheme. It is to recognise the work of staff who champion and build diversity within the Service and staff who act as a role model in championing this work and who help develop our inclusive culture. **Appendix A**, the current WRES plan 17/18 and 18/19
Disability	LAS has signed up to the Disability Confident Commitment programme which has replaced the "two ticks" scheme. As part of this a certificate of recognition of our achievement for the organisation will be used on all adverts and on the website. LAS will be completing a self-assessment to help continue our journey to becoming a Disability Confident Employer over the three layers: • Disability Confident Committed • Disability Confident Employer • Disability Confident Leader

9 Individual equality strands (protective characteristics)	Progress overview:
Sex	The gender pay gap report was published on the 31 March 2018 and shows that LAS has a 4.5% pay gap and a much wider 31.59% bonus gap. We will develop an action plan specifically targeted at addressing the gap.
Age	We will be introducing Career Clinics for staff - the target audience being 50+. These will focus on support and development options for roles within LAS as well as pre-retirement planning and will be held once a quarter.
Marriage or civil partnership	All LAS policies are non-discriminatory based on marriage and civil partnership. The Equality Act 2010 makes it unlawful to discriminate against or treat someone unfairly because they are married or in a civil partnership
Pregnancy and maternity	The Trust has a range of family friendly policies in place to support working parents. LAS recently reviewed the maternity policy RELATED to expectant mothers working on the front line.
Religion & belief	A calendar of all religious holidays and a guide giving managers guidance on how to support the staff's Religion and Beliefs in the work place is to be developed by the end of May 2018.

Next steps

14. Over the next 12 months, the LAS will focus on delivering the following:

- Progress with implementation on the WRES Action Plan for 2018/19
- Progress with delivering the Equality Objectives for 2018/19.
- Review, refresh and run Equality and Diversity training for Core Skills Refresher training – starting in November 2018 all LAS frontline staff will receive face to face Equality and Diversity training.
- Collect and monitor patients' / service users' complaints related to protected characteristics data to monitor trends. Training will be provided to the complaints team.
- Embed Equality Impact Assessments (EIA) and training across the Service for projects, initiatives, policies and any changes where an EIA must be conducted.
- Work towards the LAS achieving The Stonewall Top 100 employers index
- Work on the Disability Equality Scheme, potentially, after consultation, to develop a network
- Work to embed the new Ambulance sector version of the accessible standards
- Collaborate with other London and National Groups to seek out and where relevant adopt best practice to address the challenges we face, particularly with our BME employees

Conclusion

15. Over the last 12 months, the London Ambulance Service has seen many achievements towards improving equality and diversity across the organisation, and the foundations have been laid to build upon and progress with this area of work set as a priority.

16. Being the only Pan London NHS Trust, the organisation is in a unique position to progress the equality and diversity agenda for its diverse workforce and for the communities that we serve.

17. Work is progressing and we are achieving compliance against our equality objectives. The focus of the work programme for 17/18 and the plans for 18/19 will be on driving our recruitment commitments, improving the BME experience, improving trading and education for managers, and to bring forward work to start to tackle other major diversity areas such as disability.

Patricia Grealish
Director of People and Culture

Workforce Race Equality Standard

Introduction

1. Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

2. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The WRES was mandated through the NHS standard contract, starting in 2015/16.

3. This is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

4. It is national policy that NHS Trust Boards should be as representative as possible of the communities they serve and that this is likely to benefit the planning and provision of services (NHS Leadership Academy 2013). There is evidence (Salway et al 2013) that when Trusts commission services they often fail to cater to the most deprived communities including black and minority ethnic (BME) populations. One of the strategies that Trusts can use to mitigate this is to ensure that decision makers are drawn from a diverse pool.

