London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 25 SEPTEMBER 2018 AT 10:00- 14.00, GREEN ROOM, ETC VENUES, AVONMOUTH HOUSE, 6 AVONMOUTH STREET, LONDON SE1 6NX

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
10.00	**1.**	**TB/18/74** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
10.05	**2.**	**TB/18/75** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	Assurance
10.10	**3.**	**TB/18/76** Attachment	**Minutes of the meeting held in public on 31 July 2018** To approve the minutes of the meeting held on 31 July 2018.	HL	Decision
10.15	**4.**	**TB/18/77** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
10.20	**5.**	**TB/18/78** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
10.25	**6.**	**TB/18/79** Attachment	**Report from Chief Executive** To receive a report from the Chief Executive (CEO).	GE	Information
STRATEGY					
10.30	**7.**	**TB/18/80** Attachment	**Freedom to Speak up** To receive an update on work that has been undertaken with regard to Freedom to Speak Up and on the development of a Freedom to Speak Up Strategy	PH, KC	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
10.50	**8.**	**TB/18/81** Attachment	**Trust Board Committee Assurance Reports** To receive the reports of the Board Assurance Committee meetings that have taken place since the last meeting of the Board. **(i) Audit Committee meeting on 03 September 2018** (incl audit letter) **(ii) People and Culture Committee meeting on 06 September 2018** **(iii) Finance and Investment Committee meeting on 11 September 2018** **(iv) Quality Assurance Committee meeting on 18 September 2018**	 JJ JM FC RM	Assurance
11.15	**9.**	**TB/18/82** Attachment	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Discussion
11.30	**10.**	**TB/18/83** Attachment	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and the Corporate Risk Register	PH	Assurance
11.45	**11.**	**TB/18/84** Attachment	**Bi-Annual Quality Account Report April-September 2018** To receive assurance on progress being made against the Trust's quality priorities	TB	Assurance
12.00	**12.**	**TB/18/85** Attachment	**Serious Incident Reporting and Progress** To note declared and closed Serious Incidents across the Trust.	TB	Discussion
BREAK					
12.20	**13.**	**TB/18/86** Attachment	**Working with regional partners to meet national performance standards** To receive a report on performance against national standards since the Ambulance Response Programme (ARP) implementation.	PW	Assurance

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
GOVERNANCE					
12.50	**14.**	**TB/18/87** Attachment	**Report of the Trust Secretary** To receive information about business transacted since the last meeting of the Board.	PH	Assurance
13.00	**15.**	**TB/18/88** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
13.05	**16.**	**TB/18/89** Attachment	**Unaudited Charitable Funds Annual Report & Financial Statements for 2017/18 independently examined by Ernst & Young LLP** To receive the unaudited Charitable Funds Annual Report and Financial Statements for 2017/18 that have been reviewed by the Charitable Funds Committee and by the Audit Committee as well as a report from the Charitable Funds Committee.	LB	Discussion
13.10	**17.**	**TB/18/90** Oral	**Patient Story** To hear about the experiences of a patient treated by the Trust.	TB	Information
13.40	**18.**	**TB/18/91** Oral	**Questions from members of the public**	HL	Information
13.45	**19.**	**TB/18/92** Oral	**Any other business**	HL	Information
13.50	**20.**	**TB/18/93** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
14.00	**21.**		**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 27 November 2018 at a venue to be confirmed.				

Timing	Item	Ref.	Owner	Status Assurance Decision Discussion Information

Additional reports, circulated for information and assurance only:

TB/18/94: Quality Report
TB/18/95: Completion of CAD Action Plan
TB/18/96: Business Continuity

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 31 July 2018

DRAFT Minutes of the public meeting of the Board held on 31 July 2018 at 9.00am in the Council Room at King's College London, Strand Campus, Strand, London WC1R 2LS

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
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Amit Khutti	AK	Associate Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
In attendance		
Ross Fullerton	RF	Chief Information Officer
Patricia Grealish	PG	Director of People and Culture
Philippa Harding	PH	Director of Corporate Governance
Benita Mehra	BM	Director of Strategic Assets and Property
Jamie O'Hara	JO'H	Director of Strategy and Communications
Rita Phul	RP	Corporate Secretary
Apologies		
Jessica Cecil	JC	Associate Non-Executive Director
Jayne Mee	JM	Non-Executive Director

1. Welcome and apologies (TB/18/49)

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

2. Declarations of interest (TB/18/50)

2.1. There were no declarations of interest.

3. Minutes of the meeting held in public on 24 May 2018 (TB/18/51)

3.1. The minutes of the Trust Board meeting held in public on 24 May 2018 were approved as a true and fair record of that meeting.

4. Matters arising (TB/18/05)

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

4.1.1. It was noted that Assurance Committees of the Board had sought confirmation of the term 'closed' in relation to actions arising from their meetings. The Board considered that if an action arising from a Committee meeting was completed, it would be denoted as closed on the action log; the closing of an action did not indicate the completion of an on-going matter, which could continue reflected by new actions until the matter was addressed and considered closed by the relevant Assurance Committee.

4.1.2. The Board noted that dates of key Strategic Transformation Partnership (STP) meetings contained within Board newsletters (ref: TB/17/197 para 5.1a) would be shared shortly. It was proposed and agreed that, when making information available to the Board through the electronic Board paper portal, an email should be circulated to members to notify them of this.

4.1.3. Board members discussed the STP Steering Groups and the importance of Non-Executive Director (NED) representation alongside London Ambulance Service NHS Trust (LAS) executives. The Board considered that involvement of NEDs at the STP Steering Groups would create greater awareness and engagement with a wider group of stakeholders.

5. Report from the Chair (TB/18/53)

5.1. The report from the Chair was noted. The Board noted the increased integration of NHS Improvement (NHSI) and NHS England (NHSE) and that the focus on the two regulators was towards greater collaboration in the future.

6. Report from the Chief Executive (TB/18/54)

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

6.2. The Board noted the Trust's procurement of interims and consultants and the level of spend to support this procurement. The Board was informed that interim support was required to ensure necessary focus during restructuring activities throughout the organisation. It was noted that the use of interims provided a valuable element of independence during periods of restructuring.

6.3. Board members discussed the Staff Survey results and commended LAS for the positive response and net promoter scores, particularly in relation to place of work and quality of care. The Board noted these improved statistics were as a result of the staff champions who were actively driving better engagement with staff.

6.4. It was observed that the Electronic Patient Care Record (ePCR) project was progressing and, following a very successful engagement event with staff, a project team had now been established. The Board was made aware that whilst the ePCR was developing well, considerable work was required to ensure the business case was formulated correctly. It was anticipated that this would form the basis of some discussion at the next informal Board session.

6.5. The Chair highlighted the recent appointment of LAS's Head of Clinical Audit and Research, voted in as Chair of the National Ambulance Research Group.

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

7. Data Quality Improvement Strategy, Data Quality Policy, & Data Quality Implementation Plan (TB/18/55)

7.1. LB presented the report which sought approval for the LAS Data Quality Strategy, structured in three documents. LB communicated to the Board that initial papers discussing Data Quality Assurance had been presented to the Audit Committee and the Executive Leadership Team (ELT) in 2017, stating plans for governance, policies, best practices and data quality measures. The Board observed that following discussion and audit, a series of recommendations and next steps had been made. These three documents – the Strategy, the Policy, and the Implementation Plan – defined strategic objectives from the recommendations made by ELT and the Audit Committee, setting out a plan for implementation, and devising the governance and roles required for delivery of data quality. The Board noted implementation of the Data Quality Improvement Strategy was a "must do" from the Care Quality Commission (CQC) Quality and Improvement Plan.

7.2. The Board was informed that the three documents had been reviewed by the Trust's previous internal auditors (following an internal audit in this area in 2017/18) and that they had provided feedback confirming that, with Board level ownership and regular oversight, the documents and processes compared well in terms of good practice and were clear and concise. It was noted the papers had been circulated to Audit Committee members and their feedback had been updated within the documents where possible and fed back directly to the Audit Committee.

7.3. Board members observed that budget had been approved for the initial appointment of the Data Quality Assurance Team, which would oversee the first year of implementation. The Board also observed that the three documents would be reviewed and updated annually and a further financial assessment would be conducted once the technical plan for Phase 2 had been completed.

7.4. The Board referred to the proposed core Key Performance Indicators (KPIs) and whether these would be subject to a review, highlighting that there were a considerable number of KPIs that required addressing. LB proposed that the capability of the Trust be built as the first priority, followed by learning. This would incur investment for this year and deliverables to be identified, followed by a review of the Trust's progress and assessments. Board members deliberated on the need for a manageable and clear number of KPIs to ensure delivery.

7.5. The Board was informed that a Data Assurance Team would be in place by October 2018 subject to the Data Quality Strategy being approved. Assurance on this activity would be sought through the Logistics and Infrastructure Committee.

RESOLVED:

7.6. The Board resolved to approve the Data Quality Improvement Strategy, Data Quality Policy and Data Quality Implementation Plan.

8. North East London IUC Launch (TB/18/56)

8.1. FW tabled a paper providing the Board with an update on the North East London Integrated Urgent Care (NEL IUC) service launch, briefing the Board on the requirement for LAS to provide NHSE with detailed documentation for assurance prior to the NEL IUC becoming live. The Board observed that LAS had successfully passed this assurance with NHSE to go live on 1 August 2018. The Board noted that the final three areas of testing had been completed by Monday 30 July 2018 and that all that remained was a further assurance checkpoint call later that day.

8.2. The Board was informed that work was outstanding with regard to the booking of GP and dental appointments and that this was dependent on the providers undertaking specific updates which would take place over the course of the next 2-3 months. The Board was assured that LAS had completed all actions required to progress the NEL IUC safely.

8.3. Board members considered the final part of the NEL IUC programme which was for a number of staff to transfer to the LAS under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), and that this would happen on 1 August 2018. The Board was informed that the staff involved were very engaged and a positive outcome was perceived.

8.4. The Chair advocated the undertaking of a lessons learned exercise regarding the process of mobilisation. GE added that South East London IUC would mobilise on 30 October 2018 and would integrate with the national service, providing an opportunity to share wider lessons learned.

ACTION: Update on processes followed for go ready and assurance on NEL IUC launch to be provided to the Board together with information about processes to be put in place for lessons learned exercise to inform preparations for SEL IUC launch.

ACTION: Board briefing on integrated clinical hubs to be arranged.

9. Trust Board Committee Assurance Reports (TB/18/57)

(i) Logistics and Infrastructure Committee meeting on 5 June 2018 (TB/18/57(i))

9.1. TdP presented the report, which set out the main points arising from the Committee's meeting on 5 June 2018. He referred the Board to the Matters for Escalation and the requirement for external resources to progress the IM&T strategy. RF reported to the Board that as a result of a balanced approach, in-house services had been utilised, removing the requirement of an external resource and its associated costs.

9.2. An update was provided to the Board regarding the work being undertaken by LAS in relation to cyber security. In response to a query regarding proposed work related to cyber risks, RF advised the Board that LAS had been instructed by NHSE to seek assurance through the implementation of Cyber Essentials Plus, which included independent verification of cyber security by a Certification Body. The Board noted that the Cyber Essentials Plus was in the process of being established and RF was therefore not yet in a position to confirm what other assurances would be required to meet NHSE requirements. Board members considered the value of achieving the ISO27 standard and to review the elements in the ISO accreditation against the requirements of the Cyber Essentials Plus, to avoid duplication of effort.

9.3. NEDs observed that cyber security continued to be a BAF risk and acknowledged that, whilst the matter remained complex, it required focussed attention. The Board noted that regular reviews should be conducted through the Logistics and Infrastructure Committee (LIC), and reported to the Board, with assurance that a review be undertaken at the end of the year to remove cyber security from being a red risk.

(ii) People and Culture Committee meeting on 12 July 2018 (TB/18/57(ii))

9.4. PG presented the report, which set out the main points arising from the Committee's meeting on 12 July 2018. The Board observed several issues were discussed in regards to the summary presentation of the independent training review. PG reported on key issues raised by the Re-think, who had undertaken the review; value, quality and efficiency were highlighted as requiring improvement. Other areas that impacted the value of training included the management of training records, including digitising records. It was noted that the Executive Leadership Team (ELT) was due to receive a proposed action plan for responding to the findings of the review.

9.5. PG provided an update on the agency plan which had been escalated to the Board; People and Culture Committee (PCC) members were informed that trajectories were being built to ensure each directorate was on track with regard to its expenditure on agency. The agency plan would be managed through performance reviews and at management level.

9.6. The Board considered the implications of apprenticeships on the Trust's long-term workforce modelling, acknowledging that apprentices may require more ongoing support than other staff.

9.7. The Board observed the progress of the pilot Trainee Emergency Medical Dispatcher (TEMD) online assessments. Members considered that the online process had been an improvement, ensuring potential new joiners knew about their roles *before* joining the organisation, which thereby assisted with improving retention. It was noted that more data was required to draw any conclusions from the pilot and a more detailed analysis would be provided at the PCC later in 2018 (the approach had only been in use since May 2018).

(iii) Quality Assurance Committee meeting on 24 July 2018 (TB/18/57(iv))

9.8. RM presented the report, which set out the main points arising from the Committee's meeting on 24 July 2018. RM noted that concerns regarding the training review had also been raised at the Quality Assurance Committee (QAC). It was reported that the

QAC observed responding to the review would require a major investment of managerial time and resource and there were quality and safety implications, so the QAC should be kept informed in relation to those particular issues; however it was agreed that the ELT should agree the action to be taken, which the PCC would take forward in terms of providing overall assurance to the Board.

9.9. The Board noted an update with regard to Control Services. It was discussed that data could also inform performance, linked to incident reporting and that this would require greater management support.

9.10. Stroke management was reviewed and the Committee had been assured, by a detailed analysis, that the persistent breach of the national 60-minute (999 call to hospital) target did not adversely affect clinical outcome. Consideration was given to develop a LAS indicator of greater clinical relevance.

(iv) Finance and Investment Committee meeting on 23 July 2018 (TB/18/57(v))

9.11. FC presented the report, which set out the main points arising from the Committee's meeting on 23 July 2018. The Board was informed of the Trust's cumulative deficit of £2.5m, which was in line with budget and noted that some risks had become more significant, notably in relation to expected income. Activity to date was 0.55% below contract and if this were to continue, full year income could be £6m below plan (worst case scenario).

9.12. The Board considered the key shift in trend activity and noted that it would take approximately two months of monitoring trend activity before trends could be established. LB advised the Board that a deep dive into the underlying factors regarding activity would be presented to the next meeting of the Finance and Investment Committee (FIC); these would be reported to the Trust Board together with a complete worst/best case scenario and contingencies as required.

10. Integrated Quality and Performance Report (TB/18/58)

10.1. LB presented the report providing the Board with a high level executive summary and organisational oversight of all key areas across LAS quality and performance.

10.2. The Board was assured that the delivery of care continued to be safe but the on-going demand pressures on the system remained challenging, particularly on call activity. The Board observed that Cat 1 Mean was 7 minutes-13 minutes, falling just outside the national targets.

10.3. Board members considered the financial update, including that the Trust was projecting to meet, and was on track to achieve, the control target and Cost Improvement Programme (CIP) total. The Board noted the agency trajectory and that a clear plan was in place to bring this back in line, but that there was a slight lag in the current quarter due to the capital plan. The Board was reassured that this related to the phasing in IT expenditure, so did not currently present as a risk. The Board was made aware that the vacancy gap was improving.

10.4. TB informed the Board of an investigation into SI numbers and that these were now back to normal; the Board was reassured that 700 incidents in Datix were reviewed on a daily basis.

11. Board Assurance Framework and Corporate Risk Register (TB/18/59)

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

11.2 The Board was informed of additional risks for consideration of potential escalation to the BAF arising from two Board Assurance Committee discussions, FIC – income risk and QAC – training and new standards risk.

11.3 Board members observed that the risk register system was up-to-date however a process issue had been identified whereby updates to the risk register were being provided to an individual instead of being undertaken directly to the system. This single point of failure had been identified and was being addressed through the provision of additional trust wide training on the use of the risk register recording system (Datix) and the creation of a risk management team.

11.4 The Chair reflected that there could be a number of risks associated with the Brexit process and it was considered that the next Audit Committee meeting (September 2018) should address the Brexit issue alongside Business Continuity Planning.

ACTION: Future consideration to be given to a Brexit risk, alongside Business Continuity Planning, and for consideration to be given by the Audit Committee in September 2018.

11.5 The Board noted that work regarding horizon scanning would also be presented to the Audit Committee and presented to the Board in September.

ACTION: Horizon scanning to be addressed at Audit Committee to bring to the Board meeting in September for assurance.

12. Serious Incident Quarterly Thematic Report (TB/18/60)

12.1. The Board received a report providing an overview of the incidents reported and declared to the Trust's Clinical Commissioning Groups (CCGs) and a thematic review of serious incidents closed and submitted to the CCG in Q1. The thematic review was specifically focussed on serious incidents (SI) by category and key contributory factors.

12.2. Board members considered the key areas to focus on including despatch and call – a change in determinants could have an impact on calls but training was in place to address this issue. It was noted that there was an unprecedented demand on the Trust's resources. Themes were being reviewed and continual mitigation plans undertaken.

13. Staff Story (TB/18/66)

13.1 The Board was joined by two members of LAS Bromley Group staff who shared their experience of how they addressed the CEO's management challenges through the staff survey and actively engaged with staff in their sector.

13.2 Members observed that the approach by the Staff Survey champions had substantially improved staff involvement helping initiate discussions, reduced occurrences of musculoskeletal (MSK) injury, and supported staff development.

13.3 Board members thanked the two members of staff and commended them on their work.

14. Preparing to meet National Performance Standards (TB/18/61)

14.1 PW presented a report updating the Board regarding the new national performance standards introduced in November 2017 as part of the Ambulance Response Programme (ARP). The Board was made aware that since then, Ambulance Trusts had been given time to adapt their operating model to the new ARP system. NHSE had however set an expectation that Ambulance Trusts should be meeting each of the performance standards by 1 October 2018.

14.2 The Board observed the key points of the paper; the Trust's performance since the implementation of ARP and reviewed performance forecasts at October 2018 and over the remainder of 2018/19. The Board also observed the number of projects/initiatives being undertaken across the Trust, and with external partners, to strengthen and protect performance against the national standards and maintain patient safety.

14.3 Board members noted that since the launch of ARP the Trust's operating model had continued to be improved. Members considered the three main areas of focus for improvement; calls at Heathrow Airport and the elongated response times due to the reporting of ill patients generally being undertaken whilst in transit; upgraded calls and that the LAS system currently could not assign responders to upgrade calls due to the requirement of validation of numbers, but that this process would be updated back to April; and modelling – pre ARP it was noted that a sophisticated modelling had existed, but after 1 November 2017 the performance indicators required change and similar parameters were being utilised but only 8 months data was taken into account.

14.4 PW confirmed to the Board that improvement levels could all be achieved however a reduction in Emergency Department (ED) conveyance was required to be achieved by all frontline staff.

14.5 The Board noted the current forecast and was assured that work was being undertaken to achieve the ARP target within the safety threshold. The Board was informed of a pipeline of new recruits joining the Trust in September and further vehicles to be added to the fleet. The Board sought further assurance the Trust would achieve the necessary activity, performance and capacity to comply with National Performance Standards later in the year. PW reassured the Board that capacity was against the current pipeline and the current projections were based on the potential recruitment and vehicle provision. The Board requested the provision of a further report establishing how the ARP targets would be achieved and what actions would be required to do this.

ACTION: provision of an update report at Trust Board in September 2018, establishing how the ARP targets will be achieved and what actions would be required to do this.

15. Rest Break Policy Implementation Review (TB/18/62)

15.1 The Board noted the report providing updates on the developments which had occurred since the revised rest break policy was implemented in December 2017. The revised policy introduced the option for staff to take a 'flexible' break at a location of their choice rather than have to be returned to their base station. The Board observed further updates within the report including;

- Developments since December 2017
- Evidence of improved rest break allocation
- Evidence of improved performance in the shift handover period
- Early findings from the end of shift pilot

15.2 PW confirmed the next steps to further improve rest break allocation including flexible and fixed breaks, corresponding differences across shift changes and late finishes.

16. Report of the Trust Secretary (TB/18/63)

16.1 The Board noted the report setting out the requirement of Standing Order 34 that all sealings entered into the Sealings Register were reported to the next meeting of the Trust Board.

16.2 The Board noted that on 19 June 2018, in the presence of the Chief Executive, the Director of Finance and Performance, the Director of Strategic Assets and Property and a representative of the Trust Secretary, the seal of the Trust was affixed to the following lease contract:

Maritime House, Linton Road, Barking Essex IG11 8HG, between London Ambulance Service NHS Trust and Dooba Investments III Ltd.

17. Trust Board Forward Planner (TB/18/64)

17.1 The Board noted the Forward Planner.

17.2 Board members observed the following updates:

- Quarterly Strategy Update in September;
- Financial accounts signed off in March; and
- Business Planning – Performance against objectives (potentially to be undertaken in an informal Board meeting).

18. Annual General Meeting Preparation (TB/18/64)

18.1 JOH provided an update to the Board with regards to the Annual general Meeting (AGM) for 2018; the Board was reminded that the AGM would take place on 25 September 2018 at Union Street offices, which LAS shares with the London Fire Brigade, and would commence at 5.30pm to encourage greater attendance.

18.2 The Board observed that in order to increase engagement, showcase LAS work more effectively and provide a better forum for members of the public and stakeholders, significant changes would be made to the format of the AGM. It was also intended to use technology more effectively, making the AGM an open public meeting that could

then be watched online. The Board was advised that the report would be recorded and Facebook live also be used.

18.3 It was disclosed that mental health would be a significant focus of the meeting with a keynote speaker, a service user experience, staff experience and partner/ charity experience.

19. Questions from members of the public (TB/18/67)

19.1 There were no questions from members of the public.

20. Any Other Business (TB/18/68)

20.1 There was no other business.

21. Review of the meeting (TB/18/69)

21.1 Board members confirmed that they considered the quality of the papers presented to the meeting in a timely fashion to be good. The Chair commented that the agenda was of a good size and conducive to a quality meeting.

21.2 Feedback was provided with regard to the venue and it was noted that the acoustics were better at the Kings College building then at the LAS HQ; that IT worked effectively although there were some issues with regards to Trust laptops being able to access i-Cloud to use Convene; and the location was convenient and easy to reach. PH suggested a preference to use NHS trust building for Board meetings wherever possible, but confirmed that the Kings College building had been a good venue.

21.3 Board members discussed behaviours and the Chair reiterated the importance of voice projection to ensure effective participation for all attendees. It was confirmed that all who had wanted to speak at the meeting had been given that opportunity.

21.4 The Board agreed there had been sufficient challenge exercised by the Board and that the Board Assurance Committees were well aligned with the Board agenda.

22. Meeting close

The meeting closed at 12.30pm. The next Trust Board meeting in public will take place on 25 September 2018 – time and venue to be confirmed.

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/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	ASAP	**CLOSED**	Secure storage of records has been put in place with a professional document management provider, Iron Mountain. The provider will store the records for the remainder of the retention period required for each document set. A new project has been agreed to identify digital replacements for managing the records using paper. Analysis is underway of the full requirement set and potential solutions.
TB/18/32 para 7.4	Consider co-ordination of attendance at NHS Providers events.	Philippa Harding	24/0518	25/09/18	**CLOSED**	More information being circulated on a regular basis.
TB/18/38 para 13.6	Planning assumptions to be considered as a Board development session topic	Heather Lawrence	24/05/18	25/09/18	**On track**	Included in forward planning for informal Board sessions
TB/18/41 para 16.3	Freedom to Speak Up Strategy to be presented to the Board for approval in September.	Philippa Harding	24/05/18	25/09/18	**CLOSED**	See item on agenda
TB/18/56	Update on processes followed for go ready and assurance on NEL IUC launch to be provided to the Board together with information about processes to be put in place for lessons learned exercise to inform preparations for SEL IUC launch.	Fenella Wrigley	31/07/18	25/09/18	**On track**	To be addressed at the Quality Assurance Committee on 18 September 2018 and reported to the Board.
TB/18/56	Board briefing on integrated clinical hubs to be arranged	Fenella Wrigley	31/07/18	25/09/18	**On track**	To be addressed at the Quality Assurance Committee on 18 September 2018 and reported to the Board.

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/18/59	Future consideration to be given to a Brexit risk, alongside Business Continuity Planning, and for consideration to be given by the Audit Committee in September 2018.	Philippa Harding	31/07/18	25/09/18	**CLOSED**	This was considered by the Audit Committee in September and further information requested, due to be reported in November
TB/18/56	Horizon scanning to be addressed at Audit Committee to bring to the Board meeting in September for assurance.	Philippa Harding	31/07/18	25/09/18	**On track**	This has started and will be incorporated into future Board reports.
TB/18/61	Provision of an update report at Trust Board in September 2018, establishing how the ARP targets will be achieved and what actions would be required to do this.	Philippa Harding	31/07/18	25/09/18	**CLOSED**	See item on agenda

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Report from the Chair			
Agenda item:	05			
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

Association of Ambulance Chief Executives (AACE) meeting (17-18 July)

1. I attended the meeting of the Association of Ambulance Service Chairs and the joint Chairs and Chief Executive Officers (CEOs) meeting. This is an invaluable networking event and where a number of important and relevant issues are discussed. We need to be clear where we wish to be involved with AACE initiatives and where we operate separately or with South Central Ambulance Service NHS Foundation Trust (SCAS) and / or South East Coast Ambulance Service NHS Foundation Trust (SECAMB). I attach copies of the presentations of topics discussed: National Defibrillator Network, Speaking up in Ambulance Trusts and Stay wise. The most informative from my perspective was the presentation by Dr Henrietta Hughes, Medical Director, and National Guardian for the NHS.

2. NHS Digital also presented to the joint group and there was nothing new to add since we had a presentation at both London Ambulance Service NHS Trust (LAS) and the London Chairs' group.

Workforce Race Equality Standards (WRES) Action plan (24 July)

3. This was a well-attended event opened by the Chair of East London NHS Foundation Trust (ELFT) - Marie Gabriel. The CEO made a compelling presentation setting out why the organisation needed to change and how he expected behaviours and values to be adopted that were inclusive for all.

4. The session resulted in a range of actions which have been collated into the WRES action plan. A formal report is due to be presented to the Board in November.

Visit to North East London Integrated Urgent Care centre (NEL IUC) and Training centre (9 August)

5. Andrew Howard, Unison representative and paramedic joined me on a visit to the centre just one week after the go-live date. We were impressed by the positive attitude of staff, the environment and the communication methods being used with staff such as the daily 'huddles' a well-known approach in hospitals where staff get- together to both give feedback on how they are experiencing the work and the work environment and to be kept informed of progress and information. I listened to staff taking calls and to the algorithm being followed. I appreciate that go-live was difficult on a number of levels but it is a credit to the team that the takeover was as smooth as it was on what is arguably the most challenging week in the NHS due to the national change over day for all doctors in training.

6. We then met with the members of the training team and met some new recruits.

7. I know that both services would welcome other Board members spending time with them.

Non-Executive Director (NED) recruitment

8. The recruitment for a new replacement NED is underway. To stimulate interest from disadvantaged groups I posted a note on my Linked-In page resulting in expressions of interest. We are working closely with NHS Improvement's (NHSI) Appointments team who lead the process. The post has been advertised and I will provide an update on progress at the Board meeting. The proposed date for interviews is 16 October 2018 and Marie Gabriel Chair, ELFT will be the outside assessor and Dr Dean Spencer will represent NHSI on the panel.

Baroness Dido Harding, Chair NHSI (30 August)

9. Dido undertook a 12 hour-ride out on an overnight shift and was complementary about the crew who hosted her whilst also appreciating the challenges we faced.

Attendance at the Volunteer strategy workshop and Clinical Strategy and Clinical Education Strategy Workshop

10. Both of these sessions, for supporting strategies to the recently approved Trust- wide Strategy, were attended by a wide representation of our staff together with representations from other organisations including the Patients Forum at the Volunteering strategy session.

11. A range of ideas as to how to progress these strategies emerged and were grouped into themes. The Executive will now progress the strategies taking into account the views that emerged.

Visit to meet Kings Health care Chairman 13/9

12. Ian Smith Chairman of King's College Hospital NHS Foundation Trust (KCH) recently spent time on a ride-out with one of our crews. He gained insight into the challenges we face particularly in relation to lack of access to health records and alternative care pathways.

13. KCH is one of the most challenged trusts in London with high demand. They have recently provided our crews with direct access to their Urgent Care service rather than having to take all of the patients to the main Accident and Emergency department. Whilst there I took the opportunity to meet with our crews who were at the hospital and they advised that systems in the hospital were improving and that good relationships existed between LAS and the hospital trust.

Heather Lawrence OBE
Chair

British Heart Foundation

The National Defibrillator Network

Simon Gillespie, Chief Executive

18th July 2018

- Introducing BHF
- National Defibrillator Network
- Our vision
- What the network means for you
- Our ask


1961

We want to

beat heartbreak forever.

The problem

Our strategic objectives

Increase the rate of bystander CPR

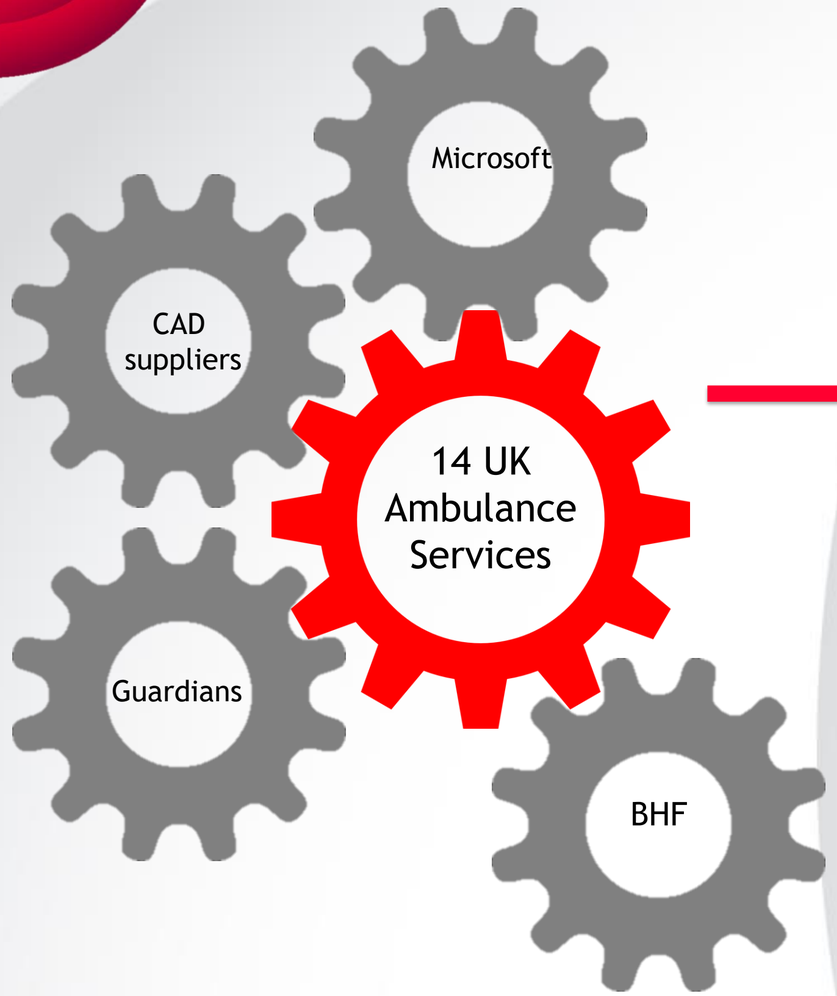
Increase the rate of bystander defibrillation

Our Vision

What does this mean for you?

- Trusted
- Resource saving
- Control
- Drives change
- Connectivity

Partnership → Impact



Increased bystander defibrillation

Increase in lives saved

Our commitment

Timelines for implementation

June 2018	• Partnered with Microsoft and technology supplier New Signature
June-Nov 2018	• Building and testing of the database
Mar 2019	• Implementation of the NDN - West Midlands Ambulance service
April 2019	• Implementation of the NDN - Scottish Ambulance service
April - June	• Rollout of the NDN solution to the remaining x12 ambulance service
April - June	• National marketing campaign to map all defibrillators in the UK

Our ask

Commitment
Collaboration


4


2019

British Heart Foundation

Thank you

National Guardian
Freedom to Speak Up

Speaking up in Ambulance Trusts – 18th July

Freedom to Speak Up

Dr Henrietta Hughes

National Guardian for the NHS

@NatGuardianFTSU


Mid Staffordshire NHS
NHS Foundation Trust
Stafford Hospital


GOSPORT WAR MEMORIAL HOSPITAL

National Guardian
Freedom to Speak Up

Speaking up is about safety and experience

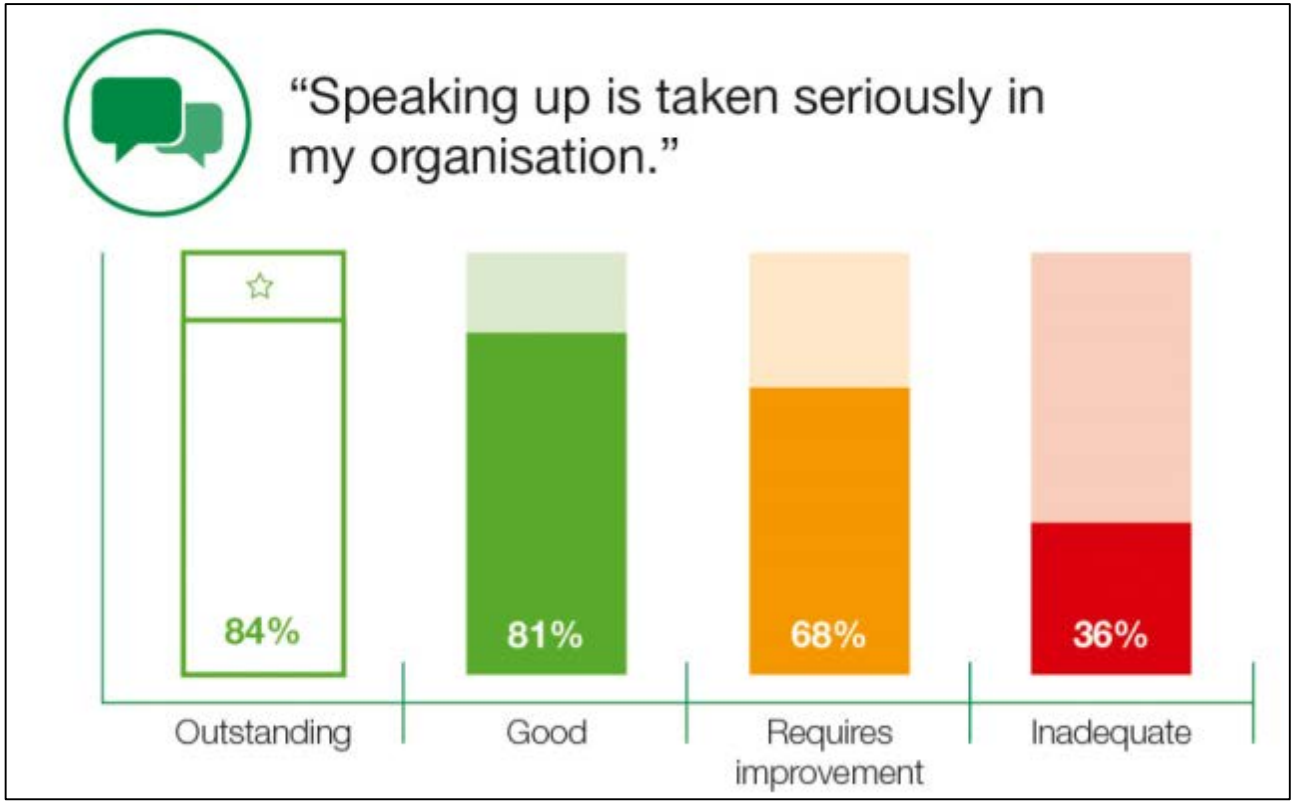
National Guardian for the NHS
Dr Henrietta Hughes

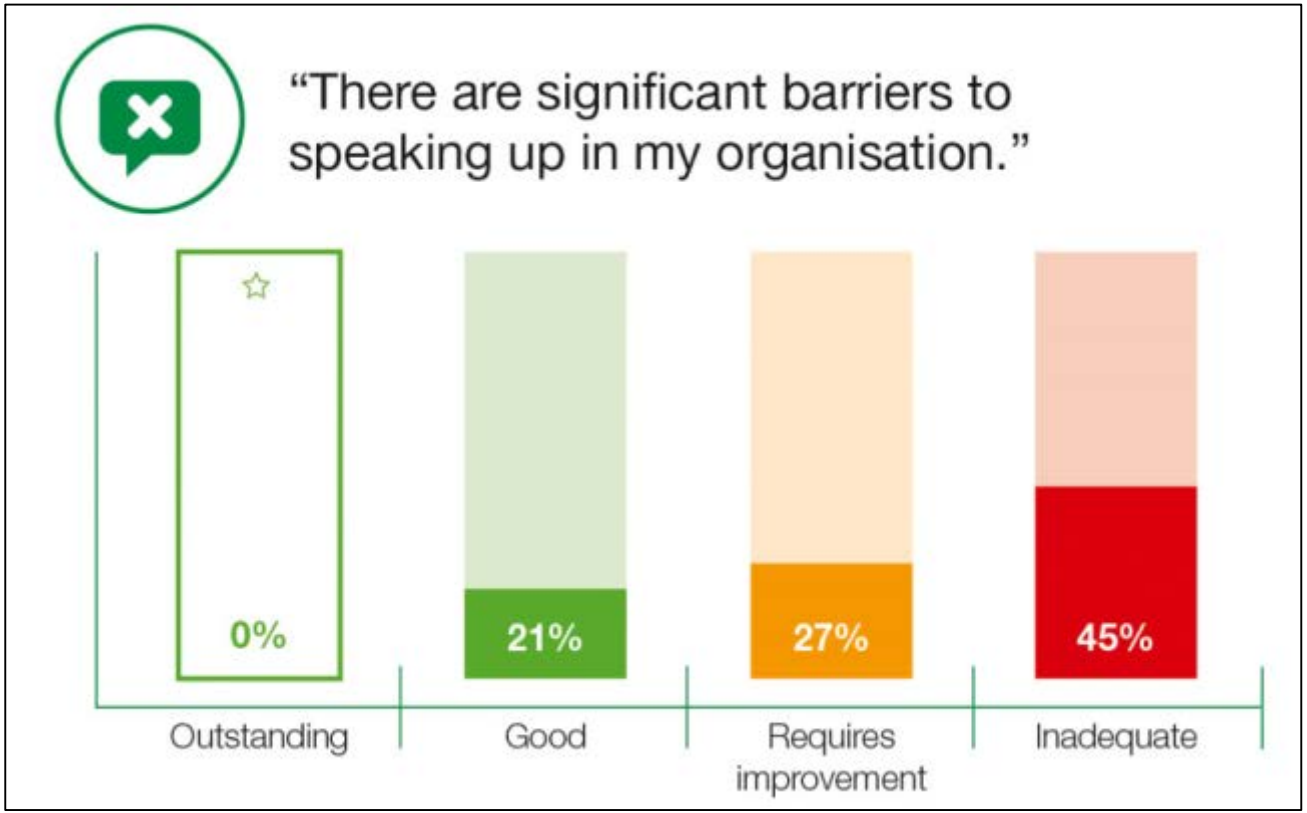
Freedom to Speak Up Guardians

National Guardian
Freedom to Speak Up

National Guardian's Office

- Freedom to Speak Up Embedded
  Recruitment, HR, Board Reports, Well Led Inspection, Leadership Development
- Training & guidance to Guardians and champions
- Organisational development – Board Guidance
- Publish Guardian Directory and Data
- Publish Case reviews & recommendations


"Speaking up is taken seriously in my organisation."
84%
81%
68%
36%
Outstanding
Good
Requires improvement
Inadequate


"There are significant barriers to speaking up in my organisation."
0%
21%
27%
45%
Outstanding
Good
Requires improvement
Inadequate


"Managers support staff to speak up."
77%
53%
29%
18%
Outstanding
Good
Requires improvement
Inadequate

National Guardian
Freedom to Speak Up

CQC inspections

- **How trusts support speaking up will potentially affect the overall rating inspectors give for the well-led domain of CQC inspections**

- ‘Speaking up is being inspected as part of the well-led domain of CQC inspections

- FTSUGs should expect CQC inspectors to speak to them

- The NGO has worked with the CQC on guidance to inspectors on speaking up

National Guardian
Freedom to Speak Up

Case reviews

- Individual cases
- Review of systems
- Make recommendations
- Support implementation
- Locally and nationally

National Guardian
Freedom to Speak Up

The speaking up process

Confidentiality
Detriment

Communication

Knowledge
Information

Hierarchy
Systems
Processes
Policies

Investigations

National Guardian
Freedom to Speak Up

Freedom to Speak Up Guardians

700+ work independently, support individuals and provide challenge to the Board

All staff have the capability to speak up effectively and are supported appropriately

The Board is engaged in all Freedom to Speak Up matters and issues that are raised

Speaking up processes are effective and continuously improved

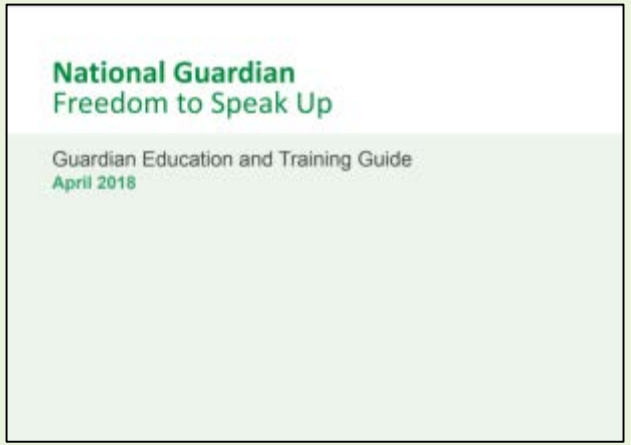
Safety and quality are assured

A culture of speaking up is instilled throughout the organisation and the NHS

National Guardian
Freedom to Speak Up

Learning and improving

- Personal development
- Organisational development
- Job Description



National Guardian
Freedom to Speak Up

Working in partnership

National Guardian
Freedom to Speak Up

Working in partnership

National Guardian
Freedom to Speak Up

A year in numbers

230

>720

12

70

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Freedom to Speak Up

Speaking up is happening

6,768 cases

45% include an element of bullying and harassment

32% include an element of patient safety

5% include perceived detriment

Based on data returns from NHS trusts and foundation trusts April ’17 – March ‘18

National Guardian
Freedom to Speak Up

A note on hierarchy

- Stanley Milgram “The Perils of Obedience”
- Nurses case study – electric shocks

National Guardian
Freedom to Speak Up

10 principles for the guardian role

National Guardian
Freedom to Speak Up

Freedom to Speak Up Guardian Survey 2017

- Guardians perceived worst speaking up culture was in Ambulance trusts

4.2 Statement	Proportion of respondents agreeing or strongly agreeing with the statement				
	Services provided				
	Acute	Community	Mental Health	Ambulance	Specialist
The guardian role is making a difference	57%	65% +	65% +	61%	50% -
My organisation has a positive culture of speaking up	48%	59%	66% +	44% -	52%
Speaking up is taken seriously in my organisation	66%	73%	82% +	44% -	62%
There are significant barriers to speaking up in my organisation	25%	29%	23% +	39% -	32%
My organisation is actively tackling barriers to speaking up	68%	69%	74% +	50% -	64%
People in my organisation do not suffer detriment as a result of speaking up	35%	41%	44% +	23% -	28%
Managers support staff to speak up	36%	38%	39% +	33% -	36%
Senior leaders support staff to speak up	62%	69%	75% +	55% -	64%
My organisation sees speaking up as an opportunity to learn and improve	73%	76%	80% +	55% -	66%

+ most positive response

- least positive response

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Data returns

NHS trust	Q1: Total number of cases	Q2: Total number of cases	Q3: Total number of cases	Q4: Total number of cases
East Midlands Ambulance Service NHS Trust	0	2	10	4
East of England Ambulance Service NHS Trust	4	4	9	7
London Ambulance Service NHS Trust	0	1	1	5
North East Ambulance Service NHS Foundation Trust	2	4	0	1
North West Ambulance Service NHS Trust		16	17	13
South Central Ambulance Service NHS Foundation Trust	1	1	0	0
South East Coast Ambulance Service NHS Foundation Trust		3	0	0
South Western Ambulance Service NHS Foundation Trust	1	0	0	0
West Midlands Ambulance Service NHS Foundation Trust	6	3	2	8
Yorkshire Ambulance Service NHS Trust	20	19	12	5

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Bullying and harassment

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Emergency services

Ambulance staff face rise in physical and verbal sexual assaults

Advertisement

Number of annual incidents in England has almost trebled over last six years, NHS figures show

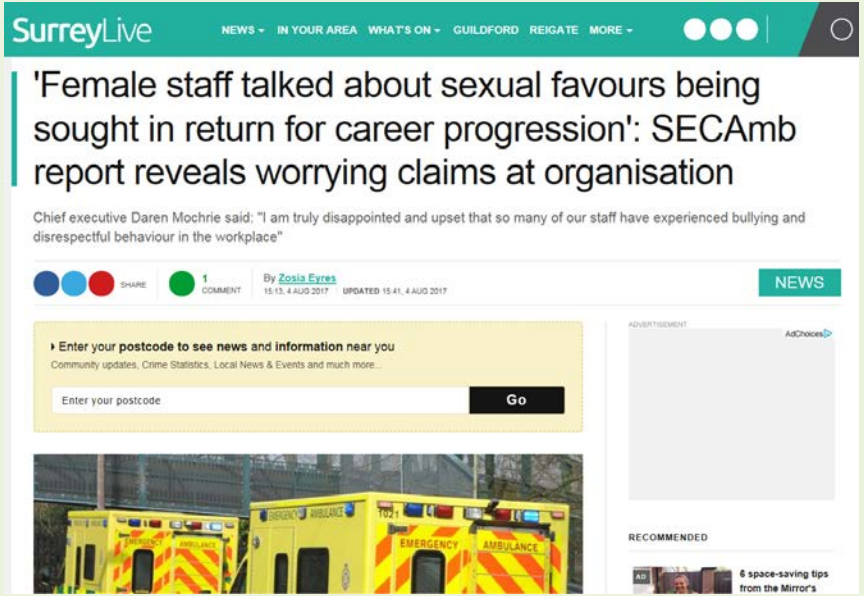
Denis Campbell
Health policy editor
Mon 23 Apr 2018 00.01 BST

299

▲ Some female paramedics have become reluctant to respond to a call about a male patient if they are working alone. Photograph: Dan Kitwood/Getty Images

Growing numbers of frontline ambulance staff are being sexually assaulted at work or having lewd comments made to them, NHS figures reveal.

The number of such incidents involving ambulance workers in England has almost trebled from 52 in 2012-13 to 145 in 2017-18. Figures from eight of the 10 NHS



SurreyLive NEWS IN YOUR AREA WHAT'S ON GUILDFORD REIGATE MORE

'Female staff talked about sexual favours being sought in return for career progression': SECAmb report reveals worrying claims at organisation

Chief executive Daren Mochrie said: "I am truly disappointed and upset that so many of our staff have experienced bullying and disrespectful behaviour in the workplace"

SHARE 1 COMMENT By Zosia Eyres 15:13, 4 AUG 2017 UPDATED 15:41, 4 AUG 2017 NEWS

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Community updates, Crime Statistics, Local News & Events and much more...
Enter your postcode Go

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RECOMMENDED

6 space-saving tips from the Mirror's

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Asks of AACE

- Continue to support your FTSU Guardians
- Adopt learning
- Aim for most positive speaking up culture
- Support Speaking Up Month – October 2018

National Guardian
Freedom to Speak Up

National Guardian Office next steps

- Primary care (GP, Dentist, Pharmacy, Opticians)
- Independent sector
- National adoption of recommendations
- Speaking Up Month – October 2018
- Award – Supportive Staff Culture November 2018

National Guardian
Freedom to Speak Up

Links

National Guardian's Office email address
– enquiries@nationalguardianoffice.org.uk

Annual report 2017
– http://bit.ly/2hu3Dxc

Case review page
– http://bit.ly/2AMfmjl

Q4 2017/18 (January-March 2018) data table
– http://bit.ly/2At9ApN

Freedom to Speak Up Guardians' Survey 2017
– http://bit.ly/2xdX9K9

Freedom to Speak Up Guardians' Directory
– http://bit.ly/2ioguC5

National Guardian
Freedom to Speak Up

Thank you

Follow us on Twitter:
@NatGuardianFTSU

StayWise

The collective
educational resources
of the emergency services

Purpose

- To create a one-stop-shop of educational resources for schools from the emergency services, linked to the National Curriculum; crossing all age groups and subject areas.
- Provide a consistent and accessible library of learning in a repository that is tried, tested and trusted by educationalists
- Reduce demand on services and underpin parity of the educational offer across the UK
- Provide a free resource for teachers and young people to increase positive behavioural changes in young people.

Benefits of StayWise

- Efficient & cost effective development of resources across all services
- Consistency of safety messaging
- Reduced planning time for educationalists
- Deliver safety messaging through our partners – for example….34,000 fire fighters or 430,000 teachers!
- Digital platforms to reduce demand on services and provide support where a physical presence is unachievable
- Ability to influence the learner and for the learning to endure
- Evidences our compliance with the duty to collaborate

Rebuilding the partnership

NFCC
National Fire
Chiefs Council

Home Office

Public Health
England

ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

?

Lifeboats

Cabinet Office
Civil Contingencies

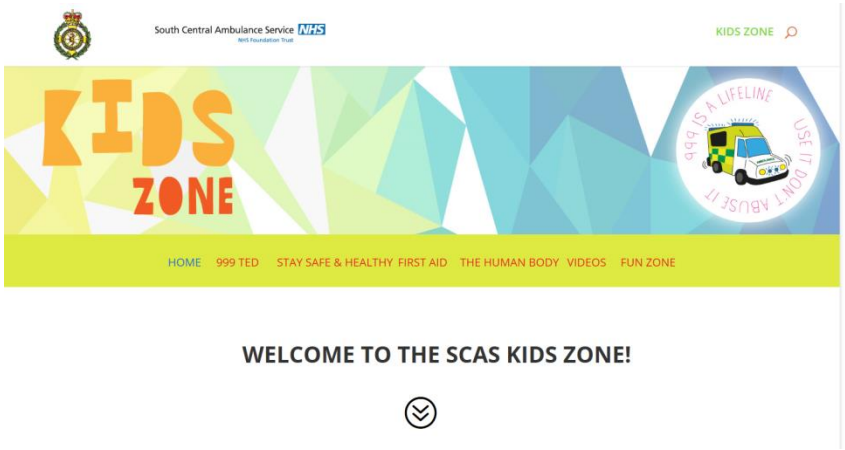
Child
CENTRED POLICING

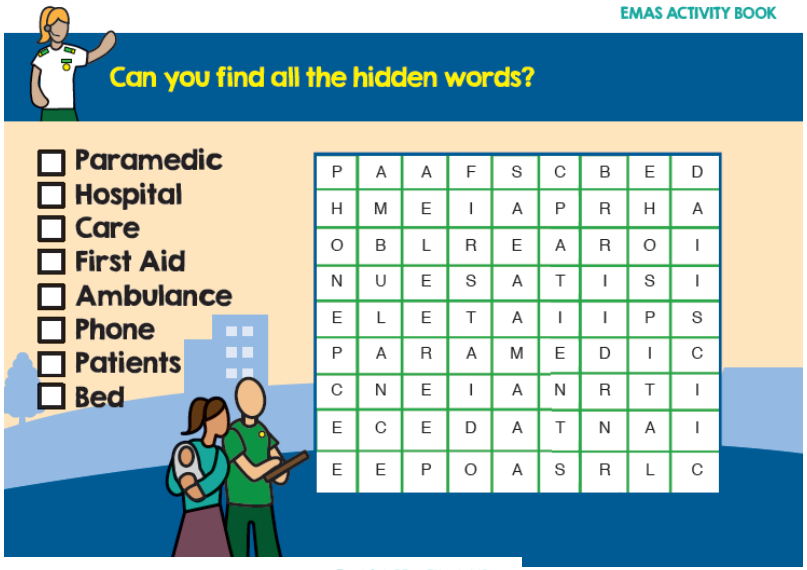
Department
for Education

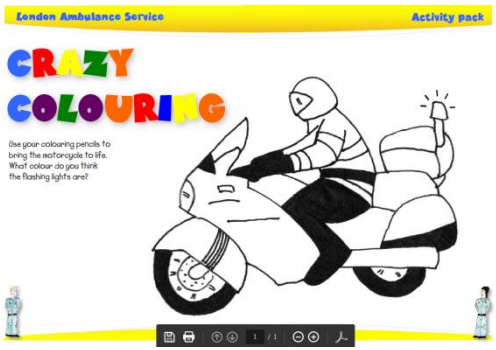
Essex & Herts
Air Ambulance
Your local life-saving charity

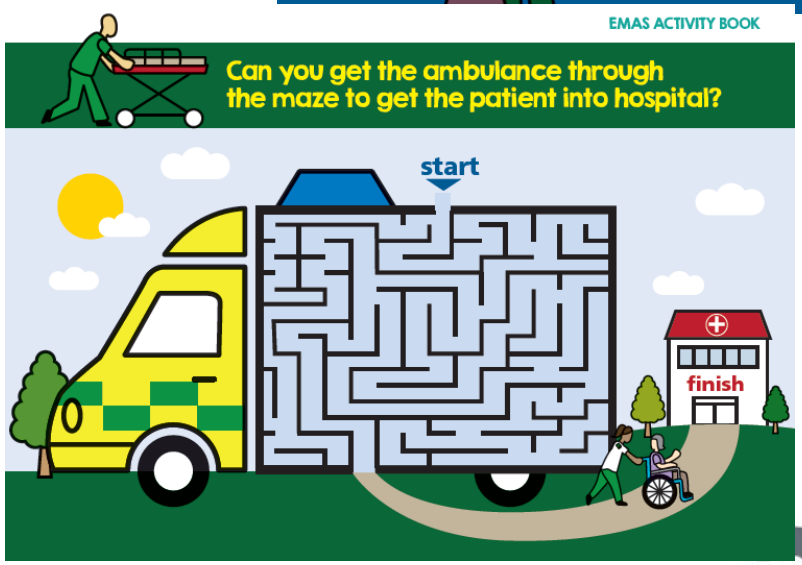
Environment
Agency

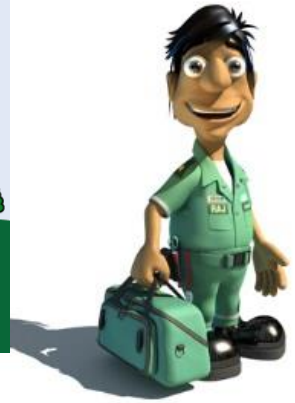
Existing resources…



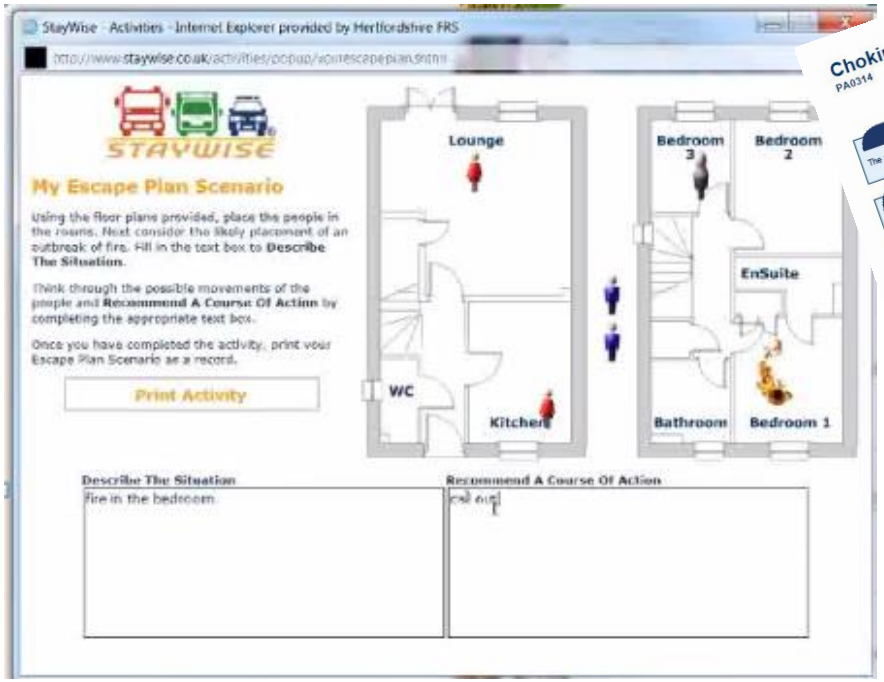


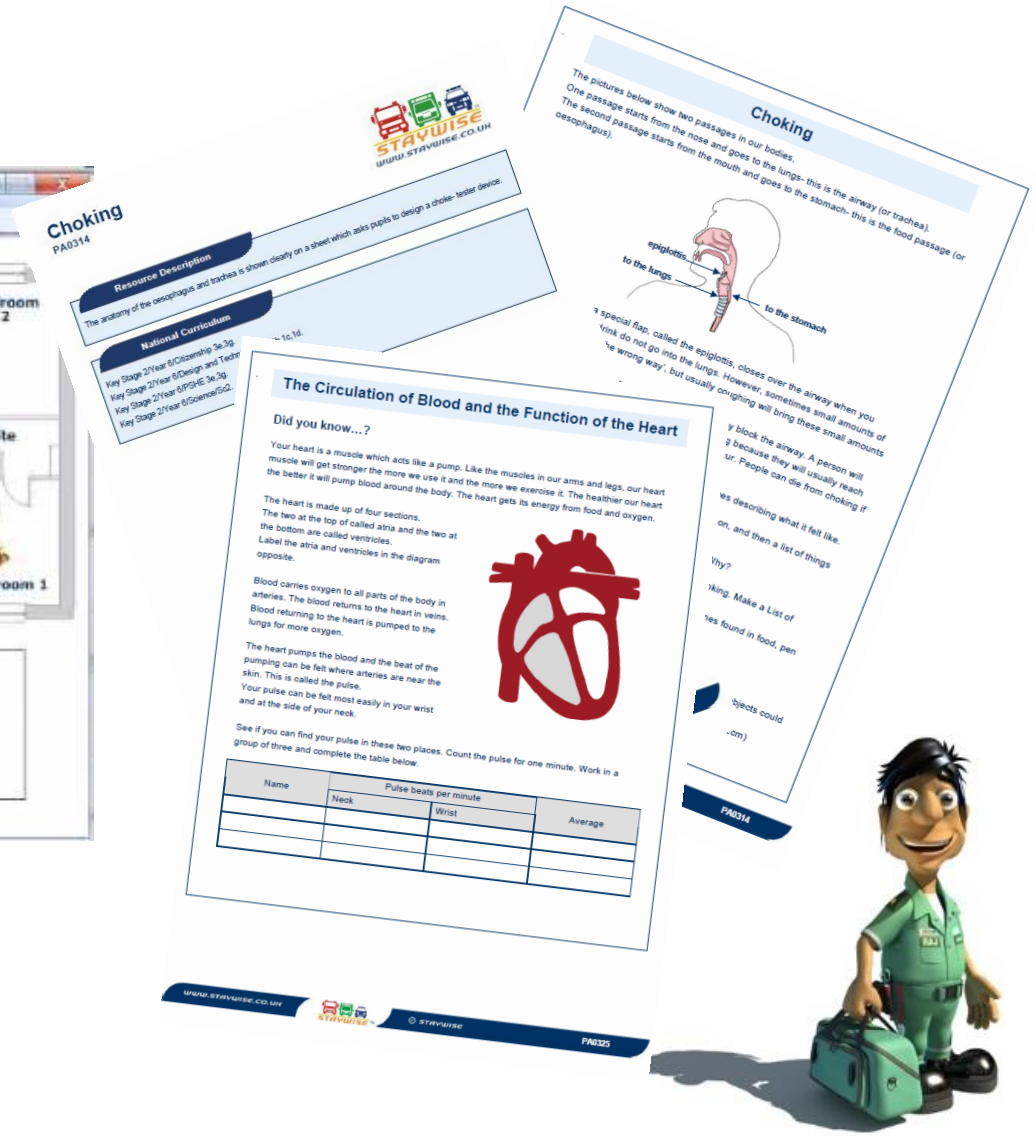






Wider curriculum opportunities





The ask…

- AACE join the partnership
- Ambulance Service support through sharing of expertise and knowledge through existing resources
- Consider StayWise as the repository for future schools education materials
- Nominate a Sector Lead Officer to join the StayWise governance arrangements on behalf of the ambulance service
- Should we create a SPoC network for the Ambulance Services.

Questions…

info@staywise.co.uk

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report Title:	Report from the Chief Executive			
Agenda item	06			
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.

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 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	☒

Report from Chief Executive

1. This report provides the Trust Board with an update regarding key issues, events and activities since its last formal meeting.

Operational Performance

999 Operations

2. July saw a period of sustained hot weather and a number of large scale summer events, increasing demand by around 6% on June 2018. As a result, July performance was challenging, particularly in relation to C2. However, as can be seen from Table 1 below, the Trust met all of its Ambulance Response Programme (ARP) targets in August 2018, when demand levels returned to near contract plan.

Table 1: ARP return v target

	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)
July 18	00:07:26	00:12:12	00:21:15	00:44:35	02:37:20	02:41:08
Aug 18	00:06:43	00:10:58	00:17:05	00:34:15	01:53:51	02:03:53
Year to Date (18/19)	00:07:01	00:11:30	00:18:51	00:38:25	02:11:19	02:19:48

3. In July, the Emergency Operations Centres (EOC), answered 78% of all calls within 5 seconds; in August, call answering improved, with 90% of calls answered within 5 seconds.

111 Operations

4. Our North East London 111/Integrated Urgent Care service (NEL) went live at 11am on 1st August 2018. This was a significant undertaking, requiring the fit out of a new centre on the fifth floor or Maritime House in Barking, along with the provision of a new telephony and IUC enabled Adastra system.

5. We also TUPE transferred a total of 170 people across from 3 private providers of the previous 111 and GP Out of Hours system. In addition, we have had to introduce and embed both GPs and Advanced Practitioners into the skill mix as a requirement of the IUC model. To date, we have a pool of 76 GPs and 43 Advanced Practitioners who are working on a sessional basis or through agencies to fill our Whole Time Equivalents (WTE) requirement of 12 and 17.6 positions respectively. Initially these senior clinicians required a significant amount of induction and support as they became familiar with the new systems and working process.

6. During the initial 4 days of operation the new service encountered a number of 'teething' problems which led to some delays for patients. These issues related to a combination of a new process for staff and some IT smart routing issues. In addition, mobilising the new service during the school summer holidays and at the time of junior doctor change-over resulted in some challenges in covering shifts. Although the queues that arose were managed effectively and no incidents of serious harm/harm have come to our attention, the issues experienced over operational launch are being reviewed – this is being undertaken in collaboration with the Commissioners.

7. There remains a high level of oversight by Commissioners and, in tandem with them, we are ensuring the safe clinical outcomes from the system. The Medical Director has

chaired a teleconference on a weekly basis in order to hear directly from partners in NEL.

8. The South East London 111 Service (SEL) responded to over 90% of calls within the SLA of 60 seconds in both July and August, against a target of 95%. This is slightly below target and was impacted by the need to provide support to the new NEL 111/IUC service in respect of call balancing. Calls to SEL that were abandoned by patients remained low at 0.8% in July and 1.4% in August. As mentioned above, we did experienced some initial problems over the operational launch of NEL, reflected in the performance in Table 2 below. 89% of calls were answered within 60 seconds and, reflective of some of the operational issues, around 4.6% of calls were deemed to be abandoned. Around 9% of calls from both SEL and NEL were transferred to 999, which remains below the national target (the standard for London is around 10-12%).

Location	Month	Calls Offered	SLA calls in 60s (Target 95%)	Abandonment	Calls to Ambulance Service
SEL	July 2018	31,034	91%	0.8%	9%
	August 2018	33,915	90%	1.4%	9%
NEL	August 2018	33,465	89%	4.6%	9%

9. Following an open tender process, South East London CCGs and London Ambulance Service have commenced mobilisation of a new 111/ Integrated Urgent Care Service for South East London (SEL).

10. Given the learning we have now taken from the introduction of NEL 111CAS, it has been agreed with SEL and NEL Commissioners, supported by NHSE, that the enhanced service will be phased in over the winter, with full implementation in place by end of February 2019.

11. A longer lead in time for full implementation will ensure that all parts of the improved integrated service for patients will be ready and, crucially, will have undergone extensive system testing, ensuring stability over the busy winter period. There will be no gap in the 111 service for any patients and we will be introducing new elements to the service over the coming months.

Appointments to the senior operational management structure

12. Recruitment to the new operational management structure continues. One of the five 'Head of Function' roles was filled by an existing post holder unaffected by change and, following a full recruitment and selection process, a Head of Operational Compliance and Standards has also been appointed. There has been a good response to the adverts for the three remaining 'Head of function' roles and the recruitment process for these posts is due to conclude by mid-October.

13. The Head of 999 Service Delivery and the Head of Quality and Continuous Improvement have also just been appointed, and 12 of the 18 Location Group Manager positions have been filled. The remaining six vacant roles have also been subject to internal and external advertising and there has been c50 applications which are currently being shortlisted. The development of the new Clinical Team Manager role is now in its final stages and a further update will be provided in the November Chief Executive's report.

Operational Recruitment

14. We continue to focus on core front line recruitment for Emergency Operations Centre (EOC) call handlers, paramedics and trainee emergency ambulance crew.

15. Significant progress has been made in closing the gap on call handler recruitment, with starters in September and again in November bringing us within touch of full establishment (a gap of 10 positions). This will require continued focus on retention, the major plank of which is the EOC restructure. Consultation on the proposed restructure commenced on 30 August, with seven launch events taking place at Waterloo and Bow, and is due to end on 8 October. We are intending to publish the final structure by 29 October.