The LAS position

5. In July 2016 the London Ambulance Service commenced its journey to work towards having an inclusive and racially diverse workforce which is representative of the local populations the LAS serve. The starting point of this journey was to obtain a baseline understanding of the position of the Trust against the 9 WRES indicators, and for each indicator data must be compared between white and BME staff. The indicators include:

Workforce indicators	**Indicator 1:** Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce. NB. Calculate separately for clinical and non-clinical staff.
	Indicator 2: Relative likelihood of staff being appointed from short listing across all posts.
	Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. NB. This indicator will be based on data from a two year rolling average of the current year and the previous year.
	Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.
	Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

National staff survey indicators	**Indicator 6:** Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.
	Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progressing and promotion.
	Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / Team Leader or other colleagues.
Board representation indicator	**Indicator 9:** Percentage difference between the Organisations Board voting membership and its overall workforce. NB. Only voting members of the Board should be included when considering this indicator.

6. The baseline position revealed the Trust had a prolonged historical trend of its workforce under representing the Black and Minority Ethnic (BME) population which it serves, with the senior management team also under representing the BME workforce. In 2016, only 11% of the LAS workforce were from BME backgrounds; this is in stark contrast to the London picture whereby 41% of NHS staff in London are from BME backgrounds, with 45% of the London population from BME backgrounds.

7. The London Ambulance Service is committed to working from a position of transparency, accepting that the current position for BME staff is a challenge and requires significant improvement in order to achieve better outcomes for BME staff and the communities we work with going forward. We are committed to working with all staff, including BME staff groups, local unions and other organised staff groups in achieving improvements.

The journey so far and achievements to date

8. In July 2016, the Trust appointed an Interim Equality and Diversity Consultant and the Trust launched the WRES 2016 / 17 action plan which provided a deep-dive of actions to address the inequalities for BME staff and close the gaps in workforce experience between white, black and ethnic minority staff and to improve BME representation at Board level.

9. The service is now working at pace and implementing the actions of the WRES 2017 / 18 **(Appendix 2)** and the organisation is 18 months into its journey.

Achievements to date

Secured funding from Health Education England

10. In January 2017 the Trusts was successful in securing £500K from Health Education England (HEE) to increase the diversity in the LAS workforce and reduce the gaps and inequalities that exsist for BME staff. This funding has been used for focus groups, analysis, recruitment of posts, external engagement and recruitment fairs i.e. shopping centres, publications and BME staff development.

Strengthen engagement with the BME network

11. Significant engagement and partnership work has been undertaken to work with ADAMAS, the LAS BME network to understand staff experiences and address issues and inequalities. The group will be re-launching and re-branding, and will be setting out a work programme which the People and Culture Directorate will support to make a difference to the BME experience at LAS.

Regular BME staff engagement events held

12. From August 2016 onwards, the Trust have held a series of BME focus groups and round table events to understand the issues, barriers and experiences of internal BME staff i.e. barriers to career progression. The most recent event was held on the 14 December 2017

13. In December 2017, the Trust commenced a series of 'lunch and learn' sessions led by our Assistant Medical Director, Agatha Nortley-Meshe, to build understanding of equality and the challenges faced by the LAS to reduce the inequalities within our workforce.

Improved recruitment activities

14. A range of targeted recruitment activities have been actioned to increase the number of BME applicants looking to join the LAS and that are successfully recruited. This includes placing recruitment vacancies in targeted BME publications, talking to local BME communities about career opportunities, ensuring recruitment publications are representative of our diverse workforce and attending career and job fairs to increase applications from the BME workforce. At present there is a review of internal recruitment processes to drill down further in to the recruitment data. It is Important to note LAS has only recently had a full set of recruitment data.

Recruitment of the LAS first BME Associate Non-Executive Director

15. In November 2017 the LAS recruited its first BME Associate NED under the 'Next Director Scheme'. This is a very positive step to ensure our decisions makers are drawn from a diverse pool (Salway et al 2013).

Re-established the Equality Committee

16. In October 2017 the Equality Committee was re-established and is now chaired by the Director of People and Culture and includes representation from the Patients Forum, Trade Unions and other community groups. The committee recently reviewed and graded the NHS Equality Delivery System which looks at all the protected characteristic for patients and staff.