16. Paramedic recruitment is making strong progress with a current vacancy rate of only 2.6%. Focus continues on delivering the target of 469 FTE, as forecast turnover (based on our experience and soft intelligence initiatives) will soon drive the vacancy rate up. Work in progress to close our forecast gap includes successful Skype interviews, a recruitment visit to Ireland in October, a recruitment campaign to Australia in February 2019 and a review of capacity for training placements.

17. Our Emergency Ambulance Crew vacancy rate is currently 16.4% as training placements were prioritised for paramedics in August and September. The pipeline of candidates for Trainee Emergency Ambulance Crew candidates (now offered as an apprenticeship) is strong with a recent TEAC advert attracting 352 applications, of which 195 candidates have been invited to assessments in September and October. There are also 82 candidates in the pipeline awaiting allocation to a course. This strong pipeline has been supported by the Trust's recent decision to fund C1 licences. To support meeting a recruitment target of 381, we are reviewing capacity for training placements in quarter 4 to enable us to accommodate an additional intake.

Emergency Preparedness, Resilience and Response

18. NHS England has recently written to the Trust setting out its expectations for the 2018/19 Emergency Preparedness Resilience & Response (EPRR) assurance process. NHS England (London) will use this process to gain assurance that the Trust is prepared to respond to an emergency, and has the necessary procedures in place to ensure resilience and the continued provision of safe standards of patient care during a business continuity event, critical or major incident. The process this year is broadly similar to that followed in previous years. The EPRR core standards have, however, been reviewed and a number of new core standards for ambulance services have been included this year. An additional set of questions on command, control and co-ordination will also be included as the 'deep dive' topic this year.

19. As always, the Trust is required to carry out a RAG-rated self-assessment against the NHS EPRR core standards and this is due for submission by 31 October 2018.

20. Following this an assurance review meeting will be held with NHS England (London) and the National Ambulance Resilience Unit (NARU) who will be reviewing progress against the action plan, developed following their inspection in December 2017. The Trust will then be required to submit the following information to NHS England (London) by 14 January 2019:

    - Results of the Trust's final EPRR RAG scores, as agreed at the review meeting
    - A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored red or amber
    - A declaration of the overall level of compliance achieved (the compliance levels range from Fully Compliant; Substantial; Partial; and Non-Compliant).

21. The results of the overall level of compliance achieved, the results of the assessment and the action/work plan for the forthcoming period will be submitted to a future Trust Board meeting.

22. The winter period historically causes increased pressure within the health system. This is not only caused by additional demand due to seasonal flu, increased falls and respiratory illnesses, but the period also encompasses a number of significant public and social events (such as New Year's Eve) which create large variations in population numbers and alcohol related incidents.

23. The Operations Directorate, together with a number of internal and external stakeholders, has already started to develop the Trust's Winter Plan 2018/19. The aim of the plan is to ensure that people within London continue to receive an effective service while acknowledging the potential additional challenges of the period. It will build on the learning from previous winter periods and will set out to maintain optimum levels of service by deploying, when and where necessary, alternative and innovative solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with requests for emergency ambulances will be at the heart of the plan. The Winter Plan 2018/19 will be shared with Board members in October 2018.

Finance & Performance

24. As reported elsewhere on the agenda, the Trust is £0.07m ahead of plan at the end of July. Income to the end of July was £0.4m lower than planned with activity 0.1% below contracted levels.

25. Pay expenditure is £3.3m below plan due to frontline vacancies partially offset by private ambulance and agency usage. The executive team continues to focus on recruitment and retention to reduce reliance on overtime and PAS to maintain safe and effective rosters.

26. The Trust has delivered £4.2m CIP year to date, of which £2.1m has been delivered non recurrently and work continues across the organisation needs to continue to ensure the full £12.3m is delivered in 2018/19. The Trust is still forecast to deliver its control total deficit of £1.564m in 2018/19, however a number of risks are being closely tracked to ensure mitigating action is taken if required.

IM&T

27. The priority for IM&T has been the delivery of systems for the new North East London 111 Integrated Urgent Care (IUC) contract. Delays in accessing the site at Barking led to compressed timescales for the IT delivery and a huge effort was required to deliver on time. The launch delivered a complete new IT infrastructure including workstations, resilient telephony and a new IUC version of our clinical system, Adastra. The Adastra implementation involved a substantial amount of work with other providers across North East London to deliver seamless direct booking into other services such as Out of Hours GPs, the provision of electronic prescriptions and introduction of rich patient records access. There have been challenges with automating granular reporting of performance from the service which have consumed a considerable level of technical resource to meet emerging requirements across the new IUC services.

28. Work has started to mobilise for the new South East London (SEL) 111/IUC contract. This includes a new telephony system, increased call handling capacity and an extension of the new Adastra IUC platform which needs to integrate with SEL's local providers.

29. We continue to address cyber security risks. New approaches to managing patches in the control room have been developed and implemented. A plan to achieve Cyber Essentials + has been drafted and shared with NHS England and the implementation of

our network perimeter security controls is well advanced. The dedicated cyber team are continuing to address the daily and weekly cyber events that effect all organisations.

Strategy & Communications

30. Following the sign off and publication the Trust's Five Year strategy in May 2018, we are now in the process of refreshing all of our enabling strategies, as well as developing some new ones. Of particular note over the past two months are:

    - We held an energetic volunteering strategy workshop on 5th September attended by about 70 people. Our staff came together with external stakeholders, voluntary organisations and patient representatives to discuss what further opportunities there are and how we can start to take these forward. The development of this new strategy is ongoing and will be discussed at a Board Briefing Session in October.

    - Our Clinical & Clinical Education Strategy was signed off in early 2017 and therefore requires a refresh in the light of our new Trust strategy. On 6th September, we ran a large workshop for clinical and non-clinical staff which was attended by 90 people from across the organisation, the Patients' Forum as well as some colleagues from the wider NHS community. The workshop looked at the challenges we currently face and how we can address them, where we can go further to improve patient outcomes, what our next pioneer services could be and how we will need to reflect any of these changes in the training and education we provide for our staff. The clinical strategy will also be brought to a Trust Board briefing session in October.

31. Significant progress has been made in refreshing our IM&T and Digital strategy, which was discussed at the Trust Board briefing session in August and is scheduled to come to the Trust Board for formal sign off in November.

32. Collaboration between the three emergency services in London continues. Key highlights include:

    Prevention: The heads of prevention meet quarterly and a bid has been submitted (for circa 700k) to fund a tripartite schools prevention team (safety first). The remit is to target schoolchildren at an early age through education and awareness of the impact and effect of crime. It is an interactive prevention workshop around decision making and consequences addressing issues such as knife and gun crime, gang membership, anti-social behaviour, drink, drugs and obesity.

    Mental Health Patients: A meeting has been agreed with MPS and LAS to take forward innovative ideas in relation to the management of mental health patients – the outcome will be reported next month.

    Control services: Work continues on the Control Services collaboration project with Metropolitan Police and London Fire Brigade. The output form this programme in year one is a strategic outline case (SOC) that will give options for integrating service delivery across the 6 active 999 control rooms in London. This is very much a scoping exercise and no decisions have been made.

33. Further to discussions with the Board, I have been in talks with the Chief Executive of the South Central Ambulance Service, with a view to developing a partnership alliance between our organisations; similar to the existing North of England Ambulance Alliance. This will help us to work together to share best practice and look at potential efficiencies through projects like joint procurement of vehicles, equipment and IT systems. We expect to be in a position to make an announcement soon.

Quality Improvement

34. The Pioneering Services Board met for the second time and is now making progress against all 5 projects. During September and October the preparation and resource will be agreed and finalised to start the Mental Health pioneer service pilot in November.

35. The next project to start will be in relation to falls in January 2019, whilst maternity Phase 1 (advice in the clinical hub) is being trialled. A business case is to be put forward to fund 3 additional midwives, subject to negotiating funding from Commissioners. The phased approach within the programme is being used to ensure minimum impact on operational delivery during the winter period. The Advanced Paramedic Practitioner (APP) recruitment has started and is on- going and the End of Life project has also begun in terms of providing education and training to our staff in the management of this patient group.

36. The first Quality Service Improvement Review (QSIR) training cohort of 28 staff will be completed in November. We are currently identifying the next cohort to start their course in November, the course and the content has been rated positively and the numbers of staff wanting to attend the training is beginning to exceed capacity. We are identifying further support through NHS Elect and NHSI and also 3 other members of staff are being trained to become training practitioners. In addition, the half day NHS Elect abridged version of the QSIR training has been included in the Leadership Programme for all Band 7 and above managers and will start within the next few weeks.

37. Our plans to achieve CQC 'Outstanding' are now being monitored via performance reviews and through the Quality Oversight Group and the Quality Assurance Committee. A bi-annual update of the current position on our quality account priorities and the plan will be provided to the Board this month.

38. Of the total of 69 actions (categorised as high/medium priority) within the Health & Safety Action Plan a total of 52 have been completed, 14 are currently underway and 3 actions were overdue. Once outstanding action has since been completed - the provision of a health and safety policy. The two remaining actions will be taken forward in October - a Legionella risk assessment and a PPE equipment Policy – with the latter being submitted to the H&S committee for approval in October.

39. A total of 2497 staff have attended the manual handling training a current compliance rate of 68% mid-year. We are on track to meet target of over 90% at the end of the year and we are also beginning to see a small reduction in manual handling incidents. We will continue to monitor the position and re-consider the current risk rating in October. We have now also been able to introduce a flagging system for bariatric patients within the Patient Specific Protocols so that staff are aware that they may need special support/equipment when attending these calls.

40. To offer assurance around Governance & Risk, further improvements to the Datix system continue, with a significant amount of work planned to align the current NHS111 system with the Trust wide system. Additional training in risk management has been provided to senior managers and the e-learning tool will be completed by the end of September.

41. The 'My Assure' app is being constructed to support peer review visits across the trust in identifying the status of all CQC Key Lines of Enquiry (KLOEs) in each sector and at a corporate level – the data will then be automatically uploaded to Health Assure for monitoring purposes.

42. We continue to meet our timescales for the review of Serious Incidents (SI) and we are currently working across the Quality and Medical Directorates to agree a comprehensive 'Learning Framework'.

43. The CQC are now requesting that all 'unexpected deaths' are reviewed and we have responded to the first request – with all cases they identified having had a review, Root Cause Analysis (RCA), Serious Incident (SI) or coroner's report. The Medical Director will be working closely with Chief Quality Officer to establish a process for ensuring we are reviewing those that currently fall outside our categorisation and to proactively provide the CQC with a report within 72 hours. The CQC are positive about working with us on this process.

44. The complaints process mapping session and the action plan from it are now being taken forward, alongside a review of the letters sent to patients to provide a much more 'patient friendly' response that includes more information of lessons learned and actions taken form the complaint.

Medical Directorate

45. The Clinicians in the Medical Directorate supported the operational delivery of Notting Hill Carnival, providing senior leadership to the LAS and St John Ambulance teams.

46. Three medical bulletins were issued in August, including a revision to airway management training and the increase in the outbreak of suspected Middle East Respiratory Syndrome-Coronavirus (MERS). 111 is also monitoring for Monkey Pox.

47. The Clinical Audit and Research Unit (CARU) contributed to the cardiac arrest chapter of the national Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and an ECG conference is planned for a weekend in September. As a direct result of our heart failure clinical audit, JRCALC have amended their 2018 clinical guidelines.

48. We have started one new research project looking into the sensitivity of the Medical Priority Dispatch System (MPDS) in detecting maternity emergencies, and are currently setting-up another trial with Imperial College looking at continuous glucose monitoring for patients with diabetes.

49. Results from the PARAMEDIC2 randomised controlled trial of adrenaline versus placebo in out-of-hospital cardiac arrest were published in the New England Journal of Medicine reporting that adrenaline use resulted in less than 1% more people leaving hospital alive, but almost doubling the risk of severe brain damage for survivors. We now wait to hear from The Resuscitation Council UK and International Liaison Committee on Resuscitation about how this will be taken forward.

50. We have been shortlisted for a Clinical Audit Support Centre Award, and a member of our team has won an Excellence in Healthcare R&D Services Award.

51. Clinical Education and Standards have supported recruitment activities to attract new recruits. A number of new trainee tutors, associate tutors and driving instructors have been recruited and the induction programs are now underway.

52. The Infection & Control team have achieved good compliance across multiple areas, including Infection Prevention Control (IPC) Training and return of Operational Workplace Reviews (OWRs). Close working relationships have been developed between stations and the IPC Team. The Trust-wide immunisation programme is progressing well and plans are on track for commencing flu vaccination.

53. Within the Community Responders team the Emergency Responder Team Leaders have completed their training and are now able to provide CPI feedback. In addition two volunteer Emergency Responders have successfully completed their blue light driving training.

People and Culture

Statutory Mandatory Training/Performance Appraisals

54. At the end of August, the Trust is 87% compliant with Statutory Mandatory Training. The EOC, which is the subject of the CQC 'Must Do' action, is at 82.4% and a specific trajectory and action plan has been agreed with the EOC management team to bring this in line.

55. Completion of Core Skills Review (CSR) training is as follows:

- CSR 2017.2 - 91.7%
- CSR.2017.3 - 88.4%
- CSR 2018.1 – 92.0%.

56. Appraisals compliance stood at 85.2% at the end of August 2018

Culture, Behaviours and Leadership

57. I launched the Visible Leader programme on 17 September 2018, with the first cohort of newly appointed Location Group Managers (LGM). Scheduling is underway with NHS Elect to support the proposed delivery plan to complete both the Engaging Leader and Visible Leader cycles for Bands 7-8d staff. Cohort 2 of The Visible Leader will pick up those LGMs who are unavailable for Cohort 1 and any newly appointed managers from recent recruitment activity across all areas of the organisation.

58. The Coaching and Mentoring pulse page is now live and provides an overview of what the Coaching and Mentoring offer is within the Trust. This includes a newsletter, FAQs and details of one to one and coaching and mentoring programmes. The Sponsorship Mentoring programme has been advertised via the RIB and Inclusion networks.

59. Reverse Mentoring training began on 13 September Mentors and Mentees have been matched and mentoring will take place soon after with the integration day (evaluation) taking place 28 February 2019.

Learning and Development

60. There has been continued focus on supporting/delivering a number of large scale engagement events - the People and Culture Conference (7 September), the Bullying and Harassment Conference (20 September), the CEO Roadshows (w/c 1 October), Station Admin. Conference (16 October), the Careers Fair (22-23 Oct). These events will give us the opportunity to capture non-clinical training needs and support our upcoming Training Needs Analysis (TNA), which will enable us to better map training provision to organisational strategy and identified skills gaps.

61. The Non-Clinical Training Needs Analysis was launched on the Pulse and RIB on 11 September 2018. The resultant data will feed into the "launch" of new training programmes in the New Year.

Occupational Health Contract Activity

62. Immunisations programmes continue across all stations with additional mantoux/TB clinics are now available and advertised. Focus is starting on working with managers to reduce instances of 'do not attend' (DNA) for appointments which wastes Nurse time, but also can mean that vaccines have to be destroyed.

63. Physio has commenced at Friern Barnet and Homerton following demand related to MSK injuries. This will be rolled out to Edmonton and Croydon stations shortly.

64. Meetings have been held with management teams for top 10 operational areas with highest sickness absence (12mth rolling including both short and long term absence). This has resulted in a more proactive stance around both MSK and counselling provision for staff off sick and early referrals to keep staff at work and expedite appointments where required. We are also progressing discussions to provide an 'occupational specialist' at the point of a colleague calling in sick so that early intervention and advice can be given.

Equality & Diversity

65. Following a successful coproduction workshop on 24 July 2018, attended by over 60 participants, we are now developing a new Workforce Race Equalty Scheme (WRES) action plan for 18/19 which features new targets and is set out across three key themes:

- Recruitment and Development
- Workforce Experience
- Senior Trust Leadership

66. A task and finish group has been established to identify the ways to reduce the number of BME staff entering the formal disciplinary process. This will include advice and guidance and the introduction of a triage process to be piloted in October 2018.

Bullying and Harassment

67. The Bullying and Harassment Advisor commenced her work in June 2018, working 3 days a month to build sustainability into the continued delivery of interventions to reduce conflict at work. The role was to focus on creating a workplace culture at the Trust that promoted Dignity at Work and positive and innovative solutions to addressing allegations of Bullying and Harassment.

68. Links with the newly appointed Freedom To Speak Up Guardian (FTSUG) are being forged with a quarterly meeting between HR, Equalities and Inclusion lead and the FTSUG and Bullying and Harassment Advisor, to share soft intelligence on trends around concerns, grievances and any trends involving allegations of bullying and harassment. The first inaugural meeting was held in August with a second meeting planned in November 2018.

Staff Survey

69. Staff Survey Action Plans continue to be implemented across the Trust. During September the focus will be on the 'we said we did' campaign. Template posters have been developed to be used locally and Champions will be responsible for getting the message out to their areas of all the activities that have been undertaken as a result of the survey. In addition, a Staff Survey newsletter will also be printed and distributed across the organisation. This will include corporate actions which have been completed

eg; appraisal audit, violence, rotational roles as a result of the survey. Examples from across the organisation will also be included.

70. This Year's Staff Survey will be launched on Friday 28th September. This year there will be 4 additional questions added by the organisation to obtain further feedback from staff about incidents of harassment, bullying or abuse from patients, relatives or the public in the last 12 months. The survey will run until Friday 30th November.

71. In order to drive up the response rate, the staff roadshows being held in the first week of October will focus on the staff survey. Champions will be asked to promote the survey in their areas and encourage completion. Areas who have struggled historically with completing the survey will receive some targeted support. Work is taking place with EOC, Fleet and Logistics and HART to identify the best approach to support staff to complete the survey.

Apprenticeships

72. We are implementing the Associate Ambulance Practitioner Apprenticeship Standard programme across our TEAC training. To date we have appointed 84 candidates. Work is continuing with the Clinical Education Team to ensure the Service is OfSTED ready. This is progressing as we follow the first cohort through the Apprentice Standard. Course reviews at the six month stage are being carried out. Apprentices and Course Tutors are being interviewed to gather information on the high and low points of the classroom delivery of the Apprenticeship Standard. This information will inform the overall Self - Assessment Report for the provision. Analysis of the themes that emerge and training and improvement plan will be developed.

73. The Leadership and Management Apprenticeship programme has been launched, to date 28 applications have been received for programmes ranging from Level 3 to level 7. The procurement process for the selection of training partners is in progress.

Strategic Assets and Property

74. 'Listening in action' events with our fleet workshop staff took place in August and September, as results of previous staff surveys had been poor and it was evident there needed to be more direct engagement from the executive leadership team. The Director of Strategic Assets and Property, together with the People and Culture team, visited each of the workshops and understand first-hand what some of the day to day issues were, including in respect of the level of technical training the teams had had, and how they managed quality technical standards when undertaking fleet repairs. A Technical Head of Fleet has been appointed to develop these technical standards, undertake peer reviews of the work undertaken across the workshops and review any skills gaps. Personalised technical training plans will be developed for each member of staff as part of their development plans. Dedicated HR support is to be provided to aid the development of a recruitment plan as the workforce is maturing in age.

75. A workshop is being planned in September with other blue light Property directors to share learning following the consolidation of the Police estate. This will look at learnings in respect of planning guidance and stakeholder engagement, but will also consider how we might make better use of our combined estate to provide improved welfare space for our operational staff.

76. As part of our plans to provide additional capacity at the Trust headquarters, the Executive office space on the 2nd floor is being remodelled to create an open plan working space. As a result, the Executive Team will be based in Union Street from

24 September for a period of up 6 weeks. The next stage of the plan, to consolidate teams such as the Finance team, who operate out of Morley Street, and the People and Culture team who operate out of two separate locations, is being developed.

Fleet Renewal

77. The Trust is planning to deliver 81 Double Crewed Ambulances (DCAs) into operation this financial year. So far; 35 have been delivered; 51 will have been delivered by end of October, and the full 81 by February 2019.

Communications

78. A media event was held on 1 August to launch our partnership with the Licensed Taxi Drivers' Association (LTDA), whereby the Trust trained 30 Licensed Taxi Drivers to undertake basic life support and in the use of Automated External Defibrillators (AEDs). Half of these drivers were registered with the GoodSAM mobile phone app to alert them when they were near a cardiac arrest patient. The other half of the group had an AED fitted in vehicle. The Duchess of Kent attended the launch in a personal capacity as she was interested in the scheme. The launch was covered in the Evening Standard, by BBC Breakfast, BBC London News and ITV News.

79. I held my second monthly live video staff Q&A session on our closed staff Facebook group. As well as being able to ask questions directly during the live broadcast, staff can also watch the recording afterwards on the PULSE and Facebook. Around 50 members of staff asked questions and there were over 2000 views of the broadcast.

80. The media team engaged with the public before, during and after Notting Hill Carnival. Our tweets about the event reached more than 320,000 people and received more than 17,000 engagements (interactions with the tweets). On Facebook, we reached almost 30,000 people, and our Instagram content reached more than 50,000 people.

81. We arranged for a reunion in early September where a child caller and his mother met the clinical hub paramedic who took the child's call when his mother had collapsed. The five year old child met the paramedic, who presented him with a certificate and showed him around our Waterloo headquarters. –The story was covered in local media.

82. Following the series of 'angry' notes left on ambulance vehicles making the headlines across the UK recently, we shared with the Huffington Post some of the 'thank you' presents and gifts our crews and call handlers have received from the public, which resulted in two positive stories.

83. On 24 August 2018, I hosted a visit by of the Secretary of State for Health and Social Care, Matt Hancock MP, when he visited our 111 Call Centre in Croydon, met call handlers and listened to calls. The night before, he also went on a short ride-out with one of our crews during a nightshift at Chelsea and Westminster Hospital.

84. Following a submission to the HSJ Awards, we have been shortlisted for the 'Trust of the Year' award. Planning is now underway for a judge's visit later this month.

85. Together with the Chief Quality Officer, I have been invited to present at the NHSI leadership conference, chaired by Professor Ted Baker, CQC Chief Inspector of Hospitals, to share the LAS success story in exiting Special Measures and going from 'Requires Improvement' to 'Good' within 18 months.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	25 September 2018			
Report title:	Freedom to Speak Up – quarterly update and proposed strategy			
Agenda item:	07			
Report Author(s):	Katy Crichton, Freedom to Speak Up Guardian Philippa Harding, Director of Corporate Governance			
Presented by:	Katy Crichton, Freedom to Speak Up Guardian Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Committee on 12 September 2018 (ref: ExCo/18/149)			
Status:	☒	**Assurance**	☒	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

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. In May 2018, NHS Improvement and the National Guardian's Office issued further guidance on what was expected of NHS Trusts with regard to Freedom to Speak Up.

Recommendation:

The Board is asked to note this report, comment on the issues raised within it and approve the 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 update and proposed strategy

Background

1. 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. In May 2018, NHS Improvement (NHSI) and the National Guardian's Office (NGO) issued further guidance on what was expected of NHS Trusts with regard to Freedom to Speak Up (FTSU). This includes the agreement of a FTSU Strategy.

2. In July 2018 Katy Crichton was appointed as permanent part-time FTSU Guardian; to raise the profile of FTSU across the organisation; continue to deliver a FTSU service across the Trust; and to represent the London Ambulance Service NHS Trust (LAS) at national and regional speaking up events.

3. This report provides information about FTSU activities that have taken place within LAS and nationally since the last Board update in May 2018. It also sets out a draft FTSU Strategy for approval by the Board.

LAS FTSU activities:

4. In line with the standard NHS contract, the LAS is required to report quarterly details of FTSU cases to the NGO. In quarter one 2018-19, one case had been raised. By way of comparison there were eight cases raised during Q1 – Q4 2017-18.

5. The format of the quarterly reporting of LAS cases was set out in the FTSU report to the Board in January 2018 (ref: TB/17/161) and is as follows.

    - **How many new speaking up cases were raised?**

      One

    - **Are there any areas of the service that have featured more than others?**

      Insufficient data

    - **Any actions taken as a result of investigation into these cases?**

      This case was initially handled by Interim FTSU Guardian, Conal Percy and was subsequently passed on to Fergus Cass, the Non-Executive FTSU Lead. It remains ongoing.

    - **Any themes arising?**

      Insufficient data

6. 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. FTSU presents a significant potential for cross-over with the Dignity at Work policy, and to prevent duplication and to ensure safety-netting, FTSU Guardian Katy Crichton

has been working closely with Bullying and Harassment Lead Cathe Gaskell. This will continue in the form of monthly meetings to assess trends and to share data around common themes.

7. Other activities during the quarter:

- The FTSU Guardian has worked from various locations across the service, including in sector and Emergency Operations Centre (EOC) in order to increase visibility.

- The FTSU Guardian was introduced to the Board at an informal meeting in August, to ensure that the Board was fully briefed on NHSI/NGO guidance and had an opportunity to have sight of an outline strategy.

- The current FTSU posters and internal literature are to be revised after input from staff at workshops.

- A description of the role of FTSU Advocate has been drafted (attached as an annex to this report). It is anticipated that 20 advocates from across the service will be recruited, each receiving NGO training with a primary task of promoting and signposting FTSU as a route to raise concerns.

- The FTSU Guardian attended the National Guardian's Office for FTSU training and the meeting of the National Ambulance Network of FTSU Guardians in Yorkshire.

- Completion of FTSU self-review tool by Board members (particularly those with FTSU responsibilities) and the FTSU Guardian and use of this to inform the development of a clear LAS FTSU vision with a realistic strategy, linking speaking up with patient safety, staff experience and continuous improvement.

- Preparations are underway for FTSU month in October. The FTSU Guardian will attend a number of the Chief Executive's Roadshows across the service, join a crew on a vehicle for a rideout, attend two administrator conferences and work with the Guardians from East of England Ambulance Trust and Barnet and Chase Farm Hospital Trust at an event on 18 October 2018.

- Work is also underway to develop an ongoing FTSU communications plan, with detailed launch in October, FTSU month.

Freedom to Speak Up survey results

8. Conal Percy, the interim FTSU Guardian launched an all staff FTSU survey at the end of 2017/18. The findings of the survey, to which approximately 200 members of staff responded can be summarised as follows:

   a) 60% of respondent had not heard of FTSU Guardian (and of those who have, most are not clear about the role)

   b) 70% of respondents said that they had raised a concern, of which:

   - 50% related to patient safety/quality
   - 40% related to staff safety
   - 73% related to senior management, middle management or leadership
   - 59% related to bullying and harassment or culture

   c) Responding to the question "What makes it easy to raise a concern?"

   - 30% responded "nothing"

- 15% referred to good approachable managers
- 5% - cited Datix

- Other themes – unions, colleagues, getting feedback (N.B> 62% would encourage their colleagues to speak up

d) Responding to the question "What makes it difficult to raise concerns?"

- 45% of respondents referred to not being listened to or fear of detriment
- 25% referred to "management"
- 8% referred to lack of confidentiality

9. On her appointment as FTSU Guardian, Katy Crichton undertook a number of workshops with staff from different parts of the service. Key themes from these workshops can be summarised as follows:

a) What makes it easy to raise a concern?

- Colleagues
- Unions
- Self confidence
- Good line managers

b) What makes it difficult to raise a concern?

- Fear of detriment
- Lack of confidentiality (incl. Datix)
- Nothing happens as a result
- Poor quality or no feedback

Proposed Freedom to Speak Up Strategy

10. In addition to the FTSU Survey and FTSU Guardian workshops, other activities undertaken to establish an understanding of the perceptions and operation of FTSU within LAS include:

- FTSU in staff survey
- Benchmarking
- Anecdotal – FTSUG and candidates for the role, Exec lead and NED, also LIA

11. The NHSI/NGO self-assessment tool has also been circulated to all Board and Executive Committee members and has completed by those with key responsibilities for Freedom to Speak Up (high level analysis of outcomes are attached as an annex to this report).

12. Earlier in 2018, the Trust Board approved the 2018-2023 Trust Strategy, which included an articulation of the Trust's new values and behaviours, setting out how the Trust and the individuals should work. The Trust's proposition to its staff through its strategy is that it will create a richer, supportive working environment with greater opportunities for learning and career development, attracting and retaining the best staff in the country from all walks of life. The values and behaviours articulated within the Trust Strategy clearly reflect FTSU:

VALUES The Qualities we embody	**BEHAVIOURS** How we demonstrate our values in actions
Respect	• Caring for our patients & each other with compassion and empathy • Championing equality and diversity • Acting fairly

Professional	• Acting with honesty & integrity • Aspiring to clinical, technical and managerial excellence • Leading by example • Being accountable and outcomes orientated
Innovate	• Thinking creatively • Driving value and sustainable change • Harnessing technology and new ways of working • Taking courageous decisions
Collaborative	• Listening and Learning from each other • Working with partners • Being open & transparent • Building trust

13. The following key conclusions have been reached as a result of this work:

    a) LAS staff feel able to raise concerns about direct patient safety issues and staff safety issues via existing routes (e.g. Datix) and without talking to the FTSU Guardian.
    b) LAS staff feel that there continue to be cultural issues which prevent them from speaking up and cause them concern in themselves (vicious circle).
    c) LAS senior leaders need to do more to demonstrate their engagement with FTSU.

14. These conclusions indicate that the Trust's FTSU strategy should address the following themes:

    1) Engaging senior leaders to ensure that FTSU is given appropriate prominence within the Trust.
    2) Ensuring that all members of staff know and understand about FTSU and the role of the Guardian.
    3) Ensuring that the systems/process/structures are in place to support raising concerns and responding to these and leaning from them.
    4) (With the People and Culture Directorate) facilitating cultural change.

Theme 1 - Engaging senior leaders to ensure that FTSU is given appropriate prominence within the Trust

What we will do:

- We will work with the Trust's senior leaders to ensure that they take an interest in the Trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.

- We will work with the Trust's senior leaders to ensure that they can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.

- We will work with the Trust's senior leaders to help them to use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.

Theme 2 - Ensuring that all members of staff know and understand about FTSU and the role of the Guardian

What we will do:

- We will establish a network of FTSU advocates to support the FTSU Guardian and ensure that dissemination of FTSU information is more widespread.

- We will have a clear communication plan that tailors and ensures appropriate FTSU communications to different groups of staff.

- We will ensure that learning from concerns is clearly communicated.

Theme 3 - Ensuring that the systems/process/structures are in place to support raising concerns and responding to these and leaning from them

What we will do:

- We will review our FTSU Policy to ensure that it remains appropriate and easily accessible.

- We will clarify the systems and processes underpinning the routes through which different claims can be made.

- We will ensure that there are links between all parts of the organisation where concerns may be raised, to avoid casework being duplicated or missed.

Theme 4 - (With the People and Culture Directorate) facilitating cultural change

What we will do:

- We will work with the People and Culture Directorate to ensure that FTSU is reflected in all of the work undertaken to implement the People and Culture Strategy.

- We will ensure that there are ongoing evaluations coherent evaluations of the FTSU environment within LAS.

- Activities undertaken to establish an understanding of the understanding of FTSU within LAS.

15. Once the Board has confirmed that it is content with the proposed FTSU strategy a detailed supporting action plan will be developed, together with metrics for reporting on a regular basis to provide assurance with regard to FTSU activity.

National Guardian's Office (NGO):

16. In July the NGO published updated guidance for the recording and reporting of FTSU cases. This guidance aims to improve consistency in reporting and captures information relating to professional background, detriment to staff and a feedback framework.

17. In July, National Guardian Dr Henrietta Hughes, presented at the AACE CEO meeting and included data with regard to Ambulance Trusts – Yorkshire Ambulance Service had the most FTSU contacts last year with 55, South Western Ambulance Service the least with 1.

18. The NGO asked FTSU Guardians in all NHS Trusts and Foundation Trusts for information on FTSU cases raised with them in the first quarter of 2018/19 (1 April to 30 June 2018). The latest results are set out in the attached table and reveal that 97 per cent of trusts have provided data this quarter.

Q1 data headlines

- 2,348 cases were raised to FTSU Guardians / ambassadors / champions
- 731 of these cases included an element of patient safety / quality of care
- 1,003 included elements of bullying and harassment

- 110 related to incidents where the person speaking up may have suffered some form of detriment
- 264 anonymous cases were received
- 12 trusts did not receive any cases through their FTSU Guardian
- 223 out of 230 NHS trusts sent returns

National Ambulance Network of Guardians (NAN):

19. 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 continuous professional development as well as an opportunity to network and share information.

20. The most recent meeting (July 2018) was held at Yorkshire Ambulance Service. National Guardian, Dr Henrietta Hughes, attended the meeting and emphasised the correlation between successful implementation of FTSU and achieving 'outstanding' in 'well led'

Conclusion

21. The LAS continues to have a high level of engagement with the NGO, the National Ambulance Network and the London Region Network of Guardians.

22. The NGO's recent case reviews and guidance to the Board are beginning to demonstrate the value of the Guardian role.

23. The LAS is making efforts to expand the reach of the Guardian, promote FTSU activities and create and environment in which staff feel safe to raise concerns.

Katy Crichton
Freedom to Speak Up Guardian

Philippa Harding
Director of Corporate Governance

FTSU Advocates

Total of 20 advocates across the Trust

10 in sector (2 per sector)
4 in EOC (2 at each site)
6 in support services.
Additional advocates in Universities.

Recruitment

Via an expression of interest.

Ideally the service will recruit advocates that represent as many job roles across the Trust as possible, ensuring that advocates are diverse and evenly distributed in order to maximise their accessibility to staff

Summary of Role

The primary functions of FTSU Advocates are to promote FTSU within the London Ambulance Service and encourage their colleagues to speak up. Advocates will signpost staff who wish to raise a concern to the FTSU Guardian, and will not have responsibility for involvement with individual cases. They will receive NGO FTSU training and be required to attend quarterly FTSU advocate meetings where possible.

Job Description

The Advocate Role

- To provide confidential advice and support to all LAS colleagues who want to speak up about a concern.
- To be approachable, to listen actively and well, to advise and to sign post people to the options available to them.
- To encourage and promote the concept of speaking up so that it continues to develop as part of our everyday life in the London Ambulance Service.

Accountabilities

- Act as a role model, demonstrating LAS values in speaking up confidently and well in their own job role. Taking every opportunity to promote a culture in the LAS where people raise and respond to concerns with kindness and compassion.
- Listen to colleagues who have a concern, helping them to think about and reflect on the situation. Support colleagues (as individuals or as a group) to raise their concern in the best way and in the most appropriate place.
- Helping colleagues to explore the options available and signposting them appropriately.
- Deal with all contacts with the utmost confidentiality except in cases where there is an unacceptable risk to a member of staff
- To raise awareness of the Freedom to Speak Up and the Dignity at Work policies. As part of this seeking opportunities to speak to colleagues at team and directorate meetings, delivering presentations and raising and maintaining awareness.
- To act as ‘buddy’ to another Freedom to Speak Up Advocate for the purposes of mutual support and the seeking of solutions to difficult situations

- To attend training in relation to the Freedom to Speak Up in conjunction with the National Guardian's Office and to participate in the regular sharing of experience and good practice in order to develop skills and experience relevant to the role
- To identify and refer serious allegations to the Freedom to Speak Up Guardian.
- Refer people to another Freedom to Speak Up Advocate where you feel there may be a conflict of interest for you to advise that individual

Specific skills and experience

- A clear commitment to a compassionate and positive culture at LAS and to equality in the workplace.
- No particular seniority, status, educational or professional qualifications are required.
- An understanding of the barriers to speaking up that exist in organisations and how these can be challenged and overcome.
- The ability to encourage and enable individuals to speak openly and confidently.
- Good communicator with well-developed interpersonal and listening skills.
- An approachable style and an ability to deal compassionately with individuals and groups.
- Ability to treat all disclosures and conversations in the strictest confidence by generating an atmosphere of trust.
- The ability to work autonomously and professionally
- An advocate and role model for LAS Values and Behaviours

Annex – analysis of self review tool responses

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
	Quantitative responses (marks out of 5)	Qualitative responses – key themes
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.	5 ? 2 4 5 4 4 5 4 3 4 4 Average: 4	• Reports to the Board • Yes, although some directors may not be as well informed as others
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.	3 ? 2 2 5 2 2 4 ? 2 2 3 Average: 2.7	• Trust values resonate with FTSU • True for some but not all; Communication about the value of FTSU and about learnings is not yet established.
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.	4 ? 3 2 5 3 3 4 ? 3 2 3 Average: 3.2	• Leadership & Development Programme in place
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	3 ? 2 1 5 2 3 3 4 2 1 ? Average: 2.6	• Strategy not yet launched

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
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.	1 ? 2 3 4 2 3 4 3 3 1 ? Average: 2.6	• Strategy not yet launched
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	? ? 2 5 3 5 3 3 3 5 5 2 Average: 3.6	• Policy in place
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	2 ? 1 3 3 4 3 5 4 5 5 2 Average: 3.36	• Strategy not yet launched
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	1 ? 1 4 3 1 2 4 2 3 1 2 Average: 2.18	• Strategy not yet launched
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.	3 ? 2 1 4 3 3 2 3 3 2 3 Average: 2.63	• Probably not the case
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	3 ? 2 5 5 3 4 3 3 3 4 4 Average: 3.54	• QAC & QOG do this formally • There is a culture of improvement and a commitment to safety, as evidenced by our CQC rating and the plan to get to "outstanding" • Review of behaviours at end of Board meeting, focus on patient safety in all meetings.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
		• Clear and comprehensive reporting in relation to patient safety, publications, learning events, quality strategy and QI training and improvement being rolled out across the organisation.
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	3 ? 2 3 5 4 4 3 4 2 3 4 Average: 3.36	• Visibility and accessibility has been an issue but this is improving
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	1 ? 2 2 5 4 4 2 4 2 2 3 Average: 2.81	• This is modelled by some senior leaders
Senior leaders model speaking up by acknowledging mistakes and making improvements.	2 ? 2 4 5 3 4 3 3 3 4 3 Average: 3.27	
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	3 ? 2 3 3 2 2 4 2 3 3 3 Average: 2.72	• There has been publicity around FTSU, but this needs to occur over a sustained period of time in multiple formats • While staff probably know how to speak up there still seems to be a reluctance to do so, as evidenced by our recent internal survey.
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.	5 ? 5 5 5 5 5 5 5 5 5 4 Average: 4.90	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	? ? 5 5 5 5 4 5 5 5 5 4 Average:4.8	
Other senior leaders support the FTSU Guardian as required.	? ? 3 3 5 5 4 4 5 4 4 4 Average: 4.1	
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.	2 ? 3 4 4 ? 4 5 3 4 4 3 Average: 3.6	
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	? ? 3 5 5 5 5 5 5 5 5 4 Average: 4.7	
Leaders receive assurance in a variety of forms		
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	? ? 2 2 3 2 1 2 2 2 2 3 Average: 2.1	• Not yet. While there probably is general awareness of FTSU, there is scepticism and some reluctance to engage. •
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	? ? 3 1 3 3 3 3 3 3 4 3 Average: 2.9	• Links with WRES lead and access to CEO and Chair.
Speak up issues that raise immediate patient safety concerns are quickly escalated	? ? 3 5 4 4 4 4 4 5 4 4 Average: 4.1	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	? ? 2 4 4 ? 4 5 3 ? ? 3 Average: 3.57	
Lessons learnt are shared widely both within relevant service areas and across the trust	? ? 2 4 4 ? 4 5 3 ? ? 3 Average: 3.57	• Sharing of lessons is dependent on the nature of the case and the willingness of the participants to have their cases shared publicly.
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	? ? 2 5 4 1 2 4 ? 2 4 4 Average: 3.11	• KPMG carried out an audit in 2017
FTSU policies and procedures are reviewed and improved using feedback from workers	? ? 3 4 3 1 3 4 3 3 1 ? Average: 2.77	• The FTSU policy needs to be refreshed to reflect current best practice from the NGO • Most recently via survey, workshops and NGO guidance to improve policy and form strategy. Needs to be ongoing
The board receives a report, at least every six months, from the FTSU Guardian.	? ? 4 5 4 2 4 5 5 5 5 4 Average: 4.3	• Quarterly reports
Leaders engage with all relevant stakeholders		
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	? ? 2 3 2 ? 4 3 4 3 1 ? Average: 2.75	• Over 250 staff were involved in shaping strategy and policy

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	4 ? 2 2 3 ? 3 5 ? 3 3 4 Average: 3.22	
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	3 ? 2 2 5 ? 2 1 5 4 3 4 Average: 3.1	
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.	? ? 2 1 2 ? 3 2 ? ? 4 3 Average: 2.43	
Reviews and audits are shared externally to support improvement elsewhere.	? ? 2 3 3 ? 2 2 4 2 4 3 Average: 2.78	• The Guardian has assisted SECAMB with developing their FTSU arrangements.
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	? ? 3 3 4 ? 3 4 ? 2 ? 3 Average: 3.14	
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	? ? 2 2 4 ? 2 4 4 4 4 ? Average: 3.25	• There has been support from NHSI. The interim Guardian uses surgeries provided by the National Guardians Office and attends both regional and national network meetings.
Senior leaders request external improvement support when required.	? ? 2 4 4 4 3 5 4 3 2 ? Average: 3.44	• NHSI support was provided until recently via Improvement Director.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Leaders are focussed 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.	? ? 3 3 5 3 3 3 3 2 1 2 Average: 2.8	• Transparency of learning opportunities requires improvement
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	? ? 2 3 4 ? 3 1 4 2 3 3 Average: 2.78	
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	? ? 3 5 4 3 3 5 3 4 4 4 Average: 3.8	
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	? ? 2 2 5 3 2 3 ? 2 2 2 Average: 2.56	
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.	? ? 1 4 5 1 2 5 4 4 1 2 Average: 2.9	
The FTSU policy and process is 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.	? ? 1 5 5 ? 2 5 4 2 3 3 Average: 3.33	
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome	? ? 1 3 5 ? 2 2 4 2 3 3 Average: 2.78	• Probably not, except through internal audit. The number of cases is small and is quality assured via Executive Lead

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
• 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.	? ? 2 1 3 ? 2 2 4 0 1 2 Average: 1.89	
Individual Responsibilities		
Chief Executive and Chair		
The chief executive is responsible for appointing the FTSU Guardian.	? ? 1 5 5 4 4 5 5 ? 5 ? Average: 4.25	• CEO was on FTSU interview panel
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	? ? 2 5 5 3 3 5 5 ? 5 ? Average: 4.13	• CEO providing support to Guardian when necessary
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	? ? 2 5 5 ? 4 5 5 ? 5 ? Average: 4.43	
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	? ? 2 5 5 ? 4 5 4 ? 5 ? Average: 4.29	
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	? ? 2 5 5 ? 3 5 3 ? 5 ? Average: 4	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Executive lead for FTSU		
Ensuring they are aware of latest guidance from National Guardian's Office.	? ? 4 5 5 5 4 5 5 ? 5 ? Average: 4.75	
Overseeing the creation of the FTSU vision and strategy.	? ? 3 5 5 5 3 5 5 ? 5 ? Average: 4.5	
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.	? ? 4 5 5 5 3 5 5 ? 5 ? Average: 4.6	
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	? ? 4 5 5 ? 3 5 4 ? 5 ? Average: 4.43	
Ensuring that a sample of speaking up cases have been quality assured.	? ? 2 5 3 1 2 2 4 ? 5 ? Average: 3	
Conducting an annual review of the strategy, policy and process.	? ? 2 5 4 ? 2 5 4 ? 5 ? Average: 3.86	
Operationalising the learning derived from speaking up issues.	? ? 3 3 5 ? 3 4 3 ? 5 ? Average: 3.71	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	? ? 3 5 5 4 3 5 3 ? 5 ? Average: 4.13	• Working in partnership with B&H lead and P&C directorate to minimise potential detriment

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	? ? 2 5 5 ? 3 5 ? ? 5 ? Average: 4.17	
Non-executive lead for FTSU		
Ensuring they are aware of latest guidance from National Guardian's Office.	? ? 3 5 5 5 5 5 5 ? 5 ? Average: 4.75	
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	? ? 3 4 5 5 4 5 ? ? 5 ? Average: 4.43	
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.	? ? 3 4 5 4 3 5 ? ? 5 ? Average: 4.14	
Role-modelling high standards of conduct around FTSU.	? ? 3 5 5 5 4 5 5 ? 5 ? Average: 4.63	
Acting as an alternative source of advice and support for the FTSU Guardian.	? ? 4 5 5 5 4 5 5 ? 5 ? Average: 4.75	
Overseeing speaking up concerns regarding board members.	? ? 3 4 5 4 4 5 ? ? 5 ? Average: 4.3	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	
Human resource and organisational development directors		
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.	? ? 2 4 4 4 4 5 4 3 5 ? Average: 3.9	
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	? ? 2 3 4 3 3 4 ? 3 1 ? Average: 2.9	
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	? ? 2 3 4 2 3 3 3 3 1 ? Average: 2.7	
Medical director and director of nursing		
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	? ? 2 2 4 ? 3 5 ? ? 5 4 Average: 3.6	
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	? ? 3 4 4 ? 4 5 ? ? 5 4 Average: 4.2	• Action always taken when issue arise either via regular monitoring of Datix, feedback and SIG weekly meeting. We also have a learning form experience group that feeds into the Quality Oversight Group
Ensuring learning is operationalised within the teams and departments that they oversee.	? ? 4 3 4 ? 3 5 ? ? 5 4 Average: 4	• All learning is shared on website and publications and throughout the trust via governance structures and reporting framework, specific events

London Ambulance Service NHS Trust

Assurance report:	**Audit Committee**	**Date:**	**03/09/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**25/09/2018**
Presented by:	**John Jones, Non-Executive Director, Audit Committee Chair**	Prepared by:	**John Jones, Non-Executive Director, Audit Committee Chair**

Matters for escalation:	The Charitable Funds Annual Accounts and Annual Report were considered and approved by the Committee. They are recommended for adoption by the Trust Board. The Annual Audit Letter for the year ended 31 March 2018 was received from the external auditors Ernst and Young. This is attached at Appendix 1.
Other matters considered:	The latest Board Assurance Framework (BAF), which continues to show five red risks, was reviewed. These are also subject to monitoring by respective Board Assurance Committees .The Committee heard that the Executive Committee meeting on 12th September will be reviewing risks to achieving the Trust's strategy, business plan and CQC action plan as well as horizon scanning. The outcome will be presented to the Trust Board meeting today. General Data Protection Regulation (GDPR) - Considerable progress has been achieved towards compliance with the new Data Protection legislation. The Committee was keen to receive detailed assurance with regard to the impact of implementing the measures required to comply with GDPR. This was requested for the next meeting of the Committee. It was also noted that additional assurance would be provided by an internal audit review in October 2018. Use of single tender waivers to July 2018 were reviewed. A report on the Losses and Special Payments to July 2018 was reviewed by the Committee. Expenditure on vehicle accidents continues at a high level and is subject to further investigation and action to seek reductions.

	An update on the internal Audit plan and counter fraud activity to date was presented by Grant Thornton and reviewed by the Committee. One internal audit study had been completed – a review of the Cost Improvement process for 2018/19.The Counter Fraud Team have been active in starting a programme of visits to each of the five sectors. This new approach, involving meetings with managers and staff, is seeking to assess the fraud risks faced by each sector/station. The Committee's forward plan was reviewed.
Key decisions made / actions identified:	Approval of the Charitable Funds Annual Accounts and Annual Report. The Committee has asked the Executive Team to pay particular attention to two areas : -action to reduce the cost of vehicle accidents and - a reduction in the number of single tender waivers.
Risks:	No new risks were highlighted but the Committee reviewed two areas (in addition to GDPR) which it had highlighted as high risk: Cyber Security – an update report on action being taken was received. Considerable activity has been and continues to mitigate this risk. However, assurance is required to confirm we are doing all we can and achievement of NHS standards is one test as well as the possible target of meeting IOS standards. This will be taken forward by the Logistics and Infrastructure Committee at its next meeting. Business Continuity – a presentation from Sarah Rodenhurst-Banks informed the Committee on the current position of the LAS on its business continuity plan. Again it is clear we have moved a long way since 2016 in establishing Business Continuity and Disaster Recovery plans. Assurance will be sought in the review of Core Standard 9 (EPRR) in October 2018 as well as a review by our Internal Audit service.
Assurance:	The Charitable Funds accounts are not required to have a full audit but are subject to an independent examiners statement. This was performed by Ernst and Young and no matters were raised to question the accuracy of the statements.

The Annual Audit Letter for 2017/18 provides positive assurance over the financial statements for 2017/18 and arrangements of value for money.

The assurance rating for the review of the Cost Improvement process for 2018/19 was Significant Assurance with minor improvements required. Four recommendations were made, all being accepted.

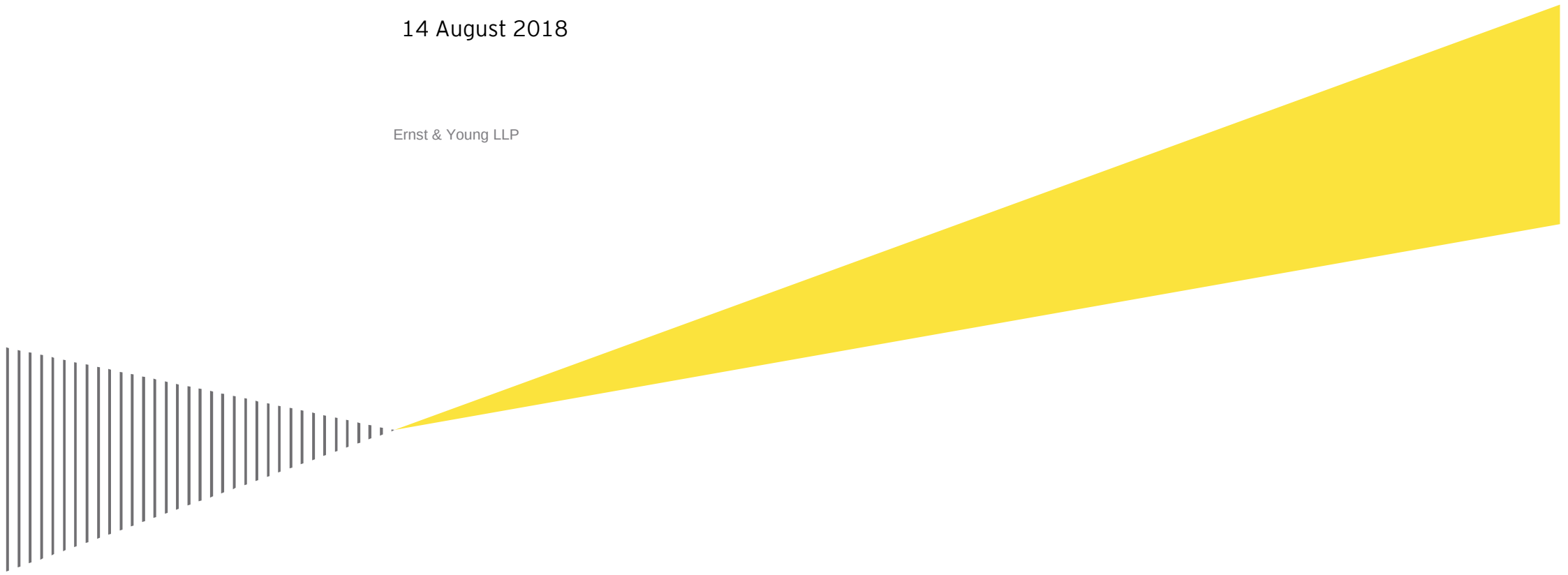
Both representatives of the internal (Grant Thornton) and external (Ernst and Young) auditors were present at the meeting.

London Ambulance Service NHS Trust

Annual Audit Letter for the year ended 31 March 2018

14 August 2018

Ernst & Young LLP



Building a better working world

Contents

Executive Summary

Executive Summary

We are required to issue an annual audit letter to London Ambulance Service NHS Trust (the Trust) following completion of our audit procedures for the year ended 31 March 2018.

Below are the results and conclusions on the significant areas of the audit process.

Area of Work	Conclusion
Opinion on the Trust's:	
► Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended
► Parts of the remuneration and staff report to be audited	We had no matters to report
► Consistency of the Annual Report and other information published with the financial statements	Financial information in the Annual report and published with the financial statements was consistent with the Annual Accounts
Reports by exception:	
► Consistency of Governance Statement	The Governance Statement was consistent with our understanding of the Trust
► Referrals to the Secretary of State	We had no matters to report
► Public interest report	We had no matters to report in the public interest
► Value for money conclusion	We had no matters to report
Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to your audited financial statements
Reporting to the National Audit Office (NAO) in line with group instructions	We had no matters to report

As a result of the above we have also:

Area of Work	Conclusion
Issued a report to those charged with governance of the Trust communicating significant findings resulting from our audit.	Our Audit results report was issued on 23 May 2018 and presented to the Audit Committee with a verbal update on 24 May 2018
Issued a certificate that we have completed the audit in accordance with the requirements of the Local Audit and Accountability Act 2014 and the National Audit Office's 2015 Code of Audit Practice.	Our certificate was issued on 25 May 2018

We would like to take this opportunity to thank the NHS Trust staff for their assistance during the course of our work.

Janet Dawson

Partner
For and on behalf of Ernst & Young LLP


Purpose

Purpose

The Purpose of this Letter

The purpose of this annual audit letter is to communicate to Members and external stakeholders, including members of the public, the key issues arising from our work, which we consider should be brought to the attention of the Trust.

We have already reported the detailed findings from our audit work in our 2017/18 audit results report to the 24 May 2018 Audit Committee, representing those charged with governance. We do not repeat those detailed findings in this letter. The matters reported here are the most significant for the Trust.


Responsibilities

Responsibilities

Responsibilities of the Appointed Auditor

Our 2017/18 audit work has been undertaken in accordance with the Audit Plan that we issued on 12 February 2018 and is conducted in accordance with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK and Ireland), and other guidance issued by the National Audit Office.

As auditors we are responsible for:

Expressing an opinion:

- On the 2017/18 financial statements;
- On the parts of the remuneration and staff report to be audited;
- On the consistency of other information published with the financial statements, including the annual report; and
- On whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the annual governance statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health if we have concerns about the legality of transactions of decisions taken by the Trust;
- Any significant matters that are in the public interest;
- Forming a conclusion on the arrangements the Trust has in place to secure economy, efficiency and effectiveness in its use of resources; and
- Reporting on an exception basis any significant issues or outstanding matters arising from our work which are relevant to the NAO as group auditor.

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its statement of accounts, annual report and annual governance statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Financial Statement Audit

Financial Statement Audit

Key Issues

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

We audited the Trust's Statement of Accounts in line with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK and Ireland), and other guidance issued by the National Audit Office and issued an unqualified audit report on 25 May 2018.

Our detailed findings were reported to the 24 May 2018 Audit Committee.

The key issues identified as part of our audit were as follows:

Significant Risk	Conclusion
Misstatements due to fraud or error As identified in International Standards of Auditing, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We identify and respond to this fraud risk on every audit engagement. At the planning stage we assessed journal amendments, accounting estimates and unusual transactions as the area's most open to manipulation. We also considered the completeness of liabilities and valuation of some estimated liabilities for any management bias.	▸ We have not identified any material weaknesses in controls or evidence of material management override. ▸ We have not identified any instances of inappropriate judgements being applied. ▸ We did not identify any other transactions during our audit which appeared unusual or outside the Trust's normal course of business.
Risk of fraud in revenue and expenditure recognition Under International Standards of Auditing there is a presumed risk that revenue may be misstated due to improper recognition of revenue. In this public sector this requirement is modified by Practice Note 10, issued by the Financial Reporting Trust, which states that auditors	▸ We have not identified any material weaknesses in the recognition of revenue or expenditure. ▸ We have not identified any instances of inappropriate judgements or estimates being applied.

should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition.

We focussed on:

- transactions where judgement was applied to calculate an accrual
- transactions occurring in the last month of 2017/18 and the first month of 2018/19 to confirm management's posting period was correct
- mismatches identified in the agreement of balances exercise.

Other Key Findings	Conclusion
Valuation of land and buildings Land and buildings is the most significant balance in the Trust's balance sheet. The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements The fair value of Property, Plant and Equipment (PPE) represent significant balances in the Trust's accounts and are subject to valuation changes, impairment reviews and depreciation charges. Management is required to make material judgemental inputs and apply estimation techniques to calculate the year-end balances recorded in the statement of financial position. This risk relates to assets that are revalued, being land, buildings excluding dwellings, and investment properties. Assets under construction, plant and equipment, transport equipment, information technology and furniture and fittings are held at cost. The Trust engages an external expert valuer to value land, buildings and the investment property. The expert obtains an understanding of the Trust's assets and agrees an appropriate valuation technique. They then apply a number of assumptions and calculations to determine an asset value. Annually, assets are assessed to identify	▸ In line with the Trust's accounting policy to carry out a full revaluation every five years and desktop revaluations in the intervening years, a desktop revaluation was carried out in 2017/18. This involves updating the value of specialised assets in line with current indices provided by the Building Cost Information Service (BCIS), and non specialised assets with reference to market movements during the period. ▸ Our audit work focussed on sample testing assumptions used by the valuer to available market information, checking that all assets were included in the revaluation, and carrying our analytical procedures to compare valuation movement to our own market indices. We also considered if there were any factors that would require a full revaluation. ▸ We have no matters report.

whether there is any indication of impairment (i.e. a reduction in their carrying value). As the Trust's asset base is significant, and the outputs from the valuer are subjective, there is a risk that the fair value of PPE may be under or overstated, or the associated accounting entries incorrectly posted. International Standards of Auditing require us to undertake procedures on the use of management experts and the assumptions underlying fair value estimates.	
Management's assessment of going concern While public sector bodies, including NHS trusts, are generally considered to be a going concern for the purposes of preparing financial statements, the Trust's management need to consider the requirements of the Department of Health and Social Care Group's Accounting Manual (GAM) in determining whether additional disclosures are required. There is a risk that management's assessment of going concern and the required disclosures within the annual report are not in accordance with the GAM.	Our approach considered: ▸ Management's assessment of going concern, and whether any required disclosures in accordance with the GAM are included within the annual report; ▸ The adequacy of any disclosures, and the impact on our opinion, should these be inadequate; and ▸ 2018/19 approved budget and cash flow monitoring and forecasting. We have no matters to report.

Our application of materiality

When establishing our overall audit strategy, we determined a magnitude of uncorrected misstatements that we judged would be material for the financial statements as a whole.

Item	Thresholds applied
Planning materiality	We determined planning materiality to be £3.551 million (2016/17 – £3.4 million), which is 1% of revenue expenditure reported in the accounts. We consider revenue expenditure to be one of the principal considerations for stakeholders in assessing the financial performance of the Trust.
Reporting threshold	We agreed with the Audit Committee Members that we would report to the Committee all audit differences in excess of £0.177 million (2016/17: £0.160 million)

We also identified the following areas where misstatement at a level lower than our overall materiality level might influence the reader. For these areas we developed an audit strategy specific to these areas. The areas identified and audit strategy applied include:

- Remuneration disclosures including any severance payments, exit packages and termination benefits.
- Related party transactions. Strategy applied: we tested the completeness of related party disclosures and the accuracy of all disclosures by checking back to supporting evidence.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations.

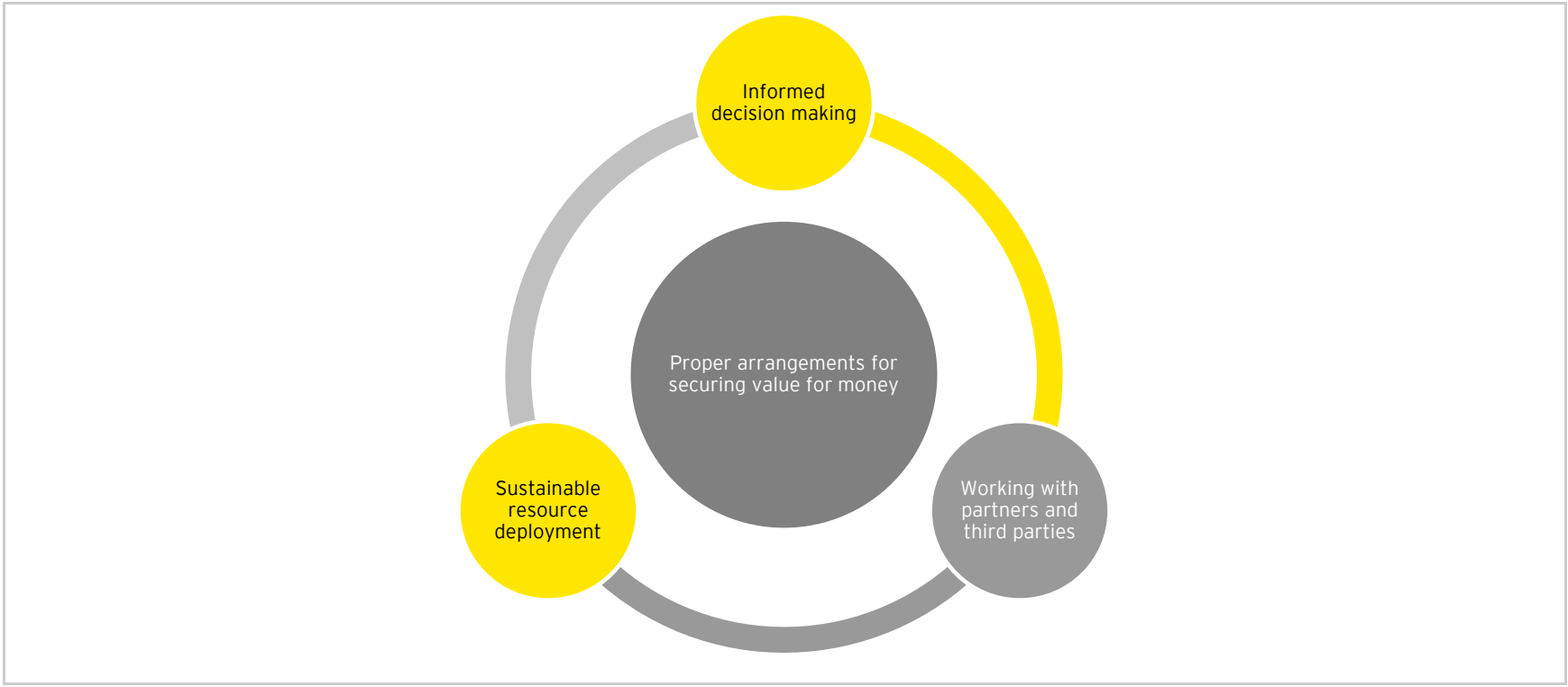

Value for Money

Value for Money

We are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is known as our value for money conclusion.

Proper arrangements are defined by statutory guidance issued by the National Audit Office. They comprise your arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.



In our Audit Planning Report we identified one significant risk in relation to these arrangements. The table below presents the findings of our work in response to the risk area and any other significant weaknesses or issues to bring to your attention.

Significant Risk	Conclusion
The Trust's environment continues to evolve with the implementation of the Ambulance Response Programme (ARP). At month seven the Trust reported pressure on the budgeted deficit of £2.4 million if CIP and CQUIN risks materialise and are not mitigated further. There remains a risk that the Trust will not achieve its budget for the year which will impact on future financial plans.	Our consideration focused on a high level review of the Trust's: • performance against the 2017/18 budget, including the delivery of planned CIPS; • 2018/19 budget setting process and the medium term financial plan; • identification and reliance on the delivery of savings plans to achieve the 2018/19 budget; and • key assumptions used in financial planning. We had no matters to report about your arrangements to secure economy, efficiency and effectiveness in your use of resources

Other Reporting Issues

Other Reporting Issues

Department of Health Group Instructions

We are only required to report to the NAO on an exception basis if there were significant issues or outstanding matters arising from our work. There were no such issues.

Annual Governance Statement

We are required to consider the completeness of disclosures in the Trust's annual governance statement, identify any inconsistencies with the other information of which we are aware from our work, and consider whether it complies with relevant guidance.

We completed this work and did not identify any areas of concern.

Report in the Public Interest

We have a duty under the Local Audit and Accountability Act 2014 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public.

We did not identify any issues which required us to issue a report in the public interest.

Control Themes and Observations

It is the responsibility of the Trust to develop and implement systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. Our responsibility as your auditor is to consider whether the Trust has put adequate arrangements in place to satisfy itself that the systems of internal financial control are both adequate and effective in practice.

As part of our audit of the financial statements, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. As we have adopted a fully substantive approach, we have therefore not tested the operation of controls.

Although our audit was not designed to express an opinion on the effectiveness of internal control we are required to communicate to you significant deficiencies in internal control.

We have not identified any other significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware.

Appendix A

Audit Fees

Appendix A Audit Fees

Our fee for 2017/18 is in line with the audit fee agreed and reported in our Audit Plan and Annual Results Report.

As part of our reporting on our independence, we set out below a summary of the fees you have paid us in the year ended 31 March 2018.

We confirm that we have not undertaken non-audit work.

Description	Final Fee 2016/17 £	Planned Fee 2017/18 £	Final Fee 2017/18 £
Statutory Audit Fee	56,996	69,690	69,690
London Ambulance Service Charitable Fund	1,688	1,870	1,870
Total non-audit services	0	0	0

The planned audit fee was based on the following assumptions:

- Officers meeting the agreed timetable of deliverables;
- Our accounts opinion and value for money conclusion being unqualified;
- Appropriate quality of documentation is provided by the Trust; and
- The Trust has an effective control environment.

EY | Assurance | Tax | Transactions | Advisory

Ernst & Young LLP

ED None

The UK firm Ernst & Young LLP is a limited liability partnership registered in England and Wales with registered number OC300001 and is a member firm of Ernst & Young Global Limited.

Ernst & Young LLP, 1 More London Place, London, SE1 2AF.

ey.com

London Ambulance Service NHS Trust

Assurance report:	**People and Culture Committee**	**Date:**	**06/09/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**25/09/2018**
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 Committee noted the challenge to meet the agency cap at the end of the financial year. The Committee was not fully assured that the Trust would meet the cap. The Committee will continue to monitor agency spend at future meetings and noted that future agency plans would provide additional assurance by including trajectories showing how each directorate would reduce their agency expenditure to ensure that the Trust was within the agency cap by the end of the financial year.

Other matters considered:

The Committee was informed that there was major exercise being undertaken to ensure the integrity of data in the Trust's Electronic Staff Record (ESR) and that this would be completed by 30 September 2018.

The Committee was advised that the Chief Executive had instructed Executive Committee (ExCo) members not to authorise any additional agency spend until assurance had been provided that action plans to reduce this expenditure across the organisation had been formulated.