WRES Indicators:		2017/ 2018	2016 / 2017	2015 / 2016	Direction of improvement
Workforce indicators	**Indicator 1:** Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	BME 13.2%	BME 12%	BME: 11%	
	Indicator 2: Relative likelihood of staff being appointed from short listing across all posts.	2 times more likely to be appointed if white than BME	1.7 times more likely to be appointed if white than BME	No data	
	Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**TBC**	BME 16-17 18%	BME 15-16 28%	
	Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.	No data	No data	No data	
National staff survey indicators	**Indicator 5:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White: 57% BME:39%	White:56% BME: 34%	White: 56% BME: 35%	
	Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White: 31% BME: 38%	White: 32% BME: 32%	White 38% BME 40%	
	Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progressing and promotion.	White: 62% BME: 47%	White: 74% BME: 57%	White: 63% BME: 42%	
	Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / Team Leader or other colleagues.	White: 11% BME: 19%	White: 9% BME: 18%	White: 13% BME: 25%	
Board represent-ation indicator	**Indicator 9:** Percentage difference between the Organisations Board voting membership and its overall workforce. NB. Only voting members of the Board should be included when considering this indicator.	White: 100% BME: 0%	White: 100% BME: 0%	White: 100% BME: 0%	

Embarked on a range of communication activities

17. The LAS Communications team has produced a number of short 'job review' videos with our employees conversing on their work at LAS The videos include BME staff from across the organisation which has received a very positive reaction.

18. Specific activities with local partnerships are underway i.e. Newham, to support candidates who apply to the LAS and undergo our assessment process. These are being shown at our domestic recruitment events, in HQ reception, and on social media and You Tube.

Introduction of sponsorship mentoring

19. The LAS is currently developing a sponsorship and reverse mentoring programme which will provide greater access for BME staff at bands 5, 6 and 7 to progress into more senior roles across the organisation. An identified Senior Manager 'sponsorship mentor' will support the mentee by providing a directive style of mentoring to enhance the mentees performance and productivity. This will be piloted and evaluated between May 2018 and September 2019.

WRES data summary

20. 2017/18 LAS has reported on 8 of the 9 WRES indicators, this is an improvement from 2016/2017 data submission where 7 of the key indicators were reported on

21. The LAS is 18 months into its journey and progressing at pace but there is still more to be done and it is important to note LAS started from a very low baseline. The data is based on the 2016/2017 staff survey results.

Next steps

22. The WRES action plan 2017/18 is currently being implemented and progress against delivery is overseen by the People and Culture committee (with engagement with the Equality Committee). The Director of People and Culture will oversee the development and the Executive leadership team will have final agreement of the WRES action plan 2018 /19 – an event is currently being arranged for July 2018.

23. Interviews skills for training for a cohort of BME (24 no.) staff to participate in interview panels for roles to be agreed – 24 May 2018. This would then be rolled out to our 'hiring managers' over the remainder of the year (it will be 'management essentials' within our Leadership Development Pathway).

24. To hold a Board Equality and Diversity seminar, with invites to include Yvonne Coghill the National WRES Director.

Appendix A: WsRES action plan 2017 / 2018 and Update

For each of these workforce indicators, compare the data for White and BME staff.

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
WORKFORCE INDICATOR. Workforce Representation							
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see above (pg 11)	Please see above (pg 11)	BME Staff at LAS are proportionately over-represented in Bands 2 and 3 by 20% and under-represented in bands 5 upwards including VSM. There has been a small improvement over the last 12months	Supportive leadership training, BME applications band 6 and above should be encouraged to participate in this programme	Julia Smyth, Consultant, People and Organisational Excellence	Ongoing	The supportive leadership training is ongoing and data will be reported on for the final WRES report 2017/2018
				With Health Education England funding, BME paramedic Science (BSc) being offered for up to 12 suitable qualified BME candidates. Course provider St Georges University of London that can lead to HCPC Paramedic Registration.	Melissa Berry, Diversity Consultant Tina Ivanov, Deputy Director Clinical Education & Standards, Clinical Development	September 2017, February 2018	26 expressions of interest were received. 7 were not suitable but have taken up additional support. 19 applications were made and 4 have successfully started on the programme at St Georges