The Committee noted that the Trust held two large engagement events on 24 and 26 July 2018. The first of these events focussed on Workforce Race Equality Standard (WRES) action planning, which was attended by over 60 participants. The second event on 26 July 2018, titled "The Big Conversation" was attended by over 200 London Ambulance Service NHS Trust (LAS) managers and focussed on race and the Trust's WRES.

The Committee discussed the nature of workforce modelling and the challenges of the ever-changing recruitment forecast. It was noted that the Trust had currently factored in a 1.8% annual growth but that demand appeared to be slowing and that this needed further analysis. The Committee noted the importance of

	dynamic modelling with sensitivity to demand in order to avoid over or under recruitment. A brief overview of the EOC Restructure was provided to the Committee. It was noted that the restructure had been primarily driven by dissatisfaction amongst staff with regard to career progression and that a consultation had been initiated on 30 August 2018 with seven launch events taking place at the Trust. The Committee noted that the consultation would last for five weeks and that job descriptions with indicative bandings had been published along with the consultation paper. It was noted that the staff survey would be formally launched on 28 September 2018. The Committee was informed that in previous years the data received from the survey had been provided based on 32 key findings but that this would now be condensed to 10 summary indicators.
Key decisions made / actions identified:	The Committee discussed the Key Performance Indicator (KPI) regarding use of the Trust's managing attendance policy (MAP). It was agreed that the number of managing attendance cases linked to disciplinaries and the split of short term and long-term absence in the 124 cases were to be brought to the next Committee meeting in November 2018. The Committee requested more information about the how the new summary indicators map to the key findings for the 2018 staff survey. The Committee noted that the agency plan would be brought back to the Committee in November 2018 to provide a further update and assurance that the Trust was making progress to reduce agency spend. An update on the ongoing EOC Restructure would be provided at the next Committee meeting.
Risks:	The Committee was advised that a potential BAF risk related to the Trust's training review had been raised at the Trust's Quality Assurance Committee. However, it was noted after further consideration that a risk would not be added to the BAF as training risks across the Trust were related to specific training requirements, and could not be generalised within the broader issues highlighted by the training review. The Committee acknowledged that BAF Risk 47 regarding low EOC staffing levels at Bow and Waterloo remained a risk.

Assurance:	The Committee were assured that the Trust was on track in its implementation of the B6 Paramedic Job Description, the transition of the 'trapped group' of Newly Qualified Paramedics (NQP) and the Fast Track process.

London Ambulance Service NHS Trust

Assurance report:	**Finance and Investment Committee**	**Date:**	**11/09/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**25/09/2018**
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 Committee reviewed income and expenditure reports for the first four months of the financial year and the forecast for the full year. The net deficit to the end of July is in line with plan at £2.4m and the forecast indicates that the full year deficit of £1.5m will be achieved. The Committee discussed an analysis of risks and scenarios related to the expected outturn, which highlighted uncertainties around activity levels, CQUIN achievement, CIP delivery and other factors. It noted the estimated financial impact of providing sufficient resource to achieve ARP performance targets. It was confirmed that further work will be done on the actions necessary to assure delivery of financial targets; the result will be reported to the Board.
- Non-pay operating expenditure is over budget by £1.9m YTD. The Committee has asked for further information about the controls in place to ensure clear accountability for approving expenditure above budget.
- The Committee and the People and Culture Committee have both reviewed the plan to bring expenditure on agency staff within the limit set by NHS Improvement (NHSI). Significant progress is being made but further work is still required to achieve the target.

Other matters considered:

- The Committee noted progress in delivering the Procurement Maturity Plan. It noted that the Trust's procurement strategy was being developed, with the aim of achieving substantial savings in non-pay costs.
- The Committee noted the business case for purchase of Double Crewed Ambulances in 2018/19 and 2019/20; this had already

	been approved by Chair's action. It noted that there is no exchange risk, as prices have been agreed in sterling. • Technical releases were noted: there are no new significant matters.
Key decisions made / actions identified:	• It was confirmed that the draft 5 year Financial Plan would be discussed by the Committee in November and would then be presented to the Board. The plan would take account of recent national announcements relating to NHS funding and of efficiency targets arising from national benchmarking. • Work is underway on Brexit-related risks and their mitigations and the Committee has asked for this to be presented at its November meeting. • The Committee was informed of the Trust's processes for ensuring compliance in relation to HMRC rules on IR35. Regular sampling of these processes and documentation was requested. • It is proposed that the Committee's Terms of Reference should be amended to transfer the responsibility for the receipt of assurance on procurement from the Logistics and Infrastructure Committee to the Finance and Investment Committee. It is also proposed that performance oversight responsibility should be removed from the Committee's remit, as this is the responsibility of the whole Board. • The Committee approved the Trust's revised Cash Management and Investment Policy
Risks:	• It is proposed that Risk 49, relating to delivery of the 2018/19 CIP of £12.3m, should remain on the BAF. • An additional risk relating to a possible shortfall in income continues to be evaluated and will be considered by the Board.
Assurance:	• The Committee has reviewed financial performance to the end of July. It has discussed the financial implications of the full year forecast as at month 4 and analysis of operational performance to aid understanding of the underlying drivers of changes in income and expenditure. • Cash flow performance and projections were also reviewed. It was noted that as at 31st August 2018, the Trust's cash balance stood at £24.7m, £8.3m above plan. 85% of creditors are being paid within 30 days. • An Internal Audit report on processes relating to CIP has given "significant assurance with some improvement required" • The Committee reviewed the recommendations of a report on financial issues and financial governance at Barking, Havering

	and Redbridge NHS Trust, where significant cash flow difficulties had been experienced. The Committee concluded that LAS already meets the relevant recommendations.

London Ambulance Service NHS Trust

Finance and Investment Committee

Terms of Reference (effective ~~March~~ September 2018-March 2019)

1. Purpose

1.1 The Finance and Investment Committee has been established in order to provide assurance and make recommendations to the Trust Board on the proposed plans of the Executive Leadership Team and to be assured of their consistency through discussion with other Board committees.

1.2 The Finance and Investment Committee shall conduct independent and objective review(s) of financial and investment policy and performance.

2. Constitution

2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust (including the Chief Executive and the Director of Finance and Performance) and shall consist of not less than five members, all of whom shall have voting rights.

6. Chair

6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

7.1 The Trust Chair should normally attend all Finance and Investment Committee meetings.

7.2 The Director of Corporate Governance and the Deputy Director of Finance should normally attend all Finance and Investment Committee meetings.

7.3 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance;

8.1.1 The Chair or Vice-Chair; and
8.1.2 At least one of the two Executive Directors, one of whom must be the Chief Executive or Director of Finance and Performance.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

11.1 Meetings will be held bi-monthly with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

Financial Policy, Management and Reporting

12.1 To consider the Trust's 2 – 5 year financial strategy, in relation to both revenue and capital prior to its submission to the Board.

12.2 To consider the Trust's annual financial targets and cash flow and to monitor progress against these.

12.3 To review the annual financial plan before submission to the Board.

12.4 To review performance against the Cost Improvement Programme focussing on specific issues raised by the Board.

12.5 To review proposals and make recommendations to the Board for major business cases and their respective funding sources.

12.6 To monitor progress with the capital programme making any recommendations for changes or re-allocation of capital.

12.7 To commission and receive the results of in-depth reviews of key commercial issues affecting the Trust on behalf of the Board.

12.8 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and related contractual risk.

12.9 To consider the Trust's tax policy and compliance.

12.10 To annually review the financial policies of the Trust and make appropriate recommendations to the Board.

12.11 To review the Trust's corporate risk register – section relating to financial risk. To review the impact of any corporate risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion onto the Board Assurance Framework.

Investment Policy, Management and Reporting

12.12 To approve and keep under review, on behalf of the Board, the Trust's investment strategy and policy.

12.13 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHS Improvement's requirements.

~~**Performance oversight**~~

~~12.14 To review the form and content of the Integrated Performance Report to ensure it is adequately focused and acts to highlight variation from intended performance, the reason for this and action to address it.~~

~~12.15 To receive assurance regarding the timeliness, relevance and accuracy of the data included within the Integrated Performance Report together with recommendations for improvement.~~

Procurement

12.14 To receive assurance regarding procurement development and the alignment of this with the Trust's overall commercial strategy development.

Other

~~12.16~~12.15 To receive any other relevant items as identified on the Committee's forward plan.

13. Review and reporting responsibilities

13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

TO BE Approved by the Board at its meeting on ~~27 March~~25 September 2018

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**18/09/2018**
Summary report to:	**Trust Board**	**Date of meeting:**	**25/09/2018**
Presented by:	**Bob McFarland, Non-Executive Director, Quality Assurance Committee Chair**	**Prepared by:**	**Bob McFarland, Non-Executive Director, Quality Assurance Committee Chair**

Matters for escalation:

- The Committee discussed whether the Trust will reliably meet the Ambulance Response Programme (ARP) Standards, particularly when fluctuations outside the Trust's control lead to peaks in activity. Meeting the standards is likely to need more than a redistribution of current resources (e.g. exchanging FRU for DCA) and we are still substantially below establishment. A paper on this issue is being presented separately to the Board.

Other matters considered:

- **Integrated Urgent Care Service NE London.** The NE London 111/IUC leadership team joined the meeting and with the Medical Director explained the new national specification for out of hours service and the practical working of the new Clinical Assessment Service (CAS) as introduced in NE London; the rationale is for a multidisciplinary team to be able to complete the emergency advice for many patients by the end of the call, reducing referrals to other emergency services out of hours. The scrutiny and ongoing governance structures to manage quality standards were presented. As an "early adopter" of the new system (first in London) LAS is adapting and developing procedures and standards as we go (with the constructive involvement of commissioners) but inevitably there have been many difficulties to overcome although no critical safety incidents. An RCA level 1 (Root Cause Analysis) has been commissioned and the Committee was thereby assured lessons would be learnt and disseminated. This is important as we are about to launch a similar service in SE London, although it has been agreed this would be a phased process between now and February 2019.

- The team were congratulated for achieving the successful launch of the CAS and thanked for the considerable time and effort involved

- **Quality Report.** The Quality Oversight Group wished to highlight two items:
  - ALL staff are required to have Level 3 Safeguarding training.

- Flu vaccination is available and documented vaccination required for all staff.

- Following the analysis of stroke clinical outcomes, it has been decided to focus on "on scene time" and "90th centile (call to hospital time)" rather than the 60-minute percentage.

- The cost of legal claims made against the Trust was noted (included in the report for the first time). Many are historical, but it was agreed any new clinical claims should be reported for learning.

- **Serious Incidents.** Several changes have been made concerning ARP decision making and Ventricular Fibrillation protocols following the thematic SI analysis and it should be possible to assess the impact of these changes over the next few months. Delay – either from lack of resource or poor decision making – remains a contributary factor in many SI and reinforces the concern about reliably meeting ARP standards.

- **Health and Safety Report** Steady progress was noted. Manual Handling is still rated a high risk but it is hoped that there will now be an improvement as 85% of staff have been trained.

- **Cost Improvement Programme (CIP) – Quality Impact Assessment** The Committee had requested more information regarding mitigation of those CIP designated as having a "High risk" to quality. Chief Quality Officer is to prepare a summary of mitigation to assure this Committee and for the Finance and Investment Committee.

Key decisions made / actions identified:

- **Mental Health Annual Report & Infection Prevention and Control Annual Report.** The Committee is pleased to commend to the Board both reports. Both reports demonstrate the considerable activity and achievement in these areas.
- There was a general discussion around the way in which these reports and other annual reports are presented. There is no consistent presentation, they entail substantial work to produce, the previous and next year's objectives are not included in all of them and reading them it is sometimes difficult to be clear on priorities and progress. These activities are however being monitored regularly through QOG and its subsidiary committees. A review of all "annual" reports will be undertaken to determine their purpose, the best way to present, which of them are statutory, which need to be presented to the Board and which can be included within the Quality Account. It may not be necessary to have them all as "end of year "reports as at present.

Risks:	• There are no new BAF risks allocated; however the Committee discussed the following key risks.
	  • The Rethink Training Review identified systemic issues across all areas of Training and Education. Some specific issues have been resolved and RCAG has reviewed several associated risks. However, the committee felt that a corporate risk should be added to the corporate risk register, until an action plan had been agreed by executives and presented to the People and Culture Committee in November.
	  • Delivery of ARP standards – matching appropriate staff and resources remains a concern as above.

Assurance:	The Committee will receive assurance on the NE London 111/IUC service through the planned RCA level 1.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	25 September 2018			
Report title:	Integrated Quality and Performance Report			
Agenda item:	09			
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

September 2018

* All available data is correct as of the 15th of every month.
- Please note that this report relates to performance throughout August 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 6 minutes 43 seconds in August. LAS ranked 2nd in both Cat 1 90th centile & Cat 4 90th centile compared to other Trusts.
Statutory and Mandatory Training and PDR rates continue to achieve above 85% compliance. Turnover has increased to 11.5% (10% target)
At month 5 the Trust has a use of resources score of 3 which is in line with plan due to the profile of income and expenditure. The Trust is forecasting a year end score of 2 in line with plan and before PSF(Provider Sustainability Funding).

OUR PATIENTS

		Aug-18	
ROSC at Hospital (* data from Apr-18)	(>30%)	35.0%	⇧
STEMI Care Bundle (* data from Feb-18)	(> 74%)	75.0%	⇩
Stroke Care Bundle	(> 98%)	97.0%	⇩
Positive compliments received	(2 per 1000)	1.14	⇔

Much work has been undertaken in regards to the risk management programme, we have seen an upward trend of incidents being reported over the last three months, including an increase in low and no harm incidents. This trend will continue to be monitored as the training of staff and easier access to Datix is continued. ⇧

The Trust is progressing well against the Quality Priorities for 2018/19. All Quality Priorities are underway with 80% of them on track, those few that are not on track have recovery plans in place to ensure that they are achieved. ⇔

The CQC good to outstanding actions are progressing well with 13 completed (15%) and 65 actions (74%) on track. A few actions have been deemed recoverable and have been escalated to a relevant committee to ensure that actions are put into place for closer monitoring. ⇔

OUR PERFORMANCE

	Aug-18	YTD		
Category 1 response - Mean	00:06:43	00:07:02	Performing within the national standard	⇩
Category 2 response - Mean	00:17:06	00:18:50	Performing within the national standard	⇩
Category 3 response - 90th centile	01:53:46	02:11:14	Performing within the national standard	⇩
Category 4 response - 90th centile	02:03:53	02:20:07	Performing within the national standard	⇩
Call answering - 999 (less than 5 seconds)	90%		Target subject to change	
Call answering - NHS 111 (within 60 seconds)	89.6%		Negatively decreasing	⇩

August saw a significant focus on helping to stabilise the North East London Integrated Urgent Care service in its first month of operation, taking up to 40% of calls on behalf of North East London.

OUR MONEY

	YTD	Forecast		
Control Total	£3.88m deficit	£1.45m deficit	Both on plan	⇔
CIP savings	£5.2m	£12.3m	On Plan with risk	⇔
Use of resources	3	2	On plan	⇔
% of Capital Programme Delivered	20.2% vs 36.4% plan	100%	Recovery plan in process	⇩
CQUIN	Q1 & Q2 on target	TBC	Work to be completed	⇔

⇩ Financial risks worsening: 999 contract income; agenda for change pay settlement

OUR PEOPLE

	Aug-18		
Vacancy rates (5% or below)	6%	Remaining steady	⇔
Staff Sickness levels (5% or below)	5.2%	Remaining steady	⇔
% of BME Staff (15% or above by 2019)	13.7%	Remaining steady	⇔
Statutory & Mandatory Training (85% or above)	87%	Negatively decreasing	⇩
Staff appraisal compliance (85% or above)	85%	Negatively decreasing	⇩

⇧	Increasing concern	⇩	Decreasing concern
⇧	Increasing negatively	⇩	Decreasing negatively
⇧	Increasing positively	⇩	Decreasing positively
⇔	Remains steady	⇔	Information only

Our Patients

Safe

There is an upward trend of incidents being reported over the last three months, including an increase in low and no harm incidents. This trend will continue to be monitored as the training of staff and easier access to Datix continues.

The Trust hand hygiene compliance for August was 98% up from July (94%).

There are currently 25 actions that are outstanding:
14 actions relate to EOC 6 for operations, 3 for Fleet & Logistics and 2 for LAS111.

Effective

ROSC at Hospital (* data from April-18) is 35.0% which is above the national standard. The Stroke Care Bundle is 97.0%

STEMI Care Bundle(* data from Feb-18) is 75.0%. There continues to be a focus on this measure.
Action: The audit results are feedback during CPI feedback sessions for learning.

At 75%, LAS completion rate in July was at its lowest for more than two years. Team Leaders also completed the lowest proportion of CPI audits since this time last year.

Caring

Changes to the HCP line for midwife requests is outstanding with no agreed completion. This has been escalation to Head of Control Services and communication has been sent to Heads of Midwifery.

There are now three trained midwives working in the Clinical Hub and the Mental Health Team is now working to a new rota providing 7 day cover to the EOC.

Responsive

Changes to the HCP line for midwife requests is outstanding with no agreed completion. This has been escalation to Head of Control Services and communication has been sent to Heads of Midwifery.

There are now three trained midwives working in the Clinical Hub and the Mental Health Team is now working to a new rota providing 7 day cover to the EOC.

Well Led

A review of the contributory factors that have influenced the root cause of incidents relating to dispatching resources and managing 999 calls highlighted a theme relating to the pre-triage of emergency calls (specifically the descriptors in MPDS vs the varying different phrases used by callers).

Action: An educational package is being developed for existing and new-entrant EMD's focused on ineffective breathing to be delivered electronically and face-to-face in EOC CSR sessions.

Projects & Programmes

The Trust is progressing well against the Quality Priorities for 2018/19. All Quality Priorities are underway with 80% of them on track, those few that are not on track have recovery plans in place to ensure that they are achieved.

The CQC good to outstanding actions are progressing well with 13 completed (15%) and 65 actions (74%) on track. A few actions have been deemed recoverable and have been escalated to a relevant committee to ensure that actions are put into place for closer monitoring.

- Metric on or ahead of target | Programme or Committee on track
- Metric off target by <10% | Programme or Committee off plan but no escalation
- Metric off target by >10% | Programme Escalation | Committee Escalation

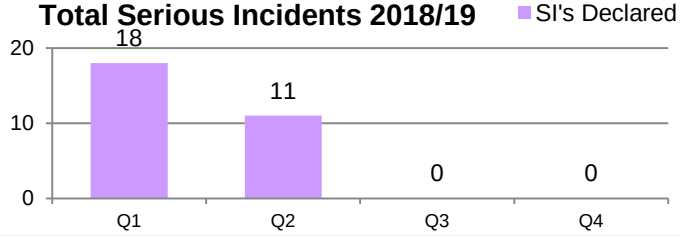
Patient Safety

Owner: Kirstie Smith | Exec Lead: Dr. Trisha Bain

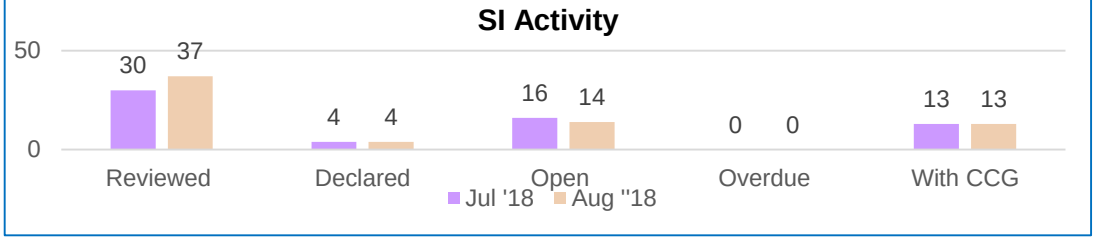
Measures	Target / Range	YTD 18/19	Jun-18	Jul-18	Aug-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	96%	96.0%	94.0%	97.0%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	2.9	2.5	3.3	3.3	↓					
Patient related Adverse Events - NO HARM	100	1024	169	227	230	↑					
Patient related Adverse Events - LOW	40	173	29	43	46	↑					
Patient related Adverse Events - MODERATE	25	75	16	16	12	↓					
Patient related Adverse Events - SEVERE		27	5	7	8	↑					
Patient related Adverse Events - DEATH		45	6	12	7	↓					
Rate of Staff related Adverse Events per 1,000 Incidents	3	3.5	2.9	3.6	3.3	↓					
Staff related Adverse Events - **NONE**		871	147	178	142	↓					
Staff related Adverse Events - **LOW**		719	118	146	159	↑					
Staff related Adverse Events - **MODERATE**		23	2	8	5	↓					
Staff related Adverse Events - **SEVERE**		2	1	0	1	↑					
Controlled Drugs - Other Reportable Incidents		332	68	80	80	↔					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	0%	90%	89%	88%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month		29	5	4	7	↑					
Serious Incidents breaching 60 days	0	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	0%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events		6%	6.7%	8.2%	5.6%	↓					
Needle Stick Injuries as % of Staff Adverse Events		2%	1.5%	1.8%	2.3%	↑					
Never Events	0	1	0	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	0%	0%	0%	0%	↔					
Missing Equipment Incidents as % of all reported incidents		3%	3%	3%	2%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents		10%	8.6%	9.7%	9.7%	↔					

Patient Safety

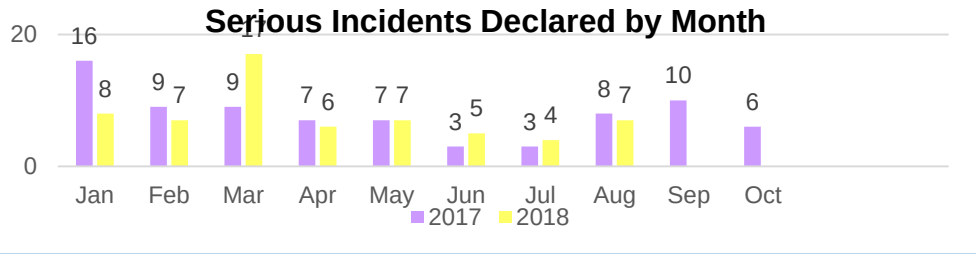
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

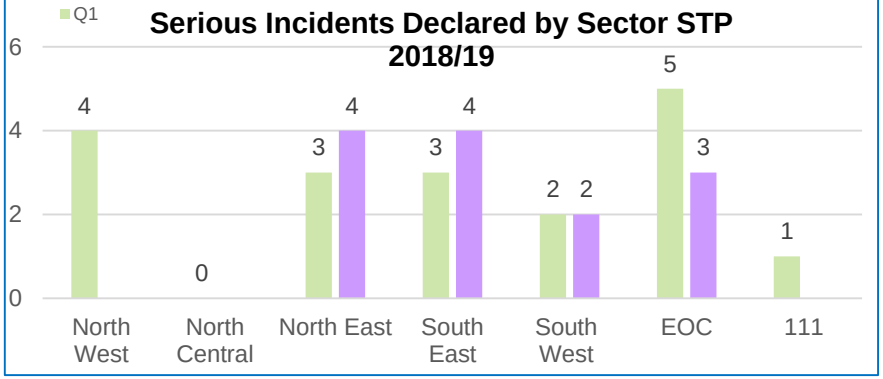


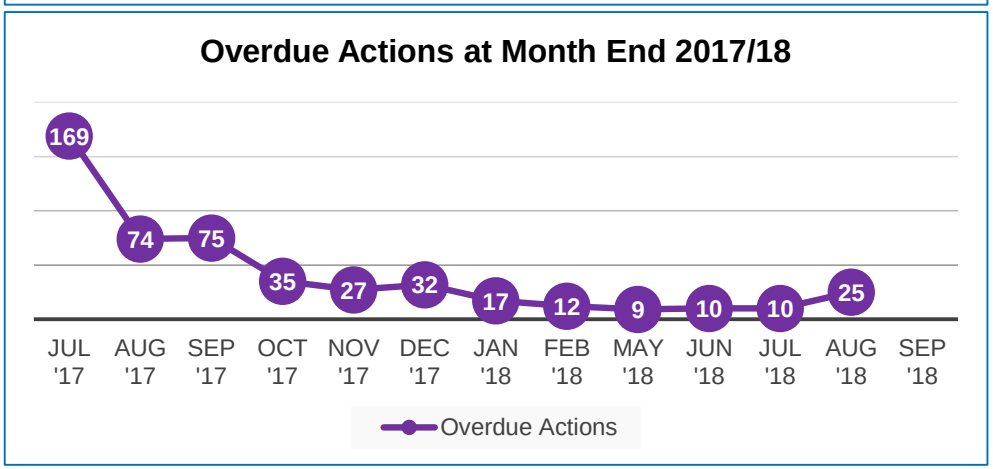
A total of 18 serious incidents (SI) were declared during Q1 which is comparable to the 17 declared the previous year. To date 11 SI's have been declared for Q2 and is in line with the seasonal average.



37 incidents were reviewed by the Serious Incident Group during August which is an increase of seven from July 2018.13 investigations submitted to the CCG are awaiting comments or closure with no breaches. The Quality Governance and Assurance Team are currently managing 14 open serious incidents.



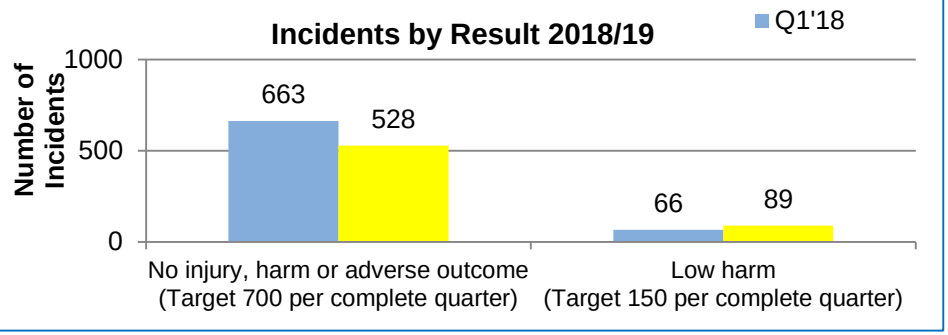


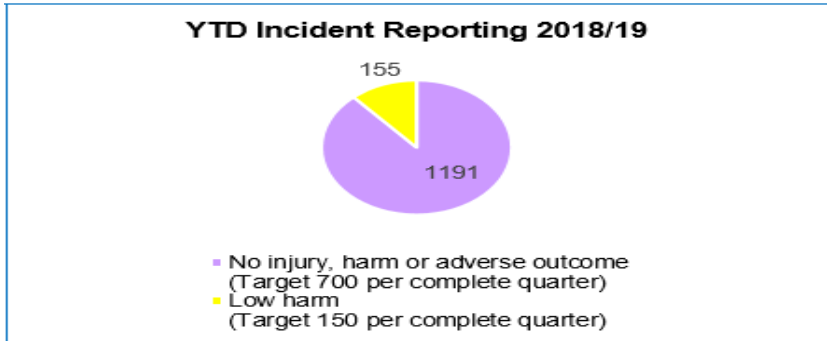


- There are currently 25 actions that are outstanding: 14 actions relate to EOC, 6 for operations, 3 for Fleet & Logistics and 2 for LAS111.
- The majority of EOC actions concern individual feedback to members of staff.
- Overdue actions continue to be managed by the Quality, Governance & Assurance team with weekly escalations.
- Actions for operations include feedback to staff, clinical reflections, sharing learning across the sector, mechanisms for increasing clinical supervision and improving the dissemination of information.

Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain



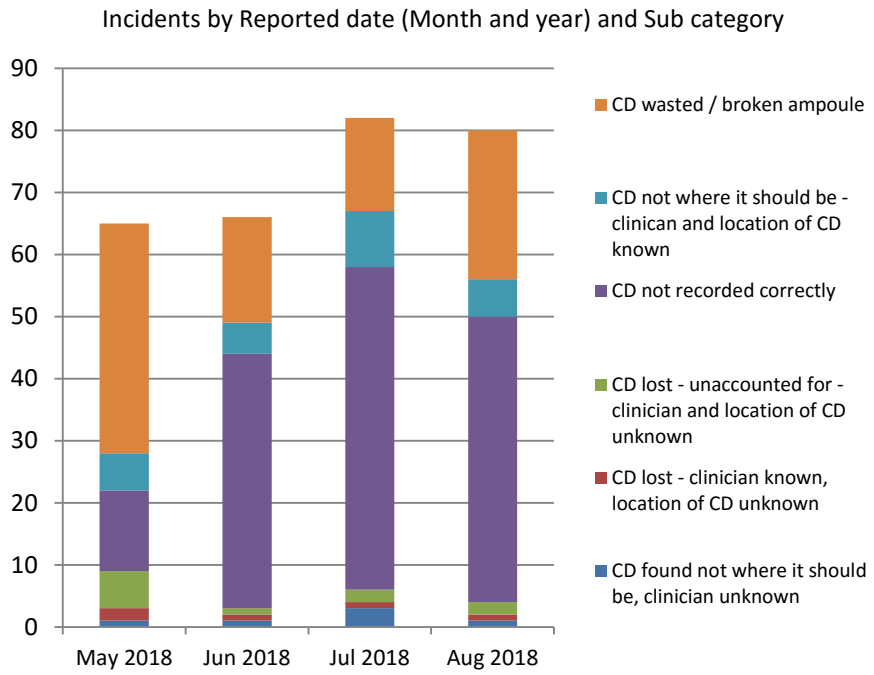


The Trust has set an annual target for the reporting of incidents that have been graded as either no harm or low harm. The new KPI's for incident reporting requires 700 no harm incidents per quarter and 150 low harm incidents per quarter. The Trust did not met these KPIs for Q1 2018/19 however this data is subject to revalidation and it is expected this value will change. Incident reporting and monitoring will continue during this time.

Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q1			Q2		
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Apr	May	Jun	Jul		
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	9	6	6	6	6	The published CQC report gave an overall rating of good. In addition the CCG have shared that they are assured the Trust has oversight and consistent management of SI's and incidents. The team have appointed to the band 6 vacancy which will focus on thematic analysis of incidents. The team have appointed a risk manager who is expected to start Sep 2018.
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. The team are currently recruiting to the remaining vacant positions.

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



- One (1) unaccounted for loss of injectable morphine
- Total of 83 other controlled drug incidents including:
  - Wastage or breakages (n=24)
  - Documentation errors (n=49)
  - Morphine retained off duty (n=6)
  - CD safe malfunction (n=1), lost drugs packs (n=1), found in wrong location (n=1)
- Non-controlled drugs incidents
  - KitPrep app malfunction or discrepancy (n=10)
  - Incorrect administration of adrenaline (n=3), aspirin (n=1), atropine (n=1), chlorphenamine (n=1) hydrocortisone (n=3), glucagon (n=1), GTN (n=1), oramorph (n=1) and salbutamol (n=2)
  - Drugs not returned to store (n=6)
  - Store open or access codes visible (n=3)
  - Non-standard drugs in PAS drugs pack (n=1)
  - Expired managers drugs packs (n=2)
  - Confusion regarding drug presentation (n=2)
  - Drugs not available at shift start (n=1)
  - Overdose of medication by non-LAS care staff (n=3)

Actions

- Report of unaccounted for loss of injectable morphine to Home Office and escalation to Metropolitan Police Controlled Drugs officers.
- Ongoing input to KitPrep contract renegotiations
- Trends in drug errors and other medicines management issues used to inform medicines teaching sessions on Core Skill Refresher (CSR) 2018.3

Assurance

- Morphine retained off-duty identified and resolved in a timely fashion
- Staff continue to report medication errors
- Vaccines ordered for winter flu programme

Effectiveness (Clinical Measures)

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	31%	27%	35%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	64%	62%					↔			LQ1b		
STEMI care bundle (AQI)		G	70%		75%					↔			LQ2c		
Stroke to HASU within 60 minutes (AQI)		G	67%	52%						↔			LQ3a		
Stroke Care Bundle (AQI)		G	97%							↔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	2%					↔					
Survival to Discharge (AQI)			10%	8%	3%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	19%	21%					↑					
STEMI- On scene duration (CARU continual audit)				00:41	3%	00:39	00:37	00:38		↑					
Call to angiography (mean hh:mm)					9%										
Call to arrival at hospital (hh:mm)															
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	87%	88%	85.0%	88.0%	75.0%		↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%		0%	0.4%	0.8%			↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	97%	97.0%	98.0%	97.0%		↓		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	94%	95%	94.0%	94.0%	92.0%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	98%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%		96.0%			↔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)		G	0%		91%		90.0%	90.0%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	97%				98.0%		↓			LQ12		

Actions

- In July, two paramedics on restricted duties and one Team Coordinator received CPI training.
- CPI auditors who had concerns about clinical safety placed 20 Datix reports and made 13 retrospective safeguarding referrals.

Assurance

- At 75%, LAS completion rate in July was at its lowest for more than two years. Team Leaders also completed the lowest proportion of CPI audits since this time last year.
- The standard of care provided by the LAS to patients under the Discharged at Scene, Glycaemic Emergency and Severe Sepsis CPIs remained high in July, as well as the standard of general documentation. LAS documentation of cardiac arrest was of a slightly lower standard than usual.
- In July, 239 members of staff (6% of all LAS frontline clinicians) received face-to-face CPI feedback; 49% of the expected number of staff across the LAS for July when taking into account the scheduled requirements for Team Leaders to fulfil patient facing duties this month.

Responsive

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Jun-18	Jul-18	Aug-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.76	3.6	3.7	4.1	↑				
Number of Frequent Caller calls			19414	5947	7549	5918	↓				
Total Frequent Callers			3009	578	650	629	↓				
Number of Public Engagement Events			0.00	0.0	46.0	0.0	↓			LQ28	
CMC records viewed			2209	419	474	426	↓			LQ30	

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 (FCT) August 18 updates:

Last month the Frequent Caller Management Database (FCMD) identified 629 new & existing frequent callers meeting the national definition. 100% of patients were matched with their NHS numbers.

The Frequent Caller Team (FCT) continue to attend multi-disciplinary meetings and Frequent Caller / Attender forums across London, and conduct joint home visits to frequent callers with their care coordinators. We discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS. FCT supports a range of requests for data, including A&E Frequent Attender meetings, CCG Forums, Mental Health Multi-Disciplinary meetings, GP meetings, and STP work on frequent callers & attenders.

The Community Involvement Officers are now F-T Frequent Caller Managers and their new job description has been agreed. The FCT now has 4 Frequent Caller Managers, 2 Frequent Caller Leads, and 1 Specialist Administrator. A further Frequent Caller Manager is on secondment outside of the team.

East London has seen an active move from CCGs in the development of forums and the use of Coordinate my Care.

In other parts of London the use of Coordinate My Care with external partners and ensuring care plans are accessed continues to be an ongoing challenge.

A recent article in 'The GIST' Guy's & St Thomas' magazine (issue 27, 2018, 'The Listening Project'), highlighted the case of 88 year old Ida, who was both a frequent caller to LAS and a frequent attender to the Emergency Dept. at St. Thomas' Hospital.

The Caller would telephone with chest pain and breathlessness. This amounted to 37 calls made over a six month period. She was usually conveyed to St. Thomas'. The Caller was experiencing social isolation & anxiety, following a fall which resulted in a fractured hip, and a subsequent move to warden-controlled accommodation, leaving her family home of 50 years. Her son explained the move was very traumatic for his mother. She would become nervous & pull her home emergency alarm, which would trigger an ambulance response. As a result of her frequent contact with St Thomas' Emergency Dept, Ida was identified by the High Intensity User (HIU) Project Team, who offered her support.

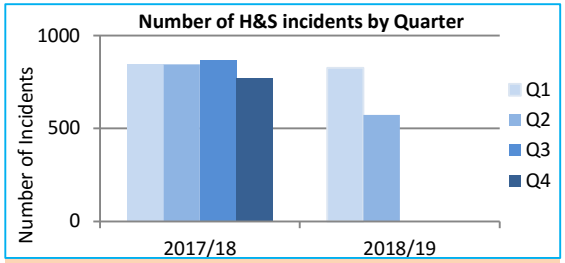
The HIU Team offer a high level of 1:1 support to St Thomas' Emergency Dept. frequent attenders and work with the person to understand the reasons for their calling. They address wider patient issues with the aim of reducing calls and attendances. The caller now feels she has sufficient support in place, and is less reliant on emergency services. Ida has not made a call since 11 July 2018.

The HIU Team receive a list of the top 50 attenders to the Emergency Department every 3 months, and attempt to engage them in support. The scheme is being rolled out across other boroughs.

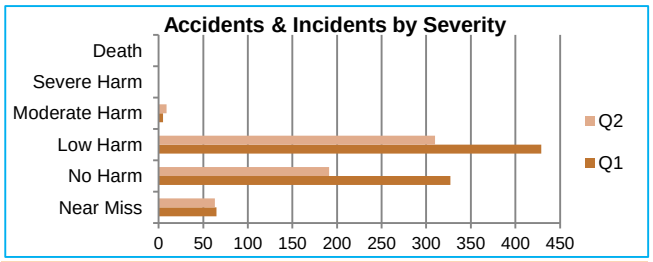
The Frequent Caller Team are able to refer patients and already provide monthly patient data to the project.

Health & Safety Scorecard

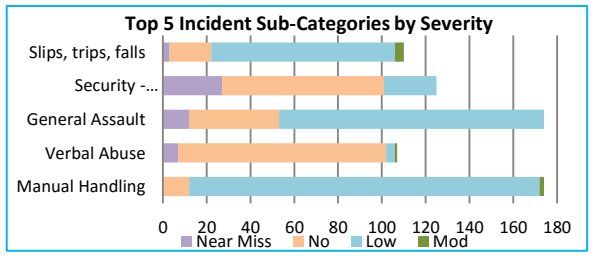
Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain



1399 incidents have been reported across the Trust during 2018/19. 293 incidents were reported in August 2018 . These H&S related incidents account for 37% of all the incidents reported across the Trust in Aug-2018.



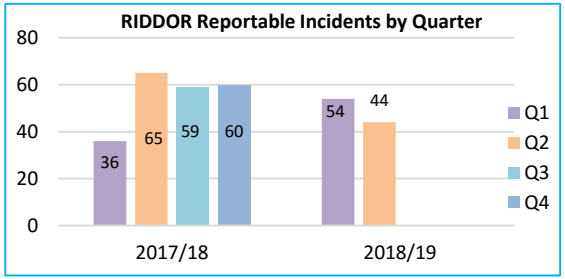
739 (53%) of the H&S related incidents reported during 2018/19 resulted in low harm. 14 (1.0%) incidents resulted in Moderate harm. 646 (46%) of the incidents were reported as 'No Harm/Near misses'.

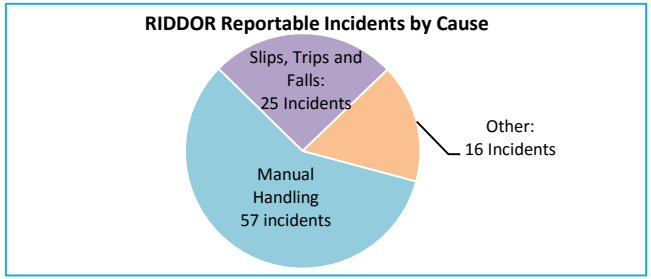


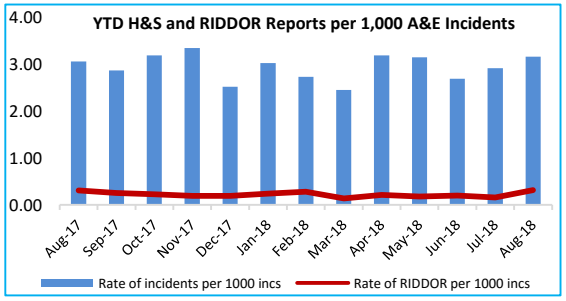
General Assault, Manual Handling – lifting patients (MH) and Security (violence, aggression & verbal abuse), incidents account for the highest number of incidents reported during August 2018.

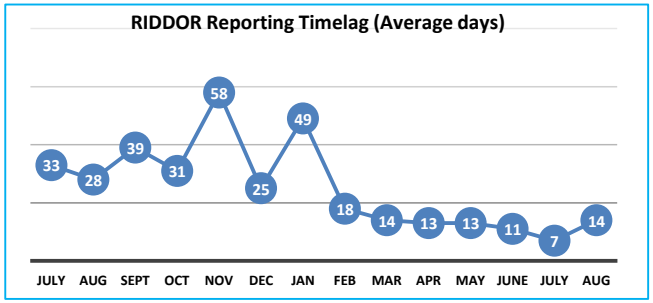
Key Updates:

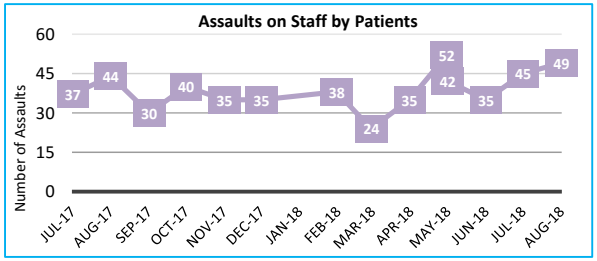
1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. 73 MH - lifting patient incidents have been reported in Q2. Some of the contributory factors included the lack of equipment or failure of a piece of equipment resulting in the manual handling of patients.
3. 24 of the MH incidents relating to the lack of or failure of equipment have been reported across the Trust during Q2, 2018/19.
4. The provision of practical MH Training to relevant frontline and support services staff is ongoing.
5. A review is ongoing to evaluate additional measures that can be implemented to further mitigate the security related incidents reported across the Trust.
6. Work is on-going to progress the actions identified on the Health and Safety Action Plan. **52 out of the 69** identified actions have now been completed.











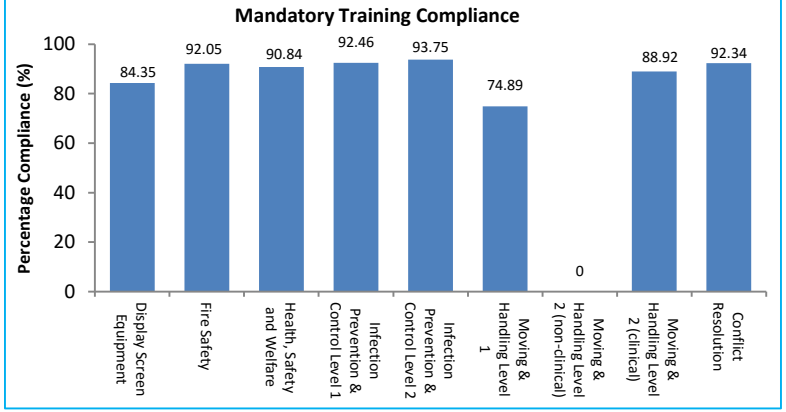
The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to August 2018.
No benchmark/comparable data was received from any of the other ambulance Trusts during August 2018.

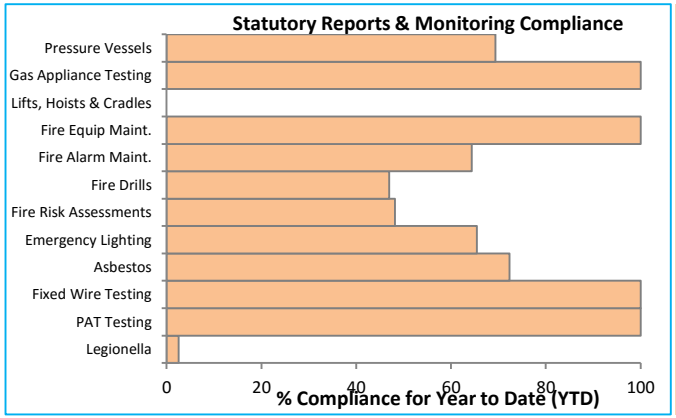
98 RIDDOR incidents were reported to the HSE in 2018/19. 29 RIDDOR incidents were reported in August 2018.
The average time lag for reporting RIDDOR incidents in August was **14 days.** 8 out of the 29 RIDDOR incidents was reported out of time in August 2018.

There was an increase in the number of assault on staff by patient related incidents in August 2018. The most common underlying causes remain: 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





7. The practical MH Level 2 (non-clinical) training is available throughout 2018 and the training dates have been circulated through the Learning and Development Team.

8. New Manual Handling audit will be included in OWR assessment once the training has been delivered to CTLs.

9. The tender specification document for the Trust's fire risk assessment contract is currently under review.

10. Fire drill Programme (6 monthly) has been rolled out across the Trust.

Health and Safety Risk Tracker

Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead	Initial Risk Rating	Current Risk Rating								Target Risk Rating	Key changes/updates since last review
						Q4 – 2017/18			Q1 – 2018/19			Q2			
						Jan	Feb	Mar	Apr	May	Jun	Jul	Aug		
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	15	15	15	15	9	Review to be undertaken to purchase new equipment for the small handling aids kit. The H&S Department monitor MH related Incidents on a regular basis and a review is currently ongoing to look into and address the equipment related failures reported across the Trust.
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	12	12	12	12	4	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	12	12	12	12	6	No updates since last review.
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	9	3	3	3	3	The average RIDDOR reporting timelag reduced to 14 days in August 2018. It is recommended that this risk should be downgraded and closed but monitored on a monthly basis by the H&S Team.
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	9	9	9	9	3	No updates since last review.
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	8	8	8	8	4	No updates since last review.
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	6	6	6	6	3	Substantive recruitment into the Health and Safety Department is ongoing.

Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 themes 2017/18/19

Complaints by subject 2015/18	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Total
Delay	26	9	22	33	19	17	40	21	21	17	11	18	16	254
Conduct	19	16	17	25	20	22	23	20	18	23	20	33	20	256
Road handling	10	7	14	9	7	6	10	6	5	8	8	14	18	104
Treatment	7	5	16	8	9	8	14	4	9	13	8	9	8	110
Non-conveyance	0	1	6	1	7	6	3	4	6	5	9	7	8	55
Totals (above)	62	38	75	76	62	59	90	55	59	66	56	81	70	849
Totals per month	86	51	94	85	84	74	102	76	77	77	70	103	94	1073

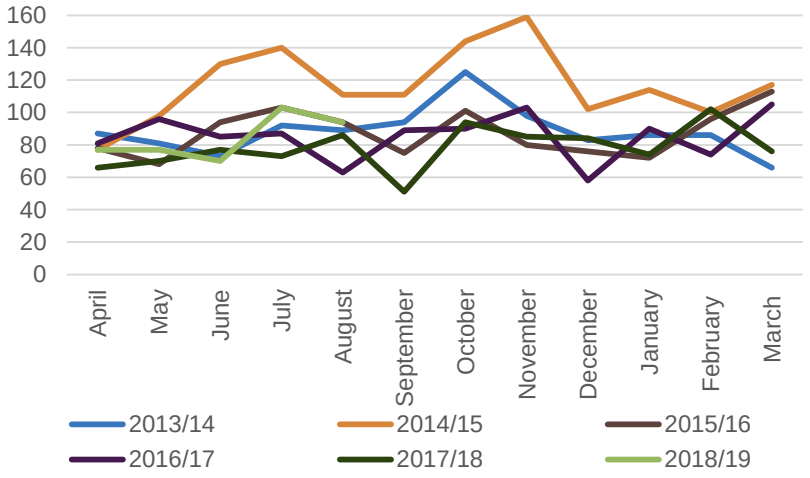
Assurance and learning

- Quality Alerts from the Metropolitan Police were brought to our attention on behalf of the Forensic Medical Examiner (FME). There were concerns that LAS was delayed responding to very unwell patients.
- We explained that EOC are now managing calls using the triage system ARP (Ambulance Response Programme). We advised MPS that it would be helpful for the FME to make the 999 call so that the *healthcare professional protocol* could be applied. We have also arranged for this topic to be clarified at the Control Services Governance meeting.
- A complaint identified that problems still occur with the PAS crews not having MDT's but having to work off the radio screen or RT. The Third Party Manager is working on a new device and application that should address this.

Review of August 2018

- During August, we received 94 complaints which reflects the extra pressure on the service.
- The percentage of complaints against face to face incidents remained at 0.10% - the current annual average is 0.9%.
- There were 17 Health Partner Alerts during August. 6 from Acute Trusts, 5 from others including urgent care and hospices, 3 from GP surgeries, 2 from community healthcare and 1 from a HASU.
- During 2018/19 the number of complaints where conduct and behaviour was the main head of complaint have exceeded complaints regarding delays (114:83)
- We received 16 complaints relating to NHS111. 11 of these were from NELIUC and we are currently collaborating with the project team to ensure the system is mirrored with the one we use with SE London 111.

Complaint numbers August 2013 to August 2018



Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Complaint response times – August 2018

Month	Total complaints remaining open/re-opened as at time of report each month	Closed during the month	opened complaints by month
Apr-18	108	93	77
May-18	105	70	77
Jun-18	107	78	70
Jul-18	123	94	103
Aug-18	102	111	94
Totals	545	446	421

- There were 32 complaints out of time that were due for response in August. Currently only 8 of the overdue complaints remain open (as at 06/09/18).
- 5 of these are waiting for sign off by the Executive office, the other 3 await further input from other departments.
- REAP 3 was in place for the whole of August due to the continued high demand.
- Throughput has increased this month but annual leave commitments in the forthcoming month will impact on that.

Assurance & Learning

- We are now utilising the '*severity of justice*' introduced by the Ombudsman in July. This will impact on future decisions when determining financial recommendations for non-financial loss.
- We managed 343 enquires this month, of which 30 were requests for medical records. There has been an increase in such request since the implementation of the new GDPA.
- There has also been an increase in requests for medical records from Solicitors who no longer have to pay a fee for these. No income was generated this month.
- Of the complaints closed this month 80 were not upheld, 11 were partly upheld, 9 were referred to other agencies, 6 were upheld and 5 were actioned.
- We continue to maintain 100% compliance with acknowledging complaints within 3 working days.
- Recruitment to the new approved posts will begin shortly and we aim to have those staff in post by November 2018.
- This will improve resourcing on the duty function and assist with the increase in Health Partner Alerts and requests for medical records.

Categories of complaint calls

August 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	6
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	19
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	12
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	8
Not CAD related/Info awaited	49
Total	94

Case example

A complaint was received from patient's nephew who was upset at the attitude and comments made by the attending staff.

The LA4 was poorly completed and despite being asked to leave the premises by the patient, no visual observations were recorded. Prior to making any decision regarding conveyance or referral, at minimum a primary survey should have been completed including observation and an assessment.

We concluded that it was not reasonable for the crew to suggest non conveyance without any of these assessments and within the first few minutes of patient interaction. This suggested an element of pre-judgement surrounding the patient's presenting complaint and the crew forming a somewhat biased opinion.

The crew have reflected about the breakdown in communication and a CTL will hold a reflective practice exercise with them regarding the poor judgement displayed and the clinical care management issues.

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No	Events in August include:
North West	1	• School and nursery visits • Community events • Knife crime • Careers events • Brownies / Scouts etc. • Patient representatives on committees • Filming for LAS Academy pain management module (children with sickle cell disease)
North Central	0	
North East	4	
South East	9	
South West	3	
Outer London/PPI	4	
Total	**21**	

Public Engagement activities

Supplementary information	
No. of public engagement events: year to date (April – August 2018)	247
Approximate audience numbers (August 2018)	1,219
Approximate audience numbers: year to date (April – August 2018)	29,940
Age profiles (August 2018): 0-5 years: 15 5-11 years: 100 11-16 years : 93 16-18 years: 31 Over 18: 80 All ages: 900	
Public engagement: no. of hours (August 2018)	56
No. of staff on LAS Public Education Facebook group	741
No. of staff on contact list	1,314

Public Engagement Highlights

- A Paramedic from Croydon attended Bromley Youth Offending Team to talk about knife crime. The feedback included:

"You did a brilliant job. I was really impressed with the young people who attended and listened without interrupting. If it stops just one young person carrying a knife, then it's a success. The young people's case workers will be doing follow up work with them to talk about how they feel about the issues, and whether the session might change their behaviour in the future."

- A Paramedic from Greenwich did her first ever public education event, with Skills for Growth. This is a charity which helps young people develop the skills they need for the world of work. The organisers said:

"Annie was excellent; the young people really liked her. We found the talk informative and enjoyable and Annie was very relaxed and accommodating with the group."

Public Engagement Highlights

- A Clinical Education Tutor, LAS Academy has been working with the Sickle Cell Society on some of the content for the paramedic training programme. Together, they organised for a group of children with sickle cell disease to make a film about their experience of living with pain. This will be used in the pain management module of the LAS Academy training programme.

  After the day's filming, the following comments were made:

"We had such a brilliant day that it's difficult to put into words. I really feel so excited that we are going to be able to develop a learning resource that will get across key elements of this disease that people would not have considered, and a unique opportunity to consider the background to this disease and how it impacts on a life straight from the mouths of these children we met. It was a privilege to spend the day with them."

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%	• 60 minutes mean response time • 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)	C1T Mean (00:19:00)	C1T 90th Centile (00:30:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
Previous month (Jul 18)	00:07:26	00:12:12	00:12:57	00:22:05	00:21:14	00:44:36	01:05:36	02:37:26	02:41:08
Last month (Aug 18)	00:06:43	00:10:58	00:11:27	00:19:11	00:17:06	00:34:15	00:49:17	01:53:46	02:03:53
Current YTD (2018/19) *	00:07:02	00:11:31	00:12:05	00:20:29	00:18:50	00:38:21	00:56:03	02:11:14	02:20:07

*from 1st April 2018

Demand

- **92,670** Incidents were provided with a face-to-face response. A decrease of 4.23% compared to the previous month. This decrease follows a similar seasonal patterns seen in previous years.
- **9,178 C1** incidents were provided with a face-to-face response. The largest decrease at 6.86% compared to the previous month.
- **50,708** incidents were categorised as **Category 2** and provided with a face-to-face response. These incidents decreased by 5.64% compared to the previous month.

Performance

- August saw **all key measures** performing **within** the designated **national standards**.
- The **C1 Mean** performed **within** the 7 minute target, at 6 minutes 43 seconds. The YTD is just above the 7 minute target.
- **C1 90th** continues to remain significantly **within** the 15 minute target for **August** as well as the **year to date** position.

Performance Overview
Response Times by Category

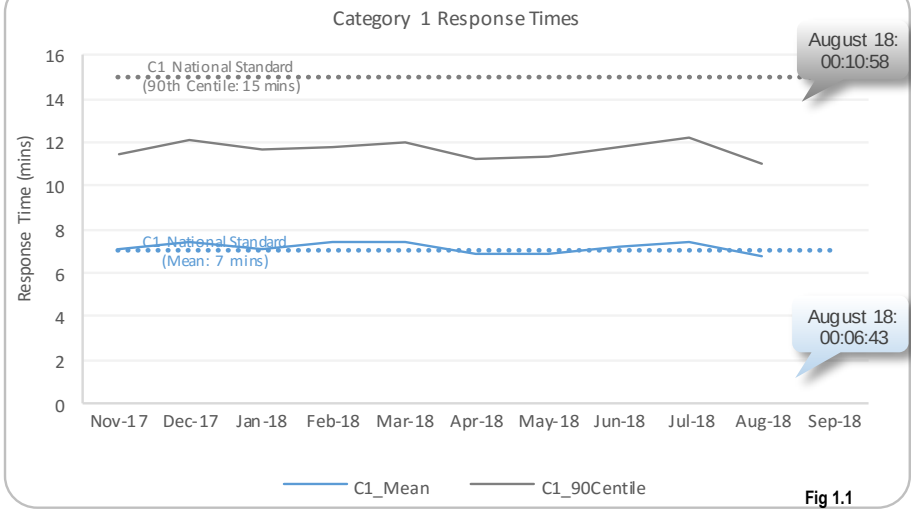


Fig 1.1

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.

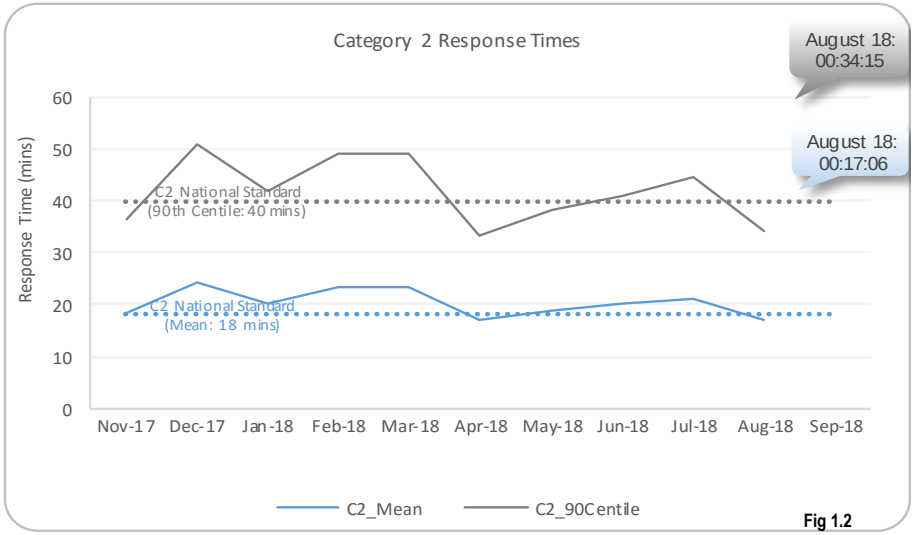


Fig 1.2

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

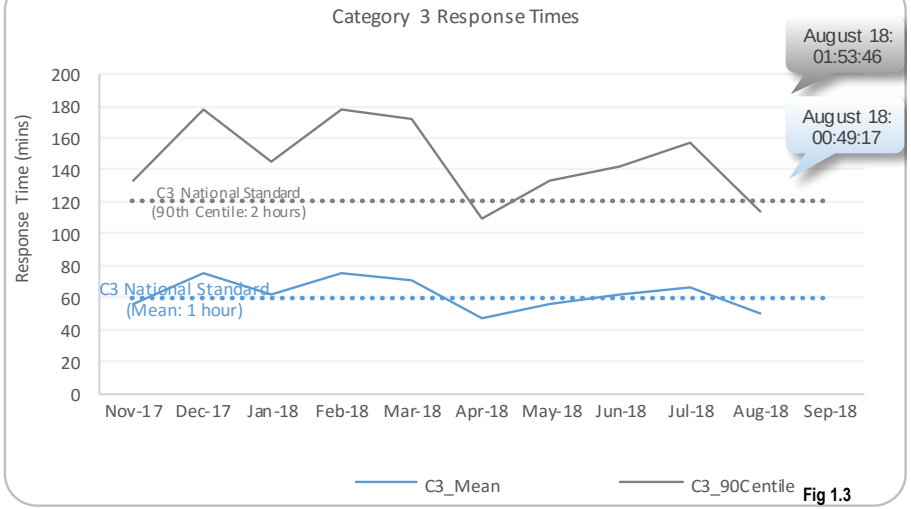


Fig 1.3

Category 3

The NEW Category 3 (C3) measure comprises 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.
  - The dotted blue line shows the National Standard of 60 minutes (1 hour) average (mean) response time. This is as a result of the recently updated specification for Ambulance Quality Indicators released in May 2018 by NHS England.

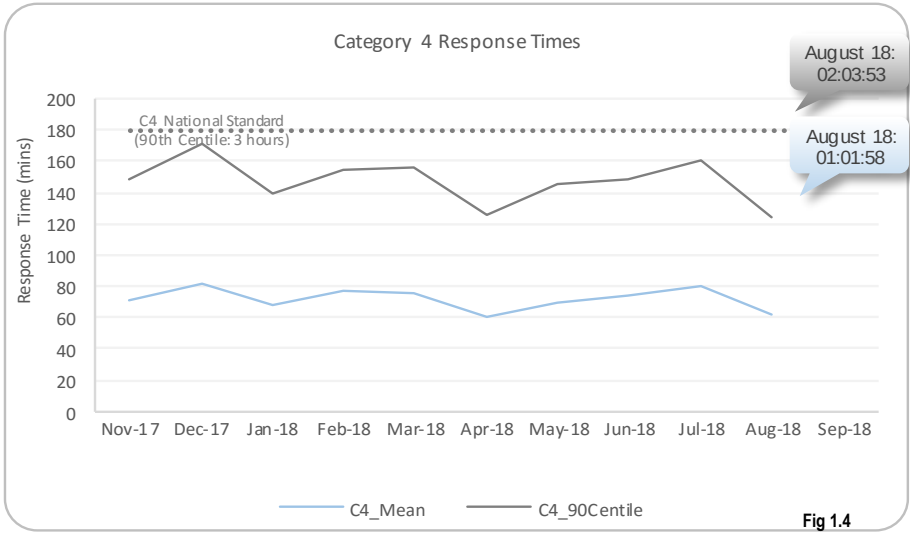


Fig 1.4

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

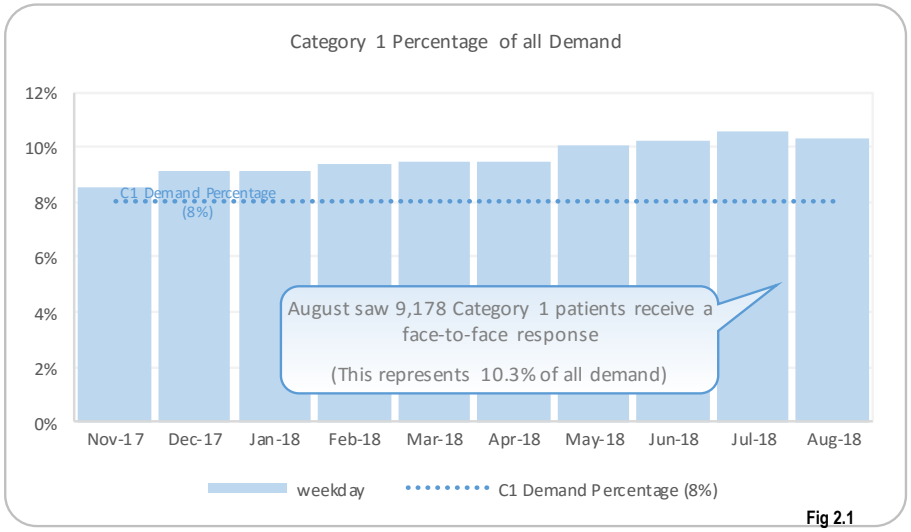


Fig 2.1

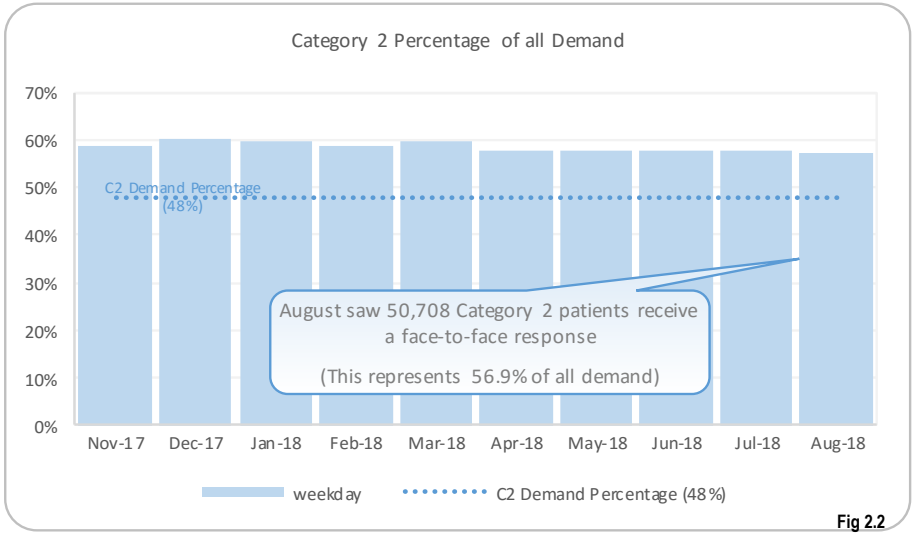


Fig 2.2

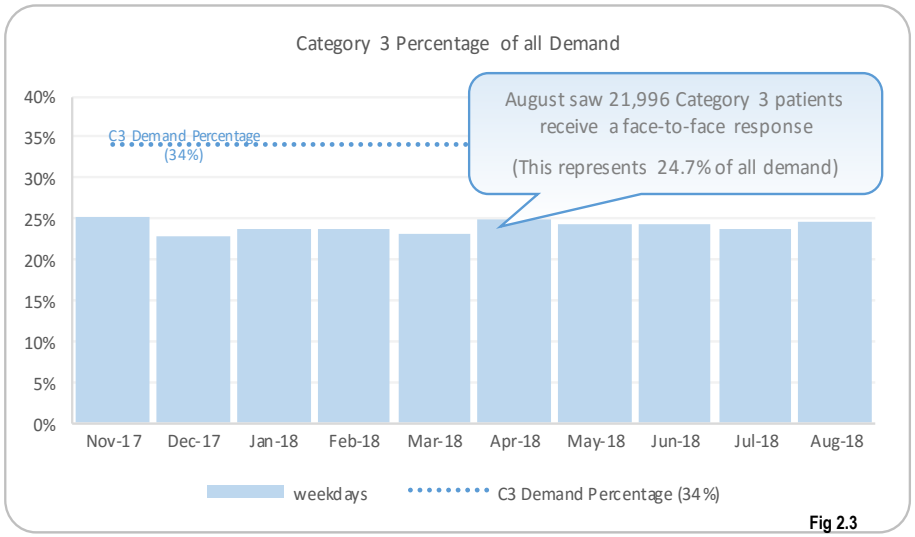


Fig 2.3

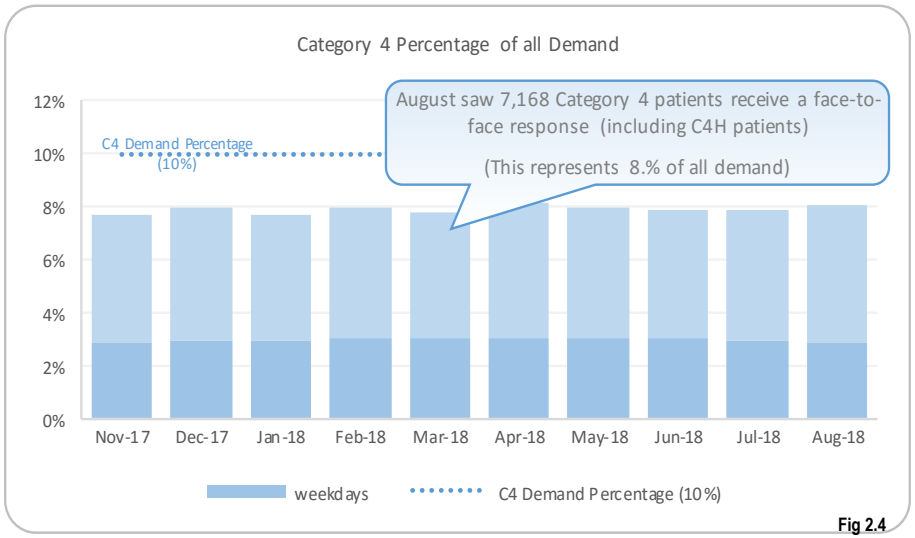


Fig 2.4

Performance Overview
90th Centile Performance

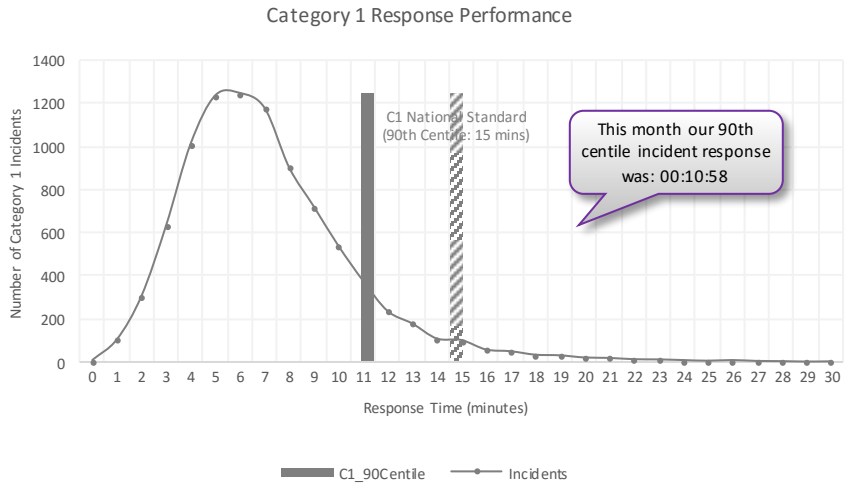


Fig 3.1

- Fig 3.1 Demonstrates the response distribution for Category 1 incidents.

The LAS 90th centile response time in **August** was **00:10:58** minutes. This is **within** the 15 minute National Standard as set out in the guidelines by NHSI.

Of the 9,178 incidents requiring a Category 1 response, 8,260 incidents received a face to face response within 00:10:58 minutes.

The LAS 90th centile has been **consistently within the 15 minutes** standard **each week** since ARP was implemented.

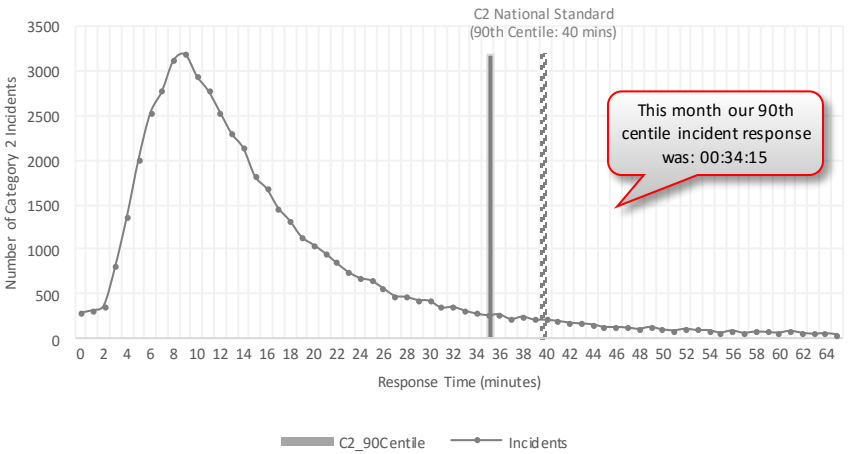


Fig 3.2

- Fig 3.2 Demonstrates the response distribution for Category 2 incidents.

The LAS 90th centile response time in **August** was **00:34:15** minutes, this is **within** the 40 minute National Standard as set out in the guidelines by NHSI.

Of the 50,708 incidents requiring a Category 2 response, 45,630 incidents received a face to face response within 00:34:15 minutes.

Performance Overview
90th Centile Performance

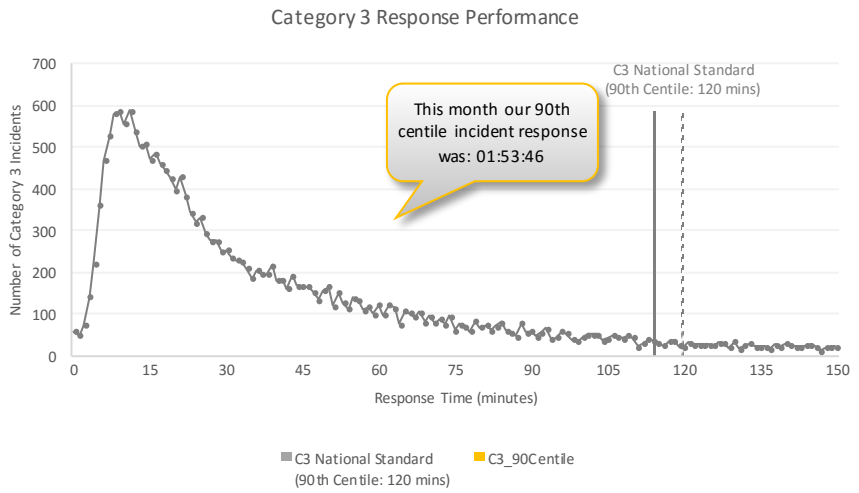


Fig 3.3

- Fig 3.3 Demonstrates the response distribution for Category 3 incidents.

The LAS 90th centile response time in **August** was **01:53:46** minutes. This is **within** the 2 hour National Standard as set out in the guidelines by NHSI.

Of the 21,996 incidents requiring a Category 3 response, 19,885 incidents received a face to face response within 01:53:46 minutes.

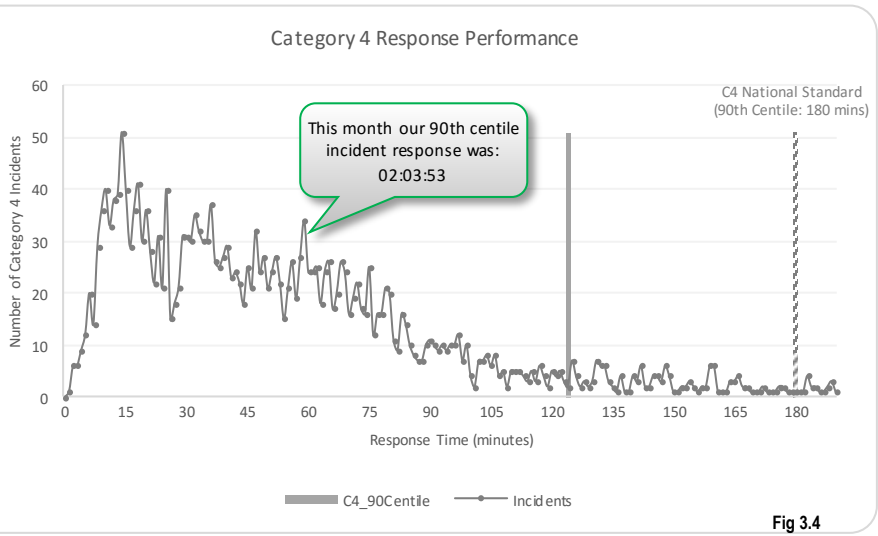


Fig 3.4

- Fig 3.2 Demonstrates the response distribution for Category 4 incidents.

The LAS 90th centile response time in **August** was **02:03:53** minutes, **within** the 3 hour National Standard as set out in the guidelines by NHSI.

Of the 2,545 incidents requiring a Category 4 response, 2,290 incidents received a face to face response within 02:03:53 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 (Aug 18)	National Standard	Variance
Category 1	Mean Response Time	**00:06:43**	7 minutes	**00:00:17**
	90th centile	**00:10:58**	15 minutes	**00:04:02**
Category 2	Mean Response Time	**00:17:06**	18 minutes	**00:00:54**
	90th centile	**00:34:15**	40 minutes	**00:05:45**
Category 3	Mean Response Time	**00:49:17**	60 minutes	**00:10:43**
	90th centile	**01:53:46**	120 minutes (2 hours)	**00:06:14**
Category 4	90th centile	**02:03:53**	180 minutes (3 hours)	**00:56:07**

Performance Overview
National Picture

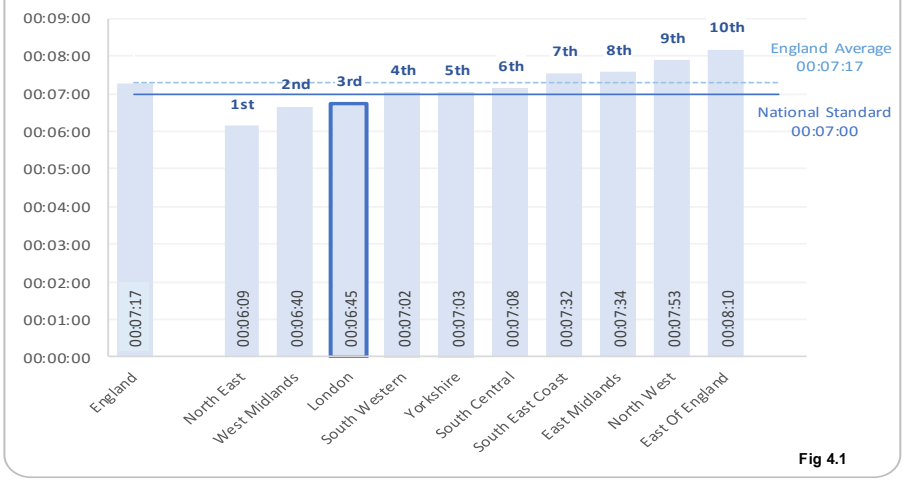


Fig 4.1

- Fig 4.1 Illustrates the Category 1 Mean Response Performance for Ambulance Trusts across England.

Additional information also displayed :

- The National Standard
- The average for England
- The ranking position for each Trust

- LAS achieved **6 minutes 45 seconds** for the **mean** response time for **Category 1** patients. This is **within** the 7 minute national standard.

- LAS performed **within** the England average.

Fig. 4.2 Displays key ARP performance measures for each Ambulance Trust across England.

The **LAS ranking improved** in **all** measures.

- **LAS ranked 2nd** in the **Category 1 90th Centile** performance measure, compared to the other Trusts.

- For the **Category 4 90th Centile**, LAS ranked **2nd.**

August 2018	Mean Category 1	90th Centile Category 1	Mean Category 2	90th Centile Category 2	Mean Category 3	90th Centile Category 3	90th Centile Category 4
National Standard	00:07:00	00:15:00	00:18:00	00:40:00	01:00:00	02:00:00	03:00:00
England	00:07:17	00:12:46	00:20:42	00:42:34	00:57:34	02:15:18	02:56:14
East Midlands	00:07:34	00:13:48	00:31:29	01:06:53	01:14:32	03:02:22	02:47:18
East of England	00:08:10	00:14:59	00:24:53	00:52:03	01:16:44	03:04:20	03:36:41
London	00:06:45	00:10:58	00:17:05	00:34:15	00:49:18	01:53:55	02:03:53
North East	00:06:09	00:10:23	00:19:01	00:38:41	01:07:30	02:37:53	02:52:47
North West	00:07:53	00:13:20	00:21:47	00:46:25	01:00:07	02:21:31	02:58:10
South Central	00:07:08	00:13:07	00:15:23	00:30:30	00:47:35	01:53:24	02:41:41
South East Coast	00:07:32	00:14:17	00:18:15	00:35:07	01:19:39	03:08:43	03:37:10
South Western	00:07:02	00:13:00	00:26:43	00:56:52	01:11:15	02:44:12	06:05:07
West Midlands	00:06:40	00:11:23	00:11:42	00:21:17	00:29:32	01:04:32	01:42:38
Yorkshire	00:07:03	00:12:05	00:19:26	00:39:47	00:50:51	01:59:28	02:45:48
Isle of Wight	00:09:49	00:20:21	00:12:59	00:30:22	00:49:22	02:59:39	03:56:11

Fig 4.2

Performance Overview

Performance by STP

These tables show key performance measures for July and August 2018 profiled by STP.

All STP areas remained **within** the 7 minute national standard (and inexorably within in the 9 minute safety standard) for **Cat 1 mean**.

- **All STP** areas saw **improved performance** across for **all key measures**.
- South West, South East and North East performed **within** the **national standards** for **all** these measures.
- Despite marginally missing the targets for two measures, the North Central STP saw the greatest improvement across all measures.

August 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 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:06:36	00:10:58	00:18:03	00:36:04	00:55:53	02:10:46	01:55:41
North East	00:06:47	00:11:06	00:16:48	00:33:06	00:50:06	01:55:29	02:20:18
North West	00:06:51	00:11:06	00:17:31	00:35:36	00:52:04	02:03:46	02:08:57
South East	00:06:42	00:10:51	00:16:09	00:31:50	00:44:01	01:41:22	01:49:16
South West	00:06:35	00:10:41	00:16:58	00:33:42	00:44:56	01:43:33	01:46:45

July 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 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:07:22	00:11:58	00:23:27	00:48:38	01:24:06	03:24:04	03:32:48
North East	00:07:19	00:12:12	00:19:24	00:38:39	01:01:28	02:23:40	02:36:25
North West	00:07:28	00:12:07	00:22:30	00:48:30	01:10:06	02:48:20	03:03:54
South East	00:07:20	00:11:59	00:19:10	00:40:01	00:53:30	02:08:51	02:11:09
South West	00:07:47	00:12:49	00:22:04	00:46:55	01:04:23	02:32:00	02:33:30

Performance Overview
Call Answering Performance

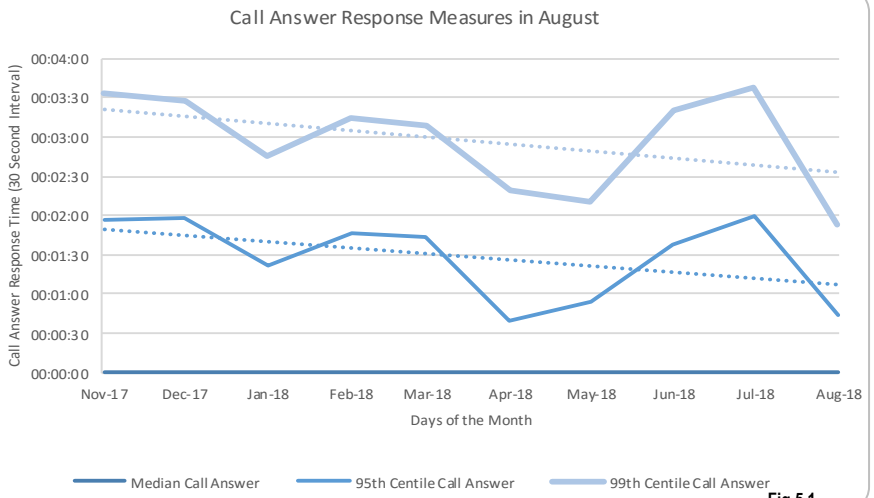


Fig 5.1

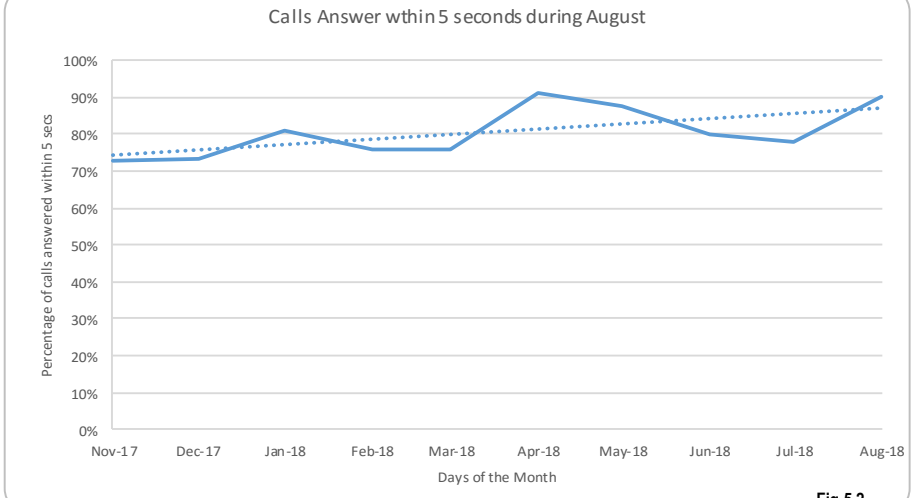


Fig 5.2

- Figure 5.1 demonstrates **three key measures** for call answering under the Ambulance Response Programme (ARP).

- During August 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 **44 seconds.**
  - In other words 95 out of every 100 calls were answered in less than 2 minutes.

- 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.

To illustrate, the graph shows the daily call taking performance in the month.

- In August 90% of all calls received into the EOC were answered within five seconds.

August saw a **considerable** improvement in call taking performance as demonstrated by the graphs above. Fig. 5.1 continues to show a positive downward trend, and conversely Fig. 5.2 shows a positive upward trend.

Hospital Handover Summary
Hospital Conveyance Lost Hours

Non-blue calls. Arrival at hospital to patient handover, August 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)	Total Handovers Over 30 mins	Total Handovers Over 60 mins	12 Week Trend
Barnet	1549	1482	400	27%	8	56	56	6	
North Middlesex	2556	2448	1492	61%	10	246	326	17	
Royal Free	1511	1411	929	66%	11	171	225	33	
University College	1830	1762	974	55%	9	138	159	7	
Whittington	1395	1342	520	39%	9	78	71	14	
Homerton	1394	1355	381	28%	5	31	23	1	
King Georges	1279	1229	1090	89%	12	215	358	2	
Newham	1986	1921	1433	75%	9	217	284	4	
Queens Romford	2971	2877	2315	80%	13	515	783	44	
Royal London	2290	2209	1302	59%	8	176	217	2	
Whipps Cross	1924	1809	1426	79%	13	305	478	30	
Charing Cross	1355	1294	687	53%	6	65	44	0	
Chelsea & West	1298	1249	396	32%	6	41	26	2	
Ealing	1380	1322	476	36%	7	52	50	1	
Hillingdon	1747	1683	1272	76%	19	396	522	78	
Northwick Park	3052	2912	1157	40%	12	240	367	9	
St Marys	1950	1859	1207	65%	8	166	173	1	
St Thomas'	2474	2320	1405	61%	7	161	130	0	
West Middlesex	1887	1845	740	40%	6	79	78	2	
Kings College	2131	2023	1401	69%	8	193	198	3	
Lewisham	1525	1410	832	59%	9	119	95	15	
Princess Royal	1892	1772	806	45%	18	240	243	89	
Queen Elizabeth II	2388	2303	651	28%	13	146	119	46	
Croydon	2060	1984	1483	75%	14	340	413	80	
Kingston	1580	1497	1033	69%	6	98	29	0	
St Georges	2097	1983	1377	69%	9	196	211	4	
St Helier	1312	1258	837	67%	9	122	124	10	
LAS TOTAL					10	4,802			

Non-blue calls. Patient Handover to Green, August 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)	Total Handovers Over 30 mins	Total Handovers Over 60 mins	12 Week Trend
Barnet	1549	1482	885	60%	6	93	70	3	
North Middlesex	2556	2448	1370	56%	8	173	164	8	
Royal Free	1511	1411	706	50%	6	74	49	1	
University College	1830	1762	1049	60%	8	132	106	3	
Whittington	1395	1342	743	55%	8	95	98	7	
Homerton	1394	1355	788	58%	7	97	89	3	
King Georges	1279	1229	574	47%	6	54	32	2	
Newham	1986	1921	974	51%	6	103	84	5	
Queens Romford	2971	2877	1574	55%	6	151	119	7	
Royal London	2290	2209	1236	56%	7	144	133	4	
Whipps Cross	1924	1809	916	51%	7	100	79	5	
Charing Cross	1355	1294	585	45%	6	55	41	1	
Chelsea & West	1298	1249	736	59%	7	84	58	2	
Ealing	1380	1322	605	46%	5	55	35	3	
Hillingdon	1747	1683	792	47%	5	68	36	0	
Northwick Park	3052	2912	1434	49%	6	142	97	3	
St Marys	1950	1859	940	51%	7	105	75	7	
St Thomas'	2474	2320	1161	50%	6	124	95	6	
West Middlesex	1887	1845	825	45%	5	63	38	1	
Kings College	2131	2023	982	49%	6	97	63	6	
Lewisham	1525	1410	630	45%	4	41	24	2	
Princess Royal	1892	1772	879	50%	5	73	42	1	
Queen Elizabeth II	2388	2303	982	43%	3	57	34	6	
Croydon	2060	1984	1024	52%	5	89	48	4	
Kingston	1580	1497	705	47%	5	59	42	3	
St Georges	2097	1983	1011	51%	6	100	67	5	
St Helier	1312	1258	656	52%	5	50	20	1	
LAS TOTAL					6	2,476			

Hospital Handover Summary
Hospital Conveyance by Location

This map shows the relative location of each ED hospital across London.

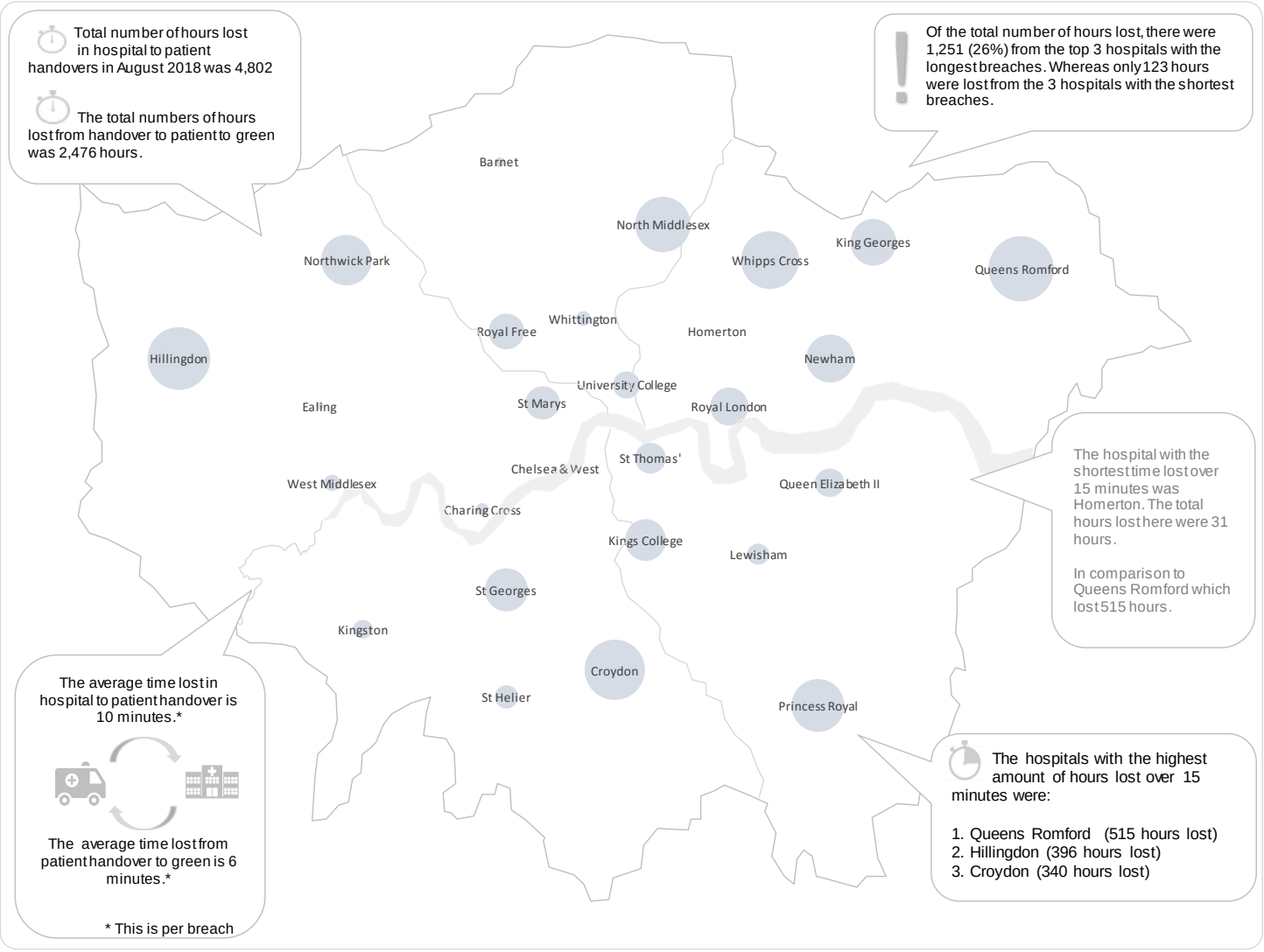
The size of the bubble relates to the comparative hours lost* at that hospital.

- The smaller the bubble, the fewer hours lost at hospital.
- The larger the bubble, the more hours lost at hospital.

* Total time accrued after 15 minutes, for arrival at hospital to patient handover.

Highest number of hours lost.

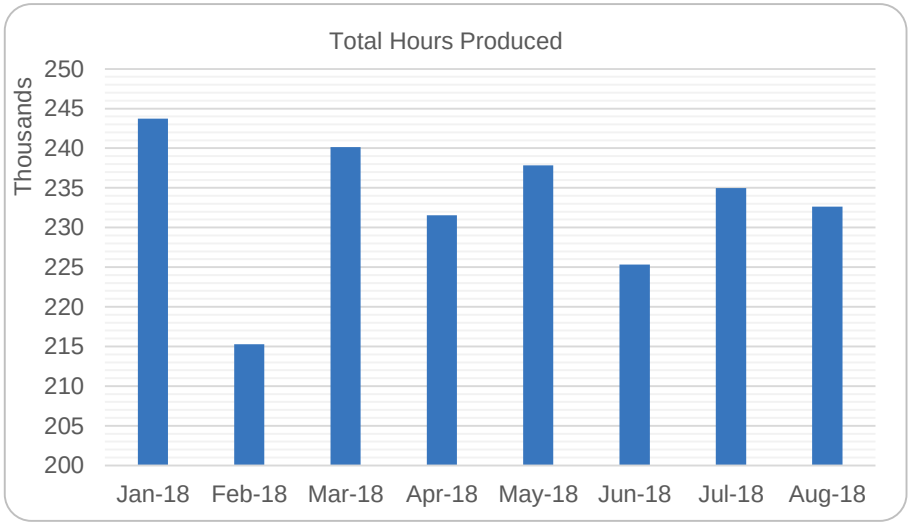
Lowest number of hours lost.

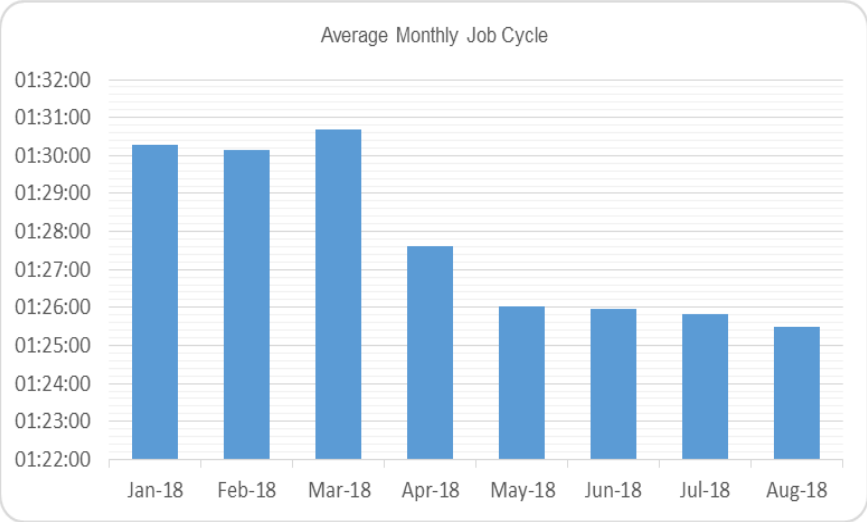


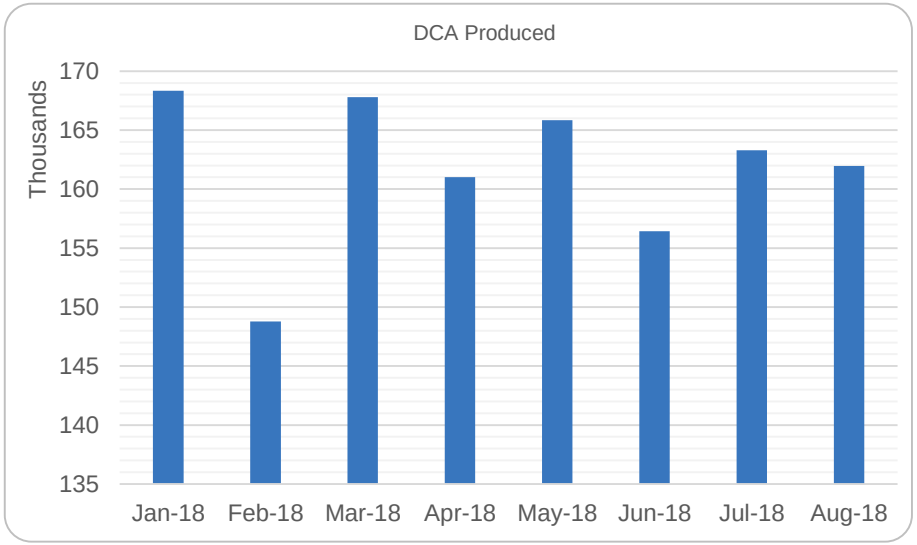
Job Cycle & Capacity
Ambulance Response Programme

- The graphs below shows the Job Cycle Time on average per month since the implementation of the Ambulance Response Programme.
    - It demonstrates that the JCT has decreased slightly from the previous month but remains steady.

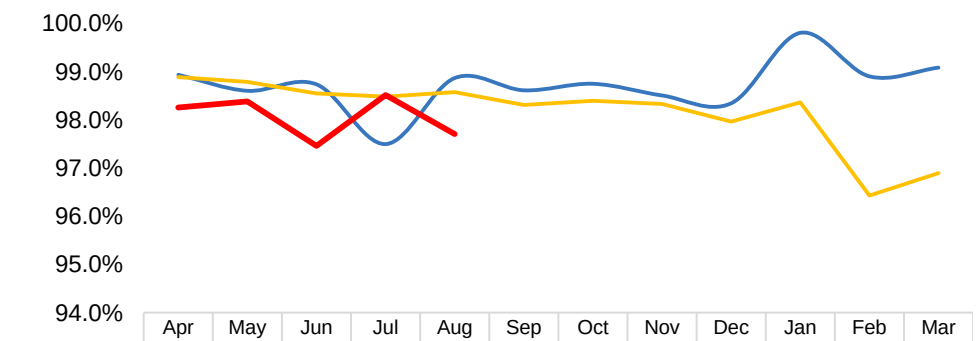
- The graphs opposite show the number of hours produced on average per month since the implementation of the Ambulance Response Programme.
    - August shows a slight decrease of 1% in Total Hours Produced.







LAS 111 (South East London)
Demand and Capacity



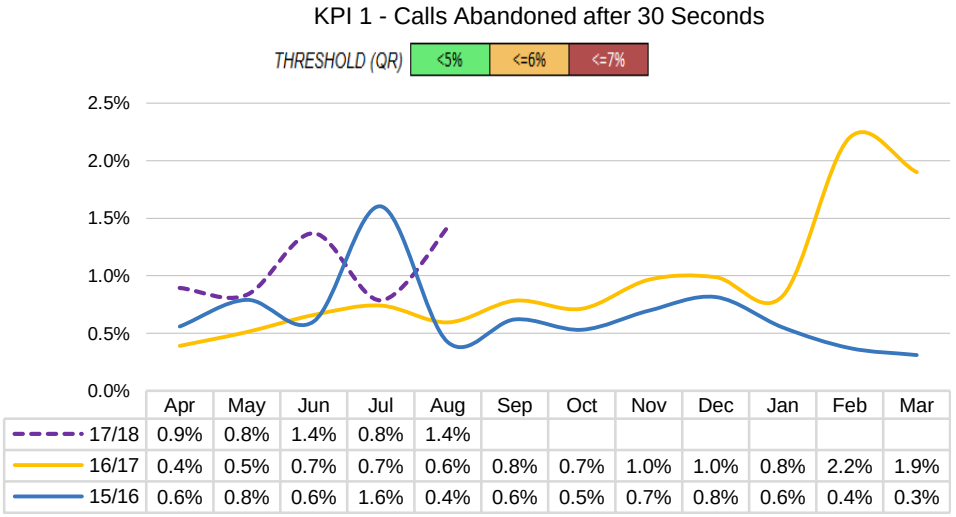
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
%16/17	98.9%	98.6%	98.7%	97.5%	98.9%	98.6%	98.8%	98.5%	98.3%	99.8%	98.9%	99.1%
%17/18	98.9%	98.8%	98.6%	98.5%	98.6%	98.3%	98.4%	98.3%	98.0%	98.4%	96.4%	96.9%
%18/19	98.3%	98.4%	97.5%	98.5%	97.7%							

Demand: Call volume was slightly higher than the previous month and 7.3% higher than in August 2017.

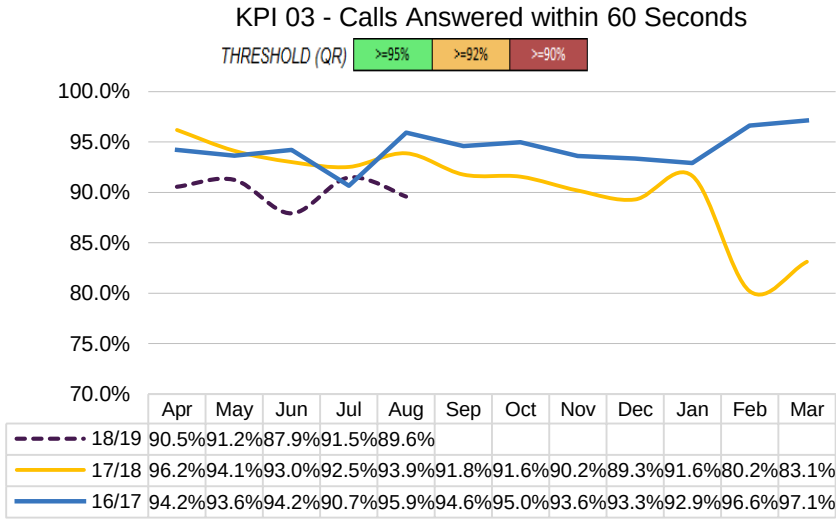
Capacity: Demand exceeded capacity in August. There were additional challenges with the requirement to support the North East London Integrated Urgent Care service in its first month of operation. This saw SEL take up to 40% of calls on behalf of North East London.

Efficiency: The percentage of calls answered in 60 seconds was 89.6% in August, with the target achieved on 12 days. The audit focus has been on ensuring appropriate referrals to 999 from clinicians, with 82.6% of referrals deemed appropriate.

Service Projects: The service focus throughout August has been on preparing for mobilisation of the Integrated Urgent Care Service in South East London



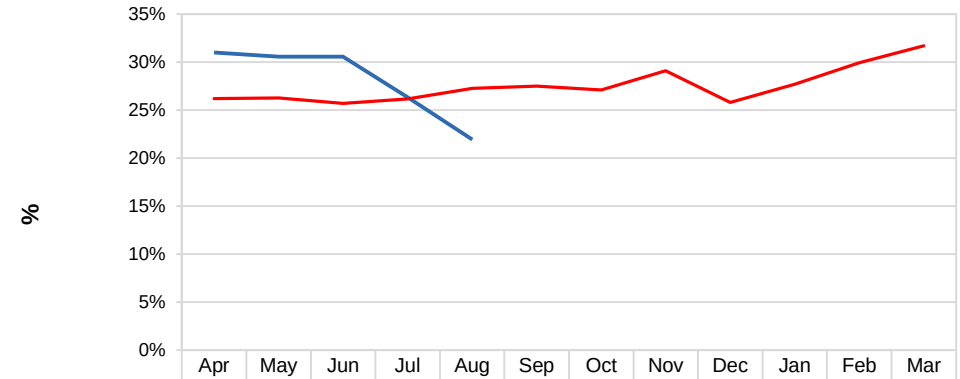
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.9%	0.8%	1.4%	0.8%	1.4%							
16/17	0.4%	0.5%	0.7%	0.7%	0.6%	0.8%	0.7%	1.0%	1.0%	0.8%	2.2%	1.9%
15/16	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	90.5%	91.2%	87.9%	91.5%	89.6%							
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



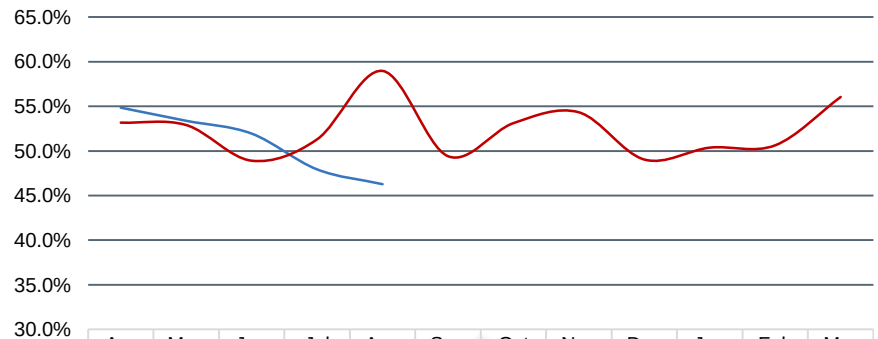
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
current year	31.0%	30.6%	30.6%	26.3%	22.0%							
Prev Year	26.2%	26.3%	25.7%	26.2%	27.3%	27.5%	27.1%	29.1%	25.8%	27.7%	29.9%	31.7%

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 Green ambulance outcomes and availability of Clinical Advisors to accept a warm transfer. A prioritisation system is in place to inform those decisions.

Safety: There were 49 Incidents in Datix with completed investigations in August. Of these, 45% (n=22) related to authorised breaches in confidentiality including safeguarding referrals made without patient consent, 4% (n=2) to failure to follow procedure, 21% (n=10) to delay in care. 2% (n=1) was due to equipment failure, 12% (n=6) due to poor handover to external agency and the remaining 16% (n=8) closed with no further action required. Incidents are under investigation and feedback is given to staff where appropriate.

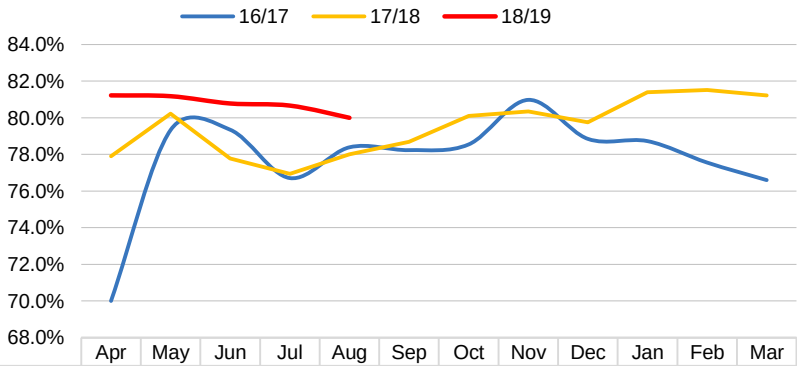
No Serious Incidents (SIs) were identified and the service received four complaints, three HCP feedback, two compliments and one complaint received about another organisation.

KPI 05
calls % warm transferred
(P1=10 min, P2=20 min, P3=60 min)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
current year	54.9%	53.4%	51.9%	47.9%	46.3%							
prev 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%

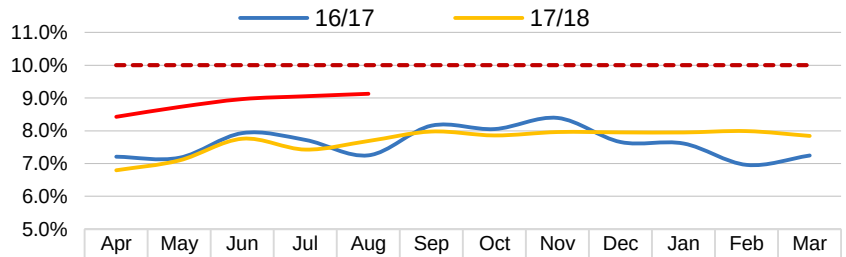
KPI 04 - Percentage (%) of answered calls Triaged



	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%	81.2%	80.8%	80.7%	80.0%							

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%	8.7%	9.0%	9.1%	9.1%							
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%

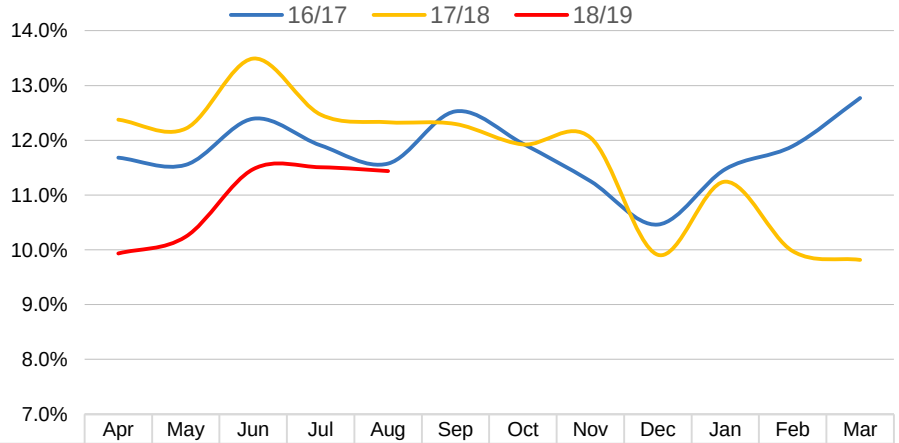
LAS 111 had the second lowest referral rate to 999 in London and second highest percentage of enhanced re-assessment for Green ambulance outcomes.

Work is on-going to identify the root cause of the increase in the percentage of referrals to 999, although audit quality data suggests an increasing number of these referrals are deemed appropriate.

An increase in demand outstripping capacity has resulted in the increased percentage of patients referred to ETC, as revalidation of ETC outcomes is suspended during times of surge.

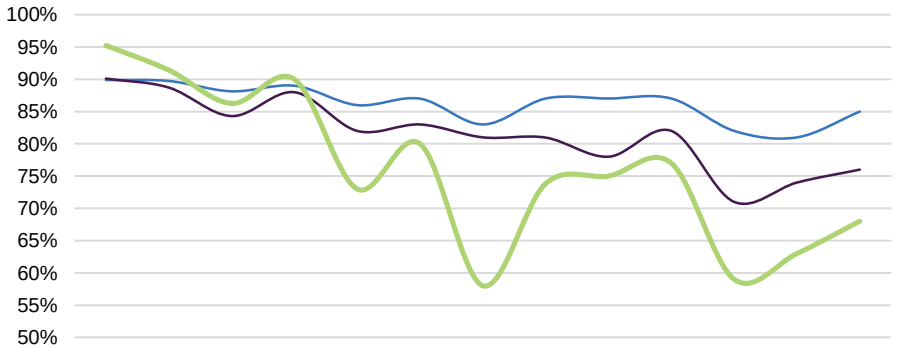
Call back performance for Priority 1 patients has improved by 4% in August and performance has also improved for both Priority 2 and 3 patients.

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%	10.2%	11.5%	11.5%	11.4%							

KPI 7,8,9 Call Backs and warm transfers (P1=10 min, P2=20 min, P3=60 min)



	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
P1 (10)	90%	90%	88%	89%	86%	87%	83%	87%	87%	87%	82%	81%	85%
P2 (20)	90%	89%	84%	88%	82%	83%	81%	81%	78%	82%	71%	74%	76%
P3(60)	95%	91%	86%	90%	73%	80%	58%	74%	75%	77%	59%	63%	68%

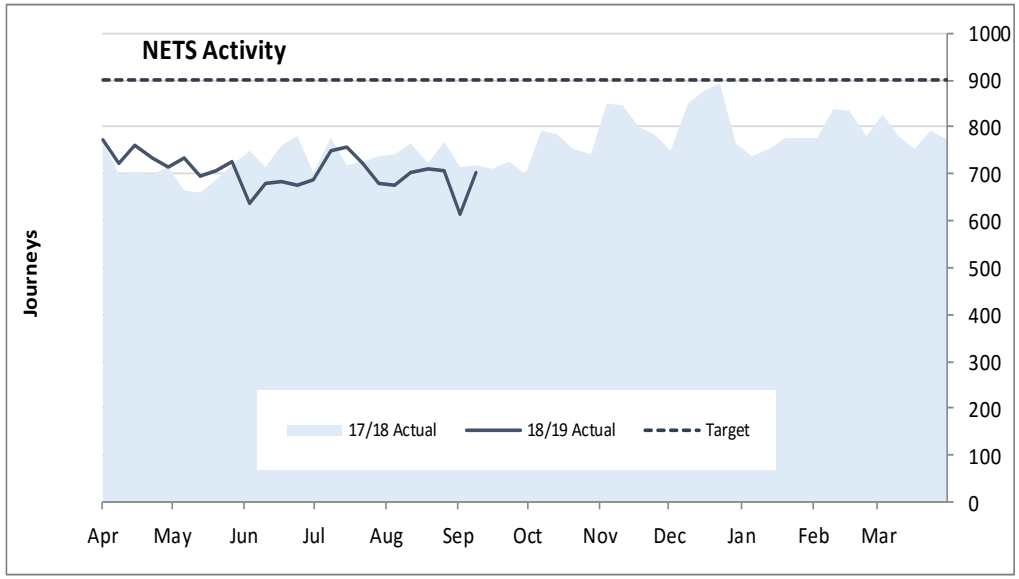
LAS 111 (South East London)
London and National Comparison

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 three 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 August 2018.

August 2018										
Description	Target	LAS SEL	LAS NEL	Care UK	LCW	Vocare	London	LAS- SEL ranking (pan-London)	LAS- NEL ranking (pan-London)	England
Total calls answered	N/A	33,137	29,513	23,180	43,082	25,231	156,655			1,128,770
% of Calls answered within 60 seconds	95%	89.57%	88.81%	96.00%	90.39%	86.74%	89.72%	3	4	85.42%
% of Calls abandoned after 30 seconds	5%	1.42%	4.68%	0.53%	1.53%	2.26%	2.42%	2	5	3.11%
% of Calls transferred to, or answered by a clinical advisor	N/A	21.12%	12.29%	22.67%	22.08%	30.11%	22.48%			24.03%
Of calls transferred, percentage transferred warm	N/A	44.27%	28.69%	19.26%	50.58%	42.29%	43.63%			30.71%
Of call backs, percentage within 10 minutes	100%	44.71%	48.25%	48.46%	46.17%	49.09%	48.87%	5	3	38.64%
% of Calls referred to 999	10%	9.05%	7.98%	10.67%	9.11%	10.70%	9.62%	2	1	11.47%
% of Calls referred to Emergency Department	N/A	13.51%	8.56%	10.10%	12.26%	14.61%	11.40%	4	1	9.41%

*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 31st August 2018**

Non-Emergency Transport Service



Week Commencing	Total Calls available to NETS	Calls Cancelled	Calls Returned	Calls Completed by NETS Incidents
02/07/2018	1061	12	293	756
09/07/2018	1061	6	297	758
16/07/2018	1031	22	286	723
23/07/2018	1005	18	307	680
30/07/2018	988	13	299	676
06/08/2018	930	10	217	703
13/08/2018	905	2	192	711
20/08/2018	952	10	236	706
27/08/2018	796	1	181	614

Non-Emergency Transport Update

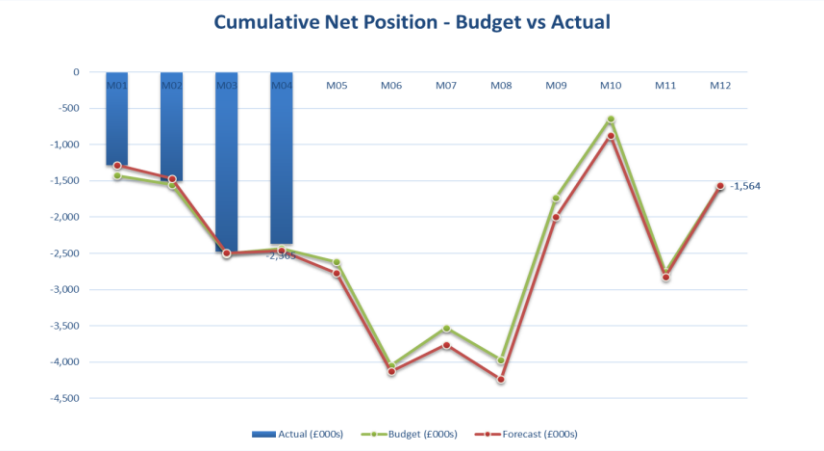
- NETs saw an decrease in the month and delivered an average of 683 journeys per week for the month, down from the previous month average of 729
- During August we saw the NETs overall weekly performance being maintain at a level in line with the impacts of resources, activity levels and waiting times. Activity in the final week in August was impacted by the Bank Holiday and the low number of HCP referrals due to summer holidays.
- 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 decreased from last months 1,039 calls per week to 895 calls per week for the month.
- NETS staffing/resourcing was also impacted by high rates of both short & long term sickness over the month averaging at 6.5% up from last months 7.0%.
- Performance continued to suffer due to increasingly lengthy handover times at hospitals with specific issues with Queens, Northwick Park and Hillingdon hospitals.
- From the review conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETs and completed

Our Money

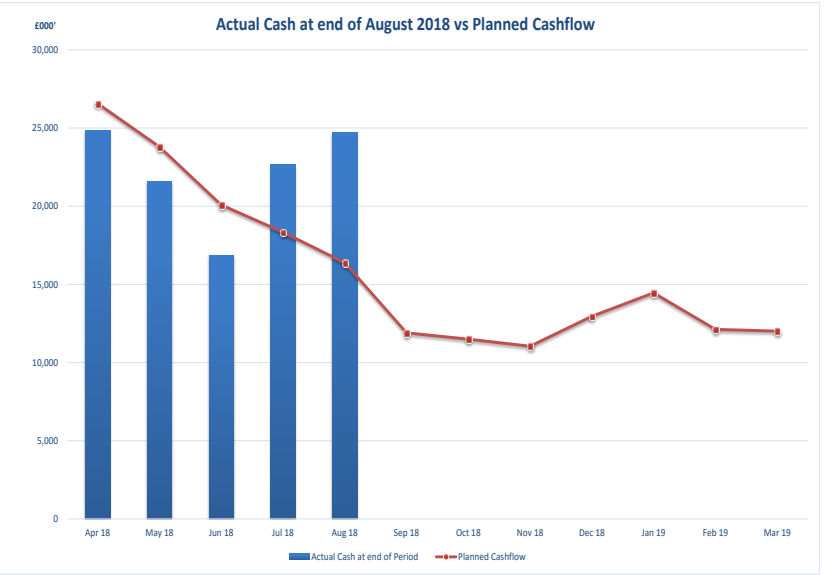
Financial Indicator	Summary Performance	Forecast Outturn	Current Month	Previous month
Surplus / Deficit (Year to date and Forecast)	Year to date the position is £0.1m ahead of plan. The Trust is forecasting achieving its control total of £1.564m deficit. Key issues in the position are: • Main contract activity for month 5 YTD is 0.1% above contract, and the variable income in relation to this (£0.113m) has been recognised in the Trust accounts as over performance. The Trust plan included 1.7% £4.6m (Full Year) of expected growth above the contract baseline, The Trust is therefore £1.8m behind planned income at the end of month 4. The forecast assumes that the Trust will deliver the contract level of activity but not the planned growth of £1.7% (£4.6m) • Pay underspends through frontline vacancies (£3m YTD) are offsetting non pay overspends.	AMBER	RED	GREEN
Income	YTD income is £2.8m adverse due to: • Main contract activity for month 5 YTD is 0.1% higher than contract, and the variable income in relation to this (£0.113m) has been recognised in the Trust accounts as over performance. The Trust plan included £4.6m (Full year) of expected growth above the contract baseline. The Trust is therefore £1.8m behind planned income at the end of month 5. • Budget adjustments £0.9m (A&E contract phasing £0.4m, £0.5m service penalty). • £300k credit for taxis 2017/18.	AMBER	AMBER	AMBER
Expenditure (incl. Financial Charges)	YTD expenditure is £2.9m favourable to plan due to: • Vacancies in frontline covered partially by overtime £0.9m. • Depreciation behind plan due to slippage in capital programme £0.6m. • Budget adjustment £0.8m (service penalty).	GREEN	AMBER	AMBER
CIPs	In month CIP was £1.1m and YTD £4.5m both on plan. Delivery of the full year target within the desired recurrent Vs non-recurrent ratios will required continued focus for the remainder of the year to ensure the Trust delivers the £12.3m whilst not exceeding the 25% non-recurrent target.	GREEN	GREEN	AMBER
Balance Sheet	Capital spend is £4.2m to M5 which is £3.4m behind plan YTD. The Trust was awarded £3.8m capital funding from the sustainability and transformation partnership ambulance scheme to buy 25 Ambulances. This is in addition to the £17.1m already planned for 2018/19.	AMBER	AMBER	AMBER
Cashflow	Cash is forecast to be £24.7m as at 31 August 2018, £8.3m above plan. This is made up of a number of offsetting variances. An analysis of the cash position shows that receipts from income are £6.9m above planned due to £5.8m 2017/18 STF Q4 and Bonus cash being received in month 4, £1.8m NEL contract income and NHSE £1.1m pay award funding received but not in plan and delays in receipt of contract income SLA (£1.8m), there are higher than planned creditor payments of £5.1m due to the recovery to normal payment service by our outsourced accounts provider, NEL set-up and operating costs and higher than planned in year non-pay spend. These are being offset by under payments of £4.3m on capital, £1.6m on pay and £0.6m on provisions.	GREEN	GREEN	GREEN
BPPC	Non-NHS 84%, NHS 88% 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 5 2018-19 £000			YTD Month 5 2018-19 £000			Full Year 2018-19 £000
	Budget	Actual	Variance fav / (adv)	Budget	Actual	Variance fav / (adv)	Budget
Surplus / (Deficits)	(453)	(1,510)	(1,057)	(3,971)	(3,876)	95	(1,564)
EFL				13,914	5,585	8,329	18,288
CRL				7,627	4,206	3,421	17,126
Suppliers paid within 30 days - NHS	95%	88%	(7.0%)	95%	92%	(3.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	84%	(11.0%)	95%	84%	(11.0%)	95%
EBITDA %	3.6%	-0.1%	(3.7%)	2.7%	2.4%	(0.3%)	5.0%
EBITDA	1,162	(38)	(1,199)	4,181	3,636	(544)	18,837
NRAF (net return after financing)				(1.08%)	(0.65%)	0.4%	(1.9%)
Liquidity Days				(3.53)	(0.94)	2.59	(2.21)
Use of Resources Rating				3.0	3.0	0.0	2.0



- Year to date the position is on plan. The Trust has a full year outturn plan of £1.564m deficit.
- Income is £1.8m behind plan due to the budget including over activity at 1.7% and actual activity being 0.1% ahead of contracted levels.
- The Trust is £3.4m behind a capital plan of £7.6m YTD. The Trust was awarded £3.8m capital funding from the sustainability and transformation partnership ambulance schemes to fund the purchase of additional ambulances so The Trust CRL of £15.5m has been increased to £19.3m.
- Cash is forecast to be £24.7m as at 31 August 2018, £8.3m above plan. This is made up of a number of offsetting variances. An analysis of the cash position shows that receipts from income are £6.9m above planned due to £5.8m 2017/18 STF Q4 and Bonus cash being received in month 4, £1.8m NEL contract income and NHSE £1.1m pay award funding received but not in plan and delays in receipt of contract income SLA (£1.8m), there are higher than planned creditor payments of £5.1m due to the recovery to normal payment service by our outsourced accounts provider, NEL set-up and operating costs and higher than planned in year non-pay spend. These are being offset by under payments of £4.3m on capital, £1.6m on pay and £0.6m on provisions.
- Non-NHS 84%, NHS 88% performance (volume) for this month, performance is still below 95% target.

Statement of Comprehensive Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Month 5 2018-19 £000			YTD Month 5 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	30,997	30,129	(867)	151,118	148,533	(2,585)	368,955	363,823	(5,132)
Other Operating Income	1,465	1,379	(86)	2,831	2,618	(213)	8,915	7,719	(1,195)
Total Income	**32,462**	**31,508**	**(953)**	**153,949**	**151,151**	**(2,798)**	**377,870**	**371,543**	**(6,327)**
Operating Expense									
Pay	(24,515)	(24,807)	(293)	(115,996)	(112,939)	3,057	(280,902)	(274,580)	6,323
Non Pay	(6,786)	(6,739)	47	(33,773)	(34,577)	(804)	(78,130)	(78,532)	(402)
Total Operating Expenditure	**(31,300)**	**(31,546)**	**(246)**	**(149,768)**	**(147,515)**	**2,253**	**(359,032)**	**(353,112)**	**5,921**
EBITDA	**1,162**	**(38)**	**(1,199)**	**4,181**	**3,636**	**(544)**	**18,837**	**18,431**	**(406)**
EBITDA margin	3.6%	(0.1%)	(3.7%)	2.7%	2.4%	(0.3%)	5.0%	5.0%	(0.1%)
Depreciation & Financing									
Depreciation & Amortisation	(1,271)	(1,180)	90	(6,415)	(5,841)	575	(16,241)	(15,784)	457
PDC Dividend	(350)	(350)	0	(1,750)	(1,750)	0	(4,200)	(4,200)	0
Finance Income	8	15	7	25	52	26	67	91	24
Finance Costs	(2)	(1)	1	(11)	(4)	7	(27)	(20)	7
Gains & Losses on Disposals	0	43	43	0	31	31	0	31	31
Total Depreciation & Finance Costs	**(1,615)**	**(1,473)**	**142**	**(8,151)**	**(7,512)**	**639**	**(20,401)**	**(19,883)**	**519**
Net Surplus/(Deficit)	**(453)**	**(1,510)**	**(1,057)**	**(3,971)**	**(3,876)**	**95**	**(1,564)**	**(1,452)**	**112**
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	0	16	16	(0)	38	38	0
Remove STP funding 2016/17	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance	**(450)**	**(1,507)**	**(1,057)**	**(3,955)**	**(3,860)**	**95**	**(1,526)**	**(1,414)**	**112**
Net margin	(1.4%)	(4.8%)	(3.4%)	(2.6%)	(2.6%)	0.0%	(0.4%)	(0.4%)	0.3%

Income

- Main contract activity for month 5 YTD is 0.1% higher than contract, and the variable income in relation to this (£0.113m) has been recognised in the Trust accounts as over performance. The Trust plan included £4.6m (Full Year) of expected growth above the contract baseline, the Trust is therefore £1.8m behind planned income at the end of month 5. The Trust has now reflected no income growth above contract in the forecast. Further recovery actions are now required to ensure the Trust delivers the required control total. These are set out in the forecast below.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £3m lower than plan YTD , due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure £1.9m and agency spend £0.8m.
- Non-Pay is over by £0.8m YTD due to overspends on consultancy & professional fees (£0.5m), conflict resolution training (£0.5m), Subsistence (£0.2m), Uniforms (£0.3m) , Adastra in EOC (£0.2m), Fuel (£0.3m), Medical gases and surgical items (£0.3m).
- Forecast Non pay expenditure has been adjusted for anticipated saving to be delivered through recovery plans listed below.

EBITDA

- The Trust delivered an EBITDA of £3,674k in July which represents EBITDA margin of 3.1%.

Depreciation and Financing

- Overall Financial Charges are £0.1m favourable at the end of June due to year to date slippage in the Capital programme.

Main Contract Variable Income

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Month:	Aug-18	2018-19 YTD Contract Plan	2018-19 YTD Actual Activity	2018-19 Actual Activity Increase / (Decrease) vs Contract Base	Total Incidents Difference to Contract Base (%)	£ 239.37	CCG Split Based on Incident Difference
Area	CCG Names	Cat 1	Cat 1	Total Incidents		Total Additional Charge or (Credit) at 85% Margina	
NEL	NHS City and Hackney CCG	15,524	16,147	623	4.01%		149,128
NEL	NHS Newham CCG	17,086	17,670	584	3.42%		139,792
NEL	NHS Tower Hamlets CCG	14,396	15,014	618	4.29%		147,931
NEL	NHS Waltham Forest CCG	12,891	13,180	289	2.24%		69,178
NEL	NHS Barking and Dagenham CCG	12,041	12,089	48	0.40%		11,490
NEL	NHS Havering CCG	14,500	14,813	313	2.16%		74,923
NEL	NHS Redbridge CCG	14,455	14,797	342	2.37%		81,865
NEL	**NEL Total**	**100,893**	**103,710**	**2,817**	**2.79%**	**674,305**	**674,305**
NCL	NHS Barnet CCG	18,377	17,593	-784	-4.27%		(187,666)
NCL	NHS Camden CCG	15,261	14,546	-715	-4.69%		(171,150)
NCL	NHS Enfield CCG	16,468	16,870	402	2.44%		96,227
NCL	NHS Haringey CCG	13,597	13,939	342	2.52%		81,865
NCL	NHS Islington CCG	13,146	13,126	-20	-0.15%		(4,787)
NCL	**NCL Total**	**76,849**	**76,074**	**-775**	**-1.01%**	**(185,512)**	**(185,512)**
NWL	NHS Brent CCG	17,919	17,648	-271	-1.51%		(64,869)
NWL	NHS Harrow CCG	11,133	11,352	219	1.97%		52,422
NWL	NHS Hillingdon CCG	19,230	18,690	-540	-2.81%		(129,260)
NWL	NHS Central London (Westminster) CCG	16,488	16,188	-300	-1.82%		(71,811)
NWL	NHS Ealing CCG	18,516	17,871	-645	-3.48%		(154,394)
NWL	NHS Hammersmith and Fulham CCG	10,570	10,431	-139	-1.32%		(33,272)
NWL	NHS Hounslow CCG	14,046	13,891	-155	-1.10%		(37,102)
NWL	NHS West London CCG	12,859	12,838	-21	-0.16%		(5,027)
NWL	**NWL Total**	**120,761**	**118,909**	**-1,852**	**-1.53%**	**(443,313)**	**(443,313)**
SEL	NHS Bexley CCG	12,792	12,767	-25	-0.20%		(5,984)
SEL	NHS Bromley CCG	15,980	16,196	216	1.35%		51,704
SEL	NHS Greenwich CCG	14,359	15,169	810	5.64%		193,890
SEL	NHS Lambeth CCG	18,211	18,487	276	1.52%		66,066
SEL	NHS Lewisham CCG	15,181	15,007	-174	-1.15%		(41,650)
SEL	NHS Southwark CCG	18,201	18,445	244	1.34%		58,406
SEL	**SEL Total**	**94,724**	**96,071**	**1,347**	**1.42%**	**322,431**	**322,431**
SWL	NHS Croydon CCG	21,387	21,059	-328	-1.53%		(78,513)
SWL	NHS Kingston CCG	8,123	7,831	-292	-3.59%		(69,896)
SWL	NHS Merton CCG	9,733	9,597	-136	-1.40%		(32,554)
SWL	NHS Richmond CCG	8,153	8,143	-10	-0.12%		(2,394)
SWL	NHS Sutton CCG	10,452	10,119	-333	-3.19%		(79,710)
SWL	NHS Wandsworth CCG	14,148	14,182	34	0.24%		8,139
SWL	**SWL Total**	**71,996**	**70,931**	**-1,065**	**-1.48%**	**(254,929)**	**(254,929)**
London Total		**465,223**	**465,695**	**472**	**0.10%**	**112,983**	**112,983**

Cash flow Statement

Owner: James Corrigan | Executive Lead: Lorraine Bewes

	Apr-18 Actual	May-18 Actual	Jun-18 Actual	Jul-18 Actual	Aug-18 Actual	Aug-18 YTD Move	Aug-18 YTD Plan	Aug-18 Var
	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	**30,300**	**24,876**	**21,585**	**16,866**	**22,634**	**30,300**	**30,300**	**0**
Operating Surplus	226	1,280	554	1,613	(35)	3,638	4,851	(1,213)
(Increase)/decrease in current assets	716	(5,174)	2,640	3,927	1,249	3,358	(487)	3,845
Increase/(decrease) in current liabilities	(2,805)	4,667	(5,814)	1,730	1,265	(957)	621	(1,578)
Increase/(decrease) in provisions	402	(673)	(284)	168	208	(179)	(2,920)	2,741
Net cash inflow/(outflow) from operating activities	(1,461)	100	(2,904)	7,438	2,687	5,860	2,065	3,795
Cashflow inflow/(outflow) from operating activities	**(1,461)**	**100**	**(2,904)**	**7,438**	**2,687**	**5,860**	**2,065**	**3,795**
Returns on investments and servicing finance	0	12	10	15	15	52	21	31
Capital Expenditure	(3,963)	(3,403)	(1,825)	(1,685)	(621)	(11,497)	(16,000)	4,503
Dividend paid	0	0	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(3,963)**	**(3,391)**	**(1,815)**	**(1,670)**	**(606)**	**(11,445)**	**(15,979)**	**4,534**
Movement	(5,424)	(3,291)	(4,719)	5,768	2,081	(5,585)	(13,914)	8,329
Closing Cash Balance	**24,876**	**21,585**	**16,866**	**22,634**	**24,715**	**24,715**	**16,386**	**8,329**

There has been a net outflow of cash to the Trust of (£5.6m), this is £8.3m lower than the planned outflow (£13.9m).

Cash funds at 31 August stand at £24.7m.

Operating Surplus

- The operating surplus at £3.6m is £1.2m below target.

Current Assets

- The movement on current assets is £3.4m, £3.8m higher than planned movement.
- Current assets movement was higher than planned due to receivables (£0.4m), accrued income £5.3m and prepayments (£1.0m). Accrued income is below plan as the Trust received its £5.8m STF income in July.

Current Liabilities

- The movement on current liabilities is (£1.0m), a (£1.6m) higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£5.1m), due to a reduction in the number of outstanding invoices and higher than planned in year non-pay spend, accruals £2.2m and Deferred income £1.3m.