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
WORKFORCE INDICATOR. Recruitment							
2. Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff Relative likelihood of White staff being appointed from interview compared to BME staff	1.7 x	No data for previous year	In 2015/2016 there was no data Due to the implementation of the TRAC system there is data for 2016/17 A person from a BME background is 1.7 times less likely to be appointed than someone from a white background	Recruitment events – attendance at recruitment events across London to promote LAS as an employer. Diversity careers fair, Emirates Stadium Skills Fair London, Excel Anticipated total footfall – 41,810	Averil Lynch, Head of Recruitment, Melissa Berry, Diversity Consultant	September 2017- January 2018	All of the recruitment events have been attended and the there are future ones for LAS to attended
				Job Centre Plus partnership – working alongside various job centres across south London, Job Centre Plus offer pre-screening of candidates and application support for LAS EMD roles (they have to be JCP clients)	Averil Lynch, Head of Recruitment	Ongoing	This partnership is still ongoing and a number of offers have been made
				Recruitment campaign – 'Be There' campaign to be developed and used to target BME candidates. Targeting areas Newham, Redbridge, Tower Hamlets, Enfield, Barnet, Haringey, Harrow, Brent, Ealing Developing catalogue of images that are reflective of BME staff	Averil Lynch, Head of Recruitment, Melissa Berry, Diversity Consultant Patricia Grealish Director of People & Organisational Development	December 2017	This action is still ongoing

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
				Partnership - working with Newham Workplace (employment support organisation funded by Newham Council) who offer pre-screening, application and interview support to Newham residents for LAS EMD roles	Averil Lynch, Head of Recruitment	October 2017- July 2018	This partnership is still ongoing and a number of offers have been made
				Require agencies to source candidates in a way which encourages applications from as diverse a pool of talent as possible and which demonstrates the Trust's commitment to diversity and inclusion. Establish targets for shortlist that ensure a diverse talent pool is considered for all post at LAS.	Patricia Grealish Director of People & Organisational Development	Ongoing	Ongoing
				All shortlisting and interview panels should only be chaired by staff who have attended LAS Recruitment and Selection Training (or NHS equivalent) in the last 3 years.	Julia Smyth, Consultant, People and Organisational Excellence	Ongoing	Recruitment training for BME staff to sit on interview panels as part of the pilot project for diverse and inclusive recruitment panels the first session will be held on the 24th May 2018

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
WORKFORCE INDICATOR. Disciplinary Action and Performance Management							
3. Relative likelihood of White staff entering the formal disciplinary process, compared to that of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	BME 16-17 18%	BME 15-16 28%	Total Disciplinary cases **2016/2017 = 60 of which 11 (18%)** were BME staff Total Disciplinary cases **2015/2016 = 95 of which 27 (28%)** were BME staff	Undertake an annual in-depth analysis of the qualitative and quantitative data from the disciplinary process to identify any issues and trends by department or sector, by profession and pay banding.	Tracey Watts, Acting Deputy Director of People and OD Chris Randall, Workforce Intelligence & Planning Manager	May 2018	A deep review is due to take place to look at the disciplinary process the. The LAS has appointed a new Head of Engagement who will lead on this indicator.
				Encourage managers undertaking disciplinary investigations, hearings and appeals to undertake Courageous Conversations Training.	Melissa Berry, Diversity Consultant Tracey Watts, Acting Deputy Director of People and OD	Ongoing	A deep review is due to take place to look at the disciplinary process

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
WORKFORCE INDICATOR. Access to Training							
4. Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	No Data	No Data	This data is not currently collected centrally and we are exploring options for recording this data for 17/18, ESR being the most likely option	A plan of action needs to be formulated to ensure that this indicator is reported on for the next WRES data submission.	Melissa Berry, Diversity Consultant Julia Consultant, People and Organisational Excellence Chris Randall, Workforce Intelligence & Planning Manager	Ongoing	Awaiting to find out if this indicator will be taken out of the WRES. An evaluation of the WRES is currently underway and being led by Michael West
NATIONAL NHS STAFF SURVEY INDICATOR. Bullying and Harassment and Fairness of Opportunity							
5. KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 56% BME: 34%	White: 56% BME: 35%		Review of datix security incident categories/descriptors to be completed by November 2017 to enable better analysis of security incidents reported	Ayo Adeyemi Head of Health, Safety & Security	November 2017	A review of the datix security categories has been completed
				A booklet to support staff and managers with the post assault process is currently being developed in the NE sector.	Ayo Adeyemi Head of Health, Safety & Security	Ongoing	This is an ongoing action