Provisions

- The movement on provisions is (£0.2m), is a £2.7m lower than planned movement.

Capital Expenditure

- Capital cash outflow is £11.5m, is a £4.5m below plan.

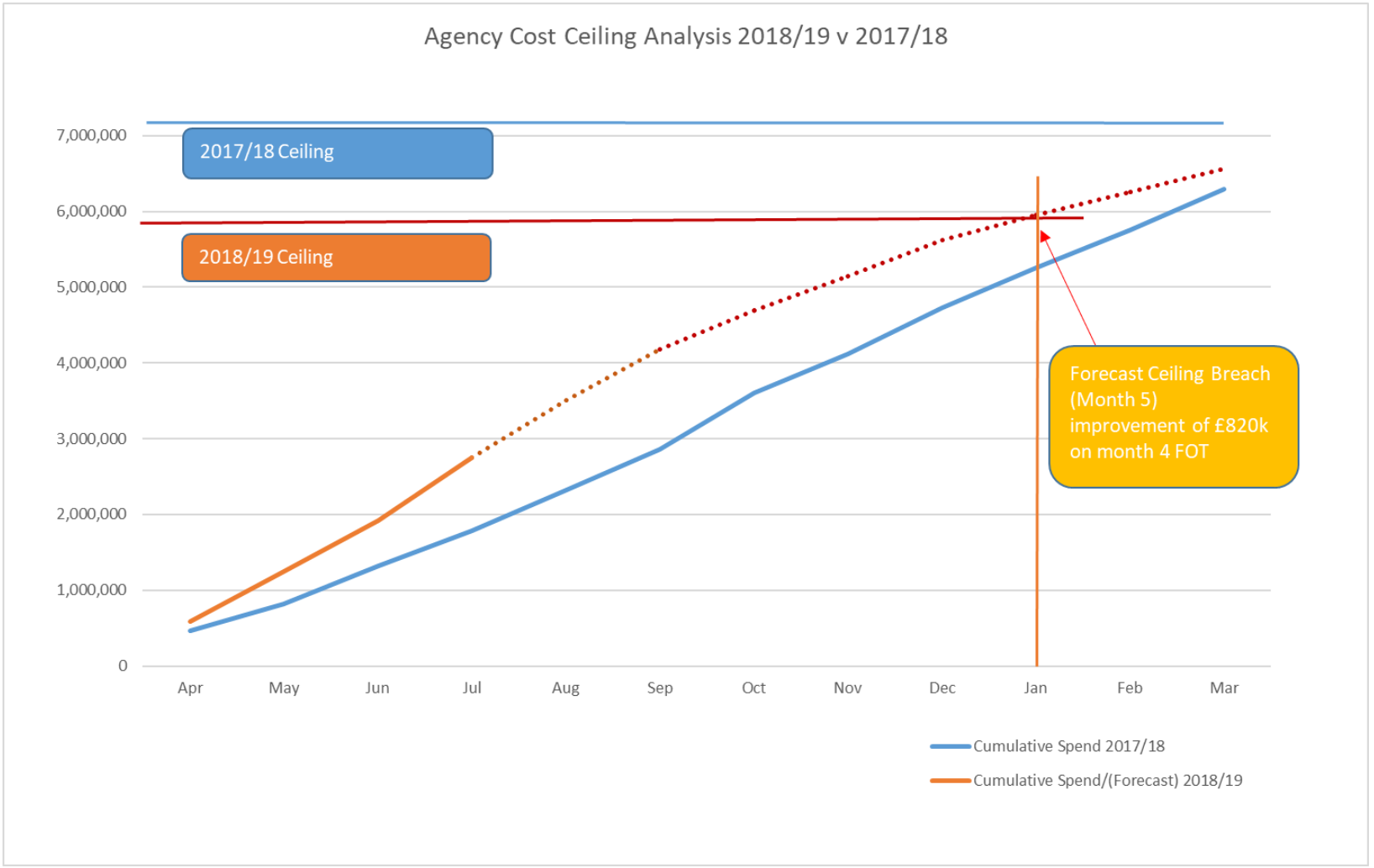
CQUINs

Owner: James Corrigan | Executive Lead: Lorraine Bewes

CQUIN Title	YTD Plan	YTD Actual	Variance	Full year Forecast £'000
National: 1a Staff Health and Well-being	0	0	0	267
National:1b Healthy food for NHS staff, visitors and patients	0	0	0	267
National: 1c Improving the uptake of flu vaccinations for front line staff within Providers -75%	0	0	0	267
National 12: Ambulance Conveyance	0	0	0	801
STP Engagement	1,335	1,335	0	2,955
Local - Digitalisation SDIP CQUIN	1,335	1,335	0	2,955
	2,671	2,671	0	7,512
100% CQUIN				8,012

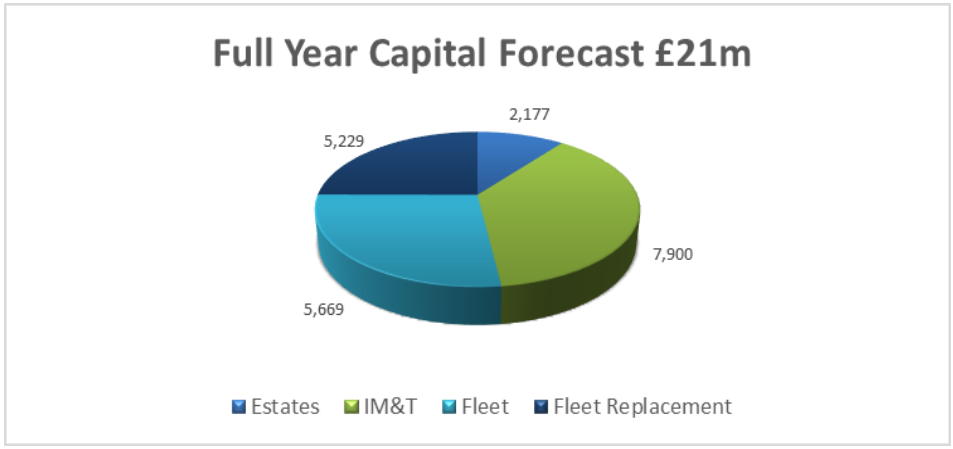
Agency Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes



Capital Summary

Owner: James Corrigan | Executive Lead: Lorraine Bewes



Source of Capital Funds	£'000
Carried forward	1,600
Internally Generated	15,526
Capital bid	3,849
Total Capital Funds Available	**20,975**

Capital Programme	Exec Lead	Month 5 Plan £'000	Month 5 Actual £'000	Month 5 Variance £'000	Full year Plan £'000	Forecast Outturn £'000	Variance £'000
Expenditure Plan:							
Estates	B Mehra	828	963	(135)	2,177	2,177	0
IM&T	R Fullerton	4,351	1,153	3,198	7,900	7,900	0
Fleet	B Mehra	1,020	1,925	(905)	5,669	5,669	0
Fleet Replacement	B Mehra	1,428	0	1,428	5,229	5,229	0
General	L Bewes	0	196	(196)	0	0	0
						0	0
Capital Expenditure Plan		**7,627**	**4,237**	**3,390**	**20,975**	**20,975**	**0**

- Capital spend is £4.2m against a budget of £7.6m, £3.4m behind plan.
- The Trust was awarded £3.8m capital funding from the sustainability and transformation partnership ambulance schemes. This is to fund the purchase of additional ambulances.
- The Trust CRL of £15.5m has been confirmed and increased by £3.8m above to £19.3m.
- General Capital £0.2m relates to VAT which will be adjusted in future months as vat is recovered relating to 2017/18.

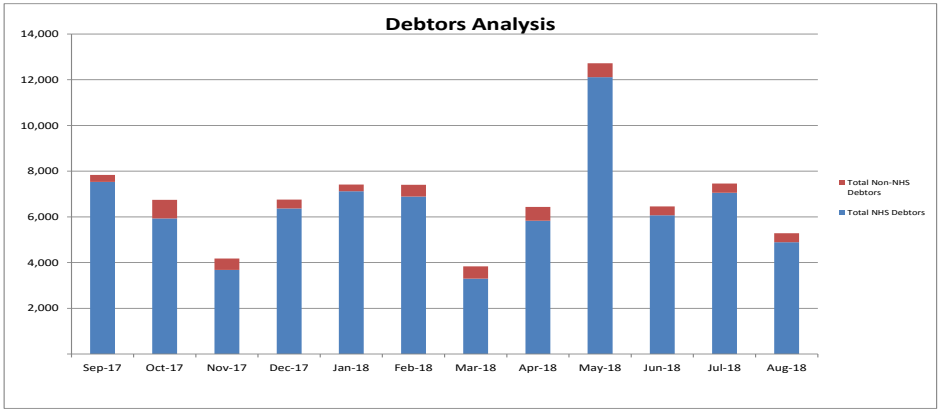
Debtors Analysis

Owner: James Corrigan | Executive Lead: Lorraine Bewes

Aged debtors Summary 31st August 2018

	Note	Total	Days Overdue			
			0 - 30	31 - 60	61 - 90	Over 91 days
		£'000	£'000	£'000	£'000	£'000
NHS Debtors						
Nhs England	2	1,408	53	1,349	1	5
Nhs Barnet Ccg	1	374	45	-	156	172
St Georges University Hospitals Nhs Ft	3	332	-	-	-	332
Nhs Enfield Ccg	1	283	38	-	131	114
Nhs Camden Ccg	1	267	51	-	141	75
Nhs Havering Ccg	1	257	61	-	108	88
<£257,000	1	1,971	494	-	1,359	118
NHS Debtors		**4,891**	**742**	**1,349**	**1,896**	**904**
NHS Future Posting						
NHS Tower Hamlets CCG (Spetember 111 NEL)	**4**	**-728**	-728	**-**	**-**	**-**
Total NHS Debtors		**4,163**	**13**	**1,349**	**1,896**	**904**
Non-NHS Debtors						
Heathrow Airport Ltd	5	112	112	-	-	-
London Stadium 185	6	31	-	31	-	-
Arsenal Football Club	7	25	25	-	-	-
Kings College London	8	19	-	19	-	-
Aeg Presents	9	17	-	17	-	-
<£17,000	10	194	41	14	2	137
Total Non NHS Debtors		**397**	**178**	**80**	**2**	**137**
TOTAL DEBTORS 31st August		**4,560**	**191**	**1,429**	**1,899**	**1,041**

Source: Debtors Ledger 31st August 2018



Debtors Position: 31st August 2018

Total outstanding NHS and Non-NHS debtors as at 31st August 2018 amounted to £4.6 million. The NHS over 60 day's figure of £2.8m includes amounts due from both CCGs £2.4m and NHS Trusts £0.4m.

1. NHS Debtors over 60 days.
   - Paramedic Re-Banding Income 2018/19 - £0.4m (7 CCGs) – NEL and NCL CCG's are not disputing our invoices, they are currently awaiting an instructional letter from NHSE informing them of when to release payments. NHS England has now confirmed with the CCGs that's the invoices can be paid.
   - Final Settlement for CQUIN 50% April 17 - March 18 - £2.3m (23 CCGs) – In September 3 CCGs paid £0.3m. CCGs are withholding payments until they have checked the calculations for 2017/18 CQUIN.

The Trust is actively pursuing the outstanding debts.

2. NHS England - £1.4m (1 Invoice) - The invoice is expected to be paid on the 15th September 2018.
3. St Georges University Hospitals NHS FT – £332k (18 PTS Invoices) The Trust's has requested a copy of the signed contract. We are liaising with the Head of PTS services to obtain a signed copy of the contract.
4. NHS Tower Hamlets CCG - £728k – NEL 111 invoice for September was paid in advance on the 30th August 2018.
5. Heathrow Airport Ltd - £109k (1 invoice) – has been approved and payment will be made 12th September 2018. £3k (1 Invoice) was paid on the 3rd September 2018.
7. Arsenal Football Club - £25k (1 Invoice) has been approved and will be paid on the 28th September 2018.
6. London Stadium 185 - £31k (4 invoices) have been paid on the 6th September 2018.
8. Kings College London - £19K (1 invoice) will be paid on the 12th September 2018.
9. AEG Presents - £17k (1 invoice) – The organisation has queried the invoice because we have over charged them. The Emergency Planning Support Team are liaising with the organisation to resolve the query.
10. Non-NHS Debtors - £194k consists of; £120k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £41k of stadia events, the stadiums have been chased for payment on a regular basis. The remaining £33k is due from local Government bodies and other miscellaneous organisations.

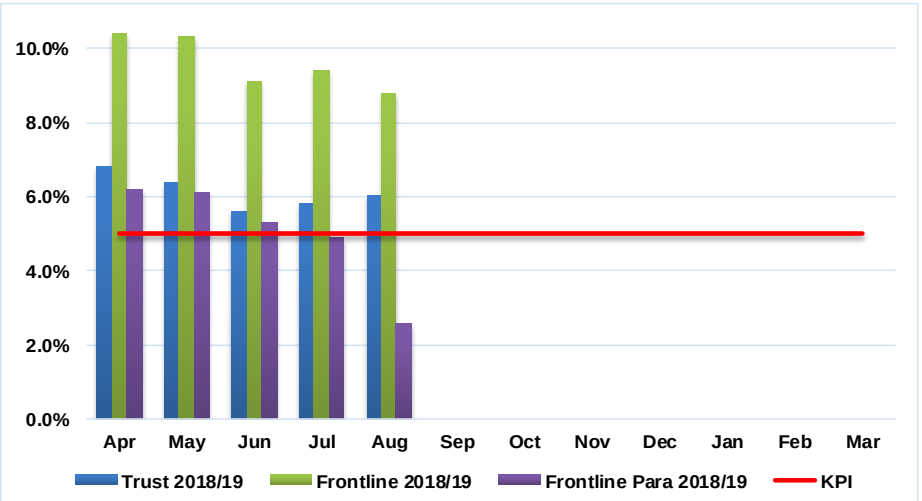
The graph to the left shows the debtors trend for the last 12 months.

Our People

Section	Key Headlines From Each Section.	August	July	June
Vacancy and Recruitment	• Frontline Paramedic Vacancy rate is 2.6% • Frontline non-paramedic vacancy rate is 16.4%. • Overall frontline vacancy rate is 8.8% • EOC EMD vacancy rate is 12.7%	6.0%	5.8%	5.6%
Turnover	• Total Trust 12 month turnover has increased to 11.5% which is 1.5% above the KPI of 10%. • Frontline turnover has remained at 10.2% compared to the previous month Please note this does not include Control Room or NHS 111 leavers. • Frontline paramedic turnover has increased from 11.0% to 11.8%.	11.5%	11.2%	11.2%
Sickness	• 12 month sickness absence has remained at 5.2%. • Sector Operations sickness remained at 5.6%.	5.2%	5.2%	5.2%

Trust wide
Vacancy

VACANCY RATE



EOC recruitment (Emergency Medical Dispatchers)

- Recruitment target of 171 FTE - forecast end of year gap of 6 FTE.
- The ExCo led task and finish group has been working to achieve double new employee intake to address gap. This has had a positive impact although there remain challenges with both trainer and mentoring capacity, building space and IT.
- The November course capacity has been increased to 30 (26 plus 4 backsquadded) and the current focus is on clearing candidates in time for this course.
- EOC restructure – the consultation process started in August (ends 7 October) and will improve retention as well as address other management capacity issues.
- The recruitment team continue to plan and attend a wide range of recruitment and engagement activities to attract people to core frontline roles. Professional apprenticeship pathways are being considered to improve retention and to be built into the apprenticeship delivery model.

FRONTLINE AND EOC VACANCY RATE

	Establishment (Business Plan)	In post as at 31st August	Vacancy wte	Vacancy %
Total Frontline (Sector)	3,380.00	3,083.01	296.99	8.8%
Frontline (Sector) Paramedics	1,859.00	1,811.16	47.84	2.6%
Frontline (Sector) Non-Paras	1,521.00	1,271.85	249.15	16.4%
EOC (EMD)	378.00	330.05	47.95	12.7%

Paramedics

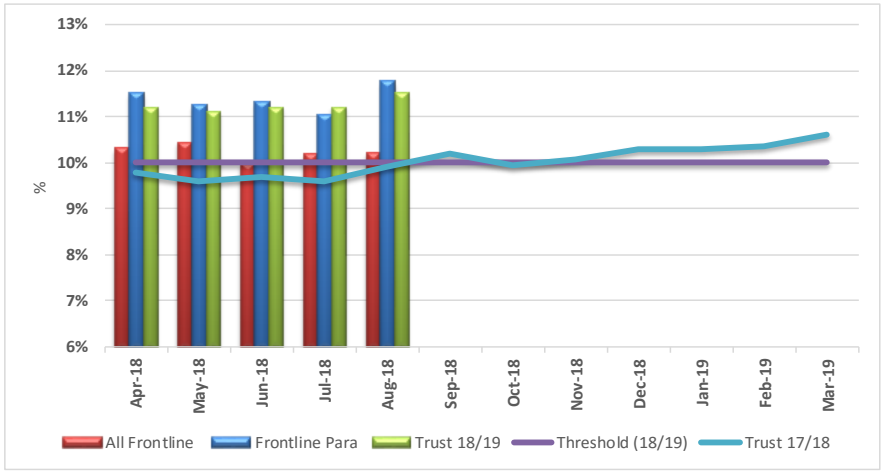
- Recruitment target of 469 FTE - recruitment supply of 364 FTE with forecast end of year gap of 105 FTE. Initiatives in progress identified to close the gap include: Skype interviews, sourcing agencies to support recruitment in Australia and Poland, a recruitment visit to Ireland in October and reviewing capacity for training placements.

Trainee Emergency Ambulance Crew

- Recruitment target of 381 FTE - recruitment supply of 261 FTE with forecast end of year gap of 120 FTE.
- Initiatives underway include TEAC Super Saturday events, continued funding for TEAC C1 licence, significant programme of domestic recruitment events and a review of capacity for training placements for Q4.

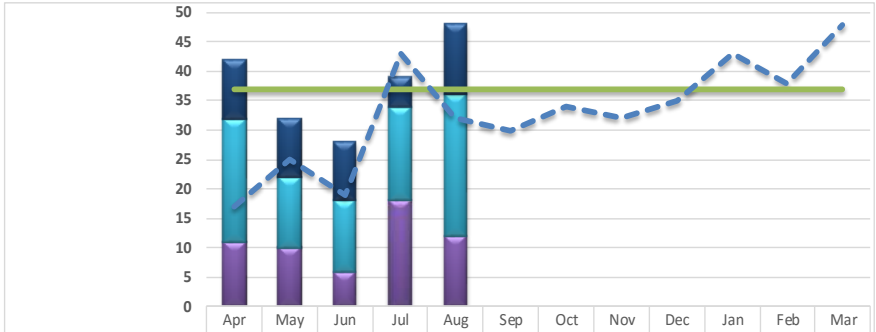
Trust wide
Turnover/Leavers

TURNOVER



- The total Trust turnover has increased to 11.5% from 11.2% (12 month rolling figure).
- Frontline turnover (Sector Ops) has remained at 10.2%.
- Frontline paramedic turnover has increased from 11% to 11.8%.
- EOC turnover has decreased slightly from 19.6% to 19.4%, NHS 111 turnover has decreased from 18.2% to 17.1%. Corporate Directorates turnover has remained at 12.9%.
- There were 48 frontline leavers in August (see table).
- 81% of the frontline leavers (36 staff) were resignations i.e. unplanned. 11 of the 25 paramedics left for reasons of relocation. 4 of the voluntary paramedic leavers have 'Abroad – non EU Country' recorded as their leaving destination.

FRONTLINE LEAVERS

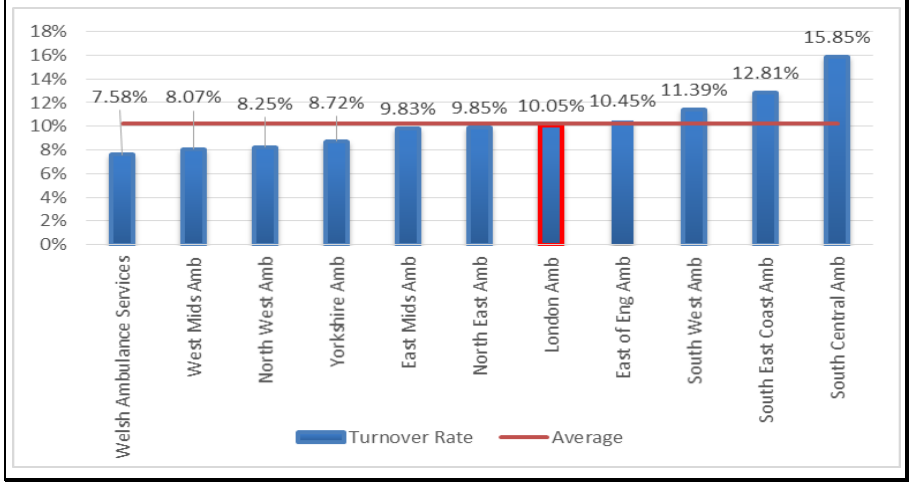


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EMD	10	10	10	5	12							
Paramedics	21	12	12	16	24							
Non-Paras	11	10	6	18	12							
Threshold (18/19)	37	37	37	37	37	37	37	37	37	37	37	37
2017/18	17	25	19	43	32	30	34	32	35	43	38	48

- Our retention efforts have focused predominantly on our EOC team and we have a number of activities including a restructure of EOC teams to address some legacy issues around role clarity and lack of progression, the introduction of a part time roster, the introduction of a range of well-being initiatives to support employees and improve attendance and the consideration of professional apprenticeship pathways.
- We have a number of international paramedics who have visas which expire this year and we have written to each of them and commenced 121 meetings to discuss their future intentions and to highlight career opportunities with the Trust.
- Other initiatives to improve our intelligence and therefore focus on retention include a new eForms system which has now been rolled out to Sectors and Corporate teams, and more fully utilising the ESR exit questionnaire functionality.

Trust wide
Benchmarking Turnover/Sickness

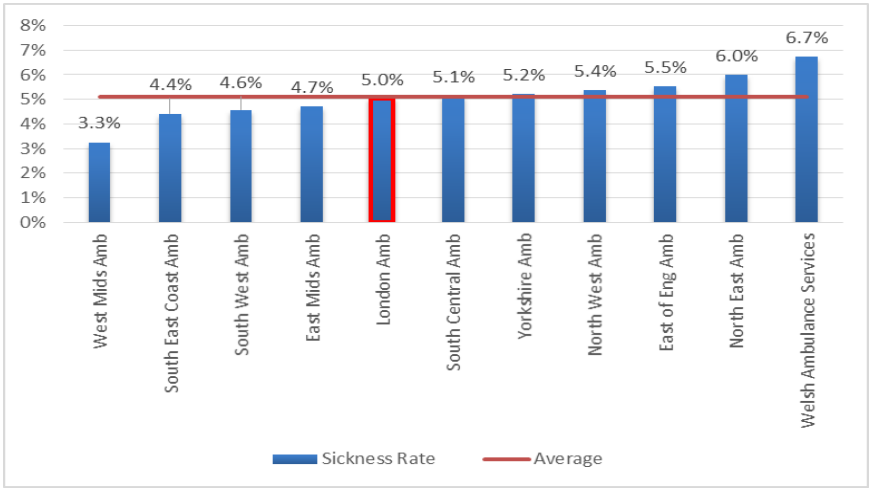
BENCHMARK TURNOVER RATE - JUNE 2018



- This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.
- The London Ambulance Trust has moved from 7th place to 8th place.
- The LAS is below the national average of 10.26%.

Source of data: NHS Health and Social Care Information Centre – data as at 30th June 2018. Data is available two months in arrears.

BENCHMARK SICKNESS RATE - MAY 2018

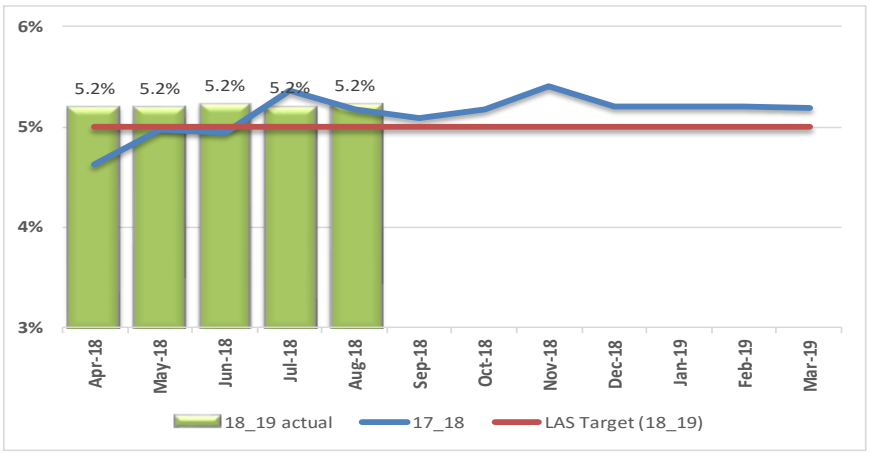


- This graph shows the in month sickness rate for all 11 Ambulance Trusts.
- The London Ambulance Service has moved from 7th place to 5th place.
- The LAS is below the national average of 5.09%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st May 2018. Data is available three months in arrears.

Trust/Sector level
Sickness Absence

SICKNESS



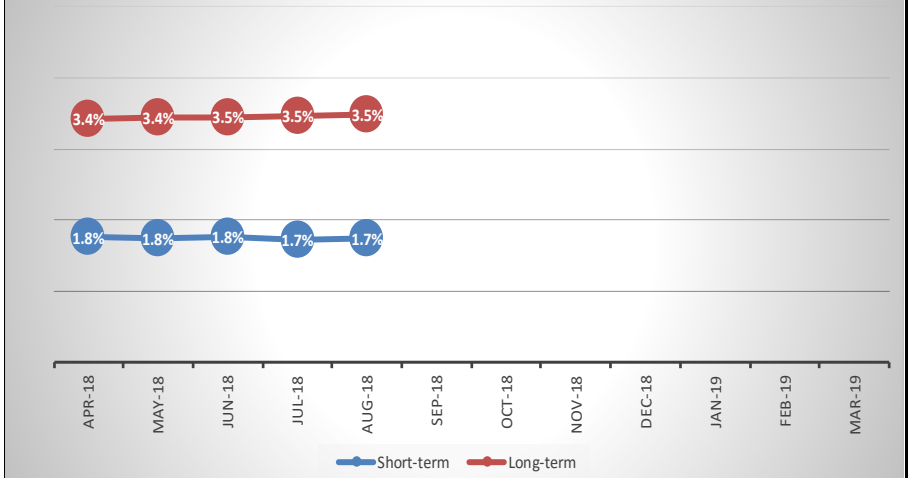
(The figures stated for sickness absence are for a 12 month rolling period).

Trust wide sickness for August has remained at 5.2%. Sector Operations sickness has remained at 5.6%. EOC sickness has remained at 6.7% compared to the previous month. NHS 111 sickness has increased from 7.4% to 7.5%. Corporate sickness has increased to 3.1%.

Our top two reasons for absence continue to be musculoskeletal injury 41% and Mental Health 11%. Both of these will be addressed as part of the Health and Wellbeing CQUIN project and the CIP Improving Attendance work stream.

Other wellbeing initiatives include a continued focus on achieving high compliance for our immunisation programme, improvements to counselling provision through dedicated trauma support and a refresh and strengthening of our approach to internal resolution of conflict.

SICKNESS - LONG-TERM V SHORT-TERM



This graph shows the sickness rate for all staff split by short-term and long-term sickness.

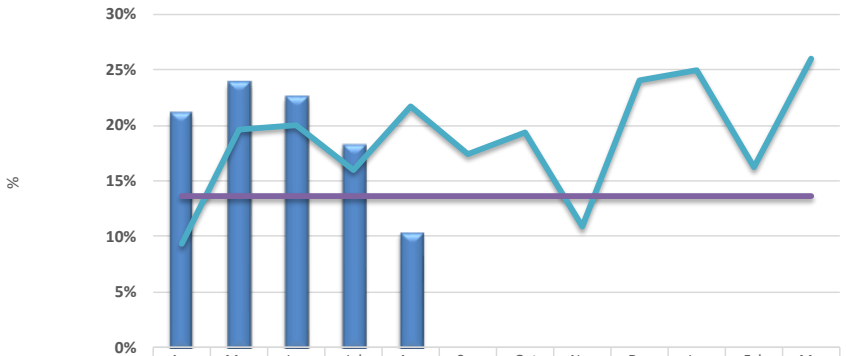
The Trust18/19 target for sickness is 5% made up of 2% short-term, 3% long-term. In August, the short-term sickness has increased slightly by 0.1%. Similarly long-term sickness has increased by 0.1% to 3.48% compared to the previous month.

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
2018/19	21%	24%	22%	18%	10%	0%	0%	0%	0%	0%	0%	0%
BME (heads)	16	16	22	8	24							
2017/18	9%	20%	20%	16%	22%	17%	19%	11%	24%	25%	16%	26%
TRUST BME %	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%

The LAS WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly.

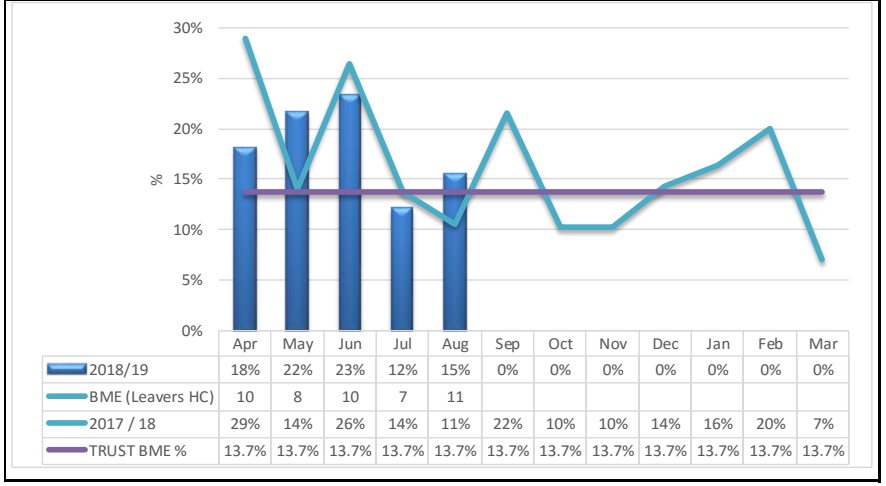
These graphs show the numbers of BME starters and leavers from April 2017 to August 2018 compared to the current Trust BME profile.

In August 2018 we had 24 BME starters of which 12 were EMD 1s. There were 230 starters in total which is significantly more than the average number of starters in previous months. There were 125 starters without an ethnicity specified (all NE111).

In August 2018 we had 11 BME leavers including 5 EMDs. There were a total of 21 leavers in August.

This year we have recruited 86 BME staff and 46 BME staff have left.

BME LEAVERS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	18%	22%	23%	12%	15%	0%	0%	0%	0%	0%	0%	0%
BME (Leavers HC)	10	8	10	7	11							
2017 / 18	29%	14%	26%	14%	11%	22%	10%	10%	14%	16%	20%	7%
TRUST BME %	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%

There has been a focus on recruitment to improve BME starter levels including domestic recruitment events, training interviewers, having representative panels and reviewing decisions where BME candidates have failed assessments.

We have developed a new WRES action plan for 18/19 which features new targets and three key themes - Recruitment and Development, Workforce Experience and Senior Trust Leadership

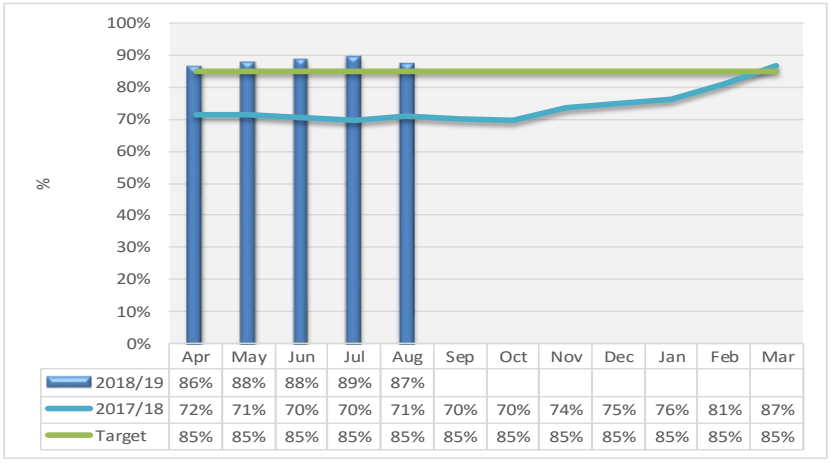
In August we also held Staff Engagement sessions in all 12 fleet workshops.

Recruitment – shortlist to appointment - we have commenced a BME pilot project to increase diverse interview panels, senior managers workshop to discuss the current LAS BME data and commitments from the senior management teams.

In discussion with the CEO, a new indicator, measuring the % of BME staff by payband, has been added to each Directorate scorecard with effect from July 2018. Monthly discussions at performance reviews with individuals managers and directorates will support targeted interventions where needed.

Statutory and Mandatory Training & Appraisals

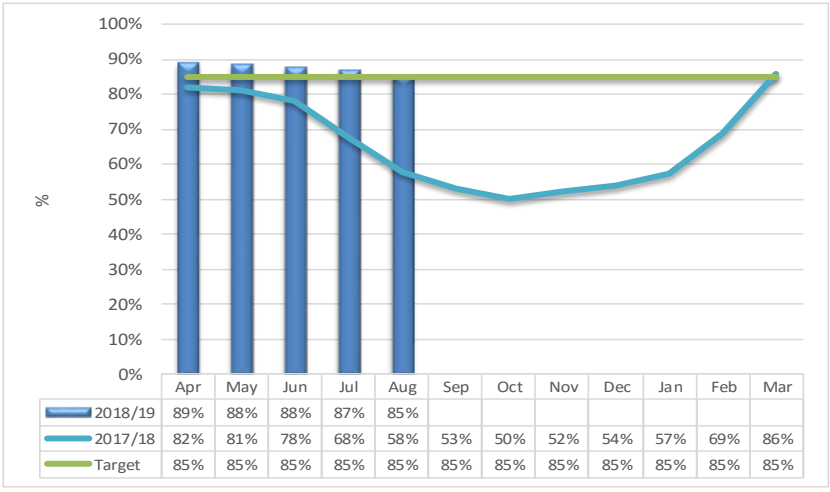
STAT AND MAND TRAINING COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	86%	88%	88%	89%	87%							
2017/18	72%	71%	70%	70%	71%	70%	70%	74%	75%	76%	81%	87%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- Over 85,000 e-learning courses have been completed since go-live. Over 4,000 staff have set-up to use from home and these numbers will increase with the newly available auto enrolment functionality.
- EOC, the subject of the CQC MustDo action, is at 82.4% and a specific trajectory and action plan has been agreed with the EOC management team to bring this in line.
- Trust compliance is 87%, Corporate compliance 89.9% and Operations is at 86.8%. Each Sector now has a compliance lead to ensure that stat and mand and PDR levels meet trajectories.
- CSR.2017.2 stands at 91.7% and CSR.2017.3 is at 88.4%. CSR.2018.1 is 92%.
- Information Governance is at 86.6% for August and will increase alongside CSR completions.

APPRAISAL COMPLIANCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	89%	88%	88%	87%	85%							
2017/18	82%	81%	78%	68%	58%	53%	50%	52%	54%	57%	69%	86%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- Appraisal completions at 85.2% at the end of August. Whilst this remains above target, the trend is downward. Some of this is attributable to the increase in REAP to L3 and the Operations restructure.
- PDR trajectories for Sector Operations frontline staff have been developed for 18/19 to ensure that PDR dates are spread more evenly across the year and that all areas remain above the 85% compliance target. The PDR dates have been adjusted and updated on ESR to deliver a higher compliance rate in June, July and September and lower compliance rates in August, November, December and January.
- As a result of the Appraisal Audit an Appraisal Improvement Programme commenced in August to take forward recommendations as well as planned move towards an eAppraisal system.
- Since launching in January, over 90 managers have attended training. Future courses are planned for September, November and December.

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

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	10			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Committee on 12 September 2018 (ExCo/18/150) and Board Assurance Committees			
Status:	☒	**Assurance**	☒	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

This paper provides the Board with an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

Recommendation:

The Board is asked to note this report and comment on the issues raised within it.

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	
2	**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	
3	**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	
4	**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	
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	

Risk discussions since May

Highly-rated CRR risks not included on the BAF

2. The following two risks currently have a rating of 15 or greater and are not included on the BAF:
    - Datix ID 706 – EOC Training have limitations on space and building facilities which may impact ability to deliver training. There is a risk that insufficient capacity and or site conditions could cause interruption to Training courses.
    - 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.

Risk discussions at Board Assurance Committees in June and July 2018

Logistics and Infrastructure Committee (minute ref LIC/18/14, para 14.2)

3. Consideration was given to the appropriateness of continuing to keep Risk 51 on the BAF at the Logistics and Infrastructure Committee on 05 June 2018. It was noted that further assurance had been provided by the Cabinet Office with regard to the risk posed by a specific third party contractor; however, Committee members considered that a generic risk remained, as the Trust held other similar contracts. Further information was requested in relation to the assurances that had been provided by the Cabinet Office, any other mitigations in place with regard to the specific risk faced by the Trust in relation to any particular third party contractor and the subsequent level of exposure related to these contracts, for consideration by the Committee in correspondence ahead of providing the Board with a recommendation to de-escalate BAF Risk 51.

4. The Committee asked for further information on the Trust's level of exposure in relation to third party contractors and the mitigations in place, together with a proposed re-drafting of BAF Risk 51 to reflect a more generic risk, which might result in its proposed de-escalation from the BAF. This has been provided to the Committee in correspondence and confirmation is awaited with regard to the Committee's view on the amendment of this risk. It is anticipated that this will be provided at the Committee's next meeting on 09 October 2018.

Finance and Investment Committee (minute ref FIC/18/25, para 10.2)

5. At the meeting of the Finance and Investment Committee on 23 July 2018, consideration was given to the level of risk faced by the Trust with regard to its income. It was suggested that the emerging risk regarding income and activity rates, discussed earlier in the meeting should be considered as a potential BAF risk. A paper on this issue was discussed at the Committee's meeting on 11 September 2018. In light of the range of issues covered by this paper the Committee recommended that the Board have an opportunity to consider these in private session. There will be an opportunity to discuss this in the private meeting of the Board.

Quality Assurance Committee (minute ref QAC/18/33, para 6.6 and QAC/18/27, para 8.2)

6. The Quality Assurance Committee requested that consideration be given to the question of whether the issues raised by the recent independent training review commissioned by the Trust required inclusion on the BAF at its meeting on 24 July 2018 and requested further work to be undertaken on this issue. A proposed action plan to respond to the findings of the review is due to be considered at the Executive Committee meeting on 17 October 2018. This approach and the risks associated with Training were discussed at the People and Culture Committee meeting on 06 September 2018 (see paragraph 12 below).

7. At its meeting on 24 July 2018, the Quality Assurance Committee also discussed a review of the contributory factors influencing the root cause of serious incidents relating to dispatching resources and managing 999 calls. This highlighted mainly education and training, along with staff factors. Failure to follow Trust issued guidance and confusion regarding the pre-triage of emergency calls were key themes in incident investigations. Additional issues relating to service demand included the current resourcing model not aligning with the Ambulance Response Programme (ARP) and issues managing complex 999 calls; these continued to cause concern, along with staffing levels. The Committee discussed and sought assurance with regard to effective decision making, dispatch and patient outcome. It was proposed that consideration might be required of the risk associated with the introduction of new standards and the Trust's ability to meet these for inclusion on the BAF.

8. At its meeting on 12 September 2018, the Executive Committee did not agree to recommend that an additional risk be included on the BAF in relation to achievement of ARP standards. The risk has been articulated as "There is a risk that patient safety may be compromised if patients do not receive the response they require in line with the timelines set out within the national performance standards". The initial rating of this risk was a score of 15; however the current rating (after taking into consideration all of the existing controls which are comprehensively documented on Datix) is 8. There is a target score of 1.

9. A separate report on this can be found elsewhere on the agenda of the Board meeting on 25 September 2018 (item 9, ref: TB/18/86). As Board papers were despatched in advance of the Quality Assurance Committee's meeting on 18 September 2018, an oral update on the Committee's views on this risk will be provided to the Board.

Audit Committee

10. At its meeting on 04 September 2018, the Audit Committee considered the BAF and Corporate Risk Register. The Committee noted that there were potential BAF risks regarding recruitment and achievement of new ARP standards at the Trust and that these were being considered for inclusion on the BAF in the future.

11. The Committee discussed the implications of Brexit on the Trust. It was noted that national work led by NHS England was currently being undertaken to assess the risk presented by Brexit. The Committee noted that additional thought would be given as to whether Brexit warranted inclusion on the Trust's BAF as a generic risk, for recommendation to the Trust Board in November 2018.

People and Culture Committee

12. The People and Culture Committee was provided with an oral update on all the current training-related risks on the Corporate Risk Register at its meeting on 06 September 2018. It was reported that there was no indication that these risks suggested an aggregate training-related risk that required inclusion on the BAF. The Committee agreed to consider the issue again at its meeting in November, alongside the proposed action plan to respond to the findings of the independent training review.

Risk Management Strategy and Policy review

13. The Audit Committee's forward plan stipulates that a review of the Trust's Risk Management Strategy and Policy should be presented to the Committee in September. In light of the fact that the Trust's new Risk Management Strategy and Policy was approved by the Board in January 2018, the Audit Committee considered it appropriate that this review should be deferred until the meeting of the Committee on 11 February 2019. A Board development

discussion on risk is scheduled to take place at the informal meeting on 18 December 2018, which will also inform this review.

Update on Trust-wide risk management activities

14. The Trust's substantive Risk Manager is due to take up her role in September 2018. This will enable a wholesale review of the risks entered on Datix to be undertaken, with a view to ensure that they are articulated and rated appropriately. Risk Co-ordinators and Risk Leads in particular will be engaged in this process, in order to ensure that the Trust continues to improve its management of risk across the organisation. This work will be in addition to the training that has been underway for some time, for all members of the organisation, on risk awareness and the use of Datix to record risk management activities.

15. A systematic review of the structure of Datix has recently been completed, enabling this tool to be structured in such a way that it facilitates risk management activities and reporting on these.

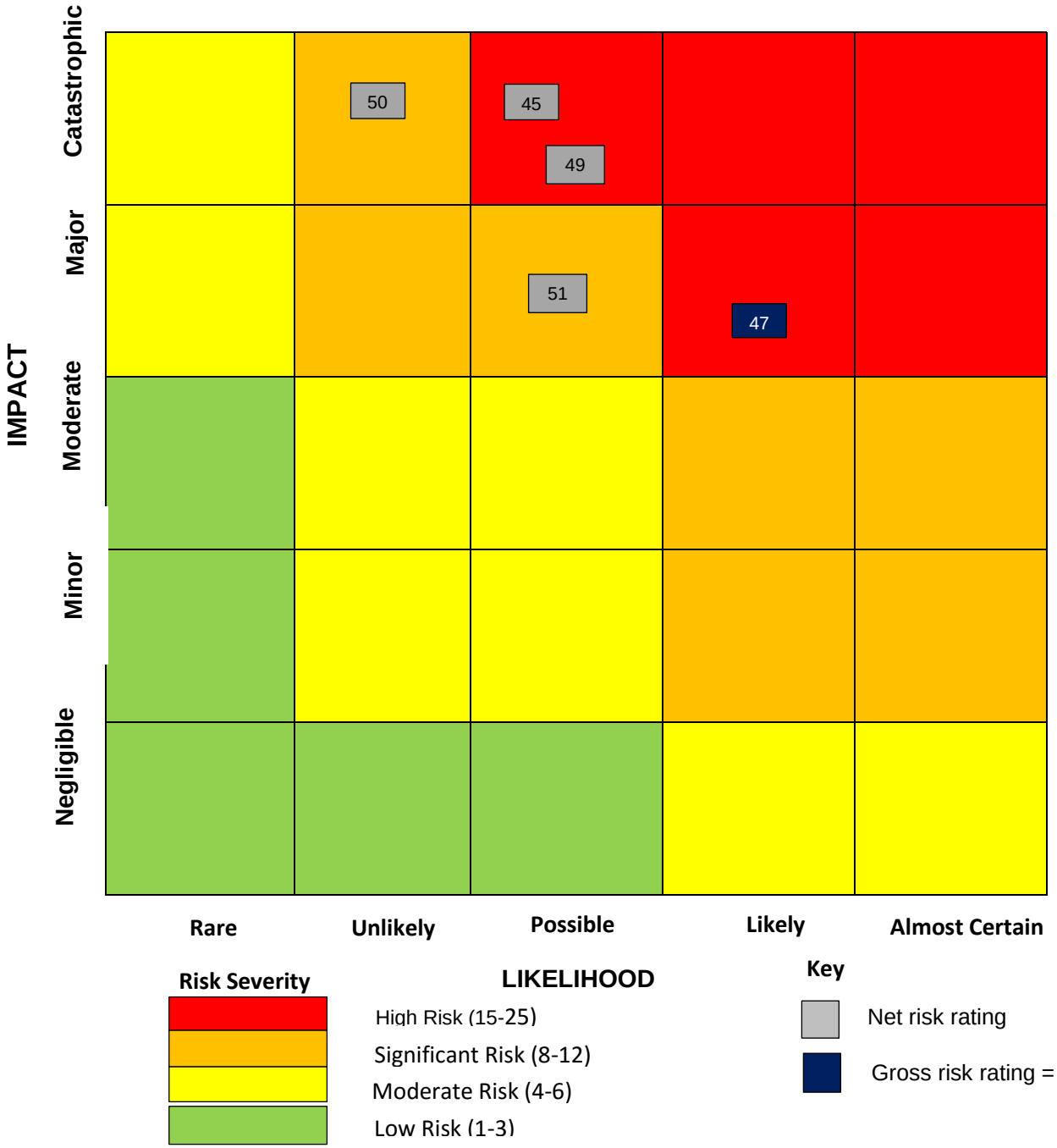
16. The Terms of Reference of the Risk, Compliance and Assurance Group have been reviewed and are due to be presented to the Executive Committee for final approval on 12 September 2018.

Review of the risks to achieving the Trust's strategy, business plan and Care Quality Commission action plan, together with any other potential risks expected on the horizon

17. A review of the risks to achieving the Trust's strategy, business plan and Care Quality Commission (CQC) action plan is being undertaken. To enhance this review ExCo members have been asked to identify their top three directorate and organisational risks. This information will be collated to inform a top-down review of the organisation's approach to risk.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – August 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

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. **Gaps in Controls** 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. Contract for 18/19 not yet agreed.	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%) **Gaps in Assurance** To be assessed	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	Completed Completed Completed Completed Completed Completed 31/12/2018 Completed

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 Head of the 999 Clinical Contact Centre. 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 EOC intensive action plan looking at increasing training capacity and collaboration with other Ambulance Trust to cover peak demand. Initial considerations will focus on a 'proof of concept' project. • Streamlining of selection process, including re-assessing pass rates and introduction of online assessments. • An ELT led task and finish group (Paul Woodrow, Patricia Grealish, Benita Mehra, Ross Fullerton – together with EOC management and Averil Lynch) are looking to achieve double new employee intake for August and September. One of the deciding factors to achieving this will be trainer and mentoring capacity. Both Estate and IT factors have been considered and solutions identified. • 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. An interim assessment has been completed but a further review of the impact of this approach will be reported in September. • EOC restructure – part of the challenge around retention is the structure across all of the EOC team. One effect of this is that EMD1s have seen slow progress because of the focus of our training teams on new starters. The restructure will address this as well as other management capacity issues. This restructure is being planned currently with consultation due to commence in July. • Professional apprenticeship pathways are being considered to improve retention and to be built into the apprenticeship delivery model. • The recruitment team continue to plan and attend a wide range of recruitment and	Include role in planned recruitment campaign Meet relevant people at Met Police to share and establish best practice and mutual ways of working Review online assessment pilot for EOC recruitment and run pilot EOC Recruitment Project Meetings take place Allocate appropriate resource to interview and assessment activities Super Saturday recruitment events supported by recruitment team and frontline staff	Completed Completed On-going On-going On-going On-going

	engagement activities to attract people to core front line roles, in addition to advertising across other online platforms than NHS jobs. • A social media campaign with boosted posts has gone live (working alongside the NHS recruitment campaign recently launched). • Building banners (for Waterloo HQ and Bow) and vehicle stickers are being developed with “join our team” messaging **Gaps in Assurance** None identified		
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: 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.

Gross Rating	Current/Net Rating	Target Rating
20	15	10

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
1. Existing defences have mitigated threats to-date; these include various technical and procedural elements 2. Independent review by PA Consulting has identified necessary mitigations for CAD system **Gaps in Controls** The existing controls do not meet good practice requirements as defined by HMG's National Cyber Security Centre.	1. Reports to Information Governance Group of cyber-related incidents each quarter – Reporting will be tied to Key Performance Indicators and services. 2. Reports from IGG to RCAG – All work carried out as part of the Cyber Security Improvement Programme will be reported to the IGG and RCAG. 3. To align with the NCSC guidance we will look to comply with Cyber Essentials by the end of February 2018. **Gaps in Assurance** The gaps are being investigated by the Cyber Security Improvement team and pragmatic/practical recommendations and an action roadmap will be drawn up.	Instigate phase 2 of the Cyber Programme for 2018-19 Introduce scenario planning and rehearsals a cyber attack on LAS NHS Digital led review of LAS cyber security Implementation of HMG good practice in cyber controls (Cyber Essentials) Potential second bid to NHSD for Cyber funding Capital (Bid 2) Implementation of a Cyber program of works (to include the recommendations from the PA Consulting report) Obtain approval for Phase 2 of the Cyber programme into 2018/19 Deliver Phase 2 of the cyber programme Initial Bid to NHSD for Cyber funding Capital (Bid 1)	Completed 30/09/2018 Completed Completed Completed Completed Completed 16/05/2019 Completed

Signed: Ross Fullerton

BAF Risk no. 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.

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:** November 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 **Gaps in Controls** To be confirmed	1. Ongoing monitoring of UPS demand 2. UPS maintenance contract in place 3. Generator maintenance and test schedule in place 4. Regular Project Group meetings **Gaps in Assurance** To be confirmed	1. Project team in place to investigate/manage upgrade project and identify window for upgrade works 2. IM&T migration programme to Cloud based services 3. Development of EOC Business Continuity Plan 4. Development of the assurance to support the implementation of the project.	05/10/2018 21/09/2018 28/09/2018 05/10/2018

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: 1. External influences to the market volatility affective service provider's ability to function.		**Gross Rating** **16**	**Current/Net Rating** **12**	**Target Rating** **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				

London Ambulance Service NHS
NHS Trust

Report to:	**Trust Board**			
Date of meeting:	25 September 2018			
Document Title:	Bi-Annual Quality Account Report April- September 2018			
Agenda item:	11			
Report Author(s):	Dr Trisha Bain, Chief Quality Officer			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	Quality Account and Strategy presented to the Board on 24 May 2018 (ref: TB/18/33)			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an overview of where the Trust is in regards to its Quality Priorities, as described in the Quality Strategy and Account.

It also provides as overview of the Care Quality Commission (CQC) quality action plan which has been designed to address the Must/Should dos from the last inspection as well as actions required to move from Good to Outstanding. The report also details progress of the pioneering service programme of work within the Trust

Recommendation(s):

The Board is asked to note bi-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	☐

London Ambulance Service
NHS Trust

Bi-Annual Quality Account Report

April- September 2018

Report published: September 2018

Contents

1. Executive Summary

This report provides the Board with an overview of where the Trust is in regards to the Quality Priorities, as described in the Quality Strategy and Account. It also provides as overview of the CQC quality action plan which has been designed to address the Must/Should dos from the last inspection as well as actions required to move from Good to Outstanding.
The report also details progress of the pioneering service programme of work within the Trust. The pioneering services include:

- Mental Health
- Falls
- Maternity
- End of Life Care

Overall, the Trust is making significant progress against all of these actions which will improve outcomes for our patients. We strive continually to improve and sustain this improvement throughout 2018-19 and beyond.

2. Quality Account Priorities

The Quality Strategy sets out the Trusts plan through which we focus on the quality of clinical care and to ensure that we continuously improve our services. With an aim to achieve an "outstanding" Care Quality Commission (CQC) rating across our service by 2020. In order to achieve this there are specific Quality Priorities to help us achieve these strategic goals.

Quality Account: Quality Priorities 2018/19		
SAFE	Target 1: 90% implementation of Health Assure functionality by December 2018. Planned actions progressing against project milestones.	
	Target 2: improve hospital handover delays; 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: 100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations. The current estates plan shows delivery for all the stations up to September 2018 plus Waterloo which will be done by November.	
	Target 4: Increase the number of defibrillator downloads year-on-year to 20% by end of 2019. Most recent figures (May 2018) showed downloads at 15%. Planned actions progressing	
EFFECTIVE	Target 1: Root and branch independent training review completed. Implementation plan developed by September 2018.	
	Target 2: New quality Indicators developed and being reported via performance scorecards by December 2018.	
	Target 3: QI training plan agreed and 100% of identified key cohorts trained by September 2018. First cohort (30 staff) commence full QSIR training in July 18. Half a day QI training on trust management essentials from August 2018.	
	Target 4: At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019.	
CARING	Target 1: Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline.	
	Target 2: Evidence of patient involvement in all QI and service re-design programmes.	
	Target 3: Reduce the number of ambulance conveyance (20%). Employ two whole time equivalent practice developments midwives and deliver a training programme 2018-19. Midwives employed.	
RESPONSIVE	Target 1: We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP.	
	Target 2: Over 75% of complaints letter being responded to within the 35 day timescale. In June 2018, 82% of complaints were responded to within the 35 day timescale.	
WELL LED	Target 1: 85% compliance with statutory and Mandatory training 2018-19.	
	Target 2: leadership programme developed and implementation plan in place.	
	Target 3: continue to implement the P&OD strategy and progress implementation of the Quality Improvement Plan and Quality Improvement capability across the organisation.	

Overview Summary	Overall Status
T1: The implementation of HealthAssure is progressing within the Trust. The milestone are being achieved but more work is needed to support full uptake by all leads responsible for completing the system. **T2:** The medical Directorate is working closely with London acute hospital trusts, to further reduce delays to patients and our crews at hospital. Monthly meetings have commenced across London to provide direction. **T3:** The project is progressing well for those where it was a agreed that new drug rooms will be built. **T4:** Actions to increase the number of defibrillators is progressing well	
T1: The implementation plan is on track and will be finalised this month. **T2:** New quality indicators have been agreed and are included in the monthly CEO performance pack for review. **T3:** The first cohort for QI training were identified earlier this year and training commenced in July 2018. The second cohort for training will commence in No ember 2018. **T4:** Sector reviews are underway with regularly feedback being received from sectors on implementation.	
T1: Work continues to address the frequent callers and a KPI to reduce the number of calls has been set. **T2:** The PPIE team continue to ensure that there is patient involvement in all key QI and Service re-design programmes. The target set earlier this year has been achieved. **T3:** Two whole time practice development midwives have been recruited and implementation of a training programme is underway.	
T1: A paper went to Board which included an action plan which was approved. **T2:** A process mapping exercise has been undertaken and an action in place, this includes extra resource	
T1: This is on course with trajectories established at station level in place. **T2:** The programme has been written and the first cohort undertaken the training this month. **T3:** The progress of this strategy is regularly discussed at the people and culture committee.	

4. Quality Improvement Programmes: Pioneering Services

Below is the overview of the planned Pioneering Service Programme of work. The first pilot will only go live in December meaning that we have to assume that they will give no/negligible impact on overall ED conveyance reduction in 2018/19

Finances: There is a lack of clarity about where the funding for these posts will come from, two sensible options are:

- Using current vacancies and converting them to Pioneer Services roles. Even if these are just for a fixed term for the purposes of the pilot. There is concern from Ops that once a vacancy is taken out of the establishment, it will never come back.
- A Business case to be put forward to fund the roles on top of the establishment, with a view that they will only be short term as we will need to negotiate with commissioners upon evaluation of the pilot

Maternity: Phase 1 would will move forward with the intention of recruiting 3-6 WTE midwives (secondment or bank). We would factor in a period of test shifts (over 2 months) and an evaluation/business case development phase. If this proves the case, we would look to put a business case forward for recruitment in 2019/20

ID	Pioneer Service	Task Name	Start	Finish
1	Mental Health	Funding agreed & sign off (internal & external)	27/08/2018	26/10/2018
2		Recruitment	27/09/2018	21/12/2018
3		Training	12/12/2018	18/12/2018
4		Control services changes made	03/09/2018	28/09/2018
5		Internal planning (estates, fleet, equipment etc)	03/09/2018	28/09/2018
6		Pilot (South East London)	19/12/2018	02/07/2019
7		Evaluation completed and roll out sign off	03/07/2019	05/08/2019
8	Falls	Funding agreed & sign off (internal & external)	27/08/2018	26/10/2018
9		Recruitment	29/10/2018	12/02/2019
10		Training	21/01/2019	25/02/2019
11		Internal planning (Control, estates, equipment etc)	26/11/2018	04/02/2019
12		Pilot	04/03/2019	30/08/2019
13		Evaluation completed and roll out signed off	05/08/2019	04/09/2019
14	Maternity (phase 1)	Funding agreed & sign off (internal & external)	27/08/2018	26/10/2018
15		Test shifts	01/10/2018	30/11/2018
16		Evaluation of test shifts and business case development	03/12/2018	03/01/2019
17		Recruitment	04/01/2019	29/03/2019
18		Training	01/04/2019	03/05/2019
19		Internal planning (Control, estates, fleet etc)	06/09/2018	22/03/2019
20		Pilot	06/05/2019	01/11/2019
21		Evaluation completed and roll out signed off	04/11/2019	04/12/2019
22	End of Life Care	Training and improving staff confidence	27/08/2018	29/03/2019
23		Clinical champion network	27/08/2018	29/03/2019
24		Schwartz Rounds	01/10/2018	29/03/2019
25		Appropriate pathway development	27/08/2018	29/03/2019
26		End of Life Care Strategy Development	02/01/2019	30/04/2019
27		Consistent measurement and audit	27/08/2018	29/03/2019

Allocate CQCAssure is an online CQC reporting, self assessment and evidence gathering software systems.

The objective of the project is to have the system embedded and to introduce quarterly submissions through the Trust, ensuring that this activity becomes business as usual. The new online tool enables managers, domain leads and sponsors to manage, monitor, evidence and report on regulatory requirements, quality standards and compliance, providing a real-time concise view of the Trust's position.

The sectors continue to populate their areas and the below table provides an overview of the assessment on the system at present:

HealthAssure Update						
Service Rating		Safe	Effective	Caring	Responsive	Well Led
	Overall London Ambulance Service NHS	Good	Good	Outstanding	Good	Good
	North West Sector	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate
	North Central Sector	Requires Improvement	Not Assessed	Not Assessed	Not Assessed	Inadequate
	North East Sector	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate
	South East Sector	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
	South West Sector	Requires Improvement	Not Assessed	Good	Requires Improvement	Requires Improvement
	NHS 111 Service	Requires Improvement	Requires Improvement	Not Assessed	Not Assessed	Not Assessed
	Emergency Operations Centre (EOC)	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed

The Quality Intelligence and Improvement team have been trained by vendor on the system. A gap analysis has been completed which has identified the need for changes within the structure of the system, corporate alignment and comprehensive lists of local evidence to support sector when reviewing against KLOE's. All of these actions are underway. The metrics module configuration has commence with the gathering of requirements.

The milestones for this project are:

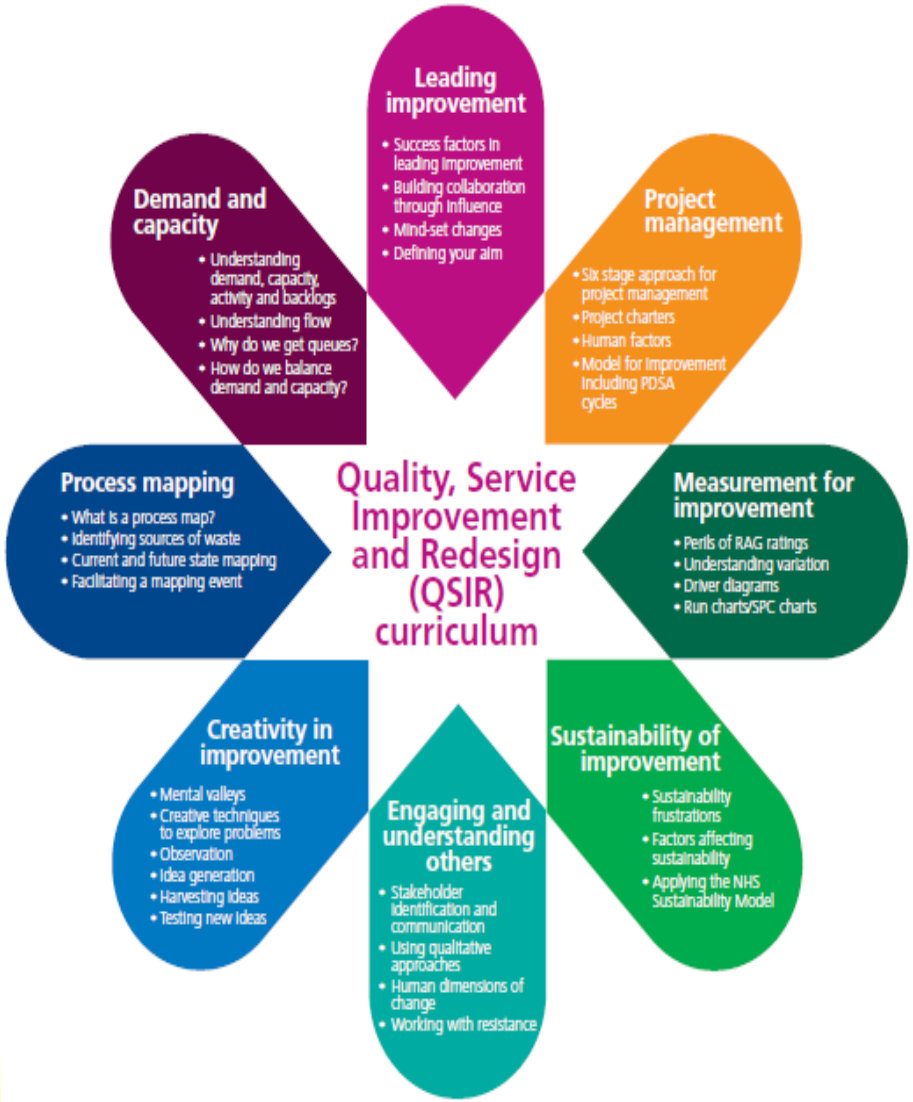
Deliverable/milestone	Completion Date	Status
Review the current status of the implementation of Health Assure which includes undertaking a Gap Analysis of CQCAssure. Health Assure system updated including Training for new QII team, structure and all KLOEs updated and mapped correctly. Develop and commence the observational peer review programme.	30/06/2018	Complete
Corporate functions aligned to CQCAssure. Review and develop HealthAssure Metric modules with first draft of metric report to be published at Trust level. On-going observational peer review.	30/09/2018	On track
Further develop the peer review programme, and implement monitoring schedules and peer reviews with key stakeholders to use CQCAssure to full advantage. Advanced metric report developed and published at sector level.	31/12/2018	
Peer Reviews BAU between Sectors Metric report to include Datix data to provide a risk management data visualisation. On-going peer review.	30/03/2019	

The Quality, Service Improvement and Redesign (QSIR) Programme 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 there is a consist approach to change becomes the way of doing things in the Trust. The staff attending this training will support the Trust overall Strategic Plan championed by the Executive Leadership Team.

The implementation plan that enables a critical mass of staff to be trained is as follows:

Deliverable/milestone	Date	Status
Agree 1 day and 5 day QSIR training programme for Trust Dates of QSIR LAS Training agreed and venue booked Delegates nominated by leaders and contacted First cohort agreed and confirmed.	30/06/18	On track
First 5 day training programme started Second cohort of staff nominated and contacted. Dates of second training programme agreed and venue booked Second cohort agreed and confirmed. Second 5 day training programme commenced Implement 1 day fundamental training programme	30/09/18	
First cohort finish 5 day programme and graduate. Identify graduates to go on to complete QSIR College and become associate members Communication of graduation communicated out across Trust. Second cohort 5 day training continues Third cohort agreed and confirmed.	31/12/18	
First cohort finish 5 day programme and graduate. Communication of graduation communicated out across Trust. Third 5 day training programme commenced	30/03/19	



3. CQC Quality Plan

The London Ambulance Service an aim to achieve an “outstanding” Care Quality Commission (CQC) rating across our service by 2020. In order to achieve this there are specific Quality Priorities and an specific CQC action plan which are designed to help us achieve these strategic goals.

There actions are progressing well with 13 completed (15%) and 65 actions (74%) on track. Those that have been escalated to a relevant committee are discussed on the next page.

CQC Quality Action Plan- Status Dashboard

		Total	Progress Status				Assurance Committee					
			Complete	G	A	R	Quality Assurance	Audit	People & Organisational Development	Logistics & Infrastructure	Finance & Investment	Executive Leadership Team
Total		88										
Change in status since last period			-	-	-	-						
Safe		15	0	14	1	0						
Effective		21	7	14	0	0						
Caring		4	0	3	1	0						
Responsive		7	1	6	0	0						
Well-Led		33	4	25	4	0					4	
Use of Resource		8	1	3	4	0						
Key:			> 1 Quality action plan with Red Status 1 Quality action plan with Red Status									

Quality Action Plan: Escalated Actions

Action ID	High Level Deliverables	Owner	Primary Domain	Secondary Domains	Current Status	End Date	Sub. Comm	Comments
27	Manage and deliver our proposed capital programme of £15.5m to support the delivery of our overall strategic objectives.	LB	UoR4	W2	RECOVERABLE	31/03/2019	FIC	At month 4 the programme is behind plan. Additional governance over the capital programme is being put in place as part of the implementation of the ePMO. There is a forecast to spend the planned capital by the end of the financial year.
28	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.	LB	UoR5	W2	RECOVERABLE	31/03/2019	FIC	There are three CQUINs at risk: conveyance, flu and staff health and wellbeing. These have a combined risk of 1m. This will be escalation through the CEO performance reviews.
29	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.	LB	UoR5	W6	RECOVERABLE	31/03/2019	FIC	There are two parts to this deliverable. The first part (CIP Delivery) is behind plan and is forecast to deliver 77% recurrently and a CIP recovery plan is being identified and will be monitored the CEO performance reviews and the Portfolio Management Board. The second part (Business planning for 19/20 &20/21) is underway with activities and meetings, to support the forward CIP, have been scheduled to identify two year CIPs in October.
30	Deliver our control total and maintain our use of resources rating with NHSI.	LB	UoR5	W6	RECOVERABLE	31/03/2019	FIC	The risk to the control total are due to a fall in incidents, income, CIP and agency spend. These have all been escalated for recovery plans and are being monitored through CEO performance meetings and FIC.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report Title:	Serious Incident Reporting and Progress			
Agenda item:	12			
Report Author(s):	Michael Ward, Head of Quality			
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 July.

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.

Recommendations:

The Board is asked to note the Serious Incident Reporting and Progress 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 Incident Update

Context

1. During July 2018, eight Serious Incidents (SI) reports were submitted to the London Ambulance Service NHS Trust's (LAS') Clinical Commissioning Groups (CCG).

2. The Trust's current position on meeting the 60 working day deadline for submitting SI reports remains at 100%.

Investigation Update

3. There were nine SI investigations closed by the CCG during July 2018. Executive summaries of all SIs closed by the CCG in July 2018 can be found in Appendix 2.

4. Of the 31 actions (detailed in appendix 1) nine have been completed and closed on the Trust incident reporting system (Datix). 19 are currently in progress and are within the assigned deadline. Three actions have breached the assigned deadline due to staffing availability and shift patterns. The responsible manager has been contacted by the Quality, Governance & Assurance team and reminded these must be completed by the end of August 2018.

SI Activity by Month

5. During July four SIs were declared. Fig. 1 shows the monthly distribution of declared SIs across the Trust compared to the previous year.

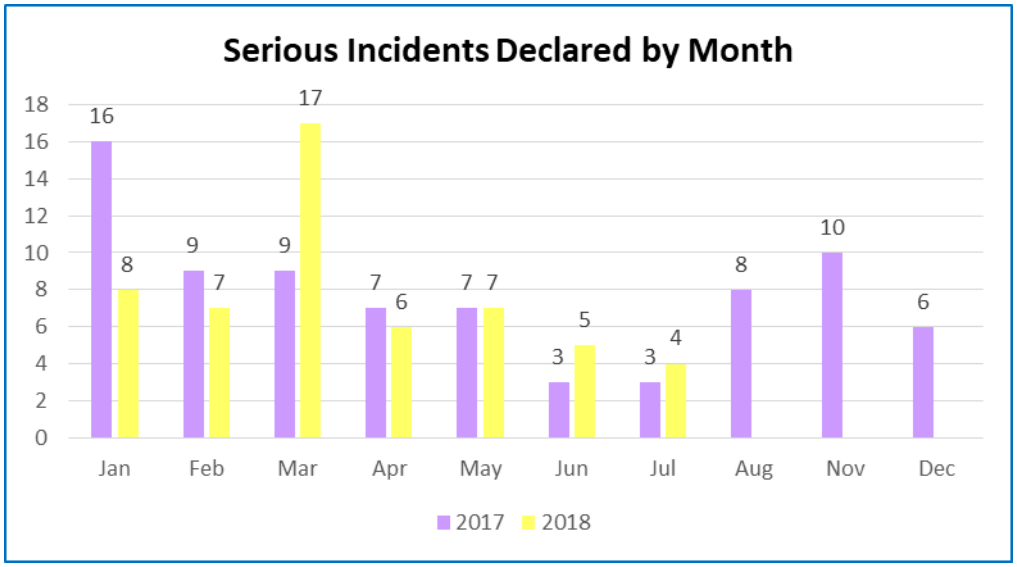


Fig. 1: Serious Incidents Declared/Month

CCG Feedback – July 2018

6. 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.

7. During July 2018 the CCG raised several questions regarding **compliance with policy and procedure**, more specifically the **dispatch of solo resources** to certain Category 2 calls where an appropriate resource has not been dispatched within 8 minutes due to demand and availability. Compliance with bulletins issued to staff is a key theme and something the Trust is looking to improve by ensuring a robust means of confirming delivery, receipt and understanding by all operational staff.

8. Additional questions were raised relating to the **delayed transfer of patients between hospitals**. The issue of the new Inter-facility guidelines by the Association of Ambulance Chief Executives is currently being reviewed by the Trust.

9. In a number of SI's the CCG provided feedback that actions were focussed on individuals and provided **limited organisational learning**. This feedback has been shared with the Quality, Governance & Assurance team and all Lead Investigators.

10. The Quality, Governance and Assurance Team will continue to monitor the comments for recurrent themes and trends.

SI Category Themes – July 2018

5.1. As reported in the quarterly thematic review, **compliance issues in call handling and dispatch** have been identified. As a result the Quality, Governance and Assurance Team have provided feedback to support the Emergency Operations Centre (EOC) action plan.

11. Of note, the pre-triage breathing question appears to be an emerging theme whereby the description used by the caller does not necessarily match the descriptors within the Medical Priority Dispatch System (MPDS). In order to address this a number of actions from SI reports have been agreed including;

    a. Producing an educational video for existing and new entrant staff

    b. Update training on the Core Skills Refresher course for Emergency Operations Centre staff

12. The focus of the Quality, Governance and Assurance Team over the coming months will be on the **clinical treatment and assessment issues** identified.

13. To date the team have provided learning from SI investigations and contributory factors training to the Paramedic Academy students, EOC Core Skills Refresher training and the Learning From Incidents group.

14. 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 Mortality Review Group.

Delayed Attendance at 999 Calls

Serious Incidents

15. Of the nine SI's closed by the CCG in July, six investigations cited a delayed response as a contributory factor.

16. The current Trust fleet ratio of Double Crewed Ambulances (DCA) vs Fast Response Units (FRU) is being reconfigured to better meet the demand placed on the Trust following the implementation of the new national ambulance standards. This is an ongoing programme and is expected to be delivered within 18-24 months and will include a review of all operational rosters, fleet and EOC staffing.

17. Whilst the operational reconfiguration is being undertaken there are a number of actions that have been introduced to mitigate further occurrence of harm attributed to a delayed response;

    a. Dispatch of a solo resource to certain Category 2 calls where an appropriate resource has not been dispatched within 8 minutes.

    b. In addition to the provision of Hear and Treat of Category 4 calls, the Clinical Hub has been tasked with maintaining oversight of all held Category 2 calls.

Incident Reports

18. In July, 5 incidents were reported that were recorded as a Delayed Response. Of these;

    a. 4 were graded as No Harm

    b. 1 was graded as Severe Harm

19. Of these, 2 were referred to the Serious Incident Group (SIG). 1 case was declared a Level 1 Root Cause Analysis. This was attributed to significant 999 demand at the time, however it was felt a review of how this was being managed is required.

20. Due to ongoing improvements of the Trust incident reporting system, the category of 'Delayed Response' was not in use in July 2017 therefore it has not been possible to undertake a comparison on the same month the previous year.

Complaints

21. The Trust Patient Experience Department received 13 complaints relating to incidents in July that cite a delayed response as the primary reason for raising a concern. Of these, 2 were from other healthcare providers.

22. This is a reduction on complaints received in July 2017 where 17 cases were recorded by the Patient Experience Department.

Weather Related Influence

23. During July, London experienced a period of prolonged hot weather.

24. In order to establish whether this had a direct impact on service delivery, the Mean response time for Category (Cat) 1/2/3 calls has been evaluated against daily maximum temperatures (Fig. 2).

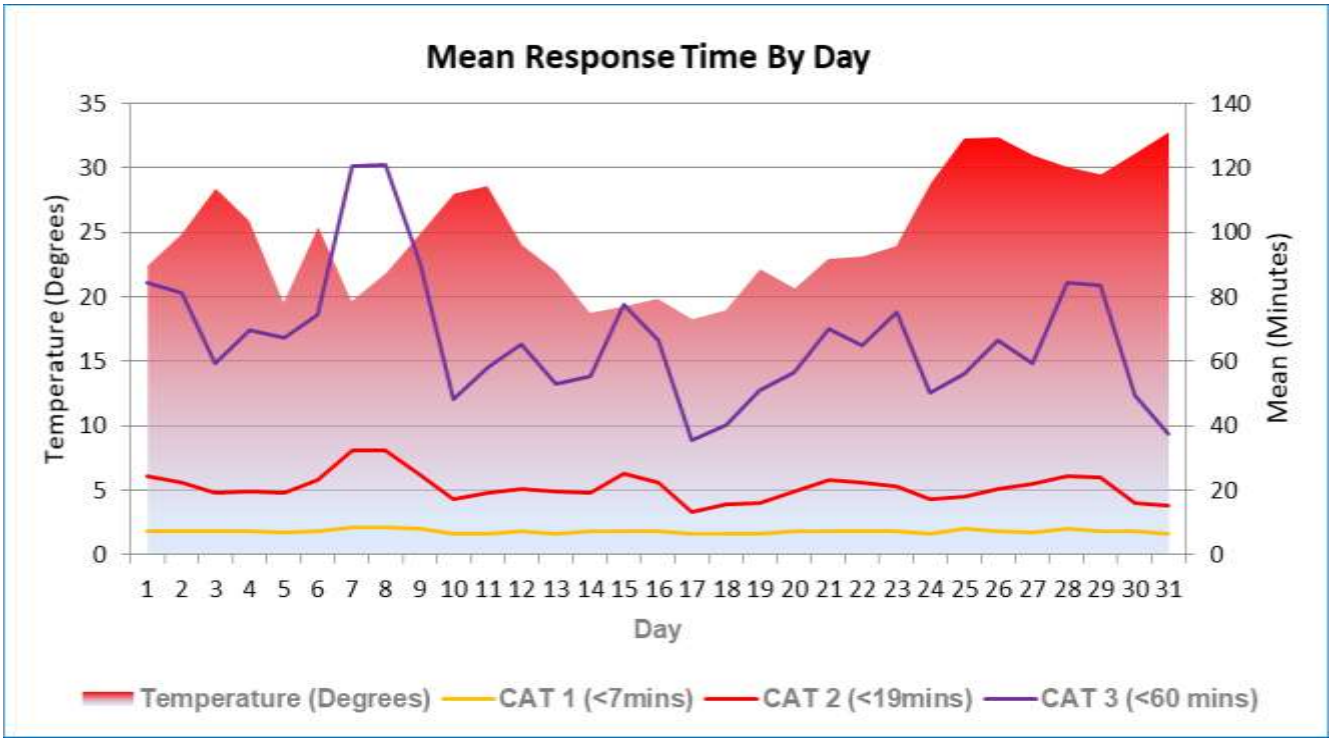


Fig. 2 Mean response times by day

25. The data would suggest that daily temperature does not directly impact on overall service performance at the time. However, learning from managing demand during winter has identified patients with chronic conditions usually develop symptoms 7-10 days after the extreme of temperature.

26. Whilst the data for 7 July 2018 appears anomalous; on this date the annual Pride London event took place. This event was attended by approximately 1 million partygoers within central London.

SI Action Compliance

27. Whilst 10 actions are currently overdue, the below graph demonstrates a significant improvement over the last 12 months. The Quality, Governance and Assurance team have been communicating on a weekly basis with the responsible managers and providing support where required. (Fig. 3)

28. The majority of actions that are currently overdue are in progress; however, some have been delayed due to factors outside of the control of the responsible manager. Staff absence and shift patterns have delayed the ability to provide additional training and/or feedback, however these actions are expected to be completed by the end of the month.

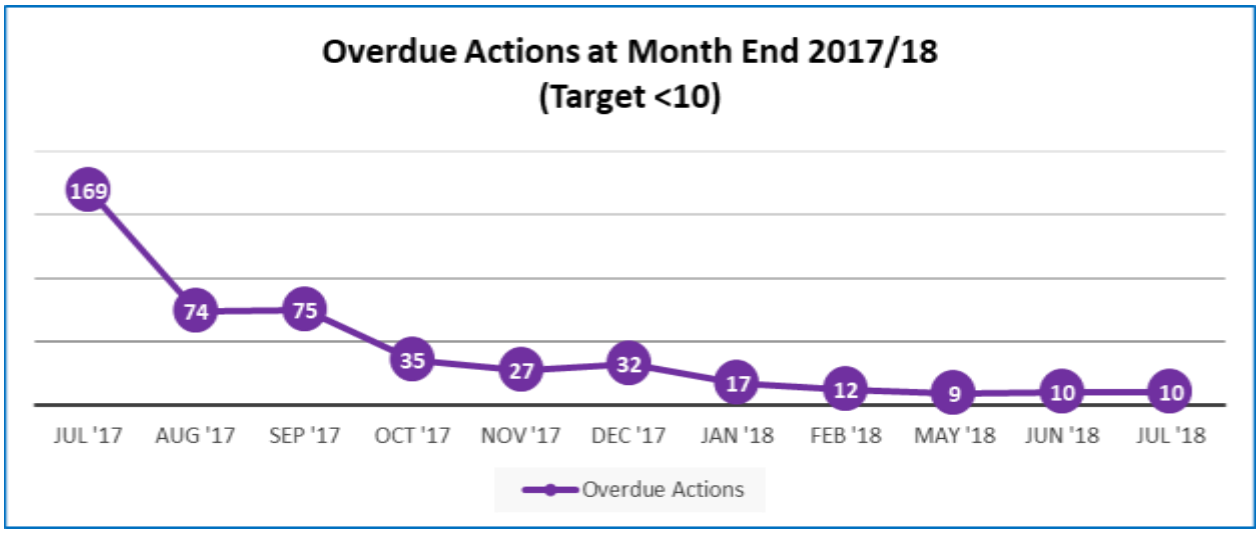


Fig. 3: Outstanding SI Actions by Month

Duty of Candour Compliance – February 2018

29. The Duty of Candour is a statutory requirement applicable to all declared SIs within the Trust.

30. Fig. 4 demonstrates the Trust current Duty of Candour compliance for serious incidents declared in 2018/19.

31. In July, one of the three declared SIs did not receive an initial apology as the Quality, Governance and Assurance Team were unable to make contact with the patient's next of kin despite significant efforts. Methods 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.

32. Formal letters were sent in all cases where details were available.

33. Currently, six reports are with the CCG awaiting official sign off before the final stage of the Duty of Candour process will be completed.

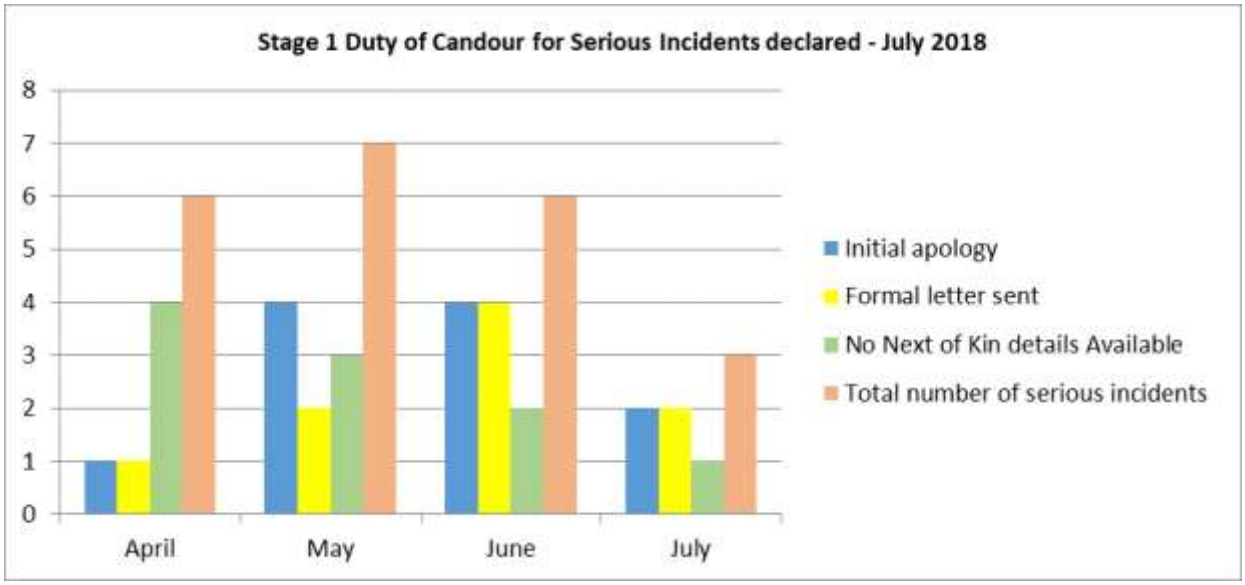


Fig. 4: Duty of Candour Compliance 1

Incidents

34. The Trust has set a year to date trajectory for the reporting of incidents that have been graded as no harm and low harm.

35. Fig. 5 provides a summary of the incidents reported by quarter and Fig. 6 demonstrates the year to date reporting figures for no and low harm incidents.

36. The year to date target for no harm incidents is 2800 which the Trust is on track to achieve.

37. The target for low harm incidents is 500 per year. The Trust is currently below the trajectory to achieving this Key Performance Indicator.

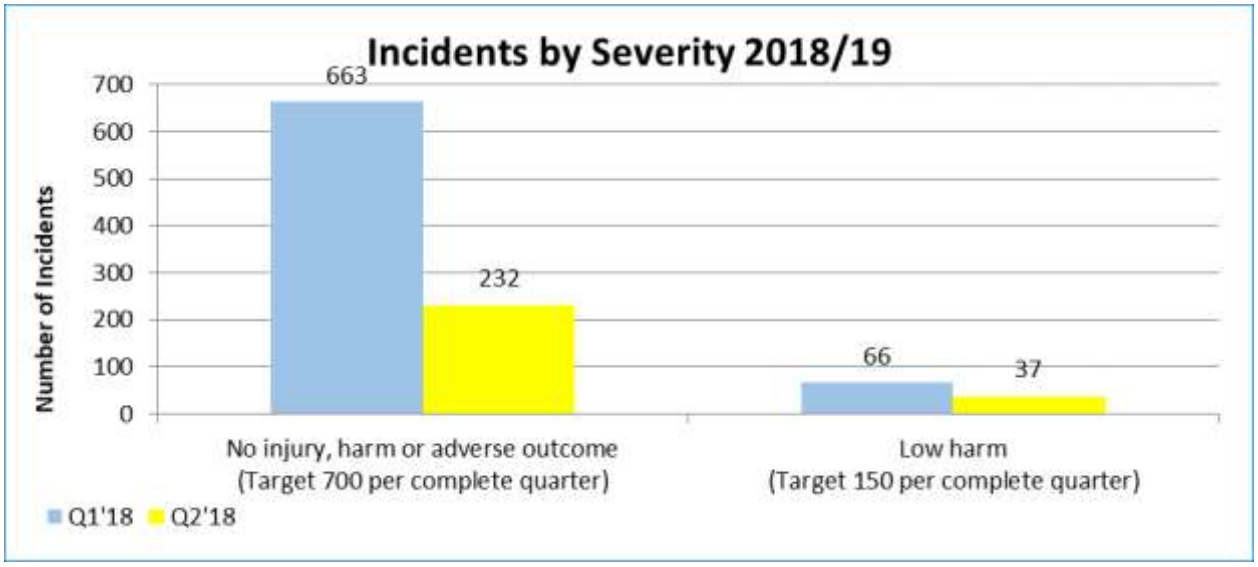


Fig. 5 No, Low & NRLS Reporting 1

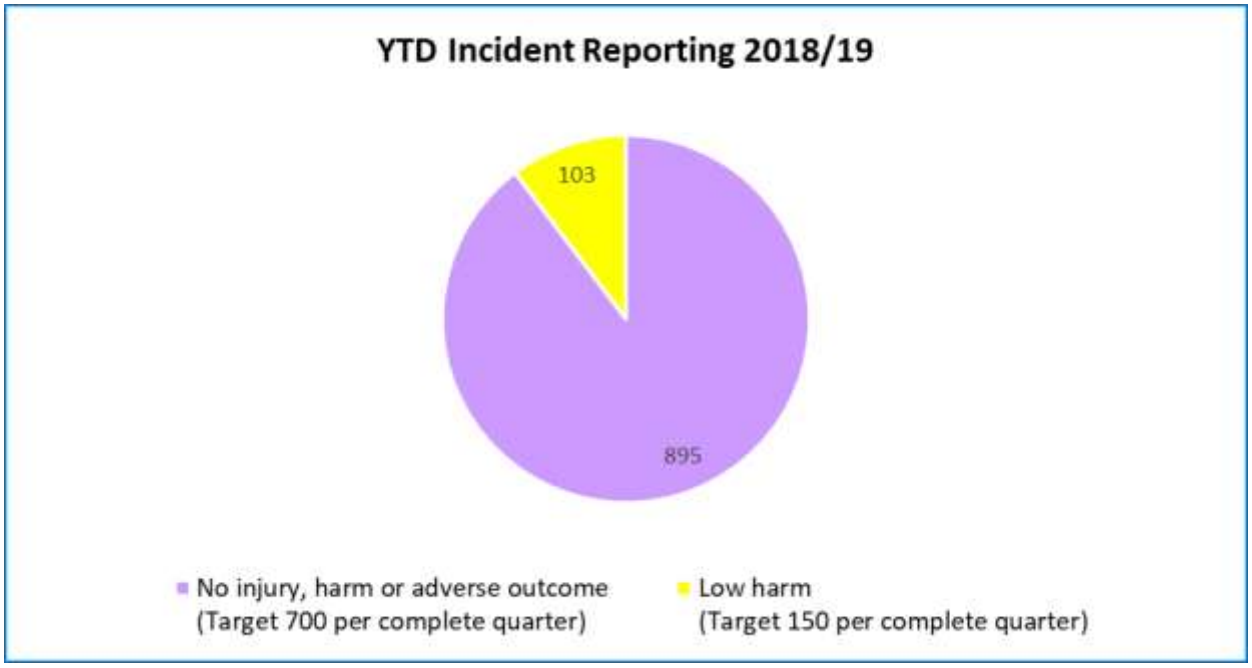


Fig. 6: Year to Date incident reporting 1

Actions & Assurance

38. We are maintaining our targets of 60 working days in relation to submitting completed SI investigations.

39. SI action compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required.

40. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the serious incident group and assurance processes.

41. 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

Appendix 1 – SI actions

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within 60 days
2018-8604	Clinical Treatment	North East	04/04/2018	Review guidance in Medical Directorate bulletin MD160	31/10/2018	18/07/2018	Yes
				Review training and guidance – Supraglottic Airway	31/10/2018		
2018-5533	Dispatch & Call	EOC	05/03/2018	Assistant Medical Director to discuss case with Medical Director at NHS111	Complete	02/07/2018	Yes
				Continue with the Trust recruitment programme	On-going Linked to Risk 337 -Trust recruitment programme		
				Continue with the oversight and review of capacity and demand	On-going (expected to be delivered within 18-24 months)		
2018-9530	Dispatch & Call	EOC	11/04/2018	The LAS to continue with the review of the operational model to ensure the fleet profile and operational rota patterns match demand.	On-going (expected to be delivered within 18-24 months)	12/07/2018	Yes
				Ensure the safe rollout of the 'End of Shift' pilot	Completed		
				All EMDs to receive reinforcement of the training provided on pre triage of breathing	31/08/2018		
				Continue with the oversight and review of capacity and demand	On-going (expected to be delivered within 18-24 months)		
2018-6643	Dispatch & Call	EOC	14/03/2018	The Trust to implement dispatch of solo clinicians to patients with chest pain, shortness of breath and clammy if no DCA available for dispatch after 8 minutes.	Completed	11/06/2018	Yes

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within 60 days
				Reiteration of Trust Policy TP003 – Statement of Duties to Patients to all operational staff detailing the actions to be taken when assistance is offered by a non-LAS clinician	30/08/2018		
				All EMDs to receive further information and training where required regarding the pre-triage of breathing. Receipt and understanding should be recorded on a personal issue of documents form	30/08/2018		
2018-5889	Dispatch & Call	EOC	07/03/2018	The LAS to continue with the review of the operational model to ensure the fleet profile and operational rota patterns match demand.	On-going (expected to be delivered within 18-24 months)	06/06/2018	Yes
				As the CHub has been tasked with the additional function of Cat 2 oversight, a review of staffing levels to enable oversight of all pending calls whilst maintaining its other core functions should	On-going Linked to Risk 337 -Trust recruitment programme		
				A robust process for the dissemination of information, updates and changes in practice to staff should be developed	31/08/2018		
				Guidance to be provided to EOC staff that standardises decision making when deciding how far is reasonable for an emergency resource to travel and removes ambiguity	30/06/2018		
				Further guidance should be issued to EOC staff in order to provide clarity as to which Cat 2 determinants would benefit from the attendance of a solo responder whilst awaiting a DCA to become available.	30/06/2018		
2018-4786	Clinical Treatment	North West	21/02/2018	Produce an article to staff on the correct administration of analgesia	20/08/2018	22/05/2018	Yes
				Attending clinicians to reflect specifically on JRCALC tools for patient assessment	Completed		
				Attending clinicians to produce a formal reflection with detailed focus on Crew Resource Management, Confirmation Bias and the moving and handling	20/08/2018		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within 60 days
				equipment provided by the Trust			
				Continue with the oversight and review of capacity and demand	On-going		
2018-7378	Clinical Treatment	North east	21/03/2018	Share a copy of the SI report with the care provider in order for a review to be undertaken	Completed	20/06/2018	Yes
				The paramedics first on scene at this incident should undertake additional training in management of tracheostomy patients and complete a reflective account to evidence the effectiveness of training.	Completed		
				The training in management of tracheostomy patients should be objectively reviewed in light of this incident to ensure that it is sufficient and adequate for competency in the management of tracheostomy patients by LAS clinicians	31/10/2018		
				Re-issue and re-emphasise the importance of referring to the Tracheostomy Management Algorithm	31/10/2018		
				The learning from this incident should be shared with all clinical staff	31/08/2018		
2018-7391	Dispatch & Call	EOC	21/03/2018	Complete the reconfiguration of DCA to FRU ratio in order to meet the requirements of the new national ambulance standards	On-going (expected to be delivered within 18-24 months)	20/06/2018	Yes
				The Trust to implement dispatch of solo clinicians to patients with chest pain, shortness of breath and clammy in 8 minutes if no DCA immediately available for dispatch.	Completed		
				Provide focussed learning by an appropriate manager to ensure compliance with all LAS policies and procedures	31/07/2018		
				The Trust needs to ensure that the CHUB and EOC have the appropriate staffing to enable the oversight of all calls that have breached the response target.	On-going Linked to Risk 337 -Trust recruitment programme		
				Control Services Bulletin of 22nd January 2018 should be	31/08/2018		

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for closure of all actions	Date sent to CCG	Within 60 days
				formally republished to all EOC and CHUB staff.			
2018-6637	Dispatch & Call	EOC	14/03/2018	The LAS to continue with the review of the operational model to ensure the fleet profile and operational rota patterns match demand	Ongoing	13/06/2018	Yes
				The EMD should receive feedback in adhering to the MPDS protocol on when to stay on the line	Completed		
				Review of the current new entrants' training package to ensure clear guidance is provided when to stay on the line	Completed		
				Review current Clinical Hub standard operating procedure to consider Category 2 ring backs and a review of staffing levels	On-going Linked to Risk 337 -Trust recruitment programme		

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Working with regional partners to meet national performance standards			
Agenda item:	13			
Report Author(s):	Brian Jordan, Head of Operational Compliance and Standards			
Presented by:	Paul Woodrow, Director of Operations			
History:	This paper follows on from the previous "Preparing to meet national performance standards" paper which was presented to July's Board meeting (ref: TB/18/61)			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

National oversight of the Trust's preparations to meet national performance standards is being managed through NHS England's Ambulance Integration Programme (AIP). The AIP is accountable to the Ambulance Improvement Programme Board and will take responsibility for the oversight of progress towards meeting the Ambulance Response Programme (ARP) performance and clinical standards and progress against reducing unnecessary conveyances to emergency departments. Our regional NHS England and NHS Improvement partners reported to the AIP on the Trust's position on 03 September 2018.

The Trust worked alongside our regional NHS England, NHS Improvement and Clinical Commissioning Group (CCG) partners in advance of meeting on 03 September 2018 to inform their national update.

Recommendation(s):

The Board is asked to note the content of the paper.

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

No BAF risks are associated with the content of this paper.

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	☒

Reporting to the Ambulance Improvement Programme Board

1. National oversight of the Trust's preparations to meet national performance standards is being managed through NHS England's Ambulance Integration Programme (AIP). The AIP is accountable to the Ambulance Improvement Programme Board and will take responsibility for the oversight of progress towards meeting the Ambulance Response Programme (ARP) performance and clinical standards and progress against reducing unnecessary conveyances to emergency departments. Our regional NHS England and NHS Improvement partners reported to the AIP on the Trust's position on 03 September 2018.

2. The Trust worked alongside our regional NHS England, NHS Improvement and Clinical Commissioning Group (CCG) partners in advance of the meeting on 03 September 2018 to inform their national update.

Regional health system priorities for performance improvement

3. The regional health system has placed priorities on the Trust's performance improvement being met through a reduction in conveyances to emergency departments; increased hear and treat and see and treat rates; digital advancements which will support performance standards as well as conveyance reduction trajectories; other internal efficiencies such as reductions in 'handover to green'; and a continued reduction in hospital handover delays.

Performance improvement initiatives

4. Following the establishment of an executive-led task and finish group, the Trust has a robust plan to fully implement reporting against all national ambulance quality indicator (AQI) standards within the coming months. Technical solutions within the computer aided dispatch (CAD) software system and Trust data storage facilities are actively being developed for:

   - Changes to the re-categorisation process for calls
   - Calculating response time for patients arriving on inbound flights at London airport
   - The introduction of Category 5.

   It is accepted that these technical solutions will have a positive impact on the delivery of the Trust's national performance standards however it is not currently possible to predict the extent of the impact.

5. As previously reported, the Trust has planned to reduce unnecessary ambulance conveyances to emergency departments by 1% in 2018/19 and this target was formally ratified at the Strategic Commissioning Board meeting on 10 September 2018. An action plan has been developed to ensure the delivery of the target and this will be monitored by commissioners on a monthly basis. The action plan is based on the following deliverables:

   - The introduction of Advanced Paramedic Practitioners (APPs) Urgent Care
   - Piloting the new pioneer services throughout 2018/19
   - The introduction of mobile devices, particularly iPads, to improve access to alternative care pathways (ACPs) and clinical guidance. Specific apps are also being monitored in terms of usage.
   - Increased usage of alternative care pathways (ACPs) where these are available
   - Developing ACPs, and the better use of ACPs, in partnership with commissioners. There is now a pan-London ACP group which is co-chaired by commissioners and

the Trust and which currently focuses on falls, district nursing and respiratory conditions
- Holding a workshop with senior operational managers to identify the current barriers to increasing see and treat rates and by identifying a number of 'quick win' solutions
- Ensuring frontline staff are pro-actively contacting, and being supported by, the clinical hub in order to increase see and treat rates. The Trust is also exploring the set-up of additional clinical hub sites in Croydon and in the North West sector.

6. The Trust has proposed a trajectory and target for improving hear and treat rates from 3.8% (the agreed baseline based on January – July 2018) to 5.1% by March 2019. The Trust will deliver this trajectory through the following actions:

   - A comprehensive review of the Clinical Hub is being undertaken which will look to increase the number of hours being provided by Clinical Hub staff to delivering hear & treat
   - Capacity in the Clinical Hub will increase as the Trust closes its vacancy gap due to reduced safety netting activity
   - Sector Senior Clinical Leads are being recruited to each of the five London sectors. This role is designed to strengthen clinical leadership for Clinical Team Leaders and APPs and to lead clinical development across the sectors. This enhanced clinical leadership in sector will provide greater capacity in the Clinical Hub to deliver hear & treat
   - Named Clinical Team Leaders will be made the official point of contact to provide local clinical supervision (24 hours per day) which will in turn increase capacity in the Clinical Hub.

7. The Trust has not yet set an internal target for increased see and treat rates. This will require some work as the reduction targets for conveyance, hear and treat, and see and treat, are to some extent dependent on each other and the flow and change of activity from one to another will need to be considered.

8. The Trust is currently losing circa 580 hours per week in time over the 14 minute handover to green target. The Trust is planning to reduce this to 480 hours per week by the end of October 2018. This will release an additional 100 hours per week into the system which would equate to an additional 40 ambulance shifts per month. The reduction in handover to green time is being delivered by the following actions:

   - Re-issuing guidance on handover to green times to all frontline staff
   - Analyse individual employee blue and non-blue handover to green times via the Trust's data portal and review these as part of the every frontline member of staff's Clinical Information Support Overview (CISO), prioritising those with the highest times over the 14 minute target
   - Review each emergency department's handover to green issues and work in partnership with Acute Trusts to manage these issues
   - Each station group's handover to green times will be scrutinised at monthly Chief Executive performance review meetings.

9. As reported to the Board in July, there are a number of other projects and interventions which are currently being undertaken internally, and with external partners, in order to improve operational performance and efficiencies. This includes:

   - Reducing Out of Service
   - Roster review and associated vehicle requirements
   - Activating fast response units (FRUs) from dedicated tier points
   - Category 1 improvements (including Signals from Noise)
   - Hospital handover delays

- London Urgent and Emergency Co-ordination Centre
- Review of intelligent conveyance.

Next steps

10. The AIP Board meeting on 3 September was the first of four quarterly meetings. Work will therefore continue between the Trust and its regional partners to progress the initiatives identified within the attached packs, and in this covering paper, to ensure that the Trust is able to meet each of the national performance standards as early as possible.

11. The Director of Operations will continue to chair a monthly ARP programme board in order to drive progress against performance improvement initiatives. The programme board is further supported internally by a weekly ARP delivery board.

12. Further scrutiny of performance against national standards, and the efficiency measures required to deliver against the standards, will take place at the monthly Chief Executive performance review meetings.

13. Progress reports will continue to be provided routinely to the Executive Committee and to the Trust Board.

Paul Woodrow
Director of Operations

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Report of the Trust Secretary			
Agenda item:	14			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	NA			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with information about the decisions that have been taken since the last meeting of the Board on 31 July 2017.

Chair's action

Standing Order 43 (Urgent Decisions) states that "where an urgent decision is required on a matter which would normally be reserved to the Trust Board in advance of a meeting of the Trust Board, the matter will normally be raised by the Chief Executive, or a Board Director with the Chairman, or in his absence the Deputy Chairman, with a recommended course of action. The Chairman, or in his absence the Deputy Chairman, shall be authorised to act on behalf of the Board where time is of the essence." It is a requirement of Standing Order 43 that any such decision shall be reported to the next appropriate meeting of the Board.

This report advises the Board of the decision taken by the Chairman on 02 August 2018 with regard to an outline case for deployment of 2018/19 capital budget to purchase double crewed ambulances (detail set out in the report attached).

Report considered in correspondence

A report was circulated to the Board for consideration in correspondence on 01 September 2018 relating to a Regulation 28 Report to Prevent Future Deaths (PFD) received by the Trust from Russell Caller, Assistant Coroner for the coroner area of Inner West London. The report was circulated in correspondence in light of the fact that a response was due by 06 September 2018. Board members were asked to consider the PFD report, the Trust's proposed response and the evidence upon which this proposed response was based.

Recommendation:
The Trust 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 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
NHS Trust

Report to:	Trust Chairman (for the purposes of Chairman's action)			
Date of meeting:	02 August 2018			
Report title:	Outline case for deployment of 2018/19 capital budget to purchase double crewed ambulances			
Agenda item:	N/A			
Report Author(s):	Garrett Emmerson, Chief Executive Officer Benita Mehra, Director of Strategic Assets and Property Lorraine Bewes, Director of Finance and Performance Philippa Harding Director of Corporate Governance			
Presented by:	Benita Mehra, Director of Strategic Assets & Property			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

The Trust's Standing Orders (Standing Order 43.1) state that, where an urgent decision is required on a matter which would normally be reserved to the Trust Board in advance of a meeting of the Trust Board, the matter will normally be raised by the Chief Executive, or a Board Director with the Chairman, or in his absence the Deputy Chairman, with a recommended course of action. The Chairman, or in his absence the Deputy Chairman, shall be authorised to act on behalf of the Board where time is of the essence.

The purpose of this paper is to seek approval from the Trust Chairman (using the powers available under Standing Order 43.1) of a proposed procurement of new and replacement Double Crewed Ambulance (DCA) vehicles totally £9.076m in the current financial year.

Recommendation(s):

The Chairman is recommended to:

- Agree the proposed modification of the procurement timescales of the DCAs in the existing 2015 business case and current capital plan to enable the placing of immediate orders for the supply of 112 Mercedes chassis, 30 box body conversions and equipment to fit out 112 DCAs.
- The placement of further orders for a further 82 box body conversions in 2019/20.
- The approval of both the additional £3.849m of funding successfully from the Department of Health and the business case for this investment contained in the successful bid document

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

The key risks relate to the availability of ambulances, if the fleet continues to age, the risk to the operation increases with little time to maintain the fleet.

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	☒

Heather Lawrence
on
3 August 2018

Purpose

1. The Trust's Standing Orders (Standing Order 43.1) state that, where an urgent decision is required on a matter which would normally be reserved to the Trust Board in advance of a meeting of the Trust Board, the matter will normally be raised by the Chief Executive, or a Board Director with the Chairman, or in his absence the Deputy Chairman, with a recommended course of action. The Chairman, or in his absence the Deputy Chairman, shall be authorised to act on behalf of the Board where time is of the essence.

2. The purpose of this paper is to seek approval from the Trust Chairman (using the powers available under Standing Order 43.1) of a proposed procurement of new and replacement Double Crewed Ambulance (DCA) vehicles totally £9.076m in the current financial year.

Introduction

3. The London Ambulance Service NHS Trust (LAS) continues to face a significant number of strategic and operational pressures with the vehicle fleet. This paper has been prepared to support the replacement of our business critical assets - Double Crewed Ambulances (DCAs) in order to minimise service risks arising from unavailability and to minimise unnecessary maintenance and running costs. LAS DCA average age profile is at the top end of 10 years as referenced in the Carter Review, where the average age across ambulance trusts ranges from five years to twelve years. The average ambulance travels at least 50,000 miles every year. This is five times more than the average personal car. The initial findings of the Carter Review in May 2018 indicated that maintenance costs escalate with the age of vehicles.

4. An ultra-low emission zone (ULEZ) is planned for implementation in London by 2019. This means the Mayor of London will levy daily fines of £100 per vehicle for all diesel engines over the age of four years in the area. The scheme will initially cover a small zone but is highly likely to expand and cover the whole of London by 2023.

5. The age and unreliability of the current fleet and the pressures on performance from the introduction of the Ambulance Response programme (ARP) means that DCAs have not been replaced on a periodic basis and now need to be replaced as some vehicles are showing higher failure rates due to high usage and age. Previous constraints on capital and revenue budgets, have led to limited DCA replacement. However a full business case for the on-going replacement of DCAs was agreed by the Trust Board in 2015, for an initial 140 DCAs (which are currently being rolled out operationally) and circa 60 DCAs per annum thereafter to 2022/23.

Future DCA Demand

6. The introduction of ARP has increased the Trust's overall demand for DCAs. The Trust now requires in the region of 510 operational vehicles to fully meet the new ambulance response standards. This requires a net increase of 68 DCAs (from an existing provision of 453 vehicles).

DCA age and ULEZ compliance

7. The table below shows the extent of the DCA age profile in support of the replacement strategy. The current DCA has a nominal design life of 7 years as defined through NHSI metrics (Carter) with evidence suggesting 'that where trusts have vehicles over 5 years,

efficiency through usage and mileage diminishes rapidly, and a correlation between an aged fleet and downtime, fuel consumption and maintenance costs.'

8. In light of DCA market limitations in 2018/19, the fleet strategy to achieve this is to retain as many DCAs as possible during fleet replacements and grow the fleet. However with some of the DCA being old and inefficient (13 years), it is not always economically viable or always possible to keep it on the road and so it is vital to undertake an annual replacement plan.

9. In addition to this, the requirement to fully meet the ULEZ emissions standards by October 2023 limits the ability of the Trust to continue using older vehicles. Currently only 244 of the Trust's DCA's are ULEZ compliant therefore, by October 2023, the Trust will need to purchase a minimum of a further 266 DCAs – an average of 54 per annum up until that time.

Registration year	Vehicle age	DCA numbers	Max life expectancy	ULEZ compliance
2005	13	3	2	X
2006	12	36	3	X
2009	9	79	6	X
2010	8	64	7	X
2011	7	18	8	X
2012	6	66	9	X
2015	3	104	12	104
2017	1	57	14	57
2018	0	83	15	83
Total DCA units		**510**		**244**

Capital Approved

10. The 2018/19 LAS capital funding allocation for DCAs includes internally generated cash of £5.227m for existing DCA replacements that was approved as part of the capital programme for 2018/19.

11. It is important to note that the Trust's current (2015) business case and approved capital plan is only sufficient to renew the current fleet to comply with ULEZ emissions standards by October 2023, it does not support the expansion necessary to achieve the 68 additional DCAs necessary to fully deliver the ARP standards. Whilst, in the shorter term, this higher number can be achieved by holding on to older vehicles, without further investment on top of the current capital programme, the Trust risks either not being able to provide enough (ULEZ compliant) vehicles to fully deliver ARP post 2023, or leave itself exposed to the punitive non-compliance charges in paragraph 2 above.

Additional Capital Now Secured

12. As a result of this LAS applied for, and has been successful in securing an additional £3.849m of capital funding from the Department of Health and Social Care (DH) via NHS Improvement (NHSI), to support the expansion of the DCA fleet to support the implementation of ARP. The funding will support the procurement of 25 of the additional 68 DCAs required by ARP. The only criteria stated by NHSI is that 25 DCA are delivered by 1st February 2019.

13. The Trust is aware of potential moves by the Department of Health nationally to develop a single national ambulance specification and procurement model. Discussions have taken place with NHSI regarding this. However as yet there is no national common specification for ambulances and, as any such specification would take some time to conclude, it was considered appropriate for LAS to continue with the replacement of box

bodies as the aged LAS fleet poses a greater risk of unreliability; would affect operational performance and; any delay in the on-going renewal process would adversely impact the Trust financially, in terms of future non-compliance with the Mayor's Air Quality Strategy.

Proposal

14. With a budget of £5.227m, LAS would ordinarily seek to deliver 41 completed DCAs; however there are significant constraints within the ambulance supply market, particularly in relation to body conversion services, and these have altered the way in which the Executive is proposing that the money will be spent over the coming two years.

15. Within these constraints, the Executive would therefore like to proceed urgently with commissioning the necessary production slot capacity as there are competing supply chain demands across Europe.

16. In addition, because of limited supply capacity in the conversion market, it is now proposed that a greater number of chassis be purchased (from Mercedes) in 2018/19, with a smaller number of body conversions being completed in 2018/19 and the remainder to be delivered in 2019/20. The overall amount of capital to be spent will remain unaltered in both years.

17. By enabling the Trust to take possession of a greater number of (EU manufactured) Chassis prior to March 2109, when the United Kingdom leaves the EU, this approach also provides additional security of supply for the Trust in the event of a 'no deal' Brexit. It also reduces the risk of currency fluctuations adding to the cost of procurement and enables an even distribution of ambulance conversions during the spring- summer period of 2019/20, when the supplier has greater slot availability, in advance of winter 2019.

2018-19

18. In 2018/19, it is therefore proposed that capital will be spent on:

    - 25 Mercedes chassis and box body conversions are completed prior to 1 Feb 2019 to comply with the terms of the recent Department of Health grant.
    - A further 5 chassis and box body conversions are completed by the 31 March (subject to supplier confirming available build slots).
    - On top of this, an additional 82 Mercedes chassis are purchased for box body fit out in 2019/20
    - Sufficient equipment is purchased for the fit out of all 112 ambulances (over the 2 year period).

19. Total spend is anticipated to be £9.022m, within a total available budget of £9.076m.

2019-20

20. In 2019/20 it is proposed that the remaining 82 box body conversions are completed, with a total spend of c£5.758m, again within the current capital plan.

Risks

21. The risks of not taking the proposed action can be summarised as:

- An increased failure rate of an aged fleet;
- An increased likelihood of having to pay fines for ULEZ charges for non-compliant vehicles;
- An inability to secure build slots with each supplier, therefore confirmation of capital allocation can only be confirmed once orders have been placed;
- An inability to spend the additional funding from NHSI;
- A failure to spend internal capital; and
- An increased level of uncertainty related to the UK's exit from the EU.

Recommendations

22. The Chairman is therefore recommended to:

- Agree the proposed modification of the procurement timescales of the DCAs in the existing 2015 business case and current capital plan to enable the placing of immediate orders for the supply of 112 Mercedes chassis, 30 box body conversions and equipment to fit out 112 DCAs.

- The placement of further orders for a further 82 box body conversions in 2019/20.

- The approval of both the additional £3.849m of funding successfully from the Department of Health and the business case for this investment contained in the successful bid document

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	15			
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	September - Tuesday 25 September 2018
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Freedom to Speak Up Strategy
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	November - Tuesday 27 November 2018
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Audit Committee Assurance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report Logisitics & Infrastructure Cttee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update
Governance	
	Report from the Trust Secretary Trust Board forward planner Business Plan progress review
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	January - Tuesday 24 January 2019
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Patient Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

Trust Board forward planner: 2018/19

Area	March - Tuesday 26 March 2019
Standing items	Welcome and apologies Declarations of Interest Minutes of previous meeting Matters arising & action log Staff Story Report from the Chair Report from the CEO
Quality, Performance & Assurance	Integrated Quality & Performance Report Quality Assurance Committee Assurance Report People & Culture Committee Assurance Report Finance & Investment Committee Assurance Report BAF & Corporate Risk Register Serious Incident Management
Strategy & Planning	Quarterly Strategy Update
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSUP Quarterly Report Annual Accountability Statements
Concluding matters	Questions from members of the public Any other business Review of the meeting
Additional reports	Quality Report

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Unaudited Charitable Funds Annual Report & Financial Statements for 2017/18 independently examined by Ernst & Young LLP			
Agenda item:	16			
Report Author(s):	Michael John, Head of Financial Services			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	The unaudited Charitable Funds Annual Report & Financial Statements for 2017/18 that have been independently were reviewed by the Charitable Funds Committee and the Audit Committee on 04 September 2018 and now require approval from the Trust Board.			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

As the corporate trustees of the London Ambulance Service charity, the Trust Board has a statutory requirement to publish, an annual report and financial statements to include the annual report; the primary financial statements and notes; a statement on the trustee's responsibilities and independent examination and report.

- The minimum content for the annual report is set out in the Charities SORP (FRS 102).
- The financial statements are in accordance with the Charities Act 2011.
- The Trust is required to submit the Charities annual report and financial statements to the Charity Commission on or before 31 January 2019.
- The cash balance as at 31 March 2018 was £81k.
- Total income was £25k; this was £7k lower than last year.
- Total expenditure was £25k; this was £139k lower than last year.
- The net movement in funds was £0.1k; last year it was (£132k).

Independent examiner's statement (page 8)

"In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in accordance with section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached."

Recommendation(s):

The Audit Committee has reviewed and endorsed the Unaudited Annual Report and Financial Statements that have been independently examined by Ernst & Young LLP for approval by the Trust Board.

The Trust Board is asked to approve:

1. The unaudited annual report and financial statement of the London Ambulance Service Charitable Fund for 2017/18 that have been independently examined by Ernst & Young LLP; and
2. The Letter of Representation

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	☐

Charitable Funds Unaudited Annual Report and Financial Statements for 2017/18 independently examined by Ernst & Young LLP

Purpose

1 To present the London Ambulance Service NHS Trust Charitable Funds Annual Report and Financial Statements for 2017/18 for approval that have been independently examined by Ernst & Young LLP.

Background

2 As the corporate trustees of the LAS Charity, the Trust Board has a statutory requirement to produce and publish an Annual Report and Financial Statements comprising the Annual Report, the primary financial statements and notes; a statement on the Trustee's responsibilities for the Trust's charitable funds and independent examination report.

3 The Annual Report is in accordance with the Charities SORP (FRS 102). The financial statements are in accordance with the Charities Act 2011. The Trust is required to submit these by 31 January 2019.

Financial Performance of Charity

4 The cash balance as at 31 March 2018 was £81k.

5 The income for the year was £25k; this was £7k lower than last year's income of £32k.

6 The expenditure for the year was £25k; this was £139k lower than last year's expenditure of £164k.

7 The Charitable Funds Committee and Audit Committee have reviewed the Unaudited Annual Report and Financial Statements for 2017/18 that have been independently examined by Ernst & Young LLP and confirm that there are no issues that should be brought to the attention of the Trust Board.

Independent examiner's statement (page 8)

8 "In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in accordance with section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations

2008 other than any requirement that the accounts give ‘true and fair’ view which is not a matter considered as part of an independent examination.

9 I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Recommendations

10 The Trust Board is asked to approve:

- the Charitable Funds Unaudited Annual Report and Financial Statements for 2016/17 that have been independently examined by Ernst & Young LLP; and
- the Letter of Representation.

Lorraine Bewes
Director of Finance and Performance

LONDON AMBULANCE SERVICE CHARITABLE FUND

DRAFT UNAUDITED ANNUAL REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2018

LONDON AMBULANCE SERVICE CHARITABLE FUND

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2018

Foreword

The Charity's annual report and accounts for the year ended 31 March 2018 have been prepared by the Corporate Trustee in accordance with the Statement of Recommended Practice by Charities (SORP FRS 102) as it applies from 1 January 2015, applicable UK Accounting Standards and the Charities Act 2011.

The Charity has a Corporate Trustee, the London Ambulance Service NHS Trust. The members of the Trust Board who served during the financial year were as follows:

Board Member	Designation within the Trust
Heather Lawrence	Chairman
Garrett Emmerson	Chief Executive (Appointed 30th May 2017)
Andrew Grimshaw	Acting Chief Executive (Resigned 29th May 2017)
Jessica Cecil	Associate Non-Executive Director
John Jones	Non-Executive Director
Robert McFarland	Non-Executive Director
Fergus Cass	Non-Executive Director
Theo De Pencier	Non-Executive Director
Jayne Mee	Non-Executive Director
Sheila Doyle	Non-Executive Director
Amit Khutti	Associate Non- Executive Director (Appointed 1st January 2018)
Andrew Bell	Acting Director of Finance (Resigned 31st May 2017)
Lorraine Bewes	Director of Finance and Performance (Appointed 17th June 2017)
Paul Woodrow	Director of Operations
Fenella Wrigley	Medical Director
Patricia Bain	Chief Quality Officer

REFERENCE AND ADMINISTRATIVE DETAILS

The London Ambulance Service Charitable Fund (No 1061191) was entered on the Central Register of Charities on 7 March 1997. It is an NHS Special Purpose Charity.

Charitable funds received by the Charity are accepted, held and administered as funds for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

Trustee

The London Ambulance Service NHS Trust is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and also the law applicable to Charities which is governed by the Charities Act 2011.

The Board has devolved responsibility for the on-going management of the funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

This committee was formed on 7 March 1997 and the names of the people who served during the year as agent for the Corporate Trustee as permitted under regulation 16 of the NHS Trust (Membership and Procedures) Regulations 1990 and reports to the Board Members were as follows:

Fergus Cass (Chairman) appointed on 13 September 2017
Heather Lawrence (Chairman) resigned on 13 September 2017
Lorraine Bewes (Director of Finance)
Michael John (Head of Financial Services)
Eddie Brand (UNISON representative)

The Charitable Funds Committee normally meets once a year and the minutes of the meeting are received by the Trust Board in the public agenda. In addition a sub group of the Charitable Funds Committee meets on a regular basis to review grant applications and financial performance of the fund.

Principle Charitable Fund Adviser to the Board

Lorraine Bewes, Director of Finance, is the budget holder, who under a scheme of delegated authority approved by the Corporate Trustee, has day-to-day responsibility for the management of the Charitable Fund, and must personally approve, on behalf of the Corporate Trustee, all expenditure over £1,000 with an upper limit of £5,000 using his delegated authority.

Michael John, Head of Financial Services, acts as the principal officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

Principal Office

The principal office, which is also the registered office, for the charity is:

Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London SE1 8SD

Principal Professional Advisers

Bankers

Lloyds Bank plc.
City Office
Bailey Drive
Gillingham Business Park
Gillingham
Kent
ME8 0LS

Independent Examiner

Janet Dawson
Ernst & Young LLP
1 More London Place
London
SE1 2AF

STRUCTURE, GOVERNANCE AND MANAGEMENT

The charity has two funds, the Voluntary Responders restricted fund and the General Fund. The General Fund was established using the model declaration of trust and all the funds held on trust as at the date of registration were part of this fund. The Voluntary Responders Fund was launched in March 2012. This fund supports the work of volunteer lifesavers in the capital.

Members of the Trust Board and the Charitable Funds Committee are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. Non-Executive members of the Trust Board are appointed by the NHS Appointments Commission and Executive members of the Board are subject to recruitment by the NHS Trust Board. The NHS Trust as corporate trustee appoints the Charitable Funds Committee to manage the charitable funds under delegated authority.

Newly appointed members of the Trustees Board and the Charitable Funds Committee receive copies of the standing orders which include the terms of reference for the Charitable Funds Committee.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources;
- Manage and monitor the receipt of income and support/guide any fundraising activities;
- Ensure that best practice is followed in the conduct of its affairs fulfilling all of its legal responsibilities;
- Ensure that the Investment Policy approved by the NHS Trust Board as Corporate Trustee is adhered to and performance is continually reviewed whilst being aware of ethical considerations; and
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The financial record and day to day administration of the funds are dealt with by the Finance Department of the London Ambulance Service NHS Trust whose address is given above.

Trustees' Responsibilities in the Preparation of Financial Statements

The trustees are responsible for preparing the trustees' annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England & Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing those financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles in the Charities SORP;
- Make judgements and accounting estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the governing document. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Risk Management

The major risks to which the charity is exposed have been identified and considered. They have been reviewed and systems established to mitigate those risks.

ACHIEVEMENTS AND PERFORMANCE

Partnership Working and Networks

London Ambulance Service NHS Trust and its staff are the main beneficiaries of the charity and is a related party by virtue of it being the Corporate Trustee of the charity. By working in partnership with the Trust, the charitable funds are used to best effect and so when deciding on the most beneficial way to use charitable funds; the Corporate Trustee has regard to the main activities and plans of the Trust. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of the fund.

OBJECTIVES AND ACTIVITIES

The Charity has the following objective:

Voluntary Responders Group

To apply the income, and at its discretion, so far as may be permissible, the capital to advance health, save lives and to promote the efficiency of ambulance services, and in particular, but without limitation by the promotion of volunteering within London Ambulance Services' geographical area of responsibility and in relation to its services.

General Fund

To apply the income, at its discretion, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the London Ambulance Service NHS Trust.

The Charitable Funds Committee have agreed that the main purpose of the general fund is to fund projects for the benefit of all employees of the London Ambulance Service NHS Trust.

The London Ambulance Service Charitable Fund is defined as a Public Benefit Entity. The Trustees confirm that they have given due consideration to the Charity Commission's published guidance on the Public Benefit requirements under the Charities Act 2011.

ANNUAL REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2018

ANNUAL REVIEW

Donations received by the Voluntary Responders Fund are applied to advance health, save lives and to promote the efficiency of ambulance services, particularly, but not limited to, the promotion of volunteering within the geographical area served by the London Ambulance Service.

Donations received by the General Fund in the past and currently are specifically given to thank ambulance staff. Hence, the main charitable activities undertaken by the fund are those which will benefit staff by providing goods and services that the NHS is unable to provide. Typical examples are grants towards improved facilities for staff at ambulance stations.

Grant Making Policy

Each year applications are invited from any member of the London Ambulance Service. Based on their knowledge of the service, the Charitable Funds Committee agrees funding priorities and reviews the applications for quality and value for money.

FINANCIAL REVIEW

Reserves are needed to provide funds, which can be designated to specific projects to enable those projects to be undertaken at short notice.

The level of reserves are monitored and reviewed by the Corporate Trustee, on an annual basis (free reserves at 31 March 2018 were £45,000).

The net assets of the charity as at 31 March 2018 were £81,000 (31 March 2017: £81,000). Overall net assets remained the same.

The main source of income of the charity is donations. Total incoming resources for the year were £25,000 (2016/2017: £32,000).

Expenditure totalled £25,000 during the year.

The charity has no employees so relies on the London Ambulance Service NHS Trust staff to review the appropriateness of grant applications. Each year the Charitable Funds Committee sets a budget and reviews income and expenditure against this budget on a twice a year.

Reserves Policy

The Trustee recognises its obligation to ensure that funds received by the charity should be spent effectively in accordance with the funds objectives. The charity's reserves comprise those funds freely available for its general purposes. The reserves are held at a level that will enable the charitable fund to operate for a year. The charities hold reserves of £3,000 for this purpose.

OUR FUTURE PLANS

The future plans for the London Ambulance Service Charitable Fund is to expand the Volunteer Emergency and Community First Responders schemes in order that more patients can benefit and also to continue to fund projects for the benefit of staff education and welfare.

The Responders Fund has been set-up to support the groups of volunteers that operate under the management of the London Ambulance Services First Responder department. These include community first responders, emergency responders, staff at public access defibrillator sites and members of the public that have received resuscitation training.

The Charity plans to maintain and more actively use their Just Giving website and hold a number of funding raising events over the coming year to procure additional and replacement vehicles to support resuscitation training in the community.

Signed: ……

Fergus Cass, Chair of the Charitable Funds Committee on behalf of the Corporate Trustee

Date: ……

STATEMENT OF TRUSTEES' RESPONSIBILITIES IN RESPECT OF THE TRUSTEES' ANNUAL REPORT AND ACCOUNTS

Under charity law, the trustees are responsible for preparing the trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the income and expenditure for that period.

In preparing these financial statements, generally accepted practice requires that the trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of the SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at the time, and to enable the trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

Signed: ……

Fergus Cass, Chair of the Charitable Funds Committee on behalf of the Corporate Trustee

Date: ……

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF THE LONDON AMBULANCE SERVICE CHARITABLE FUND

I report on the accounts of the London Ambulance Service Charitable Fund for the year ended 31 March 2018 which are set out on pages 9 to 20.

Respective responsibilities of trustees and independent examiner

The charity's trustees are responsible for the preparation of the accounts. The trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in accordance with section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 7 August 2018. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner'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 charity and the trustees as a body, for this examination, for this report, or for the statements made.

Janet Dawson
For and on behalf of Ernst & Young LLP
Chartered Accountants
London

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017-18 Unrestricted Funds £000	2017-18 Restricted Funds £000	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Income from:					
Donations and Legacies	3	22	3	25	32
Total income		**22**	**3**	**25**	**32**
Expenditure on:					
Charitable activities	4	4	21	25	**164**
Total expenditure		**4**	**21**	**25**	**164**
Net income/ (expenditure)		**18**	**(18)**	**-**	(132)
Net movement in funds		**18**	**(18)**	**-**	**(132)**
Reconciliation of Funds					
Total funds brought forward		27	54	81	213
Total funds carried forward		**45**	**36**	**81**	**81**

The net movement in funds for the year arises from the charity's continuing operation. No separate statement of total recognised gains and losses has been presented as all such gains and losses have been dealt with in the statement of financial activities.

The notes at pages 12 to 20 form part of these accounts.

LONDON AMBULANCE SERVICE CHARITABLE FUND

BALANCE SHEET AS AT 31 MARCH 2018

	Note	2017-18 Unrestricted Funds £000	2017-18 Restricted Funds £000	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Current Assets					
Debtors	5	2	-	2	1
Cash at bank and in hand	6	45	36	**81**	184
Total current assets		**47**	**36**	**83**	185
Creditors: Amounts falling due within one year	7	2	-	**2**	104
Net current assets/ (liabilities)		**45**	**36**	**81**	81
Total assets less current liabilities		**45**	**36**	**81**	81
Total net assets		**45**	**36**	**81**	81
Funds for the charity					
Income Funds:	10				
Restricted fund		-	36	**36**	54
Unrestricted fund		45	-	**45**	27
Total charity funds		**45**	**36**	**81**	81

The accounts set out on pages 9 to 20 were approved by the Corporate Trustee on ……2018, and signed on its behalf by

Signed: ……

Fergus Cass, Chair of the Charitable Funds Committee on behalf of the Corporate Trustee

Date: ……

LONDON AMBULANCE SERVICE CHARITABLE FUND

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	Note	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Cash Flows from operating activities:			
Net Cash provided by (used in) operating activities	8	**(103)**	**(31)**
Change in cash and cash equivalents in the reporting period		**(103)**	**(31)**
Cash and cash equivalents at the beginning of the reporting period	6	184	**215**
Cash and cash equivalents at the end of the reporting period	6	81	184

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2018

1. Accounting Policies

1.1 Basis of preparation

The financial statements have been prepared, in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The financial statements have been prepared to give a 'true and fair' and have departed from the charities Accounts and Reports Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and the Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The trustees consider that there are no material uncertainties about the London Ambulance Service Charitable fund ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the London Ambulance Service Charitable Fund is a fall in income from donations but the trustees have arrangements in place to mitigate those risks.

Donations and Legacies

Donations and Legacies have been grouped together on the Statement of financial activities.

1.2 Funds Structure

Where the donor has provided for the donation to be sent in furtherance of a specified charitable purpose and has therefore created a legal restriction on use of the funds the income is allocated to a restricted income fund.

The remaining funds held by the charity are classified as unrestricted income funds. The expenditure of these funds is wholly at the trustee's unfettered discretion.

The major funds held under these categories are disclosed at note 11.

1.3 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three conditions can be met:

- entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- probable – it is more likely than not that economic benefits associated with the transaction or gift will flow to the charity; and
- measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

Where there are terms and conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before income is recognised as the entitlement condition will not be satisfied until this point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

Confirmation has been received from the representative of the estate that the payment of the legacy will be made or properly transferred and once all the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimated amount receivable.

1.5 Resource expended and irrecoverable VAT

Liabilities are recognised as resources are expended as soon as there is a legal constructive obligation committing the charity to the expenditure. A liability is recognised where the charity is under a constructive obligation to make a transfer of value to a third party as a result of past transactions or events. All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category.

a. Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity.

b. Charitable activities

Costs of charitable activities comprise all costs identified as wholly or mainly incurred in the pursuit of the charitable objectives.

Grants payable which are payments, made to third parties (including NHS bodies) in the furtherance of the charity's charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. Provisions are made where approval has been given by the trustee due to the approval representing a firm intention which is communicated to the recipient.

c. Allocation of support costs

Support costs are those costs that do not relate directly to a single activity. The support costs have been allocated against charitable activities.

d. Irrecoverable VAT

Irrecoverable VAT is charged as a cost against the activity for which the expenditure was incurred.

1.6 Stock

Stock is stated at the lower of cost and net realisable value.

1.7 Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

1.8 Cash at bank and in hand

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

1.9 Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to pay to settle the debt.

2. Prior Year Comparatives by type of fund

2a. Restricted funds – Statement of Financial Activity for the year ended 31 March 2018

	2017-18 £000	2016-17 £000
Income from:		
Donations and Legacies	**3**	20
Charitable activities	**-**	-
Total income	**3**	20
Expenditure on:		
Charitable activities	**21**	160
Total expenditure	**21**	160
Net income/ (expenditure)	**(18)**	(140)
Net movement in funds	**(18)**	(140)
Reconciliation of Funds		
Total fund brought forward	54	194
Total fund carried forward	**36**	54

Restricted funds – Balance sheet for the year ended 31 March 2018

	2017-18 Total £000	2016-17 Total £000
Current Assets		
Stock	**-**	-
Debtors	**-**	1
Cash at bank and in hand	**36**	53
Total current assets	**36**	54
Creditors: Amounts falling due within one year	**-**	-
Net current assets/(liabilities)	**36**	54
Total assets less current liabilities	**36**	54
Total net assets	**36**	54
Funds for the charity		
Restricted fund	**36**	54
Total charity funds	**36**	54

2b. Unrestricted funds – Statement of Financial Activity for the year ended 31 March 2018

	2017-18 £000	2016-17 £000
Income from:		
Donations and Legacies	**22**	12
Total income	**22**	12
Expenditure on:		
Charitable activities	**4**	4
Total expenditure	**4**	4
Net income/ (expenditure)	**18**	8
Net movement in funds	**18**	8
Reconciliation of Funds		
Total funds brought forward	**27**	19
Total funds carried forward	**45**	27

Unrestricted funds – Balance sheet for the year ended 31 March 2018

	2017-18 Total £000	2016-17 Total £000
Current Assets		
Debtors	2	-
Cash at bank and in hand	45	131
Total current assets	**47**	131
Creditors: Amounts falling due within one year	**2**	104
Net current assets/(liabilities)	**45**	27
Total assets less current liabilities	**45**	27
Total net assets	**45**	27
Funds for the charity		
Unrestricted income fund	**45**	27
Total charity funds	**45**	27

3. Income from donations and legacies

	2017-18 Unrestricted Funds £000	2017-18 Restricted Funds £000	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Donations from individuals	19	2	**21**	14
Corporate donations	3	1	**4**	5
Legacies	-	-	**-**	13
	22	**3**	**25**	32

There were no legacies received during the year (2016/2017: £13,000).

4. Analysis of charitable expenditure

	Support costs £000	**2017-18 Total Funds £000**	2016-17 Total Funds £000
Goods Donated to Beneficiaries	-	-	159
Staff welfare	25	25	5
	25	**25**	**164**

All grant applications are considered and approved by a sub group of the Charity Funds Committee on behalf of the Corporate Trustee.

The independent examiners remuneration of £2,244 (2016/2017: £2,026) related solely to the independent examination with no other work undertaken (2016/2017: £nil).
The charity has no employees.

5. Debtors

	2017-18 Total Funds £000	2016-17 Total Funds £000
Amounts falling due within one year:		
Other debtors	**2**	1
	2	**1**
Total Debtors		

6. Analysis of cash and cash equivalents

	2017-18 Total Funds £000	2016-17 Total Funds £000
Cash in hand	**81**	184
Total cash and cash equivalents	**81**	184

7. Analysis of Liabilities

	2018 Total £000	2017 Total £000
Amounts falling due within one year:		
Trade Creditors	-	100
Accruals	2	4
Total creditors	**2**	104

8. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2017-18 Total Funds £000	2016-17 Total Funds £000
Net income/ (expenditure) for the reporting period as per the statement of financial activities	-	(132)
	-	(132)
Adjustment for:		
(Increase)/decrease in stock	-	159
(Increase) decrease in debtors	(1)	(1)
Increase/(decrease) in creditors	(102)	(57)
Net cash provided by (used in) operating activities	(103)	(31)

9. Allocation of Support Costs and Overhead

Governance costs are those costs which relate to the day to day management of the charity. The governance costs are wholly charged against charitable activities.