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
				Regular bulletins - issued to remind staff to be aware of security including: ensuring buildings and vehicles are secure when not in use (Procedure on Station Duties and Security Management Policy); awareness of their own safety, adhering to Uniform and Work Wear Policy.	Ayo Adeyemi Head of Health, Safety & Security	Ongoing	This is an ongoing action
6. KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White: 32% BME: 32%	White 38% BME 40%	White staff decrease of 6% BME staff decrease 8%	Implementing a programme of Lunch and Learns to support positive debate around all aspects of diversity	Patricia Grealish Director of People & Organisational Development, Melissa Berry, Diversity Consultant	April 2018	The first lunch and learn took place in December with more planned in fleet services.
				Develop a calendar of events that support diverse LAS. Help staff to become more culturally competent and reflecting on behaviours	Patricia Grealish Director of People & Organisational Development Melissa Berry, Diversity Consultant	April 2018	This action is yet to be completed but will be auctioned before the end of May 2018

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
7. KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White: 74% BME: 57%	White: 63% BME: 42%	White staff reported an increase of 11% BME Staff reported an increase of 15%which is a significant improvement in 12 months	With Health Education England funding, BME paramedic Science (BSc) being offered for up to 12 suitable qualified BME candidates. Course provider St Georges University of London that can lead to HCPC Paramedic Registration.	Melissa Berry, Diversity Consultant Tina Ivanov, Deputy Director Clinical Education & Standards, Clinical Development	September 2017, February 20187	26 expressions of interest were received. 7 were not suitable but have taken up additional support. 19 applications were made and 4 have successfully started on the programme at St Georges
				Development of a programme of coaching, mentoring and master class opportunities for BME staff as part of the BME staff networking meetings.	Melissa Berry, Diversity Consultant Agatha Nortley-Meshe, Assistant Medical Director	March 2018	Agatha Nortley-Meshe, is the new BME staff network at present a work plan is being drafted for the BME network
8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader	White: 9% BME: 18%	White: 13% BME: 25%	White staff percentage decreased by 4% And BME Staff decreased by 7%	Review of the Dignity at Work strategy Refreshing the roundtable training, with 60 people retraining in October and November 2017	Melissa Berry, Diversity Consultant Cathe Gaskell Bullying & Harassment specialist	Ongoing	A refresher of roundtables has taken place There is now a mediation contract in place There will be ongoing Bullying & Harassment support for staff

Indicator	Data for reporting year 2016-2017	Data for previous year 2015-2016	Narrative - implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Lead	Due Date	Update against action
				Developing guidance on the difference in Bullying and harassment and firm management	Cathe Gaskell Bullying & Harassment specialist Melissa Berry, Diversity Consultant	April 2018	Ongoing
BOARD REPRESENTATION INDICATOR							
9. Percentage difference between the organisations' Board voting membership and its overall workforce	White: 100% BME: 0%	White: 100% BME: 0%		The Next Director Scheme provides support to senior people who are currently under-represented on boards and helps them gain the skills needed to get In to the board room. The scheme will enable a potential BME NED to join the LAS board for 6 months.	Heather Lawrence, Chair	February 2018	This action is now completed
				Reverse Mentoring Programme - set up with Board members and senior team to mentor LAS BME staff. The benefit of this mutual mentorships is to empower emerging and established leadership to mutually mentor one another	Melissa Berry, Diversity Consultant	March 2018	Reverser /sponsorship mentorship is due to be piloted in the trust between May and November

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

London Ambulance NHS Trust

Organisation's Board lead for EDS2:

Patricia Grealish, Director of People & Organisation Development

Organisation's EDS2 lead (name/email):

Melissa Berry (melissa.berry@lond-amb.nhs.uk)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Members of Staff Equality Networks (LGBT and BME)
Patient Forum
Community, Voluntary Sector (VCS)
Equality Committee

Organisation's Equality Objectives (including duration period):

London Ambulance is currently in the process of developing a new set of Equality objectives they are proposed as:
Objective 1 Race equality /Workforce Race Equality Scheme (WRES) to continue to build on the WRES action plan and keep developing this area of work
Objective 2 Disability Equality Scheme (DES)
Objective 3 Collection of patient monitoring data – Electronic Patient Record Form
Objective 4 Sexual orientation Monitoring Standard:The standard provides the guidance around collection of sexual orientation data from our patients. This is a

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

- Improve health outcomes for patients, through better understanding of who LAS patients are and their protected characteristics data
- Improve health outcomes for LGBT patients
- Improve patient experience through involving patients and their carers' in decisions about care

WRES action plan for staff to improve representation at all levels of the organisation

Publication Gateway Reference Number: 03247

Date of EDS2 grading November 2017 **Date of next EDS2 grading** February 2018

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: We work closely with commissioners, providers and other external stakeholders to highlight specific needs Equality Impact assessments need to be completed when services are commissioned	☐
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: we do not currently record protected characteristics or specific vulnerable groups such as learning disabilities dementia so this is developing and will be supported by the implementation of e-PRF. we have conducted audits of the care provided to LD and dementia patients to provide assurance in relation to the care we provide.	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: we do not currently routinely share patient contacts with providers however the introduction of Adastra into the Emergency Operations Centre allows for the development of post event messaging for primary care.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: we have an established process for reporting and investigating and acting on concerns through the governance process and our learning from experience framework.	☐
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: we deliver a significant amount of public education events across communities, patient groups and specific demographics.	☐
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: 999 services are accessible to all without prejudice We have a Translation Service used most extensively by control rooms.	☐

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Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: we have access to coordinate my care, a system used by patients and families to identify their specific wishes largely related to end of life care. however this system is not utilized pan London. we have a process whereby patients or their responsible clinicians can register personalized plans of care to be stored on the LAS systems and flagged against their address however this process is currently undergoing review.	☐
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: positive experiences - compliments - are collated through the corporate communications department	☐
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: we have an excellent complaints process, complaints response times have improved significantly over the last 12 months, we provide patient feedback leaflets with every response as well as leaflets on responding vehicles for patients and carers to make the complaints process as accessible as possible including clear guidance on the trust web site.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☑ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation **Evidence drawn upon for rating:** The TRAC system was implemented in April 2016, The Trust has attracted funding to target recruitment activities to underrepresented BME Groups	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☑ Sex ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust is required to publish the results of its Gender Pay Audit by 31st March 2018. The National ESR team are currently developing the Discover report for all Trusts to use and it is expected that this will available in the new year.	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust is developing an evaluation process for all types of training.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Staff survey results in 16/17 showed an improving experience from staff from both colleagues and patients Staff survey results indicate that BME staff are more likely to experience bullying and harassment.	☑
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** A flexible working policy has been developed to support staff in balancing work / life demands. EOC have introduced a part time roster to support this.	☐
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Staff engagement score moved from 3.13 to 3.40 in 16/17 Staff survey results indicate under representation of BME staff in Bands 5 and upwards	☑

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: Race; Sexual orientation Evidence drawn upon for rating: The LAS board has focused on the WRES for the past 12 months to look a the experience of BME staff in the organsation. There have been various listening events and workshops and a jointly co-produced action plan . Analysis related to the recruitment process, the disciplinary process	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: Evidence drawn upon for rating: At present this is not consistent in formal reports to governance meetings.	
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: Disability; Race Evidence drawn upon for rating: As part of the P&OD & WRES action plan there will be a series of lunch and learns set up for staff to discuss and learn ways to make a more inclusive environment	