10. Analysis of Charitable income funds

a. Restricted funds

	Balance 1 April 2017 £000	Resources expended £000	Incoming resources £000	Balance 31March 2018 £000
Voluntary Responders Fund	44	(21)	3	**26**
	44	**(21)**	**3**	**26**

Name of Fund	Description, nature and purpose of the fund
Voluntary Responders Fund	The objects of the restricted fund are to advance health, save lives and to promote the efficiency of ambulance services.

b. Restricted funds

	Balance 1 April 2017 £000	Resources expended £000	Incoming resources £000	Balance 31March 2018 £000
Harrow Staff Fund	10	-	-	10
	10	**-**	**-**	**10**

Name of Fund	Description, nature and purpose of the fund
Harrow Staff Fund	The restricted fund is for the benefit of staff operating out of the Harrow area.

c. Unrestricted income funds

	Balance 1 April 2017 £000	Resources expended £000	Incoming resources £000	Balance 31March 2018 £000
General Fund	27	(4)	22	45
	27	**(4)**	**22**	**45**

Name of Fund	Description, nature and purpose of the fund
London Ambulance Service General Fund	The objects of the unrestricted fund are that it is available for any charitable purposes relating to the NHS at the absolute discretion of the trustees.

The general fund includes all donations for which the donor has not expressed any preference as to how the funds shall be spent.

11. Related party transactions

The London Ambulance NHS Trust is the corporate trustee of the charity.

During the year, none of the members of the Trust Board, senior NHS Trust staff or parties related to them were beneficiaries of the charity. Neither the corporate trustee nor any member of the NHS Board has received honoraria, emoluments or expenses in the year and the Trustee has not purchased trustee indemnity insurance.

The London Ambulance Service NHS Trust waived the annual administration fee of £2,500 in both the current and previous year.

12. Trustees' remuneration, benefits and expenses

The charity's trustees give their time freely and receive no remuneration for the work that they undertake as trustees.

13. Role of Volunteers

Volunteer Emergency Responders and Community First Responders, are activated alongside LAS employees to provide an additional response to life-threatened or seriously ill or injured patients. If they arrive before the LAS response they are able to provide emergency life support to the patient. For incidents when the volunteer arrives after an LAS solo responder, they have a vital role in providing trained support to the LAS responders, adding significant benefit to patient outcomes.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

London Ambulance Service NHS
NHS Trust

Headquarters
220 Waterloo Road
London
SE1 8SD

Tel: 020 7783 2793

Private and Confidential

Janet Dawson
Partner
Ernst & Young LLP
1 More London Place
London
SE1 2 AF

Date XX XX XX

Dear Janet

This representation letter is provided in connection with your examination of the financial statements of the London Ambulance Service Charitable Fund ("the Charity") for the year ended 31 March 2018. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention:

a. which gives you reasonable cause to believe that in any material respect the requirements:

   - to keep accounting records in accordance with section 130 of the 2011 Act;

   and

   - to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

b. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as Trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

- Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

- Additional information that you have requested from us for the purpose of the examination and

- Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: XX.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal advisers.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Grants and Donations

1. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions during the period in the application of such income.

G. Transactions with Trustees

1. The trustees during the period have received no emoluments, pensions, benefits, or compensation for loss of office.

H. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

Yours Faithfully

Signed on behalf of the Trustees

Ernst & Young LLP
1 More London Place
London
SE1 2AF

Tel: + 44 20 7951 2000
Fax: + 44 20 7951 1345
ey.com

Building a better working world

Independent examiner's report to the trustees of the London Ambulance Service Charitable Fund

I report on the accounts of the London Ambulance Service Charitable Fund for the year ended 31 March 2018 which are set out on pages 9 to 20.

Respective responsibilities of trustees and independent examiner

The charity's trustees are responsible for the preparation of the accounts. The trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in accordance with section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 7 August 2018. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner'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 charity and the trustees as a body, for this examination, for this report, or for the statements made.

Janet Dawson
For and on behalf of Ernst & Young LLP
Chartered Accountants
London

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	Quality Report			
Agenda item:	Additional report, circulated for information and assurance only			
Report Author(s):	Dr Trisha Bain Chief Quality Officer			
Presented by:	Dr Trisha Bain Chief Quality Officer			
History:	N/A			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report outlines the July 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

August 2018

All data pertains to July 2018 performance unless otherwise stated

All data is correct as at 10th of the month

Contents

1. Executive Summary

SAFE

The average time lag for reporting RIDDOR incidents in July was 7 days – this represents a sustained decrease and has remained within target since March 2018.

Medicine Management incidents categorised as Trust have been reviewed and where required have been changed to a patient safety incident.

Effective

ROSC at Hospital(* data from Jan-18) is 38.7% which is above the national standard. The Stroke Care Bundle is 97.0%

STEMI Care Bundle(* data from Feb-18) is 72.0%. There continues to be a focus on this measure.
Action: The audit results are feedback during CPI feedback sessions for learning.
The CPI rate has been lower than desired for the past few months, with the current rate being 88.0%
Action: As a result more paramedics have been trained to deliver CPI.

Caring

As part of a work stream for the National Ambulance Mental Health Leads, we have agreed a Mental Health Screening Tool which can be adapted for use within LAS. This will be monitored as part of the e-PRF project.

Maternity are presenting more data on their birth imminent, conveyance rates and birth imminent calls as measures that look to align specific improvements within the Maternity Pioneer Services

Responsive

The number of Coordinate My Care plans being accessed remains constant with an average of 465 a month. A Task & Finish group is still in progress regarding the management and review of 'care plans', including Patient Specific Protocols, and A&E plans to improve this even further.

Positive compliments received(* per 1000) is 1.14

Well Led

Dispatch and call management and clinical treatment issues are a recurrent theme. The majority of call and dispatch concerns relate to response delays.
Action: This theme will be reviewed in depth and its findings will be presented in the SI thematic report.

Projects & Programmes

The Quality Directorate are achieving against their 6 quality priorities as listed in the Quality Account. An overview of all Trust quality priorities are included in this report.

All projects are underway with two key pioneering services be implemented first. The pioneering services steering group have met twice and a phasing plan for all projects is being developed. This will be agreed at the portfolio management board in September

Metric on or ahead of target | Programme or Committee on track
Metric off target by <10% | Programme or Committee off plan but no escalation
Metric off target by >10% | Programme Escalation | Committee Escalation

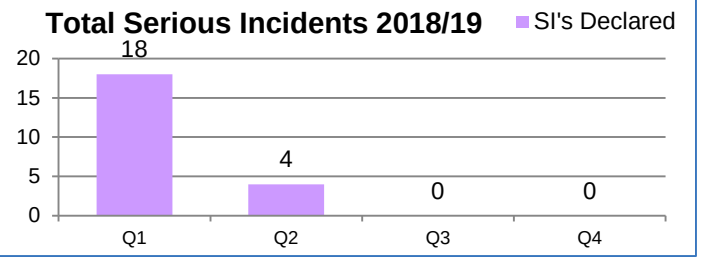
2. SAFE Scorecard

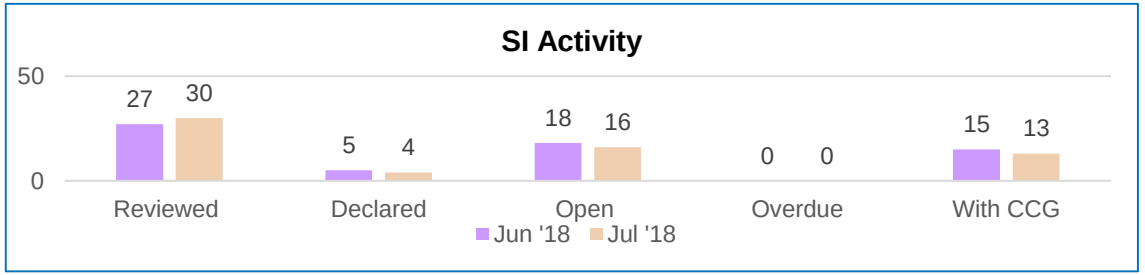
Exec Lead: Dr. Trisha Bain

Measures	Target / Range	YTD 18/19	May-18	Jun-18	Jul-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	95%	93.1%	96.0%	94.0%	↓			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	2.8	2.9	2.5	3.3	↑					
Patient related Adverse Events - NO HARM	100	794	213	169	227	↑					
Patient related Adverse Events - LOW	40	127	29	29	43	↑					
Patient related Adverse Events - MODERATE	25	63	17	16	16	↔					
Patient related Adverse Events - SEVERE		19	2	5	7	↑					
Patient related Adverse Events - DEATH		38	10	6	12	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	3.6	3.8	2.9	3.6	↑					
Staff related Adverse Events - **NONE**		729	211	147	178	↑					
Staff related Adverse Events - **LOW**		560	142	118	146	↑					
Staff related Adverse Events - **MODERATE**		18	4	2	8	↑					
Staff related Adverse Events - **SEVERE**		1	0	1	0	↓					
Controlled Drugs - Other Reportable Incidents		252	57	68	80	↑					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	0%	95%	90%	89%	↓					
Percentage of Serious Incidents (SI) reported on STEIS within 48 hours of being declared in-month	90%	100%	100%	100%	100%	↔			LQ20		
Serious Incidents declared in-month		22	7	5	4	↓					
Serious Incidents breaching 60 days	0	0	0	0	0	↔					
Serious Incidents breaching 40 days	0	0	0	0	0	↔					
Duty of Candour % Compliance (Moderate Harm Incidents)	100%	0%	100%	100%	100%	↔					
Medication Errors as % of Patient Adverse Events		7%	7.4%	6.7%	8.2%	↑					
Needle Stick Injuries as % of Staff Adverse Events		1%	2.0%	1.5%	1.8%	↑					
Never Events	0	1	1	0	0	↔					
Local Never Event : Patient falling from trolley through transfer as % of incidents	0%	0%	0%	0%	0%	↔					
Missing Equipment Incidents as % of all reported incidents		3%	4%	3%	3%	↓					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents		10%	10%	9%	10%	↑					

2. SAFE - Patient Safety

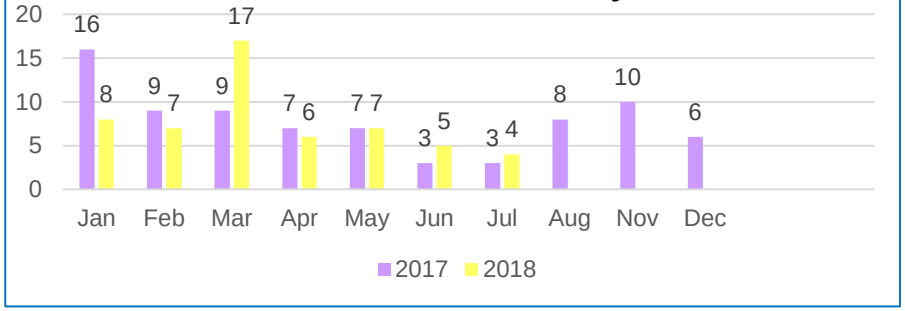
Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

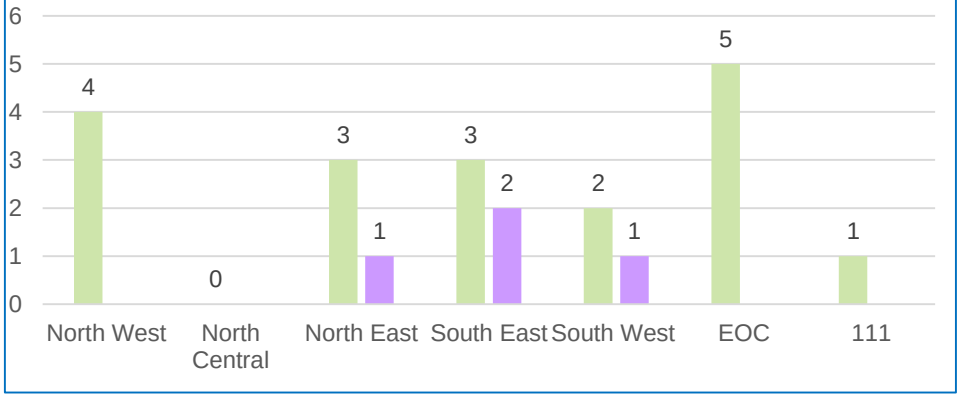


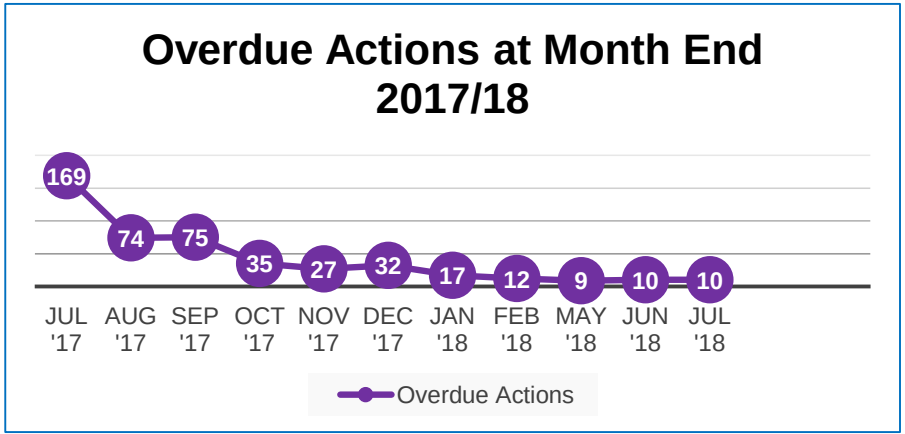


A total of 18 serious incidents were declared during Q1 which is comparable to the 17 declared during Q1 2017/17. To date 4 serious incidents have been declared for Q2.

30 incidents were reviewed by the Serious Incident Group during July which is an increase of three from June 2018.13 investigations submitted to the CCG are awaiting comments or closure with no breaches. The Quality Governance and Assurance Team are currently managing 16 open serious incidents.



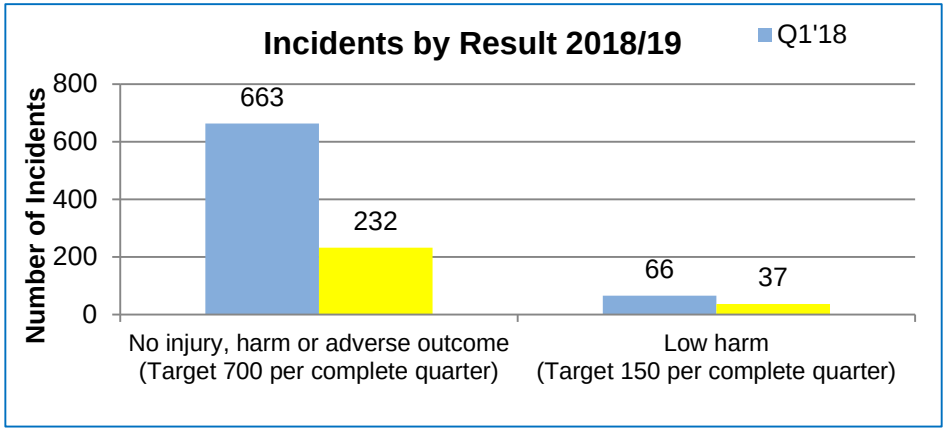


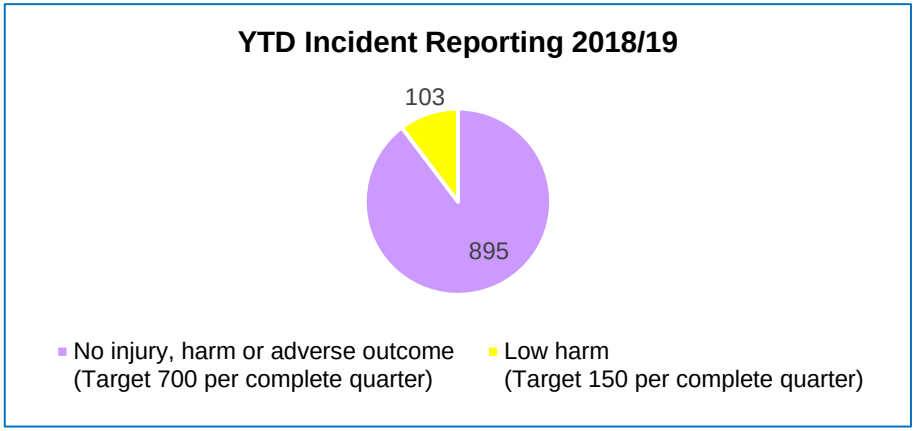


- There are currently 18 actions that are outstanding: 8 actions concern EOC, 8 for operations and 2 for LAS111.
- The majority of EOC actions concern individual feedback to member of staff.
- Actions for operations include feedback to staff, clinical reflections, sharing learning across the sector and mechanisms for increasing clinical supervision.

2. SAFE - Patient Safety

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain





The Trust has set an annual target for the reporting of incidents that have been graded as either no harm or low harm. An action plan is in place to improve the reporting of these incidents. This includes updated training, the development of an e-learning package and easier access to Datix for all staff.

Quality, Governance and Assurance Risk Tracker					Initial Risk Rating	Current Risk Rating				Target Risk Rating	Key changes/updates since last review
						Q1			Q2		
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Apr	May	Jun	Jul		
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	9	6	6	6	6	The published CQC report gave an overall rating of good. In addition the CCG have shared that they are assured the Trust has oversight and consistent management of SI's and incidents. The team have appointed to the band 6 vacancy which will focus on thematic analysis of incidents. The team have appointed a risk manager who is expected to start Sep 2018.
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. The team are currently recruiting to the remaining vacant positions.

Monthly IPC Training Compliance July 2018 (Target: 90%)

IPC training compliance for Level 1 and Level 2 is monitored via ESR, continues to improve and exceeds target of 90%.

Performance achieved in July 2018:

- Level 1 – 95.90% compared to June 2018 (95.02%), exceeded set target of 90%
- Level 2 – 95.84% compared to June 2018 (95.73%), exceeded set target of 90%

Assurance:

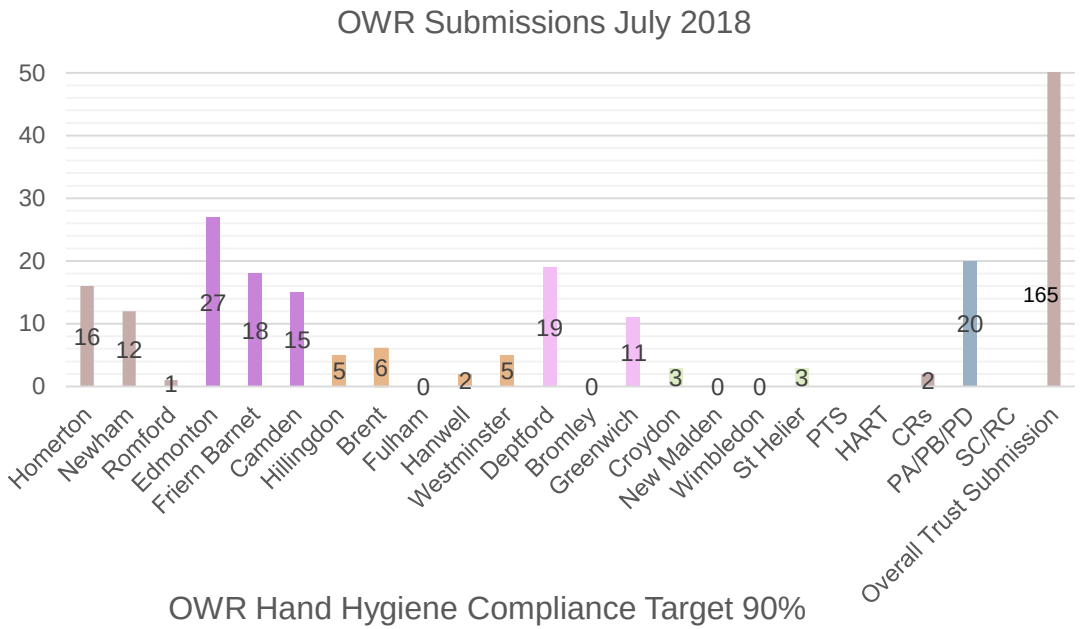
- Monitored via ESR
- Monthly Quality reporting
- Oversight at Quarterly ICDG, IPCC and QOG

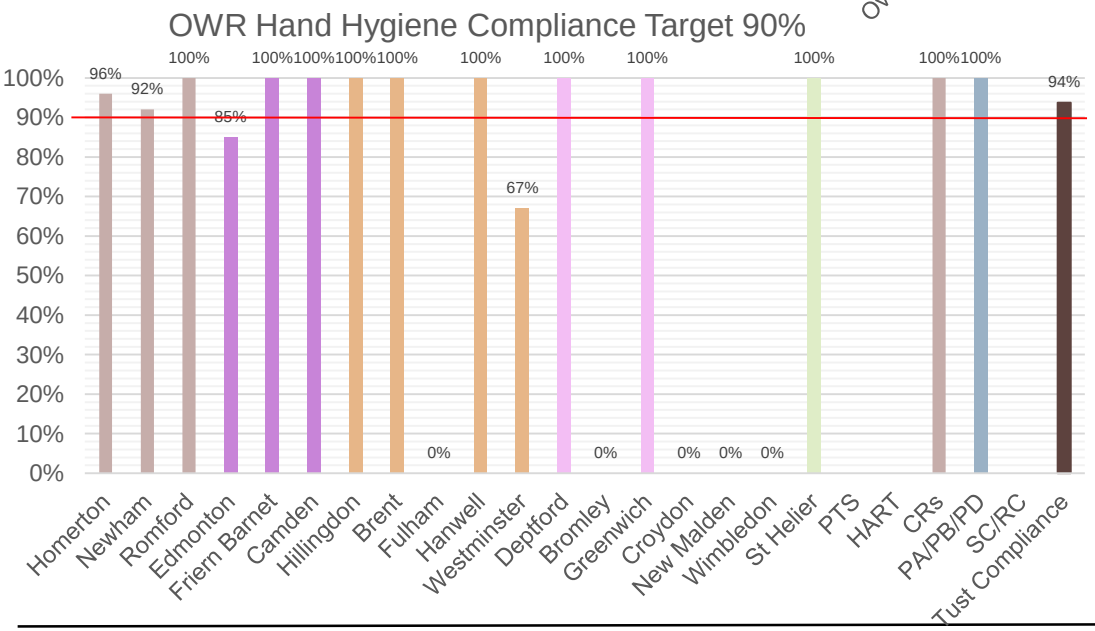
Actions taken:

- Shared good practice with SECAMB
- Monitoring process in place

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley





Hand Hygiene Performance

- New methodology for analysis of hand hygiene data was implemented in April 2018
- 16 group stations submitted their OWR data for hand hygiene; Fulham, Bromley, New Malden, Wimbledon, PTS and HART did not submit data.
- Of the 16 submissions, the Trust compliance for July 2018 was 94% up from June (91.17%)
- Cumulative rolling submissions to date: 2084; as each front line staff is reviewed by their CTLs using the OWR tool annually

Assurance

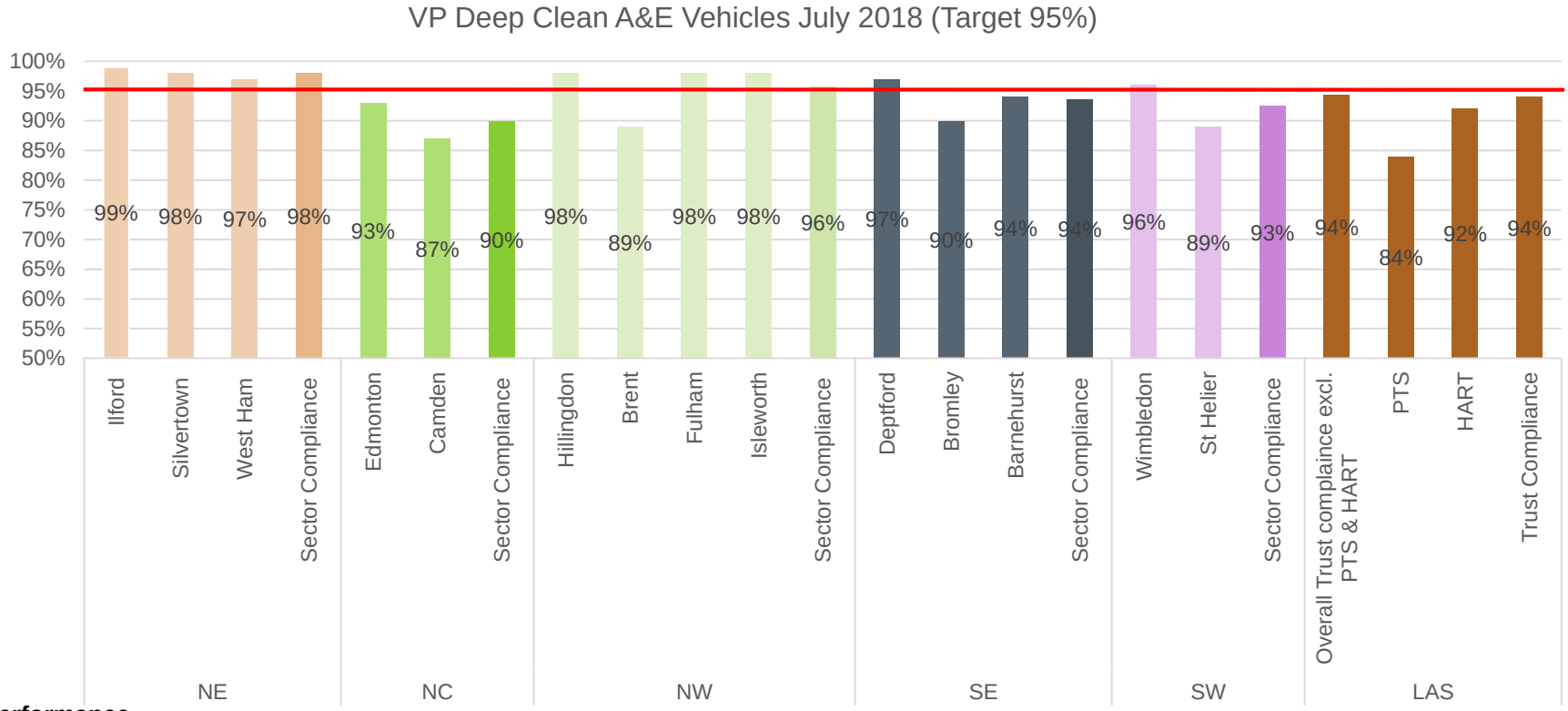
- Monthly Quality Report, CEO Performance Reviews, Quarterly Sector Quality Meetings
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Visits to EDs in London to audit and discuss hand hygiene standards continues.
- IPC Champions role to raise standards and ownership at local stations by providing practical Hand Hygiene at stations.

Actions

- Continue with Audits at EDs in London as per audit programme
- QGAMs to ensure Group Stations submit their OWR data in a timely way
- Report to Sector Quality Meeting
- Agree submission compliance and denominator figures for Operational Workplace Reviews

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Performance

- Data for each Group Station, Service (23) submitted by the VP Contract Manager, as analysed by the IPC team
- Trust compliance for July 2018 was 94%, the same as June 2018, against a contractual target of 95%
- PTS (NETS) scoring 84%, same as in June 2018
- HART achieved 92% same as in June 2018
- VP data has not changed as it is received and reported 6 weekly.

Assurance

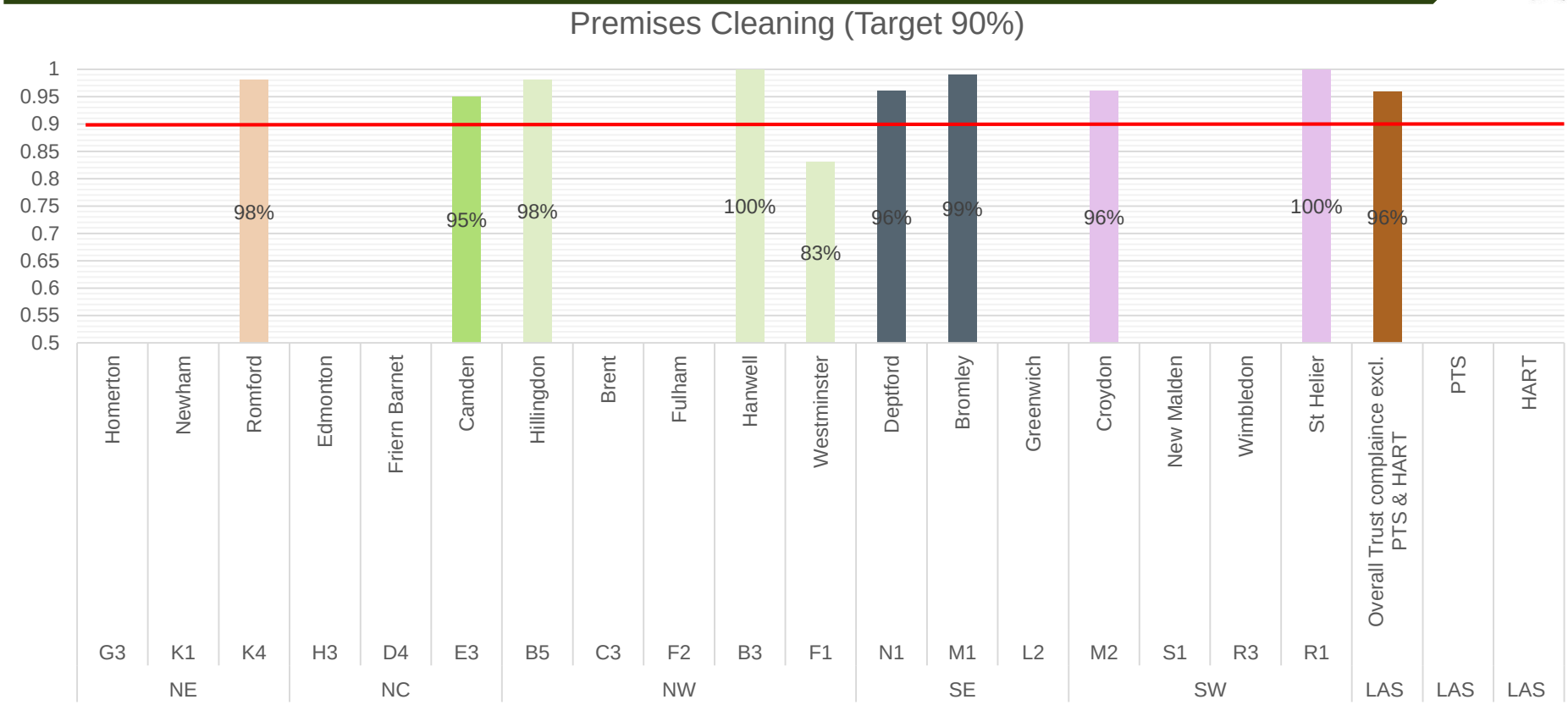
- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Logistics managers have regular contract meeting with contractors; action plan for low compliance; regular stakeholder meetings established

Actions

- Logistics to monitor action plans to improve low scores
- IPC continue to monitor monthly

Safety (Infection Control)

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Performance

- 10/20 Group Stations/Services submission received by IPC team for analysis
- Trust compliance for July 2018 was 96% based on small numbers of submissions, down from 97% in June 2018

Assurance

- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Estate contract managers have regular contract meeting with contractors; Contract managers and Contractors also undertake audits to ensure standards are maintained

Actions

- QGAMs oversight and action required for non-submissions - QGAMs to ensure Group Stations submit data in a timely way
- IPC continue to undertake validation audits, monitor monthly to provide additional assurance
- Report performance to Sector Quality Meeting

Sharps and Body Fluid Exposure (BFE) incidents April – July 2018

Type of incident	Q1 (April-July)
Bite	1
Contact with sharps (including needles)	3
Contact with sharps (non-medical sharps injury)	5
Exposure to bodily fluids	57
Injury involving broken ampoules / vials	13
Lancets - clean	1
Needlestick - cannula clean	1
Needlestick - IM clean	1
Razors - clean	7
Lancet - contaminated	3
Needlestick cannula - contaminated	7
Needlestick - IM contaminated	2
Needlestick subcutaneous contaminated	1
Razor - contaminated	1
TOTAL	103

Performance

- Cumulative incidents for year to date (April to July) – 117
- 57/103 (55%) were BFE incidents
- 5 near misses –involving sharps or amps.
- 3 actual injuries - Putting cannula into sharps box, used Razor found and contaminated cannula injury

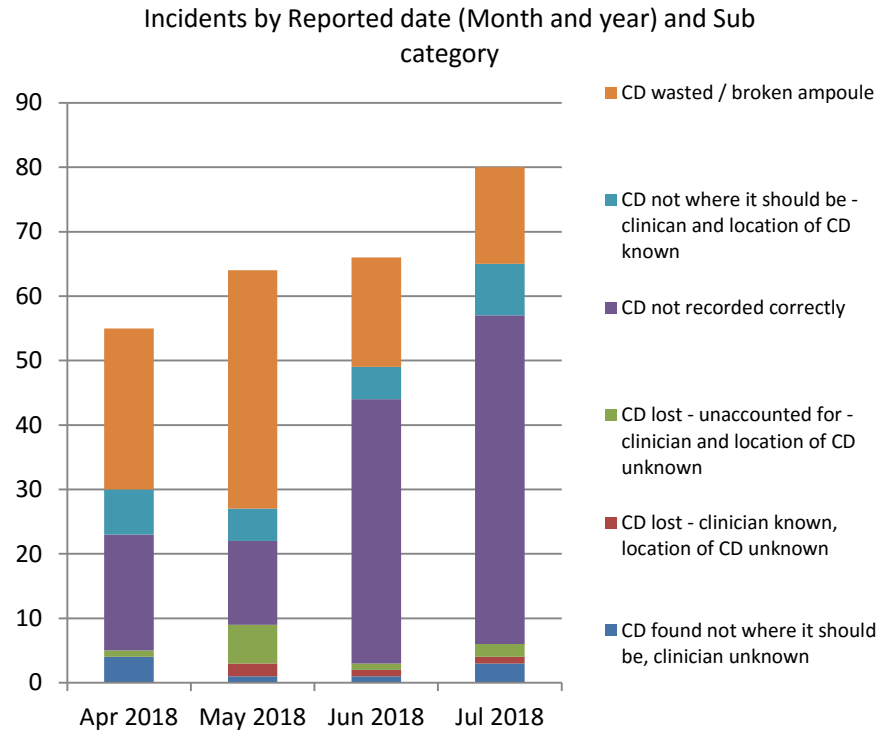
Assurance

- Monthly oversight by IPC team, Monthly Quality Reports, Quarterly Sector Report, Quarterly ICDG/IPCC/QOG oversight
- Regular Bulletins e.g. safe practice in administration for IV fluids through cannula port
- Enhanced personal PPE implementation
- Datix incident follow-up and Datix Risk Reporting
- Completion of Immunisation status project and immunisation catch-up programme

Actions: Daily review of incidents and appropriate investigations and feedback; prompt risk reporting and provision of bulletins as appropriate

2. SAFE - Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley



Medicines Management Update

- No unaccounted for losses of injectable morphine
- Total of 67 other controlled drug incidents including
  - Wastage or breakages (n=15)
  - Documentation errors (n=27)
  - Morphine retained off duty (n=8)
- Non-controlled drugs incidents
  - Medical gases storage or access issues (n=4)
  - Drugs usage forms incomplete (n=29)
  - KitPrep app malfunction or discrepancy (n=16)
  - Incorrect administration of adrenaline (n=4), atropine (n=1), diazepam (n=3), ibuprofen (n=1), morphine (n=3), salbutamol (n=1) normal saline (n=1) and ketamine (n=1)
  - Errors by other healthcare non-LAS professionals (n=8)
  - General drugs pack loss (n=1)
  - Paramedic drugs packs left at scene (n=2)
  - Sharp in drugs pack (n=1)
  - Drugs cupboard unlocked (n=1)
  - Non CD breakages (n=5)
  - Abloy key or system failure (n=2)

Actions

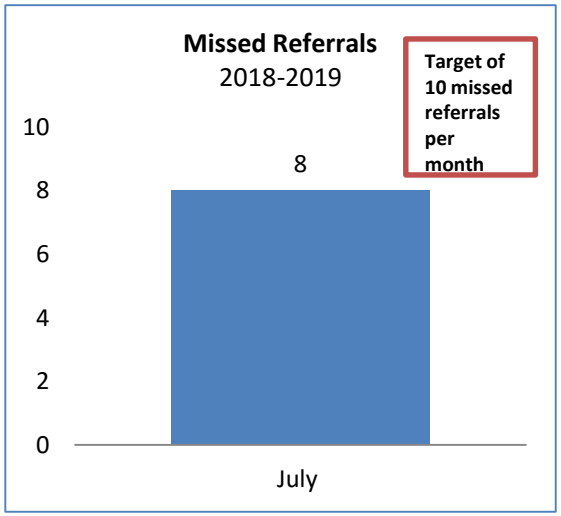
- Distribution of trays for morphine safes
- More focused monitoring of drug usage form completion at Logistic Support Unit
- Liaison with IM&T and Abloy supplier to resolve electronic access issues
- Inclusion of ampoule opening training in CSR

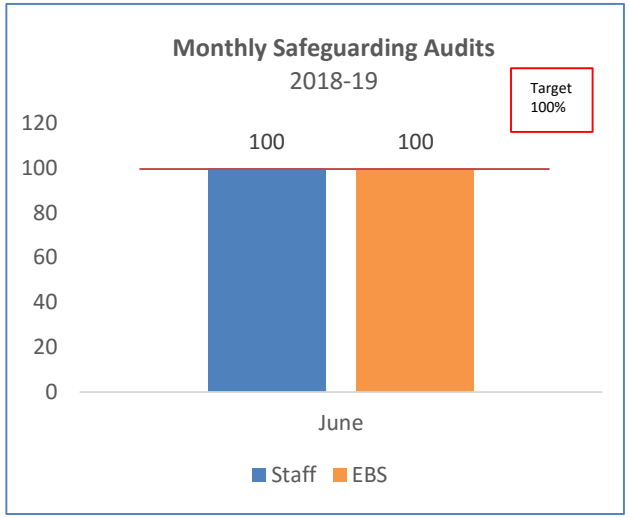
Assurance

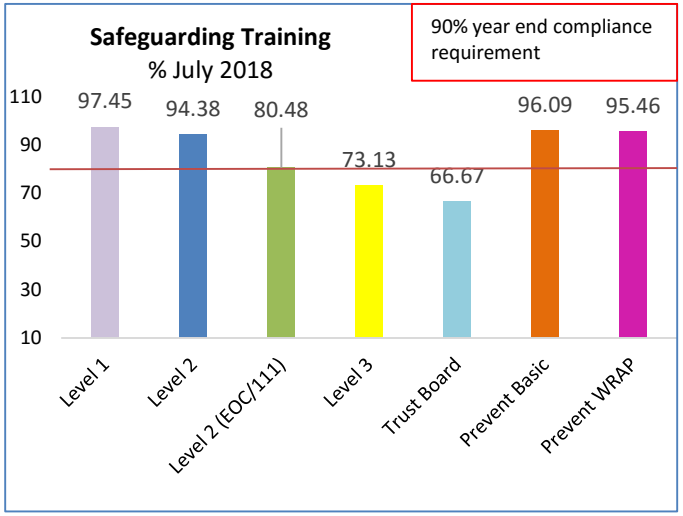
- Small reduction in incidence of breakages of morphine ampoules
- Reduction in CD register documentation errors and discrepancies
- Missing RIGHT2 trial drugs pack recovered

2. Safeguarding

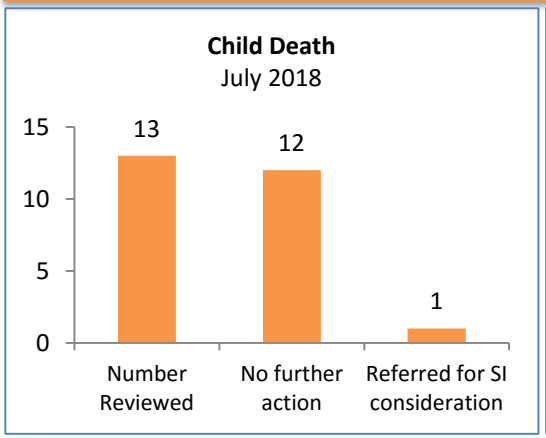
Owner: Alan Taylor | Executive Lead: Dr. Trisha Bain

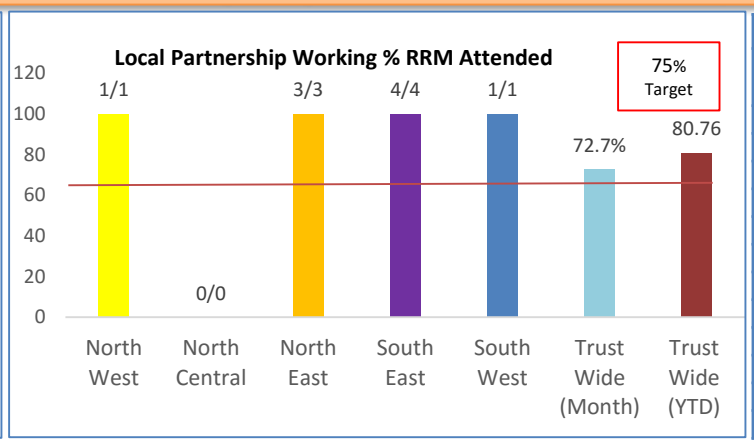






Missed Referrals (Shadow KPI) 3 children 5 adults. **Knowledge and Retention Audits** review staff learning across the Trust have a target of 13 per month = 100%. EBS Quality of referral audit 1 per staff member per month = 100% staff understanding of FGM duty showing as mixed covering in 2018 CSR. **Safeguarding Training** level 3 has now commenced to include NEL 111 staff and Clinical Team Leaders. Level 3 training was delivered on 3rd August and dates are set until the end of March 2019. Control Services figures are currently under review, however the safeguarding specialists have sat in on their delivery of the new CSR.





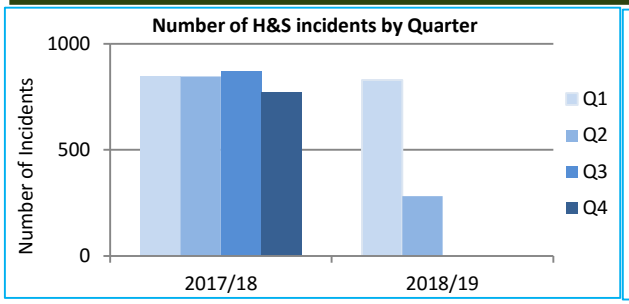
Trust safeguarding referrals and concerns raised

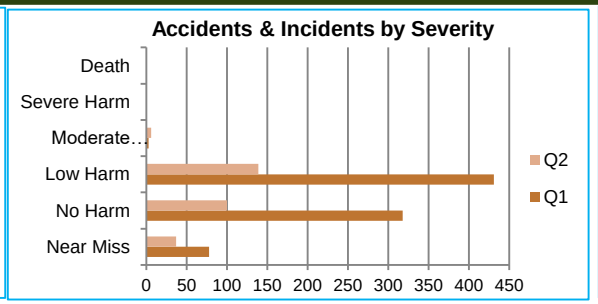
Month	Adults Safeguarding	Adults Welfare	Children	Total Referrals	% incidents
Apr-18	393	650	637	1650	1.8%
May-18	414	588	822	1824	1.9%
Jun-18	457	609	846	1912	2.1%
Jul-18	503	615	819	1937	2.0%
Aug-18					
Sep-18					
Oct-18					
Nov-18					
Dec-18					
Jan-19					
Feb-19					
Mar-19					

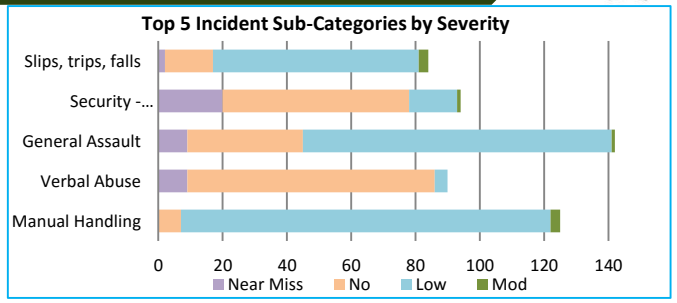
Child Death: 92% were processed within 3 weeks of receiving 1 referred to SIG not declared : **Local Partnership Working**. Excellent compliance in all areas. GSM's have been engaging in this process. **Trust Safeguarding Referrals & Concerns Raised:** Referrals remain within expected levels .

2. Health & Safety Scorecard

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain







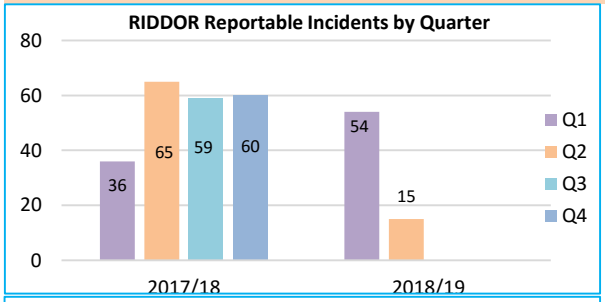
1112 incidents have been reported across the Trust during 2018/19. 282 incidents were reported in July 2018 . These H&S related incidents account for 33% of all the incidents reported across the Trust in July 2018.

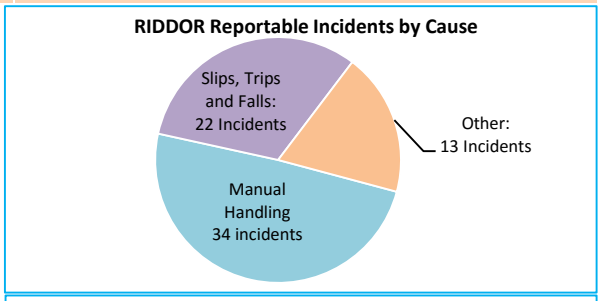
570 (51%) of the H&S related incidents reported during 2018/19 resulted in low harm. 9 (0.8%) incidents resulted in Moderate harm. 533 (48%) of the incidents were reported as 'No Harm/Near misses'.

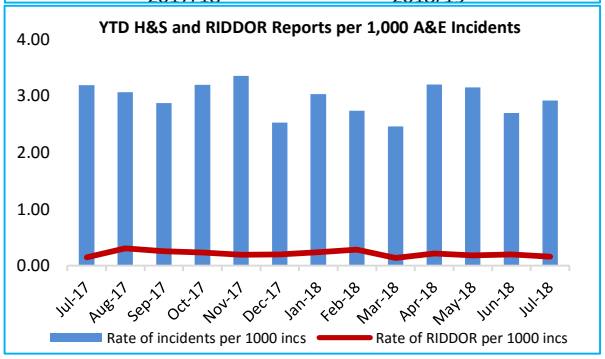
Security (violence, aggression & verbal abuse), Manual Handling – lifting patients (MH) and Slips, Trips and Falls incidents account for the highest number of incidents reported during July 2018.

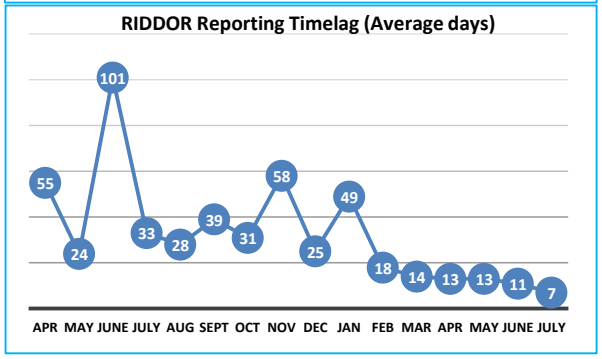
Key Updates:

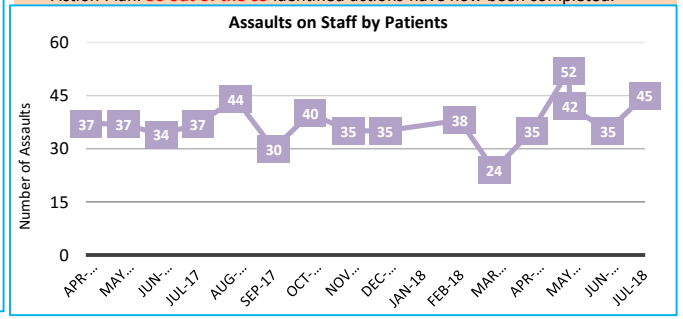
1. The risk of MH related injuries is the highest rated risk on the Health and Safety risk register. This risk is regularly monitored in order to ensure that sufficient controls/actions are implemented to minimise the impact on staff and the Trust.
2. 34 MH - lifting patient incidents have been reported in Q2. Some of the contributory factors included the lack of equipment or failure of a piece of equipment resulting in the manual handling of patients.
3. 14 of the MH incidents relating to the lack of or failure of equipment have been reported across the Trust during Q2, 2018/19.
4. The provision of practical MH Training to relevant frontline and support services staff is ongoing.
5. A review is ongoing to evaluate additional measures that can be implemented to further mitigate the security related incidents reported across the Trust.
6. Work is on-going to progress the actions identified on the Health and Safety Action Plan. **50 out of the 69** identified actions have now been completed.











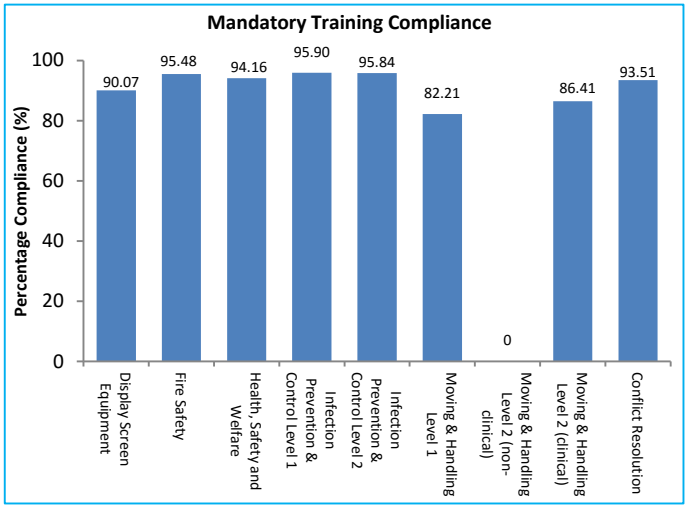
The above table highlights the rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust up to July 2018.
No benchmark/comparable data was received from any of the other ambulance Trusts during July 2018.

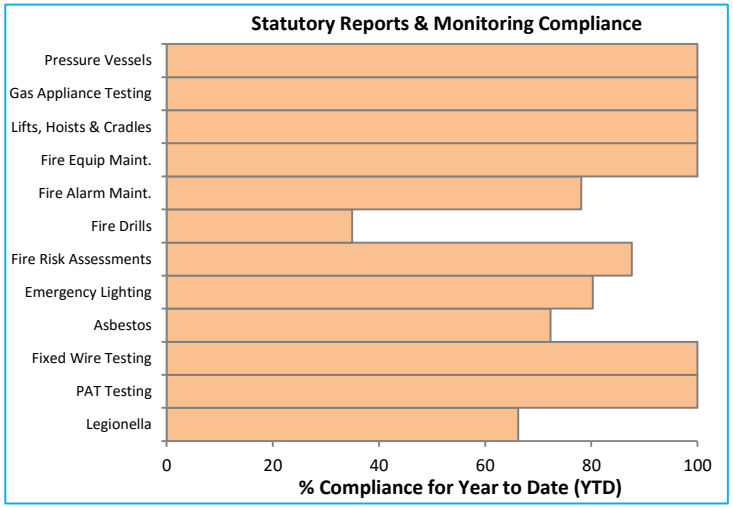
69 RIDDOR incidents were reported to the HSE in 2018/19. 15 RIDDOR incidents were reported in July 2018.
The average time lag for reporting RIDDOR incidents in July was **7 days.** 1 out of the 15 RIDDOR incidents was reported out of time in July 2018**.**

There was an increase in the number of assault on staff by patient related incidents in July 2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

2. Health & Safety Scorecard

Owner: Ayodeji Adeyemi | Exec Lead: Dr. Trisha Bain





7. The practical MH Level 2 (non-clinical) training is a new course put in place since April 2018 for non-operational (support services i.e. IM&T, Fleet, Estates) staff who undertake MH activities. 118 members of staff have been identified as requiring this training, and training dates have been circulated through the Learning and Development Team.

8. Trust-wide compliance for the Manual Handling Training (Clinical) in July 2018 was at 86.41%. Practical MH training is being delivered as part of CSR 1:2018 and it is expected that compliance will improve.

9. The tender specification document for the Trust's fire risk assessment contract is currently under review.

Moving and Handling Level 2 (Non-Clinical) training is available for IM&T and Fleet staff to book onto. However, despite reminders that the training is available, to date there have been no staff booking onto the training. Training dates listed below, for your information.

Health and Safety Risk Tracker					Initial Risk Rating	Current Risk Rating							Target Risk Rating	Key changes/updates since last review
						Q4 – 2017/18			Q1 – 2018/19			Q2		
Risk No.	Risk Type	Risk description	Risk Owner	Exec Lead		Jan	Feb	Mar	Apr	May	Jun	Jul		
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	15	15	15	9	An audit of the practical manual handling training that is being delivered to staff via CSR 1: 2018 will be undertaken in July 2018. The feedback from the audit will be used to further develop future training provided to staff. The H&S Department monitor MH related Incidents on a regular basis and a review is currently ongoing to look into and address the equipment related failures reported across the Trust.
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	12	12	12	4	Programme of annual audits approved by the CQO. 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	12	12	12	6	No updates since last review.
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	9	3	3	3	The average RIDDOR reporting timelag reduced to 11 days in June 2018. It is recommended that this risk should be downgraded and closed but monitored on a monthly basis by the H&S Team.
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	9	9	9	3	No updates since last review.
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	8	8	8	4	No updates since last review.
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	6	6	6	3	Substantive recruitment into the Health and Safety Department is ongoing.

3. EFFECTIVE Scorecard

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 17/18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	31%	39%	27%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	63%	64%					↔			LQ1b		
STEMI to PPCI within 150 minutes (AQI)	93%		93%							↔			LQ2b		
STEMI care bundle (AQI)		G	70%							↔			LQ2c		
Stroke to HASU within 60 minutes (AQI)		G	67%	54%	52%					↔			LQ3a		
Stroke Care Bundle (AQI)		G	97%	97%						↔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		00:32	00:32					↔					
Survival to Discharge (AQI)			10%	9%						↔					
Survival to Discharge UTSTEIN (AQI)			38%	17%						↔					
STEMI- On scene duration (CARU continual audit)				00:42	00:41	00:38	00:39	00:37		↓					
Call to angiography (mean hh:mm)					02:08										
Call to arrival at hospital (hh:mm)															
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	90%	87%	88.0%	85.0%	88.0%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			2%		35%	0.1%	0.4%	0.8%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	98%	97.0%	97.0%	98.0%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	94%	94%	95.0%	94.0%	94.0%		↔		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	98.0%	97.0%	97.0%		↔		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%	96%		96.0%		96.0%		↔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)		G	0%				90.0%	90.0%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%		97%		98.0%			↔			LQ12		

Actions

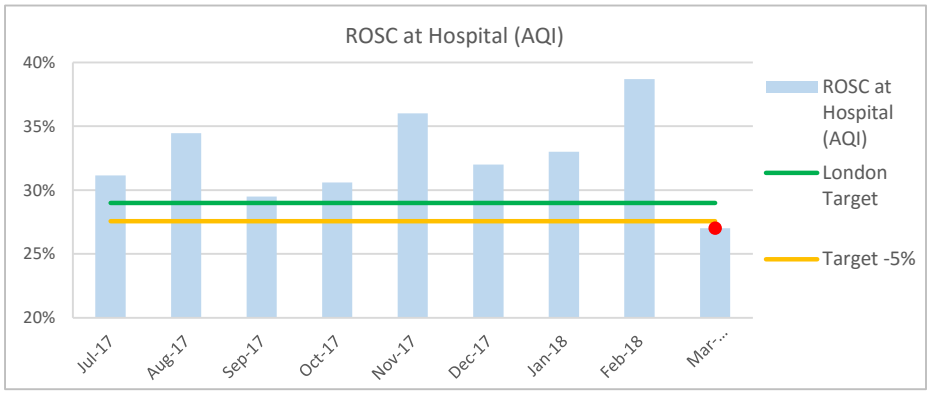
- To address the lower than desired level of completion and feedback delivery, eight paramedics on restricted duties, one Senior Paramedic and one Advanced Paramedic Practitioner received CPI training in June.
- Through CPI auditing in June, ten auditors completed a Datix report as they had clinical or safety concerns and six auditors placed a retrospective safeguarding referral.

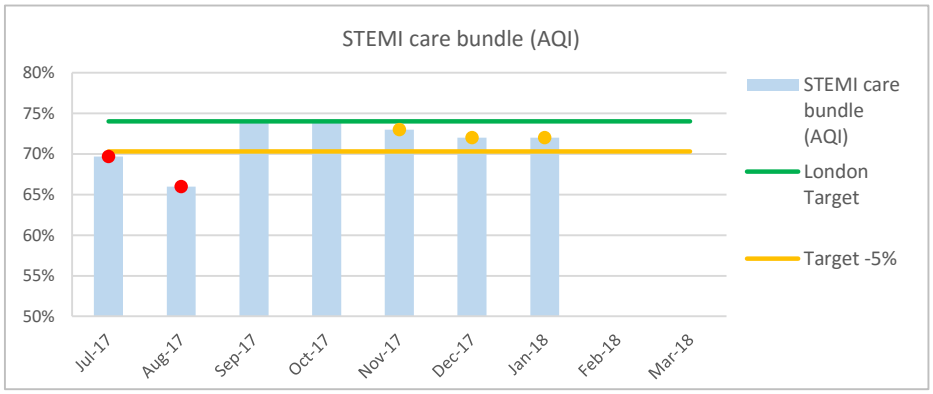
Assurance

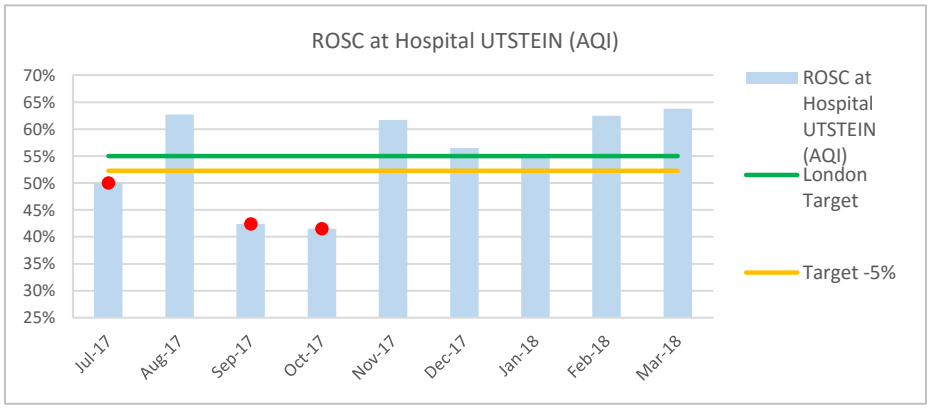
- In June, LAS CPI completion returned to 88% after a slight dip in May.
- The standard of care provided by the LAS to patients under the Discharged at Scene, Difficulty in Breathing and Severe Sepsis CPIs remained high in June, as well as the standard of general documentation. The LAS also provided a very high standard of care to patients in cardiac arrest. Care provided to patients with a diagnosed psychiatric problem was of a slightly lower standard in June than the last reporting period (April).
- In June, 418 members of staff (10% of all LAS frontline clinicians) received face-to-face CPI feedback.

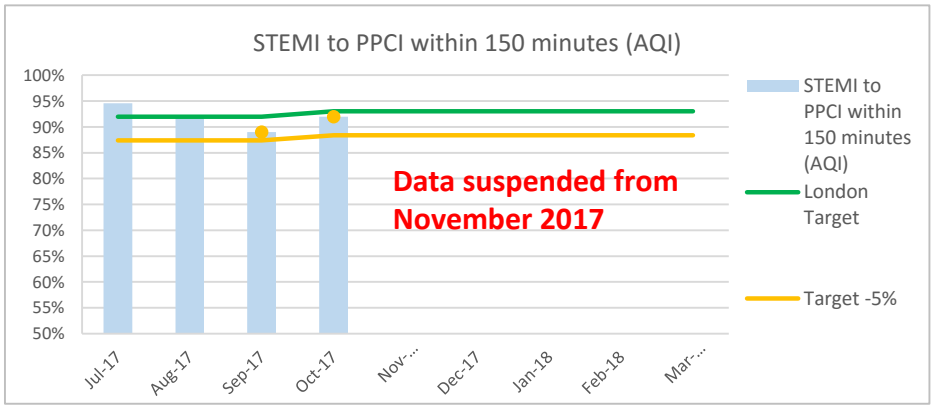
3. EFFECTIVE - Clinical AQIs

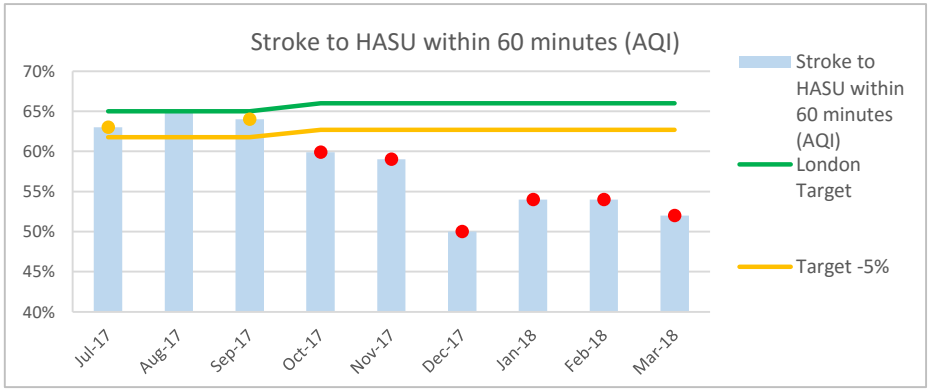
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

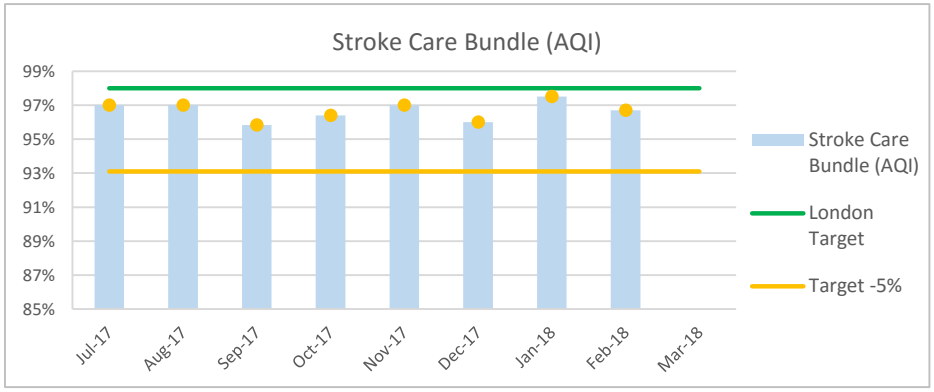








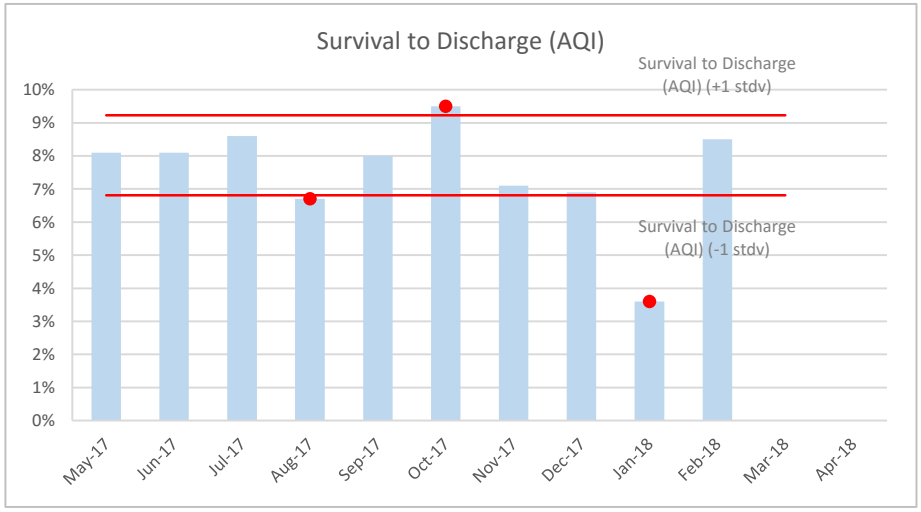


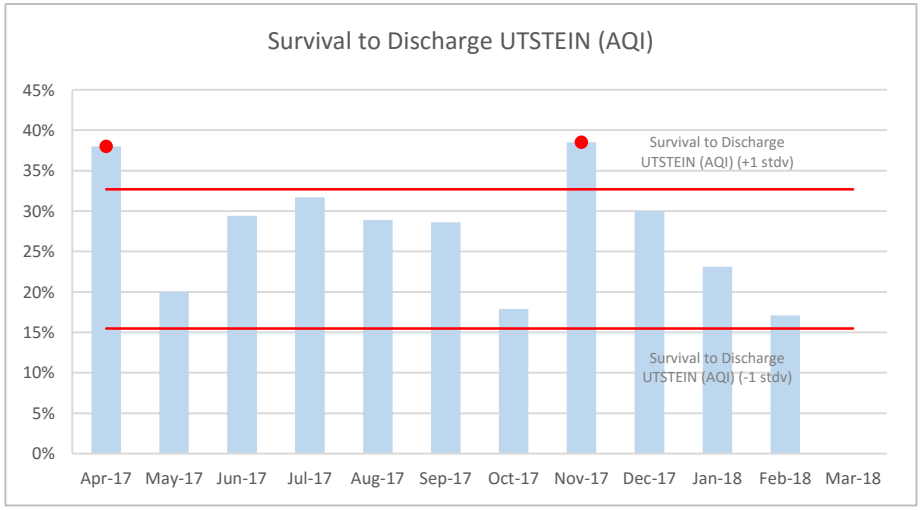


* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

3. EFFECTIVE - Clinical AQIs

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





AQI: Narrative

In March, ROSC on arrival at hospital for the overall group decreased to 27%, however, the Utstein comparator group increased to 64%. The survival to hospital discharge figures for the overall group has decreased slightly from last month to 8% and is in line with the year to date average. Survival for the Utstein group has also decreased from the previous month to 19%. Defibrillator downloads increased by 5% to 13%.

The mean call to angiography time for STEMI patients in March has remained at 2 hours and 8 minutes, with a 90th centile of 2 hours and 54 minutes. The STEMI care bundle has moved to reporting one month every quarter with the next month of submission due to be reported in September based on April data. The average on-scene time decreased by 2 minutes to 37 minutes in June.

In March, the mean and 90th centile for call to hospital for stroke patients remains consistent with the previous month, with NHS England reporting 1 hour and 18 minutes and 1 hour and 57 minutes respectively. The stroke diagnostic bundle has moved to reporting one month every quarter with the next month of submission due to be reported in October based on May data.

Note: From April, AQI data presented is NHS England's published data; not the provisional data previously presented. This therefore represents a 4.5 months time lag for: cardiac arrest (ROSC & survival); stroke (call to hospital & diagnostic bundle), and STEMI (call to angiography & care bundle). For the remaining measures, timelines are one month behind in line with Care Packs.

AQI: Actions

CARU have collected additional outcomes for cardiac arrest patients from hospitals, which will be resubmitted to NHS England in the coming months, which will show improvements in the survival data.

* The time lag for these measures is reflective of the time taken to receipt all the information required from Acute Trusts

3. Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Clinical Audit: Projects

On the 30th July, CARU published a clinical audit report examining the assessment and management of patients presenting with acute heart failure to the LAS. This report found:

- 94% of patients had a full set of vital signs measured with 82% receiving a second set of observations again after 20 minutes
- 98% and 79% of patients respectively had their medical and medication history documented
- 80% of patients had an ECG performed with 74% attached to the patient's clinical record
- Jugular venous pressure (JVP) was assessed for 3% of patients
- Every patient with oxygen saturation levels below 94% received supplemental oxygen (100%) and 87% of patients received nebulized salbutamol when indicated
- 85% of patients for whom GTN was indicated received it
- However, 24 patients received oxygen despite adequate oxygenation; 28 patients without a wheeze were administered salbutamol and 24 patients with no signs of congestion who were inadequately perfused were administered GTN

We made the following recommendations to improve future documentation:

- A Clinical Update article and infographic emphasizing the importance of: the assessment of patients especially ECGs; thorough history taking including medications; potential side effects of GTN and other drugs when administered inappropriately for AHF patients
- Current training materials are updated with these findings
- Findings presented to the LAS Clinical Practice Working Group for consideration of the practice of salbutamol administration in the management of heart failure
- Findings shared with the JRCALC Guideline Developers and Contributors for the consideration of salbutamol in the management of heart failure to be removed from the guidelines

Clinical Audit: Actions & Assurance

As a result of our Continuous Re-contact Clinical Audit, in July:

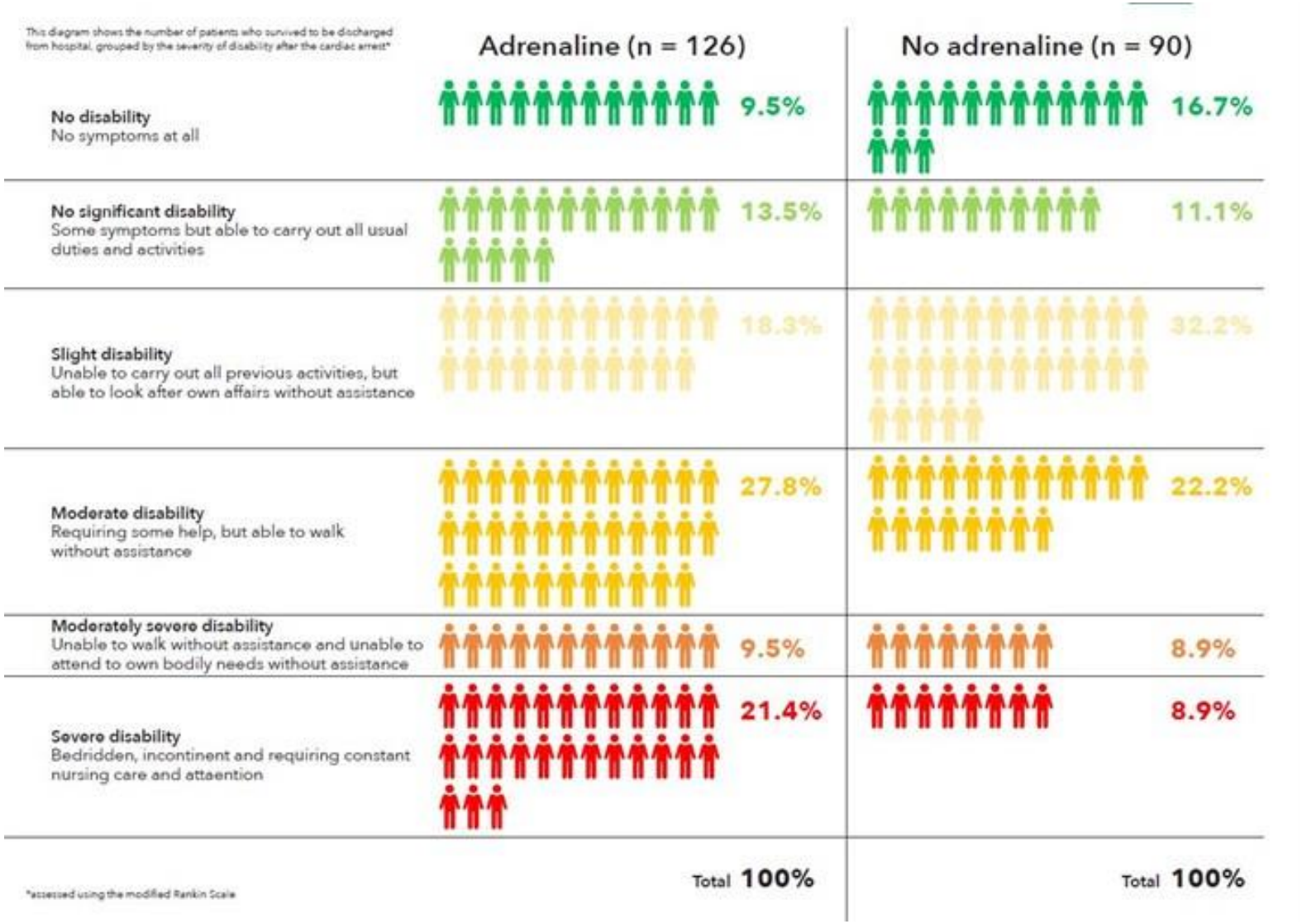
- 62 crews were recommended for feedback (19 positive & 43 constructive)
- 20 EMDs were received constructive feedback from QAU
- Six Clinical Advisors recommended for feedback (1 positive & 5 constructive)
- One potential patient safeguarding concern flagged (it did not require retrospective safeguarding)
- Five Datix forms were completed (2 x severe re-contacts not declared by SIG, 2 x severe re-contacts for local investigation, 1 x severe re-contact awaiting SIG review)

Research Update

- Results from the PARAMEDIC2 randomised controlled trial of adrenaline versus placebo in out-of-hospital cardiac arrest were published in July 2018 in the New England Journal of Medicine. The LAS recruited 2102 out of 8014 trial patients, with 521 paramedics taking part from North Central and North West sectors.
- The trial found that use of adrenaline results in less than 1% more people leaving hospital alive - but almost doubles the risk of severe brain damage for survivors.
- Of 4012 patients given adrenaline, 130 (3.2%) were alive at 30 days compared with 94 (2.4%) of the 3995 patients who were given placebo.
- However, of the 126 patients who had been given adrenaline and who survived to hospital discharge 39 (31%) had severe brain damage, compared with 16 (17.8%) among the 90 survivors who had been given a placebo.
- We now wait to hear from The Resuscitation Council UK and International Liaison Committee on Resuscitation about how this will be taken forward.

Note: Infographic produce by the University of Warwick on the next slide.

3. PARAMEDIC2 Trial



4. CARING Scorecard

Owner: Briony Sloper| Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	May-18	Jun-18	Jul-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Mental Health related calls as percentage of all calls			8%	7.9%	7.9%	7.1%	↓				
Mental Health related MPS calls as percentage of all calls			2%	2.1%	2.1%	1.9%	↓				
Mental Health related Incidents as percentage of all calls			5%	4.9%	4.9%	4.4%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.3%	0.3%	↔				

Exception Report (Positive)

Safety

Staff has now completed their induction and we can now provide 7 day cover for the EOC between 11:00-02:00hrs. The new rota also provides ensures that the Mental Health Joint Response Car will be staffed for 12hrs a day between the hours of 11:00-23:00hrs.

As part of their induction the new staff completed several ride-outs and we have received extremely positive feedback from frontline staff about the development of Mental Health Pioneer Service.

Effectiveness

We are working with our QGAM colleagues to ensure patients held on the Locality Alert Register (CAT 4) who have a Mental Health Component to their presentation have an ambulance specific care plan.

As part of a work stream for the National Ambulance Mental Health Leads we have signed off a Mental Health Screening Tool that can adapted for use within LAS when we move towards e-PRF.

Actions & Assurance

We are delivering 2 hour Mental Health Awareness Training to staff in the Emergency Operations Service as part of their Core Skills Refresher.

We continue to engage with a group of Experts by Experience around co-production.

Exception Report (Improvement Required)

Safety

There continues to be a misconception amongst some front line staff that we cannot apply the mental capacity act to a patient in a mental health crisis.

Actions & Assurance

A live module on Core Skills Refresher around applying the Mental Capacity Act to patients in a Mental Health Crisis has been implemented and is available on CSR2018.2.

An article has been published in the Insight Magazine which available to all staff and covers a case study about the application of the Mental Capacity Act to patient in a mental health crisis

Maternity – Good to Outstanding

Owner: Amanda Mansfield | Exec Lead: Dr. Trisha Bain

Improvement plan

	RAG	Update
1	Complete	• 3 Actions are complete and closed down
2	Green	• 2 have completion dates in the future
3	Amber	• 0 Actions in the past but action plans in place
4	Red	• 0 dates have past with no plans in place

Key risks

#	Risk	Action	RAG
1	Gap in Maternity Education for existing staff whilst Practice Leads are orientation	Annual plan to be agreed and signed off at Patient Safety Group 09/18	
2	Maternity Risk Oversight could be compromised due to capacity	Consultant Midwife to review 100% maternity related incidents	

Exception Report (Positive)

Safety

- 2 New Practice Leads supported LAS crews involved in Maternity Serious Incident
- Additional maternity equipment procured to enable training opportunities

Actions & Assurance

- Maternity Education Delivery Plan draft to be presented to the Clinical Education and Standards Group 09/18
- Maternity Education and Practice – Organogram/Organisational Structure 09/18

Effectiveness

- Commissioners paper to be presented detailed current cost impact upon the LAS of new maternity staff model.

Actions & Assurance

- CQRG paper to request contribution of staffing costs to provide Maternity Standards and Education Team.

Exception Report (Improvement Required)

Safety

- Roll out of Joint Maternity Training
- Existing response profile to Health Care Professional requests (midwives) escalated to the Clinical Quality Review Group

Actions & Assurance

- Maternity PikNMix launched to deliver annual programme of station based training.
- Outstanding mitigation awaiting implementation

Effectiveness

- Outstanding Obstetric Emergency audit
- Current datix analysis of maternity risk not reported

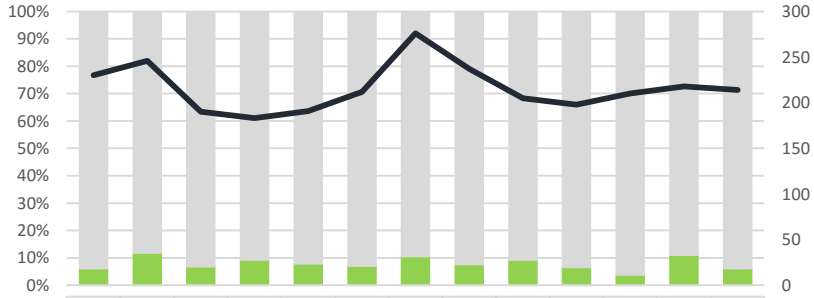
Actions & Assurance

- New audit officer identified
- Agreement of new maternity datix reports to be agreed 9/18
- 100% of maternity related incidents to receive specialist review

KEY
Red (O) = Overdue - will miss/has missed due date
Amber (R) = Recoverable - at risk of missing due date
Green (T) = On Target
Blue (C) = Complete

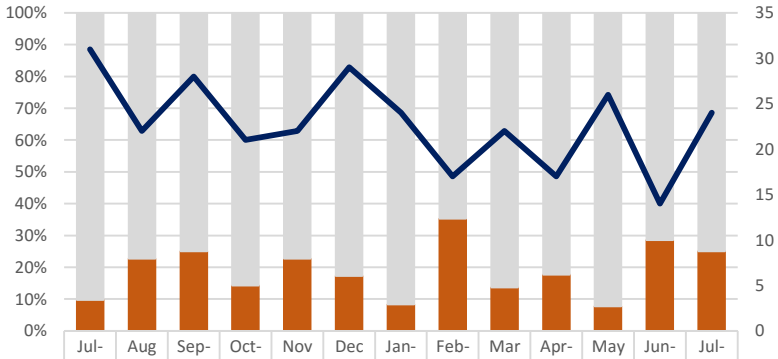
Maternity Key Performance Indicators

Haemorrhage Conveyance



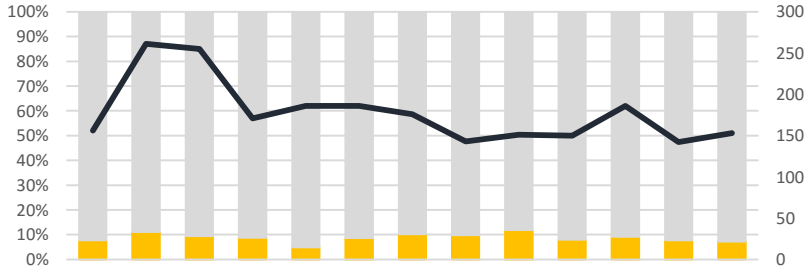
	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
% Conveyed	94%	88%	93%	91%	92%	93%	89%	92%	91%	93%	96%	89%	94%
% Not Conveyed	6%	12%	7%	9%	8%	7%	11%	8%	9%	7%	4%	11%	6%
Total Incidents	230	246	190	183	191	212	276	237	205	198	210	218	214

Head Out and Visible Conveyance



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
% Conveyed	90%	77%	75%	86%	77%	83%	92%	65%	86%	82%	92%	71%	75%
% Not Conveyed	10%	23%	25%	14%	23%	17%	8%	35%	14%	18%	8%	29%	25%
Total Incidents	31	22	28	21	22	29	24	17	22	17	26	14	24

Imminent Birth Conveyance



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
% Conveyed	92%	89%	91%	91%	95%	91%	90%	90%	88%	92%	91%	92%	93%
% Not Conveyed	8%	11%	9%	9%	5%	9%	10%	10%	12%	8%	9%	8%	7%
Total Incidents	156	261	255	171	186	186	176	143	151	150	186	142	153

Birth Imminent, conveyance rates and birth imminent calls are presented as measures that look to align specific improvements to the Maternity Pioneer Services
The existing clinical determinant of Haemorrhage after 24 weeks does not have a target benchmark

Further Performance Indicators:
Total Number of Maternity Reported Incidents with Conveyance Rates across the respective triage cardset.
Total Maternity Incidents reported in 2017 = 8626 – To year date = 4945

Patient & Public Engagement

Owner: Margaret Luce | Exec Lead: Trisha Bain

Public Engagement events

Area	No	Events in July include:
North West	7	• School and nursery visits • Community events • Knife crime • Careers events • Junior Citizen Schemes • Brownies / Scouts etc. • Summer fairs and fetes • Road safety • Deaf group • Youth Ambassador Scheme event • Patient representatives on committees • Patient involvement in LAS Academy
North Central	3	
North East	11	
South East	7	
South West	8	
Outer London/PPI	10	
Total	**46**	

Public Engagement activities

Supplementary information	
No. of public engagement events: year to date (April – July 2018)	209
Approximate audience numbers (July 2018)	7,342
Approximate audience numbers: year to date (April – July 2018)	28,865
Age profiles (July 2018): 0-5 years: 160 5-11 years: 608 11-16 years : 1330 16-18 years: 220 Over 18: 2594 All ages: 2430	
Public engagement: no. of hours (July 2018)	176
No. of staff on LAS Public Education Facebook group	738
No. of staff on contact list	1,307

Public Engagement Highlights

- James Maskell (EAC: Camden) attended a careers conference at a school in Camden. The feedback from the school said: “He was fantastic! He has really inspired lots of the pupils, who weren’t thinking about careers on the frontline before hearing him speak, to think more seriously about it.”

- Two members of front line staff supported Emma Purslow, Public Education Officer, to run a Citizenship Day at a school in south-west London. Their feedback said: “A massive thank you for doing such an amazing job. Your session was fun, interactive and informative, and you have taught 180 young people skills that could save a life. We are always so grateful for people like you that give up your time for these events to happen. This plays such an important part in the education of our students, which the academic curriculum doesn’t always give. “

Public Engagement Highlights

- Sukhi Kadri (Public Education Officer) ran a Biker Down session in West Norwood. These sessions are jointly run between the LAS and LFB, and focus on the skills and knowledge bikers may need if they come across a road traffic collision involving a bike.

  One participant gave her the following feedback: “Being former military, I’ve been through a lot of “first aid” courses and found your approach of immediate aid really enlightening. You provided very valuable information in an informal but engaging manner, that kept us focused throughout the day.”

- Sukhi is also supporting Amanda Mansfield, Consultant Midwife, with the Maternity Voices Partnership within the LAS Strategy, taking the lead on the patient involvement activities.

5. RESPONSIVE Scorecard

Owner: Briony Sloper Exec Lead: Dr. Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	May-18	Jun-18	Jul-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.68	3.5	3.6	3.7	↑				
CMC records viewed			1783	497	419	474	↑			LQ30	

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 (FCT) July 18 updates:

Last month the Frequent Caller Management Database (FCMD) identified 650 new & existing frequent callers meeting the national definition. 100% of patients were matched with their NHS numbers.

The Frequent Caller Team (FCT) continue to attend multi-disciplinary meetings and Frequent Caller forums to discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS.

FCT supports a range of requests for data, including A&E Frequent Attender meetings; CCG Forums, Mental Health Multi Disciplinary meetings, GP meetings, and STP work on frequent callers & attenders.

The Frequent Caller Team continue to meet & work with the Community Involvement Officers (CIOs) who have now joined the Frequent Caller Team. They are working together to amend the Job Description, so it better reflects the role and work undertaken.

Frequent Caller Team (FCT) challenges:

The use of Coordinate My Care with external partners and ensuring care plans are accessed continue to be ongoing challenges. A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and A&E plans.

CASE STUDY: Mr B.

Presenting situation:

62 year old male, living alone. Rising call rate over 6 months with drastic spike in June (502 calls) & July (911 calls). 12 month cost: £120,883.92. Chronic Obstructive Pulmonary Disease, anxiety, high blood pressure. Non-compliant with medication. Poor short-term memory. Risk of stroke. Poor self-care. Recent diagnosis of vascular dementia. Increasing physical aggression towards crews. Capacity to decline conveyance to hospital, & to make decisions around care & accommodation. Deemed able to live independently.

Intervention:

Early liaison with Adult Social Care (ASC), GP, Mental Health, Memory Clinic, A&E to ensure appropriate support in place to reduce reliance on LAS. Move to ground floor bed-sit aimed to reduce social isolation had no impact on call rate. Multi-agency meetings requested - all services made aware of the complexity of situation & need for a holistic assessment. 3 x daily care visits began, Mr B often denied carers entry. LAS making daily contact with services. All health professionals requested urgent move to emergency respite to complete outstanding clinical investigations. Mr B gave consent to a move. Lack of effective ASC response led to LAS' concerns being escalated to ASC Director & CCG. Temporary overnight carer started. Calls continued to rise, now including 3rd party calls from strangers finding patient confused outside home. Further pressure on ASC to move patient to 24/7 care. No clear commitment from ASC to a move. ASC over-focussed on social care needs & not on exploring worsening dementia concerns.

Outcome:

Mr B was moved to temporary 24/7 care placement after several weeks of pressure on ASC. LAS verify all of Mr B's mobile calls via care staff to confirm if ambulance required. Drastic drop in calls: 22 calls in past 11 days & 0 units dispatched.

Challenges/Areas for Development:

Effectively escalating LAS' concerns to Local Authority/CCG for a prompt response is an ongoing challenge. Delays result in inappropriate levels of LAS resources being used for much longer than necessary. Inappropriate accommodation compounds patient's clinical risks & risk to crews. ASC need to be more transparent on placement options, timescales & blocks to progress. More placement options needed for under 65s with dementia.

5. Frequent Callers

Owner: Briony Sloper | Exec Lead: Dr. Trisha Bain

Sector	CCG	Patients	Jul-18	Calls last quarter	Calls last 12 months	% of patients with NHS number
NE	BARKING AND DAGENHAM CCG	15	115	405	1105	100%
NC	BARNET CCG	35	388	959	2742	100%
SE	BEXLEY CCG	15	129	398	1222	100%
NW	BRENT CCG	21	131	432	1287	100%
SE	BROMLEY CCG	8	79	167	476	100%
NC	CAMDEN CCG	15	135	367	1328	100%
NW	CENTRAL LONDON (WESTMINSTER) CCG	22	285	708	1541	100%
NE	CITY AND HACKNEY CCG	35	372	1196	3122	100%
SW	CROYDON CCG	25	267	773	1774	100%
NW	EALING CCG	27	262	732	2753	100%
NC	ENFIELD CCG	40	517	1254	2681	100%
SE	GREENWICH CCG	26	264	702	1932	100%
NW	HAMMERSMITH AND FULHAM CCG	20	258	669	1840	100%
NC	HARINGEY CCG	34	316	907	3254	100%
NW	HARROW CCG	15	171	402	1057	100%
NE	HAVERING CCG	17	273	789	2705	100%
NW	HILLINGDON CCG	21	236	571	1141	100%
NW	HOUNSLOW CCG	21	191	438	3248	100%
NC	ISLINGTON CCG	20	238	796	2074	100%
SW	KINGSTON CCG	8	38	127	336	100%
SE	LAMBETH CCG	21	290	693	1916	100%
SE	LEWISHAM CCG	14	98	367	1101	100%
SW	MERTON CCG	13	122	359	762	100%
NE	NEWHAM CCG	29	171	691	1902	100%
NE	REDBRIDGE CCG	18	134	445	1116	100%
SW	RICHMOND CCG	7	140	400	1179	100%
SE	SOUTHWARK CCG	22	256	610	1610	100%
SW	SUTTON CCG	13	126	275	700	100%
NE	TOWER HAMLETS CCG	16	148	395	1126	100%
NE	WALTHAM FOREST CCG	19	127	755	1596	100%
SW	WANDSWORTH CCG	17	207	529	1455	100%
NW	WEST LONDON CCG	19	1065	1957	3230	100%
	Top 5					
NW	WEST LONDON CCG	M (62)	911	1453	1819	Chest pains/ anxiety/dementia
NE	HAVERING CCG	F (55)	119	251	905	Anxiety/bipolar
NC	BARNET CCG	F (69)	116	124	127	Overdoses/suicidal ideation
SW	RICHMOND CCG	F (95)	97	200	647	Anxiety/abnormal behaviour
NC	ENFIELD CCG	F (71)	88	130	166	Pain complaints/Mental Health

5. Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Top 5 themes 2017/18/19

Complaints by subject 2015/18	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Total
Delay	14	26	9	22	33	19	17	40	21	21	17	11	18	268
Conduct	19	19	16	17	25	20	22	23	20	18	23	20	33	275
Road handling	14	10	7	14	9	7	6	10	6	5	8	8	14	118
Treatment	1	7	5	16	8	9	8	14	4	9	13	8	9	111
Non-conveyance	12	0	1	6	1	7	6	3	4	6	5	9	7	67
Totals (above)	60	62	38	75	76	62	59	90	55	59	66	56	81	839
Totals per month	73	86	51	94	85	84	74	102	76	77	77	70	103	1052

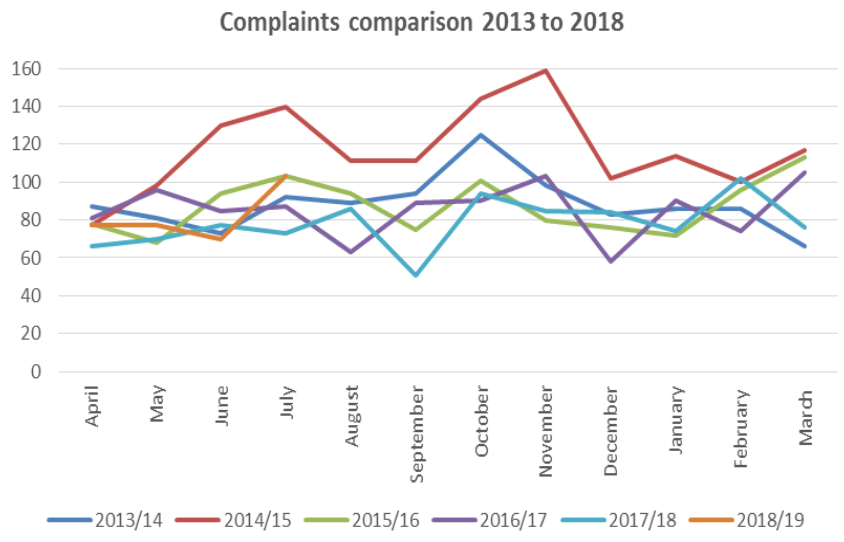
Review of July 2018

- During July we received 103 complaints which represents a 32% increase over June (70).
- The percentage of complaints against the face to face incidents increased to 0.10% (compared to a annual average of 0.08%)
- The increase in complaints has impacted on turnaround in the department (see next slide for data)
- 16 Health Partner Alerts were managed in July. 5 from Acute Trusts, 5 in respect of GP services, 2 from Cath labs, 1 from a community clinician and 3 from other healthcare professionals
- The percentage of complaints regarding conduct and behaviour continue to increase. During July there were 33 in this category against 18 delay complaints.
- The current monthly average for delay complaints is 17 and for conduct and behaviour this is 23.
- By way of comparison, in July 2014 delays accounted for 62 complaints compared to 27 regarding conduct and behaviour (total 140)

Assurance and learning

- On 1 July the *Go-live* of the new pathway trial commenced for fractured neck of femur patients in the south east area to be conveyed directly to St Thomas's not Kings – we have been asked to alert the SEM of any complaints relating to this
- We have flagged the following issue with Control Services that GP's working in Telemedicine have raised a Health Partner Alert regarding call handlers incorrectly asking to speak to the GP directly given that this information had already been provided via the telecare system. This should be sufficient to achieve an apposite priority categorisation.
- We hope to increase the establishment within the department which has been approved by the Trust Board.
- It is also hoped that we will be able to maintain the dedicated officer from the QA team and with additional support from the Medical Directorate we should be able to improve throughput

Complaint numbers July 2013 to July 2018



6. Well Led- Learning from Complaints

Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Complaint response times – July 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
May-18	105	70	77
Jun-18	107	78	70
Jul-18	123	94	103
Totals	789	594	579

- There were 44 complaints that breached the 35 day response target in July
- Of these, 18 complaints are now closed (as at 08/08/18) and 26 remain open.
- Of the remaining 26, 12 are with the Executive office for signature.
- The increase in calls to the Trust during July has impacted on throughput as there are delays in obtaining operational input, QA reports and our own ability as a department to respond to complaints due to staffing issues

Categories of complaint calls

July 2018 call category	Data
ARP Category 1 - 7 minutes mean response time (Life-threatening event)	7
ARP Category 2 - 18 minutes mean response time (Emergency – potentially serious incident)	19
ARP Category 3 - Maximum of 120 minutes (Urgent problem)	23
ARP Category 4 - Maximum of 180 minutes (Less urgent problem)	17
Category A Red 1 - 8 min response	1
Category A Red 2 - 8 min response	1
Category C2 60 min response	1
Not CAD related/Info awaited	34
Total	103

Assurance & Learning

- Currently the Parliamentary Health Service Ombudsman (PHSO) is considering 11 complaint files from 2016 to date
- The PHSO has recently published it's '*severity of justice scale*' which they will use to determine financial recommendations for non-financial loss.
- There are six levels in the scale which ranges for £0 to £10000 depending on which level the complaint falls into.
- PED have recently been invited to participate in the Trust's 'Learning from Experience' Group and will contribute cases where there has been learning or where good practice has been identified.
- There were 408 PALS enquiries in July, of which 91% were responded to within 5 days. There has been a steady increase in PALS cases year on year.
- We will be working with the local management team in the south east to look at ways of encouraging front-line staff to be more responsible for patient property
- There were 29 complaints attributed to EOC during July. The spread across operational areas was 14 south east, 11 north east, 9 south west, 8 north west, 6 north central and 3 EPRR/Central ops
- We continue to achieve 100% acknowledgement target of complaints

Case example

Complaint hosted by Acute Trust seeking why patient wasn't immobilised following a fall from height.

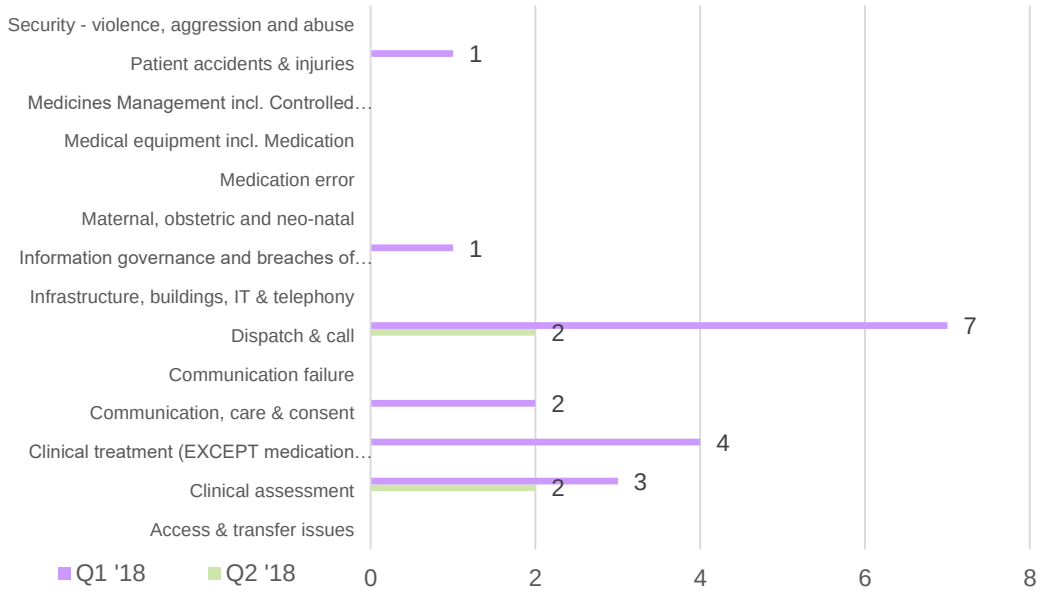
The crew omitted to clearly document any examination findings in relation to their assessment of the patient's cervical spine although they were able to determine the presence of midline thoracic spine tenderness. National clinical guidelines indicate that patients who are alert and have no abnormal neurological findings may be assisted to self-extricate where midline spinal tenderness is present, but a trolley bed should be placed as close to the incident scene as practicable; the patient was instead permitted to walk all the way to the ambulance. The crew then omitted to immobilise the patient using a cervical collar and blocks which is not consistent with national clinical guidance.

Extensive feedback will be given to the crew with a particular focus on spinal assessment and immobilisation.

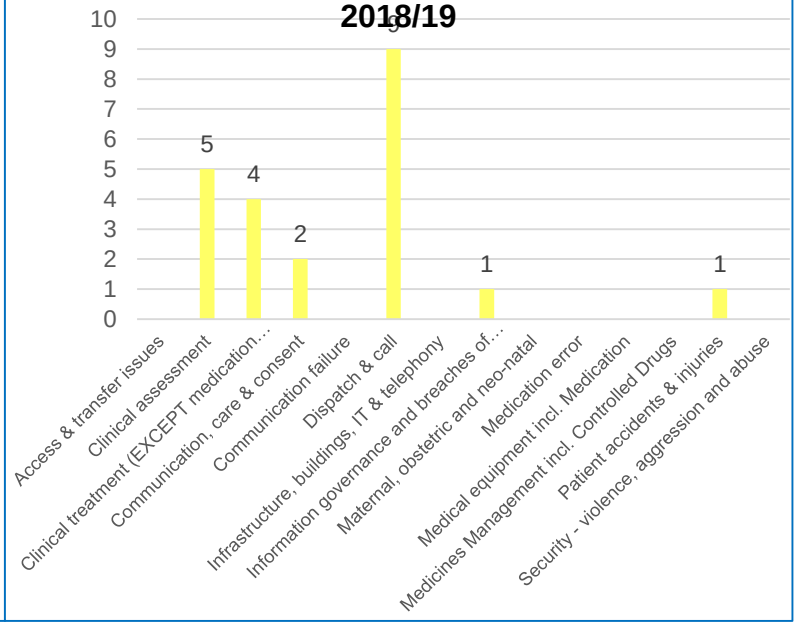
6. WELL-LED - Learning from Incidents

Owner: Michael Ward | Exec Lead: Dr. Trisha Bain

Serious Incidents by Category

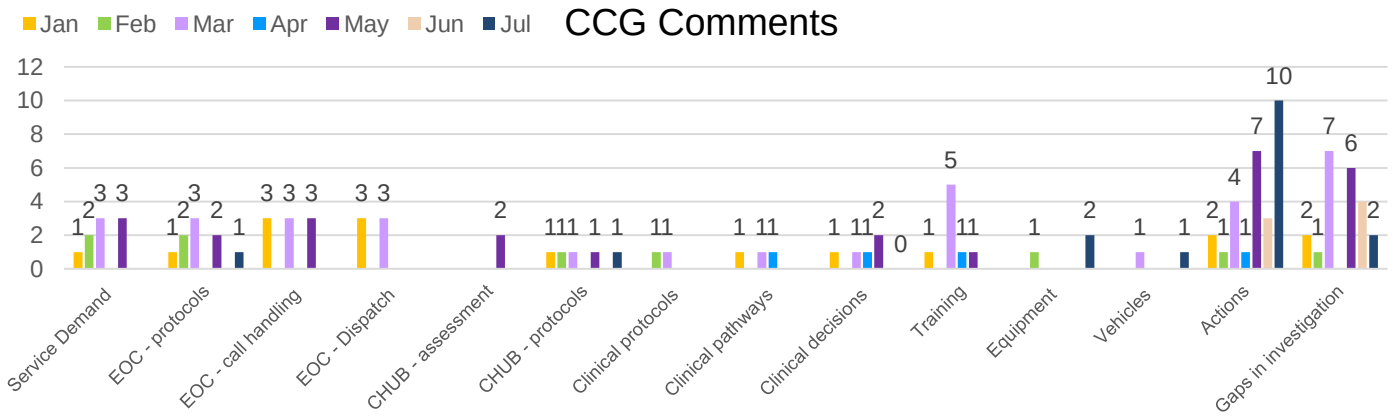


Serious Incidents by Category YTD 2018/19



Dispatch and call management and clinical treatment issues are a recurrent theme across Q1. The majority of call and dispatch concerns relate to response delays however we are noticing an increase in the number of errors made during the management of the 999 call. Clinical assessment issues are largely caused by confirmation bias or situational awareness.

CCG Comments



All questions put to the Trust were answered before the provided deadline. Gaps in the investigation and action plans continues to be a theme in the types of comments received from the CCG. It should be noted that the gaps in the investigations are largely related to wide organisational learning and not included in the terms of reference for the SI which primary looks at the isolated incident. The Trust undertakes a quarterly thematic review to look at system learning and Trust wide learning.
Additionally the gaps in the investigations largely concern questions around internal processes which need to be clarified.

6. Learning From Deaths, Inquests and Claims

Owner: Nicola Foad | Exec Lead: Dr. Fenella Wrigley & Dr. Trisha Bain

Inquests – figures and learning

	2017/18				2018/19			
	Apr-17	May-17	Jun-17	Jul-17	Apr-18	May-18	Jun-18	Jul-18
Total Prevent Future Deaths In-Month	1	1	0	0	0	0	0	1
Total Inquests where LAS asked to give evidence - In-Month	4	6	4	9	5	5	6	6
Total Inquests where LAS asked to give evidence - Year to Date	4	10	14	23	5	10	16	22

Inquests – actions and learning

Her Majesty's Coroner (HMC) issued the Trust with a Prevention of Future Deaths (PFD) report following an Inquest concluded in June 2018. The Trust's response to the report is due on 17th September 2018.

The patient was found at home at home slumped over her walking frame in cardiac arrest. There were a number of calls to the Trust from 17:30 during which time the patient was spoken to and conversing. Contact was lost around 19:37. The Trust did not reach the deceased until 20:49 by which time she was beyond help/deceased. HMC returned a Conclusion of Natural Causes.

The matters of concern set out by HMC in his PFD report are as follows;
1) The LAS failed to make a relevant and proper note of the symptoms of the deceased when these were phoned through and as a result the clinicians made an incorrect priority decisions which caused delay in a timely attendance.
2) The LAS breached its own pre-set guidelines in failing to return a call to the patient to take further details of her medical condition.

Claims – figures and learning

The NHS Resolution Quarterly Report, Q1 of 18/19 for the Clinical Negligence Scheme for Trusts (table 1) and the Liabilities to Third Parties Scheme for Trusts (table 2) shows the following:-

No. of Claims	Total Claim	Total Damages Reserve	Total Claimant Costs Reserve	Total Defence Costs Reserve	Total Outstanding Estimate	Total Payments
44	£65,817,125	£57,839,912	£6,391,258	£1,585,955	£57,060,624	£8,756,500

No of claims	Total Claim	Damages Reserve	Claimant Costs Reserve	Defence Costs Reserve	Outstanding Estimate	NHSLA Funded Payments	Total Payments
55	£2,977,164	£2,076,295	£693,469	£207,400	£2,254,765	£692,854	£722,399

Claims – actions and learning

- Ten new claims have been opened this month, five employer liability claims, four clinical negligence claims and one public liability claims.
- The employer liability claims relate to three cases of defective work equipment (front facing chair in rear of ambulance, rear step into ambulance and broken casing around overhead power lead on Station), one case involving manual handling (maneuvering a trolley bed with only two poles) and one case involving the fall of a wheelchair user.
- The clinical negligence claims relate to two cases of inappropriate treatment, one case of failure to convey and one case concerning maternity/obstetrics.
- The public liability claim was for forced entry into an empty property.
- Seven claims were settled in July, three non-clinical and four clinical. Of those claims three were settled with damages (two clinical and one non-clinical) and four without damages (three clinical and one non-clinical).

7. Quality Priorities, Projects & Programme

Owner: Various | Executive Lead: Dr. Trisha Bain

This section shows a RAG status summary for all Quality Priorities and Quality Directorate Projects.
An in-depth report will be reviewed by the Quality and Oversight Group (QOG). All relevant Directors and departments are asked for regular updates and assurances that the Quality Priorities are progressing as planned. Escalation of occurs though QOG to the Quality and Assurance Committee.
The Directorate Projects are also monitored via the Project Management Office. Quarterly updates and assurance are provided by the leads and these will also be monitored via the Quality Oversight Group.

Quality Priorities 2018/19

		Current RAG
SAFE	Target 1: 90% implementation of Health Assure functionality by December 2018. Planned actions progressing against project milestones.	
	Target 2: improve hospital handover delays; 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: 100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations. The current estates plan shows delivery for all the stations up to September 2018 plus Waterloo which will be done by November.	
	Target 4: Increase the number of defibrillator downloads year-on-year to 20% by end of 2019. Most recent figures (May 2018) showed downloads at 15%. Planned actions progressing	
EFFECTIVE	Target 1: Root and branch independent training review completed. Implementation plan developed by September 2018.	
	Target 2: New quality Indicators developed and being reported via performance scorecards by December 2018.	
	Target 3: QI training plan agreed and 100% of identified key cohorts trained by September 2018. First cohort (30 staff) commence full QSIR training in July 18. Half a day QI training on trust management essentials from August 2018.	
	Target 4: At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019.	
CARING	Target 1: Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline.	
	Target 2: Evidence of patient involvement in all QI and service re-design programmes.	
	Target 3: Reduce the number of ambulance conveyance (20%). Employ two whole time equivalent practice developments midwives and deliver a training programme 2018-19. Midwives employed.	
RESPONSIVE	Target 1: We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP.	
	Target 2: Over 75% of complaints letter being responded to within the 35 day timescale. In June 2018, 82% of complaints were responded to within the 35 day timescale.	
WELL LED	Target 1: 85% compliance with statutory and Mandatory training 2018-19.	
	Target 2: leadership programme developed and implementation plan in place.	
	Target 3: continue to implement the P&OD strategy and progress implementation of the Quality Improvement Plan and Quality Improvement capability across the organisation.	

Directorate Projects

	Mental Health Nurses	End of Life	Midwives Project	Falls	HealthAssure	QSIR Training
Status						

RAG	ID	Title	Programme	Stage	Project Manager	Milestone Progress
	PMO-024	Health Assure	HealthAssure	3 Delivery	Helen Woolford	
	PMO-027	Midwives project	Pioneering Services	1 Start Up	Amanda Mansfield	
	PMO-031	Mental Health Nurses	Pioneering Services	2 Planning	Briony Sloper	
	PMO-043	End of Life	Pioneering Services	1 Start Up	Briony Sloper	
	PMO-044	Falls	Pioneering Services	1 Start Up	Tim Edwards	

- Metric on or ahead of target | Programme or Committee on track
- Metric off target by <10% | Programme or Committee off plan but no escalation
- Metric off target by >10% | Programme Escalation | Committee Escalation

8. Quality Risk Register

Owner: Various| Exec Lead: Dr. Trisha Bain

Risk Summary:

The highest risk on the Quality Risk Register:
Risk 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.

Controls for this risk include:
- *Manual handling group and policy in place*
- *Training for staff*
- *Monitoring of incidents reported monthly*
- *Equipment to support staff being available*
- *Risk assessments in place for high risk activities*

Quality Risks this month

	Risk Rating	Risk Level	Risks	
	15-25	High	1	7%
	8-12	Significant	2	13%
	4-6	Moderate	8	53%
	1-3	Low	4	27%
		Total	15	

Commentary:

There are currently 15 risk on the Quality Directorate Risk Register from the following departments:

- Quality Governance & Assurance
- Health & Safety
- PPIE
- Patient Experience

The directorate are currently working on updating all risks and ensuring that risks from all departments are captured on this register. This will also include sector level quality risks.

There will also be a separate report for the Corporate Risks Register.

Quality Risks this month

Risk Rating	Proportion	+ / - Last Month	
High	7%	◀▶	1
Significant	13%	◀▶	2
Moderate	8%	◀▶	8
Low	4%	◀▶	4

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	25 September 2018			
Report title:	CAD Action Plan Status Report			
Agenda item:	Additional report, circulated for information and assurance only			
Report Author(s):	Ross Fullerton, Chief Information Officer			
Presented by:	Ross Fullerton, Chief Information Officer			
History:	Computer Aided Dispatch (CAD) / Information Management & Technology (IM&T) Resilience report considered by the Board at its meeting on 27 June 2017 (ref: TB/17/34)			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The report into the outage of the 2017 NYE LAS Computer Aided Dispatch system published on 27 June 2017 identified a series of actions to be completed by the London Ambulance Service NHS Trust, NHS England and the National Ambulance Resilience Unit (NARU).

The actions identified have all been completed successfully as defined in this paper.

Recommendation(s):

The Board is asked to note the content of the paper

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	☒

Review	ID	Recommendation in report	Owner	Due date	Priority	Status	Progress against timeline
RCA	R13	Empty the Recycle Bin	Chief Information Officer	Feb-17	High	Complete	
RCA	R14	Disable the Recycle Bin functionality	Chief Information Officer	Feb-17	High	Complete	
RCA	R15	Perform an OP66 on 21st and 22nd February to allow the above.	Chief Information Officer	Feb-17	High	Complete	
RCA	R18	Plan regular maintenance slots, at least an average of 2.5 a year to cover all five operational shifts every two years (NB, current approach is to perform five per year which is generally unsustainable).	Chief Information Officer	Feb-17	High	Complete	Planned schedule for system maintenance developed and agreed.
RCA	R8	LAS and Northrop Grumman must determine a detailed monitoring regime required to monitor all system resources. The overall systems management regime must be defined at lower level of detail than at present and the needs of LAS set out contractually.	Chief Information Officer	Feb-17	High	Complete	Detailed monitoring in place
RCA	R9	System maintenance must be conducted regularly.	Chief Information Officer	Feb-17	High	Complete	Replaced by Review 2 action IT1
RCA	R10	Whenever a system outage occurs there should be full checklist of data files, thresholds, and parameters etc. that are validated before a return to service. Whilst there is an existing process this should be reviewed, with NG, Oracle and other suppliers for completeness.	Chief Information Officer	Mar-17	High	Complete	Checklist in place
RCA	R17	Review all system thresholds with Oracle and NG and amend those requiring it.	Chief Information Officer	Mar-17	High	Complete	Review with suppliers complete and ongoing review now held quarterly
RCA	R16	Update the CAD system with recent patches.	Chief Information Officer	Apr-17	High	Complete	Whilst the system has been updated there continues to be patches released from Microsoft. This will be managed on an ongoing basis.
Review 1	R1	Regular refresher training must take place for EOC and operational crews (including NETS) to ensure they are familiar with the process when EOC is working on paper - EOC depend on information from crews.	Head of Control Services	May-17	High	Complete	Part of CSR for control room staff and a video published on the Pulse.
Review 1	R2	Laminated cards to be provided as an aide-memoire to EOC staff to ensure they are clear on the minimum fields that must be completed on the CRF . This was a recommendation following a previous CAD outage and has been proved effective and should continue	Head of Control Services	May-17	High	Complete	Cards issued
Review 1	R3	The watch management team on duty at the time of the fall-back should be responsible for auditing the quality of CRFs being completed to provide real-time feedback and therefore real time improvement.	Head of Control Services	May-17	High	Complete	This process was instigated for the pre-planned CAD takedown on 21st February and evidence of CRF completion compliance was witnessed by the Medical Director
Review 1	R5	When operational resources are dispatched to a call, the unique identifier should also be included and used as their CAD number on the PRF. This will enable correlation of paperwork after the incident.	Head of Control Services	May-17	High	Complete	Part of revised process
Review 1	R6	Cancellation times should be recorded on CRFs so that delays can be correctly reviewed	Head of Control Services	May-17	High	Complete	Part of revised process
Review 1	R7	Planning for periods of unprecedented or sustained demand should include adequate clinical support and leadership	Head of Clinical Hub	May-17	High	Complete	Included in operational planning
RCA	R11	The relationship between LAS and Oracle through Northrop Grumman must be reviewed alongside the implementation of other recommendations.	Chief Information Officer	Jun-17	High	Complete	Review complete and governance meetings adjusted
RCA	R21	Mid to long term, address gaps in problem management – RCA[2], capturing lessons learnt, updating procedures and maintaining known errors database.	Chief Information Officer	Jun-17	High	Complete - superseded	Superseded by Review 2 action IT5.

Review 1	R4	The CRF unique identifier should be added to the call log instead of adding a CAD number after the event. This will prevent calls being tied up incorrectly and would reduce the amount of work/manual entering required following a fall-back test of system failure	Head of Control Services	Jun-17	High	Complete	Included in paper operations processes
Review 2	IT1	Schedule and perform regular maintenance and health checks across the entire CAD solution.	Chief Information Officer	Jun-17	High	Complete	Regular maintenance performed across CAD system and managed between EOC and IM&T
Review 2	IT3	Strengthen resilience across practices throughout the Trust through a single accountable owner for IM&T on the Trust Board	LAS Chair	Jun-17	High	Complete	Chief Information Officer attends Trust Board
Review 2	IT2	Define, agree and publish EOC service resilience levels.	Head of Control Services and Chief Information Officer	Jul-17	High	Complete	Documented and signed off across control services and IM&T
Review 2	IT4	Review the size of the CAD technical team to ensure that the right capacity and capability are in place to meet service levels.	Chief Information Officer	Jul-17	High	Complete	Additional roles have been identified and filled
RCA	R12	The relationship between LAS IM&T[1] and NG and LAS IM&T and other system suppliers must be reviewed and improved such that LAS has key information regarding the systems that deliver services to LAS.	Chief Information Officer	Jul-17	High	Complete	Review complete and governance meetings adjusted
RCA	R22	Review the concerns expressed in this report on shift change and roster deployment	Director of Operations and CIO	Jul-17	High	Complete	System reporting demonstrates there is no system performance issue during shift handover.
Review 3	E10	Business continuity and resilience is a trust-wide holistic activity and should be re-aligned as part of wider corporate governance processes.	Head of Business Continuity	Jul-17	Medium	Complete	Trust wide business continuity plans in place
Review 3	E4	Investigate options for staff to multi-skill and assess the benefit of that multi skilling to provide wider support to EOC	Head of Control Services	Jul-17	Medium	Complete	Complete. Not possible due to licensing restrictions; alternative of training non-EOC staff in non-EMD activities has been completed as an alternative.
Review 3	E5	Reiterate and ensure clarity of understanding of the role of runners at both sites	Head of Control Services	Jul-17	High	Complete	Roles clarified and communicated in new paper operations process
Review 3	E6	Roles for non-EOC trained personnel should be clearly defined within the contingency arrangements	Head of Control Services	Jul-17	Low	Complete	Roles clarified and communicated in new paper operations process
Review 4	H1	All logs and records are completed using best practice for incident logging, including writing out in full, on first use, before the use of acronyms and initials to ensure clarity and that language is clear and local jargon and non-standard terms are avoided.	NHS England	Jul-17	Medium	Complete	NHS01 group to agree a common process for logging on call issues. NHS01 group to agree common terminology for on call logs. Initial NHS01 meeting held on 5 April and it was agreed that acronyms would not be used in call logs unless explained first. List of agreed acronyms has been added to the on call log template to ensure consistency. Ongoing NHS01 meetings will ensure that there is continued consistency around logging and terminology.
Review 4	H2	To ensure that there is a clear process for the management of reported CAD outages for first on call including when to escalate, who to escalate to, other parties to inform and expected actions. This involves commissioner oversight of Serious Incidents (SIs) generated as a result of CAD outages.	NHS England	Jul-17	Medium	Complete	NHS01 group to develop an algorithm /flowchart for the management of reported CAD outages. Draft algorithm /flowchart has been developed which outlines who needs to be contacted and what actions are expected at each stage of the outage, eg when a teleconference should be held with partners.
Review 2	IT6	Undertake non-pressurised simulations to ensure staff are familiar with critical incident management processes.	Head of Control Services and Chief Information Officer	Aug-17	High	Complete	Succesful paper working in February, April, August plus planned OP66 events in October and December. No IT changes planned in December OP66.

Review 2	IT7	Explore what a fully managed CommandPoint system would entail, cost and whether that would meet defined service levels.	Chief Information Officer	Aug-17 Low	Complete	Complete. LAS CAD comprises CommandPoint and several 10+ other systems. Fully managed CP service would not include the other systems and therefore has minimal impact on service risk. A clearer set of processes and governance (as per other actions) is appropriate.
Review 2	IT5	Review and improve the technical operating model to meet agreed service levels with a particular focus on service management, change management, release management, technical architecture and supplier management.	Chief Information Officer	Sep-17 High	Complete	IM&T organisation restructure complete. Responsibilities clearly set out across IM&T
Review 2	IT8	Improve monitoring of the CAD landscape to improve communication between IM&T and EOC functions	Head of Control Services and Chief Information Officer	Sep-17 Medium	In progress	System monitoring in place
Review 2	IT9	Review and improve critical incident management process for the whole of the EOC service including all functions	Head of Control Services and EPRR	Sep-17 High	In progress	Roles clarified and communicated in new paper operations process
Review 3	E7	All revised contingency plans are subjected to a rigorous testing and exercise programme supported by structured training for all levels of staff including Golds.	EPRR/Head of Business Continuity	Sep-17 High	In progress	Plan successfully tested in Dec 2017
Review 3	E8	Preparation and planning for high impact events such as New Year Eve and Notting Hill Carnival should, where possible, include planned takedowns of CAD as part of the risk management process.	EPRR/Head of Control Services	Sep-17 High	Complete	The planned schedule for paper operations exercising includes key dates. All watches have been through an exercise this calendar year.
Review 3	E9	Escalation processes for alerting partners and commissioners about CAD and other LAS system outages should be reviewed.	Head of Control services	Sep-17 Medium	Complete	Process clarified and communicated in new paper operations process
RCA	R20	Update the Oracle version to current (or one below as a default)	Chief Information Officer	Nov-17 Medium	Complete	Oracle version is current
Review 3	E13	EOC staff training records need to be reviewed and consolidated in one place prior to being integrated into service wide processes.	Head of Control services	Nov-17 High	Complete	Training records captured and recorded in Trust systems
Review 3	E14	An action plan needs to be developed to address the log keeping issues highlighted as part of this report	LAS EPRR	Nov-17 High	Complete	Loggist courses have being run by NHSE to increase capacity and quality of logging.
Review 3	E15	Escalation procedures for call management by other agencies including NHS trusts need to be reviewed and protocols agree to ensure calls can be sent back to the affected trust in a timely and appropriate manner.	NARU	Nov-17 Medium	Complete	A national reviewhas been completed and shared to to the 10 ambulance Trusts, through the National Director of Operations Group (NDOG).
Review 3	E16	Escalation, notification and management processes within and beyond NHS England (London) need to be improved.	NHSE EPRR	Nov-17 High	Complete	An algorithm/flowchart has been developed for NHS01s to use which outlines what actions need to be taken following notification from LAS of a IT/CAD issue. It outlines who needs to be contacted internally and externally and what actions are expected at each stage of an outage, eg when a teleconference should be held with partners and who should be involved (NHS Improvement, national EPRR team). The flowchart is undergoing consultation with the NHS01s group before it is formally signed off.
Review 3	E17	There should be a national resilience exercise to test mutual aid arrangements which should include BT	NARU/NHSE EPRR	Nov-17 Medium	In progress	The business as usual process for testing mutual aid agreements has been agreed and built into EPRR standard testing
Review 3	E3	Investigate options for other technical solutions to be activated when main CAD goes down 1) locally within LAS and 2) more widely	Chief Information Officer	Nov-17 High	Complete	No suitable has been identified, this has been validated by other Trusts at national IT leads meeting

Review 4	H3	To determine timescales and/or triggers for outages when further reporting and possible further investigation/root cause analysis is undertaken and identification of any impacts. Trend analysis of CAD outages to be undertaken.	NHS England	Nov-17	Medium	Complete	Across the country the national EPRR team are assessing all CAD systems for ambulance trusts to determine triggers for outages and any possible root causes. This will complete in November 2017. Completed by NARU
Review 2	IT11	Annually review the current and future service requirements ensuring they are aligned to Trust and NHS strategic direction	Chief Information Officer	Nov-17	Medium	Complete	Quarterly reviews scheduled
RCA	R19	Update the CAD servers to a modern, supported platform that replaces the existing Itanium servers	Chief Information Officer	Nov-17	Medium	Complete - superseded	Superseded by Review 2 action IT10.
Review 3	E12	The training regime for all staff groups including competency training as part of the promotion process should be revised to better equip staff to deal with CAD outages.	Head of Control Services	Nov-17	Low	Complete	The programme has been reviewed delvired in Core Skills Refresher training. It is included in assessment centres for promotion.
Review 4	H4	As part of the regional assurance done by organisations which have an oversight and assurance role of London's Ambulance Service, monitoring of the risks associated with CAD outages should be strengthened for winter periods where peak demand is expected.	NHS England	Nov-17	High	Complete	The winter assurance process led by NHS England has been updated to ensure that risks associated with the CAD system at LAS are incorporated.
Review 2	IT12	Engage a full time CIO at industry standard remunerate rates	LAS Chief Executive	Jan-18	High	Complete	CIO has been in post since May 2017
Review 3	E1	A complete revision to be undertaken of all contingency arrangements related to CAD outages and revise contingency policy OP66 and OP68.	LAS Business Continuity Lead	Mar-18	High	Complete	New procedures have been completed and successfully exercised during two planned paper working events.
Review 3	E11	OP066/068 training lesson plans and learner outcomes need to be updated to accurately reflect changes in operational procedures.	Head of Control Services	Mar-18	Medium	Complete	New procedures have been completed and successfully exercised during two planned paper working events.
Review 3	E2	Articulate clearly within OP066, OP068 the command and control structure	LAS Business Continuity Lead and Head of Control Services	Mar-18	High	Complete	The use of Silver and functional bronzes now forms part of the plan, and was used for the 21st Feb 2017 OP66 and was used again during the planned outage 26/27 April.
Review 2	IT10	Increase resilience, capacity and redundancy of CAD system architecture	Chief Information Officer	May-18	Low	Complete	CAD architecture is aligned to current demand. A rolling programme of enhancements is underway to continue ensureing that alignment.

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board				
Date of meeting:	25 September 2018				
Report title:	Business Continuity Update				
Agenda item:	Additional report, circulated for information and assurance only				
Report Author(s):	Sarah Rodenhurst-Banks, Head of Business Continuity				
Presented by:	Sarah Rodenhurst-Banks, Head of Business Continuity				
History:	Presented to Audit Committee meeting on 4 September 2018 (ref: AC/18/47)				
Status:	☒	**Assurance**	☐	**Discussion**	
	☐	**Decision**	☐	**Information**	

Background / Purpose:

The purpose of this paper is to provide an update on the current position of business continuity at LAS in relation to statutory requirements, Core Standard 9 (NHSE EPRR Assurance Framework, business continuity) and alignment to ISO 22301:2012

Recommendation(s):

The Board is asked to note the content of the paper

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	☒

Business Continuity Management Update

Introduction

1. All NHS organisations have a duty, under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012, to have contingency arrangements in place, these requirements are also set out in the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

2. Having a robust business continuity management framework allows an organisation to maintain standards during any disruption, or to recover to these standards as soon as possible

Background

3. Inspections undertaken by the Care Quality Commission (CQC), and reviews completed by NHS England and KPMG in 2016, highlighted gaps in business continuity management (BCM) and recommended that business continuity be a key area for improvement within the organisation

4. To address the gap, a Head of Business Continuity was appointed in November 2016 to work with the Trust on delivering a robust BCM plan and to ensure that the Trust's business continuity arrangements align to British Standard ISO 22301:2012, upon which the NHS England Business Continuity Management Framework (Service Resilience) is based. This is also the standard to which all NHS organisations, and providers of NHS funded care, should aspire to

5. A two year programme of work was established in order to meet statutory requirements, Core Standard 9 (NHSE EPRR Assurance Framework, business continuity) and align to ISO 22301. The actions from the work plan are set out in Appendix 1

Current Position

6. The following actions have been completed to date:

    6.1 A review of business continuity within the organisation and the development of a work programme to address the gaps

    6.2 Review and update of Business Continuity Management Policy

    6.3 Identification of business continuity leads within all departments of the Trust, and establishment of a formal business continuity working group and strategy group

    6.4 Development of a Trust business continuity management plan, and business continuity framework to deliver a consistent approach to business continuity management

    6.5 Completion of a strategic business impact analysis (BIA), local BIAs and business continuity plans for all Trust departments using a standardised template, and development of central data sheets on critical resources and estate

6.6 Implementation of a business continuity training programme for all departments, development of competency based training via an e-learning package for business continuity leads and an e-learning overview for all staff

6.7 Implementation of a business continuity exercise programme to test local and Trust plans. Seven exercise have been conducted to date, details in Appendix 2

6.8 Development of a business continuity plan for NHS 111/IUC

6.9 In addition a review has been conducted of the business continuity arrangements for the emergency operations centres (EOC). The paper operation plan (OP66) has been revised and updated, and an EOC total compromise fall back plan has been developed

Business Continuity Work Plan

7. The following work is currently being undertaken for business continuity:

7.1 Implementation of a business continuity communication plan throughout August and September to raise awareness of business continuity and direct staff to business continuity resources

7.2 Development of a business continuity work plan for 2018/19

7.3 Further development of the business continuity plans for Control Services

7.4 Development of a process for review of business continuity plans of contractors and suppliers

7.5 Development of a process to monitor standards of business continuity plans through an annual audit of compliance and testing

7.6 Annual programme of review and updates of business impact analysis and business continuity plans

7.7 Process for business continuity review/assessment of new projects and initiatives

7.8 Review of Trust requirements to work towards compliance with ISO 22301:2012

7.9 Review of the business continuity risks associated with Brexit, working with NHS England on any related National projects

7.10 Review of future business continuity staffing and resource requirements

8. In addition NHSE Assurance Standards 2018/19 were published on 1st August 2018 and include a number of new standards for business continuity in the assessment process which will be included in the 2018/19 business continuity work plan:

8.1 Organisations demonstrate compliance with the NHS Digital IG toolkit on an annual basis.

8.2 The organisation has a process for internal audit of business continuity, and outcomes are included in the report to the Board.

8.3 The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers' arrangements work with their own.

8.4 Reports on business continuity are provided to the Board annually.

9. Work has been commenced to review processes required in order to meet the additional 2018/19 assurance standards

Conclusion

10. The actions required to achieve compliance against the 2017/18 NHSE EPRR Assurance Framework, Core Standard 9, Business Continuity, have been completed ahead of the assurance review in October 2018

11. The Emergency Operations Centre Paper Operations Plan has been revised, tested and implemented as recommended in the New Year's Day Computer Aided Dispatch System incident review

12. Actions are in development to achieve compliance against the 2018/19 NHSE EPRR Assurance Framework, Core Standard 9, Business Continuity, a number of these will be in progress before the review in October 2018

13. Additional work has been undertaken and is in progress to work towards compliance with ISO 22301:2012

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Head of Business Continuity

Appendices

Appendix 1: Business Continuity Work plan Based on NHSE Core Standards (EPRR Assurance):

The core standards for business continuity and current status against these standards are identified in the table below:

	Core Standard	Action	Status
1	Organisations have an annual work programme for EPPR, including business continuity	A business continuity work plan and framework have been developed to deliver a consistent approach to BCM	
2	Organisations have an overarching framework and/or policy which sets out the requirements of business continuity	A policy and framework have been developed and approved by the Business Continuity Steering Group	
3	Duty to maintain emergency and business continuity plans. To have corporate and service level business continuity plans with effective arrangements in place to respond to any incident and maintain critical functions	A business continuity management plan has been developed and tested through a table top exercise with LAS and NHSE involved	
4	Appointment of one or more persons with the appropriate authority and competencies to be responsible for the management of business continuity	Head of Business Continuity appointed and local business continuity leads have been identified for all departments in the organisation	
5	Completion of adequate business impact analysis (BIAs) across the service	Local business impact assessments (BIAs) have been conducted across the organisation and are currently undergoing an annual review	
6	Development of business continuity plans, providing details of the overall control measures in place to respond to a disruptive incident and resume activities within their recovery time objective	Local business continuity plans have been developed and are currently undergoing testing and annual review	
7	Top management should provide evidence of its commitment to the development and implementation of the business continuity management system and continually improve its effectiveness	The Business Continuity Steering Group meets quarterly to review outputs from the working group meetings and the decision making process for business continuity plans and is attended by senior representatives from all departments within the organisation	

8	The organisation should appoint one or more specific management representatives who, irrespective of other responsibilities, should have defined roles, responsibilities and authority for business continuity management	The Business Continuity Working Group meets bi-monthly to develop and agree plans, review interdependencies, training and exercising schedules and is attended by local business continuity leads	
9	Provide evidence of embedding business continuity management in the culture of the organisation through training and awareness	A business continuity training programme has been implemented, delivering training and testing to all departments within the organisation. An e-learning package has been developed and implemented in August 2018	
10	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	A business continuity exercise programme has been implemented, 7 exercises have been undertaken in the past year	
11	Provide evidence of embedding business continuity management in the culture of the organisation through communication	A business continuity awareness campaign is under development with a planned implementation of August/September 2018	
12	Have an effective risk management process for business continuity risks	The business continuity risk management process has been added to the Business Continuity Framework	
13	Any commissioned services and subcontractors should have robust business continuity planning arrangements in place aligned to ISO22301	Business continuity arrangements are requested and reviewed as part of the contracting process. This process is under review	

Appendix 2: Business Continuity Exercises

Date	Exercise	Plan exercised	Participants
18.07.17	Bow Power Failure	Local plans, Scheduling, VRC, Fleet, CSU	Scheduling, CSU, VRC, QA, EOC, IM&T, Fleet
10.10.17	EOC Command and Control	Paper Operations Command and Control	Strategic Command, EPRR, IDM, EOC – Watch Managers, General Managers, CHUB, Duty Engineer, IM&T, Loggists
18.04.18	EOC Paper Operations	EOC Paper Operations Plan	Strategic Command, EPRR, IDM, EOC – Watch Managers, General Managers, CHUB, Loggists
24.05.18	Trust Command and Control	Business Continuity Management Plan	Strategic and Tactical Command, Medical, EOC, IDM, IRO, NHSE, IM&T, Estates, HS&S
30.05.18	Scheduling compromise	Scheduling local BC plan	Scheduling, EPRR, IM&T
28.06.18	EOC Total Compromise	EOC Total Compromise plan	Strategic and Tactical Command, EOC, EPRR, CAD support, IDM, CSU, Estates, Projects, NHSE
03.07.18	LAS 111	111 Business Continuity Plans	111, Projects, IM&T, Estates